NHS
University Hospital Southampton
NHS Foundation Trust

QUALITY ACCOUNT 2025/26



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Part 1: Statement on quality from the Chief Executive

1.1. Chief Executive's statement and welcome

Welcome to the University Hospital Southampton NHS Foundation Trust (UHS) Quality Account for 2025/26.

This report reflects not only our performance over the past year but the dedication, resilience and professionalism of our staff during what has been a very challenging year.

Throughout 2025/26, our overriding priority has been to protect and enhance the quality of patient care. The safety, experience and outcomes of our patients is at the centre of our decision making, and this commitment was particularly important when we navigated an operational environment that has tested us in unprecedented ways.

The final months of 2025/26 were affected by the fire that broke out in the endoscopy unit in the West Wing of Southampton General Hospital. While no patients or staff were directly harmed by the fire, the impact on our capacity was significant. Rebuilding clinical space, redistributing activity and making complex decisions about how best to use the facilities available to us required rapid, coordinated action. I want to recognise the exceptional efforts of our staff who responded with such professionalism and compassion, ensuring safe care for our patients continued despite the disruption.

Against this backdrop, I am proud that we have successfully delivered the quality priorities we set out at the beginning of the year.

We have continued to embed the Fundamentals of Care across the organisation. This framework ensures that patient-centred care remains at the heart of everything we do, grounding clinical excellence in the everyday interactions and care that matters most to patients.

An important achievement is the strengthening of support for patients, families and carers. The development of the Patient and Family Support Hub has provided a single, accessible source of practical and emotional help. Initiatives such as carer drop ins and the introduction of Butterfly Friends have further reinforced our commitment to compassionate, personalised support for the people who depend on us most.

Reducing health inequalities has been another core priority. We have now embedded measures to tackle inequality in both Trust wide and clinical strategies, supported by strong executive leadership and multi-agency governance. Over the past year we have delivered meaningful progress in key clinical areas including smoking cessation, obesity and hypertension.

This year also marked further development in the implementation of Martha's Rule. With new clinical leadership, updated materials, and enhanced communications around the Call 4 Concern pathway, we have strengthened the mechanisms that empower patients and families to raise concerns about deterioration. UHS has been invited to share learning nationally following our pioneering work as a pilot site, and we are proud to contribute to improvements across the wider NHS.

Looking ahead to 2026/27, our priorities will continue to focus on patient experience, safety and clinical outcomes. We will improve how unpaid carers are identified, involved and supported, so they are recognised as partners in care, have equitable access to support, and experience improved health and wellbeing during their UHS journey. Another priority is to enhance the reliability of enhanced therapeutic observations and care, and year two of our acuity and deterioration programme will progress across adult, paediatric, midwifery and neonatal services, alongside a renewed focus on communication through the Fundamentals of Care. We will advance our work to reduce the impact of health inequalities for a third year and begin developing an integrated quality management system, starting with a new clinical quality dashboard.

Collaboration will continue to be central to achieving our ambitions. Strengthened partnerships with local authorities, public health teams and the integrated care system will help us align strategies, share expertise and improve outcomes for the communities we serve. The challenges facing health and care require collective action, and I am confident that our developing relationships place us in a strong position for the future.

Following my decision to step down in the summer of 2026, this is my final Quality Account as Chief Executive Officer at UHS. I would like to express my sincere thanks to colleagues across the Trust for their unwavering commitment to high-quality care.

To the best of my knowledge, the information contained in this report provides an accurate and honest reflection of our performance and our progress. It demonstrates where we have succeeded, where we have exceeded expectations, and how we continue to deliver on the plans that matter most for our patients and communities.



David French
Chief Executive Officer
23 June 2026

Part 2:
Priorities for improvement and statements of assurance from the Board

2. Introduction

Every year, all NHS hospitals in England are required to produce and publish an annual report for the public on the quality of their services. This report, known as the Quality Account, helps ensure that we at UHS remain accountable to our patients and the wider community, supporting ongoing improvements in the care we provide. Quality in healthcare is underpinned by three core dimensions.



Patient experience - how patients experience the care they receive



Patient safety - keeping patients safe from harm



Clinical effectiveness - how successful is the care we provide?

Our Quality Account includes everything required under The National Health Service (Quality Accounts) Regulations 2010 (as amended), along with additional reporting expectations. It covers:

- Our performance against the quality priorities and goals we set for 2025/26, outlining how well we delivered against last year's commitments.
- The priorities we have agreed for 2026/27, including how we plan to achieve them in the year ahead.
- Legally required information that enables the public to compare the quality of our services with those provided by other NHS Trusts.
- Further detail on our progress and achievements in key areas related to quality.
- Statements from stakeholders and external assurance bodies, including Healthwatch, our Council of Governors, the Hampshire and Isle of Wight Integrated Care Board, and Southampton City Council's Health Scrutiny Committee.

2.1 Priorities for improvement

This section reflects on the 2025/26 quality improvement priorities at UHS and outlines our quality improvement priorities for 2026/27.

2.1.1 Progress against 2025/26 priorities

Our quality priorities for 2025/26 were developed to reflect our commitment to providing well-led, safe, consistent, and compassionate care in a way that is both transparent and measurable. These priorities were influenced by a combination of national, regional, local, and organisational considerations. UHS acknowledged the considerable operational pressures being experienced across the health and social care system. Within this challenging context, our aim remained to deliver high quality care, and our priorities were shaped to address these pressures while maintaining standards.

Overview of success

Core dimension	Quality priority	Progress
Patient experience 	Establishing and developing the Patient and Family Support Hub to address disease inequalities and meet the needs of all our patients, families, and carers (Year two)	Achieved
	Improving the care of the dying patient and those important to them	Achieved
Patient safety 	Acuity and deteriorating patients across UHS Adults/paediatrics/maternity and neonatal	Achieved
	Implementation of the national safety standards for invasive procedures (NatSSIPs)	Achieved
	Fundamentals of Care	Achieved
Clinical effectiveness 	Develop the Trusts' approach to reducing the impact of health inequalities (HIs)	Achieved
		Achieved
		Achieved

2.1.2 Quality improvement priorities - 2025/26: final reports

Quality Priority One: Establishing and developing the Patient and Family Support Hub to address disease inequalities and meet the needs of all our patients, families and carers (Year two)

Why was this a priority?

UHS is a regional centre for many disease types, but we recognised there was an inequality in provision of support facilities in the Trust for all of our patients and their friends and families regardless of their clinical conditions.

What have we achieved?

- Following the end of our agreement with Macmillan, the Patient and Family Support Hub was relaunched.
- A dedicated funding stream has been secured from the League of Friends, with each room funded individually. As a result, the full estates programme will progress over an estimated 18 month timeline.
- The first funded estates project is the carers' shower, and this is now underway and is scheduled to open in April 2026.
- A carers' afternoon tea was held in summer 2025 to engage unpaid carers and has now been established as a monthly drop in session.

Volunteer responders are now fully embedded and routinely support the UHS site team with patient discharges and equipment repatriation.

Key areas identified for further development

- After the opening of the carers' shower there will be the facility to expand on carer support, and the Patient and Family Support Hub will be the central point for this.
- To support the Trust risk related to side room capacity and dying in a bay, the next estates aspiration will be to convert the current garden room into a living room like appearance with sky lights, this will enable families to have privacy away from wards.

How will ongoing improvements be measured and monitored?

- Grant request in progress with League of Friends for garden room.
- Regular unpaid carer surveys to monitor improvement in carer experience with focus on measuring the success of the carers shower initiative.
- Monitoring of the National Audit of Care at the End of Life (NACEL) survey results.

Progress metrics

- Reduction in adverse event reporting related to patients dying in an open bay.
- Improvement in carers survey.
- Friends and Feedback Test (FFT) results.
- Formal complaints relating to carers and end of life reduction.

Quality Priority Two: Improving the care of the dying patient and those important to them

Why was this a priority?

Supporting and caring for patients at the end of their lives is very important to all our staff at UHS. We are committed to providing excellent care for patients and those important to them. We recognise that there is one chance to get this right for patients and their loved ones. We aspire to deliver excellent compassionate end of life care that enhances patient quality of life and involves those important to the patient.

Each year approximately 1,900 patients die at UHS, and we care for many more who are approaching dying (,5000 + in the last three months of life).

For those who are dying it is essential that their symptom control is effective, patients and families have accessible information about end of life care, communication with patients and those important to them is compassionate and effective.

Findings from NACEL 2024 and other feedback indicate that family's needs are not consistently identified or met, and we are not meeting family expectations in terms of communication.

What have we achieved?

- We have launched the UHS 5-year end of life care strategy. We have introduced and promoted the use of new information booklets for families of patients who are dying, to ensure supportive written information is available alongside conversations with clinical teams. We have created and launched an end of life care discharge checklist to promote safe and effective discharges at the end of life. Learning around these materials has been reinforced within clinical areas trolley dashes, bringing the learning directly to the clinical areas. A key area for development is in symptom control at the end of life. We have implemented a paper-based symptom observation chart supported by a comprehensive clinical guideline. For the first time this allows ward-based staff to objectively measure symptom burden, prompts drug and non-drug interventions and when staff should escalate concerns and seek specialist help. We have delivered targeted training at ward level to end of life care champions and clinical forums to ensure consistent use.
- Matron led walkabouts contributed to the promotion of end of life care across the Trust and provided an indication of areas of good practice and areas for further improvement work.
- The initial end of life care Butterfly Friend volunteers have started to support patients at UHS in association with the Anne Robson Trust. In quarter four, additional volunteers will be recruited and trained to increase the scope of the service to support more patients and families.

Key areas identified for further development

We have recognised that clinical teams are not always familiar with caring for dying patients and need additional support and guidance. As a result, the individualised end of life care plan clinical guideline has been updated to include the UHS standard for daily medical and surgical team reviews of dying patients. We continue to seek more feedback from families about their experience at the end of life. This includes increasing participation in the NACEL as well as through the UHS bereavement service. The need for end of life care to be part of the electronic patient record remains an unmet need.

How will ongoing improvements be measured and monitored?
• We will continue to monitor the quality of end of life care documentation and report to UHS governance groups. • Increase numbers of patients receiving support through the Butterfly Friend volunteers. • NACEL results which show improvement at UHS and benchmark positively with peer trusts.
Progress metrics
As above

Quality Priority Three: Acuity and deteriorating patients across UHS: Adult and paediatrics

Why was this a priority?

The recognition, assessment and escalation of a deteriorating patient, either adult or child, are a key element of our trust-wide patient safety and quality strategy, with the aim to improving clinical outcomes for acutely ill patients. How rapidly we respond to patient deterioration both in and out of hours is a key determinant of patient and quality outcomes.

What have we achieved?

- Monthly adult acuity data reports generated and shared across UHS. Key learning shared with clinical and education teams.
- Compliance of observations within adults incorporated within monthly acuity reports.
- Paediatric acuity data now sourced and going live with monthly reporting from March 2026.
- All unplanned ICU admissions (adults and paediatrics) reviewed, reason for admission shared with education teams to influence deteriorating patient education.
- All cardiac arrest calls (adults and paediatrics) are followed up by the resuscitation team. Reported at quarterly resuscitation committee and bi-monthly deteriorating patient group (DPG). Key learning shared with clinical and education teams. Incorporated into bi-monthly patient safety steering group resuscitation team update.
- Remote surveillance dashboard with National Early Warning Score 2 (NEWS2) and key biochemistry used by adult critical care outreach team (CCOT) team for earlier identification of deteriorating or at risk patients.
- Adult CCOT outcome data shared locally and regionally.
- Paediatric CCOT outcome data shared locally.
- National Paediatric Early Warning Score (NPEWs) compliance audited monthly with results and learning shared.
- All Call 4 Concern (C4C) reviewed, and themes identified – shared via monthly acuity page.
- An adverse event report (AER) is completed for all C4C activations for review and action at local level.
- Paediatric C4C activations discussed at PAD network meetings.
- Shared learning at DPG via quarterly report.
- Patient wellness questionnaire (adults) – first PDSA cycle completed and seconf PDSA cycle in progress. Pilot commenced within oncology and medicine for older persons.
- PWQ (paediatrics) – analysis on compliance and impact commenced.
- Adult and Paediatric internal and external communications reviewed, national brand applied.
- New clinical lead for Martha's Rule implementation in post.
- Updated all information/education materials, including patient information leaflet posters to improve awareness of Martha's Rule and Call 4 Concern across UHS.
- Quarterly Martha's Rule paper detailing key data and learning – shared with deteriorating patient group.
- Current education provision gap-analysis completed by divisional education leads.
- Recognition, evaluation and assessment acute care training (REACTs) pilot for new resident doctors and nurses successfully piloted and implemented.
- Paediatric regional education programme (ST2-8 resident drs) is well established at UHS.
- Response and assessment of the paediatric patient in deterioration (RAPPID) is well established at UHS.
- Deteriorating patient education platform on the virtual learning environment (VLE) has been developed and is available to all staff and includes NEWS 2, A-E assessment and sepsis e-learning resources. Currently for adult patients.

- Adult CCOT delivering between 2-6 deteriorating patient education sessions to healthcare professionals per month.
- Sepsis MDT meeting held, priorities agreed, emergency department (ED) sepsis data analysis, sepsis education.
- Monthly adult ED sepsis data and analysis – shared with ED, DPG and Quality Committee.
- Actions developed with ED to improve compliance with NHS contract.
- E-learning for Health (E-LfH) sepsis e-learning for adults, paediatrics and learning disability live on deteriorating patient education VLE Hub.
- REACTs and the paediatric regional education programme (PREP) (a Wessex run programme for paediatric resident doctors) has a strong link to sepsis education.
- Annual paediatric sepsis data reported with learning shared across Southampton Children's Hospital (SCH).
- Collaborative discussions with matrons, ward leaders and specialist teams to understand requirements of the quality dashboard completed and top ten priorities agreed for development.
- Collaborative discussion with UHS digital team – gap analysis completed to understand what is currently available and in what format.
- All requests reviewed into must have, should have, could have for prioritisation.

Key areas identified for further development

- Monthly ED acuity report in development.
- Exploration of remote surveillance within the paediatric CCOT service.
- Exploration of ED-ALERT formalised within ED discharge processes through new Miya system.
- Development of upscaling patient wellness questionnaire (PWQ) across adult in-patient areas.
- Enhance reporting to capture key themes and associated paediatric educational interventions.
- Development of Martha's Rule patient information video.
- Development of paediatric education resources on VLE deteriorating patient education hub.
- Development of quarterly acuity newsletter for staff.
- Implementation of a task and finish group to formalise the clinical quality dashboard priorities in line with the UHS corporate strategy.
- Gap analysis for data sources completed for all elements within the clinical quality dashboard.
- Building and implementation of the clinical quality dashboard to be agreed.

How will ongoing improvements be measured and monitored?

- Ongoing improvements in the management of patient acuity and clinical deterioration will be measured and monitored through a structured combination of quantitative indicators, qualitative insights, and robust governance processes.
- Key performance metrics — such as compliance with observation frequency, accuracy of early warning scores, timeliness of escalation, and rates of unplanned ICU admissions or cardiac arrests — will be routinely reviewed to assess the effectiveness of interventions.
- This data will be complemented by regular audits, case reviews, and staff feedback to identify emerging themes and barriers to best practice.
- Digital dashboards and real time monitoring tools will support proactive oversight, enabling early identification of trends and areas requiring targeted action.
- Progress will be reported through established clinical governance structures, ensuring accountability, transparency, and sustained focus on improving outcomes for deteriorating patients.

Progress metrics
• Progress will be assessed using a defined set of quantitative and qualitative metrics that reflect the effectiveness of interventions aimed at improving the recognition and management of deteriorating patients. • Key indicators will include compliance with observation frequency, accuracy and completeness of early warning scores, timeliness of escalation and clinical review, and reductions in unplanned ICU admissions or deterioration related incidents. • Additional measures such as cardiac arrest rates, sepsis screening compliance, and staff training completion rates will provide further insight into system performance. • Together, these metrics will offer a clear and measurable picture of progress, enabling the organisation to evaluate impact, identify areas for further improvement, and demonstrate enhanced patient safety outcomes.

Quality Priority Three: Acuity and deteriorating patients across UHS: Maternity

Why was this a priority?

In line with the three-year delivery plan for maternity and neonatal services (NHS England, 2023) to implement best practice, including the new Maternity Early Warning tools by 2025. Improving the early detection of patients who are deteriorating is vital to improving morbidity and mortality; three of the four most common direct causes of maternal death (MBRACE, 2024) would result in abnormal MEWs scores early on. Improving escalation and involving the whole MDT early, thus improving outcomes within maternity care (MBRACE, 2024). Cross-site working (Princess Anne Hospital/ Southampton General Hospital) poses unique challenges and therefore improved joint working would provide additional opportunities to enhance safety by preventing delays in identification and escalation of deteriorating patients.

What have we achieved?

- Digital recording of maternal observations has not yet been implemented due to a BadgerNet system update delay. This system update is now ready for implementation from April 2026. Staff are trained to digitally record observations, and we are currently working with our practice education team to ensure staff are updated prior to implementation and the equipment is available and continually monitored by the maternity digital team.
- UHS have successfully taken part in a pilot for implementing Martha's Rule in maternity and neonatal services. Maternity services actively engaged with both CCOT, neonatal services and external agencies throughout the pilot and have been invited to share our experiences with trusts across the region and Maternity and Neonatal Safety Investigations (MNSI). We officially launched Call 4 Concern within maternity and neonatal settings in February 2026.
- Maternity services continue to engage with CCOT, including supporting a project to raise the profile of CCOT within maternity whilst also meeting element two of Martha's Rule. CCOT continue to attend safety huddles on an ad hoc basis and spend time with our HDU (midwifery) and obstetric teams to increase their knowledge of maternity, and our HDU team are rostered days with CCOT/ITU on an annual basis. The maternity practice education team continue to ensure that maternity red flags and safe escalation are included on both inductions and PROMT. Maternity services are actively engaged with the maternal medicine lead (LMNS commissioned) to promote education on 'red flags' with all staff groups in maternity. We work closely with the LMNS lead for Martha's rule.
- Maternity will now be represented at the trust-wide deterioration working group and regularly attend a regional community of practice for deterioration within maternity.

Key areas identified for further development

- Audit of progress metrics to allow full PDSA cycle will be our next stage. These progress measures were not previously available due to delayed implementation.
- On reflection and discussion with the MDT, we have currently paused work on the CCOT surveillance tool with the aim of implementing and reviewing the need for this once we have fully implemented digital recording of observations within maternity and the escalation prompts this tool will bring.

How will ongoing improvements be measured and monitored?

Using progress metrics detailed below alongside regular attendance of deterioration working groups both within maternity and the wider Trust.

Progress metrics
• Digital observations scheduled to go live April 2026, with staff already trained and equipment readiness monitored. • Martha's Rule pilot completed, with UHS invited to share learning. Call 4 Concern launched in February 2026. • Ongoing collaboration with CCOT and LMNS, including safety huddle participation, annual HDU/CCOT-ITU rotations, and strengthened red flag/escalation training. • Maternity now represented on the trust-wide deterioration working group and regularly attending the regional deterioration community of practice.

Quality Priority Three: Acuity and deteriorating patients across the Trust: Neonatal

Why was this a priority?

The introduction of the Newborn Early Warning Track and Trigger (NEWTT2) chart was prioritised to improve patient safety as this provided a standardised escalation tool. There is also the ability to include parental concerns in the escalation and scoring which supports recommendations made in recent national maternity investigations.

What have we achieved?

We launched NEWTT2 utilising paper charts in April 2025, following the successful training of >75% of staff. The digital tool became available in the Autumn, and we launched NEWTT2 on maternity BadgerNet in December 2025. An audit showed that the majority of babies who required NEWTT2 observations in May 2025 were identified and had observations completed.

Key areas identified for further development

To review the NEWTT2 observation requirements for those babies born in the presence of meconium-stained liquor as there is current confusion and inconsistency across the service with the frequency of these.

How will ongoing improvements be measured and monitored?

A further audit will be carried out to assess compliance following the introduction of digital NEWTT2 charts. This audit will also be added to the service's audit schedule to be repeated annually to allow for ongoing monitoring. The frequency may be amended dependent on the results of the audit.

Progress metrics

An audit of compliance was undertaken in May 2025, assessing whether eligible infants were correctly identified as requiring NEWTT2 observations, whether observations were completed at the appropriate frequency, and whether escalation responses were appropriate when indicated.

The audit showed that the majority of babies who required NEWTT2 observations were identified and had observations completed. There were three babies who should have had observations for different reasons but didn't have any observations carried out. One of these were post elective section, one was for light meconium and the other for kaiser greater than one. There appeared to be some confusion around frequency of observations for those with light meconium and what that is defined as.

All appropriate and timely reviews took place for any babies who had scored on the NEWTT2 observations.

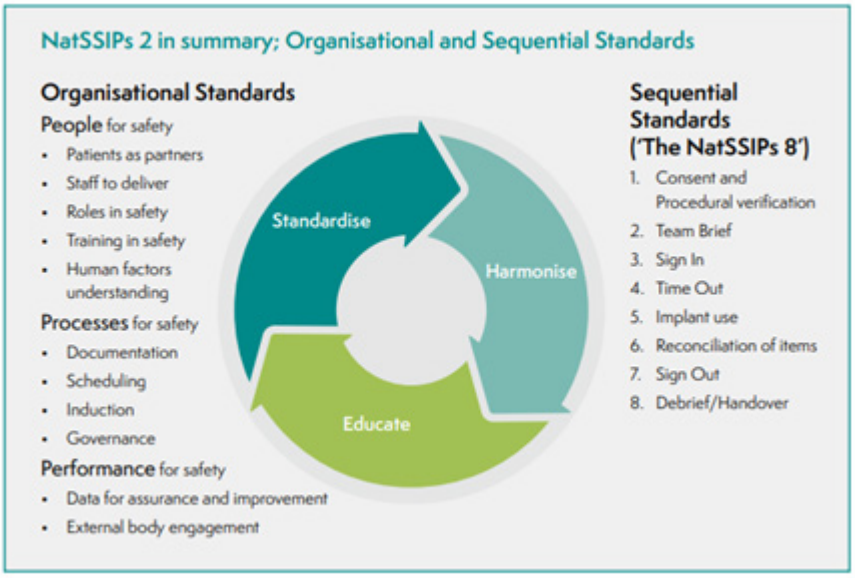
Quality Priority Four: Implementation of the national safety standards for invasive procedures (NatSSIPs) 2 at UHS

Why was this a priority?

The new national safety standards for invasive procedures (NatSSIPs 2) represent the progression of the original NatSSIPs. The key aim was to standardise, harmonise and educate across organisations and procedural teams remains central to the NatSSIPs purpose. Critical changes include improved organisational standards and proportionate checks that recognise different levels of risk during major and minor invasive procedures, and the adaptions to processes that may be necessary in life-threatening situations. This standardisation, harmonisation and education goal is set out in the table below:

Table 1

	Organisational	Sequential ('The NatSSIPs Eight')
Standardise	Safety behaviours, processes, policies, insight, involvement and performance measures across organisations and specialties.	Expected behaviour, safety standards, checklists and format across invasive specialties.
Harmonise	Across groups of hospitals. Across IT systems.	Reduce variation across specialties.
Educate	Commit to safety education, human factors expertise and systems thinking. Create a safety infrastructure, leadership understanding and training in cultural change.	Teach and train in team behaviours, human factors, systems thinking learning / co-production with patients.



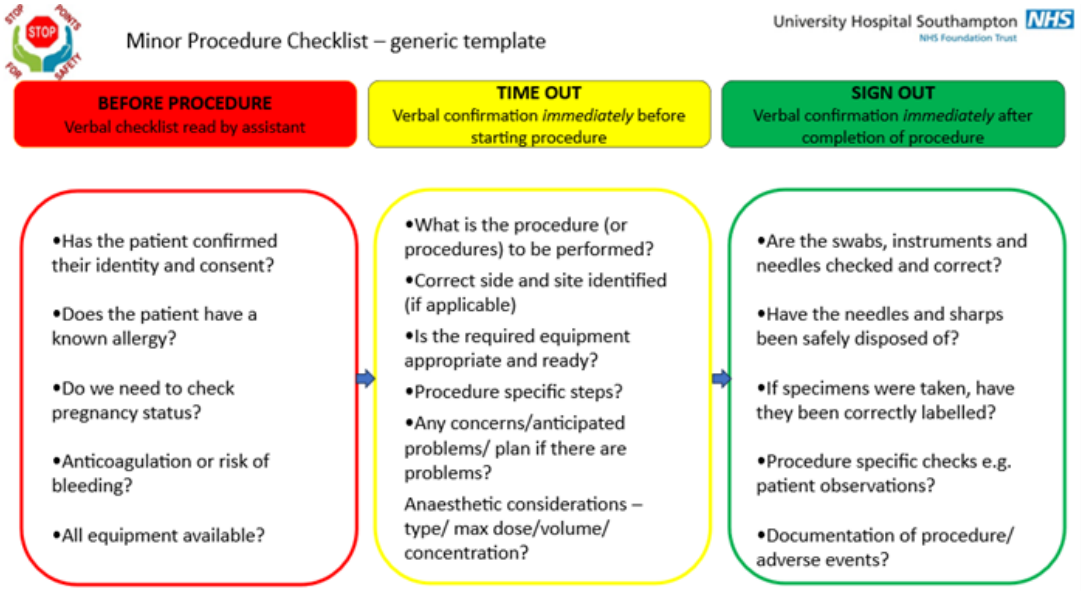
This became a quality priority following several never events across the organisation, many of which identified contributing factors related to stop points for safety. Key themes identified from never events included:

- Implementation and embedding of NatSSIPs 2.
- Empowering staff to speak up and be heard.

- Ensuring correct skill mix is available.
- Standardisation of marking lesions (correct pen).
- Clear documentation at all stages of patient's pathway.
- Utilise drapes with larger apertures.
- Improve management and documentation for NGT.
- Reconciliation of items.
- Management of implants.

What have we achieved?

- Established a NatSSIPs oversight committee led by chief medical and nursing officers to have oversight of NatSSIPs implementation and response to never events.
- Established an invasive procedures committee. Whilst this is well established and meets monthly there is some improvements to be made to ensure regular attendance. The committee is responsible for oversight of NatSSIPs workstreams, agreeing policies and checklists for invasive procedures (with the aim of harmonising these across the Trust), reviewing audit and observational data, and agreeing consent policy.
- The safer surgery policy has been updated and approved. The stop points checklists for the individual theatre areas are being updated and trialled. These are not in use in ophthalmology.
- The minor procedures policy is agreed, with a standardised template for checklists, and generic audit tool that can be adapted to each area:





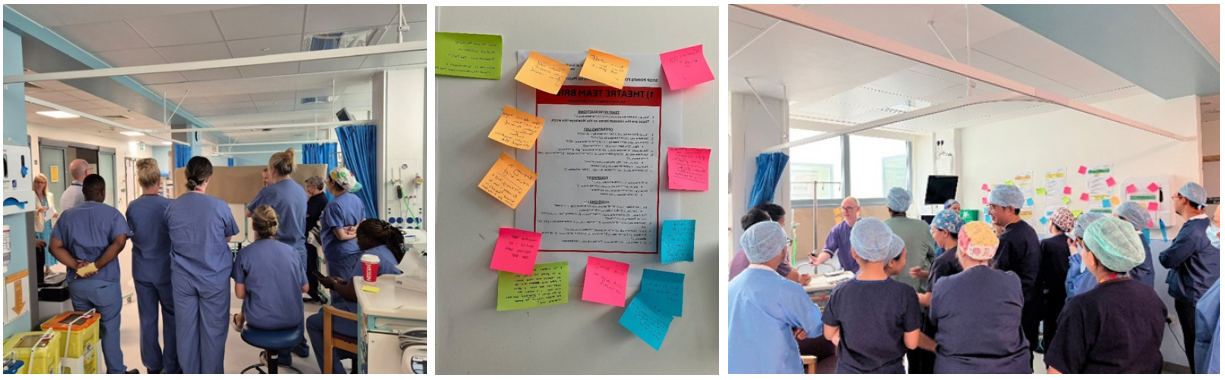


Photos of the ophthalmology simulation education session

- The job description for NatSSIPs leads for each department has been agreed.
- UHS took part in the CHECKPOINT study which is looking at adaptations to checklists and how these are implemented across the UK. We are awaiting feedback from this to see what learning can be applied at UHS.
- Several multidisciplinary safety walkabouts in wards and interventional areas have been undertaken. There is rich data from these walkabouts, and the infographic below shows how staff express how they keep patients safe. There was a good focus on teamwork, communication, falls and infection prevention. 81% of staff felt it was easy to raise incidents and 92% that learning from incidents and complaints was effective.



- Safety stop point audits in theatres: An enhanced observational audit tool has been developed to assess checklist use in theatres and is currently being trialled.
- Training requirements have been agreed, mapped to the Virtual Learning Environment (VLE), and embedded into induction. To date, 2,273 staff have completed VLE stop points training (1,701 allocated; 81% overall compliance).
- Education and simulation: A medical simulation education lead has been recruited, with simulation based training now being delivered within ophthalmology.
- Patient involvement: Two quality patient safety partners (QPSPs) now attend the invasive procedures committee, and updated patient involvement statements have been added to the admission information leaflet. A workshop with QPSPs and patients with lived experience is planned for March/April to gather feedback on how involved patients feel in their safe care.
- NatSSIPs 2 workshop: A trust-wide NatSSIPs workshop was held in August, attended by 60 staff from theatre teams and multiple professions. Learning from the session has informed checklist updates and strengthened training and guidance for NatSSIPs delivery.



Images from the workshop

- Communications: Screensaver has been used to explain the terminology of major and minor invasive procedures and need for checks. Organisational-wide learning for minor procedures was shared in September 2025. An education slide deck has been developed for education teams to use when teaching about minor procedures.

Key areas identified for further development
• Engagement – Now that the policies are in place and divisional restructuring is complete, we wish to get clinical leads from all care groups and subspecialities to help engage staff and ensure that procedures in their areas meet these requirements. • Improved reporting to local and divisional governance on NatSSIPs metrics: audits of engagement with checklists in both theatres and for minor/ward and outpatient-based procedures, VLE training, and face to face training.
How will ongoing improvements be measured and monitored?
• Education – establishing updated VLE training (potential use of a national programme once it is developed), use of simulation and non-technical skills training with the multi-disciplinary teams. • Challenges – lack of dedicated resource to deliver training and support audit work. Need to ensure a human factors and ergonomic base to the improvement work.
Progress metrics
• Increase in the completion of VLE stop points training. • Develop and implement a programme to deliver non-technical skills training. • All areas with a never event in the last two years have an up-to-date audit and action plan for compliance with NatSSIPs2.

Quality Priority Five: Fundamentals of Care

Why was this a priority?

Patient experience – Fundamentals of Care (FoC) was established as a priority in 2024-25 due to evidence that post COVID we had not yet returned to a less task-focused and more patient focused level of care. The priority was developed to create a foundation and structure to tackle these standards of care and to challenge practices, in response to patient and relative feedback.

What have we achieved?

Following on from the successes of the 2023/24 quality priority we have continued to drive forward standards of care:

- The FoC project board continues to meet every eight weeks, to evaluate progress and set and obtain clear objectives aligned to trust priorities and concerns and escalating through the governance structure to QGSG and Quality Committee. This muti-professional group continues to focus on the eight standards and the 'golden thread' of infection prevention which draws it all together to create a focus on person-centred care.
- 112 members of staff have attended bespoke FoC training sessions with more accessing FoC focused education through newly qualified professional preceptorship, healthcare support worker induction and localised care group education.
- Two new training sessions have been created with one focused on building a comprehensive network of 'champions' across the organisation to share ideas and learning, working together to improve standards of care and showcase areas that are providing an excellent patient experience.
- The second new session is particularly focused on the care of our patients who have learning disabilities and/or autism (LDA) and how we bring the nationally mandated Oliver McGowan training 'to life'.
- We have worked through the matron's walkabout and with our QPSP's to better understand the experience of patients who have LDA and their carers. We have designed this training with examples of care received at UHS and working in collaboration with carers in our community.
- We continue to value and advocate for the 'patient voice' engaging our QPSP of which we have three who advocate for the patient perspective, plus further engagement from our 3,000 involved patients.
- We have worked in collaboration with therapy colleagues across medicine for older people (MOP) to initiate a trial in two ward areas, Geriatric Rehabilitation and Care Enhancement (GRACE), looking at how we promote effective mobility in hospital to prevent deconditioning and support patients in hopefully going 'home' sooner. It also includes promoting a strength-based rehab approach through proportionate care techniques and is something being presented on regionally.



Head of patient experience celebrating the launch of the GRACE trial on G8



Therapy staff working alongside patients in the MOP wards as part of the GRACE project, to maximise single handed care opportunities for discharge home

- This project is all about supporting staff in embracing all aspects of the Fundamentals of Care to focus on what matters to our patients the most and launching a trial of our 'What Matters to Me' (WMTM) boards with the support of some of our UHS ward volunteers.
- WMTM has been trialled in G5, G8 and D4. Some barriers to progressing this and scaling this up were found but this is being worked through with a new volunteer coordinator, funded by a regional Volunteering for Health bid. Two new volunteers have been recruited into the role and are working with us to embed this in clinical areas, focusing on a picture of the patient when they are well, to remind staff of the person that they are outside of hospital.
- 80% of patients have said that the board captures what is important to them and 66% of the patients have said that the boards have led to improvement in the quality of conversation.
- 100% of staff surveyed have also said that the boards have led to higher quality conversation with the patients.

Our volunteer Sue, working with a patient to find out what matters most to them and encourage person-centred care through person-centred conversation



- The outpatient department has joined the FoC project board and has created care commitments that match the care they provide in that setting. They have worked with patients and staff to co-create this.

- A self-assessment tool was launched across the Trust for inpatient adult care with an outpatient self-assessment under development. This is designed to encourage areas to benchmark their progress against patient perceptions of care, to focus on the areas of the FoC they can improve upon.
- We have focused on improving the transparency of the FoC to the public, adding to an improving the public website, by adding new subpages can be added in future as needed, but including information our patients, families and carers commonly ask us about. Additionally, we have banners at all our entrances to the main SGH building, highlighting this to visitors and giving them a QR code that they can scan to find out more.
  - We are also promoting this widely at community forums including Healthwatch and the Carers Partnership Board to ensure that our colleagues can also promote us, our services and initiatives, creating more visibility of UHS connecting to its community and hearing and acting upon the concerns of the service users.

Key areas identified for further development

- Continuing to grow and nurture the FoC across the organisation through the launch of maternity and child health care commitments.
- Process mapping and evaluating the care of patients from ED to discharge, particularly around the care and documentation of that care focused on catheters, cannulas and intentional rounding which will encompass pressure area observation.
- Growing a 'documentation standards' working group to focus on clarity and guidance for staff on the standards of documentation expected, particularly in relation to body maps and the daily assessment of care documentation
- Employ a quality improvement facilitator to take over from the project manager and to focus on the practical clinical support staff need to overcome some of the barriers to person-centred care, ensuring implementation of key initiatives including WMTM.
- Ongoing implementation and evaluation of WMTM boards across key areas in organisation, with full volunteer support for the obtaining of photographs of the patients from themselves/ families to maintain that person-centred focus.
- Ongoing development of resources that provide our community, patients, families and carers with information that can best support their experience throughout their stay in hospital.
- Continue the focus on the care of patients who have a learning disability and/or autism, evaluating the care they experience, implementing the FoC study day focused on supporting staff to improve the care these patients and their families experience.

How will ongoing improvements be measured and monitored?

Improvements will continue to be measured and monitored through FFT feedback, our 'involved patient' surveys, focus group outcomes, evidence from the self-assessment tools and ongoing surveillance of the clinical quality dashboard. The comments we receive from PALS, complaints and national surveys will help us to improve the workstreams and focus through comprehensive thematic analysis.

Progress metrics

- Reduction in clinical incidents: Whilst we continue to see 'communication' as a broad theme in our feedback, a large proportion of these relate to waiting times, appointments and outpatient activity which has been worked on extensively by the outpatient administration team. We continue to see a decrease in the general number and severity of incidents related to the FoC across inpatient settings. However, in areas where we saw an increase, e.g. with the care of our LDA patients, we have had a specific and targeted workstream to improve this, which we aim to full evaluate in Q1 2026/27.

- Reduction in complaints: Complaints are themed in line with nationally recommended categories, which do not align directly with FoC. However, we have observed a sustained decline in complaints relating to patient care. In 2025/26, there were 959 complaints, of which 54 were coded as patient care, representing 6.05%.
- Sustained compliments about care: In 2025/26, 92.1% of our patients say that their pain was well controlled, 87.1% feel involved in decisions about their care and 88.9% involved in their discharge, with an overall increase in the number of responses we received from our FFT.

Quality Priority Six: Develop the Trusts' approach to reducing the impact of health inequalities (HIs) (year two)

Why was this a priority?

Tackling health inequalities is a key priority for the NHS. It is a moral imperative to address unfair, avoidable differences in health outcomes and experience. Addressing these gaps ensures equitable access to care, reduces long-term demand and improves health outcomes and life expectancy for those impacted.

In Southampton, health is worse than the national average, with people living fewer healthy years, about 59 years for both men and women. Over two-thirds of adults are overweight or obese, and nearly 10% of pregnant women smoke. These problems show clear health inequalities linked within our region and the Trust needs to work with our partners across the system to reduce the impact of inequalities.

At UHS we have been working to have an impact on health inequalities for several years. In 2024/25 we formalised these efforts with a governing board, chaired by our chief medical officer and with a clear programme of improvement based on recognised priorities. This formed the basis of our quality priority in 2024/25. This year's quality priority is a continuation of this work. We intend to continue to grow our understanding and actions as an organisation, improving the equity of access, outcomes and experience of our services across our community.

What have we achieved?

We set ourselves ambitious improvement aims around five themes:

- Improving care in areas of clinical priority
- Data and measurement
- Enabling the organisation
- Communications and engagement
- Strategy and programme delivery

We have made progress in all these areas in the last year.

Clinical priorities

We set three clinical priorities related to health inequalities for centralised support – tobacco dependency, hypertension and obesity. These were chosen in collaboration with public health teams within the local authorities, and the integrated care board based on national evidence related to significance of impact on health inequalities, where it was felt an acute hospital could have greatest impact, and the most prevalent challenges for our population.

Tobacco dependency

Our ambition was to improve services and support for patients and staff who smoke and to demonstrate improved access to care.

In the last year we have made progress in line with this aim:

- We recruited a smoke free site lead, funded by Hampshire County Council, who has worked with the maternity and inpatient smoking cessation teams to develop an improvement plan, bringing aligned effort with clear aims.

- Increased training in 'very brief advice', training more than 250 people by attending doctors, nurses, HCAs and AHPs inductions and engaging with various wards such as surgery and paediatric respiratory team. This training increases access to advice from local teams and clarifies how to access dedicated support from the tobacco dependency team (TDT).
- Increased onward support post discharge for patients who live in Southampton, funded by Southampton City Council.
- Where we cannot provide care directly within the TDT service we have proactively worked with services, such as paediatric respiratory.
- We have promoted the importance of a smoke free site and support available through events such as a 'Bin the Butt' campaign, reported by BBC South, and activities over October for 'Stoptober' and no smoking day in March.
- We have worked with HR to increase enforcement of the smoke free site policy for staff, taking this as an opportunity to have a supportive conversation and give stop smoking support
- We have developed a smoke free champions' network. We have now finalised the priorities for our smoke free champions and developed a badge design. These champions will be the key point of contact in their clinical areas for supporting patients who smoke to remain abstinent while on site. We launched in March 2026 with 25 champions already signed up.
- We've reviewed data on those we have support to quit smoking, to ensure our service is accessible to all and identify opportunities to make services more inclusive.
- Working with the ICB and Southampton City Council we have been able to improve the stability of tobacco dependency services with permanent posts within the teams. We are working to expand the provision and visibility on wards.
- We've continued to provide a smoking cessation programme for staff via the occupational health team. We've promoted the service and shared positive case studies of those who have been successfully supported to quit.

Obesity

High body-mass index (BMI) is the largest contributor to years of healthy life lost due to disability (YLDs) in Southampton. Five of the top six risk factors for deaths in Southampton are related to excess weight and/or dietary risks. Rates of obesity in children in Southampton are above the national average and are growing. Southampton was fifth worst among its 16 local authority comparator group for reception age healthy weight. Linked with this quality priority we aimed to improve services and support for patients and staff with obesity (children and adults).

For children, UHS has a specialist multi-disciplinary service, which is networked into the community with services such as multiagency liaison, primary care and health visitors to provide joined up care.

This service has been shown to improve children's health outcomes by reducing the linked conditions such as hypertension, sleep apnoea and type 2 diabetes. There is more to do as a system to enhance the support earlier in the pathway and supporting prevention. We have made progress in the design of services for both adults and children as follows:

- Collaborating with ICB on pilots for new approaches for children.
- We've developed our trust maternity policies and milk expressing facilities, to support staff to continue to breastfeed on return from maternity leave. This is in line with Southampton's Health and Wellbeing strategy focus on 'starting well'.
- We continue to work with Southampton Hospitals Charity to improve facilities, which will support family friendly spaces at the Trust and benefit both staff, patients and visitors with breastfeeding and expressing.
- For adults' services we have been working with clinical leadership across the region and the ICB on a model of care. We've also been working with NHSE on pathways for weight loss medication.

- Our staff health check offer within occupation health provides support with cholesterol and weight measurement and health weight support. We have increased our promotion of this service.

Hypertension

Hypertension case finding and control is a national challenge, rates across Hampshire and Isle of Wight are particularly low. Due to this, there is a regional focus on reducing cardiovascular disease. Although we do not directly treat hypertension at UHS, we recognised that we have an opportunity to improve identification rates for our system to support earlier management in primary care, which may help reduce the incidence of cardiovascular complications, such as stroke, that place a significant burden on acute hospital admissions. We have worked towards this aim in the last year through the following approaches:

- Installed a health check machine in the front entrance of the hospital where anyone can receive a blood pressure reading, and have the option to link this back to their NHS data to be picked up by primary care.
- Worked with partners across the city to set clear local guidelines for advised action related to blood pressure readings.
- Discussed opportunities to obtain regular blood pressure readings when a patient is listed for surgery and whilst on the waiting list, to reduce the risk of surgeries being cancelled due to high blood pressure.
- Encouraged staff to take part in the health check offer from occupational health, which includes blood pressure monitoring, which is beneficial for their health and increases awareness and enables staff to act as advocates for blood pressure monitoring within their communities and patient interactions.

Data and measurement

We aimed to strengthen our understanding of inequalities in access across outpatients, waiting lists and the emergency department; to enable the measurement of improvement in areas recognised as clinical priorities, and to comply to the mandated national reporting. Over the past year, we have made significant progress in the reporting of access data. In line with these objectives, we have achieved the following:

- Built a health inequalities dashboard, with around 50 access metrics over outpatients, waiting lists, the emergency department and those waiting ongoing support to be discharged. These measures can be viewed by age, gender, ethnicity and indices of multiple deprivation decile, enabling better understanding of difference in access. The dashboard also enables the user to compare to population data, to health with identifying unexpected trends and could support targeted interventions. This data can be seen from service to Trust level, giving insight to any differences in access to be further understood.
- Worked with the child health team to consider how this data could be used routinely within services.
- We have made adaptions to our health inequality dashboards following user feedback. We continue to develop our dashboards to meet the needs of the specialities engaging with the data and ensuring it provides meaningful insights for services.
- Promoted this dashboard via internal newsletters.
- Completed 1:1 demos and training by request.
- Completed mandatory annual reporting within our published Trust annual report and accounts.
- We have improved ethnicity recording within our systems in the emergency department.

Enabling the organisation

To reduce the impact of health inequalities, we must integrate the learning from this programme into services and processes across our Trust. This year we aimed to develop trust-wide training to support the understanding of health inequalities and increase the likelihood of these being investigated within services. We planned to develop a toolkit to support teams to deliver local improvement projects and define the governance structure for escalation if issues that needed broader support.

A number of these priorities have been a challenge to achieve. It was felt UHS staff did not have capacity for another mandatory training course under the pressure of this financial year. However, we have made progress in enablement as follows:

- Materials explaining health inequalities have been uploaded to our staff intranet and online training platform.
- We have worked directly with clinical teams to support in understanding health inequalities within their services, for example with 'did not attend' rates.
- We agreed an escalation route through governance for health inequalities issues to be raised.

Over the year the health inequalities board heard presentations from a number of services who have achieved improvements to reduce the impact of health inequalities, these include:

- The vulnerable adult service
- Alcohol team
- Maternity NEST service
- Patient and Family Support Hub
- Research

Communications and engagement

We aimed to adopt health inequalities into leadership and decision making, increase learning from our communities and our staff and share learning from improvements made internally and externally. We have made progress on each of these ambitions as follows:

- We have written case studies from improvement work across the organisation and shared these in our public communications such as the 'connect magazine' and online. We have also shared these internally with staff via face to face and online briefings.
- We've held a number of events including those related to tobacco dependence but also hosted a 'pop-up' engagement event following Connect (face to face briefing for all staff) which has facilitated more staff to access wellbeing support through occupational health.
- We've increased the patient voice in the programme by inviting two quality and patient safety partners (QPSP) to become members of the health inequalities board. Their role is to promote approaches that are designed with and by patients.
- As an organisation we have increased the volume and diversity in patient feedback by increasing recruitment to our involved patients' directory.
- An equality quality impact assessment (EQIA) panel has been initiated to review the impact of any cost saving initiatives raised to support financial pressures.
- The EQIA template has been updated with more guidance for completion, supporting the user to consider the ways that change may impact on inequalities.

Strategy and programme delivery

We had a focus on strategy and programme delivery so that we could coordinate our overall approach to health Inequalities across the organisation, continue to measure organisational maturity and allocate resource to project delivery where possible. We also wanted to make sure we maintained collaborative working with public health and integrated care board teams and other local healthcare providers and kept up-to-date with national recommendations and expectations, sharing this knowledge with our organisation.

Progress against these ambitions this year include:

- Inclusion of health inequalities as priorities in the updated Trust and Clinical Strategies.
- Monthly health inequalities boards, with executive leadership and continued attendance from ICB and LA public health colleagues.
- Ongoing project management allocation, with clear action plans.
- Completion of the recommended self-assessment tool, demonstrating increase in organisational maturity.
- Continued collaboration with external partners including joining the Hampshire and Isle of Wight ICB communities of practice meeting.

Key areas identified for further development

- Key to the further development of our health inequalities programme is gaining insight from our patients and communities about barriers to care.
- From a data perspective we would like to integrate the dashboard we now have into quality management of services and also build reporting that enables us to measure inequalities in experience and outcomes.
- Related to our clinical priorities we would like to identify opportunities to support patients to flow from the acute site to primary care for hypertension control and identification, for example sign posting or sharing blood pressure readings. We also need to increase the number of patients having their smoking status recorded on arrival and increase provision of advice and referrals to the tobacco dependency team. We also need to improve compliance to be a smoke free site. We need to continue to work across the system to deliver obesity services that meet demand, and support prevention.
- To enable change across our organisation we need to identify further training opportunities trust-wide and support local improvements.

How will ongoing improvements be measured and monitored?

- Our commitment to health inequalities has been stated in our Trust and Clinical Strategies. These strategies will be delivered through a governance structure from ward to board, ensuring the priorities are delivered.
- We will continue to hold a health inequalities board, overseeing implementation of HI action across the organisation.
- We will continue to utilise and build on the HI dashboards to demonstrate improvement.

Progress metrics

- Number of experience and outcome measures.
- % smoking status recorded.
- Local improvement case studies.

2.2 Priorities for improvement for 2026/27

At UHS, we set our priorities based on our dedication to making an impact on the care we provide to our patients. Our quality priorities are strategically aligned with our ambitions and commitment to delivering well-led, safe and compassionate care with transparent and measurable outcomes. We continue to be aware of the significant national and operational pressures still being felt across the health and social care system, we have considered the challenges and attempted to be realistic in our goal setting.

Our quality priorities have been established in alignment with the Trust's overarching Strategy and Clinical Strategy for 2026–2030. Within the Trust Strategy, the Outstanding Care pillar outlines our core ambitions relating to outcomes, safety, and patient experience. The quality priorities identified for this year describe our areas of focus for the first year of delivery.

The Clinical Strategy provides more detailed insight into the care models and approaches that clinical services will adopt to deliver the Trust's ambitions. Our quality priorities correspond directly with key strategic areas, including personalised care, the Fundamentals of Care, timely access, reducing health inequalities, and strengthening our quality improvement and learning culture.

This paper sets out the draft priorities we are proposing for 2026/27 for consultation. This draft will also be presented to the Trust's board, the Trust Executive Committee, senior clinical leaders, commissioners, patient representatives (through our local Healthwatch group) and our Council of Governors.

We have aligned our priorities to the three core dimensions of quality:
- Patient experience
- Patient safety
- Clinical effectiveness and outcomes

To identify our priorities, we engaged with a wide range of stakeholders, including staff, the Trust's Quality Committee, the Trust Board, the Executive Committee, commissioners, patient representatives via Healthwatch, and our Council of Governors.

- Have our patients indicated that this is important?
- Have our staff highlighted this as a key area?
- Will it make a meaningful difference to the quality of care?
- Is it achievable within our available resources and timescales?
- Does our past performance show room for improvement?
- Does the priority align with national requirements or audit finding?

2026/27 Quality Priorities

Core Dimension	Quality Priority
Patient experience 	To strengthen the identification, involvement and support of unpaid carers so they are recognised as partners in care, have equitable access to support, and experience improved health and wellbeing during their UHS journey
Patient safety 	Strengthening enhanced therapeutic observations and care (ETOC) at UHS
	Acuity and deteriorating patients across UHS: Adults, paediatrics, midwifery and neonatal (Year two)
	Fundamentals of Care: Improving communication
Clinical effectiveness and outcomes 	Develop the Trust's approach to reducing the impact of health inequalities (HIs) (Year 3)
	Development of an integrated quality management system. Year one: development of a new clinical quality dashboard

We are confident that the selected priorities reflect our long term strategic aims and focus on the areas that will have the greatest impact for the patients who rely on our services, while also remaining responsive to emerging challenges across the wider healthcare system.

The final priorities were presented to both the Quality Committee and the Trust Executive Committee in March 2026. The Quality Committee will continue to provide governance oversight, ensuring progress is monitored and that each priority is supported to achieve its intended outcomes over the year.

Quality Priority One: Carer engagement and experience

To strengthen the identification, involvement and support of unpaid carers so they are recognised as partners in care, have equitable access to support, and experience improved health and wellbeing during their UHS journey.

Core dimension

Patient experience

Rationale of selection

Unpaid carers play a critical role in enabling patients to maintain health and independence, and their contribution is fundamental to the sustainability of local health and care systems. Carers UK reported in 2024 that the economic value of unpaid care in the UK is now estimated at £184 billion a year and carers frequently report feeling overlooked, undervalued and unsupported within the NHS.

Locally, Healthwatch Southampton's 2026 findings show unpaid carers struggle to access support, are not consistently identified by health services, and feel unheard when advocating for the person they care for.

Within UHS we held a carers engagement event in May 2025 and a subsequent Carers Afternoon Tea in August 2025, the key feedback we received from unpaid carers were:

- Communication: focusing on listening, asking and involving in decisions.
- Discharge: involvement on decisions.
- Support and 'care of the carers' whilst spending time at UHS.

Key aims

Strategic alignment with the UHS 5-year strategy, Clinical Strategy and the HIOW Strategy, NHS 10-year health plan and Carers UK and Healthwatch Southampton.

- Develop and co-produce a UHS carers policy to include paid and unpaid carers.
- Develop a UHS 'our commitment to our carers.
- Improve early identification of unpaid carers.
- Build carer awareness and capability across the workforce, embed a standard question: "What support do you need as a carer while your loved one is here?"
- Strengthen carer involvement in care planning and discharge.
- Improve access to support, respite options and carer wellbeing.

Progress metrics

- Introduction of a new UHS carers policy and guideline, supporting staff with how to identify and support unpaid carers across UHS.
  - A policy will be completed and ratified by quarter two, learning from other NHS organisations and how they support the 'unpaid' carer population, whilst integrating with local health and social care and charity partners to integrate learning.
  - A 'carers charter' will be developed in collaboration with Southampton City Council and Southampton Carers Partnership Board and published with the policy in quarter two to support continuity of language and support for carers across health and social care settings.
- Improved 'unpaid carer' identification.
  - Introduction of a new confidential patient information (CPI) alert for carers by the end of quarter four, in line with the reasonable adjustment workstream, to support earlier documentation of carer involvement in a patient's care journey or for the carer themselves.

- We need to seek feedback from unpaid carers on how they wish to be identified in an acute setting. For example, would a lanyard be appropriate, or could it risk making them feel like members of staff? It is essential that we hear this feedback before implementing any changes.
- Positive engagement and attendance at the monthly drop-in sessions, jointly led by Unpaid Carers Southampton, Carers Together and the Princess Royal Trust for Carers.
- Positive thematic feedback from our partners including Healthwatch Southampton partnership reviews and Southampton Carers Partnership Board.
- A 25% increase in the uptake of digital tools, including the NHS App "My Carer" feature, benchmarked quarterly by recorded Patient and Family Support Hub (PFSH) engagement.

• Improved clinical staff recognition of and communication with an 'unpaid' carer.

- A 25% improvement in an audit of clinical documentation, with a focus on discharge summaries, to ensure there is carer involvement and engagement.
- Ensure that at >50% of cases that are referred to Learning for the Lives and Death of people with a learning disability of autism (LeDeR), have meaningful feedback from a carer's perspective.
- Improved narratives about the carer experience carer feedback surveys (free text comments).
- 20% reduction patient safety incident investigations (PSII) that have incidental learning related to carer involvement.

Link with Trust Strategy
Outstanding outcomes
Link with Clinical Strategy
Patients first: health inequalities

Quality Priority Two: Strengthening enhanced therapeutic observations care (ETOC) at UHS

Core dimension

Patient safety

Rationale of selection

Patients are admitted or attend the emergency department for reasons that include mental health needs. Patients who attend the emergency department for care and treatment of their physical health have a right to expect compassionate, therapeutic and safe support with co-existing conditions such as mental health needs, learning disability and autism and dementia. Physical health needs can present with symptoms that mirror mental health and dementia symptoms such as disorientation, anxiety, disordered thinking, paranoid ideas, aggression and hallucinations; this occurs in the context of delirium (which always has an underlying physical cause). When patients present with behaviours or symptoms that pose a risk to their own safety or that of other patients or staff, ETOC may be implemented where less restrictive approaches have been ineffective. ETOC can include bay watch, one to one care, or higher levels of supervision. Within the Trust, ETOC is a key area of focus due to its cost and impact. Current models are under review both locally and nationally, with the aim of reducing reliance on ETOC, improving staff knowledge and skills, ensuring high quality and consistent delivery, maintaining safety, strengthening alternatives, and enabling timely and safe step down.

Key aims

Complete a review of the quality and governance of ETOC with the engagement of external partners, NHSE and UHS external auditors.

- Undertake an audit of governance structures for ETOC.
- Implement recommended changes to simplify and improve the governance structures utilising principles of board to ward.
- Following a completed review of the structures, process and outcomes of ETOC work with the UHS transformation team to agree a project plan with key stakeholders including UHS staff, NHSE and ideally patient groups.
- Implement the project plan to:
  - Improve staffing structures to boost availability of skilled staff when needed.
  - Improve decision making for use and discontinuation of ETOC.
  - Improve knowledge and skills of UHS staff undertaking or overseeing ETOC.
  - Improve knowledge and skills of staff from external providers such as NHSP who are providing ETOC.

Progress metrics

- Completion of external auditor report.
- Following the completion of the external auditors' report, any recommendations for governance of ETOC will be considered and implemented where appropriate.
- Ongoing monitoring of ETOC staffing availability will be undertaken, with the expectation of improved availability over time.
- Actions will be implemented with the intention of working towards a reduction of approximately 20% in the number of shifts required to provide ETOC.
- Revisions to the ETOC policy will be progressed, clearly articulating revised approaches to practice.
- Education and training provision for UHS and external staff will be reviewed.
- Education and training for UHS and external staff will be updated, as appropriate, to align with the revised policy.

• Targeted improvement measures will be implemented with the aim of achieving a reduction of approximately 30% in concerns raised through the clinical complaints management process relating to externally provided bank and agency staff. • Opportunities will be explored to reduce both the frequency and duration of ETOC requests for 1:1 staffing, alongside a targeted reduction of approximately 20% in associated costs.
Link with Trust Strategy
Outstanding outcomes
Link with Clinical Strategy
Patients first: timely and quality care, and health inequalities

Quality Priority Three: Acuity and deteriorating patients across UHS: Adults and paediatrics

Core dimension

Patient safety

Rationale of selection

The recognition, assessment and escalation of a deteriorating patient either adult or child are a key element of our trust-wide patient safety and quality strategy with the aim of improving clinical outcomes for acutely ill patients. How rapidly we respond to patient deterioration both in and out of hours is a key determinant of patient and quality outcomes.

The NHS contract for 2026/27 stipulates that all trusts will have implemented all three recommendations of Martha's Rule by March 2027. Martha's Rule is a national patient safety-initiative designed to ensure that patients, families and carers can directly escalate concerns about a patient's condition if they feel deterioration is not being recognised or acted upon.

Recommendation one – daily structured enquiry into how the patient feels and whether they believe they are getting better or worse has been implemented within paediatrics as part of the national early warning score (NPEWS). It has yet to be implemented within adult inpatient ward areas.

Recommendation two – 24/7 escalation route for staff to request a review from a different clinical team if they are worried that deterioration is not being recognised or acted upon is embedded across all adult and paediatric in-patient ward areas.

Recommendation three – 24/7 patient-and-family-activated escalation, giving patients, carers and families a clearly advertised way to request an urgent clinical review is embedded across all adult and paediatric in-patient ward areas.

Sepsis is still a leading cause of preventable deterioration, unplanned ICU admission and mortality in acute hospitals. Sepsis is one of the most time critical deterioration pathways.

Across the NHS, there is still inconsistent delivery of:

- Timely sepsis screening.
- Antibiotics within one hour.
- Completion of the Sepsis Six bundle.

This variation is well documented and often highlighted in CQC inspections. Making sepsis a priority signals that the Trust is actively addressing a known national risk.

Key aims

Martha's Rule:

- Fixed agenda item at bi-monthly Trust deteriorating patient group to highlight key themes and actions for education and training development.
- Incorporated with monthly acuity data reports.
- Quarterly report to patient safety steering group.
- Yearly report to the Trust Quality Committee.

Recommendation one:
- Implement patient wellness questionnaire (PWQ) for all adult inpatient areas by March 2027.
- 75% staff undertaking the PWQ will have received education and training on how to complete the PWQ and escalate the appropriate actions.
- Patient/relative feedback regarding impact of the PWQ in adult and paediatric areas.
- Staff feedback regarding the impact of the PWQ in adult and paediatric areas.
- Monthly impact and thematic analysis of PWQ data for adults and paediatrics.

Recommendation two:
- All clinical staff new to UHS will receive information on how to escalate and with whom they can escalate to regarding a deteriorating patient.
- Review all adverse event forms related to failure to escalate and/or failure to rescue patients for learning and share across the organisation.
- All deteriorating education will include information on how to escalate a deteriorating patient and whom they can escalate to.

Recommendation three:
- Monthly audit of all Call 4 Concern activations for thematic analysis.
- Call 4 Concern activations reported monthly as part of the acuity data.
- Adverse event form completed for every adult Call 4 Concern activation and actioned at local level.
- Paediatric Call 4 Concern activations reviewed and discussed in bi-weekly Martha's Rule working group with quarterly report to child health care group governance.

Sepsis:
- Monthly audit of patients diagnosed with sepsis within the adult emergency department – focus on:
  - Time from arrival to diagnosis.
  - Sepsis tool utilisation.
  - Sepsis diagnosis documented in the clinical notes.
  - Appropriate antibiotics administered within 60 mins of suspected diagnosis.
  - Adherence to Sepsis Six.
- Paediatric ID team ward rounds twice/week monitoring antibiotic therapies/stewardship including IV to oral antibiotics conversion.
- Annual paediatric sepsis data reported with learning shared across SCH.
- Sepsis education available to all healthcare professionals on VLE.
- Develop reports from VLE for completion of sepsis education.

Progress metrics

Audit Martha's Rule:

Recommendation one:
- Percentage of ward nursing teams received education on Martha's Rule and patient wellness questionnaire – target 75 % Q3.
- Compliance of completion of daily patient wellness questionnaire for adult and paediatric patients aiming for a month-on-month improvement.
- Analysis of impact and escalation of patient wellness questionnaire via staff and patient feedback.

Recommendation two:

- Thematic analysis of adverse event forms or patient safety reviews related to failure to rescue and/or failure to escalate.
- Analysis of staff feedback from deteriorating patient education sessions.

Recommendation three:

- Percentage of inpatient areas with Martha's Rule/Call 4 Concern information displayed – target 100% by Q2.
- Number of Call 4 Concern activations per month – monitored for trends and shared monthly.
- Median response time from activation to clinical review for the acute deterioration calls – target < 30 mins for 90% of cases.
- Thematic analysis of non-acute clinical deterioration Call 4 Concern activations collated monthly for learning and education.
- Patient/family awareness of Martha's Rule – target: month on month improvement.

Sepsis:

- ED sepsis screening tool compliance – target > 80%
- Appropriate antibiotics administered within 60 mins for suspected sepsis (ED) – target >90%.
- Monitor unplanned ICU admissions related to sepsis with shared learning of key themes.
- Percentage of staff completing sepsis education available on VLE – target: year on year improvement

Link with Trust Strategy

Outstanding outcomes

Link with Clinical Strategy

Patients first: timely and quality care

Quality Priority Three: Acuity and deteriorating patients across the Trust: Maternity and neonatal

Core dimension

Patient safety

Rationale of selection

In line with the three-year delivery plan for maternity and neonatal services (NHS England, 2023) implement best practice, including the new MEWS tools by 2025. Improving the early detection of patients who are deteriorating is vital to improving morbidity and mortality; three of the four most common direct causes of maternal death (MBRACE, 2024) would result in abnormal MEWs scores early on. Improving escalation and involving the whole MDT early, thus improving outcomes within maternity care (MBRACE, 2024). Working cross-site (Princess Anne/Southampton General Hospital main site) poses unique challenges and therefore improved joint working and central surveillance would provide additional opportunities to enhance safety by preventing delays in identification and escalation of deteriorating patients. Build upon and maintain strong working relationships with maternal medicine and critical care outreach teams, training together and sharing learning. The NHS contract for 2026/27 stipulates that all trusts will have implemented all three recommendations of Martha's Rule by March 2027. Martha's Rule is a national patient safety initiative designed to ensure that patients, families and carers can directly escalate concerns about a patient's condition if they feel deterioration is not being recognised or acted upon. We have implemented element two and three of Martha's Rule with maternity services and element one and three within neonatal services.

Key aims

- We will implement element one within maternity services and element two within neonatal services.
- We will fully embed all three elements within both services to ensure this is normal practice.
- Implementation of digital recording of maternal observations to be implemented in conjunction with new MEWs tool. Train staff in digitally recording observations. Ensure equipment available to record observations digitally (enough iPads in each clinical area).
- Work closely with CCOT and the maternity digital team to develop a 'surveillance dashboard'.
- Work closely with the Trust Call 4 Concern lead to introduce Call for Concern to maternity. CCOT to have access to and training in BadgerNet (maternity records system).
- Work with Local Maternity and Neonatal System (LMNS) maternal medicine team & the Trust's CCOT on training including PROMT and maternity red flags.
- Open invitation for these teams to attend maternity safety huddle to share learning and/or discuss current patients.

Progress metrics

- MEWS audit: MEWS training compliance to reach ≥85% by June 2026; quarterly audits to commence one month post rollout, reviewing 20 sets of notes per month, with ≥90% compliance expected for standards and escalation.
- Exception reporting: 100% of MEWS related issues identified through audit to be reported via the adverse event reporting (AER) incident reporting system and reviewed quarterly.
- Call 4 Concern review: 100% of Calls 4 Concern to be reviewed, including frequency, referral themes, response timeliness, and documented patient outcomes where deterioration is identified.
- Patient experience: Patients' feedback to be reviewed in 100% of cases where Martha's Rule is enacted.

• Awareness: Martha's Rule posters displayed in 100% of ward areas across maternity and neonatal services, with compliance checked quarterly.
Link with Trust Strategy
Outstanding outcomes
Link with Clinical Strategy
Patients first: timely and quality care

Quality Priority Four: Fundamentals of Care – Improving communication

To strengthen the quality of care by ensuring the Fundamentals of Care (FoC) commitments through 'What Matters to Me' conversations, and clear, person centred documentation to communicate effectively and ensure person-centred care.

Core dimension

Patient experience

Rationale of selection

Feedback from patients, their families and their carers consistently highlights the importance of being actively involved in their care. This requirement is multi-faceted and is underpinned by effective communication, both in how we engage with what matters most to our patients and in how we communicate with each other to ensure the delivery of safe, consistent, and high-quality care.

'What Matters to Me' remains a central priority in our approach to delivering personalised, person-centred care. Through successful Volunteering for Health funding secured via a community partnership bid, we have appointed a dedicated volunteer coordinator to lead and strengthen this programme. This role is enabling us to build a robust and sustainable volunteer network that can support patients in articulating their priorities, enhance meaningful conversations at the point of care and ensure that individual needs and preferences are consistently understood and recorded. This investment reinforces our commitment to embedding 'What Matters to Me' as a routine part of high-quality care across our services.

High quality, accurate and timely documentation is a fundamental component of safe and effective patient care. Inconsistent recording of daily nursing care practices and incomplete or inaccurate body mapping can contribute to patient safety risks and inconsistent care experiences across a patient's hospital journey. These gaps also reduce staff confidence, make it challenging to monitor care standards and limit the organisation's ability to learn from patient outcome and experience measures.

By prioritising improvements in the standards of documentation, the Trust can strengthen the reliability of core nursing practices that directly affect patient outcomes. Standardised, robust documentation supports clearer communication between clinical teams, enhances continuity of care and provides a more accurate record on which to base clinical decision making.
The combination of these approaches aims to ensure that every patient receives equitable, safe, and consistent care, strengthening the foundations of care delivery and to create a more dependable and patient-centred experience throughout the entire hospital journey.

Key aims

- Strengthen patient involvement through 'What Matters to Me'.
  - Building on the learning from previous trials, ensure every patient is actively involved in sharing what is important to them by embedding 'What Matters to Me' conversations into routine practice, supported by a sustainable volunteer network and effective staff engagement.

- Improve the quality and reliability of documentation.
  - Raise standards of written and digital documentation across all clinical areas to ensure records are accurate and consistent, supporting safer clinical decision making, consistent delivery of core nursing practices and better monitoring of care quality.
- Reduce variation and strengthen continuity of care across the patient journey.
  - Minimise inconsistencies in care by improving the recording of essential care elements (including turnaround practices, daily assessments and body mapping) and enabling clearer information flow between clinical teams.

Progress metrics

1. Completion of 'What Matters to Me' documentation:
- A minimum of one care group will adopt the 'What Matters to Me' (WMTM) boards each quarter, embedding it into day-to-day practice.
- 80% of inpatients within the pilot areas have a completed WMTM board within 48 hours of admission to a ward area.
- A successful trial of WMTM boards with patients who have a learning disability and/or autism and an evaluation of the impact for this patient group.

2. Quality of 'What Matters to Me' documentation:
- 100% of inpatients with a WMTM board have been offered and/or have a photo of them or something that represents them as a focal point of their WMTM board.

3. Quality standards of documentation are set for body maps and daily assessment:
- Clear documentation standards are set, and training is provided to support quality body mapping and daily assessment documentation.

4. Quality standards of documentation being maintained:
- 80% of body maps and daily assessments are completed to the set expected quality standards.

5. Patient and experience measures will improve:
- We will undertake a comprehensive thematic analysis through more effective coding of complaints/PALs interactions to gain an improved understanding of what impact the 'communication' challenges are and how they impact upon patients, families and carers.
- 20% reduction in complaints and PALS enquiries related to communication.
- Patient Reported Experience Measures (PREMS).
- Friends and Family Test – Increase positive responses to "Overall, how was your experience of our service?" from 85% to 90%, and to "Were you involved in decisions about your care and treatment?" from 67% to 75%.
- National CQC survey – The inpatient survey will report improved experiences for patients when asked.

Link with Trust Strategy

Outstanding outcomes

Link with Clinical Strategy

Patients first: timely and quality care

Quality Priority Five: Year three: Develop the Trust's approach to reducing the impact of health inequalities (HIs)

Core dimension

Clinical outcome and effectiveness

Rationale of selection

Tackling health inequalities is a key priority for the NHS. It is a moral imperative to address unfair, avoidable differences in health outcomes and experience. Addressing these gaps ensures equitable access to care, reduces long-term demand and improves health outcomes and life expectancy for those impacted.

In Southampton, health is worse than the national average, with people living fewer healthy years, about 59 years for both men and women. Over two-thirds of adults are overweight or obese, and nearly 10% of pregnant women smoke. High body-mass index (BMI) is the largest contributor to years of healthy life lost due to disability (YLDs) in Southampton. Five of the top six risk factors for deaths in Southampton are related to excess weight and/or dietary risks. Rates of obesity in children in Southampton are above the national average and are growing. Southampton was fifth worst among it's 16 local authority comparator group for reception age healthy weight. These problems show clear health inequalities linked within our region and the Trust needs to work with our partners across the system to reduce the impact of inequalities.

At UHS we have been working to have an impact on health inequalities for several years. In 2024/25 we formalised these efforts with a governing board, chaired by our chief medical officer and with a clear programme of improvement based on recognised priorities. This formed the basis of our quality priority in 2024/25. In 2025/26 we continued to drive against key priorities linked with data and measurement, clinical priorities, enabling the organisation, communications and engagement and strategy.

This year's quality priority is a continuation of this work. We intend to grow our understanding and actions as an organisation, improving the equity of access, outcomes and experience of our services across our community.

Key aims

- Review our elective waiting list data to understand health inequalities within waiting times
- Improve recording of ethnicity data across our organisation.
- Continue to drive inequalities and prevention projects in tobacco dependence, obesity and hypertension. Support service priorities related to alcohol and mental health.
- Drive local change through providing training and encouraging use of experience and access data across the organisation.
- Gain patient and community insight on key barriers to care, working with system partners.
- Develop data and reporting to understand inequalities in experience and outcomes.

Progress metrics

- Improvement plan developed for elective access (Improve equity in DNA rate for pilot specialties).
- Improvement plan developed for ethnicity recording - increase ethnicity recording in the PTL to 80% (currently 70%).
- Clear priorities and measures set for each clinical priority - 10% increase smoking status recording for inpatients (currently 38%).
- Identify continued opportunities for training and education (402 staff trained in 2025/26, aim to at least replicate this in 2026/27).

Link with Trust Strategy
Outstanding outcomes
Link with Clinical Strategy
Always improving: health inequalities

Quality Priority Six: Development of an integrated quality management system

Year one: Development of a new clinical quality dashboard

Core dimension

Clinical effectiveness and outcomes

Rationale of selection

A strong quality management system (QMS) is essential in an acute hospital to ensure consistent, safe, high-quality patient-centred care while meeting growing service pressures and national expectations. Our QMS will deliver a structured framework of priorities, measures and procedures, with clear responsibility assigned to results. This will help the organisation to identify issues in a timely manner and to drive continuous improvement. It links organisational strategy to daily frontline work to improve patient outcomes, reduce safety risks and meet regulatory standards, such as those in the NHS IMPACT framework. It will also bring assurance and escalation from the ward to board level.

The NHS England 10 Year Health Plan calls for major transformation in governance, digital capability, prevention focused care and system wide quality improvement, all of which require structured oversight and coordinated quality processes.

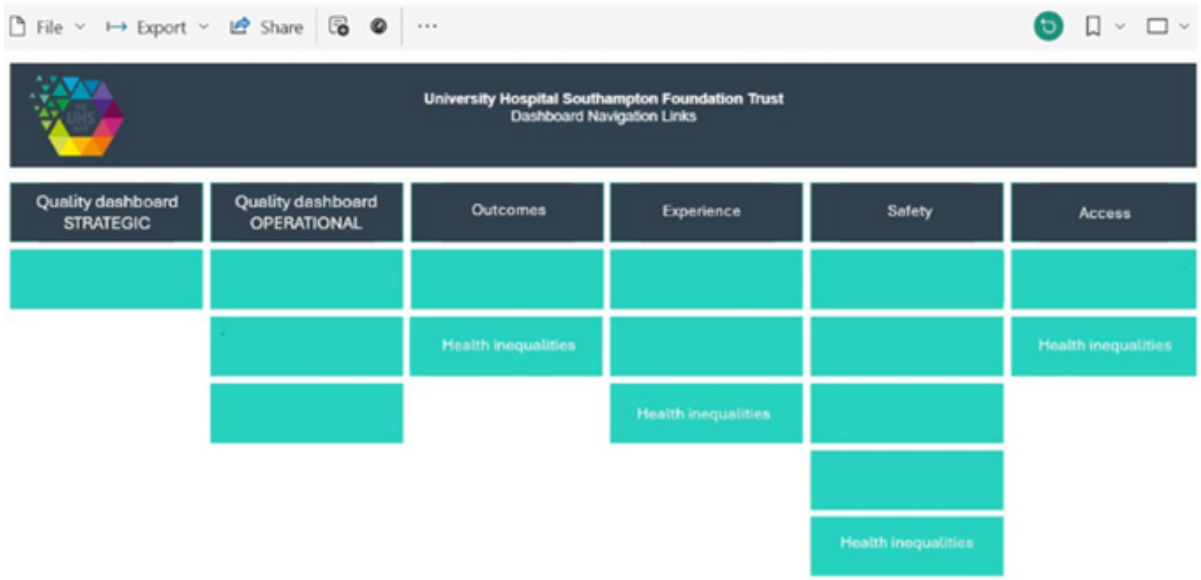
Development of an integrated quality dashboard is an ambition within the Trust Strategy and will provide quality assurance to key metrics in the outstanding care pillar covering the outcomes, safety, experience and access quality domains. This is also a core priority within the Clinical Strategy, enabling the delivery of our quality improvement and learning culture ambitions. This will also enable oversight of quality improvements linked with the other priorities within the clinical strategy, such as delivering Fundamentals of Care.

Currently staff are only able to view quality data retrospectively on a spreadsheet which will often be relying on data from the previous month. Staff feedback suggests this quality data set is difficult to interpret and as not contemporaneous doesn't enable us to be proactive in identifying and addressing issues.

This integrated quality dashboard will provide access to timely data, from ward to board, enabling proactive response to challenges, sharing of good practice, organisation-wide learning and measurement of delivery against strategic priorities.

The clinical quality dashboard will be developed using an iterative and collaborative approach, with delivery planned over approximately 12 months. As final resource allocation is still under discussion, the exact pace and scope of development may flex, but the core stages below set out the intended approach.

The diagram below is an idea of how the dashboard could look combining all the different quality domains. The clinical quality dashboard will focus on the operational part of the diagram.



Key aims

Metric review and scoping (underway and continuing into early months)

- Develop a task and finish group with key clinical, operational, digital and governance stakeholders to agree metric definitions, review feasibility and co-design dashboard functionality.
- Review the full list of proposed clinical quality indicators.
- Assess alignment with existing dashboards, mandatory reporting and current quality oversight processes.
- Explore how other trusts structure similar dashboards to ensure best practice and avoid duplication.

Data source assessment and feasibility (early phase)

- Map all relevant data sources, noting that these will vary widely and may include manual collections.
- Identify where automation, new data pipelines or upstream data redesign may be required to ensure reliability and sustainability.
- Assess data quality, completeness and governance considerations.

Power BI development and prototype build (iterative throughout the year)

- Build initial dashboard prototypes in Power BI, focusing on a small number of high priority indicators.
- Develop visual structures e.g. heat maps or trends over time views.
- Share prototypes with clinical, operational and governance users for rapid feedback.

Integration, validation and alignment (mid–later stages)

- Ensure definitions, calculations and data refresh processes are consistent across existing dashboards and reporting tools.
- Complete clinical validation of indicators and agree final presentation formats.
- Implement improvements to manual or inconsistent data sources where feasible.

Deployment, training and transition (final phase)
- Roll out the dashboard to relevant clinical and governance groups.
- Provide training and guidance to support effective use.
- Establish processes for ongoing updates, maintenance and further indicator expansion.

Progress metrics

Stage one
Metric review and scoping (underway and continuing into early months)
- Percentage of proposed indicators reviewed against feasibility.
- Number of indicators agreed for phase one build.
- Completion of alignment review with existing dashboards/tools.
- Completion of external scan of other trust's dashboards.

Stage two
Data source assessment and feasibility (early phase)
- Percentage of data sources mapped (automated and manual).
- Number/percentage of data sources assessed for quality and completeness.
- Number of sources requiring automation or redesign identified.
- Number of data pipelines drafted or partially developed.

Stage three
Power BI development and prototype build (iterative throughout the year)
- Prototype version number (v0.1, v0.2, v0.3 etc).
- Number of indicators included in the prototype.
- Feedback received from clinical and operational teams.
- Usability issues logged and resolved.

Stage four
Integration, validation and alignment (mid–later stages)
- Number of indicators clinically validated.
- Number of metric definitions approved by governance.
- Number of individuals across clinical professions involved in early testing.

Stage five
Deployment, training and transition (final phase)
- Number of users trained (or percentage of intended users).
- Early user feedback scores (such as usefulness, clarity, ease of use).
- Number of issues logged and resolved during transition.

Link with Trust Strategy

Outstanding outcomes

Link with Clinical Strategy

Always improving - quality improvement and learning culture

2.3 Statements of assurance from the Board

This section sets out the mandatory statements on the quality of services we provided during the 2025/26 financial year. These statements are consistent across all quality accounts and enable meaningful comparison of our performance with that of other organisations. They are intended to provide assurance that the Board of directors has reviewed and actively engaged with organisation wide initiatives that are strongly linked to the delivery of continuous quality improvement.

2.3.1 Review of services

During 2025/26 UHS provided and/or sub-contracted 121 relevant health services (from total Trust activity by specialty cumulative 2025/26 contractual report). UHS has reviewed all the data available to them on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by UHS for 2025/26.

2.3.2 Participation in national clinical audits and confidential enquiries

The UHS clinical audit programme was developed in line with the Trust's values of putting patients first, working together and always improving. This aligns to the Trust's clinical effectiveness approach, to ensuring robust and measurable processes are in place to plan locally and participate strategically.

Healthcare Quality Improvement Partnership (HQIP) produces a National Clinical Audit & Enquiries Directory, which identifies national audits that are included in the NHS England Quality Account List, those audits which are part of National Clinical Audit and Patient Outcomes Programme (NCAPOP) and those that deliver a Consultant Outcome Publication (COP).

NCAPOP audits are commissioned and managed on behalf of NHS England by HQIP. These collect and analyse data supplied by clinicians to provide a national picture of care standards for that specific condition. On a local level, NCAPOP audits provide trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients.

The audits listed on the NCAPOP are 'must-do' national audits. The Quality Accounts national clinical audit list also includes audits which we regard as 'best practice' to participate in, and for that reason we include these in our corporate audit plans as a priority, where they are relevant to our Trust.

UHS has a strong history for completing clinical audits. The clinical effectiveness team has a robust approach to governing and supporting the completion. We've opened discussions with senior clinical leadership within HIOW ICB regarding the current challenges with contributing to and using the outputs of national audits. Benchmarked data resulting from national audits provides strong guidance on areas of excellence and improvement, however completion can be challenging in its complexity and resource intensiveness, and timeliness of outputs can reduce our ability to be responsive to indications. Real time data supports our clinical teams to be proactive in striving to meet our always improving objectives.

During 2025/26 62 national clinical audits and 4 national confidential enquiries covered NHS services that UHS provides. During 2025/26 UHS participated in 97% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

NCEPOD studies participated in during 2025/26 were:
- Acute illness in learning disability patients.
- Stabilisation of the critically ill child.
- Rib fractures.
- Pleural procedures.

UHS fully supports the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) and all the reviews that take place under this umbrella.

The national clinical audits that UHS participated in, and for which data collection was completed during 2025/26, are listed below (Table A) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry if known at time of writing this report.

Table A

No	Total number of NCAs UHS were eligible to participate in (n=62)	Eligible (61)	Participated 60=97%)	% Actual cases submitted/ expected submissions
1.	BAUS British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	✓		
2.	BAUS Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✓		
3.	British Spine Registry	✓		
4.	Case Mix Programme (CMP) (ICNARC)	✓		2,204
5.	UK Renal Registry National Acute Kidney Injury Audit	✓		
6.	Emergency Medicine QIPs – Care of older people	✓		117 pts
7.	Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓		Approx 37 cases
8.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓		550 pts
9.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓		
10.	Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	✓		
11.	Learning from lives and deaths - People with a learning disability and autistic people (LeDeR)	✓		

No	Total number of NCAs UHS were eligible to participate in (n=62)	Eligible (61)	Participated 60=97%)	% Actual cases submitted/ expected submissions
12.	National Adult Diabetes Audit – National Diabetes Inpatient Safety audit	✓	✓	
13.	National Adult Diabetes Audit – National Pregnancy in Diabetes	✓	✓	
14.	National Diabetes Audit – transition	✓	✓	Collects data from database
15.	National Diabetes audit – gestational diabetes	✓	✓	Collects data from database
16.	National Audit of Care at the End of Life (NACEL)	✓	✓	120 case notes
17.	National Audit of Dementia (NAD)	✓	✓	Extracted from data sources
18.	National Cancer Audit Collaborating Centre – National Audit of Metastatic Breast Cancer	✓	✓	Data collected from cancer Databases * See comment below
19.	National Cancer Audit Collaborating Centre – National Audit of Primary Breast Cancer	✓	✓	
20.	National Cancer Audit Collaborating Centre – National Kidney Cancer Audit (NKCA)	✓	✓	
21.	National Cancer Audit Collaborating Centre – Non-Hodgkin Lymphoma Audit (NNHLA)	✓	✓	
22.	National Cancer Audit Collaborating Centre – National Pancreatic Cancer Audit	✓	✓	
23.	National Cancer Audit Collaborating Centre – National Bowel Cancer Audit (NBOCA)	✓	✓	
24.	National Cancer Audit Collaborating Centre – National Oesophago-gastric Cancer (NOGCA)	✓	✓	
25.	National Cancer Audit Collaborating Centre – National Lung Cancer Audit (NLCA)	✓	✓	
26.	National Cancer Audit Collaborating Centre – National Ovarian Cancer Audit (NOCA)	✓	✓	
27.	National Cancer Audit Collaborating Centre – National Prostate Cancer Audit (NPCA)	✓	✓	
28.	National Cardiac Arrest Audit (NCAA)	✓	✓	
29.	National Cardiac Audit Programme (NCAP) - Adult cardiac surgery	✓	✓	24/25 931 ops
30.	National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management (CRM)	✓	✓	24/25 1,010 procedures
31.	National Cardiac Audit Programme (NCAP) – congenital heart disease (CHD) paediatric	✓	✓	400 surgical cases & 300 catheter cases
32.	National Cardiac Audit Programme (NCAP) – Heart Failure audit	✓	✓	Approx 600 pts
33.	National Cardiac Audit Programme (NCAP) – Acute Coronary Syndrome or Acute Myocardial Infarction	✓	✓	Approx 400pts

No	Total number of NCAs UHS were eligible to participate in (n=62)	Eligible (61)	Participated 60=97%)	% Actual cases submitted/ expected submissions
34.	National Cardiac Audit Programme (NCAP) – Percutaneous coronary interventions (PCI)	✓	✓	
35.	National Cardiac Audit Programme (NCAP) – The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	✓	✓	Approx 250 cases
36.	National Cardiac Audit Programme (NCAP) – Patent Foramen Ovale Closure (PFOC) Registry	✓	✓	Approx 50 cases
37.	National Cardiac Audit Programme (NCAP) – Transcatheter Mitral & Tricuspid Valve (TMTV) Registry	✓	✓	40 cases
38.	National Child Mortality Database (NCMD)	✓	✓	
39.	National Comparative Audit of Blood Transfusion – 2025 Major Haemorrhage Audit	✓	✓	18pts
40.	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	51pts so far
41.	National Emergency Laparotomy Audit (NELA) – Laparotomy	✓	✓	150pts so far
42.	National Emergency Laparotomy Audit (NELA) – No LAP	✓	✓	
43.	National Joint Registry	✓	✓	
44.	National Major Trauma Registry (NMTR)	✓	✓	1,777 so far
45.	National Maternity and Perinatal Audit (NMPA)	✓	✓	
46.	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	2,036 pts VON – circa 113
47.	National Ophthalmology Audit Database	✓	x	** See comment below
48.	National Paediatric Diabetes Audit	✓	✓	
49.	National Perinatal Mortality Review Tool (NPMRT)	✓	✓	
50.	National respiratory Audit Programme (NRAP) – asthma in children	✓	✓	
51.	National respiratory Audit Programme (NRAP) – asthma in adults	✓	✓	
52.	National respiratory Audit Programme (NRAP) – COPD secondary care	✓	✓	
53.	National respiratory Audit Programme (NRAP) – Pulmonary rehabilitation	✓	✓	57 pts *** See comment below
54.	National Vascular Registry (NVR)	✓	✓	**** See comment below 280 incomplete data
55.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	
56.	Perioperative quality improvement programme	✓	x	***** See comment below

No	Total number of NCAs UHS were eligible to participate in (n=62)	Eligible (61)	Participated 60=97%)	% Actual cases submitted/ expected submissions
57.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient audit, organisational audit	✓	✓	Oct 24 – Oct 25 1,228
58.	Serious Hazards of Transfusion (SHOT) UK national hemovigilance scheme	✓	✓	53 cases
59.	UK Cystic Fibrosis Registry	✓	✓	208 pts
60.	UK Interstitial Lung Disease (ILD) Registry	✓	✓	400 pts
61.	UK Renal Registry Chronic Kidney Disease Audit	✓	✓	

Some of the audit / registries do not need UHS to send them data, such as the cancer collaboration as they take the data from the cancer service databases.

* For the NATCAN cancer services reports there has been an issue with the data quality / collection from the various national databases which is currently being investigated.

** The National Ophthalmology Audit Database could not be completed in 2025/26 due to the lack of audit functionality in the new ophthalmology system. We hope this will be resolved to enable completion of the audit in 2026/27.

*** National Respiratory Audit Programme Pulmonary Rehabilitation (PR) will be discontinued in May / June 2026 as the PR service at UHS is stopping.

**** For the National Vascular Registry, UHS submits all procedures, other than interventional radiology procedures.

***** Perioperative quality improvement programme - we have experienced ongoing challenges engaging effectively with PQIP. The programme is embedded within the national research delivery infrastructure but is not accompanied by sufficient funding to support the research nurse capacity required, particularly given the size and complexity of the dataset. Previous attempts to integrate PQIP within the perioperative medicine clinical service were unsuccessful, as clinical teams lacked the capacity to deliver the programme alongside routine duties. This resulted in significant data quality issues, including errors and incomplete follow up.
A further challenge is that PQIP is structured as a consented study, which creates an additional barrier to recruitment and means the current patient cohort is not fully representative of the wider UHS population. At present, only a limited number of patients are being recruited. This may increase in the future if opportunities arise to co enrol patients into other locally delivered studies.

The reports of 21 national clinical audits were reviewed by the provider in 2025/26. Appendix A lists actions identified during 2025/26, which UHS intends to take and UHS intends to take to improve the quality of healthcare provided. Progress already made against these actions is also indicated.

The reports of 61 trust-wide and local clinical audits were reviewed in 2025/26. Appendix B lists the resulting actions to improve quality of healthcare provided.

2.3.3 Recruiting to research

The number of patients receiving relevant health services provided or subcontracted by UHS in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee is 14,636 so far.

More information about our commitment to research can be found in the section 'Our commitment to research' in part 3 of this report.

2.3.4 Commissioning for Quality and Innovation (CQUIN) payment framework

University Hospital Southampton NHS Foundation Trust income in 2025/26 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUIN was "paused" by NHSE for this contracting year.

2.3.5 Statements from the Care Quality Commission (CQC)



UHS holds an unconditional registration with the Care Quality Commission (CQC) without any conditions. Since first registering in 2010, the organisation has consistently retained this status without conditions or enforcement action, including throughout 2025/26.

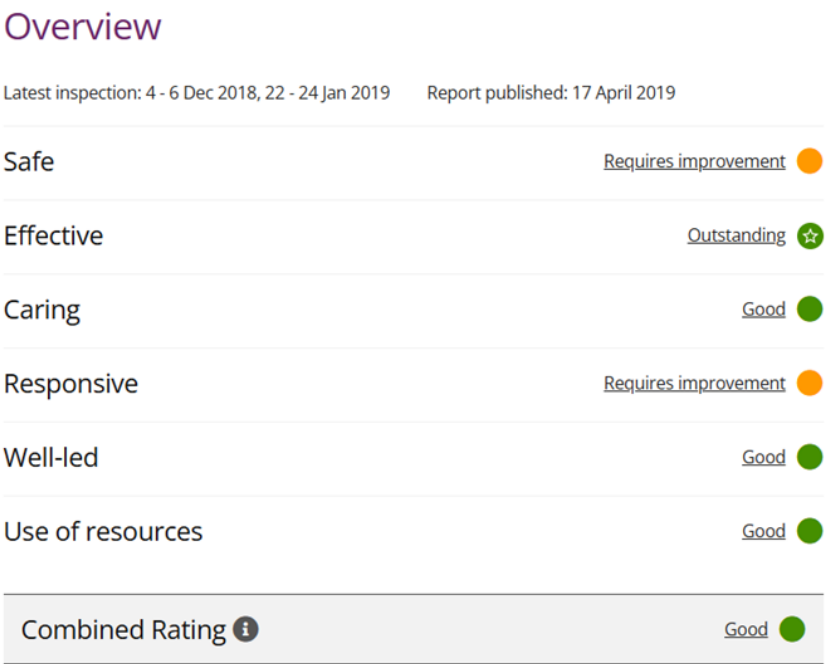
No enforcement action was taken against UHS by the CQC during 2025/26, and the Trust did not take part in any special reviews or investigations during the reporting period. Full registration information is publicly accessible via the CQC website.

Across the organisation, all sites and services are now rated as 'good' in both the effective and caring domains. Southampton General Hospital has achieved 'outstanding' ratings in these areas, and Hampshire and Isle of Wight Air Ambulance (HIOWAA) is rated 'outstanding' across all domains.

During 2025/26, the CQC undertook the following inspections:

- Hampshire and Isle of Wight Air Ambulance (HIOWAA), inspected in October 2025 and awarded 'outstanding' in every domain. This was the first inspection since the formal collaboration between HIOWAA and UHS was established in November 2018.
- End of life care and children and young people services, reviewed during an unannounced inspection in November 2025. These services were inspected concurrently due to the time elapsed since their previous assessments. UHS is currently awaiting the draft report.

UHS overview of CQC ratings:



We continue to monitor our performance internally against the highest standards of care. We continue to engage with the CQC through a range of activities including CQC engagement meetings and monthly meetings to discuss escalations, updates and sharing of good news stories.

2.3.6 Payment by results

UHS was not subject to the payment by results (PbR) clinical coding audit for 202/26 by the Audit Commission.

The last PbR audit was in 2013/14, and no further external audits were recommended for the Trust, as we were found to be fully compliant. The Audit Commission has now ceased to exist; however, the Trust continues to maintain an internal audit programme, carried out by an NHS approved clinical coding auditor.

2.3.7 Data quality

Reliable data sits at the heart of effective care and good organisational governance. When patient information is accurate, complete and up to date, it becomes possible to clearly track an individual's care journey and ensure they receive the right support at the right time. Strong data quality not only enables efficient service delivery but also plays a direct role in maintaining high standards of safety and overall care.

When data is incomplete or inaccurate, the consequences can be significant, treatment may be delayed, staff workloads can increase, income may be lost and the information used for planning or reporting can become misleading.

Our commitment to strengthening data quality continues to make a positive impact to both patient

experience and operational effectiveness. Each month, the data quality team audits hundreds of records, helping to highlight issues, support teams across the Trust and identify where further improvements can be made. Our aim is to promote better data entry practices and to keep refining the areas that matter most.

UHS submitted records between April 2025 and December 2025 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As of December 2025 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number were:
- 99.7% for admitted patient care (0.3% improvement from last year).
- 99.8% for outpatient care (no change from last year).
- 96.6% for accident and emergency care (0.8% improvement from last year).

Which included a valid General Medical Practice code were:
- 100% for admitted patient care (no change from last year).
- 100% for outpatient care (0.1% improvement from last year).
- 99.7% for accident and emergency care (0.2% improvement from last year).

UHS will be taking the following actions to improve data quality:
- Data services to routinely review and update its data quality checks and procedures to ensure they are robust and in line with any changes to national policy.
- Analyse the data and classify the inaccuracies according to the key error codes.
- Identify areas of poor data quality and bad practices.
- Make recommendations to help improve the quality of data.
- Raise awareness of data quality and its importance.
- Review and update training materials and guidance.

2.3.8 Data Security and Protection Toolkit (DSPT)

The DSPT is an online self-assessment tool that enables the Trust to measure its performance against the national data guardian's ten data security standards and the cyber assurance framework (CAF). The CAF provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed. Submission of the DSPT is a mandatory annual requirement. The Trust submitted its 2024/25 assessment in June 2025. The Trust was not able to provide the required level of assurance for all 18 principles. As a result, the Trust was not able to fully demonstrate it was practising good data security and achieved "standards not met". An improvement plan was submitted to NHSE which was accepted and as a result our rating was changed to "approaching standards".

For the 2025/26 DSPT the Trust is working towards meeting the 18 principles of the CAF under the following categories:
- Managing risk.
- Protecting against cyber-attack and data breaches.
- Detecting cyber security events.
- Minimising the impact of incidents.
- Using and sharing information appropriately.

Submission for the 2025/26 DSPT is due at the end of June 2026.

2.4 Overview of quality performance

2.4.1 Single Oversight Framework

The Single Oversight Framework is the joint NHS England and NHS Improvement framework for assessing trusts' performance against key statutory performance indicators.

Progress against the indicators in the Single Oversight Framework indicator threshold 2025/26

	2024/25	2025/26
Percentage of patients waiting less than 18 weeks (absolute performance)	63.0%	62.1%
Percentage of patients waiting over 52 weeks	1.86% (Mar 25)	1.95% (Mar 2026)
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours (all types)	77.3%	77.9%
Percentage of emergency department attendances spending over 12 hours in the department	2.0%	3.2%
Percentage of urgent cancer referrals to receive a definitive diagnosis within 4 weeks	83.5%	79.2%
Percentage of patients treated for cancer within 62 days of referral	78.1%	75.1%
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	12.1%	18.3%
Under 18s elective waiting list (number of under 18s waiting for elective treatment as at year end)	9,366	8,573

2.4.2 Reporting against core indicators for 2024/25

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital to enable the public to compare performance across organisations.

The tables below provide information against several national priorities and measures that, in conjunction with our stakeholders, form part of our key performance indicators which are reported monthly to the Trust's Board.

These measures cover patient safety, experience, and clinical outcomes. Where possible we have included national benchmarks or targets so that progression can be seen, and performance compared to other providers.

All the core indicators are updated with the most recent publications from NHS Digital/NHSE/DHSC.

Core indicator 12: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) and the percentage of patient deaths with palliative care coded at either diagnosis or speciality levels) for the Trust for the reporting period:

SHMI

	February 2023 - January 2024		February 2024 - January 2025		February 2025 - January 2026	
	Value	OD banding				
UHS	0.85	3	0.81	3	0.84	3
National average	1	-	1	-	1	-
Highest Trust score	1.25	1	1.34	1	1.34	1
Lowest Trust score	0.7	3	0.71	3	0.71	3

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: SHMI is an NHS Digital-derived tool available nationally and provided to all trusts for monitoring their rates of mortality, amongst other parameters, on a monthly basis. It follows an open and transparent process, based on the mandatory reporting of data all trusts provide via secondary user's service. UHS has had a consistently strong SHMI performance for several years and continues to provide a statistically significantly better than expected trend. The high level of coding depth measured in the monthly SHMI reports give reassurance that the mortality measures are a fair reflection of UHS' performance.

Core indicator 18: The Trust's patient-reported outcome measures scores (PROMs) for:

(i) Groin hernia surgery
(ii) Varicose vein surgery
(iii) Hip replacement surgery and
(iv) Knee replacement surgery

PROMs coverage for groin hernia and varicose vein surgery

National patient reported outcome measures (PROMs) are no longer collected on a mandatory basis for groin hernia surgery and varicose vein surgery. Following a national consultation, NHS England formally ceased mandatory PROMs collection for both procedures from 1 October 2017, as the data was assessed as providing limited additional value at national level. Since that date, national PROMs reporting has focused exclusively on hip and knee replacement surgery. There were only small numbers for hernia repair and no data available for varicose veins. Varicose veins are treated at UHS, but they are dealt with at the independent treatment centre.

PROMs: Hip and knee replacement surgery

		2023/24			2024/25		
Procedure	**Measure**	**UHS**	**Highest provider**	**Lowest provider**	**UHS**	**Highest provider**	**Lowest provider**
Hip replacement primary	Oxford hip score	20.694	25.660	18.600	22.638	25.817	16.392
Knee replacement primary	Oxford knee score	18.049	19.788	11.716	18.559	21.34	12.356
Total hip replacement	Oxford hip score	21.126	25.492	18.101	22.624	25.583	16.174
Total knee replacement	Oxford knee score	17.906	20.115	11.445	18.265	21.559	21.411

Regulatory/Assurance statement: UHS considers this data is as described for the following reasons: adjusted average health gain has improved in the last year in both hip and knee replacements. UHS is not an outlier in any domain. During the last year, a new elective hub has been created in an ICS partnership with Hampshire Hospitals NHS FT, specifically for hip and knee arthroplasty. It is expected that this hub will increase the number of participants in providing PROM scores. UHS intends to improve, through the hub, the number of participants in providing PROM scores. We hope that this unit will also increase the health gains of hip and knee arthroplasty operations as it is likely to reduce waiting times.

Core indicator 19: The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	2024/25	2025/26 YTD
Readmission rate band (within 30* days) - non elective	12.31%	12.890%

*UHS report against the NHS England metric of emergency readmissions within 30 days, rather than 28 days.

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: we have a process in place for collating data on hospital admissions from which the readmission indicator is derived. We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. UHS has implemented actions to reduce unplanned readmissions by strengthening treatment and discharge practices and working with system partners to address demand, capacity, patient flow and discharge safety.

Core indicator 20: The Trust's responsiveness to the personal needs of its patients during the reporting period.

NHS England (NHSE) no longer calculates or publishes Friends and Family Test (FFT) response rates, as there is no restriction on how frequently patients or service users can provide feedback. NHSE has also clarified that FFT data is not comparable across organisations. However, it can serve as an informal indicator to monitor trends over time within an organisation.

To better assess the Trust's responsiveness to personal needs, asking "Overall, how was your experience of our service?" offers a more meaningful measure and comparing the trends alongside our supplementary "five core questions" results.

FFT - Positive responses

A&E	Q1 2024/25	Q2 2024/25	Q3 2024/25	2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	2025/26
UHS	74.43%	81.11%	80.78%	79.14%	80.88%	78.10%	68.32%	81.73%	78.84%
National average	78.12%	80.50%	76.59%	78.64%	79.49%	79.46%	77.50%	78.74%	78.82%
Highest trust	100.00%	100.00%	98.57%	100.00%	100.00%	98.57%	100.00%	100.00%	100.00%
Lowest trust	40.00%	53.13%	12.50%	12.50%	17.39%	33.33%	22.22%	54.55%	17.39%

Inpatient and daycase	Q1 2024/25	Q2 2024/25	Q3 2024/25	2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	2025/26
UHS	97.53%	97.21%	97.85%	97.54%	97.47%	96.92%	96.99%	96.40%	97.00%
National average	94.44%	94.76%	94.61%	94.67%	94.98%	94.90%	94.69%	94.79%	94.85%
Highest trust	100.00%	100.00%	98.57%	100.00%	100.00%	98.57%	100.00%	100.00%	101.34%
Lowest trust	55.93%	53.69%	71.76%	53.69%	5.88%	80.65%	62.50%	70.73%	0.00%

Negative responses

A&E	Q1 2024/25	Q2 2024/25	Q3 2024/25	2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	2025/26
UHS	16.75%	11.11%	13.25%	13.63%	10.99%	16.43%	23.27%	11.92%	14.28%
National average	14.04%	12.49%	15.29%	13.79%	13.02%	13.09%	14.78%	13.87%	13.67%
Highest trust	52.00%	41.67%	88.00%	88.00%	82.61%	61.00%	77.78%	45.45%	82.61%
Lowest trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Inpatient and daycase	Q1 2024/25	Q2 2024/25	Q3 2024/25	2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	2025/26
UHS	0.62%	0.75%	0.62%	0.75%	1.19%	1.19%	1.20%	1.38%	1.23%
National average	2.57%	2.51%	2.61%	2.54%	2.41%	2.44%	2.48%	2.46%	2.45%
Highest trust	22.25%	16.67%	24.00%	24.00%	22.25%	13.22%	25.00%	17.07%	25.00%
Lowest trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Low UHS response rate to A&E FFT

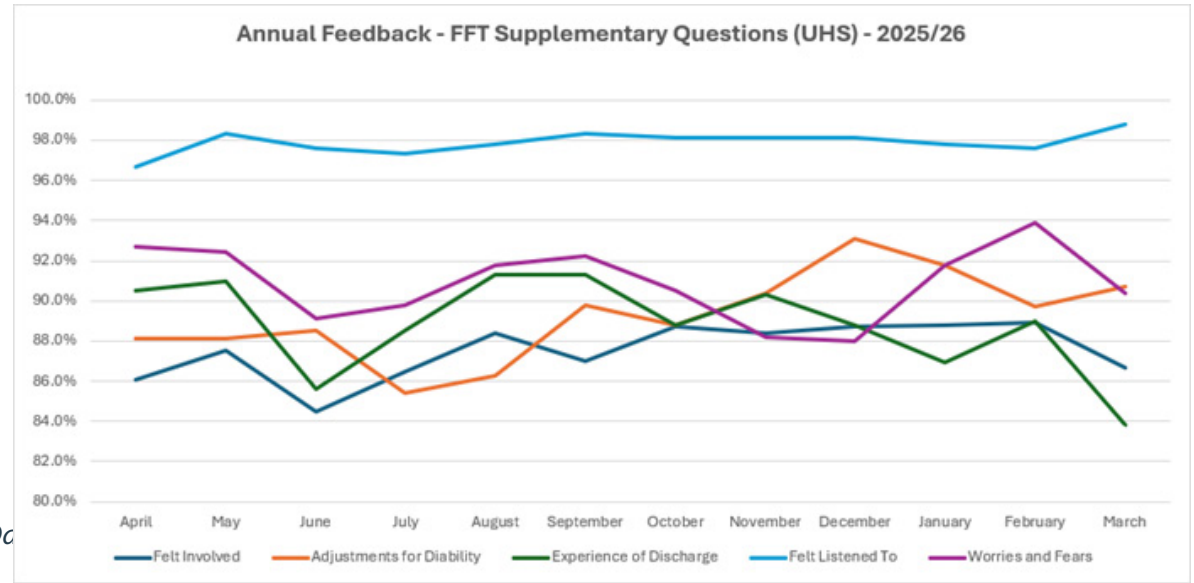
Patients are prompted to complete the FFT link sent to them by SMS text message, introducing self-selection bias into the completion rates. The continuation of SMS text messages as introduced in 2023/24 has meant that engagement continues to be significantly higher than previously attained, from previously single-digit to low-teen responses to now receiving an average of more than 200 responses a month. The Trust continues to aspire to introduce SMS text messaging for FFT surveys post-discharge for all care groups to help improve overall response and engagement rate to ensure that these figures are representative of the whole patient demographic.

Slight increase in negative response rate to inpatient and day case FFT

The slight increase in negative feedback aligns with an increase in awareness spreading of the FFT, with the introduction of QR code on bedside tables and an increase in poster campaigns. This also coincides with the growth of surveying volunteers and an increase in awareness of staff on the impact and necessity of the FFT. All care groups and divisional management teams now receive monthly notifications of their FFT score to identify successes and improvements and teams are encouraged to work on negative feedback to improve overall satisfaction, with the negative response rate showing gradual but continual improvement over the three quarters reported.

UHS FFT: Five core questions results

The Trust captures data beyond the core 'overall, how was your experience of care' question in the FFT in what is called the 'five core questions or 'supplementary' questions. These focus on core elements of patient experience: feeling involved in their care, making adjustments for people with disabilities, their experience of discharge processes, feeling listened to regarding their care, and having their worried and fears addressed. In 2025/26, the Trust scored an average of 90.8 across all of the supplementary questions asked, with 'felt listened to' achieving the highest score of 97.8.



Do

Regulatory/assurance statement: UHS considers that this data is as described as it is taken from the collection of Friends and Family Test results recorded by the Trust and processed by the third-party provider, aligns with trends and themes apparent from the national inpatient survey, and is consistent with feedback the Trust receives through other means including, but not limited to, focus groups, word-of-mouth, events.

UHS has taken the following actions to improve the Trust's responsiveness to the personal needs of its patients:

- Providing data to the governance teams on a monthly basis to allow for scrutiny of results and identification of themes requiring improvement.
- Continuing to develop ways of promoting response to the Friends and Family Test, including through the use of QR code on bedside tables and displaying FFT posters.
- Continuing to receive feedback through a number of methods, including the use of surveying volunteers, with the intention of providing greater details and response to personal needs.
- Expanding the size and role of the involved patient group, engaging with more projects and activities undertaken by the Trust.

Core indicator 21: The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends.

	2021	2022	2023	2024	2025
Your org	83.15%	78.78%	76.28%	76.75%	70.49%
Best result	89.49%	86.33%	88.81%	89.58%	88.41%
Average result	66.97%	61.78%	63.32%	61.55%	60.83%
Worst result	43.50%	39.20%	44.30%	39.68%	34.73%
Responses	6669	6921	5526	5301	4784

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: Our staff who recommend UHS as a place for their friends or family to be treated remains high, and significantly above the national average. This data represents the dedication and commitment of our staff to strive for high patient outcomes. Our staff are proud to be part of a large university teaching hospital, with a prominent research and development faculty, with specialist services delivering care regionally and nationally.

As part of the overall action to maintain or improve our results, UHS intends to take the following action:

- Increase the percentage of staff who complete the annual survey and quarterly Pulse surveys particularly in the nursing and midwifery workforce, to ensure we gain diverse and rich feedback, representing as many staff as possible.
- Develop the clinical leadership capability and confidence by delivering tailored leadership interventions to clinical leaders, in particular the senior nursing and midwifery pipeline and medical clinical leads.
- Develop a new education strategy in line with national priorities and local needs, and revise the education, training and development infrastructure to maximise the impact on people development now and the workforce of the future.
- Roll out and embed the new violence, aggression and abuse framework, increasing staff safety and managing poor behaviours, abuse and violence against staff.

Core Indicator 23: The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period.

The VTE data collection and publication resumed in 2024/25 following the original suspension due to the COVID-19 pandemic.

VTE risk assessments

	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
UHS	96.00%	95.00%	95.00%	95.00%
National average (acute trusts)	89.00%	89.00%	90.00%	90.00%
Highest trust score (acute trusts)	100.00%	100.00%	100.00%	100.00%
Lowest trust score (acute trusts)	15.00%	14.00%	13.00%	13.00%

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: UHS has continued to collect this data and remain above prescribed national averages i.e. 95%. UHS has taken the following actions to continue to maintain and improve the above average compliance and the quality of its services, by ensuring there is an ongoing hard block within our standard electronic prescribing system where resident doctors are signposted to complete VTE risk assessment. The data is shared regularly with the chair of thrombosis committee, it is a standing agenda item on the thrombosis committee, and the data is signed off by the chief medical officer. We are also working with divisions and care groups, emphasising the importance of risk assessment, as well as excluding cohorts where risk assessment is inappropriate.

Core indicator 24: The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust among patients aged two or over during the reporting period:

C difficile per 100,000 bed days

	2022/23	2023/24	2024/25	2025/26
UHS	21.85	26.36	31.58	22.01
National average	26.82	28.38	31.39	25.28
Highest trust score	84.38	92.54	77.81	54.64
Lowest trust score	0.00	0.00	0.00	0.00
Lowest trust score (non-zero)	1.4	5.9	2.3	0.83

Data source: UK Health Security Agency (UKHSA)

Regulatory/assurance statement: UHS considers that this data is described for the following reasons: We use nationally reported and validated data; we monitor performance regularly through our Trust infection prevention and control (IP&C) committee, quality governance steering group and daily and weekly reviews.

UHS has taken the following actions to improve the rate of C difficile infection per 100,000 bed days of 21.34 and the quality of the services, by:

1. Focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing including review and update of antimicrobial prescribing guidelines.

2. Ongoing focus on improving IP&C practice standards including equipment cleanliness, hand hygiene practices, appropriate glove use, care and management of patients requiring isolation.
3. Participation in the sentinel surveillance programme of Clostridioides difficile infection (CDI) by whole-genome sequencing (WGS) which will provide both C. difficile ribotyping data and further information on potential genetic relatedness of a sample our CDI cases.

Patient safety indicators data for 2024/25:
Public Health England healthcare associated infections (HCAI) data capture system (DCS) national reporting case capture compares rates and counts of infections occurring in organisation of the same type.

Benchmarking (allows users to compare their organisation to other organisations in terms of rates and counts of reported cases) – benchmarking is against nationally reported cases of healthcare associated cases rate per 100,000 overnight bed-days plus day admissions.

UHS healthcare associated figures

	2021/22	2022/23	2023/24	2024/25	2025/26
Healthcare associated infection MRSA bacteraemia reduction	1	4	7	5	8
Healthcare associated infection clostridium difficile reduction	74	84	105	120	91

MRSA performance against national limit

	2021/22	2022/23	2023/24	2024/25	2025/26
MRSA annual limit	0	0	0	0	0
UHS healthcare associated infection MRSA bacteraemia performance	1	4	7	5	8

UHS C. difficile performance against national limit

	2021/22	2022/23	2023/24	2024/25	2025/26
C.difficile annual limit	64	61	60	99	100
UHS healthcare associated infection clostridium difficile performance	74	84	105	120	91
C.difficile variance from plan	15.6%	37.7%	42.86%	17.5%	-10%

Data sources: UKHSA

Infection prevention practice standards
There is a Trust annual infection prevention audit programme in place for 2025/26 to monitor infection prevention and control practice standards in clinical and non-clinical areas.
The audit programme is made up of the following:

- High impact intervention audits (care processes to prevent infection) - self-assessed audits.

- Hand hygiene:
  - o The hand hygiene audit process covers a wide selection of staff groups and ensures any missed opportunities for hand hygiene are addressed during the audits.
  - o Monitoring and assurance of hand hygiene practice for inpatient areas in 2025/26 consisted of: Self-assessed audits by ward leaders and/or matron with clinical lead.
    Covert audits carried out by an independent infection prevention nurse out of uniform.
    Monitoring and assurance of hand hygiene practice for outpatient areas consists of peer audits.
- Miscellaneous audits – self assessed (shown in appendix C)

Areas/wards who do not achieve the expected audit standards are required to identify actions for improvement and are offered support and input from the infection prevention team. Processes are in place for regular review of areas not achieving expected standards. Performance in relation to audit standards has been reviewed monthly by the infection prevention team to identify areas of concern/ those requiring additional support to improve practice standards.

High impact intervention audits

Audit title	Actions
Infection, prevention and control (IPC) – Saving lives HII 1 central venous catheter care	**Central venous catheter insertion audit.** No individual elements of the audit fell below the 95% expected standard. **Central venous catheter ongoing care audit.** No individual elements of the audit fell below the 95% expected standard.
Infection, prevention and control (IPC) – Saving lives HII 2 peripheral intravenous cannula care	**Peripheral intravenous cannula insertion audit.** No individual elements of the audit fell below the 95% expected standard. **Peripheral intravenous cannula ongoing care audit.** No individual elements of the audit fell below the 95% expected. standard.
Infection prevention and control (IPC) – Preventing surgical site infection	**Preventing surgical site infection pre-operative audit.** No individual elements of the audit fell below the 95% expected standard. **Preventing surgical site infection intra-operative audit.** No individual elements of the audit fell below the 95% expected standard. **Preventing surgical site infection post-operative audit.** No individual elements of the audit fell below the 95% expected standard.
HII No 5 Ventilated patients - undertaking care of ventilated or tracheostomy patients	**Care of ventilated patients.** No individual elements of the audit fell below the 95% expected standard.

Audit title	Actions
Infection, Prevention and Control (IPC) – Saving lives HII 6 Urinary Catheter Care	**Urinary Catheter insertion audit.** No individual elements of the audit fell below the 95% expected standard. **Urinary Catheter ongoing care audit.** Elements not meeting expected standards: • There is a clear plan for review and removal of the catheter, which is documented in the patient's records. • When indicated, urine samples are obtained using aseptic technique non-touch technique (ANTT) via the catheter sampling port, as per the UHS ANTT Guideline for catheter urine sampling. Infection Prevention Focus continues to be on addressing themes/learning from invasive devices, specifically improving the management and care of indwelling urinary catheters.

Hand hygiene audits

Audit title	Actions
Infection, Prevention and Control (IPC) – Inpatient and outpatient hand hygiene audit	**UHS trust-wide audit of hand hygiene.** An improvement framework specifically for hand hygiene is in place with the aim of driving improvements in practice. Areas will be measured against performance improvement target. All areas are responsible for developing and implementing an action plan based upon their results following their audit.

Core Indicator 25: The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	2024/25	2025/26
Patient safety incidents (PSIs) - PSIs uploaded to learning from patient safety events - (LFPSE) portal	8,477	11,305
Number of PSIs that resulted in severe/major/catastophic harm*	77	103
PSIs that required a patient safety incident investigation (PSII)**	9 (Apr-Mar)	20
Never events	10 (Apr-Mar)	9
Avoidable hospital acquired grade III and IC pressure ulcers	184***	245***
Total number of falls with significant harm	56 (Apr-Mar)	46
Thromboprophylaxis (VTE) % patients assessed	>95%	95%

** Section 2.4.3 Learning from deaths includes details about PSI resulting in death.*

*** UHS transitioned from the serious incident (SI) framework onto the patient safety incident response framework (PSIRF) on 2 October 2023. Methodology changes from SIRIs to PSIIs in 2024/25 making comparisons to historical years not meaningful.*

**** This figure also includes pressures ulcers which are unstageable, which means they are a III or IV but unclear which. In the 2024/25 quality account, the number published for 2024/25 did not include ungradable.*

Regulatory/assurance statement

UHS considers that this data is as described for the following reasons: although an increase in the number of patient safety incident investigations attributed to increased concerns regarding patient care and pathways, this is likely led by an enhanced awareness of PSIRF and the promotion of a proactive learning culture across the Trust.

An increase in the number of PSII can be explained by a combination factors, not necessarily a deterioration in care quality:

- Improved reporting culture: ongoing work to promote openness, psychological safety, and learning has led to increased confidence among staff to report incidents. This often results in higher reporting rates and more matters meeting the threshold for PSII.
- Greater awareness of PSII criteria: enhanced training and familiarity with the PSIRF have improved recognition of incidents that warrant formal investigation.
- More robust triage and governance processes: strengthened oversight and clearer decision-making pathways leading to more consistent identification of incidents requiring PSII.
- Increasing complexity of patient need: a rise in clinical complexity, multimorbidity, and safeguarding or system interface issues can increase the likelihood of incidents meeting PSII criteria, especially in vulnerable patient groups.
- Thematic or cluster effects: multiple incidents with similar contributory factors may appropriately trigger PSII to support deeper learning and systemwide improvement.

UHS has taken the following actions to improve patient safety by continuing to enhance awareness of PSIRF and the promotion of a proactive learning culture across the Trust.

Avoidable hospital acquired pressure ulcers:
A number of changes have been agreed in relation to the pressure ulcer steering group. The group currently meets on a quarterly basis; however, this will be revised to monthly meetings to ensure it remains responsive to current issues and emerging trends, enabling timely implementation of improvements. Attendance will also be required at care group level rather than through divisional representation, in order to strengthen accountability.

A re-audit will be undertaken by the lead tissue viability nurse in quarter one/two (2026/27). The findings will be presented at the clinical leadership group (CLG), and consideration will be given to delivering a workshop event to facilitate further discussion of the key issues identified.

These actions represent the initial planned response, with further actions expected to follow. It is recognised that education and staff engagement are essential, alongside the need for consistent prioritisation of pressure ulcer prevention within nursing practice. The focus will be on identifying the most effective and accessible ways to support staff in ensuring this remains a high priority for patient care.

2.4.3 Learning from deaths

During 2025/26, a total of 1,846 UHS patients died. These deaths were distributed across the reporting year as follows, by quarter:

Number of deaths per quarter 2025/26

Q1	Q2	Q3	Q4
500	383	513	450

Mortality and morbidity (M&M) reviews
During 2025/26, 56 cases were referred by the Southampton medical examiner office for Trust mortality and morbidity review. In all cases, the deaths were deemed unavoidable, and care and treatment were assessed as appropriate.

However, a number of learning opportunities were identified and discussed as part of the review process. A summary of the learning identified from these cases is outlined below.

Case one:
Thematic learning: A case regarding mismanagement of diabetes in end of life care and renal failure.

Summary of actions: A proposal was made for the diabetes team to provide targeted education to ward staff. This action was followed up by the M&M lead in collaboration with the inpatient diabetic outreach team. Shared in learning from death report to Trust Board.

Case two:
Thematic learning: An incorrect medication route was used due to human factors associated with end-of-life care, including emotional distress, ward pressures, and increased cognitive load. This contributed to reduced situational awareness and confirmation bias, despite standard processes

being followed.

Summary of actions:
- Improved organisation and stock management of controlled drugs to support safer selection.
- Reinforced the importance of minimising interruptions during medication preparation and administration.
- Ongoing education on safe medication practices, including syringe driver use.
- Strengthened checking processes to promote open questioning and reduce bias.
- Review and clarification of medication route guidance within policy.
- Exploration of additional safety measures to reduce the risk of administration errors.

How learning has been shared: Learning has been shared through governance structures and incorporated into wider organisational learning to support practice improvement.

Case three:
Thematic learning: A patient attending the emergency department (ED) with sepsis experienced delays in review and treatment, contributing to a poor outcome.

Key learning and actions:
- Reinforce awareness and appropriate use of the critical incident escalation process, including senior clinician and duty manager responsibilities.
- Improve documentation of escalation decisions and communication, particularly during periods of ED overcapacity.
- Strengthen early recognition of sepsis by embedding effective screening processes at triage.
- Clarify escalation pathways for patients requiring urgent interventions (e.g. difficult vascular access).
- Continue monitoring risks associated with ED crowding and capacity through regular review processes.
- Share learning across relevant stakeholders to support system-wide improvement.

How has learning been shared: Learning has been disseminated through governance structures, system partners, and organisational reporting to support wider improvement.

Case four:
Thematic learning: A patient death occurred following discharge from an acute admissions area, identified as a 'failure to rescue.' The case was reported externally.

Summary of actions:
Work has been undertaken to strengthen discharge processes across the Trust, including updating the discharge checklist and associated policies. Education and training are being developed to support staff in safe discharge practice, communication, and key legal frameworks. Additional policy updates are in progress to improve communication with families and care providers, and to enhance medicines management at discharge.

How has learning been shared: Learning has been disseminated through policy updates, governance processes, leadership forums, and reporting to the Trust Board.

Mortality and morbidity (M&M) review process

During 2025/26, significant progress was made toward strengthening the consistency, transparency and learning value of M&M processes across the Trust. A key focus for this year was standardising how M&M outcomes are recorded and ensuring that learning is shared broadly to support continuous improvement in patient safety and clinical effectiveness.

Following a comparative review of three external systems for capturing M&M data, the Ulysses mortality module emerged as the preferred option.

The new Ulysses mechanism for collating M&M outcomes has now moved into its testing phase. This development is expected to significantly improve consistency, streamline data capture, and enable more robust Trust-wide analysis of themes. Alongside the system changes, parallel work continues to enhance the inclusivity of the M&M process strengthening opportunities for staff involvement and ensuring that family perspectives are captured more effectively. These improvements are aimed at supporting sustainable learning and better oversight of emerging issues. These improvements focus on embedding the M&M framework, promoting a restorative and just learning culture, and using systems based and appreciative approaches to understanding care. The medical advisor for patient safety, who leads on M&Ms, meets regularly with M&M leads to support this work.

To embed learning more deeply into governance structures, M&M learning outcomes are now being promoted as a standing agenda item at care group and divisional governance meetings. Where themes are relevant beyond local areas, a clear pathway for Trust-wide escalation and shared learning has been established. This approach will help ensure lessons from M&M reviews are routinely disseminated, discussed and acted upon, supporting a stronger safety culture across the organisation.

Focus on dying with dignity and learning from AERs

- **Dying with privacy:** We have focused on improving end of life care by prioritising dignity in death and using families' feedback to drive practice change. The experience of care team added in 'dying in bay' as AER reportable incident. 26 incidents were reported in 2025/26 in which patients died in multi-bed bays rather than in private side rooms. These occurrences were primarily due to limited availability of side rooms and constraints related to infection control. The issue has been escalated to both care group and Trust-level management, and clinical teams have been instructed to report such incidents as they occur. The majority of these cases occurred within the cancer care service. It is recognised that dying in a bay resulted in significant distress for both families and other patients in the bay, many of whom required additional emotional support. Cancer care has formally recorded the limited side room capacity on their care group risk register, with the associated risk currently scored at 16.
- **Communication:** Themes identified include inadequate guidance regarding body viewings, delays in communicating the time of death, and miscommunication surrounding DNACPR (do not attempt cardiopulmonary resuscitation) decisions. This formed part of matron walkabout focuses to identify learning gaps.
- **Improper management of implants:** On two separate out-of-hour incidents, wards were unable to deactivate implantable devices, resulting in dying patients receiving inappropriate shocks intended to prolong life. This caused significant distress for families.

Upon investigation, one incident revealed that an established care plan had not been followed, while the other highlighted a lack of awareness regarding out-of-hours device management. In response the clinical practice educator for palliative and end of life care has implemented targeted interventions including individual training, rapid-response simulations (trolley dashes) and broader

communication efforts to prevent recurrence. Initial feedback from the clinical areas indicates that these measures have already led to improved practice in recent cases.

Patient safety incidents:
The patient safety team received and triaged eight referrals from the medical examiners from April 2025 until March 2026:

- Three cases were directed to be discussed/reviewed at relevant M&M meeting.
- One case pertained to a patient who had sustained a fall; therefore, this was managed via the high harm fall process.
- One case was subject to a patient safety case review and subsequently a patient safety incident investigation.
- Three cases were deemed as not requiring any further action.

	April 2025 – March 2026			
	Q1	Q2	Q3	Q4
Cases triaged	21	22	19	16
Patient safety case review	6	5	7	5
Patient safety incident investigation	5	3	2	0

A total of 23 cases were subject to a patient safety case review meeting. Ten progressed to be investigated as patient safety incident investigations, as per UHS patient safety incident framework plan.

Three were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- One representing 0.01% for the first quarter.
- One representing 0.01% for the second quarter.
- One representing 0.01% for the third quarter.
- Zero representing 0% for the fourth quarter.

In 2025/26, the child death and deterioration (CDAD) group reviewed 22 deaths and 164 deterioration cases between the dates requested.

Improvements to learning from lives and death – people with a learning disability and autistic people (LeDeR)

A total of 18 cases were reviewed at LeDeR meetings between April 2025 and March 2026.

Engagement in the LeDeR process has remained consistently positive, supported by strong collaboration across clinical teams and a clear commitment to learning, quality improvement and patient-centred care. Overall, discussions reflected high levels of engagement and a developing culture of reflection and continuous learning. While a number of areas for improvement were identified, particularly in relation to documentation and referral pathways, there were also numerous

examples of compassionate, well coordinated care delivered to some of the most vulnerable patients.

Example of learning from a patient safety incident investigation conducted in relation to the death of a patient with learning disability is presented below:

Patient was admitted to hospital with a working diagnosis of sepsis, requiring admission to the general intensive care unit. Following a period of extensive treatment, he was found to be stable enough to be transferred to an inpatient ward. Following transfer, concerns were identified regarding a delay in identifying and subsequently managing his clinical deterioration.

Thematic learning: Gap in the process of clinical review of patients who are transferred from intensive care areas to ward areas. This includes review by the medical team and frequency of recording clinical observations. In addition, learning was identified regarding the interaction between ward staff and carers from external agencies, as well as gaps in communication with patients' families and understanding of complex individual needs.

Summary of completed actions: Improve handover process for patients transferred from general intensive care to ward areas, which includes the critical care outreach team. Formation of a carers policy to improve patient safety providing clear agreement on communication, roles and responsibilities. A local learning review of incidents with a reoccurring theme identified across division B that patients with a learning disability have had concerns raised and adverse events reported regarding aspects of their care.

How learning has been shared: Presentation and discussion of findings at deteriorating patient group. Dissemination through peer education meetings. Launch of new communications package regarding Call 4 Concern. Fundamentals of Care training.

2.4.4 Seven-day hospital services

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed and since 2015 trusts have been asked to report on four priority standards:

- Clinical standard 2: consultant-directed assessment.
- Clinical standard 5: diagnostics.
- Clinical standard 6: interventions.
- Clinical standard 8: ongoing review.

The Trust currently meets all four of these standards and delivers a comprehensive 7DS which helps keep patients safe and helps with flow through the hospital seven days a week. This has been particularly important during our recovery from the COVID-19 pandemic and while working to meet the national challenges around patient flow.

Clinical standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

All emergency specialties have consultant on call rotas with either planned ward round review to

support the standard or continuous review throughout the shifts. The timing of review is entered through the electronic system which enables monitoring.

Clinical standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within one hour for critical patients.
- Within 12 hours for urgent patients.
- Within 24 hours for non-urgent patients.

UHS consistently achieves this standard across seven days a week, all specialties provide consultant cover and interventions seven days a week:

- Within one hour for critical patients.
- Within 12 hours for urgent patients.
- Within 24 hours for non-urgent patients.

We also provide many of these services for neighbouring trusts, including interventional radiology, MRI, interventional endoscopy, emergency surgery, percutaneous coronary intervention and complex cardio arrhythmia and microbiology.

Clinical standard 6: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

Due to radiology working practices and economies of scale UHS consistently achieves clinical standard 6 target across seven days a week for:

- Critical care.
- Interventional radiology.
- Interventional endoscopy.
- Emergency surgery.
- Emergency renal replacement therapy.
- Urgent radiotherapy.
- Stroke thrombolysis and seven-day mechanical thrombectomy cover.
- Percutaneous coronary intervention.
- Cardiac pacing.

Clinical standard 8: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

The Trust is meeting this standard by twice daily consultant reviews taking place in admission areas, intensive and high care areas and once daily review in other inpatient wards.

UHS supported achieving this standard by implementing NEWS2 across all adult areas (excluding obstetrics) as described previously in this report. Patient acuity and needs are updated daily on the

doctors' worklist application which provides detail on handover and to the on call team. Patients requiring urgent review are seen by the duty team as highlighted through the national early warning score (NEWS2) or by the nursing team.

2.4.5 Freedom to Speak Up

Freedom to Speak Up (FTSU) is available to anyone who works in health. This includes all healthcare professionals, non clinical staff, senior, middle and junior managers, volunteers, students, locum, bank and agency workers, as well as former employees.

The Trust has an independent and impartial Freedom to Speak Up guardian who provides confidential advice and support to anyone wishing to speak up. The FTSU guardian is supported by both an executive and a non executive lead, each of whom is knowledgeable about Freedom to Speak Up. The role of the executive lead is to provide the Board with reliable, independent and integrated information that assures the Board that:

Workers across all areas understand and support the FTSU vision, are aware of the policy, and have confidence in the speaking up process.

To support this, the Trust provides FTSU awareness sessions at corporate induction so that all new starters are aware of the FTSU guardian and champions, as well as the Trust's raising concerns (whistleblowing) policy.

We provide training to ensure managers understand their roles and responsibilities when handling concerns and are equipped to respond effectively. We also issue regular Trust-wide communications to raise the profile and understanding of the raising concerns agenda.

Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, including Black, Asian and minority ethnic (BAME) staff, agency workers, disabled staff and all staff with protected characteristics. We have developed a network of fully trained FTSU champions so that all staff can access confidential and impartial support.

Champions support staff who may be subject to, or accused of, bullying, harassment or discrimination, staff who need advice on issues such as workplace conflict and staff considering leaving UHS.

We continue to expand our community of champions and now have 78 trained champions from a wide range of backgrounds, staff groups and areas across UHS.

Speak up issues involving immediate patient safety concerns are escalated quickly.
Action is taken wherever there is evidence that workers have been victimised as a result of speaking up, regardless of seniority.

Lessons learned are shared widely across the Trust. Concerns are reviewed through a **multidisciplinary raising concern (whistleblowing)** steering group, chaired by an executive lead.

This group shares key findings and recommendations from concerns raised in order to foster a culture of openness, transparency and learning. It also monitors whether investigations are evidence based and carried out by individuals who are suitably independent.

FTSU policies and procedures are reviewed and improved using feedback from workers. The Trust's raising concerns policy clearly sets out escalation routes, including:
a) Raising the concern with a line manager.
b) Contacting the FTSU guardian or an FTSU champion.
c) Contacting the executive lead for FTSU.
d) Contacting the non executive lead for FTSU
e) Raising the concern externally.

The FTSU guardian sends a feedback form to individuals once their case has closed to understand their experience, learn how the process is working and identify improvements.

In addition, the Board receives a report every six months from the FTSU guardian. These reports are provided frequently enough to allow the Board to maintain effective oversight of FTSU matters. Reports are presented by the FTSU guardian in person.

Our progress and performance are measured through the annual staff survey, Friends and Family Test (FFT) results and direct feedback from those who have raised concerns. Benchmarking against the National Guardian's Office (NGO) data and the regional FTSU network also helps us track performance. We discuss progress against national FTSU office guidance, the NHS Trust **self-assessment** tool and any recommendations arising from national publications.

In July 2025, the Dash Review of patient safety across the health and care system recommended that the responsibilities of the NGO should be incorporated into providers, with functions aligned to wider staff voice mechanisms within NHS England. The review emphasised that ensuring these functions are carried out consistently by commissioners and providers should be a core function of theCQC.

Following the review, a national engagement exercise was launched to set out proposals for the future of Freedom to Speak Up as the NGO prepares to close. Views were sought, with the consultation closing on 20 February 2026. We now await confirmation of the new arrangements, which are due to take effect from July 2026.

Key points include:
- The National Guardian's Office will close by the end of June 2026 in line with the Dash Review recommendations.
- Essential FTSU functions will transfer to NHS England, the Department of Health and Social Care (DHSC), the CQC, and individual providers.
- There is a commitment to maintaining support for FTSU guardians and the wider speaking up agenda.
- The national engagement exercise ran from January to February 2026.

What Staff tell us:

Reassurance during difficult times:
"Thank you for arranging the meeting with the manager. It was truly reassuring for me during this stressful time. The support and advice received from both of you will really help me recharge and move forward."

Grateful for continued guidance:
"I am sincerely grateful for all the wonderful support and guidance you have offered me, as well as to my colleagues. With heartfelt thanks."

Growing in confidence and succeeding:
"I spoke with you last year about the stress I was experiencing because of how I was treated by colleagues. You met with me on Teams and were really supportive and encouraging. I started coaching through UHS and developed tools to build my self confidence and communication skills. The job went out again as a six month development post and I'm really pleased to tell you that I was successful at interview! I've been recruited."

2.4.6 Rota gaps

The resident doctor contract was introduced in 2016 in part to ensure that the doctors in training and thus their patients and colleagues are safe.

The contract enshrines several important rules which pertain to issues such as the maximum length of shifts, the number of shifts which can be worked in a row, the numbers of out of hours shifts and the number of hours of uninterrupted rest that is required between shifts.

The guardian of safe working hours (GOSW) supports the implementation and maintenance of the contract for all doctors in training, has independent oversight of resident doctors'(RD) working hours and works with the medical workforce team to identify any training challenges.

The GOSW provides a route whereby safety concerns relating to working hours and rota gaps can be identified, responded to and addressed. A regular report is submitted to Trust Board which includes updates on rota compliance, short term vacancies and longer gaps with plans for improvement. In addition, at UHS the GOSW has a role as a senior figure for the RDs to seek out for advice, concerns, ideas and suggestions about all aspects of the resident role. In this role the guardian works closely with the chief resident, the director of education and workforce, the executive and the resident doctor representatives.

The GOSW works with the medical workforce team, the rota leads and care group clinical leads to make sure that rota gaps are identified and filled wherever possible. We aim for proactive engagement with Health Education England (HEE) so we can accurately plan targeted campaigns for hard to recruit specialties and the judicious use of locums where necessary. We also embrace the UHS fellowship and aim to offer the same safeguards for all our resident doctors whether in deanery training posts or not.

At present there are 826 Wessex training resident doctors employed by the Trust and they all work on the 2016 contract. This figure includes hosted posts such as radiology, general practice and foundation community posts.

There are 448 locally employed doctors; they work on UHS local terms and conditions which mirror the 2016 contract.

The current vacancy rate (from February) is 5.39% which equates to 52 whole time equivalent vacant posts. Recruitment continues for current vacancies and medical HR are working with departments to plan for future gaps. There are certain specialties including ophthalmology, cancer care and pathology where recruitment and retention are particularly challenging and the relevant departments are actively involved in managing specific challenges.

Medical recruitment remains a high priority for the Trust and there is continued vigilance around

rotas, sickness and sustainability of the working patterns of resident doctors.

UHS has an internal medical locum bank which supports the management of both short-term vacancies and longer-term gaps in the rotas, with the expenditure being monitored continuously. From February 2025 to February 2026 there were 4,901 requests for locum shifts of which 3,595 (73%) were filled by the UHS system.

In February 2026 the exception reporting system underwent significant change. The main changes involve a simplification of the system for exception reports (ERs) less than two hours, the introduction of consistent confidentiality within the ER system and a fines system for immediate safety concerns.

In 2025 the number of ERs we received at UHS averaged 56 each month; since February 2026 we have received 184 ERs, a monthly average of 92. Although these numbers remain both low risk and low cost to the Trust there is ongoing monitoring of exception reporting and appropriate support is given to the clinical rota leads, the medical workforce team and the education teams.

Rota annualisation can help alleviate the problem of annual leave and the utilisation of the internal medical locum bank has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention.

Work is ongoing around the role of resident doctors, advanced nurse practitioners, physician assistants and a range of non clinical roles.

NHS England published the Priorities and Operational Planning Guidance paper in March 2024 which had specific recommendations around improving resident doctors working lives. In April 2024 actions were requested from each trust to implement these recommendations and this piece of work led to the launch of the NHS Ten Point Plan which seeks to mandate the changes which are aimed at fundamentally improve the lives and working conditions of RDs.

In April 2024 UHS formed a working group to ensure that the appropriate improvements were made. This work is ongoing; many of the recommendations were already in place at UHS and other improvements have been made. Of note this group has been able to open discussions about a number of important issues, most notable non clinical space for resident doctors which remains challenging.

These problems reflect the national picture and are well understood internally with improvement plans being generated and reviewed regularly to ensure that the building blocks for a successful RD workforce are in place in UHS.

The executive and non executive teams are fully cognisant of the challenges that RDs face and engaged in finding solutions. The medical workforce and the medical education teams work hard to support the residents and optimise their time at UHS.

2.4.7 Duty of Candour

The Duty of Candour, set out in regulation 20 of the Health and Social Care Act 2008, establishes a statutory obligation for all providers registered with the Care Quality Commission (CQC) to act with openness and transparency when patient harm occurs.

Both the statutory and professional Duty of Candour share a common purpose: to ensure that healthcare professionals communicate with honesty, clarity and integrity when something has gone wrong while providing care.

An incident is subject to the Duty of Candour requirements when harm arises during the delivery of care, regardless of whether an error has occurred. The harm must be a direct consequence of the incident, rather than the result of the individual's underlying condition or the natural progression of their illness.

The Duty of Candour policy provides guidance on the principles and standards that healthcare staff must follow when engaging with patients, relatives or carers after a patient safety incident. Its aim is to support and strengthen a culture that prioritises openness, honesty and transparency across the organisation.

The impact of patient safety incidents can be significant and far reaching for patients, families, carers and staff. A compassionate, transparent and respectful response is therefore essential to maintaining trust and supporting all those affected.

Resources and guidance are available to support staff in fulfilling the requirements of the Duty of Candour and in contributing to the wider patient safety investigation process.

Oversight of Duty of Candour compliance rests with the divisional governance groups, with additional support provided by the corporate patient safety team when the Duty of Candour relates to a patient safety incident investigation. This structure ensures that statutory obligations are met consistently and that staff are supported to apply the Duty of Candour effectively and appropriately.

Part 3:
Other information

3.1 Our commitment to safety

We are proud of our long-standing commitment to patient safety and continue to strengthen the quality of care we provide. In line with the principles of the Patient Incident Response Framework (PSIRF) we prioritise a proactive safety culture in which staff feel psychologically safe to speak up, report concerns and share learning without fear of blame.

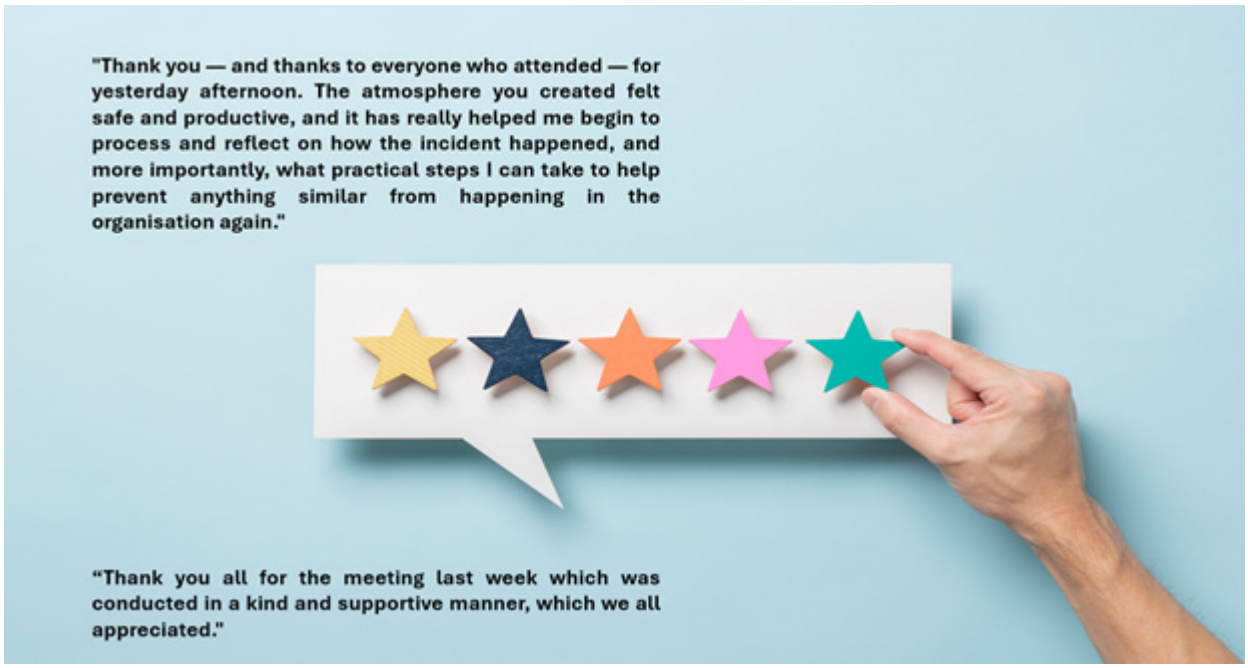
We recognise the vital importance of providing compassionate, appropriate and timely support to staff involved in patient safety incidents, as we recognise that being involved in a patient safety incident might feel difficult and overwhelming. Resources are available, explaining the investigation process, its expectations and information such as, key contacts to provide additional support, when needed.



Use of after-action reviews (AAR) for never event investigations
Following NHS England never event consultation and the move toward proportionate learning focused responses, we have adopted an approach that allows flexibility in how potential never events are reviewed. After action reviews have been used to explore incidents that may meet the never event criteria, ensuring that the response remains centred on learning rather than attributing blame.

These have been well received by those involved so far and helped foster an open and safe

environment in which staff involved in the incident feel able to reflect and contribute to the learning.



Patient safety focused matron's walkabout

As part of developing a more proactive approach to patient safety, a dedicated matron's walkabout was carried out with a specific focus on safety culture. The purpose of this walkabout was to understand what staff felt most proud of in their work, as well as how they perceived patient safety concerns to be raised, managed, and communicated back as learning. In addition, the walkabout explored staff knowledge and practice related to minor invasive procedures, particularly those undertaken outside of the theatre environment.

Although further work is needed to continue strengthening our safety culture, feedback from the walkabouts indicated that staff generally feel comfortable using the Trust wide electronic incident reporting system. They also reported that learning from incidents and complaints is effective and helps support ongoing improvement.







Improvements to learning from lives and death – people with a learning disability and autistic people (LeDeR)
Engagement in the LeDeR process has remained consistently positive, with strong collaboration from clinical teams and a clear focus on learning, quality improvement, and patient-centred care.

Overall, the discussions demonstrated strong engagement and a growing culture of reflective practice and learning. While several areas for improvement were identified, primarily around documentation and referral processes, there were also multiple examples of compassionate and coordinated care for some of the most vulnerable patients.

Good practice was identified with the most consistent themes being:
- Compassionate, personalised end of life care.
- Early and effective family engagement.
- Positive multidisciplinary team collaboration.
- Advocacy for patients without next of kin, ensuring their wishes were upheld, with appropriate escalation of community barriers to discharge.
- Sensitive communication with families aligned with patient preferences.

Going forward, in order to continue to strengthen the LeDeR process, we will focus on:
- Exploring a new meeting model that includes inviting the clinical team directly involved in the patient's care to present cases, which in turn will support better real time learning and immediate dissemination of key findings.
- Improving timeliness and quality of documentation.
- Ensuring prompt referrals to learning disabilities and autism services.
- Enhancing DNACPR documentation standards.

Improvements / next steps

1. Increase use of the central action plan module
Strengthen consistency, visibility and accountability for actions arising from patient safety incidents. This will improve follow through on learning actions, better organisational oversight and reduced risk of repeated incidents due to unmet actions.

2. Expand use of broader investigative tools and techniques
Promote and increase staff confidence in using a wider variety of investigative tools, such as SWARM huddles, thematic analysis to enhance the quality and depth of patient safety investigations. This will lead to improved multidisciplinary input (clinical, operational, human factors, and digital systems) into complex investigation and stronger learning.

3. Establish clear feedback routes for those involved in patient safety incidents
Improve transparency, close the loop for staff and strengthen a culture of learning by:
- Creating standardised communication pathways to ensure individuals who reported incidents or were involved receive timely updates.
- Set expectations for feedback timelines.
- Capture and analyse feedback from staff to ensure communication processes remain effective and supportive.

This will lead to enhanced staff engagement in patient safety, increased reporting confidence and improved organisational learning.

3.2 Our commitment to improving the experience of the people who use our services

Strengthening patient involvement and voice
The Trust is committed to ensuring that patients, families, and carers are central to service design and improvement. Historically, patient feedback relied primarily on the Friends and Family Test (FFT), which, while valuable, did not fully capture the breadth of patient experience or support consistent patient involvement across the organisation.

From October 2024, the patient experience team led a comprehensive redesign and expansion of the patient involvement programme to establish a more systematic, inclusive and visible approach to engagement. A coordinated framework was introduced, incorporating targeted promotion, increased onsite presence and a wider range of engagement methods, including specialist surveys, focus groups, patient led assessments of the care environment (PLACE), face-to-face events, and virtual opportunities.

This work has resulted in a significant increase in patient involvement and strengthened the representativeness of patient insight across the Trust.

Patient involvement programme – key metrics

- Involved patients: increased from 34 (Q2 2024/25) to 3,000+ (Q2 2025/26)
- Growth in patient involvement: over 8,700%.
- Increase in engagement opportunities: 185%.
- Targeted survey responses received: 5,491.
- Bespoke engagement activities delivered: 37.

- Approximately equal split between face-to-face and remote engagement.
- Face-to-face involvement events: 11, including PLACE assessments and Trust Board attendance.

Involved patients have contributed to service improvement activity including appointment communication reviews, outpatient signing improvements, PLACE assessments and attendance at Trust Board meetings to share patient stories. Patient feedback has directly informed the co-production of the locally recognised waiting well project and supported the development of the Trust strategy, ensuring that patient, family, and carer priorities are embedded.

The Trust has strengthened feedback loops through, "You Said, We Did" communications, providing assurance that patient contributions lead to tangible change. Targeted staff awareness activity has supported consistent use of involved patients across clinical and non clinical workstreams. Whilst these projects make a difference to the standard of care we can provide to future patients and families, we are now also seeing the benefits to the involved patients themselves by sharing, 'You Said, We Did' actions with them after their involvement.

Speaking on one of the co-produced projects, one involved patient told us: **"This is the perfect support needed. It shows that we are cared about and considered."**

Staff that have taken part in these events alongside patients have also shared their thoughts, with one stating: **"It's been invaluable hearing about the patient experience and seeing the service through their eyes".**

Learning from this programme has been shared across the local health system and national patient experience networks. This work provides assurance that UHS is embedding meaningful patient involvement at scale and strengthening patient experience in line with Trust values and quality priorities.



Some targeted awareness activities have also been carried out with our staff, helping to support the understanding of how involved patients can be contacted and used to support with key workstreams (clinical and non clinical) and what this process looks like. With the support of multidisciplinary teams, we have now hosted 37 bespoke feedback opportunities for our involved patients, with an almost equal split between face-to-face and remote engagement.

Learning that has been captured from growing the involved patient group has been shared across the local NHS network, including with other providers and the integrated care board as well as with the national patient experience network through forums and leadership meetings. The work and development of our involved patients is gold standard and is a prime example of how regional and nationwide services can enhance the patient, family and carer voice to truly and wholly embody the values of UHS.

Improving preprocedural hydration: Sip 'til Send

Issue identified

Baseline experience data collected in January 2025 highlighted that many patients experienced prolonged thirst prior to procedures, driven by traditional fasting practices that exceeded evidence-based requirements.

Intervention
Sip 'til Send was introduced across adult and paediatric services to support patients to safely drink clear fluids until transfer for their procedure. The initiative focused on clear messaging, consistent staff practice and patient reassurance, aligning with national fasting guidance.

Impact (October 2025 review)
All patients surveyed had consumed water within the previous two hours; almost all within the previous hour.

Reports of significant thirst fell by over 50 percentage points compared to baseline.

Patients reported fewer symptoms associated with dehydration, including nausea, light-headedness and headache.

Outcome
Sip 'til Send has improved patient comfort without compromising safety and has supported a more compassionate, consistent approach to care delivery across the Trust.

UHS Patient and Family Support Hub
The Patient and Family Support Hub (PFSH) was established last year to provide equitable access to support for all UHS patients and their families and carers. Its operational delivery continues to develop, with volunteer responders now supporting an average of three patient discharges each day. Typical activities include transporting personal laundry for long-stay patients, delivering essential mobility aids such as zimmer frames to support timely discharge and ensuring urgent respiratory equipment reaches patients in the community. These services make a significant contribution to patient experience and safe, efficient transitions of care.

The PFSH team have had a high impact this year, supporting 22 patients a day on average:





The PFSH will be supporting our quality priorities for 26/27 focusing on unpaid carers support. We aim for the PFSH to be a central hub for unpaid carer support within the Trust. Work has already commenced in engaging with our local community by holding our first carers engagement event.

We have also secured funding from the UHS League of Friends to provide dedicated washroom facilities for unpaid carers. We are pleased that this estates work has started, and the facilities will be available in early summer 2026. Feedback has highlighted that carers often spend extended periods with loved ones and currently rely on patient or staff facilities. Locating these facilities within the PFSH will both address this need and provide opportunities to identify unpaid carers who may benefit from additional support and signposting.

Nobody should die alone - Butterfly Friends volunteer service

The bereavement and family support team has partnered with the Anne Robson Trust to introduce Butterfly Friends, supporting patients at end of life and their families, in line with the belief that no one should die alone (unless this is personal choice).

Since the November 2025 launch, 11 volunteers have completed approximately 360 visits to provide end of life companionship. Feedback has been overwhelmingly positive, with the initiative reducing the emotional burden on staff and enabling them to focus on the care of other patients. We were proud that the BBC News covered the successful launch and the news campaign meant we received 30 expressions of interest from the public to sign up as Butterfly Friends.





3.2 Our commitment to improve the quality of our patients' environment

The environment in which the Trust cares for patients plays a crucial role in their overall experience and, in some cases, their clinical outcomes. We believe that every patient should feel assured that they will receive care with compassion and dignity in a clean, safe setting.

Patient led assessments of the care environment (PLACE) is a patient-focused assessment system designed to evaluate the quality of the care environment from the patient's perspective, rather than through traditional technical audits. These assessments are led by patients and their representatives,

with support from Trust staff. The patient assessors reflect the diverse demographic of those receiving care within the Trust, ensuring that their insights provide a direct and meaningful perspective on how the environment affects them and where improvements can be made.

In 2025, PLACE assessments were conducted across five UHS operational sites. These assessments were unannounced and carried out by teams comprising both staff and patient representatives. We were privileged to have ongoing support from Healthwatch Southampton, Trust governors, independent representatives, Trust volunteers and a strong presence of youth ambassadors. This diverse group of assessors brought valuable insights and experiences, strengthening the overall assessment process.

Our 2025 results compared to 2024 were:

	Cleanliness	Combined food	Organisational food	Ward food
2025	97.56%	87.90%	97.92%	86.29%
2024	98.71%	87.22%	97.40%	85.54%

	Privacy, dignity and wellbeing	Condition, appearance and maintenance	Dementia	Disability
2025	86.24%	95.14%	80.95%	82.32%
2024	83.87%	95.64%	75.50%	78.84%

We have seen some significant improvements in dementia and disability score following work and focus through the year, whilst maintaining good scores across all other areas.

Premises assurance model (PAM) assessment: The NHS Premises Assurance Model (PAM) return for 2025 provided a comprehensive overview of estate and service-related assurance across the Trust. The findings highlighted areas of strong performance, particularly within the safety hard domain, where most improvements and outstanding results were recorded. Positive progress was also evident in safety soft, patient experience, effectiveness, and efficiency, reflecting a balanced approach to maintaining high standards of care and operational effectiveness. Overall, the PAM assessment improved by 8.63% against a target of five percent.

Capital development and infrastructure improvements: The capital projects team is managing over 27 projects within design, development, and construction phases. Notable project completions include:

- **Robbie's Rehab:** A specialist four-bed rehabilitation ward has officially opened at Southampton Children's Hospital for children with neurological injuries and illnesses. Funded by a charity in memory of Robbie Keville, this £500,000 investment transforms neurorehabilitation by providing tailored care at the bedside in a dedicated, child-friendly environment. The unit significantly improves the quality of care, offering dedicated spaces for therapy sessions and personal care, ultimately leading to shorter hospital stays and better long-term outcomes for patients. This development also enhances efficiency for staff by centralising rehabilitation activities.
- **Solar PV project:** The Trust has completed a significant solar project, installing 444 solar panels

on the roof of car park 4 as part of its decarbonisation programme. This initiative, funded by a public sector decarbonisation grant, will generate approximately 225,150 kWh of clean energy annually. The project will reduce the Trust's carbon footprint by 47 tonnes of CO2 equivalent and saves around £83,000 in electricity costs each year, while also providing shade and rain cover for 52 parking spaces.

- **Woodlands ward neo-natal unit:** The Trust has unveiled a new state-of-the-art special care baby unit (SCBU), Woodlands Ward, at Princess Anne Hospital, marking a significant advancement in neonatal care. This purpose-built expansion increases capacity with 12 cot spaces and four family integrated care rooms, allowing parents to stay overnight with their babies. Designed to provide enhanced specialist and family-centred care for sick and premature babies, the unit serves approximately 900 babies annually from across the region and beyond. This £10 million investment transforms the environment for some of the region's most vulnerable patients and their families.

These achievements underscore the exceptional capabilities of our project management team and their dedication to enhancing both patient and staff experience. The Trust's healthcare facilities are continually being optimised to meet the evolving demands of modern healthcare delivery.

Estates: Throughout the past year, the estates (engineering) team has intensified its focus on clinical support. By fostering closer collaboration, the team has demonstrated increased responsiveness to issues directly impacting patient outcomes. This enhanced agility has resulted in improved uptime of clinical facilities and, consequently, a better patient experience. Furthermore, the estates team has made significant strides in statutory compliance, achieving a five percent increase in planned maintenance over the last six months, thereby ensuring safer and more compliant buildings. Recognising the challenges posed by rising summer temperatures, substantial investment has been made over the winter to upgrade cooling equipment, anticipating more reliable theatre availability during warmer months.

Facilities: The comprehensive support provided by our facilities teams is also crucial to maintaining a high-quality patient environment. Our catering services continue to deliver patient satisfaction, with new menus and increased survey participation. Cleaning teams, despite facing challenges in meeting national standards, have implemented action plans and are improving audit performance. Waste management efforts are focused on improving compliance and recruiting dedicated auditors. Linen services have seen a smooth transition to new suppliers and efficient management of scrubs. Transport initiatives have successfully reduced reliance on hire vehicles and improved cost-effectiveness. Security teams are actively managing incidents and exploring new contract options to enhance safety. Car parking solutions are being explored to ensure improved services and financially favourable outcomes for the Trust, and post services are transitioning to more efficient digital methods.

Compliance and business: The estates and facilities compliance and business team remains instrumental in upholding a safe, efficient, and regulatory-compliant patient environment. Key accomplishments this year include:

- Formulating new fire strategies for Trust buildings to guide future refurbishment and investment.
- Systematically reviewing critical infrastructure risks to inform investment priorities.
- Successfully implementing a new computer-aided facilities management system to ensure optimal maintenance, safety, and suitability of facilities for patient care.
- Bolstering emergency preparedness and resilience through comprehensive reviews of contingency plans for power failures, extreme weather events, and facility-related emergencies.

3.4 Our commitment to sustainability and the environment

The climate emergency is a health emergency, with climate change posing a significant threat to both human health and the planet. The World Health Organisation identifies it as the greatest health challenge facing humanity. The NHS, contributing around 5% of the UK's carbon footprint, must act urgently to mitigate its impact. Many aspects of care, such as surgery and intensive care, are resource-intensive, requiring a shift towards more sustainable healthcare delivery.

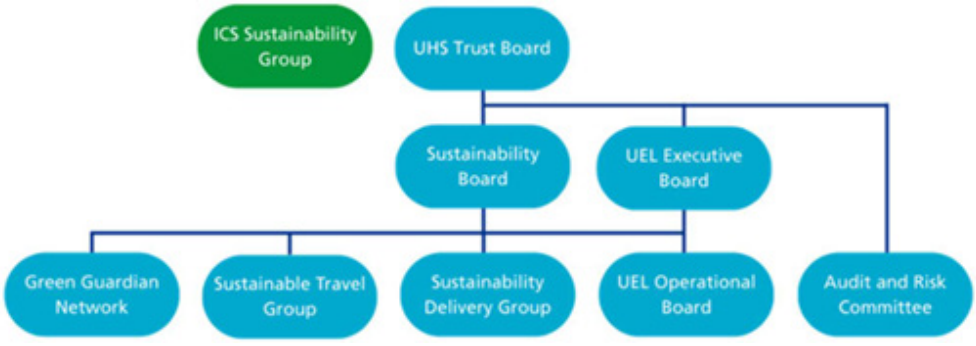
Sustainable healthcare means helping people stay well, empowering patients to manage their conditions, reducing unnecessary interventions, optimising resource use and switching to lower carbon alternatives, where possible. These changes not only improve health outcomes but can also reduce costs. In October 2020, the NHS became the world's first health service to commit to achieving net zero carbon emissions, reinforcing the need for urgent action. This commitment was further emphasised by Lord Darzi in his independent review of the NHS in England, highlighting that health and climate goals are often mutually reinforcing and that the NHS must remain committed to its net zero ambitions. The 10 Year Health Plan for England also stipulates that the NHS's commitments to delivering a net zero health service must be prioritised.

UHS set out its response to the net zero challenge via our green plan, updated in 2025. It outlines how we as an organisation are planning to help address environment and sustainability issues at a local level, the metrics that are being measured and the progress made since the first Trust green plan was published in 2022.

During 2025, we have continued to work towards becoming a more sustainable trust, with progress on ambitions declared in our green plan reported against each of the 10 key areas covered within the document:



Delivery of the green plan is overseen by a reporting structure that ensures clear visibility of both progress and challenges across all priority areas and allows for both strategic and operational decisions to be made in a timely and effective manner.



For specific projects, the Trust continues to roll out a package of energy efficiency improvements via funding awarded through the public sector decarbonisation scheme (PSDS), to ensure that our buildings can cope with the impact of the changing climate and reduce our environmental impact. Works are progressing to deliver a heat pump facility aimed at replacing the old gas boilers, expected to reduce carbon footprint by approximately 2,000 tonnes CO2e, and a solar car port has been installed on top of the multi storey car park 4 to provide additional on-site energy generation. Once fully commissioned, the project will generate approximately £83k financial savings and reduce carbon emissions by approximately 47 tonnes.

In January 2025, the Trust received £100k from the NHS energy efficiency fund to expand the electricity live sub-monitoring system at SGH. This system enhances visibility and understanding of power usage in buildings, enabling targeted actions to reduce energy waste. It also provides insights into essential and non essential loads, which is crucial as service demand increases.

Across clinical pathways we have continued to make good progress in terms of reducing environmental impact as a result of our activities and adopting triple bottom line principles in decision making. Notable impacts include:

- Appointment of a clinical lead with oversight of net zero clinical transformation.
- Engagement with patient pathways, including the recognition of sustainability priorities in quality and patient safety partnerships.
- Support for direct action by clinical teams to implement operational change projects, for example reducing the use of printers in endoscopy department.
- Decommissioning of nitrous oxide manifolds, transitioning to cylinders.
- Improved waste segregation compliance in theatres and ICUs.
- Cessation of single use inhalers in paediatric ED and transition from Ventolin to Salamol branded inhalers, halving related GHG emissions/CO2e.
- RCN-led gloves off campaign to reduce unnecessary single use glove use.
- Stopped routine use of the anaesthetic gas desflurane and switched to lower carbon alternatives (currently 0.4% of total volatile anaesthetic gas use across the Trust).
- Implemented reusable fabric gowns and hats in theatres.
- Introduced systems and processes to reduce medication waste and return any unused medication to the pharmacy.
- Implemented a walking aid reuse scheme across all three sites reducing waste and saving money.
- Introduced remanufactured catheters in cardiac treatment pathways.

The majority of these interventions have reduced operational costs as well as improving sustainability outcomes.

For travel and transport, we updated our travel plan in January 2026, setting objectives and targets relating to staff, patient and visitor travel options and working closely with local authority partners. The 2025 travel survey indicated that 37% of Trust staff currently drive as their primary mode of transport, which is a significantly lower percentage than other Trusts as a result of good connectivity via other modes. The updated travel plan therefore focuses on further improvements to facilities for sustainable travel and increasing use of the park and ride facility at Adanac Park, for those with no option other than driving.

The Trust has taken additional steps to electrify its fleet vehicles, with the addition of charging facilities and electric vehicles for our estates team. Planning is also underway to support the migration of ambulance fleet to full electric, working with regional partners. This switch to EVs will contribute to the reduction in air pollution from the Trust's transport fleet, and associated vehicle movements, benefiting staff, patients and the environment.

Overall, the Trust continues to make good progress towards our sustainability objectives and has a robust structure in place to report and measure impact, aligned with our updated green plan. The early focus for 2026 is to add resource to the delivery team, with recruitment of a sustainability manager and development of cross-trust relations to support increased impact and visibility.

3.4 Our commitment to staff

Key achievements and celebrations for 2025/26
In 2025/26 a key priority of the Trust has been to balance operational priorities with the funding available, and part of that work has been to reduce workforce costs.

We undertook an organisational restructure of the clinical divisions in summer 2025, with an aim to align services to the NHS 10 Year Plan priorities, and improve operational efficiency, enabling more effective care for our patients. During this time leaders were offered tailored support to lead and manage change and resources to support their own and others wellbeing during the transition, over 700 leaders participated in the leading through change programme. We also made a significant reduction in agency usage, improving cost efficiency of our staffing and consistency of skill mix.

We have continued to deliver our flagship programmes in relation to inclusion and belonging; our allyship programme achieved its target participation of over 11,500 staff, and in 2026 we will be designing the "next steps" of this programme aligned to our revised approach to tackling violence, aggression and abuse at UHS. We also celebrated the graduation of 24 more leaders from our positive action leadership programme, which aims to develop and support leaders from a range of underrepresented backgrounds into senior roles at UHS, to improve the representation of our senior leaders from across the communities we serve.

Our reward programmes have continued to thrive in 2025/26, 2,675 people were given High-5 awards, and 19 monthly Star awards were presented, these nominations highlight the extraordinary contributions made by our dedicated teams, whether it's through their clinical excellence or invaluable support in non- linical roles.

As part of our annual awards ceremony, UHS Champions, we recognised teams who had achieved excellent outcomes or had shown dedication to service delivery.



Our Proud2bAdmin network celebrated its first year anniversary reflecting on the achievements during the previous 12 months, which included strengthening the network membership and implementing Trust-wide admin huddles to share best practice, communicate changes and priorities, and celebrate success.

We have continued to invest in our wellbeing faculty across the organisation. We have increased the number of trauma risk management (TRiM) managers and practitioners, and in January 2026 we trained a group of staff to use the REACTMH tools from March on stress. This will enable managers and supervisors to be trained in having psychologically informed and supportive conversations with colleagues about their mental health, with anxiety and mental health now the main reason for sickness absence, this is a critical programme of work for 2026.

In October we held our third We Are UHS week, which celebrated the innovations and achievements of our staff and offered a variety of ways to recognise each other in local teams. The week included a special edition of our monthly Spotlight session which focused on individuals and teams who have been recognised throughout the year both internally and externally. We also recognised the contribution of the Filipino nursing community at UHS, noting a milestone of 25 years since the first Filipino nursing cohort started at the hospital.





In February 2026 a major incident was declared at the hospital due to a major fire in our endoscopy department. This unprecedented event saw the evacuation of 500 patients from the west wing of the hospital to safe areas within 40 minutes. The professionalism, compassion and courage shown from the staff during the event to keep patients and other staff safe and cared for was truly outstanding. Equally the actions from staff in the days and weeks afterwards in managing the incident and the subsequent recovery was tremendous. We are immensely proud of how the staff, patients and visitors dealt with the major incident; we are planning to recognise our staff more formally during 2026.

The fire and subsequent recovery efforts had a significant impact on our staff; many staff were displaced from their usual place of work or had to work differently. A pathway of wellbeing support was stood up within 24 hours of the fire starting, including psychological support, trauma risk management (TRiM), bespoke wellbeing interventions, regular wellbeing walk arounds and drop in sessions. Leadership visibility was increased and the Southampton Hospital Charity supported the delivery of over 500 boost boxes, filled with refreshments, wellbeing items and treats delivered across the hospital.

What you are most proud of in 2025/26

- Increased professional nurse advocates significantly from five in 2021 to 40 qualified, 12 in training and 20 on waiting list; this symbolises our commitment to ongoing professional development and support.
- We continue to offer interest free loans for Indefinite leave to remain payments for staff – 18 provided this year. This is a local initiative that has received plaudits nationally and others are looking to adopt. This is part of our staff support programme which also includes hardship grants, food vouchers and meal.
- We have a hardship support programme offering small grants to support unexpected expenses e.g. replacement washing machine and/or food vouchers/free food at our staff canteen (Feast). Unfortunately, given the cost of living challenges many are facing, these are well used by our staff. We appreciate the support for this from Southampton Hospitals Charity.

Some quotes:

- *"I am very appreciative of the help the Trust charity gave me towards my car repairs in July, thank you so much for that" (hardship grant).*
- *"Thank you very much this will take lots of pressure off myself" (hardship grant).*
- *"Thank you so much. This will be a great help to me" (Feast vouchers).*
- *"I just want to thank you and let you know how helpful these have been" (Feast vouchers).*
- *"Having the vouchers means I can ensure my family have good meals at home and I don't have to worry about sourcing lunches" (Feast vouchers).*
- *"Thank you so much. This will be a great help to me" (Feast vouchers).*

Interesting or innovative plans for the coming year

2026/27 will be about consolidation and a continued focus on maximising the productivity of our staff, to deliver the optimal care for our patients. We are focusing on how we can use AI and automation to simplify people processes and free up time for our colleagues to contribute to patient care.

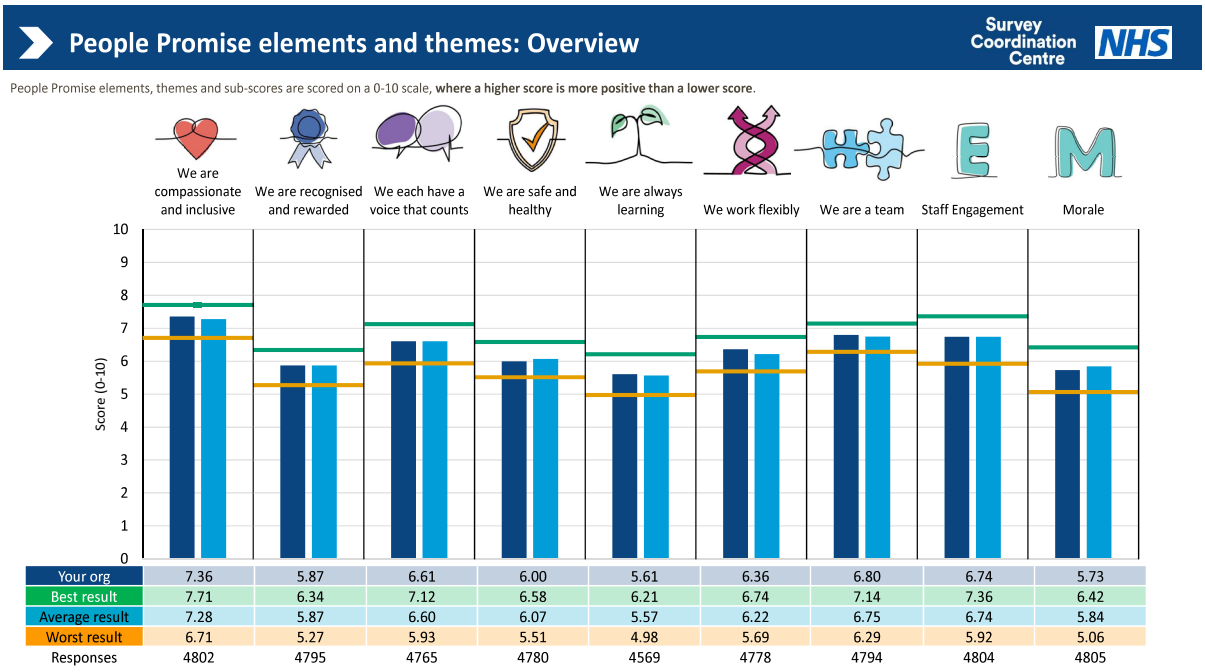
We have launched an early-stage staff benefits engagement campaign, discover and win, to increase awareness and uptake of available benefits through targeted daily highlights and prize draws. In the first 28 days, the campaign generated 125 new Vivup registrations, increasing total registrations to 11,693 (89.9% of the workforce). Activity data shows a sustained upward trend, supported by a "treasure hunt" approach that signposts existing users to benefits, savings and support they may not have previously accessed. The employee assistance programme continues to be well utilised, providing counselling and financial wellbeing support.

We will be launching and embedding our revised approach to tackling violence, aggression and abuse towards staff which enables compliance to the NHS violence prevention reduction standard.

The programme includes a refreshed policy and process, staff training, communications and engagement, and collaboration with other community partners.

The annual NHS staff survey continues to be the largest mechanism which enables us to gauge how staff are feeling and their experiences at work. This year 4,808 staff completed the survey (35% of staff).

Overall, despite the significant challenges, UHS Trust-wide results remain at or above average across seven of the nine NHS people promise themes. Our highest scores relate to being compassionate, inclusive, effective teamwork and staff engagement. Our areas of improvement relate to learning, morale and recognition and reward. We will be continuing to work on improving staff experience this year.



3.6 Our commitment to education and training



As a university teaching hospital, the training, development and support of our current and future workforce lies at the heart of what we do. Despite the significant financial and workforce challenges of the past year, we continue to aspire to the highest standards, to ensure our staff and students are equipped with the right skills and are supported to deliver the best quality care to our patients.

July 2025 heralded the publication of the long-awaited 10 Year Health Plan for England. The plan outlined a commitment to expanding and integrating education and training across all professions to build a skilled, flexible and compassionate workforce capable of delivering high-quality care. In 2025/26, our focus has been on ensuring that workforce and education initiatives demonstrably contribute towards quality, safety and experience.

Skills for practice

In 2025/2026 the skills for practice (SfP) team have successfully provided regular clinical skills training sessions to meet the needs of the revalidated undergraduate medical curriculum, in partnership with the University of Southampton Faculty of Medicine. We will continue, with the Faculty of Medicine, to deliver key elements of the revalidated curriculum over the next four years.

The SfP team continue to offer high-quality training for support workers. In collaboration with stakeholders across the organisation, we have developed an ambitious and structured support worker development programme. This programme is designed to support individuals new to care, enabling them to progress from agenda for change (AfC) band 2 role to a band 3 senior healthcare support worker position within six months.

The support worker development programme curriculum is aligned with the care certificate standards and integrates key internal initiatives, including the Fundamentals of Care and

deteriorating patient working groups. This ensures that participants not only meet national requirements but also contribute meaningfully to the Trust's strategic priorities.

UHS continues to lead the way in support worker education. Our dedicated support worker hub, comprising of experienced support workers who now educate and mentor the future workforce, exemplifies this commitment. This work continues to evolve and the hub are now running quarterly housekeeper development days and beginning to expand the competencies to include housekeepers, research support workers and AHP support workers.

In 2025 we have further strengthened our relationship with South Hampshire College Group, by developing a tailored learning programme consisting of accredited level 3 diploma units for support workers. This opportunity has enabled individuals to explore further education and gain confidence to undertake study.

Widening participation and apprenticeship provision

Apprenticeships
We currently have 480 active learners on apprenticeships with 26 currently paused and 38 referred pending start dates. Within this calendar year we have had 48 successful completions and attrition has remained under the 5% benchmark from previous years.

UHS encouraged the uptake of level 7 programmes before the levy funding cut-off date at the end of December 2025. This resulted in 37 members of staff being referred to various providers for both clinical and non clinical programmes.

UHS has worked closely with Hampshire Hospitals NHS Foundation Trust's apprenticeship centre to become an apprenticeship training subcontractor to deliver the level 2 pharmacy apprenticeships, with the first UHS apprentices starting towards the end of 2025.

We are also continuing the work around development pathways facilitated using apprenticeships, most notably HCSW roles undertaking healthcare support worker apprenticeships as part of their employment with UHS to progress onto clinical degree apprenticeships.

Career events
We have continued to attend career events at a range of local education establishments ranging from primary schools to universities. This calendar year we have attended 32 career events and supported activities including mock interview facilitation, career presentations and career fairs.

Through these we have reached over 3,000 local students and other young people who are not in employment, education or training (NEET), giving advice and information on the career in the NHS. We are particularly keen to ensure that many of these events reach those in socio-economically disadvantaged areas of Southampton to support young people better in making informed career choices.

We have received very positive feedback from these activities and will be looking to continue this into 2026.

Work experience
Although the Trust has not been able to offer as much on-site work experience opportunities to local young people, we are looking to increase this over the next year.

We have also organised and facilitated multiple virtual medical work experience events in conjunction with University of Southampton. These events allow aspiring young people nationwide who are considering a career in medicine to observe and engage with our medical staff online. Through the virtual work experience we have reached over 300 individuals, many of whom qualify under the "widening participation" selection criteria. We will also be continuing these in 2026 due to the positive feedback and popularity of the events.

T level placements
We have also continued the support of internal work placements via the T level route for aged 16–18 and choices college initiative for young people with disabilities who are aged between 18 and 25.

UHS works with three local colleges to offer both clinical and non-clinical T level placements. We have also been exploring more placement options related to areas of targeted growth within the NHS 10 Year Plan, particularly in digital areas. We continue to offer successful clinical T level placements and now offer these for up to 45 health T level students.

The Trust continues to support young people who are undertaking a technical level (TL) in health. UHS has provided a total of 63 placements over the last year in a wide variety of clinical areas. We successfully recruited four students into health care support worker (HCSW) posts at the end of their programme and most other learners who have completed programme have commenced healthcare related degree programmes.

Through the choices college initiative, we facilitated seven supported internships this calendar year with one attendee obtaining a permanent job offer as a result.

In the coming year we are hoping to increase this provision and work towards the Government's new aim of providing "meaningful work experience" to more secondary school students.

Pre-employment training - insight days and boot camps
Work with both the King's Trust pre-employment training placements and Yuzu training health bootcamps have continued this year. We have facilitated six events for 67 attendees in total.

These events help us to reach NEET individuals who have some interest, or previous experience, in healthcare roles. At the on-site sessions Trust staff come along to explain their roles and career pathways and the support worker hub provide demonstrations of care activities and insight of the HCSW induction. Yuzu health bootcamp attendees are guaranteed an initial interview for a HCSW post upon successful completion of the programme which has resulted in some attendees being offered roles.

Feedback from these events has been extremely positive and we are on course to increase our provision of these in the year ahead.

Education quality team

Safe learning environment charter
Following the release of the NHSE safe learning environment charter (SLEC), the framework has supported the development of a SLEC based update for nursing and midwifery students as well as the UHS practice assessor training. A pre-placement information pack, started by three senior nursing students from Solent University, has been completed and forwarded to universities to support students as they prepare for placement.

The next workstream, which has started is to use the SLEC framework as a comprehensive quality assurance driver, which will enable self-assessment, collection of evidence and the development of ongoing action plans, supported by external scrutiny by universities.

Continuous professional and personal development
Through last year's streamlining of applications for CPPD (continuous professional and personal development) we have seen a 27% increase in applications from 2024/25. The new digitalisation has decreased the time taken to complete forms for applicants from over one week to 23 minutes on average.

By January 2026, 1,553 applications have been processed of which 40% are accredited modules. The evaluations received have continued to express positive impact on skills, knowledge and development which in turn will contributed towards improving services for our patients.

Out of 702 evaluations received to date 86.8% stated there was an improvement to their delivery of safe patient care.

89.6% of colleagues said they would recommend the training they had received to other colleagues. The aim for 2026/27 is to focus on the impact of learning on patients and continue to strive to reduce administration input for CPPD processes.

Inplace – non-medical student placement management system
The contract for InPlace student placement management system has been agreed for the next year, which will support improvements in collaboration with universities and local HIOW trusts to support placements. UHS will be working on ensuring staff who need access to this system are independently able to use all required functions, with the education quality team looking to expand system use to placements for those on nursing apprenticeships and college students undertaking a T level. This allows for better oversight of utilised placements and use of the system to support data collection for non medical placement tariff.

Schwartz rounds
As an evidence based, multidisciplinary forum to help all staff reflect on the emotional impact of working in healthcare, Schwartz rounds deliver significant, measurable improvements in staff wellbeing, team connection and compassionate culture. In 2025 we have seen the successful embedding of Schwartz round across the organisation. We have delivered 18 rounds including 45 multi-professional storytellers and 548 attendees.

With 327 evaluations (60% return rate), this provides strong evidence of:
- High impact on emotional wellbeing, staff support and understanding of colleagues.
- Excellent experience ratings (mean = 4.68/5).
- Broad multidisciplinary engagement, with representation from 25+ staff groups.
- Strong return on investment (ROI) in relation to retention, morale, team functioning and alignment with NHS people plan / CQC well-led expectations/Trusts strategic aims.

Staff frequently described the sessions as:
- *"reassuring"*, *"re-energising"*, *"restorative"*, *"powerful"*, *"inspiring"*
- Helping them reconnect with *"why we do this work"*

Schwartz rounds have demonstrably become a core cultural asset at UHS, supporting psychological safety, compassion and retention — especially for newly registered professions, internationally

recruited and high-risk staff groups.

Fundamentals of Care
Maintaining our focus on the Fundamentals of Care and keeping patients safe, a new one-day course 'applying the Fundamentals of Care in clinical practice' has been developed. The aims are to enable learners to listen to the voices of patients and carers to help guide their practice, to identify how they can evidence that they are applying the Fundamentals of Care in their everyday work and to understand how to involve patients with additional needs in their care and in accordance with what matters to them most.

The course was offered Trust-wide and to staff of all professions mirroring the ambition to be inclusive in our practice and celebrate the diverse roles of staff and how we each contribute to person-centred care through the application of the fundamentals of care.

The initial day had 31 staff participate, comprising of nurses, health care support workers, therapists and healthcare science practitioners. The rich diversity of learner's experiences and knowledge was enhanced and increased by a multi-professional faculty.

Feedback on the day has been overwhelmingly positive with learners suggesting that further courses should be made available so that more staff can attend. Learners particularly referenced how powerful it was to listen to the experiences of patients and carers and their intention to use and share these stories in their workplaces as part of an individual action plan for implementing their learning from the day.

A second course is planned and designed to offer a more focused approach by exploring the fundamental care needs of patients with a learning disability and/or autism and their carers. Reference to patient and carer feedback of their experiences of care at UHS will be used to identify three specific areas of practice which would be addressed, these being communication, pain and working with carers. 52 staff from eight different professions are attending.

Moving forward, this course will contribute to a planned portfolio of programmes aimed at enabling staff across the trust to recognise and share the good work they are doing in embedding the Fundamentals of Care in their practice and provide staff with the tools they need to support them in areas where patient experiences of care could be improved.

Recognise, evaluate, act, communicate, teamwork and simulation (REACTS)
To build on the ongoing improvement of keeping people safe, in 2025 skills for practice and education teams have created a UHS specific deteriorating adult programme called REACTS – recognise, evaluate, act, communicate, teamwork and simulation. This was initially piloted with the new resident doctors during their induction week. Consisting of an initial e-learning package, followed by a three-hour simulation session, REACTS is a training programme that utilises simulation facilities to deliver an experiential learning opportunity.

Within this session staff are exposed to three different clinical scenarios that they need to work through and utilises real simulated patients. The learning point for each scenario is related to themes gathered from incidences and in conjunction with the trust acuity lead.

During the first phase over 100 doctors completed the programme and an average confidence score increased from 5.9 to 8.23. As a result of this success a REACTS for nurses has been created and piloted with 30 nurses from various clinical areas. The content of the course mirrors that of the doctors to give assurance that all staff have received the same training. This small pilot showed an

average confidence score increase from 6.37 to 8.27.

Due to the success of both programmes, REACTS is now embedded in the resident doctor induction and is to be included in the trust preceptorship programme for nurses.

Ongoing work will begin to look at widening the REACTS offer to allied health professionals and the wider work force for 2026/27 as well as developing a specific package for those caring for paediatric patients.

This has been part of a larger piece of work expanding simulation training at UHS, specifically the use of simulated participants, focused on training in the fundamentals of care and leadership skills.

Post graduate medicine
The 2025 General Medical Council (GMC) survey results for the Trust have been positive with overall improvement on previous years. Overall satisfaction was 79.13, which is higher than the national average of 78.4. UHS ranked 209 in 2025 in comparison to 223/460 in 2024.

There were several areas where the trust was a positive outlier within the GMC survey. These include eendocrine, GP F2, medical oncology, neonatal, neurosurgery, paediatric emergency medicine, paediatric surgery, palliative, vascular surgery, and rheumatology.

Surgery F1 feedback has improved considerably in this year's GMC survey following being placed on the NHS England risk register. NHSE has now removed the risk. There is now in place a lower risk for cardio-thoracic, but this does not need reporting to the GMC.

In 2025 we introduced the REACTS course as outlined above. This replaced the ALERT course and was developed within UHS by our postgraduate medicine education fellow. REACTS focuses on developing recognition of the acute deteriorating patient and how to manage these patients within UHS. It has been rolled out for resident doctors, international fellows, and nursing staff. We have had positive feedback on the course so far since its formal rollout in August 2025.

UHS has continued to deliver education to our medical trainers and residents. The educational supervision course has been updated to include new session on feedback, locally employed doctors (LEDs), and kindness within the workplace. This year as the educational supervision offering by the Deanery has changed we will also be offering a new supervisor course. Last year we ran a successful portfolio pathway study day for specialty, associate specialist and specialist (SAS) doctors and LEDs. We had over eighty delegates attend in person and forty attend online. The feedback was excellent, and we are planning to run the course again this year. We also ran a webinar for breast surgery portfolio pathway. This was the first of its kind in the UK and had more than one hundred national and international graduates.

Undergraduate medicine
Over the past 12 months, University Hospital Southampton has managed a substantial increase in undergraduate medical student numbers, including a 46% rise in year 3 placement sessions following the increase of the year 3 University of Southampton cohorts. As the University's largest clinical placement provider, UHS has taken deliberate steps to ensure that educational quality, student safety, and clinical standards are maintained during this period of growth. This has included the appointment of additional clinical teaching fellows to strengthen bedside teaching, structured clinical reasoning, and simulation-based learning, alongside the appointment of a deputy associate clinical sub-dean to enhance governance capacity, resilience, and senior oversight of placements across the Trust.

The Trust has continued the transparent allocation of undergraduate placement tariff income into care groups in line with delivery, while reinvesting in central infrastructure to support educational leadership, supervision, and administrative coordination. This has enabled expansion of educational leadership roles within specialties, strengthened job-planned teaching capacity, and reduced reliance on informal goodwill. In response to student feedback and quality assurance recommendations, the Trust has also improved practical aspects of the placement experience, including clearer induction processes and the provision of Trust ID badges to ensure appropriate access to clinical areas and systems, supporting both student integration and site security.

Collectively, these developments are designed to ensure that increasing student numbers do not compromise supervision, patient safety, or the quality of the learning environment, while positioning the organisation to continue to deliver the revalidated undergraduate curriculum in 2026/27 in a sustainable and governance-aligned manner.

Preceptorship
Preceptorship is embedded within UHS for all newly registered nurses, nursing associates, midwives, AHPs and return to practice staff. Whilst there are national frameworks for each professional group, UHS extends the programme and offer of preceptorship to newly registered health care scientists and pharmacists. Although there are currently no national frameworks for these professions, UHS felt it important to be fully inclusive in our multi-professional preceptorship. In July 2025, UHS were proud to be awarded the national preceptorship quality mark, this recognises the programme and its support to both preceptees and preceptors.

Overall, between October 2024 and September 2025 UHS has supported 269 preceptees, with another 90 recorded from October 2025 – January 2026. Preceptee and preceptor meetings require protected time to ensure effective planning for the preceptee development. This can be one of our greatest challenges but also our highest commitment to ensure preceptorship is effective. We have seen an improvement in initial meetings occurring potentially because of improved digital templates and overall awareness.

UHS has designated preceptor champions within education and clinical areas to promote preceptorship. UHS now has 39 nominated champions being recognised for working above and beyond in their role. This is an esteemed accolade for our preceptors, who have been nominated by preceptees and matrons over the past two years.

To ensure a robust and effective programme is provided, preceptees were invited to appraise their preceptorship through written evaluations and forums. This provides essential information which will support the future planning of programmes. Some of the most current data demonstrates that 100% of preceptees felt welcomed at the start and 94% of preceptees at the end of preceptorship felt that preceptorship has been very useful or useful in helping to build their confidence. Retention data is also collected, collated and shared as a way of recognising how preceptorship can impact on the retention of our early careers staff. In the most recent review, there was a significantly improved reduction in two yearly turnover of newly registered staff across UHS.

Recommendations and improvement plans are focusing on continuing to evaluate and review the offer of preceptorship across UHS, to introduce REACTS training for all newly registered nurses and continue to be inclusive and interactive in the delivery of the programme.

Pharmacy education
Our pharmacy education team continue to work with our partner universities (Portsmouth, Reading and Bath) to deliver increased undergraduate placements for the new MPharm course including

supporting students to reach the prescriber-ready status which is now required on qualification. The number of pharmacist prescribers in the Trust has increased, currently sitting at 79 trained and registered with eight qualified pharmacists in training and a further 14 trainee pharmacists being supported to complete their prescribing qualification (12 employed by UHS on a training contract and two externally employed and on a split placement with UHS).

In November 2025 the pharmacy team began delivery of the pharmacy support assistant L2 apprenticeship in partnership with HHFT and open awards, currently two on programme and three to start in Q4 of this year.

The training team continue to support L2 SMPO, L3 SMT and L4 pharmacy technician apprentices with all candidates to date having passed, the team are supporting our first 2 individuals on the scientist training programme, alongside the aseptic services team.

In addition to the above pharmacy specific training programmes the pharmacy team are also supporting one business administrator apprenticeship and one chartered management degree apprenticeship in health and care currently for the first time.

End of life care

To increase the offer of education for palliative and end of life care we have reinvigorated the use of palliative care champions and created a community of practice. We now have 100 staff members from across the Trust from a range of different professions including, but is not limited to, health care support workers, ward clerks and nurses.

This in turn has increased our reach with updates and communications for end of life care and has supported the roll out of the end of life observations. We rely on our champions to help promote best practice, highlight policy changes and to ensure we deliver a high standard of care, which in turn gives our patients and relatives a positive experience.

Since January 2025 we have run multiple ward-based teaching sessions covering a range of topics including documentation at the end of life, anticipatory medications, care of the patient after death and syringe driver teaching. By delivering education this way we have reached 468 members of staff including health care support workers, nurses, physiotherapist, occupational therapist, pharmacy staff, doctors and more. On the ward teaching topics are directed by incidences that have occurred and reported from clinical areas.

Included in the portfolio of end of life care teaching is a new programme called 'the Introduction to palliative and end of life care'. It is offered to all staff professions including those who work in non-clinical areas. Since January 2025 we have run this day four times and have had a total of 76 attendees. Attendance has been from a variety of staff groups including, student nurses, student allied health professionals, health care support workers, physiotherapist, occupational therapists and administrators.

Advancing practice

In 2025/26 we have continued to grow our advancing practice teams and services. This was demonstrated in another successful annual forum where individuals and teams working across advanced practice roles presented examples of service improvement and innovative ways of working to improve patient pathways and make tangible cost savings.

In 2025/26 we have had 15 advanced practitioners (APs) go successfully through the panel process on completion of an MSc AP programme, or equivalent, and showcase portfolios that evidence meeting

the four pillars of advancing practice and their capabilities in practice.
We have had trainees and qualified APs present and receive recognition locally and nationally. We had our first ACP (physiotherapist) for neurocritical care, not just at UHS but nationally, qualify and go through panel.

We finalised and went live with our advancing practice accountability and assurance document which was a multidisciplinary piece of work and will ensure standards and equity of practice throughout UHS.

Healthcare science
Healthcare science (HCS) has continued to prioritise workforce development to support safe, high-quality and innovative services across UHS.

Through a structured learning needs analysis process, over £155k of priority training needs were identified in 2025/26, reflecting the scale and complexity of the HCS workforce.

We are incredibly grateful to Southampton Hospitals Charity for awarding £86,557 to support key development initiatives. This investment has enabled targeted training aligned with service delivery, regulatory requirements, and emerging technologies.

Work continues to strengthen sustainable development pathways for the wider HCS workforce, ensuring staff are supported to maintain professional standards and adapt to evolving service

National School of Healthcare Science funded programmes			
	Scientist training programme (STP)	Higher specialist (HSST)	Echocardiography training programme (ETP)
Audiology	1		
Cancer genomics	3		
Cardiac science	2		1
Clinical biochemistry	1		
Clinical bioinformatics genomics	3		
Clinical immunology	1	1	
Clinical scientific computing	1		
Critical care science	4		
Genomic counselling	5		
Genomics	2		
Haematology & transfusion science	1		
Histopathology	2		
Imaging (non-ionising)	1		
Microbiology	2		
Nuclear medicine	2		
Pharmaceutical science	2		
Radiation safety and diagnostic radiology	2		
Radiotherapy physics	1	1	
Respiratory and sleep sciences	1		
Vascular science	1		
	37	2	1

demands.

Workforce
UHS continues to embed systematic evidence-based workforce planning, aligned to national policy and local service need. Workforce KPIs are reported monthly through established governance routes; particularly via the people report at various people-based forums and committees. Significant reductions in agency usage have been sustained into 2025/26, supported by strengthened approval processes.

UHS continued to further integrate work between various departments and services to align our internal direction with national policy initiatives such as the NHS people plan, NHS England focus on strategic workforce planning.

Workforce key performance indicators and workforce planning data (including forecasting) are reported monthly to the Trust Executive Committee (TEC), people & OD committee (PODC), and the UHS Trust Board in line with our governance requirements, highlighting any risk areas. These are also reviewed monthly with each division and weekly with the ICB Community of Practice. A monthly staffing status and patient safety report is also submitted.

There are regular internal and external (to NHS England and Hampshire & Isle of Wight ICB) reports that have been provided throughout the year on workforce trends, KPIs, and performance. Our focus is also on future workforce planning and oversight for 2026/27 and beyond; a moderate substantive growth (reflecting approved business case whole time equivalent (WTE) and expansion in referral to treatment pathways), and continued and sustained bank and agency reduction. UHS has reduced agency usage by 66% since January 2023 and reduced agency usage further by another 36% since January 2024.

There are now extra approval/control layers needing executive sign off for all agency and non-clinical/medical bank placements and dual approver requirement for nursing bank shifts before being released. New system functionality introduced, ensures that available hours in the rosters are being used before a person can work additional bank shifts.

Some of the initiatives include reviews to streamline processes, improving the systems and support rostering managers to be able to utilise staff across functions, as well as have better visibility of shifts going out across multi-shift holders. We have managed to bring the full process of placing shifts, approving shifts and take up of shifts into the same rostering system.

Along with the weekly reviews of bank and agency, we are actively reviewing pay rates across the region to ensure there is consistency.

Regular (internal and external) workforce reporting and reviews including the following:
- **Monthly provider workforce return (PWR).**
- **Monthly people report.**
- **Vacancy report.**
- **Weekly and monthly workforce trends (substantive, bank and agency).**
- **Unavailability (headroom).**
- **Regular HCA tracker.**
- **Monthly appraisals.**
- **AHP monthly return.**
- **Monthly divisional breakdown by cost centre of workforce trends (substantive, bank and agency).**
- **Care hours per patient day.**

- **Human resources (HR) divisional business partner reports (workforce data, HR data, EDI data, statutory and mandatory training, retention, bank/agency/overtime usage, financial detail).**
- **Weekly starter and leaver report to Hampshire & Isle of Wight ICB.**
- **NHS England monthly temporary staffing data submission via our temporary resourcing team.**

From April 2025 to January 2026, there have been successful targeted recruitment in areas of need:
- Medical and dental 29 WTE.
- AHPs 23 WTE.
- Nursing and midwifery 15 WTE.

UHS completed and returned a self-assessment for NHS England and NHS Improvement levels of attainment and were reviewed by the ICB roster optimisation team. The results continue to be positive, and our teams are working on sharing best practice and establishing benchmarking across the region.

Electronic rostering continues to be fully adopted for all agenda for change staff and significant progress has been made with medic rostering and job planning. This will improve the workforce capacity and planning for all staff groups, identify gaps in service through accurate recording of activities delivered and identify income generated from activities to contribute to financial planning and objectives.

The 'improving working lives (doctors in training)' initiative was launched last year, and UHS is continuing to make good progress in meeting the standards. These are being reported at the Trust Executive Committee and people & OD committee on a routine basis.

UHS were early adopters to ensure all previous statutory and mandatory training compliance is transferred over from previous trusts to prevent repetition of training, we are also supporting the digital passporting workstream.

The appraisal process has been improved with new functionality deployed within our virtual learning environment which supports a better quality of conversation and review whilst also enabling better metrics to improve staff pathways with their development and learning.

In 2025/26, the Trust intensified its focus on sickness absence reduction, wellbeing support and career development, recognising the link between staff health, continuity of care and patient experience. This included learning from the major incident (endoscopy fire) on 1 February 2026 and the subsequent wellbeing and support offers to all affected staff.

UHS coaching

UHS has been running an all staff coaching service since April 2024. Previous external evaluation (2023) of the service for consultant staff had demonstrated its benefits for retention of staff and reducing the likelihood of sickness absence due to stress and burnout. Over 300 consultants have now had coaching via this service and almost 100 non-medical staff since we started. Over the past year, numbers of non-medical staff have begun to make up the majority of those who approach the service for coaching.

The coaching faculty is made up of coaches with various equivalent qualifications. We have 29 active coaches and another 16 who have trained but not yet qualified. Training to be a coach is time consuming and can be extremely challenging whilst working full time, so we have introduced a mentoring scheme to try to increase the chances of our trainee coaches completing their qualification. The coaches are from a range of professional backgrounds such that anyone seeking

coaching can see that there are people like them who coach.

Coaches are supported by weekly peer supervision and regular external CPD support which is highly valued. In 2025 we introduced an additional quarterly half day CPD to broaden the appeal of the offering. In addition, one of our coaches is training to be a coach supervisor so that our service has that expertise.

In the later part of the year, we have focused on raising awareness of our offer as we recognise that it can be challenging to appreciate the benefits of coaching until you, yourself, have experienced it. 2026 will focus on this work as well as strengthening the administrative system behind the offer.

3.7 Our commitment to clinical research



In 2023, Caroline Palmer, 50, was diagnosed with a rare and aggressive blood cancer affecting the brain and spinal cord.

"When I was diagnosed, I was really scared because I thought I was going to die, and my first thought was for my son, who was just ten," she said. "We'd waited a long time to become parents, and I just thought, 'I can't die, I need to be here for him.'"

Primary central nervous system lymphoma (PCNSL) is typically treated with a combination of four to five drugs designed to kill cancer cells, followed by a stem cell transplant to prevent the cancer returning. While effective, these drugs are highly toxic to the body. Around a third of patients are unable to complete treatment, and between 30% and 50% do not survive.

The OptiMATe clinical trial, running from 2022 to 2026, was the first trial funded by Stand Up To Cancer to address this challenge. Delivered by the Southampton Clinical Trials Unit, it tested a gentler treatment approach using fewer cycles. Caroline explained, "I was offered the OptiMATe clinical trial, and it was a complete lifeline. Now thanks to the people who fundraise for Stand Up To Cancer, I'm here today watching my son grow up..."

Our commitment to research makes it possible to offer innovative treatments to patients like Caroline. This same commitment underpins our work to keep people well and out of hospital.

In 2023, UHS co-led an international clinical trial of a respiratory syncytial virus (RSV) vaccine for babies. RSV affects nine in ten children by the age of two, hospitalises 30,000 under-fives in the UK each year, and causes around 30 deaths. The HARMONIE trial demonstrated an 80% reduction in infections among newborns. In October 2025, the NHS extended the vaccination programme to pre-term babies. Approximately 9,000 babies are born in the UK before 32 weeks' gestation each year, and the vaccine could prevent around 350 hospital admissions if 95% of eligible infants are vaccinated.

Ceri Cox, 33, and her son Harry, now two, took part in the research at UHS. Ceri told UHS: "I wanted Harry to be protected as much as he could against RSV. I know quite a bit about the virus from working as a paediatric nurse in a unit where we see a lot of children with RSV every year. It's amazing that this immunisation will now be offered to young babies around the country. I hope we will see

fewer little ones in our hospital this winter."

Other life-changing research this year included:
- A targeted drug that controlled the growth of a rare cancer caused by asbestos.
- Results showing antibody treatment works for children with a rare cancer.
- A world-first trial of a fridge-free vaccine. That tetanus-diphtheria jab could transform immunisation globally. With no need for refrigeration, it could protect millions across developing countries.
- Positive results for a new vaccine for whooping cough. That jab could prevent debilitating and life-threatening infections in newborns and infants.
- Development of a stick-on patch that could help children overcome peanut allergy.
- Promising results for a new drug to tackle a fatal lung scarring condition. That paves the way to slowing progressive pulmonary fibrosis, with fewer side effects.
- Positive effects of a weight loss pill that mimics fullness by expanding in the gut. The results open a new front in tackling obesity.
- Data showing surgery is better than antibiotics for a common, debilitating sinus condition.

Acute hospital and acute healthcare research
Prehabilitation helps people prepare both mentally and physically for major surgery. UHS clinicians pioneered this approach in cancer surgery, and in 2023 we established the first NHS funded prehabilitation clinical service. This was built on evidence from our trials showing:
- Faster recovery, shorter hospital stays, and fewer complications.
- Improved quality of life.
- Cost savings and better use of hospital resources.

In 2025, national prehabilitation guidelines were launched, co developed by experts from Southampton working alongside colleagues across the UK, Macmillan Cancer Support, and the World Cancer Research Fund. The guidelines cover exercise and nutrition, psychological support, and how to embed prehabilitation into routine care. They also support hospitals to set up their own services, with advice on technology, workforce models, and business cases.

June Davis, Lead Nursing and Allied Health Professional Advisor at Macmillan Cancer Support, said: "We know from listening to people with cancer and clinicians what a difference good preparation for cancer treatment and surgery can make. We would now like to see cancer prehabilitation widely adopted across the healthcare system to benefit people with cancer, in preparation for and recovery from cancer."

Other advances in acute care included:
- Becoming a partner in the NIHR Translational Research Collaboration in Surgery and Perioperative Care, which aims to improve surgical safety, recovery, and outcomes nationwide. UHS experts also contributed to an international agreement on how surgical training programmes should operate.
- Southampton surgeons becoming the first in the world to trial a new surgical device, informing best practice for cutting and sealing blood vessels as well as cutting, grasping, and dissecting tissue.
- UHS becoming the first NHS trust to use a device that monitors kidney pressure during surgery, with the potential to reduce serious complications and speed recovery.

Early diagnosis – vital and fairer
Early, simple diagnosis is critical to improving survival and quality of life across many conditions. It is also central to reducing health inequalities by bringing testing closer to communities with poorer access to healthcare. This year's advances included:

- Discovery of new genetic patterns linked to increased risk of pancreatic cancer, alongside the launch of a clinical trial of a new blood test for the disease.
- Introduction of improved scoring systems for severe asthma, designed to identify high risk patients earlier and tailor treatment more effectively.
- Trials of a rapid diagnostic test to reduce the time taken to identify winter respiratory viral infections.
- A study assessing a new blood test aiming to detect ten different cancers at very early stages.
- Trials of a 'pill on a thread' device for oesophageal cancer screening.
- Further evidence supporting 'virtual' stroke assessments, where paramedic video calls en route to hospital speed decision making and reduce long term disability.

Access to clinical trials

We believe every patient and staff member should have the opportunity to participate in research. Through strong regional and national partnerships, we continue to widen access. In 2025/26, key achievements included:

- The inflammatory bowel disease (IBD) genetics study exceeding 3,000 participants, improving understanding of the condition and supporting the development of more personalised treatments.
- A major children's hip study reaching 1,000 participants, strengthening evidence to improve care for children with hip dysplasia.
- Enrolment of more than 1,000 babies into a newborn eye screening study testing a new approach to detecting cataracts, the leading cause of preventable childhood blindness.
- A further 1,000 participants joining a Southampton led study on respiratory infections to improve prevention and treatment strategies.
- Fast tracking patients across the South into cancer vaccine trials, including a new head and neck cancer vaccine and national melanoma vaccine studies.
- Securing £16.3 million to support applied health research across Wessex until 2031. The NIHR Applied Research Collaborative focuses on dementia, long term conditions, obesity,and health data innovation.
- Official opening of a new commercial research centre hosted by UHS, expanding access to cutting edge treatments and trials across the region.
- Joining a new UK wide partnership accelerating the development of better treatments for brain tumours.

Award winning research

In 2025/26, UHS staff received national and international recognition for their work:

- Professor Tristan Clark was named one of six new national research leaders through an NIHR Research Professorship, recognising his work on rapid diagnosis to combat antibiotic resistance.
- The Southampton Antibody and Vaccine Group and Professor Jessica Teeling received awards at the British Society for Immunology Awards 2025 for outstanding achievements in cancer immunotherapy and public engagement.
- Dr Harnish Patel and colleagues were recognised by the International Journal of Older People Nursing for research showing the importance of listening to patients to reduce avoidable hospital readmissions.
- Dr Elizabeth Curtis, Dr Leo Westbury, and Dr Faidra Laskou received Young Scientist, Experimental Research, and Young Investigator awards respectively at the 25th World Congress on Osteoporosis, Osteoarthritis and Musculoskeletal Diseases.
- Mr M. Waqas Ilyas received a national award for his contributions to hip trauma research at the Orthopaedic Trauma Society and NIHR awards.
- Professor Lisa Roberts became President Elect of Eurospine, reflecting her international leadership in spinal health and back pain management.

- iFAST Diagnostics, a spin out co founded by UHS researchers, won a prestigious award for innovation in rapid blood and urine testing to guide antibiotic use.
- Professor Tom Wilkinson was appointed Chair of the NIHR Respiratory Translational Research Collaboration.
- Professor Keith Godfrey received the 2025 David Barker Award for outstanding contributions to medical research.
- Professor John Holloway was elected as one of only 14 new Fellows of the European Respiratory Society.
- Dr Mark Burton secured a prestigious Vivensa Foundation Proleptic Fellowship to advance research into muscle loss in later life.

Adding value through investment
World class research relies on exceptional people, technology, and infrastructure, all of which directly support patient care. This year's highlights included:

- A £600 million national investment in health data research, including a UHS hosted Wessex Secure Data Environment. This will enable safe, linked data research to accelerate discovery and service improvement across the NHS.
- A £1.6 million award for advanced imaging technologies, including cryo fluorescence tomography (CFT), allowing researchers to explore cancer spread, drug distribution and gene behaviour deep within tissues.
- Completion of a next generation, UHS hosted sterile pharmacy serving the region, enabling faster delivery of personalised treatments and clinical trials closer to home across the South.
- A record intake of 12 staff into the UHS Research Leaders Programme, investing in and supporting the next generation of research talent.

3.8 Our commitment to technology

The Trust has continued to commit to the use of technology to deliver safe, high-quality, patient care in 2025/26.

UHS Digital has a wide portfolio of activities, including managing the Trust's IT infrastructure, protecting the organisation against cyber-security threats and providing and maintaining vital apps and systems that help clinicians deliver patient care.

The period 2025/26 has seen a number of major upgrades and improvements in the Trust's IT and technology systems and capabilities.

The most significant advance in IT systems this year has been the introduction of Miya ED, an entirely new, cutting-edge IT system in the emergency department (ED), which replaced a legacy system that was reaching end of life.

The new system allows the full digital recording and management of the ED-patient journey from arrival to discharge or transfer to onward flow wards.

Introducing an entirely new system required a significant amount of change management in preparing staff for new and improved ways of working.

The project therefore required a high degree of collaboration among a multi-disciplinary team representing the external supplier, digital, clinical, admin and operational colleagues.

ED consultant Dr Alasdair Moffat, who was the clinical-digital lead for the Miya ED project, said: "Miya ED is our new electronic patient record in the emergency department. It allows us to manage patient flow as patients arrive to the point where they're ready to leave the department. It manages electronic observations. It has task management, referrals, and allows us to work well with our specialty teams. It also integrates with the rest of the UHS digital systems, meaning we're able to see results in real time as they come through. And this improves the efficiency of our department."

The system was rolled out in October 2025, following a period of intense training and preparation for a significant number of staff who now use the system on a daily basis.

ED matron Carole Spratt, the digital nursing lead on the project said: "The development of Miya ED has been a huge project for us both in ED and UHS in the digital team. In ED, between our nursing, clinicians and our admin team, we have about 500 people. And so that implementation obviously involved all those people learning a brand-new system right from scratch. It's been an absolutely huge task, but very rewarding."

As well as having been a successful implementation of a system that is helping improve patient care in our emergency department, the Miya ED project has also been shortlisted for two HSJ awards in 2026, which is testament to a powerful collaboration between clinical and digital teams.

Whilst UHS Digital have been busy implementing new systems, developing and releasing new system updates which have provided valuable security and user improvements, providing digital education to support our clinical colleagues is equally important.

3.9 Conclusion

We are proud of the significant improvements we've made in the quality of our services. However, we remain committed to our ongoing journey towards achieving excellence in every aspect.

This quality account allows us to thoroughly assess our progress and establish priorities for 2025/26. By setting clear goals and benchmarks, we can ensure that our efforts are focused and measurable. Future reports will provide quantitative measures against our targets, offering a transparent view of our achievements and areas for improvement.

We are confident that our priorities, processes, and plans are well-positioned to enhance patient care and hospital experiences. Our dedicated teams are continuously working to implement innovative solutions and best practices. As we strive for excellence throughout 2026/27, we will remain vigilant in monitoring our progress and adapting our strategies to meet the evolving needs of our patients.

Part 4: Appendices

Appendix A - National Clinical Audit: actions to improve quality identified during 2025/26

National audit title	Actions	Action update
1. National Cardiac Audit Programme (NCAP) Transcatheter Aortic Valve Implantation (TAVI) Registry Report 2025	• Every patient to be rapidly appraised and treated in a timelier manner to increase TAVI procedure rates. • Steps to be taken to mitigate long waiting lists.	Actions ongoing
2. NCAP Transcatheter Mitral & Tricuspid Valve Registry (TMTV) Report 2025	• Discussions to take place regarding low volumes of mitral TEER procedures.	Action ongoing
3. National Respiratory Audit Programme (NRAP) Pulmonary Rehabilitation Report (QA/0110v4)	• To ensure all patients are entered into NRAP for all respiratory conditions. • To continue with ISWT. • To ensure all who attend PR have a formal discharge assessment.	Actions complete
4. NCAP Myocardial Ischaemia National Audit Programme (MINAP) Report (QA/0050v8)	• For self-presenters to ED processes have been put in place and is audited monthly. Collaborative working with ED has led to alternative working. Ongoing audits to be maintained. • Monthly audits are ongoing to ensure referrals from surrounding hospitals are well timed and any issues resolved quickly. • Monthly audits on MINAP data are ongoing and reports written to showcase both successes and areas for improvement.	Actions complete
5. Society for Acute Medicine Benchmarking Audit (SAMBA) Report (QA/0141v2)	• To fill gaps in rota on HCA and nursing front to increase compliance around timely EWS recording.	Action ongoing

National audit title	Actions	Action update
6. National Neonatal Audit Programme (NNAP) report (QA/0043v7)	• To ensure data is entered for thermal management and parental presence on ward rounds.	Action ongoing
7. NRAP Children's and Young Persons Asthma Audit report (QA/0072v5)	• To complete further education sessions to remind staff to complete the wheeze proforma. • To signpost families and children to smoking cessation advice. • To remind staff of the importance of documenting on the proforma that inhaler technique and PAAP has been completed.	Actions ongoing
8. Female Genital Mutilation Report (6956v5)	• Joint policy going through ratification now and will then be publicised across the Trust. • Communication on the new policy will be put into a newsletter and shared trust-wide. • The new ED lead will be focusing on the new policy and will complete training within ED for staff. • To recirculate FGM as Theme of the Week as a reminder to all staff to document disclosures of FGM on BadgerNet form.	Actions complete
9. NCAP National Audit of Cardiac rhythm Management (NACRM)	• To increase AF ablations to comply with NHSE Blueteq process for AF ablations. • To update the TA324 and TA314 secondary prevention data on the website.	Action ongoing
10. National Paediatric Diabetic Audit (NPDA) Quarter 4 2024/25 data report	• To get approval for a business case for additional staffing within the MDT, which are a diabetes educator to help with patient and carer diabetes education also ward staff education, additional administrator time and a family support worker. • To increase number of patients being offered hybrid closed loop in line with other centres nationally.	Actions complete
11. National Ovarian Cancer Audit Quarter 1 2023 data report	• To increase compliance with data collection on 'morphology of tumour'. • To discuss with NOCA the data from UHS as this is believed not to be accurate. • To conduct a separate audit on this data.	Ongoing review of data. National problem with reports
12. National Pancreatic Cancer Audit Quarter 4 2024	• To review the areas on low compliance and increase reporting on these couple of areas.	Action ongoing

National audit title	Actions	Action update
13. National Child Mortality Database (NCMD) Learning from child deaths reviews on palliative and end of life care provision published July 2025	• Funding for provision of key worker role within UHS child health for all deaths will be reviewed and made available within the next year. • A requirement for a dedicated pharmacy experienced in paediatric palliative care to be reviewed and followed up within the next year.	Actions ongoing
14. NHS Organ and tissue donation transplantation activity report published August 2025	• To continue to raise awareness in the community about organ transplant. • To raise awareness in the community about registering their donation decision on the NHS Organ Donor Register and to tell their family.	Actions ongoing
15. UK Renal registry for chronic kidney disease audit report 2025	• To review the upload criteria and the new v5 renal dataset / submission process.	Action complete
16. National Pregnancy in (NPID) Diabetes Audit Report 2025	• To discuss results of audit within the diabetes maternity team with review of pregnancy timing and admission to NNU. • To maintain contact with primary care and specialist diabetes services to continue progress towards better preconception care.	Actions ongoing
17. NCEPOD Review of acute limb ischaemia (ALI) report	• To update referral protocol for ALI. • To review all SLAs with all participating centres in our vascular network.	Complete Ongoing
18. National Cardiac Audit Programme (NCAP) – Transcatheter Mitral & Tricuspid Valve (TMTV) Registry	• To formally audit the mitral service locally in September 2026.	Not started yet
19. National Vascular Registry	• To rework the SLAs for the network to try and increase the amount of work managed in peripheral trusts as UHS currently overloaded with work.	Action ongoing

National audit title	Actions	Action update
20. National Audit of Care at the End of Life (NACEL) report	• To launch the UHS end of life care strategy 2025 – 2030. • To launch the end of life care resources for patients and families. • To launch the comfort observations and guideline. • To launch the end of life discharge checklist • To launch the new programme of education for the UHS foundation programme.	Actions ongoing
21. Sentinel Stroke National Audit Programme (SSNAP)	• To complete a quality improvement project to improve CT and CT angiography door to scan times. • To increase discharge capacity with more patients being sent home with early supported discharge in line with national average with the help from a regional project via the ICB. • To work through the integrated stroke delivery network to increase thrombectomy treatment numbers, to aim for 10% of all ischaemic strokes across Wessex.	Actions ongoing

Appendix B - Local Clinical Audit: actions to improve quality identified during 2025/26

Audit title	Actions	Action update
1. Daily external temporary pacemaker threshold check (7718v1)	• To hold education sessions for both nurses and junior doctors to emphasise the importance of daily pacemaker checks and documentation. • To create a daily pacemaker, check sheet to add in to all patients record for ease of use. • To re-audit in a couple of months once sheet has been created and been in use for several months.	Actions complete Re-audit in progress
2. An audit to assess image quality and DRLS of KUB x-rays (7824v1)	• To improve staff knowledge and understanding of departmental protocol for KUB collimation, centring and positioning for additional views (cross kidney views and bladder views). • To discuss he change exposure or change of protocols for additional views or change the local diagnostic reference levels to have a more appropriate baseline for abdomen x-rays.	Actions complete

Audit title	Actions	Action update
3. Anticoagulation and antiplatelet therapy post cardiac surgery Evidence vs practice (8010v1)	• To develop a guide on the most recent ESC/ EACTS guidelines for the management of ACS, AF and Valve heart disease to ensure practice is standardised for the prescribing of anticoagulation and antiplatelet therapy. • To ensure staff add these therapies to discharge summaries for continuity of care.	Actions complete
4. Insulin safety at UHS (8092v1)	• To provide additional training to staff on diabetes and insulin safety. • To consider adding this training within the statutory and mandatory training requirement. • To create a poster for staff to ensure they use insulin needles for making insulin infusions. • To ensure staff do not store insulin needles next to or mix with 1ml needles. • To provide additional training on disposable insulin pen needles to improve staff awareness. Outcome of actions – Ongoing training sessions on insulin and diabetes safety and education sessions which highlights the risk of storing the diabetes needles correctly.	Actions complete
5. Opioid stewardship at UHS - Is UHS preventing opioid related harm in the trauma and orthopaedic population (8131v1)	• To add a compulsory section to discharge summaries to ensure why the opioid has been prescribed, what type of pain it was prescribed for and the ongoing plan.	Action complete
6. UHS Trust wide Audit of Hand Hygiene Practice by Infection Prevention Team Quarter 4 24/25 (7506v2)	• Divisions, care groups and clinical teams to review their individual reports and identify areas and actions for improvement as per Hand Hygiene Improvement Framework • Report to be reviewed and discussed at Infection Prevention Committee, with divisional representation, and improvement actions agreed.	Actions complete
7. Infection Prevention & Control (IPC) – Saving lives Hll8 Cleaning and decontamination (5581v6)	• 38 areas to complete the audit within the next month. • 15 areas scored below 85% to develop and action plan and re-audit within 1 month. • 1 area scored between 85% and 94% to re-audit within 3 months.	Actions complete

Audit title	Actions	Action update
8. IPC – Personal Protective Equipment (PPE) (5588v8)	• 23 areas to complete the audit within the next month. • One area scored below 85% to develop and action plan and re-audit within one month. • 17 areas scored between 85% and 94% to re-audit within three months.	Actions complete
9. Heart failure management and follow up post cardiac surgery (7249v2)	• To discuss with heart failure department on results and to decide the ongoing plan. • A protocol for the management of patients with severe LVSD post cardiac surgery to be implemented. • A re-audit to be completed for assurance of improvement. Outcome of actions – Agreed protocol for the management of patients with severe LVSD post cardiac surgery, this was implemented as a development plan, and the service was then re-audited.	Actions complete
10. Quality of diagnostic chest X-ray (8068)	• To do regular teachings and re-enforcement on importance of Posterior-Anterior (PA) view chest X-ray over Anterior-Posterior (AP) view. • To add reason for performing AP view chest X-ray rather than the PA view.	Actions complete
11. Clinical Audit – Image Quality of Y View Shoulder (8127v1)	• Radiographers to improve their collimation, centring and position on the interest area and the marker placement. • Radiographers to adjust the exposure factors to increase the quality of the images. Outcome of actions – Teaching helped to improve the collimation and improve the selection of exposure factors. • To re-audit in one years' time.	Actions complete Waiting re-audit
12. X-ray confirmation of nasogastric tube placement: documentation in patient notes (8048v1)	• To update the chest x-ray review form on MetaVision. Outcome of action – Form reviewed and updated by CIS team on MetaVision.	Action complete

Audit title	Actions	Action update
13. Auditing the Acute Medical Units' Speech and Language Therapy Referrals Against the Oropharyngeal Dysphagia Policy and Communication expectations (8087v1)	• To feedback results to lead on general medicine, SLT team lead and wider SLT team. • To circulate report to ward leads/matrons/ AMU medical leads, AMU therapy leads. • To meet with ward managers and matrons to share audit data and create an action plan for improvement where required. • To provide training to wards as appropriate. • To re-audit post training to see if this has improved how the standards are met. Outcomes of actions – Trolley dashes completed, shared report and shred to wider AMU team and wider SLT teams. Further trolley dash due in January 2026.	Actions complete
14. The prevalence of use of reduced coverage CTPA and projected effectiveness of reduced coverage CTPA in reducing patient dose (8132v1)	• To provide teaching to registrars and present at cardiothoracic radiology department.	Action complete
15. IPC – Handwashing and facilities audit (5590v5)	• Care group managers/matrons/care group clinical leads to provide support to 24 areas scoring between 94% and 85%. • 10 areas scoring below 85% to produce an improvement plan and re-audit.	Actions complete
16. Initiating Methotrexate in Rheumatology Outpatients (7844v1)	• To create Methotrexate Initiation Bundle on e-quest. • To do a promotion on the Methotrexate checklist in poster form for clinic rooms to promote consistent counselling and documentation.	Actions complete
17. Audit of the appropriate prescription of Thorax Jackets following cardiac surgery (7901v1)	• To create a Standard Operating Procedure for the Prescription of Post Thoracic Jackets (PTJ). • To update cardiovascular & thoracic (CV&T) matrons and CV&T care group manager. • To consider alternative RTJ. • To audit patient compliance in wearing a PTJ. • To evaluate the effectiveness of a new PTJ.	Actions complete

Audit title	Actions	Action update
18. Compliance to hand hygiene guidelines on ASU ward (8271v1)	• Spread the awareness among both ASU nurses and doctors through poster presentations that contain audit results, recommendations and QR codes with hand hygiene guidelines. • Email audit results, recommendations and hand hygiene guidance to all ASU doctors, outcome of actions – Poster presentation designed and provided to ASU ward and junior doctor's office. Audit results and hand hygiene guidance were delivered to all ASU nurses and doctors through presentation and email address. • Monitor compliance through re-audit within two to three months.	Actions complete
19. Review of local pathway for patients with acute knee injuries and inappropriate referrals to ED physio clinic (7416)	• To feedback to ED nursing staff on ENP day on audit findings. • The clinical knee specialists teaching to ED staff to improve compliance. • To feedback to the clinical effectiveness MSK meeting on findings and improvement • Re-audit in one year.	Actions complete Waiting re-audit
20. A pilot 'Physiotherapist in organ donation' (POD) role to improve competence and confidence in the respiratory management of patients on the organ donation pathway (7920)	• To produce a grab pack. • To distribute the grab pack within the physiotherapy department. Outcome of action – Grab pack produced and distributed to therapy department. • Teaching the physiotherapists on the respiratory physiotherapy in organ donor patients, on yearly bases. This will be ongoing educational sessions.	Actions complete Ongoing training sessions
21. Handover from T&O night shift team to dayshift foundation doctors (8079v1)	• A handover sheet to be implemented into the current practice to measure the compliance rate of efficient and accurate handover of jobs to the day team.	Action complete
22. Saving Babies Lives Element 1 Reducing Smoking in Pregnancy 2024/2025 (8066v3)	• To continue support for Band 4 TDA smoking status and CO monitoring at 36 wks. • To continue to attend community meetings and work collaboratively with community matron.	Actions complete
23. The prevalence of use of reduced coverage CTPA and projected effectiveness of Reduced coverage CTPA in reducing patient dose (8132v2)	• The results to be discussed with the clinical supervisor for them to decided how to promote this protocol.	Action complete

Audit title	Actions	Action update
24. Management of weight loss in Idiopathic Intracranial Hypertension (IIH) (7161v1)	• To establish and disseminate the appropriate referral pathways for overweight patients with IIH. • To encourage colleagues to make documentation of BMI and weight a priority when seeing these patients by presenting results. • To encourage brief check ins with patients at most contacts to inquire about weight loss and whether the patient needs additional support by presenting results. Outcome of actions – Meeting held to discuss findings and actions required. Referral pathways established and disseminated.	Actions complete
25. Medical prescribing AERs in T&O department (7446v1)	• To add a time frame for prescribing when patient is admitted.	Action ongoing
26. An audit on DNA mismatch repair enzyme immunohistochemistry and sequential molecular testing strategies for lynch syndrome undertaken in colorectal biopsies (7935v1)	• To investigate this further, we plan to determine the methods used by the individual consultant gastrointestinal pathologists for the administration of notifying when lynch syndrome is suspected.	Action complete
27. Indications for PPI prescription on cardiac surgery on discharge vs practice (8011v1)	• The audit results will inform the development of a flowchart, based on the current available evidence and recommendation, that will inform practice in the initiation of PPI post cardiac surgery and improve standardisation and continuity of care. Outcome of action - Flowchart for gastric protection on discharge post-cardiac surgery has been created in collaboration with pharmacy and is being implemented. A re-audit might take place in the future to ensure there was improvement in practice.	Actions complete
28. Compliance with European guidelines for initiating anticoagulation bridging post-mechanical heart valve replacement (8232v1)	• To assess the blood products, use in the re-audit group. Outcome of action – Re-audit completed and shows a clear improvement. Lessons have been embedded into departmental protocols.	Action complete

Audit title	Actions	Action update
29. Compliance to boast guideline for ankle fractures documentation (8253v1)	• To send an email to all SHOs and registrars reminding them of the parameters they need to document while assessing patients with ankle fractures in ED. Outcome of action – Email sent to all colleagues and next audit cycle in progress.	Action complete
30. Auditing provision of driving advice and completion of National Adult Cardiac Surgery Audit data input on discharge after cardiac surgery (8215v2)	• To add poster to clinician offices explaining how to fill out HICSS form to register into NACSA, and what it is used for. • To educate new SHOs rotating into department on importance of NACSA registry and to remind of driving advice. Outcome of action – Improvement in next cycle increased to 78%. Further improvement required in next cycle.	Actions complete
31. An internal audit of speech and language therapy (SLT) communication intervention in relation to the therapy outcome (8088v1)	• To roll out TOMS scoring to SLT stroke service.	Action complete
32. Improving sedation safety in interventional radiology (8175v1)	• All nursing staff to undergo sedation training. Outcome of action – Funding agreed for nurses to complete training. • To re-audit after sedation course completed. Outcome of action – Nurses were reaudited after the course. • Departmental protocol for sedation to be developed.	Actions complete
33. Evaluation of intravenous vancomycin prescription on cancer care wards (8243v1)	• Education and increasing awareness of the protocol: a) during teaching sessions involving doctors and advanced clinical practitioners. b) peer to peer reminders.	Actions ongoing
34. Neurosurgical recovery handover audit (8282v1)	• To implement aide memoire to assist handover. • To re-audit to assess efficacy.	Actions ongoing

Audit title	Actions	Action update
35. Uterine Rupture (8347v1)	• Consensus not to change current counselling (keep with UKTOCS data) as limitations to our data. • Consensus to update guideline so that consultant should be informed if suspected/ proven rupture but discussion about whether they are required to attend (rather than must attend). Uterine rupture to be updated to reflect discussion at meeting. Currently submitted for consultation. • Consensus that follow-up should be offered but individualise (as majority of our cases had uneventful recovery and good outcomes). • Agreement that we need to obtain uterine rupture rate for our VBAC group so we can better look as to whether the rate is higher than expected in this group (and also those VBAC who undergo IOL).	Action complete All ongoing
36. Re-audit: Compliance to hand hygiene guidelines on ASU ward (8271v2)	• Posters summarising hand hygiene guidelines and providing brief advice to be distributed across all surgical wards, patient bays, and doctors' offices. Outcome of action – Posters added to all areas.	Action complete
37. Compliance of WHO checklist in procedures performed in Interventional Radiology (8439v1)	• Education to the lead radiographers of IR over a power point presentation to be completed. Outcome of action –Education delivered to staff.	Action complete
38. Paediatric foreign body aspiration (7395v1)	• To disseminate the results of this audit to the ENT and paediatric respiratory teams. Outcome of action – This audit has been discussed at paediatric respiratory clinical governance meetings and ENT registrar training days as well as published in the International Journal of Paediatric Otolaryngology.	Action complete
39. MUST audit on the Acute Medical Unit (1-5) and HOBS (8039v1)	• To recommend ward based talks/training on MUST assessments and how important it is to have an accurate weight recorded when possible. • To have discussions with staff to ensure they have enough equipment to weigh patients.	Actions ongoing

Audit title	Actions	Action update
40. Compliance with the ERAS medications protocol, for patients undergoing elective HPB surgery on post operative admission to Surgical High Dependency (8155v1)	• Prescribing bundle to be created for MetaVision in collaboration with ITU pharmacists – Implemented on 2 of April and explained to new doctors in induction. Outcome of action – second cycle of audit showed improved compliance to 100%.	Action complete
41. An audit on Perioperative temperature monitoring and management of hypothermia in patients undergoing elective hip and knee replacement (8262v1)	• To put up posters in various areas. • Email all staff with actions. Outcome of actions – Posters have been placed in all wards in T&O and in theatre areas. Recommendations were finalised and emailed to respective department leads.	Actions complete
42. Cord gases audit (8328v1)	• Indications for taking cord gases to be discussed on foetal monitoring study day, which all staff delivering intrapartum care must attend. • Need for increased awareness amongst senior MW (band 7) and obstetric staff on need to cord gasses even if normal birth and well-baby if previous CTG concerns. Advice to be put on LW comms board for discussion at each clinical handover.	Actions complete
43. Narrow Your Focus! A journey of treatment escalation plan (TEP) forms on cancer care wards (8476v2)	• Results to be presented to haematology consultants in haematology morbidity and mortality meetings, to multiple oncology consultants, speciality registrars and senior house officers in oncology audit meeting. Outcome of action – Oncology teams are on board with the TEP forms and the importance of them.	Action complete
44. Use of arterial lines within HEMS (7494v1)	• Need to be able to rely on times stated. • Need to not only use speed as the only metric. • To consider a drop-down menu (device type, US yes/no, where transduced). Outcome of actions – All presented at clinical governance day and discussed in detail.	Actions complete

Audit title	Actions	Action update
45. The monitoring of respiratory function in Gillian Barre Syndrome (GBS) patients admitted to Southampton Children's Hospital 2018-2023 (8485v1)	• To create GBS clinical pathway or guideline which outlines respiratory monitoring steps to follow in paediatric patients to reduce variability and strengthen early detection of respiratory decline. • To develop a structured alternative monitoring pathway for children unable to perform conventional monitoring techniques (e.g. FVC) and clarify thresholds for escalation for these children. • To enhance early identification of respiratory deterioration and reinforce the need to begin early respiratory monitoring on day of admission wherever possible. • To standardise criteria for PICU referral to ensure consistent practice, documenting triggers from FVC or alternative markers.	Actions ongoing
46. Compliance with speech and language therapy (SLT) case note standards (6189v3)	• To review SLT abbreviation list. Outcome of action – Abbreviation list reviewed and updated.	Actions complete
47. IPC – Saving Lives Hll6 urinary catheter care audit (5585v9)	• Ongoing care – Care groups that scored below 85% to submit an action plan and re-audit within one month.	Actions complete
48. Major trauma secondary transfers from Isle of Wight (IoW) (6182v1)	• To disseminate wider the trauma unit bypass tool amongst both ambulance crews and acute healthcare staff working in the Emergency Department (ED) at St Marys hospital IoW. • A discussion to be held to form the best way forward for an education plan at HEMS CG and IoW helicopter operations group where this will be presented. • To ensure documentation to be completed and stored appropriately in line with the TARN data handling standards. Data collection for audit should be transparent and timely. This will be addressed with education of pre-hospital health care professionals and ED staff at IoW.	Actions complete

Audit title	Actions	Action update
49. Audit of consistencies used in video fluoroscopy (VFS) Clinic (6983v2)	• Review all recipes used for barium preparation in VF clinics. Outcome of action – Recipes have been amended with a view to improving compliance. • Ensure fork drip test is being used to test consistency of level 4 during VF clinics. Outcome of action – Information was cascaded to radiographers and assistants to ensure this is being completed during preparation.	Actions complete
50. Povidone iodine application Re-Audit (7941v2)	• To apply a printed paper in theatres to remind staff about the time to leave Iodine prep three minutes before starting the surgery.	Action complete
51. 4AT - Are we appropriately identifying and escalating patients with a presentation of delirium in trauma and orthopaedics? (8474v1)	• Educational poster, prompting review of patients with signs of delirium and prompting referral for senior review. Outcome of action – Poster created and posted across department in T&O wards and trauma meeting room. This poster shows a pathway of actions to follow. • Teaching with foundation trauma and orthopaedics doctors. Outcome of action – Teaching completed on audit findings to group of T&O FY1 doctors and advised them on referring patients with delirium. • • Presentation of audit at trauma and orthopaedics doctors' induction. Outcome of action – At doctor's induction day for new doctors in T&O we presented the audit. We focused the first part on education, what delirium is, how to complete a 4AT assessment, establishing who the orthogeriatric team are, how to refer for senior review, what the reversible causes of delirium are. We then discussed the findings, where we noted that we need to improve by referring patients for senior review. • Informed nursing team that patients with delirium need senior OG review to prompt patient referrals for review i.e. at handovers. Outcome of action – Nursing teams on orthopaedic wards informed of audit and pathway to refer to OG seniors for individual review of patients with delirium.	Actions complete

Audit title	Actions	Action update
	• To create clear pathway for doctors to follow when patients have delirium. Outcome of action – This pathway was created on audit presentation and posters. This pathway gives doctors a guide on what to do when patients present with signs of delirium, to establish cognition with 4AT, identify reversible causes, refer patient for senior orthogeriatric review, treat reversible causes.	
52. Audit of 'Drainage of Malignant Ascites in Cancer Care' clinical guideline (7532v1) (7532v1)	• To review and amend procedural documentation as part of update to clinical guideline. • To re-share expectations of procedural documentation and post-management instruction with clinicians responsible for performing paracentesis and temporary ascitic drain insertion.	Actions ongoing
53. An audit on perioperative temperature monitoring and management of hypothermia in patients undergoing elective orthopaedic surgeries (8262v2)	• To ensure the availability of temperature monitoring devices in all areas. • To hold education sessions for staff in various areas - surgical day unit, theatres, recovery, orthopaedic wards	Actions complete
54. To assess compliance with documentation of paediatric trauma meeting discussions following presentation of cases by the adult T&O department (8505v1)	• To Introduce a standardised trauma meeting documentation proforma. • To agree a named individual responsible for documentation - fellows / registrar. • To have a standardised location of documentation in the EPR.	Actions complete
55. Compliance with speech and language therapy case note standards (6189v4)	• A further update to the approved abbreviations list to be completed. • To request amendment to SLT liaison template to ensure there is a time and location box. • To hold a team discussion around which templates are acceptable in the different areas of the service.	Actions ongoing

Audit title	Actions	Action update
56. Audit the use of the local lumbar puncture (LP) checklist (both the inclusion and completeness of the documentation) on the acute medical unit (AMU) (8041v1)	• To consider whether any further improvements in LP completeness are required. • To consider ways to improve the uptake of the LP documentation and safety checklist among clinicians performing LP on AMU.	Actions ongoing
57. Review of obstetric service for substance misuse during pregnancy, and of compliance to local guideline (8165v1)	• The substance misuse MDT to review PN contraception plan via eDocs proforma. • To review proformas to determine % documented.	Actions ongoing
58. Compliance of WHO checklist in procedures performed in interventional radiology (IR) (8439v2)	• To email CT radiographers superintendent to make sure compliance of procedural checklist alongside the contrast related / CT checklist.	Action complete
59. IPC Saving Lives HII 1 Central venous catheter group report (5584v9)	• Eight areas to submit their audit within one month. • Ongoing care – One area scored between 85-94% to re-audit within three months ensuring compliance addressed through action plan. • One area scored below 85% and will need to produce an action plan and then re-audit within one month.	Actions ongoing
60. IPC Saving Lives HII 2 peripheral intravenous cannula care (5582v9)	• 38 areas to submit their audit within one month. • Insertion – three areas scored between 85% and 94% are required to re-audit within three months. • Five areas scored below 85% and the following actions will be required: o To produce action plan to address non-compliance and provide evidence of implementation. o To re-audit within one month ensuring compliance addressed through action plan. • Ongoing care – five areas scored between 85% and 94% are required to re-audit within three months.	Actions ongoing

Audit title	Actions	Action update
	• Eight areas scored below 85% and the following actions will be required: o To produce action plan to address non-compliance and provide evidence of implementation. o To re-audit within one month ensuring compliance addressed through action plan.	

Appendix C - Miscellaneous IPC audits

Audit title	Actions
Infection prevention and control (IPC) audit programme patient placement / assessment of infection risk / isolation.	**Patient placement / assessment of infection risk / isolation** No elements fell below the 95% expected standard.
Infection prevention and control (IPC) audit programme personal protective equipment (PPE) audit	**Personal protective equipment** One element of the audit fell below the expected 95% standard: • No evidence (witnessed) of PPE being worn inappropriately for near patient administrative tasks e.g., when using the telephone, using a computer or tablet, writing in the patient chart; giving oral medications; distributing or collecting patient dietary trays • All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection prevention and control (IPC) audit programme safe management of equipment	**Safe management of equipment** No individual elements of the audit fell below the 95% expected standard.
Infection prevention and control (IPC) audit programme safe management of environment	**Safe management of environment** No individual elements of the audit fell below the 95% expected standard.

Audit title	Actions
Infection prevention and control (IPC) audit programme safe management of linen	**Safe management of linen** One element of the audit fell below the expected 95% standard. • There is no build-up of linen receptacles awaiting collection. All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection prevention and control (IPC) audit programme waste	**Safe management of waste** One element of the audit fell below the expected 95% standard. • There is no build-up of waste receptacles awaiting collection All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection, prevention and control (IPC) – occupational safety: prevention of exposure (including sharps injuries)	**Occupational safety** Prevention of exposure (including sharps injuries) Two elements of the audit fell below the expected 95% standard. • Sharps are not passed directly hand to hand. • Used needles/sharps are not re-sheathed/recapped or disassembled after use. All areas are responsible for developing and implementing an action plan based upon their results following their audit

Data source: UHS

Annex 1: Statements from commissioners, governors and overview and scrutiny committee

Response to the Quality Account from the Health Overview and Scrutiny Panel

The Southampton Health Overview and Scrutiny Panel welcomes the opportunity to comment on the University Hospital Southampton NHS Foundation Trust Quality Account for 2025/26.

The Panel recognises the challenges that the Trust has experienced during the previous financial year. Despite significant progress achieving savings, the Trust remains in a difficult financial position; interventions have been put in place with the support of the NHS Emergency Care Improvement Support Team and regional teams to improve the performance of the Emergency Department and nearly 60,000 patients are currently on a waiting list at UHS.

In addition, in February 2026 a major incident was declared at the hospital due to a fire. While no patients or staff were directly harmed by the fire, the impact on capacity at UHS was significant. The Panel have commended the response of UHS staff and the wider system to the incident, but it has drawn attention to the ongoing problem with discharging patients from hospital with, on average, 223 inpatients that were medically optimised for discharge occupying hospital beds every day at UHS in 2025/26.

Despite these challenges we are encouraged by the Trust achieving progress against all six of the quality priorities set for 2025/26. This reflects the hard work of staff and their commitment to providing well-led, safe, consistent, and compassionate care.

Aligning the quality priorities set for 2026/27 with the Trust's Strategy and the Clinical Strategy is sensible and understandable. The Panel remain supportive of the continued focus on improving outcomes for unpaid carers, including how unpaid carers are identified, involved and supported, so they are recognised as partners in care, have equitable access to support, and experience improved health and wellbeing. These actions will contribute to the citywide efforts to support unpaid carers that include the development of a Carers Vision, Charter and Action Plan.

The ongoing prioritisation of the Trust to tackle health inequalities is particularly welcome. The focus on tobacco dependency, hypertension and obesity in 2025/26, chosen in collaboration with public health teams, will have a long-term impact on health outcomes in Southampton. However, as UHS recognises, there remains a need to work with partners across the system over the longer-term to reduce the impact of inequalities and help to address the most prevalent challenges for our population.

The Panel looks forward to working closely and positively with UHS in 2026/27. The commitment in the Statement on quality from the Chief Executive on collaboration being central to achieving the Trust's ambitions, strengthened partnerships with local authorities, public health teams and the integrated care system, is encouraging. The HOSP will continue to advocate for a system wide response because, as the Quality Account identifies, the challenges facing health and care require collective action to improve outcomes for the communities we serve.

We greatly appreciate and value the work of UHS and your dedicated staff in our city. With that in mind, the Panel would also like to give thanks to your efforts at the helm of UHS over the past six years and wish you every success in your new ventures after you leave the Trust in July.



Cllr Warwick Payne
Chair of the Health Overview and Scrutiny Panel
Southampton City Council

Response to the Quality Account from NHS Hampshire and Isle of Wight Integrated Care Board

NHS Hampshire and Isle of Wight Integrated Care Board (ICB) welcomes the opportunity to review and comment on the Trust's Quality Account for the 2025/26 reporting period, in line with its statutory responsibilities for commissioning and oversight of quality.

The ICB is satisfied that the Quality Account meets the required regulatory standards and presents a clear and balanced overview of the Trust's quality priorities, achievements, and areas for ongoing development.

Through ongoing engagement with the Trust, the ICB has sought assurance that commissioned services are delivered in line with expected standards of safety, effectiveness and person-centred care. Where required, the ICB has supported and overseen agreed improvement actions through established governance and assurance arrangements.

The ICB recognises and commends the Trust for achieving all of its stated priorities for 2025/26. In particular, the continued focus on the Fundamentals of Care and the work undertaken to embed approaches that reduce health inequalities demonstrate a strong and sustained commitment to improving outcomes and experiences for patients and communities.

The ICB acknowledges the ongoing challenges associated with the number of surgical incidents meeting the current Never Event criteria. The ICB supports the Trusts continued focus on safer surgical interventions as demonstrated through the 2026/27 contract and welcomes the Trust's plans to further strengthen safety reporting through local and divisional governance structures. The ICB expects that these actions will contribute to continued improvements and looks forward to seeing the impact of this on safety outcomes.

The ICB is also pleased to see that the Trust has identified ongoing, key areas for further improvement linked to each of last year's priorities, along with methods for ongoing monitoring and measurement, to support further embedding during 2026/27.

The ICB acknowledges and values University Hospital Southampton NHS Foundation Trust's engagement in quality governance arrangements, including facilitating ICB participation in internal quality meetings and on peer support visits, to support assurance and commissioning oversight. We also recognise the Trust's contribution to local and system-wide quality improvement through its active participation in the Hampshire and Isle of Wight (HIOW) System Quality Group and through the Patient Safety Specialist Network.

The ICB welcomes the 2026/27 quality priorities set out in the Quality Account and is looking forward to seeing the progress on the development of an integrated quality management system. Successful delivery of this priority will enable improved access to timely data, from ward to Board, proactive response to challenges, sharing of good practice, organisation wide learning and measurement of delivery. Learning and good practice can be shared through appropriate system quality forums, including Hampshire and Isle of Wight System Quality Group.

Overall, the ICB considers the Quality Account for 2025/26 to be a fair and accurate reflection of the services provided. The ICB will continue to work with University Hospital Southampton NHS Foundation Trust during 2026/27 through established assurance and oversight arrangements to support ongoing improvement.in the quality of care delivered to the population we serve.

Yours sincerely



Wendy Newnham
Interim Chief Nursing Officer
NHS Hampshire and Isle of Wight Integrated Care Board

Response to the Quality Account from from our lead governor on behalf of the Council of Governors

Governance and Engagement
UHS Council of Governors meets regularly to consider key Trust matters and issues relevant to our constituents. We also attend regular Governor Focus Sessions which strengthen our understanding and keep us informed of important developments within the Trust. As quality is a key area of interest for Governors, one of these sessions includes an annual presentation of the draft Quality Report from the Head of Clinical Quality Assurance.

Review and Challenge
During this focus session, Governors were given the opportunity to consider the report in detail before its completion. This provided the opportunity for us to question the content and challenge decisions from an external perspective, particularly on behalf of our constituents. The Quality team considered governors' comments and ensured that relevant issues were reflected in the final version.

Value of Early Involvement
Early involvement has been valuable in sharpening our focus on governance responsibilities and ensuring that our constituents' views are represented.

Progress Against Previous Objectives
It was encouraging to see that all the previous quality objectives had been achieved over the year, despite the significant challenges encountered in many areas.

Confidence in Delivery
Our discussions about the priorities, together with the responses to our questions, reinforced our confidence in the Trust's competence, care, and commitment. They also strengthened our view that the Trust is well placed to deliver the new objectives, despite the increasing level of challenge they present.

Priorities for 2026/27
We were encouraged that the priorities identified for 2026/27 focus clearly on the quality and safety of patient care while also recognising the needs of families and carers. The development of the Patient Support Hub and improvements to End of Life Care are likely to make a meaningful difference. We will continue to monitor the progress measures for both of these priorities, alongside the Fundamentals of Care standards.

Health Inequalities
Reducing health inequalities remains a long-term issue of particular interest in our focus groups. Continued efforts to address this across our community are therefore especially relevant and closely aligned with the Trust's values.

Leadership and Culture
Through our access to Board committee meetings, we see a consistent focus on delivering the agreed priorities. We also see constructive challenge from Non-Executive Directors and staff to ensure this focus is maintained and that solutions are developed collectively. This collaborative culture has clearly

supported the quality framework and contributed to the delivery of previous objectives through the hard work and dedication of staff, despite increasing pressures on resources.

Stakeholder Involvement
We believe that the priorities for 2026/27 have been developed in consultation with relevant stakeholders and reflect the Trust's requirements accurately and realistically. Governors hope that despite the announced future changes to the governance structure, this level of external involvement and independent scrutiny of Trust decisions will continue.

Ongoing Support and Transparency
Governors recognise the effort and expertise required to produce this report and value its role in supporting continuous improvement and transparency. We will continue to monitor progress against these objectives and support their success wherever we can. In particular, we will seek to ensure that our constituents are aware of the substantial work being undertaken to deliver the Trust's strategic quality improvement aims.

Oversight and Assurance
We will continue to monitor the performance of the Non-Executive Directors to ensure they support the Board in delivering these objectives and provide constructive challenge on its effectiveness.

Acknowledgement
The Council of Governors would like to thank the Quality Assurance team and all staff for their tireless work in delivering high-quality services and ensuring that the patient voice is heard across University Hospital Southampton NHS Foundation Trust.

Signed



Shirley Anderson
Lead Governor
University Hospital Southampton NHS Foundation Trust