University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	15/07/2025
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd
Apologies	Alison Tattersall
In attendance	Lauren Anderson, Corporate Governance and Risk Manager (from 9:30) (shadowing Craig Machell)

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 13 May 2025** Approve the minutes of the previous meeting held on 13 May 2025
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Audit and Risk Committee** Keith Evans, Chair
5.2	9:25	**Briefing from the Chair of the Finance and Investment Committee** Dave Bennett, Chair
5.3	9:30	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.4	9:35	**Briefing from the Chair of the Quality Committee** Tim Peachey, Chair including Maternity and Neonatal Safety 2024-25 Quarter 4 Report and Maternity and Neonatal Workforce Report
5.5	9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.6 **Performance KPI Report for Month 2**

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

5.7 **Break**

10:40

5.8 **Finance Report for Month 2**

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

5.9 **ICS Operational Delivery Report for Month 2**

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

5.10 **People Report for Month 2**

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

5.11 **Freedom to Speak Up Report**

11:20 Review and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

5.12 **Infection Prevention and Control 2024-25 Annual Report**

11:30 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Julian Sutton, Clinical Lead, Department of Infection/Julie Brooks, Deputy Director of Infection Prevention and Control

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

11:40 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2025-26 Quarter 1 Review**

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

6.2 **Research and Development Plan 2025-26**

12:00 Discuss and approve the plan
Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Christopher Kipps, Clinical Director of R&D/Karen Underwood, Director of R&D/Laura Purandare, Deputy Director of R&D

6.3 **Board Assurance Framework (BAF) Update and Risk Appetite Statement**

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

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

7.1 **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

7.2 **Review of Standing Financial Instructions 2025**

12:35 Review and approve the SFIs
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Phil Bunting, Director of Operational Finance

8 **Any other business**

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

9 **Note the date of the next meeting: 9 September 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**

12:45

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Agenda links to the Board Assurance Framework (BAF)

15 July 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)	4 x 4 16	3 x 2 6	Apr 27
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 4 12	3 x 2 6	Mar 27
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 30
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 30
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 4 8	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 2	1a, 1b, 1c			x
5.8	Finance Report for Month 2	5a			x
5.9	ICS Finance Report for Month 2	5a			x
5.10	People Report for Month 2	3a, 3b, 3c			x
5.11	Freedom to Speak Up Report	3b			x
5.12	Infection Prevention and Control 2024-25 Annual Report	1c			x
5.13	Guardian of Safe Working Hours Quarterly Report	3b			x
6.1	Corporate Objectives 2025-26 Quarter 1 Review	All			x
6.2	Research and Development Plan 2025-26	2a	x		

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	13/05/2025
Time	9:00 – 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) Diana Eccles, NED (DE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Duncan Linning-Karp, Interim Chief Operating Officer (DL-K) David Liverseidge, NED (DL) Tim Peachey, NED (TP)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Ceri Connor, Director of OD and Inclusion (CC) (item 5.11) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.2) Diana Hulbert, Guardian of Safe working Hours and Emergency Department Consultant (DH) (item 5.12) Kelly Kent, Head of Strategy and Partnerships (KK) (item 6.1) Jenny Milner, Associate Director of Patient Experience (JM) (item 5.13) Natasha Watts, Deputy Chief Nursing Officer (NW) (item 5.13) Helena Blake, Head of Clinical Quality Assurance (shadowing G Byrne) Raquel Domene Luque, Interim Lead Matron, Ophthalmology (shadowing G Byrne) 1 governor (observing) 6 members of staff (observing) 3 members of the public (observing)
Apologies	Keith Evans, Deputy Chair and NED (KE) Alison Tattersall, NED (AT)

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

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

It was noted that apologies had been received from Keith Evans and Alison Tattersall.

2. Patient Story

Item postponed to the next meeting.

3. Minutes of the Previous Meeting held on 11 March 2025

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 11 March 2025.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted. It was noted that action 1218 could be closed.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

Ian Howard was invited to present the Committee Chair's Report in respect of the meeting held on 17 March 2025, the content of which was noted. It was further noted that:

- The committee considered the going concern assessment in respect of the 2024/25 annual accounts and agreed that it was appropriate that the accounts be prepared on a going concern basis.
- The committee additionally noted that there had been no significant issues raised by the Trust's external auditors.
- The committee received a report on losses and special payments during 2024/25, noting that these payments generally related to lost patient property.
- An update was received in respect of Information Governance. The Trust – in common with most others – was not expected to meet the standards set out in the Data Security and Protection Toolkit due to the introduction of the Cyber Assurance Framework as part of the Toolkit requirements.

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 24 March and 28 April 2025, the content of which was noted. It was further noted that:

- The committee reviewed the Finance Report for Month 12 (item 5.8), noting that the Trust had achieved its forecast deficit of £7m for 2024/25 following the receipt of revenue support. Furthermore, the Trust had achieved £85.3m of Cost Improvement Programme delivery and Elective Recovery performance of 127%. Nonetheless, the Trust's underlying deficit was circa £75m.
- The Trust's cash position remained challenging with the Trust likely to require revenue support during either the first or second quarters of 2025/26.
- The committee reviewed the Trust's proposed 2025/26 plan during March 2025 and noted that there were no material changes between the draft reviewed and that submitted on 23 April 2025.
- The committee supported a proposal for the Trust to participate in the elective hub at Winchester.

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 March and 25 April 2025, the content of which was noted. It was further noted that:

- The committee received a briefing in respect of the Staff Survey 2024 (item 5.11).
- The committee reviewed the People Report for Month 12 (item 5.10), noting that the Trust had ended the year 373 whole-time-equivalents (WTE) above plan. This was largely due to the reductions in patients having no criteria to reside and mental health patients not materialising. In addition, there had been higher than normal use of bank staff in March 2025 and lower than anticipated staff turnover.

- An update in respect of the planned organisational restructuring, including regarding the Equality and Quality Impact Assessment process being developed.
- It was considered likely that the delivery of the Trust's 2025/26 workforce plan would necessitate additional workforce controls. It would be important to ensure that appropriate support was provided to staff in managing at a time of increased demand, financial pressures, and a reducing workforce.

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 17 March 2025, the content of which was noted. It was further noted that:

- The committee reviewed the Trust's quality indicators, which continued to indicate that the organisation was under pressure.
- Following an incident at Derriford Hospital in Plymouth on 4 March 2022 whereby a member of the public had suffered fatal injuries due to the downwash from a landing helicopter, the Trust had commissioned a review of its own safety arrangements. It was noted that some additional safety measures would be required.
- A visit by NHS South East Region to the Princess Anne Hospital in February 2025 had provided some positive feedback about the service.

The Maternity and Neonatal Safety 2024/25 Quarter 3 Report was noted. It was further noted that:

- The report had been reviewed by the Quality Committee at its meeting held on 17 March 2025.
- The proportion of births via caesarean section remained high at over 40%, with late requests in particular placing additional pressure on theatre capacity.
- Following successful recruitment of additional staff in late 2024, operational pressures had reduced substantially compared with the previous situation.
- A never event relating to a missing swab was under investigation.
- The Trust was currently over establishment in terms of its number of midwives and expected to be staffed above the requirement indicated by the anticipated birthrate for the area by the end of 2025/26.

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:

- Significant reorganisations of NHS England and integrated care boards (ICBs) had been announced. NHS England was to be abolished, and certain functions merged into the Department of Health and Social Care. Integrated care boards were expected to have to reduce their costs by 50%.
- A 'model' integrated care board blueprint had been published, which appeared to imply that a significant proportion of ICB functions could be redistributed to providers.
- It was expected that the number of ICBs would reduce to 25-30, with each serving populations of c.2m. In Hampshire, ICB and local authority boundaries were expected to align, which was considered to be beneficial.
- The British Social Attitudes Survey 2024 showed the lowest satisfaction rating for the NHS since the survey began.
- The Spring Statement and subsequent messaging indicated that there would not be additional funding during 2025/26.
- The Trust continued to face significant pressure due to patients having no criteria to reside. Historically, there were typically around 100 such patients at

any one time, whereas 281 had been reported on 13 May 2025. This was the equivalent of six wards.

- The Trust faced significant financial pressure during 2025/26 with a lower financial settlement than expected. In order to meet its plans, the Trust would be required to deliver c.£110m of Cost Improvement Programmes, reductions of 5% in divisions and 10% in Trust Headquarters, coupled with clinical and non-clinical recruitment controls. The Trust continued to experience high demand for services, especially in the Emergency Department.
- It was important to protect the frontline and assist the organisation with managing at such a time.

5.6 Performance KPI Report for Month 12

Duncan Linning-Karp was invited to present the Performance KPI Report for Month 12, the content of which was noted. It was further noted that:

- The Trust continued to face significant challenges in terms of its Emergency Department performance, with only 57.2% of patients spending less than four hours in the main Emergency Department. An external review was to take place.
- There had been a four-month trajectory of increasing numbers of falls. Whether there was any correlation between the increasing number of falls and number of patients having no criteria to reside was being investigated.
- The Trust continued to report strong Elective Recovery performance, although the size of the Trust's waiting list continued to increase. There was some concern as to whether the financial pressures were impacting elective performance and waiting times.
- There had been a decrease in the number of virtual outpatient appointments.
- Ten never events had been reported as of the end of March 2025. The Trust expected regulatory scrutiny as a result.
- The metrics reported in respect of research and development were being reevaluated.

Duncan Linning-Karp was invited to present the spotlight on the Mental Health Patient Cohort, the content of which was noted. It was further noted that:

- Regular reports on mental health patients were provided to the Quality Committee.
- During 2024, there were 347 patients with a decision to admit to a mental health bed whilst at UHS (2023: 303), of these only 13.2% were transferred within the expected 12 hours (2023: 18.5%). During the first quarter of 2025, there had been 92 such patients. If the numbers remained consistent for the rest of 2025, a growth rate of 6% was expected.
- In terms of patients brought to the Emergency Department as a hospital-based place of safety detained under section 136 of the Mental Health Act 1983, only 22% of patients brought to the Trust had a physical need, whereas the remaining patients were brought to the Emergency Department due to the lack of an available facility.
- There were insufficient beds available at mental health providers, who were also impacted by delayed discharges.
- The enhanced care required by mental health patients placed significant demand on the Trust's resources. The situation appeared to be worsening with around 100 patients at any one time, of which around 10 were acute.
- The Trust has met with the Integrated Care Board and mental health provider to push for a working group to address the issue that care for mental health patients at the Trust cost significantly more than the cost for looking after

patients at a dedicated facility due to the need to engage specialist agency staff.

Actions
Duncan Linning-Karp agreed to investigate why the number of virtual outpatients appointments had reduced.

Gail Byrne agreed to examine the trend in respect of the friends and family test negative score for inpatients.

5.7 Break

5.8 Finance Report for Month 12
Ian Howard was invited to present the Finance Report for Month 12, the content of which was noted. It was further noted that:

- The Trust had delivered its forecast £7m deficit at year end. This had been achieved through a combination of additional Cost Improvement Programme (CIP) delivery and additional revenue support
- Whilst the Trust had delivered £85.3m of CIP, a significant proportion of this was non-recurrent. The Trust continued to record an underlying deficit of £6-7m per month.
- The Trust had £17m in cash, below its usual minimum holding of £30m. The Trust continued to closely monitor and manage its cash position, but it was likely that support would be required in the first quarter.
- During 2024/25, the Trust had carried out £34m of unpaid for activity, particularly in terms of Emergency Department, non-elective and outpatient follow ups. There were, however, limited opportunities to reduce this activity due to quality impacts

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5.9 ICB Finance Report for Month 12
Ian Howard was invited the present the ICB Finance Report for Month 12, the content of which was noted. It was further noted that:

- The Hampshire and Isle of Wight Integrated Care System had achieved a breakeven position for 2024/25. It was noted that this represented a significant achievement given that the system was reporting a cumulative deficit of £80m at Month 5.
- The system-wide transformation programmes had had a lower-than-expected impact on the Trust.

5.10 People Report for Month 12
Steve Harris was invited to present the People Report for Month 12, the content of which was noted. It was further noted that:

- At year end the Trust was 373 WTE above its 2024/25 plan. There had been a significant increase in use of bank staff in March 2025 due to annual leave and the number of mental health patients. The size of the substantive workforce had, however, reduced, albeit at a lower level than expected.
- The formal consultation in respect of the organisational changes had been commenced with the unions. The Trust would be moving from four to three divisions and reducing its workforce.
- The Trust had announced its intention to reduce the size of its workforce by 780 WTE (c.6%). This was to be achieved via a combination of natural

attrition and vacancy control and through a Mutually Agreed Resignation Scheme.

- There were a number of risks to achievement of the Trust's 2025/26 workforce plan, including: quality and safety risks (mitigated through Equality and Quality Impact Assessment); a lower-than-expected turnover rate due to a lack of opportunities elsewhere; the Trust's cash position; and delivery of non-criteria to reside and mental health patient reductions.
- The Trust had released a statement to staff and was awaiting guidance in respect of the recent Supreme Court ruling regarding the definition of a woman under the Equality Act 2010.

5.11 UHS Staff Survey Results 2024 Report

Steve Harris was invited to present the UHS Staff Survey Results 2024 Report, the content of which was noted. It was further noted that:

- The results of the Staff Survey had been discussed in detail by the People and Organisational Development Committee on 24 March 2025 and at a Trust Board Study Session held on 1 April 2025.
- The Trust benchmarked well in certain areas, such as recommendation as a place to work and in terms of views of line management. However, the response rate was lower than in previous years and violence and aggression and civility and dignity scores remained areas of concern.

The Board discussed the results of the Staff Survey and agreed that the Trust should focus its efforts on violence and aggression and on helping staff to manage change. It was noted that there was a strong correlation between line manager engagement and the survey response rate.

5.12 Guardian of Safe Working Hours Quarterly Report

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

- There was to be a change in the exception reporting process from September 2025. The Trust was considering how best to manage these changes.
- The financial constraints during 2025/26 would potentially impact the locum fill rate.
- The Trust's estate remained an issue, but work was ongoing, including consideration of re-purposing existing spaces.
- Concerns had been expressed from some seeking consultant posts about the impact of the organisational changes on these opportunities.
- The duration of handovers continued to result in breaches of working hour limits.

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

Jenny Milner was invited to present the Learning from Deaths Report, the content of which was noted. It was further noted that:

- The Trust's expected death rate remained lower than the national average, with the Trust ranked 12 out of 119.

- Further improvements in terms of the sharing of learning from Mortality and Morbidity meetings were required. Consideration was been given to using the Ulysses tool.
- The Trust's medical examiner service had reviewed more than 1,000 deaths since inception.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2024-25 Quarter 4 Review

Martin de Sousa and Kelly Kent were invited to present the Corporate Objectives 2024/25 Quarter 4 Review, the content of which was noted. It was further noted that:

- The Trust had delivered 50% of its annual objectives for 2024/25 and 37.5% of objectives had been partially achieved or had incurred minor delays. Two objectives remained 'red'.
- Particular areas to highlight included progress on long-waiters, patient experience, turnover/sickness of staff, and capital scheme delivery. The Trust had also been successful in slowing the rate by which the waiting list grew and in delivering Cost Improvement Programmes.
- Areas of concern included the financial position, patients with no criteria to reside, and staff experience.
- The Trust was in control of the delivery of some of the objectives, but full delivery of others was outside of the Trust's control.

6.2 Board Assurance Framework (BAF) Update

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

- The BAF had been previously reviewed by the Board in March 2025, following which it had been reviewed by the relevant executive directors and committees.
- None of the ratings of the risks had been amended. However, the target dates for three risks had been extended to reflect the challenges in achieving the target rating.
- The Trust was holding a higher overall level of risk than had previously been the case. It was considered important to ensure that risks were managed across domains and not in silos.
- The Trust was using its risk appetite to support decision-making such as in capital prioritisation and in terms of the decisions required to deliver its 2025/26 plans.
- A risk appetite review had been scheduled at a future Trust Board Study Session on the basis that the current situation potentially necessitated changes in terms of the Trust's stated risk appetite.

Action

The review of risk appetite was to be scheduled to take place at the Trust Board Study Session on 3 June 2025.

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

Paul Grundy and Clare Rook were invited to present the South Central Regional and Research Delivery Network (SC RRDN) 2024/25 Annual Performance Review and the SC RRDN 2025/26 Annual Plan, the content of which was noted. It was further noted that:

- During the year the organisation transitioned from the Clinical Research Network Wessex to the South Central Regional Research Delivery Network, whereby the Wessex and Thames Valley and Midlands Clinical Research Networks were integrated into a single entity.
- In the Wessex region, 33,000 participants were recruited to over 500 studies during the first half of the year. A further 35,000 participants were recruited to over 800 studies during the second half of the year in the South Central region.
- Commercial research remained a priority, with the South Central region benchmarking well in terms of recruitment.
- In terms of the 2025/26 plan, the NHS 10-year plan was awaited, as this would likely impact the plan. It was currently intended that the network would focus on the National Institute for Health Research's seven priorities. A stakeholder group was being convened to inform the SC RRDN's direction of travel.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governos' (CoG) meeting 29 April 2025

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

- Chief Executive Officer's Performance Report
- Annual Report and Quality Account Timetable 2024/25
- Draft Quality Account
- Corporate Objectives
- Non-NHS Activity
- Governor Attendance at Council of Governor meetings
- Council of Governors' Elections 2025
- Appointment to the Governors' Nomination Committee
- Membership Engagement and Governor activity
- Chair's and Non-Executive Directors' appraisal outcomes

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, due to an issue with the electronic signature platform, a number of items were included in the report, which should have been included in previous reports.

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'.

8. Any other business

Gail Byrne informed the Board that a joint targeted area inspection of the Trust's Emergency Department and Maternity service by the Care Quality Commission (CQC), social services and the police was scheduled to take place on 20 May 2025, which would focus in particular on safeguarding of children. In addition, a routine Ionising Radiation (Medical Exposure) Regulations inspection was due to take place in June 2025.

It was noted that the CQC had recently carried out unannounced inspections at Portsmouth Hospitals University NHS Trust and at South Central Ambulance Service NHS Foundation Trust. Accordingly, it appeared likely that the Trust should also expect an unannounced CQC visit, followed by a Well-Led review.

It was noted that this was Dave Bennett's last formal scheduled Board meeting, as his second three-year term was due to expire on 14 July 2025. The Board expressed its thanks to Dave Bennett.

9. Note the date of the next meeting: 15 July 2025

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.

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List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 13/05/2025 - 5.6 Performance KPI Report for Month 12				
1246.	Virtual outpatients appointments	Linning-Karp, Duncan	15/07/2025	Pending
	Explanation action item Duncan Linning-Karp agreed to investigate why the number of virtual outpatients appointments had reduced.			
1247.	Friends and family test	Byrne, Gail	15/07/2025	Pending
	Explanation action item Gail Byrne agreed to examine the trend in respect of the friends and family test negative score for inpatients.			
Trust Board – Open Session 13/05/2025 - 6.2 Board Assurance Framework (BAF) Update				
1248.	Risk appetite	Byrne, Gail	03/06/2025	Completed
	Explanation action item The review of risk appetite was to be scheduled to take place at the Trust Board Study Session on 3 June 2025.			

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Agenda Item 5.1

Committee Chair's Report to the Trust Board of Directors 15 July 2025			
Committee:	**Audit & Risk Committee**		
Meeting Date:	**9 June 2025**		
Key Messages:	• The committee considered the results of a review of historical private activity (pre-2022/23) which had not been invoiced by the Trust. It was noted that, of the £2.5m total, £1.6m had since been paid, but that £0.9m should be written off. It was further noted that this issue should not arise in future due to changes in contracting arrangements and improvements in processes. • The committee noted an update in respect of the Trust's submission as part of the annual National Cost Collection exercise. • The committee received a report on waivers of competitive tendering between October 2024 and March 2025, noting that these represented c.£11m of activity over the period. • The committee reviewed a draft of the Annual Report and Accounts for 2024/25. The committee noted that the external audit had not progressed as planned. • The committee received the Quarter 4 Fraud, Bribery and Corruption Work Plan Update Report, noting that under the Counter-Fraud Functional Return that the Trust was green-rated.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.3 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• There had been an increase in the number of critical risks recorded from 30-35 to c.50. Many of these risks related to staffing or capacity. • It was noted that some of this increase was driven by new risks being identified (or existing risks worsening), but that existing critical risks were not being closed due to insufficient resources. • In addition, following the Six Facet survey, there had been an improvement in the articulation of Estates-related risks, which was now reflected in the total number of operational risks. • The committee reviewed the Board Assurance Framework, noting that all risks had been reviewed by the relevant executive(s).		
	7.2 Review of Standing Financial Instructions 2025-26	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• The committee reviewed the Trust's Standing Financial Instructions, noting that changes were proposed to two areas: employee expenses and non-pay requisition limits.		
Any Other Matters:	• The committee reviewed the Trust's internal audit plan and agreed that a cyber security audit should be included as part of the plan.		

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 15 July 2025	
Committee:	**Finance and Investment Committee**
Meeting Date:	**2 June 2025**
Key Messages:	• The committee reviewed the Finance Report for Month 1. The Trust had reported a deficit of £4.4m in line with its plan whereby the Trust would move from a deficit to breakeven to surplus over the course of the year thereby achieving an overall breakeven position at year end. • The Trust's underlying deficit was £7.2m in month. This was driven by patients having no criteria to reside, activity above block contract levels, and mental health patients. Use of bank staff had normalised when compared to Month 12, but there had been high drugs spend and lower than expected income which was under investigation. • The Trust was on track in terms of its Cost Improvement Programme (CIP). • The committee received an update in respect of the Trust's cash position, noting that the Integrated Care Board had agreed to move scheduled payments to aid the Trust's position. The Trust was forecasting a £7m negative balance in March 2026. • The committee reviewed the 'Acute Drivers of Deficit' report prepared by Deloitte, noting that many of the identified areas were long-term and/or structural issues. • The committee received an update on the Trust's financial improvement programmes, noting that although c.£80m of the £110m CIP was currently viewed as 'high risk', this was expected to improve as schemes became more mature. • The committee noted the Trust's response to a request to consider proposed workforce targets based on removing 50% of reported increases in corporate services expenditure since 2018/19. It was noted that the Trust expected to deliver this target through its existing plans. • The committee received an update in respect of the national and local contracting process, noting that most areas had now been agreed. The potential changes in Elective Recovery Funding posed a risk to the Trust. In addition, it was likely that £20-30m of activity would remain unfunded.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	N/A
Any Other Matters:	The committee received the Always Improving – Transformation End of Year Report, noting progress made.

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.
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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
15 July 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance and Investment Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">23 June 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee reviewed the Finance Report for Month 2 (see below).
• The committee received an update in respect of the Trust's cash position, noting that the position continued to deteriorate. It was further noted that discussions were underway with local providers, as some providers have cash whilst at the same time others risked running out.
• The committee received an update on the Urgent and Emergency Care Transformation Programme, noting that the Trust was targeting a reduction in length of stay by a further 5%.
• The committee noted an update from UHS Estates Limited and progress on a number of programmes.
• The committee considered a summary of the Spending Review presented by the Chancellor of the Exchequer on 11 June 2025.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.8 Finance Report for Month 2</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust had recorded an in-month deficit of £3.8m, which was in line with its plan to reach a breakeven position by year end.
• The Trust had achieved its planned Cost Improvement Programme delivery level, although much of this was due to non-recurrent savings, which creates a challenge later in the year.
• The Trust's underlying deficit remained at £7.2m, consistent with Month 1.
• Income had been lower than expected with reductions in income from pathology and the Channel Islands. Non-pay costs for drugs and clinical supplies also remained a challenge.
• The committee reviewed the Trust's workforce trajectory for 2025/26, noting that even if all 'red' CIP schemes were to deliver, this would still result in a shortfall.</td></tr>
<tr><td>6.2 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
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>
<tr><td>Any Other Matters:</td><td colspan="3">N/A</td></tr>
</table>

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.
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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

Committee Chair's Report to the Trust Board of Directors 15 July 2025	
Committee:	**People and Organisational Development Committee**
Meeting Date:	**25 June 2025**
Key Messages:	• The committee reviewed the People Report for Month 2 including progress on the Workforce Plan for 2025/26 (see below). • The committee noted that the plans for the Divisional restructure are now underway with the intention of implementing these on 01 July 2025. It is understood that whilst not all people plans have been finalised at a granular level, it is anticipated that most issues will be resolved through natural attrition and through the Mutually Agreed Resignation Scheme (MARS). • The MARS application window has now closed and there has been significant interest with 220+ applications submitted. These are currently being assessed for suitability and it is planned that the outcomes will be shared with applicants by 04 July 2025. Not all applications will be accepted as some posts cannot be surrendered, and the organisation cannot afford to accept them all. Whilst each resignation will represent a long-term saving there is a very real risk to in year cost pressures as all successful MARS applications will need to be funded locally, as there is no national funding to support this. • Additional recruitment controls also remain in place including a freeze on non-clinical recruitment, and a hold on 30% of clinical recruitment. • The committee noted that the scale of organisational change is significant and this is likely to be unsettling for staff. A number of support mechanisms have been implemented focussed on wellbeing, and this includes specific organisational change workshops targeted at leaders across the Trust to support them in supporting the wider workforce. The committee reflected that this is a positive step and that once the organisational restructure has completed, this should be used as a foundation for implementing change and leadership training as business as usual. • The committee received an update on the organisation's education position and the current challenges and opportunities related to this. The committee acknowledged the significant risk to future workforce as a result of the current challenges across the NHS, in combination with the restricted and reduced funding streams which facilitate staff access to education and development. The committee noted the need to review education capacity again at UHS once the long-term workforce plan is published later in the year.

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's overall workforce grew by 19 WTE in May 2025 however it is still below the NHSE plan by 107 WTE. It was noted that turnover remains lower than average and it is suspected that this will be due to system wide recruitment controls limiting roles UHS staff may move into, in addition to a wider lack of opportunity in the jobs market as general employer confidence reduces. • Additionally, whilst both remain below plan, there has been an increase in temporary staffing bank and agency usage noting that April was a very low month. • The committee noted that the workforce plan is ambitious and sets out a reduction in headcount of c.750. All schemes to deliver this have been assessed for maturity and continue to be worked up, although even if it were to be assumed that all are followed through to completion, there is still a shortfall which needs to be addressed. Significant work has been undertaken to forward plan the trajectory. • It was noted that consideration had been given to the recruitment controls and whether these needed to be taken further, however as it will take several months to fully implement and see the benefit of those in place currently, this was decided against. The improvements in forecasting, and monthly review, will support this decision so that it can be reviewed again later in the year, probably September. • The committee discussed the need to track indicators related to people, money, performance and quality and consideration will be given to a balanced scorecard.		
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. • The committee also received a series of updates on recent national letters to Trusts including a required review of job evaluation processes and analysis work on non-frontline nursing roles.		

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.4

Committee Chair's Report to the Trust Board of Directors 15 July 2025			
Committee:	**Quality Committee**		
Meeting Date:	**2 June 2025**		
Key Messages:	• It was noted that two never events had been reported during Quarter 4 and that there had been nine high-harm falls during March. These falls were typically falls from commodes. Subsequently, a potential new never event had been recorded in Dermatology, although there was some debate as to whether it met the criteria. • The committee reviewed a draft of the Trust's Quality Account for 2024/25. • The committee reviewed the Experience of Care Report for Quarter 4, noting that the top three complaints related to communications, treatment, or staff values and behaviours. The staff values complaints were being looked at, as this was an area of particular concern and had not appeared in the top three in the past two years. Care of learning disability patients had become an emergent theme identified by Experience of Care and Patient Safety teams. • The committee received the End of Life Care Report, noting the result of a national audit which highlighted the gap between the expectations of families and staff capacity. It was noted that the Trust was rated as above the average in seven out of ten measures. • The committee received an update in respect of the Trust's roll out of NatSSIPS. • The committee reviewed the current position with respect to pressure ulcers. It was noted that an audit had been conducted following an increase in the number of pressure ulcers. This audit identified areas of concern with respect to regular turning of patients and recommended reviewing education and recommencing intensive support.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.12 Infection Prevention and Control 2024-25 Annual Report**	***Assurance Rating:* Substantial**	***Risk Rating:* Medium**
	• The committee received the Infection Prevention and Control 2024/25 annual report, noting that there had been significant numbers of Influenza, COVID and RSV cases during December and January as well as a national surge in norovirus cases in February and March 2025. • There was also concern regarding the upward trend in MRSA cases over the past three years. • The Trust had achieved a 1% reduction in anti-microbial prescribing.		
Any Other Matters:	The committee reviewed the Maternity and Neonatal Safety Report for Quarter 4, noting that whilst there had been a spike in mortality during the quarter, this was due to the complexity of cases referred to the Trust. It was further noted that the Integrated Care Board had reported an issue with the BadgerNET system to the ICO.		

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 4.4	Report to the Quality Committee, 2 June 2025
Title:	Maternity and Neonatal Safety 2024-25 Quarter 4 Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

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:

This report is presented in line with NHS Resolution (NHSR) requirements, which mandate regular reporting from Maternity and Neonatal (MatNeo) Services to the Trust's Quality Committee.

The Quarter 4 Safety Report reflects our ongoing commitment to adapt and respond to emerging safety concerns, while continuing to strengthen quality and safety across maternity and neonatal care. It provides assurance to members of Quality Committee regarding the actions taken to improve outcomes for women, birthing people, babies, and staff, and demonstrates our compliance with NHSR's Maternity Incentive Scheme (MIS) Year 7 requirements.

The report outlines key areas of learning, safety improvements, and developments across the service, ensuring transparency and accountability. Committee members are asked to continue to support the MatNeo Services through appropriate oversight, challenge, and assurance.

Contents:

This report provides an update in relation to the following areas for Quarter 4 2024/25:

Risk(s):
University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Services operate within a complex regulatory and governance framework. Several key risks have been identified that may impact service delivery, organisational performance, and the safety of women, birthing people, babies, and staff: • **Reputational Risk**: Any concerns relating to safety or quality of care may be raised by service users or stakeholders to external regulatory bodies such as NHS Resolution and the Care Quality Commission (CQC), potentially affecting public confidence in our services. • **Financial Risk**: Ongoing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) remains essential. Failure to meet all ten required Maternity Safety Actions could result in the loss of financial incentives and increased scrutiny. • **Governance Risk**: Significant concerns regarding safety or quality can be escalated to a range of national and regional stakeholders, including the CQC, NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, and the Regional Chief Midwife. This may lead to formal reviews or additional oversight. • **Safety Risk**: Non-compliance with national requirements, standards, or recommendations can have serious consequences, including increased clinical risk to women and babies, reduced staff morale and wellbeing, and ultimately poorer outcomes. The Maternity and Neonatal Safety Improvement (MNSI) programme has the authority to raise formal concerns and trigger external reviews where safety is questioned. UHS remains committed to proactively addressing these risks through robust governance processes, continuous quality improvement, and transparent engagement with our staff, service users, and external partners.

Equality Impact Consideration:	N/A

1. Perinatal Quality Surveillance – Maternity & Neonatal full Dashboard

The red flag exceptions can be found here most of these remain known to the Quality Committee with no 'new exceptions', key areas to note are:

1.1 Post Partum Haemorrhage (PPHs) – OBS UK 4-month update

Members of the Quality Committee have previously been made aware of concerns regarding postpartum haemorrhage (PPH) rates. As part of our response, MatNeo Services are actively participating in the Obstetric Bleeding Study (OBS-UK), a national quality improvement initiative aimed at reducing the use of red cell transfusions through earlier recognition and improved management of obstetric bleeding. A key component of the study is the adoption of a standardised care bundle, which includes the cumulative measurement of actual blood loss, replacing the historically used Estimated Blood Loss (EBL). This supports more accurate detection and escalation of bleeding.

A four month implementation review has recently been completed. Encouragingly, 87% of reviewed cases now include measured blood loss documentation, a significant improvement from the baseline of 40% prior to study commencement. While the Trust's rate of PPH >1500mls has remained relatively stable over the past year (between 3.8% and 6% of single term births), a slight increase in the reported rate of PPH >500mls was noted in February 2025. This trend has also been observed at other study sites and is attributed to improved detection accuracy with measured blood loss, rather than a true rise in incidence. **Appendix 1** provides a summary of implementation progress to date.

Committee members are asked to note the improved documentation compliance, the stable rate of higher-severity PPH, and the likely artefactual increase in lower-severity PPH figures due to improved measurement. Continued monitoring and learning from the OBS-UK programme will inform future actions and assurance reporting.

1.2 3rd and 4th degree tears OASI (episiotomy)

This red flag has previously been reported and our MatNeo Services have developed a targeted action and improvement plan to address it. A central component of this plan is the implementation of the Royal College of Obstetricians and Gynaecologists' OASI Care Bundle, which was launched across the service in April 2025. The care bundle aims to reduce the incidence and severity of obstetric anal sphincter injuries through standardised, evidence-based clinical practice.

Progress is being actively monitored, and a locally developed Power BI dashboard has been introduced to support real-time data review and oversight. **Appendix 2** provides a detailed summary of the action plan and implementation progress to date.

Committee members are asked to note the structured approach being taken, the emphasis on measurable improvement, and the tools in place to support ongoing monitoring and assurance. (https://app.powerbi.com/links/6UFu-NTeBo?ctid=d7ebf946-7775-4c9b-b232-8b66ed67ade1&pbi_source=linkShare).

1.3 Apgar's less than 7 at 5 minutes

The proportion of term, singleton, liveborn babies with an Apgar score of less than 7 at 5 minutes continues to be a key indicator of perinatal wellbeing and is closely monitored within the MatNeo quality and safety programme.

In Quarter 4 of 2025, the rate rose to 2.83%, significantly exceeding both the national benchmark of 1.1% (NMPA 2018/19) and the Trust's internal threshold (revised in Q1 2022/23). Monthly fluctuations were observed, with a peak of 4.15% in February and a low of 1.69% in January; however, all three months remained above the national average.

This upward trend has been evident over the past 3 years (2022–2024) and continues to raise concern. In response, our MatNeo Service have initiated focused case reviews, strengthened multidisciplinary training in fetal monitoring and reinforced clinical escalation protocols.

A bespoke Power BI dashboard is being developed to support in-depth analysis and real-time monitoring. This will inform the design of targeted interventions aimed at improving neonatal outcomes. **Appendix 3** sets out the current action plan and next steps. Committee members are asked to note this quality concern and the measures being taken to address it.

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

Appendix 4 provides assurance to the Quality Committee that appropriate governance and reporting processes have been followed in Quarter 4. It includes a summary of all new referrals to the Maternity and Neonatal Safety Investigations (MNSI) programme (n=2), and all applicable Patient Safety Incident Investigations (PSIIs). The report also outlines the status of all cases closed within the same period, highlighting any emerging themes or learning identified through the investigation process.

In keeping with our commitment to transparency, the appendix also includes data on new and closed perinatal mortality cases, including those where no direct care or safety concerns were identified. Additionally, a summary of moderate harm incidents reported during Q4 is provided. One MNSI case (MNSI 036861 / 9969358) was closed in the quarter, and the associated learning is presented in the form of a dedicated learning slide within the appendix.

Committee members are asked to note the comprehensive reporting, the identified learning, and the continued commitment to safety, openness, and improvement in maternity and neonatal care.

3. Perinatal Mortality Review Tool learning and themes

A summary of Quarter 4 PMRT case reviews and associated learning is provided in **Appendices 4 and 5. Appendix 5** includes additional contextual information, such as the ethnicity and Index of Multiple Deprivation (IMD) decile of the women and birthing people involved, and whether they were initially booked to give birth at Princess Anne Hospital (PAH).

The MatNeo Service provides assurance that there is high-level oversight of all reported and processed cases, with a clear focus on ensuring timely reviews, family engagement, and the effective dissemination of learning. Case data is reviewed in detail to identify emerging themes and any disproportionate impact on vulnerable groups. Learning is regularly shared with the Local Maternity and Neonatal System (LMNS) to support wider system improvement.

As previously reported, a spike in perinatal mortality was observed in March 2025, resulting in a stillbirth rate of 12.08 per 1,000 births for the month. The overall stillbirth rate for Quarter 4 was 5.91 per 1,000 births.

Appendix 5 provides details of five cases reviewed during this period:

- Four of the cases had involvement from the Fetal Medicine team.
- Three are currently undergoing PMRT review and have also been discussed through the Clinical Events Review process (see **Appendix 4** for associated learning).
- Two cases were feticide for congenital abnormalities and are therefore excluded from PMRT review under national criteria.

Committee members are asked to note the escalation in stillbirth cases during March, the assurance provided regarding case oversight and review, and the actions taken to capture and share learning both internally and across the LMNS.

4. ATAIN update

There has been a reduction in term neonatal admissions in Quarter 4, with 34 admissions compared to 45 in Quarter 3 (see **Appendix 6**). The proportion of unexpected term admissions as a percentage of total births remains below the 5% target, reflecting continued improvement in this area.

The most common reasons for admission remain consistent, primarily involving respiratory issues or poor perinatal adaptation. Notably, there has been an increase in babies admitted for less than 24 hours in Q4 (n=11), up from 6 in the previous quarter. All term admissions, including those under 24 hours, are subject to individual case review to assess avoidability and extract any learning. Identified themes or concerns are used to inform local practice improvements and shared learning across teams.

Committee members are asked to note the reduction in overall admissions, the increased short-stay activity, and the ongoing focus on clinical review and service learning to improve outcomes.

5. Triangulation of incidents, claims and complaints

Appendix 7 provides an overview of maternity related claims, complaints, and incidents reported or settled during Quarter 4. Thematic analysis continues to highlight recurring issues including delays or failures in treatment, communication breakdowns (within teams and with patients or relatives), and medication related concerns, particularly in prescribing and management.

In response to these themes, the service has implemented several key actions to strengthen safety and improve patient experience. These include:

- **Implementation of the Newborn Early Warning Trigger and Track Tool (NEWTT2)** in April 2025, supporting early recognition of neonatal deterioration and timely escalation, while reinforcing the importance of listening to parental concerns.
- **Launch of the "Cultivating Kindness" campaign** at PAH, aimed at addressing workplace incivility and fostering a positive and respectful team culture - an essential foundation for safe, effective, and compassionate care.

Committee members are asked to note the thematic learning emerging from Q4 data and the proactive steps being taken to address identified issues and support continuous improvement.

6. 3 Year Delivery Plan Benchmarking

The Trust is currently in the second year of the national Three-Year Delivery Plan for Maternity and Neonatal Services. In line with our commitment to continuous improvement, our MatNeo Service has completed a comprehensive benchmarking exercise to assess our current performance against the expectations outlined in the plan. This initiative forms part of our broader ambition to deliver safe, equitable, and high-quality care for all women, birthing people, babies, and families.

As a service, we remain fully committed to the successful delivery of this plan, recognising its critical role in enhancing clinical safety, improving service user experience, and addressing health inequalities across maternity and neonatal care.

Starting from Q1 2025/26, we will provide quarterly updates on a dedicated theme aligned with the delivery plan. Any areas of risk or concern will be identified and escalated through the appropriate governance channels, including this committee, for timely action. At the conclusion of the 2025/26 reporting period, we will present a comprehensive summary of progress across the four thematic areas, ensuring a transparent reflection of both our achievements and areas requiring further development.

This report will continue to be used for regular updates, enabling the Committee to track key develop.

7. SCORE Survey

Our MatNeo service is now concluding Phase 3 of the Perinatal Culture and Leadership Programme, which has entered the **SCORE actions and cultural conversations** stage. During this phase, an action plan has been developed to support the ongoing cultural transformation and leadership development within the service. A copy of the action plan can be found in **Appendix 8**.

The action plan will be actively monitored and reviewed through this committee to ensure progress is being made, and any required adjustments are identified in a timely manner.

8. Patient Voice and progress with MNVP

Quarter 4 of 2024/25 has seen a concerted effort to gather and amplify service user feedback across key areas of MatNeo services. This has included a combination of digital engagement, one-to-one conversations, and group events to ensure comprehensive insights from families and service users.

Appendix 9 provides an overview of the ongoing work led by the Maternity and Neonatal Voices Partnership (MNVP) Chair, including a patient story that highlights user experience. The appendix also outlines plans for further engagement and feedback activities in the next quarter.

9. NHS Resolutions Maternity Incentive Scheme Year 6 submission and Year 7 launch

In Quarter 4 of 2024/25, significant efforts were made to gather and amplify service user feedback across various key areas of MatNeo services. This included a combination of digital engagement, one-to-one conversations and group events aimed at capturing diverse experiences and insights from service users.

Appendix 9 provides a summary of the ongoing work led by the MNVP Chair, featuring a patient story that reflects user experience. Additionally, the appendix outlines the plans for further engagement and feedback activities in the upcoming quarter.

Conclusion:

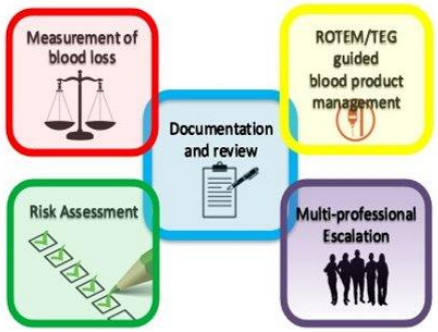
The report presents critical updates and ongoing improvement actions within the MatNeo Services for Quarter 4 of 2024/25. Continued oversight, feedback, and proactive governance will be essential in ensuring the delivery of high-quality and safe care for women, birthing people, babies and families across the Trust.

Appendix 1

UHS OBS UK Study Update

University Hospital Southampton NHS Foundation Trust

OBS UK
Obstetric Bleeding Study UK



Month 4 audit findings

- Snapshot of 30 women
- Births between 1st-3rd Feb 2025
- Type of birth: 5 EMCS, 3 ELCS, 19 SVD, 3 Instrumental births
- Location: 11 Theatre, 13 in Delivery Suite Room, 5 MLU, 1 Pool
- Blood loss: 500mls + blood loss = 15

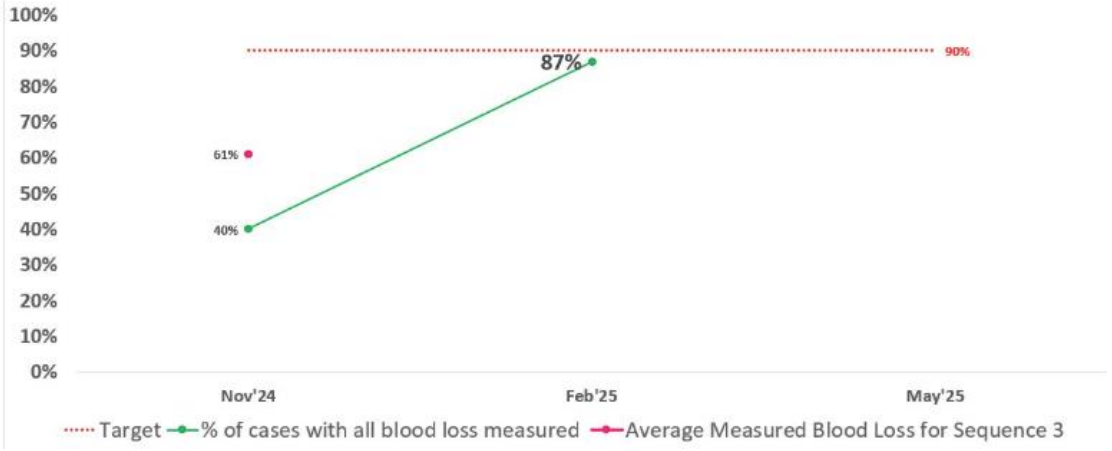
Please Remember:

1. Use the OBS UK Proforma for all births in all areas (including theatre)
2. Escalation – as per the proforma
3. Cumulative weighing & record as Measured blood loss.

- 60% had Risk Assessments completed
- 57% had the OBS UK Proforma in the notes

Measured blood loss

Measured Blood Loss at all Births



Feedback from the OBS UK Team

You've made a brilliant start to implementation and the data really reflects this.

Local PPH Data

	Q3 total	Q4	
		January	February
PPH 500ml or more - NMPA	44.6%	43.7%	48.5%
PPH 1500ml or more - NMPA	4.7%	5.3%	5.0%

% of term, singleton births with an obstetric haemorrhage more than or equal to 500ml. Source NMPA 2016/17 - UHS 34.5%(unadjusted) & 34.3% (adjusted) - **National Mean 34.1%**
% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml. Source NMPA 2016/17 - UHS 3.4%(unadjusted) & 3.3% (adjusted) - **National Mean 2.9%.**

Appendix 2

OASI Work Stream

Complete		In progress		Reviewing	

Actions	Comments	Lead	Status
Create a stakeholder group **Microsoft Word - OASI Care Bundle Guide final v0 15 to print**	Group in place and meeting monthly including LMNS leads	MC	
Recruit to the Pelvic Health Role	Recruitment completed and start date will be 14th April	RB LMNS	
Patient voice representative	Rosemary will explore representation	RB LMNS	
External Pelvic Health (LMNS) meeting attendance	Attendance by the Cons MW team	MC & AB	
Business Intelligence Dashboard	Dashboard of information	SM	
OASI Theme of the Week		MC & KF	
Discussions at 11 AM Safety Huddle	On the Huddle info - ongoing	MC	
Escalate concerns through Governance framework	Quality Matrons	QA Matrons	
Improve recording around ethnicity on BagerNet	Digital team to review and make changes	Digital Team	
Review Birth Trauma Information	Meeting planned with the education team	MC & AB	
Consider Epis scissors		AT & CM	
2nd MW at the birth consideration	Workstream to be planned	MC	

Antenatal Work Streams

Complete		In progress		Reviewing	

Actions	Comments	Lead	Status
Discuss perinatal health with birthing people	AN education	LP & Lorna Bird	
Discuss perinatal health with birthing people	Information (RCOG resources)	LP & Lorna Bird	
MNVP involvement		LB	

Education Work Streams

Complete		In progress		Reviewing	

Actions	Comments	Lead	Status
Discussions with the university leads	Practice Education Team in discussion with University	AB	
Band 5 training		AF	
Band 7 training	Training planned throughout the year	AF	
Band 6 training	Training planned throughout the year	AF	
Medical training ½ day	Additional training planned throughout the year	AT	
Develop education ½ day	Once Pelvic Health MW in post to develop	AF & Practice Ed Team	
OASI training level 1/2/3 **OASI care bundle**	All staff level 1 Individual staff level 2 (as required)	Practice Ed Team	
Explore Finnish Grip training		AF & Practice Ed Team	

Postnatal Work Streams

Complete		In progress			Reviewing	

Actions	Comments	Lead	Status
Review Patient experience	Review of feedback	LB	
UHS MNVP	Review of feedback	LB	
LMNS involvement	Awaiting contact with MNVP lead	LB	

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion	Status
1) Review cases of Apgar's <7 at 5mins to identify any themes or areas of learning.	1) Monitor through the dashboard, which goes to Quality committee quarterly. 2) Deep dive in Q3 24-25, further planned. 3) Audit of case notes, 10 sets per quarter.	QA Matrons	Completed (plan to re-audit)	
2) Formally agreed process for who calculates the APGAR score in the delivery room.	Midwife and (Dr/others present) to agree the APGAR score at relevant times.	Mat Neo team/All staff	Shared via TOTW	
3) Considerations of fetal monitoring in relation to APGAR score.	1) Ensure staff training on Fetal surveillance in line with NHSR requirements (90%) 2) Any cases identified used to inform Fetal surveillance training.	Fetal Surveillance leads	Cases shared with Fetal Surveillance leads to audit	
4) Cascade reminders to staff through a Theme of the Week.	TOTW cascaded to all staff as a reminder.	KF	**MAY 2025**	
5) Development of working group, including key stakeholders to review Apgar's <7 at 5 mins.	In progress	Stakeholder group	**TBA**	

Appendix 4
Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases – Quarter 4 2024/25

New Patient Safety Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
Patient safety	9994045	15 – 17/02/2025	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 15 – 17/02/2025.	Harm tool to be completed.
MNSI / PMRT	MI-040754 / 97777	14/03/2025	Neonatal death	Antenatal diagnosis of transposition of great arteries (TGA). Planned induction of labour (IOL). Delivered at 39+4 weeks gestation via Category 2 caesarean section following prolonged second stage. Difficulty to ventilate. Admitted to NICU. Unsuccessful septostomy and massive pulmonary haemorrhage. Baby girl died at 2 hours of age.	Reported to MNSI who have confirmed that they will **not** proceed for investigation as the underlying cause of death was a congenital anomaly. Reported to PMRT and to be reviewed through Neonatal Child Death Review Meeting (CDRM). PMRT ongoing in timescale. Reviewed through Clinical Events Review (CER).
MNSI / PMRT	MI-040825 / 97898	24/03/2025	Intrapartum stillbirth	Low risk pregnancy. In her 4th pregnancy. Presented at 39+2 in labour. On arrival, reviewed on Broadlands and no fetal heart (FH) heard. Transferred to Labour Ward (LW) and confirmed intrauterine death (IUD) with ?concealed abruption. Baby born 39+3 weeks gestation.	Reviewed through Clinical Events Review (CER) with SCAS and Maternity Triage Line (MTL) representation. SCAS to review further. Reported to MNSI however although the family initially agreed for MNSI to have access to their records, they have since declined MNSI accessing their records. Discussed at the Patient Safety New Cases Group and plan to wait for SCAS review before confirming plans for investigation. Reported to PMRT and to be reviewed through Perinatal Mortality Review Group (PMRG). PMRT ongoing in timescale.
Patient Safety Case	9994802	07/03/2025	Major incident	Baby abducted from Woodland Ward by her parents. The missing baby policy was followed, and the police contacted. The	Reviewed through a Patient Safety Case Review meeting on 28/03/2025. To be investigated as Patient Safety Incident Investigation (PSII).

				baby was found by the police and returned to the hospital. The parents were arrested at the time and bailed. The baby has since been discharged home with both parents under supervision with family members with social services involvement and assessment.	

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
96731	03/01/2025	Antepartum stillbirth	Presented at 36+3 weeks gestation with APH. Confirmed placental abruption and IUD. Baby boy delivered at 36+4 weeks gestation.	Reported to PMRT. To be closed with gradings B / A. PMRT ongoing within timeframe. Reviewed through CER. Learning identified relating to referral to FGR clinic and incorrect process, though this would not have altered the outcome. Difficulties with communication on Labour Ward re management of APH. Good practise identified with the use of the TEG. To note, the family have submitted a formal complaint.
97324	14/02/2025	Neonatal death	Known to fetal medicine with oligohydramnios and bilateral renal abnormalities. She was born at 38+4 weeks at PAH. Postnatal renal USS confirmed absent right kidney and multicystic, dysplastic left kidney. There was also a postnatal diagnosis of cloacal abnormality. She was commenced on peritoneal dialysis which was complicated with suspected peritonitis and abdominal distension. On day 16 she had a further deterioration with suspected bowel perforation – laparotomy identified total gut ischaemia and care was redirected. She died on day 17 of life.	Reported to PMRT. Closed with gradings B / C / B. Reviewed through Neonatal Child Death Review Meeting (CDRM). Multiple learning points identified including documentation, reassessing the whole situation to avoid confirmation bias, avoid over diagnosis, ensure adequate assessment and the role of the neonatologist including responsibility for overview of care.
97495	25/02/2025	Intrapartum stillbirth	DCDA twin. Twin 2 demise at 20+4 weeks gestation on 03/01/25. Twin 1 had known congenital cardiac	Reported to PMRT. To be closed with gradings B / A. PMRT ongoing within timeframe.

			conditions. Presented at 28+1 weeks gestation in threatened preterm labour and? chorioamnionitis. Baby boy born via vaginal delivery with no signs of life. 2 rounds of inflation breaths given by Neonatologists with no response. Confirmed that baby had been stillborn.	Reviewed through CER and at Perinatal Mortality Review Group (PMRG). No learning identified.
97659	08/03/2025	Neonatal death	Baby boy born at 23+0 weeks gestation at QAH. Transferred to UHS for neurosurgical review at 31+6 weeks corrected gestation. A subgaleal shunt was inserted and he was transferred back to QAH. He had a further transfer at 33+5 weeks corrected gestation back to UHS for a repeat neurosurgical review. He had confirmed meningitis which was not responding to antibiotics. A decision was made with the MDT and the parents to redirect to comfort care. He died at 34+5 weeks corrected gestation.	Reported to PMRT. To be closed with gradings C / A / A. PMRT going within timeframe. Reviewed at Neonatal CDRM in April with representation from the other units involved in this baby's care. Learning identified relating to pre-term birth referral for the local Trust.
97700	10/03/2025	Antepartum Stillbirth	Antenatal diagnosis of complete congenital heart block. Attended pre-assessment for elective C section at 35+6 weeks gestation. Reported reduced fetal movements (RFMs) for 12 hours. Cat 1 section called. Baby girl born with no heart rate and unable to be resuscitated.	Reported to PMRT. PMRT ongoing within timeframe. Reviewed at CER. Multiple questions received from the family and highlighted concerns that they were not being heard when they attended on the day of delivery with RFM. To be reviewed at PMRG. To note, the family have submitted a formal complaint.
97702 / 1	10/03/2025	Neonatal death	MCDA twin pregnancy. Twin to twin transfusion stage 3 with laser ablation on 06/01/25. Transferred from Poole to PAH with RFMs at 27+1 weeks gestation. Difficulty in locating fetal heart using CTG. Unable to find heart rate for one of the twins. Difficulty in monitoring and decision for Cat 2 section. Twin 1 born and admitted to NICU. Twin 2 confirmed as IUD. Twin 1 was born in poor condition and unstable throughout her admission. She had multiorgan dysfunction and poor long term prognosis.	Reported to PMRT. PMRT ongoing within timeframe. Reviewed at Neonatal CDRM in April. No learning identified.
97702 / 2	08/03/2025	Antepartum Stillbirth		Reported to PMRT. PMRT ongoing within timeframe. To be reviewed at CER and Neonatal CDRM in April.

			Discussion with the family to redirect care to comfort care.	
97777 (also reported in MNSI section above)	14/03/2025	Neonatal death	Antenatal diagnosis of transposition of great arteries (TGA). Planned induction of labour (IOL). Delivered at 39+4 weeks gestation via Category 2 caesarean section following prolonged second stage. Difficulty to ventilate. Admitted to NICU. Unsuccessful septostomy and massive pulmonary haemorrhage. Baby girl died at 2 hours of age.	Reported to MNSI who have confirmed that they will **not** proceed for investigation as the underlying cause of death was a congenital anomaly. Reported to PMRT and to be reviewed through Neonatal Child Death Review Meeting (CDRM). PMRT ongoing in timescale. Reviewed through Clinical Events Review (CER).
97874 / 2	22/03/2025	Neonatal death	DCDA twin. Twin 2 antenatal diagnosis of complex limb body wall difference. Extensive counselling with advanced care plan (ACP) in place. Baby girl born at 33+5 weeks gestation and died at 4 hours of age.	Reported to PMRT. PMRT ongoing within timeframe. To reviewed at Neonatal CDRM in May.
97898 (also reported in MNSI section above)	24/03/2025	Intrapartum stillbirth	Low risk pregnancy. In her 4th pregnancy. Presented at 39+2 in labour. On arrival, reviewed on Broadlands and no fetal heart (FH) heard. Transferred to Labour Ward (LW) and confirmed intrauterine death (IUD) with ?concealed abruption. Baby born 39+3 weeks gestation.	Reviewed through Clinical Events Review (CER) with SCAS and Maternity Triage Line (MTL) representation. SCAS to review further. Reported to MNSI however although the family initially agreed for MNSI to have access to their records, they have since declined MNSI accessing their records. Discussed at the Patient Safety New Cases Group and plan to wait for SCAS review before confirming plans for investigation. Reported to PMRT and to be reviewed through Perinatal Mortality Review Group (PMRG). PMRT ongoing in timescale.

Closed Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
MNSI	9969358 / MI-036861	26/02/2024	Therapeutic cooling	39+1 weeks, primip, spontaneous labour. Pathological CTG therefore ventouse extaction. Baby born slightly floppy but APGAR 5. DCC for 2 mins. Baby collapsed once cord cut. Required resuscitation for approx 20 mins. Admitted to NNU. Criteria A, B and C met, therefore therapeutic cooling commenced. Baby subsequently diagnosed with left ventricular failure and required ECMO on PICU.	MNSI investigation completed. Action plan written and approved at Patient Safety Incident Investigation Oversight Group (PSIIOG). 1 safety recommendation due to the placenta not being sent for histology. Other findings relate to sharing GBS status and taking cord samples. The learning slide is included within this report.
Patient Safety	Cohort of patients	26/03/2024	Tissue damage cohort	6 patients were identified as having concerns regarding skin integrity on their buttocks / thighs. It was felt that this was potentially due to iodine being used as a vaginal prep.	Incidents reviewed through a local learning response which was approved at Women and Newborn Governance in October and noted at Division C Governance. The following recommendations / actions were made: • Restart the practice of completing vaginal prep during caesarean birth in women with ruptured membranes, following the NICE Guidance 192, recommendation 1.4.25 - Use aqueous povidone-iodine for preparation and if not available or is contraindicated, aqueous chlorhexidine vaginal preparation can be used. • Reminder to medical teams that aqueous povidone-iodine solution should dry, when time allows, and should not pool underneath the patient
Patient safety	9976771	12 – 14/06/2024	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 12 – 14/06/2024.	Harm tool completed and presented to Patient Safety Steering Group in September 2024. No new

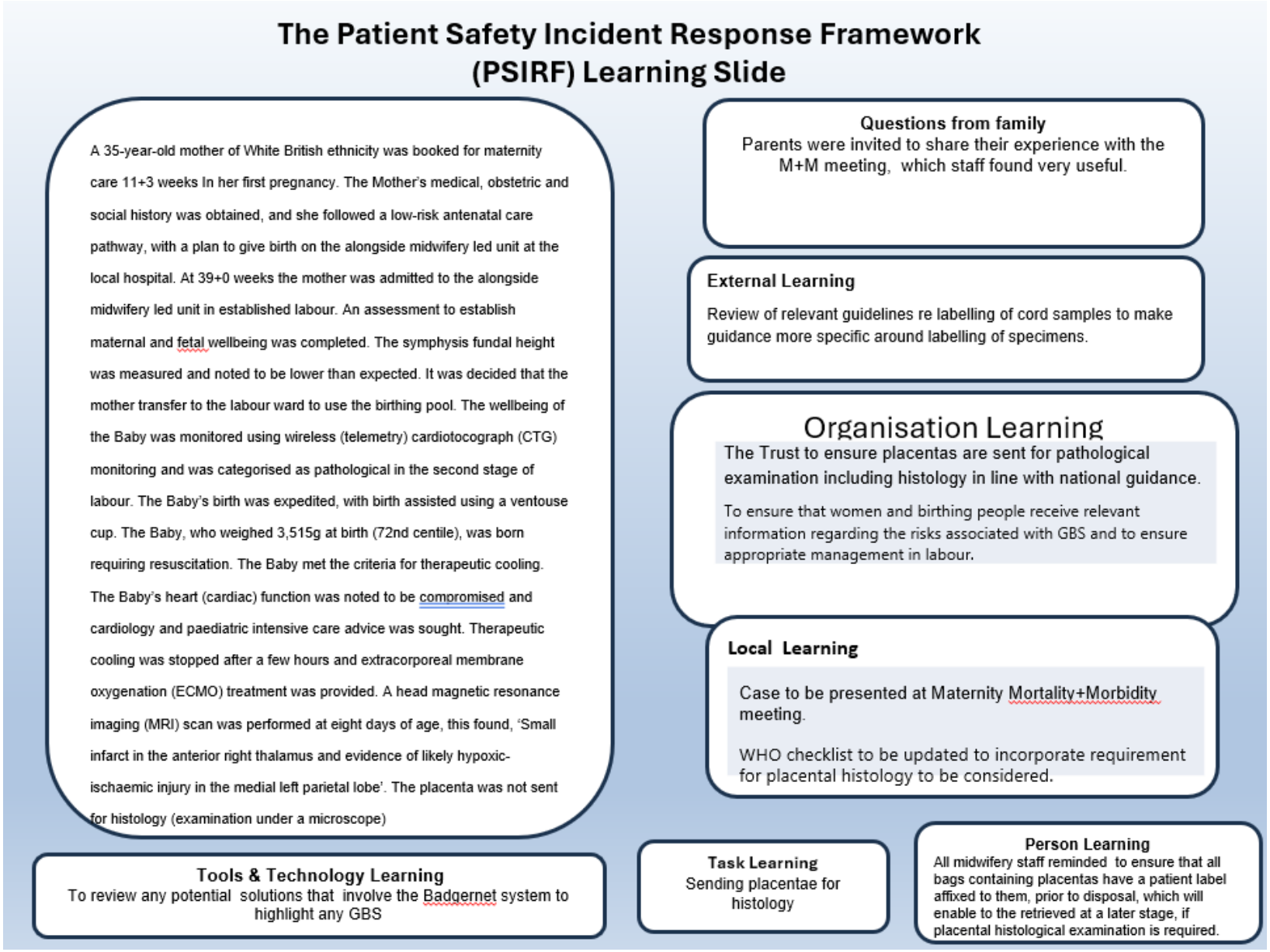
					learning identified. Thematic review of Opel 4 alerts shared with the LMNS.
Patient safety	9976595	10/06/2024	Retained vaginal swab	Seen in Gynaecology Assessment Unit (GAU) at 9 weeks post partum following a GP referral for ?retained swab and purulent discharge. She had had a straightforward ventouse delivery in Labour Ward with an episiotomy and 950ml blood loss. On speculum, a swab was seen at the top of the vagina in the anterior fornix. The swab was removed and DoC completed.	Patient Safety Incident Investigation (PSII) completed and approved through PSIIOG on 06/02/25. The action plan was shared with Quality Committee in the Quarter 3 24/25 MatNeo Safety report.
PMRT	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. Closed with grading A / B / A. Reviewed through PICU CDRM. No learning identified for UHS.
PMRT	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. Closed with grading A / B. 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.
PMRT	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. Closed with grading A / A. No learning identified.

Moderate or above incidents

Incident Date/Number	Type of Incident	Summary of incident	Outcome of incident
18/01/25 9991263	Moderate	4th degree tear, 3000mls PPH. 2 unit RBC.	For thematic review looking at 3rd and 4th degree tears.
18/01/25 9991244	Moderate	Escalated to Opel 4 due to capacity, exacerbated by medical staffing deficit / sickness.	Closed as moderate incident.
02/02/25 9992337	Moderate	4th degree tear, 3000mls PPH. 2 unit RBC.	For thematic review looking at 3rd and 4th degree tears.
15/02/25 9994045	Moderate	Escalated to Opel 4 for over 24 hours.	For review using the harm tool (see new cases section above).
07/03/25 9994802	Major incident	Baby abducted from Woodland Ward by her parents. The missing baby policy was followed and the police contacted. The baby was found by the police and returned to the hospital. The parents were arrested at the time and bailed. The baby has since been discharged home with both parents under supervision with family members with social services involvement and assessment.	Reviewed through a Patient Safety Case Review meeting. To be investigated as Patient Safety Incident Investigation (PSII). (see new cases section above) Debriefs held with staff for support.
22/03/25 9995757	Moderate	Maternity services escalated to Opel 4. Maternity patients diverted to other hospitals due to increased activity and reduced staffing.	Closed as moderate incident.
26/02/25 9995209	Moderate	G1 Low risk pregnancy – advised birth on LW due to large for dates baby. Attended ED at term with sore throat/ear pain, however, was also found to be contracting and was therefore sent to PAH. Influenza was diagnosed and was discussed. After several hours of induction, it was agreed that this was not successful, and no progress had been made. A discussion was undertaken with the patient regarding having an Emergency LSCS, in view of the poor progress and Mum was feeling very unwell with the influenza symptoms. On review in CER today, it was noted that there were several aspects of care that were deemed to be missed opportunities that warranted a further review of care.	Reviewed through CER. To be discussed with Patient Safety Team to determine whether further investigation is required.

27/03/25 9996156	Moderate	A baby born via Elective C-Section yesterday on 27/03/25 suffered a birth injury - confirmed by X-Ray to be a right humeral fracture.	To be reviewed through CER.

Lessons Learned Slide – MI-036861 / 9969358

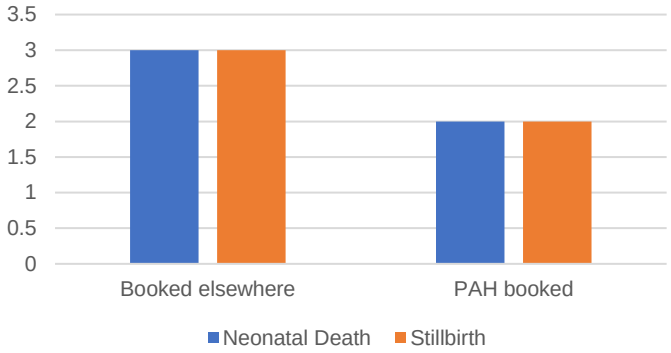


Appendix 5

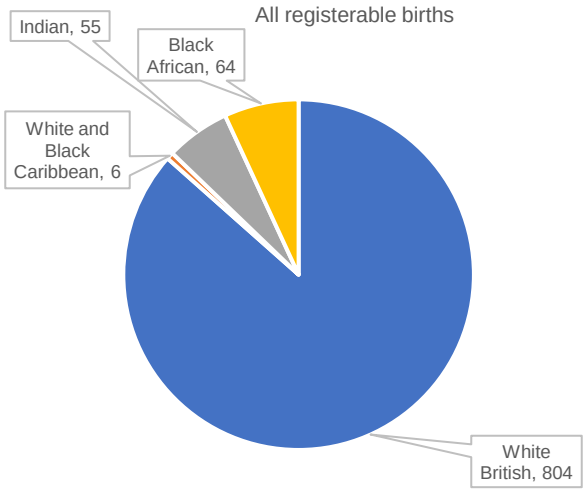
PMRT cases for Q4 2024/25

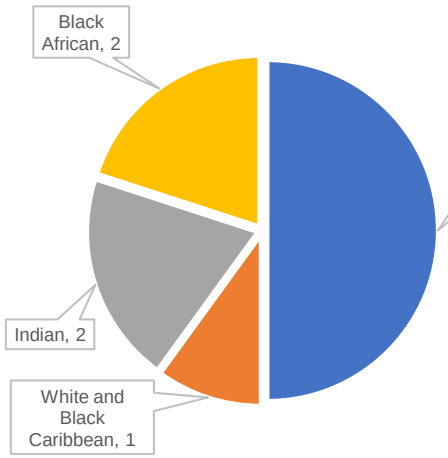
Eligible cases for PMRT = 10

- Antepartum stillbirth = 3
- Intrapartum stillbirth = 2
- Neonatal death = 5

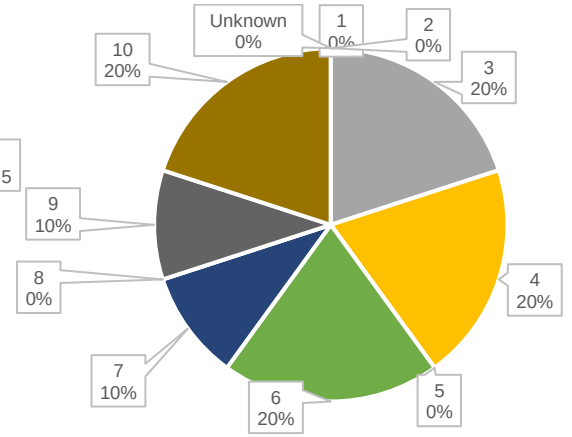


Ethnicity of women / birthing people

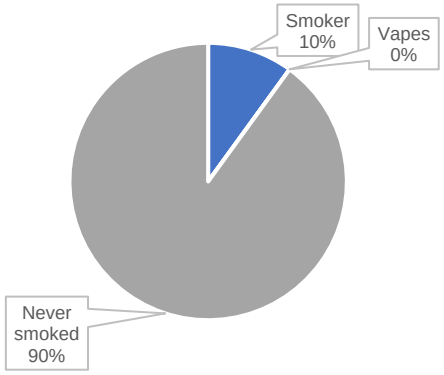




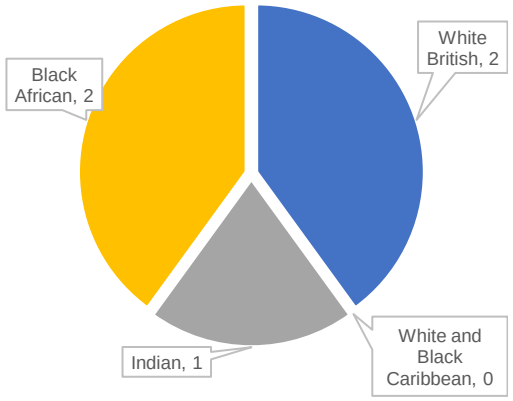
IMD deciles of women / birthing people of the MBRRACE reportable deaths



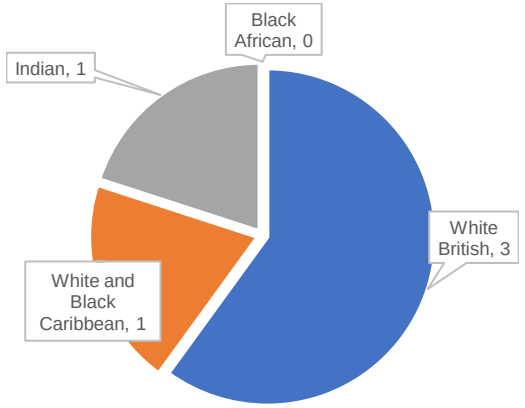
Smoking status at booking



Neonatal death by ethnicity



Stillbirth by ethnicity



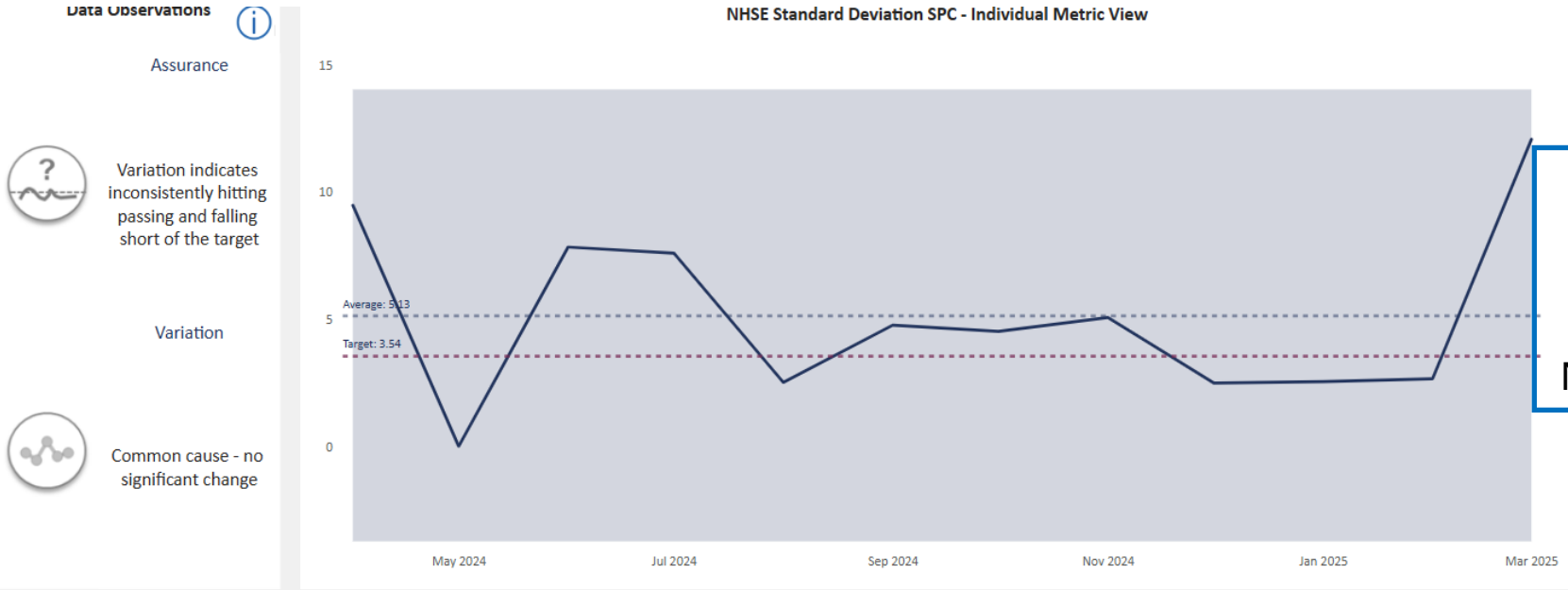
Gradings and learning:

Antepartum stillbirth:

- B / A – no FGR clinic referral, although this may not have affected the outcome
- B / A – lack of understanding of women util HTA and MTL

Neonatal death:

- B / C / B – multiple learning points identified including documentation, reassessing the whole situation to avoid confirmation bias, avoid over diagnosis, ensure adequate assessment and the role of the neonatologist including responsibility for overview of care.
- C / A / A – PTB clinic referral (local Trust)
- A / A / A



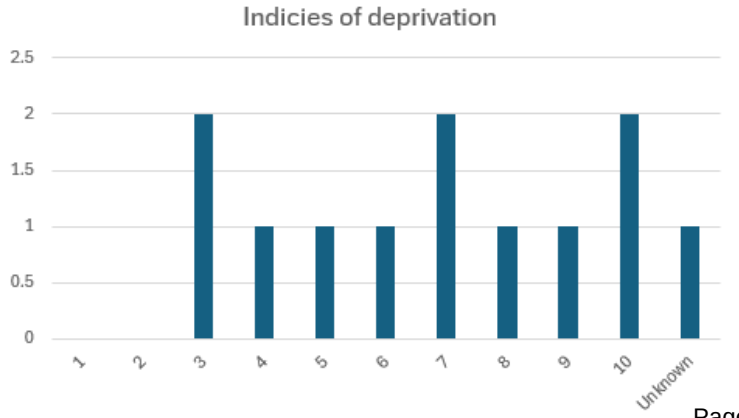
University Hospital Southampton NHS Foundation Trust

2024 rate: 4.47 per 1,000 births
2025 current rate: 5.91 per 1,000 births
March rate: 12.08 per 1,000 births
Q4 rate: 5.91 per 1,000 births
National target (2021) <4.2 per 1,000 births

Case Overview

5 cases (42% were transfers into our service for Fetal Medicine)

- Antepartum stillbirths = **4** (2 had feticide for complex abnormalities, 1 Mono twin post laser, 1 total heart block)
- Intrapartum stillbirth = **1**



Fetal Medicine Involvement (92%)

- Antepartum stillbirth – all cases
- Intrapartum stillbirth – Nil – 1 case unexpected (abruption)

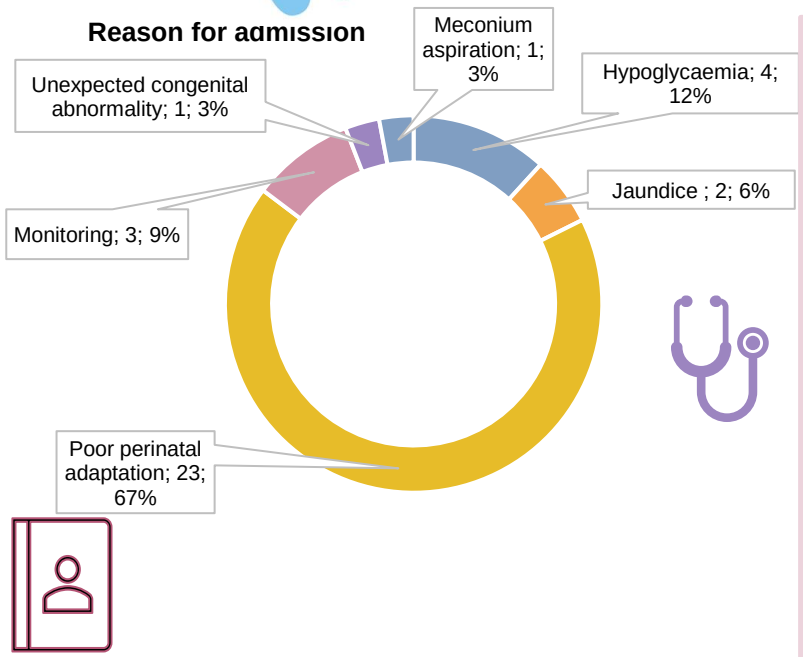
ATAIN

Appendix 6

Qtr. 4 2024/25 – 34 unexpected term admissions

NHS University Hospital Southampton NHS Foundation Trust

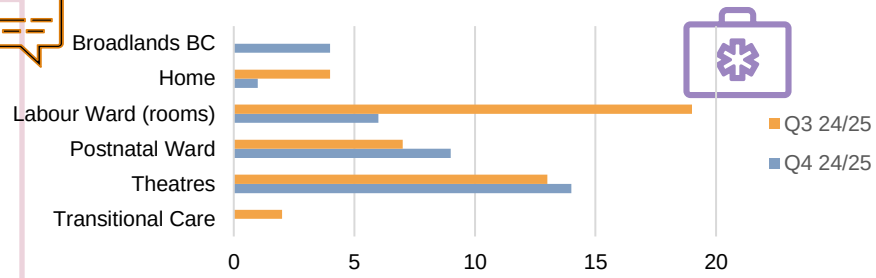
Reason for admission



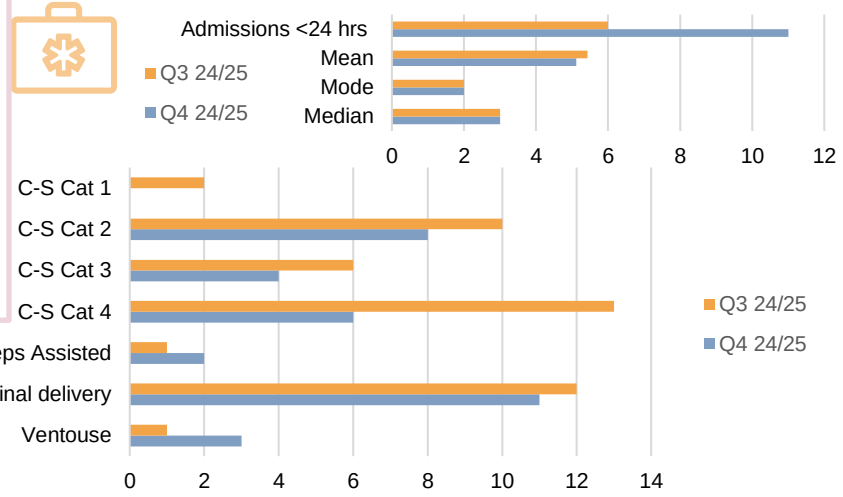
Learning identified

- 19 cases identified for review
- 17 reviews completed
- 4 cases deemed avoidable admissions
- The admission for 2 of the babies admitted for less than 24 hours was felt to be avoidable if an in reach nurse was available.
- 8 of the 11 babies admitted for less than 24 hours were transferred to TCU
- Themes/issues highlighted:
  - Documentation
  - Thermoregulation
  - Staffing / acuity
  - Situational awareness

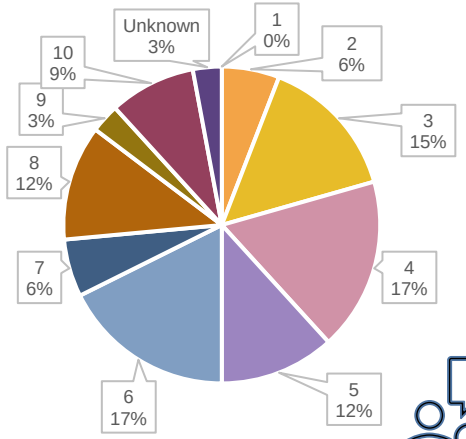
Admission from



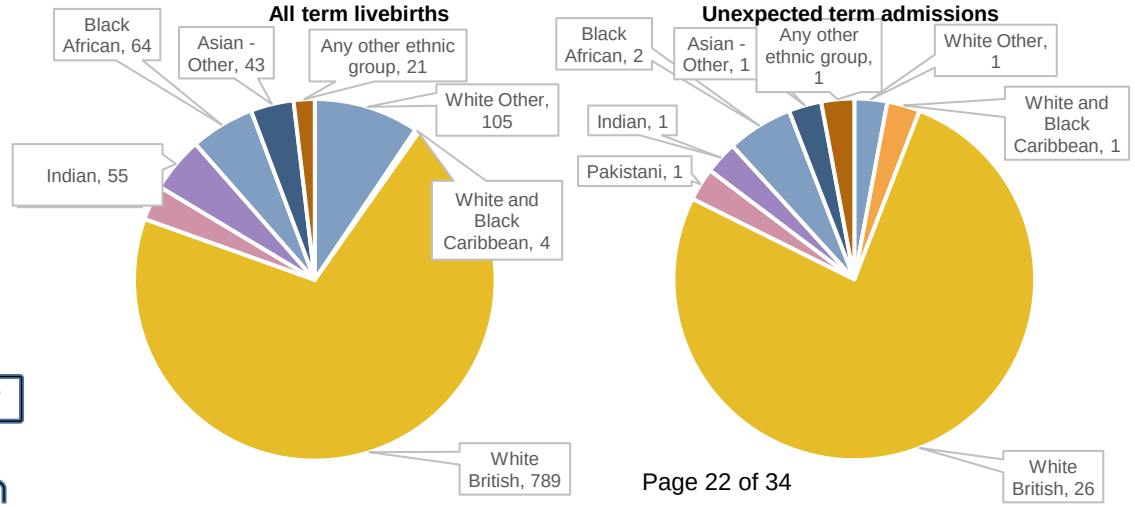
Average number of care days

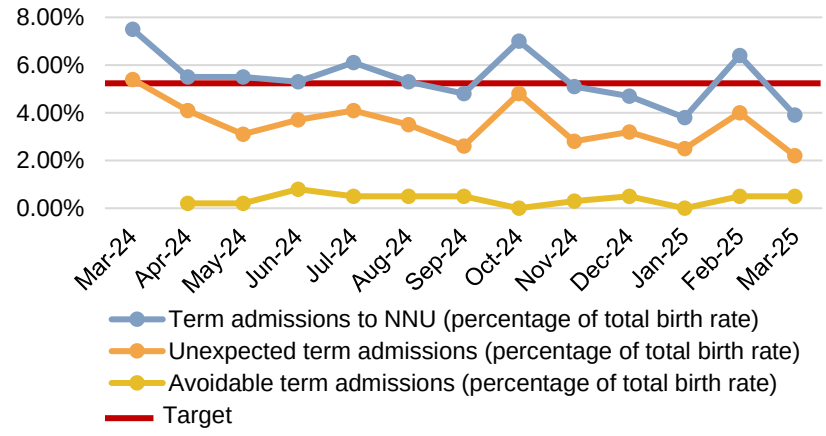


IMD deciles of women / birthing people



Ethnicity of women / birthing people





Appendix 7

Triangulation of claims, incidents and complaints – Q4 24/25

Claims

Early notification scheme:

- 1 case (Dec 2024) – therapeutic hypothermia

Pre-action disclosure:

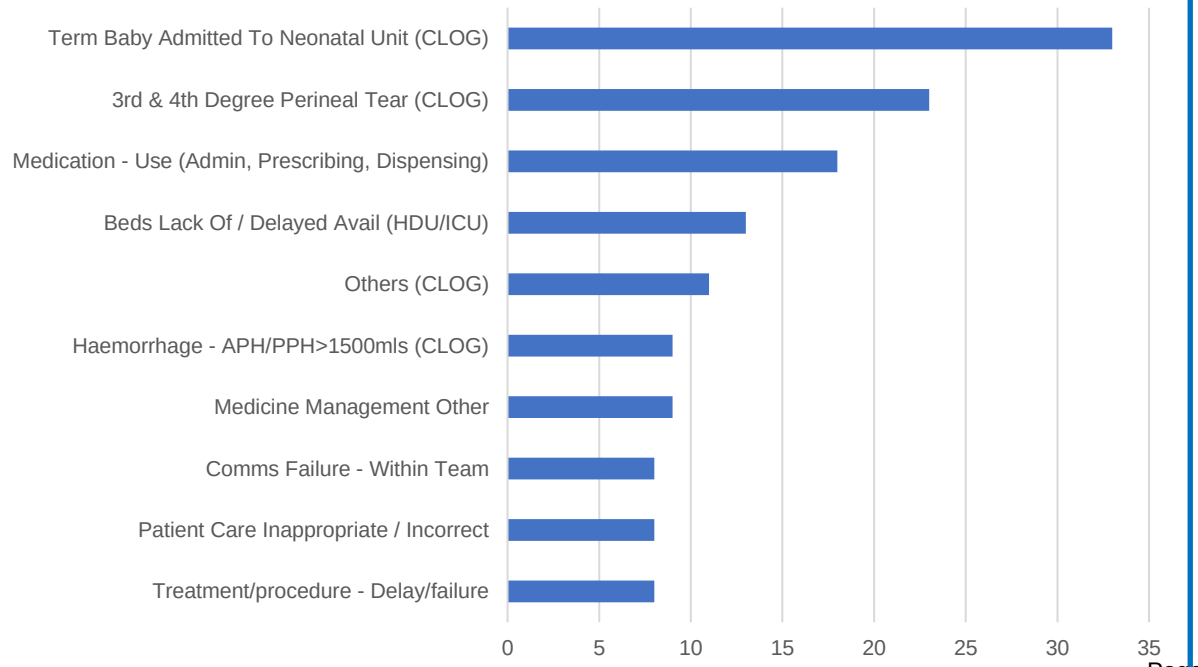
- 1 case (Sept 2023) – delay to treat

Settled claims:

- 1 case (July 2019 – failure to treat, settled with £20k damages
- 1 early notification case (Feb 2021) – settled with £0k damages

Incidents

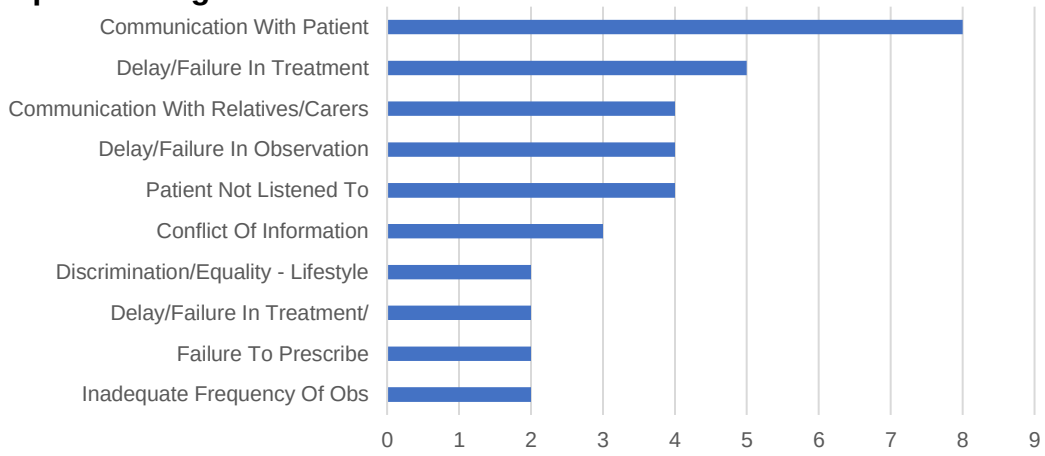
Top 10 reported incident categories



Complaints:

- 12 complaints received in Q4 24/25 with 2 complaints re-opened.
- 8 complaints closed:
  - 2 complaints upheld
  - 4 complaints partially upheld
  - 2 complaints not upheld

Top 10 complaint categories



Commonalities:

- Delay / failure to treat
- Communication – with patients / with relatives / with carers / within team
- Medication (including prescribing and management)

Actions:

- Launched NEWTT2 within Maternity Services
- Launch of revised digital MEWS within Maternity Services
- Launch PAH cultivating kindness campaign

Appendix 8

UHS Perinatal Culture & Leadership Quadrumvirate (QUAD) Team

Emma Northover
Director of Midwifery

Bala Thyagarajan
Consultant Neonatologist

SCAN ME

Hannah Kedzia
Care Group Manager W&N

SCAN ME

Ganga Verma
Maternal Fetal Medicine Consultant

SCAN ME

Marie Cann
Consultant Midwife

SCAN ME

QUAD Survey

The Quad Team has three main aims:

1. Nurture a positive safety culture.
2. Enable psychologically safe working environments.
3. Build compassionate leadership to make work a better place to be.

Please feel free to contact us

Where Are We In The Programme?

We Are Here - at the end of Phase 3 of programme and in the SCORE Actions & Cultural Conversations stage

Phase 1 – 'Practive' Programme (7 months)

- 3 Modules (completed)
- 4 Action learning sets (ongoing)

Phase 2 – SCORE Survey (3 - 4 months commenced Feb 2023)

Mapping (complete) → **Live survey (in progress)**

↓

Results

'Change' Team

- Themes and findings of score survey (once completed)
- Areas of improvement (taken forward by Change Team)
- Shared learning and feedback on the programme

Phase 3 – Korn Ferry (5 - 6 months)

- **Context to programme**
- **Quad development sessions**
- **Quad check in sessions**
- **Cultural conversations**

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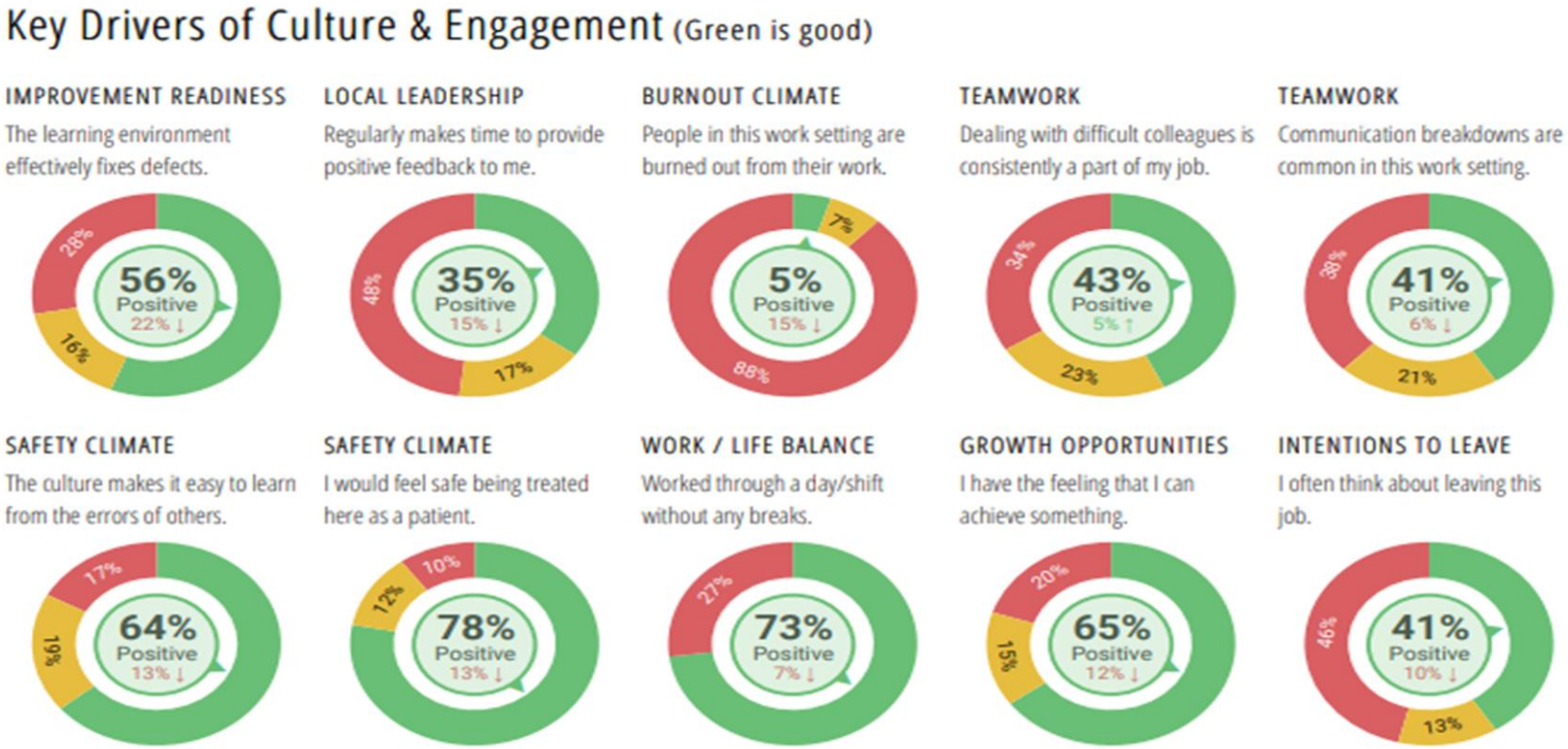
SCORE Survey and Action Plan Update

Key Drivers of Culture & Engagement (Green is good)



Safe & Reliable HEALTHCARE

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NHS Foundation Trust

Quad Action Plan

Recommendation	Action / Improvement	Who will be responsible	Current Compliance	Completion	Comments
To promote efficient & effective use of technology	Make use of Digital innovations wherever possible.	Digital lead & Digital team	Amber	Continual digital innovations for staff and families in our service	eWhiteboards
To empower staff to role model positive behaviours & compassionately challenge incivility	Incorporate Civility sessions in all training. Project & transformation teams to focus on civility. Revisit Teach or Treat approach. Hold QUAD walkabouts/focus sessions Launch MOMENTS training	Practice Education team & Clinical leads	Amber	Training contains civility. QUAD – Posters and Survey Involve MNVP PAH Cultivating Kindness Campaign launched April 25.	Involve Q&S Partners in MatNeo.
Create environments for constructive feedback to support continuous improvement	Work with AHSN team to explore approaches.	QUAD team	Amber	In progress	AHSN are completing supportive sessions for the QUAD and change team
Share findings from the SCORE survey with the wider service	Work with the Change team to implement findings	Change Team		In progress	QI sessions relaunched in the service

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Appendix 9

Maternity and Neonatal Voice Partnership

Q4 Update

MNVP Chair Quarterly Update – Quarter Four (Jan–Mar 2025)

Summary of Activity:

This quarter has seen a strong focus on gathering and amplifying service user feedback across several key areas of maternity and Neonatal care. Particular focus areas have been to explore experiences around neonatal care specifically home oxygen therapy and developing of educational videos and Caesarean births. A combination of digital engagement, one-to-one conversations, and group events has helped ensure a broad range of voices were heard.

Key Highlights

Feedback Themes:

- **Neonatal Feedback** – Home Oxygen Therapy: Feedback was collected from families who had experience with home oxygen use post-discharge. Themes included the clarity of instructions, emotional support provided at home, and confidence in using the equipment, all of which came back positive. Key constructive feedback was to try to empower parents and provide confidence for use at home.

- **Caesarean Birth Experiences**: Feedback was actively sought through social media channels. Service users who had planned Caesareans largely reported positive experiences, noting clear communication and supportive staff. In contrast, those who underwent emergency or unplanned Caesareans described feeling confused about their options and uncertain about the decision-making process at the time.

- **Antenatal Care:** While many participants expressed satisfaction with booking appointments and regular midwife contact, a number raised concerns about poor communication, especially around the non-responsiveness of designated midwife phone numbers, even during times of medical concern such as bleeding. Additional anxieties were raised around the language used during growth scans, particularly regarding measurements of the baby's head, abdomen, and the mother's bump size, which sometimes led to heightened stress in the final weeks of pregnancy.

Events and Engagement

- Listening Evening: A virtual session was held with five service users who logged on to discuss their experiences in a safe and supportive space.
- MNVP Meeting: The MNVP network meeting had 21 attendees, including a mix of professionals, community representatives, and service users.
- One-to-One Meetings: Individual conversations were held throughout the quarter, enabling deeper exploration of personal experiences and concerns.
- Mum's Drop-In Group (3rd March): This in-person session brought together local mothers with their babies to share feedback in a relaxed environment. Themes raised during the drop-in included both positive and negative experiences:

Sample Feedback – Mum's Drop-In:

- Positive:
  - *"My midwife was really reassuring throughout, and I always felt I could ask questions without being rushed."*
  - *"The continuity of care meant I saw the same person most weeks, which helped me feel really supported."*
- Needs Improvement:
  - *"When I had concerns about appointments or further questions , I was told to text my midwife – but I never got a response, ever."*
  - *"Being told my baby's head was measuring large without much explanation really made me anxious."*

Service User Voice.

I am really grateful to all of the staff that I came into contact with. I was overdue and went into hospital with reduced movements. I was strapped and monitored and then booked in to be induced. When I arrived I was given the 24 hour pessary which fortunately worked for me and my body responded well with contractions starting about 6 hours after the pessary was inserted. I was alone that night as my husband could not stay because I was on a ward (which I understand). I could feel my contractions all night and could not sleep. I did go and speak to the midwifes on duty and they recommended that I sleep. The following day my contractions were getting stronger and closer together but I was left to go through this as I had to wait until I reached the 24th hour of my pessary. The only criticism I have is that I feel I was not really checked properly for my contractions until after I removed the pessary. When they did they said 'wow, you are having hoping contractions' and at this point I was only on paracetamol and working on my breathing with my husband. I eventually was moved off the ward and down to the labour ward. My straps remained on my belly as I went into hospital for reduced movements. Due to this I was not allowed to have the water birth I hoped for. However I am grateful that the straps were on and I didn't try a water birth. I then had my waters popped by the midwife and then the pain kicked in. My baby went into a terrible position, one that he had not done until now. Before my waters were broken I could handle the contractions on my breathing. The pain was so bad I ended up trying Remifentanil which worked for about 20 minutes. Then I started to fall asleep and my breathing reduced to the point my husband asked the midwife to take me off. I was then sick and given anti sickness tablets. I ended up having an epidural (something I was against and did not want to have). My anaesthetist was amazing! Then I went to sleep for a couple of hours and woke up to a different midwife. One my husband asked to swap to suit our needs. I was woken up to several people in the room informing me that I need to have a c section because his heart rate had dropped. At this point I did not care what happened to me and agreed to do it. However, when we were ready to go to theatre my boy decided he was OK and they asked if I want to try for a vaginal delivery. I said yes and waited until I dilated more and tried to deliver naturally. However, when I was assessed by two consultants they said my boy was in too much of a difficult position that they recommend a c section. I then went into theatre completely unprepared for this to happen. However, it was the best decision I made and I have no regrets at all. The team were amazing and got him here safely. After his delivery, the consultant informed me that I would not have been able to deliver him vaginally due to the position he got himself into. I only have amazing things to say about the team at Princes Anne.

Ongoing Work:

- Continuing to gather targeted feedback on postnatal care, with a focus on emotional wellbeing, continuity, and partner involvement.
- Exploring ways to improve midwife communication pathways, especially regarding access outside of regular appointments and mobile numbers.
- Strengthening co-production partnerships with community organisations to ensure the voices of underrepresented groups are heard and acted on.
- Reviewing feedback from the Caesarean birth campaign to inform future information-sharing for parents navigating both planned and emergency sections.
- Working in collaboration with the bereavement team and bereaved service users to develop a memorial space at Princess Anne Hospital—a dedicated space for reflection and remembrance.
- Establishing a co-production group made up of committed service users who are keen to contribute regularly to policies, documents, and public-facing information. This group will help ensure materials are relevant, inclusive, and grounded in real experiences.

Looking Ahead

Next quarter, we aim to:

- Host a community event at Café 329 – Nigerian Café and Community Hub
- Promote clearer communication pathways for midwife contact outside of appointments.
- Co-produce supportive resources around unexpected birth outcomes, particularly unplanned Caesarean births.
- Continue expanding one-to-one engagement, especially with underrepresented voices.
- Regular ward MNVP presence. Work with DOM and HOM to plan set times each month for MNVP representation at PAH.
- Plan the next Listening Event and a further in-person engagement session.
- Work with trust to arrange 15 steps to take place

University Hospital Southampton
NHS Foundation Trust

Agenda Item 4.7	Report to the Quality Committee, 14 July 2025
Title:	Maternity and Neonatal Workforce Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

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 on workforce. The information provided is for assurance and reassurance, whilst meeting the requirements of NHSR Maternity Incentive Scheme (MIS) Year 7 and highlights the safety improvement work and learning from all aspects of the service. 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:

Appendices:

1. Midwifery Workforce

This report sets out the Trust's current midwifery staffing position against the requirements of the NHSR MIS Year 7 – Safety Action 5. It confirms that:

- A full Birthrate Plus® (BR+) assessment was completed in July 2024.
- The Trust is currently not fully compliant with the BR+ recommended establishment, with a total variance of 8.94 WTE.
- UHS maintains 100% compliant with one-to-one care in active labour and supernumerary labour ward coordination.
- A workforce recovery plan is in place and actively monitored through a live dashboard and strategic recruitment programme.
- The report is submitted in accordance with the requirement for six-monthly staffing oversight reporting.

The Trust is meeting 4 of the 5 MIS Year 7 Safety Action 5 requirements and has a mitigation plan in place for the remaining area of partial compliance.

Background:
The NHS Resolution Maternity Incentive Scheme (MIS) Year 7 includes ten safety actions. Safety Action 5 requires Trusts to demonstrate a systematic and effective approach to midwifery workforce planning. Key requirements include:

- Completion of a recognised, evidence-based staffing review within the last three years.
- Funded establishment that reflects the calculated requirement.
- Compliance with national standards for labour ward coordination and intrapartum care.
- Board-level reporting and oversight every six months.

University Hospital Southampton (UHS) uses Birthrate Plus®, the nationally endorsed workforce planning tool, to calculate its midwifery staffing needs.

Assessment and Assurance:
1.1 Birthrate Plus® Review (Requirement a):
✅ *Compliant*

A full BR+ assessment was completed in July 2024, based on a 3-month casemix sample. Key findings included:

- Total annual births: 4,993
- High acuity casemix: 76.6% in Categories IV & V (high risk)
- Recommended establishment: 257.76 WTE (230.14 clinical; 27.62 specialist/managerial)

1.2 Funded Establishment (Requirement b):
❌ *Partial Compliance*

The current funded WTE is 248.82, resulting in a variance of -8.94 WTE from BR+ recommendations.

Workforce Group	Funded WTE	BR+ WTE	Variance
Clinical Midwives & MSWs	226.42	230.14	-3.72
Specialist/Managerial Roles	22.40	27.62	-5.22
Total	248.82	257.76	-8.94

To mitigate the current shortfall in funded establishment against Birthrate Plus® recommendations, the Maternity Service has implemented a range of measures to ensure continued safe and sustainable service delivery. These include:

- Ongoing recruitment activity, 34 WTE band 5 midwives joined the maternity team in November 2024 / January 2025, and a further 16.6 WTE newly qualified midwives with conditional offers in the pipeline to offset forecasted leavers between January and November 2025.
- A proactive skill mix review**,** focusing on safely increasing the contribution of Maternity Support Workers (MSWs) in postnatal and community settings, working toward a 90/10 RM:MSW ratio, in alignment with Birthrate Plus® recommendations.
- Continued use of a live workforce dashboard, which integrates data from e-rostering and ESR to provide real-time monitoring of funded versus actual WTE, absence, maternity leave, and recruitment pipeline.
- Active engagement with the Local Maternity and Neonatal System (LMNS) and regional workforce planning groups, particularly in support of graduate recruitment and workforce supply**.**

In addition to the structural staffing gap, operational availability is further impacted by workforce demographics, with the maternity workforce being predominantly female. As of July 2025:

- 5.0 WTE staff are currently pregnant and awaiting maternity leave, and
- 7.9 WTE (3.8%) are currently on maternity leave.
- Short-term sickness absence accounts for 8.6 WTE (4.1%).

These factors contribute to a dynamic and often constrained staffing environment, reinforcing the importance of robust mitigation measures and flexible deployment strategies to maintain safe care provision.

1.3. Labour Ward Coordination (Requirement c): reporting period 02/04/25 to 30/11/25 – this report covers 02/04/25 to 30/06/25

✅ *Compliant*

UHS maintains 100% supernumerary labour ward coordinator presence on all shifts, supported by:

- Rostered and actual presence validation.
- Formal escalation process in the event of unavailability.
- No Red Flags (RF10).

1.4. One-to-One Midwifery Care in Labour (Requirement d): reporting period 02/04/25 to 30/11/25 – this report covers 02/04/25 to 30/06/25

✅ *Compliant*

The Trust continues to meet the requirement for 1:1 care in active labour. Supporting evidence includes:

- 100% compliance via acuity tool monitoring.
- No Red Flags (RF9).
- OPEL escalation used appropriately (23 declarations YTD).

Number of Red Flags recorded
02/04/2025 to 30/06/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	5	21%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	1	4%
RF5	Delay between presentation and triage	1	4%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	13	54%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator not able to maintain supernumerary/supervisory status	0	0%
RF11	Unable to facilitate women's choice of birth place	4	17%
TOTAL		24	

*The % is rounded to nearest whole number

1.5. Oversight Reporting (Requirement e):

✅ *Compliant*

This paper serves as the first of two required six-monthly oversight reports to the Trust Board during MIS Year 7. The next report is scheduled for submission in January 2026.

Risks and Mitigations:

Risk	Impact	Mitigation
Understaffing	Potential impact on maternal/neonatal outcomes	Escalation protocols, temporary staffing, on-call cover
Financial	Risk to MIS incentive and increased bank/agency reliance	Recruitment pipeline and retention initiatives
Workforce sustainability	Risk of burnout, low morale, and reduced retention	Staff wellbeing, flexible working, career development
Reputational/Regulatory scrutiny	Non-compliance with BR+ recommendations	Transparent Board reporting; active commissioner engagement

Conclusion:

The Trust has in place a robust midwifery workforce planning and assurance framework that satisfies the majority of requirements under MIS Year 7 – Safety Action 5. Where full compliance has not yet been achieved, clear plans and mitigations are in place, with timelines agreed and shared with system partners.

Recommendation to the Trust Board:

The Board is asked to:

1. Note the completion of the Birthrate Plus® workforce review (July 2024).
2. Acknowledge the current shortfall of 8.94 WTE and partial compliance with the funded establishment requirement.
3. Endorse the current recovery plan and workforce trajectory to address this shortfall.
4. Confirm that UHS continues to provide safe care with full compliance in 1:1 labour care and supernumerary coordination.
5. Approve this report as formal evidence for submission to NHS Resolution in line with MIS Year 7 – Safety Action 5 requirements.

2. Obstetric Workforce

2.1 Overview of Services

University Hospital Southampton (UHS) delivers a wide range of maternity tertiary-level services within the Wessex region. These services include fetal medicine for areas such as Hampshire, the Isle of Wight, Dorset, Salisbury, and the Channel Islands. UHS also provides fetal cardiac services for patients from Oxford and Plymouth, a Level 3 neonatal service, and paediatric surgical services.

The hospital operates as part of the Wessex Maternal Medicine Network, offering a regional maternal cardiac clinic and access to a network obstetric physician. Additionally, there are maternal medicine subspecialists available, along with specialist clinics in haematology and neurology. UHS also runs other specialised clinics focusing on preterm birth, multiple pregnancy, substance misuse, diabetes and endocrine disorders, and fetal growth restriction.

2.2 Current Obstetric Consultant Workforce

The current consultant workforce is comprised of 14 consultants (including one long term locum) contributing to the non-resident on-call rota, 2 consultants resident on-call and one consultant not on an on-call rota.

There are also obstetric PAs provided by consultants who cover both obstetrics and gynaecology and undertake planned caesarean lists and antenatal clinics. Overall, 22 consultants have Obstetric PAs as part or all of their job plan (2 of whom are in locum posts) totalling 16 WTE.

For provision of tertiary services, there are six subspecialist consultants in fetal medicine and two consultants with a special interest in the field. In maternal medicine, there are five subspecialist consultants (some of whom also work in fetal medicine), and two consultants with a special interest. One consultant is currently on phased return with reduced duties, and one is working in a locum capacity. The obstetric physician post is additional to the obstetric workforce and is currently vacant following retirement in May 2025. Recruitment posts are currently underway for the obstetric physician post as well as to convert the maternal medicine special interest post from locum to substantive.

In addition to these, there are five consultants with combined obstetrics and gynaecology practice, and three consultants focused solely on obstetrics, one consultant who did sole obstetrics retired in May 2025 and this post is currently in the recruitment process.

2.3 Middle Grade and SHO Staffing

The middle grade rota operates on a two-tier system with a 1:9 pattern. It includes deanery trainees, clinical fellows, and those from gynae-oncology and reproductive medicine subspecialties. The senior house officer (SHO) rota also runs on a 1:9 basis.

2.4 Key Challenges

A recent capacity and demand analysis has identified a gap of 4.5 whole-time equivalent (WTE) consultants required to adequately support the current service needs. It is important to note that this 4.5 WTE deficit will not be addressed by the recruitment processes that are currently underway. The existing rota does not have built-in compensatory rest, and there is a growing requirement for evening ward round coverage. Consultants are being called in more frequently during overnight hours, and there remains an ongoing reliance on consultants acting down to cover middle grade gaps.

The middle grade rota is experiencing instability due to gaps in staffing and a rise in sick leave. Sick leave is currently at 9.6% among this workforce, well above the Trust average. As of June 2025, there are 3.6 WTE gaps on the junior rota and 1.6 WTE gap on the senior rota, totalling 5.2 WTE, see A**ppendix A**. While two new fellows are expected to start in June and July, upcoming resignations, maternity leave, and continued sick leave, are likely to create further gaps. These issues have negatively affected staff morale and training opportunities, prompting input from Human Resources and the Director of Medical Education. Furthermore, the current processes for managing cover arrangements are not robust and require improvement.

Guidance on appropriate standards for compensatory rest for consultants and senior SAS doctors following non-resident on-call activity from the RCOG states that compensatory rest for consultants should be actively supported and facilitated by the management team. It recommends that the decision to take rest is not left to the individual consultant but agreed via constructive discussion between the manager/clinical director and clinician and that job planning should factor in these recommendations for compensatory rest. The British Medical Association's (BMA) compensatory rest guidance recommends that consultants who are unable to take 11 hours of consecutive rest per day should be entitled to take compensatory rest. This reflects both in person attendance and telephone calls disrupting sleep. Compensatory rest should not be calculated on a minute-for-minute basis, with the guidance recommending it should be for the full value of 11 hours' continuous rest with the clock starting when a consultant gets back to resting.

There is currently no compensatory rest built in following on-calls for obstetric consultants, going forward, efforts are being made to try and schedule on-calls prior to non-clinical activities so that if a consultant is required to be in the building after midnight they can be supported to have the morning off without a major impact on clinical activities, however this still does not allow for 11 hours uninterrupted rest.

2.5 Actions Taken

In response to these challenges, the team has taken several proactive measures. Most resident on-call consultants have been transitioned to non-resident status. A process for providing compensatory rest following on-call shifts has been introduced and is now actively monitored. A diary exercise has recently been completed and is being analysed to evaluate consultant workload and call-in frequency.

Recruitment processes are underway for the replacement of consultant posts as explained above. However, these will not address the 4.5 WTE gap identified in the demand and capacity exercise. Two senior fellows have also been recently appointed to help address staffing shortfalls.
The risk register has been updated to reflect workforce concerns.

2.6 Next Steps

Anticipating further gaps in the middle grade rota, there is intention to recruit in advance to ensure continued service stability and to continue developing the Fellow Programme. There is a current consultation to improve the processes around sick leave to optimise support and supervision with the aim of reduction in rate.

Once the current consultant replacement recruitment processes are completed, support is required to compose a business case to address the 4.5 WTE gap.

A redesign of the consultant rota is underway. The proposed changes include a fixed on-call pattern with resident coverage extended to 22:00 and the inclusion of built-in compensatory rest. This redesign aims to balance on-call responsibilities, rest periods, tertiary service provision, and gynaecology sessions. Further recruitment is likely to be needed to support this.
Finally, UHS aims to expand its range of specialist services by establishing new clinics, such as the Rainbow Clinic, Perinatal Mental Health (PNMH) services, and a Placenta Accreta Spectrum (PAS) service to reflect its standing as a tertiary service.

3. Neonatal Nursing Workforce

Over the last few years, the Neonatal Service has expanded. The Neonatal Service has increased the number of commissioned intensive care (IC), high dependency (HD) and special care (SC) cots.

	Previously commissioned	Currently commissioned
IC	12	15
HD	13	12
SC	14	16

To comply with BAPM standards, 21 nurses are required for every shift. There is currently a vacancy of 39 WTE band 5 QIS nurses. The lack of suitably trained neonatal nursing staff to safely care for intensive care babies remains on the Trust Risk Register. There is an ongoing plan to increase the number of qualified in speciality (QIS) nurses with inhouse training. At present, due to the inability to safely staff all cots, there are 8 cots flexed down. There is an aim to open 2 cots by the end of November 2025, with the rest of the cots opening early 2026.

Please see **Appendix B** for evidence progress against the previously agreed action plan from NHSR MIS Year 6. **Appendix C** is the action plan for Year 7.

4. Neonatal Medical Workforce

In 2024 Southampton Neonatal Unit delivered 3089 ITU care days. Medical staffing meets the BAPM recommendations for units delivering >2500 <4000 ITU care days as follows:

- All consultants are on the specialist register and dedicated only to the Neonatal Unit and only have primary duties here.
- As a minimum on both day and night shifts there are two tier 1 doctors or ANNPs and two experienced resident doctors ST4-8 or appropriately trained specialty doctor or ANNP covering the Neonatal Unit.
- During normal working hours, there are 3 consultant-led teams covering the Neonatal Unit. During 2025 this will increase to 4 consultants on service during the week following the Neonatal Unit expansion and increase in cot numbers.
- On-site consultant cover is provided for more than 12 hours a day (0830-2300) Monday to Friday and 0830-2200 at the weekend.

4.1 Current Risks

At night (2030-0830) one of the tier 2 staff covers the regional transport service so may be called away from the unit, leaving only 1 dedicated tier 2 medical team member.

4.2 Risk Mitigation

Due to minimum staffing of both two tier 1 and two tier 2 doctors on all shifts, even if the tier 2 doctor/ANNP covering the transport service is called out overnight, there will still be 3 medical staff on the unit. In addition, as well as the on-call consultant (who will be on site till 2300) there is a second consultant available on-call at home if needed. Furthermore, the number of transport referrals requiring medical cover at night are minimal.

4.3 Recruitment and Retention Strategy

We have a good track record of ensuring our resident doctor rota at both tier 1 and 2 are filled and compliant. We have done this through innovative approaches including a highly successful medical training initiative (MTI) scheme, joint recruitment to clinical fellow posts with general paediatrics and continuous training and recruitment of ANNPs. Whilst not having enough resident medical staff is always a risk, we are confident that we can continue to maintain a full compliant resident medical rota.

Due to reorganisation of existing PAs, an additional 10 PA consultant was required and has been recruited, commencing in September 2025. Due to several long-term sickness absences, this has been recruited to as a locum basis for expediency, with a view to conversion of this into a substantive position in 2026. Another existing filled locum position is also due for conversion into a second substantive post in the Autumn 2025 - but we plan to delay this to enable a single round of recruitment for both posts to take place simultaneously. A third short term locum contract (3 months) has been recruited to cover the clinical workload until commencement of the successful appointee in September. This contract could be extended if required to cover ongoing long-term sickness absence and/or out-of-hours cover during phased return to work processes.

4.4 Conclusion

Medical staffing essentially meets BAPM recommendations although this has been challenging to maintain at times with long-term sickness absence in the consultant workforce. The clinical service has been maintained with cover provided by the existing senior team, and plans are in place to extend a 3 month locum contract if required to reduce the need for this to continue indefinitely.

Risk(s):
The University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Services operate within a complex regulatory and governance framework. Several key risks have been identified that may impact service delivery, organisational performance, and the safety of women, birthing people, babies, and staff: • **Reputational Risk**: Any concerns relating to safety or quality of care may be raised by service users or stakeholders to external regulatory bodies such as NHS Resolution and the Care Quality Commission (CQC), potentially affecting public confidence in our services. • **Financial Risk**: Ongoing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) remains essential. Failure to meet all ten required Maternity Safety Actions could result in the loss of financial incentives and increased scrutiny. • **Governance Risk**: Significant concerns regarding safety or quality can be escalated to a range of national and regional stakeholders, including the CQC, NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, and the Regional Chief Midwife. This may lead to formal reviews or additional oversight. • **Safety Risk**: Non-compliance with national requirements, standards, or recommendations can have serious consequences, including increased clinical risk to women and babies, reduced staff morale and wellbeing, and ultimately poorer outcomes. The Maternity and Neonatal Safety Improvement (MNSI) programme has the authority to raise formal concerns and trigger external reviews where safety is questioned. UHS remains committed to proactively addressing these risks through robust governance processes, continuous quality improvement, and transparent engagement with our staff, service users, and external partners.

Equality Impact Consideration:	N/A

Middle Grade and SHO staffing deficits – Appendix A

JR	WTE			SR	WTE		
1	GAP (trust fellow employed in this post will start in July)	Deanery	Mat leave	1	100%	Fellow	
2	100%	Deanery		2	100%	Deanery	?IDT
3	100%	Fellow		3	100%	Deanery	
4	60% no on call cover	Deanery	Career break- August	4	GAP from 31/07	Fellow	
5	80%	Deanery		5	100%	Fellow	
6	100% no on call cover	Deanery	Not doing on-call (maternity leave August?)	6	60%	Fellow	
7	100%	Fellow		7	50/50%	SSTx2	Mat leave Aug (50%)
8	100%	Deanery		8	80%	Deanery	
9	GAP			9	60%	Deanery	Leaves Jul
TOTAL WTE	7.2			TOTAL WTE	7.0		

Appendix B

Progress against action plan for NHS Resolution 2024 MIS Year 6

Safety Action 4: Can you demonstrate an effective system of neonatal nursing workforce planning to the required standard?

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion	Current Status
1 – Increase further the numbers for inhouse QIS training	• We have a strategy with approved funding for increasing QIS training rates in house and talent management in recruiting the right people for the training positions. • Full recruitment to non-QIS vacancies to support their development prior to starting.	Victor Taylor Neonatal Services Matron	This is a long-term goal. Sept 24 vacancy for B5 QIS is 16 WTE, which equates to approximately 2 training cohorts. However, with the neonatal expansion, the vacancy will increase to 30 WTE. This equates to approximately 4 training cohorts in total. At present, there is 1 cohort a year.	This continues to be ongoing. 8 QIS Qualifying in July 2025 reducing B5 QIS vacancy from 26 WTE to 18 WTE (this vacancy had increased due to expansion).
2 – Continued education and training needs of the workforce	• Consultant Nurse now in post to support the B7 education lead and to take a lead on nurse education.	Victor Taylor Neonatal Services Matron	Completed Sept 23.	Completed.
3 – Continue rolling advert for B5 and B6 QIS nurses	• Rolling advert continues. • Engagement with recruitment team to promote this hard to recruit cohort.	Victor Taylor Neonatal Services Matron	Ongoing recruitment into B5 and B6 QIS posts. Review March 25.	This is an Ongoing Action. Adverts continue with a remarketing approach to offer trainee neonatal nurse positions.

Recommendation	Action Plan	Action Owner	Target for Completion	Current Status
4 – Continue to recruit at B4	• Rolling adverts. • Internal development for promotion. • Link to Trust international recruitment team to identify those with appropriate experience for neonatal services.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 25.	Successful recruitment reducing Band 4 vacancy to 9.6 WTE. Current recruitment plans are to focus on trained vacancy and current Band 4 applicants. Once embedded further recruitment for Band 4s will continue.
5 – Continued focus on wellbeing and culture	• Engagement with staff survey and “you said, we did” feedback to teams on outcomes with specific action plan linked to feedback results. • Formulate an action plan following results of the 2023 staff survey and SCORE survey, focusing on burnout and continuing personal professional development. • Improve response rate to the staff survey 2024. • Continue to celebrate diversity.	Victor Taylor Neonatal Services Matron	Ongoing. Review March 25.	Expansion completed June 2025, this has enhanced the rooms and working environment. Wellbeing team continues to be developed and grown with a Band 7 lead. Neonatal TRIM team expanding. There has been a continued focus on celebrating diversity including celebrating pride month and days focusing on international nurses' cultural awareness. Continued encouragement with staff survey and ‘’you said, we did’’.

Appendix C

Action plan for NHS Resolution 2025 MIS Year 7

Safety Action 4: Can you demonstrate an effective system of neonatal nursing workforce planning to the required standard?

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion
1 – Increase further the numbers for inhouse QIS training	• Embed 8 QIS Qualifying in July 2025	Felicity Oldman Neonatal Services Matron	July 2025
	• 8 staff to complete QIS training in July 2026.		July 2026
	• 8 staff to complete QIS training in December 2026.		December 2026
	• Continue to recruitment to non-QIS vacancies to support their development prior to starting.		Ongoing action – with the aim for the total NNU vacancy to decrease to 10 WTE by December 2025.
2 – Continued education and training needs of the workforce	• Enhance Education Team by employing additional clinical educators (1WTE B4, B5 and B6), who would provide clinical teaching focus only.	Felicity Oldman Neonatal Services Matron	September 2025.
3 – Continue to recruit B5 QIS nurses and non-QIS nurses.	• Rolling advert continues with engagement with recruitment team to promote this. • 8 newly qualified nurses to start in October 2025	Felicity Oldman Neonatal Services Matron	Ongoing recruitment into B5 and B6 QIS and non-QIS posts. Adverts continue with a remarketing approach to offer trainee neonatal nursing positions. Plan to review in March 2026.
4 – Continue to recruit at B4	• Rolling adverts. • Internal development for promotion. • Support Apprenticeships to grow our own workforce.	Felicity Oldman Neonatal Services Matron	Ongoing. Review March 26.

Recommendation	Action Plan	Action Owner	Target for Completion
5 – Recruit Band 7 with BFI & FI Care focus	• Grow and support Breastfeeding and Milk Bank service. Band 7 6-month secondment. • To enhance use of 4 X FI Care rooms.	Laura Campbell Neonatal Operations Matron	December 2025.
5 – Continued focus on wellbeing and culture	• Grow and develop wellbeing team with Band 7 leadership. • Explore more flexible working and staff preferences as vacancies decrease – use of staff survey to get full understanding of thoughts around rostering. • Grow Neonatal TRIM team – encourage staff with an interest in TRIM to attend trust training. • Continued focus on celebrating diversity including celebrating pride month and days focusing on international nurses' cultural awareness. • Lead identified to join EDI PAH working group. • Continued encouragement with staff survey and ‘’you said, we did’’.	Felicity Oldman Neonatal Services Matron	Long Term & Ongoing. Review March 26.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.5 Report to the Trust Board of Directors, 15 July 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:

- Spending Review 2025
- 10 Year Health Plan
- Assisted Dying Bill
- Review of Patient Safety Across the Health and Care Landscape
- National Maternity Investigation
- NHS Oversight Framework 2025/26
- Urgent and Emergency Care Plan
- NHS Waiting Lists
- Industrial Action – BMA Ballots
- Agenda for Change Pay Deal
- North East London NHS FT Verdict
- Statutory and Mandatory Training
- Hampshire and Isle of Wight Healthcare Strategy
- Council of Governors Elections

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

Spending Review 2025

The Chancellor of the Exchequer presented her Spending Review to Parliament on 11 June 2025. The review is intended to set planned spending totals for all government departments for the next three to four years.

Day-to-day spending will increase from £517.5bn in 2025/26 to £583.9bn in 2028/29, an average real terms increase of 1.2% a year. Over half of this increase will go to the Department of Health and Social Care, with education and defence accounting for much of the rest. Investment spending too (capital departmental expenditure limit) will increase in real terms an average of 1.8% per annum.

Health spending has received the largest day-to-day increase in cash terms, although the increase is smaller than in previous years – historically, 3.6% per annum. Most of the investment spending increases were for defence, transport, energy, and science and innovation.

In general, the increases in spending were smaller than those in the previous two Spending Reviews. Several departments will have decreases in their budgets across the Spending Review period.

Over the Spending Review period (2023/24 to 2028/29), the NHS in England will receive 3% on average real terms growth in day-to-day spending, equivalent to £29bn. In addition, whilst capital will increase by 3.2% over the whole period, the level of the capital departmental expenditure limit between 2026/27 and 2029/30 is broadly flat.

Table 5.6: Department of Health and Social Care

								Average annual real growth[4]	
£ billion (current prices)	Outturn 2023-24	Plans[1] 2024-25	Plans[2] 2025-26	Plans 2026-27	Plans 2027-28	Plans 2028-29	Plans 2029-30[3]	Phase 2 Period[5]	SR 2025 Period[6]
Resource DEL	177.9	193.3	202.0	211.0	221.3	232.0	–	2.8%	2.7%
of which: NHS England[7]	171.0	186.8	195.6	204.9	215.4	226.1	–	3.0%	3.0%
Capital DEL	10.5	11.6	13.6	14.0	13.5	14.8	14.6	0.0%	3.2%
of which: Financial Transactions	0.0	–	–	–	–	–	–	–	–
Total DEL	**188.5**	**204.9**	**215.6**	**225.0**	**234.9**	**246.7**	**–**	**2.7%**	**2.8%**

[1] Figures for 2024-25 represent departments' final plans as of Supplementary Estimates 2024-25. Official outturn figures will be published in Public Expenditure Statistical Analyses 2025 later this year.
[2] Figures include Spring Statement 2025 plans, plus Machinery of Government changes.
[3] Resource DEL plans have been set for all departments for years up to 2028-29, and Capital DEL plans for years up to 2029-30.
[4] The RDEL average annual growth rates have been adjusted to account for employer NICs changes, Machinery of Government changes, increased pension contributions (SCAPE), and budget cover transfers in 2023-24.
[5] This refers to the period starting in 2025-26, and ending in 2028-29 for Resource DEL and Total DEL, and 2029-30 for Capital DEL.
[6] This refers to the period starting in 2023-24, and ending in 2028-29 for Resource DEL and Total DEL, and 2029-30 for Capital DEL.
[7] The "of which: NHS England" line contains updated figures for DHSC funding spent via NHS England, including historic transfers and savings redirected to frontline services. Growth rates additionally adjust for non-baselined technical transfers (mainly pay).

It should be noted that this additional funding will need to cover any costs such as pay awards above inflationary levels, new drugs, new technologies, increases in patient demand, and the impact of demographics. The level of funding will likely be insufficient to deliver the NHS's targets in isolation, without significant efficiency and productivity improvements.

An investment of up to £10bn in NHS technology and digital transformation by 2028/29 was also announced.

10 Year Health Plan

On 3 July 2025, the Government published its 10 Year Health Plan for England. The plan sets out how the Government intends to reform the NHS through three shifts:

- Hospitals to community
- Analogue to digital
- Sickness to prevention

Under the plan the pattern of health spending will be shifted resulting in a fall in the share of expenditure on hospital care and greater investment in out-of-hospital care. This will also include changes in the operations of GPs and establishing a neighbourhood health centre in every community.

More urgent care will be delivered in the community and the use of same day emergency care services and urgent treatment centres will be expanded.

The plan also seeks to address health inequalities through greater levels of investment in deprived areas.

A single patient record is to be introduced, and the NHS App transformed to provide substantially greater functionality, such as in enabling patients to book directly into tests, manage medicines, and manage long-term conditions. In addition, greater use will be made of technology such as AI.

Steps will also be taken to improve general population health, such as through smoking cessation measures and steps to address obesity and harmful levels of alcohol consumption.

The plan outlines changes to the NHS operating model, including allowing the strongest foundation trusts to become 'integrated health organisations', which will be given the responsibility of managing the budget for the health and care of a designated population.

The Government intends to reinvent the foundation trust model and aims for every NHS provider to be a foundation trust by 2035 with freedoms including the ability to retain surpluses and borrow for capital investment.

In addition, it is proposed to modify the governance of foundation trusts by no longer requiring foundation trusts to have governors and, instead, to replace public and staff representatives with more 'dynamic' ways of reflecting their views. It is not clear what this means in practice and such a change would require amendment of primary legislation to remove the statutory obligation to have a council of governors.

It is understood that the Department of Health and Social Care will seek to approve the first 'new' foundation trusts in 2026.

There will be a focus on high-quality care for all with publication of easy-to-understand league tables, greater use of patient reported outcome and experience measures, and enabling patients to view provider performance through the NHS App and use this to influence their choice of provider.

The plan also includes a number of measures impacting the NHS workforce, including establishing a college of executive and clinical leadership, changes in senior manager pay to incorporate performance-related elements, and reorientating recruitment away from dependency on international recruitment.

The plan intends to 'restore financial discipline' and move the NHS into surplus, with the majority of providers achieving this by 2030.

In addition, there will be changes to change the contracting model to deconstruct block contracts and move away from national tariffs to tariffs based on best clinical practice that maximises productivity and outcomes.

There is also the potential for public-private partnerships and access to low-risk pension capital as a means of funding capital programmes.

The 10 Year Health Plan can be read at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Assisted Dying Bill
On 20 June 2025, the Terminally Ill Adults (End of Life) Bill was passed in the House of Commons, with 314 MPs voting in favour and 291 against. The Bill will now proceed to the House of Lords for further scrutiny.

The Bill would allow terminally ill adults with six months or less to live to get medical assistance to end their own lives. This decision would be subject to approval by two doctors and a panel featuring a social worker, senior lawyer, and psychiatrist.

Whilst a doctor would prepare the substance used, the patient would take it themselves. The Bill includes provisions stating that staff, such as nurses and doctors are not obliged to participate in the process.

It would be illegal to coerce someone into declaring they want to end their life, with a possible 14-year custodial sentence.

The Secretary of State for Health and Social Care has expressed concerns about the lack of a budget for the NHS to provide the service.

Review of Patient Safety Across the Health and Care Landscape
The Government published the independent review of patient safety across the health and care landscape, conducted by Dr Penny Dash, on 7 July 2025. The review was asked to look at six organisations that were established to either assure or contribute to improving the safety of care. These organisations were:

- Care Quality Commission
- Health Services Safety Investigations Body
- Patient Safety Commissioner
- National Guardian's Office
- Healthwatch England and Local Healthwatch
- The patient and safety learning aspects of NHS Resolution

The review found that whilst there had been a shift towards safety over the past five to ten years, with considerable resources deployed, only relatively small improvements had been seen. In addition, it was noted that a large number of organisations carry out reviews and investigations, making a very high number of recommendations to the NHS that often lack any cost-benefit analysis.

The review has made a number of recommendations, which have been accepted by the Government:

- Revamp, revitalise and significantly enhance the role of the National Quality Board
- Continue to rebuild the Care Quality Commission with a clear remit and responsibility
- Continue the Health Services Safety Investigation Body's role as a centre of excellence for investigations and clarify the remit of any future investigations
- Transfer the hosting arrangement of the Patient Safety Commissioner to MHRA, and broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within the Department for Health and Social Care
- Bring together the work of Local Healthwatch, and the engagement functions of integrated care boards and providers, to ensure patient and wider community input into the planning and design of services
- Streamline functions relating to staff voice
- Reinforce the responsibility and accountability of commissioners and providers in the delivery and assurance of high-quality care
- Technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care
- There should be a national strategy for quality in adult social care, underpinned by clear evidence

The review can be read at: https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape/review-of-patient-safety-across-the-health-and-care-landscape

National Maternity Investigation

The Secretary of State for Health and Social Care announced on 23 June 2025 that a 'rapid' investigation into NHS maternity services had been launched by the Government.

This inquiry will look at the worst-performing maternity and neonatal services in the country and would involve the victims of maternity scandals, giving families a voice into how the inquiry is run.

The investigation will consist of two parts. The first will urgently investigate up to ten of the most concerning maternity and neonatal units. The second part will undertake a system-wide look at maternity and neonatal care, bringing together lessons from past inquiries to create a national set of actions to improve care.

It is expected that the report will be published by the end of 2025.

NHS Oversight Framework 2025/26

NHS England published the NHS Oversight Framework 2025/26 on 26 June 2025. This was developed with engagement and contributions from NHS leadership, staff, representative bodies and think tanks, as well as through two public consultations.

The one-year framework sets out how NHS England will assess providers and integrated care boards using a range of agreed metrics. The framework will be reviewed in 2026/27 to incorporate the changes in the ICB operating model and the 10 Year Health Plan.

The metrics cover the following areas:

- Access to services
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and productivity
- Improving health and reducing inequality

Providers will be assessed and then assigned a segment from 1 to 5, with 5 representing the most challenged providers.

Under the framework, unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

Providers rated low for both performance and capability will be considered for entry into the Provider Improvement Programme (PIP), which replaces the Recovery Support Programme (RSP). All providers in the PIP will be placed in segment 5. Providers currently in the RSP will be placed in segment 5 when the initial segments for 2025/26 are published.

The Trust has been informed by NHS England that the Trust was rated 1.88, which, absent the Recovery Support Programme and financial overrides outlined above, would translate to segment 1. With the financial override, the Trust would be placed in segment 3 as 36/134 in the acute hospital provider league table. However, due the Trust being in the Recovery Support Programme, the Trust will be initially placed in segment 5.

NHS England has also launched a consultation on the restructuring of its Recovery Support Programme team ahead of the planned merger of NHS England and the Department of Health and Social Care. It is expected that there will be a 27.8% reduction in whole-time-equivalent posts.

The NHS Oversight Framework 2025/26 can be read at: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

NHS Waiting Lists
On 12 June 2025, it was reported that the NHS waiting list had fallen to its lowest level in two years, the first April drop since 2008.

The NHS waiting list was reported as having fallen from 7.42 million to 7.39 million. Additional progress had been made during April 2025 to clear the backlog with 1.45 million treatments delivered during the month – equivalent to around 72,500 planned treatments each day and a 3% increase compared with the previous year.

In addition, the average time patients had been waiting for planned treatment fell to the lowest level since June 2022 at 13.3 weeks.

This performance was in the context of increasing demand for NHS services, with 77,287 patients attending accident and emergency during May 2025 – a 10% increase on pre-pandemic levels.

In contrast to the national picture, the Trust has seen its waiting list continue to grow, reaching 62,949 in May 2025, a 1% increase on April 2025. In part this is due to the Trust being above the cap under the Elective Recovery Fund and, consequently, has ceased outsourcing some procedures, as this is not financially viable at this time.

Urgent and Emergency Care Plan
NHS England published its Urgent and Emergency Care Plan 2025/26 on 6 June 2025.

The plan lists the following priority actions:
- Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter.
- Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter.

- National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference.

Through these actions, it is intended that:

- Ambulance waiting times will improve and handover delays will be addressed.
- The 78% emergency department target will be achieved.
- Length of stay and delays on discharge will be reduced and flow improved.
- Vaccination rates for staff will move towards pre-pandemic levels.
- Allocation of over £370m of capital investment to support additional same day emergency care centres and urgent treatment centres, mental health crisis assessment centres, additional mental health inpatient capacity, and expansion of connected care records for ambulance services.

The plan can be viewed at: https://www.england.nhs.uk/long-read/urgent-and-emergency-care-plan-2025-26/

Industrial Action – BMA Ballots

The British Medical Association (BMA) opened a ballot of resident doctors on 27 May 2025 to authorise further industrial action following the re-opening of a formal pay dispute with Government in April 2025 and in response to the proposal of a 4% uplift in pay plus £750 for 2025/26. On 8 July 2025, it was announced that 90% of those who voted, on a 55% turnout, supported granting a mandate for strike action. This mandate will last until January 2026.

On 9 July 2025, the BMA announced a five-day strike by resident doctors, commencing on 25 July 2025.

Furthermore, on 19 June 2025, the BMA announced that it was launching indicative ballots of senior doctors in respect of the proposed pay uplift for 2025/26. The ballots will commence on 21 July and close on 1 September 2025. Whilst the results of these ballots will not be binding, it might lead to further ballots seeking approval for industrial action.

Agenda for Change Pay Deal

On 22 May 2025, the Government announced the NHS pay award for 2025/26 for staff employed on Agenda for Change contracts in England. The recommendation of the NHS Pay Review Body for a 3.6% uplift, backdated to 1 April 2025, was accepted.

The Royal College of Nursing commenced its consultation on the proposed pay deal on 9 June 2025, asking members to vote on the proposal. The level of the proposed increase has faced some criticism and there is potential that the Royal College of Nursing will ballot for industrial action.

North East London NHS FT Verdict

North East London NHS Foundation Trust was charged with corporate manslaughter and an offence contrary to section 3 of the Health and Safety at Work Act 1974 following the death of a detained patient, Alice Figueiredo, at Goodmayes Hospital on 7 July 2015.

The patient had attempted to harm herself on 18 occasions using plastic bags or bin liners, often in the same communal toilet. Despite this, the bags were not removed, and the toilet was left unlocked. On the 19th occasion, Alice took her own life.

The police investigation involved review of more than 2,600 medical documents, dozens of witness statements from staff, family and friends of the patient as well as consultations with experts about their experience of being on similar wards and with senior individuals in other NHS trusts, the Care Quality Commission and NHS England.

The verdicts were delivered after the joint-longest jury deliberation in English legal history.

The trust was found not guilty of the corporate manslaughter charge but was found guilty of an offence under the Health and Safety at Work Act for failing to ensure the health and safety of non-employees.

A not guilty verdict was also returned for ward manager, Benjamin Aninakwa, who had been charged with gross negligence manslaughter. However, he was found guilty of a charge of failing to take reasonable care for the health and safety of patients on the ward.

Sentencing will take place on a date to be confirmed.

The offence of corporate manslaughter was introduced by the Corporate Manslaughter and Homicide Act 2007 and is an offence whereby the way in which an organisation's activities are managed and organised causes a person's death and amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased. An organisation that is guilty of the offence is liable to a fine. It should be noted that the offence of 'corporate manslaughter' relates solely to an offence committed by an organisation (such as a company, public body, or police force) and should be differentiated from gross negligence manslaughter, a common law crime for which an individual can be held culpable.

Statutory and Mandatory Training
NHS England has set out plans to make significant changes to statutory and mandatory (Stat&Mand) training across the NHS in England. This was outlined to trusts in April 2025.

From 1 May 2025, NHS staff will no longer need to repeat core Stat&Mand training when moving between NHS organisations. NHSE expect his change to save up to 200,000 days of staff time annually across the NHS, leading to greater efficiency and improved staff experience. The saved time will allow staff to focus more on patient care and reduce the burden of training outside normal working hours.

A new national people policy framework for mandatory learning has been launched, providing a consistent approach for managing nationally and locally mandated learning. This framework aims to optimise, rationalise, and redesign statutory and mandatory training to improve staff experience and deliver better outcomes. Trusts are required to adopt this by 30 September 2025.

Key points to note:
- All employees and bank workers can have their prior core Stat&Mand training accepted when they move between NHS organisations, particularly benefiting resident doctors who frequently rotate.
- New starters will still need to complete local orientation, induction, and other locally mandated training.

The UHS people team have been reviewing the Trust's response to this issue. The UHS People Board agreed to sign the national memorandum of understanding supporting transfer of training history between trusts earlier in the year.

All new starters are informed at the point of recruitment that they need to bring their evidence of prior training so this can be updated at UHS, and this is reiterated at trust induction. Staff are also advised to download their training records if they leave the Trust.

The Trust is in the process of refreshing its Statutory and Mandatory Policy, which will be ratified at People Board in September 2025 (after completing the policy approval process via HR policy group, staff partnership etc). The information from the template NHS England have provided has been used, but it has been adapted to be in the UHS approved format.

UHS is also required to produce a local annual plan to quantify the amount of mandatory learning and evidence of improved outcomes and benefits as part of business planning for 2026/27. National guidance is being sought on the local plan and how improved outcomes can be evidenced ready for business planning for 2026/2027. This will be taken through the People Board and the People and Organisational Development committee.

Hampshire and Isle of Wight Healthcare Strategy
Our local community and mental health provider, Hampshire and Isle of Wight Healthcare, has released a new organisational strategy for 2025-2030. This strategy reflects the collective ambition of the newly merged organisation and focusses on four priority areas – population health outcomes, delivering outstanding care, improving staff experience, and delivering value for money.

A summary of the strategy is available here- Our Trust Strategy 2025-2030 and the full version here HIOWH_Trust_Strategy_25-30.pdf.

Council of Governors Elections
Nominations for election to the Trust's Council of Governors opened on 17 June 2025 and will be open until 30 July 2025. Elections are being held for the following vacancies:

- Public: Southampton City – Five vacancies
- Public: New Forest, Eastleigh and Test Valley – Three vacancies
- Public: Isle of Wight – One vacancy
- Staff: Non-Clinical and Support – One vacancy
- Staff: Nursing and Midwifery – One vacancy

Eligible members were emailed the Notice of Election by Civica Election Services on 17 June 2025. The notice is also available on the Trust's website at: https://www.uhs.nhs.uk/whats-new/news/notice-of-election-to-council-of-governors-2025

The elections will open on 19 August and close on 22 September 2025, with results being declared on 23 September 2025.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.6 Report to the Trust Board of Directors, 15 July 2025	
Title:	Performance KPI Report 2025-26 Month 2
Sponsor:	David French, Chief Executive Officer
Author:	Sam Dale, Associate Director of Data and Analytics

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

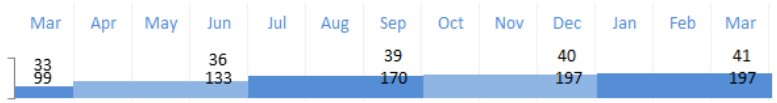
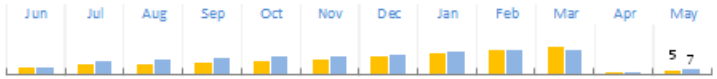
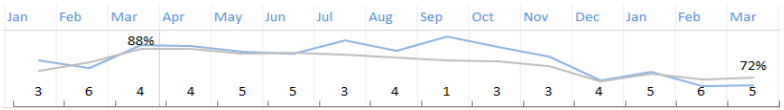
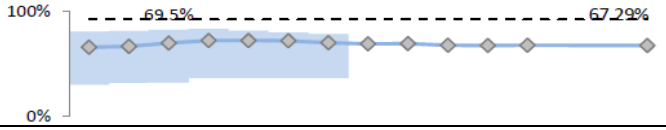
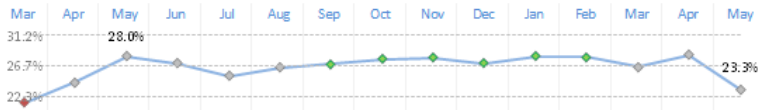
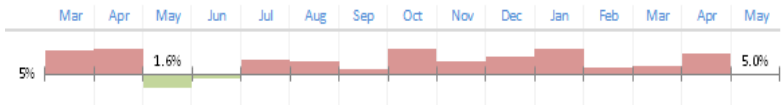
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
May 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 waiting list position and performance against 2025/26 referral to treatment waiting time targets.

The report highlights that:-

- The trust's waiting list has continued to increase reaching 62,949 in May 2025 which is a 1% increase on April 2025 and a 5.2% increase on May 2024. This is against a backdrop of a decrease to the national waiting list seen in April 2025.
- The recent waiting list growth in referrals is significant and beyond pure seasonality in a handful of specialties most notably Dermatology, Clinical Immunology and Allergy, Cardiology and Oral Surgery.
- The organisation has continued to benchmark in the top quartile for the volume of patients waiting over 52, 65 and 78 weeks but recognises there are several services facing demand and capacity imbalances and staffing restrictions which are preventing them from maintaining the same levels of high performance seen in previous months.
- The organisation continues to deliver activity levels far in excess of pre-COVID levels, however the current financial architecture includes a capped payment system for elective activity which reduces our ability to treat more patients.
- A series of interventions including increases in advice and guidance, patient initiated follow-ups, pathway validations and theatre utilisation are being delivered across 2025/26 to ensure we meet the national expectation of improved efficiency and productivity whilst living within our means.

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

1. Attendances to the Emergency Department (ED) have remained high now averaging 433 attendances per day across March, April and May 2025 for all types. The trust reported a four hour performance position of 56.2% for Type 1 attendances which is a reduction of 4.5% from the April position. An external review completed by regional clinical leads for ED and AMU (acute medical unit) was undertaken at the end of June. Initial feedback provided helpful areas for improvement and the full report is expected in July and will form the basis for our ongoing improvement work.
2. The hospital 30 day readmission rate has further reduced since the peak of 14.5% reported at the start of the calendar year. The May 2025 position is 12.6% with reductions visible predominantly within medical and paediatric specialties.
3. There is a reported increase in Category 2 Pressure Ulcers (per 1000 bed days) to 0.37 for May 2025 which is above the target of 0.3. The Tissue Viability team have undertaken an audit of all adult inpatient areas relating to risk assessments, prevention and equipment involved in the pressure ulcer prevention process. The resulting report will drive an action plan predominantly focussed on improving trustwide education.
4. The hospital maintained compliance against two of the national cancer Performance targets (28 day faster diagnosis and 62 day pathways), benchmarking in the top quartile when compared to peer teaching organisations across the country. Performance for the 31 day metric was 95.25% in April 2025 against a target of 96% which places the trust in the second quartile in the peer comparator. The validated May position is still awaiting publication by the national team.

5. The average number of patients per day who remained in the hospital despite being medically optimised for discharge increased to 252 across May 2025 which is an increase of 18% on April 2025. A joint workshop with Hampshire and Southampton City councils, the ICB and HIOW Healthcare was held recently supported by Newton to develop a robust plan to reduce the number of patients not meeting the criteria to reside.
6. The trust reported zero never events and one patient safety incident investigation in May 2025
7. The percentage of patients waiting over six weeks for diagnostics increased to 17.5%. This is the highest percentage of the last twelve months despite delivering 3% more activity than the previous month. Two key areas with demand and capacity challenges are echocardiography and cystoscopy and the cessation of insourcing is impacting the Neurophysiology service.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 23rd June 2025, our average handover time was 14 minutes 58 seconds across 831 emergency handovers and 16 minutes 21 seconds across 55 urgent handovers. There were 31 handovers over 30 minutes and 7 handovers taking over 60 minutes within the unvalidated data. Across May 25 the average handover time was 16 minutes 41 seconds which is consistent with April 25 performance.

Spotlight: Referral to Treatment Waiting Times

1. Introduction

This month's spotlight report provides an update on the Trust's waiting list and waiting times including comparisons to the national position and that of peer teaching hospitals. It highlights the key services facing demand and capacity constraints, the impact of the 25/26 financial architecture and describes the interventions being embedded to drive additional capacity, reduce demand and ensure we are appropriately managing our longest waiting patients. At the time of writing, UHS data was available up until May 2025 with national data published for April 2025.

2. National Context

The NHS in England continues to face unprecedented demand for elective care, with the national waiting list remaining at historically high levels. In response, the Elective Recovery Plan set out a phased series of ambitions to improve access, including eliminating 104-week waits (by July 2022), 78-week waits (by March 2023), and 65-week waits (by March 2024). The longer-term goal was to reduce the proportion of patients waiting over 52 weeks to no more than 1% of the total waiting list by March 2026. These targets sat alongside a broader ambition to increase activity to 130% of pre-pandemic levels and to expand use of community diagnostics, surgical hubs, and digitally supported pathways. This is combined with a series of early pathway interventions designed to improve access to first outpatient appointments.

Progress against these targets has been mixed. The NHS successfully eliminated most 104-week breaches and made significant reductions in the number of patients waiting over 78 and 65 weeks. However, these long waits have not been fully eradicated, and the number of patients waiting over 52 weeks remains well above pre-pandemic levels. That said, recent months have shown signs of progress, with a slight but consistent reduction in the overall national waiting list from a peak of 7.8m in September 2023 to 7.4m in April 2025.

This reflects increased activity and focused efforts to manage long-waiting patients including increased validation to ensure all patients on a waiting list are accurately reported and waiting for treatment. The reduction in April 2025 is the first time the waiting list has seen a reduction in April in 17 years and the average time patients had been waiting for planned treatment fell to the lowest level since July 2022 – 13.3 weeks. This is despite services facing greater demand, with 2.3% more patients being added to the waiting list per working day than compared to last year.

The recent reduction in the national waiting list and the encouraging trajectory on the percentage of patients waiting over 52 weeks is illustrated in Chart 1 below.

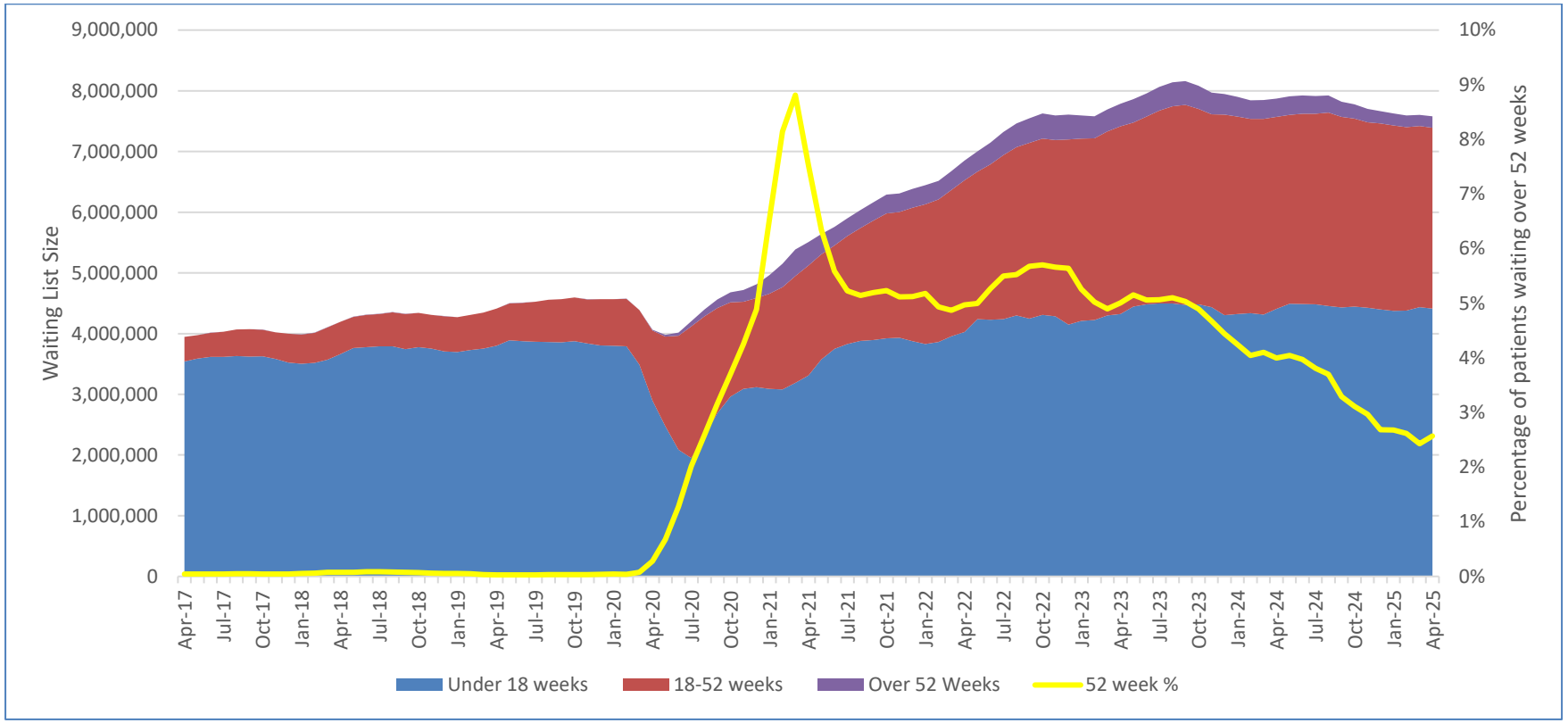


Chart 1: National NHS Waiting List Size and 52 week performance trend

3. UHS Performance Position

The 2025/26 priorities and operational planning guidance cited three key metrics to measure success in the reduction of the time people wait for elective care. These targets and the latest UHS performance position is listed in table 1. It should be noted that the 18 week metrics have a national target for the NHS, but this will be delivered by all trusts delivering a 5% improvement against their November 24 baseline position, hence why local targets differ from the national target. In effect, UHS was already delivering above the national baseline, but is still required to improve by 5%.

25/26 National Priority Measures	Baseline Nov-24	NHS Target Mar-26	UHS Target Mar-26	**UHS Current May-25**
Patients waiting over 18 weeks (%)	62.4%	65.0%	67.4%	**64.4%**
Patients waiting over 18 weeks (%) for their first appointment	66.2%	72.0%	71.2%	**69.9%**
Patients waiting over 52 weeks (%)	1.9%	1.00%	1.00%	**2.1%**

Table 1: 2025/26 Key Performance Indicators

The table indicates that UHS is making positive progress on the 18 week targets and this is certainly evident in some specialties who have made significant strides in increasing activity and reducing waiting times for their patients. However the performance is also a reflection of the ongoing referral increases seen within our waiting list which inevitably increase the volume of patients at the start of the pathway and therefore below 18 weeks. This is better illustrated in chart 3 which highlights that the overall waiting list increase for UHS is not in line with the reduction described for the national picture over the last two months. The May 2025 waiting list position is 62,949 which is a 1% increase on April 2025 and a 5.2% increase on May 2024.

In 2024/25 the trust made significant progress in treating the longest waiting patients consistently reporting zero patients over 104 weeks and 78 weeks with the only challenged area being ophthalmology patients impacted by a national shortage of corneal tissue to allow transplants to proceed.

Whilst similar progress was made for those patients over 65 weeks, we have seen a deterioration within a handful services due to increased demand particularly for those services that are balancing the prioritisation of elective demand with emergency admissions and urgent cancer pathways.

Chart 2 illustrates the volume of patients for specialties which had patients waiting over 65 weeks in May 24.

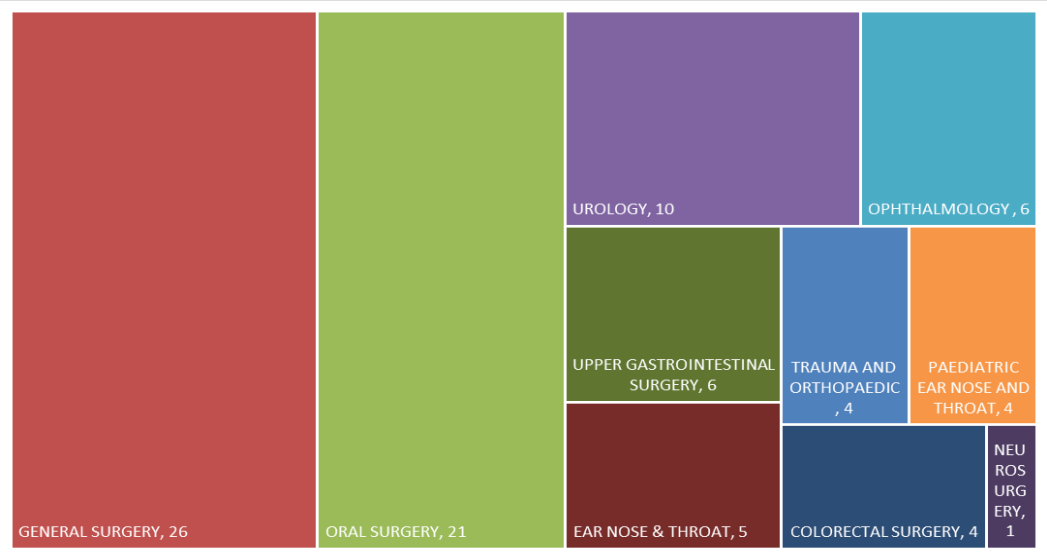


Chart 2: Volume of patients waiting over 65 week waits by specialty (May 24)

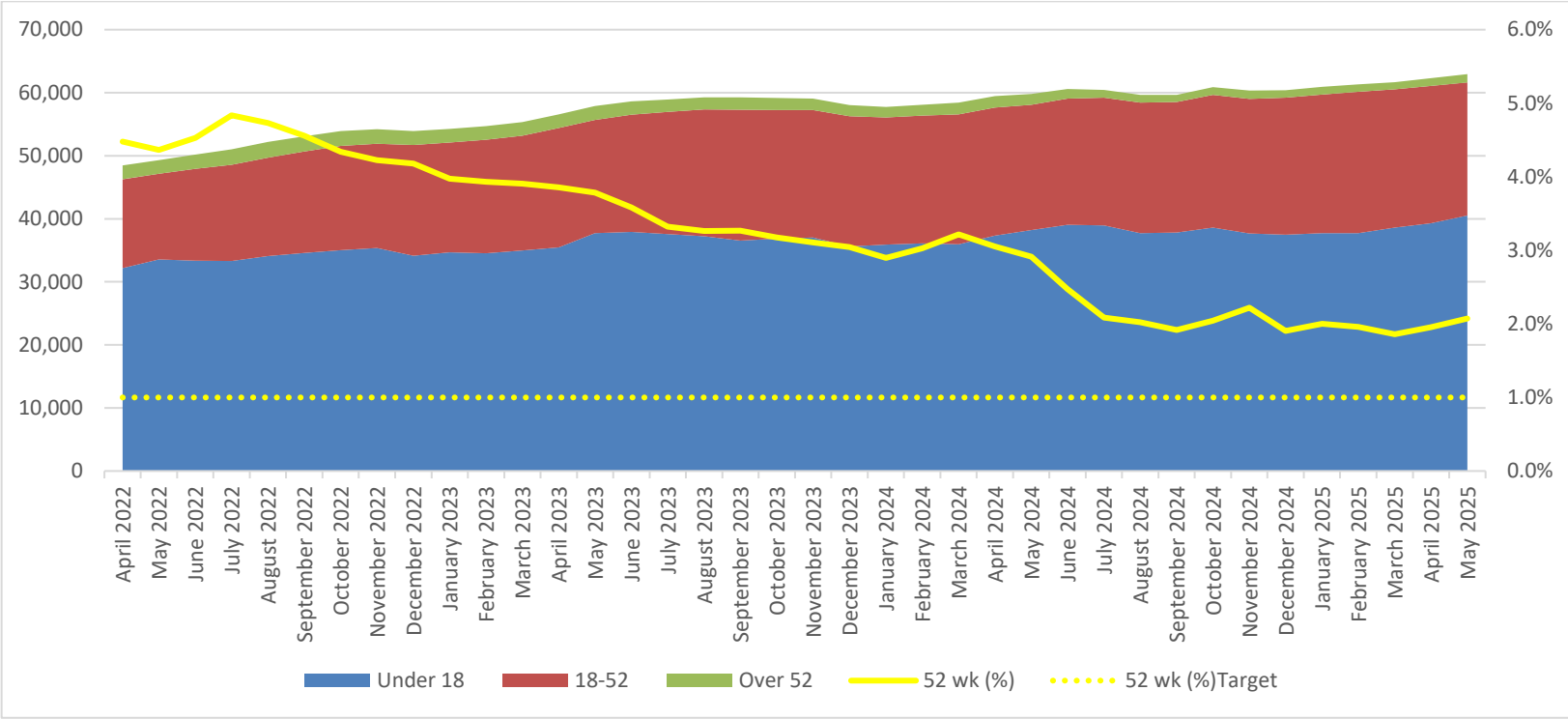


Chart 3: UHS Waiting List Size and 52 week performance position)

Whilst seeking to recover the 65 week position, the organisation is committed to achieving the 52 week target and monitors the trajectory closely at a specialty level. At the end of May 2025, the hospital reported 1305 patients on the waiting list who had been waiting over 52 weeks for definitive treatment which is 2.1% of the waiting list against a national target of 1.0% by March 2026. The entire waiting list is spread across 75 different specialties and 55 of these (73.3%) are already below the 1.0% target. However, over 60% of the 52 week patients sit within five challenged specialties – Oral Surgery, Gynaecology, Trauma & Orthopaedics, Urology and Paediatric ENT.

4. Performance Benchmarking

Whilst the trust scrutinises the hospital's RTT performance and waiting list position, it also pays close attention to the performance of surrounding trusts and peer teaching hospitals across the country. The recent pressures on the waiting list are felt across peer organisations meaning the hospital continued to benchmark in the top quartile for April 2025 for all the key waiting list metrics.

TQ = Top Quartile TH = Top Half BH = Bottom Half

	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	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	Apr-25	May-25
RTT 52ww	7	6	4	4	4	4	5	4	4	5	7	6	6	5	3	3	3	4	6	6	6	6	7	5	
RTT 65ww	4	4	4	5	5	3	3	3	3	3	3	3	2	2	1	1	2	1	2	2	1	2	2	4	
RTT 78ww	5	8	8	7	6	5	6	5	5	5	10	10	10	11	9	9	4	8	8	1	5	5	6	1	
RTT Perf	5	5	6	6	6	5	4	4	4	4	4	4	4	4	3	4	4	3	5	5	5	7	6	5	

Table 2: UHS ranking vs 20 peer Teaching Hospitals within the NHS

5. Key Organisational Challenges

As highlighted above, whilst several services are delivering consistent improvements in managing their waiting lists, there are challenged specialties which are facing operational and financial barriers in tackling patient backlogs whilst treating higher priority patients and referrals increases. The key challenges are described in more detail below.

5.1 Financial Environment

The financial position remains extremely challenging for UHS and the wider NHS. The current architecture means a greater majority of the trust's income is fixed (or capped) therefore savings are required to be achieved mainly via cost out schemes covering both pay and non pay. UHS has been one of the leading trusts across the country in recovering elective activity levels significantly beyond pre-COVID levels. However the income cap removes any financial incentive to go further given the associated costs with treating more patients.

In parallel, the strict financial controls needed has led to the cessation of most outsourcing arrangements and tight restrictions on recruitment, further limiting the ability to bring in additional capacity. Services that previously relied on external solutions such as private providers have therefore lost capacity. Whilst the biggest impact is expected to be seen in June, chart 4 illustrates the volume of elective surgery that was being delivered through outsourcing for four key specialties and the drop off already seen in May.

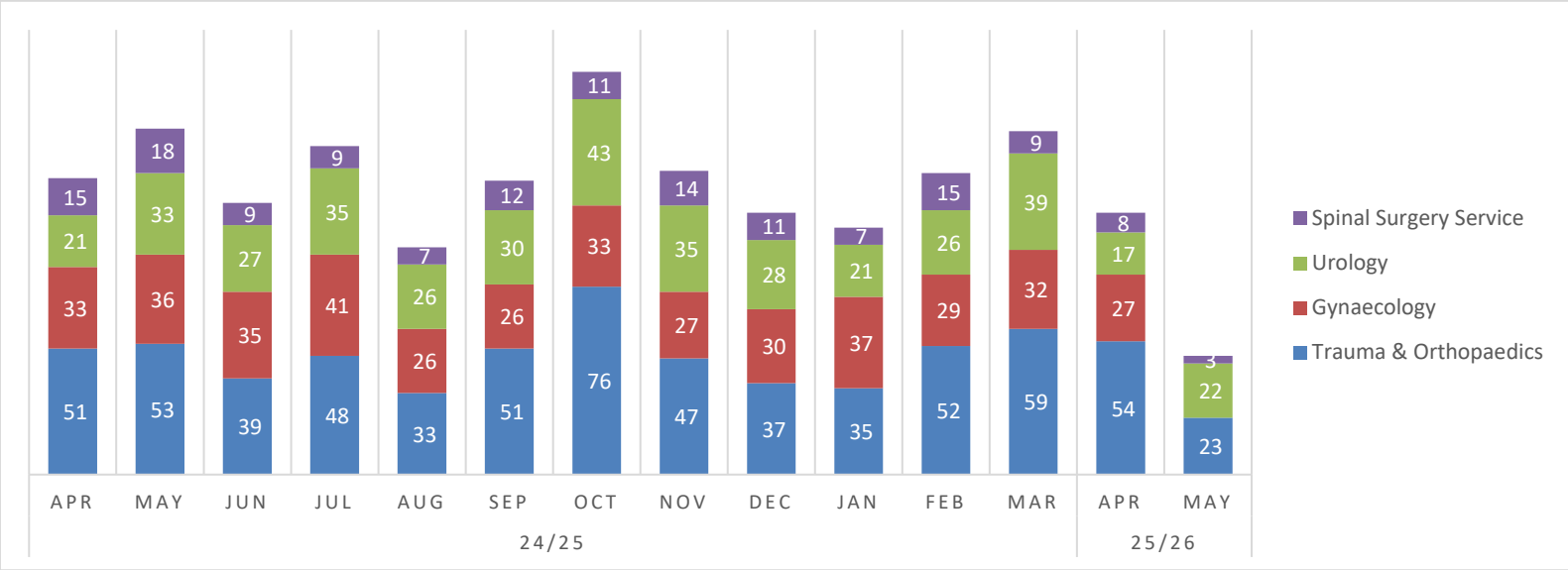


Chart 5: Volume of elective cases outsourced to private providers for four key specialties

5.2 Demand and Capacity

A sustained imbalance between demand and available capacity remains a critical challenge across several specialties. Certain large services including Dermatology, Clinical Genetics, Oral Surgery, Immunology and Allergy have experienced unprecedented levels of referrals across the Spring. This surge in demand beyond expected seasonality places considerable pressure on outpatient clinic capacity, exacerbating delays in patient access and contributing to longer waits for first appointments.

Dermatology specifically has been impacted by the closure of two Tier 2 services within the community. The two services received on average 50 referrals per month for non-complex inflammatory skin conditions and non-urgent suspected cancer skin lesions (adult services only).

The recent growth in waiting times within the surgery caregroup has multiple causes. Skin surgery continues to face high volumes of melanoma and complex benign cases without sufficient plastic surgery clinical resource. Urology's workload has outstripped in-house capacity following the temporary

closure of PPG's urology service due to workforce challenges. ENT faces similar pressures after the cessation of insourcing contracts which is compounded by sustained high demand in both adult and paediatric pathways. The maxillofacial service has seen a notable increase in referrals, especially from dentists, adding to existing backlogs. The result is an ongoing struggle to keep up with routine and urgent activity across services.

Spring 2025 has also been a particularly difficult period for the Trauma and Orthopaedic Service due to the volume of non-elective admissions which have been 10-15% higher than the same period in 2024. This is evident in the recent volumes of outlier patients within the organisation. The greatest challenge is limited to a handful of surgeons whose operating capacity has recently been impacted by the combination of on-call activity, Bank Holidays and personal leave.

5.3 Workforce Challenges

Multiple specialties have experienced consultant absences or long-standing vacancies particularly within the surgery caregroup. Urology have recently lost key staff supporting prostate cancer surgery and the maxillofacial service is operating with a temporarily reduced consultant workforce due to sickness. Currently ENT is reliant on locum support with longer-term recruitment plans expected to improve the situation but not until later in the year. The situation is compounded by middle grade and resident doctor shortages with Maxillofacial increasingly reliant on locums and forcing consultants to act down, further reducing elective and outpatient capacity. Capacity shortfalls extend beyond theatres and clinical staff into administrative and operational teams within the surgery caregroup. Services are reporting reduced administrative capacity to track pathways and mobilise additional clinics or waiting list initiatives as effectively as possible.

6. Mitigations and Actions Plans

Despite the described pressures and the need to live within the financial envelope and plan, there are multiple interventions and improvements in place or being planned across 2025/26 to ensure we increase efficiency and productivity or manage patient pathways through the organisation more effectively.

6.1 Referral Management

A comprehensive review of referral volumes has been undertaken to better understand demand patterns and identify opportunities to manage incoming referrals more effectively. Whilst the trust fully recognises the specialist and therefore regional services it provides, and patient choice, there is a need to ensure out of area patients are being appropriately referred to Southampton hospital and not as the result of pressures being felt by other organisations. The trust is in regular dialogue with commissioners to monitor GP referral trends to ensure we understand changes in patterns.

A workstream is also underway to highlight referrals for elective activity which meets the definitions of the Evidence Based Intervention Programme (previously procedures of limited clinical value). The aim of the EBI Programme is to improve the quality of care being offered to patients by reducing

unnecessary interventions and preventing avoidable harm. In addition, by only offering interventions on the NHS that are evidence-based and appropriate, the programme frees up resources that can be put to use elsewhere in the NHS.

6.2 Outpatient Pathways

Our transformation team is actively delivering a 25/26 outpatient elective programme to tackle key waiting list challenges. This includes driving the shift from analogue to fully integrated digital systems by embedding tools such as eRS, electronic prescribing, the patient engagement portal, referral optimisation, appointment outcome capture and ambient listening. They are also enhancing referral management through greater use of advice and guidance. Efforts are underway to increase patient-initiated follow-up (PIFU) in specialties below the national 5% benchmark, reshaping pathways to embed this approach. Additionally, work is focused on optimising outpatient clinic processes — from booking and scheduling to room utilisation — to increased capacity and productivity. The hospital continues to work collaboratively with system partners to streamline patient pathways and reduce unnecessary steps in the care journey.

6.3 Theatre Utilisation

Our elective programme aims to support caregroups in reducing the number of patients waiting for treatment and safely increasing throughput through our theatres. To achieve this, the programme is identifying specialties and lists where extra capacity can be delivered based on robust gap analysis, while standardising booking and scheduling practices across the Trust. A dedicated workstream with Pre-Assessment is embedding best practice with strong clinical leadership and communication. The team is also working closely with the Invasive Procedures Committee and NatSSIPs to ensure safety recommendations are fully supported.

In addition, the programme is embedding the NHSE Federated Data Platform (FDP) to improve theatre scheduling and list management, and is maintaining close partnerships with Johnson & Johnson, the NHSE FDP team and Deloitte, particularly around job planning and resourcing. Collaborative work with ICS partners remains integral to this approach, ensuring alignment across the system. Additional theatre capacity will also be delivered for Trauma and Orthopaedics via the launch of the Elective Hub with Hampshire Hospitals later this year.

6.4 Pathway Validation

NHSE England requested a higher level of scrutiny on waiting lists at the start of the 2025/26 financial year with the belief that patients were on waiting lists who no longer required or wished to receive treatment. To support this, hospitals have been undertaking a series of sprints to increase patient pathway validations in areas which warrant higher scrutiny. The success of the sprints is measured by monitoring overall clock stops in quarter one compared to quarter one in 2024/25. Draft data indicates that UHS has overperformed the baseline by 3% or 1,948 additional clock stops recognising that not all will be driven by validation actions. The overall ambition is to validate all patients waiting over twelve weeks every twelve weeks.

The Trust benefits from a central pathway validation team, which plays a crucial role in managing the waiting list and has done for several years. This team manually reviews patient pathways to identify discharge opportunities and uses advanced machine learning software to prioritise focus areas, ensuring that all parts of the waiting list receive appropriate scrutiny. Additionally, they oversee a patient texting system that allows patients to confirm whether they wish to continue their pathway or opt out, helping to reduce unnecessary waits.

7. Performance Management

The trust has a well-established performance management approach which has been successful and embedded for a number of years. Performance meetings are held every week with each caregroup to ensure waiting lists and long waiting patients are discussed and understood at a granular level particularly when falling behind forecasts. The cohort of patients is tapered each month to ensure a well-managed transition from patients waiting over 65 weeks down to 52 weeks later in the year. The approach is overseen by the Trust's Chief Operating Officer and colleagues at the ICB and Regional Teams are consistently briefed on areas of concern, success and where there may be opportunities for mutual support across Hampshire and Isle of Wight.

8. Conclusion

The organisation has historically performed well in the management and reduction of long waiting patients, consistently benchmarking in the top quartile compared to peer organisations. Despite this, there is a recognition that the waiting list has continued to increase and there are a select number of services where patients are waiting longer than we would like. The financial architecture has limited our ability to treat more patients while maintaining financial balance and the consistent increase in referrals both locally and out of area is impacting performance in some areas. Nevertheless, there are clear success stories across the organisation and a series of robust interventions being delivered which align with the national requirement to increase operational performance via increased efficiency and productivity.

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

		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD
34	% Patients on an open 18 week pathway (within 18 weeks) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	4	4	4	4	4	4	4	4	4	4	4	4	3	3		≥67.4%	63.7%
		4	4	4	4	3	4	4	3	5	5	5	7	6	5			
34 - As of April 2025, YTD and **Monthly target changed to local target (67.4%)**. N.B. new national target of 65%																		
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 19)** **South East average (& rank of 17)**	7	4	6	5	5	4	3	5	4	4	2	10	4	10		≥75%	75.4%
		3	1	4	3	3	2	2	2	1	2	2	4	2	3			
43 - As of April 2025, YTD and **Monthly targets changed from 70% to 75%** in line with latest operational guidance																		
30	Patients spending less than 4hrs in ED - (Type 1) **UHSFT** **Teaching hospital average (& rank of 16)** **South East average (& rank of 16)**	4	9	6	8	6	10	6	6	12	15	9	16	14	10	14	≥78%	58.4%
		2	5	2	4	5	6	4	4	9	12	6	12	12	7	15		
30 - As of April 2025, YTD and **Monthly target changed from 95% to 78%** in line with latest operational guidance																		
41	% of Patients waiting over 6 weeks for diagnostics **UHSFT** **Teaching Hospital average (& rank of 20)** **South East Average (& rank of 18)**	5	5	4	5	5	5	5	6	6	6	6	6	7	9		≤5%	16.70%
		4	5	5	5	6	6	6	8	9	8	9	6	7	10			
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	100.0 92.0 90.0 80.0												90.0 88.4			≤100	90.0	≤100
2	HSMR - Crude Mortality Rate	3.0% 2.7% 2.2%												2.2%			<3%	2.2%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital	15% 12.8% 10%												12.6%			-	13.2%	-
		Q4 2023/2024			Q1 2024/2025			Q2 2024/2025			Q3 2024/2025			Q4 2024/2025			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	78 76 74 75			76			76			76			76			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100% 75% 50% 41 62 334			36 77 342			39 79 319			36 76 317			36 88 309			-		

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		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	22	27	37	47	55	60	69	79	88	94	85	112	93	120	12	8	19	19	≤8	19	≤16
7	MRSA bacteraemia	1	1	0	0	0	0	1	0	0	2	1	0	0	1	0				0	1	0
8	Gram negative bacteraemia	16	31	25	25	29	22	34	23	29	31	20	35	18	21	14				≤16	35	≤32
9	Pressure ulcers category 2 per 1000 bed days	0.22														0.37				<0.3	0.37	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.12														0.25				<0.3	0.25	<0.3
11	Medication Errors (severe/moderate)	1														6				≤3	12	6
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2023/24**														2,662	2,305				<2578	2,418	<2552

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

Safety		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)			3												1	-	3	-
14	Never Events			0												0	0	1	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity			0												0	-	0	-
16	Number of falls investigated per 1000 bed days			0.11												0.09	-	0.13	-
17	% patients with a nutrition plan in place (total checks conducted included at chart base)			93.8%												91.4%	≥90%	92%	≥90%
				1,012	930	973	977	930	869	826	964	961	828	901	989	965	895	945	
18	Red Flag staffing incidents			7												4	-	19	-

Maternity		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	428	411	415	379	390	400	410	438	392	396	395	372	410	390	390	-	-	-
		409	448	633	517	501	480	403	523	451	467	496	466	494	450	448			
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	6	0	3	8	8	2	12	6	1	0	1	1	1	1	1	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	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%	48.46%	45.38%	-	-	-
		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%	37.69%	43.59%			

Patient Experience		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients	3%		0.7%												1.6%	≤5%	1.2%	≤5%
		0%																	
23	FFT Negative Score - Maternity (postnatal ward)	10%		3.7%												2.7%	≤5%	1.8%	≤5%
		0%																	
24	Total UHS women booked onto a continuity of carer pathway	30%		12.5%												13.7%	≥35%	13.2%	≥35%
		0%																	
25	Total BAME women booked onto a continuity of carer pathway	100%		22.3%												14.2%	≥51%	12.6%	≥51%
		0%																	
26	% Patients reporting being involved in decisions about care and treatment	100%		87.5%												86.1%	≥90%	85.7%	≥90%
		80%																	
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%		88.4%												88.0%	≥90%	87.8%	≥90%
		80%	268	339	340	280	258	317	221	353	247	296	323	273	483	491	442			
27 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
28	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	110		61												108	-	166	-
		0																	
29	Number of mental health patients spending over 12 hours in A&E	100		40												52	-	99	-
		0																	

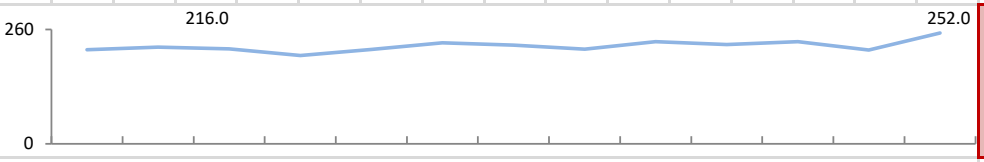
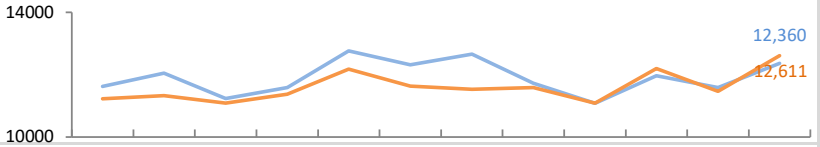
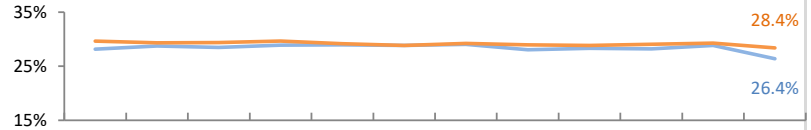
Access Standards		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	80% 40%	69.2%													56.2%	≥78%	58.4%	≥78%
			4	9	6	8	6	10	6	6	12	15	9	16	14	10	14		
			2	5	2	4	5	6	4	4	9	12	6	12	12	7	15		
31	Average (Mean) time in Dept - non-admitted patients	05:00 02:00	03:16													03:24	≤04:00	03:21	≤04:00
32	Average (Mean) time in Dept - admitted patients	07:00 03:00	05:30													06:09	≤04:00	05:51	≤04:00
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year	100% 95%														97.5% 98.4%	-	97.8%	>98.0%
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	70% 50%	63.9%													64.4%	≥67.4%	63.7%	≥67.4%
			4	4	4	4	4	4	4	4	4	4	4	4	3	3			
			4	4	4	4	3	4	4	3	5	5	5	7	6	5			
35	Total number of patients on a waiting list (18 week referral to treatment pathway)	65,000 55,000	59812													62949	-	62,949	-
36	Percentage of patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	6% 1%	2.91%													2.07%	1.0%	2.1%	1.0%
			7	6	6	5	3	3	3	4	6	6	6	6	7	5			
			8	9	9	8	6	6	6	6	7	7	7	7	7	7			

		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
37	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			1743												1305	0	1305	0
38	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			55												87	0	87	0
39	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			14												0	0	0	0
40	Patients waiting for diagnostics			8883												10283	-	10,283	-
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			10.0%												17.5%	≤5%	16.7%	≤5%

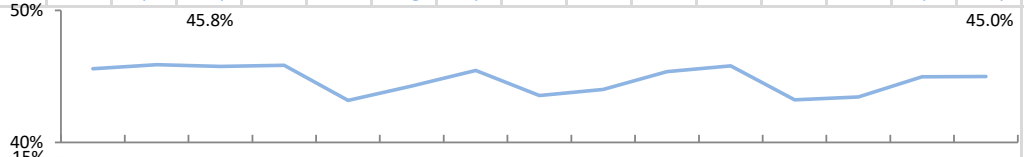
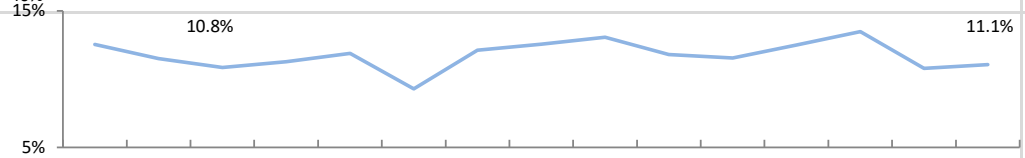
41 - As of **April 2024**, **YTD and Monthly Target** changed from **1% to 5%** to reflect latest guidance

		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks															69.9%	≥71.2%	69.9%	≥71.2%
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)		79.4%													75.4%	≥75%	75.4%	≥75%
44	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)		86.3%													81.8%	≥80%	81.8%	≥80%
45	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)		91.7%													95.2%	≥96%	81.8%	≥96%

R&D Performance		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
46	Recruitment performance ranking	15	9	7	6	9	9	8	10	8	8	9	10	11	16	7	Top 10	-	-
47	Performance in initiating clinical trials	64%	50%	55%	47%	100%	44%	38%	78%	36%	70%	44%	47%	44%	44%	25%	≥80%	-	-
48	Performance in delivering clinical trials														44.0%	53.0%	≥80%	-	-
49	Proportion of sponsored studies open/on track														81.0%	82.0%	≥80%	-	-

Local Integration		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	233	-
51	Emergency Department activity - type 1 This year vs. last year																-	23,949	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	27.7%	≥25%

Digital		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			202621												246086	-	246,086	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			35097												37951	-	74,899	-
54 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
55	Average age of IT estate Distribution of computers per age in years																-	-	-
56	CHARTS system average load times - % pages loaded <= 5s - % pages loaded <= 3s																		
56 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			

Health Inequality		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted																-	45.0%	-
58	Percentage of under 18s attending emergency departments to be admitted																-	10.9%	-

University Hospital Southampton
NHS Foundation Trust

Agenda Item 4.1 Report to the Trust Board of Directors, 15 July 2025	
Title:	Finance Report 2025-26 Month 2
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 May report are as follows:

- The Trust has reported a £3.8m deficit in M2. This is consistent with the plan submitted to NHS England. The Trust has a full year plan to achieve a breakeven position.
- The underlying deficit is £7.2m in M2, which is consistent with the underlying position compared to M1.
- The underlying position has improved from the "do-nothing" scenario; however, not at the required pace to deliver our plan. Broadly, cost reduction schemes have started to deliver (reduced outsourcing costs, pay costs controlled and on trajectory to reduce). However, other challenges have impacted the position.
- This includes reductions in other income – notably the Trust is seeing pressures with income from Channel Islands and pathology reducing, as well as funding reductions from NHSE Spec Comm (ERF £250k, Genomics £1.1m, Mechanical Thrombectomy £3m – full-year numbers).
- The Trust has also seen run-rate cost growth within clinical supplies and drugs, which is being explored further.
- Additional income received from HIOW ICB for deficit support has landed in the Q1 position, which is supporting the position remaining on plan. However, this means the financial improvement trajectory will be even more challenging from Q2.
- Deficit drivers remain consistent with 2024/25 namely non elective demand exceeding block funded levels of activity, non criteria to reside patient volumes and inpatient mental health patient costs with regards to enhanced care requirements. We are seeing no improvement, if anything a further deterioration, within our position.
- 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 and chaired by the Chief Executive.
- UHS continues to deliver significant levels of financial savings (£6.5m has been achieved in M2, in line with the plan).
- Cash has increased to £19.1m in month. This represents just 5 operating days of expenditure. However, this was supported by holding circa £13m of payments in month. There is a significant risk in H1 2025/26 that cash will reduce close to zero and mitigations are currently being explored and the subject of a further paper.

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 – M2

Headlines

In M2, the Trust reported a £3.8m deficit, in line with the annual plan. The Trust's underlying position has increased from 2024/25 and is now at £7.2m in M2. This is driven by additional efficiency requirements within our funding, continuing NCTR (non-criteria to reside) pressures as well as an increase in drugs spend. The underlying position has however reduced below the do-nothing plan scenario as savings schemes are starting to have an impact.

There has been an increase in the total workforce of 20 WTEs, linked to additional surge capacity being open during May. Without these pressures, workforce levels would have continued to reduce. Total pay only moderately decreased, after normalising for bank holiday enhancements, National Insurance uplifts, National Living Wage increases and pay award accruals. The latter elements have been centrally funded via the cost uplift factor.

The financial plan trajectory for the year requires significant month on month improvement which is a key focus for the newly formed Financial Improvement Group. Workforce reductions of 785 wte are required over 2025/26 and £110m of savings are required for plan delivery focused predominantly on pay and non pay.

NHS Income

NHS income has been subject to several changes in 2025/26:

- 2% efficiency target applied to all NHS contracts in addition to convergence and deficit repayment targets (-£21m per annum)
- Urgent and Emergency Care (UEC) investment from HIOW ICB (+£14.7m per annum) partly offsetting historic overperformance.
- Deficit Support Funding (+£10.6m per annum, noting £11.2m received non-recurrently in 24/25).
- Inflationary uplifts have also been applied but are fully offset by inflationary costs

Elective Recovery Fund (ERF) income will be capped in 2025/26 and therefore is no longer subject to overperformance payments. This encompasses elective, daycase, outpatient new appointments and outpatient procedures. Most other NHS income (predominantly non elective and A&E activity) will be paid on a block and therefore is also not subject to activity related funding adjustments. UHS is therefore challenged to 'live within its means' and control costs to ensure they do not exceed funded levels.

Currently UHS is operating significantly above the levels of activity funded within our contracts. As part of financial recovery, attempts are therefore being made to reduce the level of demand on the hospital. Historically the Trust has been a "sponge" for additional demand from multiple systems – this cannot continue if the Trust is to "live within its means" in the current environment. This may mean the Trust needs to take a firmer stance on referrals from areas that are not fully funding activity levels.

ERF performance for M2 is above the 2024/25 average. Current forecasting suggests UHS may exceed funded levels in 2025/26 however this will be monitored closely in year with mitigations activated accordingly should they be required. Insourcing and outsourcing activity has already been subject to review with some areas planned to stop in the coming months. Specialised Commissioning have yet to confirm the specifics of the capped funding arrangement for 2025/26 therefore there is greater risk in this area.

Financial Improvement

The Trust continues to target month on month financial improvement from its savings and transformation programmes. Key achievements for month 2 include the following:

- UHS has delivered £6.5m (>5% of addressable spend) of CIP in M2, which is in line with the 25/26 annual plan.
- New workforce controls have been embedded, targeting reductions of 5% in divisions and 10% in corporate departments. The trust is £0.2m below the pay expenditure plan in M2.
- UHS is currently utilising agency for just 0.3% of our total workforce, significantly below the national target of 3.2%. Just 51 wte agency were utilised in month.
- Decisions have been made to reduce high cost insourcing and outsourcing unless considered a significant clinical priority. This is expected to save c£0.5m per month from June onwards.
- The financial improvement group is now established and meeting weekly. This group has approved initiatives across a number of different programmes and projects all targeting sustainable cost reductions and increased efficiency.

Key Deficit Drivers

The key drivers for the underlying deficit remain consistent with 24/25:

- Levels of non-elective and emergency department remain significantly in excess of block funded levels. Reporting for this will re-commence in future months once contract envelopes and indicative activity plans (IAPs) have been agreed with commissioners.
- Non-Criteria to Reside (NCTR) patient numbers have increased above 250. This is a notable increase on the trajectory of the past two years. The period at Easter is particularly challenging with partner services often reducing provision over bank holiday periods putting additional strain on hospital providers.
- Mental Health patient numbers remain high with significant resources often required to support patient safety. Numbers have increased slowly over the last 12 months peaking at 150 inpatient admissions in recent months and spiking up in M2. This is the subject of a financial improvement group workstream with discussions with partner organisations underway.
- Historic underfunding of pay awards has created legacy cost pressures.
- Non pay cost pressures including the impact of inflation above planned levels continues to cause pressure.

Pay Awards

Announcements have recently been made regarding pay awards for 2025/26 that are now subject to union discussion and ratification. The levels announced were above that signalled within the planning guidance and the current funding envelope. It is therefore anticipated further funding will be forthcoming from within internal NHS sources however this is currently unknown. The committee will be updated at future meetings with regards to any funding risks should these materialise.

Capital

Capital expenditure to M2 is £2.3m below plan due to timing across all key projects at this early stage in the year. The forecast is £66.9m for 2025/26 which is expected to be delivered in full. Slower progress than plan is noted on Strategic Maintenance, the Diagnostic Centre, and other Estates projects. Capital has been reduced to fully-funded and critical schemes only in response to cash concerns.

Spending Review 2025

The Chancellor of the Exchequer presented her Spending Review to Parliament on 11 June 2025. The review is intended to set planned spending totals for all government departments for the next three to four years.

A paper was presented to Finance & Investment Committee summarising the spending review and an early view of the implications for the NHS.

Table 5.6: Department of Health and Social Care

								Average annual real growth[4]	
£ billion (current prices)	Outturn 2023-24	Plans[1] 2024-25	Plans[2] 2025-26	Plans 2026-27	Plans 2027-28	Plans 2028-29	Plans 2029-30[3]	Phase 2 Period[5]	SR 2025 Period[6]
Resource DEL	177.9	193.3	202.0	211.0	221.3	232.0	–	2.8%	2.7%
of which: NHS England[7]	171.0	186.8	195.6	204.9	215.4	226.1	–	3.0%	3.0%
Capital DEL	10.5	11.6	13.6	14.0	13.5	14.8	14.6	0.0%	3.2%
of which: Financial Transactions	0.0	–	–	–	–	–	–	–	–
Total DEL	**188.5**	**204.9**	**215.6**	**225.0**	**234.9**	**246.7**	**–**	**2.7%**	**2.8%**

[1] Figures for 2024-25 represent departments' final plans as of Supplementary Estimates 2024-25. Official outturn figures will be published in Public Expenditure Statistical Analyses 2025 later this year.
[2] Figures include Spring Statement 2025 plans, plus Machinery of Government changes.
[3] Resource DEL plans have been set for all departments for years up to 2028-29, and Capital DEL plans for years up to 2029-30.
[4] The RDEL average annual growth rates have been adjusted to account for employer NICs changes, Machinery of Government changes, increased pension contributions (SCAPE), and budget cover transfers in 2023-24.
[5] This refers to the period starting in 2025-26, and ending in 2028-29 for Resource DEL and Total DEL, and 2029-30 for Capital DEL.
[6] This refers to the period starting in 2023-24, and ending in 2028-29 for Resource DEL and Total DEL, and 2029-30 for Capital DEL.
[7] The "of which: NHS England" line contains updated figures for DHSC funding spent via NHS England, including historic transfers and savings redirected to frontline services. Growth rates additionally adjust for non-baselined technical transfers (mainly pay).

OBR forecasts to assess inflation have been used (26/27 – 2.2%, 27/28 – 2%, 28/29 – 2%)

- Government announced £30bn of additional funding for the NHS.
- In real terms, this equates to £18bn real terms growth - £5bn in 2026/27, £6.4bn in subsequent years.
- NHSE Real Terms growth of 3% across the 3-year period (noting slightly lower per year with compounding effect).
- Notably lower at 2.6% in 2026/27.
- There is an assumed 2% per year productivity improvement for the NHS, providing the investment required to deliver improvements.
- Expectation that U&EC performance improves and RTT target of 95% within 18 weeks is met by the end of the parliamentary period.
- Local Authorities to receive £800m of increased grant income – a 1.1% real terms increase. The government has also supported a fair pay agreement for the adult social care sector.

Capital:

- Government announced an additional £4bn of capital funding per year for the NHS.
- However, this announcement referred to the period from 2023/24. It is therefore flat with capital budgets in 2025/26.
- Capital budgets are currently significantly constrained for healthcare systems. However, there has been an increased level of central capital budgets to bid for funding, including to support constitutional standards (Urgent Care Centres, Elective Hubs), Digital (single EPRs) and Estates Safety funding.
- Treasury have not supported an increased level of private financing to support NHS capital.
- £10bn has been confirmed as investment into NHS technology and digital transformation, primarily on the NHS app and single patient record. It is yet to be seen how this is managed within the overall envelope (may require reductions in other funding pots).

NHS Hampshire and Isle of Wight

System Operational Delivery Report

1. Introduction

1.1 This report serves as a comprehensive overview of the Hampshire and Isle of Wight Integrated Care System's performance across several domains, including Performance, Finance and Workforce. This holistic approach enables a better understanding of our progress against the Operating Plan 2025/26.

1.2 Performance assessments for each area are conducted systematically. As well as monitoring progress against plan, performance is also reviewed in line with the NHS England 'Making Data Count' guidance – Statistical Process Control (SPC) mapping ensures a consistent methodology for identifying areas that require additional focus and attention, for example, the latest performance may highlight an improvement on the previous data period and achieving target in any given month, but the trend may show 'special cause variation' over a greater period, which may suggest the target is unlikely to be achieved at year end.

1.3 This report is based on data published on 12 June 2025 – up to May 2025 for Urgent and Emergency Care metrics and up to April 2025 for Planned Care, Local Care, Primary Care, Mental Health / Learning Disability and Autism metrics.

2. Operating Plan Summary

2.1 In the 2025/26 operating plan, there are a total of 42 performance metrics (not including activity metrics) – for the purpose of this report, we have categorised the performance metrics under three sub-headings: headline metrics, drivers and enablers. For any headline metric not achieving plan, an exception report is provided, outlining current performance and actions, working assumptions and considerations.

2.2 In June 2025, the ICB is ranked red against 7 headline operating plan metrics:

- Emergency Department total mapped performance (M2)
- % of attendances in A&E over 12 hours (M2)
- RTT 52 week waits (M1)
- Diagnostic 6 week waits (9 key tests) (M1)
- Urgent Community Response (UCR) referrals (M1)
- Access to general practice – number of available appointments (M1)
- Average length of stay for Adult Acute MH beds (M1).

2.3 General Practice appointments are not included in the escalation section as performance will continue to be closely monitored across the financial year.

Urgent Community Response referrals will be addressed in July reporting. Elective long waits for 65 weeks and 78 weeks have also been included in the escalation section due to the current position and increase against the 2024/25 year end position (which achieved plan). The national expectation was to eradicate any long waits over 65 weeks by March 2025.

3. Escalation Reports

3.1 Urgent and Emergency Care (2 metrics)

3.1.1 Performance Overview

Accident and Emergency attendances: performance in M2 is below plan for all 3 operating plan metrics (eg. Type 1, All Types and Other attendances). The ICB also remains below the 78% national target for total mapped Emergency Department footprint with 74.8%.

Percentage of attendances in A&E over 12 hours – M2 performance is 1.1% above plan. The number of 12 hour waits from decision to admit decreased from 699 in M1 to 524 in M2 (against a zero national standard).

- For **Type 1 A&E performance**, Hampshire and Isle of Wight ICB are ranked **28th out of 42** ICBs for their May performance of 58.7%. (**Interquartile**)
  The National average is 61.2%.

- For **all Type A&E performance**, Hampshire and Isle of Wight ICB are ranked **22nd out of 42** ICBs for their May performance of 74.8%. (**Interquartile**)
  The National average is 75.4%.

- For **Percentage of attendances in A&E over 12 hours**, Hampshire and Isle of Wight ICB are ranked **15th out of 42** ICBs for their May performance. (**Interquartile**)
  The National average is 9.3%.

3.1.2 Risks to Delivery

Below is a summary table of the Acute Trust 4-hour performance which includes all attendance types. Each Trust is measured against their operational plan trajectory for the year.

Acute Trust Performance for 'all type' of attendances

NHS Trust		Apr-25	May-25
Hampshire Hospitals	Actual	65.1%	65.6%
	Operational Plan	62.3%	63.9%
University Hospital Southampton	Actual	63.6%	59.3%
	Operational Plan	63.0%	65.9%
Portsmouth Hospitals University	Actual	70.2%	72.9%
	Operational Plan	70.0%	72.9%
Isle of Wight	Actual	70.1%	73.0%
	Operational Plan	70.1%	76.2%

Performance remains challenged in M2, with some providers showing a significant variance against plan.

All providers have set plans to achieve the 78% operating plan guidance metrics on 4hour waits by March 2026. However, each have provided varying approaches and profiles within their monthly trajectories of planned performance through the year, to achieve 78% by the close of the year.

There will be emergency care pressures and subsequent risks through the winter period and Trusts have included an impact during these periods, as a result there are some expected peaks during the summer and then in the late winter/early Spring.

A core risk across the whole ICB continues to be the high level of patients within the acute system who occupy a bed but have 'No Criteria to Reside' (NCTR). There is a high reliance on bedded care within the system and available capacity is unable to keep pace with demand. There is also an increasing level of patients, especially the growing elderly cohort, whose discharge needs are more complex. NCTR levels remain close to 700 for the system and this patient cohort are occupying approximately 23% of acute beds, which is impacting on whole system flow, including at the front door for patients requiring a timely admission.

Each provider system is also recognising a series of process and estate constraints that are identified as requiring a mitigation to ensure front door flow is as efficient as possible.

3.1.3 Mitigations and Improvement Actions

The Hampshire & Isle of Wight health system remains in Tier 1 for Urgent and Emergency Care services. As such the system receives intensive support from NHS England and tiering calls are held every 3 weeks with NHS England and local system leaders. The frequency of meetings has reduced recently with overall UEC performance improvements highlighted by the Ambulance response times and Ambulance handover programme successes.

Acute Trusts have provided an ongoing log of short/intermediate term (4–6 week) actions in order to support improved function and performance at the front door.

3.2 Diagnostics 6 week waits

3.2.1 Performance Overview

The operating plan performance for April 2025 shows a deteriorating position for <6 week diagnostics, increasing from 25% in March 2025 to 33% in April 2025. This is above the M1 operating target of 29.9%.

Performance remains challenged in M2, with some providers showing a significant deterioration on previous month and variance against plan. The total diagnostic waiting list has grown by 10.7% since Oct 2024.

Main areas of concern include: Non-Obstetric Ultrasounds, MRI and CT scans, Audiology Assessments and Echocardiography.

- For **Diagnostic 6+ weeks**, Hampshire and Isle of Wight ICB are ranked **38th out of 42** ICBs for their April performance with 32.6% (**Lowest Quartile**)
  The National average is 21.2%.

3.2.2 Risks to Delivery

Performance against the 6 week wait for diagnostics continues to be a risk for the ICB with performance deteriorating and not achieving plan. For 2025/26 across the ICB, the plan is to limit growth in year to 10% for Gastroscopy and target a 2% reduction for Echocardiology, DEXA scan and Audiology.

3.2.3 Mitigations and Improvement Actions

Current and planned actions include:

- HIOW ICB to put in place Diagnostic Oversight Committee aligned to the diagnostic strategy.
- PHU have an Audiology business case which details the building of testing facilities, software upgrading and recruitment, which will increase activity (enabling 12,000 more Audiology tests to be completed in 2025/26), which will bring waiting times comfortably within 6-weeks.
- PHU plan to utilise additional Community Diagnostic Centre (CDC) capacity for MRI and Non-Obstetric ultrasounds which is due to start within 2025/26.
- PHU plan to use Elective Endoscopy Centre (EEC) capacity and increase inefficiencies by reducing DNAs for Endoscopy and Gastroscopy.

- Implement usage of iRefer across system – HHFT Pilot has gone live and has shown initial reductions in external demand.
- Increase efficiency of tests by introducing AI where possible, such as the use of Advanced Acceleration Technology (AAT) in MRI.
- Standardise pathways where possible to ensure requests are warranted and for the least invasive diagnostic.
- Reduce duplication of community sites where not aligned to population context or efficiency could be increased.
- All providers have been asked to develop recovery plans to address 6 week wait performance as soon as possible.
- Imaging site visit with NHS England/ICB undertaken this month at PHU with further site visits to other providers planned.
- Endoscopy network recovery plan in place.
- Portsmouth and Southampton CDCs opening across 2025/26 and 2026/27.
- Options appraisal to be undertaken around options for consolidation, ensuring affordability, sustainability and efficiency.

3.3 Elective Waiting Times

3.3.1 Performance Overview

The end of April 2025 position shows 5,526 patients are waiting over 52 weeks, representing an increase on the previous month of 4,625 and not achieving plan. All HIOW providers are significantly above plan in M1.

The number of patients waiting over 65 weeks deteriorated in M1 to 220 (compared to 89 previous month). Latest unvalidated position indicates further deterioration in months 2 and 3, with improved position forecast for end of July.

The ICB also continues to report patients waiting over 78 weeks with 41 in M1 (compared to 15 previous month) and over 104 weeks with 20 in M1 (compared to 6 previous month). However, forecasts for May 2025 show a significant reduction (to 6 and 2 respectively for 78/104 week waits) and zero for June 2025.

- For **Percentage of 52+ weeks**, Hampshire and Isle of Wight ICB are ranked **28th out of 42** ICBs for their April performance with 2.9% (**Interquartile**)
  The National average is 3.0%.

- For **Percentage seen within 18 weeks**, Hampshire and Isle of Wight ICB are ranked **22nd out of 42** ICBs for their April performance with 59.9% (**Interquartile**)
  The National average is 60.1%.

3.3.2 Risks to Delivery

52 weeks remains a challenge for all providers, with latest unvalidated position indicating further deterioration in M2.

3.3.3 Mitigations and Improvement Actions

Current and planned actions include:

- HHFT are reviewing what actions can be taken to address ENT capacity issues which are impacting on 65 week waits

- UHS have weekly meetings with their surgery care group to review the 65 week surgical breaches. In addition, they are reviewing reasons for increase in overall waiting lists to see if any issues can be identified to address 52/65 waits. Increases have been seen in 7 specialities; Clinical Genetics and Oral surgery, Dermatology, Allergy and Immunology, Urology and Cardiology

- Providers are focusing on improving validation of waiting lists as a result of validation sprints. Latest unvalidated position (RAIDR as at 8 June) shows 54.5% patients waiting over 12 weeks across the 4 acutes have been validated in the last 12 weeks (vs 90% national target). Performance varies from 66.7% in HHFT, 62.9% in UHS, 46% in PHU to 14.9% in IOW.

- Improving management of procedures of limited clinical value, to ensure only those patients needing secondary care intervention are on waiting list.

- Conducting a system wide review of dermatology advice and guidance in comparison to outpatient capacity, with a view to improving the pathway

- Work with primary care to implement the GP advice and guidance enhanced service, ensuring the approach supports increased utilisation and diversion

- Transformation work, including Audiology, Community Musculoskeletal Services and Community Urgent Eye Care Services, to maximise opportunities for demand management and left shift of activity

- Improving productivity, working with the national Getting It Right First Time (GIRFT) team, focusing on high pressure specialties including ENT, Orthopaedics, Urology, as well as cross cutting issues such as theatre utilisation

- Identifying opportunities to shift from analogue to digital, including extending the use of Dora Artificial Intelligence assistant to create a routine post-operative cataract follow up pathway, reducing the need for refraction tests and post cataract follow ups.

- Ensure mutual aid opportunities are maximised and identify opportunities for shared waiting list approaches.

4. Integrated Care System Financial Overview

4.1 Purpose

The purpose of the Integrated Care System (ICS) Financial Overview section is to provide an overview of the financial position for NHS organisations within Hampshire and Isle of Wight ICS throughout the financial year 2025/26.

4.2 Background

The agreed system plan for 2025/26 is a surplus of £0.468m, consisting of a £0.468m surplus plan for Hampshire and Isle of Wight (the Integrated Care Board), and a breakeven plan for all other NHS providers.

The final plan for 2025/26 includes £63.2m of non-recurrent Deficit Support Funding (DSF). Since completion of the 2025/26 planning round, NHS England has announced that DSF will only be released to ICBs to pass-through to NHS Providers on a quarterly basis, conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

4.3 Financial Position

Table 1 below summarises the in-month and year-to-date financial position as at Month 02 (May) for all Hampshire and Isle of Wight organisations

Table 1: Summary of M02 results

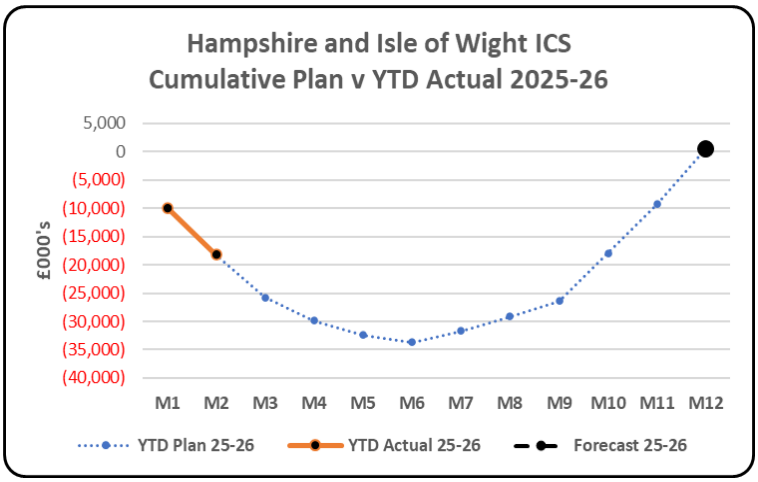
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	(8,371)	(8,326)	45	(18,307)	(18,253)	54	468	468	0

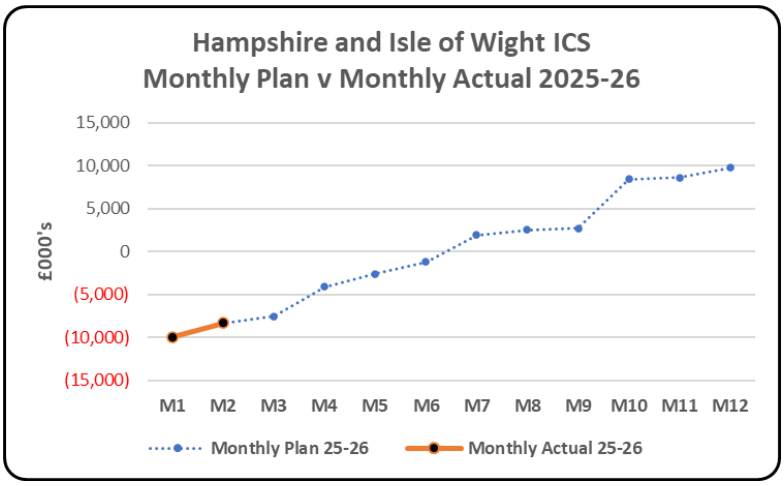
In May 2025 itself, the ICS reported a deficit of £8.33m against a planned deficit of £8.37m, so £0.04m better than plan. Year-to-date the system has

reported a deficit of £18.25m at Month 02 compared to a planned deficit of £18.30m, therefore £0.05m better than plan.

The graphs below summarise the ICS position reported at month 02 (May) 2025/26.

Figure 1: Summary YTD and in-month actuals 2025/26





4.4 System Actions to Support Financial Recovery

In 2023/24, additional controls were developed and implemented, aligned to those 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 remain extant in 2025/26.

Our system plan for 2025/26 intends to address the challenges impacting our financial position that required a system response. Together we have identified key programmes for corrective action to enable delivery of each organisation's operating plan.

Our 2025/26 plan includes actions specifically targeted at reducing pressure on our acute systems by focusing on projects that could reduce ambulance conveyance, ED attendances, non-elective admissions and occupied bed days in 2025/26.This is consistent with our commitment to a "left shift" from acute to community and from treatment to prevention.

5 Workforce

5.1 System Oversight

The system has a weekly System Workforce Oversight Committee in place to ensure grip and control of the system workforce plan. This includes provider data review against plan and course correction actions required.

5.2 M2 System Performance

Month 2- All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 45 whole time equivalent (WTE) under plan in 2025/26.
- All Trusts are under plan except for South Central Ambulance Service (207 WTE) & Portsmouth Hospital University (42 WTE). Main causation is due to Substantive whole time equivalent being above plan.
- Hampshire Hospital Foundation Trust & University Hospital Southampton are notably under plan by 123 & 108 whole time equivalent, respectively.

Month 2- Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 14 whole time equivalent (WTE) under plan.
- All Trusts are under plan except for South Central Ambulance Service (150) & Portsmouth Hospital University (36 WTE).
- 'NHS Infrastructure Support' & 'Support to Clinical' Staff Groups are above plan by 210 & 122 whole time equivalent, respectively.
-

Bank and Agency Trajectories – Whole Time Equivalent – Month 2

- Hampshire & Isle of Wight systems temporary staffing usage accounts for 2,813 whole time equivalent (WTE), 31 WTE (1.1%) better than plan figure of 2,844.
- Bank & Agency usage both continue to remain below plan, by 17 & 14 whole time equivalent, respectively.
- South Central Ambulance Service are notably over Bank WTE plan by c.54 WTE. South Central Ambulance Service have mitigation plans in place to ensure the Trust can meet the planned end of year position.

Month 2 – Bank & Agency Spend (YTD Month 2)

- HIOW System YTD to Month 2 in 25/26 has seen a reduction of c.£4.5m in temporary staffing costs compared to the same period in 24/25.
- Bank has seen a reduction of c.£1.0m whilst Agency has seen a reduction of c.£3.4m.
- IOW has seen the largest reduction in temporary staffing costs in this period of c.£1.4m.
- Increases in Bank costs have been seen across UHS (c.£0.4m), HHFT (c.£0.2m) and HIOWH (c.£0.2m).

6 Quality

The Board is asked to note that, apart from the Infection Prevention and Control data, the information included in the quality section below relates to NHS Trust provider and General Practice data and not whole System data.

6.1 Regulatory

Care Quality Commission: during May 2025, nine Care Quality Commission inspection outcomes were reported all of which related to care homes or home care.

Care Quality Commission – General Practice: 126 of the 129 Hampshire and Isle of Wight GP Practices currently hold an overall *Good* rating with the Care Quality Commission and one is rated *Outstanding* (this rating is from April 2020). There are two GP Practices that are currently rated as *Requires improvement*. There are currently no GP Practices in Hampshire and the Isle of Wight that are rated as *Inadequate*.

Where a GP Practice is rated as *Inadequate* or *Requires Improvement* or where regulatory warning notices are issued, the GP Practice is required to submit an action plan to the Care Quality Commission for review and in addition multi-disciplinary support and oversight is provided through the NHS Hampshire and Isle of Wight quality and primary care commissioning teams.

Quality Assurance and Improvement Surveillance Levels: all the large NHS providers are in the routine quality assurance and improvement surveillance levels.

6.2 Patient Experience

Patient Experience: in April 2025, NHS England regional team informed Integrated Care Boards that they had been notified that the monthly publication of Friends and Family Test data had been paused, and no data would be produced whilst future arrangements for the data are finalised. The update

states the National team will endeavour to resume monthly publications as soon as possible. Therefore recent Friend and Family Test data has not been reviewed for our large system providers or General Practices.

Online reviews for large system providers continue to be monitored and triangulated with other intelligence to inform quality insight and system improvement processes. The total number of online feedback entries received is statistically very low and therefore it is difficult to gauge the significance of the findings and should be viewed with caution. However, most of the provider online feedback was positive with highlighted areas referencing positive feedback about staff (empathetic, kind, professional and helpful); the environment (calm and clean) and one feedback related to the speed of being seen in the Emergency Department in comparison to a year ago. The negative feedback was in relation to an Accident and Emergency Department and referenced waits, corridor care, environment and parking charges, although it did include one positive about the staff being kind.

Despite the year-on-year increase in appointments, of the complaints related to General Practice received by the NHS Hampshire and Isle of Wight, themes include access and challenges in booking an appointment. It is important to note that the number of complaints received by NHS Hampshire and Isle of Wight relating to General Practice are low in comparison the number of appointments and the daily activity within primary care. During 2024/25, 688,239 extra appointments were delivered across Hampshire and Isle of Wight compared with the year before, representing a 6.2 % increase year-on-year. As an average, 60% of these appointments were face -to-face with some practices and Primary Care Networks exceeding 60% and the national average, for example 68% of appointments across Romsey Primary Care Network were face-to-face.

Across NHS Hampshire and Isle of Wight, the Integrated Care Board holds regular complaint review panels to review the information for contractual and other implications and to identify shared learning themes for improvement.

Mixed-Sex Accommodation Breaches (up to March 2025): all providers continue to report mixed sex accommodation breaches. Across NHS Hampshire and Isle of Wight, in March 2025 there were 57,840 finished consultant episodes and 102 mixed-sex accommodation breaches (rate 1.8) - this represents a further reduction in comparison to the January and February 2025 performance. All acute providers reported a reduction in comparison to the previous month, apart from one, the number of breaches reported by providers ranged from 1 to 113.

As previously reported, Trusts manage their breaches, aiming to rectify them as soon as possible and ensuring patient privacy and dignity. The hospital estate has an impact on breaches, for examples those estates with bays including en-suite facilities are less likely to incur breaches.

6.3 Safety

Infection Prevention and Control – Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infections: the threshold for Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infections is zero. Two healthcare associated cases were reported in April 2025, both of which remain under investigation. NHS Hampshire and Isle of Wight have a robust infection prevention and control action plan in place.

Dermatology Never Events – May 2025: May 2025 was the first month in 12 months where no Never Events were reported in the Hampshire and Isle of Wight System.

Actions:

- in response to provider surgical Never Event performance, thematic analysis of provider incidents and feedback during 2024/25, and through collaboration with providers, one of the key 2025/26 system quality priorities is to improve patient safety, team-working and efficiency in settings that undertake invasive procedures.
  All providers have agreed this as part of their 2025/26 quality contract (Schedule 4c).
- reviewing Quarter 1 submissions from providers regarding their levels of assurance in relation to 12 key areas within the National Safety Standards for Invasive Procedures (NatSSIPS) and for areas where Trusts are not assured or partially assured, their improvement action plan in place.
- raised through joint assurance meetings with NHS England (Sout East) – deep dive presentations from provider to gain assurance regarding provider plans.
- contract progress via System Quality Group.
- system review of 2024/25 Never Events to further support learning and improvement.

Regulation 28 - Prevention of Future Death reports: during May 2024, none of the Hampshire and Isle of Wight providers received a Prevention of Future Death report.

General Practice - National Patient Safety Incident Response Framework (PSIRF): GP Practices across Hampshire and Isle of Wight continue to transition to the national Patient Safety Incident Response Framework (PSIRF) with a GP practice pilot commencing on the Isle of Wight supported by a Clinical Director. The purpose of this pilot is to further test patient safety principles and processes aligned with the Patient Safety Incident Response Framework (PSIRF) in general practice. At the end of the pilot year, the outputs and insights from the experiences of general practice pilot sites will provide a road map for other general practices implementing the framework.

6.4 Clinical Effectiveness

Standardised Hospital-level Mortality Indicator (SHMI) – up to December 2024: all providers are reporting 'as expected' (band 2) or 'lower than expected' (band 3) mortality rates. One Trust is showing a declining position, but remains within the 'as expected' level, this will continue to be monitored.

National Hip Fracture database – hours to operation (May 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. 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. In May 2025, within Hampshire and Isle of Wight, one Trust met this target.

In May 2025:

- two Trusts remained above the national rate
- one Trust continued to show a declining variation.

All Trust are performing better than the national 30-day mortality rate. Quarter 1, 2025/26 provider quality contract reports awaited, which will include actions to address key performance challenges associated with compliance against the seven Fractured Neck of Femur Best Practice Tariff characteristics.

Covid-19 Spring 2025 campaign: the Covid-19 Spring 2025 campaign came to an end on the 17 June 2025. Across Hampshire and Isle of Wight 174,776 covid vaccinations (62.9% of the eligible cohort) were administered to cohorts as defined in the Joint Committee on Vaccination and Immunisation (JCVI) guidance. Two thirds of these covid vaccinations were administered via HIOW GP practices and one third by local community pharmacies. Hampshire and Isle of Wight have administered the highest percentage and highest number of covid vaccinations in comparison to other ICB's across the South East region and were the third highest ICB nationally for the percentage of covid vaccinations administered.

7 Recommendations

It is recommended that the Board:

- Notes the detail of this report
- Accepts that this report demonstrates oversight of performance and actions being taken for improvement.

Of note:

- Each Board needs to gain its own assurance that their organisation has robust plans in place for delivery of their 2025/26 operating plan, noting that Deficit Support Funding will now be released quarterly, based on system financial performance.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.10 Report to the Trust Board of Directors, 15 July 2025	
Title:	People Report 2025-26 Month 2
Sponsor:	Steve Harris – Chief People Officer
Author:	Farid Khalil - Workforce Systems Specialist

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:

Overall workforce grew in May by 19 WTE however is still currently below NHSE plan by 107 WTE. Drivers of growth were underpinned by increases in temporary staffing in the bank and agency, although these both remain below plan.

The substantive workforce decreased by 14 WTE. There is still a predicted lag for new starters continuing to join the organisation from the pre-March recruitment slowdown. There has been a significant increase in focus on forecasting detail conducted by finance and workforce teams to understand the impact of anticipated organisational change and local workforce reduction plans. This has been discussed through FIG and will be the subject of TEC debate. Some limited additional recruitment controls have been agreed at FIG (Slowing starters).

Turnover has remained lower in month contributing to slowed reduction in WF. Rolling average is at 10%, however in month has been equivalent to an annual level of between 7-8% during the last 4 months. An assumption of lower turnover for the rest of the year is being included in the detailed forecasting work.

The Trust is continuing to recruit newly qualified staff to ensure key vacancy pipelines are addressed however the starters are being phased over the autumn to avoid significant spikes.

There has been several national letters received during May and early June, and the updates on these are summarised in the People report.

The Trust continues to deliver its organisational change programme, including a focus on reduction in clinical divisions from 4 to 3, a MARS programme, focus on temporary staffing, and a reduction in pay costs across Divisions and corporate services.

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.
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.

Equality Impact Consideration:	EQIA assessments undertaken as required for specific streams within the People Strategy

UHS People Report

WORLD CLASS PEOPLE

May 2025

THRIVE EXCEL BELONG

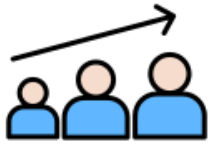
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M2 (MAY-25)

In-month sickness is currently 3.2%, lowest level since June 2024 and 0.5% below target (3.7%).

Appraisal completion rates reduced by 1% to 72% in May

R12m turnover rate (10.1%), which is below target (10%).



Substantive workforce is currently below NHSE 25/26 workforce plan.

Bank usage increased from prior month and is now 13 WTE below plan.

Increase in agency staffing usage. Agency remains under plan.

Decrease in patient safety incidents from 62 to 61 in May

Pulse Survey for Q4 shows a stable engagement score

Executive Summary

Overall workforce grew in May by 19 WTE however is still currently below NHSE plan by 107 WTE. Drivers of growth were underpinned by increases in temporary staffing in the bank and agency, although these both remain below plan.

The substantive workforce decreased by 14 WTE. There is still a predicted lag for new starters continuing to join the organisation from the pre-March recruitment slowdown. There has been a significant increase in focus on forecasting detail conducted by finance and workforce teams to understand the impact of anticipated organisational change and local workforce reduction plans. This has been discussed through FIG and will be the subject of TEC debate. Some limited additional recruitment controls have been agreed at FIG (Slowing starters).

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The Trust continues to deliver its organisational change programme, including a focus on reduction in clinical divisions from 4 to 3, a MARS programme, focus on temporary staffing, and a reduction in pay costs across Divisions and corporate services.

Overall Position

WTE Movement (M1 to M2)

Total Workforce

The total workforce **increased by 19 WTE** to 13,411 WTE from M1 (13,391) to M2.

During this period, the substantive workforce decreased by **14 WTE**, while the total temporary staffing increased by **34 WTE.**

As of M2, the Trust is **below the total plan** (by 107 WTE).

Substantive WTE

Substantive WTE decreased by **14 WTE** between end of April and end of May.

Substantive workforce position has been adjusted to fully include UEL, and exclude all Capital hosted posts within DIGITAL, TDW GP Lead Employer and TDW Education Hosted posts.

Without adjustments in the inclusion and exclusion criteria, substantive WF decreased by 18 WTE in May, driven by offers pre the significant extra restrictions in recruitment that were applied in March, in addition to lower than expected turnover.

Bank & Agency WTE

Total Bank and Agency usage increased by 34 WTE in May 2025.

Bank usage **increased** in May by 4% (698 to 728 WTE; 29 WTE increase).

Agency usage **increased** in May by 9% (46 to 51 WTE).

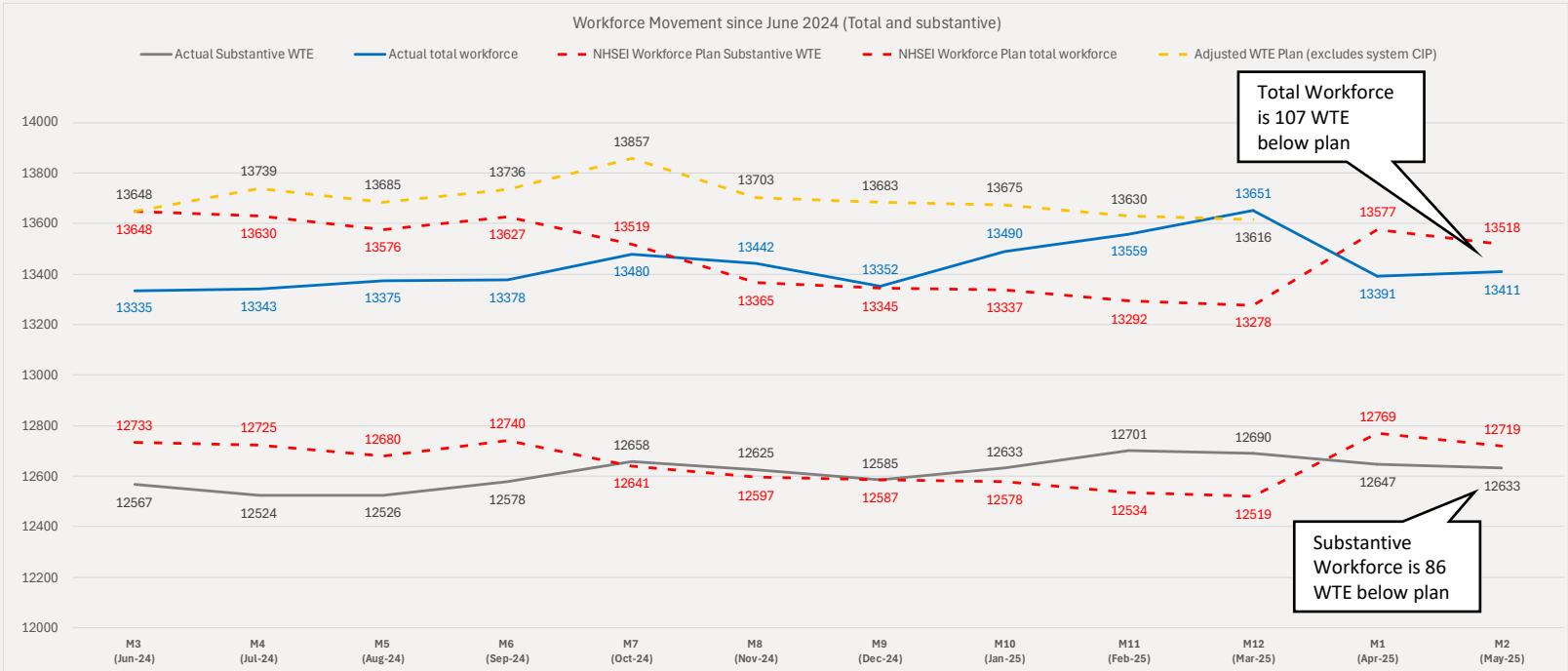
Key Challenges & Actions:

Ongoing Pressures: Mental health demand continues to present safety, quality, and financial challenges for the Trust. UHS is actively escalating concerns to the ICB and advocating for broader system-wide solutions.

Active Workforce Management: The staffing hub team keeps detailed records of 1:1 Enhanced Care staffing requests. To improve data quality, a Microsoft Form has been introduced into the process to ensure consistent and accurate data collection.

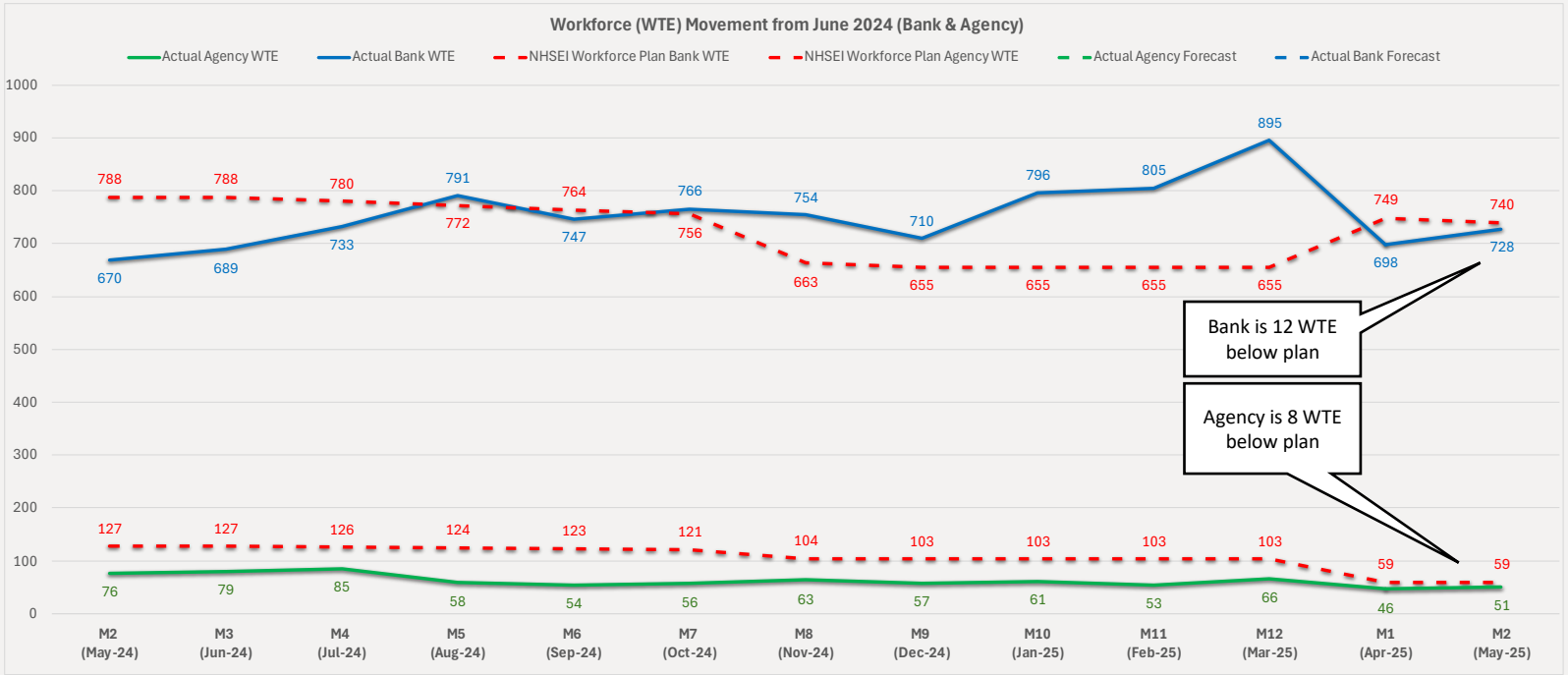
Rising Numbers of Detained Patients: There is a month-on-month increase in patients detained under Section 2 of the Mental Health Act. This is driving higher demand for 1:1 RMN-prescribed enhanced care.

Workforce Trends: Total & Substantive



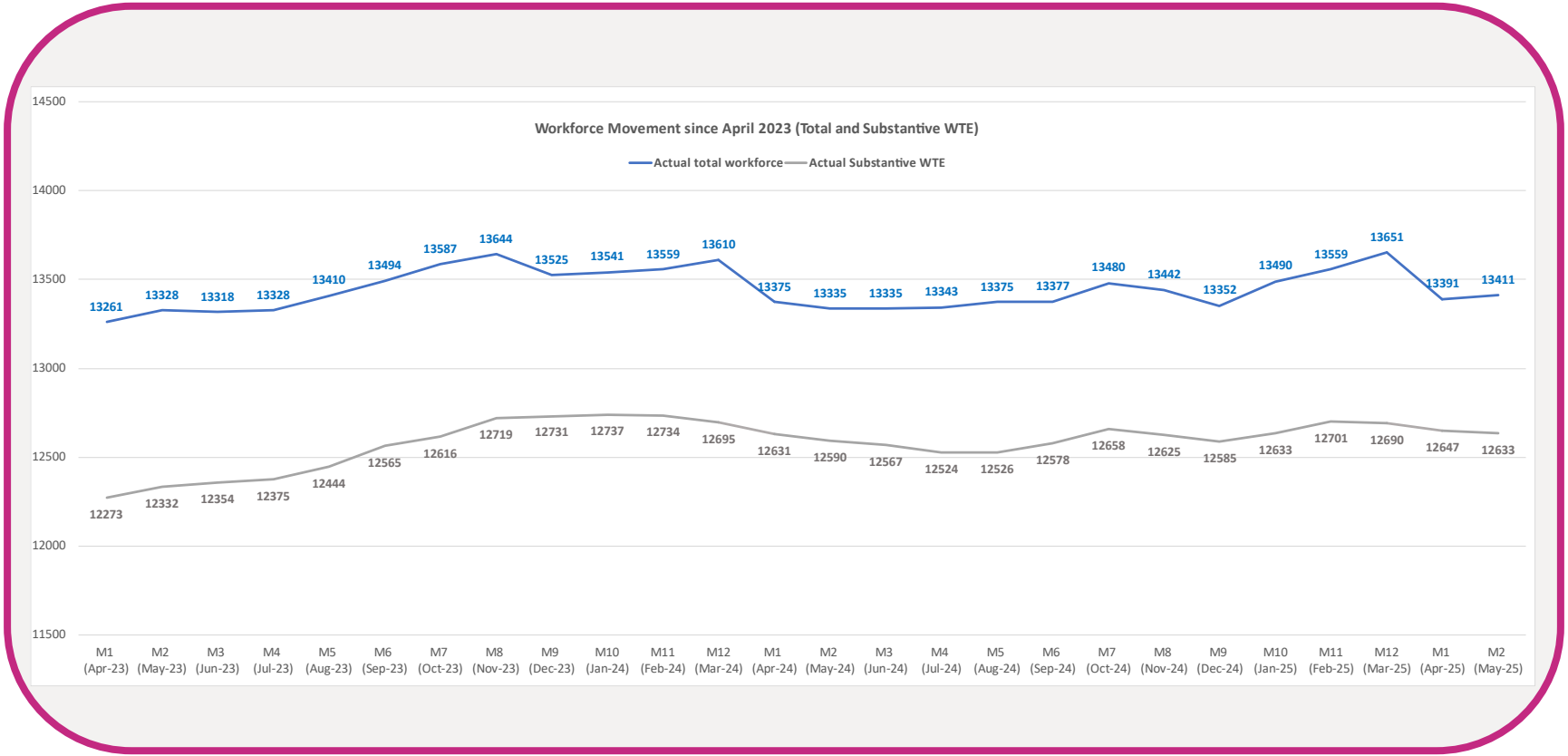
Source: ESR as of May 2025.
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



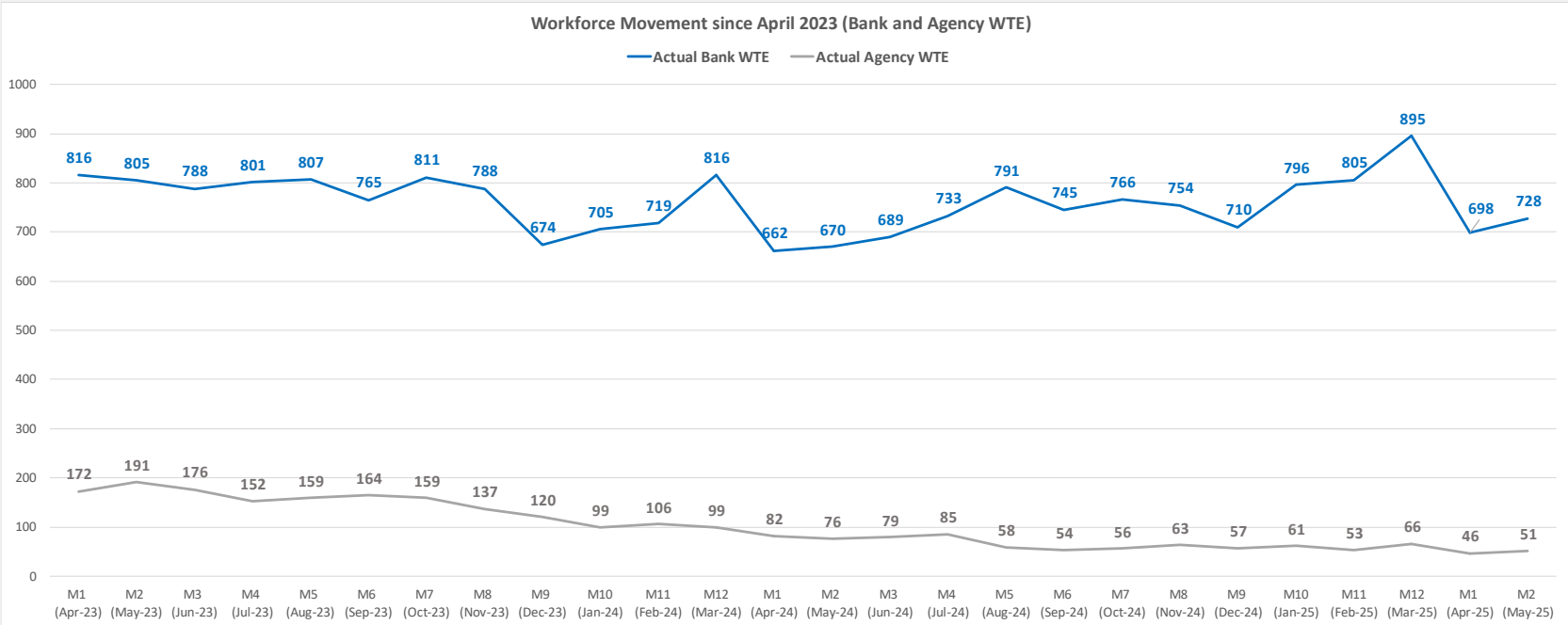
Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of May 2025
Forecast for bank is based on average past performance over the last 3 years for May, June, July, and August.

Workforce Trends: Total & Substantive over 2 years



Source: ESR as of May 2025.

Workforce Trends: Bank & Agency over 2 years



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of May 2025
Forecast for bank is based on average past performance over the last 3 years for May, June, July, and August.

Workforce Trends: WLI and Overtime

WLI	M2 - M3	M3 - M4	M4 - M5	M5 - M6	M6 - M7	M7 - M8	M8 - M9	M9 - M10	M10 - M11	M11 - M12	M12 - M1	M1 - M2
Movement	2	0	5	-7	5	-11	0	4	-4	8	-6	3

Source: Healthroster as of May 2025.

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

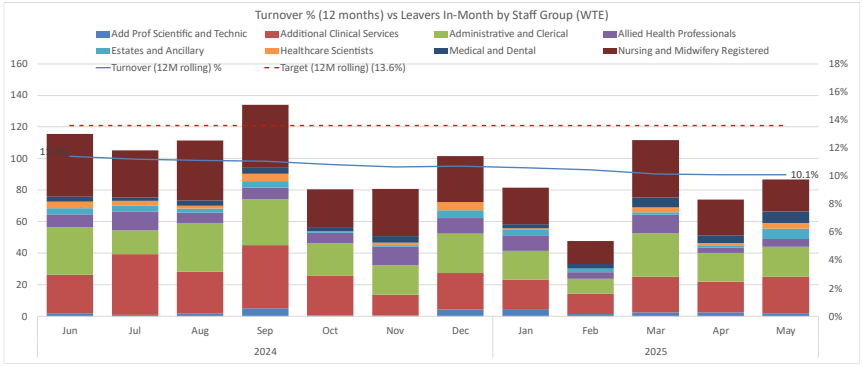
THRIVE

Substantive SIP by Staffing Group
2025-26 Counting Criteria

Substantive Monthly Staff in Post (WTE) for last 12 months														
	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)	2025/26 M1 (Apr)	2025/26 M2 (May)	M1 to M2 movement	Mar24 to Mar25 Movement
Add Prof Scientific and Technic	396	396	401	301	301	300	295	294	297	302	301	300	**-1**	**-100**
Additional Clinical Services	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	**2**	**-29**
Administrative and Clerical (Divisions)	1279	1271	1268	1261	1252	1231	1216	1228	1237	1241	1352	1350	**-3**	**-51**
Administrative and Clerical (THQ)	970	959	955	954	947	970	983	992	994	996	899	893	**-6**	**0**
Allied Health Professionals	699	688	686	808	815	813	805	806	820	816	823	822	**-1**	**120**
Estates and Ancillary	373	376	373	370	373	375	374	374	377	378	414	409	**-4**	**-2**
Healthcare Scientists	498	496	497	495	504	510	509	512	518	521	523	520	**-2**	**23**
Medical and Dental	2161	2155	2217	2240	2244	2241	2233	2239	2256	2248	2135	2123	**-12**	**65**
Nursing and Midwifery Registered	4030	4025	3998	3998	4055	4038	4035	4035	4028	4010	4010	4024	**13**	**-43**
Students	58	58	58	58	58	56	56	56	69	69	70	69	**-1**	**11**
Grand Total	**12593**	**12540**	**12550**	**12583**	**12635**	**12625**	**12585**	**12633**	**12701**	**12690**	**12647**	**12633**	**-14**	**-5**

Source: ESR substantive staff as of May 2025; includes consultant APAs and junior doctors' extra rostered hours, excludes CLRN, Wessex AHSN, and WPL (revised criteria for 25/26). Numbers relate to WTE, not headcount.

Turnover



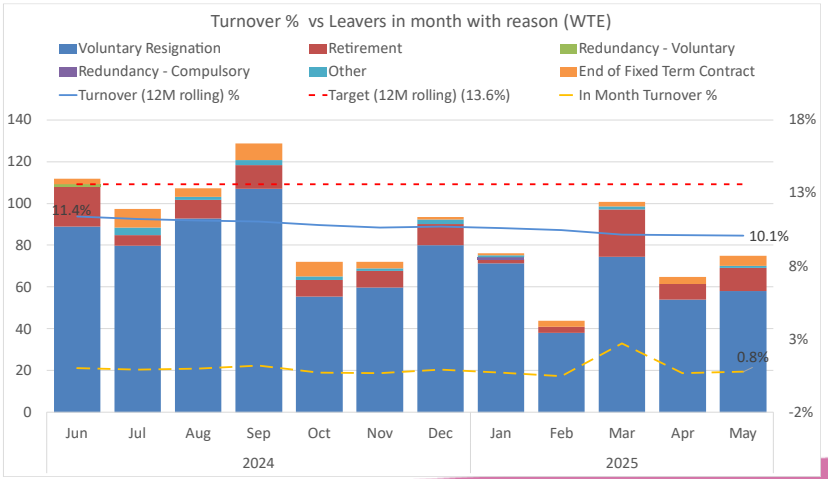
In May 2025, there was a total of 87 WTE leavers, 13 WTE less than April 2025 (74 WTE). Division C recorded the highest number of leavers (25 WTE). Within Division C, Nursing and Midwifery Registered staff group and Additional Clinical Services had the highest number of leavers (6 WTE respectively), followed by the Medical and Dental staff group at 4 WTE.

Divisions B and D had the second and third highest number of leavers (22 and 15 WTE respectively); with the largest number of leavers being the Additional Clinical services staff group in Div B (9 WTE), in Division D both Additional Clinical services, and Admin and Clerical staff groups in both recorded 5 WTE leavers.

Total leavers by division are as follows:

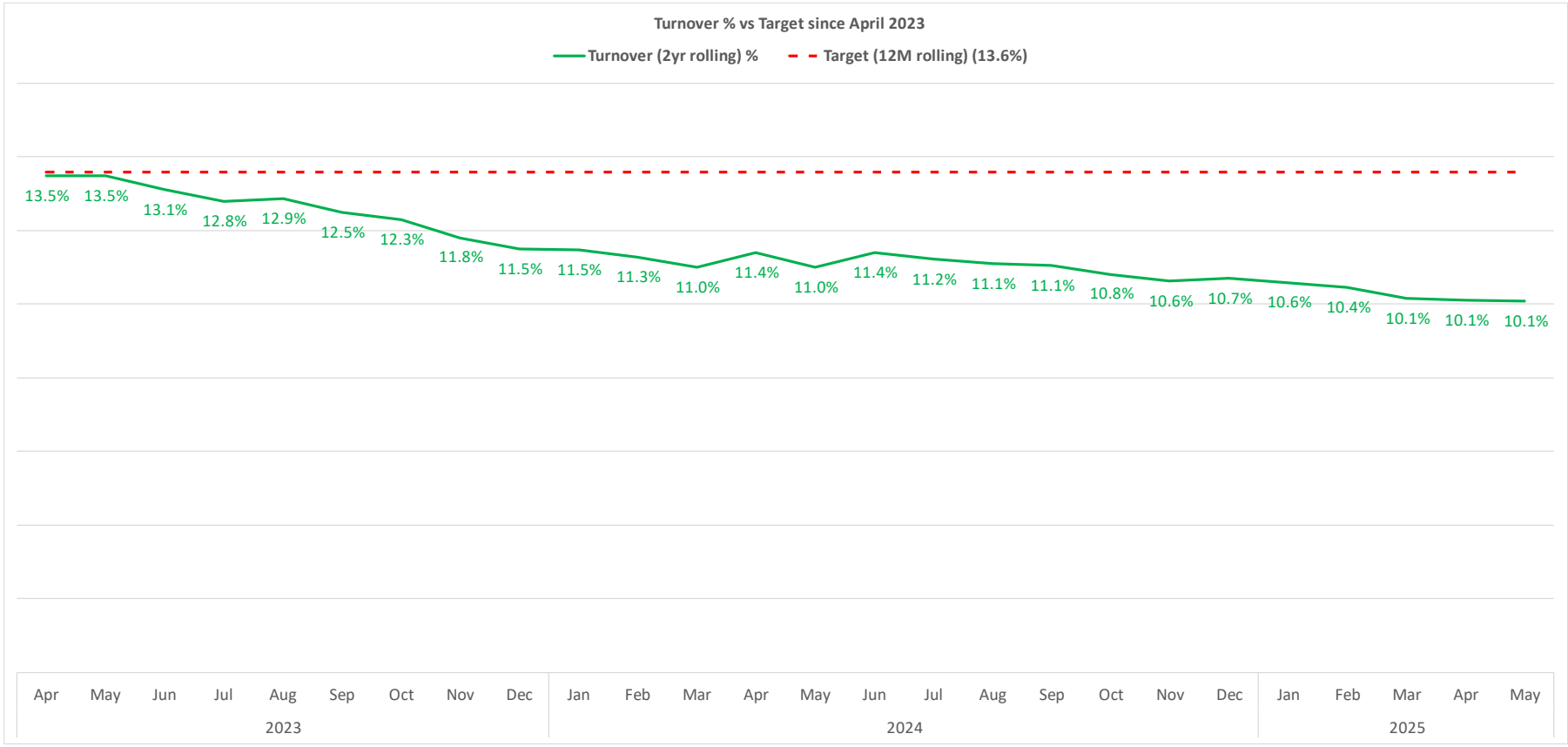
- **Division A: 10 WTE leavers**
- **Division B: 22 WTE leavers**
- **Division C: 25 WTE leavers**
- **Division D: 15 WTE leavers**
- **THQ: 13 WTE leavers**
- **UEL: 2 WTE leavers**

Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	2.0	0.7%	8.9%
Additional Clinical Services	23.0	1.1%	14.1%
Administrative and Clerical	19.1	0.8%	11.3%
Allied Health Professionals	5.0	0.6%	11.6%
Estates and Ancillary	6.3	1.4%	8.7%
Healthcare Scientists	3.6	0.7%	5.7%
Medical and Dental	7.4	0.8%	4.8%
Nursing and Midwifery Registered	20.2	0.5%	9.2%
UHS total	**86.7**	**0.8%**	**10.1%**



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

Turnover 2 years Rolling % since April 2023

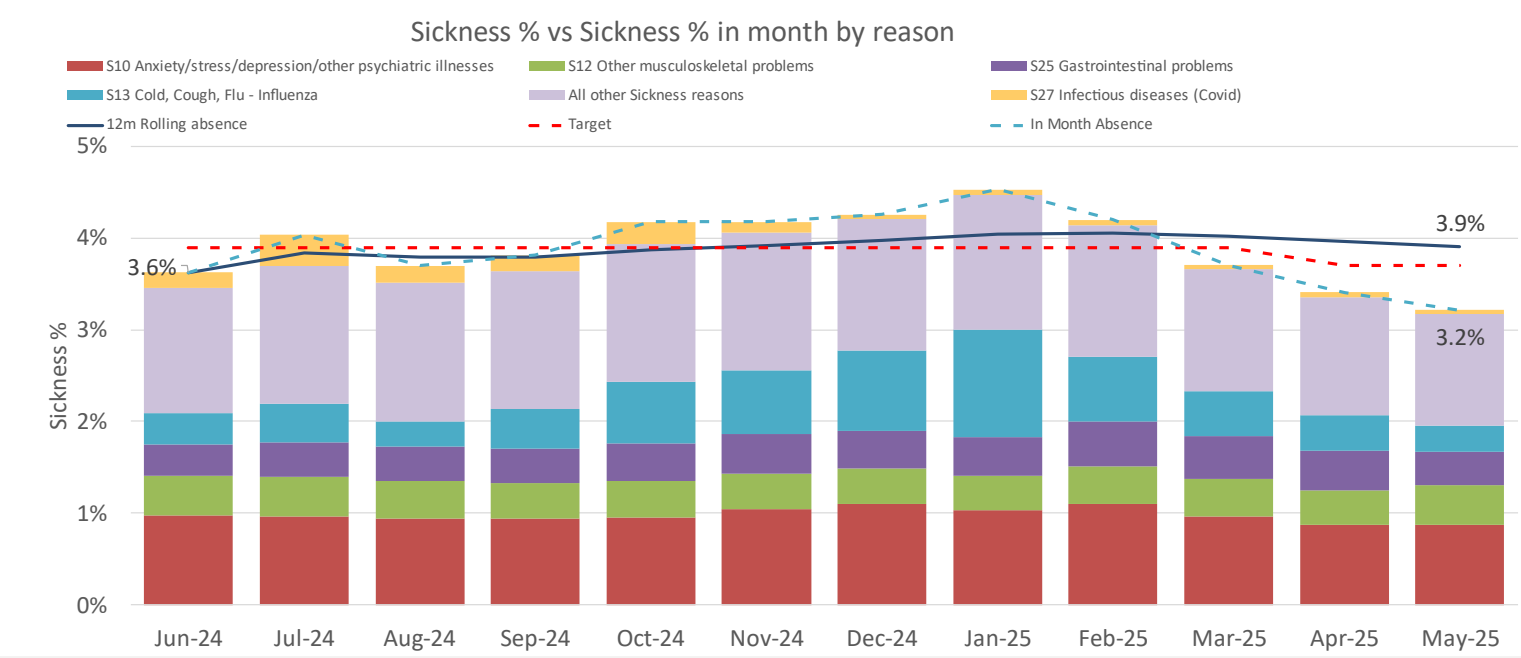


Source: ESR – Leavers Turnover WTE, ESR Staff Movement May 2025 (excludes junior doctors & hosted services)

Sickness

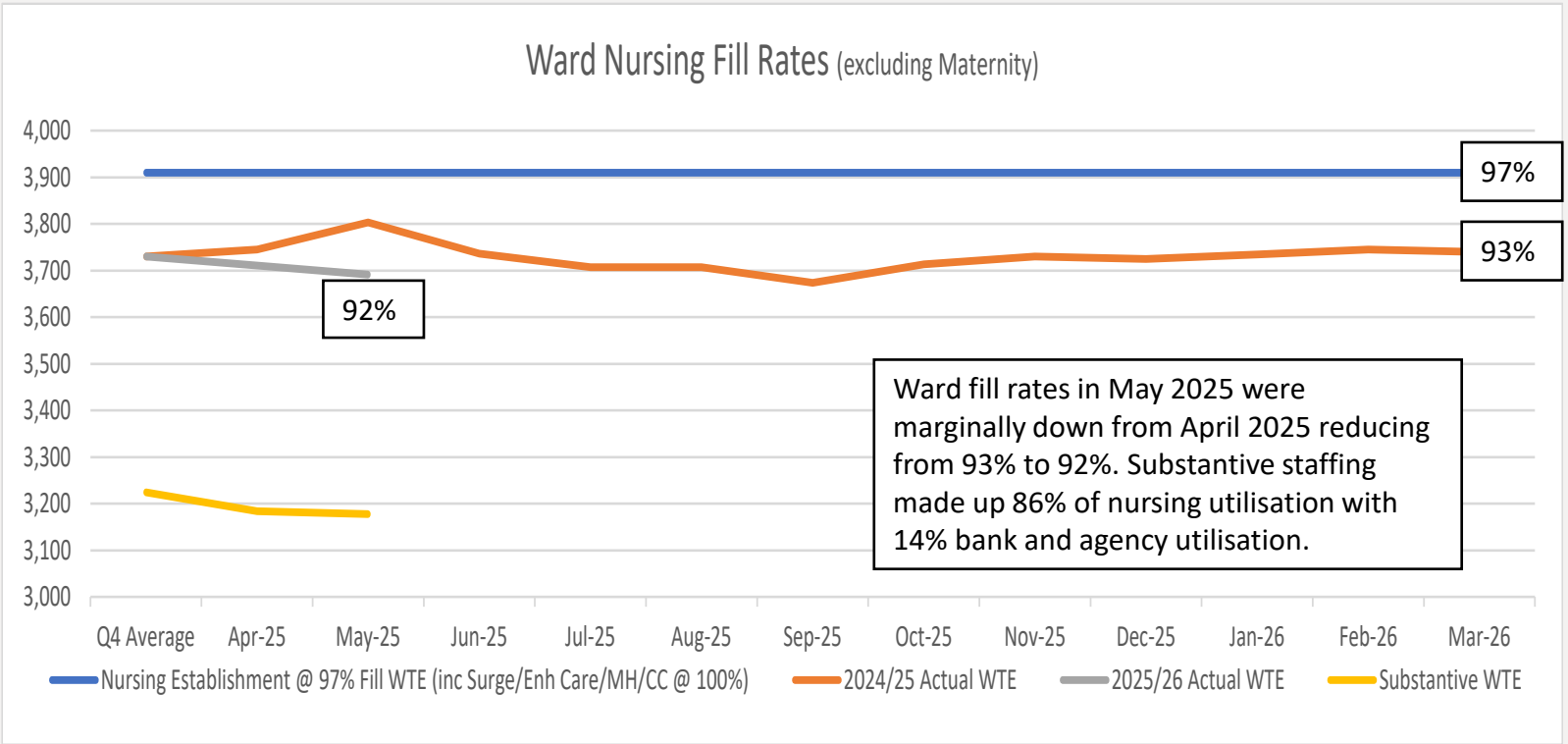
Current in-month sickness: 3.2% | Rolling 12-month sickness: 3.9% | Year-to-date sickness 3.3%

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



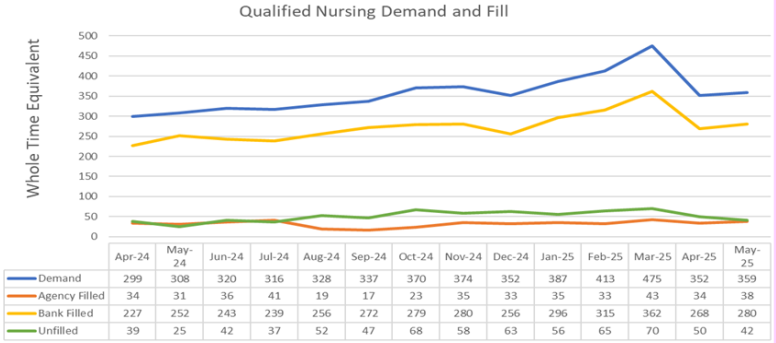
Source: ESR – May 2025

Ward Nursing Fill Rates (excluding Maternity)

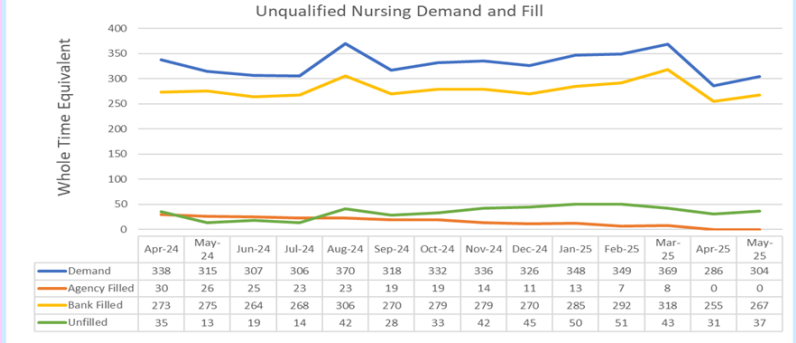


Source: Finance - Apr 2025

Temporary Staffing



	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-25	May-25
Demand	299	308	320	316	328	337	370	374	352	387	413	475	352	359
Agency Filled	34	31	36	41	19	17	23	35	33	35	33	43	34	38
Bank Filled	227	252	243	239	256	272	279	280	256	296	315	362	268	280
Unfilled	39	25	42	37	52	47	68	58	63	56	65	70	50	42



	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-25	May-25
Demand	338	315	307	306	370	318	332	336	326	348	349	369	286	304
Agency Filled	30	26	25	23	23	19	19	14	11	13	7	8	0	0
Bank Filled	273	275	264	268	306	270	279	279	270	285	292	318	255	267
Unfilled	35	13	19	14	42	28	33	42	45	50	51	43	31	37

Qualified nursing demand/fill (WTE) status:

- **Demand increased** from 352 to 359 WTE in May (+7).
- **Bank fill increased to** 280 WTE(+12 from previous month) and **Agency filled** 38 WTE (+4 from the previous month).
- **Unfilled shifts decreased**: 42 WTE remained unfilled (-8 on previous month).
- **Year-on-year demand increase**: 51 WTE higher than May 2024.

HCA demand/fill (WTE):

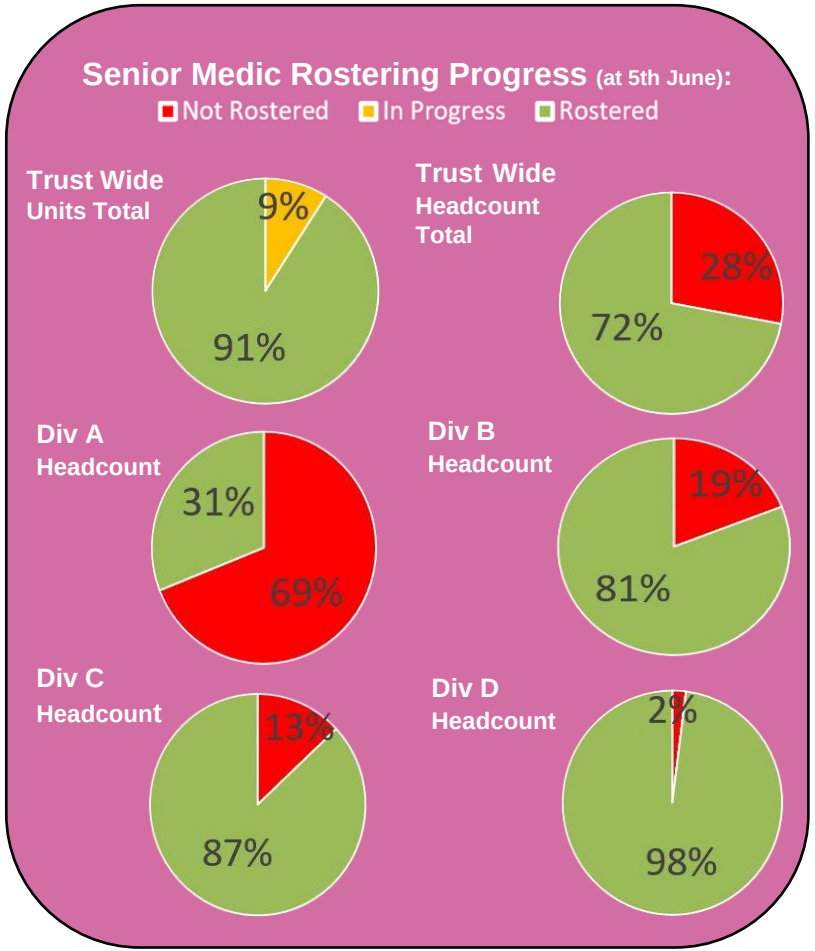
- **Demand increased** from 286 to 304 in May (+18).
- **Bank filled increased** from 267 WTE (+12)
- **Unfilled shifts increased**: 37 remained unfilled (+6 on prior month)
- **Year-on-year demand increase**: 11 WTE lower than May 2024.

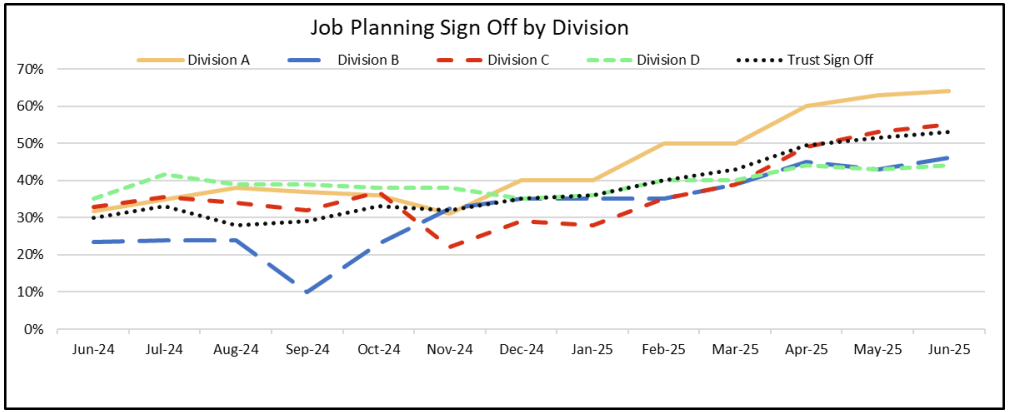
Actions

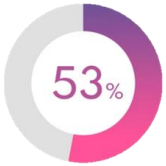
- Proposal to equalise pay across all shift types for Mental Health HCAs to stabilise staffing levels, promote fairness, and ensure consistent care delivery across all shifts has been submitted to finance for review.
- RMN and PICU agency migration ongoing
- Reduction in Premium Bank Rates with the DDN's.
- Process for transition for bank 2/3 is being implemented and go live date 1st July proposed.
- Further restrictions in Healthroster being explored.
- New process for requesting MH workers implemented to ensure better recording and management.

Source: Temporary Resourcing - May 2025

Workforce: Medical Rostering and Planning





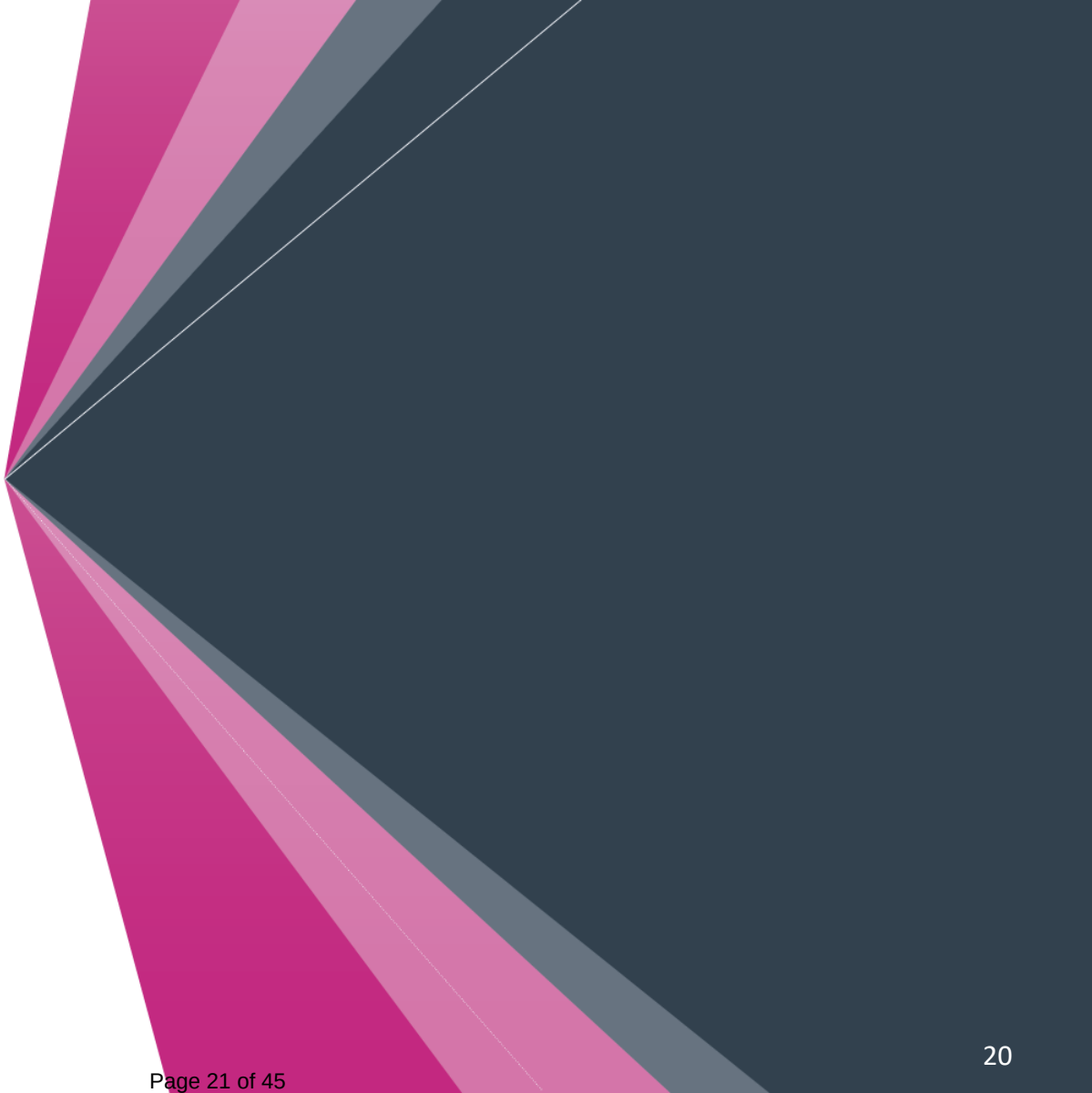


Signed off Job Plans

Active Job Plans

- Sign Off up 2% to 53%
- Active Job Plans steady at 90%
- UHS as a pilot with NSHE to develop an automated link from JobPlan to ESR.
- Linking with Data Analytics team to create Planned vs Delivered activity reports.
- Div C Consistency Report shared in May.

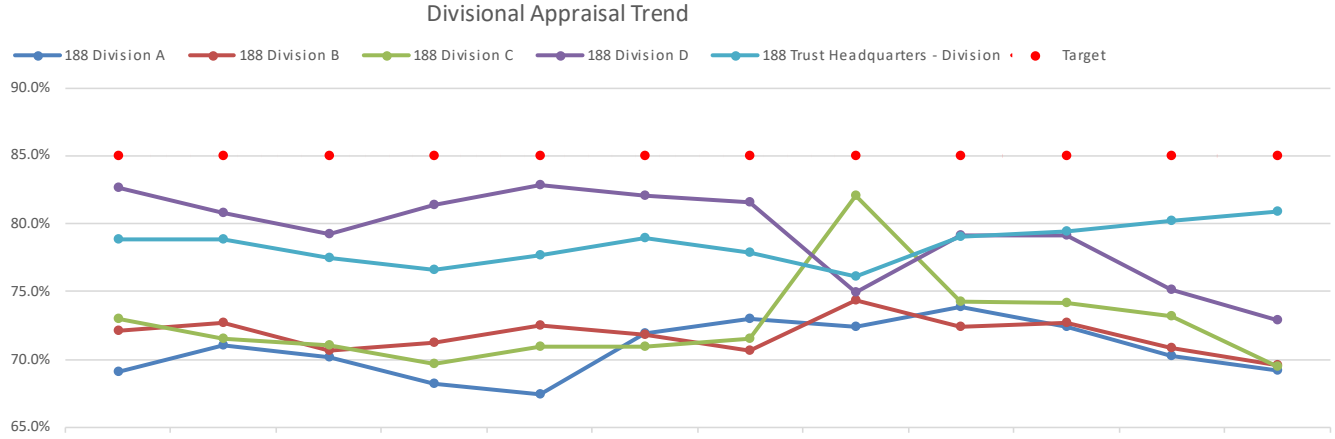
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 72% as of May 2025, 1% lower than April 2025 (73%).

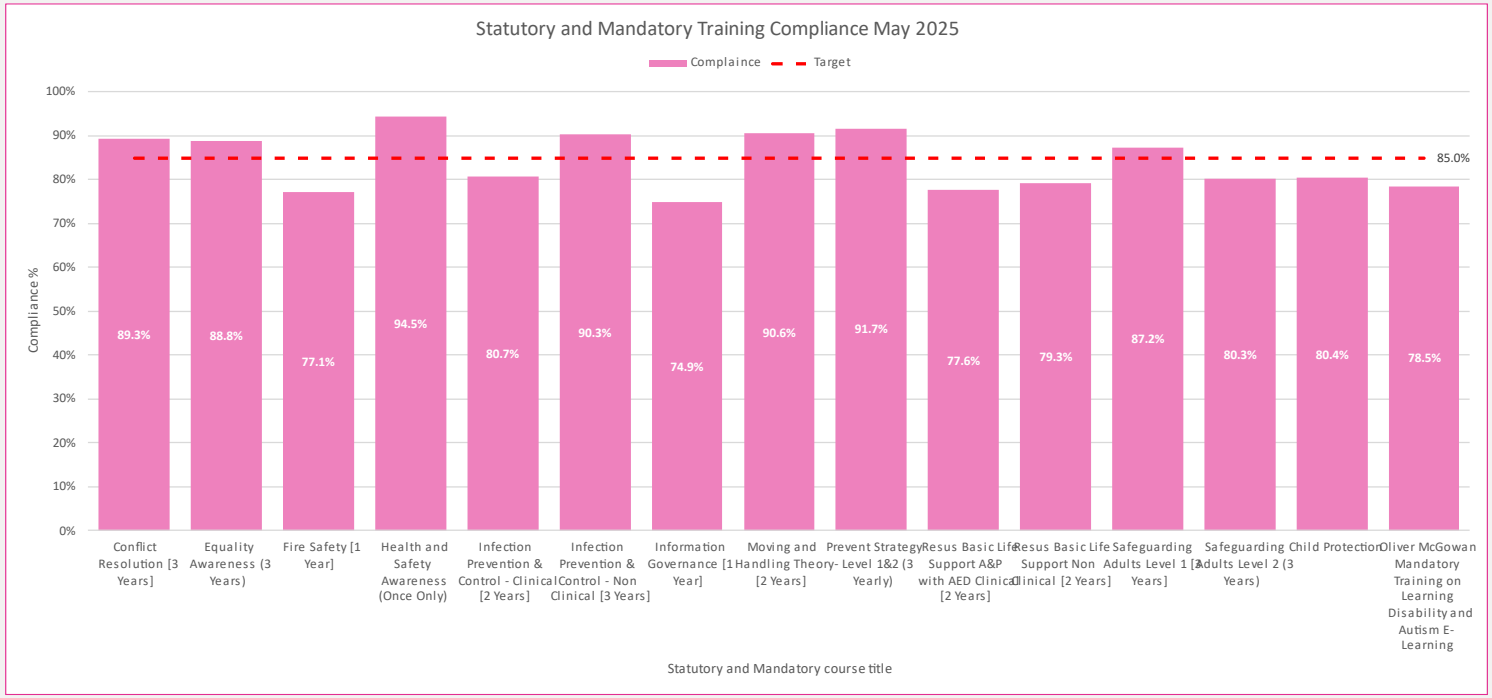


	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
188 Division A	69.1%	71.0%	70.1%	68.2%	67.4%	71.9%	73.0%	72.3%	73.9%	72.4%	70.3%	69.1%
188 Division B	72.1%	72.7%	70.6%	71.2%	72.5%	71.8%	70.6%	74.3%	72.4%	72.7%	70.8%	69.5%
188 Division C	73.0%	71.5%	71.1%	69.7%	70.9%	71.0%	71.5%	82.0%	74.3%	74.1%	73.2%	69.5%
188 Division D	82.7%	80.8%	79.2%	81.4%	82.8%	82.1%	81.6%	74.9%	79.2%	79.1%	75.2%	72.9%
188 Trust Headquarters - Division	78.9%	78.8%	77.4%	76.6%	77.7%	78.9%	77.9%	76.1%	79.0%	79.4%	80.2%	80.9%
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) May 2025

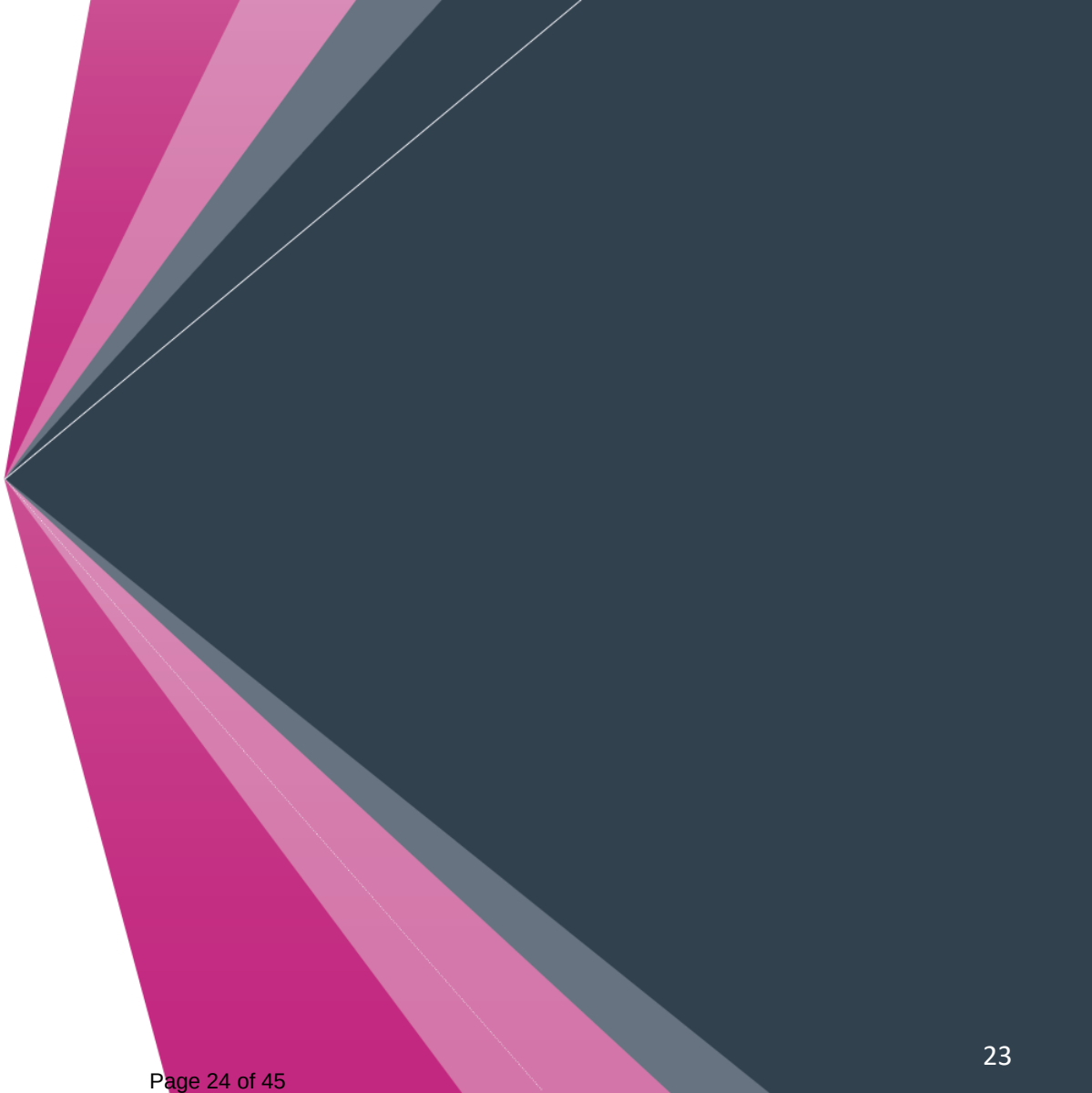
Statutory & Mandatory Training

The Trust's average completion rate for April 2025 is 83%, same level as April 2025 at 83% with 7 of 15 measures above the 85% target. Please note that the audiences for both Safeguarding Adults and Children is currently under review.

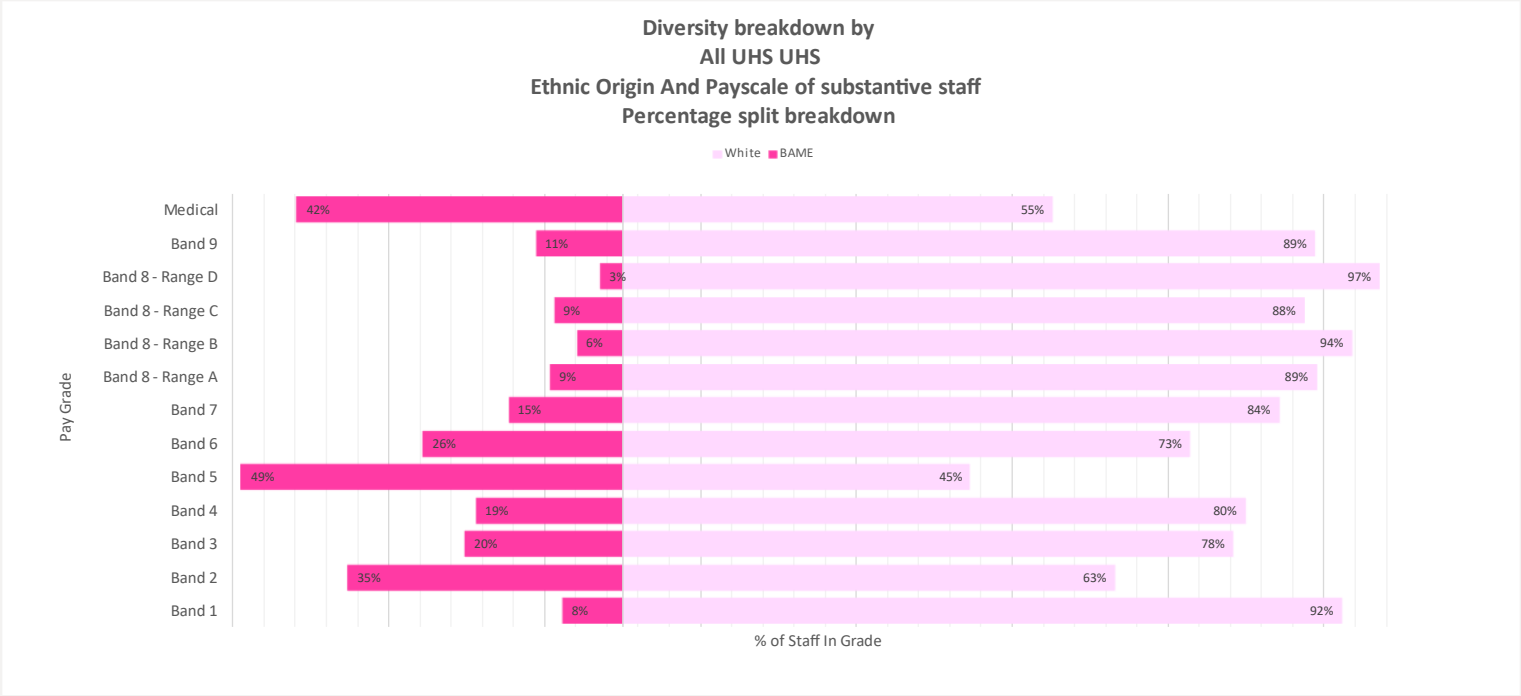


Source: Virtual Learning Environment (VLE) May 2025

BELONG



Staff in Post - Ethnicity



Source: ESR – May 2025

Supreme Court Ruling on the term "sex" under the Equality act 2010

On 16 April 2025 the Supreme Court handed down judgment in *For Women Scotland v The Scottish Ministers*. The judgement clarified interpretation of terms “man”, “woman” and “sex” under Equality Act 2010 (EA) and in light of the Gender Recognition Act 2004. It is important to note there are **no changes** to the EA legislation, only clarification of where protection is applied under characteristics of sex and gender reassignment.

The main implications for this ruling are not fully known, national NHS guidance is awaited. Implications likely around the provision of single sex and gender non-specific (shared) spaces. This ruling is specifically challenging for those who have undergone gender reassignment and have a Gender Recognition Certificate, as the ruling determined this is their "acquired sex" not their biological sex. The court ruled that those with GRC would remain protected This is because, in addition to protection based on the protected characteristic of gender reassignment, they would also be protected from discrimination based on being perceived as or associated with a sex which differed from their biological sex.

Practically the ruling is difficult to manage, both in terms of patient accommodation but also access to staff facilities. The critical factor in applying the EA is proportionality and This ruling has been incredibly divisive and challenges the principles of inclusion. Many of our LGBTQIA+ community have already expressed upset and concern, and uncertainty.

Further guidance from NHSE expected, HIOW system working together for consistent approach. No change to policy or practice is advised at this point. Immediate steps being undertaken in readiness:

- Review locations of all shared and single sex toilets and changing room (using audit undertaken in 2022)
- Review proportionality of facilities against population and staff data.
- Review signage on facilities.

OD capacity and cost reduction: Impact

A shift in focus to organisational change, coupled with a significant reduction in OD team resources, has resulted in an impact on a range of programmes and initiatives at UHS

Programme/Interventions paused or stopped

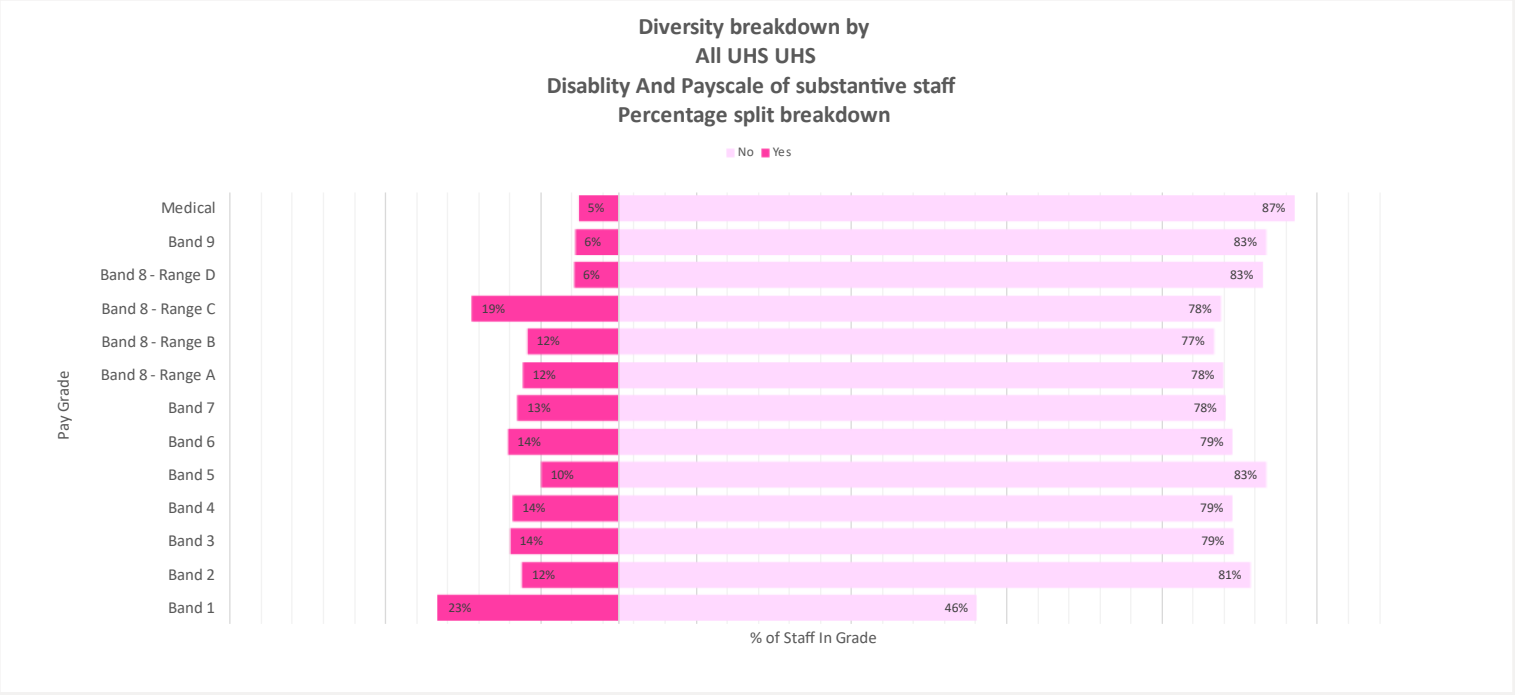
- Strategic leaders programme
- Senior leaders programme
- Care Group Managers programme
- Bespoke Team support/away days/team sessions and interventions unless part of approved OD programme.
- 360/MBTI/Psychometrics as part of team or leadership development.
- EDI events other than Pride, Black History Month and Disability History Month with Networks.
- Succession Planning and talent management
- Inclusive recruitment programme
- Managers Induction
- Progamme to Improve experiences for people with disabilities and long-term illness; disability declaration, improving adjustments model, improving accessibility and experience.
- Staff survey support for teams
- Closed OD support request form (Staffnet)
- Moved Corporate Induction to online.

Impact / Risk

Overall, negative impact on achieving People strategy and Inclusion and Belonging Strategy, and staff engagement and experience.

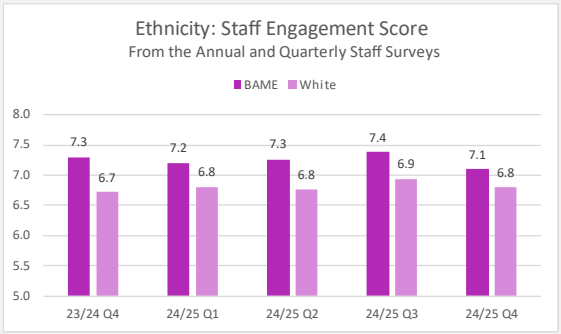
- Slow down of cultural improvements in particular loss of momentum on inclusion and belonging, and therefore impact staff experience. More marginalised and disengaged staff from certain communities, increasing likelihood of poor behaviours, bulling, harassment.
- Loss of impact of UHS Allyship programme (significant investment since 2022.)
- Less support for teams, particularly teams with challenging dynamics or conflict.
- Less leadership and management support: skills, behaviours and knowledge impacting on team effectiveness and staff experience.
- Worsening WRES and WDES and staff survey indicators on wellbeing and inclusion.
- CQC risk, Well Led and EDI

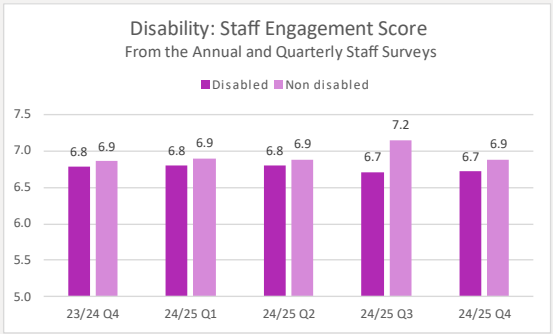
Staff in Post – Disability Status

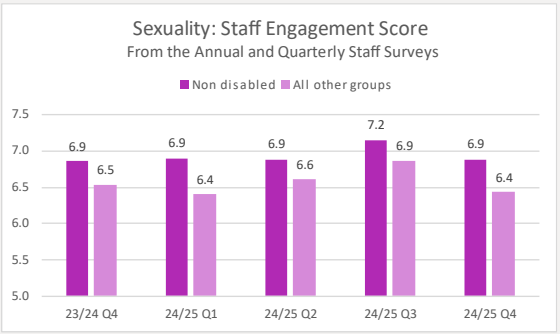


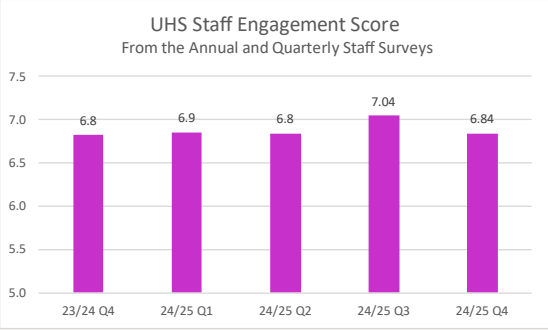
Source: ESR – May 2025

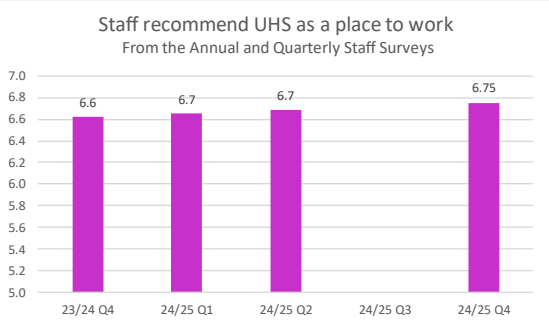
Pulse Survey – 2024/25 (Q3 and Q4 Updated)





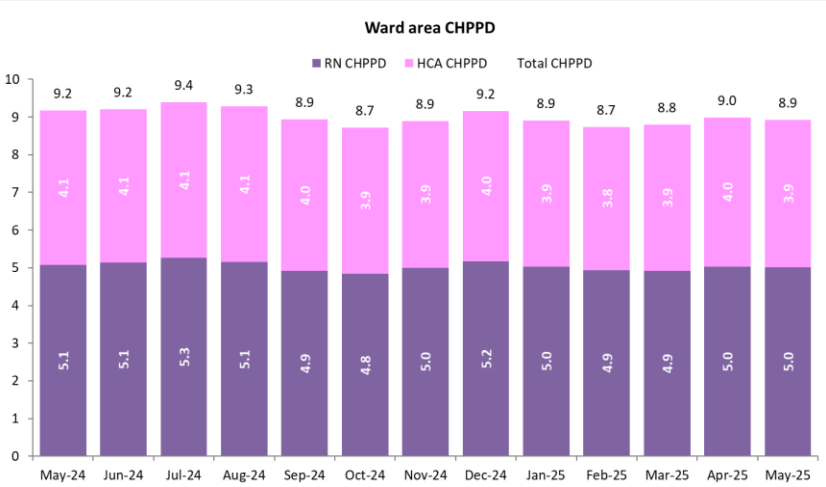


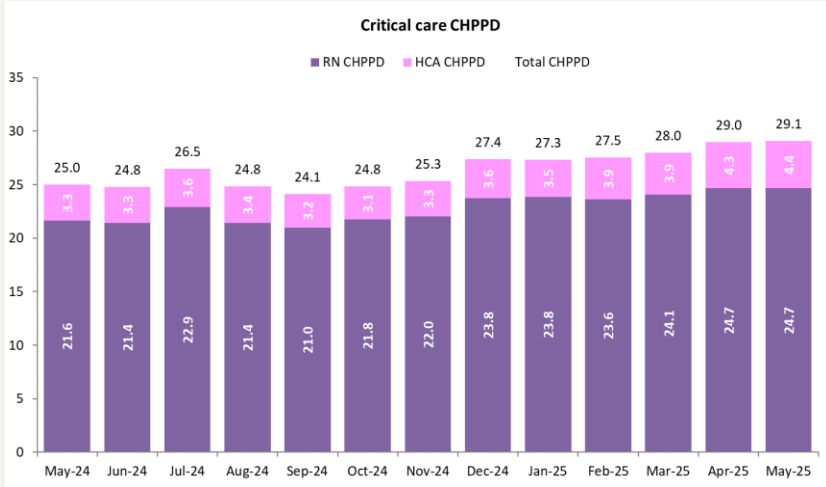




Source: Picker (Qualtrics)

CHPPD





The Ward areas CHPPD rate in the Trust remained the same for RN 5.0 (previously 5.0), HCA decreased to 3.9 (previously 4.0), overall, 8.9 (previously 9.0)

The CHPPD rate in Critical Care remained the same for RN (25), while HCA increased from 4.3 to 4.4. Overall CHPPD increased from 29.0 to 29.1.

Source: HealthRoster, NHSP & eCamis – May 2025

Patient Safety – Staffing Incidents & Red Flags

In total 61 incident reports were received in May 2025 which cited staffing. This is a decrease on the 62 reported in April.

Incidents by Division May 2025 vs April 2025

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
May 2025	11	22	21	1	6	61
Total	11 ↓ (16)	22 ↑ (12)	21 ↓ (23)	1 ↓ (7)	6 ↑ (4)	61 ↓ (62)

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
April 2025	16	12	23	7	4	62
Total	16 ↓ (24)	12 ↓ (16)	23 ↔ (23)	7 ↓ (10)	4 ↑ (1)	62 ↓ (74)

Source: Safeguard System May 2025

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

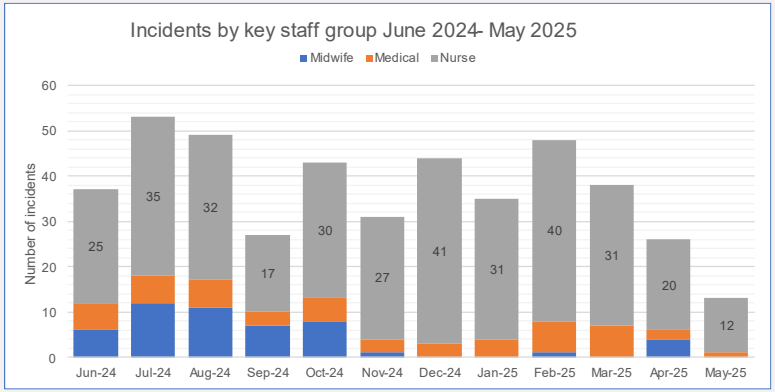
Div A:
Eleven incidents reported in May 2025, down from 16 in the previous month. Red Flags were down from 6 to 0.

Div B:
Twenty-two incidents were reported in May 2025 (up from 12 in the previous month). Red flags were up to 4 from 3 in April

Div C:
Twenty-one incidents reported in May (slightly lower than the previous month). There were 0 red flags reported.

Div D:
1 incident reported in May (down from 7 in the previous month). Red flags decreased from 8 to 0.

THQ:
Six incidents reported in May (up from 4 in the previous month).



May 2025	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
	Delay in medication	1	0	1	0	0	0
	Delay in pain relief	1	0	1	0	0	0
	Delay in observations	2	0	1	0	0	1
	Less than 2 registered	2	0	1	0	0	1
	Total	**6**	**0**	**4**	**0**	**0**	**2**

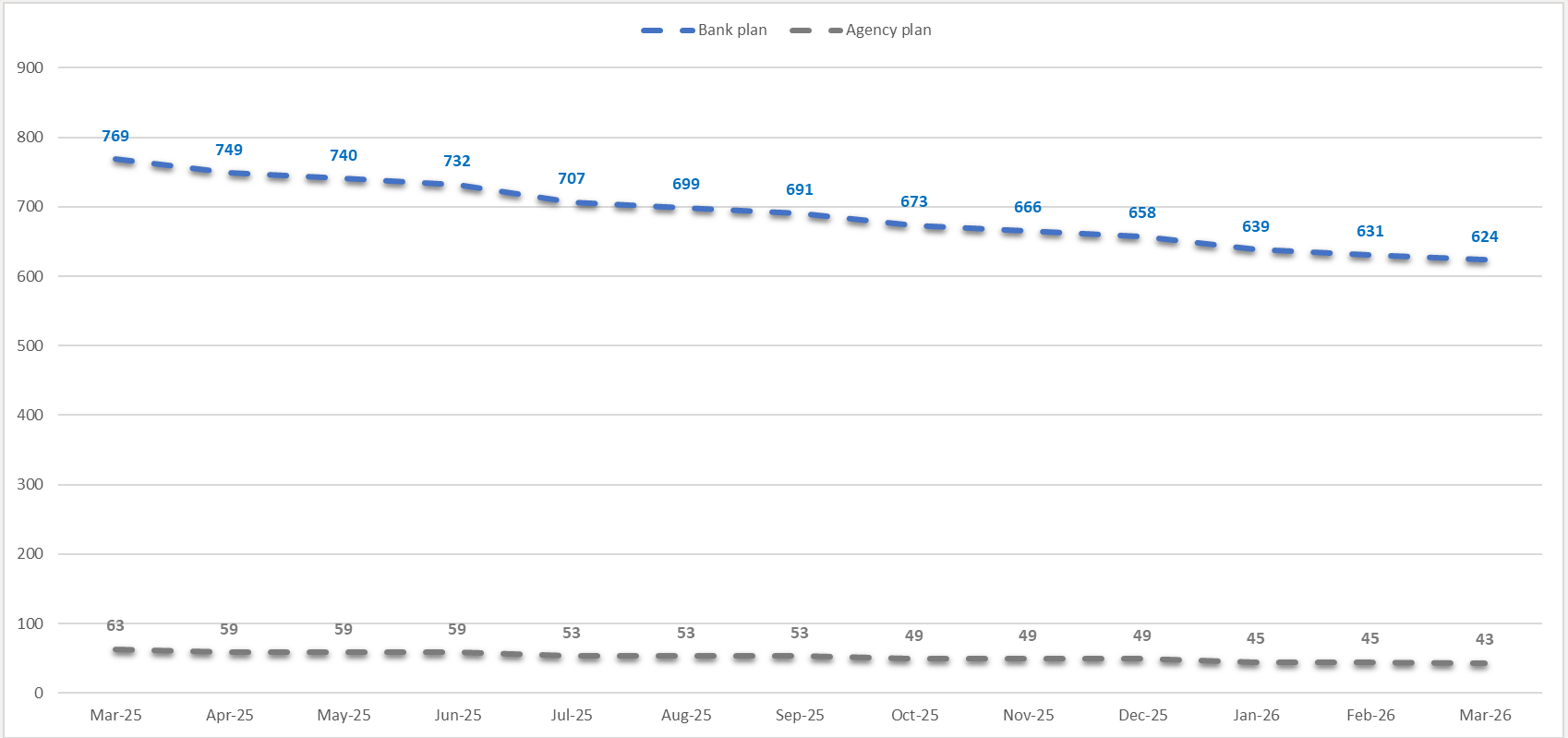
April 2025	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
	Delay in medication	6	3	1	0	2	0
	Delay in pain relief	4	1	0	1	2	0
	Delay in observations	5	1	1	0	2	1
	Less than 2 registered	5	1	1	0	2	1
	Total	**20**	**6**	**3**	**1**	**8**	**2**

Source: Safeguard System May 2025

25/26 Total and substantive workforce plan

Source: 2025-2026 Operational Plan

25/26 Bank and agency workforce plan



Source: 2025-2026 Operational Plan

Delivery of the Workforce Plan

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.

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.
- **Capacity** – Delivery of changes will require local leadership capacity and capability, coupled with HR support. The scale of changes and the burden on local teams already carrying vacancies is a significant risk.

Workforce Plan 25/26 – Progress on delivery

Trust Action	Detail	Timescale
Vacancy Management	• All Trust in Hampshire and Isle of Wight IBC have implemented a freeze on external non-clinical recruitment and 70% of clinical posts • Lag in impact of changes due to offers made pre March controls, additional forecasting taking place with Divisions • Additional measures added included greater internal recruitment for clinical roles, and phasing of start dates where appropriate.	In place
Clinical Divisional Structure	• Consolidation from four clinical divisions to three aligned to national planning priorities • THQ support functions complete change work to align to new Divisional structures • Consultation commencing with roles affected by the new Divisional structure • Divisional leadership roles will be in place from 1 July	Divisions to go live 1 July
Divisional and THQ pay cost base reductions	• Divisional teams reviewing plans to reduce overall pay costs by 5% • THQ teams have been set a target overall reduction of 10% • Executive reviews of plans taking place in May. Change management to take place in May onwards • Focus on substantive and temporary staffing expenditure	Second reviews during June
MARS	• Scheme opened to a wider co-hort of indidivauls (All A4C excluding ward based, ED and HCAs) • Over 200 applications received to date and process closing on 14 June • Review with Trade unions, CPO and CFO planned mid June.	Review and decisions in June
Temporary staffing	• FIG review of temporary staffing premium rates for A4C with proposals to consider actions made • Review of WLI and Bank expenditure for medical staff • Introduction of additional controls on approval of bank shifts (2nd approval) within Allocate.	September new rate go live
Change management, Communication and engagement	• 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	Ongoing

Leading Through Change support offer

Workshop 1:

- Organisational change process and policy.
- Reactions to change and introduction to techniques to support self and teams.

Workshop 2:

- Techniques and strategies for leading teams through uncertainty and complexity.

Workshop 3:

- How to create a positive team environment through change.
- Delivering messages, supporting business and usual, and enabling positive team dynamics.

Online resource hub for use with teams and individuals including templates, videos and learning materials.

Wellbeing through Change, wellbeing package to support people through change, and in times of uncertainty.

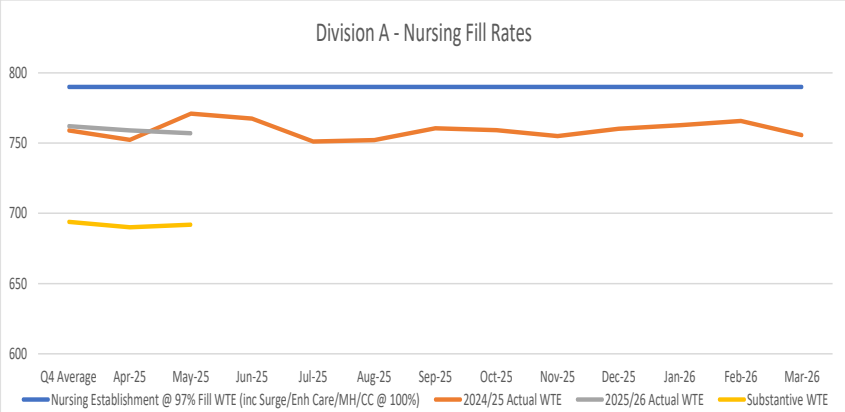
National Updates

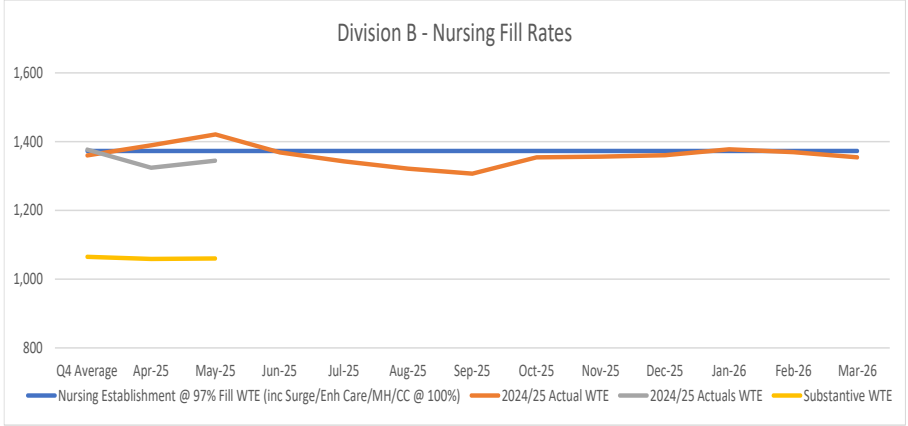
National Updates

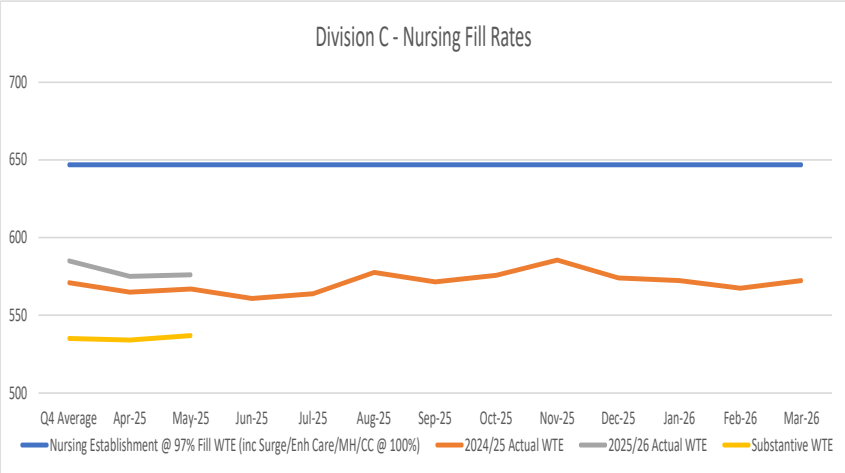
Area	Issue / Implication	Action being taken
National Job Evaluation and nurse profiles	The recent letter from Navina Evans, Chief Workforce Officer, NHSE, highlighted the critical role of NHS organisations in correctly and robustly applying the NHS job evaluation scheme. It is important that there is clear board ownership of local job evaluation and that boards are assured it is being implemented correctly, and organisations are encouraged to work collaboratively across their regions to ensure a consistent approach. To support this work, updated national job matching profiles for nursing and midwifery (bands 4 and above) have been published by the NHS Staff Council's Job Evaluation Group. Early indications suggest no significant risk for UHS, however detailed needs to be worked through.	• Review of JE processes to be conducted in partnership with Unions and presented to People and OD Committee on behalf of the Board. • Review of Nursing profiles initially discussed at People Board. Review underway against national profiles
Agency Spend DHSC letter	A letter sent to NHS provider and ICB Executive teams from SoS and Sir Jim Mackey on 30th May reiterated the need to reduce agency spend by at least 30%, as set out in the NHS Planning Guidance. DHSC and NHSE will be taking action to ensure that targets are met, and a joint Delivery Group has been set up to help support Trusts. There is also likley to be future direction stopping agency for Band 2 to 3 roles, with a clear news expected in the next few weeks.	• Overall temporary staffing review being undertaken as part of financial recovery. • UHS agency spend already low compared to relative peers. • Impact review required on Band 2 / Band 3 agency if prevented from using through regulation
Nursing 'Non patient facing' Manager review	NHS England have conducted a top-level national review of corporate and non-frontline nursing roles with the aim of increasing efficiency and accountability, integrating expertise from frontline services, and addressing challenges such as budget constraints. The review highlights the growth of non-patient facing roles since 2019, improvements in workforce metrics, and the need to balance these roles with frontline services to maintain high standards of patient care. The review used centrally harvested ESR data using certain codes and has provided benchmarking and potential cost reduction opportunities to return to the mean. For UHS the data presents and opportunity of £8m however there are significant concerns about how roles have been classified and counted.	• UHS has reviewed the data provided by NHSE and linked with NHSE SE team. • Local coding of ESR inflating level of perceived opportunity • Review of genuine opportunity and correction of coding. Nurses' leaders and Charge nurses (band 7 and band 6) incorrectly identified in NHSE data has non patient facing.

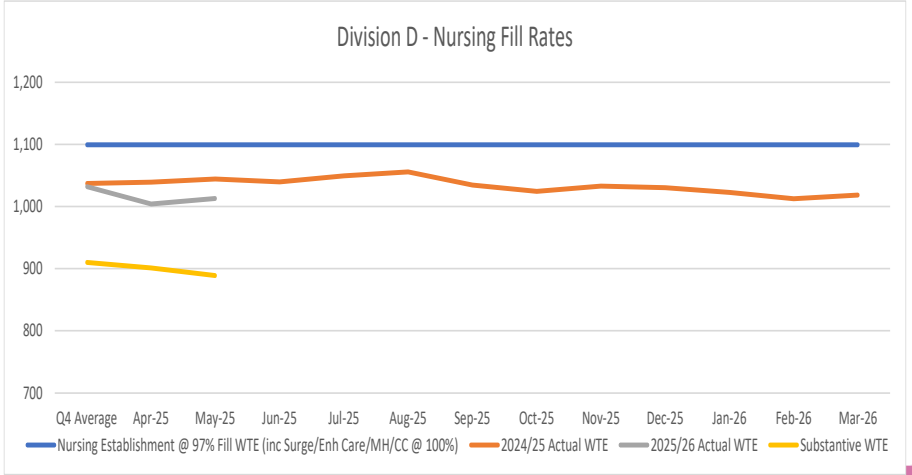
Appendicies

Ward Nursing Fill Rates (excluding Maternity)









Source: Finance - Apr 2025

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 25/26 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 Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	ESR (Appraisals completed in-month and last 12 months)	AfC staff only
Statutory & Mandatory Training	VLE	No exclusions
Staff in Post (Ethnicity & Disability)	ESR	No exclusions
Pulse Survey	Picker (Qualtrics)	No exclusions
Care Hours PER Patient Day (CHPPD)	HealthRoster (In-month shifts) eCamis (In-month daily patient numbers)	Clinical inpatient wards, Critical Wards, and ED only


WORLD CLASS PEOPLE

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.11 Report to the Trust Board of Directors, 15 July 2025	
Title:	Freedom to Speak Up Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Christine Mbabazi, Freedom to Speak Up Guardian

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:

To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, themes and actions taken and lessons learnt from the concerns raised.

1. Mechanism to support a culture where staff feel safe and can speak up about concerns.
2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust.
3. Compliance with the Public Interest Disclosure Act 1998.

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the lessons learnt from concerns raised.

Contents:

Paper
Appendix A – FTSU Cases

Risk(s):

1. Failure to keep improving services for patients and the working environment for staff.
2. Failure to support a culture based on safety, openness, honesty and learning.
3. Failure to comply with NHS requirements and best practice and commissioning contracts

Equality Impact Consideration:	N/A

1. Executive Summary / Purpose

To provide an update following the last report written in January 2025. This report provides an update on the Freedom to Speak Up (FTSU) agenda. In addition, it also makes note of the lessons learnt from concerns raised to the FTSU guardian.

2. Key Issues

2.1 Case Update

The Trust has received 37 FTSU cases from (December 24 – June 25) compared to 64 cases received in the same period last year (December 23 – June 24).
As noted above, the number of cases has dropped significantly due to fear of detriment in this time of change. Several people have mentioned that they have been afraid to raise concerns due to the uncertainty and departmental changes happening.

Different communications like “Talk to David”, Staff briefings and connect as well as the OD training on change have filled in some gaps giving some staff the confidence to speak up with out fear of losing their jobs

3. Progress on the FTSU Agenda

3.1 Red Flag Report

The responding to challenge report was published by the Patient Experience Library in April 2025, looking at how to identify ‘red flags’ (early warning signals) and harmful patterns of behaviour in health and social care. CQC commissioned the Patient Experience Library to produce the report, which analyses warning signals from 10 years of avoidable harm inquiries in health and social care.

We discussed the red flags report in our Raising concerns Steering group in May following the decreasing numbers of people speaking up. Care Quality Commission (CQC) and the National Guardian office have continued to educate red flags report through webinars on the early warning signals especially in this time of uncertainty and change.

Findings
The report found that where there is a problem, it usually involves multiple people who have failed to spot or deal with avoidable harm.
It identifies 3 states in which problem cultures can give rise to failures:

- complacency
- avoidance
- denial.

It further identifies 6 different organisational subcultures that feed into an overall harmful culture where failures happen. These are:

- reporting culture
- compliance culture
- caring culture
- teamwork culture
- accountability culture
- learning culture.

Through these findings, a framework to help spot red flags in harmful cultures was set out. The Red Flag Tracker. This is an online resource and tool that groups ‘red flags’ and provides a framework to identify and report on an organisational culture in which safety failures are more likely to occur.

3.2 The National Guardian Office.

It has been reported there are going to be Changes to the National Guardian office function, details are not yet known but should be confirmed in the upcoming Dash review. We will keep you updated once all is clear.

4 Next Steps / Way Forward / Implications / Impact

The FTSU Guardian and Champion network will continue to work with different teams to embed speaking up as business as usual. The importance of doing this is to ensure that we create a culture where patients and staff safety are at the centre of what we do, as has been noted by the National Guardian Office and CQC.

5 Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the progress on the FTSU agenda.

Appendix A – FTSU CASES December 2024 – June 2025

Year	Qtr	Date Concern Raised	Month Raised	Department	Contact Method (Internal /	Professions	Trust Board Summary
2024	Q3	19/12/2024	December	Division B	Internal	Healthcare Assistants	Bullying and Harassment
2024	Q3	31/12/2024	December	Trust HQ	Internal	Administrative and clerical	Discrimination / Unfair Treatment
2024	Q3	31/12/2024	December	Division D	Internal	Administrative and clerical	HR issue or process concerns
2025	Q4	02/01/2025	January	Trust HQ	Internal	Administrative and clerical	HR issue or process concerns
2025	Q4	02/01/2025	January	Division A	Internal	Medical and Dental	Discrimination / Unfair Treatment
2025	Q4	03/01/2025	January	Division A	Internal	Registered Nurses and Midwives	Discrimination / Unfair Treatment
2025	Q4	13/01/2025	January	Trust HQ	Internal	Administrative and clerical	Recruitment Concerns
2025	Q4	15/01/2025	January	Trust HQ	Internal	Administrative and clerical	HR issue or process concerns
2025	Q4	22/01/2025	January	Division D	Internal	Medical and Dental	Bullying and Harassment
2025	Q4	22/01/2025	January	Division D	Internal	Registered Nurses and Midwives	Team Dynamics
2025	Q4	27/01/2025	January	Division B	Internal	Allied Health professionals	HR issue or process concerns
2025	Q4	10/02/2025	February	Division A	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q4	11/02/2025	February	Division A	Internal	Administrative and clerical	HR issue or process concerns
2025	Q4	12/02/2025	February	Division D	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q4	12/02/2025	February	Division B	Internal	Allied Health professionals	HR issue or process concerns
2025	Q4	14/02/2025	February	Division A	Internal	Unknown	HR issue or process concerns
2025	Q4	17/02/2025	February	Division B	Internal	Allied Health professionals	HR issue or process concerns
2025	Q4	04/03/2025	March	Trust HQ	Internal	Registered Nurses and Midwives	HR issue or process concerns
2025	Q4	14/03/2025	March	Division B	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q4	13/03/2025	March	Division A	Internal	Healthcare Assistants	Other
2025	Q4	18/03/2025	March	Trust HQ	Internal	Administrative and clerical	HR issue or process concerns

2025	Q1	02/04/2025	April	Division D	Internal	Healthcare Assistants	Discrimination / Unfair Treatment
2025	Q1	02/04/2025	April	Division D	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2025	Q1	10/04/2025	April	Division B	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2025	Q1	15/04/2024	April	Division A	Internal	Registered Nurses and	Discrimination / Unfair Treatment
2025	Q1	16/04/2025	April	Division B	Internal	Medical and Dental	Bullying and Harassment
2025	Q1	29/04/2025	April	Trust HQ	Internal	Administrative and clerical	HR issue or process concerns
2025	Q1	30/04/2025	April	Division B	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2025	Q1	19/05/2025	May	Division B	Internal	Medical and Dental	HR issue or process concerns
2025	Q1	21/05/2025	May	Division B	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2025	Q1	23/05/2025	May	Division B	Internal	Healthcare Assistants	Discrimination / Unfair Treatment
2025	Q1	02/06/2025	June	Division C	Internal	Healthcare Assistants	Bullying and Harassment
2025	Q1	12/06/2025	June	Division A	Internal	Medical and Dental	Team Dynamics
2025	Q1	12/06/2025	June	Division B	Internal	Registered Nurses and	HR issue or process concerns
2025	Q1	13/06/2025	June	Division D	Internal	Administrative and clerical	HR issue or process concerns
2025	Q1	14/06/2025	June	Division A	Internal	Registered Nurses and Midwives	HR issue or process concerns
2025	Q1	16/06/2025	June	Division D	Internal	Medical and Dental	Patient Safety

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.12	Report to the Trust Board of Directors, 15 July 2025
Title:	Infection Prevention and Control 2024 2025 Annual Report
Sponsor:	Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control
Author:	Julie Brooks, Consultant Nurse and Deputy Director of Infection Prevention & Control Dr Julian Sutton, Lead Infection Control Doctor.

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 provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection (HCAI) in UHS including:

- Performance against key infection indicators and antimicrobial usage.
- Assurance of infection prevention standards, practices and processes.
- Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.

Performance in 2024/25 in relation to HCAIs has remained challenging with annual target thresholds in all 5 HCAI indicators exceeded. Improvements are required across all indicators along with an enhanced focus on ensuring that the fundamental standards of infection prevention and control practice and antimicrobial prescribing are consistently applied by all staff to reduce risk of transmission of infection and risk of antimicrobial resistance.

Members of the Thrust Board are asked to review the report and actions identified to support improvements in performance and note the following actions requested of Divisions/care Groups:

1. Divisions and Care Groups to ensure that the detailed actions in each section are addressed via the Divisional Governance processes, with relevant teams and staff group.
2. Divisions and Care Groups to ensure processes and plans are reviewed and enhanced to facilitate improvements in IP&C practice standards, including hand hygiene, management and care of invasive devices, cleanliness of equipment and measures to reduce the risk of colonisation and infection with key organisms such as MRSA, CPE (multidrug-resistant gram-negative bacteria) and *Candidozyma* (formerly *Candida*) *auris*.

Contents:

Risk(s):

Strategic: Board Assurance Framework Risk number 1c

Operational: Risk No. 489 inadequate ventilation in in-patient facilities. High risk (risk score:15)

Equality Impact Consideration:	N/A

1.Introduction

Category		Annual Limit	Action /Comment
National Objectives:	MRSA bacteraemia (Threshold = 0)	R	5 MRSA BSI attributable to UHS
	Clostridioides difficile infection (Threshold = 99)	R	120 cases in 2024/25
	E coli Bacteraemia (Threshold = 141)	R	200 cases in 2024/25
	Pseudomonas Bacteraemia (Threshold = 22)	R	36 cases in 2024/25
	Klebsiella Bacteraemia (Threshold = 56)	R	81 cases in 2024/25
Other	MSSA		53 post 48hr cases in 2024/25
	VRE		10 post 48hr cases in 2024/25
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	National AMR 5-year plan target: reduction of 5% overall human antibiotic use (compared to a baseline of calendar year 2019) = 1% reduction per year.
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	R	Analysis of IP&C audits for 2024/25 show 59% of areas have not meet requirements needed to achieve full accreditation.

2. Analysis

2.1 Healthcare Associated Infection

Summary of progress in reducing healthcare associated infection in UHS.

MRSA Bloodstream Infection (MRSA BSI)

5 cases of Healthcare Associated (HOHA/COHA) MRSA BSI were attributed to UHS in 2024/25 against a nationally set threshold of 0. This compares to 7 cases in 2023/24. 1 case occurred in Q4 as summarised below . All cases underwent a detailed concise review led by the Infection Prevention Team and an after-action review (AAR) with the relevant clinical teams to identify learning and areas for improvement

Summary of Q4 case:

January 2025 (Cancer Care) Hospital Onset / Healthcare Associated	23-year-old with Hodgkin's lymphoma and immunocompromised. Elective admission for Hickman line insertion and allogenic transplant. Known to be MRSA positive (first positive screen in 2023). Admission screen and subsequent screening also tested positive. A Hickman line was inserted the day after admission in interventional radiology with no complications noted. Parenteral nutrition commenced via Hickman line 15 days after insertion and the following day the patient felt unwell, was pyrexial and had raised inflammatory markers. Blood cultures grew MRSA. The Hickman line site also tested positive for MRSA. The source of the MRSA BSI was considered likely to be related to the central venous catheter (Hickman Line). Review of the case identified a lack of acknowledgment of the patients prior MRSA positive status on admission, despite an infection alert being present on e-camis/CHARTS (not acknowledged on inpatient noting admission infection assessment or on the interventional radiology checklist completed pre Hickman line insertion). MRSA decolonisation therapy (chlorhexidine washes & nasal Bactroban) was not commenced on admission, following subsequent positive screens or following confirmation of the positive blood culture result. In addition, there was a lack of clarity regarding the protocol for changing of the bungs on the Hickman line in relation to manufacturer's guidance.

Summary of learning from review of the previous 4 MRSA BSI cases is outlined below:

April 2024 (Child Health)	• Gaps in admission screening for MRSA at UHS • The use of MRSA risk reduction washes for emergency paediatric cardiac patients admitted as an emergency is not clearly defined within the paediatric MRSA policy.
September 2024 (Trauma and Orthopaedics)	• Lack of assurance related to the management of the IV cannula during the patients previous admission - no insertion/ongoing care record on the patient's electronic in-patient noting record and thus no documented record of observation of the cannula site. • Challenges and potential risk of having different electronic systems and a combination of electronic and paper records for recording patient care. • Medical management of cellulitis in the right hand in respect to the short course of antibiotics which were discontinued on discharge.
December 2024 (Paediatrics)	• Challenges with the care and management of the central line site, including difficulties in securing dressings due to the patient's skin condition (severe eczema) and soiling of the dressings due to frequent vomiting, resulting in the need for more frequent dressing changes.
December 2024 Cancer Care	• Review of the case identified that all infection prevention and control measures to prevent MRSA acquisition had been correctly followed since the patient's admission in October. • No concerns were identified on the ward relating to IP&C practices.

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

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

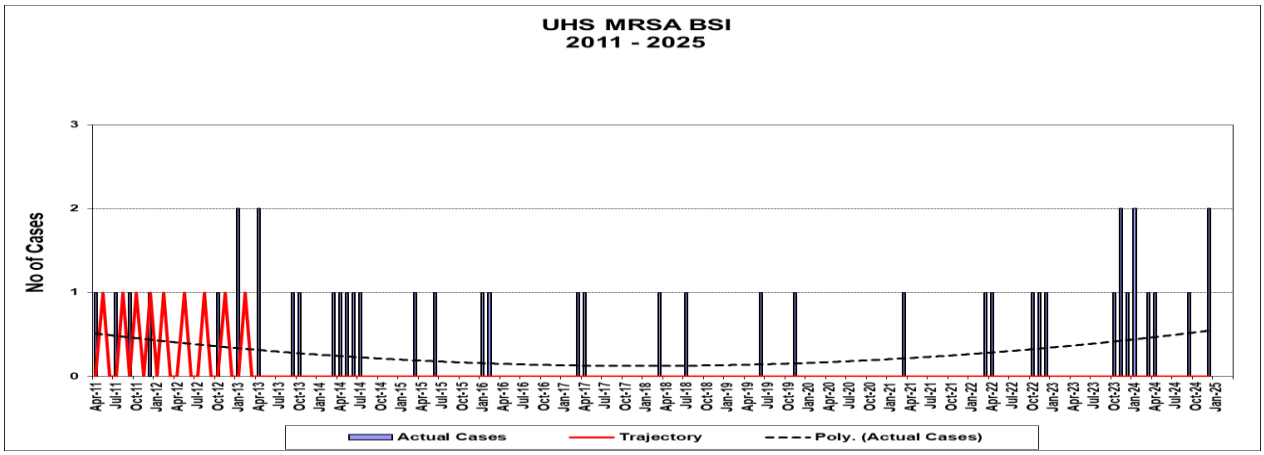
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

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

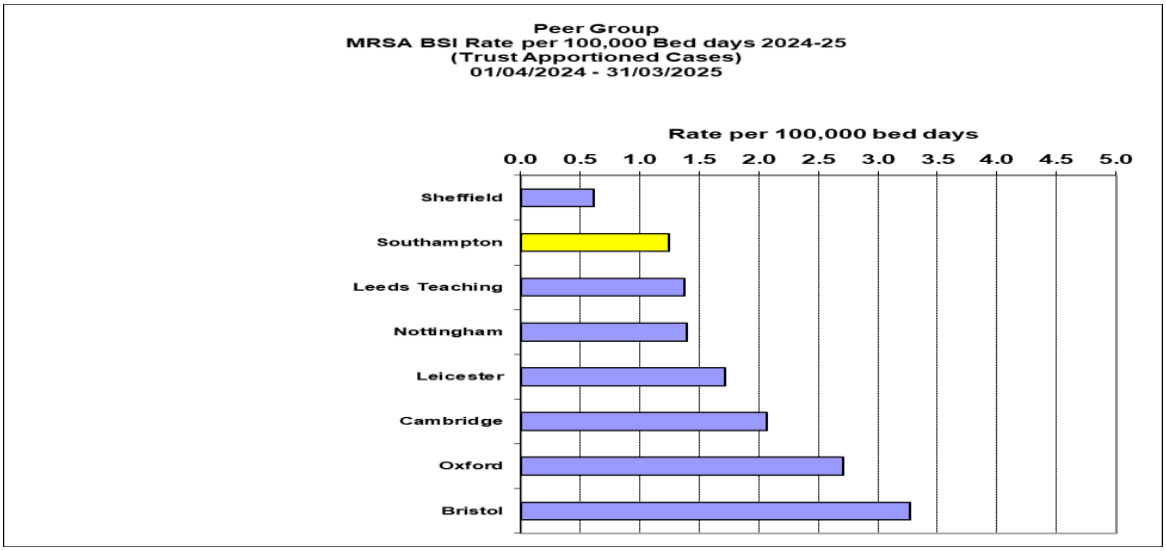
**Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

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

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

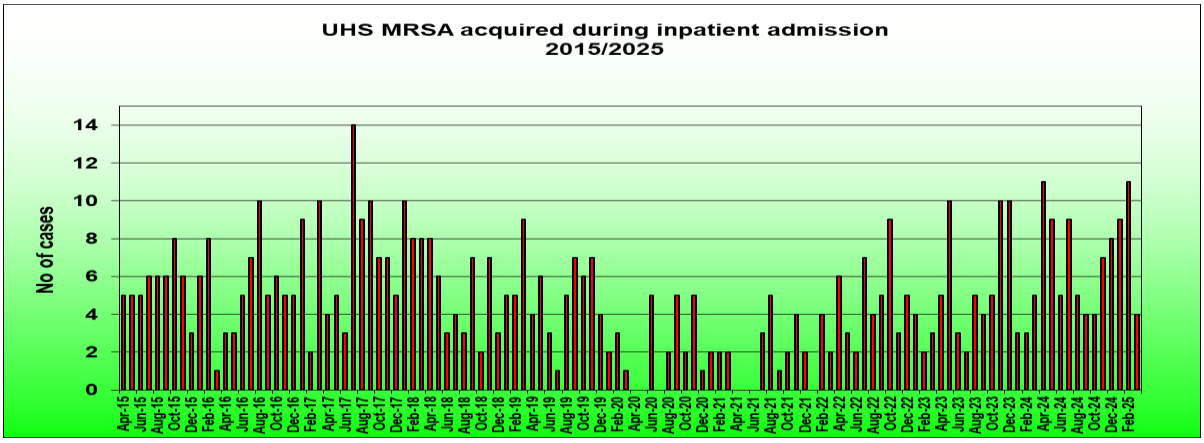


UHS has an attributable MRSA BSI rate of 1.25 cases/100,000 bed days and ranks 2 of 8 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.0, 1.32 and 6.6 cases/100,000 bed days.



Acquisition of MRSA colonisation in UHS

86 patients acquired MRSA (colonisation or infection) in UHS in 2024/25, an increase compared to the previous 2 years (68 patients in 2023/24, 54 patients in 2022/23).



Infection prevention & control (IP&C) practice reviews were undertaken by the Infection Prevention Team (IPT) on 84 of the patients who were newly colonised with MRSA to ensure that all expected measures were undertaken as per UHS policy. Key themes/learning from IP&C C.MRSA practice reviews undertaken identified:

- 25 (30%) of the 84 patients did not have documented evidence of MRSA risk reduction washes on or prior to admission.
- 23 (27%) of the 84 patients did not have MRSA topical decolonisation therapy prescribed following confirmation of positive MRSA result.
- 19 (23%) of the 84 patients did not have their MRSA status documented in their patient notes.
- 27 (32%) of the patients did not have a UHS isolation risk assessment completed.

A range of actions and interventions have been undertaken throughout the year to support improvements in practice including provision of targeted education/training relating to MRSA risk reduction washes and MRSA topical bioburden reduction/decolonisation, ongoing focus and awareness on IP&C practice standards Despite this, key themes from IP&C practice reviews have remained consistent.

A targeted programme of work will be undertaken in 2025/26 including:

- Extending MRSA IP&C practice reviews to include known MRSA positive cases who are newly admitted (new admissions who have an existing MRSA alert) as well as new cases (admissions/inpatients who test positive & are not previously known to be MRSA positive).
- Monitoring/auditing and feedback of the prescribing of MRSA risk reduction washes.
- Launch and rollout of a revised MRSA policy supported by a communication, education and improvement campaign.
- Ongoing focus on improving IP&C practice standards including hand hygiene and care of invasive devices.

Clostridioides difficile (C.difficile)

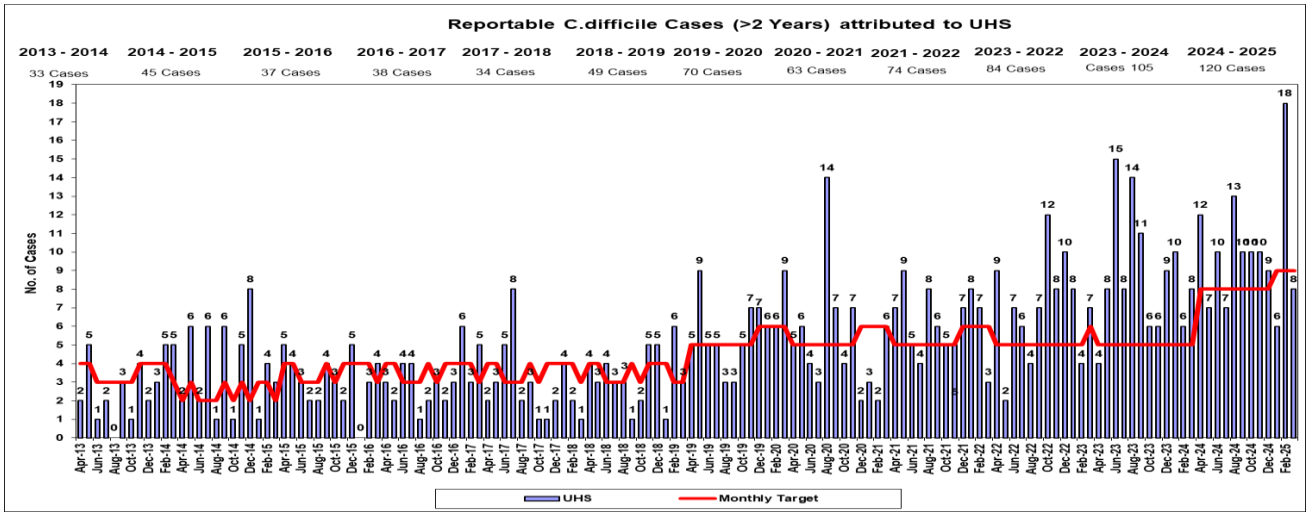
Trusts are required under the NHS Standard Contract 2024/25 to minimise rates of *C. difficile* so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

End of year outcome

120 cases in 2024/25 against a nationally set threshold of 99. This compares to 105 cases in 2023/24.

- 38 Community Onset – Healthcare associated (COHA)
- 82 Hospital Onset – Healthcare associated (HOHA)

2024/25	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
HOHA	8	5	8	4	10	10	8	3	7	5	9	5	**82**
COHA	4	2	2	3	3	0	2	7	2	1	9	3	**38**



IP&C practice reviews (277) were undertaken throughout the year on wards where patients with a newly confirmed positive result were isolated (toxin positive and toxin negative cases irrespective of whether hospital/ community onset or healthcare/community associated) for assurance that all expected standards were in place to reduce the risk of onward transmission. Key themes/learning from IP&C C.difficile practice reviews identified:

- 34% of commodes that were found to be clean were missing an “I am clean” sticker,
- 29% of commodes were found to be visibly soiled with body fluids including faeces
- 23% of patients were not isolated in a timely manner as per UHS isolation of patients with infectious conditions policy.
- 19% of cases had incorrect cleaning products being used for the cleaning of equipment for patients in isolation.
- 35 % of cases did not have an isolation risk assessment completed.

Six periods of increased incidence (PII) were declared during the year (two or more new cases of *C. difficile* on a ward in a 28-day period) and actions implemented in response including enhanced cleaning of the whole ward; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice); review of isolation procedures; request for review of antibiotic usage and enhanced communications with staff. *C. difficile* isolates sent to the national reference laboratory for strain typing (ribotyping) did not show any links between the cases on the individual wards. I.e. there was no evidence of transmission between patients on the ward either directly or via the ward environment.

A range of actions and interventions have been undertaken throughout the year to support improvements in practice and reduction of *C.difficile* including:

1. Focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing including:
    - Review and update of antimicrobial prescribing guidelines.
    - Education/awareness during World Antimicrobial Awareness week.

- Antimicrobial stewardship ward rounds (microbiologists & pharmacists).
- Combined IP&C and AMS ward rounds (by IPT and pharmacy-micro team).
- Pilot, in Q4, of a focused *C.difficile* ward round to review patients with a new diagnosis of *C.diffficile* including review of prior antimicrobial prescribing, clinical management of the patient post *C. difficile* positive result, and IP&C practices.

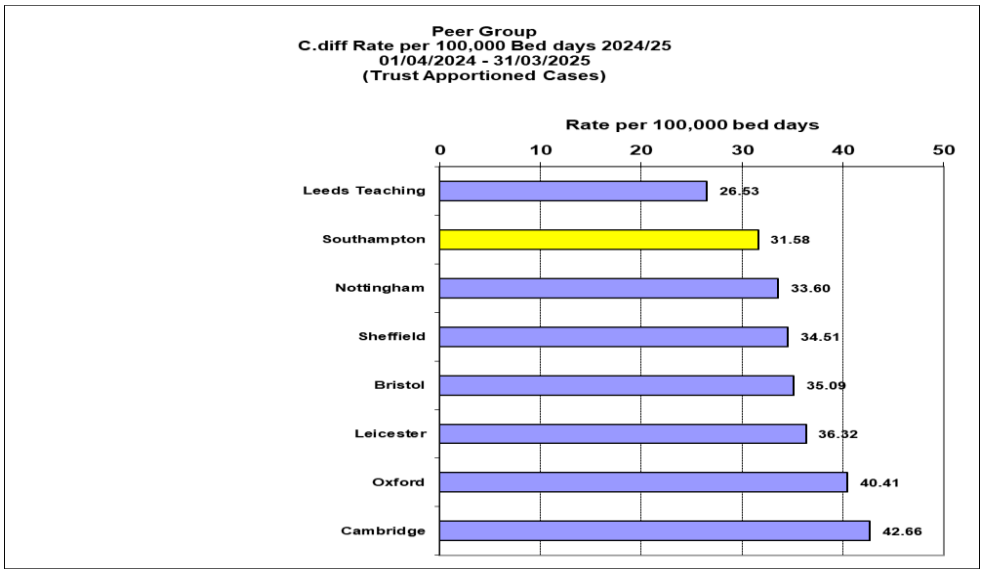
2. Focus on improving the management of patients requiring isolation and isolation care
   - Launch of an updated Isolation Policy supported by education/awareness activities to improve knowledge of the expected standards of isolation care and practices.
   - Focused isolation care ward rounds/reviews undertaken by the Infection Prevention Team, supported by education/awareness activities to improve knowledge of the expected standards of practice.
   - Review of isolation care and IP&C practices included in the *C.difficile* ward round pilot in Q4.
3. Focus on improving IP&C practice standards related to equipment cleanliness and hand hygiene:
   - Promotion of hand hygiene practices including a hand hygiene awareness week in May 2024 to coincide with global hand hygiene awareness day; awareness messaging, education & teaching throughout the year.
   - Ongoing focus on appropriate glove use to support reduction of unnecessary use of gloves and increased focus on hand hygiene.
   - Development and delivery of actions within an IP&C improvement plan, focusing on hand hygiene and equipment cleaning.
   - Launch of the clinical cleaning escalation framework.
   - IP&C awareness campaign throughout the month of October focused on equipment cleaning (especially items shared between patients) and hand hygiene
   - IP&C focused Trust Matron walkabouts in March 2025 to review equipment cleanliness & processes and hand hygiene practice.

Despite these activities, themes from IP&C practice reviews have remained relatively consistent and an ongoing programme of improvement work will remain in 2025/26.

Since 2021, *C. difficile* infection (CDI) incidence has been climbing nationally with UKHSA reporting that cases were 35% higher in 2023/24 than 2018/19 (CDI's lowest point in recent years). End of year national data for 2024/25 is awaited. The increases are seen in all age groups and across all regions, placing increasing burden on NHS services, especially infection prevention and control and isolation facilities. The causes of this increase are likely multifactorial but have not yet been established. In response to the ongoing climb in cases, UKHSA stood up a national incident response Q3 and it is likely that this will result in actions/requirements (e.g. additional epidemiological and microbiological investigations) that will provide better understanding of the recent increases and help target control measures and mitigations.

From April 2025 UKHSA is introducing active surveillance of *C. difficile* strains circulating in England using whole genome sequencing (WGS). UHS has been selected as one of 20 sites to participate in a sentinel surveillance programme of *Clostridioides difficile* infection (CDI) by WSG which will provide both C. *difficile* ribotyping data and further information on potential genetic relatedness of a sample our CDI cases.

UHS ranks second out of 8 self-selected peer acute trusts, with a rate of 31.58 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



Healthcare Associated Bloodstream Infection (excluding MRSA)

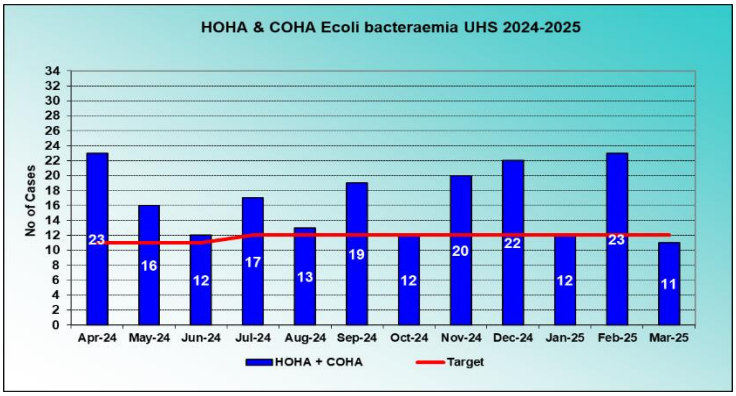
Gram- Negative Bloodstream Infection (BSI)

Trusts were required under the NHS Standard Contract 2024/25 to minimise rates of Gram-negative bloodstream infections so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e., Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

	2024-25	2023-24	2022-23	2021-22	2020-21
E coli	200 (141)	147 (120)	154 (127)	138 (151)	67
Klebsiella	81 (56)	58 (56)	51 (73)	64 (64)	40
Pseudomonas	36 (22)	24 (33)	35 (36)	30 (34)	13

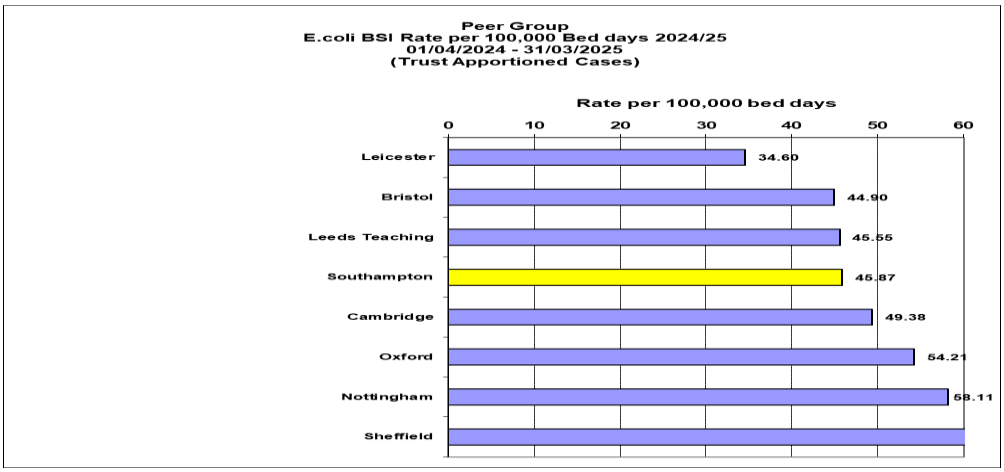
(National thresholds in brackets)

E coli BSI:

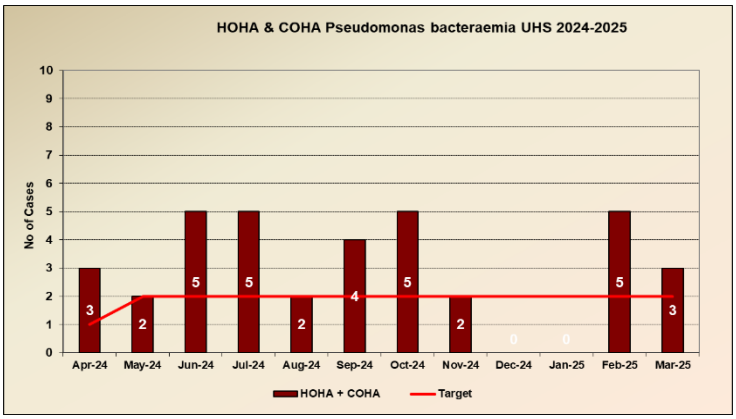


End of year outcome
200 cases in 2024/25 against a threshold of 141

- 115 Community Onset – Healthcare Associated (COHA)
- 85 Hospital Onset – Healthcare Associated (HOHA)



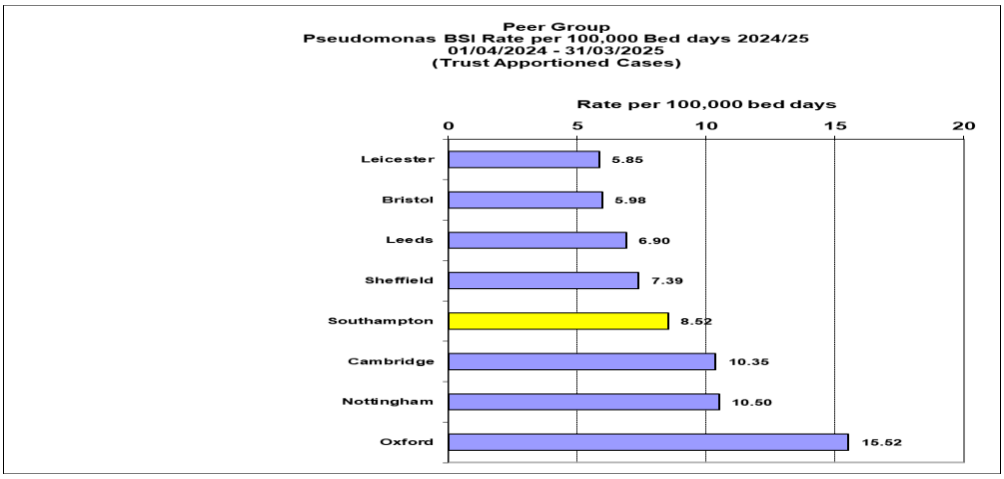
Pseudomonas BSI:



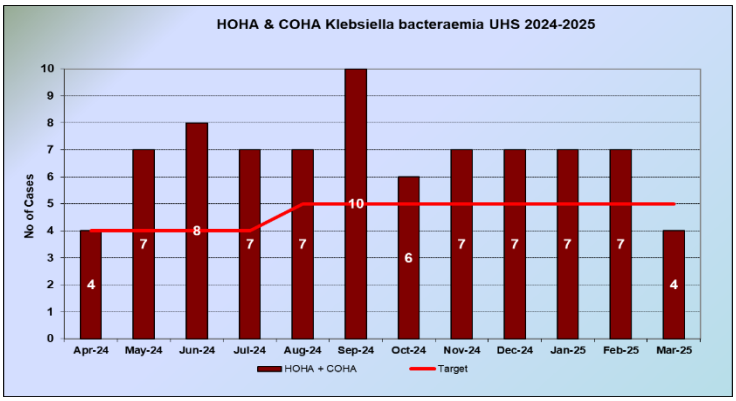
End of year outcome

36 cases in 2024/25 against a threshold of 22

- 9 Community Onset – Healthcare Associated (COHA)
- 27 Hospital Onset – Healthcare Associated (HOHA)



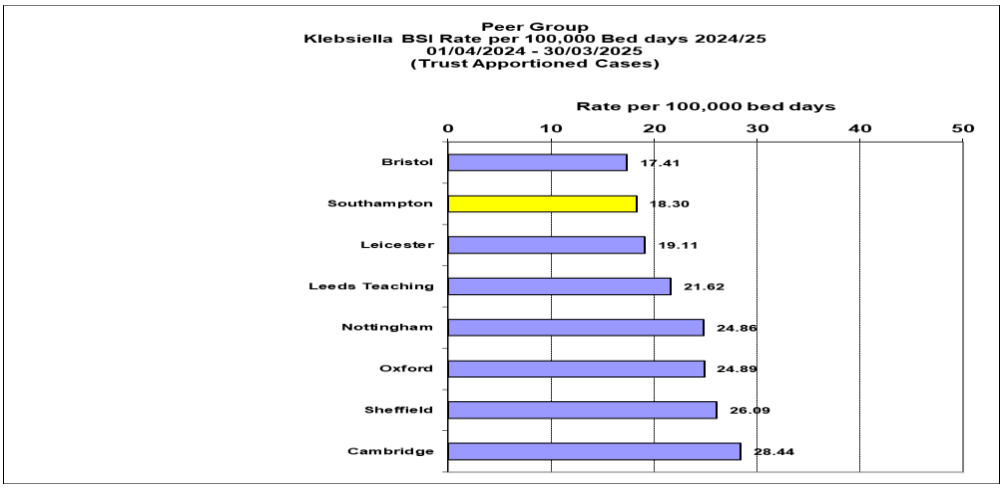
Klebsiella Bacteraemia:



End of year outcome

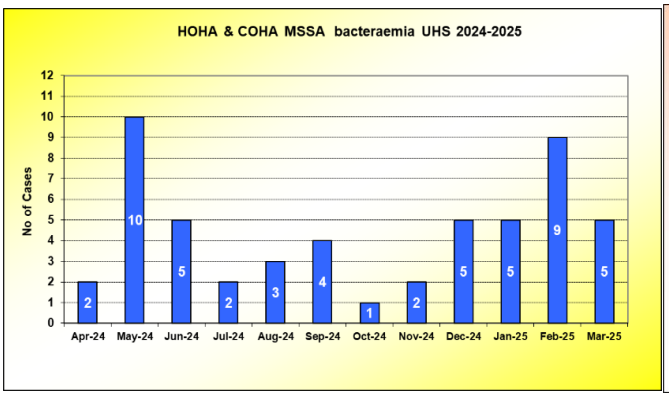
81 cases in 2024/25 against a threshold of 56

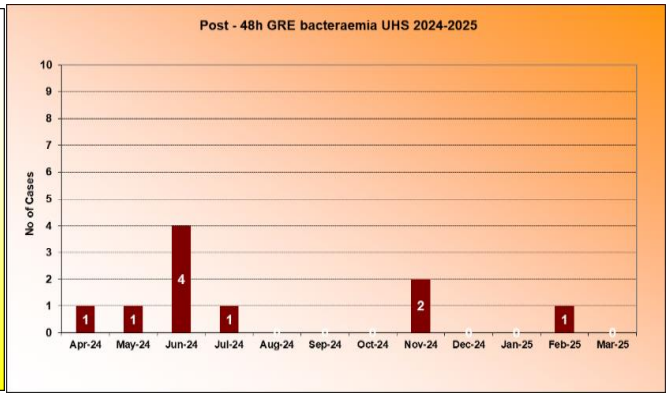
- 21 Community Onset – Healthcare Associated (COHA)
- 60 Hospital Onset – Healthcare Associated (HOHA)



MSSA & VRE BSI : No nationally set threshold level but ongoing focus to minimise MSSA bloodstream infections

	2024-25	2023-24	2022-23	2021-22	2020-21
MSSA	53	59	45	43	36
VRE	10	12	4	9	7





Summary of BSI case reviews for 2024/25

A total of 380 cases of healthcare associated BSI (gram negative, MSSA & VRE) were reviewed in 2024/25 to identify the likely source of infection:

Unclear	16.32% (n=62)
Lower Urinary Tract	14.21% (n=54)
Hepatobiliary	13.16% (n=50)
Intravascular Device (Including Pacemaker/ICD or CVC)	11.58% (n=44)
Lower Urinary Tract (Catheter Associated)	10.53% (n=40)
Lower Respiratory Tract (Pneumonia, VAP, Bronchiectasis, EXAC COPD ETC)	7.37% (n=28)
Neutropenic Sepsis	5.79% (n=22)
Gastrointestinal or Intraabdominal collection (excluding Hepatobiliary)	5.26% (n=20)
Upper Urinary Tract (Pyelonephritis / Abscess)	4.47% (n=17)
Gut Translocation	3.16% (n-12)
Skin or Soft Tissue (including Ulcers, Cellulitis, Diabetic Foot infections without OM)	3.16% (n=12)
Bone and Joint (with Prosthetic Material)	2.63% (n=10)
Cardiovascular or Vascular (without Prosthetic Material, including Fistula Infection)	1.05% (n=4)
Upper Respiratory Tract and ENT	1.05% (n=4)
Genital System (including Prostate If Male)	0.26% (n=1)

A concise review and/or IP&C practice review was completed by the Infection Prevention Team for selected cases that were deemed likely related to IV access devices, urinary catheters, surgical site infection or ventilator associated pneumonia where an initial review (by infection control doctor/senior infection prevention practitioner) identified potential concerns with IP&C practices or patient management that may have contributed to developing the BSI and where new learning was likely. Where deemed necessary, subsequent after action review meetings were held with the relevant clinical team to review the case and focus on lessons learned, good practice, recommendations for improvement, agree actions & how learning will be shared.

Key themes/learning from the reviews that were undertaken remained similar to those in 2023/24:

- Gaps in documentation and assurance related to insertion and daily review and care of urinary catheters, including ongoing reason for catheter and plan for TWOC.
- Gaps in documentation and assurance related to daily review and care of IV devices including CADI form completion and reason for retention of cannula.

A range interventions and actions have been undertaken throughout the year to support improvements in practice and reduction of healthcare associated BSI including

1. Focus on reducing risk of catheter associated UTI (CAUTI) through improving management of urinary catheters, avoiding unnecessary catheterisation and ensuring appropriate early removal of catheters:
    - Quality improvement initiatives/ in defined areas. Examples include: .
        - Ongoing project in T&O to reduce the duration of catheterisation & development of a flowchart for the early removal of catheters with pilot of a nurse led TWOC protocol.
        - Ward G9 participation in the UCast project – a project with 3 other sites to develop and test a surveillance tool for urinary catheters and catheter-associated urinary tract infection following a successful funding application to the Infection Prevention Society.
        - The ‘A-void’ catheter project on Ward G9, a nurse led project to reduce the use of urinary catheters on the ward by 50% by end of March 2025 (through nurse-led review and timely removal) and to provide a management plan for patients discharged from G9 ward with a

catheter to the primary care team. The target of 50% reduction was achieved prior to the target date and has been sustained.

- Review of patients with indwelling urinary catheters as part of the weekly combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team) to support discussions regarding ongoing need for catheter and plans for removal.
- Completion of a detailed audit of urinary catheter records on inpatient noting by the UHS digital educator team with a subsequent request for changes to the inpatient noting system to support daily review of the ongoing need to catheters.

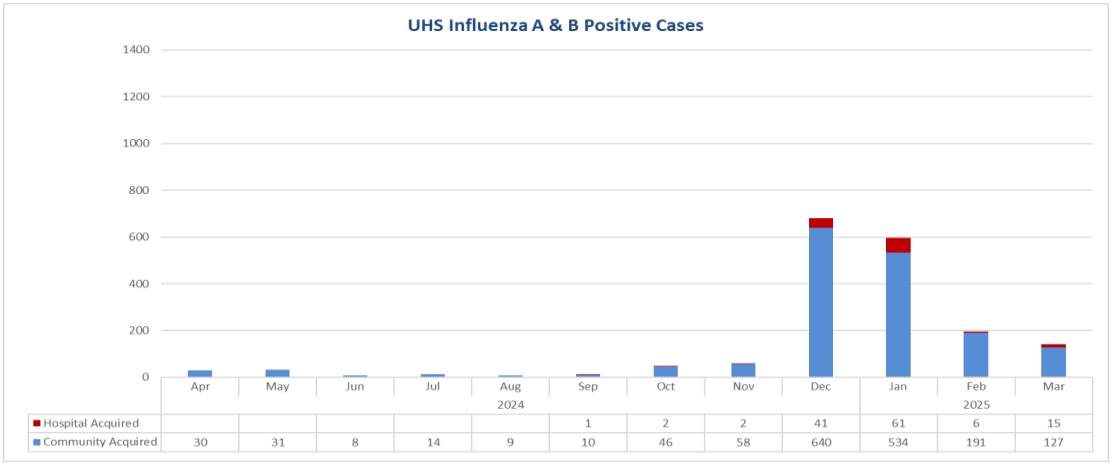
2. Focus on IV device care and management
   - Review of patients with IV cannulas as part of the weekly combined IP&C and AMS wards rounds (by IPT and pharmacy-micro team) to support discussions regarding device care, management and ongoing need.
   - Focused activities relating to the management and care of intravenous access devices, including IPT ward reviews and targeted education/awareness and support activities.
   - Education and awareness activities relating to skin preparation prior to IV device insertion and for ongoing care (delivered to wards by company representatives)

3. Improving hand hygiene practices and reducing gloves use
   - Ongoing observation, education and awareness activities related to hand hygiene.
   - Delivery of actions within the IP&C improvement plan focusing on hand hygiene including an IP&C awareness campaign throughout the month of October.
   - Ongoing focus on appropriate glove use to support reduction of unnecessary use of gloves and increased focus on hand hygiene.

4. Ongoing implementation of the UHS Fundamentals of Care Commitments e.g. nutrition & hydration, mouth care, promoting mobility, maintaining skin integrity, bladder and bowel care, personal hygiene, communication, pain management.

2.2 Respiratory Viruses

Influenza



	Apr	May	Jun	Jul	Aug 2024	Sep	Oct	Nov	Dec	Jan	Feb 2025	Mar
Hospital Acquired						1	2	2	41	61	6	15
Community Acquired	30	31	8	14	9	10	46	58	640	534	191	127

Influenza activity in 2024/25 was significantly higher (58%) than in 2023/24 with 1826 cases compared to 765 in 2023/24. Of these 527 were children (0-17Yrs.) and 1299 adults (>=18 Yrs.).

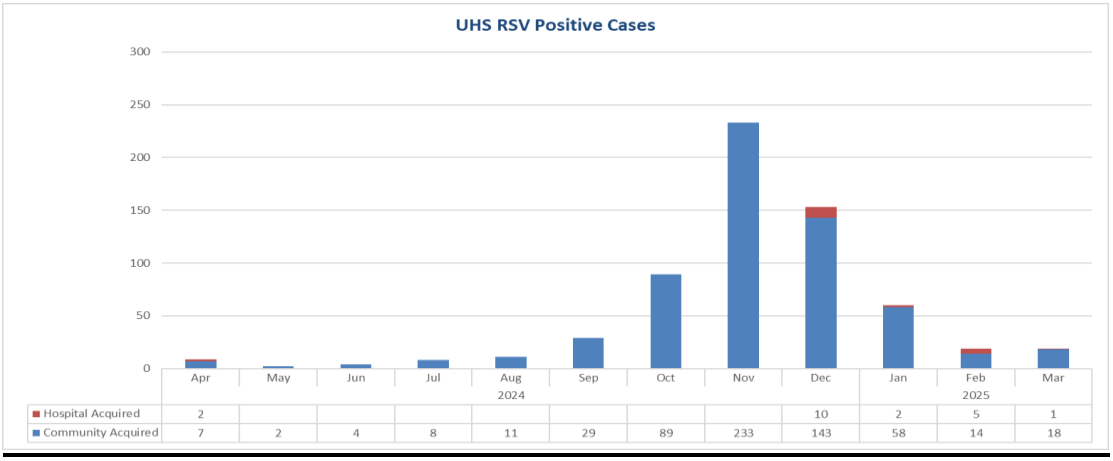
A sharp increase in cases was seen in December 2024 (particularly after Christmas) which continued into January 2025 in line with a surge in cases nationally. This along with high numbers of patients attending the emergency department, other operational pressures and challenges associated with respiratory virus-related staff absence, had a significant impact on the operational capability of the Trust.

The majority of positive cases were identified in patients attending the emergency department or in admission areas by rapid in-lab testing. Reporting of results within 2 hours facilitated early decision making re: patient management (e.g. decision to admit/discharge) and appropriate patient placement to minimise the risk of transmission to other patients. Influenza cohort bays where established where needed (predominantly in Emergency Medicine/Medicine care group) including within admission areas such as AMU, in order to accommodate patients who tested positive.

Of the patients who tested positive in the emergency department 584 (45%) were admitted to hospital (97 children and 487 adults).

Source	Number of Cases	Number Admitted
ED	1286	584
Admission Areas (AMU, MAOS,TAU)	236	
Inpatients	262	
Outpatients / Clinics	42	
Total	1826	

RSV



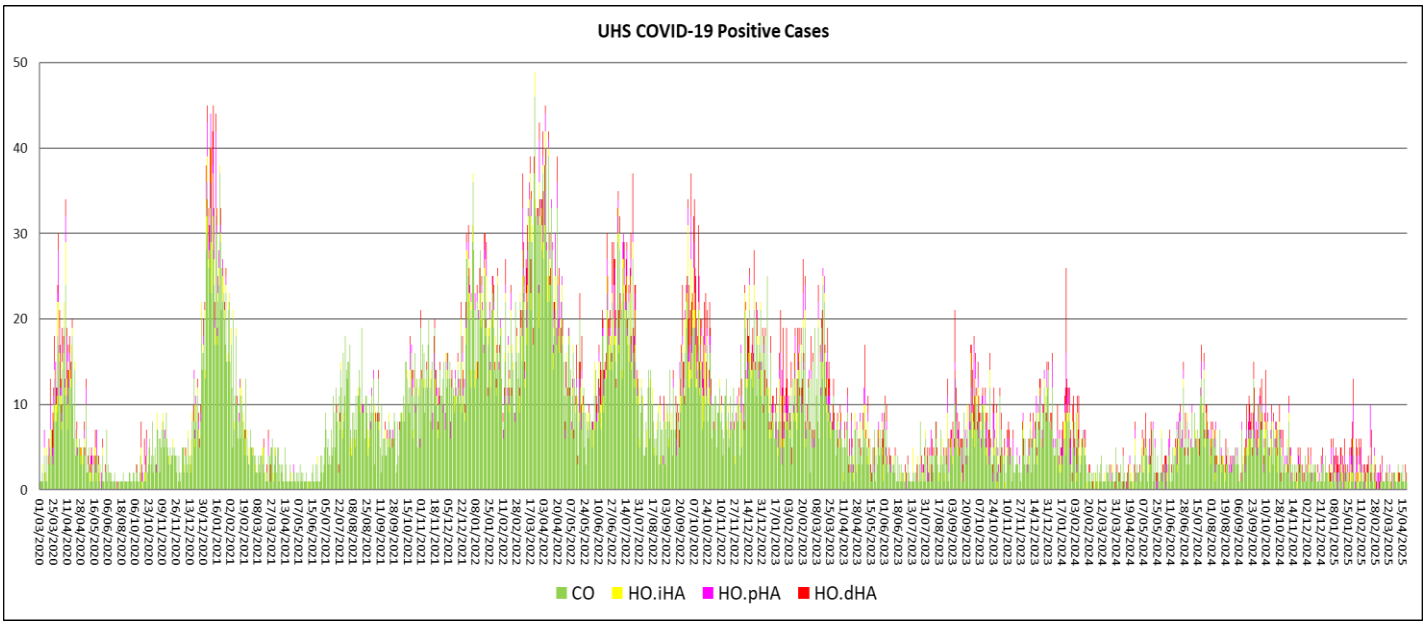
RSV activity in 2024/25 was slightly lower than the previous year with 636 cases in 2024/25 compared to 715 in 2023/24. The majority of cases occurred in Q3 as per expected seasonal trend. Of the 636, cases 405 were in children (0-17Yrs) and 231 adults (>=18 Yrs.).

Most of the cases were seen in the emergency department (521). Of the patients who tested positive in the emergency department 258 (49%) were admitted to hospital (149 children and 109 adults).

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

Source	Number of Cases	Number Admitted
ED	521	258
Admission Areas	67	
Inpatients	39	
Outpatients / Clinics	9	
Total	636	

COVID-19



Prevalence of COVID-19 fluctuated during 2024/24 with the breakdown of cases as follows:

	Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
Q1 (April – June)	255	23	26	40
Q2 (July-Sept)	447	31	41	50
Q3 (Oct-Dec)	290	30	27	46
Q4 (Jan – Mar)	116	30	62	60
Total	**1108**	**114**	**156**	**196**

Definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals
Definite (HO.dHA): *hospital-onset definite healthcare-associated first positive specimen date 15 or more days after admission to Trust (RCA required)*
Probable (HO.pHA)*: hospital-onset probable healthcare-associated – first positive specimen date 8–14 days after admission to Trust (RCA required)*

Indeterminate (HO.iHA): *hospital-onset indeterminate healthcare-associated – first positive specimen date 3–7 days after admission to Trust*
Community Onset (CO*) - positive specimen date <=2days after hospital admission or hospital attendance.*

Respiratory Virus Outbreaks

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

	Number of COVID-19 Outbreaks	Total Number of Positive Patients
Q1	3	21
Q2	11	49
Q3	10	37
Q4	12	76
Total	**36**	**183**

	Number of Influenza Outbreaks	Total Number of Positive Patients
Q1	0	0
Q2	0	0
Q3	5	23
Q4	6	30
Total	**11**	**53**

Outbreaks continue to be managed by the Infection Prevention Team, with control measures implemented as required and ongoing monitoring until 14 days following the last confirmed case.

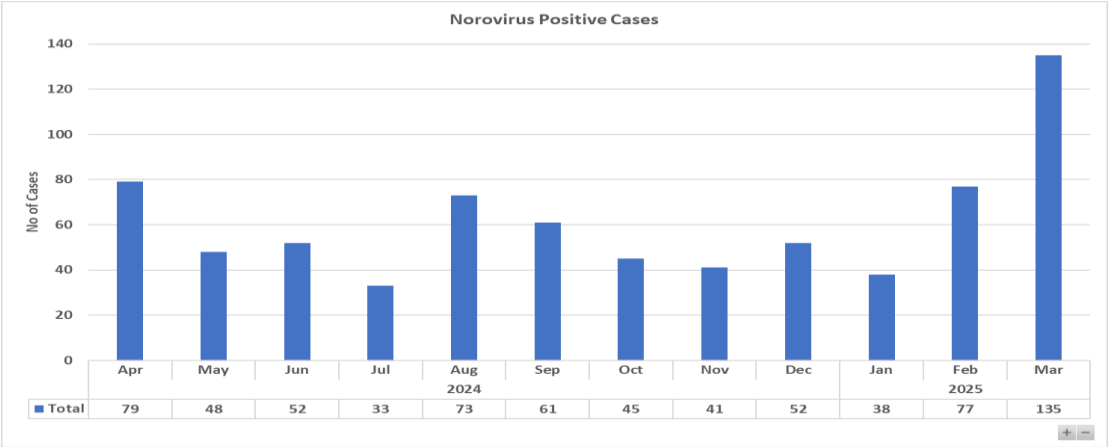
Key themes/ learning from outbreaks in 2024/25 remained similar to 2023/24:

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

health guidance) but not wearing surgical masks as per IP&C guidance.

2.3 Viral Gastroenteritis, including Norovirus.

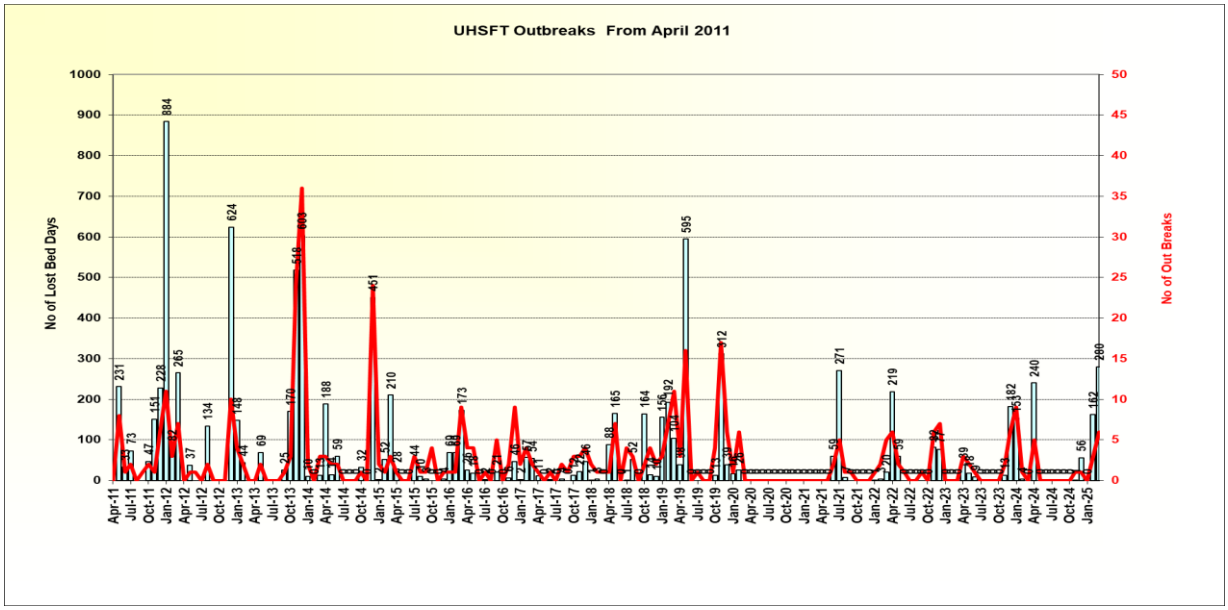
The Trust experienced an increase in Norovirus activity in April and August 2024 and a significant surge in cases in February/March 2025. This is in the context of a rise in cases both locally and nationally, specifically in February/March 2025 when cases of Norovirus were reported to be at an all-time high nationally with a new genotype circulating and some individuals experiencing reinfection in the same winter season.



The majority of the Norovirus positive cases were identified through use of rapid in-lab diagnostic testing for gastrointestinal (GI) pathogens for symptomatic patients (those with potentially infective diarrhoea) either on admission (in agreed admission pathways in ED and AMU) or, within ward bays throughout the hospital.
The use of rapid GI testing continues to facilitate faster diagnosis (or exclusion of an infectious GI pathogen) within 2-3 hours of a rectal swab sample being taken rather than 24-48hrs if waiting for a standard laboratory test result on a stool sample. This results in earlier implementation of targeted control measures, such as isolation of patients with a confirmed positive result and quarantine of contacts (for Norovirus), reducing the risk of transmission to other patients and outbreaks occurring.

The ability for Norovirus to disrupt our capability to treat patients remained ever present within our hospitals, particularly in February/March 2025. Bay and ward closures due to the need to quarantine patient contacts or as a result of ward outbreaks, along with other operational pressures and challenges, had a significant impact on the operational capability of the Trust.

	No. of outbreaks	Cause	No of Bed Days Lost	No of Pts	No of Staff	No of Bays Closed	Wards closed
Q1	5	Norovirus	240	38	5	0	5
Q2	0	Norovirus	25	20	0	20	0
Q3	1	Norovirus	56	4	0	3	1
Q4	9	Norovirus	448	112	14	3	9
Total	**15**		**769**	**174**	**19**	**26**	**15**



Year	Bed days lost due to Norovirus bay/ward closures
2019-2020	1039
2020-2021	0
2021-2022	361
2022-2023	503
2023-2024	477
2024-2025	769

Key themes/learning from Norovirus outbreaks included:

- Ensuring completion of the outbreak daily ward review tool by ward teams to support review and management of the outbreak by the IPT.
- Ensuring accurate documentation of patient's bowel movements.
- Management of contaminated linen to avoid potential contamination of clean linen.
- Signage not displayed on entrance to the ward to alert staff/visitors of outbreak/infection risk.
- Limited toilet/bathroom facilities in some of the wards.

2.4 Actions to support prevention and control of Respiratory Viruses and Norovirus.

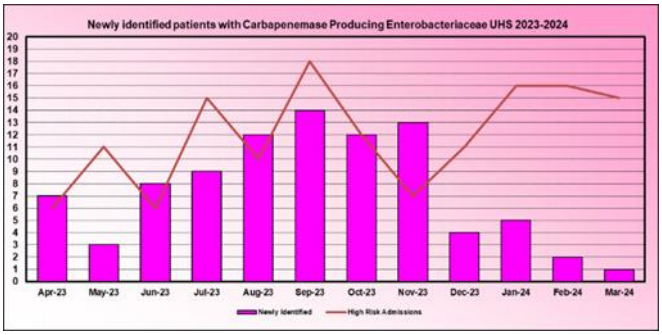
Actions and strategies to support prevention and control of respiratory viruses and Norovirus and reduce risk of in-hospital transmission and associated outbreaks, along with planning for potential increases in cases, have remained in place and under ongoing review. Actions taken in 2024/25 included:

- Promotion of the annual 'flu and COVID-19 booster vaccination for staff and patients.
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.

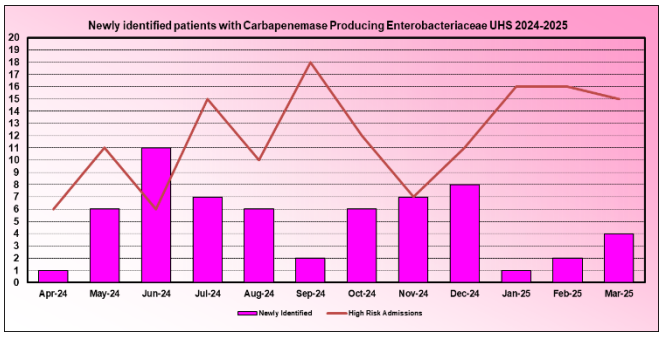
- Use of rapid in-lab testing to test patients with symptoms suggestive of respiratory virus or viral gastroenteritis to facilitate early identification and placement of positive cases.
- Isolation or cohorting of symptomatic patients who have a positive respiratory virus test (COVID--19 and influenza) or Norovirus and quarantine of patient contacts where required (Norovirus).
- Education & training activities, including a winter virus awareness campaign led by the IPT.
- Communications to staff regarding levels of infection, expected IP&C practices, situational updates.
- Proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Ongoing focus on effective management of existing isolation capacity within UHS to ensure optimal use.
- Monitoring and focus on infection prevention and control practices in clinical areas.
- Active deployment of portable air-purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks.

2.5 Carbapenemase-producing Gram negative bacteria

2023/24



2024/25



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

- 61 newly identified CPE cases were identified in 2024/25 compared to 90 in 2023/24, a decrease of 32%
- 226 high risk patients were admitted to UHS in 2024/25 compared to 143 in 2023/24, an increase of 37%

Key actions to reduce risk and transmission from CPE:

- Ongoing focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially the carbapenem group of antibiotics (e.g. Meropenem).
- To continue to undertake appropriate screening for CPE, including patients admitted that meet the high-risk criteria for CPE carriage (e.g. patients who have recently been an inpatient in a hospital overseas) and patients currently on carbapenems, (e.g. IV Meropenem).
- Ensuring consistent application of high standards of infection prevention practices, including regular review of inpatient cases of CPE/CPE contacts by the IPT for assurance that correct IP&C precautions are in place to reduce minimise risk of transmission to other patients.

2.6 *Candida auris outbreak*

The outbreak of *Candida auris* (now referred to as *Candidozyma auris*) centred on D4 Vascular ward at UHS, but also impacting on Trusts within the region whose patients access the UHS Vascular service, has continued during 2024/25. A wide range of control measures, remain in place and under ongoing review, with guidance and support from regional and national colleagues from UKHSA and other expert colleagues with experience of managing *C. auris* outbreaks. Outbreak/incident meetings remain in place to review the situation and control measures, with representation from HHFT, PHU, IOW, HIOW ICB, UKHSA, SCAS and HIOW NHS trust.

Since January 2023 to date (end of March 2025), 106 cases of *C.auris* have been confirmed within UHS. 99 of the cases are specifically linked to the vascular outbreak (first declared in March 2023) with the large majority of positive cases having spent some time as an inpatient on D4 ward or contacts of cases who have spent time on D4. Nearly all patients have been identified via surveillance screening (e.g. axilla and groin) within UHS (for Vascular patients on admission, twice weekly, during their inpatient stay, and upon discharge), rather than from clinical samples (such as wound swabs).

The ward environment on D4 was highlighted as a factor which is highly likely to have impacted on the ability to effectively control transmission of *C. auris* and thus potentially contributing to the continuation of the outbreak. This includes high ambient temperature, poor ventilation (no mechanical ventilation and limited natural ventilation), aging and deteriorating ward infrastructure (e.g. floor, walls and ceiling tiles), limited space, cluttered and a crowded ward environment which overall compromises the ability to effectively clean the ward.

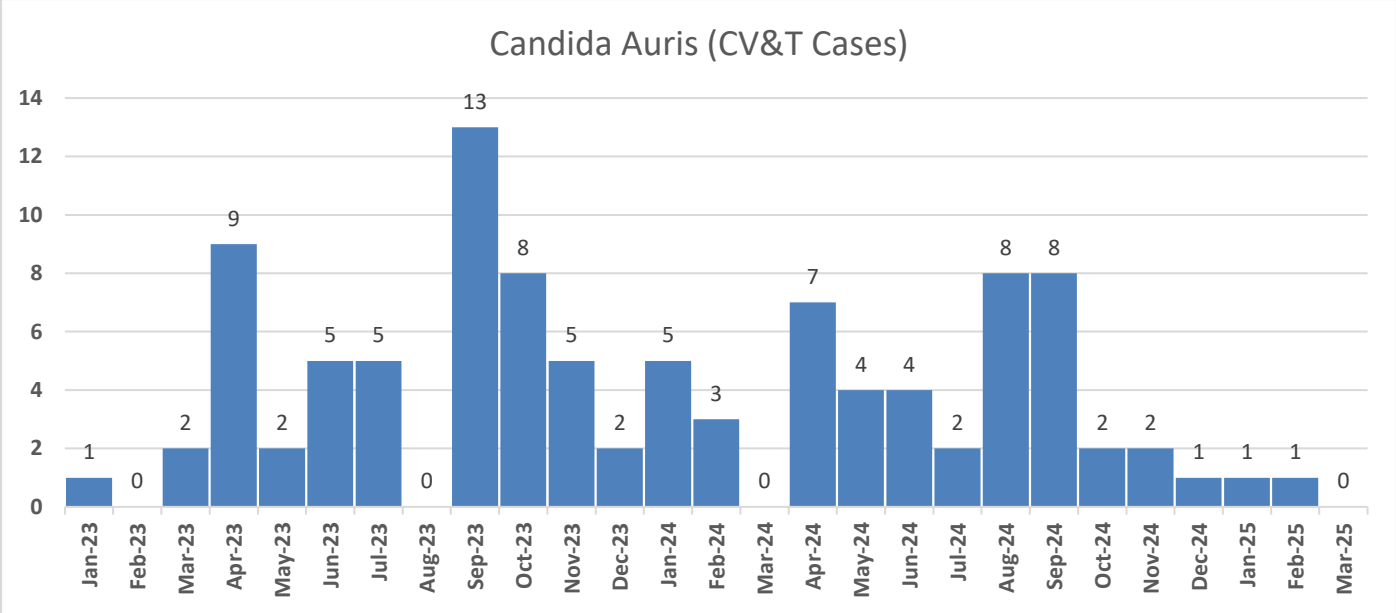
In response to the further escalation of the above concerns in the 2023/24 IP&C annual report remedial estates work was undertaken to improve the D4 ward environment involving a full decant of the ward's vascular inpatients to an alternative inpatient ward, followed by a ward deep clean and ward-wide full high-level decontamination of the ward environment using hydrogen peroxide vapour (HPV). D4 was closed for a period of 3 weeks to facilitate this with the vascular service relocated to ward F6 during this time.

Following re-opening of D4 on 09/09/2024, 10 new *C. auris* positive patients were identified through surveillance testing, 8 tested on D4 and 2 tested at other NHS trusts following UHS discharge, 1 from D4 and 1 from GICU. A further review of control measures was undertaken in response to this including introduction of additional surveillance screening, further review of IP&C practices, cleanliness standards and equipment.

In Q3 (October to December 2024) 5 (five) new cases if *C. auris* were identified. Detailed analysis of the patients' inpatient timeline and contacts revealed that it is almost certain that four of those five acquisitions took place in the first 3 weeks of September 2024 (rather than more recently). Analysis of the single *C. auris* case that was newly identified in December 2024 revealed that it is almost certain that that particular patient acquired the organism in theatre, as they underwent a procedure in one of the CV&T theatres on a theatre list immediately after a patient known to be colonised with *C. auris* had also undergone a procedure in the same theatre. In direct response to this highly likely in-theatre acquisition, the IPT conducted surveillance, observation of IPC practice and remedial staff training in CV&T theatres, including clarification and re-training in appropriate and effective chlorine-based cleaning of all items of clinical furniture and items of equipment within the theatre environment to prevent further instances of avoidable transmission within theatres.

In Q4, 2 (two) new cases if *C. auris* were identified. Analysis of the patients' inpatient timeline and contacts revealed that one of the patients had spent time on D4 Vascular as well as E3 Blue/Green and D3 during the January admission and had theatre visits for vascular surgery and therefore likely acquired at UHS. Screening of patient contacts did not identify any subsequent onward transmission. The second patient tested positive on admission with a previous admission at Portsmouth Hospitals (with negative *C.auris* screens), two attendances at community podiatry clinics and no admission to UHS since early 2022. It was considered that acquisition for this patient may have occurred in a community podiatry clinic and a detailed review of the case was undertaken by the HIOW healthcare Infection Control Team.

In 2024/25 Q4, UHS, along with another large teaching hospital Trust in London also managing a significant and prolonged, *C. auris* outbreak was named in a UKHSA briefing note on the status of *C. auris* outbreaks in the UK, with note of several other smaller outbreaks having been identified in hospitals in London, including those in the Private Healthcare sector. In Q3, UKHSA announced that as from Q1 2025/26, *Candidozyma auris*, will become a nationally 'reportable organism'; this is a vital first step if UKHSA is to begin to receive, collate and analyse reliable data on the risk *C. auris* colonisation, infection and *C. auris* outbreaks currently pose, and will in the future pose to NHS and other UK hospitals.



2.7 Other infections

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

Measles

Nationally, cases of measles remained high going into 2024/25 and within UHS numbers rose significantly in Q1 with a cluster of cases identified in the trust between 27th April 2024 and 8th June 2024:

- 13 Patients (11 adults and 2 children)
- 4 Staff – all breakthrough infections in vaccinated individuals and confirmed as contacts with UHS cases.

Patient cases presented in number of clinical pathways including the emergency department, surgery and obstetrics & gynaecology. For some cases a diagnosis of measles was not considered on presentation to the hospital which subsequently resulted in the need to undertake large scale contact tracing involving up to 100 patients and over 150 members of staff for each individual case of measles admitted when prompt isolation a side room had not been implemented and the patient had been moved to downstream wards without appropriate precautions in place.

The contact tracing exercises determined for staff and patients exposed to a case of measles in the same open indoor area at UHS, their individual immune status and whether actions such as exclusion from work (e.g. until evidence of immunity to measles is known); isolation in single room (inpatients) whose immune

status is unknown/not immune; rapid blood testing for antibodies to Measles and/or whether post-exposure prophylaxis (PEP) with Immunoglobulin, were required. All relevant staff/patient contacts were sent a warn & inform letter. The Infection Prevention Team, Occupational Health, Virology/Microbiology Consultants and the Infection Control Doctors jointly undertook these time critical exercises when required, which was extremely time and resource intensive for all involved.

Throughout the period, key learning points were identified relating to the early recognition and subsequent management of measles and patient contacts. Several actions/measures were implemented with the aim of reducing risk of exposure to patients and staff.

High Consequence Infectious Disease (HCID), including response to international outbreak of Clade 1 Mpox.

Preparedness to safely respond to patients presenting with a potential High Consequence Infectious Disease (HCID) has been a key area of focus in 2024/25 with plans and pathways being reviewed and updated, including Mpox management pathways in response to the international outbreak of Clade 1 Mpox. This has been led by one of the UHS Infectious Disease Consultants and Infection Prevention Matron, working in collaboration with clinical teams. Clade 1 Mpox was subsequently downgraded from being classified as a HCID in March 2025.

2.8 Surgical Site Infections

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

Hip replacement

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2024 Q1	58	2	3.4%	0	0.0%	2	3.4%
2024 Q2	79	2	2.5%	0	0.0%	3	3.8%
2024 Q3	72	0	0.0%	0	0.0%	0	0.0%
2024 Q4	75	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Data shows a downward trend in SSI incidence rate in the hip replacement category.

Knee replacement

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2024 Q1	44	0	0.0%	0	0.0%	0	0.0%
2024 Q2	72	0	0.0%	0	0.0%	0	0.0%
2024 Q3	55	0	0.0%	1	1.8%	1	1.8%
2024 Q4	52	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

To ensure validity and reliability of the infected cases submitted to UK Health Security Agency, the cases are first discussed with the Consultant Microbiologist and the Consultant.

2.9 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards
The Trust annual infection prevention audit programme remains in place for 2024/25 to monitor infection prevention and control practice standards in clinical and non-clinical areas.

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

	Month	Element	% Standards met
Urinary Catheter Care	April 2024	Insertion	99%
		Ongoing Care	97%
	October 2024	Insertion	100%
		Ongoing Care	96%
Central Venous Catheter Care	June 2024	Insertion	89%
		Ongoing Care	94%
	December 2024	Insertion	89%
		Ongoing Care	99%
Peripheral Intravenous Cannula Care	June 2024	Insertion	94%
		Ongoing Care	96%
	December 2024	Insertion	96%
		Ongoing Care	96%
Preventing Surgical Site Infection	August 2024	Pre-Operative	98%
		Intra-Operative	93%
		Post-Operative	99%
	February 2025	Pre-Operative	95%
		Intra-Operative	100%
		Post-Operative	95%
Care of Ventilated Patients	August 2024		91%
	February 2025		90%

Miscellaneous Audits (all self-assessed)

Audit	Month	% Standards met	
Hand Hygiene Facilities	April 2024	97%	
Cleaning and Decontamination	September 2024	Non-Infected	94%
		Infected	98%
	March 2025	Non-Infected	96%
		Infected	96%
Standard Precautions	October 2024	97%	
Sharps Safety	July 2024	97%	
	January 2025	97%	
PPE (Clinical Areas)	September 2024	98%	
	March 2025	98%	
Isolation Audit	July 2024	98%	
	January 2024	98%	

Hand Hygiene

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

Monitoring and assurance of hand hygiene practice for inpatient areas in 2024/25 consisted of:

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

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

- peer audits only

Audit type	Month	% Standards met	
Inpatient and Outpatient areas (self- assessed)	May 2024	92%	
	November 2024	93%	
Surgical Scrub	May 2024	100%	
	November 2024	100%	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Quarter 2 (July/Aug 2024)	Overall trust median score = 54% Overall trust median score following re-audits = 60%	Against a performance improvement target of 62% (the trust median score established following Q4 2023/24).
	Quarter 4 (Feb 2025)	Overall trust median score = 64%	

Improving standards of hand hygiene practice remained an ongoing area of focus in 2024/25. Within the hand hygiene performance improvement framework (non-self-assessed audits) inpatient areas are measured against a performance improvement target with all areas expected to improve performance to score above

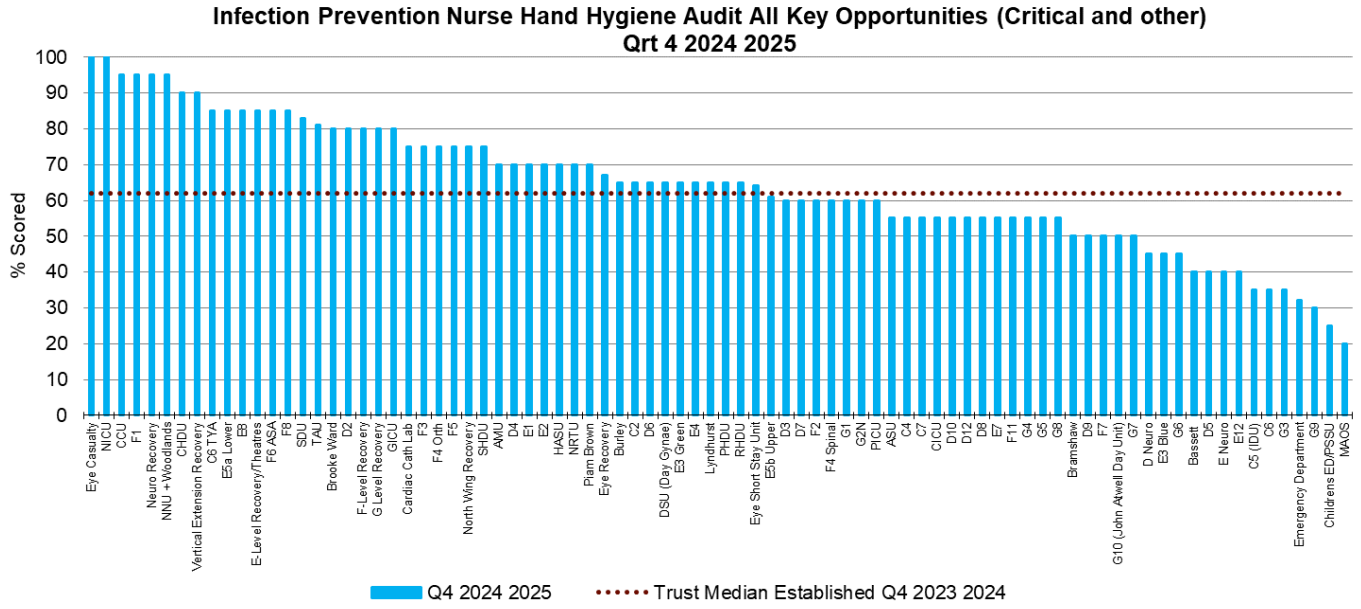
the trust median score (a target of 62%). All areas are expected to improve performance to score above the trust median score.

Improvements were seen in Q4 2024/2025 with an overall Trust score of 64%, compared to 54% in Q2. In addition a greater number of clinical areas met or exceeded the trust median score of 62%.

Of the 84 areas audited within UHS Trust in Q4 2024/25:

- 45 areas (54%) achieved on or above the Trust median score of 62% compared to 28 areas (33%) in Q2, an improvement of 17 areas
- 39 areas (46%) achieved below the Trust median score of 62% compared to 55 areas (65%) in Q2.
- 3 areas achieved equal to or below 30% compared to 12 areas in Q2.

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



Processes are in place for regular review of areas not achieving expected audit standards.

In addition to formal audits, ongoing monitoring of infection prevention and control practices continues through a range of avenues:

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

A range of actions/activities have been undertaken in 2024/25 to facilitate improvements in practice:

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

Infection Prevention Ward Accreditation 2024/25

Target**:** All areas to achieve full accreditation at year end 2024/25.

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

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

End of year outcome (152 areas)

- 63 areas achieved Full accreditation (41%)
- 51 areas achieved Partial accredited (34%).
- 38 areas did not achieve accreditation (25%).

Of the 89 areas who did not achieve full accreditation 30 (34%) of the areas were due to non-submission of audits and 59 (66%) due to both non-submission of audits and not meeting expected audit/practice standards.

Actions to improve accreditation status in 2024/25

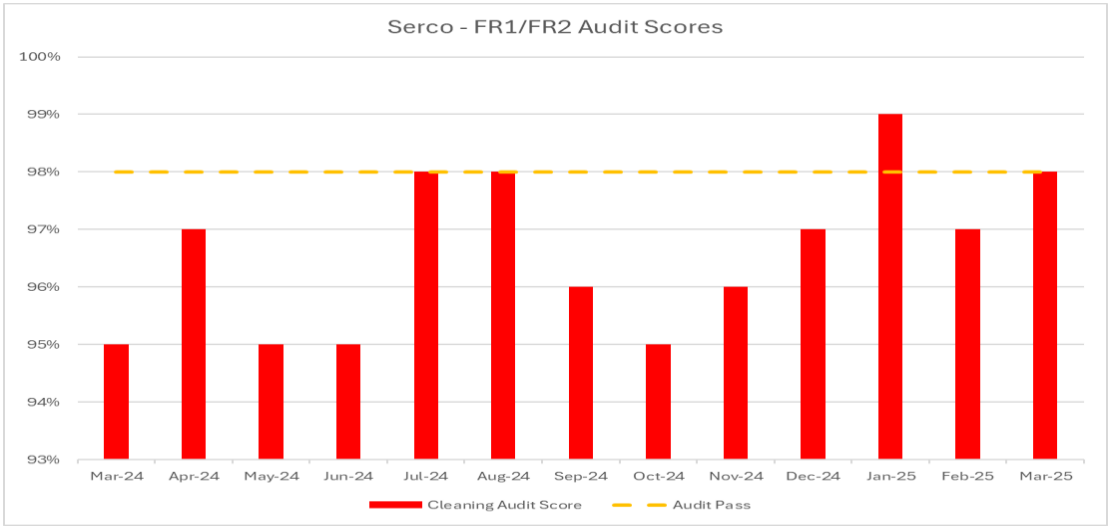
1. Divisions and Care Groups to review and discuss the detailed ward accreditation report and take action to improve performance, including ensuring that required audits are submitted as per the annual infection prevention audit programme.
2. The Infection Prevention Team will continue to work with areas to support achievement of full accreditation for year ending 2025/26.
3. Performance for individual clinical areas will continue to be subject to monthly review by the IPT as part of a continual improvement process.

Environmental Cleaning

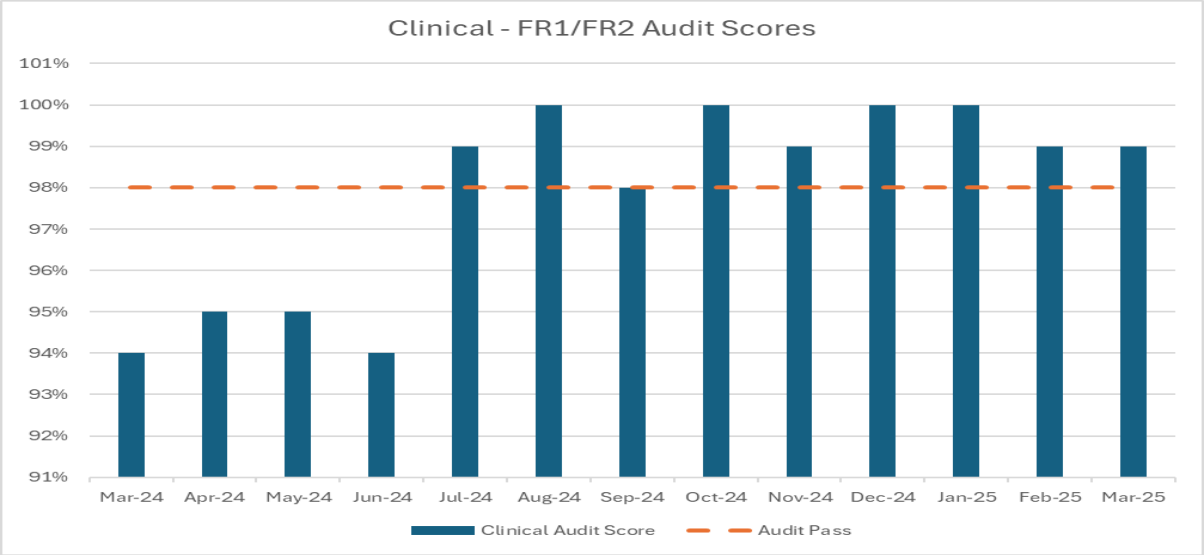
Monitoring of environmental cleaning standards (domestic and clinical) continues to be undertaken by the environmental monitoring team and Serco in Q4.

During this period, the EMT continue not to be operational at full capacity due to the vacant position of the clinical auditor and educator role within the team. The focus has remained to meet the requirements of the national cleaning standards with the levels of audits being consistent across all areas of the hospital. Ensuring star ratings are being updated and sitting at 5* across the entire trust.

The average score of Serco domestic audits per month is 99%. There have been improvements in the monthly pass percentage with the national target of 98%, being achieved during the months of January and March.

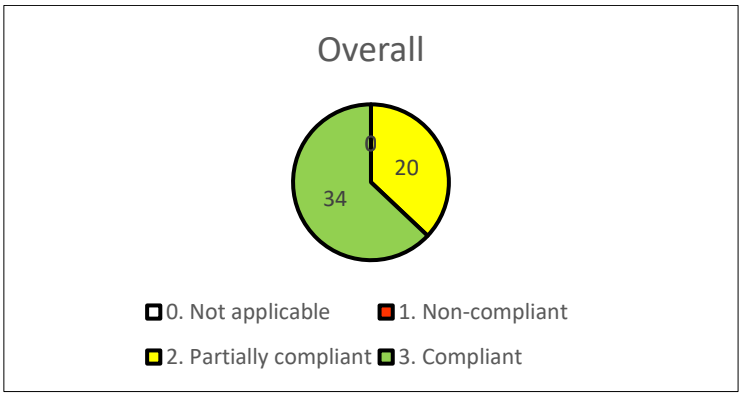


Clinical cleaning has seen an improvement with the average score sitting at 99% and clinical pass rates of 100% in January as well as 99% in February & March. This is a significant improvement from 12 months ago. The work completed by the clinical auditor & education lead prior to leaving has continues to demonstrate improvements in clinical cleaning across the site.



Infection Prevention and Control Board Assurance Framework (BAF)

The IP&C Board Assurance framework was updated by NHSE/I in September 2022 to enable a self-assessment of compliance with the new National Infection Prevention and Control Manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents, gaps in assurance and actions to mitigate/control risks. The UHS self-assessment against the 10 key lines of enquiry within the framework was reviewed and updated in Q2 2024/25 and presented to the Infection Prevention Committee. Gaps in assurance have resulted in a number of elements being assessed as partially compliant, with either mitigating actions in place or actions identified to meet assurance.



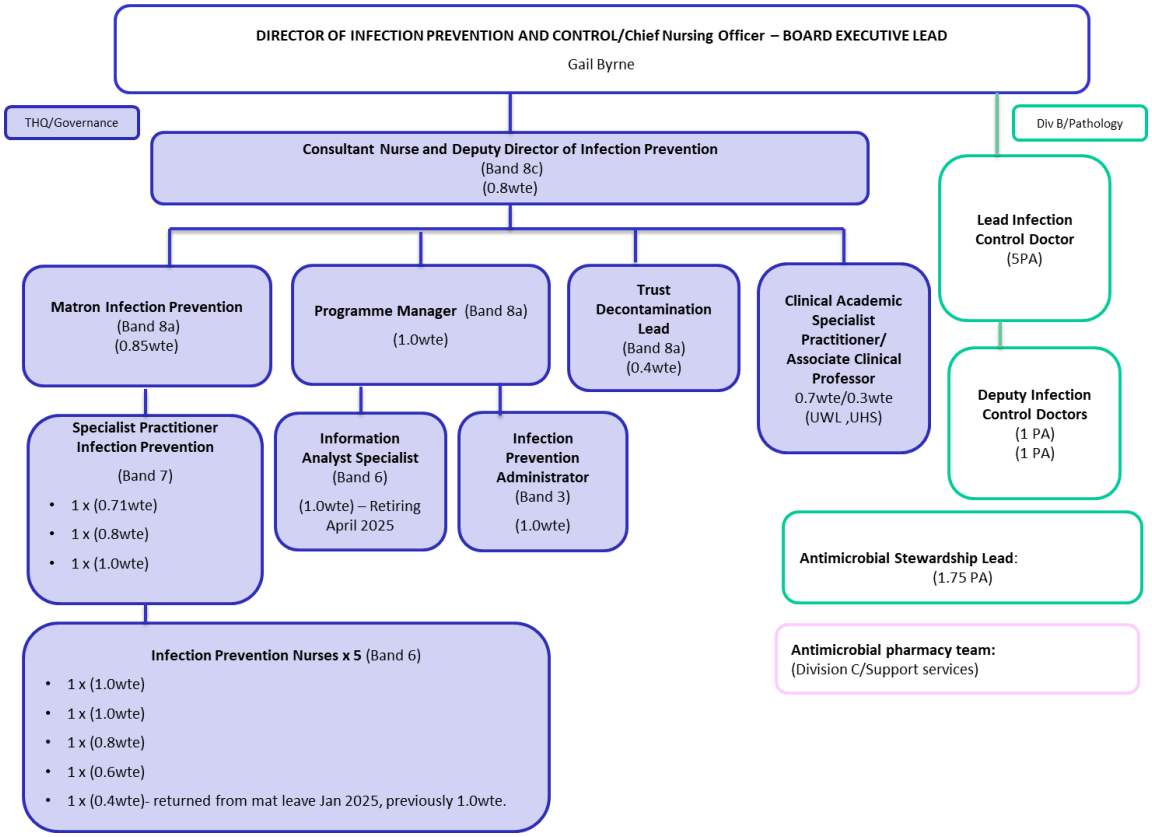
A further review will be undertaken in Q1 2025/26 following publication of an updated BAF by NHSE.

2.10 Antimicrobial Stewardship.

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

The UK 5-year national action plan (NAP) for antimicrobial resistance 2024 to 2029 sets a target to reduce overall human antibiotic use by 5% by 2029, using calendar year 2019 as the baseline. This equates to a 1% reduction per year. Appendix 1 provides a full report on antibiotic usage/consumption within UHS and performance against the NAP.

2.11 Infection Prevention Team/Service



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

The medical Consultant PA allocation shown in the green boxes in the right of the diagram represents the PA allocation for medical IPC work from 2019 to 2022. The current Lead Infection Control Doctor has only 2.7 PAs (rather than 5 PAs) in their job plan for this role and the total Consultant PA allocation for IPC work between the Lead Infection Control Doctor and the two Deputy Infection Control Doctors in Job plans is currently 5.0 PAs, rather than 7 PAs. This is below nationally recommended PA allocation and represents a challenge in the medium to long term in maintaining adequate medical input into the Trust's IPC service. 1.75 Consultant PAs for Antimicrobial Stewardship Lead is also below nationally recommended PA allocation for a Trust of this size.

A wide range of activities have been undertaken throughout the year focused on preventing and controlling infection and a programme of IP&C policy and guidance reviews remains in place to ensure that UHS policies are aligned with the National Infection Prevention & Control Manual for England (2022) and other relevant national guidance. The team have continued to support Divisions in the prevention and control of infection as well as providing expert advice/input into other services such as estates, cleaning, waste, procurement and supporting environmental sustainability projects.

2.12 Estates & the Built Environment

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

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

Concerns continue to be highlighted in relation to the existing environment in many areas of our hospital sites (e.g. lack of mechanical ventilation, limited toilet/bathroom facilities, limited isolation facilities (side rooms), general repair of ward/outpatient environments) and the impact on preventing & controlling infection. Reviews undertaken by the IPT and other walkabouts continue to highlight a wide range of issues associated with the general fabric/repair of the environment which can have an impact on the ability to effectively prevent and control infection e.g. damage to the fabric of the environment which can provide a reservoir for micro-organisms and cannot be cleaned effectively. Whilst some progress continues to be made in addressing some of these issues funding remains a limiting factor. Progress in 2024/25 includes improvements to the ward environment on ward D4 (as outlined in section 2.6), rectification measures to address mould in labour ward rooms, expansion/refurbishment of the Neonatal Unit.

Water Quality

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

The Trust Water Safety Group has continued to meet quarterly with a remit to:

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

A sub-group is also in place with the remit to focus on key operational topics at each meeting e.g. use of point of use filters, sampling.

The annual Water Safety Audit was undertaken by the Trust Appointed Authorising Engineer in August 2024 and an action plan developed to address findings and recommendations. This is being overseen and monitored by the Trust Water Safety Group. The Trust Water Safety Plan was reviewed at the November Water Safety Group and approved in January 2025.

Progress continues to be made in addressing Pseudomonas in our water systems (as demonstrated by a continued reduction in positive water samples) and in completing remedial works required to improve water hygiene. Where sample failures do occur, investigations are undertaken to identify potential cause, measures implemented to mitigate risk to patients and actions identified to address issues.

Multidisciplinary Water Action Groups (Pseudomonas) have been established for areas that have experienced multiple sample failures e.g. Piam Brown, D12, with the remit explore and identify measures to address the issues, including review of IP&C practices, such as sink cleaning, and engineering solutions related to the outlets. Enhanced focus through these groups is resulting in a reduction in positive water samples.

Pseudomonas Risk Assessments were undertaken in all augmented care areas in March 2025 with an action plan being developed to address findings/recommendations.

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. Good ventilation is an important line of defence for controlling transmission of infection which was highlighted further during the COVID-19 pandemic, where the association between transmission and outbreaks of respiratory virus infection, and poor ventilation in a range of settings (healthcare and non-healthcare) was clearly established. Focus on ventilation in the built environment may also further reduce the risk from many other healthcare associated infections such Norovirus, MRSA and multi-drug resistance organisms.

General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation. Many of the general inpatient wards within the SGH & PAH sites have no mechanical ventilation or do not meet the current standard for inpatient areas of 6 air changes per hour. Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

Ventilation remains on the estates risk register (Risk 489) and is identified as one of estates highest priorities for addressing. It continues to be included in the backlog maintenance replacement programme but requires funding. Long term solutions to improve/install mechanical ventilation in existing inpatient wards will require a large scale of work with potential disruption and significant investment. Long term solutions to install

ductwork will be scheduled in line with future ward refurbishment programmes and any newly built inpatient wards will be designed with mechanical ventilation.

Replacement of the existing air handling units (AHU's) which serve general west wing wards is scheduled for Spring 2025 with the intention to deliver 4 AHUs compliant in design to HTM03-01 capable of delivering compliant airflows to areas served.

The use of portable air purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks and in high-risk areas such as admission units have continued to be used to address the risk relating to poor/lack of ventilation.

3.0 Operational and financial impact of Healthcare Associated Infection

Outbreaks of infection e.g. Norovirus, Influenza, COVID-19 can result in significant impact on operational capability/capacity of the Trust resulting in cancellation of elective procedures and staff absence. The increased length of stay and treatment costs associated with healthcare associated infection e.g. C. difficile, *C.auris*, bloodstream infections, contributes further to decreased operational productivity. A recent study has estimated the total annual cost of healthcare associated infection in the UK to be 774 million pounds.

4.0 Appendices

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

Appendix 1 : Pharmacy Anti-infectives Team Report

March 2025: FY 2024/25 (note March 2025 admission figures tbc)

Introduction

Anti-Microbial Resistance (AMR) is an emerging crisis threatening health outcomes across all healthcare settings. The Health and Social Care Act 2008 outlines responsibilities for antimicrobial stewardship (AMS) activity to ensure appropriate antimicrobial use in order to optimise patient outcomes whilst reducing the risk of adverse events and antimicrobial resistance. AMS functions well when there is strong leadership across clinical specialities and when adequate resources are deployed to allow effective change to occur. At UHS oversight is provided by the antimicrobial stewardship team reporting via this medium to TEC. Whilst there are no set quality improvements linked to AMS in FY 24/25; the second UK government AMS policy paper National Action Plan (NAP) 'Confronting antimicrobial resistance' 2024 to 2029 was published in May 2024 which sets out targets relating to antimicrobial usage as well as the bigger picture to combat AMR which we are working towards meeting.

On average, 40% of inpatients at UHS are prescribed one or more antimicrobials. Current approaches to support better antimicrobial usage are being directly impacted by operational pressures and lack of time available for ward based clinical staff to focus on antimicrobial prescribing and review. As evidenced by the failure to change prescribing practice relating to switching from IV to oral antibiotics, failure to meet statutory obligations for monitoring of prescribing and lack of time available to update guidelines through engagement with clinical teams. The detrimental impact on guideline updates is added to by the need for clinical staff to conduct administrative tasks.

This report includes data shared with TEC in January 2025 and updates to overall antimicrobial usage and fluoroquinolone use.

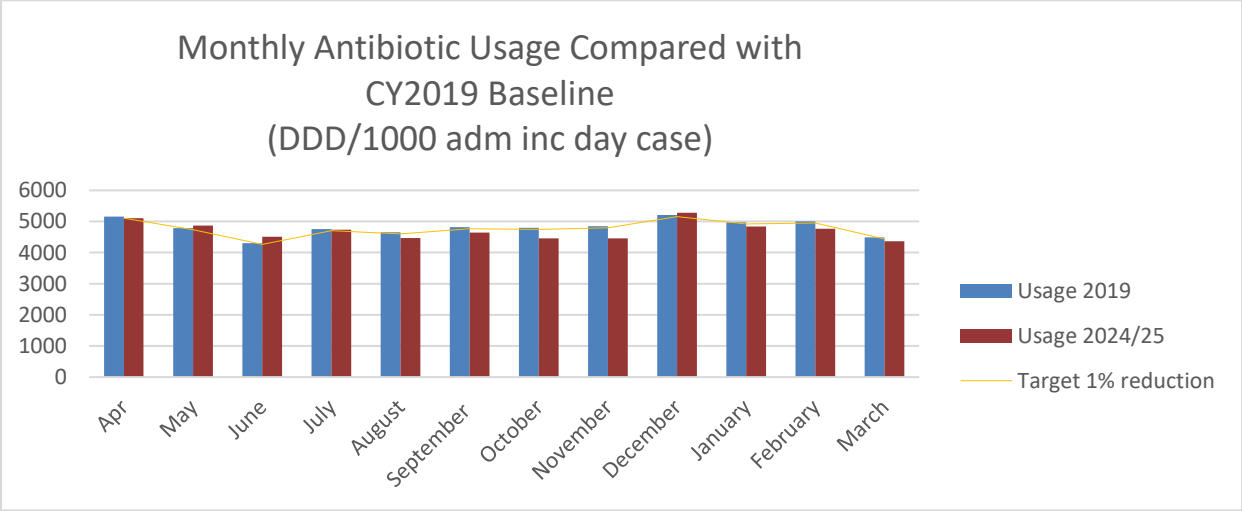
1. Reduction in Antibiotic Usage

a. Total Antibiotic Consumption Reduction (updated to Feb 2025)

The NAP sets a target to reduce overall human antibiotic use by 5% by 2029, using calendar year 2019 as the baseline. This equates to a 1% reduction per year.

The chart below compares total antibiotic use (adjusted for activity) between April 2024 and February 2025 with the 2019 baseline. The amber line represents the level of reduction required to remain on track with the NAP target. It is of note that the reduction target was met from August to November 2024, this improvement is likely to be linked to the increased presence of microbiologists working alongside pharmacists in some clinical areas, enabling more timely review and optimisation of antimicrobial therapy. We have achieved 1% reduction in antibiotic use in 2024/25 compared with CY 2019 baseline.

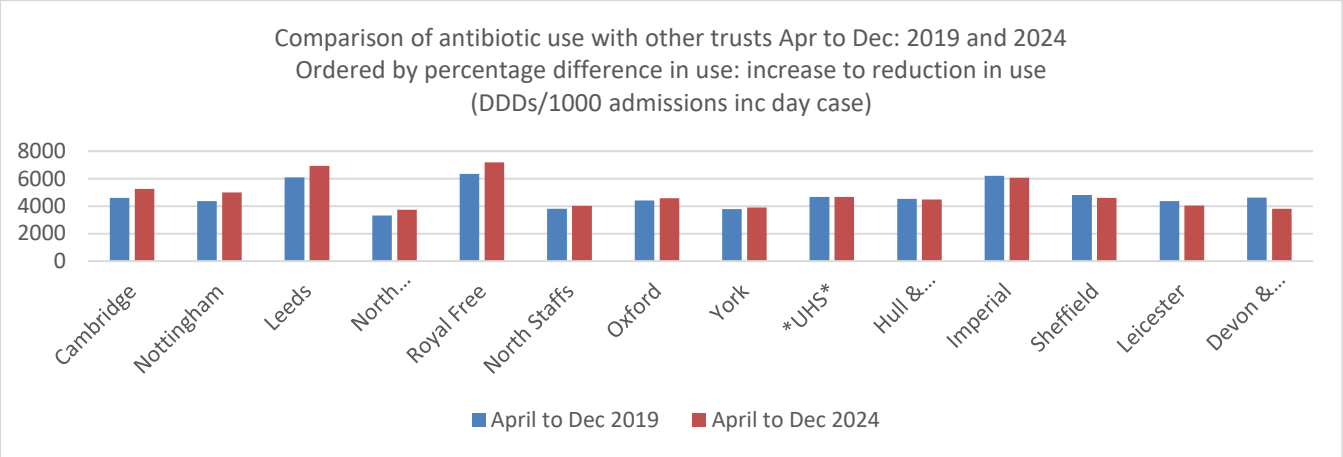
Please note that the charts on antimicrobial use are based on medication issues rather than prescriptions or administrations. This is currently the only available method for assessing inpatient and outpatient antimicrobial use.



Report - Define Reports

The following chart shows how UHS compares to other teaching trusts in overall antibiotic use and change since 2019 baseline, UHS has shown promising improvement since the last quarter, moving towards the right of this chart, indicating lower usage than 2019 when compared with other trusts. We await March admission figures to revise this graph for FY 2024/25.

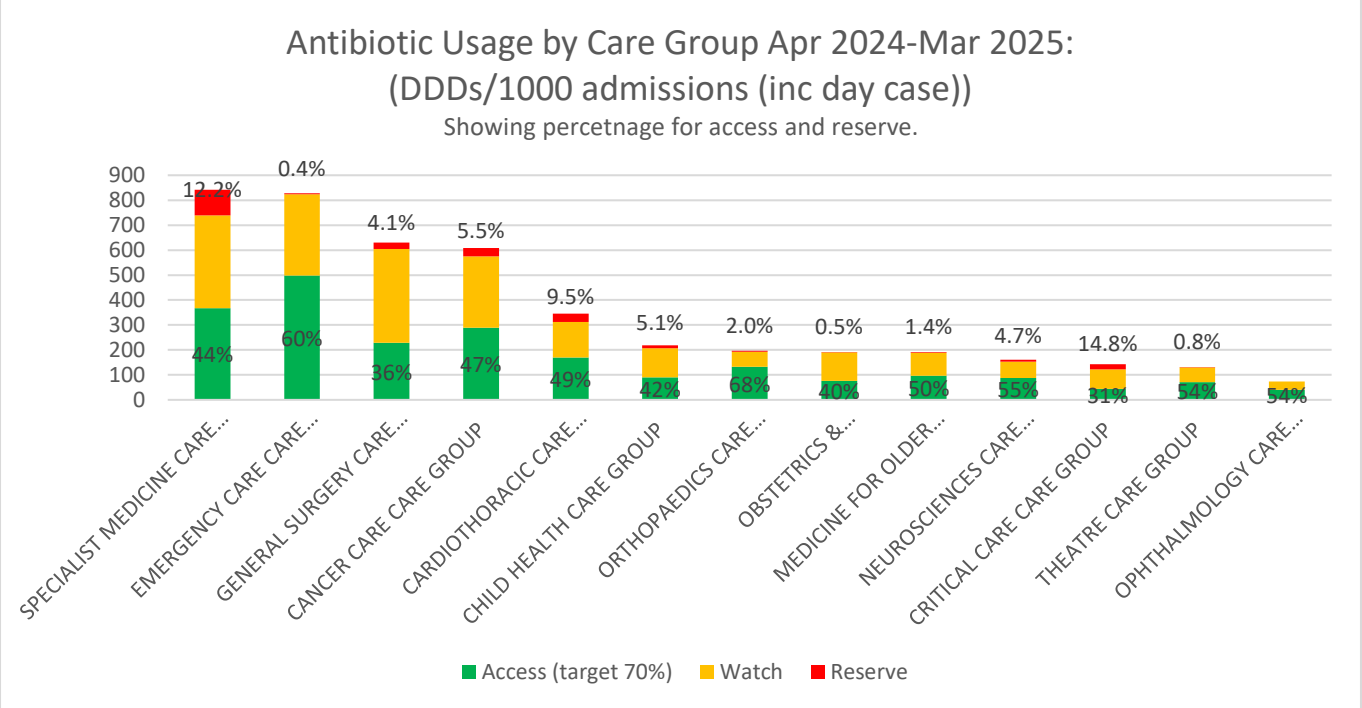
Ref: Internal reporting; source data from Ref: Define Reports



b. Type of Antibiotic Prescribed (up to Q3 2024/25)

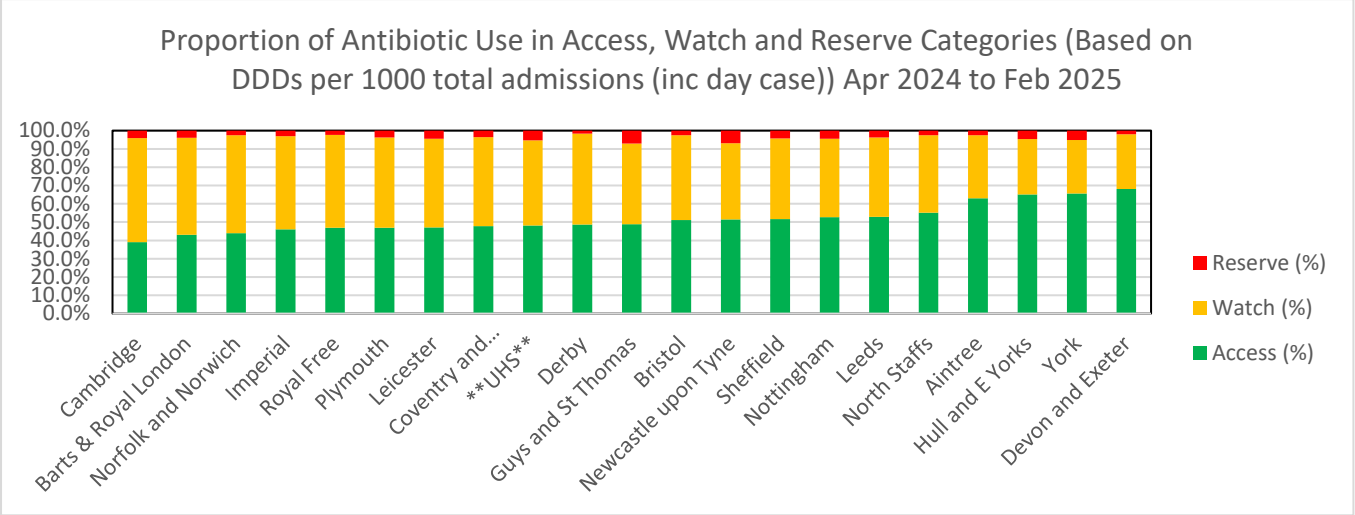
The NAP requires that the proportion of antibiotics from the Access category of the UK adapted WHO AWaRe antibiotic classification should increase to 70% of total human usage by 2029. In the AWaRe antibiotic classification system, antibiotics are classified into three groups: Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms and their use should be limited. Watch and Reserve antibiotics tend to carry a higher risk of *C. difficile* infection and causing AMR.

The chart below shows overall antibiotic use and the relative proportions of Access (green), Watch (amber), and Reserve (red) antibiotics by care group. In Specialist Medicine, 12.2% of antibiotic use falls into the Reserve category, largely reflecting prescribing for cystic fibrosis patients, where broader-spectrum agents are often necessary to manage resistant infections. The emergency medicine care group shows the second highest overall antibiotic use but includes medical outpatients and ED as well as medical wards but this area shows one of the highest proportions of access category use.



Ref: Report - Refine reports

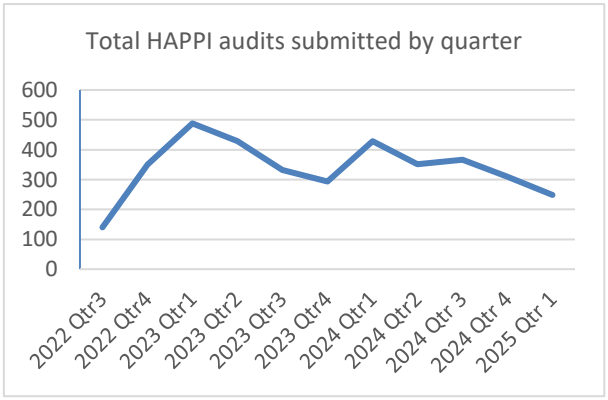
This chart compares the proportions of Access, Watch, and Reserve antibiotics prescribed at UHS with those at other teaching hospitals between April 2024 and February 2025. UHS has maintained an average Access antibiotic usage of 48%, which has remained relatively stable over the past 11 months. This places UHS as the 9th lowest Access user - close to the median - among 21 acute hospitals. Access usage across the group ranges from 40% to 68%, with little variation over the same period. We await March admission figures to update this graph.

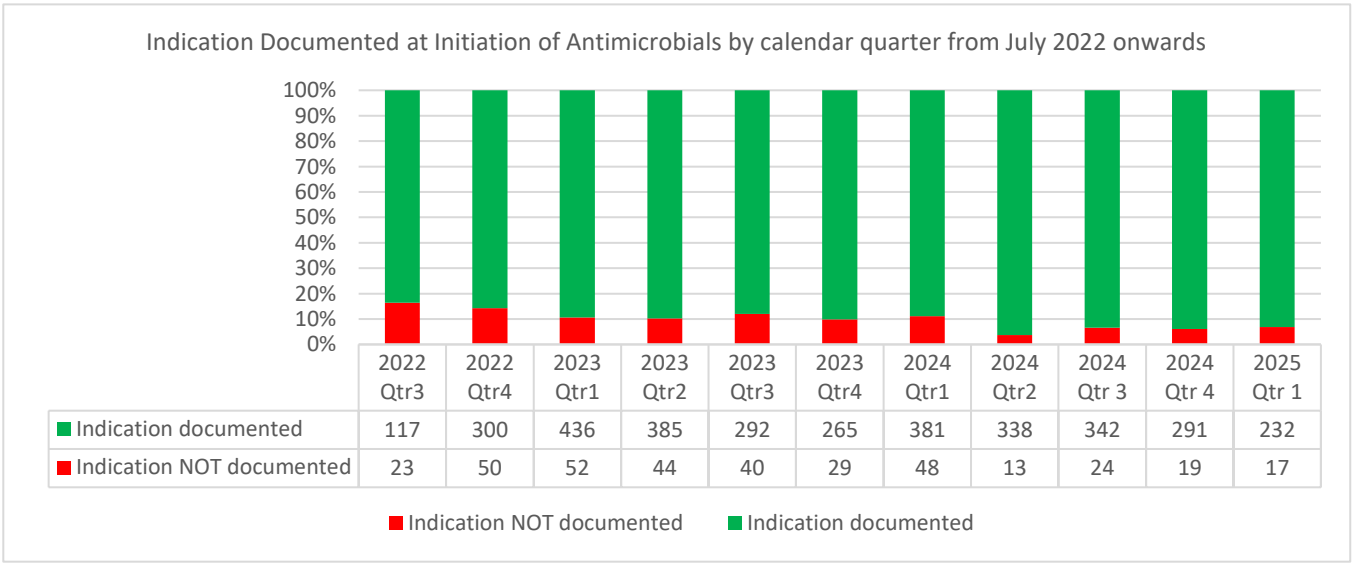


Ref: Report - Define Reports

c. Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) Audits

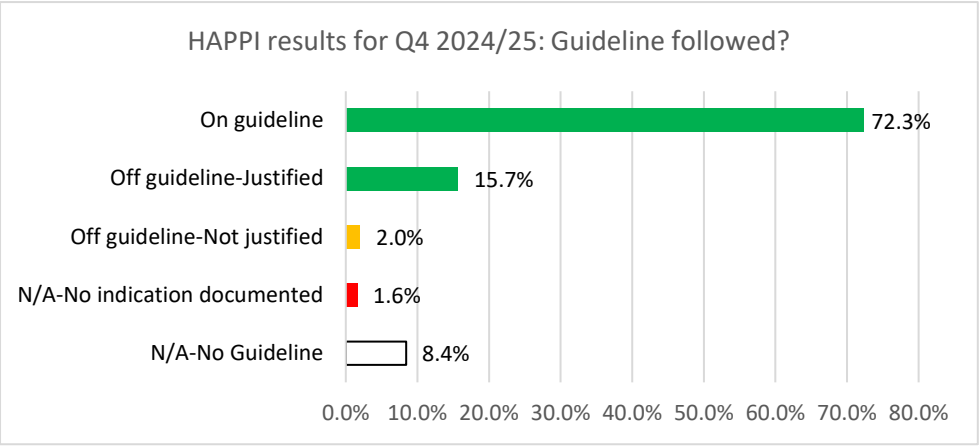
These are rolling audits of 5 patients per ward per month to assess appropriateness of antimicrobial prescribing: documentation and compliance with guidelines. These are reported on quarterly TEC reports, last shared in January 2025. Number of audits carried out per month continues to show a decline from 112 in Oct 2024 to an average of 83 a month for Q1 2025. Bed pressures and focus on discharge is diverting pharmacists from inpatient care and continues to impact on the number of audits completed.





	2022 Qtr3	2022 Qtr4	2023 Qtr1	2023 Qtr2	2023 Qtr3	2023 Qtr4	2024 Qtr1	2024 Qtr2	2024 Qtr 3	2024 Qtr 4	2025 Qtr 1
Indication documented	117	300	436	385	292	265	381	338	342	291	232
Indication NOT documented	23	50	52	44	40	29	48	13	24	19	17

Documenting the indication for an antibiotic is part of the national Start Smart then Focus antimicrobial stewardship toolkit. Data from Q4 2024/205 shows sustained improvement in documenting indication over Q3 2022 baseline.



The number of times guidelines were followed (or justifiably deviated from) remains at 88% of cases. Revision and updates to the antimicrobial guidelines in the Eolas system is an ongoing workstream, with significant administrative burden, currently undertaken by clinical pharmacists.

A further element of the Start Smart then Focus toolkit is a documented review of antimicrobial prescriptions at 48 to 72 hours. In Q4 2024/25 of 249 completed audits 114 were audited beyond 72 hours. Of these prescriptions 88% had a documented review, a fall from 93% in the previous quarter. The outcomes from the review are shown below and the documentation of decisions to continue unchanged are reassuring.

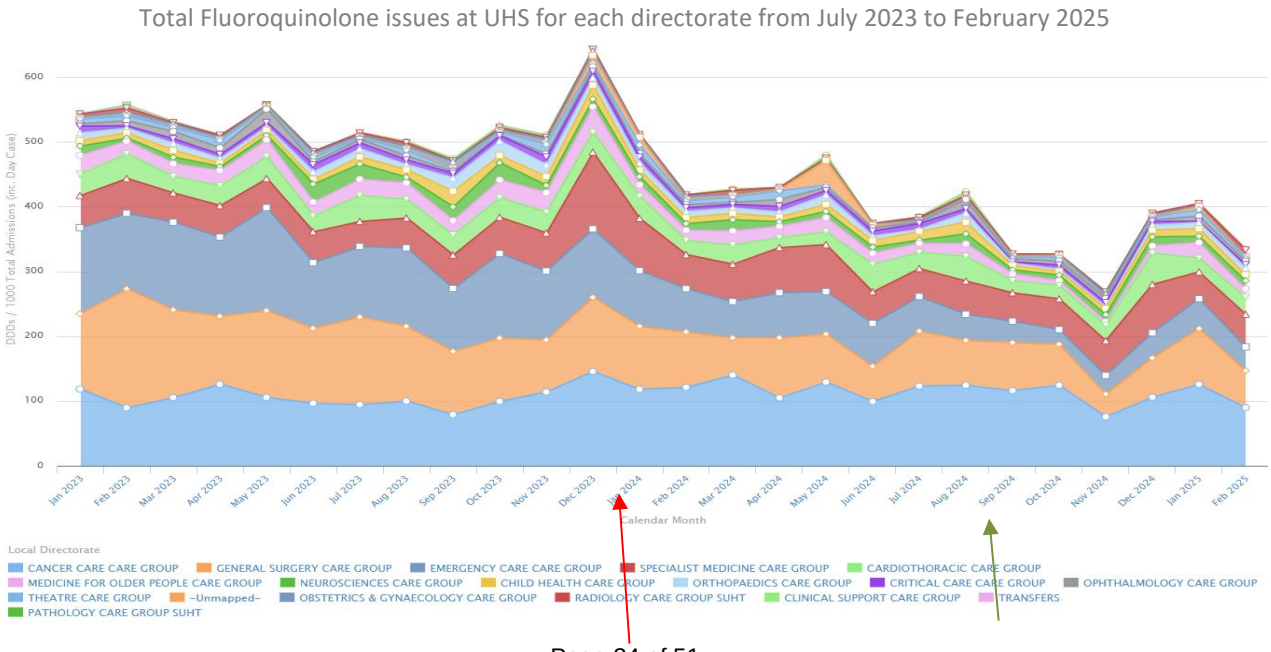
IV-Oral switch	Stop	Change drug to narrower spectrum	Change drug to broader spectrum	Continue unchanged
22	10	2	9	57

2 Stewardship Targets

2a. Reduction in Fluoroquinolone use (updated)

Following the updated MHRA alert in January 2024 mandating that this class of antibiotics (including ciprofloxacin, levofloxacin, moxifloxacin and delafloxacin) should only be prescribed when other commonly recommended antibiotics are inappropriate, work has been done to update guidelines and inform prescribers. Guideline updates to minimise fluoroquinolone use were published in August 2024. Overall use has reduced over the last 12 months. ED has shown sustained reduction in use.

Ensuring patients are counselled on the risks associated with fluoroquinolones remains an important focus due to local reported incidents of Achilles tendon rupture. A HIOW wide leaflet is being developed by the ICB AMS group which is being submitted for local adoption to replace the MHRA leaflet which is designed for healthcare professionals rather than patients.



Ref: Internal reporting; source data from Rx info(Refine)

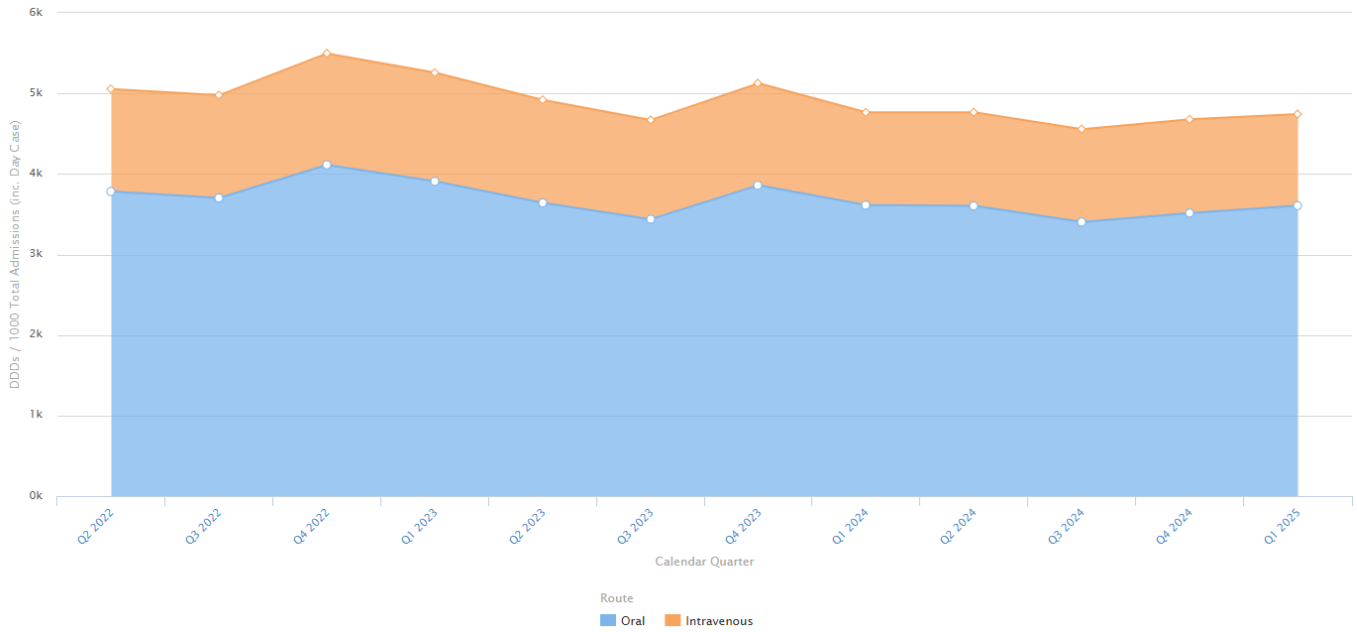
2b. Timely IV to Oral switch (up to Q3 2024/25)

Switching antibiotics from intravenous (IV) to oral offers several benefits, including reduced nursing time, shortened length of hospital stay, fewer healthcare-associated infections, and lower plastic waste. This initiative was a 2023–24 quality improvement CQUIN and remains a key focus moving forward. Estimates suggest that 20% of patients on IV antibiotics at UHS could be switched to oral therapy—potentially saving £250k–300k annually in drug costs and freeing nursing capacity equivalent to 15 WTE.

Despite executive leadership support, extensive communication, and regular discussions at care group and leadership meetings, practice has not changed in the past two years. However, one clinical area has shown improvement through weekly microbiologist-led ward rounds focused on IV-to-oral switching; demonstrating that targeted resources and oversight can yield results. A focused QI project is underway in the Medicines for Older Persons Directorate: engaging medical, nursing, and pharmacy teams to assess whether localised, multidisciplinary efforts can improve outcomes.

IVOS: Quarterly UHS proportion of intravenous to oral antibiotic use predating CQUIN to current time (Q2 2022 to Q1 2025 – Calendar Quarters)

Ref Rx info (Define)



Outpatient Parenteral Antimicrobial Therapy (OPAT) is currently underutilised: there continue to inpatients who are medically fit for discharge but remain in hospital beds due to the need for regular administration of intravenous antimicrobials. The transformation team are involved in remodelling the current service to maximise benefit for new investment.

Appendix 2 : Q4 Division A Matron and CGCL Report

Care Groups: Surgery, Critical Care, Ophthalmology and Theatres and Anaesthetics
Matrons: Kerry Rayner, Kate Stride, Jake Smokcum, Charlie Harding, Linda Monk, Tracy Richards, Mitzi Garcia, Raquel Domene Luque, Kirsty Turner, Simon Jacob, Claire Liddell, Jack Bowers and Jude Salas.
Clinical Lead: John Knight, Aris Konstantopoulos and Aby Jacob
Date of Report: April 2025
Author: Colette Perdrisat

Performance Quarter 4 – 1st January to 31st March 2025

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	0	Trust Limit 0	Trust Total 1 (HOHA +COHA)
Clostridium difficile diarrhoea	4	Trust Limit 27	Trust Total 32 (HOHA + COHA)
E. coli (HOHA)	3	Trust Limit of 36	Trust Total 46 (HOHA + COHA)
Pseudomonas (HOHA)	0	Trust Limit of 6	Trust Total 8 (HOHA + COHA)
Klebsiella (HOHA)	6	Trust Limit of 15	Trust Total 18 (HOHA + COHA)
MSSA Bacteraemia	1	No Limit	Trust Total 19
GRE	1	No Limit	Trust Total 1

Incidents / Outbreaks of Infection and PIIs	
None	

Performance Year to Date: 1st April 2024 – 31st March 2025

Key Indicator	Division A	Limit	Trust Status
MRSA Bacteraemia	0	Trust Limit 0	Trust Total 5 (HOHA +COHA)
Clostridium difficile diarrhoea	9	Trust Limit 99	Trust Total 120 (HOHA + COHA)
E. coli (HOHA)	24	Trust Limit of 141	Trust Total 200 (HOHA + COHA)
Pseudomonas (HOHA)	5	Trust Limit of 22	Trust Total 36 (HOHA + COHA)
Klebsiella (HOHA)	22	Trust Limit of 56	Trust Total 81 (HOHA + COHA)
MSSA Bacteraemia	4	No Limit	Trust Total 53
GRE	2	No Limit	Trust Total 10

Key Learning from Investigation of Infections and Deaths:

GICU – CDiff 4 cases in Q4 - x1 in January – 1 unclean commode, 1 commode clean but not labelled; x2 February – commodes not labelled as clean; x1 March 1 unclean commode, missing documentation in integrated care pathway, some missing rationale why antibiotics were continuing. Learning: information cascaded via email, newsletter and face to face discussions on unit, new prompt added to task section on CIS to complete integrated care pathway if patient develops CDiff.

CICU – MRSA x1 (December but review occurred in January). Appropriate risk reduction washes were not prescribed (i.e. Octenisan rather than chlorhexidine 4%). The isolation risk assessment form was not updated to reflect change in infectious status (i.e. MRSA not recorded only VRE). Missing PPE whilst in the isolation room. Learning: information cascaded via email, IP newsletter, face to face education on the unit and spot checks continue to ensure/ educate necessity for MRSA risk reduction measures, to check isolation risk alerts as part of the daily safety checks.

All key learning is shared via email and in local IP newsletters and MSD across critical care.

Progress and Success:

Surgery

Candida Auris for one medical patient hosted on F6, patient isolated as soon as identified, shared learning for Medicine and Surgery in relation to checking of CPI alerts on admission and prior to transfer of patients. No onward transmission and managed as per guidelines.

C-Diff cases within surgery, isolated at point of symptoms, no onward transmission to other patients.

Critical Care

Environmental monitoring team audits across critical care 99% -100% in quarter 4.

IP audits – sharps, isolation and surgical site infection audits 100% across critical care; VAP 100% in CICU, GICU, PPE and cleaning/decontamination audit 97-100% in GICU, CICU, NICU and SHDU,

Covert hand hygiene audits by IPT 100% in NICU (up from 80% in Q2).

Waste audits – ongoing support from the waste management team to encourage correct waste segregation to come off high incineration. Huge improvement in audit results seen across the care group, continuous education and surveillance. Staff engagement and attendance/ booked onto the waste ambassador course to assist with improvement plans.

Invasive devices review by IPT – focus on peripheral cannulas. 100% in CICU and SHDU, 1 missing record in GICU 4/5. Information cascaded and spot checks continue to ensure records are maintained as they should be.

Ophthalmology:

- All areas are working through the accreditation framework to ensure high standards.
- Improved Cleaning Standards audit results across the Unit.

Full Accreditation

Ward	2024 2025 %	Ward	2024 2025 %	Ward	2024 2025 %
ESSU	**100**	Eye OPD	**99**	Eye Unit Theatres	**100**
Medial Retinal Suite	**99**				

Partial Accreditation

Ward	2024 2025 %	Comment
Eye Casualty	**91**	Audits not meeting expected audit/practice standards. • Hand hygiene audit May 2024 – 80% • Hand hygiene audit November 2024 – 65% • Hand hygiene facilities audit April 2024 – 89% • PPE audit September 2024 – 94% • PPE audit March 2025 – 94% • Standard precautions audit October 2024 – 86%

Ongoing Challenges:

Surgery

Side room capacity remains a challenge for surgery. This leads at times to delays in patients coming up from ED and step downs from Critical care. Good processes are in place to review patients in side rooms with collaboration with infection prevention.
Recent matrons walkabout on F5 was not positive, commode clean was an issue, alongside receptacles not being cleared in a timely manner. Feedback and action plans put in place immediately. Surgical matrons to continue to do their own walkabout in relation to these issues.
Hand hygiene audits – 3 wards were below the trust target. All areas have completed an action plan and will be reaudited. To note however the median result for surgery care group is above trust target, but still need to strive for higher.

Critical Care

Covert hand hygiene audits by IPT CICU 55% (down from previous 60%) RN and Drs missed before and after patient contact; SHDU 75% (up from 70%) Physio, RN and Drs missed before and after patient contact and after contact with patient surroundings; GICU 80% (up from 50%) Dr and RN missed after patient contact and contact with patient surroundings.

Local hand hygiene audits variable in GICU and CICU with ongoing surveillance and reminders of key moments of when to decontaminate hands.
NICU VAP audit 90% (RASS score documentation) cleaning/decontamination audit 90%. (reaudit next quarter)
Invasive devices review by IPT – focus on peripheral cannulas. Missing VIP documentation in NICU 5/5 – information cascaded, and spot checks carried out by IP links.
Ongoing reminders to ensure commodes are cleaned after use and labelled in GICU.
Ongoing reports of beds and mattresses arriving unclean from the wards, CC staff are cleaning and reporting and tele-tracking mattresses to be exchanged for others regularly, particularly in SHDU. Some beds have missed on arrival with the portering team and have been identified as unclean by IP link spot checks and the EMT during their audits
Some evidence of incorrect waste segregation, however it is in fewer bags and only 1 unit (different unit) at each time within the last month. Ongoing education, emails and education to remind staff of correct process.

Fit testing continues sporadically across critical care, when staffing acuity allows for staff to leave to get fit testing with the regular fit testers across the care group. Approx. 56% of nursing staff (band 2-8) are fit tested to 2 masks as per Trust requirement, 21% fit tested to 1 mask, 23% of nursing staff have not been fit tested within the last 2 years as per Trust requirements.

Ophthalmology

Increase in Endophthalmitis Cases- 2 cases in February: Learning has been shared and discussed in Governance and monthly meetings.

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

Critical Care

HCID emergency box GICU storeroom – still awaiting delivery of fluid repellent gowns, although C5 and ED do have a supply if required. Information updated as required.

Continuing to focus on correct waste segregation and hand hygiene across all areas and improvements in other IP audits, whilst highlighting actions/ lessons learnt following post infection reviews and based on audit results. Continuing to encourage AERs to be written for any dirty beds/ mattresses arriving from other ward areas.

Critical Care IP link sister support the care group, completing observations of practice, surveillance to ensure staff are following policy and providing assurance that infection prevention practices are adhered to. Information is cascaded via newsletter, emails and one to one education whilst in the clinical areas.

Ophthalmology

Close monitoring of Endophthalmitis cases.

Endophthalmitis Outbreak Management SOP under development.

Effective communication between Theatres and Ward teams during patient IPC alert handovers

Quarterly IPC Meetings: Positive Feedback

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

None

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
April 2025	April 2025

Appendix 3: Q4 Division B Matron and CGCL Report

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

Matrons: Steph Churchill, Julia Tonks, Susie Clake, Matthew Payne, Claire Smith, Emma Chalmers,, Sandra Souto, Carole Spratt, George Kirk, Steve Hicks, Gillian Lambert, Nat Kinnaird, Samantha Brownsea and Kat Black

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

Date of Report: April 2025

Author: Suzy Pike

Performance Quarter 4 – 1st January to 31st March 2025

Key Indicator	Division B	Limit	Trust Status
MRSA Bacteraemia	**1**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**12**	**Trust Limit 27**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**6**	**Trust Limit of 36**	**Trust Total 46** (HOHA + COHA)
Pseudomonas (HOHA)	**0**	**Trust Limit of 6**	**Trust Total 8** (HOHA + COHA)
Klebsiella (HOHA)	**6**	**Trust Limit of 15**	**Trust Total 18** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	**Trust Total 19**
GRE	**0**	**No Limit**	**Trust Total 1**

Incidents / Outbreaks of Infection and PIIs	
Scabies in G6	Scabies patient in Red Bay on G6 admitted 12/02/2025 and diagnosed 19/02/2025 (delay of 7 Days). Patient had also been seen by dieticians and had ECG on G8. 7 patient contacts identified and prescribed prophylaxis treatment of Permethrin cream. Occupational health identifying staff contacts. Learning: Prompt action required to identify causes of skin rash and appropriate action taken.
CPE positive patient on MAOS	CPE and VRE positive patient with alert on system placed in B bay of MAOS with other patients. 4 contacts identified and alerted as CPE contacts. Learning: Alert not acknowledged. - Measures put in place by ward manager to ensure alerts are checked on multiple levels and not just once.
MRSA PII on Bassett Ward	MRSA period of increase incident on Bassett ward. 2 cases of healthcare associated MRSA with 28 days. Learning: Not using actichlor in source of isolation

	Not including urine samples / wounds for patients when screening for MRSA Missed hand hygiene opportunities MRSA risk assessment for known MRSA positive patients were not completed MRSA screening missed on long stay patient Some staff wearing gloves for all patient contact Staff sitting on patient beds.
Patient with C. auris positive on AMU & F6	Patient with C. auris positive alert not isolated on AMU or on F6 resulting in 6 contacts. Learning: CPI alert not checked on admission to SDEC, AMU, by bed manager/flow co-ordinators or by F6 when accepting the patient.
Measles patient on Paeds ED/PSSU	Patient not isolated in Paeds ED / PSSU and has confirmed positive for Measles. Learning: Staff in CED wearing FFP3 masks but not eye protection. 12 contacts identified and sent warn and inform letters.

Performance Year to Date: 1st April 2024 – 31st March 2025

Key Indicator	Division B	Limit	Trust Status
MRSA Bacteraemia	**2**	**Trust Limit 0**	**Trust Total 5** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**43**	**Trust Limit 99**	**Trust Total 120** (HOHA + COHA)
E. coli (HOHA)	**35**	**Trust Limit of 141**	**Trust Total 200** (HOHA + COHA)
Pseudomonas (HOHA)	**7**	**Trust Limit of 22**	**Trust Total 36** (HOHA + COHA)
Klebsiella (HOHA)	**18**	**Trust Limit of 56**	**Trust Total 81** (HOHA + COHA)
MSSA Bacteraemia	**8**	**No Limit**	**Trust Total 53**
GRE	**5**	**No Limit**	**Trust Total 10**

Key Learning from Investigation of Infections and Deaths:

Medicine and MOP:

G6 commended for practice on review, learning was early identification of skin rash, and prompt contact tracing. Bassett outbreak learning was improvement in hand hygiene and revision of MRSA policy. Staff acknowledged their knowledge of MRSA had decreased with the focus being on respiratory and gastro viruses.

Spec Med: Nil to note.

ED: CED reminded of importance of screening for foreign travel and isolating appropriately following measles patient. All staff aware of correct PPE to ensure staff contacts are minimal.

AMU: SDEC, AMU flow team and admin team reminded of importance to action any alerts and isolate promptly.

Cancer care: improved process for checking CPI Alerts on AOS needs enhancing.

Progress and Success:

Medicine and MOP:
CDiff reviews recently have not needed action plans, but hand hygiene before patient contact and food were themes, we picked up.
Consistent sharing of IPC reports and guidance within the medicine and MOP governance structures.
Ward leaders have asked if actions can be divided nursing/Therapy /clinical, so action plans are created by those leads and shared with and actioned by the relevant staff.
Managing multiple infections, combined with need to isolate patients due to behaviour has been done well.

Spec Med:
Some areas on non-submission remain with SNAP audits- to discuss at 1:1s.
Audit programme circulated for this coming year.
Of submitting areas, 100% scored on PPE audit, 100% on cleaning audits.
Ongoing review of PPE requirements with some surgical procedures in Derm- discussions with IPT for consideration if sterile gloves are required for ALL surgical procedures.

ED:
2nd suspected measles in CED isolated promptly and PPE warn.
Adults' early identification of possible infections, (Mpox and measles) isolated on arrival and correct PPE warn.
Working with infection prevention team to improve hand hygiene compliance, joint audits to understand challenges.

AMU- All air filters now working in AMU 3.
Hand Hygiene audits continue to improve.
Monthly meeting with IPT to support any ongoing issues.

Cancer care: emergency phone practitioners requested to check and flag any CPI Alerts to add an additional checking step.

Ongoing Challenges:

Medicine
Ongoing issues across medicine of Actichlor not being used, staff not being aware of when it needs to be used and not knowing within their areas how to access it. Infection prevention has sent information that has been shared with all areas, IP are discussing this on their walkarounds, and the matron team are also discussing on their walkarounds.
Hand Hygiene compliance remains below trust standards, and continued focus and oversight by matrons to enhance compliance.

Spec Med: Nil challenges to note.

ED:
Sustained compliance with hand hygiene remains a challenge, regular internal and external audits, new posters and elements added to every teaching opportunity to support this.
Challenges continue with isolation due to high MH attendances and low number of SR in ED, where possible patients are isolated or cohorted together. Increased gastro POCT during norovirus peaks to support symptomatic patients needing admission.

AMU:
Visiting teams non-compliance with correct PPE and hand hygiene processes.
Isolation of infections delayed due to limited cubicle capacity and flow out of AMU.

Cancer care: improvements needed following matron walkabouts focusing on IP (meeting held on 2/5 to discuss and put actions in place)
Improvements in HH results needed. AOS met with Gail Byrne and infection prevention to discuss and provide assurance of steps being taken to improve

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

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

Spec Med: Feedback from local audits non submissions and clarification/removal from audit schedule if not appropriate. To ensure all areas are included in audit schedule where required.

ED: Continued hand hygiene focus, improved audit results but still variable and not sustained.

Cancer care: HH action plan to be shared and agreed with Band 7's.
Mask requirements in cancer care reviewed and changed in majority of areas during low prevalence period.

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

Challenges with replacing mouldy ceiling tiles in corridors ref 477608.

Cancer care : capacity risk on register which includes side rooms score increased due to frequency of issues, potential impact and risk assessments being made to try and manage lack of side rooms.

Estates work needed on D12, C4, C2 and AOS. Need support of division as unable to reduce side room capacity within the care group to complete the work so will need alternative side room support.

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
April 2025	April 2025

Appendix 4: Q4 Division C Matron and CGCL Report

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

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

Clinical Lead: Balamurugan Thyagarajan and Charlie Keys

Date of Report: April 2025

Author: Louisa Green, Emma Northover

Performance Quarter 4 – 1st January to 31st March 2025

Key Indicator	Division C	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**1**	**Trust Limit 27**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**2**	**Trust Limit of 36**	**Trust Total 46** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 6**	**Trust Total 8** (HOHA + COHA)
Klebsiella (HOHA)	**0**	**Trust Limit of 15**	**Trust Total 18** (HOHA + COHA)
MSSA Bacteraemia	**5**	**No Limit**	**Trust Total 19**
GRE	**0**	**No Limit**	**Trust Total 1**

Incidents / Outbreaks of Infection and PIIs	
Gastroenteritis on E1	An increase in viral gastroenteritis and secondary spread was linked to several issues: non-cleanable toys and unassessed children using the playroom, poor kitchen hygiene with crockery and cutlery, missed evening cleans in nursery and high care rooms, and inability to isolate infected patients. A matron's walkabout also identified unclean shared equipment. Immediate improvements in infection control and cleaning practices are required.
Mould in Ventilation on G3	Eight roof-mounted mechanical ventilation heat recovery units were found with water ingress and mould in the filters. The units lacked secondary weatherproof shelters, allowing water entry and creating a risk to air quality. Installation of proper protection is required to prevent future issues.
C.difficile PII on Piam Brown	Three healthcare-associated *C. difficile* cases were reported over 28 days on Piam Brown ward. Key issues included poor storage practices, missed stool chart updates, inadequate cleaning due to lack of supplies, unsafe handling of specimens, and non-compliance with infection control measures. Immediate action is needed to improve environmental hygiene, equipment availability, and staff practice.

Performance Year to Date: 1st April 2024 – 31st March 2025

Key Indicator	Division C	Limit	Trust Status
MRSA Bacteraemia	**2**	**Trust Limit 0**	**Trust Total 5** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**8**	**Trust Limit 99**	**Trust Total 120** (HOHA + COHA)
E. coli (HOHA)	**10**	**Trust Limit of 141**	**Trust Total 200** (HOHA + COHA)
Pseudomonas (HOHA)	**8**	**Trust Limit of 22**	**Trust Total 36** (HOHA + COHA)
Klebsiella (HOHA)	**10**	**Trust Limit of 56**	**Trust Total 81** (HOHA + COHA)
MSSA Bacteraemia	**10**	**No Limit**	**Trust Total 53**
GRE	**0**	**No Limit**	**Trust Total 10**

Key Learning from Investigation of Infections and Deaths:

Gastroenteritis on E1 – Non-cleanable toys were removed from the playroom, and tighter access controls were implemented. Enhanced cleaning routines were introduced across high-risk areas, including the nursery and high care rooms, with daily checks and deeper cleans.

Parents were informed about limiting contact between their children and others, and kitchen hygiene standards were reinforced with mandatory dishwasher use. New glove and apron dispensers were installed to ensure proper PPE use, and a patient isolation prioritisation system was introduced.

Regular IPC audits and matron-led spot checks will ensure these measures are consistently followed, aiming to reduce infection risks and maintain high standards of care.

Neonates

Between June 14, 2024, and October 3, 2024, there was an increase in the number of cases of blood in stool on the unit, with a total of 17 reported cases. However, from October 4, 2024, to March 17, 2025, only two cases were identified, prompting a noticeable decrease in the frequency of these occurrences. While the situation continues to be monitored, it has not yet been deemed necessary to investigate further at this time.

Progress and Success:

Child Health

All staff passed the hand hygiene audit, with no failures related to not being bare below the elbow. This followed a targeted drive, including emails reminding staff to remove watches.

Most wards received positive feedback during infection control matrons' walkabouts. Areas facing challenges, such as commodes, dirty linen on the floor, and incorrect food storage in fridges, are developing action plans to address these issues.

A patient admitted to C5 for 3 days tested positive for measles. The C5 trolley was equipped and used, and teams collaborated to ensure staffing coverage for all shifts. This highlighted additional kit and equipment are necessary to ensure all aspects of patient care (personal

hygiene, nutrition, basic paediatrics medication) are covered. A comprehensive list should be created to support preparedness for such cases.

PICU

Since June 2024, cleaning audit scores on PICU have consistently remained between 97-100%, reflecting a strong commitment to maintaining high standards and individualised bedside cleaning. The Mask Fit Testing process has made significant progress with the support of the Mask Fit Testing Hub and Ian Peach. So far, 133 staff members have been tested, with 65 staff members fitted to two masks. Continued collaboration with GICU's IP Sister and Link Nurses has been key in ensuring success, and additional Portacount training days are planned to further improve compliance.

Bi-monthly Statutory and Mandatory training has been running effectively, providing regular education and updates on key areas like hand hygiene and practical training. Recent training sessions have also focused on VAP prevention and oral hygiene. VAP education posters have been installed on PICU, and improvements have been made to Metavision documentation, including updates to assessment forms and the addition of a VAP bundle checklist. These changes, alongside closer collaboration with the IP team, have led to better bed elevation and improved mouthcare practices.

Additionally, the Infection Control section of the Initial Assessment on Metavision has been updated, helping staff better adhere to guidelines on Octenisan and Mupirocin administration, particularly for surgical patients. These ongoing efforts are making a tangible impact on both compliance and patient care.

Neonates

In February 2025, the unit achieved a 95% score in the Trust's hand hygiene audit, a significant improvement from the previous year's 60%. Following discussions with the IP team and the neonatal senior leadership team, isolation practices were reviewed and adjusted to align more closely with the rest of the trust, while also making them more family friendly. The unit is working towards implementing a Neonatal Isolation Quick Reference Guide.

Medical induction ANTT (Aseptic Non-Touch Technique) training was successfully completed by the education and infection prevention link teams, and all new medical team members are now signed off as ANTT compliant. Additionally, one of the ANNPs has joined the infection prevention team as a representative for the medical team, and an extra team member has completed the waste management ambassador course to help improve waste compliance on the unit.

Collaborations with the leadership team have ensured that the new NICU room layouts meet infection control standards, while work is also underway on streamlining TPN administration guidelines with Child Health. The neonatal suction guideline is currently under review.

Unit audits continue to show strong compliance with infection prevention practices, and regular infection prevention updates are sent via email to remind the neonatal team of key points to reduce infection risks.

Women's Health

PAH Outpatient Services consistently maintained high environmental cleaning standards across various departments, including EPU/GAU, Pre-assessment/Outpatients, Urodynamics/Physio, and Colposcopy/Hysteroscopy, with a collective rating of 98.5% (Serco: 98%, Clinical: 100%). Infection prevention standards remained effective, and staff continued to comply with practices.

In Theatres, Recovery, and DSU, environmental cleaning compliance remained exemplary, with all areas receiving a 5-star rating. Similarly, Bramshaw achieved 100% in hand hygiene and infection prevention audits. Despite these successes, ongoing estates work in Bramshaw has raised concerns about increased dust levels, prompting continuous monitoring of infection risks due to the environmental challenges.

Maternity

Work is being done to try to improve cleaning records by introducing a QR code system.

Remedial works to improve mould around windows are progressing well and continues.

Clinical Support

Clinical cleaning scores are high, with an overall score of 98% and 100% for clinical cleaning, maintaining a 5-star rating.

Accreditation is being met in gym areas and therapy services are up-to-date with risk assessments.

Hand hygiene scores are strong, with B level achieving 100% accreditation and other gyms scoring well.

There is full compliance with PPE and sharps handling in certain areas, including G level therapies and the Physio B level Gym.

On-call respiratory physiotherapists are compliant with suctioning competency requirements.

Ongoing Challenges:

Child Health

Hand hygiene audits across multiple wards showed failures due to staff not washing hands at key moments, including nurses, doctors, and allied health professionals. Action plans are being developed, and the B7 team will explore additional support to improve compliance and patient safety.
The high demand for cubicles in Child Health is being managed through individual risk assessments, ensuring that patients are allocated appropriate spaces based on their specific needs.

PICU

Since June 2024, PPE education has focused on improving mask and eye protection use on PICU. A PPE chart, reviewed by the IP team, has been introduced to enhance compliance. However, the December 2024 CVC insertion audit showed 0% compliance due to challenges with eye protection during line insertions. Discussions with the Consultant team and IP team are ongoing, and a future MDT meeting is planned to address these issues.

Estates and IPT are aware of ongoing leaks in several areas, including near bed 15 and the sluice room, with repairs pending. VAP audit scores recently hit 60%, and focused education on oral hygiene, teeth cleaning, and cuff pressure monitoring continues, alongside bedside teaching and support from the education team. Statutory and Mandatory training emphasizes VAP prevention and oral hygiene, while continuous cuff pressure monitoring is being integrated into practice.

A hand hygiene education drive is in progress due to missed opportunities in audits, with a 60% score in a recent IP covert audit. Light box exercises, feedback, and an emphasis on Bare Below Elbows are part of the action plan. Documentation challenges persist, particularly with the isolation risk assessment, but updates to forms and training are helping improve completion rates.

Neonates

The unit is currently undergoing construction, but efforts are being made to minimise disruption and maintain cleanliness. The existing apron dispensers are not developmental care-friendly, and while an alternative was trialled, it was not successful. Hydration station boxes are in the communal space of the nursery but lack lids, and there is limited space for a larger box.

The unit's fluid waste disposal point in the sluice is out of action, so a toilet at the far end of the unit has been isolated for the disposal of contaminated water. Efforts are underway to re-locate incubator decontamination and recommission the fluid disposal unit in the sluice. Additionally, Woodlands Ward has no sluice and is sharing one with Broadlands Ward.

Staff shortages are creating challenges, increasing workload and pressure on staff, which makes it harder to maintain compliance with infection control practices.

Women's Health

No new challenges but to note on going estates work is expected on Bramshaw into May requiring extra cleaning enhancements.

Maternity

Our Maternity Day Assessment Unit has noted an increase in caesarean section wound infections. An audit is currently underway, led by a consultant, to review the cases and identify any required actions or learning. Maternity will liaise with general surgical teams in UHS for advice and education.

With the increase in winter viruses, it was identified that not all staff were compliant with their two-yearly fit mask test. The Education team is supporting fit testing, but challenges remain due to time and equipment requirements. Staff have been encouraged to book tests via the central hub, though availability is limited. The Senior Leadership Team is in discussions to explore in-house testing solutions and tackle this with a PAH collaboration strategy between Neonates, Maternity and Women's Health.

The Princess Anne Hospital's window replacement scheme left some windows, particularly in Broadlands Birth Centre and Labour Ward, unresolved, leading to ongoing issues with mould, damp, and poor insulation. Mould poses a risk to patients and staff, particularly those with asthma, and may contribute to infection outbreaks. The poor insulation also risks babies becoming cold, with several AERs completed. Estates have begun temporary remedial work, though the issue persists due to the need for full window replacement. Additionally, the fabric and flooring in the maternity wards are in poor condition, with damage to paintwork and cracking flooring joints, highlighting the need for repairs and upgrades.

Clinical Support

Domestic cleaning score of 97% is slightly lower than clinical cleaning.

There were missed audits for sharps in B level, but this was addressed with a retrospective submission.

ANTT (Aseptic Non-Touch Technique) is not part of the standard training for the therapies team, and no data on flu jab compliance has been provided recently.

Some key points were missed during inpatient ward audits, prompting the need for updates in future briefings.

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

Child Health

Robbie's Rehab near completion after several moves of other wards to facilitate its completion.

PPE – Fit mask testing continues across all staff groups.

PICU

IPT investigating salmonella cases on PICU, with no new cases reported. Should any further cases materialise all members of staff caring for the patient will be tested. Hand hygiene and cleaning awareness remain a priority. Mask fit testing continues, with growing compliance, though it remains a significant ongoing project. Bi-monthly training addresses key areas such as VAP, PPE, and hand hygiene, with good communication between the MDT and the Mask Fit Testing Hub to improve practices.

Neonates

The unit has achieved high scores in audits, including hand hygiene. Isolation practices are being actively reviewed to align with trust policy and improve family focus, with a Neonatal Isolation Quick Reference Guide currently being drafted for staff use. All new medical staff are now ANTT compliant, and a new medical team representative has joined the infection prevention team. Additionally, another waste management ambassador has been trained on the unit.

A new TPN administration guideline is being developed, and the suction guideline is under review. Regular infection prevention updates are sent to staff to help reduce infection risks. Ongoing maintenance of the unit aims to improve infection prevention compliance, focusing on cleanliness, PPE accessibility, and waste safety.

Maternity

Remedial works to improve mould in clinical areas started on the 8th April 2024. Labour Ward and Broadlands has had all remedial works complete. Estates are now working on Burley Ward.

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

Maternity - Reoccurring issue of mould growing on the walls and sealant around the windows that have not been replaced as part of the new windows scheme at PAH.

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
April 2025	April 2025

Appendix 5: Q4 Division D Matron and CGCL Report

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

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

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

Date of Report: April 2025

Author: Sarah Halcrow

Performance Quarter 4 – 1st January to 31st March 2025

Key Indicator	Division D	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 1** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**2**	**Trust Limit 27**	**Trust Total 32** (HOHA + COHA)
E. coli (HOHA)	**4**	**Trust Limit of 36**	**Trust Total 46** (HOHA + COHA)
Pseudomonas (HOHA)	**3**	**Trust Limit of 6**	**Trust Total 8** (HOHA + COHA)
Klebsiella (HOHA)	**2**	**Trust Limit of 15**	**Trust Total 18** (HOHA + COHA)
MSSA Bacteraemia	**4**	**No Limit**	**Trust Total 19**
GRE	**0**	**No Limit**	**Trust Total 1**

Incidents / Outbreaks of Infection and PIIs	
MDRO in CCU	Known MDRO positive patient placed in main bay on CCU. CPI alert not checked.

Performance Year to Date: 1st April 2024 – 31st March 2025

Key Indicator	Division D	Limit	Trust Status
MRSA Bacteraemia	**0**	**Trust Limit 0**	**Trust Total 5** (HOHA +COHA)
***Clostridium difficile* diarrhoea**	**22**	**Trust Limit 99**	**Trust Total 120** (HOHA + COHA)
E. coli (HOHA)	**16**	**Trust Limit of 141**	**Trust Total 200** (HOHA + COHA)
Pseudomonas (HOHA)	**7**	**Trust Limit of 22**	**Trust Total 36** (HOHA + COHA)
Klebsiella (HOHA)	**10**	**Trust Limit of 56**	**Trust Total 81** (HOHA + COHA)
MSSA Bacteraemia	**10**	**No Limit**	**Trust Total 53**
GRE	**0**	**No Limit**	**Trust Total 10**

Key Learning from Investigation of Infections and Deaths:

Ecoli – BSI – Urinary Catheter Source:

Learnings:

- Genitalia care for patients with urinary catheter: External urethral meatus should be cleaned adequately.
- Improvement required in the entry and documentation of catheter care record
- Daily assessment of urinary catheter and skin area
- Above the floor and below the bladder positioning of urinary catheter bags:
- Surgical ANTT during catheterisation and appropriate supervision if task is delegated to a practising member of staff.

Progress and Success:

1. General improvement in the quarterly covert hand hygiene conducted by IPT – 8 out of CVT's 10 areas achieved scores above the trust median compared to the previous quarters' audits.
2. CVT alongside with IPT have been able to massively curb the incidence of Candida auris- No new incidence in the 4th quarter and we've been able to successfully deisolate candida auris contacts**.** Many thanks to staff members most especially D4 for their involvement and compliance with IP protocols
3. In neuro 5 star cleaning audits in all areas

T&O-We are having an increased compliance to hand hygiene in Trauma & Orthopaedics, evidenced by the Infection Prevention Team (IPT) covert audits. In Q4, 5 of our wards achieved a score well above the Trust median score of 62%. We are celebrating our success, with TAU being given a High5 for scoring the highest accumulative score and F1 scoring the highest score in Q4.

Ongoing Challenges:

1. Failures in waste management audits. – There is ongoing education and regular weekly audits being caried out by waste management team in the care group.
2. Surgical wound infection still a concern causing complex management and long hospital stay
3. Several cannula care audits conducted by IPT. Mixed results and some work to do around documentation. Challenges around patients being admitted from region or via ambulance crew with limited cannula documentation. Also, patients returning from theatre with limited documentation (this will be discussed with theatre counterparts) Hand hygiene audits for D Neuro and E Neuro achieving 45% and 40% respectively

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

Plan to have extended peer session to discuss how to improve hand hygiene and peripheral cannula care within the care group

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

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting
April 2025	April 2025

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.13 Report to the Trust Board of Directors, 15 July 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:

There are currently 79 Resident Doctor posts vacant which is in keeping with previous years and the current fill rate for August is looking good.

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 year from August 2024 to date there have been 711 reports received.

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Report – Guardian of Safe Working
Appendix 1 Vacancy data
Appendix 2 Exception Reporting Reform Options Paper

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

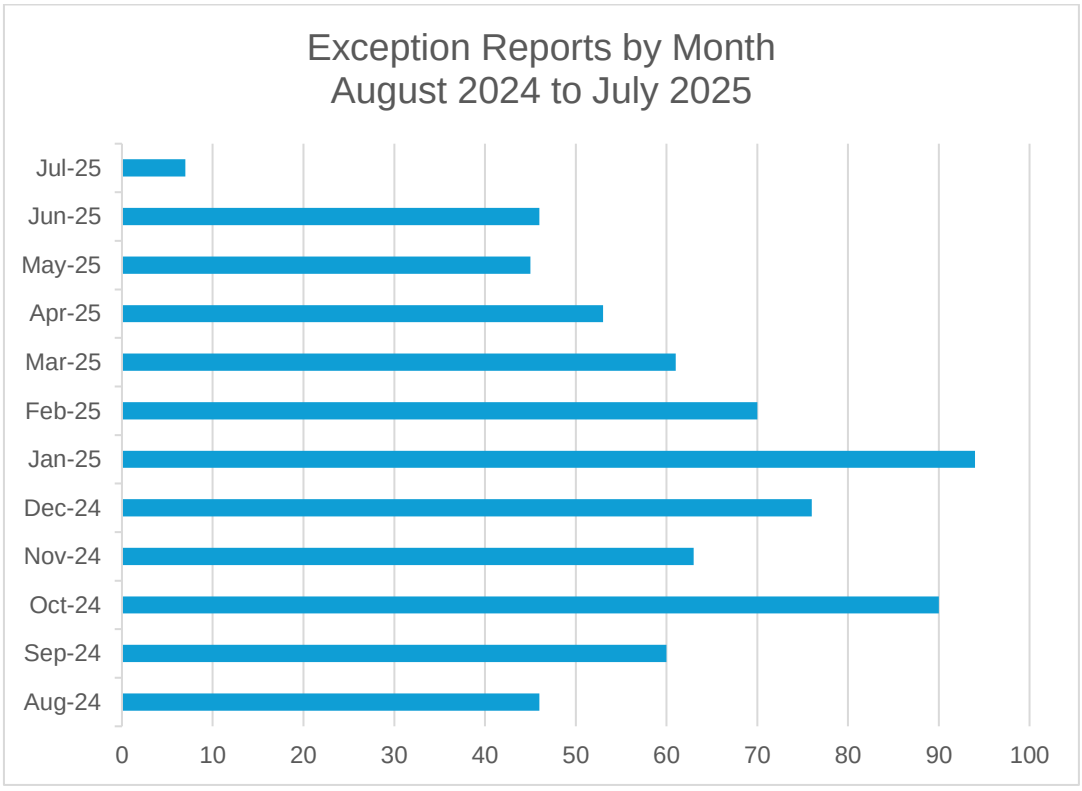
Quarterly Report - Guardian of Safe Working Hours

Employment

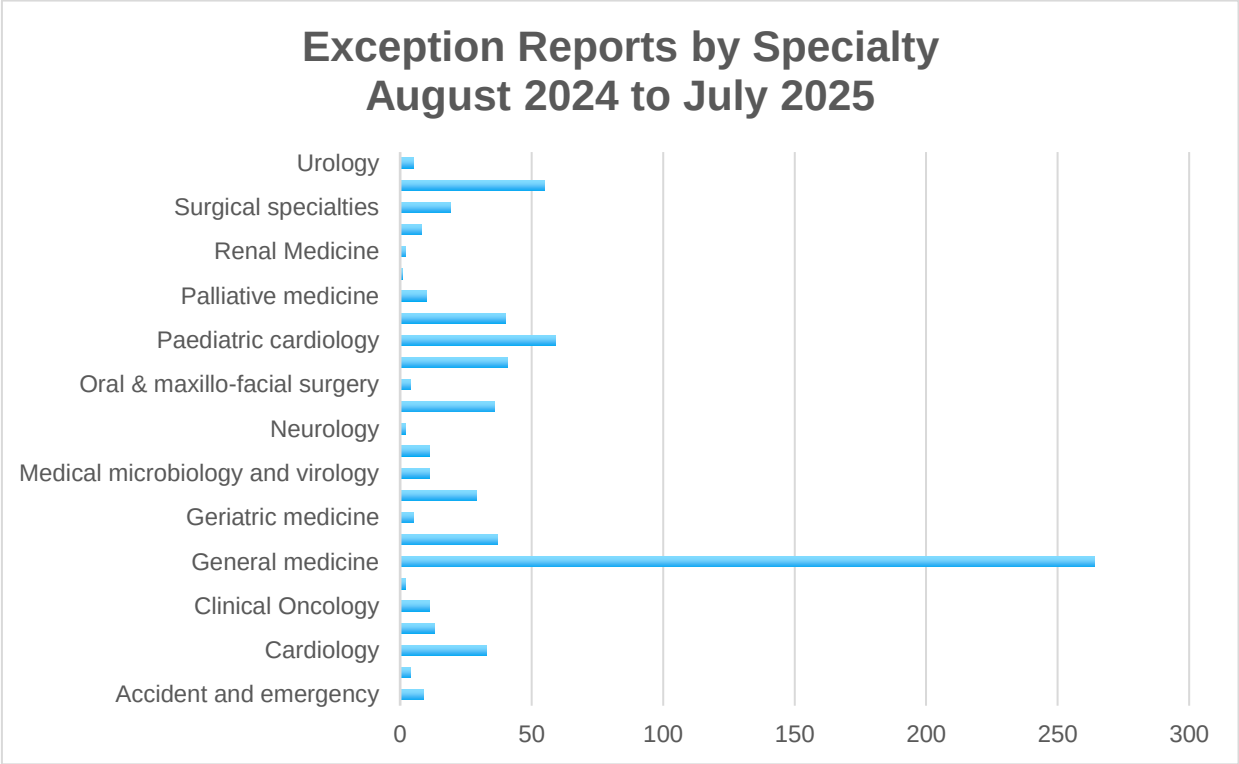
In July 2025 the vacancy rate for resident and local employed doctor posts across the Trust is 7.96 %.
Recruitment continues for current approved vacancies and Medical HR continues to work with departments to plan for future gaps. (Appendix 1)
The present financial situation of the NHS remains a cause 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 most recent Resident forum three members of the Executive discussed the situation with the Residents and took questions; excellent feedback was reported.

Exception reporting

There were 711 exception reports received over last 12 months, an average of 59 per month:



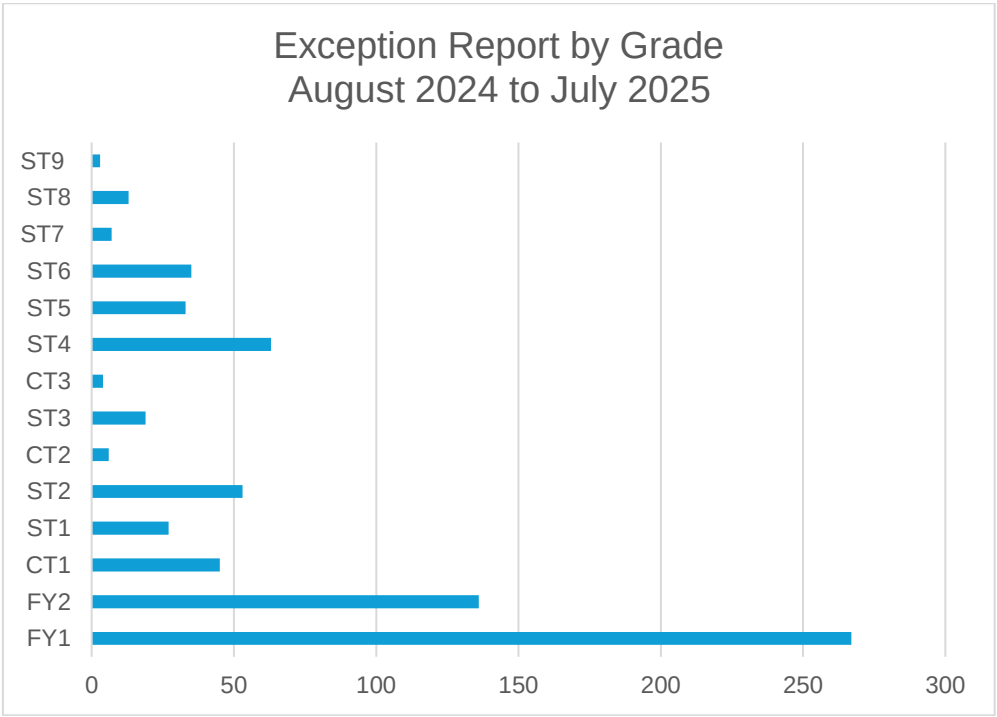
Exception reporting over the 12 months has been highest in January 2025



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 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 9 exception reports stating missed SDT.

Activity

The Resident Doctors' Executive Committee, led by the Chief Resident, 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 Doctors' Forum, also led by the Chief Resident, 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 Resident, Dr Guendalina Bonifacio (a senior doctor in training in neurology), is currently on maternity leave until March 2026.
Dr Genevieve Southgate, a senior doctor in training in paediatric palliative care, is the present Chief Resident.
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 co-writing of an induction booklet for new F1s and an on-going review of non-clinical space.

Genevieve led the organisation of the Doctors' Awards which took place on 15th May. This was a successful, happy and positive event which was fully sponsored and thus cost-neutral for the Trust.

I am delighted that UHS continues to support the chief Resident role which is invaluable for Resident engagement and representation.

Challenges

Rota Gaps

The vacancy rate for Resident Doctors is 7.96% which is similar to previous years.
The impact of staff sickness continues to be significant, 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.

NHS Employers and the BMA have issued a framework agreement outlining changes to the exception reporting process.
These changes have to be implemented by 12th September 2025 to meet the terms and conditions of service in England.
The changes are outlined in Appendix 3 and I shall talk in more detail about this in my paper for the Trust Board in November 2025

Provision of Non-Clinical Space
Members of the Executive are helping the chief resident, the DME 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.

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 David, Duncan, 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	Number of Vacancies	Fill rate as of 4/6/25
A	Critical Care	Anaesthetics	67	6	91.04%
A	Critical Care	CICU	11	1	90.91%
A	Critical Care	GICU	48	5	89.58%
A	Critical Care	NICU	12	1	91.67%
A	Critical Care	SHDU	10	0	100.00%
A	Ophthalmology	Ophthalmology	28	3	89.29%
A	Surgery	ENT	16	0	100.00%
A	Surgery	General Surgery	50	2	96.00%
A	Surgery	OMFS	10	2	80.00%
A	Surgery	Urology	13	1	92.31%
B	Cancer Care	Clinical Oncology	19	0	100.00%
B	Cancer Care	Haematology	24	0	100.00%
B	Cancer Care	Medical Oncology	19	2	89.47%
B	Cancer Care	Palliative Care	9	2	77.78%
B	Cancer Care	Acute Oncology	3	1	66.67%
B	Emergency	Acute Med	23	1	95.65%
B	Emergency	Acute Med OOH	6	0	100.00%
B	Emergency	ED	70	2	97.14%
B	Emergency	PHEM	2	0	100.00%
B	MOP	MOP	44	2	95.45%
B	Pathology	Chemical Pathology	2	0	100.00%
B	Pathology	Microbiology	13	2	84.62%
B	Pathology	Histopathology	24	9	62.50%
B	Specialist Med	Allergy/Respiratory	30	1	96.67%
B	Specialist Med	Clinical Genetics	4	0	100.00%
B	Specialist Med	Dermatology	11	0	100.00%
B	Specialist Med	Endo/Diabetes	4	0	100.00%
B	Specialist Med	General Medicine	14	0	100.00%
B	Specialist Med	GI Renal	33	1	96.97%
B	Specialist Med	Rheumatology	5	0	100.00%
C	Child Health	Paediatric Cardiology	14	0	100.00%
C	Child Health	Paediatrics	57	5	91.23%
C	Child Health	Paeds ED	13	2	84.62%
C	Child Health	PICU	18	2	88.89%
C	W&N	Neonates	27	6	77.78%
C	W&N	O&G	36	3	91.67%
D	CV&T	Cardiology	38	3	92.11%
D	CV&T	Cardiothoracic Surgery	35	0	100.00%
D	CV&T	Vascular Surgery	12	2	83.33%
D	Neurosciences	Neurology	22	4	81.82%
D	Neurosciences	Neurophysiology	2	1	50.00%
D	Neurosciences	Neurosurgery	25	3	88.00%
D	Neurosciences	Stroke	8	0	100.00%

D	Neurosciences	Spinal Surgery	3	0	100.00%
D	T&O	T&O	58	4	93.10%
		Total	**992**	**79**	92.04%

Appendix 2

Exception Reporting Reform – Position/Options Paper

Paper to: Kate Nash, Interim Director of Education and Workforce
Diana Hulbert, Guardian of Safe Working Hours

Paper from: Becci Mannion, Medical Workforce Manager

Date: May 2025

Purpose: To provide current position at UHS and impact on the NHS Employers Exception Reporting Reform for implementation 12th September 2025.

Exception Reporting Reform:

NHS Employers and BMA have issued a framework agreement outlining changes to the exception reporting process for resident doctors to be implemented no later than 12th September 2025 for the 2016 Terms and Conditions of Service (TCS) in England.

Key points of the reform:

- All educational exception reports will go to the Director of Medical Education (DME) for approval
- All other exception reports (relating to total hours of work, difference in pattern of hours, inability for rest breaks, inability to have Self Development Time (SDT)) will go to Medical Workforce (MW) for approval
- The Guardian of Safe Working Hours (GoSWH) will retain oversight of all exception reports
- A three-tier approval system will be used to determine if hours were indeed worked
- Doctors will have the choice of time off in lieu (TOIL) or payment, except when a breach of safe working hours mandates the award of TOIL.
- Employers must provide access to exception reporting to residents within 7 days of starting employment. £250 per resident per week fine for access and completion breach from 12 September to 31 January 2026, then increasing to £500 from 1st February 2026 if not provided access.
- Employers will face penalties of £500 per resident per instance for proven information breach
- Residents will be required to submit exception reports as soon as possible but no later than 28 days from the day they occurred.
- MW have 10 working days from ER submitted to complete investigation
- Immediate safety concerns no timeframe limit
- GoSWH required to conduct quarterly surveys of breach of access, breach of information and actual or threatened detriment, with results to be included in the quarterly GOSWH report.

Twelve Principles that need to be adhered to:

1. Doctors should be enabled and encouraged to exception report
2. They should not suffer any detriment as a result of reporting
3. None of these changes should undermine the GoSWH ability to undertake their role and identify unsafe working practices
4. Claims for overtime/additional working needs to be agreed sign-off process, but challenges to claims should be the exception rather than the norm.
5. The system for reporting should be clear and straightforward

6. Where a doctor worked additional hours of 2 or less as per the exception report in one occurrence, the only determination MW will seek to reach when deciding whether to pay the doctor is whether or not the additional hours were indeed worked; the perceived retrospective merits of the doctors decision to work the additional hours should not be considered when determining whether to make payment for additional hours.
7. Exception reports arising from a doctor having worked more than 2 hours in one occurrence, should be investigated to ensure safe staffing is maintained and could be subject to a locally determined process.
8. Claims should be based upon clear agreed criteria for what constitutes additional working, e.g., Theatre overruns.
9. All educational exception reports to go to DME for approval.
10. All other exception reports to go to MW for approval.
11. Review the contractual deadlines to ensure that they are sufficient for exception reporting submission to remove the undue burden from doctors and replace with timeframes that empower doctors to manage exception reporting when convenient to them.
12. The underlying ethos to this reform should be to empower and trust doctors to conduct themselves professionally, and to remove wherever possible, and minimise wherever it is not, the time-consuming aspects of the process.

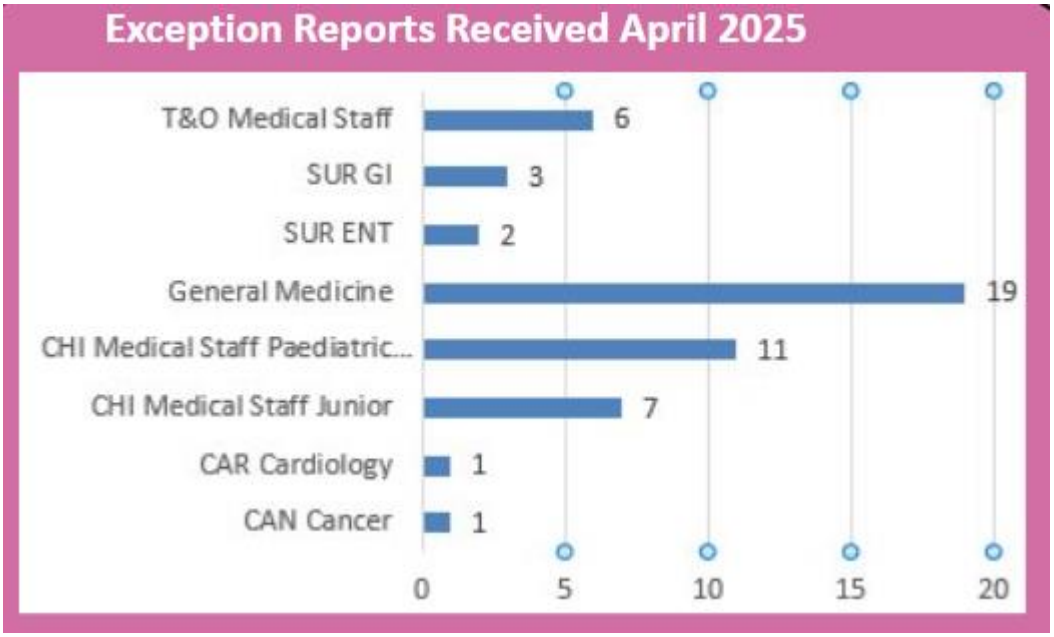
Three-tier approval system will be used to determine if hours were indeed worked:

- **Level 0** – doctor submits exception report for processing; it will include 3 pieces of information:
  1) Exception report data confirming category of exception and duration
  2) Evidence of additional hours worked. Time, Date, Location.
  3) Doctors Rota – to be checked.
- **Level 1** – when information submitted in Level 0 does not align
- **Level 2** – doctor states that ER is accurate (and wish to pursue their claim) MW has rejected at Level 1. MW to contact GoSWH

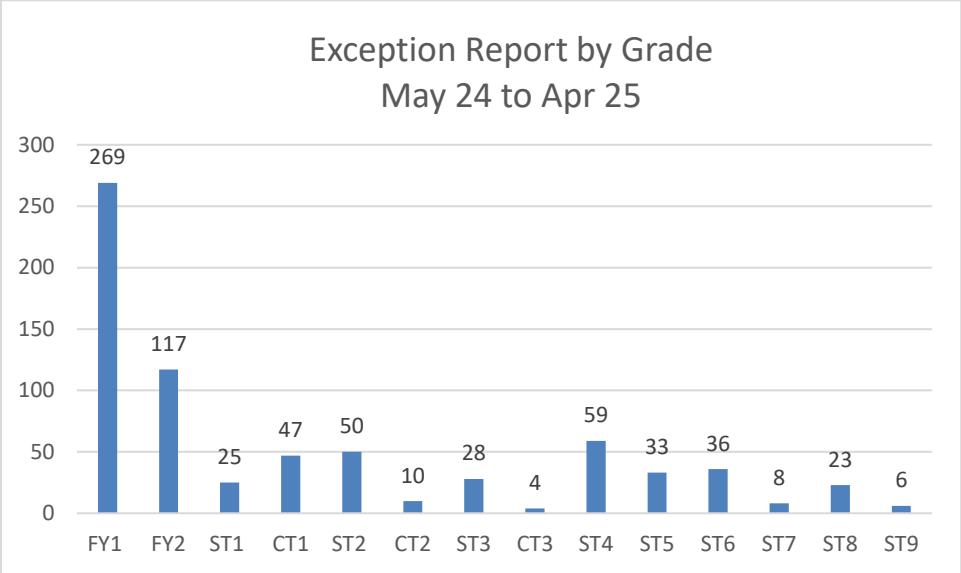
Current position at UHS:

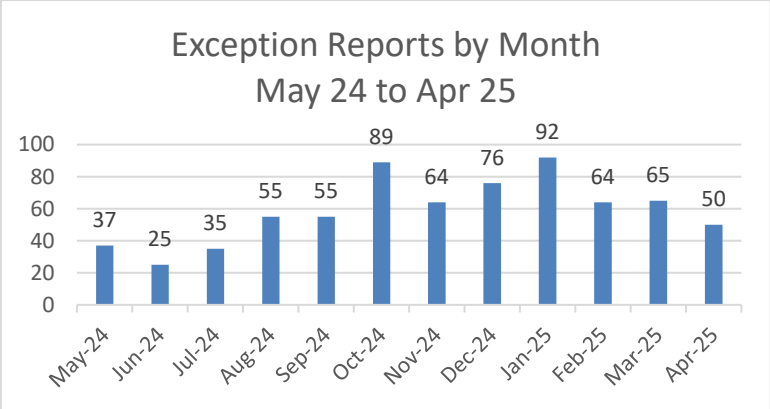
- Average 56 exception reports a month – 92% are additional rostered hours, claiming overtime.

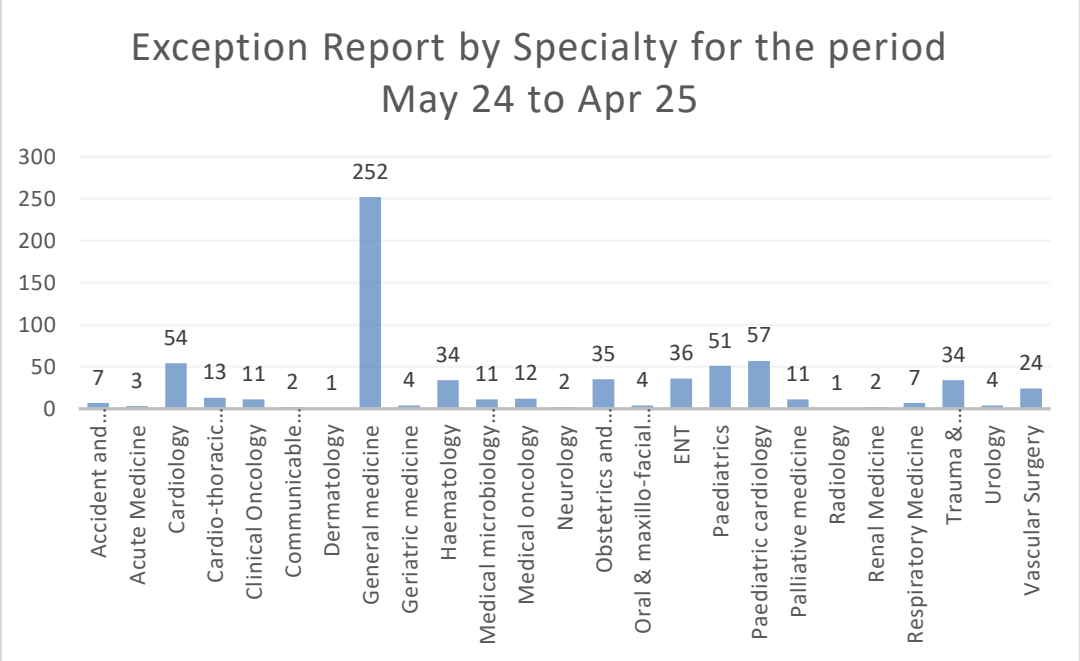
Exception reports received in one month:

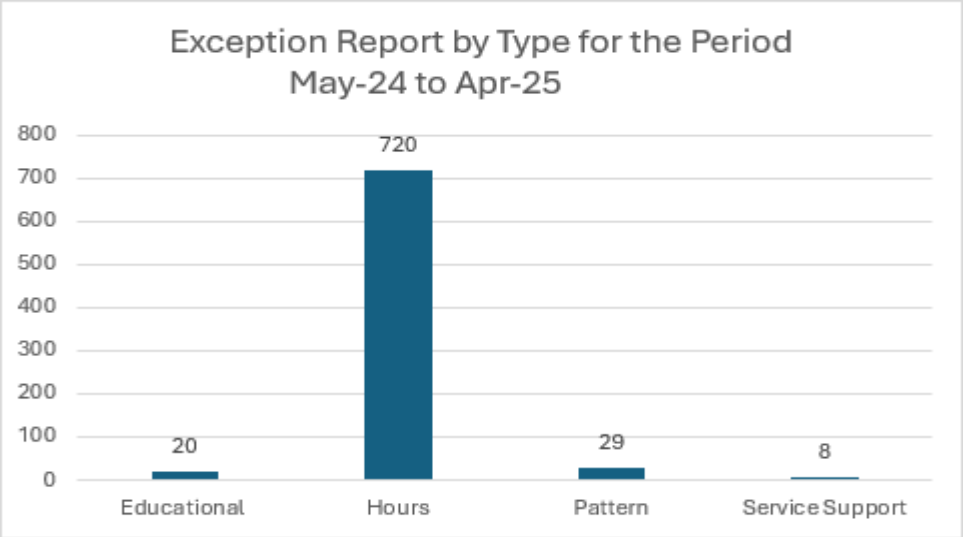


- Majority of the exception reports received are by FY1 grade







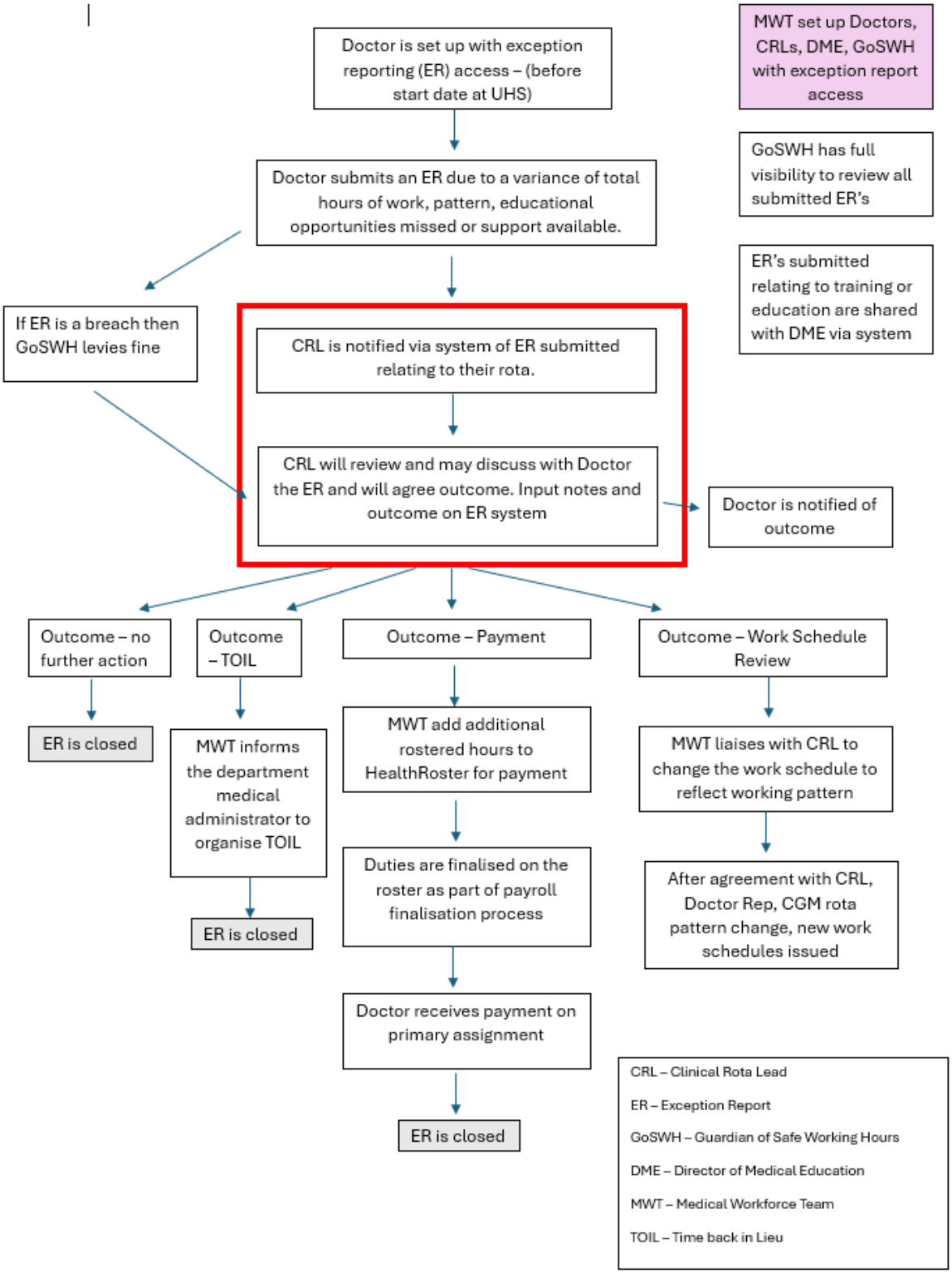


Whilst the average exception reports submitted per month is quite high, the average request is for payment for 1 hour or under.

Total payments processed from April 24 to March 25:

		Amount processed & paid in 24/25
Division A	Surgery	£1,672.00
Division B	Cancer Care	£3,197.00
	Emergency Medicine	£621.00
	Medicine	£1,687.00
	Specialist Medicine	£11,238.00
Division C	Child Health	£5,281.00
	Women & Newborn	£1,746.00
Division D	CV&T	£6,424.00
	Radiology	£171.00
	Trauma & Orthopaedics	£2,253.00
		£34,290.00

Since the implementation of the 2016 contract – UHS has only been fined on one occasion from a FY1 General Surgery breach in October 2023. This affected 5 doctors for breaching the 13-hour rule, the total penalty enhancement was £271.05 and the Guardian levied a fine to the department to pay £416.96 to the Guardian pot. The total financial penalty for the Surgery department was £688.01.



Activities in the red box are those that are being proposed to be removed under the reform.

Points for consideration	Key Risks / Challenges	Pros/Cons/ Additional information		Notes
1	Removal of the Clinical Rota lead (CRL) from the process – removes the current ability to validate the hours worked, understand the issues on the ward/theatre etc	Reform is looking to remove the medical roles influencing the outcomes and those that could have a detrimental effect on doctor's career.	Reduce time for the CRL role Removes the Medical Workforce process to chase, remind CRL to conclude and have meeting with the doctor who raised exception.	
2	Medical Workforce does not have financial authority to approve additional rostered hours (overtime)	Would Care Groups give delegated authority to support the process?	Overtime would be added to HealthRoster by Medical Workforce Team but Care Group Manager/Ops Manager of the departments would finalise the unit as part of payroll finalisation each month The decision for payment would still sit with Medical Workforce but the Care Group would have site of these decisions. Reform states that it's not deciding to pay the doctor – it is whether or not the additional hours were indeed worked.	Overtime for ER can be reported directly from HealthRoster as there is a reason code for ER Doctor will be required to confirm via self-declaration that the information submitted adheres to the 2016 TCS.
3	If Medical Workforce is deemed not the appropriate department /role for the decision to sit – delegated authority could be given to CGMs or Divisional Operational Managers or Medical Administrators within Division to have access to the system and approve outcome of ER	The reform does state that the role involved in the ER process should not be co-located with the clinical workforce	Would need agreement by the LCNC, Medical Education and Workforce Mtg for the ability to delegate the role to another. Would need to inform doctors as part of the user setup who has access to the ER system/data.	This point was considered not a suitable option to delegate out from the Medical Workforce Team

4	Current Medical Workforce capacity to deliver the three-tier process No additional resource required would be incorporated in current Medical Workforce headcount	Requirement for higher approval / agreement for outcome decision within Medical Workforce Team	Option is the Band 6 role (current within Medical Workforce Team) would oversee and agree outcome of all ERs submitted. The Band 4 role (4 in post currently) would then be able to input the outcome onto HealthRoster (this is the existing arrangement – B4's add overtime approved by CRL to HealthRoster) The approved HealthRoster Unit approver will finalise the roster for payroll submission, which will include these ER payments/TOIL arrangements.	Need to be aware of any potential changes in the Finance authorisation Framework
5	Ability to conclude Level 0	Emphasis on real time roster and accuracy – decision to be made based on duties on HealthRoster	Difficulty would arise if rosters were not kept real time as could reject based on incorrect duties on roster.	Greater support required with Medical Administrators to ensure rosters kept real time
6	System changes required: • Educational exceptions to go straight to DME for action • Removal of Educational Supervisors from system • Management of TOIL • Ability to have 2 GoSWH/DME to manage host ERs	Working with RL Datix (Allocate) to support the system changes required	Enable faster process Reduces risk of data/confidentiality breach	
7	PLE/Lead Employer (GPs, FY1/2s in HOIW) • Ability to have 2 GoSWH and multiple DMEs on the system to	Currently host employer transfer doctors' exception account to host so that they manage ER raised against their rota.	Lead employer for clinical placements will carry the responsibility for the process and outcomes, also liable for the fines. Therefore, need to keep ERs with Lead Employer and share trends with Host.	Recharge would be needed to send overtime payments to host employer

	enable the Host to oversee the ERs • Ability to have a tick box option to highlight community or host	Concern is that doctor has two assignments - one with UHS and the other as Honorary with Host – payment being made on secondary assignment which would incur different tax codes for doctor.	Weekly reporting to host employers if system not able to have 2 GoSWH Could Host give UHS access to view live roster on Host's HealthRoster?	
8	Management of those exceptions submitted over 2 hours	Requires additional investigation to ensure safe staffing is maintained	Need agreement of a locally determined process to ensure: • Work schedules are still representative of hours • Utilisation of the Medical Locum Bank Ensure doctors have had the required compensatory rest following an ER	
9	Concern there may be an increase of ER cases due to the absence of CRL input	May encourage increase in ERs being raised	May increase the financial impact of ERs on the Trust May demonstrate a more accurate representation of demand on current services	
10	Management of TOIL – when doctor elects to receive TOIL for additional hours worked	Reform states the doctor will need to select an appropriate clinical person to share ER with to enable TOIL to be taken.	TOIL to be taken within 10 days of ER being approved. Within 1 day of award if mandatory due to ISC. Complexity may arise if relating to on-call duties.	
11	Educational exceptions – reports sent directly to DME or DME deputies – they can take action to replace or reinstate any missed educational opportunities	Will require the DME to react to notifications of Educational ERs	DME /Deputy would need to gain doctors explicit consent to share – or doctor to select an appropriate clinical person to enable missed educational opportunities to be reinstated.	
12	GoSWH will need to conduct quarterly surveys to • assess breach of access	Results to be included in the Quarterly GoSWH reports	Additional requirement on GoSWH	

	• Breach of information • Actual or threatened detriment			

Options/ Next Steps

Actions for the Medical Workforce Team:

- Update current user guides (with system changes) and include table of user roles who would have direct access to the doctors ER data. (User Roles to be agreed – Appendix 1)
- Update Medical Staffing Administrators with changes and awareness of the reform
- Communicate with the Clinical Rota Leads/Educational Supervisors – informing of changes
- Audit of current user accounts; review against ESR payroll report

Seek agreement from Medical Education & Workforce Group and LCNC for:

- Agreed user role list who would have direct access to the ER data
- Agreement that an access fine will not be levied where the delay has been caused by an event beyond the control of the employer, for example, cyber-attack.
- Financial authority – Medical Workforce team will need to have delegated authority to approve ER overtime and toil for all resident / locally employed doctors
- No payment for time under 15 mins of work
- Exception reporting is a contractual right for those doctors and dentists who are employed on the 2016 Terms and Conditions of Service in England. At UHS we also mirror those T&Cs for those locally employed doctors (LEDs), therefore this reform will be extended to all trainees and LEDs
- Currently there is delegated authority from Educational Supervisors to Clinical Rota Leads to manage and approve exception reports. Under this reform this would cease
- Currently we allow any exception report regardless of timeframes – to encourage the reporting process. Under this reform this would cease – doctors will be required to submit all ER within 28 days.
- For ER over 2 hours the locally determined process

Conclusion

- Need to protect the anonymity of the doctors
- Need to ensure no medic is part of the decision-making process (apart from GoSWH when required, and DME if education)
- Reporting and review of trends would support the requirement to manage/support doctors with time management concern
- Need assurance that user accounts will be set up in advance of doctors starting at the Trust
- Exception reports must be reviewed independently of budgetary constraints.

References:

Exception reporting reform for resident doctors | NHS Employers

Appendix 1 – Proposed User Roles/Access to ER

User Role	Access
GoSWH	Full exception reporting access
DME	Education exception reporting access only
Medical Workforce Team (Manager, Lead Specialist, Assistants, Administrator)	Full exception reporting access
PLE GoSWH	Exception reporting access to PLE doctors only
PLE DME	Education exception reporting access to PLE doctors only

Need to consider DME/GoSWH absence for annual leave/longer sickness who covers – can the GoSWH cover the DME?

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.1	Report to the Trust Board of Directors, 15 July 2025
Title:	Corporate Objectives 2025-26 Quarter 1 Review
Sponsor:	David French, Chief Executive Officer
Author:	Martin de Sousa, Director 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 1 for 2025-26.

Our objectives were agreed at Trust Board in March 2025. This is the first progress report for this financial year.

After the first quarter the majority of objectives remain on track, and none are red-rated currently although there are a number of risks identified in the report.

A scoring summary of progress is below:

Ref	Corporate ambition	Leads	Number of Objectives for 2025/26	Q1 Green	Q1 Amber	Q1 Red
1	Outstanding patient outcomes, safety and experience	COO/CNO	4	4	0	0
2	Pioneering research and innovation	CMO	2	2	0	0
3	World class people	CPO	2	0	2	0
4	Integrated networks and collaboration	COO/CMO	1	1	0	0
5	Foundations for the future	CFO/CEO/CNO/CMO	3	2	1	0
Totals			12	9	3	0
			% against	75%	25%	0%

RAG Rating for corporate objectives updates	In Year Updates
Green	On track to be delivered in full
Amber	Minor Delays/or shortfall in target
Red	Significant delays/or shortfall in target

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 2025/26 Corporate Objectives were approved by the UHS Board in March 2025. Twelve objectives were agreed, which was an attempt to focus priorities across our five strategic themes, whilst recognising the breadth and complexity of work that was ongoing in the Trust. Following agreement of the twelve objectives, quarterly milestones have now been set for each objective to measure progress against across the year. This report assesses progress against the first quarter. We have not yet included a year-end forecast of success but will introduce that during the year.

Quarter 1 Update
Overall achievement against our objective milestones is good at this stage, with the majority of objectives reported as fully on-track (green). Our current areas of risk are delivery of our finance and people objectives, which follows a similar trend to recent years.

Outstanding Patient Outcomes, Safety and Experience
There has been positive achievement across all four objectives in this area – the Fundamentals of Care programme and Quality Priorities have both completed their milestones in this quarter, and both the Elective and UEC transformation programmes are on track.

Pioneering Research and Innovation
There has been good progress on both objectives in this area. Cohort 5 of the Research Leader's Programme launched in April 2025, as did a Senior Leaders' Programme in June 2025. Other pieces of work have either been completed successfully or are on a positive trajectory.

World Class People
The two objectives for this theme cover achieving our workforce plan in 25/26 whilst delivering targeted improvements to staff experience, culture and wellbeing. There are risks in both areas to achieving these aims – good progress has been made on identifying workforce reductions required to meet our plan, but further work is needed to achieve the targets set. At the same time, those workforce reductions are impacting our capacity to deliver improvements for staff experience, despite achieving the milestones set in the quarter. Both of these areas are rated as amber currently.

Integrated Networks and Collaboration
There is a single objective for this theme which focusses on developing network relationships within our ICS. Progress on this has been positive in quarter 1 and UHS is an active contributor to some ongoing pieces of system-level work developing proposals to redesign particular services (for example Upper GI, Breast, Pelvic Floor).

Foundations for the Future
Our financial progress is rated as amber achievement currently- updated controls and governance processes have been implemented under the oversight of the Financial Improvement Group, and there is significant focus in this area. We are however off plan at this stage in the year so further work will be needed to recover our position. Our capital plan delivery has remained on track, as has work on the elective hub at Royal South Hants, our Private Patient Unit strategy and our Trust Strategy refresh.

Summary

The Board is asked to note the overall positive start in delivering the Corporate Objectives for 25/26, whilst recognising the expected challenge in certain areas, particularly delivering our financial plan.

Outstanding Patient Outcomes, Safety and Experience

Ref	Lead	Objective	Q1 Milestone	Q1 Update
1(a)	CNO	Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme.	Review of the driver diagrams and Key Performance Indicators (KPIs) to establish more robust reporting in evidence of the work taking place. These include: - Categorised pressure damage incidences - Specifically identified Friends and Family Test (FFT) responses e.g. pain This milestone will support effective reporting and escalation of FoC challenges to QGSG and Trust Board.	**Green:** Driver diagrams have been reviewed and there is ongoing work with clinical teams to establish KPIs that are the most useful for reporting. It has been identified that a key area of development relates to patient 'turnaround' and this has been escalated in support of Fran Norman and the Tissue Viability Team. Collaborative work through the FoC Project Board is supporting this including work directly with the Support Worker Development Senior Lead, Naomi Wilson. Plans are underway with the Division B therapy team, ward staff on G8 and G5 and volunteers moving from F7, to support the project looking at how we can prevent deconditioning of patients and improve the FoC.
Ref	Lead	Objective	Q1 Milestone	Q1 Update
1(b)	CNO	Deliver the quality priorities for 25/26. **1)Experience of Care** **2)Improving the care of the dying patient and those important to them** **3)Fundamentals of Care:** See above **4)Acuity and deteriorating patients:** **5)NATSSIPs Implementation** **6)Health Inequalities**	The following quality priorities are being implemented as per the oversight of the Quality Committee. 1)Experience of Care 2)Improving the care of the dying patient and those important to them 3)Fundamentals of Care 4)Acuity and deteriorating patients 5)NATSSIPs Implementation 6)Health Inequalities	**Green:** The following quality priorities are being implemented as per the oversight of the Quality Committee. 1)Experience of Care 2)Improving the care of the dying patient and those important to them 3)Fundamentals of Care: See above 4)Acuity and deteriorating patients: 5)NATSSIPs Implementation 6)Health Inequalities

Ref	Lead	Objective	Q1 Milestone	Q1 Update
1(c)	COO	Deliver the objectives of the elective programme, including achievement of national targets for RTT improvement.	- Local delivery plans at care group level approved through TOG - Go-live of Federated Data Platform (FDP) to improve theatre scheduling - Review of out of area referrals, consultant to consultant (C2C) referrals to improve referral management - DNA weighted Impact analysis for specialties to identify clinic utilisation opportunities - Continuous Service Improvement (CSI) week to improve theatre productivity	**Green**: All care groups presented local elective transformation plans TOG in May. **Theatres:** The FDP had a successful go-live and has been used to drive 6:4:2 scheduling processes throughout June. Running a 2 week 'Focus Festival' with strong social media prescence and staff engagement to gain momentum behind the programme and listen to ideas for improvement. **Outpatients:** Reviews and analysis of out of area referrals, C2C referrals have been conducted at FIG with an Out of area referral pilot initiated in May with continued expansion throughout Q1. Business case has been developed for 'Elective Front Door' referral management platform for approval in July TIG
Ref	Lead	Objective	Q1 Milestone	Q1 Update
1(d)	COO	Deliver the objectives of the UEC programme, including achievement of national target for ED performance improvement.	- Local delivery plans at care group level approved through TOG - Agreed plan for bed closures to be implemented - UEC clinical lead appointed	**Green**: All care groups presented UEC transformation plans at May TOG. - Bed closure plan agreed and escalation capacity closed - Gail Stryke appointed as UEC Clinical Director - Workshop held with health and social care partners to create shared plan for NCtR improvement - OPAT Business case developed for July TIG approval

Pioneering Research and Innovation

Ref	Lead	Objective	Q1 Milestone	Q1 Update
2(a)	CMO	Deliver Year 5 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.	Onboarding cohort 5 of RLP, scoping reviews. Cohort 2 ROI conversations and onward planning. Draft RLP annual report for FY 2024/25. Agree metrics to report for ROI. Continue to investigate and develop an ongoing sustainable funding model. Streamline ATIMP risk assessments. Aim for 5% increase in the number of specialties running ATIMP research over 25/26. Test SETT MedTech pathway. Streamline SETT/SDE processes.	Complete. Cohort 5 launched April 2025. Annual report for 24/25 in draft. Metrics for ROI agreed. Work underway to develop a sustainable funding model for ongoing programme delivery. In progress. Risk assessment process in review, revised paperwork in draft. In progress. Expressions of interest for new studies submitted. In progress. In progress. Process review underway. Overall progress **Green.**

Ref	Lead	Objective	Q1 Milestone	Q1 Update
2(b)	CMO	Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.	Complete mapping to identify gaps and opportunities for set of initiatives that recognise and reward staff for engaging in research.	Completed in start of Q2, report being prepared for review in Q2.
			Develop plan for growing the identified strategic areas of growth including those linked to BRC application.	In progress. Will be completed in Q2.
			Centres of excellence identified. Develop plan for growing the identified strategic areas of growth including those linked to BRC application.	In progress. Further work required in Q2 to complete.
			Develop and begin to deliver a senior leaders programme focussed on research culture.	Complete, Leadership programme launched 26.06.25
			Develop UHS PI Offering	In progress. Further work required in Q2 to complete.
			Plan to conduct annual evaluation as part of strategy implementation plan going forward.	Complete. Annual review undertaken reviewing progress against KPIs .
				Overall progress **Green**.

World Class People

Ref	Lead	Objective	Q1 Milestone	Q1 Update
3(a)	CPO	Deliver a workforce plan for UHS for 2025/26 which meets the national planning requirements and is safe, sustainable, and affordable.	Divisions establishing plans for 5% reduction in pay costs THQ functions establishing plans for 10% reduction in pay costs Review of temporary staffing opportunities Launch of second MARS scheme	Amber: workforce targets agreed and plans submitted by divisions and THQs. Some areas plan meeting 5/10% targets, further work required in other areas. Divisional restructure on track for 1st July completion. Second MARS scheme launched. Further staffing opportunities being reviewed through Financial Improvement Group.

Ref	Lead	Objective	Q1 Milestone	Q1 Update
3(b)	CPO	Deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy.	Comprehensive communication plan to cover organisational change. Workshops, resources and support packages to support change. Positive action leadership programme - cohort 4. Impact assessment completed for Allyship.	Amber - Comprehensive communication plan launched to support organisation change through Connect meetings and talk to David sessions. Leading through change programme launched to focus on culture aspects of change management in addition to policy and practice. Positive action leadership programme launched (Cohort 4). Impact assessment for allyship to be included at People Board in July.

Integrated Networks and Collaboration

Ref	Lead	Objective	Q1 Milestone	Q1 Update
4(a)	CMO	Develop network relationships within our Integrated Care System, including progression of shared services work with partners.	• Support development of the ICS acute provider collaborative clinical strategy • Continue membership and support for the ICB acute provider collaborative board • Decision on future provision of upper GI cancer for HIOW • Outline business case developed for pelvic floor and complete analysis of gaps • Decision on future provision model for breast DIEPs • Agree next steps for clinical service collaboration with HHFT • Work with UAN clinical lead and operational management to set achievable aims for the year.	**Green:** Continued contribution to ICS acute provider clinical strategy and membership of Board meeting. Draft system strategy in development. Regional groups for UGI, Pelvic Floor, and Breast working towards proposals for future service provision with UHS input into all. Further clinical workshops planned with HHFT for Q2/3.

Foundations for the Future

Ref	Lead	Objective	Q1 Milestone	Q1 Update
5(a)	CFO	Deliver the financial plan for 25/26, supported by delivery of schemes within the Improving Value programme.	Develop and embed grip and control environment for successful financial plan delivery within 25/26. This will include refreshed SFIs/Business Rules/Budget Sign Off Process/CIP guidance and review of control environment including in year monitoring tools and recruitment controls. Establish Financial Improvement Group (FIG) to oversee successful delivery of the savings plan for 25/26 including a robust EQIA process. Target full identification of all schemes by end of Q1 with less than 25% in opportunity phase. Delivery of Q1 CIP target = £19.5m Savings Delivery of I&E Plan = £11.6m deficit YTD	**Amber**: Refresh of financial controls and oversight partially completed. SFIs refresh supported by June audit committee and going to July Trust Board. CIP guidance has been issued to divisions as have budget setting sign off letters. Further review of non-pay controls still to be completed. Financial Improvement Group has been established 2hrs/week with whole senior leadership team. EQIA process implemented. As at M2, 86% of CIP identification either relates to either fully developed schemes or plans in progress, rather than opportunities. This is ahead of the 75% target. Overall financial plan delivery is on track for Month 1 and Month 2 both for I&E and CIP. £5m of over delivery on non recurrent schemes however offsets £5m under delivery on recurrent schemes.

Ref	Lead	Objective	Q1 Milestone	Q1 Update
5(b)	CFO	Deliver the prioritised 2025/26 capital programme and set a prioritised capital plan for 2026/27, as well as setting aspirations for future year programmes.	Embed capital monitoring tools for 2025/26 including capital expenditure updates for TIG/F&IC and programme updates for IISS/Strategic Maintenance/Digital and other material projects. Commence completion of short form business case documents where external funding has been earmarked for UHS. Complete the application for capital cash support to enable successful project completion if/where necessary.	**Green**: Capital plan agreed and prioritised and projects underway. External funding business cases on track for submission in Q2. Capital cash support submission has been made to NHS England.

Ref	Lead	Objective	Q1 Milestone	Q1 Update
5(c)	CNO	Progress key strategic objectives for this year, to include: a. Elective centre for UHS at RSH b. Progress towards onsite PPU c. Refresh for UHS strategy	a. Agreed Heads of Terms for safe and orderly transfer of property	On track - Negotiations ongoing with incumbent provider at RSH. Further letter of support received from ICB. Revised business case drafted for submission to NHSE.
			b. Market Engagement Event Potential Bidder Engagement 1:1 Sessions UK4 PIN released	Market engagement Event and engagement sessions successfully completed. UK4 tender notice release delayed due to ensuring compliance of new procurement regulations and system changes, scheduled release date 7/7/2025. To note, this has not impacted the overall programme and managed service commencement is still on track for November 2027.
			c. Analysis of engagement feedback and horizon scanning	On track- Engagement process completed and feedback collated and reviewed at Quarterly Strategy Group. Trust Board Study Session held to review and set next steps. Moving into drafting phase for Q2.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.2 Report to the Trust Board of Directors, 15 July 2025	
Title:	Research and Development Plan 2025-26
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Karen Underwood, Director of R&D; Chris Kipps, Clinical Director of R&D; Laura Purandare, Deputy Director of R&D; Marie Nelson, R&D Head of Nursing and Health Professions

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 purpose of this paper is to inform Trust Board of the R&D plans for 2025-26 to enable delivery against the Corporate Objectives and to seek approval from Trust Board for the UHS R&D Annual Plan 2025-26. The plan describes the successes and challenges encountered in 24/25 and the objectives for 25/26.

Trust Board Investment in Research
We have seen a 40% reduction of the investment required over the 5-year period from £15.66m to £9.51m which we are forecasting will generated significantly more income than originally forecast - an 43% increase over the anticipated income – we are forecasting we will have generated £220m by the end of Year 5, compared to the original prediction of £153m.
There has also been a 20% increase in overhead contribution from £6m to £7.2m, and an anticipated 40% increase in funding flowing across to Divisions from a baseline of £4.09m in 21/22 to £6.07m in 25/26.

The Research Leaders Programme is thriving – the return on this investment can be clearly articulated, cohort 1 has now finished and the diversity of professions within the latest cohort (5) demonstrates the embedding of a sustainable and thriving research culture at UHS across all professions.

Through the Southampton Emerging Therapies & technologies (SETT) Centre we are seeing an increase in the number of specialties opening advanced therapy studies providing potentially life changing treatment options for our patients, we have secured further investment for the Secure Data Environment from NHSE and are working with a number of companies and Southampton innovators on new medtech device trials.

The ongoing sustainability of these initiatives is a key focus in the annual plan for 25/26.

R&D Trust Board KPIs for 25/26 have been updated to reflect the new national DHSC UK Clinical Research Delivery KPI Dashboard. There is increased scrutiny of commercial clinical trial delivery from Ministers looking to support the life sciences agenda (seeking to make UK attractive for global pharma) has brought in new national performance metrics around study set-up times, and patient recruitment. R&D Trust Board KPIs have been updated to reflect these in 25/26.

Trust Board is asked to approve the R&D Annual Plan for 2025/26.

Contents:	
Cover sheet Appendix 1 – UHS R&D Annual Plan 25-26.	
Risk(s):	
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

University Hospital Southampton NHS Foundation Trust

THE UHS WAY

RESEARCH FOR IMPACT

R&D Annual Plan 2025-26

Research for Impact
R&D Annual Plan 2025-26

1. Foreword

Pioneering Research and Innovation is one of five pillars in our strategic framework supporting our Trust ambition of World Class People delivering World Class Care and is vital to the successful delivery of the Trust's strategy.

As a leading UK teaching hospital known for research excellence, we are committed to enhancing our local, regional, and international reputation through the quality and impact of our research. We aim to constantly surpass the benchmarks set by our peers to be a leader in the field.

Now in the second year of our five-year Research Strategy: Research for Impact and working in partnership with the University of Southampton, known for its world-leading research, this year has seen the development of the first joint research vision for the partnership. Further work has been undertaken to identify collaborative clinical research centres of excellence and areas of future strategic growth to increase the relevance, quality and impact of the research we do to deliver world class care.

Research For Impact (2023-28) Vision: We deliver research with impact to help bring the future of healthcare closer to today.

Our mission is to seamlessly integrate delivery of research that supports and enhances our clinical services to achieve world class care.

A key focus for the first half of 2025-26 will be reviewing our priorities and processes to ensure sustainability (both within our workforce and in terms of the green agenda) and innovative practice remain at the forefront of our strategic ambitions.

Another area of exploration is renewing our efforts to align the research management and governance functions within the UHS-UoS partnership and further exploring Joint Research Office functions to streamline support for researchers working between the university and the trust.

The UHS R&D annual plan reflects on key achievements in 2024-25 and sets out the programme of work for 2025-26 supporting the delivery of the overall R&D ambition.

2. Summary of 2024/25 Activities

2.1 Key Highlights

Hosting Research Infrastructure (see Appendix 7 for updated Research Infrastructure diagram)

- Working with regional partners as part of our research hub model, UHS was awarded £4.7 million to host new NIHR research infrastructure, a Commercial Research Delivery Centre (CRDC) in November 2024. The Wessex CRDC is one of 20 CRDCs awarded across the UK by the government as part of the Voluntary Scheme for Branded Medicine Pricing, Access and Growth (VPAG) Investment Programme – a unique partnership between the government and the pharmaceutical industry. We are already working collaboratively with other CRDC's to maximise the opportunities presented by the new infrastructure. Working under the governance of Wessex Health Partners (WHP), the new centre will build on the success of the Wessex Research hub model and officially launched on 1st April 2025. We are working closely with national and regional partners and industry as we develop the CRDC's capabilities.
- The new South Central Regional Research Delivery Network (RRDN), hosted by UHS, was formally launched following a period of transition in October 2024. Serving three Integrated Care Systems and 12 NHS Trusts across Buckinghamshire, Oxfordshire, West Berkshire, Hampshire and the Isle of Wight, recruitment of leadership and operational roles has taken place in the last two quarters of the year. As well as being the successful network hosts, several staff from across the Southampton partnership have been successful at interview for part time (funded) positions within the network. This will enable greater collaboration with colleagues within the region over the next few years.
- The Applied Research Collaboration (ARC) Wessex renewal bid was launched and submitted this year. We have been shortlisted and invited to submit a revised application in Q1 25/26 with the outcome expected in Q2. This iteration of the ARC Wessex will be led by Prof. Cathy Bowen as Prof. Alison Richardson will step down as ARC Director at the end of the existing ARC term.
- UHS, led by Professor Chris Kipps, will be part of the NIHR Dementia Translational Research Collaboration Trials Network (D-TRC-TN). This is a coordinated network of dementia trials sites across the UK, with £50m of new funding for the initiative at the start of this year. It aims to build capacity and expertise, so that more people with dementia can take part in research.

Digital Transformation

Much like our colleagues across the UK, R&D has historically managed clinical trial documentation through a combination of paper files and electronic folders and documents saved on shared drives. This leads to inconsistent document management and increases risks of Good Clinical Practice non-compliance. This was raised as a finding at a statutory regulatory (MHRA) GCP Inspection in May 2023 with a requirement to procure an appropriate digital solution as part of the corrective and preventative action (CAPA) plan.

Throughout 2023-24 members of the R&D team explored digital filing and preservation solutions with different vendors to evaluate their appropriateness for UHS purposes. In September 2024, following a robust procurement process, we signed contracts with Florence Healthcare Inc.

We did not undertake this in isolation, the procurement and use of regulatory compliant, validated electronic folder systems is a 'hot topic' within the NHS R&D community. As an early adopter of Florence, UHS has teamed up with other trusts who have recently procured the system to form a national group. Together, we are sharing learning, writing national SOPs and developing the system in conjunction with Florence to ensure its long-term viability in the UK as we prepare for the implementation of the new UK clinical trial regulations next year.

An electronic system for the management and long-term preservation of clinical trial paperwork and data will improve our compliance with document storage, reducing the paper burden of clinical trials thus freeing up physical storage space and supporting the sustainability agenda and UHS Green Plan. Use will free up time and improve efficiencies for all staff during the conduct of a study – from chasing signatures, to locating documents, waiting for files between dispensations/ participant visits and reducing costs and time associated with quality assurance activities.

We will be launching our first fully digitised research studies in Q1 25/26. It is likely that a Wessex SDE study (wAIHA) will be first, shortly followed by a UHS sponsored multicentre clinical trial of a vaccine. Both studies will use a range of digital platforms throughout their life-course from participant identification through to digital preservation.

Our delivery teams are working collaboratively with the SETT centre's data team to embrace digital innovations and enhance the way that eligible patients are pre-screened for potential participation in research studies. The data team's ability to build algorithms to quickly search high volumes of clinical records daily has enabled our delivery teams to focus on recruitment. This has enabled studies such as SMA and OBS-UK to recruit 3,000 and 5,683 participants respectively (both studies had recruitment targets of 2,000). The teams continue to work closely together to refine the pre-screening capabilities presented by digital tools.

R&D embraced the opportunity to present at the UHS digital days this year. This is enabling closer working as we look to further integrate research with the digital ambitions of the trust.

Involvement in national groups

Our research leaders continue to work at a national level, ensuring that Southampton's voice helps to drive national research agendas and initiatives, including University Hospital Association R&D Directors group, UKRD, R&D Forum, NIHR Springboard Programme Advisory Group, Health Research Authority (HRA) and cCOG working groups, NIHR Chief Nurse meetings, NIHR Academy Forum, NIHR Clinical Research Facility network and NIHR RDN directors and leads groups.

Moving care from hospitals to community

Our Southampton research hub has been based at RSH since decanting from UoS sports halls in late 2020. With the space at RSH being required for other clinical activity, the opportunity presented to move the hub once again. Working in collaboration with UHS estates and NHS Property services, in the last quarter of the year we have secured space in Shirley medical centre as a new research hub. This space will be shared with colleagues from Hampshire and Isle of Wight Healthcare Trust and places the research hub firmly within our community with excellent transport links and a short walk from the high street. The hub will open its doors towards the end of Q1 25/26 enabling greater access

to care within research studies for our local population and reducing time spent travelling to clinics at the hospital site.

NIHR recognition

In December 2024, the NIHR published their 12 favourite NIHR research stories that hit the headlines in 2024. 3 of the 12 press releases published were from our Southampton NIHR infrastructure (the Natasha trial, the NiPPeR study and TB biological markers). The norovirus vaccine trial from the Wessex Research Hubs (hosted by UHS) was also on the list, meaning a third of the NIHR's national highlights in this feature recognise the exceptional research being delivered by our infrastructure.

Regulatory Inspections

There have been no new regulatory inspections impacting R&D in the last year, however significant work has been undertaken to strengthen our governance and quality assurance processes. Aligning more closely with divisional governance structures and reporting to RDSG, a R&D quality and oversight group has been established to enable a focussed and strategic review of research quality, regulatory matters, risks and incidents.

Research Reset – sponsor focus

In Q3 23/24 following a letter from DHSC as per of the national research reset programme, NHS and University sponsors were encouraged to maintain a portfolio of studies opening within planned timelines and where at least 80% are delivering to time and target. The letter further stated that future NIHR infrastructure competitions would consider whether applying organisations sponsored study portfolios are at/near 80% or that there is demonstration of significant progress from the September 2023 baseline towards the 80% target.

NHS Trusts and Universities sponsoring studies but not meeting the target or able to demonstrate significant progress by the time of applying for the infrastructure award will remain eligible to apply for 90% of the funding envelope set out in the guidance for the scheme. This applied to infrastructure competitions launched from 1st April 2024. As such, the CRDC was the first part of Southampton's infrastructure to be impacted by this change.

Increased performance monitoring and portfolio management oversight is enabling both UHS and UoS to improve metrics, with UHS now consistently delivering between 88%-92% of studies each month to time and target. We were pleased to be eligible to apply for the full funding envelope available for the CRDC, as well as the more recent ARC award and continue to closely monitor this metric.

Driving inclusive research

We made big strides in widening research access for our diverse communities over 2024-25. The Southampton Centre for Research Engagement & Impact (SCREI) is pivotal in this.

In partnership with HiOW ICB, we expanded the Raising Voices in Research (RVIR) initiative. This now engages 21 VCSE organisations with researchers to address community priorities. Advances this year include:

- A programme with Mental health organisations for NIHR Wessex Applied Research Collaboration.
- New training, empowering VCSEs to better engage with researchers on prioritisation and design.

Alongside this, SCREI piloted Inclusive Engagement Staff Link roles for research nurses. grant-funded protected time enabled them to train in and deliver community engagement events. Four staff took part, engaging over 200 people from black communities. That work supported our delivery of the national Improving Black Health Outcomes programme.

Working with other UHS teams, we expanded our engagement at major cultural events. This year we attended:

- Southampton PRIDE
- Southampton Mela festival of Asian culture and arts
- Southampton Black Business, Arts and Music festival
- UoS Freshers Fair and Science & Engineering Festival

Together, these have seen the diversity of voices in our research increase. With the range of reported ethnicities alone among new joiners to our public involvement work rising from three to 14 over the year.

Shifting from treatment to prevention

Southampton CTU, in partnership with UHS, has been coordinating the NHS Cancer Vaccine Launch Pad (CVLP) for one year. This national collaboration was initially with BioNTech, a pharmaceutical company who is now keen to forge a strategic relationship with UHS. Work is underway to define the scope of this relationship which will formalise in 25/26. This relationship, combined with the local coordination of CVLP, puts Southampton at the forefront of cancer prevention innovations.

This year our Wessex Research Hubs, hosted by UHS, were the top UK recruiter for Moderna's NOVA trial, the first phase 3 trial in the UK for a norovirus vaccine. There are currently no licensed norovirus vaccines in use globally. If successful, this vaccine could have a profound impact for our most vulnerable citizens and on reducing the burden of seasonal illness on the NHS.

Wessex Health Partners

UHS along with UoS is one of the founding partners of Wessex Health Partners, a strategic alliance of health and care organisations, Universities and Health Innovation in Wessex, which aims to accelerate, through partnership working, improvement in health and care through research, innovation and training. Now approaching the end of the first term of WHP (31st March 2025) support for a second, 5-year term has been confirmed by partners.

<u>Key highlights 24/25</u>

- Round 2 of the WHP/WEMN small grants scheme awarded – 36 projects funded (15 projects funded in round 1).
- 4 themes identified to be taken forward as WHP academic themes: air quality, genomics, services health, inequalities and multimorbidity. Research questions formulated within each theme and appropriate funding streams for grant proposals are being identified.
- Collaborative pan-Wessex funding applications supported throughout the year
- Themed R&I regional programme for maternal health inequalities supported (launching April 2025)
- Supported the successful application for the Wessex NIHR CRDC

- Profile of WHP strategic alliance increased through communications activities and regional, national, and international meetings and conferences.
- Pan-Wessex network development and learning events, focused on system priorities.

2.2 Research Portfolio

Returning to pre-pandemic research activity levels has remained a challenge this year, although we have seen an improvement in our national performance (see below). We have continued to see the impact of the recruitment pause on our capacity to set up and deliver research studies, and as a result our national recruitment performance ranking has not improved as much as we had anticipated (see below).

- The total number of participants recruited into NIHR portfolio studies 2024-25 was 17,808 - 91% of 2024/25 target (pre-pandemic five-year average of 19,510 participants). A further 1,750 participants were recruited into non-portfolio research studies.
- Opened 220 new studies – 77% of our 2024/25 target (pre-pandemic five-year average of 284 studies).

This year, in response to the O'Shaughnessy report and to ensure appropriate levels of income, we have had a specific focus on opening more commercial studies. As a result, this year we have opened more industry-led studies than ever before at UHS, with commercial research accounting for 38% of the total number of studies opened compared to 25% previously. We consistently rank in the top 5 trusts in the country for recruitment to commercial studies and continue to foster strong links with industry partners.

We recognise that the length of time taken to set up studies falls below our key performance indicator of 80% of new studies achieving contract execution within 40 days. Significant work has been undertaken this year to streamline processes and R&D staff are contributing to the national programmes seeking to address this issue across the system. This continues to be a priority focus for 2025-26 and it is anticipated that we will begin to realise the impact of this work this year.

The national portfolio reset process has resulted in more studies which were failing to recruit close this year, with work planned nationally in 2025-26 to reduce the number further. Challenges remain with participant recruitment processes for some trials in the post pandemic NHS environment, virtual clinics limit the integration between clinical care and research with research staff unable to approach patients during routine diagnostic appointments. This is being addressed in two ways:

1. An internal QI programme focussed on specific specialties to understand the challenges, put actions into place and then monitor these has been initiated. As part of this, plans to integrate research further with MyMedical record and other software is being explored.
2. R&D continue to have presence as part of the outpatient transformation programme and are engaging with the UHS Digital Days to articulate the advantages for research integration further.

2.3 Delivery Against Corporate Objectives

2.3.1 Corporate Objective 2(a) 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.

SETT centre key achievements in 24/25

The SETT centre held its first conference in the autumn, with approximately 120 attendees. Feedback from attendees was excellent and there are plans underway for a larger conference with a greater external focus in 25/26.

The longer term sustainability of SETT has been a key focus this year. Governance has continued to be an area of focus as well as planning for year 6 and beyond.

Emerging Therapies

- SETT Emerging Therapies group is working with the Midlands and Wales Advanced Therapy Treatment Centre Network. This is increasing our reputation as a gene and cell therapy centre, maximising the opportunity for new studies and working in partnership with national teams.
- An evening webinar event was held at the request of members of the public to discuss and share advances and opportunities in Advanced Therapy research.
- The national contract review process (NCVR) was piloted and subsequently launched on October for ATMP studies. UHS was involved in the pilot phase which has enabled excellent collaborative working with other ATMP delivery centres.
- Continued to increase the range of studies/specialties expressing interest and delivering at UHS, increasing study income and clinical care impact. The first ophthalmology and respiratory ATMP studies at UHS opened to recruitment this year.
- Supported regional aspirations for ATMP delivery, including primary care.

MedTech

- The MedTech pathway is established and is now linked to the UHS Commercial Team pathway to maximise opportunity and use of capacity to support MedTech innovation and research.
- SETT MedTech presented at the AHSN event to demonstrate the work we do to local industry and innovation partners.
- Supported the submission of 4 significant i4i grant applications and NICE tender supporting researchers and partners to bring future funding to UHS.
- Launch of MESH (Mapping Excellence in Supporting HealthTech in Wessex) survey in conjunction with Wessex Health Partners polling local partners to identify avenues of MedTech support across Wessex streamlining the pathway and expediting concept to trial pathway efficiency
- The SmartMG study has been supported by SETT through the full pathway from concept, trial design, costing and protocol and in now open to recruitment (utilising AI and technology to support patients with the degenerative neurological condition myasthenia gravis).

Data and AI

- First Fast Inquiry (FiFI) process has been established to provide rapid response to commercial inquires on data held at UHS for real world data study feasibility
- Work on data cataloguing commenced in key specialities (cancer, dementia) is leading regional SDE development of future data availability.
- Successful delivery of first commercial real world data study of rare disease - Autoimmune Haemolytic Anaemia (wAIHA)
    - First commercially costed data study outside of NCVR
    - First use of live SDE platform enabling safe secure data sharing and access
    - Utilised both large scale data curation and clinical validate to provide data for future submission for FDA analysis
    - First data study using the Florence platform at UHS
- Significant work has been undertaken to support the implementation of the Wessex SDE, instrumental in data curation and provision. Systems and governance in place to transfer data from SETT Data into Wessex SDE via an API.
- Members of the RDS team won the Royal Society AI in Orthopaedics hackathon and were runners up in the Cardiff NHS hackathon using LLMs (Large Language Models) to support clinicians pulling data from patient records using questions.
- Ongoing development of SETT data infrastructure to provide cost effective test beds for AI research.

Research Leaders Programme (RLP) key achievements in 24/25

Some of the key achievements of the Research Leaders Programme this year are listed below (see Appendix 6 for further information).

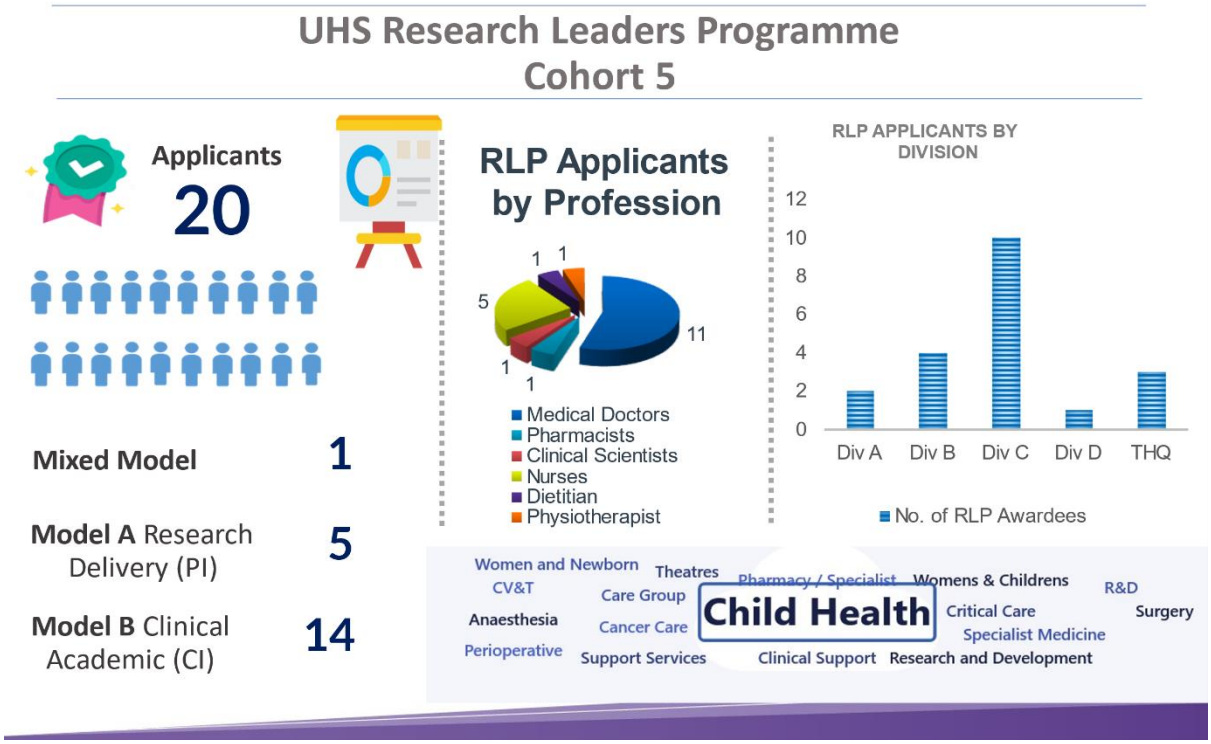
- We have now appointed to Cohort 5 of the Research Leaders Programme (RLP). It represents the most diverse group of healthcare professionals and the largest cohort size to date, with 12 members, bringing the recruited cohort members total to 43 (C1 = 10, C2 = 7, C3 = 5, C4 = 9, C5 = 12).
- In 2022-24, 18 personal grants were awarded (totalling £6.2m).
- In 2024-25, 5 personal Awards and 18 grants were awarded totalling £11.6M including seven fellowships, securing long-term funding for research time:
    - **Caroline Anderson C4** - NIHR Senior Clinical and Practitioner Research Award (SCPRA)
    - **Sofia Michopoulou C4** - NIHR Senior Clinical and Practitioner Research Award (SCPRA)
    - **Cathy McKenzie C2** - NIHR Efficacy and Mechanism Evaluation Advanced Fellowship (EME)

  (**Catherine McKenzie C3** and **Jessica Bate C1** (2023-24) and **Stephen Lim C1** and **Dushi Ahilanadan C1** (2022-23) are also fellowship award holders as discussed in last year's annual plan.)
- Supervision and support of clinical nurse specialists, registrars and junior doctors to carry out clinical research projects, in addition to master's degree and PhD student supervision.

Examples of leadership activities and recognition:

- **Sophie Fletcher C1** - awarded an Honorary Associate Professorship in recognition of outstanding achievements throughout her career; her national and international reputation derived from a sustained and continuing track record of excellence in her area of activity; and her contribution to the Research and Education agenda of the University of Southampton.

- **Sophie Fletcher C1** – recruited and mentored five international clinical fellows through the NIHR Associate PI Scheme, four of whom achieved NIHR Associate PI status.
- **Sophie Fletcher C1** - received the National Clinical Impact Award 2024, a public acknowledgement of the individual's sustained commitment and dedication to the NHS and a recognition of the national impact of their efforts over and above their contractual requirements.
- **Jessica Bate C1** - awarded Vaccine Task Force funding for a Covid vaccine study in children with cancer.
- **Matt Stammers C2** - appointed SETT Data and AI Lead.
- **Mark Banting C1** and **Sophie Fletcher C1** - successful collaboration led to the UHS becoming a recruiting site for the non-commercial clinical trial *BREEZE 2: A randomised controlled trial of a complex intervention to manage breathlessness in pulmonary fibrosis*.
- **Hannah Markham C2** - co-applicant on a £3.5 million MRC grant proposal, in collaboration with colleagues at Imperial College, University of London – awaiting outcome.
- **Bhaskar Somani C1** - has two patents filed and has launched four UK National Endourology training courses. He is Research Lead and Board Member of the European Association of Urology Section of Endourology.
- **Caroline Anderson C4** - developing local, regional and national Dietetic Research Networks.
- **Linden Stocker C3** – appointed to the new position of NIHR RDN Specialty Lead for Reproductive Health and Childbirth.
- **Tracy Coelho C4** - Hosts his own podcast '*The pIBD Digest – the rising incidence of paediatric inflammatory bowel disease (pIBD)*'.
- **Mark Johnson C4** - Led a successful Health Technology Assessment (HTA) application for £2.5m. Appointed Professor of Child Health at University of Southampton.
- **Richard Marigold C4** - tasked by NHS England, Richard created a 24/7 Thrombectomy Service which launched in March 2025.
- Several RLP members have collaborative projects with former RLP member **Luise Marino C2**, including **Steven Lim C1** leading an ARC Wessex study investigating the prediction of falls.
- SETT team is directly supporting the projects of several RLP members, including **Thom Daniels C3**, **Mark Wright C3**, **Boyd Ghosh C2**, **Catherine McKenzie C2** and **Andy Fox C2**.



Delivery Infrastructure

In last year's annual plan, we focussed on the anticipated impact of the appointment of dedicated, ringfenced resource dedicated solely to the creation and approval of clinical trial prescriptions and worksheets. We anticipated that we would realise the impact of this strategy in Q1 24/25. We have seen several oncology studies which had been stuck in the set-up phase for many months (and in a few cases over a year) open to recruitment. We have also increased the number of medicinal studies in set up each month, increasing from 8 to 14 new study set ups by January 2025. A new, multidisciplinary prioritisation meeting has been established each month to ensure that the right studies are being prioritised at the right time, being mindful of capacity challenges across teams, maximising delivery opportunities for our patients and ensuring robust communication regarding study set up with realistic timeframes with industry partners.

Return on Investment

Research and Development Financial Plan update FY2025/26

Original Investment Plan 20/21 Financial Year

Income £m's	Year 1 21/22	Year 2 22/23	Year 3 23/24	Year 4 24/25	Year 5 25/26	Total	
	£26.34	£27.57	£30.46	£32.81	£35.94	£153.12	
Expenditure £m's	£28.92	£30.63	£33.71	£36.31	£39.21	£168.78	
Trust I&E Position £m's	**-2.58**	**-3.06**	**-3.25**	**-3.5**	**-3.27**	**-15.66**	Investment required
Contribution to Trust Overheads	£1.20	£1.20	£1.20	£1.20	£1.20	£6.00	
Net Trust I&E Position £m's	**-£1.38**	**-£1.86**	**-£2.05**	**-£2.30**	**-£2.07**	**-£9.66**	

Annual plan FY25/26. Actuals FY21/22 - FY24/25 and proposed budget FY25/26

	Year 1 21/22 Actuals	Year 2 22/23 Actuals	Year 3 23/24 Actuals	Year 4 24/25 Actuals	Year 5 25/26 Proposed budget	Total
Income £m's	£46.45	£44.66	£43.50	£43.00	£42.80	£220.41
Expenditure £m's* **	£48.46	£46.96	£45.90	£45.40	£44.60	£231.32
Underlying Trust I&E Position £m's	**-£2.01**	**-£2.30**	**-£2.40**	**-£2.40**	**-£1.80**	**-£10.91**
Movement in Provisions (one-off)*	£0.00	£0.00	£1.40	£0.00	£0.00	£1.40
Trust I&E Position £m's	**-£2.01**	**-£2.30**	**-£1.00**	**-£2.40**	**-£1.80**	**-£9.51**
Contribution to Trust Overheads**	£1.20	£1.20	£1.20	£1.80	£1.80	£7.20
Net Trust I&E Position £m's	**-£0.81**	**-£1.10**	**£0.20**	**-£0.60**	**£0.00**	**-£2.31**
Allocation to UHS Divisional Workforce**	**£4.09**	**£4.52**	**£5.59**	**£6.10**	**£6.07**	**£26.37**
UHS contribution to PI funds, ETCs etc***	**£0.75**	**£0.43**	**£0.43**	**£0.43**	**£0.40**	**£2.44**

* In 23/24 Provisions totalling £1.4m were released into the R&D position to support the Trusts finances
The release of these funds improved the R&D position from an underlying £2.4m deficit to a £1.0m deficit in year
** Overheads contributions have increased for 24/25 Financial year by £0.60m up to £1.80m
*** The above figures include Principal Investigator Expenditure not included in original investment plan figures
**** States research allocations to divisions funding workforce costs to deliver research projects
*****States UHS contribution to PI funds etc, over and above the investment case

2.3.2 Corporate Objective 2(b) Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.

- **Develop a set of initiatives to recognise and reward staff for engaging in research.**
- **Show a clear return on investment of the Research Leaders Programme.**
- **Develop a set of initiatives with QI, education, and innovation teams to develop an approach to collaborative / system working.**
- **Agree UHS/UoS collaborative clinical research centres of excellence and areas of strategic growth.**

The existing initiatives in place across UHS to recognise and reward staff for engaging in research have been mapped this year with a working group established to focus this work. Mechanisms have been developed to capture and track the return on investment for the Research Leaders Programme, used in the 23/24 RLP annual report to demonstrate the ROI of the programme.

This year saw the agreement and launch of the joint research vision between UHS and UoS after approval from the Joint Research Strategy Board and Senior Operational Group. This marks the first time that there has been a formalised joint research vision for the partnership. Mapping of interdisciplinary and operational projects across the partnership is ongoing, this year saw the mapping of overlapping areas between UHS and UoS which gives us key strategic priority areas to focus on.

3. Challenges in 2024-25

3.1 Workforce

The impact of the recruitment controls on vacancy rates in both the research and clinical support services workforces continue to have a significant impact on capacity to host and deliver research and have contributed to our performance in 2024/25 not improving to pre-pandemic levels. The impact of the recruitment pause across research teams and support departments meant withdrawing from some studies we had been selected for this year, and sponsors withdrawing us as a site due to our inability to meet set up timeframes, this equates to an estimated loss of income of £1.25m. The total number of studies set up has declined over the past two years as a consequence of workforce capacity constraints.

The recruitment pause in 2023/24 coincided with a significant number of departures from the R&D study set-up team, which delayed appointing to vacancies. Additionally, several new team members were still within their initial six months of training, limiting immediate capacity. Most leavers transitioned into higher-banded roles within the R&D infrastructure, which was a positive outcome as their expertise was retained and developed within UHS. Vacant posts were gradually filled, with full staffing achieved by the end of Q3 2024/25. While headcount was maintained, recruitment progressed at a slower pace. The net effect of all of this was reduced capacity during 2024-25 and affected study set-up which is our most resource-intensive activity.

Currently, the set-up team has only one vacancy due to maternity leave. Looking ahead to 2025-26, we aim to minimise the impact of any future recruitment pauses through ongoing process streamlining.

Despite this, some improvements have been made and this is reflected in our participant recruitment metrics for this year. There has been a specific focus on balancing the portfolio to include more commercial studies, changing from a 25:75 split of commercial:non-commercial trials opening at UHS at the start of the year to a set up balance of approximately 40:60, achieved half way through the year. We have also recruited more patients to commercial trials as a result, benefitting from the income this generates. We appreciate that many of the workforce issues we face are reflected across UHS and the NHS nationally. Our portfolio is weighted towards experimental, early phase research with significant resourcing requirements and reliance on support services to deliver.

We continue to scrutinise staff survey results with aligned action plans implemented throughout the research infrastructure. A focus for this year included promoting strategies to feel satisfied at work, personal development and celebrating success. This helps to ensure that we maintain a focus on staff health, development and wellbeing and support staff retention.

3.2 Impact on Delivering the Research Strategy

This year saw a focus on our strategy implementation plan and establishing the baseline measures for our key performance indicators to enable robust monitoring of progress. We aligned the R&D annual workplan with the strategy implementation plan ensuring all areas of research infrastructure were appropriately sighted and working together to achieve the strategic aims.

The capacity constraints detailed in 3.1 above have meant our capacity for delivery of some of our strategic ambitions have been constrained. Nevertheless, we continue to make progress, with some

undeniable areas of slippage. Progress is being closely tracked and the annual workplan template for 25/26 is aligned to the implementation plan to ensure a focus on the priority areas required for the future successful delivery of the strategic aims.

3.3 Grants and Early Career Researchers

It is promising that once again there has been an increase in the number of grants and personal awards applied for and secured this year.

- There was a 27% increase in number of funding applications for grants and personal awards from 2023-24 to 2024-25.
- There was a 30% increase in total costs requested; 52% increase in the UHS costs requested.
- The number of successful grants increased by 41% from 2023-24 to 2024-25 (22% rise in total award value, 63% rise in UHS award value) and by 72% on 2022-23
- Successful personal awards jumped significantly but from a low base in 2023-24 – a more realistic comparison is with 2022-23, and last year was 27% higher than then.
- The RLP cohorts and SoAR's support and facilitation offered in additional to the R&D grants team support is demonstrating an impact.

Despite this, the trajectory is not back to or exceeding the desired pre-pandemic position. The clinical demands on our investigators have led to fewer grant applications being submitted, with some submissions rushed and costings requested at very short notice. Several new, short deadline calls linked to the BRC were issued in Q4 unexpectedly. Research costs have risen, particularly in salaries and grant funding envelopes have not risen to match these rises.

Limited resource within the R&D grants team due to the recruitment pause placed pressure on the remaining staff member to support researchers pre and post award. With staff now in place, there will be a renewed focus on drop-in clinics for researchers to promote the support available.

3.4 Support Department Capacity Constraints

Pharmacy: The significant work undertaken within pharmacy over the past couple of years has had a significant impact on our ability to set up and deliver clinical trials in a timely manner. Backlogs within oncology are being cleared because of the additional NIHR funding received focussed on prescription work on ARIA. However, pharmacy continues to encounter capacity constraints due to staffing.

- Pharmacy technician vacancies within the clinical trials pharmacy team have not been filled, despite advertising on multiple occasions. This causes backlogs, particularly in relation to the processing of clinical trial amendments.
- Capacity issues within the aseptic pharmacy team have caused a delay in worksheet sign off for some oncology studies. This relatively small team have been struggling with prioritising specific studies against the backdrop of the work required to support the build, validation and commissioning of our new aseptic unit. Improving communication and prioritisation between the clinical trials team and aseptic teams should support resolving this in conjunction with the opening of our new aseptic unit.

- Progress has been made this year with addressing the challenges relating to advanced therapy studies, however, with a key member of staff leaving the team at the end of 24/25 there is a possibility that issues will be encountered within the ATIMP portfolio in 25/26.

Imaging: The plan to bring some MRI and CT imaging for commercial trials back in house commenced this year, reducing the reliance on external providers and retaining more income and capacity build arising from research imaging internally. The majority of this work is still outsourced and continues to be reviewed on a study-by-study basis with the aim of increasing the volume of work re-patriated over the coming year.

- Imaging Guided Research Biopsies**:** Capacity constraints have been experienced with imaging guided biopsies for research due to a lack of capacity within the clinical service. We are now considering utilising space within the Clinical Research Facility for post procedure observations where clinically appropriate to mitigate this.
- Radiology Reporting: Capacity constraints within neuroradiology have also impacted the trial set up portfolio due to lack of capacity for reporting. There is currently no ability for the set-up of studies requiring paediatric neuroimaging, which has been the case all year. In addition, radiology capacity issues relating to capacity for RECIST and RANO reporting has created challenges for a number of cancer studies. Successful recruitment to vacancies will enable these constraints to ease, and we continue to explore outsourcing options and opportunities for regional collaboration in the interim.
- PET Scanning capacity: In addition, where clinical trials require PET scans, delays continue to be experienced with effective study set up and capacity constraints cited by the provider. Scoping work undertaken last year revealed this to be a national issue with the provider and national discussions have been ongoing this year by the Health Research Authority, to which we continue to contribute. Regional and national dialogue with other Trusts also continues.

3.5 Finances

- FY24/25 total income of £43m vs FY23/24 of £44.8m (includes provisions). The £1.8m reduction was driven mainly by Cov Boost income - FY24/25 income was £2.8m vs FY23/24 income of £4.5m. If we exclude Cov Boost, income increased by £0.1m.

FY24/25 income consisted of:

- Commercial income £7m (£0.5m increase on the previous year)
- Non-commercial income £18m (£2.9m decrease on previous year, of which £1.7m is Cov Boost)
- NIHR income £18m (£1.2m increase on the previous year)

- FY24/25 total expenditure of £45.4m vs FY23/24 of £45.9m. Despite an increase in pay costs due to the pay award of c£1m there was less spend on non-pay.
    - R&D Pay costs £19.4m (£1m increase on the previous year mainly due to the pay award. There was also an increase of c9 wte)
    - Non pay costs £18.1m (£2.6m less than previous year)
    - Contribution to Trust and Divisions £7.9m (£1.1m increase on the previous year). This includes a contribution to overheads, support department infrastructure plus pay and

non-pay costs to deliver studies. The overhead contribution of £1.8m increased by £0.6m when comparing to the previous year.

The £1.2m reduction in non-commercial income (excluding CovBoost) in 2024/25 is partly attributed to a decline in recruitment to interventional commercial studies, which typically generate higher income, and partly to a general decrease in study setup activity. We continue to monitor the NIHR portfolio closely, and this trend reflects a national shift—particularly a reduction in high-recruiting interventional studies—rather than a strategic move away from non-commercial research in favour of commercial studies. While we anticipated a greater increase in commercial income, we expect this to improve as current commercial studies progress and patient recruitment increases.

We have observed that some interventional non-commercial studies are underfunded, though they offer other strategic value to UHS, patients, and the NHS (e.g., cost avoidance). A national initiative is now underway to review the costing of non-commercial research, with UHS actively contributing to the working groups. Encouragingly, we have recently seen more studies offering improved income potential for UHS, and we hope this trend continues. Our portfolio is reviewed weekly to identify risks and inform national discussions.

FY24/25 total expenditure of £45.4m vs FY23/24 of £45.9m. Despite an increase in pay costs due to the pay award of c.£1m there was less spend on non-pay.

- R&D Pay costs £19.4m (£1m increase on the previous year mainly due to the pay award. There was also an increase of c.9 WTE)
- Non pay costs £18.1m (£2.6m less than previous year)
- Contribution to Trust and Divisions £7.9m (£1.1m increase on the previous year). This includes a contribution to overheads, support department infrastructure plus pay and non-pay costs to deliver studies. The overhead contribution of £1.8m increased by £0.6m when comparing to the previous year.

4. R&D Corporate Objectives for 2025-26

Our overarching ambition is to be a leading teaching hospital with a growing, reputable and innovative research and development portfolio that attracts the best people and efficiently delivers the best possible research, treatments and care for our patients.

Our corporate objectives provide us with a focus on effective and efficient clinical research delivery over the coming year to aim to bring us back to (and exceed) our pre-pandemic performance. The current workforce challenges provide the impetus to streamline processes and seek efficiency savings to maximise performance and ensure we offer a diverse research portfolio to provide research opportunities for our patients.

Pioneering research and innovation - a leading teaching hospital with a growing reputable and innovative research and development portfolio that attracts the best staff and efficiently delivers the best possible treatments and care for our patients.

Ambition 1	We will recruit and enable people to deliver pioneering research in Southampton
Ambition 2	We will optimise access to clinical research studies for our patients.
Ambition 3	We will enable innovation in everything we do, and ensure that 'cutting edge' investigations and treatments are delivered in Southampton

Ref	Lead	New Objective for 2025-26
2(a)	CMO	Deliver year 5 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure. • Aim to secure long-term sustainability of the Research Leaders Programme • Develop MedTech pathway, assessment method and UoS/UHS advisory group • Aim for 5% increase in the number of specialties running ATIMP research

Ref	Lead	
2(b)	CMO	Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact. • Develop and deliver UHS PI Offering • Develop plan for growing identified strategic areas of growth • Complete mapping identifying gaps and opportunities for initiatives to encourage and support staff engaging in research, agree initiatives and assign leads to progress. • Conduct annual evaluation of strategy KPIs • Develop and deliver a organisational development programme focussed on culture within research through the senior leadership team.

4.1 Key Initiatives for 2025-26

The key priorities for the next year are summarised below.

4.1.1 Strategic & Operational

Research for Impact (2023-28) strategy: We will ensure ongoing alignment of the strategy implementation plan and implement tracking and monitoring of strategic KPIs with the annual workplan. These include:

- Delivering a consensus statement addressing collaborative working across improvement, innovation, research and teaching to deliver a learning health care system.
- Developing & refining a set of initiatives to recognise and reward staff for engaging in research.
- Improving researcher satisfaction across the UHS/UoS strategic partnership with research support.
- Developing a plan for growing the identified strategic areas of growth.

- Fostering a culture of compassionate and collective leadership across R&D infrastructure.
- Undertake internal infrastructure reviews in addition to the planned BRC external review planned for this year.

UK Clinical Research Delivery Programme (UKCRD): UKCRD replaced the UK Clinical Research Resilience, Recovery & Growth (RRG) in 24/25. The UK research ecosystem continues to work together on a coordinated, coherent programme of work addressing capacity and growth of the UK clinical research delivery system and looks to develop an ambitious strategy to support and deliver government plans, including the 10-year Health Plan, aligning research delivery with the three big reform shifts. At UHS, workstreams continue to take forward the implementation programme, contributing to national working groups to influence national decision making and reviewing local implications of national strategies.

Clinical research is considered key to the vision of building a health and social care system fit for the future and to drive economic growth for the country, as laid out in the Health and Growth missions of the government. With site level performance metrics being published in relation to commercial study set up times and recruitment of the first participant at site once the study is open from April 2025 we continue to focus on optimising our processes to ensure efficient, streamlined study set up maximising the opportunities for patients to take part in clinical trials. The national KPIs are reviewed at monthly internal performance meetings in addition to other data from internal dashboards to understand and address operational challenges and identify where improvements can be made.

The UKCRD workstreams and forthcoming 10-Year Health Plan reform shifts needed to move healthcare from hospital to the community, analogue to digital and sickness to prevention are aligned with the strategic plans outlined within our Research Strategy and continue to influence the work plans for 2025-26.

Optimise UHS Research Portfolio: Our ongoing goal for 25/26 remains continuing to restore and exceed pre-pandemic levels of research activity while aligning the research portfolio to strategic priorities. Our ambitions need to be aligned to workforce capacity, requiring a considered focus on streamlining processes and ensuring efficient resource utilisation to achieve this.

- We will monitor our performance against nationally agreed research KPIs (due to be published in Q1) against our peers.
- We will develop an operational process for prioritisation of our study pipeline for both medicinal studies and other types of research.
- We will continue to focus on our study set-up processes, to ensure that our timelines map to national metrics.

Research Infrastructure: We have discussed the data considered by DHSC for NIHR research infrastructure competitions in order to be eligible for the full infrastructure award funding envelopes at the time of the funding call (see section 2.1). We were pleased to be able to apply for the full envelope for the NIHR Commercial Research Delivery Centre (CRDC) and NIHR Applied Research Collaborative (ARC) Wessex competitions in 24/25. With the revised ARC application due for submission in Q1 25/26, and preparation for the next BRC application commencing this year, we continue to closely monitor our sponsored study metrics, scrutinising this data within performance dashboards.

Digital Adoption

We described the steps taken within 24/25 to increase digitisation of research within section 2.1. This work will continue this year. The implementation of Florence e-binders will see the system being used as the trial master file for all UHS sponsored studies in 25/26, meaning no more paper folders for these studies. A training programme is in the process of roll-out to ensure all research staff feel competent and competent using the system. Once trained, a phased roll out for the system will commence for new hosted studies at UHS. This will dramatically change the way we manage health research study paperwork at UHS, creating efficiencies in our processes and reducing the resource required to manage research governance and study oversight. UHS has been seen as leading the way in this space, we have been working nationally to support other hospitals with implementation and contributing to national meetings and working groups on behalf of NHS R&D to ensure a digital system compliant with UK clinical trial regulations now and in the future meets the needs of hospitals conducting research.

A multidisciplinary approach to the identification of potentially eligible patients for research maximised opportunities for research participation for our patients in specific observational research studies in 24/25. Our aim in 25/26 is to increase this, ensuring working with our data team is business as usual when considering recruitment strategies for new studies and expanding this method of pre-screening to more complex studies.

<u>Research Delivery</u>

- Establish a regional CRDC working group focussed on workforce, inputting into the business, operational and annual working plans as required.
- Identify and understand specific patient pathways crossing organisational boundaries and how best to support clinical research delivery along the patient pathways.
- Continue to work with regional partners through the Wessex Research Hubs, Wessex Health Partners and Wessex Leadership Groups to explore opportunities as they arise to deliver NIHR portfolio studies requiring cross system working.
- Achieve an annual increase of the number of UHS patients being approached and participating in research studies, defining solutions to identified challenges for patient recruitment and formalising updates to set-up tools to incorporate recruitment strategies.
- Aim to implement a research champion role at UHS to engage more frontline staff in research, collating regional and national examples of research champion staff roles, creating a plan for implementation at UHS in the longer term.
- Work with local, regional and national partners to promote available resources for the variety of NMAHP career pathways, mapping the available pathways and opportunities for development and increasing presence and research awareness in both undergraduate training and newly qualified staff programmes through opportunities including student placements, NIHR Insight Programme, HEI engagement and the RCN Cadet scheme.

<u>Community Engagement</u>

This year we aim to involve more research staff in the planning and delivery of our major community events. This follows the success of research staff involvement at an event delivered to over 100 Zimbabwean women in 24/25. We will also endeavour to resolve barriers to community payments, evaluating the solutions and impact of these later in the year. Our BRC viking governance programme will continue to be delivered, with the viking group co-delivering our refreshed patient and public involvement and engagement (PPIE) strategy and objectives for NIHR annual reporting.

4.1.2 Strengthen our existing and develop new partnerships.

- Through the Joint Research Vision identify the strategic areas of growth across the UHS/UoS partnership and look to strengthen the partnership by realising research opportunities outside of existing areas (e.g. operational, health inequalities and sustainability research).
- Continue work on Joint Research Functions between UoS and UHS – determining the key areas to enable joint working and optimising the interface between academia and the NHS to streamline processes and enable mechanisms to provide a single function where possible.
- Continue to expand activity and reach of Wessex Health Partners in particular seeking to combine the 'one NIHR' offer with Health Innovation Wessex expertise to support our Integrated Care Boards to meet their statutory responsibility to 'Maximise the benefits of research and innovation'.
- Working with Wessex Health Partners, transition the governance structure of the Wessex research hubs to the newly awarded CRDC infrastructure, growing the model to include additional partners including Hampshire Hospitals, Salisbury Hospital and Hampshire and Isle of Wight Healthcare.
- Develop systems to capture research participation and socioeconomic & protected characteristics data, initiating a pan-infrastructure UHS-UoS diversity data project, reporting findings and an action plan to RDSG in Q2 before implementing recommendations in the latter half of the year.

4.1.3 Deliver year 5 plan for R&I Investment Case for new infrastructure and activity

Creation of an overarching strategy, year 6 plan and communications plan and metrics are the key themes for the Southampton Emerging Therapies and Technology Centre (SETT Centre) along with building the centre's reputation as we look to future sustainability beyond the investment case. There are planned roles in for developing and delivering the Wessex Secure Data Environment.

  - Emerging therapies: Streamline risk assessments, work across UHS and the ATTC network to identify new study opportunities thus increasing the range of specialties undertaking ATIMPs and improve capacity for ATIMP delivery, in relation to apheresis capacity and liquid nitrogen storage processes.
  - MedTech & Innovation: Develop and deploy a SETT/commercial EOI pathway, assessment method and assessment committee, launch MedTech roadmap and innovation rounds (1&2) and develop a joint UHS/UoS MedTech ISO13485 advisory group.
  - Data & AI: Transfer the UHS-UoS Data Access Committee to Wessex wide under the SDE, improve study pipeline management and flow, implement a new ICD cohort dashboard, release three open-source packages over the year and submit two data and AI independent papers.

- Continue to deliver the Research Leaders Programme (RLP), delivering cohorts 2-5 and aiming to award cohort 6 in 25/26 depending on securing ongoing investment in the programme.

Our strategic priorities are provided in more detail in Appendix 3.

5. Budget setting 2025-26

Budget setting for 2025-26 is in line with previous years' annual budget setting process. A high-level summary of the budget is provided in Appendix 4.

5.1 R&D Budget Setting

This is the final year of the five-year Trust investment plan, with a Trust investment budget of £1.4m. In addition, the Trust have also provided £0.35m PI fund budget and £0.008m Excess Treatment Cost. The total expenditure budget is £1.758m. All other expenditure plans must be within forecasted income.

5.2 R&D Income

Total income is projected to be £42.8m which is £0.2m (1%) lower than the 2024-25 actuals. This is detailed in Appendix 4, summarised as:

- NIHR income is £17m which is £1.1m (6%) lower than 2024-25 actuals (£18.1m). RCF income for 2025 -2026 has been budgeted at £1m vs £2.1m actuals in 2024-25.
- Study and grant income is projected to be £25.8m which is £0.8m (3%) higher than 2024-25 actuals (£25m). COVID related studies and grants including COV-BOOST closed in 2024-25. If we exclude this amount of £2.7m the increase is £3.5m (16%).

5.3 R&D Expenditure

Total expenditure is budgeted to be £44.6m, which is £0.8m (2%) lower than 2024-25 actuals (£45.4m), this consists of:

- Pay of £20.8m which is £1.4m (6%) more than 2024-25 actuals. Contributing factors are 2.1% inflation has been included, and due to the recruitment freeze at the beginning of the year there were several vacancies that were not filled until later in the financial year, which impacted on the actual costs for FY24/25. Due to recent events around the financial landscape all divisions across the Trust will need to reduce their wte. Once this has been agreed with R&D the budget and wte will be reduced accordingly.
- Non-pay of £15.9m which is £2.2m (12%) less than 2024-25 actuals, largely due to lower COVID study and grant costs.
- Transfer to Divisions of £7.9m is in line with 2024-25 actuals.

As income follows activity, research active departments across UHS will realise the benefits from all income streams. The strategy adopted by the Trust of reinvesting R&D income in resource to deliver activity, has resulted in year-on-year benefits to clinical research and thus patients, whilst also minimising the risk to the overall financial position of the Trust. The budgets set ensure that:

- All income is spent in accordance with funders' requirements.
- Income offsets all direct and indirect expenditure incurred, including a contribution to overheads.
- Contract commercial income is distributed with the 'profit' re-invested in delivering research for patients.
- Key research activity targets for 2025-26 are achieved.

- R&D budgets are set in detail and in consultation with Divisional Finance Managers as part of the Trust annual budget setting timetable.
- Budgets within R&D are signed off by the relevant budget holder.

In line with the workforce reductions the expenditure budget will reduce once this has been confirmed.

6. Trust Board Key Performance Indicators

Towards the end of 24/25 we undertook a review of the Trust Board key performance indicators to ensure alignment with national priorities and changes to performance metrics for R&D.

Performance against the finalised key performance indicators will be reported monthly to Trust Board. More detailed metrics are monitored monthly by the R&D Steering Group. The KPIs will be reviewed during 2025/26 to ensure that they remain fit for purpose and aligned with national strategic research priorities.

No	Title	Subtitle	Description	Target
1	Recruitment performance (absolute and ranking comparator)		Absolute recruitment, Number of studies recruiting and UHS national ranking amongst acute Trusts for all commercial and non-commercial NIHR portfolio studies.	Top 10
2	Performance in initiating clinical trials		Number of days taken to set up all commercial and non-commercial NIHR portfolio studies, negotiate costs and confirm C&C. Important for sponsor confidence in UHS as a site.	80% of studies taking ≤40 days
3	Performance in delivering clinical trials		Number of days taken to recruit the first participant once the study is open to recruitment (except where this is not expected in the study milestone plan (e.g. rare disease studies)). Compared to national metric (%).	80% of studies recruiting within ≤30 days
4	Proportion of sponsored studies open/on track		Proportion of UHS sponsored studies on track, delivering to time and target. Important to demonstrate sponsor competence and to be eligible to apply for the full envelope available for infrastructure awards and for NIHR confidence in organisational ability.	80-90% of studies open/on track

Appendix 2 – Research Impact

Stroke research changes clinical practice

Dozens of UHS patients took part in research that is now transforming stroke treatment. Tenecteplase, a new clot-busting drug studied in the national ATTEST-2 trial, will become the main drug used here for thrombolysis treatment. Dr Richard Marigold was the local lead for the trial. He is supported by the UHS Research Leaders Programme (RLP). Preliminary results helped inform guidance published by the National Institute for Health and Care Excellence (NICE) in 2024. They highlighted that tenecteplase's lower cost could save the NHS millions. Delivered as a single injection, it enables faster treatment and improves patients' chances of recovery.

'Transformative' cystic fibrosis drugs

Three modulator drugs have been approved for NHS patients with cystic fibrosis in England. Patients at UHS took part in pivotal trials that led to their approval. These took place at the NIHR Southampton Clinical Research Facility. The drugs treat the root cause of the disease, bypassing the genetic error that causes it. They can have a huge impact on patients' lives. Our researchers have worked with Vertex, the company who develop these modulator drugs, for over a decade. Southampton continues to be at the forefront of research in cystic fibrosis. The team recently treated one of the first patients in the world with a gene therapy breathed into the lungs.

Tackling Inflammatory Bowel Disease

Southampton researchers are driving new understanding of Inflammatory Bowel Disease (IBD) through the Genetics of IBD study. They have recruited over 3,000 patients at UHS. Key discoveries to date include specific DNA changes in over 7% of patients with Crohn's disease. Analysis showed that changes affecting the *NOD2* bacterial-sensing gene are the genetic root of these patients' disease. The research team have also showed that patients with this genetic cause are ten times more likely to need intestinal surgery. Working alongside a pharmaceutical company, the team is now helping to develop a gene-therapy treatment for *NOD2*-deficient Crohn's disease. It could prove transformational for this group of patients.

Treating leukaemia

New research into a cancer drug is changing the way a type of leukaemia is treated. This is based on evidence from two studies led by UHS haematologist Professor Francesco Forconi. The studies showed venetoclax can help treat patients with Chronic Lymphocytic Leukaemia (CLL). It is a type of targeted cancer drug called a cancer growth blocker, which is not considered a type of chemotherapy. The National Institute for Health and Care Excellence has now approved the use of venetoclax, in combination with another treatment, for NHS patients with CLL. Patients are already receiving the treatment at UHS as part of a new service.

Gene therapy 'cure'

A 'functional cure' for the blood clotting disorder haemophilia A has been approved for NHS use in England. The breakthrough follows years of Southampton research to progress new treatments, led by Dr Rashid Kazmi. Patients at UHS were among the first in the UK to receive the treatment. They took part in a landmark clinical trial that showed a single injection of the gene therapy dramatically cuts the risk of bleeding. It will significantly improve the lives of hundreds of people. The treatment is also gaining approval around the world. It has been approved by the US Food and Drug Administration (FDA) and European Medicines Agency (EMA).

Award-winning research

Pioneering staff from across our research community have been recognised for their advances with national and international awards in 2024-25:

- Professor Chris Edwards has been presented with the AESKU Lifetime Contribution to Autoimmunity Award. Prof Edwards is a leading expert in inflammatory rheumatic diseases. He has been a Consultant Rheumatologist at UHS for 23 years.
- Dr Cathy McKenzie and Dr Jessica Bate have each secured NIHR Senior Clinical and Practitioner Research Awards. This follows their time on the UHS RLP. The SCPRA award will fund the next stage of their careers as research leaders.
- Dr Sophie Fletcher's work to improve understanding and treatment of fibrotic lung disease has received a national award for clinical impact. She has thanked the UHS RLP for giving her the skills she needed to achieve this award.
- Three Southampton researchers have been selected as Senior Investigators by the National Institute for Health and Care Research (NIHR). Professors Miriam Santer, Nicholas Harvey and Tracey Sach are all driving new research at our NIHR Southampton BRC.
- Professor Philip Calder, a senior scientist in our NIHR Southampton BRC, has been honoured with a lifetime achievement award by the International Society for the Study of Fatty Acids and Lipids.
- Professor Tim Underwood has been selected for a national network promoting responsible artificial intelligence (AI) in health and social care. The surgeon leads a research team at UHS.

Appendix 3 – Annual plan 2025-26 Strategic Priorities

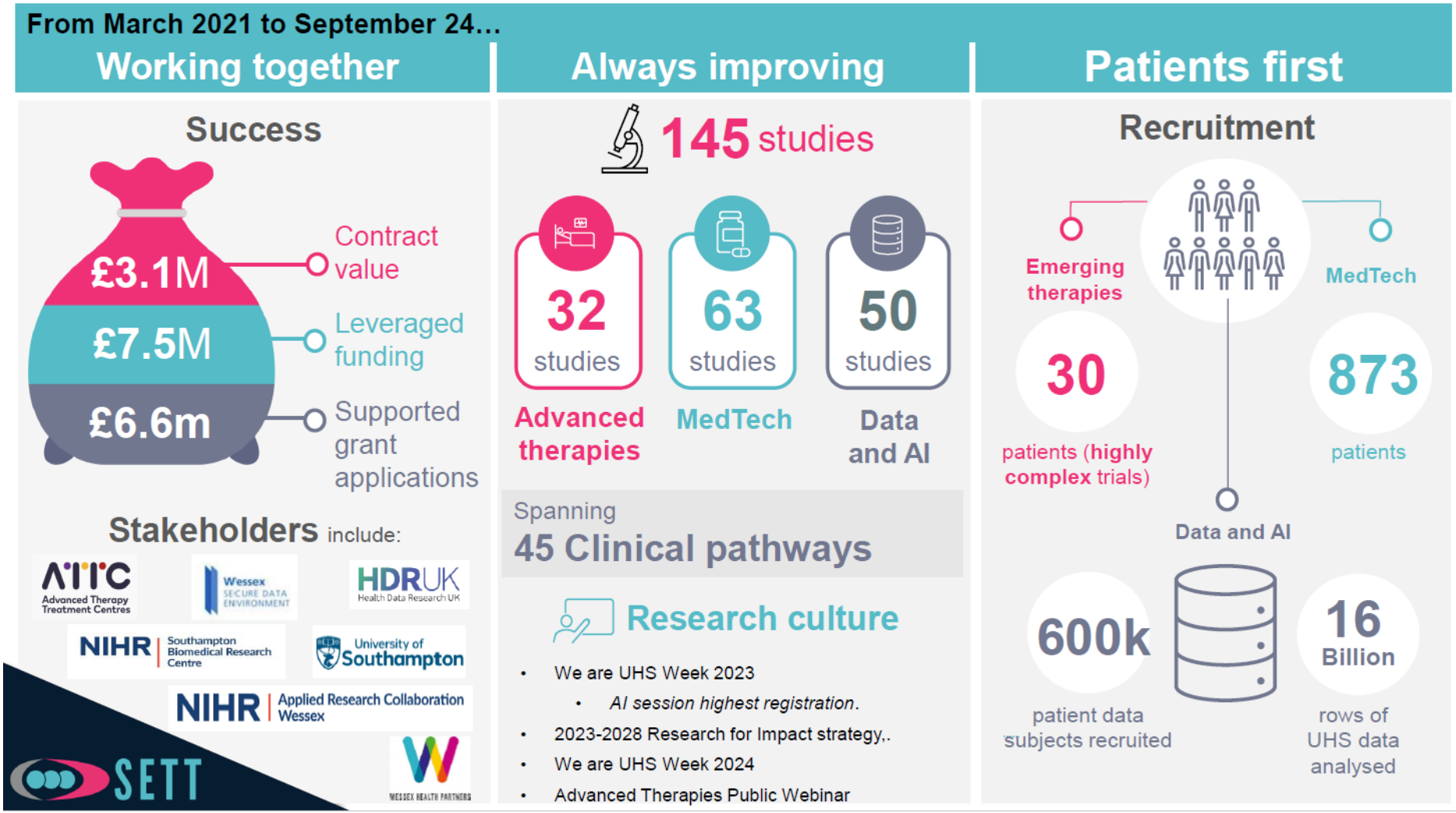
Theme/area	Q1	Q2	Q3	Q4
Organisational development/ culture	Develop and begin to deliver a organisational development programme	Deliver a organisational development programme	Deliver a organisational development programme	Evaluate and determine next steps of organisational development programme
Research culture	1. Analyse researcher satisfaction survey results and use to inform workplan going forward. 2. Complete mapping to identify gaps and opportunities for set of initiatives that recognise and reward staff for engaging in research. 3. Plan to conduct annual evaluation as part of strategy implementation plan going forward.	1. Deliver workplan (detail to follow) 2. Agree set of initiatives and assign leads to progress. Plan to conduct annual evaluation as part of strategy implementation plan going forward.	Use new updated corporate framework to include consensus statement addressing collaborative working (published in Q3)	
Optimise UHS Research portfolio	Develop UHS PI offering	Project INSPIRE - Finalise PI offer document, present to RDSG 25/26 Q2.	Deliver PI offering and project INSPIRE	Plan for an evaluation of project INSPIRE after 1 year (Autumn 26/27)
Alignment and broadening of strategic areas across UHS/UoS portfolio	1. Develop plan for growing the identified strategic areas of growth including those linked to BRC application. 2. Determine the baseline for the number of interdisciplinary and operational projects across UHS/UoS partnership	1. Implement plan 2. Plan for how to increase the number of interdisciplinary and operational projects across UHS/UoS partnership		
Wessex Health Partners	1. BRC internal review Q1/Q2 2. Determine studies delivered under WHP umbrella that have led to changes in practise.	1. CTU and ECMC review discussions to be progressed 2. Explore mechanisms for capturing/flagging studies under WHP umbrella (e.g. EDGE)	1. CRF internal stakeholder survey. BRC external review Q3/Q4. 2. Implement data capture	

Appendix 4 – R&D Budget Summary 2025-26

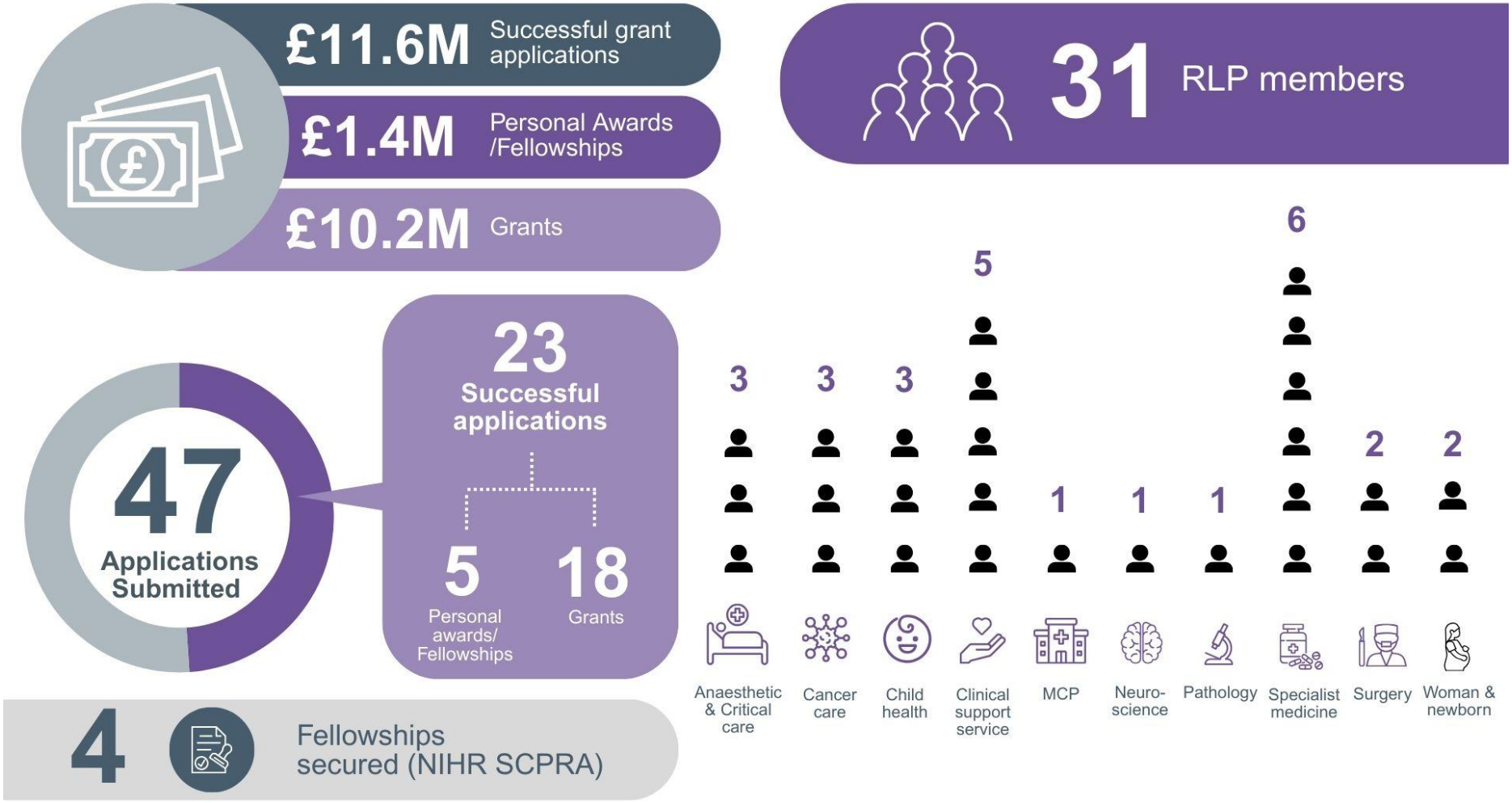
	FY 25/26 budget
R&D	**Estimated £m**
Income	
RRDN core ABF	7.23
RRDN additional (e.g. SGLs)	0.11
RRDN Clinical Support	0.13
RRDN Fellows	0.34
Commercial Income	9.24
Non-Commercial income	4.64
NIHR grants	4.16
Other grants	4.67
RCF Funding (estimated)	1.06
NIHR/NHSE infrastructure awards*	11.24
Total Income	**42.82**
Expenditure	
Division A	0.46
Division B	1.43
Division C	2.86
Division D	1.48
THQ	1.63
Contributions to Trust	7.86
ATIMP	0.84
CRF	4.55
BRC	4.55
SCREI	0.25
ECMC	0.20
Patient Participant Involvement team	0.13
SOAR	0.14
RLP	0.15
Strategic Development fund	0.16
Strategic Leadership team	0.37
SETT	1.37
RRDN	0.09
Non-medical trustwide delivery team	8.34
Trust wide research fellows	0.41
PI funds	0.84
R&D central office	2.47
External study costs	11.85
Sub total R&D	36.72
Total Expenditure	44.58
Net budget**	1.76

*NIHR Infrastructure Awards – Includes, BRC £5.2m, CRF £1m, ECMC £0.2m, ARC £3.1m.
** Net budget. Agreed as part of investment case.

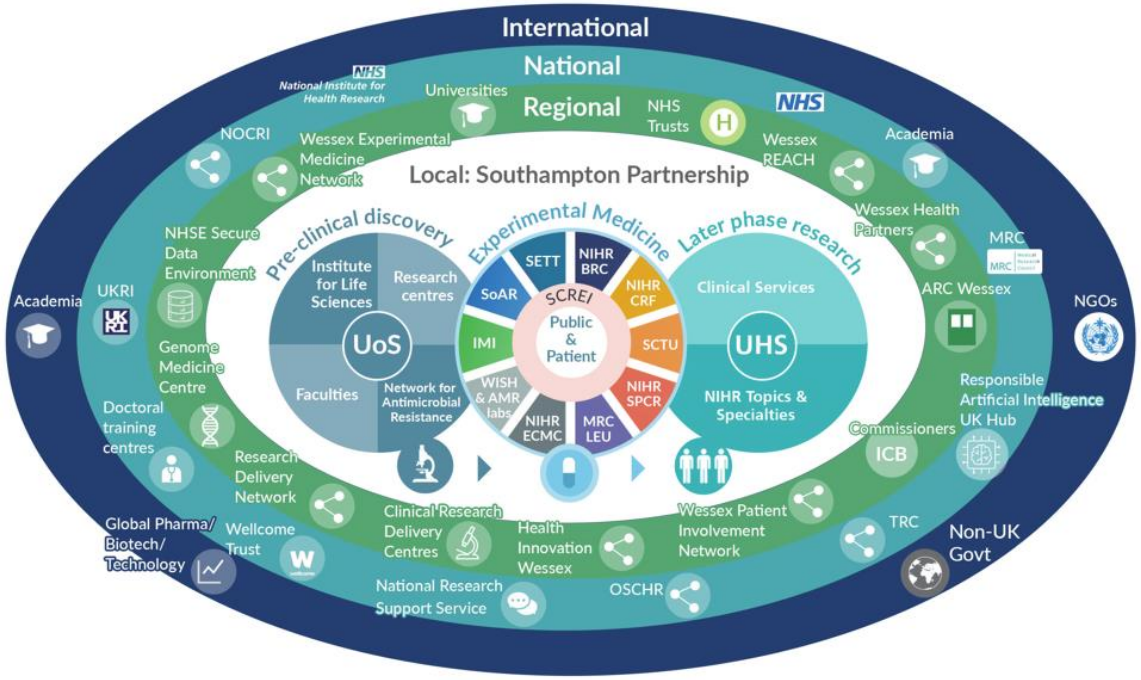
Appendix 5 – Southampton Emerging Therapies & Technologies (SETT) Centre



Appendix 6 – Research Leaders Programme 24/25



Appendix 7 – UHS/UoS / Regional Research Infrastructure



UoS:	University of Southampton
IMI:	Institute for Medical Innovation
WISH & AMR labs:	Wessex Investigational Sciences Hub and translational Antimicrobial Resistance laboratories
NIHR ECMC:	Experimental Cancer Medicine Centres
MRC LEU:	MRC Lifecourse Epidemiology Unit
NIHR SPCR:	School for Primary Care Research
SCTU:	Southampton Clinical Trials Unit
UHS:	University Hospital Southampton
SCREI:	Southampton Centre for Research Engagement & Impact
SETT:	Southampton Emerging Therapies and Technologies Centre
SoAR:	Southampton Academy of Research

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.3	Report to the Trust Board of Directors, 15 July 2025
Title:	Board Assurance Framework (BAF) and Risk Appetite Statement
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Lauren Anderson, Corporate Governance & Risk Manager Craig Machell, Associate Director of Corporate Affairs

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	x	x	x	x

Executive Summary:

The Board Assurance Framework (BAF) sets out the organisation's strategic risks and provides assurance that these are being managed to contribute to successful delivery of 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 includes articulation of 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.

To support effective risk management, the Board has engaged in a risk appetite workshop with the intent of reviewing and revising the organisation's risk appetite statement. The updated statement has been included within the report and it is asked that the Board review and ratify this if they are satisfied it reflects the current position.

Contents:

Paper
Appendix A – The full Board Assurance Framework
Appendix B – Risk Appetite Statement

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 May 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, Audit & Risk Committee, 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.

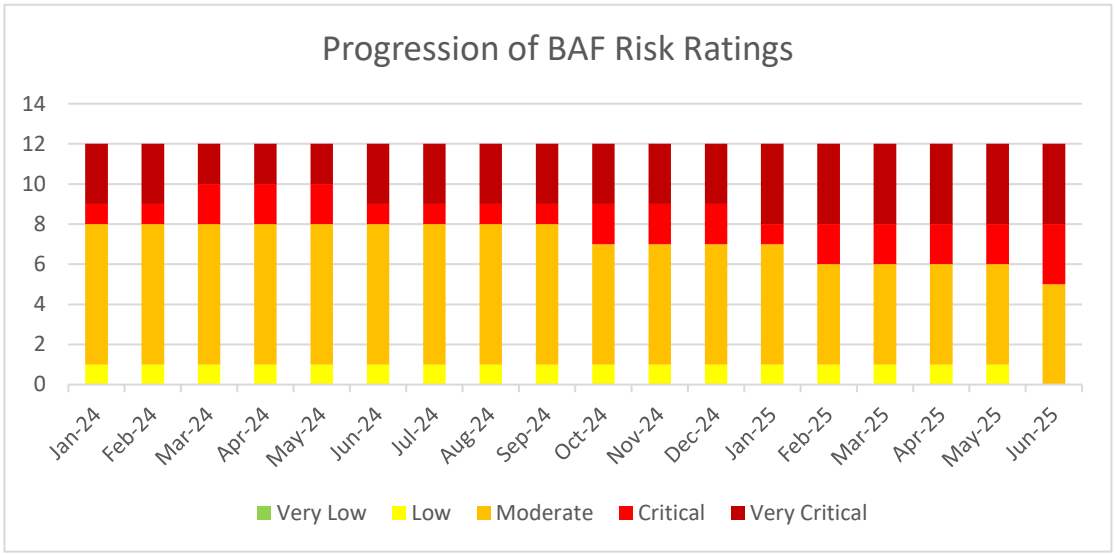
2.3. The risk rating for three risks have increased:

- 1b (Effectiveness and Outcomes) has increased from a moderate risk of 9 (moderate x possible) to a critical risk of 16 (severe x likely). This is based on the impact currently being seen, and anticipated to continue to be seen in the coming future, on patients. This includes increased numbers of category 4 pressure ulcers, increased falls, and high levels of complaints. This means that the risk is outside of our tolerable and optimal risk appetite, although plans are in place to reduce this over the next two years.

- 2a (Research) has increased from a risk rating of 9 (moderate x possible) to a risk rating of 12 (moderate x likely). This is in recognition of the planned reduction in headcount as part of the workforce reduction across the organisation. The impact of this is predicted to include slippage in national Trust Board KPI rankings, as previous improvements will be challenging to sustain.

- 5d (Sustainability) has increased from a low risk rating of 6 (low x possible) to a moderate rating of 8 (low x likely) due to the absence of leadership to progress management of this workstream. Key post holders have left their roles and due to the recruitment controls in place, these vacancies have not been appointed to, nor have newly created clinical speciality lead posts.

2.4. In total there are now 7 critical risks recorded on the BAF, which accounts for 60% of the total risks. The graph below provides a visual demonstration of how this has increased, evidencing the continued and growing tension between clinical and operational pressures, and the constraints of available resources and finances.



2.5. Currently there are 7 risks (60%) with a risk rating outside of the organisation's risk appetite. Each of these articulate a clear intent to reduce the risk and align it with the risk appetite, and include actions to demonstrate how this will be delivered. It is recognised that this will take some time with all risks reductions anticipated to be successful between 2027 and 2030.

3. Risk Appetite Statement

3.1. On 03 June 2025 a risk appetite workshop was held at the Trust Board Study Session to review and update the organisation's risk appetite statement. The Board closely considered the organisation's current approach to risk and reflected that due to the current challenges related to finance and capacity, the organisation is forced to tolerate much more risk than would typically be accepted. This means that whilst overall the organisation's approach to risk could be considered more open at present, in order to manage risk in a holistic manner which balances varying workstreams and threats, some specific risk positions have changed to facilitate this. In consideration of this, key changes agreed were:

- Finance related risks: Appetite reduced from Cautious to Minimal
- Experience related risks: Appetite increased from Cautious to Open
- Technology & Innovation: The appetite remains as Open, however the organisation is much less tolerant of cyber security risks specifically.
- Workforce: The appetite remains as Open, however the context to this and our approach to management of these risks, has altered.

3.2. To support this, the individual risk statements for the positions referenced above have been rewritten, as has the foreword to reflect the current context and overall position. It is noted that the framework for risk appetite has not changed.

UHS Board Assurance Framework (BAF)

Updated June 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

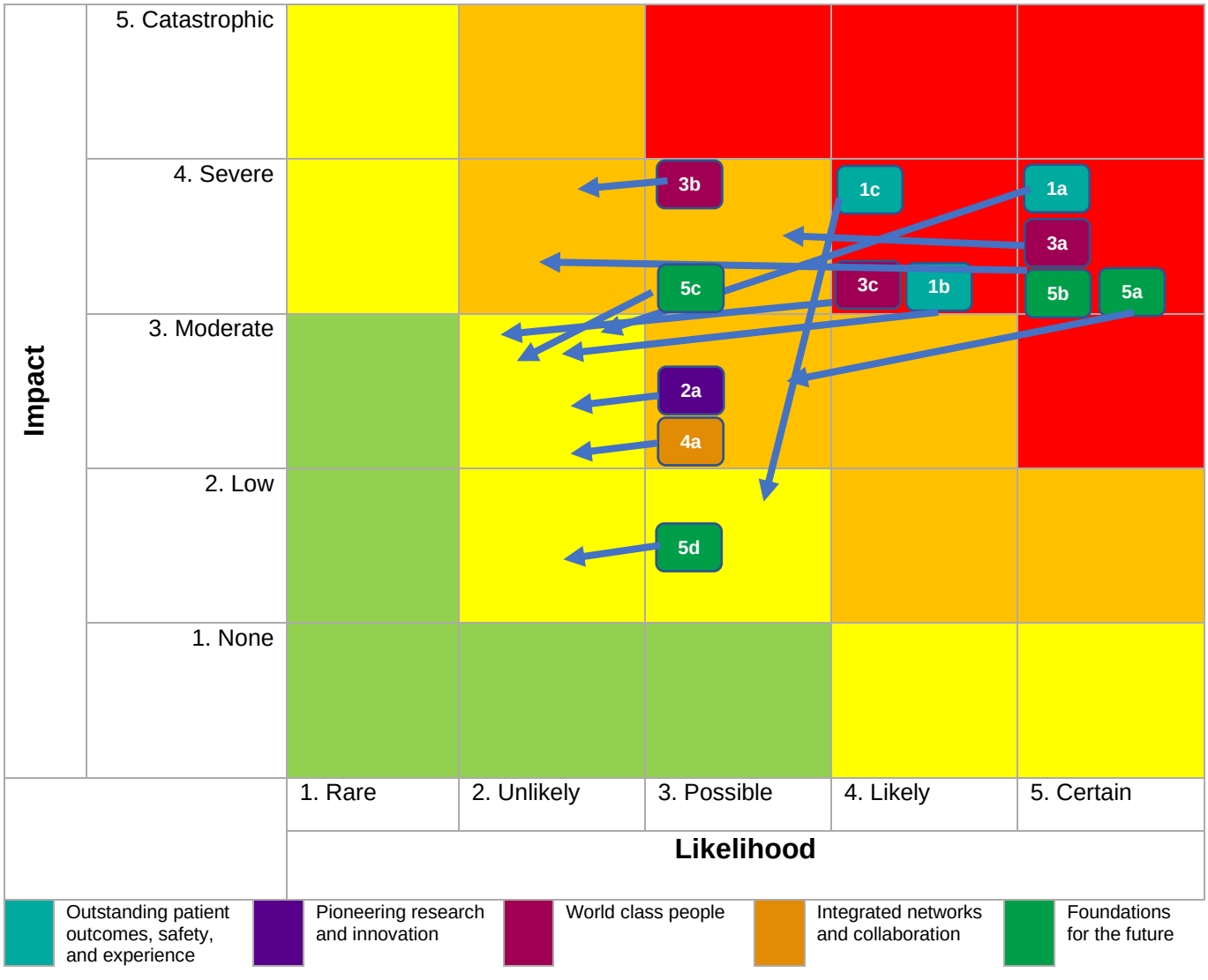
There are 7 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1b) Outcomes & Experience (4 x 4 = 16)
- 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 *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 5 20	April 2022	4 x 5 20	July 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed by the responsible executives in June 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.

Capacity remains a live challenge as evidenced through deteriorating targets, for example at present only 54% of suspected cancer referrals are achieved within 2 weeks. To manage this capacity is being prioritised within oncology and P2 patients (those who should be treated within one month) and the organisation's transformation programmes aligned to this continue to be a key focus. Patients are being supported to make informed decisions when choosing where to be treated through transparency about wait times, particularly when we are not the closest or quickest option for the patient. Additionally work progresses to reduce procedures of limited clinical value to redirect capacity to more urgent and higher risk patients. Limited outsourcing continues for some high risk and high demand specialities such as urology/prostate, and some mutual aid is still being sought for cardiac patients. Despite this though, demand continues to grow and the organisation continues to deliver more elective work than commissioned for which is untenable in the current financial climate.

In addition to the challenges around elective capacity described above, mental health also remains a challenge, as does capacity in ED. The refurbishment of the ambulatory majors corridor has now been completed, facilitating a better line of sight of patients which may reduce the number of admissions. 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 as well. It is hoped that this will aid urgent and emergency capacity once completed. It is noted that the second Emergency Care Intensive Support Team (ECIST) visit has been delayed by a month but is expected to occur at the end of June 2025.

The organisation continues to complete harm review tools where patients are suspected to have been harmed, or will experience a worse outcome, as a result of insufficient capacity and increased wait times. To enhance and formalise the governance around these, a Trustwide SOP is being developed.

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use. Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand. Use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. 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. Rapid Improvement Plans to support improvements across cancer pathways.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. However emerging NHS HIOW transformation programmes are focussed on discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure. 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. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow. Lack of a clear capacity and demand plan to resolve cardiac capacity issues. 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. Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. 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. NHSE and NHS HIOW ICS supportive quality visit to ED (September 2024). 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.

Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists - complete. Activity targets for 2025/26 set:

- < 1% patients waiting over 52 weeks
- > 72% of patients seen with 18 weeks

Pursue significant improvement in cardiac wait times through development of a demand and capacity plan and mutual aid.

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 June 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	2 x 3 = 6	3 x 2 = 6	31/10/2025
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	30/06/2025
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	31/12/2025
259	Capacity and Demand in Maternity Services	4 x 4 = 16	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
610	Insufficient capacity to provide a safe and effective Out of Hours medical and ANP service across Div B	4 x 2 = 8	3 x 2 = 6	31/08/2025
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.	4 x 4 = 16	3 x 2 = 6	31/12/2025

681	Adult inpatient pain service is struggling to deliver a robust service - demand is exceeding the current capacity in the pain service.	3 x 3 = 9	3 x 1 = 3	30/10/2025
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 4 = 12	3 x 1 = 3	30/09/2025
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	30/09/2025
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 overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	31/08/2025
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	01/09/2025
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	30/06/2026
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2025
840	Paediatric haemodialysis capacity	4 x 2 = 8	2 x 2 = 4	31/10/2025
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	4 x 4 = 16	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 *The current risk rating is outside of the risk appetite however the target risk rating is within the optimal risk rating.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	June 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been reviewed with the responsible executives in June 2025 and the risk rating has been reassessed in consideration of the current challenges experienced at UHS, and across the wider NHS, as a result of the financial constraints. Consequently, the impact has increased from moderate to severe, and the likelihood has increased from possible to likely, which results in an overall increase from 9 (moderate risk) to 16 (critical risk). The rationale for this is based on the impact we understand some patients are already experiencing due to the tension between clinical/operational demand and the financial resource available, as well as the likelihood that this will continue throughout the coming months. Examples of this impact are:

- An increase in pressure ulcers including grade 4 pressure ulcers which have a long-lasting impact to a patient's quality of life. An audit and deep dive thematic analysis is being undertaken to understand the increase and how this can be mitigated.
- An increase in patient falls, with a deep dive review also being undertaken and presented to quality committee.
- A poorer patient experience as evidenced through complaints and the evolving themes within: for the first time 'staff compassion' has featured as a top three common theme. Complaints continue to be investigated individually, and reviewed collectively, to identify and implement learning.

In addition to reviewing the current risk rating, the target risk rating has also been reviewed. This remains at 6 (moderate x unlikely) as whilst we recognise that the current risk of poor quality of care is far outside of our optimal risk appetite, we still have an unwavering aspiration to reduce this risk as low as is reasonably practical and fully intend to manage this risk to a more acceptable level. The target date to achieve this has however been extended by one year which aligns this risk with the other quality risks 1a and 1c. In support of management of this risk, the Trust's Quality & Equality Impact Assessment (EQIA) review group has now been fully established as a subgroup of the Financial Improvement Group (FIG). The purpose of the group is to support FIG in making informed decisions by evaluating the potential equality and quality impacts to proposed business changes, and

understanding the overall risk picture to balance financial, quality and workforce risks. This means that whilst we cannot completely avoid negative impact on care whilst managing the financial risk, the level of impact and risk is recognised and understood, and consideration is given to whether that is tolerable or not, and how it can be mitigated.

Additionally work continues to roll out and embed NatSSIPs 2, of which the key objectives will include:

- NatSSIPs implementation plan is being developed which will include planning, resource development, education and training, MDT training and audit review.
- An audit of stop points for safety against the NatSSIPs standards. This has been undertaken across all theatres in February. – 149 Audits undertaken to date, additional work to incorporate an observational audit tool is ongoing so that there is a greater learning of engagement; and a minor procedure audit has been developed and is being trialled
- Develop and implement a plan for education around NatSSIPs, non-technical skills and MDT training around engagement with stop points for safety. Part time medical simulation education lead appointed whose initial aim is to focus on MDT training/resource development for ophthalmology and neuro theatre team in the first 6 months.
- Review current VLE resource and update as necessary.
- Map current induction training. Who needs to be undertaking this training currently under review
- Involve patients, including reviewing information about safety checks provided to patients. QPSP involvement as an active member within the invasive procedure committee, patient experience team to assist with engaging patients to be involved within the patient involvement workstream
- Review NatSSIPs 8 steps to assess where the gaps are. Workshop being held in August to address some of the key issues around the checklist in theatres including who needs to be present for team brief, what safety clutter could be removed, how we improve debriefs, and what do we do if people don't engage with checks
- Communication plan. Initial step of trust wide screen saver has been implemented, Organisational Wide Learning (OWL) on minor procedures to be shared in July, Staffnet pages to be updated.
- Workshop for improving stop points checks in theatres planned for 6th August aimed at Multi-Disciplinary Teams

Key controls	Gaps in controls
Trust Patient Safety Strategy and Experience of care strategy. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews. Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of 23/24 and 24/25 Always Improving Programme aims, continuing into 25/26. 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.	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. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. 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.

Directory of 2000 patients who are willing to engage in projects and provide a patient voice. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. 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. Maternity safety champions. Listening events and community engagement. Equality & Quality Impact Assessment (EQIA) review group. Ward to Board governance and escalation route.	
Key assurances	**Gaps in assurances**
Monitoring of patient outcomes with QPSP input. CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Current and previous performance against NHS Constitution and other standards. Matron walkabouts and executive led back to the floor. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits. Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Health Inequalities Board Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints. Divisional and committee AAA (Alert, Advise, Assure reports).	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.

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.

Review of the clinical quality dashboard and how it reports up to Board.

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	30/06/2025
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	31/12/2025
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	29/08/2025
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	31/03/2026
904	Quality of patient care and treatment may be compromised due to the significant financial challenges faced within the NHS	4 x 3 = 12	4 x 2 = 8	01/04/2026
909	Patients may come to harm with vision loss due to reduced clinics at Lymington Hospital	3 x 3 = 9	2 x 2 = 4	30/06/2026

Outstanding patient outcomes, safety and experience

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

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	June 2025	2 x 3 6	April 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

The risk has been reviewed by the responsible executive in June 2025 with no alterations to the risk rating or target required at this time. It is understood that a high level of risk is still present and this can be evidenced through infection rates, practices and audits; for example through continued poor hand hygiene surveillance scores. To help mitigate this work is in process to empower ward IPC link nurses to challenge staff and promote basic practices, and to review low scoring audits in conjunction with the CNO.

The national IPC BAF has recently been updated and released with the inclusion of antimicrobial standards which link to CQC regulation 12. The team are currently in the process of assessing this, but all pre-existing standards around wider and related IPC matters remain either compliant or partially compliant.

Positive assurance is noted in relation to the previous Candida Auris outbreak in Vascular as no new positive cases have been reported since the end of April 2025.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. PPE requirements, specifically the	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections.

requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the 'give up the gloves' campaign. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. 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. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need. Point of Care testing in AMU. Expedited laboratory testing facilities for respiratory and GI infections. CNO/CMO reviews with clinical teams for MRSA cases.	Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced. 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. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery.	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.

Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). 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.	

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: • insufficient research workforce and limited capacity in clinical support services; • an organisational culture which does not encourage and support staff to engage with research and innovation.	This could lead to: • an inability to set-up and deliver research studies in a safe and timely manner; • a lack of development opportunities for staff which impacts the next generation of researchers and innovators.	Resulting in: • failure to deliver against existing infrastructure awards; • impact our national ranking; • reduced access for patients to innovative new treatments; • reputational damage to our university teaching hospital status and ability to secure funding awards in the future.

Category	Appetite	Status
Technology & Innovation	Open *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)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 4 12	June 2025	3 x 2 6	March 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been reviewed by the responsible executive in June 2025 and the risk rating has increased from 9 (moderate x possible) to 12 (moderate x likely) due to the planned reduction in headcount as part of the workforce reduction across the organisation. The impact of this is predicted to include slippage in national Trust Board KPI rankings, as previous improvements will be challenging to sustain. Accordingly, the target date for mitigation of the risk has also been extended in recognition of the growing gap in where we are currently and where we aspire to be.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. 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. Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation. 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. 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. 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. Deliver R&I Investment Case. Annual Plan for 25/26 will be taken to TB which includes investment RoI evaluation. 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. 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. 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. Review the Trust's approach to corporate-wide innovation. 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 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. 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. 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. Funding application from Wessex Health Partners to take forward outputs from Innovation workshop unsuccessful but funding secured from the NHSE Secure Data Environment 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.	

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3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	June 2025	4 x 3 12	March 2030

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- This risk has been reviewed and updated with the Chief People Officer in June 2025. The risk rating is considered to still be an accurate reflection of the risk present within the organisation, particularly considering the financial challenges and necessary recruitment controls.

- As above, extensive recruitment controls are in place presently which have been necessary to slow overall headcount growth in light of nationally directed financial pressures. However, this continues to result 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, and actions to implement and support this are underway:
  - ICB wide recruitment controls are ongoing 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 01st July 2025. Divisional teams are currently constructing plans which will achieve a 5% reduction in pay costs.
  - 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 was initiated in May 2025, open to a wider pool of candidates, and this closed 15 June 2025. It is intended that this will act as a mitigation to reduce any necessary redundancies.
  - A robust EQIA process has been implemented to support decisions made through the Financial Improvement Group, which supports the organisation in identifying potential impact to the workforce as a result of changes, and prompts consideration and scrutiny of mitigations where the impact is likely to be negative.

- 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, Unite, and ACAS, a deal was agreed and industrial action avoided. Work is still underway to deliver a series of agreed actions, with UHS and Unite working closely together to implement these.

- 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. Recruitment and resourcing processes. Workforce plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. 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. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2025/26 submitted to ICB. Organisational change policy including management of redeployment. RCP (Recruitment Control Panel). Creation of an organisational change management group to govern the current restructure. Financial Improvement Group established with a supporting Equality and Quality Impact Assessment Review Group. Planned change management and wellbeing support for staff and managers. Continual joint working between finance and workforce to align data and improve forecasting.	Completion of objectives for South-East temporary collaborative for 2024/25, 2025/26, and beyond. Planned improvements for medical job planning to be implemented.
Key assurances	**Gaps in assurances**
Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes.	Universal rostering roll out including all medical staff.

Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Temporary staffing collaborative diagnostic analysis on effectiveness. 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. Review of implications for education and training infrastructure from national workforce plan.	

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.

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.

Plan and deliver shared corporate services across Hampshire and the Isle of Wight, commencing with a shared recruitment resource hub planned to be implemented October 2025.

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
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	30/08/2025
604	Risk in epilepsy nursing service	3 x 2 = 6	2 x 2 = 4	18/06/2025
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 4 = 16	2 x 1= 2	24/06/2025
646	Reduced ACP Cover across Neurosciences care group	4 x 2 = 8	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	31/08/2025
726	Ophthalmology clinical/AHP workforce	4 x 3 = 12	4 x 1 = 4	01/01/2026
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	2 x 4 = 8	2 x 1 = 2	31/08/2025
776	Insufficient clinical pharmacy workforce	3 x 5 = 15	3 x 3 = 9	31/08/2026
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
837	Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing	3 x 4 = 12	3 x 2 = 6	31/03/2026

	workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs			
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 2 = 6	3 x 1 = 3	30/09/2025
872	Lack of administrative support within cancer care	3 x 5 = 15	2 x 1 =2	31/08/2025
873	A&C Spinal Staffing	3 x 3 = 9	2 x 2 = 4	30/06/2025
879	IISS Programme (project management resource)	3 x 3 = 9	2 x 2 = 4	01/07/2025
881	Retention and Sustainability of Specialist Neurosciences CNS Workforce	3 x 2 = 6	3 x 1 = 3	31/12/2025
883	Lack of dedicated ophthalmology pharmacy support	3 x 3 = 9	2 x 2 = 4	31/07/2025
891	Risk of Paediatric Neurosurgical Care Being Delivered by Non-Specialists Due to Staffing Shortages	4 x 2 = 8	4 x 1 = 4	01/07/2025
896	There is a risk that patients could come to harm if there is not sufficient staffing and support for the Breast PIFU Service	3 x 4 = 12	3 x 2 = 6	31/12/2025
899	Trust recruitment pause, impact on staffing levels and service delivery (EFCD)	4 x 3 = 12	4 x 1 = 4	30/07/2025
900	Concern regarding insufficient, unfunded critical care education provision to meet service need and direct impact on staff and patient safety.	3 x 5 = 15	2 x 2 = 4	31/10/2025
903	If admin and clerical vacancies cannot be recruited to there is a risk that operational efficiency may be compromised effecting performance, patient safety/experience, and staff wellbeing.	4 x 3 = 12	3 x 2 = 6	31/03/2026

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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 *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	June 2025	4 x 2 8	March 2030

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

- This risk has been reviewed by the responsible executive in June 2025 and updated as required. The risk rating has been considered and agreed to remain accurate. It is noted that a significant level of organisational change is underway and that this may impact on staff experience, therefore a comprehensive range of measures have been implemented to support staff through this. This includes:

  - 'Leading through change' workshops to support and equip UHS leaders to manage and understand organisational change, lead people and teams through change, and create an environment which facilitates successful change.
  - Regular communications for all staff including briefings and 'Talk to David' sessions, further complemented by targeted communications for specific staff groups such as 'Connect' for senior managers and leaders, and briefings for medical staff.
  - Creation of an Equality & Quality Impact Assessment (EQIA) review group 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.
  - The established 'Windows into wellbeing' Staffnet page which promotes access to a range of services such as occupational health, chaplaincy, and the employee assistance programme.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2026 (74% as at March 2025).

Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. Proud2BeAdmin & Proud2Bops campaigns and networks. Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing. Launch of digital appraisal process. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed – cohort 2. Cohort 3 advertised. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake. A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments. Inclusive recruitment review undertaken.	Improving implementation of national improving working lives actions for junior doctors following national letter May 2024. 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 Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board.	Maturity of staff networks. Maturity of datasets around EDI, and ease of interpretation.

Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25 and beyond. NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area. 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	
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.	

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3c) We fail to create a sustainable and innovative education and development response to meet the current and the future workforce needs identified in the Trust's longer term workforce plan

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If there is: • Limited ability to recruit staff with suitable skills to support education; • Lack of current national education financing and changes in the way the education contract will function; • Inflexibility with apprenticeship regime;	There may be: • Inability to develop and implement a strategic vision for development of staff; • A lack of development for staff affecting retention and engagement; • Reduced staff skills and competencies; • Inability to develop new clinical practices.	This could result in: • An adverse impact of quality and effectiveness of patient care and safety; • An adverse impact on our reputation as a university teaching hospital; • Reduced levels of staff and patient satisfaction.

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the organisations risk appetite however the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 4 16	June 2025	3 x 2 6	March 2029

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed in June 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. It is noted that the T&D review of the infrastructure and long term workforce plan has now been completed and that this will be presented to People and Organisational Development Committee (POD) in the near future.

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
Executive succession planning	Releasing staff to engage in personal development and training opportunities
VLE relaunched to support staff to undertake self-directed learning opportunities.	Limited succession planning framework, consistently applied across the Trust.
TNA process completed for 2025/26.	Areas of concern in the GMC training survey

Escalation to NHSE with offer to assist in identifying future solutions.	National CPD guidance for 2025/26: scope of application is limited by rigid national rules. New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included. 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. Trust appraisal process GMC/NETs Survey Education review process with NHSE WTE. Utilisation of apprenticeship levy. Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. 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 and will be presented to POD in Q2 2025/26.

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	31/10/2025
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
900	Concern regarding insufficient, unfunded critical care education provision to meet service need and direct impact on staff and patient safety.	3 x 5 = 15	2 x 2 = 4	31/10/2025

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. Additionally, and more acutely, NHS organisations are challenged by capacity and financial constraints at present, limiting the ability to network and grow strategically, as available resource is directed to managing current issues instead.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	3 x 3 9	June 2025	3 x 2 6	Dec 2025

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

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. Additionally national direction is shifting accountability, drawing clearer lines in responsibilities between Trusts and commissioning bodies, which may empower organisations to engage in networking when there are clear benefits to be maximised.

Key controls	Gaps in controls
• Key leadership role within local ICS • Key leadership role within local networked care and wider Wessex partnership • UHS strategic goals and vision	• Potential for diluted influence at key discussions • Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local.

• Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes. • Establishment of UHS Integrated Networks and Collaboration Board • Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner organisations to agree priorities and ensure there is executive commitment to delivering network models. • ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor. • Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to. • 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. • 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. • 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. • 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. • ICS oversight of waiting lists and forecasts in addition to provider level intelligence.	• Engagement and pace from organisations we are looking to partner with is not within our control. • Resource within the UHS clinical programme team can prove challenging. • 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.
Key assurances	**Gaps in assurances**
• CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys • Friends and Family Test • Outcomes and waiting times reporting. Included within cases for change being built for networks. • 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. • Ability to network is difficult and manifests in capacity challenges. • 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 has been 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 progressed 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. 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. However there is not current alignment across the three organisations on how this will be delivered therefore this is now with the ICB for consideration of how this is commissioned, with an outcome expected early Q3 2024/25.
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. This will be worked up into a business case ahead of the next financial year. Plastic leadership has also been strengthened within UHS to support this change.
Planning underway to increase performance supported by a common assumption across the system and leadership from David French for the ICS elective programme. However. the Indicative Activity Plan (IAP) is lower than our current run rates resulting in termination of outsourcing in most specialities.
Once networks have been established, define a core set of KPI metrics to be monitored. INC board has been disbanded therefore ownership and oversight will sit within the Acute & Community Provider Collaborative with engagement from UHS.
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:

- **A reducing cash balance impacting the Trust's ability to meet payment terms for suppliers and staff, meet statutory requirements such as payments to HMRC, and invest in line with the capital plan.**
- **NHS England imposing additional controls/undertakings.**

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (including NCtR and mental health), 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 and that our cash balance will significantly reduce resulting in an inability to make payments to suppliers and staff, and make payments in line with our statutory requirements.	This may directly impact the organisation's operational ability to provide care to patients if services or staffing are withdrawn due to failure to make required payments. Additionally it may impact on the organisation's ability to grow and transform due to limitations in investment.
Category	**Appetite**	**Status**
Finance	Cautious *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 20	April 2022	4 x 5 20	July 2025	3 x 5 = 15 3 x 3 = 9	April 2027 April 2030

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	3 x 5 15	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed and updated by the Chief Finance Officer in June 2025, including updates to the title and description of the risk to better articulate the organisation's challenges around cash availability and the impact of this. The risk rating remains at 20 (severe x certain) considering the significant and sustained fiscal pressures present within the organisation and wider system, with the intent to reduce this in incremental and sustainable steps over the next 5 years.

Currently the organisation is operating with less than 4 days cash balance and controls are in place to manage this, including time managed payments to control cash flow, and steps to seek receipt of income earlier. Additionally, bids are being made to NHSE for support with both capital and revenue, and discussions are underway regarding ICB provision of deficit payment up front, and transfer of cash from other providers. Both arrangements would require payment to be returned later but would assist in management of the immediate cash risk.

The Financial Improvement Group (FIG) is fully established, and meetings are held weekly to identify and deliver opportunities for savings. Initiatives continue to be progressed such as reduction in temporary staffing rates from September 2025, subject to satisfactory completion of an Equality and Quality Impact Assessment (EQIA). Steps are also being taken to assess risk within Cost Improvement Planning (CIP) and to review the maturity and development of schemes to ensure that schemes which are identified as opportunities can be developed, progressed, and delivered.

Recruitment controls remain in place and plans to reduce workforce headcount are progressing. Recruitment of non-clinical posts remains frozen unless by exception, and clinical recruitment has reduced to 70%. Plans for an organisational restructure are underway and divisional teams continue to work on their schemes to reduce headcount. This is supported by the Mutually Agreed Resignation Scheme (MARS) which closed to new applications mid-June. Over 200 applications were received, and these are currently being assessed for suitability.

Key controls	Gaps in controls
Internal • Financial strategy and Board approved financial plan. • Newly (2025/26) established Financial Improvement Group supported by the Financial Improvement Director. . • Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits. • Implementation of revised recruitment controls, including revised Affordable Workforce Limits (AWLs), reduction in clinical recruitment, and a freeze on non-clinical recruitment. • Robust business planning and bidding processes • Robust controls over investment decisions via the Trust Investment Group and associated policies and processes • Monthly VFM meetings with each Care Group • Monthly cash flow forecast review. Improving Value transformation programme. • Mutually Agreed Resignation Scheme **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved “grip and control” measures with consistent application across all organisations.	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. **System wide/external** • Elements of activity growth unfunded via block contracts. • 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. • Full financial report for the system to Trust Board. • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity. • Monthly cash reporting to F&IC.	• Current short-term nature of operational planning • Lack of assurance in ability to deliver system wide plans focussing on reduction in NCTR, and mental health. • Concern over any further industrial action not incorporated into plan.

Key actions
• Delivery of 2025/26 financial plan. • Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete. • Reset CIP and transformation programmes based on 25/26 targets – complete. • Set programmes/projects for delivery as part of the Financial Improvement Group – underway and ongoing. • Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway and established. • Workforce forecasting and delivery of workforce reduction schemes.

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 *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 4 16	April 2024	4 x 5 20	June 2025	4 x 2 8	April 2030

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed with the Chief Finance Officer in June 2025 with no revisions to the current or target risk ratings required. It is noted that the transfer of EFCD to UEL is now complete which will support efficiency and collaborative working across the support services.

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	Lack of Estates strategy for the next 5 years.
Asset replacement programme	
Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)	

Six Facet survey of estate informing funding and development priorities Estates masterplan 22-23 approved. Clear line of sight to Trust Board for all risks identified.	
Key assurances	**Gaps in assurances**
Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	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. Identify future funding options for additional capacity in line with the site development plan. Delivery of 2025/26 capital plan. Implement the HIOW elective hub. Deliver £3.5m of critical infrastructure backlog maintenance in 2025/26. Agree plan for remainder of Adanac Park site. 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
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	31/06/2025
818	Centralised Chilled water system - power supply resilience	28/05/2024	5 x 2 = 10	5 x 1 = 5	31/07/2025

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 = 12	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
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 *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Target risk rating (I x L)**	
3 x 4 12	April 2022	4 x 3 12	June 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

This risk has been reviewed with the Interim Chief Operating Officer in June 2025 with no revisions to the current or target risk ratings required.

It is noted that UHS had a recent cyber issue whereby the Ivanti Endpoint Manager Mobile equipment was accessed by unauthorised users. The UHS cyber team worked with the NHS England Cyber Security Operations Centre and the National Cyber Security Centre to address these issues. There has been no evidence of data being stolen, and patient data was not part of this ring fenced system. A recent Trust Board Study Session went through the incident in detail with the Board, including correcting some of the incorrect media reports, and outlining our wider cyber security posture at UHS. A further session is being set up for the Board to participate in the NHS Board Cyber training which contributes to our DPST scoring.

Additionally, actions in progress to aid mitigation of this risk include:

- The rollout of the Windows 11 and RAM upgrade is progressing well with over 2500 devices replaced or upgraded. The remaining devices will be addressed by the 'switch off' date in October 2025, and a team is currently addressing every single ward.
- The data centre has been included within the provisional 2026/27 capital plan.
- Across HIOW, the trend is to move to shared systems – for example, the SWASH imaging network, or the Southern Counties Pathology Network shared LIMS, and in the coming years the move to the OneEPR. Where the system is cloud based, this should improve cyber security, although it may impact cross-HIOW business continuity.

Key controls	Gaps in controls
Failure in physical network infrastructure • All Digital UPS tested. • Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this. • Replacement of key infrastructure on a case-by-case basis once it fails.	**Failure in physical network infrastructure** • The current Data Centre is end of life and requires a capital plan for replacement. • There is currently no phased replacement of switch and network equipment due to absence of funding.
Cyber Risk • Cyber security infrastructure refreshed and in place. • Staff training on cyber risks, with regular refreshers and clear policies. • Key cyber roles recruited to, with one remaining outstanding.	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training. • Penetration testing contract pulled forward to 2024/25.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover.	**Single points of failure in staffing** • 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 • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout planned for 2025/26. • Single EPR business case via NHS England EPR Investment Board.	**Implementation and sustainability of digital technology** • Funding to cover the development programme, improvements, and clinical priorities.
Loss of access to critical IT systems • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Scenario testing completed.	**Loss of access to critical IT systems** • Time to fully stress test business continuity plans.
Key assurances	**Gaps in assurances**
Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed weekly on UHS Digital leadership team call. UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams.	Funding to cover the development programme, improvements, and clinical priorities. Difficulties in understanding benefits realisation of digital investment. ICS digital strategy yet to be agreed. UHS digital strategy to be reviewed (runs until 2026 but requires prior review).

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). Standardised change control, testing, and assurance processes implemented across the Development team. NHSE annual DPST assessment completed to highlight gaps in services. Business Continuity Plans in place for clinical areas in the event of IT outages. Trust Board Study Session digital update (June 2025).	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	31/08/2025
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
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
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 *Both the current and target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 4 8	June 2025	2 x 2 4	December 2027

Risk progression: (previous 12 months)	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6

Current assurances and updates

This risk has been reviewed in June 2025 by the responsible executive resulting in an increase in risk rating, from 6 (low x possible) to 8 (low x likely). The reasons are multifactorial:

- A lack of leadership is challenging as the Head of Sustainability, as well as another member of the sustainability team, have left their roles. Due to the current recruitment controls these posts have not currently been replaced. To mitigate this, joint working with other organisations is being explored, however whilst there is no dedicated leadership in place, pace of key actions such as review of the Green Plan will slow.
- A further challenge is the lack of clinical speciality leads. Although the business case for these roles was approved, the recruitment controls have meant that these posts cannot be appointed to.
- A £19m bid to Salix to support the heat recovery programme of work has been approved. Whilst this is positive news, it is noted that due to government restrictions in funding, this is now likely to be the last grant secured in the foreseeable future.
- Whilst there is some assurance that the risk of not reducing direct emissions is lower, there is less assurance in relation to indirect emissions as this is more challenging to address.

Key controls	Gaps in controls
Governance structure including Sustainability Board Clinical Sustainability Lead Head of Sustainability and Energy Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan 2022-2025.	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy Communications plan. 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. 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. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators. Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board. Sustainability Board	Definition of and reporting against key milestones.

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.

Appendix B

UHS Risk Appetite Statement

July 2025

Foreword

University Hospital Southampton NHS Foundation Trust recognises that risk is an inherent aspect of delivering healthcare services. In the context of the significant and ongoing pressures facing the NHS, particularly rising demand and financial constraints, this reality is more pronounced than ever.

To support effective governance, robust risk management, and informed decision-making, the Trust has established a clear risk appetite statement. This framework facilitates consistent, transparent, and proportionate risk management aligned with the organisation's strategic priorities, ambitions, and long-term objectives. This is a vital anchor for us in uncertain and challenging times.

Given the current climate, the Trust acknowledges that it is, by necessity, tolerating a higher level of risk than would typically be acceptable. These risks may manifest as threats that cannot be mitigated as swiftly or comprehensively as desired, or as calculated short-term risks taken in pursuit of longer-term benefits. To manage these risks as safely and effectively as possible, the Board has carefully considered the organisation's appetite for each key category of risk.

By articulating these positions, the Trust promotes a holistic approach to risk management—one that considers different types of risk in an integrated, collaborative manner rather than in isolation. This ensures that risk-taking remains deliberate, proportionate, and aligned with our commitment to delivering safe and effective care, and value for money.

The Trust's risk appetite

Utilising guidance from the 'Orange Book[1]' in 2023 the Trust established the following risk appetite scale which continues to be used today:

Averse	Avoidance of risk and uncertainty is the key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimal	Preference for safe options that carry a low degree of inherent risk. The potential for benefit/return is not a key driver whilst the avoidance of a high level of risk is.
Cautious	Preference for safe options that carry a low degree of residual risk. Willing to accept a degree of risk where there are significant opportunities for benefit.
Open	Willing to consider all options and choose one that is most likely to result in successful delivery of our objective. Those activities may carry or contribute to some residual risk.
Eager	Eager to be innovative and to chose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

[1] The Orange Book Risk Appetite Guidance Note, UK Government Finance Function, May 2023 (https://www.gov.uk/government/publications/orange-book)

Using the scale set out above the Trust has determined that its risk appetite is defined as follows.

Safety	**Effectiveness**
Minimal	Cautious
Experience	**Regulation**
Open	Minimal
Finance	**Reputation**
Minimal	Open
Technology and innovation	**Workforce**
Open	Open

This means that:

Safety: We have a **MINIMAL** appetite for risks relating to patient or staff safety. This means that we expect services to be delivered safely and without undue harm to patients or staff. While limited clinical risks may be accepted when essential to the safe delivery of care, such risks must be rigorously assessed and managed with robust mitigation measures in place.

Effectiveness: We have a **CAUTIOUS** appetite for risks that may compromise delivery of effective care for our patients. Services are expected to be delivered in a manner that upholds patient safety and supports positive outcomes. A low level of risk may be accepted where there is clear potential to enhance service delivery, provided that any residual risks are well understood and effectively mitigated.

Experience: We have an **OPEN** risk appetite in relation to patient experience. While our ambition is to provide a consistently positive experience for all patients, we acknowledge that current pressures on capacity and financial resources may impact our ability to fully achieve this goal. For instance, some patients may experience longer waits for treatment than is optimal, which falls short of the standard of experience we strive to deliver. However, in prioritising patient safety and ensuring that the most vulnerable receive timely care within available resources, such compromises may be unavoidable. Despite these challenges, we remain committed to putting patients first and will pursue opportunities to enhance patient experience provided these do not compromise safety or introduce unacceptable financial risk.

Regulation: We have a **MINIMAL** appetite for regulatory risks which may compromise the Trust's compliance with its statutory duties and regulatory requirements. This means that we expect all services to comply with nationally mandated standards and targets as measured through key performance indicators. However, if there is a valid justification for non-compliance which is essential for safe and effective patient care, then we are willing to be challenged.

Finance: We have a **MINIMAL** appetite for fiscal risks that could undermine the organisation's financial resilience and, by extension, its ability to maintain operational continuity. While low levels of financial risk may be accepted where there is a clear opportunity to set and strengthen foundations

for the future, our core priorities are delivering value for money, living within our means, and the achievement of long-term financial stability and sustainability.

Reputation: We have an **OPEN** appetite for risks which may expose the Trust to additional scrutiny where these are to the advantage of safe and effective patient care, and steps can be taken to minimise adverse exposure. This means that whilst we will not actively seek out any reputational risks, decisions will be made based on the benefits to patients, staff, and service delivery, even if this means that there may be a short-term impact to the Trust's reputation in pursuit of putting our patients and staff first in the longer term.

Technology & Innovation: We have an **OPEN** risk appetite for adopting technology and innovation to enhance service delivery. This is underpinned by a commitment to compliance, ensuring our digital systems are secure, resilient, and support the safe delivery of clinical care. We actively pursue technological advancements to improve services, while maintaining patient safety through robust governance and change management frameworks. However, we maintain a low tolerance for cybersecurity risks that could compromise operational or financial stability.

Workforce: We have an **OPEN** appetite for risks relating to our workforce. Our staff are one of our most valuable assets and we are committed to cultivating a skilled, diverse, and sustainable workforce. In view of ongoing challenges across the NHS, we recognise that to achieve long-term goals whilst also managing financial risk, tolerance of greater short- to medium-term workforce risks may be necessitated. This could limit immediate investment in education and wellbeing; however, staff satisfaction and development remain long term priorities. All risks will be managed thoughtfully and compassionately, and with our staff in mind.

Putting this into practice

The Good Governance Institute (GGI) defines risk appetite as *'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives[2]'*. In line with this definition, University Hospital Southampton NHS Foundation Trust has developed a structured approach to defining its risk appetite. Accordingly, when determining the Trust's risk appetite, the Board has considered two key thresholds:

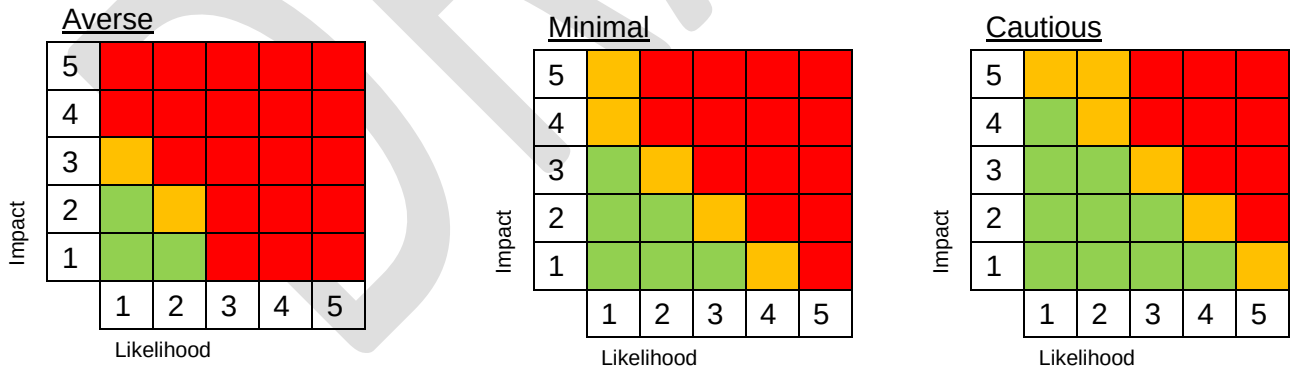
- **Optimal risk appetite:** the level of risk within which the Trust **aims** to operate
- **Tolerable risk appetite:** the level of risk within which the Trust is **willing** to operate

This dual approach enables the Trust to pursue the greatest possible reduction of risks that threaten the achievement of its core aims and objectives, while also recognising that a certain level of risk must be accepted, and at times actively pursued, to enable effective service delivery, innovation, and long-term development.

The tables below demonstrate the optimal and tolerable risk ratings for each position within the risk appetite scale. This applies to both the operational risk register and the risks held within the Board Assurance Framework (BAF).

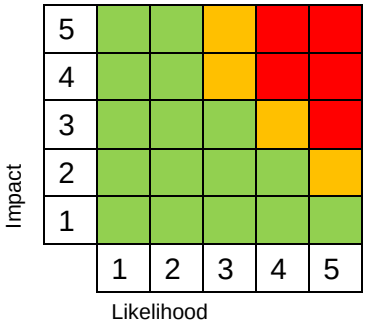
When assessing a risk, the target risk rating (the residual risk rating once all mitigations have been fully implemented) should ideally align with the optimal appetite for that type of risk. However, it is recognised that in some cases, the target rating may only align with the tolerable appetite, due to factors beyond the control of the risk owner/organisation, or limitations in available resources. Through development of this risk appetite statement the Trust has acknowledged a willingness to operate within the tolerable level of risk where the optimal appetite cannot be achieved.

Within these tables, based on the Trust's risk scoring matrix with the risk management policy, Green cells indicate an optimal risk appetite and Amber cells indicate a tolerable risk appetite.

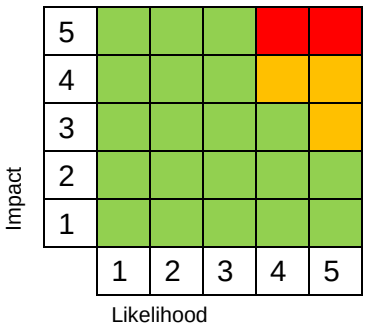


[2] ISO31000 and Board Guidance on Risk Appetite, GGI, May 2020 (www.good-governance.org.uk)

Open



Eager



Escalation of Risks Outside Appetite

If the achievable target risk rating falls outside both the optimal and tolerable appetite, escalation is required to ensure appropriate oversight and decision-making:

- If the target risk rating is 12 or lower and outside both appetites, it must be escalated to the Divisional Management Team (or equivalent THQ lead) and communicated to the organisation through the Quality Governance Steering Group forum via the divisional 'Alert, Advice, Assure' report.

- If the target risk rating is 15 or higher and outside both appetites, it must be escalated to the Executive Team via the Trust Executive Committee forum.

In such cases, senior management will determine whether further action can be taken to reduce the risk, or whether it is acceptable to **consciously tolerate** the risk and operate outside the defined appetite.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.1	Report to the Trust Board of Directors, 15 July 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.

There have been no actions since the last report.

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 Signing and Sealing

1.1 **Duty of Care Deed** between Menard Limited (the Sub-Contractor), Willmott Dixon Construction Limited (the Contractor) and University Hospital Southampton NHS Foundation Trust (the Beneficiary) relating to a new Sterile Services Facility and Aseptic Pharmacy and Offices at Adanac Park, Nursling, Southampton. Seal number 302 on 3 June 2025.

1.2 **Lease** between NHS Property Services Limited (Landlord) and University Hospital NHS Foundation Trust (Tenant) relating to Part of Shirley Health Centre, Grove Road, Southampton, Hampshire SO15 3UE, for occupation by Southampton Research Hub. Seal number 303 on 6 June 2025.

1.3 **Agreement** between University Hospital NHS Foundation Trust (the Authority) and Veolia Energy and Utility Services UK Limited (the Company) for the provision of energy and energy management and other facilities at Southampton General Hospital. Seal number 304 on 10 June 2025.

2 Recommendation

The Board is asked to ratify the application of the seal.

Agenda Item 7.2 Report to the Trust Board of Directors, 15 July 2025	
Title:	Review of Standing Financial Instructions 2025
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Michael Chapman, Assistant Director of Finance

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 Standing Financial Instructions (SFIs) require an annual review and update. This paper outlines the main changes proposed.

There are two major changes to the SFIs, which are as follows:

1. Adding a section on Employee Expenses (which wasn't previously covered) with approval by Care Group Manager / department manager by default and allowance to delegate to suitable deputy senior manager (minimum band 8a). Currently bands 4 and 5 are approving expense claims, in 24/25 value was £960k (o/w £790k course/study)

2. Reducing the non-pay requisition (PO) approval limits for B5-7 and B8a-8b to control the amount of expenditure that can be approved at those bands. Currently over 8 month period (Sep'24 to Apr'25) £9.5m of expenditure approved by B5-7, proposed change would reduce by £6.0m to £3.5m

Contents:

Paper, Appendix 1: SFIs with tracked changes

Risk(s):

1. Lack of clarity about financial authorities and responsibilities.
2. Insufficient probity and accuracy in financial transactions
3. Financial transactions do not support the delivery of economy, efficiency, and effectiveness by the Trust

Equality Impact Consideration:	N/A

1. Introduction and Background

The Trust's Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They require annual review with the last review having been completed in January 2024.

The review completed has included engagement with the following people:

- Associate Director of Corporate Affairs (Craig Machell)
- Director of Wessex Procurement Limited (WPL) (Rob Houston)
- Chief Procurement Officer (David Duly)
- Chief Information Office (Jason Teoh)
- Commercial Director (Pete Baker)
- Director of Planning and Productivity (Andrew Asquith)
- Deputy Chief People Officer (Brenda Carter)
- Local Counter Fraud Specialist (Alec Gaines)
- Chief Financial Officer (Ian Howard)
- Director of Operational Finance (Phil Bunting)
- Assistant Directors of Finance (Natalie Jupp, Anna Schoenwerth)
- External auditors (Grant Thornton)
- Internal auditors (KPMG)

In additional this year the UHS SFIs have been compared to HHFT. In the most part they are similar with differences in areas such as approval limits which is to be expected given the difference in size of the 2 entities.

2. Changes to Core SFIs

There are two major changes to the SFIs, which are as follows:

1. Employee Expenses

In adding this section a review was performed of which staff have authorisation to approve Expense Claims. This showed currently bands 4 and 5 are approving expense claims - in 24/25 value was £960k (o/w £790k course/study). The proposal aims to increase the strength of the Trusts' controls posture by setting approvers at Care Group Manager / department manager, or appropriate delegate band 8a of above. Consideration has been taken for the resultant administrative burden with the highest volume Care Group receiving on average 5 a day which should be manageable.

2. Non-pay requisition (PO) approval limits

UHS framework has been compared with 5 other Hospitals (inc. Hampshire Hospitals, Oxford, Bristol) and UHS approval limits were notably higher. In addition, the financial situation within UHS (inc. segment 4 of NHSE recovery support program, monthly underlying deficit and recent reviews highlighting excessive non-pay spend in areas such as expenses, taxis, maintenance) would indicate increased controls are needed. Various options have been considered and it is proposed to reduce B5-7 from £5k to £1k & B8a-8b from £25k to £10k. For context in 8 months in new financial system, NEP, £9.5m of non-pay expenditure was approved by B5-7, reducing the approval limit would reduce this by £6.0m (62%), while at the same time only being 12% of volume as such shouldn't be a significant administrative burden on higher bands.

The main changes to the SFIs are outlined below.

Section	Section Title	Overview of the Change	Rationale
2.3	External Audit	Reworded external audit responsibilities, how to manage potential problems and additional work	To provide clearer explanation after feedback from Grant Thornton
3.2.4	Operational Plan and Budget Setting process	Added section on revenue-only business cases based on wording from section 12.2 Approval of Capital Business Cases	TIG covers both revenue and capital business cases, but SFIs previously only mentioned capital
7	Tendering & Contracting Procedures	Re-written in full by WPL	Large amount of adjustments driven by the Procurement Act 2023 (effective Feb 2025)
10.3.5	Purchase Cards	Added section	Prior SFIs didn't mention Purchase Cards, when comparing to HHFT they included section on Credit Cards
10.4	Employee Expenses	Added section	Prior SFIs didn't mention Employee expenses
10.5	Management Consultants	Added section	Prior SFIs didn't mention Management Consultants, added wording based on NHSE National guidance
12.2.4	Approval of Capital Business Cases	If forecast to exceed budget reduced limit requiring review from 10% to 5%	On a large project 10% would be a significant value
17	Charitable Funds held on Trust	Removed section covering charity and replaced with paragraphs on how to manage charity grants	The charity is now a separate entity
Annex 2 Section 2	Non-Pay Authorisation Framework	Removal of approval hierarchy	Not required in (new) NEP Oracle system
Annex 2 Section 2	Non-Pay Authorisation Framework	Change in authorised non-pay expenditure limits B5-7: £5k reduced to £1k B8a-8b: £25k reduced to £10k	Increase Control posture over non-pay expenditure. Would bring UHS limits closer to other Trusts. Across 8 months of requisitions in (new) NEP Oracle system (Sep'24 to Apr'25) B5-7 approved £9.5m of requisitions. Change would move 62% of value (£5.9m), or 12% of volume (2,669 approvals) up to B8a-8b And £9.7m (613 approvals) from B8a-8b to B8c-8d
Annex 2 Section 4	Trust Authorisation Framework	Replaced section 4 and added Section 5	Large amount of adjustments driven by the Procurement Act 2023 (effective Feb 2025)

A tracked changes version of the SFIs is also enclosed within the appendix. Other changes around language and terminology are not explicitly outlined above but are included in the tracked changes document supplied.

Following Audit and Risk Committee review, the Computer Systems and Data section has been updated to include reference to Cloud computing infrastructure and requiring approval by (rather than knowledge of) the UHS Digital Department.

In addition, following Audit and Risk Committee review it has been confirmed that PO requisitions approved by CFO or CEO require a full approval trail by the team before it reaches CFO or CEO for ultimate sign off.

3. Conclusion

In summary, this paper outlines proposed changes to SFIs following annual review and put forward for approval by the Audit and Risk Committee to Trust Board.

Following Trust Board approval, the SFIs will be circulated across the organisation and training will be delivered accordingly.

4. Recommendation

Trust Board is asked to approve the proposed changes to the SFIs for circulation across the organisation.

5. Appendices

Standing Financial Instructions – final version with track changes.

University Hospital Southampton NHS
NHS Foundation Trust

Standing Financial Instructions

University Hospital Southampton FT

For avoidance of doubt Subsidiaries have separate SFIs

Version:	**January 2025~~4~~**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	**30 January 2024**
Signature of authorising Committee:	**Jenni Douglas-Todd, Trust Chair**
Ratification Committee (Category 1 documents):	**N/A**
Date of Ratification (Category 1 documents):	**N/A**
Signature of ratifying Committee Group/Chair(Category 1 documents):	**N/A**
Lead Job Title of originator/author:	**Chief Financial Officer**
Name of responsible committee/individual:	**Ian Howard**
Date issued:	**7 February 2024**
Review date:	**31 January 2026~~5~~**
Target audience:	**All Divisions/Directorates**
Key words:	**Trust powers; Trust Board; Chair; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Divisions/Directorates**
Consultation:	**Audit and Risk Committee** **Trust Executive Committee**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**51**
Type of document:	**Level 1**

Standing Financial Instructions

Commented [MC1]: Was this replaced by " National Health Service Act 2006 "

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 University Hospital Southampton NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st October 2011, following authorisation by NHS Improvement (formerly Monitor), the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England, which this document represents).

1.1.3 The *NHS Oversight Framework* details how NHS England oversees and supports all NHS Trusts. Additional financial guidance is included in *National Audit Office – Code of Audit Practice,* NHS Foundation Trust Annual Reporting Manual and the *Department of Health and Social Care Group Accounting Manual (DHSC GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its hosted organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the CFO must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such Executive Directors in the Scheme of Delegation, Subsidiary Boards or committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive Officer (CEO), Chief Financial Officer (CFO)

1.2.4 The Chief Executive Officer and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive Officer is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health and Social Care, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive Officer has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive Officer to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

1.2.7 In the event of absence of the Chief Executive Officer, the Deputy Chief Executive will temporarily be delegated the authorisation limits outlined within this document.

The Chief Financial Officer

1.2.8 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and

maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.9 In the event of absence of the Chief Financial Officer, the Director of Operational Finance will temporarily be delegated the authorisation limits outlined within this document.

Board of Directors and Employees

1.2.10 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS England, the conditions of the NHS provider licence, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.11 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

1.2.12 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2. AUDIT

2.1 Chief Financial Officer

2.1.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS England's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS England's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSC, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and also provides assurances to the Audit and Risk Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive Officer, the Audit and Risk Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations/project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's Annual Governance Statement and Assurance Framework;

i) The Trust's compliance with the Care Quality Commission's fundamental standards.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Specialist ~~Service~~ (LCFS) must be notified.

2.2.4 The Head of Internal Audit (or equivalent title) will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chair and Chief Executive Officer.

2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum".

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.

2.3.2 The Audit and Risk Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practise~~The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.~~

2.3.5 Should there appear to be a problem with the external audit service being provided, then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Audit and Risk Committee~~If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.~~

2.3.6 All additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors must be approved by the Audit and Risk Committee. ~~Prior approval must be sought from the Audit and Risk Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors.~~ Competitive tendering is not required and the CFO is required to authorise expenditure.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive Officer and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate counter-fraud, bribery and corruption arrangements,

having regard to the NHS Counter Fraud Authority counter-fraud requirements and guidance (informed by Government Functional Standard GovS 013: Counter Fraud).

2.4.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of counter-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Authority counter-fraud requirements and guidance.

2.4.4 The LCFS shall report to the CFO and shall work with staff in the NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority counter-fraud requirements and guidance, the NHS Counter Fraud Manual, including the NHS Counter Fraud Authority's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Authority.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit and Risk Committee.

2.4.8 In accordance with the Raising Concerns (Whistleblowing) Policy, the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by the NHS Counter Fraud Authority.

2.4.9 The Trust will report annually on how it has met the Government Functional Standard GovS 013: Counter Fraud in relation to counter-fraud, bribery and corruption work and the CFO and Audit Committee Chair will ~~shall~~ sign-off the annual return and authorise its submission to the NHS Counter Fraud Authority. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 The Chief Executive Officer has overall responsibility for the safety and security of employees, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider and for keeping the Trust's premises secure. However, the management of security risks within the Trust has delegated to the Chief Operating Officer and also to the appointed Local Security Management Specialist ("LSMS") in line with Trust policies and procedures.

2.5.2 Any prosecution of other offences relating to fraud, bribery or corruption against the Trust not involving the LCFS should be authorised by the CFO and will be reported to the Audit and Risk Committee.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Operational Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive Officer will compile and submit to the Board of Directors and to the Council of Governors the annual "Operational Plan" which takes into account financial targets and forecast limits of available resources. The Trust Operational Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in workload, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS England.

3.1.2 The annual Operational Plan must be submitted to NHS England in accordance with NHS England's requirements.

3.1.3 The CFO will, on behalf of the Chief Executive Officer, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Operational Plan;

b) Accord with demand, workforce and capacity plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the regulatory framework for FTs.

3.1.4 The Trust Operational Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.5 The CFO shall monitor financial performance against budget, and report to the Board of Directors.

3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.7 The CFO has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage their budgets successfully.

3.2 Operational ~~Operating~~ Plan and Budget Setting Process

3.2.1 The Chief Financial Officer will submit to the Board of Directors a paper outlining the annual budget setting process for the year. This will include a baseline formed from a set of clearly defined assumptions.

3.2.2 Each Division and Director will be enabled to submit a list of proposed Business Cases and cost pressures for consideration in budget setting. Only approved requests will be incorporated into delegated budgets. ~~Funded b~~Business cases will require approval as per the Trust Approval Framework in Annex 2, section 1.

3.2.3 The Chief Executive Officer and Chief Financial Officer will set an annual process for approving cases to be incorporated into the budget and Operational Plan. Approval of revenue-only business cases will follow the approval routes and limits outlined in the Trust Approval Framework in Annex 2.

3.2.4 The delivery of revenue schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than 5%, whichever is greater, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.

3.2.5 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:

a) An option appraisal of potential benefits compared with known costs;

b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and

c) An analysis of the project's discounted cash flow, based on an agreed rate of return.

3.2.6 The Trust Investment Group will report on major issues to the Trust Executive Committee, Finance & Investment Committee and Trust Board as required.

3.2.~~4~~7 The Trust's 'Production Plan' (NHS clinical income plan) will be set utilising internal data sources, approved UHS business cases, and after consultation with service managers alongside external data sources including Commissioner and Integrated Care Board plans. This will be aligned to all other elements of the business plan.

3.2.~~5~~8 The Chief Financial Officer will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder, and reduce the delegated expenditure budgets accordingly.

3.2.~~6~~9 The Chief Financial Officer may set reserves to cover potential cost pressures and risks at the planning stage, which may then subsequently be delegated in-year.

3.3 In-Year Adjustments to Budgets

3.3.1 The Chief Financial Officer may authorise budget virements in the following circumstances:

a) To reflect an in-year business case approved by the relevant committee;

b) To utilise reserves;

c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral for the Trust.

3.3.2 Budget virements for in-year business cases can only be allocated on an overall neutral basis, to ensure the budget remains balanced to the Operational Plan. Additional expenditure would require funding via additional income assumptions, release of reserves or additional savings above the required plan in another part of the budget.

3.4 Budgetary Delegation

3.4.1 The Chief Executive Officer, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

d) Achievement of planned levels of service;

e) The provision of regular reports.

3.4.2 Except where otherwise approved by the Chief Executive Officer, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.4.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.4.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive Officer or the CFO.

3.4.5 Budget Holders are expected to sign their acceptance of their annual expenditure budget.

3.5 Budgetary Control and Reporting

3.5.1 The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Board of Directors in a form approved by the Board of Directors, containing sufficient information to allow the Directors of the Board to ascertain the financial performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Movements in working capital;

iii) Movements in cash;

iv) Capital project spend and projected outturn against plan;

v) Explanations of any material variances from budget;

vi) Details of any corrective action where necessary and the Chief Executive Officer's and/or CFO's view of whether such actions are sufficient to correct the situation

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial and workforce budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.5.2 Each Budget Holder is responsible for ensuring that:

a) all expenditure is lawful (in accordance with Managing Public Money) and is incurred in accordance with the No Purchase Order, No Payment protocol, see section 10.2.4;

b) all expenditure is incurred or committed in accordance with the SFIs, including the appropriate levels of internal and external approval;

c) planned and actual expenditure takes full account of the need to achieve value for money in terms of economy, efficiency and effectiveness;

d) all employees are appointed within the budgeted workforce establishment. Any planned expenditure beyond budgeted establishment will require prior approval

in accordance with these SFIs;

e) they meet with the designated Finance Business Partner regularly;

f) forecasting of expenditure against budget is robust and where a budget allocation is no longer fully needed or where there is a risk of overspending this is reported to the Finance Business Partner; and

g) information can be supplied to the Chief Financial Officer as required to enable budgets to be compiled.

3.5.3 The Chief Executive Officer is responsible for identifying and implementing cost improvement programmes ("CIPs"), and income generation initiatives, in order to deliver a budget that will enable compliance with NHS England's Use of Resources regime.

3.5.4 The Chief Executive Officer will incorporate a Recruitment Control Panel, responsible for approving recruitment as per Terms of Reference agreed by the Trust Executive Committee. Proposed recruitment will be considered by the Recruitment Control Panel where within scope of the criteria contained within the Terms of Reference.

3.5.5 All new Clinical consultant appointments will require the approval of the Trust Executive Committee.

3.6 Capital Expenditure

3.6.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the DHSC Group Accounting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.7 Performance Monitoring Forms and Returns

3.7.1 The Chief Executive Officer is responsible for ensuring that the appropriate monitoring forms and returns are submitted to NHS England. The performance figures reported to the Board of Directors should reflect the same figures, though not necessarily presented in the same format.

3.8 In-Year Business Cases

3.8.1 It is expected that most business cases will be identified and prioritised in principle during the setting of the Trust Operational Plan and therefore Budget Setting Process for the financial year ahead. These cases will then be prepared for approval at an appropriate point during the year.

3.8.2 Any case with a capital implication will be considered in section 12 and outlined in Annex 2, section 1.

3.8.3 Revenue cost only business cases will be subject to the approval as outlined in Annex 22, section 1.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS England and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS England as to their technical accounting

content and information/data shown therein, before submission to NHS ~~Improvement~~England.

4.2 The Associate Director of Corporate Affairs will prepare the Annual Report in accordance with the guidance in the NHS Foundation Trust Annual Reporting Manual.

4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHS England must be audited by the external auditor in accordance with appropriate international auditing standards.

4.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors, or by the Audit and Risk Committee (when specifically delegated the power to do so, under the authority of the Board of Directors).

4.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.7 The Chief Nursing Officer will prepare the Annual Quality ~~Report~~ Account in the format prescribed by NHS England and the Care Quality Commission and in accordance with the NHS Foundation Trust Annual Reporting Manual incorporating the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

4.8 The Chief Executive Officer and Chair shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality ~~Report~~Account" .

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts in accordance with these SFI's and the Treasury Management Policy.

5.1.2 The Audit and Risk Committee of the Board of Directors will review banking arrangements ~~periodically~~annually as part of the Treasury management policy review.

5.1.3 The Audit and Risk Committee will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.1.4 All bank accounts used solely for the purposes of Trust activity must be in the name of the Trust and overseen by the Trust Finance team.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/Natwest accounts do not exceed the amount credited to the account except where arrangements have been made;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

e) Monitoring compliance with NHS England or DHSC guidance on the level of cleared funds;

f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the financial regime as determined by NHS England where applicable. The CFO may agree alternative payment mechanisms with Commissioners or the Integrated Care Board.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by legislation. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and operational plans of the Trust and shall be approved according to the limits specified at SFI Annex 22, section 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits.

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £1,000	Assistant Director of Operational Finance, or Assistant Director of Finance for Workforce
Up to £10,000	Director of Operational Finance
Up to £100,000	CFO
£100,000 plus	Audit and Risk Committee

Commented [MC2]: Check with Phil if this should include Nat for pay related items as she sits on PSG. Assistant Director of Finance for Workforce.

The limits apply to individual items. ~~A schedule of written off debt shall be presented to the Audit and Risk Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit and Risk Committee should be presented to the Trust board for noting.~~

6.3.4 A schedule of written off debt and salary overpayments that haven't been recovered shall be presented to the Audit and Risk Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit and Risk Committee should be presented to the Trust board for noting.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes,

unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss and written and signed "declarations of indemnity" must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

7.1.1 The Tendering and Contracting Procedures provide a corporate framework for the procurement of all goods, services and works for the Trust. The Procedures are designed to ensure that all procurement activity is conducted with openness, probity, and accountability. They should ensure that the Trust obtains value for money and the required level of quality and performance in all contracts, whilst complying with relevant legislation. Every contract for the supply of goods and services and for the execution of works made by, or on behalf of, the Trust shall comply with these Procedures.

7.1.2 Failure to comply with Trust SFIs will be reported to the Audit and Risk Committee and could result in disciplinary action.

7.1.3 University Hospitals Southampton procurement services are provided through Wessex NHS Procurement Ltd (WPL), and it has a to duty to comply with the Trust SFIs.

7.2 Procurement Process and Contract Signature

7.2.1 If it is established that specific goods or services cannot be sourced through existing contractual arrangements the tables outlined in Annex 2 Section 4 stipulate the procurement process to be followed. These are relative to the value and the type of product or service being purchased.

7.2.2 The estimated contract value is the total value over the whole term of the contract, including any potential extensions, excluding VAT. Staff may not deliberately disaggregate the value of a contract/split the value up to reduce the number of quotes to be obtained or carry out multiple procedures to avoid the Tendering and Contracting Procedures.

7.2.3 Contracts repeatedly let on an annual basis do not provide value for money and will be seen as disaggregation and circumvention of due process. Aggregation should apply where repeated contracting with the same supplier year on year occurs.

7.2.4 Quotes or tenders need not be invited where the goods, services or works can be sourced via an appropriate compliant framework agreement. WPL can provide advice on compliant framework agreements, access arrangements, and whether direct call-off or further competition is possible.

7.2.5 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders specified in Annex 2 Section 4 must be recorded.

7.2.6 The relevant UK public procurement rules (determined by the date of the call for competition) must be followed. Contracts above specified thresholds must be advertised, awarded, and managed in accordance with these rules. Transparency requirements must also be met. Please refer to the WPL Procurement Manual for further details on the UK public procurement rules.

7.2.7 Subject to the limits outlined in Annex 2, the Managing Director of Wessex Procurement Limited, Director of Estates, Facilities & Capital Development, Chief Information Officer, Divisional Directors of Operations and Chief Pharmacist may sign and enter into contracts on the Trust's behalf, providing a valid Procurement Approval Document or Competitive Procedure Waiver is signed by the relevant Trust authorised signatory.

7.3 Tendering Process

7.3.1 Wherever possible tenders shall be issued, and bids submitted, via the Trust's e-tendering system, with information being published to the Government hosted central digital platform by WPL as required. Where a framework provider is facilitating a tendering activity then their e-tendering solution may be utilised, but records must still be maintained by WPL.

7.3.2 All tendering activity will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.7. Issue of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

7.3.3 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both WPL staff and suppliers will be recorded within the system.

7.3.4 Tenders submitted in hard copy will be rejected.

7.3.5 Any conflicts of interest must be identified, assessed, and mitigated throughout the procurement lifecycle. WPL will advise on a case-by-case basis.

7.3.6 WPL will ensure records are kept for both audit and government requirements; including, but not limited to;

- The rationale for the procurement route taken.
- The invitation to tender, including the specification.
- All tender submissions.
- Details underpinning material decisions made during the award of the contract e.g. excluding suppliers, assessment of tenders, the decision to award the contract etc.
- Any communications with suppliers in relation to the award (prior to the award taking place).
- The conflict of interest assessment(s).

7.3.7 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in section 7.3.8 and 7.3.9 below.

7.3.8 Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 or NEC 4 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers (IMechE) and the Association of Consulting Engineers (ICE) (Form A) or, in the case of Civil Engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

7.3.9 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions wherever possible. In the limited circumstances where they are not appropriate then legal advice should be sought to ensure the proposed contract is in a suitable form.

7.4 Admissibility and Acceptance of Formal Tenders

7.4.1 Where a tender is submitted within a competitive process and is received after the specified time then it shall be disqualified. This shall however be subject to a test of reasonableness by WPL. The decision whether to accept or reject a late tender should be recorded in writing within the e-tendering system and communicated accordingly.

7.4.2 Unless variants have been expressly permitted, a tenderer who submits a qualified or conditional tender shall be given the opportunity to withdraw the qualification or condition without amendment to the tender. If the tenderer fails to do so the tender must be rejected.

7.4.3 Prior to final contract award, and as stipulated in the tender documentation instructions, the contractor must provide evidence of requested insurance.

7.4.4 Where possible contracts should be awarded to a single entity or lead contractor, who in turn will take contractual responsibility for the performance (and risks) for all sub-contractors and supply-chains. This reduces the risk of the Trust becoming party to disputes between contractors.

7.4.5 Where only one tender/quotation is received WPL shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

7.4.6 All tenders shall be evaluated on the basis of MAT (Most Advantageous Tender) in line with invitation to tender assessment methodology and weightings.

7.4.7 All quotes and tenders should be treated as confidential.

7.5 Quotation & Tendering Procedures – Building and Estates Engineering Contracts

7.5.1 Financial limits and the authorisation framework for placing Building and Estates Engineering contracts are outlined in Annex 2 Section 3.

7.5.2 The number of firms to be invited to quote or tender for a particular contract shall be in accordance with the procurement process specified in Annex 2 Section 4.

7.5.3 Constructionline (a database managed by HSDirect, where construction industry companies can seek accreditation) may be used to determine the suitability of a company to be selected to participate in a tendering exercise.

7.5.4 Before obtaining Tenders for the execution of any work the Director of Estates, Facilities & Capital Development will arrange for a pre-tender estimate to be prepared. This should include works, VAT, fees, equipment, and any other costs.

7.5.5 Where there is a wide discrepancy (>10%) between the pre-tender estimate and the final total scheme cost involving an increase in expenditure this is to be reported by the Director of Estates, Facilities & Capital Development to the CFO for further instructions.

7.5.6 A tender report will be completed by the relevant project manager or appointed consultant engaged to provide cost management services by the Trust in advance of the tenders being invited. It will include the scheme name, pre-tender estimate, names of contractors invited, date of invitation and date and time of return. According to the limits of delegation, it will be signed by the Director of Estates, Facilities & Capital Development / Deputy Director of Estates / Head of Estates Projects or the Chief Executive Officer in accordance with these SFIs.

7.5.7 All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact, this should include presenting it to the Associate Director of Corporate Affairs, when appropriate, to meet the requirement for signing and sealing where required.

7.5.8 Where an order over the value of £25,000 (excl VAT) is to be placed following the appropriate procurement process, approval must be sought utilising the Procurement Approval Document (PAD).

7.5.9 Where no tenders, or no suitable tenders, are received under a tendering process WPL

may advise that the waiving of this process takes place and propose a "Switch to Direct Award". A Competitive Procedure Waiver (CPW) will need to be completed in this instance. See section 7.7.

7.6 Quotation & Tendering Procedures – Goods and Services Contracts

7.6.1 Financial limits and the authorisation framework for placing goods and services contracts are outlined in Annex 2 section 3. The values listed also apply to disposals (SFI 14).

7.6.2 The number of firms to be invited to quote or tender for a particular contract shall be in accordance with the procurement process specified in Annex 2 Section 4.

7.6.3 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

7.6.4 The Chief Information Officer is authorised to place contracts for UHS Digital Contracts only.

7.6.5 When contracting with subsidiary companies and companies where UHS are shareholders, the trust will follow the goods and services authorisation framework. In examples where there is a conflict of approving personnel, due to individuals holding multiple directorships within each entity, the approval level will escalate to the next appropriate person in the hierarchy.

7.6.6 Where the total contract value exceeds the published UK legislative thresholds then the Trust is committed to following a compliant procurement process, following the advice of WPL.

7.6.7 Where an order over the value of £25,000 (excl VAT) is to be placed following the appropriate procurement process, approval must be sought utilising the Procurement Approval Document (PAD).

7.6.8 Where no tenders, or no suitable tenders, are received under a tendering process WPL may advise that the waiving of this process takes place and propose a "Switch to Direct Award". A Competitive Procedure Waiver (CPW) will need to be completed in this instance. See section 7.7.

7.7 Waiving or Variation of Tendering/Quotation Procedure

7.7.1 The procurement of goods and services or works with whole life costs in excess of £25,000 (excl VAT) should be competed, or a framework utilised, subject to the exemptions detailed in 7.7.3. This requirement may, following receipt of advice from WPL, be waived in the following specific circumstances:

a) Prototypes and development: This justification relates to research and development contracts, where the production or supply concerns a specific prototype, or "novel" goods and services which the contracting authority has commissioned for development.

b) Single supplier - intellectual property or exclusive rights: there must be no reasonable alternative to those goods, services, or works that might enable competition.

c) Single supplier - technical reasons: This is not to be used as a reason for the continued use of an existing supplier, but only where there is justified specialist expertise that is only available from one source.

d) Additional or repeat goods, services or works - extension or partial replacement: This is permitted where the sourcing of alternative goods, services, or works would result in an incompatibility with the existing goods, services, or works, causing disproportionate technical difficulties.

e) Additional or repeat goods, services or works - further goods, services or works following a competitive procedure: This justification can only be used if: (a) the original contract was awarded within the last 5 years; and (b) the intention to rely on this direct award justification to procure those similar goods, services or works was made clear in the authority's tender documents for the original contract.
f) Extreme and unavoidable urgency: These must be unforeseen. This justification does not apply where the urgency stems from a failure to plan/oct or omission that should have been foreseen.
g) Switch to Direct Award: On advice from WPL following a failed competitive process.
h) To protect life etc: Where the Minister of the Crown has made Regulations, under the Procurement Act 2023 Section 3, to allow certain specified contracts to be awarded. The scope of permitted contracts and time period it covers will be specified.

7.7.2 Where justification permits the avoidance of a procurement exercise under 7.7.1 a Competitive Procedure Waiver (CPW) form must be completed and appropriate signatures received in line with Annex 2 Section 5.

7.7.3 Waivers are not required in a limited number of circumstances. Firstly, if a partnership / joint venture contract exists that precludes the requirement for a competitive tendering process. This should be subject to confirmation by the Director of Wessex Procurement Limited and CFO. Secondly if a single supplier is mandated by NHS England or the contract is intra-NHS and not open to competition. Thirdly as part of a pay over agreement to another government entity. The Chief Financial Officer will maintain and monitor the list of exemptions, including:
a) Pay overs i.e. HMRC, Pensions, child voucher schemes, court fees;
b) Intra NHS Recharges;
c) NHS Litigation Services (NHS Resolution);
d) NHS Pensions Authority
e) Transactions between UHS Group entities e.g. WPL, UEL, UPL
f) University of Southampton shared service provisions i.e. consultant medical staff with joint contract"
g) Complete Fertility Ltd (as commissioned by the ICB, UHS acts as payment agent, service has now transferred)
h) Payments to charitable bodies
i) Defence Business Services (covering payments for military doctors operating within UHS)
j) Payments to NHS Professionals (NHSP) for temporary resourcing (bank and agency staffing)
k) CQC fees

7.7.4 The waiving of tendering/quotation procedures shall be reported to the Audit and Risk Committee retrospectively on a six-monthly basis highlighting all CPWs over £25,000 (excl VAT).

7.8 Contract Requirements
7.8.1 All Trust quotations, tenders or waivers that result in a signed contract between the supplier and the Trust under agreed terms and conditions should include clear specifications and key performance indicators (KPIs) where appropriate.

Where a formal contract document is required (see Annex 2 Section 4) it must contain the following as a minimum:
- A clear description of the services, works or goods to be supplied/specification
- Supplier details (name, address etc)
- Price and payment terms
- Contract start and end dates
- Delivery date(s) where appropriate
- The provision of liquidated damages if appropriate
- Appropriate insurance where relevant

- Signatures and signature dates

7.8.2 Any contracts for pilots, non-recurrent investments or short-term projects are to be for a maximum of 1 year.

7.8.3 Each party must ensure that the contract is signed by an officer with the appropriate delegated authority.

7.8.4 The aim is that that contract terms, conditions, scope, and deliverables, KPI reporting, and relationship management are clearly established in the signed contract and understood by all parties.

7.8.5 The Trust does not allow for contracts that have no defined end date (for example rolling contracts).

7.8.6 Where the service provided requires access to/processes Trust/patient data, the Trust Data Protection Team must be consulted, and necessary information sought from the supplier.

7.8.7 Where the estimated contract value is unknown then an Above Threshold procurement process must be followed.

7.8.8 Where the proposed contract has a value of over £5m it must contain a minimum of 3 KPIs. This obligation does not apply if it is considered the supplier's performance could not appropriately be assessed in this manner (for example where the contract is for a one-off delivery of goods). Performance against the KPIs must be monitored regularly and data published (by WPL) in accordance with relevant UK public procurement legislation. Legal advice may need to be sought prior to publication this should there be a serious breach of contract/poor performance.

7.8.9 A copy of the signed contract may be required to be published in certain circumstances under UK public procurement legislation. WPL will advise when this is required and complete the necessary steps to publish to the central digital platform.

7.9 Contract Management

7.9.1 Where a competitive tender process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the Trust Investment Group to approve any subsequent lease contract award for the same goods or equipment.

7.9.2 Staff with contract management responsibilities must ensure contractual obligations are met at the agreed cost and quality by monitoring the contract throughout its lifecycle. This may extend beyond the term of the contract if there are ongoing obligations associated with maintenance agreements, warranties and guarantees.

7.9.3 Contract management activity should maximise business benefit realisation and ensure value for money is achieved.

7.9.4 Price adjustments may only be made in accordance with the agreed mechanism included within the contract, following the involvement of WPL.

7.9.5 Staff are responsible for managing contracts in a manner that is appropriate for the contract complexity, value, and risk.

7.9.6 A regular process of evaluating supplier performance within the terms of the contract may be required. Performance matters should be discussed in an open, professional and transparent manner with the supplier.

7.9.7 It is the responsibility of the Contract Manager to ensure that appropriate meeting and performance monitoring records are retained.

7.9.8 Where possible performance management should focus on continuous improvement and delivering improved outcomes. Should poor performance be identified the appropriate escalation processes must be followed. WPL will support with any contractual disputes relating to existing issues or an exit plan.

7.9.9 It is the responsibility of the Contract Manager to ensure that all risks associated with the contract are understood, assessed, and managed.

7.9.10 Any concerns regarding supplier fraud or potential for fraud must be identified and reported to the local Fraud Officer.

7.9.11 Variations to building and engineering contracts shall be authorised by the Director of Estates, Facilities & Capital Development. These variations shall not be authorised if doing so would result in exceeding the values within the capital project approved business case. Where a variation does result in the capital project approved business case financial value being exceeded then further approval shall be required from the appropriate authorising body. These values are subject to the tolerances contained in these SFIs.

7.9.12 Where building and engineering contracts are being varied to include new pieces of work outside the scope of the original business case then a new business case will be required to be approved prior to this variation being issued.

7.9.13 Should contract variations be required robust change control mechanisms must be in place and appropriate approvals must be sought (in line with Annex 2 Section 3) utilising the Contract Change Approval Document (CCAD).

7.9.14 In all cases where optional extensions to a contract are outlined at the time of tendering, and the user wishes to exercise the options, appropriate approval must be sought (in line with Annex 2 Section 3) utilising the Contract Change Approval Document (CCAD).

7.10 Contract Exit or Termination

7.10.1 Contracts may only be terminated before the end of their contractual term following engagement WPL. Legal advice may need to be sought depending on the termination grounds to ensure the correct procedure is followed.

7.10.2 Contractual notice periods must be followed. Options upon termination/expiry of an existing contract must be evaluated prior to this to allow for appropriate decision making regarding the provision of existing services.

7.10.3 Contract Managers are responsible for managing the exit strategy, ensuring a smooth transition to a new supplier(s).~~The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders.~~

~~7.1.2 University Hospitals Southampton procurement services are provided through Wessex NHS Procurement Ltd ("WPL").~~

~~**7.2 Thresholds Tender Guide/Placing Contracts/Waivers**~~

~~7.2.1 The tables outlined in the Trust Authorisation Framework in Annex 2 outlines the correct procurement process to be followed relative to value and the type of product or service being purchased.~~

~~7.2.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded.~~

~~7.2.3 Subject to the limits outlined in Annex 2, the Managing Director of Wessex Procurement Limited, Director of Estates, Facilities & Capital Development, Chief Information Officer, Divisional Directors of Operations and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Procurement Approval Document is signed by~~

the relevant Trust authorised signatory.

7.2.4 The waiving or variation of the competitive tendering and quotation procedure can be approved subject to the limits outlined in Annex 2.

7.3 Electronic Tendering

7.3.1 All formal invitations to tender shall utilise the WPL on line E-tendering solution. Where there are national framework providers facilitating tendering activity then those E-tendering solutions may be utilised, but records maintained by WPL.

7.3.2 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.8.2. Issue of all tender documentation should be undertaken electronically through a secure website with controlled access using secure login, authentication and viewing rules.

7.3.3 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both WPL staff and suppliers are recorded within the system audit reports.

7.4 Manual Tendering – General Rules

7.4.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

7.4.2 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.4.3 and 7.4.4 below.

7.4.3 Every tender for building and engineering works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 or NEC 4 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers (IMechE) and the Association of Consulting Engineers (ICE) (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

7.4.4 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.5 Receipt, Safe Custody and Record of Formal Tenders

7.5.1 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

7.5.2 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

7.5.3 The appropriate officer shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.6.

7.6 Opening Formal Tenders

7.6.1 As soon as practicable after the date and time stated as being the latest time for the

receipt of tenders they shall be opened by two officers designated by the officer as appropriate.

7.6.2 Every tender received shall be stamped with the date of opening and initialled by two of those present at the opening.

7.6.3 A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record.

7.6.4 Except as in SFI 7.6.5 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

7.6.5 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure set out in SFI 7.6.4 above unreasonable.

7.7 Admissibility and Acceptance of Formal Tenders

7.7.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the CFO or nominated officer.

7.7.2 Tenders received after the due time and date may be considered only if the CFO or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The CFO, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting.

7.7.3 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the CFO or nominated officer be regarded as having arrived in due time.

7.7.4 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.7.2.

7.7.5 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

7.7.6 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

7.7.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the CFO.

7.7.8 Where only one tender/quotation is received the CFO /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

7.7.9 All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

7.7.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive Officer or nominated officer (within 7.9.1 below).

7.7.11 All tenders should be treated as confidential and should be retained for inspection.

7.8 Extensions to Contract

7.8.1 In all cases where optional extensions to contract are outlined at the time of tendering, approval will be required as if it were a new contract.

7.8.2 Variations to building and engineering contracts shall be authorised by the Director of Estates, Facilities & Capital Development. These variations shall not be authorised if doing so would result in exceeding the values within the capital project approved business case. Where a variation does result in the capital project approved business case financial value being exceeded then further approval shall be required from the appropriate authorising body. These values are subject to the tolerances contained in these SFIs.

7.8.3 Where building and engineering contracts are being varied to include new pieces of work outside the scope of the original business case then a new business case will be required to be approved prior to this variation being issued.

7.9 Quotation & Tendering Procedures – Building and Engineering Contracts

7.9.1 Quotation & Tendering Procedures Summary - Building and Engineering Contracts

a) Unless permitted by Standing Orders, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2.

b) Tender documents will be issued by the office of the Director of Estates, Facilities & Capital Development via the Delta e-tendering portal administered by Wessex NHS Procurement Limited (WPL). All tenders will be returned via the Delta e-tendering portal and will opened automatically at the prescribed date/time set at the time tenders were published in accordance with the SFIs of the Trust.

c) Tender lists for building and engineering works will be compiled by the Director of Estates, Facilities & Capital Development from "Constructionline" the Trust's approved list of Contractors.

d) Before obtaining Tenders for the execution of any work the Director of Estates, Facilities & Capital Development will arrange for a pre-tender estimate to be prepared. This should include works, VAT, fees, equipment and any other costs.

e) Where there is a wide discrepancy (>10%) between the pre tender estimate and the final total scheme cost involving an increase in expenditure this is to be reported by the Director of Estates, Facilities & Capital Development to the CFO for further instructions.

f) The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

g) A tender report will be completed by the relevant project manager. It will include the scheme name, pre tender estimate, names of contractors invited, date of invitation and date and time of return. According to the limits of delegation, it will be signed by the Director of Estates, Facilities & Capital Development / Associate Director of Estates / Head of Estates Projects or the Chief Executive Officer in accordance with these SFIs.

h) Adjudication must be made in accordance with SFI 7.7. A tender ratification prepared by the Design Team and endorsed by the Project Manager should be submitted to the Director of Estates, Facilities & Capital Development for approval or to seek authorisation, according to delegated limits.

i) Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.

j) All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact, this should include presenting it to the Associate Director of Corporate Affairs to meet the requirement for signing and sealing where required.

k) The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee regularly.

7.10 Quotation & Tendering Procedures – Goods and Services Contracts

7.10.1 Financial limits for placing goods and services contracts are outlined in Annex 2, Section 4.

7.10.2 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally

agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

7.10.3 The Chief Information Officer is authorised to place contracts for UHS Digital Contracts only.

7.10.4 When contracting with subsidiary companies and companies where UHS are shareholders, the trust will follow the goods and services authorisation framework. In examples where there is a conflict of approving personnel, due to individuals holding multiple directorships within each entity, the approval level will escalate to the next appropriate person in the hierarchy.

7.10.5 The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2.

7.10.6 The legally compliant tendering process will be advised by WPL.

7.10.8 Where the total contract value exceeds the published UK legislative thresholds (currently defined as the WTO GPA thresholds) then the Trust is committed to a compliant procurement process as advised by WPL.

7.11 Waiving or Variation of Competitive Tendering/Quotation Procedure

7.11.1 Where goods, services and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Competitive Procedure Waivers will be required as part of the Procurement Approval Document for all waivers over £25,000 (excluding VAT).

7.11.2 In circumstances where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers) the reasons for receiving a lower number of quotations/tenders must be recorded.

7.11.3 Waivers are not required in a limited number of circumstances. Firstly, if a partnership / joint venture contract exists that precludes the requirement for a competitive tendering process. This should be subject to confirmation by the Director of Wessex Procurement Limited and CFO. Secondly if a single supplier is mandated by NHS England or the contract is intra NHS and not open to competition. Thirdly as part of a pay over agreement to another government entity. The Chief Financial Officer will maintain and monitor the list of exemptions, including:

a) Pay overs i.e. HMRC, Pensions, child voucher schemes, court fees;
b) Intra NHS Recharges;
c) NHS Litigation Services (NHS Resolution);
d) NHS Pensions Authority
e) Transactions between UHS Group entities e.g. WPL, UEL, UPL
f) University of Southampton shared service provisions i.e. consultant medical staff with joint contract
g) NHS Patient voucher schemes (eg opticians)

7.12 Quotation & Tendering Procedures Summary - Contracts

7.12.1 Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

7.12.2 No Pre-Qualifications stages should be conducted for below threshold quotations/tenders in accordance with Public Contract Regulations 2015 (Regulation 111).

7.12.3 Quotations will be obtained for single purchases where the estimated value does not

~~exceed the limit specified in SFI 7.2.~~

~~7.12.4 Tenders shall be invited for all purchases of goods and/or services to be supplied over a period of time where the estimated contract value exceeds that specified in SFI 7.2.~~

~~7.12.5 Tenders will be issued by WPL and shall incorporate standard NHS Terms and Conditions of Contract.~~

~~7.12.6 After tenders/quotations have been opened, WPL will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.7.~~

~~7.12.7 A Procurement Approval Document and Ratification Report prepared by WPL should be submitted for approval according to delegated contract approval limits as specified in SFI 7.2.~~

~~7.12.8 Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2.~~

~~7.12.9 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit and Risk Committee on a six monthly basis highlighting all waivers over £25,000 (excluding VAT) and those over £75,000 (excluding VAT) approved by the Chief Executive Officer or Chief Financial Officer.~~

~~7.12.10 Where a competitive tender ratification process has already been conducted for goods or equipment and approved within the delegated levels, authority is given to the Managing Director of Wessex Procurement Limited to approve any subsequent lease contract award for the same goods or equipment.~~

~~7.12.11 All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and publication to the Government Contracts Finder.~~

~~7.12.12 All Trust quotation/tenders or waivers over £25,000 (excluding VAT) in value that result in a signed contract between the supplier and the Trust under agreed terms and conditions, should include clear specifications and KPI's where appropriate. These will be retained through the WPL Source To Contract System. Any exceptions to this are at the discretion of the Managing Director of Wessex Procurement Limited.~~

7.11~~3~~ Non-Disclosure Agreements

7.11~~3~~.1 Non-disclosure agreements (also referred to as NDAs or confidentiality agreements) may be entered into by the Trust when it is developing a new product, service or process with someone else. The agreement will restrict the way in which any confidential information shared by the Trust and the other party can be used and ensure that this information and the fact that the parties are working together are kept confidential. These agreements are entered into at the outset of the process and will not generally have a financial value associated with them.

7.11~~3~~.2 Legal advice should be sought when the Trust is asked to enter into a non-disclosure agreement or the agreement entered into should follow the format of the template non-disclosure agreement used by the Trust. Non-disclosure agreements must be authorised and signed by any Executive Director, the Chief Information Officer, the Managing Director of Wessex Procurement Limited, Head of Innovation or the Commercial and Enterprise Director.

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive Officer, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Integrated Care Boards and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health and Social Care or NHS England are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive Officer should take into account:

(a) Costing and pricing (in accordance with the NHS England financial regime or any alternatively agreed payment mechanism) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 The CFO shall produce regular reports detailing actual and forecast income.

8.1.7 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

8.1.8 The authorisation limits for signing service contracts are set out in Annex 2.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive Officer to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where UHS is a competing body)

8.3.1 Where UHS participate in a tendering exercise (whether in competition with others or not) for a health-related service, approval must be sought according to the delegated authority limits. This includes bidding for external sources of capital or revenue funding.

8.3.2 Delegated authority limits associated with tendering are outlined in Annex 2.

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute

clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the stated financial limits as per the Trust Authorisation Framework. All tender decisions will be reported to the Trust Executive Committee for noting.

8.3.4 Staff who participate in a tendering exercise must notify the Planning and Business Development team and/or commercial team and follow processes in accordance with the "Bidding for Contracts" policy (available on Staffnet).

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration and Appointment Committee

9.1.1 The Trust Board shall establish a Remuneration and Appointment Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and some Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director posts above the salary of the Prime Minister (currently circa £160k) must be referred to NHS England and onward opinion from the Secretary of State.

9.2 Staff Appointments, Terminations and Changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Recruitment Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy; subject to the Recruitment Control Panel Terms of Reference.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short-term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off-payroll engagements must be compliant with IR35 legislation and approved by the CFO prior to contract signature.

9.2.3 All contracts of employment including recruitment, promotions and terminations will be transacted via ESR (Electronic Staff Record) by Self Service or where applicable through the appropriate HR team. Please see the Staffnet Quick Guide to HR processes for guidance.

9.2.4 All staff employed by the Trust will be issued a contract of employment. All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place. Engagement of agencies should also be in line with prevailing NHS England / NHS Improvement requirements and rules.

9.2.5 A termination of employment form must be submitted by the employee's line manager through manager self service on ESR before the termination date.

9.2.6 Any appointments should follow the Trust Recruitment Policy found on Staffnet.

9.2.7 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.8 In the event that redundancy cannot be avoided the Trust shall:

i) Develop selection criteria based upon the agreed Trust Organisational Change Policy which includes affordability, and

ii) Complete the Trust redundancy approval form (RAF) and submit to the HR Business Partner. The form must be approved by the Chief People Officer and Chief Financial Officer. The approval process must be completed and agreed prior to any consultation commencing.

9.2.9 Changes to, and / or the creation of, local terms and conditions require approval by Pay Steering Group. Where necessary, for major changes, it may be appropriate for this to be authorised by either the Trust Board's Remuneration and Appointment Committee or Trust Board.

9.3 Processing Payroll

9.3.1 The Chief People Officer shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with current agreements.

9.3.2 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.

9.3.3 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.4 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under / overpayments is contained in the Trust's Pay Policy.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive Officer will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions – see Annex 2.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Chief Financial Officer will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services, via an approvals hierarchy; and

b) The maximum level of each requisition and the system for authorisation above

that level. Authorisation limits are specified at Annex 2.

10.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of Wessex Procurement Limited shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.2.3 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition.

10.2.4 The Trust operates a "No Purchase Order No Pay" policy. All orders require a Purchase Order prior to being placed. The Chief Financial Officer will maintain and monitor a list of exemptions, including:

a) Pay overs i.e. HMRC, Pensions, child support, court fees, salary sacrifice schemes;
b) Patient reimbursements, such as travel Intra NHS recharges;
c) Transactions between UHS Group entities e.g. WPL, UEL, UPL
d) Patient voucher schemes (eg opticians) Out of scope of the above are payments via purchase cards, expense claims and invoices processed in JAC for Pharmacy.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.2 The CFO will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees able to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do

preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are evidenced;

- in the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except where a prepayment is agreed).

10.3.3 Prepayments are only permitted where the financial advantages outweigh the disadvantages. In such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.4 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

b) The following contracts should be submitted to the Finance department for review prior to seeking approval as they are likely to need submission to Trust Investment Group under revised accounting standard IFRS16:

- Equipment leases

- Property leases (including those with peppercorn rents)
- Other contracts which include the supply of equipment which include separate charges for that equipment (embedded leases)
- Other contracts which include the supply of equipment which do not include separate charges for that equipment (as the charging mechanism may need apportioning between the supply of goods or services and the supply of equipment as an embedded lease)
- Other property guarantees

c) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the relevant approval body outlined in Annex 2;

d) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

e) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

f) Petty cash records are maintained in a form as determined by the CFO;

g) Contracts above specified thresholds are advertised and awarded in accordance with UK legislation and WTO rules on public procurement; and

h) All requisitions must be approved in line with the Trust Authorisation Framework.

i) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one-off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.3.5 Purchase Cards

10.3.5.1 Purchase Cards may be issued to employees only when specifically approved by the Chief Financial Officer. Managers and staff must ensure that they comply fully with the guidance regarding the use of cards as specified within the Purchase Card Policy.

10.4 Employee Expenses

10.4.1 The Trust's Expenses Policy is available on StaffNet to ensure all employees are aware of their responsibilities regarding the claiming of business travel expenses and other forms of subsistence and authorisation of related claims. The primary purpose of travel and subsistence allowances is to reimburse employees the cost incurred for meals, accommodation and travel in the performance of their duties. The Trust has an expenses system for staff related expenses. No expenses should be claimed outside of this system.

10.4.2 Staff expenses claims should be approved by Care Group Manager (for Clinical Divisions) or by the Director for Trust Headquarters. They may, however, be delegated to suitable deputy senior manager (minimum band 8a) at the discretion of the Care Group Manager or THQ director.

10.5 Management Consultants

10.5.1 Consultancy contracts over £50,000 require approval by NHS England in line with National guidance.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS England's NHS Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Operational Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 The Trust will comply with the guidance on dividend payments contained in the DHSC Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Audit and Risk Committee.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS England and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Audit and Risk Committee on an annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held to the Board through the Audit and Risk Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Trust Investment Group comprising at least two Executive Directors and chaired by the Chief Financial Officer to oversee its allocation of capital investment. The Chief Financial Officer will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Operational Plan and the Capital Investment Plan.

12.1.2 The Investment Group will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year.

12.2 Approval of Capital Business Cases

12.2.1 Approval of capital business cases will follow the approval limits outlined in the Trust Approval Framework in Annex 2.

12.2.2 All expenditure should be within the program budget as agreed by Trust Board on an annual basis. Program reporting is required by Trust Investment Group (TIG) on a periodic basis

12.2.3 Delegated capital limits refer to overall contract values, regardless of the form of funding (e.g. lease, capital up-front, bullet payment or managed service contract).

12.2.4 The delivery of capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than ~~10~~5%, whichever is greater, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.

12.2.5 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:

a) An option appraisal of potential benefits compared with known costs;

b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and

c) An analysis of the project's discounted cash flow, based on an agreed rate of return.

12.2.6 The Trust Investment Group will report on major issues to the Trust Executive Committee and Trust Board via the capital section of the monthly Finance Report and within the quarterly capital update.

12.2.7 The Southampton Hospital Charity, or other charities, may choose to donate assets to the Trust. The governance outlined in Section 17 (Charitable Funds Held on Trust) shall apply. Any financial consequences on the Trust must be approved by the appropriate body as outlined in the Trust Authorisation Framework (Annex 2).

12.2.8 Once capital is approved, the Chief Financial Officer is responsible for choosing the most appropriate source of finance, aligned to the Trust Treasury Management Policy.

12.2.9 Finance leases reaching the end of their contractual term are included as Capital expenditure. The Trust Investment Group has authorised the Leasing Sub-Committee to manage and approve the buy-out and/or direct replacement of leases. Where new equipment is required, a business case needs to go to Trust Investment Group for approval before a decision on whether to lease or direct purchase can be made.

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Trust Investment Group for approval or review prior to request for approval by Trust Board if required.

12.4 Asset Registers

12.4.1 The Chief Executive Officer is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register and the method of updating. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to the associated senior service user/ owner and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive Officer.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for:

a) Equipment on loan;

b) All contents of furnished lettings.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and the Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:
a) An Estate Strategy;
b) Acquisition of freehold property over £2.5 million (excluding VAT); and
c) Acquisition of property where the total value of the agreement is over £2.5 million (excluding VAT) by means of a lease, whether it is deemed to be capitalised or not under IFRS 16.

12.6.3 Property purchases, licences and leases up to £150,000 each (excluding VAT) may be authorised by the CFO and those at or above this value but not exceeding £2.5 million each (excluding VAT) may be authorised by the Trust Investment Group, provided in each case that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation. Licences connected with existing leases or other transactions previously authorised by the CFO, Trust Investment Group and Trust Board will not require separate authorisation provided that these do not result in significant changes to the Trust's Estate.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;
b) Details of the period of the lease;
c) Details of the required accounting treatment;
d) Annual running costs of the property;
e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;
f) The results of property and ground surveys;
g) Professional advice taken and the resultant cost;
h) Details of any legal agreement entered into;
i) Any restrictive covenants that exist on the property; and
j) Planning permission.

12.6.5 Any property acquisition should be in accord with Department of Health and Social Care guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive Officer.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £2.5 million (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets require the approval of NHS England.

12.6.11 Material or Significant Transactions, as defined in NHS England's transactions guidance, may require the approval of NHS England.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £2.5 million.

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First In First Out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Managing Director of Wessex Procurement Limited. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Deputy Chief Pharmacist; and the control of fuel oil the responsibility of the Director of Estates, Facilities & Capital Development. The control of stock within UHS subsidiaries shall be the responsibility of subsidiary directors and their respective Boards.

13.1.3 The CFO, in conjunction with the Managing Director of Wessex Procurement Limited, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate

goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.4 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.5 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.6 The Managing Director of Wessex Procurement Limited shall be responsible for a system approved by the CFO for a review of slow-moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.7 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.8 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.

13.1.9 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Chief Executive Officer shall identify those authorised to requisition and accept goods from the store.

13.1.10 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100k (higher of either market value or net book value) must be approved by the Chief Executive Officer.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DHSC Group Accounting Manual and prepare a register. Approval limits where approval is required from NHS England and HM Treasury are defined in Annex 1.

14.2.2 The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See Trust Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The CFO is responsible for monitoring compliance with the Government Functional Standard GovS 013: Counter Fraud ~~Directions of the Secretary of State~~ and with any other instructions issued by the NHS Counter Fraud Authority.

14.2.5 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive Officer in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. Losses and special payments are defined at Annex 1.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Chief Executive Officer, supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and the UK General Data Protection Regulation; ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment, ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage and ensure that appropriate technical and organisational measures are in place to achieve compliance. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Information Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment or infrastructure (e.g. PCs, laptops, tablets, servers, cloud computing infrastructure) should be purchased without the

approval by the UHS Digital department. Any quotes to purchase software or contract for cloud hosted services should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the UHS Digital department.

The Trust's Digital Board has an approval limit of £300k for projects where within budgetary limits. It will be at the discretion of the Chief Information Officer or other senior UHS Digital managers whether a case requires discussion at Digital Board."~~No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the UHS Digital department. Any quotes to purchase software should therefore be managed through the IT helpdesk.~~

~~No hardware equipment should be connected to the network without the approval of the UHS Digital department.~~

~~The Trust's Digital Board has an approval limit of £300k for projects where within budgetary limits. It will be at the discretion of the Chief Information Officer or other senior UHS Digital managers whether a case requires discussion at Digital Board.~~

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions. This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive Officer is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into health service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Work and Pensions instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

~~**17.1 Introduction**~~

17.1~~.1~~ The Trust no longer administers any Charity, including the Southampton Hospital Charity which is a wholly separate entity.

17.2 The Southampton Hospital Charity is the only vehicle for the collection and administration of charitable funds. No Trust department may collect or administer funds without prior authorisation from the Charity team. For the avoidance of doubt it is prohibited to set up bank accounts for Charitable purposes without Board approval.

17.3 The Southampton Hospital Charity acts as an independent grant awarding body. Grants awarded to UHS should be spent in line with the grant award guidance and records should be maintained to document that this is adhered to.

~~The Trust is the sole corporate Trustee of Southampton Hospital Charity (registered charity number 1051543), and is responsible for the management of funds it holds on trust. Although the management processes may overlap with those of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.~~

~~17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management and governance of funds held on trust.~~

17.1.~~3~~ ~~The overriding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.~~

~~17.1.4 The Trust Board hereby nominates the Chief People Officer, who has executive responsibility for the Charitable Funds team, to have primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.~~

~~17.1.5 The Trust shall ensure the establishment of the Southampton Hospital Charity Charitable Funds Committee, to which it delegates the majority of its Trustee role as set out in the Committee's Terms of Reference.~~

~~**17.2 Administration of Charitable Funds**~~

~~17.2.1 The CFO or nominated deputy shall:~~

~~a) Authorise any transaction of funds between investment vehicles;~~

b) Oversee the preparation and procedure of the annual accounts and the annual audit.

17.2.2 The Charity Director shall arrange for the following functions to be undertaken:

a) Arrange for the administration of all existing charitable funds including clear electronic and paper record keeping in accordance with the recommendations of internal and external audit;

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within restricted accounts are managed in accordance with charity law;

e) Periodically review the funds and any subsidiary funds, rationalise funds within statutory guidelines, and report changes to the Southampton Hospital Charity Charitable Funds Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals on a monthly basis to the Chief People Officer and to the Southampton Hospital Charity Charitable Funds Committee at the quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Southampton Hospital Charity Charitable Funds Committee and the Charity Commission.

17.3 Fundraising & Incoming Funds

17.3.1 The Director of Southampton Hospital Charity shall:

a) Ensure that the Charity is the only vehicle for the collection and administration of charitable funds. No other department may collect or administer funds without prior authorisation from the Charity team.

b) Introduce and enforce policies, systems and procedures to ensure that officers of the Trust are informed as to how to proceed when offered funds that donors' intentions are recorded and that formal receipting and thanking procedures are in place;

c) Identify and prioritise, in conjunction with appropriate elements of the Trust, fundraising projects/appeals.

d) Market and promote fundraising while maintaining a unified brand and adhering to charity regulations;

e) Build, maintain and utilise donor records in accordance with the Data Protection and Freedom of Information Acts;

f) Work in close partnership with other charities supporting the hospital, performing a liaison role where appropriate;

g) Build and maintain a staff team and network of volunteers and funders;

h) Generate continuous and unrestricted income in order to become sustainable;

i) Alert the Charitable Funds Committee to any irregularities regarding the use of the charity's name or its registered charity number;

j) Ensure that adequate insurance is in place for all fundraising activities.

17.4 Investment Income

17.4.1 Investment will be the responsibility of Southampton Hospital Charity Charitable Funds Committee or if appropriate will be devolved to a sub-committee (to include the Charitable Funds Committee Chair, the CFO, and the Charity Director and/or appropriate replacements when required).

17.4.2 Its responsibilities will include:

a) Ensure that investment is in accordance with the Charity's investment policies;

b) Commission any required investment advisors;

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

e) Review and recommend to the Trust Board the appointment of investment advisors every three years.

17.4.3 The Charity Director, with support from the Trust Finance Team will:

a) Report investment performance to the Southampton Hospital Charity Charitable Funds Committee;

b) Minute investment decisions;

c) Allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Fund Expenditure and Grants

17.5.1 Day-to-day management of individual expenditure is delegated to the Charity Director and in turn to the individual charitable fund holders, within the limits set out in these instructions.

17.5.2 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.3 The Charity Director is responsible for ensuring appropriate fund holders are appointed to support the effective management and use of charitable funds. This includes periodic review of fund holders and their role.

17.5.4 A connected multiple order could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.5 **Levels of Authority**

The following levels of approval shall apply:

£ (excl VAT)	**Approval Process for designated funds**

All levels	Application made to the Charity funds officer. Proposed expenditure discussed with fund holders and approval code issued if agreement. The Charity will require additional sign-off in support of the application depending on amount requested: Up to £10k – Fund holders £10k - £75k – Fund holders + CGM (or THQ director) £75k+ – Fund holders + DDO (or THQ director)
	Once approval code is issued the following approval levels apply
Up to £5k	Senior Funds Officer
£5k - £25k	Head of Charity Operations
£25k - £75k	Charity Director
£75k - £1m	Charitable Funds Committee *Requires a business case*
£1m+	Trust Board as Corporate Trustee *Requires a business case*

For the purpose of the non-pay authorisation framework, the CFO will be the £1m approver and the CEO will be the unlimited approver.

17.5.6 Points to note:

a) If the Fund Holder is absent from work for an extended period of time or , in cases where, for example the Fund Holder and the Care Group Manager are one and the same, the Charity Director or Head of Charity Operations can exercise discretion to accept authorisation from fewer signatories, subject to the minimum of two.

b) If anyone seeking to authorise the expenditure of charitable funds is in any doubt whether the proposed expenditure is legitimate charitable expenditure, they should contact the Charity Director.

c) Expenditure above £75,000 must be supported by an appropriate business case.

17.5.7 Where the expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.5.8 The delivery of charitably funded capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £10k or more than 5% then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting.

17.5.9 Although exempt from public sector procurement roles, the Charity will follow the Trust's procurement processes except in situations where these rules are not appropriate or applicable to charitable purposes. In these cases approval will be sought from Charitable Funds Committee.

17.6 Asset Management

17.6.1 Charitable funds can be considered as a source of funds for the maintenance of assets granted to the Trust, subject to agreement between the Charity and the Trust.

~~17.6.2 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.~~

~~17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure other than where the Charity has agreed to fund the maintenance or revenue costs.~~

~~17.6.3 The Trust shall:~~

~~a) Be responsible for insuring, safeguarding and protecting all equipment and must pay its operating, maintenance costs (unless prior agreement to be funded by the Charity), and all other costs arising from the day to day running of the equipment, including any insurance;~~

~~b) Be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.~~

~~**17.7 Risk Management**~~

~~17.7.1 The Charity Director will be responsible for updating an annual risk register for agreement by the Southampton Hospital Charity Charitable Funds Committee. This will address the following key areas of risk for the charity:~~

~~a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;~~

~~b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;~~

~~c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;~~

~~d) External risks – e.g. public perception and adverse publicity, government policy;~~

~~e) Compliance with law and regulation – e.g. breach of charity law, lottery regulations.~~

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive Officer shall ensure that all staff, volunteers, and any other person associated with the activities of the Trust are made aware of, and comply with, the Trust's Standards of Business Conduct Policy. This policy details the conduct and behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships and loyalties which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made in accordance with the Trust's Standard of Business Conduct Policy for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising, or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so.

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Standards of Business Conduct and Raising Concerns (Whistleblowing) policies, available via Staffnet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National NHS fraud and corruption reporting line (0800 028 4060) or via the National Fraud Reporting website reportfraud.cfa.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive Officer shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS England/DHSC guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	**Held By**
Property Deeds	Director of Estates, Facilities & Capital Development
Building & Engineering Contracts	Director of Estates, Facilities & Capital Development
Estate Maintenance Contracts	Associate Director of Estates
Maintenance Contracts	WPL
Clinical Contracts	Director of Operational Finance
WPL Contracts	Associate Director of Corporate Affairs
Contracts for goods and services other than the above	WPL

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which

may be held by other Managers must be reported to the Associate Director of Corporate Affairs for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS England/DHSC guidance (Records Management Code Of Practice 2023) shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive Officer or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive Officer shall ensure that the Trust has a sound system of risk management and internal control set out in strategy, policy, and procedural documentation. The functioning and efficacy of the system of internal control and risk management shall be monitored and assessed for suitability by the Board of Directors and its duly established committees.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including internal audit, external audit, clinical audit and health and safety reviews.

The existence, integration and evaluation of these elements will provide a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current NHS guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Associate Director of Corporate Affairs shall act as the Trust's lead contact on insurance matters and ensure Insurance Brokers are liaised with over queries and negotiating renewal terms.

20.2.3 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Associate Director of Corporate Affairs shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.2.5 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.3 Clinical Risk Management/CNST

20.3.1 The Chief Nursing Officer shall:

a) Provide a central point of contact within the Trust for NHSR/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where NHS Resolution, in joint agreement with the Associate Director of Corporate Affairs, considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the Trust within the excess of £3k will be notified and approved by the Trust Legal Services Facilitator and Head of Claims and Insurance.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the University Hospital Southampton NHS Foundation Trust as the defendant.

Up to £500k	DCD or DHoN or DDO
£501k - £1.5m	DCD and DHoN and shared with an Executive Director (usually Medical or Nursing)
£1.5m+	DCD and DHoN and shared with at least two Executive Directors and the CEO for final review and approval then reported to Trust Board

The DHSC must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care (Community Health and Standards) Act 2003 – NHS Charges

Commented [MC3]: Was this replaced by National Health Service Act 2006 ?

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS trust. In the event the compensator is University Hospital Southampton NHS Foundation Trust the act provides that UHS is exempt from repaying their “own” costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the Chief Financial Officer. In certain cases, additional approval should be sought from NHS England and/or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £50,000	Chief People Officer and Chief Financial Officer
£50,001 - £100,000	Chief Executive Officer
£100,000+	Trust Board

22.4 NHS England must be consulted before making any special payments that are novel, contentious or repercussive. The Chief People Officer, in the case of any compromise agreements, shall submit a business case to be approved by HM Treasury. Any payments made against legal advice must be approved by the Trust Board.

23. SUBSIDIARIES, SHAREHOLDINGS, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries and Shareholdings

23.1.1 Subsidiary companies and companies where UHS are joint-shareholder (e.g. WPL) are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries and shareholdings are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable, with the exception of where the group position is directly impacted (e.g. Group CDEL limit for capital). Reference to the subsidiary's documentation will need to be made.

23.1.2 Whilst subsidiaries operate independently, their SFIs include a schedule of changes where prior written approval of the Shareholder is required. This includes alteration of any constitutional documents of the company. Any changes to the schedule of prior Shareholder approval will require approval of Trust Board, following review and recommendation by the Audit and Risk Committee.

23.2 Hosted Bodies, Partnerships and Collaborations

23.2.1 Hosted bodies are organisations for which UHS provide services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Commercial Development Team. UHS also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.2 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case by case basis.

24. FORCE MAJEURE

24.1 In the event of a force majeure, such as a Pandemic, the existing Standing Financial Instructions and Scheme of Delegation should be followed as normal where possible.

24.2 If compliance with Standing Financial Instructions (SFIs) and Schemes of Delegation (SODs) is expected to generate delays to the procurement of goods (either revenue or capital expenditure) and such delay causes unacceptable detriment to patients and / or staff, the SFIs and SODs may be waived on the written authority of either the

CFO or Director of Operational Finance. In the event that neither the CFO nor Director of Operational Finance is available, the CFO may delegate the authority to waive SFIs / SoD to another Executive Director.

24.3 If the value of the transaction exceeds £2.5m, the written authority of the Chair, or another Non-Executive Director nominated by the Chair, will also be required.

24.4 A schedule of transactions showing transactions where SFIs / SoD have been waived shall be maintained to include the date of waiver, name of supplier, description of goods ordered, name of approving officer and why the waiver was approved. This schedule shall be reported regularly to Trust Board and to each Audit and Risk Committee.

24.5 The Audit and Risk Committee are responsible for ratifying decisions made under force majeure.

24.6 The Trust Board and / or Audit and Risk Committee need to confirm when Force Majeure arrangements can come into force and when they are terminated.

24.7 The CFO or Director of Operational Finance can also waive section 10.3.3 of Trust SFIs relating to prepayments, where this is in line with HM Treasury policy regarding payments to Suppliers during a force majeure (for example “Procurement Policy Note 02: Supplier relief due to coronavirus”).

Annex 1

Losses, Gifts and Special Payments

LOSSES:
1. Losses of cash due to:
   a. theft, fraud etc.
   b. overpayment of salaries etc.
   c. other causes
2. Fruitless payments
3. Bad debts and claims abandoned in relation to:
   a. private patients
   b. overseas visitors
   c. other
4. Damage to buildings, property etc. due to:
   a. theft, fraud etc.
   b. other

SPECIAL PAYMENTS:
5. Compensation under legal obligation
6. Extra contractual to contractors
7. Ex gratia payments in respect of:
   a. loss of personal effects
   b. clinical negligence with advice
   c. personal injury with advice
   d. other negligence and injury
   e. severance payments on termination of employment
   f. other employment payments
   g. patient referrals outside the UK and EEA Guidelines
   h. other
   i. maladministration, no financial loss
8. Extra statutory and regulatory

Type	Approval thresholds by NHSE and HMT
Special severance payments	All non-contractual payments
Special payments	£95k+
Losses	£95k+
Gifts	£300k+
Anything novel, contentious or repercussive	All must be approved

Annex 2 – Trust Authorisation Framework

Section 1 – Authorisation Bodies and Limits

Expenditure limits refer to per annum budget thresholds.

Group	Revenue (Annual Gross Cost)	Capital
Divisional Management Boards	Utilisation of approved expenditure budget only.	Up to £150k where this is within the annual capital allocation for ~~the~~ all Divisions. All capital expenditure to be reported to TIG.
Defined groups	N/A	Up to £150k where this is within annual capital allocation: • Director of EFCD – backlog maintenance / Infrastructure / Advanced design fees. • Leasing sub-committee – replacement leases / buy-outs. • Medical Equipment Panel • UEL Board • IISS Investment Committee Up to £300k where this is within annual capital allocation: • Digital Board
Recruitment Control Panel	As per Terms of Reference, reporting into TEC	N/A
People Board	As per Terms of Reference, reporting into TEC	N/A
Pay Steering Group	As per Terms of Reference, reporting into People Board	N/A
Payroll Approvals Group	As per Terms of Reference, reporting into Pay Steering Group	N/A
DoOF or COO	Up to £50k – exceptional circumstances only.	Up to £50k – exceptional circumstances only. All capital expenditure to be reported to TIG.
CEO or CFO	Up to £150k	Up to £150k. All capital expenditure to be reported to TIG.
TIG (Trust Investment Group)	Up to £2.5m additional expenditure budget. Schemes over £2.5m and/or of significant strategic importance should include a recommendation from TIG to F&IC.	Up to £5.0m. Schemes over £5.0m and of significant strategic importance should include a recommendation from TIG to F&IC.
TEC (Trust Executive Committee)	Receive minutes and note decisions from TIG. • Business cases relating to staff recruitment / training programmes. • New consultant business cases • Replacement consultant business cases – for noting.	Receive minutes and note decisions from TIG.
F&IC (Finance & Investment Committee)	£2.5m+ and schemes of significant strategic importance for commercial review and recommendation to Trust Board.	£5.0m+ schemes of significant strategic importance for commercial review and recommendation to Trust Board.

Trust Board	£2.5m+ and: - schemes judged of significant strategic importance - major schemes with compliance arrangements	£5.0m+ and: - schemes judged of significant strategic importance - major schemes with compliance arrangements
NHS England	Major schemes with compliance arrangements	Major schemes with compliance arrangements

Annex 2 – Trust Authorisation Framework

Section 2 – Non-Pay Authorisation Framework

~~**Finance and Procurement System - Rulesets**~~

~~Approver limits according to Hierarchy~~

-	-	~~**First Approver**~~	~~**Second Approver**~~	~~**Third Approver**~~	~~**Fourth Approver**~~	~~**Fifth Approver**~~	~~**Sixth Approver**~~
~~**Rule 1**~~	~~**Divisional Hierarchy**~~	~~£5k~~	~~£25k~~	~~£75k~~	~~£250k~~	~~£1m~~	~~Unlimited~~
~~**Rule 2**~~	~~**R&D Hierarchy**~~	~~£5k~~	~~£25k~~	~~£75k~~	~~£250k~~	~~£1m~~	~~Unlimited~~
~~**Rule 3**~~	~~**THQ Hierarchy**~~	~~£5k~~	~~£75k~~	~~£250k~~	~~£1m~~	~~Unlimited~~	
~~**Rule 4**~~	~~**Other Hierarchy - Inc. Capital, Estates**~~	~~£75k~~	~~£250k~~	~~£1m~~	~~Unlimited~~		

Authorised Non-Pay Expenditure Limits	
	Limit £
All Staff	
Band 1-4	£0k
Band 5-7	£~~5k~~1k
Band 8a-8b	£~~25k~~10k
Band 8c-8d	£75k
Band 9	£250k
Trust Board/Directors	
Chief Executive Officer	Unlimited
Chief Financial Officer	Unlimited
Chief Operating Officer	£1m
Chief Information Officer	£1m
Other Executive Director	£1m
~~Director of Operational Finance~~	~~£1m~~
-	-
~~**Finance**~~	-
~~Assistant Director of Finance~~	~~£250k~~
Pharmacy	
Chief Pharmacist	£250k

The expenditure limit is in respect of total contract/tender value. E.g. a three year contract with an annual value of £26k has a total value of £78k and has to follow protocol for signing off up to £250k.

Annex 2 – Trust Authorisation Framework

Section 3 – Contracting – Financial Limits

Total Contract Value (exc VAT)	Type of Contract	Authorisation to place/sign Contract
Nil	Non-Disclosure Agreements	Executive Director, Chief Information Officer, Director of R&D, Managing Director of WPL, Head of Innovation, Commercial and Enterprise Director
Up to £0.5m	Goods & Services	Director of Estates, Chief Information Officer, Chief Pharmacist, Director of Operational Finance, Director of R&D, DDO
£0.5m - £1.0m	Goods & Services	Chief Financial Officer, Managing Director of WPL
£1.0m - £2.5m	Goods & Services	Chief Executive Officer
£2.5m+	Goods & Services	Trust Board, Chair

Ensuring Procurement and Tender limits also comply with

Up to £0.5m	Building & Engineering	Associate Director of Estates, Deputy Director of Estates, Director of Operational Finance
£0.5m - £1.0m	Building & Engineering	Director of Estates
£1.0m - £2.5m	Building & Engineering	Chief Financial Officer
£2.5m - £5.0m	Building & Engineering	Chief Executive Officer
£5.0m+	Building & Engineering	Trust Board, Chair

Ensuring Procurement and Tender limits also comply with

Up to £0.5m	Non-NHS Income	DDO, Commercial Director, Director of Operational Finance, Director of R&D
£0.5m - £1.0m	Non-NHS Income	Chief Financial Officer
£1.0m - £2.5m	Non-NHS Income	Chief Executive Officer
£2.5m+	Non-NHS Income	Trust Board, Chair

Up to £10m	NHS Income	Director of Operational Finance
£10m - £200m	NHS Income	Chief Financial Officer
£200m+	NHS Income	Chief Executive Officer

Up to £0.5m	Bidding for Tenders	DDO, Commercial Director, Director of R&D, Director of Planning
£0.5 - £10m	Bidding for Tenders	Tender Steering Group, Chief Financial Officer
£10m - £20m	Bidding for Tenders	Chief Executive Officer
£20m+	Bidding for Tenders	Trust Board

Based on gross expenditure, not offset with income

Annex 2 – Trust Authorisation Framework

Section 4 – Procurement Process~~Authorisation Framework for Procurement and Tendering of expenditure~~

Goods, Services, Works & Consultancy (Non-Property)

Minimum Procurement Process	Form of Contract / Governance Requirement	Contract Value excl VAT			
		Up to £25,000	£25,001-£75,000	£75,001 – UK Threshold Values	Above UK Threshold Values
Trust Catalogue, or Compliant Framework, or 1 Written Quotation	• Purchase Order	Yes			
Compliant Framework, or 3 Written Quotations	• Purchase Order • PAD		Yes		
Compliant Framework, or Local Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD			Yes	
Compliant Framework, or Above Threshold Compliant Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD				Yes

Building and Estates Engineering

Minimum Procurement Process	Form of Contract / Governance Requirement	Contract Value excl VAT				
		Up to £25,000	£25,001-£75,000	£75,001-£499,999	£500,000 - UK Threshold Values	Above UK Threshold Values
Trust Catalogue, or Compliant Framework, or 1 Written Quotation	• Purchase Order	Yes				
Compliant Framework, or 3 Written Quotations	• Purchase Order • PAD		Yes			
Compliant Framework, or Local Tender Exercise (minimum 3 invited) *WPL to Lead*	• Purchase Order • Contract • PAD			Yes		
Compliant Framework, or Local Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD				Yes	
Compliant Framework, or Above Threshold Compliant Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD					Yes

The contract values above represent the contract's lifetime value e.g., a 5-year contract of £25,000 per year requires £125,000 method and authorisation.

For current UK Threshold Values please refer to the WPL Procurement Manual.

The Authorisation Framework for a Procurement Approval Document (PAD) or Change Control Approval Document (CCAD) is detailed in Annex 2, Section 3.

Section 5 – Authorisation Framework/Financial Limits for Competitive Procedure Waiver (CPW)

Goods, Services, Works, Consultancy & Building and Estates Engineering

Authorisation to place/sign Contract	Contract Value excl VAT		
	£25,000 to £1m	£1m - £2.5m	£2.5m+
Director of Estates, or Managing Director of WPL, or Chief Information Officer, or Head of Estates Maintenance, or Divisional Director of Operations	Yes		
Chief Executive Officer, or Chief Financial Officer		Yes	
Chair on behalf of Trust Board			Yes

Area of spend	Contract Value (Exc VAT)	Quotations/ Tenders for Goods & Services	Min number invited to Quote/Tender	Form of Contract
All	Up to £10,000	No formal tender requirement	0	Purchase Order
All	£10,001 - £75,000	Quotation	3	Up to £24,999 - Purchase Order £25,000+ - Procurement Approval Document (PAD)
Products and Services Procurement only	£75,001 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
Building and Estates Engineering Procurement only	£75,001 - £499,999	Formal Local Tender	3	Contract as specified in Tender and Purchase Order
	£500,000 - published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender and Purchase Order
All	> published UK PCR Limit (as advised by WPL)	Formal Local Tender	4	Contract as specified in Tender or via compliant framework process and Purchase Order

~~Threshold limits represent the contract's lifetime value e.g., a 5-year contract of £25,000 per year requires £125,000 method and authorisation.~~

~~Waiving or Variation of Competitive Tendering/Quotation procedure~~

~~Type of Contract~~	~~Monetary Value (Exc VAT)~~	~~Authorisation to place/sign Contract~~
~~Products/Services Building/Engineering/Works Contracts/Consultancy Services~~	~~Up to £1.0m~~	~~Director of Estates, Managing Director of WPL, Chief Information Officer, Head of Estates Maintenance, DDO~~
	~~£1.0m - £2.5m~~	~~Chief Executive Officer, Chief Financial Officer~~
	~~£2.5m+~~	~~Trust Board~~