University Hospital Southampton NHS Foundation Trust

Agenda Trust Board – Open Session

Date	28/03/2024
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Minutes of Previous Meeting held on 30 January 2024** Approve the minutes of the previous meeting held on 30 January 2024
3		**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.
4		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
4.1	9:05	**Briefing from the Chair of the Audit and Risk Committee (Oral)** Keith Evans, Chair
4.2	9:10	**Briefing from the Chair of the Charitable Funds Committee (Oral)** Steve Harris, Chief People Officer
4.3	9:15	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Dave Bennett, Chair
4.4	9:20	**Briefing from the Chair of the People and Organisational Development Committee (Oral)** Jane Harwood, Chair
4.5	9:25	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
4.6	9:30	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
4.7	10:00	**Performance KPI Report for Month 11** Review and discuss the report Sponsor: David French, Chief Executive Officer

4.8 **Non-Criteria to Reside Spotlight Report**

10:30 Review and discuss the report
Sponsor: Joe Teape, Chief Operating Officer

4.9 **Break**

10:45

4.10 **Finance Report for Month 11**

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

4.11 **People Report for Month 11**

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

4.12 **UHS Staff Survey Results 2023 Report**

11:25 Discuss and note the report
Sponsor: Steve Harris, Chief People Officer
Attendees: Ceri Connor, Director of OD and Inclusion/Sophie Limb, HR Project Manager

4.13 **Maternity and Neonatal Perinatal Quality Surveillance Dashboard Report**

11:40 Receive and note the report
Sponsor: Gail Byrne, Chief Nursing Officer

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

11:45 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

5 **Patient Story**

12:00 The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Board Assurance Framework (BAF) Update and Risk Management Strategy and Policy**

12:15 Review and discuss the update. Review and ratify the Strategy and Policy.
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 Remuneration and Appointment Committee Terms of Reference

12:35 Review and approve the Terms of Reference
Sponsor: Jenni Douglas-Todd, Trust Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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: 6 June 2024

10 Resolution regarding the Press, Public and Others

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

11 Follow-up discussion with governors

12:45

University Hospital Southampton NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30/01/2024
Time	9:00 – 13:00
Location	Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Gail Byrne, Chief Nursing Officer (GB) Jenni Douglas-Todd, Chair (JD-T) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Femi Macaulay, Interim NED (FM) Tim Peachey, NED (TP) Joe Teape, Chief Operating Officer (JT)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 7.2) Phil Bunting, Director of Operational Finance (PB) (item 8.2) Kelly Kent, Head of Strategy and Partnerships (KK) (item 7.1) Alison Millman, Safety & Quality Assurance Matron (AM) (item 6.10) Emma Northover, Director of Midwifery (EN) (item 6.10) 1 member of the public (item 2) 3 governors (observing) 6 members of staff (observing) 6 members of the public (observing)
Apologies	Diana Eccles, NED (DE)

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

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

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

The Chair provided an overview of her activities since December 2023, including visits to hospital departments, meetings with peers and other key stakeholders.

2. Patient Story

Rachel and Gary Blackman were invited to speak about their daughter, Lydia, who had died 19 days after birth at the Princess Anne Hospital in 2009, and about the events which led to her death.

The Board noted the importance of the voice of the patient in decision-making and the need for staff to be compassionate.

3. Break

4. Minutes of the Previous Meeting held on 30 November 2023

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 30 November 2023.

5. Matters Arising and Summary of Agreed Actions

It was noted that no actions were yet due for completion.

6. QUALITY, PERFORMANCE and FINANCE

6.1 Briefing from the Chair of the Audit and Risk Committee

The chair of the Audit and Risk Committee was invited to provide an overview of the meeting held on 15 January 2024. It was noted that:

- The committee had reviewed the Internal Audit report on risk management and that all actions identified were in progress.
- The project to address overdue Internal Audit actions had been successful in closing these actions.
- The Trust had made good progress on the annual plan for proactive work undertaken by the Fraud team.
- The Trust had a new external audit partner and the process for a joint tender with Hampshire Hospitals NHS Foundation Trust for an external audit firm was commencing.

6.2 Briefing from the Chair of the Finance and Investment Committee

The chair of the Finance and Investment Committee was invited to provide an overview of the meeting held on 29 January 2024. It was noted that:

- The committee had reviewed the Trust's financial position for Month 9 (item 6.7), along with the progress in respect of the Trust's financial turnaround programme and 2024/25 annual budget setting process.
- The committee had received an update from the Always Improving team, and noted that it would be challenging to deliver further contributions in 2024/25 due to the limited capacity available to teams to enable them to focus on transformational initiatives.
- The committee had received an update from the Estates, Facilities and Capital Development team, and noted that there were concerns with staffing levels and that there was a risk posed due to the potential need to repair or replace the Trust's ducting system.
- The committee agreed with a proposal to extend the joint venture with Prime.
- The committee reviewed proposals for a single Electronic Patient Record system across the Hampshire and Isle of Wight Integrated Care System.

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

The chair of the People and Organisational Development Committee was invited to provide an overview of the meeting held on 22 January 2024. It was noted that:

- The committee had reviewed the People Report for Month 9 (item 6.8), and noted that the Trust's substantive workforce had grown by 12 whole time equivalents (WTE) and bank and agency use had reduced. It appeared that the additional controls put in place were having an effect.
- The committee reviewed a report on the Trust's productivity and noted that only 5% of nursing staff had 15 or more years of experience.

- The committee received a report on the review undertaken into the Trust's Freedom to Speak Up measures and noted that the review had been broadly positive.

6.4 Briefing from the Chair of the Quality Committee

The chair of the Quality Committee was invited to provide an overview of the meeting held on 29 January 2024. It was noted that:

- The committee had reviewed the Trust's quality indicators, including the never events in Dermatology. It was noted that these events, potentially, did not meet the criteria for never events and this continued to be investigated in conjunction with the British Association of Dermatologists. There were also some concerns in respect of the provision of antibiotics within the required timescales.
- The committee received the Maternity safety report (item 6.10) and noted that there were no particular escalations arising from this.
- The committee received a report on Mental Health services and noted that there were a significant number of patients presenting with mental health issues and that these individuals often required a significantly higher length of stay compared to others due to a lack of Mental Health service provision from elsewhere in the ICS. Concerns were expressed regarding whether the Trust was receiving the same level of service from Mental Health service providers compared to others.
- There continued to be a large backlog in terms of Ophthalmology patients despite the additional investment. A review was in progress.

6.5 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:

- The Trust was under significant operational pressure and had also received specific directions from NHS England in terms of its financial position.
- The Trust had been required to queue ambulances, which was an indicator of the pressure on the service. It was noted that at Portsmouth Hospitals University NHS Foundation Trust there had, at times, been 30 ambulances queueing.
- Mask wearing had been reintroduced in clinical areas to manage the increased seasonal infection rates.
- There had been the highest ever number of patients with no criteria to reside at 270. Despite the opening of two new wards, this had proven insufficient to manage the demand.
- The Trust had implemented a pause on recruitment on 22 December 2023 in order to attempt to meet its planned WTE for 2023/24.
- Consultants had narrowly rejected a pay offer in respect of the ongoing industrial action by the British Medical Association.
- The accounts of the Department of Health and Social Care had been qualified by the National Audit Office due to the accounting for the Elective Recovery Fund.
- The Trust's neuro-physiotherapy team had received an award from the Intensive Care Society.

The Board discussed the report and, in particular, the issue of the number of patients with no criteria to reside. It was noted that the underlying issue was a lack of investment in social care despite this being a less expensive solution. It was further noted that the CEO of Southampton City Council had resigned, and

that the Council was close to issuing a notice under section 114 of the Local Government Finance Act 1988.

6.6 Performance KPI Report for Month 9

Joe Teape was invited to present the Performance KPI Report for Month 9, the content of which was noted. It was further noted that:

- Both Hampshire Hospitals NHS FT and Portsmouth Hospitals University NHS FT had announced critical incidents, but that the Trust had avoided this largely due to the efforts of its staff.
- The Trust's overall performance continued to be strong when compared to peers, with most measures indicating that the Trust is in the top half or top quartile.

The Board noted the spotlight report on the Trust's performance against cancer targets. It was further noted that:

- The Trust's performance was good overall with the backlog in 62-day waits the lowest ever.
- There continued to be particular areas of challenge such as in urology and head and neck cancers. In addition, although the Trust's capacity had increased in radiology, this had been more than offset by the increase in demand.
- The Trust was taking steps to prioritise the actions it could take in terms of supporting public health initiatives such as those relating to smoking cessation, diabetes and diet.

The Board discussed the Trust's performance and noted that:

- There had been an increase in the number of cases of Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections. It was considered that this was potentially due to a lack of staff experience and the change of focus during COVID-19.
- The number of incidents of falls and failures to give medicines on time was on an upward trajectory.
- The occupancy level at the Trust remained very high.
- The Research and Development team continued to improve its performance.
- The metrics in respect of My Medical Record were questioned in terms of what the Trust was trying to achieve. It was noted that the Trust needed to decide what its future plans for My Medical Record were.

6.7 Finance Report for Month 9

Ian Howard was invited to present the Finance Report for Month 9, the content of which was noted. It was further noted that:

- The Trust's current deficit was circa £23m against a year-end target of £26m. The forecast had been adjusted to take into account the impact of industrial action, which would likely result in a year-end deficit of £30m.
- The Trust's in-month Elective Recovery performance had been 112%, which was below expectations even taking into account industrial action. However, the Trust remained among the top performers in England in terms of its Elective Recovery performance.
- The Trust's staffing costs were £900k lower during the month.
- Confirmation had been received in respect of the £10m of cash required for the refurbishment of the neonatal unit.
- The Hampshire and Isle of Wight Integrated Care Board continued to be an outlier, forecasting a year-end deficit of £130m, which would be within the top

three highest in England. As a result, significant pressure was being applied on providers.

6.8 People Report for Month 9

Steve Harris was invited to present the People Report for Month 9, the content of which was noted. It was further noted that:

- The Trust had been successful in recruiting substantive staff during 2023/24, but usage of bank staff had been fairly static. In addition, delivery on the Cost Improvement Programme had been insufficient.
- The Trust had introduced a pause on recruitment in December 2023 with conditional offers already made being phased based on decisions made by a prioritisation panel.

The Board discussed the additional recruitment controls and their impact. It was noted that:

- Where there were significant risks as a result of staff numbers, the Divisions had been encouraged to ensure that these risks were raised.
- There was concern that the staff were not supportive of the controls on recruitment, as there was a disconnect between the increased demand on the service and the need to meet the Trust's planned WTE number.
- The impact of these controls was not equally spread throughout the organisation with teams which had been prudent in terms of staff numbers being disproportionately impacted.
- The action taken was correct, but the impact on staff morale and engagement should not be underestimated. It was also noted that if the Trust had been paid for all the activity delivered in prior years, the Trust's position would be significantly improved.
- It was likely unrealistic that the Trust would be able to fully cover the requirements across financial, performance and quality areas in the current environment, with increasing Emergency Department demand and increasing number of patients with no criteria to reside being the most significant contributory factors.

6.9 Break

6.10 Maternity Safety 2023-24 Quarter 3 Report

Emma Northover was invited to present the Maternity Safety 2023-24 Quarter 3 Report, the content of which was noted. It was further noted that:

- The Trust had faced a challenging quarter both operationally and due to gaps in the workforce and winter pressures.
- Changes had been made to the continuity of carer team to remove them from the contingency framework, as this interfered significantly with their core role.
- The criteria to receive Non-English Speaking Team (NEST) support had been tightened due to resource constraints.
- There had been an increase in the post-partum haemorrhage rate and number of term admissions.
- The Trust had successfully recruited to the safety and quality teams.
- The Trust's declaration under NHS Resolution's Maternity Incentive Programme was due to be submitted on 1 February 2024.

Actions:

Emma Northover agreed to provide further information in respect of continuity of carer as part of the next Maternity Safety report.

Emma Northover agreed to provide further assurance in respect of the increase in post-partum haemorrhage rate and term admissions.

7. STRATEGY and BUSINESS PLANNING

7.1 Corporate Objectives 2023-24 Quarter 3 Review

Martin De Sousa and Kelly Kent were invited to present the Corporate Objectives 2023-24 Quarter 3 Review, the content of which was noted. It was further noted that:

- The Trust was on track to meet 60% of its objectives, with 28% showing as 'amber' and 12% 'red'.
- The proposed corporate objectives for 2024/25 would be presented to the Board in February 2024.
- In terms of the 65-week wait target, it was considered unlikely that the Trust would meet this objective, as there was a risk of a small number of patients missing the target due to factors beyond the Trust's control.
- Consideration should be given to mapping the objectives against the Trust's risk appetite.

7.2 Board Assurance Framework (BAF) Update

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

- Work was ongoing to update the BAF and proposed risk appetite statements based on the outputs from the Trust Board Study Session held on 18 December 2023 had been circulated for comment.
- It was intended to create stronger links between the risks detailed in the BAF and the Trust's operational risks.

8. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

8.1 Register of Seals and Chair's Actions Report

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

Decision:

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

8.2 Review of Standing Financial Instructions 2023-24

Ian Howard was invited to present the review of the Trust's Standing Financial Instructions, the content of which was noted. It was further noted that:

- The proposed changes to the Standing Financial Instructions had been reviewed by the Audit and Risk Committee at its meeting on 15 January 2024, which had resulted in an amendment to the approval levels for the Director of Estates, Facilities and Capital Development.

- Further changes were proposed to reflect the role of the Trust Investment Group (TIG) and to remove duplication between TIG and the Trust Executive Committee.

Decision:
Having reviewed the proposed changes to the Trust's Standing Financial Instructions, the Board approved the revised Standing Financial Instructions tabled to the meeting.

8.3 Finance and Investment Committee Terms of Reference

It was noted that the Finance and Investment Committee had reviewed its terms of reference at its meeting held on 29 January 2024.

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

8.4 Quality Committee Terms of Reference

It was noted that the Quality Committee had reviewed its terms of reference at its meeting held on 29 January 2024.

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

9. Any other business

It was noted that the Trust's organ donation team was struggling with its eye retrieval programme, as it needed someone to lead and run the programme.

Action:
Gail Byrne and Paul Grundy agreed to look at the leadership and running of the eye retrieval programme.

10. Note the date of the next meeting: 28 March 2024

11. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/09/2023 6.2 Health and Safety Annual Report 2022-23				
1041.	Violence and aggression update	• Byrne, Gail • Harris, Steve • Machell, Craig	25/04/2024	Pending
	Explanation action item Gail Byrne, Steve Harris and Craig Machell agreed to schedule a further update in respect of violence and aggression at a future Trust Board Study Session. Item deferred to April.			
Trust Board – Open Session 30/01/2024 6.10 Maternity Safety 2023-24 Quarter 3 Report				
1100.	Continuity of carer	• Northover, Emma	25/04/2024	Pending
	Explanation action item Emma Northover agreed to provide further information in respect of continuity of carer as part of the next Maternity Safety report.			
Trust Board – Open Session 30/01/2024 6.10 Maternity Safety 2023-24 Quarter 3 Report				
1101.	Post-partum haemorrhage	• Northover, Emma	28/03/2024	Pending
	Explanation action item Emma Northover agreed to provide further assurance in respect of the increase in post-partum haemorrhage rate and term admissions.			
Trust Board – Open Session 30/01/2024 9 Any other business				
1102.	Eye retrieval programme	• Byrne, Gail • Grundy, Paul	28/03/2024	Pending
	Explanation action item Gail Byrne and Paul Grundy agreed to look at the leadership and running of the eye retrieval programme.			

Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**4.6**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • Hampshire and Isle of Wight Integrated Care Board Consultation • Industrial Action • Spring Budget • Annual Workforce Race Equality Standard Data Report			
Response to the issue:	The response to each of these issues is covered in the report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Any implications of these issues are covered in the report.			
Summary: Conclusion and/or recommendation	The Board is asked to note the report.			

Hampshire and Isle of Wight Integrated Care Board Consultation

On 21 March 2024, the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) launched a consultation which will run until 5 May 2024 in respect of how the HIOW ICB will re-shape itself for the future.

The HIOW ICB has been required to reduce its running costs by 20% in 2024/25 and by a further 10% in 2025/26. It has already made some changes to its staff structure and roles.

A set of high-level principles was developed in 2023, which include:

- Limiting variations in processes, structures, roles and ways of working across the ICB;
- Creating a flexible workforce that can work across different programmes and portfolios;
- Designing teams and functions to enable system working; and
- Making it easy for system partners to work with the HIOW ICB, with clear accountability and decision-making.

Industrial Action

The results of a ballot of British Medical Association doctors were announced on 20 March 2024. Junior doctors voted by 98 per cent in favour of a mandate to continue industrial action for a further six months. Turnout was 62 per cent.

Nearly 1.5m appointments have been delayed since industrial action began and strikes are expected to cost the NHS £3bn.

Spring Budget

On 6 March 2024, the Chancellor of the Exchequer delivered his Spring Budget. In his Budget speech, the Chancellor sought to balance pressure for tax cuts, his own fiscal rules and lack of public appetite for reductions in spending, and the implications of the broader electoral and polling context.

In terms of the key announcements:

- Class 1 employee national insurance contributions (NICs) will be cut from 10% to 8% from 6 April 2024. Class 4 NICs will fall to 6% from 6 April 2024.
- The alcohol duty freeze has been extended until 1 February 2025.
- The Government is introducing a new duty on vaping and increasing tobacco duty from October 2026.
- An additional £45m of funding for medical charities' research agendas was announced.
- Fuel duty is to be maintained at current levels for a further 12 months.
- The £500m of new funding for councils to support provision of adult and children's social care announced on 24 January 2024 was confirmed.
- Working age benefits will be uprated by the September 2023 CPI figure of 6.7%.

In terms of health-related announcements, the Chancellor announced a £2.5bn revenue funding increase for the NHS in 2024/25, a £3.4bn increase in capital funding over three years from 2025/26 and £35m over three years from 2024/25 to improve maternity safety.

The £2.5bn revenue funding increase is intended to protect current funding levels in real terms.

	2022/23 (outturn)	2023/24 (plan)	2024/25 (plan)
DHSC revenue budget (£bn)	171.8	178.5	179.6
Of which NHSE (£bn)	155.1	163.2	164.9

The £3.4bn of additional capital funding will double the NHS's investment in digital over the next three years and will be split across the following areas:

- £1bn to transform the use of data to reduce time spent on administrative tasks.
- £2bn to update outdated IT systems.
- £430m to transform access for patients.

	2022/23 (outturn)	2023/24 (plan)	2024/25 (plan)
DHSC capital budget (£bn)	9.9	11.0	12.6

The Government announced the next steps on the Public Sector Productivity Programme and committed £4.2bn of funding, including the £3.4bn of capital funding for digital and technology in the NHS. In return the NHS has committed to 1.9% average productivity growth from 2025/26 to 2029/30, rising to 2% over the final two years.

NHS England will start reporting against new productivity metrics regularly from the second half of 2024/25 at a national, integrated care board and trust level. Further detail is expected in the summer.

Annual Workforce Race Equality Standard Data Report

On 18 March 2024, NHS England published its annual Workforce Race Equality Standard (WRES) data report.

In terms of key findings from the report:

- The overall percentage of ethnic minority staff across the NHS workforce has increased year-on-year and now stands at 26.4% in 2023, compared to 24.2% in 2022 and 17.7% in 2016.
- The percentage of staff at Very Senior Manager level has also increased year-on-year with 11.2% of staff from an ethnic minority, compared to 10.3% in 2022 and 5.4% in 2016.
- Whilst there has been an increase in the diversity of board members, the increasing diversity in the overall workforce has resulted in the mean gap between overall workforce and board diversity increasing.
- There have been improvements in the relative likelihood of ethnic minority staff entering the formal disciplinary process compared to white staff, falling from 1.14 in 2022 to 1.03 in 2023. However, at 46% of trusts, ethnic minority staff are over 1.25 times more likely to enter the disciplinary process.
- Ethnic minority staff remain more likely to experience abuse, bullying or harassment from patients, their families and the public.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 11**			
Agenda item:	**4.7**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance** **Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Performance KPI Report reflects the current operating environment and is aligned with our strategy.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust performance metrics. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

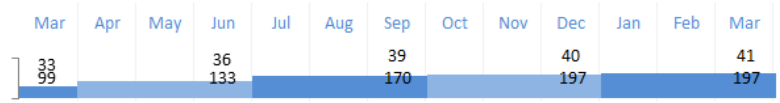
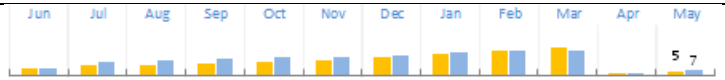
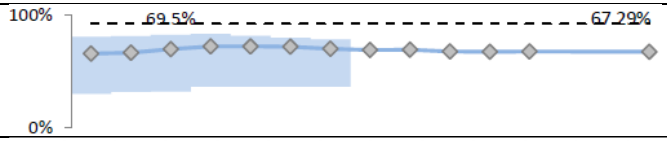
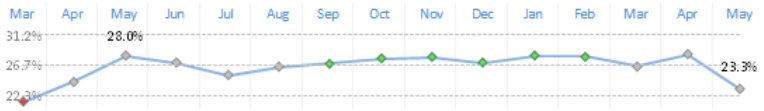
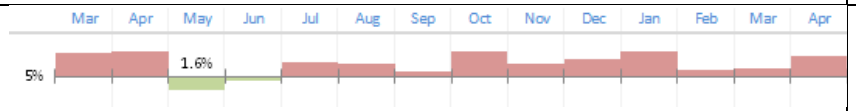
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
February 2024

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

Report guide

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

Introduction

The Performance KPI Report is presented to the Trust Board each month to provide assurance:

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

The content of the report includes the following:

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

Adjustment of note within the report include:

- **17** – a correction to the data feed for the number of Red flag staffing incidents was required to ensure current and historic values are fully aligned to the Trust's Healthroster system.
- **52** – for quarter four within the Digital metrics, ransomware attempts are now merged with the metrics for Malware attempts received within the Trust as part of our Cyber Security reporting.

Summary

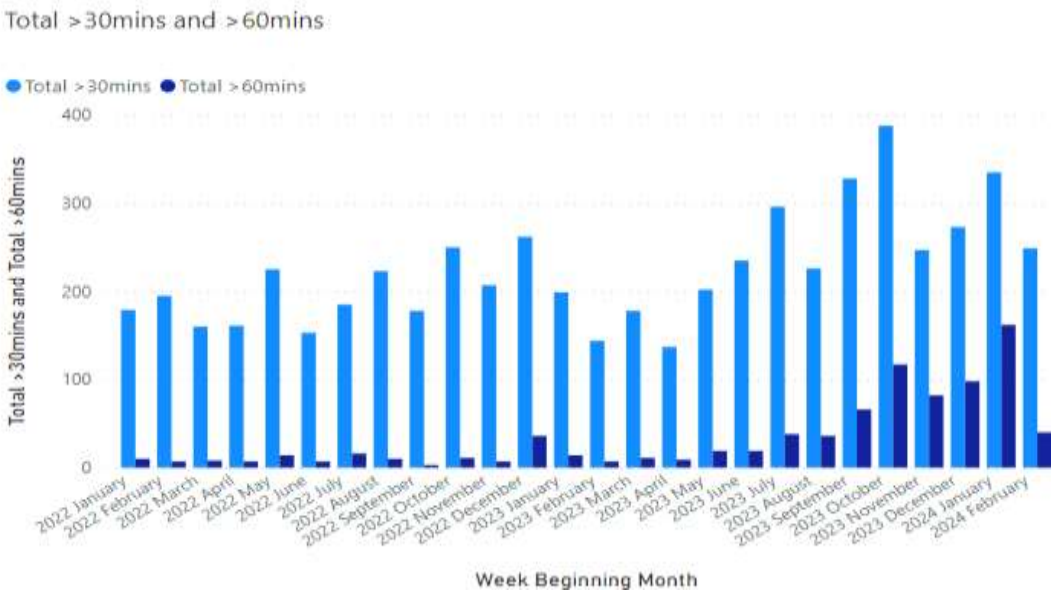
This month's spotlight report explores UHS performance against the current waiting time targets. It highlights that UHS has maintained its position in minimising patients waiting over 78 weeks and 65 weeks in line with the elective recovery ambitions set for the year. Subject to any urgent reprioritisation in the remaining two weeks of the year, the trust is anticipating zero patients waiting over 78 weeks by the end of March 2024 excluding a small cohort of twenty ophthalmology patients currently impacted by the national shortage of corneal tissue availability. The Trust has also remained aligned with the trajectory set at the start of the year for patients waiting over 65 weeks, forecasting fewer than fifty patients waiting by the end of March. Again, the majority are corneal transplant patients. In recent months, UHS performance on these waiting time metrics has consistently remained in the top quartile when compared to teaching hospitals across the country. The paper outlines the Care Group interventions and operational oversight put in place to deliver this achievement, it evidences a recent reduction in our PTL and looks towards 2024/25 where the Trust will strive to ensure no patient is waiting over 52 weeks by March 2025.

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

1. The Emergency Department (ED) four hour performance marginally increased from January 2024 (66.1%) to February 2024 (66.9%) for all types. For Type one attendances (64.2% for February 2024) the hospital continues to rank well, placing 3rd against peer teaching hospitals across the country and 4th against all hospitals in the South East region for February 2024.
2. The hospital has continued to deliver improvement on Diagnostic performance in February with 691 patients waiting over 6 weeks for diagnostics which reflects a 40% reduction since January 2024. This is the lowest number of breaches since the pandemic and reflects a performance position of 91.8% for the month.
3. Cancer services continue to deliver strong waiting time performances. The latest validated position available for 28 day faster diagnosis (84.3% for January 2024) means the Trust has now ranked as the top teaching hospital five months in a row and remains second for 62 day performance (77.8% in January 2024).
4. The average number of patients in the hospital not meeting the criteria to reside continued at similarly high levels as the prior month (236 in February 2024, 234 in January 2024). These patients continue to place significant pressure on the flow and bed capacity across the organisation.
5. The increase in the monthly income position for Research and Development (Metric 46) was due to £1.7m of Secure Data Network Infrastructure income received in February 2024.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Coast Ambulance Service (SCAS). In January's report we highlighted concerns over increases in handover times and outlined key actions that were being jointly discussed to improve efficiency of handover and gain assurance on the accurate recording of handover timestamps.



The graph above illustrates an improvement in February 2024 in the volume of handovers taking over 30 minutes and over 60 minutes.
For all weeks commencing in February 2024, we averaged 10 handovers per week taking over 60 minutes and 63 handovers per week taking over 30 minutes. In January 2024, we averaged 32 handovers taking over 60 minutes per week and 67 taking over 30 minutes. We will continue to highlight the position to gain assurance that long term, consistent improvements result from the agreed actions plans.

Spotlight: Referral to Treatment Waiting Times

Introduction

As the 2023/24 financial draws to a close, this month's spotlight paper provides an end of year update on UHS performance against the national targets for NHS waiting times for patients on a referral to treatment (RTT) pathway. The paper highlights UHS' current position on 78 and 65 week waiters, how they align to original forecasts and compare to peer trusts. It outlines the challenges and pathway management successes and looks towards the expected 2024/25 national targets and the Trust plans in place to deliver them. The following information is based on the validated January 2024 submission, with operational insight based on the latest position for our long waiters.

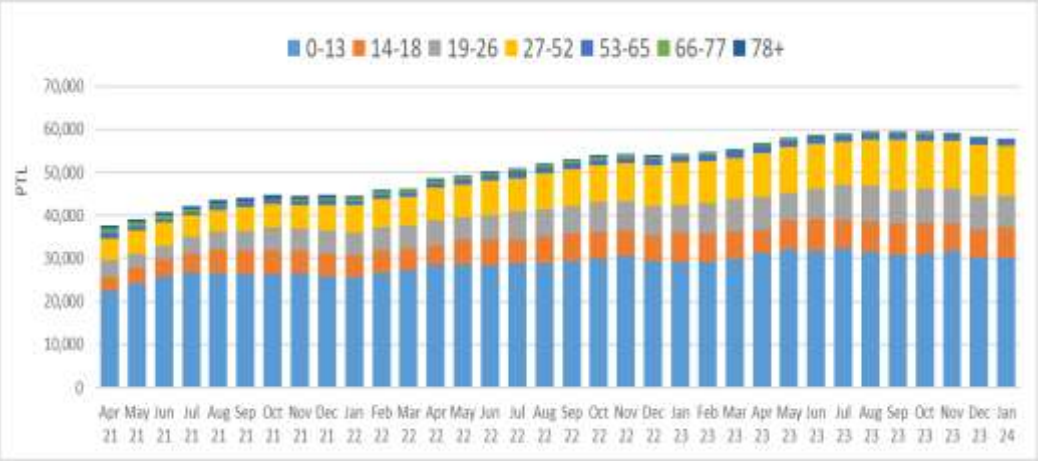
National Targets

In the original 2023/24 NHS operational planning guidance, the priority for elective care was for all hospitals to eliminate patients waiting over 65 weeks for first definitive treatment by March 2024 (except where patients choose to wait longer or in specific specialties). In 2022/23, an equivalent priority was set for patients waiting over 78 weeks. At the time of writing, we are waiting for publication of the final 2024/25 operational planning guidance, we anticipate it will reiterate this original 65 week target in light of the varied performance by trusts seen across the country, whilst introducing a target of zero patients waiting over 52 week waits by March 2025. This reiteration of the 65week target reflects the operational challenges and impact of industrial action experienced by hospitals throughout 2023/24 and therefore the ability for this to be fully achieved across the country.

UHS RTT Waiting List Size

The Patient Treatment List (PTL) reported for UHS at the end of January 2024 was 57,725. This reflects an increase of 2.7% since April 2023 (56,568) but a decrease of 2.0% since its peak of 59,277 in August 2024. In the previous financial year, the PTL increased by 12% between April 2022 and January 2023.

Graph 1 illustrates the recent slow down in growth within the PTL and also highlights the significant reduction in long waiting patients as we maintain our focus on any patients who are waiting over 65 weeks. Within the final February PTL, there were 19 patients who have been waiting over 78 weeks and 198 who have been waiting over 65 weeks. In February 2023, the equivalent numbers were 143 (78 weeks) and 633 (65 weeks).



Graph 1: PTL trend by waiting time groups (up to January 2024)

Patients waiting over 78 and 104 weeks

The hospital no longer has any patients waiting over 104 weeks and the only cases throughout the entire 2023/24 financial year related to a national tissue shortage for corneal transplants which is outlined further below.

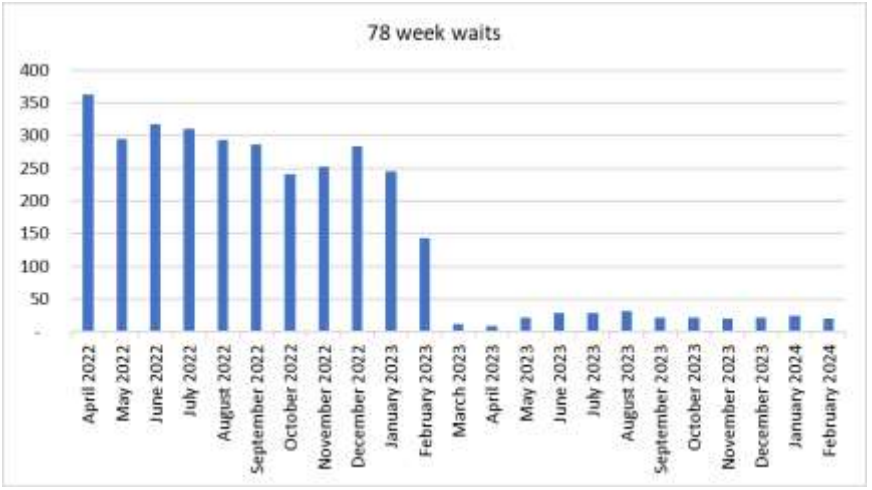
Throughout 2023/24 the Trust has been successful in maintaining a low volume of patients waiting over 78 weeks. In the second half of the financial year, the Trust has consistently reported fewer than five patients over 78 weeks (excluding corneal transplant patients). These patients have been under the care of a handful of complex specialties including Neurosurgery, Gynaecology, and Paediatric Spinal Surgery. In most cases, the required surgery has been complex often requiring joint surgeons and was provisionally booked before 78 weeks. However, industrial action, clinical complications or managing a higher priority patient at short notice has required a cancellation. Any 78 week breaches have always been rebooked in the following month.

At the time of writing, we are forecasting zero (non corneal) patients over 78 weeks by the end of March 2024. All patients in that risk cohort have treatment dates in place, however we accept that very late patient complications and/or cancellations and urgent prioritisation decisions remain a final risk particularly in areas such as paediatric cardiac surgery.

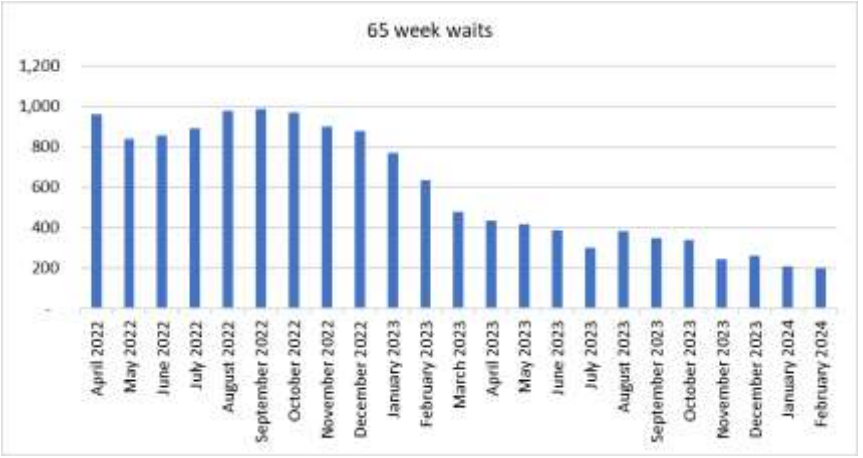
Patients waiting over 65 weeks

Throughout the year, all services put in place monthly forecasts and pathway management processes to target zero patients waiting over 65 weeks by the end of March 2024. At the time of writing, the Trust is forecasting fewer than fifty patients will breach 65 weeks which includes thirty patients within the corneal graft national waiting list.

This reflects a significant and extremely successful reduction across the year - Graph 3 illustrating that in April 2023 there were 510 patients within this waiting time cohort.



Graph 2: Volume of patients waiting over 78 weeks by month

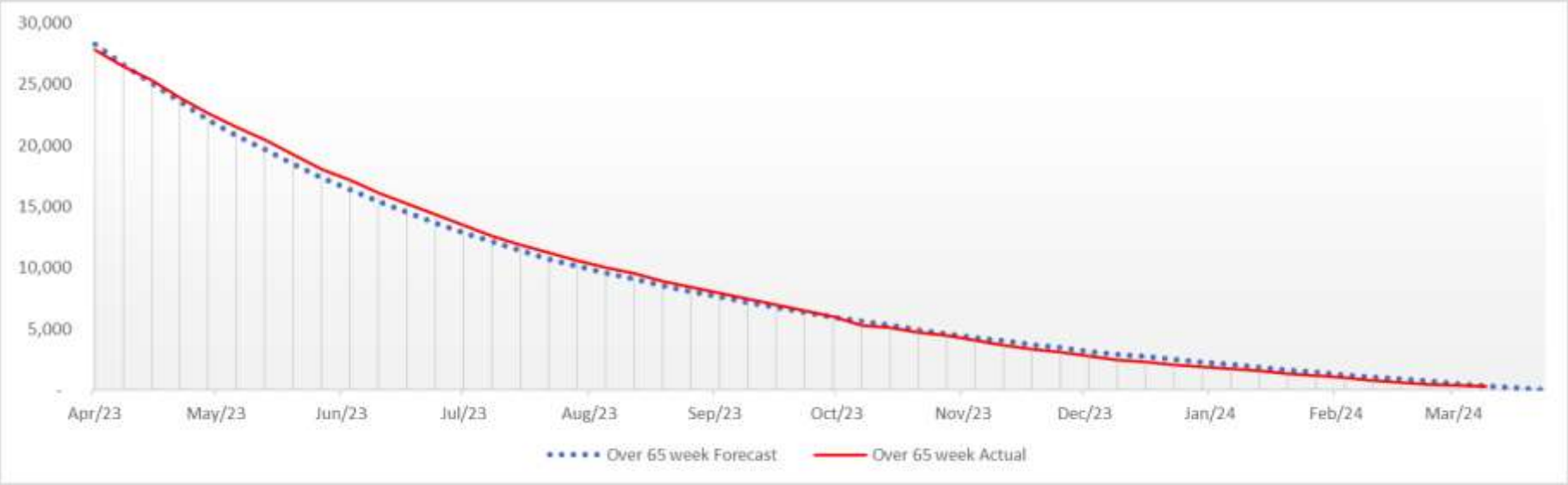


Graph 3: Volume of patients waiting over 65 weeks by month

The trust performance team put in place an oversight structure at the start of 2023/24 which transitioned focus from 78 week waiters to 65 week waiters in a manageable way throughout the year. Weekly performance meetings with all services provided assurance that all "at risk" patients were constantly monitored, discussing all treatment options and dates and providing early executive and clinical support on appropriate prioritisation and capacity allocation.

The impact of industrial action was closely monitored to understand the impact on long waiting patients and ensure any necessary cancellations had an immediate rebooking plan. Alongside the oversight structure, the central validation team are constantly reviewing high risk cohorts through pathway reviews and patient texting services to ensure any changes to circumstances or preferences are captured and reflected in treatment times and pathway steps.

Graph 4 is a high level illustration of the original Trust wide glide set at the start of the year and how the hospital has tracked alongside it. These glides have been employed at trust and Care Group level to monitor the cohort of patients on the PTL who would breach 65 weeks by March 2024 if their clock is not stopped through treatment or discharge of care back to the original referrer.



Graph 4: Cohort of patients on the PTL who could breach 65 weeks by March 24 without a clock stop – original forecast vs actual

Service Interventions: Trauma and Orthopaedics

The successful reduction in long waiting patients to achieve the national published target is the result of proactive and early management of waiting lists across all services. The interventions within Trauma and Orthopaedics over the last twelve months are described below and mirrored across several Care Groups who entered the year with a high volume of patients who would need focussed attention to receive treatment by the end of March 2024.

Patients are contacted and offered dates as early as possible and services such as Trauma and Orthopaedics have moved to offering dates before the Trust's standard of six weeks where possible. If the patient refuses a date, the service immediately offers them one that they can accept, ensuring that the surgery is listed at a time that suits them. Careful scrutiny is placed on all elements of the pathway leading up to treatment to minimise interruption or changes.

There is significant and constant clinical engagement by operational teams to appropriately manage the varying lengths and demands of waiting lists even within a single specialty. Consultants have been willing to flex their DCC (direct clinical care) and give up elective theatre lists to ensure that consultants with long waiters have appropriate theatre capacity to undertake the operations. The consultants who have given up their list, are then utilised in clinic or on ward rounds still delivering DCC as per their job plan.

Administrative teams have also been adaptable at working ahead of the six week consultant rota, whilst ensuring the patient has a treatment date that suits them is still a priority. The nursing teams have flexed their staffing to match the need for additional capacity in outpatients whilst the site team have often gone at risk on bed capacity, to ensure that the long waiters aren't cancelled. The management team have been the glue that have pulled all this together - a team effort, all with the patient front and centre.

Service Interventions: Gynaecology

Similarly, the Gynaecology service has a high volume PTL containing a varied casemix which (like Trauma and Orthopaedics) is regularly impacted by volatility in their emergency services. Nevertheless, the operational team have put several steps in place internally and through their outsourcing contracts to ensure we remain in a much improved position on long waiter patients.

They have achieved this through constant oversight and patient tracking by their access and operational management teams. This includes redesigning surgical list structures to appropriately prioritise long waiting patients and ensure visibility of waiting times to the theatre team. This ensures it is a factor in any discussions around potential cancellations or surgical over runs.

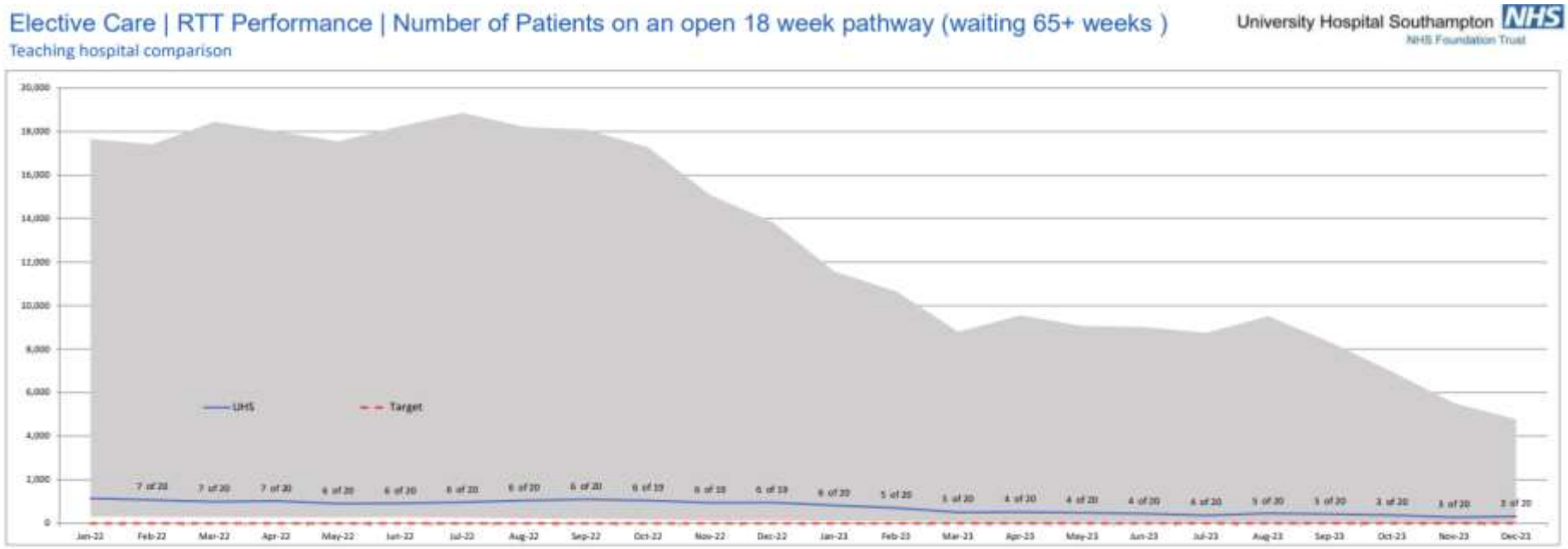
Improvements in theatre utilisation have supported improved flow alongside closer liaison with private providers and other local trusts to ensure outsourcing availability is always understood and maximised where appropriate. Where capacity is particularly challenging, the senior team including Care Group managers review all lists to scope for additional opportunities.

Service Interventions: Corneal Transplants

As noted in earlier sections, there is a cohort of long waiting patients within Ophthalmology that continue to impact national performance against 78 week and 65 week targets. These patients are on a waiting list for corneal transplants which is reliant on the availability and allocation of corneal graft tissue by the NHS Blood and Transplant Service. There was a pause for corneal surgery during Covid which increased the national waiting list causing an ensuing mismatch between demand and donor supply within the UK. The UHS ophthalmology service are in constant liaison with NHSBT to ensure that patient, theatre and surgeon availability is lined up as soon as tissue is made available.

Performance Comparison with other Trusts

In the latest available data at the time of writing (up to December 2023), UHS places 5th for the number of patients waiting over 78 weeks compared to other Teaching Hospitals across the country. UHS ranks 3rd for patients waiting over 65 weeks and 4th for patients waiting over 52 weeks. It should be noted that the metric is based on overall volume of patients rather than a percentage of the Trust's overall PTL size which has not been made available.

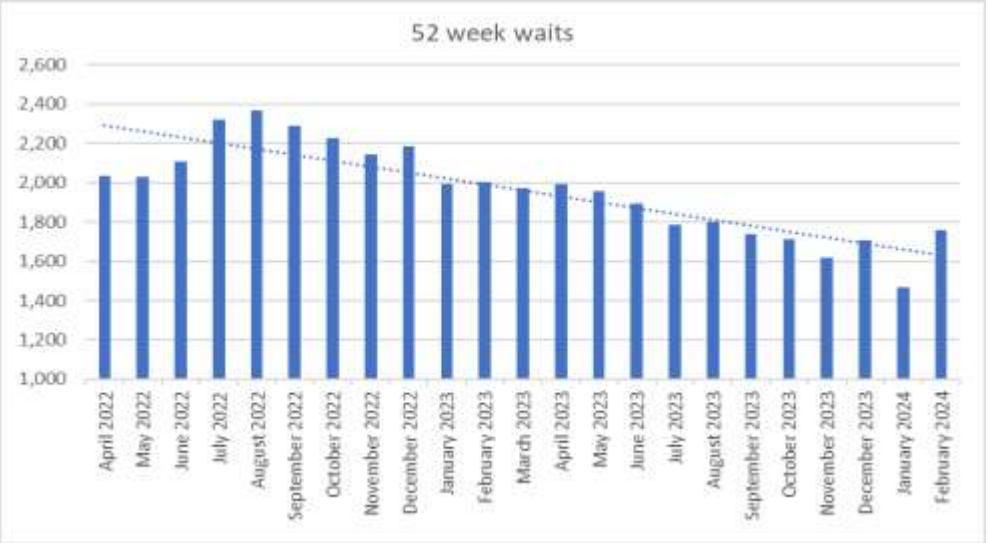


Graph 5: Teaching hospital comparator: patients waiting over 65 weeks

Patients waiting over 52 weeks

As we approach the new financial year, focus has already transitioned towards the expected national target of zero patients waiting over 52 weeks by March 2025 which we are committed to achieving. The processes put in place throughout 2023/24 to deliver 65 week targets have been reset and realigned towards the new targets ensuring performance reporting, PTL monitoring and recovery discussions are focussed on the appropriate cohort of patients throughout the year.

Graph 6 reflects the current volumes of patients waiting over 52 weeks which illustrates that a reduction has already been seen throughout 2023/24. Our intention is to manage the reduction of patients waiting 52 weeks in the same way as 65 week waits have been managed this year. Weekly performance meetings will take place with each Care Group to review patient level detail and there will be a phased trajectory aiming to reduce waits to 52 weeks in most specialities by December 2024. Quarter 4 of 2024-25 will then provide a buffer for any remaining specialities, and also in the event of further industrial action, significant winter pressures or other unforeseen events.



Graph 6: current trendline for patients waiting over 52 weeks for treatment

While this represents a significant challenge, our track record with 104, 78 and 65 week waits suggests that the approach is the right one. However, it is essential that in tandem the overall size of the waiting list continues to reduce. It is self-evidently impossible for us to continue to indefinitely reduce long waiting patients while the overall size of the waiting list rises.

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

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	63.2%														62.1%	≥92%	62.9%
		5	5	5	4	4	4	4	5	4	4	4	4	4				
		5	5	5	6	6	5	5	6	6	6	5	4	4				
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	82.3%														88.4%	≥96%	77.9%
		14	13	15	17	17	17	16	16	16	13							
		10	11	18	16	19	18	16	13	10	9							

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

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	50.0%														77.8%	≥85%	63.3%
		17	14	14	18	9	14	13	10	15	6	11	7	6				
		12	11	7	14	5	9	7	3	6	1	2	3	2				
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	64.8%														64.2%	≥95%	61.4%
		6	7	5	4	9	12	9	8	8	12	10	11	8	4	4		
		4	3	3	3	5	7	5	5	5	7	7	7	5	2	3		
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	28.7%														8.2%	≤1%	18.5%
		12	12	12	12	11	11	11	10	9	7	7	6	7	5			
		10	7	8	8	7	7	8	7	10	8	7	7	7	7			

Outcomes		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
1	HSMR - UHS HSMR - SGH	89.78												88.83			≤100	92.7	≤100
		87.98												87.58					
2	HSMR - Crude Mortality Rate	3.1%															<3%	2.8%	<3%
		2.9%												2.7%					
		2.5%																	
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15%															-	12.2%	
		11.5%												12.1%					
		10%																	
		Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24			Quarterly target		
4	Cumulative Specialties with Outcome Measures Developed (Quarterly)	75															+1 Specialty per quarter		
		71			72			72			73			74					
		70																	
		65																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%																	
		35			34			37			41			42					
		81			82			75			67			65					
		75%																	
		336			340			333			337			338					
		50%																	

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

Safety		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	74	84	9	4	11	12	18	27	24	35	28	49	35	60	47	66	55	72	65	81	73	91	77	97	≤5	97	≤55
7	MRSA bacteraemia	1	0	0	0	0	0	0	1	0	0	1	2	1	2	0	0	7	0
8	Gram negative bacteraemia	16	17	14	32	14	19	27	16	21	15	25	18	17	20	19	≤18	211	≤191

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.30														0.46	<0.3	0.41	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.43														0.59	<0.3	0.44	<0.3
11	Medication Errors (severe/moderate)	3														3	≤3	25	33
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,569	2,916												2,524	2,797	2,524	30,414	28,384

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

Safety		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
13	PSII's (based upon month reported, excluding Maternity)			7												2	-	33	-
13	From October 2023, as part of move to PSIRF, reporting of SIRIs was stopped. Patient Safety Incident Investigations (PSII) are reported going forward. Never Events will be reported as separate metric for next month's report to allign with Patient Safety team reporting conventions																		
14	PSII's- Maternity			2												0	-	4	-
15	Number of falls investigated per 1000 bed days			0.11												0.03	-	0.09	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			97.1%												96.6%	≥90%	95%	≥90%
		711	1624	780	1600	844	871	788	806	798	772	770	894	879	956	930			
17	Red Flag staffing incidents			28												28	-	215	-

Maternity		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	440	436	383	387	416	402	418	417	400	400	467	409	428	406	401	-	-	-
		363	453	432	513	449	477	450	382	424	442	446	469	392	483	429			
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	5	1	0	2	1	1	4	6	1	3	3	1	4	4	0	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	37.5%	37.2%	36.0%	36.7%	40.6%	32.6%	43.3%	43.7%	44.8%	43.0%	43.5%	43.5%	38.6%	39.2%	38.9%	-	-	-
		48.2%	49.3%	54.8%	48.8%	46.9%	53.0%	43.3%	38.6%	44.8%	43.5%	44.3%	45.2%	49.3%	47.3%	50.6%			

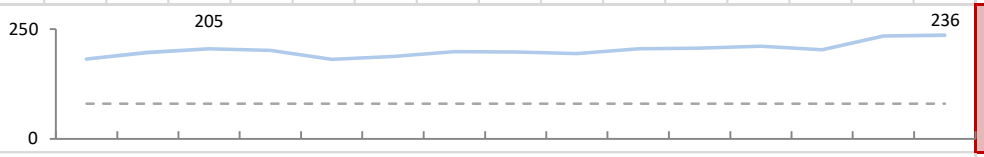
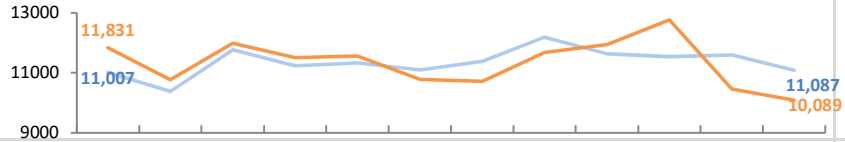
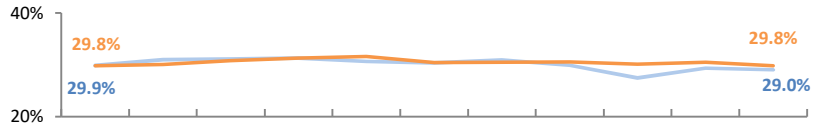
Patient Experience		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	3%		0.6%												0.6%	≤5%	0.6%	≤5%
		0%																	
22	FFT Negative Score - Maternity (postnatal ward)	10%		2.8%												5.4%	≤5%	2.7%	≤5%
		0%																	
23	Total UHS women booked onto a continuity of carer pathway	50%		14.8%												10.8%	≥35%	13.0%	≥35%
		0%																	
24	Total BAME women booked onto a continuity of carer pathway	80%		31.6%												14.8%	≥51%	27.1%	≥51%
		5%																	
25	% Patients reporting being involved in decisions about care and treatment	100%		87%												89%	≥90%	87.4%	≥90%
		80%																	
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100%		89%												91%	≥90%	90.3%	≥90%
		70%	197	169	290	209	209	300	301	287	249	214	234	336	208	272	304		
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	200		64												44	-	736	-
		0																	

Access Standards		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	64.8%														64.2%	≥95%	61.4%	≥95%
		6	7	5	4	9	12	9	8	8	12	10	11	8	4	4			
		4	3	3	3	5	7	5	5	5	7	7	7	5	2	3			
29	Average (Mean) time in Dept - non-admitted patients			03:10												03:24	≤04:00	03:38	≤04:00
30	Average (Mean) time in Dept - admitted patients			05:34												06:18	≤04:00	06:03	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)			63.2%												62.1%	≥92%	62.9%	≥92%
		5	5	4	4	4	4	5	4	4	4	4	4	4	4				
		5	5	5	6	6	5	5	6	6	6	5	4	4					
32	Total number of patients on a waiting list (18 week referral to treatment pathway)			54,692												58,106	-	58,106	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)			2,151												1,760	≤2,011	1,760	≤2011
		5	5	5	4	4	4	4	3	3	3	2	2	2	2				
		12	12	12	11	11	11	9	8	8	8	8	8	9	10				

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6 12	6 13	5 12	5 12	4 11	4 11	4 10	4 9	5 9	5 9	3 8	3 8	3 8	3 6	198	-	198	-
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7 15	7 15	6 15	4 12	4 10	5 11	8 12	8 11	7 10	6 9	5 9	6 9	5 9	19		0	19	0
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	1 0 1	1 0 1	1 0 1	1 0 1	1 1 1	8 4 13	14 5 13	17 2 17	15 2 13	16 1 14	12 1 10	13 1 11	13 0 9	0		0	-	0
36	Patients waiting for diagnostics	10,525													8,462		-	8,462	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	12 10	12 7	11.5% 8	12 8	11 7	11 7	11 8	10 7	9 10	7 8	7 7	6 7	7 7	5 8.2%		≤1%	18.5%	≤1%

		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	14	13	15	17	17	17	16	16	16	13						≥96%	77.9%	≥93%
		10	11	18	16	19	18	16	13	10	9								
			82.3%													88.4%			
38	Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data																		
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	17	14	14	18	9	14	13	10	15	6	11	7	6	4		≥85%	63.3%	≥85%
		12	11	7	14	5	9	7	3	6	1	2	3	2	2				
			50.0%													77.8%			
39	From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes.																		
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	4	8	7	8	7	7	6	3	1	2	3	3	1			≥75%	79.3%	≥75%
		5	9	5	8	7	5	3	2	1	1	1	1	1					
			70.0%													84.3%			
41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	16	16	18	16	15	17	15	13	13	11	15	12	13	11		≥96%	89.1%	≥96%
		12	14	20	12	10	14	11	5	9	6	15	9	8	9				
			82.3%													86.0%			
41	From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes.																		

R&D Performance		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	14	15	15	13	14	17	19	19	21	17	17	16	15	15	15	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	10	10	11	9	9	6	12	14	15	12	11	12	9	11	11	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection					25%	47%	59%	64%	46%	60%	67%	46%	88%	55%	50%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	79.2%	166.3%	83.8%	69.5%	35.6%	50.7%	65.2%	84.7%	104.1%	45.8%	133.3%	133.3%	84.7%	65.2%	157.6%	≥5%	-	-

Local Integration		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	202	-
48	Emergency Department activity - type 1 This year vs. last year																-	125,182	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.3%	≥25%

Digital		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	192,073	-
51	My Medical Record - UHS patient logins (number of logins made within each month)																-	32,360	-
51 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
52	Average age of IT estate Distribution of computers per age in years																-	-	-
53	CHARTS system average load times - % of pages loaded under 5s																		
53	Data only available from April 2023 onwards																		
				Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24			
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month																-	-	-
54	Ransomware attempts have been included within # of Malware attempts as part of changes to Cyber Security reporting data source for Q4 23-24																		
55	Inpatient noting progress Left axis: IP Noting data recorded (100s) IP Noting unique user views Right axis: IP pages scanned (1000s)																-	-	-

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Non-Criteria to Reside Spotlight Report**			
Agenda item:	**4.8**			
Sponsor:	**Joe Teape, Chief Operating Officer**			
Authors:	**Duncan Linning-Karp, Deputy Chief Operating Officer** **James House, HIOW Integrated Care Board**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	UHS continues to have over two hundred beds occupied by patients not meeting the criteria to reside. This impacts on emergency and elective flow, and also leads to surge spaces being used at significant cost. It has a negative impact on patients, with increased (unnecessary) hospital stays leading to a heightened risk of both morbidity and mortality, as well as poor patient experience.			
Response to the issue:	UHS continues to focus on the elements within our control through the Inpatient Flow Programme. We are also engaging with the local Southampton and South West Hampshire system and across the ICS through the Discharge Board. Despite significant work taking place to date, the number of patients not meeting the criteria to reside has increased over the last year. This report is an update on December's report to Trust Board and provides further details about the ICB's planned response to the number of patients not meeting the criteria to reside.			
Implications: (Clinical, Organisational, Governance, Legal?)	Clinical, financial, organisational.			
Risks: (Top 3) of carrying out the change / or not:	If the number of patients not meeting the criteria to reside fails to be reduced, there will be: - Continued increased risk of morbidity and mortality for patients remaining in hospital unnecessarily, and poor patient experience - Continued increased risk of delays for admission for non-elective patients and increased crowding in the Emergency Department, and increased likelihood of elective cancellations - Continued increased likelihood of surge capacity remaining open, leading to financial pressure			
Summary: Conclusion and/or recommendation	Trust Board is asked to note the report.			

Introduction

Over a number of years UHS has had a significant proportion of beds occupied by patients who medically do not need to remain in hospital. This number is now at approximately 230 patients, about 22% of our total adult beds. The reasons for these delays are largely due to inadequate capacity in community health and social care, combined with complex processes, some of which could be simplified or improved.

This paper is an updated version of the one that went to Trust Board in December 2023. It provides more up-to-date data, a summary of UHS's internal response to the problems and more detail on the wider system's planned response, both in financial year 2023-24 and 2024-25. It is tabled at the request of Trust Board following on from December's discussion.

While a significant amount of work is taking place both within the hospital and across the system, this has yet to lead to a reduction in the number of patients in hospital who do not meet the criteria to reside.

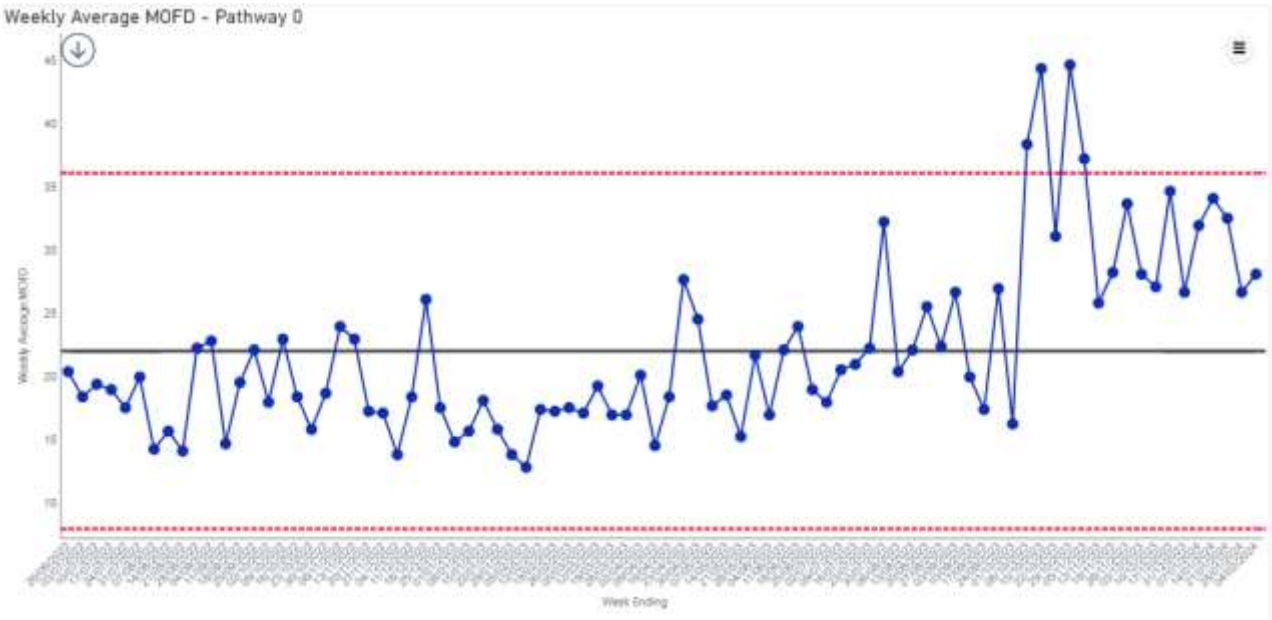
Definitions & Performance

Patients not meeting the criteria to reside (n-CTR) is the latest definition for patients who remain in an acute hospital setting who are medically fit for discharge. While definitions vary slightly, broadly speaking this group of patients were previously called Medically Optimised for Discharge (MOFD), or before that Delayed Transfers of Care (DTOC).

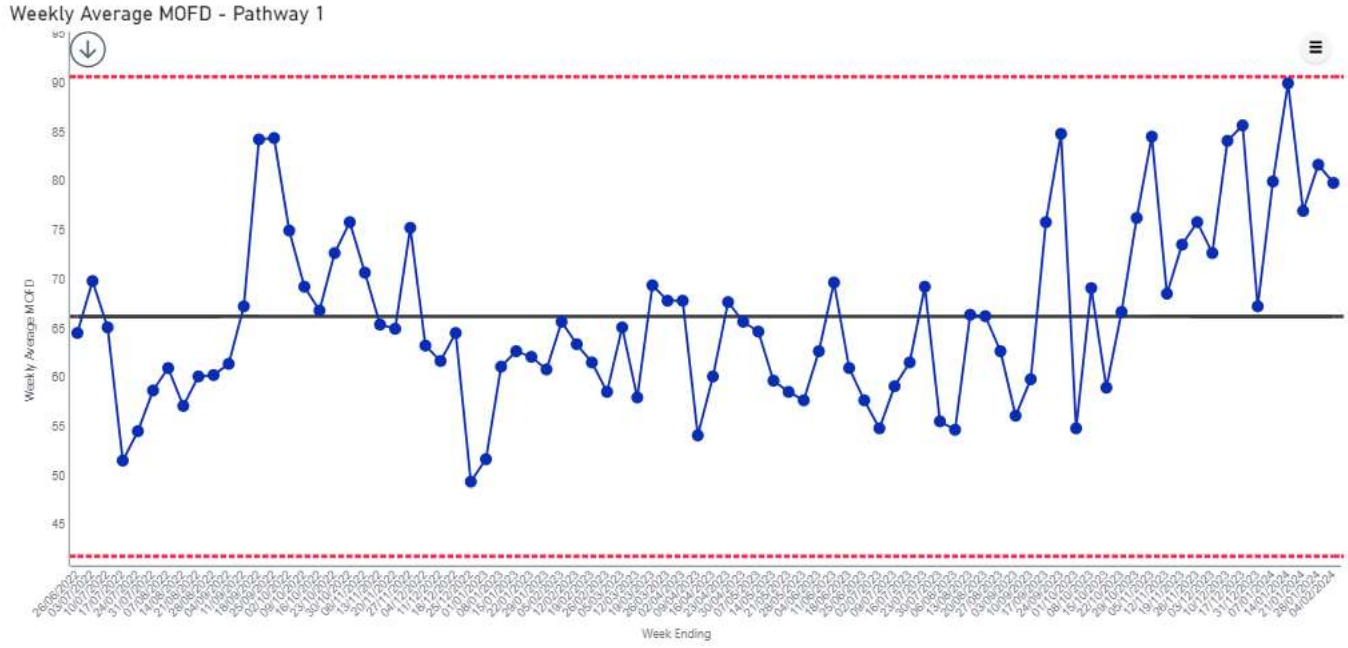
N-CTR groups patients in one of four pathways:

- Pathway 0 – discharge to a patient's usual place of residence with no additional support needed.
- Pathway 1 – discharge to a patient's usual place of residence with additional support needed.
- Pathway 2 – discharge to a to a temporary rehabilitation or reablement setting.
- Pathway 3 – complex discharge to a longer-term placement or home with complex support needs.

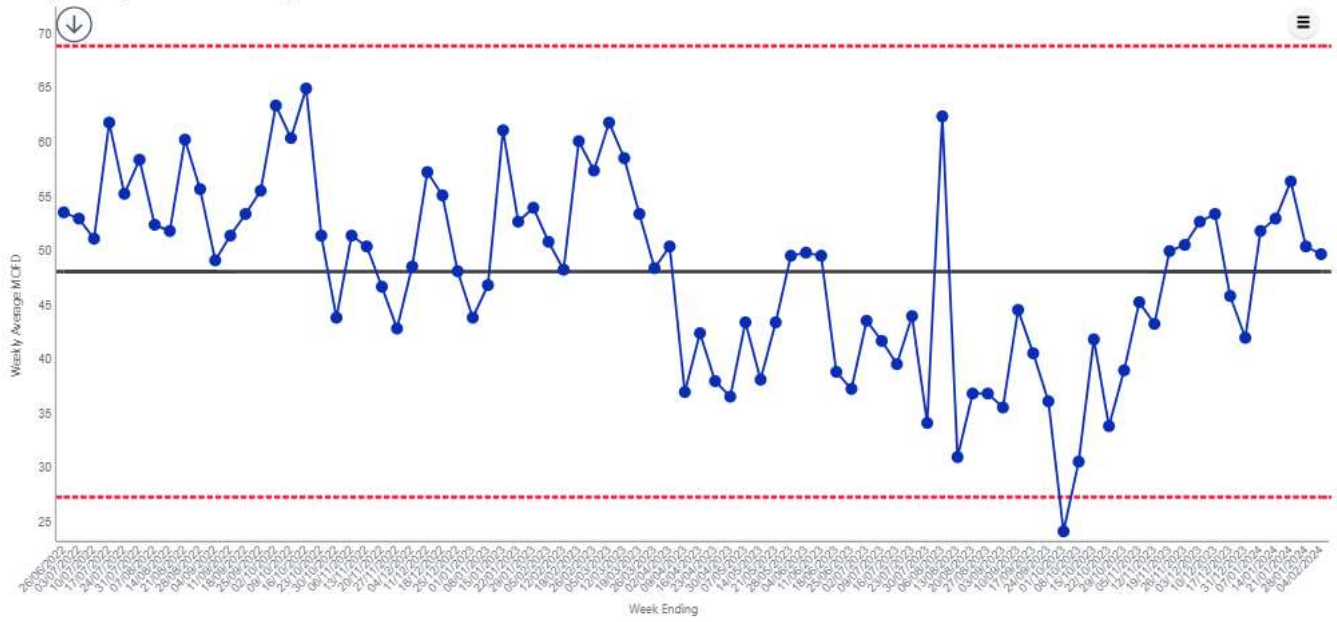
The number of patients on each pathway is shown:



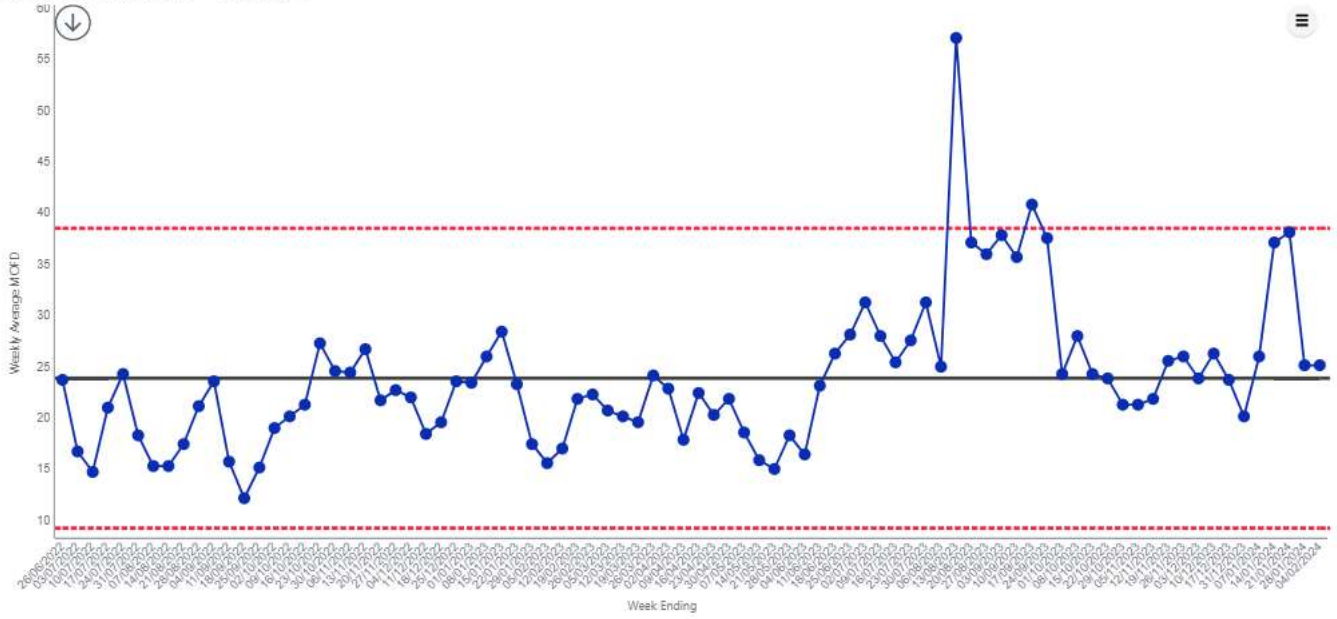
(Note the recent increase in P0 was a change of counting and coding)



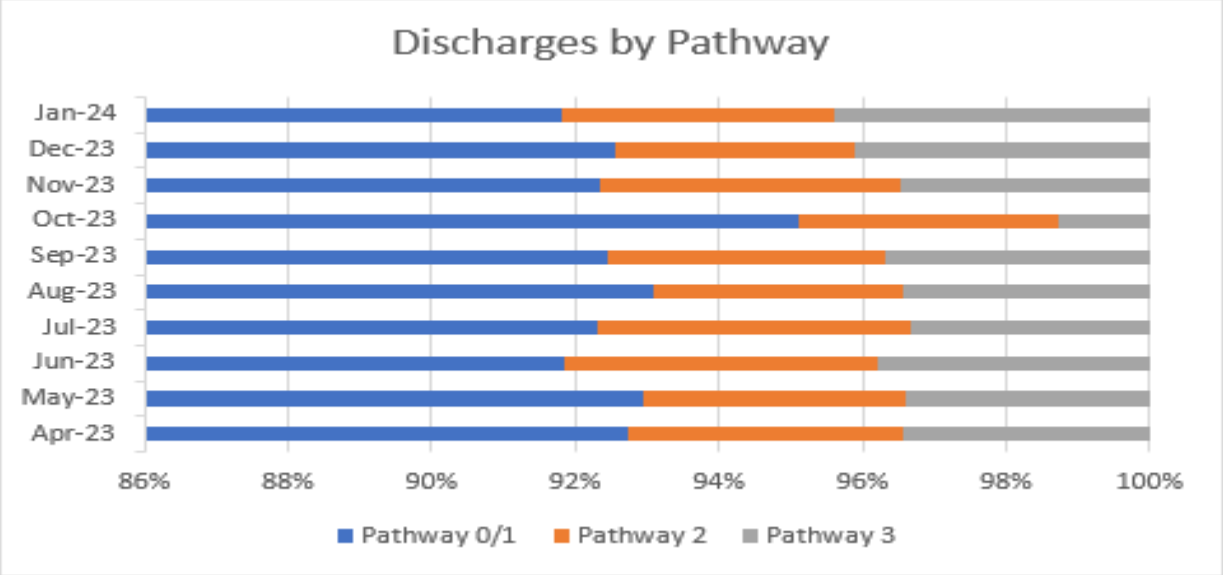
Weekly Average MOFD - Pathway 2



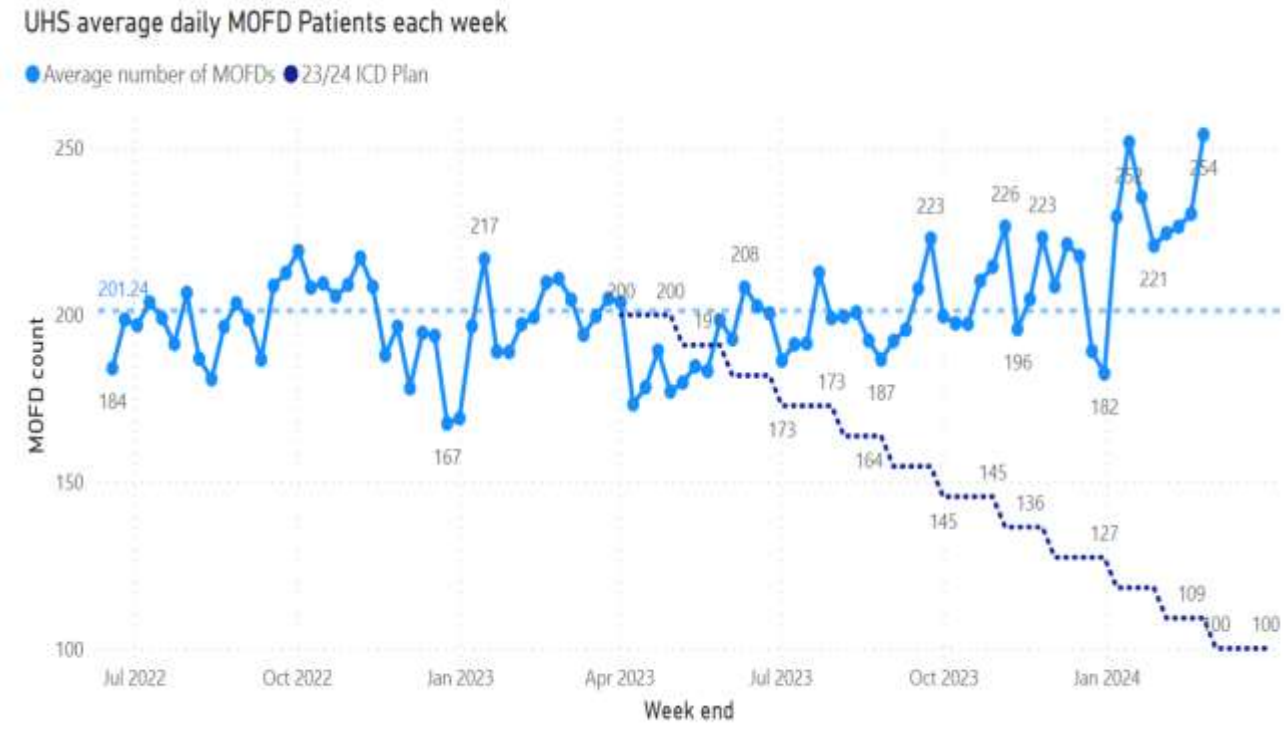
Weekly Average MOFD - Pathway 3



National best practice is that 95% of patients should be discharged on Pathways 0 or 1, 4% on pathway 2 and 1% on pathway 3. While performance varies, we are not currently achieving the national best practice. There is, however, not clear evidence of overprescription of care, and indeed UHS staff *describe* the patient's care needs and then others *prescribe* the level of care. It is therefore not clear that a significant change in the split by pathway could be made.



At the start of this financial year the planning assumption was a halving of n-CTR across the ICS. Based on numbers at the time this meant a phased reduction to one hundred patients not meeting the criteria to reside by March 2024. However, in reality the number has increased significantly.



Internal Improvements

There are processes and pathways that can be improved internally. These largely fall under the governance and oversight of the Urgent and Emergency Care Board and the Inpatient Flow Programme. The focus is on both admission avoidance (via Same Day Emergency Care or in reach from other agencies) and reducing length of stay for inpatients.

December's paper outlined the key priorities in the internal inpatient flow programme in 2023-24. This paper looks forwards to 2024-25. While the key tenets remain the same, with a focus on reducing overall length of stay, improving 'home before lunch' and weekend discharge rates, the programme in 2024-25 will have a greater focus on the operational processes within the hospital and greater oversight of flow and discharge.

Use of data

Data for unscheduled care has historically been more limited than for elective care. In 2024-25 there will be a significant focus on how we can collect more accurate real time data, and use that to drive improvements in performance. Embedding the eWhiteboards as the single source of truth for bed management will play an important role, as will focusing on some key performance metrics including time from referral in the Emergency Department to admission, and the time from an inpatient bed becoming available to it being filled. The intention is to work with the Care Groups, using the data, to identify improvements and also best practice that can be shared.

Improving flow

There are a number of interventions we plan to take to ensure patients can leave hospital more quickly. Our intention is to identify two wards and two admission areas to focus on, put in a significant level of support and oversight to embed the changes and then, assuming success, move on. This is a different approach to previous years, where we have tried to implement changes across the whole organisation in one go, with mixed success. Key improvements will include use of criteria led discharge, senior oversight to ensure maximum use of discharge lounges, formal escalation of delays, trialling different board rounds and an education programme for Band 6 and 7 shift and ward leaders.

We will also be reviewing a number of initiatives to improve flow and discharge, including a pilot to shorten length of stay for patients requiring emergency surgery, improving the use of Same Day Emergency Care units, reducing the length of Healthcare Management Records (discharge summaries) and shortening the length of time patients wait for their drugs to take home on discharge.

Changing culture

Led by Drs Howson, Smith and Wright, we will continue to work with both junior and senior doctors across the Trust to emphasise the importance of discharge as early as safely possible. The over-arching narrative is that there is significant potential harm in an unnecessarily prolonged length of stay, both to the patient themselves, and also to others who may be delayed

in either a non-elective admission or cancelled for elective surgery because of a lack of a bed. This is not about asking clinical staff to work harder, but to think differently. An example is, if you saw this abnormal blood result in clinic would you admit a patient, and if the answer is no why would the abnormal result be a barrier to discharge.

External Improvements

The Hampshire and IOW Integrated Care Board (ICB) has leads on five system wide transformation programmes. The programmes pull together system partners, including local authorities, community providers and acute Trusts (including UHS), in order to collaborate around specific goals. The Discharge Transformation Board oversees the discharge programme, with the key aim of reducing patients who are in acute beds, but no longer have the criteria to reside. Alex Whitfield, CEO of Hampshire Hospitals NHS Foundation Trust, has been the Senior Responsible Executive for this programme.

The 2024/25 is currently under development with partners, with the aim of delivering the following key benefits:

- **Optimised flow and right sized capacity –** Improved ability to undertake demand and capacity modelling to ensure funding levels are the right size for the right need. Greater accuracy and improved access to the right metrics to be able to measure impact on onward care services, to ensure value for money and good patient outcomes. Increase grip on funding to reduce overspend (End of Q4 2023/24).
- **Reducing unnecessary delays when someone is in hospital –** Reduced number of lost bed days through the elimination of waste from discharge processes, elimination of variation across discharge process and methods in place to ensure continuous quality improvements are aligned with national standards (e.g. NICE guidelines), standardised key policies, frameworks and key metrics (End of Q1 2024/25).
- **More people having longer independent long-term outcomes –** with more patients referred on a home first pathway, increasing numbers discharged within 3 days of being medically fit to leave, fewer patients at risk of deconditioning as a result of delays in hospital waiting for discharge, more patients know what their discharge plan is and when they will leave the hospital, more patients discharged before noon, home for lunch (End of Q2 2024/25).

In order to deliver these benefits, the Discharge Transformation Board is creating the following workstreams, each with a dedicated working group:

Workstream 1: Improving Hospital Discharges Processes	Workstream 2: Reduce Delays as Patients Transfer between Settings	Workstream 3: Onward Care Improvement Processes, access and outcomes	Workstream 4: Mental Health Improvement Processes, access and outcomes	Workstream 5: Right sized commissioning best value
Finish date	Finish date	Finish date	Finish date	Finish date 31/03/2024
% Completed 39	% Completed 36	% Completed 21	% Completed 11	% Completed 24
WS Lead: Sara Courtney (TBC)	WS Lead:	WS Lead:	WS Lead: Steven Trembath	WS Lead:
RAG level: Green	RAG level: Green	RAG level: Amber	RAG level: Green	RAG level: Amber
Project Outputs Amber	Project Outputs Amber	Project Outputs Amber	Project Outputs Amber	Project Outputs Amber
System winter plans ✓ HIOW Discharge Policy / Escalation / roles SOPs (Wards, referrals and TOCHs) Homelessness Discharge Policy	Joint HIOW Discharge Framework SOP for CHC Brokerage SOP for fast track PTS Review	Care Home Fourms - place level Therapy demand and capacity tool xxxxxxx	MH Discharge Delays paper Perfect week recommendations paper xxxxxxx	Onward Care demand and capacity tool nCTR Trajectory 24/25 STS / RSS contract agreed for 24/25 Community Bed #agreed 24/25
Key workstream Projects	**Key workstream Projects**	**Key workstream Projects**	**Key workstream Projects**	**Key workstream Projects**
Plan for a Safer Winter Lead: Jayne Tunstal	Transfer of Care Hubs & Discharge Standards Lead: Sara Courtney	Scale AHP Optimisation across HIOW Lead:	MH Discharges review Lead: Steven Trembath	Demand and Capacity Model Lead: Anna Shaw and Hisham Zaman Link with Steve Bolam
Reset of Discharge - SAFER Lead: Sara Courtney / Katarzyna Cirino	Complex Care Pathway Processes Alignment ICB/HCC Lead: Nicky Shaw / Michael Burton	Therapy demand and capacity modelling part of mission of recondition	SHFT Perfect week Lead: Darren Bate / Nicky McD Link with Ali Young	Onward care contracting RSS/STS beds Community beds Lead: Clare Whalley
Trusted / Blended Assessor Roles Lead: Sara Courtney	Fast Track Processes Improvement Lead: Sara Courtney / Matthew Richardson	Care Homes admissions - Project TBC Lead: Matthew Richardson / Jonathan Davies	Project Name Lead:	BCF Alignment, BCF Support Programme 2023-25 Lead: Jonathan Smith
Discharge Lounges Review Lead: Katarzyna Cirino	Patient Transport Service (PTS) Access and flow Lead:	Virtual Wards Expansion Model - step down Lead: Ali Young	Project Name Lead:	Onward Care services levels - IIC Lead: Clare Whalley **Cross project with Local Care Programme**
Mission to Recondition Lead: Sara Courtney	Hampshire Equipment Services Transformation Lead: George Podd / Stephen Cameron	Project Name Lead:	Project Name Lead:	Quality Contract Schedule 2, SC11 - Transfers of and Discharge from Care Lead: Sara Courtney
Workstream KPIs / Programme Outcomes 50% increase use of discharge lounges 95% pts discharged via P0&1 Increase pre-noon discharges by 25%	**Workstream KPIs / Programme Outcomes** +7, +14, +21 days ALOS / LBD #P2 discharges within 3 days # P3 discharges within 6 days Fast track discharge within 48 hr % of deaths in prefered place - 5% annual increase	**Workstream KPIs / Programme Outcomes** ALOS in STS beds / RSS hours # patients still at home after 91 days xxxxxxx	**Workstream KPIs / Programme Outcomes** # MH delays by type 50% reduction # patients waiting MH bed xxxxxxx	**Workstream KPIs / Programme Outcomes** STS 28 / RSS 14 ALOS Community beds ALOS - 28 days xxxxxxx

Key Actions:

- Agree 2024/25 trajectories and performance metrics to align with planning priorities and ambitions, using system trend and reporting data from discharge programme dashboard.
- To agree 24/25 delivery plan that will ensure key trajectories, performance metrics and programme benefits are achieved at the right time.
- Engaging with key stakeholders to agree and align delivery plans and performance metrics in local delivery systems.
- Implementing a HIOW Delivery Group that will report into Discharge Programme Board and be responsible for delivery of localised plans.
- Align planning with24/25 Better Care Fund (BCF) Plans.
- Agree HIOW Joint HIOW Discharge Framework that will align with NHSE discharge standards, provide consistency of standards and practices across HIOW.
- Undertake Therapy demand and capacity modelling review as part of mission of recondition across all systems, starting with PSEH system. Baseline data across our acute delivery systems will be used to inform future system solutions and transformation opportunities across therapy services.
- Develop and stress test an Onward Care demand and capacity tool for HIOW with support from Changeology as part of ongoing BCF support programme.
- Linking with key component parts of other transformation programme as part of benefits realisation across whole patient pathway.

Whilst success measures for 2024/25 are still under development as part of the design stage, some already identified are:

For our residents:

- 95% people able to be discharged back to their usual place of residence (increased from baseline of 84% across HIOW, >90% for UHS) on Pathway 0 and Pathway 1 discharge pathways.

For NHS organisations:

- Improve discharge rates with reduction in bed days related to patients with no criteria to reside
- Length of stay reduction across short term community services.

For the system:

- Reduce average length of stay for patients

It is also recognised that there are key enablers that need to be further developed by the programme:

- **Monitoring and Performance –** Development of a system dashboard via the SHREWD platform
- **Communications and Engagement –** Staff and patient engagement
- **Workforce and Leadership and Culture –** SocialKemistri independent review of discharge operating model and leadership

The progress against each workstream, key deliverables, and updates from stakeholders, will be monitored through the Discharge Transformation Board, which meets monthly, and of which UHS is a member.

Conclusion

There are numerous interventions within the hospital's control that will reduce length of stay and improve discharge, and the Inpatient Flow Programme is focused on resolving these where possible. The programme's plan for 2024-25 has been outlined in this paper. This should not only make a difference to patients leaving on Pathway 0, reducing delays and improving patient experience, but also ensure patients on Pathways 1-3 are listed as soon as possible, go home the day their care outside of hospital becomes available and are not cancelled for reasons that are within the hospital's control.

There are also some improvements taking place across the system, with laudable aims to reduce length of stay in community and short-term service beds, and some early signs of progress. However, despite close working across the ICS there remains some risk in the plans. While improvements in the number of patients leaving hospital on Pathway 0 or 1 can still be made, UHS performs comparatively well, suggesting there is less opportunity than elsewhere. Capacity in community or social care also remains a barrier to timely discharge, and there is a gap in current plans when it comes to resolving this.

None of this should stop ongoing work both internally and externally to ensure our pathways and processes are as efficient as possible, and that we control the things that we can. However, without a shift in either capacity our how that capacity is used (e.g. a material number of patients

going down a less dependent pathway) it seems unlikely that we will see enough of a reduction in patients not meeting the criteria to reside.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2023-24 Month 11**			
Agenda item:	**4.10**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			

Response to the issue:

M11 Financial Position

In month UHS has received additional funding of:

- £24.6m of cash support from NHS England (as outlined in M10 report).
- £5m of funding in relation to the impact of industrial action in December, January and February.

This has resulted in a surplus of £26.75m in February, meaning the Trust is now at a Year-to-Date deficit of £0.9m.

Forecast

We are currently forecasting to end the year with a **£1.4m deficit** – being our £26m plan position less the £24.6m additional funding received. We are therefore anticipating achieving our plan position.

There is likely to be an additional improvement ask from HIOW ICB aligned to the cash support funding received. This was previously identified at £1m; however, industrial action funding received was £1.2m lower than anticipated, which has off-set this position.

Even at this late stage of the year there does remain some uncertainty in the financial position. For example, there has been a national proposal to fix ERF funding based on an extrapolation of M8 performance. This would be detrimental to the Trusts forecast income position due to structural changes (e.g., new wards in December), financial recovery measures and the drive for additional activity to reduce waiting lists by the end of March. It is unlikely a risk that materialises could be mitigated.

Underlying Position

Given the volatility in the in-month position, it is important to focus on the underlying position of the Trust.

Throughout the year the Trust has been operating at an underlying deficit ranging between £4m - £5m on a monthly basis, with significant levels of CIP delivery being off-set by financial pressures associated with Non-Criteria to Reside, Mental Health and shortfalls in funding for pay awards.

In M11 the Trust's underlying position was a £4m deficit. We have also restated prior months following additional back-dated income linked to ERF, contract variations and Channel Islands income. The average underlying position has improved to £4.1m since the financial recovery actions commenced in November (previously £4.5m).

Financial Recovery

In October, UHS set itself a financial recovery plan in order to deliver an improvement in its forecast position from £31.5m deficit back to £26m plan deficit.

An update on progress is outlined in appendix 2. Overall, whilst some of the measures have been extremely challenging within the organisation, the result has been achievement of the financial plan position and additional cash support therefore being received.

The additional control measures have ensured pay costs remaining broadly flat over the period, significantly altering the trajectory. They have also controlled non-pay costs and increased our anticipated income position.

ERF

In month ERF performance was above target at 115% and is 117% YTD. The revised target is now 109% following a 4% in-year reduction linked to industrial action. This overperformance has generated £16.3m of additional income YTD.

In month ERF performance was below the 120% targeted in the recovery programme. However, some upside was generated from reviewing prior month estimates. Industrial action and non-elective pressures caused a strain on additional elective activity in the month.

Deficit Drivers

The drivers of our financial deficit continue to be:

- Further growth in the number of patients not meeting the criteria to reside (NCTR). Our plan submission was based on an assumption that the HIOW ICS discharge transformation programme would support a 50% reduction in NCTR patients from 200 to 100. However, numbers have spiked since January and are regularly 220 – 250. The Trust has additional surge capacity open and has utilised additional bed capacity intended to support the elective programme to manage this growth, resulting in a significant unfunded cost pressure. It is estimated the Trust could save £13m should this reduce to 100.
- Further growth in the number of patients presenting with mental health conditions only who would be better cared for in an alternative care setting. It is estimated to be costing the Trust £6m per year in providing agency nursing & care assistants to support these patients safely within the hospital. This has grown by circa £2.5m in 23/24 alone.
- A shortfall in additional funding for nationally negotiated pay awards has added a £5.2m pressure to the Trust. That is set to grow to £6.5m once non-recurring funding is removed in 24/25. It is thought this shortfall has arisen due to the Trust having a higher proportion of medical staff than the average Trust.
- The Trust is continuing to face funding pressures in managing NEL and ED activity above block funded levels.
- The Trust is continuing to deliver outpatient follow-up activity above block funded levels – including in areas such as cancer and managing long-term conditions in Ophthalmology.
- We also entered the year with an underlying deficit from the previous year, with pressures outlined above plus non-pay inflation pressures, particularly in relation to energy prices. High-cost drugs spend was also significantly above block funded levels.

	We continue to raise these financial pressures, particularly those linked to unfunded levels of additional activity, with our commissioners and hope to resolve these issues in 2024/25. **Cost Improvement Plans** The most-likely risk assessed position of cost improvement delivery sits at £62m (5%). This includes the £5.5m targeted improvement within the financial recovery plan. This level of CIP delivery is a record for UHS, £17m higher than delivered in the previous year. Whilst we have made good progress with CIP performance, it is heavily supported by non-recurrent delivery that cannot be relied upon for underlying financial improvement. The aim is now to shift this into recurrent delivery. **Capital** The Trust has approximately £23m to spend in M12 in order to achieve the forecast position of £60m and utilise internal and externally funded CDEL in full. Currently there is confidence in forecast delivery of the planned level of expenditure. A trajectory has been developed and is being tracked with project managers particularly in estates to ensure risks are understood at the earliest opportunity and mitigations put in place where possible. **Cash** As reported in previous finance report the trusts cash balance remains a significant concern, and last month the value dropped below the internal target minimum threshold of £30m. However, the cash balance increased by £7m in month to close at £32m in February. We are anticipating cash receipts in relation to the cash support (£24.6m), industrial action funding (£5m) and external capital funding (£9m) in M12. We are therefore anticipating closing the year with a cash balance of >£60m. Moving into 2024/25 additional vigilance will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also ensure the NHS England draw down process is ready if and when required.
Implications:	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
Risks: (Top 3) of carrying out the change / or not:	• Financial risk relating to the underlying run rate and projected potential deficit if the run rate continues. • Investment risk related to the above • Cash risk linked to volatility above • Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2024/25 due to the forecast deficit for 2023/24.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2023-24 Month 11**			
Agenda item:	**4.11**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**28 March 2024**			
Purpose	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS people, was approved by Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The monthly people report summarises progress against the delivery of the critical metrics in the strategy. It is provided monthly to Trust Executive Committee and People and OD Committee. The information is based on February (M11).			
Response to the issue:	**Progress against the pillars of the UHS People Strategy:** THRIVE (Workforce Capacity) • Total workforce (Substantive, Bank, Agency) reduced by 20 **WTE** this month. The extended recruitment controls have helped to slow substantive growth, which reduced by 3 WTE from February. • Total workforce variation to NHSE plan is now **266 WTE** but is currently in line with our financial recovery plan. • The significant additional **controls on substantive recruitment** have helped to slow growth. The senior clinical prioritisation panel are reviewing all recruitment decisions for priority posts and subsequently over 260 posts have moved forward to recruitment. • In addition, centralised processes for operational admin recruitment are being implemented, working with the Divisions to prioritise highest areas of need. • **Temporary staffing usage** has reduced overall since February. Reported **bank usage** fell in February, although it should be noted the short month (29 days) has an impact on calculations which will understate the position.			

	• There was a marginal increase in **agency WTE**, however UHS remains below plan. We are reporting 1.6% of the total pay bill to spent on the agency against a new NHSE target of 3.7%. We are recognised as a high performing Trust in regards to agency spend and control • **Turnover** continues to reduce, with rolling average now running at 11%, well below our target of 13.6%. • **Sickness continues** to be below the Trust target of a rolling average at 3.8% (Target 3.9%). In month absence fell in February to 3.8%. Excel (Capability, Reward, Wellbeing) • **Appraisal rates** remain below target at 76%. Continuing pressure across the Trust, coupled with delays in reporting on ESR, are contributing to the current level of uptake. • Work has commenced on creating an **electronic appraisal form in our virtual learning environment (VLE)** system to support the process. Appraisals will be reviewed at the People and OD committee during Q1. Belong • **Staff Survey** results were published nationally. UHS remains above average in all People Promise domains and in the top quartile for engagement. Improvements are noted in a number of areas. However, some key metrics have deteriorated. The Survey is covered later in the Board agenda. • 64% of the Trust has completed the **Actionable allyship training programme**, a key part of year 1 of the Belonging and Inclusion Strategy • A new leadership programme completed in March with 30 participants at 8a and 8b. The evaluation of the programme was extremely positive. Key modules included compassionate leadership and inclusion.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery.
Risks: (Top 3) of carrying out the change / or not:	We need to meet our strategic objectives as set out in the business assurance framework for UHS. Specifically: a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. b) We fail to develop a diverse, compassionate, and inclusive workforce providing a more positive experience for all staff.

	c) We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs.
Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

February 2024

THRIVE EXCEL BELONG

Workforce Position

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Substantive WTE between January and February decreased by **3 WTE**. The overall **total workforce** decreased by **20 WTE** (see below table for movements)**.**
The staffing groups with the largest net substantive growth were Medical and Dental (+22 WTE), Students (+5 WTE; all on a Nursing (Adults) Degree course) and Allied Health Professionals (+2 WTE). There were reductions in Admin and Clerical (-13 WTE), Nursing & Midwifery (-9 WTE) and Additional Clinical Services (-6 WTE). February saw considerably fewer leavers (63 WTE) than January (93 WTE).

Category	WTE	Comments
Newly Qualified Nurses/Midwives	6	Staff start as supernumerary. Should reduce future bank usage
Medical and Dental workforce growth	22	An interval between junior doctor rotational cohorts joining and leaving in Jan/Feb typically causes a temporary workforce spike in these months
Additional Clinical Services growth	(6)	Reduction in the HCA workforce due to fewer starters
Nursing and Midwifery change	(9)	Reduction in the Nursing and Midwifery workforce due to increased turnover in Feb
Admin and Clerical change	(13)	Reduction in the Admin and Clerical workforce due to fewer starters
All other substantive change	(3)	
Reduction in bank usage	(23)	Largest decrease was in Infrastructure (19 WTE); Estate and Ancillary decreased by 16 WTE; Medical and Dental saw a drop of 2 WTE. Nursing (both RN and HCA) had an increased use of Bank
Increase in agency usage	6	Increased from the lowest usage month of Jan
Total	**-20**	

Bank usage **decreased** from January to February by 3% (705 to 682 WTE)

Agency usage **increased** from January to February by 6% (99 to 105 WTE)

Workforce Growth

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Growth versus plan since April:

Additional Clinical Services (HCAs) recruitment to vacancies and reduced turnover

Allied Health Professionals growth due to filling vacancies in Occupational Therapy (OT), ODPs and radiographer staffing groups

Medical growth in junior doctors (no hosted service posts) and three additional consultants in Feb

Continued pressure in Emergency Medicine (Div B) due to mental health and enhanced care requirements. The largest growth in Div C has been due to the Nursing and Midwifery workforce

New cohorts of internationally educated nurses joined the trust between Nov and Dec

Staff Group	Plan WTE	Actual WTE	Variance WTE	Variance %
Add Prof Scientific and Technic	409	401	(8)	-2%
Additional Clinical Services	2488	2542	54	2%
Administrative and Clerical	2357	2346	-11	0%
Allied Health Professionals	668	732	64	10%
Estates and Ancillary	401	391	(9)	-2%
Healthcare Scientists	478	507	29	6%
Medical and Dental	2084	2234	150	7%
Nursing and Midwifery Registered	4360	4367	6	0%
Total	13246	13520	275	2%

Division	Plan WTE	Actual WTE	Variance WTE	Variance %
Division A	2541	2549	8	0%
Division B	3539	3680	142	4%
Division C	2779	2892	113	4%
Division D	2456	2479	23	1%
THQ (inc EFCD and R&D)	1861	1894	33	2%
Other	71	26	(44)	-63%
Total	13246	13520	275	2%

Variance is against internal UHS trajectory since April 2023; data is for total workforce (substantive, bank, agency) as of February 2024.
'Other' category refers to 'THQ other services'

Workforce Controls

Area	Action taken forward
New substantive recruitment Controls	• A recruitment pause was initiated on 22 December to slow substantive growth to the end of 23/24. Unconditional offers made are starting as committed during the remainder of Q4 and into Q1. • A senior clinical oversight panel was established to prioritise conditional offers in the pipeline and identify critical posts that require start dates sooner. This is supported by risk-based assessments on impact. The panel has met six times and approved 266 posts (P1-2s) to date to move to recruitment. • Additional controls on fixed-term contract extensions, hours changes, and internal recruitment requests are in place. • Lower priority conditional offers are now being given phased start dates into Q4 and Q1. • HCA recruitment is continuing each month to cover expected turnover with a cohort starting in March. • Fully centralised admin and clerical recruitment process initiated for Band 2/3 Divisional posts. The prioritisation of placement is to be led by divisions. • Externally funded posts proceeding straight to recruitment
Forecasting	• Detailed staff group and care group forecasting analysis for the substantive workforce to March 2024 has been undertaken and shared with divisions and has been updated after February final figures. This is based on known starters and predicted turnover and the forecast is being projected forward to the next financial year. • This will be used to forecast for 24/25 and to support continued decisions relating to recruitment controls
Temporary Staffing Controls	• The CNO is leading a specific nursing group focused on bank demand supported by Finance and Workforce. • Dual approval for nursing NHSP shifts enacted on 3 January 2024 • Nursing rosters on wards have been reviewed to ensure maximum deployment of staff • The Deputy CNO continues to review the use of mental health nursing agency, including reviewing opportunities for safe reduction. • Role by role review of all A&C bank and agency by executive directors with assignments agreed to end where feasible. Executive sign-off for all new A&C bank and agency placements.
Reporting	• Continued weekly reporting on WF (substantive, bank, agency) internally and to the ICB, including quantification of mental health pressure. Weekly reporting updated to include variation to forecast in addition to plan • Divisional WF trajectories completed for all divisions and THQ included in the People Report to TEC

Workforce Controls

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Spotlight on Nursing Workforce

The Nursing workforce group meets bi-weekly with a focus on controls to reduce demand for bank and agency whilst maintaining patient safety and quality. The following initiatives are being implemented and in the process of being quantified for ongoing monitoring.

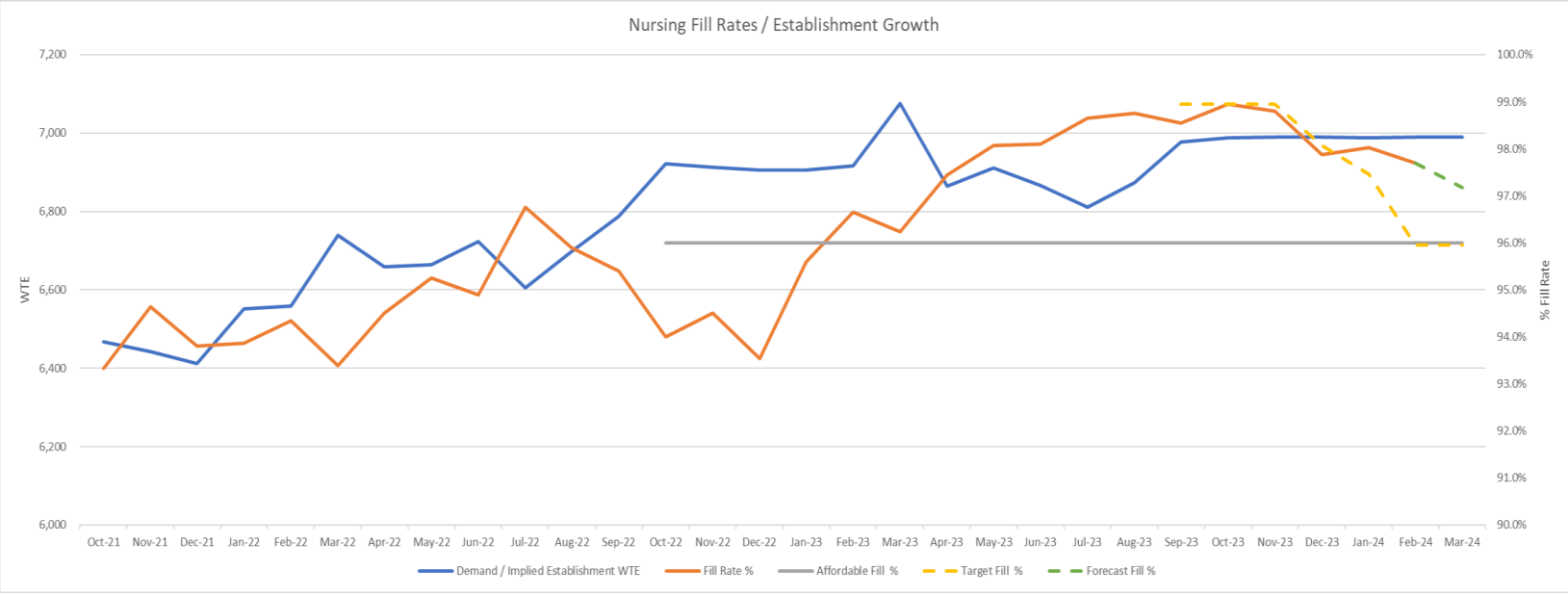
- Second level approval implemented on Nursing rosters from January
- Mental Health Care Support Worker (CSW03) require 'golden key' approval from matron / DHN
- Matrons reviewing all bank requests to ensure appropriateness offering additional oversight and challenge
- A "guide to manage bank requests" has been launched for bleep holders including a flowchart for managing short term absence
- Bank shift times have been amended for early and late shifts to ensure cover is only for key hours (i.e. early shift to finish at 1300 rather than 1500)
- Housekeeping process to be completed for supernumerary periods to ensure they are compliant with the agreed timescales

A detailed review into nursing bank workforce trends is being led by the nursing team to determine the impact of the controls on bank and agency WTE. It will include quantifying the cost reductions of bank and agency WTE and evaluation of spend; as well as assessing usage of additional temporary WTE in relation to income-generating activity

Workforce Position

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

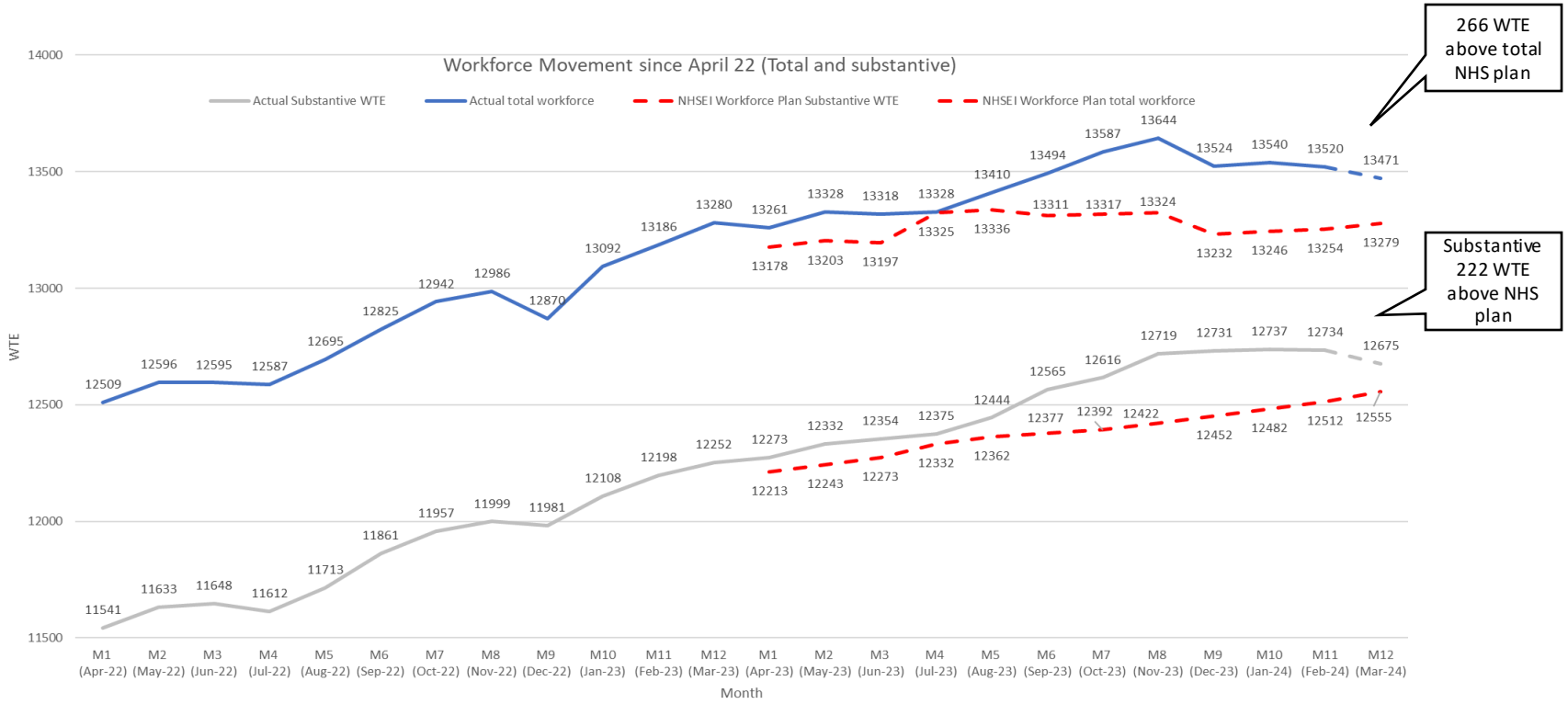
Nursing Fill Rate



Dashed lines represent a forecast

Workforce Position

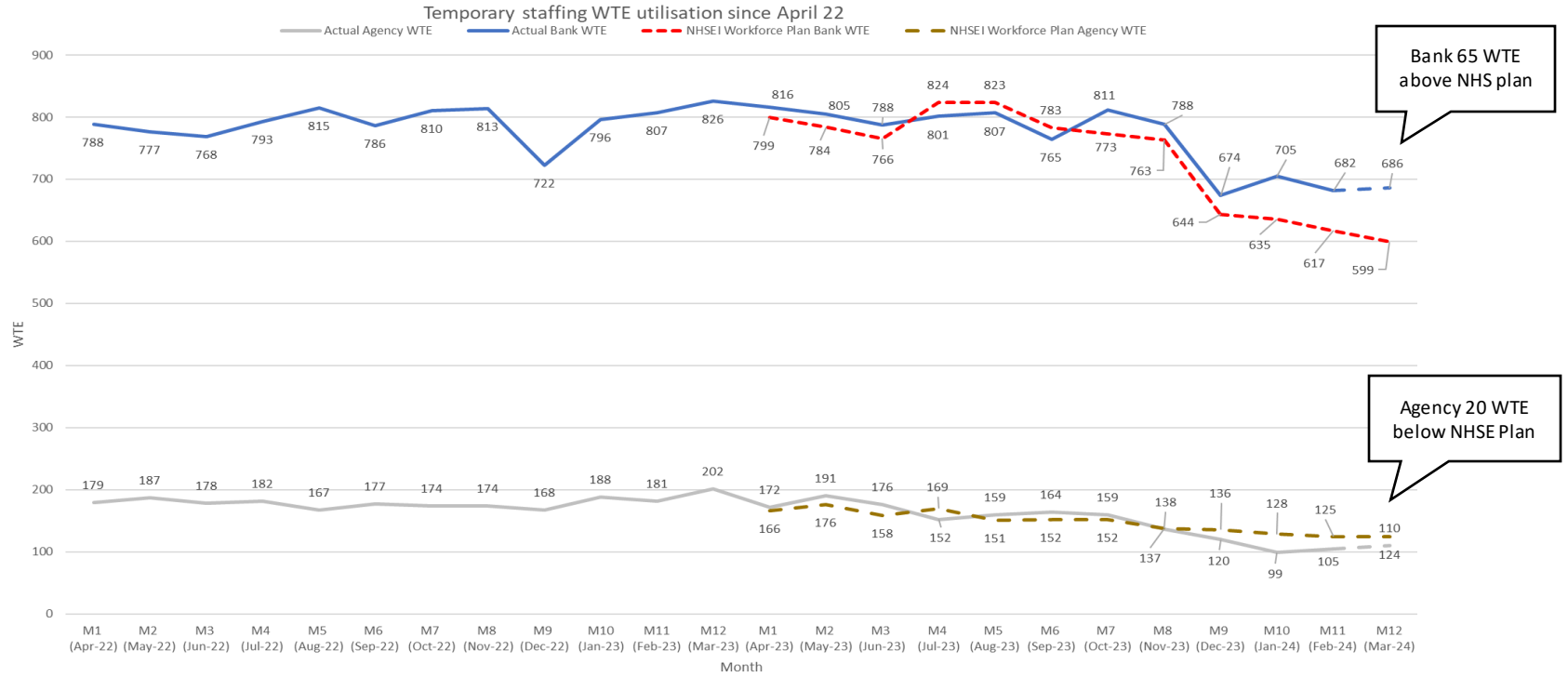
NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: ESR as of February 2024
Note – forecasting for substantive staff based on know n starters and predicted leavers
Forecasting for Bank and Agency based on expected requirements to deliver financial recovery plan

Workforce Position

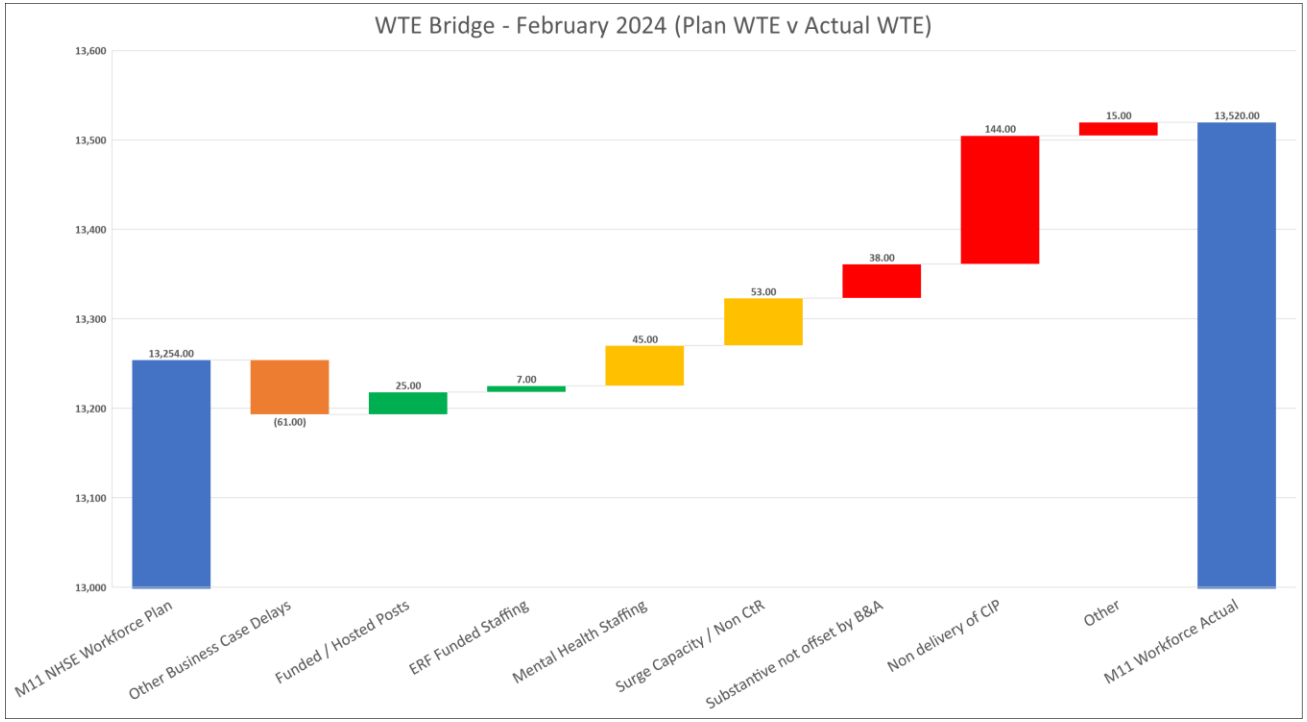
NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of February 2024
Forecasting for Bank and Agency based on expected requirements to deliver financial recovery plan

Workforce Position

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH



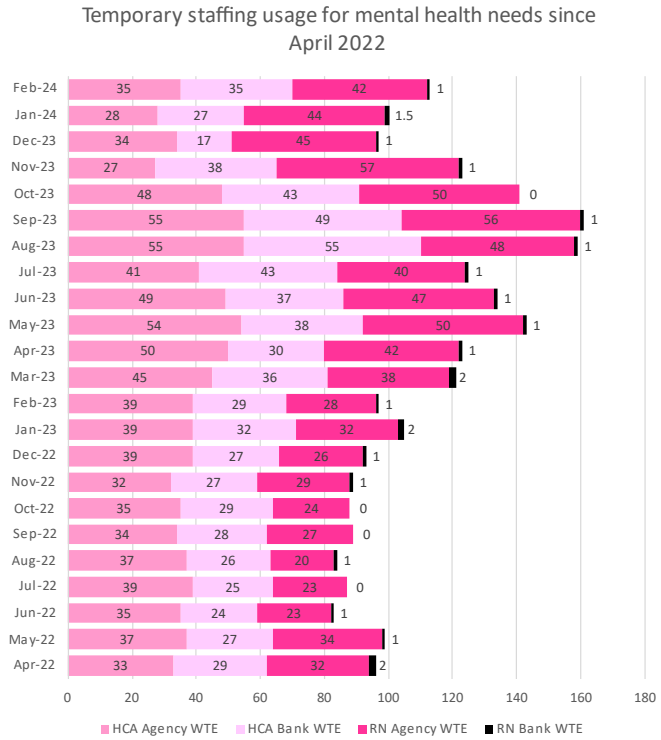
NB: Industrial Action impact is within WLI/Overtime/Excess Hours which is excluded from the above

Workforce Position

NARRATIVE | WTE GRAPHS | WTE WATERFALL | MENTAL HEALTH

Mental Health narrative:

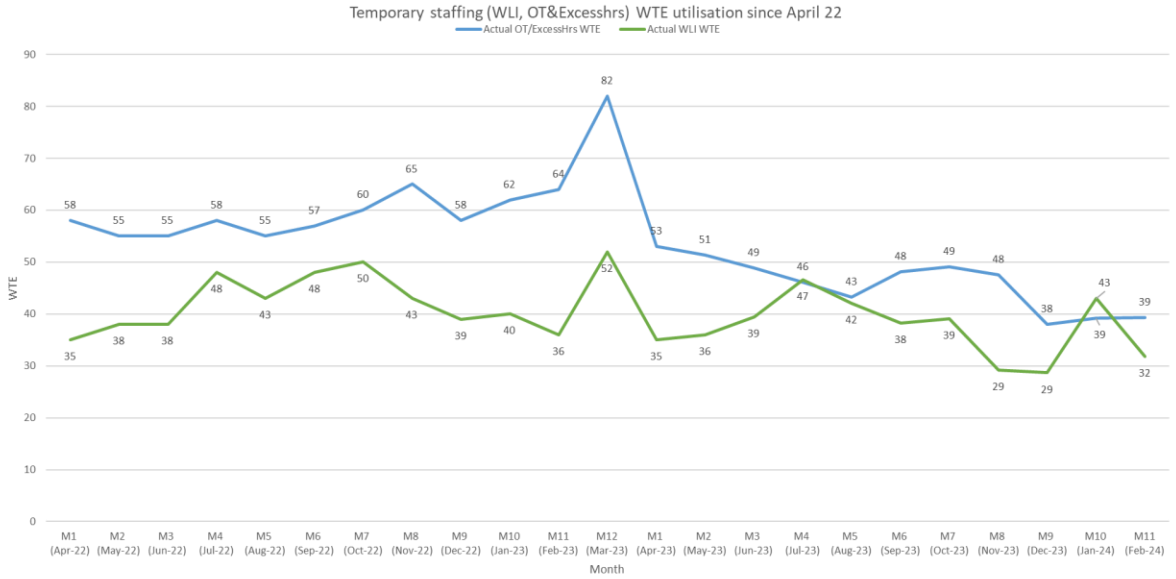
- Mental Health (February 2024):
  - Total of 113 WTE of temporary resources required for MH needs (nursing and HCAs).
  - 43 WTE were MH Registered Nursing, (42 were agency).
  - 70 WTE HCAs (35 agency & 35 bank).
- Mental health workers are being actively migrated to bank by NHSP.
- Temporary Resourcing team are exploring MH training with NHSP for all workers.



People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

WLI Movement	M11 – M12	M12 – M1	M1 – M2	M2 – M3	M3 - M4	M4 – M5	M5 – M6	M6 – M7	M7 – M8	M8 – M9	M9 – M10	M10 – M11	M11 – M10 Total
	16	-17	1	3	7	-4	-4	1	-10	-1	14	-11	**-4**



WLI and OT/Excess hours all increased this month following record lows (since April 2022) in December.

WLI dropped down by 11 to 32 after a substantial increase of 14 WTE last month. OT/Excess hours stayed at same level at 39 WTE.

OT/Excess Hours and WLI all saw peaks in March 2023.

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

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

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

	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	YTD Growth	Sparkline Trend
Add Prof Scientific and Technic	379	383	381	380	386	393	402	404	403	402	401		24	
Additional Clinical Services	2106	2113	2118	2129	2124	2153	2143	2143	2146	2158	2152		57	
Administrative and Clerical	2256	2271	2284	2287	2282	2295	2298	2321	2328	2317	2304		52	
Allied Health Professionals	682	673	681	690	691	699	703	702	698	698	700		28	
Estates and Ancillary	383	381	385	386	380	380	382	382	385	382	380		-3	
Healthcare Scientists	486	484	486	491	494	493	490	496	493	497	497		10	
Medical and Dental	2087	2074	2065	2061	2109	2120	2134	2145	2137	2161	2183		104	
Nursing and Midwifery Registered	3850	3910	3912	3908	3935	3987	4009	4072	4086	4069	4060		195	
Students (Apprentices)	43	43	43	43	43	43	54	53	53	53	58		14	
Grand Total	**12273**	**12332**	**12354**	**12375**	**12444**	**12565**	**12616**	**12719**	**12731**	**12737**	**12734**		**482**	

Substantive increase is due to improved vacancy fill and new approved business cases. Students increase is due to new courses starting.

Source: ESR substantive staff as of February 2024; includes consultant APAs and junior doctors' extra rostered hours, excludes Wessex AHSN, UEL and WPL. Numbers relate to WTE, not headcount.

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TRUST-WIDE TURNOVER (February 2024)

Staffing group	Leavers (WTE) in month	Turnover 12m rolling %
Add Prof Scientific and Technic	0.5	8.2%
Additional Clinical Services	16.5	16.7%
Administrative and Clerical	21.4	12.8%
Allied Health Professionals	4.6	11.0%
Estates and Ancillary	3.4	11.7%
Healthcare Scientists	0.0	9.7%
Medical and Dental	0.0	5.0%
Nursing and Midwifery Registered	16.7	8.5%
UHS total	**63.1**	**11.0%**

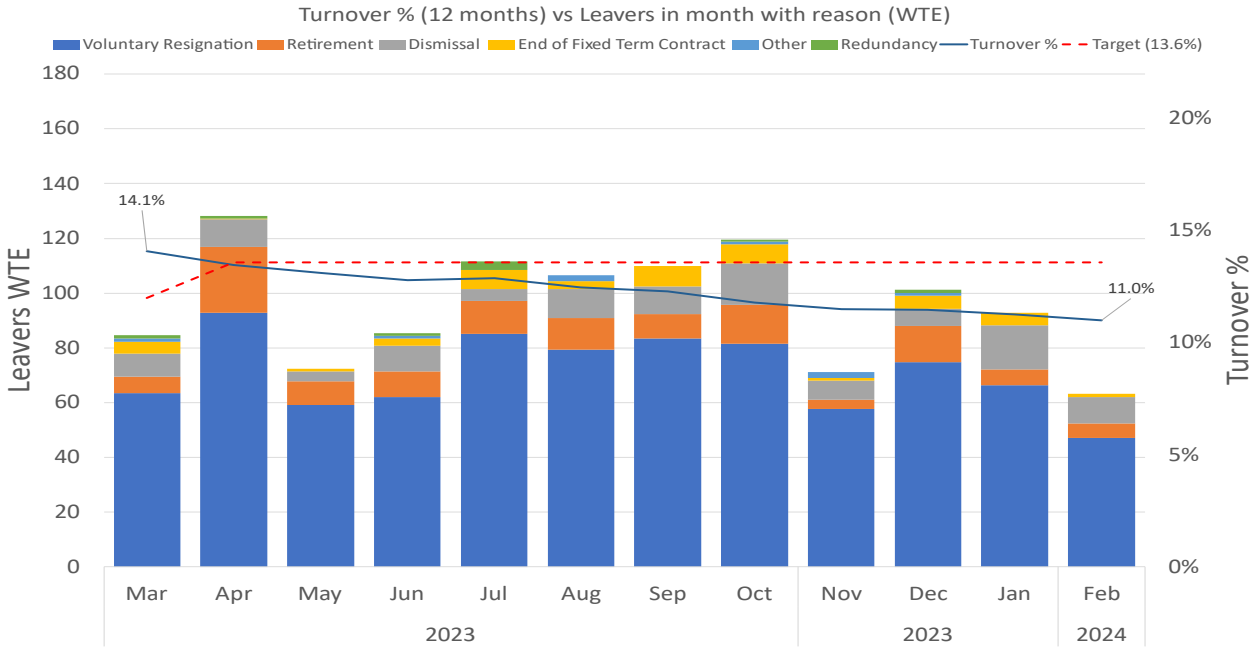
Source: ESR leavers February 2024 (excludes junior doctors)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY LEAVING REASON

In February 2024, a total of 63.1 WTE employees left the organisation. This is fewer than the monthly leavers during the last 12 months. Most of the leavers were voluntary resignations, accounting for 47.1 WTE (75%) of all leavers. Retirement accounted for 5.4 WTE (9%), while dismissal and end of a fixed term accounted for 9.6 (15%) and 1.0 WTE (2%) respectively.



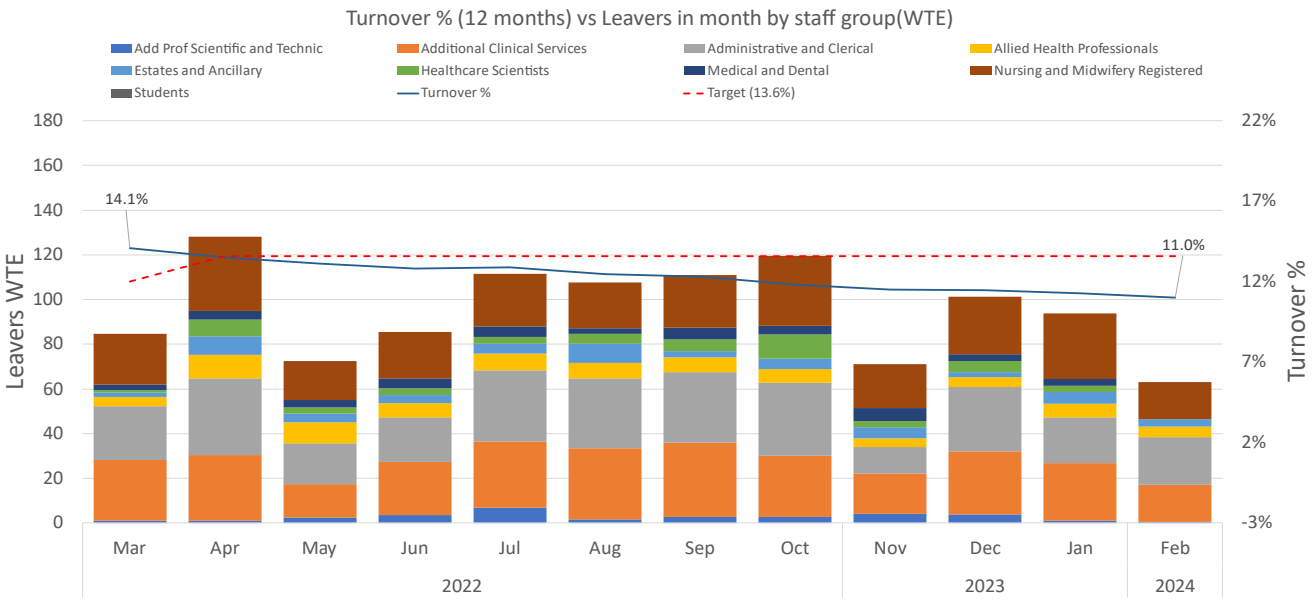
Source: ESR Leavers Report

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

TURNOVER BY STAFF GROUP

. Turnover (12 month rolling average) has been on a downtrend since March 2023, and is currently at 11.0% keeping the Truststurnover below the 23/24 target of <13.6%; in February 2024 there were 63.1 WTE leavers, which is 30.7 WTE lower than January 2024. It is important to note that the Trusts Turnover has reduced by -3.1% from Mar 2023 figures of 14.1%.



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

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

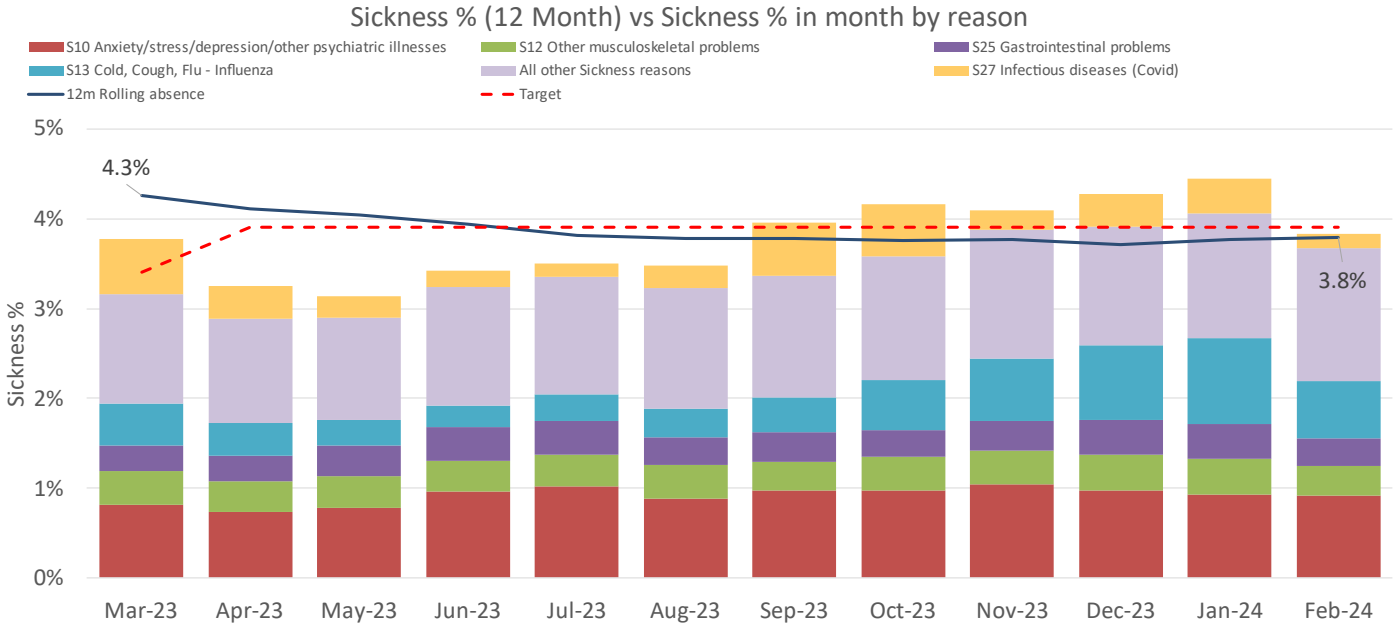
Source: ESR – Leavers Turnover WTE, HRBPs

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

SICKNESS

The current rolling sickness rate as of February 2024 is 3.8%, below the sickness target for 23/24 <3.9%. In-month sickness for February is 3.8%. The rolling sickness rate for February 2024 is lower than March 2023 figure (4.3%). Covid prevalence has decreased over the last 12 months.



Source: ESR – Sickness data

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

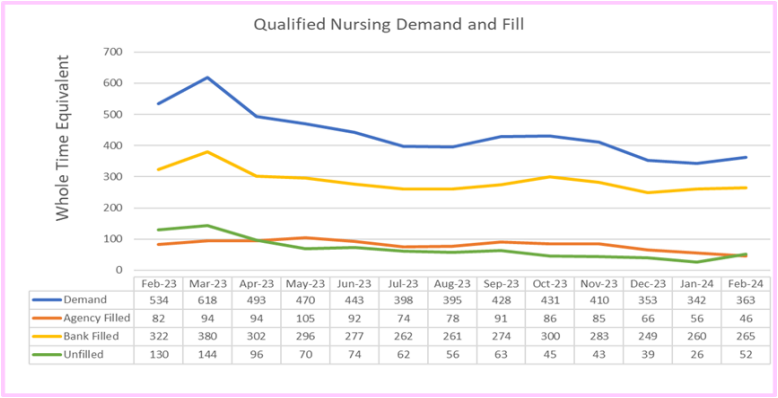
TEMPORARY RESOURCING

Status

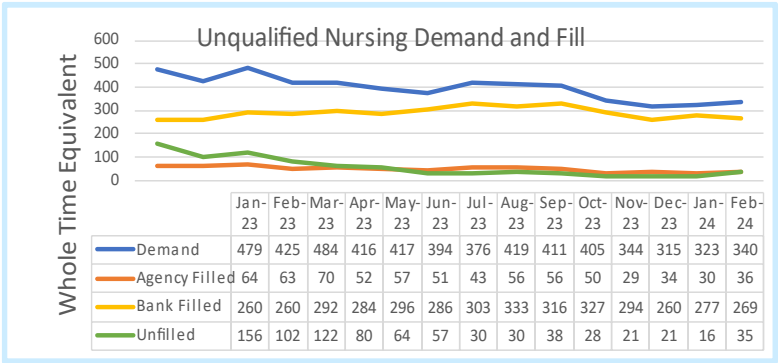
- **Qualified nursing demand/fill (WTE):** Demand increased from 342 in January to 363 in February, of which, bank filled 265 (up 5 on last month), agency filled 46 (down 10 on prior month) and 52 remained unfilled (up 26 on prior month).
- Bank fill for qualified nursing decreased from 76.0% in January to 73.1% in February.
- Demand for February is 171 WTE lower than February 2023.
- HCA demand/fill (WTE): Demand increased from 323 in January to 340 in February, of which, bank filled 269, agency filled 36 WTE (36 WTE were MH HCAs) and 35 remained unfilled.
- Bank fill for HCA decreased from 85.9% in January 79.3% in February.
- Demand for HCAs is 85 WTE lower than in February 2023.

Actions

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



	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Demand	534	618	493	470	443	398	395	428	431	410	353	342	363
Agency Filled	82	94	94	105	92	74	78	91	86	85	66	56	46
Bank Filled	322	380	302	296	277	262	261	274	300	283	249	260	265
Unfilled	130	144	96	70	74	62	56	63	45	43	39	26	52

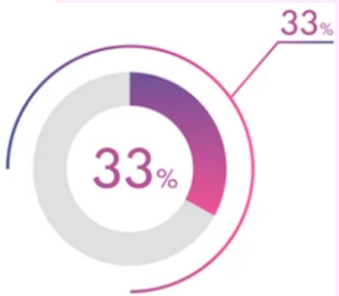


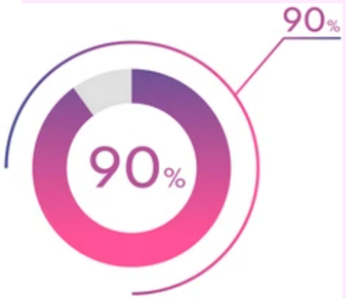
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Demand	479	425	484	416	417	394	376	419	411	405	344	315	323	340
Agency Filled	64	63	70	52	57	51	43	56	56	50	29	34	30	36
Bank Filled	260	260	292	284	296	286	303	333	316	327	294	260	277	269
Unfilled	156	102	122	80	64	57	30	30	38	28	21	21	16	35

Source: NHSP February 2024

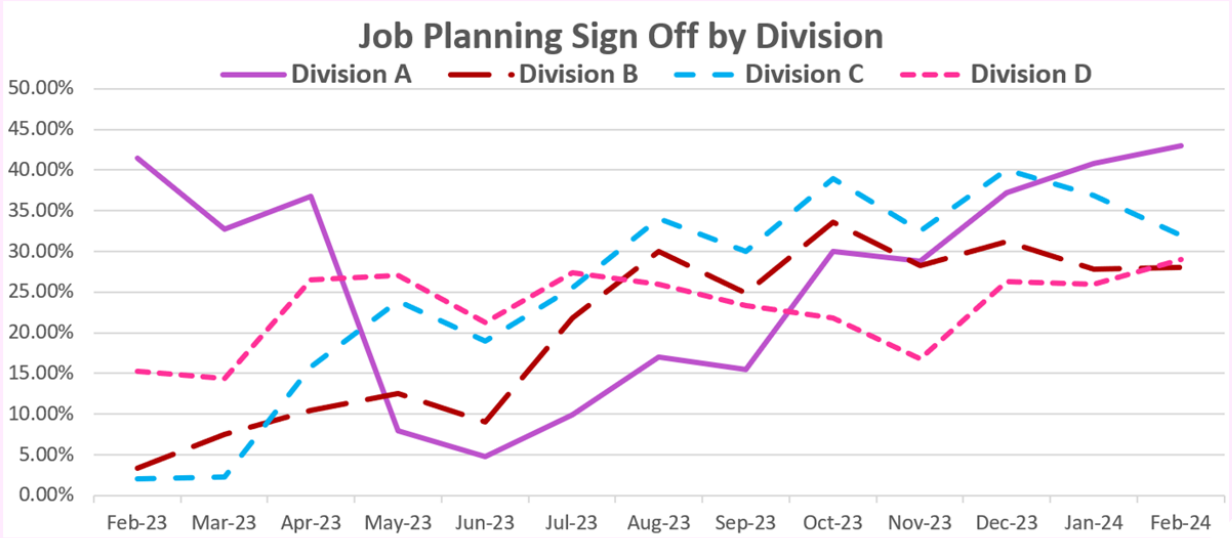
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





- Job planning sign off levels steady at 33%
- Active Job Plans steady at 90%
- Job Planning VLE Training for Clinical Leads
- Investigating On Call Supplement variations
- 30 Seconds of Job Planning News – Review of Job Planning Cycle.

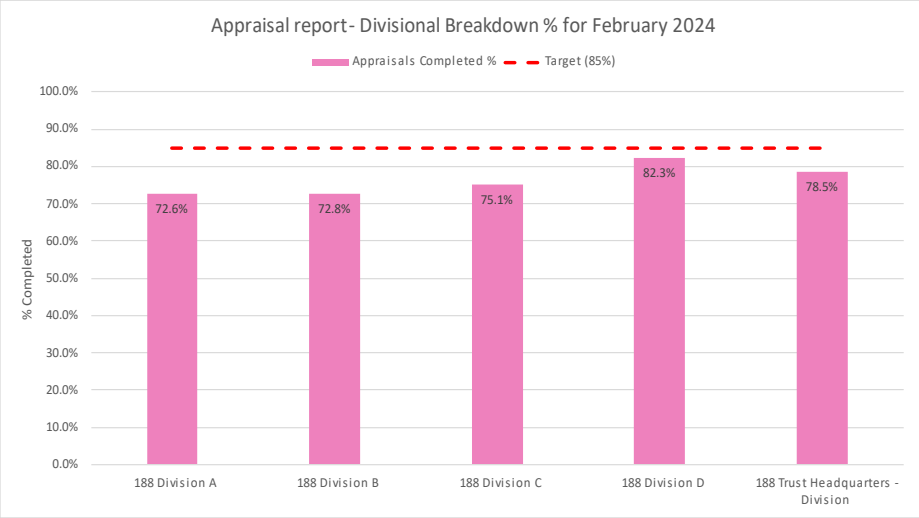


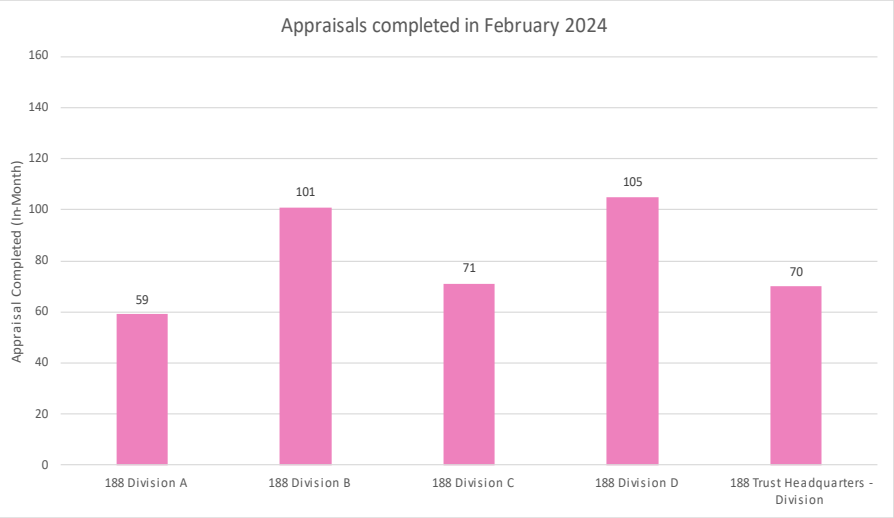
People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

APPRAISALS

A total of **406** appraisals **(75.9%)** were completed in M11 (February 2024).
Phase 2 of the 'Appraisal Improvement Project' has started. This involves the development of the digital appraisal using new 'Talent' functionality on the VLE. Goal implementation: April 2024





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

People Report

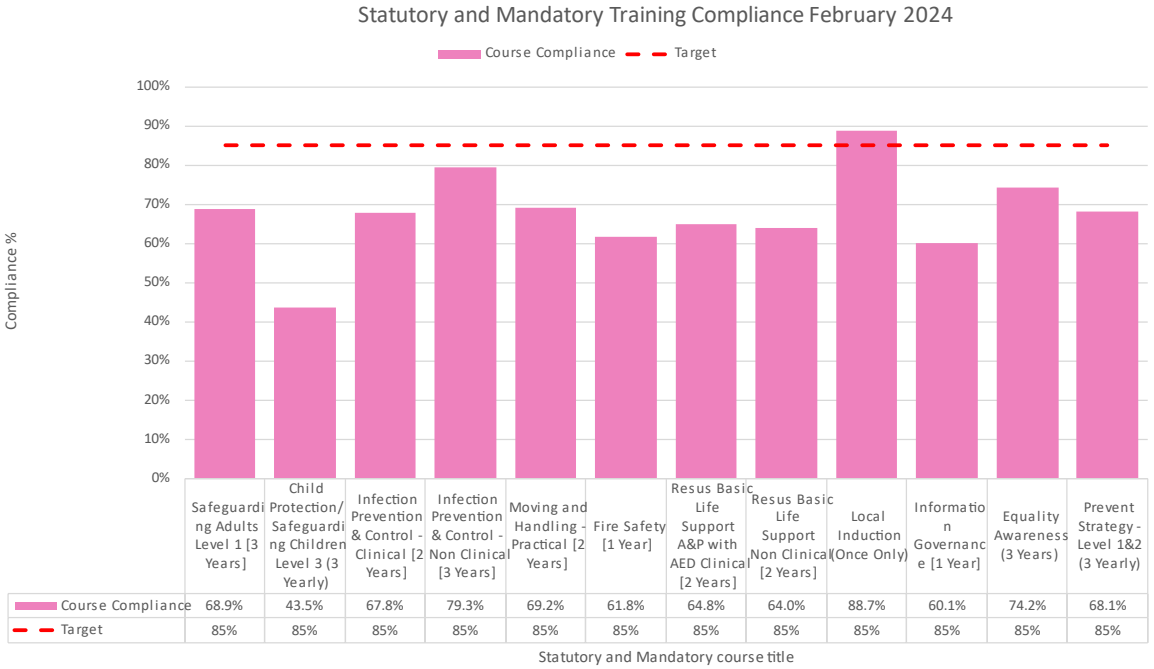
THRIVE | EXCEL | BELONG | PATIENT SAFETY

Statutory and Mandatory Training

Revised VLE launched late November 2023

Recommendations were accepted to change Stat & Mand matrix to just be statutory (legal) and mandatory (core skills training)

Free 'Totara digital accessibility' add-on in testing



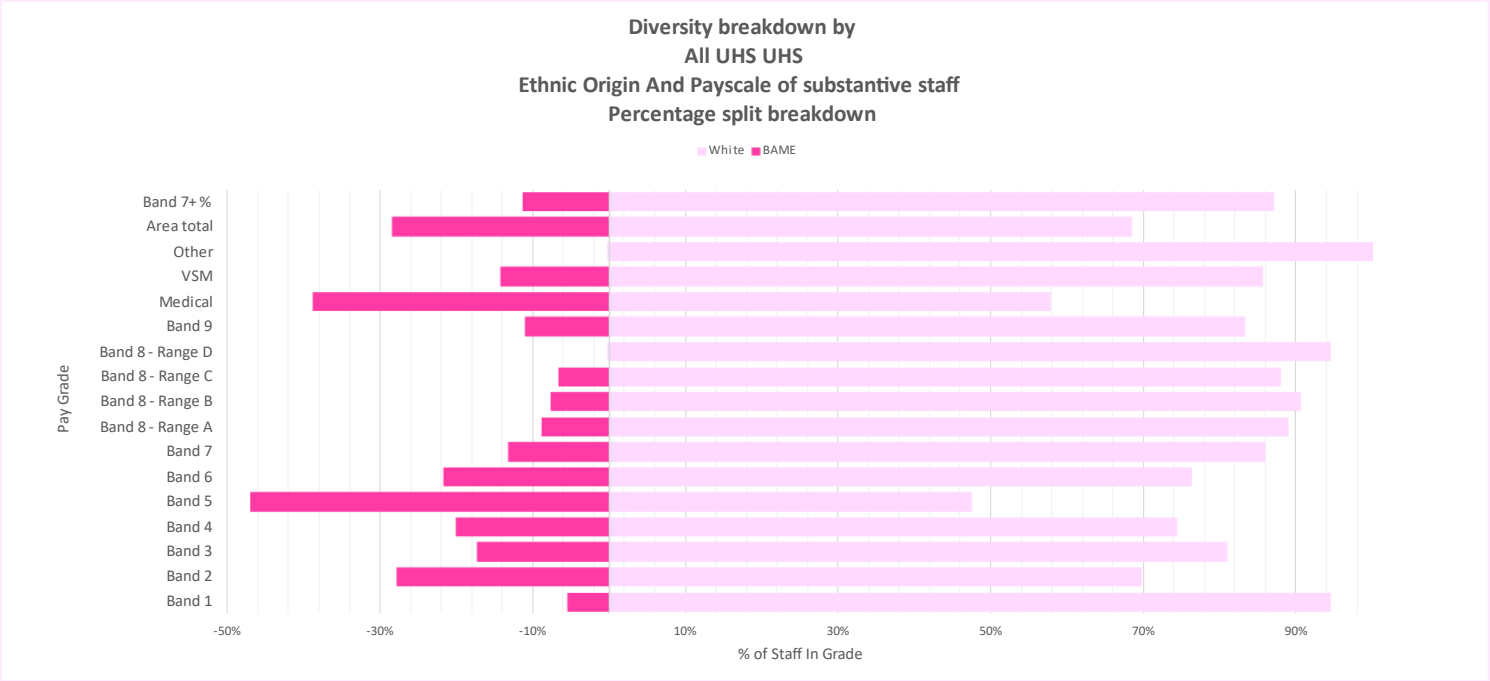
	Safeguarding Adults Level 1 [3 Years]	Child Protection/ Safeguarding Children Level 3 (3 Yearly)	Infection Prevention & Control - Clinical [2 Years]	Infection Prevention & Control - Non Clinical [3 Years]	Moving and Handling - Practical [2 Years]	Fire Safety [1 Year]	Resus Basic Life Support A&P with AED Clinical [2 Years]	Resus Basic Life Support Non Clinical [2 Years]	Local Induction (Once Only)	Information Governance [1 Year]	Equality Awareness (3 Years)	Prevent Strategy - Level 1&2 (3 Yearly)
Course Compliance	68.9%	43.5%	67.8%	79.3%	69.2%	61.8%	64.8%	64.0%	88.7%	60.1%	74.2%	68.1%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Virtual Learning Environment (VLE)

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

STAFF IN POST – ETHNICITY

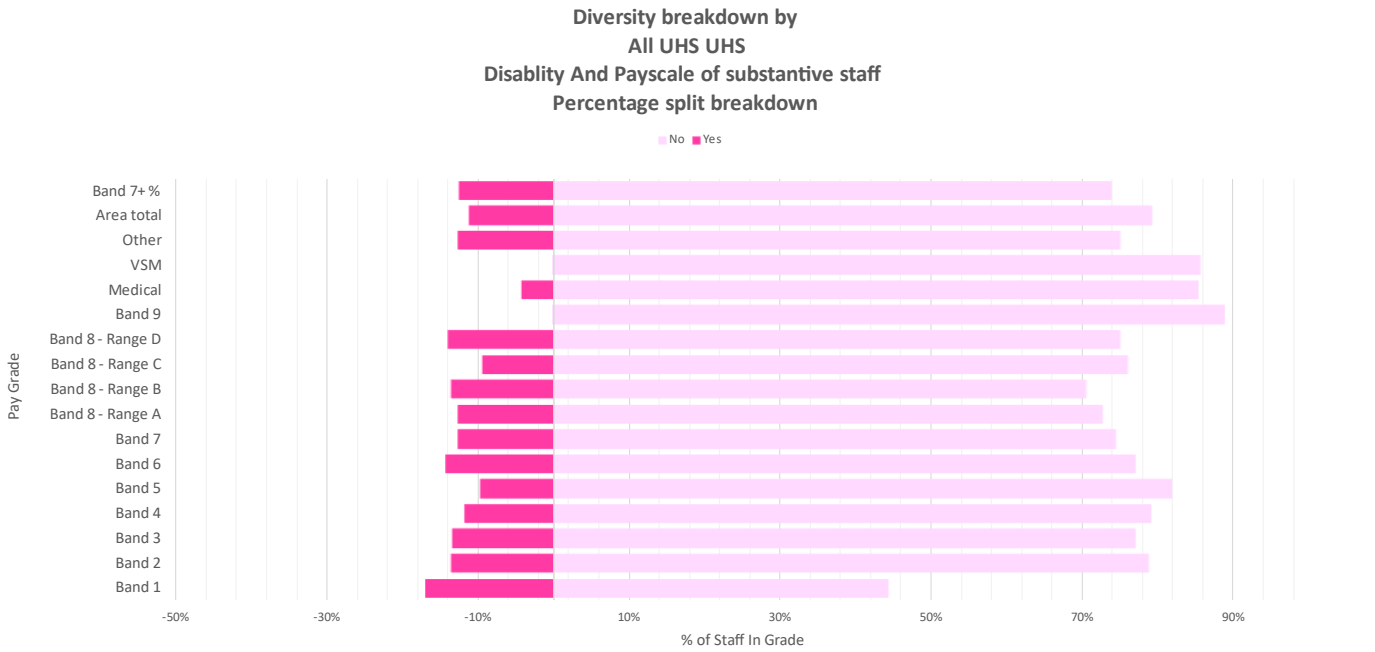


Source: ESR – February 2024

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY

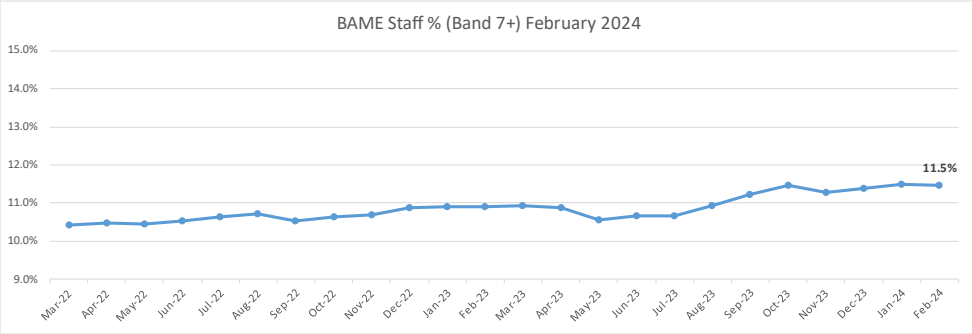
STAFF IN POST – DISABILITY STATUS

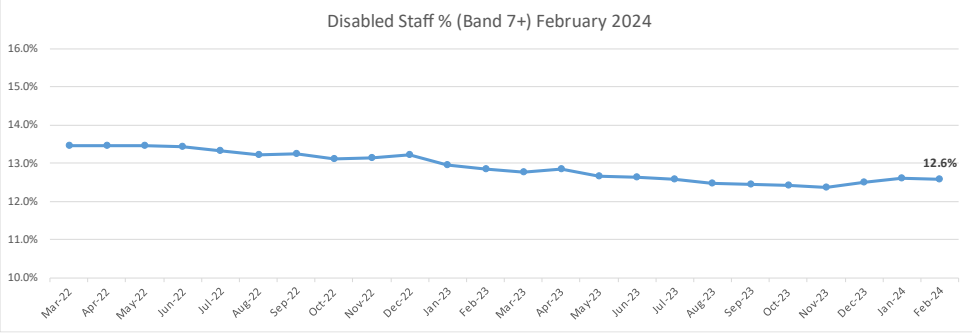


Source: ESR - February 2024

People Report

THRIVE | EXCEL | BELONG | PATIENT SAFETY





STAFF IN POST – ETHNICITY and DISABILITY

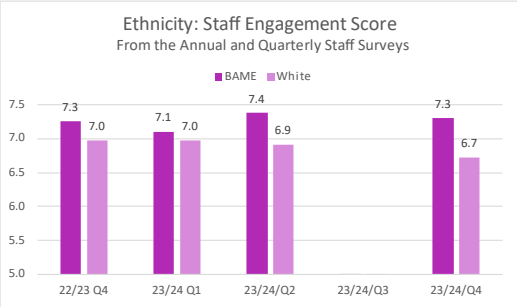
- Work continues under the themes of the Inclusion and Belonging Strategy with some work priorities deferred to April
- Nursing Positive Action Programme with Florence Nightingale Foundation has completed, with the final presentations and celebration on 5 December. Twenty-three people completed the programme and are now moving onto the career support phase
- Following the results of the 2023 Workforce Disability Equality Standard (WDES) at UHS which showed that disparity levels between those with disability and those without at UHS have increased, an action plan has been agreed to specifically focus on improving experiences of disabled colleagues
- -0.03 percentage point decrease for B7+ BAME staff from M10 to M11.
- -0.02 percentage point decrease for B7+ Disabled staff from M10 to M11.

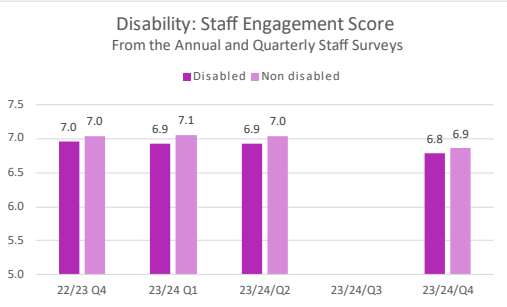
Source: ESR

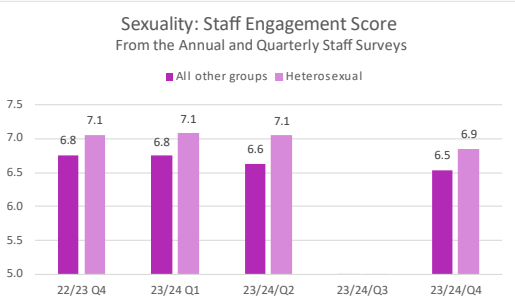
People Report

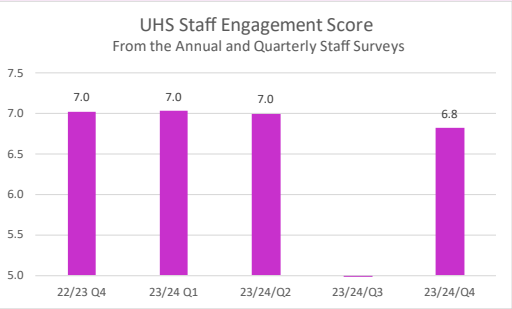
THRIVE | EXCEL | BELONG | PATIENT SAFETY

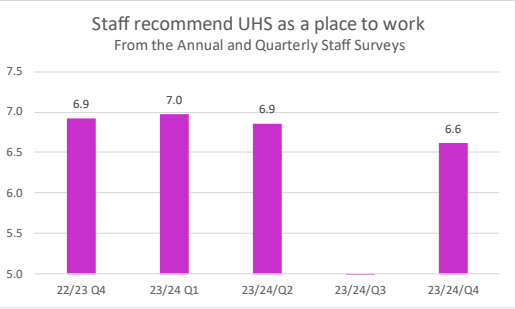
Pulse Survey – Q2 2023/24











The Staff Survey results were embargoed until 7 March 2024 and will be featured in next month's report

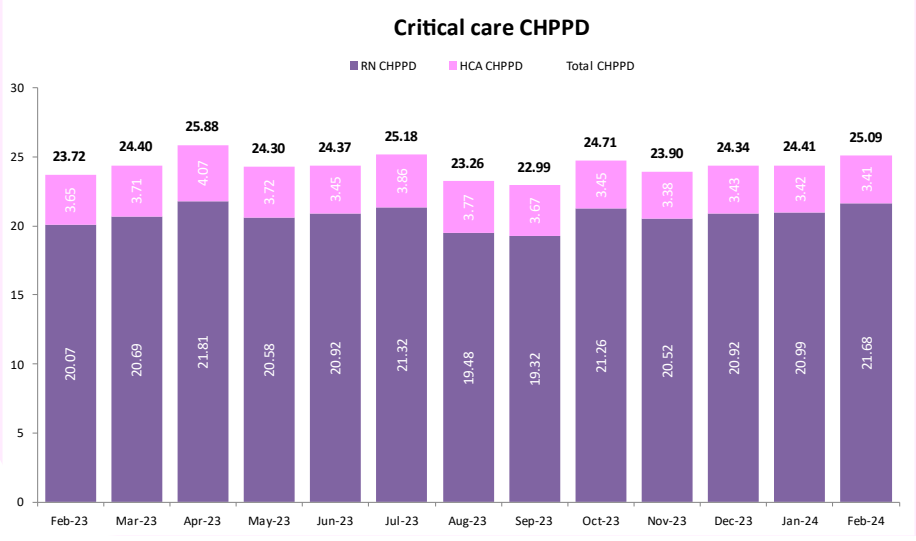
Source: Picker (Qualtrics)

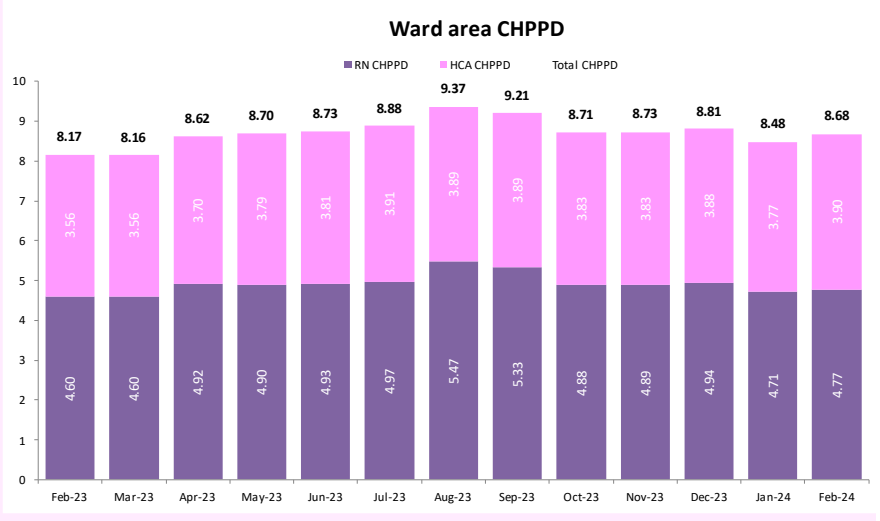
People Report

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

CARE HOURS PER PATIENT DAY
February 2024

The Ward areas total CHPPD rate in the Trust increased by 2.0 from last month to 8.68 from 8.48. RN increased from 4.7 to 4.8. HCA increased from 3.8 to 3.9.





The CHPPD rate in Critical care increased overall from last month. RN 21.7 (previously 21), HCA remained in the 3.4 region and overall, 25.1 (previously 24.4). Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require.

Source: HealthRoster & eCamis

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)	Exclusions: Honorary contracts; Career breaks; Secondments; UPL; UEL; WPL; Wessex AHSN
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	Exclusions: UPL; UEL; WPL; Wessex AHSN
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

Report to the Trust Board of Directors				
Title:	**Staff Survey Results 2023**			
Agenda item:	**4.12**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Ceri Connor, Director of Organisational Development and Inclusion**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance** **x**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	1. To review the feedback and experiences of our staff in the 2023 national NHS Staff Survey and compare against national averages for comparable NHS Trusts. 2. To review results in relation to progress of the UHS People Strategy 2022-26, and wider UHS strategies. 3. To consider the challenges in the healthcare environment, the impact on staff experience, retention, and patient care, identify risks and potential mitigations. 4. Summarise the main action to take forward into people objectives for 2024/25			
Response to the issue:	The NHS staff survey is the only consistent sector wide tool available to help us to canvas the views and experiences of all our staff on an annual basis, which is then benchmarked nationally, and results can be tracked over time. The staff survey is the main indicator to inform regulators, national bodies, stakeholders, partners, staff and patients on our culture and what it feels like to work at UHS. The annual survey is supported by a shorter quarterly pulse survey. We report our results annually and a process is embedded to share results with staff, and then engage them in local improvements. Trust wide, we analyse results and reflect the themes against the progress and actions of the UHS People Strategy 22-26 and other UHS strategies. Conclusions and recommendations will be made in terms of the 2023 results and trends over time in relation to the UHS culture, risks and actions required in terms of the People Strategy ambitions and the Corporate Objectives for 24/25.			

Implications: (Clinical, Organisational, Governance, Legal?)	The following implications should be noted: • **Culture:** Actions to continually improve UHS survey results align to the three elements of the People Strategy; *Thrive, Excel and Belong* and is a central part of the UHS 5 Year Strategy. Feedback relating to staff experience, sentiment and advocacy forms a critical part of delivery plans to strengthen organisational culture. • **CQC:** The annual staff survey and specifically the engagement score is a leading indicator of staff satisfaction and engagement with the CQC and will be used as evidence in terms of the Well Led domain. Organisations who are rated Outstanding have evidenced continual improvements in staff survey results and are rated "the best" in their benchmark groups. • **Organisational:** The staff survey actions are aligned to the programmes of work underpinning the UHS People Strategy and underpin the NHS People Strategy.
Risks: (Top 3) of carrying out the change / or not:	BAF risk 3b) We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Receive the 2023 survey results. • Consider results overall in relation to progress against the People Strategy. .

Executive Summary

It has been an exceptionally challenging year for UHS and this has been reflected in our staff survey results. Significant financial pressure, coupled with ongoing operational demands, and strike action, have undoubtedly affected results and left the Trust with a mixed picture.

The survey itself measures against the 8 themes within the NHS People Promise and is a key strategic tool for UHS to measure progress against the delivery of its People Strategy.

Overall, the NHS has seen a rise in average scores, albeit from a low position in the acute Trust category. UHS's relative position to its peers has deteriorated as a result.

Things to celebrate in our scores

Overall, despite the significant challenges, UHS remains above average across all people promise themes within the survey. UHS also still remains in the top quartile of similar organisation for recommendation as a place to work and for staff engagement.

During this year a number of programmes have been completed which have positively contributed to the staff survey results.

- Our score for line manager support has increased, emphasising the importance of these roles in the everyday experience of our people. This has been driven by successful development programmes under the Leadership and Management framework.
- We have seen improvements in our overall scores in access to well-being support linked to our Wellbeing Plan, and the increase in staff facilities (Wellbeing hub, Roof garden, staff rooms).
- Flexible working opportunities remains a strong area for UHS, which has been supported by our agile work programme and work through the recruitment and retention group.
- Effectiveness of appraisal has continued to improve driven by the new appraisal process roll out and training.

Areas of challenge

There are areas of challenge and concern in the survey this year. It requires our collective consideration to understand and act on how we can mitigate and stop further deterioration in these areas:

- Participation rate significantly fell this year to 41% (5556 staff) and was below the national average for acute Trusts for the first time.
- Our staff engagement (a composite of advocacy, morale, and involvement) fell this year from 7.1 to 7.0. The national average rose to 6.9.
- Advocacy for UHS has fallen. Staff recommending UHS as a place to work has fallen to 67.5%. Staff recommending UHS as a place to be treated has fallen to 76%. Our Q4 pulse results have also shown a further indicative drop in these markers.
- Since 2021 there has been a 6% decline in my organisation acts on concerns from patients, and a 5% decline in feeling safe to speak up about anything that concerns me. There has also been a 7% decline in confidence that the organisation would address my concerns.
- Burnout has increased at UHS with more staff reporting this during 2023.
- Whilst still better that the national average, bullying scores from line managers and colleagues have deteriorated by 2%.

Next steps

We face a hugely challenging 2024/25, with continued financial constraints limiting investment, resources, and our ability to expand the workforce. The People Strategy at UHS still remains an aspiration we all should believe in; however, we need to pay attention to our current results and the temperature at UHS.

Our next steps for this year should focus on things we can address within the current climate and then relentlessly pursue these.

The Corporate response to the Staff Survey will be finalised in the objectives for Year 3 of the People Strategy through People Board and TEC in April. This will build also on the conversation held at People Board in February, and then at TEC in March.

Key areas are likely to cover:

- Focusing on the issues affecting current morale, including empowerment and the voice of our people. This should be linked to continuing to cultivate an improvement culture in the Trust as part of our Transformation programme.

- Listening with intent to our people. Enhancing leadership visibility, corporate engagement and making practical tangible changes where we can do this. This is particularly important for middle management roles in the Trust.

- Continue to develop and support line managers, who make a critical difference to local experience.

- Continue to embed the recommendations from the review into Employee Relations process and Freedom to Speak up following the review commissioned regarding bullying concerns raised on social media in 2023.

- Focusing on the areas of the Trust locally we are most concerned about and taking targeted action. Supporting our Divisional teams with corporate resources to make meaningful change to areas of concern.

- Continuing to dial up our mechanisms to celebrate the success of our people, recognising and rewarding those delivering in line with our values.

- Implementing year 2 of our Belonging Strategy, including implementing the recommendations of the recruitment review, completing the role out of the Allyship programme, supporting teams to understand their team purpose, objectives, and team development planning. Implementing the outputs from our inclusive recruitment group, continuing the development of our leaders to have an inclusive ethos, as well as intentional support to ensure our leaders are diversely represented at a senior level.

Once the Objectives have been agreed for 24/25, including the corporate actions to be taken forward, these will be monitored through People Board and through People and OD committee.

1. Introduction and purpose

1.1 The National NHS staff survey annually measures the satisfaction of employees across all parts of the NHS. It is a critical source of information that UHS can use to measure our employee experience and importantly to measure our progress against our UHS People Strategy. It is a key source of information that drives our annual objectives for People at UHS.

1.2 This paper sets out the details of our national staff survey results for 2023. In addition the report considers the indicators which have declined, and the connected trends over time which provides a critical picture of the culture at UHS, what it feels like for our staff to work here. Also, the risks related to the delivery of our People Strategy 22-26 and other related strategies, and the potential risks to retention, recruitment and patient care.

2. Context

2.1 We must celebrate where we have done well and be proud of what we are achieving. However, this year, more than ever, we need to pay appropriate attention to where we have declined, particularly where this has happened over several years.

2.2 It is also important to be mindful that the staff survey is just one tool, and we must balance the results with what we know to be true from staff on the ground, data, other feedback and evidence.

2.3 This report will provide a summary of the 2023 survey results but also provide a specific focus on how trends across the last two to three survey years, can provide a vital picture of staff experience, indications of our culture, and, in turn, the impact on patient care. This evidence is an important piece of the jigsaw to inform decision making as part of the development of corporate objectives and organisational priorities for 24/25, given the landscape we are operating in.

3. The 2023 Survey results

3.1 The National published Benchmark Report 2023 is available in full from the NHS Survey Centre here.

3.2 The 2023 results present a mixed picture; there are elements where improvements have been made and show that our work programmes within the UHS People Strategy are making year-on-year improvements.

4. Participation rates

4.1 Participation in the survey is considered as an indicator of engagement, particularly by regulators. 41% of those eligible participated in the survey in 2023, 5,556 people. This was a drop of 14% from 2022. This is the first time in 4 years we have seen a significant drop.

4.2 There are many contributing factors to this; due to financial constraints we did not offer coffee vouchers as an incentive as per previous years. Staff reported that due to time constraints they did not have the time to complete the survey in work time, and access to UHS emails was reported as another barrier. Many clinical staff told us they access emails purely to process clinical actions, and often use shared computer stations preventing easy access to the unique personal survey email.

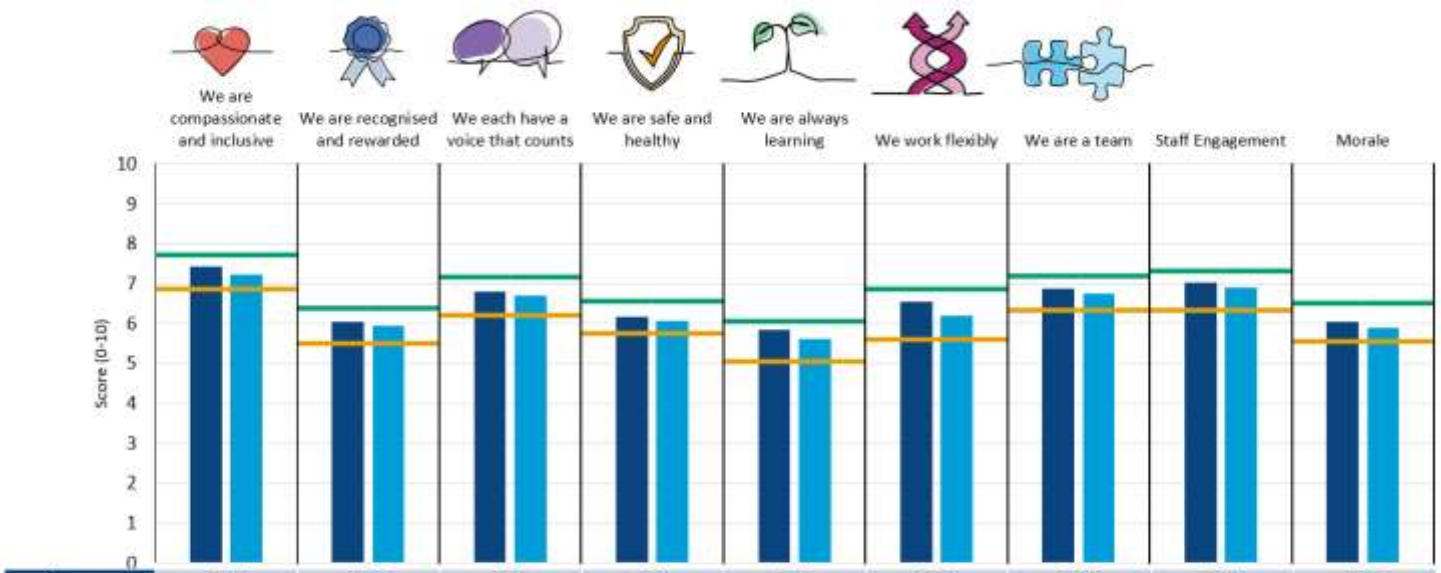
4.3 The drop in participation was still evident despite significant work to provide laptops in clinical areas, and drop-ins where staff could access a laptop and get support to access emails.

4.4 Participation by professional group is an important indicator. Participation rates is seen in Appendix 1, including the changes in participation by professional group 2022-2023. It shows a decline in clinical participation in 2023 which is likely to have impacted on the overall results.

5. People Promise Performance

5.1 In terms of the **NHS People Promise themes**, where organisational results are grouped under each theme, and are compared to the "Best, Average, Worst" where available, we have maintained our "above average" position across all themes, Fig 1.

Figure 1 – 2023 Scores by People Promise themes



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.43	6.04	6.81	6.16	5.85	6.54	6.88	7.03	6.05
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	5549	5538	5504	5516	5204	5521	5543	5552	5552

5.2 In 2022 we reported we were "significantly above average" on several indicators, this gap has narrowed in 2023 as the national average score increased across all themes. UHS have declined slightly on 4 themes; Compassionate and Inclusive, Voice that Counts, We are a Team, Staff Engagement and Morale. We have remained the same on four themes; Rewarded and Recognised, Healthy and Safe, Always Learning, and Morale. We have improved on one theme; Working Flexibly. This has impacted on our national rankings.

5.3 For **Recommendation as a place to work** we now rank 22nd out of 122 trusts, compared to 7th in 2022. For our **Engagement score** (combination of the advocacy, morale and involvement scores) we now rank 26th out of 122 Trusts.

5.4 It Is important to benchmark our results against others in our category. However, we must be mindful that not all Trusts are comparable in size and complexity. Nevertheless, our 2022 rankings compared to 2023, shows we improved our ranking on **14 questions**, declined our ranking on **82,** and **remained the same** on **3, out of 99 questions**. Fig 2 below shows the question and the number of ranked places we have dropped nationally (red) or number of ranked places we have improved (green):

5.5 Our Staff Engagement score is now 7.0 against a national average of 6.9. Fig 2. shows the UHS score since 2018 compared to the best, worst and average in our category.

Fig 2. Staff Engagement Score 2018-2023

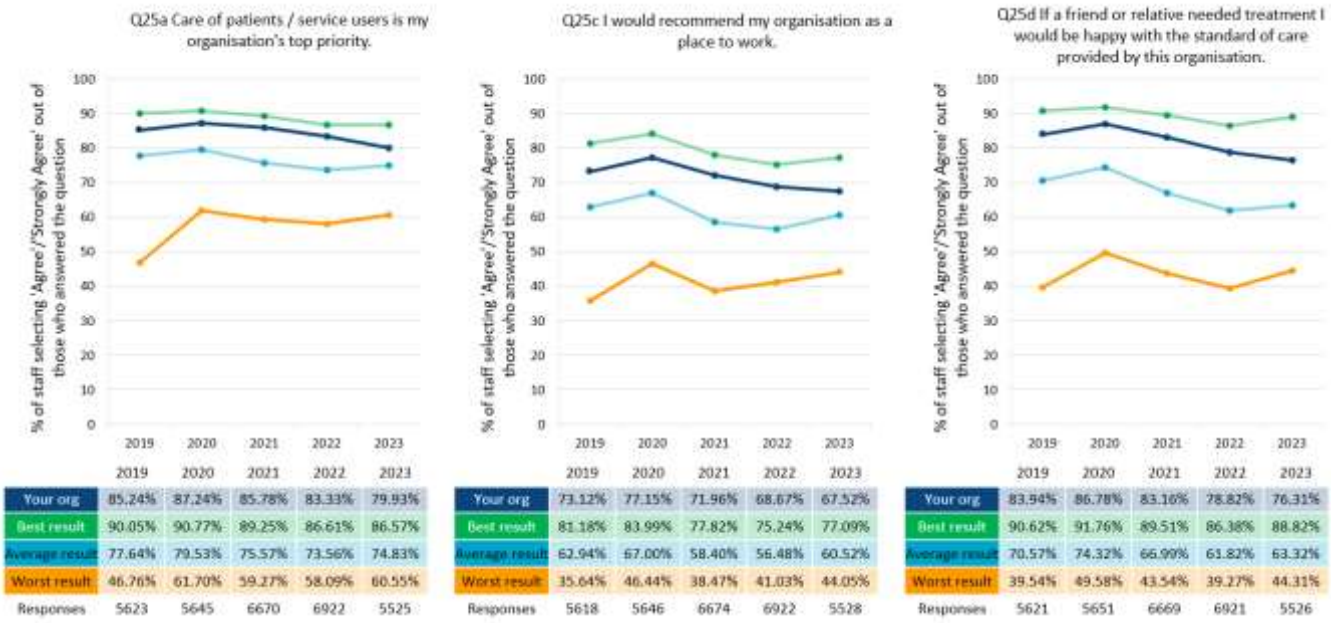
5.6 The **engagement score** is a combination of the motivation, involvement and advocacy scores.

5.7 All the advocacy scores have continued to see a year on year decline since 2021**.**

- **Recommend UHS as a place to work** is now 68%, this indicator has seen a 4% decline since 2021 and a total decline of 9% since 2020.
- **Care of the patient is my organisations top priority** is now 79%, a decline of 6% since 2021.
- **If a patient or relative needed treatment, I would be happy with the standard of care provided** is now at 76%, a decline of 7% since 2021.

5.8 UHS has seen a greater decline in results since 2021 than the best and average on the three advocacy questions, as detailed in Fig 3.

Fig. 3 – Advocacy scores comparison 2019-2023



	2019	2020	2021	2022	2023
Your org	85.24%	87.24%	85.78%	83.33%	79.93%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	5623	5645	6670	6922	5525

	2019	2020	2021	2022	2023
Your org	73.12%	77.15%	71.96%	68.67%	67.52%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	5618	5646	6674	6922	5528

	2019	2020	2021	2022	2023
Your org	83.94%	86.78%	83.16%	78.82%	76.31%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	63.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	5621	5651	6669	6921	5526

5.9 **Motivation scores**: A mixed set of results, some declines some improvements although all remain above the average. The number of people saying there are enough people to do my job has improved from 2022, although this is only **32% of staff.**

5.10 **Involvement scores:** These have remained mostly unchanged since 2021 and are still above the national average.

5.11 A breakdown of the staff engagement scores can be found in appendix 2.

5.12 We have seen improvements 2022 to 2023 on the areas where we have been focussing efforts against the People Strategy in relation to:

- Flexible working opportunities.
- Satisfaction with pay (although overall satisfaction remains low).
- Satisfaction with immediate managers, specifically in terms of managers caring about their staff, supporting staff during challenges, and listening to concerns.
- Increase in confidence to report bulling and harassment.
- Access to learning, development and careers.
- % of staff experiencing discrimination on the basis of ethnicity, sexual orientation, gender and disability.
- Appraisal helping people to have clear objectives, and helping people to do their job.
- Ensuring adjustments are made for people in the workplace.
- UHS taking positive action on health and wellbeing.

6 Inclusion, belonging, and civility

6.1 In April 2023 The Trust launched its inclusion and Belonging Strategy and in year 1 has delivered a planned range of interventions and actions to support this agenda.

6.2 Our results in relation to **inclusion and belonging** have not changed significantly in 2023, although it is accepted that some of the interventions on culture and behaviours may take longer to bed in.

6.3 We have sustained our above average position in relation to making workplace adjustments to enable people to carry out their work, at 81%. This is positive and we need to continue to focus on delivering this for those with long term illnesses and disabilities.

6.4 Sexual Safety has been a key subject in the NHS in 2023. There were two new questions in the survey this year relating to unwanted behaviour of a sexual nature. 9.11% of people said they had experienced at least one incident of unwanted sexual behaviour from patients, service users and members of the public. 4.08% said they had experienced the same from staff or colleagues. A group is continuing to focus on this, and sessions have been held with medical leaders following the publication of the Royal College of Surgery work on sex discrimination in UK practice. [1]

6.5 Staff at UHS are still experiencing violence at work, although experiences from members of the public, patients and service users **has improved by 3% from 15% to 12%.** Bullying, harassment and abuse at work from patients, service users and members of the public has **remained unchanged at around 25% of staff.** The UHS violence and aggression group maintain their focus on this issue, a in partnership with Hampshire Police.

6.6 Experience of bullying and harassment from **managers has increased slightly from 2022 by almost 2% to 9.56%,** against a national average of 10.49%. Bullying and harassment **from colleagues has also slightly increased by 2% to 18.68%.** Given the context of the working environment and factors described in this report, the decline in these indicators may be linked to behaviours seen under stress, resulting in less civility in daily interactions between staff. There is significant evidence to suggest that staff under high levels of stress and pressure are more likely to exhibit negative behaviours, and less likely to be kind and civil, this in turn impacts on inclusion, motivation, morale and performance.

6.7 The Trust has previously commissioned a review of employee relations processes and freedom to speak up. This followed concerns raised on social media about bullying. The review was broadly positive, and TEC has previously agreed to delivery of the actions identified as a result. We will continue to embed these actions, also ensuring that poor behaviour is addressed appropriately.

6.8 People are still experiencing discrimination, bullying, harassment, and abuse on the grounds of ethnicity, gender, disability, religion, age and sexual orientation. Discrimination on the grounds of ethnicity remains the highest, other protected characteristics are as follows:

- Ethnicity – 53.34 (slightly decreased from 2022)
- Gender – 21% (slightly increased from 2022)
- Age – 17% (2% improvement)
- Disability or long term illness – 10.80% (3% decline)
- Sexual orientation – 4.34 (remained the same)
- Religion – 3.64% (remained the same)
- Other – 21.67% (3% improvement).

[1] Sexual misconduct in surgery — Royal College of Surgeons (rcseng.ac.uk)

6.9 61% of staff feel UHS acts **fairly** in relation to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age, this remains generally unchanged from 2021.

6.10 71% of staff said they feel **valued** by their team, and 74% said their immediate manager values their work. 73% said they receive the **respect** they deserve from colleagues at work, 74% said the people they work with are **polite and treat each other with respect**. All these indicators are unchanged from 2022.

6.11 **25% of staff said they often think about leaving UHS**, 18% said they will be looking for a job in a new organisation in the next 12 months, and 12% said as soon as they find another job, they will leave UHS. All these indicators have improved from 2022.

6.12 The rate of actual leavers (turnover) at UHS has significantly decreased overall from 13.6% to 11.5% as at Feb 2024.

6.13 Working in an inclusive and civil culture is critical and is a key component of both the People Strategy and the Inclusion and Belonging Strategy. We need to continue collectively ensuring we are taking appropriate actions to tackle poor behaviour as it arises and also working with local teams where issues of incivility are identified.

6.14 The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are derived from many of the staff survey questions. Our results this year can be seen in appendix 8, with a three year trend comparison 2020 to 2023. The results show that there are some improvements and some declines. Some indicators improved during the Covid Pandemic but have now returned to pre Pandemic results.

6.15 In terms of race equality standards, some improvements in terms of opportunities for career development and experience of bullying, harassment and abuse from managers. Our Allyship programme and positive action programmes may have contributed to this.

6.16 For WDES, a decline in experiences of people with disability and long term illness has previously been identified as part of the full WDES results reported in October 2023. A series of actions were agreed and being implemented to address this decline. Progress is reported via Equality, Diversity and Inclusion Committee.

7 Local areas of concern

7.1 The staff survey continues to reinforce concern with some local care groups, particularly where staff experience has been consistently lower over a number of years**.**

7.2 Appendix 3 provides a rag rated breakdown of performance against the people promise themes by care group.

7.3 The areas of lowest staff engagement (compared to the UHS average) are set out below to identify the factors that are causing lower engagement and where additional support can be provided to make improvements.

Care Group/Area	Engagement score
Emergency Care	6.5
Estates	6.6
Pathology	6.7
Surgery	6.8
Theatres and Anaesthetics	6.8
Cancer Care	6.8
Neuro	6.8

8 Staff survey as a strategic indicator of culture at UHS

8.1 The staff survey can provide critical intelligence on themes within our culture. It is our people who are completing the survey, describing what it is like for them to work at UHS at a given moment in time.

8.2 It is right for us to celebrate where we have done well, and where efforts have seen a positive return in relation to staff experience. We must understand the characteristics of what has gone well and try to replicate that success more widely.

8.3 We know from extensive research both in and out of the NHS that those with highly engaged, motivated staff, who feel valued, involved, supported and have the tools to do the job to the best of their ability, will bring about high performance. In NHS organisations, this impacts on high levels of patient satisfaction and high levels of safety.

8.4 This report details the results Trust wide, which tells one picture when results are aggregated, but when analysis is undertaken at locality levels, the picture can be very different and, in some places, quite concerning for the wellbeing of our staff.

8.5 The survey results are a critical indicator to inform us about how our people are feeling and their ability to perform in their roles. Not all indicators are declining but there are key strategic indicators of culture within the survey results, where declines have been seen over recent years. This, coupled with the gap narrowing between UHS and national average, there is a risk if results continue on this trajectory that this could lead to more a significant impact on organisational performance and patient care. The general themes in the staff survey correlate to the other feedback being received via staff partnership forum, via team development sessions, listening sessions, and recent reviews from external bodies.

8.6 Using an evidence based framework to help us view the survey results as a strategic tool, can help us take a holistic look. The illustration in Fig 4 uses the ***Components of Motivation Theory***[2] to show how separate elements of motivation: **Safety, Autonomy, Mastery and Purpose** come together to impact on organisational performance. These are then directly linked to the survey questions and results positive and negative. This in turn can be used to consider areas of strength, potential areas of concern or risks to organisational performance and actions we may need to take to meet our strategic ambitions.

[2] Motivation Theory: The surprising truth about what motivates us, Daniel Pink 2018

Fig 4. Theory of Motivation linked to NHS Staff Survey questions

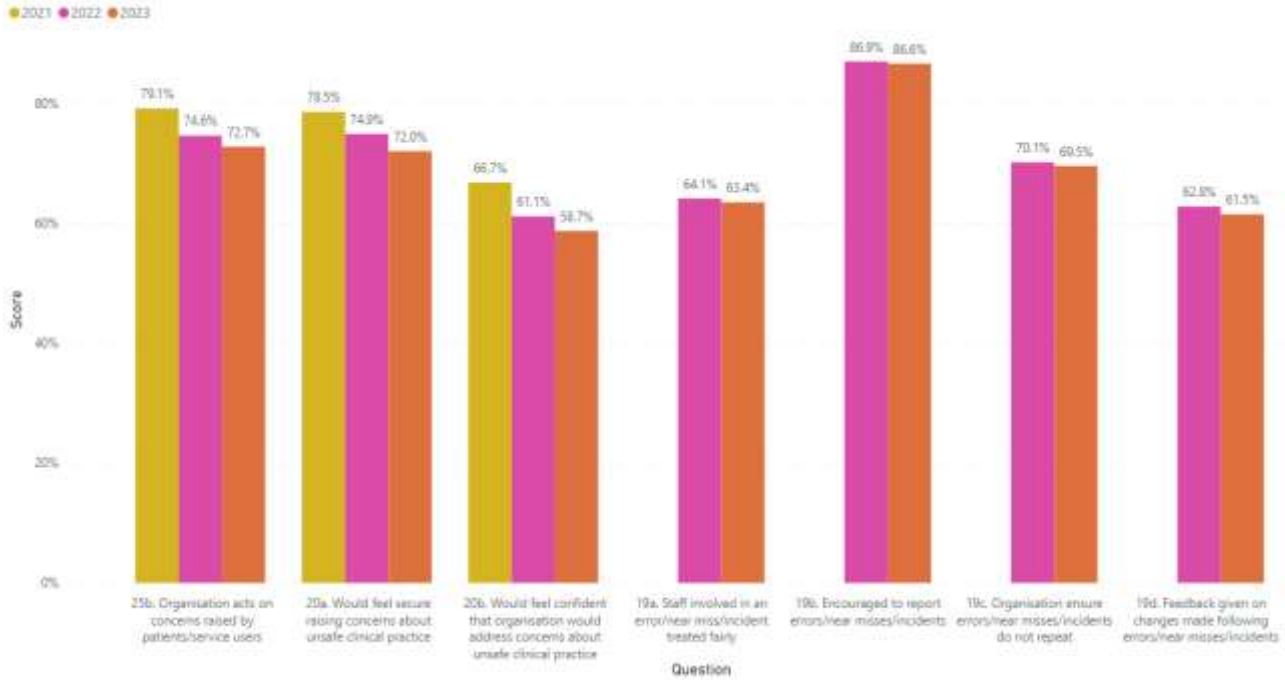
- 72% of staff would feel secure raising concerns about unsafe clinical practice. This has declined 6% since 2021.
- 58.7 % of staff would feel confident the organisation would address my concerns, a decline of 8% since 2021.
- 65% of staff would feel safe to speak up about concerns, a decline of 6% since 2021.
- 72% of staff think the Organisation acts on concerns from patients, a decline of 7% since 2019.

- 73% of staff say they are able to make suggestions to improve their team or department. A decline of 3% since 2019.
- 55% of staff say they look forward to coming to work. A decline of 8% since 2019.
- 69% of staff are enthusiastic about their job. A decline of 8% since 2019.
- 58% of staff say they are able to make improvements happen.
- 53% say they are involved in changes that affect their work.

- 62% say there are opportunities to develop their career. Declined 2% on 2022 where UHS was the best nationally.
- 61% say they are supported to develop their potential.
- 76% say there are opportunities to develop knowledge and skills.
- 36% say appraisal helped me agree clear objectives for my work.
- 87% always know what their responsibilities are.
- 79% believe that care of patients is the organisations top priority, a decline of 6% since 2021.

8.7 Trends in relation to speaking up, raising concerns, staff involved in near misses, and confidence to address concerns, 2021 to 2023 is shown in Fig 5 below.

Fig 5. Trends in speak up, near misses 2021-2023



8.8 The increase of work related stress shows that if staff are feeling **high *levels* of burnout and high levels of stress**, they are less likely to be motivated and *engaged,* this has *a* direct impact on performance at work. Public Health England describes burnout and the implications as "*workload and time pressure, role conflict and role ambiguity, lack of social support, lack of feedback, lack of autonomy and lack of participation in decision-making. Burnout has been associated with absenteeism, intention to leave the job and staff turnover. Among those who remain in the job, burnout leads to lower productivity and effectiveness at work, decreased job satisfaction and a reduced commitment to the job or organisation."*[3] As of March, the reported rolling average over the past 12 months, approximately 1% of the organisation are absent from work due to stress or mental health, which is on average 135 people. These figures do not correlate with the anecdotal feedback we are getting about staff feeling stress at work. Factors such as stigma surrounding mental health reporting may be a factor in low numbers reporting as reason for sickness. Feedback has also been that staff are carrying on working despite feeling significant stress and anxiety and therefore not taking time off.

8.9 There has been significant amount written about moral injury in the NHS where our people not being able to give the care they aspire due to the working conditions and pressures. This also has an impact on morale, wellbeing, accountability, speaking up culture, and staff engagement results. Although not explicit in the NHS annual staff survey, other surveys and research have been carried out on moral injury. The British Medical Association surveyed 1900 doctors in 2021, 52% said moral distress was caused by not having enough staff to suitably treat patients.

8.10 Whilst we find ourselves operating under significant scrutiny and pressure, we must remember that it is **our people** who are managing this pressure on a daily basis. We must pay deep attention to the themes in the survey and other themes that are emerging to ensure we are taking action within our control, and ensure we are carrying out our duty of care to our staff, whilst recognising the immense challenges we face.

[3] Public Health England and Leeds Beckett University. Interventions to prevent burnout in high risk individuals: evidence review, 2016.

9 Corporate and divisional response

9.1 Our corporate response continues to be aligned to the delivery programmes of the People Strategy and other UHS strategies that impact on staff experience. However, it should be noted that delivery against the strategy is becoming ever more challenging due to the change in the operating environment since the strategy was agreed. The financial position of the Trust, coupled with significant ongoing emergency and elective pressure, has meant achieving progress against the strategy has been a challenge. Next year, there will also be further pressure on corporate and divisional resources as the Trust is required to live within an affordable workforce and financial envelope.

9.2 **Appendix 6** provides some of the highlights of work completed during 2023 against the Thrive, Excel, and Belong domains of the People Strategy 22-26.

9.3 We will be undertaking a review of survey themes against the planned Corporate objectives for 24/25 to ensure the results and any actions required are fully understood and considered. UHS People Board will be used as a vehicle to agree our priority areas for next year and these will return to TEC in April.

9.4 There were significant efforts to publicise the work undertaken to support improvements last year. This included a comprehensive letter from the CEO and CPO, and publication of infographics showing progress made in key areas. However, we still receive feedback that people are not aware of the Trust responses to the survey result, and there remains cynicism that feedback is not reviewed or considered. With this in mind, we will be offering divisions and care groups additional support to engage with teams, to seek their views on their team results, and identify areas they would like to celebrate and improve. Additional support will be made available locally to enable improvements to happen in collaboration with the OD, HR, Transformation, F2SU and Patient Safety teams.

9.5 Divisions and key THQ areas will meet with the CEO, CPO and Director of OD and Inclusion to review ongoing local responses and progress to the staff survey during Q2.

10 Next steps

10.1 The Trust Executive Committee (TEC) have reviewed the 2023 survey results and agreed the next steps proposed in the paper. In addition, TEC members suggested focus on the following:

- Focus on supporting and communicating with the middle leadership and management tier of the organisation due to their wide level of responsibility and influence across teams.

- Ensure we use a tone of communication which recognises the strengths of the organisation and highlights the great things that happen on a daily basis. Continue to celebrate the work of our staff, whilst recognising the work environment is challenging, and providing support.

- Building on the work in 2023 to improve rest spaces for staff from the auction of the Banksy artwork. Scope the areas that still require improvement and consider how these may be prioritised.

- Undertake further analysis to identify the teams in the staff survey which have performed well, recognise those areas and share learning across the Trust.

- Consider methodologies for enabling more autonomy through the organisation and enable more local accountability.

10.2 We face a hugely challenging 2024/25, with continued financial constraints limiting investment, resources, and our ability to expand the workforce. The People Strategy at UHS still remains an aspiration we all should believe in; however, we need to pay attention to our current results and the temperature at UHS.

10.3 The Corporate response to the Staff Survey will be finalised in the objectives for Year 3 of the People Strategy through People Board and TEC in April. This will build also on the conversation held at People Board in February, and then at TEC in March.

Key areas are likely to cover:

- Focusing on the issues affecting current morale, including empowerment and the voice of our people. This should be linked to continuing to cultivate an improvement culture in the Trust as part of our Transformation programme.

- Listening with intent to our people. Enhancing leadership visibility, corporate engagement and making practical tangible changes where we can do this. This is particularly important for middle management roles in the Trust.

- Continue to develop and support line managers, who make a critical difference to local experience.

- Continue to embed the recommendations from the review into Employee Relations process and Freedom to Speak up following the review commissioned regarding bullying concerns raised on social media in 2023.

- Focusing on the areas of the Trust locally we are most concerned about and taking targeted action. Supporting our Divisional teams with corporate resources to make meaningful change to areas of concern.

- Continuing to dial up our mechanisms to celebrate the success of our people, recognising and rewarding those delivering in line with our values.

- Implementing year 2 of our Belonging Strategy, including implementing the recommendations of the recruitment review, completing the role out of the Allyship programme, supporting teams to understand their team purpose, objectives, and team development planning. Implementing the outputs from our inclusive recruitment group, continuing the development of our leaders to have an inclusive ethos, as well as intentional support to ensure our leaders are diversely represented at a senior level.

Once the Objectives have been agreed for 24/25, including the corporate actions to be taken forward, these will be monitored through People Board and through People and OD committee.

Appendix 1 – 2023 Participation data by professional group and by Division

Staff Group	Eligible Sample	Respondents	Response Rate
ADD PROF SCIENTIFIC AND TECHNIC	439	218	49.7%
ADDITIONAL CLINICAL SERVICES	2525	908	36.0%
ADMINISTRATIVE AND CLERICAL	2623	1664	63.4%
ALLIED HEALTH PROFESSIONALS	770	355	46.1%
ESTATES AND ANCILLARY	502	199	39.6%
HEALTHCARE SCIENTISTS	527	250	47.4%
MEDICAL AND DENTAL	1980	427	21.6%
NURSING AND MIDWIFERY REGISTERED	4297	1617	37.6%

Divisional participation rates 2023

Division	Eligible	Respondents	Response Rate
Division A	2476	969	39.1%
Division B	3521	1268	36.0%
Division C	3042	1174	38.6%
Division D	2447	901	36.8%
Hosted Services	267	146	54.7%
THQ	1912	1181	61.8%

Changes in participation by professional group 2022-2023

Staff Group	% difference
ADD PROF SCIENTIFIC AND TECHNIC	-16.2%
ADDITIONAL CLINICAL SERVICES	-13.6%
ADMINISTRATIVE AND CLERICAL	-10.8%
ALLIED HEALTH PROFESSIONALS	-19.4%
ESTATES AND ANCILLARY	-0.8%
HEALTHCARE SCIENTISTS	-15.8%
MEDICAL AND DENTAL	-11.0%
NURSING AND MIDWIFERY REGISTERED	-16.6%

Appendix 2 – Staff Engagement Scores 2022 to 2023 comparison UHS vs National Average							
Area	**Question**	**UHS 2023**	**UHS 2022**	**UHS Difference**	**Average 2023**	**Average 2022**	**Difference in average**
Motivation	**Often/always look forward to going to work**	**55.8%**	**55.9%**	**-0.1%**	**55.0%**	**52.5%**	**2.5%**
	Often/always enthusiastic about my job	**69.2%**	**69.0%**	**0.2%**	**69.4%**	**66.7%**	**2.7%**
	Time often/always passes quickly when I am working	**71.5%**	**72.2%**	**-0.7%**	**72.3%**	**72.5%**	**-0.2%**
Involvement	**Opportunities to show initiative frequently in my role**	**75.8%**	**77.7%**	**-1.9%**	**73.7%**	**72.8%**	**0.9%**
	Able to make suggestions to improve the work of my team/department	**73.0%**	**74.8%**	**-1.8%**	**71.4%**	**70.9%**	**0.5%**
	Able to make improvements	**58.1%**	**57.3%**	**0.8%**	**56.4%**	**54.8%**	**1.6%**

	happen in my area of work						
Advocacy	Care of patients/service users is organisations top priority	79.9%	83.3%	-3.4%	74.8%	73.6%	1.2%
	Would recommend organisation as a place to work	67.5%	68.7%	-1.2%	60.5%	56.5%	4%
	If a friend/relative needed treatment would be happy with standard of care provided by organisation	76.3%	78.8%	-2.5%	63.3%	61.8%	1.5%
	Engagement score	7.0	7.1	-0.1	6.9	6.8	0.1

Appendix 3 – Comparison across UHS against People Promise Theme Areas.

	Responses	We are compassionate and inclusive score	We are recognised and rewarded score	We each have a voice that counts score	We are safe and healthy score	We are always learning score	We work flexibly score	We are a team score	Staff Engagement Score	Morale score
UHS Overall	5639	7.4	6.1	6.8	6.2	5.9	6.6	6.9	7.0	6.0
Division A										
Critical Care	185	7.1	5.5	6.5	5.7	5.7	6.2	6.5	6.7	5.8
Ophthalmology	141	7.6	6.3	6.9	6.5	5.7	6.5	7.0	7.2	6.4
Surgery	223	7.3	5.9	6.5	5.8	5.6	6.4	6.8	6.8	5.9
Theatres & Anaesthetics	420	7.2	5.5	6.5	5.9	5.8	6.3	6.6	6.8	5.8
Division B										
Cancer Care	258	7.2	5.6	6.5	5.7	5.4	5.9	6.5	6.8	5.6
Emergency Care	201	6.7	5.3	6.1	5.0	5.2	6.1	6.2	6.5	5.4
Medicine	271	7.6	6.3	7.1	5.9	6.7	6.7	7.2	7.4	6.5
Pathology	249	7.2	5.8	6.6	6.1	5.3	6.2	6.4	6.7	5.7
Specialist Medicine	260	7.4	6.1	6.8	6.3	5.8	6.6	6.7	7.2	6.2
Division C										
Child Health	403	7.3	5.8	6.6	6.0	5.4	6.4	6.6	6.9	5.8
Clinical Support	461	7.7	6.3	7.0	6.2	6.2	6.4	7.2	7.2	6.0
Women & Newborn	310	7.3	5.9	6.7	6.0	5.6	6.2	6.6	6.9	5.8
Division D										
CV&T	259	7.6	6.1	7.0	6.1	5.9	6.6	7.0	7.2	6.3
Neuro	227	7.2	5.8	6.6	5.7	5.8	6.3	6.7	6.8	5.8
Radiology	235	7.6	6.1	7.0	6.5	6.2	6.5	6.9	7.0	6.4
T&O	180	7.5	6.1	7.0	6.0	6.2	6.7	7.0	7.0	6.2
THQ										
Chief Finance Officer	109	7.6	6.5	7.1	6.8	5.9	7.1	7.1	7.2	6.2
Clinical Development	154	7.6	6.5	7.0	6.6	6.1	7.2	7.2	7.3	6.2
Estates	188	7.1	5.8	6.4	6.4	5.4	6.8	6.6	6.6	5.8
Informatics	133	7.9	6.6	7.1	6.8	5.7	7.3	7.3	7.3	6.3
People	155	8.1	6.9	7.5	6.9	6.6	7.1	7.6	7.6	6.4
R&D	268	7.9	6.7	7.1	7.0	6.4	7.2	7.6	7.4	6.6
THQ Other Services	320	7.8	6.7	7.2	7.0	6.2	7.5	7.4	7.4	6.5

Key:	
>0.4 above	UHS score
>0.2 above	UHS score
<0.2 below	UHS score
<0.4 below	UHS score
In between	UHS score

Appendix 4 – People Promise Themes – Trust Level

	Responses	We are compassionate and inclusive score	We are recognised and rewarded score	We each have a voice that counts score	We are safe and healthy score	We are always learning score	We work flexibly score	We are a team score	Staff Engagement Score	Morale score
UHS Overall	5639	7.4	6.1	6.8	6.2	5.9	6.6	6.9	7.0	6.0
Division A	969	7.3	5.7	6.6	5.9	5.7	6.3	6.7	6.9	5.9
Division B	1268	7.3	5.9	6.7	5.8	5.7	6.3	6.6	7.0	5.9
Division C	1174	7.4	6.0	6.8	6.1	5.8	6.3	6.8	7.0	5.9
Division D	901	7.5	6.0	6.9	6.1	6.0	6.5	6.9	7.0	6.2
THQ	1181	7.7	6.5	7.0	6.8	6.0	7.1	7.3	7.2	6.3
Hosted Services	146	7.9	6.8	7.3	6.9	6.5	7.4	7.5	7.5	6.6

Appendix 5 – People Promise Themes – Staff Groups

	Responses	We are compassionate and inclusive score	We are recognised and rewarded score	We each have a voice that counts score	We are safe and healthy score	We are always learning score	We work flexibly score	We are a team score	Staff Engagement Score	Morale score
UHS Overall	**5639**	7.4	6.1	6.8	6.2	5.9	6.6	6.9	7.0	6.0
Add Prof Scientific and Technic	218	7.3	5.9	6.7	6.0	5.6	6.3	6.7	7.0	5.8
Additional Clinical Services	908	7.4	5.9	6.7	6.2	5.9	6.4	6.9	7.0	6.2
Administrative and Clerical	1664	7.7	6.4	7.0	6.8	5.8	7.1	7.2	7.1	6.4
Allied Health Professionals	355	7.6	6.1	6.9	6.0	6.0	6.4	7.0	7.2	5.9
Estates and Ancillary	199	6.9	5.8	6.4	6.2	5.3	6.6	6.4	6.6	5.9
Healthcare Scientists	250	7.4	6.2	6.9	6.3	5.6	6.3	6.7	7.1	5.9
Medical and Dental	427	7.1	5.8	6.4	5.7	5.6	5.6	6.3	6.8	5.8
Nursing and Midwifery Registered	1617	7.4	5.9	6.8	5.7	6.1	6.4	6.9	7.1	5.8

Appendix 6 – Key progress against the People Strategy Themes

THRIVE

Growing, deploying, innovating our workforce

- Our exit survey tool was redesigned in 2022 to align with Hampshire and IOW system partners. It will provide a deeper understanding of why staff are leaving UHS, and their destinations. This data will be reviewed alongside other staff experience data and information.
- Implementation of the Agile working programme. Introduction of agile desk space and a desk booking system across THQ to enabled shared working spaces, identification of desk capacity and space saving. This is being rolled out across early adopter clinical areas.
- Turnover has reduced from 14.2% in January 2023, to 11.3% in January 2024, below our trust target of 12%
- An innovative new platform to make applying for roles at UHS has been implemented, Talk N Job is a voice-based application platform which can be used via a person's mobile phone enables applicant to answer a short series of questions to identify suitability for the role prior to a follow up call from the recruitment team. This award-winning initiative has improved inclusivity
- Due to successful recruitment programmes, we have reduced our registered nurse vacancy position to 7%. We have also filled other key vacancies driven by our 'Leading the Way' recruitment brand.

EXCEL

A great place to work, develop and achieve

- WeAreUHS week took place in October 2023. An incredibly well evaluated week of innovation, showcasing staff achievements, workshops, and celebration events for all staff at UHS, including our annual staff awards ceremony.
- Three new leadership programmes launched –Strategic, Senior and Operational Leaders programmes with over 130 leaders participating across the first cohorts. The human leaders programme, Research Leaders Programme, and Connective Leadership also launched.
- 2023 saw the opening of the Princess Ann Roof Garden and the Wellbeing Hub funded by the auction of the Banksy artwork. Both facilities have been highly utilised, and staff have reported feeling highly valued and have appreciated the spaces.
- Our Trust wide reward and recognition process was relaunched. Our monthly Spotlight in person event where staff are recognised and provided with general Trust updates. UHS Star, Champion and High Five recognitions were launched in 2023, over 2,500 High 5's have been given to staff since the launch.

BELONG

Compassionate and inclusive culture for all

- As part of our Inclusion and Belonging goal to increase diverse representation at senior leadership levels at UHS, two cohorts of our Positive action leadership programme completed in 2023. One programme facilitated by the Florence Nightingale Foundation for nursing colleagues, and another programme for all other staff delivered in partnership with Mahaa People..
- Two new staff networks established in 2023, the Armed Forces Network and Womens Network began to grow members and host events during 2023.
- We enhanced our Allyship programme in 2023, adding a e-learning option to aid access. Over 8800 (over 65%) UHS staff have participated in allyship since 2022.
- We embedded our Inclusive Leadership Module into all our leadership development programmes in 2023 to support inclusive leadership practice at all levels.

Appendix 7 – Current KPI performance against People Strategy (22-26)

Pillar	KPI Measure	Source	Strategy start point (March 2022)	Current Position	End 2024 Target	2026 Target
Thrive	Vacancy Rate: All staff	ESR	7%	6%	6%	5%
	Vacancy Rate: Registered Nurses	ESR	13.4%	7%	10%	8%
	All Staff Turnover	ESR	13.7%	11.5%	12%	11%
	Sickness Absence	ESR	4.2%	3.9%	3.4%	3.2%
	NHS Staff Survey: We work flexibly	NSS	6.4	6.5	6.7	7.0
	NHSE Levels of attainment (Rostering maturity)	NHSE Team	None	Level 1	Level 1	Level 4
Excel	Recommendation as a place to work (%)	NSS	72%	68%	76%	80%
	Overall Staff engagement Score	NSS	7.2	7.0	7.4	7.5
	Trust NHS Rank engagement of official channels on social	Social Media Metrics	Top 5	2nd	Top in all Channels	
	% of Appraisals completed	ESR	72.6%	77%	85%	92%
	NHS Staff Survey: We are always learning	NSS	5.7	5.9	6.0	6.5
	NHS Staff Survey: My organisation takes positive action on health and wellbeing	NSS	61%	61%	75%	80%
	External Industry Accreditation	Times Top 100 Employer				Award Achieved
Belong	NHS staff Survey: We are passionate and inclusive	NSS	7.5	7.4	7.8	8.0

	% of staff who feel a sense of belonging	Qrt Pulse survey	74%	68%	77%	80%
	% of staff employed at Band 7 and above from BME backgrounds	ESR	10%	11.5%	14%	19%
	Recommendation as a place to work by Diverse Communities	BME		7.3	Target is to match overall staff engagement score for UHS.	
		LGBTQ+		6.9		
		LID		6.7		
	CQC Outstanding for Well Led	CQC	Good	Good	Good	Outstanding

Appendix 8 - WRES and WDES staff survey questions only, comparison 2020 to 2023

WRES Survey Question	All other ethnic groups	White	Disparity between groups
% of staff experiencing bullying, harassment or abuse from patients/relatives/public In last 12 months	30% ↔ Although fluctuated since 2020, now same % as in 2020.	23% ↓ Down 2% since 2020 Although has fluctuated +/-ve in that time	7%
% of staff experiencing bullying, harassment or abuse from staff in last 12 months	27% ↑ Dropped in 2020-21 by 6% now same as in 2020	20% ↑ Dropped 2% 2021 and 2022 now same as 2020	7%
% of staff believing UHS provides equal opportunities for career progression or promotion	55% ↑ Improved 4% since 2020	63% ↓ Declined 3% since 2020	8%
% of staff experiencing discrimination at work from manager/team leader or colleague in the last 12 months	12% ↓ Improved 4% since 2020	6% ↔ Remained within 1% +/-ve change since 2020	6%

WDES Survey Question	Staff with long term condition or illness	Staff without long term condition or illness	Disparity between groups
% of staff experiencing bullying, harassment or abuse from patients/relatives/public In last 12 months	29% ⟷ Although fluctuated since 2020, now same % as in 2020.	23% ↓ Down 2% since 2020 Although has fluctuated +/-ve	6%
% of staff experiencing bullying, harassment or abuse from managers in last 12 months	13% ↑ Dropped in 2020-21 by 2% now same as in 2020	8% ↑ Dropped 3% 2021 and 2022 now 1% less than 2020	5%
% of staff experiencing bullying, harassment and abuse from colleagues in the last 12 months	25% ↑ Dropped in 2021-2022 by 5% now 1% under 2020 result	16% ↑ Improved in 2021 by 3% has been steadily declining back to 2020 levels of 26%	9%
% of staff saying the last time they experienced harassment, bullying or abuse at work they reported it	50% ↑ Declined 3% to 47% in 2021 and 2022 now back to 50% same as 2019 and 2020	48% ↑ A steadily improving picture since 2020, by 2%	2%
% of staff believing UHS provides equal opportunities for career progression or promotion	57% ⟷ Remained static between 58-60% since 2020	62% ↓ Declined 2% since 2020	5%
% of staff who have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties	26% ⟷ Improved 7% from 2020 to 2021, since then has remained unchanged at 26%	16% ↑ Improved by 7% since 2020	10%

% of staff satisfied with the extent to which UHS values their work	39%  Declined 3% 2020 to 2021, remained unchanged since	49%  Declined 5% 2020 to 2021, remained unchanged since	10%
% of staff with a long lasting health condition or illness saying UHS has made reasonable adjustments to enable them to carry out their work	81%  Unchanged from 2022, against a national average of 73%		

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Maternity and Neonatal Perinatal Quality Surveillance Dashboard Report**			
Agenda item:	**4.13**			
Sponsor:	**Gail Byrne, Director of Nursing** **Emma Northover, Director of Midwifery & Professional Lead for Neonatal Services**			
Author:	**Marie Cann, MatNeo Safety Lead** **Jessica Bown, Safety & Quality Assurance Midwifery Matron** **Hannah Mallon, Safety & Quality Assurance Neonatal Matron**			
Date:	**27 March 2024**			
Purpose:	**Assurance or reassurance** ✓	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The Quality Surveillance Model seeks to provide for consistent and methodical oversight of all services, specifically Maternity and Neonatal (MatNeo) Services. The model has been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Overall, it is designed to strengthen Trust level oversight for quality and safety, supporting proportionate action, and triggering escalation. Our MatNeo Dashboard (Appendix 1) provides the information to comply with the Quality Surveillance Model requirements. Our Quarter 3 (Qtr.3) MatNeo highlights for this report include the following: **1.** Timeliness of testing KPI for Sickle Cell and Thalassemia screening **2.** % Bookings ≤ 9+6 weeks **3.** Scheduled Caesarean Section Capacity **4.** PPH 1500ml or more **5.** 3rd/4th Degree Tears **6.** Apgar's <7 at 5 minutes **7.** Maternity Continuity of Carer **8.** Ockenden Antenatal Risk Assessments			
Response to the issue:	**1. Timeliness of testing KPI for Sickle Cell and Thalassemia screening** Families at high risk of having a baby with Sickle Cell Disease or a Thalassaemia should be offered prenatal diagnosis by 12 weeks and 0 days gestation with the test being performed by 12 weeks and 6 days. Screening of all pregnant women and birthing people as early as possible is essential to meet this screening standard. The key performance thresholds are that 50% or greater of the booked pregnancy population have a result reported by 10 weeks and 0 days with the achievable threshold being 75% or greater. Our Qtr.3 data is currently at 11.2%. It should be noted that Qtr.3 compliance is provisional only as of 8 January 2024. The key performance threshold for this indicator is closely related to the **%** Bookings ≤ 9+6 weeks key performance indicator (section 2) as the earlier the service can instigate antenatal care the quicker the blood testing can be commenced. Whilst the reasons for low compliance are complex, our current performance indicators have been influenced greatly by gaps within the midwifery workforce. In view of the lower-than-expected performance threshold our service is being monitored via an improvement plan by Public Health England. Further meetings and oversight of improvement plan will occur on 27 March 2004 and further actions may be required.			

2. % Bookings ≤ 9+6 weeks

NICE guidance NG201 recommends that services should "*offer a first antenatal (booking) appointment with a midwife by 10+0 weeks of pregnancy*". To meet the standards the key performance thresholds set as acceptable level of >50% with an achievable level of >75%. The performance threshold for bookings by ≤ 9+6 weeks is currently at 7% compliance due to a delay in allocating women and birthing people into appropriate booking or phlebotomy appointments. Our service has a stepped approach to achieving this NICE standard, which includes a First Point of Contact (FPoC) with a midwife and an appointment with a support worker for blood tests by 9+6 weeks. Our current FPoC performance is currently at 44%, however there is a robust action plan in place to increase the performance over the next quarter to meet at least the 50% performance threshold. To note this delay has an impact on the timeliness of testing for Sickle Cell and Thalassemia screening.

3. Scheduled Caesarean Section Capacity

Our services have calculated that the capacity of elective caesarean sections (ELCS) as 157 slots per quarter, equalling 627 a year. For Qtr.3 the number of ELCS was 225. There has been an increasing ELCS rate requiring more theatre capacity for elective. In addition, there is also background risk of not having sufficient emergency obstetric theatre provision adding additional pressures on our Labour Ward environment.

The Saving Babies Lives care bundle shows that implementation has been associated with a significant increase in both emergency and planned caesarean birth (Widdows et al 2021). Furthermore, NICE Caesarean guidance NG192 recommends ALL women should be offered information to support informed decision making about mode of birth and this has been associated with an increase in primary requests. Our service is not only the tertiary referral unit for cardiac disease and maternal medicine conditions but also for fetal medicine. We also accept referrals from the Isle of Wight for complex surgical cases (for example placenta accreta). This gives us a high-risk profile for many of our families and some of those will have to have elective caesareans. The consequence of limited elective capacity is challenging to the safe and quality provision includes:

- Causing disruption in providing admin and oversight of planning lists according to clinical prioritisation and impacting upon the workload of the team
- Elective surgery or the ELCS list is often delayed due to capacity issues (i.e., intrauterine transfusion or other emergency cases from Labour Ward requiring urgent delivery or management in theatre)
- Elective lists including elective CS or elective cerclages being cancelled on the day or being done much later to facilitate obstetric capacity - these women will be starved for a period of time.
- When women are delayed to the afternoon there is no dedicated elective theatre or staffing to accommodate and therefore it increases the workload on emergency staff and can cause potential delays in emergency work as staff busy in theatre
- Some cases are delayed to the following day which has a significant 'knock-on' effect for the already busy service.
- Dissatisfaction from women as their elective date has to be moved multiple times due to capacity.
- Delivery <39weeks for example some women will need to have their ELCS at 38+ weeks due to capacity (this may cause an inadvertent increase in neonatal admissions)
- Requirement for central prioritisation of theatre time, anaesthetics and staffing to meet demand.
- The issue of theatre capacity within the PAH is recognised and noted both at divisional and corporate level. The team are working together to identify solutions going forward.

The capacity of elective caesarean sections (ELCS) is a significant risk to the service and is currently captured on our Risk Register (Risk 788 Red 15) where it is being monitored and actioned as appropriate as part of the Trust Risk Management Policy.

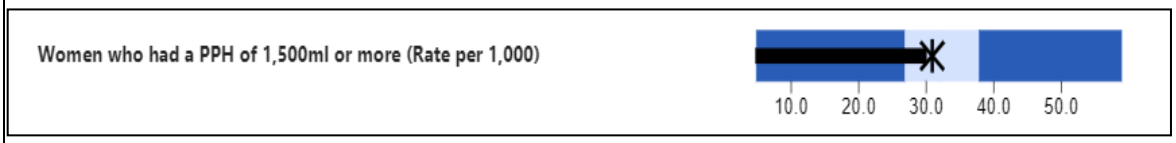
4. PPH 1500ml or more

The National Maternity & Perinatal Audit (NMPA) 2016/17 standard for obstetric haemorrhage of women and birthing people with a term, singleton birth who have a postpartum haemorrhage (PPH) of more than or equal to 1500ml is nationally agreed at 2.9 % Our performance threshold is currently 4.1% and suggests that our service has a greater proportion of PPH rates. See deep dive below.

4.1 National Maternity Dashboard

The National Maternity Dashboard publishes data monthly. The last data submission was for December 2023 which showed:

- In December 2023, it was reported that the Trust value was 30 per 1000 births for women/birthing people who had a PPH of 1500mls. Both National and MBBRACE group value was 31.0 per 1000.



4.2 Review of UHS Data

A review of the data for January 2024 found that 22 women/birthing people had a PPH of >1500mls, a rate of 5.4% A further deep dive looking into this data found:

- 48% were spontaneous vaginal births
- 24% were instrumental births and 4 of those sustained a 3rd degree tear
- 24% were a caesarean birth
- 86% of women/birthing people had interventions in theatre to control their PPH
- 95% of women/birthing people received care in HDU by an appropriately trained member of the team.

The review into this data provided assurance around the clinical care which did not highlight any obvious concerns. The Quality and Safety Team will continue to closely monitor, investigate, and seek to identify any thematic learning.

Audit monitoring is in place to understand any safety concerns. We have reviewed our processes around the management of blood loss and ongoing improvement work has recently seen the introduction of whiteboards in the clinical areas to improve the recording of blood loss, portable scales on the PPH emergency trolley and digitalisation of the equipment checks, including PPH trolley and emergency drugs.

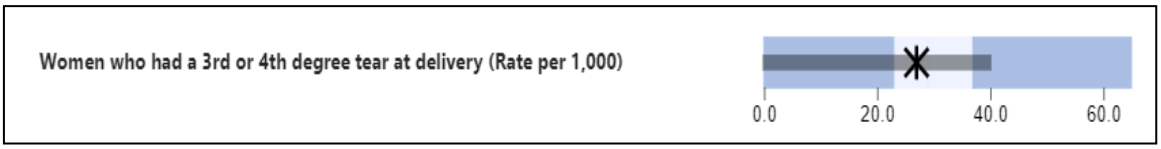
5. 3rd/4th Degree Tears

The NMPA 2016/17 standard for % of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear is nationally agreed at 3.1% November / December 2023 local audit to understand increase in cases.

5.1 National Maternity Dashboard

The National Maternity Dashboard publishes data monthly. The last data submission was for December 2023 which showed:

- In December 2023, it was reported that 40.0 per 1000 women/birthing people had a 3rd or 4th degree tear at delivery. Both National and MBBRACE group value was 27.0 per 1000.



5.2 Review of UHS Data

A review of the data for January 2024 found that 16 women/birthing people had a 3rd degree tear, with no reported 4th degree tears, and an overall rate of 6.5% A further deep dive looking into this data found:

- 9 women/birthing people had a spontaneous vaginal birth, 80% of these were offered and accepted 'hands on' for delivery
- 7 women/birthing people had an instrumental birth, 100% of these appropriately had an episiotomy
- 4 of these women/birthing people who sustained a 3rd/4th degree tear subsequently had a PPH of >1500mls
- 100% of women/birthing people received appropriate antibiotics following the repair.

The review into this data provided assurance around the clinical care and did not highlight any obvious concerns. The Quality and Safety Team will continue to closely monitor, investigate, and seek to identifying any thematic learning.

6. Apgar's <7 at 5 minutes

The Apgar score is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the health care provider how well the baby is doing outside the mother's womb. The Apgar test examines the baby's breathing effort, heart rate, muscle tone, reflexes and skin colour. Each category is scored with 0, 1 or 2, depending on the observed condition. The Apgar score is based on a total score of 0 to 10. The higher the score, the better the baby is doing after birth.

6.1 National Maternity and Perinatal Audit (NMPA)

The NMPA published data in 2016/17, 2017/18 and 2018/19 which showed:

Date range	% of term babies born with a 5-minute Apgar score of less than 7	National mean
2016/17	2.1%	1.2%
2017/18	2.5%	1.2%
2018/19	2.3%	1.1%

The denominator was number of singleton, liveborn infants born between 37+0 and 42+6 weeks (inclusive) of gestation. The numerator was number of singleton, liveborn infants born between 37+0 and 42+6 weeks (inclusive) of gestation with a 5-minute Apgar score less than 7.

6.2 National Maternity Dashboard

The National Maternity Dashboard publishes data on a monthly data. The last final data submission was for November 2023, which showed:

- In November 2023, it was reported that the Trust rate was 23 per 1000 births of babies which an Apgar score between 0 and 6. The current 3-month birth rate is 1345.

There are 7 Trusts in England who have a comparable Neonatal Unit with UHS (i.e., Level 3 Neonatal Intensive Care Unit, Neonatal Cardiac Surgery and Neonatal Surgery.

Trust	Rate per 1000 births	Current 3 -month birth rate
University Hospitals of Leicester NHS Trust	6	2090
The Leeds Teaching Hospitals NHS Trust	9	1950
Liverpool Women's NHS Foundation Trust	12	1535
St Michaels Hospital (part of University Hospitals Bristol and Weston NHS Foundation Trust)	15	970
Birmingham Women's and Children's NHS Foundation Trust	16	1935
Evelina Children's Hospital (part of Guy's and St Thomas' NHS Foundation Trust)	18 (reported Sept 2023)	Data not available
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	27	1490

The National Maternity Dashboard includes singleton, liveborn infants born between 37+0- and 45+0-weeks' gestation with an Apgar score between 0 and 6.

6.3 Trust Maternity Dashboard

The Trust produces a quarterly maternity dashboard which has showed:

Quarter	% of term babies born with a 5-minute Apgar score of less than 7
Quarter 1 2023/24	2.7%
Quarter 2 2023/24	3.0%
Quarter 3 2023/24	2.6%

The denominator was number of singleton, liveborn infants born between 37+0 and 42+6 weeks (inclusive) of gestation (excluding babies born before arrival). The numerator was number of singleton, liveborn infants born between 37+0 and 42+6 weeks (inclusive) of gestation with a 5-minute Apgar score less than 7 (excluding babies with known congenital abnormalities or under care of fetal medicine). Reviewing the data for Quarter 3 2023/24 and including those with known congenital abnormalities or under care of fetal medicine, the rate decreased slightly to 2.5% Therefore, it is proposed that there are no exclusions from the data bar babies born before arrival.

6.4 Review of UHS data

A review of the data for Quarter 3 2023/24 showed that there were 30 term babies born with a 5-minute Apgar score of less than 7. The liveborn, singleton term birth rate in Quarter 3 was 1191, 13 of those babies had a score of 5 or less, 5 of those babies with a score of 5 or less were delivered via caesarean section with the mother under general anaesthetic, 17 babies born in Quarter 3 2023/24 had an Apgar score of 6.

- 15 were born following a caesarean section
- 2 were admitted to the Neonatal Unit from Theatres
- A member of the Neonatal Team was present at the birth for 13 of those babies
- A member of the Neonatal Team was called and were present around 5-6 minutes of age at the births of 3 those babies
- All Apgar scores, bar 1, were recorded as 2, 1, 1, 1, 1
- There were 2 babies where the narrative suggests that the Apgar score may be 7 at 5 minutes rather than 6 (as the babies had good respiratory effort).

	The review into this data provided assurance around the clinical care did not highlight any obvious concerns. The Quality and Safety Team will continue to closely monitor, investigate, and seek to identify any thematic learning including contacting services who are better performing for any learning opportunities. **7. Maternity Continuity of Carer** Maternity Continuity of Carer (MCoC) model is a key workforce model for our service ensuring all families, particularly those most vulnerable, have safer and improved pregnancy and birth outcomes. During COVID, and in response to the Final Ockenden Report, we were asked to consider suspending the MCoC model, to preserve our staffing resources and provide a safer workforce overall. After careful consideration, we decided that it would be safe for us to continue providing care within a continuity framework to our vulnerable families, but would not expand the model further, hence the work around the two pilot sites was paused. The current reduction in compliance reflects these changes. It is important that we know that the most vulnerable families are still supported by our Needing Extra Support Teams (NEST) and as we progress workstreams around future workforce plans it will be likely that new and more sustainable MCoC models of care may be successfully implemented which in turn will see an increase in compliance levels. In October 2023 MCoC provision was further affected by staffing and operational pressures over the summer. The majority of this has affected continuity around intrapartum care. The Maternity Service is trialling a different way to recruit into these teams by offering more flexible options for midwives to seek to increase recruitment into these rewarding but very challenging roles. To give assurance the Maternity Service monitors and audits outcomes to ensure that groups most likely to be offered a MCoC model are not showing as exceptions in our data or when clinically reviewing adverse outcomes. **8. Ockenden Antenatal Risk Assessments** The Ockenden Report findings, conclusions and essential actions requires MatNeo services to review and monitor performance indicators relating to antenatal and place of birth risk assessments, which should be undertaken at each antenatal contact. The accepted compliance for adequate performance acceptable level ≥ 80% and achievable ≥ 90%. Currently the service is at 55% and 59%. The performance discrepancy is related to the capture of data within Badgernet. Compliance via Badgernet is reliant on the authorisation of each note on Badgernet therefore there is some data quality work to be undertaken by the Badgernet developers. At local level risk assessments at each antenatal contact continue to be monitored via local audits where compliance is shown to be good. This serves to provide some assurance that we are meeting the required performance indicator.
Implications: (Clinical, Organisational, Governance, Legal?)	The risk implications for the UHS Trust and Maternity Service sit within several frameworks including: • **Reputational** – Safety concerns can be raised by the public to both NHS Resolution and the CQC. The CQC can undertake reviews of services who they believe have safety concerns. • **Financial** – Compliance with NHS Resolution Maternity Safety Actions to meet all ten is an expectation for many maternity safety requirements. • **Governance** – Safety concerns can be escalated to the Care Quality Commission for their consideration, and to NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, the Regional Chief Midwife and DHSC for information. • **Safety** - Non-compliance with requirements or recommendations would have a detrimental impact on patients and their families leading to increased poor outcomes and staff wellbeing.
Risks: (Top 3) of carrying out the change / or not:	Risk register entries related to the performance indicators: • Risk 38 (Orange 12) - Timeliness of screening for Sickle Cell and Thalassaemia in early pregnancy • Risk 788 (Red 15) - Elective caesarean section list capacity

	• Risk 258 (Orange 12) - Maternity staffing during peaks of activity • Risk 259 (Orange 9) - Capacity and demand in Maternity Services.
Summary: Conclusion and/or recommendation	Our MatNeo Service continues to be mindful of all the safety and quality performance indicators continuing to provide Perinatal Quality Surveillance (MatNeo dashboard) information to Board members as required. The MatNeo dashboard continues to be modified to provide a platform for clear oversight of key outcomes, providing data for both assurance and reassurance purposes, areas for improvements and innovations in collaboration with both our service users and staff members. Performance indicators that are outlying will be continually monitored and reviewed to ensure no harm or poor outcome consequence occurs. Some of the key indicators will be represented on the Trust agreed Risk Register and will have monitoring and actions in place to ensure the risk is well managed. Our service will continue to provide this information as required for the Trust Board members and continue to provide assurance and reassurance, escalating where required.

UHS MatNeo Perinatal Surveilance Dashboard									
			Q1 = April - June		Q2 = July - September		Q3 = October - December		Q4 = January - March
Antenatal Booking	**Q3 23/24**				**2022 Totals (calendar year)**	**2023 Totals (calendar year)**	**Green**	**Red**	**Comments**
	October	**November**	**December**	**Q3 total**					
Total number of women/clients booked	446	469	392	1307	5475	5336	No performance threshold		Total number of clients booked during 2023 - 5336
Timeliness of testing KPI for Sickle cell and Thalassemia screening	9.0%	9.00%	Provisional data 15.6%	11.2%	5.8%	17.5%	Performance threshold of testing Acceptable level >50% Achievable level >75%		The proportion of pregnant women/clients having antenatal sickle cell and thalassemia screening for whom a screening result is available ≤10 weeks + 0 days gestation.
First point of contact with a midwife ≤ 9+6 weeks	17.50%	20.5%%	70.5%	44.00%	13.17% (April - Dec)	34.40%	Acceptable level >50% Achievable level >75%		NICE recommends that Maternity Service's should *"offer a first antenatal (booking) appointment with a midwife to take place by 10+0 weeks of pregnancy"*.
% Bookings ≤ 9+6 weeks (NICE recommendation)	4.7%	7.5%	7.70%	6.63%	6.30%	9.90%			
Birth Outcomes - mothers	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Total number of Births (women/people)	467	409	428	1304	5094	4963	1375 or fewer a quarter	More than 1375 a quarter	Total number of births for 2023 - 4963
Predicted birth rate	418	429	383	1230	4897	4808	1375 or fewer a quarter	More than 1375 a quarter	The final predicted birth numbers for Quarter 3 2023/24 was 1230, we had 1304 births.
Sets of Multiples	7	5	2	14	74	79	20 a quarter	21+ a quarter	Office for National Statistics 2020 data - National rate 14.4 per 1,000 women/birthing people.
Home birth rate	0.63%	0.70%	0.50%	0.61%	0.56%	0.63%	No performance threshold		ONS 2021 - 2.5% of maternities delivered at home
IOL rate	32.10%	32.00%	33.90%	32.67%	30.23% (1540)	32.46% (1677)	Less than 33%	More than 33%	
Scheduled Caesarean Section capacity	83	72	70	225	689	814	157 or Less a QTR. 52 or less a month	Greater than 157 a QTR. Or 52 a month	The Maternity services have calculated the number of elective caesarean sections capacity a 157 slots per quarter, equalling 627 a year.
Number of scheduled CS slots blocked due to complexity of cases on the list	5	6	7	18	New measure 2023	77	No performance threshold		New measure added to show the number of elective slots blocked out due to complexity of th cases on the lists
PPH 500ml or more - NMPA	34.1%	38.7%	37.3%	36.7%	35.6%	35.7%	34.0% or less	Over 34.1%	% of term, singleton births with an obstetric haemorrhage more than or equal to 500ml. Source NMPA 2016/17 - UHS 34.5%(unadjusted) & 34.3% (adjusted) - National Mean 34.1%
PPH 1500ml or more - NMPA	3.3%	5.1%	4.0%	4.1%	3.4%	3.8%	2.8% or Less	Over 2.9	% of term, singleton births with an obstetric haemorrhage more than or equal to 1500ml. Source NMPA 2016/17 - UHS 3.4%(unadjusted) & 3.3% (adjusted) - National Mean 2.9%.
Episiotomy rate	24.2%	25.90%	26.60%	25.6%	25.5%	26.8%	24.6% or less	Over 24.6%	NMPA 2018/19 total episiotomy rate 24.6% Reported figure related to all births, not NMPA specification
3rd/4th degree tears - NMPA	3.2%	7.2%	4.6%	5.0%	3.0%	3.9%	3.1% or Less	Over 3.1%	% of term, singleton, cephalic, vaginal births with a 3rd or 4th degree perineal tear. Source NMPA 2018/19 - National Mean 3.1%

ITU Transfers	0	1	1	2	8	9	1	2 or more	ITU data obtained via Trust BI team from Camis data. All cases shared with Maternity Risk Team and Maternity Audit Midwife for review
Hysterectomy	0	0	0	0	2	0	0	1+	Hysterectomy data obtained via Divisional BA from Camis held data and BadgerNet. Cases shared with Maternity Risk Team for review
Birth Outcomes - Babies	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Total babies born	474	414	430	1318	5169	5043	1375 or fewer	More than 1375	Total number of babies born during - 2022 - 5169 2023 - 5043
Total number of registerable babies	473	412	428	1313	5149	5012	No performance threshold		All liveborn babies plus stillborn babies born from 24 weeks gestation
Normal Birth Rate (babies)	43.70%	44.20%	48.60%	45.50%	48.79%	45.91%	No performance threshold		All babies born via normal vaginal delivery
Apgar's <7 at 5 minutes - NMPA	2.6%	2.5%	2.7%	2.6%	2.1%	2.6%	1.1% or Less	Over 1.1%	% of liveborn, singleton, term babies with an Apgar score of less than 7 at 5 minutes (BBAs excluded). Source NMPA 2018/19 - UHS 2.3%(adjusted)) - National Mean 1.1% - Local indicators updated Q1 2022/23 - 1.1%
Pre-term birth rate (registerable babies)	9.7%	8.0%	8.4%	8.7%	8.7%	9.7%	No performance threshold		ONS 2021 - 7.6% of liveborn babies were pre-term Pre-term birth rate ambition announced in the NHS Long term Plan aims to achieve a 25% reduction in pre-term births by 2025 by reducing from 8% to 6%. Supportive improvement programme within our service include SBLs, specialist pre-term birth clinics, implementation of MCoC model of care. The recent improvements lead by MatNeoSIP include peri and post-partum optimisation of a very preterm infant additionally contribute to improving outcomes.
Neonatal outcomes	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Encephalopathy >34 weeks (inborn babies, graded moderate and above)	0	0	0	0	4	7	No performance threshold		Awaiting further clarification from the LMNS on this outcome measure
Term Admission to NNU -All babies	5.7%	5.60%	4.40%	5.7%	4.8%	5.7%	Less than 5%	More than 5%	2020/21 comparison 4.9% Data source - Neonatal Network.
Avoidable Term Admission to NNU -Excluding surgical/cardiac/congenital babies	4.9%	3.20%	2.50%	4.9%	3.3%	3.9%	Less than 5%	More than 5%	2020/21 comparison 3.7% Data source - Neonatal Network and excludes babies coded under the surgical and cardiac categories -
Appropriate place of birth	100%	100%	100%	100%	100%	100%	100%		Ensuring births occur in an appropriate place for the gestation of delivery is a measure reported upon by the National Neonatal Audit Programme and also falls part of Safety Action 6 (Saving Babies Lives) in the Trust's yearly submission of evidence to NHSR
Number of neonatal deaths	0	0	2	2	23	18	No performance threshold		Safer Maternity Care Progress Report published in 2021 removes the performance threshold for Neonatal Deaths occurring at any gestation. Moving forward the measure have changed to reflect liveborn from 24+0 weeks gestation who sadly die. Dashboard measure to be adjusted
Neonatal deaths per 1000 live births	0.00	0.00	4.69	1.53	4.50	3.60	No performance threshold		
Public Health Outcomes	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Infant feeding - Breast Feeding Initiation (mothers)	81.1%	80.2%	76.9%	79.4%	75.3%	77.1%	More than 75.0%	Less than 75.0%	Source - NHS Digital 2018/19 - 75% Q2 2021/22 - Data taken from the BadgerNet feeding summary report - On BadgerNet Breastfeeding initiation is defined as "The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast (including familiarization) or the baby is given any of the mothers breast milk".

Infant feeding - Breast Feeding at Discharge to community (babies)	71.6%	72.6%	70.5%	71.6%	67.7%	64.7%	More than 70.6%	Less than 70.6%	Source NMPA 2016/17 - UHS 70.5% - National Mean 70.6% Q2/Q3 - it's worth noting there has been an increase in the number of records with missing data, this has been highlighted to the Digital Midwives and Infant Feeding Lead
Smokers at booking	9.2%	6.6%	6.9%	7.6%	11.1%	11.3%	No performance threshold		Percentage of women who declare a smoking status at booking. In response to the National Tobacco Dependency Long Term Plan, UHS Maternity have trained nearly all community midwives as Tobacco Advisors who will be offering support to women who wish to undertake a supported quit attempt. And the inpatient pathway has been implemented.
Smoking at Delivery	9.4%	7.6%	8.6%	8.5%	9.8%	8.2%	Less than 6.0%	More than 6.0%	The smoking at the time of delivery data is used to monitor the national ambition to reduce smoking in pregnancy to 6% by the end of 2022. Dashboard target changed from 11% to 6% December 2019
% of delivered women who quit during pregnancy	25.5%	27.0%	40.0%	30.9%	26.8%	29.1%	No performance threshold		New measure. This figure is our quit rate comparing the smoking status declared at booking and whether the women is a smoker or non-smoker at time of delivery
Southampton City Smoke Free Pregnancy Monitoring	Quarterly reporting due next quarter				24.0%	Reportable next quarter	Greater than 35%	Less than 35%	% of Southampton locality women / pregnant people who successfully quit smoking during pregnancy
Booked Continuity of Carer	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Booked - total women/birthing people booked onto a CoC pathway	12.0%	8.9%	11.8%	10.9%	12.4%	13.1%	Greater than 35%	Less than 35%	Maternity continuity of care model is a key workforce model for our service ensuring all families, particularly those most vulnerable, have safer and improved pregnancy and birth outcomes. During COVID, and in response to the Final Ockenden Report, we were asked to consider suspending the MCoC model, so as to preserve our staffing resources and provide a safer workforce overall. After careful consideration, we decided that it would be safe for us to continue providing care within a continuity framework to our vulnerable families, but would not expand the model further, hence the work around the two pilot sites was paused. The current reduction in compliance reflects these changes. It is important that we know that the most vulnerable families are still supported by our Needing Extra Support teams (NEST) and as we progress workstreams around future workforce plans it will be likely that new and more sustainable MCoC models of care may be successfully implemented which in turn will see an increase in compliance levels.
Booked - total Global Majority women / birthing people booked onto a CoC pathway	21.7%	11.8%	9.1%	14.2%	71.8%	18.6%	Greater than 51%	Less than 51%	
Booked - total women living within an IMD-1 area booked onto a CoC pathway	34.2%	37.5%	54.2%	42.0%	75.1%	31.7%	Greater than 51%	Less than 51%	
Ockenden review	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
% Risk assessments undertaken at each AN contact	53.4%	57.3%	54.9%	55.2%	46.9%	59.7%	Acceptable level ≥ 80% Achievable ≥ 90%		New dashboard measure. Data for these performance indicators is currently under review by the Quality/Digital Team. Risk assessment at each antenatal contact and place of birth continue to be monitored via local audits where compliance is greater. Compliance via BadgerNet is reliant on the authorisation of each note on Badgernet therefore there is some data quality work to be undertaken.
% Place of birth risk assessments undertaken at each AN contact	74.3%	24.7%	77.2%	58.7%	68.9%	75.3%			
% High Risk women allocated a named consultant at any point during pregnancy	100.0%	99.46%	99.6%	99.7%	94.0%	97.3%			
Saving Babies Lives v3	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
% Precept Mag Sulphate Criteria (<30 weeks)	100%	100%	100%	100%	100%	85%	Greater than 80%	Less than 80%	% of singleton live births <30 weeks receiving Magnesium Sulphate within 24 hours prior to birth
Number of Stillbirths	1	2	2	5	17	15	5 or less	6 or above	Actual number of Stillbirths each quarter
Stillbirth rate per 1000 births	2.10	4.85	4.67	3.81	3.30	2.99	4.1 or less	4.2 or above	National rate 2021 4.2 per 1000 births
% <3rd centile >37+6 weeks	63.60%	50.00%	40.00%	51.20%	New measure 2023	57.7%	To be defined		Numerator - number of babies born greater than 37+6. Denominator - total babies born less than the 3rd centile

Low Birth Weight at Term (<2500g	2.1%	2.1%	2.8%	2.3%	2.5%	2.2%	Less than 2.8%	More than 2.8%	Source Public Health England 2017 National average 2.82% of live term births.
Risk and Patient Safety cases	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Total number of cases UHS have reported to MNSI	0	0	0	0	6	5	n/a	n/a	December 2023 - no new cases. Four cases remain open - MI-023716/MI-026554/MI-0129127/MI-031668
Total number of UHS cases accepted for review by MNSI	0	0	0	0	6	5	n/a	n/a	
Term Intrapartum Stillbirths	0	0	0	0	0	0	n/a	n/a	
Early neonatal death	0	0	0	0	1	1	n/a	n/a	
Severe brain injury	0	0	0	0	4	5	n/a	n/a	
Maternal death	0	0	0	0	3	0	n/a	n/a	
The number of incidents logged graded as moderate or above and what actions are being taken	2	1	4	7	48	30	n/a	n/a	Moderate incidents are reported to the Board Level Maternity Safety Champions and the LMNS on a monthly basis. These figures now include moderate neonatal incidents but do not include HSIB reportable incidents which are reported separately. December 2023. 9963797 - ruptured ectopic pregnancy, case reviewed and felt to be well managed. Closed no further actions 9964396 - Suspected birth injury, baby reviewed and referrals made. 9964824 - delay in baby receiving IV antibiotices. Case closed with learning shared 9965240 - skin to skin in theatre, case with LW matron for learning
Number of SIs reported and under investigation	0	0	0	0	11	6	n/a	n/a	New figure reporting to provide clarity around SIs reported and under investigation per quarter. Only incidents reported as a SIRI (i.e. on STEIS) have been included. These may not include cases under HSIB investigation. 3 Current MNSI cases are still being investigated (which are STEIS reportable)
Number of major complaints received for Maternity Services	0	0	0	0	10	3	n/a	n/a	No Major complaints in Q3 Total maternity complaints received: Oct 1 Nov 1 Dec 3
Education and training	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Provider Board Level Measure - Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training									UHS Maternity service has a dedicated lead midwife and lead obstetric consultant with demonstrated fetal monitoring expertise to focus on and champion best practice in fetal monitoring.
	94.4%	86.4%	87.8%	89.5%			Midwives		
	100.0%	100.0%	73.7%	91.2%			Consultant Obstetricians		
	97.0%	94.0%	89.3%	93.4%			Obstetric trainees		
Friends and Family Test	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Responders as % of eligible populations	22.6%	32.8%	25.3%	26.9%	24.2%	28.2%	20% or more	Less than 20%	Our rates have been consistently above the 20% Trust target since the introduction of sending a text to all families on Day 7 postnatal with the reminder and link to the 'Gather Survey' which

Recommenders as % of responders	81.5%	83.3%	83.2%	82.7%	86.4%	85.7%	90% or more	Less than 90%	commenced in April 2022. Ongoing work continues in all areas to help improve our services to reduce the percentage of families who would not recommend our service.
NOT recommending as % of responders	4.1%	4.8%	4.5%	4.5%	3.9%	3.9%	Less than 5%	5% or more	
Service monitoring	**October**	**November**	**December**	**Q3 total**	**2022 Totals**	**2023 Totals**	**Green**	**Red**	**Comments**
Concerns raised	0	0	0	0	New reporting measure June 2023	4	0	1 or more a month	Qtr3 - No concerns raised to the Safety Champions. Intentional rounding taking place daily in all areas across the MatNeo service.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Guardian of Safe Working Hours Quarterly Report**			
Agenda item:	**4.14**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Dr Diana Hulbert, Emergency Medicine Consultant & Guardian of Safe Working Hours**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	The vacancy rate for doctors in training is currently 10.56%, 89.44% fill rate. The budget 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 junior doctors' strikes have continued to provide a complex challenge for all Trusts. The significant work done by the Executive and senior clinical leaders at UHS ensured that all available information was widely shared and the help and support made available to all was appreciated. The results of negotiations between the Government and the BMA are awaited. In the last 12 months we have received 7 exception reports which have constituted a breach incurring a financial penalty and 2 of these include an immediate safety concern. We have met the relevant teams to recommended change to the rotas to avoid these breaches happening again.			
Response to the issue:	See main report below.			

Implications: (Clinical, Organisational, Governance, Legal?)	UHS maintains ongoing monitoring of exception reporting with support given to the Consultant/Clinical Rota Leads (CRL). UHS must continue to respond appropriately where the patterns of rotas lead to safety concerns. Medical recruitment must remain a high priority for the Trust even in periods of financial challenge. There must be continued vigilance around rotas, sickness, and sustainability of the working patterns of doctors in training.
Risks: (Top 3) of carrying out the change / or not:	Risk of financial penalties if rota gaps and vacancies are not addressed. There is a risk of poor recruitment in the future if there is any perception that UHS fails to fulfil the basic needs of doctors in training.
Summary: Conclusion and/or recommendation	The Board is invited to note the report and the concerns regarding work intensity, exception reporting, fines, rota gaps, locum expenditure and the working lives of doctors in training. The next quarterly report will be submitted to Trust Board in July 2024.

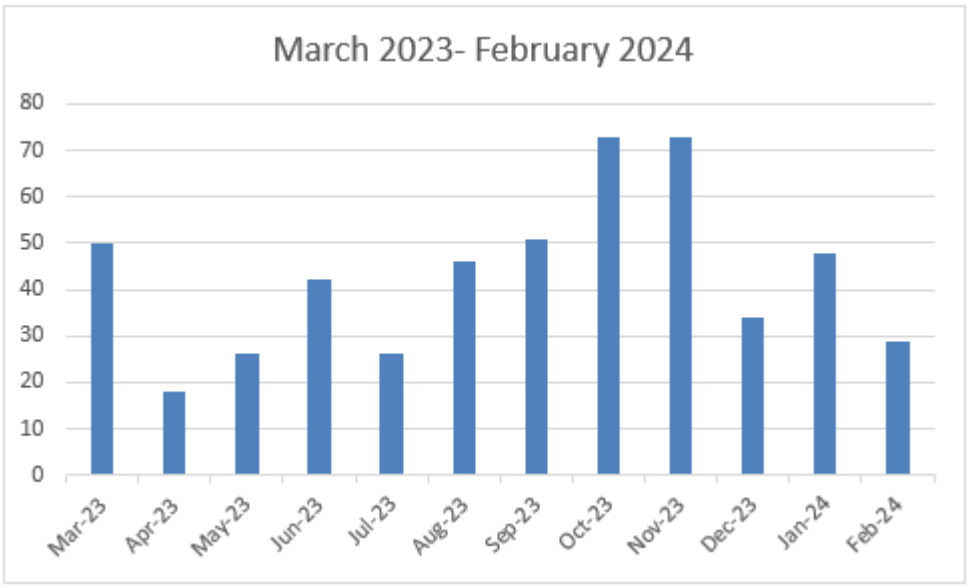
Executive Summary

Employment

There are currently 985 filled posts across the divisions: with 104 vacancies. Recruitment continues for current vacancies and Medical HR are working with departments to plan for future gaps. (Appendix 2)

Exception reporting

Total exception reports received over last 12 months:

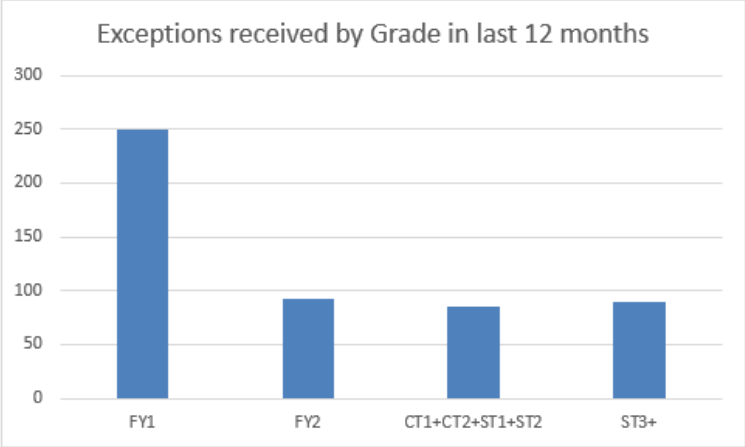


The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked.

The 7 exception reports that constituted in a breach and financial penalty were due to exceeding the maximum 13-hour shift length. All 7 reports were received from General Surgery, and we are working with the CRL to review current and August rotas to remove the 13-hour shift duration.

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

Majority of the exception reports received are by FY1 doctors.



Self Development Time (SDT)

All doctors in training are required to be given two hours of dedicated SDT per week to complement that already available for training and is a requirement to be recorded in the doctors' work schedules.

To enable doctors to take SDT 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.

In the last 12 months we have only received 10 exception reports stating missed SDT

We are working towards a streamlined approach to the provision of SDT across the Trust. Approximately 72% of doctors in training rotas have SDT embedded; the remaining rotas use HealthRoster to record SDT as unavailability. We aim to ensure that the best system is used for each team.

Activity

The Junior Doctor Executive Committee, led by the chief registrar, meets quarterly to bring together the junior doctors representing the doctors in training in all the care groups, the Guardian, the DME and members of the UHS Executive. This meeting facilitates discussion between the juniors (via their reps) with senior figures in the Trust who can help effect change. The Junior Doctor Forum, also led by the Chief Registrar, meets monthly and acts as an open and informal meeting to allow easy communication between the doctors in training, the Chief Registrar, the Guardian, the DME, and the Medical Workforce Team.

Both these meetings now take place in the Doctors' Mess wherever possible and via Teams to encourage wider participation

The Guardian and Medical Workforce Team attend monthly Trust induction to ensure that all the doctors in training and the non-training fellows who join UHS feel connected to the team and can ask for help and advice.

The Chief Registrar, Dr Ellie Starkey (a senior doctor in training in oncology) has set out an ambitious programme of projects for her year in post. This includes a project to improve the process and support for doctors in training pertaining to patient safety incidents, complaints, and coroners' cases.

Challenges

There are ongoing concerns over the issue of rota gaps in several areas of the hospital. There are certain specialties where recruitment and retention is particularly challenging including intensive care and PICU.

Exception reporting remains highest in general medicine and general surgery in the last four months.

In October 2023, UHS incurred fines for exception reports for the first time which highlighted immediate safety concerns.

Work intensity remains high and the ongoing impact of the covid pandemic on patient behaviour and the rather stuttering recovery of the NHS generally has been significant.

In the last year the impact of staff rather than patient sickness has also been huge, and rotas have been over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on doctors in training work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. Of note the reduction of night cover by ACPs in several specialties (a consequence of workforce gaps) still significantly impacts the out of hours work burden for some doctors in training.

These problems are national; I am confident that the divisional management and executive teams are aware of these issues and seeking improvement plans.
Rota annualisation can help alleviate the problem of annual leave and 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 a review of medical and non-medical staffing is required to increase our baseline staffing which should lead to a decrease in the locum spend.
An uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention.

There remains a need to discuss the evolution of the workforce. Work is being carried out around the role of doctors in training, 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.

There is greater transparency, more consistency, and a better understanding around rotas and rota gaps. It is important to recognise that there are some particularly hard-pressed specialties including Emergency Medicine and Paediatrics and this is reflected in the locum pay rates.
I am hopeful that these pay agreements will continue to be successful and acceptable to all. There will be regular review of the agreements. It will be particularly important to review the needs of the most hard-pressed specialties by assessing the regularity with which exceptional payments are requested, the number of unfilled locums and the number of exception reports.

The recent doctor strikes have been challenging for all. The doctors in training have informally told us that they feel supported although there have been instances of peer pressure both to strike and not to strike. Emotions run high in these situations and the most important support we can give is up to date information, support, advice and judicious rotas which offer patient care and safety. The longer recent strikes have been particularly hard not least because more colleagues were away, and more strike fatigue was felt. We fervently hope that a settlement can be reached so that we can all move on.

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 the junior and senior clinicians in various departments rather more than through the exception reporting system.
Recent discussions with the FY1s and FY2s have been invaluable and highlight system challenges and their potential solutions. To this end M-Edison's lab has been set with Dr Mark Wright to generate practical answers to tricky questions.

In addition to the challenges of providing rotas which are sustainable and promote high quality work alongside an attractive life/work balance there are other issues that are important to the training and non-training doctor workforce.
These issues are the subject of the work that I do with the trainee doctors, the Chief Registrar, the Medical Workforce Team led by Becci Mannion, the Executive and other colleagues.

The main concerns include new post induction, provision of non-clinical space, IT provision, the availability of reasonably priced hot meals overnight, free tea and coffee and the presence of sleep rooms after night shifts.

I am delighted that Kate Nash, the DME, has taken on the challenge of local induction for the Trust as this is regularly highlighted as an area of concern by the doctors in training.

Members of the Executive have taken on the challenge of the provision of non-clinical space alongside our Chief Resident. There is a piece of ongoing work which has scoped the office space available to doctors in training.

Provision of hot meals and hot drinks remains a challenge.

We are re-examining the provision of sleep rooms to ensure we make the system simple and effective.

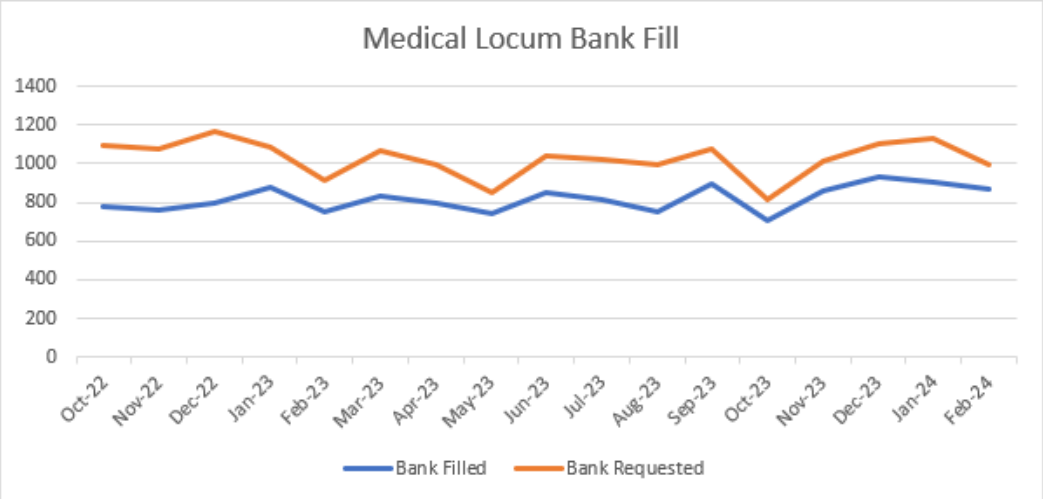
A significant aim for UHS is the understanding of the different expectations of different generations of doctors.
In a big teaching hospital trust with more than 1000 doctors in training and more than 1000 consultants it can be difficult to fully understand how people feel. It is only by walking in peoples' shoes that we can understand how to create a happy workforce who give their best to UHS.
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 of the doctors in training in this situation may only have four months to understand, assimilate and succeed before moving on. It is the provision of support in all its forms that determines the ability to thrive.

If I were to offer an ambitious suggestion I do wonder if UHS should offer accommodation to staff who are new to the area and working in short-term posts.

We are determined to ensure that the building blocks for successful doctor workforce are in place in UHS.

Appendix 1 - Medical Locum Bank Data

Month	Agency filled	Bank Filled	Requested	Bank fill %
October 22	48	774	1093	70.81
November 22	58	762	1076	70.82
December 22	54	795	1163	68.36
January 23	40	873	1081	80.76
February 23	20	753	916	82.21
March 23	12	835	1063	78.55
April 23	16	796	993	80.16
May 23	12	745	849	87.75
June 23	19	848	1039	81.62
July 23	16	816	1023	79.77
August 23	0	755	991	76.19
September 23	0	893	1077	82.92
October 23	0	704	810	86.91
November 23	0	859	1015	84.63
December 23	0	932	1105	84.34
January 24	0	907	1129	80.33
February 24	0	865	997	86.76



Appendix 2 - Vacancy data for February 2024

Division	Care Group	Cost centre	No of posts	No of vacancies (7/2/24)	Fill rate @ 7/2 24
A	Critical Care	Anaesthetics	74	9	87.84%
A	Critical Care	CICU	12	3	75.00%
A	Critical Care	GICU	47	10	78.72%
A	Critical Care	NICU	14	2	85.71%
A	Critical Care	SHDU	8	0	100.00%
A	Ophthalmology	Ophthalmology	27	0	100.00%
A	Surgery	ENT	17	1	94.12%
A	Surgery	General Surgery	48	4	91.67%
A	Surgery	OMFS	10	0	100.00%
A	Surgery	Urology	13	2	84.62%
B	Cancer Care	Clinical Oncology	19	0	84.62%
B	Cancer Care	Haematology	21	0	100.00%
B	Cancer Care	Medical Oncology	23	0	100.00%
B	Cancer Care	Palliative Care	8	1	100.00%
B	Emergency	Acute Med	23	7	87.50%
B	Emergency	Acute Med OOH	6	1	69.57%
B	Emergency	ED	70	3	95.71%
B	Emergency	PHEM	2	0	100.00%
B	MOP	MOP	46	2	95.65%
B	Pathology	Chemical Pathology	2	1	50.00%
B	Pathology	Histopathology	25	10	60.00%
B	Pathology	Microbiology	12	3	75.00%
B	Specialist Med	Allergy/Respiratory	30	2	93.33%
B	Specialist Med	Clinical Genetics	4	1	75.00%
B	Specialist Med	Dermatology	8	0	100.00%
B	Specialist Med	Endo/Diabetes	4	0	100.00%
B	Specialist Med	General Medicine	22	0	100.00%
B	Specialist Med	GI Renal	31	2	93.55%
B	Specialist Med	Rheumatology	4	1	75.00%
C	Child Health	Paediatric Cardiology	14	1	92.86%
C	Child Health	Paediatrics	54	7	87.04%
C	Child Health	Paeds ED	16	3	81.25%
C	Child Health	PICU	16	4	75.00%
C	W&N	Neonates	30	7	76.67%
C	W&N	O&G	41	0	100.00%
D	CV&T	Cardiology	37	6	83.78%
D	CV&T	Cardiothoracic Surgery	32	3	90.63%
D	CV&T	Vascular Surgery	11	0	100.00%
D	Neurosciences	Neurology	23	0	100.00%
D	Neurosciences	Neurophysiology	2	0	100.00%
D	Neurosciences	Neurosurgery	24	2	91.67%
D	T&O	Spinal Surgery	3	0	100.00%
D	T&O	T&O	52	6	88.46%
		Total	**985**	**104**	89.44%

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Board Assurance Framework (BAF)**			
Agenda item:	**6.1**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Lauren Anderson, Corporate Governance & Risk Manager** **Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance** ✔	**Approval**	**Ratification** ✔	**Information**
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. The report has been updated following discussions with the relevant executives and their teams.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is fundamental to the delivery of the Trust's strategic objectives and is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be aware of key risks, or may not understand failures in the control environment and actions planned to address these failures.			
Summary: Conclusion and/or recommendation	The Board is asked to note the updated Board Assurance Framework and information contained within this report. Additionally, they are asked to review the updated risk management strategy and policy (appendix B) which includes the updated risk appetite statement following the Trust Board study session in December, and if they are satisfied with this ratify this as the final document.			

1. Purpose

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

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

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

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

2. Key updates

2.1. The board last received the BAF in January 2024. Since then all risks have been reviewed by the responsible executive(s) and updated where appropriate. They have also been transferred into a new BAF format which is designed to support risk-based decision making through greater articulation of the risk and cause, greater visibility of the current status of the risk, and inclusion of the risk appetite. This is supported by the revised risk appetite statement which forms part of the updated risk policy.

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

2.3. At present there are 5 risks which sit outside of the Trust's stated risk appetite, however all but one have a target risk appetite within the tolerable and optimal appetite parameters. The outstanding risk which requires further review of the target rating is 1a.

3. Risk management strategy and policy

3.1 The risk management strategy and policy (v3) has been updated and is attached to this report for the Board's review and ratification. This has been circulated to all divisions and Trust HQ, as well as to the board members, as part of a two-week consultation and has received local governance approval at QGSG. The key changes to the document are stated below:

- Updated risk management definitions, specifically the definitions of 'corporate' risks and 'critical' risks.
- Updated guidance regarding who should review risk assessments when being submitted to the risk register.
- Updated guidance on risk review frequency.
- A revised risk appetite statement following the Trust Board study session in December 2023.

University Hospital Southampton NHS
NHS Foundation Trust

UHS Board Assurance Framework (BAF)

Updated March 2024

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

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

1. Outstanding patient outcomes, safety, and experience

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

2. Pioneering research and innovation

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

3. World class people

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

4. Integrated networks and collaboration

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

5. Foundations for the future

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

Executive Summary

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

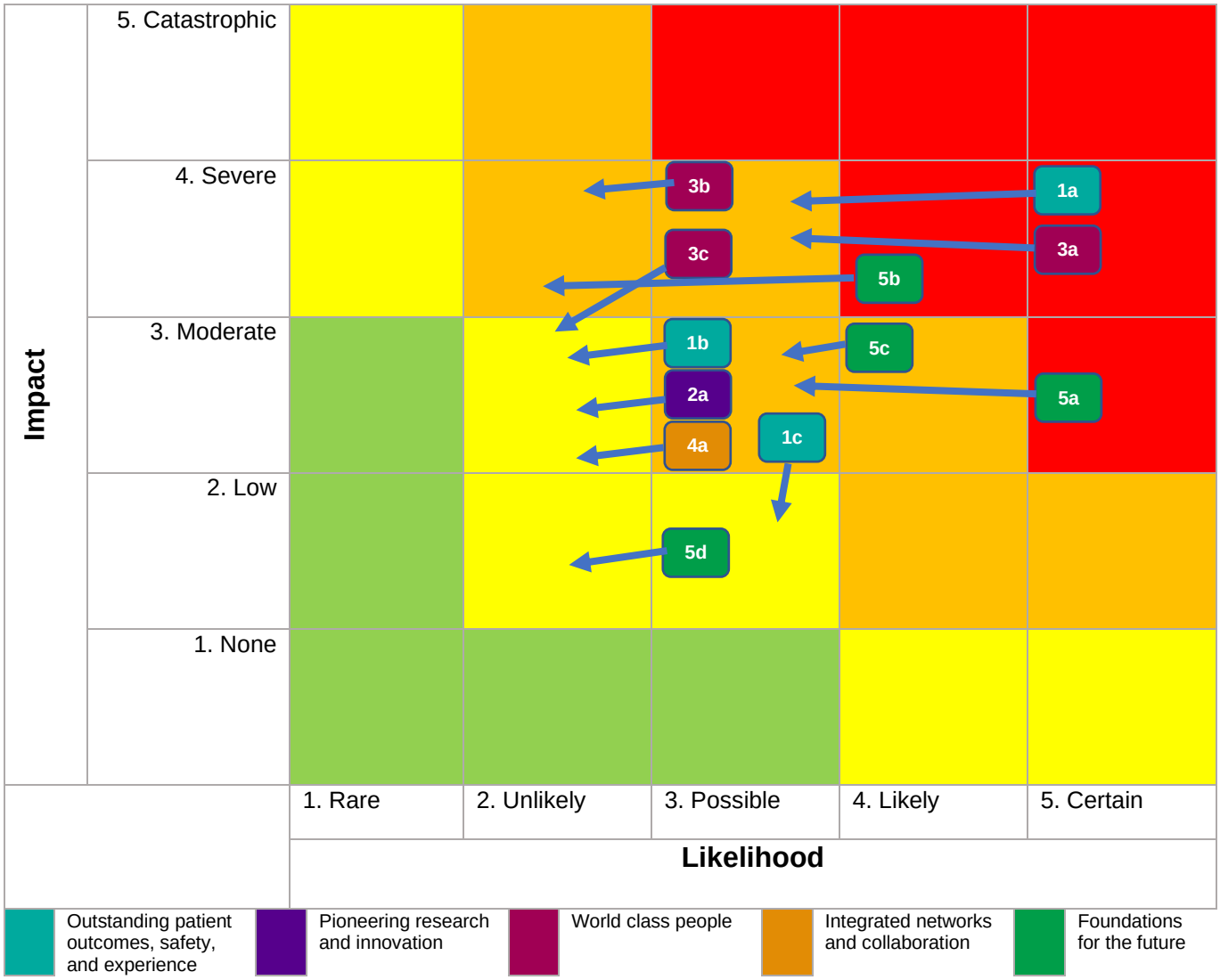
- 1a) Capacity (4 x 5 = 20)
- 3a) Staffing (4 x 5 = 20)
- 5a) Finances (3 x 5 = 15)
- 5b) Estates (4 x 4 = 16)

At present there are 5 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1c, 3a, 5a, and 5b. All of these risks are being actively treated with the aim of reducing the risk score.

1 risk has a target risk rating which sits outside of the optimal or tolerable risk appetite. This is 1a.

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 *Both current and target risk ratings are outside of the optimal and tolerable appetites.*	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	March 2024	4 x 3 12	April 2025

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

Current assurances and updates

- An external visit from the Emergency Care Intensive Support Team took place in February 2024 and we have now received their report with findings and recommendations to review and implement.
- Managing risk around urgent care remains a key priority as we continue to see high demand for services, and challenges discharging patients without a criteria to reside (medically fit). This results in queuing within the emergency department and a higher number of ambulances waiting outside than usual.
- UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board.
- There is a current increased focus on home before lunch, flow, and utilisation of discharge lounges.
- Waiting lists for elective care have stabilised with a 3-400 patient waiting list reduction in January.

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. Outpatient transformation programme focused on reducing follow up demand. Operating services transformation programme to improve theatre utilisation / treat more patients. Use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. Challenges in staffing ED department during periods of extreme pressure. Ongoing industrial action through 23-24 and into 24-25 presents significant risk to the Trust's ability to meet ongoing demand on our services.

Rapid Improvement Plans to support improvements across cancer pathways.	Staff capacity to engage in quality improvement projects due to focus on managing operational pressures.
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	Lack of granular plans at specialty level to support reduction in outpatient follow ups. Plans are being formulated to address flow however these are not fully established and robust enough to provide full assurance that the issue can be addressed comprehensively and sustainably. Local system plans to reduce patients without a criteria to reside are emerging but currently lack detail to provide assurance.

Key actions

Self-assessment against NHS Impact with a strategic plan generated regarding leadership, quality improvement and organisational development.

Review of local delivery system plan for reducing delays throughout the hospital.

Deliver target of 113% of 19/20 baseline activity to secure additional funding and address waiting lists.

Deliver plans to hit the trajectory of no patients waiting over 65 weeks by March 2024.

Community Diagnostic Hub opening in Q4 2024/5 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign.

Engagement in the NHSE Further Faster programme for elective care.

Improvement work on flow focussing on 3 key areas: home before lunch, clinical standards, and Urgent & Elective Care (UEC).

Implementation of cardiology pathway within ED.

Use of SDEC to deliver appropriate care based on acuity and support flow within ED. Supported by GPs at the front door between January and March 2024, and on strike days, as funded by the ICB.

Review of ED workforce model against national workforce tool has been completed resulting in an uplift to nursing staff.

Additional wards have been opened (Cancer Care D12 opened in August 2023 and a medical ward E12 opened December 2023).

New appointment to the leadership team with TS as Clinical Director of the UEC.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	3 x 5 = 15	3 x 3 = 9	31/08/2024
95	Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital.	3 x 5 = 15	2 x 3 = 6	29/02/2024
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	30/06/2024
218	Patients will experience loss of vision if additional outpatient follow up capacity is not identified.	5 x 3 = 15	4 x 3 = 12	30/06/2024
259	Capacity and Demand in Maternity Services	4 x 4 = 16	2 x 2 = 4	31/08/2023
394	Patients will come to harm due to long waiting times if there is Insufficient capacity for elective neurosurgery	4 x 4 = 16	3 x 2 = 6	31/08/2024

470	Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery.	4 x 4 = 16	3 x 2 = 6	30/09/2024
541	An increase in 2ww referrals within dermatology	5 x 3 = 15	3 x 3 = 9	31/07/2024
566	Delays in patient treatment and surgery due to insufficient theatre capacity for Gynaecology patients	3 x 5 = 15	2 x 2 = 4	31/12/2024
640	There is a risk that medically fit for discharge (MOFD) patients, or those not meeting criteria to reside, will suffer harm as a result of increased length of stay and limited bed capacity.	5 x 5 = 25	4 x 3 = 12	01/04/2024
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 5 = 15	3 x 1 = 3	31/12/2024
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	26/04/2024
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	30/06/2024

Outstanding patient outcomes, safety and experience

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

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

Cause	Risk	Effect
If demand outstrips capacity, and/or we have insufficient workforce to meet the demand,	This could result in an inability to provide a fully comprehensive, and exceptional, experience of care,	Resulting in not fully meeting the needs of our patients and their families and carers, which may lead to an increase in complaints and poor feedback. Additionally patents may suffer delays, complications, poorer outcomes, and longer lengths of stay if their needs are not addressed at the earliest opportunities.
Category	**Appetite**	**Status**
Experience	Cautious *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk rating.*	Treat

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

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

Current assurances and updates

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

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

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

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

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

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

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

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

Fundamentals of care programme roll out across all wards.

Patient experience initiatives

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

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

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

Measures in place to identify and share thematic learning.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
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	30/11/2023
765	Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS	4 x 4 = 16	4 x 2 = 8	31/01/2024

Outstanding patient outcomes, safety and experience

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

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

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

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

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

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

Current assurances and updates

- PPE guidance has been reviewed including launch of a reduced glove usage campaign.
- Covid measures have been reviewed including removal of the need to cohort covid contacts as data has shown as reduced conversion rate from contact to infection, and that those who did become infected only displayed mild symptoms.
- The fundamentals of care are currently being rolled out which includes embedding IPC protocols. This also addresses learning from the recent MRSA BSIs around use of chlorhexidine.
- Guidance disseminated around identifying potential cases of measles and monitoring symptoms, supported by national messaging and encouragement of vaccinations.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention agenda. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Assurance Framework. COVID ZERO and #Don'tGoViral campaigns. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify HCAIs. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.	Transmissibility of Covid and other infections such as norovirus, RSV and influenza. Non-compliant patients and lower uptake of vaccinations due to 'vaccine fatigue'. Refamiliarisation with response to resurgence of other common infections such as norovirus. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.

Key assurances	Gaps in assurances
Gold command infection control. Hand hygiene and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery. Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.).	Ward and bay closures due to norovirus outbreaks. Increased in C.Diff and MRSA including a small number of MRSA BSIs (blood stream infections).
Key actions	
Ongoing campaigns to include all viruses supported by internal and external communications plan. Review infection prevention measures in response to changes in guidance and move to 'living with COVID'. Completed work to decentralise COVID pathways, with COVID positive patients to be cared for in the appropriate specialist areas. Review of infection prevention methods for C-diff following missing trajectory. Focussed education on catheter associated urinary tract infection (CAUTI) prevention through Trust wide newsletter August 2023.	

Pioneering research and innovation

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

Monitoring committee: Trust Board	**Executive leads:** CMO

Cause	Risk	Effect
If there is: • insufficient research workforce and limited capacity in clinical support services; • an organisational culture which does not encourage and support staff to engage with research and innovation.	This could lead to: • an inability to set-up and deliver research studies in a safe and timely manner; • a lack of development opportunities for staff which impacts the next generation of researchers and innovators.	Resulting in: • failure to deliver against existing infrastructure awards; • impact our national ranking; • reduced access for patients to innovative new treatments; • reputational damage to our university teaching hospital status and ability to secure funding awards in the future.

Category	Appetite	Status
Technology & Innovation	Open *Both the current and target risk ratings are within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 3 9	March 2024	3 x 2 6	January 2025

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

Current assurances and updates

- Impact of recruitment processes on vacancy rates in research workforce and clinical support services starting to impact performance, with 10% vacancy rates across research delivery teams. Some recruitment now proceeding.
- Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency.
- R&D Trust Board KPI's being monitored closely to benchmark our performance nationally.
- Joint Research Vision being developed with University of Southampton, to agree strategic alignment and future opportunities for growth as a university hospital partnership.
- Innovation workshop - to develop processes for UHS/UoS partnership and in longer term a UHS innovation strategy.
- Research & Improvement workshop as starting point for closer system working.

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.	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. No overarching strategy to support innovation.

Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	
Key assurances	**Gaps in assurances**
Governance structure surrounding University partnership. Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint executive group for innovation. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation.	Limited corporate approach to supporting innovation across the Trust. National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway.
Key actions	
Staff survey to test staff engagement and understanding of innovation at UHS. Deliver R&I Investment Case. Ongoing work to review investment and return. International Development Centre, attracting external funding to support staff in pursuing innovation. Execute an agreed joint programme of work with partners through establishing executive group for education. Maximise the benefits of the newly established Wessex Health Partnership as a founding member. Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Review the Trust's approach to corporate-wide innovation.	

World class people

3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles

Monitoring committee: People & Organisational Development Committee | **Executive leads:** CPO

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience, and may be damaging to staff engagement and morale.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	March 2024	4 x 3 12	March 2026

Risk progression: (previous 12 months)

Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- There are extensive recruitment controls in place presently which have been necessary to slow overall headcount growth in light of nationally directed financial pressures. However this results in a tension between current clinical and operational demand and the workforce available.
- Current turnover rate is acceptable at 11.5% and we are meeting the sickness target (rolling average of 3.8%).
- Good progress has been made in year re: the nursing vacancy rate (7%). This has supported good progress in reducing bank and agency staff in recent months.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year2 monitored through POD. Recruitment and resourcing processes. Workforce plan and overseas recruitment plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Overseas recruitment including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review).	Ability to fully manage demand on workforce requirements due to external factors such as patient needs, criteria to reside, industrial action. Complete data reviews to ensure alignment of HR and Finance information. Completion of divisional workforce plans to ensure local ability to track progress. Differential pay grading across the ICS leading to retention difficulties. Full workforce CIP identification for 2023/24.

Key assurances	Gaps in assurances
Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative diagnostic analysis on effectiveness.	Improving forecasting of WF position at year end. Universal rostering roll out including all medical staff. Full review of new national workforce plan (published July) for impacts at UHS.

Key actions

Approval of Year 2 objectives supporting delivery of the Trust's People Strategy.

Deliver workforce plan for 22/23 including increasing substantive staff in targeted areas offset by reducing temporary agency spend.

To develop and implement Divisional Workforce Plans.

To deliver specific plans to reduce reliance on temporary workforce. To focus on delivery of workforce CIP in partnership with finance and the Divisional teams.

To improve data reporting on workforce to support decision making, and alignment with finance reporting. To improve workforce prediction and forecasting.

To implement a range of programmes to reduce turnover to 13.6%.

To implement a range of measures to reduce our staff absence to 3.9%.

To implement a range of measures to improve medical deployment. Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups.

Continued management of industrial action to mitigate patient impact, and continue to support staff motivation, morale and wellbeing.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
258	Maternity Staffing during peaks of activity	4 x 5 = 20	5 x 1 = 5	31/10/2024
578	Impact of reduced critical care outreach team service due to vacancy rate and skill mix on patient safety for adult deteriorating patients and ward based teams across UHS and personal health and wellbeing impact on CCOT ACPs.	4 x 4 = 16	2 x 2 = 4	31/12/2024
658	There is a risk that UHS resources within the trust are unable to keep up with the workload generated by HM Coroner.	3 x 5 = 15	3 x 3 = 9	01/04/2024
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2024
705	Significant Risk to Service Provision for Neuroradiology	4 x 5 = 20	3 x 3 = 9	31/05/2024

World class people

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If longstanding societal and NHS wide challenges surrounding inclusion and diversity, and current operational pressures on the NHS post covid, are not mitigated;	There is a risk that we will not recruit a diverse workforce with a range of skills and experience, and that we will not develop and embrace a positive and compassionate working culture where all staff feel valued;	Resulting in a detrimental impact to staff morale, staff burnout, higher absence and turnover, and the potential for reputational risk and possible litigation. This in turn has an impact on our patients when staff capacity cannot match clinical requirements, as we need to look after our staff to enable them to look after our patients.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	March 2024	4 x 2 8	March 2027

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

Current assurances and updates

- The annual staff survey results are being published 07 March 2024 with action plans to be developed where there are areas of concern.
- NHSE are conducting a review of the surgical directorate supported by workshops developing action plans.
- The inclusion and belonging strategy continues to be implemented.
- All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. **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.	To recruit to the new network leads for the Trust and re-energise the network capacity and capability. Coverage of allyship training. Embedded responsibility for all leaders on inclusion.

Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation
Key actions	
Building an inclusive and compassionate culture Deliver year 1 objectives of the new Inclusion and Belonging strategy by March 2024: This includes • 50% of UHS staff to have participated in Allyship training by 31 March 2024 • Completing the inclusive recruitment review • Strengthening the role of the staff networks • Embed the belonging blue print • Deliver another cohort of positive action programmes • To improve the quality and dept of EDI data to support decision making, • Ensuring all Board members objectives include a focus on EDI. To deliver an enhanced staff recognition and reward programme including: • Delivery of the new We are UHS Awards • Deliver We are UHS week in September 2023 • New in-person monthly staff spotlight meetings • Refreshed weekly news to keep staff up to date • Peer to peer thankyous which are easy to enact Refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.	

World class people

3c) We fail to create a sustainable and innovative education and development response to meet the current and the future workforce needs identified in the Trust's longer term workforce plan

Monitoring committee: People & Organisational Development Committee	**Executive leads:** CPO

Cause	Risk	Effect
If there is: • Limited ability to recruit staff with suitable skills to support education; • Lack of current national education financing and changes in the way the education contract will function; • Inflexibility with apprenticeship regime;	This may be: • A lack of development for staff affecting retention and engagement; • Reduced staff skills and competencies; • Inability to develop new clinical practices.	This could result in: • An adverse impact of quality and effectiveness of patient care and safety; • An adverse impact on our reputation as a university teaching hospital; • Reduced levels of staff and patient satisfaction.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 3 12	March 2024	3 x 2 6	March 2025

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

Current assurances and updates

- New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.
- Reported inability of staff to participate in statutory, mandatory, and other training opportunities.
- TNA process completed for 2024/25. Allocations will be made when funding confirmed.

Key controls	Gaps in controls
Education Policy	Quality of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development
Access to CPD funding from HEE and other sources	Releasing staff to attend core training, due to capacity and demand
Leadership development talent plan 2023-2024	Releasing staff to engage in personal development and training opportunities
Executive succession planning	Limited succession planning framework, consistently applied across the Trust.
	Areas of concern in the GMC training survey
Key assurances	**Gaps in assurances**

Annual Trust training needs analysis reported to executive Trust appraisal process GMC Survey Education review process with Health Education Wessex Utilisation of apprenticeship levy Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme Full review of new national workforce plan(published July) for impacts at UHS.
Key actions	
To increase the proportion of appraisals completed and recorded to 85%, and increase staff quality perceptions on appraisal by March 2024. Take specific targeted action to improve areas of low satisfaction in the GMC survey. Building strategic partnerships with new Southampton UTC and the new FE colleges alliance, increasing our overall usage of the apprentice levy (March 2024) Relaunch/refresh of the VLE need to be put down as a key action in terms of supporting people to access more self directed learning opportunities? Implement the leadership development and talent plan throughout 2023 and 2024 Strategic leadership programme and positive action programmes	

Integrated networks and collaboration

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

Monitoring committee: Quality Committee	**Executive leads:** CEO, CMO, Director of Networks & Strategy

Cause	Risk	Effect
Historical structures and culture have not encouraged or enabled collaborative networked pathways.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits within the tolerable risk appetite and the target risk rating sits within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	3 x 3 9	March 2024	3 x 2 6	April 2024

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

Current assurances and updates

Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list, but discussion for several specialties includes where services should be delivered. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy.

The strategic intent is to bring the two ISTCs (RSH and St Mary's) back into NHS control when the current contracts with PPG expire. Commissioners are aligned and will support the change contractually.

Elsewhere, discussions with UHD regarding UGI surgery are ongoing. Practical implementation of new pathways and working arrangements, eg UHD surgeons operating in Southampton is, as always, difficult to achieve.

Key controls	Gaps in controls
Key leadership role within local ICS	Potential for diluted influence at key discussions
Key leadership role within local networked care and wider Wessex partnership	Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local
UHS strategic goals and vision	Form and scope of role for HIoW APC in relation to ICS and other acute provider collaboratives
Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC)	Work to develop a shared pharmacy model with Portsmouth has been delayed, and the Trust is looking at alternative options.
Establishment of UHS Integrated Networks and Collaboration Board focussing on delivery of the four network types, (Integrated community, Hospital networks, Specialised services and Diagnostic networks)	The costs associated with the Elective Hub in Winchester may have been underestimated. Additional funding sources may need identifying.
	Vacancies and movement within the senior leadership team has slowed pace.

Key assurances	Gaps in assurances
CQC and NHSE/I assessments of leadership CQC assessment of patient outcomes and experience National patient surveys Friends and Family Test Outcomes and waiting times reporting Integrated networks and collaborations Board set up for regular meetings at executive level	Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. Specialised Commissioning budget delegation deferred until April 2024. Ability to network is difficult and manifests in capacity challenges.

Key actions

ICS and PCNs

Priority networks reviewed and updated against UHS network maturity framework; and agreed by trust board for 2023/24.

Integrated Networks and Collaboration

Urology Area Network plan agreed. Progress stalled due to lack of programme management resource and clinical lead stepping down. Clinical leadership

Support for networks from clinical programme team continues. This is challenging due to lack of resources from other organisations and constrained resource within the UHS team.

Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in Q1 of 2024/25.

Business case development for aseptic services and elective hub by HIoW APC has been approved and is moving into the implementation phase.

Further development of HIoW APC to drive improvements in outcomes

Development of proposals for next phase for Community Diagnostics Centres.

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.

NHSE has approved the business case for the Elective Hub, this is a significant step forward and now moving ahead.

Tim Briggs, National Director of Clinical Improvement, and team engaged to support HIOW on 'Further Faster' programme.

ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor.

Funding for dermatology AI pathway secured.

Foundations for the future

5a) We are unable to deliver a financial breakeven position resulting in:

- **Inability to move out of the NHS England Recovery Support Programme.**
- **NHS England imposing additional controls/undertakings.**
- **A reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.**

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (NCtR), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position;	This may result in the measures outlined above regarding the Recovery Support Programme, and the Trust's inability to invest and grow due to a reducing cash balance.
Category	**Appetite**	**Status**
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 5 20	April 2022	3 x 5 15	March 2024	3 x 3 9	April 2025

Risk progression: (previous 12 months)	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	3 x 5 15	3 x 5 15	3 x 5 15

Current assurances and updates

- The risk rating was reduced in December 2023 following a piece of work to review the overall BAF and the impact, and ensure that these align. It is important to note that the risk itself has not changed and that this remains a critical strategic risk for the Trust.
- The latest updates to this risk reflect the new recruitment controls implemented and the framework for this providing governance, senior oversight and leadership.
- The risk has been updated to reflect that we are in the Recovery Support Programme and aiming to exit in 24/25, updated from the risk of entering RSP.
- The controls have been reviewed with a view to streamlining content and aligning to new report format.
- Interim target reduction in risk has been pushed back due to known continuation of financial pressures that cannot be resolved by April 24. Aligned to planned exit of RSP in October 24.

Key controls	**Gaps in controls**
Internal • Financial strategy and Board approved financial plan. • Financial Recovery Plan agreed in November and reported monthly into Trust Board. • Trust Savings Group (TSG) oversight of CIP programme (£69m). • Transformation Oversight Group (TOG) overseeing delivery of 23/24 transformation programmes including financial benefits. • Implementation of further recruitment controls including a recruitment pause and clinical prioritisation panel which work alongside	**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. • Grip of system wide initiatives and assurance of delivery e.g., Non-Criteria to Reside. • Shortfall in funding from the pay award.

existing robust controls via the recruitment control panel. • 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 **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local / Primary Care • Staffing Improved "grip and control" measures with consistent application across all organisations.	• Continued impact of industrial action on activity levels, impacting Trust income and cost.
Key assurances	**Gaps in assurances**
• Regular finance reports to Trust Board & F&IC • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • Trust Savings Group oversight of financial recovery plan and CIP programme actions • F&IC visibility and regular monitoring of detailed savings plans • Operating plan based on cash modelling to ensure affordability of capital programme.	• Current short-term nature of operational planning • Lack of confidence in system-wide initiatives – for example impact of reduced Hospital Discharge Programme funding on Non-Criteria to Reside patients in UHS.
Key actions	
• Deliver the planned financial deficit for 23/24, including the Financial Recovery Plan. • Improve the underlying financial run-rate back to break-even by October 2024 as required by the Recovery Support Programme. *(to be reviewed in planning for 24/25)* • Improve identification of CIP and reduce value of high-risk schemes. • Work across health system partners to deliver system initiatives (e.g., planned care, urgent care, Non-Criteria to Reside etc.) • Support the organisation to understand the current financial environment, whilst balancing performance, quality and staff morale. • Quantify and monitor delivery of financial productivity benefits from 24/25 Transformation programme. • Work with the system to review payment infrastructures and incentives in 24/25. • Exit short-term recruitment pause / control measures, agreeing a new sustainable recruitment control process and an agreed affordable workforce plan. • Broadly on-track to deliver 23/24 forecast deficit, noting some planned improvements are required to deliver in M11/M12.	

Foundations for the future

5b) We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services;	There is a risk that our estate will prohibit delivery and expansion of clinical services;	Resulting in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose

Category	Appetite	Status
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
4 x 4 16	April 2024	4 x 4 16	March 2024	4 x 2 8	April 2027

Risk progression: (previous 12 months)	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

- The target risk rating has been reviewed in consideration with the risk appetite and this has been reduced from 12 (4 x 3) to 8 (4 x 2).
- The target date for reaching the target risk rating has been extended until April 2027 (from April 2025) in light of operational and financial pressures, and the intention to further reduce the risk as above.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Missing funding solution to address identified gaps in the critical infrastructure.
Up-to-date computer aided facility management (CAFM) system	Missing funding solution to address procurement of new system.
	Timescales to address risks, after funding approval.
	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
Asset register (90% in place)	Requires new CAFM system to fully understand gaps and address outstanding assets.
Maintenance schedules	Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work.
Trained, accredited experts and technicians	Recruitment controls inhibiting recruiting to key roles.
Asset replacement programme	Missing funding solution to address procurement of new system.
Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)	Derogation policy to be introduced.
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. Estates strategy for the next 5 years.	 Missing process to highlight all 12+ risks from the six facet survey. Missing funding solution to deliver strategy.
Key assurances	**Gaps in assurances**
Compliance with HTM / HBN monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Derogation policy to be introduced. Gap in funding to respond to issues. Funding streams to be identified to fully deliver capacity and infrastructure improvements

Key actions

Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn.

Identify future funding options for additional capacity in line with the site development plan.

Delivery of 2023/24 capital plan

Implement the HOIW elective hub.

Deliver £5m of critical infrastructure backlog maintenance. £4.2m in 2024/25.

Agree plan for remainder of Adanac Park site

Site development plan for Princess Anne hospital.

CAFM System to be presented to November 2023 Trust Investment Group. Complete – this was rejected.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
34	Imminent failure of the pharmacy logistics robot	3 x 5 = 15	2 x 2 = 4	29/03/2024
260	Insufficient space in the induction of Labour Suite.	4 x 4 = 16	3 x 1 = 3	29/03/2024
262	Insufficient space on Maternity Day Unit	4 x 4 = 16	5 x 1 = 5	29/03/2024
489	Inadequate Ventilation in in-patient facilities	5 x 3 = 15	5 x 1 = 5	31/05/2024
548	HV West side transformer circuit breaker trip not operating	4 x 4 = 16	4 x 1 = 4	31/08/2024

Foundations for the future

5c) We fail to introduce and implement new technology and expand the use of existing technology to transform our delivery of care through the funding and delivery of the digital strategy

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If there are inhibitors to implementing digital technology either due to funding, capacity, technology, or resource constraints	This could mean that our digital technology or infrastructure is unable to support the Trust in delivering clinical, financial, or operational objectives	Resulting in an inability to deliver the right level of patient care required in line with Trust strategy
Category	**Appetite**	**Status**
Technology & Innovation	Open *The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	3 x 4 12	March 2024	3 x 3 9	March 2025

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

Current assurances and updates

- The long term target risk achievement date has been extended to March 2025.
- New firewall and email gateway equipment has been installed and has added to our cyber capacity and protection available to the Trust.
- Major system upgrades across Ophthalmology (Open Eyes), ED (Alcidion Miya), and Pathology (WinPath Enterprise) will be going live through Q1 and Q2 2024/25. This moves UHS to more up to date and stable software.

Key controls	Gaps in controls
Digital prioritisation programme, informed by clinical priorities, supported by chief clinical information officers and chief nursing information officers, and safeguarded by clinical safety officers Digital strategy incorporating: • technology programme • clinical digital systems programme • data insight programme	Hampshire and Isle of Wight ICS digital strategy yet to be fully finalised, including digital convergence, and alignment with wider expectations. Funding to technically refresh and for digital development, including the impact of proposals for 'levelling up' as part of funding distribution decisions for the funding available. Ability to implement workforce plan to retain staff needed to underpin strategy Cyber security and recovery capability requires investment and development Development of a non-clinical/business systems strategy
Key assurances	**Gaps in assurances**
Monthly executive-led digital programme delivery group meeting Finance oversight provided by the Finance and Investment Committee	Funding to cover the development programme, improvements, and clinical priorities Difficulties in understanding benefits realisation of digital investment.

Quarterly Digital Board meeting, chaired by the CEO	ICB outline business case funding for EPR

Key actions

Ongoing recruitment of key Digital resource to mitigate operational risk. Cyber security and leadership roles have been recruited to.

Achieve 200,000 My Medical Record (MMR) accounts and 30% paper switch-off

Inpatient noting for nursing has been rolled out to all appropriate wards

Digital ophthalmology system project 'open eyes' to be implemented

Identify opportunities for funding for digital transformation and programmes.

Robust programme prioritisation in line with available funding.

Develop benefits realisation calculations across whole digital programme, linked to other Trust transformation programmes

Develop digital literacy across trust to support rollout of new products

Explore commercial partnership options to mitigate lack of UHS workforce to deliver strategy.

Implementation of new Emergency Department patient flow and vital signs systems via Alcidion.

Joint delivery of Outpatient, Inpatient and Operating Efficiency programmes with Transformation team through single programme governance

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	31/03/2024
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2024

Foundations for the future

5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045

Monitoring committee: Trust Executive Committee	**Executive leads:** CMO

Cause	Risk	Effect
If we fail to deliver the current decarbonisation plan and build upon it to meet 2032 target.	This could lead to increased costs, reputational damage and potentially subject UHS to national scrutiny.	Resulting in higher costs, reduced national standing and reduced resilience
Category	**Appetite**	**Status**
Technology & Innovation	Open *Both the current and target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 3 6	March 2024	2 x 2 4	December 2024

Risk progression: (previous 12 months)	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6

Current assurances and updates

- Current decarbonisation plan does not complete journey to Net Zero and further steps will require funding to be sourced but continuing to identify opportunities.
- Progress EPC Works – Veolia on site, established, met year one programme which lines us up to meet interim benefits in year 2.
- Secured additional LED lighting funds from grant sources to reduce energy usage.
- Travel plans progressing well nearing final draft, and sustainable travel promotions through various avenues.
- Clinical Sustainability plan yet to be completed though several actions underway.
- Have now developed a dashboard-based set of metrics reporting to sustainability board.
- Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.

Key controls	**Gaps in controls**
Governance structure including Sustainability Board (with patient representation), Sustainability Delivery Group and Clinical Sustainability Group Appointment of Executive Lead for Sustainability Green Plan	Clinical Sustainability Plan/Strategy (CSP) Sustainable Development Management Plan (SDMP) Long-term energy/decarbonisation strategy Communications plan
Key assurances	**Gaps in assurances**
Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 Quarterly reporting to NHS England and NHS Improvement on sustainability indicators Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones

Key actions	
Agree funding requirements to commence the delivery of the strategies Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. Develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies. Review green energy ambitions following extreme rises in electricity costs. Forward plans to review energy contract.	

Risk Management Strategy and Policy, Version 3 (draft)

Description	This document describes the Trust's approach to managing risk. It sets out the method of identification, assessment, treatment and tolerance of risk across the organisation. The overall objectives for this document are: ▪ to provide a clear process for undertaking and escalating a risk assessment, ▪ to detail the framework for risk management at all levels of the organisation, ▪ to deliver assurance that risks are appropriately identified, assessed, prioritised, addressed and monitored, ▪ to detail staff roles and responsibilities to embed the concepts of risk management into day-to-day working practices, and ▪ to support and promote ongoing development of risk.
Description	Level one Trust-wide corporate policy – controlled document.
Target audience	All staff employed by University Hospital Southampton NHS Foundation Trust.
Related documents/policies (do not include those listed as appendices)	Health & Safety policy UHS Patient safety incident response plan
Author(s) (names and job titles)	Lauren Anderson, Corporate Governance & Risk Manager.
Policy sponsor	Gail Byrne, Chief Nursing Officer

Approval committee		Approval date	
Trust Board		TBC	
	Version	Publication date	Next review due
CA003	3	TBC	TBC

This is a controlled document. Whilst this document may be printed, the electronic version posted on Staffnet is the controlled copy. Any printed copies of this document are not controlled.

As a controlled document, this document should not be saved onto local or network drives but should always be accessed from Staffnet.

1 Version control

Date	Author	Version created	Page	Key changes
August 2021	Jake Pursaill	1	All	Combination and re-rewrite of separate appetite, strategy, and policy documents.
July 2022	Jake Pursaill	2	12 6	Review of risk appetite statement by Audit and Risk Committee, approved by Trust Board. Minor spelling mistake corrected.
February 2024	Lauren Anderson, Corporate Governance & Risk Manager	3	7 9 12 12 14 All	Updated risk management definitions. Updated risk assessment guidance to clarify who should review risk assessments before addition to the risk register. Updated guidance on risk review frequency. Updates to the risk appetite statement as reviewed by the Board in December 2023. This is now included as appendix 4. Updated appendices to include the risk appetite statement as above and the updated risk assessment template. Minor grammatical and formatting amendments throughout.

2 Index

3 Introduction

3.1 The Board of Directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (the **Trust**) has established its risk strategy and risk appetite. This policy sets out the key aims and objectives for risk management, and the systems on processes by which we will achieve these aims.

3.2 The overall aim of this Risk Management Strategy and Policy is to support the delivery of the organisational aims and objectives through effective management of risks across all of the Trust's functions and activities using effective risk management processes, measurement, analysis and organisational learning.

3.3 The Trust recognises that risk management forms an integral part of its philosophy, practices and the business planning cycle. The Board must be able to assure itself that the organisation is operating effectively and meeting its key aims, goals and principal strategic objectives.

3.4 This document is designed as guidance to assist with proactive risk management and risk mitigation:

- to support the organisation in its approach to ensuring the safety of staff, patients, visitors and others affected by the Trust's activities, and
- to ensure that both risk and opportunity are taken into account in business planning and operations.
- to comply with legal and statutory requirements and with the requirements of external regulators and other relevant bodies,

3.5 The Trust's approach to risk management aims to be forward-looking, innovative and comprehensive; to make the effective management of risk an integral part of everyday practice. It aims to support a culture which encourages continuous improvement and development and a focus on proactive rather than reactive risk management and to support well thought through decision-making. Risk management is embedded in the Trust's governance framework and is an integral part of business planning and investment decisions.

3.6 This policy and its procedures aim to clarify the systems, roles and responsibilities in place to enable the Trust to adequately address risk in its operating environment.

4 Purpose and Scope

4.1 The purpose and scope of the Trust's Risk Management Strategy and Policy is to detail the framework within which the Trust leads, directs and controls the risks to its key functions in order to ensure the safety of services and care delivered to patients, that the wellbeing of patients, staff and visitors is optimised, that the assets, systems and income of the Trust are protected and that the strategy and objectives of the Trust are achieved. The Risk Management Strategy and Policy underpins the Trust's reputation and performance and is fully endorsed by the Board. The framework will enable the Trust to comply with health and safety legislation, its provider licence and principles of good governance.

4.2 This policy is separate to the Trust's clinical risk assessment tools and the health and safety risk assessment, and risks to delivery of projects, though there are clear overlaps.

4.3 The Trust acknowledges its legal and moral duty to safeguard all staff, patients and members of the public. There are also sound moral, financial and good practice reasons for

identifying and managing both clinical and non-clinical risks. Failure to manage risks effectively can lead to harm/loss or damage in terms of both personal injury but also in terms of loss or damage to the Trust's reputation; financial loss; potential for complaints; litigation or claims, and adverse or unwanted publicity.

4.4 This document is therefore intended for use by all Trust employees, both permanent and temporary, and contractors. All staff members will be made aware of the contents on commencement of employment as part of the mandatory e-learning for all staff.

4.5 Significant changes to this document will also be cascaded via the Trust's staff update communication process and/or line management.

4.6 The Trust uses a web-based risk management system, Ulysses Safeguard, for the recording, management, and reporting of risk and management of risk at all levels.

5 Objectives and Overview

5.1 The objectives of this Risk Management Strategy and Policy are as follows:

- to set out the Trust's approach to risk and provide a framework and clear process for robust risk management at all levels within the organisation.
- to outline the framework which provides assurance that risks at all levels of the organisation are being appropriately identified, assessed, prioritised, addressed and monitored.
- to detail the expectations in terms of roles and responsibilities of all staff in order to embed the concepts and ideas of risk assessment, risk management and risk accountability into the day-to-day working practices of the organisation.
- to support and promote ongoing development as a learning organisation.

5.2 By its very nature healthcare is a high risk activity and effective management is often based on taking calculated risks. Risk management helps to ensure that those judgements can be made from a measured range of fully identified options and from a sound knowledge of the risk causes, effects and consequences.

5.3 Effective risk management is best achieved in an environment of openness and transparency in which it is recognised that whilst risk can never be eliminated, it can and must be managed.

5.4 The Board has delegated the responsibility for the management of risk to key groups and committees. These groups and committees are responsible for ensuring divisions, care groups and specialties undertake a full programme of risk management activities, maintain up-to-date risk registers and take action to control these risks commensurate with their risk management responsibilities.

5.5 Committees and groups have terms of reference which have been agreed by the Board or appropriately authorised committee or group. Board committee terms of reference are held by the Company Secretary. A full depiction of the Trust's governance structure and the purpose of each key committee can be found in Appendix 1.

5.6 Risk management is also monitored by external and internal agencies (e.g. Care Quality Commission (**CQC**), NHS England and NHS Improvement, internal and external audit). Performance is monitored against national standards and is subject to self-assessment review and audit. Where performance in these assessments falls below acceptable levels, detailed action plans will be produced and work programmes put in place to improve standards.

5.7 There are a number of indicators that support the implementation and monitoring of the Trust's Risk Management Strategy and Policy, for example; adverse incidents, complaints and

litigation or claims. These indicators are reported monthly at the Quality Governance Steering Group and are reported on in more detail by the divisions at divisional and care group governance meetings.

6 Accountabilities and Responsibilities

6.1 The management of risk is an integral part of management and clinical practice. Every individual within the Trust is therefore responsible for identifying and managing risk. The following individuals have specific risk management responsibilities, accountability and authority, as part of their existing roles.

6.2 All employees (including contracted employees) are responsible for:

- The identification of both clinical and non-clinical risks that exist or emerge within the area in which they work, and the escalation of these identified risks to managers, risk leads or senior management, as appropriate.
- Undertaking working practices that comply with all policies, regulations, procedures and department, workplace and/or task specific safe systems of work.
- Ensuring they act in a manner which is safe and secure for themselves, colleagues, patients, visitors and others who may be affected by their actions, being aware they have a duty to take reasonable care for their own safety and safety of others who may be affected by their acts or omissions.
- Reporting any hazardous situations and accidents/near-miss incidents to the relevant manager(s) as soon as possible and through the Trust incident and near miss reporting system in line with the Incident Management Policy.

6.3 Divisional, care group and service managers are responsible for:

- Ensuring that they and their staff fulfil their responsibility for risk management by identifying, reporting, monitoring and managing risk in line with this and other associated policies, including the Incident Management Policy.
- Ensuring that appropriate and effective governance processes are in place to proactively identify, assess and manage risk within their designated area and scope of responsibility.
- Ensuring that identified risks are recorded, properly assessed, escalated, communicated and managed effectively and appropriately in line with guidance within their area of responsibility so that the consequences of a risk – patient harm, financial loss, reputational damage, etc. – are minimised.

6.4 Chairs of care group and divisional governance meetings are responsible for:

- Ensuring all relevant risks are brought to the meeting on a regular basis for review to ensure they are up to date and being effectively managed.
- Ensuring risks identified at the meeting are transferred to risk registers and are correctly assessed.

6.5 Divisional governance managers are responsible for:

- Playing a key role in supporting the systems and processes for the review and recording of all risks from team level to divisional management board, providing expert advice on grading and escalation/de-escalation where appropriate. This will involve working closely with underperforming teams, providing education and encouragement of how risk reporting improves patient safety.
- Providing education throughout the division on the reporting of risks through the Ulysses Safeguard system.
- Supporting their division in the identification, assessment and reporting of risk.

6.6 The Corporate Governance & Risk Manager is responsible for:

- The development of strategic plans, policies, procedures and statement of purpose documents with regard to risk management.
- The provision of training, information and support for Trust staff in relation to risk management.
- Supporting the divisional governance managers in developing and educating staff regarding risk management including risk registers and the Board Assurance Framework.
- Ensuring relevant risks are reported to external agencies such as commissioners through the oversight groups.
- Ensuring the Ulysses Safeguard risk management system and associated processes are maintained and updated in line with organisational requirements.
- Providing, through oversight, a 'check and challenge' process for all risks on the register with the risk owners through a systematic and documented process.
- Ensuring an appropriate Board Assurance Framework (**BAF**) is prepared and regularly updated, and that it receives appropriate consideration at relevant committees and groups.

6.7 The Associate Director of Corporate Affairs and Company Secretary is responsible for**:**

- Operational management of the implementation of all aspects of the governance and risk management agenda through management of the Corporate Affairs team.

6.8 The Chief Nursing Officer is responsible for:

- Executive sponsorship of the Trust's Risk Management Strategy and Policy.
- Ensuring that the annual governance statement in the Trust's annual report adequately reflects the risk management process within the Trust.

6.9 The Chief Executive Officer has responsibility for:

- Maintaining a system of internal control and assurance that supports the achievement of the Trust's objectives.
- Ensuring that the Trust implements effective policies, systems and processes for the management of risk.
- Ensuring that full support and commitment is provided and maintained in every activity relating to risk management
- Planning for adequate staffing, finances and other resources, to ensure the management of those risks which may have an adverse impact on patients, staff, finances or Trust stakeholders.
- Signing off the Trust's annual governance statement and ensuring it adequately reflects the risk management issues within the Trust.

6.10 Operationally, the Chief Executive Officer delegates responsibility for the implementation of the Risk Management Strategy and Policy to other individuals, as described above.

6.11 Non-Executive Directors, as part of their role as members of the Board and sub-committees, will challenge risk management and governance arrangements within the organisation and receive assurance of the robustness of these arrangements.

6.12 The Quality Governance Steering Group is responsible for ensuring proactive, regular risk management processes are embedded within the divisions. This group will review the quality of risk information escalated to the executive.

6.13 The Audit and Risk Committee is responsible, through delegated authority from the Board, for reviewing the establishment and maintenance of an effective system of integrated governance,

risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives.

6.14 The Board has collective responsibility for the success of the Trust, including the effective management of risk and compliance with relevant legislation. The Board will provide the strategic direction and leadership to the Trust including:

- Protecting the reputation of the Trust;
- Providing leadership on the management of risk and ensuring the approach to risk management is consistently applied;
- Determining the risk appetite for the Trust;
- Ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately; and
- Endorsing risk related disclosure documents.

7 Definitions of Risk Management

7.1 A well implemented risk management framework will improve the quality of services and provide strategic direction to the Trust by guiding staff on the appropriate level of risk they are permitted to take while enabling staff to seize important opportunities.

7.2 Risk can relate to**:**

- **A threat** - an event, circumstance, or hazard which could cause harm or loss, or affect the ability of the organisation to achieve its objectives.
- **An opportunity** – the organisation must take some risks in order to obtain a benefit, to innovate, grow and improve.

7.3 How and where a risk is recorded is dependent on whether it is a strategic or operational risk:

- **Strategic risks** are captured on the **Board Assurance Framework (BAF).** These are organisation wide risks which have the potential to compromise the Trust's ability to deliver its strategic aims and objectives. These risks are identified and managed by the Board and are usually expected to materialise within the next 2-5 years if not appropriately mitigated.

- **Operational risks** are captured on the Trust's risk register system, **Ulysses Safeguard.** These risks are identified within divisions or corporate functions and are usually managed by a local department or division. It is usually expected that they will materialise within the next 24 months if not appropriately mitigated.

7.4 The Trust's **operational risk register** held on Ulysses Safeguard has three levels of management:

- **Trust** – Any risk which affects the whole organisation or multiple divisions; and requires senior ownership and support in mitigating.
- **Divisional** – Any risk that affects multiple services across a division or will have severe consequences which will impact the wider division. Risks that are within the divisional management team's delegated budgetary limits and financial resources.
- **Care Group** – Any risk that affects service or team level only. Risks that are within the local managers' delegated budgetary limits and financial resources.

7.5 Within the Trust's **operational risk register** there are subsets of risks:

- **Corporate risks–** these are operational risks which may impact the strategic risks held on the Board Assurance Framework.

- **Critical risks–** these are the highest rated risks scoring 15 or above in the risk assessment matrix. Targeted management of these risks with the aim of reducing the level of risk should be a priority as if the risk materialises it is likely that there will be a significant impact.

8 Cycle of Risk Management and Review

8.1 The Trust's process for identification and management of risks requires proactive and forward looking risk identification, coupled with a regular review of existing risks:

8.2 These steps are illustrated in more detail in the following sections, and a glossary of terms used is provided as Appendix 2*.*

8.3 For risks scoring 12 or above a monthly review of risk information is required. Senior leaders and members of the executive team will use this risk information for decision-making and timely information is therefore key.

9 Risk Identification

9.1 The principal tool the Trust uses for managing its identified risks is the risk register, which can be described as "a log of risks identified, both clinical and non-clinical, that might have an impact on the Trust's delivery of its aims and objectives". The Trust uses the web-based governance tool Ulysses Safeguard to manage the risk register. To help determine whether a risk is present which requires entry onto the risk register, a risk assessment may be completed. This is included as appendix 5 of this policy.

9.2 Risks will be identified from both internal and external sources. The Trust aims to be as proactive as possible, as this makes a managed response to risk possible. This avoids the need to make decisions under unnecessary pressure without adequate information or resource.

9.3 The Trust has a range of risk assessment tools to identify risks and potential risks associated with its activities. Examples include: risk assessments (clinical and non-clinical), peer reviews, audit (clinical and non-clinical), impact assessments, CQC inspections and monitoring visits, complaints and concerns, incidents and SIRIs and claims.

10 Risk Assessment

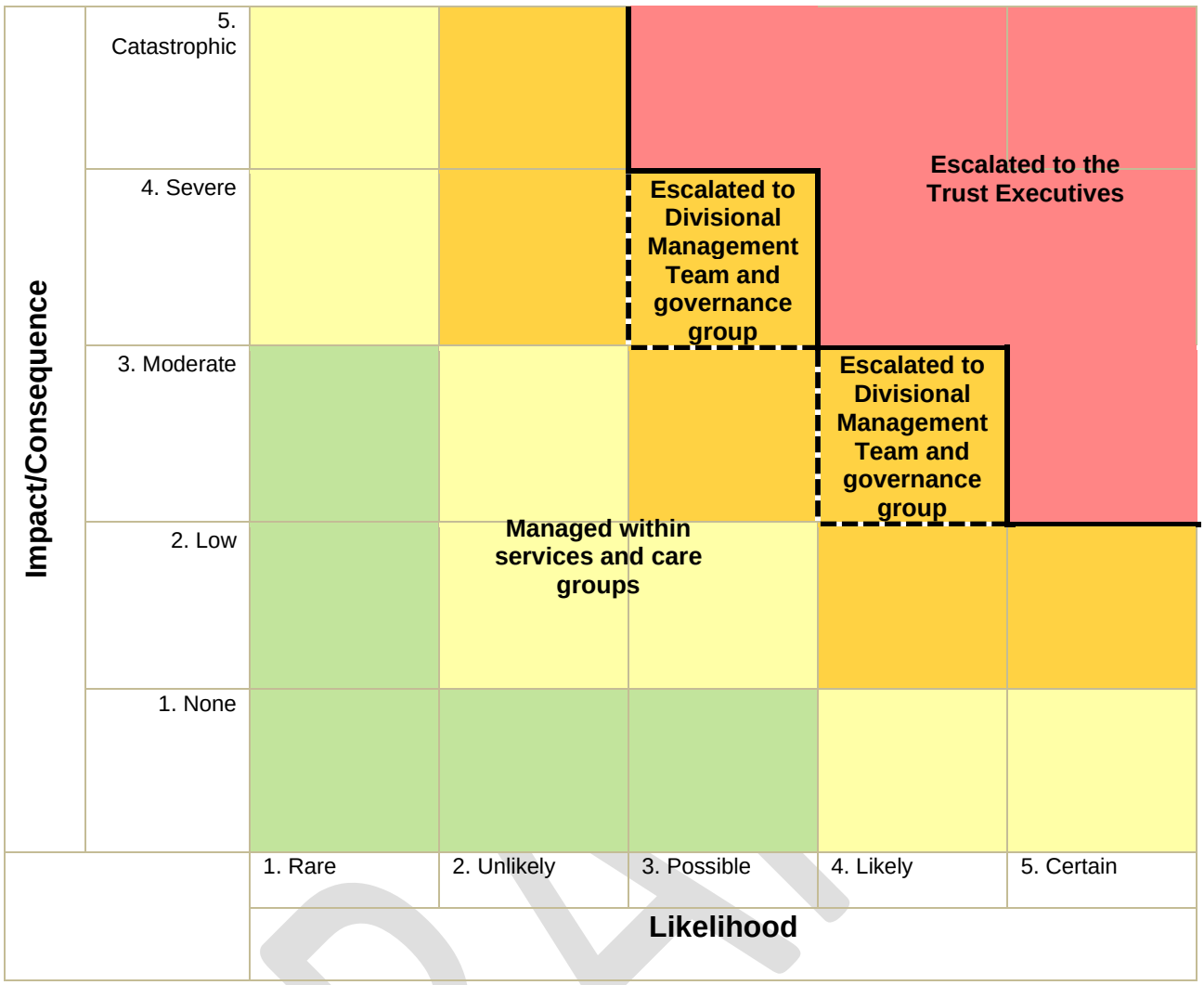
10.1 The Trust deploys a standardised approach to risk assessment across the entire organisation to ensure consistency.

- Risks are assessed based on the impact of the risk and the potential likelihood to occur: The impact is based on a number of factors, for example; the financial implications, the number of service users or staff potentially affected, the ability of the Trust to achieve its objectives or the effect on the Trust's reputation.
- The likelihood is based on the probability of the risk emerging, or the timeframes in which the risk might occur, e.g. weekly, monthly, etc.

10.2 The Trust uses a standard 5x5 risk scoring matrix for assessing the consequence and likelihood of the risk (see table overleaf).

10.3 Divisional governance teams should review all risk assessments within their division before they are added to the risk register so that they can check and challenge them, and ensure they are written and scored appropriately.

10.4 Divisional management teams should review all risk assessment with a residual (current) risk rating of 12 or more before they are added to the risk register.



10.5 Risk scores are not intended to be precise mathematical measures of risk, but are a useful tool to help in the prioritisation of control measures for the treatment of risk. The scoring system allows the levels of risk to be easily identified and therefore prioritised. Further detail on risk scoring and effective assessment is given in Appendix 3.

10.6 The Trust Executive Committee has responsibility to review and monitor on a monthly basis all critical risks scored at 15 and above outside the tolerance threshold of the Trust and the course of action to take. In addition, the Trust Executive Committee will also review on a monthly basis any and all risks scored at 10 with a likelihood rating of unlikely (2) and a consequence rating of catastrophic (5).

10.7 As part of the risk assessment process, a course of action must be agreed in line with the Trust's defined risk appetite approach and risk tolerance levels. Courses of action to be taken are to:

- Treat – The most likely approach to managing a risk. We may act to reduce the likelihood of the risk occurring, or the severity of the consequences if it does, by identifying actions to improve and develop the existing control framework.

- Tolerate - It may be appropriate to do nothing. The likelihood and impact of the risk is low, or the cost of additional actions is preventative. This should always be an informed

decision, recognising the practicalities of providing a complex service with limited resources.

- Terminate – A risk may be far outside our risk appetite or assessed as having such a severe impact that we may have to stop (i.e. terminate) the activity causing it.

- Transfer – It may be possible to transfer the activity to a third party that is better equipped to manage the risk, and accepting of liability if the risk materialises.

10.8 The Trust expects that risks outside of tolerance are mitigated (treated), transferred or terminated. We do not expect teams to tolerate high-scoring risks without first escalating them appropriately.

11 Managing and Mitigating Risks

11.1 As part of the risk assessment process, each identified risk will be assessed three times:

- Inherently, as though there were no controls in place, or that all of the controls are failing.
- Residually (or currently), assuming the controls in place are adequately designed and operating effectively.
- Target, the risk score that should be achieved through implementing actions, bringing the risk in line with articulated appetite and tolerance.

11.2 Controls that describe the systems and processes that are currently in place must be identified. These may include policy and guidance documentation, training and specialisms and physical limitations to guide behaviour.

11.3 Measures of assurance should indicate the adequacy of the controls in place. Assurance should be identified as internal or external and the information gathered using these measures should be identified as reflecting either positively or negatively on the effectiveness of controls in place.

11.4 Gaps in controls should also be clearly identified with actions in place to address. Actions should be specific, measurable, achievable, realistic and timely (SMART) and should have an identified action owner. The target date to achieve the action must also be recorded.

11.5 Recorded risk information, controls and actions should be reviewed thoroughly by the monitoring group to ensure these are adequate, effective and current.

11.6 The target risk score should be agreed in line with the risk appetite and tolerance by the monitoring committee to establish at what point the risk becomes acceptable and can be closed. Attention should be given to high risks that have target timeframes long into the future.

12 Review and Escalation

12.1 All areas of the Trust will, on a regular basis, review their identified risks and the controls and actions identified to manage those risks.

12.2 Risks rated 15 or above will be escalated to the Trust Executive Committee for executive review and management of these critical risks.

12.3 Risks rated 12 or above will be escalated to the appropriate Divisional governance group for review and management by the Divisional Management Team.

12.4 The frequency of review of risks, dependent on their risk score, is as follows:

- Critical (red) risks scoring 15+ will be reviewed monthly.
- Moderate (amber) risks scoring between 8 and 12 will be reviewed bi-monthly.
- Low (yellow) risks scoring between 4 and 6 will be reviewed at least quarterly.
- Very low (green) risks scoring between 1 and 3 will be reviewed at least every six months.

12.5 Risk review frequency may be increased based on the risk's alignment with the Trust's identified risk appetite.

12.6 When risks are reviewed, this must be recorded on the Ulysses Safeguard system to provide an audit trail that this has occurred. This must clearly identify when the risk was identified and by whom, and this should describe the current status of the risk and anything that has changed or been updated.

13 Risk Appetite and Tolerance

13.1 The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives.

13.2 Therefore, the Board has considered and developed a risk appetite statement which has been included as appendix 4 within this document. This sets out the Trust's optimal and tolerable risk appetites and includes guidance on escalating risks which sit outside of these appetites.

14 Communication of Risk with Third Parties

14.1 If a risk is identified within one department or division, but it has an impact on another department or division, or there is a reliance on another department or division to take actions which will aid mitigation, the risk must be communicated as soon as this impact is recognised. Examples of this may include, but are not limited to, those risks which require input from clinical and non-clinical support services, or risks within a pathway that crosses over multiple departments. The risk must be communicated with the appropriate divisional and care group governance leads / governance group chairs, and documented at the relevant care group governance or risk meeting. Any risk relating to paediatric patients must be communicated to the Children's Hospital's governance and management teams. Divisional governance teams and/or care group or divisional management teams will support communication of cross departmental/divisional risks to ensure that all stakeholders

are informed and have been provided with the opportunity to input into the risk assessment and management.

14.2 If an organisational risk is identified which is shared with or wholly relates to another organisation the risk should be shared with that organisation. Advice on the appropriate method of communicating and sharing the risk should be sought from the relevant executive or divisional management team. The third party should not be named in the risk register and the risk should not be entered on to the risk register without the knowledge of the third party organisation.

15 Training Requirements

15.1 All staff should be offered access to risk management training. Attendance will be recorded and monitored in accordance with the Education & Training Policy. Training is provided by the Trust Corporate Governance and Risk Manager.

15.2 Managers are expected to discharge elements of the Risk Management Strategy and Policy and therefore are encouraged to access risk management training.

15.3 The Board will receive targeted risk development as part of the Board development programme. Details of this programme are held by the Associate Director of Corporate Affairs and Company Secretary.

16 Process for monitoring compliance

16.1 The purpose of monitoring is to provide assurance that the agreed approach is being followed. This ensures that we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of this policy will be monitored:

Element to be monitored	Review of identified risks
Lead (name/job title)	Corporate Governance & Risk Manager
Tool	Audit
Frequency	Quarterly
Reporting arrangements	Quality Governance Steering Group

Element to be monitored	Risk management training attendance
Lead (name/job title)	Corporate Governance & Risk Manager
Tool	Audit
Frequency	Annual
Reporting arrangements	Quality Governance Steering Group

Where monitoring identifies deficiencies actions plans will be developed to address them.

17 Communication

17.1 This Risk Management Strategy and Policy will be circulated to all members of the executive leadership team, divisional management teams and divisional governance managers, for cascading to relevant staff.

17.2 The full document will be available for download on Staffnet for all staff to access.

18 Equality Impact Assessment (for policies only)

18.1 Equality and diversity are at the heart of Trust values. Throughout the development of the policies we give regard to the need to eliminate discrimination, harassment and victimisation, to advance equality or opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

18.2 As part of its development this policy and its impact on equality has been analysed and there is no negative impact presented by this policy.

18.3 The Policy Management Team hold all equality impact assessments centrally. These are available upon request from Policy&Guidance@uhs.nhs.uk

19 Document review

19.1 All UHS policies will be subject to a specific minimum review period of three years; or sooner if changes in legislation occur or new evidence becomes available.

19.2 Where a policy becomes subject to a partial review due to legislative or national guidance, but the majority of the content remains unchanged, the whole document will still need to be taken through the agreed process as described in this policy with highlighted changes.

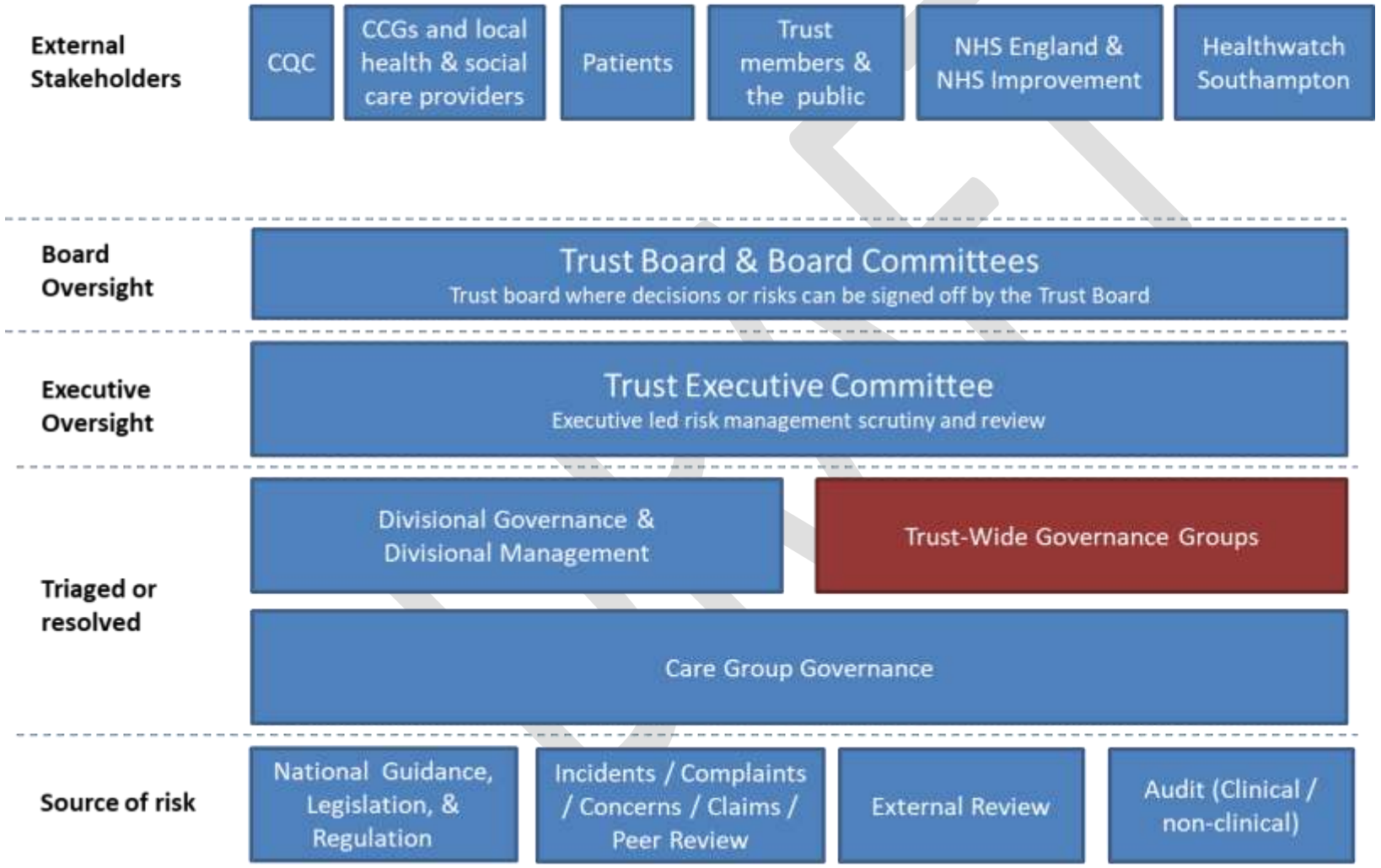
19.3 This policy will be reviewed every three years, with authorisation provided by the Board.

20 Appendices

Appendix 1 – Governance Structure
Appendix 2 – Glossary of terms
Appendix 3 – Risk Scoring Criteria
Appendix 4 – Risk Appetite Statement
Appendix 5 – Risk Assessment Template
Appendix 6 – Equality Impact Assessment

Appendix 1 –Governance Structure

Governance Structure



Appendix 2 – Glossary of terms

Term:	Meaning:
Assurance	Also referred to as assurance measures. These are methods of measuring the level of risk and effectiveness of controls in place, for example; monitoring incidents related to the risk, formal audit reports (clinical, internal, external, etc.) or compliance with external standards (NHS England and NHS Improvement, NICE, etc.).
Assurance Gaps	Where there are inadequate assurances; or where assurance measures are limited and cannot provide full assurance that controls are effectively mitigating the risk. Gaps should be identified and listed with actions to close.
Board Assurance Framework or BAF	The BAF enables the Board to: identify and understand the principal risks to achieving its strategic objectives, and understand the control and assurance frameworks in place to manage these risks. Further; action plans are provided for areas of identified weakness.
Control	Mitigations in place to reduce either the likelihood of the risk occurring; or the impact if the risk were to materialise. Examples include professional, clinically trained staff, appropriate skill mixes and staff numbers, etc.
Control Gap	Where there are inadequate controls or where the control measures are limited or incomplete. Where gaps are identified, there should be a list of actions to close them.
Current or Residual Risk Score	It is the score assigned to any risk after the control measures in place are taken into account. It is derived from the 5 x 5 risk matrix with consequence and likelihood typically being lower than the inherent risk score (reflecting the effectiveness of controls).
Inherent Risk Score	This is the score assigned to any risk, which reflects how severe and likely a risk is to occur if the controls in place are found to be ineffective, or absent. It is derived from the 5 x 5 risk matrix.
Negative Assurance	Negative assurance is where evidence shows that controls are not operating effectively to mitigate the risk to the achievement of objectives. An example would be a critical audit report that identifies failings.
Neutral Assurance	A neutral assurance indicates either a new control, for which it is hard to provide sound assurance, or a mixed assurance that provides some criticism of the control framework, but also identified positives. An example would be a Friends and Family survey that contains criticism of a service, but still reflects a high percentage of satisfaction.
Positive Assurance	Positive assurance indicates that controls are operating effectively to mitigate the risk to the achievement of objectives. An example would be a positive peer review, or a CQC monitoring visit that identifies no issues to be addressed in an action statement.
Risk Score	A risk score is derived from the 5 x 5 risk matrix with consequence and likelihood being multiplied to reach the risk score. The scoring system allows individual risks to be prioritised. Risk scores are not intended to be precise mathematical measures of risk, but are a useful tool to help in the prioritisation of action plans for the treatment of risk.
Target Risk Score	The keyword here is “target”. This is the future (or prospective) risk score assigned to any risk after gaps in control measures have been addressed, and outstanding actions implemented. It is the level of risk which the department of division feels it can tolerate in line with the risk appetite statement.

Appendix 3 – Risk Scoring Criteria

Table 1: Consequence score (C)

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact of COVID-19 on clinical care	The few patients outside waiting times are at no clinical risk and / or are delayed through their own choice. The reasons for these delays are understood. Waiting lists are appropriately managed. Changes in pathways and actions to increase capacity have been completed. Patients awaiting treatment are at no risk of harm or disease progression.	Changes to pathways expose patients to the risk of minor, non-permanent harm, but are required for effective infection control. Patients awaiting treatment have been clinically risk assessed and are at minimal risk.	Patients awaiting treatment have been clinically risk assessed and are at risk of moderate harm or disease progression, e.g. requiring additional treatment and / or pain relief. Patients suffer psychological impact of delayed treatment.	Patients awaiting treatment may not have been clinically risk assessed and / or are at risk of major harm or disease progression, e.g. requiring additional procedures or intervention. The treatment plan may differ significantly from the original treatment plan. Patients are at risk of attending ED for the same condition.	Patients awaiting treatment may not have been clinically risk assessed and / or are at catastrophic clinical risk, e.g. irreversible treatment progression resulting in severe harm or death.
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

			Major patient safety implications if findings are not acted on		
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss. Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claims or losses less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) or losses between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) or losses between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) or losses >£1 million

Service/business interruption. Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2: Likelihood score (L)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain/certain**
Proximity: How soon might we expect the risk to occur	The risk may materialise next year.	The risk might be expected to materialise within the next twelve months.	The risk is expected to materialise this quarter	The risk is expected to materialise this month	The risk is expected to materialise this week or next week
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Likelihood of it occurring within a given time frame	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

Table 3: Risk Scoring Matrix R (Risk) = C (Consequence) x L (Likelihood)

Likelihood		Consequence				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic/Death
Rare	**1**	Green 1	Green 2	Green 3	Yellow 4	Yellow 5
Unlikely	**2**	Green 2	Yellow 4	Yellow 6	Orange 8	Orange 10
Possible	**3**	Green 3	Yellow 6	Orange 9	Orange 12	Red 15
Likely	**4**	Yellow 4	Orange 8	Orange 12	Red 16	Red 20
Almost Certain/Certain	**5**	Yellow 5	Orange 10	Red 15	Red 20	Red 25

Scoring Guidance: The risk scoring guidance provided here is intended to provide examples of what might constitute a catastrophic risk, versus a moderate or minor risk. It is expected that scoring will be arrived at through an analysis of incident information and other key performance indicators, coupled with soft intelligence and professional expertise.

Where high risks are identified without supporting performance information these scores should be challenged by divisional leadership. It is important to note, however, that there must be scope for key risks with no historic information to be escalated if the professional belief is held.

Appendix 4 – Risk Appetite Statement

UHS Risk Appetite Statement

Background

University Hospital Southampton (UHS) NHS Foundation Trust recognises that risk is inherent in the provision of healthcare and its services, and a defined approach is therefore necessary to inform the Trust's management of its risk. 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[1]'.

By defining the Trust's risk appetite, the organisation is enabled to work within a framework which defines the level of risk which is deemed acceptable in pursuit of its aims and objectives and to support informed decision making. How a risk is subsequently managed (i.e. treated, tolerated, terminated, or transferred) will be informed by the risk appetite. Considering the risk appetite in the cold light of day can help decision making when under pressure.

The Trust's risk appetite has been carefully determined by the Board and was last reviewed in December 2023. When developing the risk appetite at UHS, the Board has considered both:

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 allows the Trust to strive for maximum reduction of risks which threaten delivery of its key aims and objectives, whilst recognising that some level of risk will need to be accepted and sometimes sought, to allow for operational delivery of services and for innovation and development.

Risk appetite scale

Utilising guidance from the 'Orange Book[2]' the Trust has set out the following risk appetite scale:

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] ISO31000 and Board Guidance on Risk Appetite, GGI, May 2020 (www.good-governance.org.uk)

[2] The Orange Book Mana- Risk Appetite Guidance Note, UK Government Finance Function, May 2023 (https://www.gov.uk/government/publications/orange-book)

The Trust's risk appetite

Using the scale set out above the Trust has determined that its risk appetite is defined as follows.

Finance	**Regulatory**
Cautious	Minimal
Safety	**Effectiveness**
Minimal	Cautious
Experience	**Reputation**
Cautious	Open
Technology and innovation	**Workforce**
Open	Open

This means that:

Finance: We have a CAUTIOUS appetite for financial risks which means that the Trust is prepared to accept limited financial loss in pursuit of reward where there are significant opportunities to improve patient care, develop our workforce, and set foundations for the future. Value for money is still the key concern. However, the Trust is willing to consider other benefits and constraints.

Regulatory: 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.

Safety: We have a MINIMAL appetite for risks relating to patient or staff safety. This means that we expect services to be delivered safely with no harm to patients or staff. Limited clinical risks are accepted if they are essential for delivery of safe patient care, and such risks are thoroughly assessed with fully mitigating actions in place.

Effectiveness: We have a CAUTIOUS appetite for risks that may compromise delivery of effective care for our patients. We expect services to be delivered effectively and to not adversely affect patient safety and outcomes. We will accept a low degree of risk where there is significant opportunity to improve how we deliver services and residual risks can be mitigated.

Experience: We have a CAUTIOUS appetite for risks that may affect our patients' experience of our services. This means that we expect that patients will receive a positive experience whilst under our care unless it is necessary to prioritise safety over experience. We will accept a low degree of risk where there is opportunity for significant benefit to patient experience, and we are confident that patient or staff safety will not be compromised, and residual risks can be mitigated.

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 the use of technology and innovation in service delivery. This is within the context of compliance with delivering clinically safe, secure, available and having resilient systems and digital architecture. This will be supported by robust governance and change management frameworks. This means that we will seek to use technology and innovation to improve service delivery whilst maintaining safe care for our patients.

Workforce: We have an OPEN appetite for risks relating to our workforce. This means that we are prepared to think innovatively and to invest in our people to build a skilled and diverse workforce that facilitates delivery of a sustainable and safe service for our patients. The Trust recognises its workforce as a valuable asset and accepts that in order to seek long term development and benefit for the workforce, both as individuals and as a collective, acceptance of short-term risk may be necessary.

Putting this into practice

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 preferably align with the optimal appetite for that type of risk. However it is not unusual for it to align with the tolerable appetite instead as there may be factors outside of the risk owner's or organisation's control, or the resources available for mitigation may be insufficient to align this to the optimal risk appetite. 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.

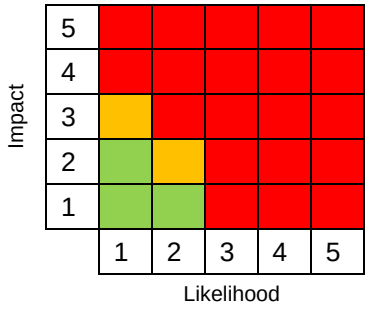
If there are occasions where the achieveable target risk rating cannot be aligned with either the optimal or the tolerable risk appetite this must be escalated to senior management for consideration whether further action can be taken to treat the risk, or whether it is acceptable to tolerate the risk instead and be conciously non-compliant with the risk appetite.

- If the achievable target risk rating is 12 or lower and outside of both optimal and tolerable appetite then this should be escalated to the divisional management team (or equivelent THQ lead).

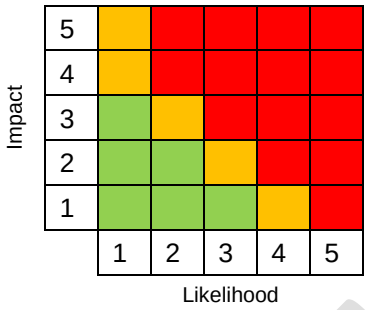
- If the achievable target risk rating is 15 or higher and outside of both optimal and tolerable appetite then this should be escalated to the executive.

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.

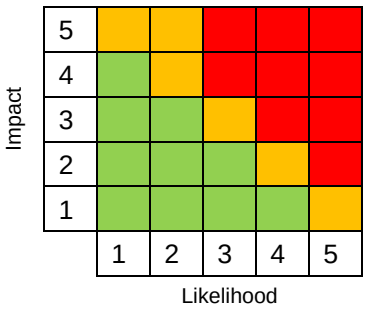
Averse



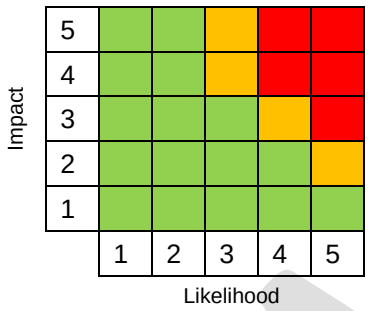
Minimal



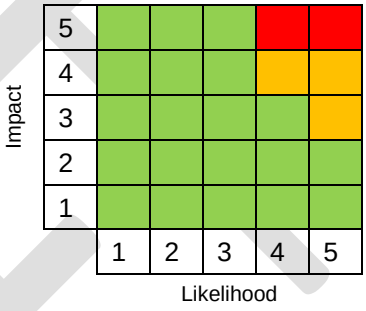
Cautious



Open



Eager



Appendix 5 – Risk Assessment Template

Risk Assessment and Risk Register Escalation Form

Section one: risk identification			
Risk title:			
Date assessed:		**Target completion date:**	
Name & role of assessor:			

Risk category (select <u>one</u> only):											
Clinical innovation		Commercial gain		Compliance		Effectiveness		Finance/value for money	
Informatics		Partnerships		Patient experience		Reputation		Safety (Estates)	
Safety (Patients)		Safety (Staff)		Workforce					

Risk description: a risk is something which has the potential to occur or to go wrong.

Do not confuse it with an issue. An issue is defined as an event which has happened and is having an impact on your project. Issues are not captured on a risk register.

What are you considering as part of your risk assessment? Before composing your risk description it may be worth considering the following prompts. You do not need to record your thoughts here.

What are the issues? What is currently happening?

What could/may happen?

What is the cause? Why could/is this happening?

What is the effect/consequence? What could happen?

What is the wider impact if we don't do anything now?

Risk level (to what extent is this risk present):							
Department		Directorate		Division		Trust-wide	
If department/directorate/division only, specify where:							

Individual responsible (person with overall accountability and responsibility for overseeing the action plan):			
Name:		**Title:**	
Risk owner (person with responsibility for managing and updating the risk assessment/register):			
Name:		**Title:**	

Section two: risk assessment

Use the grid below to assess the initial/current and target risk rating. Remember to multiply not add together your scores.

Refer to the UHS risk management policy on Staffnet for further guidance.

Risk matrix:					
Likelihood → Consquence ↓	**1. Rare**	**2. Unlikely**	**3. Possible**	**4. Likely**	**5. Certain**
5. Catastrophic	Score: 5	Score: 10	Score: 15	Score: 20	Score: 25
4. Severe	Score: 4	Score: 8	Score: 12	Score: 16	Score: 20
3. Moderate	Score: 3	Score: 6	Score: 9	Score: 12	Score: 15
2. Low	Score: 2	Score: 4	Score: 6	Score: 8	Score: 10
1. None	Score: 1	Score: 2	Score: 3	Score: 4	Score: 5

INITIAL (inherent) risk rating This is the level of 'raw' untreated risk without any process or action in place to control, mitigate or manage it.										**Total Score: C x L**
Consequence	1. None		2. Low		3. Moderate		4. Severe		5. Catastrophic	
Likelihood	1. Rare		2. Unlikely		3. Possible		4. Likely		5. Certain	

CURRENT (residual) risk rating This is the level of current level of risk when taking into consideration the controls now in place. *If this is a new risk with no controls in place then do not include this rating.*										**Total Score: C x L**
Consequence	1. None		2. Low		3. Moderate		4. Severe		5. Catastrophic	
Likelihood	1. Rare		2. Unlikely		3. Possible		4. Likely		5. Certain	

TARGET risk rating This is the level of residual risk expected once all actions are in place.										**Total Score: C x L**
Consequence	1. None		2. Low		3. Moderate		4. Severe		5. Catastrophic	
Likelihood	1. Rare		2. Unlikely		3. Possible		4. Likely		5. Certain	

Section three: risk management

Control(s) – are mitigations in place to manage the risk in order to reduce the likelihood and / or consequence of that risk. Controls must describe the practical steps that need to be taken to manage and control the risk.

Assurance –assurance is an objective examination of evidence for the purpose of providing an independent assessment of the controls.

Current controls in place (list each control already in place to mitigate the risk and rate its effectiveness below):

If the control is 100% reliable effectiveness is high, 80-100% medium <80% low.

(Add additional lines as required)

Control (Identify what is in place to mitigate the risk)	**Effectiveness of control** ***low/medium/high/not assessed***	**Gaps in this control** (Identify anything which will prevent this control from being effective)	**Assurance** (Identify anything which shows that this control is working)	**Gaps in assurance** (Identify anything that provides negative assurance and shows it is not working)

Action Plan:

Please add at least one action which will be taken forward to mitigate the risk, identifying who is responsible for this, when work on this will commence, when it is expected to be completed, and the completion date if this has already happened.

Only one named individual can be assigned to be responsible for each action. Add additional lines as required.

Details of action	**Individual responsible**	**Start date**	**Target date**	**Completion date**

Appendix 6 – Equality Impact Assessment

University Hospital Southampton NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

The Equality Analysis is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by the Equality Act 2010.

A Trust Policy (which impacts across the whole organisation)
A new service development, service change or change management proposal
A commissioning or procurement proposal

Title of policy/proposal	Risk Management Strategy and Policy v3
Name of person initiating policy/proposal	Lauren Anderson, Corporate Governance & Risk Manager
Name of authorising committee	Trust Board
Name of person with authority to approve this EIA (chair of committee)	Jenni Douglas-Todd, UHS Chair
Date EIA approved	28 March 2024
Details of who was involved in the consultation process	Extensive consultation of the policy undertaken involving all divisions within the organisation.

Please describe fully the positive and any potential negative impact of the policy/service on service users or staff on blank page

In the case of negative impact, please indicate any measures planned to mitigate against this by completing stage 2. Supporting Information can be found be following the link: www.legislation.gov.uk/ukpga/2010/15/contents

Protected characteristic	Positive impact	Negative impact
Age	N/A	N/A
Disability (mental, physical and learning disability)	N/A	N/A
Gender reassignment	N/A	N/A
Marriage & civil partnership	N/A	N/A
Pregnancy & maternity	N/A	N/A
Race/ethnicity	N/A	N/A
Religion or belief	N/A	N/A
Sex/gender	N/A	N/A
Sexual orientation	N/A	N/A

Stage 2: Full impact assessment

What is the impact?	Mitigating actions	Monitoring of actions
N/A	N/A	N/A

Document checklist

Please ensure that this checklist is submitted to the Expert Group at the same time as the document for approval. The absence of this document will cause a delay in the approval process. This checklist will be used by:

- The author: as a guide to the completion of the document
- The Expert Group: as a guide to approving the document
- Policy&Guidance@uhs.nhs.uk to retain as evidence

TO BE COMPLETED BY DOCUMENT AUTHOR(S)

Document title:	Risk Management Strategy and Policy		
Version number to be issued:	v3.0		
Detail title, version number and file path of the document to be replaced on Staffnet:	http://staffnet/TrustDocsMedia/DocsForAllStaff/GovernanceAndSafety/RiskManagementPolicy/Risk-Management-Strategy-and-Policy-Version-2.pdf		
Author(s): Name(s) and job title(s)	Lauren Anderson, Corporate Governance & Risk Manager		
Responsible job title or committee: To contact in future years regarding document review	QGSG Trust Board		
Trust reference: This is a new system being introduced, if unknown please leave blank	CA003	Date checklist completed	25/02/2024

Is the document required? Explain the reasons why this document is needed (e.g. no existing document covering this area or responding to new regulation/guidance), whether it replaces a document that already exists, whether an existing document could be amended to include it.

Yes – this is an update to the existing risk management strategy and policy which is required when satisfying the organisation's good governance requirements.

Is the document based on current best practice and does it reflect current national standards and legislation? Provide details.

Yes

Are all relevant sections included within the document?	Yes

For policies:
- Index
- Introduction
- Scope and purpose
- Definitions
- Roles and responsibilities
- Communication and training
- Equality impact assessment
- Document review
- Process for monitoring compliance

For other documents:
- Introduction
- Scope
- Aim/purpose
- Definitions
- Implementation
- Roles and responsibilities
- Document review
- Process for monitoring compliance

Has a flowchart/key steps/quick reference guide been provided **at the front** of the document?	Yes

Detail below the appropriate consultation that has taken place
Insert details of consultation including complete list of everyone consulted (names and job titles), groups consulted including local governance, and actions taken as a consequence of the consultation. (Relevant clinical and corporate services, patient and service user groups. A cross-section of staff).

Executive and non-executive directors
Divisional governance teams
Divisional management teams
Care group managers
Matrons
THQ leads
Members of the patent safety steering group
Estates compliance and risk team
IT risk lead

Has the Drugs Committee triaged the document (if not the authorising expert group)?	Not applicable

Detail the committee(s) which have approved this document and date(s) of approval: (So that minutes can be cross referenced)

Discussed at Division A and Division C governance group meetings. Virtual consultation to Division B and D. For committee approval at QGSG followed by ratification at Trust Board.

Does the style/format of the document follow the Trust template?	Yes
Are all abbreviations and definitions explained?	Yes
Are monitoring arrangements appropriate and fit for purpose, with outcomes that can be evidenced?	Yes

Detail below the plan to implement the document:

Policy is already established and implemented. Further plans are in progress to develop an education framework which promotes the fundamentals of the policy, and also to develop SOPs which support implementation of the policy.	
List as many keywords as possible to aid the searching and retrieval of this document on Staffnet:	
Risk, risk management, safety, litigation, claims, health and safety, risk appetite, risk matrix,	
Has an equality impact assessment (EIA) been completed and provided with this checklist? Applies to all policies only.	Yes
Does the EIA identify any detriment or positive impact?	No
All new policies/procedures must be reviewed within 12 months of issue to ensure that they are working effectively, unless otherwise agreed. After this initial review, the Trust has a standard default review period for all documents of between a minimum of one year a maximum of three years. What is this appropriate for this document? Please detail below why and when it should be reviewed.	
3 years	

TO BE COMPLETED BY EXPERT GROUP

Please review the checklist and answer the following questions:

Name of Expert Group approving document:		Date of meeting:	
Chair name and job title:			
Has sufficient, appropriate consultation taken place?		Yes / No (delete as appropriate)	
Is the content easy to read, jargon free and includes only relevant information?		Yes / No (delete as appropriate)	
Could the document be picked up by someone that does not deal with this in their everyday role and be understood easily?		Yes / No (delete as appropriate)	
Is communication and implementation of the document adequately planned?		Yes / No (delete as appropriate)	
Is executive level support required in communication, implementation, training etc.? If yes, please provide details		Yes / No (delete as appropriate)	
Is the Expert Group satisfied and happy to approve the document? If no, please return the document to the author explaining the additional input required If yes, please notify author and relevant divisional team		Yes / No (delete as appropriate)	

TO BE COMPLETED BY POLICY & GUIDANCE TEAM

Trust reference allocated/checked	Version number confirmed	Review date confirmed	EIA saved if applicable	Document checklist saved	Administrative check e.g. numbering
Uploaded to Staffnet	Previous versions archived	Author(s) advised	DGMs advised	Master index updated	

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.1**			
Sponsor:	**Jenni Douglas-Todd, Trust Chair**			
Date:	**28 March 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. There have been no Chair's actions since the last report.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal.			

1 Signing and Sealing

1.1 **Licence for alterations** (Retrospective) between University Hospitals Southampton NHS Foundation Trust (Landlord) and Compass Contract Services (UK) Limited (Tenant) relating to Part of the Staff Wellbeing Hub at Southampton General Hospital (Bevans café). Seal number 269 on 8 March 2024.

1.2 **Lease of Part** between University Hospitals Southampton NHS Foundation Trust (Landlord) and Compass Contract Services (UK) Limited (Tenant) relating to Part of the Staff Wellbeing Hub at Southampton General Hospital (Bevans café). Seal number 270 on 8 March 2024.

1.3 **Deed of Transfer** between University Hospital Southampton NHS Foundation Trust as sole corporate trustee of Southampton Hospitals Charity (the Transferor) and Southampton Hospitals Company (the Receiving Charity). Seal number 271 on 19 March 2024.

2 Recommendation

The Board is asked to ratify the application of the seal.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Remuneration and Appointment Committee Terms of Reference**			
Agenda item:	**7.2**			
Sponsor:	**Jenni Douglas-Todd, Chair**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**28 March 2024**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.			
Response to the issue:	Some minor changes are proposed to the terms of reference. These changes are largely to update references to documentation and NHS organisations. In addition, a number of changes are proposed to the Executive Pay Principles set out in Appendix A to better reflect the current guidance and available frameworks. The terms of reference have been reviewed by the Remuneration and Appointment Committee.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Remuneration and Appointment Committee are clear and support transparency and accountability in the performance of its role and comply with Code of Governance for NHS Provider Trusts.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, Code of Governance for NHS Provider Trusts and the Trust's constitution relating to the composition of Board committees. 2. The Board of Directors and the committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the terms of reference.			

University Hospital Southampton NHS
NHS Foundation Trust

Remuneration and Appointment Committee Terms of Reference

Version: ~~5~~6

Date Issued:	~~28 February 2023~~ 28 March 2024
Review Date:	February 20~~24~~ 25
Document Type:	Committee Terms of Reference

Contents Paragraph		Page
1	Role and Purpose	2
2	Constitution	2
3	Membership	2
4	Attendance and Quorum	3
5	Frequency of Meetings	3
6	Conduct and Administration of Meetings	3
7	Duties and Responsibilities	3
8	Accountability and Reporting	5
9	Review of Terms of Reference and Performance and Effectiveness	5
10	References	5

Appendices		Page
Appendix A	Executive Director Pay Principles	6

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.
As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

1. Role and Purpose

1.1 The Remuneration and Appointment Committee (the **Committee**) is responsible for identifying and appointing candidates to fill all the executive director positions on the board of directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and for determining their remuneration and other conditions of service.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of remuneration and executive director appointments in accordance with relevant laws, regulations and Trust policies.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 The Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be the non-executive directors of the Trust except as provided in paragraph 3.2 below.

3.2 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

3.3 The chair of the Board will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

3.4 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Chief People Officer; and

3.4.2 Associate Director of Corporate Affairs/Company Secretary.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas that are the responsibility of a particular executive director or manager. Any attendee will be

asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be four members, including the chair of the Board (or the Deputy Chair in their absence). A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

5.1 The Committee will meet as required, which will usually be four times each year.

5.2 The Committee may establish a sub-committee for a specific purpose where it would be impractical for the Committee to be involved, for example the appointment of an executive director following agreement by the Committee of the process, job description and person specification.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief People Officer and the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than three working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The Company Secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

7.1 The Committee will carry out the duties below for the Trust.

Remuneration Role

7.2 The Committee will:

7.2.1 establish and keep under review a remuneration policy in respect of executive directors (as set out in Appendix A);

7.2.2 consult the Chief Executive Officer about proposals relating to the remuneration of the other executive directors;

7.2.3 in accordance with relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors, including salary, any performance-related pay or bonus, provisions for other benefits,

including pensions and cars, allowances, payable expenses and compensation payments;

7.2.4 adhering to all relevant laws, regulations and Trust policies:

7.2.4.1 establish levels of remuneration that are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level that is affordable to the Trust;

7.2.4.2 decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

7.2.4.3 make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the Trust, and take as a baseline for performance any competencies required and specified in the job description for the post;

7.2.4.4 consider all relevant and current directors relating to contractual benefits such as pay and redundancy entitlements;

7.2.4.5 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors while ensuring that increases are not made where Trust or individual performance do not justify them;

7.2.4.6 be sensitive to pay and employment conditions elsewhere in the Trust;

7.2.5 monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

7.2.6 on an annual basis monitor the remuneration of non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions;

7.2.7 approve the level of remuneration or any proposed change to remuneration for a senior leadership role referred to in 7.2.6 where the proposed remuneration for the role would exceed that of any executive director; and

7.2.8 consider issues of equality and diversity when evaluating and setting remuneration.

Appointment Role

7.3 The Committee will:

7.3.1 regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board and the Governors' Nomination Committee, as applicable, with regard to any changes;

7.3.2 give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future;

7.3.3 keep the leadership needs of the Trust under review at executive director level to ensure the continued ability of the Trust to operate effectively in the health economy;

7.3.4 be responsible for identifying the and appointing candidates to fill posts within its remit as and when they arise;

7.3.5 when a vacancy is identified, evaluate the balance of skills, knowledge and experience of the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In

identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

7.3.6 ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation and monitor procedures to ensure that executive directors remain 'fit and proper' persons;

7.3.7 ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;

7.3.8 ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

7.3.9 carefully consider what compensation commitments (including pension contributions) the executive directors' terms of office would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing executive director's obligation to mitigate loss. Appropriate clawback provisions should be considered in the case of an executive director returning to the NHS within the period of putative notice; and

7.3.10 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive directors and the process it has used in relation to the appointment of executive directors.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 National Health Service Act 2006

10.2 ~~NHS Foundation Trust Code of Governance~~Code of Governance for NHS Provider Trusts

10.3 NHS ~~Improvement~~ England Guidance on pay for very senior managers ~~in NHS trusts and foundation trusts~~

Appendix A
UHS Executive Director Pay Principles

1. **The importance of executive director pay**
   The delivery of the Trust's 5 year strategy and annual ~~forward vision and our annual~~ Trust objectives is predicated on ensuring talent is available at all levels of the Trust. Good senior leadership is vital, and therefore a key strategy for UHS must be to recruit and retain the best executive director talent into the Trust. This will be from a combination of both good internal succession planning, bringing top talent from the NHS and also seeking high calibre individuals from other sectors.

2. **Determination of pay levels of posts**
   Pay for executive director posts will be determined by:
   - Use of NHS England (NHSE) ~~NHS Improvement (**NHSI**)~~ data on pay for executive director (Very Senior Manager – VSM) positions in comparable trusts (Figure 1).
   - Any other available NHSE frameworks for setting of executive pay
   - Use of other salary benchmarking exercises, particularly from comparable NHS organisations~~.~~
   - Job evaluation as required.
   - The conditions required to attract suitably qualified individuals, particularly where commercial, financial or other niche business skills are required.

   Pay levels will be reviewed not less frequently than annually by the Committee in accordance with the Trust's pay review cycle to ensure that salary levels are both appropriate and provide value for money.

3. **Setting salary of executive directors**
   The following principles will apply:
   - UHS will aim to pay at around mid-point of ~~NHSI~~ NHSE levels for trusts of a comparable nature and scale.
   - UHS will review pay based on performance, changes in the NHSE~~I~~ framework levels, comparable NHS Trust benchmarking and ~~and~~, in particular, the need to retain key individuals likely to be of interest to the external market.~~other trusts.~~
   - UHS will not recognise relevant changes of ~~NHSI~~ NHSE framework levels in respect of individuals where this is not justified by individual performance.
   - UHS will be mindful of equality and diversity, particularly in relation to gender and ethnicity in pay levels.
   - UHS will ensure all VSM nationally applicable cost of living pay awards ~~increases~~are ~~nationally awarded are~~ reflected in executive director pay each year, as decided by the Committee. The committee may choose to withhold a national pay increase where individual performance has been unsatisfactory and where the guidance permits this.~~, unless performance of an individual is unsatisfactory.~~
   - Any decision to introduce performance-related pay, or bonuses, will be subject to decision by the Committee based on a sound business case and adherence to NHSE~~I~~ guidance on executive pay.

4. **Approval process**
   All decisions on pay for executive directors will be managed in line with the terms of reference for the Committee.

The Committee, supported by the Chief People Officer, will also ensure that the NHSE~~I~~ prevailing guidance on setting executive director pay, including any required approval process, will be followed as appropriate.

Figure 1 – Current NHS England ~~Improvement~~ Pay Thresholds

Supra large acute NHS trusts and foundation trusts (£750m+)	Lower quartile	Median	Upper quartile
Chief executive	£236,000	£250,000	£265,000
Deputy chief executive	£185,500	£188,000	£195,500
Director of finance/Chief finance officer	£166,000	£172,500	£190,500
Director of workforce	£142,500	£155,000	£165,500
Medical director/Chief medical officer	£205,000	£214,000	£233,500
Director of nursing/Chief nursing officer	£150,000	£163,500	£168,000
Chief operating officer	£143,500	£162,500	£174,500
Director of corporate affairs/governance	£113,000	£117,500	£134,000
Director of strategy/planning	£135,000	£144,000	£152,500
Director of estates and facilities	£129,500	£137,000	£146,500

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~28 February 2023~~28 March 2024
Responsible Committee:	Remuneration and Appointment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	February 20~~24~~25
Target audience:	Board of Directors, Remuneration and Appointment Committee, NHS Regulators, Staff and Public
Key words:	Remuneration, Appointment, Nomination, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~No changes.~~ Minor changes to update references to documentation and NHS organisations. In addition, changes to the Executive Pay Principles set out in Appendix A to reflect the current guidance and available frameworks.
Consultation:	Remuneration and Appointment Committee
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No