University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	10/09/2024
Time	9:00 - 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles (10:00-12:00)
In attendance	Jessica Bown, Midwifery Quality Assurance and Safety Matron (shadowing Gail Byrne)

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

5.5 **Patient Safety and Quality of Care in Pressurised Services**

9:55 Review and discuss the report
Sponsor: Joe Teape, Chief Operating Officer
Attendee: Duncan Linning-Karp, Deputy Chief Operating Officer

5.6 **Performance KPI Report for Month 4**

10:05 Review and discuss the report
Sponsor: David French, Chief Executive Officer

5.7 **Finance Report for Month 4**

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

5.8 **Break**

10:40

5.9 **People Report for Month 4**

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

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

11:10 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Emergency Medicine Consultant and Guardian of Safe Working Hours

5.11 **Learning from Deaths 2024-25 Quarter 1 Report**

11:25 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

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

11:40 Receive and note the Annual Report. Approve the Statement of Compliance.
Sponsor: Paul Grundy, Chief Medical Officer

5.13 **Safeguarding Annual Report 2023-24**

11:55 Receive and discuss
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Corinne Miller, Named Nurse for Safeguarding Adults/ Danielle Honey, Named Nurse for Safeguarding Children

6 **STRATEGY and BUSINESS PLANNING**

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

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

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions Report

12:20 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 Health and Safety Annual Report 2023-24

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

7.3 People and Organisational Development Committee Terms of Reference

12:35 Review and approve
Sponsor: Steve Harris, Chief People Officer

8 Any other business

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

9 Note the date of the next meeting: 5 November 2024

10 Items circulated to the Board for reading

10.1 CRN: Wessex 2024-25 Q1 Performance Report

Note the report
Sponsor: Paul Grundy, Chief Medical Officer

11 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.

12 Follow-up discussion with governors

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	25/07/2024
Time	9:00 – 13:00
Location	Anaesthetic Seminar Room (CE95/99)/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Dave Bennett, NED (DB) Jenni Douglas-Todd, Chair (JD-T) Diana Eccles, NED (DE) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Tim Peachey, NED (TP) (until 12:00) Joe Teape, Chief Operating Officer (JT) Alison Tattersall, NED (AT) Natasha Watts, Interim Deputy Chief Nursing Officer (NW) (for G Byrne)
In attendance	Martin De Sousa, Director of Strategy and Partnerships (MDeS) Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.3) Kelly Kent, Head of Strategy and Partnerships (KK) (item 6.1) Marie Nelson, R&D Head of Nursing and Health Professions (MN) (item 6.2) Karen Underwood, Director of R&D (KU) (item 6.2) Kerrie Montoute, Head of Programmes, CDO Directorate at NHSE (shadowing JDT) 1 member of the public (item 2) 3 governors (observing) 3 members of staff (observing) 2 members of the public (observing)
Apologies	Gail Byrne, Chief Nursing Officer (GB)

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 Gail Byrne.

The Board welcomed Alison Tattersall, who joined the Board as a non-executive director on 1 June 2024.

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

2. Patient Story

Georgia Blackman and her parents were invited to relate their story following Georgia's admission with serious head and abdominal injuries after a car accident in November 2023. She had not been expected to survive, but had instead made

a very good recovery and was undergoing rehabilitation and had regained some sight. The family related their experience of being told that their daughter was going to die and the importance of how this message is delivered was highlighted. It was further noted that where a patient is between 16 and 18 years old it was necessary to consider whether they are managed as a child or as an adult in terms of their care.

3. Minutes of the Previous Meeting held on 6 June 2024

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 6 June 2024.

4. Matters Arising and Summary of Agreed Actions

It was noted that there were no matters arising or overdue actions.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

The chair of the Audit and Risk Committee was invited to provide an overview of the meeting held on 27 June 2024 and the subsequent meeting of a committee authorised to approve the final annual report and accounts for 2023/24 held on 16 July 2024. It was noted that the annual report and accounts had been submitted to NHS England on 19 July 2024 and that the Trust's external auditor had provided a 'clean' audit opinion.

5.2 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 22 July 2024. It was noted that:

- The committee had reviewed the Finance Report for Month 3 (item 5.8).
- The committee had examined the Trust's progress on its transformation programme, and noted in particular the success in reducing length of stay by 5% for P0 patients as part of the discharge programme.
- The committee received a report on the Trust's productivity and noted that the national methodology used created a confusing position and did not incorporate the impacts of certain factors which should be included.
- The committee reviewed the Trust's activities in the digital space and noted that capital in this area was primarily used for maintenance rather than development and that there was a significant infrastructure risk due to the Trust's current data centre set up. It was further noted that better understanding of the benefits of digital development and timescales was required.
- The Trust had agreed to participate in establishing a separate legal entity to seek investment to exploit intellectual property rights jointly developed by the Trust and the University of Southampton.

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

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

- The committee reviewed the revised People Report for Month 3 (item 5.9), noting that the workforce plan was at risk if there was no reduction in patients having no criteria to reside and mental health demand.
- The committee had reviewed the Trust's Employee Relations activities and received an update on an investigation into comments made on social media.

- In its review of the Board Assurance Framework (item 6.3), it was agreed that culture also needed to be reflected in the people-related risks.

5.4 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 15 July 2024. It was noted that:

- In its report from the Quality Governance Steering Group, the committee noted that there were two new never events under investigation. In addition, there were national shortages of certain medicines. The committee also noted an increase in violence and aggression linked to the increasing number of patients with mental health issues.
- The committee reviewed the Fundamentals of Care programme and noted that it was very comprehensive.
- The committee also received updates following a visit by Southern Health and the impact of demand by patients with mental health issues on the Trust.
- The committee also noted a report by the Royal College of Radiologists on the Trust's radiotherapy department, which provided positive feedback, and noted the expansion in use and scope of the service.
- In its review of the Board Assurance Framework (item 6.3), the committee noted that the risk of staff availability could be due to both unaffordability as well as national lack of availability of qualified individuals.

Action

Craig Machell agreed to add an item covering the impact of technology over the next 5-10 years to a future Trust Board Study Session agenda.

5.4.1 Maternity and Neonatal Safety 2024-25 Quarter 1 Report

The chair of the Quality Committee was invited to provide an overview of the Maternity and Neonatal Safety 2024/25 report for the first quarter, the content of which was noted. It was further noted that:

- Under the terms of the NHS Resolution Maternity Incentive Scheme, the Board had delegated review of the report to the Quality Committee.
- There had been sustained improvement in meeting the required timescales for booking of appointments and screening since April 2024.
- The continuity of carer need should be focused where it could make the most difference.
- Appointment of a community partner by the Integrated Care Board was expected soon.
- The Trust was approximately 40 members of staff short. However, plans were in place to address this deficit, including use of newly qualified nurses on rotations and the 36 new entrants expected between November 2024 and March 2025.

5.5 Chief Executive Officer's Report

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

- David French had met with the new Secretary of State for Health and Social Care on 19 July 2024 where the Secretary of State had outlined his priorities in terms of urgent and emergency care and addressing the backlog in elective care through using private sector capacity. In addition, it was noted that the intention for the longer term was to focus on preventative health and digital.
- Following the General Election, there were also a number of new Members of Parliament for the area served by the Trust.

- On 1 July 2024, the new pathology laboratory information management system had been rolled out across the region. There had been some initial issues with providing information to primary care providers.
- David French had been asked and had agreed to remain as the provider representative on the Hampshire and Isle of Wight Integrated Care Board until September 2024.
- A new referral system for Ophthalmology had been launched, which would use A/I in supporting the booking process.

5.6 Performance KPI Report for Month 3

Joe Teape was invited to present the Performance KPI Report for Month 3, the content of which was noted. It was further noted that:

- The Trust's performance was in the top quartile for six out of nine measures and the top half for two others.
- There had been a fairly stable period with better occupancy levels and improvements in timings of discharges.
- There were ~220 patients no longer meeting criteria to reside during June 2024, and the Trust was considering a new plan with local partners for a local system delivery plan.
- The Trust's cancer performance continued to be impacted by the challenge posed by increasing demand.
- The Trust's performance against the 31-day standard had fallen to the third decile, with capacity issues in radiology and prostate services.
- Further understanding of who was being referred under cancer pathways was required, as this could identify health inequality concerns in terms of who was accessing the Trust's services.
- Increases in referrals could be due to national campaigns which raise public awareness of certain forms of cancer and the possible symptoms.

5.7 Break

5.8 Finance Report for Month 3

Ian Howard was invited to present the Finance Report for Month 3, the content of which was noted. It was further noted that:

- Nationally, the NHS's deficit was above £1bn, representing 4-5%. The Hampshire and Isle of Wight Integrated Care Board had recorded a £57m deficit (6%) for month 3. The average deficit for university teaching hospitals was 4.1%.
- The Trust had recorded a £13m deficit (year-to-date) and an in-month deficit of £4.5m.
- There had been some early signs of improvement with the underlying position having improved since month 1.
- The Trust's elective recovery performance was 128% and there had been improvements in length of stay.
- The Trust's workforce numbers and pay costs were below plan, and agency numbers had halved since summer 2023.
- The underlying monthly deficit was c.£5m, with approximately £1m of this attributable to unfunded pay awards and costs of industrial action.
- Meeting the Trust's plan for Quarter 2 of 2024/25 was expected to be challenging, as it assumed that the Integrated Care System's transformation programmes would begin to deliver.
- The Trust's cash reserves were now below £30m, and the Trust might need to consider the need for additional cash from NHS England.
- The Trust would continue to focus on its transformation programmes.

- The level of the anticipated pay award for 2024/25 and a likely shortfall in funding for the award was a risk to the Trust's financial position.

5.9 People Report for Month 3

Steve Harris was invited to present the People Report for Month 3, the content of which was noted. It was further noted that:

- A number of improvements were in the process of being made to the report to incorporate a 'heat map' and provide additional focus on culture.
- The Trust was under its overall workforce plan by 313 whole-time equivalents (WTE) at the end of June 2024. However, in terms of its overall plan, ~200 WTE were reliant on improvements in the non-criteria to reside and mental health position.
- Violence and aggression remained a key concern, with increasing use by the Trust of its warning and exclusion policy.
- Work was ongoing to review the number of statutory and mandatory training courses with a view toward rationalising the number.
- The 'We Are UHS' Champions award ceremony was to be held in October 2024.
- The Integrated Care Board recruitment control panel appeared to be limiting the number of requests for recruitment likely due to improved filtering taking place by the individual trusts.

5.10 Annual Complaints Report 2023-24

Natasha Watts was invited to present the Annual Complaints Report for 2023/24, the content of which was noted. It was further noted that:

- The number of complaints received had decreased slightly compared to the previous year, and the number of complaints upheld or partially upheld had decreased compared to the previous year and remained lower than the national average.
- There had been four cases reviewed by the Parliamentary and Health Service Ombudsman, of which two were closed and two were partially upheld.
- The overall quality of responses to complaints had improved.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2024-25 Quarter 1 Review

Martin De Sousa was invited to present the Corporate Objectives 2024/25 Quarter 1 Review, the content of which was noted. It was further noted that:

- The Trust's performance was largely positive with 11 (out of 16) objectives on track to be delivered in full.
- The major risks for achievement of the objectives were the Trust's financial position and the possible impact of this on the workforce, and the Trust's ability to reduce the number of patients not having criteria to reside.
- Inclusion of a predicted future rating for each objective in reports was to be considered.

6.2 Research and Development Plan 2024-25

Karen Underwood was invited to present the Research and Development Plan for 2024/25, the content of which was noted. It was further noted that:

- During 2023/24, the Trust had recruited its 250,000th participant and had launched its Research for Impact strategy.
- Income for 2024/25 was predicted to be lower than previously due to the impact of Covid-19-related studies on prior years.
- Vacancies and the reliance on clinical support services would be a challenge for 2024/25.

Decision

Having discussed the proposal, the Board approved the Research and Development Plan for 2024/25.

Action

Ian Howard agreed to obtain clarification regarding the discrepancy between the Return on Investment table and Appendix 4 in the plan.

6.3 Board Assurance Framework (BAF) Update

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

- All risks had been reviewed by the Executive leads since June 2024.
- The recorded gaps and controls were being checked and the BAF would differentiate between actions and aspirations in terms of the Trust's steps to mitigate or address areas of risk.
- It was intended to more closely link the BAF risks to the Board's agenda.
- The maturity assessment undertaken during 2023/24 as part of the audit of risk management carried out by KPMG would be reviewed to determine where the Trust would be against its aspirations by the end of the year.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (CoG) Meeting 24 July 2024

The Chair provided an overview of the meeting of the Council of Governors held on 24 July 2024. It was noted that the meeting had addressed the following matters:

- The appointment of Shirley Anderson as the new Lead Governor.
- Reports from the Chief Executive Officer and Chief Financial Officer.
- The Trust's annual report and accounts for the year ended 31 March 2024.

7.2 Register of Seals and Chair's Actions Report

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

Decision:

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

8. Any other business

There was no other business.

9. Note the date of the next meeting: 10 September 2024

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

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List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 28/03/2024 4.14 Guardian of Safe Working Hours Quarterly Report				
1127.	Junior Doctors	Grundy, Paul	24/10/2024	Pending
	Explanation action item Paul Grundy and Diana Hulbert agreed to include an item regarding junior doctors on a future Trust Board Study Session agenda. Due to industrial action on 27 June, this item has been deferred to the next TBSS on 24/10/2024.			
Trust Board – Open Session 06/06/2024 5.6 Performance KPI Report for Month 1				
1152.	Digital	Teape, Joe	24/10/2024	Pending
	Explanation action item JT agreed to include Digital as an agenda item at a future Trust Board Study Session. This item is tentatively scheduled for TBSS on 24/10/2024.			
Trust Board – Open Session 25/07/2024 5.4 Briefing from the Chair of the Quality Committee (Oral)				
1163.	Impact of technology	Machell, Craig	27/02/2025	Pending
	Explanation action item Craig Machell agreed to add an item covering the impact of technology over the next 5-10 years to a future Trust Board Study Session agenda. Update: Item tentatively scheduled for 27/02/25 Study Session.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 25/07/2024 6.2 Research and Development Plan 2024-25				
1165.	Discrepancy	Howard, Ian	10/09/2024	Pending
	Explanation action item Ian Howard agreed to obtain clarification regarding the discrepancy between the Return on Investment table and Appendix 4 in the plan.			

University Hospital Southampton
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Report to the Trust Board of Directors				
Title:	**Chief Executive Officer's Report**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	My report this month covers updates on the following items: • NHS Pay Offers • National Unison Campaign – Collective Pay Grievance for Healthcare Support Workers • Civil Unrest • Hampshire Together • Maternity Services and Sustainable Staffing • CQC Annual Hospital Inpatients Survey • Annual Regulation and Oversight Survey • Cass Review Implementation • Aseptic Preparation Audit • Human Tissue Authority inspection			
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.			

NHS Pay Offers
On 29 July 2024, the Government announced that it would accept in full pay review body advice on NHS staff salaries and would make a pay offer to junior doctors in an attempt to end the ongoing industrial action.

The Government accepted the 2024/25 recommendations of the NHS Pay Review Body for a 5.5% increase, backdated to 1 April 2024, for all Agenda for Change staff. This increase is expected to be reflected in October pay. In addition, intermediate pay bands will be created for Band 8 and 9 staff. In line with national guidance UHS will also offer back pay payments to be spread out over six months if individuals request this to help mitigate any impact on universal credit.

The offer made to the junior doctors represents a 22.3% uplift over two years. This comprises an additional average of 4.05% for 2023/24 on top of the existing 8.8% implemented last year, taking the average uplift to 13.2%. In addition, 2024/25 pay would increase by an average of 12.4% against current 2023/24 payscales. The British Medical Association junior doctors committee recommends acceptance of this offer. Voting opened on 19 August and closes on 15 September 2024.

The Government has also announced its intention to repeal the Strikes (Minimum Service Levels) Act 2023, which provides a mechanism to require workers in particular sectors, such as health, education, fire and rescue, and transport, to guarantee certain minimum levels of service during periods of industrial action. This will form part of a range of employment law modifications the government is considering, and the Board will be updated with further details once these are finalised.

National Unison Campaign – Collective Pay Grievance for Healthcare Support Workers
During August, UHS formally received a collective grievance relating to pay for Healthcare Support Workers (HCSWs). This is a national campaign led by UNISON pushing for recognition of duties carried out by these staff, formal re-grading of pay band, and appropriate back pay. UHS has over 1,200 individuals in these roles. The Chief People Officer is formally meeting with UNISON to discuss how the matter can be resolved. Whilst this is a national campaign, we have been told not to expect national resolution and Trusts have been directed to resolve locally as appropriate.

Civil Unrest
The nation experienced significant violent and racially motivated civil unrest during August. Far-right anti-immigration rallies were planned in a number of cities across the UK, including Southampton. Healthcare workers had been directly targeted in some parts of the country by far-right groups. This understandably generated fear and concern from our black, minority ethnic communities which was raised through various routes to leaders at the Trust.

Communication was sent by the Chief Executive Officer and Chief Nursing Officer to all staff setting out our stance on the situation and proposed practical measures, coupled with local support from managers to those who were concerned.

Led by the Chief Nurse through the Trust's incident management process, we rapidly implemented practical measures in addition to wider wellbeing and psychological support. Measures included additional security, additional transport and other local actions to help with people's safe journey to work on the day of planned demonstrations. Friday prayers were also attended by the Chief Medical Officer and the Director of OD and Inclusion to provide support to our Muslim communities.

The unsavoury events have also triggered a collective drive to push again to focus on the violence and aggression issues at UHS. Staff still experience unacceptable violence, aggression and hate crimes by patients and service users at UHS and across the whole NHS. A multi-stakeholder workshop, including police partners, is planned for 2 October 2024 to re-energise

delivery of our existing commitments. We also want to use the expertise and advice of a range of people to explore and plan where we can go further and be bolder with this important agenda.

At the national level, NHS England wrote to all integrated care boards, NHS trusts and foundation trusts, GP and dental practices, pharmacy contractors, and general ophthalmic service contractors on 12 August 2024 emphasising the NHS position that 'discrimination is unacceptable, and the NHS should have a zero tolerance of racism towards our patients and colleagues'.

NHS England also sets out some guidance in the following areas for organisations to listen to and support affected staff:

- Ensuring staff can access the support they need
- Involving staff networks in the organisational response
- Dealing with instances of racism and discrimination
- Demonstrating ongoing commitment to equality, diversity and inclusion

The response can be read at: https://www.england.nhs.uk/long-read/nhs-response-to-2024-riots/

Hampshire Together

HM Government has announced that it is pausing approval of the business cases for the '40 new hospitals', of which Hampshire Hospitals is one. Public consultation had recently been completed and submission of the final business case was anticipated before the end of this year but the timing of submission and approval of the business case is now uncertain pending the national review.

Separately, the 'Save Winchester Action Group' has written to board members of HIOW ICB with concerns regarding the proposed changes at Winchester Hospital, specifically around the loss of acute services from the Winchester site. The overall programme was discussed at the ICS board meeting on 4 September 2024.

The executive has a planned session with Hampshire Hospital NHS Foundation Trust executives at the end of September to discuss ideas around future models for services across all sites.

Maternity Services Safe and Sustainable Staffing

In August 2024, the Trust produced a briefing paper for the Care Quality Commission which provided a summary of the Trust's action plan in respect of staffing of its Maternity services. The paper is attached as Appendix A.

CQC Annual Hospital Inpatients Survey

On 21 August 2024, the Care Quality Commission (CQC) published its adult inpatient survey for 2023. The survey examines the experiences of people over 16 who stayed at least one night in hospital during November 2023.

The results showed a deterioration in people's experiences of inpatient care since 2020, although the results for 2023 remained broadly consistent with those in 2022 and 2021.

Most respondents reported a positive experience in their interactions with doctors and nurses, such as being treated with respect, dignity, kindness and compassion and being included in conversations. However, discharge from hospital remains a challenging part of people's experience of care, with 29% saying that they had little to no involvement in decisions about their discharge, and only 48% saying that they were given enough notice about when they were going to leave.

In addition, 23% of elective patients said they would have liked to have been admitted 'a bit sooner' and 19% 'a lot sooner', and 43% of elective patients believed that their health had deteriorated while waiting to be admitted.

The survey results can be viewed at: https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey

Annual Regulation and Oversight Survey
NHS Providers published the results of its annual regulation and oversight survey on 8 August 2024.

According to the survey, trust leaders had reported an increased regulatory burden during the year, particularly noting a lack of coordination between regulators and questioning whether reporting requirements are proportionate or realistic. There were also questions as to whether regulators appropriately recognised the level of risks trusts had been absorbing in balancing the demands of financial and operational performance.

Seventy-two per cent of trust leaders believed that the burden of integrated care board (ICB) regulation had increased, compared to 48% from NHS England and 36% from CQC. Less than a third of trusts were comfortable with the role of ICBs as performance managers and 62% saw their activity as duplicating that of NHS England.

Respondents also questioned CQC's credibility, feeling its judgements were not objective enough and inspection teams lacked sector-specific expertise. In addition, the majority of trust leaders would like to see a move away from the CQC's one-word ratings, seeing it as too simplistic, often demoralising for staff, and confusing for patients.

The survey report can be viewed at: https://nhsproviders.org/a-pivotal-moment-for-regulation-regulation-and-oversight-survey-2024

Cass Review Implementation
On 7 August 2024, NHS England published its plan to implement the advice from the Cass Review – the review of gender identity services for children and young people. This plan includes establishment of regional centres and changes to the referrals process to help trusts to deliver holistic, therapeutic and evidence-based care.

The implementation plan can be read at: https://www.england.nhs.uk/long-read/children-and-young-peoples-gender-services-implementing-the-cass-review-recommendations/

The Trust continues discussions with NHS England regarding whether Southampton could or should be one of these new regional centres.

Aseptic Preparation Audit
On 1 August 2024, the Trust was informed of the outcome of the external audit of unlicensed preparation of medicines for the pharmacy aseptic unit at Southampton General Hospital conducted on 4 June 2024. The unit's operation was assessed as posing a low risk with respect to the quality of the medicines produced within it. The report also stated that the unit 'is well managed and has good pharmaceutical quality systems in place'.

Human Tissue Authority (HTA) inspection
The HTA conducted an inspection of our mortuary arrangements in August. The formal feedback report has not been received but informal feedback has been shared by the inspection team. We expect the report to have no significant findings but we do anticipate a number of minor procedural and documentation recommendations. The inspection team advised us that the failings at Maidstone and Tunbridge Wells mortuary which enabled criminal activity to go unnoticed have triggered a recent 'raising of the bar', particularly regarding security / access arrangements. We will share the final inspection report when it is received, along with our response and action plan.

Appendix A

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UHS Briefing Paper to CQC	
Title:	Maternity Services Safe and Sustainable Staffing
Sponsor:	Gail Byrne, Chief Nursing Officer
Author(s):	Emma Northover, Director of Midwifery Carly Springate, Head of Midwifery Marie Cann, Maternity and Neonatal Safety Lead
Date:	August 2024
Purpose:	The purpose of this report is to note the current challenges in maternity staffing and provide assurance on the mitigations to maintain appropriate and safe staffing levels, which, in turn, ensures the delivery and support of high-quality care.
Issue(s) to be addressed:	Over recent weeks and months our Maternity Service has faced significant operational challenges, leading to more frequent than usual service diversions. This has led to impacts not only on the experience of our families and staff but across the wider Local Maternity and Neonatal System (LMNS). As from the beginning of July 2024, UHS Maternity Services have escalated to OPEL 4 on 23 occasions from the start of this year. Across the whole of 2023 OPEL 4 was declared 28 times. This shows a significant increase in service pressure that our Maternity Service is experiencing with staffing and acuity accounting for the majority of incidents. Whilst we are compliant with providing 1:1 care in active labour and we are safe, we are seeing an increase in other reportable red flags such as delays in induction and being unable to facilitate birthplace choices. In terms of our current position, staffing levels across the Maternity Service have remained challenging with vacancy rates across the registered workforce currently sit around 14%, equating to around 30 Whole Time Equivalents (WTE). Addressing these staffing challenges will require a coordinated effort and it is hoped that by collaborating with our partners we can develop a more comprehensive and effective approach to improving workforce provision. The enclosed plan of action sets out to address the staffing issues as much as possible until the newly qualified midwives start and vacancy is significantly reduced The DoM and the Senior Midwifery Leadership Team are committed to ensuring safe and sustainable staffing levels across UHS Maternity Services. We remain open and honest around our changing clinical environment as well as being sensitive and responsive to any rapidly changing picture. Escalation processes and frameworks are robust and well established. Further to this we have excellent engagement from our

	Maternity Safety Champions with whom we meet with regularly. This includes full support from Gail Byrne, Chief Nursing Officer and Executive Maternity Safety Champion, and Tim Peachey, Non-Executive Director and Maternity Safety Champion, who together ensure that the DoM has a platform and a voice at Trust Board. Despite the immediate challenges in respect of the Maternity Services workforce at UHS, we are looking to offer assurances to the CQC in terms of the actions both short and longer term that are being taken and the mitigations in place to reduce harm and maintain safety to our service users.
Risks (top 3) of carrying out the change or not:	• 285 - Red 20 Maternity Staffing during peaks of activity • 259 - Red 16 Capacity and Demand in Maternity Services • 617 - Orange 12 Lack of postnatal care provision (staffing) • 815 - Red 15 Poor compliance with NICE guidance for Antenatal Bookings
Summary/ conclusion	The CQC are asked to review this report and the mitigations in place and seek further assurance if required.

University Hospital Southampton
NHS Foundation Trust

Maternity Staffing Action Plan

	Issue/Action	Progress	Lead	Date	RAG
1.	Following a successful newly qualified midwife recruitment drive, 34 WTE band 5 midwives to join UHS Maternity Services in November 2024.	• Our current preceptorship programme (18 months in hospital) has been recently reviewed in terms of content and structure to ensure that these staff are retained.	Practice Education lead	Aug 2024	
2.	Utilisation of contingency framework	• Provides contingency measures in releasing and redeploying additional staff.	Head of Midwifery	Aug 2024	G
3.	Utilise birthrate plus as a framework for workforce planning and strategic decision making	• The last assessment of UHS Maternity Services by BR+ in 2018 suggested an overall clinical establishment based on a midwife V birth ratio of 1:24, calculated against an annual birth rate of 5500 births. This is soon to be recalculated	Director of Midwifery	Sept 2024	A
4.	Increased staff support in the clinical environment in addition to pastoral and psychological support to enhance retention of the workforce.	• We have retained 100% of our newly qualified preceptees who started with us in November 2023.	Head of Midwifery Practice Education Lead	Aug 2024	G
5.	The senior leadership team, including the Director of Midwifery (DoM), commit to a high number of out-of-hours on-calls to support the service when in escalation and when staffing does not match the acuity and activity across the acute clinical areas.	• To review how we maintain this going forward to ensure sustainability	Director of Midwifery / Chief Nursing Officer	Aug 2024	G

6.	Two fixed term matron roles have been appointed to oversee antenatal and postnatal pathways.	• This provides additional cushioning to the matron team and a development opportunity for our existing workforce.	Director of Midwifery	Aug 2024	G
7.	Development of a systematic process for workforce planning in the form of a monthly dashboard.	• This live data is reflective of total staff unavailability include vacancy rates, sickness ratios, maternity leave, and study time, all of which is compared alongside the budgeted versus actual staffing establishment overall.	Maternity Business Support Manager	Aug 2024	G
8.	The labour ward coordinator will not take responsibility for any patients, or cover breaks for other members of staff.	• This enables the labour ward coordinator to have continuous oversight of their clinical environment and oversee safety.	Head of Midwifery	Aug 2024	G
9.	An extensive listening exercise has been undertaken place to help inform the future direction and structure of the Maternity Service workforce.	• To align with current service needs, and with staff wellbeing as a central focus, the DoM and Senior Midwifery Leadership Team are reviewing the way the service is delivered with the potential of a workforce restructure.	Director of Midwifery	Aug 2024	A
10.	12 – 16 Registered nurses are to be seconded to maternity in this interim period to help release midwife time with roles such high dependency, vaccination, fundamentals of care	• Divisions seeking staff who are interested in supporting and with the right skillset. • A review will be undertaken to see if this could be a longer-term proposition to support the maternity workforce	Director of Midwifery	Aug 2024	A
11.	Dedicated programmes for career development starting at band 2 and progressing to band 9.	• Our prime focus is to consider new ways in which we can future proof our Maternity Services going forward, whilst investing in our people.	Director of Midwifery	Aug 2024	A
12.	A NHSP Incentive Scheme has been agreed to run over the summer months	• This action has enabled staff to feel valued and appreciated for all their gestures of good will and their contributions to	Director of Midwifery	Aug 2024	A

		the workforce that are worked outside of contractual commitments.			
13.	A review to look at tipping points (as happens in Emergency Department) to be scoped introduced	• Contact to be made with the ED to review learning and any processes and systems.	Head of Midwifery	Aug 2024	A
14.	A roster review will be undertaken to ensure the correct staffing levels and skills are in place.	• Full review of the roster template to ensure fit for purpose and staff allocated correctly.	Maternity Business Support Manager	Aug 2024	A
15.	To introduce legacy midwives (recently retired midwives) to support newly qualified staff and education	• Review of legacy midwives roles and recruitment processes.	Director of Midwifery Practice Education Lead	Aug 2024	A

R	Red: Immediate remedial action required
A	Amber: Action in progress
G	Green: Complete

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Patient Safety and Quality of Care in Pressurised Services**			
Agenda item:	**5.5**			
Sponsor:	**Joe Teape, Chief Operating Officer**			
Author:	**Duncan Linning-Karp, Deputy Chief Operating Officer**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Urgent and Emergency Care (UEC) services are under significant pressure nationally, with some high-profile cases of poor care highlighted, including in the press. In response NHSE has asked Trust Boards to assure themselves that they are doing all they can to: • Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence. • Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on.			
Response to the issue:	This paper will outline UHS's response to the above issues, including the improvement programmes focused on flow and the Emergency Department, the response to the UEC recovery plan year two document, work taking place across the local system and mitigations that take place when the Emergency Department becomes over-crowded.			
Implications: (Clinical, Organisational, Governance, Legal?)	Clinical, organisational, governance, legal			
Risks: (Top 3) of carrying out the change / or not:	• Harm to patients in the Emergency Department through prolonged waits and / or overcrowding. • Harm to patients who remain in hospital longer than necessary because of delayed discharge. • Harm to patients on an elective waiting list who are delayed because of a lack of capacity due to high levels of patients not meeting the criteria to reside.			
Summary: Conclusion and/or recommendation	Trust Board is asked to **note** this report.			

Introduction

NHS England wrote to all NHS Trusts (see Appendix 1) to ask Trust Boards to assure themselves that Trusts, and wider systems, were doing all they can to reduce demand on Emergency Departments, improve flow across the UEC pathways including out of hospital, ensure basic standards of care are in place across all care settings and ensure executive visibility and leadership, and non-executive presence.

This paper provides assurance to the Board, addressing the key requests outlined in the letter and benchmarks UHS's response to the year two UEC plan. It also outlines work taking place in the local system to support admission avoidance and reduce delayed discharge. Finally, it outlines mitigations the organisation has put in place to manage risk at times when the Emergency Department (ED) is overcrowded, and to support flow through the hospital.

Patient Safety and Quality of Care in Pressurised Services

NHSE wrote to all Trusts to outline key actions Boards were required to assure themselves on to ensure patient safety and quality of care is maintained in pressurised services. The table below outlines those actions and UHS's compliance against them.

Request	Assurance
Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.	There are community alternatives in place, including Urgent Community Response and virtual wards. More work is taking place to set-up Integrated Neighbourhood Teams.
Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on.	In-hospital flow is something UHS is continuously seeking to improve via the inpatient flow programme, focusing on all aspects of flow within the hospital's control and ensuring patients only remain in hospital when necessary. Ward rounds take place daily with appropriate input from a senior decision maker.
Their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter.	UHS is compliant with these actions, outlined in the following section.
Basic standards of care, based on the CQC's fundamental standards, are in place in all care settings.	Fundamentals of care standards have been rolled out across the organisation. A CQC Oversight Group, chaired by the CNO, provides assurance on compliance against the standards.
Services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund.	The wider system does support flow out of ED and the wider hospital, and the Better Care fund is used. However, the system continues to struggle with a high number of patients remaining in hospital who do not meet the criteria to reside.
Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance.	Seven Day Hospital Services are reported via the annual Quality Account to the Board and the Trust is compliant. A further audit is due in 2024.
There is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place	There is consistent, visible executive leadership across the UEC pathway including a fortnightly ED meeting chaired

every day of the week at both trust and system level.	by the Chief Executive, a monthly UEC Board chaired by the COO, a monthly CQC Oversight meeting chaired by the CNO and regular executive walkabouts. UHS has an internal escalation plan as does the wider system. The Trust appointed a clinical Director for Urgent and Emergency Care.
Regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board.	Non-executive directors undertake walkabouts as part of Trust Board.

Year two UEC Plan

Benchmarking against the second year of the UEC plan shows that UHS is compliant against the key metrics. There has, however, been a reduction rather than an increase in some out of hospital capacity because of the financial challenges facing the ICB, Local Authorities and wider system.

Request	**Assurance**
1A. Maintain acute G&A beds at the level funded and agreed through operating plans in 2023/24.	UHS's 2024/25 plan included the dual aspirations of halving the number of patients not meeting the criteria to reside and reducing length of stay by 5%. If these were both met, it is unlikely that we would require all current beds. However, while beds that are not needed would not be staffed, they will remain available if needed. In recent months routine surge capacity has remained closed but is available to open as needed.
1B. Maintain ambulance capacity and support the development of services that reduce ambulance conveyances to acute hospitals.	Primarily for the ambulance trust. However, UHS is reviewing a trial for 'call before convey' that, if possible, will be supported to see if it is successful in reducing conveyances to hospital, or alternatively conveying to a setting other than the Emergency Department.
1C. Focus on reduction in ambulance handover delays to support system flow.	UHS continues to perform well on ambulance handovers. Over the last month our performance has been second in the South East region.
1D. Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care.	Bedded and non-bedded intermediate care capacity has been reduced because of the financial challenges faced across the system.
1E. Improve access to virtual wards through improvements in utilisation, access from home pathways, and a focus on frailty, acute respiratory infection, heart failure, and children and young people.	Virtual ward capacity has been maintained but not increased.
2A. Focus on reductions in admitted and non-admitted time in ED.	UHS continues to focus on reducing the time patients spend in the Emergency Department, supported by the inpatient flow

	programme and the ED transformation programme. This includes implementing the ECIST recommendations from the visit earlier in the year, expanding the use of Same Day Emergency Care (SDECs) facilities, implementing internal professional standards, and focussing on faster flow from the department. UHS remains one of the top performing emergency departments in the country as outlined in the Emergency Care Data Sets.
2B. Focus on reductions in the number of patients still in hospital beyond their discharge ready date (DRD).	The inpatient flow programme is focused on reducing length of stay and ensuring patients leave hospital as soon as they are ready.
2C. Focus on reductions in length of stay in community beds.	Community partners have their own length of stay programmes.
2D. Improve consistency and accuracy of data reporting.	UHS is using the national definitions and SHREWD to calculate our OPEL status. Moving to the national data collection for SDECs is dependent on implementing the new ED system in 2025.
3A. Increase referrals to and the capacity of urgent community response (UCR) services.	Referrals made to UCR services from both frailty and ED.
3B. Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week.	UHS has an SDEC service at 15 hours a day, 7 days a week.
3C. Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week.	UHS has a dedicated frailty service 12 hours a day 7 days a week.
3D. Provide integrated care co-ordination services.	This is an out of hospital response, the local system is looking to support setting up integrated neighbourhood teams.

System Response

The wider system has a key role in maintaining safety within the acute hospital, by supporting admission avoidance (either preventing patients from attending the ED in the first place, or supporting discharge from the ED rather than admission to the hospital) and supporting discharge from inpatient beds, reducing the number of patients not meeting the criteria to reside.

Hampshire and the Isle of Wight ICS is starting to develop the concept of 'Delivery Units', focused on driving improvements in both admission avoidance and discharge. These are at both ICS and local system level. The units, and plans, are in their infancy.

At a local system level, the plans for admission avoidance are focusing on improvements in the Same Day Emergency Care (SDEC) pathway, Integrated Care Services and improved use of Virtual Wards and Urgent Community Response. For the latter three, action plans are being developed. Improved Same Day Emergency Care use was already a focus at UHS, with three clear workstreams. The first is focused on improving pathways to existing SDECs, particularly medicine and frailty, to allow a wider cohort of patients to go there. Secondly, teams have trialled an improved SDEC offer in acute surgery and have plans to trial in both stroke and T&O. Thirdly,

funding has been secured and there are plans to build a multi-speciality SDEC to expand the physical estate and increase the number of specialties and patients who have access.

The work on reducing the number of patients not meeting the criteria to reside is focused on reducing process delays in the pathway. However, there is at present minimal assurance that the plan will deliver a significant reduction in the number of patients not meeting the criteria to reside. It seems unlikely that process delays will yield a big enough benefit on their own, and either there needs to be more capacity, or a fundamental shift in how existing capacity is used. This is currently being reviewed with system colleagues to identify the capacity investments needed to yield the most significant gains in advance of winter.

Mitigations

While a significant amount of work is taking place both within the organisation and across the local system, a combination of significant demand and, at times, poor flow from the ED does frequently lead to overcrowding within the ED. This is a significant risk, scored 25 on the Trust's risk register. The overcrowding means that patients are often cared for in corridors. This is done in order to facilitate the offloading of waiting ambulances, as a greater risk is to have undifferentiated patients waiting long periods of time in their own home as ambulances are queueing outside an acute trust. A paper outlining in more detail the risks and mitigations was taken to the Trust Board's Quality Committee in June 2024. The following paragraphs provide a summary of how the risk is managed.

1. Significant investment has been made by the Trust to support permanently recruiting to additional nursing and HCA hours to manage the queue of patients in the ED over a 24/7 period. This investment includes the management of some "surge areas" to support decompressing the majors part of the department.

   Majors has space for a total of 32 patients (trollies in bays) to include 8 pitstop bays. During busy periods the number of patients in majors has been double this capacity.

   When the ED starts to exceed its maximum capacity efficiency will likely start to drop off impacting on the ability to achieve the 4hr emergency access performance standard.

   The ED team with the support from operational teams and trackers will follow an agreed standard operating procedure to manage the flow in the department to ensure patients are cared for appropriately. This will include ensuring patients in majors are seen according to clinical need via clinical prioritisation to ensure wait to be seen is not given the highest priority. This process will often start in pitstop. Queue nurses are also in place to ensure appropriate care for these patients during periods of long delays.

2. Review of the triage process at reception to avoid higher acuity patients waiting too long before being streamed to the most appropriate part of the department. The pilot involves an initial rapid assessment being made by a nurse on the reception desk of the patient the diagram below showing the two stage model of initial assessment.

   Early signs show significant improvements to patient safety and experience with a 24mins reduction in time to assessment. This new process is being reviewed by the senior nursing to discuss how this is further embedded from a pilot into business as usual.

3. During busy times our purpose-built resus area which caters for 6 patients has been required to be double-bayed. This puts stress on the clinical teams in resus but also relies on colleagues from other areas of the department to come and join them in resus to manage the numbers of patients with high acuity.

   For mid-May to the end of July the average occupancy at midnight was 4 patients in resus.

When resus is double-bayed the ops team and clinical site team follow an escalation process designed to support the decant of resus, this will include reviewing the two step-down patients the clinical team earmark in resus in case of the area being full.

4. Holding and Cohorting of Ambulances is linked to the strained occupancy levels inside the ED. To support managing the patient safety aspect of holding ambulances the clinical team alongside the clinical site office and COO team has designed a standard operating procedure (SOP) which is used before we make a decision to cohort ambulances.

   Cohorting does require holding ambulance crews however, in reality for every 4 patients being cohorted (looked after inside UHS but before they get into the ED) only 1 crew is being held back although national ambulance reporting metrics will show all 4 crews as being delayed in handing over.

   For UHS our collective ambition is to NOT hold ambulances either as part of our cohorting SOP or on the ambulance apron.

5. An MDT of people from the ED, hospital site team and Emergency Medicine Care Group will huddle at least 4 times a day as standard. These huddles provide opportunity to discuss departmental pressures in both adults and paediatrics and discuss items for escalation and/or further support.

6. Inpatient flow programme is designed to support improving flow across the Trust. This focus will ultimately support the timely flow of patients out of the ED making the department more resilient to when attendances surge during a 24hr period.

   The programmes focus is aiming to reduce inpatient length of stay by 5%, increase home before lunch performance to over 25% and increase the number and % of weekend discharges. Currently a reduction in length of stay for Pathway 0 patients (those discharges within UHS's control) of 5% is being achieved.

   This programme led by the CNO, COO, Dep CMO & Dep COO supported by the Transformation Team in conjunction with the Divisions and Care Groups

Other large areas of focus both internally within ED but also in the wider hospital are:

- ECIST workstreams post their visit in early January 2024:-
  - COD leadership
  - Use of pitstop
  - Review of CDU
  - Review of ambulatory pathways
- UEC Board – to follow-up and drive through on the workstreams related to Urgent & Emergency Care across the Trust
- Medical flow programme of work within Division B
- Same Day Emergency Care pathways expansion (medical)
- SCAS escalation processes
- Overall trust wide escalation policy
- Trust wide SDEC focus
- The following of the agreed and published Internal standards for all specialty teams to follow at UHS
- System working to reduce the number of patients who have no criteria to reside at UHS, plus support to ensure more timely discharge of mental patients into a more suitable place to better care for their needs.

Conclusion

UHS is busier than ever, treating more patients than before both electively and non-electively. This paper aims to assure the Trust Board that, while at times patients are looked after in sub-optimal locations, this is a risk based decision and appropriate mitigations are put in place. It also provides assurance that UHS is meeting the standards outlined in both the letter and the 2 year UEC plan.

However, clearly queueing patients in corridors, or putting overnight patients in day units, is sub-optimal and should not be normalised. The improvement work within the Emergency Department, through the inpatient flow programme and across the local system have to provide long term solutions to ensure that we can manage growing demand within our footprint. There is some success, with Pathway 0 length of stay reducing by 5% this year, and significant changes within the Emergency Department and Same Day Emergency Care facilities. However, reducing Emergency Department attendances, and patients remaining in hospital who do not meet the criteria to reside are fundamental to addressing the challenges faced. While there is a renewed focus there remains much to do to ensure that the plans will deliver at the scale needed.

To:
- Integrated care board:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Integrated care partnership chairs
- NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
- Regional directors

CC:
- Local authority chief executives

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

26 June 2024

Dear colleagues,

Action required: Maintaining focus and oversight on quality of care and experience in pressurised services

Thank you for everything that you and your teams continue to do to provide patients, the public and people who use our services with the best possible care during the period of sustained pressure that colleagues in all health and social care services are experiencing.

Despite the hard work of colleagues, and everything they are achieving in the face of these challenges, we would all recognise that on more occasions than we would like, the care and experience patients receive does not meet the high standards that the public have a right to expect, and that we all aspire to provide.

However busy and pressurised health and care systems are, people in our care – as well as their families and carers – deserve at all times to be treated with kindness, dignity and respect. This week's Channel 4 Dispatches documentary, filmed in the Emergency Department at Royal Shrewsbury Hospital, was a stark example of what it means for patients when this is not the case. While Urgent and Emergency Care (UEC) is facing real pressures as a result of increasing demand, lack of flow and gaps in health and social care capacity,

the documentary highlighted examples of how the service some patients are experiencing is not acceptable.

We are therefore asking every Board across the NHS to assure themselves that they are working with system partners to do all they can to:

- provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence
- maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility on

These interventions are clearly set out in the UEC recovery plan year 2 document, and it is evident from the data that those systems with fewer patients spending over 12 hours in an emergency department are doing a combination of all of them, consistently, with direct executive ownership.

In addition, wherever a patient is receiving care, there are fundamental standards of quality which must be adhered to. Corridor care, or care outside of a normal cubical environment, must not be considered the norm – it should only be in periods of escalation and with Board level oversight at trust and system level, based on an assessment of and joined up approach to managing risk to patients across the system (through the OPEL framework). Where it is deemed a necessity – whether in ED, acute wards or other care environments - it must be provided in the safest and most effective manner possible, for the shortest period of time possible, with patient dignity and respect being maintained throughout and clarity for all staff on how to escalate concerns on patient and staff wellbeing.

While these pressures are most visible in EDs and acute services, they are also wider issues which need whole-system responses, including local authorities, social care and primary and community services. There is therefore a shared responsibility to ensure that quality (patient safety, experience, and outcomes) is central to the system-level approach to managing and responding to significant operational pressures.

In achieving this, Board members across ICS partners should individually and jointly assure themselves that:

- their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter
- basic standards of care, based on the CQC's fundamental standards, are in place in all care settings
- services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund
- executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance
- there is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level

- regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board

In line with the NHS operating framework, regional COOs, chief nurses and chief medical directors will continue working with ICB colleagues across systems (CMO, CNO, COO/CDOs) and trusts to support a planned approach to clinical and operational assessment of system pressures and risks, ensuring an integrated approach to any tactical response and balancing clinical risk across the system. This collaboration should include provider CEOs, system executives, local authority, and third sector partners where applicable.

Where any organisation is challenged we will work with you to use the improvement resources at our disposal, including clinical and operational subject matter expertise from the highest performing organisations, GIRFT, ECIST and Recovery Support. We also have a joint improvement team with the Department for Health and Social Care for complex discharge led by Lesley Watts, CEO of Chelsea and Westminster. If you are unclear how to ask for help in any of these areas, please do so via your regional COO in the first instance.

We recognise that all colleagues across health and social care are working extremely hard in very difficult circumstances, and that UEC is not the only pathway in which this is the case. However, there are interventions and standards that do make a difference and can address much of the variation in quality and waiting times across the country, and it is incumbent on us all to do everything we can to ensure that the poor quality of care we saw on Monday evening is not happening in our own organisations and systems.

Yours sincerely,

Sarah-Jane Marsh

National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer

NHS England

Dr Emily Lawson DBE

Chief Operating Officer

NHS England

Professor Sir Stephen Powis

National Medical Director

NHS England

Dame Ruth May

Chief Nursing Officer

England

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2024-25 Month 4**			
Agenda item:	**5.6**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**10 September 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.			

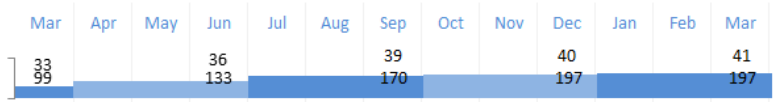
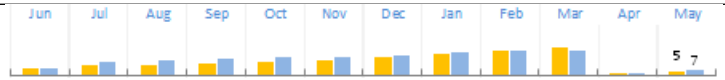
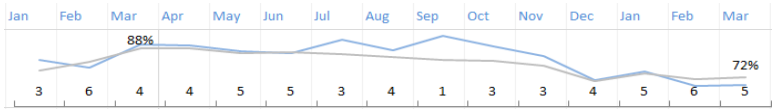
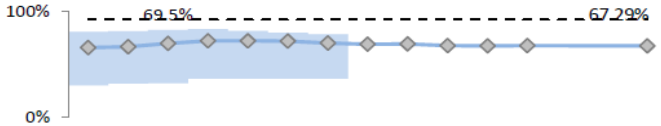
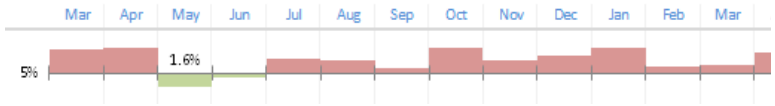
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
July 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.

The following data points have now been updated for both June and July 2024:-

- 31 - Patients on an open 18 week pathway (within 18 weeks)
- 32 - Total number of patients on a waiting list (18 week referral to treatment pathway)
- 33 - Patients on an open 18 week pathway (within 52 weeks)
- 34 - Patients on an open 18 week pathway (within 65 weeks)
- 35 - Patients on an open 18 week pathway (within 78 weeks)
- 35a - Patients on an open 18 week pathway (within 104 weeks)
- 3: Percentage of non-elective readmissions within 28 days of discharge from hospital

Changes of note within the report itself: -

- 1 and 2: HSMR data has now been published for April 2024 and May 2024
- 4: Volume of specialties with outcome metrics was revalidated for quarter 1 and increased from 75 to 76

Summary

This month's spotlight report focusses on the Referral to Treatment (RTT) waiting list and long waiting patients. It highlights that the organisation has seen a period of growth in the waiting list across the 2024 calendar year following stability in the second half of the 2023 calendar year. The growth is within the referral cohort of the waiting list and predominantly within ten main specialties including dermatology, genetics and oral surgery. The section outlines the known causes and implications of the increases in the main specialties whilst exploring how to manage the demand, streamline pathways or address staff shortages. The report illustrates how the trust is benchmarking well for volume of patients waiting over 65 weeks and the progress made towards the ambition to have no patients 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 position improved to 70.6% (July 2024) from 67.0% (June 2024) for type 1 attendances. UHS remain in the top quartile when compared to peer teaching hospitals for this metric. The mean time in department for both admitted and non admitted patients has continued to reduce in July 2024.
2. The volume of patients not meeting the Criteria to Reside in the hospital decreased in July 2024 to 216 when compared to 223 for June 2024. This remains a significant influence on patient flow within the organisation.
3. Whilst the percentage of patients waiting over six weeks for diagnostics marginally increased to 11.6% in July 2024, the trust remains in the top quartile when compared to peer teaching hospitals. The total volume of patients waiting for diagnostics reduced to 9,132 in July 2024.
4. The hospital remains above the national target for the cancer 62 day standard and the cancer 28 day faster diagnosis standard for the latest validated month (June 2024). The hospital reported 88% for June 2024 for the 31 day cancer standard which is below target. The trust remains in the bottom half when compared to peer teaching hospitals.
5. The organisation reported zero never events and one patient safety incident investigation (PSII) for July 2024.
6. The percentage of outpatient appointments delivered virtually shows a reduction in the 2024/25 calendar year. This is not a reflection of service change, but a temporary backlog in data reporting for telephone consultations.
7. The research and development department achieved 100% for study set up times in July 2024. This success reflects a series of actions put in place by the department and pharmacy teams to streamline processes following site selection, including resource ringfencing for drug oncology studies.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 19th August 2024, our average handover time was 13 minutes 55 seconds across 756 emergency handovers and 13 minutes 52 seconds across 39 urgent handovers. There were 20 handovers over 30 minutes, and one handover taking over 60 minutes within the unvalidated data for that week. In July, the average volume of weekly handovers over 60 minutes was 2.2 which was a significant reduction since June 2024 (15 per week).

Spotlight: Referral to Treatment Waiting Times

1. Introduction

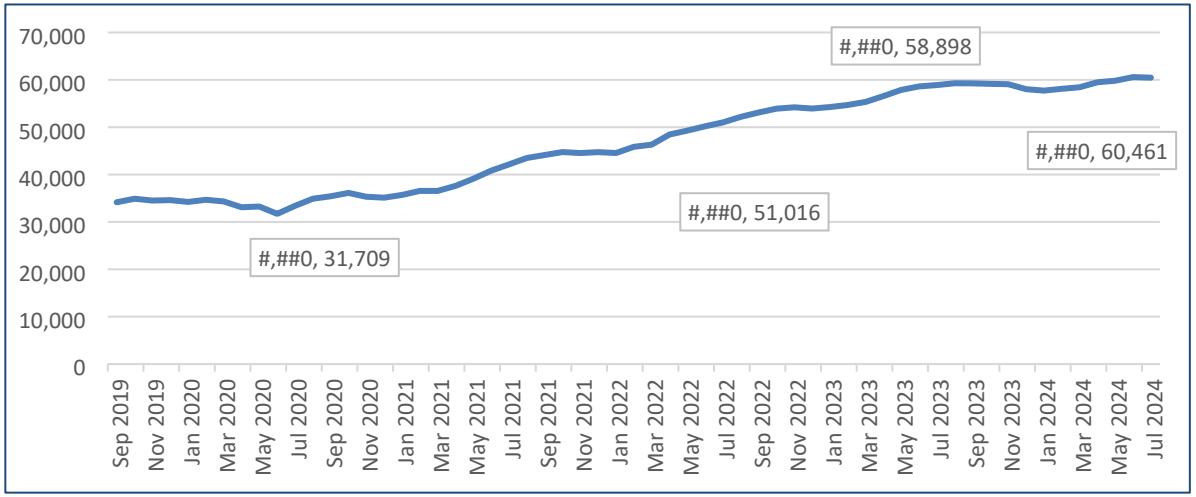
Waiting times and waiting lists have always been a key indicator of a hospital's performance, directly impacting patient experience and clinical outcomes. Growing demand for services, coupled with resource constraints, has placed well documented pressure on the entire NHS. This was exacerbated by the pandemic, which caused significant disruptions to routine services, creating a substantial backlog of patients awaiting diagnosis, treatment, and elective procedures. Annual targets are set for all NHS trusts to drive a reduction in long waiting patients alongside the ambitions to reduce the overall waiting list.

This month's spotlight report provides an in year update on the position of the UHS Referral to Treatment (RTT) waiting list and the organisation's progress against the 24/25 national ambitions for long waiting patients. It highlights the services which are experiencing growing demand, the steps taken to understand and manage the cause, and the potential interventions to realign resources or remodel pathways. It also explores how the organisation benchmarks against peer hospitals for patients waiting over 52 weeks and the oversight in place which ensures patients' pathways are appropriately monitored, managed and validated. The following information is based on the validated July 2024 RTT submission, with operational insight based on the latest situation for our longest waiting patients.

2. UHS Waiting List Position

There was a significant and well discussed period of growth within the trust's overall PTL during the long recovery period which followed the pandemic.

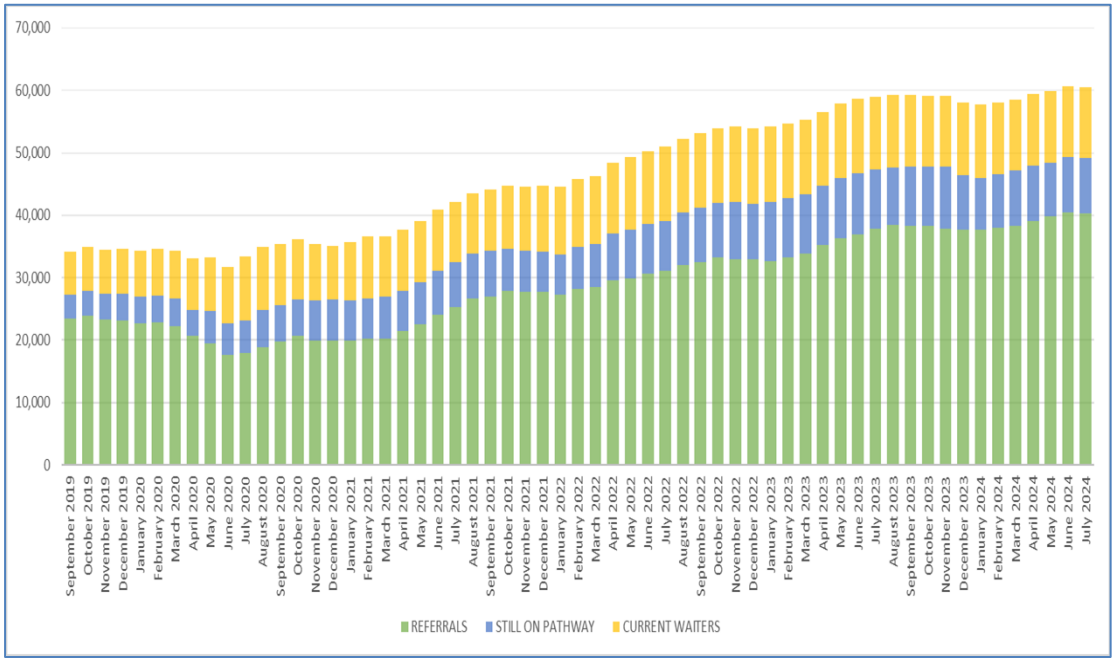
This peaked at 59,277 patients in August 2023, then slowly reducing to 57,725 by the start of the 2024 calendar year. The July 2024 reported position is 60,461 which reflects growth of 2.6% over the last twelve months and 4% since the start of this calendar year.



Graph 1: RTT monthly PTL trendline

The growth in the waiting list since the start of the calendar year is evidenced in graph 2, but with a break down by pathway type. This highlights that the recent increase is primarily within the referral stage of the patient pathway, rather than patients who are waiting for an admission (current waiters) or still undergoing diagnostics and assessments ahead of a decision to treat or discharge (still on pathway). The growth in this referral cohort is 6% over the last twelve months (37,880 in July 2023 against 40,215 in July 2024) and 7% in 2024 alone.

Whilst the organisation's waiting list is spread across 95 different specialties, the majority of this recent referral growth sits within services that are predominantly delivered in an outpatient setting as illustrated in table 1.



Graph 2: PTL Trendline by Pathway Cohort

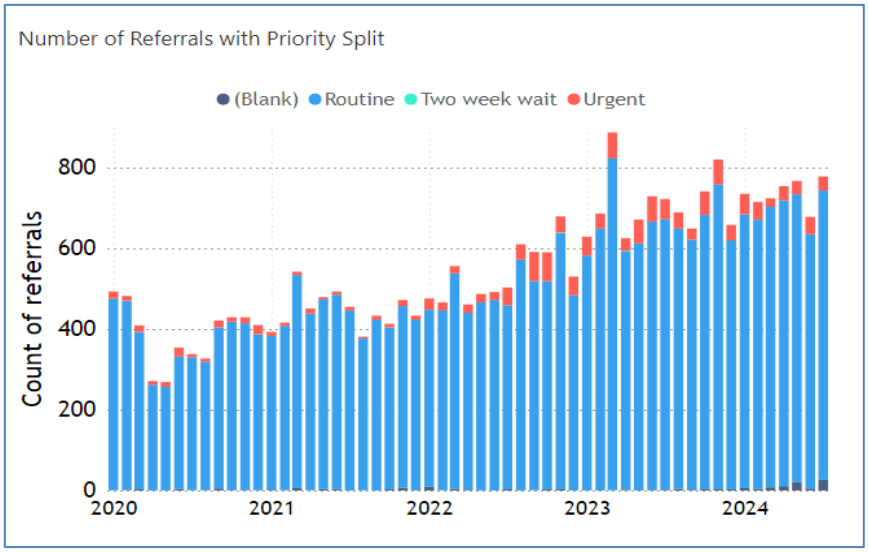
Volume of Patients at Referral Stage - PTL				
Specialty	**Dec 23**	**Jul 24**	**Change**	**Growth**
CLINICAL GENETICS	2,160	2,998	838	39%
DERMATOLOGY	2,128	2,903	775	36%
ORAL SURGERY	1,403	1,841	438	31%
IMMUNOLOGY \ ALLERGY	977	1,364	387	40%
NEUROLOGY	4,666	4,889	223	5%
PAEDIATRIC CARDIOLOGY	257	421	164	64%
PAED DERMATOLOGY	427	539	112	26%
OTHER SPECIALTIES	22,258	22,366	108	0%
GYNAECOLOGY	3,390	2,894	(496)	-15%
Total	**37,666**	**40,215**	**2,549**	**7%**

Table 1: PTL Referral Growth by Service

Whilst it is recognised that referral growth has some predictable seasonality and monthly volatility, early detection of any change in the referral position is crucial to flex capacity and resourcing, discuss with primary care colleagues or implement pathway modifications. In the following section, we provide service narrative to document the current understand of the referral growth in some of these key specialties.

2.1 Clinical Genetics

The increase in this service is a result of longer term national pathway changes, general referral growth and recent administration delays due to resourcing gaps within the UHS service. Towards the end of the 2022/23 financial year, GPs were incentivised to screen their patient lists based on specific criteria (DES indicators) and make referrals. This has led to a significant increase in referrals particularly connected to the Familial Hypercholesterolemia service. Alongside this pathway increase, rare diseases and cancer referrals have increased by between 5% and 10% year-on-year from both primary and secondary care. The administration resources within the team are currently stretched due to long term sickness and a high vacancy rate. This has caused some delays in the outcoming of appointments and resourcing for patient pathway validations. Temporary staffing and central validation team support will improve the situation and ensure the reported position is a closer reflection of patients waiting.

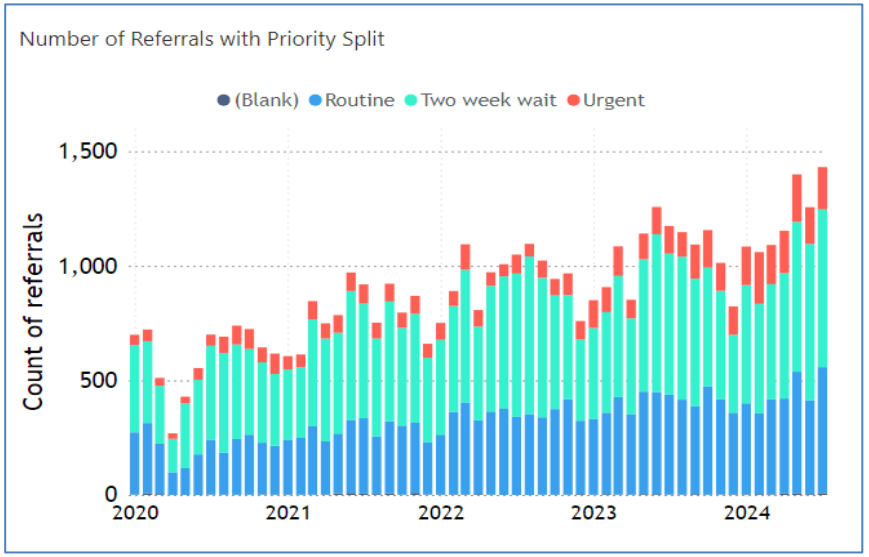


Graph 3: Clinical Genetics referral volumes by month

2.2 Dermatology

The waiting list increases are due to the high number of two week wait referrals but also routine and urgent referrals. The seasonal volatility of the service is well recognised as skin referrals increase approaching and during the summer. The service capacity has also been impacted by industrial action, staff sickness and vacancies in both medical and non-medical roles. In surgery, urgent 31-day procedures are always prioritised which has pushed routine surgeries towards a nine-month wait.

Whilst the Teledermatology iTriage pathway for urgent cancer patients is now established, the volumes of cases requiring face-to-face consultations remains at approximately 80%. Collaborations with Wessex Cancer Alliance and GP surgeries aim to improve photo quality for the iTriage platform, with a goal of discharging over 50% of patients through advice and guidance without needing a face-to-face visit.



Graph 4: Dermatology referral volumes by month

Similarly to genetics, the adult service is turning towards temporary staffing to cover administration vacancies whilst using insourcing to enable weekend capacity, waiting list initiatives and super Saturdays. The "Was Not Brought" (WNB) rate within paediatric dermatology is a current concern increasing to 14% this financial year (4% higher than last year). The service is conducting a WNB pathway audit and working closely with the Clinical Lead for Triaging to better understand the factors driving referral growth.

2.3 Oral Surgery

Throughout 2022 and 2023, the service received approximately 450 referrals per month. In 2024 we have consistently received over 500 referrals a month peaking at 568 in July 2024. The service is exploring options on how to accommodate these increased referrals which are understood to correlate with the national shortage of dentists and longer waiting times for dental treatment. The service has also seen a noticeable rise in the demand for dental extractions prior to cardiac surgery and radiotherapy treatment. These are essential pre-emptive workups for treatments to reduce the risk of infection and endocarditis following surgery or treatment.

Graph 5: Oral Surgery referrals – 12 month timeline

2.4 Immunology and Allergy

While referrals received haven't increased overall, patients are waiting longer for their first appointment which has caused an increase in the referral position on the PTL. This is the result of long term consultant sickness and subsequent reduction in their clinic availability following return to work.

Unfortunately further reductions in PAs are expected due to an upcoming retirement and planned surgery among the medical staff. A strategic review of demand and capacity is under way and the service is about to undertake a pilot process to address DNA rates. Rather than issuing patients with an outpatient date, for two weeks the admin team will call patients to mutually agree an appropriate date and then monitor the impact.

2.5 Neurology

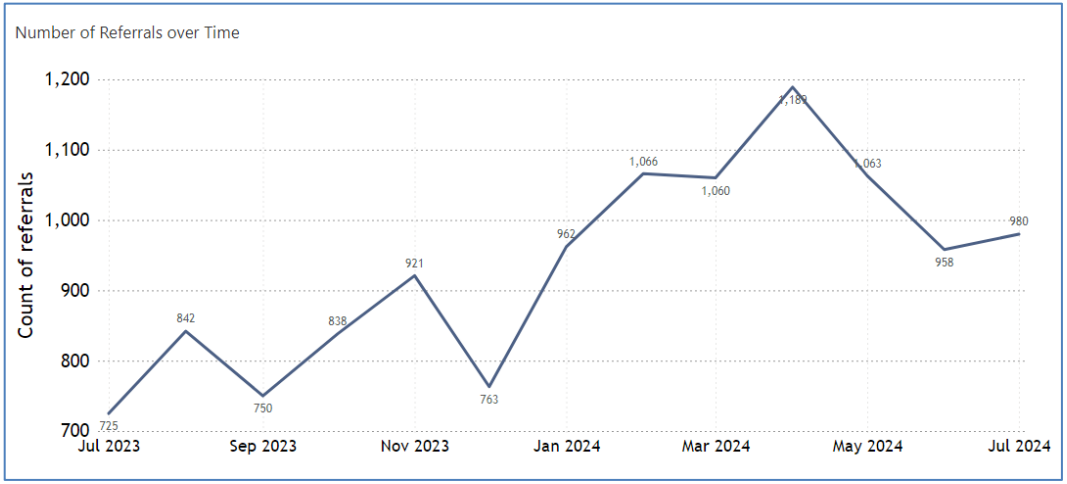
Growth in the PTL is mainly driven by GP referrals, where we see around 900 referrals per month reflecting an increase of 50% compared with pre-Covid volumes. To manage the increased workload, consultant clinic time has been reduced to support referral triage which is resulting in 300 referrals per month being redirected back to GP with advice and guidance. Triage of 900 referrals takes approximately 90 hours of consultant time monthly. To maintain the current demand, the service hope to increase staffing levels with two consultant positions currently being advertised, which will help one of the four sites reach a stable operating state.

2.8 Cardiology

The trust has seen an increase in Cardiology referrals since January 2024, with three of the last six months peaking over 1000 per month (see graph 6). This is a multi-faceted service which will always be impacted by public awareness alongside rising rates of diabetes, obesity, and hypertension. A key driver is also more aggressive screening and diagnostic practices in primary care which identify patients who need specialist cardiology care.

More specifically, heart failure referrals have increased beyond existing capacity, with the team now receiving approximately 20 referrals per day against capacity for 21 clinic slots per week. We have limited scope to increase our capacity within the existing headcount and there has been minimal uptake for WLIs following the recent industrial action.

There are workstreams underway to streamline the management of these referral volumes through advice and guidance services, however, as the outpatient clinics for cardiology are booked up to a year in advance, it will take some time for the full effect to be felt.



Graph 6: Cardiology referrals – 12 month timeline

The transformation team is actively supporting the paediatric cardiology and cardiac surgery teams to map out the levels of demand for the multiple referral routes into a complex service. This pathway mapping process has been beneficial in other paediatric services providing opportunities for referral

management and pathway streamlining. Additionally, the clinical teams are participating in an NHSP Deep Dive review in September 2024 to assess service quality and the impact on patients.

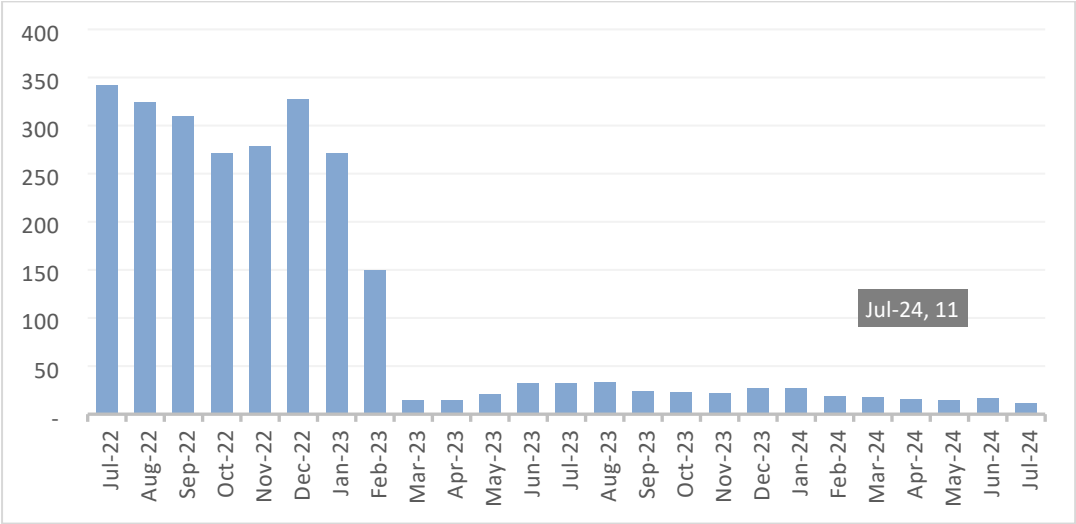
3. Long Waiting Patients

In the 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. Given the operational challenges faced across the NHS during that period, this target was extended and reiterated in the 2024/25 financial year to "Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)". Whilst UHS has prioritised this national target, the organisation is also striving to achieve no patients waiting over 52 weeks by March 2025. In the section below, we outline the position for each of the waiting time cohorts under national, regional and internal scrutiny.

3.1 Patients waiting over 78 weeks

Throughout the 2024/25 year to date, the only patients waiting over 78 weeks (by the month end validated position) have been within the corneal transplant service in ophthalmology. This reflects an ongoing national shortage of corneal tissues which is a situation being managed by the National Blood and Transplant (NHSBT) service.

The UHS service, ICB and NHSBT are in regular dialogue to ensure that patients of highest clinical risk are prioritised alongside those waiting the longest. The Trust had eleven patients waiting over 78 weeks at the end of July 2024 and surgical capacity is lined up to ensure these patients are treated as soon as tissue is released.



Graph 7: Volumes of patients waiting over 78 weeks

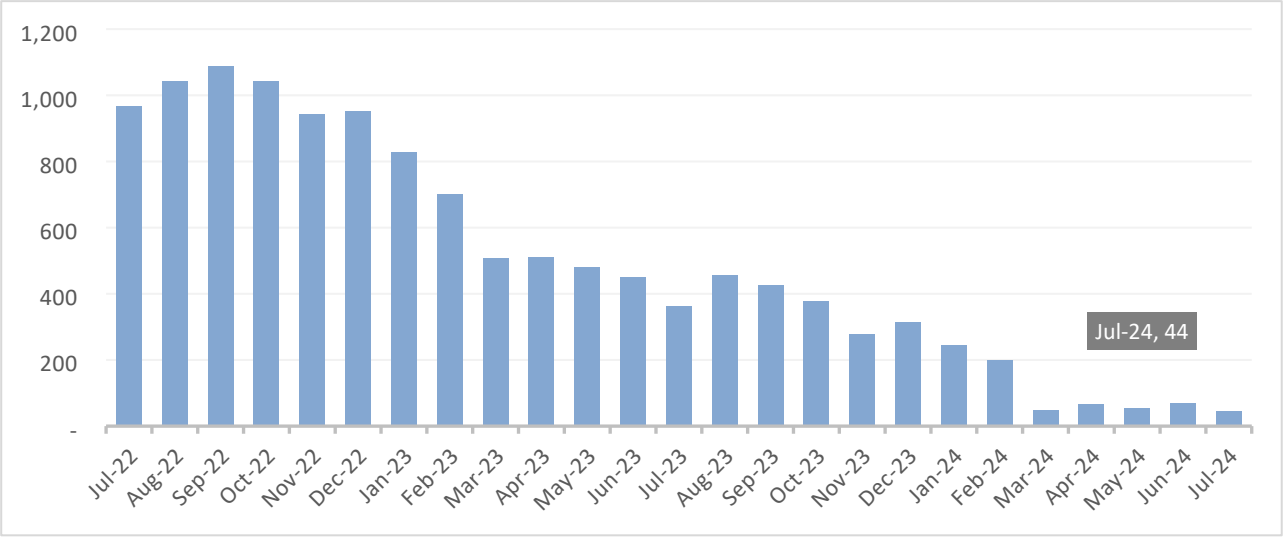
The latest benchmarking information available is for June 2024 where the corneal issue places UHS in 11th place when compared to 20 peer teaching hospitals across the UK for 78 week waits. The overall 78 week volumes range from zero to 296 patients across the different hospitals.

3.2 Patients waiting over 65 weeks

At the close of the 2023/24 financial year, the organisation reported 49 patients waiting over 65 weeks which was spread across seven different specialties. At the end of July 2024, the organisation reported 44 patients in this cohort, across five specialties. 35 of these patients are again the impact of the corneal tissue availability, six are within Gynaecology and the remaining three were unique patient or late service complications within Dermatology, Cardiac Surgery and Neurosurgery. The Gynaecology service has made significant progress on treating its longest waiting patients but remains an area of concern for meeting the national target. Gynaecology is a high volume service with numerous pathways delivered in (and outsourced to) multiple sites for outpatients, diagnostics and inpatients. One key issue has been the alignment of consultant, theatre and anaesthetic resources for complex joint urogynaecology cases, but also operational administration challenges during a period of staff sickness.

Weekly performance meetings consistently focus on this remaining cohort of patients, walking through each pathway to fully understand and pre-empt any patient complications and surgical capacity risks. The central validation team have also redirected their resources to ensure all patient pathways are constantly reviewed and verify patients are still wishing to continue with treatment and available.

National benchmarking for the 65 week cohort ranks UHS in second place against peer teaching hospitals (for June 2024). UHS are only one of two hospitals with less than hundred patients in this cohort with the comparator ranging from 48 patients to 5,592 patients.

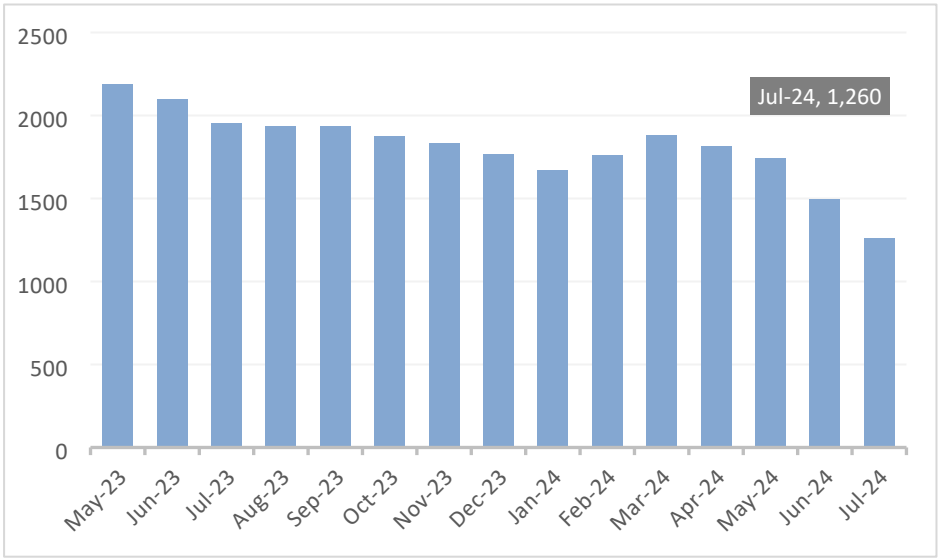


Graph 8: Volumes of patients waiting over 65 weeks

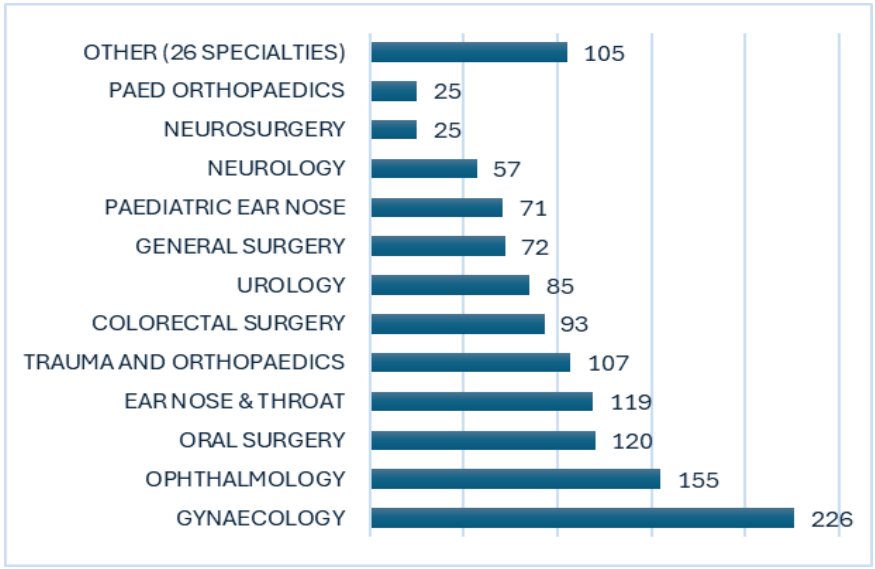
3.3 Patients waiting over 52 weeks

Graph 9 reflects the current volumes of patients waiting over 52 weeks illustrating the significant progress that has been made since March 2024 as the cohort reduced by 33%. The organisation reported 1,260 patients waiting over 52 weeks at the end of July 2024 and a breakdown by key specialties is shown in Graph 10. The last comparator data uses percentage of entire PTL for this category – UHS reporting 2.5% which ranks them 8th against 20 peer teaching hospitals. Of those patients breaching 52 weeks, 26% are at referral stage, 20% are still on pathway whilst 55% are waiting for an admission. It must be recognised that the majority of those breaching at referral stage are within specialties that are predominantly outpatient services such as neurology and ophthalmology and won't require surgery following consultation.

The organisation has continued to approach performance management and improvement in the same way as previous years. Weekly performance meetings take place with each Care Group to review patient level detail for all long waiting patients transitioning focus from the 65 week cohort down to 52 weeks 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 9: Volumes of patients waiting over 52 weeks



Graph 10: July 2024 breakdown by key specialties

4. Summary

In summary, this report highlights that the hospital is experiencing growth in the waiting list predominantly within the referral cohort but limited to specific specialties. It is recognised that some of this is monthly volatility or seasonable variation, but also an underlying increase in referrals from primary care. Internally we also see clinical and administration staffing pressures due to sickness or vacancies which have increased waiting times or slowed down pathway validation or system discharge processes. It is imperative that we have early recognition of waiting list fluctuations to enable flexibility on pathway and patient management as we strive to meet national targets and ensure our patients receive high quality treatment as early as possible.

The organisation has been successful in reducing the volume of long waiting patients on the waiting list across the last two years. It is now in a strong position against the national target for 65 weeks but recognises there are a handful of complex specialties and pathways which could be impacted by operational issues, resourcing complications or patients deemed to be of a higher clinical priority. The organisation has ambitions to achieve the 52 week target by March 2025 and continues to benchmark strongly against peer organisations. The level of oversight on our long waiters is operationally and clinically appropriate and the monthly position and forecast is a regular discussion topic with ICB, regional and national colleagues.

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

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	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)	63.8%														64.4%	≥92%	63.9%
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)	60.4%														74.3%	≥70%	73.5%
39 - As of April 2024, YTD and Monthly targets changed from 85% to 70% in line with latest operational guidance																		
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	64.3%														70.6%	≥95%	68.2%
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	22.4%														11.6%	≤5%	10.7%
37 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	86.89												90.05			≤100	77.6	≤100
		85.07												88.37					
		75																	
2	HSMR - Crude Mortality Rate	3.1%															<3%	2.0%	<3%
		2.8%												2.6%					
		2.5%																	
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15%															-	12.4%	
		11.8%												11.5%					
		10%																	
		Q2 23-24			Q3 23-24			Q4 23-24			Q1 24-25			Q2 24-25			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80															+1 Specialty per quarter		
		72			73			75			76			76					
		70																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%																	
		37			41			42			37			39					
		75			67			65			80			75					
		75%																	
		333			337			338			343			337					
		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		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	28	35	47	49	60	66	55	72	65	81	73	91	77	97	84	105	4	12	12	19	27	29	35	38	≤5	38	≤20
7	MRSA bacteraemia	0	0	0	0	0	0	1	2	1	2	0	1	1	0	0	0	0	1	0
8	Gram negative bacteraemia	19	28	16	21	15	28	20	18	22	19	16	31	25	25	29	≤18	110	≤72
9	Pressure ulcers category 2 per 1000 bed days	0.57	0.32	<0.3	0.36	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.34	0.32	<0.3	0.27	<0.3
11	Medication Errors (severe/moderate)	3	1	≤3	10	12
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2023/24**	2,587	2,760	2,761	2,576	2,736

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

Safety		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)			4												1	-	4	-
13a	Never Events															0	0	2	0
14	Patient Safety Incident Investigations (PSIIs)- Maternity															0	-	0	-
15	Number of falls investigated per 1000 bed days			0.10												0.07	-	0.08	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			95.8%												94.2%	≥90%	94%	≥90%
				871	788	806	798	772	770	894	879	956	930	949	889	968	976	883	
17	Red Flag staffing incidents			10												33	-	65	-
Maternity		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	402	418	417	400	400	467	409	428	406	401	428	411	415	379	390	-	-	-
		477	450	382	424	442	446	469	392	483	429	409	448	633	517	501			
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	1	4	6	1	3	3	1	4	4	0	6	0	3	8	8	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	53.0%	43.3%	38.6%	44.8%	43.5%	44.3%	45.2%	49.3%	47.3%	50.6%	46.7%	46.0%	46.5%	53.0%	44.8%	-	-	-
		32.6%	43.3%	43.7%	44.8%	43.0%	43.5%	43.5%	38.6%	39.2%	38.9%	40.9%	43.8%	39.0%	35.9%	44.4%			

Patient Experience		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	3% / 0%		1.1%												0.9%	≤5%	0.7%	≤5%
22	FFT Negative Score - Maternity (postnatal ward)	10% / 0%		5.5%												2.9%	≤5%	2.6%	≤5%
23	Total UHS women booked onto a continuity of carer pathway	30% / 0%		15.0%												13.3%	≥35%	13.1%	≥35%
24	Total BAME women booked onto a continuity of carer pathway	80% / 5%		28.9%												19.2%	≥51%	21.3%	≥51%
25	% Patients reporting being involved in decisions about care and treatment	100% / 80%		86.0%												89.4%	≥90%	87.9%	≥90%
26	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100% / 70%		90.0%												89.9%	≥90%	85.1%	≥90%
		300	301	287	249	214	234	336	208	272	304	268	339	322	280	258			
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 / 0		50												46	-	207	-

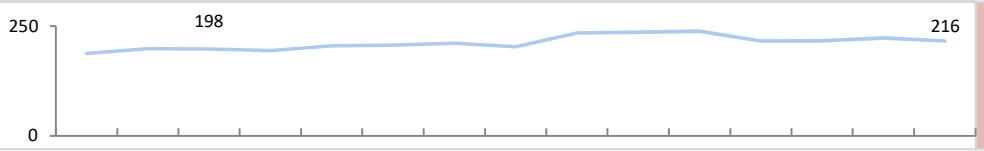
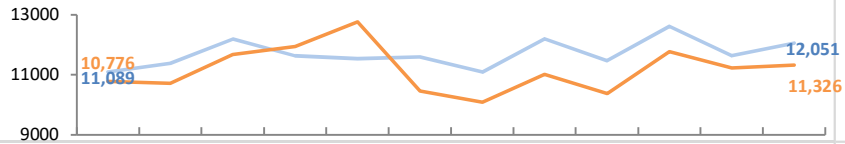
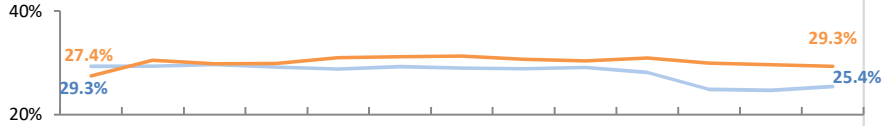
Access Standards		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	64.3%														70.6%	≥95%	68.2%	≥95%
		12	9	8	8	12	10	11	8	4	4	4	9	6	8	6			
		7	5	5	5	7	7	7	5	2	3	2	5	2	4	5			
		40%																	
29	Average (Mean) time in Dept - non-admitted patients	06:00															≤04:00	03:13	≤04:00
				03:16												03:05			
		01:00																	
30	Average (Mean) time in Dept - admitted patients	08:00															≤04:00	05:31	≤04:00
				05:29												05:02			
		01:00																	
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	75%															≥92%	63.9%	≥92%
				63.8%												64.4%			
		4	4	5	4	4	4	4	4	4	4	4	4	4	4				
		5	5	6	6	6	5	4	4	4	4	4	4	4	4				
		50%																	
32	Total number of patients on a waiting list (18 week referral to treatment pathway)	60,000															-	60,461	-
				58,898												60,461			
		40,000																	
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	8,000															≤1393	1260	≤1393
		4	4	3	3	3	2	2	2	2	3	3	4	3	2				
				1,957												1,260			
		11	9	8	8	8	8	8	9	10	9	10	10	10	9				
		0																	

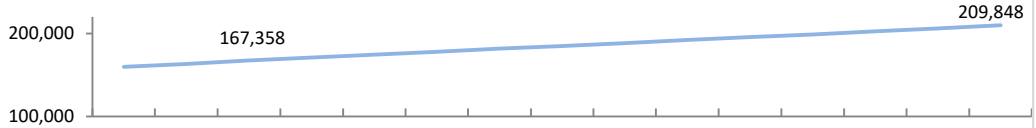
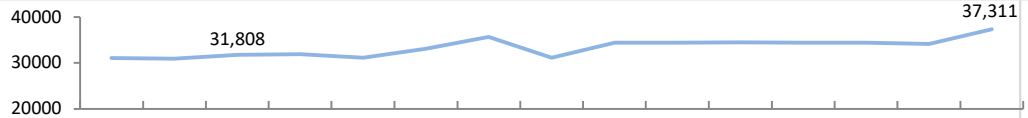
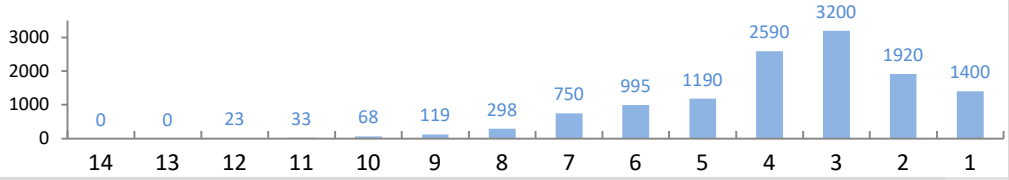
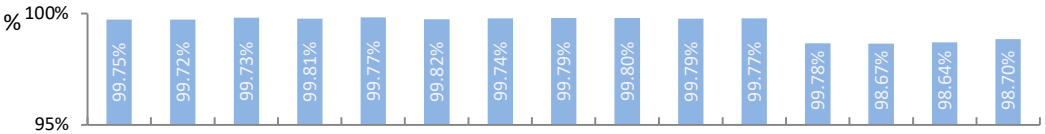
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	4	4	4	5	5	3	3	3	3	3	3	3	2	2	44	0	44	0
		11	10	9	9	9	8	8	8	6	7	8	6	5	4				
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	8	32	8	7	6	5	6	5	5	5	10	10	10	11	0	11	0
		11	12	11	10	9	9	9	9	8	8	10	10	10	11	11			
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	8	14	17	15	16	12	13	13	1	1	1	1	1	1	0	0	-	0
		13	13	17	13	14	10	11	9	1	1	1	1	1	1				
36	Patients waiting for diagnostics	9,174														9,132	-	9,132	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	11	11	20.1%	10	10	8	7	7	7	5	5	4	5	5	5	≤5%	10.7%	≤5%
		7	8	7	9	7	7	6	7	7	5	5	5	4	5	11.6%			

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

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	14	60.4% 13	10	15	6	9	7	6	4	3	7	4	9	74.3% 7		≥70%	73.5%	≥70%
		9	7	3	6	1	2	3	2	2	1	3	3	5	5				
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. As of April 2024, YTD and Monthly targets changed to 70% in line with latest operational guidance																			
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	80.2% 7	3	1	2	3	3	1	2	2	1	2	2	82.3% 2		≥77%	84.6%	≥77%
		7	5	2	1	1	1	1	1	1	1	1	1	1	5				
40 - As of April 2024, YTD and monthly targets changed from 75% to 77% in line with latest operational guidance																			
41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	17	87.0% 15	13	13	11	15	13	14	11	11	10	15	11	88.0% 14		≥96%	89.2%	≥96%
		14	11	5	9	6	14	9	8	8	10	6	7	13	13				
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		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	17	19	19	21	17	17	16	15	15	15	15	9	7	6	9	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	6	12	14	15	12	11	12	9	11	11	11	6	8	9	10	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection	47%	59%	64%	46%	60%	67%	46%	88%	55%	50%	64%	50%	55%	47%	100%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	65.2%	84.7%	104.1% 26.0%	45.8%		133.3%	133.3%	84.7%	65.2%	157.6%	75.0%	26.8%	119.5%	70.7%	51.2% 12.8%	≥5%	-	-

Local Integration		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	218	-
48	Emergency Department activity - type 1 This year vs. last year																-	#N/A	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	25.8%	≥25%

Digital		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)																-	209,848	-
51	My Medical Record - UHS patient logins (number of logins made within each month)																-	35,040	-
51 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
52	Average age of IT estate Distribution of computers per age in years																-	-	-
53	CHARTS system average load times - % of pages loaded under 3s																		
53 -Data only available from April 2023 onwards. From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2024-25 Month 4**			
Agenda item:	**5.7**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**10 September 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:	The Trust reported the M4 financial position to the Finance and Investment Committee on 19 August 2024. **Headlines** The Committee noted the position of: • M4 financial position of £3.9m deficit (£1.7m adverse to plan). • YTD £16.9m deficit (£5.5m adverse to plan). • The financial run-rate is improving on a month-by-month basis. **Overall Narrative** The Trust is continuing to substantively deliver on financial improvements where outcomes are within its direct control. For example: • The Trust has delivered LOS improvements for P0 patients of 5%, supporting surge capacity to remain closed. • The Trust has implemented new workforce controls embedded within Divisions, which have been widely supported. We are significantly below our pay expenditure plan. • UHS is performing well on ERF activity through transformation programmes and other initiatives, with YTD performance at 126% of baselines (although marginally below our planned target). • UHS has delivered £19.5m CIP in M4 which is above the trajectory from 23/24. However, a number of issues have presented in year: • It is estimated that industrial action has cost the Trust £1.5m from additional cost and lost income opportunity. • The tariff uplift for the consultant pay award announced in May is expected to leave an unplanned shortfall of £2m (£0.7m YTD). • The ERF target for specialised commissioning has been unexpectedly increased by £1.2m (£0.4m YTD). • Collective system transformation initiatives have not yet delivered the improvements required to deliver the plan – particularly the level of nCTR and Mental Health patients within the Trust remains higher than anticipated. • UHS had high levels of unidentified CIP built into the final plan submission. Significant progress has been made, but this remains a gap to plan delivery. A			

	detailed paper on CIP identification and delivery was presented to the Committee. • UHS have YTD performed circa £10m of activity above block contract levels, which is unfunded. The Committee took assurance from the report, in particular the progress on UHS transformation programmes such as improving flow. However, the Committee also noted the actions will not alleviate the full risk without substantial further improvement, including operational metrics across the healthcare system. **Capital** Capital expenditure of £10.5m YTD is consistent with plan but leaves over £50m to be spent across the remainder of 24/25. Changes to the Building Safety Act have created delays in several key projects notably the Neonatal expansion. Discussions are currently going on with key programme and project leads to inform accurate forecasts and consider potential slippage and overspend risks together with mitigation opportunities. This will be discussed at the Trust Investment Group in September with a view to sharing with Trust Board on the conclusion of this. There remains a high degree of confidence that the capital programme can be delivered. HIOW ICS has also launched the process for strategic capital planning for 25/26 noting that the highest priority programmes for UHS included the Western Ward development, Surgical Robot and Maternity Induction of Labour suite. Further to this a radiological bi-plane suite is also under consideration as it supports the continued expansion of the mechanical thrombectomy service. **Pay Awards 2024/25** Agenda for Change pay awards and junior doctor pay awards have now been proposed for 2024/25. It is expected these will be ratified and proposed for payment in October. The Trust has yet to receive any official guidance on the funding envelope being made available for these and how this will be distributed to providers. **Next Steps** • We are continuing to prioritise focus on delivery of transformation programmes, with significant energy going in across the Trust. • We are maintaining our performance on workforce through robust controls and governance. • We are engaged and supporting Tim Briggs review within HIOW, focussing on a number of specialties. • We have requested and received support from the RSP programme to bring in additional resource to support GIRFT reviews. • The Trust Savings Group process continues to provide governance and direction to a number of improvement programmes across the Trust. • We are currently scoping whether additional support could be requested from the Recovery Support Programme that can help provide additional focused resource and deliver improvements at pace. This is likely to be focussed on opportunities within non-pay expenditure and contracts.
Implications:	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties. • Trust remains within the NHSE Recovery Support Programme, until the system collectively achieves a run-rate break-even position.

Risks: (Top 3) of carrying out the change / or not:	• Financial risk relating to the underlying run rate and projected potential deficit if the run rate continues. • Cash risk linked to volatility above. • Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2024/25.
Summary: Conclusion / recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People Report 2024-25 Month 4**			
Agenda item:	**5.9**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Workforce Team**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance** X	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The UHS People Strategy (World Class People) sets out our goals to support the delivery of the Trust's Corporate Strategy. The 5-year Strategy, based on the insights from our UHS people, was approved by the Trust Board in March 2022. Its key areas of THRIVE, EXCEL, and BELONG shape the work of people focus across UHS. The strategy reflects the priorities of the NHS national People Promise. 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 July (M4).			
Response to the issue:	**Key items to note for Month 4 (July 2024) of the People Report** • The Trust remains **under its overall workforce plan by 288 WTE** at the end of July. Substantive workforce continues to remain below plan by 200 WTE. • During the month **temporary workforce** usage increased in both bank and agency, however both still remain below plan. Bank increases have been driven by the holiday season. This trend continues during August with higher levels of staff unavailability during the school holiday period. • Our substantive workforce is forecast to increase over the autumn as newly qualified staff join. The Trust is predicting over 100 Newly qualified nurses to join in September and October, followed by 33 newly qualified midwives in November. • **Our workforce plan** (a reduction overall of 333 WTE) is predicated on the delivery of **external system programmes** to reduce NCTR and mental health presentation. These system programmes so far have shown little change in patient numbers, and therefore the reductions in staffing linked to this are not predicted to be transacted as planned. This is predicted to leave us over our NHSE workforce plan from October.			

	• Divisions and THQ departments are now working within their **affordable workforce limits** (AWLs), and monthly detailed finance and workforce review meetings are now in place to monitor delivery. • There has been a **small uptick in sickness** during July driven by COVID. Sickness remains below target at 3.9%. • **The Q2 pulse survey** results have been published for UHS which the 3,037 participants reported a small increase from Q1 in both engagement and a recommendation as place to work. Recommendation as a place to work is 64.1% and engagement is 6.84. National results from Q1 show a deterioration across the NHS with staff engagement scores dropping from 6.57 to 6.47 in our benchmark group. Q2 national results are yet to be published. • The Government has supported the recommendation from the pay review body for **a 5.5% increase to the agenda for change pay**. This will be backdated to 1 April 2024 and paid to our staff in October. **Doctors are set to receive a 6% uplift** following government acceptance of review body recommendations. • The trust put in place support to our staff during the **civil unrest** in early August. A range of practical measures were put in place to support the safety and well-being of internationally educated staff, in addition to those from a non-white background. This support was well received but further demonstrates a local and national need to do more on **violence and aggression** across the NHS. This issue still remains a challenge for UHS, and a multi stakeholder workshop is being held on 2 October to further discuss actions that can be taken.
Implications: (Clinical, Organisational, Governance, Legal?)	Implications are for good governance, meeting legal requirements, and providing safe clinical and organisational delivery.
Risks: (Top 3) of carrying out the change / or not:	Our strategic risks are set out in the UHS business assurance framework (BAF) Specifically for world class people: 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.

Summary: Conclusion and/or recommendation	Trust Board is required to: • Note the feedback from the Chief People Officer and the People Report

UHS People Report

WORLD CLASS PEOPLE

July 2024

THRIVE EXCEL BELONG

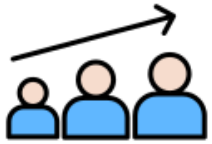
Summary

PEOPLE REPORT OVERVIEW: 2024/25 M4 (JUL-24)

In-month sickness (3.9%) on target

Reduced appraisal completion rates (75%)

R12m turnover rate (11.2%) below target



Substantive workforce currently under NHSE 24/25 workforce plan but forecasted to exceed plan post September

Three consecutive months of increase in bank but under plan

6 WTE (7%) uptick in agency but staffing remains under plan

Increase of staffing safety incidents from 75 to 82 in July

Pulse Survey for Q2 shows a stable engagement score

Executive Summary

The Trust remains below its overall NHSE workforce plan by 288 WTE at the end of July. Substantive workforce has seen six consecutive months of net reductions and is now below plan by 200 WTE. However, it is anticipated that the substantive workforce will increase over summer and into autumn as over 100 newly qualified staff join the trust. Our NHSE workforce plans are predicated on the delivery of system-wide programmes to reduce nCTR and mental health presentation. Significant workforce reductions are associated with system schemes and at present do not show material signs of delivery. As a result, after September, we are forecasting we will be above our NHSE workforce plan. These forecasts assume a stable level of bank and agency. Divisions are currently operating within their agreed AWL limits.

Q2 Pulse survey scores have been released and the heat map has been updated to include this information. There was a small increase (1%) in recommendations for a place to work; however, overall results still show the challenges within the workforce. The portering department have formally raised concerns about a range of working practices via UNITE and have undertaken a consultative ballot with a view to taking industrial action. The CPO, Deputy CPO, and COO have been meeting with UNITE in regard to this. We have also received a collective grievance from UNISON in relation to the national Band 2 / Band 3 pay campaign. The People team, working with nursing and finance, have undertaken an analysis of other Trust's responses to this issue and prepared a plan of management. The dispute focuses on regrading of Band 2 HCAs staff to Band 3 and a claim for back pay.

Planning is underway for We are UHS week in October, including our We Are UHS Champions Awards. Over 600 nominations have been received. The Trust also issued its 4000th 'High Five' in July.

Overall Position

WTE Movement (M3 to M4)

Total Workforce ↑

The total workforce **increased by 8** WTE to 13,343 WTE from M3 to M4.

During this period, the substantive workforce decreased by **43 WTE**, while the overall temporary staffing increased by **51 WTE.**

As of M4, we remain **under the total plan** (by 288 WTE).

Substantive WTE ↓

Substantive WTE **reduced by 43 WTE** from M3 to M4

The largest reductions occurred in **Additional Clinical Services (-13 WTE)** and **Allied Health Professionals (-11 WTE)**. All other staff groups saw marginal reductions ranging from 1 to 5 WTE. **Division C** had the most significant reduction at **-20 WTE**.

Additionally, there were fewer **leavers** in July (94 WTE) compared to June (107 WTE)

Bank & Agency WTE ↑

Bank usage **increased** from June to July by 6% (689 to 733 WTE).

Increased demand in July has resulted in higher bank usage, particularly for Additional Clinical Services.

Agency usage **increased** in June by 7% compared to June 2024 (79 to 85 WTE).

Category	WTE	Comments
Additional Clinical Services	(13)	In July 2024, there were 38 WTE ACS leavers, yielding a net reduction of 13 WTE
Allied Health Professionals	(11)	There were 11 WTE leavers for the AHP staff group, and a net reduction of 11 WTE in July 2024, mostly physios (-5 WTE) and radiographers (-3 WTE)
Admin and Clerical	(8)	In July 2024, there were 14 WTE leavers from the A&C staff group, yielding a net reduction of 8 WTE
Other staffing groups	(12)	Medical and Dental, and Nursing and Midwifery staffing groups saw net reductions of 7 WTE and 5 WTE respectively
Increase in bank usage	44	Increase in bank usage for July 2024 compared with June 2024, particularly for HCAs
Increase in agency usage	6	Slight increase in agency usage for July 2024 compared with June 2024 owing to increased mental health need

WTE Delivery against 2024/25 Plan

As of July 2024 (2024/25 M4), our total workforce is 288 WTE below planned levels. This is largely attributed to the ongoing impact of substantive recruitment controls. The Admin and Clerical staff group is particularly affected, reaching its lowest point since April 2023, and seeing accumulative net reductions since December 2023. There has also been steady progress in reducing bank and agency staff since 2023/24 with the latter seeing concerted and sustained reductions. Bank WTE has shown more volatility; however, the last three months have seen a consecutive increase in WTE usage.

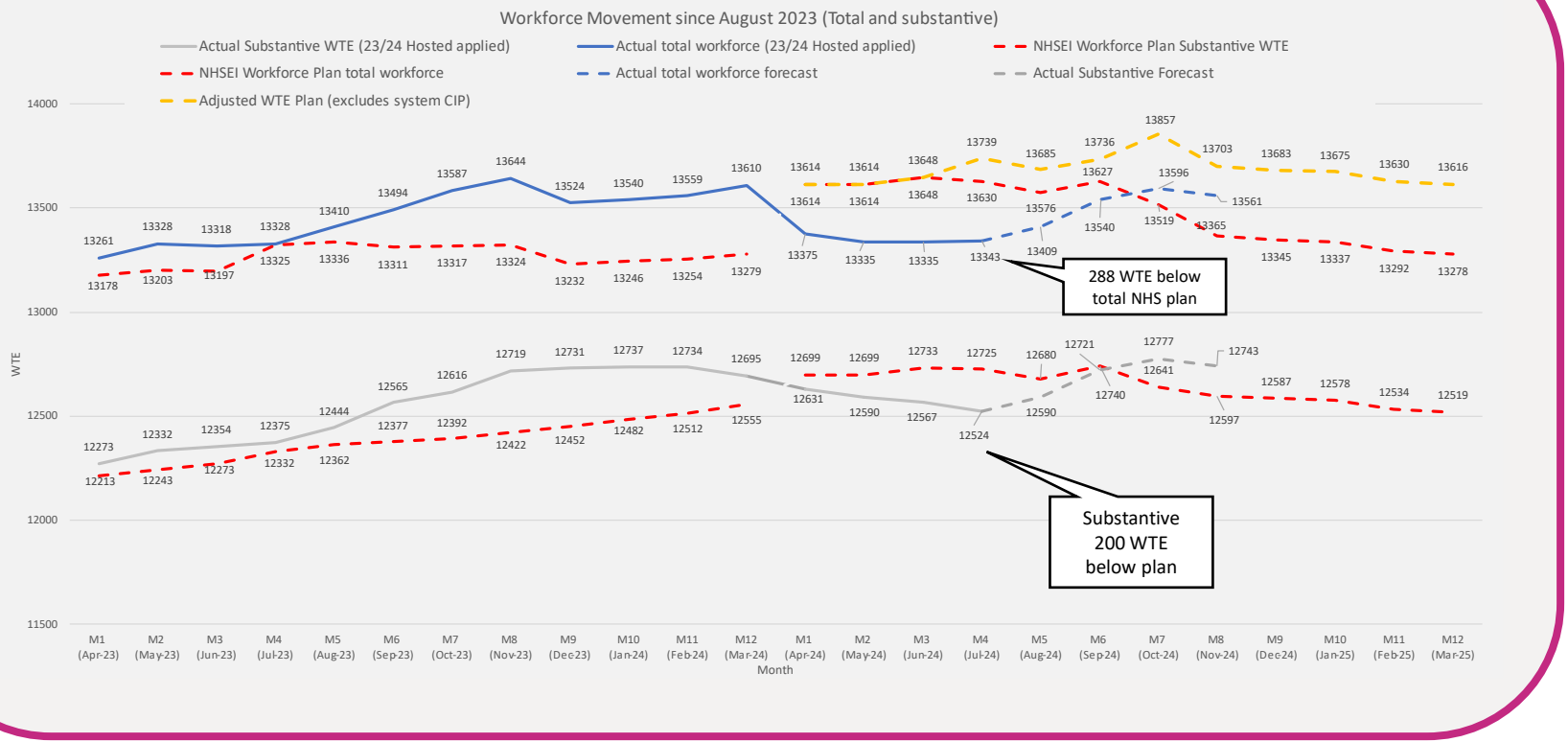
The variance includes the following:

- Substantive WTE is **200 WTE** below plan, primarily due to fewer starters in July compared to June. We anticipate 100 NQNs starting in September and October, with annual plans estimating demand at this level. There is ongoing work with divisions to assess the impact of future and planned WTE given the new affordable workforce limits (AWL).

- Bank WTE is **47 WTE** below plan. There was a slight increase in Additional Clinical Services bank staff usage from June to July due to higher demand in July.

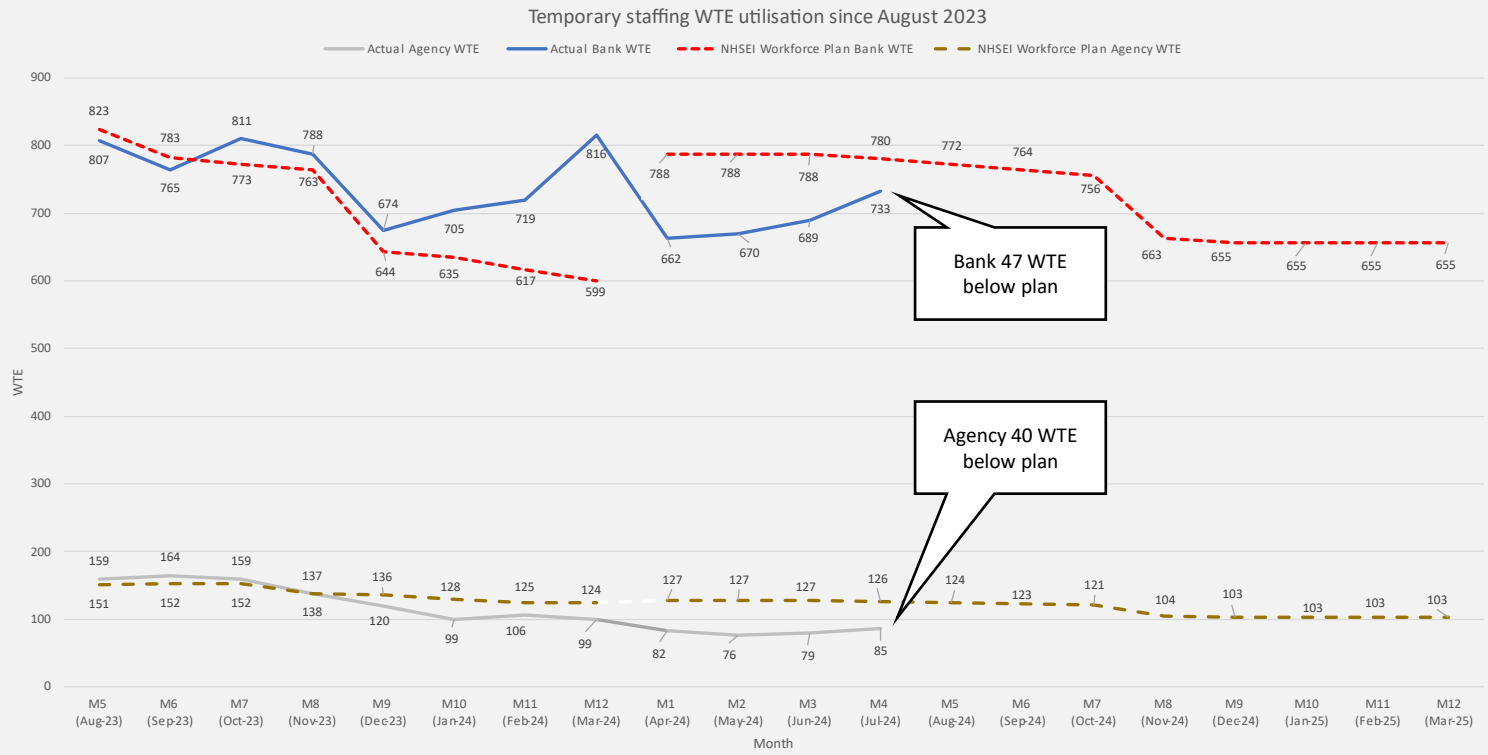
- Agency WTE is **40 WTE** below plan; from June to July, RN agency staff increased slightly from 36 to 41 WTE, while HCA agency staff decreased from 25 to 23 WTE.

Workforce Trends: Total & Substantive



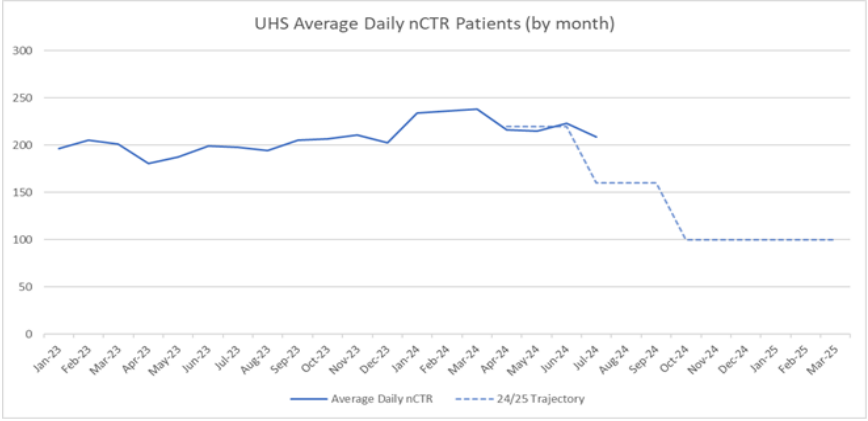
Source: ESR as of July 2024. Please note that the total workforce forecast is based on expected substantive starters and July's Bank and agency actuals. It assumes bank and agency stays the same going forward..
NB: Please note that the hosted service criteria in 2024/25 is the same as in 2023/24

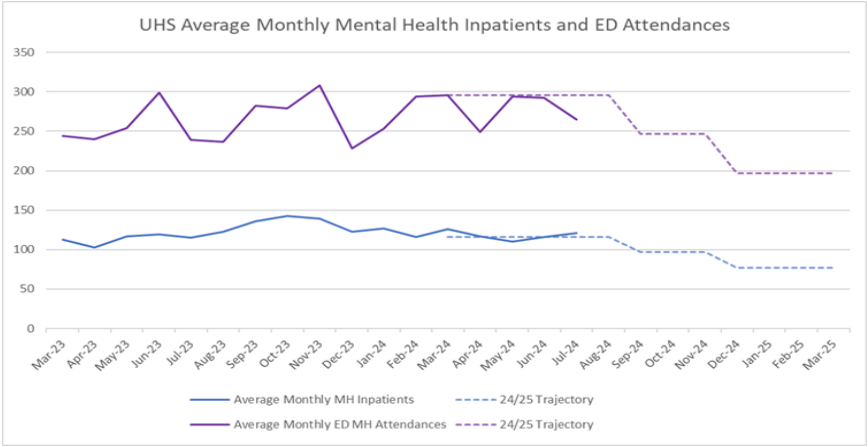
Workforce Trends: Bank & Agency



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

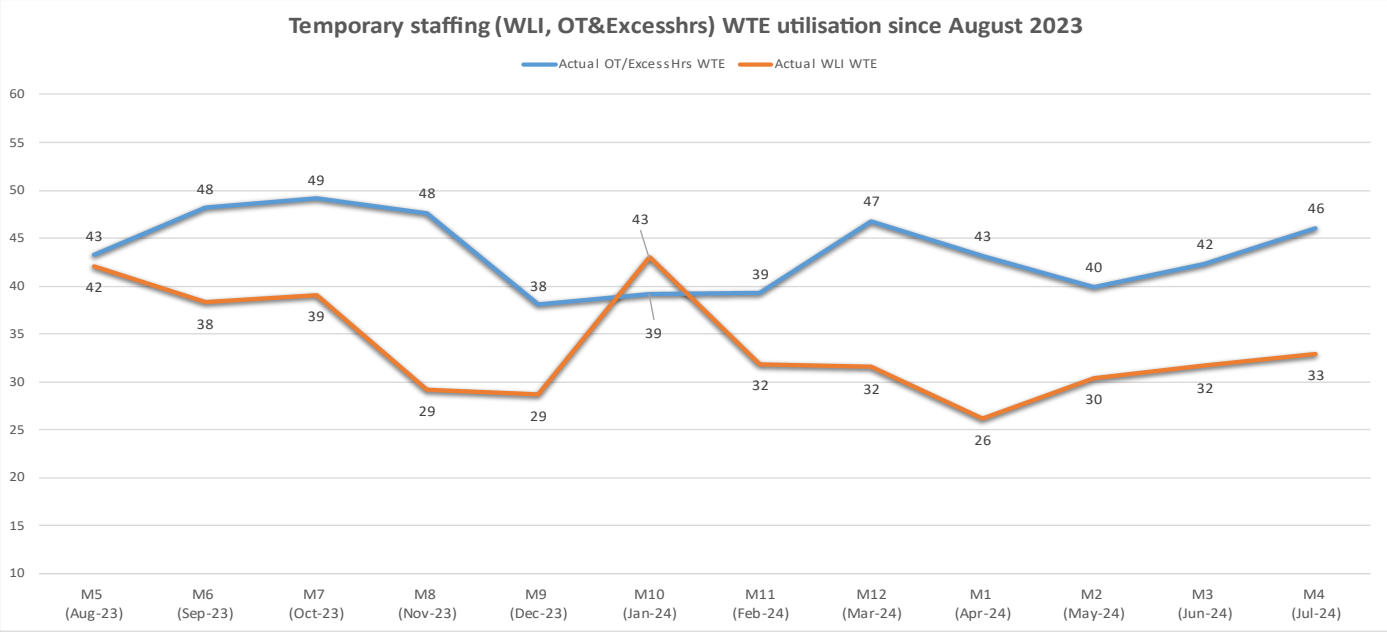
Delivery against Schemes (nCTR & MH)





Workforce Trends: WLI and Overtime

WLI Movement	M4 – M5	M5 – M6	M6 – M7	M7 – M8	M8 – M9	M9 – M10	M10 – M11	M11 – M12	M12 – M1	M1 – M2	M2 - M3	M3 - M4	M12 - M4
	-4	-4	1	-10	-1	14	-11	0	-5	4	3	0	**2**



Source: Healthroster as of July 2024; retrospective WLI figures have been updated from August 2023

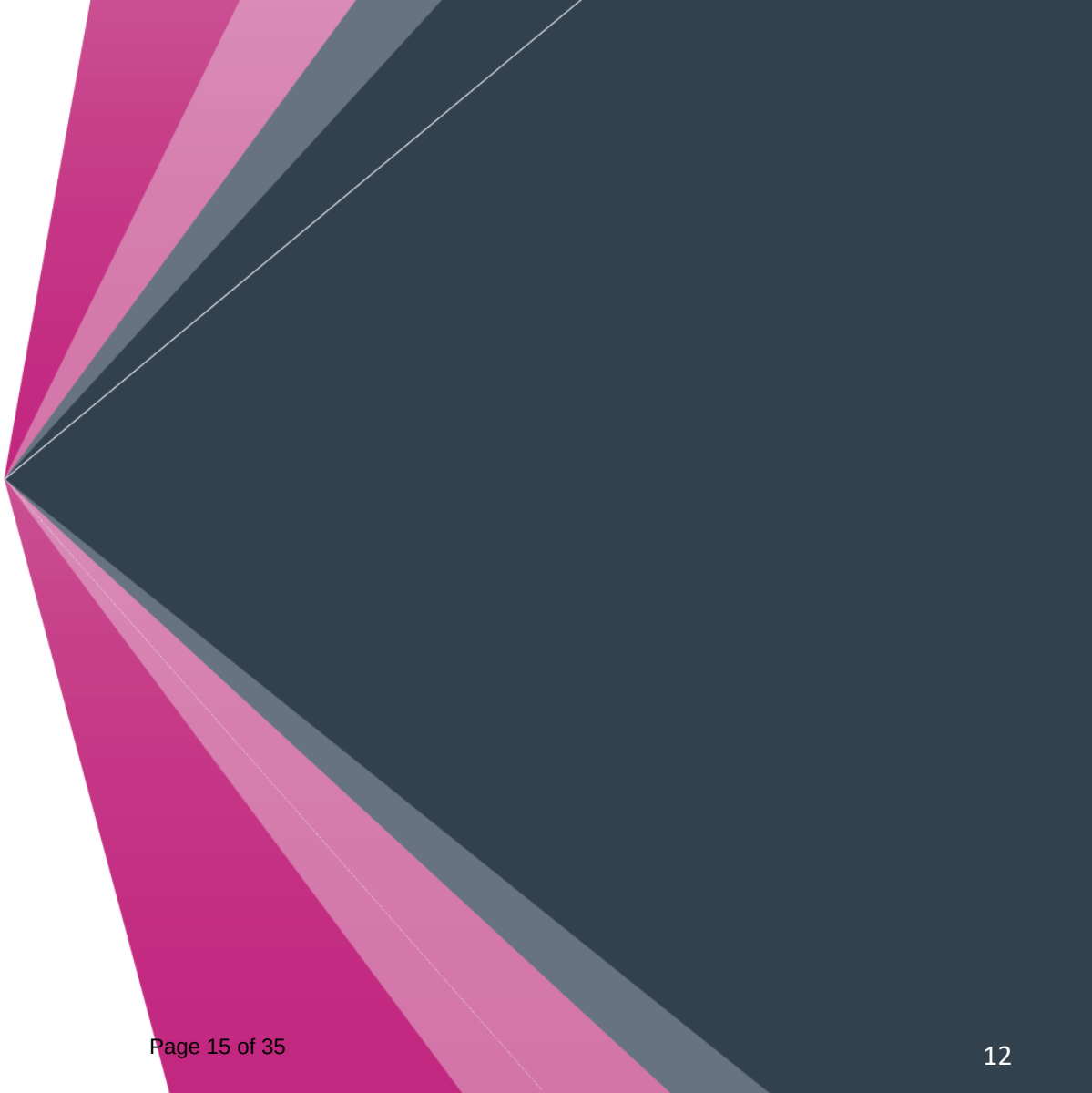
Quarterly People Heatmap – 2024/25 Q1 (NOTE: Pulse Survey outcomes updated to July 2024)

		THRIVE			EXCEL			BELONG				
	AWL as of M4	% Turnover	Vacancies (AWL - WTE Worked)	Apprentice numbers	Appraisals completed	Sickness absence	% Flexible working requests approved	Pulse Survey * - Recommendation as a place to work	Pulse Survey - Staff Engagement	Pulse survey - sense of belonging	% of staff at Band 7 and above (BAME)	% of staff band 7 and above LID
UHS Overall	**13107**	**11.22%**	701	**429**	**74.70%**	**3.60%**	93.20%	64.1%	6.84	65.2%	11.3%	12.2%
Division A Overall	2499	9.5%	105	51	69.1%	3.5%	100.0%	57.3%	6.56	61.8%	14.2%	13.8%
Critical Care	660	10.1%	26	17	69.5%	3.1%	100.0%	72.6%	6.75	65.9%	8.0%	10.7%
Ophthalmology	325	10.2%	13	10	52.4%	4.3%	100.0%	54.8%	6.72	67.1%	13.3%	6.7%
Surgery	582	13.3%	16	21	57.7%	2.8%	100.0%	51.6%	6.34	56.4%	7.7%	13.8%
Theatres & Anaesthetics	913	6.5%	48	38	81.7%	4.0%	100.0%	53.2%	6.51	58.8%	33.3%	22.2%
Division B - Overall	3534	10.9%	255	110	72.1%	3.8%	87.1%	61.9%	6.73	60.9%	12.7%	14.5%
Cancer Care	741	9.8%	41	16	63.3%	3.8%	95.2%	53.2%	6.31	51.6%	17.8%	17.1%
Emergency Care	712	12.1%	106	20	75.1%	3.8%	72.4%	57.9%	6.30	56.4%	8.8%	23.5%
Medicine	783	9.3%	49	41	88.3%	3.6%	100.0%	73.6%	7.22	71.9%	22.7%	9.1%
H&IOWAA	0	11.0%	-29	0	90.3%	0.0%	-	-	-	-	0.0%	10.7%
Pathology	611	13.0%	52	25	61.1%	3.7%	88.2%	60.2%	6.71	61.0%	11.5%	9.9%
Specialist Medicine	614	10.1%	9	8	69.2%	4.0%	86.7%	64.1%	7.03	64.7%	10.0%	14.3%
Division C - Overall	2814	11.6%	120	90	73.0%	3.3%	97.9%	63.6%	6.79	63.5%	9.9%	12.3%
Child Health	900	8.8%	57	32	69.1%	3.9%	100.0%	60.4%	6.72	61.7%	3.7%	13.6%
Clinical Support	882	13.4%	7	44	76.7%	1.9%	95.2%	68.6%	6.86	65.3%	13.2%	10.4%
Women & Newborn	860	10.7%	53	14	74.0%	4.3%	100.0%	60.2%	6.75	63.0%	6.5%	17.1%
Division D - Overall	2511	11.0%	157	102	82.7%	3.8%	100.0%	66.6%	6.90	70.1%	16.0%	14.2%
CV&T	945	11.0%	66	45	78.2%	3.8%	100.0%	73.6%	7.12	72.0%	18.9%	16.8%
Neuro	480	11.7%	21	25	88.2%	4.7%	100.0%	57.6%	6.69	65.2%	19.7%	12.7%
Radiology	518	9.9%	14	13	88.6%	3.8%	100.0%	68.6%	6.84	75.4%	9.0%	11.5%
T&O	470	10.7%	46	19	82.9%	3.4%	100.0%	64.4%	6.89	67.0%	19.4%	9.7%
THQ - Overall	1749	13.3%	64	86	78.9%	3.6%	95.5%	67.3%	7.07	69.2%	10.1%	12.4%
Chief Finance Officer	119	7.7%	-11	10	73.9%	2.6%	-	64.3%	7.17	73.3%	9.1%	12.1%
Chief Operating Officer	87	9.7%	-1	1	59.6%	5.0%	-	66.7%	7.02	66.7%	10.3%	10.3%
Clinical Development	81	18.7%	-3	0	76.5%	0.9%	100.0%	66.7%	7.15	71.1%	8.9%	26.7%
Estates	376	14.5%	42	21	73.0%	5.9%	100.0%	56.6%	6.63	61.0%	4.3%	8.5%
Informatics / Digital	270	7.2%	-15	12	78.0%	1.7%	100.0%	66.2%	6.99	68.5%	16.0%	6.2%
People / HR	172	18.7%	9	15	81.1%	3.4%	100.0%	74.3%	7.31	71.1%	2.6%	18.4%
R&D	400	16.9%	17	13	90.6%	3.6%	100.0%	75.3%	7.21	72.7%	14.8%	9.9%
Training & Education	228	11.8%	18	14	96.1%	2.7%	100.0%	79.4%	7.61	70.6%	11.1%	11.1%

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

* Pulse Survey participation rate was 21% (3,037 of 14,401 eligible staff headcount)

THRIVE

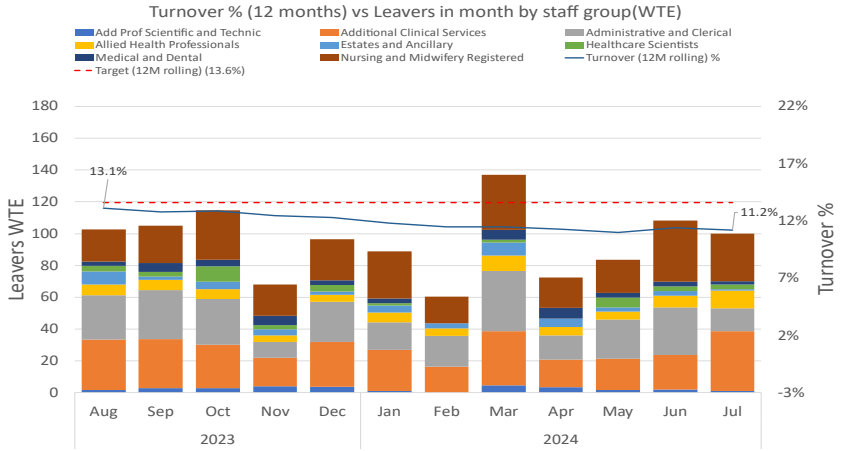


Substantive SIP by Staffing Group

Substantive Monthly Staff in Post (WTE) for last 12 months													
	2023/24 M5 (Aug)	2023/24 M6 (Sep)	2023/24 M7 (Oct)	2023/24 M8 (Nov)	2023/24 M9 (Dec)	2023/24 M10 (Jan)	2023/24 M11 (Feb)	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	M3 to M4 movement
Add Prof Scientific and Technic	386	393	402	404	403	402	401	402	397	400	396	396	↓ -1
Additional Clinical Services	2124	2153	2143	2143	2146	2158	2152	2136	2135	2134	2130	2117	↓ -13
Administrative and Clerical	2282	2295	2298	2321	2328	2317	2304	2288	2248	2230	2223	2214	↓ -8
Allied Health Professionals	691	699	703	702	698	698	700	696	703	700	699	688	↓ -11
Estates and Ancillary	380	380	382	382	385	382	380	380	374	372	373	376	↑ 3
Healthcare Scientists	494	493	490	496	493	497	497	498	499	495	498	496	↓ -2
Medical and Dental	2109	2120	2134	2145	2137	2161	2183	2184	2165	2163	2161	2155	↓ -7
Nursing and Midwifery Registered	3935	3987	4009	4072	4086	4069	4060	4053	4052	4039	4030	4025	↓ -5
Students	43	43	54	53	53	53	58	58	58	58	58	58	→ 0
Grand Total	**12444**	**12565**	**12616**	**12719**	**12731**	**12737**	**12734**	**12695**	**12631**	**12590**	**12567**	**12524**	↓ -43

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

Turnover



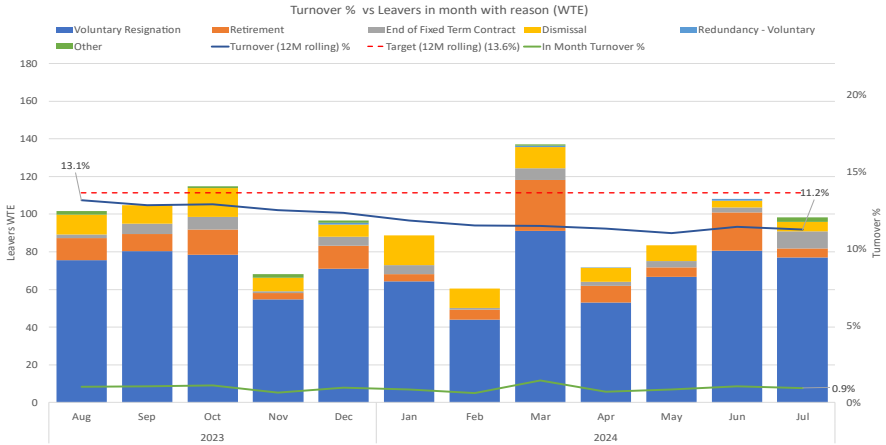
In July 2024, UHS had a total of 100 WTE leavers. The highest number of leavers was in Division C, with 32.4 WTE leavers. Within Division C, the Additional Clinical Services staff group had the highest number of leavers (13.3 WTE)
Our local turnover target for 2024/25 is <13.6%

Division B and D had the second highest number of leavers (19.8 and 19.9 WTE respectively); with the largest numbers being Additional Clinical Services staff group in both Divisions (6.8 WTE leavers in Div B and 10 WTE leavers in Div D).

Total leavers by division is as follows:

- **Division A: 14.0 leavers**
- **Division B: 19.8 leavers**
- **Division C: 32.4 leavers**
- **Division D: 19.9 leavers**

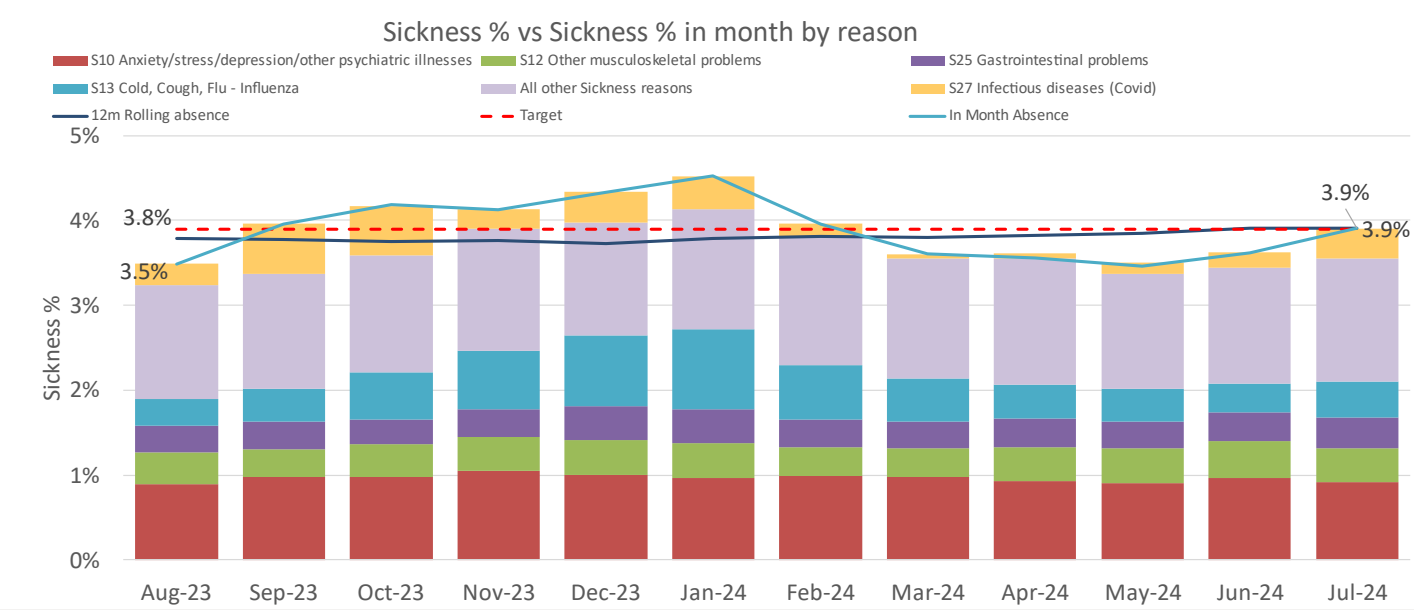
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.0	0.3%	7.3%
Additional Clinical Services	37.8	1.8%	16.9%
Administrative and Clerical	14.2	0.7%	12.4%
Allied Health Professionals	11.1	1.7%	11.1%
Estates and Ancillary	1.0	1.0%	13.4%
Healthcare Scientists	3.0	0.6%	9.5%
Medical and Dental	2.0	0.2%	5.2%
Nursing and Midwifery Registered	29.9	0.7%	9.0%
UHS total	**100.0**	**0.9%**	**11.1%**



Source: ESR – Leavers Turnover WTE, ESR Staff Movement July 2024 (excludes junior doctors & hosted services)

Sickness

Current in-month sickness: 3.9% | rolling 12-month sickness: 3.9%



Source: ESR – July 2024

Temporary Staffing

TEMPORARY RESOURCING

Qualified nursing demand/fill (WTE) status:

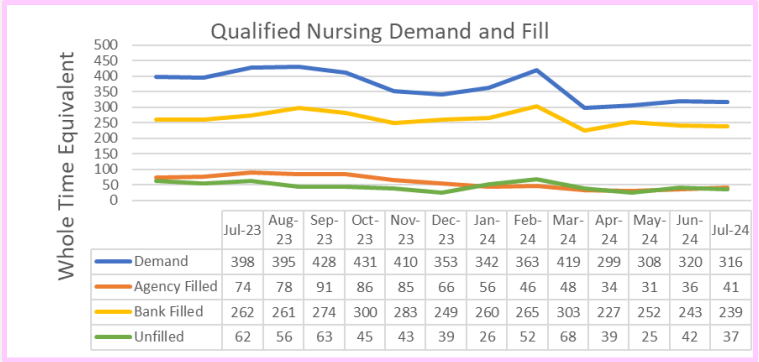
- Demand decreased from 320 in June to 316 in July, of which bank filled 239 (down 4 on last month). Agency filled 41 (up 5 on prior month), and 37 remained unfilled (down 5 on prior month).
- Bank fill for qualified nursing decreased from 75.7% in June to 75.5% in July.
- Demand for Registered Nurses in July 2024 is 82 WTE lower than July 2023.

HCA demand/fill (WTE):

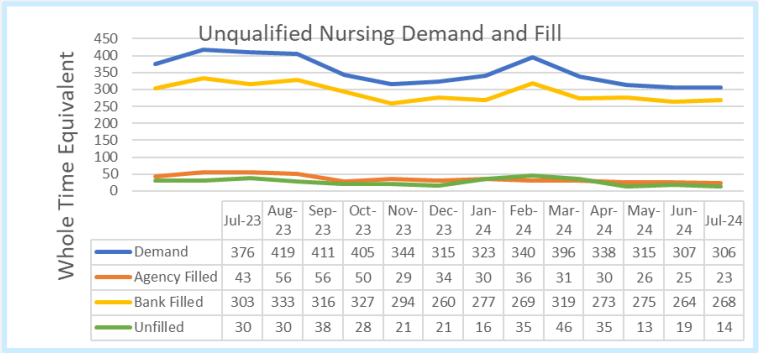
- Demand decreased from 307 in June to 306 in July, of which bank filled 268, while agency filled 23 WTE (all MH HCAs) and 14 remained unfilled.
- Bank fill for HCA decreased from 85.9% in June to 87.8% in July.
- Demand for HCA's is 70 WTE lower than in July 2023.

Actions:

- Agency rate reduction plan – NHSI cap compliance for majority of shifts.
- All nursing shifts are within the SE collaborative rate ceiling.
- Off Framework agency (TNS) removed from the cascade 1st July.
- Migration of Mental health agency workers to NHSP on going.
- Plan to remove agency from cascade for mental health care support workers on 1st September 2024.



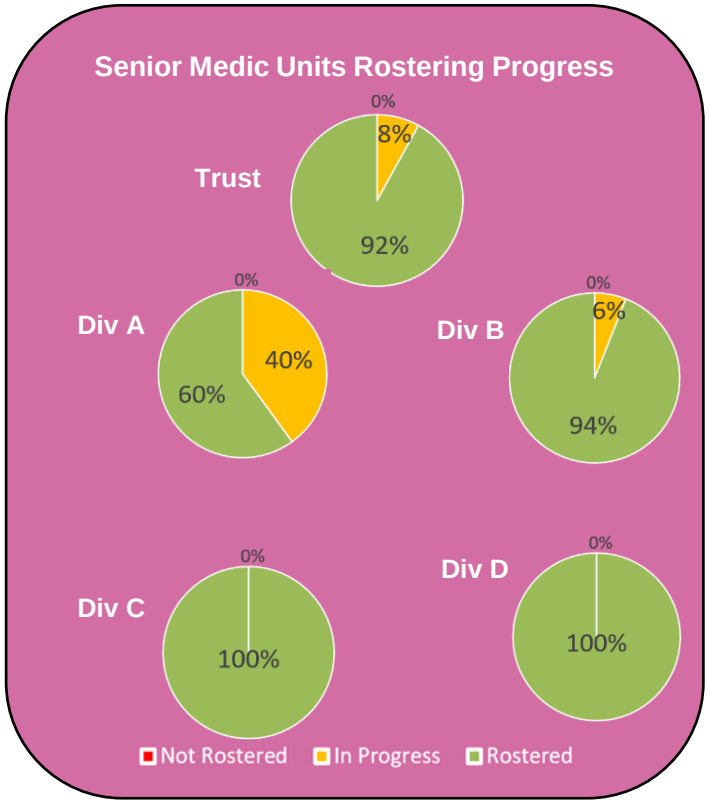
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Demand	398	395	428	431	410	353	342	363	419	299	308	320	316
Agency Filled	74	78	91	86	85	66	56	46	48	34	31	36	41
Bank Filled	262	261	274	300	283	249	260	265	303	227	252	243	239
Unfilled	62	56	63	45	43	39	26	52	68	39	25	42	37

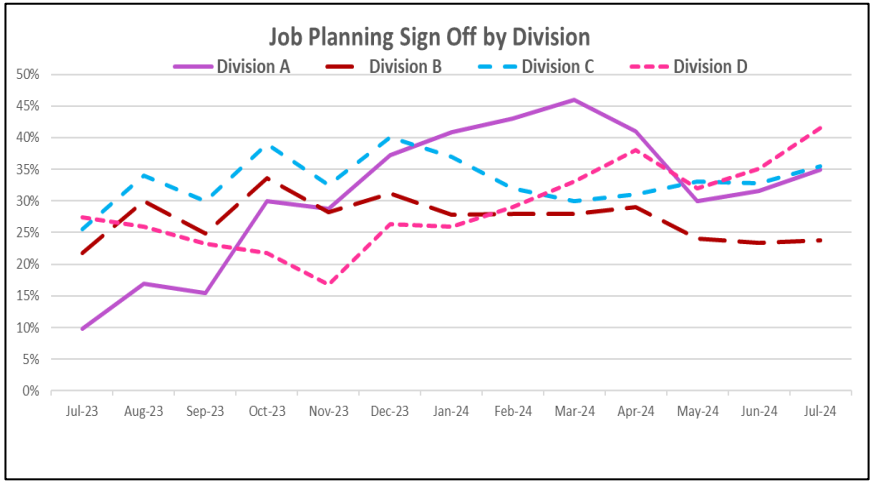


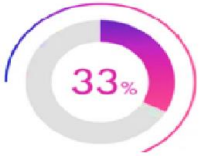
	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Demand	376	419	411	405	344	315	323	340	396	338	315	307	306
Agency Filled	43	56	56	50	29	34	30	36	31	30	26	25	23
Bank Filled	303	333	316	327	294	260	277	269	319	273	275	264	268
Unfilled	30	30	38	28	21	21	16	35	46	35	13	19	14

Source: NHSP July 2024

Workforce Deployment and Medic Online Utilisation





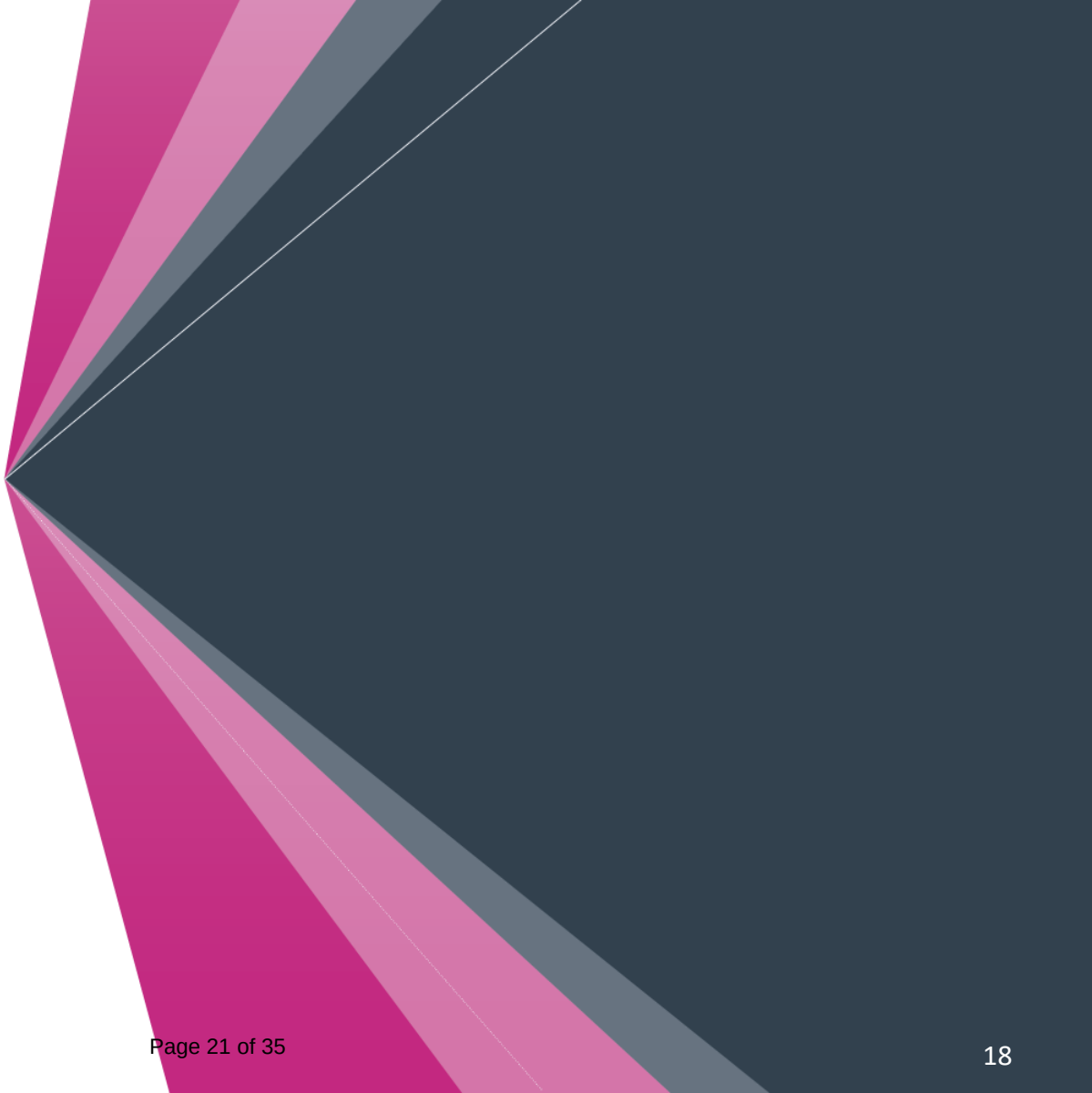


Signed off Job Plans

Active Job Plans

- Job planning sign off levels remain at 33%
- Active Job Plans down 1% to 87%
- High numbers awaiting Manager Sign off (21%)
- New Job Planning Cycle and option to Extend Job Plans in effect
- Revised Job Planning Policy Published at the end of July
- Consistency Report for Div B and Quality Committee Report published.

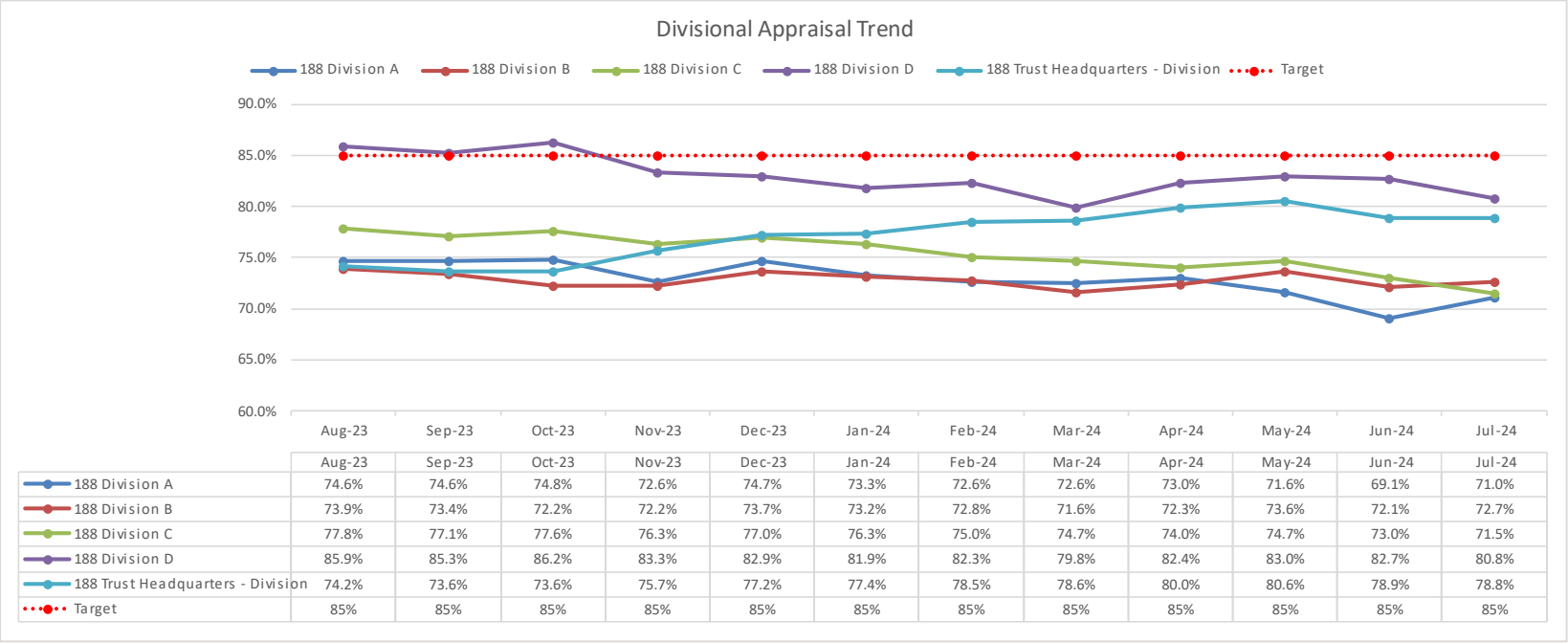
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 75% (647 appraisals completed) as of July 2024 (previously 75% in May 2024).

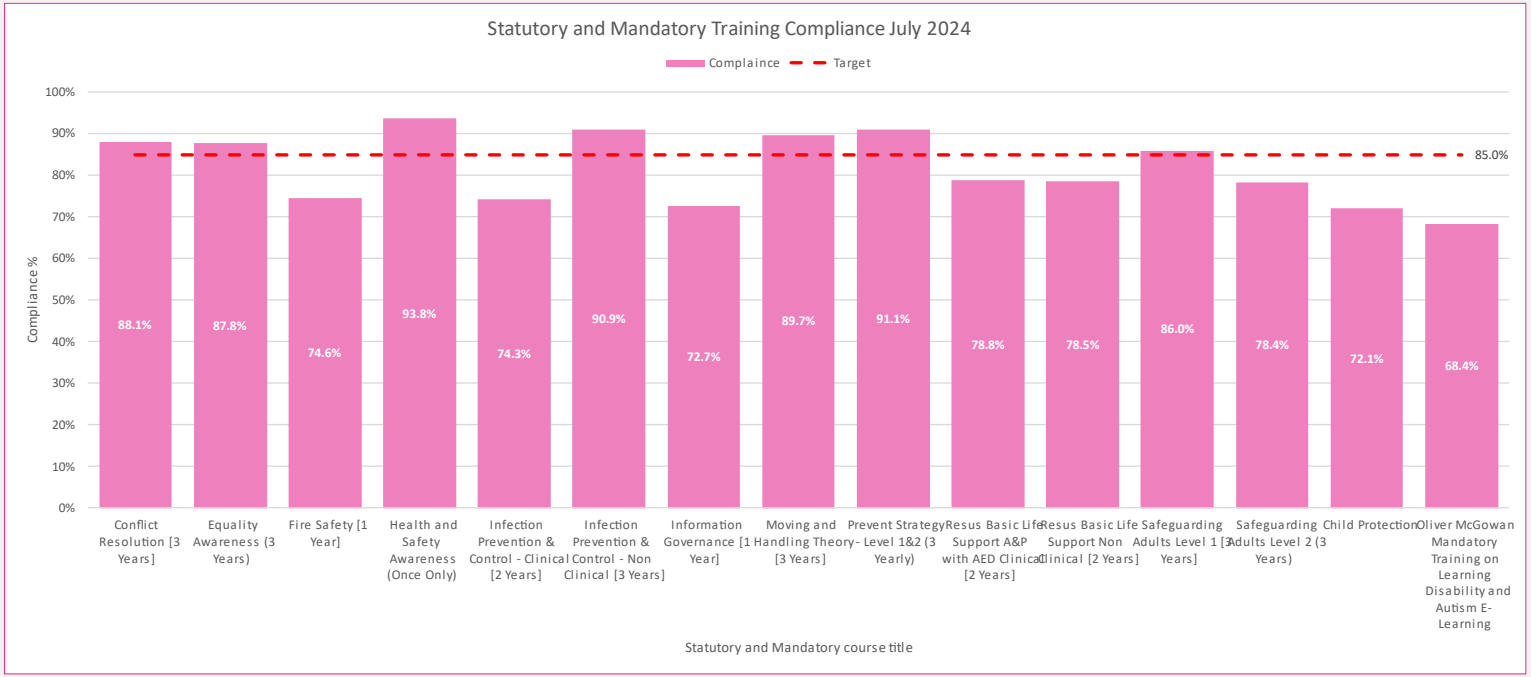


	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
188 Division A	74.6%	74.6%	74.8%	72.6%	74.7%	73.3%	72.6%	72.6%	73.0%	71.6%	69.1%	71.0%
188 Division B	73.9%	73.4%	72.2%	72.2%	73.7%	73.2%	72.8%	71.6%	72.3%	73.6%	72.1%	72.7%
188 Division C	77.8%	77.1%	77.6%	76.3%	77.0%	76.3%	75.0%	74.7%	74.0%	74.7%	73.0%	71.5%
188 Division D	85.9%	85.3%	86.2%	83.3%	82.9%	81.9%	82.3%	79.8%	82.4%	83.0%	82.7%	80.8%
188 Trust Headquarters - Division	74.2%	73.6%	73.6%	75.7%	77.2%	77.4%	78.5%	78.6%	80.0%	80.6%	78.9%	78.8%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: ESR – Appraisal data for Divisions A, B, C, D and THQ only July 2024

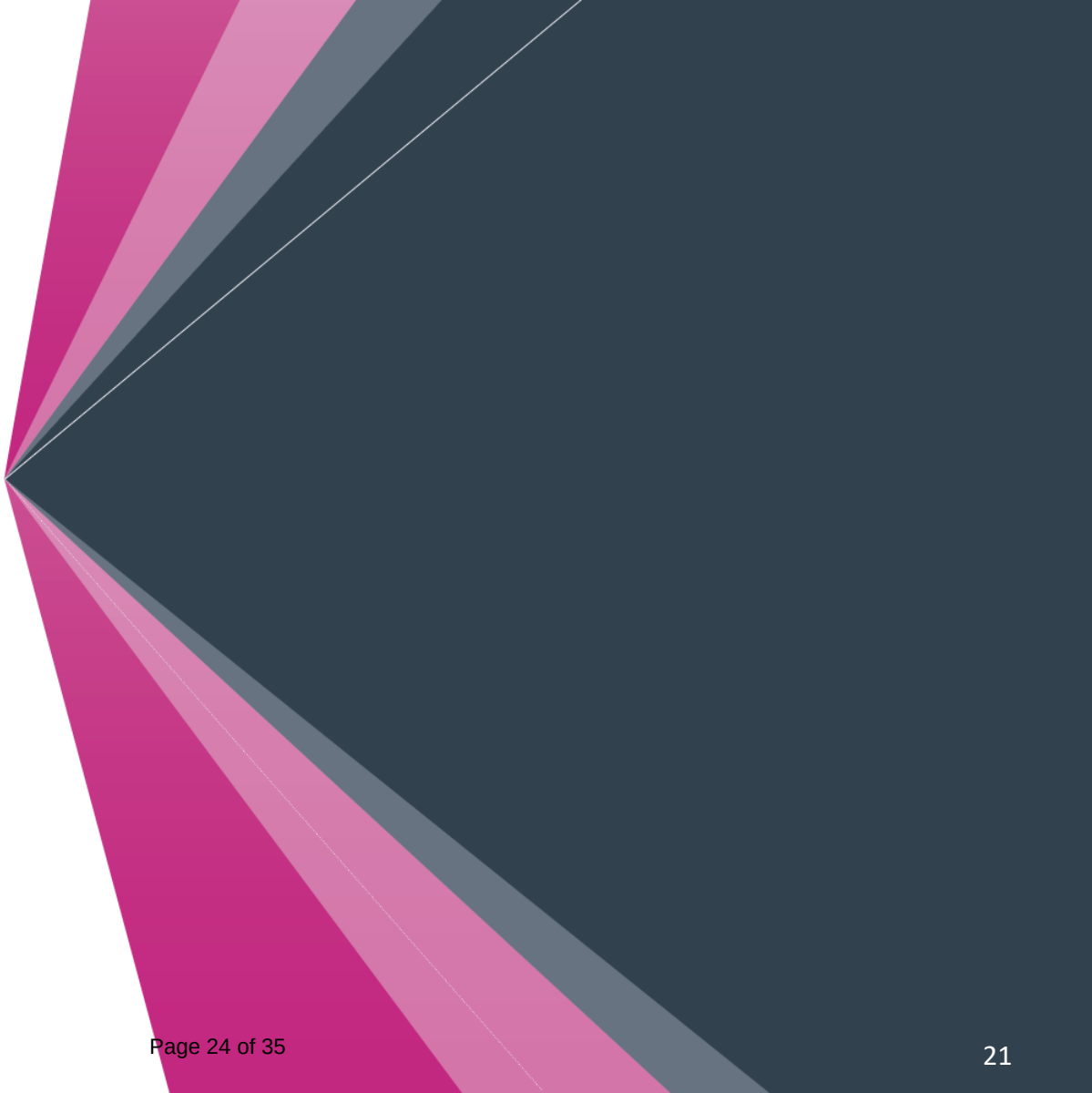
Statutory & Mandatory Training

The Trust's average completion rate for July 2024 is 80.3%, higher than June 2024 at 71.4% with seven of 15 measures above the 85% target.
The audiences for both Safeguarding Adults and Children is currently under review.

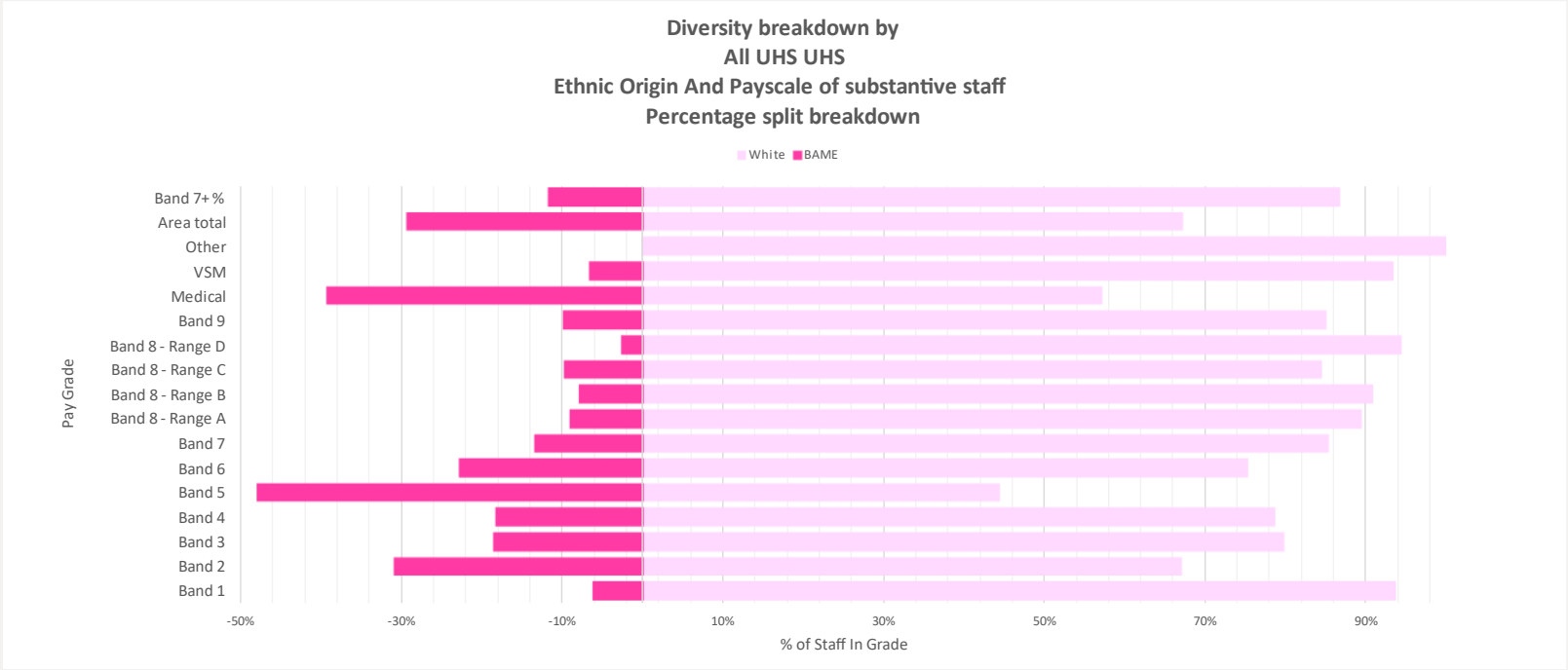


Source: Virtual Learning Environment (VLE) July 24

BELONG

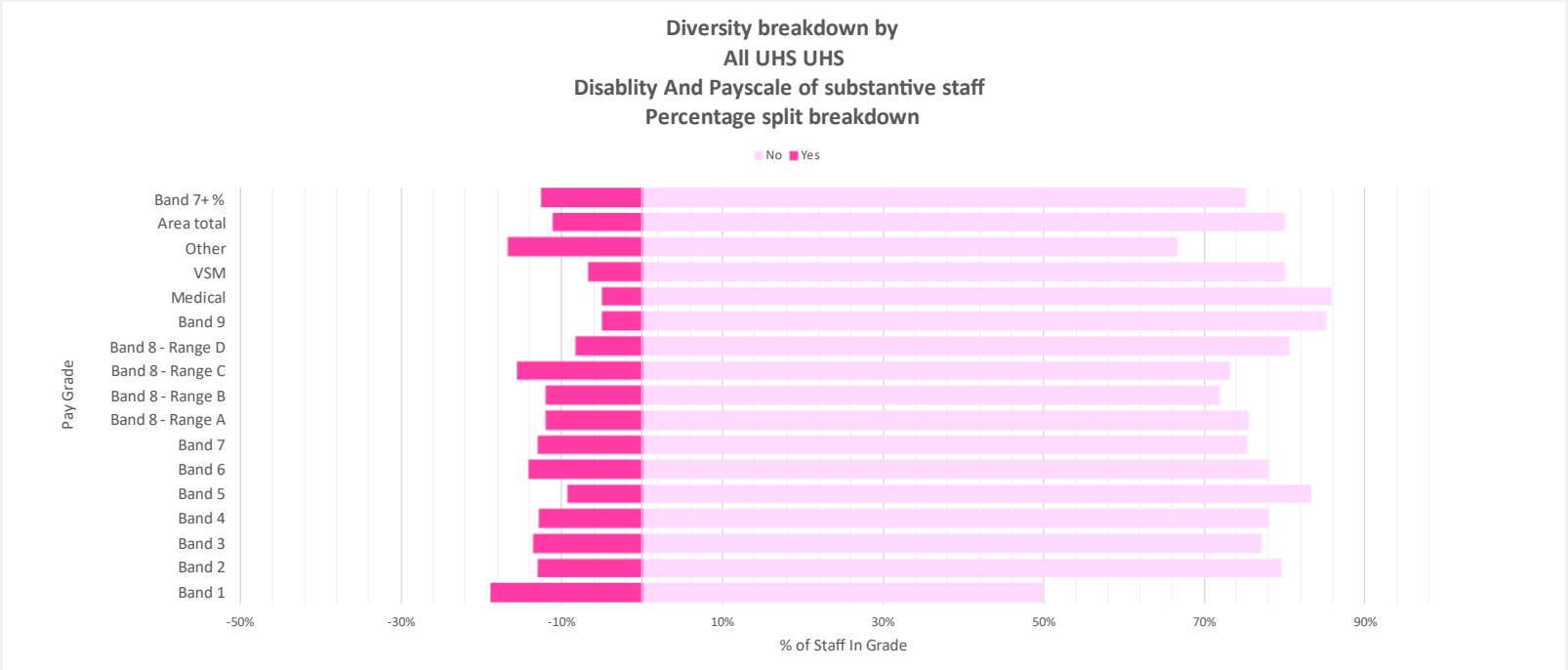


Staff in Post - Ethnicity



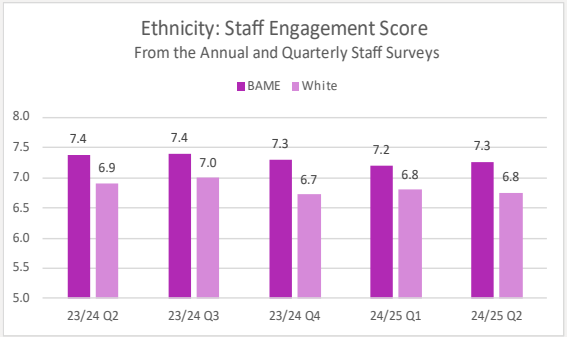
Source: ESR – July 2024

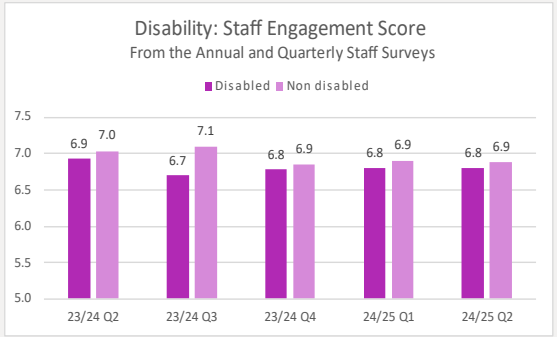
Staff in Post – Disability Status

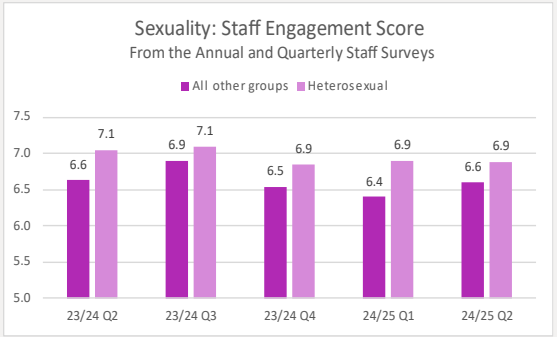


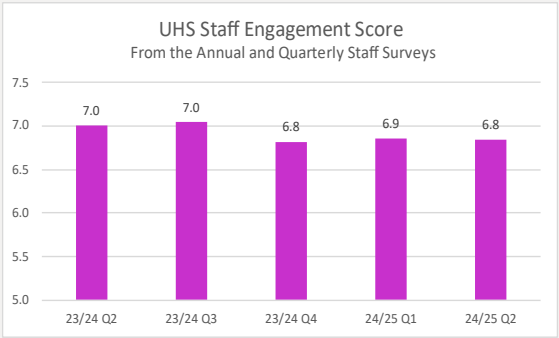
Source: ESR – July 2024

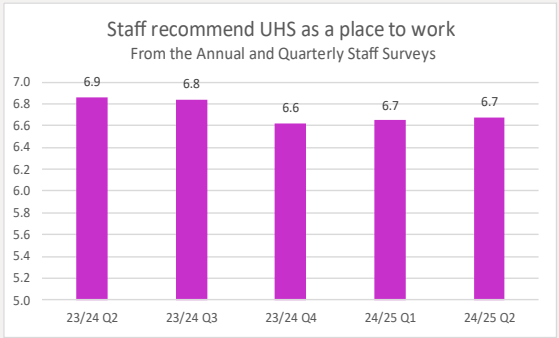
Pulse Survey – 2024/25 Q2











Source: Picker (Qualtrics)

Exit Reasons

Top 5 reasons for leaving UHS this quarter

Not feeling valued and/or recognised	13
Pay	12
Promotion	11
Career change	10
Excessive workload or pressure	10

Previous quarter

Not feeling valued and/or recognised	19
Excessive workload or pressure	14
Retirement	14
Lack of development opportunities	9
Pay; Health reasons; Lack of flexible working	8

Top reason for leaving by staff group

Add Prof Scientific & Technic	Retirement; Pay; Poor working environment/facilities; Lack of development opportunities; Excessive workload or pressure; Not feeling valued and/or recognised
Additional Clinical Services	Pay; Promotion
Admin & Clerical	Promotion; Not feeling valued and/or recognised
Allied Health Professionals	Pay; Relocation outside of the UK
Estates & Ancillary	Health Reasons
Healthcare scientists	Retirement; Promotion; End of fixed term contract/training; Excessive workload or pressure
Medical & Dental	End of fixed term contract or training
Nursing & Midwifery	Not feeling valued/recognised; Career change

I would recommend UHS as a place to work

68%

% of staff who strongly agree or agree

In comparison to the staff survey results (2023): **68%**

If a friend or relative needed treatment, I would be happy with the standard of care provided by UHS

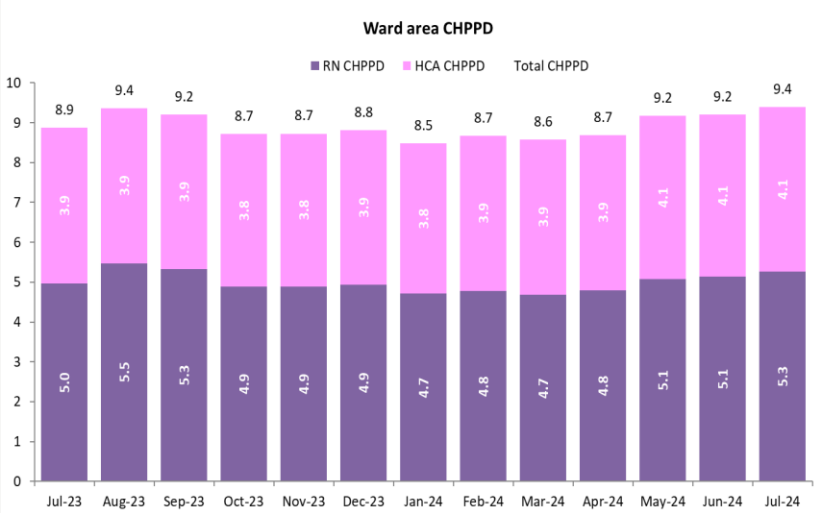
88%

% of staff who strongly agree or agree

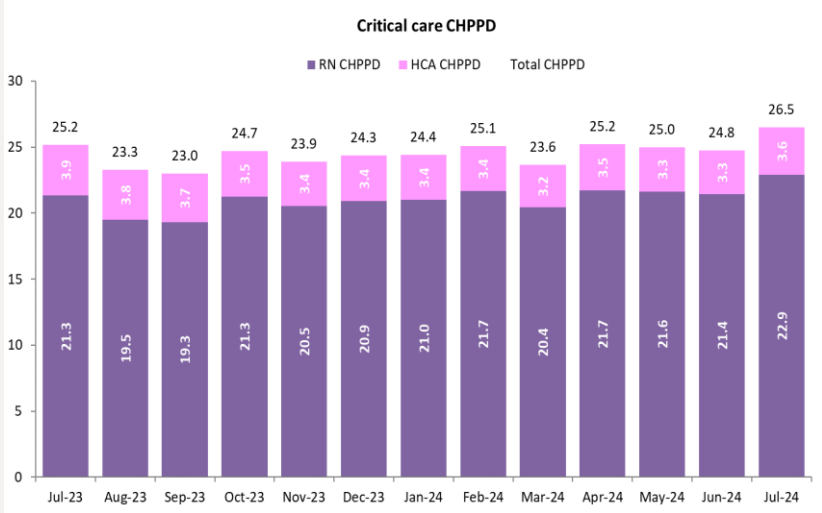
In comparison to the staff survey results (2023): **76%**

Source: UHS Exit Survey; 101 responders participated in the survey

CHPPD



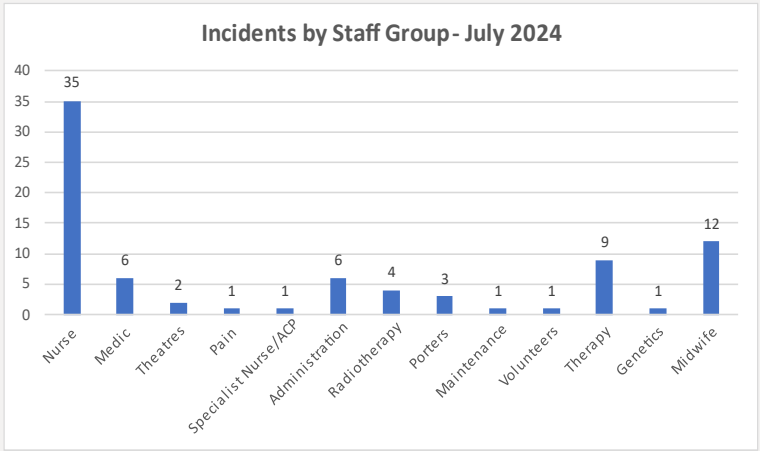
The Ward areas total CHPPD rate in the Trust increased by 0.2 in July to 9.4 from 9.2. RN increased from 5.1 to 5.3, while HCA remained the same at 4.1.



The CHPPD rate in Critical care increased overall by 1.7 in July 2024. RN 22.9 (previously 21.4), HCA increased from 3.3 to 3.6. Overall, 26.5 (previously 24.8).
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, NHSP & eCamis – July 2024

Patient Safety – Staffing Incidents & Red Flags



Incidents by Division July 2024 vs June 2024

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
July 2024	15	21	32	9	5	82
Total	15 (15)	21 ↑ (17)	32 ↑ (30)	9 ↓ (11)	5 ↑ (2)	82 ↑ (75)

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
June 2024	15	17	30	11	2	75
Total	15 ↓ (18)	17 ↑ (12)	30 ↑ (28)	11 ↑ (3)	2 ↑ (1)	75 ↑ (62)

Source: Safeguard System July 2024

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

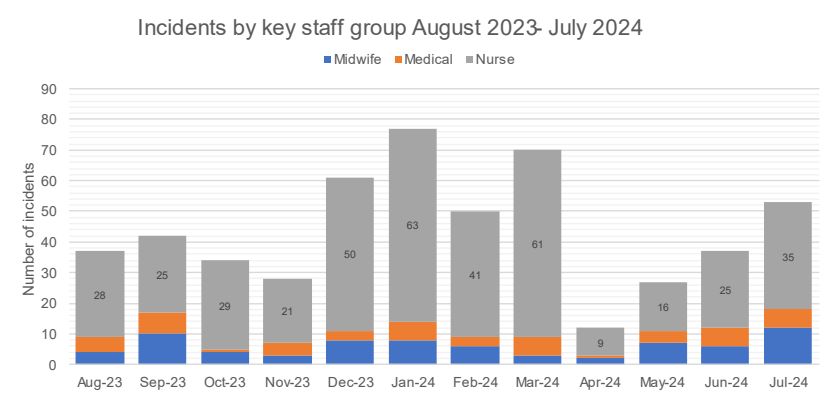
Div A: Fifteen incidents reported in July 2024, the same level as the previous month. For a 3rd month there were no red flags reported.

Div B: Twenty-one incidents reported in July 2024 (up on the 17 in the previous month and rising for a 2nd month). Red flags were up to 14 from the 10 reported in the previous month and the 4 reported in May. This is a more normal level for the Division and were spread across all 4 reported categories.

Div C: Thirty-two incidents reported in July 2024, a similar level to the previous month. There were 5 red flags, spread across all 4 categories.

Div D: Nine incidents reported in July 2024 (a similar level to the previous month). There was a significant rise on the number of red flags raised in the month with 14 compared to the previous 6.

THQ: Five incidents reported in July 2024 (up from 2 in the previous month). The incidents were reported from portering, bed repairs and volunteers.



	Red flag category	Number of reports	Div A	Div B	Div C	Div D
July 2024	Delay in medication	9	0	3	1	5
	Delay in pain relief	9	0	4	1	4
	Delay in observations	8	0	4	2	2
	Less than 2 registered	8	0	3	1	3
	Total	**33**	**0**	**14**	**5**	**14**

	Red flag category	Number of reports	Div A	Div B	Div C	Div D
June 2024	Delay in medication	1	0	1	0	0
	Delay in pain relief	5	0	3	0	2
	Delay in observations	5	0	3	0	2
	Less than 2 registered	5	0	3	0	2
	Total	**16**	**0**	**10**	**0**	**6**

Source: Safeguard System July 2024

Appendices

UHS Workforce Plan 2024/25

WTE Movement Summary
Total reduction of -333 WTE
Substantive reduction of 176 WTE
Bank reduction of 133 WTE
Agency reduction of 24 WTE

KPIs
Sickness – **3.9%**
Turnover – **13.6%**

Governance
Via the People Board, Trust Savings Group, FIC, PODC, TEC

Substantive

Substantive WTE baseline is M12's closing position (12,695 WTE) and is projected to be 12,519 WTE (a **reduction of 176 WTE**).
NQNs (100 WTE), **IENs** (108 WTE), and **business case growth** (135 WTE) are included in growth

Bank

Bank WTE baseline is 788 WTE and is projected to be 655 WTE by March 2025 (a **reduction of 133 WTE** or 17%). Bank WTE has grown from December 2023 to March 2024 by 20% from 674 to 816 WTE

Agency

Agency WTE baseline is 127 WTE and is projected to be 103 WTE by March 2025 (a **reduction of 24 WTE** or 19%). Agency WTE throughout 2023/24 has been steadily reducing by over 40% and we closed agency under plan last year

Total WTE

By March 2025, there will be a total WTE **reduction of 333 WTE** from the baseline of 13,610 WTE (M12) to 13,277 WTE. Each of substantive, bank and agency are expected to reduce, with a bigger focus on temporary resourcing

Risks

Ensuring safe staffing
Affordability of workforce versus demand
System delivery of NCTR and Mental health reductions

Assumptions

National assumption of low/no Covid impact and low/negligible industrial action impact. There will be 50% reduction in **ncTR** and **mental health** (and WTE associated with both) and a stretch ambition of -120 WTE

Data Sources

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

WORLD CLASS PEOPLE

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Guardian of Safe Working Hours Quarterly Report**			
Agenda item:	**5.10**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Dr Diana Hulbert, Emergency Medicine Consultant & Guardian of Safe Working Hours**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** ✓
Issue to be addressed:	The vacancy rate for doctors in training is currently 8.42 %, in keeping with previous years. The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing spending and is seen in all NHS trusts. In the last four months there have been 3748 locum requests, 86.6% of which was filled by the Medical Locum Bank. The June/July Junior doctors' strikes resulted in complex challenges 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 final details of the negotiations between the Government and the BMA are still awaited but the outcome seems to be broadly positive			
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 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 report will be submitted to the Trust Board in November 2024.

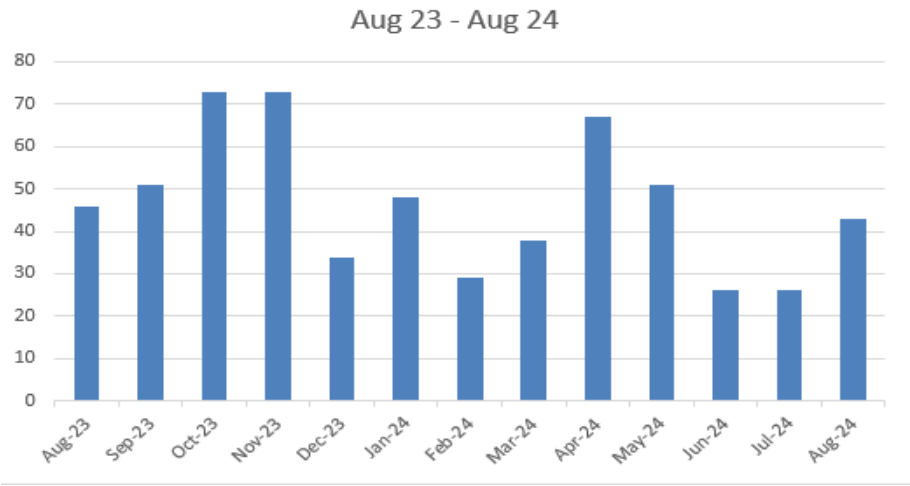
Executive Summary

Employment

As of August 2024, the vacancy rate for junior doctor posts across the Trust is 8.42%; this is in keeping with previous years, but a good position.
Recruitment continues for current vacancies and Medical HR are working with departments to plan for future gaps. (Appendix 1)

Exception reporting

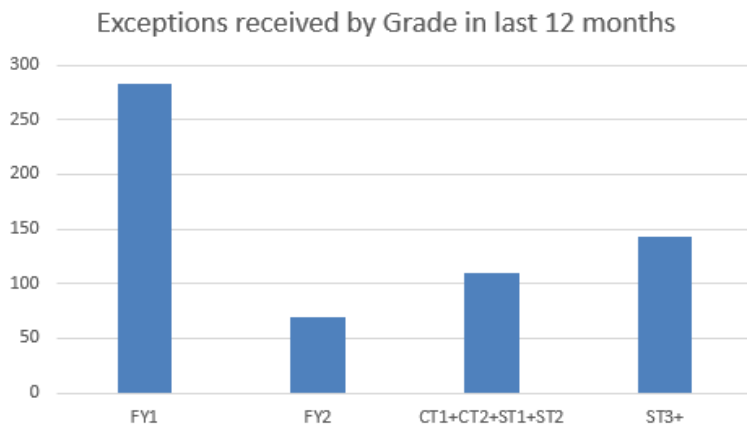
Total exception reports received over last 12 months:



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 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.

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



Self Development Time (SDT)

All doctors in training and trust appointed doctors 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 7 exception reports stating missed SDT

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. These meetings facilitate discussion between the juniors (via their reps) with senior figures in the Trust who can help effect change.

The 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. We are currently trialing in person meetings for this forum to encourage attendance.

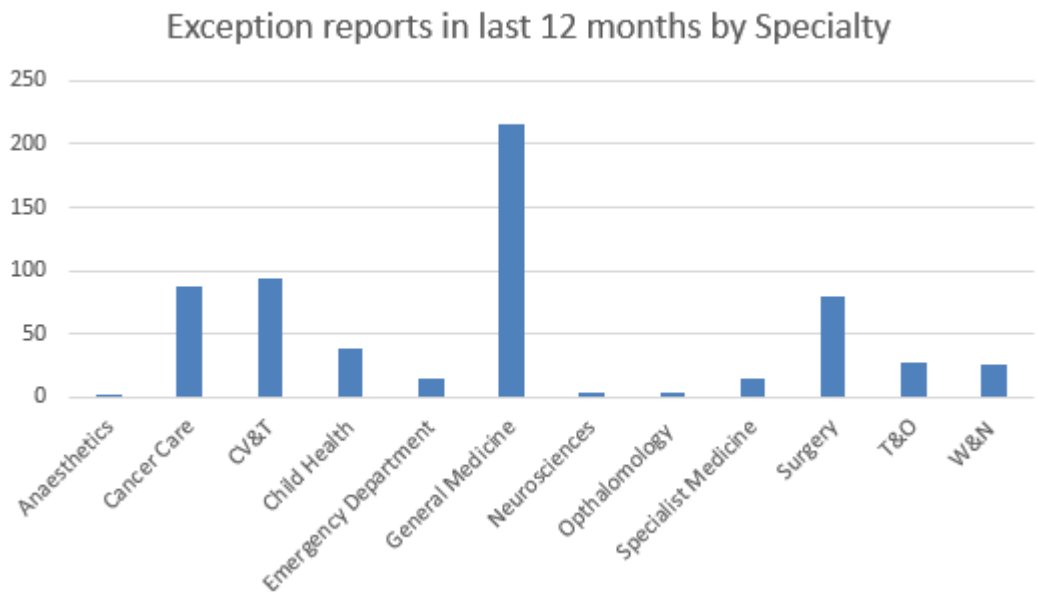
The Guardian and Medical Workforce Team attend monthly Trust induction to ensure that all the doctors in training and the trust appointed doctors who join UHS feel connected to the team and can ask for help and advice.

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. I am delighted that UHS continues to support this role and we have a new Chief Registrar, Dr Gwendolina Bonnifacio starting with us this month. There will, unusually, be a short period where we have two people in post which will allow for a highly effective handover period.

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 currently particularly challenging including renal medicine, rheumatology and neurosurgery.

Exception reporting over the last year has been understandably highest in General Medicine where they have the highest number of FY1's.



Work intensity remains high and the impact of the covid pandemic on the health-seeking behaviour and health anxiety of patients and on the rather stuttering recovery of the NHS generally remains difficult to quantify but feels significant.

The impact of staff rather than patient sickness has also been huge, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on doctors in training work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some 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 regular reviews of medical and non-medical staffing is required to ensure appropriate staffing levels are maintained.
Any uplift in the workforce will need innovative solutions for staffing patterns and recruitment but would undoubtedly help retention. (Appendix 2)

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 were challenging for all. We fervently hope that a settlement is fully 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 teams 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 meetings continue with Dr Mark Wright and I hoping to generate practical answers to tricky questions from the doctors who often see the solutions and ask why not? rather than seeing the problems and asking why?

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 local induction, provision of non-clinical space, IT provision, the availability of reasonably priced hot meals overnight and the presence of sleep rooms after night shifts.

I am delighted that Dr 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 are helping Kate and I review the provision of non-clinical spaces alongside our Chief Registrar The scoping exercise is about to be re-energised with the new doctors who started in August.

The provision of inexpensive hot meals and hot drinks 24/7 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 and SAS doctors 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 can 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 to another team. It is the provision of support in all its forms that determines the ability to thrive.

If I were to offer an ambitious suggestion it would be to view doctors in short-term posts as having unique challenges and treat them accordingly.
Historically different professional groups were viewed and treated differently; over the last 20 years we have endeavored to ensure that the highest standards of care are given to all.
However, there is a unique challenge in being in a short-term post dictated by career necessity, not by choice.
Some of our doctors in training will not only be at UHS for only six months, they will only be in Hampshire for six months. In some cases this may be their second job in the UK.

We expect them to manage their job and their life with relatively little practical support at a time when they are isolated socially and new to everything in their professional and private life.

I believe that, in the short-term at least, UHS should try to be their family and offer robust support which is more granular than the induction package we can offer at present.

I would like to conclude by offering huge thanks to the Becci Mannion, Lynne Stassen and their team without whom doctors in training would have no rotas which work so effectively for the doctors, the teams and the patients at UHS.
Great thanks also to Ellie Starkey (Chief Registrar) and Angharad Chilton (deputy) who have been superb in their additional roles.
I am delighted that the doctors' awards were so efficiently run and so well-received this year.
Final thanks to the Executive team (particularly Joe, Paul and Steve) who continue to engage with the challenges facing these doctors so positively.
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Appendix 1 - Vacancy data

Division	Care Group	Cost centre	Fill Apr 24	Fill May 24	Fill June 24	Fill July 24	Fill Aug 24
A	Critical Care	Anaesthetics	87.50%	88.89%	88.89%	88.89%	80.82%
A	Critical Care	CICU	58.33%	66.67%	66.67%	66.67%	100.00%
A	Critical Care	GICU	76.60%	80.85%	80.85%	80.85%	79.59%
A	Critical Care	NICU	91.67%	100.00%	91.67%	91.67%	100.00%
A	Critical Care	SHDU	100.00%	100.00%	100.00%	100.00%	100.00%
A	Ophthalmology	Ophthalmology	100.00%	96.30%	96.30%	96.30%	100.00%
A	Surgery	ENT	88.24%	94.12%	94.12%	94.12%	100.00%
A	Surgery	General Surgery	91.30%	89.13%	89.13%	89.13%	91.30%
A	Surgery	OMFS	100%	100%	100.00%	100%	90%
A	Surgery	Urology	84.62%	100.00%	92.31%	92.31%	92.31%
B	Cancer Care	Clinical Oncology	89.47%	89.47%	94.74%	100.00%	94.74%
B	Cancer Care	Haematology	100%	100%	100.00%	100%	91%
B	Cancer Care	Medical Oncology	87%	89%	89.47%	89%	100%
B	Cancer Care	Palliative Care	88.89%	88.89%	88.89%	88.89%	88.89%
B	Emergency	Acute Med	74%	74%	78.26%	78%	87%
B	Emergency	Acute Med OOH	83%	83%	83.33%	83%	50%
B	Emergency	ED	95.52%	95.45%	92.42%	93.94%	95.71%
B	Emergency	PHEM	100.00%	100.00%	100.00%	100.00%	100.00%
B	MOP	MOP	93.48%	95.35%	95.35%	95.35%	100.00%
B	Pathology	Microbiology	50%	50%	50.00%	50%	50%
B	Pathology	Chemical Pathology	63%	63%	62.50%	63%	77%
B	Pathology	Histopathology	66.67%	50.00%	50.00%	75.00%	100.00%
B	Specialist Med	Allergy/Respiratory	96.67%	100.00%	96.55%	96.55%	100.00%
B	Specialist Med	Clinical Genetics	100%	100%	100.00%	100%	100%
B	Specialist Med	Dermatology	100%	100%	100.00%	100%	100%
B	Specialist Med	Endo/Diabetes	100%	100%	100.00%	100%	95%
B	Specialist Med	General Medicine	100%	100%	100.00%	100%	100%
B	Specialist Med	GI Renal	93.33%	90.63%	96.88%	96.88%	75.00%
B	Specialist Med	Rheumatology	100%	100%	100.00%	100%	77%
C	Child Health	Paediatric Cardiology	71.43%	71.43%	71.43%	71.43%	83.33%
C	Child Health	Paediatrics	87.04%	88.89%	88.89%	88.89%	94.44%
C	Child Health	Paeds ED	88.24%	88.24%	88.24%	88.24%	100.00%
C	Child Health	PICU	88.89%	83.33%	83.33%	83.33%	83.33%
C	W&N	Neonates	80.00%	100.00%	80.00%	80.00%	100.00%
C	W&N	O&G	97.14%	97.14%	94.29%	94.29%	92.11%
D	CV&T	Cardiology	84.62%	84.62%	84.62%	84.62%	93.94%
D	CV&T	Cardiothoracic Surgery	87.50%	87.50%	87.50%	87.50%	100.00%
D	CV&T	Vascular Surgery	100%	100%	100.00%	100%	100%
D	Neurosciences	Neurology	100%	100%	100.00%	100%	100%
D	Neurosciences	Neurophysiology	100%	100%	100.00%	100%	88%
D	Neurosciences	Neurosurgery	87.50%	87.50%	87.50%	87.50%	66.67%
D	T&O	Spinal Surgery	100%	100%	100.00%	100%	89%
D	T&O	T&O	94.23%	94.23%	94.23%	94.23%	91.49%
		Total	88.94%	90.37%	89.55%	90.06%	91.58%

Appendix 2 - Locum data

Count of Unit		Status		
Unit	Date	**Filled**	**UnFilled Bank**	**Grand Total**
CAN Clin Onc Med Staff	Apr	25	2	27
	May	25		25
	Jun	29	3	32
	Jul	25	1	26
CAN Clin Onc Med Staff Total		104	6	110
CAN Haematology Medical Staff	Apr	10	1	11
	May	25	2	27
	Jun	46	10	56
	Jul	42	3	45
CAN Haematology Medical Staff Total		123	16	139
CAN Medical Oncology Medical Staff	Apr	32	2	34
	May	18	1	19
	Jun	8		8
	Jul	14	2	16
CAN Medical Oncology Medical Staff Total		72	5	77
CAN Palliative Care Medical Staff	Jun	2		2
	Jul	5		5
CAN Palliative Care Medical Staff Total		7		7
CAR Med Staff Vascular	Apr	3		3
	Jun	4		4
	Jul	1		1
CAR Med Staff Vascular Total		8		8
CAR Medical Staff Cardiac Surgery	Apr	34	10	44
	May	22	9	31
	Jun	42	7	49
	Jul	18	5	23
CAR Medical Staff Cardiac Surgery Total		116	31	147
CAR Medical Staff Cardiology	Apr	10	3	13
	May	19	5	24
	Jun	29	9	38
	Jul	36	15	51
CAR Medical Staff Cardiology Total		94	32	126
CC CICU Medical Staff	Apr	11	2	13
	May	14		14
	Jun	15	1	16
	Jul	14		14
CC CICU Medical Staff Total		54	3	57
CC GICU Medical Staff	Apr	2	3	5
	May	4	4	8
	Jun	9	4	13
	Jul	10	24	34
CC GICU Medical Staff Total		25	35	60
CC NICU Medical Staff	Apr	3	2	5
	May	7		7
	Jun	8	1	9
	Jul	22		22
CC NICU Medical Staff Total		40	3	43
CC SHDU Medical Staff	Apr	3	2	5
	May	3		3
	Jun	5	6	11
	Jul	13	8	21

CC SHDU Medical Staff Total		24	16	40
CHI Medical Staff Junior	Apr	30	2	32
	May	23	3	26
	Jun	18		18
	Jul	21		21
CHI Medical Staff Junior Total		92	5	97
CHI Medical Staff Paediatric Cardiology	Apr	1		1
	May	22		22
	Jun	17		17
	Jul	22	5	27
CHI Medical Staff Paediatric Cardiology Total		62	5	67
CHI Medical Staff PICU	Apr	5	2	7
	May	10	2	12
	Jun	10	8	18
	Jul	14	7	21
CHI Medical Staff PICU Total		39	19	58
CHI Paed ED Junior Doctors	Apr	16	3	19
	May	26	1	27
	Jun	23	4	27
	Jul	20	9	29
CHI Paed ED Junior Doctors Total		85	17	102
ECM AMU Medical Staff	Apr	46	5	51
	May	56	2	58
	Jun	48	3	51
	Jul	69	15	84
ECM AMU Medical Staff Total		219	25	244
ECM Emergency Dept Medical - Junior Doctors	Apr	54	16	70
	May	35	5	40
	Jun	51	28	79
	Jul	54	18	72
ECM Emergency Dept Medical - Junior Doctors Total		194	67	261
ECM Out of Hours Medical Team	Apr	10		10
	May	10		10
	Jun	10		10
	Jul	6		6
ECM Out of Hours Medical Team Total		36		36
MED Medical Staff MOP	May	15		15
	Jun	25	1	26
	Jul	36	4	40
MED Medical Staff MOP Total		76	5	81
MED Medical Ward Based	Apr	23	4	27
	May	7	1	8
	Jun	25	8	33
	Jul	12	4	16
MED Medical Ward Based Total		67	17	84
NEU Med Staff Neurology	May	2	1	3
	Jun	8	1	9
	Jul	11	3	14
NEU Med Staff Neurology Total		21	5	26
NEU Med Staff Stroke	Jun	3		3
NEU Med Staff Stroke Total		3		3
NEU MedStaff Neurosurgery	Apr	15	1	16
	May	16	1	17
	Jun	42	3	45

	Jul	39	2	41
NEU MedStaff Neurosurgery Total		112	7	119
OPH Medical Staff	Apr	7		7
	May	11	2	13
	Jun	9		9
	Jul	11		11
OPH Medical Staff Total		38	2	40
RAD Wessex Registrars	Apr	5		5
	May	14		14
	Jun	11	1	12
	Jul	10	1	11
RAD Wessex Registrars Total		40	2	42
RD Fellows	Apr	1		1
RD Fellows Total		1		1
SME General Medicine Med Staff	Apr	69		69
	May	66	3	69
	Jun	69	1	70
	Jul	75	8	83
SME General Medicine Med Staff Total		279	12	291
SME MedStaff Dermatology	Apr	9		9
	May	7		7
	Jun	5	3	8
	Jul	1		1
SME MedStaff Dermatology Total		22	3	25
SME MedStaff GI/Renal	Apr	2		2
SME MedStaff GI/Renal Total		2		2
SME MedStaff Respiratory	Apr	19		19
	May	11		11
SME MedStaff Respiratory Total		30		30
SME MedStaff Rheumatology	Apr	21		21
SME MedStaff Rheumatology Total		21		21
SPI Med Staff Spinal	Apr	2		2
SPI Med Staff Spinal Total		2		2
SUR Med Staff ENT	Apr	22	5	27
	May	9	1	10
	Jun	10	1	11
	Jul	8		8
SUR Med Staff ENT Total		49	7	56
SUR Med Staff GI	Apr	86	21	107
	May	86	7	93
	Jun	102	36	138
	Jul	94	14	108
SUR Med Staff GI Total		368	78	446
SUR Med Staff Urology	Apr	7		7
	May	7		7
	Jun	9		9
	Jul	10		10
SUR Med Staff Urology Total		33		33
SUR OMF Medics	Apr	9	2	11
	May	4	1	5
	Jun	20	1	21
	Jul	24		24
SUR OMF Medics Total		57	4	61
T&O Medical Staff	Apr	101	8	109
	May	107	13	120

	Jun	118	13	131
	Jul	118	15	133
T&O Medical Staff Total		444	49	493
THR Anaesthetics Medical Staff	Apr	11		11
	May	13		13
	Jun	14		14
	Jul	20	1	21
THR Anaesthetics Medical Staff Total		58	1	59
W&N Med Staff Junior	Apr	18		18
	May	13	1	14
	Jun	14	1	15
	Jul	16	1	17
W&N Med Staff Junior Total		61	3	64
W&N Neonatal Med Staff	Apr	12	2	14
	May	9	1	10
	Jun	15		15
	Jul	24		24
W&N Neonatal Med Staff Total		60	3	63
RD NIHR WTCRF	Apr	1		1
RD NIHR WTCRF Total		1		1
CHI High Dependency Unit	Apr		4	4
	Jun		14	14
CHI High Dependency Unit Total			18	18
W&N Med Staff Breast/Endo	May	1		1
	Jun	2		2
	Jul	5		5
W&N Med Staff Breast/Endo Total		8		8
Grand Total		**3247**	**501**	**3748**

Report to the Trust Board of Directors				
Title:	**Learning from Deaths 2024-25 Quarter 1 Report**			
Agenda item:	**5.11**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Jenny Milner, Associate Director of Patient Experience** **Alex Woodhead, Mortality and Data Insight Co-ordinator**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board. The report also provides an update on the development and effectiveness of the medical examiner service.			
Response to the issue:	The National Guidance on Learning from Deaths sets out expectations that: *Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced*. This paper sets out a plan to meet these requirements more fully.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. The Trust does not reduce avoidable deaths in our hospitals. 2. The Trust does not promote learning from deaths, including relating to avoidable deaths and good and poor quality of care. 3. The Trust does not promote an open and honest culture and support for the duty of candour.			
Summary: Conclusion and/or recommendation	• Q1 has seen a decrease in death rate compared to Q4 and the previous Q1. Nationally UHS continues to benchmark lower than expected death rates. • The SHMI data shows UHS continues to have lower-than-expected outcomes with 5 diagnoses' being lower than expected nationally. • A recurrent theme via incident reporting has emerged regarding provision of specialist out of hours paediatric palliative care advice and support.			

1. Introduction

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

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

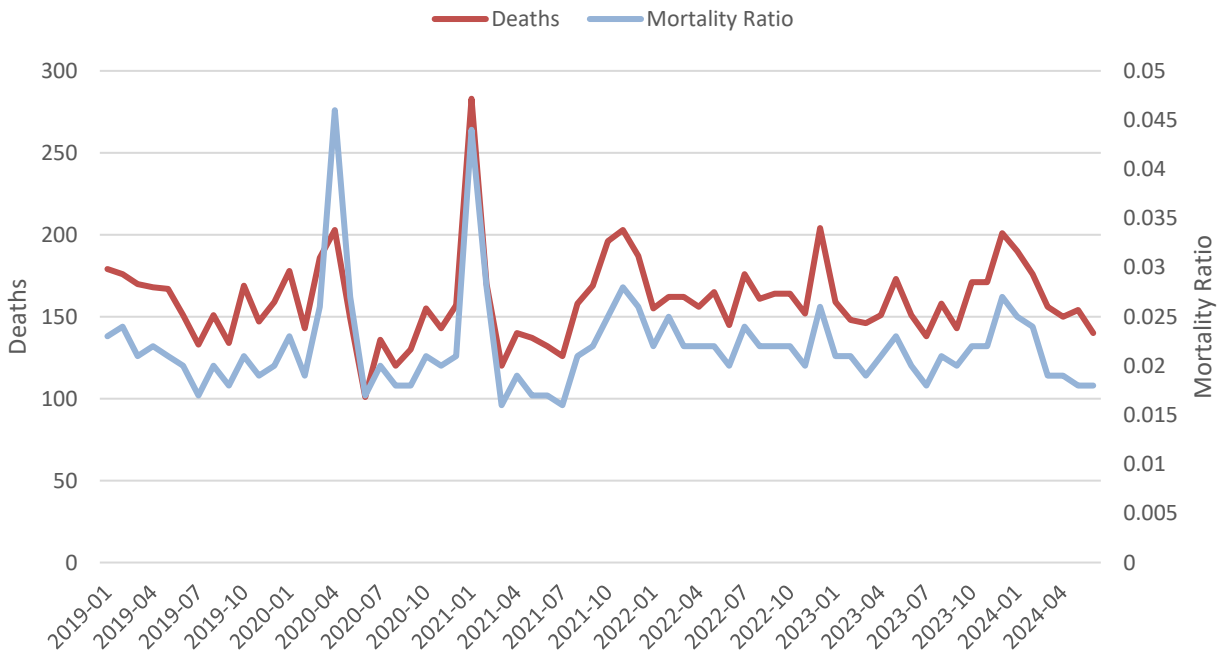
Morbidity and mortality meetings remain a focus for the improvement of data capture and availability, so that learning identified in these meetings can be shared both in this report and across the Trust.

2. Analysis and Discussion

2.1 Deaths at UHS

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

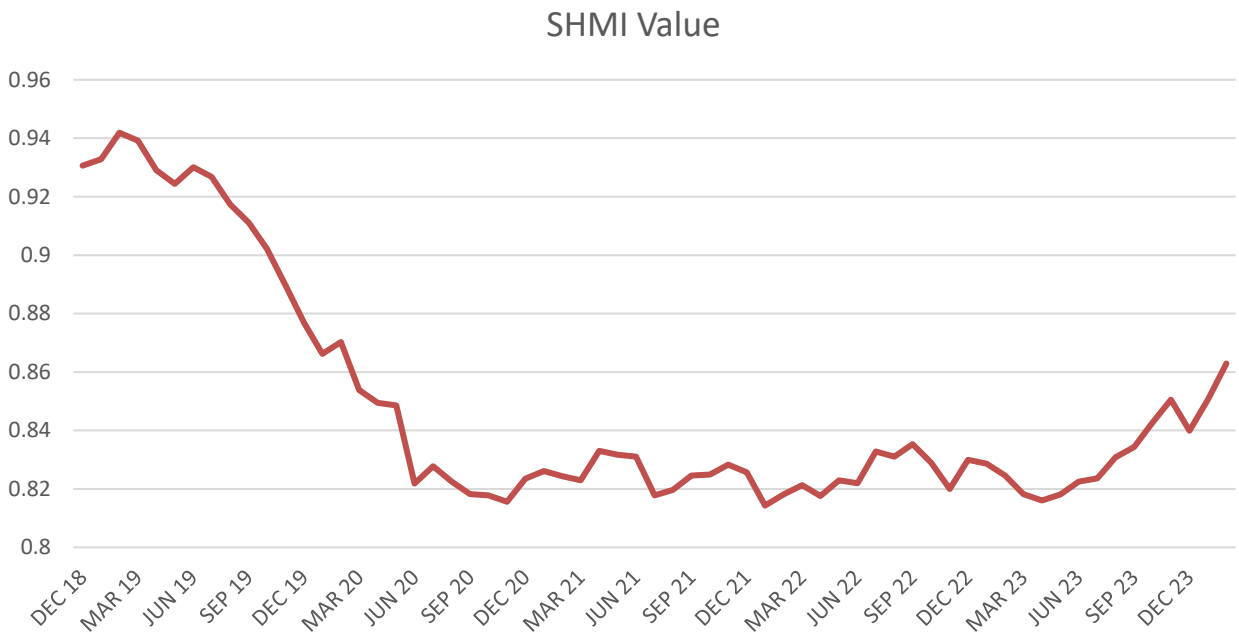
The first quarter of 2024-25 saw 466 deaths at UHS sites, compared to 512 in Q1 2023-24 which is a 16% reduction from previous quarter. This is expected as the winter period ends. Year on year Q1 deaths have fallen by 9%.



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

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

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



SHMI remains in the 'lower than expected' range at 0.85 for the 12 months to February 2024.

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

Diagnosis Group Description	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	0.9577	As Expected
Cancer of bronchus; lung	0.688	Lower Than Expected
Secondary malignancies	0.5713	Lower Than Expected
Fluid and electrolyte disorders	0.5289	Lower Than Expected
Acute myocardial infarction	0.7096	Lower Than Expected
Pneumonia (excluding TB/STD)	1.0047	As Expected
Acute bronchitis	0.7181	As Expected
Gastrointestinal haemorrhage	0.7513	As Expected
Urinary tract infections	0.6645	Lower Than Expected
Fracture of neck of femur (hip)	0.8675	As Expected

For the 12 months to February 2024 5 diagnosis level values are in the 'As Expected' range, 5 are in the 'Lower than Expected' range.

2.3 **Medical Examiner Reviews**

In Q1 the Medical Examiner Service (MES) reviewed 753 deaths of which 443 occurred at UHS acute sites, 310 occurred in the community. This compares to 678 deaths reviewed in Q1 2023/24, an increase of 11%.

2.3.1 **Referrals to M&M**

11 cases were referred to speciality M&Ms by MES. The learning from these 11 cases have been shared when relevant and most cases highlighted there was no further learning identified.

For example, one of the referred cases to Emergency Medicine identified learning from ECG reviews the ECG is now featured in the ED junior and senior teaching sessions, and has been shared with Cariology team as there was inter-speciality challenges identified.

2.3.2 **Referrals to Patient Safety**

2 cases were referred to Patient Safety by MES. 1 case redirected to M&M and awaiting outcome and 1 case did not require a review.

2.4 **UHS 'End of Life' (EOL) and 'Last Offices' Incident Reports**

9 incident reports relating to EOL care were recorded in Q1.

- 3 were due to paperwork filled out by ward staff incorrectly stating that no pacemaker was in place for the patient. In all 3 cases mortuary staff later discovered devices on in situ.
- 1 relates to supply issues of DNRCPR forms.
- 1 reports a delay of over 5 hours to certify death in medicine, the outcome of this was due to ANP not having the specific competency, and the FY1 was inundated with unwell patients, learning was identified to escalate to out of hours consultant and AER forming part of data review of out of hours staffing levels.
- 1 relates to missing property. The item was subsequently found.
- 1 related to paediatric palliative care advice out of hours (May Bank Holiday), this is a recurrent theme in Child Health, as there is no commissioned service for on call specialist paediatric palliative service. This has been escalated to Child Health CGMT and to the End-of-Life Programme Board.
- 2 relate to the bereavement service, 1 to service and 1 regarding provision of a suitable environment to have family discussions.

2.5 **UHS Complaints relating to End-Of-Life Care**

7 formal complaints were received in Q1 relating to End-Of-Life care. The themes primarily related to communication, symptom management and location of death.
Of these, 1 was upheld, 1 was partially upheld, 1 was not upheld and 4 remain open.

3. Morbidity and Mortality Data Capture & Standardisation

With the trial of the Morbidity & Mortality Meeting Recording app now complete, the app is now in the process of being ported onto UHS systems. This will allow records of M&M discussions and their outcomes to become part of the patient record as well as allowing M&M co-ordinators to access patient demographics easily and reduce data input.

4. Medical Examiner Service Update

In Q1:
88% of families were contacted by the service.
57% of MCCDs (Medical Certification of Cause of Death) were completed by day 3.
21% of deaths were referred to the coroner (HMC) with 10% cases being taken on for further investigation.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**			
Agenda item:	**5.12**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Liz Brown, Medical HR Operations Manager**			
Date:	**10 September 2024**			
Purpose	**Assurance or reassurance**	**Approval** x	**Ratification**	**Information** x
Issue to be addressed:	New framework published by NHS England following the full return to appraisal requirements in 2022/23. The framework is designed to allow the organisation to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement.			
Response to the issue:	This is the second year of full appraisal and revalidation requirements since the pandemic. The focus of the central appraisal teams has been on full implementation of the electronic system, compliance rates and appraisal quality.			
Implications: (Clinical, Organisational, Governance, Legal?)	The responsible officer (RO) has a statutory duty to ensure compliance with NHS England and GMC requirements for appraisal and revalidation. The Chief Medical Officer is the RO for the Trust.			
Risks: (Top 3) of carrying out the change / or not:	Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended) and related guidance.			
Summary: Conclusion and/or recommendation	The Board is asked to note the summary information included in this report and approve the “Statement of Compliance” at Appendix A, confirming that the organisation, as a designated body, is compliant with the medical profession regulations.			

Section 1 – General:

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

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

Comments:	Yes, the chief medical officer.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Comments:	Two full appraisal cycle has now been completed on the electronic appraisals system, compliance rates have continued to improve and evidence for revalidation recommendations can be easily accessed. The Deputy RO and Trust appraisal leads support the RO with the day-to-day responsibility for delivering medical appraisal. This includes the development of policy, appraiser training and quality assuring the process. The Medical HR team supports the RO with all associated administration and reporting.
Action for next year:	Renewal of appraisal software licence.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Comments:	The medical appraisals and revalidation officer sits as part of the wider medical HR team. Recruitment and management of connected doctors' contracts is carried out in partnership. All connections are reviewed and managed by the appraisals officer via the SARD platform.
Action for next year:	Maintain monthly review of connections and ensure communication between the responsible parties continues.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Comments:	The appraisal and revalidation policy was reviewed and updated in line with GMC and Academy of Royal College recommendations.
Action for next year:	Update as needed in line with national changes.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Comments:	UHS has not had a further peer review. Internal process review and quality assurance exercises have been completed. The Trust uses this information to make changes and address any areas of concerns.
Action for next year:	Continue programme of process review and annual quality assurance exercise.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continue to improve access to appraisal for connected doctors in bank or locum roles, enlist the support of appraisers or consider the viability of standalone appraisers for this group.
Comments:	Limited numbers of long-term locums and bank only doctors have meant as yet standalone appraisers for the group have not been established. The central appraisal team, care group appraisal leads, and the Trust appraisal leads support as required.
Action for next year:	Continue to monitor and if it is identified that this group are struggling to access support and appraisal a review will be taken, and remedies implemented.

1B – Appraisal

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

Action from last year:	Further work with DCDs and appraisal leads to improve appraisal compliance levels and manage non-engagement.
Comments:	DCDs, DCMO and CMO manage non-compliant doctors as issues occur, addressing problems with the CGCL and letters of concerns issued as appropriate. Full cleanse of SARD undertaken, list compiled of those with multiple missed appraisals and shared with DCDs. Early identification of problems will avoid revalidation recommendation deferrals. The appraisal conversation covers whole scope of practice.
Action for next year:	Continue to focus on managing annual compliance rates.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments:	Doctors with overdue appraisals are contacted and reminded of their responsibility to complete their appraisal. Automated reminders via the appraisal system highlight approaching and overdue appraisals and remind doctors of their obligation. A list of doctors with an overdue appraisal of 3 months or more without an acceptable reason are reviewed regularly and escalated as appropriate. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process.
Action for next year:	Continue to focus on managing annual compliance rates.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments:	The Trust's Medical Appraisal and Revalidation policy is compliant with national policy and has incorporated several national recommendations. The policy has been approved via the central policy ratification group.
Action for next year:	None. The policy will be updated in line with national changes as required.

1B(iv) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	Increase appraiser numbers through encouragement, identifying individuals or promotion of courses.
Comments:	Consultant appraisers have increased to 176, two training courses for new appraisers are run each year. Trust appraisal leads and care group appraisal leads encourage others to become appraisers and it has been agreed that newly appointed consultants can attend the training if keen to be appraisers.
Action for next year:	Work with the Trust Appraisal leads to identify ways to increase appraiser numbers and succession plan.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Carry out a further quality assurance exercise (ASPAT) exercise in Q4, increasing the review sample to 2 appraisal output forms per appraiser.
Comments:	Action completed, detailed report shared with appraisal leads and the Decision-Making Group. Outcomes are used to inform required changes and address any areas of concerns. Several quality assurance mechanisms are in use on an annual basis to collect feedback on the appraisal process and review the outputs of the appraisal. Within this, there is both quantitative and

	qualitative data available. The Trust uses this information to make changes and address any areas of concerns. It allows the opportunity to provide feedback to individual appraisers on their appraisal skills as part of the annual quality assurance process. Appraisers have access to regular training, bi-annual update sessions and appraiser feedback reports support professional development.
Action for next year:	Training course feedback to move to an online collection mechanism to support improved development.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments:	All doctors are asked to rate the quality of appraisal and the suitability of the appraiser. 97% of appraisees rated their appraiser as very good or good. >95% strongly agreed or agreed with the statements regarding appraiser support, constructive advice and feedback, areas for development and listening skills. 268 ASPAT questionnaires were sent out, 2 per consultant appraiser: **236 out of 268** appraisals with a completed ASPAT questionnaire have scored between 75% and 100%. **5 out of 268** appraisals with a completed ASPAT questionnaire have scored between 50% and 74%. **0 out of 268** appraisals with a completed ASPAT questionnaire have scored 49% or lower.
Action for next year:	Trust appraisal leads to review further appraisal output forms for the 5 appraisers who scored between 50% and 74%. Outcomes to be shared with the department appraisal leads which will allow for a constructive conversation and feedback session to take place.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Comments:	The Trust's CMO, Deputy CMO and Associate Director of HR meet once a quarter with the GMC Employment Liaison Officer throughout the year to discuss cases.
Action for next year:	• GMC and UHS meetings will continue on a quarterly basis. • Advice will be sought for new and ongoing professional affair cases. • Referrals will be made if the threshold is met under Good Medical Practice.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Comments:	The review process begins well in advance of the revalidation recommendation date and the appraisal team highlights the outstanding actions to the doctors, the DCD and the RO. Where a deferral was recommended, the doctor was notified with confirmation of the actions required.
Action for next year:	Further improvement of non-compliant rates. • Implementation of bi-monthly report to care group appraisal leads. • Leads to then offer support and guidance to minimise missed appraisals.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

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

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Comments:	Management teams monitor performance of teams and review complaints and incidents at monthly governance meeting. An annual report of any doctor with more than three complaints is presented to the CMO. In many areas activity data is available from divisional analysts at the request of doctors in advance of appraisal, this is more accessible in surgical areas where procedure data and length of stay information is tracked.
Action for next year:	None.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Comments:	The current governance systems for complaints, serious incidents and risk incidents are not easily searchable and a total combined report if not accessible. For all complaints where a doctor is named, the individual is asked to respond. This should be captured in the annual appraisal and reflections undertaken. CMO and Appraisal Leads have met with governance teams before to discuss and review systems limitations. Sufficient

	information is available for appraisal was combined with self-reporting, reflection, and a probity statement.
Action for next year:	Trust appraisal leads to explore improved reporting opportunities with the governance team.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

Comments:	Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists Policy. Concerns are addressed accordingly with support from HR. The Trust has a lead for managing conduct and capability issues, the Deputy Chief Medical Officer, who is the NHSR trained case manager for UHS.
Action for next year:	The above policy is due for review in November 2025.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Comments:	All cases at UHS are stored on secure online software (CaseWorkER). Case level information is extracted from CaseWorkER into a report to be discussed at the monthly ER Performance Board. This group is chaired by the Associate Director of HR (ADHR), has a staff-side representative, the ER team, and the FTSU Guardian in attendance. All medical cases are discussed at this group, which looks at whether the case is being managed in a fair, timely, and proportionate way and in line with EDI principles. Following the meeting, a monthly ER report is compiled and distributed to key stakeholders (including the designated NED). An ER Performance Report is submitted to the People and OD Committee (a Trust Board sub-group) on an annual basis to appraise the board on ER activity and key themes. The designated NED for medical cases is sent a copy of the terms of reference (TOR) document for any new medical cases and meets with the ADHR on a quarterly basis to discuss all medical cases and provide oversight. Practitioners are able to contact the NED if they have any concerns with how a case is being managed. The Deputy CMO, Case Manager, and ADHR meet on a monthly basis to discuss all cases and meet regularly with NHS Resolution and the GMC.
Action for next year:	Continue to schedule ER Performance Board and submit assurance data to the People and OD Committee.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

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

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.

Comments:	The UHS policy for Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists is in line with Maintaining High Professional Standards guidance. All policies are ratified by the relevant Trust 'expert' group following consultation with all applicable groups. This also applies to all clinical governance and safeguarding policies and processes.
Action for next year:	None.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture.

Comments:	Trust and departmental management teams ensure that information is readily available to all doctors and that any required actions are well documented and understood.
Action for next year:	Appraisal leads to look at appraisal guidance with specific mention of 'response to national reports and reviews'.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible.

Comments:	Professional standards for regulated positions align with the Trust values. The overarching policies apply to all groups with professional registration and incorporate the standards expected by professional bodies.
Action for next year:	None.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments:	The medical HR team is responsible for undertaking pre-employment checks, in line with NHS Employers mandatory standards. Monthly compliance audits are carried out on a sample of new starters. The temporary resourcing team are responsible for ensuring that appropriate pre-employment documents are provided for any temporary workers, supplied via a locum agency.
Action for next year:	Update processes in line with mandated policy changes.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Comments:	At UHS we have “Always improving” as one of our core values. Our transformation team supports the trust leadership in delivering on continuous improvement supported by the medical lead, Kate Pryde. We run annual “We are UHS” weeks with poster presentations submitted for display at our mini-conference event.
Action for next year:	Continue to embed the link between effectiveness, outcomes, and improvement.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity, and inclusivity are proactively promoted within the organisation at all levels.

Comments:	At UHS we champion equality, diversity, and inclusion (ED&I), which is about being pro-active, practical and positive. As our Trust reflects wider society, we believe that a hospital that promotes equity from within creates a culture of belonging amongst staff and ultimately better health outcomes for patients. The Trust is committed to developing a culture that embeds the effective management of ED&I in all that we do, providing the necessary resources and leadership to make this happen. Our governance arrangements allow for our equality objectives to be externally regularly reviewed and our progress against them to be monitored nationally, regionally and locally.
Action for next year:	The inclusion and belonging strategy outlines the five key themes the Trust is committed to achieving before 2026.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Comments:	The CMO meets 1:1 all new consultant appointments to UHS to discuss our values and offer support in continuous improvement and in managing conduct and capability issues, as well as coaching and mentorship. We have embedded PSIRF lead by Christina Rennie, head of patient safety with a just and learning culture at the centre of our response to safety events. We have well established FTSU process with a guardian and multiple champions in every division.
Action for next year:	None.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Comments:	There are several routes which support both informal and formal feedback. The Trust supports a culture of openness, honesty, and transparency. Concerns can be raised with line managers, directly to the Freedom to Speak Up Guardian, or a local champion, via the Raising Concerns (Whistleblowing) policy or through the incident reporting system.
Action for next year:	None.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Comments:	The ER Performance Board assesses the ethnicity of all staff involved in all types of formal HR process and the Trust's WRES data compares whether a staff member is more likely to enter into a formal disciplinary process if they are from a White / BAME background. The data does not currently assess the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristic.
Action for next year:	Look specifically at the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristic.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Comments:	Deputy RO and Trust appraisal leads attend RO network meetings and relevant training sessions.
Action for next year:	None.

Section 2 – metrics

Year covered by this report and statement: 1st April 2023- 31st March 2024.

2A - Prescribed connections and compliance 2023/24

Total number of doctors with a prescribed connection as of 31 March 2024	1439
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	995
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	242
Total number of agreed exceptions	202

The number of prescribed connections has increased by 80 this year, the number of unapproved missed appraisals increased by 4.5% to 16%. The medical HR team have undertaken a full review of all electronic appraisal records (SARD system) and have compiled a list of those with multiple missed appraisals. It is hoped that with DCD support these issues can be addressed and rectified in advance of the revalidation recommendation.

2B - Recommendations and deferments 2023/24

Recommendations made	158
Deferments: Insufficient evidence for a recommendation to revalidate	67
Non-engagement	1
Total	**226**

In previous years deferrals accounted for 33-37%, this year this has reduced to 29%. While this is still higher than the Trust considers acceptable, improvements are being made and we will continue to build on this momentum.

2C – Governance

Total number of trained case investigators	12
Total number of trained case managers	2
Total number of new concerns registered	9
Total number of concerns processes completed	4

Longest duration of concerns process of those open on 31 March	13 months
Median duration of concerns processes closed	4 months
Total number of doctors excluded/suspended	2
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation (excludes doctors in training)	338
Number of new employment checks completed before commencement of employment	338

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

General review of actions since last Board report:	
All actions from the 2022/23 report have been completed in year.	
Actions for next year:	
Good medical practice 2024 implementation	• Planned implementation from April 2025. • Appraisal Leads meeting planned. The GMC and SARD support team will be in attendance to upskill the appraisers. • Communications plan to all appraisers and connected doctors scheduled for Q4 to ensure preparations made for the change.
Course feedback: move to an online questionnaire	• Appraisal leads working with the training team.
Completed SARD domain descriptions review	• Update 'hints and tips' guidance for key sections of the appraisal template to encourage appraisees to include all relevant information. System updates to be published when the new appraisal form is rolled out in Q4.
Further improve non-compliance rates	• Implementation of bi-monthly report to care group appraisal leads. • Leads to then offer support and guidance to minimise missed appraisals.
Review improved reporting opportunities for governance and complaints	• Trust appraisal leads to explore options with the governance team.
Overall concluding comments:	
Two full appraisal cycles have now taken place via the electronic platform SARD, individual familiarity with the system has since increased engagement levels from connected doctors and great improvements in overall compliance levels. We plan to build on this momentum in the next appraisal cycle and the combined appraisals team are continuing to focus on process and system improvements. The electronic system allows both patient and multisource feedback to be gathered via a variety of methods which has resulted in improved response rates. Summary feedback reports can be produced and incorporated into individual appraisal portfolios and reviewed as part of the appraisal discussion. There continues to be a focus on quality appraisals, 85% of appraisees gave feedback and results demonstrated high levels of staff satisfaction in the process and doctors commented that they feel supported and motivated through discussions with appraisers. The expanded ASPAT exercise gave further assurance that appraisals were being carried out in line with national guidance and local policy. Appraiser numbers have continued to increase to support the expanding workforce and ensure that appraisals are readily accessible.	

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

Chief executive or chairman

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

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

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

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

University Hospital Southampton
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Report to the Trust Board of Directors				
Title:	**Safeguarding Annual Report 2023-24**			
Agenda item:	**5.13**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Danielle Honey, Named Nurse Safeguarding Children** **Corinne Miller, Named Nurse Safeguarding Adults** **Julie Davies, Named Safeguarding Midwife**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance X**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The safeguarding annual report summarises the key achievements and activity for 2023/2024 and highlights key areas of work for 2024/2025 for adult, child, and maternity safeguarding services within UHSFT. This includes the Paediatric Liaison Nursing Service (PLNS) and the MCA/DoLS Service. This year has seen a continued increase in activity across all services, excepting maternity safeguarding and PLNS although complexity has remained a feature across all services. The MCA/DoLS Service has now been in place for 2 years and there has been a sustained increase in the number of DoLS applications across the Trust alongside requests for support with complex MCA case management. Whilst reviewing safeguarding children training compliance, inconsistencies in the mapping to levels have been identified, raising concerns that the data may not be accurate. A full review of the mapping and associated data cleanse is underway to enable an accurate picture to be gained and plans to improve compliance developed. All teams have continued to adapt their collaborative working approaches both within UHSFT and across the multi-agency partnership in order to meet service demand. The report has been written to provide high level assurance as to the safeguarding arrangements within UHSFT.			
Response to the issue:	Members of the Trust Board are asked if the report gives the required assurance around UHSFT adult, child, and maternity safeguarding services. Summary of key points within the report include: • Progress updates and what we have achieved since the last annual report. • Activity data and analysis • Feedback received by the team from within UHSFT and across the multi-agency partnership.			

	• A patient story encompassing input from adult, child, and maternity safeguarding services. • Key areas of work for 2024/25
Implications: (Clinical, Organisational, Governance, Legal?)	The safeguarding report outlines the strategic and operational work of the safeguarding team which encompasses clinical, organisational and governance implications.
Risks: (Top 3) of carrying out the change / or not:	Not applicable.
Summary: Conclusion and/or recommendation	The safeguarding annual report has highlighted the safeguarding team's activity for 2023/24. From a strategic and operational perspective this is pivotal to ensure we continue to improve outcomes for children and adults. The key areas of work for 2024/25 are outlined at the end of the report and align with the 2022-2025 Safeguarding Strategy standards.

Safeguarding Annual Report 2023/2024

Dannie Honey, Named Nurse Safeguarding Children

Corinne Miller, Named Nurse Safeguarding Adults

Julie Davies, Named Midwife Safeguarding

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Midwife

Introduction

This year's Safeguarding Annual Report summarises the key achievements, areas of work and activity for 2023/2024 for Adults, Children and Maternity Safeguarding within UHSFT. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT.

Throughout the past year, the Safeguarding Team have continued to adapt and innovate to provide a robust, responsive and supportive service to both UHSFT colleagues and multi-agency partners to safeguard the most vulnerable patients who come into our care and their families. We have continued to utilise a hybrid method of working across the team but have maintained a daily onsite presence during core working hours.

This year has seen a further increase in activity, staff sickness and staff resignations and the Named Nurse for Safeguarding Children post has been vacant for a significant amount of time. Although positive progress has been made with most work streams, capacity and demand has meant that operational case management has needed to be the priority, meaning some workstreams have been paused at points throughout the year. This will be reflected in this year's report.

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Progress updates – Safeguarding

Last year (22/23) we said we would;	We have achieved (23/24);
Review and refinement of the joint Safeguarding Supervision Policy	The updated Safeguarding Supervision Policy has been rewritten to take an integrated approach across adult/child/maternity services and has been approved. The safeguarding teams continue to offer responsive supervision for staff who require additional advice and support via ward rounds and telephone advice lines. The safeguarding teams provide drop-in supervision sessions in clinical areas across the Trust where there is higher safeguarding acuity. In addition, monthly supervision for NEST teams is provided by maternity safeguarding. The Deputy Named Nurse is part of a working group to embed the newly launched ICB Adult Safeguarding Supervision Strategy across the local area. Supervisees are now able to directly record supervision sessions on the VLE platform and the Safeguarding Supervision Conversations form on Edocs in patients' records.
Continue to embed the MCA as everyday business Trust-wide.	The Lead Practitioner has worked to raise the profile of the Mental Capacity Act across the Trust as everyday business, with a focus on supporting frontline staff with legal requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and reviewing MCA training provision across the Trust. The MCA Champions network has grown to a cohort of 35 staff who have a special interest in the practical application of the MCA. A quarterly MCA newsletter has been established and is disseminated across the Trust.
As an action from the Safeguarding Strategy , to develop a Safeguarding Training Strategy	The UHS Safeguarding Training Strategy has been developed in relation to Safeguarding Adults, Children, Maternity and the Mental Capacity Act. The Strategy has been through the approval process and work has commenced to embed this across the Trust. The Safeguarding Training Strategy takes an integrated and blended approach to safeguarding training and takes a Trauma Informed and Think Family Approach. The overarching Safeguarding Strategy focuses on key priorities, aligning this with the Trust Values. Date of review 2025.
To further develop domestic abuse processes in collaboration with Maternity, ED, all adult areas, Children's Hospital and well-being lead which encompasses support for both our patients and staff	Domestic Abuse Working Group has been paused due to operational pressures Trust-wide. A new integrated Domestic Abuse Policy is in draft, with an anticipated approval date in Q2 2024. A domestic abuse awareness day was hosted by maternity safeguarding and included representatives from local domestic abuse services.

Safeguarding Policy Updates

Safeguarding Policies approved 2023-24

- Safeguarding Adults Policy
- DNA/WNB Adults at Risk Policy
- Allegations Management (Adults at Risk) Policy
- Safeguarding Supervision Policy
- Substance Misuse in Pregnancy Policy

Safeguarding Policies under review 2024-25

- FGM Policy
- Domestic Abuse Policy
- Management of Risk Posed by Offenders Subject to Multi-Agency Public Protection Arrangements (MAPPA) Whilst on UHSFT Premises (New Policy document)
- Mental Capacity Act and DoLS Policy
- Safeguarding Children in Maternity Policy

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Adults Safeguarding

Adults Safeguarding

- **Level 3 Safeguarding Adult Training.** Level 3 training is available to staff via the e-learning for health module which is accessible via VLE. In line with the UHS Safeguarding Training Strategy, Level 3 Safeguarding Adult training will be launched across the Trust in July 2024 and role profiling is underway in collaboration with Education Leads.

- **MSP Audit**. Completion of an audit on Making Safeguarding Personal looking at whether and how patient's views and wishes are captured at the point of a safeguarding referral. Following this work, recommendations have been identified to improve the quality of safeguarding referrals and work is underway to embed these.

- **Working pattern.** On-site presence of the Adult Safeguarding Team during core hours has continued for most of the working week . This has enabled the team to provide a timely response when immediate and complex safeguarding concerns are identified and to complete regular visits to clinical areas.

- **Newsletter.** Publication of Safeguarding Adults Matter newsletter has continued and is widely disseminated across the Trust. The newsletter contains information on both local and national issues and learning from Safeguarding Adult Reviews. Due to operational pressures, only 3 issues have been published this year.

- **Safeguarding Supervision.** Weekly drop-in safeguarding supervision session continues to be well attended.

- **ICB Adult Safeguarding Supervision Strategy.** The Deputy Named Nurse Safeguarding has been representing UHS and is supporting with rolling out this Strategy Trust-wide.

- **Statutory Safeguarding Activity.** Continued engagement with the Local Safeguarding Adults Boards and participation in Statutory Reviews and Practitioner Workshops.

Adults Safeguarding

- **Safeguarding Adult Engagement Group.** Due to operational pressures, meetings were paused earlier in the year. It is intended to relaunch bi-monthly meetings during the next year.

- **Review of Adult Safeguarding Concerns Pathway.** Work is underway with neighbouring Local Authorities (SCC and HCC) to review the process for raising safeguarding concerns within UHS, how these concerns are reviewed by the UHS Safeguarding team and the format of the daily triage meetings with the Local Authority. This work is ongoing at time of writing, and it is anticipated that any process changes will be made during Q2 2024-25.

- **Protection Planning.** A review is underway to look at current protection planning arrangements when an adult at risk is admitted to UHS. Consultations have taken place with different staff groups across UHS in order that the views of frontline practitioners can be built into the revised document.

- **UHS Team of the Year (non-clinical).** The Adult Safeguarding Team were honoured to receive the UHS Champions Team of the Year award.

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Children's Safeguarding

Children's Safeguarding

- **Audits.** Keeping Children Safe Section 11 Children Act (2004) was completed and submitted in August 2023. The audit is designed to provide a multi-agency benchmark using a common tool and language as to how agencies are currently meeting their safeguarding requirements. This provides a more consistent approach to considering safeguarding arrangements across Hampshire, Isle of Wight, Portsmouth & Southampton (HIPS). These self-assessments are repeated once every two years. The audit highlighted no specific areas of concern or gaps.
- The HSCP multi-agency audit – Vulnerable Children in Disrupted Education was completed in August 2023.
- HSCP multi-agency audit – Child Sexual Abuse was completed in March 2024.
- Due to operational pressures, completion of the Safeguarding Proforma audit, including the voice of the child has been delayed. The recommendations and actions will be shared at Divisional Governance meetings and the Safeguarding Governance Steering Group following completion.

- **L3 Safeguarding Children Training.** Due to operational pressures throughout the Trust, multiple planned training sessions have had to be cancelled at short notice. This is reflected in the drop in L3 safeguarding children training compliance trust wide.

- **Technology.** Migration of Symphony to Miya in September 2024. Work is underway with IT and community public health colleagues to look at how the new system can be used to most effectively disseminate information to public health teams in respect of children where there is an identified safeguarding concern or where parents/carers present to ED in circumstances which may impact on the children in their care.

- **Newsletters.** Due to staffing shortages and operational pressures, only 2 newsletters were published this year. Newsletters are disseminated across the Children's Hospital and are available to all staff via Staffnet.

Children's Safeguarding

- **Safeguarding Champions.** This workstream has been paused due to operational pressures. Recruitment of new champions and content and structure of champions meetings is under review with an anticipated re-start date of September 2024.

- **Safeguarding Supervision.** The safeguarding nurses have continued to provide safeguarding supervision/case discussion for identified teams (Obesity, Diabetes, Neurology) and participate in Peer Review.

- **Safeguarding Ward Rounds.** Despite staffing challenges within the team, face-to-face ward rounds have continued 2-3 weekly with telephone contact being made on other days. Due to operational pressures within ED, regular drop-in sessions were paused in July 2023. The duty safeguarding nurse attends daily child health huddle when on site and a child health Matron joins the safeguarding huddle weekly, thus strengthening oversight and working relationships with active safeguarding cases.

- **Leadership.** The Children's Safeguarding team have experienced an unsettled year due to multiple unplanned changes in leadership and staff sickness which has impacted on service and work stream delivery. Although the team have continued to deliver an operational service as usual, the appointment of the new Named Nurse means that previously halted work streams are now being reviewed and actioned.

Maternity and Neonatal Safeguarding

- **Maternity Safeguarding Team Structure:** The Named Midwife for Safeguarding Children is now based alongside the corporate trust team and is currently jointly managed by the Director of Midwifery and Deputy Director of Nursing. There are further plans to integrate the remaining maternity safeguarding team with the corporate team to align with the Trusts 'Think Family' approach. We are currently reviewing how this can be managed but continue to maintain visibility and support for maternity and neonatal services. The changes implemented in July 2023 to move towards a framework of using supervision to support the Nest Midwifery teams to manage their cases has received positive feedback. The maternity safeguarding team have shifted the focus to support to complex cases and cases requiring escalation. We continue to monitor this through audit, monitoring cases and supervision
- **Safeguarding Supervision.** We are offering a blended approach to supervision for different teams and individuals and includes a monthly safeguarding drop- in session available to all UHSFT maternity staff and safeguarding supervision to neonatal unit staff.
- **HIPS Unborn and Newborn Protocol**: As recorded in the 2023 annual report the Unborn Protocol is due to be reviewed by HIPS. UHSFT have raised the need for a review with our partner agencies as we identify there are some challenges with the current Unborn Protocol in terms of information sharing, mental capacity of parents which impacts on the unborn and concealed pregnancy or non-engagement in pregnancy.
- **Level 3 training.** We have achieved a 90 % compliance in December 2023 (see L3 training compliance)
- **Hope Boxes.** The HOPE Boxes are designed to help mothers capture important memories of their time with their baby prior to separation and importantly to promote the ongoing connection between mother and baby. The boxes have been well received by most parents who are active participants in completing the boxes with midwives. We have currently secured some further funding for this valuable project and are now supporting other trusts across the local LMS to receive this service

Maternity and Neonatal Safeguarding

- **Maternal Mental Health service and trauma informed care.** We continue to work closely with the perinatal mental health midwife and maternal mental health service to ensure that trauma informed care is embedded into our practice, education plans. We know that supporting maternity practitioners to understand how trauma can impact on parental behaviour is important to allow them to better understand and support families in their transition to parenthood and to prevent re-traumatising parents to be and their families. The perinatal mental health service has continued to grow and develop to ensure birthing people across Southampton and New Forest area have access to the most appropriate mental health service. Midwives and maternity support workers have continued with their education and development particularly around asking about mental health, using the perinatal pathways screening tool and referring to the appropriate service.
- **Safeguarding Newsletters.** We offer quarterly newsletters to maternity and neonatal colleagues. We use this to highlight topics in depth and to support learning from safeguarding reviews, media topics and to provide signposting to services and information. In December 2023, we compiled a ‘Support for families 'directory which was sent to maternity staff. This was a combination of support services offered (voluntary and statutory) for parents within Southampton to enable midwives to signpost parents for support.
- **Ligature audit.** Completed May 2023 for maternity which demonstrated good compliance with Trust policies.

Mental Capacity Team

Mental Capacity Team

- **MCA Champions Network.** The network has grown over the last year and consists of multi-disciplinary practitioners from across the Trust who meet 8 weekly. The meetings are chaired by the Lead Practitioner and are an opportunity for MCA Champions to make positive links across the Trust, learn from each other and access specialist support from the MCA team.
- **Monthly drop-in sessions.** These are run quarterly in conjunction with specialist teams including Learning Disability and Autism and Delirium and Dementia teams.
- **Lead practitioner BIA accreditation.** After undertaking additional specialist study, the Lead Practitioner has been awarded BIA accreditation. She now has advanced skills and knowledge to support with complex MCA cases and decision making.
- **DoLS focus.** A focus on DoLS across the Trust and daily ward rounds in core working hours has seen a significant and sustained rise in DoLS applications since the Lead Practitioner has been in post.
- **Audits.** IMCA and BI decision-making audits have been completed in line with contract requirements.
- **DoLS Spot Audits.** Over the next year, weekly audits will commence with a focus on a different ward each week. The audit involves a review of patient records and identification of potential gaps where DoLS applications should have been considered but where patients are not detained at UHS under a legal framework. It is anticipated that this work will support identification of inpatient areas where there may be a gap in recognising when DoLS applications should be considered. Targeted training and support can then be offered to clinical staff.

Transition Safeguarding

- **Service impact** transition service has been regularly covering absence in the SG Adults, SG Children and Paediatric Liaison teams since July 2023. This has impacted on the Transition service workstreams.

- **Onsite ward rounds** have continued within scope of covering other parts of the safeguarding service. These include visits to wards where there are safeguarding concerns/cases. This is to gain updates for cases, provide safeguarding updates to the ward, offer support, education and ad hoc safeguarding supervision to staff, give relevant information leaflets and forms and speak directly to the children/young people. Visits/contact to adult areas where under 18s (children) are admitted are prioritised to offer guidance, education and support to the ward as the patient is still legally a child. Support is also provided to clinical staff with raising any new safeguarding concerns to the UHS Apps system.

- **Under 18s checklist** written by Transition Service lead is now on Inpatient Noting (UHS Apps).

- **Transition specific training** written and implemented additional training, with PowerPoint package, about Under 18s in adult areas across UHS. This has been delivered across several specialities at UHS.

- **Meeting attendance** Adult High Intensity Service User (HISU) group, Childrens HISU group, Adults and Children Safeguarding meetings, MDTs, MARMs, Delayed Discharge Meetings, Professionals meetings, Patient Safety meetings, CAMHS/In-Reach CAMHS daily huddle.

- **Transition in-patient review** continue to review the daily 16- & 17-year-old inpatient and the 18–25-year-old inpatient checklist. Support ward areas as appropriate.

- **Promotion of transitional safeguarding service** contacts forged with other corporate safeguarding teams and transition nurse specialist has spoken at ECHO and cardiac conferences.

Activity – Safeguarding Adults

Safeguarding Referrals = **2521 – 23/24** (4% increase from 22/23 -2414)

AER's screened: 2018 (67% increase from 22/23 - 1204)

Section 42 enquiries = 331 (351 22/33)

Prevent referrals: **3** (1 22/23)

Safe and Well Referrals = **3**

DoLS = **1041 – 23/24** (27% increase from 22/23 - 755)

Number of Court of Protection cases supported: 1 with support given to **4** further cases where applications were considered.

Total number of SAMA cases: 72 (44% increase from 22/23 - 50)

Complaints screened: 5 (decrease from 22/23 - 6)

Training delivered; adult sessions = 11 / joint adult & child sessions = **9**

LeDeR Reviews Deaths reviewed: **34**

Statutory Activity: 24 scoping's for consideration of SARs. Panel representation for 4 SARs.

Analysis of Safeguarding Adults data

- The **4%** increase in referrals into the Safeguarding Adults team reflects the ongoing high acuity of the operational workload. The referral numbers, however, do not recognise the complexity of many of the referrals which are multi-faceted, and the time taken to manage these complex cases in conjunction with Local Authority and police colleagues. Although the increase is less than the previous year (13%) there is still an ongoing impact on service delivery. It is anticipated that the new safeguarding concern review process which will come into effect during the next year, the launch of L3 safeguarding adults training and the implementation of the revised Pressure Ulcer Protocol, will result in a reduction in safeguarding referrals Trust-wide.

- For 2023/24, **331** referrals to the Safeguarding Adults team met statutory safeguarding criteria, a slight decrease from the previous year. Where the Trust is caused to undertake a S42 enquiry by the Local Authority, this is sent to the relevant clinical area for response, in order that information and learning can be disseminated effectively.

- There has been a **27%** increase in applications relating to DoLS referrals. There remains a delay, however, in authorisation by the Supervisory Body which is recognised and reflected on the Trust's Risk Register. This is a nationwide issue since the Cheshire West ruling in 2014 whereby the "acid test" provided additional clarity as to what constitutes a deprivation of liberty. The daily presence of the MCA team in clinical areas has potentially increased the recognition of DoLS across the UHSFT footprint.

- There has been a **44%** increase in SAMA referrals (concerns in relation to members of staff who are in a position of trust) in the past year. The new Allegations Management (Adults at Risk) Policy was launched this year and communications about this Trust wide may have led to the increase in referrals. This increase in referrals has had a significant impact on the safeguarding workload where collaboration with HR, Temporary Resourcing, Patient Safety Team and the Local Authority is required to review risks and decide on required actions.

- The number of complaints screened and responded to by the Safeguarding Adults Team was at a similar level to the preceding year.

Analysis of Safeguarding Adults data continued

- AER's screened by the Safeguarding Adults Team allow for a Safeguarding lens to be cast over incidents reported within the Trust. This year **2018** reports were screened, representing an increase of **67%** from last year. **403** of these reports were subsequently assessed to require a safeguarding referral and were duly forwarded to the local authority. **242** were in relation to pressure ulcers. Following the launch of the new national guidance in relation to pressure ulcers and adult safeguarding in March 2024, it is anticipated that this number will fall significantly next year.

- The safeguarding and LDA teams reviewed **34** deaths as part of the internal LeDeR process this year. The now established Teams module to centralise LeDeR activity enables data in relation to themes and trends to be compiled and analysed more comprehensively and allows for targeted dissemination of learning across the Trust.

- **20** training sessions were completed this year, both solely in relation to safeguarding adults and alongside Safeguarding Childrens Team colleagues, thus promoting the Family Approach ethos. **8** sessions were cancelled due to poor staff uptake and safeguarding team availability.

- **3** Prevent referrals were made this year. 1 referral was made the previous year. Although a small rise, it is possible that this was due to an overall increase in staff training compliance in relation to Prevent awareness and the bedding in of the revised Prevent policy. Prevent data is collated quarterly and returned to the NHS Data Collection team on behalf of the Trust by the Safeguarding Adults team.

- **3** Safe and Well referrals were recorded as being made this year by the Safeguarding team however the number is likely to be higher. The Safeguarding Adults team triage referrals alongside Local Authority colleagues who will also raise referrals, and this number does not capture referrals directly raised by the Local Authority. Safe and Well referrals are routinely discussed where concerns around self-neglect are raised. Safe and Well referrals raised elsewhere in the Trust are not included in the safeguarding data return.

Activity – Transition Safeguarding

Safeguarding Referrals = **346** (16&17yr olds) + **157** (18 to 25yr olds) = **503** (524 in 22/23)

Training delivered = within training figures (topic specific course establishes and delivered)

16 & 17yr old inpatients at UHS per day = average of **15-20 per day** (**4** on adult wards, **1-2** cases alerted to SG team via this list only (i.e. not captured via Apex referral or ISF)

18–25-year-old inpatients – average of **50-60 daily** (0-2 known to SG team)

0 Scoping's completed for Transition Safeguarding age group (2 in 2022/23)

AERs, Complaints, Section 42, 47 enquiries: contained within children and adults safeguarding figures

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Analysis of Transition Safeguarding Data

There has been a **4%** decrease in referral figures from the previous year, however, there has been an increase in cases relating to mental health.

The referral numbers do not reflect the complexity of many of the referrals. They are multi-faceted and take time to manage, keep the young person safe, keep UHS staff safe, and work with wider multi-agency teams and organisations

Safeguarding concerns for this age group are frequently complex in nature due to the still developing brain, emerging MH issues, ACEs, hormones, individual and societal expectation, contextual safeguarding (may or may not be known), complex or lack of support networks, current risk and/or experience of abuse.

Legislation can be unclear for this age, particularly in relation to mental capacity, and differs either side of the 18th birthday, the risk and experience, however, does not differ.

Lack of recognition of under 18s in adult areas may lead to a lack of Professional Curiosity or knowledge /recognition of Safeguarding concerns. This may lead to under reporting.

Activity – Safeguarding Children

23/24 Safeguarding referrals to UHSFT Safeguarding Children Team =1252 (28% increase from 976 in 2022/23). The main reasons for referral were for children with a mental health issue -**160** (282 in 2022/23) , Parent an inpatient – **202** (70 in 2022/23) , Actual harm – **110** (100 in 2022/23), Suspected harm - **120** (100 in 2022/23)

Telephone/email advice = 581 (291 in 2022/23).

Serious Incident reporting = **49** (38 in 2022/23) completed for unexpected child deaths, non-accidental injury, complex cases and distributed to key leads within the organisation.

AER's screened: 190 (106 in 22/23)

Statutory Activity

- **10** (30 in 22/23) requests for statutory scoping's for Child Safeguarding Practice Reviews. These requests are predominately from Southampton, Hampshire and Portsmouth Safeguarding Children Partnerships
- Of the 10 requests submitted, the Safeguarding Children Team have contributed to **8** of these, due to the child/sibling/parents receiving care at UHSFT. This is one more from 7 in 2022/23. All requests must be reviewed, completed and submitted whether the child/siblings/parents have had contact with UHSFT or not.

Published Child Safeguarding Practice Reviews

4 Reviews were published in 2023/24 from Hampshire, Portsmouth and Southampton Safeguarding Children Partnerships . Any reports where UHSFT are not directly involved are reviewed for any transferable learning. Children and Maternity Safeguarding are required to update the Partnerships on a quarterly basis on all the ongoing and completed reviews; progress needs to be evidenced as to how learning improvements are being progressed within the organisation.

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Activity – Safeguarding Children

Total number of LADO cases = 23 This is lower than 2022/23 **(27)**

Paediatric Liaison Nurse Specialist (PLNS) Team
Triaged **5564** Information sharing forms (ISF) in 2023/24. This represents a 10% decrease from 6184 forms completed in 2022/23.

Other Specific ISF data related to children
Deliberate self-harm 2023/24 -**721 (** 2022/23 -879)
Drugs and Alcohol 2023/24 -**175** (2022/23-154)
Assaults 2023/24- **183** (2022/23- 197)

NNU reports The Princess Anne Neonatal Unit (NNU) is one of the largest units in the country caring for up to 23 intensive and high dependency beds and 14 special care cots; The PLNS Team have been responsible for disseminating 1441 NNU Reports (new admissions and updates) in 2023/24 a slight decrease from 1456 in 2022/23

Safeguarding Children Training Level 3 –
24 sessions delivered (37 sessions delivered in 22/23)This includes both planned and bespoke training. A further **16** sessions were cancelled due to low numbers and safeguarding team availability due to long-term sickness.

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Summary and Analysis of Safeguarding Children data

- **Safeguarding referrals to UHSFT Safeguarding Children Team-** there is a **28%** increase from the previous year. The Safeguarding Children team have experienced significant long-term sickness and staff vacancy this year and there is potential that staff have raised a safeguarding referral due to being unable to access an immediate response for advice from the safeguarding team. The highest reason for referrals to the UHSFT Safeguarding Children Team was children with a mental health issue, this is consistent with 2022/23. This year the 2nd highest reason for referrals was children who were assessed to be at risk of actual harm and then suspected harm. The referrals require strong collaboration with the UHSFT Children's Hospital, including CAMHS, Adult and Maternity Safeguarding Teams, multiagency partnership working with social services and police with many cases leading to meetings to put a plan in place to safeguard the child.
    - There are clear pathways which support staff to assess whether a referral to the Safeguarding Children Team is required.
    - As per pathway, all children admitted to UHSFT with a mental health concern should be referred to the team.
    - All children who are 16/17 years and admitted to an adult area, are reviewed daily by the Safeguarding Children Team/Transition Nurse to ensure no further actions are needed to safeguard the child.
    - Information sharing forms (ISF) which are triaged the next working day, trigger referrals to the safeguarding team when the criteria is met as per ISF guidelines

- **Serious Incident forms** The return is higher than last year, possibly due to a team focus on reporting criteria, but does not fully capture the complexity of all referrals into the team.

- **Safeguarding meetings 327** meetings were held, either attended by or with input from the safeguarding children team. The meetings include, strategy meetings, professionals' meetings, discharge planning meetings amongst others. Going forwards, the safeguarding meetings dataset will be able to provide an acute record of the cases of complexity and future quarterly/annual reports will be able to review the data for further analysis.

Summary and Analysis of Safeguarding Children data continued

- **Telephone/email advice.** A 99% increase in requests for safeguarding advice has been recorded since the previous year. This is believed to be largely due to an increased focus on accurate recording of advice requests by the safeguarding children team. The rise in safeguarding referrals may also be linked to the increased requests for safeguarding advice

- **ISF's.** A 10% decrease has been recorded overall from the number of ISFs completed in 2022/23. An ISF is required when it is identified there are possible safeguarding concerns- this can range from a safety issue where a child swallows a tablet to a child presenting with suspected/actual harm.
  - It is a requirement that all children presenting to ED with a mental health concern should have an ISF completed.
  - An ISF is also required where an adult presents with a safeguarding concern (mental health/substance misuse/domestic abuse) where it is identified they are a parent/carer.
  - All 16/17-year-olds who attend ED are reviewed by the Paediatric Liaison Nurses to ensure no further actions are needed to safeguard the child

- **AERs reviewed.** AERs received by the safeguarding team in relation to children are routinely screened and concern forms are raised on the safeguarding children module on UHS Apps where required. This year has seen a 90% increase in the number of forms reviewed. Again, this could be attributed to the overall rise in the number of referrals in relation to safeguarding children.

- **Statutory Activity.** There has been a significant reduction in the number of scoping requests sent to the team. We will raise this with the Southampton and Hampshire LSCP as a point of discussion

Maternity safeguarding and data 2023/24 and comparisons with 2022/23 in percentages

Number of maternity safeguarding notifications raised **= 784 (- 2.74 % from 2022/23)**
Number of referrals sent to children social care **= 274 (+ 9.12%)**

Outcome of pre-birth plans

- Pre- birth plans commenced by children services (NB this includes 3rd party referrals e.g. police, health visiting) = **232**
- No further action = **137**
- Newborns on Child protection plan at birth = **61 (-1.61%)**
- Newborns on child in Need plan at birth = **93 (+ 22.36%)**
- Interim care orders at birth= **24 (-20.68%)**
- Newborn police protected at birth = **4 (+50%)**
- Number of cases that have been referred for child practice reviews which main focus was maternity related = **2 cases**

Number of:
Teenagers under the aged of 19 years **= 63 (-14.8 %)**
Teenagers under the age of 16 years **= 18 (+27.77%)**
Reported FGM cases **= 60 (+150%)**

Activity – Maternity safeguarding

Meeting activity

Number of meetings with children services attended by midwifery pre-birth (safeguarding or Nest Teams) **= 192**

Number of post birth meetings attended **= 15**

Number of additional professional meetings including JAR, strategy meetings, MARM, neonatal psych-social meetings substance misuse meetings and MDT meetings **= 133**

Total number of meetings covered by maternity services **= 330 meetings -**
239 of these meetings were supported by the maternity safeguarding team

Safeguarding Children Training Level 3 (including bespoke sessions delivered to NNU staff/ maternity staff**) = 26 sessions**

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Maternity Data Analysis

The maternity data is very consistent with 2022/23 in terms of activity numbers. This perhaps does not reflect the complexity of the cases that have been managed by the maternity safeguarding team. This is best demonstrated by the 50% increase in police protection plans. These cases are our most challenging in terms of MDT work and ensuring staff are feeling supported.

There has also been a significant increase in FGM reporting which illustrates the changing demographic of the maternity services within Southampton and New Forest area.

The level of meeting activity is a new data collection and demonstrates the large proportion of time spent supporting maternity and neonatal services to ensure that there is good professional liaison and pre-birth planning is in place.

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Training Compliance - Mandatory training report by Division Groups as of 04.04.24

	Div. A % (Targeted audience)	Div B % (Targeted audience)	Div C % (Targeted audience)	Div D % (Targeted audience)	Trust HQ % (Targeted audience)	Trust % (Targeted audience)	Trust Target
Safeguarding Adults level 1 (3yr)	**81.2%** 1549	**85.9%** 2610	**90.0%** 2624	**87.8%** 2269	**84.2%** 676	**86.6%** 9723	>85%
Safeguarding Adults level 2 (3yr)	**77.0%** 2091	**78.2%** 2592	**80.5%** 2179	**79.6%** 2229	**73.5%** 426	**78.6%** 9513	>85%
Mental Capacity Act level 1	**80.5%** 123	**82.9%** 256	**82.6%** 363	**76.1%** 685	**84.7%** 124	**79.8%** 1551	>85%
Mental Capacity Act level 2	**62.8%** 2257	**64.7%** 2555	**64.0%** 2239	**64.0%** 1557	**54.9%** 419	**63.5%** 9023	>85%
Prevent levels 1&2	**87.5%** 321	**90.4%** 1188	**91.4%** 1235	**86.4%** 404	**92.3%** 1431	**90.7%** 4575	>85%
Child Protection level 1	**77.7%** 188	**80.6%** 797	**90.9%** 569	**81.8%** 273	**85.6%** 1171	**84.4%** 2995	>85%
Child Protection level 2	**76.5%** 2186	**79.2%** 2096	**82.0%** 913	**79.5%** 2217	**74.3%** 397	**78.6%** 7806	>85%
Child Protection level 3	**37.7%** 146	**36.4%** 580	**52.8%** 1440	**39.3%** 56	**53.7%** 41	**47.3%** 2261	>85%

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Analysis of Training compliance

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

Children's training

The compliance for level one Safeguarding Children Training remains stable at 84.4% compared to 84.9% in 2022/23,For level Two Safeguarding Children Training has shown a slight increase and is now at 78.6 % compared to 76.3% in 2022/23

Level Three safeguarding children training

For Level Three Safeguarding Children Training, this is at 47.3% compared to 63.4% in 2022/23, indicating a significant decrease.

Level 3 requires a minimum of 12 hours of training to be completed within 3 years as per the Intercollegiate Document 2019. The current figures reflect the capacity/demand within the hospital for staff to complete the training requirements;

Actions to improve compliance have been initiated-

- Standing agenda item at the Safeguarding Governance Steering Group to ensure all actions to improve compliance are being reviewed
- Training levels per division communicated in safeguarding updates at Divisional Governance Meetings and support requested from clinical leaders in supporting staff to access training.
- Dates for training advertised for the year to enable managers to roster staff to be released for training
- 24 training sessions delivered , the majority planned sessions but some bespoke sessions delivered , for example, ICON/Safer sleep training for Childrens staff.
- Upgrade of the VLE training page to support staff to understand and complete training requirements
- Review of passporting for new staff joining the Trust, this is being led by the Education Leads
- Regular communications from the safeguarding team reminding staff of the training requirements
- The number of Level 3 safeguarding children training sessions available for staff to attend remained at 40 however low numbers, staff sickness and no response following requests for training resulted in the cancellation of 16 of these sessions.

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Analysis of Training Compliance

- **Maternity Safeguarding Level 3 Training** The maternity safeguarding Level 3 compliance is at 90% which is to be commended. There has been excellent team working and communications between the Maternity Safeguarding team and the Practice Education team. Alongside this we offer a full day of Level 3 safeguarding training for new starters and preceptors. The neonatal teams receive Level 3 training through the wider trust and are not included in our compliance figures. We do support the neonatal team to deliver some bespoke training for example confident conversations and new starter training for neonatal unit staff.
- **Adults Training** The compliance levels for Safeguarding Adults Levels One and Two training have remained stable at 86.6% and 78.6%, respectively. Health Education England Level 3 e-learning package is available via VLE but is not mandatory, hence figures are not included within this report. The UHS Safeguarding Training Strategy incorporates Level 3 Safeguarding Adults training which will form part of statutory and mandatory training for those staff profiled to complete Level 3 training going forwards. Level 3 Safeguarding Adults training will be launched across the Trust in July 2024.
- **MCA Training** MCA Levels One and Two compliance remains stable at 79.8% and 63.5%, respectively. The new Safeguarding Training Strategy incorporates Level 3 training and will offer a more robust training offer at Level 2. This will include an increased focus on Mental Capacity Assessments, Best Interest Decision Making and Deprivation of Liberty Safeguards.
- **Prevent** Compliance with Prevent Level 1 & 2 training remains stable at 90.7%.

Key areas of work for 2024/25

Joint

- Continued development of the joint Safeguarding Training Strategy
- Launch of new integrated Domestic Abuse Policy
- Further development and strengthening of links across maternity, children and adult safeguarding to deliver a cohesive safeguarding team Think Family approach
- Planning and launch of Safeguarding Event for UHS staff during Q3 2024.

Adult specific

- Launch of Level 3 safeguarding adult training.
- In partnership with SCC and HCC, launch of new review process for safeguarding adult concerns.
- Launch of new pressure ulcer/safeguarding adult's pathway in partnership with TVN and Patient Safety teams.
- Relaunch of Safeguarding Adults Engagement Group.

MCA Specific

- Review of MCA and DoLS Policy
- Audits: Best Interests decision making documentation (Q2), staff knowledge re role of IMCA (Q3), weekly DoLS spot audits for inpatient areas
- Launch of L3 MCA training

Transition specific

- Awareness raising of the Transition Safeguarding Service across the Trust footprint.
- Awareness raising re the specific needs of Under 18s in Adult areas who require a safeguarding response.

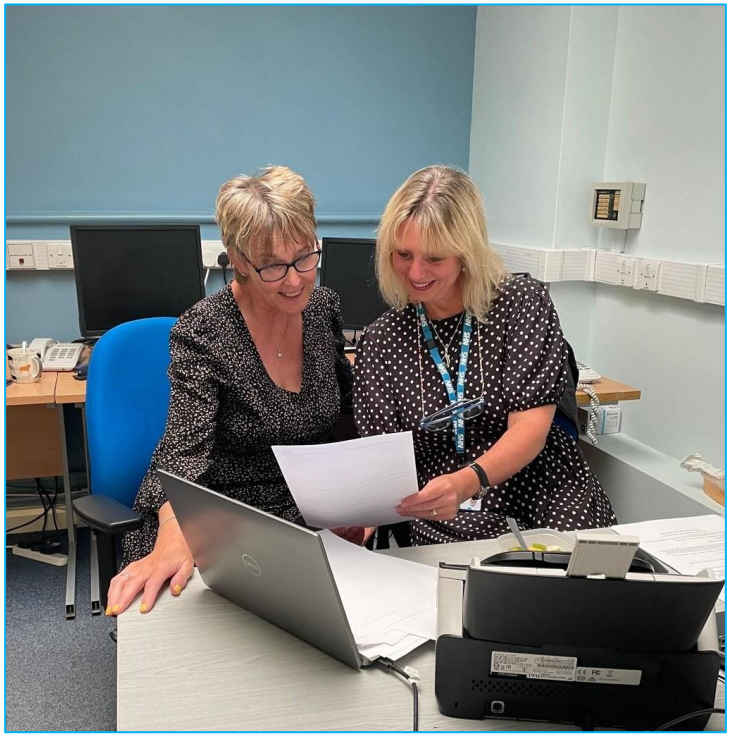
Key areas of work 2024/25 continued

Children specific

- Review of information sharing forms as part of ED migration to Miya
- Review and relaunch of Safeguarding Champions network
- Review and improvement of Level 3 safeguarding training offer and compliance
- Review of the Supervision offer and uptake within the Trust.
- Increasing the visibility and profile of Safeguarding within the Trust.

Maternity specific

- Completion of safe sleep and ICON audit
- Audit of Safeguarding referrals
- Introduction of Undetermined Mark Pathway in partnership with Solent and Southampton children services
- Review of Maternity Safeguarding Children in Maternity policy to include additional support around legal framework around the time of birth and police protection
- Move towards working closely with the corporate safeguarding team
- Strengthening support with safeguarding supervision



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Safeguarding Team Feedback (2023/24)

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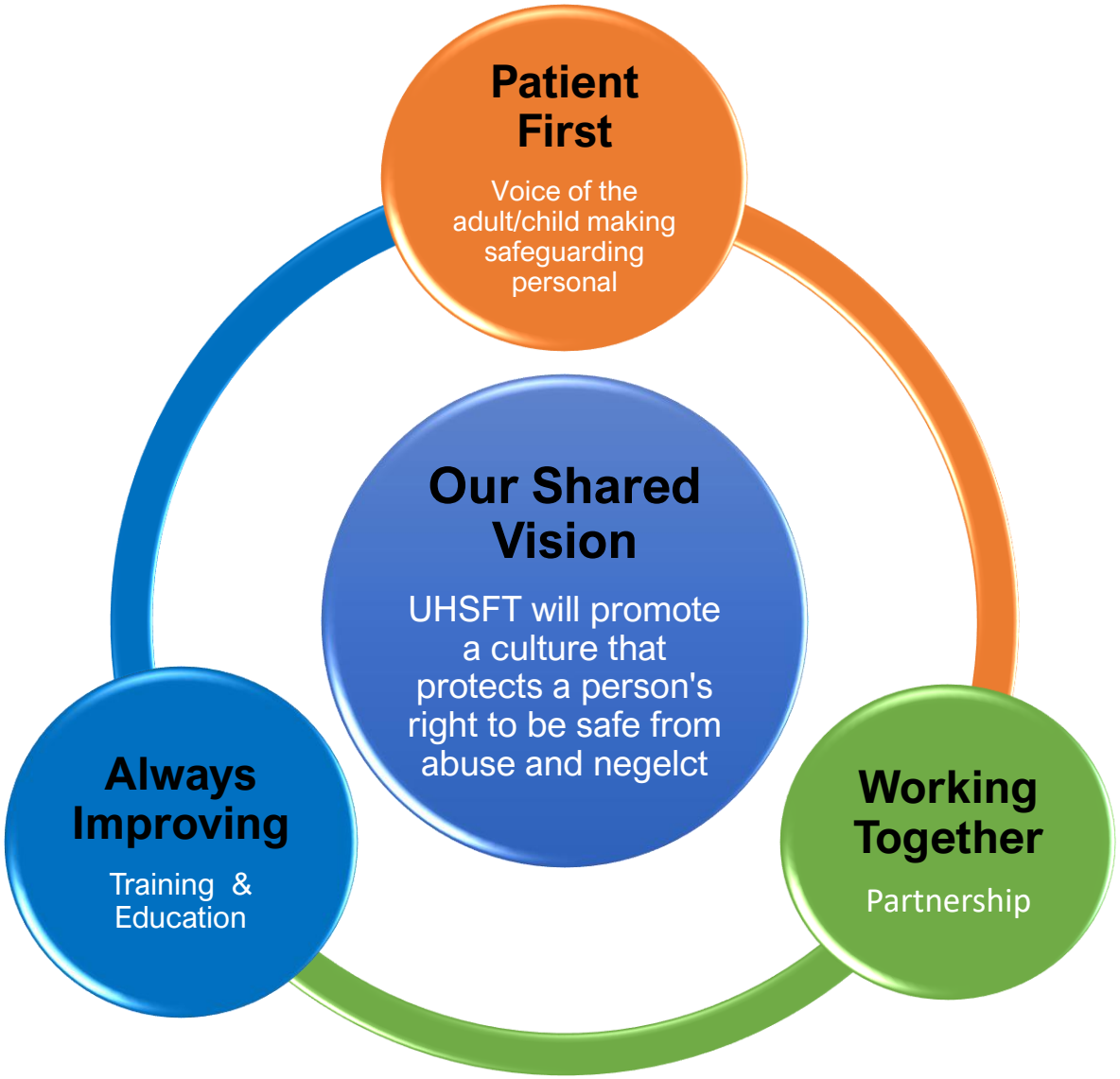
Patient and Family Story

- A 35-year-old woman presented to ED for treatment of a physical health concern with her 3 children aged 12,7 and 3 months and disclosed domestic abuse from the father of the older children. She received an assessment from the Vulnerable Adult Support Team and a referral to the UHS Safeguarding team was made. Information sharing forms were completed for all children.
- ED liaised with Children's Services and the family were accommodated in a hotel. They left the department prior to the mother receiving treatment.
- ED liaised with the police to encourage the mother to return for treatment. She re-presented and concern was noted regarding her behaviour and the level of care she was providing to the children in the department. A psychiatric assessment was completed.
- A discussion with paediatrics took place and a decision was made for the children to be seen and assessed. The mother's behaviour appeared to be escalating and a decision was taken to admit all 3 children as information and assurance that mother was able to provide safe care was not available. Mother agreed to this plan. Mother left the ward and despite stating she would return, did not come back to the hospital.
- The safeguarding team had liaised with the children's social workers who were in 2 different local authorities, and they travelled to the hospital with the children's fathers to support with returning the children home. Neither social worker had concerns about the fathers' care of the children, but all 3 children were on Child in Need plans due to concerns around mother's mental health.

Patient and Family Story continued

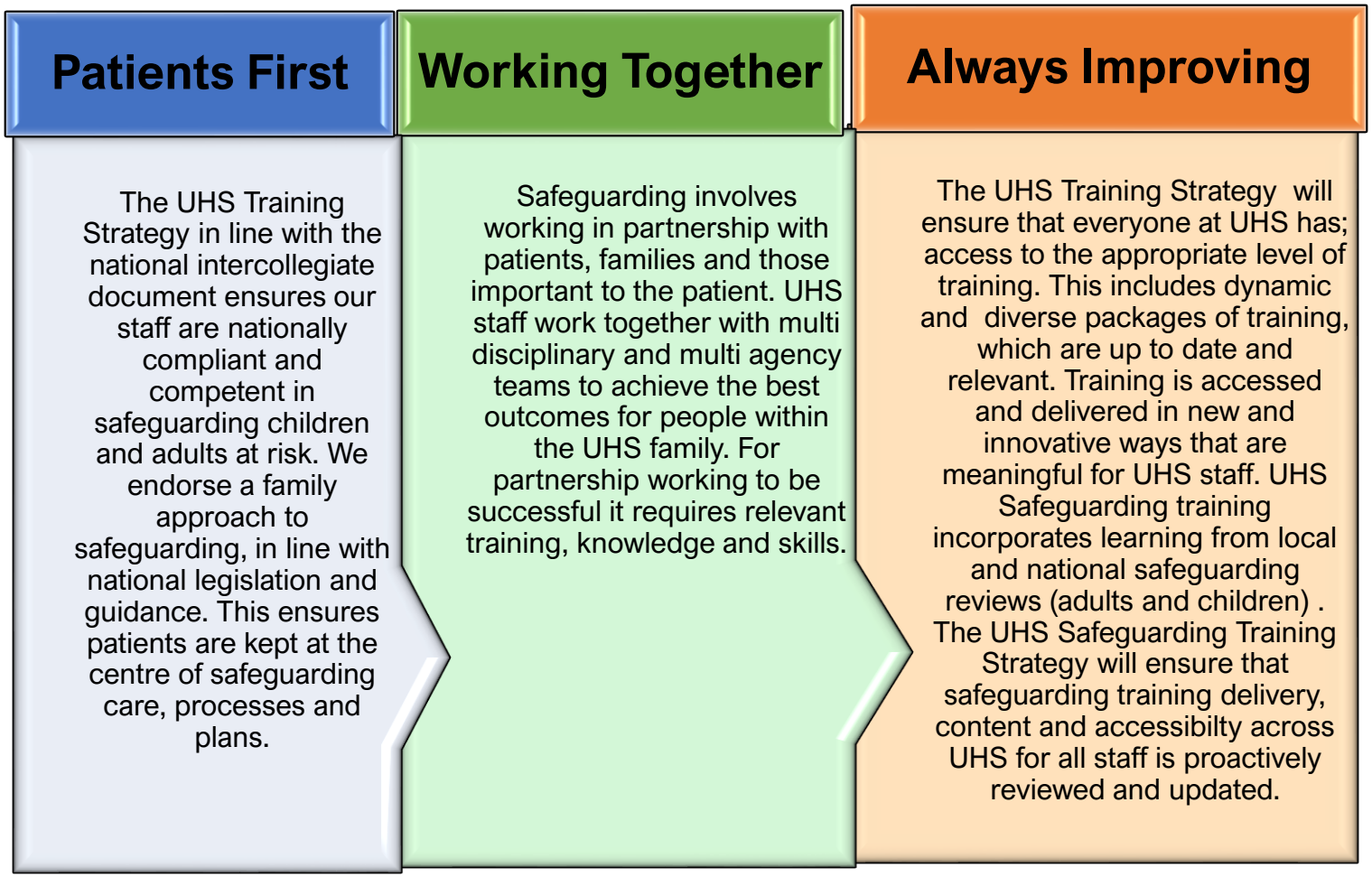
- As mother did not return to the ward despite saying that she would, the children returned home in the care of their fathers and allocated social workers.
- Sadly, their mother later presented to another local hospital in mental health crisis and was subsequently admitted to a mental health hospital for further treatment.
- At the time of mother's initial presentation to UHS, there was no reason to doubt her mental capacity. She was later seen by the liaison psychiatry team who did not identify any immediate risk and so there was no cause for her to be detained at UHS under a legal framework.
- Throughout the time the family were known to UHS, the children and adults safeguarding nurse specialists worked together to take a family approach to managing the concerns in respect of mother's disclosure of domestic abuse, her mental health and the impact on the children, as well as their sudden removal by mother to an area far from their home and which was unfamiliar to them.
- The safeguarding team liaised with 2 local authorities located a significant distance from Southampton and arranged for the social workers and fathers to be met at UHS and to be reunited with the children. They also advised and supported ED and ward staff who were caring directly for the family.
- This patient and family story demonstrates the importance of taking a family approach in managing safeguarding concerns. The strengths, risks and vulnerabilities for this family were interlinked and did not exist in isolation of each other and all factors needed to be considered together.

UHS Safeguarding Training Strategy



Introduction

Safeguarding is everyone's responsibility. It is an integral part of upholding people's human rights. The UHS Safeguarding Training Strategy sets out the standards for the UHS workforce to meet statutory requirements based on individual role profiles. This ensures UHS staff are equipped to recognise and respond to any safeguarding concerns they encounter in their daily work..



Purpose

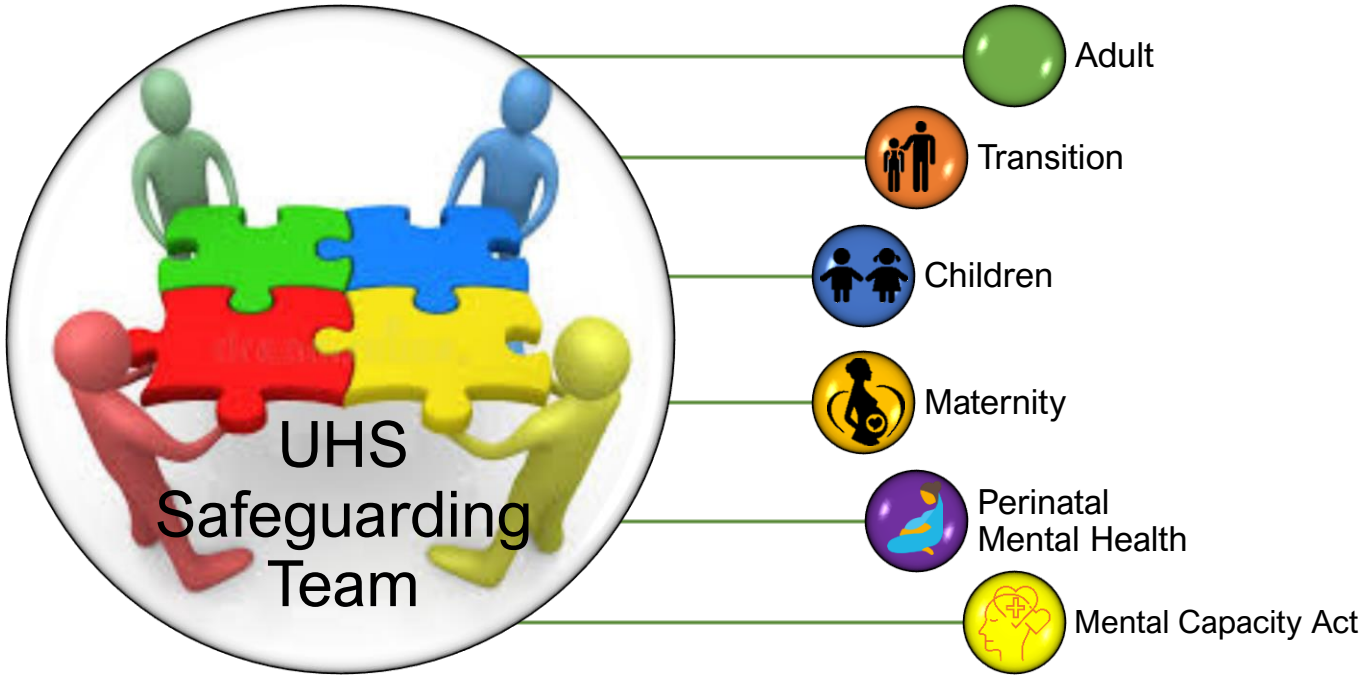
- To ensure people receive a proactive, compassionate, and safe response when safeguarding concerns are identified.
- To ensure a Think Family approach to safeguarding is embedded across the UHS workforce.
- To ensure staff are equipped to recognise and respond to safeguarding concerns in line with evidence based statutory expectations.
- To ensure staff are supported to achieve the safeguarding training level commensurate with their job role.
- To align the UHS safeguarding training offer with the requirements of the safeguarding intercollegiate document for adults and children

Delivery of the UHS Safeguarding Training Strategy

The UHS Safeguarding Training Strategy incorporates a Think Family approach with a variety of sessions offered.

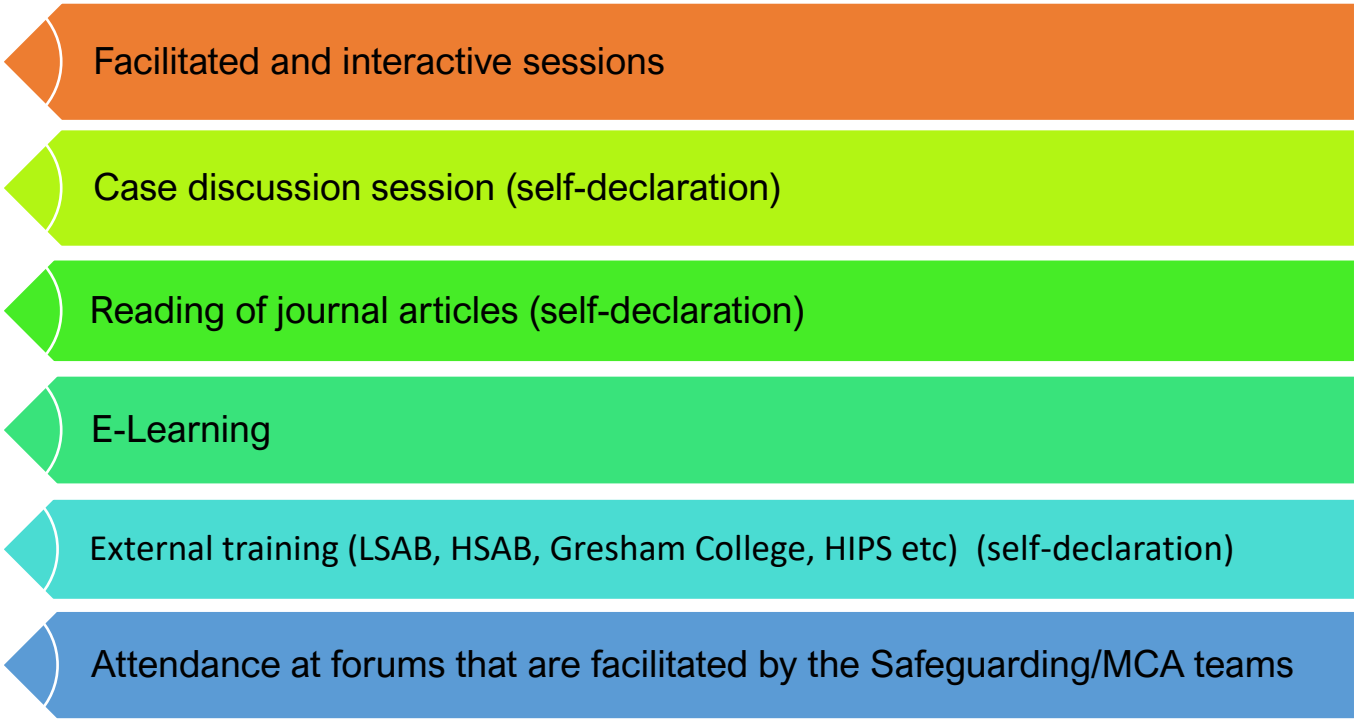
Safeguarding Training encompasses all disciplines and specialities across the Trust.

A blended and flexible learning approach to training is essential to ensure staff have access to the level of training required.

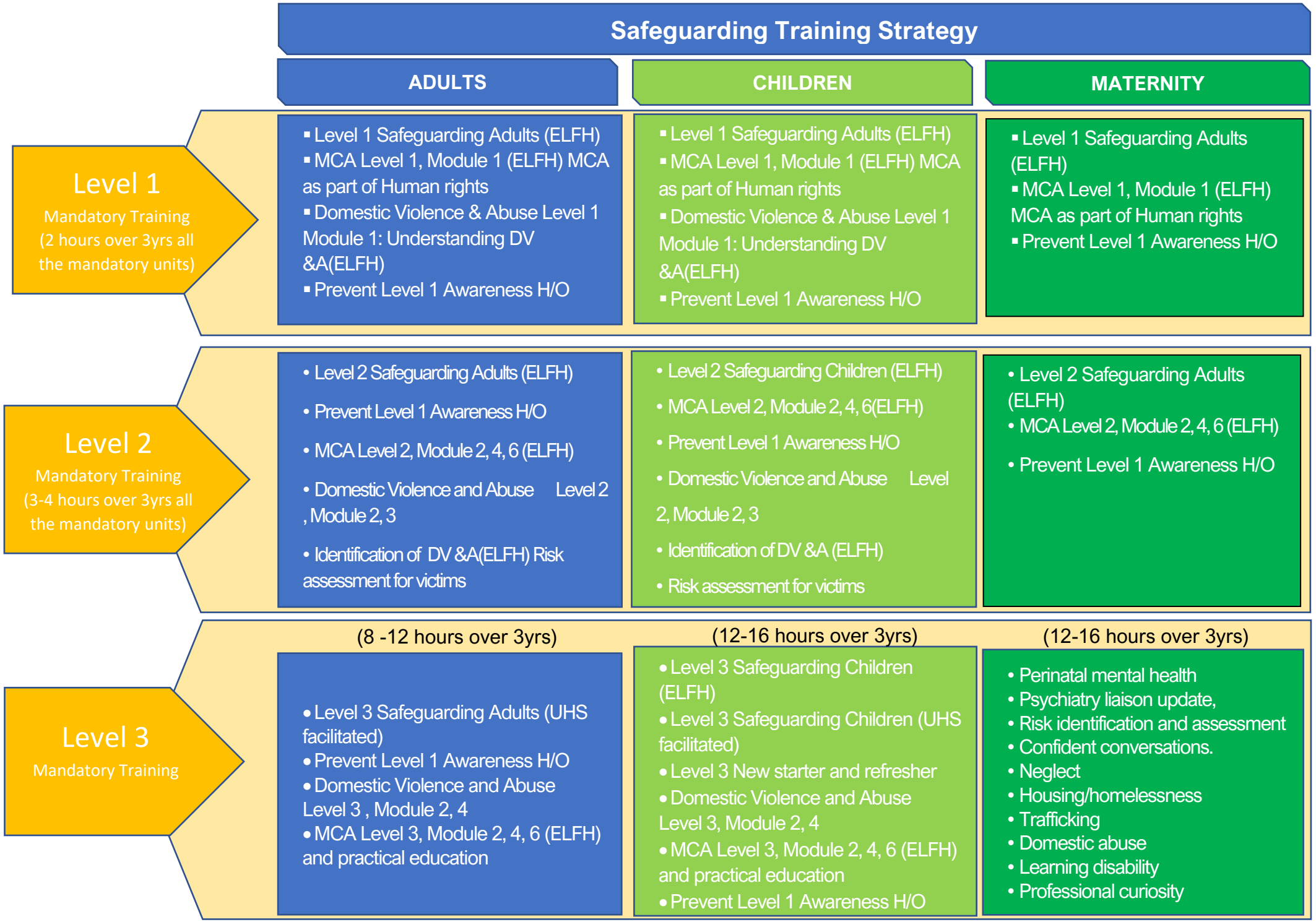


The Safeguarding Training Strategy sets out Statutory and Mandatory expectations utilising a variety of modules and a blended style of learning.

To reach required training compliance, staff are required to undertake a combination of mandatory modules and self-selected learning options.



Safeguarding Training Strategy



Level 3 compliance for Adults or Children; upon completion of the required mandatory units, select relevant courses and types of learning from the below sessions to achieve full compliance.

LUNCH AND LEARN

- Modern Slavery
- Self-Neglect
- ACEs (Adverse Childhood Events)
- ISF/APEX/MASH what's the difference, and which one to use
- Trauma Informed Practice
- Learning Disability
- Professional Curiosity
- 30 min Case based (Adults, Transition, Children)
- SCR/CSPR Case Discussion
- Under 18's in Adult Areas
- ICON and Safer Sleep
- Allegations Management/SAMA/LADO (for managers)
- Challenging Conversations with patients (adults and children) and families

ADULTS

- Suicide Awareness
- Journal Articles
- External Training Courses
- Case discussions

CHILDREN

- Emotional Abuse and Neglect
- Child with disabilities
- Looked After Children/Children in Care
- Child Exploitation
- MASH, Safeguarding Referrals and Record Keeping
- Safeguarding care of 16/17yr year old
- Child Sexual Abuse in the Family Environment
- Fabricated and Induce Illnesses
- External Training Courses
- Case Discussions
- Journal Articles

MATERNITY

- Making an Effective Childrens Service Referral (MASH/IARF)
- Bruising Protocol
- ICON
- Drugs and Alcohol
- FGM
- Child sexual exploitation
- Trafficking/Modern Slavery
- Learning from Serious Case Review

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

1. Purpose

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

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

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

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

2. Key updates

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

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

2.3. There have not been any changes to risk ratings, target risk ratings, or target dates since the committee last received this report.

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

2.5. Further planned development work to strengthen the assurance provided within the BAF, and how it is used, includes:

- Assessing the identified gaps in controls against the action plan to ensure that all identified gaps which are within the organisation's remit to mitigate are addressed. Where there are gaps which the organisation is unable to directly address (for example where wider system work is required) this gap in delivering mitigations should be articulated.
- Reviewing how assurances are articulated to focus on assurance rather than reassurance using a 1st/2nd (internal) 3rd (external) assurance framework.
- Ensuring that aspirations and actions are differentiated and that actions have target timeframes so that progress can be monitored.
- Further steps to the above 2 points could include assessment of assurances and actions against hierarchy pyramids to assess the strength of these.
- Introduction of an agenda annex for the Board and sub committees which maps individual agenda items to BAF risks, to promote risk-based discussions and decision making (Q3). Development of a dynamic risk assessment may support this where decisions are needed which may have a detrimental effect on one risk to the benefit of another.

UHS Board Assurance Framework (BAF)

Updated August 2024

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

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

1. Outstanding patient outcomes, safety, and experience

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

2. Pioneering research and innovation

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

3. World class people

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

4. Integrated networks and collaboration

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

5. Foundations for the future

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

Executive Summary

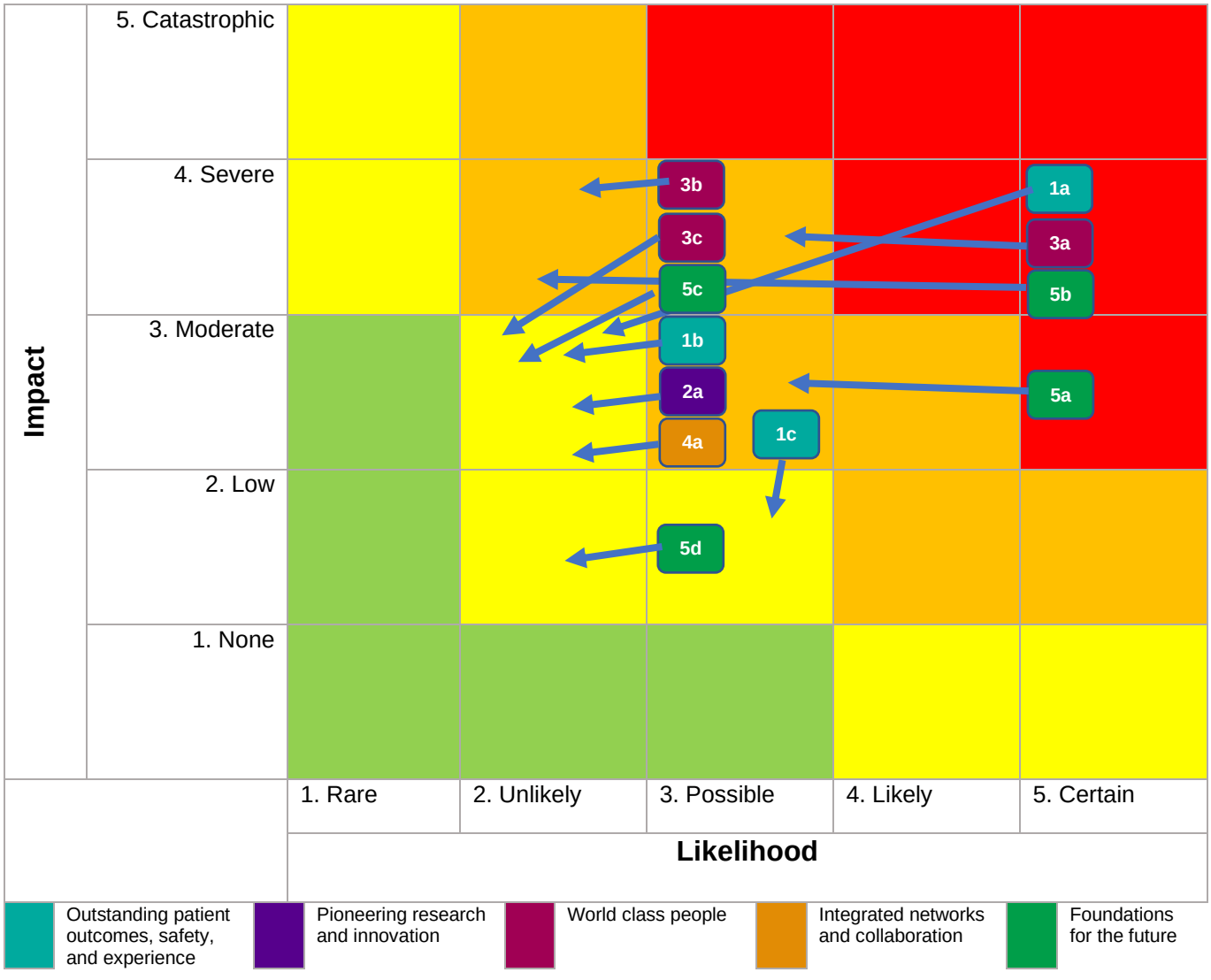
There are 4 critical strategic risks with a red risk rating above 15. These are:

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

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

Trajectory

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



Outstanding patient outcomes, safety, and experience

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

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

Cause	Risk	Effect
If there is inadequate capacity due to increasing demand, suboptimal flow, and limited resources (including funding, workforce, estate, and equipment);	This could lead to an inability to respond to emergency demand in a safe, timely and appropriate manner, delays in elective admissions and treatment, and delays in timely diagnostics;	Resulting in avoidable harm to patients and increased incidents, complaints, and litigation.

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

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

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

This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required.

- There is a current push from the ICB for all ambulances to be handed over within 45 minutes of arrival, and where this cannot happen for patients to be transferred to another acute hospital site for intake instead. This would have an operational impact on UHS and has not yet been agreed, CEO meeting scheduled to discuss further.
- The Trust is also receiving ongoing requests to support other providers with mutual aid in respect of elective recovery which is increasing demand further.
- A recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care has prompted a letter from NHSE to all acute hospitals outlining steps Boards must take in an attempt to address similar issues. A paper in response will go to Board in September.
- Further to the above NHSE letter, the Chief Nursing Officer at the HIOW ICB has also written to UHS to advise that an ED quality assurance visit is scheduled in September.

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. However emerging NHS HIOW transformation programmes are focussed on discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure.

Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand. Use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board. Rapid Improvement Plans to support improvements across cancer pathways.	Ongoing industrial action through 23-24 and into 24-25 presents significant risk to the Trust's ability to meet ongoing demand on our services. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow.
Key assurances	**Gaps in assurances**
Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP. Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans.	Local system plans to reduce patients without a criteria to reside are emerging but currently lack detail to provide assurance.

Key actions

Establish local delivery system plan for reducing delays throughout the hospital.

Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists.

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

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

New theatres and MRI suite scheduled to open in September 2024.

Engagement in the NHSE Further Faster programme for elective care.

Delivery of improvement work in 2024/25 on patient flow and optimising operating services and outpatients.

An external visit from the Emergency Care Intensive Support Team took place in February 2024 and we have now received their report with findings and recommendations to review and implement. The Emergency Department Team have clear actions to take forward as well as some Trust wide schemes. Revised pathways have been trialled in ambulatory majors and pitstop both demonstrating improved safety and more timely access. Pilot is being reviewed with a view to implement.

The Trust has been awarded capital funding to build a multi-speciality SDEC unit to support the emergency department through provision of alternate presentation options for patients requiring urgent care. Plans to be developed with a projected timeframe of March 2025.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	3 x 5 = 15	3 x 3 = 9	31/08/2024
95	Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital.	3 x 5 = 15	2 x 3 = 6	31/12/2024

187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	28/11/2024
259	Capacity and Demand in Maternity Services	4 x 5 = 20	2 x 2 = 4	30/03/2025
470	Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery.	4 x 4 = 16	3 x 2 = 6	30/09/2024
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/07/2024
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 5 = 15	3 x 1 = 3	31/12/2024
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	26/04/2024
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	30/06/2024
788	Elective caesarean section list capacity	3 x 5 = 15	2 x 2 = 4	21/09/2024
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	01/09/2024
814	Inability to provide a safe pleural service	4 x 4 = 16	2 x 2 = 4	01/01/2025
816	Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity	5 x 4 = 20	3 x 2 = 6	31/03/2025
822	Ophthalmology Glaucoma Capacity	4 x 4 = 16	4 x 4 = 16	30/06/2025
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2025

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	July 2024	3 x 2 6	December 2024

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

Current assurances and updates

- This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required. The assurances and actions have been updated to reflect the ongoing work with establishment of the Health Inequalities Board and implementation of QPSPs.

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. Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients.There are no involved patients embedded on estates works and projects. The implementation of QPSPs (quality safety partners) will support the transition for the Trust. Currently there are no SOPs/Frameworks for involved patients. The role of Head of Inequalities was not invested in after the charity funded project 2022-23, although a Health Inequalities Board has now been established. The Head of Patient Involvement role was not replaced in Sept 2023 and therefore there is limited capability to engage the local community. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures .

Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Maternity safety champions.	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.
Key assurances	**Gaps in assurances**
Monitoring of patient outcomes with QPSP input. CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Current and previous performance against NHS Constitution and other standards. Matron walkabouts and executive led back to the floor. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits. Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Health Inequalities Board Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. Patient experience week (May 2024) evidencing and celebrating FFT and sharing learning from complaints.	Ongoing industrial action through 22-23 and 23-24, and into 24-25 presents risk to the Trust's ability to meet ongoing demand on our services. There is no additional resource to support patient feedback with community engagement. The average reading age of Southampton is 7-10 yr. age, so therefore there needs to be officers reaching out personally to get feedback on care.
Key actions	
Introducing a robust and proactive safety culture: Implement plan to enable launch of PSIRF in Q3 2023/24 and continued implementation and embedding into 2024/25. Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy. Introduce thematic reviews for VTE. Implement the second round of Ockenden recommendations – completed.	

Empowering and developing staff to improve services for patients

Ongoing completion of SDM project, data analysis and formulate plan for ongoing roll-out, predominantly focussed on specialist services. Engagement and rollout within adult congenital heart disease, head and neck cancer, and also orthopaedics across the ICS. To embed as business as usual from April 2024. Baseline assessments and two quarters' submissions have completed and this will form part of the CQINN this year.

Always Improving programme

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

Embedding 'voice of the patient' into all improvement activities through aligning each Division with a QPSP who will champion patient insight and involvement.

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

Introducing exec and senior leadership team walkabouts focussed on improvement.

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. This in part has started, the ED SMS survey has proven to be a success and yielded a 700% improved response rate for ED. The learning from this has now been shared trust wide and Eye Casualty and Ophthalmology are now next to move to FFT SMS, which captures a wider demographic of patients.

Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience. This is ongoing work, there have been several vacancies in the Experience of Care, but with the recruitment of a new Head of Patient Experience there is now a renewed focus to provide divisional tailored reports at care group and divisional level.

We are Listening events to be held in local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust. This is an aspiration however currently there is no resource to do this with loss of Head of Patient Involvement.

Measures in place to identify and share thematic learning. There has been a refresh on the 'Learning from Death' and 'Experience of Care', with both board reports now reporting on patients lived experiences and including cross sections of patient experience related AERS which previously did not feature. For example, there is a now a review of AERs relating to End of Life care and a current theme on deaths outside of a side room/private area.

Linked operational risks

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

Outstanding patient outcomes, safety and experience

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

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

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

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

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

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

- This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required.
- High Consequence Infectious Diseases (HCID) guidance, including M Pox, has been updated and disseminated to all assessment areas and protocols and assessment tools have been developed.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. PPE requirements, specifically the requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the 'give up the gloves' campaign. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards.	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.

Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need.	Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped.
Key assurances	**Gaps in assurances**
Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery. Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). Ongoing focus on hand hygiene by the IPT and Divisions/Care groups – improvements starting to be seen in hand hygiene practice (as demonstrated in audits) and evidence of ongoing focus within clinical areas to drive improvements in practice.	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.
Key actions	
Ongoing programme of IP&C policy review to ensure alignment with national infection prevention & control manual for England and other national guidance. e.g.standard infection control precautions policy, high consequences infectious disease policy, policy for the management of patients with unexplained/unexpected diarrhoea and/or vomiting.	

Ongoing focused IP&C education and awareness campaigns supported by internal and external communications plan.
Re-enforce processes to ensure all areas submit required audits to demonstrate assurance of IP&C practice standards and follow up/support provided by the IPT.
Delivery of IPT work plan to support improvements in practice (MRSA focus in Q1, Isolation care focus in Q2).
Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission.
Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement.
Monthly Infection Prevention Newsletter to provide updates/education and share learning.

Pioneering research and innovation

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

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

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

Category	Appetite	Status
Technology & Innovation	Open *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	August 2024	3 x 2 6	January 2025

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

This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required. The action plan has been updated to reflect recent progress and the next planned steps.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. No overarching strategy to support innovation. Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Recruitment proceeding and appointment to vacancies, with an agreed pathway for research posts going forward.
Key assurances	**Gaps in assurances**
Governance structure surrounding University partnership.	Limited corporate approach to supporting innovation across the Trust.

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. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we are seeing the impact of the focus on our recruitment with improvement in our national performance.	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.

Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency.

Joint Research Vision, developed with University of Southampton, went to Senior Operational Group in June 2024, and will be finalised by Joint Research Strategy Board in July 2024.

UHS led on a regional bid for an NIHR Commercial Clinical Research Delivery Centre (submitted 02/07/2024) for £4.7m supported by all Wessex NHS Partners, Dorset and HIOW ICBS, Wessex Health Partners and Heath Innovation Wessex. Outcome expected Autumn 2024.

Seeking funding from Wessex Health Partners to take forward outputs from Innovation workshop - to develop processes for UHS/UoS partnership and in the longer term a UHS innovation strategy.

QI & R&D continuing to work together to identify opportunities and strategic approaches to work collaboratively together.

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	August 2024	4 x 3 12	March 2026

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

- This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required.
- 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. The current workforce forecast anticipates growth through out August, September and October 2024.
- Unison are leading a national campaign disputing the banding, duties and pay for band 2 and 3 HCA staff, and there is also an ongoing industrial dispute with portering staff. Both disputes are being managed at UHS through the collective dispute procedures with individual operational risk assessments underway.
- Current turnover rate is acceptable at 11.5% and we are meeting the sickness target (rolling average of 3.8%).

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes. Workforce plan and overseas recruitment plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Overseas recruitment including a reduced level of nurse vacancies. Recruitment campaign. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget.	Completion of objectives for South-East temporary collaborative for 2024/25. People report for Board to be refreshed. Phase 1 completed – phase 2 underway.

Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2024/25 submitted to ICB. Plan for nursing recruitment agreed for 2024/25 including overseas recruitment, newly qualified recruitment, and domestic recruitment to ensure the overall nurse vacancy position is sustained.	
Key assurances	**Gaps in assurances**
Fill rates, vacancies, sickness, turnover and rota compliance . NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Joint finance and Workforce working group on data assurance. Temporary staffing collaborative diagnostic analysis on effectiveness.	Universal rostering roll out including all medical staff. Review of implications for education and training infrastructure from national workforce plan.
Key actions	
Approval of Year 3 objectives supporting delivery of the Trust's People Strategy. Deliver workforce plan for 2024/25 including increasing substantive staff in targeted areas offset by reducing temporary agency spend. To develop and implement Divisional Workforce Plans. Completion of objectives for South-East temporary collaborative for 2024/25. To implement a range of programmes to ensure turnover remains below 13.6%. To implement a range of measures to ensure our staff absence remains below 3.9%. To implement a range of measures to improve medical deployment. Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. Review and refresh of the People report to Board (Q2 2024/25 Phase 1 completed. Phase 2 underway.)	

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
258	Maternity Staffing during peaks of activity	4 x 5 = 20	5 x 1 = 5	31/10/2024
578	Impact of reduced critical care outreach team service due to vacancy rate and skill mix on patient safety for adult deteriorating patients and ward based teams across UHS and personal health and wellbeing impact on CCOT ACPs.	4 x 4 = 16	2 x 2 = 4	31/12/2024
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2024

705	Significant Risk to Service Provision for Neuroradiology	4 x 5 = 20	3 x 3 = 9	31/05/2024
746	Risk of harm to patients on a suspected cancer pathway if they are not triaged appropriately (PSC)	4 x 4 = 16	5 x 1 = 5	27/09/2024

World class people

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

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

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

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

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

- This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required.
- In relation to the recent racially motivated right wing disorder across the country, UHS responded quickly and proactively with a compressive package of support for minority and international staff. This was overseen at executive level and included extended park and ride, on-site parking for night shift staff, wellbeing drop in sessions, and executive briefings which signposted staff to chaplaincy and windows to wellbeing, and reinforced the report to support.
- A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments.
- £250k charitable staff fund has been provided for improvement of staff facilities. Staff rooms have been identified by divisions and they are now working through plans with estates. This also includes some minor adjustments to the wellbeing hub to improve accessibility. A £25k fund has also been allocated to the wellbeing champions group for specific projects. Progress is being overseen by people board.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2025. Launch of digital appraisal process. Improving implementation of national improving working lives actions for junior doctors following national letter May 2024.

Building an inclusive and compassionate culture Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of staff networks Maturity of datasets around EDI, and ease of interpretation Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25. NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area.
Key actions	
Building an inclusive and compassionate culture Deliver year 2 objectives of the Inclusion and Belonging strategy by March 2025: This includes: • To get to 85% of all staff having completed the Actional Allyship Training by March 2025.	

- To implement the 1st phase recommendations of the Inclusive Recruitment Programme
- To deliver improvement plan in terms of experience of people with disabilities and long-term illness.
- To deliver a programme of work to meet the NHSE Sexual Safety Charter standards and increase sexual safety at UHS.
- Refresh the underpinning behaviours of our Trust Values and produce a new behaviours framework. This will underpin future leadership development and OD interventions.

World class people

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

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

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

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

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

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

- This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required.
- Discussions are still underway with the Southampton Hospital Charity re: £100k charitable funding for training.

Key controls	Gaps in controls
Education Policy	Quality of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development
Access to CPD funding from NHSE WTE and other sources	Releasing staff to attend core training, due to capacity and demand
Leadership development talent plan 2024/25	Releasing staff to engage in personal development and training opportunities
Executive succession planning	Limited succession planning framework, consistently applied across the Trust.
VLE relaunched to support staff to undertake self-directed learning opportunities.	Areas of concern in the GMC training survey
TNA process completed for 2024/25.	National CPD guidance for 2024/25: scope of application is limited by rigid national rules.

	New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.
Key assurances	**Gaps in assurances**
Annual Trust training needs analysis reported to executive. Trust appraisal process GMC/NETs Survey Education review process with NHSE WTE. Utilisation of apprenticeship levy. Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.

Key actions

To increase the proportion of appraisals completed and recorded to 85% and increase staff quality perceptions on appraisal by March 2025.

Take specific targeted action to improve areas of low satisfaction in the GMC survey.

To continue to build the education strategic partnerships and capacity for delivery of the NHS workforce plan and UHS People Strategy Including:

- Continuing to develop our formal partnership with the new UTC
- Developing a partnership agreement with South Hampshire Colleges Group
- Developing a stronger partnership with Solent University
- Reviewing the education infrastructure requirements to support increases in placement capacity and quality (including T Level placements), preceptorship, apprenticeships and internationally educated registrants.
- Preparing UHS for changes to the national apprentice model in 25/26

To continue to develop the skills and capability of line managers through roll out of the leadership and management framework. Specifically to:

- Deliver a second year of leadership development framework including Strategic and Senior Leaders programmes, Operational Leaders and Implement Team Leaders Programmes.
- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes.
- Roll out of a targeted programme of development for Care Group Clinical Lead

Integrated networks and collaboration

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

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

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

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

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

This risk has been reviewed with the executive leads throughout Q1 and Q2 2024/25 and minor changes made to the controls, assurances, and actions, to ensure it is up to date. Significant work is underway to advance integrated and networked care and progress continues to be made. There is an expectation that this will take time to establish and embed as it is a complex workstream due to the number and nature of stakeholders and the need to engage and negotiate with them, both internally and externally.

It is noted that, as referenced within BAF entry 1a, a current strain on capacity at UHS is the increasing number of requests for mutual aid in respect of elective recovery. This further highlights the importance of integrated care and networked pathways to aid mitigation of this issue and resultant risk, ensuring that provision of care is responsive to patient need and that the right patient is seen in the right place and at the right time.

Key controls	Gaps in controls
• Key leadership role within local ICS • Key leadership role within local networked care and wider Wessex partnership • UHS strategic goals and vision • Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes. • Establishment of UHS Integrated Networks and Collaboration Board • Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner organisations in over to agree priorities and ensure there is executive commitment to delivering network models. • ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor.	• Potential for diluted influence at key discussions • Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local. • Engagement and pace from organisations we are looking to partner with is not within our control. • Resource within the UHS clinical programme team can prove challenging.

• Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to. • Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward. • Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list, 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. • Network arrangements in Urology, pelvic floor and plastics have also been prioritised for focus during 2024/25. • A new programme oversight role has been appointed to the ICB to enable progress on clinical networks. We are engaging with this post; sharing priorities, opportunities and challenges with a view moving forward networks within HIOW ICB. • The 'Acute Clinical Services Operating Model programme' has been initiated with agreed focus areas from providers and the ICB, these are Breast surgery, Upper GI, Pelvic floor, Urology, Ophthalmology, Dermatology and Orthodontics	
Key assurances	**Gaps in assurances**
• CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys • Friends and Family Test • Outcomes and waiting times reporting. Included within cases for change being built for networks. • Integrated networks and collaborations Board set up for regular meetings at executive level	• Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. • Specialised Commissioning budget delegation deferred externally until April 2025. • Ability to network is difficult and manifests in capacity challenges. • Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track.
Key actions	
Urology Area Network plan agreed. Progress had stalled due to lack of programme management resource and clinical lead stepping down. This programme has now picked up again and new workstreams have been agreed. Challenges to moving forward related to aligning clinician's availability across multiple organisations. Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board in Q3 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. NHSE has approved the business case for the Elective Hub, this is a significant step forward and now moving ahead. This is expected to open May 2025. Elective hub – in construction. Mr AK, Ophthalmology clinical lead, leading ongoing improvement work focussed on theatre productivity and point of access for cataract referral.	

A high level options paper has been developed for Upper GI across UHS and UHD, This has been shared with executives and broadly agreed between CMOs and Directors of strategy. A detailed options appraisal will be produced by September 24. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI.

We have agreed to join in a collaborative with Salisbury NHSFT, enabling joint governance of clinical networking arrangements between our two organisations and regular review of opportunities. Principles for collaboration and TORs for a board have been developed. We are waiting on Salisbury's response on these to move forward with arranging regular board meetings.

A Pelvic floor networks away day was held at the end of May 2024 and was well attended by representatives across care settings and the region. A paper outlining the model in more detail is in draft in preparation for sharing with all linked providers and ICBs.

Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. Plastic leadership has been strengthened within UHS to support this change, oversight will now sit within division D.

Planning underway to increase performance and meet targets for the Elective Recovery Fund supported by a common assumption across the system and leadership from David French for the ICS elective programme.

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. Work is underway to align with commissioners and to support the change contractually.

Once networks have been established, define a core set of KPI metrics to be monitored and reported through INC board.

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	August 2024	3 x 3 9	April 2025

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

Current assurances and updates

- The risk has been reviewed in August 2024 and the risk rating remains unchanged, with a reduced risk score targeted by April 25 should we be successful in delivering our operation plan.

Key controls	**Gaps in controls**
Internal • Financial strategy and Board approved financial plan. • Trust Savings Group (TSG) oversight of CIP programme. • Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits. • Implementation of revised recruitment controls, including setting revised divisional Affordable Workforce Limits • Robust business planning and bidding processes • 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**	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. **System wide/external** • Elements of activity growth unfunded via block contracts. • Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance. •

Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved "grip and control" measures with consistent application across all organisations.	
Key assurances	**Gaps in assurances**
• Regular finance reports to Trust Board & F&IC • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • Trust Savings Group oversight of financial recovery plan and CIP programme actions • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity.	• Current short-term nature of operational planning • System wide plans under development to work collaboratively focussing on reduction in NCTR, and mental health, however there remains a lack of assurance around the detail to ensure delivery. • Lack of reporting on system transformation initiatives to individual Trust Boards. • Concern over any further industrial action not incorporated into plan. • Concern that pay awards will not be fully funded. • Formation of Trust delivery units may take resource away from Trust programmes / lack of additional resource to deliver programmes.
Key actions	
• Finalise 24/25 plan to be agreed with NHSE - complete • Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete. • Reset CIP and transformation programmes based on 24/25 targets - complete. • Review formation of Delivery Units to support system transformation programmes. • Reset organisational focus onto flow, theatres and outpatients' transformation programmes. • Continue to implement and monitor workforce controls throughout 2024/25 to slow growth and reduce spend.	

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. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.	This would result in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
4 x 4 16	April 2024	4 x 5 20	August 2024	4 x 2 8	April 2027

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

Current assurances and updates

This risk has been reviewed in August 2024 with no revisions to the ratings or target dates required. It is recognised that whilst the level of risk can be difficult to quantify, it is undoubtedly high and has a direct impact on the quality of patient care and experience. For example, whilst the cause of nosocomial infections may be multifactorial, we are aware that one of the factors will be ventilation within the hospital. A recent example of this is the Candida Auris outbreak on D4.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Missing funding solution to address identified gaps in the critical infrastructure.
Up-to-date computer aided facility management (CAFM) system	Missing funding solution to address procurement of new system.
	Timescales to address risks, after funding approval.
	Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain
Asset register (90% in place)	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
Maintenance schedules	Lack of decant facilities
Trained, accredited experts and technicians	Requires new CAFM system installing to fully understand gaps and address outstanding assets.
Asset replacement programme	Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work.
Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)	Recruitment controls inhibiting recruiting to key roles.
	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.	Lack of Estates strategy for the next 5 years Missing process to highlight all 12+ risks from the six facet survey. Missing funding solution to deliver strategy.
Key assurances	**Gaps in assurances**
Compliance with HTM / HBN monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors	Derogation policy to be introduced. Gap in funding to respond to issues. Funding streams to be identified to fully deliver capacity and infrastructure improvements The annual six facet survey has recently been completed and is being used to facilitate risk-based prioritisation of funding through the Trust Investment Group (TIG). This has highlighted 17 new operational risks which are being assessed ahead of addition to the operational risk register. Although UHS is an acute physical health facility, there is a growing ligature risk due to the increasing numbers of mental health presentations. It is recognised that as the organisation is not a mental health facility, the organisation is not a ligature free environment, therefore some level of risk is present in the majority of treatment areas. However there are some designated ligature reduced treatment areas across the organisation with additional controls in place focussed on patient centred care and management. There hasn't been an estates ligature audit to fully ascertain the extent of this risk but estimated costs and a timeframe for this have been requested from an external provider following NHS England enquiries. It is currently unclear whether this audit will be mandated by NHS England and if so whether there will be any financial provision to support this.
Key actions	
Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn. Identify future funding options for additional capacity in line with the site development plan. Delivery of 2024/25 capital plan Implement the HIOW elective hub. Deliver £4.2m of critical infrastructure backlog maintenance. £3.5m in 2025/26. Agree plan for remainder of Adanac Park site Site development plan for Princess Anne hospital.	

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
34	Imminent failure of the pharmacy logistics robot	3 x 5 = 15	2 x 2 = 4	31/10/2024
260	Insufficient space in the induction of Labour Suite.	4 x 4 = 16	3 x 1 = 3	31/12/2024
262	Insufficient space on Maternity Day Unit	4 x 4 = 16	5 x 1 = 5	31/12/2024
489	Inadequate Ventilation in in-patient facilities	5 x 3 = 15	5 x 1 = 5	31/10/2024
548	HV West side transformer circuit breaker trip not operating	4 x 4 = 16	4 x 1 = 4	31/08/2024
817	Lack of UPS backup on power failure	5 x 3 = 15	5 x 1 = 5	30/09/2024

Foundations for the future

5c) Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation

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

Cause	Risk	Effect
If there are inhibitors to implementing and sustaining digital technology either due to funding, capacity, technology, or resource constraints	This could mean that our digital technology or infrastructure is unable to support the Trust in delivering clinical, financial, or operational objectives. Key areas of concerns are the ability to provide reliable and fit for purpose hardware and infrastructure, defence against cyber threats, and being able to recruit and retain the right number of staff with the right skill mix.	Resulting in an inability to provide and maintain the digital infrastructure required to facilitate outstanding patient care.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	4 x 3 12	August 2024	3 x 2 6	March 2025

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

Current assurances and updates

This risk has been reviewed by the Finance & Investment Committee in August 2024, and by the Chief Operating Officer as the executive lead, and the Chief Information Officer. The risk rating and targets remain, but the description of the risk has been updated to greater reflect the key concerns:

- Ability to provide reliable and sustainable hardware (end user devices and network infrastructure) due to a funding gap.
- The risk of cyber security not being managed appropriately due to the absence of the correct hardware (as above) and funding to allow ongoing development.
- Provision of a skilled and comprehensive workforce due to the competitive nature of the industry and funding to support recruitment and retention.

Key controls	Gaps in controls
Failure in physical network infrastructure • All Digital UPS tested. • Investment cases for key infrastructure (air cooling and data centres) being developed. • Replacement of key infrastructure on a case-by-case basis once it fails.	**Failure in physical network infrastructure** • The current Data Centre is end of life and requires a capital plan for replacement. • There is currently no phased replacement of switch and network equipment due to absence of funding. • Windows 10 is end of life in October 2025 with no funding available to replace all devices with Windows 11. Some mitigations underway including purchase of additional RAM and hard drives, and

	upgrading suitable equipment, however not all equipment is suitable for this.
Cyber Risk • Cyber security infrastructure refreshed and in place. • Staff training on cyber risks, with regular refreshers and clear policies. • Key cyber roles recruited to, with one remaining outstanding.	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training. • Penetration testing contract expires in October 2024, with no funding to renew until 2025/26.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover.	**Single points of failure in staffing** • Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry. • Digital apprentices hired in September 2023, but will require time to train. Funding not currently available for additional apprentices.
Implementation and sustainability of digital technology • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout being assessed	**Implementation and sustainability of digital technology** • Funding to cover the development programme, improvements, and clinical priorities. • ICB outline business case funding for EPR
Loss of access to critical IT systems • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Scenario testing completed. •	**Loss of access to critical IT systems** • Time to fully stress test business continuity plans.
Key assurances	**Gaps in assurances**
Finance oversight provided by the Finance and Investment Committee Quarterly Digital Board meeting, chaired by the CEO.	Funding to cover the development programme, improvements, and clinical priorities Difficulties in understanding benefits realisation of digital investment.
Key actions	
• Ongoing recruitment of key Digital resource to mitigate operational risk. • Inpatient noting for doctors scheduled for 24/25 • Replacement of key clinical systems to more modern systems: OpenEyes, LIMS, Alcidion scheduled in 24/25 • Development of Single EPR across HIOW to provide a more modern EPR • Identify opportunities for funding for digital transformation and programmes.	

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the	4 x 4 = 16	3 x 1 = 3	31/07/2024

	network but all of the facilities described have significant problems.			
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	4 x 4 = 16	2 x 3 = 6	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	31/07/2024
556	Workforce Resourcing - Risk to provision of Pathology test results (all departments) if there are delays or errors in the implementation of the new Path IT system	4 x 3 = 12	4 x 1 = 4	30/09/2024
653	Accommodation / Infrastructure - No suitable IT storage and distribution space available within the footprint of SGH	3 x 4 = 12	3 x 3 = 9	24/01/2022
736	Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps	3 x 4 = 12	1 x 2 = 2	08/01/2024
282	Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity.	3 x 4 = 12	2 x 2 = 4	30/04/2021
800	Cyber security - Vulnerability with the Ivanti preventing remote iPad use	3 x 4 = 12	2 x 1 = 2	30/04/2024
743	Accommodation / Infrastructure - Excessive heat generated from the failure of air-conditioning units in the ICU Data Centre (aka Comms/Server Room) can lead to unplanned shutdown of critical IT systems	3 x 4 = 12	2 x 1 = 2	26/07/2024
829	Cyber Security - Windows 11 Roll-out before Win10 EOL	4 x 3 = 12	2 x 2 = 4	14/10/2025

Foundations for the future

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

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

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

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

Risk progression: (previous 12 months)	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 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. Continuing to identify funding opportunities.
- Progress EPC Works: Veolia on site, established, met year one programme which lines us up to meet interim benefits in year 2.
- Delivered additional LED lighting replacement at PAH utilising 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.
- To 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). Clinical Sustainability Lead Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy Communications plan. Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change. Do not have a fully funded plan to achieve the national targets set out.
Key assurances	**Gaps in assurances**
Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.	Definition of and reporting against key milestones.

Quarterly reporting to NHS England and NHS Improvement on sustainability indicators. Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	

Key actions

Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore Low carbon skills funding)

Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme.

Continue to further develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.

Finalise energy performance contract to deliver a responsive and progressive energy plan.

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:	**10 September 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 **Deed of Easement** for Gas Infrastructure relating to Adanac Park, Land on the East Side of Adanac Drive, Nursling, Southampton SO16 9LG between University Hospital Southampton NHS Foundation Trust (Grantor) and Express Utilities Ltd (Grantee) and Southern Gas Networks PLC (Works Contractor). Seal number 278 on 26 July 2024.

1.2 **Lease** relating to land for an electricity substation site including cable easements at the east side of Adanac Drive, Nursling, Southampton between University Hospital Southampton NHS Foundation Trust (the Landlord), The Electricity Network Company Limited (the Tenant) and Just Retirement Limited (the Grantor). Seal number 279 on 6 August 2024.

1.3 **Lease** relating to Units 19 to 21 and 25 to 27, The Innovation Centre, 2 Venture Road, The University of Southampton Science Park, Southampton, between The University of Southampton Science Park Limited (the Landlord) and University Hospital Southampton NHS Foundation Trust (the Tenant). The space is occupied by NIHR ARC Wessex hosted by the Tenant. Seal number 280 on 13 August 2024.

2 Recommendation

The Board is asked to ratify the application of the seal.

Report to the Trust Board of Directors				
Title:	**Annual Health and Safety Report 2023-24**			
Agenda item:	**7.2**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Jane Fisher, Head of Health & Safety Services**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Implications: (Clinical, Organisational, Governance, Legal)	1. Staff may suffer injury or illness which could result in litigation (personal injury claims), staff may leave, and recruitment opportunities may be affected. 2. Regulatory enforcement action by the Health & Safety Executive (HSE) or Care Quality Commission (CQC) 3. Non-compliance with industry and national standards 4. Reputational damage to the Trust.			
Risks: (Top 3) of carrying out the change / or not:	As above.			
Summary: Conclusion and/or recommendation	This report outlines the key activities carried out by the six staff delivering services for health and safety (H&S), moving and handling (M&H) and FFP3 Resilience from 1st April 2023 to 31st March 2024. Members of the Trust Board are asked to continue to support the following key staff safety matters to improve the safety culture at UHS; • Involvement of local, ward/departmental Health and Safety (H&S) Leads and Moving and Handling (M&H) Trainers and ensure they have protected time to fulfil their roles. • Active identification of hazards and assessment of risks, supporting the action planning process for the control and management of health and safety-related risks. • Promoting the “No Excuse for Abuse” approach and support staff to report any violence and aggression towards them. • Staff attendance at appropriate practical moving and handling training to help reduce the risk of sustaining musculoskeletal injuries/disorders. • Reviews of display screen equipment/workstation assessments are completed annually. • Appropriate use and wearing of personal protective equipment/clothing to reduce exposure to hazardous substances. • Safety sharp devices are used correctly, and safe systems of work are followed. • Staff exposed to infectious respiratory diseases and/or are involved in aerosol-generating procedures are fit tested to two models of FFP3 mask (including PeRSo respirators) where appropriate. • Appropriate segregation of waste bags into carts for disposal (to help the Trust save unnecessary costs). • Reporting of near miss incidents so that serious accidents can be prevented. • Recording work-related absences on HealthRoster and reporting cases directly to the H&S Team.			

	Graphical summaries are provided of the top five causes of adverse events relating to staff health and safety, which include violence and aggression, moving and handling, slips, trips and falls, sharps and collision/contact with objects. The Health & Safety Services Department continues to provide advice, guidance, training and support to staff, managers and senior leaders to ensure that the Trust's statutory duties are met with regard to staff health and safety in the workplace; this supports the Trust values so that a positive health and safety culture is embedded into all of the Trust's activities.

1. Introduction

This report provides a summary of the activities carried out by the six staff within the Health & Safety Services Department, covering health and safety (H&S), moving and handling (M&H) and FFP3 Resilience.

The Health & Safety Services Department continued to advise, guide, train and support staff at all levels to ensure that a positive health and safety culture is embedded into all of the Trust's activities.

The Corporate Health & Safety Committee (CHSC), chaired by the Chief Nursing Officer (CNO), met quarterly; it monitors the Trust's activities in relation to staff health and safety, moving and handling and FFP3 resilience, receiving quarterly reports from all three services. The committee also received quarterly reports from Divisional Risk and Governance Groups and key supporting departments (EFCD, Occupational Health) and an annual report of non-clinical claims from the Claims & Insurance Department

Appendix 1 provides graphical summaries of the staff-related adverse event statistics from 1st April 2023 to 31st March 2024.

2. Summary of the H&S Service

Apart from the main business as usual activities, there were some key projects completed this year;

- ✓ Implementation of the new display screen equipment/workstation (DSE) training and assessment course on VLE
- ✓ Production of an "A to Z of Safety Risk Management" guide to evidence how the various health and safety-related risks are controlled and managed across the Trust.
- ✓ Review and update of generic H&S-related risk assessments:
  - New and expectant mothers
  - Agile working
  - Slips/trips/falls
  - Lone working
- ✓ Collaboration with the Workforce systems team to create health and safety-related "Skills" on HealthRoster for the roles of H&S Lead, M&H Trainer and Fit Tester.
- ✓ Contributions to the review and update of Trust-wide policies for Agile Working and Managing Stress in the Workplace.

3. Summary of the Moving & Handling Service

The team was established in its new set-up this year; the M&H Officer took over the role of M&H Adviser and the Lead M&H Trainer post was made permanent (we had to lose the M&H Officer post in order to fund this).

Key projects undertaken by the M&H Team;

- ✓ Implementation of the new workstation assessment and training course on VLE, which will support collation of evidence of compliance with the legal requirement to carry out annual workstation assessments.
- ✓ Working with OH and leading on support and guidance for staff who need complex DSE assessments to help them remain and/or return to work safely; eighty-nine (89) complex assessments for staff (a cost saving of c£42K, if this had been outsourced).
- ✓ Completion of the bariatric rental equipment tender, securing another five-year contact for the provision of equipment for plus-size patients across the Trust.
- ✓ Specialist rehabilitation equipment for the Children's Hospital.
- ✓ Back Care Awareness week, "Backs to the Future", showcasing the "Cobot" exoskeleton.
- ✓ Review and overhaul of the M&H policy to bring it up-to-date and in line with current best practice.

Providing support, advice and guidance for the implementation of Trust-wide projects;

- ✓ Successful pilot of the "Raizer Chair" in Ophthalmology
- ✓ Fundamentals of Care
- ✓ Single-Handed Care/Optimising Care
- ✓ Safe use of bedrails (national patient safety alert).

4. Summary of the FFP3 Resilience Service

The delivery of the mask fit testing service had to be taken in-house as the national DHSC funding was stopped (as of 31st March 2023), but this left the Trust with only one member of staff to deliver all aspects of the service.
The FFP3 Resilience Lead, gained national Fit2Fit accreditation, which meant that the Trust could deliver its own fit tester training (saving c£10K per annum).

Forty (40) staff from across the Trust were able to meet the majority of the local fit testing requirements from within their care groups.

1266 fit tests were carried out in the central fit testing hub by the FFP3 Resilience Lead.

The digital method of fit testing using portacount machines was set as the standard, as this is quicker and less subjective (compared to the taste/hood method).

PeRSo respirators were issued to staff who could not use a disposable FFP3 mask. The numbers of FFP3 masks and PeRSo equipment being used have reduced in line with the easing of infection prevention requirements. A quarter of the PeRSo stock was moved to off-site storage, with plans for more to be stored off-site, and a contingency plan is in place for the use of PeRSo equipment should another crisis/pandemic occur.

5. Training

The teams continued to support corporate and new managers inductions and delivered specialist face-to-face training courses;

- H&S Leads (33 attendees)
- H&S Risk Assessment (29 attendees)
- COSHH (14 attendees)
- Fit Testers (49 attendees and assessed as competent to fit test in their care groups)
- Clinical M&H Train-the-Trainer (44 attendees)
- Non-Clinical M&H Trainer-the-Trainer (10 attendees)
- Level 2 M&H Statutory & Mandatory (101 courses attended by 570 clinical staff).
- Bespoke M&H training for specialist teams and services (e.g. Mortuary, HEMS, SALT) and specific refresher training for existing M&H Trainers.

6. Proactive Monitoring

The H&S Team carried out support visits throughout the year in response to requests from H&S Leads and ward/dept managers, and to investigate accidents and incidents.

The M&H Team carried out 259 visits to wards to support the care of complex patients, to train staff 'at the bedside' and to investigate staff injuries whilst handling patients.

The FFP3 Resilience Lead worked with local fit testers to ensure they were competent and confident to deliver fit testing in their wards/departments.

Support visits to satellite sites increased this year compared to previous years, however the programme of health and safety inspections/tours was significantly reduced due to lack of capacity. Therefore, there was limited formal monitoring of the management of health and safety within wards or departments.

There were 165 active H&S Leads, 136 clinical M&H Trainers and 18 non-clinical M&H Trainers across the Trust; some cover more than one area and some role-share within wards/departments.

There was a very good level of engagement with both the H&S and M&H self-audit programmes this year; a summary of returned data from the H&S audit was presented to the CHSC in July.

The dangerous goods safety audit programme was completed by the contracted external company who act as the Trust's Dangerous Goods Safety Adviser (DGSA). Recommendations were actioned by each department, with a common theme of poor segregation of different types of waste by wards/departments (now being managed via a Trust-wide project led by Facilities).

The Trust maintains an honorary contract for biological safety advice via the University of Southampton; the Biological Safety Adviser provides regular updates on any issues of concern and supported the Trust with inspections of research studies from enforcement agencies.

Monitoring of occupational exposure to entonox (nitrous oxide) was managed via the Medical Gas Committee and the Pharmacy Quality Team, as required by the national guidance and recommendations from the DHSC. A gap analysis of the Trust's position was carried out and recommendations have been implemented.

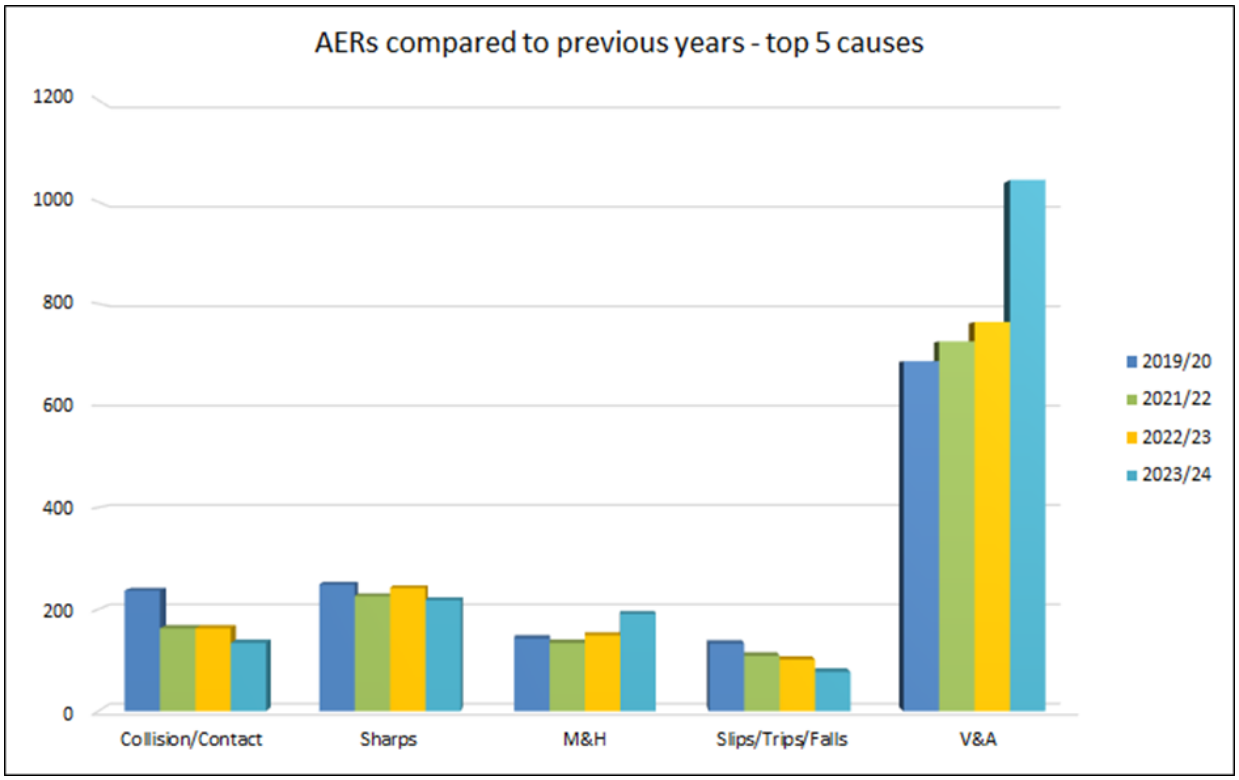
7. Reactive Monitoring:

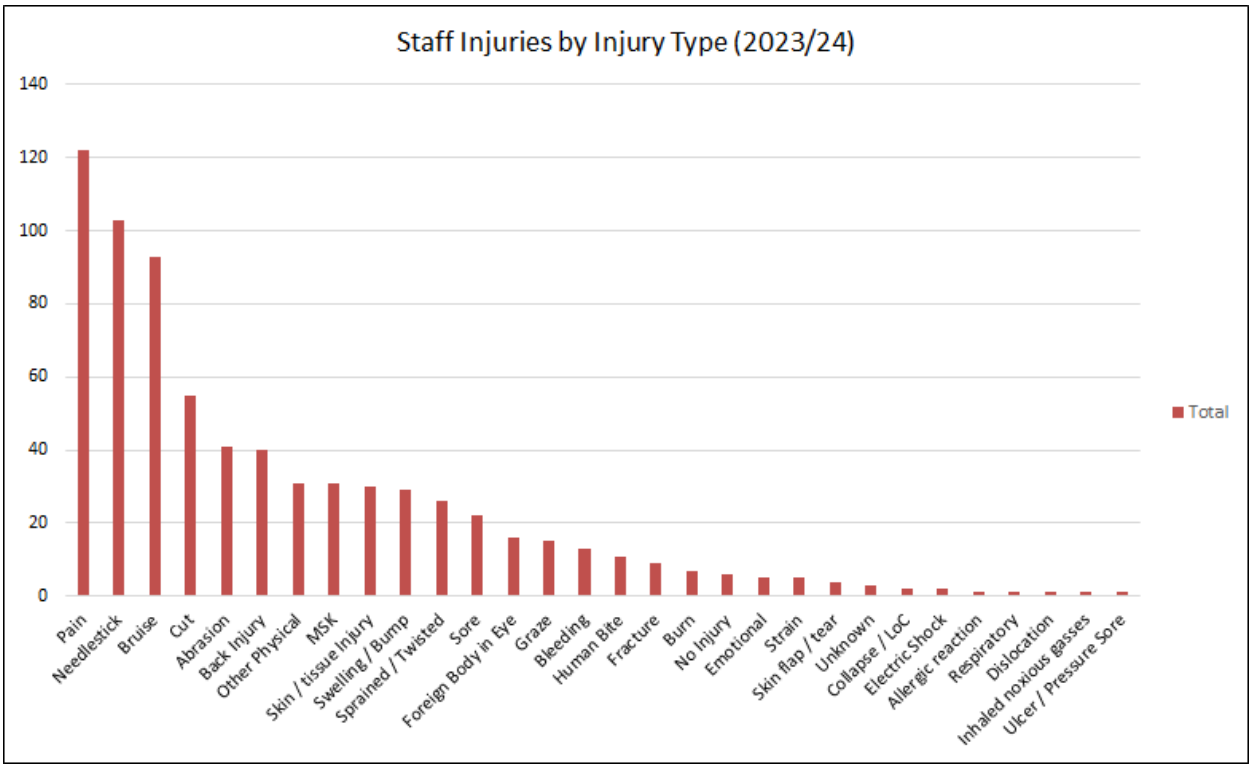
The H&S and M&H Teams continued to monitor the staff-related adverse event reports and support staff and managers with accident investigations and validating reports in the Ulysses Safeguard Reporting system.

7.1 Adverse Events Involving Staff and Visitors

Comparing incident numbers to previous years, the standout feature is a marked drop in health and safety AERs and a large climb in violence and aggression. This may be driven in part by a recategorization in many incident types within the reporting system at the start of the year, which have made it easier to report violence and aggression incidents and has led to an increase in reporting. The Violence and Aggression Steering Group continued to promote the Trust's "No Excuse for Abuse" approach and the reporting of violence and aggression incidents, which may have also increased report numbers.

Year	H&S AERs	V&A AERs	Total
2020/21	1441	605	2046
2021/22	1455	733	2188
2022/23	1279	764	2043
2023/24	949	1043	1992





There were no incidents rated “severe / major” in this year.

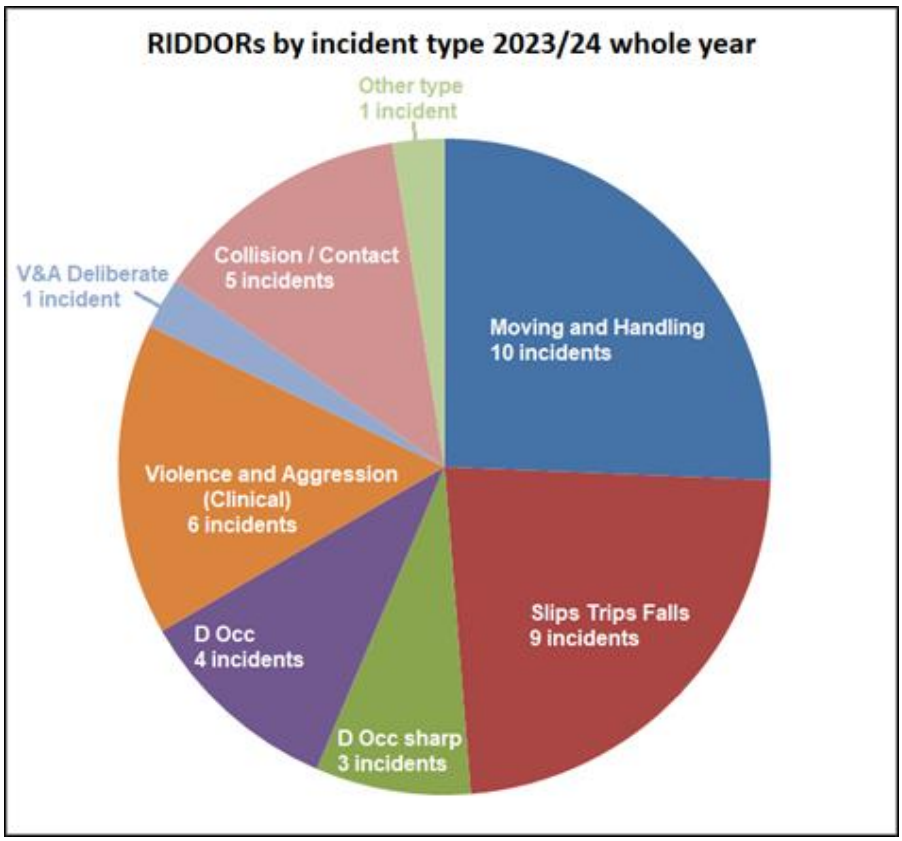
A breakdown of the specific incident causes was presented to the CHSC in July; graphical summaries of the health and safety-related AERs is provided in Appendix 1.

7.2 RIDDOR Reportable Incidents

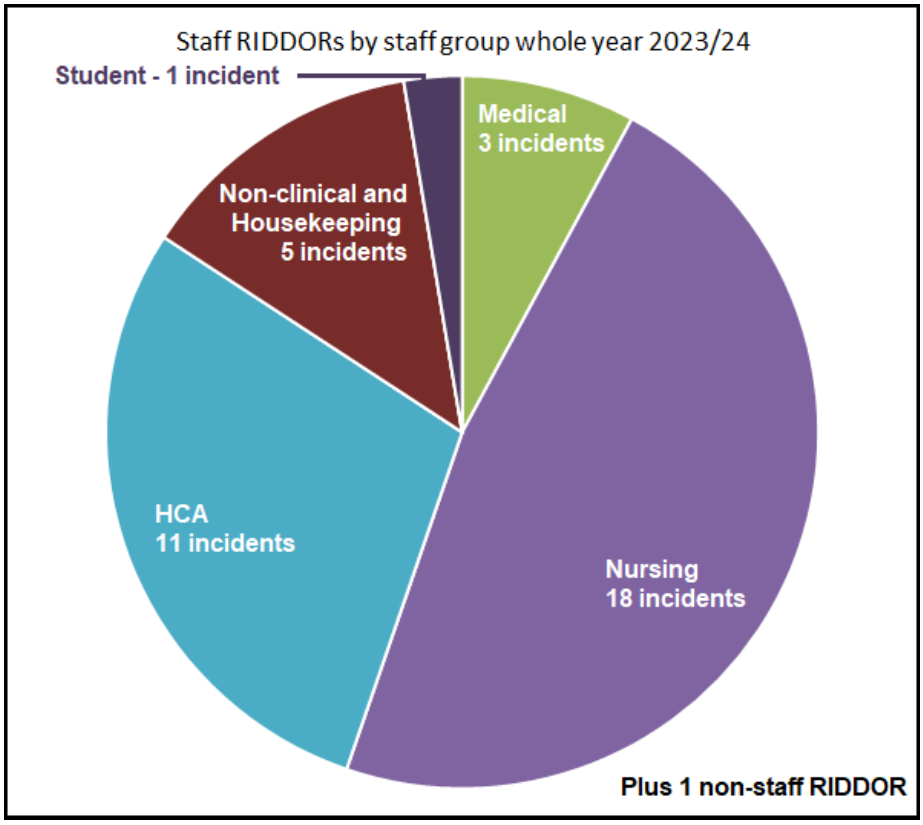
The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) is a statutory requirement; RIDDOR incidents are reported to the Health and Safety Executive by the Health and Safety Services Team, following investigations conducted locally in wards/departments and followed up by the H&S Adviser, M&H Adviser and/or the Head of H&S Services.

Monthly RIDDOR Panel meetings continued to review reportable incidents/cases and involved the Trade Union Representative, the Head of Claims & Litigation, EFCD Compliance Team as well as clinical teams as appropriate. The review panel ensures investigations have been carried out appropriately, any outstanding actions are followed-up and the lessons learnt to help prevent recurrence are shared.

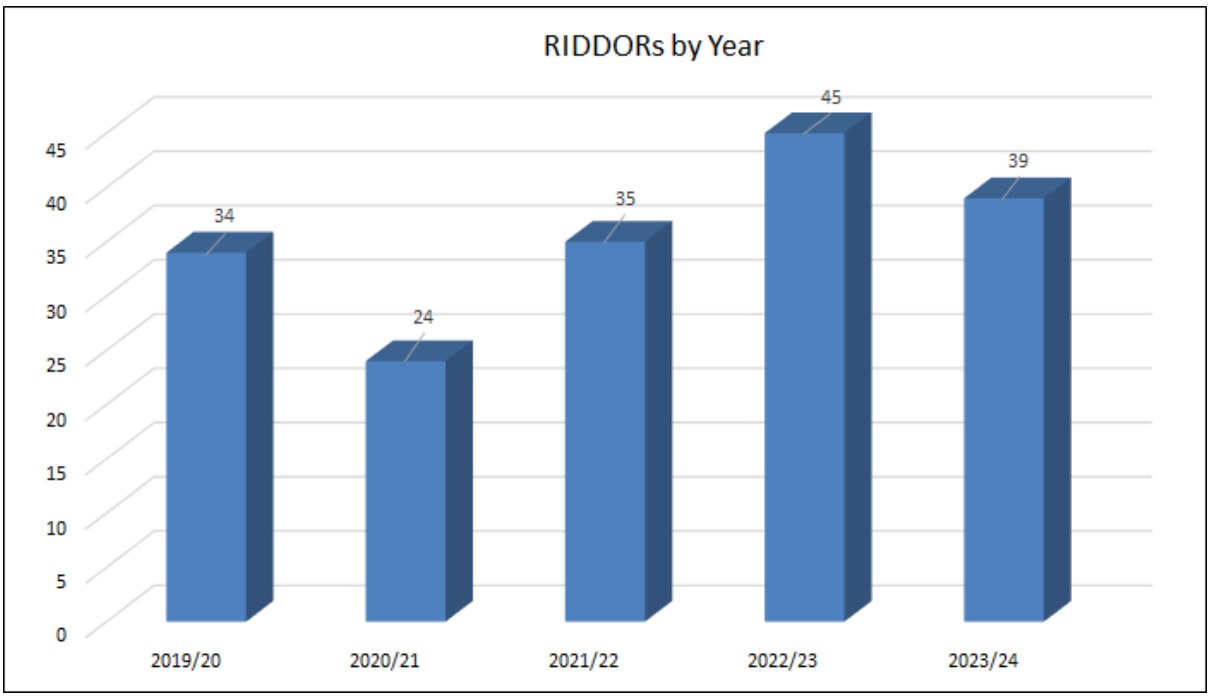
A total of thirty-nine (39) incidents were reported under RIDDOR.



The profile of staff types affected by RIDDOR incidents remains very similar to previous years



The profile of staff types affected by RIDDOR incidents remains very similar to previous years, and broadly reflects the numbers of staff in each of the staff groups, so the proportions are loosely what would be expected.



7.3 Staff Radiation Incidents

Staff incidents caused by ionising or non-ionising radiations are either reported on Ulysses Safeguard at the time of the incident or discovered after the fact by occupational radiation dose monitoring; they are investigated and managed by the Radiation Protection team.

There were fourteen (14) staff incidents involving exposure to ionising radiation or radioactive materials; twelve (12) incidents were actual events, two (2) were classed as near misses. This is a reduction from twenty-one (21) incidents last year.

The following trends were identified:
Eight (8) incidents related to potential loss of control of safety systems for radioactive materials such as spills of radioactive material, leaking containers, radioactive patients not remaining in the isolation room, patient bodily fluids in public areas, radioactivity not put away after use.
In each case an investigation of the causes was carried out and the potential radiation effects were calculated by the Radiation Protection team.

There were six instances of contingency plans being enacted (spill of radioactivity, unauthorised entry to radiation-controlled area) which were recorded on Ulysses Safeguard. It is a formal requirement of the Ionising Radiation Regulations that such events are recorded and analysed.

There were forty (40) occupational radiation doses recorded on body, finger or eye dose monitors that were above the investigation level for high doses in a single monitoring period (monthly or quarterly) and three instances where an annual dose investigation level was exceeded. All events were investigated to identify the cause. The annual investigations were determined to be due to higher than usual workload per person in Interventional Radiology.

7.5 External Agency Involvement

There were no formal incident-related inspections or visits by external safety agencies during this period. There were planned inspections of Research & Development studies by the Health & Safety Executive (on behalf of DEFRA) but the H&S Services dept was not involved in these.

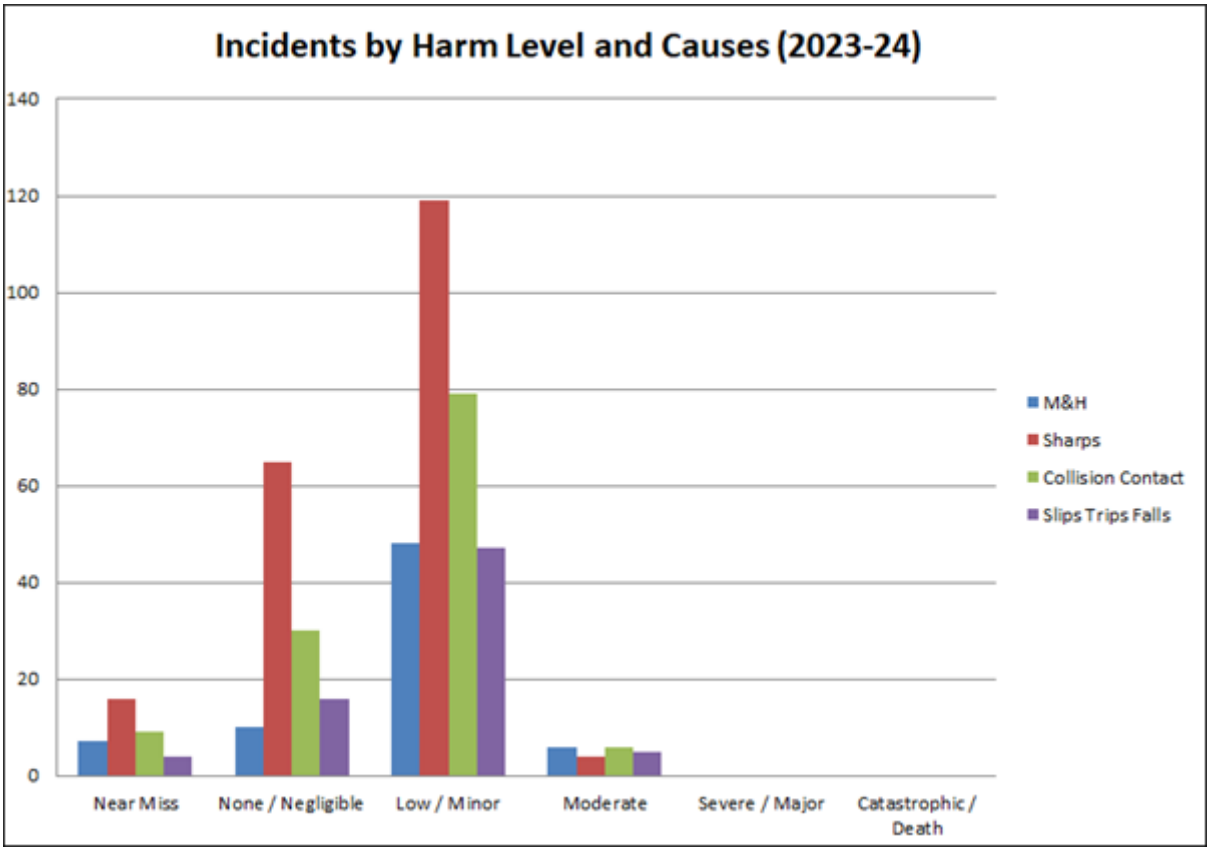
8. Summary

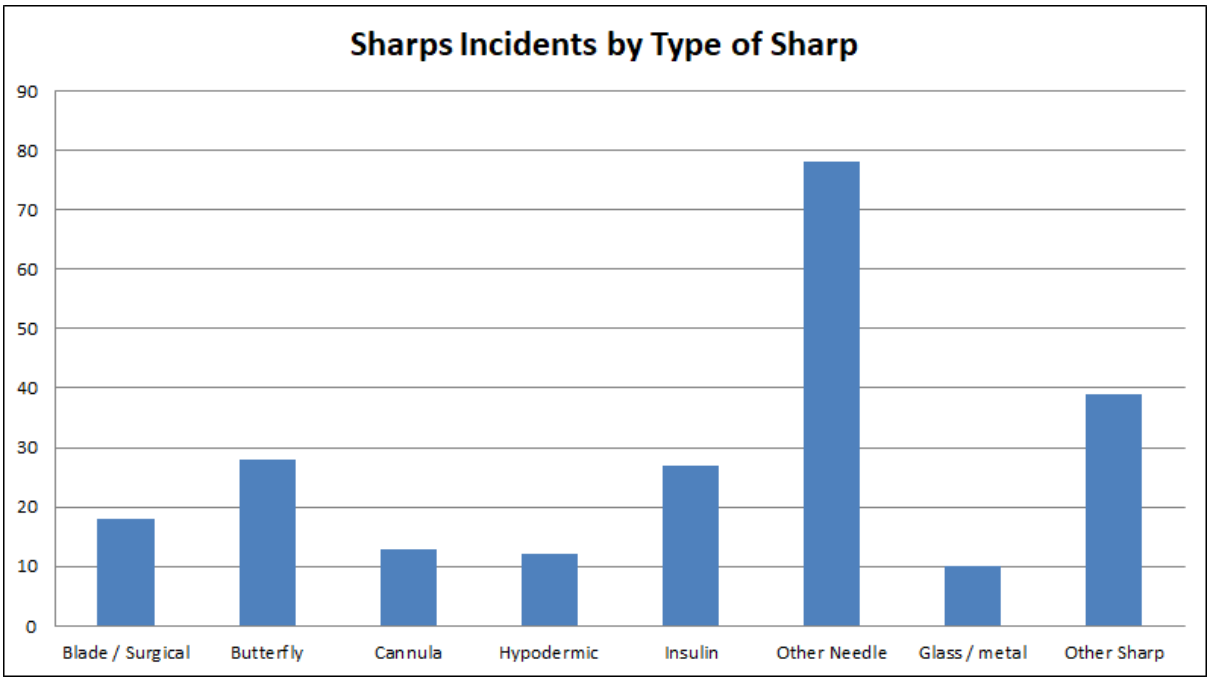
Another positive and proactive year, where the profile of the department and services was raised by providing training, advice, guidance, support and collaboration with staff to enable them to work safely.

The approach of "Working Together" and "Always Improving" has delivered the following structure of assurance and reassurance for staff health and safety;

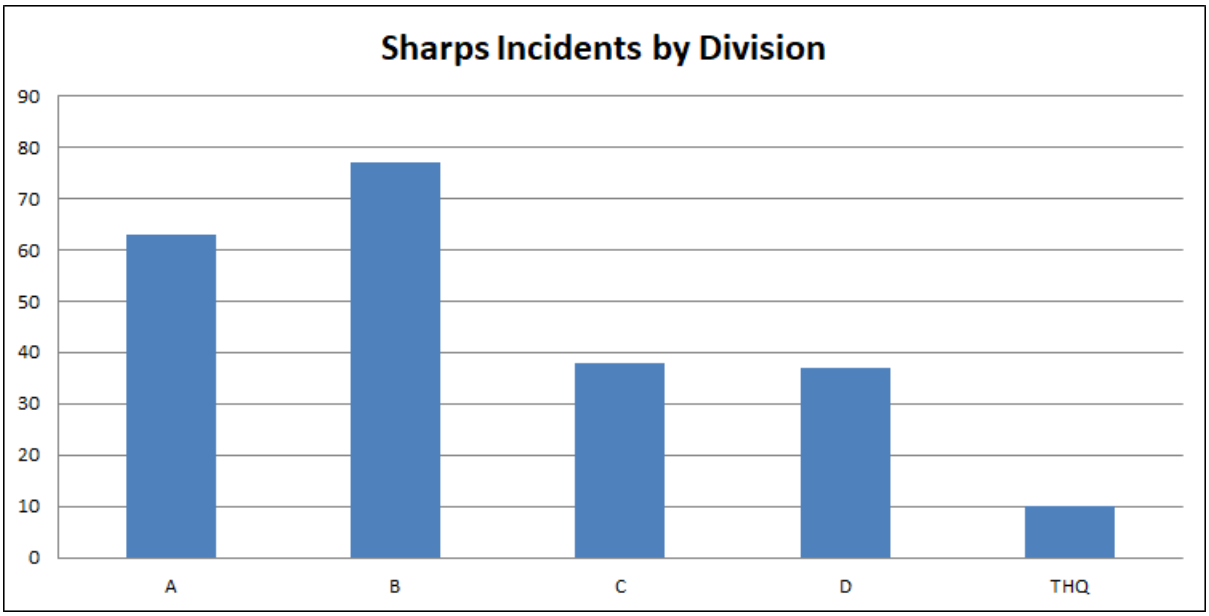
- comprehensive training programmes
- implementing systems of robust evidence of compliance
- a community of peer support through H&S Leads, M&H Trainers, and Fit Testers
- up-to-date information and guidance available to all staff via Staffnet
- proactive and reactive monitoring and analysis tools
- supportive governance; reviewing and updating Trust-wide policies and procedures
- advice, guidance and contributions to specialist/corporate groups and projects.

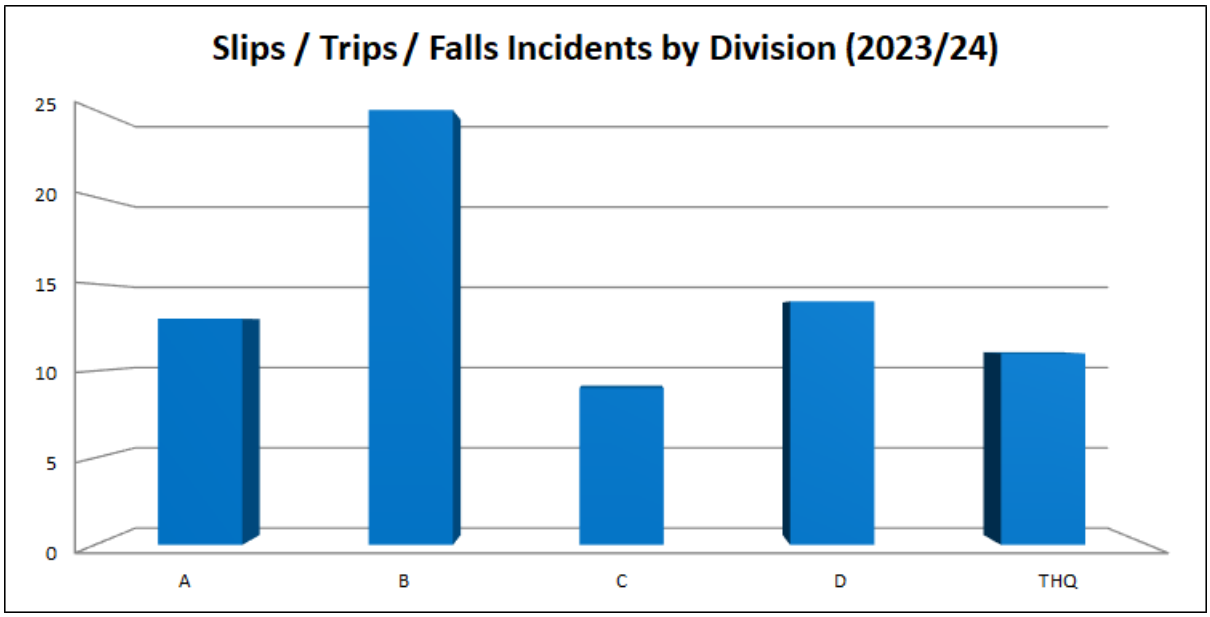
Appendix 1: Graphical summaries of the top five causes of H&S-related AERs

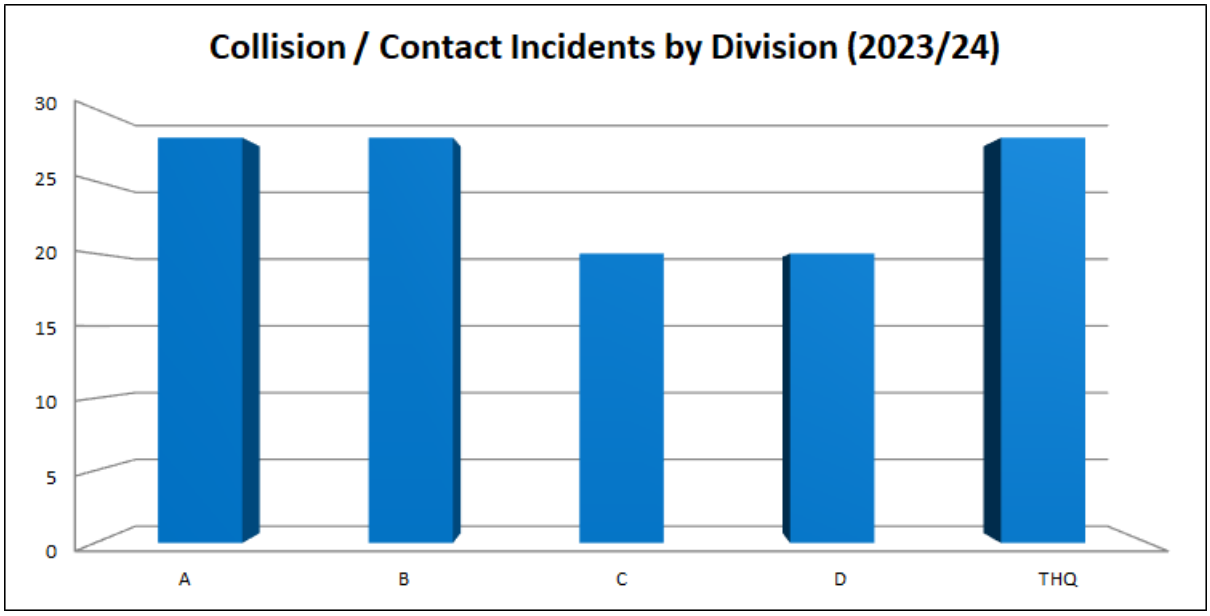


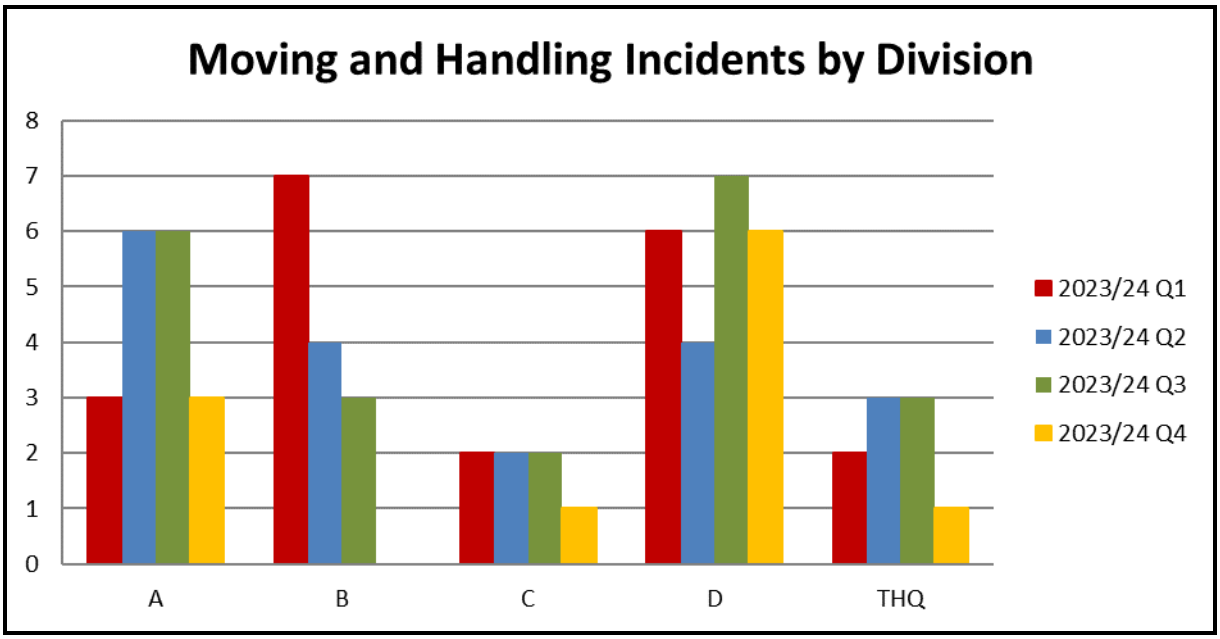


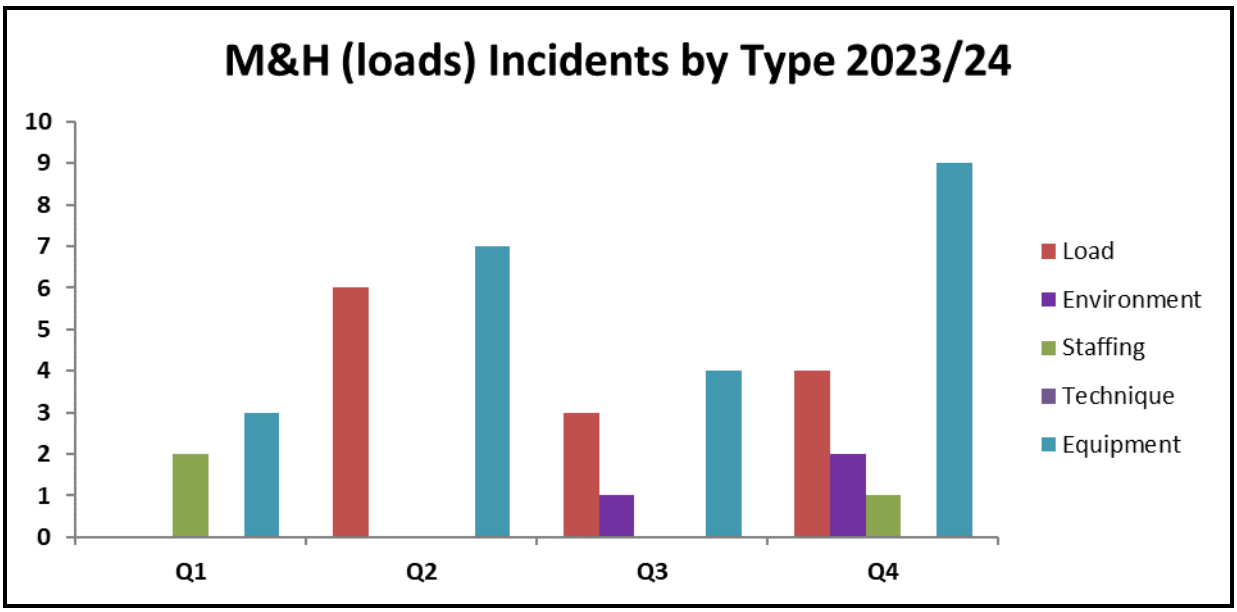
The category “glass/metal” was added to sharps incident categorisation for this year, leading to a small decrease in the number of “other sharp” incidents

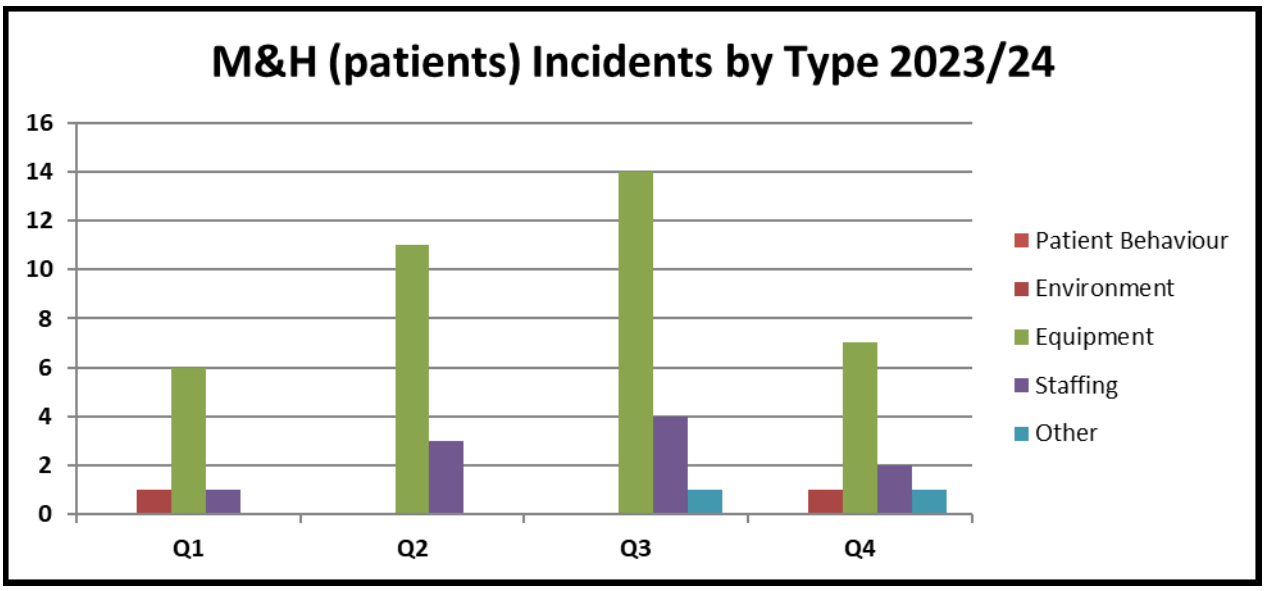


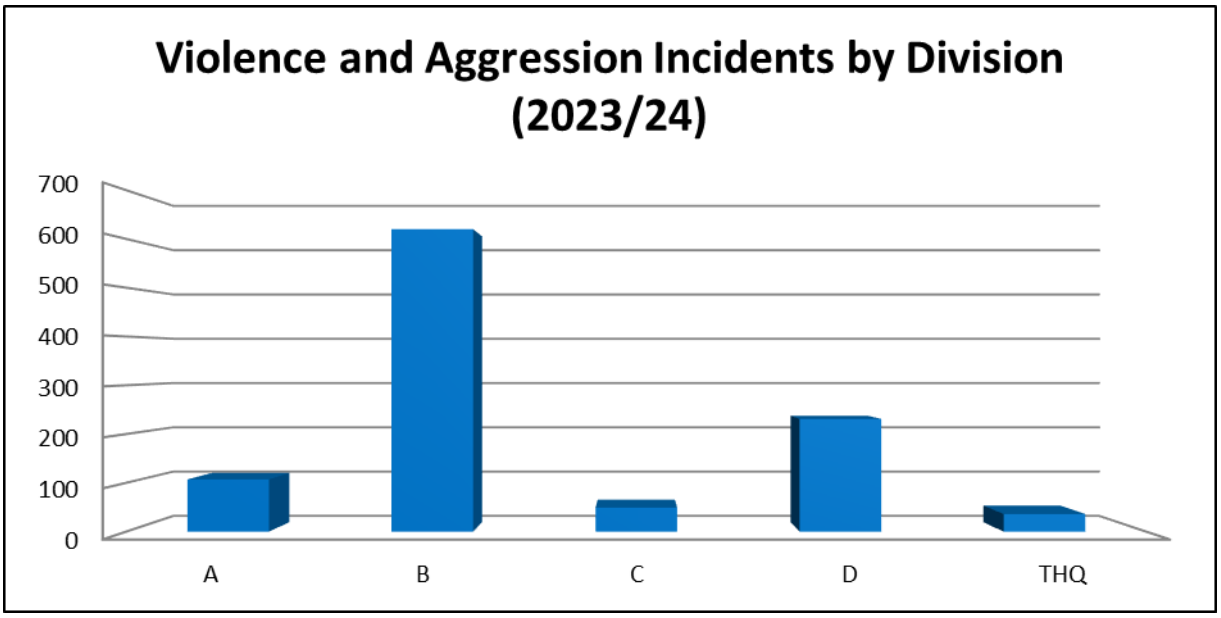

Slips / Trips / Falls Incidents by Division (2023/24)
25
20
15
10
5
0
A
B
C
D
THQ

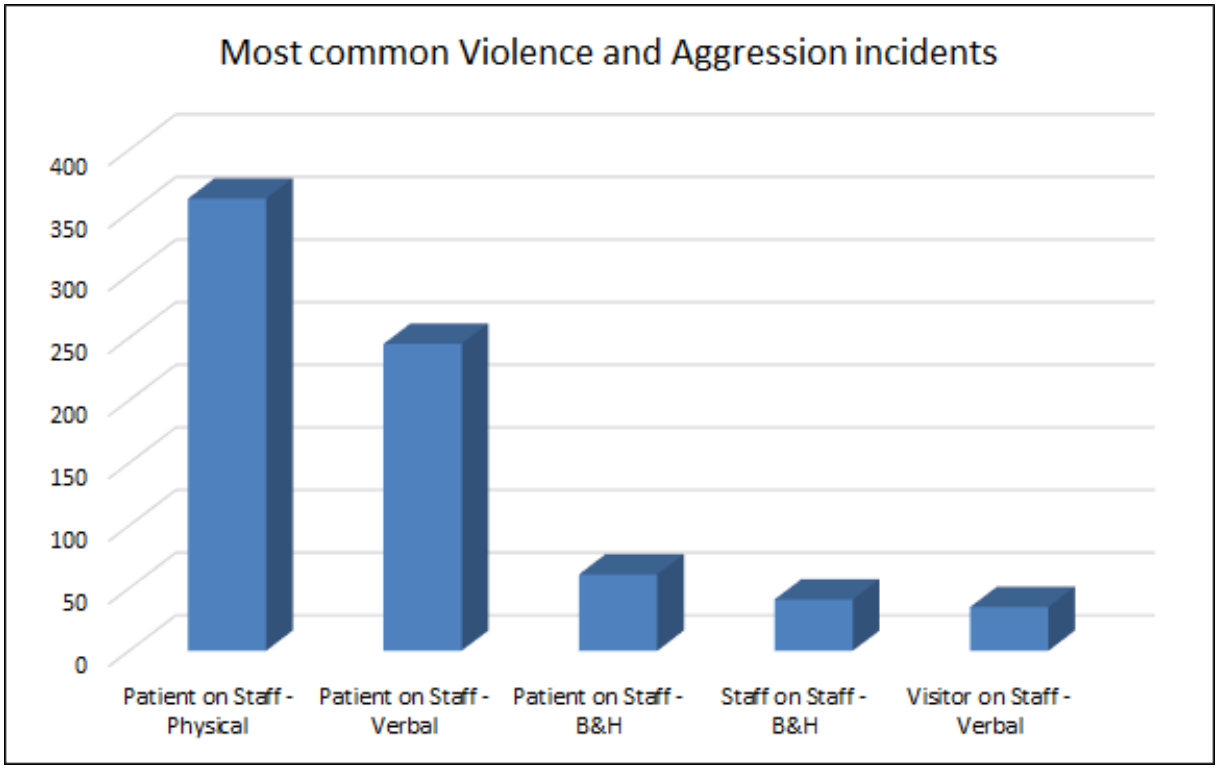

Collision / Contact Incidents by Division (2023/24)
30
25
20
15
10
5
0
A
B
C
D
THQ


Moving and Handling Incidents by Division
8
7
6
5
4
3
2
1
0
A
B
C
D
THQ
2023/24 Q1
2023/24 Q2
2023/24 Q3
2023/24 Q4


M&H (loads) Incidents by Type 2023/24
10
9
8
7
6
5
4
3
2
1
0
Q1
Q2
Q3
Q4
Load
Environment
Staffing
Technique
Equipment


M&H (patients) Incidents by Type 2023/24
16
14
12
10
8
6
4
2
0
Q1
Q2
Q3
Q4
Patient Behaviour
Environment
Equipment
Staffing
Other





The distribution of violence and aggression incidents closely follows that seen in previous years: The highest-reporting division, Division B, has Emergency Medicine and Medicine for Older People, where a number of incidents originating in delirium and dementia are reported: Emergency Medicine also reports a number of deliberate violence and aggression incidents. Similarly, Division D includes Neurosciences, another area where a number of incidents caused by the patient's clinical condition are reported.

The Violence & Aggression Steering Group reviews and scrutinises the adverse event reporting data (from a corporate perspective) for violence and aggression, bullying and harassment and challenging behaviour.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**People and Organisational Development Committee Terms of Reference**			
Agenda item:	**7.3**			
Sponsor:	**Steve Harris, Chief People Officer**			
Author:	**Craig Machell, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**10 September 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 People and Organisational Development Committee reviewed and approved its terms of reference at its meeting held on 21 August 2024. The terms of reference are to be approved by the Board of Directors.			
Response to the issue:	No changes are proposed to the current terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the People and OD Committee are clear and support transparency and accountability in the performance of its role and comply with The NHS Foundation Trust Code of Governance.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006, The NHS Foundation Trust Code of Governance and the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Audit and Risk Committee. 3. 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 is asked to approve the terms of reference.			

People and Organisational Development Committee Terms of Reference

Version: ~~5~~ 6

Date Issued:	~~28 September 2023~~10 September 2024
Review Date:	~~September~~ August 20~~24~~25
Document Type:	Committee Terms of Reference

Contents

Document Status

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1. Role and Purpose

1.1 The People and Organisational Development Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the development and implementation of the people and organisational development strategies and operational plans for University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the three areas of culture, capacity and capability and skills and the Trust's response to specific workforce issues arising from the coronavirus pandemic and the recovery of the organisation.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's culture, capacity and capability and skills in support of the provision of world-class care for all.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least two non-executive directors of the Trust;

3.1.2 the Chief Executive;

3.1.3 the Chief Nursing Officer;

3.1.4 the Chief Medical Officer; and

3.1.5 the Chief People Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the non-executive director members present to chair the meeting.

3.3 Other individuals may be invited for one of more topics to be present depending on the nature of the agenda item.

3.4 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of two-thirds of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief People Officer or the Chief Nursing Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf. A deputy for an executive director will not count towards quoracy.

5. Frequency of Meetings

5.1 The Committee will meet at least six times each year and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief People Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust whilst making reference to the People Strategy and in particular the three pillars of Thrive, Excel and Belong

7.1 ***Culture***

7.1.1 The Committee will ensure that there are robust policies, systems and procedures for the development and monitoring of an inclusive culture with the Trust.

7.1.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.1.2.1 staff and team engagement;

7.1.2.2 compassionate and inclusive leadership;

7.1.2.3 quality improvement;

7.1.2.4 equality, diversity and inclusivity;

7.1.2.5 bullying and harassment;

7.1.2.6 staff sickness and wellbeing

7.1.2.7 Freedom to Speak Up and raising concerns;

7.1.2.8 people aspects of the corporate and clinical strategy; and

7.2 ***Capacity***

7.2.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of workforce planning and recruitment and retention of staff.

7.2.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.2.2.1 strategic workforce planning;

7.2.2.2 recruitment and retention;

7.2.2.3 staffing levels;

7.2.2.4 reports from the Guardian of Safe Working Hours;

7.2.2.5 talent management;

7.2.2.6 reward including pensions;

7.2.2.7 CQUINs;

7.2.2.8 bank and agency staff; and

7.2.2.9 volunteers.

7.3 ***Capability and Skills***

7.3.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of staff appraisal and development.

7.3.2 The Committee will review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It willidentify areas for action at a corporate and local level, ensuring follow up takes place:

7.3.2.1 appraisals;

7.3.2.2 education and training;

7.3.2.3 mandatory training;

7.3.2.4 gaps to meet the long-term corporate and clinical strategy;

7.3.2.5 the annual staff survey;

7.3.2.6 the 'fit and proper persons' requirements;

7.3.2.7 the Staff Friends and Family Test; and

7.3.2.8 flu vaccinations and other national vaccination programmes.

7.4 ***Risk***

7.4.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.4.2 The Committee will establish and maintain an overview of the Trust's people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks.

7.4.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.4.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.5 ***Reporting***

7.5.1 The Committee will advise the Trust Board on the appropriate key performance indicators, measures and benchmarks in the three areas of culture, capacity and capability and skills.

7.5.2 The Committee will ensure robust supporting data quality for any key performance indicators, measures and benchmarks within the areas of culture, capacity and capability and skills.

7.5.3 The Committee will review any submissions to national bodies before these are presented to the Board for approval.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the staff report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive the minutes of those meetings and at least an Annual Report of their work.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 Employment Rights Act 1996

10.2 Equality Act 2010

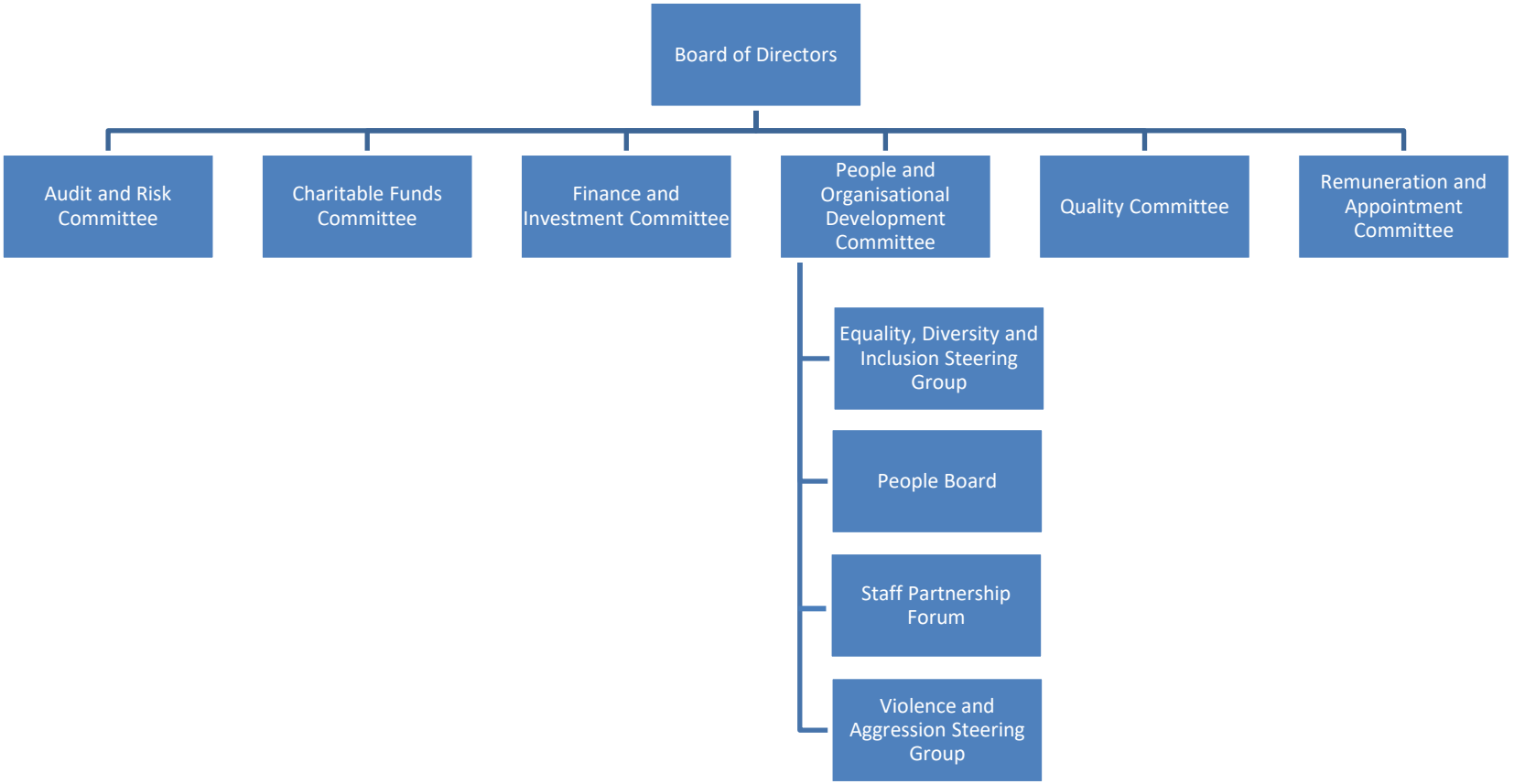
10.3 Public Interest Disclosure Act 1998

10.4 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

10.5 NHS Constitution

10.6 Terms and conditions of service for doctors and dentists in training (England) 2016 - December 2019

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Equality, Diversity and Inclusion Steering Group
People Board
Staff Partnership Forum
Violence and Aggression Steering Group

People and Organisational Development Committee Terms of Reference	Version: ~~5~~6

Document Monitoring Information	
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Consultation:	Chief People Officer
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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

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**CRN: Wessex 2024-25 Q1 Performance Report**			
Agenda item:	**10.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Author:	**Clare Rook, Network Director, RRDN South Central** **Graham Halls, Business Intelligence Manager, CRN Wessex**			
Date:	**10 September 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	● This report covers Clinical Research Network (CRN) Wessex's performance in quarter one of the 2024/25 financial year (April to June 2024) against the Department of Health and Social Care's (DHSC) high level objectives (HLOs) for research and other local metrics.			
Response to the issue:	● Wessex organisations that either sponsor research studies or employ the chief investigator are not currently meeting the objective for eighty per cent of their studies to be on track to recruit their target number in their original timelines. This is on par with English average performance for commercially led research and below for non-commercial studies. ● Wessex is meeting the DHSC objective to deliver sufficient responses to the National Institute of Health and Care Research's (NIHR) Participant in Research Experience Survey (PRES), with forty-three per cent of the annual target achieved in the first quarter. ● Over 16,500 participants have been recruited in quarter one on 391 research studies from 115 sites across the Wessex region. This recruitment is a 90 per cent increase over the participation in quarter one of the 2023/24 financial year.			
Implications: (Clinical, Organisational, Governance, Legal?)	● All NHS organisations have a duty to their local population to participate in and support health and care research. The NIHR provides service support and grant funding to facilitate research activity within Wessex. Therefore, CRN Wessex and its partner organisations must ensure the funding is used effectively.			
Risks: (Top 3) of carrying out the change / or not:	● CRN Wessex maintains a risk register, which can be found in Appendix One. The top three identified risks are: ○ NHS pressures ○ Reduced access to PET scan tracers required for research studies ○ Staff burnout. *Please review the risk register in Appendix One for details of the already underway or planned responses.*			

1

Summary: Conclusion and/or recommendation	• Wessex is currently meeting one of three high level objectives set by DHSC. These apply to the whole of England, but the Wessex region contributes to their performance. The study delivery objectives are not being met. • Wessex sponsors, who are responsible for their study delivery, receive information from CRN Wessex to enable performance management. Sponsors can also request the support of CRN staff where studies are not on track to meet their objectives. • When benchmarked against the same time last year, research recruitment in Wessex was very strong in quarter one. This is a result of continuing work to strengthen the Wessex research portfolio. The result is that more patients are offered the opportunity to participate in research. • The experience of participants in research is reported as generally very good, with some areas with lower scores being addressed through regional improvement projects. • The Board will continue to be updated on performance quarterly.

University Hospital Southampton
NHS Foundation Trust

NIHR | Clinical Research Network Wessex

CRN: Wessex 2024-25 Q1 Performance Report

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

September 2024

Introduction

This report informs the UHS Board of Directors of the clinical research activities within the Wessex region. The report covers the performance against the National Institute of Health and Care Research's (NIHR) high level objectives, as well as general research activity in Wessex during quarter one of the 2024/25 financial year (April to June 2024), unless otherwise stated.

Key issues

National areas of strategic focus for health research

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

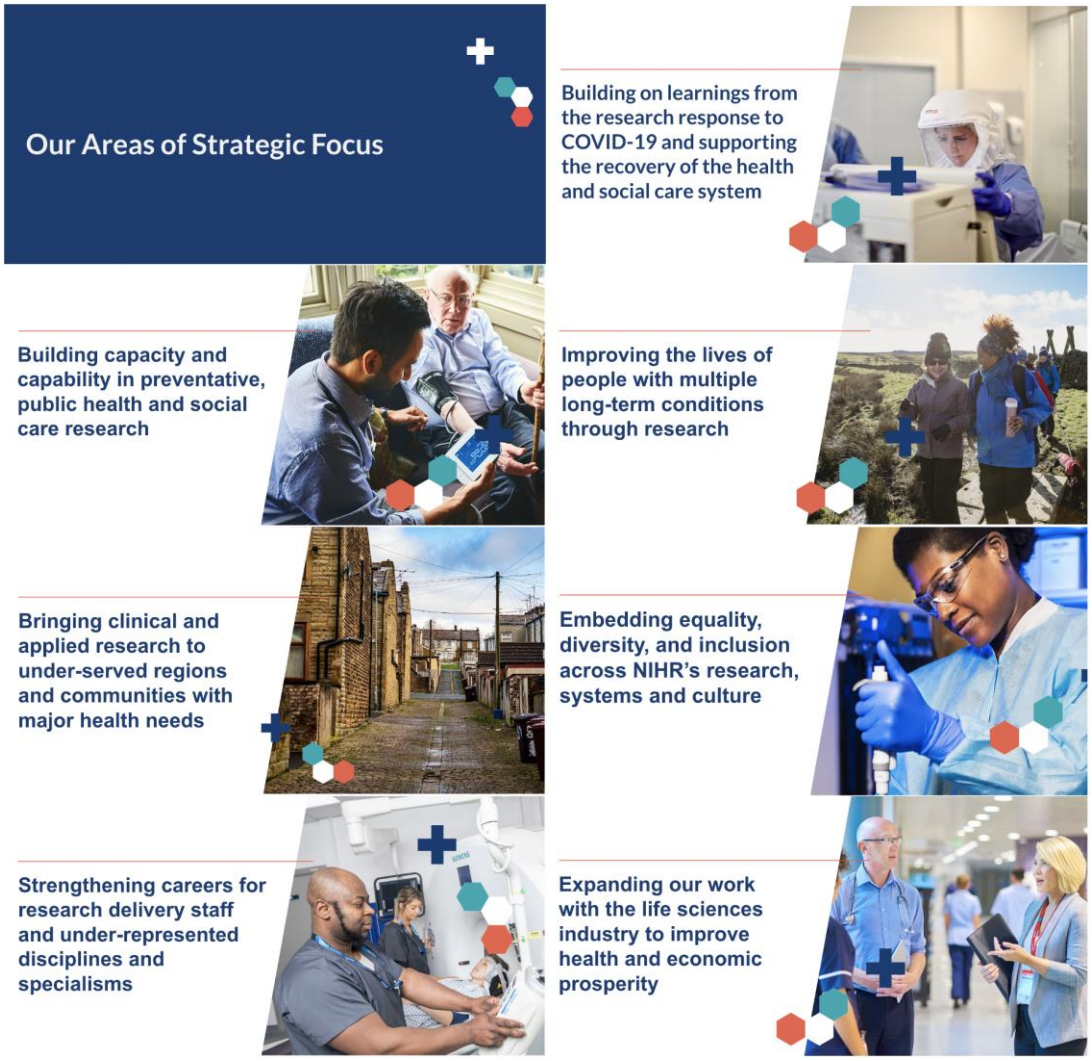


Figure 1 - NIHR Areas of strategic focus from Best Research for Best Health: The Next Chapter.

DHSC & NIHR high level objectives (HLOs) and the new NIHR Research Delivery Network

In April 2024, the NIHR Clinical Research Network became the NIHR Research Delivery Network (RDN).

The NIHR RDN has two primary purposes:

1. To support the successful delivery of high quality research, as an active partner in the research system
2. To increase capacity and capability of the research infrastructure for the future.

The NIHR have produced a short video which provides a summary of the changes: The Future NIHR Research Delivery Network.

NIHR Clinical Research Network Wessex (CRN Wessex) will be transitioning to the South Central Regional Research Delivery Network (SC RRDN) on 1st October 2024. SC RRDN will continue to be hosted by University Hospital Southampton NHS Foundation Trust. This article on the Trust's website explains these hosting arrangements: Southampton to host new network for health and care research across region.

In this period of transition, CRN Wessex will continue to operate under the 2023/24 NIHR CRN high level objectives. Therefore, the quarter one and two reports will provide the region's performance under the 2023/24 HLOs, unless these are revised by the NIHR RDN. These objectives are provided in Figure 2, with quarter one Wessex and English (all local CRN regions combined) performance linked to ambitions agreed with the DHSC.

Objective		Measure	Ambition	Wessex	England
Study delivery	Support sponsors to deliver NIHR CRN Portfolio studies to recruitment target	Percentage of **open to recruitment commercial** contract studies which are predicted to achieve their recruitment target	80%	74% (25/34 open Wessex-led studies)	75%
		Percentage of **open to recruitment non-commercial** studies which are predicted to achieve their recruitment target	80%	78% (98/126 open Wessex-led studies)	84%
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the **Participant Research Experience Survey**	1,237	537 (43%)	18,000 ambition (the total national responses received to date is to be announced)

Figure 2 – Local and national performance for the DHSC & NIHR CRN High Level Objectives for quarter one of the 2024/25 financial year.

The Wessex region has a slightly lower average performance on the Study Delivery objectives compared to the average for England. These measures apply to commercial and non-commercial studies that are being led from Wessex and the whole of England, respectively. CRN Wessex's role is to support the delivery of this objective for the studies that have sponsors or study chief investigators located in this region. The sponsor for these studies has ultimate responsibility for the performance. To facilitate their performance management, monthly reports are sent to the Wessex sponsor organisations. An interactive study delivery dashboard, provided and maintained by CRN Wessex, is also available online.

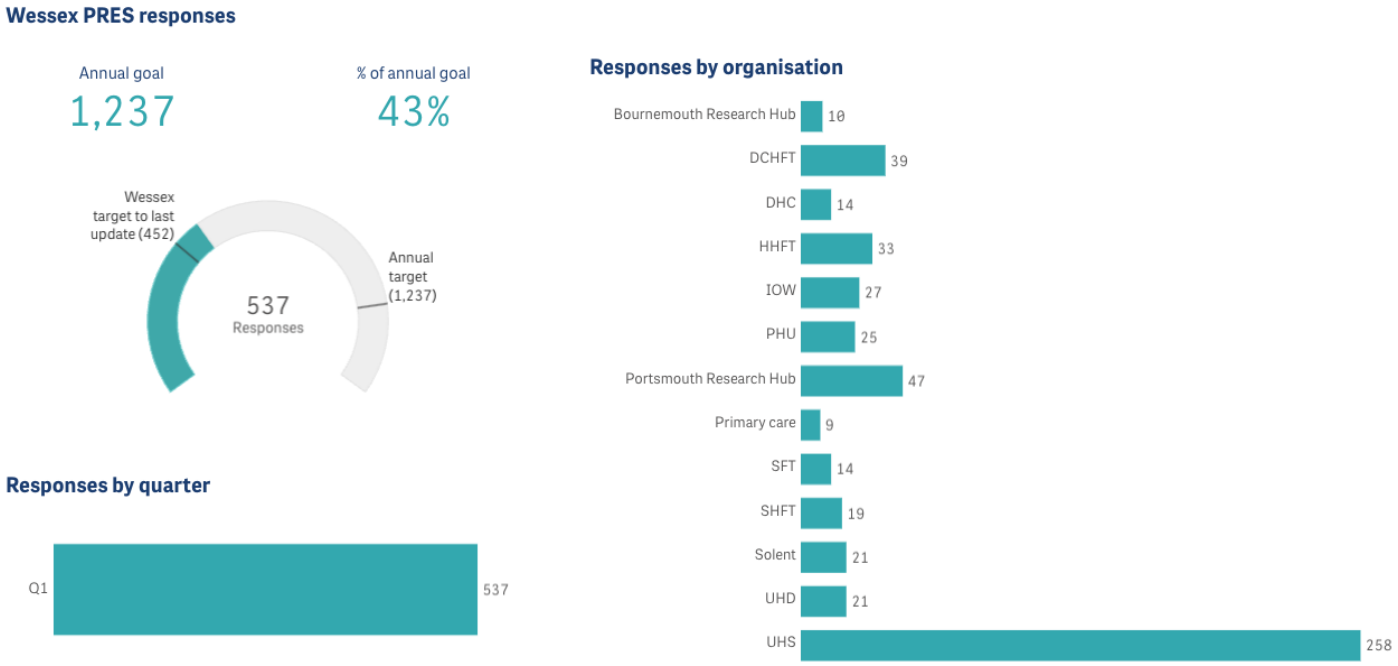


Figure 3 - Participant in research experience survey responses in Wessex in quarter one of the 2024/25 financial year. The glossary in appendix two contains expanded organisation acronyms.

The ambition for the *Participant Experience* objective in Wessex is 1,237 completed Participant Research Experience Surveys (PRES). In quarter one, 537 responses were received, and therefore this objective is on track to be met by the end of the financial year. PRES is important to health and care organisations that support research in England as it is the main mechanism for identifying ways to improve the participant's experience. Figure 4 summarises the responses that were received in quarter one.

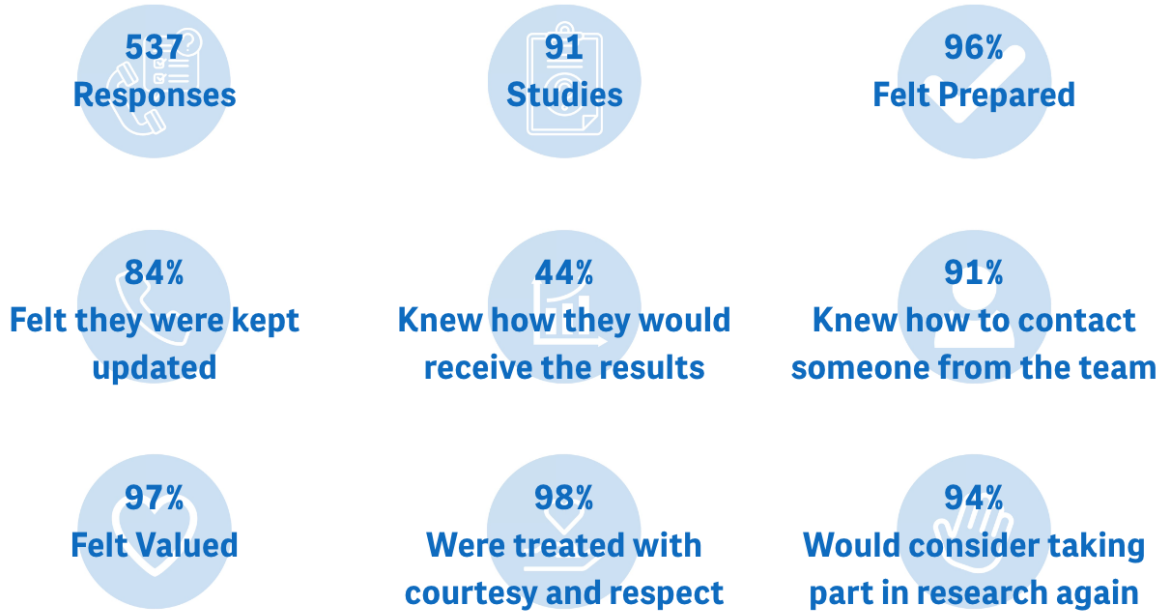


Figure 4 - Summary of the Participant in research experience survey results in Wessex in quarter one of the 2024/25 financial year.

Overall, the PRES responses have been positive, with the main areas of concern that fifty-six per cent did not know how they would receive the study results and sixteen per cent did not feel they were kept updated. These are both reliant on the study design and the participant communications that have been ethically approved. The PRES process is overseen by a regional working group comprising representatives from Wessex health and care organisations and research participants. This group has, for example, provided participant feedback to study sponsors about particular studies, resulting in amendments to the study design that applied to all national sites.

Research activity in Wessex

All research activity

CRN Wessex benchmark recruitment on to studies against both the region's previous activity and the recruitment in the fourteen other local CRN regions in England. Wessex has recruited 16,548 participants in quarter one across 115 sites and 391 studies.

Directed by CRN Wessex's Executive Group, the CRN's study support and industry teams were tasked in quarter two of the 2023/24 financial year to identify studies with either a high potential to recruit, or that could open at other sites in the region. This was to increase opportunities for the Wessex population to participate in health and care research. Wessex organisations responded by increasing their recruitment

(Figure 5) without increasing the number of studies that the region participated in (Figure 8). These high recruiting studies have on the whole continued into the 2024/25 financial year.

Figure 5 - Wessex research recruitment benchmarked against England since April 2022.

Wessex was ranked between fifth and seventh of the fifteen local CRN regions in England for recruitment in each of the three months of quarter one (Figure 6). Wessex has around five per cent of the English population, so the expected rank would be around seventh or eighth if recruitment correlated directly with the size of the population. When weighted for the population in each English region, Wessex was ranked between second and fourth in each month in quarter one (Figure 7).

Month	Apr	May	Jun
Wessex rank	7	5	6

Figure 6 - Wessex's recruitment rank within each month of quarter one of the 2024/25 financial year, compared to the fifteen local clinical research network regions in England.

Month	Apr	May	Jun
Wessex rank	4	2	3

Figure 7 - Wessex's recruitment (weighted per million population) rank within each month of quarter one of the 2024/25 financial year, compared to the fifteen local clinical research network regions in England.

The number of commercial and non-commercial studies that Wessex organisations have recruited to has remained stable since the middle of the 2021/22 financial year (Figure 8). A seven per cent reduction in recruiting studies between quarter four 2023/24 and quarter one 2024/25 will be monitored to see whether the portfolio of studies may be shrinking. While maximising opportunities for participating in research is important, having a broad selection of research studies available to our population is also a significant consideration.

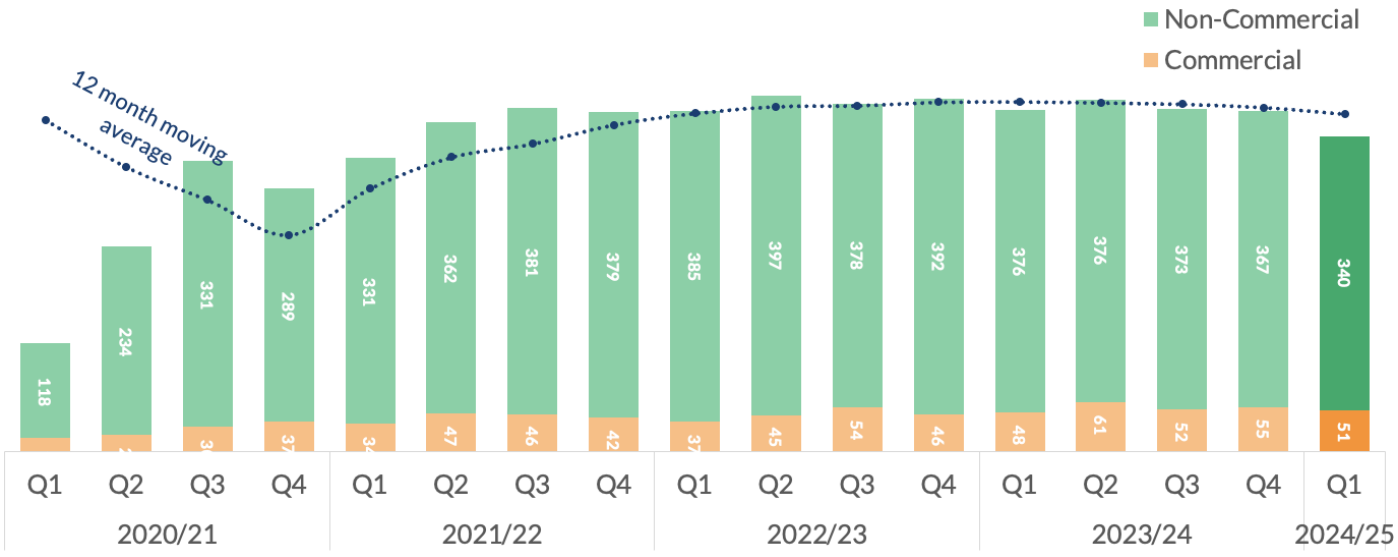
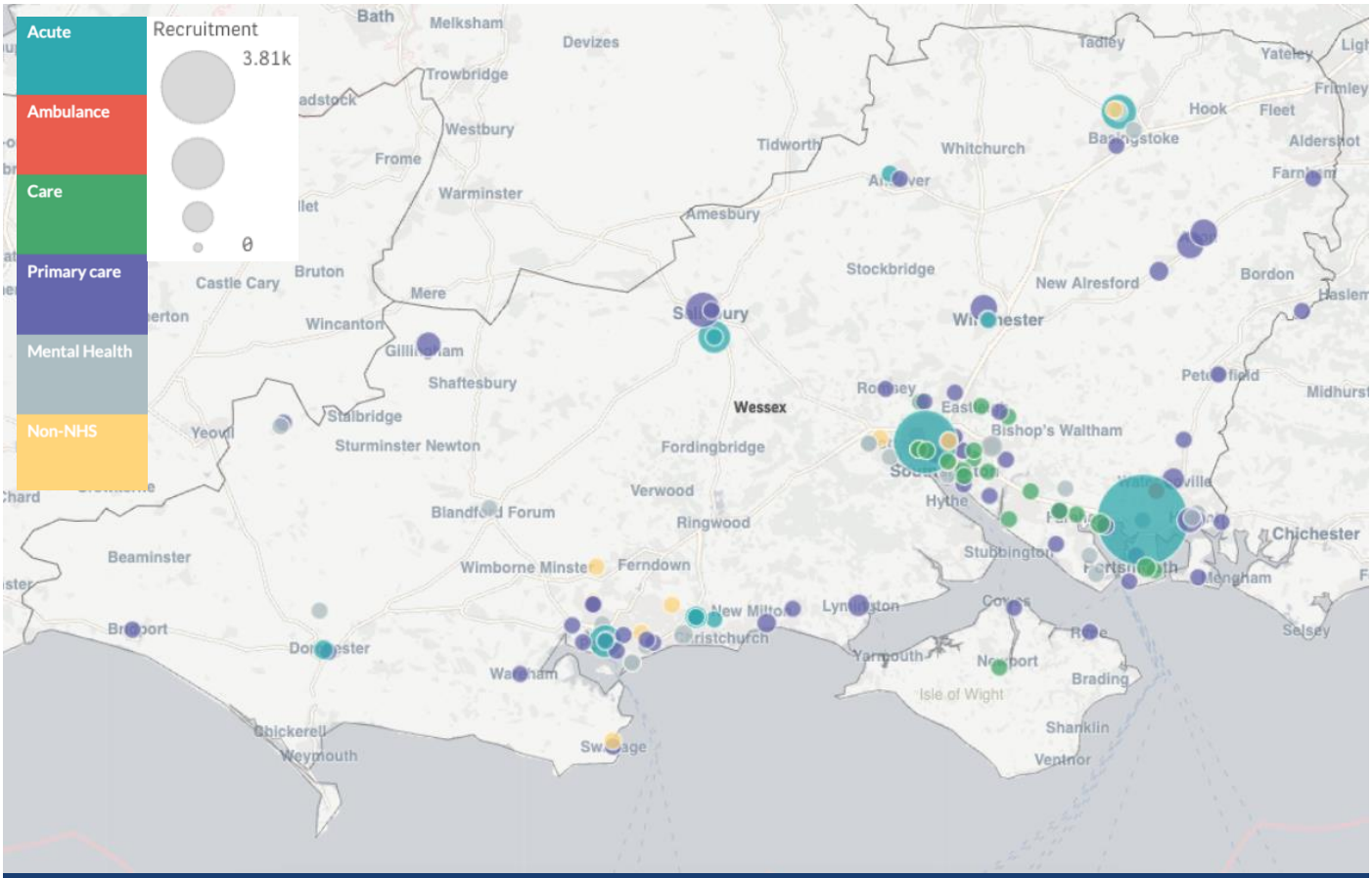


Figure 8 - Recruiting studies in Wessex by funding type in the last five financial years (April 2020 to June 2024).

Figure 9 shows how research activity is distributed across the Wessex region by type of organisation. Recruitment in quarter one has primarily taken place in the largest towns and cities, however sites outside of hospital settings have accounted for twenty-eight per cent of recruited participants. For reference, Figure 10 provides quarterly recruitment for Wessex organisations in the last twelve months.



Organisation type	Trusts	Recruiting sites	Recruitment	Recruiting studies	% of organisations recruited this year
Acute	7	17	11,264	336	100% (ambition 100%)
Ambulance	1	3*	192	5	100% (ambition 100%)
Care	1	21	572	23	100% (ambition 100%)
Primary care	*N/A*	44	4,490	24	18% (ambition 100%)
Mental Health	2	21	468	28	100% (ambition 100%)
Non-NHS	*N/A*	9	42	8	N/A

*Ambulance recruitment happens across Wessex but is primarily recorded at the South Central Ambulance Service Trust Headquarters in Oxfordshire.

Figure 9 – Research activity in Wessex by organisation type in the first quarter of the 2024/25 financial year.

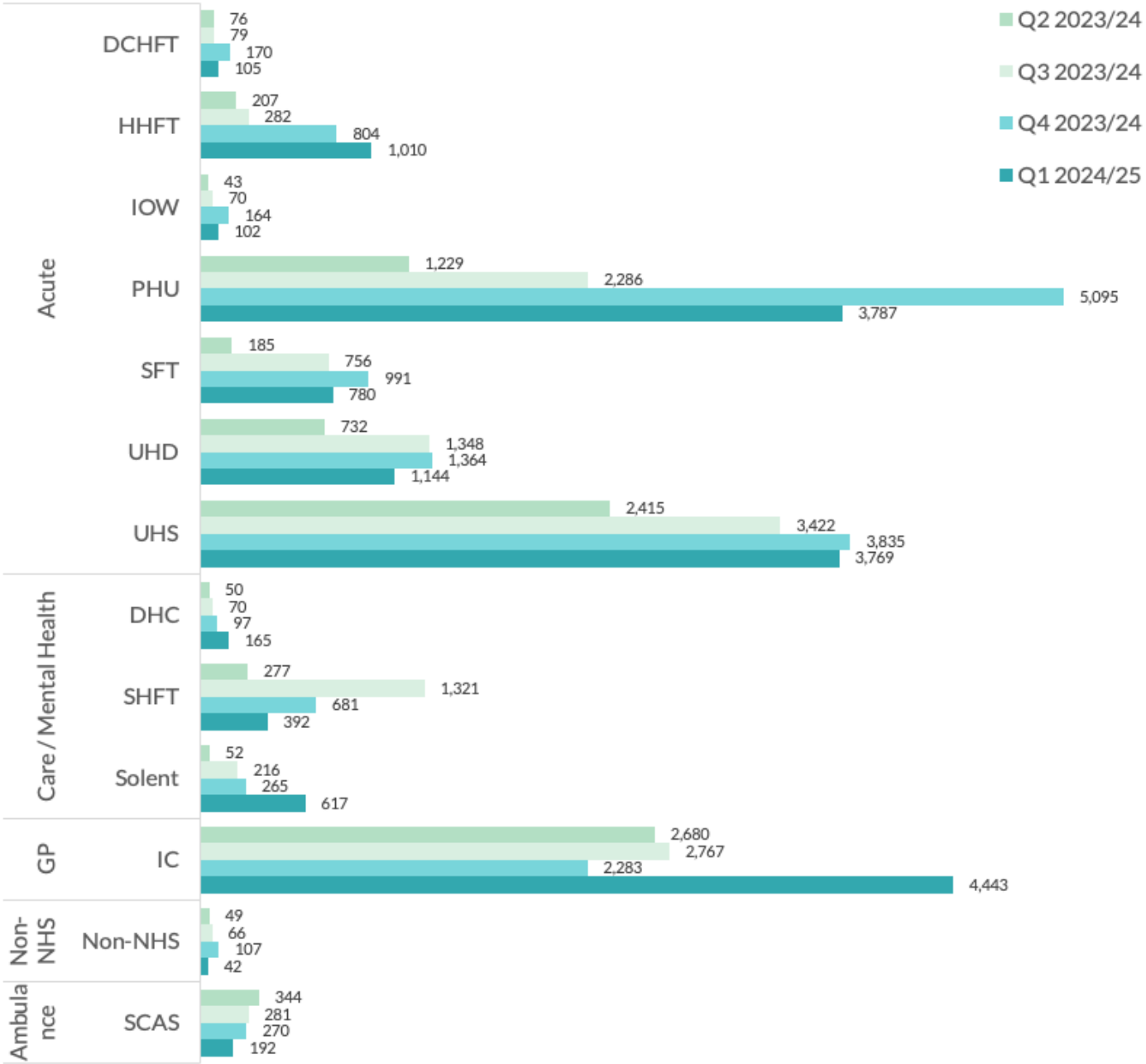


Figure 10 – Quarterly CRN Portfolio study recruitment by organisation type in Wessex in the first quarter of the 2024/25 financial year.

Commercial research activity in Wessex

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

Twenty-five per cent of Wessex's recruitment in the first quarter has been on to a total of fifty-one commercial research studies. Of the 4,180 participants on commercial studies, 3,878 have been recruited on to the Omnigen Discover Me genetics profiling study (https://www.discovermestudy.com/) within primary care. Commercial recruitment by organisation in the last four quarters is provided in Figure 11.

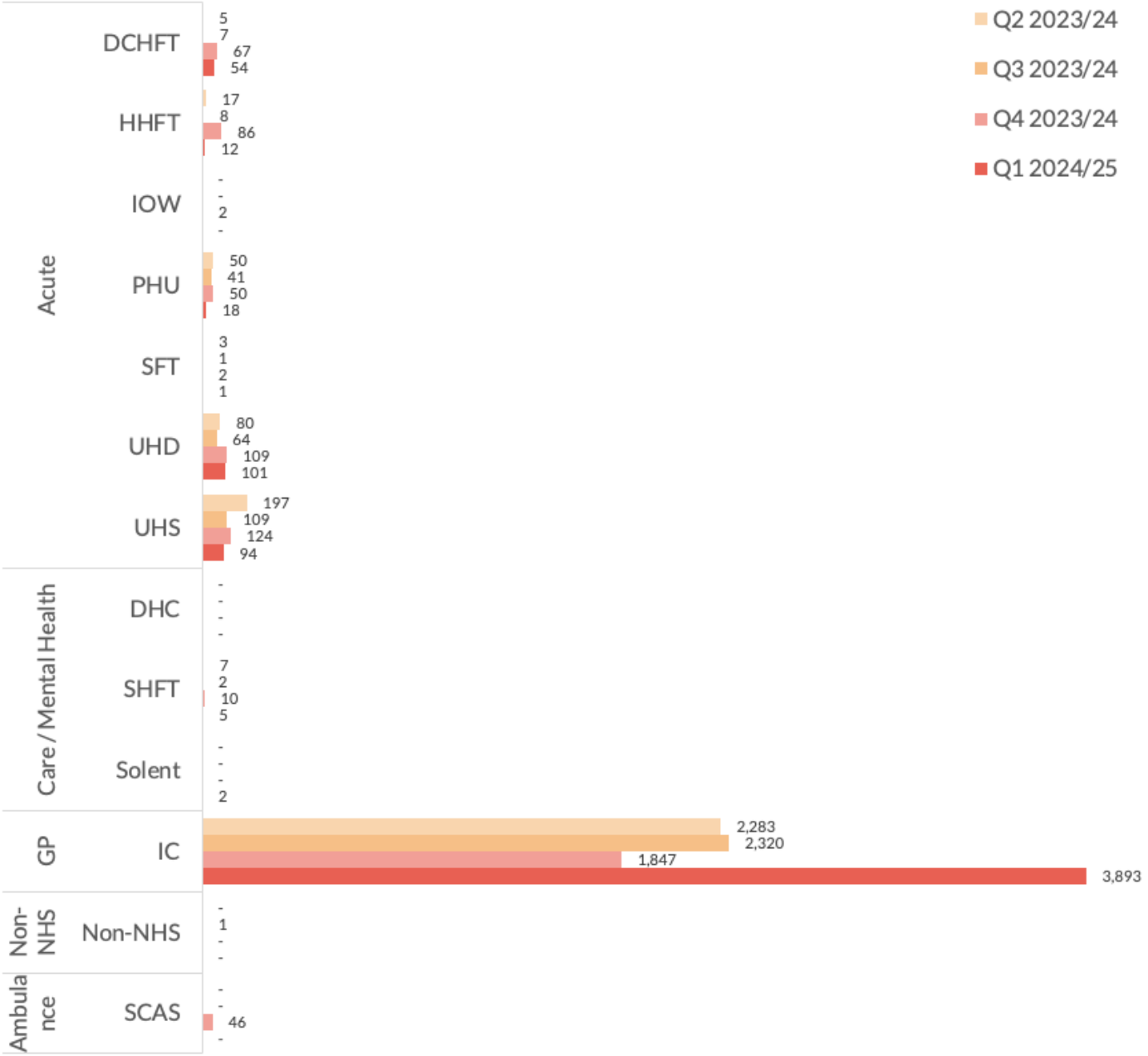


Figure 11 – Quarterly commercially funded and sponsored CRN Portfolio study recruitment by organisation type in Wessex in quarter one of the 2024/25 financial year.

Appendix

Appendix 1 – CRN Wessex Risk Register

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

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 10	Workforce	Sep-22	CDs/COO	**Cause: End of LCRN contract September 2024** **Event: Existing staff may leave for other roles in the system to avoid uncertainty, leading to a depleted team and difficulty delivering to the POF. Difficulty recruiting into vacant posts for the final 'transition' year (2023/24)**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies 2. Implement staff transition survey to gather opinions and suggestions 3. Involve staff in wellbeing initiatives to support through the transition 4. Work with UHS transition leads and HR to keep staff up to date with process to support transition to new roles and services	COO/DCOO	All - ongoing	3	3	9	Open	Static
CRN 11	Performance	Oct-22	CDs/COO	**Cause: NHS pressures** **Event: Staff shortages due to sickness impacting on delivery, pharmacy, imaging: redeployment of research staff to clinical services**	4	4	16	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	4	16	Open	Static
CRN 14	Performance	March	CDs/COO	**Cause: Junior doctor strike action** **Event: Redeployment of clinical staff to cover emergency care leading to lack of staff to deliver clinical trials**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies	COO/DCOO	All - ongoing	4	3	12	Open	Static
CRN16	Workforce	Dec-23	CDs/COO	**Cause: RRDN transition** **Event: CRN Wessex host organisation and incoming South Central RRDN host, UHS, has placed a recruitment freeze on the CRN Wessex team. This is currently impacting the agile clinical delivery team that has 6 vacancies and a further 5 team members going on mat leave in the new year. A lack of registered staff in the team has been highlighted as a risk by CRN Wessex chief research nurse**	4	3	12	Current	1. Raise locally and nationally for advice on prioritisation of key activities/studies 2. With support of CRN Wessex chief nurse, quantify the level of WTEs missing from the team and impact on skill mix required to deliver the upcoming portfolio	COO/DCOO	All - ongoing	3	3	9	Open	Static
CRN17	Workforce	Apr-24	CDs/COO	**NHS Handbook staff mileage cap < 3500 annual mileage restrictions impacting agile delivery team capacity to travel across the region to deliver research to communities currently under-served by research opportunities**	3	3	9	Current	1. Raised locally with HR and nationally through CC	COO/DCOO	All-ongoing	3	3	9	Open	Static
CRN18	Performance	Jun-24	IOM	**Cause: Reduced access to PET tracers (amyloid and tau) required for both clinical and research scans** **Event: Limited access to PET scans for research purposes. Reduced opportunities for access to research for neurology and oncology patients. Threat to safety and data integrity if schedule of imaging events cannot be adhered to.**	4	4	16	Near future	1. Raised at OMG and IOM/BDM meeting, to monitor.	IOM						

Appendix 2 - Glossary

Partner organisation abbreviations used by CRN Wessex:

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

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

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