University Hospital Southampton
NHS Foundation Trust

# Agenda Trust Board – Open Session

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| **Date** | 11/03/2025 |
| **Time** | 9:00 - 13:00 |
| **Location** | Conference Room, Heartbeat Education Centre |
| **Chair** | Jenni Douglas-Todd |

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|---|---|---|
| **1** | 9:00 | **Chair's Welcome, Apologies and Declarations of Interest**<br>Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda. |
| **2** | | **Patient Story**<br>The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better. |
| **3** | 9:15 | **Minutes of Previous Meeting held on 7 January 2025**<br>Approve the minutes of the previous meeting held on 7 January 2025 |
| **4** | | **Matters Arising and Summary of Agreed Actions**<br>To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting. |
| **5** | | **QUALITY, PERFORMANCE and FINANCE**<br>Quality includes: clinical effectiveness, patient safety, and patient experience |
| **5.1** | 9:20 | **Briefing from the Chair of the Audit and Risk Committee**<br>Keith Evans, Chair |
| **5.2** | 9:25 | **Briefing from the Chair of the Finance and Investment Committee**<br>Dave Bennett, Chair |
| **5.3** | 9:30 | **Briefing from the Chair of the People and Organisational Development Committee**<br>Jane Harwood, Chair |
| **5.4** | 9:35 | **Briefing from the Chair of the Quality Committee**<br>Tim Peachey, Chair |
| **5.5** | 9:40 | **Chief Executive Officer's Report**<br>Receive and note the report<br>Sponsor: David French, Chief Executive Officer |

**5.6** **Performance KPI Report for Month 10**

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

**5.7** **Break**

10:45

**5.8** **Finance Report for Month 10**

11:00 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

**5.9** **ICS Finance Report for Month 10**

11:15 Receive and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

**5.10** **People Report for Month 10**

11:20 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

**5.11** **Mortuary Standards Compliance Update (Oral)**

11:35 Sponsor: Gail Byrne, Chief Nursing Officer

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

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

11:40 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendees: Martin De Sousa, Director of Strategy and Partnerships/Kelly Kent, Head of Strategy and Partnerships

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

11:50 Review and discuss the update
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

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

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

12:00 Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:05 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

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

12:10 Review and approve the Terms of Reference
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

12:15 Review and approve the Terms of Reference
Sponsor: Dave Bennett, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

**7.5** **Quality Committee Terms of Reference**

12:20 Review and approve the Terms of Reference
Sponsors: Tim Peachey, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

12:25 Review and approve the Terms of Reference
Sponsor: Jenni Douglas-Todd, Trust Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

**7.7** **Trust Executive Committee Terms of Reference**

12:30 Approve the proposed amendments to the Terms of Reference
Sponsor: David French, Chief Executive Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

**8** **Any other business**

12:35 Raise any relevant or urgent matters that are not on the agenda

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

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

*29 January 2025*
Message from Ian Howard re Update on legal dispute with BAM

**10.1** **South Central Regional Research Delivery Network (SC RRDN) 2024-25 Q3 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
NHS Foundation Trust

# Agenda links to the Board Assurance Framework (BAF)

11 March 2025 – Open Session

## Overview of the BAF

| Risk | Appetite (Category) | Current risk rating | Target risk rating | |
|---|---|---|---|---|
| 1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients. | Minimal (Safety) | 4 x 5 20 | 4 x 2 6 | Apr 27 |
| 1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes. | Cautious (Experience) | 3 x 3 9 | 3 x 2 6 | Mar 26 |
| 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection. | Minimal (Safety) | 4 x 4 16 | 2 x 3 6 | Apr 27 |
| 2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients. | Open (Technology & Innovation) | 3 x 3 9 | 3 x 2 6 | Dec 25 |
| 3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. | Open (workforce) | 4 x 5 20 | 4 x 3 12 | Mar 26 |
| 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. | Open (workforce) | 4 x 3 12 | 4 x 2 8 | Mar 27 |
| 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan. | Open (workforce) | 4 x 4 16 | 3 x 2 6 | Mar 29 |
| 4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay. | Cautious (Effectiveness) | 3 x 3 9 | 3 x 2 6 | Dec 25 |
| 5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives. | Cautious (Finance) | 4 x 5 20 | 3 x 3 9 | Apr 30 |
| 5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity. | Cautious (Effectiveness) | 4 x 5 20 | 4 x 2 8 | Apr 30 |
| 5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation, | Open (Technology & Innovation) | 3 x 4 12 | 3 x 2 6 | Apr 27 |
| 5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045. | Open (Technology & Innovation) | 2 x 3 6 | 2 x 2 4 | Dec 27 |

## Agenda links to the BAF

| No | Item | Linked BAF risk(s) | Does this item facilitate movement towards or away from the intended target risk score and appetite? | | |
|---|---|---|---|---|---|
| | | | Towards | Away | Neither |
| 5.6 | Performance KPI Report for Month 10 | 1a, 1b, 1c | | | x |
| 5.8 | Finance Report for Month 10 | 5a | | | x |
| 5.9 | ICS Finance Report for Month 10 | 5a | | | x |
| 5.10 | People Report for Month 10 | 3a, 3b, 3c | | | x |
| 5.11 | Mortuary Standards Compliance Update | 1b | x | | |
| 5.11 | Corporate Objectives 2024-5 Quarter 3 Review | All | | | x |

# Minutes Trust Board – Open Session

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|---|---|
| **Date** | 07/01/2025 |
| **Time** | 9:00 – 13:00 |
| **Location** | Conference Room, Heartbeat/Microsoft Teams |
| **Chair** | Jenni Douglas-Todd (JD-T) |
| **Present** | Dave Bennett, NED (DB)<br>Gail Byrne, Chief Nursing Officer (GB)<br>Jenni Douglas-Todd, Chair (JD-T)<br>Diana Eccles, NED (DE)<br>Keith Evans, Deputy Chair and NED (KE)<br>David French, Chief Executive Officer (DAF)<br>Paul Grundy, Chief Medical Officer (PG)<br>Steve Harris, Chief People Officer (SH)<br>Jane Harwood, NED/Senior Independent Director (JH)<br>Ian Howard, Chief Financial Officer (IH)<br>David Liverseidge, NED (DL)<br>Tim Peachey, NED (TP)<br>Joe Teape, Chief Operating Officer (JT)<br>Alison Tattersall, NED (AT) |
| **In attendance** | Martin De Sousa, Director of Strategy and Partnerships (MDeS)<br>Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM)<br>James Allen, Chief Pharmacist (JA) (item 5.14)<br>Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.1)<br>Julie Brooks, Deputy Director of Infection Prevention & Control (JB) (item 5.13)<br>Rosemary Chable, Head of Nursing for Education, Practice and Staffing (RC) (item 5.15)<br>Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.11)<br>Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian (CMb) (item 5.10)<br>John Mcgonigle, Emergency Planning & Resilience Manager (JMc) (item 7.1)<br>Jenny Milner, Associate Director of Patient Experience (JM) (item 5.12)<br>Danielle Sinclair, Deputy Emergency Planner (DS) (item 7.1)<br>Julian Sutton, Lead Infection Control Director (JS) (item 5.13)<br>Fatemeh Jenabi, Specialty Registrar (FJ) (shadowing JT)<br>1 member of the public (item 2)<br>6 governors (observing)<br>4 members of staff (observing) |



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

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

The Board welcomed David Liverseidge, who had been appointed as an independent non-executive director with effect from 1 January 2025.

It was noted that Joe Teape had accepted an appointment as chief executive officer of Torbay and South Devon NHS Foundation Trust, and, accordingly Joe Teape would be leaving the Trust in February 2025.

It was further noted that Jenni Douglas-Todd had been appointed as chair of the partnership between Portsmouth Hospitals University NHS Trust and Isle of Wight NHS Trust, commencing on 1 April 2025.

**2. Patient Story**

Gillian Muir, one of the Trust's 'involved patients', was invited to relate their experience of treatment for tongue and thyroid cancer in 2022. It was noted that:

- Both the treatment received and staff were rated positively. However, the referral process was open to criticism.
- In addition, it was considered that it would be beneficial to have a single point for information for patients as well as more information about self-help and on the patient journey.
- The importance of the emotional aspect of treatment was noted as was the benefit of using patients to help other patients.

**Action**

Gail Byrne agreed to consider how the recommendations made in patient stories could be captured and action taken as a result.

**3. Minutes of the Previous Meeting held on 5 November 2024**

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 5 November 2024.

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

It was noted that all actions were either closed or not yet due for completion.

**5. QUALITY, PERFORMANCE and FINANCE**

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

The chair of the Finance and Investment Committee was invited to present the Committee Chair's Reports in respect of the meetings held on 25 November and 16 December 2024, the content of which was noted. It was further noted that:

- The Trust's financial position remained challenging with additional cost pressures due to the pay awards and non-delivery of system-wide transformation programmes resulting in a year-to-date deficit of £18.2m.
- There was a shortfall of £17m in respect of delivery of the Trust's Cost Improvement Programme (CIP), largely due to non-delivery of system transformation programmes.
- The Trust benchmarked well against comparator organisations in terms of its value-for-money and elective recovery delivery.
- As at the end of November 2024, the Trust had carried out £21m in unfunded activity.
- The Trust's cash balance remained a concern, as it was being eroded by the Trust's underlying monthly deficit and was expected to fall below the minimum required level in the first quarter of 2025/26.

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

The chair of the People and Organisational Development Committee was invited to present the Committee Chair's Report in respect of the meeting held on 13 December 2024, the content of which was noted. It was further noted that:

- As anticipated, the Trust's workforce had grown slightly in November 2024. However, the main challenge to meeting the Trust's 2024/25 plan remained the non-delivery of system-wide transformation programmes in mental health and non-criteria to reside, which the Trust had assumed would enable a reduction in its workforce by 218 whole-time-equivalents (WTE).
- The committee received an update in respect of the ongoing industrial dispute with portering staff and in respect of the Band 2/3 pay dispute.
- The committee reviewed the Board Assurance Framework and suggested that the rating of risk 3c should be increased to reflect the financial situation and uncertainty around the NHS long-term workforce plan (item 6.1).
- Issues such as ongoing industrial disputes were impacting the Trust's capacity to make progress on other areas such as organisational and cultural development and transformation.

**5.3 Briefing from the Chair of the Quality Committee including Maternity and Neonatal Safety 2024-25 Quarter 2 Report**

The chair of the Quality Committee was invited to present the Committee Chair's Report in respect of the meeting held on 25 November 2024, the content of which was noted. It was further noted that:

- There had been seven 'never events' during 2024/25.
- The committee had reviewed the Learning from Deaths 2024-25 Quarter 2 report (item 5.12), and it was noted that the risk rating attributable to this area in the Chair's Report was aggregated.
- The committee had reviewed the Infection Prevention and Control 2024-25 Quarter 2 report (item 5.13).
- The committee had scrutinised the Maternity and Neonatal Safety 2024-25 Quarter 2 report in detail.

**5.4 Chief Executive Officer's Report**

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

- There had been a water supply failure on 18 December 2024 due to a technical problem at a nearby water treatment works, which resulted in a loss of water for three days. Southern Water supplied the Trust with water via tankers during this period to ensure that soft (non-potable) water was available throughout the interruption. The Trust's Estates team managed this incident well.
- It had been a difficult start to 2025 with high Emergency Department attendance levels and ambulance volumes, exacerbated by the national prevalence of seasonal illnesses such as influenza, which impacted both patient and staff numbers.
- In order to manage Emergency Department attendances as high as 450 patients per day, the Trust had been required to situate patients in other areas of the hospital, which placed additional logistical burdens on staff.
- The high rates of attendance meant that the Trust was close to declaring a critical incident, noting that other local providers had already done so.
- There were 263 patients having no criteria to reside awaiting discharge.

- The Government had made a number of announcements prior to Christmas in respect of possible reforms, including introduction of a league table for NHS providers.
- In addition, the Government had announced its targets for the NHS, including a commitment that 92% of patients were seen within 18 weeks, which would likely pose a significant challenge, as currently only around 60% of patients were seen within this timeframe. There was also a possibility that a cap would be introduced on Elective Recovery Funding.
- Based on discussions with NHS England, it was understood that the £22bn of additional funding announced in the Autumn Statement had already been allocated to address pay awards and other cost pressures, and accordingly 2025/26 would likely feel like a 1-2% decrease in terms of funding. The messaging from NHS England appeared to have also altered to one of providers doing what they could within the available funding envelope, rather than attempting to deliver against all targets whilst at the same time delivering a break-even financial position.
- It was proposed to regulate NHS managers, and a consultation, closing on 18 February 2025, had been launched on 26 November 2024. It was agreed that any such regulation needed to be fair and equitable.
- The Trust had opened a new state-of-the-art special care baby unit, designed to increase capacity and offer enhanced specialist care.

**5.5 Performance KPI Report for Month 8**

Joe Teape was invited to present the Performance KPI Report for Month 8, the content of which was noted. It was further noted that:

- The Trust continued to perform well when compared to other equivalent organisations.
- During November 2024, there had been an average of 450 patients per day attending the Emergency Department, and four-hour performance at Southampton General Hospital was 56.1%.
- There had been improvements in cancer waiting times against the 28-day faster diagnosis and 31-day targets.
- The Trust's Referral To Treatment waiting list had reduced slightly, and the Trust's performance against the 18-week target was top-quartile.
- Between August and October 2024, the Trust's performance against the six-week diagnostic standard was 87%, which although below the national target, was top-quartile.

**5.6 Break**

**5.7 Finance Report for Month 8**

Ian Howard was invited to present the Finance Report for Month 8, the content of which was noted. It was further noted that:

- The Trust had reported a £5.7m in-month deficit (£18.2m year-to-date) and was £14.8m behind its 2024/25 plan.
- The Trust had submitted its financial recovery plan to the Hampshire and Isle of Wight Integrated Care Board and was on track with this plan, with the exception of the pressures due to the pay award.
- Based on the national month 7 productivity data, average national increased productivity was 1.7% whereas the Trust had recorded 4% during the same period.
- The Trust's cash position continued to deteriorate and there was a significant risk that additional cash support would be required in the fourth quarter.

- There was a risk that a cap would be applied to Elective Recovery funding in 2024/25 based on month 8 performance.

**5.8 ICB Finance Report for Month 8**

Ian Howard was invited to present the ICB Finance Report for Month 8, the content of which was noted. It was further noted that:

- The Integrated Care System had reported a year-to-date deficit of £39.71m, compared to a planned year-to-date deficit of £10.23m.
- £70m of cash support had been received and the ICS was forecasting achieving break-even at the end of the year.

The Board discussed the ICB Finance Report for Month 8 and challenged the requests contained in the report in respect of the assurance to be given by Executive Directors regarding the system-wide transformation programmes. It was noted that whilst Executive Directors would be able to provide assurance regarding the Trust's contribution, it would not be reasonable to expect them to provide assurance regarding matters outside their control.

The Board additionally challenged the assertion that the Hampshire and Isle of Wight Integrated Care System would achieve break-even at the end of 2024/25, noting that there was no expectation that the system transformation programmes would deliver significant benefits in the final quarter.

**Actions**

Ian Howard agreed to coordinate a report to the Board in respect of the Trust's contribution to the Hampshire and Isle of Wight Integrated Care System transformation programmes.

The Chair and David French agreed to discuss the requests of the Board in the ICB Finance Reports with the Integrated Care Board's chair.

**5.9 People Report for Month 8**

Steve Harris was invited to present the People Report for Month 8, the content of which was noted. It was further noted that:

- The Trust was 77 whole-time-equivalents (WTE) above its 2024/25 plan and was projecting to be 186 WTE above plan at year end. The plan assumed a reduction of 218 WTE linked to improvements in mental health and patients having no criteria to reside through successful delivery of system-wide transformation programmes. These transformation programmes had yet to deliver any significant benefit.
- An update was provided in respect of the industrial dispute with portering staff. It was noted that an ACAS-facilitated deal had been brokered and agreed with staff, although the mandate for strike action remained in force until May 2025.
- An update was provided regarding the ongoing pay dispute relating to Band 2 and 3 staff.

**5.10 Freedom to Speak Up Report**

The Freedom to Speak Up Report was tabled to the meeting, the content of which was noted. It was further noted that:

- There had been 97 cases reported during 2024, most of which related to allegations of bullying or issues with team dynamics. Only one report related to a patient safety issue.

- It would be necessary to review responses to the staff survey regarding attitudes toward speaking up.
- A 'heatmap' to triangulate safety, quality and wellbeing concerns was under consideration.

The Board discussed the report and queried why staff felt unable to utilise line or senior management to resolve many of the issues reported via the Trust's Freedom to Speak Up process. The importance of visibility on the part of the leadership team was noted.

**Actions**
Gail Byrne agreed to consider how Freedom to Speak Up can be used for its original purpose of raising concerns of safety.

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

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

- The vacancy rate for resident doctors was 9.16%, which was in line with previous years and low compared with peers.
- There had been an average of 48 exception reports per month over the past 12 months. The most common reason had been due to working hours breaches and the majority had been in relation to F1 grades.
- A lack of office space and lockers remained an issue.
- The generation of a sense of belonging amongst resident doctors posed a challenge.
- The session on resident doctors at the Trust Board Study Session in November 2024 was a welcome opportunity to speak to the Board about the lives of resident doctors.

**5.12 Learning from Deaths 2024-25 Quarter 2 Report**

Jenny Milner was invited to present the Learning from Deaths 2024-25 Quarter 2 Report, the content of which was noted. It was further noted that:

- The Trust's relative mortality rate was lower than expected compared with national figures. The Trust was one of 12 other trusts (out of 119) in this position.
- The Independent Medical Examiners Group had commenced work during the second quarter and was responsible for reviewing all deaths.
- An electronic application was being developed to assist in disseminating the outputs from Mortality and Morbidity meetings.
- There had been an increased number of reports of patients dying in bays rather than side-rooms, which correlated with complaints received.

**5.13 Infection Prevention and Control 2024-25 Quarter 2 Report**

Julian Sutton and Julie Brooks were invited to present the Infection Prevention and Control 2024-25 Quarter 2 Report, the content of which was noted. It was further noted that:

- In line with a more general national trend, the Trust was not expecting to meet its targets in respect of infection prevention and control.

- However, the Trust compared favourably with peers.
- A hand-washing campaign had been carried out in October and November 2024.
- Rates of clostridioides difficile were increasing both nationally and internationally.
- The situation with regard to the candida auris outbreak appeared to be improving following the interventions made by the Trust. The screening arrangements would likely be required indefinitely and the maintaining of the fundamentals of care programme expectations was crucial to preventing future outbreaks.

**Action**
Gail Byrne agreed to include an item on infection prevention control at a future Trust Board Study Session to include details of an Australian study, point of care testing, and progress on the roll out of the Fundamentals of Care programme.

**5.14 Annual Medicines Management 2023-24 Report**

James Allen was invited to present the Annual Medicines Management 2023-24 Report, the content of which was noted. It was further noted that:

- During 2023/24, the Trust spent £219m on medicines, a four per cent increase compared to 2022/23.
- Training continued successfully, although operational pressures had led to some challenges in this area.
- The pharmacy team's support to clinical trials had improved.
- Improvements were required to the Trust's estate to make it more suitable for the safe storage of medicines, especially given the increased volume and acuity of mental health in-patients and the resulting challenges in terms of security of patients' medication.
- The aseptic site at Adanac Park was expected to be ready in the coming months
- Consideration was being given as to whether to stop prescribing over-the-counter medicines on discharge in order to accelerate the discharge process.

**5.15 Annual Ward Staffing Nursing Establishment Review 2024**

Gail Byrne was invited to present the Annual Ward Staffing Nursing Establishment Review 2024, the content of which was noted. It was further noted that:

- It was a requirement from the National Quality Board that the Establishment Review be discussed by the Board in open session.
- Out of the 37 recommendations which were made following the Francis inquiry in 2013, the Trust was compliant with 35. The areas of non-compliance related to the allocation of time for supervision time for statutory and mandatory training and in relation to equality, diversity and inclusion. Progress was being made in these areas, but further action was required to achieve full compliance.
- The Trust was compliant with 37 out of 38 of the recommendations included in the NICE guideline on safe staffing for in-patient wards. An action plan was in place to address the single area of non-compliance.

- The Trust had conducted a robust six-monthly ward staffing review. Areas of challenge related to night shifts and the increasing number of patients with enhanced care needs.

## 6. STRATEGY and BUSINESS PLANNING

### 6.1 Board Assurance Framework (BAF) Update

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

- Five of the Trust's risks were rated 'critical' and five were outside of appetite.
- The rating of risk 5a had been increased from 15 to 20 due to the continuing financial pressures and the erosion of the Trust's cash balance.
- A new scoring matrix was being rolled out for the operational risk register and BAF risks.

## 7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

### 7.1 Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

John Mcgonigle was invited to present the Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response, the content of which was noted. It was further noted that:

- The Trust had reported full compliance in 60 out of 62 core standards as part of the self-assessment, with an overall assurance rating of 'substantially compliant'.
- The two key areas for improvement were in respect of lockdown procedures and the Trust's approach to business continuity.
- The Trust had also carried out a deep-dive into its cyber security arrangements.

### 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

The Board expressed its thanks to Joe Teape for his time as Chief Operating Officer, noting that this would be his last Board meeting at the Trust.

## 9. Note the date of the next meeting: 11 March 2025

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

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

The meeting was adjourned.

University Hospital Southampton
NHS Foundation Trust

List of action items

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| Trust Board – Open Session 25/07/2024 5.4 Briefing from the Chair of the Quality Committee (Oral) | | | | |
| 1163. | Impact of technology | Machell, Craig | 01/04/2025 | Pending |
| | *Explanation action item*<br>Craig Machell agreed to add an item covering the impact of technology over the next 5-10 years to a future Trust Board Study Session agenda.<br><br>Update: Item tentatively scheduled for 01/04/2025 Study Session. | | | |
| Trust Board – Open Session 07/01/2025 2 Patient Story | | | | |
| 1200. | Recommendations | Byrne, Gail | 11/03/2025 | Pending |
| | *Explanation action item*<br>Gail Byrne agreed to consider how the recommendations made in patient stories could be captured and action taken as a result. | | | |
| Trust Board – Open Session 07/01/2025 5.8 ICB Finance Report for Month 8 | | | | |
| 1201. | Transformation programmes | Howard, Ian | 11/03/2025 | Pending |
| | *Explanation action item*<br>Ian Howard agreed to coordinate a report to the Board in respect of the Trust's contribution to the Hampshire and Isle of Wight Integrated Care System transformation programmes. | | | |

| Agenda item | | Assigned to | Deadline | Status |
|---|---|---|---|---|
| Trust Board – Open Session 07/01/2025 5.8 ICB Finance Report for Month 8 | | | | |
| 1202. | ICB Finance Reports | • Douglas-Todd, Jenni<br>• French, David | 11/03/2025 | Pending |
| | *Explanation action item*<br>The Chair and David French agreed to discuss the requests of the Board in the ICB Finance Reports with the Integrated Care Board's chair. | | | |
| Trust Board – Open Session 07/01/2025 5.10 Freedom to Speak Up Report | | | | |
| 1203. | Raising concerns of safety | • Byrne, Gail | 11/03/2025 | Pending |
| | *Explanation action item*<br>Gail Byrne agreed to consider how Freedom to Speak Up can be used for its original purpose of raising concerns of safety. | | | |
| Trust Board – Open Session 07/01/2025 5.13 Infection Prevention and Control 2024-25 Quarter 2 Report | | | | |
| 1204. | Trust Board Study Session | • Byrne, Gail | 03/06/2025 | Pending |
| | *Explanation action item*<br>Gail Byrne agreed to include an item on infection prevention control at a future Trust Board Study Session to include details of an Australian study, point of care testing, and progress on the roll out of the Fundamentals of Care programme.<br><br>Update: Item tentatively scheduled for TBSS on 3 June 2025. | | | |

University Hospital Southampton
NHS Foundation Trust

**Agenda item 5.1**

| **Committee Chair's Report to the Trust Board of Directors 11 March 2025** | | | |
|---|---|---|---|
| **Committee:** | **Audit & Risk Committee** | | |
| **Meeting Date:** | **20 January 2025** | | |
| **Key Messages:** | • The committee considered the accounting policies and management judgements in respect of the 2024/25 annual accounts, noting that most of these were consistent with previous years. It was further noted that a full re-valuation was due to take place this year in respect of the Trust's property, plant and equipment, a process which occurs every five years. The impact of IFRS16 was also noted.<br>• The committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts, noting that the Trust was compliant in all areas or had appropriate explanations for areas of non-compliance, of which there were only a few. These had also been areas of non-compliance during 2023/24.<br>• The committee received a report on cyber risk, including recent trends and the steps that both the NHS and the Trust were taking to counter the threat posed.<br>• The committee received updates in respect of the internal audit programme, including the reports in respect of an audit of the Fit and Proper Persons framework and of Data Quality.<br>• An update was provided in respect of the work of the counter-fraud team, including an update on the work being undertaken to manage the risk impersonation fraud by those pretending to be agency/temporary staff. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **6.2 Board Assurance Framework (BAF) Update** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • All risks had been reviewed with the relevant executive director(s).<br>• It was suggested that the BAF needed to more adequately reflect the Trust's estate risk and the target date should be reconsidered. | | |
| | **7.3 Audit and Risk Committee Terms of Reference** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • The committee reviewed its Terms of Reference, proposing to only make minor changes.<br>• The committee recommended that the Board approve the revised Terms of Reference. | | |
| **Any Other Matters:** | • The committee received an update in respect of the tenders for internal and external auditors. | | |

## Assurance Rating:

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

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

**Risk Rating:**

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

**Agenda item 5.2 i)**

| **Committee Chair's Report to the Trust Board of Directors 11 March 2025** | | | |
|---|---|---|---|
| **Committee:** | **Finance and Investment Committee** | | |
| **Meeting Date:** | **27 January 2025** | | |
| **Key Messages:** | • The committee reviewed the Finance Report for Month 9. The Trust's financial position remained challenging with a £4.5m in-month and £22.7m year-to-date deficit recorded against a plan of £3.3m. Furthermore, the Trust's cash position remained challenging.<br>• The underlying position had deteriorated during December 2024 due to lower than expected Elective Recovery income. In addition, there had been up to 500 Emergency Department attendances per day and circa 250 patients having no criteria to reside.<br>• The Trust was anticipating a year-end deficit of circa £35m once additional pay pressures had been taken into account.<br>• There were concerns that a cap would be applied to Elective Recovery funding based on month 8 figures.<br>• A significant proportion of the Trust's undelivered Cost Improvement Programme related to non-delivery of system-wide transformation programmes.<br>• The Trust's capital programme was £11.6m behind plan with £50.4m due to be spent during the remainder of the financial year.<br>• The committee received a report on the management of leases from an accounting perspective, noting that further work on reviewing leases was required.<br>• An update was received in respect of the annual planning and budget-setting process, noting that no national planning guidance had yet been received. It was expected that 2025/26 would be challenging due to an anticipated real terms reduction in funding and possible cap on Elective Recovery funding.<br>• The committee received an update in respect of the Trust's project to optimise operating services as part of the Always Improving programme, noting good progress being made in this area.<br>• The committee received an update in respect of Digital, noting the progress being made in respect of system developments and laptop upgrades as well as the latest position regarding the proposed system-wide Electronic Patient Record system and the planned go-live for the new Emergency Department system in April 2025. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **7.4 Finance and Investment Committee Terms of Reference** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **Low** |
| | • The committee reviewed its Terms of Reference, proposing to only make minor changes.<br>• The committee recommended that the Board approve the revised Terms of Reference. | | |
| **Any Other Matters:** | N/A | | |

## Assurance Rating:

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

## Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

**Agenda item 5.2 ii)**

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors<br>11 March 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance and Investment Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">24 February 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee considered a draft of the Trust's annual plan submission to the Hampshire and Isle of Wight Integrated Care Board. The draft plan identified significant financial challenges continuing from the underlying financial pressures reported during 2024/25.<br>• The committee received an update in respect of the Trust's inpatient flow programme, noting that whilst a 5% improvement in length of stay had been achieved, much of this had been offset by increased demand.<br>• The committee reviewed the Finance Report for Month 10 (see below).<br>• The committee received an update in respect of the Trust's cash position, noting that it appeared likely that additional revenue support would be required in the first quarter of 2025/26.<br>• The committee received an update regarding the Trust's 2024/25 Cost Improvement Programme. The Trust had identified £89.3m of schemes and forecast delivery of £76.3m of improvements.<br>• The committee received an update on the Trust's decarbonisation programme, including on proposals for installing heat pumps, solar panels and renewing/replacing infrastructure.<br>• The committee noted an update in respect of UHS Estates Limited, including the risk associated with the management of endoscopy scopes and their replacement.</td></tr>
<tr><td rowspan="4">Assurance:<br>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.8 Finance Report for Month 10</td><td>Assurance Rating:<br>Substantial</td><td>Risk Rating:<br>High</td></tr>
<tr><td colspan="3">• The Trust's underlying monthly deficit was c.£6.5m. There was a year-to-date deficit of £15.2m, £11.8m behind plan.<br>• The Trust had reported a £7.5m surplus during the month due to one-off items.<br>• The Trust was forecasting an year-end deficit of £17.65m following work to agree a Hampshire and Isle of Wight Integrated Care System 'landing plan' for 2024/25.<br>• The Trust's capital programme was £12m behind plan, with £39.3m due to be spent during the remainder of 2024/25.</td></tr>
<tr><td>6.2 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:<br>Substantial</td><td>Risk Rating:<br>N/A</td></tr>
<tr><td colspan="3">• Risks 5a, 5b and 5c have been updated, following discussions with the respective Executive Director(s).<br>• It was proposed to extend the target date for risk 5a, but to include an interim target as at April 2026 between the current position and the ultimate objective of reducing this risk to 9.</td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">N/A</td></tr>
</table>

## Assurance Rating:

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

## Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

**Agenda item 5.3 i)**

| **Committee Chair's Report to the Trust Board of Directors 11 March 2025** | |
|---|---|
| **Committee:** | **People & Organisational Development Committee** |
| **Meeting Date:** | **24 January 2025** |
| **Key Messages:** | • As forecast, the Trust's workforce was seven whole-time-equivalents (WTE) above its plan at the end of December 2024. However, the total workforce had decreased by 90 WTE, owing to the impact of Christmas resulting in deferral of start dates until January 2025.<br>• It was forecast that the Trust would be 146 WTE above plan at the end of 2024/25, noting that the Trust had assumed a reduction of 220 WTE due to the impact of system-wide transformation programmes including Non-Criteria to Reside and mental health.<br>• The Trust was experiencing particularly high sickness levels due to the impact of seasonal illnesses.<br>• The committee received a presentation on the Trust's internal leadership development programmes, including those relating to senior, operational, and emerging leaders as well as programmes targeted at under-represented groups.<br>• The committee received an update on staff health and wellbeing, noting that uptake for influenza and Covid-19 vaccinations was low at 50% and 30% respectively.<br>• The committee was updated on the status of the disputes with UNITE for Portering and with UNISON regarding Band 2 and Band 3 pay.<br>• The committee noted that the formal consultation in respect of transfer of staff to UHS Estates Limited had commenced. |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | Not applicable. |
| **Any Other Matters:** | The committee noted that an action plan had been agreed with the porters and that the team had moved from Estates, Facilities and Capital Development to the Site team. |

## Assurance Rating:

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

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

**Risk Rating:**

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

University Hospital Southampton
NHS Foundation Trust

**Agenda item 5.3 ii)**

| **Committee Chair's Report to the Trust Board of Directors 11 March 2025** | | | |
|---|---|---|---|
| **Committee:** | **People & Organisational Development Committee** | | |
| **Meeting Date:** | **24 February 2025** | | |
| **Key Messages:** | • The committee reviewed the People Report for Month 10 (see below). It was noted that January 2025 had been challenging, especially in terms of managing high levels of staff sickness due to seasonal illnesses as well as the impact of increased demand on the Trust's services. Furthermore, the increasing number of patients requiring enhanced care placed further pressure on the Trust's workforce numbers.<br>• It was expected that difficult decisions would be required to meet the financial and workforce expectations for 2025/26. As part of this, it would be necessary to ensure that quality indicators were monitored. In addition, the Trust will need to be focused on ensuring that staff still feel valued and supported to deliver the first class care they aspire to. This would require strong and supportive leaders and should be considered when making choices about future investments.<br>• The committee received an update in respect of the Band 2/3 pay dispute, noting that Unison would be putting a proposal to its members to resolve the matter.<br>• An update was provided in respect of the action plan agreed with UNITE for the porters. It was noted that progress was being made to address the issues set out | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **5.10 People Report for Month 10** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **High** |
| | • The Trust had exceeded its workforce plan by 153 WTE at the end of January 2025.<br>• High levels of sickness (an increase from 4.1% to 4.4%) had resulted in increased use of bank staff during the period.<br>• The Trust was forecasting a total workforce of 13,403 WTE at the end of the year, which would be 125 WTE above plan. However, it was anticipated that the Trust's substantive workforce would be 50 WTE less than as at 31 March 2024.<br>• The overall forecast assumes no impact on staff numbers as a result of delivery of system-wide transformation programmes, but does assume a reduction in bank staff as newly qualified nurses become part of the established workforce from January 2025 onward.<br>• Turnover had slightly increased during January 2025 to 10.6%, although this remained well below the target of 13.6%.<br>• There was a 10% vacancy rate in respect of registered nurses. | | |
| **Any Other Matters:** | N/A | | |

## Assurance Rating:

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

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

**Risk Rating:**

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

University Hospital Southampton
NHS Foundation Trust

**Agenda item 5.4**

| **Committee Chair's Report to the Trust Board of Directors 11 March 2025** | | | |
|---|---|---|---|
| **Committee:** | **Quality Committee** | | |
| **Meeting Date:** | **27 January 2025** | | |
| **Key Messages:** | • Five additional 'never events' had been reported, bringing the total year-to-date to 11. As a result, the roll out of the National Safety Standards for Invasive Procedures (NatSSIPS) workstream was being looked at. In addition, the Trust had met with the Care Quality Commission and was reporting into the Integrated Care Board and region on this matter. An increase in the number of 'never events' had also been seen across England.<br>• Quality indicators were indicating the challenges that the Trust is facing<br>• In terms of infection prevention and control, the number of cases was in excess of the national threshold.<br>• The Trust's cancer and diagnostics performance remained strong, but demand on the Emergency Department was posing a significant challenge.<br>• There were concerns about increasing waiting times for cardiac surgery.<br>• The Trust had experienced a 14% increase in mental health admissions compared to 2023. This demand was placing significant demand on the Trust's workforce and there were concerns about the service provided by local mental health trusts.<br>• The committee received an update in respect of the Trust's Always Improving programme, noting that there had been a 5% reduction in length of stay and 2.2% more theatre procedures. | | |
| **Assurance:** *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)* | **6.2 Board Assurance Framework (BAF) Update** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **N/A** |
| | • Risks 1a, 1b, 1c and 4a have been updated, following discussions with the respective Executive Director(s).<br>• It was agreed that increased reference should be made to the dependencies associated with the system-wide transformation programmes and the Trust's achievement of its target ratings. | | |
| | **7.5 Quality Committee Terms of Reference** | ***Assurance Rating:*** **Substantial** | ***Risk Rating:*** **Low** |
| | • The committee reviewed its Terms of Reference, proposing to only make minor changes.<br>• The committee recommended that the Board approve the revised Terms of Reference. | | |
| **Any Other Matters:** | The committee reviewed the Interim Maternity and Neonatal Safety report, noting that the Trust Board had approved the Maternity Incentive Scheme declaration and that the Trust was compliant with the terms of the Scheme. | | |

## Assurance Rating:

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

## Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

| Agenda item 5.5 | Report to the Trust Board of Directors, 11 March 2025 |
|---|---|
| **Title:** | Chief Executive Officer's Report |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

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

- NHS England Leadership
- General Practitioner Contract
- National Minimum Wage
- NHS Providers Annual Governance Survey
- NHS Management and Leadership Standards
- Trust Strategy Refresh
- Cardiac Quality Review
- Maternity Visit
- Muslim Prayer Room Facilities
- Mechanical Thrombectomy Service
- Royal College of Radiologists
- Consultation on Devolution

**Contents:**

Chief Executive Officer's Report

**Risk(s):**

N/A

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

# Chief Executive Officer's Report

## NHS England Leadership

On 25 February 2025, Amanda Pritchard formally notified the NHS England Board of her intention to stand down as chief executive at the end of the financial year. Sir James Mackey, currently chief executive of Newcastle Hospitals NHS Foundation Trust and national director of elective recovery, will be taking over as Transition CEO before taking up post formally on 1 April 2025.

On 3 March 2025, it was confirmed that Dr Penny Dash, currently chair of the NHS North West London Integrated Care Board, would be appointed as the new chair of NHS England following the announcement by Richard Meddings in October 2024 of his intention to step down at the end of March 2025.

## General Practitioner Contract

The Government announced on 27 February 2025 that it had agreed a new deal with the British Medical Association to reform the General Practitioner (GP) contract. The key points from the deal are:

- To modernise general practice by requiring GP surgeries to allow patients to request appointments online throughout working hours from October 2025 to avoid the '8am scramble'.
- To increase funding for general practice by an extra £889m next year, an increase of 7.2%.
- To scrap 'unnecessary' targets by removing 32 of the 76 targets which GPs must currently report against.
- GPs will be encouraged to seek specialist advice and guidance when unsure about making a referral to hospital and up to £80m will be made available to support this.

In addition, on 7 February 2025, it was announced that there would be a 5.4% increase in the public health grant paid to local authorities in 2025/26 to support services focused on prevention, including drug and alcohol services, smoking cessation, and sexual health services.

## National Minimum Wage

In the Autumn Statement, the Chancellor announced an increase in the National Minimum Wage and National Living Wage, accepting the Low Pay Commission's recommendations. Accordingly, the National Living Wage, applicable to those aged 21 and over, will increase by 6.7% to £12.21 per hour from 1 April 2025.

Within the NHS this has resulted in a review of Band 2 and Band 3 salaries to ensure that individuals at Band 2 are paid at or above the new statutory minimum and that individuals at Band 3 continue to be paid a higher wage than those at Band 2. Therefore, pay scales will increase as follows from 1 April 2025:

- A pay increase of 2.35% for all staff at Band 2, taking them to a salary of £24,169
- A pay increase of 2.3% for staff with fewer than two years of experience at Band 3, taking them to a salary of £24,625.

In addition, it should be noted that the rate of national insurance paid by employers will increase by 1.2% to 15% from April 2025.

## NHS Providers Annual Governance Survey

NHS Providers published the results of its annual governance survey on 31 January 2025. The survey was completed by chairs, company secretaries and other corporate governance leads in NHS trusts and NHS foundation trusts in November and December 2024. NHS Providers received 124 responses from 104 trusts, accounting for 50% of the sector.

The key findings from the survey are:

- The quality of board governance is holding up, despite significant, sustained pressure.
- Recent national guidance has been positively received, such as that relating to the fit and proper persons test and the insightful board. However, the chair appraisal framework has been subject to criticism.
- Respondents consistently expressed concerns about proposals to introduce league tables and performance-linked pay.
- Some trusts are experiencing difficulty in recruiting executive and non-executive directors and a reduction in the number and quality of applicants was reported.
- Experience of system governance remains variable, but is improving overall.

The full report can be read at: https://nhsproviders.org/governance-survey-2024

**NHS Management and Leadership Standards**

Following the announcement of a programme of reforms to recognise and professionalise NHS management and leadership at the NHS Providers conference in November 2024, the Trust has received a request to provide feedback on the draft management and leadership standards and competencies by 14 March 2025 to which the Executive intends to respond.

The draft standards and competencies have been developed in partnership with a range of stakeholders, including the Chartered Management Institute, the Faculty of Leadership and Management, the Florence Nightingale Foundation, NHS staff, representative bodies across health and care, patients, and leading experts.

The framework will comprise:

- A code of practice for all managers and leaders across health and social care.
- Standards and competencies at defined levels of management and leadership from entry level to executive level.
- Core curricula for every level of management and leadership, linking directly to the code of practice, standards and competencies.

**Trust Strategy Refresh**

Wider staff and stakeholder engagement has been underway in this quarter to inform the refresh of our Trust Strategy. Staff feedback has been received through a mix of face-to-face events across our sites, virtual events and written feedback. We have set a realistic ambition to have feedback from over 1,000 staff through these different methods. Early themes from staff feedback link well with the divisional and care group strategic presentations, with a focus on the experience of patients and staff being key topics. We plan to conclude this engagement at the end of March 2025 and move into a phase of collating these ideas and creation of the updated strategic framework.

**Cardiac Quality Review**

Following the growth in the UHS adult cardiac waiting list due to the mismatch in referrals vs. operations performed, NHS South East Region requested a cardiac surgery improvement plan. The Trust has submitted its plan to Region and NHS South East Region undertook a Quality Visit on 4 February 2025. The plan includes actions to increase the number of operations performed by purchasing capacity from Spire Southampton, scheduling weekend lists at Southampton General Hospital and efficiency improvements to ensure two operations are performed consistently on each list. The capacity needed to reduce the waiting list quickly is significant so we are also reviewing referral patterns to determine whether other centres could accept referrals for a period until UHS waiting times are reduced.

**Maternity Visit**

On 6 February 2025, NHS South East Region and the Local Maternity and Neonatal System (LMNS) team visited the Trust's maternity service. The purpose of the visit was to carry out some benchmarking against the Trust's progress in delivering against the 3 Year Delivery Plan as well as hearing from staff about what was going well, and what had been a challenge over the previous 12 months.

Overall, the visit went well and some positive feedback was received. The team was considered to be doing some exceptional work in driving improvements and should explore how to be better at sharing and celebrating its successes.

**Muslim Prayer Room Facilities**

On 28 February 2025, the Trust announced that the new washroom facilities for Muslim colleagues and patients were now officially open. The project to renovate existing facilities and to install dedicated Wudu washroom facilities was brought about through a collaborative effort involving the estates capital projects team and Concept Building. The Southampton Hospital Charity also contributed to and supported the project.

**Mechanical Thrombectomy Service**

From 3 March 2025, the Trust's stroke service will be providing life-changing mechanical thrombectomy treatment for some stroke patients around the clock, offering a 24/7 service.

Mechanical thrombectomy involves removing a blockage in a large blood vessel in the brain, restoring blood flow to brain tissue. Approximately 15% of patients with ischaemic stroke (blocked blood vessels) benefit from this treatment.

During 2024, 280 patients were treated with mechanical thrombectomy and that number is expected to increase up to 1,200 patients a year over the next five years.

Forty per cent of patients treated will return home with little or no neurological disability, and the remainder will have much better outcomes.

**Royal College of Radiologists**

On 28 February 2025, it was announced that Dr Stephen Harden had been elected as the incoming president of the Royal College of Radiologists for a three-year term, commencing 1 September 2025.

Dr Harden has been a consultant in cardiothoracic radiology at UHS since 2005 and we are honoured for him to be appointed to this prestigious role.

**Consultation on Devolution**

A public consultation has been launched by the Government inviting everyone in Hampshire and the Solent area to have their say on the proposal to form a Mayoral Combined County Authority for Hampshire, Portsmouth, the Isle of Wight, and Southampton. The consultation runs until 13 April 2025 and is open to responses from organisations. Our Integrated Care Board have proposed coordinating a response from all NHS partners by the end of March.

The consultation can be viewed at: https://www.gov.uk/government/consultations/hampshire-and-the-solent-devolution/hampshire-and-the-solent-devolution-consultation

University Hospital Southampton
NHS Foundation Trust

| Agenda item 5.6 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Performance KPI Report 2024-25 Month 10 |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Sam Dale, Associate Director of Data and Analytics |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

This report covers a broad range of trust performance metrics. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives, whilst providing assurance regarding the successful implementation of our strategy and that the care we provide is safe, caring, effective, responsive, and well led.

**Contents:**

The content of the report includes the following:

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

**Risk(s):**

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

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

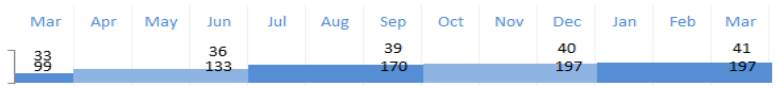
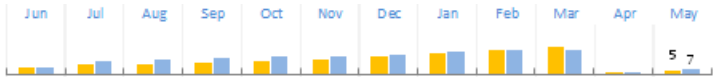
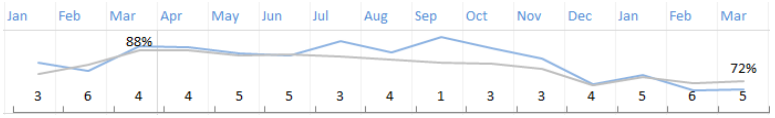
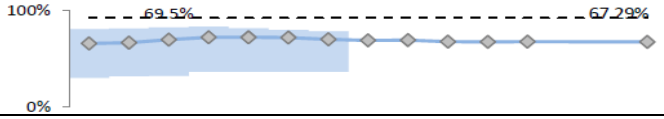
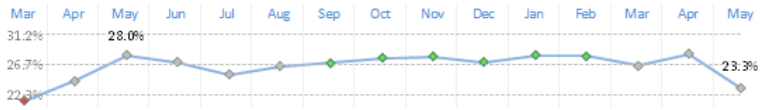
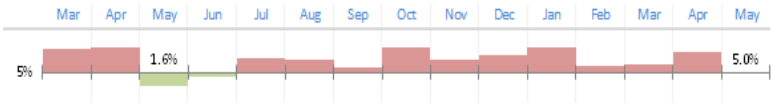
University Hospital Southampton NHS
NHS Foundation Trust

# Performance KPI Board Report

Covering up to
January 2025

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

# Report guide

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

# Introduction

The Performance KPI Report is prepared for the Trust Board members each month to provide assurance:

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

The content of the report includes the following:

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

# Summary

This month's spotlight report explores UHS recent performance on cancer waiting times. The report highlights that:-

- The trust has continued to see referral growth for suspected cancer across most tumour sites averaging 2,274 referrals per month across the 24/25 calendar year which is a 3% increase on 2023/24 and a 10% increase on 2022/23.
- The trust is above the 24/25 waiting time targets for both 28 day faster diagnosis and 62 day standards in December 2024, consistently benchmarking in the top quartile when compared to peer teaching organisations. The trust benchmarks in the second quartile for the 31 day standard but performance has been consistently improving with the validated December position being 94.9% against a national target of 96%.
- There are key challenges within urology, lung and head and neck services but recruitment, upskilling and pathway streamlining opportunities are constantly in development to reduce waiting times across all elements of the pathway.
- The organisation has a robust performance management process in place ranging from individual patient level reviews to performance position scrutiny with service leads.

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

1. The overall RTT waiting list increased by 523 patients between December 2024 (60,387) and January 2025 (60,910). The majority of the increase is within the diagnostic element of the waiting list. Whilst this is the highest position for the UHS waiting list, the number of patients waiting over 18 weeks remained consistent at 62%. The latest comparator data (December 2024) for this metric places UHS in the top quartile compared to peer organisations.
2. The trust reported just one patient waiting over 78 weeks for January 2025 following a further release of corneal tissue enabling the treatment of our longest waiting ophthalmology patients. The trust reported 39 patients waiting over 65 weeks for January 2025. Fifteen of these patients were also awaiting corneal tissue release - the remaining patients were in trauma & orthopaedics, clinic genetics and complex cases within the surgery care group. The latest comparator information showed that UHS ranked in second place when compared to twenty equivalent teaching hospitals across the UK for 65 week waits and joint first place for 78 week waits.
3. The trust reported 11,728 attendances to the Main ED department in January 2025 with a four hour performance position of 61.2%. The trust is reporting a reduction in average time in the department for patients who went on to be admitted (5hr31m) and not admitted (3hr15m).
4. Despite the ongoing commitment and actions to improve flow through the hospital, the average number of patients per day not meeting the Criteria to Reside in hospital increased in January to 232.
5. The backlog of data entry required for virtual outpatient appointments has now been resolved and the latest reported position of 28.4% (December 2024) is an appropriate reflection of the proportion of outpatient attendances delivered virtually.
6. The trust reported one case of MRSA, one Never Event and two Patient Safety Incident Investigations for January 2025.
7. There were six medication errors reported for the trust in January 2025. Three of these are still open cases and under investigation.

8. The trust reported an increase in patients logging into the digital platform My Medical Record. This aligns with an increase in outpatient appointments and blood tests result notifications issues in the month.

**Ambulance response time performance**

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 24th February 2025, our average handover time was 20 minutes 24 seconds across 813 emergency handovers and 24 minutes 29 seconds across 28 urgent handovers. There were 82 handovers over 30 minutes and 29 handovers taking over 60 minutes within the unvalidated data. Across January the average handover time was 16 minutes 30 seconds.

# Spotlight: Cancer performance

## 1. Introduction

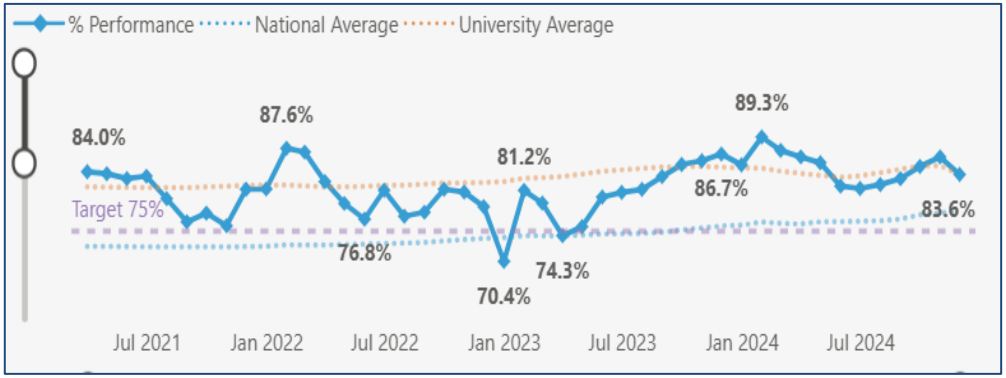
Cancer waiting times are a key indicator of NHS performance, reflecting the efficiency of cancer pathways from referral to diagnosis and treatment. Timely access to cancer care is essential, as early diagnosis and prompt treatment significantly improve patient experience and outcomes, increasing survival rates and enhancing quality of life. However, despite national efforts to streamline cancer services, the NHS and UHS has faced challenges in meeting waiting time targets, reflecting the difficulties surrounding service capacity, growth in demand and workforce shortages.

Current cancer waiting time standards are reflective of modern cancer care, with a greater focus on definitive diagnosis or treatment instead of process measures such as first appointments. They support equitable access to care by measuring waiting times for all patients, regardless of how they came to be on a waiting list for cancer diagnosis or treatment. They also give clinicians more encouragement and flexibility to adopt remote tests and efficient pathways. The NHS prioritises three key cancer waiting time standards and (at the time of writing) validated data is published up to December 2024.

## 2. UHS Waiting Time Performance

The **Faster Diagnosis Standard** reflects a maximum 28-day wait for diagnosis from urgent GP referral and from NHS cancer screening programmes. In December 2024, UHS reported 83.6% of patients met the standard, against a national target of 77% by March 2025 and 80% by March 2026.

The trust has consistently achieved this standard however the success is reliant on ensuring that front end capacity and diagnostics are available and that patients are appropriately informed of the importance of attending. Against twenty peer teaching organisations, the trust consistently benchmarks in the top quartile and has frequently placed in first place. The national NHS position for December is 78.1%.



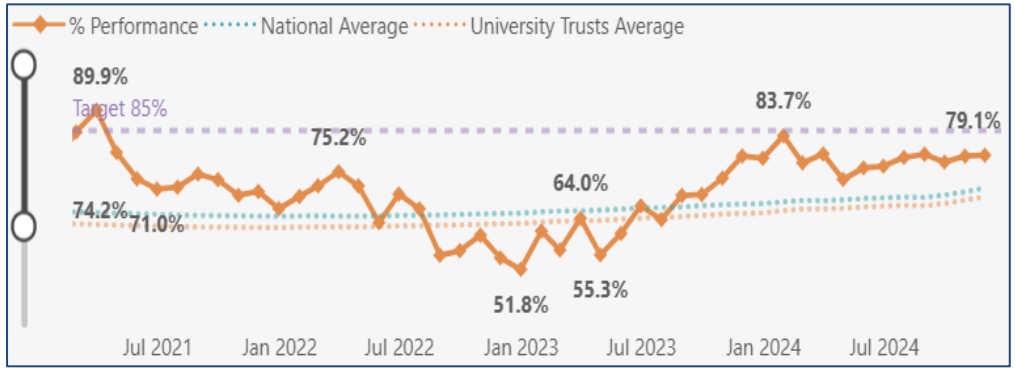

*Graph 1: 28 Day Faster Diagnosis Performance Trend*

**The 62-day standard** measures the time from urgent GP referral, cancer screening referral or consultant upgrade to the treatment. The first cancer treatment after diagnosis is often surgery, but can also be chemotherapy or radiotherapy. The Trust reported 79.1% for December 2024. Whilst the long term national ambition remains at 85%, an interim target of 70% was

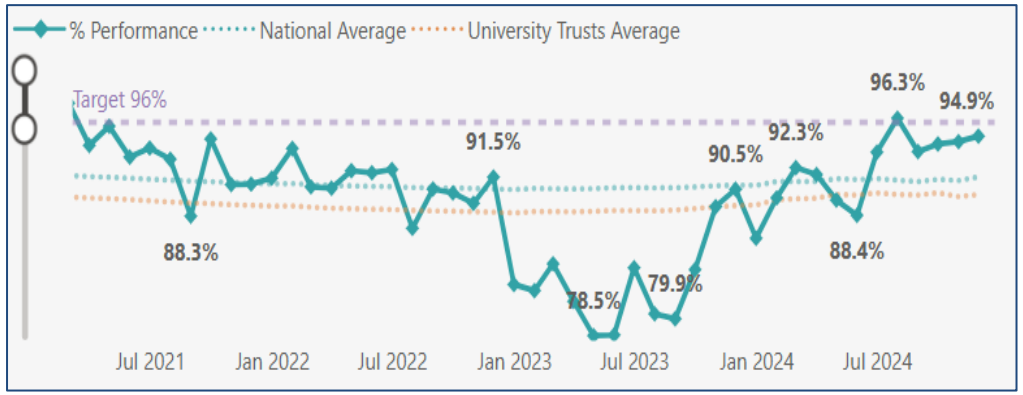
set in the 2024/25 NHS operational priorities publication which UHS has consistently achieved since October 2023. Again, the organisation benchmarks extremely well against our peers placing in first or second place since August 2024. The national average for December was 71.3%

Patients who start their pathway at UHS are more likely to achieve the 62 day target than those referred from other centres. This would improve if UHS had the capacity to treat patients within the 24 day window which would allow reassignment of a breach to the referring provider, however as a Trust we have seen consistent improvement in this since May 2023. The single most significant impact on 62 day achievement at present are pathology delays, where currently capacity and demand are not aligned.

The **31-day standard** reflects the time for treatment to commence once a treatment plan has been agreed - the national ambition is for trusts to deliver for 96% of patients. Whilst UHS has only achieved the target once since April 2021, performance has consistently improved over the last twelve months peaking at 94.9% in December 2024. The urology service is the main area which continues to have an impactful volume of breaching patients. The organisation has consistently benchmarked in sixth place compared to twenty peer organisations. The national NHS position for December is 91.5%.




*Graph 2: 62 Day Standard - Performance Trend*

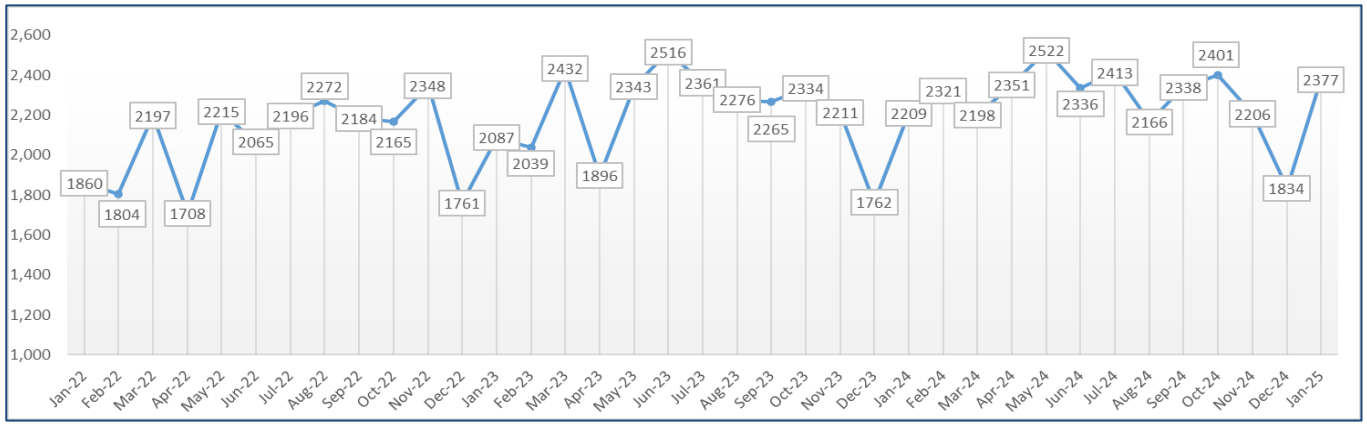



*Graph 3: 31 Day Standard - Performance Trend*

## 3. Cancer Referrals and Waiting List

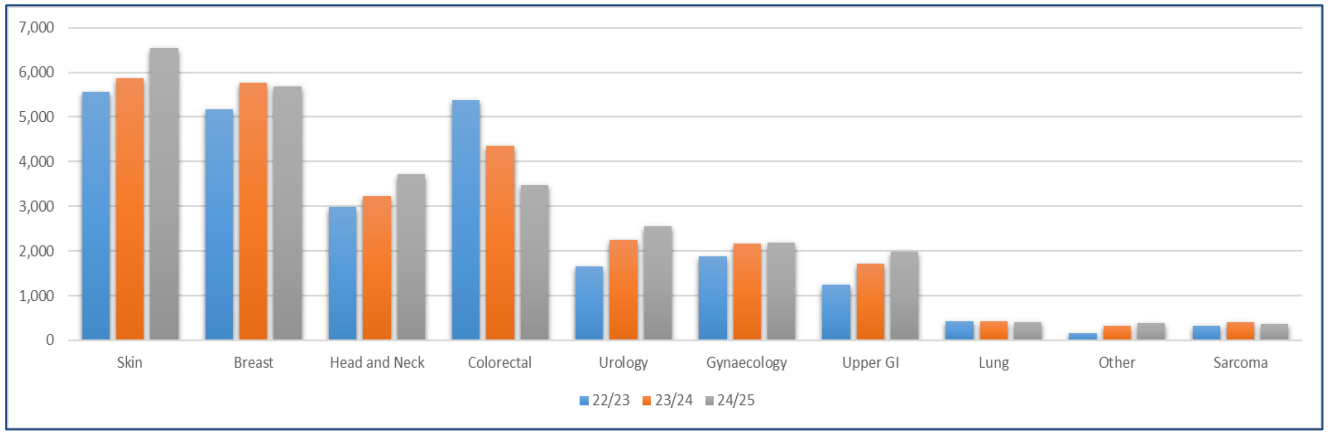
Several factors impact cancer referrals, influencing both the timeliness and appropriateness of patient pathways. Key determinants include primary care recognition of symptoms, patient awareness and willingness to seek medical advice, and the efficiency of referral systems. Delays can arise from workforce shortages, administrative bottlenecks, and variation in referral guidelines. Additionally, diagnostic capacity, such as access to imaging and pathology

services, plays a crucial role in processing referrals efficiently at UHS. External pressures, including seasonal variations, pandemic-related backlogs, and socioeconomic disparities further contribute to fluctuations in referral volumes.




*Graph 4: UHS urgent suspected cancel (USC) - referral volumes by month*

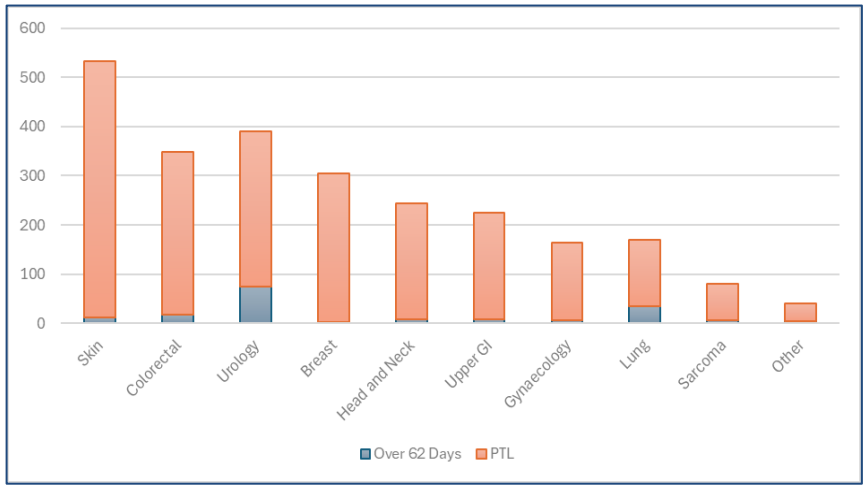
Across the 2024/25 calendar year, the trust received on average 2274 referrals per month which is a 3% increase on 2023/24 and a 10% increase on 2022/23. The trust is developing further modelling for cancer referrals to better support annual planning, capacity modelling and business cases development. Graph 5 illustrates how most UHS cancer services have experienced annual referral growth but predominantly in Skin, Head and Neck and Urology.




*Graph 5: Annual Referral Volumes by Tumour Site*

The overall waiting list size is heavily dependent on the number of urgent suspected cancer referrals and the speed of seeing these patients, as the majority of patients will leave the cancer waiting list at the point of being told that they don't have cancer. At the time of writing, the cancer patient treatment list (PTL) was 2339 which reflects some stability since the peaks reached in the summer (2729 by June 2024) which was predominantly due to the seasonal volatility in skin cancer referrals. The number of patients waiting over 62 days from the date of receipt of referral is the subset of the PTL known as the backlog. Graph 7 reflects a breakdown of the entire PTL by tumour sites and the recent backlog volumes illustrating the challenges in Urology and Lung services.


*Graph 6: UHS overall PTL trend line*




*Graph 7: Latest Cancer PTL by Tumour Site and Backlog (<62 day waits)*

## 4. Tumour Site Summaries

The section below describes some of the key challenges being faced by specific cancer services and the actions being taken to address them.

### 4.1 Breast Service

Referrals into the breast service remain steady but with the usual month on month variance. The backlog has been well managed and remained consistently low. Weekly PTL review meetings including members of the MDT continue to support the early escalation of any delays in a patient's pathway and the reallocation of patients to other consultants depending on capacity and suitability. The cancer pathway navigator role has continued to improve the

tracking of pathways between one stop clinics and treatment. This role is currently funded until May 2025 and the ambition is to fund and appoint to this role permanently.

The surgical consultant workforce supporting the service has been reduced across the last 6 months due to long term absence. The service has recently (January 2025) appointed a substantive consultant post and are aiming to recruit substantively again in April 2025. Capacity for one-stop clinics has been impacted by this reduced workforce which has meant initial one-stop appointments have trended at 16-18 days, despite this the average 28-day performance for the last four months has been 91%. This has been sustained through the service delivering additional clinics, often on weekends. Job plans are being reviewed and coupled with the appointment of the new surgical consultants, capacity across all elements of the pathway is expected to improve.

**4.2 Gynaecology Service**

There has been a steady referral rate into the gynaecology service. The cancer pathway navigator role continues to co-ordinate the initial appointments for these patients which ensures full utilisation of capacity and gives support to patients. Capacity for first outpatient appointments is consistently reviewed against demand and additional clinics are stood up when needed to ensure the waiting time is consistently maintained around 14 days. Additional fortnightly capacity at Lymington (started June 24) has supported those patients requiring a biopsy under general anaesthetic. Weekly PTL review meetings with clinical input continue to support the early escalation of any delays in patient's pathway and the reallocation of patients to other consultants depending on capacity and suitability. This has supported the achievement of 85% for 62-day performance over the last four months and a reduced backlog.

The unscheduled bleeding on HRT pathway trial is expected to start in spring 2025 which should help manage the demand on referrals and prioritise fast-track clinic capacity for those at higher risk of endometrial cancer. This pathway will allow primary care to manage this group of patients while providing diagnostics to rule out endometrial pathology. Patients who meet a strict criterion will be referred to have their TVS (transvaginal scan) at a CDC and from there will either be managed in primary care or referred into our service.

The service has created a gynaecology capacity working group as often our ability to deliver additional outpatient capacity has been limited by space, equipment and staffing. The theatres team are being trained to support with the outpatient procedures and have purchased additional scopes. Also, clinic rooms at Princess Anne have been repurposed to be suitable procedure rooms. This will enable us to have further flexibility for additional clinics. Another part of this working group is to review and improve our success rate with outpatient biopsies to prevent the need for GA, thus aligning with NICE and BADS guidance which focuses on completing procedures in the right environment in line with guidance and patient experience.

**4.3 Head and Neck Service**

Whilst the backlog on 62 Day pathways has recently reduced (currently at eleven patients) the wait for neck ultrasound is on average four weeks which is causing a delay within the ENT elements of the pathway. The average wait for a panendoscopy is 20 days which has significantly reduced from last year when it was 60 days. Weekly PTL meetings with the clinical team were implemented and proving successful which is highlighting and enabling booking dates for patients that require both diagnostic and surgery appointments. The service is trialling generic result letters to help improve our 28 day performance for ENT but this is in its early stages of implementation. A locum consultant is now in post and the ENT Fellow contract has been extended in the interim of the replacement being organised. We are also still reviewing the workforce required to deliver the head and neck pathway and the need for additional substantive posts.

**4.4 Urology Service**

The urology service continues to be one of the most challenged areas of the cancer services with 28day performance at 68.8% and 31day at 86.0% for December which are both below the target. There are currently fifty-one patients on the robot prostatectomy waiting list although this is a reduction since the volumes were above 70 patients late last year. Additional outsourced lists at the Spire continue to support the waiting list.

Work is continuing to enable the flexible cystoscopy process of imaging taking place prior to the cystoscopy to support 28 day performance, however there are still significant challenges around capacity for flexible cystoscopy as the budgeted capacity is approximately 60% of current capacity required. The current wait for a nurse led prostate clinic is 3 weeks and 6 weeks for a consultant surgeon MDT clinic slot. The team continue to run the patient initiated follow up (PIFU) prostate project to enable patients to be moved from Clinic to PIFU to create space in the clinic for MDT patients.

The team have been able to increase nursing resource however skill mix remains a challenge due to maternity leave, but the ACP returns in April which will help support delivery of the nurse led pathway. Nurse led prostate clinics are now back to full utilisation with newly trained staff and registrar consultant of the week clinics are now fully embedded with two clinics per week taking place to support on urgent referrals. There are continued challenges on delivery of the small bladder cancers (TURBT pathway) with patients currently waiting 4 weeks, despite our ambition for them to have their surgery within 2 weeks.

**4.5 Lung Service**

Theatre capacity for the lung and respiratory service has improved over the past few months, with the thoracic team covering for any absences and reducing the impact of potential lost lists. Access to the surgical robot is still a pressure but the team are working with surgical care group colleagues on prioritisation, working flexibly to maximise any opportunity of additional ad hoc days.

The thoracic service continues to work towards four weeks of acceptance onto the waiting list, but this prioritisation has an ongoing impact on the non-cancer waits for thoracic patients. Following a review of clinic templates and the mix of slots, outpatient appointments are now generally being booked within two

weeks. The 31-day and 24-day tertiary performance has improved as a result of detailed weekly validation of patient pathways and improved communication with referring hospitals. The service work closely with the Tertiary Co-ordinator to expedite investigations and streamline pathways wherever possible.

Following the roll out of regional Lung Cancer Screening Programmes (previously known as Targeted Lung Health Check Programme) in Hampshire and Dorset, the service is continuing to see an increase in the number of referrals.

**4.6 Dermatology Service**

The key issue within the service is balancing demand and capacity particularly throughout the seasonal peaks seen each year. Overall the service saw a 10% growth in referrals this year and a 20% growth in referrals across the last three years. The key focus at the moment is a task and finish group established in November 2024 in anticipation of the 2025 seasonal peak. New models of working are being developed to facilitate high volume clinics enabling increased throughput in the department across the summer period. A workforce paper and analysis are also under development to improve recruitment of our own workforce to reduce the reliance and expense of insourcing.

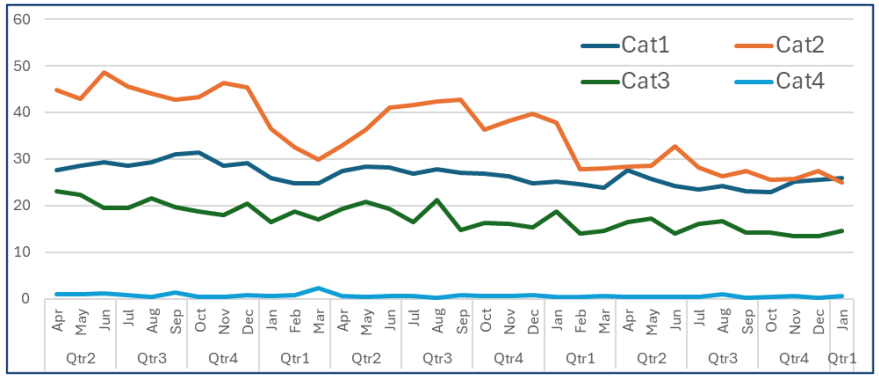
**4.8 Radiotherapy Service**

The department uses two main measures of waiting times performance, 31 Day % and compliance with Royal College of Radiologist (RCR) waiting times guidance for the four clinical categories of patients. On both measures the department is performing well due primarily to the maximisation of capacity through weekend working (Saturday shifts as voluntary overtime) and supplementing Linac staff through agency Radiographers to compensate for residual vacancies.

- Category 1 (fast growing, curative) – Target 31 Day. Average wait 26 days.
- Category 2 (other curative) – Target 31 Day. Average wait 26 days.
- Category 3 (palliative) – Guidance 14 days. Average wait 14 days.
- Category 4 (emergency) – Treated within 24 hours.

Demand continues to rise, particularly for the Category 2 patients who make up the bulk of the workload and typically have more daily treatments (a longer course of fractionated treatment).

The implementation of prostate hypo-fractionation (SABR) has completed its pilot stage and entered routine practice. The delivery method is forecast




*Graph 8: Radiotherapy Waiting Times by Category*

to reduce prostate demand (in Linac hours of activity) by 4-7% as the number of daily treatments (fractions) reduce from 20 to 5.

A risk remains that this treatment may become significantly more attractive to patients than surgery which may drive a further increase in radiotherapy referrals

Radiographer recruitment has improved over the last 6 months through a combination of international recruitment and students who have trained locally and are now working with us. We continue to be supported by agency radiographers but this will gradually be reduced as newly recruited substantive staff gain competence and HCPC registration, to maintain capacity.

One of the two CT scanners at the UHS site has significantly reduced functionality and a replacement is required to support efficiencies, shorten patient pathways and support 31-day Category 2 cancer performance. The CT scanner is anticipated to be funded for replacement in 2025-26.

Artificial Intelligence (AI) tools offer the potential to support the Radiotherapy planning process by automating some key parts of the pathway. A successful pilot has been undertaken at UHS with an expectation of NHSE funding into 25/26 which has now been withdrawn by the current government. Alternative options are being assessed but this currently remains as a workforce and financial pressure.

## 5 Conclusion

The trust continues to benchmark well against all three national cancer standards but has ambitions to be compliant on all three targets as we start a new calendar year. Referrals continue to increase year on year and services are looking for more sophisticated ways to forecast and model this impact to enable alignment of demand and capacity or more accurately assess the gap where capacity is restricted. The introduction of pathway navigators has been beneficial but there is a need to identify a recurrent funding source, alongside recruitment against vacancies and the upskilling of existing staff. The organisation is well aware of the volatility of certain services and ensures appropriate prioritisation and performance management steps are in place to ensure cancer patients are seen and treated as soon as possible as we strive to deliver improved services for all our patients.

# NHS Constitution - Standards for Access to services within waiting times

The NHS Constitution* and the Handbook to the NHS Constitution** together set out a range of rights to which people are entitled, and pledges that the NHS is committed to achieve, including:

The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected

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

- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

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

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

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

| | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31 | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 62.0% | ≥92% | 63.2% |
| | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 3 | 5 | 5 | | | |
| 39 | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) | 7 | 6 | 4 | 3 | 7 | 4 | 9 | 7 | 6 | 4 | 5 | 5 | 4 | 5 | 79.1% | ≥70% | 76.2% |
| | | 3 | 2 | 2 | 1 | 3 | 3 | 5 | 5 | 6 | 2 | 2 | 2 | 1 | 2 | | | |
| 39 - As of April 2024, YTD and Monthly targets changed from 85% to 70% in line with latest operational guidance | | | | | | | | | | | | | | | | | | |
| 28 | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 16)<br>South East average (& rank of 16) | 11 | 8 | 4 | 4 | 4 | 9 | 6 | 8 | 6 | 10 | 6 | 6 | 12 | 15 | 9 | ≥95% | 64.1% |
| | | 7 | 5 | 2 | 3 | 2 | 5 | 2 | 4 | 5 | 6 | 4 | 4 | 9 | 12 | 6 | | |
| 37 | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching Hospital average (& rank of 20)<br>South East Average (& rank of 18) | 7 | 7 | 7 | 5 | 5 | 5 | 4 | 5 | 5 | 5 | 5 | 6 | 6 | 6 | 15.7% | ≤5% | 12.43% |
| | | 6 | 7 | 5 | 5 | 4 | 5 | 5 | 5 | 6 | 6 | 6 | 8 | 9 | 8 | | | |
| 37 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance | | | | | | | | | | | | | | | | | | |

| Outcomes | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | HSMR (Rolling 12 Month Figure) - UHS<br>HSMR (Rolling 12 Month Figure) - SGH | 95.0<br>87.5 | | | | | | | | | | | | 87.8 | | 75.0<br>86.2 | ≤100 | 88.1 | ≤100 |
| 2 | HSMR - Crude Mortality Rate | 3.0%<br>2.7% | | | | | | | | | | | | 2.3% | | 2.2% | <3% | 2.1% | <3% |
| 3 | Percentage non-elective readmissions within 28 days of discharge from hospital | 15%<br>12.1% | | | | | | | | | | | | 11.8% | | 10% | - | 12.1% | - |
| | | Q1 2023/2024 | | | Q2 2023/2024 | | | Q3 2024/2025 | | | Q4 2024/2025 | | | Q1 2024/2025 | | | Quarterly target | | |
| 4 | Cumulative Specialties with Outcome Measures Developed (Quarterly) | 80<br>73 | | | 75 | | | 76 | | | 76 | | | 76 | | 70 | +1 Specialty per quarter | | |
| 5 | Developed Outcomes RAG ratings (Quarterly)<br>Red<br>Amber<br>Green | 100%<br>41<br>67<br>335 | | | 41<br>62<br>334 | | | 36<br>77<br>342 | | | 39<br>79<br>319 | | | 36<br>76<br>317 | | 50% | - | | |

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

| Safety | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Cumulative Clostridium difficile<br>**Most recent 12 Months** vs. **Previous 12 Months** | 77 | 85 | 84 | 93 | 9 | 12 | 14 | 19 | 22 | 29 | 27 | 38 | 37 | 51 | 47 | 61 | 55 | 71 | 60 | 81 | 69 | 85 | 79 | 89 | ≤9 | 89 | ≤81 |
| 7 | MRSA bacteraemia | 2 | 1 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 5 | 0 |
| 8 | Gram negative bacteraemia | 20 | 18 | 22 | 19 | 16 | 31 | 25 | 25 | 29 | 22 | 35 | 23 | 29 | 31 | 20 | ≤19 | 270 | ≤182 |
| 9 | Pressure ulcers category 2 per 1000 bed days | 0.45 | | | | | | | | | | | | | | 0.50 | <0.3 | 0.40 | <0.3 |
| 10 | Pressure ulcers category 3 and above per 1000 bed days | 0.36 | | | | | | | | | | | | | | 0.50 | <0.3 | 0.34 | <0.3 |
| 11 | Medication Errors (severe/moderate) | 3 | | | | | | | | | | | | | | 6 | ≤3 | 23 | 30 |
| 12 | Watch & Reserve antibiotics, usage per 1,000 adms<br>**Most recent months** vs. **2023/24** | 2,598 | | | | | | | | | | | | | | 2,613 | <2700 | 2,712 | <2615 |

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

| **Safety** | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity) | | | 0 | | | | | | | | | | | | 2 | - | 9 | - |
| 13a | Never Events | | | 1 | | | | | | | | | | | | 1 | 0 | 9 | 0 |
| 14 | Patient Safety Incident Investigations (PSIIs)- Maternity | | | 0 | | | | | | | | | | | | 0 | - | 0 | - |
| 15 | Number of falls investigated per 1000 bed days | | | 0.14 | | | | | | | | | | | | 0.09 | - | 0.11 | - |
| 16 | % patients with a nutrition plan in place (total checks conducted included at chart base) | | | 94.3% | | | | | | | | | | | | 96.8% | ≥90% | 95% | ≥90% |
| | | | | 932 | 935 | 962 | 961 | 1,012 | 930 | 973 | 977 | 930 | 869 | 826 | 964 | 961 | 828 | 901 | |
| 17 | Red Flag staffing incidents | | | 26 | | | | | | | | | | | | 8 | - | 177 | - |

| **Maternity** | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18 | Birth rate and Bookings<br>Birth Rate - total number of women birthed<br>Bookings - Total number of women booked | 409 | 428 | 406 | 401 | 428 | 411 | 415 | 379 | 390 | 400 | 410 | 438 | 392 | 396 | 395 | - | - | - |
| | | 469 | 392 | 483 | 429 | 409 | 448 | 633 | 517 | 501 | 480 | 403 | 523 | 451 | 467 | 496 | | | |
| 19 | Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4. | 1 | 4 | 4 | 0 | 6 | 0 | 3 | 8 | 8 | 2 | 12 | 6 | 1 | 0 | 1 | - | - | - |
| 20 | Mode of delivery<br>% number of normal birthed (women)<br>% number of caesarean sections (women) | 45.23% | 49.30% | 47.29% | 50.62% | 46.73% | 45.99% | 46.51% | 53.03% | 44.80% | 44.25% | 43.90% | 41.10% | 46.68% | 40.91% | 47.85% | - | - | - |
| | | 43.52% | 38.55% | 39.16% | 38.90% | 40.89% | 43.80% | 39.04% | 35.88% | 44.40% | 43.00% | 42.44% | 48.40% | 41.07% | 47.47% | 42.03% | | | |

| **Patient Experience** | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 21 | FFT Negative Score - Inpatients | 3% | | 0.8% | | | | | | | | | | | | 1.5% | ≤5% | 0.8% | ≤5% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 22 | FFT Negative Score - Maternity (postnatal ward) | 10% | | 2.8% | | | | | | | | | | | | 0.9% | ≤5% | 2.2% | ≤5% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 23 | Total UHS women booked onto a continuity of carer pathway | 30% | | 11.1% | | | | | | | | | | | | 17.5% | ≥35% | 14.3% | ≥35% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 24 | Total BAME women booked onto a continuity of carer pathway | 100% | | 19.8% | | | | | | | | | | | | 21.6% | ≥51% | 20.6% | ≥51% |
| | | 0% | | | | | | | | | | | | | | | | | |
| 25 | % Patients reporting being involved in decisions about care and treatment | 100% | | 87.3% | | | | | | | | | | | | 85.5% | ≥90% | 87.5% | ≥90% |
| | | 80% | | | | | | | | | | | | | | | | | |
| 26 | % Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base) | 100% | | 86.4% | | | | | | | | | | | | 87.5% | ≥90% | 88.3% | ≥90% |
| | | 80% | 336 | 208 | 272 | 304 | 268 | 339 | 340 | 280 | 258 | 317 | 221 | 353 | 247 | 296 | 323 | | |
| 26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0. | | | | | | | | | | | | | | | | | | | |
| 27 | Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs) | 100 | | 96 | | | | | | | | | | | | 76 | - | 621 | - |
| | | 0 | | | | | | | | | | | | | | | | | |

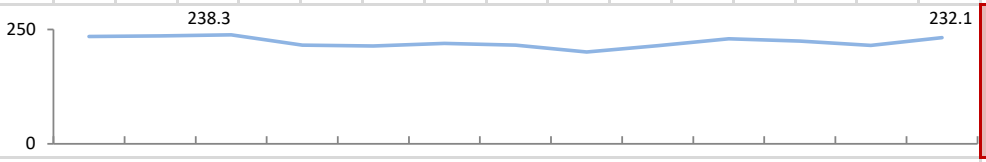
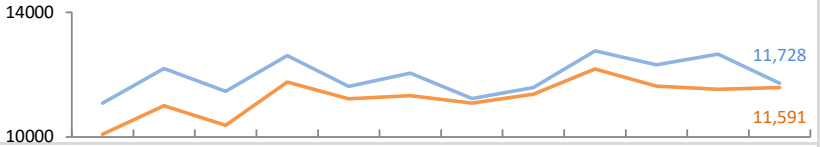
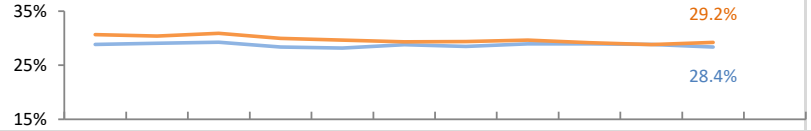
| Access Standards | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28 | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 16) | 95%<br>30% | 63.7% | | | | | | | | | | | | | 61.2% | ≥95% | 64.1% | ≥95% |
| | | 11 | 8 | 4 | 4 | 4 | 9 | 6 | 8 | 6 | 10 | 6 | 6 | 12 | 15 | 9 | | | |
| | | 7 | 5 | 2 | 3 | 2 | 5 | 2 | 4 | 5 | 6 | 4 | 4 | 9 | 12 | 6 | | | |
| 29 | Average (Mean) time in Dept - non-admitted patients | 05:00<br>02:00 | 03:24 | | | | | | | | | | | | | 03:15 | ≤04:00 | 03:21 | ≤04:00 |
| 30 | Average (Mean) time in Dept - admitted patients | 07:00<br>03:00 | 06:40 | | | | | | | | | | | | | 05:31 | ≤04:00 | 05:33 | ≤04:00 |
| 31 | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 75%<br>50% | 62.3% | | | | | | | | | | | | | 62.0% | ≥92% | 63.2% | ≥92% |
| | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | | |
| | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 4 | 3 | 5 | 5 | | | | |
| 32 | Total number of patients on a waiting list (18 week referral to treatment pathway) | 65,000<br>55,000 | 57725 | | | | | | | | | | | | | 60910 | - | 60,910 | - |
| 33 | Patients on an open 18 week pathway (waiting 52 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 8,000<br>0 | 1672 | | | | | | | | | | | | | 1220 | ≤1393 | 1220 | ≤1393 |
| | | 2 | 2 | 2 | 3 | 3 | 4 | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | | | | |
| | | 8 | 9 | 10 | 9 | 10 | 10 | 10 | 9 | 9 | 8 | 9 | 8 | 9 | 9 | | | | |

| | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 34 | Patients on an open 18 week pathway (waiting 65 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 245 | | | | | | | | | | | | | | 39 | 0 | 39 | 0 |
| 35 | Patients on an open 18 week pathway (waiting 78 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 27 | | | | | | | | | | | | | | 1 | 0 | 1 | 0 |
| 35a | Patients on an open 18 week pathway (waiting 104 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 0 | | | | | | | | | | | | | | 0 | 0 | 0 | 0 |
| 36 | Patients waiting for diagnostics | 8052 | | | | | | | | | | | | | | 9388 | - | 9,388 | - |
| 37 | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 14.5% | | | | | | | | | | | | | | 15.7% | ≤5% | 12.4% | ≤5% |

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

| | | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 39 | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | | 78.9% | | | | | | | | | | | | | 79.1% | | ≥70% | 76.2% | ≥70% |
| 39 - From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes.<br><br>As of April 2024, YTD and Monthly targets changed to 70% in line with latest operational guidance | | | | | | | | | | | | | | | | | | | | |
| 40 | Cancer 28 day faster diagnosis Percentage of patients treated within standard<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | | 86.7% | | | | | | | | | | | | | 83.6% | | ≥77% | 83.7% | ≥77% |
| 40 - As of April 2024, YTD and monthly targets changed from 75% to 77% in line with latest operational guidance | | | | | | | | | | | | | | | | | | | | |
| 41 | 31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | | 90.5% | | | | | | | | | | | | | 94.9% | | ≥96% | 83.7% | ≥96% |
| 41 | From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes. | | | | | | | | | | | | | | | | | | | |

| R&D Performance | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 43 | Comparative CRN Recruitment Performance - non-weighted | 16 | 15 | 15 | 15 | 15 | 9 | 7 | 6 | 9 | 9 | 8 | 10 | 8 | 8 | 9 | Top 10 | - | - |
| 44 | Comparative CRN Recruitment Performance - weighted | 12 | 9 | 11 | 11 | 11 | 6 | 8 | 9 | 10 | 10 | 10 | 10 | 10 | 12 | 12 | Top 5 | - | - |
| 45 | Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection | 46% | 88% | 55% | 50% | 64% | 50% | 55% | 47% | 100% | 44% | 38% | 78% | 36% | 70% | 44% | - | - | - |
| 46 | Achievement compared to R+D Income Baseline<br>Monthly income increase %<br>YTD income increase % | 133.3% | 84.7% | 65.2% | 157.6% | 75.0% | 26.8% | 119.5% | 70.7% | 51.2% | 90.2% | 80.5% | 26.8% | 80.5% | 61.0% | 80.5% | ≥5% | - | - |

| **Local Integration** | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 47 | Number of inpatients that were medically optimised for discharge (monthly average) |  | | | | | | | | | | | | | | | ≤80 | 225 | - |
| 48 | Emergency Department activity - type 1<br>This year vs. last year |  | | | | | | | | | | | | | | | - | 120,046 | - |
| 49 | Percentage of virtual appointments as a proportion of all outpatient consultations<br>This year vs. last year |  | | | | | | | | | | | | | | | ≥25% | 28.3% | ≥25% |

| **Digital** | | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 50 | My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month) | | | 188436 | | | | | | | | | | | | 230982 | - | 230,982 | - |
| 51 | My Medical Record - UHS patient logins (number of logins made within each month) | | | 34454 | | | | | | | | | | | | 43781 | - | 371,668 | - |
| 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 | | | 0 | 21 | 12 | 27 | 54 | 158 | 451 | 659 | 969 | 2270 | 2850 | 1810 | 1910 | 200 | - | - | - |
| | | | | 14 | 13 | 12 | 11 | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | | | |
| 53 | CHARTS system average load times<br>- % pages loaded <= 5s<br>- % pages loaded <= 3s | | | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% | 99.3% | 99.2% | 99.3% | 99.3% | 99.4% | 99.4% | 99.4% | 99.3% | 99.3% | | | |
| 53 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s** | | | | | | | | | | | | | | | | | | | |

| Agenda item 5.8 | Report to the Trust Board of Directors, 11 March 2025 |
|---|---|
| **Title:** | Finance Report 2024-25 Month 10 Report |
| **Sponsor:** | Ian Howard, Chief Finance Officer |
| **Author:** | Philip Bunting, DoOF and Anna Schoenwerth, ADOF |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

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

The headlines for the January report are as follows:

- UHS has been working with system partners to agree a HIOW ICS "landing plan" for 2024/25. As a result, UHS has improved it's forecast to £17.65m deficit at year-end. The Trust has identified a series of non-recurrent improvements to the position and have also been supported by additional cash from HIOW ICB.
- The Trust has reported a £7.5m surplus in month and a £15.2m deficit YTD. The Trust is now £11.8m behind plan YTD. The trust has submitted a forecast to NHS England of £17.65m deficit which forms part of the HIOW ICB 'landing plan'.
- UHS continues to deliver significant levels of financial savings (£67.1m YTD), from UHS transformation programmes on patient flow, theatres and outpatients.
- UHS benchmarks as providing good value for money across a wide range of metrics.
- One of the main drivers of the deficit continues to be the non-delivery of system transformation initiatives, in particular, Non-Criteria to Reside (NCTR).
- The Trust continues to overtrade – undertaking activities beyond funding levels being received.
- The Trust financial position remains off-plan, with monthly improvements required to deliver our Financial Recovery Plan.
- There are further risks to the Trusts financial position regarding ERF income levels, staffing costs and winter pressures.
- Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. The Trust also continues to work with Deloitte around non pay savings opportunities.
- Cash has increased to £15.4m in month, as forecast. There is a significant risk in Q1 2025/26 that cash will reduce close to zero and cash support will be required.
- The Trust's capital programme is £12.0m behind plan YTD, with £39.3m to be spent in the remainder of the year.

**Contents:**

Finance Report

**Risk(s):**

5a - We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.

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

# UHS Finance Report – M10

## Headlines

As reported in previous months, following the receipt of £11.2m of deficit support funding in October, UHS is now being measured against an annual plan of £3.3m deficit. This deficit is fully phased into the first half of the year with the prevailing plan for the second half of the year a monthly breakeven target.

The below table illustrates both the in-month and YTD reported I&E position both before and after the deficit support funding:

| Financial Position – Pre-Deficit Support | M10 | YTD | Annual |
|---|---|---|---|
| **Plan** | 0.0 | (14.5) | (14.5) |
| **Actual Surplus / (Deficit)** | 7.5 | (26.3) | |
| **Variance** | 7.5 | (11.8) | |

| Financial Position - After Deficit Support | M10 | YTD | Annual |
|---|---|---|---|
| **Re-set Plan** | 0.0 | (3.3) | (3.3) |
| **Actual Surplus / (Deficit)** | 7.5 | (15.2) | |
| **Variance** | 7.5 | (11.8) | |

In month £13.3m a series of one-off benefits has meant the trust has reported a surplus of £7.5m. These are as follows:

- The conclusion of a legal claim creating a favourable benefit of £1.4m
- A VAT benefit associated with car parking income in prior years generating a one benefit of £2.2m
- £0.8m of IFRS 16 remeasurement benefits following the conclusion of an internal review of leases and the appropriate accounting treatment.
- £2.6m of confirmed additional non recurrent ICB income
- £3.7m of costs incorrectly accounted for within revenue have been reclassified as capital
- £2.6m of other one-off benefits

The trusts underlying position does however remain similar to previous months at £6.1m deficit.

## "Landing Plan" Forecast

UHS has been working with partners across HIOW ICS to agree a forecast "landing plan" with NHS England. Improvements have been identified within the UHS financial position from one-off benefits (some of which are outlined above), which have been partially matched by additional funding from HIOW ICB and NHSE. This has resulted in an improved I&E position and cash position, with further potential benefit identified in 2025/26.

UHS has submitted a revised forecast deficit of £17.65m to NHS England. However, £3.3m has been identified for a specific provision of which NHSE is aware, which is not consolidated into the national RDEL accounts and therefore has been considered an "allowable miss". For performance monitoring purposes we are therefore forecasting a deficit of £14.35m, an £11m variance to plan.

Further work is underway across HIOW to identify additional improvements, and therefore this number may be subject to change again; however, movements are anticipated not to be material.

To deliver this position UHS is required to report a deficit of no more than £2.5m over the remaining months of the year. At present there is still a prevailing system deficit therefore discussions remain ongoing around further targeted improvements.

**Financial Improvements**

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

- The Trust has delivered length of stay improvements for P0 patients of 5%.
- We have delivered a significant improvement to our outpatient ratio, undertaking more first appointments, procedures and advice & guidance.
- The Trust has implemented new workforce controls embedded within Divisions, which have been widely supported. We are below our pay expenditure plan YTD with all divisions operating within workforce control totals.
- We are currently utilising agency for 0.5% of our total workforce, significantly below the national target of 3.2%. Our temporary staffing remains below plan.
- UHS is performing well on ERF activity through transformation programmes and other initiatives, with YTD performance at 126% of baselines, above the overall national target of 107% (although below our internal plan target of 133%).
- UHS has delivered £67.1m (>6% of addressable spend) of CIP by M10, which is above the trajectory from 23/24.
- Since March 24, our ERF performance has increased by 8%, and at the same time our staffing levels have reduced by 1%.
- The Trust has recently received benchmarking information which highlights its relative efficiency, notably:
    - National Cost Collection score of 89 – 11% more efficient than national average.
    - Model Hospital data for 22/23 – further improvement to 15th national performance, above peer organisations.
    - Back-office benchmarking highlighting efficient use of resources.

**Key Drivers**

The key drivers for the £11.8m variance to plan YTD are as follows:

- System Transformation programmes targeted delivery of reductions to Non-Criteria to Reside (NCTR) and Mental Health numbers attending the hospital. Despite best endeavours of UHS and system partners, patient numbers remain above planned levels, meaning the Trust continues to incur additional temporary staffing costs and is maintaining additional bed capacity above funded levels. Savings of £10.6m have not been delivered across all system transformation schemes YTD.
- Final elements of the pay award have been made to resident doctors and Band 8+ staff on the November payroll (taxes were paid in December). The combined impact of pay awards is confirmed to have an in-year funding shortfall of c£2m with c£1.7m impacting YTD. This poses a significant risk to the delivery of the financial recovery plan.
- The UHS ERF target with Specialised Commissioning was increased by £1.2m after the plan was submitted (£1.0m YTD). This was related to movement in the target of another Trust. This was challenged but upheld by NHS England.
- Non pay cost pressures including the impact of inflation above planned levels continues to cause pressure.
- The Combined Heat and Power (CHP) units have broken down on several occasions, meaning electrical power is imported from the national grid at a higher cost. This has had an in-year

impact of £1.2m YTD. One of the units has recently been serviced with the aim of reducing the number of breakdowns.

- Non-Elective growth and staffing challenges have resulted in under-performance against our elective income plan in Cardiac Surgery.
- Pay is £12.5m adverse to plan YTD after removing the impact of the pay award. After having an underspend in the first half of the year, an overspend is now prevailing as planned system transformation savings have not been achieved.

**Other Headlines**

Income performance increased in month with Elective Recovery Fund (ERF) performance reducing to 130% of 19/20 levels. This is above the YTD average of 126% driven by strong performance in month. ERF overperformance has generated income of £22.5m YTD.

Pay expenditure increased in month by £0.5m to £67.2m in M10. WTEs increased 137 overall although last month did decrease by 90 and it was noted that December is not a typical month due to bank holidays and annual leave. There is however evidence of some reduced bank and agency due to newly qualified staff now completing their supernumerary periods of working.

Non pay expenses (excluding pass through) are reporting a £19.5m adverse variance YTD with the majority of this relating to unidentified CIP that was planned for within this category (£16.7m YTD / £20m FY). Savings have however been achieved in other areas partially offsetting this variance. We are also currently working with Deloitte to review and implement non pay savings opportunities.

The underlying position, removing all further one-off items of income and expenditure, totals £6.1m in month deficit. The underlying trend continues to be refreshed for any backdated costs and benefits.

An assessment of YTD performance highlights that the Trust delivered over £26.0m of valued activity above block contracts in months 1 - 10. Discussions are in progress around increased funding for block areas as part of the 2025/26 planning round.

**Risks**

- ERF data has now been received by NHS England for months 1-7. We continue to review prior months data to ensure levels of data quality are robust.
- There are seasonality risks that may mean surge capacity costs increase and elective income cannot be maintained at prior month levels. Notably NCTR levels have increased in month. This has risks for both increased expenditure and reduced ERF income.

We have been notified of a change in payment mechanism for ERF for 24/25, whereby the Trust will be funded at the lower of:

- M10 forecast adjusted for regional intelligence (note – this has changed from last month); or
- System cap (based on M8 forecast)

There is an added complexity in that this is transacted by system:

- HIOW ICB:
  - UHS forecast is slightly above our system cap following strong M10 performance.
  - Likely to be paid at our system cap level.
  - There is some potential volatility in M10-12 – targeting improvements, but off-set by winter pressures.

  - We have not reduced additional activity targeted at meeting 52/65 week performance standards, and have continued Q4 plans in cardiac and glaucoma to reduce the levels of risk in those areas.

- Specialised Commissioning:
  - UHS forecast to be at or marginally under our system cap.
  - We have proposed a block based on the system cap and are awaiting feedback from commissioners on this proposal.

**Cash**

The cash position has been supported by £12m of additional funding in year to support our capital programme. We are now forecasting that we will not require revenue support in Q4; however, the position remains challenged, and we will keep this under regular review. A further update is provided in the separate cash paper. The improved I&E forecast has also had a positive impact with additional cash being received by the Trust.

**Capital**

Capital expenditure of £34.2m YTD is £12.0m (35%) behind plan, leaving £39.3m to be spent across the remainder of 24/25 (excluding IFRS 16 capital additions/remeasurements). Changes to the Building Safety Act have created delays and overspends in several key projects notably the Neonatal expansion and the decarbonisation programme. The Community Diagnostic Centre (CDC) development is the other project facing slippage risks.

During February capital forecasts have been reviewed across HIOW ICB which resulted in a revised forecast for IFRS 16 (reduced from £19.3m to £8.8m) and an additional CDEL allocation of £5.0m which will be spent. This will reduce the annual expected spend from £79.0m to £73.5m. The capital priorities for 25/26 and 26/27 will be discussed at February's Trust Board Study Session.

# Month 10 system report

## 1. Purpose

1.1 The purpose of the Month 10 (M10) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the financial position and system recovery plan for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of January 2025.

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

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

## 2. Background

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

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

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

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

# 3. Discussion

## 3.1 Integrated Care System Financial Overview

3.1.1 The £70m deficit cash support funding received in month 6 resulted in the ICS being required to improve its combined annual plan from £70m deficit to breakeven, however at month 10, following agreement from NHS England, the ICS revised its forecast to an £18.5m deficit and our M10 reporting is against this revised deficit forecast. The table below shows how the deficit cash support funding was phased into the financial position.

| Organisation | M6 | M7 | M8 | M9 | M10 | M11 | M12 | Full Year |
|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| Hampshire and Isle of Wight ICS | 55,282 | 2,435 | 2,265 | 5,339 | 2,198 | 1,795 | 684 | 69,998 |

3.1.2 The table below summarises the ICS financial position reported at month 10 (January 2025). In January itself, the ICS reported a surplus of £4.8m against a planned surplus of £2.9m, so a positive variance to plan of £1.9m.

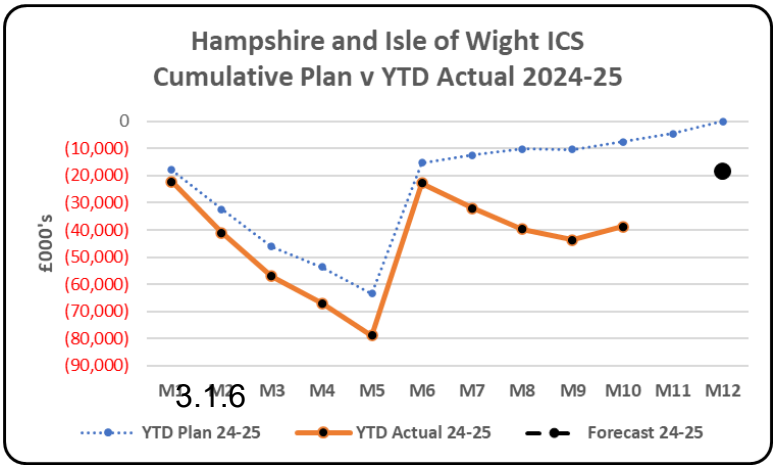
| Organisation | In Month | | | Year to date | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | In Month Plan £'000 | In Month Actual £'000 | Variance £'000 | YTD Plan £'000 | YTD Actual £'000 | Variance £'000 | Annual Plan £'000 | Forecast Outturn £'000 | Variance £'000 |
| Hampshire and Isle of Wight ICS Total | £2,862 | £4,790 | £1,928 | (£7,570) | (£38,845) | (£31,275) | £0 | (£18,478) | (£18,478) |

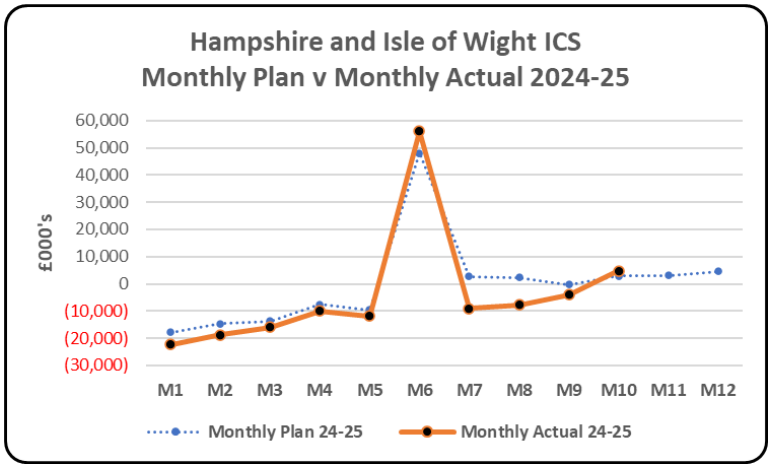
3.1.3 The system is currently reporting a year-to-date deficit of £38.8m at month 10 compared to a planned £7.6m deficit, therefore a £31.3m adverse variance to plan.

3.1.4 The ICS revised its forecast at month 10 and is now forecasting to achieve a combined £18.5m deficit

3.1.5 The ICS will continue to prioritise the implementation of the agreed system plan and transformation programmes to support achievement of our financial plan in financial year 2024/25.

3.1.5 The graphs below summarise the ICS position reported at month 10:




3.1.6

## 3.2 System Actions to Support Financial Recovery

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

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

3.2.3 System leaders have agreed additional steps in 2024/25 to strengthen our delivery of plans, including:

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

3.2.4 Additional external support has been commissioned for some system organisations, either to support continued delivery of their 2024/25 plan, or to support recovery where organisations are already materially off-plan.

## 3.3 System Transformation Programmes

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

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

3.3.2 Each transformation programme reports on progress and key metrics into the

monthly System Transformation and Recovery Board, which is attended by all Provider Chief Executives. Reporting is supported by a system Programme Management Office.

## 3.4 Elective Recovery Fund

3.4.1 The Elective Recovery Fund (ERF) aims to increase elective activity in the NHS by providing additional funding to Integrated Care Boards (ICBs). The funding was initially uncapped meaning that additional funding would be given to ICBs and NHS Providers that over perform and exceed their individual targets.

3.4.2 Each organisation has a specific target level of activity growth (compared to 2019/20) above which additional income is earned. For Hampshire and Isle of Wight as a whole, our target level is 108.7% of 2019/20 activity, but our operating plans for 2024/25 were based on achieving 120.5%. At Month 10, initial data estimates show achievement of 122.6%.

3.4.3 NHS England initially communicated that the ERF funding was uncapped meaning that additional funding can be given to ICBs and NHS Providers that exceed their individual targets. However, in December/January 2025 it was confirmed that there would be a ceiling on ERF funded activity 2024/25 and that there would be no reconciliation of adjustments for 2024/25 overperformance in 2025/26.

# 4. Quality

## 4.1 Regulatory

**Care Quality Commission**: during January 2025, four Care Quality Commission inspection outcomes were published – three were rated Good and one was rated as Inadequate (please see the Quality Metrics Report for full details). Two providers showed a worsening position. None of the published reports related to NHS providers. None of the published reports related to NHS providers.

**Quality Assurance and Improvement Levels**: all providers, apart from one, remain in the routine quality assurance and improvement level.

## 4.2 Patient Experience

**Friends and Family Test Performance**: the latest data relates to November 2024, in general, for our key NHS providers, performance in relation to positive feedback is equal to or greater than the national rate, apart from in the following areas:

- **Emergency Department (national positive 95%):**
  - One Trust received 74% positive
- **Inpatient (national positive 95%):**
  - One Trust received 92% positive
- **Outpatient (national positive 94%):**
  - One Trust received 93% positive
- **Maternity Postnatal (national positive 92%):**

  - One Trust received 75% positive
- **Maternity Postnatal Community (national positive 91%):**
  - One Trust received 87% positive but continue to show an improving position.

Trust Friends and Family Test performance is used as part of our intelligence when reviewing their overall quality.

**Mixed-Sex Accommodation Breaches (December 2024):** the threshold for mixed sex accommodation breaches is >0. All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient (Statistics » Mixed-Sex Accommodation Data):

- **One Trust:** reported 21 (↑8 from previous month) mixed sex accommodation breaches.
- **One Trust:** reported 105 (↓16 from previous month) breaches; the Trust has consistently not met the target this financial year.

It is anticipated that the work being undertaken in relation to improving hospital and system flow should have an impact on some of the mixed-sex accommodation breaches.

As a System, this metric continues not to be met, although December 2024 performance represents an improving position.

### 4.3 Safety

**SO40a Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections**: 2023/24 saw an increase in Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection, in particular healthcare associated cases. There is an improving trend in cases with a reduction from 29 cases in the rolling 12 months (January 2024 to December 2024) to 28* cases in the 12 months between February 2024 to January 2025.

The Quarter 3, 2024/25 Oversight Framework metrics evidence an improving trend when compared to the Oversight Framework metrics in March 2024 (Count = 31/42 Rate = 28/42).

NHS Hampshire and Isle of Wight is predicted to have a similar number of Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection compared to 2023/24. While the Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection oversight Framework data was calculated on count, a rate takes into consideration the size of the population.

There has been an increasing trend in contaminated Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream samples, these cases cannot be removed from the Integrated Care Board and trusts total.

| Table 1: Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection infections - current position | | | | | |
|---|---|---|---|---|---|
| **Total number of cases - financial year to date*** | **No learning/ lapses in care** | **Lapse in care** | **Incidental Learning post Methicillin-resistant Staphylococcus aureus Blood Stream Infections** | **Cases under review** | **Qtr 3 Quartile position against latest OF metrics** |
| 26 | 7 | 10 | 2 | 7 | **Count = 28/42 Rate = 18/42** |
| *** The June case has been successfully appealed but it has not yet been reallocated.** | | | | | |

The Infection Prevention and Control Team has collated all learning associated with the contaminated blood culture cases which will be shared with all relevant providers. The emerging theme has been discussed at the Hampshire and Isle of Wight Infection Prevention and Control Network meeting.

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

**S041a: Clostridium difficile infection rate:** the monthly trajectory for Clostridium difficile is 44.5 – the January 2025 data currently shows that this has not yet been exceeded (31 cases), however, it is likely that the laboratories may report more cases. There were only 35 cases reported in December 2024 which is a significant reduction on the average of 52 cases per month.

The Quarter 3, 2024/25 oversight framework metrics show a significant improving trend when compared to the oversight framework metrics in March 2024 (20/42). NHS Hampshire and Isle of Wight will finish the year above threshold; however the Integrated Care Board ranking position has improved significantly when compared to 2023/24. Since 2021/22 the ICB has seen a 9-18% year-on-year increase in CDI cases; this annual increase is predicted to be reduced this year to 6% against and NHS England average increase of 14%.

| Table 2: Clostridium difficile infections - current position | | | |
|---|---|---|---|
| **Number of cases reported* in month (January 2025)** | **Total number of cases financial year to date*** | **Performance against 2024/25 trajectory*** | **Quartile position against latest OF metrics** |
| 38 | 489 (+43) | 489/535 | 10/42 |
| **Narrative:** January 2025* case number is likely to increase by a further 5-10 cases before the data capture system closes. The Integrated Care Board has now used 91% of its annual trajectory in month ten against a target of 83%. | | | |
| ** January 2025 data will not be confirmed until the 16 January, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of January 2025 cases.* | | | |

The Infection Prevention and Control team has identified a small number of Integrated Care Board's that have significantly reduced their Clostridium difficile infection rates; the team will contact them to identify if there are any actions we can adopt in Hampshire and Isle of Wight.

Overall, Hampshire and the Isle of Wight is following the same trend as other areas in the South East Region – learning seems to imply increased complexity, frailty and acuity of patients post pandemic and decreased conditioning of the population. There is concern in relation to the number of Clostridium difficile cases reported by one of the Trusts and support is being provided.

**ALERT: SO42a Escherichia coli (E. coli) bloodstream infections (BSI):** the monthly trajectory for Escherichia coli (E. coli) bloodstream infections is 102 cases. NHS Hampshire and Isle of Wight will finish the year above threshold and a slightly worse oversight framework ranking position compared to 2023/24. The annual increase is predicted to be reduced this year to 6% from a 10% increase in 2023/24.

| Table 3: Escherichia coli (E. coli) bloodstream infections - current position | | | |
|---|---|---|---|
| **Number of cases reported* in month (January 2025)** | **Total number of cases financial year to date*** | **Performance against 2024/25 trajectory** | **Quartile position against latest OF metrics** |
| 118 | 1176 (+166)* | 1176/1219 | **28/42** |
| **Narrative:** The Integrated Care Board has now used 96% of its annual trajectory in month ten against a target of 83%. However there are likely to be a further 10 -20 cases added to January before the reporting system closes on the 16 February 2025. | | | |
| ** January 2025 data will not be confirmed until the 16 February, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of January 2025 cases.* | | | |

The Infection Prevention and Control team has identified Dorset Integrated Care Board as having significantly reduced their Escherichia coli (E. coli) Blood Stream Infection; a meeting held in January 2025 identified that the Dorset system undertook a system wide hydration project over an 18-month period. The Hampshire and Isle of Wight Infection Prevention and Control Team are looking to roll out the NHS England South East Hydrate to Feel Great project.

It is of concern that the trajectory for Escherichia coli (E. coli) bloodstream infections is not being met. Support is being provided to those Trusts that have exceeded their 5% trajectory for the month and learning from the cases is shared across the System. The main change seems to be associated with Community Onset, Healthcare Associated cases, however the reason for this is unknown. NHS Hampshire and Isle of Wight is assured that very few cases are associated with initial treatment failures in primary care. The majority are spontaneous events.

**Never Events:** the national threshold for Never Events is zero. Nationally, the latest provisional data indicates that there were 297 Never Events reported between April 2024 and December 2024 – 4.4% of these cases will have been attributable to Hampshire and Isle of Wight NHS providers. In January 2025, four Never Events were reported. During 2024/25 to end of January 2025, there were 17 Never Events formally reported within our System.

**South Central Ambulance NHS Foundation Trust – Regulation 28 – Reference 2025-0064 – Wyllow-Raine Swinburn:** The incident took place in Oxford, but learning will be for the organisation.

The coroner raised two key concerns:

- a delay in the 999 call being connected to an Emergency Call Taker (ECT) – seven-minute delay
- the length of time for an ambulance/paramedic to attend – the response time for the first paramedic to attend was 31 minutes.

The full report is available via: https://www.judiciary.uk/prevention-of-future-death-reports/wyllow-raine-swinburn-prevention-of-future-deaths-report/. The Trust has until 1 April 2025 to respond.

## 4.4 Clinical Effectiveness

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

**National Hip Fracture database – 30-day mortality (November 2024):** the latest data from the national hip fracture database shows that all Hampshire and Isle of Wight acute providers continue to be below the national mortality 30-day rate.

**National Hip Fracture database – hours to operation (November 2024):** early surgery for hip fractures has been shown to reduce mortality rates and surgical complications. The national target is for patients to have surgery within 36 hours, this is because delays beyond this are shown to have increased mortality. Within Hampshire and Isle of Wight, only one Trust met this target.

### 4.5 Quality Impact Assessments

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

During January 2025, no Quality Impact Assessments were formally submitted to the Hampshire and Isle of Wight panel for review – this was not submitted by a provider.

## 5. Recommendations

5.1 Each Board needs assurance that their organisation is going to deliver on their financial landing plan, and that appropriate mitigations and recovery plans are in place where required.

5.2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme.

| Agenda item 5.10 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | People Report 2024-25 Month 10 |
| **Sponsor:** | Steve Harris, Chief People Officer |
| **Author:** | Matthew Kelly, Interim Head of Workforce |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

As forecasted the Trust has further exceeded its NHSE workforce plan by 153 WTE at the end of January, back in line with the trend from November. The total Workforce increased by 72 WTE, with a significant increase of 86 WTE in bank usage. This is largely owing to continued high levels of sickness absence for winter Flu and surge capacity within the trust.

Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of 24/25. Current forecasting indicates the Substantive workforce is predicted to reduce from January by to 31 March 20124 by 14 WTE. The Trust conducted enhanced recruitment of HCAs during January to combat high vacancy levels, yielding growth of 19 WTE in this staff group.

At present, the forecast for the end of the year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13,403 WTE which would be 125 over the NHSE plan.

The overall forecast assumes no impact of NCTR and mental health reductions but, does assume gains made in bank through the benefit of NQNS becoming part of the established workforce during January onwards. Turnover has slightly decreased in January, taking the UHS rate to 10.6% and well below target of 13.6%. Overall sickness further increased in month to 4.4% to exceed the trust target of 3.9%. Sickness has been driven by winter respiratory illnesses such as Flu and Covid.

Negotiations with UNISON regarding the band 2/band 3 dispute are ongoing.

Consultation commenced on the 24th January on the transfer of over 200 staff in the EFCD function (excluding portering and clinical engineering from UHS to UEL (UHS's estates wholly owned subsidiary) on the 1st April 2025.

Appraisal rates across the trust have further decreased across the trust to 71%; this is a rolling 12-month figure. This is a notable drop and the team are investigating if this is connected to data and reporting following the transfer to the new system on VLE.

**Contents:**

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

**Risk(s):**

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

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

# UHS People Report

WORLD CLASS PEOPLE

January 2025

THRIVE EXCEL BELONG

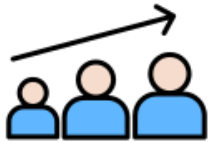
# Summary

# PEOPLE REPORT OVERVIEW: 2024/25 M10 (JAN-25)

In-month sickness (4.4%) above target (3.9%)

Appraisal completion rates decreased in January (71%)

R12m turnover rate (10.6%), which is below target (13.6%)



Substantive workforce currently above NHSE 24/25 workforce plan

Bank usage increased from prior month and is now 140 WTE above plan

Increase (4 WTE) in agency staffing. Agency remains under plan.

Decrease in patient safety incidents from 74 to 62 in January

Pulse Survey for Q2 shows a stable engagement score

## Executive Summary

As forecasted the Trust has further exceeded its NHSE workforce plan by 153 WTE at the end of January, back in line with the trend from November. The total Workforce increased by 72 WTE, with a significant increase of 86 WTE in bank usage. This is largely owing to continued high levels of sickness absence for winter Flu and surge capacity within the trust.

Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of 24/25. Current forecasting indicates the Substantive workforce is predicted to reduce from January by to 31 March 20124 by 14 WTE. The Trust conducted enhanced recruitment of HCAs during January to combat high vacancy levels, yielding growth of 19 WTE in this staff group.

At present, the forecast for the end of the year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13,403 WTE which would be 125 over the NHSE plan. The forecast assumes a stable level of turnover in each month.

The overall forecast assumes no impact of NCTR and mental health reductions but, does assume gains made in bank by realising the benefit of NQNS becoming part of the established workforce during January onwards. Turnover has slightly decreased in January, taking the UHS rate to 10.6% and well below target of 13.6%. Overall sickness further increased in month to 4.4% to exceed the trust target of 3.9%. Sickness has been driven by winter respiratory illnesses such as Flu and Covid.

Negotiations with UNISON regarding the band 2/ 3 band dispute are ongoing.

Consultation commenced on the 24th January on the transfer of over 200 staff in the EFCD function (excluding portering and clinical engineering from UHS to UEL (UHS's estates wholly owned subsidiary) on the 1st April 2025.

Appraisal rates across the trust have further decreased across the trust to 71%; this is a rolling 12-month figure. This is a notable drop and the team are investigating if this is connected to data and reporting following the transfer to the new system on VLE.

# Overall Position

# WTE Movement (M9 to M10)

## Total Workforce

The total workforce **increased by 137 WTE** to 13,490 WTE from M9 (13352) to M10.

During this period, the substantive workforce increased by **47 WTE**, while the total temporary staffing increased by **90 WTE.**

As of M10, the Trust is now **over the total plan** (by 153 WTE).

## Substantive WTE

**Substantive WTE increased** by **47 WTE** between December and January.

Additional Clinical Services and Administrative and Clerical staff groups increased by 19 WTE and 20 WTE respectively from M9 to M10.

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

## Bank & Agency WTE

**Total Bank and Agency** usage increased by 90 WTE in January 2025.

**Bank** usage **increased** from December to January by 12% (710 to 796 WTE; 86 WTE increase).

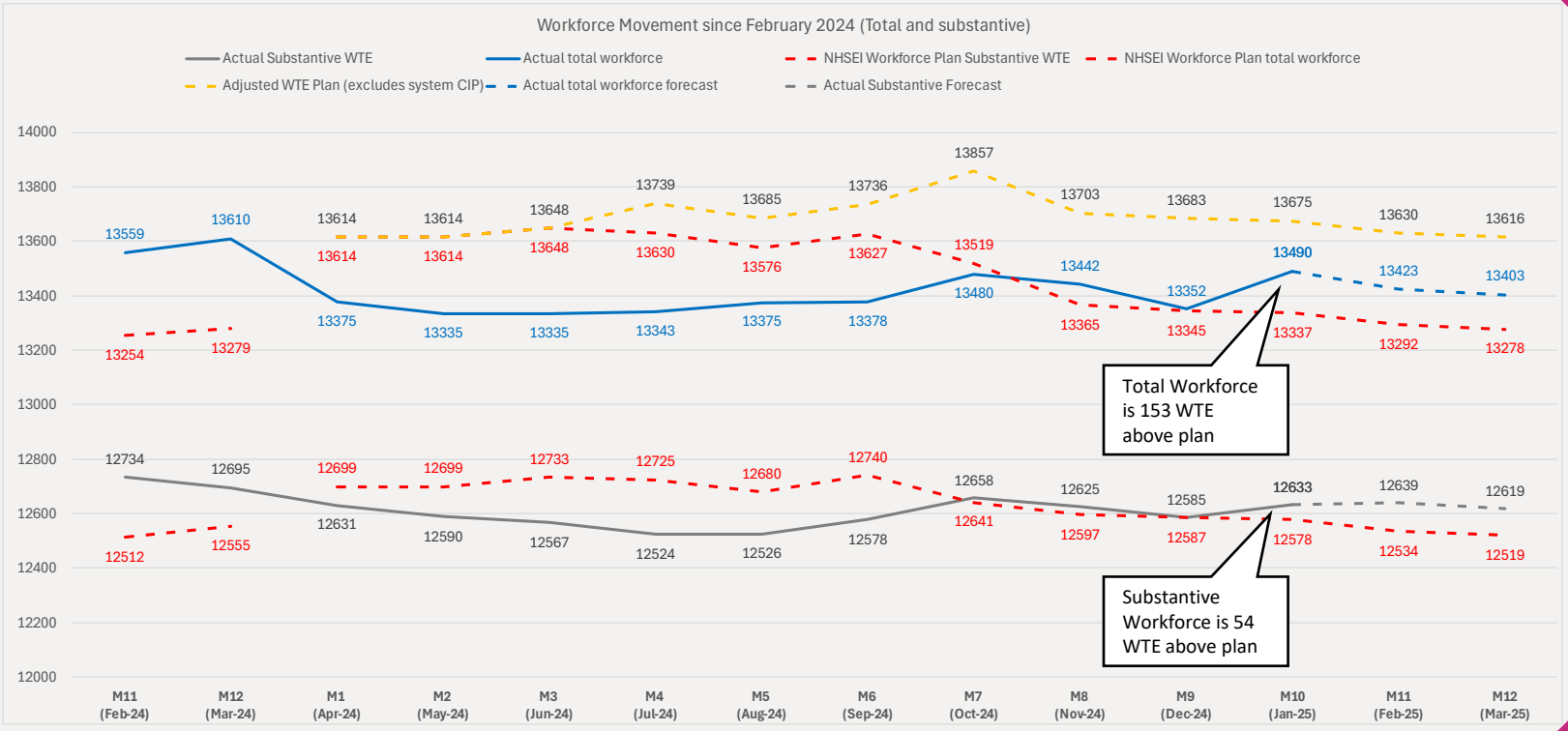
**Agency** usage **increased** in January by 8% compared to December 2024 (57 to 61 WTE).

**Key Challenges & Actions:**

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

**HCA Shortages Impacting MH Care:** General HCA vacancies are increasing, with unfilled shifts rising from 5% in January 2024 to 15% in January 2025. This has led to higher demand for MH HCAs to support patients requiring Enhanced Care.

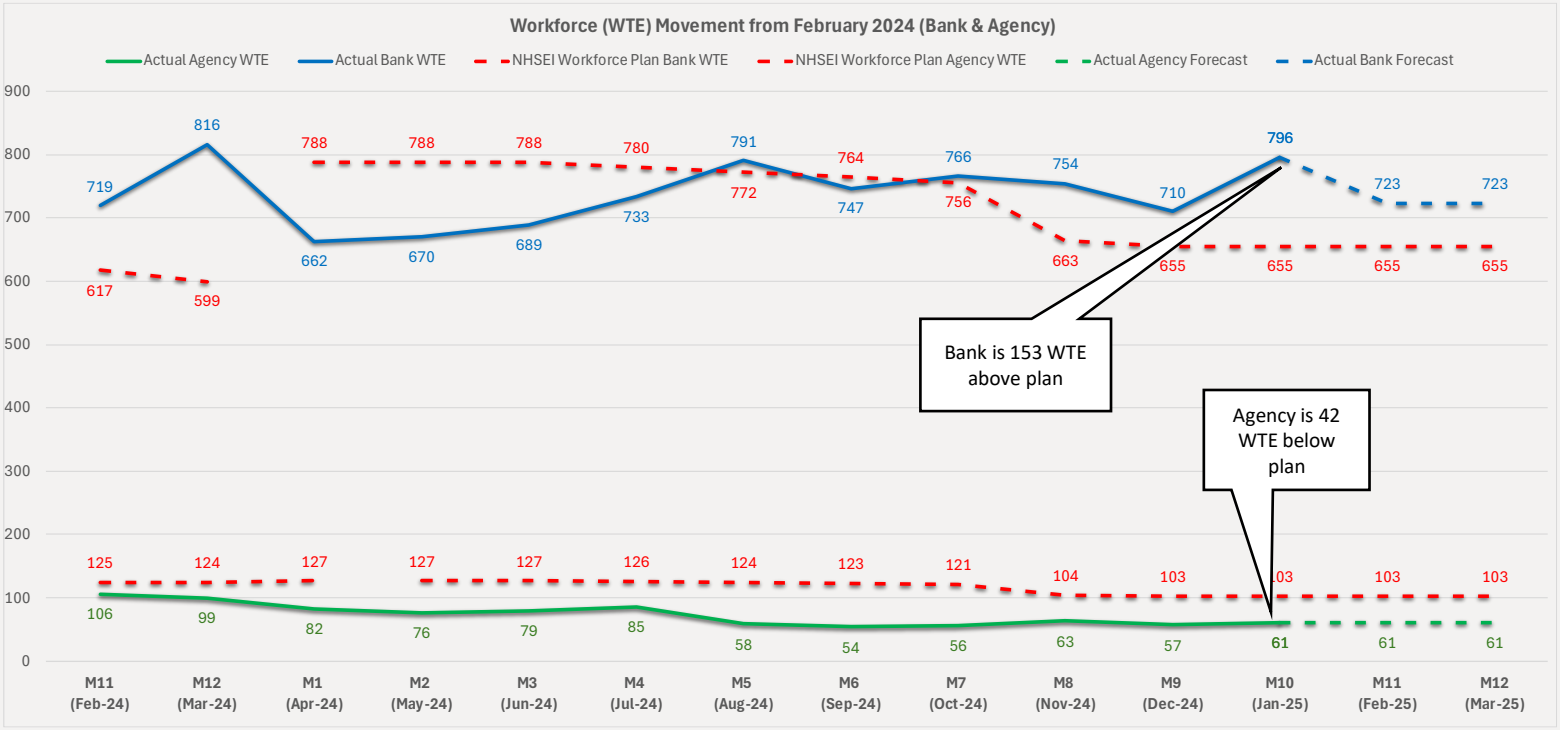
# Workforce Trends: Total & Substantive




Source: ESR as of January 2025. Please note that the total workforce forecast is based on expected substantive starters and November B&A actuals

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

# Workforce Trends: Bank & Agency




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

# Forecast to March 25 (staff group)

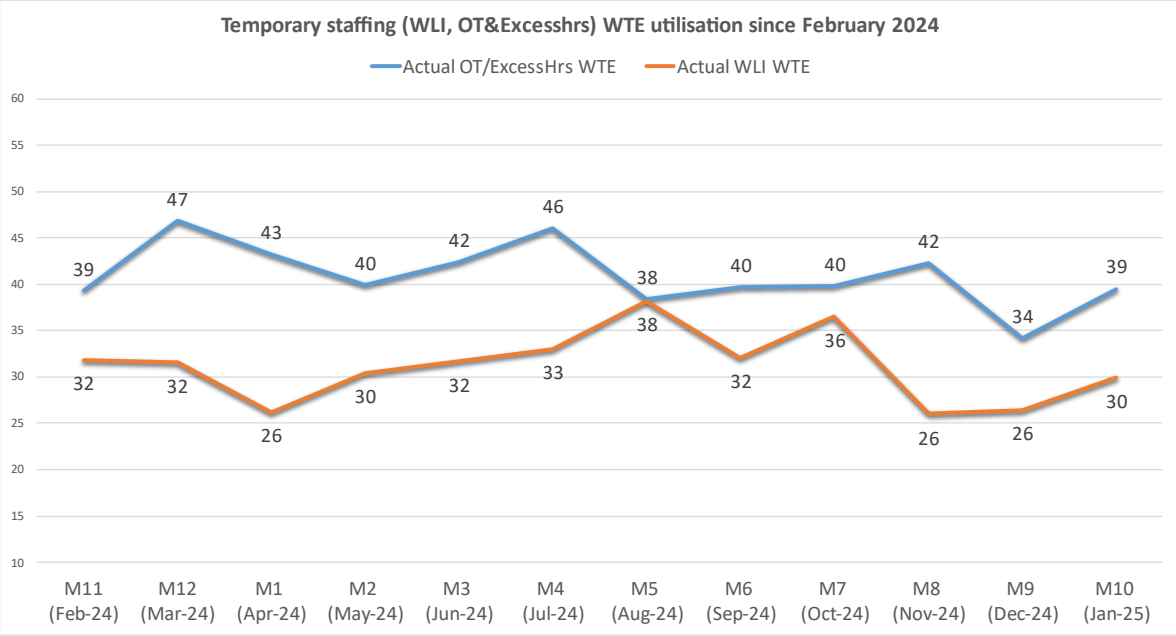
| STAFF GROUP | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Change from 31 January 24 - March 25 | Total Change to March 25 | % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Add Prof Scientific & Tech | 302 | 297 | 300 | 296 | 296 | 301 | 301 | 301 | 300 | 295 | 294 | 296 | 297 | 4 | -5 | -1.57% |
| Additional Clinical Services | 2136 | 2135 | 2134 | 2130 | 2117 | 2099 | 2098 | 2088 | 2098 | 2078 | 2097 | 2078 | 2058 | -39 | -79 | -3.68% |
| Admin & Clerical | 2288 | 2248 | 2230 | 2223 | 2214 | 2199 | 2210 | 2222 | 2221 | 2199 | 2219 | 2250 | 2261 | 42 | -27 | -1.20% |
| Allied Health Professionals | 796 | 803 | 800 | 799 | 788 | 786 | 808 | 815 | 813 | 805 | 806 | 809 | 814 | 8 | 18 | 2.28% |
| Estates & Ancillary | 380 | 374 | 372 | 373 | 376 | 373 | 370 | 373 | 375 | 374 | 374 | 373 | 370 | -4 | -10 | -2.50% |
| Healthcare Scientists | 498 | 499 | 495 | 498 | 496 | 497 | 495 | 504 | 510 | 509 | 512 | 510 | 510 | -1 | 13 | 2.55% |
| Medical & Dental | 2184 | 2165 | 2163 | 2161 | 2155 | 2217 | 2240 | 2244 | 2241 | 2233 | 2239 | 2241 | 2242 | 3 | 58 | 2.67% |
| Nursing & Midwifery Registered | 4053 | 4052 | 4039 | 4030 | 4025 | 3998 | 3998 | 4055 | 4050 | 4035 | 4035 | 4025 | 4010 | -26 | -43 | -1.06% |
| Students | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 56 | 56 | 56 | 56 | 56 | 0 | -1 | -2.08% |
| TOTAL | 12695 | 12631 | 12590 | 12567 | 12524 | 12526 | 12578 | 12658 | 12665 | 12585 | 12633 | 12639 | 12619 | -13 | -75 | -0.59% |
| | | | | | | | | | | | | | | | | |
| Variation from March 24 | | -64 | -105 | -128 | -171 | -169 | -117 | -37 | -30 | -109 | -62 | -56 | -75 | | MARS Scheme | -20 |
| Substantive Plan 24/25 | | 12699 | 12699 | 12733 | 12725 | 12680 | 12740 | 12641 | 12597 | 12587 | 12578 | 12534 | 12519 | | | |
| Variation to 24/25 actuals/forecast | | -68 | -109 | -166 | -200 | -154 | -162 | 16 | 68 | -1 | 54 | 105 | 100 | | | |

| STAFF GROUP | Plan | Actual | Forecast |
|---|---|---|---|
| Add Prof Scientific & Tech | 307 | 294 | 297 |
| Additional Clinical Services | 2171 | 2097 | 2058 |
| Admin & Clerical | 2121 | 2219 | 2261 |
| Allied Health Professionals | 841 | 806 | 814 |
| Estates & Ancillary | 349 | 374 | 370 |
| Healthcare Scientists | 497 | 512 | 510 |
| Medical & Dental | 2153 | 2239 | 2242 |
| Nursing & Midwifery Registered | 4023 | 4035 | 4010 |
| Students | 56 | 56 | 56 |
| TOTAL | 12519 | 12633 | 12619 |

Updated as of January 2025

# Workforce Trends: WLI and Overtime

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




Source: Healthroster as of January 2025; retrospective WLI figures have been updated M9 to M10 movement.

# Quarterly People Heatmap – 2024/25 Q3 (NOTE: Current staff survey data under embargo)

| | THRIVE | | | | EXCEL | | | BELONG | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AWL as of M9 (Dec 24) | % Turnover | Vacancy Rate (AWL - WTE Worked) | Apprentice numbers (WTE) | Appraisals completed | Sickness absence | % Flexible working requests approved | Pulse Survey - Recommendation as a place to work | Pulse Survey - Staff Engagement | Pulse survey - sense of belonging | % of staff at Band 7 and above (BAME) | % of staff band 7 and above LID |
| **UHS Overall** | **13163** | **11.06%** | **1311** | **619.4** | **74.3%** | **4.1%** | **94.6%** | **64.1%** | **6.84** | **65.2%** | **12.0%** | **13.1%** |
| **Division A Overall** | 2529 | 9.2% | 61 | 89.8 | 70.2% | 4.0% | 96.7% | 57.3% | 6.56 | 61.8% | 14.7% | 12.5% |
| **Critical Care** | 658 | 9.0% | -16 | 20.9 | 73.4% | 3.8% | 100.0% | 72.6% | 6.75 | 65.9% | 7.8% | 9.1% |
| **Ophthalmology** | 333 | 10.7% | 23 | 11.6 | 65.7% | 4.9% | 100.0% | 54.8% | 6.72 | 67.1% | 14.3% | 7.1% |
| **Surgery** | 589 | 11.1% | -2 | 18.7 | 78.1% | 3.2% | 75.0% | 51.6% | 6.34 | 56.4% | 7.7% | 15.4% |
| **Theatres & Anaesthetics** | 929 | 7.5% | 48 | 37.7 | 72.2% | 4.3% | 100.0% | 53.2% | 6.51 | 58.8% | 33.9% | 16.1% |
| **Division B - Overall** | 3548 | 10.0% | 55 | 122.4 | 72.3% | 4.2% | 90.4% | 61.9% | 6.73 | 60.9% | 13.4% | 14.2% |
| **Cancer Care** | 757 | 10.6% | 41 | 21.9 | 63.2% | 4.4% | 100.0% | 53.2% | 6.31 | 51.6% | 18.3% | 17.5% |
| **Emergency Care** | 722 | 11.5% | 1 | 16.8 | 73.3% | 4.2% | 82.8% | 57.9% | 6.30 | 56.4% | 10.1% | 21.5% |
| **Medicine** | 819 | 9.6% | 3 | 33.9 | 83.8% | 4.4% | 100.0% | 73.6% | 7.22 | 71.9% | 25.6% | 7.0% |
| **H&IOWAA** | 0 | 10.5% | 0 | 0.0 | 18.5% | 0.5% | 100.0% | - | - | - | 0.0% | 10.7% |
| **Pathology** | 612 | 9.3% | 13 | 40.1 | 56.5% | 4.4% | 92.0% | 60.2% | 6.71 | 61.0% | 12.2% | 9.9% |
| **Specialist Medicine** | 618 | 8.6% | 21 | 4.4 | 81.0% | 3.5% | 100.0% | 64.1% | 7.03 | 64.7% | 9.7% | 12.5% |
| **Division C - Overall** | 2867 | 11.8% | 96 | 155.5 | 72.1% | 4.0% | 94.5% | 63.6% | 6.79 | 63.5% | 9.8% | 12.4% |
| **Child Health** | 918 | 9.9% | 26 | 35.0 | 71.6% | 4.0% | 100.0% | 60.4% | 6.72 | 61.7% | 4.3% | 13.6% |
| **Clinical Support** | 903 | 14.0% | 39 | 90.7 | 76.4% | 2.8% | 94.6% | 68.6% | 6.86 | 65.3% | 13.2% | 10.3% |
| **Women & Newborn** | 871 | 9.3% | 26 | 24.3 | 70.7% | 5.2% | 92.9% | 60.2% | 6.75 | 63.0% | 5.5% | 17.8% |
| **Division D - Overall** | 2560 | 11.0% | 140 | 97.8 | 83.3% | 3.8% | 100.0% | 66.6% | 6.90 | 70.1% | 15.5% | 13.7% |
| **CV&T** | 969 | 10.7% | 47 | 42.1 | 82.5% | 4.0% | 100.0% | 73.6% | 7.12 | 72.0% | 18.7% | 15.8% |
| **Neuro** | 493 | 13.0% | 7 | 19.6 | 82.8% | 4.2% | 100.0% | 57.6% | 6.69 | 65.2% | 19.4% | 13.9% |
| **Radiology** | 522 | 9.9% | 42 | 16.7 | 84.3% | 3.0% | 100.0% | 68.6% | 6.84 | 75.4% | 7.3% | 9.8% |
| **T&O** | 469 | 11.0% | 25 | 14.8 | 75.8% | 4.4% | 100.0% | 64.4% | 6.89 | 67.0% | 20.0% | 10.0% |
| **THQ - Overall** | 1575 | 11.7% | 959 | 152.8 | 75.5% | 3.6% | 100.0% | 67.3% | 7.07 | 69.2% | 10.2% | 13.3% |
| **Chief Finance Officer** | 119 | 9.1% | 2 | 15.0 | 77.0% | 2.6% | 100.0% | 64.3% | 7.17 | 73.3% | 9.5% | 14.3% |
| **Chief Operating Officer** | 87 | 12.2% | 5 | 1.0 | 57.4% | 4.4% | - | 66.7% | 7.02 | 66.7% | 11.1% | 7.4% |
| **Clinical Development** | 80 | 18.0% | -11 | 1.0 | 80.6% | 2.9% | - | 66.7% | 7.15 | 71.1% | 10.9% | 26.1% |
| **Estates** | 337 | 13.8% | 43 | 50.0 | 84.7% | 5.6% | 100.0% | 56.6% | 6.63 | 61.0% | 2.2% | 10.9% |
| **Informatics** | 276 | 4.1% | 20 | 25.9 | 63.5% | 1.9% | 100.0% | 66.2% | 6.99 | 68.5% | 16.0% | 7.4% |
| **People / HR** | 172 | 17.1% | 17 | 18.4 | 82.2% | 3.5% | - | 74.3% | 7.31 | 71.1% | 2.7% | 18.9% |
| **R&D** | 401 | 14.1% | 10 | 11.8 | 85.5% | 3.5% | 100.0% | 75.3% | 7.21 | 72.7% | 14.8% | 11.1% |
| **Training & Education** | 223 | 7.8% | 13 | 17.0 | 86.3% | 3.2% | 100.0% | 79.4% | 7.61 | 70.6% | 10.5% | 10.5% |

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

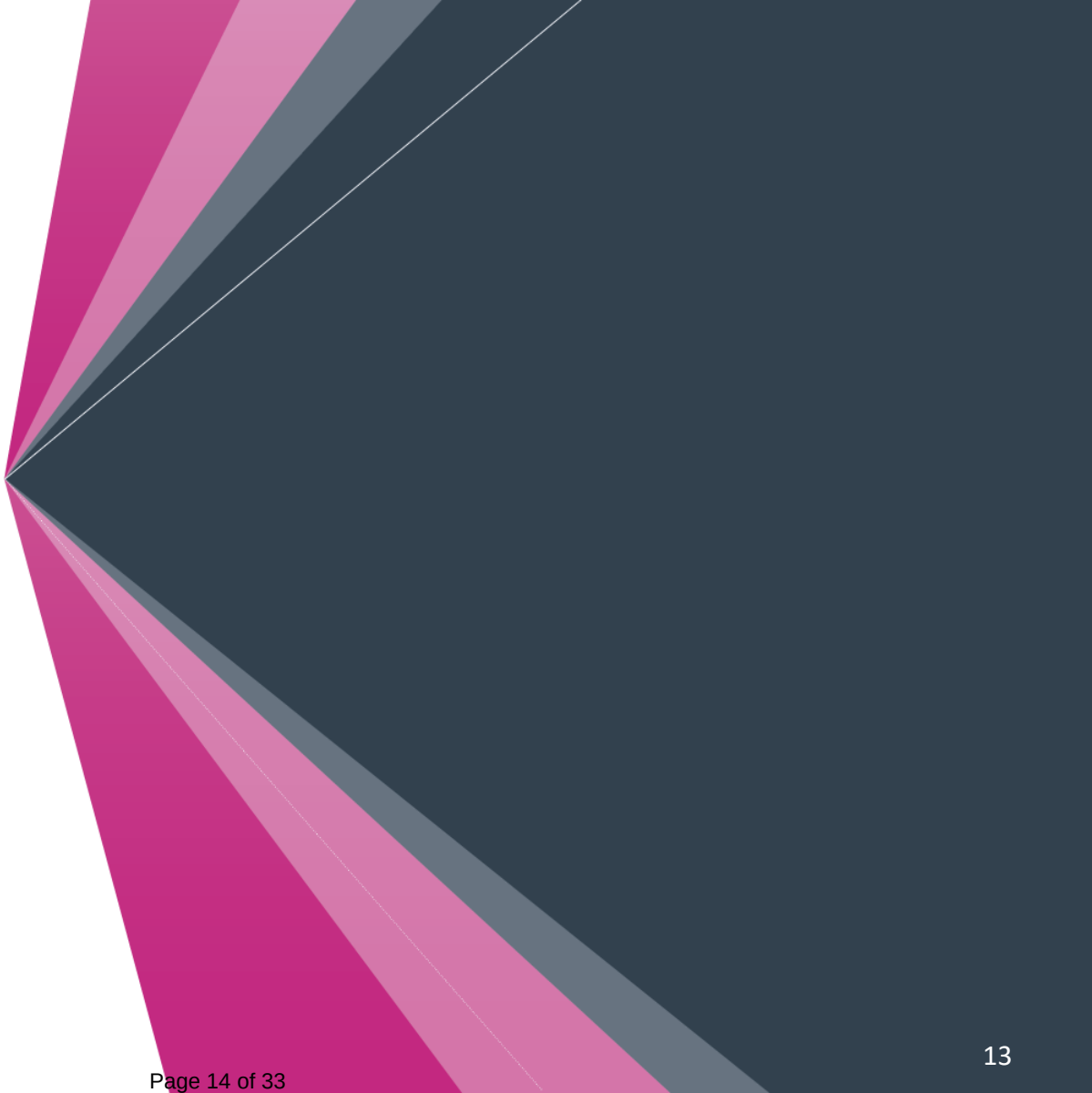
* Pulse Survey participation rate was 21% (3,037 of 14,401 eligible staff headcount)

# Key hotspot areas

| Area | Issue and actions |
|---|---|
| **Portering** | • Resolution of industrial through settlement with UNITE working with ACAS<br>• External review of culture and capability through IBEX Gale<br>• Specific discrete HR investigations into concerns raised<br>• Movement of portering team from EFCD to Site Control Team |
| **Surgical Department (Medics)** | • GMC continued enhanced monitoring following December 2023 visit regarding concerns of education and culture<br>• Comprehensive action plan being delivered by the Divisional Management and Care Group Management team with the support of Education and OD.<br>• Positive visit by NHSE England in November recognising improvements made |
| **Outpatient administration centre (OAC)** | • Focus on culture work by the Divisional Management team<br>• Concerns raised via FTSU anonymously regarding leadership culture<br>• Exec review meeting to take place to review actions being taken and support |

| Area | Issue | Mitigation plans |
|---|---|---|
| **Cardiac (Scrub Nurses)** | Impact of Cardiac Srub nursing on clinical operating capacity | • Incentives for NHSP in place to drive additional bank work<br>• Culture work in department, and operational support to ensure most efficient working practices.<br>• Review of establishment and the balance between learners and fully trained staff |
| **Perfusion** | Lack of trained perfusion staff impacting on cardiac operating | • Recruitment and retention premia in place<br>• Continued targeted recruitment campaigns<br>• Incentive scheme to support additional NHSP bank work<br>• Job banding review to ensure parity and competitive<br>• Recruitment to new service leader<br>• Review of training opportunities locally and regionally |
| **HCAs** | Growth in HCA vacancies over last 3 months | • Increased cohort recruitment in Jan, Feb, to fill vacancies<br>• HCA hub to provide dedicated support to new starters, improving retention. UHS retention has significantly improved in the last 2 years<br>• Resolution of band 2/band 3 dispute |
| **Maternity** | Workforce challenges in maternity | • 40 NQMS commenced in November<br>• A high level of newly qualified Midwives means that team are putting in additional staffing to provide extra support.<br>• National funding to recruit 5 international midwives, which is a new pipeline for UHS<br>• Support work on leadership development and culture |

# THRIVE

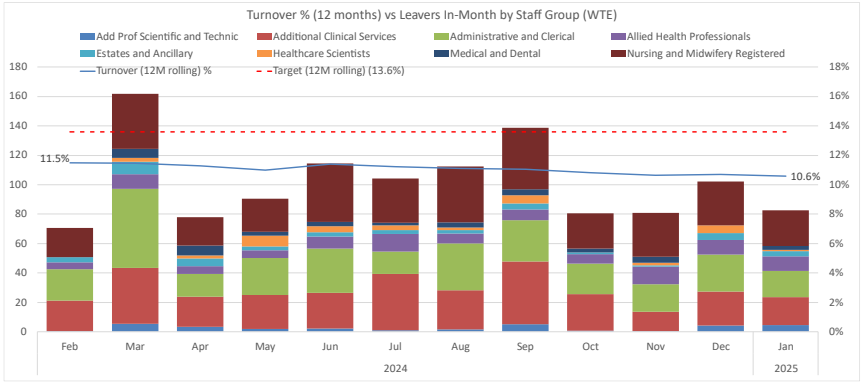


# Substantive SIP by Staffing Group

| Substantive Monthly Staff in Post (WTE) for last 12 months | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2023/24 M11 (Feb) | 2023/24 M12 (Mar) | 2024/25 M1 (Apr) | 2024/25 M2 (May) | 2024/25 M3 (Jun) | 2024/25 M4 (Jul) | 2024/25 M5 (Aug) | 2024/25 M6 (Sep) | 2024/25 M7 (Oct) | 2024/25 M8 (Nov) | 2024/25 M9 (Dec) | 2024/25 M10 (Jan) | M9 to M10 movement |
| Add Prof Scientific and Technic | 401 | 402 | 397 | 400 | 396 | 396 | 401 | 301 | 301 | 300 | 295 | 294 | **-2** |
| Additional Clinical Services | 2152 | 2136 | 2135 | 2134 | 2130 | 2117 | 2099 | 2098 | 2088 | 2091 | 2078 | 2097 | **19** |
| Administrative and Clerical | 2304 | 2288 | 2248 | 2230 | 2223 | 2214 | 2199 | 2210 | 2222 | 2201 | 2199 | 2219 | **20** |
| Allied Health Professionals | 700 | 696 | 703 | 700 | 699 | 688 | 686 | 808 | 815 | 813 | 805 | 806 | **1** |
| Estates and Ancillary | 380 | 380 | 374 | 372 | 373 | 376 | 373 | 370 | 373 | 375 | 374 | 374 | **0** |
| Healthcare Scientists | 497 | 498 | 499 | 495 | 498 | 496 | 497 | 495 | 504 | 510 | 509 | 512 | **2** |
| Medical and Dental | 2183 | 2184 | 2165 | 2163 | 2161 | 2155 | 2217 | 2240 | 2244 | 2241 | 2233 | 2239 | **6** |
| Nursing and Midwifery Registered | 4060 | 4053 | 4052 | 4039 | 4030 | 4025 | 3998 | 3998 | 4055 | 4038 | 4035 | 4035 | **1** |
| Students | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 58 | 56 | 56 | 56 | **0** |
| Grand Total | **12734** | **12695** | **12631** | **12590** | **12567** | **12524** | **12526** | **12578** | **12658** | **12625** | **12585** | **12633** | **47** |

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

# Turnover



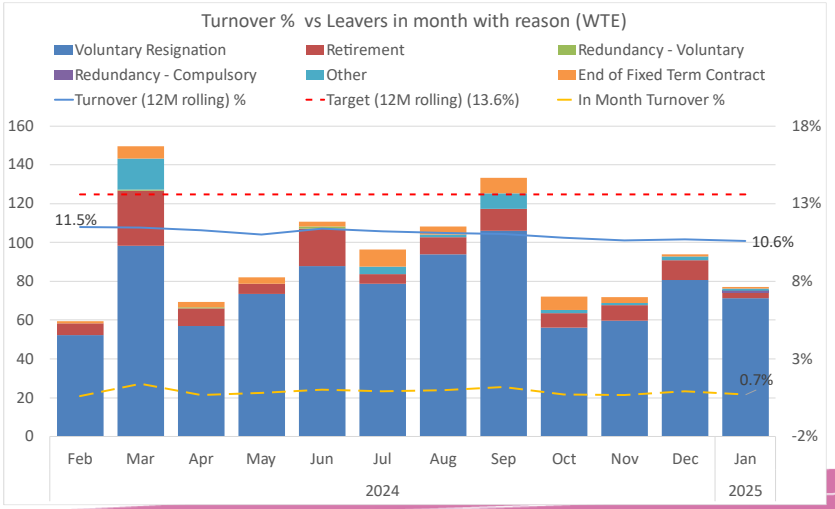

In January 2025, there was a total of 81.7 WTE leavers, 17.8 WTE fewer than December 2024 (99.5 WTE). Division C recorded the highest number of leavers (22.6 WTE). Within Division C Nursing and Midwifery Registered staff group had the highest number of leavers (6.0 WTE), followed by the Additional Clinical Services staff group at 4.5 WTE.

Divisions B and A had the second and third highest number of leavers (21.4 and 18.4 WTE respectively); with the largest numbers being the Nursing and Midwifery Registered staff group staff group for Div B (7.5 WTE), and Nursing and Midwifery Registered staff group for Div A (7.3 WTE).

Total leavers by division are as follows:

- **Division A: 18.4 WTE leavers**
- **Division B: 21.4 WTE leavers**
- **Division C: 22.6 WTE leavers**
- **Division D: 11.3 WTE leavers**
- **THQ: 8.0 WTE leavers**

| Staffing group | Leavers (WTE) in month | Turnover In-Month | Turnover 12m rolling % |
|---|---|---|---|
| Add Prof Scientific and Technic | 4.5 | 1.5% | 8.4% |
| Additional Clinical Services | 18.9 | 0.9% | 15.0% |
| Administrative and Clerical | 18.1 | 0.7% | 12.2% |
| Allied Health Professionals | 9.8 | 1.2% | 12.4% |
| Estates and Ancillary | 3.5 | 0.8% | 11.4% |
| Healthcare Scientists | 1.0 | 0.2% | 6.1% |
| Medical and Dental | 2.6 | 0.3% | 4.3% |
| Nursing and Midwifery Registered | 23.3 | 0.6% | 9.2% |
| **UHS total** | **81.7** | **0.7%** | **10.6%** |

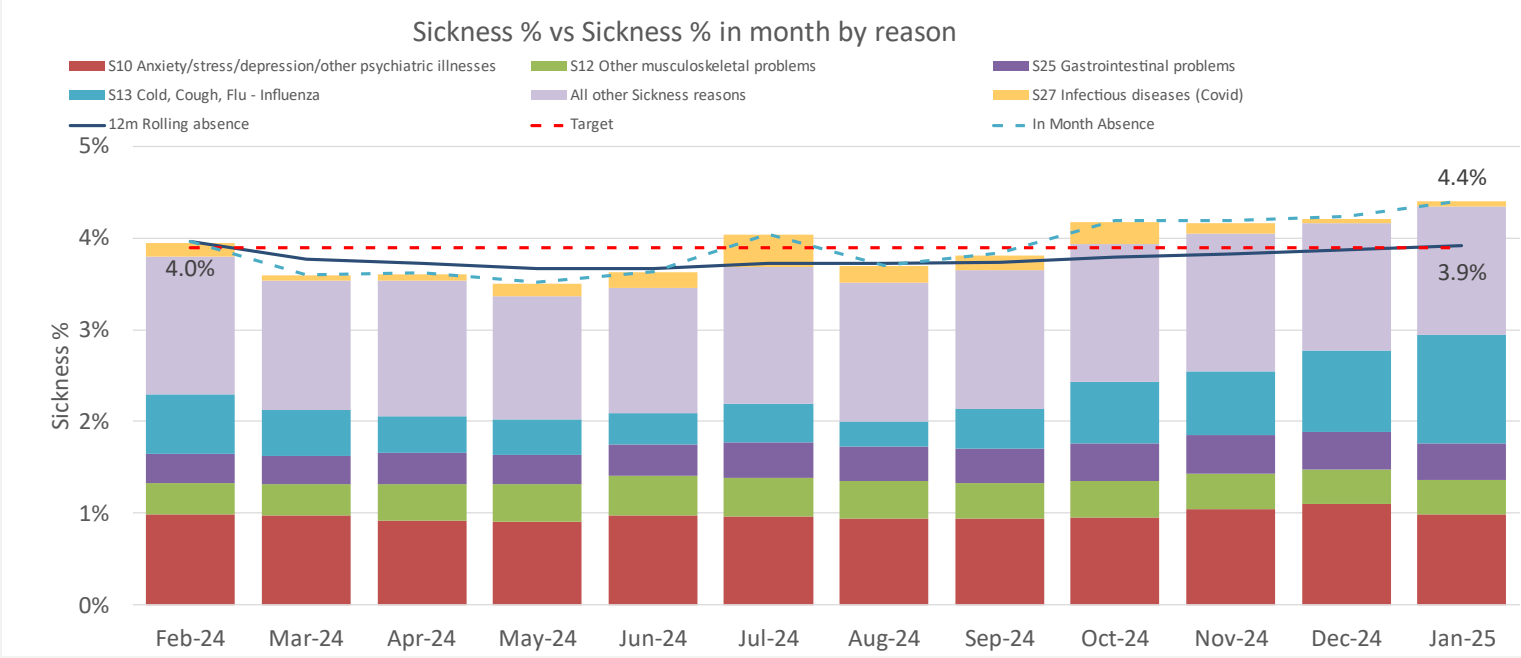



Source: ESR – Leavers Turnover WTE, ESR Staff Movement January 2025 (excludes junior doctors & hosted services)

# Sickness

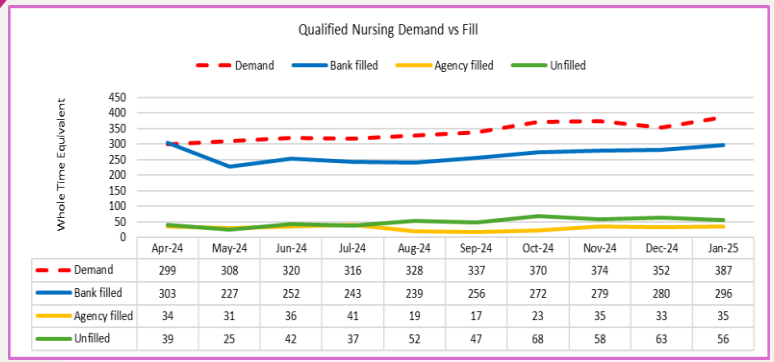
**Current in-month sickness: 4.4% | Rolling 12-month sickness: 3.9%**

**Cold, cough, and flu-related absences have been on the rise since September 2024, with a 0.5% increase in January 2025 compared to February 2024.**

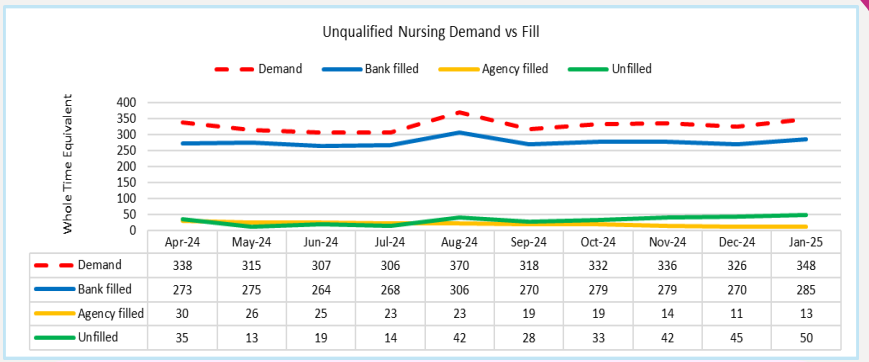



Source: ESR – January 2025

# Temporary Staffing




| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Demand | 299 | 308 | 320 | 316 | 328 | 337 | 370 | 374 | 352 | 387 |
| Bank filled | 303 | 227 | 252 | 243 | 239 | 256 | 272 | 279 | 280 | 296 |
| Agency filled | 34 | 31 | 36 | 41 | 19 | 17 | 23 | 35 | 33 | 35 |
| Unfilled | 39 | 25 | 42 | 37 | 52 | 47 | 68 | 58 | 63 | 56 |




| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|
| Demand | 338 | 315 | 307 | 306 | 370 | 318 | 332 | 336 | 326 | 348 |
| Bank filled | 273 | 275 | 264 | 268 | 306 | 270 | 279 | 279 | 270 | 285 |
| Agency filled | 30 | 26 | 25 | 23 | 23 | 19 | 19 | 14 | 11 | 13 |
| Unfilled | 35 | 13 | 19 | 14 | 42 | 28 | 33 | 42 | 45 | 50 |

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

- Demand increased from 352 to 387 in January (+35).
- Bank filled 296 WTE(+40 from previous month) and Agency filled 35 WTE (+2 from the previous month).
- Unfilled shifts: 56 WTE remained unfilled down (-4) on previous month.
- Year-on-year demand increase: 45 WTE higher than January 2024.

**Actions:**

- Focus on reducing agency rates to comply with NHS Improvement (NHSi) cap for majority of shifts.
- SE Collaborative Bank rate project – reviewing UHS current Nursing rates.

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

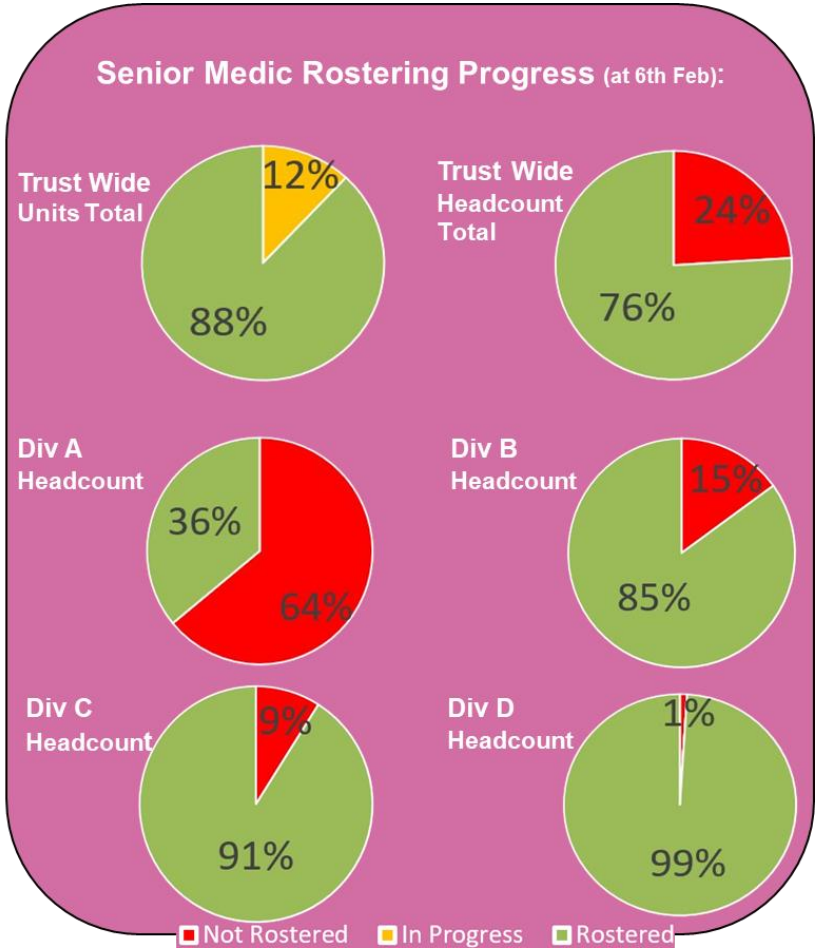
- Demand increased from 326 to 348 in January (+22).
- Bank filled 285 WTE
- Agency filled 13 positions (all MH HCAs).
- Unfilled shifts: 50 remained unfilled (up 5 on prior month)
- Year-on-year demand increase: 25 WTE higher than January 2024.

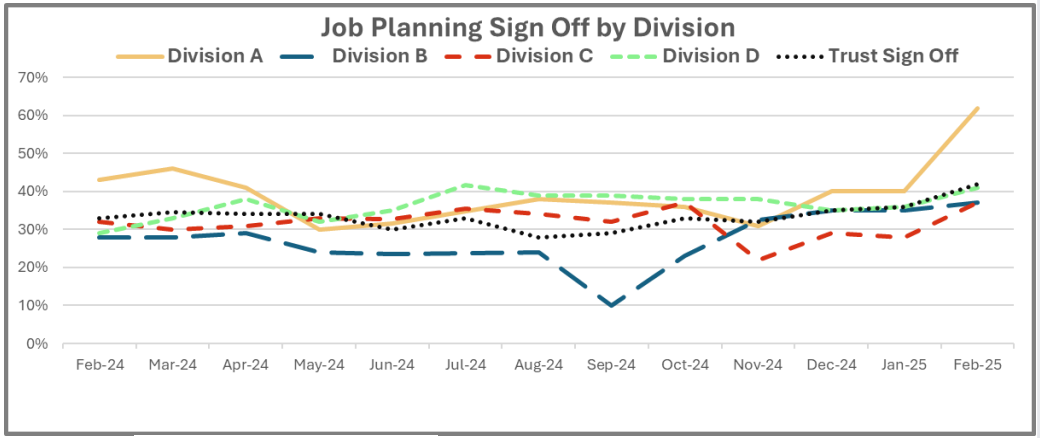
**Actions:**

- HCA/RN Bank Worker Recruitment: Emphasis on increasing the number of HCA/RN bank-only workers joining NHSP.
- Medical Students as HCAs: Medical students are now working as HCAs at UHS to enhance the HCA pool.

Source: Temporary Resourcing - January 2025

# Workforce: Medical Rostering and Planning



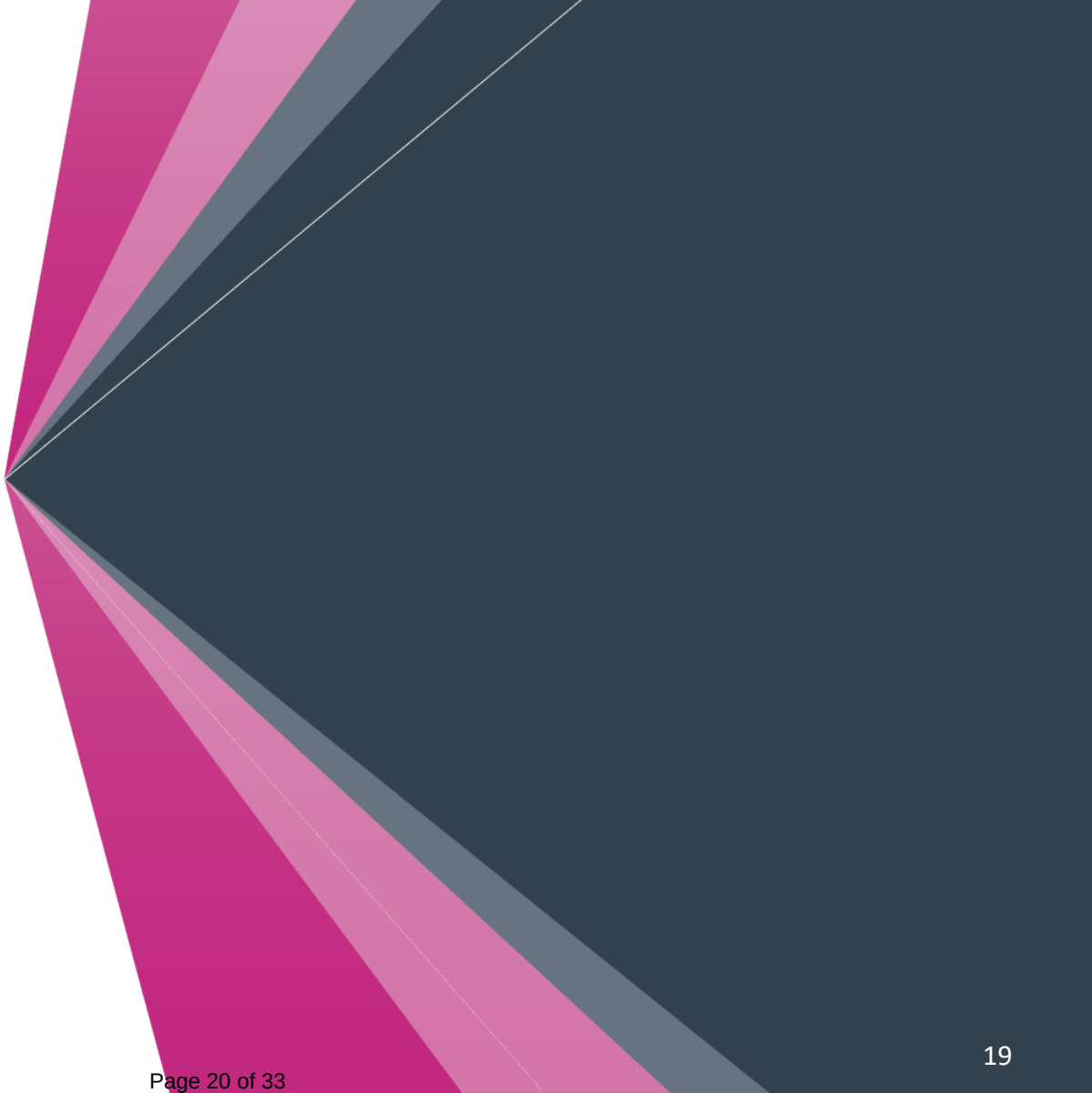


Signed off Job Plans


Active Job Plans

- Job planning sign off levels up 6% to 42%
- Active Job Plans up 2% to 88%
- NHSE Target of 95% Signed Off in 2025.
- We have improved our ESR reporting to better inform Clinical Leads
- Completed Division D Consistency Report

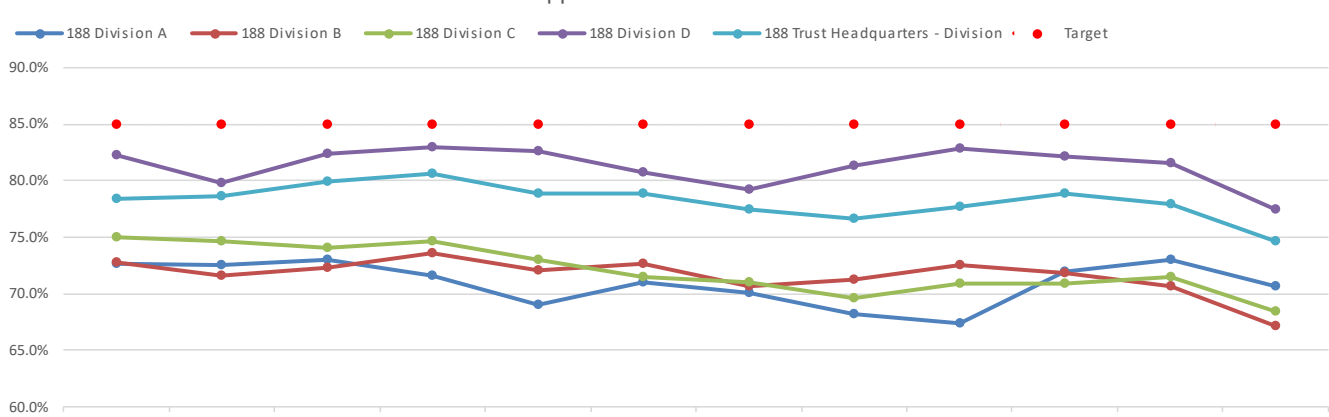
# EXCEL



# Appraisals

## Summary

**The Trust's appraisal completion rate is 71% as of January 2025 (down from 74% in December 2024).**

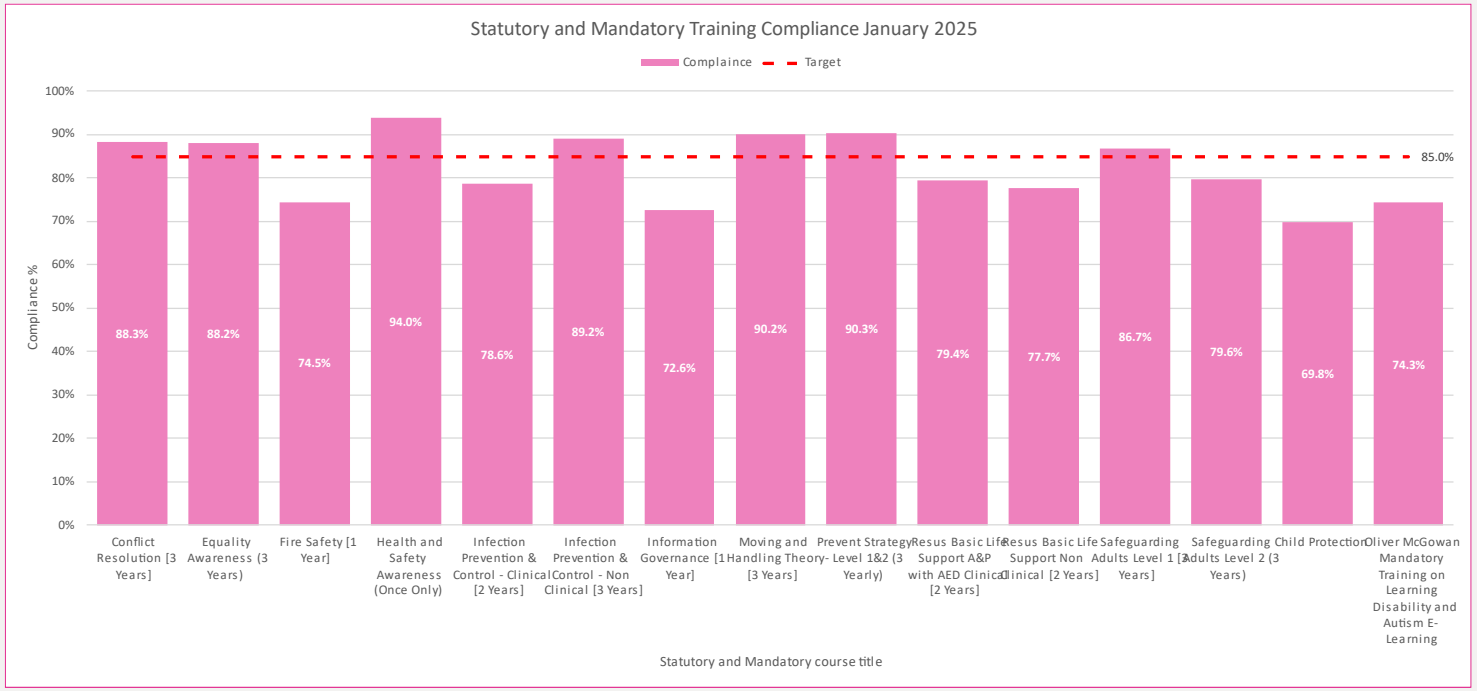



| | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 188 Division A | 72.6% | 72.6% | 73.0% | 71.6% | 69.1% | 71.0% | 70.1% | 68.2% | 67.4% | 71.9% | 73.0% | 70.7% |
| 188 Division B | 72.8% | 71.6% | 72.3% | 73.6% | 72.1% | 72.7% | 70.6% | 71.2% | 72.5% | 71.8% | 70.6% | 67.2% |
| 188 Division C | 75.0% | 74.7% | 74.0% | 74.7% | 73.0% | 71.5% | 71.1% | 69.7% | 70.9% | 71.0% | 71.5% | 68.4% |
| 188 Division D | 82.3% | 79.8% | 82.4% | 83.0% | 82.7% | 80.8% | 79.2% | 81.4% | 82.8% | 82.1% | 81.6% | 77.5% |
| 188 Trust Headquarters - Division | 78.5% | 78.6% | 80.0% | 80.6% | 78.9% | 78.8% | 77.4% | 76.6% | 77.7% | 78.9% | 77.9% | 74.6% |
| Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

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

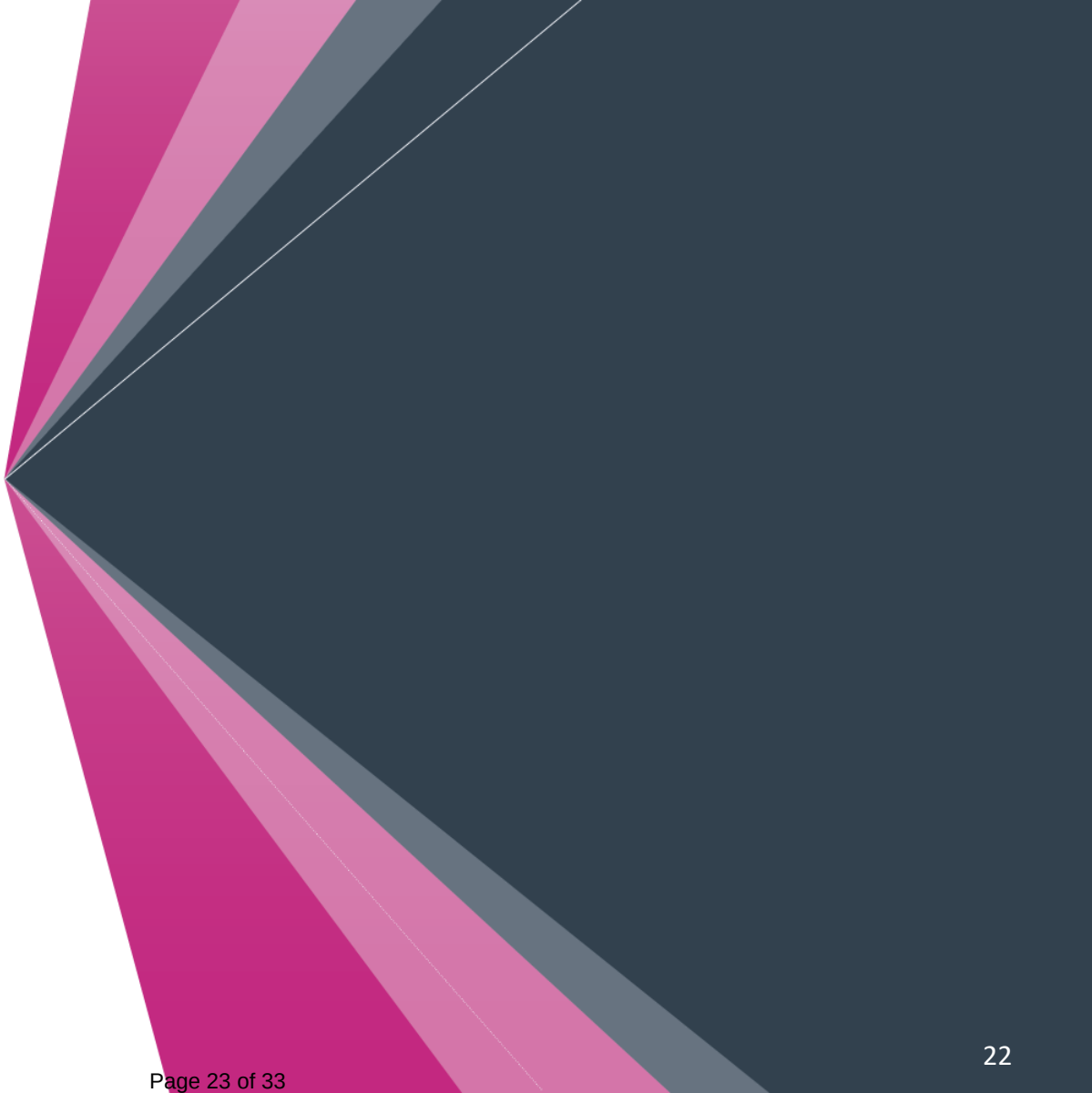
# Statutory & Mandatory Training

**The Trust's average completion rate for January 2025 is 81%, same level as December 2024 at 81% with 7 of 15 measures above the 85% target. Please note that the audiences for both Safeguarding Adults and Children is currently under review.**

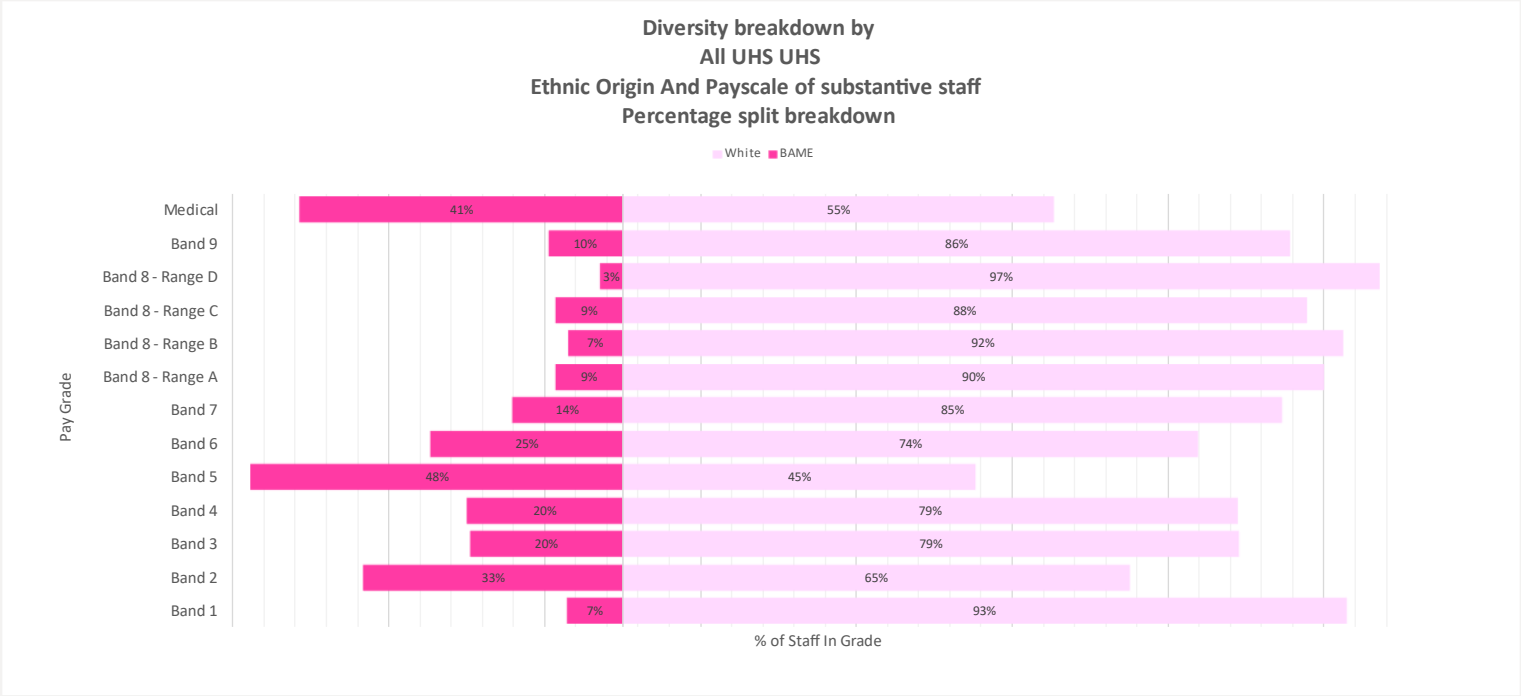



Source: Virtual Learning Environment (VLE) January 2025

# BELONG

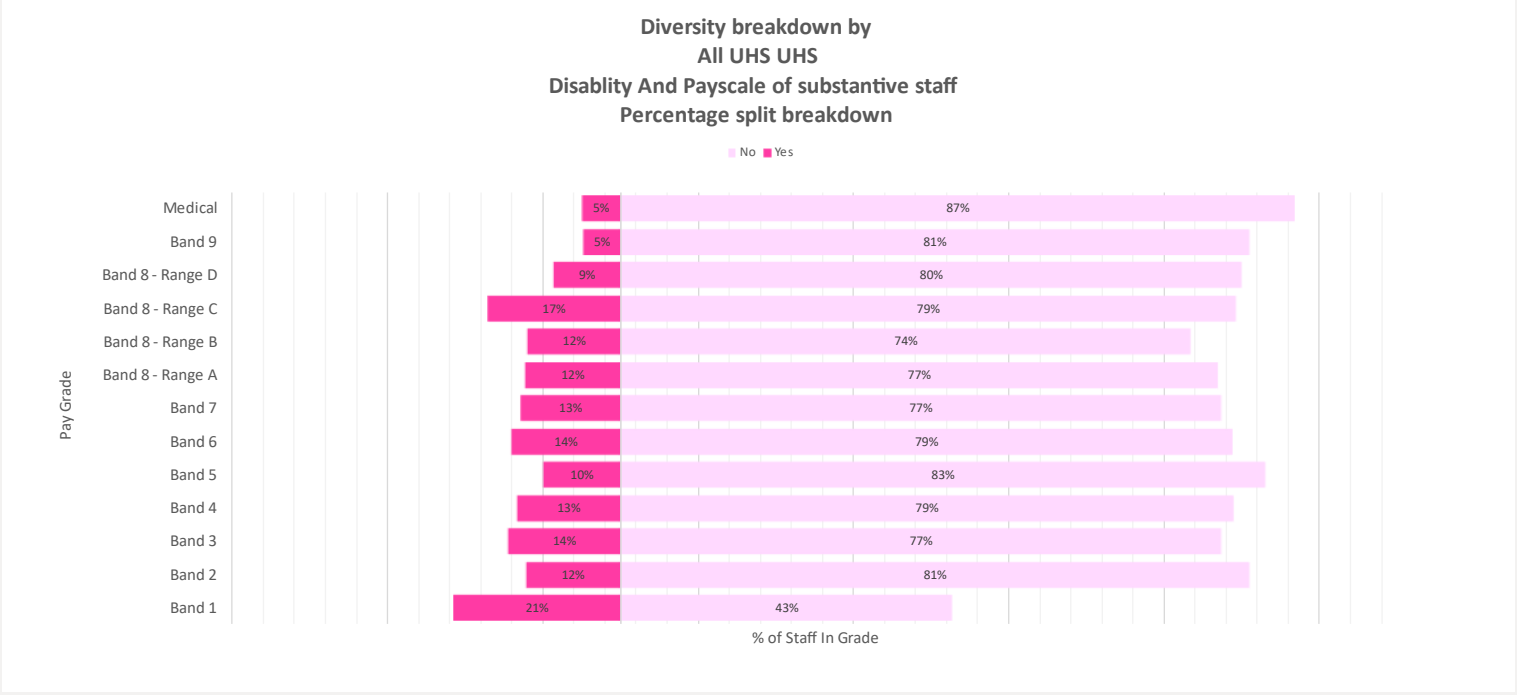


# Staff in Post - Ethnicity



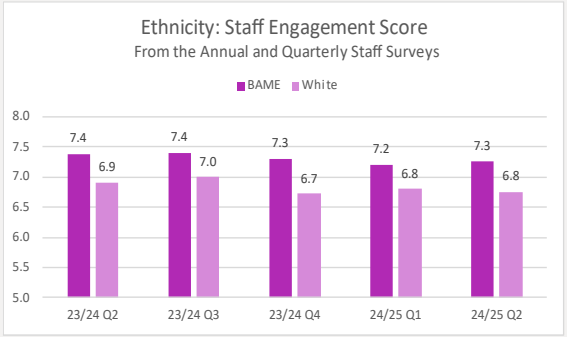

Source: ESR – January 2025

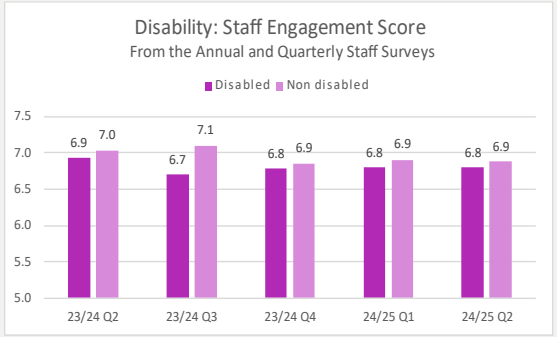
# Staff in Post – Disability Status

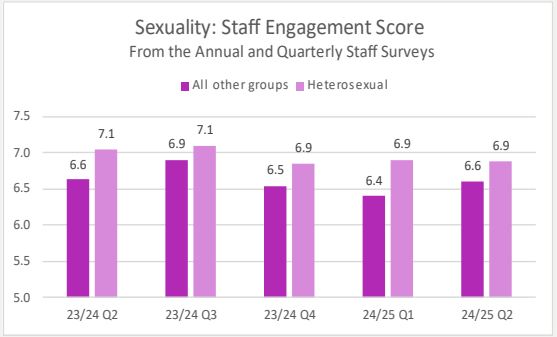


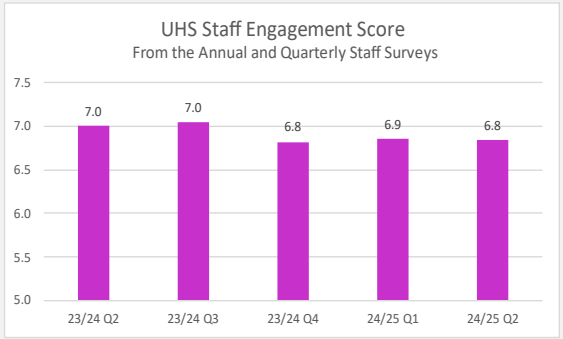

Source: ESR – January 2025

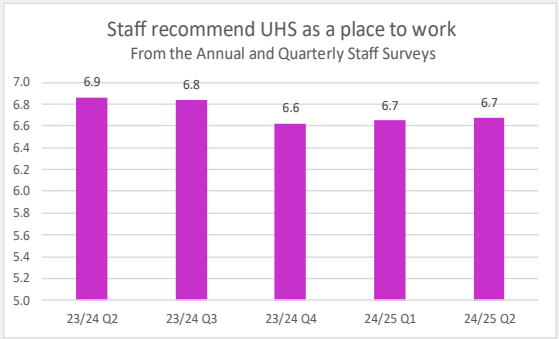
# Pulse Survey – 2024/25 (July 2024)



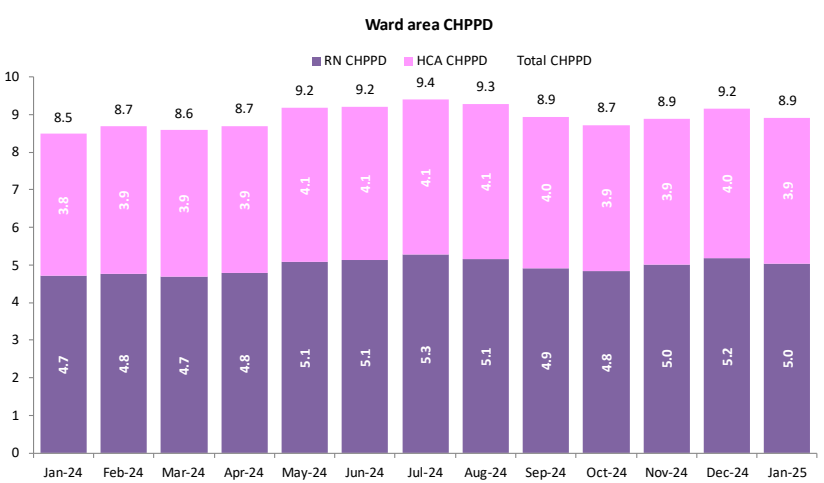



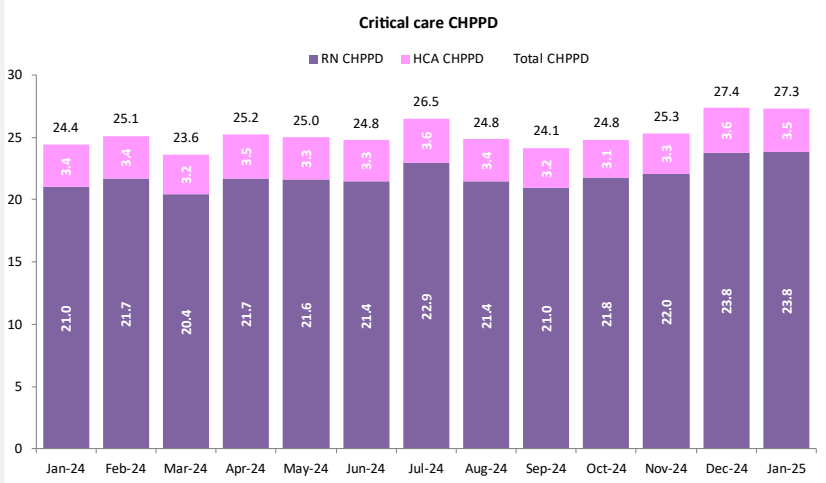

Latest available data source – current staff survey data under embargo

Source: Picker (Qualtrics)

The Ward areas CHPPD rate in the Trust has increased from last month to RN 5.00 (previously 4.84), HCA 3.89 (previously 3.88) overall 8.89 (previo
The Ward areas CHPPD rate in the Trust has decreased from last month to RN 5.03 (previously 5.17), HCA 3.88 (previously 3.99) overall 8.91 (p
The Ward areas CHPPD rate in the Trust has decreased from last month to RN 5.03 (previously 5.17), HCA 3.88 (previously 3.99) overall 8.91
The CHPPD rate in Critical care has decreased overall from last month. RN 23.83 (previously 23.76), HCA 3.51 (previously 3.59) overall 27

# CHPPD



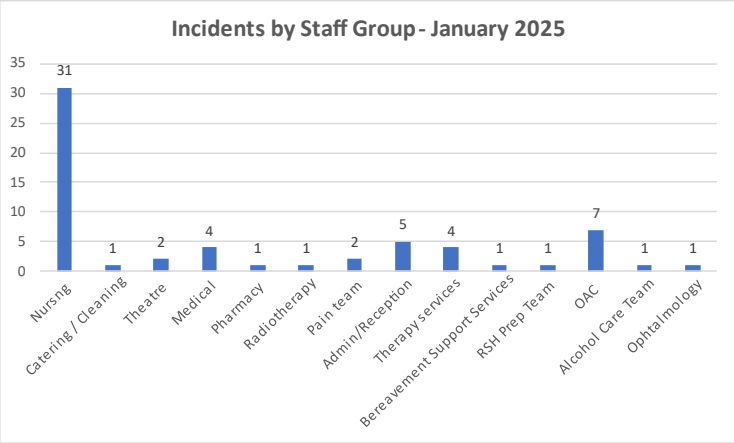

The Ward areas CHPPD rate in the Trust has decreased from last month to RN 5.0 (previously 5.2), HCA 3.9 (previously 4.0) overall 8.9 (previously 9.2)

The CHPPD rate in Critical care has decreased overall from last month. RN 23.8 (previously 23.8), HCA 3.5 (previously 3.6) overall 27.3 (previously 27.4)

Source: HealthRoster, NHSP & eCamis – January 2025

# Patient Safety – Staffing Incidents & Red Flags

In total 62 incident reports were received in January 2025 which cited staffing. This is a decrease on the 74 reported in December and represents a continued fall on the elevated level of 109 reported in March 2024.




**Incidents by Division January 2025 vs December 2024**

| Month Incident occurred | Division A | Division B | Division C | Division D | THQ | Trust total |
|---|---|---|---|---|---|---|
| January 2025 | 14 | 15 | 19 | 11 | 3 | 62 |
| Total | 14 ↓ 22 | 15 ↓ 20 | 19 ↓ 23 | 11 ↑ 6 | 3 ↔ 3 | 62 ↓ 74 |

| Month Incident occurred | Division A | Division B | Division C | Division D | THQ | Trust total |
|---|---|---|---|---|---|---|
| December 2024 | 22 | 20 | 23 | 6 | 3 | 74 |
| Total | 22 ↓ (27) | 20 ↑ (12) | 23 ↑ (17) | 6 ↔ (6) | 3 ↓ (5) | 74 ↑ (67) |

Source: Safeguard System January 2025

# Patient Safety – Staffing Incidents & Red Flags cont.

**DIVISIONAL BREAKDOWN:**

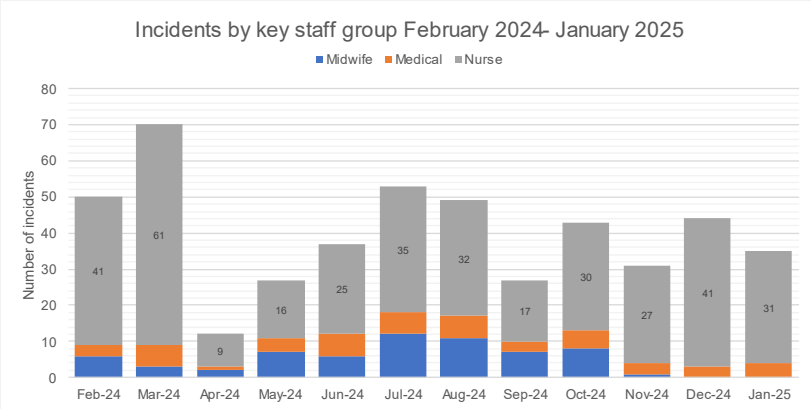
**Div A:**
Fourteen incidents reported in January 2025, down on the 22 in the previous month. Red Flags were down from 10 to zero.

**Div B:**
Fifteen incidents were reported in January 2025 (down from 20 in the previous month). Red flags were down from 15 to 1.

**Div C:**
Nineteen incidents reported in January 2025 (down from 23 in the previous month). There were no red flags reported.

**Div D:**
Eleven incidents reported in January 2025 (increase from 6 in the previous month). Red flags decreased, with 4 reported (down from 5).

**THQ:**
Three incidents reported in January 2025 (same as the previous month). The incidents were reported across a range of services.




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

| December 2024 | Red flag category | Number of reports | Div A | Div B | Div C | Div D |
|---|---|---|---|---|---|---|
| | Delay in medication | 6 | 1 | 3 | 0 | 2 |
| | Delay in pain relief | 8 | 3 | 4 | 0 | 1 |
| | Delay in observations | 8 | 3 | 4 | 0 | 1 |
| | Less than 2 registered | 8 | 3 | 4 | 0 | 1 |
| | **Total** | **30** | **10** | **15** | **0** | **5** |

Source: Safeguard System January 2025

# 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; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. |
| **Additional Hours (WTE)** | Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs | For 24/25 Exclusions: WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. |
| **Temporary Staffing (WTE)** | Bank: NHSP; MedicOnline<br><br>Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies | Exclusions: Vaccination activity |
| **Turnover** | ESR (Leavers in-month and last 12 months) | Trainee/junior doctors excluded |
| **Sickness** | ESR (Sickness absence in-month and last 12 months) | No exclusions |
| **Appraisals** | ESR (Appraisals completed in-month and last 12 months) | AfC staff only |
| **Statutory & Mandatory Training** | VLE | No exclusions |
| **Staff in Post (Ethnicity & Disability)** | ESR | No exclusions |
| **Pulse Survey** | Picker (Qualtrics) | No exclusions |
| **Care Hours PER Patient Day (CHPPD)** | HealthRoster (In-month shifts)<br>eCamis (In-month daily patient numbers) | Clinical inpatient wards, Critical Wards, and ED only |


WORLD CLASS PEOPLE

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 6.1 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Corporate Objectives 2024-25 Quarter 3 Review |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Kelly Kent, Head of Strategy and Partnerships |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

This paper provides an update regarding progress against our Corporate Objectives for Quarter 3 for 2024-25. During Q3, there has been a decrease to 50% of the Q3 objectives which were noted as on track to be delivered in full. With 37.5% recorded as amber, there has been no increase in red which remains at 12.5%.

A scoring summary of progress is below:

| Ref | Corporate ambition | Leads | No. of Objectives for 2024/25 | Q1 Green | Q1 Amber | Q1 Red | Q2 Green | Q2 Amber | Q2 Red | Q3 Green | Q3 Amber | Q3 Red |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Outstanding patient outcomes, safety and experience | COO/CNO | 4 | 4 | 0 | 0 | 4 | 0 | 0 | 2 | 2 | 0 |
| 2 | Pioneering research and innovation | CMO | 2 | 2 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 |
| 3 | World class people | CPO | 3 | 2 | 1 | 0 | 2 | 1 | 0 | 1 | 2 | 0 |
| 4 | Integrated networks and collaboration | COO/CMO | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 0 |
| 5 | Foundations for the future | CFO/CEO/CNO/CMO | 5 | 2 | 2 | 1 | 3 | 0 | 2 | 2 | 1 | 2 |
| Totals | | | 16 | 11 | 4 | 1 | 12 | 2 | 2 | 8 | 6 | 2 |
| | | | % against 16 Objec | 69% | 25% | 6% | 75% | 13% | 13% | 50.00% | 37.5% | 12.5% |

| RAG Rating for corporate objectives updates | In Year Updates | Q4 Update |
|---|---|---|
| Green | On track to be | Achieved in Full |
| Amber | Minor Delays/ | Partially Achieved |
| Red | Significant del | Not Achieved |

**Contents:**

Summary of progress.

Appendix 1-5 Updates in full by strategic theme.

**Risk(s):**

Objectives relate directly to all BAF risks.

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

**Background**
The 2024/25 Corporate Objectives were approved by the UHS Board in April 2024 and were noted to be highly focused and within the confines of the overall financial position.

**Quarter 3 Update**
This paper provides an update regarding achievements of Quarter 3 for 2024-25.

During Q3, there has been a decrease to 50% of the Q3 objectives which were noted as on track to be delivered in full. The areas with the highest on track objectives are: -

***Pioneering research and innovation*** continue with both their objectives on track and forecasting strong progress through 24/25.

**Outstanding Patient outcomes, safety and experience** continues to deliver well on reduced length of stay and improved patient experience. However there has been some slippage related to the implementation of the quality dashboard and the number of outstanding patients waiting 65 weeks. This has resulted in two objectives turning to amber.

The areas with the highest number of objectives outstanding or greatest risks are:

- World Class People
- Integrated Networks and Collaboration
- Foundations of the future

***World Class People***: The greatest risk is to the workforce plan with a combination of planned increases of substantive staff during September and October for newly qualified employees and the NHSE plan reducing during Q3 and Q4. The reductions in the NHSE plan were based primarily on 218 WTE in both temporary and permanent staff linked to significant improvements in mental health and NCTR. Performance in these areas, linked to large-scale system transformation, has not improved and thus closure of bed capacity has not been possible. The plan is significantly backloaded to Q4 so it is anticipated we will move further away from plan.

Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of the 24/25.

At present the forecast for the end of year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13424 WTE which would be 146 over plan but will have decreased by 186 WTE from March 2024.

***Integrated networks and collaboration****:* greatest risk of non-achievement is the objective to reduce NCTR patient numbers. Progress is being made in establishing a formal group and investigating the issues and barriers using evidence and data. However, the realisation of reduction in number of patients without criteria to reside is likely to take longer to come to fruition.

***Foundations of the Future:*** The NHS/Trust financial position is a recognised risk within this strategic ambition. Year-end delivery is a risk, and subject to further financial recovery actions in the second half of 24/25. Complications have also developed with the decarbonisation scheme such that this is now red-rated due to significant risk to delivery of the de-steaming project and the additional capital required to complete the planned projects.

**Summary**

The Board is asked to note the progress made delivering the corporate objectives in the context of the agreed objectives being deliberately stretching and in a very challenging financial climate.

## Outstanding patient outcomes, safety and experience

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 1(a) | CNO | Establish an integrated approach to quality management through review of current governance structures, aligning work in the domains of safety, outcomes, experience, and improvement and consolidation of management information in a quality dashboard. | An integrated quality report has been commissioned by TEC and is in design including a supporting dashboard. Site visits to learn from other Trusts approaches have taken place in Q1 with others planned for Q2. A draft for a future quality management system was presented at TOG in July | On track - Work continues on refining the draft integrated quality report with key stakeholders. Integrated quality report planning to go to TEC in Q3 with visits to other sites still planned for learning. Further plans to integrate quality approaches and functions planned for Q3 and Q4 | Partially achieved: Work continues on the integrated quality report expected to be tabled at TEC in Q4 and a workshop is planned to create a specification for a revised quality dashboard across the quality teams however both of these items have been delayed from Q2 and Q3. Engagement and learning from others continues with Royal Berkshire and Salisbury to inform future approaches. | Partially achievable but delay in revised quality dashboard. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 1(b) | COO | Treat patients according to need but aim to meet national target of zero 65 week waiters by end of September 2024, and continued reduction of longer waiters subsequent to this. | Currently on plan to achieve no 65 week breaches by the end of September other than for corneal grafts (driven by a national shortage of graft material). However, there remains a degree of risk in the position. | Progress has continued to be positive in this area. There are currently a very small number of outstanding 65 week waiters, with 20 awaiting corneal grafts and 1 from another specialty. Our performance in this area remains among the best in the region. | The positive work in this area continues, although there has been a very slight increase in outstanding 65 week waiters with the current total being 56. The majority of which are with ophthalmology and surgery. | Slight slippage against objective for year end. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 1(c) | COO | Reduce length of stay across elective and non-elective pathways by focusing on inpatient flow improvement | On plan. Flow programme objectives for 2024/25 agreed. Length of stay for patients on pathway 0 is reducing, although being offset by an increase in length of stay for patients on pathways 1-3. UHS COO leading a group with the local system with agreed actions to try to improve n-ctr position. | On track. LoS currently 2.9% lower than last year creating capacity for elective activity, reduced escalation capacity open and absorbing increased non-elective demand. We still have c.220 NCtR patients in beds so a Complex discharge workshop is planned in November to tackle this with system partners | On plan: Length of Stay reduced by 4.65% this year against 5% target. However, sustained high attendances in the emergency department couple with non-criteria to reside patients still averaging 225 each day is impacting patient flow. A discharge week followed by a complex discharge workshop with system partners was held in December to agree a shared action plan on nCTR. | On track to meet objective by year end. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 1(d) | CNO/ CMO | Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme. | Fundamentals of Care' (FOC) launched in February 24. The campaign was successful and well received and theory behind the 8 commitments embedded. The next phase is the 'What Matters To Me?' project focusing on patient centered care. This phase focuses on recognition that all quality projects should reflect the FOC principles. | 'What Matters to Me' is now in pilot on E7 and G7. We have actively recruited volunteers in to support project and will be evaluating after all the phases of project completed, March 2025 we then plan to roll out to care groups and the wider Trust . | As a key Fundamentals of Care workstream 'What Matters to Me' pilot was started on F7 and G7 but due to volunteer recruitment challenges this is on pause until Volunteering for Health funding is released from a regional partnership in April 2025.<br>The campaign remains successful with some work on sharing the messaging at local universities, alongside different internal platforms. Project Manager engaged to embed the FoC into the new Clinical Quality Dashboard for effective monitoring of developments and progress. Links built with existing Proportionate Care workstream to build the Enhancing Safe Movement work and support a reduction of length of stay in | On track to meet objective by year end. |

## Research and Innovation

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 2(a) | CMO | Deliver year 4 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure. Anticipate an impact on growth in activity and the financial return from the investment as a result of staffing challenges across the research infrastructure. | On track. Cohort 4 of RLP started Q1. Cohort 1 RLP ROI discussions and onward planning in progress. ROI metric setting in progress for annual report. SETT delivery on track, risk register in progress, performance dashboards in place. Activity growth and financial return from the investment case is being closely monitored. | On track. New Project Manager to support development and implementation of new RLP awardees tracking due to start in post in Q3. SETT delivery on track, inaugural SETT conference planned for start of Q3. Activity growth and financial return from the investment case is being closely monitored, staffing has been challenging over the last two quarters. Whilst vacancies are now being filled, vacancy rates have had an impact on activity levels. | On track. New Project Manager in place from start of Q3 with development and implementation of RLP awardee tracking now underway. SETT conference held in Q3 for >120 attendees received excellent feedback. Study numbers, conversion rates and long-term ambition to take place in Q4 as part of year 5 investment case planning. Activity growth and financial return from the investment case continues to be closely monitored, staffing has been challenging this year with some areas still feeling capacity constraints which have had an impact on activity levels. | On track to delivery objective by year end. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 2(b) | CMO | Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.<br>• Develop a set of initiatives to recognise and reward staff for engaging in research.<br>• Show a clear return on investment of the Research Leaders Programme.<br>• Develop a set of initiatives with QI, education, and innovation teams to develop an approach to collaborative / system working.<br>• Agree UHS/UoS collaborative clinical research centres of excellence and areas of strategic growth. | In progress/on track. Working group is being established in Q2 tasked with developing the set of initiatives for recognising and rewarding staff. Mechanisms are being developed with cohort 1 of the RLP to capture and track ROI. Workshops with QI and Innovation taken place, with funding / resources being secured to take forward. The joint research vision, developed with UoS was taken to the Senior Operational Group in June 24 and will be finalised by Joint Research Strategy Board in July 24 with collaborative research centres of excellence and areas of strategic growth identified. | In progress/on track. Implementation plan underway with baseline for relevant KPIs identified, agreed and being monitored. RLP ROI metrics have now been agreed with RLP Cohort 1 ROI 1:1 discussions completed enabling post RLP plans to be formulated. The joint research vision between UHS and UoS has been approved by the Joint Research Strategy Board, mapping of interdisciplinary and operational projects across the partnership is ongoing. | In progress/On track – implementation plan has been put into action with baseline measures collated and working groups formulating. In Q3, the RLP Annual Report was published, shared via R&D Comms outlets and copies shared directly with research leaders within the region. RLP metrics were presented in JEG-R and in Annual Report, demonstrating ROI of RLP. We have now mapped overlapping areas between UHS and UoS which will give us strategic priority areas to focus on. | On track to meet objective by year end. |

## World Class People

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 3(a) | CPO | To deliver a workforce plan for UHS for 2024/25 which is safe, sustainable and affordable. | Workforce plan agreed per division/THQ area in Q1. Revised recruitment controls agreed and implemented. Workforce numbers have remained under target in Q1.<br><br>Despite the positive start, there is risk to this position in future months due to reliance on delivery of ICS-wide schemes to support safe and appropriate workforce reductions (e.g. nCTR reduction and mental health) | The Trust remains below its overall NHSE workforce plan by 249 WTE at the end of September. Agency, bank and substantive are currently all below plan. It is anticipated that the substantive workforce will continue to increase as the remainder of the Newly Qualified staff (Nurses, midwives, and AHPs) commence during the autumn.<br><br>Divisions continue to work against their agreed AWL targets with oversight from the monthly Finance and Workforce combined meetings.<br><br>From October it will become more challenging to remain within our overall plan are the numbers are predicated on the delivery of system-wide programmes to reduce nCTR and mental health presentation. | At the end of December, as Forecast, the Trust is 7 above its NHS overall NHS plan. This is through a combination of planned increases of substantive staff during September and October for newly qualified employees and the NHSE plan reducing during Q3 and Q4. The reductions in the NHSE plan were based primarily on 218 WTE in both temporary and permanent staff linked to significant improvements in mental health and NCTR. Performance in these areas, linked to large-scale system transformation, has not improved and thus closure of bed capacity has not been possible. The plan is significantly backloaded to Q4 so it is anticipated we will move further away from plan.<br><br>Divisions are all still operating within their AWL limits as part of UHS controls and are forecast to remain so for the remainder of the 24/25.<br><br>At present the forecast for the end of year 24/25 is for UHS to finish at a total workforce (Substantive, bank and agency) of 13424 WTE which would be 146 over plan. | UHS forecast to be 146 over WF plan on March 31 2025. Workforce at year end is forecast to have shrunk by 186 WTE compared to 31 March 2024 |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q2 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 3(b) | CPO | To deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy. | Action plan response to staff survey agreed at TEC. £250k funding from charity agreed to support staff wellbeing in 24/25. UHS Week and UHS Champions Awards scheduled for October 2024.<br><br>2nd cohort of the Positive Action Leadership Programme has been launched for applications, programme commences in September. Team Leaders Programme and Operational Leaders Programme continue in Q1. Coaching Culture: Faculty of internal UHS accredited coaches now available and a 2nd cohort onto the L5 Coaching is being recruited to.<br><br>Delivery of schemes relating to staff improvements within the People Directorate are constrained by funding and controls on workforce affecting capacity in the current context.<br><br>Q1 Pulse Staff Survey results show staff engagement scores continue to see a small reduction from previous year. | Annual Staff Survey launched in September and closes end of November. Various engagement methods deployed to encourage participation.<br>Preparations have been ongoing during Q2 for WeAreUHS week to be held 14th to 18th October including the annual WeAreUHS Champions awards. This year the champions awards had a record breaking 604 nominations made.<br>The 2nd cohort of Positive Action Leadership has commenced with 24 participants. During Q2 we hit a milestone of 10,000 having attended UHS allyship training within the last two years. 72% of staff against a target of 85% by the April 2025. Impact analysis of allyship training has now started with the outcome due end of March 2025.<br>Hospital Charity grants have provided for range of staff wellbeing, recognition and celebration purposes, as part of this a number of staffrooms refurbishments have been identified, scoping has taken place in Q2, and works will be started in Q3.<br>During July the annual Resident Doctor awards took place - this was a well-attended and popular event and has become an established feature in recognising the contribution of this workforce.<br>Pace of delivery has been constrained by resources through recovery workforce controls. Some key replacement posts are expected to commence during Q3 and Q4. | Annual staff survey closed in December with participation rates below target and below the national average participation rates.<br><br>Full results remain embargoed until February 2025.<br><br>Significant focus has been placed on key risk areas. An industrial dispute with the portering department led by UNITE has been. The Trust has been in negotiations with UNITE, with support from ACAS regarding the porters dispute. A deal has been reached and focus now turns to implementation.<br><br>There has also been targeted work in Cardiac services to try to improve culture and capacity.<br><br>WeAreUHS week took place in October which proved to be a popular and well attended event. The Trust also celebrated the achievements of its staff during October at the We are UHS Champions awards. Over 600 nominations were made, a record for UHS.<br><br>UHS launched the #proudtobeadmin and #proudtobeops movements in partnership with the national support team. Events where attended by over 100 staff as a platform for creating a greater community with these vital roles. | Some improvements being delivered but some constrained by resource within People directorate and capacity across the organisation. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 3(c) | CPO | To sustain turnover at less than 13% and maintain sickness absence under 4% to March 2025. | Both turnover and sickness absence have remained on track below target in Q1. Sickness in month is currently 3.6% and Turnover is 11.2%. | Both turnover and sickness absence have remained on track below target in Q2. Sickness in month is currently 3.6% and Turnover is 11.1%.<br><br>The Trust launches both its Flu and COVID vaccination programmes during October. | Turnover has reduced again in November, taking the UHS rate to 10.7% and well below target of 13.6%.<br><br>Overall sickness in December was 4.1% but rolling average remains below target.<br><br>The Trust has launched its Flu and COVID campaigns. At present uptake (both locally and nationally) is lower than desired. Uptake is currently 52% for Flu and 36% for COVID. | On track for delivery by year end. |

## Networks and Collaboration

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 4(a) | CMO | Work in partnership with acute trusts, working directly with priority areas to progress joint network strategies with the principle aim to create capacity onsite. Internally embed networking frameworks to drive delivery and demonstrate progress against the UHS maturity networks. | On track: INC Board agreed priority areas of focus for 24/25- Plastics, Pelvic Floor, Urology and Upper GI. Cases of support for Pelvic Floor and UGI agreed internally and circulated to partners. Successful stakeholder day for Plastics held with Salisbury in Q1 and full strategic case being drafted. Regular network meetings underway with UHD and Salisbury focusing on priority pathways. ICB group also being formed. | On track- progress is being made in all priority areas:<br><br>Plastics- working group in place with attendance across UHS and Salisbury, potential future service models being finalised with business case to follow<br><br>Urology- Progress is challenging due to conflicting pressures and availability to attend meetings across all trusts. Urology has been listed within the ICB priority programme<br><br>Upper GI- successful meeting with representatives across UHD and UHS have confirmed commitment to move forward together and to integrate PHU into this work. Agreed on initial areas of focus including on call and MDTs.<br><br>Pelvic floor- Successful stakeholder day held. Steering and working groups established monthly. Good lines of communication established with Dorset and Hampshire ICBs. Agreed to work towards ambitious timeframe for initial model to be ready for January. | On track – progress is being made in all priority areas.<br><br>Plastics – The working group has finalised the demand data and started assessment of income potential and modelling staffing options. Working with planning team on progress towards business case.<br><br>Urology – Progress remains challenging due to conflicting pressures and availability. There is a meeting scheduled in January to continue the work on the BPH pathway and another to look at MyMR. Urology is listed within the ICB priority programme.<br><br>Upper GI – The ICB has communicated that there needs to be one central service for the region that will include UHS, PHU and UHD. Going forward this work will be organised by the ICB.<br><br>Pelvic Floor – All three working groups have made significant progress and are close to finalising the initial objectives. The network will look to conduct a GAP analysis and organise an in-person meeting in March 2025 to discuss next steps.<br><br>Neurology – On October 18th there was a meeting between UHD/UHD to discuss the possibility of joint recruitment to support sustainability of the UHD service. It was agreed that there were good reasons to explore this and other areas of collaboration, such as MT cover, research trials, epilepsy nurse support. A working group has been organised which will meet in January.<br>Colour: Amber due to conflicting pressures and commitment to move forward. | On Track |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 4(b) | COO | Work with the Local Delivery System on vertical integration to reduce the number of patients without criteria to reside in UHS. | UHS COO has set-up a group in the Local Delivery System focused on a few key actions that can be collectively taken to reduce admissions and the number of patients not meeting the criteria to reside. However, there remains risk about whether these will be enough, particularly as there has been a reduction in out of hospital capacity, with further reductions planned | The Southampton and South West Hampshire Delivery Unit is now established chaired by Dr Mark Kelsey from Southern Health. A plan for the system based on the ICB transformation themes is in place and progressing. UHS are undertaking a discharge pathways workshop with all partners in October / early November to audit discharge delays with an aim to reach consensus as to whether these are occurring due to capacity or process issues (or both). This in turn will be used to refine plans and priorities for winter 2024/25. | Patients without a criteria to reside in hospital remain very high.<br><br>2 key actions have taken place:- a discharge focus week was held between UHS and key partners and a workshop with all partners to focus on P1 delays and gaining a mutual understanding of the issues.<br><br>From these events an action plan to address the issues identified is being jointly agreed across the system with support from UHS transformation team.<br><br>Alongside this a visit was made to Oxford University Hospitals who have a very low number of patients without a criteria to reside. To progress a model of this nature a business case for investment would be required e.g. additional discharge officers, additional short term beds, changes to market offer etc. This will be further developed as we progress towards 2025/26. | Minor delays/shortfall in target - Progress is being made in establishing a formal group and investigating the issues and barriers using evidence and data. However the realisation of reduction in number of patients without criteria to reside is likely to take longer to come to fruition. |

## Foundations of the future

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 5(a) | CFO | Deliver a stretching financial plan for 2024/25, including identifying what needs to be true to recover to a sustainable financial position and exit RSP. This will be supported by delivery of the CIP plan and improvements in productivity across all Divisions/Departments. | UHS' financial position is a £13m deficit at the end of Q1, £3.8m adverse to plan YTD. There has been a month-on-month improvement in the underlying position, and we have maintained workforce numbers within the agreed targets. The key contributor to the position relates to delivery of CIP to date, against what we recognised was a challenging plan when agreed. | UHS financial position is an £8m deficit after Half 1, which is £4.7m adverse to plan. This has been supported by non-recurrent national deficit funding.<br><br>Whilst improvements have been made, the underlying position remains challenging at c£6m per month deficit.<br><br>The drivers of the deficit are primarily system-wide pressures, with the Trust effectively "overtrading" by undertaking activity beyond funded levels.<br><br>The Trust is currently producing a Financial Recovery Plan in conjunction with HIOW partners, which is focused on identifying what factors need to be true to achieve a break-even run-rate position by Q4. | UHS financial position of £22.7m YTD deficit, £19.3m adverse to plan.<br><br>UHS has continued to deliver significant levels of savings (£48m YTD) and continues to benchmark well; however, the underlying position remains challenging at £6m per month deficit.<br><br>The main drivers of the deficit continue to be system-wide pressures, including NCTR, Mental Health and UEC activity. The Trust is effectively overtrading by undertaking activities well beyond funded levels.<br><br>The cash position has deteriorated to £14.7m, with a risk that cash reduces close to £0 in the coming months. | UHS will not achieve its Plan position of £3.3m deficit. However, a revised "landing plan" is in discussion with HIOW ICB that may support an improved year-end position from the £35m forecast deficit. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 5(b) | CEO | Engage the organisation in the challenge to manage demand so that capacity and demand are in equilibrium. Stop the PTL growth by Q3 and begin to see a reduction of the PTL in Q4. | PTL was static and beginning to reduce in Q4 23/24 but has begun to rise again in Q1 24/25. This is driven by capacity and demand issues in a few specific specialties. Transformation Team are focusing effort in these areas as part of the overall OP workstream to support with managing demand. | PTL has remained static in Q2 at around 60k patients. Transformation Team continue to deliver a number of initiatives to support referral management. Continued growth in a key few areas which remain focus within UHS and also through ICS/GIRFT workstreams. | PTL has remained static for the second quarter in a row at around 60K. The transformation team continue to deliver the agreed initiatives. | Growth of PTL has been reduced this year. Moving to reduction in PTL will require a further step-change in demand/capacity balance. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 5(c) | CNO | Deliver the aims of the 24/25 Transformation programmes and Always Improving strategic priorities. Realise targeted reductions in length of stay and outpatient follow-up and increases in theatre utilisation whilst increasing our maturity against the NHS Impact framework | All transformation programmes are mobilised and positive movement in metrics for all programmes is being seen (5% LoS reduction for P0, lowest DNA rate since Covid, more cases per 4hr session from 1.5 to 1.7). Additional assurance through Care Group Improvement Meetings chaired by COO. Held TBSS focused on NHS Impact and our improvement culture | Improvements in key metrics have sustained in Q2 and we anticipate partial delivery in all programmes of work (2.86% reduction in LoS, 52.7% New & OPROC appts and 788 additional theatre cases year to date). NHS IMPACT improvement guides have been released nationally and are guiding planning process for 25/26. | All programmes continue to deliver improvements in key metrics (4.65% length of stay reduction, 52.8% new & OP procedure appts, 1,150 additional theatre cases) projecting delivery of 72% of the productivity benefits in our plans (£20.1m vs £27.6m). NHS IMPACT guides and benchmarking, the elective recovery plan and GIRFT Further Faster continue to drive focus and 25/26 plans. | On track to meet objective at year end. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 5(d) | CFO | Deliver the prioritised 2024/25 capital programme and set a prioritised capital plan for 2025/26, as well as setting aspirations for future year programmes. | On track: Work underway on capital schemes. Additional national capital secured for the Emergency Department - planning underway for this, will present a challenge to deliver in year. There are risks to delivery including Building Safety Regulations sign-off delays. BSR sign-off achieved for Neonates in June 2024 but still awaited for other projects. Slippage on other schemes also currently being assessed. | The Trust has encountered delays to programmes due to new Building Safety Regulator procedures.<br><br>However, we remain on-track overall to utilise our full CDEL allocation in 2024/25. The new Aseptic Unit at Adanac Park is on track to deliver on time & budget. The Neonates project is continuing on a revised schedule following previous delays. We are finalising plans for investment of national funding into our ED. | The Trust's capital programme is £11.6m behind plan YTD, with £50.4m to be spent in the remainder of the financial year. Slippage risks on schemes are currently being reviewed with the capital planning process for 2025/26 and 2026/27 having now commenced. | Whilst some risks remain, we are targeting full delivery by the end of the financial year. |

| Ref | Lead | Objective | Q1 Update | Q2 Update | Q3 Update | End of Year Forecast |
|---|---|---|---|---|---|---|
| 5(e) | CMO | Complete Year 2 of the Public Sector Decarbonisation Scheme | Most of the work programmes are underway, with most of the Air Handling Units (AHU), Split AC's and 40% of the lights installed. The Solar on Car Park 4 and cladding works are progressing, however there are risks to delivery including securing the route for the Low Temperature Hot Water (LTHW) pipework. | Most of the decarbonisation work programmes are underway, with Solar PV, LED lighting and R22 air conditioning replacement and general improvements in the energy centre are rated green for delivery within project timelines and Salix requirements.<br>Delivery of the Lab and Path cladding & windows, the heat pump building and air handling units have faced a number of significant issues, although we can still deliver in time to recover the Salix funding, although the trust capital contribution will need to roll into 2025/26/<br><br>Achievement of the low temperature hot water system to facilitate de-steaming has been severely disrupted due to the deteriorated state of the steam duct tunnels, which require substantial remediation to make safe for the works. While extensive progress has been made in establishing the remediation required, and the proposal to achieve this, it will require additional capital funding to deliver and as such is currently red rated, and reviews are underway to determine viability. | The LED lighting and R22 split A/C replacements have both been completed along with the improvements required to the energy centre.<br>The AHU's and Solar CP will be completed but with a slight slippage on the timelines projected for September 2025.<br>The heat pump and desteam work remains with an amber rating due to timelines and the required extra capital for 2025/26 to complete the project. A paper went to Finance and investment committee in February.<br>It has been proposed to pause the L&P cladding and windows until additional funding can be sourced, this will allow the completion of the above projects. | Currently red rated due to the timeline slippages and the 2m extra capital required for 25/26 to complete the projects. |

University Hospital Southampton
NHS Foundation Trust

| Agenda item 6.2 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Board Assurance Framework (BAF) |
| **Sponsor:** | Gail Byrne, Chief Nursing Officer |
| **Author:** | Lauren Anderson, Corporate Governance & Risk Manager<br>Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the annual governance statement and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position.

The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring. The report has been updated following discussions with the relevant executives and their teams.

The Board is asked to note the updated Board Assurance Framework and information contained within this report.

**Contents:**

Paper
Appendix A – The full Board Assurance Framework

**Risk(s):**

All BAF risks are contained within this report as well as the linked operational risks where applicable.

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

## 1. Purpose

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

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

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

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

## 2. Key updates

**2.1.** The board last received the BAF in January 2025. Since then, all risks have been reviewed by the responsible executive(s) and/or committees, and updated where appropriate.

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

**2.3.** The risk rating for one risk has increased since the committee last received this report. This is risk 3c relating to the training and development provision to meet the needs of the current and future workforce needs of the organisation. This was previously assessed as 12 (severe x possible) however this has now been reassessed as 16 (severe x likely) and the target date for optimum risk reduction extended from 2027 to 2029. The increase in likelihood is based upon the reduction in national funding for education and funding and the tighter restrictions in accessing this, coupled with the national planning guidance which sets out the intent to reduce the NHS corporate infrastructure as it is recognised this could have an effect on T&D staff. In response to this the concern has been escalated to NHSE with an offer from UHS to engage and support in exploring potential solutions.

**2.4.** The target dates for risk reduction for a further 5 risks have also been extended:

- 2a: Extended from March 2025 to March 2026 whilst assurance is gathered that the improved Trust Board KPIs are sustained.
- 4a: Extended from April 2025 to December 2025 whilst work continues to target risk reduction in specific specialities, such as Upper GI.
- 5a: Extended from April 2026 to April 2030 in recognition of the growing fiscal risk and the gap between this and our planned risk reduction. It is however noted though that we will still intend to reduce this risk in increments between now and then, therefore do still anticipate a level of risk reduction in April 2026.
- 5b: Extended from April 2027 to April 2030 in recognition of the fact this continues to be a critically rated risk for the organisation with the limiting factor in mitigation being adequate funding.
- 5d: Extended from December 2024 to December 2027 as there is assurance that targets related to direct emissions will be met, however there is less assurance relating to indirect emission targets.

**2.5.** At present there are 6 risks which sit outside of the Trust's stated risk appetite, however all of them have target ratings which do sit within either the tolerable or optimal appetite, along with actions identified to achieve this.

# UHS Board Assurance Framework (BAF)

Updated February 2025

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

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

## 1. Outstanding patient outcomes, safety, and experience

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

## 2. Pioneering research and innovation

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

## 3. World class people

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

## 4. Integrated networks and collaboration

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

## 5. Foundations for the future

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

# Executive Summary

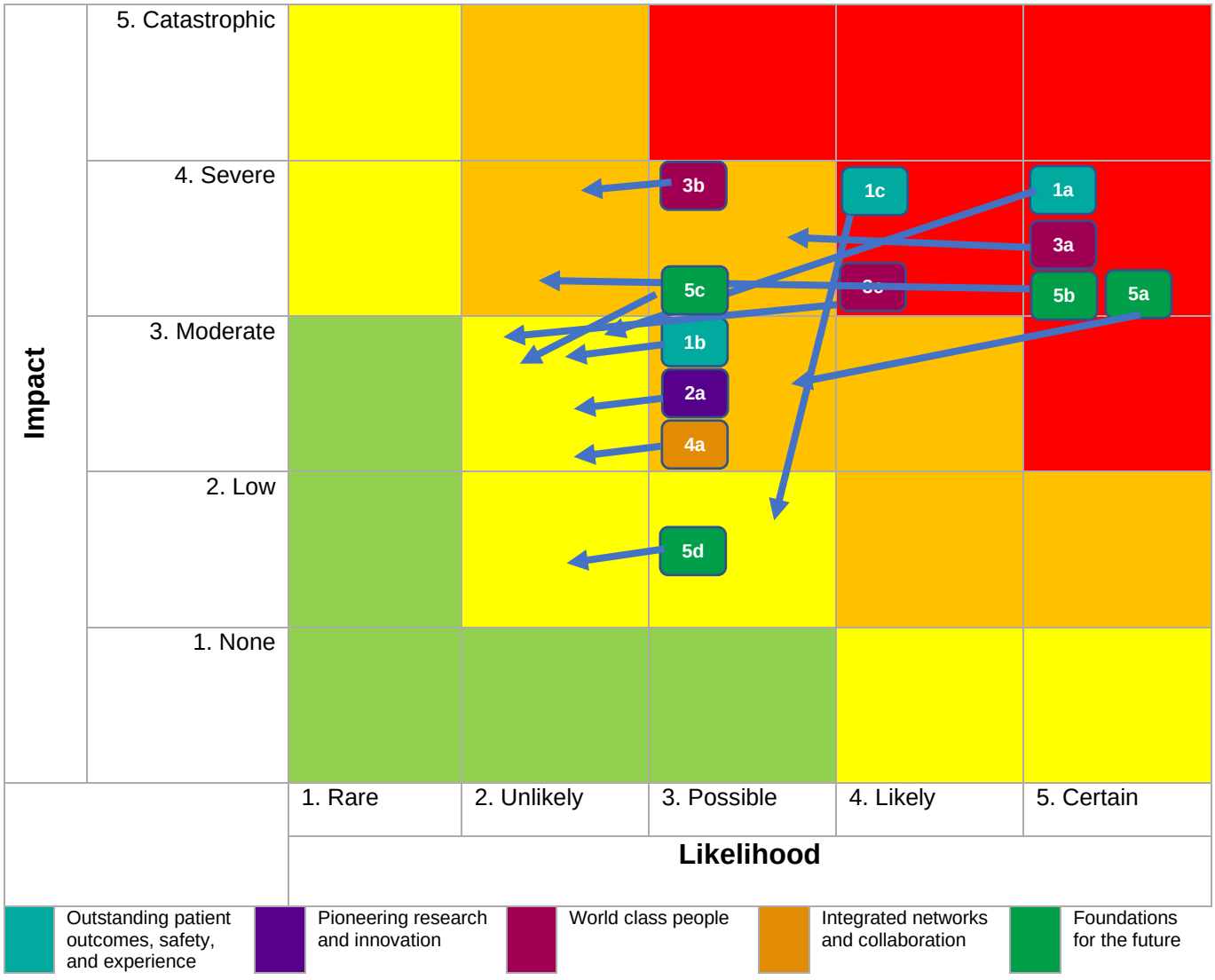
There are 6 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1c) Infection Prevention (4 x 4 = 16)
- 3a) Staffing (4 x 5 = 20)
- 3c) Future Workforce Planning inc. Training & Development (4 x 4 = 16)
- 5a) Finances (4 x 5 = 20)
- 5b) Estates (4 x 5 = 20)

At present there are 6 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1c, 3a, 3c, 5a, and 5b. All of these risks are being actively treated with the aim of reducing the risk score and all risks set out within the BAF have a target risk rating which sits within the optimal or tolerable risk appetite.

# Trajectory

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



## Outstanding patient outcomes, safety, and experience

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

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 4 x 5<br>20 | April<br>2022 | 4 x 5<br>20 | February<br>2025 | 3 x 2<br>6 | April<br>2027 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

### Current assurances and updates

This risk has been reviewed by the responsible executives in February 2025 with minor updates included within the controls, assurances, and actions as appropriate to ensure the risk is current. No revisions to the risk rating or target are required at this time.

Current updates include:

- Work has commenced to reconfigure the ambulatory majors corridor in ED, facilitating a better line of sight of patients which may reduce the number of admissions.
- There continues to be a significant increase in type 1 attendances (self-presentations) to ED since September 2024 which contributes to long waits for patients. This is reflective of capacity restraints in the wider system as some patients may have been suitable for care through other avenues (e.g. GP, Urgent Treatment Centre, etc..) and work is underway to look at alternative avenues for patient care throughout winter. Funding has been agreed to recommission GPs in ED to provide support until the end of the 2024/25 financial year, however to date we have not been able to secure any GPs to undertake this work.

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

| | |
|---|---|
| underpinning the objectives include criteria led discharge and discharge lounge use.<br>Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand.<br>Use of independent sector to increase capacity.<br>Urgent and Emergency Care Board established to drive improvements across UEC pathways.<br>UEC recovery plan to support improvements across UEC pathways.<br>UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board.<br>Rapid Improvement Plans to support improvements across cancer pathways. | discharge, planned care, local mental health care, and urgent and emergency care.<br>Challenges in staffing ED department during periods of extreme pressure.<br>Ongoing industrial action through 23-24 and into 24-25 has presented significant risk to the Trust's ability to meet ongoing demand on our services. This could continue into 25-26.<br>Staff capacity to engage in quality improvement projects due to focus on managing operational pressures.<br>Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow.<br>Lack of a clear capacity and demand plan to resolve cardiac capacity issues.<br>Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities. |
| **Key assurances** | **Gaps in assurances** |
| Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP.<br>Harm reviews identifying cases where delays have caused harm.<br>Weekly divisional performance meetings with a particular focus on cancer and long waiting patients.<br>Live monitoring of bed occupancy and capacity data.<br>Monitoring and reporting of waiting times.<br>Implementation of PSIRF with oversight of red incidents at TEC.<br>Transformation programme work plans.<br>An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns.<br>NHSE and NHS HIOW ICS supportive quality visit to ED (September 2024). | 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.<br>Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists - complete.<br>Deliver plans to hit the trajectory of no patients waiting over 65 weeks by September 2024 - complete. Update October 2024: excluding corneal patients, this was achieved except for 2 patients (cardiac and gynae) remaining. Update November 2024: 16 corneal and 8 surgical patients outstanding.<br>Pursue significant improvement in cardiac wait times through development of a demand and capacity plan and mutual aid.<br>Community Diagnostic Hub opening in Q4 2024/5 (March 2025) to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign.<br>New theatres and MRI suite scheduled to open in September 2024 - complete. 5 new all day theatre lists opened. | |

Engagement in the NHSE Further Faster programme for elective care.

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.

Following a successful trial in Portsmouth, a single point of access within the ambulance service will commence with support from our ED clinicians. The intent is to divert suitable patients away from ED to the most appropriate place of care which may be in the community, or may be a direct speciality admission.

A pilot for a stroke SDEC has been undertaken at UHS with the intent of reducing admissions and providing patients with quicker access to the care they need, which in turn improves outcomes and lowers the risk of patients' experiencing further TIAs. This has been very successful with 69 patients seen in SDEC, a third of whom would normally have been seen in ED or HASU. 25% of patients were able to avoid a HASU admission.

**Linked operational risks**

| No. | Title | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|
| 74 | If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being | 3 x 3 = 9 | 3 x 2 = 6 | 28/02/2025 |
| 95 | Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital. | 3 x 5 = 15 | 2 x 3 = 6 | 31/12/2024 |
| 187 | Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients. | 5 x 5 = 25 | 4 x 3 = 12 | 30/06/2025 |
| 259 | Capacity and Demand in Maternity Services | 5 x 5 = 25 | 2 x 2 = 4 | 30/04/2025 |
| 266 | There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity | 4 x 4 = 16 | 2 x 2 = 4 | 06/01/2025 |
| 395 | This risk is related to the cardiac surgical patients who are on our waiting list that may come to harm whilst they wait for their surgery. | 4 x 5 = 20 | 2 x 3 = 6 | 30/06/2025 |
| 443 | Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service. | 3 x 4 = 12 | 3 x 2 = 6 | 31/07/2025 |
| 470 | Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery. | 4 x 4 = 16 | 3 x 2 = 6 | 16/12/2024 |
| 473 | Insufficient capacity within the Paediatric Neurology to cope with current demand. | 3 x 3 = 9 | 2 x 2 = 4 | 11/04/2025 |
| 610 | Insufficient capacity to provide a safe and effective Out of Hours medical and ANP service across Div B | 4 x 3 = 12 | 3 x 2 = 6 | 30/04/2025 |
| 652 | Prostate cancer capacity | 4 x 4 = 16 | 3 x 2 = 6 | 31/03/2025 |
| 671 | Capacity within the melanoma and soft tissue cancer pathways. | 3 x 4 = 12 | 3 x 2 = 6 | 31/01/2025 |
| 681 | Adult inpatient pain service is struggling to deliver a robust service - demand is exceeding the current capacity in the pain service. | 3 x 4 = 12 | 3 x 1 = 3 | 31/03/2025 |
| 687 | Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital. | 3 x 4 = 125 = 15 | 3 x 1 = 3 | 31/03/2025 |
| 697 | Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list | 5 x 4 = 20 | 3 x 2 = 6 | 30/06/2025 |
| 758 | Urology stone service - including stent change delays & capacity challenges | 4 x 4 = 16 | 3 x 2 = 6 | 31/03/2025 |

| | | | | |
|---|---|---|---|---|
| 766 | Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre. | 5 x 5 = 25 | 4 x 2 = 8 | 30/06/2025 |
| 767 | HoLEP capacity issues | 3 x 3 = 9 | 3 x 1 = 3 | 31/03/2025 |
| 775 | Patients with kidney cancer may experience worse outcomes and survival due to capacity issues and delays in their treatment pathways | 4 x 3 = 12 | 4 x 1 = 4 | 31/07/2025 |
| 804 | Congenital cardiac (adult & paeds) surgery demand | 4 x 4 = 16 | 4 x 2 = 8 | 30/09/2025 |
| 814 | Inability to provide a safe pleural service | 4 x 1= 4 | 2 x 2 = 4 | 30/05/2025 |
| 816 | Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity | 5 x 4 = 20 | 3 x 2 = 6 | 31/03/2026 |
| 822 | Ophthalmology Glaucoma Capacity | 4 x 4 = 16 | 4 x 4 = 16 | 30/06/2025 |
| 823 | Ophthalmology Medical Retina Service Capacity | 4 x 4 = 16 | 4 x 2 = 8 | 30/09/2025 |
| 840 | Paediatric haemodialysis capacity | 4 x 3 = 12 | 2 x 2 = 4 | 18/04/2025 |
| 845 | There is a risk that the obstetrics service will be compromised due to excess levels of demand and unmatched capacity within the consultant team | 3 x 4 = 12 | 4 x 1 = 4 | 01/04/2025 |
| 850 | Inability to effectively run the pelvic floor service due to staffing and capacity | 3 x 3 = 9 | 2 x 2 = 4 | 31/08/2025 |

**Outstanding patient outcomes, safety and experience**

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 3 x 3<br>9 | April<br>2022 | 3 x 3<br>9 | February<br>2025 | 3 x 2<br>6 | March<br>2026 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

**Current assurances and updates**

- This risk has been reviewed by the responsible executive leads in February 2025. No revisions to the risk rating or targets are required.
- Full deployment and implementation of NATSIPPS2 is a priority for the organisation and one medical PA per week has now been allocated to this, as well as some project management support from the transformation team. Additionally, an executive led oversight meeting has been initiated which includes oversight and scrutiny of never event incidents, to seek assurance that lessons are learnt and embedded. These meetings have commenced including focus on education around 'the NatSSIPs 8' sequential standards.

| Key controls | Gaps in controls |
|---|---|
| Trust Patient Safety Strategy and Experience of care strategy.<br>Organisational learning embedded into incident management, complaints and claims.<br>Learning from deaths and mortality reviews.<br>Mandatory, high-quality training.<br>Health and safety framework.<br>Robust safety alert, NICE and faculty guidance processes.<br>Integrated Governance Framework.<br>Trust policies, procedures, pathways and guidance.<br>Recruitment processes and regular bank staff cohort.<br>Culture of safety, honesty and candour. | 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.<br>The Head of Patient Involvement role was not replaced in Sept 2023 limiting capability to engage the local community, although the Associate Director of Patient Experience has now been appointed.<br>Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . |

| | |
|---|---|
| Clear and supportive clinical leadership.<br>Delivery of 23/24 Always Improving Programme aims.<br>Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects.<br>Implementation of PSIRF.<br>Patient Involvement and engagement in capital build projects<br>Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with sponsors for priorities, health inequalities liaison role sitting within patient experience, and allocation of dedicated time across multiple roles in the clinical strategy and BI teams.<br>Maternity safety champions. | Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges.<br>There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support. However work across the system on value based care will feed into this. |
| **Key assurances** | **Gaps in assurances** |
| Monitoring of patient outcomes with QPSP input.<br>CQC inspection reporting: Good overall.<br>Feedback from Royal College visits.<br>Getting it right first time (GIRFT) reporting to Quality Committee.<br>External accreditations: endoscopy, pathology, etc.<br>Kitemarks and agreed information standards.<br>Clinical accreditation scheme (with patient involvement).<br>Internal reviews into specialties, based on CQC inspection criteria.<br>Current and previous performance against NHS Constitution and other standards.<br>Matron walkabouts and executive led back to the floor.<br>Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits.<br>Performance reporting.<br>Governance and oversight of outcomes through CAMEO and M+Ms<br>Patient Safety Strategy Oversight Committee<br>Transformation Oversight Group (TOG) including TOG dashboard to oversee impact.<br>Health Inequalities Board<br>Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board).<br>Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice.<br>Patient experience week (May 2024) evidencing and celebrating FFT and sharing learning from complaints. | Ongoing industrial action through 22-23, 23-24 and 24-25, and into 25-26 presents risk to the Trust's ability to meet ongoing demand on our services.<br>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:**<br>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.

**Always Improving programme**

Delivery of 23/24 and 24/25 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. outpatient follow-up reduction) completed with a 5% reduction in LOS and 81.7% YTD optimisation in theatres. 2025/26 projects realigned with national priorities: Emergency & Urgent Care (Flow), Improving Value, and Elective Care.

Embedding 'voice of the patient' into all improvement activities through aligning each Division with a QPSP who will champion patient insight and involvement. Complete, including QPSP at TOG. Next steps are to work closely with patient experience to embed the patients' lived experiences in all layers of improvement work and planning.

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

Introducing exec and senior leadership team walkabouts focussed on improvement have been embedded with focus on sustaining these and facilitating a continuous loop of feedback to inform decisions and measure effectiveness.

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

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

Always Improving self-assessment against NHSE guidance taken to Trust Board in December 2023.

Fundamentals of care programme roll out across all wards.

**Patient experience initiatives**

Roll out of SMS and other feedback mechanisms, offering clinical teams targeted response surveys to ensure specific care needs are not only identified they are also addressed. This in part has started, the ED SMS survey has proven to be a success and yielded a 700% improved response rate for ED. The learning from this has now been shared trust wide and Eye Casualty and Ophthalmology are now next to move to FFT SMS, which captures a wider demographic of patients.

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.

**Health inequalities Programme**

The UHS health inequalities programme and board have been initiated with key priorities crossing how we enable change within our organisation, how we have impact on nationally recognised drivers of health inequalities with high prevalence in Southampton, data and measurement and engagement and communications.

A health inequalities liaison post has been recruited within patient experience. They will be working with the clinical strategy team and transformation to support the organisation to understand health inequalities, to recognise inequalities within their service provision, to make changes to reduce the impact of health inequalities and to escalate challenges and risks as required. These actions will support to improve the experience and outcomes of our patients.

| Linked operational risks | | | | |
|---|---|---|---|---|
| **No.** | **Title** | **Current risk rating** | **Target risk rating** | **Target Date** |
| 440 | Children and young people with acute mental illness or behavioural disturbance will be at increased risk of harm if there are no dedicated CAMHS facilities and insufficient CAMHS staffing at Southampton Children's Hospital; this risk will be exacerbated if there are also delays in their discharge. | 4 x 5 = 20 | 2 x 3 = 6 | 31/03/2025 |
| 645 | Increase in mental health patients and ligature risk in ED and AMU | 3 x 5 = 15 | 2 x 2 = 4 | 02/04/2025 |
| 765 | Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS | 4 x 4 = 16 | 4 x 2 = 8 | 31/12/2024 |
| 805 | Clinical harm and never events may occur if NATSIPPS2 cannot be embedded due to insufficient resource | 4 x 4 = 16 | 3 x 1 = 3 | 31/12/2025 |

**Outstanding patient outcomes, safety and experience**

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

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 3 x 3<br>9 | April<br>2022 | 4 x 4<br>16 | February<br>2025 | 2 x 3<br>6 | April 2027 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 |

**Current assurances and updates**

- The risk has been reviewed by the responsible executive with no alterations to the risk rating or target required at this time.
- Rapid testing for respiratory infections and norovirus has been successful evidenced through reduced outbreaks in comparison with peers. There has been only one case of candida auris since the infected ward was deep cleaned.
- Upcoming campaigns for education and awareness include a ‘spring clean’ and focus on commode cleanliness in response to recent audits.

| Key controls | Gaps in controls |
|---|---|
| Annual estates planning, informed by clinical priorities.<br>Digital prioritisation programme, informed by clinical priorities.<br>Infection prevention & control agenda, annual work plan, audit programme.<br>Local infection prevention support provided to clinical teams.<br>Compliance with NHSIE Infection Prevention & Control Assurance Framework.<br>Focused IP&C educational/awareness campaigns e.g. hand hygiene, ‘Give up the gloves’ winter virus. campaigns. PPE requirements, specifically the requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the ‘give up the gloves’ campaign.<br>Digital clinical observation system.<br>Implementation of My Medical Record (MMR). | Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections.<br>Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE.<br>Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections.<br>Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. |

| | |
|---|---|
| Screening of patients to identify potential transmissible infection and HCAIs.<br>Programme of monitoring/auditing of IP&C practice and cleanliness standards.<br>Review of incidents/outbreaks of infection and sharing learning and actions.<br>Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety.<br>Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations.<br>Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers.<br>The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE.<br>Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training.<br>Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need.<br>Point of Care testing in AMU.<br>Expedited laboratory testing facilities for respiratory and GI infections. | IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced.<br>Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped although currently there are no extraordinary requirements for contact tracing. |
| **Key assurances** | **Gaps in assurances** |
| Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits.<br>Patient-Led Assessment of the Care Environment.<br>National Patient Surveys.<br>Capital funding monitored by executive.<br>NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board.<br>Clinical audit reporting.<br>Internal audit annual plan and reports.<br>Finance and Investment Committee oversight of estates and digital capital programme delivery.<br>Digital programme delivery group meets each month to review progress of MMR.<br>Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.).<br>Ongoing focus on hand hygiene by the IPT and Divisions/Care groups – improvements starting to be seen in hand hygiene practice (as demonstrated in | Ward and bay closures due to norovirus outbreaks.<br>Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds.<br>Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices. |

| | |
|---|---|
| audits) and evidence of ongoing focus within clinical areas to drive improvements in practice. | |

**Key actions**

Ongoing programme of IP&C policy review to ensure alignment with national infection prevention & control manual for England and other national guidance. e.g.standard infection control precautions policy, high consequences infectious disease policy, policy for the management of patients with unexplained/unexpected diarrhoea and/or vomiting.

Ongoing focused IP&C education and awareness campaigns supported by internal and external communications plan.

Re-enforce processes to ensure all areas submit required audits to demonstrate assurance of IP&C practice standards and follow up/support provided by the IPT; this is improving.

Delivery of IPT work plan to support improvements in practice (e.g. MRSA focus in Q1 2024/25, Isolation care focus in Q2).

Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission.

Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement.

Monthly Infection Prevention Newsletter to provide updates/education and share learning.

## Pioneering research and innovation

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

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 4 x 2<br>8 | April<br>2022 | 3 x 3<br>9 | February<br>2025 | 3 x 2<br>6 | December<br>2025 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

### Current assurances and updates

This risk has been reviewed by the responsible executive in February 2025 with no revisions required to the risk rating, however the target date for full mitigation has been extended until the end of 2025 whilst assurance is gathered that the recent improvement in performance in Trust Board KPI national ranking is sustained.

| Key controls | Gaps in controls |
|---|---|
| Research strategy, approved by Board and fully funded.<br>Always improving strategy, approved by the board and detailing the UHS improvement methodology.<br>Partnership working with the University and other partners.<br>Clinical academic posts and training posts supporting strategies.<br>Secured grant money.<br>Host for new regional research delivery network, supporting regional working.<br>Local ownership of development priorities, supported by the transformation team. | Operational pressures, limiting time for staff to engage in research & innovation.<br>Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities.<br>Research priorities with partners not necessarily led by clinical or operational need.<br>Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Vacancies being filled, but R&D turnover still higher than Trust average or target. |
| **Key assurances** | **Gaps in assurances** |
| Governance structure surrounding University partnership.<br>Board to Council meetings. | Limited corporate approach to supporting innovation across the Trust. |

| | |
|---|---|
| Joint Senior operational group.<br>Joint Research Strategy Board.<br>Joint executive group for research.<br>Joint executive group for innovation.<br>Joint Innovations and Commercialisation Group – UHS/UoS.<br>Monitoring research activity funding and impact at R&D steering group.<br>MHRA inspection and accreditation.<br>Strategy and transformation process.<br>CQC review of well-led criteria, including research and innovation.<br>R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we are seeing the impact of the focus on our recruitment with improvement in our national performance: recruitment ranking has improved from 16th in 23/24 to 8th in September 2024, and weighted recruitment has improved from 13th in 23/24 to 10th in September 2024. | National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway. Now meeting Trust Board KPI for recruitment ranking (improvement from 16th in 23/24 to 8th September 2024) and weighted recruitment has improved (from 13th in 23/24 to 10th September 2024). |

**Key actions**

Staff survey to test staff engagement and understanding of innovation at UHS.

Deliver R&I Investment Case. Annual Plan approved by TB which includes investment RoI evaluation.

Established mechanisms to capture RoI on investment are now built into annual planning process. International Development Centre, attracting external funding to support staff in pursuing innovation.

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. WHP Annual Review starting to identify RoI, UHS ongoing commitment being sought for next 3 year term.

Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Staff engagement initiatives to be present to TBSS in February 2025.

Review the Trust's approach to corporate-wide innovation.

Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency. On-going improvement programme, but impact being felt as seeing improved recruitment ranking.

Joint Research Vision, developed with University of Southampton, went to Senior Operational Group in June 2024, and was finalised by the Joint Research Strategy Board in Q4 2024/25.

UHS led on a regional bid for an NIHR Commercial Clinical Research Delivery Centre (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. Links to review of corporate wide innovation approach above.

## World class people

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

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 4 x 4<br>16 | April<br>2022 | 4 x 5<br>20 | February<br>2024 | 4 x 3<br>12 | March<br>2026 |

**Risk progression:** (previous 12 months)

| Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

### Current assurances and updates

- This risk has been reviewed in February 2025 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. Planning for 2025/26 is now underway in line with national guidance, and to balance affordability and availability.
- As an additional mitigation to the financial pressures, UHS initiated MARS (Mutually Agreed Resignation Scheme) in line with national terms in January 2025. The deadline for applications closed in February and the organisation are now reviewing these and managing accepted exits.
- In November Unite union issued notice of a series of strike days throughout December and January, however through ongoing discussion and negotiation between UHS, portering staff and ACA, a deal was agreed and industrial action avoided. Work is underway to deliver a series of agreed actions.
- Similarly, discussions and negotiations have been ongoing with Unison regarding the national dispute around banding, duties and pay for band 2 and 3 HCA staff. Unison are consulting with their members throughout Q4 2024/25 on the resultant proposal.

| Key controls | Gaps in controls |
|---|---|
| New 5-year People Strategy and clear objectives for Year 2 monitored through POD.<br>Recruitment and resourcing processes.<br>Workforce plan and overseas recruitment plan.<br>General HR policies and practices, supported by appropriately resourced HR team.<br>Temporary resourcing team to control agency and bank usage.<br>Overseas recruitment including a reduced level of nurse vacancies. | Completion of objectives for South-East temporary collaborative for 2024/25 and beyond. |

| | |
|---|---|
| Recruitment campaign.<br>Apprenticeships.<br>Recruitment control process to ensure robust vacancy management against budget.<br>Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review).<br>Improved data reporting.<br>ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services.<br>ICB recruitment panel established to limit recruitment within HIOW for specific roles.<br>Affordable workforce limits have now been agreed with all divisions and THQ.<br>Workforce plan for 2024/25 submitted to ICB, planning for 2025/26 underway.<br>Plan for nursing recruitment agreed for 2024/25 including overseas recruitment, newly qualified recruitment, and domestic recruitment to ensure the overall nurse vacancy position is sustained. Planning for 2025/26 underway. | |
| **Key assurances** | **Gaps in assurances** |
| Fill rates, vacancies, sickness, turnover and rota compliance .<br>NHSI levels of attainment criteria for workforce deployment.<br>Annual post-graduate doctors GMC report.<br>WRES and WDES annual reports - annual audits on BAME successes.<br>Gender pay gap reporting.<br>NHS Staff Survey results and pulse surveys.<br>Joint finance and Workforce working group on data assurance.<br>Temporary staffing collaborative diagnostic analysis on effectiveness.<br>A system wide rostering audit has taken place across Hampshire and Isle of Wight, and UHS have now received the findings which provides strong, positive, assurance of our practice with continued opportunities around medical rostering and job planning. | Universal rostering roll out including all medical staff.<br>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.<br>Deliver workforce plan for 2024/25 including increasing substantive staff in targeted areas offset by reducing temporary agency spend.<br>To develop and implement Divisional Workforce Plans.<br>Completion of objectives for South-East temporary collaborative for 2024/25 and beyond.<br>To implement a range of programmes to ensure turnover remains below 13.6%.<br>To implement a range of measures to ensure our staff absence remains below 3.9%.<br>To implement a range of measures to improve medical deployment. Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. | |

| Linked operational risks | | | | |
|---|---|---|---|---|
| **No.** | **Title** | **Current risk rating** | **Target risk rating** | **Target Date** |
| 20 | Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection | 3 x 4 = 12 | 1 x 5 = 5 | 01/10/2025 |
| 67 | There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc. | 2 x 4 = 8 | 3 x 2 = 6 | 31/03/2025 |
| 86 | Reduced skill mix, education and experienced critical care nursing staff | 4 x 3 = 12 | 3 x 2 = 6 | 31/03/2025 |
| 167 | MRI physics staffing risk | 4 x 2 = 8 | 2 x 1 = 2 | 31/03/2025 |
| 180 | Lack of pathology staff and inappropriate skill mix | 3 x 4 = 12 | 3 x 2 = 6 | 31/07/2025 |
| 286 | Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service | 3 x 4 = 12 | 3 x 3 = 9 | 31/12/2024 |
| 458 | Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input. | 3 x 4 = 12 | 2 x 2 = 4 | 31/03/2025 |
| 604 | Risk in epilepsy nursing service | 3 x 3 = 9 | 2 x 2 = 4 | 18/06/2025 |
| 623 | Insufficient reporting capacity (Specialist radiologist reporters) | 4 x 3 = 12 | 2 x 1= 2 | 24/06/2025 |
| 646 | Reduced ACP Cover across Neurosciences care group | 3 x 3 = 9 | 4 x 1 = 4 | 28/02/2025 |
| 661 | Insufficient Medical staff to safely manage patient activity within cancer care | 4 x 3 = 12 | 2 x 3 = 6 | 31/10/2025 |
| 662 | Cellular Pathology Staffing and Capacity | 4 x 5 = 20 | 4 x 2 = 8 | 31/03/2025 |
| 711 | Insufficient staff resource in Robotic SFA to meet the Robotic service demand | 2 x 4 = 8 | 3 x 1 = 3 | 31/03/2025 |
| 712 | Risk to patient safety due to no designated junior doctors on the major trauma unit | 4 x 3 = 12 | 4 x 2 = 8 | 29/02/2024 |
| 726 | Ophthalmology clinical/AHP workforce | 4 x 3 = 12 | 4 x 1 = 4 | 31/01/2025 |
| 748 | There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service | 3 x 4 = 12 | 2 x 1 = 2 | 28/02/2025 |
| 776 | Insufficient clinical pharmacy workforce | 3 x 5 = 15 | 3 x 3 = 9 | 31/03/2025 |
| 782 | Paediatric dietetics staffing risk | 3 x 3 = 9 | 2 x 3 = 6 | 31/01/2025 |
| 785 | The provision of the congenital cardiac service in theatres may be affected due to high vacancy and slow throughput of learners | 3 x 2 = 6 | 3 x 1 = 3 | 31/03/2025 |
| 791 | Outpatients Administration Centre (OAC) - Staffing Risk | 3 x 3 = 9 | 2 x 3 = 6 | 31/03/2026 |
| 797 | Paediatric Speech and Language Therapy Staffing Risk | 3 x 3 = 9 | 2 x 3 = 6 | 03/03/2025 |
| 820 | CED consultant under staffing due to vacancies and also increased capacity | 4 x 3 = 12 | 3 x 1 = 3 | 31/04/2025 |
| 837 | Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs | 3 x 4 = 12 | 3 x 2 = 6 | 31/03/2026 |
| 844 | Patients may not receive lifesaving emergency cardiac surgery due to a lack of cardiac trained staff. | 4 x 4 = 16 | 4 x 1 = 4 | 31/03/2025 |
| 859 | Reduced Portering workforce (volume and skill/knowledge) due to industrial action may affect the operational ability of UHS to provide safe and efficient patient care | 3 x 5 = 15 | 3 x 1 = 3 | 31/03/2025 |

**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<br>*The current risk rating is within the tolerable risk appetite and the target risk rating is within the optimal risk appetite.* | Treat |

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 4 x 3<br>12 | April<br>2022 | 4 x 3<br>12 | February<br>2025 | 4 x 2<br>8 | March<br>2027 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 |

**Current assurances and updates**

- This risk has been reviewed in February 2025 with no revisions to the ratings or target dates required.
- Following allocation of charitable funding to refurbish the Muslim prayer facilities at UHS for both staff and patients, this work has been undertaken and was completed ahead of this year's Ramadan to ensure facilities were fit for purpose.
- A working group has been set up focussing on improving the working facilities for resident doctors to ensure a sense of belonging, and this has now been expanded to oversee facilities for all staff and to report into People Board. The group will also have oversight of the £250k expenditure from charity funding allocated to staff wellbeing.
- Staff survey results have been received and are currently in embargo. This will be lifted later in March and shared with People Board, TEC, and Trust Board for review and action.

| Key controls | Gaps in controls |
|---|---|
| **Great place to work including focus on wellbeing**<br>UHS wellbeing plan developed.<br>Guardian of Safe Working Hours.<br>Re-launched appraisal and talent management programme.<br>Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards.<br>Proud2BeAdmin & Proud2Bops campaigns and networks. | Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks.<br>Coverage of allyship training to increase to 80% compliance by 31/03/2025.<br>Launch of digital appraisal process.<br>Improving implementation of national improving working lives actions for junior doctors following national letter May 2024.<br>Organisational capability and capacity to fully support LID, external support being sought. |

| | |
|---|---|
| **Building an inclusive and compassionate culture**<br>Inclusion and Belonging Strategy signed off at Trust Board.<br>Creation of a divisional steering group for EDI.<br>FTSU guardian, local champions and FTSU policies.<br>Diversity and Inclusion Strategy/Plans.<br>Collaborative working with trade unions.<br>Launch of the strategic leaders programme with a cohort of 24 across UHS.<br>Senior leader programme launched.<br>Positive action programme completed – cohort 2. Cohort 3 advertised.<br>Nurse specific positive action programme also launched.<br>All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake.<br>A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments. | |
| **Key assurances** | **Gaps in assurances** |
| **Great place to work including focus on wellbeing**<br>Annual NHS staff survey and introduction of quarterly pulse engagement surveys.<br>Guardian of Safe Working Hours report to Board.<br>Regular communications monitoring report Wellbeing guardian.<br>Staff Networks.<br>Exit interview process.<br>Wellbeing Guardian and wellbeing champion.<br><br>**Building an inclusive and compassionate culture**<br>Freedom to Speak Up reports to Board.<br>Qualitative feedback from staff networks data on diversity.<br>Annual NHS staff survey and introduction of quarterly pulse engagement.<br>Listening events with staff, regular executive walkabouts, talk to David session.<br>Insight monitoring from social media channels.<br>Allyship Programme.<br>Gender Pay Gap reporting.<br>External freedom to speak up and employee relations review. | Maturity of staff networks<br><br>Maturity of datasets around EDI, and ease of interpretation<br><br>Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25.<br><br>NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area.<br>An independent external review has highlighted issues relating to culture, capability, and capacity within the UHS portering service. Work is underway to address these concerns including negotiations with the Unite union. |

| Key actions |
| --- |
| **Building an inclusive and compassionate culture**<br><br>Deliver year 2 objectives of the Inclusion and Belonging strategy by March 2025:<br><br>This includes:<br><br>• To get to 85% of all staff having completed the Actional Allyship Training by March 2025 (February 2025, 72%).<br><br>• To implement the 1st phase recommendations of the Inclusive Recruitment Programme<br><br>• To deliver improvement plan in terms of experience of people with disabilities and long-term illness.<br><br>• To deliver a programme of work to meet the NHSE Sexual Safety Charter standards and increase sexual safety at UHS.<br><br>• 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:<br>• Limited ability to recruit staff with suitable skills to support education;<br>• Lack of current national education financing and changes in the way the education contract will function;<br>• Inflexibility with apprenticeship regime; | This may be:<br>• A lack of development for staff affecting retention and engagement;<br>• Reduced staff skills and competencies;<br>• Inability to develop new clinical practices. | This could result in:<br>• An adverse impact of quality and effectiveness of patient care and safety;<br>• An adverse impact on our reputation as a university teaching hospital;<br>• Reduced levels of staff and patient satisfaction. |

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Long term target (I x L) | |
|---|---|---|---|---|---|
| 3 x 3<br>9 | April<br>2022 | 4 x 4<br>16 | February<br>2025 | 3 x 2<br>6 | March<br>2029 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 | 4 x 3<br>12 |

**Current assurances and updates**

This risk has been reviewed in February 2025 and the risk rating has increased from 12 (severe x possible) to 16 (severe x likely) due to the reduction in national funding for education and training, as well as the national planning guidance which sets out the intent to reduce the NHS corporate infrastructure which may have an impact on T&D. Accordingly the target for risk reduction has also been reviewed and has been extended from 2027 to 2029.

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

| | |
|---|---|
| Escalation to NHSE with offer to assist in identifying future solutions. | National CPD guidance for 2024/25: scope of application is limited by rigid national rules.<br><br>New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included.<br><br>Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships. |
| **Key assurances** | **Gaps in assurances** |
| Annual Trust training needs analysis reported to executive.<br>Trust appraisal process<br>GMC/NETs Survey<br>Education review process with NHSE WTE.<br>Utilisation of apprenticeship levy.<br>Talent development steering group<br>People Board reporting on leadership and talent, quarterly | Need to develop quantitative and qualitative measures for the success of the leadership development programme.<br>Review of implications for education and training infrastructure from national workforce plan.<br>There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities. |

**Key actions**

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

A review is underway within T&D to look at the infrastructure and longterm workforce plan.

| Linked operational risks | | | | |
|---|---|---|---|---|
| **No.** | **Title** | **Current risk rating** | **Target risk rating** | **Target Date** |
| 173 | Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training. | 3 x 3 = 9 | 3 x 1 = 3 | 31/12/2025 |
| 833 | Safeguarding children Statutory Training Compliance Levels are below required. | 4 x 3 = 12 | 4 x 1 = 4 | 31/05/2025 |

## Integrated networks and collaboration

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

| **Monitoring committee:** Quality Committee | **Executive leads:** CEO, CMO, Director of Strategy & Partnerships |
|---|---|

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Long term target (I x L) | |
|---|---|---|---|---|---|
| 3 x 3<br>9 | April<br>2022 | 3 x 3<br>9 | February<br>2025 | 3 x 2<br>6 | Dec<br>2025 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 | 3 x 3<br>9 |

### Current assurances and updates

This risk has been continually reviewed and updated with the executive leads throughout 2024/25 and 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.

During the latest review it has been considered whether the target date for risk mitigation, which is April 2025, should be revised. Subsequently this has been extended until the end of 2025 as whilst a number of key actions and targeted areas of risk reduction have completed, for example within Ophthalmology with the introduction of the single point of access for cataract referrals, work remains ongoing in other key specialities such as Upper GI as discussions take place to align views and agree a model.

Work is also ongoing to enhance the process to proactively identify risk within elective waiting lists across the system and plan ahead to address this collaboratively in a structured manner. This is facilitated through introduction of a singular database across HIOW which allows modelling by both provider and speciality, thus ensuring that provision of care is responsive to patient need and that the right patient is seen in the right place and at the right time.

| Key controls | Gaps in controls |
|---|---|
| • Key leadership role within local ICS<br>• Key leadership role within local networked care and wider Wessex partnership<br>• UHS strategic goals and vision<br>• Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes.<br>• Establishment of UHS Integrated Networks and Collaboration Board<br>• Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner | • Potential for diluted influence at key discussions<br>• Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local.<br>• Engagement and pace from organisations we are looking to partner with is not within our control.<br>• Resource within the UHS clinical programme team can prove challenging.<br>• Resource and capacity within clinical services can also prove difficult, for example pelvic floor has been chosen as a clinical speciality focus, however |

| | |
|---|---|
| organisations to agree priorities and ensure there is executive commitment to delivering network models.<br>• ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor.<br>• Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to.<br>• Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward.<br>• Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list. Positive outcomes are being seen from this work as UHS has successfully increased the number of cataract operations undertaken which has resulted in an increased number of referrals due to reduced waiting times, with NHS referrals now outweighing private referrals Further targeted work includes introduction of a Single Point Of Access for ENT to establish a network for procedures of limited clinical value. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy.<br>• Network arrangements in Urology, pelvic floor and plastics have also been prioritised for focus during 2024/25.<br>• A new programme oversight role has been appointed to the ICB to enable progress on clinical networks. We are engaging with this post; sharing priorities, opportunities and challenges with a view moving forward networks within HIOW ICB.<br>• The 'Acute Clinical Services Operating Model programme' has been initiated with agreed focus areas from providers and the ICB, these are Breast surgery, Upper GI, Pelvic floor, Urology, Ophthalmology, Dermatology and Orthodontics.<br>• ICS oversight of waiting lists and forecasts in addition to provider level intelligence. | capacity at UHS is a challenge as evidenced on the operational risk register. |
| **Key assurances** | **Gaps in assurances** |
| • CQC and NHSE/I assessments of leadership<br>• CQC assessment of patient outcomes and experience<br>• National patient surveys<br>• Friends and Family Test<br>• Outcomes and waiting times reporting. Included within cases for change being built for networks.<br>• Integrated networks and collaborations Board set up for regular meetings at executive level. | • Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking.<br>• Specialised Commissioning budget delegation deferred externally until April 2025.<br>• Ability to network is difficult and manifests in capacity challenges.<br>• Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track. |
| **Key actions** | |

Urology Area Network plan agreed. Progress had stalled due to lack of programme management resource and clinical lead stepping down. This programme has now picked up again and new workstreams have been agreed. Challenges to moving forward related to aligning clinician's availability across multiple organisations.

Business case for future working of the Southern Counties Pathology Network due for consideration by Trust Board with a CFO/COO workshop planned for the end of Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment.

Business case for a Southampton elective hub has been written and approved at TIG and Trust Board, with a letter of support provided by the ICB as well. Capital funding has been set aside and plans have been sent to NHSE for approval, with the aim of opening this in April 2026.

NHSE has approved the business case for the Winchester Elective Hub however the government funding has now been delayed, likely to be 2037, There will be a need to consider clinical reconfigurations to bridge this gap however a forum hasn't yet been established.

Mr AK, Ophthalmology clinical lead, leading ongoing improvement work focussed on theatre productivity and point of access for cataract referral. This has been established and NHS provision of cataract care has increased from 40% to 72%, with all patients waiting less than 10 weeks for treatment.

A high level options paper has been developed for Upper GI across UHS and UHD. This has been shared with executives and broadly agreed between CMOs and Directors of strategy. A detailed options appraisal to follow this which UHS are committed to provided, but will require continued engagement from UHD too. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this.

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

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

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

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

Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2032 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this.

**Foundations for the future**

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

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

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

| Cause | Risk | Effect |
|---|---|---|
| Due to existing and growing financial pressures including unfunded activity growth, system pressures (NCtR), workforce growth above funded levels, and challenges with the NHS payment infrastructure. | There is a risk that we will be unable to deliver a financial breakeven position; | This may result in the measures outlined above regarding the Recovery Support Programme, and the Trust's inability to invest and grow due to a reducing cash balance. |
| **Category** | **Appetite** | **Status** |
| Finance | Cautious<br>*The current risk rating sits outside of the stated risk appetite, however the 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<br>20 | April<br>2022 | 4 x 5<br>20 | February<br>2025 | 3 x 3<br>9 | April<br>2030 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 3 x 5<br>15 | 4 x 5<br>20 | 4 x 5<br>20 |

**Current assurances and updates**

- This risk has been reviewed and updated by the Chief Finance Officer in February 2025. The risk rating remains at 20 (severe x certain) considering the significant and sustained fiscal pressures present within the organisation and wider system. Following discussion at the Finance & Investment Committee the target date for risk reduction has also been extended from April 2026 to April 2030, although it is acknowledged that incremental risk reduction is anticipated between now and then.
- These pressures are evidenced through the recent escalation of HIOW ICS into segment 4 of the Recovery Support Programme. This has triggered the initiation of the Investigation & Intervention (I&I) regime, and subsequent appointment of Deloitte to facilitate this process within the system. UHS are currently engaging with Deloitte to rapidly identify key opportunities for improvement and implement these in the upcoming weeks and months. Alongside this, the organisation is also engaging with the national recovery programme support team to ensure adherence to the financial playbook.
- Following the cash flow forecast review undertaken and reviewed at the Finance & Investment Committee in December 2024, it is anticipated that the organisation will need to request cash support from NHSE in Q1 2025/26. To continuously monitor the cash forecast, the review will be repeated every two months.
- As planning for 2025/26 is underway, an additional Trust Executive Committee (TEC) was held in January 2025 to identify opportunities for improvement schemes in the coming year, with 10 schemes selected for exploration to determine feasibility, benefits and risks. Agreed schemes will be supported by the Improving Value transformation programme which is being established, with governance and oversight from the Improving Value Board and Transformation Oversight Group.
- Following the financial self-assessment undertaken and submitted to NHSE in June 2024, NHSE had written to the HIOW ICB to express concern that boards have not fully complied with their undertakings to date and further work and improvements are required. In response, a further self-assessment has been undertaken at UHS and submitted to the HIOW ICB who in turn shared this with the NHSE regional team in January 2025. Within the self-assessment, as an organisation we have declared that we are partially assured and now await feedback from NHSE.

- UHS have submitted a Financial Recovery Plan to HIOW ICB and NHS England which has been agreed. This includes actions required by UHS as well as what needs to be true in the wider system to deliver an ongoing break-even position. Subsequently a landing plan has been developed for 2025/26 with key milestones to track delivery of the plan.
- In January 2025 UHS launched the Mutually Agreed Resignation Scheme in line with national terms, with voluntary applications accepted for consideration until 14 February 2025.
- An emerging risk has been identified in relation to the newly established ceiling for paid activity within the elective payment framework, which poses a risk that UHS will not receive payment for all elective work delivered. Mitigations are currently being agreed and implemented including agreement and movement of organisational ceilings across the system, and potential reduction of work outsourced to independent providers.

| Key controls | Gaps in controls |
|---|---|
| **Internal**<br>• Financial strategy and Board approved financial plan.<br>• Trust Savings Group (TSG) oversight of CIP programme. (To be replaced by the Improving Value Board in 2025/26).<br>• Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits.<br>• Implementation of revised recruitment controls, including setting revised divisional Affordable Workforce Limits<br>• Robust business planning and bidding processes<br>• Robust controls over investment decisions via the Trust Investment Group and associated policies and processes<br>• Monthly VFM meetings with each Care Group<br>• Bi Monthly cash flow forecast review. Improving Value transformation programme.<br>• Mutually Agreed Resignation Scheme<br><br>**System wide/external**<br>Financial Recovery Programmes / Transformation Programmes:<br>• Planned Care<br>• Urgent & Emergency Care<br>• Discharge<br>• Local Care<br>• Workforce<br>• Mental Health<br>Formation of new Delivery Units & mapping of UHS resources to support delivery.<br>Improved “grip and control” measures with consistent application across all organisations. | **Internal**<br>• Remaining unidentified and high-risk schemes within CIP programme.<br>• Ability to control and reduce temporary staffing levels.<br>**System wide/external**<br>• Elements of activity growth unfunded via block contracts.<br>• Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance. |
| **Key assurances** | **Gaps in assurances** |
| • Regular finance reports to Trust Board & F&IC.<br>• Full financial report for the system to Trust Board.<br>• Divisional performance on cost improvement reviewed by senior leaders – quarterly.<br>• Trust Savings Group / Improving Value Board oversight of financial recovery plan and CIP programme actions | • Current short-term nature of operational planning<br>• System wide plans under development to work collaboratively focussing on reduction in NCTR, and mental health, however there remains a lack of assurance around the detail to ensure delivery.<br>• Lack of reporting on system transformation initiatives to individual Trust Boards. |

| | |
|---|---|
| • F&IC visibility and regular monitoring of detailed savings plans<br>• Capital plan based on cash modelling to ensure affordability.<br>• Regular reporting on movements in overall productivity.<br>• Bi-monthly cash reporting to F&IC. | • Concern over any further industrial action not incorporated into plan. |
| **Key actions** | |
| • Finalise 24/25 plan to be agreed with NHSE - complete<br>• Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete.<br>• Reset CIP and transformation programmes based on 24/25 targets - complete.<br>• Review formation of Delivery Units to support system transformation programmes.<br>• Reset organisational focus onto flow, theatres and outpatients' transformation programmes.<br>• Establish and deliver the Improving Value transformation programme.<br>• Engage with Deloitte and the HIOW ICS in the I&I regime and deliver agreed outputs.<br>• Deliver on the HIOW ICS landing plan.<br>• Adherence with the national financial playbook.<br>• Continue to implement and monitor workforce controls throughout 2025/26 to slow growth and reduce spend.<br>• Review of non-pay spend with Deloitte and implementation of agreed next steps.<br>• Planning for 2025/26. | |

**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<br>*The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.* | Treat |

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Long term target (I x L) | |
|---|---|---|---|---|---|
| 4 x 4<br>16 | April<br>2024 | 4 x 5<br>20 | February<br>2025 | 4 x 2<br>8 | April<br>2030 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 4<br>16 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 | 4 x 5<br>20 |

**Current assurances and updates**

This risk has been reviewed with the Chief Operating Officer, and Director of Estates, Facilities and Capital Development, in February 2025 with minor amendments made. The target date for mitigation of the risk has been extended from 2027 to 2030 in recognition of the fact this continues to be a critically rated risk for the organisation with the limiting factor in mitigation being adequate funding. A comprehensive board paper detailing this further will be shared with the Finance & Investment Committee shortly and work is underway to assess the individual operational risks identified in the most recent six facet survey.

| 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. Requires new CAFM system installing to fully understand gaps and address outstanding assets. |
| | 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 | Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work. |
| Asset replacement programme | |

| | |
|---|---|
| Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)<br>Six Facet survey of estate informing funding and development priorities<br>Estates masterplan 22-23 approved.<br>Clear line of sight to Trust Board for all risks identified. | Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits.<br>Derogation policy to be introduced.<br>Lack of Estates strategy for the next 5 years.<br>Missing funding solution to deliver strategy. |
| **Key assurances** | **Gaps in assurances** |
| Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight<br>Patient-Led Assessments of the Care Environment. Reported to QGSG.<br>Statutory compliance audit and risk tool for estates assets<br>Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey<br>Quarterly updates on capital plan and prioritisation to the Board of Directors | The annual six facet survey has recently been completed and is being used to facilitate risk-based prioritisation of funding through the Trust Investment Group (TIG). This has highlighted 17 new operational risks which are being assessed ahead of addition to the operational risk register. |
| **Key actions** | |
| Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn, but this is currently under consideration as to how to move this forward.<br>Identify future funding options for additional capacity in line with the site development plan.<br>Delivery of 2024/25 capital plan.<br>2025/26 capital planning.<br>Implement the HIOW elective hub.<br>Deliver £4.2m of critical infrastructure backlog maintenance. £3.5m in 2025/26.<br>Agree plan for remainder of Adanac Park site<br>Site development plan for Princess Anne hospital. | |

**Linked operational risks**

| No. | Title | Initial Date | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|---|
| 16 | Estates Maintenance PPM Programme | 26/06/2019 | 4 x 2 = 8 | 4 x 1 = 4 | 28/11/2025 |
| 75 | Site wide electrical infrastructure resilience | 05/03/2019 | 4 x 3 = 12 | 4 x 1 = 4 | 31/01/2025 |
| 157 | Site wide electrical infrastructure resilience, HV and LV. | 05/03/2019 | 4 x 3 = 12 | 4 x 1 = 4 | 30/11/2024 |
| 260 | Insufficient space in the induction of Labour Suite. | 28/10/2019 | 4 x 4 = 16 | 3 x 1 = 3 | 31/12/2025 |
| 421 | There is a risk that the Trust does not appropriately manage or maintain its assets. | 28/08/2020 | 4 x 3 = 12 | 4 x 1 = 4 | 30/06/2025 |
| 489 | Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures | 07/02/2021 | 5 x 3 = 15 | 5 x 1 = 5 | 31/03/2026 |
| 727 | Black start electrical test | 25/07/2023 | 5 x 2 = 10 | 5 x 1 = 5 | 30/11/2024 |

| | | | | | |
|---|---|---|---|---|---|
| 732 | Sitewide obsolete nurse call systems | 08/08/2023 | 4 x 3 = 12 | 4 x 1 = 4 | 30/04/2025 |
| 773 | Impact of the Building Safety Act (2022) on Capital Project Delivery | 24/01/2024 | 3 x 3 = 9 | 3 x 2 = 6 | 30/05/2025 |
| 817 | Lack of UPS backup on power failure | 28/05/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 31/03/2025 |
| 818 | Centralised Chilled water system - power supply resilience | 28/05/2024 | 5 x 2 = 10 | 5 x 1 = 5 | 31/03/2025 |
| 846 | PAH – General ward areas and Neonatal Unit air handling units beyond service life | 11/10/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 851 | Lab and Path Chiller 1 Aged and Not Operational | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 853 | Lab and Path Chilled Water Pumps | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 854 | P.M.S Computer room AC Chillers | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 855 | West Wing SHDU AC Units - Beyond Service Life | 06/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 01/12/2025 |
| 856 | Non-compliant & unmaintainable fire dampers in West wing | 12/11/2024 | 5 x 3 = 15 | 5 x 1 = 5 | 31/08/2025 |
| 861 | PICU Computer hub gas suppression system faults alongside various breaches in fire compartmentation and fire stopping. | 18/12/2024 | 5 x 2 = 10 | 5 x 1 = 5 | 31/05/2025 |
| 875 | John Atwell ward, Single means of fire escape, non-compliant to HTM 05:02, Fire safety legislation. | 11/02/2025 | 5 x 2 = 10 | 5 x 1 = 5 | 31/12/2025 |
| 876 | Fire-fighting dry riser water supply accessibility to Urology Centre, Day surgery unit, is non compliant to HTM 05:02, current Fire legislation. | 11/02/2025 | 5 x 2 = 10 | 5 x 1 = 5 | 31/12/2025 |

**Foundations for the future**

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

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

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

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

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Target risk rating (I x L) | |
|---|---|---|---|---|---|
| 3 x 4<br>12 | April<br>2022 | 4 x 3<br>12 | February<br>2025 | 3 x 2<br>6 | April<br>2027 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 | 3 x 4<br>12 |

**Current assurances and updates**

This risk has been reviewed with the Chief Operating Officer and Chief Information Officer in February 2025. The risk rating and target has been confirmed to be correct with no alterations required.

Key actions which are progressing which aid in mitigation of this risk are:

- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience. The air conditioning for the A-Level communications room is also now under review.
- The rollout of the Windows 11 and RAM upgrade is progressing well with over 900 devices upgraded and 1000 devices replaced. A plan has been developed for the remaining 2,300 devices which require replacement – leveraging preferential pricing – to be discussed at the February TBSS.
- Cyber software upgrades are being accelerated using investment from 2024/25 capital.

| Key controls | Gaps in controls |
|---|---|
| **Failure in physical network infrastructure**<br>• All Digital UPS tested.<br>• Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this.<br>• Replacement of key infrastructure on a case-by-case basis once it fails. | **Failure in physical network infrastructure**<br>• The current Data Centre is end of life and requires a capital plan for replacement.<br>• There is currently no phased replacement of switch and network equipment due to absence of funding.<br>• Windows 10 is end of life in October 2025 with no funding available to replace all devices with Windows 11. Some mitigations underway and |

| | |
|---|---|
| | ongoing including purchase of additional RAM and hard drives, and upgrading suitable equipment, however not all equipment is suitable for this. |
| **Cyber Risk**<br>• Cyber security infrastructure refreshed and in place.<br>• Staff training on cyber risks, with regular refreshers and clear policies.<br>• Key cyber roles recruited to, with one remaining outstanding. | **Cyber Risk**<br>• Funding: cyber security and recovery capability requires ongoing investment and development.<br>• Ability to enforce more robust training due to lack of time for staff training.<br>• Penetration testing contract being pulled forward to 2024/25. |
| **Single points of failure in staffing**<br>• Partial implementation of Digital workforce plan.<br>• Prioritisation of key posts.<br>• Upskilling existing staff to provide cross cover. | **Single points of failure in staffing**<br>• Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry. |
| **Implementation and sustainability of digital technology**<br>• Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout planned for 2025/26.<br>• Single EPR business case via NHS England EPR Investment Board. | **Implementation and sustainability of digital technology**<br>• Funding to cover the development programme, improvements, and clinical priorities. |
| **Loss of access to critical IT systems**<br>• Absolute back-ups of data created.<br>• Business continuity plans developed for Digital team and Wards.<br>• Robust system and regression testing completed on system developments.<br>• Scenario testing completed. | **Loss of access to critical IT systems**<br>• Time to fully stress test business continuity plans. |
| **Key assurances** | **Gaps in assurances** |
| Finance oversight provided by the Finance and Investment Committee.<br>Quarterly Digital Board meeting, chaired by the CEO.<br>Digital risks and actions reviewed weekly on UHS Digital leadership team call.<br>UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams.<br>UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc). | Funding to cover the development programme, improvements, and clinical priorities.<br>Difficulties in understanding benefits realisation of digital investment.<br>ICS digital strategy yet to be agreed.<br>UHS digital strategy to be reviewed (runs until 2026 but requires prior review).<br>Digital team provide guidance to clinical services developing BCPs but the team do not review these at service/ward level due to time and capacity. |

| | |
|---|---|
| Standardised change control, testing, and assurance processes implemented across the Development team.<br>NHSE annual DPST assessment completed to highlight gaps in services.<br>Business Continuity Plans in place for clinical areas in the event of IT outages. | |

**Key actions**

- Ongoing recruitment of key Digital resource to mitigate operational risk.
- Inpatient noting for doctors scheduled for 2025/26.
- Replacement of key clinical systems to more modern systems: Alcidion scheduled in April 2025
- Lessons learned from LIMS project being shared across UHS Digital, Estates, and other major project teams.
- Procurement of Single EPR across HIOW to provide a more modern EPR.
- Identify opportunities for funding for digital transformation and programmes.
- Acceleration of cyber software upgrades.

**Linked operational risks**

| No. | Title | Current risk rating | Target risk rating | Target Date |
|---|---|---|---|---|
| 129 | Workforce Resourcing - UHS does not have sufficient Clinical Safety Officer cover for deployment and use of clinical systems.<br>This is detailed within legislation:<br>- DCB0129: Clinical Risk Management - Its Application in the Manufacture of Health IT Systems, and<br>- DCB0160: CRM - Its Application in the Deployment and Use of Health IT Systems. | 4 x 3 = 12 | 2 x 2 = 4 | 31/03/2025 |
| 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 | 20/01/2025 |
| 556 | Workforce Resourcing - Risk to provision of Pathology test results (all departments) if there are delays or errors in the implementation of the new Path IT system | 4 x 3 = 12 | 4 x 1 = 4 | 31/12/2024 |
| 634 | Accommodation / Infrastructure - Fibre optic cabling at the ONH | 4 x 3 = 12 | 4 x 3 = 12 | 29/09/2025 |
| 650 | Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems. | 4 x 4 = 16 | 3 x 1 = 3 | 29/09/2025 |
| 653 | Accommodation / Infrastructure - No suitable IT storage and distribution space available within the footprint of SGH | 3 x 4 = 12 | 3 x 3 = 9 | 27/01/2025 |
| 676 | Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk. | 4 x 4 = 16 | 2 x 3 = 6 | 31/12/2025 |
| 677 | Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure. | 5 x 3 = 15 | 2 x 3 = 6 | 30/12/2024 |
| 679 | Accommodation / Infrastructure - Single point of failure on the UHS network (external connections) | 4 x 3 = 12 | 4 x 1 = 4 | 31/03/2026 |
| 709 | Workforce Resourcing - There is inconsistency in the sharing and coding of co-morbidities, diagnoses, allergies and past medical history within and between different clinical systems - potentailly resulting in critical patient information being missed pre, during and post treatment | 3 x 4 = 12 | 2 x 1 = 2 | 30/12/2024 |
| 736 | Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps | 3 x 4 = 12 | 1 x 2 = 2 | 29/09/2025 |

| | | | | |
|---|---|---|---|---|
| 757 | Cyber Security – If there are unsupported server operating systems this could expose the Trust to cyber attack. | 4 x 2 = 8 | 2 x 1 = 2 | 31/12/2024 |
| 800 | Cyber security – Clinical care may be compromised if data cannot be accessed via the iPads in secondary locations. | 3 x 4 = 12 | 2 x 1 = 2 | 30/12/2024 |
| 802 | Accommodation / Infrastructure - A/C in the A Level comms room (DR) | 3 x 3 = 9 | 2 x 2 = 4 | 30/12/2024 |
| 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, as well as adding to risks of worse health for our local population and staff, and increased risk of major climate change consequences. | Resulting in higher costs, reduced national standing and reduced resilience to climate change |
| **Category** | **Appetite** | **Status** |
| Technology & Innovation | Open<br>*Both the current and target risk rating is within the optimal risk appetite.* | Treat |

| Inherent risk rating (I x L) | | Current risk rating (I x L) | | Long term target (I x L) | |
|---|---|---|---|---|---|
| 2 x 3<br>6 | April<br>2022 | 2 x 3<br>6 | February<br>2025 | 2 x 2<br>4 | December<br>2027 |

| **Risk progression:** (previous 12 months) | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 | 2 x 3<br>6 |

**Current assurances and updates**

The risk has been reviewed in February 2025 by the responsible executive and the organisation's sustainability leads. The target date for risk mitigation has been extended from 2024 to 2027 as whilst there is assurance that the risk of not reducing direct emissions is very low and well managed, there is less assurance in relation to indirect emissions as this is more challenging to address.

Successful bids for external funding continue to be key to mitigation of tis risk, to allow progression of plans of key projects such as the movement from gas boilers to more energy efficient heat pumps. Work to reduce consumption also continues, for example a recent initiative to reduce use of single use oxygen probes in ED.

The organisation's Green Plan is also a key control and is currently under review and will be reviewed at April's sustainability board with the intent of ratifying this by July.

It is also noted that whilst the majority of planned programmes of work funded by the public sector decarbonisation scheme has progressed, there have been challenges in the steam duct programme which has meant that further work in the lab and path block has now been put on hold.

| Key controls | Gaps in controls |
|---|---|
| Governance structure including Sustainability Board<br><br>Clinical Sustainability Lead<br>Head of Sustainability and Energy<br><br>Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post.<br><br>Green Plan 2022-2025. | Clinical Sustainability Plan/Strategy (CSP)<br><br>Long-term energy/decarbonisation strategy<br><br>Communications plan.<br><br>Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change – TIG paper due March 2025 with a proposal to address this. |

| | |
|---|---|
| | 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.<br>Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.<br>Quarterly reporting to NHS England and NHS Improvement on sustainability indicators.<br>Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.<br>Sustainability Board | Definition of and reporting against key milestones. |
| **Key actions** | |
| Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore Low carbon skills funding)<br><br>Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme.<br><br>Continue to further develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies.<br><br>Finalise energy performance contract to deliver a responsive and progressive energy plan. | |

University Hospital Southampton
NHS Foundation Trust

| Agenda Item 7.2 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Register of Seals and Chair's Actions Report |
| **Sponsor:** | Jenni Douglas-Todd, Trust Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.

The Board has agreed that the Chair may undertake some actions on its behalf.

There have been no Chair's actions since the last report.

The report provides compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.

**Contents:**

Report

**Risk(s):**

N/A

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

## 1 Signing and Sealing

1.1 **Duty of Care Deed** between Creagh Concrete Products Limited (the Sub-contractor), Willmott Dixon Construction Limited (the Contractor) and University Hospital Southampton NHS Foundation Trust (the Beneficiary) relating to a new Sterile Services Facility and Aseptic Pharmacy and Offices at Adanac Park, Nursling, Southampton. Seal number 286 on 14 January 2025.

1.2 **Duty of Care Deed** between Snashall Steel Fabrications Company Limited (the Sub-contractor), Willmott Dixon Construction Limited (the Contractor) and University Hospital Southampton NHS Foundation Trust (the Beneficiary) relating to a new Sterile Services Facility and Aseptic Pharmacy and Offices at Adanac Park, Nursling, Southampton. Seal number 287 on 14 January 2025.

1.3 **Duty of Care Deed** between Mitie Technical Facilities Management Limited (the Sub-contractor), Willmott Dixon Construction Limited (the Contractor) and University Hospital Southampton NHS Foundation Trust (the Beneficiary) relating to a new Sterile Services Facility and Aseptic Pharmacy and Offices at Adanac Park, Nursling, Southampton. Seal number 288 on 14 January 2025.

1.4 **Licence to Alter** between University Hospital NHS Foundation Trust (Superior Landlord), Canada Life Limited (Landlord) and University Hospital Southampton NHS Foundation Trust (Tenant) relating to the Multi-Storey Car Park, Southampton General Hospital, Tremona Road, Southampton, SO16 6YD. Seal numbers 289 and 290 on 29 January 2025.

1.5 **Lease** between The University of Southampton Science Park Limited (Landlord) and University Hospital Southampton NHS Foundation Trust (Tenant) relating to Unit 29, The Innovation Centre, 2 Venture Road, The University of Southampton Science Park, Southampton, for the office space to be occupied by NIHR ARC Wessex. Seal number 291 on 25 February 2025.

## 2 Recommendation

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

University Hospital Southampton NHS Foundation Trust

| Agenda item 7.3 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Committee Terms of Reference |
| **Sponsor:** | Keith Evans, Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

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 Code of Governance for NHS Provider Trusts requires that Council of Governors is consulted on the terms of reference. The terms of reference are approved by the Board of Directors.

It is proposed to amend 10.2 to Code of Governance for NHS Provider Trusts and remove Charitable Funds Committee from Appendix A.

No other changes are proposed.

The terms of reference have been reviewed by the Audit and Risk Committee on 20 January 2025.

The Council of Governors has been consulted on this change on 29 January 2025.

The Board of Directors is asked to approve the terms of reference.

**Contents:**

Revised Terms of Reference (marked up)

**Risk(s):**

N/A

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

# Audit and Risk Committee Terms of Reference

**Version:** ~~6~~7

| | |
|---|---|
| **Date Issued:** | ~~29 February 2024~~ 11 March 2025 |
| **Review Date:** | ~~30 January 2025~~ January 2026 |
| **Document Type:** | Committee Terms of Reference |

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## 1. Role and Purpose

1.1 The Audit and Risk Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and the external and internal audit functions.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

## 2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board 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 will primarily utilise the work of internal audit, external audit and other assurance functions. It is also 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 independent non-executive directors of the Trust (other than the chair of the Board). The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

3.2 The Board will appoint the chair of the Committee from among its members (the **Committee Chair**).The Committee Chair may be the deputy chair of the Board. However, in the event that the deputy chair must act as chair of the Board for an extended period of time, the deputy chair will resign as Committee Chair. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.3.1 representative(s) from the external auditor;

3.3.2 representative(s) from the internal auditor;

3.3.3 representative(s) from the local counter fraud service;

3.3.4 Chief Financial Officer;

3.3.5 Chief Nursing Officer; and

3.3.6 Associate Director of Corporate Affairs/Company Secretary.

3.4 The Chief Executive Officer will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 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 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be two members. 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.

## 5. Frequency of Meetings

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

5.2 At least once each financial year the Committee will meet with representatives of the external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.3 Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including the chair of the Board, the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the external audit lead partner and the head of internal audit.

## 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, or at the request of external or internal auditors if they consider it necessary.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer and the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five 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.

### 7.1 *Integrated Governance, Risk Management and Internal Control*

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

7.1.1.1 all risk and control related disclosure statements (in particular the annual governance statement), together with the head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;

7.1.1.2 the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of annual disclosure statements; and

7.1.1.3 the policies and arrangements for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self-certifications, including the NHS Constitution, the Trust's NHS provider licence, registration with the Care Quality Commission and the Trust's constitution, standing orders and standing financial instructions and management of conflicts of interest.

### 7.2 *Internal Audit*

7.2.1 The Committee will ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board. This will be achieved by:

7.2.1.1 considering the provision of the internal audit service and the costs involved;

7.2.1.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in any risk assessment;

7.2.1.3 considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;

7.2.1.4 ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and

7.2.1.5 monitoring the effectiveness of internal audit and carrying out an annual review.

### 7.3 *External Audit*

7.3.1 The Committee will review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

7.3.1.1 considering the appointment and performance of the external auditors, including providing information and recommendations to the council of governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the council of governors and the Committee;

7.3.1.2 discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

7.3.1.3 discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;

7.3.1.4 reviewing all external audit reports, including reports addressed to the Board and the council of governors, and any work undertaken outside the annual external audit plan, together with any significant findings and the appropriateness and implementation of management responses; and

7.3.1.5 ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

7.4 ***Financial Reporting***

7.4.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.4.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

7.4.3 The Committee will review the annual report and financial statements before these are presented to the Board in order to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board. This review will cover but is not limited to:

7.4.3.1 the annual governance statement and other disclosures relevant to the work of the Committee;

7.4.3.2 areas where judgment has been exercised;

7.4.3.3 appropriateness and adherence to accounting policies and practices;

7.4.3.4 explanation of estimates or provisions having material effect and significant variances;

7.4.3.5 the schedule of losses and special payments, which will also be reported on separately during the financial year;

7.4.3.6 any significant adjustments resulting from the audit and unadjusted audit differences; and

7.4.3.7 any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.4 The Committee will provide advice, where requested by the Board, on whether the annual report and accounts, taken as a whole, are fair, balanced and understandable, and provide the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy.

7.5 ***Counter Fraud***

7.5.1 The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

7.6 ***Raising Concerns/Freedom to Speak Up***

7.6.1 The Committee will review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns and possible improprieties in

financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently with appropriate follow-up action and safeguards in place for those who raise concerns.

7.6.2 The Committee will ensure that the Trust's policy reflects the minimum standards for raising concerns set out by NHS Improvement and that the arrangements in place are regularly audited.

## 8. Accountability and Reporting

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

8.2 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

8.2.1 the fitness for purpose of the board assurance framework;

8.2.2 the completeness and maturity of risk management in the Trust;

8.2.3 the integration of governance arrangements;

8.2.4 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 The Trust's annual report will include a section describing the work of the Committee in discharging its responsibilities including:

8.3.1 the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;

8.3.2 an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and

8.3.3 if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

## 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 in consultation with the council of governors.

## 10. References

10.1 National Health Service Act 2006

10.2 ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts

10.3 NHS Foundation Trust Annual Reporting Manual

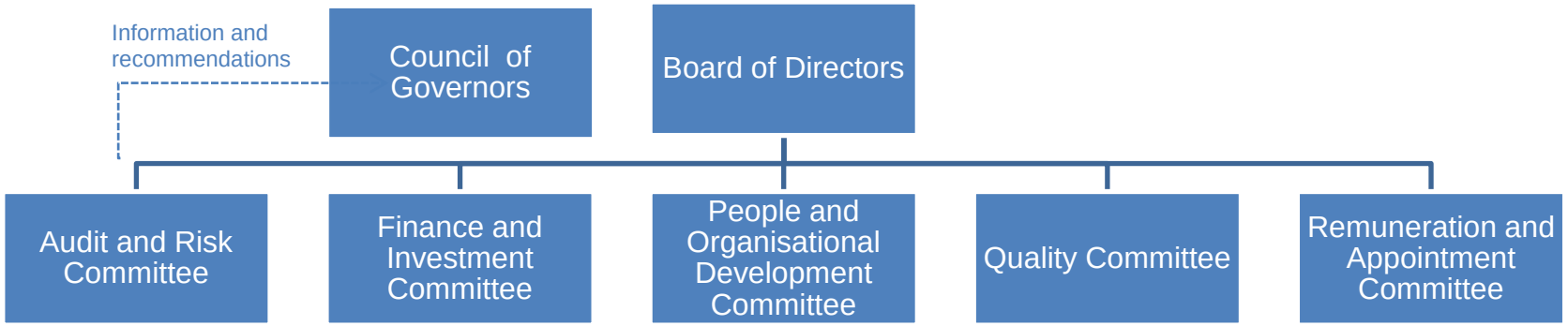
10.4 National Audit Office Code of Audit Practice

10.5 Public Sector Internal Audit Standards

10.6 NHS Counter Fraud Authority's counter fraud standards

10.7 NHS Improvement guidance on Freedom to Speak Up

**Appendix A**


Information and recommendations
Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee

| Document Monitoring Information | |
|---|---|
| **Approval Committee:** | Board of Directors |
| **Date of Approval:** | ~~29 February 2024~~ 11 March 2025 |
| **Responsible Committee:** | Audit and Risk Committee |
| **Monitoring (Section 9) for Completion and Presentation to Approval Committee:** | ~~January 2025~~January 2026 |
| **Target audience:** | Board of Directors, Audit and Risk Committee, NHS Regulators, Staff and Public |
| **Key words:** | Audit, Risk, Committee, Board, Terms of Reference |
| **Main areas affected:** | Trust-wide |
| **Summary of most recent changes if applicable:** | ~~Addition of para 7.4.4~~Amendment of 10.2 to Code of Governance for NHS Provider Trusts and the removal of Charitable Funds Committee from Appendix A. No other changes. |
| **Consultation:** | Council of Governors, Internal Audit, External Audit, Counter Fraud |
| **Number of pages:** | 8 |
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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

| Agenda item 7.4 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Finance and Investment Committee Terms of Reference |
| **Sponsor:** | Dave Bennett, Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference ensure that the purpose and activities of the Finance and Investment Committee are clear and support transparency and accountability in the performance of its role and comply with the Code of Governance for NHS Provider Trusts.

It is proposed to remove Charitable Funds Committee from Appendix A.

No other changes are proposed.

The Board of Directors is asked to approve the terms of reference following review and approval by the Finance and Investment Committee on 27 January 2025.

**Contents:**

Revised Terms of Reference (marked up).

**Risk(s):**

N/A

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

University Hospital Southampton NHS
NHS Foundation Trust

# Finance and Investment Committee Terms of Reference

**Version:** ~~9~~10

| | |
|---|---|
| **Date Issued:** | ~~30 January 2024~~ 11 March 2025 |
| **Review Date:** | January ~~2025~~ 2026 |
| **Document Type:** | Committee Terms of Reference |

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## 1. Role and Purpose

1.1 The Finance and Investment Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the stewardship of the Trust's finances, investments and sustainability of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including planning, financial performance, capital expenditure and the delivery of the informatics and estates, facilities and capital development annual plans.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's financial position and capital and revenue investments to enable world-class people to deliver world-class care.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

## 2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. 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 three non-executive directors of the Trust, at least two of whom should be independent, including the chair of the Audit and Risk Committee;

3.1.2 the Chief Executive Officer;

3.1.3 the Chief Financial Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). The Committee Chair will not be the chair of the Audit and Risk Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance/Deputy Director of Finance;

3.4.2 Director of Planning, Performance and Productivity; and

3.4.3 Associate Director Always Improving.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 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 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors (one of whom must be either the Committee Chair or the chair of the Audit and Risk Committee) and either the Chief Financial Officer or Chief Operating 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.

## 5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) 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 Financial 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.

### 7.1 *Financial planning and performance*

7.1.1 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives, and consider the adequacy and effectiveness of any corrective action proposed:

7.1.1.1 the Trust's long-term financial model;

7.1.1.2 the Trust's long-term and annual financial plans encompassing income, expenditure and capital;

7.1.1.3 the capital plan including any changes in the Trust's performance that may impact on the delivery of the long-term capital plan;

7.1.1.4 financial performance and forecasts and projections including achievement of the control total and other targets;

7.1.1.5 performance against revenue budgets at both Trust and divisional level;

7.1.1.6 capacity, activity and productivity including any significant variation and the impact on income;

7.1.1.7 cash, liquidity and working capital;

7.1.1.8 the use of any working capital facilities; and

7.1.1.9 performance of the Trust's subsidiaries and any joint ventures against agreed performance indicators.

### 7.2 *Always Improving Value for Money*

7.2.1 The Committee will ensure that there is an Always Improving: Value for Money (**AIVFM**) programme in place each financial year that aligns with the Trust's annual plan.

7.2.2 The Committee will seek assurance that a recovery plan is in place and being implemented where any AIVFM schemes are at risk of delivery.

### 7.3 *Investment*

7.3.1 The Committee will review business cases of £2.5 million or more in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.2 The Committee will review capital business cases over £5 million in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.3 The Committee will review all business cases identified by the Trust Executive Committee as of significant strategic importance regardless of value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.4 The Committee will assess benefits realisation through post-implementation reviews, ensuring any learning is shared.

7.4 ***Informatics annual plan***

7.4.1 The Committee will monitor and oversee the delivery of the Trust's annual plan for IT including funding and ongoing alignment with the Trust's objectives.

7.5 ***Estates, facilities and capital development annual plan***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's estates, facilities and capital development annual plan including funding and ongoing alignment with the Trust's objectives.

7.6 ***Risk***

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

7.6.2 The Committee will establish and maintain an overview of the Trust's financial risks and risks to delivery of the Trust's informatics or estates, facilities and capital development plans and ensure the effectiveness and implementation of controls for financial risks and actions to mitigate risks to the delivery of the Trust's informatics or estates, facilities and capital development plans.

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

7.6.4 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.

7.7 ***Reporting***

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

7.7.2 The Committee will review the National Cost Collection Index for the purposes of benchmarking the Trust's performance.

## 8. Accountability and Reporting

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

8.2 The 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 financial statements 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.

## 9. Review of Terms of Reference and Performance and Effectiveness

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

## 10. References

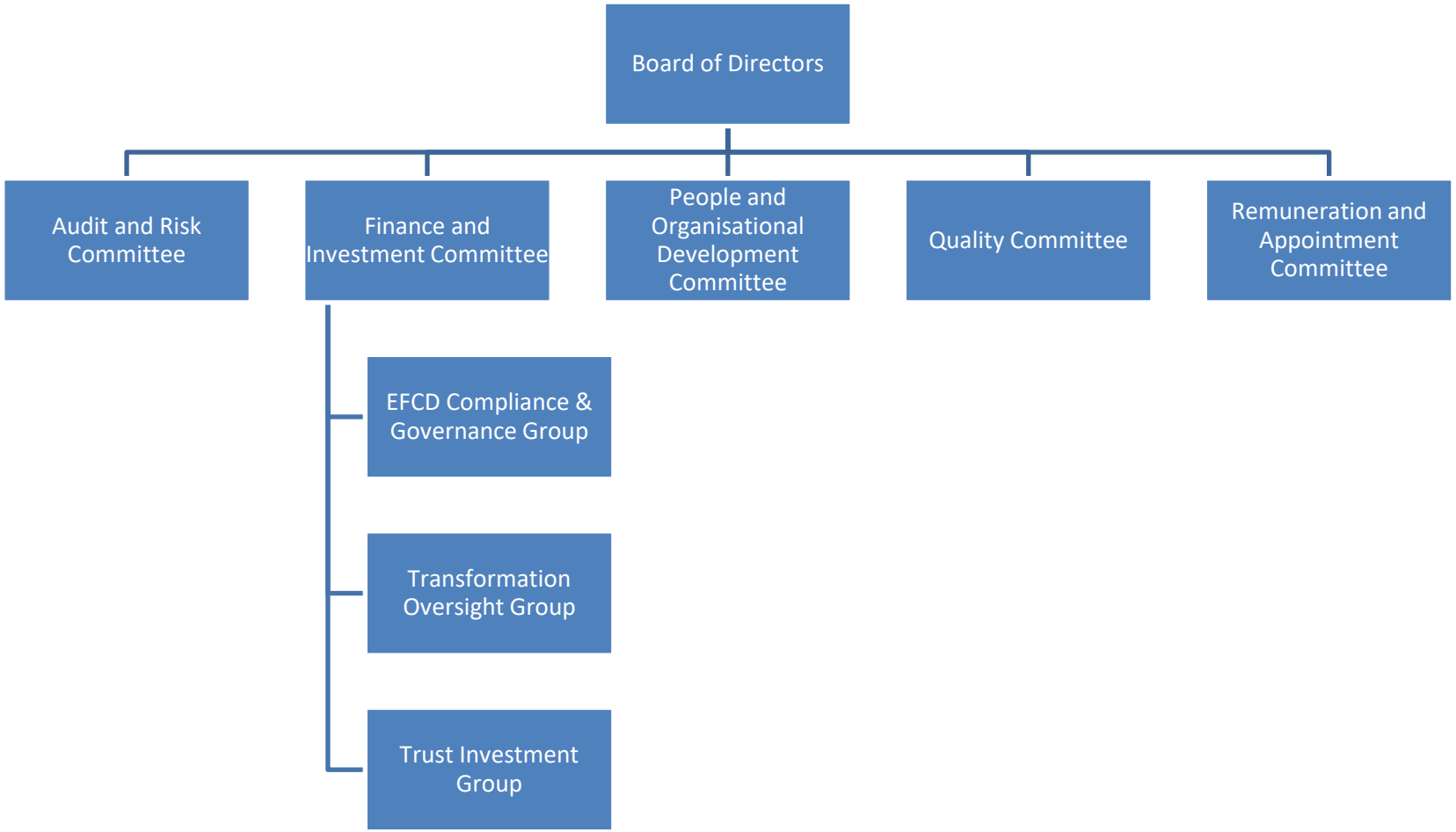
10.1 National Health Service Act 2006

10.2 NHS System Oversight Framework

10.3 NHS Improvement and Care Quality Commission Use of Resources: assessment framework

10.4 Standing Financial Instructions

**Appendix A**


Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
EFCD Compliance & Governance Group
Transformation Oversight Group
Trust Investment Group

| Finance and Investment Committee Terms of Reference | Version: ~~9~~10 |
|---|---|

| Document Monitoring Information | |
|---|---|
| **Approval Committee:** | Board of Directors |
| **Date of Approval:** | ~~30 January 2024~~ 11 March 2025 |
| **Responsible Committee:** | Finance and Investment Committee |
| **Monitoring (Section 9) for Completion and Presentation to Approval Committee:** | January ~~2025~~ 2026 |
| **Target audience:** | Board of Directors, Finance and Investment Committee, Staff |
| **Key words:** | Finance, Investment, Committee, Board, Terms of Reference |
| **Main areas affected:** | Trust-wide |
| **Summary of most recent changes if applicable:** | ~~Appendix A – Transformation Oversight Group replaced the Always Improving Strategy Board in the groups reporting to the Committee.~~ Charitable Funds Committee removal from Appendix A. No other changes. |
| **Consultation:** | Chief Financial Officer |
| **Number of pages:** | 8 |
| **Type of document:** | Committee Terms of Reference |
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| **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

| Agenda item 7.5 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Quality Committee Terms of Reference |
| **Sponsor:** | Tim Peachey, Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference ensure that the purpose and activities of the Quality Committee are clear and support transparency and accountability in the performance of its role and comply with the Code of Governance for NHS Provider Trusts.

It is proposed to amend 10.2 to Code of Governance for NHS Provider Trusts and remove Charitable Funds Committee from Appendix A.

No other changes are proposed.

The Board of Directors is asked to approve the terms of reference following review and approval by the Quality Committee on 27 January 2025.

**Contents:**

Revised Terms of Reference (marked up)

**Risk(s):**

N/A

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

University Hospital Southampton NHS
NHS Foundation Trust

# Quality Committee Terms of Reference

**Version:** ~~6~~7

| | |
|---|---|
| **Date Issued:** | ~~30 January 2024~~ 11 March 2025 |
| **Review Date:** | January ~~2025~~ 2026 |
| **Document Type:** | Terms of Reference |

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## Document Status

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## 1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

## 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 the 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 three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating 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 other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Deputy Director of Nursing (Quality);

3.4.2 Medical Lead for Safety (Patient Safety Specialist); and

3.4.3 patient representative(s).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 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 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary of the Committee in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical 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.

## 5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the 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 Nursing Officer and the Chief Medical Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five 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.

7.1 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.

7.5.4 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

7.5.5 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.6 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

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

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

7.6.4 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.

7.7 ***Reporting***

7.7.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

## 8. Accountability and Reporting

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

8.2 The 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 quality accounts/quality 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.

## 9. Review of Terms of Reference and Performance and Effectiveness

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

## 10. References

10.1 National Health Service Act 2006

10.2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

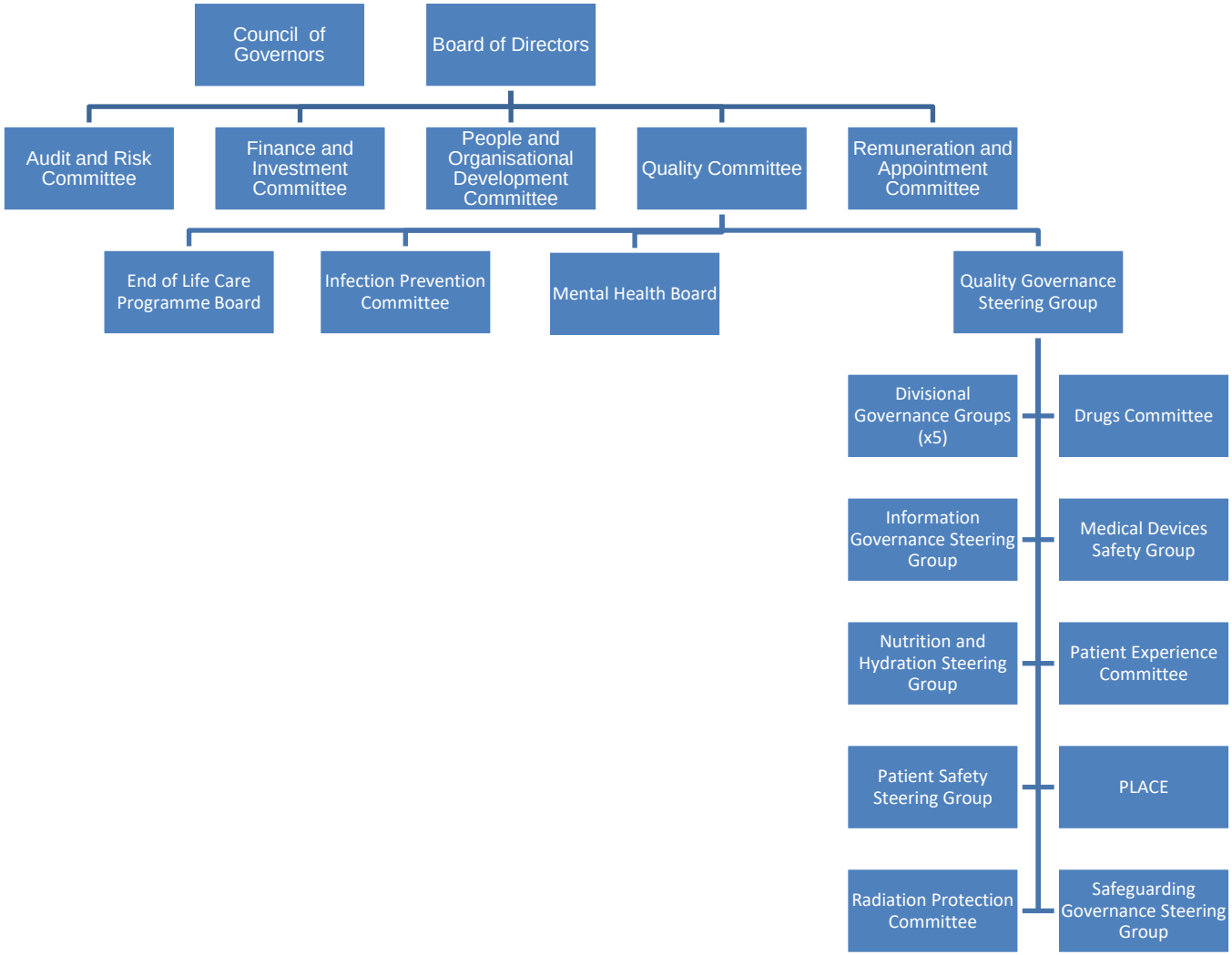
10.6 ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts

10.7 NHS System Oversight Framework

10.8NHS Foundation Trust Annual Reporting Manual

10.9NHS England and NHS Improvement’s requirements for quality accounts

## Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

| Quality Committee Terms of Reference | Version: ~~6~~ 7 |
|---|---|

| Document Monitoring Information | |
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| **Approval Committee:** | Board of Directors |
| **Date of Approval:** | ~~30 January 2024~~11 March 2025 |
| **Responsible Committee:** | Quality Committee |
| **Monitoring (Section 9) for Completion and Presentation to Approval Committee:** | ~~January 2025~~ January 2026 |
| **Target audience:** | Board of Directors, Quality Committee, NHS Regulators, Staff |
| **Key words:** | Quality, Governance, Committee, Board, Terms of Reference |
| **Main areas affected:** | Trust-wide |
| **Summary of most recent changes if applicable:** | ~~No changes~~ Amendment of 10.6 to Code of Governance for NHS Provider Trusts and removal of Charitable Funds Committee from Appendix A |
| **Consultation:** | Chief Nursing Officer |
| **Number of pages:** | 8 |
| **Type of document:** | Terms of Reference |
| **Does this document replace or revise an existing document?** | Yes |
| **Should this document be made available on the public website?** | Yes |
| **Is this document to be published in any other format?** | No |

University Hospital Southampton NHS Foundation Trust

| Agenda item 7.6 | Report to the Trust Board of Directors, 11 March 2025 |
|---|---|
| **Title:** | Remuneration and Appointment Committee Terms of Reference |
| **Sponsor:** | Jenni Douglas-Todd, Trust Chair |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference ensure that the purpose and activities of the Remuneration and Appointment Committee are clear and support transparency and accountability in the performance of its role and comply with the Code of Governance for NHS Provider Trusts.

No changes are proposed.

Note: the pay scales in Appendix A are those currently published by NHS England for trusts with more than £750m in revenue per year. In due course, we are expecting revised pay scales to reflect, among other matters, the situation of trusts with revenue significantly above £750m, such as UHS.

The Board of Directors is asked to approve the terms of reference following review and approval by the Remuneration and Appointment Committee on 11 March 2025.

**Contents:**

Revised Terms of Reference (marked up)

**Risk(s):**

N/A

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

University Hospital Southampton NHS
NHS Foundation Trust

# Remuneration and Appointment Committee Terms of Reference

**Version:** ~~7~~6

| | |
|---|---|
| **Date Issued:** | ~~28 March 2024~~ 11 March 2025 |
| **Review Date:** | ~~February 2025~~ March 2026 |
| **Document Type:** | Committee Terms of Reference |

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**Document Status**

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

## 1. Role and Purpose

1.1 The Remuneration and Appointment Committee (the **Committee**) is responsible for identifying and appointing candidates to fill all the executive director positions on the board of directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and for determining their remuneration and other conditions of service.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of remuneration and executive director appointments in accordance with relevant laws, regulations and Trust policies.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

## 2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

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

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

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

## 3. Membership

3.1 The members of the Committee will be appointed by the Board and will be the non-executive directors of the Trust except as provided in paragraph 3.2 below.

3.2 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

3.3 The chair of the Board will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

3.4 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Chief People Officer; and

3.4.2 Associate Director of Corporate Affairs/Company Secretary.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas that are the responsibility of a particular executive director or manager. Any attendee will be

asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

## 4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be four members, including the chair of the Board (or the Deputy Chair in their absence). A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

## 5. Frequency of Meetings

5.1 The Committee will meet as required, which will usually be four times each year.

5.2 The Committee may establish a sub-committee for a specific purpose where it would be impractical for the Committee to be involved, for example the appointment of an executive director following agreement by the Committee of the process, job description and person specification.

## 6. Conduct and Administration of Meetings

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

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

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

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

## 7. Duties and Responsibilities

7.1 The Committee will carry out the duties below for the Trust.

### *Remuneration Role*

7.2 The Committee will:

7.2.1 establish and keep under review a remuneration policy in respect of executive directors (as set out in Appendix A);

7.2.2 consult the Chief Executive Officer about proposals relating to the remuneration of the other executive directors;

7.2.3 in accordance with relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors, including salary, any performance-related pay or bonus, provisions for other benefits,

including pensions and cars, allowances, payable expenses and compensation payments;

7.2.4 adhering to all relevant laws, regulations and Trust policies:

7.2.4.1 establish levels of remuneration that are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level that is affordable to the Trust;

7.2.4.2 decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

7.2.4.3 make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the Trust, and take as a baseline for performance any competencies required and specified in the job description for the post;

7.2.4.4 consider all relevant and current directors relating to contractual benefits such as pay and redundancy entitlements;

7.2.4.5 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors while ensuring that increases are not made where Trust or individual performance do not justify them;

7.2.4.6 be sensitive to pay and employment conditions elsewhere in the Trust;

7.2.5 monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

7.2.6 on an annual basis monitor the remuneration of non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions;

7.2.7 approve the level of remuneration or any proposed change to remuneration for a senior leadership role referred to in 7.2.6 where the proposed remuneration for the role would exceed that of any executive director; and

7.2.8 consider issues of equality and diversity when evaluating and setting remuneration.

***Appointment Role***

7.3 The Committee will:

7.3.1 regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board and the Governors' Nomination Committee, as applicable, with regard to any changes;

7.3.2 give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future;

7.3.3 keep the leadership needs of the Trust under review at executive director level to ensure the continued ability of the Trust to operate effectively in the health economy;

7.3.4 be responsible for identifying the and appointing candidates to fill posts within its remit as and when they arise;

7.3.5 when a vacancy is identified, evaluate the balance of skills, knowledge and experience of the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In

identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

7.3.6 ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation and monitor procedures to ensure that executive directors remain 'fit and proper' persons;

7.3.7 ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;

7.3.8 ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

7.3.9 carefully consider what compensation commitments (including pension contributions) the executive directors' terms of office would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing executive director's obligation to mitigate loss. Appropriate clawback provisions should be considered in the case of an executive director returning to the NHS within the period of putative notice; and

7.3.10 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

## 8. Accountability and Reporting

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

8.2 The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive directors and the process it has used in relation to the appointment of executive directors.

## 9. Review of Terms of Reference and Performance and Effectiveness

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

## 10. References

10.1 National Health Service Act 2006

10.2 Code of Governance for NHS Provider Trusts

10.3 NHS England Guidance on pay for very senior managers

## Appendix A
## UHS Executive Director Pay Principles

### 1. The importance of executive director pay

The delivery of the Trust's 5-year strategy and annual Trust objectives is predicated on ensuring talent is available at all levels of the Trust. Good senior leadership is vital, and therefore a key strategy for UHS must be to recruit and retain the best executive director talent into the Trust. This will be from a combination of both good internal succession planning, bringing top talent from the NHS and also seeking high calibre individuals from other sectors.

### 2. Determination of pay levels of posts

Pay for executive director posts will be determined by:

- Use of NHS England (NHSE) data on pay for executive director (Very Senior Manager – VSM) positions in comparable trusts (Figure 1).
- Any other available NHSE frameworks for setting of executive pay
- Use of other salary benchmarking exercises, particularly from comparable NHS organisations
- Job evaluation as required.
- The conditions required to attract suitably qualified individuals, particularly where commercial, financial or other niche business skills are required.

Pay levels will be reviewed not less frequently than annually by the Committee in accordance with the Trust's pay review cycle to ensure that salary levels are both appropriate and provide value for money.

### 3. Setting salary of executive directors

The following principles will apply:

- UHS will aim to pay at around mid-point of NHSE levels for trusts of a comparable nature and scale.
- UHS will review pay based on performance, changes in the NHSE framework levels, comparable NHS Trust benchmarking and, in particular, the need to retain key individuals likely to be of interest to the external market.
- UHS will not recognise relevant changes of NHSE framework levels in respect of individuals where this is not justified by individual performance.
- UHS will be mindful of equality and diversity, particularly in relation to gender and ethnicity in pay levels.
- UHS will ensure all VSM nationally applicable cost of living pay awards are reflected in executive director pay each year, as decided by the Committee. The committee may choose to withhold a national pay increase where individual performance has been unsatisfactory and where the guidance permits this.
- Any decision to introduce performance-related pay, or bonuses, will be subject to decision by the Committee based on a sound business case and adherence to NHSE guidance on executive pay.

### 4. Approval process

All decisions on pay for executive directors will be managed in line with the terms of reference for the Committee.

The Committee, supported by the Chief People Officer, will also ensure that the NHSE prevailing guidance on setting executive director pay, including any required approval process, will be followed as appropriate.

**Figure 1 – Current NHS England Pay Thresholds**

| Supra large acute NHS trusts and foundation trusts (£750m+) | Lower quartile | Median | Upper quartile |
|---|---|---|---|
| Chief executive | £236,000 | £250,000 | £265,000 |
| Deputy chief executive | £185,500 | £188,000 | £195,500 |
| Director of finance/Chief finance officer | £166,000 | £172,500 | £190,500 |
| Director of workforce | £142,500 | £155,000 | £165,500 |
| Medical director/Chief medical officer | £205,000 | £214,000 | £233,500 |
| Director of nursing/Chief nursing officer | £150,000 | £163,500 | £168,000 |
| Chief operating officer | £143,500 | £162,500 | £174,500 |
| Director of corporate affairs/governance | £113,000 | £117,500 | £134,000 |
| Director of strategy/planning | £135,000 | £144,000 | £152,500 |
| Director of estates and facilities | £129,500 | £137,000 | £146,500 |

| Remuneration and Appointment Committee Terms of Reference | Version: ~~6~~7 |
|---|---|

| Document Monitoring Information | |
|---|---|
| **Approval Committee:** | Board of Directors |
| **Date of Approval:** | ~~28 March 2024~~ 11 March 2025 |
| **Responsible Committee:** | Remuneration and Appointment Committee |
| **Monitoring (Section 9) for Completion and Presentation to Approval Committee:** | ~~February 2025~~ March 2026 |
| **Target audience:** | Board of Directors, Remuneration and Appointment Committee, NHS Regulators, Staff and Public |
| **Key words:** | Remuneration, Appointment, Nomination, Committee, Board, Terms of Reference |
| **Main areas affected:** | Trust-wide |
| **Summary of most recent changes if applicable:** | ~~Minor changes to update references to documentation and NHS organisations. In addition, changes to the Executive Pay Principles set out in Appendix A to reflect the current guidance and available frameworks.~~ No changes are proposed. |
| **Consultation:** | Remuneration and Appointment Committee |
| **Number of pages:** | 8 |
| **Type of document:** | Committee Terms of Reference |
| **Does this document replace or revise an existing document?** | Yes |
| **Should this document be made available on the public website?** | Yes |
| **Is this document to be published in any other format?** | No |

University Hospital Southampton NHS Foundation Trust

| Agenda item 7.7 Report to the Trust Board of Directors, 11 March 2025 | |
|---|---|
| **Title:** | Trust Executive Committee (TEC) Terms of Reference |
| **Sponsor:** | David French, Chief Executive Officer |
| **Author:** | Craig Machell, Associate Director of Corporate Affairs |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

It is good practice for a committee to regularly review its terms of reference and the terms of reference for the Trust Executive Committee (TEC) provide for a review to be undertaken annually. The TEC reviewed its terms of reference at its meeting on 12 February 2025 and approved a number of changes.

The most significant proposed amendments are as follows:

- Introduction of the pre-TEC process for business cases requiring additional expenditure (6.3).
- The role of the TEC as a forum for discussion of significant strategic matters (7.1.3).
- The TEC's role in identification of opportunities for ICS collaboration (7.1.7)
- Updates in respect of the current role of the Trust Investment Group and the TEC under the Standing Financial Instructions (7.1.4, 7.1.5, 7.3.1).
- Other amendments to add clarity about the TEC's operation and reports received (7.2.1, 7.4.3)

It is additionally proposed to make certain other amendments to clarify the operation and administration of the committee, and to update membership.

The Board is requested to approve the updated terms of reference.

**Contents:**

Revised Terms of Reference (marked up)

**Risk(s):**

N/A

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

# Trust Executive Committee Terms of Reference

**Version:** ~~11~~12

| | |
|---|---|
| **Date Issued:** | ~~19 December 2023~~11 March 2025 |
| **Review Date:** | ~~December 2024~~March 2026 |
| **Document Type:** | Terms of Reference |

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| 5 | Frequency of Meetings | 3 |
| 6 | Conduct and Administration of Meetings | 3 |
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**Document Status**

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## 1. Role and Purpose

1.1 The Trust Executive Committee (the **Committee**) is responsible for supporting the Chief Executive Officer in the performance of their duties as accounting officer of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and all Executive Directors in fulfilling the duties and responsibilities delegated to them by the board of directors of the Trust (the **Board**).

1.2 The Committee ensures that executive, divisional and broader clinical and non-clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

## 2. Constitution

2.1 The Committee has been established by the Chief Executive Officer. 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 Committee as shown in Appendix A.

2.2 The Committee is authorised 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 management and 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 Chief Executive Officer and will be:

3.1.1 the Chief Executive Officer;

3.1.2 all other Executive Directors;

3.1.3 the Deputy Medical Directors;

3.1.4 the Director of Strategy and Partnerships;

3.1.5 all Divisional Clinical Directors;

3.1.6 all Divisional Directors of Operations;

3.1.7 all Divisional ~~Heads~~ Directors of Nursing and Professions;

3.1.8 the Director of Midwifery;

3.1.9 the Director of Research and Development;

3.1.10 the Director of Education;

3.1.11 the Deputy ~~Director of Nursing for Quality~~Chief Nursing Officer;

3.1.12 the Chief Information Officer;

3.1.13 the Director of Estates, Facilities & Capital Development;

3.1.14 the Director of Communications;

3.1.15 the Director of Planning and Productivity;

3.1.16 the ~~Director of Commercial Development~~Commercial and Enterprise Director;

~~3.1.17 the Director of Contracting;~~

~~3.1.18~~3.1.17 the Deputy Chief Operating Officer;

~~3.1.19~~3.1.18 the Chief Pharmacist;

~~3.1.20~~3.1.19 the Director of Operational Finance;

3.1.20 the Deputy Chief People Officer;

3.1.21 the Associate Director Always Improving;

3.1.22 the Associate Director of Corporate Affairs and Company Secretary; and

3.1.23 the Dean of Medicine, University of Southampton.

3.2 The Chief Executive Officer will chair ~~of~~ the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of ~~themselves~~the Executive Directors present to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings.

3.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of strategy, risk or operation that are the responsibility of that individual.

## 4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary of the Committee in advance.

4.2 The quorum for a meeting will be ten members including at least four (4) executive directors and at least one (1) representative from each division. 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 a member is unable to attend a meeting, they may appoint a deputy to attend on their behalf. However, this deputy will not count towards the quorum stipulated in 4.2.

## 5. Frequency of Meetings

5.1 The Committee will meet monthly 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 Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee no later than three working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 Any business cases requiring approval of additional expenditure is required to be presented to a pre-TEC meeting, chaired by the Chief Financial Officer or a deputy. The purpose of this meeting will be to ensure the business case contains all the necessary information to support TEC in making a decision.

~~6.3~~6.4 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~~6.5 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.

## 7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

### 7.1 *Objectives and strategy*

7.1.1 The Committee will develop the strategy and operational plans for recommendation to the Board including strategic objectives~~,~~ and quality priorities ~~and the capital plan~~, working for the benefit of patients, staff, and other stakeholders.

7.1.2 The Committee will monitor and manage the successful execution of strategy and the delivery of strategic objectives, quality priorities, and financial plans once approved.

7.1.3 The Committee will review and discuss matters of significant strategic concern to the Trust, and will make recommendations to the Chief Executive Officer in respect of such matters. These matters can include, but are not limited to:

- Material organisational changes
- Proposals to significantly increase or reduce the Trust's workforce or otherwise materially alter its composition

7.1.4 The Committee will review all business cases for consultant posts and approve any business cases for the creation of new consultant posts.

7.1.5 The Committee will review and approve any business cases relating to staff recruitment or education and training programmes in accordance with the Trust's standing financial instructions.

7.1.6 The Committee will approve significant changes to the Trust's estates strategy.

7.1.7 The Committee will seek to identify opportunities for collaborative working with other organisations in the Hampshire and Isle of Wight Integrated Care System.

### 7.2 *Performance and operations*

7.2.1 The Committee will receive regular reports in respect of the Trust's financial and operational performance, and in respect of the Trust's workforce.

~~7.2.1~~7.2.2 The Committee will monitor and manage quality and safety of patient care and the delivery of patient outcomes.

~~7.2.2~~7.2.3 The Committee will monitor and manage the delivery of services to nationally mandated standards.

~~7.2.3~~7.2.4 The Committee will monitor and manage operational plans and budgets.

~~7.2.4~~7.2.5 The Committee will seek to optimise the allocation of resources.

~~7.2.5~~7.2.6 The Committee will support the active liaison, coordination, and cooperation between divisions, care groups, and services.

~~7.2.6~~7.2.7 The Committee will ensure that issues of equality, diversity, and inclusivity are considered and addressed.

7.2.8 The Committee will monitor staff experience, identifying actions to support the positive engagement, retention, and recruitment of staff.

7.3 ***Resources***

~~7.3.1 The~~ In accordance with the Trust's Standing Financial Instructions, the Committee will ~~monitor the staff experience, identifying actions to support the positive engagement, retention and recruitment of staff.~~

~~7.3.2 The Committee will review revenue business cases of £1 million or more in value, approving those with a value of £2.5 million or less, referring those above that value to~~receive minutes from the ~~Finance and~~Trust Investment ~~Committee for approval.~~

~~7.3.3~~7.3.1 ~~The Committee will review capital business cases over £2.5 million in value, approving those with a value of £5 million or less, referring those above that value to~~Group and note the ~~Finance and~~decisions made in respect of the matters delegated to the Trust Investment ~~Committee for approval.~~Group.

~~7.3.4 The Committee will approve all business cases requiring significant clinical or strategic input regardless of value.~~

~~7.3.5~~1.1.1 ~~The Committee will review all business cases for consultant posts and approve any business cases for the creation of new consultant posts.~~

~~7.3.6 The Committee will approve significant changes to the Trust's estate.~~

~~7.3.7~~7.3.2 ~~All~~Where appropriate, such as where there is a material strategic impact, decisions of the Trust to tender for health-related services will be reported to the Committee.

7.4 ***Governance and risk management***

7.4.1 The Committee will ensure that effective management systems and processes are in place to support the delivery of the Trust's strategy and plans.

7.4.2 The Committee will review any changes to the organisational structure of the Trust, making recommendations for change.

7.4.3 The Committee will review significant risks to the delivery of the Trust's strategy, plans and performance and monitor and manage risk management processes and internal controls~~.~~, including through regularly reviewing the Trust's operational risk register (especially 'Critical Risks' as defined in the Trust's risk management policy).

7.4.4 The Committee will monitor and manage compliance with relevant legislation and regulations.

7.4.5 The Committee will monitor and manage the integrity of management information and financial reporting systems.

7.5 ***Innovation***

7.5.1 The Committee will identify and support the execution of innovation in the delivery of services and areas of activity.

7.6 ***Policies***

7.6.1 The Committee will consider, and approve as appropriate, policies identified by the Chief Executive Officer for its consideration.

## 8. Accountability and Reporting

8.1 The Chief Executive Officer 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 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive minutes from these sub-committees, and the respective chairs of these sub-committees shall report matters that should be noted by the Committee.

## 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, other than changes to the membership and attendees, which will require approval by the Committee alone.

## 10. References

10.1 National Health Service Act 2006

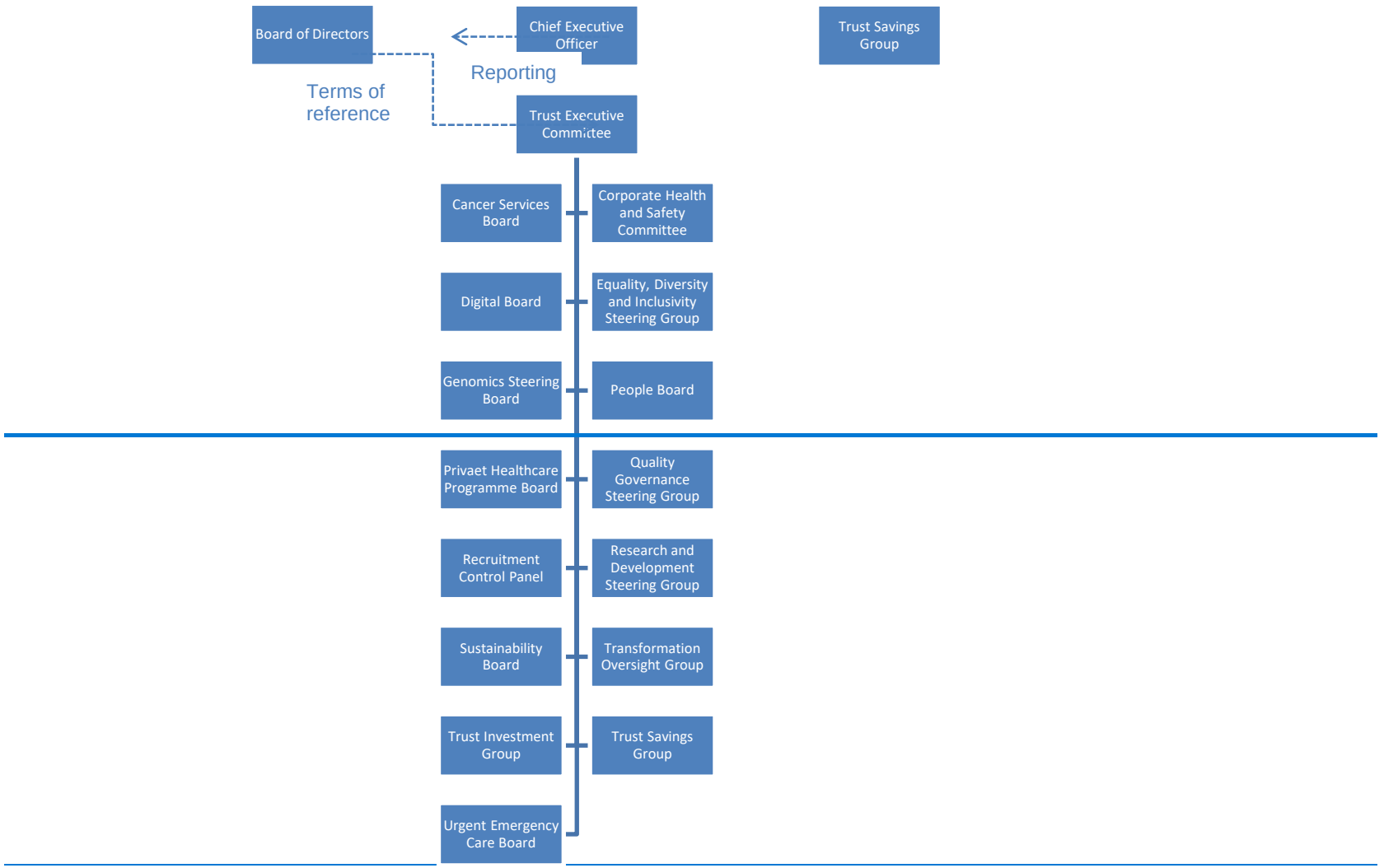
10.2 ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts

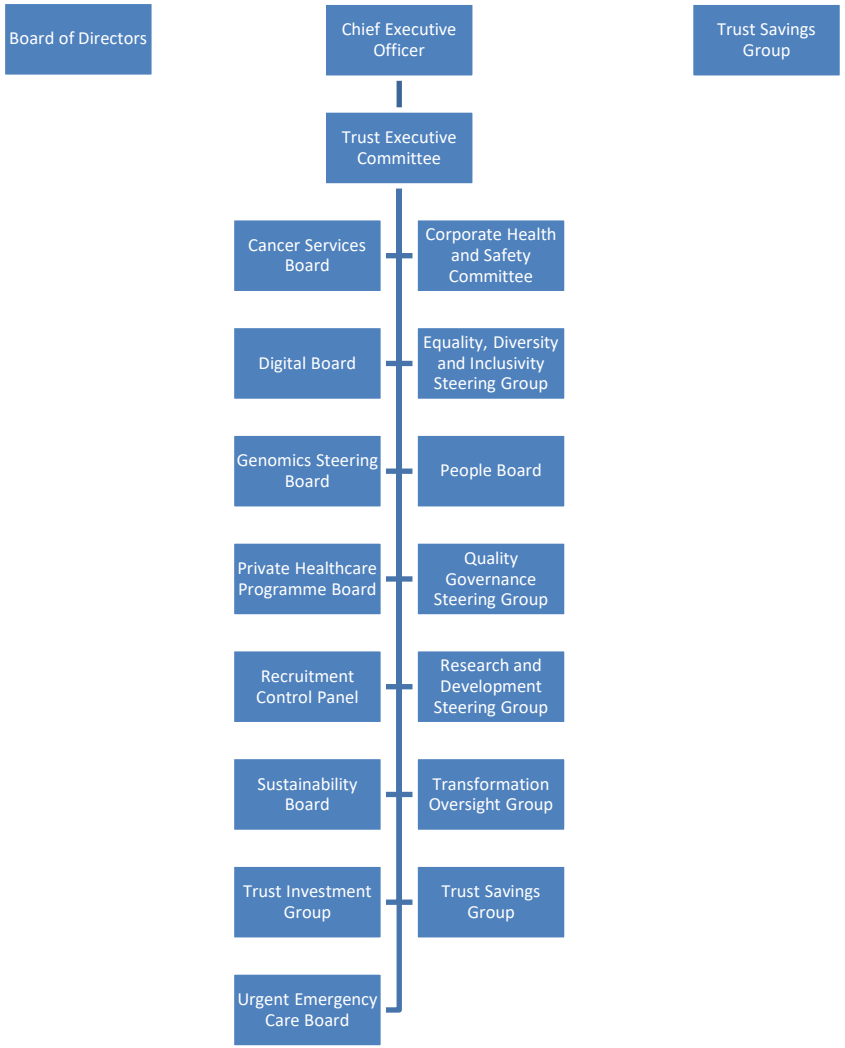
10.3 NHS foundation trust accounting officer memorandum (August 2015)

10.4 NHS Oversight Framework

10.5 Standing Financial Instructions

**Appendix A**


Board of Directors
Chief Executive Officer
Trust Savings Group
Reporting
Terms of reference
Trust Executive Committee
Cancer Services Board
Corporate Health and Safety Committee
Digital Board
Equality, Diversity and Inclusivity Steering Group
Genomics Steering Board
People Board
Privaet Healthcare Programme Board
Quality Governance Steering Group
Recruitment Control Panel
Research and Development Steering Group
Sustainability Board
Transformation Oversight Group
Trust Investment Group
Trust Savings Group
Urgent Emergency Care Board


Board of Directors
Chief Executive Officer
Trust Savings Group
Trust Executive Committee
Cancer Services Board
Corporate Health and Safety Committee
Digital Board
Equality, Diversity and Inclusivity Steering Group
Genomics Steering Board
People Board
Private Healthcare Programme Board
Quality Governance Steering Group
Recruitment Control Panel
Research and Development Steering Group
Sustainability Board
Transformation Oversight Group
Trust Investment Group
Trust Savings Group
Urgent Emergency Care Board

| Trust Executive Committee Terms of Reference | Version: ~~11~~13 |
|---|---|

| Document Monitoring Information | |
|---|---|
| **Approval Committee:** | Board of Directors |
| **Date of Approval:** | ~~19 December 2023~~11 March 2025 |
| **Responsible Committee:** | Trust Executive Committee |
| **Monitoring (Section 9) for Completion and Presentation to Approval Committee:** | ~~December 2024~~March 2026 |
| **Target audience:** | Board of Directors, Trust Executive Committee, NHS Regulators and Staff |
| **Key words:** | TEC, Executive, Committee, Terms of Reference |
| **Main areas affected:** | Trust-wide |
| **Summary of most recent changes if applicable:** | ~~Changes to membership and removal of Major Incident Planning Group as a reporting group in Appendix A~~Annual review – amendments to 7 to reflect revised emphasis of TEC and role of TIG, amendments to 1.2, 3.1, 3.2, 4.3 and 8.2, and updated reference in 10.2. Insertion of 6.3. |
| **Consultation:** | Executive Directors |
| **Number of pages:** | ~~7~~8 |
| **Type of document:** | Terms of Reference |
| **Does this document replace or revise an existing document?** | Yes |
| **Should this document be made available on the public website?** | No |
| **Is this document to be published in any other format?** | No |

| Agenda item 10.1 | Report to the Trust Board of Directors, 11 March 2025 |
|---|---|
| **Title:** | South Central Regional Research Delivery Network 2024-25 Q3 Performance Report |
| **Sponsor:** | Mr Paul Grundy, Chief Medical Officer |
| **Author:** | Clare Rook, Network Director, SC RRDN<br>Graham Halls, Data and Analytics Senior Manager, SC RRDN |

**Purpose**

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

**Strategic Theme**

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

**Executive Summary:**

This report introduces the UHS Board of Directors to the National Institute of Health and Care Research (NIHR) Research Delivery Network (RDN) and informs the Board of the health and care research activities within the South Central Regional Research Delivery Network (SC RRDN) region during quarter three of the 2024/25 financial year.

***Key points to highlight:***

- ***NIHR SC RRDN Transition:***
  - Successfully transitioned from two clinical research networks (Thames Valley & South Midlands and Wessex) to SC RRDN with significant structural and operational changes.
- ***Research Performance:***
  - SC RRDN organisations have recruited 62,297 participants on 898 studies across 236 locations during the first three quarters.
  - Recruitment is declining regionally and nationally due to the closure of several high-recruiting studies. While the number of recruiting studies is decreasing overall, commercial research remains stable.
  - SC RRDN ranks between fourth and seventh of the twelve RRDN regions nationally for recruitment adjusted for population size each month; above the expected position of eighth.
  - The region leads all RRDNs in commercial research recruitment within primary care.
  - Achieved 84% for non-commercial studies meeting recruitment targets, exceeding the 80% ambition, but slightly underperformed on commercial studies at 77%.
  - Surpassed the target for quarter three responses to the Participant in Research Experience Survey, achieving 108%.
- ***Next steps for SC RRDN:***
  - Finalise outputs from service design workshops in quarter four to align SC RRDN services and functions with the NIHR strategic aims.
  - Monitor and address recruitment trends, particularly in clinical specialties disproportionately affected by a decline in recruiting studies.

**Contents:**

South Central Regional Research Delivery Network 2024-25 Q3 Performance Report, Appendix 1 – South Central RRDN Risk Register, Appendix 2 - Glossary.

**Risk(s):**

1b, 2a *(for full details, please see Appendix 1)*

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

University Hospital Southampton
NHS Foundation Trust

NIHR | Research Delivery Network

# South Central Regional Research Delivery Network 2024-25 Q3 Performance Report


## Clare Rook, Network Director
## Graham Halls, Data and Analytics Senior Manager


## March 2025

## Introduction

This report introduces the UHS Board of Directors to the NIHR Research Delivery Network (RDN) and informs the Board of the health and care research activities within the South Central Regional Research Delivery Network (SC RRDN) region during quarter three of the 2024/25 financial year (October to December 2024). Previous performance at research delivery organisations within the same region has been included in some charts for comparison purposes.

## Establishment of the NIHR RDN

The NIHR funds, enables and delivers all aspects of health and social care research to improve people's health and wellbeing and promote economic growth. Support for research delivery, via the RDN, includes studies funded by government, industry and charity partners. The government's strategy is to make the UK the best place in the world for commercial companies to bring new treatments and technologies. The RDN is designed to ensure a strong and seamless connection between industry and the NHS.

The new **government priority projects** below set out a clear roadmap for how the UK can become one of the world's most attractive destinations to conduct high quality research. The government priority projects are:

1. Network-wide implementation of processes to ensure compliance with RDN Support Terms and Conditions.
2. Development and launch of Network-wide Site Identification service for England.
3. Development and launch of a Key Account management service for commercial and non-commercial sponsors with significant UK portfolios.
4. Continued support for the implementation of the National Contract Value Review and associated processes to streamline costing and contracting for all commercial contract research taking place in the NHS.
5. Implementation of the Be Part of Research Development plan, including achieving one million registered participants by March 2025.
6. Input into the development of the Research Delivery Data Intelligence (RDDI) 'system of systems' ensuring RDN needs are effectively communicated, captured and

met. Support testing and implementation of the systems developed.

7. Lead and support the development and implementation of Service Delivery Tools required specifically for RDN to effectively deliver its services utilising the RDDI 'system of systems' (RDN SDT).
8. Support, and lead on specific elements of, the NIHR-wide strategy to increase commercial research in primary care.
9. Support the successful implementation of the Vaccines Innovation Pathway and delivery of government strategic partnerships with Moderna and BioNTech.
10. Implement a new approach to the oversight and use of support cost allocations to delivery partners to increase the flexibility with which NHS support costs funded by the Department of Health and Social Care (DHSC) can be used for the delivery of research.
11. Develop and implement an approach to collect site-level set-up data.

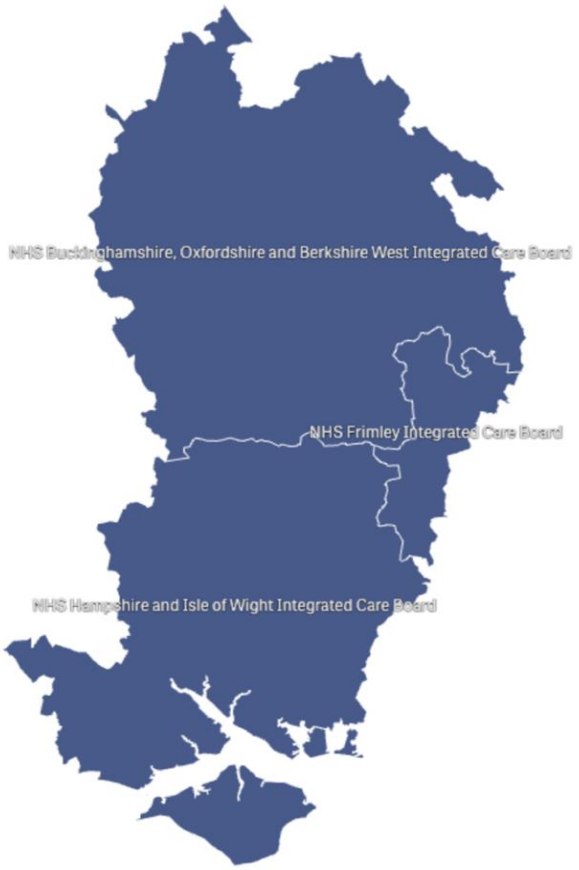



*Figure 1 - Map of the NIHR South Central Regional Research Delivery Network region*

## Transition from NIHR Clinical Research Network Thames Valley and South Midlands and NIHR Clinical Research Network Wessex to NIHR SC RRDN

From quarter three of the 2024/25 financial year (October 2024), two clinical research networks in southern England transitioned to NIHR SC RRDN. This included changes to the geographical area covered by the new organisation, which is now coterminous with three National Health Service (NHS) integrated care board regions (Figure 1). The RDN, which consists of a coordinating centre and twelve regional research delivery networks, has the following **change statements** that explain how it differs from the previous Clinical Research Network:

1. A single organisation with greater consistency of experience for customers
2. Collective responsibility and joint leadership of the organisation
3. A collegiate and a customer-focused partner
4. Stronger focus on strategic development of research capacity and capability, nationally and regionally, with partners
5. Emphasis on continuous improvement, learning and value for money in every part of RDN.

SC RRDN has made significant changes to its team and operations to follow an organisational structure and revised contract with the DHSC that is consistent across the twelve RRDNs in England. These changes are ongoing, with an upcoming restructure within SC RRDN's clinical and clinical support teams. University Hospital Southampton NHS Foundation Trust is the host organisation for SC RRDN.

Service design workshops that have taken place in January and February have involved RDN stakeholders and employees, with the outputs to be announced in quarter four of the 2024/25 financial year. These workshops, which have happened within all RRDNs and the RDN Coordinating Centre, focus on how the RDN services and functions meet the strategic aims of the RDN.

## RDN Vision, Mission, Purposes and Strategic Aims

| Vision | Mission |
|---|---|
| The UK is a global leader in the delivery of high quality, commercial and non commercial research that is inclusive, accessible and improves health and care. | Enabling the health and care system to attract, optimise and deliver research across England.<br><br>We do this as part of the NIHR's overall mission to improve the health and wealth of the nation through research. |

The 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 delivery infrastructure for the future.

As a result, **research will reach more people, address changing population needs, support the health and care system and the economy, and become a routine part of care**.

The **strategic aims** of the RDN are:

1. As a system partner, we will facilitate the efficient delivery of RDN Portfolio research, which is collaborative and inclusive, and supports the participant journey through the health and social care system at the right time and in the most appropriate setting.
2. As a system partner, we will support and promote a culture to ensure that research delivery is the responsibility of everyone working within health and social care.
3. As a system partner, we will develop an internationally renowned, responsive, sustainable and diverse research delivery workforce.
4. As a system partner, we will support the development of novel delivery methods to develop capacity and capability for research delivery.
5. As a system partner, we will support the UK in its aim to become one of the top five countries of choice to enable world leading delivery of life sciences research.

### NIHR High Level Objectives (HLOs)

The NIHR High Level Objectives are provided in Figure 2, with SC RRDN and English (all RRDN regions combined) performance linked to ambitions agreed with the DHSC.

The **Study delivery** objective indicates whether research sponsor organisations in the region are managing their studies effectively, and that the organisations that are delivering the studies have the capacity and capability to deliver them.

South Central is exceeding the ambition for the Study delivery objective for non-commercial research studies led from the region. These are studies that are sponsored by local NHS trusts, charities, universities and other similar organisations. The region is performing above the England average, but just below the eighty per cent ambition, for regionally led studies funded and sponsored by the life sciences industry ('commercial contract').

| Objective | | Measure | Ambition | SC RRDN | England |
|---|---|---|---|---|---|
| **Study delivery** | Support sponsors to deliver NIHR RDN Portfolio studies to recruitment target | Percentage of **open to recruitment commercial** contract studies which are predicted to achieve their recruitment target | 80% | 77%<br><br>(68/88 open SC RRDN-led studies) | 76% |
| | | Percentage of **open to recruitment non-commercial** studies which are predicted to achieve their recruitment target | 80% | 84%<br><br>(305/364 open SC RRDN-led studies) | 87% |
| **Participant experience** | Demonstrate to participants in NIHR RDN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery | Number of NIHR RDN Portfolio study participants responding to the **Participant in Research Experience Survey** | 1,000<br><br>(total RRDN target for quarters 3 to 4 only) | 542<br><br>(54%) | 12,000 ambition<br><br>(the total responses received to date in England is to be announced) |

*Figure 2 - Local and national performance for the NIHR RDN High Level Objectives in quarter three of the 2024/25 financial year.*

The experience of participants while supporting a research study is measured using a national 'Participant in Research Experience Survey' (PRES). There were **542 responses** in the third quarter collected by organisations within the SC RRDN region. The total ambition for SC RRDN in the

second half of the financial year is 1,000 responses. The **Participant experience** high level objective is currently being met.

Responses to PRES have been generally positive, with a ninety per cent or more agreeing with most statements (Figure 3). These include participants feeling prepared, valued and being treated with courtesy and respect. The areas that the survey indicates require improvement relate to communications about the study and its results. This can only be directly influenced where the sponsor is within the SC RRDN region, as research governance requires contact with participants to be approved by an ethics committee.

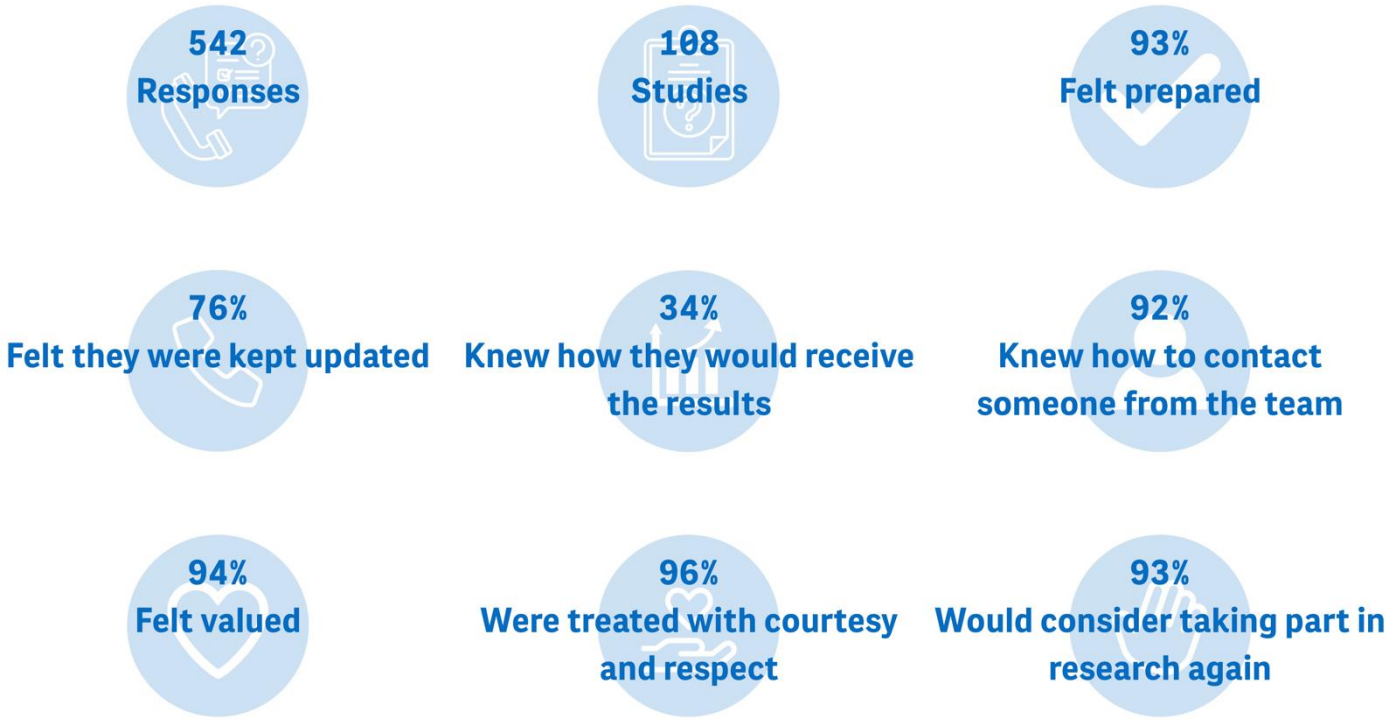



*Figure 3 - Summary of the Participant in research experience survey results in the SC RRDN region in quarter three of the 2024/25 financial year.*

## Research activity in the SC RRDN region

SC RRDN benchmarks the region's recruitment against the activity taking place in all RRDN regions (England). In the first three quarters of the 2024/25 financial year, SC RRDN organisations have recruited **62,297 participants** on **898 studies** across **236 locations**.

Figure 4 shows that recruitment is trending downwards in the SC RRDN region, as well as England as whole. A very large genetics profiling study called Discover Me, which has recruited over

146,000 participants nationally, paused recruitment in November 2024. At the same time, other previously high recruiting studies have had slower enrolment across all regions. When the top five recruiting studies are excluded to control for their variability, activity across the SC RRDN region remains stable, with an average of 3,750 participants recruited per month this financial year.


*Figure 4 - SC RRDN research recruitment benchmarked against England since April 2023.*

SC RRDN was ranked between fourth and tenth for recruitment among the twelve RRDNs for each of the nine months in this financial year (Figure 5). When the population in each region is factored in by weighting recruitment per million residents, this range narrows to being ranked between fourth and seventh (Figure 6). SC RRDN is a small to medium sized region, with a population of 4.4 million compared to the average RRDN population of 5.2 million. If recruitment only tracks the population size, then SC RRDN would expect to be ranked eighth of twelve. The presence in the SC

RRDN region of NIHR infrastructure, such as the UHS-hosted Commercial Recruitment Delivery Centre, large research sponsors like the University of Oxford, and established research-active NHS organisations means that the region typically performs above this expectation.

| Month | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|
| SC RRDN rank | 4 | 4 | 6 | 4 | 7 | 4 | 5 | 6 | 10 |

*Figure 5 – SC RRDN's recruitment rank within each month of the first three quarters of the 2024/25 financial year.*

| Month | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|
| SC RRDN rank | 4 | 5 | 6 | 4 | 4 | 4 | 5 | 6 | 7 |

*Figure 6 – SC RRDN's weighted recruitment per million population rank within each month of the first three quarters of the 2024/25 financial year.*

Quarterly recruitment by organisation in the SC RRDN region is included in Figure 7 for reference.

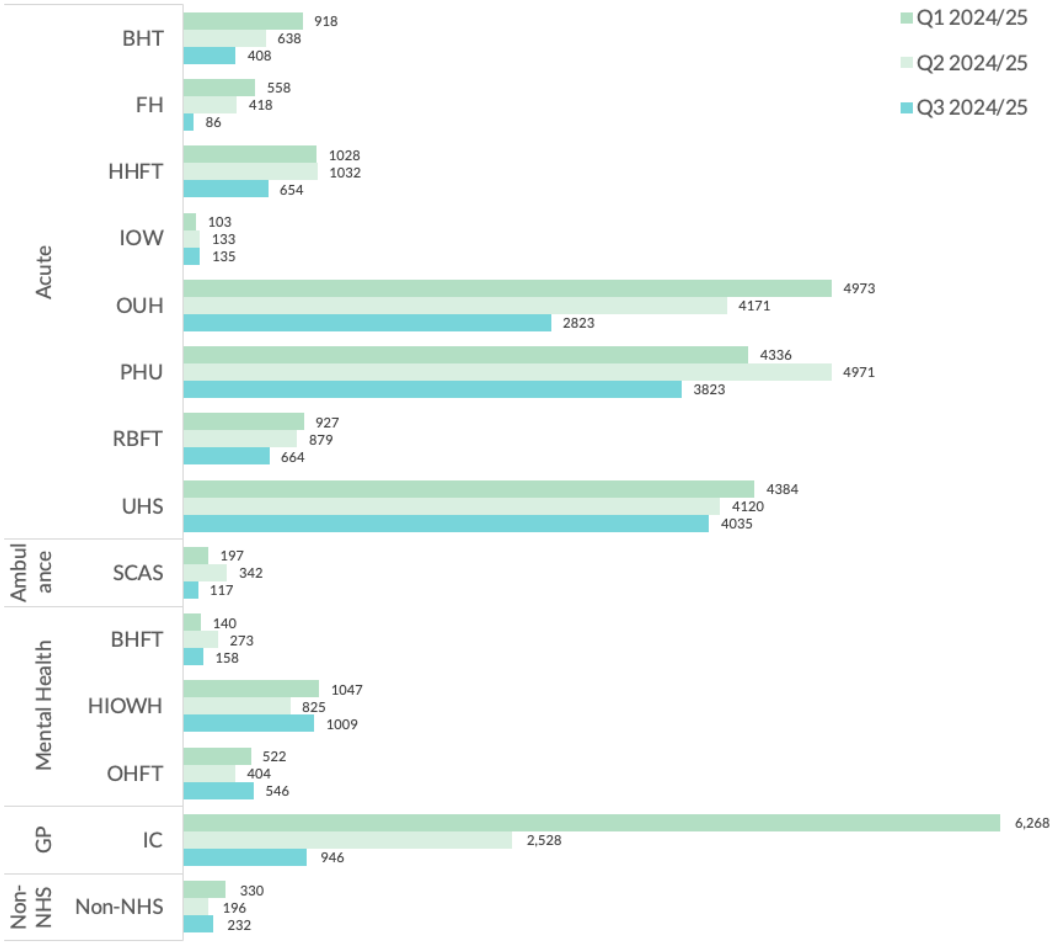
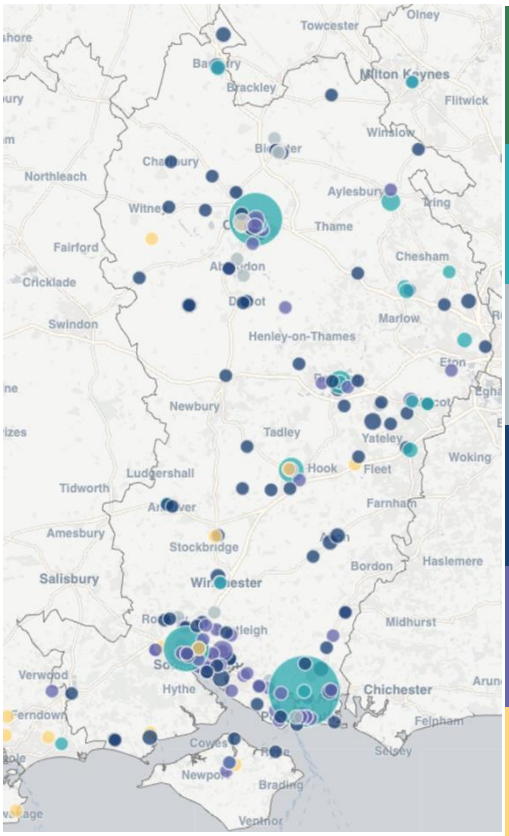



*Figure 7 – RDN Portfolio study recruitment by organisation type in the SC RRDN region in the first three quarters of the 2024/25 financial year.*

Figure 8 shows how research activity is distributed across the SC RRDN region by type of organisation. This is typically aligned with the largest population centres, although more rural areas have been reached by primary care, mental health services and non-NHS organisations.

All NHS Trusts have recruited research participants, as well as twenty seven per cent of general practice sites. The ambitions provided in Figure 8 have been set by SC RRDN in line with previous performance.




| Organisation type | Trusts | Recruiting sites | Recruitment | % of organisations recruited this financial year |
|---|---|---|---|---|
| Acute | 8 | 35 | 46,217 | 100% (ambition 100%) |
| Ambulance | 1 | 13 | 656 | 100% (ambition 100%) |
| Primary care | *N/A* | 100 | 9,742 | 27% (ambition 45%) |
| Mental Health | 3 | 66 | 4,924 | 100% (ambition 100%) |
| Non-NHS | *N/A* | 23 | 751 | *N/A* |

*Figure 8 – Research activity in the SC RRDN region by organisation type in the first three quarters of the 2024/25 financial year.*

Like recruitment, the number of non-commercial studies that SC RRDN organisations have recruited to each quarter is trending downwards (Figure 9). The number of recruiting commercial studies has remained stable across the same period. The root-cause of the downwards trend is not certain. However, when investigating by the clinical specialty, the greatest reductions between the quarter one of the 2023/24 financial year and quarter three in 2024/25 are within cancer, trauma & emergency care, mental health and cardiovascular disease, with collectively 38 fewer recruiting studies. This trend will be monitored and investigated further should it continue into the next quarter.

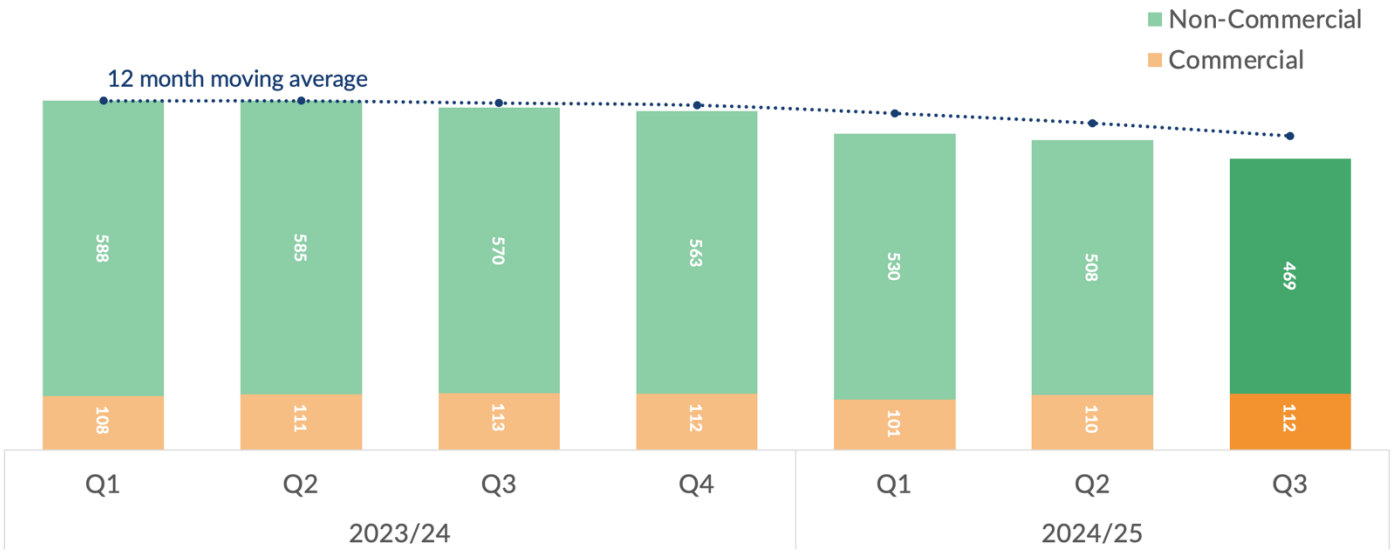



*Figure 9 - Recruiting studies in the SC RRDN region by funding and sponsorship type since April 2023.*

## Commercial research activity in the SC RRDN region

Commercial research, funded and sponsored by the life sciences industry, is important to the SC RRDN region and is a priority area for the DHSC and the NIHR. It provides novel treatment options for patients, supports the expansion of research infrastructure and often generates savings on treatment costs for participating organisations. This supports the NIHR's mission to increase the health and wealth of the nation through research (NIHR website). In the first three quarters of the 2024/25 financial year, organisations in the SC RRDN region have recruited **8,760 participants** across **54 recruiting locations** and on **196 commercial studies**.

In the first three quarters, SC RRDN was the **top recruiting RRDN region within primary care** (Figure 10) and second for all research delivery organisation types. This strong performance was primarily driven by recruitment on to the HARMONIE trial of an antibody that may lead to the prevention of respiratory syncytial virus (RSV), as well as other trials targeting RSV and norovirus.

Quarterly recruitment by organisation in the SC RRDN region is included in Figure 11 for reference.

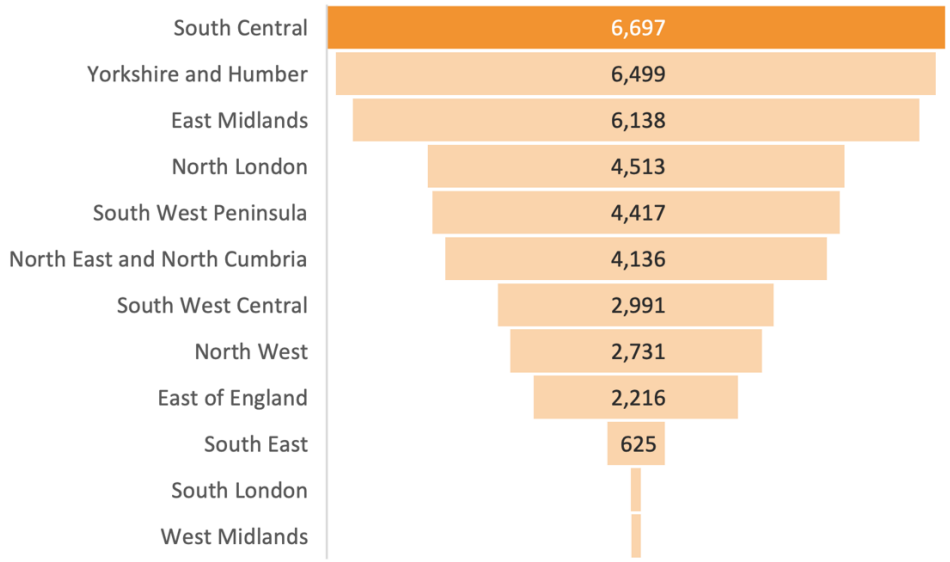



*Figure 10 - Commercially funded and sponsored RDN Portfolio study recruitment within primary care by RRDN region in the first three quarters of the 2024/25 financial year.*

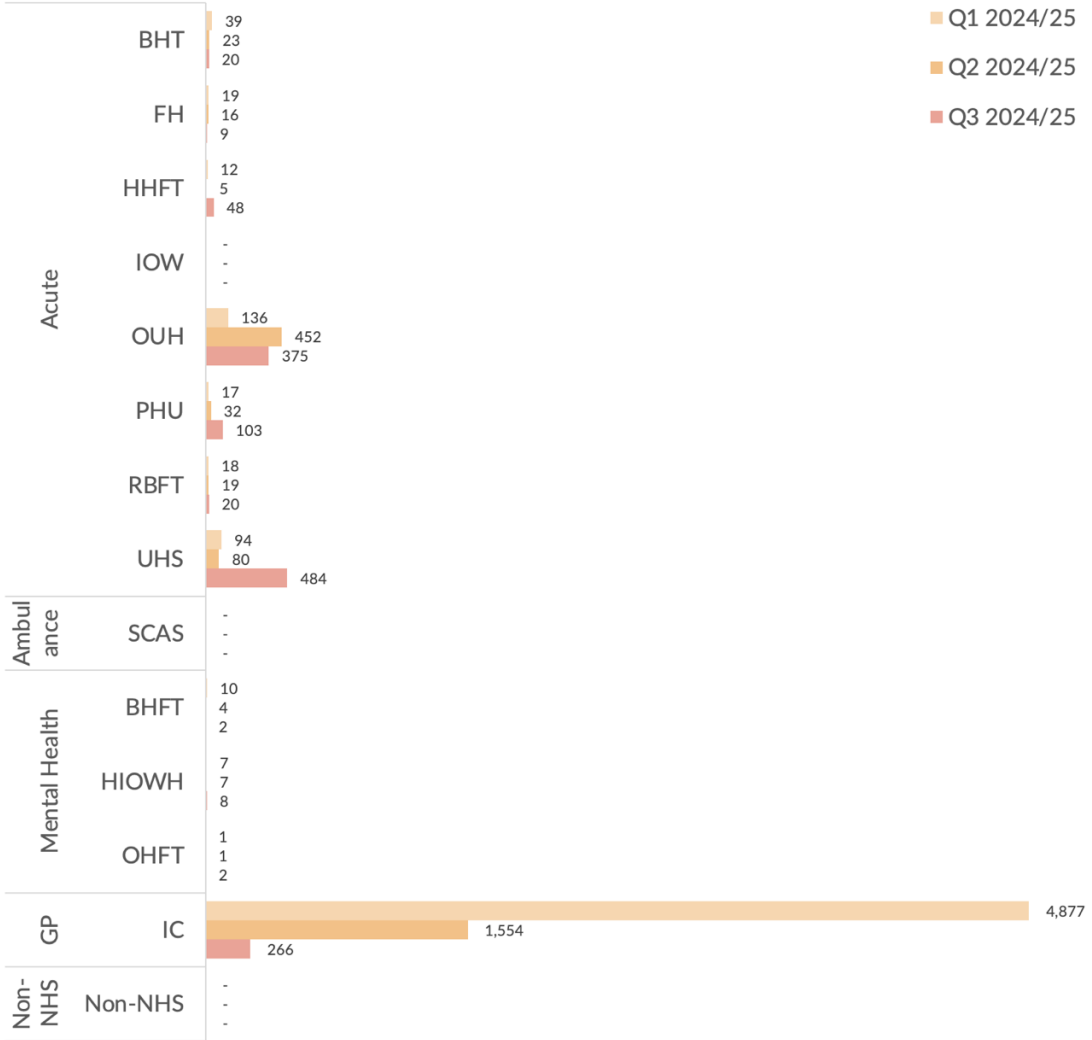



*Figure 11 – Commercially funded and sponsored RDN Portfolio study recruitment by organisation type in the SC RRDN region in the first three quarters of the 2024/25 financial year.*

# Appendix

## Appendix 1 – SC RRDN Risk Register

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | | | | | | Pre Respone Rating | | | Response | | | | CURRENT (RESIDUAL) RATING | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Risk Category** | **Risk Title** | **Area of RRDN raising the risk** | **SCRRDN Reference Number** | **Specific POF Ref** | **Date raised** | **Risk Lead Job Title** | **Named Individual Risk Manager** | **Risk Description (to include cause/event)** | **Effect/Impact** | **Probability Value** | **Impact Value** | **Score (Col JxK)** | **Mitigation Actions** | **Mitigation Lead** | **Risk Manager/Contact** | **Mitigation actions Outstanding** | **Current Likelihood** | **Current Impact** | **Current Score** | **Notes** |
| 20. Workforce Learning and Organisational Development | Research Registered NMAHPs shortage in partner organisations and job freezes in place. | | SCRRDN 001 | | August 2021 | ND, WDLs/DCOOs | | **Cause:** Lack of availability of registered NMAHPs. **Event** :Leading to a shortfall in registered staff qualified to deliver clinical trials | Fewer clinical trials are delivered and/or quality of research conducted becomes reduced leading to repuational damage. | 3 | 3 | 9 | 1. 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. 5. to be aware of trusts with job freezes and implications of RRDN funded posts | WFLs/ND | | all Ongoing | 2 | 2 | 4 | |
| 20. Workforce Learning and Organisational Development | Network Agile Research Delivery Team (ARDT) Workforce | | SCRRDN 002 | | August 2021 | CDs/ND | | **Cause:** Staff exhaustion due to ongoing workload and uncertainty. **Event**: Staff we have invested in and developed to work in this Agile capacity leave and we lose this capability | Unable to deliver Goverment priority studies as DOHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the decoupling of the ARDT team | 4 | 4 | 16 | 1. Ongoing recruitment to the direct delivery team - PAUSED 2. Reinvestment of hub income to increase head count - PAUSED 3. Wellbeing programme established for the team and delivered by the team 4. Ensure regular check-ins at 1:1 meetings with all staff 5. Continue to keep a close eye on any changes using all possible tools, e.g. 1:1s, team meetings, wellbeing 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. | WFLs/ND | | Recruitment paused, reinvestment of hub income paused | 4 | 4 | 16 | |
| 20. Workforce Learning and Organisational Development | All Core Team workforce (Management and ARDT) moral and anxiety during restructure | | SCRRDN 003 | | Oct 2014 | CDs/ND | CD | **Cause:** Staff wellbeing affected due to the longevity and emotional impact of transition. **Event:** Staff mental health impacted and unable to be at work and also unable to engage in the consultation progress. | SC RRDN unable to meet contract requirements | 5 | 3 | 15 | 1.Wellbeing iniatives established as new RRDN team, 2.UHS wellbeing check ins and informal check in with Line Managers. 3.Signposting to the services available via UHS to support staff wellbeing as outlined in the consultation pack. 4. Consultation process to be delivered with kindness and consideration. | | | | 3 | 4 | 12 | |
| 15. Research Delivery | NHS Pressures | | SCRRDN 004 | | Oct 22 | NM/DCOOs | | Impact of NHS pressures on clinical services impacting on delivery of Research | thus causing research staff to be redeployed to clinical services | 4 | 4 | 16 | 1. Raise locally and nationally for advice on prioritisation of key activities/studies | | | Ongoing | 4 | 4 | 16 | |
| 15. Research Delivery | PET Scanning Access | Hampshire and IOW area | SCRRDN 005 | 19.1.2 | Jun 24 | ND, DCOOs | Kelly Adams | Cause: Reduced access to PET scanning capacity and tracers (amyloid and tau) required for both clinical and research scans Event: Limited access to PET scans for research purposes. Reduced opportunities for access to | Threat to safety and data integrity if schedule of imaging events cannot be adhered to. | 4 | 4 | 16 | 1. Raised at OMG and IOM/BDM meeting, to monitor. 2. Discussed with COO and local escalation to ICBs via WHP | Clare Rook | Kelly Adams | Ongoing | 3 | 3 | 9 | |
| 19. Health and Care Services Engagement | BOB and Frimley ICB Engagement | | SCRRDN 006 | | Apr-22 | | | Difficulties engaging with ICS organisations that cover the South Centra; egion. Slow establishment of BOB ICS compared with other regions. | Failure to progress with workstreams and opportunities missed. | 3 | 2 | 6 | 1) Liaise with RDN CC and with fellow RRDNs to align work. 2) Leverage relationships already in place with the BOB ICS (eg OUHFT and AHSN) 3) ICS-focussed Stakeholder Day was held in January 2025 | | | Ongoing | 3 | 2 | 6 | |
| **17. Communications** | Low researcher useage of Be Part of Research volunteer service | Communications | SCRRDN 007 | *Engagement opportunities offered by the RDNCC-managed services, such as Join Dementia Research (JDR) and Be Part of Research, should be communicated and promoted to all appropriate stakeholders.* | 30/10/24 | Communications and Engagment Lead Manager | Oliver Evans | Low awareness and useage of Be Part of Research volunteer service by researchers could see opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering. Details about trials using the service have been requested from CC. | Opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering | 3 | 2 | 6 | Promotion of service to researchers through study support service and other teams and wider promotion e.g. newsletters | Oliver Evans | | | 3 | 1 | 3 | |
| **17. Communications** | Low awareness of branding guidelines | Communications | SCRRDN 008 | *Ensure the whole RRDN operates in line with the brand guidelines* | 30/10/24 | Communications and Engagment Lead Manager | Oliver Evans | Low awarness of name change to RDN and inappropriate use of South Central RRDN name with external stakeholders could result in negative impact on perception of the RDN as one network | Could result in negative impact on perception of the RDN as one network | 3 | 2 | 6 | Promotion of branding guidelines and files to RRDN staff and delivery organisations, responses ot queries via shared inbox | Oliver Evans | | | 3 | 1 | 3 | |
| **12. Governance** | Delay in services and appointment etc. | Governance | SCRRDN 009 | 12.2, 12.3 | 5/11/24 | DCCC | Mark Dolman | Delays to appointments of senior management team and the resultant effects of these delays on | Delays in the delivery of several POF requirements such as business continuity | 4 | 4 | 16 | Review of all POF requirements and prioritisation with Network Directorof those | Mark Dolman | | All | 4 | 3 | 12 | |
| **14. RDN Specialties and Settings** | Failure to appoint to all specialty and setting lead posts | | SCRRDN 010 | 14.1.1 | 30/10/24 | Network Director Operations Director Health and Care Directors (Medical & NMAHP) ? | | Risk of having vacant specialty or settting lead post due to absence of applications or inability to appoint | Lack of strategic clinical oversight and leadership. Lack of local clinical engagement | 3 | **3** | 9 | Re-advertise posts Identify and directly approach appropriate individuals Encourage NMAHP applications Consider job shares | Clare Rook | | | **2** | **3** | **12** | |

| South Central Regional Research Delivery Network | | PENDING RISK DESCRIPTION | | | | | | | | Pre Respone Rating | | | Response | | | | CURRENT (RESIDUAL) RATING | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Risk Category** | **Risk Title** | **Area of RRDN raising the risk** | **SCRRDN Reference Number** | **Specific POF Ref** | **Date raised** | **Risk Lead Job Title** | **Named Indvidual Risk Manager** | **Risk Description (to include cause/event)** | **Effect/Impact** | **Probability Value** | **Impact Value** | **Score (Col JxK)** | **Mitigation Actions** | **Mitigation Lead** | **Risk Manager/Contact** | **Mitigation actions Outstanding** | **Current Likelihood** | **Current Impact** | **Current Score** | **Notes** |
| **18. Patient and Public Involvement and Engagement (PPIE)** | Engagement with Public Partnerships Commmunity of Practice | PPIE | SCRRDN 011 | 18.1 | 7/11/24 | Network Director | CR | **Cause:** Uncertainty around roles and responsbilities<br>**Event:** Transition from Clinical Research Network to Research Delivery Network | Uncertainty around who should represent South Central Regional Research Delivery Network at Public Partnerships Community of Practice meetings, working groups, and other activities leading to inefficiencies if multiple people attend etc | 3 | 2 | 6 | N/A | N/A | CR | N/A | 3 | 2 | 10 | |
| **18. Patient and Public Involvement and Engagement (PPIE)** | Threatened relationships | PPIE | SCRRDN 012 | 18.1.2<br>18.1.3<br>18.1.6 | 7/11/24 | Network Director | CR | **Cause:** Change of region/staff/uncertainty<br>**Event:** Transition from Clinical Research Network to Research Delivery Network | Relationships threatened with:<br>1. Organisations work with through Research Ready Communities initiative<br>2. Research Champions<br>3. Public Contributors | 3 | 4 | 12 | Maintain relationships through regular contact | ZS<br>KD | CR | N/A | 3 | 4 | 12 | |
| **15. Research Delivery** | Delivery to RDN High Priority Studies - Lead Network | Industry | SCRRDN 013 | | 07/11/24 | Network Director / Operations Director / Key Account Manager | | Failure to succesfully deliver high priority studies led by SC RRDN | 1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations<br>2. Potential loss of future studies and associated income<br>3. Negative impact of staff moral<br>4. Reduction in commercial income could hinder capacity build and growth within delivery organisations | 3 | 4 | 12 | 1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations.<br>2. Agile delivery team resource allocated to support delivery in all RRDNs<br>3. Importance of high priorty studies communicated to delivery organisations at a senior level<br>4. Supporting sponsor and sites with timely rectuitment uploads to allow recruitment to be closely monitored and issues identified | Network Director / Operations Director / Key Account Manager | | All ongoing | 2 | 4 | 8 | |
| **15. Research Delivery** | Delivery to RDN High Priority Studies - Participating Site | Industry | SCRRDN 014 | | 07/11/24 | Network Director / Operations Director / Key Account Manager | | Failure to succesfully deliver high priority studies at delivery organisations within SC RRDN | 1. Reputational damage to SC RRDN delivery orgganisations and to the UK as a place to deliver research<br>2. Potential loss of future studies and associated income<br>3. Negative impact of staff moral<br>4. Reduction in commercial income could hinder capacity build and growth within delivery organisations | 3 | 4 | 12 | 1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations.<br>2. Local Agile delivery team resource allocated to support delivery organisations.<br>3. Importance of high priorty studies communicated to delivery organisations at a senior level | Network Director / Operations Director / Key Account Manager | | All ongoing | 2 | 4 | 8 | |
| **15. Research Delivery** | Agile team members working in new enviroments | Agile | SCRRDN 015 | | 07/11/24 | Operations Director/Head of Research Delivery and Support for Out of Hospital Settings | Head of Research Delivery and Support for Out of Hospital Settings TBC | Expectation for the Agile team to expand research delivery to wider commmunity and out of hospital settings. This will include settings where SC RDN does not have prior experiece of delivering research, which may present unfamiliar risks to the safety and well-being of staff members e.g. prisons and probation service, severe mental health services. There is a lack of national guidance for staff working in these new settings and current training may not sufficently cover. | Potential threat to agile staff safety and well-being when working in new environments. Unforseen safety considersations and risks that potentially prevent continuation of research delivery. | 3 | 4 | 12 | 1) Wider SC RRDN agile meeting 21/11/24 - agreed management plan. 2) Expand SC RRDN training where gaps are identified during study specific feasibility assessment. Training can can be sourced from in-house expertise, regional expertise and nationally available training resources. General training (e.g. de-escalation methods) to be provided as required to benefit staff who deliver research across settings and during engagement activities with patients, service users and the public. 3) Nancy to raise risk at the next national agile meeting to discuss, including how RDNs can collectively pool resources such as best practice, SOPS and training resources 4) Agile and primary care teams to | Head of Research Delivery and Support for Out of Hospital Settings | | All ongoing | 3 | 4 | 12 | |

## Appendix 2 - Glossary

Research delivery organisation acronyms:

| Delivery organisation | Acronym |
|---|---|
| Berkshire Healthcare NHS Foundation Trust | BHFT |
| Buckinghamshire Healthcare NHS Trust | BHT |
| Frimley Health NHS Foundation Trust | FH |
| Hampshire and Isle of Wight Healthcare NHS Foundation Trust | HIOWH |
| Hampshire Hospitals NHS Foundation Trust | HHFT |
| Isle of Wight NHS Trust | IOW |
| Independent contractors (primary care) | IC |
| Non-NHS organisations in the SC RRDN region | Non-NHS |
| Oxford Health NHS Foundation Trust | OHFT |
| Oxford University Hospitals NHS Foundation Trust | OUH |
| Portsmouth Hospitals University National Health Service Trust | PHU |
| Royal Berkshire NHS Foundation Trust | RBFT |
| Solent NHS Foundation Trust | Solent |
| South Central Ambulance Service NHS Foundation Trust | SCAS |
| University Hospital Southampton NHS Foundation Trust | UHS |

NIHR Regional Research Delivery Network abbreviations and their population:

| NIHR Regional Research Delivery Network (RRDN) | Acronym | Population |
|---|---|---|
| East Midlands | EM | 4,934,939 |
| East of England | EoE | 6,697,937 |
| North East and North Cumbria | NENC | 3,005,519 |
| North London | NL | 5,561,092 |
| North West | NW | 7,199,831 |
| South Central | SC | 4,418,268 |
| South East | SE | 4,655,433 |
| South London | SL | 3,305,088 |
| South West Central | SWC | 3,384,367 |
| South West Peninsula | SWP | 2,387,206 |
| West Midlands | WM | 6,021,653 |
| Yorkshire and Humber | YH | 5,535,065 |