University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

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

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story *(item deferred)*** The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3		**Minutes of Previous Meeting held on 9 September 2025** Approve the minutes of the previous meeting held on 9 September 2025
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:05	**Briefing from the Chair of the Audit and Risk Committee** Keith Evans, Chair
5.2	9:10	**Briefing from the Chair of the Finance, Investment & Cash Committee** David Liverseidge, Chair
5.3	9:15	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.4	9:20	**Briefing from the Chair of the Quality Committee** Tim Peachey, Chair
5.5	9:25	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.6 **Performance KPI Report for Month 6**

10:00 Review and discuss the report
Sponsor: Andy Hyett, Chief Operating Officer

5.7 **Break**

10:40

5.8 **Finance Report for Month 6**

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

5.9 **ICB System Report for Month 6**

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

5.10 **People Report for Month 6**

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

5.11 **NHSE Audit and review of 'Developing Workforce Safeguards' including**
11:20 **UHS Self-Assessment Return**

Review and approve the self-assessment return
Sponsor: Natasha Watts, Acting Chief Nursing Officer

5.12 **Guardian of Safe Working Hours Quarterly Report and Update on 10-Point**
11:30 **Plan**

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

5.13 **Annual Clinical Outcomes Summary Report**

11:45 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendees: Lucinda Hood, Head of Medical Directorate/Kate Pryde, Clinical Director for Improvement and Clinical Effectiveness

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2025-26 Quarter 2 Review**

11:55 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendee: Martin de Sousa, Director of Strategy and Partnerships

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

12:05 Review and discuss the update
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

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

7.1 **Feedback from the Council of Governors' (CoG) meeting 28 October 2025 (Oral)**
12:15
Sponsor: Jenni Douglas-Todd, Trust Chair

7.2 **Register of Seals and Chair's Actions Report**
12:25
Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 **Health and Safety Services Annual Report 2024-25**
12:30
Receive and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Vickie Purdie, Head of Patient Safety/Scott Spencer, Health and Safety Adviser

8 **Any other business**
12:40
Raise any relevant or urgent matters that are not on the agenda

9 **Note the date of the next meeting: 13 January 2026**

10 **Items circulated to the Board for reading**
12:45

10.1 **South Central Regional Research Delivery Network (SC RRDN) 2025-26 Q2 Performance Report**
Note the report
Sponsor: Paul Grundy, Chief Medical Officer

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

12 **Follow-up discussion with governors**
12:45

University Hospital Southampton NHS
NHS Foundation Trust

Agenda links to the Board Assurance Framework (BAF)

11 November 2025 – Open Session

Overview of the BAF

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

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.6	Performance KPI Report for Month 6	1a, 1b, 1c			x
5.8	Finance Report for Month 6	5a			x
5.9	ICB System Report for Month 6	5a			x
5.10	People Report for Month 6	3a, 3b, 3c			x
5.11	Workforce Safeguards Self-Assessment	1a, 3a			x
5.12	Guardian of Safe Working Hours Quarterly Report	3a, 3b			x
5.13	Clinical Outcomes Summary Report	1a, 1b			x

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	09/09/2025
Time	9:00 – 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Diana Eccles, NED (DE) Keith Evans, Deputy Chair and NED (KE) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Andy Hyett, Chief Operating Officer (AH) David Liverseidge, NED (DL) Alison Tattersall, NED (AT)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.1) Danielle Honey, Named Nurse for Safeguarding Children (DH) (item 5.14) Lucinda Hood, Head of Medical Directorate (LH) (item 5.15) Duncan Linning-Karp, Deputy Chief Operating Officer (DL-K) (item 5.6) Corinne Miller, Named Nurse for Safeguarding Adults (CMi) (item 5.14) Jenny Milner, Associate Director of Patient Experience (JM) (items 5.11-5.12) 1 member of the public (item 2) 30 members of staff (observing) 6 members of the public (observing)
Apologies	Gail Byrne, Chief Nursing Officer (GB) David French, Chief Executive Officer (DAF) Tim Peachey, NED (TP)

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

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

It was noted that apologies had been received from Gail Byrne, David French and Tim Peachey.

The Chair provided an overview of meetings she had held and events that she had attended since the previous Board meeting.

2. Patient Story

Aelwen Emmett, a volunteer at the Trust and former patient was invited to present her experience, focusing particularly on her work to improve the standard of food offered to patients.

3. Minutes of the Previous Meeting held on 15 July 2025

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 15 July 2025.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted.

In respect of action 1246, it was noted that virtual outpatient appointments had now been built into the Trust's programme. Furthermore, meetings were to be held with commissioners and the cancer network to improve the quality of referrals. It was noted that action 1246 could be closed.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Finance and Investment Committee

David Liverseidge was invited to present the Committee Chair's Reports in respect of the meetings held on 21 July and 2 September 2025, the content of which was noted. It was further noted that:

- In July 2025, the Trust had reported that it was £1.1m adverse to its plan, but that the underlying trajectory was improving.
- The committee received an update from Wessex NHS Procurement Limited, noting that the company was on track in terms of its Cost Improvement Programme target.
- The committee had received an update in respect of both the proposed Hampshire and Isle of Wight elective hub and a possible Urgent Treatment Centre at Southampton.
- The committee reviewed the Finance Report for Month 4 (item 5.8), noting that the Trust had reported a year-to-date deficit of £19.5m, which was £5.8m adverse to plan. Key drivers for the Trust's financial position included the lack of improvement in the number of patients having no criteria to reside and mental health patients, the continued difference between funded and actual activity under block contracts, lower than anticipated income, and higher than planned workforce numbers.
- The Trust was ahead of its plan on Cost Improvement Programme delivery.
- The committee reviewed the Trust's proposed Financial Recovery Plan and noted the need to ensure that the long-term impact of decisions needed to be taken into account.
- The committee reviewed the Trust's cash position and noted that cash support would be required in the Autumn and that the committee would be amending its terms of reference to expand its role in terms of cash monitoring and oversight.
- The committee reviewed the Board Assurance Framework risks within its remit, noting that Risk 5a had increased to 25 due to the risk associated with the Trust's cash position (item 6.1).

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

Jane Harwood was invited to present the Committee Chair's Reports in respect of the meetings held on 21 July and 1 September 2025, the content of which was noted. It was further noted that:

- The committee reviewed the People Report for Month 4 (item 5.10), noting that there continued to be significant demands on the Trust's workforce, especially due to the number of patients having no criteria to reside and patients with a primary mental health need. Whilst the Trust's substantive workforce had reduced, there had been an increase in the number of temporary staff resulting in the Trust reporting that it was 55 whole-time-equivalents above its plan.

- The committee considered the impact of the recruitment controls on the administrative and clerical workforce and the potential for shortages in these areas causing issues elsewhere.
- The committee received an update in respect of the Mutually Agreed Resignation Scheme (MARS), noting that 65 applications had been approved.
- The committee received an update on the recruitment of newly qualified nurses, noting that the Trust had pre-empted the announcement of a 'guarantee' by the Secretary of State.
- The committee reviewed the workforce related elements of the Trust's Financial Recovery Plan, noting the challenges in delivering what was required and the Trust's reliance on improvements in patients having no criteria to reside and mental health patients.
- The committee reviewed its terms of reference, proposing to make only minor changes (item 7.2).

5.3 Briefing from the Chair of the Quality Committee

Diana Eccles was invited to present the Committee Chair's Report in respect of the meeting held on 18 August 2025, the content of which was noted. It was further noted that:

- The committee considered the proposal to revise enhanced rates paid to temporary staff in certain areas to remove the enhancement and bring rates into line with Agenda for Change rates. The committee noted the impact on staff and the concerns expressed by staff members. However, it was further noted that the enhancements were not intended to be permanent.
- The committee received the Experience of Care report and noted a continuation in the trend observed during Quarter 4 of staff attitudes featuring as a reason for complaint. It was considered likely that this was indicative of the pressures on staff.
- The committee reviewed the Maternity and Neonatal Safety 2025-26 Quarter 1 Report, noting that an action plan was in place in respect of the Maternity Triage Line to address some shortcomings identified in the process.
- The committee received the Learning from Deaths 2025-26 Quarter 1 Report (item 5.11), noting that the Trust was one of only 11 trusts out of 119 with a lower-than-expected death rate during the period.
- The committee reviewed the Safeguarding Annual Report 2024-25 and Strategy 2025-26 (item 5.14), noting that activity levels remained consistent with prior years, but the complexity of cases had increased.

5.4 Chief Executive Officer's Report

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

- The NHS league tables for 2025 had been published on 9 September 2025. The Trust had ranked 48th out of 134 and had been placed in segment 3 of the NHS Oversight Framework due to the effect of the 'financial override'. The Trust was temporarily in segment 5 due to being in the Recovery Support Programme.
- Trusts were required to submit self-assessments for the Provider Capability Assessment during October 2025. This would inform decisions relating to which organisations to place in the Performance Improvement Programme.
- Resident doctors undertook strike action between 25 and 30 July 2025. Approximately one-third of those eligible at the Trust took part in the industrial action and the Trust had performed well in terms of mitigating the impact on activity.

- The Royal College of Nursing had published results of its analysis of violence and aggression against nursing staff in emergency departments, noting that the number of incidents had increased from 2,093 in 2019 to 4,054 in 2024.
- NHS England had published a series of urgent and emergency care improvement guides to assist organisations with managing the winter period.
- A number of changes to the organisation of local councils in Hampshire and Southampton were proposed as part of national plans to create unitary councils in place of existing county and district/borough councils.

5.5 Performance KPI Report for Month 4

Andy Hyett was invited to present the Performance KPI Report for Month 4, the content of which was noted. It was further noted that:

- The Trust had reported an increase in the number of patients waiting over 52, 65 and 78 weeks alongside an increase in the overall waiting list. The Trust had entered Tier 2 escalation for Referral To Treatment performance.
- The Trust had been placed in Tier 1 escalation due to the gap between its current Emergency Department performance and its performance plan for 2025/26. However, indicative data for August and September 2025 showed improved performance.
- Work was ongoing to improve flow with task and finish groups established to review the discharge process and to implement rapid improvements.
- The number of patients having no criteria to reside and those with a primary mental health need remained high. A workshop had been set up with Hampshire and Isle of Wight Healthcare NHS Foundation Trust in respect of mental health patients.
- Steps were being undertaken to reduce the number of inappropriate attendances in the Emergency Department with patients potentially redirected to other areas. However, an Urgent Treatment Centre would be key to alleviating pressure on the Emergency Department in the longer term.

The Board discussed the Trust's performance against national standards. This discussion is summarised below:

- Performance against the 62-day standard for cancer waiting times was an area of focus to ensure more consistent performance.
- Work was ongoing to extend shared decision-making in order to involve patients in decisions about their care and treatment, noting however that this was more of a challenge with inpatients.
- There was a challenge in terms of managing the demand for patients requiring diagnostic services. It was noted that there had been issues with availability of equipment over the summer period. It was acknowledged that diagnostics performance also impacted other areas such as cancer and Emergency Department metrics.
- The percentage of over 65s attending the Emergency Department was expected to be a key metric to monitor over the winter period.

Actions

Andy Hyett agreed to look at the roll out of Pharmacy First.

Andy Hyett agreed to carry out a deep-dive into Diagnostics to be either provided as a 'Spotlight' in the Performance KPI Report or via a Trust Board Study Session.

5.6 UHS Operating Plan 2025-26 and Board Assurance Statement

Andy Hyett was invited to present the Operating Plan 2025-26 and Board Assurance Statement, the content of which was noted. It was further noted that:

- The Operating Plan provided a summary of plans from October 2025 to September 2026, sitting alongside other key policies such as those relating to infection prevention control, major incidents, and influenza.
- The Operating Plan would also serve as the Trust's winter plan, which was recognised as a period of increased pressure.

The Board discussed the proposed Operating Plan for 2025/26, this discussion is summarised below:

- It was considered likely that, even with delivery of the demand management schemes being led by the Integrated Care Board (ICB), there would be a gap between demand and capacity over the winter period in particular. Therefore, further interventions to improve discharge rates and to reduce the number of patients having no criteria to reside would be necessary. In addition, the Trust would be required to make potentially difficult decisions in respect of prioritisation of patients and possible cancellation of elective procedures.
- Concerns were expressed in relation to the trend of low uptakes of seasonal vaccinations, such as that against influenza, which had been seen since the COVID-19 pandemic. This situation would likely create further challenges due to patients with seasonal illnesses requiring additional infection prevention control measures. Furthermore, low uptake by staff members would likely result in increased rates of staff sickness and, accordingly, reduced capacity and/or increased expenditure on temporary staffing.
- It was understood that there was a NHS campaign to encourage staff in particular to be vaccinated against influenza, and that plans were in place for senior leaders to visibly support this campaign through being vaccinated.
- The Board challenged whether the Trust could meet the targets set out in the Operating Plan given the financial and other pressures currently experienced.
- It was additionally noted that the Trust was reliant on external support and delivery of external demand management programmes led by the ICB in order to be able to meet the performance targets, especially in terms of management of the number of patients having no criteria to reside and those with a primary mental health need.
- Furthermore, the Trust's financial position was such that it was required to produce a financial recovery plan, which would require additional financial savings to be made.
- It was agreed that the Board should fully consider whether to approve the Operating Plan once it had considered the Trust's financial recovery plan in the Closed Session of the meeting.

[Note: the matters below forming part of item 5.6 were discussed following the approval of the Trust's financial recovery plan in the Closed Session.]

Noting that the Board had discussed and supported the Trust's financial recovery plan, subject to certain caveats, the Board again discussed the proposed Operating Plan for 2025/26. This discussion is summarised below:

- The Trust's financial recovery plan would need to be supported by NHS England and would also need to deliver in order for the Trust to be able to meet the performance targets set out in the Operating Plan.
- The Trust continued to have significant dependence on third parties, especially other providers, the Integrated Care Board, and local authorities, to be able to successfully reduce the number of patients having no criteria to

reside or number of mental health patients. Without these reductions, the Trust would face significant capacity constraints, which would impact its performance, especially during periods of high demand.

Decision

Noting the discussions in the Closed Session in respect of the financial recovery plan, and having reviewed the proposed Operating Plan 2025-26 and accompanying Board Assurance Statement, the Board approved the Operating Plan 2025-26 and its submission, subject to the following:

- delivery of system-wide programmes to manage demand and reduce numbers of non-criteria to reside and mental health patients,
- appropriate support being provided by third parties, including local providers, the Integrated Care Board, and local authorities, especially in terms of supporting discharges and managing numbers of non-criteria to reside and mental health patients, and
- support from NHS England for and delivery of the Trust's financial recovery plan.

In addition, the Board authorised the Chair and Chief Executive Officer to sign the Board Assurance Statement.

5.7 Break

5.8 Finance Report for Month 4

Ian Howard was invited to present the Finance Report for Month 4, the content of which was noted. It was further noted that:

- The Trust had reported an in-month deficit of £6.8m (£4.8m above plan), although the underlying deficit was showing improvement, reducing to £6.6m. However, this trajectory was not sufficient to deliver the plan.
- The Trust was carrying out approximately £2.5m of unfunded activity per month. In order to tackle some of this amount, the Trust had conducted negotiations with other providers and systems to address underfunding on contracts.
- There were concerns about whether the Trust's elective over-performance during the first half of the year would be fully funded. Whilst agreement had been reached in respect of funding three months of over-performance, it was not clear whether this would be replicated in the future.
- The Trust would be seeking an activity management plan, which would detail which activities to cease to perform on the basis that the Trust continuing to over-perform against agreed funded activity levels was financially unsustainable and that it was not reasonable that the Trust should be criticised for falling performance in areas such as waiting lists as it sought to manage its finances.
- The Trust's cash position remained an area of concern with cash support to be requested from NHS England.
- There appeared to be an emerging risk of slippage against the Trust's capital programme, which was to be discussed at the Finance and Investment Committee.

5.9 ICS Operational Delivery Report for Month 4

Ian Howard was invited to present the ICS Operational Delivery Report for Month 4, the content of which was noted. It was further noted that:

- The Trust was the only organisation within the system currently reporting being off plan. However, there were indicators from other providers with

significant risks being highlighted about organisations' abilities to meet their 2025/26 plans.
- There was an error in the report in respect of the Trust's workforce numbers. A correction to the report had been requested.
- The Hampshire and Isle of Wight ICS plan was for a breakeven position at the end of 2025/26. However, this was reliant on receipt of £60m of deficit support funding from NHS England, which was at risk because the Trust was no longer reporting being on plan.

5.10 People Report for Month 4

It was noted that two questions had been received from members of the public prior to the meeting (see Annex A), both of which related to the decision to remove the enhancement from NHS Professionals rates paid to staff in certain areas of the Trust such as in Theatres and in the Emergency Department. It was further noted that:

- A discussion had also been held with staff prior to the Board meeting, at which a number of other questions had been raised. In particular, staff had expressed concerns about their feeling valued by the organisation.
- The reasoning behind the decision to remove the enhancement previously paid on temporary staffing rates was explained as being to provide consistency with other staffing groups and with other providers by aligning rates paid with Agenda for Change rates. This change was part of a package of measures to improve the financial position of the Trust.
- The decision to remove the enhancement was supported by an Equality and Quality Impact Assessment as part of the Trust's process for making decisions of this nature.

[Post meeting note: Following the meeting, the Royal College of Nursing, on behalf of its members in the affected areas, submitted a collective dispute. The questions raised in advance of the meeting, together with other related points, were to be addressed as part of the collective dispute process.]

Steve Harris was invited to present the People Report for Month 4, the content of which was noted. It was further noted that:

- The Trust's plan for 2025/26 was for a reduction in whole-time-equivalents (WTE) by 765. Whilst the Trust had reduced the size of its workforce, it was still 55 WTE off-plan.
- The Trust had reduced the number of divisions from four to three and had implemented recruitment controls whereby only 70% of clinical posts would be recruited to and a prohibition on recruitment to non-clinical posts.
- The Trust had also carried out a Mutually Agreed Resignation Scheme (MARS) and had made some redundancies in discrete areas. It was noted, however, that there was a lack of funding for severance payments, which limited the Trust's options with respect to steps it could take to reduce its workforce.
- Temporary staffing was a particular area of focus, both in terms of numbers of temporary staff but also in terms of the cost paid for such staff. This aligned with the work of the South East temporary staffing collaborative which aimed to reduce the price of temporary labour in both bank and agency.

- Despite its challenges during 2025/26, the Trust had proactively offered roles to newly-qualified nurses ahead of the Secretary of State's announcement of a 'graduate guarantee' on the basis that, from a strategic perspective, the Trust needed to take into account its future workforce requirements.

Action
Steve Harris and Andy Hyett agreed to respond to the questions and points raised at the meeting held with staff in respect of the NHS Professionals rates matter.

5.11 Learning from Deaths 2025-26 Quarter 1 Report

Jenny Milner was invited to present the Learning from Deaths 2025/26 Quarter 1 Report, the content of which was noted. It was further noted that:

- The Trust's summary hospital-level mortality indicator (SHMI) score continued its downward trajectory and was the lowest value recorded since 2018. As such, the Trust was one of only 11 trusts nationally to achieve a lower-than-expected mortality rate.
- Work was ongoing to disseminate lessons from end-of-life care and an additional module for the Ulysses system had been purchased to facilitate data capture and standardisation for Morbidity and Mortality meetings.

Action
Jenny Milner was to provide further information to the Board in respect of why the Trust's SHMI score remained low.

5.12 Annual Complaints Report 2024-25

Jenny Milner was invited to present the Annual Complaints Report 2024/25, the content of which was noted. It was further noted that:

- The report provided details of complaints received between 1 April 2024 and 31 March 2025 and was the first full year of reporting against the new standard introduced by the Parliamentary and Health Service Ombudsman (PHSO).
- Complaints activity had increased by 40% and the Trust was not currently meeting response targets.
- The Trust benchmarked higher than others in terms of complaints not upheld.

The Board discussed the Trust's approach to complaints handling and, in particular, whether the Trust was an outlier in terms of the number of complaints not upheld. The Board challenged whether complaints deemed as 'not upheld' ought, in some instances, to be considered 'partially upheld'. Consideration should therefore be given to reviewing the Trust's complaints against PHSO referrals and outcomes.

Action
Jenny Milner was to provide further information regarding how the Trust was planning to meet complaints response times.

5.13 Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance

Paul Grundy was invited to present the Medical Appraisal and Revalidation Annual Report, the content of which was noted. It was further noted that:

- The framework published by NHS England was designed to allow the Trust to provide assurance that its professional standards processes meet the relevant statutory requirements and support quality improvement.
- Feedback in respect of the appraisals process had been largely positive.
- Appraisal compliance rates had continued to rise across the year with a current average of 88.8%.
- The Board was required to approve a Statement of Compliance confirming that the Trust was compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended).

Decision

Having considered the Medical Appraisal and Revalidation Annual Report tabled to the meeting, the Board authorised the Chair or Chief Executive Officer to sign the Statement of Compliance.

5.14 Safeguarding Annual Report 2024-25 and Strategy 2025-26

Danielle Honey was invited to present the Safeguarding Annual Report 2024/25 and Strategy for 2025/26, the content of which was noted. It was further noted that:

- The report summarised the activity of the Trust's safeguarding service in 2024/25. It was noted that the service had contributed to reviews of 56 patients where a statutory review had been considered.
- The number of referrals under section 42 of the Care Act 2014 caused by Southampton City Council had reduced following the implementation of the council's new processes. This was not reflective of a reduction in the number of UHS referrals or the complexity of the referrals responded to.
- There had been an increase in the number of open cases with Southampton City Council and there had been a 13% increase in the number of patients subject to Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005.
- There had also been an increase in the number of scoping reviews compared to prior years, although fewer were progressing to formal reviews.
- Following a survey of staff, work was underway to improve the visibility of the team and there was a focus on team wellbeing with support from the psychology team.
- The situation in respect of expected changes in the role of integrated care boards was being monitored due to the potential for changes in the team's scope and remit.

6. STRATEGY and BUSINESS PLANNING

6.1 Board Assurance Framework (BAF) Update

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

- All risks had been reviewed by the relevant executive directors since July 2025.
- The revised risk appetites agreed by the Board in July 2025 were being embedded.
- The rating of Risk 5a had increased from 20 to 25 due to the lack of agreement for cash support. However, once this agreement had been obtained and the Financial Recovery Plan was in place, it was expected that this risk would again reduce to 20.
- An audit of the Trust's risk management maturity by the Trust's internal auditors was near to completion.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (COG) Meeting 16 July 2025

The Chair presented a summary of the Council of Governors' meeting held on 16 July 2025. It was noted that the meeting had considered the following matters:

- Chief Executive Officer's Performance Report
- The Trust's 2025/26 Operating Plan
- Council of Governors' Terms of Reference
- Membership Engagement
- Feedback from the Governors' Nomination Committee

Furthermore, the Council of Governors approved the extension of the appointment of Tim Peachey as a non-executive director for a period of 12 months.

7.2 People and Organisational Development Committee Terms of Reference

Craig Machell was invited to present the proposed changes to the People and Organisational Development Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The People and Organisational Development Committee had reviewed its terms of reference at its meeting on 1 September 2025.
- It was proposed to make only minor changes to remove reference to the Charitable Funds Committee, which no longer existed.

Decision

Having considered the proposed amendments to the People and Organisational Development Committee's Terms of Reference, the Board approved the changes.

8. Any other business

It was noted that it was organ donation week during 22-28 September 2025.

Action

Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session.

9. Note the date of the next meeting: 11 November 2025

10. Items circulated to the Board for reading

The item circulated to the Board for reading was noted. There being no further business, the meeting concluded.

11. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

Annex A
Questions:

1. *The Board has agreed a cut in bank pay rates for nursing staff, resulting in local staff being unlikely to maintain their bank roles in this organisation, (based on a survey of over 450 nurses within the affected areas). Currently these roles provide staffing in areas such as theatres and other specialised areas, the impact being these departments can use local skills and knowledge to provide seamless operational delivery.*
   How can the board provide assurance that, a) this will not impact on safety for patients, and b) they truly value nurses for the professional skills they provide for this Trust.

2. *Our Emergency Department has recently been placed under Tier 1 monitoring by NHS England, reflecting serious national concerns about safety and performance. The department is already regularly understaffed, with patient care frequently delayed as a result. In light of this, how can the Trust justify reducing NHSP pay rates for Emergency Department nurses — a decision that risks deterring skilled staff from covering shifts and further compromising patient safety and the delivery of safe, timely care? What specific steps will the Trust take to mitigate these risks to patients and staff if the changes go ahead?*

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 15/07/2025 - 5.11 Freedom to Speak Up Report				
1267.	Data	Mbabazi, Christine Watts, Natasha	13/01/2026	Pending
	Explanation action item Christine Mbabazi to include data from other mechanisms for reporting concerns in future Freedom to Speak Up reports.			
Trust Board – Open Session 09/09/2025 - 5.5 Performance KPI Report for Month 4				
1281.	Pharmacy First	Hyett, Andy	11/11/2025	Pending
	Explanation action item Andy Hyett agreed to look at the roll out of Pharmacy First.			
1282.	Diagnostics	Hyett, Andy	11/11/2025	Pending
	Explanation action item Andy Hyett agreed to carry out a deep-dive into Diagnostics to be either provided as a 'Spotlight' in the Performance KPI Report or via a Trust Board Study Session.			
Trust Board – Open Session 09/09/2025 - 5.10 People Report for Month 4				
1283.	NHS Professionals rates	Harris, Steve Hyett, Andy	11/11/2025	Pending
	Explanation action item Steve Harris and Andy Hyett agreed to respond to the questions and points raised at the meeting held with staff in respect of the NHS Professionals rates matter.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 09/09/2025 - 5.11 Learning from Deaths 2025-26 Quarter 1 Report				
1284.	SHMI score	• Milner, Jenny • Watts, Natasha	11/11/2025	Pending
	Explanation action item Jenny Milner was to provide further information to the Board in respect of why the Trust's SHMI score remained low.			
Trust Board – Open Session 09/09/2025 - 5.12 Annual Complaints Report 2024-25				
1285.	Response times	• Milner, Jenny • Watts, Natasha	11/11/2025	Pending
	Explanation action item Jenny Milner was to provide further information regarding how the Trust was planning to meet complaints response times.			
Trust Board – Open Session 09/09/2025 - 8 Any other business				
1286.	Organ donation	• Machell, Craig	18/12/2025	Pending
	Explanation action item Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session. Update: To be scheduled 18/12/25 or 03/02/26.			

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.1

Committee Chair's Report to the Trust Board of Directors 11 November 2025			
Committee:	**Audit & Risk Committee**		
Meeting Date:	**13 October 2025**		
Key Messages:	• The committee reviewed and discussed the outputs of a 'lessons learned' activity following the late publication of the Trust's annual report and accounts. It was noted that a number of actions had been agreed and that a trial run would be conducted at Month 9. • The committee noted the proposal to tender for new valuers for 2025/26 and the review of the Modern Equivalent Asset estimation methodology that would be carried out during the year. • The committee agreed with a proposal to write off historical debt from private (mostly overseas) patients on the basis that it was irrecoverable. • There had been 68 waivers of competitive tendering during the first half of 2025/26, most of which related to continued service provision. • It was noted that the submission as part of the National Cost Collection exercise had been completed in July 2025 and that the Trust was 7% more efficient than the average based on the data. • An update was received in respect of Information Governance. The Trust's Data Security and Protection Toolkit was now rated as 'approaching standards' and progress had been made in respect of the backlog in subject access requests. • The committee received an update in respect of legal expenditure and claims during 2024/25. • The committee reviewed the internal audit reports on the Data Security and Protection Toolkit, CQC Readiness, and risk maturity. • The committee received an update on the progress of the Trust's local counter-fraud team against the plan for 2025/26, noting that imposter fraud was an area of focus.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• The committee had last reviewed the BAF in March 2025, and there had been a definite increase in the level of risk with the ratings of four of the risks having increased since then. • Approximately 25% of the risks on the Trust's operational risk register were rated 'critical' (i.e. 15 or above). • The internal audit of risk management had been positive and the Trust's risk management framework was considered as being mature.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 i)

Committee Chair's Report to the Trust Board of Directors 11 November 2025	
Committee:	**Finance and Investment Committee**
Meeting Date:	**22 September 2025**
Key Messages:	• The committee reviewed the Finance Report for Month 5. The Trust had reported an in-month deficit of £5.9m and £25.4m deficit year-to-date. The in-month deficit was £4.2m above the original plan, but was in line with the trajectory in the Financial Recovery Plan. • The Trust's underlying deficit had continued to improve, reducing to £6.2m, although this improvement was not yet at the pace required. • The main drivers of the variance to plan were variances in income compared with what had been expected during 2025/26 and variances in terms of pay costs. The Trust was expecting to be 95 whole-time-equivalents above plan at year end based on current assumptions. • It was noted that the Trust had identified 100% of Cost Improvement Programme savings at Month 5 and 76% of schemes were fully developed. Approximately £37m of savings had been delivered between Months 1 and 5, although higher than anticipated levels of non-recurrent savings had been delivered. • The committee reviewed the Trust's capital forecast, noting that there was a risk of a shortfall against the Trust's internal CDEL. • An update was received regarding the Urgent and Emergency Care transformation programme. • The committee received the annual assurance report from UHS Pharmacy Limited, noting the company's performance during the year and the work being done to expand services internally and externally. • The committee considered the Trust's cash forecast for Month 5, noting that the Trust's underlying deficit was steadily eroding the Trust's cash balance. The Trust had introduced strict treasury management measures and had previously received advance payments from the ICB as a means to mitigate the cash position. However, it had been necessary to submit a request for revenue support from NHS England in September 2025 and further such applications would be required from November 2025 onwards. • In order to increase the focus on and governance of cash-related matters, the committee reviewed its terms of reference to strengthen the cash-related provisions and agreed to recommend to the Board that the committee be re-constituted as the Finance, Investment and Cash Committee with an Operating Cash Group reporting into the committee.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**N/A**
Any Other Matters:	The revised terms of reference for the committee were reviewed and approved at the Board meeting held on 7 October 2025.

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 ii)

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
11 November 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance, Investment and Cash Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">3 November 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee reviewed the Finance Report for Month 6 (see below).
• The committee received an update in respect of the Trust's performance against its Financial Recovery Plan, noting that progress had been made in terms of putting plans in place regarding patients with no criteria to reside and mental health patients. Good progress had also been made in respect of the 'grip and control' measures. At Month 6, the Trust remained on track with the Financial Recovery Plan.
• An overview of the recently published Medium Term Planning framework was provided. It was noted that the first submission of the Trust's three-year plan was due before Christmas 2025.
• The committee received an update regarding the Outpatient Transformation Programme, noting that whilst there had been an overall improvement, this was at an insufficient level to offset the increased demand.
• The committee reviewed the six-monthly assurance report from UHS Estates Limited, noting that the company continued to focus on integrating teams following the transfer of staff earlier in the year.
• The committee reviewed the Trust's latest cash position and forecast as well as the governance arrangements in operation to manage the Trust's cash, noting that the Trust's cash balance at Month 6 was £42.1m. This amount was higher than originally expected due to lower than anticipated supplier payments. However, it was underpinned by the receipt of advances from the Integrated Care Board, without which the Trust would have a negative cash balance.
• The Trust had made two requests for cash support from NHS England in October (£21.3m) and in November (£16.7m). It was unclear at this stage how much support NHS England would agree to provide during November, as only £10m had been agreed for October.
• The committee noted the quarterly report from UHS Digital.</td></tr>
<tr><td rowspan="2">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.8 Finance Report for Month 6</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust had reported an in-month deficit of £5.4m (£30.8m year-to-date), and was £14.2m adverse to plan (year-to-date).
• The Trust's financial performance was consistent with the revised trajectory submitted to NHS England in August 2025 in the Financial Recovery Plan.
• Whilst the number of whole-time-equivalent members of staff had continued to reduce, it was not doing so at the pace required. In addition, cost improvements had been offset by other pressures such as reduction in income levels and a pay award funding shortfall.
• The Trust had delivered £6.5m in financial savings during the month, although this was £2.5m behind plan. The committee discussed this under-performance and requested additional information about the CIP trajectory for the remainder of the year. To date, the Trust had delivered £43.5m in savings.</td></tr>
</table>

	• There was a risk of slippage in terms of the Trust's capital programme.		
	6.2 Board Assurance Framework (BAF) Update	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• Risks 5a, 5b and 5c have been updated, following discussions with the respective Executive Director(s). • Risk 5a remained rated at 25 due to the continued uncertainty around cash. • The committee questioned whether the target date for risk 5c was realistic.		
Any Other Matters:	The committee received an update in respect of the One Electronic Patient Record programme and in respect of the work ongoing for the creation of an Urgent Treatment Centre at the Southampton General Hospital site.		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.3 i)

Committee Chair's Report to the Trust Board of Directors 11 November 2025			
Committee:	**People & Organisational Development Committee**		
Meeting Date:	**22 September 2025**		
Key Messages:	• The committee reviewed the People Report for Month 5, noting that the Trust was above its workforce plan by 135 whole-time-equivalents. However, this number was partially driven by the impact of resident doctor rotations with additional leavers due to be processed in September 2025. Further measures were being taken to control the Trust's workforce numbers, including management of starters to ensure that these numbers were based on the expected number of leavers each month. • The national pulse survey results for Quarter 2 had been released. Staff engagement had declined compared to 2024. • The Trust had implemented a programme to remove enhanced rates paid to bank staff in critical care, theatres and the emergency department, and to instead align rates to Agenda for Change rates. It was noted that there had been significant challenge from staff and there was potential for a collective dispute from the Royal College of Nursing. • Following a discussion at the Trust Executive Committee, it was proposed that the Trust adopt a harder line in terms of its approach to violence, aggression and/or abuse directed at staff, including an increased willingness to exclude individuals. • The committee considered the GMC National Training Survey results for 2025, together with the NHS 10-Point Plan to improve resident doctors' working lives. It was noted that the Trust had already had plans in place in this area and that it was in a good position in terms of management of rotas and payroll. The lack of reference to estates-related concerns, especially a lack of office space, in the 10-Point Plan did not appear to be consistent with feedback from the Trust's resident doctors.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• Risks 3a, 3b and 3c have been updated, following discussions with the respective Executive Director(s). • Risk 3a had been updated to reflect the tensions between the financial risk and operational demand and the available workforce, as well as updates to the mitigations in place to support the financial risk through steps to reduce the workforce.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.3 ii)

Committee Chair's Report to the Trust Board of Directors 11 November 2025			
Committee:	**People & Organisational Development Committee**		
Meeting Date:	**3 November 2025**		
Key Messages:	• The committee reviewed the People Report for Month 6 (see below) including progress against the workforce plan and Financial Recovery Plan. • The committee received report in respect of the work carried out as part of the national programme to review job evaluation processes and to ensure that roles matched to the updated nursing and midwifery national profiles, noting that the Trust had carried out a self-assessment and had developed a local action plan. • The committee received a report regarding the NHS England Audit and review of the 'Developing Workforce Safeguards' standard and accompanying self-assessment, noting that the Trust continued to comply with the majority of standards and reviewed safe staffing levels at least daily. • The committee received an update in respect of the work of the Employee Relations team between April 2024 and September 2025. This included reviewing assurances on how the Trust manages its employee relations processes (such as disciplinary, grievance and sickness management).		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.10 People Report for Month 6**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The overall workforce fell during September 2025 due to a combination of the controls on recruitment and a significant reduction in the use of temporary staff. However, the Trust remained 54 whole-time-equivalents (WTE) above its 2025/26 plan. • There had been a slight increase in sickness levels over the period and appraisal completion rates remained a concern linked to overall capacity at the Trust • Statutory and mandatory training was discussed, and the committee plans to review this at a future meeting including progress against the national statutory and mandatory training review. • The Trust was relaunching its Violence & Aggression approach, which was to be based on a greater willingness to refuse treatment where patients exhibited violent, aggressive or abusive behaviours. The committee noted the importance of the Trust's strategy in this area being able to give support and guidance to staff 'in the moment' as well as after the event. • The Trust had issued an exclusion letter to a patient for racist and discriminatory behaviour. • Flu vaccine take up for staff was 35%, 10% higher than the prior year. • The national Staff Survey 2025 is due to close in November 2025. Only 29% of Trust staff had so far completed the survey against a national average of 32%.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.4

Committee Chair's Report to the Trust Board of Directors 11 November 2025			
Committee:	**Quality Committee**		
Meeting Date:	**13 October 2025**		
Key Messages:	• It was noted that there had been no Never Events reported during July 2025 and a reduction in the number of falls over the summer. • There had, however, been a 40% increase in the number of complaints compared to the prior year. There were also significant delays in response times. • The committee was informed of two patient safety incident investigations – one relating to a ligature and another relating to storage of human tissue samples. • The committee noted that there had been some initial teething problems with the new MIYA system in the Emergency Department, largely driven by events happening in series in the system rather than in parallel. • The committee received an update in respect of the Fundamentals of Care programme, noting that early data regarding the 'what matters to me' programme indicates an improvement in patients and earlier discharge through earlier interventions. The committee also noted that patients with autism/learning disabilities needed to be an area of focus. • The committee received an update regarding mental health, noting the continuing challenge with waits for mental health beds. It was noted that, since January 2025, the Trust had incurred around £425k of additional costs due to delays in transferring patients to a mental health facility and that 60% of the Trust's costs for enhanced care related to patients who were medically optimised for discharge. • The committee noted the progress made with respect to the Critical Care Outreach Team (CCOT) Service and how the team had gone from a position of 50% vacancies to now providing 24/7 care for adults. The team provides a proactive service for high-risk patients and those at high risk of deterioration. The committee also noted that of the 106 calls made using the Call for Concern process, only one resulted in a patient going into intensive care. • The committee noted the summaries of key clinical outcomes as presented in CAMEO meetings between May and September 2025.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• Risks 1a, 1b, 1c and 4a have been updated, following discussions with the respective Executive Director(s). • Risk 1b had been reassessed and increased from 12 to 16 in recognition of the impact on patients of the tension between clinical/operational demand and available resources.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

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

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

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

- Medium Term Planning Framework
- Strategic Commissioning Framework
- Change in Tiering Status
- Mid-Year Review
- National Stance on Racism
- NHS Confederation and NHS Providers Joint Statement
- Industrial Action
- Staff Survey 2025
- Future NHS Workforce Solution
- NHS Workforce Plan
- NHS England Review of Postgraduate Medical Training
- NHS Online
- Paediatric Hearing Improvement Visit
- NIHR Funding

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

Medium Term Planning Framework

On 24 October 2025, NHS England published the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29.

This planning framework covers three years and commits to more ambitious targets across cancer, urgent care, waiting times, access to primary and community care, mental health, learning disabilities and autism, and dentistry. It contains an ambition to achieve constitutional standards by 2028/29 where possible and aims to support delivery of the ambitions in the 10-Year Health Plan.

Providers are expected to develop their first submissions in the following areas between October and December 2025:

- Three-year revenue and four-year capital plan return
- Three-year workforce return
- Three-year operational performance and activity return
- Integrated planning template showing triangulation and alignment of plans
- Board assurance statements confirming oversight of process.

Plans are expected to be finalised in early February 2026.

The Framework can be read at: https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/

Further analysis is included as an agenda item in the closed session of the meeting.

Strategic Commissioning Framework

NHS England published its Strategic Commissioning Framework on 4 November 2025. Based on the Model ICB Blueprint, which establishes a shared vision for integrated care boards (ICBs), strategic commissioning will be the central purpose of ICBs in the future.

Strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term in order to improve population health, reduce health inequalities and improve equitable access to healthcare.

According to the framework, NHS England's ambition for strategic commissioning is that:

- ICBs will continue to work in partnership with providers, local government and other stakeholders, prioritising system goals within total available resource.
- ICBs will work with public health and local stakeholders to assess the needs of local populations, creating a strong evidence base for commissioning decisions.
- ICBs will take a biological, psychological and social view of population health.
- ICBs will develop a clear, evidence-based methodology for determining priorities and the commissioning or decommissioning of services.
- ICBs will be transparent in making decisions.
- ICBs will commission across pathways of care and increasingly focus on population-based care.
- ICBs will be capable of driving efficiency and performance and will fulfil their quality duties as part of strategic commissioning.
- ICBs will strengthen their understanding of the role of technology and data in how and what they commission.

- ICBs will continue to develop a clear set of skills and capabilities to carry out strategic commissioning and will support providers to develop their commissioning and integrator capabilities as some look to take on new roles as multi-neighbourhood providers and integrated health organisations.

The Framework can be read at: https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

Change in Tiering Status
NHS England informed the Trust on 23 October 2025 that it would move into Tier 1 for Elective. This followed an earlier letter, which set out an expectation that all providers were to see and treat any remaining patients who had been waiting longer than 65 weeks by 21 December 2025.

Organisations that were expected to have more than 100 65-week waits at the end of October 2025 have been moved into Tier 1. There are currently 350 patients waiting longer than 65 weeks at UHS and the latest forecast is to have 70 remaining by 21 December 2025. We know this will not be acceptable to NHS England and we are working hard to find additional capacity to treat these patients, including with the private sector and other NHS providers through mutual aid. The ICB have helpfully offered funding to facilitate this activity.

Being in Tier 1 will involve regular meetings with regional and national teams to discuss delivery progress and track immediate actions required to deliver the required reductions. These arrangements will remain in place until all 65-week waits have been cleared, at which point the tiering status will be reviewed.

Mid-Year Review
The Chair and Chief Executive Officer are due to attend the Trust's mid-year review with NHS England on 13 November 2025. There is currently a lot of focus on the Trust due to its financial position and its performance in areas such as the four-hour emergency department standard and the number of patients waiting longer than 65 weeks.

The Chair and Chief Executive Officer will report back to the Board after 13 November 2025. Most providers' mid-year reviews are with regional NHSE teams, however, UHS is one of only a handful to have its review with the national team, including the NHS CEO.

National Stance on Racism
On 16 October 2025, NHS England wrote to all integrated care board, NHS trust and NHS foundation trust chairs, chief executives and chief people officers requesting action on racism, including antisemitism.

The letter reiterated NHS England's 'zero tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour.' NHS England is also formally adopting the International Holocaust Remembrance Alliance's working definition of antisemitism and encourages all NHS organisations to do so.

NHS England will also be updating its existing uniform and workwear guidance to ensure that patients feel safe and respected at all times, and that staff political views do not impact on patients' care or comfort.

The NHS Core Skills Framework on Equality, Diversity and Human Rights will be updated to extend the section on discrimination and content on antisemitism and Islamophobia.

The Royal College of Nursing has also carried out analysis of calls to the RCN which show a surge in complaints about racism at work, revealing a 55% increase in three years.

NHS Confederation and NHS Providers Joint Statement
On 27 October 2025, NHS Confederation and NHS Providers jointly called for additional NHS funding in the budget to cover three unplanned cost pressures that were not included in the NHS budget for 2025/26. According to the statement:

- Redundancy costs: over £1bn is needed to enable integrated care boards and NHS trusts to deliver the reductions in workforce costs expected by the UK Government.
- Strike action: the recent industrial action has led to further cost pressures estimated to be £300m.
- Higher drug prices.

Altogether these costs are estimated to generate a cost pressure of up to £3bn that the NHS may be expected to absorb during 2025/26.

The statement can be read at: https://www.nhsconfed.org/news/pay-redundancies-or-risk-waiting-times-rising-nhs-confederation-and-nhs-providers-warn

Separately, following a consultation with members, NHS Confederation and NHS Providers have announced their intention to merge.

Industrial Action
The British Medical Association announced on 23 October 2025 a further five-day strike by resident doctors, commencing at 7am on 14 November 2025. This will be the thirteenth strike since March 2023 in the long-running dispute.

The Trust has extensive experience of managing periods of industrial action and, where possible, mitigating the impact on patients. We will work with clinical and operational teams to minimise any cancellations of appointments or procedures as a result of the strike.

On 31 October 2025, it was announced that unions had rejected the Government's submission to the pay review body which proposed a 2.5% rise for Agenda for Change staff in 2026/27, with the head of the Royal College of Nursing describing the offer as 'derisory'.

Staff Survey 2025
The NHS Staff Survey 2025 went live on 29 September 2025 and closes on 28 November 2025.

The annual NHS Staff Survey is one of the largest workforce surveys in the world. It is sent to over 1.5m NHS staff and was completed by over 750,000 in 2024.

Four socio-economic background questions have been added to online versions of the survey in order to provide additional demographic information and to enable employers to better understand staff experience by socio-economic background.

More information can be found at: https://www.nhsstaffsurveys.com/

Future NHS Workforce Solution
The NHS Business Services Authority (NHSBA) has announced it has awarded a £1.2bn contract to Infosys to deliver a new and enhanced workforce management system for the NHS. The Future NHS Workforce Solution will replace the Electronic Staff Record and support areas such as recruitment, onboarding, career development, workforce management, payroll, and retirement.

Implementation is expected to be completed by 2030.

NHS Workforce Plan
On 24 October 2025, the Health Service Journal announced that the publication of the NHS Workforce Plan has been delayed until Spring 2026.

NHS England Review of Postgraduate Medical Training
On 24 October 2025, NHS England set out its recommendations following the first phase of a review into postgraduate medical training. The Government's Chief Medical Officer, Professor Chris Whitty and the former National Medical Director at NHS England, Professor Stephen Powis, have led a medical training review to understand current challenges and identify areas for improvement.

An engagement exercise generated over 8,000 responses from doctors, patients and professional and regulatory bodies, including more than 6,000 resident doctors.

The phase one report identifies eleven recommendations, including four key priorities needed to modernise training:

- Training must become more flexible.
- Excellence beyond formal training routes must be built on, including around the increasing role played by speciality and specialist (SAS) doctors and locally employed doctors.
- Current training bottlenecks are damaging and must be addressed.
- Inclusive team structures need to be rebuilt where doctors at every stage of training feel valued.

The report can be read at: https://www.england.nhs.uk/2025/10/englands-leading-doctors-set-out-medical-training-recommendations/

NHS Online
NHS England announced on 29 September 2025 that it was setting up an 'online hospital' in a significant reform of the way healthcare is delivered in England. The first patients will be able to use the service from 2027.

It is intended that when a patient has an appointment with their GP, they will have the option of being referred to the online hospital for their specialist care. They will be able to book directly through the NHS App and have the ability to see specialists from around the country online without leaving their home or having to wait longer for a face-to-face appointment.

Patients will also be able to book a scan, test or procedure at a time that suits them at Community Diagnostic Centres and be able to track prescriptions and get advice on managing their condition.

It is claimed that NHS Online will deliver the equivalent of up to 8.5m appointments and assessments in its first three years.

Paediatric Hearing Improvement Visit
The Hampshire and Isle of Wight Integrated Care Board, in collaboration with NHS England South East Region, carried out a visit to the Trust's paediatric hearing services on 16 May 2025 as part of the national Paediatric Hearing Services Improvement Programme.

The Trust received the report from the visit on 23 October 2025. The report was largely positive and noted that clinical care was observed to be safe, with only some minor recommendations. The service has been recommended as a paediatric assured recall centre.

NIHR Funding

The National Institute for Health and Care Research (NIHR) has awarded the Trust and the University of Southampton £16.3m to continue valuable applied research across the South of England.

The Trust was one of only four organisations out of 15 applications to receive an award and so this is a great outcome for the Trust – congratulations to the team!

This funding is part of a £157m investment over five years in ten NIHR Applied Research Collaboratives. The Trust is a member of the NIHR Applied Research Collaboration Wessex, which has been running since 2019.

The main research themes are: healthy communities and prevention, living well with long-term conditions, mental health, integrated health and social care, data and technology.

Agenda Item 5.6 Report to the Trust Board of Directors, 11 November 2025	
Title:	Performance KPI Report 2025-26 Month 6
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Sam Dale, Associate Director of Data and Analytics

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

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

Contents:

The content of the report includes the following:

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

Risk(s):

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

Equality Impact Consideration:	NO

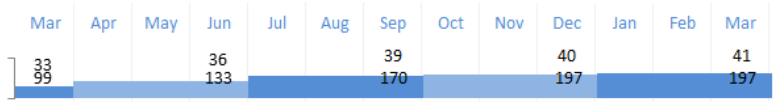
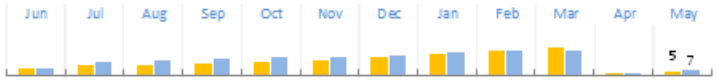
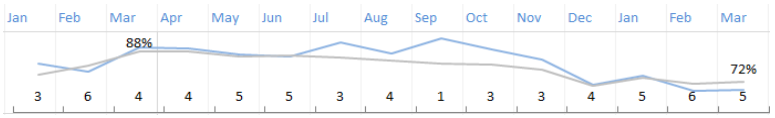
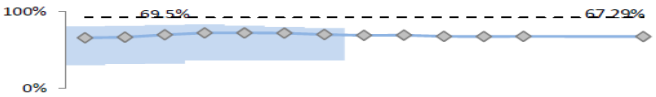
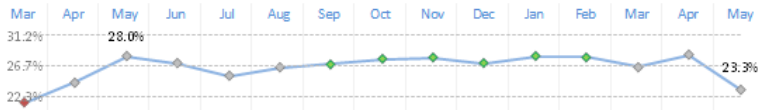
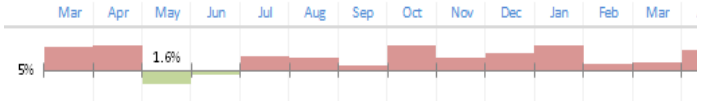
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
September 2025

Sponsor – Andy Hyett, Chief Operating Officer
Author – Sam Dale, Associate Director of Data and Analytics

Report guide

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

Introduction

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

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

The content of the report includes the following:

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

Summary

This month's spotlight report describes current activity levels, waiting times and six week performance for the fifteen reportable diagnostic modalities.

The report highlights that: -

- The trust's latest performance position for the percentage of patients waiting under six weeks for diagnostics is 80.3% (September 2025). Reducing waiting times for diagnostics is a national priority for 2025/26, although a formal target percentage was not published.
- There are several diagnostic services which continue to deliver at levels well above 90% including Audiology, Sleep Studies, Computed tomography (CT) and several modalities within the Endoscopy associated services.
- The most challenged areas are Neurophysiology, Cystoscopy and more recently MRIs due to unexpected downtime for equipment.
- Trust performance is above overall NHS performance particularly on the percentage of patients waiting over 13 weeks. The latest comparator information shows the trust is in 11th placed compared to 20 peer teaching organisations.

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

1. The trust's waiting list remained stable in September closing at 63,160 which is an increase of just 142 patients since August 2025 or 152 since July 2025. 18 week performance is 61.0% which is a 0.8% decrease since August (61.8%). The waiting list breakdown illustrates that more people are waiting at the diagnostic element of their pathway or admissions, but less people waiting at the initial referral stage of their pathway compared to August.
2. The trust reported 39 patients waiting over 78 weeks, 268 patients waiting over 65 weeks and 3.1% of the waiting list above 52 weeks compared to a national ambition of 1% by March 2027. The key areas with challenges on long waiting patients are within the surgical caregroup plus gynaecology and trauma and orthopaedics. These services are now agreeing or implementing a series of interventions to provide additional capacity internally or externally to significantly reduce the number of patients over 65 weeks before the end of the calendar year.
3. The hospital's emergency departments have sustained the recent performance improvement seen since the start of the year. Four hour performance for September was 67.6% across all emergency departments and 64.9% for Main ED. There were 54 mental health patients who spent over 12 hours in A&E in September which is the highest volume since October 2024 (57). The trust continues to be in Tier 1 for emergency department performance with a series of interventions being put in place with the support of ECIST and regional teams.
4. Cancer performance has been maintained across the 28 day fast diagnosis standard (80.5%) and the 31day standard (94.7%) with a small reduction on the 62 day standard (75.8%) for August 2025. The key challenged areas for 62 day standard in August were Lung, Head and Neck and Urology with all other tumour sites reporting performance above 80%.
5. The trust reported zero cases of MRSA in September 25, one never event and two Patient Safety Incident Investigations (PSII).

6. There has been an increase in the percentage of patients with a disability or reporting additional needs/adjustments met to 90.4% which is above the monthly target of 90%. A contributing factor has been renewed focus on communicating accessibility issues to divisional governance teams via the patient engagement team.
7. The volume of patients within the hospital who are categorised as having no criteria to reside (nCTR) has remained consistent over the last three months reporting 230 for September 2025. This continues to significantly impact bed availability and flow through the organisation.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 27th October 2025, our average handover time was 19 minutes 9 seconds across 810 emergency handovers and 22 minutes 59 seconds across 36 urgent handovers. There were 78 handovers over 30 minutes and 7 handovers taking over 60 minutes within the unvalidated data. Across September the average handover time was 14 minutes 15 seconds.

Spotlight: Diagnostic Performance

The following report is based on the validated September 2025 position.

Introduction

Diagnostic services are fundamental to the NHS's ability to detect disease early, plan effective treatment and improve patient outcomes and experience. These services cover a broad spectrum of tests and procedures including imaging, physiological assessments, and pathology-based investigations all of which underpin safe and timely clinical decision-making.

Diagnostic waiting time standards measure the interval between referral and test completion across fifteen key modalities. These are grouped into three broad categories:

- **Endoscopy** (e.g. gastroscopy, cystoscopy)
- **Imaging** (e.g. CT, MRI, barium enema)
- **Physiological measurement** (e.g. echocardiogram, sleep studies)

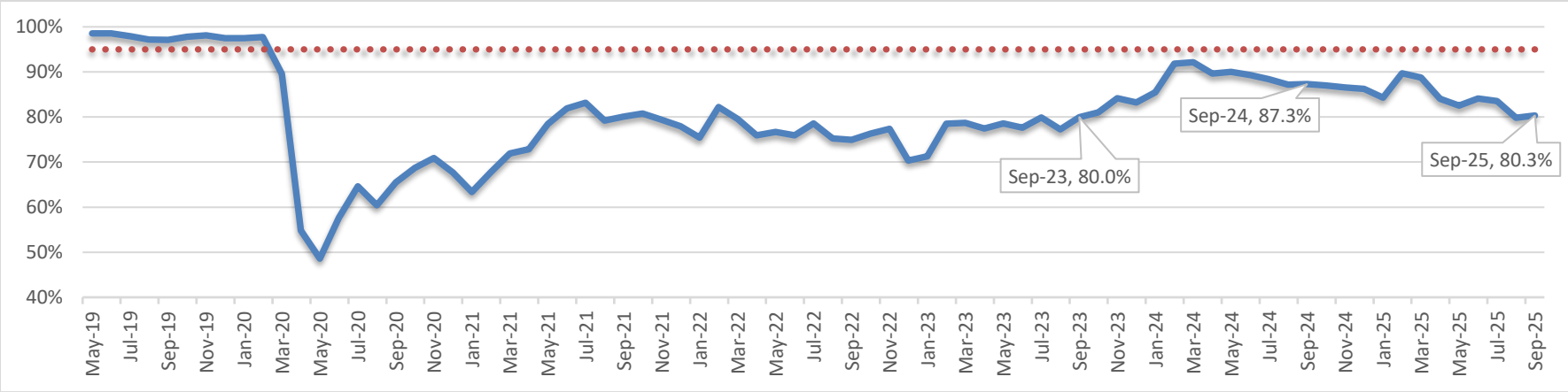
At the outset of the 2025/26 financial year, a key national priority was to improve the time people wait for elective care. Whilst a diagnostics performance target was not specifically stated in the operational planning guidance, it is recognised that the diagnostic pathway is a crucial element of overall waiting times. For reference, in 2024/25 the guidance stipulated that trusts should increase the percentage of patients that receive a diagnostic test within six weeks with an ambition of 95% by March 2025.

This report outlines the recent six week waiting time performance for diagnostics across all fifteen modalities. It examines the volume of diagnostic activity undertaken, the size and profile of the waiting list, and provides benchmarking against peer organisations and national figures. The report also summarises any relevant reporting updates, areas of improvement, and targeted actions being implemented to address performance challenges. The Trust remains focused on reducing diagnostic waiting times, improving productivity, and ensuring fair access to timely, high-quality diagnostic services for all patients.

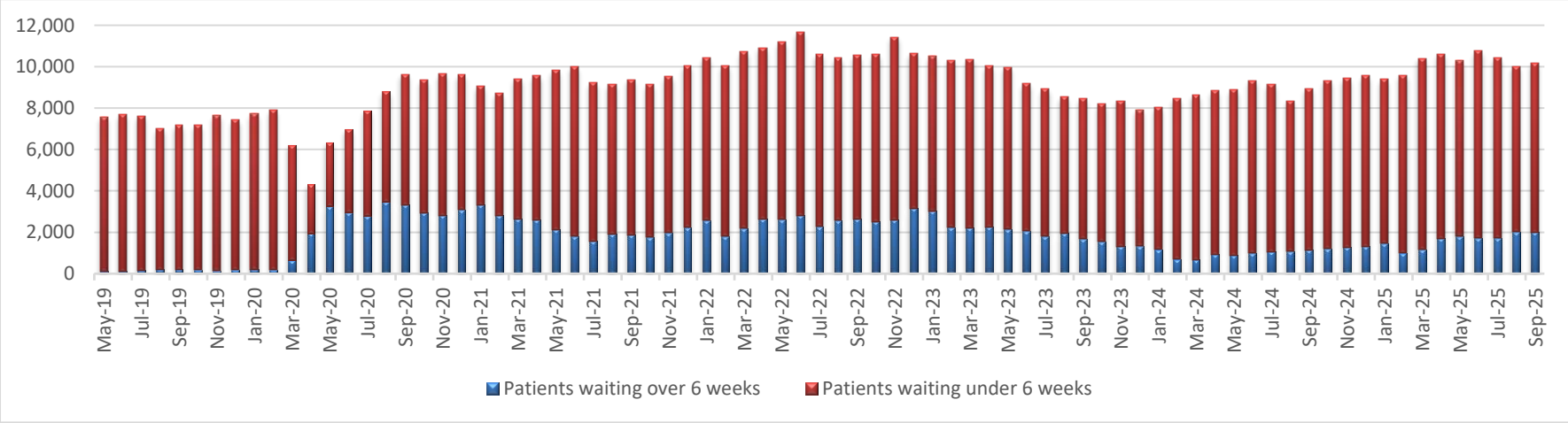
Performance Overview

In the pandemic, the performance position (for patients waiting under 6 weeks for diagnostics) reduced below 50% (May 2022). UHS performance recovered significantly across the following four years but has struggled to maintain the upward trajectory across the last eighteen months despite

ambitions to recover our waiting times to pre-pandemic levels. In September, the organisation reported 80.3% with exactly 2000 patients waiting over six weeks. The performance trend and waiting list size is illustrated in graphs 1 and 2 respectively below.

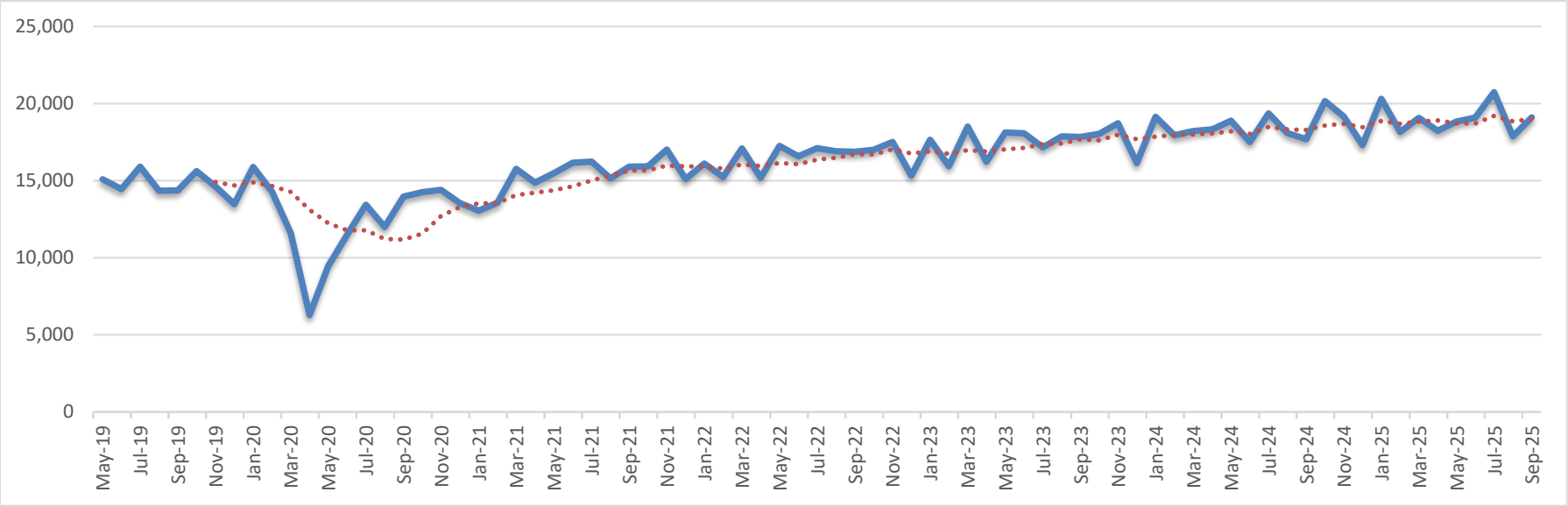


Graph 1. UHS Diagnostic Performance Trend (% patients waiting over 6 weeks)



Graph 2. Diagnostic Waiting List with breakdown

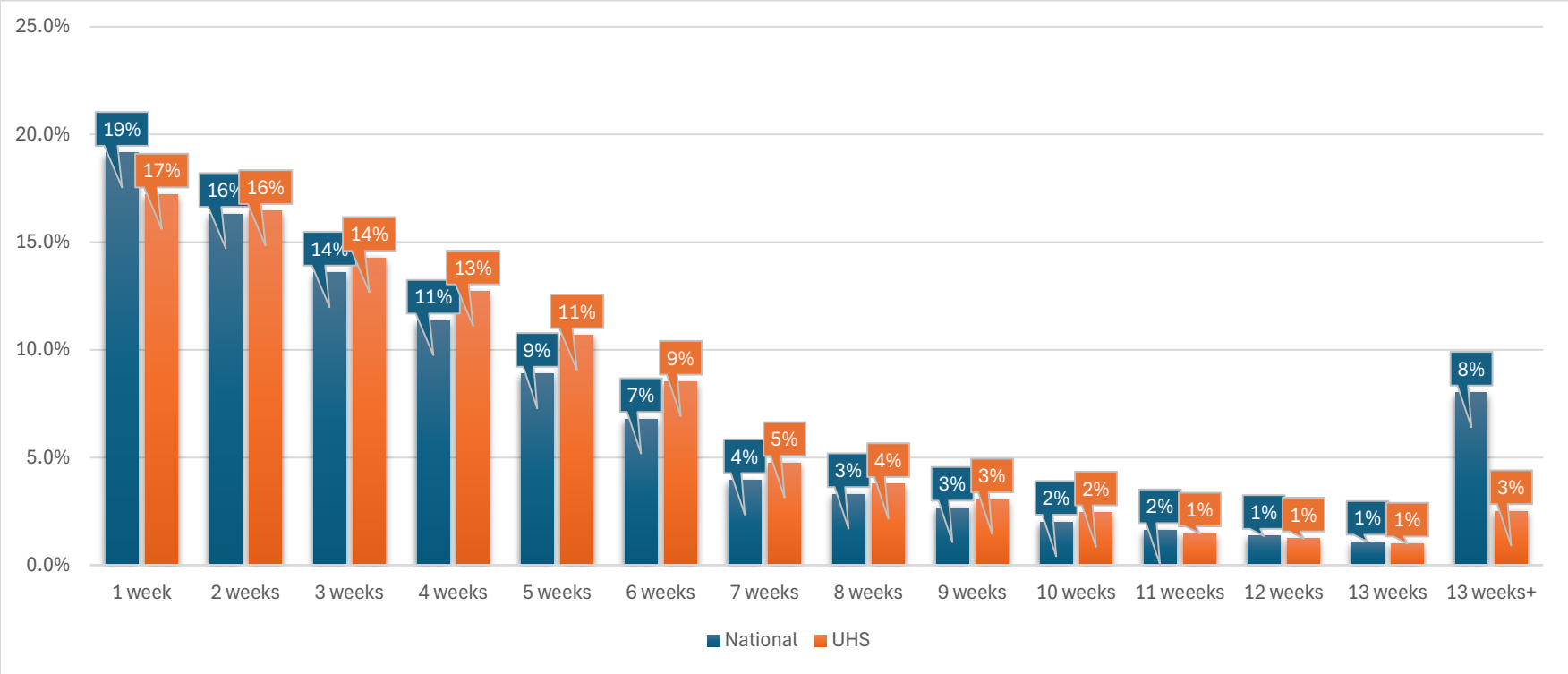
The interventions and actions that have been embedded as part of the Trust's annual plan have proved successful in delivering more activity as illustrated in Graph 3. In the first six months of 2025/26 the trust delivered 114k diagnostic tests which is 3.6% more than the same period in 2024/25.



Graph 3. UHS Diagnostic activity delivered

The volume of diagnostic tests and procedures reported include those delivered for emergency admissions/attendances, patients on an RTT waiting list and also patients on a planned pathway i.e. those who are on an existing pathway and require a future diagnostic to monitor their ongoing condition. Whilst there can be some volatility within different radiology services due to demand and clinical prioritisation, the split is consistently 60% of diagnostics being delivered for the waiting list, 25% for emergency services and 15% for planned or surveillance pathways.

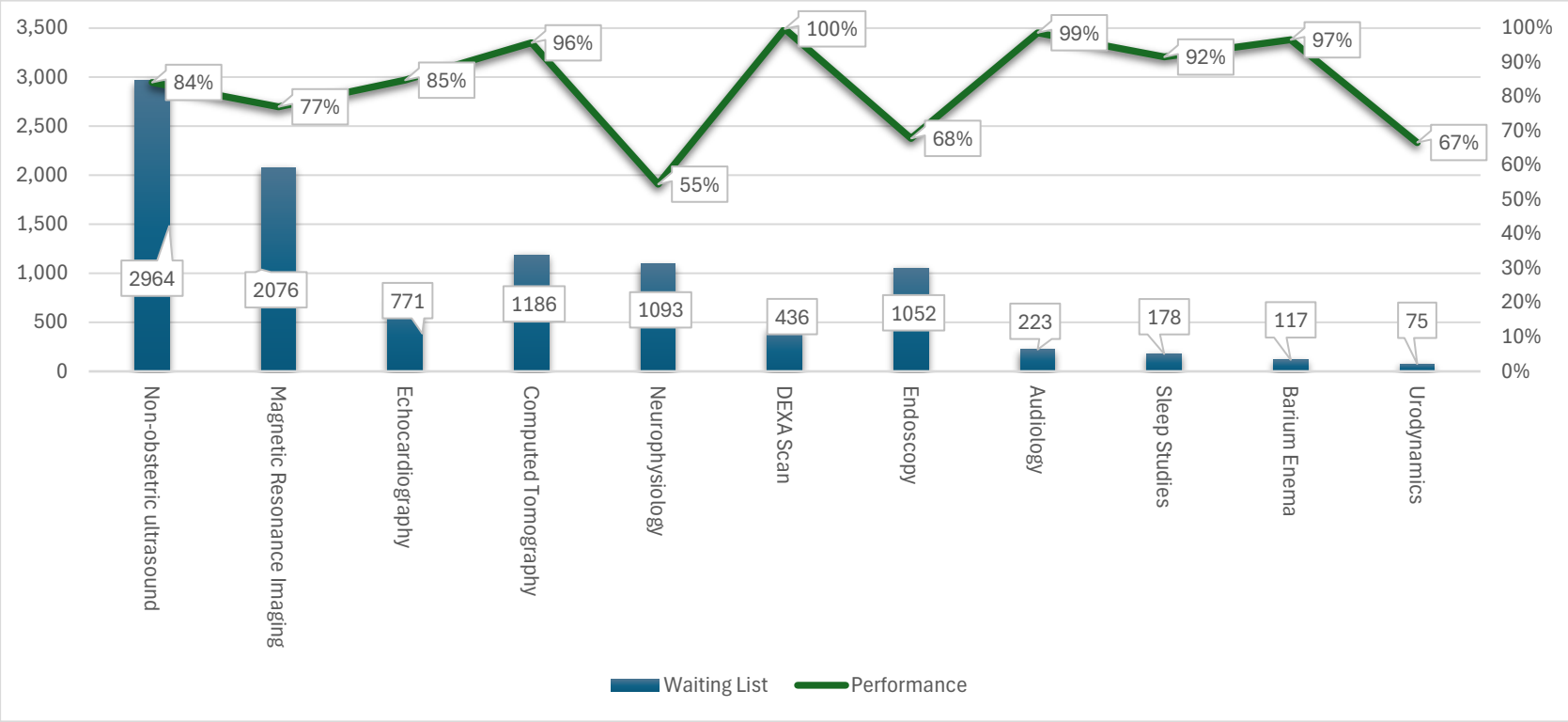
Over the last twelve months, the trust's overall performance on diagnostics has consistently placed the organisation in the second quartile compared to twenty peer teaching hospitals across the country. The latest comparative month available is August 2025 and whilst most organisations showed a decline in performance, UHS dropped into the third quartile. Graph 4 illustrates the split of the current UHS diagnostic waiting list by waiting times and compares it to the overall NHS position. In August 2025, the total number of patients waiting less than six weeks was 76% across the country compared to 80% at UHS. The equivalent statistics for patients waiting less than 13 weeks are 97% (UHS) and 92% (National). The trust had 251 patients waiting over 13 weeks at the end of August 2025 predominantly within Non-Obstetric Ultrasound, Cardiology Services and Endoscopic Services.



Graph 4: Proportion of the waiting list (August 2025) by waiting time – UHS vs National position

Modality Focus

Although national reporting aggregates performance across all fifteen diagnostic tests at Trust level, UHS monitors diagnostic waiting times internally at both service and individual test level. This provides assurance that patients are prioritised appropriately, regardless of the relative size or scale of the service. Larger services (particularly within Radiology) have some flexibility to adjust capacity in response to fluctuations in demand but are also more exposed to the impact of urgent and emergency pressures. In contrast, smaller specialised areas such as Electrophysiology and Urodynamics can face greater operational challenges due to limited staffing and capacity resilience. Graph 5 illustrates waiting list size and performance by test type.



Graph 5: September 2025 Performance (%) and Waiting List Size by Diagnostic Area

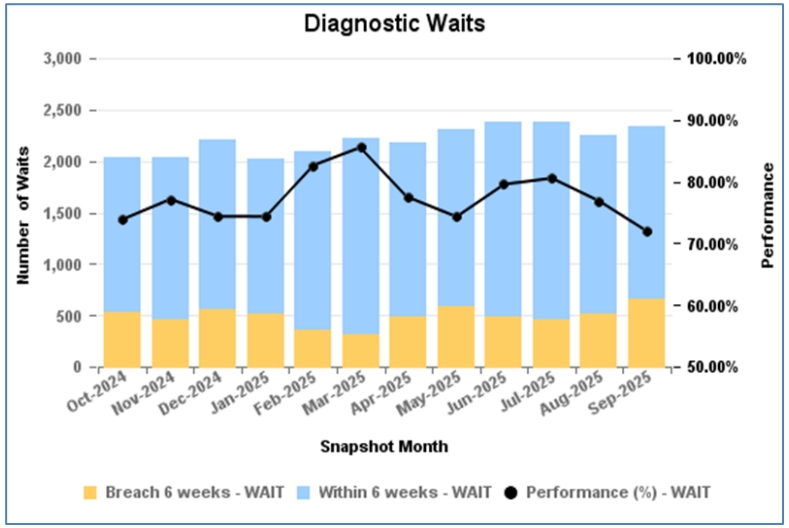
The **Physiological Modality** includes Audiology, Echocardiography, Neurophysiology and Sleep Studies. Whilst performance has dropped in recent months across this cohort it is mainly driven by Neurophysiology and there are several success stories across other services as described below.

The **Audiology** service continues to meet trust performance ambitions with just three patients waiting over six weeks in September 2025 and performance of 98.6%. There has also been significant progress made within the **Sleep Studies** service driving a 10% performance improvement over the last 12 months to 91.6% for September 2025. This reflects the clinical team's hard work in ensuring diagnostic patients are prioritised alongside a project to review reasons behind a high DNA rate and actions to address this. A monthly operational meeting has proved successful in improving full visibility of the waiting list to enable quicker pathway decision making. The service has approval for additional hours within the clinical team to deliver more diagnostic activity.

Cardiology performance for echocardiograms has increased to 84.8% (September 2025) compared to 62.3% at the start of this financial year (April 2025). This additional activity has been driven by additional Saturday lists and recruitment into vacancies, although there are still some training needs before staff are fully contributing to service.

Neurophysiology has experienced a sustained increase in demand over recent years that has consistently outpaced available capacity. Temporary insourcing between December 2024 and April 2025 helped to restore performance briefly but largely masked the gradual and sustained decline seen across the service.

A further contributing factor has been the growing demand for intraoperative monitoring (IOM) which, while clinically necessary, continues to draw neurophysiologist time away from routine diagnostic activity such as EEGs and NCS. This has required an ongoing balance between maintaining service performance and managing the significant costs associated with IOM delivery.



Graph 6: Performance and waits for all physiological metrics

To support short-term recovery, the service is reviewing triage practices in line with the recently published ANS/BSCN guidelines and assessing study leave distribution to ensure service continuity and avoid capacity dips caused by overlapping absences. Early indications suggest that improvements from triage changes may be limited, given that the new guidance already reflects much of the existing practice developed and used by UHS.

Longer-term actions focus on reintegrating targeted insourcing to support backlog reduction and embedding digital diagnostic advancements, including AI-assisted EEG reporting, to enhance efficiency and throughput. The Trust has submitted an initial bid for national funding to support this implementation, with the programme expected to begin in early 2026/27.

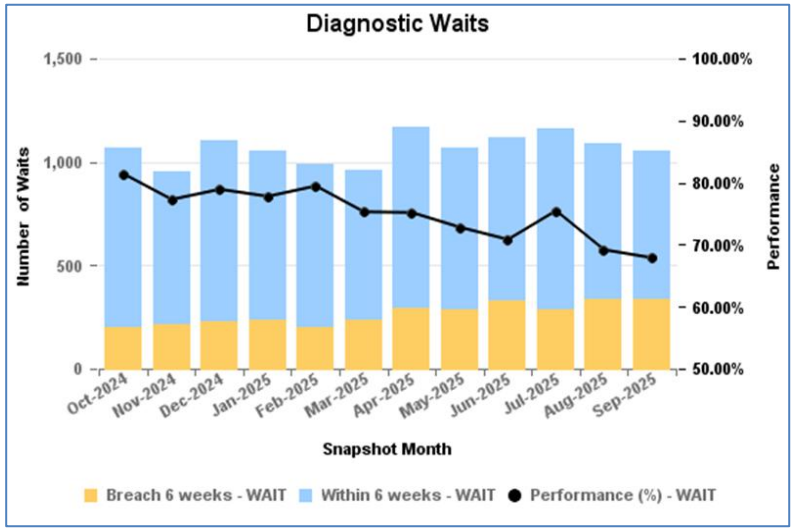
The **Endoscopy Modality** includes colonoscopy, cystoscopy, flexi-sigmoidoscopy and gastroscopy for both adult and paediatric services. The September 2025 performance position combined across all these services is 67.9% with 388 patients breaching the six week waiting time target. The waiting list currently stands at 1052 patients.

Within the adult services, three of the four endoscopic procedures consistently deliver six week performance at or close to 100%. Across gastroscopy, flexi-sigmoidoscopy and colonoscopy just six patients were waiting over six weeks. The excellent performance position is a combination of waiting list management processes overseen by an Endoscopy coordinator, constant patient engagement to minimise DNAs and strong oversight through bi-weekly operation meetings.

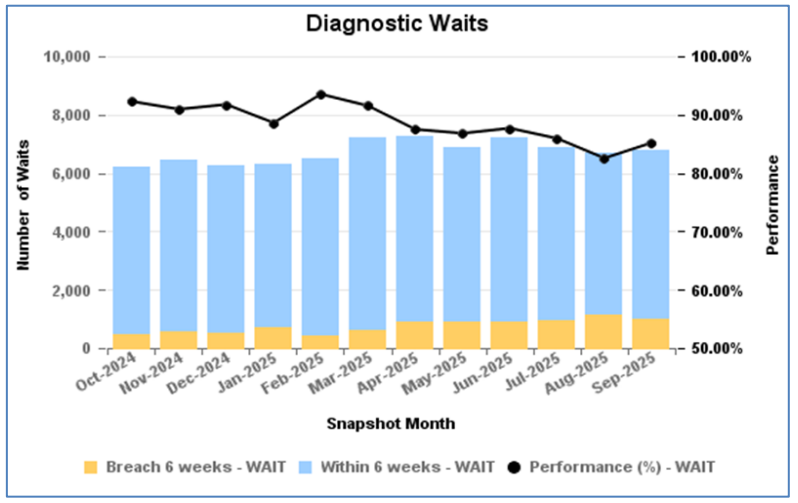
However, the cystoscopy service continues to be the main area of challenge with performance at 43% in September 2025, primarily driven by a mismatch between demand and available capacity. The service is managing a backlog of 238 patients on a planned pathway, the majority of whom have known cancers and require a follow-up procedure to check for recurrence. The same clinical capacity is used to deliver this planned backlog, meet two week wait referrals and manage the diagnostic waiting list. Given that the diagnostic cohort often presents a lower level of clinical urgency, available capacity has been prioritised for higher-risk patients.

The **Imaging Modality** includes MRI, CT, Non-Obstetric Ultrasounds, Dexa Scans and Barium Enemas. The September 2025 performance position is 85.1% with 1003 patients breaching the six week waiting time target. The waiting list currently stands at 6780 patients. The key concern and driver of reduced performance across the year has been unexpected downtime of our fleet of **MRI** scanners. This includes unexpected delays in our equipment replacement programme but also water ingress and humidity issues that have impacted existing scanners.

CT performance has been consistently strong and above 96% for all months this year. **Non-Obstetric Ultrasound** performance was 84% for September 2025. Sonographer recruitment has consistently been a challenge but the services have built up a resilient bank sonographer to absorb staffing gaps alongside the development of an in-house training programme for more complex scans.



Graph 7: Performance and waits for all endoscopy metrics



Graph 8: Performance and waits for all imaging metrics

Summary

The trust fully recognises that strong diagnostic performance is fundamental to the improvement of flow through the organisation and improved waiting times. Whilst the Trust has generally benchmarked in the second quartile against peer teaching hospitals for diagnostic waiting times, progress in a number of modalities has been constrained in recent months by staffing, equipment, capacity and demand challenges. These factors have temporarily slowed our planned trajectory but the issues are well understood and remedial action plans are under way or in discussion. The hospital has excellent visibility of data to support the understanding of demand, activity and waiting times and this is the foundation of performance meetings and service discussions.

With clear governance, targeted recovery plans, and strong analytical insight, the Trust is well positioned to deliver sustained improvement and achieve compliance with the national diagnostic ambitions.

NHS Constitution - Standards for Access to services within waiting times

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

- The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible
- The right to start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- The right to a maximum 28-day wait from receipt of an urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme, or receipt of urgent referral with breast symptoms (where cancer not suspected) to the date you will be informed of a diagnosis or that cancer is ruled out

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

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

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

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

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

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	70%		63.4%												61.0%	≥67.4%	63.0%
		4	4	4	4	4	4	4	4	3	3	3	3	4	6			
		3	4	4	3	5	5	5	7	6	5	5	6	5	6			
		50%																
34 - As of April 2025, YTD and **Monthly target changed to local target (67.4%)**. N.B. new national target of 65%																		
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100%		78.6%												75.8%	≥75%	75.4%
		5	4	3	5	4	4	2	10	4	10	3	10	7	9			
		3	2	2	2	1	2	2	4	2	3	2	6	2	4			
		40%																
43 - As of April 2025, YTD and **Monthly targets changed from 70% to 75%** in line with latest operational guidance																		
30	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	80%		65.5%												64.9%	≥78%	60.4%
		6	10	6	6	12	15	9	16	14	10	14	15	15	7	8		
		5	6	4	4	9	12	6	12	12	7	15	13	17	5	6		
		40%																
30 - As of April 2025, YTD and **Monthly target changed from 95% to 78%** in line with latest operational guidance																		
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	40%		12.7%												19.7%	≤5%	17.57%
		5	5	5	6	6	6	6	6	7	9	9	9	10	11			
		6	6	6	8	9	8	9	6	7	10	11	9	10	9			
		0%																
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	100.0	91.6											90.9			≤100	92.5	≤100
		80.0	89.9											88.9					
2	HSMR - Crude Mortality Rate	3.0%	2.6%											2.2%			<3%	2.2%	<3%
		2.0%																	
3	Percentage non-elective readmissions within 30 days of discharge from hospital	15%		11.6%										13.4%			-	13.4%	-
		10%																	
				Q2 2024/2025			Q3 2024/2025			Q4 2024/2025			Q1 2025/2026			Q2 2025/2026	Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80		76			76			76			77			74	+1 Specialty per quarter		
		75																	
		70																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%		39 79 319			36 76 317			36 88 309			35 90 309			34 90 310	-		
		75%																	
		50%																	

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

Safety		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**																≤8	62	≤48
7	MRSA bacteraemia																0	3	0
8	Gram negative bacteraemia																≤19	138	≤106
9	Pressure ulcers category 2 per 1000 bed days																<0.3	0.29	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days																<0.3	0.38	<0.3
11	Medication Errors (severe/moderate)																≤3	19	12
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent 12 months** vs. **Previous 12 months**																<2578	2,496	<2552

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

Safety		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)	0														2	-	10	-
14	Never Events	0														1	0	3	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity	0														0	-	0	-
16	Number of falls investigated per 1000 bed days		0.19													0.17	-	0.13	-
17	% patients with a nutrition plan in place (total checks conducted included at chart base)		94.6%													94.9%	≥90%	93%	≥90%
		930	869	826	964	961	828	901	989	965	895	945	1,074	981	870	878			
18	Red Flag staffing incidents		9													18	-	58	-

Maternity		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	390 / 501	400 / 480	410 / 403	438 / 523	392 / 451	396 / 467	395 / 496	372 / 466	410 / 494	390 / 450	390 / 448	425 / 447	440 / 472	432 / 411	431 / 456	-	-	-
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	8	2	12	6	1	0	1	1	1	1	1	4	4	1	3	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	44.80% / 44.40%	44.25% / 43.00%	43.90% / 42.44%	41.10% / 48.40%	46.68% / 41.07%	40.91% / 47.47%	47.85% / 42.03%	47.85% / 42.47%	48.54% / 40.98%	48.46% / 37.69%	45.38% / 43.59%	45.65% / 39.76%	45.23% / 42.05%	48.61% / 40.51%	43.62% / 45.01%	-	-	-

Patient Experience		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients	3%		1.2%												1.3%	≤5%	1.1%	≤5%
		0%																	
23	FFT Negative Score - Maternity (postnatal ward)	10%		2.3%												2.4%	≤5%	2.7%	≤5%
		0%																	
24	Total UHS women booked onto a continuity of carer pathway	30%		12.4%												16.0%	≥35%	14.6%	≥35%
		0%																	
25	Total Global Majority women booked onto a continuity of carer pathway	100%		20.0%												27.6%	≥51%	17.6%	≥51%
		0%																	
25 - metric renamed from "BAME" to "Global Majority"																			
26	% Patients reporting being involved in decisions about care and treatment	100%		87.7%												85.8%	≥90%	85.7%	≥90%
		80%																	
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%		88.9%												90.4%	≥90%	88.0%	≥90%
		80%	258	317	221	353	247	296	323	273	483	491	442	504	416	357	276			
27 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
28	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	110		71												88	-	471	-
		0																	
29	Number of mental health patients spending over 12 hours in A&E	100		34												54	-	288	-
		0																	

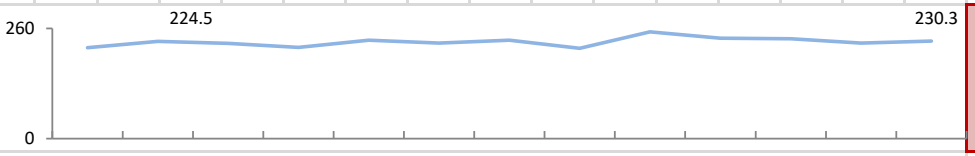
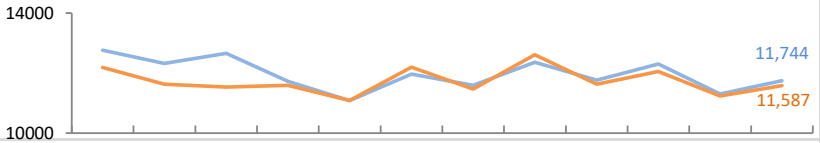
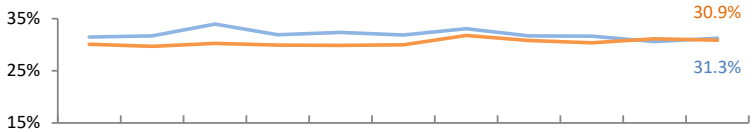
Access Standards		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	80%		65.5%												64.9%	≥78%	60.4%	≥78%
		40%	6	10	6	6	12	15	9	16	14	10	14	15	15	7	8			
			5	6	4	4	9	12	6	12	12	7	15	13	17	5	6			
31	Average (Mean) time in Dept - non-admitted patients	05:00		03:19												03:15	≤04:00	03:19	≤04:00
		02:00																	
32	Average (Mean) time in Dept - admitted patients	07:00		05:41												05:43	≤04:00	05:44	≤04:00
		03:00																	
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year	100%														97.9%	-	97.8%	>98.4%
		95%														97.1%			
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	70%		63.4%												61.0%	≥67.4%	63.0%	≥67.4%
		50%	4	4	4	4	4	4	4	4	3	3	3	3	4	6			
			3	4	4	3	5	5	5	7	6	5	5	6	5	6			
35	Total number of patients on a waiting list (18 week referral to treatment pathway)	65,000		59653												63160	-	63,160	-
		55,000																	
36	Percentage of patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	6%		1.92%												3.10%	1.0%	3.1%	1.0%
		1%	3	3	3	4	6	6	6	6	7	5	8	8	10	11			
			6	6	6	6	7	7	7	7	7	7	7	8	8	11			

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
37	Patients on an open 18 week pathway (waiting 52 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	1144														1956	0	1956	0
		2	2	2	2	3	3	3	3	2	2	2	4	5	8				
		9	8	9	8	9	9	10	9	9	9	9	10	11	12				
38	Patients on an open 18 week pathway (waiting 65 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	17														268	0	268	0
		1	1	2	1	2	2	1	2	2	4	8	12	13	13				
		4	4	6	4	5	6	7	7	9	10	13	15	16	14				
39	Patients on an open 18 week pathway (waiting 78 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	2														39	0	39	0
		9	9	4	8	8	1	5	5	6	1	1	10	16	20				
		7	6	6	7	8	1	4	6	7	1	1	14	16	18				
40	Patients waiting for diagnostics	8947														10172	-	10,172	-
41	% of Patients waiting over 6 weeks for diagnostics **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	12.7%														19.7%	≤5%	17.6%	≤5%
		5	5	5	6	6	6	6	6	7	9	9	9	10	11				
		6	6	6	8	9	8	9	6	7	10	11	9	10	9				

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

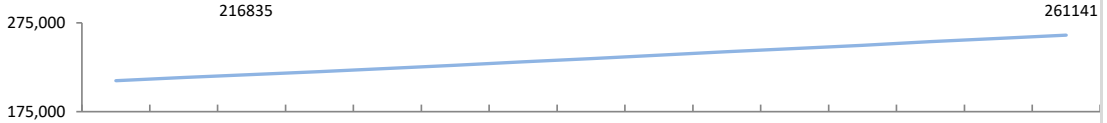
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks															65.3%	≥71.2%	65.3%	≥71.2%
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	78.6%	5	4	3	5	4	4	2	10	4	10	3	10	7	75.8% 9	≥75%	75.4%	≥75%
			3	2	2	2	1	2	2	4	2	3	2	6	2	4			
44	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	82.1%	2	2	1	1	1	3	3	6	5	3	9	16	10	80.5% 5	≥80%	78.6%	≥80%
			5	5	2	3	1	5	2	4	5	2	5	18	5	5			
45	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	96.3%	10	6	12	9	10	13	6	14	11	7	7	10	9	94.7% 11	≥96%	95.4%	≥96%
			8	7	6	6	6	6	5	8	7	7	7	7	7	7			

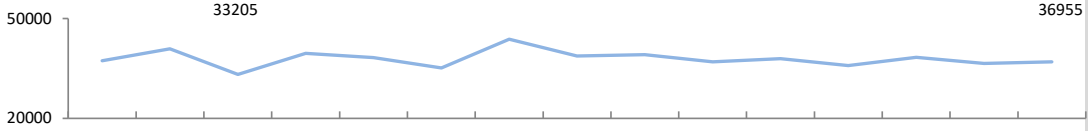
R&D Performance		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
46	Recruitment performance ranking	9	9	8	10	8	8	9	10	11	16	7	7	5	5	6	Top 10	-	-
47	Performance in initiating clinical trials	100%	44%	38%	78%	36%	70%	44%	47%	44%	40%	53%	39%	67%	87%	55%	≥80%	-	-
48	Performance in delivering clinical trials										23%	23%	35%	21%	21%	23%	≥80%	-	-
49	Proportion of sponsored studies open/on track										81%	82%	84%	87%	87%	87%	≥80%	-	-

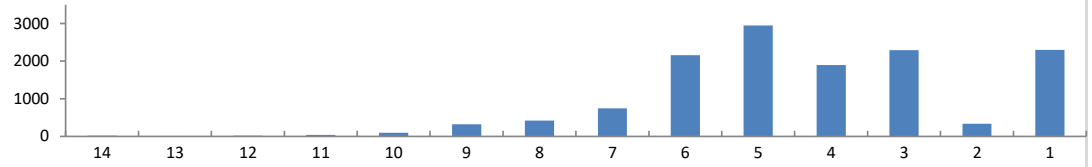
Local Integration		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	232	-
51	Emergency Department activity - type 1 This year vs. last year																-	71,074	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	31.6%	≥25%

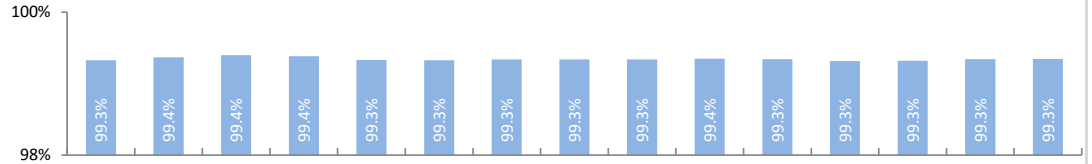
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month

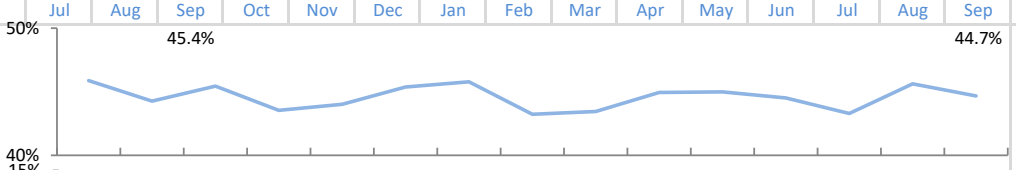
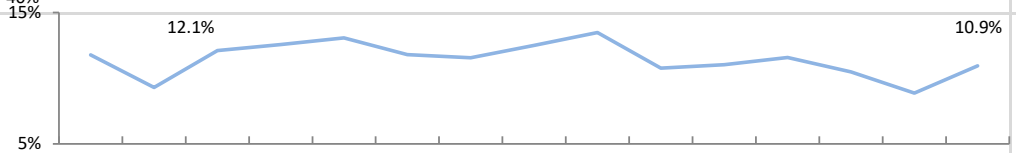
Digital		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			216835												261141	-	261,141	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			33205												36955	-	222,511	-
54 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
55	Average age of IT estate Distribution of computers per age in years																-	-	-
56	CHARTS system average load times - % pages loaded <= 3s																		
56 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			









Health Inequality		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted																-	44.7%	-
58	Percentage of under 18s attending emergency departments to be admitted																-	10.6%	-

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.8 Report to the Trust Board of Directors, 11 November 2025	
Title:	Finance Report 2025-26 Month 6
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Philip Bunting, DoOF and Anna Schoenwerth, ADOF

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

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

The headlines for the September report are as follows:

- A revised delivery trajectory, submitted to NHS England in August as part of the Trust's Financial Recovery Plan (FRP), signalled a full year deficit risk of £54.9m (assuming non receipt of H2 deficit support funding). This was dependent on £23.0m of financial improvement.
- The Trust has reported a £5.4m deficit in M6 (£30.8m deficit YTD). This is in line with the FRP trajectory for M6, but £4.2m above the original plan submitted to NHS England (£14.2m adverse to plan YTD). The Trust originally submitted a full year plan to achieve a breakeven position.
- The underlying deficit has shown a marginal improvement in M6 to £6.4m which is £1.0m higher than the reported position due to one off benefits.
- WTEs continue to be on a downward trajectory overall and decreased by 152 in M6 to 13,177 helping reduce pay costs by £0.2m in month.
- Whilst the trajectory is improving overall, it is not yet at the pace required to deliver the original plan. Cost improvements have been offset by other pressures, such as reductions to income levels in a number of areas and a pay award funding shortfall.
- Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, non-criteria to reside patient volumes increasing and inpatient mental health patient costs remaining high.
- Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. This includes a weekly FIG (Finance Improvement Group) supported by the Financial Improvement Director and chaired by the Chief Executive Officer. This includes an additional weekly non-pay review panel.
- UHS continues to deliver significant levels of financial savings, £6.5m has been achieved in M6 and £43.5m YTD. This is however £2.5m behind plan. Transformation programmes centred around patient flow, theatre optimisation and outpatients remain core to this.
- Cash has decreased to £42.1m in month; however, has been underpinned by one off support. There is a significant risk in 2025/26 that the Trust will require cash support from NHS England.

Contents:

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

UHS Finance Report – M6

Financial Position

In M6, the Trust reported a £5.4m deficit, £4.2m adverse to the annual plan. The Trust's underlying position has marginally improved in M6 to £6.4m deficit.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
Plan 25/26	(4.39)	(3.76)	(3.43)	(2.09)	(1.68)	(1.27)	**(16.62)**
Actual 25/26	(4.39)	(3.76)	(4.50)	(6.85)	(5.86)	(5.43)	**(30.78)**
Actual Variance to Plan	(0.00)	0.00	(1.07)	(4.75)	(4.18)	(4.15)	**(14.16)**
Underlying Position 25/26	(8.75)	(8.21)	(7.71)	(6.84)	(6.45)	(6.44)	**(44.40)**
Underlying Variance to Plan	(4.35)	(4.46)	(4.29)	(4.75)	(4.77)	(5.16)	**(27.78)**

Key driving factors of the UHS position include:

- UHS were set an extremely challenging target of delivering a breakeven plan, noting pressures within the starting underlying position, with activity levels above contract funding levels, NCTR and MH pressures. The Trust signed up to deliver the plan, but highlighted significant levels of risk, including the reliance upon the Trust achieving £110m (9%) of real cash releasing savings.
- The plan relied upon a set of assumptions. Despite positive CIP delivery to date, a number of those assumptions have not held true – notably:
    - Activity levels are above contracted levels
    - NCTR has not improved, but has instead deteriorated
    - MH has not improved, but has instead deteriorated
    - New unexpected pressures have materialised, including the impact of industrial action and the income received for the pay award not covering the full costs
    - Workforce reduction targets have been challenging to deliver in full, with a reduced turnover rate and lack of funding to support cost of change (e.g., MARS programme costs were expected to be funded)
    - The Trust has delivered less recurrent CIP than targeted, off-set by an increase in non-recurrent CIP, putting pressure on the monthly underlying run-rate.
    - The Trust has seen an unplanned reduction in income levels following the plan submission, including:
        - Unplanned cut in Genomics funding
        - Unplanned reduction in funded activity from Channel Islands (replaced by unfunded growth in NHS activity)
        - Unplanned loss of pathology income (contracts from other systems repatriating activity to their host system)
        - Reduction in private patient activity
- Our underlying financial position is improving on a monthly basis, with a reducing workforce trajectory following management actions including a recruitment freeze, MARS programmes and divisional restructure. However, the position has not improved quickly enough to keep pace with the plan.
- In M6 we have reported a £5.4m deficit (£4.2m adverse variance to plan) which was £1.0m lower than the underlying position. £0.9m one-off 2024/25 ERF income was identified in M6, based on the latest refreshed data.
- YTD UHS continues to accrue for £6.7m of ERF income for M1-6. There is a risk that commissioners will provide the Trust with an Activity Management Plan, which may require the Trust to reduce activity to affordable levels in the coming months.

- Due to specific areas of operational pressure and clinical risk, our outsourcing expenditure is £2.8m adverse to plan at M6, driven by Spire Cardiac and Dermatology activity. This is partially driving the ERF overperformance outlined above.
- CIP is reporting below plan by £2.5m YTD to M6 with achievement of £43.5m reported. There is however an underachievement of £14.2m on recurrent CIP offset by an overachievement of £11.6m on non-recurrent CIP.
- The Trust is working hard to improve its financial recovery, with robust governance including a weekly Financial Improvement Group. We have taken difficult decisions around workforce and reducing expenditure on insourcing and outsourcing, which has started to impact performance.
- The underlying position includes a pressure of the number of NCTR patients remaining in the Trust, meaning bed capacity is over optimal levels. Despite this challenge significant progress has been made with regards to ward closures with two wards currently closed.
- A further challenge is the number of Mental Health patients attending the Trust. Recently our MH provider has had success in repatriating activity from out of area; however, bed pressures and NCTR within their beds means patients are remaining in hospital beds. This creates a significant additional cost, including utilising specialist agency to ensure we have sufficiently skilled staff capacity to care for these patients safely often including additional security costs.
- The Trust remains committed to delivering significant financial improvements in-year; however, it remains an extremely challenging position, and we are unable to continue to absorb additional cost pressures.
- A Financial Recovery Plan (FRP) has now been developed to refocus efforts on financial improvement and respond to the scale of challenge faced in year.

Financial Improvement - CIP

The Trust continues to target month on month financial improvement from its savings and transformation programmes. Key highlights for M6 include the following:

- UHS has delivered £6.5m (>5% of addressable spend) of CIP in M6, which is £2.4m below the 25/26 annual plan. This brings the YTD achievement of CIP under plan by £2.5m with £43.5m delivered against a target of £46.0m.
- Workforce controls continue to be embedded, targeting reductions of 5% in divisions and 10% in corporate departments. The Trust is £5.5m adverse to the pay expenditure plan in M6 but has delivered additional workforce savings month on month.
- UHS is currently utilising agency for just 0.4% of our total workforce, significantly below the national target. Just 57 agency WTE were utilised in month mainly relating to the support of mental health patients.
- The Financial Improvement Group is now established and meeting weekly. This group has approved initiatives across a number of different programmes and projects all targeting sustainable cost reductions and increased efficiency.

Workforce Expenditure

There has been a decrease in the total workforce of 152 WTEs; workforce numbers are below average levels seen in 24/25 and strict workforce controls continue to be in place.

Total pay decreased in month from £70.8m to £70.6m. The pay award has been fully accounted for, generating a YTD pressure of £1.2m with an ongoing £0.2m per month pressure resulting from funding not covering costs in full.

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

Corporate Services

All Trusts in England were set a target of reducing expenditure on Corporate Services by 50% of the growth since 2019/20. This was adjusted for service developments and specific investments (e.g. Microsoft licence costs in digital). As part of this, UHS were set a target of £47.3m.

UHS workforce controls and corporate non-pay savings target means the Trust are on track to deliver against this target in full, with expenditure of £23.5m in M1-6.

We have also recently received the results of the 2024/25 corporate services benchmarking exercise, with the Trust being in the top or second quartile across all metrics, improving on the 2023/24 position.

	Digital & Technology		HR	Governance & Risk	Finance †	Procurement	Legal	Payroll
	Transactional	Non-transactional						
National quarter	1	2	1	1	1	2	2	1
Quarter change from last year	▬	▬	▲	▬	▬	▲	▬	▬

This will be explored in more detail in a future benchmarking report.

Net Risk Reporting / Financial Recovery Plan (FRP)

The Trust is currently reporting net risks of £54.9m consistent with the FRP trajectory. This includes the assumption that H2 deficit support funding of £5.3m will not be received.

The FRP has now been shared within NHS England for regional oversight and review. Several discussions have taken place over the last month to provide additional clarity around underpinning assumptions and areas of targeted improvement. A more formal meeting with NHS England executives is due to take place in November 2025.

Exit Underlying Position Reporting

As part of preparation for future years plans the Trust has been asked to provide analysis of its underlying position. This differs from the YTD underlying position reported above as it is focussed on the Trust's exit position (i.e., the M12 underlying run-rate), with a view on the impact on 2026/27 planning.

This continues to be reported as a deficit of £40.6m which is consistent with:

- The year-end position forecast within the FRP trajectory which totals £2.5m per month underlying deficit (£30m per annum), aligned to the contract funding gap, for which we anticipate additional funding in 2026/27.
- The removal of non-recurrent deficit support funding of £0.9m per month (£10.6m per annum), which adds to the contract funding gap, for which we anticipate additional funding in 2026/27.

The Trust is requesting that it is fully funded for expected levels of activity in 2026/27. If this is achieved, the Trust exit run-rate position would be breakeven from April 2026 – consistent with the targeted improvement within our FRP.

Capital

Capital expenditure to M6 is £9.6m (£6.7m below plan) with delays across several projects suppressing expenditure. An internal capital forecast of £29.5m is still expected to be achieved in full over 2025/26. Slippage has however been reported across Strategic Maintenance, the Community Diagnostic Centre (CDC), and several other estates projects with mitigation plans currently being worked through.

There has been minimal spend on externally funded schemes at M6, as planning and designs are still being finalised to secure funding arrangements. Several new bidding opportunities have also recently been subject to review and response by the Trust.

Forecast capital expenditure for the year is currently projected at £73.1m, of which 60% (£43.6m) is externally funded and 40% (£29.5m) internally funded. This may increase further if bids are successful.

Cash

The Trust ended the month with a cash balance of £42m. However, this was supported by advance payments from HIOW ICB. Without this repayable advance funding, the Trust cash position would have been significantly challenging. The Trust is engaging with NHS England seeking cash support, which will be discussed further in the Closed Session.

Report To	Board meeting in Public		
Title of Paper	System Report 2025/26 (Month 6)		
Purpose of Paper	For information	**Date of Meeting**	5 November 2025
Author	Natasha Taplin, Director of System Performance Improvement	**Agenda Item**	Item no. will be added by Governance team
Executive Sponsor	James Lowell, Interim Chief Delivery Officer	**Clinical Sponsor**	If applicable

Prior Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
Executive Committee	21 October 2025	For information
Future Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
	Click or tap to enter a date.	

Executive Summary

This report provides the Board with a summary of how the Hampshire and Isle of Wight system is performing against the 2025/26 operating plan, highlighting areas of non-delivery and what actions are being taken to mitigate key risks.

Please note that Month 6 (M6) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 5 (M5), with some exceptions depending on reporting frequency.

Performance Overview

This report provides an overview of in-month performance against operating plan metrics based on latest published data and highlights 13 headline metrics currently performing worse than plan across the Hampshire and Isle of Wight system. This represents an increase against previous month (11 metrics). The metrics below plan in current month reporting are:

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M6)
- Access to general practice – number of available appointments (M5)
- Adults in inpatient care who are autistic, with no learning disability (M5)
- Access to Children and Young People's Mental Health Services (M5)
- Diagnostic 6 week waits (9 key tests) (M5)
- Cancer 28 day faster diagnosis (M5)
- Cancer 62 day referral to treatment (M6)
- Time to First Appointment (M6) – *unvalidated*
- RTT 52 week waits (M5)
- RTT waiting list within 18 weeks (M5)
- Emergency Department 4 hour performance (total mapped footprint) (M6)
- % of attendances in A&E over 12 hours (M6)
- Category 2 ambulance response times (M6)

Quality Overview

Quality overview can be found on pages:12-15

Financial Overview

The purpose of the Month 06 (M6) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position for the ICS as at the end of September 2025.

The ICS position in month 6 is a deficit of £5.37m compared to a planned deficit of £1.22m, so £4.15m adverse variance to plan in month.

The ICS is reporting a year-to-date deficit of £47.65m, compared to a planned year-to-date deficit of £33.66m, so £13.99m adverse variance to plan.

The ICS submitted a £0.468m surplus plan for 2025/26, and forecast outturn is unchanged, in line with the plan.

Workforce Insights

Month 6 Workforce Performance Overview (September)

- Total Workforce: 48,147 WTE, which is 239 WTE worse than submitted plan. Compared to August 2025, the system saw a net decrease of 259 WTE.
    - Trusts better than plan: HHFT (14 WTE), HIOWH (147 WTE).
    - Trusts worse than plan: IOW (89 WTE), PHU (124 WTE), SCAS (135 WTE), UHS (53 WTE).
    - Substantive: 184 WTE worse than plan.
    - Bank: 43 WTE worse than plan.
    - Agency: 12 WTE better than plan.

- Compared to March 2025 baselines in submitted Planning templates:
    - Total Workforce: Reduced by 1,147 WTE.
    - Substantive: Reduced by 756 WTE.
    - Bank: Reduced by 334 WTE.
    - Agency: Reduced by 57 WTE.

Recommendations	It is recommended that the Board: Notes the detail of this report and escalations for awareness and management of these.

Governance and Compliance Obligations	
Relation to Strategic Objectives	Please select which of the following strategic objectives this paper addresses: ☒ 1) Improve outcomes and reduce inequalities for the people of Hampshire and Isle of Wight ☒ 2) Work with partners to transform the local NHS into an effective and sustainable system

	☒ 3) Continuously improve the quality of and access to services for the people of Hampshire and Isle of Wight ☒ 4) Make best use of our resources by living within our means ☐ 5) Be an organisation that is a meaningful and fulfilling place to work.
Risk or Board Assurance Framework	No new risks to escalate. Please select which of the following BAF risks relate to your paper: ☐ 1A) **Strategic Commissioning for Population Health** – there is a risk that NHS Hampshire and Isle of Wight is unable to strategically commission effectively for improved population health outcomes and reduce health inequalities across its population. ☐ 2A) **System Delivery of Core Standards** – there is a risk that NHS Hampshire and Isle of Wight is unable to use strategic commissioning to enable the delivery of core system standards and capabilities through collaboration, innovation and continuous improvement. ☐ 2B) **Enable Sustainable System Change** – there is a risk that NHS Hampshire and Isle of Wight is unable to create the conditions through its leadership, commissioning and partnerships to enable system change at the pace and scale required to meet the changing needs of the population and achieve system sustainability. ☐ 2C) **Organisational Transition Risk (temporary)** – there is a risk that ongoing organisational redesign disrupts strategic leadership and system coordination during the transition period. ☐ 3A) **Quality and Access** – there is a risk that system-wide quality standards of safety, experience, effectiveness and equitable access are not met. ☐ 4A) **ICB Financial Sustainability** – there is a risk that financial plans and sustainability measures are insufficient or fail to deliver annual plans or the required long-term financial resilience. ☐ 4B) **ICS Financial Sustainability** – there is a risk that the Integrated Care System's financial plans and sustainability measures are insufficient or fail to deliver annual plans or the required long-term financial resilience. ☐ 5A) **System Workforce Capability and Sustainability** – There is a risk that the system workforce is not sufficient, sustainable, capable or affordable to meet current and future population needs or deliver strategic priorities.
Regulatory and Legal Implications	Standard Operating Framework Ratings, Regulatory Standards

Financial Implications	See Finance section of the report.
Communications and Stakeholder or Staff Engagement Implications	There are no specific communications and stakeholder/staff engagement implications from this report.
Patient or Staff Implications	Summarises Key Performance Indicators linked to Constitution and Regulatory Standards. Indicates pressures faced by NHS workforce.
Equality Impact Assessment **Quality Impact Assessment**	This paper provides an aggregated overview of performance in Hampshire and Isle of Wight. Equality and Quality Impact Assessments are carried out across commissioners and providers; these are reported through organisational Boards. The System Quality Board maintains oversight of Quality. The Prevention & Health Inequalities Board maintains oversight across health and care and the People Board maintains oversight across the workforce. Systemic measurement and reporting of equality objectives is being developed, building on public sector equality duty and NHS standards. NHS Hampshire and Isle of Wight will need to set new equality objectives. The measures in future iterations of this report will allow the Board to track progress against equality measures at that aggregate level, although this report does not replace any regular assurance reports from those domains or any deep dive reports requested by the Board.
Data Protection Impact Assessment	N/A
Appendices or Supporting Information	N/A

1. Introduction

This report serves as an overview of the Hampshire and Isle of Wight Integrated Care System's performance against the national priorities and success measures outlined in the NHS operational planning guidance for 2025/26. It should be considered alongside reports noting the financial, workforce and transformation overview for the system.

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

This report is based on data published on 9 October 2025 – up to September 2025 for Urgent and Emergency Care metrics and up to August 2025 for Planned Care, Local Care, Primary Care, Mental Health / Learning Disability and Autism metrics.

2. Operating Plan Summary

In the 2025/26 operating plan, there are a total of 42 performance metrics (not including activity metrics) – for the purpose of this report, we have categorised the performance metrics under three sub-headings: headline metrics, drivers and enablers.

In October 2025, NHS Hampshire and Isle of Wight is ranked red against 13 headline operation plan metrics:

- **Percentage of beds occupied by patients not meeting the Criteria to Reside (NCTR)** - % of beds occupied by patients not meeting the criteria to reside remains significantly above the 12% target (no operating plans set in 25/26), increasing in M6 to 23.3% (compared to 22.9% in M5).

- **Access to general practice – number of available appointments** - performance in M5 is 6.7% below plan.

- **Adults in inpatient care who are autistic, with no learning disability (M5) -** There remains a shortage of admission alternatives for Autistic Adults (aged 25+) - in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Access to Children and Young People's Mental Health Services (M5) -** below M5 plan with 24,905 vs 25,413 target.

- **Diagnostic 6 week waits (9 key tests) (M5) –** Performance in M5 shows a deteriorating position for the diagnostic 9 key tests, and remains above the operating plan of 28.6%.

- **Cancer 28 day faster diagnosis (M5) -** Performance in M5 is 1.9% below plan at 77.4%. This represents a marginal decline on previous month.

- **Cancer 62 day referral to treatment (M6) -** Performance in M5 deteriorated significantly to 70.5% (compared to 73.6% in M4), not achieving plan.

- **Time to First Appointment (M6) – *unvalidated* –** Latest M6 position shows ICB is 4% below plan, however, this is based on unvalidated data and is subject to change. M5 was 3.1% below plan.

- **RTT 52 week waits (M5) -** In M5, 6,114 patients are waiting over 52 weeks, representing an increase on M4 (5,831) and not achieving plan. All providers are above plan in M5.

- **RTT waiting list within 18 weeks (M5) –** Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has declined marginally to 62% in M5 (compared to 62.3% previous month) – not achieving in-month plan by 0.1%.

- **Emergency Department 4 hour performances (total mapped footprint) (M6) -** Performance in M6 deteriorated to 76.7% (compared to 78% previous month) – not achieving the 78% standard.

- **Percentage of attendances in A&E over 12 hours (M6)** Waits from decision to admit (DTA) increased in M6 to 1,286 (compared to 1,058 previous month) and % over 12 hours from arrival decreased in M6 to 3.9% (compared to 7.3% previous month), but remaining above M6 plan (e.g. not achieving).

- **Category 2 ambulance response times (M6) -** performance declined in M6 and is marginally above in-month plan (by 11 seconds) and the 30-minute operating plan ambition.

National priorities / success measures for 2025/26 currently achieving plan / expected to maintain plan are as follows:

- **Primary Care Access –** based on current YTD performance and the increase in appointments offered compared to same period previous year.

- **Units of Dental Activity -** performance in Jun 25 (latest published data) shows 83.7% vs 79.3% Q1 plan (e.g. achieving).

The following metrics are national priorities, but there is no data currently published for the 2025/26 financial year:

- **% of patients with hypertension treated according to National Institute for Health and Care Excellence (NICE) guidance** – latest position for March 2025 shows 68.3% vs 80% national target.

- **% of patients with GP recorded Cardiovascular Disease (CVD), who have their cholesterol levels managed to NICE guidance** – latest position for March 2025 shows 58.7% vs 65% national target.

National comparators (where available) for headline metrics not achieving plan are reflected below:

- **Percentage of beds occupied by patients not meeting the Criteria to Reside (NCTR) –** NHS Hampshire and Isle of Wight are ranked 40 out of 42 Integrated Care Boards for their September performance with 719 patients with no CTR as at 30 September 2025, which is 23.7% of total G&A beds available. (Lowest quartile)
  The National average is approximately 13.9%

- **Access to Children and Young People's Mental Health Services (M5) -** are ranked 11 of 42 Integrated Care Boards for their August performance with 24,905 (Interquartile).

- **Diagnostic 6 week waits (9 key tests) (M5) –**– NHS Hampshire and Isle of Wight are ranked 35 of 42 Integrated Care Boards with a total of 32.8% of patients waiting over 6 weeks for diagnostic testing. (Lowest quartile)
  The national average is 24%

- **Cancer 28 day faster diagnosis (M5) -** NHS Hampshire and Isle of Wight are ranked 13 of 42 Integrated Care Boards for their August performance with 77.4% (Interquartile)
  The national average is 74.6%.

- **Cancer 62 day referral to treatment (M6) –** NHS Hampshire and Isle of Wight are ranked 19 of 42 Integrated Care Boards for their September performance with 70.5% (Interquartile)
  The national average is 69.1%

- **RTT 52 week waits (M5) –** NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their August performance with 3.2% (Lowest quartile)
  The national average is 2.6%

- **RTT waiting list within 18 weeks (M5) –** NHS Hampshire and Isle of Wight are ranked 18 out of 42 Integrated Care Boards for their August performance with 62% (Interquartile)
  The national average is 61%

- **Emergency Department 4 hour performances (total mapped footprint) (M6) –** NHS Hampshire and Isle of Wight are ranked 12 out of 42 for their September performance with 76.7%. (Interquartile)
  The national average is 75%.

- **Percentage of attendances in A&E over 12 hours (M6**) – NHS Hampshire and Isle of Wight are ranked 9 out of 42 Integrated Care Boards for their September performance with 7.7% (Highest quartile)
  The national Average is 9.8%

- **Category 2 ambulance response times (M6) –** NHS Hampshire and Isle of Wight are ranked 7 out of 11 for their performance in September with 30:44.
  The national Average is 30:46.

3. Integrated Care System Financial Overview

3.1 Purpose

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

3.2 Background

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

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

At close of M6 the Hampshire and Isle of Wight system has received Q1 and Q2 of the DSF (M1 to M6). Deficit Support Funding for Q3 (M7 to M9) has been withheld by NHS England following the adverse financial performance reported at M5. NHS England have advised systems where Q3 DSF was withheld to anticipate earning this funding back in Q4 (M10 to M12) but this will be conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

3.3 Financial Position

Table 2 below summarises the in-month and year-to-date financial position as at Month 06 (September) for all Hampshire and Isle of Wight organisations:

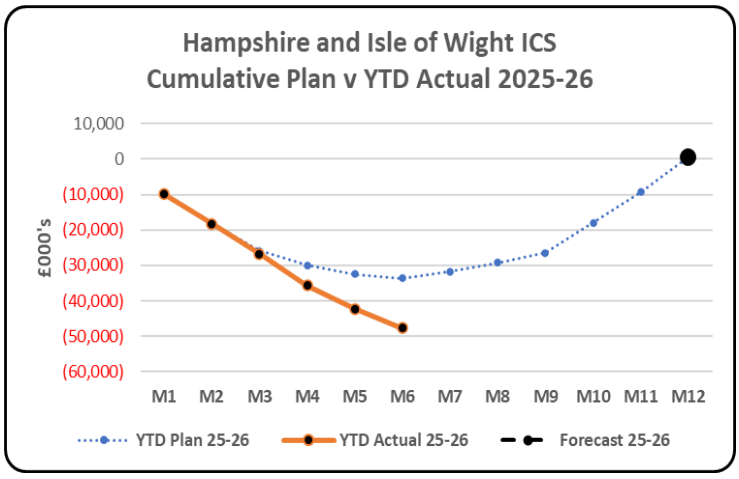
Table 2: Summary of M06 results

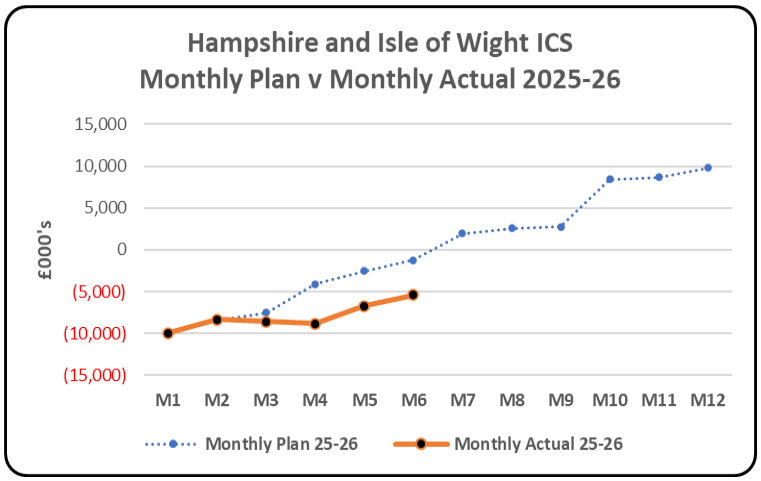
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	(1,220)	(5,367)	(4,147)	(33,659)	(47,653)	(13,994)	468	469	1

In September 2025 itself, the ICS reported a deficit of £5.37m against a planned deficit of £1.22m, so £4.15m adverse variance to plan. Year-to-date the system has reported a deficit of £47.65m at Month 06 compared to a planned deficit of £33.66m, therefore £13.99m adverse variance to plan.

The graphs below summarise the ICS position reported at month 06 (September) 2025/26.

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





3.4 System Actions to Support Financial Recovery

In 2023/24, additional controls were developed and implemented, aligned to those required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remain extant in 2025/26.

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

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

4 Workforce

Month 6 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is worse than plan by 239 WTE in M6 2025/26, broken down by Substantive (184 WTE), Bank (43 WTE) and Agency (12 WTE).
- Compared to August 2025, the system saw a net decrease of 259 WTE.
- Trusts worse than plan are Isle of Wight (89 WTE), Portsmouth Hospitals University (124 WTE), South Central Ambulance Service (135 WTE) and University Hospital Southampton (53 WTE). Better than plan are Hampshire Hospitals (14 WTE) and Hampshire & Isle of Wight Healthcare (147 WTE).

Month 6 - Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 184 WTE worse than plan.
- Trusts worse than plan are Isle of Wight (86 WTE), Portsmouth Hospitals University (135 WTE), South Central Ambulance Service (77 WTE) and University Hospital Southampton (132 WTE). Better than plan: Hampshire Hospitals (31 WTE) and Hampshire & Isle of Wight Healthcare (214 WTE).
- 'Registered Nursing, Midwifery' and 'Any Other Staff' staff groups are better than plan by 202 and 2 WTE, respectively. Whilst 'NHS Infrastructure Support' is worse than plan by 173 WTE, alongside 'Registered Qualified Scientific' (109 WTE), and Medical & Dental (104 WTE) staff groups.

Month 6 - Bank & Agency Trajectories – Whole Time Equivalent (excluding Integrated Care Board)

- Total Temporary staffing usage is 2,656 WTE, 55 WTE (2.1%) worse than the plan of 2,601 WTE.
- In Month 6, both Bank & Agency usage are worse than plan by 43 WTE (1.9%) & 12 WTE (4.0%), respectively.
- Better than plan for Bank & Agency combined: Portsmouth Hospitals University (11 WTE) and University Hospital Southampton (79 WTE).

5. Quality

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

The key quality challenges this month fall into the following categories:

- **Workforce:** staffing gaps across all care sectors (including social, primary, secondary, mental health, autism, and learning disability) are affecting access, waiting times, supervision, training, and overall experience for both service users and staff.
- **Demand and capacity:** challenges across all pathways in relation to demand, capacity (including access to equipment) and access are leading to delays, increased waiting times, patient harm, and poor experiences, with responses which may impact the wider system.
- **Surgical safety:** the need for continued focus on embedding the National Safety Standards for Invasive Procedures (NatSSIPs).

5.1 Regulatory

5.1.1 Care Quality Commission: during September 2025, thirteen Care Quality Commission inspection outcomes were published for Hampshire and Isle of Wight. Twelve related to social care (care homes and home care) and one to General Practice. Peartree Practice remained rated as overall *good* following their assessment in June 2025.

5.1.2 Care Quality Commission – General Practice: 124 of the 128 Hampshire and Isle of Wight GP Practices currently hold an overall *Good* (123) or *Outstanding* (1) rating with the Care Quality Commission. One GP Practice is rated as *Requires improvement* and another as *Inadequate* and two remain unrated.

5.1.3 Quality Assurance and Improvement Surveillance Levels: all the large NHS providers remain in routine quality assurance and improvement surveillance levels. This position will be reviewed at the next System Quality Group in November 2025.

5.2 Patient and Staff Experience

5.2.1 Friends and Family Test Performance – July 2025: listening to those that use our services to help identify areas to improve or share good practice is key. The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

- **Emergency Department:** performance suggests Emergency Department services are generally well-regarded across Hampshire and the Isle of Wight, with all Trusts apart from one achieving satisfaction rates above national performance
- **Inpatient:** performance generally highlights strong inpatient satisfaction across the system however, one Trust was below the national rate, with 92.3% positive feedback
- **Community:** positive feedback demonstrates improving variation and is above the national positive satisfaction rate
- **Mental Health:** performance higher than the national positive satisfaction rate has been demonstrated (94.4% in comparison to the national rate of 89.1%).

Average Friends and Family results across Hampshire and the Isle of Wight are strong, with all above the national rate, indicating overall good system-wide performance. Actions taken in response to Friends and Family feedback and other patient feedback is monitored through quality contract processes to ensure patient voices drive improvements.

5.2.2 Mixed-Sex Accommodation Breaches (up to July 2025): the NHS has a policy of eliminating mixed-sex accommodation except in cases where it is deemed clinically necessary. This is to create a more comfortable, safe, and dignified environment for all patients, ultimately contributing to a better overall healthcare experience. The NHS standard contract (Annex A, Service Conditions) requires providers to report the number of breaches on a monthly basis, and this performance is monitored as part of quality contracting.

All providers, apart from two reported mixed sex accommodation breaches in July 2025. Across Hampshire and Isle of Wight, in July 2025 there were 62,145 finished consultant episodes (an increase on the previous month) and 116 mixed-sex accommodation breaches (a decrease of one in comparison to the previous month and representing a rate of 1.9).

Trusts actively manage breaches to uphold patient privacy and dignity, aiming for prompt resolution. Hospital estate design influences breach risk, for example, facilities with en-suite bays are less likely to experience breaches.

A review of provider mixed sex accommodation processes and reporting is planned to take place during Qtr. 3, 2025/26.

5.3 Safety

5.3.1 Infection Prevention and Control – August 2025: the NHS standard contract (Annex A, Service Conditions) requires providers to have zero cases of Methicillin-resistant Staphylococcus aureus and to perform within their individually assigned thresholds for Clostridium difficile and gram-negative bloodstream infections. Key areas to note include**:**

- **Methicillin-resistant Staphylococcus aureus:** the threshold for Methicillin-resistant Staphylococcus aureus is zero, Hampshire and Isle of Wight did not report any cases during August 2025. However, to date, the system has reported eight cases.
- **Clostridium difficile infections:** fifty-eight cases were reported in August 2025 across the Hampshire and Isle of Wight leading the system to be 47 cases above planned trajectory (although one case below this time last year) but remaining below the annual threshold of 521.
- **Escherichia coli:** 131 cases were reported across the System in August 2025 with performance 97 cases above trajectory but remaining below the annual threshold of 1250**.**

5.3.2 **Never Events**: five Never Events were reported in September 2025, of which only one took place during that month. All incidents are being investigated by the relevant Trust and improvement actions taken in response.

Over the last two years, the local quality contract has supported providers in embedding the National Safety Standards for Invasive Procedures (NatSSIPs). There is an expectation that these procedures will be fully embedded by 2026/27. Compliance will be monitored as part of the contract through regular provider audit and reporting with evidence of Board oversight.

5.3.3 **Update on the Never Event Framework review:** the National Patient Safety Team has written to Patient Safety Specialists to inform them that their comprehensive consultation revealed that a number of respondents considered the current Never Events framework unfit for purpose. They noted strong support for revising the framework, particularly the definition and designation process. The proposed direction is to move away from the requirement that Never Events be “wholly preventable”, enabling a more practical and supportive approach to patient safety.

They advised that NHS England will now initiate a six-to-twelve-month discovery phase to further engage with stakeholders, including patients, NHS staff and Royal colleges.

The letter advised that the revised framework will:

- emphasise learning over rigid definitions
- align with Patient Safety Incident Response Framework (PSIRF) principles
- promote a just culture, encouraging open reporting by staff.

The current Never Events framework remains in place during the transition. Providers must continue to record qualifying events under the Never Event category in the Learn from Patient Safety Events (LFPSE) service. Organisations are now encouraged to adopt a proportionate response, focusing on learning and improvement, in line with the Patient Safety Incident Response Framework.

5.4 Clinical Effectiveness

5.4.1 Standardised Hospital-level Mortality Indicator (SHMI) – up to April 2025: all providers are reporting 'as expected' (Band 2) mortality rates apart from one Trust who is showing 'lower than expected' (Band 3).

5.4.2 Fractured Neck of Femur: compliance with the National Falls and Fragility Audit Programme (FFFAP) and Fractured Neck of Femur Best Practice Tarriff is reviewed monthly. The Best Practice Tariff (BPT) percentages show how much of the care delivered met the nationally agreed standards. Higher percentages assure that patients are more likely to receive care aligned with best outcomes.

In comparison to the July 2025 fractured neck of femur Best Practice Tarriff data:

- one Trust continues to stand out as a relative high performer – with prompt surgery well above the England performance and orthogeriatric, nutritional and delirium assessment performing between 98 – 100%
- one Trust has shown challenges across nearly all metrics and a decline in performance
- all Trusts saw a decline in physiotherapy assessment compliance
- all Trusts apart from one saw a decline (or no improvement) in orthogeriatric assessment.

Best Practice Tariff improvement plans will be monitored via usual contractual routes and through quality oversight. 30-day mortality remains below the national rate for all providers.

5.5 Quality Impact Assessments

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

During September 2025, four Quality Impact Assessments were reviewed at the NHS Hampshire and Isle of Wight weekly panel, of which two were submitted by providers.

6. Recommendations

It is recommended that the Board notes the detail of this report and escalations for awareness and management of these.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.10 Report to the Trust Board of Directors, 11 November 2025	
Title:	People Report 2025-26 Month 6
Sponsor:	Steve Harris, Chief People Officer
Author:	Workforce BI Team

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

Overall workforce fell during September and is now 54 WTE over NHSE plan. The 73 WTE reduction in substantive workforce was underpinned by the effects of continued recruitment controls, coupled with MARS exits. There has also been some capitalisation of IT posts (27 WTE).

There was a significant drop in bank expenditure during the month. This has been partly attributed to a reduction in NHSP shift fill in areas where rates have been reduced. In addition, an improved substantive fill rate in resident doctors (up to 97%) has resulted in less bank expenditure. In all bank fell by a total of 90 WTE, the largest drop seen for a number of months. There was however an increase in agency linked to mental health demands.

Further planned ward closures are linked to improvements in NCTR and should deliver temporary staffing savings if achieved. The temporary staffing plans are reliant on continued robust control in addition to internal and external efforts to manage capacity.

The capped substantive recruitment will continue throughout the year in line with ICB wide recruitment controls. The effect of recruitment freeze on non-clinical areas continues to drive overall reductions; however, it is also placing significant pressure on a number of admin and clerical areas and driving bank expenditure. Overall A&C in divisional areas has fallen by 71 WTE since March 25 (5%). THQ has WTE has fallen by 75 WTE (8%) since March 25. To manage critical risks, targeted A&C recruitment may be required to attempt to mitigate negative effects on clinical service affecting performance. This is in discussion at present between the executive and the Divisional teams.

The Trust celebrated we are UHS week in early October. In partnership with the Charity, this was an opportunity to focus on celebrating staff and showcasing innovation. Feedback from our people who engaged with the week was positive.

The Trust Board has also confirmed its commitment to increase UHS focus on violence and aggression, an issue which, despite sustained efforts from UHS, continues to be a real concern. The governance of the VAA agenda has been overhauled, and new resources and energy has been put into taking a tougher and more robust stance on poor patient and service user behaviour.

The national NHS staff survey has gone live in September with a current response rate of 29% against the national acute average of 34%.

Contents:	
The report contains workforce data and reporting set out against our People Strategy, Thrive, Excel and Belong pillars.	
Risk(s):	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.	
Equality Impact Consideration:	EQIA assessments undertaken as required for specific streams within the People Strategy

UHS People Report

WORLD CLASS PEOPLE

THRIVE EXCEL BELONG

September 2025

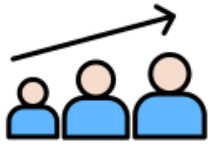
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M6 (Sep-25)

In-month sickness is currently 3.8%, 0.1% above target (3.7%).

Appraisal completion rates remained the same (71%)

R12m turnover rate (10.1%), which is below target (13.6%).



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

Bank usage decreased from prior month and is now 82 WTE below plan.

Increase in agency staffing. Agency is 4 WTE over plan.

Increase in patient safety incidents to 98 (70 in August)

Executive Summary

Overall workforce fell during September and is now 54 WTE over NHSE plan. The 73 WTE reduction in substantive workforce was underpinned by the effects of continued recruitment controls, coupled with MARS exits. There has also been some capitalisation of IT posts (27 WTE). There was a significant drop in bank expenditure during the month. This has been partly attributed to a reduction in NHSP shift fill in areas where rates have been reduced. In addition, an improved substantive fill rate in resident doctors (up to 97%) has resulted in less bank expenditure. In all bank fell by a total of 90 WTE, the largest drop seen for a number of months. There was however an increase in agency linked to mental health demands. Further planned ward closures are linked to improvements in NCTR and should deliver temporary staffing savings if achieved. The temporary staffing plans are reliant on continued robust control in addition to internal and external efforts to manage capacity.

The capped substantive recruitment will continue throughout the year in line with ICB wide recruitment controls. The effect of the recruitment freeze on non-clinical areas continues to drive overall reductions; however, it is also placing significant pressure on a number of admin and clerical areas and driving bank expenditure. Overall A&C in divisional areas has fallen by 71 WTE since March 25 (5%). THQ has fallen by 75 WTE (8%) since March 25. To manage critical risks, targeted A&C recruitment may be required to attempt to mitigate negative effects on clinical service affecting performance. This is in discussion at present between the executive and the Divisional teams.

The Trust celebrated we are UHS week in early October. In partnership with the Charity this was an opportunity to focus on celebrating staff and showcasing innovation. Feedback from our people who engaged with the week was positive.

The Trust Board has also confirmed its commitment to increase UHS focus on violence and aggression, an issue which, despite sustained efforts from UHS, continues to be a real concern. The governance of the VAA agenda has been overhauled, and new resources and energy has been put into taking a tougher and more robust stance on poor patient and service user behaviour.

The national NHS staff survey has gone live in September with a current response rate of 29% against the national acute average of 34%.

Overall Position

WTE Movement (M5 to M6)

Total Workforce

The total workforce **decreased by 152 WTE** to 13,177 WTE from M5 (13,329) to M6.

During this period, the substantive workforce decreased by **73 WTE**, while the total temporary staffing decreased by **79 WTE.**

As of M6, the Trust is **above the total plan (by 54 WTE).**

Substantive WTE

Substantive WTE decreased by **73 WTE** between end of August and end of September.

The overall substantive decrease is largely driven by reduction of Admin and Clerical and Additionally Clinical Staff, with majority of THQ A&C reduction due to the capitalisation of EPR Project Posts (24.25 WTE).

Substantive workforce position for 25/26 has been adjusted to fully include UEL, and exclude all Capital hosted posts within DIGITAL, TDW GP Lead Employer and TDW Education Hosted posts.

Bank & Agency WTE

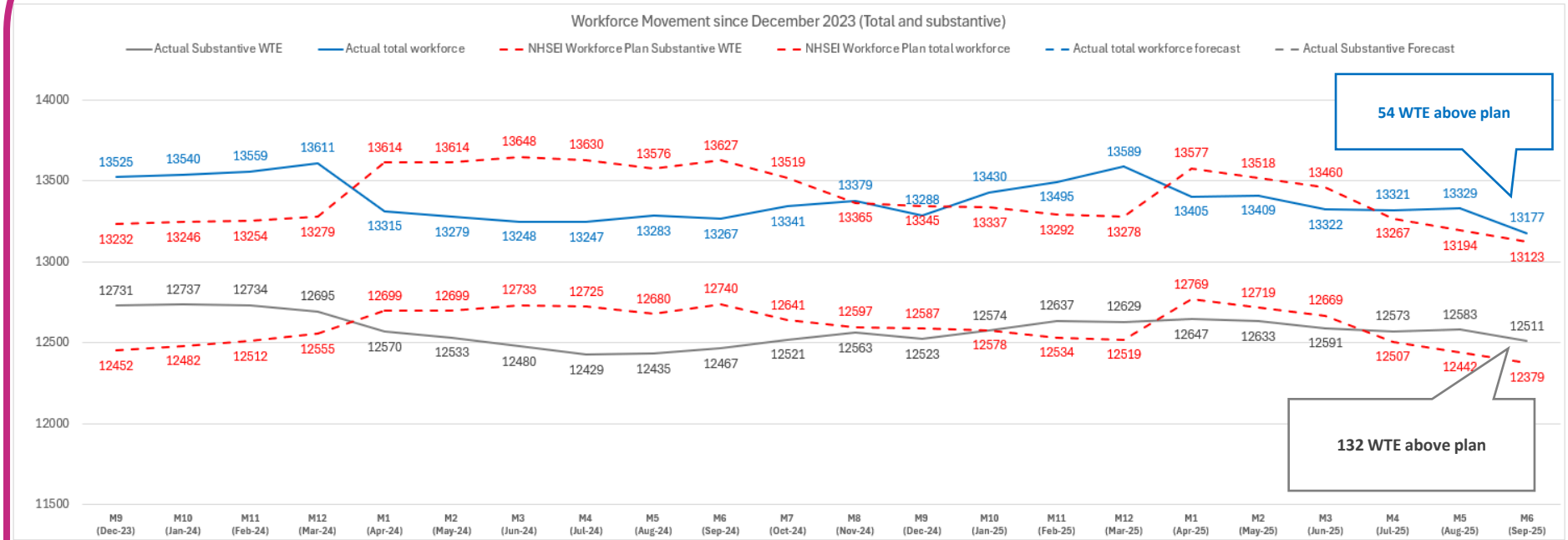
Total Bank and Agency usage decreased by 79 WTE in September 2025.

Bank decreased in September by 13%, while
Agency usage **increased** in August by 24%.

Ongoing Pressures
Mental health demand continues to present safety, quality, and financial challenges for the Trust.

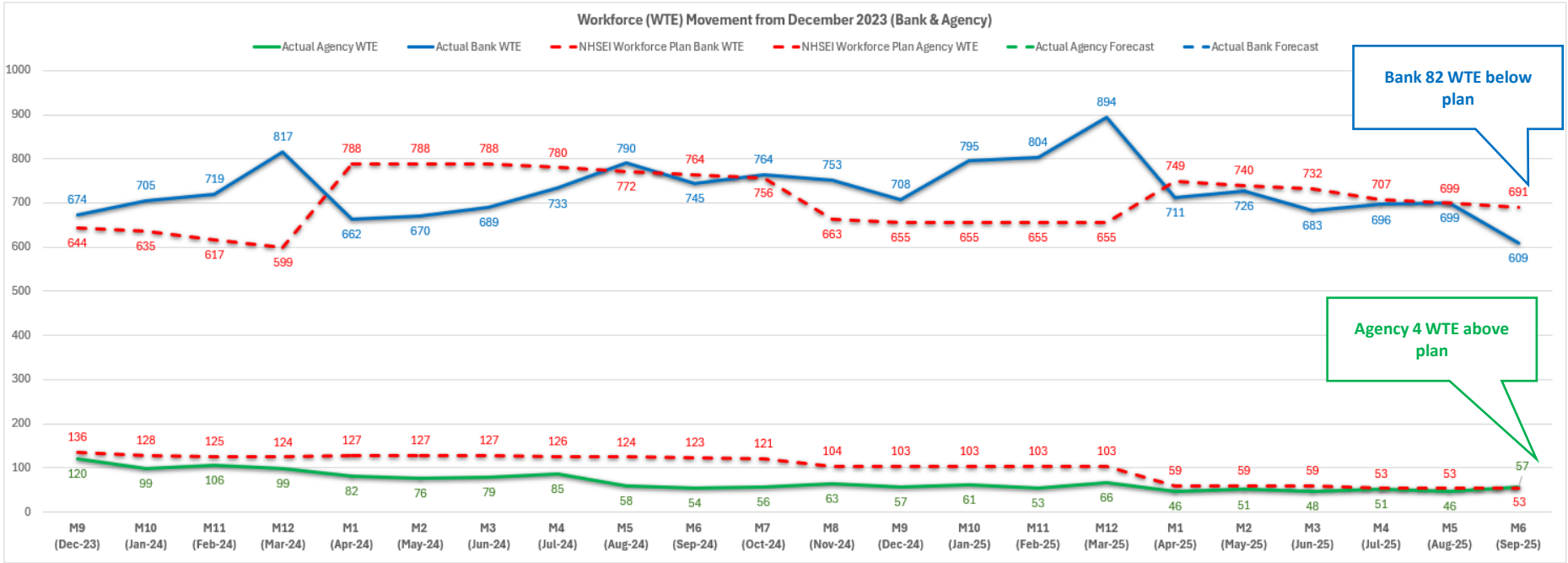
Enhanced Bank Rate Reduction
Nursing Bank band 5 shifts that were previously receiving a Band 6 pay rate have been reduced to align with AfC band. An initial impact on bank fill rates was observed; however, this has recovered in most areas, except for Theatre Scrub. Staff remain concerned by the reduction.

Workforce Trends: Total & Substantive



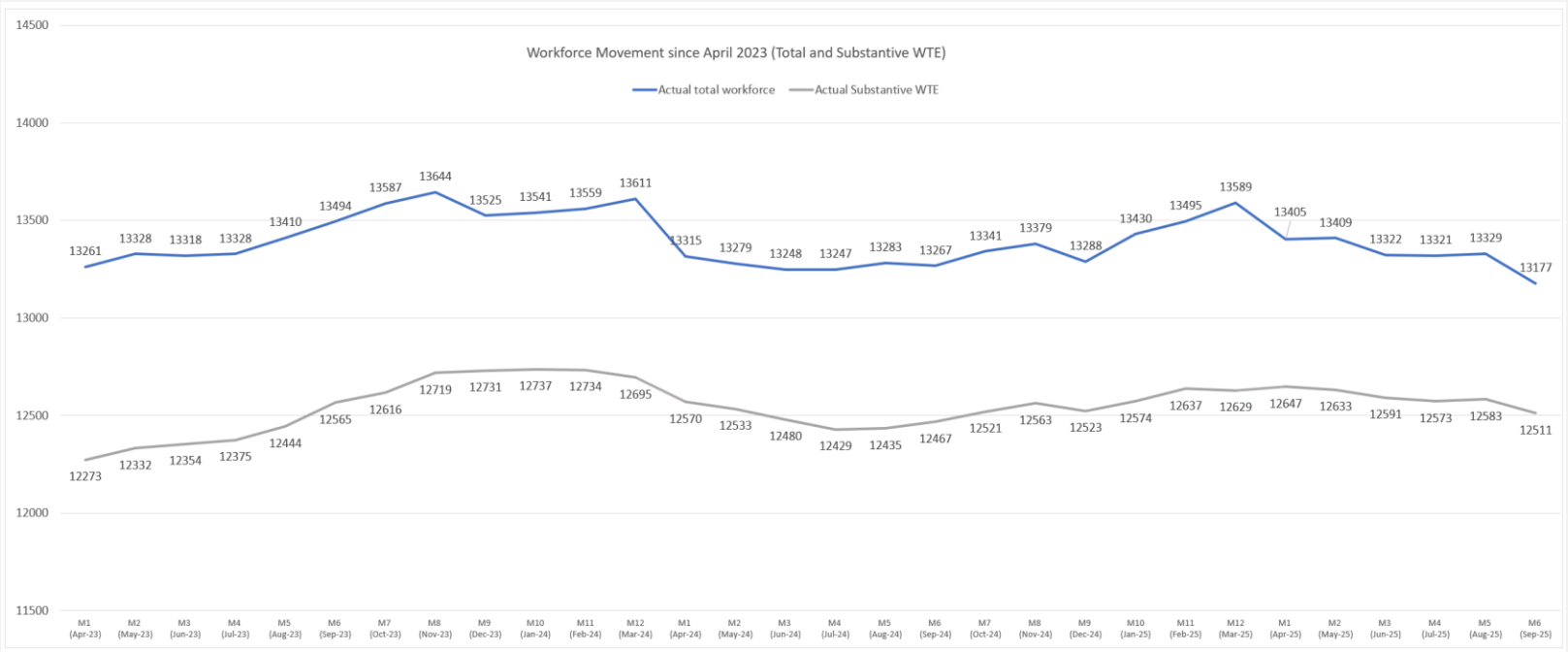
Source: ESR as of September 2025.
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



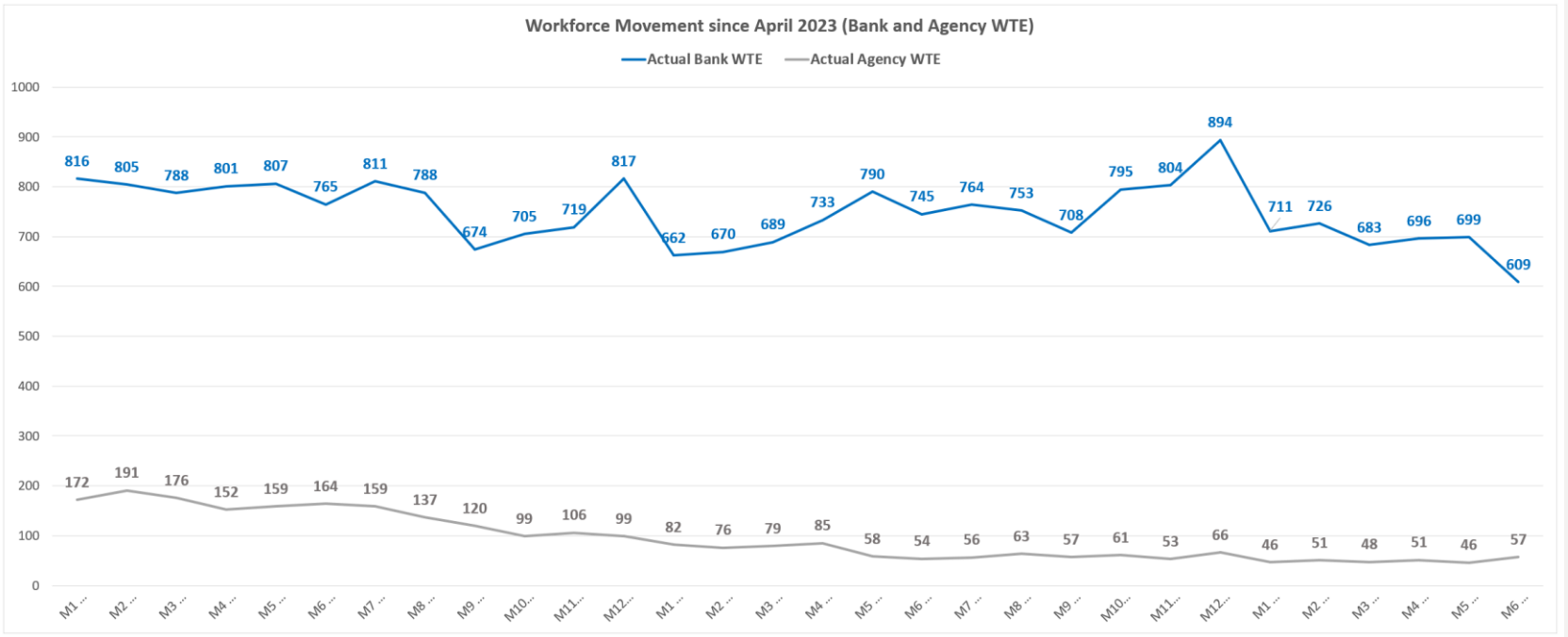
Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of September 2025
Forecast for bank is based on average past performance over the last 3 years for May, June, July, and August.

Workforce Trends: Total & Substantive (over 2 years)



Source: ESR as of September 2025.

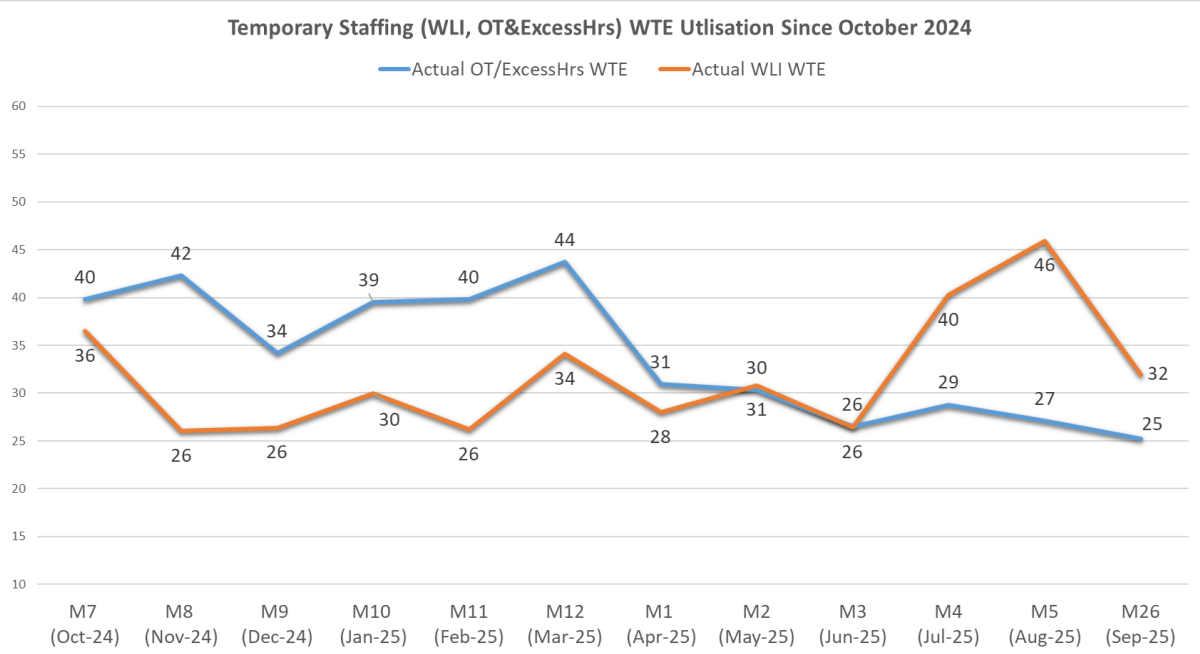
Workforce Trends: Bank & Agency over 2 years



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

Workforce Trends: WLI and Overtime

WLI Movement	M5 - M6 2024	M6 - M7 2024	M7 - M8 2024	M8 - M9 2024	M9 - M10 2024	M10 - M11 2024	M11 - M12 2024	M12 - M1 24/25	M1 - M2 2025	M2 - M3 2025	M3 - M4 2025	M4- M5 2025	M5- M6 2026
	-7	-10	4	0	4	-4	8	-6	3	-4	14	6	-14



Source: Healthroster as of September 2025.

Quarterly People Heatmap – 2025/26 Q2

		THRIVE			EXCEL		BELONG	
	AWL as of M6 (Sep 25)	% Turnover	Appreatice numbers (WTE)	Appraisals completed	Sickness absence	% Flexible working requests approved	% of staff at Band 7 and above (BAME)	% of staff band 7 and above LID
UHS Overall	**12181**	**9.9%**	**675**	**65.5%**	**3.8%**	**40.8%**	**14.3%**	**12.9%**
Division A Overall	3924	9.3%	130.9	62.0%	3.8%	28.2%	19.8%	13.2%
Cardiovascular And Thoracic	306	9.7%	46.9	61.8%	3.8%	30.6%	21.8%	14.3%
Critical Care	652	9.4%	23.8	65.4%	3.8%	20.0%	11.2%	9.0%
Division A Management	16	14.4%	1.0	48.0%	2.4%	100.0%	11.1%	1.2%
Neurosciences	459	10.9%	25.3	65.1%	3.4%	21.1%	22.2%	11.6%
Spinal Service	58	17.0%	4.0	72.7%	4.2%	16.7%	0.0%	55.6%
Surgery	562	9.0%	24.4	59.2%	3.3%	33.3%	13.0%	13.9%
Theatres And Anaesthetics	851	8.2%	42.5	57.6%	4.0%	32.0%	32.1%	15.3%
Trauma And Orthopaedics	421	8.3%	23.1	65.5%	4.1%	17.6%	21.9%	15.7%
Division B - Overall	3089	9.6%	121.8	66.6%	4.0%	44.4%	16.3%	15.4%
Cancer Care	716	11.7%	32.2	66.2%	3.9%	55.6%	18.8%	16.4%
Division B Management	-13	4.1%	5.6	43.1%	4.8%	40.0%	18.4%	25.3%
Emergency Care	707	9.5%	18.1	63.5%	4.5%	55.7%	11.0%	20.8%
Hampshire And Iow Air Ambulance	0	19.5%	0.0	15.4%	2.5%	75.0%	0.0%	7.4%
Medicine	778	8.2%	45.5	80.3%	3.9%	24.7%	28.1%	8.4%
Ophthalmology	297	12.8%	14.9	61.8%	4.7%	31.4%	15.8%	7.7%
Specialist Medicine	605	7.0%	5.4	56.7%	3.1%	41.1%	13.2%	14.6%
Division C - Overall	3833	9.8%	246.6	63.6%	3.9%	44.0%	12.3%	12.6%
Child Health	867	9.6%	42.4	63.8%	3.3%	22.2%	3.5%	15.0%
Clinical Support	898	12.2%	113.7	68.2%	2.9%	51.4%	16.8%	9.8%
Division C Management	188	17.2%	4.6	59.8%	5.5%	38.3%	15.8%	8.9%
Pathology	577	7.6%	38.4	52.8%	4.3%	37.9%	13.8%	14.1%
Radiology	481	7.5%	18.3	73.3%	2.7%	39.5%	10.4%	9.2%
Women And Newborn	822	8.0%	29.4	61.2%	5.2%	52.7%	6.3%	20.7%
Division D - Overall	29	9.8%	1.0	47.4%	1.2%	0.0%	0.0%	16.3%
Division D Management	29	9.8%	1.0	47.4%	1.2%	0.0%	0.0%	16.3%
THQ - Overall	1305	10.6%	114.9	70.7%	3.5%	40.0%	12.0%	14.2%
Chief Finance Officer	122	11.0%	17.0	28.6%	1.9%	27.3%	8.4%	12.3%
Chief Operating Officer	182	13.8%	1.0	60.5%	6.1%	50.0%	14.1%	9.8%
Digital	251	9.9%	27.1	81.9%	2.4%	50.0%	17.3%	10.9%
Human Resources	162	15.6%	17.7	78.0%	3.0%	23.5%	3.2%	18.2%
Research and Development	373	11.4%	15.3	80.7%	3.0%	41.7%	14.1%	13.1%
Training And Education	207	10.2%	36.8	80.0%	3.6%	73.3%	7.7%	7.7%

NB: Care groups & THQ departments < 50 WTE are excluded

Substantive SIP by Staffing Group (2025-26 Counting Criteria)

Substantive Monthly Staff in Post (WTE) for last 12 months																					
	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	2024/25 M5 (Aug)	2024/25 M6 (Sep)	2024/25 M7 (Oct)	2024/25 M8 (Nov)	2024/25 M9 (Dec)	2024/25 M10 (Jan)	2024/25 M11 (Feb)	2024/25 M12 (Mar)	2025/26 M1 (Apr)	2025/26 M2 (May)	2025/26 M3 (Jun)	2025/26 M4 (Jul)	2025/26 M5 (Aug)	2025/26 M6 (Sep)	M5 to M6 movement	Mar24 to M6 Movement	Mar25 to M6 Movement
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	295	294	297	302	301	300	300	312	303	306	**3**	**4**	**3**
Additional Clinical Services	2136	2135	2134	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	2134	2131	2117	2101	**-16**	**-35**	**-6**
Administrative and Clerical (Divisions)	1386	1399	1387	1374	1366	1363	1356	1347	1342	1328	1340	1348	1352	1352	1350	1327	1316	1298	1282	**-17**	**-105**	**-71**
Administrative and Clerical (THQ)	902	904	902	875	864	860	859	852	875	888	897	900	902	899	893	879	874	859	826	**-32**	**-76**	**-75**
Allied Health Professionals	796	803	800	799	788	786	808	815	814	806	807	821	817	823	822	832	831	839	842	**3**	**46**	**25**
Estates and Ancillary	380	374	372	373	376	373	370	373	407	405	407	415	416	414	409	407	403	398	392	**-6**	**12**	**-24**
Healthcare Scientists	498	499	495	498	496	497	495	504	510	509	512	518	521	523	520	523	524	522	523	**1**	**25**	**2**
Consultant & Career Grade Doctor	949	947	946	949	948	951	964	965	971	971	976	983	984	990	983	982	986	991	989	**-3**	**40**	**5**
Resident Doctor	1235	1103	1102	1099	1096	1150	1161	1164	1155	1147	1149	1152	1146	1145	1140	1132	1125	1198	1194	**-4**	**-42**	**48**
Nursing and Midwifery Registered	4053	4052	4039	4030	4025	3998	3998	4055	4041	4038	4039	4032	4013	4010	4024	4008	4003	3990	3990	**1**	**-63**	**-23**
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	**-1**	**9**	**-2**
Grand Total	**12695**	**12570**	**12533**	**12480**	**12429**	**12435**	**12467**	**12521**	**12563**	**12523**	**12574**	**12637**	**12629**	**12647**	**12633**	**12591**	**12573**	**12583**	**12511**	**-73**	**-184**	**-119**

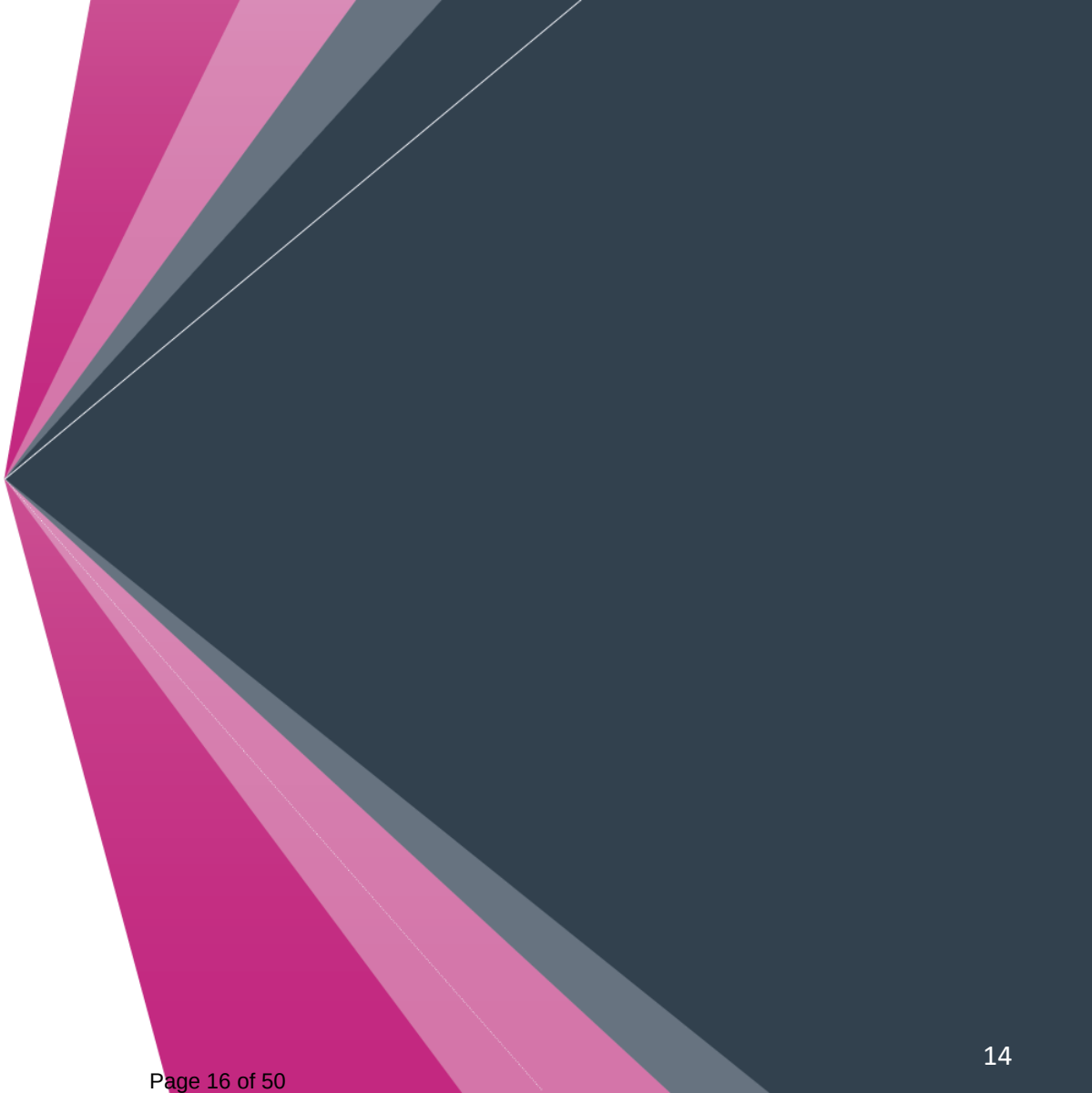
Source: ESR substantive staff as of September 2025; includes consultant APAs & Resident Doctors' Extra Rostered Hours, excludes CLRN, Wessex AHSN, WPL (revised criteria for 25/26). From September 2025, EPR Project posts are excluded due to capitalisation. Numbers relate to WTE, not headcount.

Total Monthly Workforce - Substantive Bank & Agency
(2025-26 Counting Criteria)

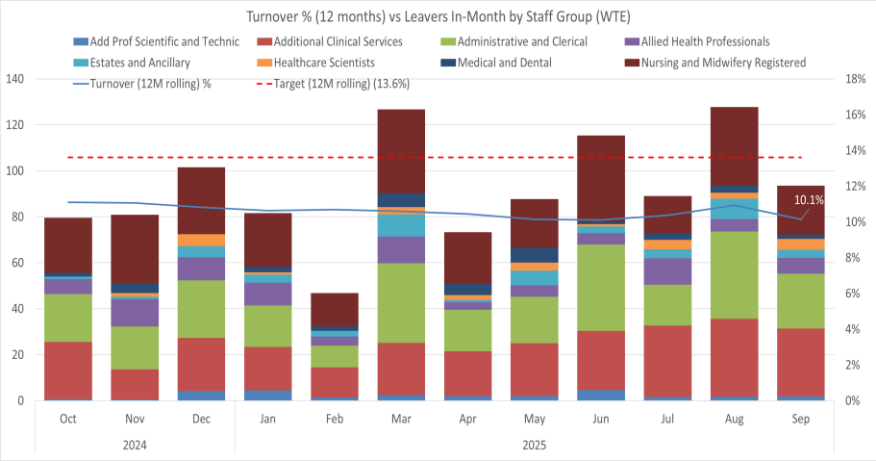
Total Monthly Workforce (WTE) for last 12 months (Substantive, Bank and Agency)																					
	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	2024/25 M5 (Aug)	2024/25 M6 (Sep)	2024/25 M7 (Oct)	2024/25 M8 (Nov)	2024/25 M9 (Dec)	2024/25 M10 (Jan)	2024/25 M11 (Feb)	2024/25 M12 (Mar)	2025/26 M1 (Apr)	2025/26 M2 (May)	2025/26 M3 (Jun)	2025/26 M4 (Jul)	2025/26 M5 (Aug)	2025/26 M6 (Sep)	M5 to M6 movement	Mar24 to M6 Movement	Mar25 to 6 Movement
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	296	294	298	303	302	303	303	315	305	308	**3**	**6**	**5**
Additional Clinical Services	2522	2464	2464	2449	2453	2476	2430	2425	2418	2391	2433	2438	2475	2419	2430	2421	2432	2421	2379	**-42**	**-173**	**-96**
Administrative and Clerical	2348	2356	2342	2304	2303	2297	2286	2274	2287	2282	2315	2321	2330	2311	2296	2255	2241	2203	2149	**-54**	**-199**	**-181**
Allied Health Professionals	826	825	824	822	816	813	834	839	837	825	828	844	845	844	843	849	850	855	858	**3**	**32**	**13**
Estates and Ancillary	410	401	403	404	409	403	398	403	435	431	436	442	443	439	437	434	418	410	414	**4**	**4**	**-29**
Healthcare Scientists	509	508	505	506	509	511	508	517	524	522	525	528	532	532	529	531	532	531	532	**1**	**23**	**0**
Medical and Dental	2231	2093	2092	2101	2100	2151	2165	2168	2165	2158	2172	2175	2174	2176	2162	2152	2165	2225	2211	**-14**	**-20**	**37**
Nursing and Midwifery Registered	4404	4311	4292	4308	4304	4273	4287	4357	4356	4327	4370	4379	4418	4312	4341	4309	4300	4310	4259	**-51**	**-145**	**-159**
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	**-1**	**9**	**-2**
Grand Total	**13611**	**13315**	**13279**	**13248**	**13247**	**13283**	**13267**	**13341**	**13379**	**13288**	**13430**	**13495**	**13589**	**13405**	**13409**	**13322**	**13321**	**13329**	**13177**	**-152**	**-463**	**-412**

Source: ESR substantive staff, NHSP Bank & Agency temporary staff, THQ Medical Bank staff & 247 Agency staff as of September 2025.
Excludes CLRN, Wessex AHSN, WPL (revised criteria for 25/26). Numbers relate to WTE, not headcount.

THRIVE



Turnover



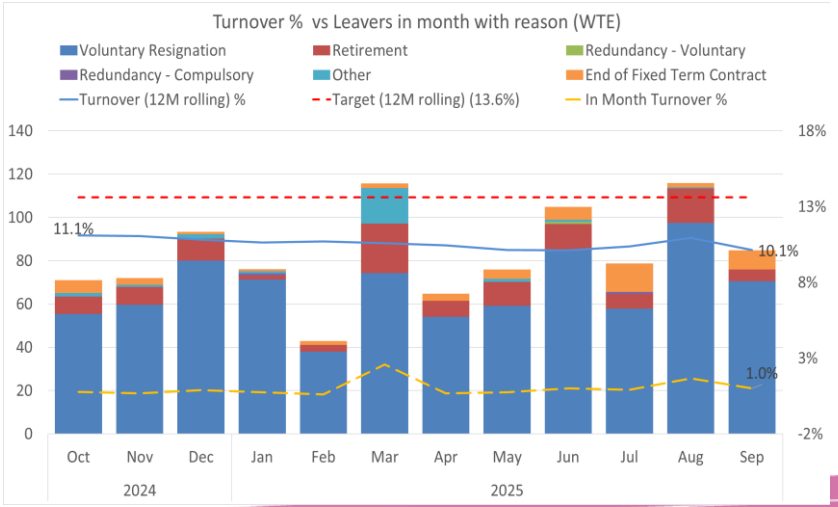
In September 2025, there was a total of 93.6 WTE leavers, 28.4 WTE less than August 2025 (122 WTE). Division C recorded the highest number of leavers (37.6 WTE). Within Division C, Administrative and Clerical staff group had the highest number of leavers (12.3 WTE).

Divisions A and B had the second and third highest number of leavers (37.5 and 29.3 WTE respectively); with the largest number of leavers for Division A being the Nursing and Midwifery Registered staff group (16.4 WTE), while in Division B Nursing and Midwifery Registered staff group accounted for 10.8 WTE leavers.

Total leavers by division are as follows:

- **Division A: 37.5 WTE leavers**
- **Division B: 29.3 WTE leavers**
- **Division C: 37.6 WTE leavers**
- **Division D: 1 WTE leavers**
- **THQ: 19.8 WTE leavers**
- **UEL: 2.6 WTE leavers**

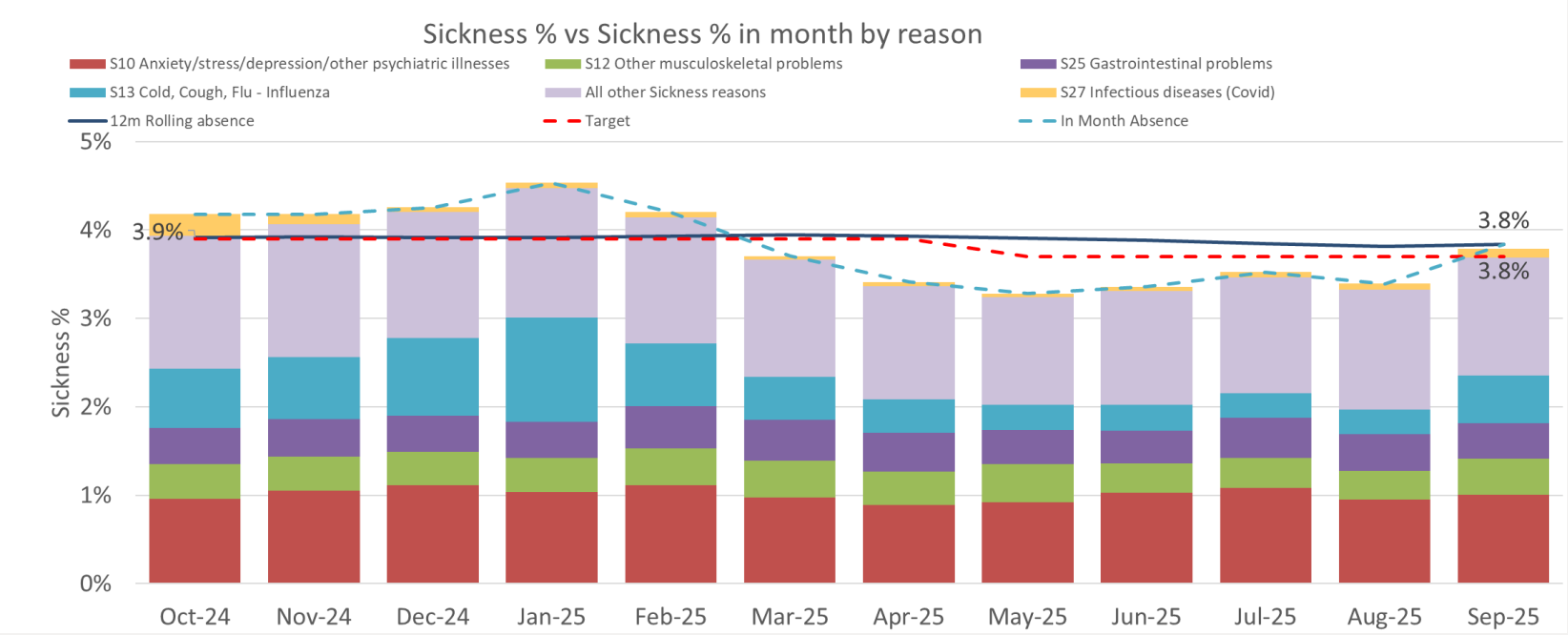
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.8	9.1%	9.1%
Additional Clinical Services	29.6	13.4%	13.4%
Administrative and Clerical	23.9	11.8%	11.8%
Allied Health Professionals	6.9	10.6%	10.6%
Estates and Ancillary	3.5	7.6%	7.6%
Healthcare Scientists	4.8	5.3%	5.3%
Medical and Dental	1.8	4.3%	4.3%
Nursing and Midwifery Registered	21.3	8.2%	8.2%
UHS total	**93.6**	**1.0%**	**10.1%**



Source: ESR – Leavers Turnover WTE, ESR Staff Movement Sept 25 (exc.resident doctors & hosted services, includes UEL)

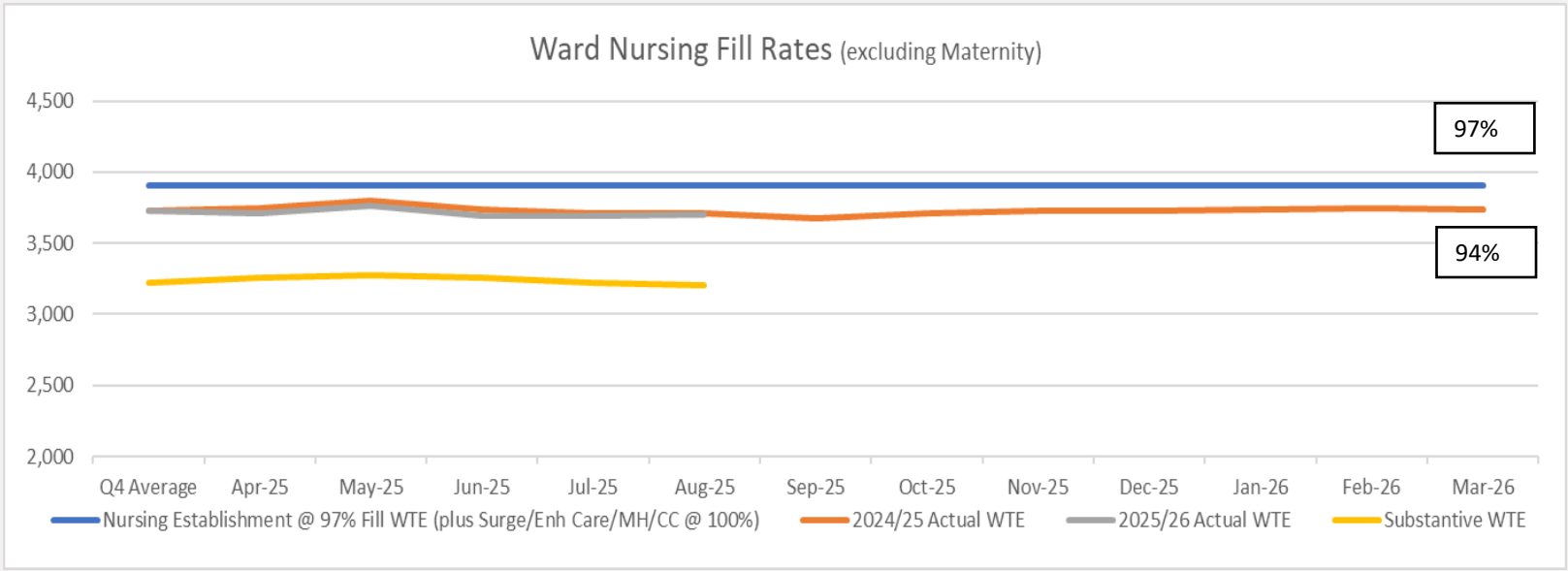
Sickness

Current in-month sickness: 3.8% | Rolling 12-month sickness: 3.8% | Year-to-date sickness 3.5%



Source: ESR – September 2025

Ward Nursing Fill Rates (excluding Maternity)



Source: Finance – September 2025

Temporary Staffing

Status

Qualified Nursing (WTE)

- **Demand decreased** from 377 WTE in August to 339 WTE in September (-38).
- **Bank fill decreased** from 286 WTE to 224 (-62 from previous month).
- **Agency filled** 46 WTE (+11 from the previous month).
- **Unfilled shifts increased**: 69 WTE remained unfilled (+13 on previous month).
- **Year-on-year demand increased:** 2 WTE higher than September 2024

Healthcare Assistants (HCA) (WTE)

- **Demand decreased** from 304 in August to 294 in September (-10).
- **Bank filled decreased** from 266 WTE to 241 WTE (-25)
- **Unfilled shifts increased**: 54 WTE remained unfilled (+16 on prior month)
- **Year-on-year demand decrease**: 27 WTE lower than September 2024.

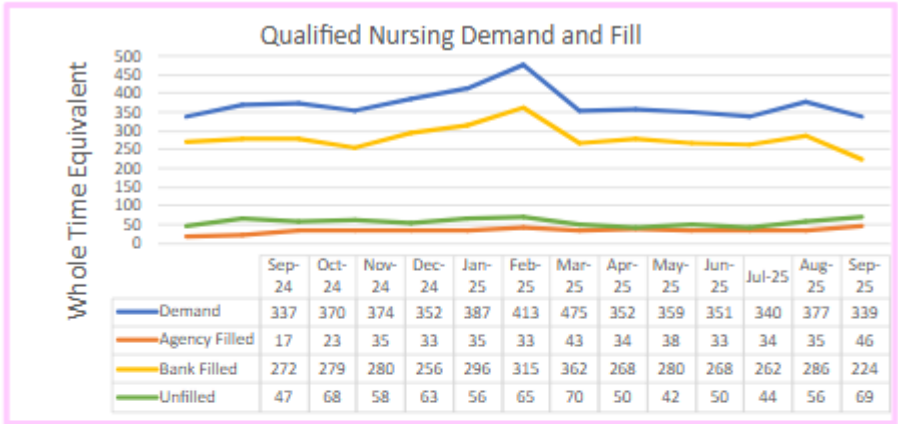
Actions

RMN Use Increase; Some increase in RMN usage is linked to shifts being released due to unfilled HCA shifts. Actions are being taken to ensure correct governance processes in placed to address, as we are seeing increase agency use across the trust driven by higher RMN reliance.

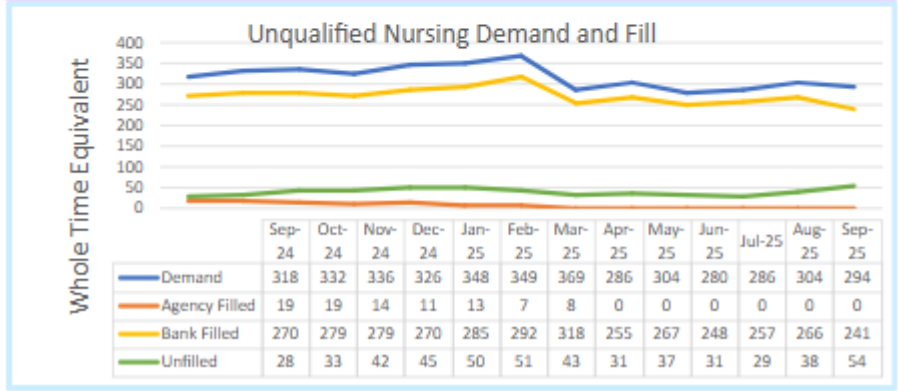
Enhanced Bank Rate Reduction; Nursing Bank band 5 shifts previously receiving a Band 6 pay rate have been reduced to align with AfC band. An initial impact on bank fill rates was observed; however, this has recovered in most areas, except for Theatre Scrub. Staff remain concerned by the reduction.

Bank 2/3 Transition; The transition project is complete for bank shifts and is live. Some shifts still being advertised in in-scope Band 3 areas, and some Bank workers have not yet engaged with the process to obtain their Band 3 code, which may continue to impact bank shift fill rates. We are currently reviewing the next steps and assessing the risks involved

Agency Reduction; Agency rates were reduced on 1st October to align with Band 5 NHSi cap rates.



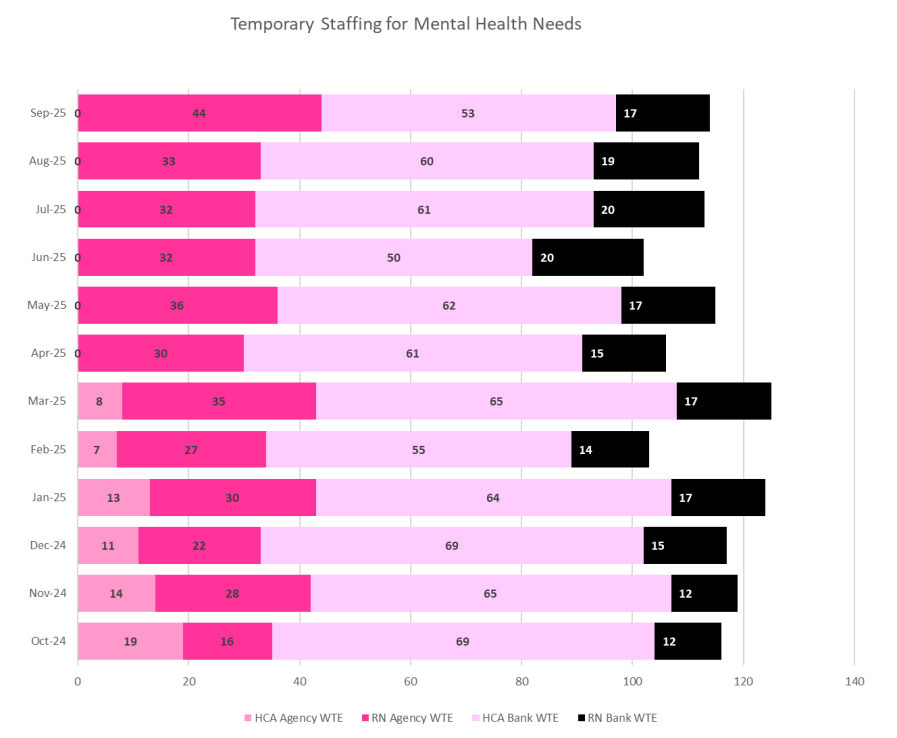
	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Demand	337	370	374	352	387	413	475	352	359	351	340	377	339
Agency Filled	17	23	35	33	35	33	43	34	38	33	34	35	46
Bank Filled	272	279	280	256	296	315	362	268	280	268	262	286	224
Unfilled	47	68	58	63	56	65	70	50	42	50	44	56	69



	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Demand	318	332	336	326	348	349	369	286	304	280	286	304	294
Agency Filled	19	19	14	11	13	7	8	0	0	0	0	0	0
Bank Filled	270	279	279	270	285	292	318	255	267	248	257	266	241
Unfilled	28	33	42	45	50	51	43	31	37	31	29	38	54

Source: Temporary Resourcing – September 2025

Temporary Staffing: Mental Health



Mental Health Staffing Summary – September 2025

Total Temporary Staffing: 114 WTE , increase of 2 WTE from previous month.
Registered Mental Health Nurses (RMNs): 61 WTE (+9 WTE on prior month), of which 44 WTE were agency and 17 WTE were bank staff.
Healthcare Assistants (HCAs): 53 WTE (decrease of 7 WTE on prior month).
Year-on-Year Comparison: 2 WTE increase compared to September 2024 (44 WTE decrease in HCAs, 26 WTE increase in RMN requests).

Key Challenges & Actions

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

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

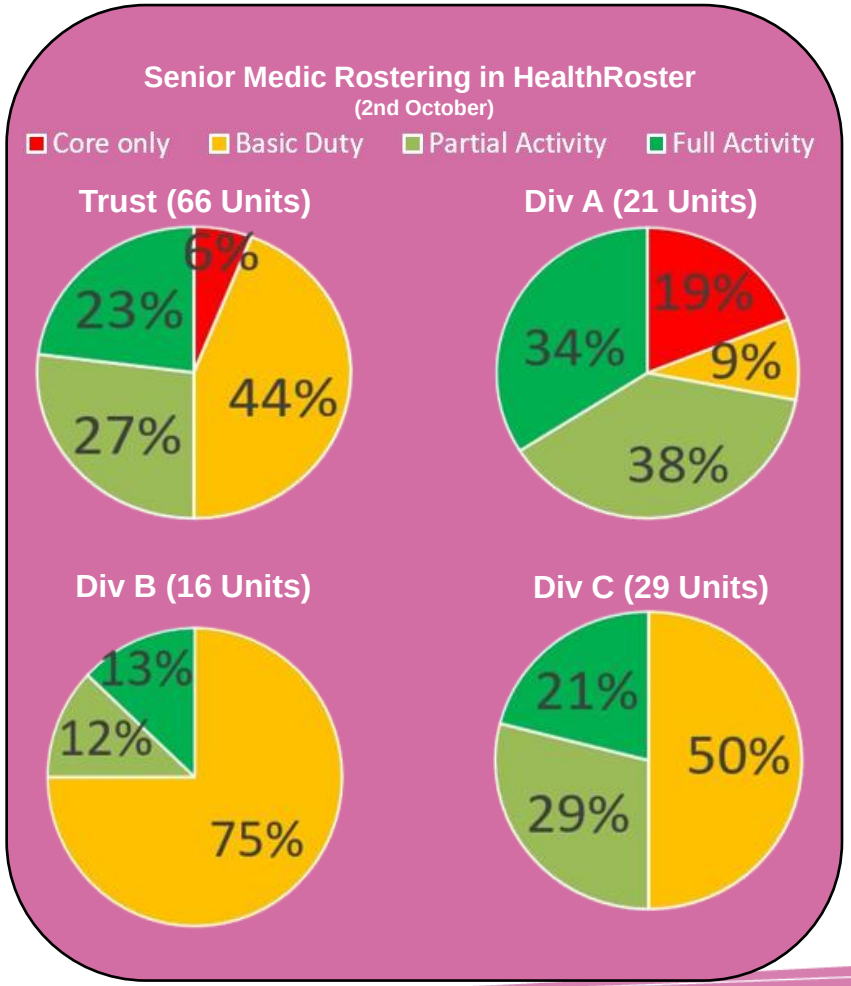
Shift from Agency to Bank Staff: Agency shift fill rates have declined, reflecting the ongoing efforts to transition mental health workers from agency contracts to Bank roles. This strategic shift aims to strengthen governance and workforce stability. However, it is important to note that current NHSP pay rates exceed the total charge rates for agency staff, resulting in increased overall staffing costs when shifts are filled via the Bank. This cost implication has been escalated for collective review and discussion within the SE Collaborative.

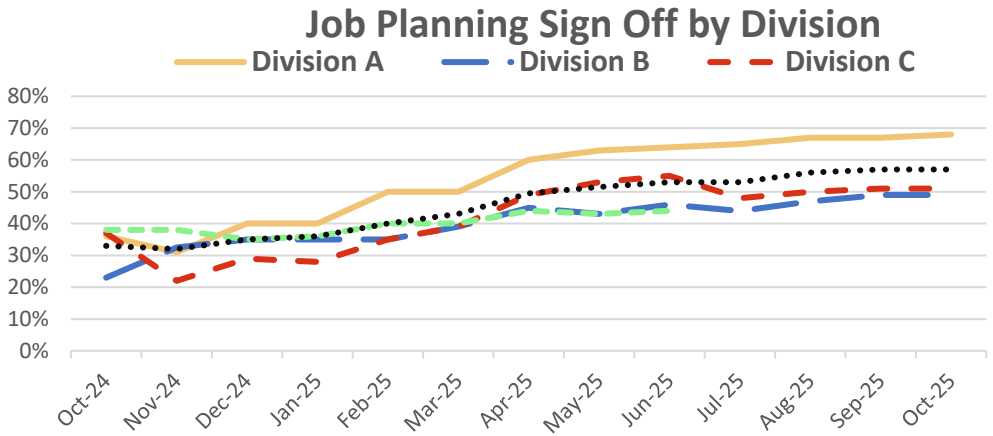
Rising Numbers of Detained Patients: A month-on-month increase in patients detained under Section 2 of the Mental Health Act. This is driving higher demand for 1:1 RMN-prescribed enhanced care.

Increase in RMN Use to Cover HCA Roles: RMN usage has increased by **144%** compared to previous year. Primarily due to a reduction in HCA fill rates following the removal of agency staff, with some of this shortfall being covered by RMNs. Additionally, the increased acuity of our patient group, as outlined above, has contributed to the higher demand for RMNs. We are currently working to strengthen governance processes around the decision-making and approval required when replacing an HCA with an RMN

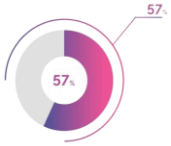
Source: Temporary Resourcing – September 2025

Workforce: Medical Rostering and Planning

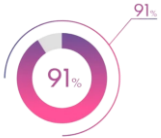




- Sign-off steady at 57%, active job plans steady at 91%
- ED not renewed yet. Hoping to build more detailed Job Plans before renewal.
- Demand/Capacity/Group Plan template uploaded to Staffnet
- Important support request open with our supplier (RLDatix) to fix an error restricting reporting for recently renewed teams. To mitigate, we have delayed the renewal of Radiology

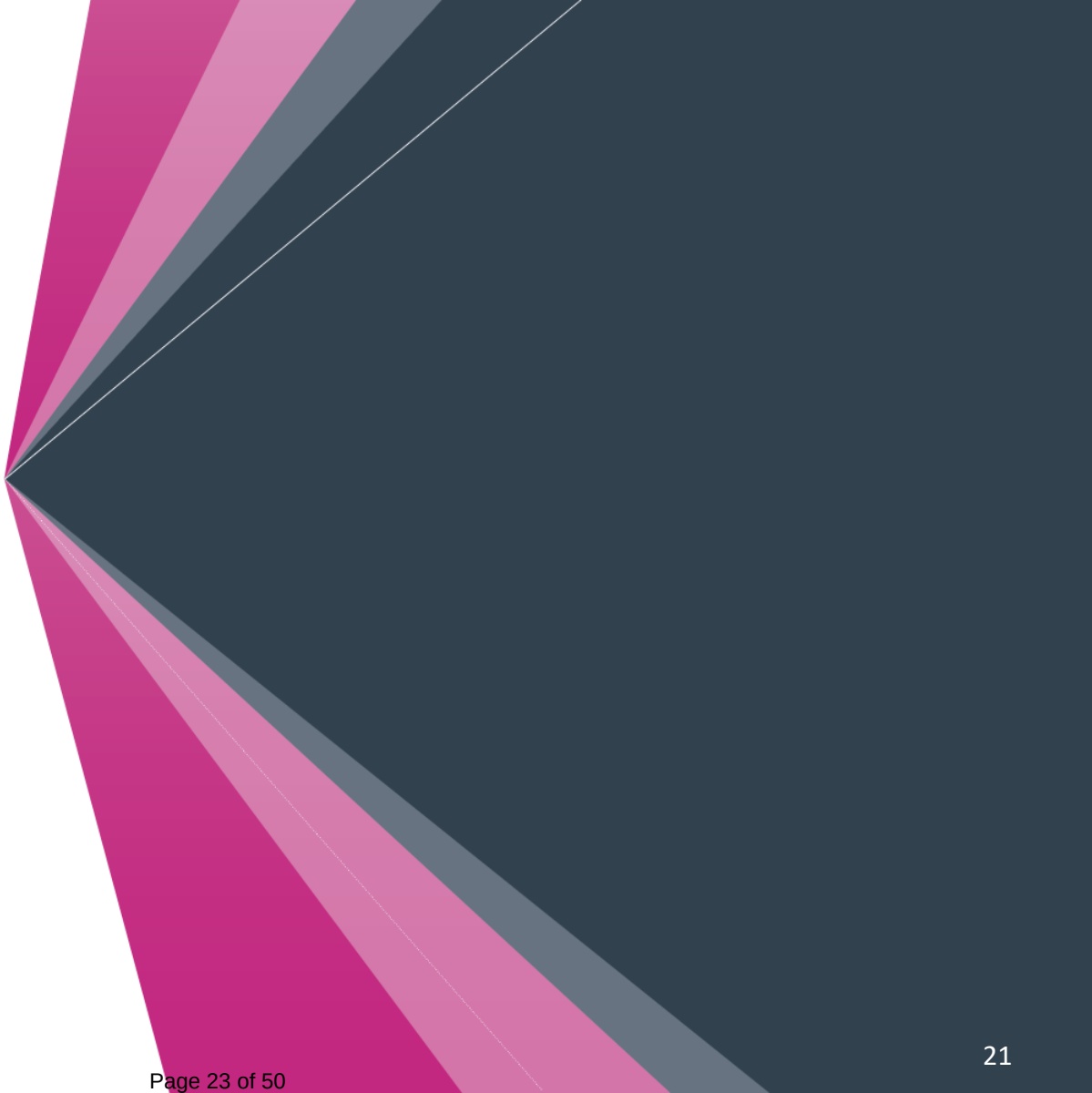


Signed Off Job Plans



Active Job Plans

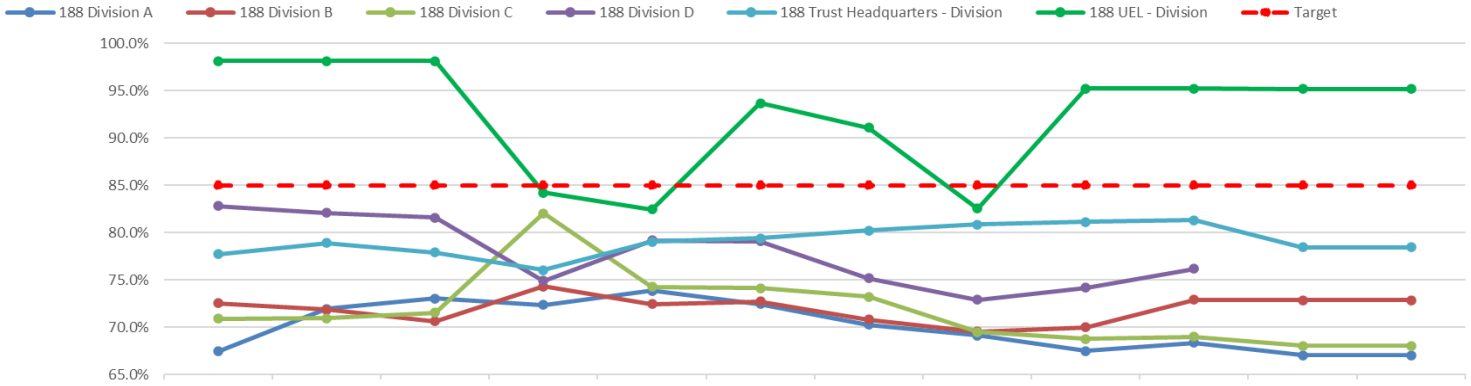
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 71% as of September 2025, the same as August 2025

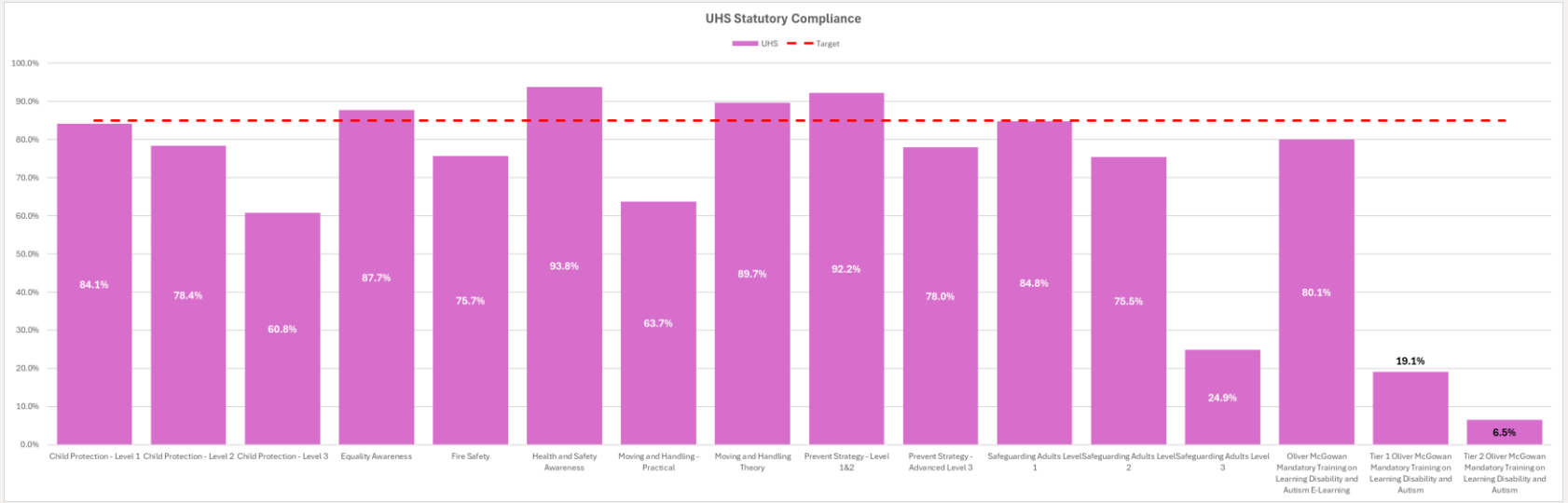


	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
188 Division A	67.4%	71.9%	73.0%	72.3%	73.9%	72.4%	70.3%	69.1%	67.5%	68.3%	67.0%	67.0%
188 Division B	72.5%	71.8%	70.6%	74.3%	72.4%	72.7%	70.8%	69.5%	70.0%	72.9%	72.8%	72.8%
188 Division C	70.9%	71.0%	71.5%	82.0%	74.3%	74.1%	73.2%	69.5%	68.8%	69.0%	68.0%	68.0%
188 Division D	82.8%	82.1%	81.6%	74.9%	79.2%	79.1%	75.2%	72.9%	74.2%	76.2%		
188 Trust Headquarters - Division	77.7%	78.9%	77.9%	76.1%	79.0%	79.4%	80.2%	80.9%	81.1%	81.3%	78.5%	78.5%
188 UEL - Division	98.1%	98.1%	98.1%	84.2%	82.5%	93.7%	91.1%	82.5%	95.2%	95.2%	95.2%	95.2%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: ESR & VLE – Appraisal data for Divisions A, B, C, D & THQ only (exc.Medical & Dental group) Sept 2025

UHS Statutory Compliance

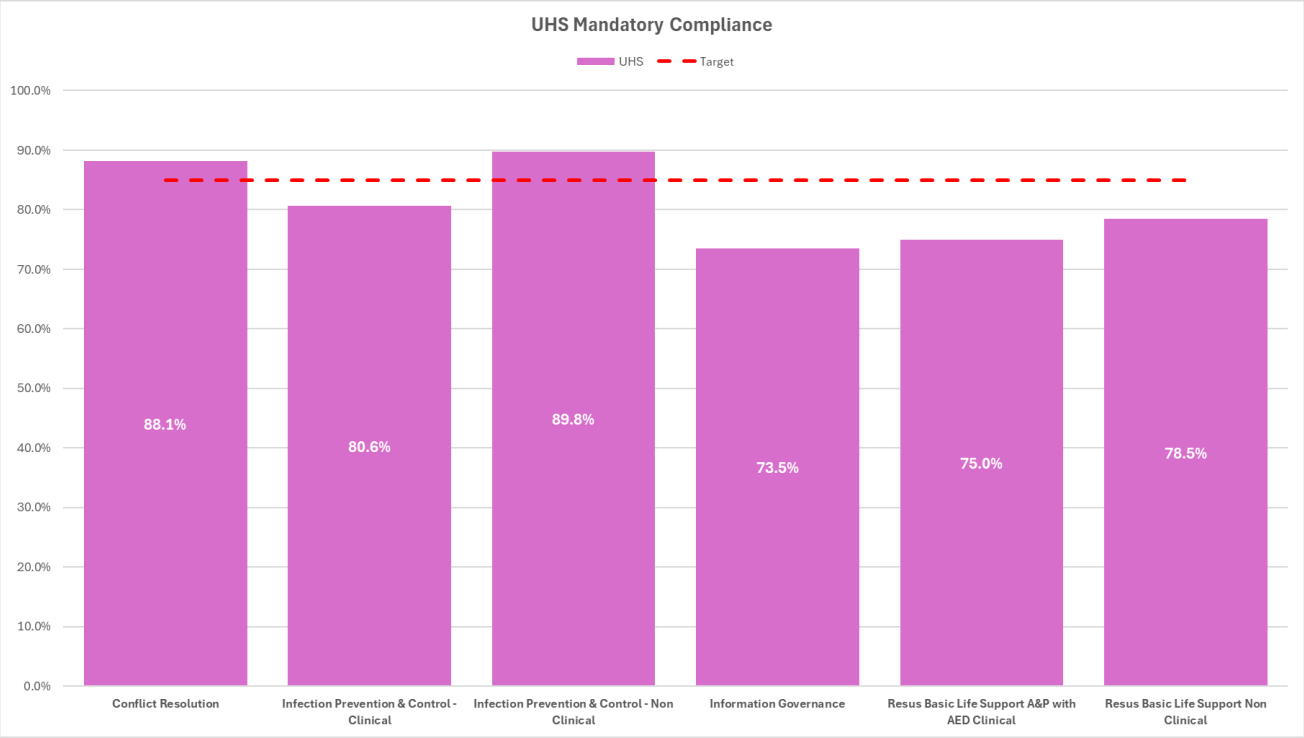
The Trust's average Statutory compliance rate for September 2025 is 68%, with 4 of 16 measures above the 85% target.



Source: Virtual Learning Environment (VLE) September 2025

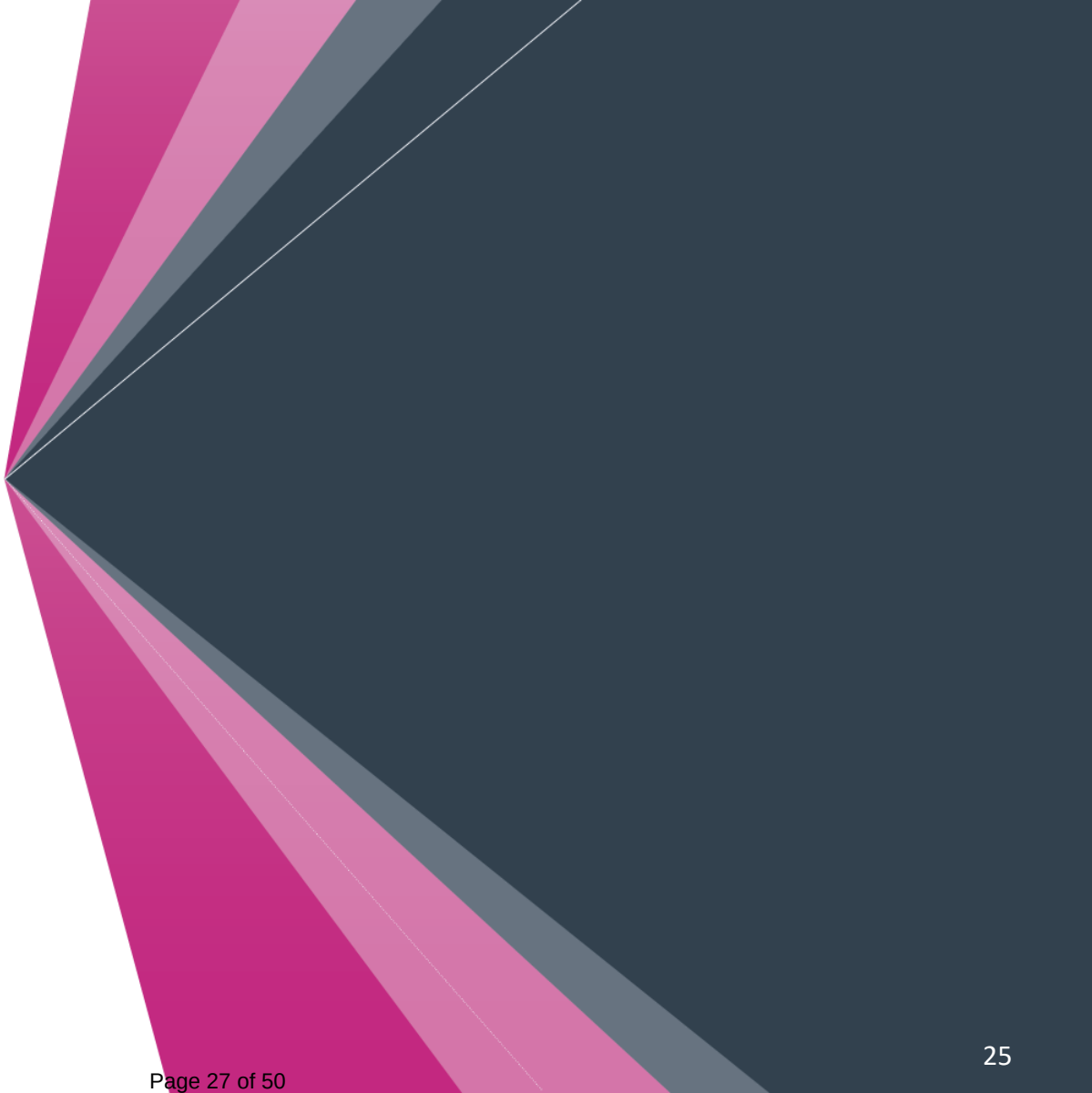
UHS Mandatory Compliance

The Trust's average mandatory compliance rate for September 2025 is 81%, with 2 of 6 measures above the 85% target.



Source: Virtual Learning Environment (VLE) September 2025

BELONG



Violence and aggression, our response

In recent months we have seen increases of violence, abuse and aggression towards our staff. We have had a programme of work to tackle violence, abuse and aggression which has made important changes to policy, training and collaborative working with Hampshire Police and other partners. However, we want to strengthen our approach, and our Trust board have given their backing to a set of revised actions, under 5 domains, which will protect our staff against violence, abuse and aggression at work. We have already started by improving the consistency of our response, providing support for colleagues when they need to take action, and strengthening public messaging, making it clear that we respect diversity and we are proud of our global workforce, against the backdrop of wider social tensions.

Steps already taken

Creation of violence and aggression board

Support for secured from Trust board

New creative displayed on digital boards posters around the Trust, supporting diversity and inclusion.

Restricted access letter issued to a patient due to unacceptable behaviour.

Immediate next steps

Rapid review of existing violence, aggression exclusion policy and Communicate to staff.

Creation of action cards to support consistent approach across UHS

Prioritising programmes of work, assigning named leads and delivery timelines.

We Are UHS Week

Running from 6 to 10 October, We Are UHS Week was dedicated to recognising the hard work, commitment, and care shown by colleagues across UHS every day, supported and funded by Southampton Hospitals Charity.
Throughout the week, we came together to reflect on the difference we make to our patients, our teams, and our community. It was also a chance to pause, connect, and take time for wellbeing and learning.

Programme highlights

The week kicked off with our awards-themed Spotlight event in the Heartbeat Education Centre with guests and winners celebrated.
Treat trolleys made daily appearances across our sites with 150 areas visited including SGH, PAH, New Forest Birth centre, Taplins nursery, Lymington and RSH.
Daily CSI 7s sessions attracted more than 60 attendees, whilst staff submitted more than 50 posters to showcase their work.
In person sessions with guest speakers and local facilitators were hosted throughout the week with a focus on wellbeing.

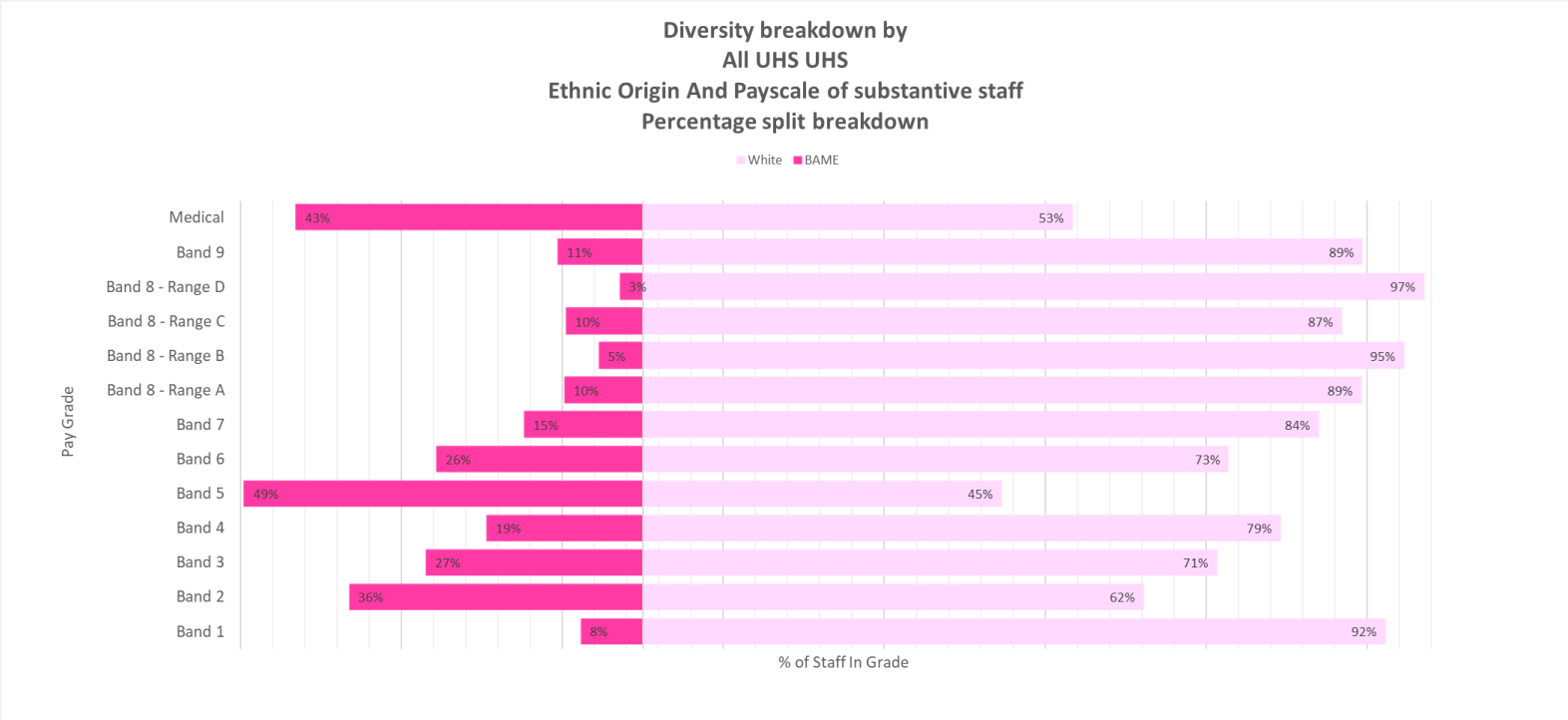
Content catch up

Wrap up Sway - (internal intranet link access) round up of all We Are UHS week activity

AMM write up – (internal intranet link access) summary of the meeting, 50 attendees

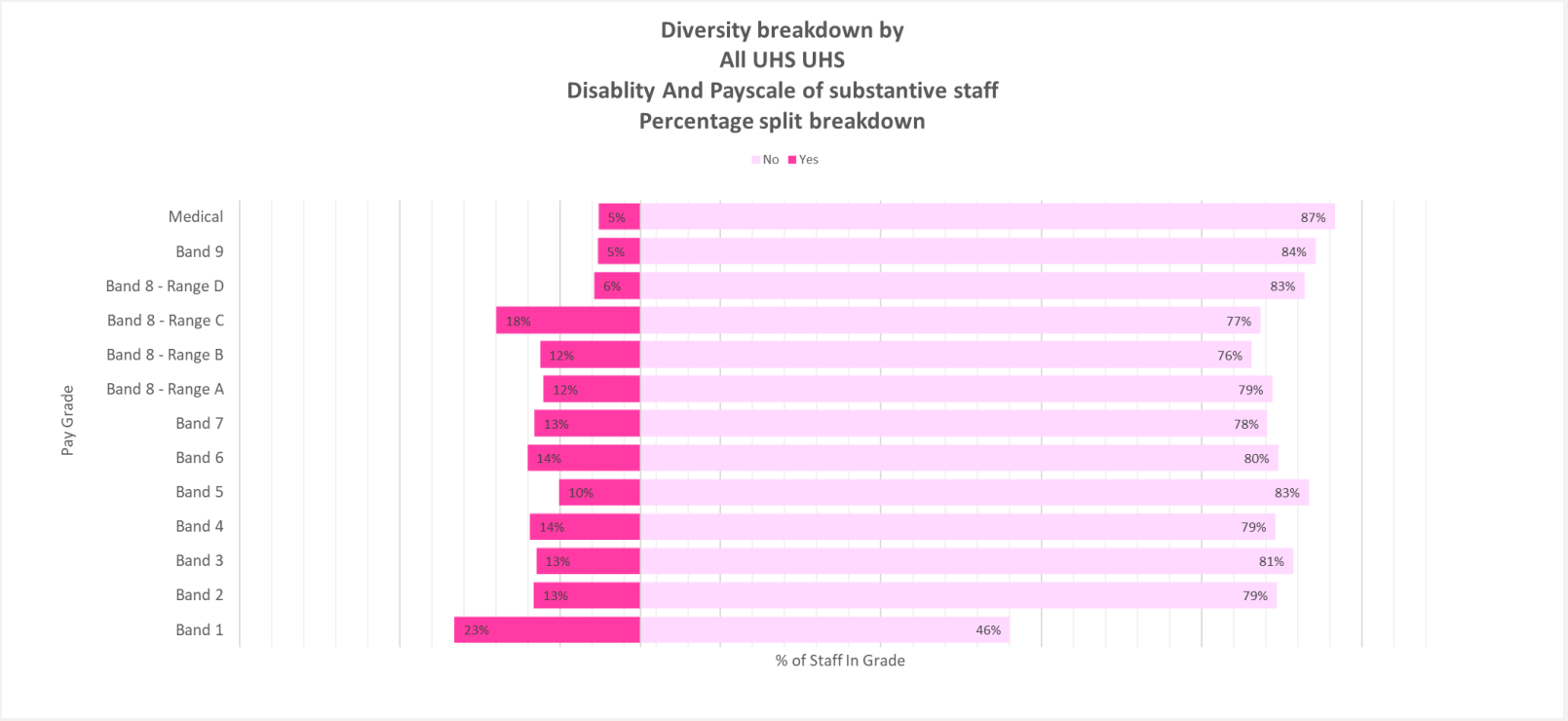
Awards press release – (website link) external round up of award winners

Staff in Post - Ethnicity



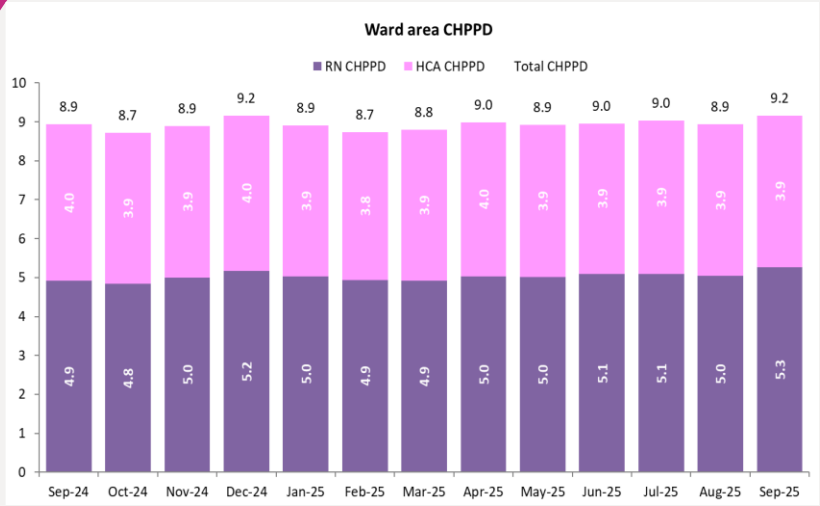
Source: ESR – September 2025

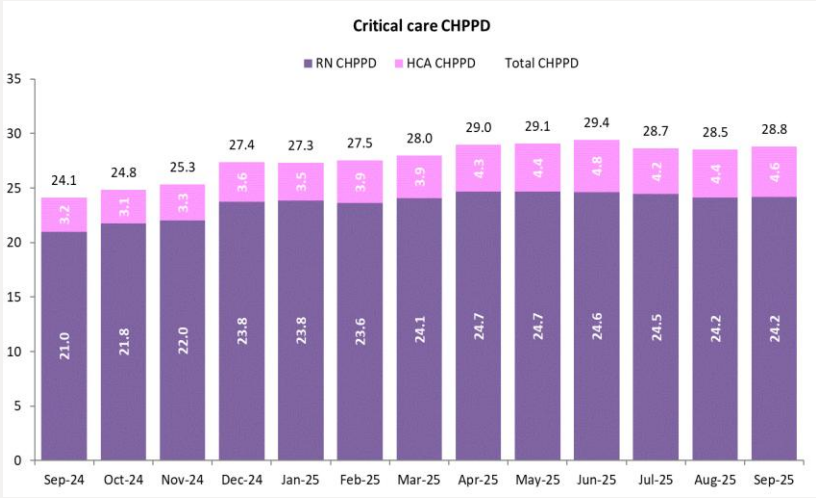
Staff in Post – Disability Status



Source: ESR – September 2025

CHPPD





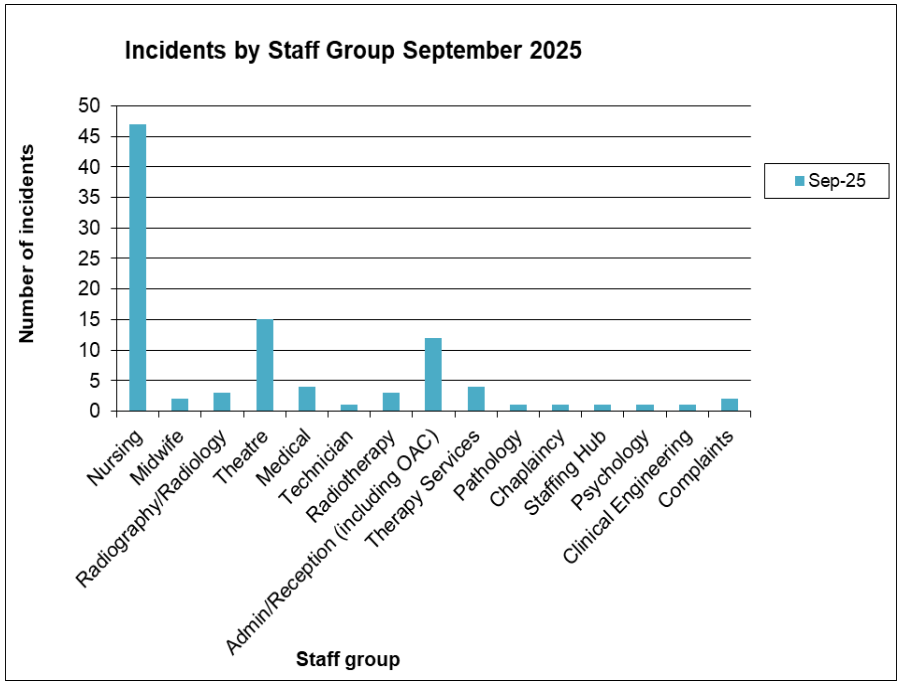
The Ward areas CHPPD rate in the Trust has increased overall from last month. RN 5.26 (previously 5.04), HCA 3.91 (previously 3.90) overall 9.16 (previously 8.94)

The CHPPD rate in Critical care has increased overall from last month. RN 24.18 (previously 24.15), HCA 4.64 (previously 4.36) overall 28.82 (previously 28.51)

Source: HealthRoster, NHSP & eCamis – September 2025

Patient Safety – Staffing Incidents & Red Flags

In total 98 incident reports were received in September 2025 which cited staffing. This is a significant increase on the 70 reported in August.



Incidents by Division September 2025 vs August 2025

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
Sept 2025	28	29	33	4	4	98
Total	28 ↑ (24)	29 ↑ (21)	33 ↑ (16)	4 ↓ (6)	4 ↑ (3)	98 ↑ (70)

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
Aug 2025	24	21	16	6	3	70
Total	24 ↑ (17)	21 ↑ (14)	16 ↓ (25)	6 ↓ (12)	3 ↔ (3)	70 ↓ (72)

Source: Safeguard System September 2025

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

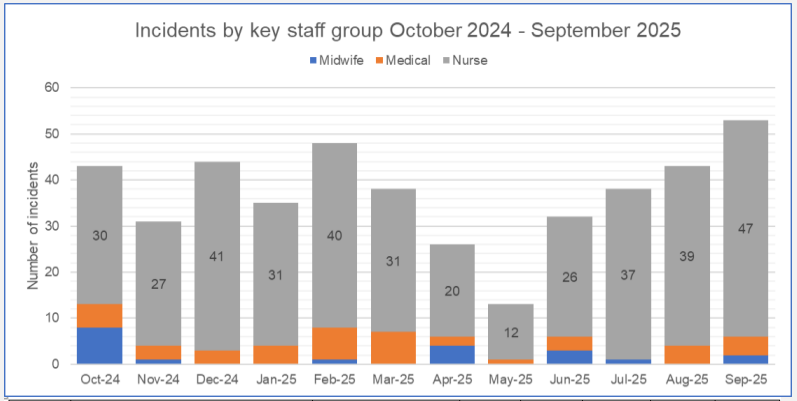
Div A:
Twenty-eight incidents reported in September 2025, up from 24 in the previous month. Red Flags up from 0 to 8.

Div B:
Twenty-nine incidents were reported in September 2025 (up slightly on the 21 in the previous month). Red flags up from 0 to 5.

Div C:
Thirty-three incidents were reported in September 2025 (up from the 16 in the previous month). There were 4 red flags reported (0 reported in August).

Div D:
Four incidents reported in August (down from the 6 reported in the previous month). There was 1 red flags raised.

THQ:
Four incidents reported in September (up from 3 in August)



September 2025

Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
Delay in medication	5	3	1	1	0	0
Delay in pain relief	5	2	1	1	1	0
Delay in observations	5	2	2	1	0	0
Less than 2 registered	3	1	1	1	0	0
Total	**18**	**8**	**5**	**4**	**1**	**0**

August 2025

Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
Delay in medication	0	0	0	0	0	0
Delay in pain relief	1	0	0	0	1	0
Delay in observations	1	0	0	0	1	0
Less than 2 registered	1	0	0	0	1	0
Total	**3**	**0**	**0**	**0**	**3**	**0**

Source: Safeguard System September 2025

Workforce Plan and Recovery Actions

UHS Workforce Plan 2025/26

WTE Movement Summary

Total reduction of 785 WTE
Substantive reduction of 620 WTE
Bank reduction of 145 WTE
Agency reduction of 20 WTE

KPIs

Sickness – **3.7%**
Turnover – **10%**

Governance

Via the People Board, Trust Savings Group, FIG, PODC, TEC

Substantive

Substantive WTE planned baseline is **12,654** WTE and is projected to be 12,034 WTE by March 2026 (a **net reduction of 620 WTE**).

Bank

Bank WTE planned baseline is 769 WTE and is projected to be 624 WTE by March 2026 (**a net reduction of 145 WTE**). Bank increased in March 2025 but has fallen again in April.

Agency

Agency WTE baseline is 63 WTE and is projected to be 43 WTE by March 2026 (a **reduction of 20 WTE**). Agency WTE throughout 2024/25 has reduced steadily the Trust closed agency under plan for the 2024/25 financial year.

Total WTE

By March 2026, there will be a total WTE **net reduction of 785 WTE** from the baseline of 13,486 WTE (M12) to 12,701 WTE. Substantive, bank and agency are expected to reduce, with a bigger focus on temporary resourcing.

Risks

Focusing on safety and quality
Affordability of workforce versus patient demand
Turnover levels to enable reductions
Improvements in NCTR and Mental Health

Assumptions

National assumption of low/no Covid impact and low/negligible industrial action impact. Assumes continued levels of turnover. NCTR reductions are linked to the success of wider system programmes on discharge and frailty.

Workforce Plan 25/26

UHS has submitted its workforce plan for 25/26 to NHSE. This sets out a challenging reduction target as part of the Trust's requirement to deliver a balanced financial position as part of the national planning guidance. Overall, the plan sets out a **net reduction of 785 WTE (6%)** in total workforce and this is phased over the year.

Overall, the breakdown of the net planned reductions is as follows:

- Substantive reductions – 620 WTE (5%)
- Bank reductions – 145 WTE (20%)
- Agency reductions – 20 WTE (30%)

Delivery risks

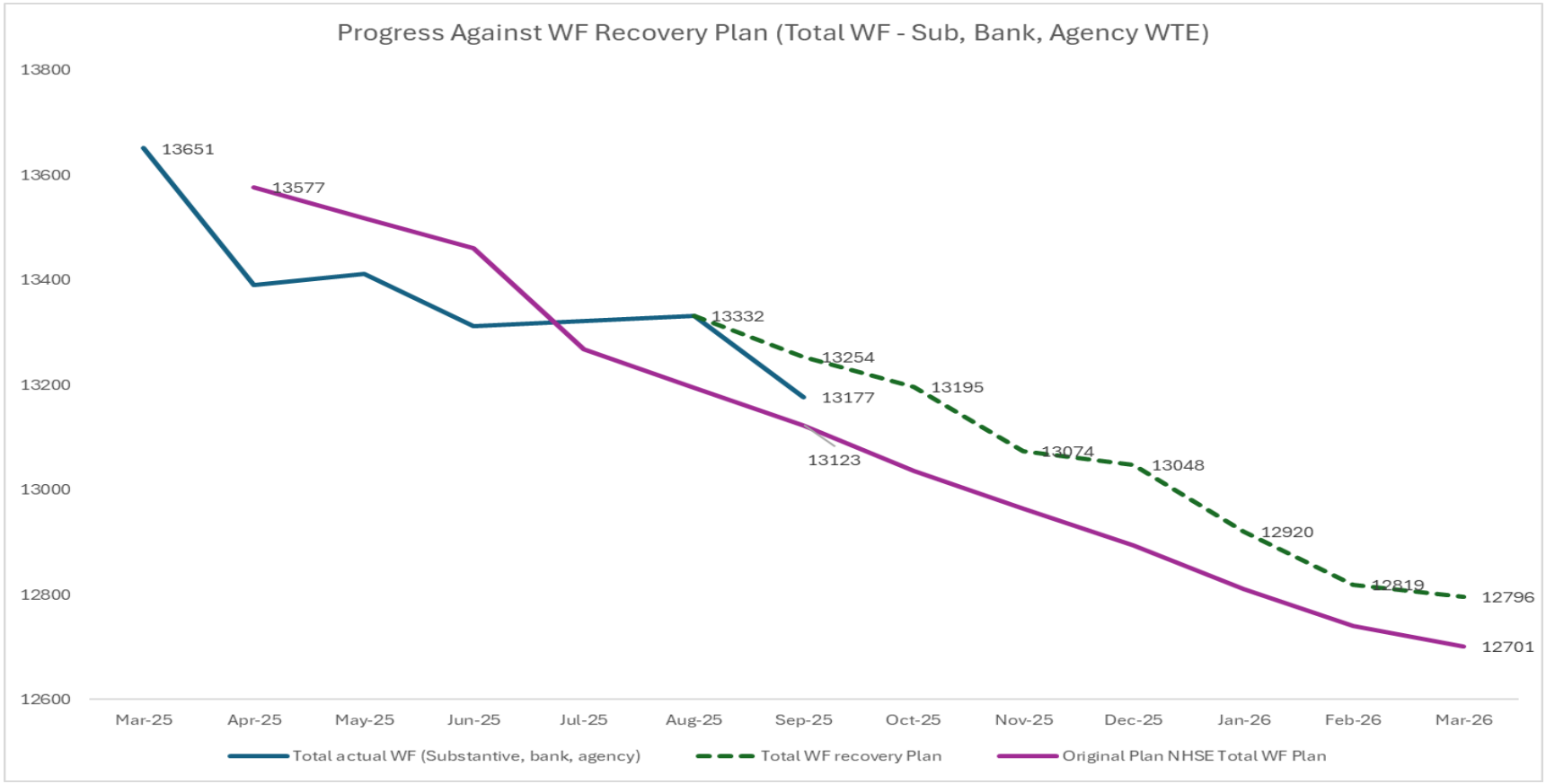
There are key risks to the delivery of the plan discussed along with appropriate mitigation factors being considered:

- **Impact on quality and safety** – workforce proposals will have a full QIA process for changes. A QIA committee has been set up as a reporting subgroup to the Financial Improvement Group (FIG) Chaired by the Chief Nurse.
- **Reduced turnover** – plans are reliant on natural attrition, which is slowing in the local health system and wider local economy. Slowing attrition rates will be a risk to plan delivery.
- **Severance payments** – cost of significant severance payments without external cash support. Our cash position will limit the ability to make a high volume of exits.
- **Temporary staffing** – reductions in temporary staffing are linked to closure in capacity, including improvements in mental health and NCTR. System schemes designed to support improvements in out-of-hospital capacity are key.
- **Capacity** – delivery of changes will require local leadership capacity and capability, coupled with HR support. The scale of changes and the burden on local teams already carrying vacancies is a significant risk.

Workforce Plan 25/26 – Progress on delivery

Trust Action	Detail	Timescale
Vacancy Management	• All Trust in Hampshire and Isle of Wight IBC have implemented a freeze on external non-clinical recruitment and 70% of clinical posts • Lag in impact of changes due to offers made pre-March controls, additional forecasting taking place with Divisions • Additional measures added included greater internal recruitment for clinical roles, and phasing of start dates where appropriate. • Significant risks emerging in A&C particularly with consideration required on small levels of recruitment to mitigate	In place
Clinical Divisional Structure	• New Division live from 1 July • DMT leadership teams in place, HQ support functions in place • Consultations ongoing with some discrete staff groups to finalise divisional infrastructure. Most areas complete • Review process of change in 3 months linked to EQIA • Savings achieved of circa £00k	Divisions live 1 July
Divisional and THQ pay cost base reductions	• Divisional teams reviewing plans to reduce overall pay costs by 5% • THQ teams have been set a target overall reduction of 10% • Reviews have taken place and amber, red, green schemes identified • Change management underway to deliver schemes where possible including discrete consultations with staff where required.	Summer and Autumn
MARS	• Applications closed – 224 applications reviewed (14 ineligible or withdrawn) • All applications reviewed by CFO and CPO • 65 accepted and progressing to finalisation (51 WTE) • Rejections on the basis of critical posts / affordability	Summer and Autumn
Temporary staffing	• FIG review of temporary staffing premium rates for A4C with proposals to consider actions made • Reduction in premium rates for nursing areas (ED, critical care, Paediatrics, Theatres) live from September. Collective dispute submitted by the RCN. • Review of WLI and Bank expenditure for medical staff • Introduction of additional controls on approval of bank shifts (2nd approval) within Allocate. • Detailed review of WLI / EDC at FIG. Extra payments model built. Review of overtime.	New nursing rates now live
Change management, Communication and engagement	• Changes managed in line with the Trust's organisational change procedures. Focus on redeployment as a priority supported through vacancy management. • Consultation with unions has commenced on overall level of change required. Weekly union meetings in place. • Transparent ongoing communication with staff through range of mediums including CEO led 'connect' and 'Talk to David' sessions with staff across the Trust	Ongoing

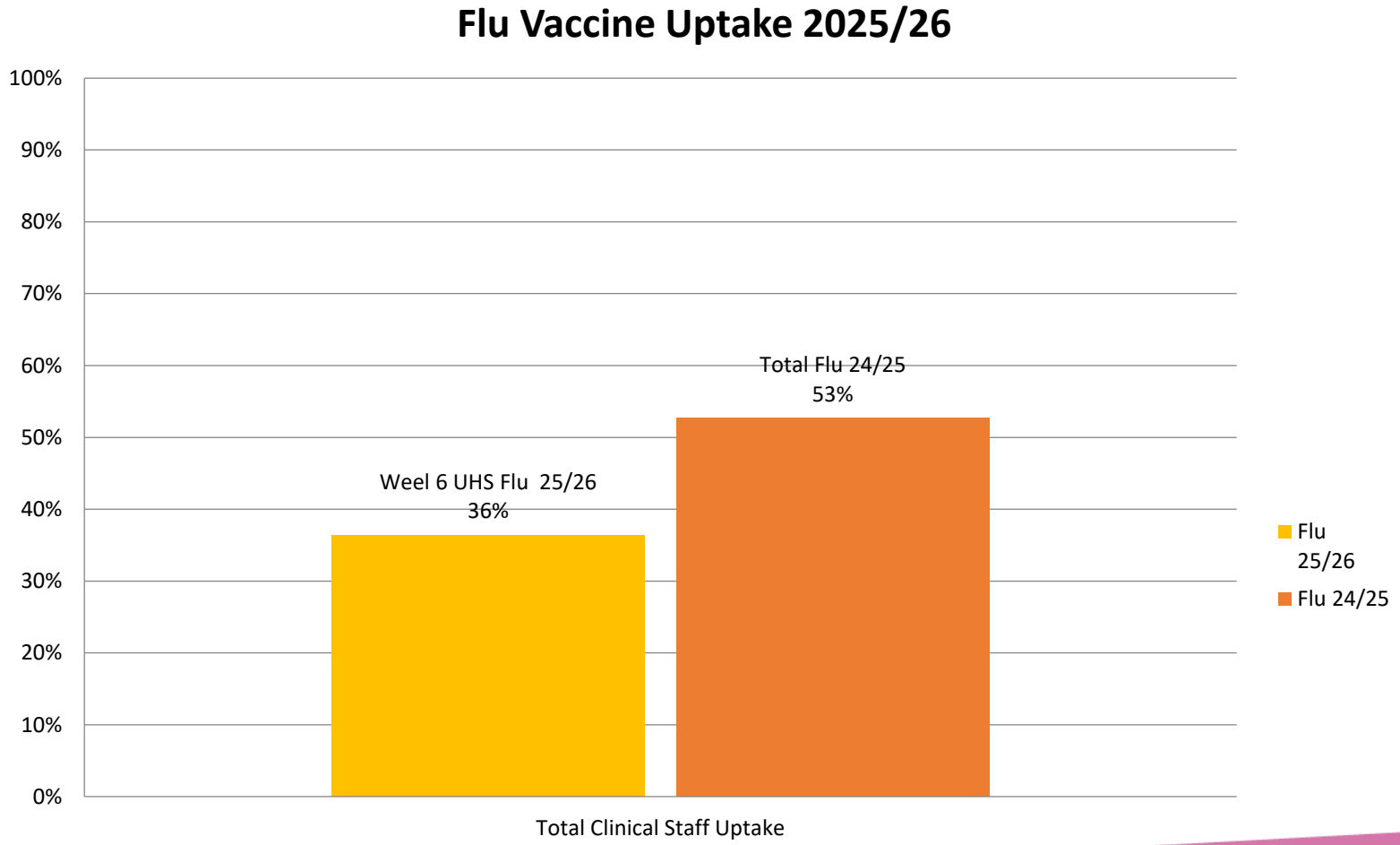
Progress against NHSE workforce recovery plan M6



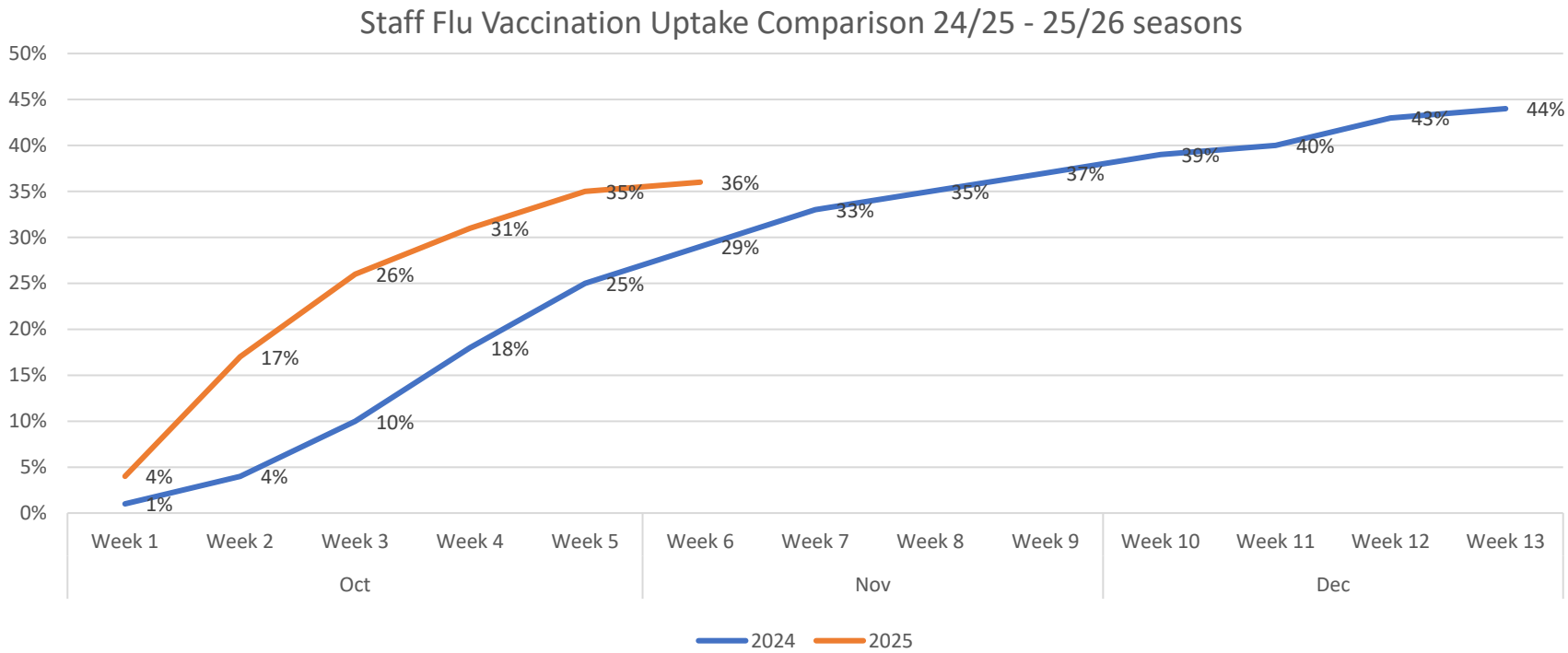
Source: ESR – September 2025

Flu Vaccination Programme 25/26

2025-2026 Programme Update



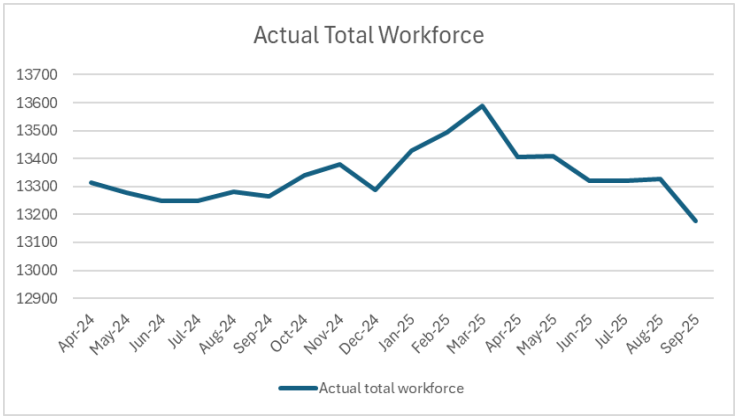
UHS Flu performance - % of frontline staff vaccinated

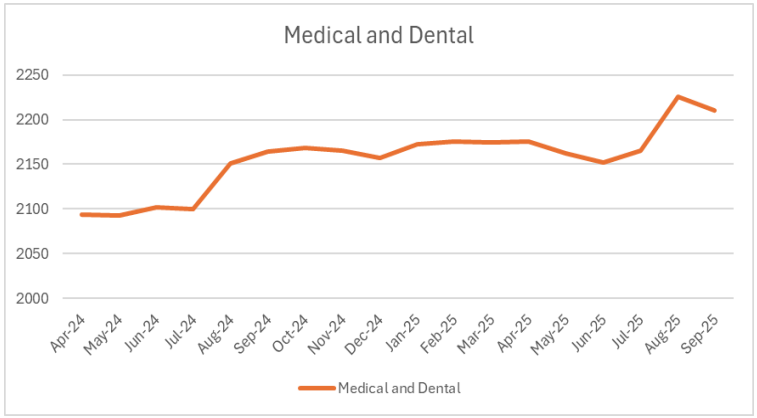


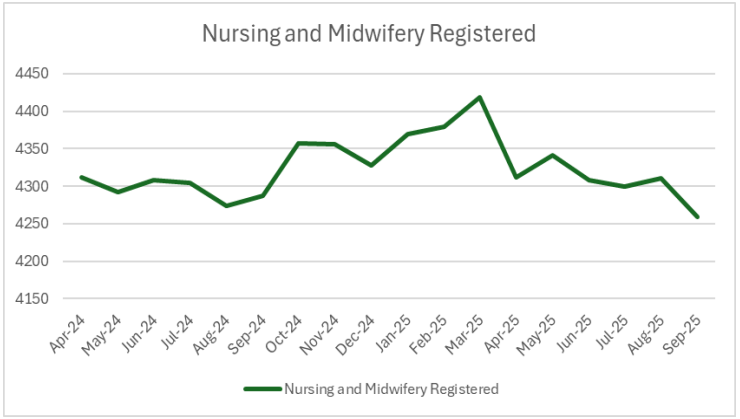
- UHS achieved a total flu uptake of 53% in 24/25
- Change of approach this year – planned clinics across the Trust
- Much quicker uptake due to ease of access to vaccination
- Very similar uptake across all professions
- Drop-in clinics available at OH and ongoing clinics across Trust
- UHS declared 3rd highest performing Trust across SE Region
- 4 months of the programme remaining, currently at over half the final uptake figure for last year

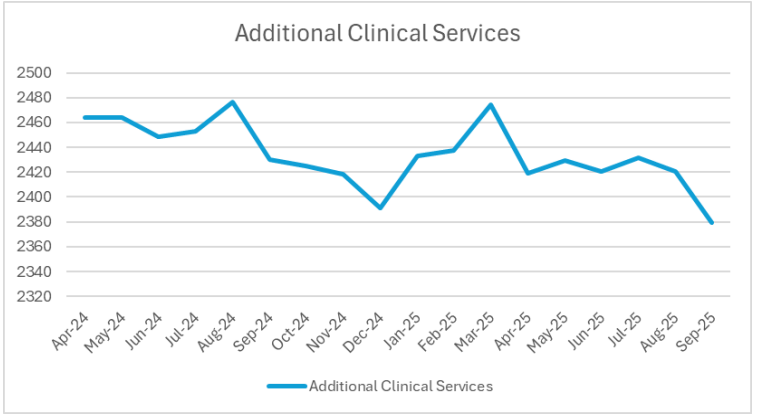
Appendices

Total Monthly Workforce (Substantive, Bank & Agency)



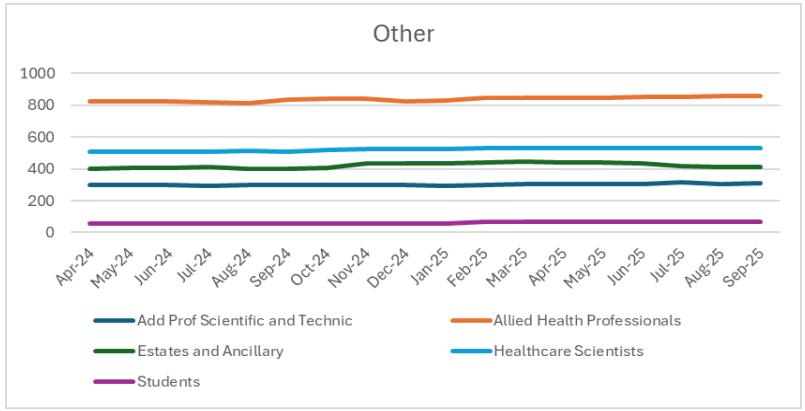


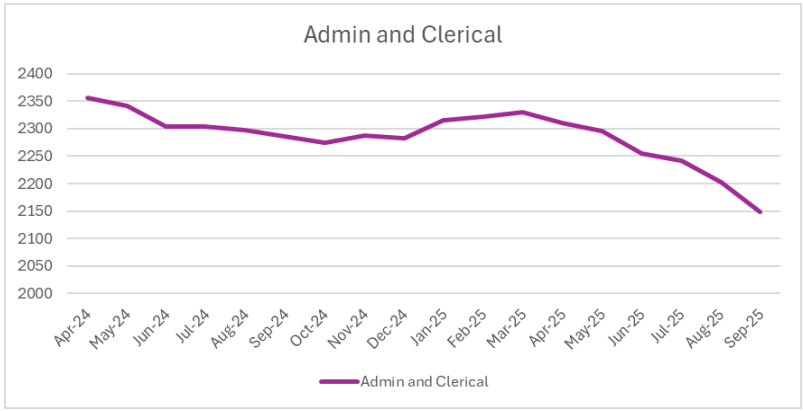


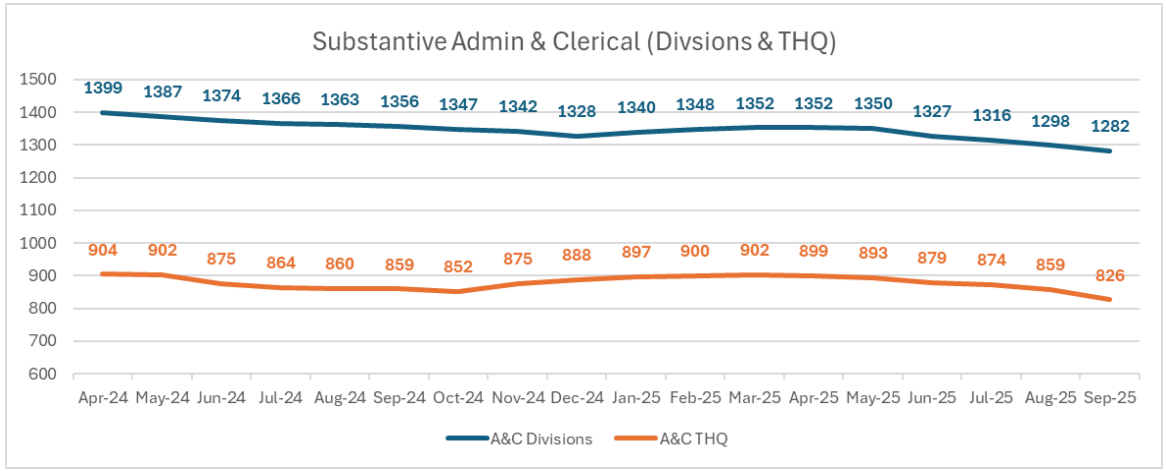


Source: ESR – September 2025

Total Monthly Workforce (Substantive, Bank & Agency)

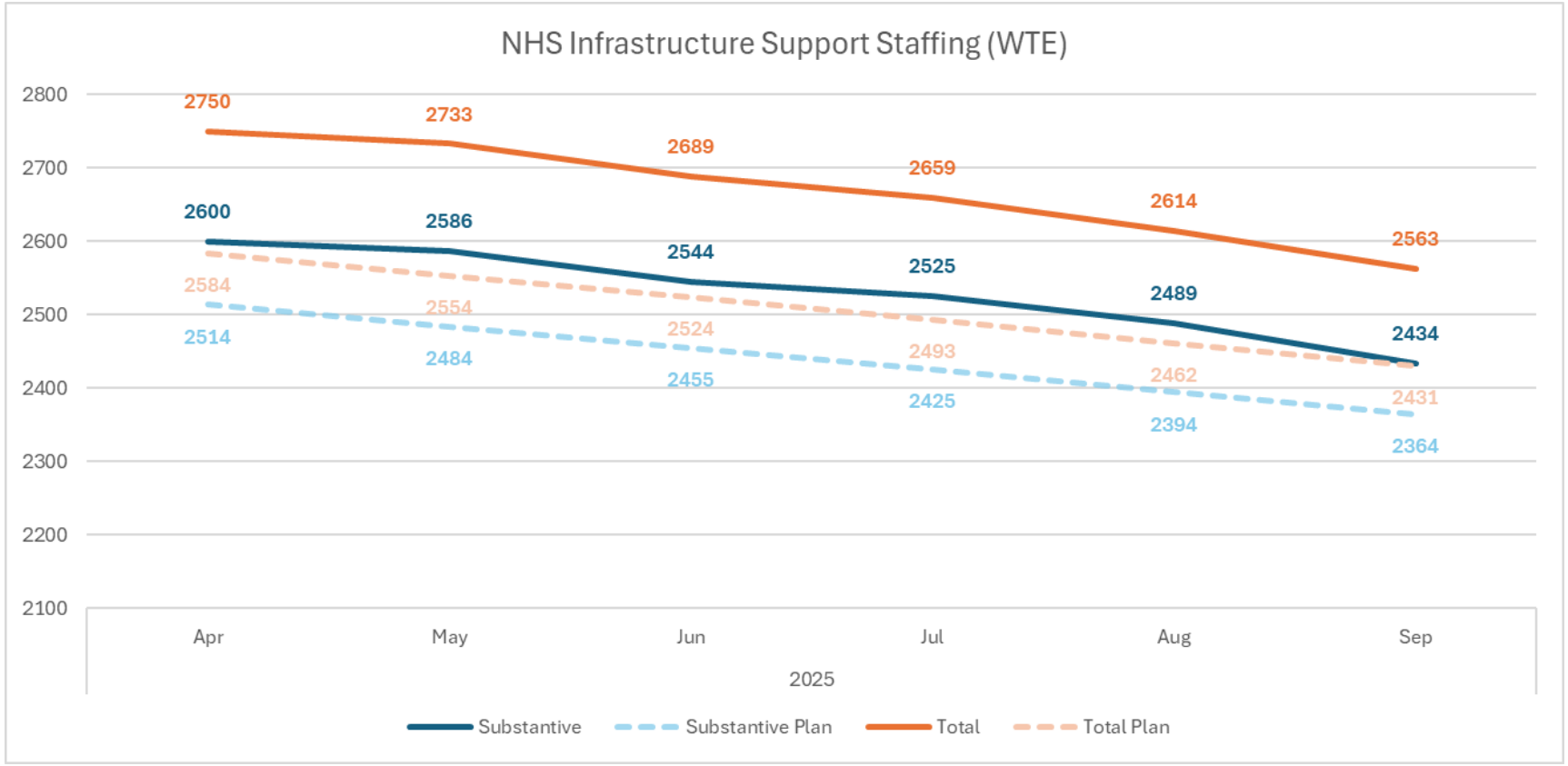






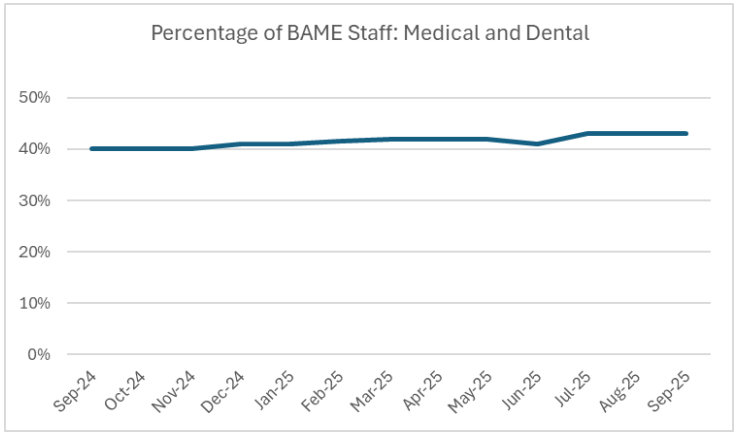
Source: ESR – September 2025

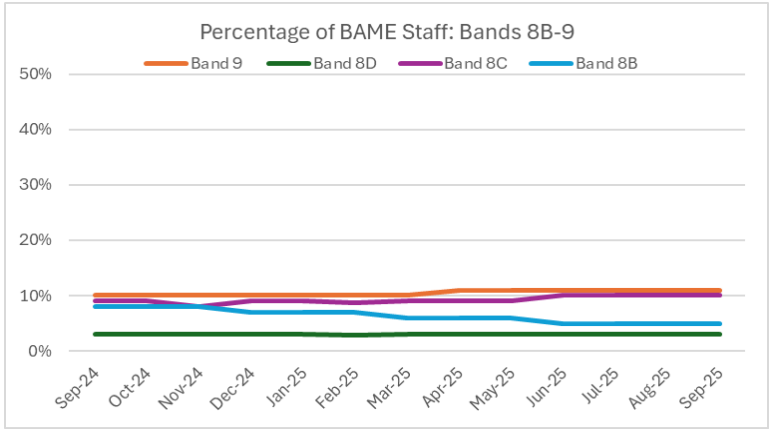
NHS Infrastructure Support Staffing

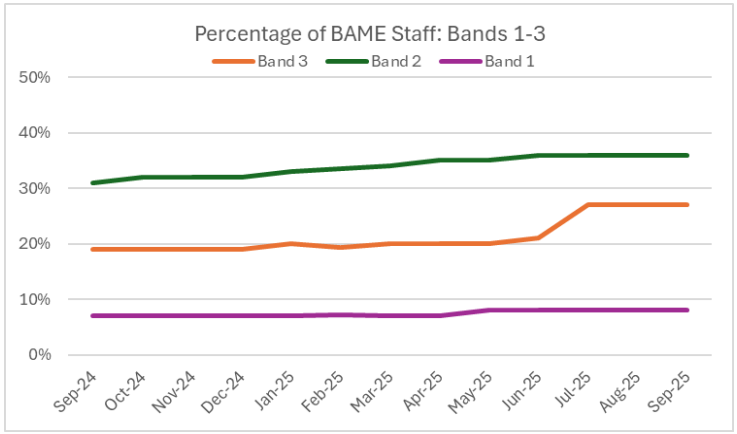


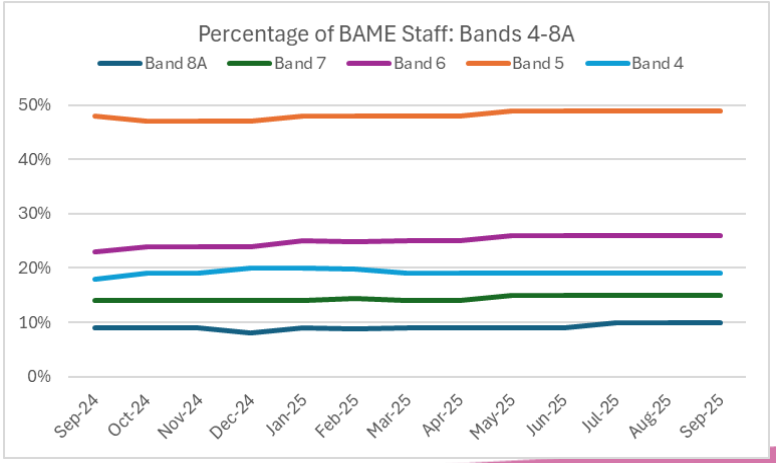
Source: ESR – September 2025

Staff in Post Ethnicity Trend



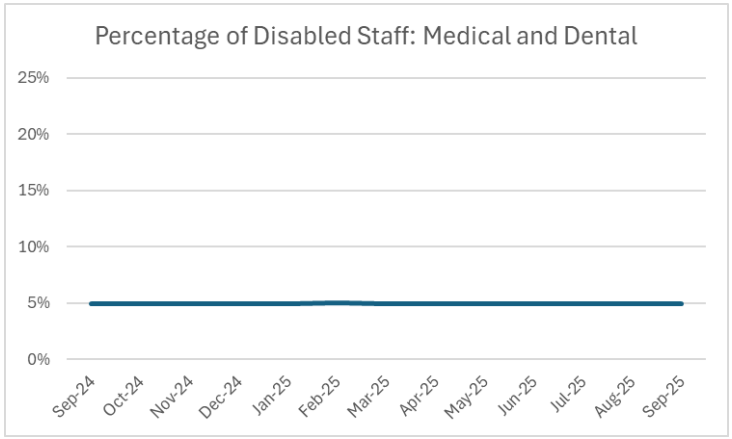


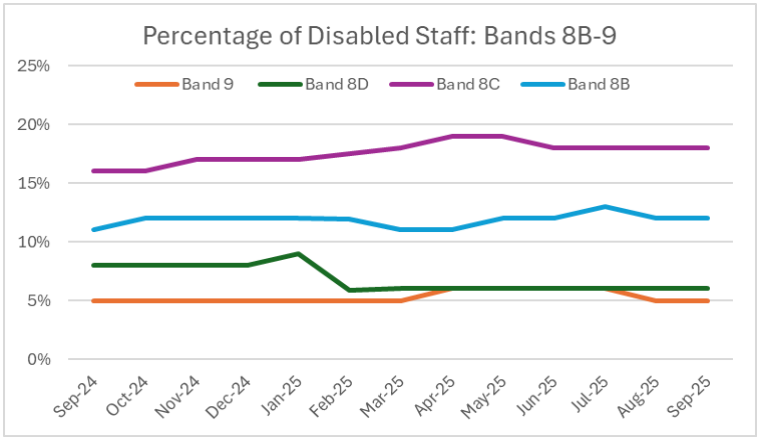


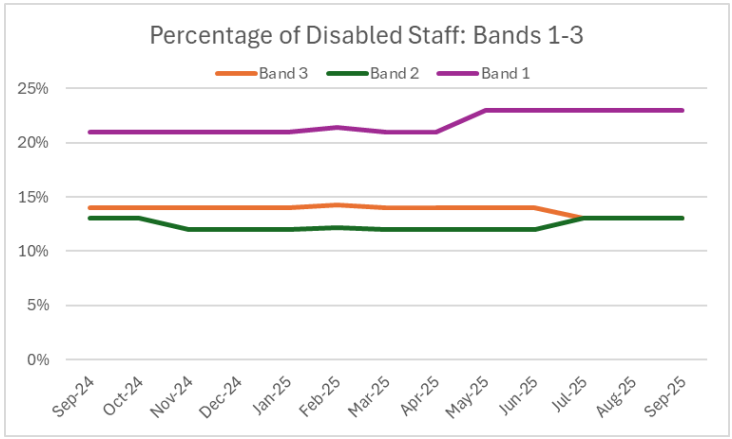


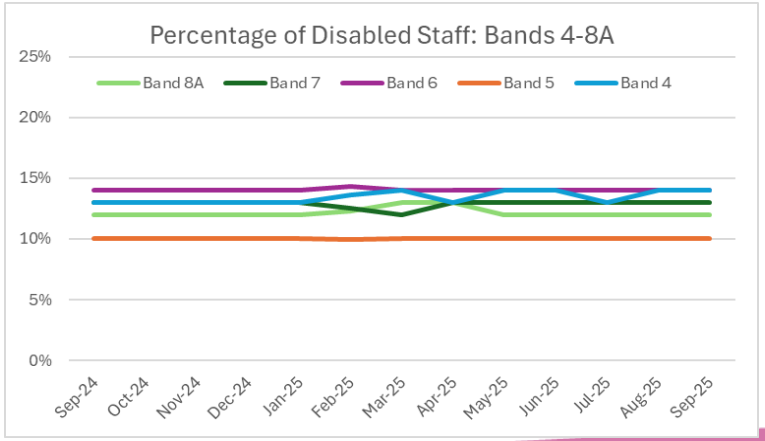
Source: ESR – September 2025

Staff in Post Disability Status Trend









Source: ESR – September 2025

Data Sources

Metric	Data Source	Scope
Industrial Action	HealthRoster	All staff rostered for strike action during IA periods
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; junior doctors' extra rostered hours)	For 25/26 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	For 24/25 Exclusions: WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Temporary Staffing (WTE)	Bank: NHSP; MedicOnline Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	ESR (Appraisals completed in-month and last 12 months)	AfC staff only
Statutory & Mandatory Training	VLE	No exclusions
Staff in Post (Ethnicity & Disability)	ESR	No exclusions
Pulse Survey	Picker (Qualtrics)	No exclusions
Care Hours PER Patient Day (CHPPD)	HealthRoster (In-month shifts) eCamis (In-month daily patient numbers)	Clinical inpatient wards, Critical Wards, and ED only


WORLD CLASS PEOPLE

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.11 Report to the Trust Board of Directors, 11 November 2025	
Title:	NHSE Audit and review of 'Developing Workforce Safeguards' (2018) including UHS self-assessment return
Sponsor:	Steve Harris, Chief People Officer Natasha Watts, Acting Chief Nursing Officer
Author:	Rosemary Chable – Head of Nursing for Education, Practice and Staffing

Purpose

(Re)Assurance	Approval	Ratification	Information
x	x		

Strategic Theme

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

Executive Summary:

(a) To provide an update on the NHSE approach to refreshing and reviewing compliance with the standards included in the 'Developing Workforce Safeguards' (2018). Previously presented to board in January 2019.

To present the 2025 submitted self-assessment and resulting action-plan to achieve UHS compliance with the standards.

(b) Developing Workforce Safeguards (Appendix 1) was published in October 2018 and included a range of standards that Trusts were required to meet in order to assure safe staffing across the workforce. This document emerged from the NQB safe staffing guidance, published as a key action from the Francis enquiry (2013).

Post COVID-19, NHSE have identified a national downturn in compliance and have initiated a 2025 audit, review and improvement plan to ensure the standards are brought back into focus for Trusts.

UHS submitted the self-assessment for the July 31st deadline and are awaiting to hear whether we will be included in the trusts selected for further review and support.

UHS has continued to comply with the majority of the standards included in the 2018 workforce safeguards document, particularly related to nursing and midwifery. At UHS this activity was maintained throughout COVID-19 and beyond.

The 2025 audit exercise has been used in UHS as an opportunity to identify key improvement opportunities and to identify where processes need to be refreshed and revisited. Of the 12 recommendations, 9 were assessed as green and 3 as amber.

(c) Trust board is asked to note the report and the submitted action plan with the key areas identified for improvement:

- Review all processes and information flows to match the new 2 monthly meeting schedule for trust board to ensure all relevant escalations are visible at board.
- Principles of NQB guidance and Workforce safeguards to be embedded in all other staff groups beyond nursing and midwifery.
- Continue to strengthen and expand the role of the staffing hub.

- Safe staffing working group (subgroup of NMSRG) to develop a rollout plan for 26/27 for separate Safer Nursing Care Tool (SNCT) reviews to work alongside the annual staffing review cycle.
- Ongoing review of all staffing metrics and the risk process to monitor impact linked to QIA process.
- Chief Nurse and medical director must confirm safe staffing review in annual governance statement to board – this is well embedded for Nursing and Midwifery, need to broaden this to cover all other staff groups.
- Consider reinstating the 6 monthly direct reporting to trust board of the light touch staffing review which currently goes to Divisional boards.
- Ongoing review of the clinical quality dashboard (CQD) and clinical review processes.
- Develop new quality report for trust board which will have more explicit detail on nursing and midwifery staffing and links to quality.
- Real-time quality reporting for maternity to link into dashboard.
- Develop a specific Nursing safe staffing policy including SOP for escalation by 31st December 2025

Contents:

Paper; Developing Workforce Safeguards; Workforce self-assessment guiding recommendations; UHS submitted action plan; Annual governance statement – safe staffing

Risk(s):

1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.

Equality Impact Consideration:	N/A

1 Purpose

This report provides an update on the NHSE 2025 approach to the review and refresh of the Developing Workforce Safeguards standards published in 2018 (PDF Developing Workforce Safeguards).

Detail around the self-assessment and review process is included as well as a summary of the UHS self-assessment submitted for the 31st July 2025 deadline including the actions identified to ensure compliance.

2 Key Issues

'Developing Workforce Safeguards (DWS) – Supporting providers to deliver high quality care through safe and effective staffing' was published in 2018 with expectations around delivery of the recommendations by April 2019.

This guidance built on existing National Quality Board (NQB guidance) around safe staffing and within UHS was reviewed through People Board and actions embedded into the ongoing cycle for assuring safe staffing.

Following a recent national audit that identified a decline in compliance post-COVID, regional teams were asked to undertake a similar review.

The national workforce assurance process set the expectation for regions to work with all trusts to undertake a self-assessment against the standards, reporting back to the NHSE National Nursing Workforce team.

Each organisation was required to submit a self-assessment of compliance by completing a Safe Staffing Gap Analysis spreadsheet by 31st July 2025.

There were 12 DWS recommendations included in the self-assessment (PDF Workforce Safeguards Self-Assessment) framed around:

- Effective workforce planning.
- Structured and systematic approach to workforce changes including robust Quality Impact Assessment (QIA) process.
- Use of validated establishment setting tools for Nursing.
- No local manipulation of identified nursing resource.
- 6 monthly nurse staffing reviews reported to Board.
- CHPPD compliance and publishing for the public.
- Safe staffing escalation policies and information provided to Board.

3 Specific Detail

Of the 12 recommendations, UHS has self-assessed as green for 9 and amber for 3 (PDF UHS Workforce Safeguards gap analysis).

The 3 recommendations that have been rated as amber are:

- ***Trust to confirm there is no local manipulation of identified nursing resource from approved evidence based tools***:
  Within UHS we use the Safer Nursing Care Tool (SNCT) for adult inpatient wards and Children's areas. This is incorporated into our Healthroster system through the Safecare module. Where other evidence-based tools are available we also use these as part of our triangulated approach to setting staffing levels. In all areas, we use the tools in conjunction with other methods to set our staffing establishments (detail presented to board as part of our 6 monthly nurse staffing reviews). Nationally it is recommended that

the SNCT is used as a standalone tool and staffing establishments set against this. Our action-plan outlines how we will move to more standalone use of the SNCT whilst still ensuring we are fully triangulating with other staffing metrics. Additionally in 2025/2026 as part of our financial recovery plans we have agreed to manage nursing levels below agreed establishment whilst balancing the risk. For full transparency we included this approach as part of our declaration on the self-assessment.

- ***Agreed local quality dashboards on staffing and skill mix that is cross checked with comparative data each month and reported to the Board**:*
  Whilst there are a number of dashboards that involve both quality and staffing KPI's within UHS, these are not always cross-checked, compared and presented to Board in a consistent way. The new quarterly quality report prepared for Board will address some of this recommendation and further work on the quality dashboard will further inform monthly updates to the Board.

- ***Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified:***
  Whilst there are very clear processes and escalations for nursing and midwifery, managed through the staffing hub, these have not previously been captured in a comprehensive safe staffing policy. A policy is now being developed as part of our action plan.

Additionally, the self-assessment highlighted that within UHS the workforce safeguards have been implemented and are well embedded and assured for nursing and midwifery. This is not consistent for all other staff groups and further work will be required – led through the workforce team, to ensure that these recommendations are assured across all staff.

4 Next Steps / Way Forward

People Board to monitor completion of the actions identified to achieve compliance with the workforce safeguards:

- Review all processes and information flows to match the new 2 monthly meeting schedule for Trust Board to ensure all relevant escalations are visible at Board.

- Principles of NQB guidance and Workforce safeguards to be embedded in all other staff groups.

- Continue to strengthen and expand the role of the staffing hub.

- Safe staffing working group (subgroup of NMSRG) currently developing a rollout plan for 26/27 for separate SNCT reviews to work alongside the annual staffing review cycle.

- Ongoing review of all staffing metrics and the risk process to monitor impact linked to QIA process.

- Chief Nurse and Medical Director must confirm safe staffing review in annual governance statement to Board – this is well embedded for Nursing and Midwifery, need to broaden this to cover all staff groups. (Appendix 1 Annual Governance Statement).

- Consider reinstating the 6 monthly direct reporting to Trust Board of the light touch staffing review which currently goes to Divisional Boards.

- Review of the clinical quality dashboard (CQD) and clinical review processes currently ongoing. New quality report currently being developed for Trust Board which will have more explicit detail on nursing and midwifery staffing and links to quality. Awaiting the development of real-time quality reporting for maternity to link into dashboard.

- Safe Staffing working group currently completing a specific Nursing safe staffing policy including SOP on escalation. This needs to be considered for all other staff groups.

5 Recommendations

Trust Board are asked to:

Note and discuss the report and the implications identified for UHS including the requirement for Board level sign-off of a workforce plan annually and the need to review what regular Board information is presented on safe staffing in order to meet the regulatory requirements.

Developing-workfo rce-safeguards.pdf

Workforce safeguards self-asse

UHS Workforce safeguards gap ana

(see attached)

Appendix 1

The disclosure in the 2024/25 annual governance statement is as follows:

Safe Staffing
The National Quality Board guidance is fully embedded for nursing and midwifery and includes:

- annual review and re-setting of nursing establishment and skill mix using a triangulated methodology and approved tools, refreshed six-monthly, and both reported to the Board.
- regular reporting to the Board of nursing and midwifery staffing hours and any 'red flag' events for staffing as part of performance reporting.
- availability of staffing information for the public via ward displays and on the public website.
- dynamic staffing risk assessments and formal escalation processes; and
- implementation of new roles such as nursing associates, apprentices and advanced practitioners, accompanied by strong quality impact review.

The Trust also complies with the developing workforce safeguards recommendations through a bi-annual ward staffing review process, development of a quality impact assessment template for service changes and regular reports to the Board on staffing establishment. Plans to make significant changes to the workforce are reviewed to assess the impact on safety and quality of services.

Staffing metrics are combined with the wider performance report to ensure the quality impact is reviewed as a whole. A formal quality impact assessment approval is required from the Chief Nursing Officer and Chief Medical Officer with respect to major changes in the workforce.

All staffing metrics are regularly monitored, using a variety of sources including data from the model hospital and these are reported monthly with a six-monthly focus to the Quality Committee and the Board.

Electronic rostering is well embedded within the Trust, having been introduced in 2009. It is used across the professions and integrated with other workforce systems. Further work is ongoing to embed this further for medical staff and expand job planning for all staff where this is appropriate.

The guardian for safe working hours also reports quarterly to the Board providing assurance that the Trust's resident doctors have safe working hours.

NHS Improvement

Developing workforce safeguards

Supporting providers to deliver high quality care through safe and effective staffing

October 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Foreword

The NHS is proud of the care and services it delivers to communities across England. At the centre of this important work are the staff who support patients, service users and clients from hospital wards to their own homes. Recent reports have highlighted the continuing challenges facing the supply and retention of the NHS's workforce. Demand for healthcare staff continues to exceed supply, despite increases. Staff have risen to this challenge. They continue to provide outstanding care as they develop flexible approaches to their roles, improving efficiencies and maximising their impact on patients' and service users' lives. Innovative ways of working have been introduced to achieve this, alongside new roles and development of existing ones. This is a challenging time, but one that brings significant opportunities for workforce development.

However, we recognise that these ongoing pressures require health systems and boards to make tough decisions to ensure services achieve best outcomes at a time of financial challenge. Boards must ensure that this does not have an adverse impact on the quality of care, as well as patient, service user and staff experience.

This document has been developed by system leaders to highlight policy that supports organisations to use best practice in effective staff deployment and workforce planning. It offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce, and it describes NHS Improvement's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually. As a result, it includes new recommendations on workforce safeguards to strengthen the commitment to safe, high quality care in the current climate.

Ruth May
Executive Director of Nursing
NHS Improvement

1. Introduction

This document is designed to help trusts manage common workforce problems. It contains new recommendations to support them in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on the National Quality Board's (NQB) guidance.[1,2]

From now on we will assess trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time (see Appendix 1). It is based on patients' needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

To assess trusts' compliance with this, we will use information collected through the Single Oversight Framework (SOF). We will also ask trusts to include a specific workforce statement in their annual governance statement (for more details, see Section 7: NHS Improvement's yearly assessment).

By implementing this document's recommendations and strong, effective governance, boards can be assured that their workforce decisions will promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, our Use of Resources assessment and the board's statutory duties. We recognise that further work is necessary to develop a consistent approach to safe staffing levels across all clinical workforce groups. We particularly need to develop evidence-based tools for assessing the impact of variations in acuity and dependency on medical, allied health professional (AHP) and other non-nursing clinical staff groups.

In addition to following our recommendations, we urge senior leaders to consider their organisation's wider culture. Evidence shows that an organisation's leadership is the single biggest influence on culture: paying attention to it will make success in implementing the recommendations more likely.

[1] NQB (2013) *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability*. https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[2] NQB (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing*. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

2. Recommendations

NQB's guidance states that providers:

- **must** deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- **must** use an approach that reflects current legislation and guidance where it is available.

Meeting NQB's expectations helps providers comply with CQC's fundamental standards on staffing – for example, in the well-led framework[3] – and related legislation.

In support of the NQB expectations, we will ensure that trusts take the required action to ensure that these principles are in place. Therefore:

1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.

2. Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

   – evidence-based tools (where they exist)
   – professional judgement
   – outcomes.

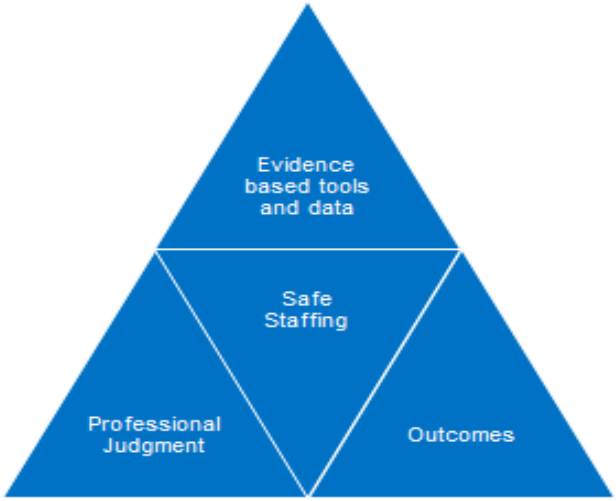
   We will check this in our yearly assessment.

3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.

[3] https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led

4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.

Figure 1: Principles of safe staffing



5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes.

6. As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

7. Trusts **must** have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.

For more details on our yearly assessment, see Section 7.

NQB guidance contains further principles boards **must** follow:

8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard.[4] Trusts should report on this to their board every month.

[4] https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf Section 3

9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance[5] and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

11. As stated in CQC's well-led framework guidance (2018)[6] and NQB's guidance[7] any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.

12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.

13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.

14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

[5] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
[6] http://www.cqc.org.uk/sites/default/files/20180130_9001100_well-led_Trust-wide_inspection_framework_NP_v4.pdf
[7] NQB (2012) *How to quality impact assess provider cost improvement plans* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

3. Effective workforce planning

Effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users.[8,9]

Establishment setting must be done annually, with a mid-year review, and should take account of:

- patient acuity and dependency using an evidence-based tool (as designed and where available)
- activity levels
- seasonal variation in demand
- service developments
- contract commissioning
- service changes
- staff supply and experience issues
- where temporary staff have been required above the set planned establishment
- patient and staff outcome measures.

It is important that all stakeholders, including commissioners, are sighted on all recommendations to maintain or change establishments. Stakeholders should understand the rationale behind such recommendations and their anticipated impact.

Our annual planning process supports this assessment and includes monthly returns to identify trusts' progress and inform wider strategic workforce planning.

[8] http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/
[9] https://www.hee.nhs.uk/our-work/workforce-strategy

What a workforce plan should do

An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity and performance plans, and directly involve leaders and managers of the service. You may find our workforce planning toolkit helpful (see page 15).

A good workforce plan will:

- be constructed from robust plans focused at clinical service-line level that draw on available evidence –particularly the Getting It Right First Time (GIRFT) programme – describing 'what good looks like'
- ensure multidisciplinary workforce numbers are evidence-based, while considering specific system and organisational requirements
- ensure staffing capacity and capability are sustainable and sufficient to provide safe and effective care to patients and service users, taking account of any predictable patterns of variation in demand
- take account of financial restraints by setting an accurate and achievable staffing budget agreed by clinicians and the finance department
- minimise or negate the need for expensive agency staff by effectively planning the workforce needed for service requirements[10]
- inform and be informed by an organisation's clinical strategy, business cases and efficiency plans
- encourage leaders, managers and staff to work collectively on the workforce planning process, which should be informed by comprehensive staff engagement
- include a comprehensive QIA where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles (eg physician associates, nursing associates, ACPs)
- set the standard for expected staffing levels – encouraging transparency and enabling staffing decisions to be based on evidence
- be formulated by multidisciplinary teams and consider the whole service and the workforce required to deliver the activity, at the required quality standards; from a financial perspective, this should include realistic calculations of workforce 'headroom' for all professional groups and support workers, and consider likely

[10] https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/

staffing costs such as a percentage of parental or study leave, to avoid overspending when such leave is required

- promote a proactive rather than reactive approach to staffing because workforce planning is a continuous process and should be continually monitored and reviewed.

The planning cycle

Plans are typically initiated in accordance with NHS Improvement and Health Education England (HEE) cyclical timescales. However, we recommend that workforce plans are regularly reviewed as workforce or operational issues are identified. They must take account of the six-monthly establishment reviews and the annual establishment re-set identified in NQB's guidance.[11] Plans will typically be aligned to the business planning cycle. However, an effective workforce plan should also be revised 'as and when' needed when a change is identified. It should reflect the workforce position based on service need at any time. It is vital that managers and clinical leaders are involved in developing the plan whatever prompted it, so it is effectively informed and aligned to the clinical strategy and stakeholders' support is sought.

Approach to workforce planning

We recommend a two-step approach to workforce planning. First, take account of actual staffing levels and second, understand the gaps and what is required to close them, supported by a workforce planning model. A range of data sources can help with this:

- **The electronic staff record** (ESR) provides information on contracted whole-time equivalents (WTEs), headcount, leave (sickness, maternity, adoption and annual) and turnover information. ESR can also be used to project when staff will reach pensionable age and forecast the potential impact of the number of staff who could retire.
- **Evidence based decision support tools** that demonstrate patient acuity and dependency aligned to staffing resource requirements. These can provide robust establishment recommendations when used according to their guidance.

[11] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

- **E-rostering systems** provide evidence to detail workforce utilisation including leave trends and types of staff utilised (bank, agency, substantive). We recommend using these systems for all staff groups.
- **Electronic job-planning systems** provide evidence of available clinical capacity across the seven-day working week. We recommend using these systems for all clinical staff not working a 24/7 shift system.
- **Financial systems** provide information on planned and actual substantive workforce costs and establishments. They also provide details on the historical use of temporary staffing.

Case study: Safe staffing for occupational therapy

Needs assessment: The joint North West Allied Health Professional Project Group identified these issues:

- difficulties associated with cross-site cover in a large organisation
- concerns about the consistency of allocating staff resources in line with clinical need as opposed to historical staffing levels
- forward planning of leave and cover to avoid crisis management
- staff awareness of pressures in the whole service
- ability to clinically reason staffing levels required for an existing service.

Aims and objective: The initial aim was to agree safe staffing levels within the occupational therapy team, enabling effective management, planning of safe levels of care and to escalate concerns when safe staffing levels were not met.

Method and approach: Physiotherapy colleagues shared their existing annual leave planner. On further development, the occupational therapy team devised a principle locally for a simple, single patient pathway caseload:

Clinical time needed for an average patient x the number of patients + an uplift to account for non-clinically related time = how much staff time you need to safely manage the needs of that patient group

Non-clinical time uplift = 15% (based on national benchmark)

Vacancy uplift = 23% (based on trust current value)

For more complex teams, the patient pathways were split and added together to produce a whole-time equivalent calculation for the whole team.

Results and evaluation: Tools were developed and updated through joint working with local physiotherapy colleagues.

- As the annual leave planning tool is visual and updated by the teams, the team leaders and wider teams have a much better understanding of service pressures as a whole.
- Planning for leave is done with team leaders and is regularly reviewed to avoid crisis management of shortages.
- Safe staffing levels are reviewed monthly and cross-checked against activity data. This has resulted in some changes, with staff being reallocated in line with clinical need.
- The calculator can be used to compare staffing requirements pre and post-service initiatives.

Key learning points:

- Comparison across localities between expected and actual clinical need allowed a quality check on the typical estimated acute patient pathway being around 2.5 to 3 hours for occupational therapy.
- Highlighted the need to incorporate time working as ‘doubles’, when two clinicians are working with a patient.
- Highlighted the need for the tool to be used for specific condition-related pathways (eg weight management) as well as general caseload pathways (eg acute surgery).

Next steps:

1. Pilot tools across additional North West sites and include dieticians and speech and language colleagues, to:

   - investigate the possibility of predicting typical patient pathways in some areas with more data comparisons available
   - fine tune the tool to work for other professions
   - develop more examples of how the tools can be put into practice.

2. To work with IT teams to develop the tools so they are more user-friendly and easier to share.

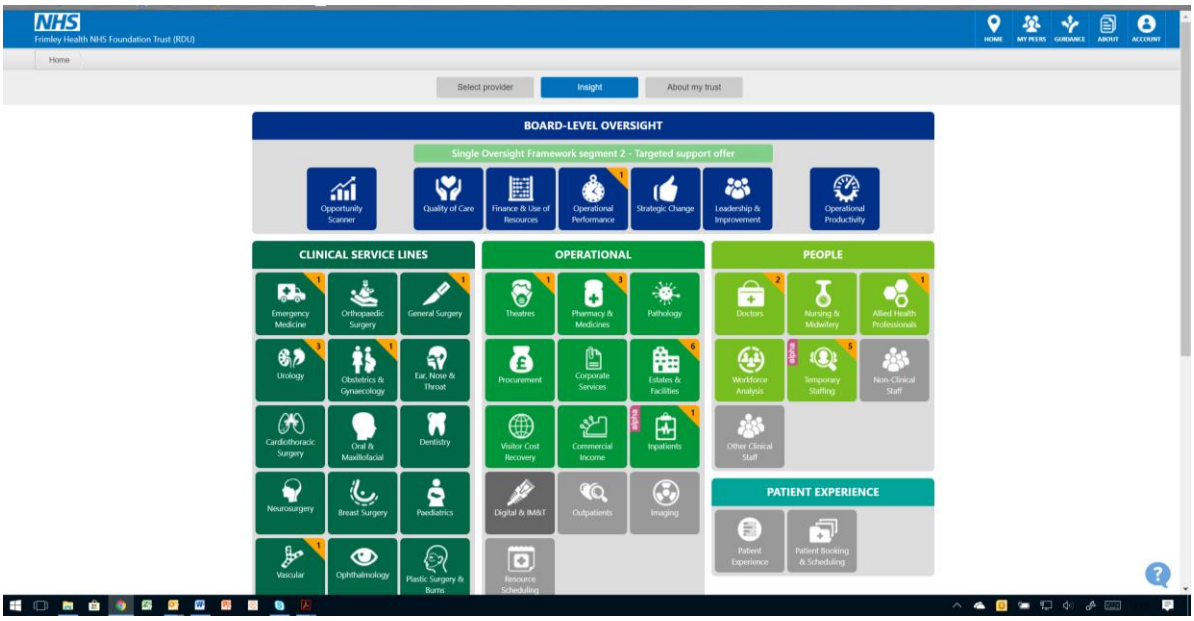
NHS Improvement's Model Hospital[12] is a digital information service that enables trusts to compare their productivity, quality and responsiveness to identify and realise productivity opportunities by tackling unwarranted variation. Its datasets are drawn from providers' returns and other data held by arm's length bodies, displayed in a format that allows benchmarking and peer comparison.

The Model Hospital holds a wealth of workforce data (see Figure 2 below) that can and should be used for workforce planning:

- care hours per patient day (CHPPD) and cost per care hour (CPCH) help identify and benchmark typical nursing and care staff utilisation in various specialty settings
- further metrics are under development for other elements of the workforce – for example, clinical hours to contact (CHtC) and cost per contact for non-ward based settings.

[12] https://improvement.nhs.uk/resources/model-hospital/

Figure 2: Model Hospital compartment screenshot



Better workforce planning and avoiding agency usage

The NHS workforce strategy[13] highlighted significant workforce shortages and an over-reliance on temporary solutions such as locums and agency staff.

Some temporary staffing options are important so the workforce can be flexible to service demands, but the NHS's over-reliance on locum and agency solutions is unsustainable and may affect service continuity and quality.

Our agency reduction programme[14] helps trusts reduce costs and ensure that internal bank systems are first choice. Effective rostering of substantive staff should maximise productivity and reduce demand for temporary staffing.

In the short term, we expect effective workforce planning to have a positive impact on quality of care and patient, service user and staff experience, while ensuring financial resources are used efficiently. Longer term, accurate plans will help predict the numbers of healthcare workers required to meet future demand and supply. This aligns with our Use of Resources assessments.[15] Trusts have already made progress: for example, spending on bank staff now exceeds agency spend.

[13] https://hee.nhs.uk/our-work/workforce-strategy
[14] https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/
[15] https://improvement.nhs.uk/improvement-hub/finance-and-use-resources/

Workforce planning toolkit

Our workforce planning toolkit[16] identifies five components of workforce planning, as well as the characteristics and processes of effective workforce planning.

- **Leadership:** Is there an executive sponsor, such as the director of workforce, and are internal and external stakeholders involved?
- **Technology:** What systems are there to assist with workforce planning and assess performance against the plan?
- **Information, method and governance:** Is workforce planning based on evidence? Is planning supported by applying a workforce planning model?
- **Engagement and integration:** To what extent are staff involved in workforce planning? How is this integrated/cross-checked with other aspects of planning including activity and finance?
- **Strategy:** Is short, medium and long-term horizon-planning included? Have future scenarios been considered within the local health and care systems, including sustainability and transformation partnerships or integrated care systems?

The toolkit complements other workforce planning resources and enables self-assessment against typical workforce planning requirements. It will promote discussion at a senior level to identify factors such as culture and leadership that underpin effective workforce planning. It covers the factors we use to review workforce plans and includes links to other workforce planning resources. Some of our other toolkits – such as the pathology toolkit essential services laboratory template[17] – also help with workforce planning.

[16] https://improvement.nhs.uk/resources/operational-workforce-planning-self-assessment-tool/
[17] https://improvement.nhs.uk/documents/2366/Template_structure_for_ESL_blood_sciences_RE03.pdf

4. Deploying staff effectively

This section contains advice on trust boards' responsibilities for making sure staffing arrangements are safe, sustainable and productive. It also considers emerging roles such as nursing associates, physician associates and ACPs, who will be integral to the future NHS workforce.

Useful guidance

NQB's guidance[18] explicitly requires trusts to meet three expectations – deploying the right staff with the right skills at the right place and time (see Appendix 1). These set the foundations on which any workforce plan should be based, while not ignoring other organisational development needs such as values and behaviours.

In addition, the Cavendish report[4] highlights that well-performing organisations use their workforce as a strategic asset. This underlines the need to deploy the workforce effectively and efficiently: it accounted for 63% of trusts' costs on average in 2017/18.

Boards should also take account of guidance from bodies such as royal colleges. For example, in July 2018 the Royal College of Physicians published *Guidance on safe medical staffing*.[19] This recommends standards for medical staffing in acute settings. It aims to help those planning and organising core medical services to calculate how many doctors and related personnel they need to provide timely and effective care.

We have developed sector-specific evidence-based workforce improvement resources for:[20]

- adult inpatients
- urgent and emergency care
- maternity
- mental health and learning disability

[18] NQB (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing*. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf
[19] https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing
[20] https://improvement.nhs.uk/search/?q=safe+staffing&page_type=52&=Filter+results

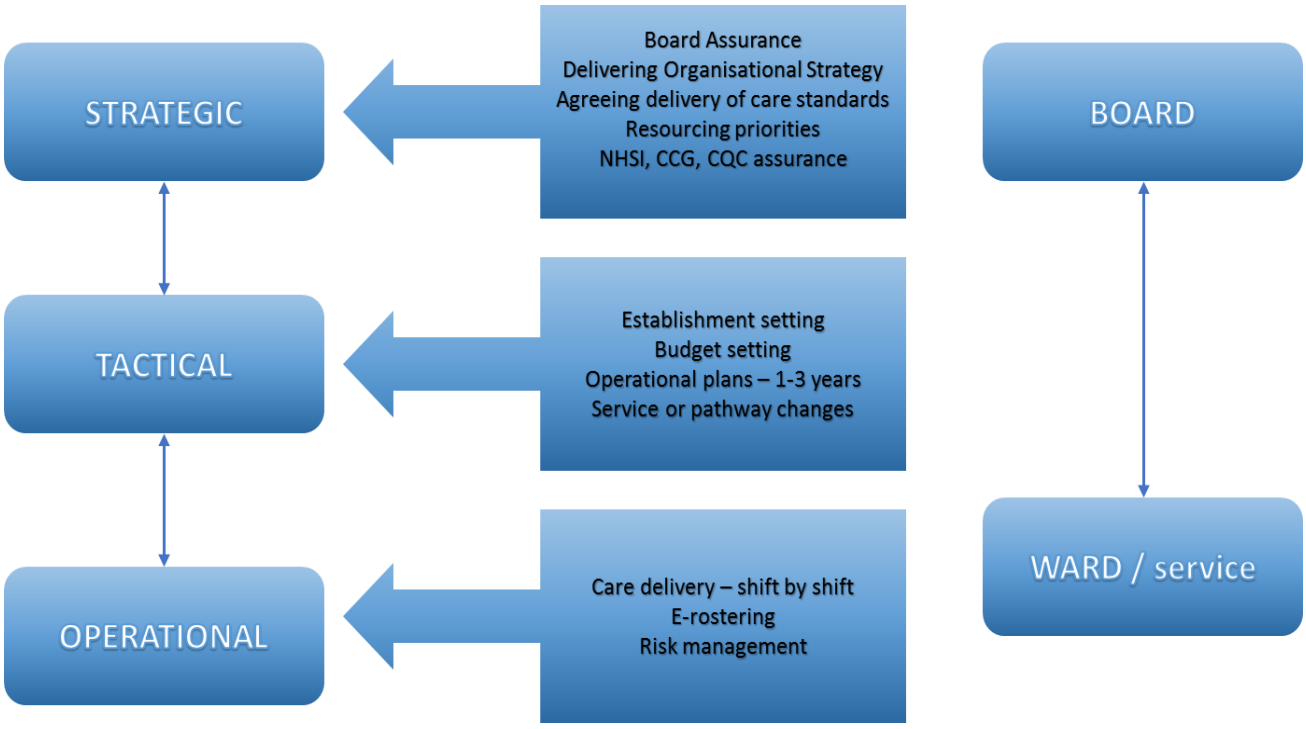
- district nursing
- children and young people
- neonatal
- pathology.

Board reporting

It is critical that boards oversee workforce issues and grasp the detail of any risk to safe and high quality care. NQB highlighted that boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing. While ultimate responsibility for safe staffing rests with the chief executive, boards are also responsible for proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care. This also reflects CQC's 'well-led' requirements.

Trusts must have a clear focus and process from the front line to the board, making sure their tactical and operational systems address strategic needs (see Figure 3).

Figure 3: Ward-to-board model for workforce safeguards



Boards need to collaborate with their local health and care system, specialist networks, commissioners and other providers to ensure the best possible care and value for patients, service users and the public. This may mean making difficult decisions about resourcing as local sustainability and transformation plans are developed and agreed.

So it is critical that boards review workforce metrics, quality and outcome indicators, and productivity measures monthly – as a whole and not in isolation from each other – and there is evidence of continuous improvements across all these areas. To best assign workforce resources and improve outcomes, boards must implement NQB's 2016 guidance and the Carter recommendations,[21] and use information from the Model Hospital or other data sources.

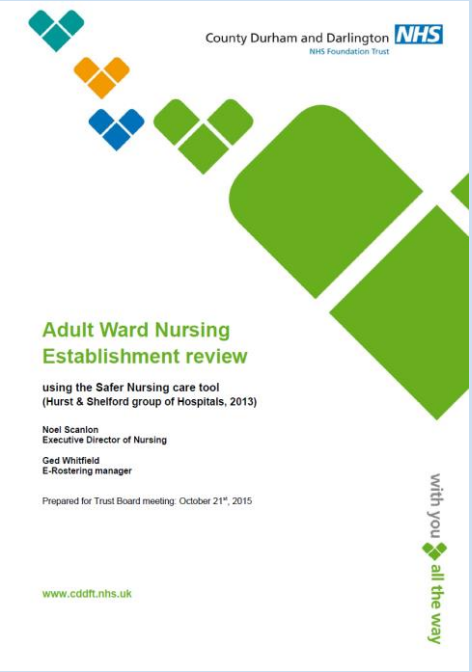
This includes:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, and nationally agreed quality metrics published at provider level
- developing metrics for patient/service user outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and the NHS experts' views, taking account of any underlying differences
- supporting and engaging staff to remove barriers to their productivity and ensure their time is used in the best way possible to provide direct or relevant care or care support
- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers
- using evidence-based decision support tools (where available and appropriate)
- using e-rostering and e-job planning tools to support efficient and effective staff deployment
- reconciling the ESR and finance ledger every month.

[21] http://www.nhsemployers.org/news/2016/02/carter-report

Case study: County Durham and Darlington NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust, like many trusts, has taken a comprehensive approach to safe staffing. This approach is aligned with NQB's guidance and evidence-based practice, and it includes publicly displaying information reports and data.



Key elements of the trust's detailed reporting of the adult inpatient establishment review are:

- understanding and analysing the wider workforce market and operational demands
- use of evidenced-based tools and professional judgement
- clear link to quality indicators
- clear action on areas that do not comply or require investment or review.

https://www.cddft.nhs.uk/quality-and-safety/reports,-policies-monitoring/safer-staffing.aspx?style=highcontrast

From working with providers, we suggest further best practice on the following areas at board level.

- Any workforce review and assessment and the safeguards reported should cover all clinical groups, areas and teams. Nursing/midwifery is the most often represented group at board level, but a focus on medical staff, AHPs, healthcare scientists and the wider workforce is needed too.
- Reports need to cover all areas, departments and clinical services.

- It is vital that the board sees the actual data from the tools used, such as the Safer Nursing Care Tool, BirthRate Plus and other European working-time directive reporting such as diary cards and exception-reporting information. This should be clearly cross-checked with other data such as ratios, fill rates and CHPPD.
- A clear link should be made between the quality outcomes, operational and finance performance, and patient, service user and staff experience in the ward, department or area. Boards must ensure that intelligence on patient, service user and staff experience is explicitly linked with metrics on quality outcomes, operational and finance performance, so they can oversee and monitor how these areas are interdependent.
- Boards must assure themselves that robust governance systems and processes around staffing and related outcomes are embedded down to ward or service level. This may include formally reviewing or adding processes such as QIAs to organisational policy. Ultimate responsibility for governance around staffing decisions should rest with the chief executive.
- Chairs and chief executives should ensure that time is allocated at board meetings or similar to discuss and agree clear actions in response to the data, and they should identify the key performance indicators (KPIs) to measure success and adverse outcomes.

Boards must assure themselves that an effective response to 'areas of concern' is described and consistently implemented. Escalation processes for ward, service or professional group should be activated if risks associated with staffing continue or increase, or mitigations prove insufficient, so that safety and care quality are maintained.

New and developing roles

Skill-mix changes that modify funded establishments to develop new roles or new ways of working within existing roles – for example, nursing associates or apprenticeship frameworks – must be informed by a comprehensive assessment using evidenced-based tools and a QIA. They must be signed off at executive sign-off level (see Section 5: Governance considerations: redesigning roles and skill mix). We expect risks to be recorded on local and corporate risk registers (depending on severity) as well as the QIA, to enable regular monitoring. Trusts must have measures that are routinely assessed against KPIs to ensure safety and effectiveness.

Nursing associate

The nursing associate role was created to bridge the gap between unregistered healthcare support workers and registered nurses – creating a further entry point into registered nurse training – and to provide additional support in clinical practice. The role will help provide high quality person-centred care across health and social care settings.

We are working to ensure that this role is effectively and safely introduced into healthcare workforce establishments. We plan to publish guidance to support decision-making in their deployment in early 2019.

Maternity support worker

The maternity support worker (MSW) role bridges the gap between healthcare support workers and registered midwives. MSWs should be recruited and trained as employees specific to maternity care, not as general healthcare assistants. This will require MSWs to complete of a formal competency-based education programme. MSWs support midwives in providing high quality, personalised, safe care across the pregnancy and postnatal care pathway.

Physician associates

Physician associates are healthcare professionals with a generalist medical education who work alongside doctors, physicians, GPs and surgeons providing medical care as an integral part of the multidisciplinary team. Physician associates have been practising in the UK for 10 years, so are relatively new members of clinical teams. They practise medicine in collaboration and through supportive working relationships with a dedicated clinical supervisor (a consultant), so they always have access to someone senior who can discuss cases with them, give advice and attend to patients if necessary. They are trained to perform various tasks including diagnosis, treatment, complex medical procedures and taking medical histories. Physician associates are working in primary and secondary care across at least 20 specialties throughout the UK.

Supervision of a qualified physician associate resembles that of a doctor in training or trust-grade doctor in that the physician associate is responsible for their actions and decisions. However, the clinician who is ultimately responsible for the patient is the consultant.

At present there is no regulatory body for physician associates. However, the Department of Health and Social Care consulted on this in 2017 and the results are awaited.[22]

As physician associates are already in practice, trusts must ensure they have safeguards to support safety and care quality. Any proactive skill-mix changes that modify funded establishments to develop physician associate roles must be based on a comprehensive assessment using evidenced-based tools, a QIA and executive sign-off. The Royal College of Physicians has published guidance on physician associate roles for employing organisations.[23]

It is critical that trusts ensure all physician associates fulfil continuing professional development requirements, receive appropriate clinical supervision, fulfil recertification requirements when needed and retain membership of the Physician Associate Managed Voluntary Register. We will monitor this at trust level, advising as required.

Advanced clinical practitioners

Advanced clinical practice can be undertaken by a nurse, midwife, pharmacist or AHP who has completed additional training and has experience in areas such as health assessment, diagnosis and prescribing. Once trained through an accredited university programme, they can be deployed in many clinical settings to manage patient pathways. ACPs can work independently or alongside medical and other clinical staff. They can see and treat a range of simple to complex clinical problems in a range of settings and clinical areas.

The advanced clinical practice role has developed in the NHS for several years, although without specific standards. We worked with HEE over 18 months to develop a standardised multiprofessional framework for advanced clinical practice in England (2017),[24] building on best practice examples in the regions and internationally. The framework defines a new beginning for this innovative work solution for the NHS.

As with any new care model, trusts must ensure they have safeguards to support safety and care quality. Skill-mix changes that modify funded establishments to develop ACP roles must be based on a comprehensive assessment, including a full QIA and executive sign-off.

[22] https://consultations.dh.gov.uk/workforce/regulation-of-medical-associate-professions/
[23] http://www.fparcp.co.uk/employers/guidance
[24] https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

We have developed plans with HEE and NHS England so that the ACP model is developed and applied consistently. In particular, we intend:

- by 2019 to ensure the framework is used throughout the acute, mental health, learning disability, community, primary care and ambulance sectors
- to ensure workforce planning through sustainability transformation partnerships (STPs) and integrated care systems (ICSs), via local workforce action boards, optimises the development and funding of ACP roles
- by the end of 2018 to assess the implementation of the framework and adherence to principles and practice
- by the end of 2018 to provide system and trust-level support to implement roles effectively and safely
- by the end of 2018 to agree timescales with higher education institution representatives to align ACP course curricula to the new framework
- to work with the Department of Health and Social Care and professional regulators to advance discussions on regulating ACPs
- to work with the devolved nations to provide further alignment of advanced clinical practice.

5. Governance considerations: redesigning roles and skill mix

Increasing demands on healthcare and the gap in workforce supply mean introducing new roles and changing the skill mix of clinical teams will continue to be necessary across nursing, medical, AHPs, healthcare scientists and all other staff groups.

This creates opportunities to change the composition of the current health service workforce. Some will come unexpectedly and require a prompt and reactive response; others will be planned and enable a more considered and proactive response. In either case, this guidance is designed to encourage and support you to take a structured systematic approach to planning, implementing and monitoring new roles or changes to skill mix.

When planned effectively, new roles and skill-mixes will contribute to securing safe and sustainable care. But identifying and managing the potential risks they pose requires strong and effective governance arrangements from the front line to the board.

Governance arrangements

Effective governance gives boards confidence about maintaining and continually improving both the delivery and quality of their services, despite rising demand, cost pressures, advancing science, changing expectations, tough economic circumstances and the complexity of the healthcare system.

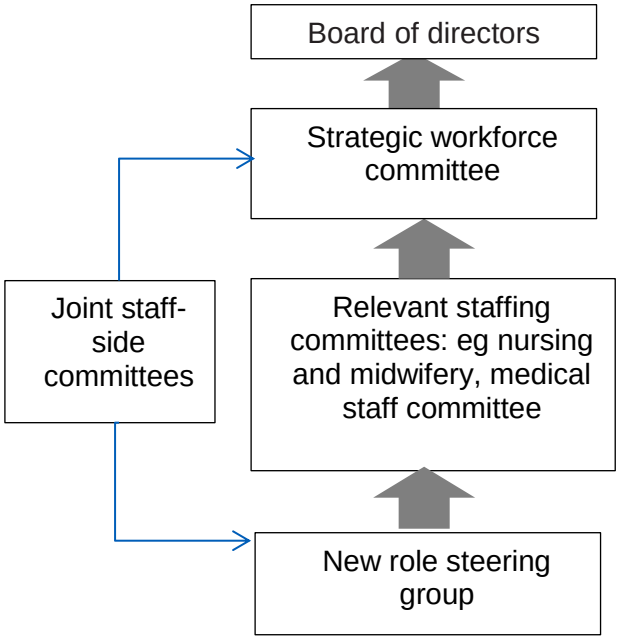
Boards should have the necessary assurance to support any proposed changes to skill mix that go beyond traditional professional boundaries and/or national guidance[25] or regulatory frameworks (see Figure 4).[26] They must ensure they have strong and effective governance frameworks and a systematic and structured approach to workforce changes.

[25] Such as NHS Improvement's *Safe staffing for nursing in adult inpatient hospitals* (2017) and the Royal College of Physicians' *Guidance on safe medical staffing* (2018).

[26] Such as, but not limited to, CQC regulations 12(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; and 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed;

This is important to protect patient and service user safety and maintain a positive patient, service user and staff experience: some new roles do not have an extensive evidence base or statutory registration requirements. They may lack recognition from other clinicians, patients, service users, commissioners and regulators, or from developing care systems such as STPs and ICSs.

Figure 4: Example of governance route for approving and supporting new roles



Information required to provide assurance up through the governance structure

Provide assurance to each committee, at each stage of the work, which you understand and can describe:

a) the workforce challenge
b) what is needed from the new roles
c) the remit of any new role
d) the competencies required and how they will be acquired
e) how the new role(s) will be costed, assessed and monitored
f) the measures to ensure the new roles are fit for purpose and deliver what was expected
g) any risks identified through the quality impact assessment
h) lines of accountability for the new roles
i) the supervision arrangements in place.

Taking a structured and systematic approach to workforce change

A structured and systematic approach to workforce change entails:

- **Understanding and articulating the staffing challenge:** is it anticipated to be short or long-term? Is the challenge confined to one clinical area/specialty, clinical pathway or more? What opportunities and innovative or collaborative solutions are available to address the challenge? What are the potential risks and what are the mitigating actions taken so far?

(2) (a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

- **Identifying the staff group(s) affected:** this may include clinical and non-clinical staff who therefore should be involved in exploring solutions. Identifying an appropriate executive lead to sponsor and advise on changes. Consideration of the impact on patients, service users and carers, who should also be involved in any significant workforce changes.
- **Agreeing a process or framework** to work through the challenges, opportunities and risks.
- **Governance systems and processes** that provide checks and balances during the workforce changes and seek the necessary assurance at all levels. This is based on an effective governance committee reporting structure, where the committees are responsible for, and focus on, workforce, quality, risk and finance.

The Nuffield Trust, commissioned by NHS Employers, published practical guidance[27] for reshaping the workforce, drawing on the literature and interviews with stakeholders. The report cites examples where new roles have been developed, and where staff developed skills and took on responsibilities in response to service need or gaps in staff capacity. These include ACPs, support workers and associate practitioners.

It identified important lessons for organisations seeking to redesign their workforce:

- be realistic about the time and capacity needed to support change
- create a receptive culture for change
- support transformation with a strong communication and change management strategy
- build roles on a detailed understanding of the work, staff skills and patient/service user needs
- invest in the team, not just the role
- develop and invest in a training capability
- build sustainability for new and extended roles
- evaluate change
- adopt a systematic approach to workforce development and change.

[27] www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

Case study: implementing ACPs at Sheffield Teaching Hospitals NHS Foundation Trust

Needs assessment: Critical care was one of the first areas to realise it faced a workforce shortage and put together a proposal to fill the gap. It produced a comprehensive plan and mapped patient need to clinical competencies.

Raising awareness: The trust raised awareness internally through intense communications, staff meetings and handbooks.

Supporting systems: The trust has a robust mentorship and supervision programme for its ACPs. Each has a consultant supervisor who signs off the trainee as they go through the programme, and a mentor who acts as a second port of call if the supervisor is unavailable.

Training: The trust has standardised training requirements for ACPs. They take two to three years to complete the postgraduate diploma from the Master's degree in advancing professional practice at Sheffield Hallam University. Once in substantive posts, ACPs are supported and expected to complete the full Master's degree programme. Most trainees are supernumerary, which the trust has found to be the most effective way of training them.

The trust has a formal partnership with Sheffield Hallam University. It worked with the university to tailor the course modules and recruit students with the right aptitude and values. The trust supplements the university's modules with in-house training modules, for which trainees can receive academic credit if required.

Sustainability: In the longer term, it was felt that it would become clear where in the hospital ACPs could add value, and their position there would be sustained.

Buy-in to the roles: Medical champions in each department have increased the 'buy-in' from others, and many consultants are willing to act as supervisors and mentors. This buy-in has continued at all levels of the hospital. Board approval for project plans and proposals has been sought at each stage.

Comprehensive business cases and potential savings from avoiding agency costs helped ensure board-level support.

Note: this is a synopsis of a case study taken from the Nuffield Trust report (2016).

Another effective and systematic tool when implementing new roles and ways of working is the Calderdale Framework.[28] Its founders offer trusts training and support when using this approach.

Assessing risk and impact on quality

As part of the governance process, trusts must assess the potential impact on quality before service changes or where there is any substantial workforce transformation, including the introduction of new roles (eg physician associates, nursing associates, ACPs). This is normally done by completing a QIA.

QIAs systematically assess and record the likely impact on quality and safety of an activity or policy. They focus on assessing the impact on patients, service users and staff. This involves anticipating, monitoring and measuring the consequences of activities and making sure that, as far as possible, any negative consequences are eliminated or mitigated.

NQB's 'how to' guide[29] outlines best practice on applying a QIA to efficiency and transformation plans. This guidance can be extended to using QIAs in relation to workforce changes. The key aspects are:

- There is a clear governance structure surrounding the development of the scheme, acceptance and monitoring of implementation and impact (positive and negative).
- Initiatives are assessed according to their potential impact on all aspects of quality (including patient/service user experience or patient/service user safety).
- Initiatives are developed with clinicians and have a clinical sponsor, or clinicians have been consulted. The medical director and director of nursing scrutinise and sign off all schemes. Schemes are modified (or rejected) because of staff

[28] Smith and Duffy (2010) www.calderdaleframework.com/the-framework
[29] NQB (2012) *How to: quality impact assess provider cost improvement plans* www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

concerns, and there should be clear routes for staff to raise concerns at the outset and on an ongoing basis.

- Measures of quality and early warning indicators are identified for each initiative and are monitored before (baseline), during and after implementation; mitigating action and/or escalation to the medical director or director of nursing is taken where necessary (including stopping or reversing the scheme).
- The board is aware of, and understands, the ongoing impact of schemes in place; monitoring of financial, operational and quality outcomes as appropriate.

Trusts must adopt a similar approach for introducing new roles or skill-mix changes. From the outset, all such proposals must be subject to ongoing assessment for their potential impact on quality. The minimum elements for this QIA exercise are patient/service user safety, clinical outcomes, patient/service user experience and staff experience.

To be assured, a board will require confirmation that all proposals for changing the workforce have been systematically assessed for their impact on quality. Many will be familiar with completing and reviewing QIAs as a normal part of their efficiency and transformation arrangements, and they will have seen how QIAs support considered and proportionate decision-making.

A model QIA template is shown in Appendix 2. Trusts should tailor it to meet their structures and governance arrangements.

The board must ensure that the quality risk assessments are of sufficient quality and have captured all foreseeable risks. Risk scores should be attributed to each risk using a standard 5 × 5 risk matrix, which should be consistent with the organisation's risk management policy.

The board must be assured of the quality and comprehensiveness of the risk assessment. It must also ensure there is a way to identify the cumulative impact of smaller or less risky schemes to ensure the risk does not increase.

For all schemes, long and short-term KPIs and other quality measures should be identified and monitored before and after implementation. Identify the mitigating actions necessary to avoid any negative impact on quality.

Case study: using QIAs in governance for efficiency and transformation

We have helped trusts make improvements in governance and the 'well-led' domain. This has revealed many examples of 'what good looks like' when using QIAs for efficiency and transformation schemes, which can be applied to plans for workforce changes and introducing new roles. Typically:

- staff undertaking QIAs need training
- QIAs must assess all the domains of quality (including staff impact)
- QIAs require appropriate depth and must include foreseeable risks
- the risk matrix must be the same as the trust's 5 × 5 risk matrix
- risks must be adequately discussed and realistic, with clear thresholds for escalation to the medical director/director of nursing
- holding vacancies/removing posts should be subject to a QIA
- the cumulative impact of workforce schemes across pathways/ professional group should be recognised
- KPIs and other quality indicators – short and long-term and including staff and patient/service user feedback – should be identified for all schemes, and tolerances set
- KPIs need to be sensitive enough to identify the impact of the specific scheme
- where generic indicators are used, and a change is noted, evidence is needed to identify if the workforce change has caused the impact
- the quality data – eg complaints, harm events, serious incidents, patient/service user and staff experience – must be cross-checked
- risks should be recorded on local/corporate risk registers.
- Use soft intelligence, including service user and staff feedback, to enhance knowledge/support assurance.

6. Responding to unplanned workforce challenges

Boards must review workforce metrics, quality and outcome indicators, and productivity measures monthly and receive a comprehensive staffing report every six months (NQB 2016).

We recommend that, given day-to-day operational challenges, trusts have dynamic staffing risk assessments and escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in the risk assessments. For example, the Royal College of Physicians (2018) recommends audit topics and standards for medical personnel are subjected to scrutiny to ensure medical care is safe, timely and effective. The National Institute for Health and Care Excellence (NICE 2014) recommends the nurse staffing level available for each shift – or at least each 24-hour period – is systemically assessed to ensure it is adequate to meet patients' nursing needs.

Should risks associated with staffing continue or increase, and mitigations prove insufficient, trusts must refer this to the executive to ensure action is taken to maintain safety and care quality.

Unplanned workforce challenges

We recognise that day-to-day operational management requires dynamic solutions to align staffing numbers to acuity, dependency and demand. However, at times staff numbers may be insufficient to meet this demand or complexity. In this case, an organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis. For example, in midwifery, NICE guidance sets out the procedures services must have in place for monitoring and responding to unexpected changes in midwifery staffing requirements, including the use of specific red flags.

A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. Within this, associated thresholds need to be developed with frontline staff to inform and trigger concerns about safe staffing deployment. This includes a clear escalation

approach describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift.

The SOP's purpose is to help manage daily staffing levels so that the right staff and skill mix are available for safe, effective patient care.

Such an assessment may require a decision to:

- increase staffing numbers to meet patient demand
- partially or fully close a ward or service for a determined period until the issues are resolved
- temporarily reduce service delivery or take another demand-management approach to redeploy the available workforce to areas of critical need to sustain safe and adequate care delivery
- close the service, facility or model of care in the long term
- implement business continuity plans.

In such circumstances, the trust must notify NHS Improvement and NHS England (including commissioners) so they can provide support and assess the wider impact across the sector, system and care providers.

Case study: Sherwood Forest Hospitals NHS Foundation Trust

The trust devised a safe staffing SOP to support decision-making for wards and departments. It created a clear framework and escalation approach with defined measures and metrics so staff were clear about what to do and when. The key components of this fulfilled NQB and NHS Improvement's approaches to effective workforce safeguards.

Daily staffing reviews

- These include each ward's staffing and minimum staffing levels, number of agency staff and RAG rating. Reviews take place three times a day and are shared with ward sisters, charge nurses, matrons, heads of nursing, deputy and chief nurse, and silver and gold on call.

- The SOP helps manage nursing and midwifery staffing levels to ensure the right staff and skill mix for safe, effective patient care and to robustly manage staffing levels as part of the trust's operational management.

Thresholds – referred to as 'tipping points'

- The trust developed tipping points around safety levels within minimum staffing levels on each ward. These trigger a review of every ward position that breaches these levels and prompt a face-to-face discussion with the registered nurse (RN) in charge for that shift to ensure they feel 'safe' with their staffing for that shift:
  - the trust-employed RN on each shift to take charge
  - minimum of two RNs on each shift
  - ≥50% of RNs on each shift are employed by the trust
  - critical care unit has a maximum of 20% agency staff, in accordance with the specifications for adult critical care
  - no less than one RN for every eight patients
  - sudden changes in the acuity/dependency on a ward to be agreed at divisional level.

Risk factors

- Low risk (green) – staffing is safe. Ward teams are managing their workload. Reassess on routine walk-round.
- Moderate risk (amber) – caution: staffing is at 50% trust RN and 50% agency. Monitor staffing out of hours and ensure wards are visited regularly.
- High risk (red) – depleted: trust RN considers area to be high risk. In-hours, ensure the matron has evaluated the areas and has mitigated the risks. Out of hours, duty nurse manager to assess the risk, mitigate where able and complete incident reporting if no mitigation.

- Unmitigated high risk (black) – unmitigated: high risk that has not been mitigated adequately by the ward-based teams/matron. Head of nursing to investigate and implement mitigations.

Roles and responsibilities

- Ward sister/charge nurse – remains accountable for providing safe staffing levels to meet patient needs and service demands, and should ensure the duty roster reflects the agreed workforce model.
- Matron – responsible for ensuring each ward is safely staffed in their specialty. Where risks on rosters have been identified by the ward sister/charge nurse, the matron should try to assist in any mitigation to ensure all rosters are safe and meet patient needs and service demands, escalating any safety issues to their head of nursing.
- Heads of nursing – responsible for ensuring all wards in their division are safely staffed and all risks have been minimised. It is the head of nursing's responsibility to ensure the deputy chief nurse/chief nurse is informed.
- Chief nurse – executive director responsible for overall safe staffing on the wards and departments across the trust. It is their responsibility to report to the board on the safe staffing position.

7. NHS Improvement's yearly assessment

We are committed to supporting trusts to manage common workforce problems by making informed, safe and sustainable workforce decisions.

In accordance with NQB guidance, trusts must ensure that the three components – evidence-based tools, professional judgement and outcomes – are used in their staffing governance processes.

From now on we will actively assess trusts' compliance with this 'triangulated approach'.

Annual governance statement

The Department of Health and Social Care's group accounting manual[30] requires NHS trusts and foundation trusts to include an annual governance statement in their annual report. Paragraph 3.29 of the manual states that trusts must follow NHS Improvement's guidance on the format of the annual governance statement.

We have added a section to the annual governance statement specifically about staffing governance processes. In their response to this section, trusts will be able to describe or explain the extent of their compliance with the NQB guidance.

We will review this statement through our usual regulatory arrangements and performance management processes.

Single Oversight Framework

The SOF is designed to help trusts attain and maintain CQC ratings of 'good' or 'outstanding'.

The SOF describes how we oversee NHS trusts and foundation trusts. Their performance is monitored against five themes (quality of care, finance and use of resources,

[30] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2018-to-2019

operational performance, strategic change, and leadership and improvement capability) and helps determine the level of support we may offer them.

Within the SOF, the organisational health section contains information on monthly staff sickness, staff turnover and the volume of temporary staffing a trust uses, as well as the annual staff survey. These are high level organisational metrics that we will continue to analyse.

In addition, our assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual trusts. These will be available from 'board to ward' and sourced from ESR, e-rostering and financial systems, as well as a quality dashboard reviewed by the trust board.

As described in board reporting (see Section 4), individual trusts are expected to collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also expect evidence of continuous improvements across all these areas. To optimise allocation of workforce resources and improve outcomes, boards should implement the NQB (2016) and Carter recommendations,[31] together with the information available from the Model Hospital.

This includes:

- using local quality and outcomes dashboards published locally and discussed in public board meetings, including nationally agreed quality metrics to be published at trust level
- developing metrics that measure patient/service user outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and NHS experts' views, taking account of any underlying differences
- supporting and engaging staff to remove barriers to their productivity and ensure their time is used in the best way possible to provide direct or relevant care or care support
- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers

[31] http://www.nhsemployers.org/news/2016/02/carter-report

- using e-rostering and e-job planning tools to support efficient and effective staff deployment
- ensuring workforce data and finance information reconcile and are regularly checked to ensure they do so.

What happens next?

Trusts unable to demonstrate satisfactory compliance with the NQB guidance – through their annual governance statement or the SOF processes – may be offered support in line with that described in the SOF. This is called segmentation and is described in Table 1 and in more detail on our website.[32]

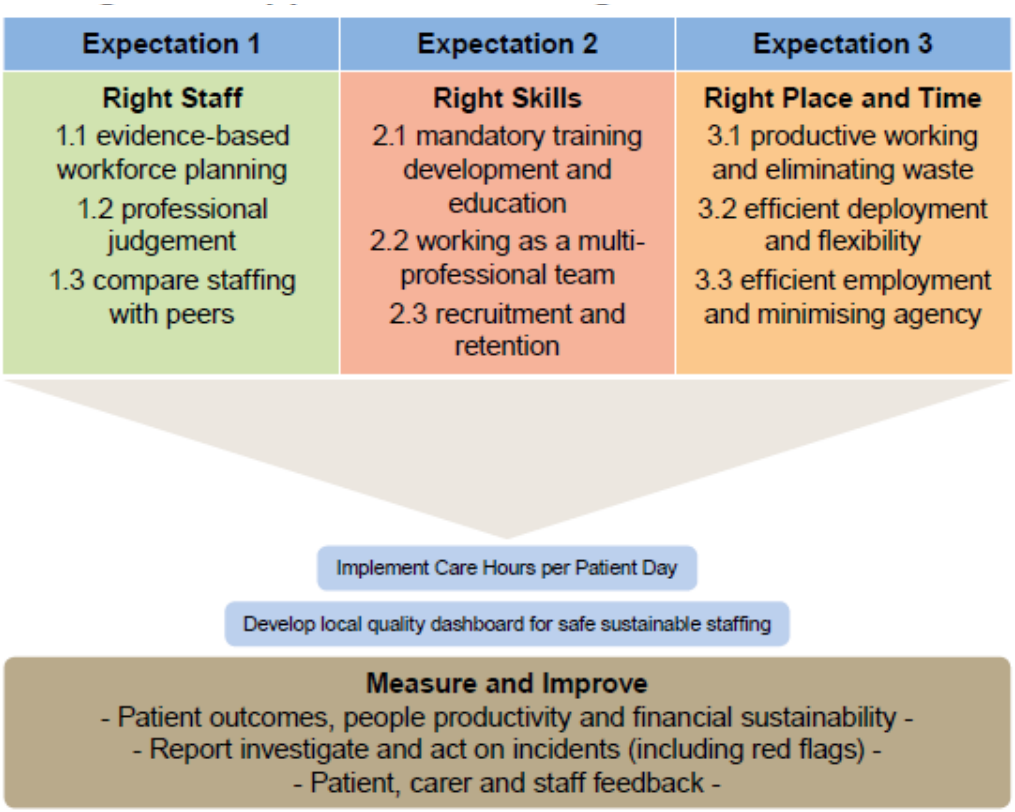
Table1: Single Oversight Framework segmentation

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. Targeted support has been identified that the provider can access, but they are not obliged to take it up.
3	Providers receiving mandated support for significant concerns.
4	Providers in special measures: very serious and/or complex issues.

For trusts challenged by elements of the NQB guidance, we may offer bespoke assistance aligned to the SOF segmentation so that our national and regional teams support them to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

[32] https://improvement.nhs.uk/resources/single-oversight-framework-segmentation

Appendix 1: NQB's triangulated approach to staffing decisions



For more details: https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Appendix 2: Quality impact proforma

Name of scheme:	
Reference:	
Division:	
Indicative value of scheme:	
Saving recurrent or non-recurrent	
Proposed start date:	

Quality Impact Risks

Note: insert extra rows/leave blank rows as necessary.

			Initial Asssessment				Post Mitigation				
	Y/N (If yes complete the following)	**Risk Description**	**Impact**	**L**	**C**	**Rating**	**Mitigations**	**L**	**C**	**Rating**	**KPI monitoring**
Impact on duty of quality (CQC/constitutional standards)											
Impact on pt safety?											
Impact on clinical outcomes?											
Impact on patient experience											
Impact on staff experience											

Clincal Business unit sign off (e.g division,locality)

Name	**Position/ job title**	**Signature & Date**
	Divisional Medical Director*	
	Divisional Nurse Director*	
	Divisional Operations Director*	

* or equivalent titles in the organisatoin

COMMITTEE REVIEW

	Date	Status	Comments & Date of Committee meeting
Clincal Senate / Star Chamber		Unchecked	
Quality Committee		Unchecked	
Trust Management Board		Unchecked	

Medical Director/ Chief Nurse Authorisation

By signing this section employees of the Trust are acknowledging that they have been reasonably assured that appropriate steps have been taken to ensure that this proposal will not put registration

Name	**Position/ job title**	**Signature & Date**
	Medical Director*	
	Chief Nurse*	

Appendix 3: References

National Quality Board

How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability (2013)

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing (2016)

NHS Improvement

Series of improvement resources: Safe, sustainable and productive staffing:

- an improvement resource for adult inpatient wards in acute hospitals (June 2018)
- an improvement resource for learning disability services (December 2016)
- an improvement resource for the district nursing service (March 2017)
- an improvement resource for mental health (March 2017)
- an improvement resource for maternity services (June 2017)
- an improvement resource for urgent and emergency care (June 2018)
- an improvement resource for neonatal care (June 2018)
- an improvement resource for children's and young people's inpatient wards in acute hospitals (June 2018)

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (2017)

Care Quality Commission

Well-led trust-wide inspection framework (2018).

Combined trust-level quality and Use of Resources ratings (2018)

National Institute for Health and Social Care

Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)

Safe midwifery staffing for maternity settings (2015)

Appendix 4: More resources

Culture

NHS Improvement has co-designed a culture and leadership programme with trusts, developed in partnership with the King's Fund. It provides practical support to help trusts diagnose their cultural issues, develop collective leadership strategies to address them and implement changes.

https://improvement.nhs.uk/resources/culture-and-leadership-programme-phase-2-design/

Setting appropriate staffing budgets

Establishment Genie: https://improvement.nhs.uk/resources/establishment-genie/

Finance and use of resources: https://improvement.nhs.uk/improvement-hub/finance-and-use-resources

Effective job planning for medical staff and allied health professionals

Best practice guide for consultant job planning: https://improvement.nhs.uk/resources/best-practice-guide-consultant-job-planning/

Best practice guide for AHP job planning: https://improvement.nhs.uk/resources/allied-health-professionals-job-planning-best-practice-guide/

Using agency staff

Reducing expenditure on NHS agency staff: https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps

Appendix 5: Stakeholder list

External stakeholders

Name	Role/organisation
Jane Avery	Safe Care Lead Northamptonshire Healthcare NHS Foundation Trust
Rose Baker	Associate Chief Nurse Royal Wolverhampton NHS Trust
Suzanne Banks	Chief Nurse Sherwood Forest NHS Foundation Trust
Debrah Bates	Deputy Chief Nurse (Workforce and Education) Lincoln County Hospital
Helen Blanchard	Director of Nursing and Midwifery Royal United Hospitals Bath NHS Foundation Trust
Sue Covill	Director of Development and Employment NHS Employers
Maria Croft	Director of Quality 2gether Foundation Trust
Sir Robert Francis QC	Non-executive Board Member, Care Quality Commission
Helen Inwood	Deputy Chief Nurse Royal Stoke University Hospital
Heather McClelland	Head of Nursing and Midwifery Leeds Teaching Hospital NHS Trust
Stuart Murdoch	Consultant, St James's University Hospital Leeds Teaching Hospitals NHS Trust
Clare Parker	Safe Care Lead Northamptonshire Healthcare NHS Foundation Trust
Carolyn Pitt	Lead Nurse Workforce University Hospitals Birmingham NHS Foundation Trust
Alan Robson	Department of Health and Social Care
Anna Stabler	Deputy Director of Nursing, Midwifery and AHPs North Cumbria University Hospital NHS Trust

Liz Staples	Deputy Director of Nursing Worcestershire Health and Care NHS Trust
Helen Watson	Head of Nursing Workforce Birmingham Women's & Children's NHS Foundation Trust
Hannah White	Senior HR Business Partner Dudley and Walsall Mental Health Partnership NHS Trust
Ellen Armistead	Care Quality Commission

NHS Improvement stakeholders

Name	Role
Helen Brooks	Workforce Insight Manager
Rosalind Campbell	AHP Professional Lead
Ann Casey	Clinical Workforce Lead
Joanne Fillingham	Clinical Director, Allied Health Professionals
Jennie Hall	Programme Director, Strategic Nursing Adviser
Fabian Henderson	Head of Workforce Policy & Improvement
Andy Howlett	Clinical Productivity Operations Director
Jeremy Marlow	Executive Director, Operational Productivity
Ruth May	Executive Director of Nursing
Emma McKay	Senior Clinical Lead
Toni Meyers	Project Manager
Gina Naguib-Roberts	Project Director, Partnerships
Professor Mark Radford	Director of Nursing Improvement
Paul Reeves	Strategic Nurse Advisor
Lorna Squires	Head of Quality Governance
Rebecca Southall	Quality Governance Associate
Karen Swinson	Productivity Lead
Zephan Trent	Assistant Director of Strategic Finance
David Wells	Head of Pathology Services Configuration

Appendix 6: SNCT assessment to meet criteria

1. Where the Safer Nursing Care Tool is used to set establishments the following assessment will be deployed.

2. There should be no local manipulation of the decision matrix and/or the nursing resource, or of the evidence based criteria or the figures embedded in the evidence based tool used.

Criteria	Y/N	Evidence required
Have you got a licence to use the SNCT from Imperial Innovations?	Y	Licence agreement must be signed by board and available for viewing.
Do you collect a minimum of 20 days' data twice a year for this?	Y	A minimum of two datasets of 20 days at distinct points of the year, eg January and June, must be available for review.
Are a **maximum** of three senior staff trained and the levels of care recorded?	Y	Need to see details of training and inter-rater reliability assessment of senior sister/charge nurse and two additional senior nursing staff members for each ward.
Is an established external validation of assessments in place?	Y	Must be evidence of a rota of senior staff with no direct management duties to the allocated ward for each data collection episode/written evidence that this was completed.
Has inter-rater reliability assessment been completed with these staff?	Y	All ward sisters/matrons should be trained as part of induction/management development and inter-rater reliability assessment is inbuilt.
Is A&D data collected daily, reflecting the total care provided for the previous 24 hours as part of a bed-to-bed ward round review?	Y	Must be data available showing the **daily** acuity/dependency levels for previous 24 hours for the full 20 days (minimum) at two distinct points of the year.

Are enhanced observation (specialed) patients reported separately?	Y	Enhanced care is not factored into SNCT (2013); therefore this is an additional requirement as no evidence base is included for this. How this has been assessed and included must be an additional requirement.
Has the executive board agreed the process for reviewing and responding to safe staffing recommendations?	Y	There must be a local policy setting out how (process) staffing establishments are reviewed bi-annually and reset annually, andagreed by the trust board.

Contact us:

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

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSImprovement

This publication can be made available in a number of other formats on request.

 Publication code: CG 84/18

	Developing workforce safeguards recommendations	Further detail	Resource
1	**The Trust is formally using National Quality Board 2016 safer staffing guidance.** **Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time : Safe sustainable and productive staffing.**	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance approaches. The NHS standard contract (5.2, 5.3) sets clear requirements to adhere to NQB staffing guidance in respect of clinical staffing levels. Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every twelve months; they must undertake quality impact assessments before making material changes to staffing levels; and they must implement a standard operating procedure for responding to day-to-day shortfalls in staff numbers.	https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf https://www.england.nhs.uk/wp-content/uploads/2025/05/04-nhssc-2526-full-length-general-conditions-final.pdf
2	**The Trust apply the principles of safer staffing - triangulation.**	The evidence of triangulation should be used in the safe staffing review process. This should include the methodology used to set staffing levels, eg output from staffing decision support tools (where available), review of patient quality and safety outcomes and application of professional judgement.	
3	**Evidence based tools are used where available.**	Identify which evidence based tools you used eg SNCT, MHOST, CNSST II and the outputs of the tools are available to trust boards to review You must have an updated current licence to use these tools to support establishment reviews. Confirm that the tool has been applied as per implementation guidance of the tool, therefore the 'red rules' have been adhered too. Confirm that training has been received for accurate application of such tools.	If training is required on the widely used evidenced based tools in England contact: england.cnosafestaffingfaculty@nhs.net
4	**Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence based tools.**	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	
5	**Monthly actual vs planned staffing levels are available for review.**	This staffing data should be reviewed each month and signed off as accurate by the chief nurse (or appropriate delegation) before external publication. The monthly actual v planned staffing data should be included within monthly board reporting and easily available to the public on the trust website to ensure transparency and accountability in safer staffing. This data set will now contain care hours per patient day (CHPPD) metric for registered and care staff for days and nights and should be shown separately by staff group. Internally you should review staffing actual v planned levels for non-wards regularly. There should be a regular paper or section within the Integrated performance report (IRP) highlighting staffing (by ward / service level) which is triangulated with quality, safety and workforce metrics, skill mix and staffing red flags reported from ward to board.	https://www.england.nhs.uk/long-read/care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts/
6	**Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board.**	As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in an annual governance statement to their Public Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable for all workforce groups.	NHS Trusts and NHS FTs guidance for AGS confirming safe staffing review compliant with DWS recommendations **(navigate to 11/03/25 section)**
7	**A workforce plan must be in place and agreed / signed off annually by CEO & executive leaders and discussed at Public Board meeting.**	Trusts must have an effective workforce plan for all staff groups that is updated annually and signed off by the chief executive and executiv leaders. The Board should discuss the workforce plan in a public meeting.	
8	**Nursing and midwifery staffing establishments for all clinical areas must be reviewed twice a year and reported to the Public Board.**	An assessment or review of the nursing establishment and skill mix must be reported to the board by ward or service area twice a year, in accordance with NQB guidance. This must also be linked to professional judgement and outcomes. These papers should contain the triangulated approach used, describing the methodology and evidence based tools used (where they exist) to set staffing establishments. This should also include a staffing breakdown by ward / service level, results of any evidence based tools used, confirming skill mix, and highlighting any changes within the previous 6 months. It should contain the Director of Nursing and Medical Director statement confirming to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. Within the paper, if any changes have been recommended such as service changes, new roles and including skill-mix changes, then there should be reference to a full quality impact assessment (QIA) review undertaken.	
9	**Agreed local quality dashboards on staffing & skill mix that is cross checked with comparative data each month and reported to the board.**	Trusts must ensure their have agreed local quality dashboard that cross-checks comparative data internally and externally, on staffing levels and skill mix with other efficiency and quality metrics. Model health system can be utilised to support this benchmarking and comparison with peers. Trusts should report on this to their board as part of the monthly safer staffing report / Integrated performance report (IRP).	NHS England - Model Hospital
10	**Quality Impact Assessment (QIA) review for service changes including skill mix changes, redesign or introduction of new roles.**	Any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review. Any redesign or introduction of new roles (including but not limited to nursing associates, advanced clinical practitioners – ACPs, peer support workers, activity workers) would be considered a service change and must have a full QIA.	
11	**Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified.**	A clear safe staffing and escalation policy is required. Given day-to-day operational challenges, it is expected that trusts carry out business-as-usual dynamic staffing risk assessments including formal escalation processes with clear documentation of decision making. This would include locally agreed process for escalating any staffing concerns, including staffing red flags, which are monitored at board level. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.	Safe staffing for nursing in adult inpatient wards in acute hospitals https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
12	**Boards to be made aware of continuing or increasing staffing risks.**	Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix. Clear governance process must be in place in order for line of sight from ward / team to board.	

Trust:	University Hospital Southampton NHS Foundation Trust	Date completed: 31/07/25

	Developing workforce safeguards recommendations	Current Position	Evidence to Support Current Compliance	Gap analysis outcome Red = not yet achieved Amber = partially compliant, in progress Green = comoliant	State actions required to meet compliance
1	**The Trust is formally using National Quality Board 2016 safer staffing guidance. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time : Safe sustainable and productive staffing.**	Both NQB and NICE guidance embedded in governance structures. Action plans has been in place since publication in 2016 and are reviewed systematically 4 monthly at the Nursing and Midwifery Staffing Review Group (NMSRG - sub group of the People Board). Reported to the board through safe staffing reporting. Staffing hub created in response to Covid-19 and sustained to manage realtime staffing - managed through a bronze/silver/gold system with Divisional Director of Nursing acting in gold and reporting directly to Chief Nurse.	Action plans for NQB and NICE guidance. Minutes of NMSRG. Staffing review papers to TEC (Trust Executive Committee) and Trustboard. Website pages on nurse staffing: **https://www.uhs.nhs.uk/about-the-trust/performance/nursing-and-staffing-levels**	Green	Principles of NQB guidance and Workforce safeguards to be embedded in all other staff groups. Continue to strengthen and expand the role of the staffing hub
2	**The Trust apply the principles of safer staffing - triangulation.**	Triangulation is embeddded in the annual staffing review process. SNCT output (embedded in the safecare tool) used alongside strong professional judgement conversations, review of quality indicators from dashboard, metrics of registered ratios and nurse per patient ratios. Model Hospital benchmark data used as a compairtor.	Staffing review papers to TEC (Trust Executive Committee) and Trustboard. Agenda and papers from the staffing reviews. Designated nurse staffing lead and Deputy Chief Nurse (safer staffing faculty member) authored on professional judgement national guidance.	Green	
3	**Evidence based tools are used where available.**	The SNCT is used for the acute inpatient areas with the childrens version for childrens areas and the admission version used for admission areas. Licensed annually via the use of safecare in Healthroster and the contract. Birthrate+ used for midwifery. Also have license for the ED tool but have found this is not representative of the activity and acuity/dependency levels througout the diverse department. Designated nurse staffing lead, Deputy Chief Nurse (safer staffing fellow) and Matron (safer staffing rellow) trained by national team for rollout. Separate process in place for "hotspot" areas highlighted in year around acuity/dependency and staffing levels to support staffing reviews to complete for SNCT review. Recent areas completed include Medicine and Medicine for Older Persons, Cancer Care and Spinal Ward.	Staffing review papers to TEC (Trust Executive Committee) and Trustboard. Healthroster reports. Notes from contract meetings with RLDatix re license acquisition. Example of Cancer Care moved ward (D12)report.	Green	Safe staffing working group (sub group of NMSRG) currently deveoping a rollout plan for 26/27 for separate SNCT reviews to work alongside the annual staffing review cycle
4	**Trust to confirm that there is no local manipulation of identified nursing resource from approved evidence based tools.**	Tools are used fully in conjunction with professional judgement. Outputs from the SNCT are used as an indicator as part of the triangulation process and reported as part of the overall reviews. It is noted that in a number of specialty wards, and in geographically large or small wards (below an optimum 24/26 beds) the SNCT loses accuracy. Not all the recommended increases identified through triangulation at the staffing reviews are successful at budget setting as the trust prioritises investment. This is clearly risk assessed and managed locally and detailed in the reports to board. In 2025/26, as part of the current national directive to 'work within our means' we are actively working to manage slightly below establishmentsin relation to bank usage, where this is possible within a safety framework. Escalation processes in place to manage risks.	TEC and board papers re staffing. Monthly people report. Safe care reports.	Amber	Ongoing review of all staffing metrics and the risk process to monitor impact linked to QIA process
5	**Monthly actual vs planned staffing levels are available for review.**	Monthly actual versus planned nurse staffing levels reviewed systematically monthly for submission as part of PWR. Validation process from matron, through Divisional Directors of Nursing to Head of Nursing for submission. This ensures ward/ward exceptions and explanations are noted. Monthly template report (including explanatory ward by ward comments) included in monthly board reporting and posted on the public website pages on nurse staffing including guidance notes. Red flags and quality indicators also included in board reporting with detailed red flag reports presented at NMSRG and escalated to People Board and included in the monthly people report.	Website pages on nurse staffing: **https://www.uhs.nhs.uk/about-the-trust/performance/nursing-and-staffing-levels** People report. CHPPD detailed ward by ward report. Evidence of monthly validation process	Green	Review all processes and information flows to match the new 2 monthly meeting schedule for trustboard to ensure all relevent escalations are visible at board.
6	**Director of Nursing & Medical Director must confirm safe staffing review in an annual governance statement to the Public Board.**	Included in the annual goverance statement in line with the FT guidance	24/25 annual goverance statement	Green	Well embedded for Nursing and Mwifery, need to broaden this to cover all staff groups. Could make this green but with this added action as it is covered for N&M
7	**A workforce plan must be in place and agreed / signed off annually by CEO & executive leaders and discussed at Public Board meeting.**	Workforce planning process well embedded and triangulated across HR workforce team and finance. Plan developed and signed off through TEC and by the executive team via trustboard. Progress reported monthly as part of the People Report	25/26 workforce plan. People Reports	Green	
8	**Nursing and midwifery staffing establishments for all clinical areas must be reviewed twice a year and reported to the Public Board.**	Cycle of 6 monthly staffing reviews in place for all nursing inpatient and midwifery areas. Reported separately to board. 6 monthly reviews are completed as light touch and reported through the Divisional boards and NMSRG and noted to Trustboard. Focussed reviews are also carried out for areas such as theatres, critical care and outpatients.	Annual ward staffing reports. Ward staffing agenda example. Annual ward staffing cycle. Divisional Light touch reports. NMSRG notes.	Green	Consider reinstating the 6 monthly direct reporting to trustboard.
9	**Agreed local quality dashboards on staffing & skill mix that is cross checked with comparative data each month and reported to the board.**	Local Clinical Quality Dashboard (CQD) includes a range of metrics on safe staffing. Red flags both real-time (via Healthroster) and retrospective (via the incident reporting system) are routinely monitored and mitigated at local level and through the staffing hub. Red flags included in People report and separately in the IPR to trust board. Also included in the quality review of clinical areas via matron walkabouts (15 steps) and the Clinical Accreditation Scheme (CAS) reviews.	CQD extract. 15 steps Matron walkabout templates CAS reviews. Red flag reports. Board IPR	Amber	Review of the clinical quality dashboard (CQD) and clinical review processes currently ongoing. New quality report currently being developed for trustboard which will have more explicit detail on nursing and midwifery staffing and links to quality. Awaiting the development of real-time quality reporting for maternity to link into dashboard.
10	**Quality Impact Assessment (QIA) review for service changes including skill mix changes, redesign or introduction of new roles.**	Robust process in place with a QIA panel meeting monthly within the trust chaired by the CNO/CMO	Quality Impact process. Examples of completed QIA's	Green	
11	**Formal risk management and escalation processes in place for all staff groups outlined within a safe staffing policy with appropriate staffing escalation process clearly identified.**	Formal risk management and escalation processes in place for nursing and midwifery through care group and divisional structures through to the staffing hub. Rostering policy and site policies outline this however there is not currently a specific Nursing safe staffing escalation policy. Maternity safe staffing policy and escalation processes in place.	Existing SOP and escalation policies. Rostering policy. Midwifery escalation policy.	Amber	Complete a specific Nursing safe staffing policy including SOP on escalation.
12	**Boards to be made aware of continuing or increasing staffing risks.**	Updated through people report and CNO/CMO updates to trustboard	Trustboard minutes.	Green	

University Hospital Southampton NHS Foundation Trust

Agenda item 5.12 Report to the Trust Board of Directors, 11 November 2025	
Title:	Guardian of Safe Working Hours Quarterly Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Dr Diana Hulbert, Guardian of Safe Working Hours

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

Outstanding patient outcomes, safety and experience	Pioneering research and innovation	World class people	Integrated net-works and collab-oration	Foundations for the future
		x		x

Executive Summary:

The current Resident Doctor Post fill rate is 95.13%.
The current Resident Doctor vacancy rate is 4.87%.
The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing and is seen in all NHS trusts.
The Exception Reporting system reveals the self-reported hours worked above those contracted and highlights missed educational opportunities; these numbers remain low.
The changes to the Exception Reporting system will be operational from February 2026.
NHS England have issued a Ten Point Plan to improve the working lives of Resident Doctors; we are working to achieve the outcomes required.

Contents:

Risk(s):

3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.

Equality Impact Consideration:	N/A

Quarterly Report - Guardian of Safe Working Hours

Employment

In November 2025 the fill rate for resident and locally employed doctor posts across the Trust is 95.13%.

Recruitment continues for current approved vacancies and Medical HR continues to work with departments to plan for future gaps. (Appendix 1)

The present financial situation of the NHS remains a cause for concern; there is a recruitment freeze which will inevitably impact both directly and indirectly on the Resident Doctor workforce. UHS continues to take clear steps to keep the Resident Doctors regularly informed of the situation and members of the Executive regularly attend the Resident doctor forum and Executive forum to discuss the situation with the Residents and take questions; the residents value these interactions very highly and excellent feedback is received.

Locums

The use of the Medical Locum Bank system has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention. (Appendix 2)

At present the only unique locum rate is paid to Specialist Registrars in Emergency Medicine and Obstetrics and Gynecology as previously agreed. This is under regular review.

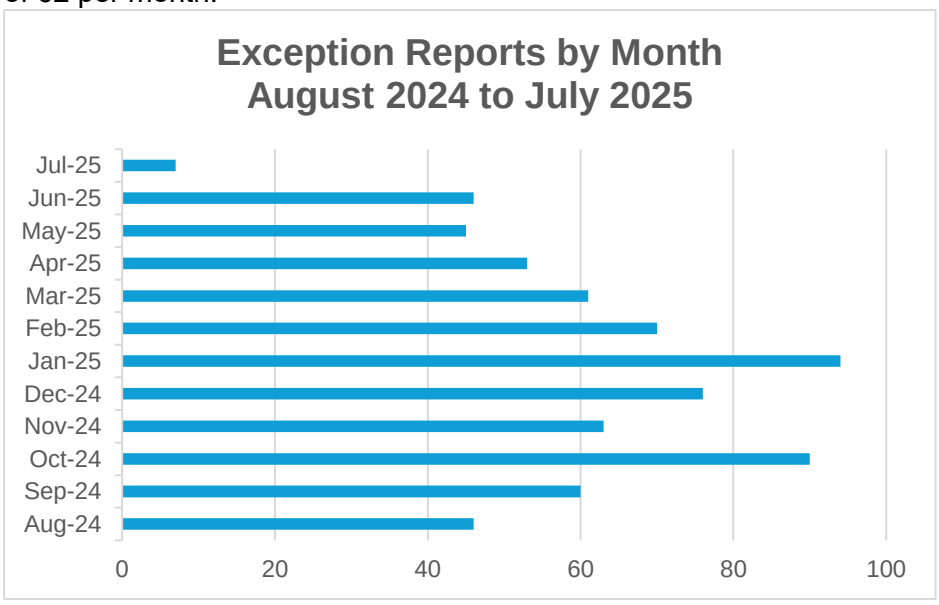
Exception reporting

Engagement with the exception reporting system remains variable; whilst it has highlighted some areas that need review, it is unlikely that this system reflects the true situation across the hospital. A true understanding of most of the areas of concern has come from direct discussion with teams in various departments.

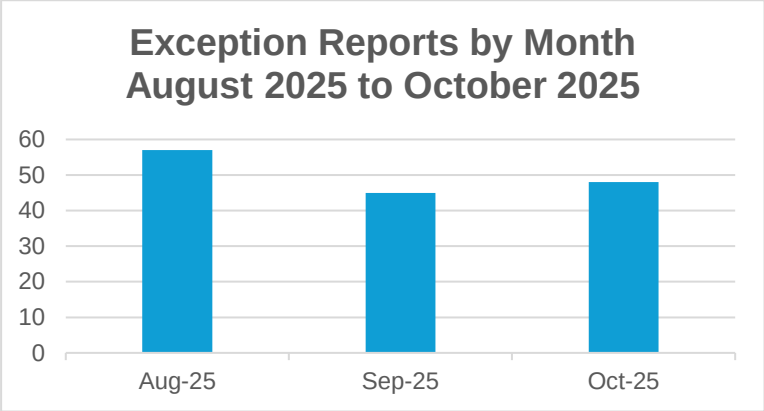
NHS Employers and the BMA have issued a framework agreement outlining changes to the exception reporting process.

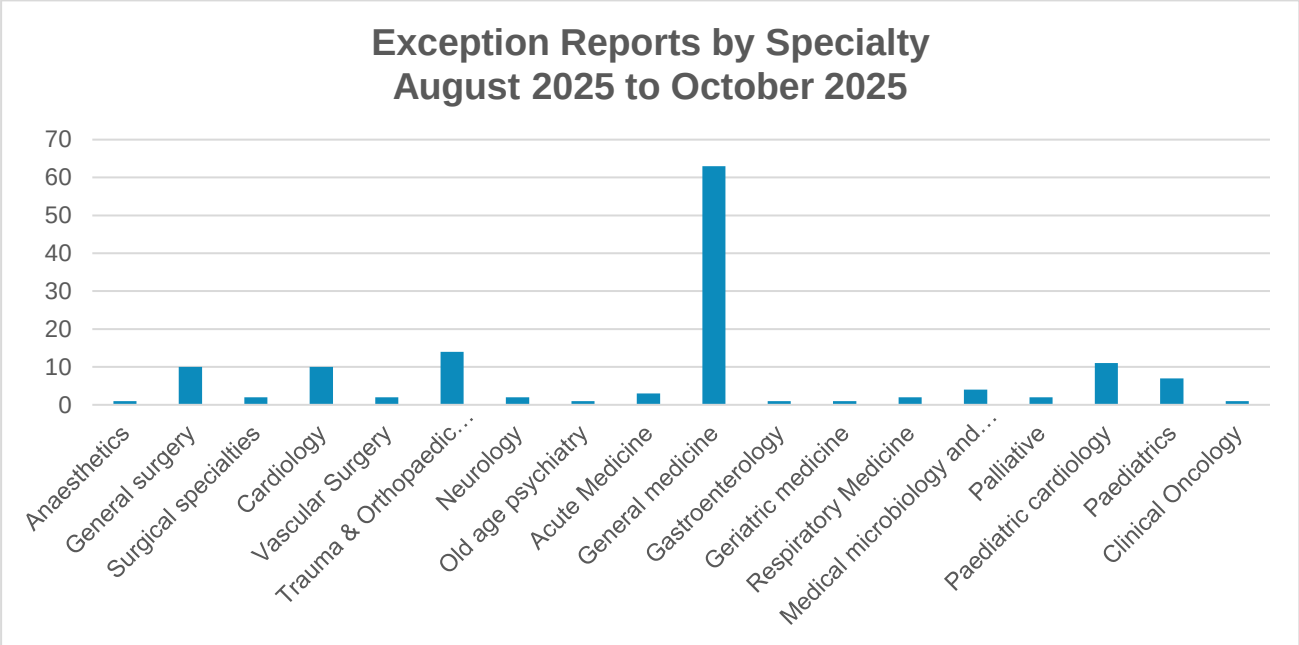
These changes are timetabled to be implemented in February 2026; we have confidence that Becci Mannion and her team have set up an effective system which will meet the terms and conditions of service in England. (Appendix 3)

There were 755 exception reports received in the year from August 2024 to July 2025, an average of 62 per month:



In the last three months there have been 150 Exception Reports submitted, an average of 50 per month:



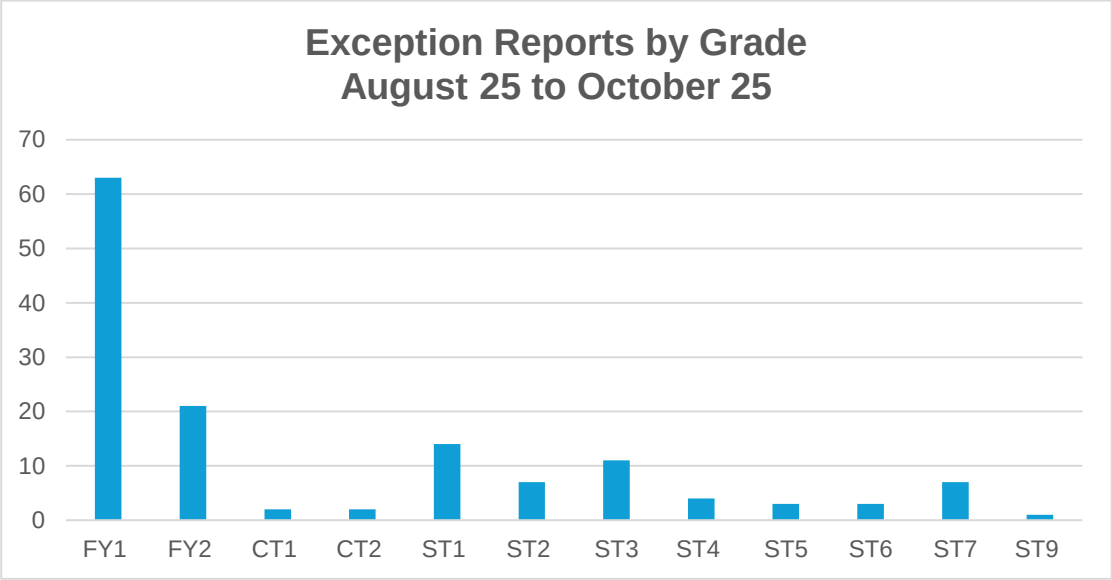


*General Medicine includes the complete cohorts of the out of hours rotas

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

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

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



Self-Development Time (SDT)

All doctors are given two hours of dedicated SDT each week to be used in addition to their formal training hours; this is recorded in the doctors' work schedules.

UHS encourages the use of the exception reporting mechanism to raise concerns when SDT has been missed on at least 25% of occasions over a 12-week period. This allows us to review and adjust rotas accordingly.

In the year from August 2024 – July 2025 we received 19 exception reports stating missed SDT; in the last three months we have received 0 reports

Activity

The Resident Doctors' Executive Committee, led by the Chief Resident, meets quarterly to bring together representatives of the Residents from all the care groups, the Guardian, the DME and members of the UHS Executive. These meetings facilitate discussion between the Residents (via their representatives) with senior figures in the Trust who can help explain current operational policy and be part of open discussions to effect useful change.

The Resident Doctors' Forum, also led by the Chief Resident, meets monthly and acts as an open and informal meeting to allow easy communication between the Residents, the Chief Registrar, the Guardian, the DME, and the Medical Workforce Team. We are encouraging in-person meetings for this forum to generate more open discussions.

The Guardian and Medical Workforce Team attend monthly Trust inductions to ensure that all the Residents who join UHS feel connected to the team and know that they can ask for help and advice. In addition we explain about their contracts, duty rosters and rotas and how to use the exception reporting system.

Dr Genevieve Southgate, a senior doctor in training in paediatric palliative care, is the present Chief Resident.
Genevieve is taking on several projects during her year in post. These include the continuation of the project to provide a management teaching programme for the Registrars at UHS and an ongoing review of non-clinical space with a view to potential improvements.

I am delighted that UHS continues to support the Chief Resident role which is invaluable for Resident engagement and representation.

Rota Gaps

The vacancy rate for Resident Doctors is 4.87%, which illustrates a significant improvement as the rate in November 2023 was 9.2%

The impact of staff sickness continues to be significant, particularly with flu, Covid and norovirus cases, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on Residents' work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some Residents.

In the last three years there has been greater transparency, more consistency, and a better understanding of rotas and rota gaps at UHS and the systems place are regularly reviewed to ensure efficiency and effectiveness.

Workforce Evolution

There remains a need to discuss the evolution of the workforce. Work is being carried out around the role of Residents, advanced nurse practitioners, physician assistants and a range of non-clinical roles. The is controversy surrounding many of these roles and we at UHS actively engage in the debate to get the best solutions.

Provision of Non-Clinical Space

Members of the Executive are helping the chief resident, the DME and I review the provision of non-clinical spaces alongside our Chief Registrar. The scoping exercise has revealed a number of challenges in many areas of the hospital for many colleagues. In most areas of the Trust the lack of space impacts all sectors of the workforce and solutions have to be inventive.

Strikes

There have now been 12 strikes since the dispute between the residents and the government began in March 2023

The 13th strike is planned for November 14th - 19th; it is interesting to note that the reasons for striking have slightly changed. The recent talks centred on both pay erosion and job shortages.

UHS will ensure that there are appropriate communications to all parties around the strike and emphasise that residents are supported to take the actions they choose.

NHS England 10 Point Plan to Improve Resident Doctors' working Lives

In April 2024 NHS E sent a paper to all NHS Trusts outlining a plan to improve the working lives of Junior Doctors (now Residents)

All Trusts were required to rate their performance in three domains:

1) Increased choice and flexibility
2) Reduction of duplicative inductions and pay errors
3) Creating a sense of value and belonging for our doctors

We ensured wide representation in a working group which includes the Chief Resident and an F1 representative to ensure that we made progress in all three domains.
The area that required improvement was provision of non-clinical facilities, which has long been a area of concern for us.

In August, following this paper and resultant bench-marking exercise, NHS E issued the Ten Point Plan to improve Resident Doctors' working Lives. (Appendix 3)

This plan sets out clear expectations and has a short time frame; there is a 12-week delivery window for the initial actions (approximately mid-November) and there will be further actions required in the following weeks and into 2026.

The 10 Priority Areas are:

- Working environment and wellbeing
- Work schedules and rota information
- Annual leave
- Appointment of two leaders - one senior and one peer
- Statutory and Mandatory Training
- Exception Reporting
- Reimbursement of course-related expenses
- The impact of rotations on residents' lives
- The impact of changing employers when rotating

Following an initial benchmarking document there are actions for both Trusts and NHS E pertaining to each of these "deliverables"
We have re-convened the Improving Resident Doctors' Lives group and set up a programme of work to ensure that we meet the expectations of the directive from NHS E
Following our meeting this week we have a number of actions to ensure that UHS is compliant. At present our rating is 84%
In addition I am part of a South East workstream which holds regular webinars and meetings to ensure that all the actions are completed.

This work is clearly a significant priority for NHS E and we aim to meet all the necessary requirements.

The Ten Point Plan seeks to address many of the issues we have discussed for the past three years; we have been cognisant for some time that there are unique challenges for Residents in 2025 which are very different from those which beset previous tranches of medical graduates. These challenges exist in the wider context of social change, financial complexity and an unstable international landscape.
Although true for all professional groups at UHS we have a specific opportunity to improve the working lives of our residents who will be the Consultant workforce of the future and we should grasp this moment.

I would like to conclude by offering huge thanks to the Becci Mannion, Lynne Stassen and their team who work so hard to provide rotas, support and in-depth knowledge, which is so effective for the doctors, and therefore crucial for all members of the multidisciplinary teams and the patients at UHS.

I also owe great thanks to Genevieve Southgate who is an excellent, thoughtful and highly effective Chief Resident.

Finally, thanks to the Executive team (particularly Paul and Steve) who continue to positively engage with the challenges facing these doctors and who remain consistently supportive in these complex times.

Appendix 1 - Vacancy data - October 2025 - total 95, 13%

Division	Care Group	Cost centre	No of posts	Number of	Sep-25	No of posts	Number of	Oct-25
A	Critical Car	Anaestheti	65	2	96.92%	65	2	96.92%
A	Critical Car	CICU	11	1	90.91%	11	0	100.00%
A	Critical Car	GICU	51	5	90.20%	51	5	90.20%
A	Critical Car	NICU	11	0	100.00%	11	0	100.00%
A	Critical Car	SHDU	10	1	90.00%	10	1	90.00%
A	Surgery	ENT	16	1	93.75%	16	0	100.00%
A	Surgery	General Su	51	1	98.04%	51	1	98.04%
A	Surgery	OMFS	10	0	100.00%	10	0	100.00%
A	Surgery	Urology	13	1	92.31%	13	0	100.00%
A	CV&T	Cardiology	38	2	94.74%	38	2	94.74%
A	CV&T	Cardiothor	35	0	100.00%	35	1	97.14%
A	CV&T	Vascular Su	12	1	91.67%	12	0	100.00%
A	Neuroscien	Neurology	23	2	91.30%	23	2	91.30%
A	Neuroscien	Neurophys	2	0	100.00%	2	0	100.00%
A	Neuroscien	Neurosurge	24	0	100.00%	24	0	100.00%
A	Neuroscien	Stroke	8	0	100.00%	8	0	100.00%
A	Neuroscien	Spinal Surg	3	0	100.00%	3	0	100.00%
A	T&O	T&O	57	2	96.49%	57	2	96.49%
B	Ophthalmo	Ophthalmo	28	5	82.14%	28	5	82.14%
B	Cancer Car	Clinical Onc	19	0	100.00%	19	1	94.74%
B	Cancer Car	Haematolo	24	2	91.67%	24	2	91.67%
B	Cancer Car	Medical Or	20	2	90.00%	20	3	85.00%
B	Cancer Car	Palliative C	9	1	88.89%	9	1	88.89%
B	Cancer Car	Acute Onco	3	2	33.33%	3	2	33.33%
B	Emergency	Acute Med	23	0	100.00%	23	0	100.00%
B	Emergency	Acute Med	6	0	100.00%	6	0	100.00%
B	Emergency	ED	70	2	97.14%	70	3	95.71%
B	MOP	MOP	47	0	100.00%	47	0	100.00%
B	Specialist M	Allergy/Res	29	1	96.55%	29	0	100.00%
B	Specialist M	Clinical Ger	4	1	75.00%	4	1	75.00%
B	Specialist M	Dermatolo	11	0	100.00%	11	0	100.00%
B	Specialist M	Endo/Diabe	4	0	100.00%	4	0	100.00%
B	Specialist M	General Me	14	0	100.00%	14	0	100.00%
B	Specialist M	GI Renal	32	2	93.75%	32	2	93.75%
B	Specialist M	Rheumatol	5	0	100.00%	5	0	100.00%
C	Pathology	Chemical P	2	1	50.00%	2	1	50.00%
C	Pathology	Microbiolo	12	4	66.67%	12	4	66.67%
C	Child Healt	Paediatric (	13	0	100.00%	13	0	100.00%
C	Child Healt	Paediatrics	57	1	98.25%	57	2	96.49%
C	Child Healt	Paediatric (	1	0	100.00%	1	0	100.00%
C	Child Healt	Paeds ED	8	0	100.00%	8	0	100.00%
C	Child Healt	PICU	18	2	88.89%	18	1	94.44%
C	W&N	Neonates	28	5	82.14%	28	1	96.43%
C	W&N	O&G	36	2	94.44%	36	2	94.44%
C	W&N	Breast Surg	2	0	100.00%	2	0	100.00%
		Total	**965**	**52**	94.61%	**965**	**47**	95.13%

Appendix 2

Exception Reporting Reform

NHS Employers and BMA have issued a framework agreement outlining changes to the exception reporting process for resident doctors to be implemented in February 2026 for the 2016 Terms and Conditions of Service (TCS) in England.

Key points of the reform:

- All educational exception reports will go to the Director of Medical Education (DME) for approval
- All other exception reports (relating to total hours of work, difference in pattern of hours, inability for rest breaks, inability to have Self Development Time (SDT)) will go to Medical Workforce (MW) for approval
- The Guardian of Safe Working Hours (GoSWH) will retain oversight of all exception reports
- A three-tier approval system will be used to determine if hours were indeed worked
- Doctors will have the choice of time off in lieu (TOIL) or payment, except when a breach of safe working hours mandates the award of TOIL.
- Employers must provide access to exception reporting to residents within 7 days of starting employment. £250 per resident per week fine for access and completion breach from 12 September to 31 January 2026, then increasing to £500 from 1st February 2026 if not provided access.
- Employers will face penalties of £500 per resident per instance for proven information breach
- Residents will be required to submit exception reports as soon as possible but no later than 28 days from the day they occurred.
- MW have 10 working days from ER submitted to complete investigation
- Immediate safety concerns no timeframe limit
- GoSWH required to conduct quarterly surveys of breach of access, breach of information and actual or threatened detriment, with results to be included in the quarterly GOSWH report.

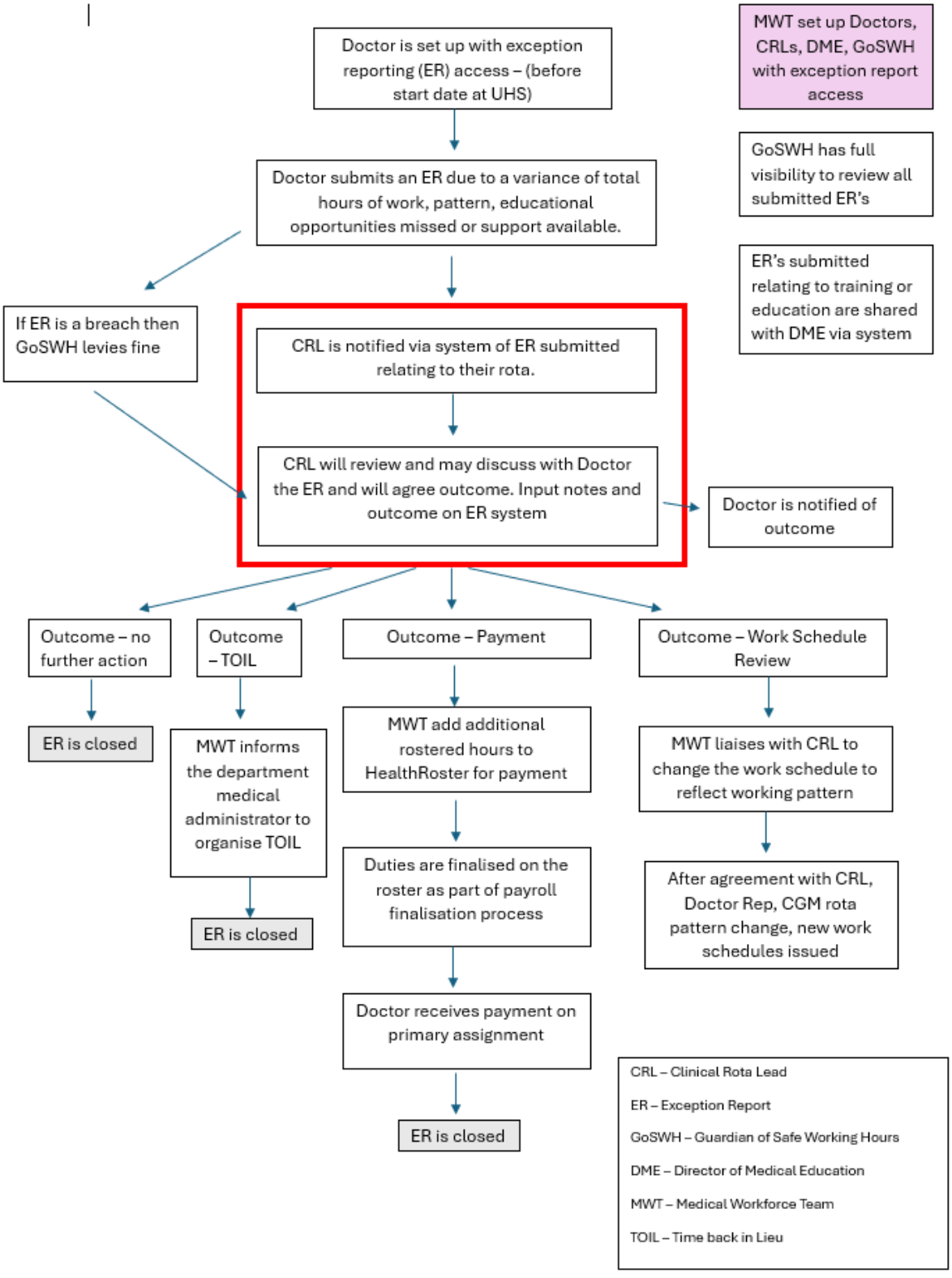
Twelve Principles that need to be adhered to:

1. Doctors should be enabled and encouraged to exception report
2. They should not suffer any detriment as a result of reporting
3. None of these changes should undermine the GoSWH ability to undertake their role and identify unsafe working practices
4. Claims for overtime/additional working needs to be agreed sign-off process, but challenges to claims should be the exception rather than the norm.
5. The system for reporting should be clear and straightforward
6. Where a doctor worked additional hours of 2 or less as per the exception report in one occurrence, the only determination MW will seek to reach when deciding whether to pay the doctor is whether or not the additional hours were indeed worked; the perceived retrospective merits of the doctors decision to work the additional hours should not be considered when determining whether to make payment for additional hours.
7. Exception reports arising from a doctor having worked more than 2 hours in one occurrence, should be investigated to ensure safe staffing is maintained and could be subject to a locally determined process.
8. Claims should be based upon clear agreed criteria for what constitutes additional working, e.g., Theatre overruns.
9. All educational exception reports to go to DME for approval.
10. All other exception reports to go to MW for approval.

11. Review the contractual deadlines to ensure that they are sufficient for exception reporting submission to remove the undue burden from doctors and replace with timeframes that empower doctors to manage exception reporting when convenient to them.
12. The underlying ethos to this reform should be to empower and trust doctors to conduct themselves professionally, and to remove wherever possible, and minimise wherever it is not, the time-consuming aspects of the process.

Three-tier approval system will be used to determine if hours were indeed worked:

- **Level 0** – doctor submits exception report for processing; it will include 3 pieces of information:
  1) Exception report data confirming category of exception and duration
  2) Evidence of additional hours worked. Time, Date, Location.
  3) Doctors Rota – to be checked.
- **Level 1** – when information submitted in Level 0 does not align
- **Level 2** – doctor states that ER is accurate (and wish to pursue their claim) MW has rejected at Level 1. MW to contact GoSWH



Activities in the red box are those that are being proposed to be removed under the reform.

Points for consideration	Key Risks / Challenges	Pros/Cons/ Additional information		Notes
1	Removal of the Clinical Rota lead (CRL) from the process – removes the current ability to validate the hours worked, understand the issues on the ward/theatre etc	Reform is looking to remove the medical roles influencing the outcomes and those that could have a detrimental effect on doctor's career.	Reduce time for the CRL role Removes the Medical Workforce process to chase, remind CRL to conclude and have meeting with the doctor who raised exception.	
2	Medical Workforce does not have financial authority to approve additional rostered hours (overtime)	Would Care Groups give delegated authority to support the process?	Overtime would be added to HealthRoster by Medical Workforce Team but Care Group Manager/Ops Manager of the departments would finalise the unit as part of payroll finalisation each month The decision for payment would still sit with Medical Workforce but the Care Group would have site of these decisions. Reform states that it's not deciding to pay the doctor – it is whether or not the additional hours were indeed worked.	Overtime for ER can be reported directly from HealthRoster as there is a reason code for ER Doctor will be required to confirm via self-declaration that the information submitted adheres to the 2016 TCS.
3	If Medical Workforce is deemed not the appropriate department /role for the decision to sit – delegated authority could be given to CGMs or Divisional Operational Managers or Medical Administrators within Division to have access to the system and approve outcome of ER	The reform does state that the role involved in the ER process should not be co-located with the clinical workforce	Would need agreement by the LCNC, Medical Education and Workforce Mtg for the ability to delegate the role to another. Would need to inform doctors as part of the user setup who has access to the ER system/data.	This point was considered not a suitable option to delegate out from the Medical Workforce Team

4	Current Medical Workforce capacity to deliver the three-tier process No additional resource required would be incorporated in current Medical Workforce headcount	Requirement for higher approval / agreement for outcome decision within Medical Workforce Team	Option is the Band 6 role (current within Medical Workforce Team) would oversee and agree outcome of all ERs submitted. The Band 4 role (4 in post currently) would then be able to input the outcome onto HealthRoster (this is the existing arrangement – B4's add overtime approved by CRL to HealthRoster) The approved HealthRoster Unit approver will finalise the roster for payroll submission, which will include these ER payments/TOIL arrangements.	Need to be aware of any potential changes in the Finance authorisation Framework
5	Ability to conclude Level 0	Emphasis on real time roster and accuracy – decision to be made based on duties on HealthRoster	Difficulty would arise if rosters were not kept real time as could reject based on incorrect duties on roster.	Greater support required with Medical Administrators to ensure rosters kept real time
6	System changes required: • Educational exceptions to go straight to DME for action • Removal of Educational Supervisors from system • Management of TOIL • Ability to have 2 GoSWH/DME to manage host ERs	Working with RL Datix (Allocate) to support the system changes required	Enable faster process Reduces risk of data/confidentiality breach	
7	PLE/Lead Employer (GPs, FY1/2s in HOIW) • Ability to have 2 GoSWH and multiple DMEs on the system to	Currently host employer transfer doctors' exception account to host so that they manage ER raised against their rota.	Lead employer for clinical placements will carry the responsibility for the process and outcomes, also liable for the fines. Therefore, need to keep ERs with Lead Employer and share trends with Host.	Recharge would be needed to send overtime payments to host employer

	enable the Host to oversee the ERs • Ability to have a tick box option to highlight community or host	Concern is that doctor has two assignments - one with UHS and the other as Honorary with Host – payment being made on secondary assignment which would incur different tax codes for doctor.	Weekly reporting to host employers if system not able to have 2 GoSWH Could Host give UHS access to view live roster on Host's HealthRoster?	
8	Management of those exceptions submitted over 2 hours	Requires additional investigation to ensure safe staffing is maintained	Need agreement of a locally determined process to ensure: • Work schedules are still representative of hours • Utilisation of the Medical Locum Bank Ensure doctors have had the required compensatory rest following an ER	
9	Concern there may be an increase of ER cases due to the absence of CRL input	May encourage increase in ERs being raised	May increase the financial impact of ERs on the Trust May demonstrate a more accurate representation of demand on current services	
10	Management of TOIL – when doctor elects to receive TOIL for additional hours worked	Reform states the doctor will need to select an appropriate clinical person to share ER with to enable TOIL to be taken.	TOIL to be taken within 10 days of ER being approved. Within 1 day of award if mandatory due to ISC. Complexity may arise if relating to on-call duties.	
11	Educational exceptions – reports sent directly to DME or DME deputies – they can take action to replace or reinstate any missed educational opportunities	Will require the DME to react to notifications of Educational ERs	DME /Deputy would need to gain doctors explicit consent to share – or doctor to select an appropriate clinical person to enable missed educational opportunities to be reinstated.	
12	GoSWH will need to conduct quarterly surveys to • assess breach of access	Results to be included in the Quarterly GoSWH reports	Additional requirement on GoSWH	

	• Breach of information • Actual or threatened detriment			

Options/ Next Steps

Actions for the Medical Workforce Team:

- Update current user guides (with system changes) and include table of user roles who would have direct access to the doctors ER data. (User Roles to be agreed – Appendix 1)
- Update Medical Staffing Administrators with changes and awareness of the reform
- Communicate with the Clinical Rota Leads/Educational Supervisors – informing of changes
- Audit of current user accounts; review against ESR payroll report

Seek agreement from Medical Education & Workforce Group and LCNC for:

- Agreed user role list who would have direct access to the ER data
- Agreement that an access fine will not be levied where the delay has been caused by an event beyond the control of the employer, for example, cyber-attack.
- Financial authority – Medical Workforce team will need to have delegated authority to approve ER overtime and toil for all resident / locally employed doctors
- No payment for time under 15 mins of work
- Exception reporting is a contractual right for those doctors and dentists who are employed on the 2016 Terms and Conditions of Service in England. At UHS we also mirror those T&Cs for those locally employed doctors (LEDs), therefore this reform will be extended to all trainees and LEDs
- Currently there is delegated authority from Educational Supervisors to Clinical Rota Leads to manage and approve exception reports. Under this reform this would cease
- Currently we allow any exception report regardless of timeframes – to encourage the reporting process. Under this reform this would cease – doctors will be required to submit all ER within 28 days.
- For ER over 2 hours the locally determined process

Conclusion

- Need to protect the anonymity of the doctors
- Need to ensure no medic is part of the decision-making process (apart from GoSWH when required, and DME if education)
- Reporting and review of trends would support the requirement to manage/support doctors with time management concern
- Need assurance that user accounts will be set up in advance of doctors starting at the Trust
- Exception reports must be reviewed independently of budgetary constraints.

References:

Exception reporting reform for resident doctors | NHS Employers

Appendix 1 – Proposed User Roles/Access to ER

User Role	Access
GoSWH	Full exception reporting access
DME	Education exception reporting access only
Medical Workforce Team (Manager, Lead Specialist, Assistants, Administrator)	Full exception reporting access
PLE GoSWH	Exception reporting access to PLE doctors only
PLE DME	Education exception reporting access to PLE doctors only

Need to consider DME/GoSWH absence for annual leave/longer sickness who covers – can the GoSWH cover the DME?

Appendix 3 – Baseline Assessment Ten Point Plan to Improve Resident Doctors' Working Lives NHS England

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: **UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST**

Amenities

Access to Lockers	Yes, but not all
Rest facilities	Yes, but not all
Designated on-call parking access	Yes
Access to hot and cold food 24/7	Yes
Access to cold food 24/7	Yes
Access to inductions specifically designed to meet the needs of Resident Doctors	Yes
Beds/sleeping pods available free of charge	Yes, but not all
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes
Is there access to free psychological support treatment?	Yes
Are there positive feedback mechanisms in place to reward and promote staff?	Yes
Are there protected breaks?	Yes, but not all
Do you promote the Safe Learning Environment Charter?	Yes, but not all
Offer sexual safety/harassment training and awareness?	Yes, but not all

Appointing senior leads to take action on Resident Doctor issues

Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes
If yes, please provide their name and role.	Dr Diana hulbert Guardian of Safe Working
Do you have a peer representative Resident Doctor who your Board consults with on local issues relating to Resident Doctors?	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (Executive team, Trust Board, People Committee or All)	
GMC Training survey	All
NETS survey	All

Annual Leave

Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors?	Planning to introduce (6 months)
Is good annual leave practice covered at resident doctor induction?	Yes
Do you allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)
How much leave can Resident Doctors carry over?	5 days
Do your rostering systems for Resident Doctors allow for self/preferential rostering?	Yes

Payroll and Expenses

Have you implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes
Have there been changes in payroll errors over the last 12 months?	No change
How do you process course related expenses?	After course attendance, planning to change (3 months)

Mandatory Training & Learning

Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?	Yes, both

* Baseline assessment score **84%**

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.13	Report to the Trust Board of Directors, 11 November 2025
Title:	Annual Clinical Outcomes Summary Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Diana Ward, Clinical Outcomes Manager, Lucinda Hood, Head of the Medical Directorate, Kate Pryde, Clinical Director for Improvement and Clinical Effectiveness

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This paper provides an overview of the clinical outcomes reviewed by the Clinical Assurance Meeting for Effectiveness and Outcomes (CAMEO) over the 12 months to September 2025. It highlights areas of success, including exceptional performance benchmarked both nationally and across Europe, as well as areas of concern with corresponding improvement plans.

The paper also illustrates the varying levels of access to outcome data across the organisation, which affects the ability to provide consistent assurance on clinical effectiveness.

Overall, this paper serves as both an opportunity to celebrate the clinical excellence demonstrated across our organisation and to reflect on opportunities for further improvement.

Contents:

Paper

Risk(s):

1a) The lack of capacity is impacted on timely appointments and diagnostics, there is a risk that if we do not meet targeted treatment waiting times, then there will be an impact on clinical effectiveness and outcomes.
1b) A number of specialties have flagged a risk that if staff capacity does not improve then there could be an impact on quality of care and outcomes.

Equality Impact Consideration:	NO

Annual clinical outcomes summary November 2025

Table of Contents

Introduction

This paper summarises a year of reporting to the Clinical Assurance Meeting for Effectiveness and Outcomes (CAMEO), a panel of clinicians and patient representatives led by the Clinical Director for Improvement and Clinical Effectiveness. Each specialty presents evidence of clinical effectiveness to CAMEO annually, including outcome data, audit results, compliance with national standards, improvement projects, and newly approved procedures.

This year, we focused on improving the clinical outcome data reviewed by CAMEO. We prioritised data that reflects meaningful outcomes for patients, allows benchmarking, and can be tracked over time.

Collecting this data is often challenging for teams. Our systems do not currently allow for easy recording and collation of outcomes. At UHS, we contribute to many national clinical audits to benchmark our performance and use patient surveys to gather Patient Reported Outcome Measures (PROMs), although this is less well collected than patient experience data.

The below content highlights areas of clinical excellence at UHS, including where we outperform national or European averages. It also identifies areas for improvement and outlines our plans to address them.

High level summary

The following tables highlight areas of clinical excellence, and of greatest concern across the organisation.

Outstanding outcomes

Service	Outcome/ service	Comment
Paediatric Respiratory Medicine: Cystic Fibrosis	Age adjusted FEV1% predicted (a lung function index that is the best predictor of long-term outcome)	2 standard deviations above the national average which makes us the highest performing large CF service for this outcome measure in the UK
Paediatric Cardiology- congenital heart disease	Survival rates Complications Waiting list safety	Amongst the highest nationally, against some of the highest complexity scores (99% 2020-23, 2023-25 data not yet published) Low rate of benchmarked complications after surgery Excellent clinical management of the second largest waiting list in the UK
Medical and clinical oncology	30-day mortality rates for Systemic anti-cancer therapies	Below the national average for all tumour groups. (The national average data is due to be updated as the figures are pre-covid.)
Bone Marrow Transplant and cellular therapy	Allograft outcomes Allogeneic transplantation Allogeneic stem cell transplant	The last EBMT risk-adjusted benchmarking exercise show that our outcomes continue to be excellent for Allografts Our centre in Southampton has performed extremely well and continues to have the best transplant outcome for allogeneic transplantation in Europe, defined by 1 year mortality and remains better than average for autologous transplantation of 440 transplant centres across UK and Europe WBMTCT still has the best outcomes reported to EBMT for allogeneic stem cell transplant of 395 transplant centres in Europe
Upper GI	New procedures	First in UK Paediatric POEM (per-oral endoscopic myotomy) First in UK robotic RefluxStop procedure
Colorectal	Bowel cancer Pelvic exenteration	Excellent outcomes in all aspects of bowel cancer surgery which are exceptional for a high-volume centre with 90-day mortality and re-admission rate well below the national benchmark and a two-year mortality comparable to the national average. 90-day mortality for pelvic exenteration is 0 for conventional cases and 0.8% for complex/ advanced cases for 294 curative cases. At this level of complexity this was reported as outstanding.
Trauma and Orthopaedics	Fractured neck of femur- 30-day mortality	We have significantly lower than average case mix adjusted 30day mortality. In 2024 we received a letter from the Royal College Physicians requesting to showcase our success
Critical care	CICU- congenital heart disease	The National congenital heart disease audit showed higher than expected survival rates.
Cardiac surgery	Survival rate	The latest NACSA data that covers the period 2021-24 where the survival probability of the unit is well above the national average.
Anaesthetics	Obstetrics- epidural request	In obstetrics, the target of attending within 30 mins of epidural request is being met for 92% of women, this is up from 90.4% last year, target is >80%.
Maternity/ obstetrics	Maternal death rate Stillbirth rates	Maternal death rates remain low. In 2024, there was one maternal death. A full review found no concerns regarding the standard of care provided. Stillbirth rates are around the national average, despite being a Level 3 neonatal unit and a tertiary centre with specialist fetal medicine service. There was a small local increase in March 2025 of 12 cases of which 42% were transfers in for fetal medicine from around the region. All cases were reviewed, and no concerns were raised.
Neonatal	National neonatal audit programme and VON	Consistently performing well in necrotising enterocolitis (NEC), consultation with parents and brain injury, improving numbers of delayed cord clamping (DCC) and retinopathy of prematurity (ROP) consistently performing well in patent ductus arteriosus (PDA) surgery, NEC and NEC surgery. Overall stable mortality and morbidity
Neurosurgery	Subarachnoid haemorrhage	Death rate low (7.5% vs 14% national average) Long-term neurological outcomes above national average (‘good recovery’ 75% vs. 67% nationally)

Areas of for improvement and planned actions

Service	Outcome/ service	Comment
Radiology	Mechanical thrombectomy	Mechanical thrombectomy patients' Modified Rankin Scale worsened function by 2 levels at discharge is worse than the national average. The scale is a measure of functional disability used in stroke patients and can be used to predict long-term outcomes. This may be because of patient cohort acceptance rates. 72% of patients are transferred in from other centres compared to 60% nationally which is associated with the delay to treatment. UHS accepts older patients with borderline function therefore affecting outcomes. Procedural complications are better than the national average
PICU	Readmissions	The proportion of emergency readmissions to PICU within 48 hours of a previous discharge / transfer from PICU are higher than the national benchmark. Some patients are discharged sooner from L3 care than ideal due to unit capacity. The data suggests a spike in re-admissions in Q3 (Oct/Nov/Dec) which fits with typical peak occupancy/admission rates in early winter. The unit continuously runs at a high occupancy level, around 103%. The PICANet target is 85%. It is recognised that several readmissions come from E1/E1 High Care. Patients with congenital heart disease have fragile physiology and a greater risk of deterioration. Work is ongoing to support education around recognition of the deteriorating child/ escalation pathways, with early escalation to Outreach/PICU for review.
Vascular	Amputation versus limb salvage and longer-term mortality	We are not achieving target for the time to treatment of National Screening Programme (NAAASP) for aortic aneurysms, carotid surgery or revascularising critical limb ischemia. Revascularising is improving but is still short of the upper CQUIN target. Investment in the service is required to be able to achieve the targets. The group that will be affected the most are patients with critical limb ischaemia, as timely revascularisation determines the likelihood of amputation versus limb salvage and longer-term mortality.
Pharmacy	Dispensing rate errors	Dispensing error rates: This has increased and is now above the national benchmark. However, this does represent an accuracy rate of 99.975% was achieved from a total annual workload of 526,015 items
Medicine for older people	Delayed discharged/ readmission impact	Length of stay and readmission metrics remain high. Both these issues reflect increasing pressure within the social care sector, with increasing delays in discharge from the acute hospital. This also drives readmissions when social care needs cannot be met on discharge, often made worse by having had a delayed admission with the inherent deconditioning and reduced independence that this brings.
Maternity/ obstetrics	Apgar score PPH 3rd and 4th degree tear rate	Sustained outlier in the number of term, singleton, liveborn babies with an Apgar score <7 at 5 minutes. Quarter 4 2025 data shows a continued upward trend, with a rate of 2.83%, significantly exceeding the national and local benchmark of 1.1%. Analysis indicates that approximately one third of these cases are associated with the use of maternal general anaesthetic, some of which are administered at maternal request. All unplanned NICU admissions were reviewed. No trends or care concerns were identified. The rate of massive post-partum haemorrhage (PPH ≥1500ml) observed in 2023 and 2024 were consistent at 3.45% and 3.80% which consistently exceeds the local target of ≤2.9%. 2025 data suggests that efforts to reduce PPH occurrences are making gradual progress, though require further improvement. To address persistently elevated rates of severe postpartum haemorrhage (PPH), a comprehensive review of clinical practice and associated risk factors has been completed. Plans are in place to implement targeted interventions to strengthen the identification and management of high-risk pregnancies. In addition, focused education and training will be delivered to enhance early recognition and timely response to PPH, with an emphasis on multi-disciplinary collaboration and the optimisation of care pathways. National Maternity and Perinatal Audit (NMPA) - third- and fourth-degree tear rate Obstetric Anal Sphincter Injury (OASI) report is due for publication in June 2025. The Trust's rate of third- and fourth-degree perineal tears (OASI) has remained in the red category on the local maternity dashboard for a sustained period. This has been escalated.
Breast	Reconstruction rate	The immediate autologous reconstruction rate was 8%, which is notably lower than the GIRFT. The ICB are supporting clinical network discussions on the breast pathway between UHS and local partners.
Trauma and Orthopaedics	Hip and knee implants	Implant survival has presented challenges in recent years. The division proactively discontinued the use of the CPT femoral stem (hip) and NexGen knee prior to their national withdrawal, a decision later validated by a field safety notice that our reporting helped to trigger. Findings on the associated poor outcomes were subsequently published in peer-reviewed journals and presented at national professional meetings to raise awareness. National Joint Registry (NJR) 'alert' and 'outlier' feedback processes, detailed reports and an action plan were submitted, resulting in a gradual return to normal implant survival rates.

Appendix

Summary by division

The following content covers areas of success, areas for improvement and planned actions to each specialty across the organisation, alongside data to evidence this performance.

The outcome reporting processes requests that specialities report on an annual basis. Due to this reporting cycle, there will be areas of focus and actions listed in this report that were discussed up to twelve months ago. We will be able to provide an update on these following the next CAMEO presentation. As a department we are improving the frequency of updates on actions by implementing quarterly meetings with clinical effectiveness leads alongside the existing annual process.

Division A

Trauma and Orthopaedics

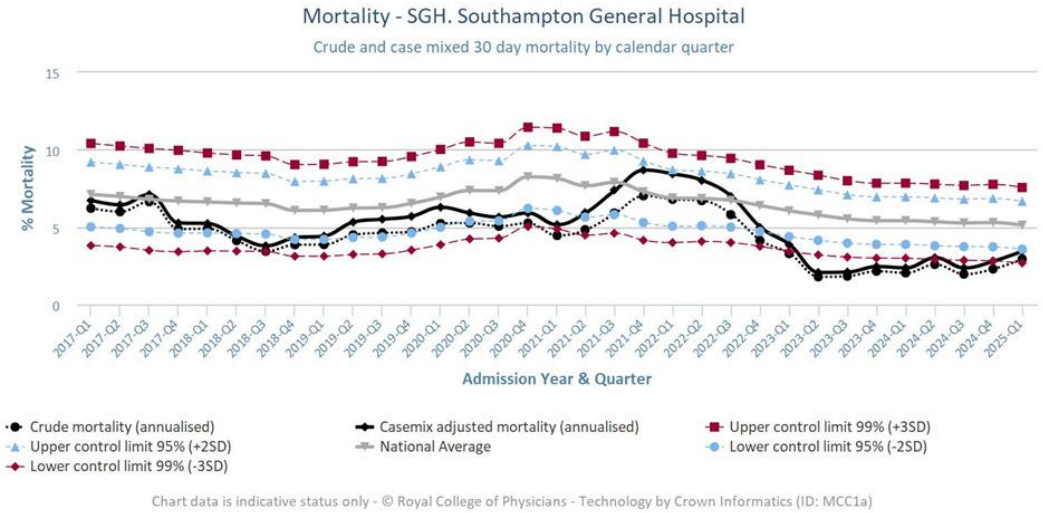
(Presented at CAMEO 22.9.2025)

Highlights of success:

Fractured neck of femur (#NOF)

- UHS is a positive outlier for #NOF 30-day mortality, consistently performing better than the national benchmark.
- The Best Practice Tariff (BPT) for fractured neck of femur and femoral fractures, is designed to promote high-quality care for patients aged 60 and over who sustain these injuries. There are a number of areas we are performing well in, including % of patients admitted received a nutritional risk assessment during their time in hospital, % of patients admitted assessed by a geriatrician within 72 hours of admission, % of patients admitted received fracture prevention assessments (bone health assessments) and % of patients were assessed by a physiotherapist either on the day of, or the day after, surgery.

Fractured neck of femur mortality



Areas of focus:

- Implant survival has presented challenges in recent years. The division proactively discontinued the use of the CPT femoral stem (hip) and NexGen knee prior to their national withdrawal, a decision later validated by a field safety notice that our reporting helped to trigger. Findings on the associated poor outcomes were subsequently published in peer-reviewed journals and presented at national professional meetings to raise awareness. National Joint Registry (NJR) 'alert' and 'outlier' feedback processes, detailed reports and an action plan were submitted, resulting in a gradual return to normal implant survival rates.
- There are measures within the best practice tariff the service are focusing on improving, % of patients having surgery within 36 hours of arrival, % patients receiving a pre-operative delirium assessment and % patients receiving a post-operative delirium assessment.

Name	Code	Number of cases submitted	Admitted to orthopaedic ward within 4 hours	Mental test score recorded on admission	Perioperative medical assessment	Physiotherapist assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment	Not delirious when tested post-op.	Received falls assessment^	Received bone health assessment^	Met best practice criteria
Southampton General Hospital	SGH	783	11.4	48.9	84.8	96.9	62.6	99.2	27.5	98.0	97.6	6.3
All NHFD		71,901	12.5	92.4	88.6	97.5	82.1	96.9	71.6	95.7	95.4	48.8
England		65,152	12.2	93.1	89.9	97.6	82.3	97.8	72.5	96.9	96.1	51.5
Northern Ireland		2,347	9.3	91.8	84.4	98.5	87.5	73.8	63.3	88.4	96.1	4.5
Wales		4,402	20.2	82.5	71.8	95.6	75.9	95.5	62.6	82.1	85.8	32.2

Action Plan:

- Actions to increase timely theatre access include escalated support over weekends and during surges in cases; daily huddles to identify volumes and visible monitoring of numbers waiting for surgery, admissions and breaches.
- Completion of delirium assessments has been discussed at Care group governance group and is on the list of areas of focus for the care group quality improvement group.

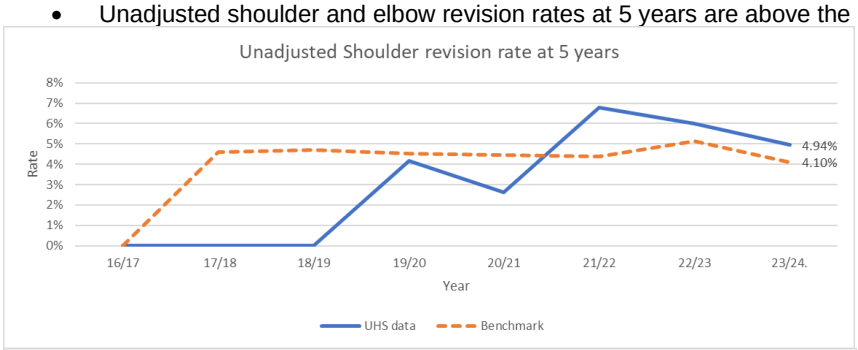
Upper Limb

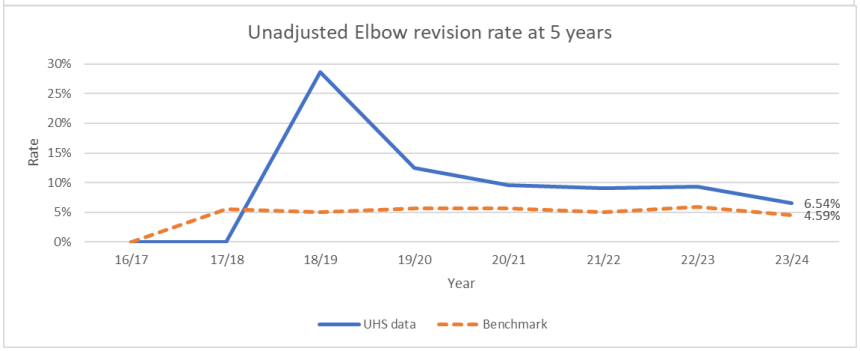
Highlights of success:

- UHS is above the national benchmarks for upper limb compliance for shoulder and elbow primary and revision with 100% of procedures entered onto NJR.
- The percentage of Pre-op Shoulder PROMs collected is 23% against the national average of 17.53% for 23/24.

Areas of focus:

- Unadjusted shoulder and elbow revision rates at 5 years are above the national revision rate for 23/24.





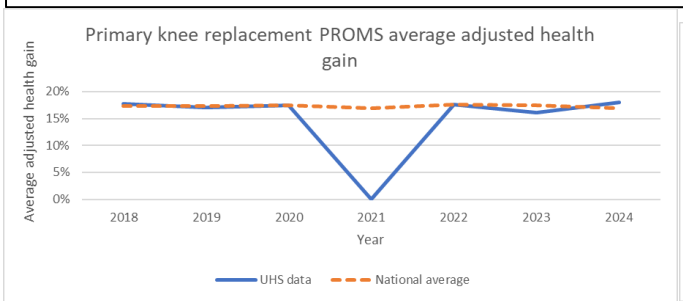
Lower Limb

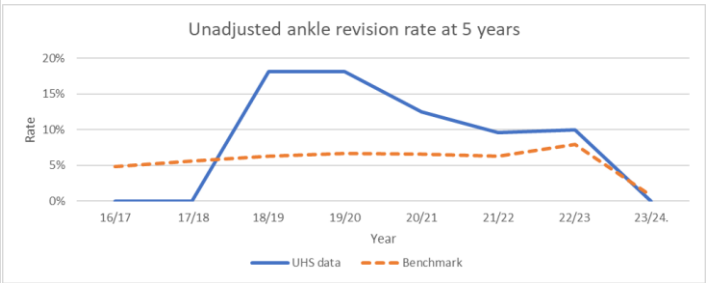
Highlights of success:

- Low surgical site infection (SSI) rate, with only 1 SSI in the last 4 quarters. Cause of SSI was reviewed.
- The adjusted health gain for primary knee replacement PROMs aligns with the national average.
- The unadjusted ankle revision rate has improved and is now consistent with the national average.

Number of infected knee replacement cases

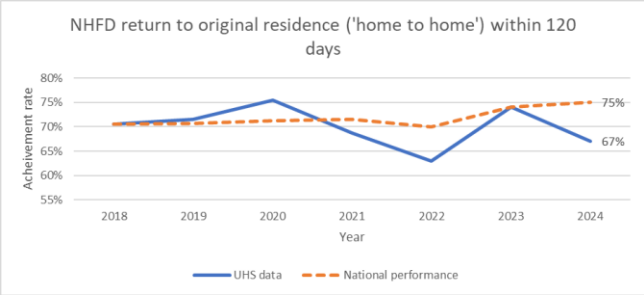
Year and Period	No. operations	Patient questionnaire No. Given	Patient questionnaire % complete	Inpatient & readmissions No.	Inpatient & readmissions %	Post discharge confirmed No.	Post discharge confirmed %	Patient reported No.	Patient reported %	All SSI * No.	All SSI * %
2024 Q2	72	72	100.0	0	0.0	0	0.0	0	0.0	0	0.0
2024 Q3	55	55	94.5	0	0.0	1	1.8	0	0.0	1	1.8
2024 Q4	51	50	94.1	0	0.0	0	0.0	0	0.0	0	0.0
2025 Q1	69	69	85.5	0	0.0	0	0.0	0	0.0	0	0.0





Areas of focus:

- UHS is undertaking a high number of revision procedures in lower limbs due to poor prosthesis longevity.
- UHS manages a higher proportion of highly complex surgical cases, whereas lower-risk patients are operated on at other centres which may explain the lower than the national average return to original residence within 120 days.



Fragility fractures and Fracture Liaison Service (FLS)

Highlights of success:

- The data for 2024 demonstrates a significant improvement in our identification of vertebral fractures assisted by ADOPT study (AI detection of osteoporosis for treatment)

Measure	Outcome
KPI 2: Non-spine fragility fracture identification	UHS 61.8% vs national 42.3%
KPI 3: Spinal fracture ID	UHS 105.2% vs national 31.6%
KPI 5: DXA within 90 days	UHS 77.1% vs National 41.7%
KPI 6: Falls Assessment	UHS 82.2% vs National 65.9%

Areas of focus:

- Clinic appointments are currently being scheduled 8 weeks post-fracture due to DEXA report delays of up to 2 weeks. As a result, primary care services have only 6 weeks to initiate patients on bone protection therapy.
- KPIs 9-11 are reliant on the activity of our community partner to deliver follow ups. Unfortunately, patients were not being followed up within the KPI time frame. The ADOPT study has been taking place and therefore a large proportion of follow ups completed in 2024 are attributable to this.

Measure	**Outcome**
KPI 4: FLS assessment within 90 days	UHS 62.3% vs National 67.7%
KPI 7: bone treatment recommended	UHS 56.6% (2023 = 84.2%) vs National 56.6%
KPI 9: Monitoring contact 12–16 weeks post fracture	UHS 16.6% vs National 31.8%
KPI 10: Treatment started by first follow up	UHS 19.9% vs National 32.1%
KPI 11: Patient's adherence to anti-osteoporosis medication at 12 months post fracture.	UHS 11.5% vs National 24.2% NB % for UHS will be underrepresented as follow ups not completed.

Action plan:

- A new contract for community-based follow ups and the fracture prevention service follow up activity both started 1st April 2025. Therefore, improvements expected in follow up performance metrics from 1st August 2025, and in adherence to anti-osteoporosis medication from April 2026.

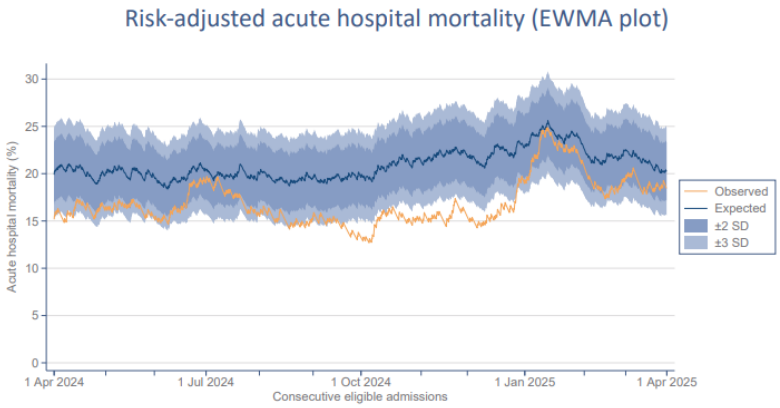
Critical care

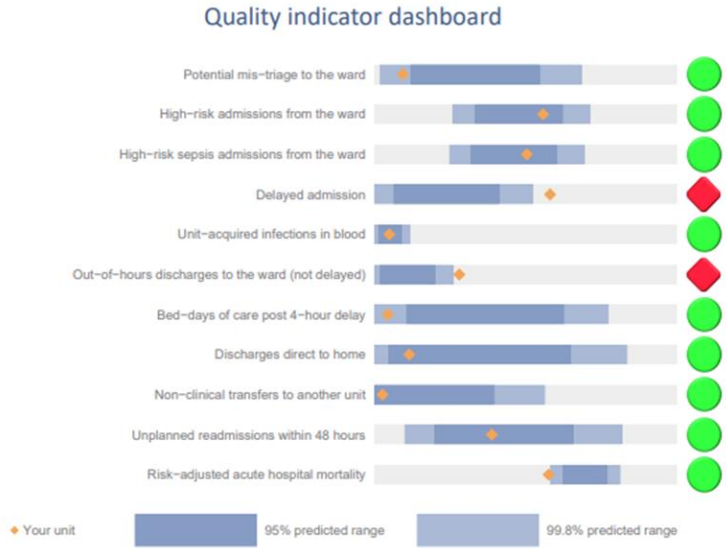
(presented at CAMEO 22.9.2025)

General intensive care

Highlights of success:

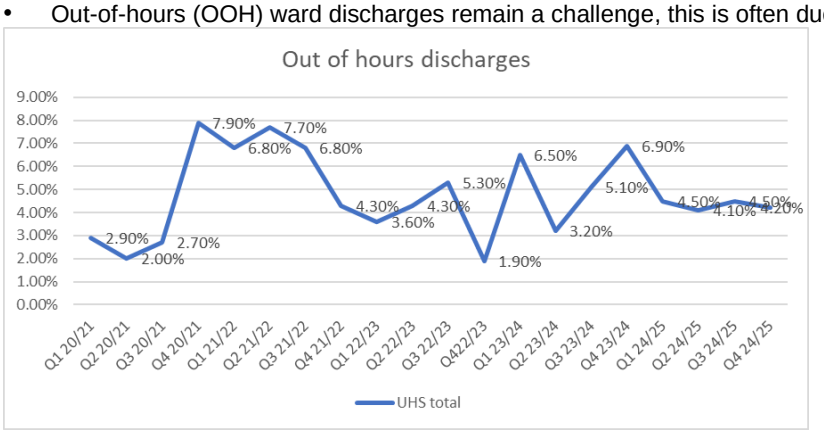
- GICU continues to perform at the expected level for the majority of ICNARC quality indicators (9 of 11).
- Risk adjusted acute hospital mortality remains consistently lower than the national benchmark.





Areas of focus:

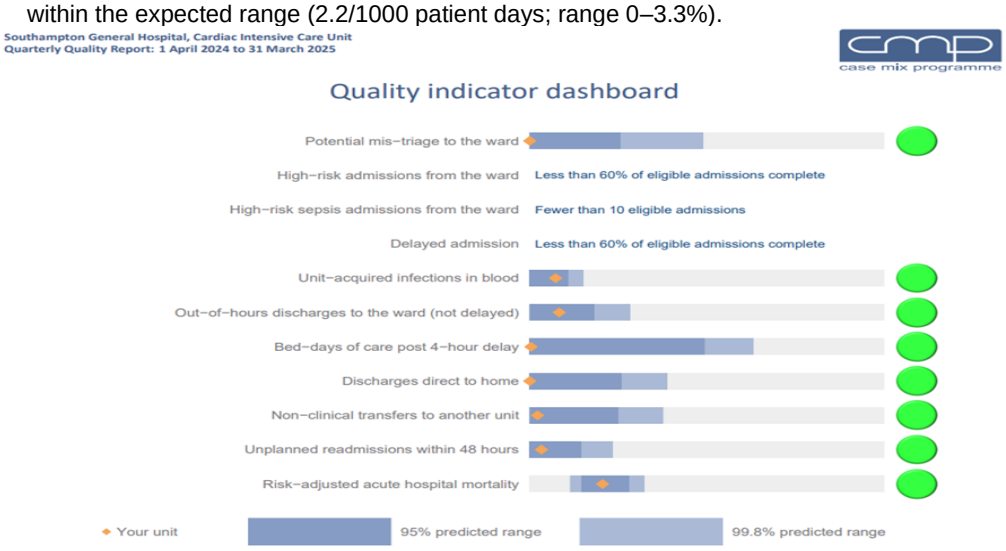
- Delayed admissions to critical care have been identified as an area for improvement. The ICNARC team are enhancing data collection on the time from decision to admit, and clinical teams are utilising dashboards to monitor these intervals. A trial of categorising admission urgency was run as a pilot and is ongoing. Reduced nursing staff numbers have also been recognised as a potential contributor to delays, reflecting the impact of reduced critical care capacity.
- Out-of-hours (OOH) ward discharges remain a challenge, this is often due to hospital flow and service demand.



Cardiac Intensive Care

Highlights of success:

- Risk adjusted hospital mortality is 5.1 vs 5.4 nationally.
- National adult of cardiac surgery audit (NACSA) results showed a higher-than-expected complexity with a recalibrated Euro score 2.47 vs 1.87 national average, indicating that inpatient survival is better than predicted.
- National congenital heart disease audit showed a congenital cardiac surgery mortality 1.7% and survival higher than expected.
- Bloodstream infection rates have been an area of focus since the last report. Current infection rates have improved and are within the expected range (2.2/1000 patient days; range 0–3.3%).



Areas of focus:

- UHS is experiencing higher rates of AKI (acute kidney injury) compared to other units (57.3% compared to 41.3% in similar units) however, positively there's a lower overall AKI mortality rate of 7.9% compared to 11.8% in similar units.
- ICNARC data is incomplete. Ongoing audits are being undertaken to review high risk admissions, delayed admissions, readmission rates and high-risk sepsis admissions.
- CICU reports a complex situation regarding staffing, capacity and activity balance. Overall, there is a concern that ongoing staff challenges will affect clinical effectiveness

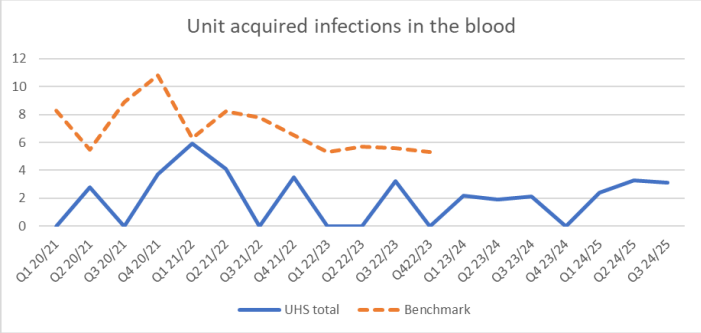
Action plan:

- CICU consultant lead will investigate the high AKI rate at UHS compared to similar centres.
- A board-level recovery plan has been established to address the issues raised.

Neuro Intensive Care

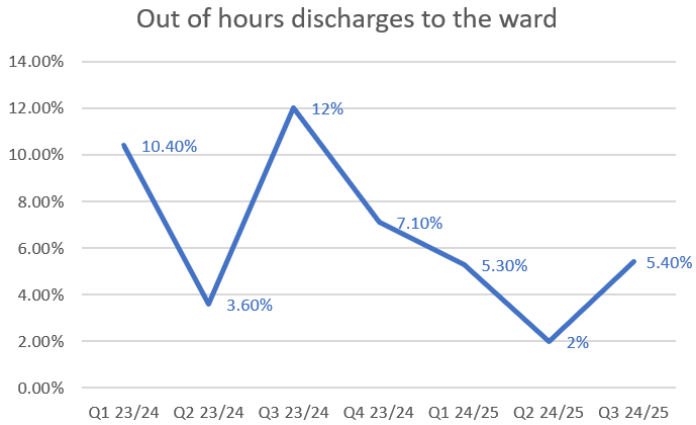
Highlights of success:

- A weekly multidisciplinary rehabilitation ward round has been introduced, improving communication and discharge planning.
- Completion of vancomycin audits highlighted the need for higher loading and maintenance infusion rates in neuro ICU patients. These findings have directly informed safer prescribing practices.
- UHS remains well under the national average for unit acquired blood stream infections.



Areas of focus:

- ICNARC data has identified UHS as an outlier for out of hours discharges. Many of these discharges are not true ward step-downs but reflect capacity-driven transfers to General ICU, where patients continue to receive level 2/3 care. Operational pressures sometimes prevent timely discharge, which can result in an OOH discharge.



Action plan:

- An MDT team with job-planned time will oversee ICNARC data quality and reporting, including working with the ICNARC team to improve categorisation of transfers. Governance discussions will focus on understanding causes of OOH discharges and highlighting when this relates to bed pressures and flow challenges, rather than interpreting them as ward-based safety events.
- We anticipate a rise in observed mortality linked to thrombectomy patients, reflecting the very high-risk patients being transferred to neuro ICU. We are engaging closely with the Stroke Service to review patient selection criteria and ensure that outcome signals are interpreted in the context of disease severity.
- It remains challenging to collect, analyse and report outcomes data. The department plan to coordinate these processes across their MDT involving senior nursing staff, ACP's and a data coordinator.

Surgical high dependency unit (SHDU)

Highlights of success:

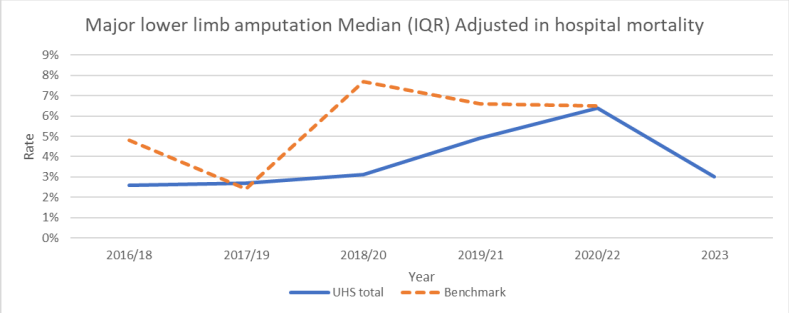
- SHDU performs at expected level for all ICNARC (intensive care national audit and research centre) quality indicators.

Areas of focus:

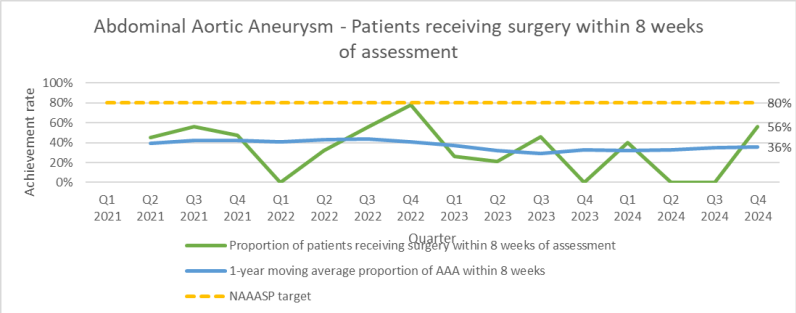
- UHS is experiencing the national and local downward trend in organ donation consent rates including neuro and cardiac intensive care units. Our current consent rate is 62% compared to the national benchmark of 70%. Reasons are for this trend are being reviewed at national and local level.
- The Critical care outreach team is providing a 24hour, 7-day week service, despite this, meeting 750 referrals a month is challenging.

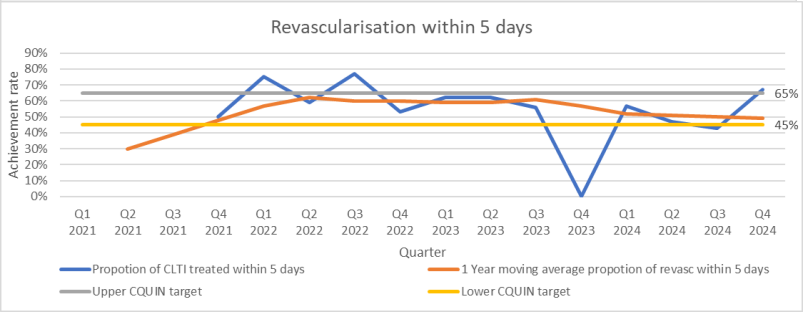
Cardiovascular &Thoracic
(presented at CAMEO 18.9.24)

Vascular
Highlights of success:
- We have consistently achieved the lower CQUIN for time to revascularisation for lower limb ischaemia. Lower limb mortality is better than the national average.



Areas of focus:
- UHS is not achieving the National Screening Programme target for the time to treatment for aortic aneurysms, carotid surgery, or revascularisation of critical limb ischemia. Revascularisation is short of the upper CQUIN target.





Action plan:
- Service expansions would be required to achieve the targets.

Interventional cardiology
Highlights of success:
- Use of intra-coronary imaging in both complex and left main stem PCI are above national average.

Myocardial Ischemia National Audit Project
Highlights of success:
- Non-ST-Elevation Myocardial Infarction (NSTEMI) data favourable, with a high percentage of patients receiving angiography within 48hours, 72 hours and 96 hours – all above national targets.

Areas of focus:
- There is delay in call to reperfusion times linked to variables outside of UHS such as national ambulance pressures.
- We are not meeting our local 60-minute target for 'door to reperfusion.

Action Plan:
- Monthly audit of causes and themes for delays; learning is communicated with all departments involved.
- A new protocol for working in Emergency Department has been implemented.

Heart Failure
Highlights of success:
- Adherence to National prescribing guideline therapy is >90%. National benchmark is 59%.

Cardiac rhythm management
Highlights of success:
- Rates of Intervention for Simple Ablation within 2 years is significantly below national average (2021/22)

Areas of focus:

- 4.46% rate of re-intervention within 1 year for Complex Devices (CIED), higher than national benchmark of 4% (2022/2023)
- 5.5% rate of re-intervention within 1 year for Complex atrial ablation, higher than national benchmark of 5% (2022/2023)

Cardiac surgery

Highlights of success:

- NACSA data 2021-24 showed that survival probability of the unit is well above the national average.
- UHS is fourth in volume of major cardiac operations performed in a total of approximately 40 cardiac units in the UK and Ireland
- UHS was one of the 6/40 units that achieved the target of less than 12 weeks from angiography to elective CABG and for time from referral to surgery for urgent CABG.

Thoracic

(presented at CAMEO 18.9.2024)

Highlights of success:

- Excellent length of stay (LOS) when benchmarked nationally. Robotic surgery has enabled further improvement to LOS, with a reduction from 4 to 3 days on average.

Action Plan:

- To enrol onto the ESTS database to improve collection of clinical outcomes

Anaesthetics and theatres

(presented at CAMEO 27.6.2025)

Highlights of success:

- Substantial improvement in obstetric epidural response times, 92% of patients now within 30 minutes.
- The anaesthetic allergy service is improving patient safety by testing individuals who experienced complications during surgery.
- UHS is a statistical positive outlier for 30-day mortality following fracture neck of femur.

Rate of Regional block in theatre for Neck of Femur Fracture patients undergoing fixation

Type of anaesthesia	Year	Percentage of patients at UHS having this type of anaesthesia	National rate
General Anaesthetic	2022	84%	65%
	2023	81%	65%
Neuraxial block	2022	70%	49%
	2023	67%	49%

Areas of focus:

- The inpatient pain service saw same-day referral-to-review rates fall from 50% in 2023 to 34% in 2024 when operating four days a week. The service has since expanded to five days a week, supporting better patient access and responsiveness.
- If patients have a nerve block, they are less likely to need opioids which would improve mortality and morbidity. A business case is in progress for a local anaesthetic block service.

Neurosciences

(presented at CAMEO 12.5.2025)

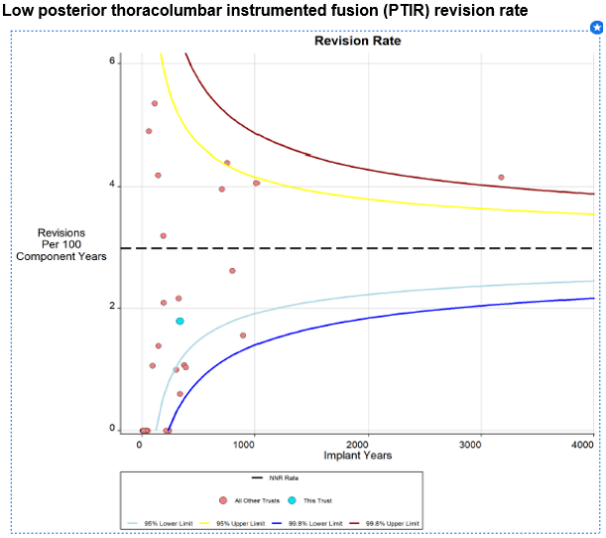
Neurosurgery

Highlights of success:

- Low Subarachnoid haemorrhage re-bleed rate 6% compared to 7% national average. There is a death rate of 7.5%, which is significantly lower than the national average of 14%. UHS rates of “good recovery” are higher than national average.
- Use of PROMS at 6 months for spinal cord stimulator pain outcomes shows good long-term results for patients.
- Low posterior thoracolumbar instrumented fusion (PTIR) revision rate and low explant PTIR rate
- Neuro-oncology surgeons at UHS have driven forward a day-case biopsy under local anaesthetic study with excellent results consistently over several years. Benefits to performing these under local include non diagnostic rate of 3%, haemorrhages under 1% and a low 0.4% death rate.

Outcome	UHS	National Benchmark
Subarachnoid haemorrhage (SAH) re-bleed rate	6%	7%
SAH mortality	7.5%	14%
Long-term neurological outcomes:		
“Good recovery”	75%	67%
“Moderate disability”	12%	8.9%
“Severe disability”	4.7%	5%

Low posterior thoracolumbar instrumented fusion (PTIR) revision rate



Areas of focus:

- National audit reports are often delayed and frequently lack robust data-over-time metrics, making benchmarking and service evaluation more challenging.
- There is scope to further improve local databases to enhance audit quality and completeness.

Stroke

Mechanical thrombectomy

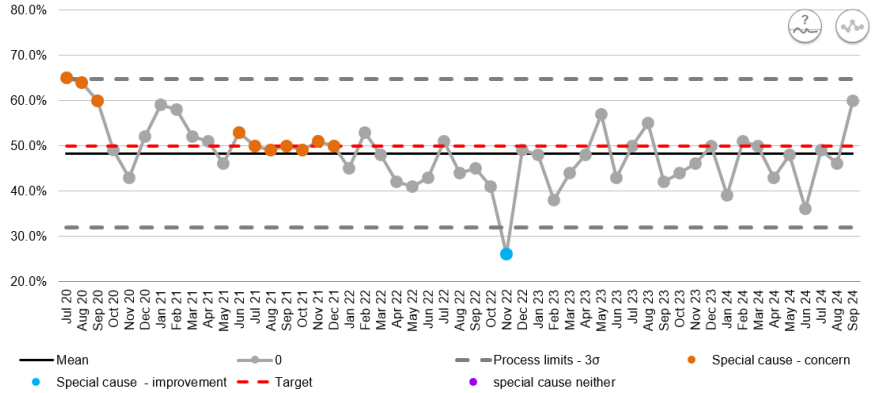
Highlights of success:

- Same day repatriations following mechanical thrombectomy rate has attracted national recognition: 50% of patients return to their local hospital the same day following mechanical thrombectomy.
- In 2023/24 we performed 260 procedures, the fifth highest number in the UK, 11% of all thrombectomies. By March 2025 we did the third highest number of procedures in the country
- Time to being seen by a consultant on admission is 3 hours 13 minutes, which is half the national average time of over 6 hours

Areas of focus:

- There has been a deterioration in performance for time to patient review due to demand, with a median time of 1 hour 49 minutes compared to a national average of 29 minutes, slowing down clinical assessment, imaging and HASU admission times.
- Hyperacute Stroke Unit (HASU) at UHS has thirteen beds, making it one of the smallest units of any tertiary neuroscience centre in the UK. Referrals have risen by 15% and stroke admissions have increased by 10% year-on-year. The inpatient bed footprint does not meet demand, this has resulted in delays to admissions, leading to treatment delays for thrombolysis and thrombectomy, poorer patient outcomes, and an increasing number of patients being outlied to neurological wards where they cannot receive the specialist stroke care they need.
- 30% of patients were discharged with Early Supported Discharge (ESD), compared with a national average of over 50%. This highlights the need for greater investment in community stroke services to enable patients with higher dependency needs to be discharged earlier from hospital.

CT within an hour of admission for acute strokes-Neurosciences - Stroke starting 01/07/20



Action Plan

- Further pilots with neurology and/or spines to create a Multi-disciplinary SDEC and ensure the staffing and rapid access to CT and MRI are available 12hrs a day 7 days a week to ensure that it becomes business as usual.

Neurology

Highlights of success:

- The headache readmission rate has continuously declined, and recent treatment developments have shown positive results.
- Continue to ensure timely access to novel therapies for neurological diseases such as spinal muscular atrophy, myasthenia gravis, and multiple sclerosis for patients across the region.

Areas of focus:

- A recent GIRFT indicated no areas of underperformance; however, there is limited local and national data available to effectively benchmark the service.

Neuro Rehabilitation

Highlights of success:

- Botulinum toxin clinics for treatment of muscle spasticity achieved a 93% success rate, compared to 85% in the previous year.
- Intrathecal Baclofen (ITB) therapy clinics achieved 100% on-time pump refills. All patients reported a benefit from treatment.

Areas of focus:

- ITB caseload has increased to 53 patients for refills. Lack of robust system for reviewing when pump replacement is due.
- There were 2 reported incidents relating to incorrect pump programming.

Action Plan

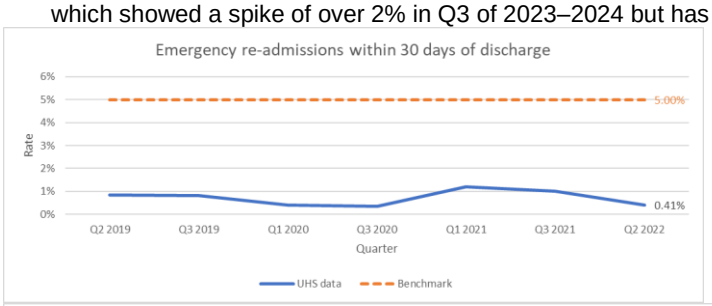
- Exploration of alternative treatments and collaboration with surgical colleagues
- Use of Patient Reported Outcome Measures (PROMs). LIVE chart now rolled out for selected patients to enhance monitoring and patient engagement.

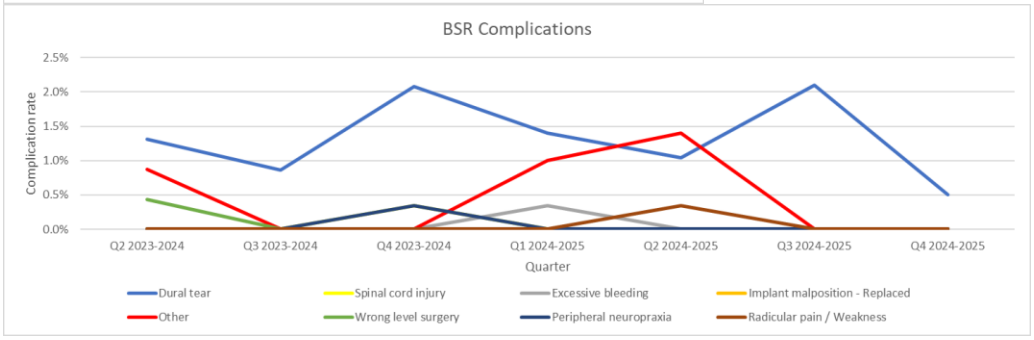
Spines

(Report sent to CAMEO committee 12.5.25 but not presented)

Highlights of success:

- Significantly lower emergency re-admissions than the national benchmark
- Overall complication rates remain low across procedure types. The highest complication rate is associated with dural tears, which showed a spike of over 2% in Q3 of 2023–2024 but has since declined.





Source: British Spinal Registry (BSR)

Areas of focus:

- The British Spinal Registry collects PROMs, but full participation requires each patient to provide consent for their data to be recorded, along with a valid email address. Currently, the collection of consent and email addresses is limited by a lack of administrative support, which negatively impacts the ability to engage fully with the registry.

Action plan:

- GIRFT review took place in June 2025, Spinal board has reviewed recommendations.

Surgery

(presented at CAMEO 4.12.24)

The below gives an update on outcomes related to Urology and General surgery. ENT and Max Fax were unable to attend the CAMEO meeting in December.

General surgery

ASU

Highlights of success:

- The National Emergency Laparotomy Audit (NELA) demonstrates that UHS are performing above the national and ICB average for case ascertainment. We are also above ICB and national average for CT reported by a senior radiologist, however, this is below the target level.

Areas of focus:

- The NELA demonstrates that we are performing better than the national average for infection management, but lower than the ICB mean and the national target.

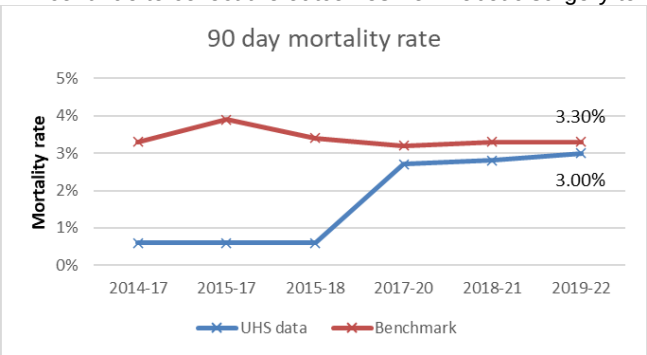
Action plan:

- Improvement focus has been placed on sepsis, including identification of patients who have potential sepsis and starting with antibiotics on admission.

Upper GI

Highlights of success:

- First in UK Paediatric POEM (per-oral endoscopic myotomy)
- First in UK robotic RefluxStop procedure
- Esophagectomy 90-day mortality has increased to 3%, this is still below the national average of 3.3%.
- Robotic Oesophagectomy is demonstrating several improved outcomes in comparison to minimally invasive procedures. These include reduced transfusions, reduced complications, reduced hospital acquired pneumonia, reduced length of stay and improved lymph node yield. There has been an increase in chyle leak and also the operation time is increased. The service will continue to collect the outcomes from robotic surgery to better understand these outcomes.



Colorectal

Highlights of success:

- Excellent outcomes in bowel cancer surgery which are exceptional for a high-volume centre with 90-day mortality and re-admission rate well below the national benchmark and a two-year mortality comparable to the national average.
- 90-day mortality for pelvic exenteration is 0 for conventional cases and 0.8% for complex/ advanced cases for 294 curative cases. At this level of complexity this was reported as outstanding.
- The intestinal failure service also reported low 90-day morality rates, with only 1 death since January 24 (39 patients) and with the cause linked to an unrelated cancer, rather than the IF surgery.

Action plan:

- Increased collection of Patient Reported Outcome Measures through My Medical Record

Urology

Highlights of success:

- Prostatectomy service demonstrated a significant focus on patient reported outcomes and experience post Radical prostatectomy.

Areas of focus and action plan

- Data collection from patients following radical prostatectomy has found that erectile dysfunction was the area of greatest concern to patients, pathways need to be established to improve timeliness of treatment and satisfaction with the service.

Division B

Cancer care
(presented at CAMEO 24.1.2025)

Medical and clinical oncology
Highlights of success:
- 30-day mortality rates for Systemic anti-cancer therapies (SACT) are below the national average for all tumour groups. The national average data is due to be updated; figures are pre-covid.
- This data demonstrates our overall 30- day mortality rates normalised for the population and shows similarly excellent results as the SACT data demonstrated below. For Bowel cancer we are a positive outlier for 30-day mortality rates.

Systemic Anti-Cancer Therapy (SACT) 30-day mortality rates						
Tumour type	Most recent national average	2019-20	2020-21	2021-22	2022-23	2023-24
Bowel	3.6	2.4	3.4	1.1	1.8	1.7
Breast	2.7	1.6	2.0	1.4	1.9	2.5
Gastric cancer	7.9	12	7.7	0.0	9.5	0.0
Lung	10.5	5.7	7.7	6.0	8.8	6.9
Ovarian	8.3	1.2	5.5	2.4	0	3.8
Pancreatic	14.1	3.4	2.4	2.1	5.9	4.0
Prostate	5.4	0	0	1.4	0	0.8
All malignancies	4.44	3.6	3.7	2.8	3.6	2.8
All malignancies- curative	1.52	2.1	1.5	0.2	0.9	1.2
All malignancies- palliative	7.11	4.2	5.2	4.1	5.8	3.7

Areas of focus:
- The service would like to capture and report actual survival data post treatment, treatment response rates/ durability, treatment related morbidity (e.g. hospital admissions). Morbidity data is indirectly available but no informatics resource to codify and process. The lack of integration between charts and the NHS spines makes it challenging to retrieve survival data.

Action plan:
- The Cancer data team providing onward support, particularly around the completeness of data being submitted nationally.
- The Cancer team are also building the ability to identify any potential health inequalities within performance and staging by enabling break down by gender, age, ethnicity and IMD decile.

Bone Marrow Transplant and cellular therapy
Highlights of success:
- The results for the Wessex Blood and Marrow Transplant and Cellular Therapy (WBMTCT) Program from the last EBMT risk-adjusted benchmarking exercise show that our outcomes continue to be excellent for Allografts.
- Southampton has performed extremely well and continues to have the best transplant outcome for allogeneic transplantation in Europe, defined by 1 year mortality and remains better than average for autologous transplantation of 440 transplant centres across UK and Europe
- These important results show the risk-adjusted analysis for our centre for allogeneic transplants and autologous transplants. This includes variables such as age, disease risk and status at transplant and comorbidity etc.
- WBMTCT still has the best outcomes reported to EBMT for allogeneic stem cell transplant of 395 transplant centres in Europe.
- Survival rates for first Autologous transplants are better or in line with averages for 1 to 4 years, with a slight drop off, within the expected range after 4 years. This may be related to complexity and case selection; a review of internal data will take place to understand this.

Areas of focus:
- Concerns over timely admissions for Transplant patients due to BMT ward capacity, which is on the Risk Register. This could adversely affect our current excellent patient outcomes.

Action plan:
- Improvement of ward facilities through a refurbishment and increase number of beds through extension of ward into C5.
- Introduction of Ambulatory Care in January and the start of Auto Transplant at Salisbury Hospital also to help with inpatient capacity issues.

Supportive and palliative care
Highlights of success:
- 82% of referrals seen within 24 hours, with around 8-10 patients per day and average case load of 66 patients at any time.
- Following feedback from families in bereavement, the team trialled proactively visiting all patients on an end-of-life care plan, without referral. They were able to influence the care of patients in 88.2% of cases. Now adopted as routine practice.
- A flagging system on Ecamis and Charts that highlights when a patient is known to the palliative care team is having a positive impact on teams on referring for onward support. This flag also enables the palliative care team to respond proactively, which, amongst other benefits, has resulted in direct discharges from ED.

Areas of focus:

- Keen to collect data against the Integrated Palliative Care Outcome Scale, which would help them to capture results that matter to their patients regarding physical symptoms and psychological challenges for palliative patients.

Action plan:

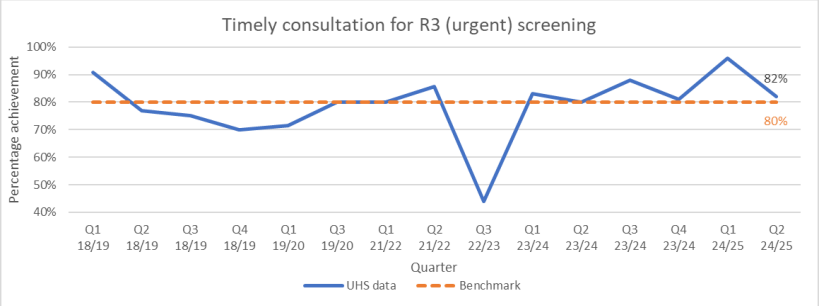
- Comfort observations are being implemented for all patients who are dying, which will be digital and auditable to understand the impact of the palliative care team's interventions.

Ophthalmology

(presented at CAMEO 25.6.25)

Highlights of success:

- Excellent Endophthalmitis rates post- intravitreal injection of 0.06% from a total of 17,713 injections. The national benchmark is 0.07%. This outcome covers all injections given in the eye unit for all diagnoses.
- Endophthalmitis following cataract surgery is well within the expected benchmark. The total number of surgeries was 4,646 and an excellent rate of 0.02% with a national benchmark of 0.14%. UHS had only 1 case of endophthalmitis. UHS surgeons perform surgery on patients with highly complex cataracts.
- Capsular ruptures following cataract surgery is slightly higher than expected, this could be a data error due to the change in audit database. Over 4,646 surgeries were performed with a 2.2% capsular rupture rate. The national benchmark is 2%.



Areas of focus:

- Working with GIRFT to redesign the glaucoma service, with a focus on improving efficiency and patient flow
- Data retrieval for clinical outcomes remains a challenge, as much of the available information is over two years old (from 2023). Implementation of the OpenEyes IT system in 2024 caused data transfer issues with the National Ophthalmology database audit therefore the department has not been able to submit data to participate in 2025. The department has been receiving support to enhance data extraction and reporting.

Emergency Medicine

(presented at CAMEO 12.5.2025)

Emergency department
Highlights of success:

- A diverse range of projects and audits have been undertaken by clinical staff at all levels within the department. Including post-ROSC imaging in non-traumatic cardiac arrest, community acquired pneumonia and the use of Maternal Obstetric Early Warning Score (MEOWS) in the Emergency Department and impact on patient escalation and RCEM care of older people national audit

Areas of focus:

- An increasing number of patients are presenting with more complex clinical needs, requiring longer consultation times and greater involvement from multidisciplinary teams to deliver comprehensive care.

Acute Medical Unit

Highlights of success:

- 100% target on the AMU and Same Day Emergency Care (SDEC) dashboard for timely consultant reviews—within 4 hours—both during and outside of regular hours
- "Medicine direct" Consultant shift pilot: over a two-week period, consultants working this shift are responsible for seeing medical patients directly in ED aiming to accelerate time to first clinical assessment, reduce dependency on ED referral systems, decrease ED congestion and improve flow through AMU. A 15% reduction in admission rate was observed.

Medicine direct consultant shift pilot results

Majors patients (0900-1700)	**Admission Rate**	**Breach Rate**
Pre-Pilot Week	66.0%	66.0%
Pilot Week	51.6%	64.7%

	Avg Time in Department (mins)	**Median Time in Department (mins)**
Pre-Pilot Week	**428.8 minutes**	**390.0 minutes**
Pilot Week	**398.6 minutes**	**362.0 minutes**

Areas of focus:
Timely Early Warning Score (EWS) Recording: A slight improvement has been observed since the last SAMBA audit in 2023; however, substantial progress is still required to reach above-average performance levels. The main challenges relate to ongoing shortages in nursing and healthcare assistant staffing.

HIOWAA

(presented at CAMEO 12.5.2025)
Highlights of success:
- PHEA/intubation success rate with no untreated adverse effects from procedure. The figure of 99.51% overall success is excellent, far superseding the target to be above 95%.

Areas of focus:
- Challenges in data linkage between organisations, currently being addressed in collaboration with ICB.

Medicine

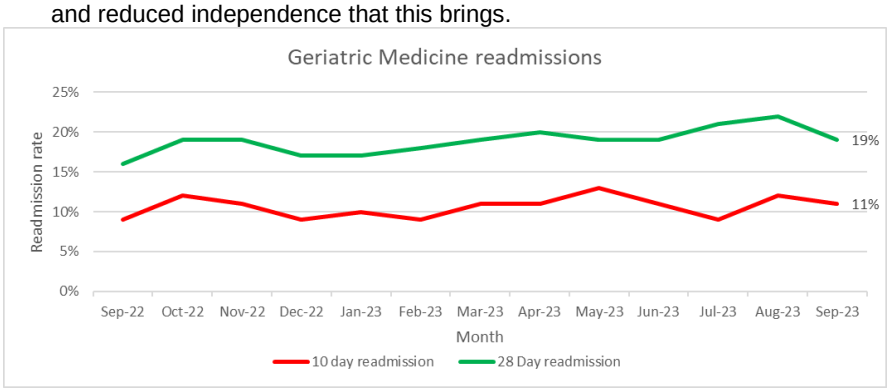
(presented at CAMEO 25/3/2025)

Medicine for older people

Highlights of success:
- Number of HAIs (Health associated infections), mortality rate, complaints and readmissions within 10 days are less than last year.

Metric	2020	2021	2022	2023	2024
Mortality (HSMR)	88.3	91	83.7	98.38	89.42
HAIs	12	38	51	59	55
Readmission within 10 days		6.3	9.7	10.6	10.55%
Readmission within 28 days	9.5	9.9	14.9	18.8	19.66%

Areas of focus:
- Length of stay and readmission metrics remain high. Both these issues reflect increasing pressure within the social care sector, with increasing delays in discharge from the acute hospital. This also drives readmissions when social care arrangements fall down on discharge, often made worse by having had a delayed admission with the inherent deconditioning and reduced independence that this brings.

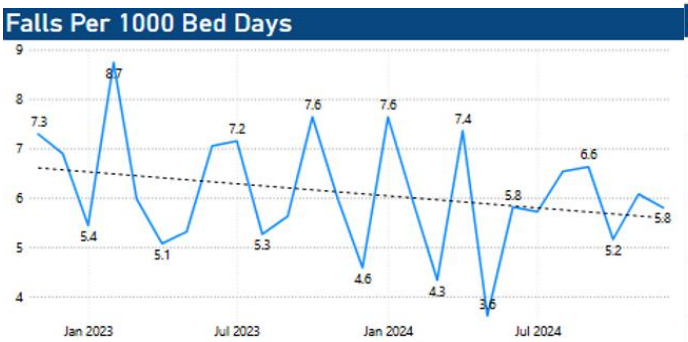


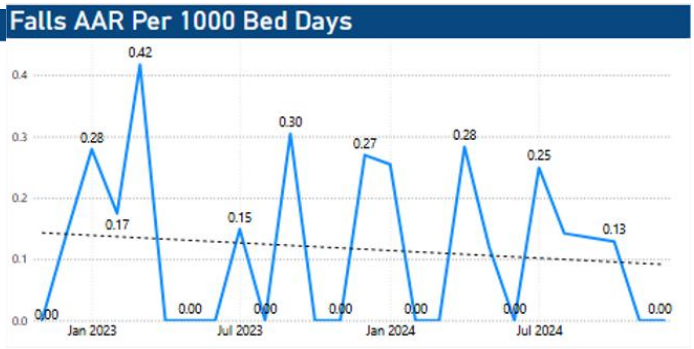
Action plan:
- Monitor data and discuss in appropriate forums.
- Continue to work on improving communication between the members of the MDT.
- LLOS project seeks to address the issues relating to discharge within our direct control.

General internal medicine

Highlights of success:
- The number of Hospital Acquired Infections on D7 and E7 in the GIM Patient Group from 1st January 2024 to 31st December 2024, are low with only 18 infections noted in this 1-year period.

Areas of focus:
- There has been a significant focus on reducing falls (see action plan below). The fall rates are reducing but there is scope for improvement.





Action plan:
Interventions taken to address falls:

- Escalated to falls trust lead. Cases discussed at consultant-led high harm falls meetings and RCA completed in consultation with coroners reports where indicated.
- Audit on osteoporosis for those at falls risk, dedicated study days, senior falls prevention champion for E7 ward.
- Autumn 2024 plans started about having a focus on movement / acute rehab on the ward in conjunction with the therapy and education team.
- Co-horting and “Baywatch” significantly reduces falls.
- Early identification on admissions about who is falls, red slipper socks supplied/alerts on the handovers to easily identify falls risk patients.

Specialist medicine

Dermatology

(presented at CAMEO 18.9.24)
Highlights of success:

- Surgical site infection remains low. Mean of 1.16% from August 2023 – August 2024 which is well below the national average of 2%.
- Direct to surgery: An audit of urgently referred patients listed directly for surgery showed 100% compliance with audit standard. There was high level of patient satisfaction as eliminated need for additional clinic appointment prior. This method has been shared with GPs in the region to encourage inclusion of clear photographs and information in referrals to enable further cases to be performed.

Areas of focus:

- Complete excision rate: from recorded data is close to that of national standard (94.9% compared to 95% for BCCs, 95.8% compared to 97% for SCCs). Although not far off expected levels, this represents a decline in performance from last year, particularly with the BCCs. However, data could have been skewed due to incompleteness. Responses were obtained from 11 clinicians instead of all operators and no data received from the in-sourcing service team. The in-sourcing team are currently under-taking data analysis, and this is awaited. Clear documentation of surgical margins on surgical request forms helps guide operators.
- Waiting times for skin cancer urgent referrals and patch testing: Meeting national targets for urgent skin cancer referrals remains a challenge particularly due to year-on-year increase of referrals. This is not unique to Southampton/Hampshire but is seen nationally resulting in innovations such as tele dermatology and consideration of utilisation of artificial intelligence.

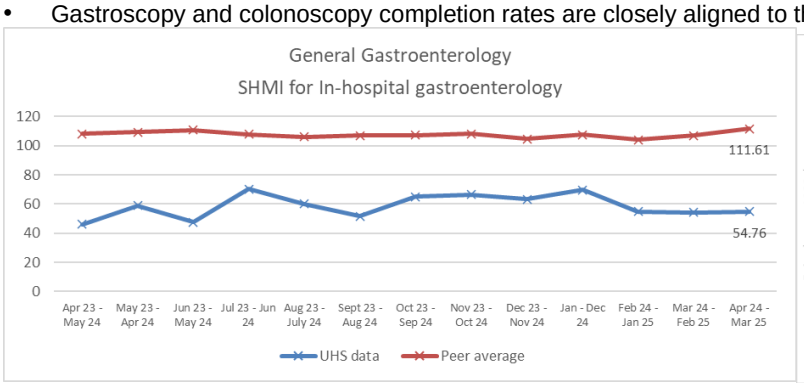
Action plan:

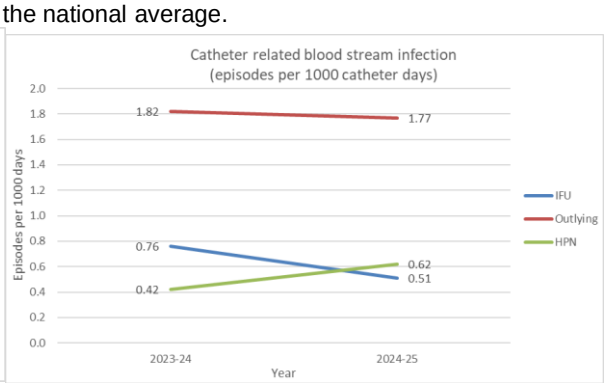
- BCC incomplete excisions: The in-sourcing team are currently under-taking data analysis. Clear documentation of surgical margins on surgical request forms helps guide operators.

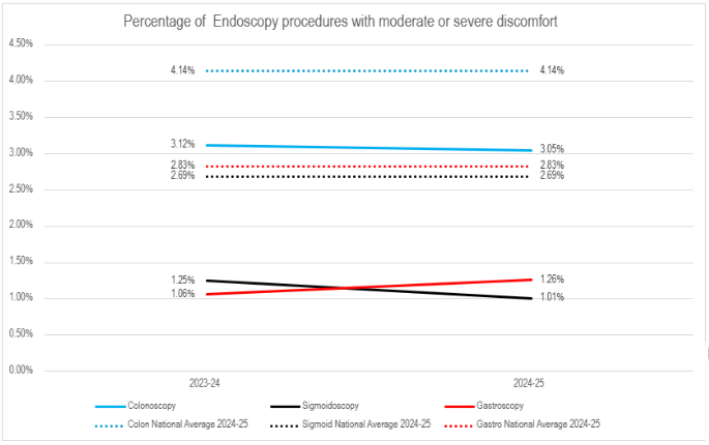
Gastroenterology

(presented at CAMEO 17.9.2025)
Highlights of success:

- Summary hospital-level mortality indicator (SHMI) continues to show well below average mortality.
- Catheter related blood stream infections remain low. Outlying patients (orange line) are acutely unwell or receiving chemotherapy, so a higher rate of infections is expected.
- UHS are below the national average for moderate or severe discomfort patient-reported outcomes for sigmoidoscopy, colonoscopy, gastroscopy.
- Gastroscopy and colonoscopy completion rates are closely aligned to the national average.





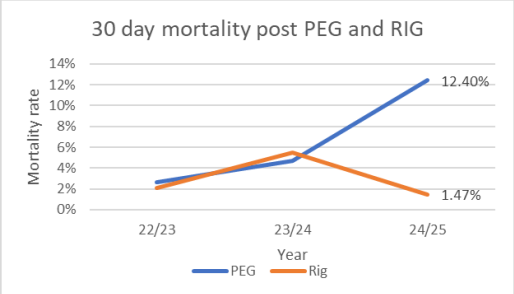


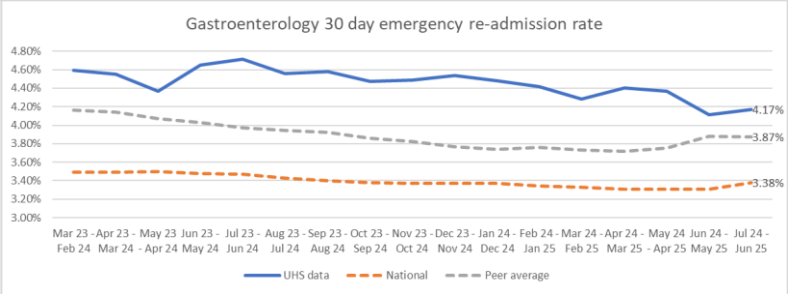
Endoscopy completion rates

Endoscopy procedure	UHS	National average
Gastroscopy completion (to D2)	92.22	>95%
Colonoscopy completion (to caecum)	95.16	>90%

Areas of focus:

- 30-day mortality rates post-PEG insertion has risen to 12% (3 individuals). No obvious concerns and scheduled for review at Morbidity & Mortality meeting. National 30-day post PEG mortality is 5.3%.





Source for all graphs: HED / HES databases

Action plan:

• Follow up M&M meeting outcomes (PEG insertion)

Rheumatology

(presented at CAMEO 17th September 2025)

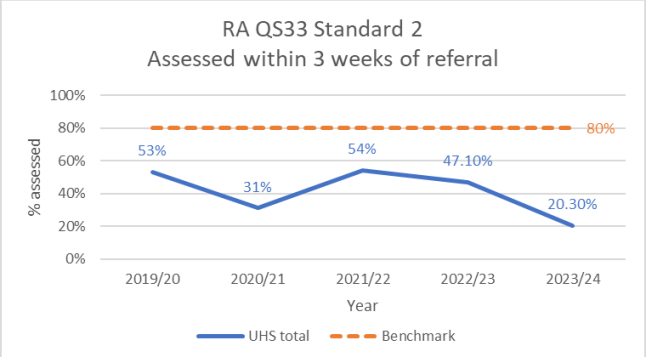
Highlights of success:

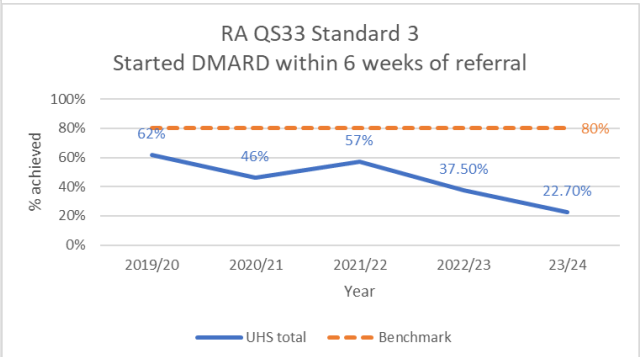
Rheumatoid Arthritis (RA)

- Excellent use of patient-reported outcome measures (PROMs), enabling patients with RA to record disease activity scores at home. This supports remote monitoring, improves access, and helps clinicians track progress.
- All patients with RA started on treatment show improvements in DAS28 scores (validated measure of RA), with most achieving significant improvement within 3 months of initiating a DMARD +/- steroid. DAS28 scores are calculated at initial presentation, and every follow up review.

Areas of focus:

- The National Early inflammatory arthritis audit (NEIA) quality standard RA QS33 Performance covers assessing, diagnosing and managing rheumatoid arthritis in over 16s. UHS has dipped in performance due to waiting lists and clinic capacity for new patients.
- Standard 2. Patients referred by GP seen by rheumatology within 3 weeks. UHS performance is 20% which has dropped from 25.4% last year is well below the national benchmark of 80%.
- Standard 3. Treatment with DMARDs within 6 weeks of referral. UHS has improved their performance from 29.1% last year to 35.3% this year but is still well below the national benchmark of 80%.
- Some patients are being referred inappropriately by GPs without a prior face to face clinical assessment. The management team is aware of this issue and monitoring its impact on clinic efficiency and wait times.





Respiratory

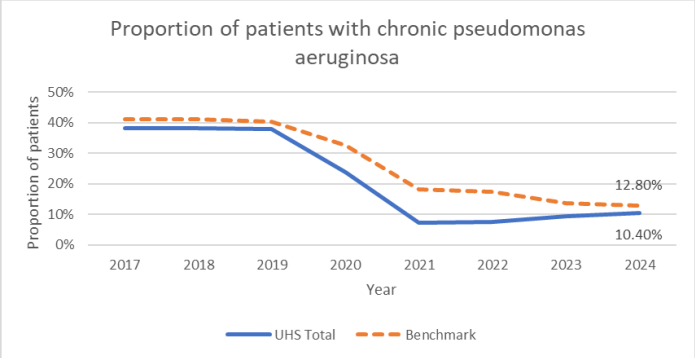
(presented at CAMEO 17.9.2025)

Cystic fibrosis

Highlights of success:

- FEV1s rate (forced expiratory volume in 1 second) of 77.8 is higher than national average of 75.1 and continues to show year-on- year improvement. FEV1 is an indicator of lung function.
- Pseudomonas carriage rate of 10.4 has increased slightly since 2022 but remains below the national average of 12.8.
- We continue to meet the standard of admitting patients to a side room on the CF ward within 24 hours of arrival, ensuring appropriate infection control and patient safety.

Outcome	UHS data	National Benchmark
1.Age adjusted FEV % predicted at annual review	77.8	75.1
2.Age adjusted best FEV % predicted	79.4	78.2
3.Age adjusted BMI among patients aged 16 years and over	24.5	24.5
4.Proportion of patients with chronic pseudomonas aeruginosa	10.4	12.8
5.Proportion of patients receiving DNase treatment	48.3	57.2
6.Proportion of patients on hypertonic saline treatment	21.3	28.1



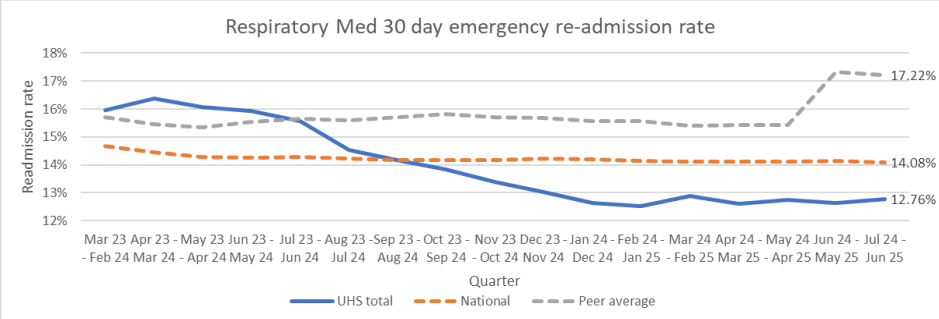
Areas of focus:

- The presence of a dietitian and physiotherapist at clinic review is below recommended levels due to significant staffing shortages, including recruitment challenges, limited maternity backfill, and periods of sick leave. During this time, priority was given to inpatient care, annual reviews, and face-to-face clinic patients. Dietitians and physiotherapists were not routinely present in virtual clinics, the nursing team ensured that any issues raised were passed on to the relevant specialist for follow-up outside the clinic. The MDT agreed that there is limited value in dietitians and physiotherapists covering virtual clinics, and their time and expertise are better directed towards ad hoc reviews, medication trials, and specialist services such as the CF diabetes and CF bone clinics.

General respiratory inpatients

Highlights of success:

- 30-day readmission rates have been brought down below the national average. UHS 12.59% (CF) against a 14.1% national average

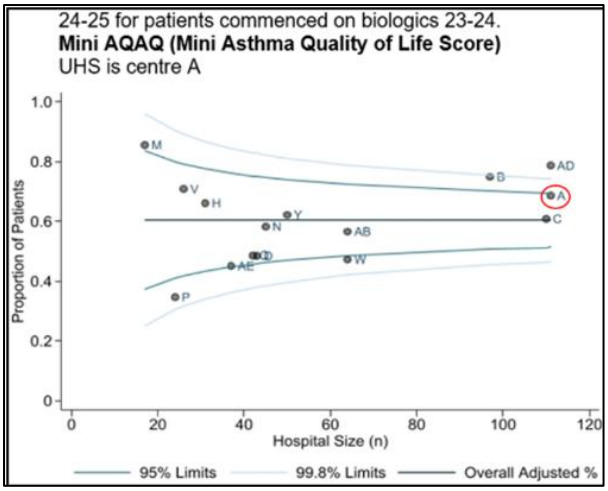


Severe Asthma

(presented at CAMEO 17.9.2025)

Highlights of success:

- The number of patients with no ED attendances or admissions following commencement of biologics has continued to improve and remain above national average. Patients stop corticosteroids once they are commencing biologics avoiding side effects.
- The percentage of patients able to withdraw from oral corticosteroids remains above the national average.
- The percentage of patients with a clinically significant improvement in asthma related quality of life above the national average



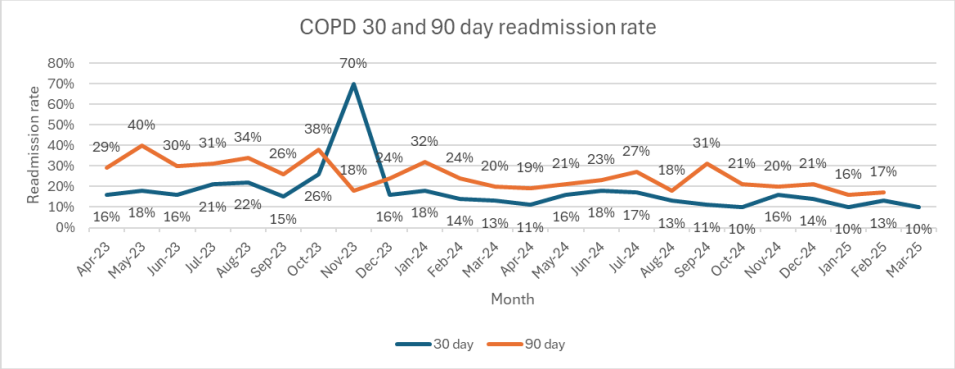
Areas of focus:

- UHS is not achieving the severe asthma 4-week biologic initiation target due to limited staffing capacity. In the absence of increased staffing, we are utilising more home initiation. We are also planning to change from the current two-dose plus home-care model to a one-dose plus home-care model, which should improve timeliness.
- We are unable to deliver on the 'review while inpatient' aspect of NRAP (National respiratory audit programme) due to staffing.

COPD

Highlights of success:

- We continue to remain above the 60% national target for NRAP (National respiratory audit programme) COPD. However, performance in the 'respiratory review within 24 hours' component has declined, which reduces our overall achievement of the target. This shortfall is primarily due to limited staff availability and ongoing under-recruitment within the team.
- COPD readmission rates within 90 days have fallen and readmission rates within 30 days are stable.



Nephrology inpatients

The scope of this report is limited to the inpatient service. Outpatient care is managed separately at QA Hospital

Highlights of success:

- 100% of haemodialysis patients are now dialysed on site now compared to 30% patients before the new ward opened in 2023.
- Nil dialysis-related infections / complications to report evidencing a safe and effective service.
- All AKI Stage 3 cases are reviewed by a specialist (AKI ACP during weekdays, renal consultant at weekends)

Area of focus:

- Patients are under all specialties with varying clinical needs. It is challenging to compare outcomes across different specialties.

Infectious diseases

(presented at CAMEO 25.9.2024)

Action plan:

- Collecting patient outcomes for infectious diseases has proven difficult. The clinical team have searched to find what other sites collect but without any resulting opportunities. The CAMEO panel discussed options including considering what matters most to patients, reviewing the paediatric ID submission and collecting PROMs such as EQ5D.

Medical genetics

(presented at CAMEO 17.9.2025)

Highlights of success:

- The recent Quality Service Review commended the high standard of patient care, robust processes, research output, and active engagement with national bodies.
- UHS is a lead centre for the Rare Disease Collaborative Network. PTEN (Phosphatase and Tensin Homolog) is a tumour suppressor gene located on chromosome 10 that produces an enzyme regulating cell growth and division. A specialist PTEN clinic has now been approved, supporting optimised long-term care for these patients.
- This year genetic testing was offered to 82% of the 156 patients seen (128 patients)

Areas of focus:

- Timely communication of results to patients is dependent on clinic space and clinical staff availability. Clinical Genetics does not have dedicated clinic rooms, and there are specific requirements for children and adults at Princess Anne and the main hospital. Occasionally, the spaces provided are unsuitable for the sensitive discussions required, which negatively impacts patient communication.

Action plan:

- Offering video clinics where appropriate and agreed with patients.
- Redirecting genetic testing to mainstream clinicians, in line with the National Genomic Test Directory criteria
- Involvement of local paediatric teams/community paediatricians in requesting genetic testing prior to the Clinical Genetics appointment

Endocrinology

(presented at CAMEO 21.5.2025)

Highlights of success:

- Excellent Post pituitary surgery readmission rates (0.01%) compared to national benchmark (0.04%)
- All patients undergoing adrenalectomy and pituitary surgery are discussed in a multidisciplinary team (MDT) meeting both pre- and post-operatively. Each patient receives a comprehensive endocrine work-up, along with clearly defined perioperative and postoperative management plans.
- High cure rates for adrenocorticotropic (ACTH) driven Cushing's patients 82% (between 2016-2024)

Division C

Pathology

(Presented at CAMEO 23.10.24)

Highlights of success:

- Significant investment in Digital Pathology from Pathlake, NSHE and Wessex Cancer Alliance Fund for procurement, equipment installation and calibration. Also, investment from NHSE/digital diagnostic capability fund for service changes including Digital reporting, off-site reporting, Digital Outsourcing and AI technology development

Areas of focus:

- Our overall departmental turnaround times continue to be a challenge. The impact is mostly felt within specialities where there is significant additional elective work (WLIs), where resource for pathologist capacity has not been matched with clinical capacity. There is a lack of prospective recruitment to pathology to meet influxes of clinical work.

Action plan:

- Challenges have been escalated at care group level, including fortnightly governance meetings and placed on the risk register.
- 4 business cases for substantive posts approved/in progress and Laboratory workforce redesign.
- Improving agility of expanding reporting capacity

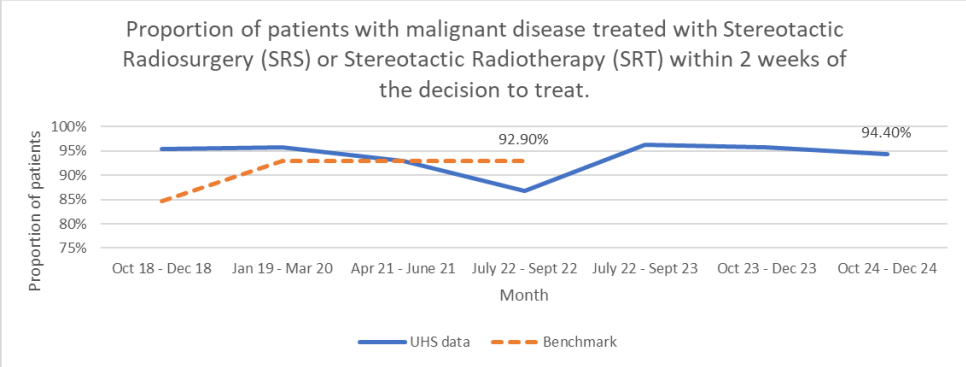
Support services

(presented at CAMEO 11.3.2025)

Medical Physics

Highlights of success:

- Contract for treating Stereotactic radiosurgery cases has been re-awarded. UHS is one of few sites performing this treatment.
- Over the past year the treatment sites have been expanded using SABR (Stereotactic ablative body radiotherapy) technique involving external assessment from the RTTQA (Radiotherapy Trials Quality Assurance) Group and external auditing of techniques. Lung SABR has been expanded to treating spine, liver, adrenals, prostate, and bone cases.
- Improved waiting times because of new surface guided radiotherapy technology



Areas of focus:

- NHS England funding for AI contouring solution was withdrawn. This technology was used to auto generate contours for each treatment CT, therefore reducing treatment planning time.
- Complicated re-irradiation cases where treatment has been successful in a patient's primary cancer and then patients are returning for complex secondary cancer treatments is causing an increase in the number of assessments of treatment plans using offline adaptive radiotherapy, which is a time intensive process.

Action plan:

- Planning to design an app for patients to upload/report their symptoms.
- Identify reportable clinical outcomes. The process measures are reported to other forums.
- Current treatment planning system (TPS) is finishing after next year after a period of no upgrades. A successful business case has authorised a new TPS incorporating newer technology/ faster calculation times for treatments and improved plan evaluation methods.

Dietetics

Highlights of success:

- All nutritional targets are being met for patients with eating disorders. Outcomes are measured at discharge from acute admission.

Outcome measure	2023	2024
Promote improvement of nutritional status as per dietetic goal met aim to gain weight or remain stable	81%	79%
Improve nutritional intake: Increased nutritional oral intake at discharge		83%
Reduce use of NGT feeding (All patients): NGT avoided	54%	63%
Reduce use of NGT in Eating Disorder patients (Excluding disordered eating): NGT avoided	68%	67%
Reduce use of NGT in Disordered Eating patients (Excluding ED patients): NGT avoided	0%	61%
Reduce abnormal biochemistry Micro-nutrients: Nutritional deficiencies investigated and treated		75%
Refeeding biochemistry: refeeding bloods checked appropriately and treated (if needed)		100%
Refeeding vitamins and minerals: multivitamin and mineral and thiamine started on admission or during admission		91%

Areas of focus:

- Improvements could be made by checking nutrition bloods during admission/ ensuring refeeding guidelines are adhered to with a multi-vitamin and starting Thiamine on admission.
- A clear pathway to be embedded into ED department for patients admitted with eating disorders.

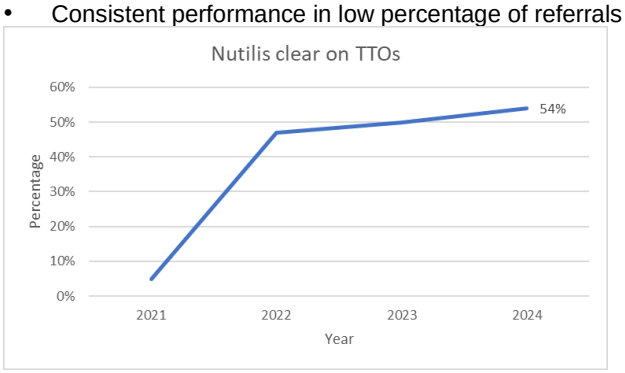
Action plan:

- Develop and embed digital data collection tools relevant to all our specialities and services.
- Develop PROMS relating to weight target (inpatients/outpatients)

Speech and language therapy (SLT)

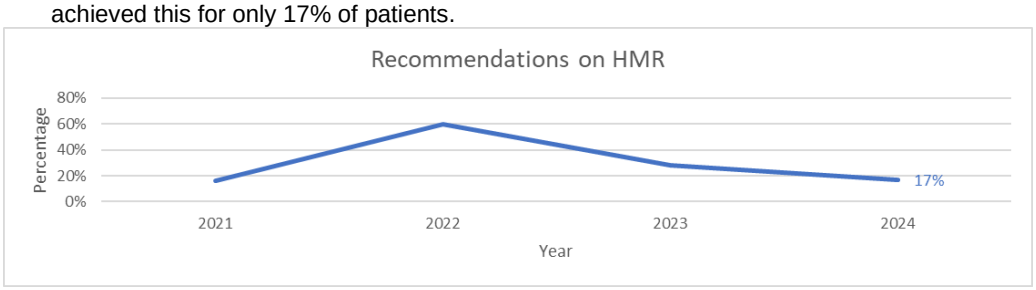
Highlights of success:

- Improvement in the percentage of patients who require thickened fluids have Nutilis Clear Thickening Powder included on their TTOs, (standard is 100%).
- Consistent performance in low percentage of referrals breaching.



Areas of focus and action plan:

- Voice service waiting and response times are an area of challenge. The team are reworking operational processes to improve waiting times, patient experience and clinical outcomes by reviewing patient reminders/ “did not attend” reduction.
- Response times to stroke referrals on a weekend due to lack of SLT 7-day provision at present. (Business case is in progress to address this)
- The standard for patients who require thickened fluids to have the correct recommendation on their HMR is 100%. In 2024 we achieved this for only 17% of patients.



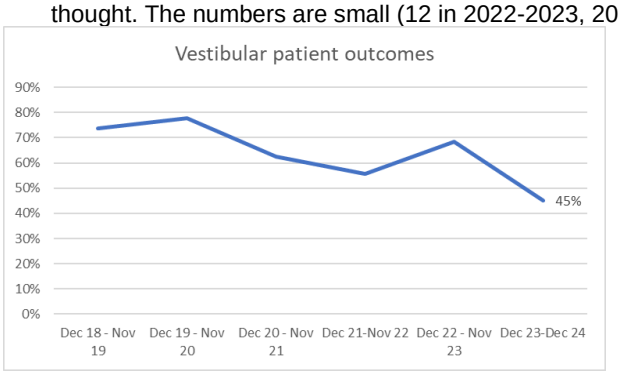
Audiology

Highlights of success:

- The service is meeting achievable Speech Intelligibility Index (SII) scores for children fitted with hearing aids indicating that the hearing aids are being set up correctly and the children are gaining good access to speech when using the devices which is essential for speech and language development.
- All patients who have completed both initial and follow-up TFI questionnaires have reported benefit from the tinnitus therapy provided by the service.
- Parents’ evaluation of aural/oral performance in children (PEACH) scores indicate that 90% of parents report improved function following hearing aid fitting.

Areas of focus:

- There appears to be a downward trend in Vestibular rehabilitation benefit questionnaire outcome (VRBQ) scores, indicating that patients receiving vestibular rehabilitation who return for follow-up may not be gaining as much benefit as was previously thought. The numbers are small (12 in 2022-2023, 20 in 2023-2024)



Action plan:

- VRBQ has recently been reviewed and will be shared at the next vestibular team meeting. The service is considering whether it highlights a training need within the department.

Therapies

(Presented at CAMEO 19.3.2025)

Highlights of success:

- Pre-service therapy readmission rate at 30 days from discharge is 22%. Therapy re-admission rate due to a therapy-related problem e.g. falls is 8.5%.
- The NHS Long Term Plan target for therapy assessment is 840 minutes (14 hours) from presentation. The UHS response time from patient arrival at ED to therapy assessment averaged at 210 minutes (3.5 hours) during the new service from April 2022 to end of August 2022

	2023	2024
Patient Contacts	7288	6786
Patient Contacts in ED	1118	1272
No. Patients seen in AMU & ED by therapy	5254	6078
Number of pts discharged by therapy	2657 (53%)	2557 (42%)

Areas of focus:

- It has been challenging for therapies to collect and analyse data due to lack of resource.
- There are estate challenges. Therapies cannot assess patients in corridors due to privacy and dignity and lack a designated assessment space.

Action plan:

- The team are exploring opportunities with primary care for admission avoidance.
- "Proportionate care project" focusses on upskilling staff and earlier identification of patients who would benefit from therapy.
- "RESTORE" pilot (rehab, step down, therapy outreach"). There is no current provision of an ICU recovery service at UHS which is non-compliant with NICE guidelines and makes UHS an outlier nationally. The pilot aims to improve patient outcomes after ICU admission, raise awareness of Post Intensive Care Syndrome (PICS) for patients, family, and staff. This aims to reduce length of stay and increase patient function.

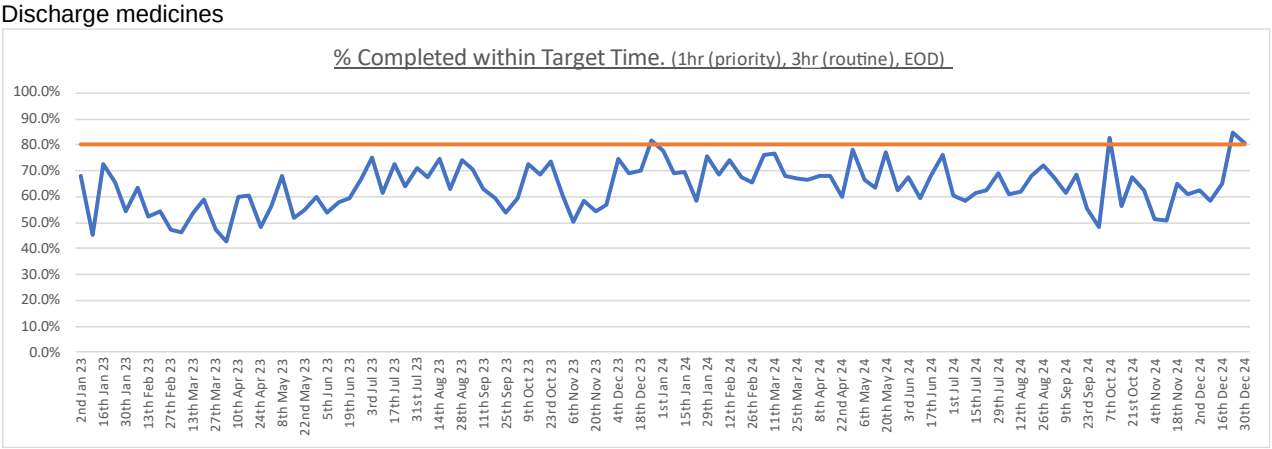
Pharmacy

(presented at CAMEO 19.3.2025)

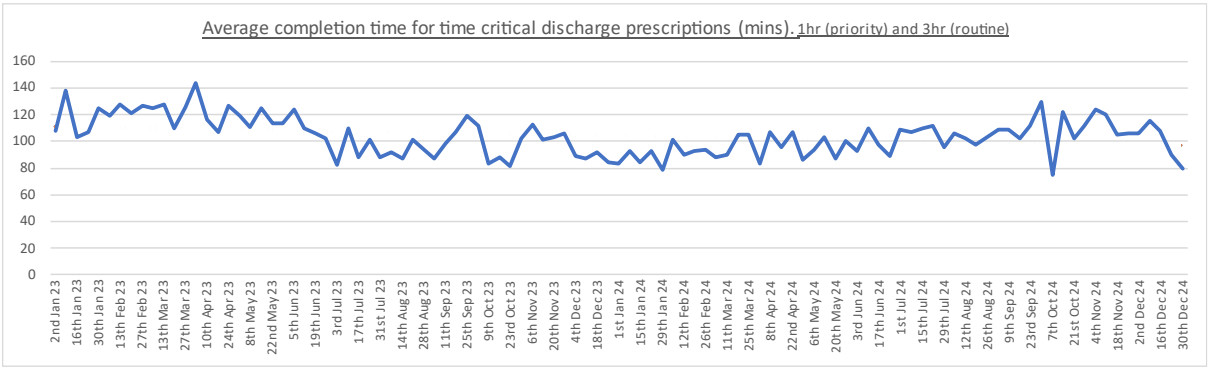
Highlights of success:

- Patients report a high level of satisfaction with the medicine helpline.
- UHS achieves a referral rate to community pharmacy that exceeds the national benchmark.
- Pharmacy is consistently achieving a high percentage of discharge medicines dispensed within target timeframes.

Discharge medicines



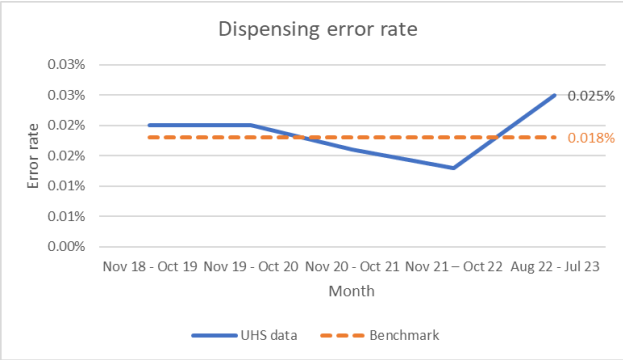
- **Benchmark**
- **UHS Data**

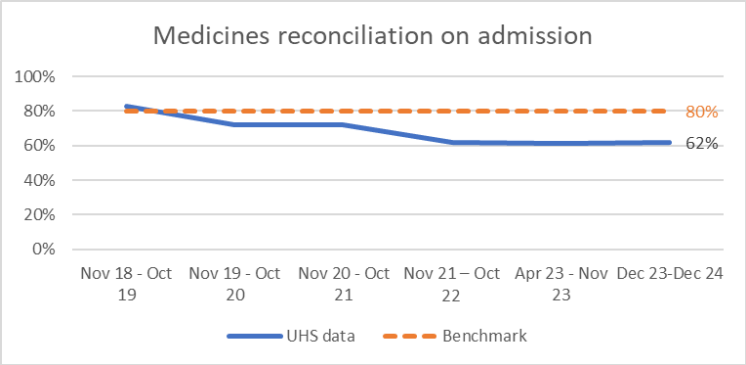


- **Benchmark**
- **UHS Data**

Areas of focus:

- Dispensing error rates: This has increased and is now above the national benchmark. However, this does represent an accuracy rate of 99.975% was achieved from a total annual workload of 526,015 items.





Action plans:

- Dispensing error rates have been escalated to QGSG and divisional meetings.

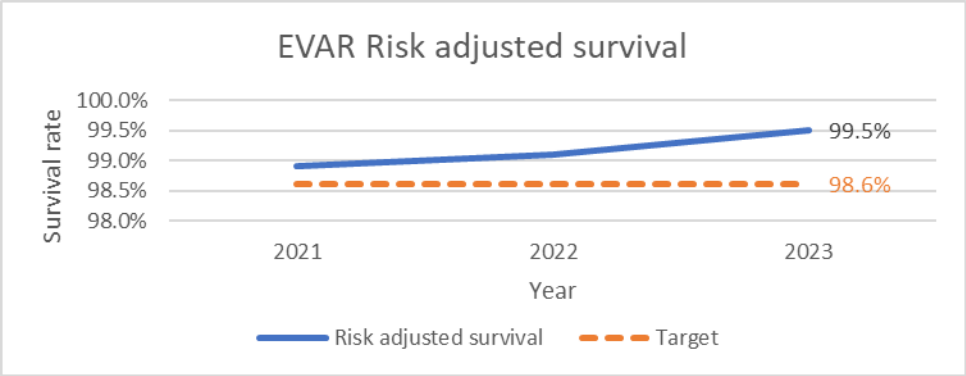
Radiology

(Presented at CAMEO 19.3.2025)

Highlights of success:

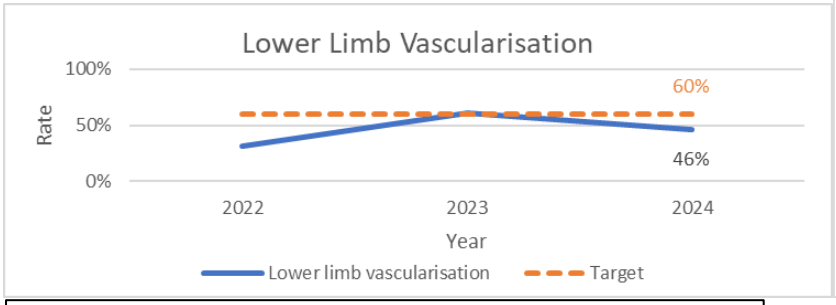
- Performance has remained consistent since January 2023. Prior to this, the average wait for suspected cancer imaging was around 7.5 days, but is now 5 days.
- Improvement in ultrasound performance. 41% of patients are seen within 7 days with a reduction of waiting time from 13.5 days to 12.9 days)
- Interventional radiology is achieving above the national benchmarks for all measures except percutaneous liver biopsy mortality which is 6.5% at 30-days. National benchmark is 3%. Many indications were for metastatic liver cancer. Given the lack of re-intervention, mortality is likely to reflect the baseline population with poor prognosis rather than a direct complication of the biopsy.
- Radiology services have reacted effectively to acute changes in demand and been able to shift focus on where to prioritise capacity. This has helped support trust flow and balance inpatient and outpatient demand.

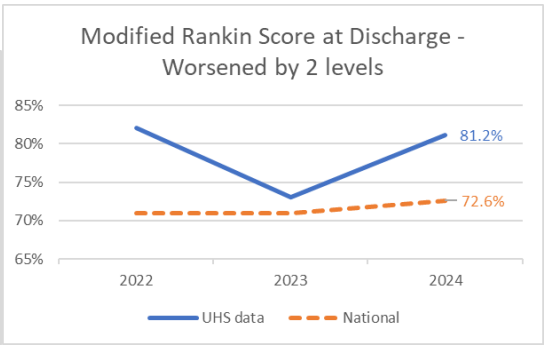
EVAR (endovascular aneurysm repair) outcomes

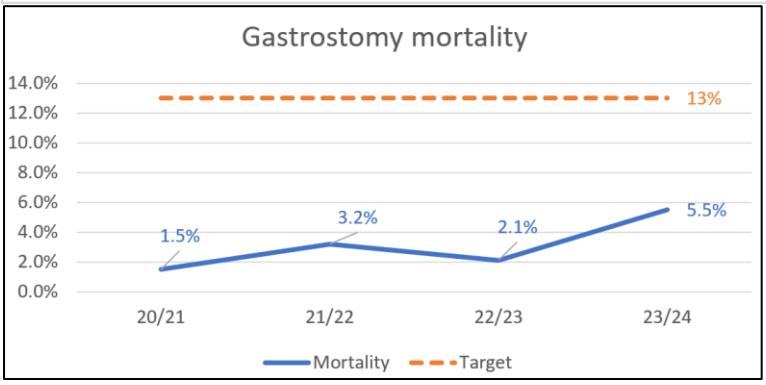


Areas of focus:

- Diagnostic turnaround times have shown declines in many areas due to the shortage of radiologists and complicated by an increasing scanning workload.
- The department is actively trying to recruit in areas of severe shortages e.g. paeds, neuroradiology, head and neck and need the support of the trust to tackle recruitment.
- CQUIN for critical limb revascularisation. The standard is patients treated within 5 days of admission with critical limb ischaemia.
- Mechanical thrombectomy patients' Modified Rankin Scale (mRS) worsened function by 2 levels at discharge is worse than the national average. The scale is a measure of functional disability used in stroke patients and can be used to predict long-term outcomes. This may be because of patient cohort acceptance rates. 72% of patients are transferred in from other centres compared to 60% nationally which is associated with the delay to treatment. UHS accepts older patients with borderline function therefore affecting outcomes. Procedural complications are better than the national average
- Gastrostomy mortality has increased compared to previous years but aligns with percutaneous endoscopic gastrostomy (PEG) and is below the national target, likely due to accepting a frailer population.







Action plans:

- Diagnostic areas are being actively managed and have expanded their outsourcing capacity which has AI augmented workflows to improve turnaround.
- Sonographers are being upskilled to assist with head and neck ultrasound gaps and improving cardiac MR workforce issues by increasing capacity with new scanners and optimising patient lists.

Women and Newborn

(presented at CAMEO on 21.5.2025)

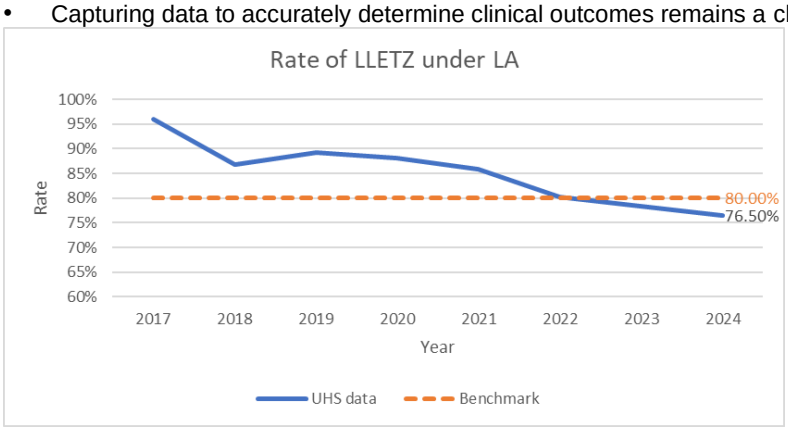
Gynaecology

Highlights of success:

- Readmission rates following total laparoscopic hysterectomy have decreased from 7.2% to 4.2% (no benchmark is available), the current reattendance rate is 1.7%.
- Low Gynaeoncology complication rates are being maintained11% in 24/25 cf 14% in 23/24 despite increasing case complexity

Areas of focus:

- LLETZ (Large Loop Excision of the Transformation Zone) rates under local anaesthetic are declining, due to changing patient demographics. A growing number of postmenopausal women > 60 years are presenting with abnormal cervical smear results. Anatomical changes can make the procedure more challenging and painful under local anaesthetic resulting in a preference for general anaesthetic.
- Capturing data to accurately determine clinical outcomes remains a challenge.



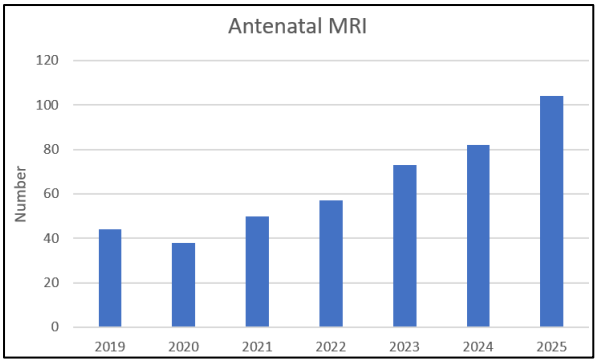
Fetal Medicine

Highlights of success:

- UHS remains one of the few centres in the region offering excellent multidisciplinary team (MDT) counselling and comprehensive discussions with families facing complex fetal diagnoses offering all invasive fetal procedures for the Wessex region.

Areas of focus:

- The service is facing increased demand on services, particularly fetal MRI which provided additional diagnostic information in 387 (49%) of 783 cases, changed prognostic information in at least 157 (20%), and led to changes in clinical management in more than one in three cases. There is a lack of appropriately trained radiologists.



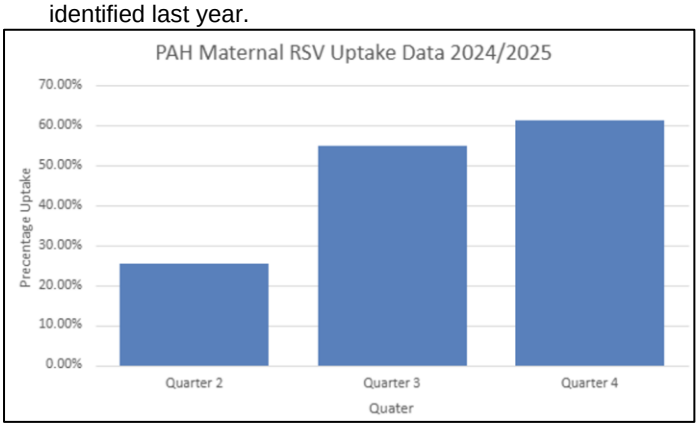
Action plan:

- There is evidence of need for a dedicated “rainbow” clinic to support women who have experienced a stillbirth or neonatal death (1 in 250). These women require continuity of care and careful antenatal management in subsequent pregnancies to optimise outcomes and reduce anxiety. Establishing a specialist clinic would provide a safe and supportive environment, offering tailored monitoring and counselling.

Maternity/Obstetrics

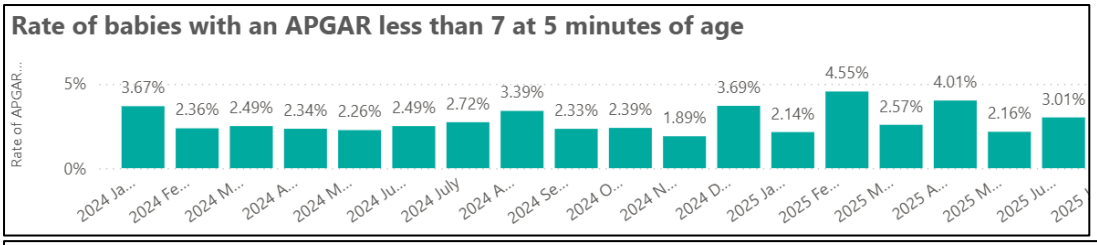
Highlights of success:

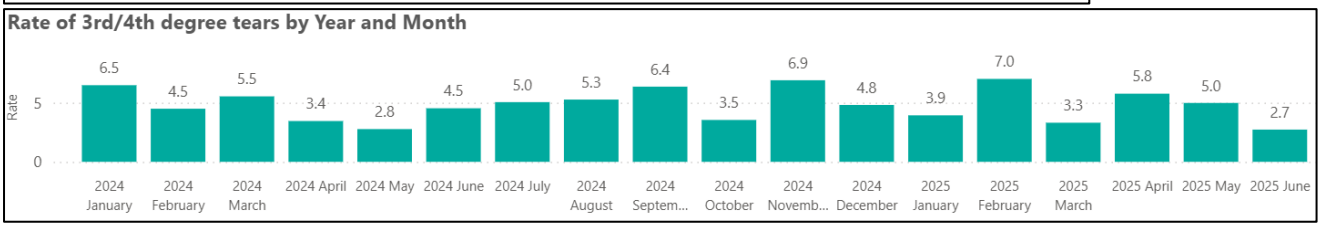
- Maternal death rates remain low. In 2024, there was one maternal death, which required the involvement of neurological care services. A full review found no concerns regarding the standard of care provided.
- Stillbirth rates are around the national average, despite being a Level 3 neonatal unit and a tertiary centre with specialist fetal medicine service. There was a small local increase in March 2025 of 12 cases of which 42% were transfers in for fetal medicine from around the region. All cases were reviewed, and no concerns were raised.
- High RSV (respiratory syncytial virus) and pertussis vaccination rates achieved in pregnant women through workforce restructuring and flexible working patterns, improving service delivery and accessibility.
- Breastfeeding initiation rates have shown year-on-year improvement, with 75.5% of babies receiving breast milk at the point of discharge to community care.
- Smoking at Time of Delivery (SATOD) rate decreased from 8.18% in 2023 to 6.35% by the end of 2024. Quarter 3 data for 2024/2025 shows a further reduction to 6.06%, aligning closely with the national ambition of achieving a SATOD rate below 6%.
- Significant improvement in early antenatal booking and haemoglobinopathy screening, addressing a key area of concern identified last year.



Areas of focus:

- Sustained outlier in the number of term, singleton, liveborn babies with an Apgar score <7 at 5 minutes. Quarter 4 2024/25 data shows a continued upward trend, with a rate of 2.83%, significantly exceeding the national and local benchmark of 1.1%. Analysis indicates that approximately one third of these cases are associated with the use of maternal general anaesthetic, some of which are administered at maternal request. All unplanned NICU admissions were reviewed. No trends or care concerns were identified.
- The rate of massive post-partum haemorrhage (PPH ≥1500ml) observed in 2023 and 2024 were consistent at 3.45% and 3.80% which consistently exceeds the local target of ≤2.9%. 2025 data suggests that efforts to reduce PPH occurrences are making gradual progress, though require further improvement.
- National Maternity and Perinatal Audit (NMPA) - third- and fourth-degree tear rate Obstetric Anal Sphincter Injury (OASI) report is due for publication in June 2025. The Trust’s rate of third- and fourth-degree perineal tears (OASI) has remained in the red category on the local maternity dashboard for a sustained period. This has been escalated.
- Demand for caesarean section (CS) planned CS procedures continues to exceed UHS safe delivery capacity. In Quarter 4, 189 elective procedures were scheduled—surpassing the threshold of 157 per quarter. This over-utilisation reflects increasing clinical complexity, greater patient choice, and transfers from neighbouring trusts. Additionally, 21 elective CS slots were blocked due to complex cases, underscoring the sustained need for specialist surgical maternity input.
- The Induction of Labour (IOL) rate for Quarter 4 of 2024/25 was 35.17%, an increase from previous quarters and above the locally defined threshold of 33%. This upward trend mirrors the national pattern and aligns with updated NHS England guidance and the Saving Babies’ Lives Care Bundle, which advocate for timely interventions to reduce perinatal risk, personalise care, and support maternal choice.





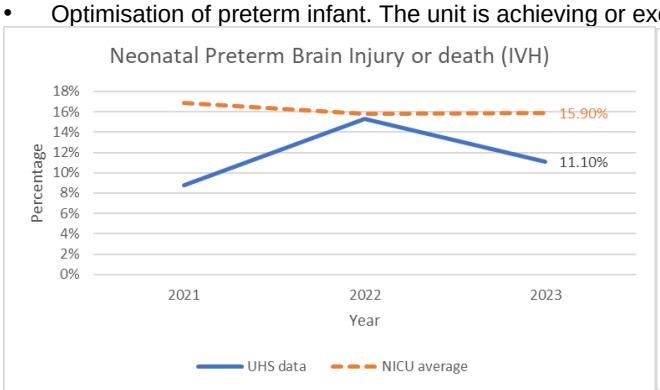
Action Plans:

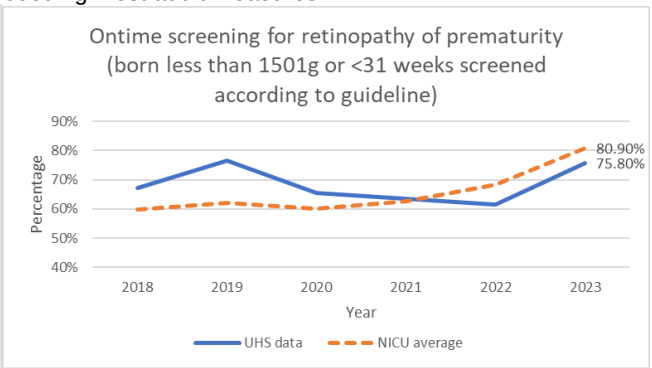
- To address persistently elevated rates of severe postpartum haemorrhage (PPH), a comprehensive review of clinical practice and associated risk factors has been completed. Plans are in place to implement targeted interventions to strengthen the identification and management of high-risk pregnancies. In addition, focused education and training will be delivered to enhance early recognition and timely response to PPH, with an emphasis on multi-disciplinary collaboration and the optimisation of care pathways.

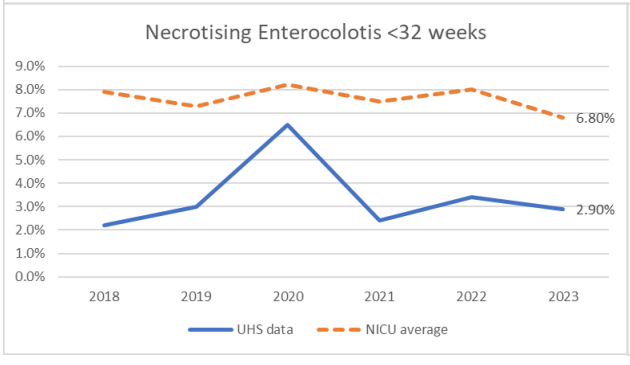
Neonatal

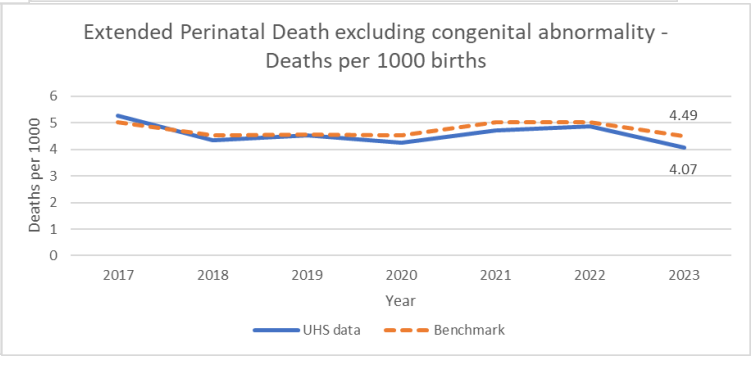
Highlights of success:

- UHS Neonatal Services report on all the key national and international benchmarking data:
- National Neonatal Audit Programme (NNAP). Consistently performing well in necrotising enterocolitis (NEC), consultation with parents and brain injury, improving numbers of delayed cord clamping (DCC) and retinopathy of prematurity (ROP)
- VON (<22 to <29+6 weeks, =>401 to <1500g) – consistently performing well in patent ductus arteriosus (PDA) surgery, NEC, and NEC surgery. Overall stable mortality and morbidity
- Transitional care shows a reduction in the use of antibiotics, increased used of NG feeding and improved staffing levels.
- Lower than average mortality rates (including and excluding congenital anomalies)
- Proportion of transfers for investigation of bilious vomiting for babies is following BAPM framework has reduced.
- Optimisation of preterm infant. The unit is achieving or exceeding most audit measures.



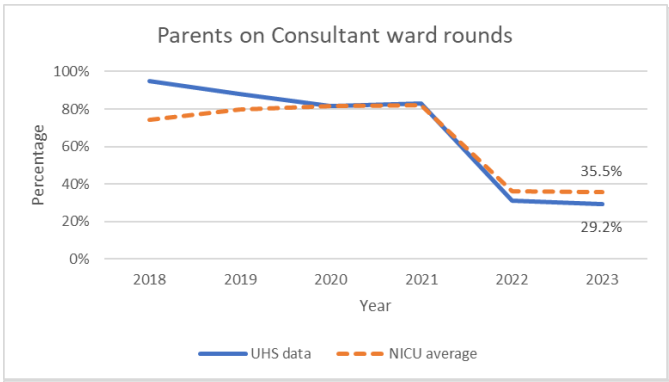


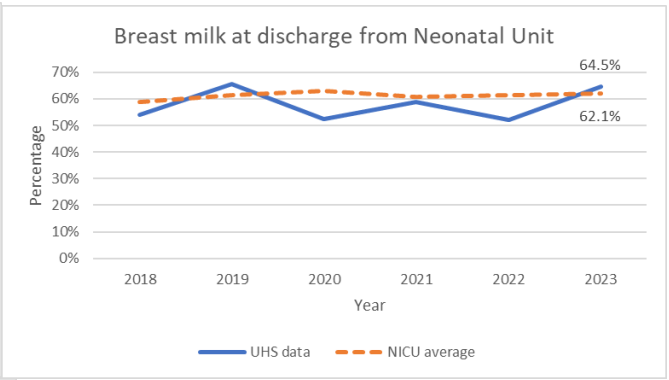


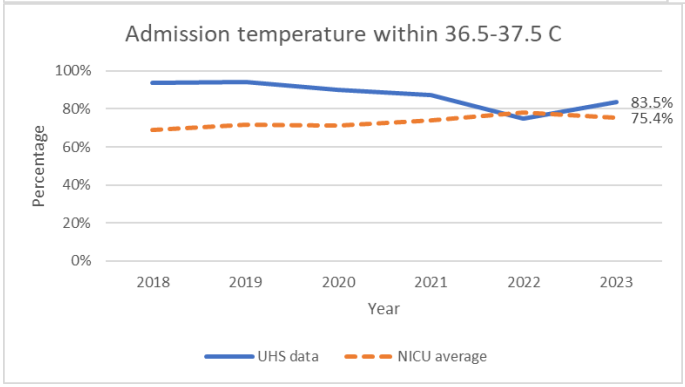


Areas of focus:

- Parental presence on consultant ward rounds continues to drop. There is Consultant presence on the unit 0830 – 2300 7 days a week.
- Further education and support are planned to improve the breastmilk at discharge from neonatal care metrics.
- Thermal Regulation on Admission Temperature is reported in real-time. 2023 compliance rate exceeded the national standard, performance declined in 2024, with unverified data showing an end-of-year compliance rate of 64.2%. This decrease should be considered in the context of a higher average gestational age within this year's cohort, which may have influenced thermal regulation outcomes. Targeted QI and focus during mid to late 2024 has resulted in 80.5% compliance (unvalidated) so far in 2025.



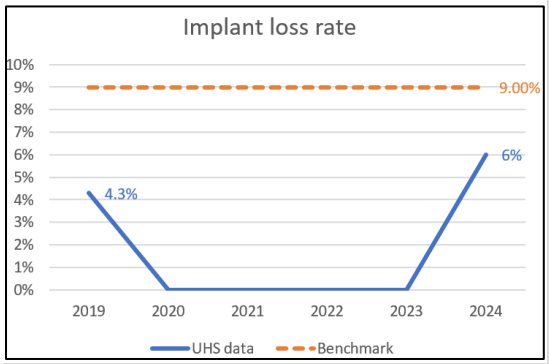


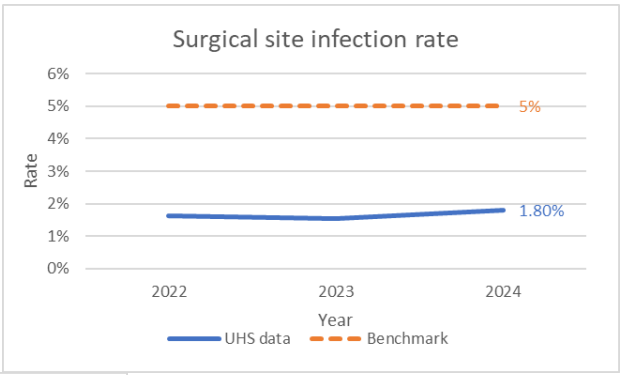


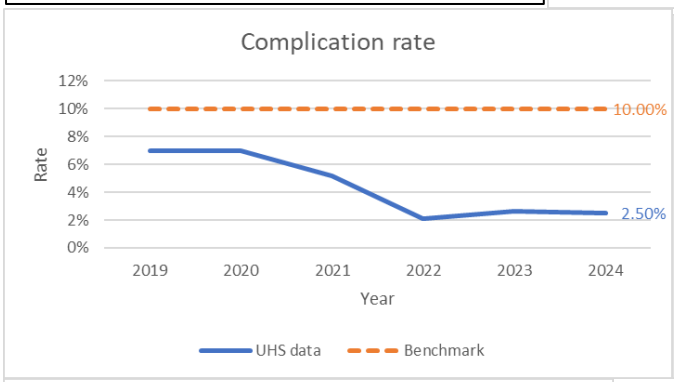
Breast services

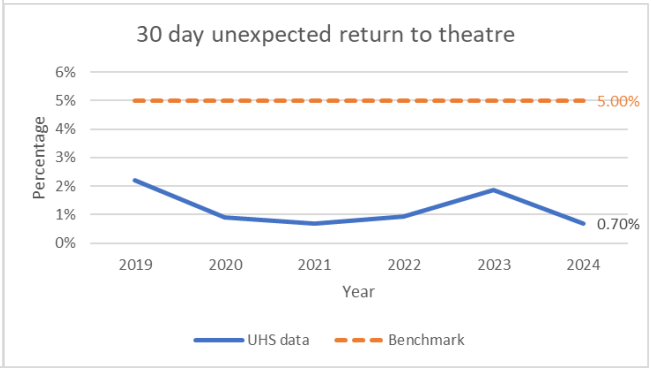
Highlights of success

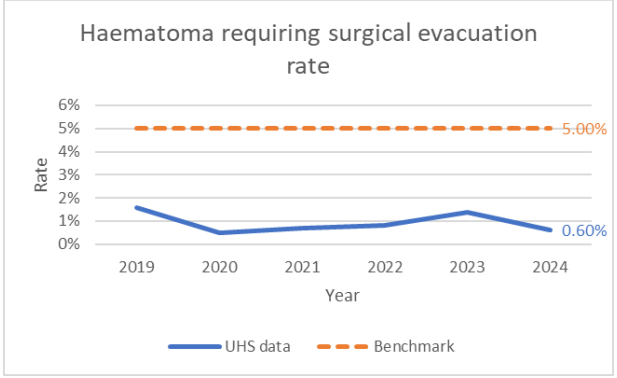
- Despite pressures on the department and increasing cancer numbers, the specialty is performing within all national targets regarding surgical outcomes, with haematoma evacuation, complication rate, implant loss rate, and surgical site infection rate well within benchmarks and accepted national standards.











Areas of focus:

- The immediate autologous reconstruction rate was 8%, which is notably lower than the GIRFT recommended rate of 25%. This is primarily due to the absence of onsite plastic surgery services. We are working with other organisations across the region on the pathway for this service.
- Histopathology reporting frequently exceeds two weeks, with HER2 results taking longer due to a lack of in-house service. This delay has a direct negative impact on the ability to meet the 62-day cancer treatment target. It is recognised that current staffing and resource levels are significantly below what is required to meet demand.

Child Health

(presented at CAMEO 28.1.2025)

Bursledon House

Highlights of success:

- GAS (goal attainment scaling) is set for each patient by the patient and MDT during inpatient stay and are assessed on admission and discharge. There is a significant positive difference seen in patients' ratings of their goals between admission and discharge, in the last year all patients have met or exceeded their goals.

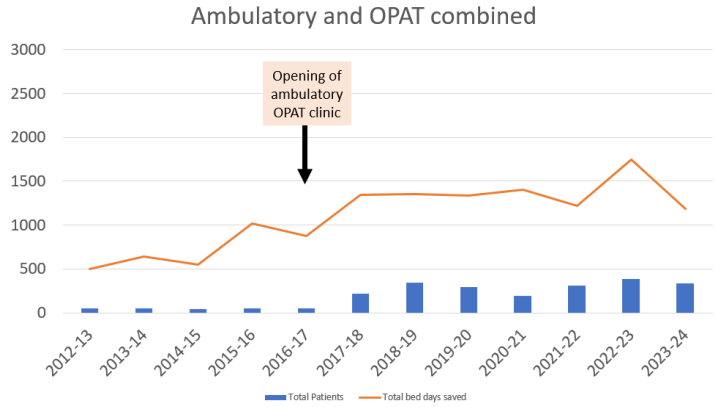
GAS outcome	2023/ 2024	2024/ 2025
Less than expected outcome (-1) and baselines function	1%	0%
Expected level of outcome (0)	36%	57%
More than expected level of outcome (+1)	49%	38%
Much more than expected level of outcome (+2)	14%	5%

Paediatric infectious diseases

Highlights of success:

- The ambulatory OPAT (outpatient parenteral antimicrobial therapy) clinic shows continued savings on bed days since its introduction. The recent decline on the graph is likely due to improved antimicrobial stewardship.

Bed Days Saved



Areas of focus

- Development of antimicrobial stewardship
- A challenging amount of clinical time is spent managing patients with nosocomial infections with increasingly resistant bugs.

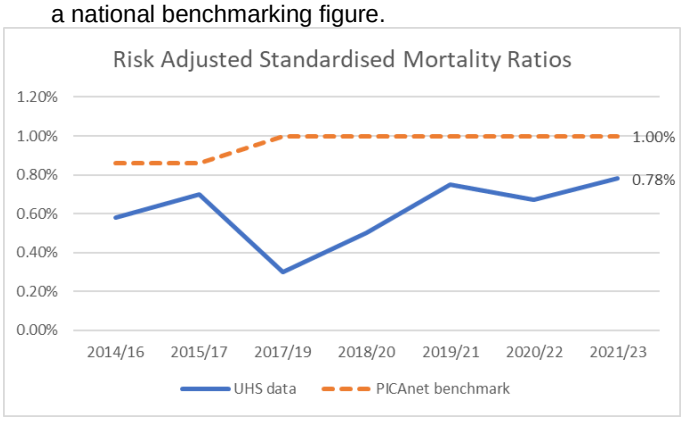
Action plan

- PICU and NICU are collaborating to analyse the data on nosocomial infections and develop an action plan.

PICU

Highlights of success:

- Performing better than the national benchmark for risk adjusted standardised mortality ratios and unplanned ventilator days.
- Expanded collection & reporting of healthcare associated infection (HCAI), with national reporting of CLABSI (Central line-associated bloodstream infection) & CAUTI (Catheter-associated urinary tract infection) to PICANET which should in time, give a national benchmarking figure.



Areas of focus

- The proportion of emergency readmissions to PICU within 48 hours of a previous discharge / transfer from PICU are higher than the national benchmark.
- It is recognised that a number of readmissions come from E1/E1 High Care. Patients with congenital heart disease have fragile physiology and a greater risk of deterioration. Work is ongoing to support education around recognition of the deteriorating child/ escalation pathways, with early escalation to Outreach/PICU for review.

Action plan:

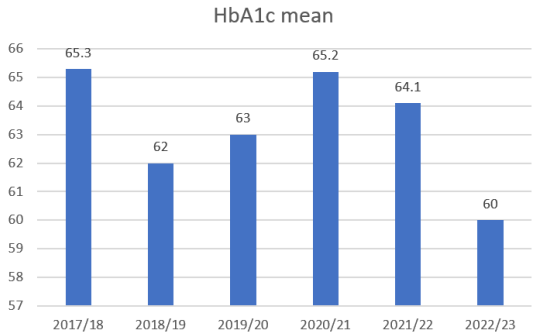
- The SORT team are working on improving departure time from base following the decision that a critical care transport is required.

Paediatric Diabetes

(presented at CAMEO 11.2.2025)

Highlights of success:

- HbA1c (blood glucose levels) mean score in the patient population has reduced due to the adoption of new technology.



Areas of focus:

- 63% of patients are using hybrid closed loop insulin pumps. The team have been limited in the number of insulin pumps they have been allowed to start due to funding/discussions.
- Schools require education on diabetes and need to allow students to keep their mobile phones with them for monitoring purposes. Within this area schools are aware. This is a Nationally recognised issue.

Paediatric Respiratory Medicine: Asthma

Highlights of success:

- National asthma audit shows significant improvements in most KPIs for management of children presenting with acute asthma this year. UHS is no longer in the lower quartile for any of the KPIs.
- Nearly double the percentage of children are receiving steroids in the first hour of their presentations.
- Four times as many smoking parents were given smoking cessation advice.

KPI	April 2022- March 2023		April 2023- March 2024	
	National benchmark	UHS	National benchmark	UHS
KPI 1: Steroids administered within 1 hour of arrival %	40%	28.7%	41.7%	49.5%
KPI 2: Current smokers (patients 11+) dependency addressed %	68.7%	50%	46.4%	50%
KPI 3: Current smokers (Parent/carer) dependency addressed %	35.7%	7.1%	46.1%	29.4%
KPI 4: Inhaler technique checked as part of discharge planning %	62.5%	42.7%	63.8%	45.7%
KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %	47.3%	34.3%	50%	50.6%

Areas of focus:

- The department aims to increase the proportion of asthma patients having their wheeze pro-forma completed.

Action plan:

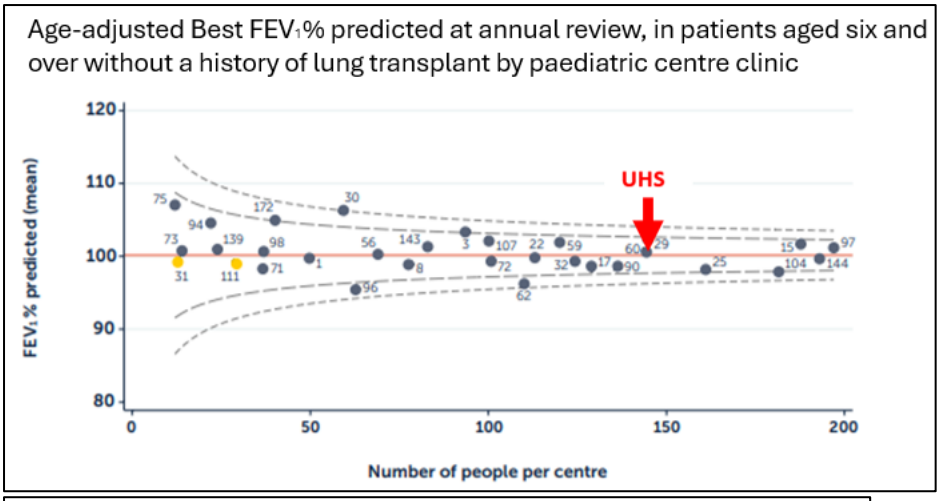
- Educational sessions are planned to encourage ED staff to utilise the wheeze proforma for children presenting with acute exacerbations. Planned ED I.T system changes should result in patients presenting with an exacerbation of asthma automatically having their wheeze pro-forma completed on admission.

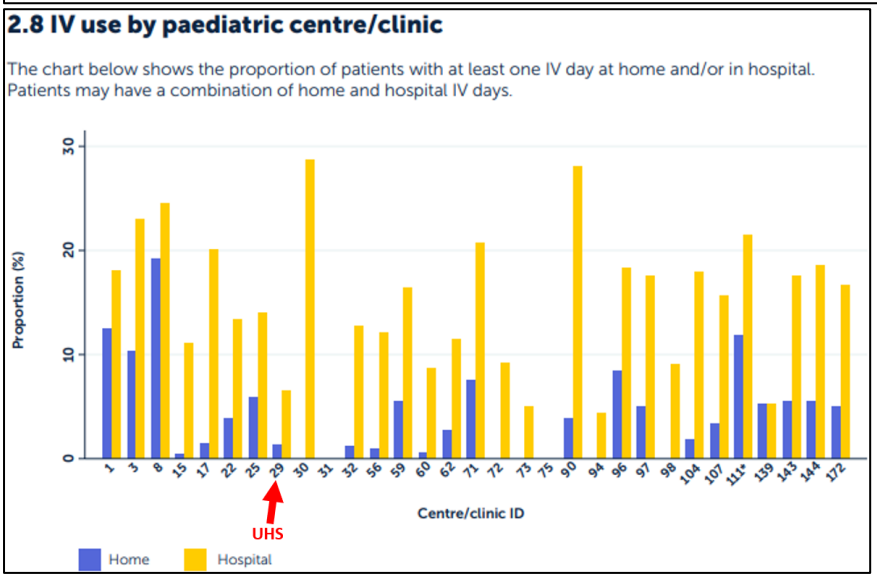
Paediatric Respiratory Medicine: Cystic Fibrosis

(presented at CAMEO 25.2.2025)

Highlights of success:

- Age adjusted FEV1% predicted (a lung function index that is the best predictor of long-term outcome) for our full service puts us 2 standard deviations above the national average which makes us the highest performing large CF service for this outcome measure in the UK.
- Due to excellent outpatient management, IV antibiotic use is very low when benchmarked against others in the country, reducing the need for inpatient treatment with more intensive medication.
- Excellent PROMS results from Holistic Care survey carried out by Cystic Fibrosis Trust





Areas of focus:

- The move to virtual consultation (50% of follow ups) has resulted in a lack of microbiology/height/weight data being captured.
- Paediatric respiratory Medicine asked to bring effectiveness/outcomes for other areas of service e.g. PCD, LTV in future.

Paediatric non-respiratory sleep service

(presented at CAMEO 11.2.2025)

Highlights of success:

- In 2024, over 300 new patients and 264 new families were supported by the sleep practitioner team with excellent qualitative feedback.

Areas of focus:

- Waiting time to 1st consultation remains long although the waiting times have reduced significantly since 2022.

Measure	November 2022	January 2024
Number of patients breaching 52 week wait	52	0
Number of patients breaching 18 week wait	211	115
Longest wait (in weeks)	81	50

- Inadequate quality of polysomnography and multiple sleep latency studies due to noise disturbance
- False negative diagnostic studies for narcolepsy have resulted in a risk of harm. Therefore, studies require repeating at significant financial cost, staff time and inconvenience to families.
- Risk of actigraphy waiting time increasing due to insufficient number of actigraphy devices

Action plan:

- A new sleep Fellow due to start in March 2025
- Business cases underway for ACP post and consultant post
- Ongoing work with ICB to improve public health, primary care and secondary care sleep pathways in HIOW.
- Escalated to care group manager, remains risk register.
- Actigraphy waiting time: No actions planned, no budget is available to replace devices.
- Noise disturbance and testing quality
- Business case underway for new combined paediatric day ward and sleep laboratory

Paediatric Gastroenterology

Highlights of success:

- Ileoscopy (77.18% of emergency endoscopy patients) - zero cases of adverse events
- Paediatric fibroscans are now performed in-house.

- Intestinal failure – zero rate of mortality for patients on home parental nutrition (HPN)

Areas of focus
- Potential to reduce hospital IBD caseload by providing subcutaneous infliximab at home (alternative is half-day infusion on ward)
- Service sustainability is under strain due to increasing numbers & complexity.
- Absence of a dedicated monoclonal pharmacist is limiting managing monoclonal therapies efficiently.
- Lack of backup support for HPN threatens the service stability.

Paediatric Allergy Day Ward & Immunology

Highlights of success:
- Low rates of anaphylaxis (1.7%)
- Low rates of inconclusive/incomplete challenges (4.3%), this is believed to be related to the highly skilled clinical & nursing team.

Actions
- Collect meaningful Patient Reported Outcome Measure data.

Paediatric Cardiology- congenital heart disease

Highlights of success:
- Survival rates amongst the highest nationally, against some of the highest complexity scores (99% 2020-23, 2023-25 data not yet published)
- Low rate of benchmarked complications after surgery
- Excellent, low rate of complications after catheter interventions and EP procedures (second lowest nationally)
- Excellent clinical management of the second largest waiting list in the UK.

Actual and predicted average survival rates for paediatric CHD cases using PRAiS2 model (2020/23)

Hospital	Code	Surgical Episodes	Survivors	Deaths	Actual Survival	Predicted Survival	Actual/Predicted Survival	Average Predicted Mortality PerCase	Order
[redacted]		1429	1420	9	99.4%	98.2%	1.012	1.8%	
[redacted]		675	666	9	98.7%	97.6%	1.011	2.4%	
Southampton Wessex Cardiothoracic Centre	SGH	705	698	7	99.0%	97.9%	1.011	2.1%	
[redacted]		504	499	5	99.0%	98.0%	1.010	2.0%	
		912	895	17	98.1%	97.6%	1.005	2.4%	
		800	785	15	98.1%	97.7%	1.004	2.3%	
		1524	1499	25	98.4%	98.2%	1.001	1.8%	
		1062	1038	24	97.7%	97.6%	1.002	2.4%	
		897	876	21	97.7%	97.9%	0.998	2.1%	
		478	465	13	97.3%	97.8%	0.995	2.2%	
		8986	8841	145	98.4%	97.9%	1.005	2.1%	

Paediatric Dermatology

Highlights of success
- UHS have set up a regional remote MDT to discuss complex referrals/give advice.
- Specialist Nurses involved with follow up & a dietitian has been appointed to help with dietary management of skin conditions.

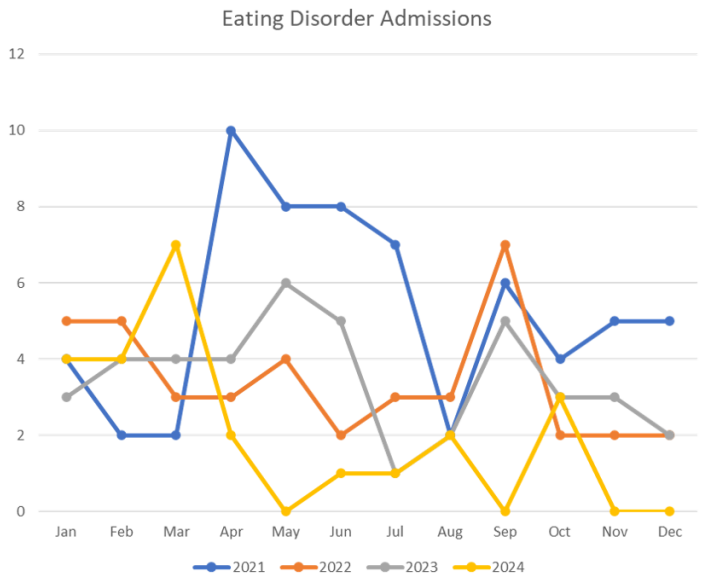
Areas of focus
- Expansion of regional MDT treatment options

Planned actions
- Quality of life tool to be introduced
- Capture the volume of ad-hoc advice given with advice & guidance record.

General Paediatrics

(presented at CAMEO 11.2.2025)

Highlights of success
- Epilepsy – positive outlier nationally against service standards. PROMS reporting in place for teenagers with excellent outcomes.
- Eating disorders. Significant drop in admissions since changes to service (consultant working one day/week in community setting to support YP to stay at home and NG moved to in/out rather than remain in situ:



Areas of focus

- Challenging to identify clinical outcomes in general paediatrics – regional work with RCPCH should help identify and measure outcomes.

Planned actions

- Creating annual audit plan and how to utilise resident doctors to support with National audits.

University Hospital Southampton NHS Foundation Trust

Agenda Item 6.1 Report to the Trust Board of Directors, 11 November 2025	
Title:	Corporate Objectives 2025-26 Quarter 2 Review
Sponsor:	David French, Chief Executive Officer
Author:	Martin de Sousa, Director of Strategy and Partnerships

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This paper provides an update regarding progress against our corporate objectives for Quarter 2 of 2025-26.

Our objectives were agreed at Trust Board in March 2025. This is the second progress report for this financial year. There has been an increase in amber and red rated objectives since Quarter 1 which reflects some of the challenges in the organisation currently, most notably finance and workforce.

A scoring summary of progress is below:

Ref	Corporate ambition	Leads	Number of Objectives for 2025/26	Q2 Green	Q2 Amber	Q2 Red
1	Outstanding patient outcomes, safety and experience	COO/CNO	4	2	2	0
2	Pioneering research and innovation	CMO	2	2	0	0
3	World class people	CPO	2	0	1	1
4	Integrated networks and collaboration	COO/CMO	1	1	0	0
5	Foundations for the future	CFO/CEO/CNO/CMO	3	1	1	1
Totals			12	6	4	2
			% against	50%	33%	17%

RAG Rating for corporate objectives updates	In Year Updates
Green	On track to be delivered in full
Amber	Minor Delays/or shortfall in target
Red	Significant delays/or shortfall in target

Contents:	
Summary of progress + Appendix 1-5: updates in full by strategic theme	
Risk(s):	
Objectives relate directly to all BAF risks.	
Equality Impact Consideration:	NO

Quarter 2 Update
The 2025/26 corporate objectives were approved by the UHS Board in March 2025. Twelve objectives were agreed, which reflected an attempt to focus priorities across our five strategic themes, whilst recognising the breadth and complexity of work that was ongoing in the Trust. Following agreement of the twelve objectives, quarterly milestones have now been set for each objective to measure progress against across the year.

This report assesses achievement to the end of quarter 2 2025/26. There has been an increase in amber and red rated objectives in comparison with quarter 1 which reflects increased challenges across the Trust in delivering a complex agenda with a large number of priorities within constrained resources. The two red rated objectives relate to delivery of our workforce and finance plans.

Outstanding Patient Outcomes, Safety and Experience
Two of the four objectives in this area, both relating to quality, remain on track. A detailed review of the Quality Priorities has taken place at Quality Committee. Both the Elective and UEC Programme objectives have moved to being rated as amber, predominantly due to challenges in meeting national targets for RTT improvement and ED performance, despite positive progress in some areas of transformation. Additional actions are underway in quarter 3 to address this position.

Pioneering Research and Innovation
There has been good progress against both our objectives in this area. Despite some delays in completing some of the milestones that were set in this area, the leadership team are confident that these objectives will be achieved, and they remain green rated.

World Class People
Delivery of our workforce plan is now red rated as our workforce plan is 54WTE over plan at the end of Q2. There remains a large amount of focus to improve this position whilst maintaining safe and sustainable services. At the same time there have been some further challenges in terms of staff morale that have arisen. Work is ongoing to support teams in the organisation and provide targeted interventions on staff experience but is limited in scale due to resource constraints.

Integrated Networks and Collaboration
The objective for this area remains rated as on track. UHS has contributed positively to network projects within the ICS, including providing clinical leadership time and administrative support where possible. Constructive discussions on specific services have been held with partners both within the ICS and nearby (Salisbury, UHD). In terms of focus, there has been a shift away from prioritising widespread clinical collaboration with HHFT given leadership changes there and a delay in the plans for a new hospital in Hampshire. Nonetheless, there remain regular meetings between exec teams at UHS and HHFT and work ongoing on specific services.

Foundations for the Future
Our financial position is extremely challenged and therefore has been assed as red. This aligns with an increase to the BAF risk score to a 25, noting the critical cash position of the Trust. UHS Board approved a Financial Recovery Plan in September, which is attempting to mitigate the position by delivering further financial improvements. However, the financial trajectory forecasts non-delivery of the financial plan for 2025/26, with improvements targeted at returning the Trust to a run-rate breakeven position from April 2026.

Our capital plan delivery is amber rated at this point due to risks around slippage on a number of schemes- work is ongoing to review this and bring forward schemes from 26/27 where possible. Positive progress has continued on our Private Patient Unit strategy and our Trust Strategy refresh, although there are some developing risks to timeframes for delivery of the elective centre at RSH.

Summary

The Board is asked to note the overall position for delivering our objectives and the increase in amber and red rated objectives. The areas of challenge are subject to specific recovery actions and will be well understood by Trust Board through other reporting. Nonetheless there are still a number of achievements within our objectives which reflects a significant effort by teams across the Trust.

Outstanding Patient Outcomes, Safety and Experience

Ref	Lead	Objective	Q2 Milestone	Q2 Update
1(a)	CNO	Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme.	Deconditioning project roll out on G5 and G8, working with Hannah Foxley and team and supporting 'Proportionate/Single Handed Care' Collaboration between clinical teams, therapy teams and experience of care team to roll out a pilot (1 month per ward) with the intention of the following: - Implementing therapy action to support staff in prevention of 'deconditioning' in hospital - Reducing length of stay through active engagement in therapy and activities of daily living from day 0 in hospital - Reducing the number of patients who need to go 'home' with a care package that requires more than 1 carer (in line with the 'proportionate care' workstream - Work with Voluntary Services to intensively trial What Matters To Me with experience of care support - Reduction of high harm falls and hospital acquired pressure ulcers through effective 'intentional rounding' and care - Monitoring and reduction of NEWS2 activations/ requirement of Critical Care Outreach support in managing deteriorating - Improved documentation of care through the Inpatient Noting digital system - Benchmarking and self-assessment of FoC standards to demonstrate improvement and engagement to sustain this moving forward	Deconditioning Project**:** The project was rebranded to the Geriatric Rehabilitation and Care Enhancement (GRACE). It was undertaken in collaboration with the therapy team in Division B and across the proportionate care/single handed patient care team. Alongside this, the What Matters to Me trial was completed to implement WMTM boards in the clinical areas of G5 and G8. Success of this trial has led to further implementation on ward D4 where the first phase of the trial has been completed and consultation for improvements to the methodology is ongoing. Hannah Foxley and Charlie Colby are leading on the GRACE outcomes whilst data is still being collated, early information is supporting an application for further research and funding via the ICB to develop this concept further. Volunteer Services**:** A volunteer coordinator has been funded by a Volunteering for Health grant to focus on objectives, including increasing volunteers to support this trial. Documentation via Inpatient Noting: this remains a challenge and is under discussion, amendments to system requested but not yet at priority level for action by Digital team FoC Standards: More clinical areas are utilising the FoC self-assessment tool and we are beginning to see areas of good practice e.g. E12. This is inspiring next steps to develop a FoC champion network with training and development opportunities to support cultural changes in teams. Overall: **Green**

Ref	Lead	Objective	Q2 Milestone	Q2 Update
1(b)	CNO	Deliver the quality priorities for 25/26. **1)Experience of Care** **2)Improving the care of the dying patient and those important to them** **3)Fundamentals of Care:** See above **4)Acuity and deteriorating patients:** **5)NATSSIPs Implementation** **6)Health Inequalities**	The following priorities will be reported on in full at Quality Committee 1)Experience of Care 2)Improving the care of the dying patient and those important to them 3)Fundamentals of Care: See above 4)Acuity and deteriorating patients: 5)NATSSIPs Implementation 6)Health Inequalities	**Green**: 6 month review of Quality Priorities was presented to Quality Committee in October 2025. Good progress has been made with 4 of the 6 priorities being fully on track and 2 partially achieved.

Ref	Lead	Objective	Q2 Milestone	Q2 Update
1(c)	COO	Deliver the objectives of the elective programme, including achievement of national targets for RTT improvement.	- Elective front door business case to be approved - Clinic template standardisation to improve utilisation and DNA's - Transition from analogue to digital for referral optimisation and outcome reporting - Implementation of six-week partial booking process - OOA referral SOP developed	**Amber:** Elective front door business case not currently approved due to financial case, eGrading being pursued as an alternative with full rollout planned by March 26' - Work continued in the outpatient transformation programme to standardise booking processes and templates - Paper-free outpatients rollout continuing, ophthalmology and two surgical specialities next. - OOA SOP embedded and being monitored. - Continue to deliver activity above plan, but despite this waiting times are challenged in key areas - additional actions around capacity agreed for Q3.

Ref	Lead	Objective	Q2 Milestone	Q2 Update

1(d)	COO	Deliver the objectives of the UEC programme, including achievement of national target for ED performance improvement.	- Business case approved for OPAT service - Sign-off place based plan for delivery with system partners - Centralised discharge lounge identified and implementation plan in development - Expand Criteria-Led Discharge (CLD) engagement and adoption	**Amber:** - business case for OPAT approved, first phase to go live in Oct 25' - Place based plan for NCTR developed and approved by all partners. - Criteria led discharge expanded across further surgical specialities. - Significant increase in the proportion of patients being sent to discharge lounge - Improved UEC performance in August and September, returning to on or above agreed plan. - UEC improvement program in place and monitored weekly

Pioneering Research and Innovation

Ref	Lead	Objective	Q2 Milestone	Q2 Update
2(a)	CMO	Deliver Year 5 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.	Detailed planning for recruitment of Cohort 6. Open call to potentially open in September – dependent upon securing budget for RLP in 26/27. Review and update RLP Panel process and associated guidance documents. Finalise and disseminate annual report. Collect and collate metrics to evidence ROI as defined. Complete RLP evaluation. Develop assessment method for MedTech. Summary of impact of SETT data and AI delivered research to be released.	Recruitment to cohort 6 is paused. A Trust Board Study Session is arranged for 18-Dec-25 at which RLP will be presented with a discussion regarding the continuation of the programme. Therefore, recruitment planning and review of panel process is delayed until Qtr4. Annual report is near completion, metrics to evidence ROI continue to be collected and collated. Qualitative evaluation of RLP is underway with regular progression sessions scheduled. MedTech Assessment method developed (scoring, assessment, pipeline)and outlined in an SOP which is awaiting QC review prior to release. Impact of SETT workstreams presented at second SETT conference on 16th October. Overall progress: **Green**

Ref	Lead	Objective	Q2 Milestone	Q2 Update
2(b)	CMO	Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.	Agree set of initiatives and assign leads to progress. Plan to conduct annual evaluation as part of strategy implementation plan going forward. Implement plan Deliver a senior leaders programme Project INSPIRE - Finalise PI offer document, present to RDSG 25/26 Q2.	Gap analysis on initiatives identified. Formalise and assign leads to take forward in Q3. Action plan has been developed and will now be implemented in Q4. Senior leaders programme initiated with 3 sessions held so far. Project INSPIRE and PI offer in progress, deferred presentation to RDSG in Q3 due to leave in Q2. Overall progress: **Green**

World Class People

Ref	Lead	Objective	Q2 Milestone	Q2 Update
3(a)	CPO	Deliver a workforce plan for UHS for 2025/26 which meets the national planning requirements and is safe, sustainable, and affordable.	Implementation of new divisional structure from 1st July. Implementation of wider organisational structures. Initiation of enhanced job planning and medical rostering as a trust wide project.	**Amber:** New divisional structure implemented, internal review of changes planned for Q3/4. Implementation of wider organisational changes also taking place in line with revised WTE targets agreed for 25/26. Plan agreed for job planning and medical rostering projects under leadership of Trust education team. Workforce numbers overall reduced in September to 54WTE over plan by end of Q2. This was supported by decreased substantive numbers, with increased recruitment controls, as well as a reduction in bank expenditure.

				MARS programme exits agreed and taking place up to November 2025.
Ref	Lead	Objective	Q2 Milestone	Q2 Update
3(b)	CPO	Deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy.	Initiate target work in discreet challenged areas of the trust. Continue to deliver Leading through change programme Implement complimentary wellbeing through change package Re-energise internal communication with staff Maintain and improve staff survey participation rates Plan and deliver leadership programmes	**Amber:** Over 600 managers have attended the Leading Through Change workshop designed specifically to provide support, resources and strategies to deal with change, lead teams through change, and create the environments for people to work in challenging times and with uncertainty. Wellbeing through Change also designed and delivered, with practical tools and resources to support people to deal with emotional aspects of change, manage stress and stay well. Cohort 4 of PALP completed and graduation presentations took place in October 2025. 3 participants already achieved promotions during the programme. Impact Analysis for Allyship complete and presented outcomes to People Board, set of recommendations agreed and now in development. We are UHS week took place in October with participation from across the Trust and celebration of achievements. UHS Voices launched to complement existing communication mechanisms with organised visitors of executive directors to local departments. Staff survey launched in September, however the Trust is currently just below average on participation rates. Q2 Staff engagement scores in the NHS pulse survey have dropped attributed to the current significant pressures in the Trust.

Integrated Networks and Collaboration

Ref	Lead	Objective	Q2 Milestone	Q2 Update
4(a)	CMO	Develop network relationships within our Integrated Care System, including progression of shared services work with partners.	• Support development of the ICS acute provider collaborative clinical strategy • Continue membership and support for the ICB acute provider collaborative board • Develop Pelvic floor full business case • Establish financial, operational and governance model for upper GI, breast DIEPs • Surgical collaboration meeting with HHFT • Set up DCD to DCD meetings with HHFT to review wider collaboration opportunities	**Green:** The first draft of the ICS provider collaborative clinical strategy has been developed and shared with our contribution through continued membership of the ICB provider collaborative board. The pelvic floor business case is in development, work over this quarter has focused on answering detailed questions to enable this completion. Decisions for clinical models for Upper GI and Breast DIEPs for the system are being overseen by the ICB. UHS continues to contribute to these conversations. Collaboration meetings with HHFT are yet to take place. However there have been partnership meetings on pathway collaboration with Salisbury and HIOW FT.

Foundations for the Future

Ref	Lead	Objective	Q2 Milestone	Q2 Update
5(a)	CFO	Deliver the financial plan for 25/26, supported by delivery of schemes within the Improving Value programme.	Target less than 20% of savings in opportunity phase or unidentified. Delivery of Q1/Q2 Savings Target = £46m Delivery of I&E Plan = £16.6m deficit YTD	**Red:** The Trust is now £14.2m behind plan YTD at the end of Q2. CIP delivery is £43.5m YTD (£2.5m behind plan). Trust Board approved a Financial Recovery Plan in September, with financial improvements to mitigate the ongoing financial risk. The recovery plan targets a return to a breakeven run-rate from April 2026.
Ref	Lead	Objective	Q2 Milestone	Q2 Update
5(b)	CFO	Deliver the prioritised 2025/26 capital programme and set a prioritised capital plan for 2026/27, as well as setting aspirations for future year programmes.	Complete finalised short form business cases to enable successful capital draw down of 2025/26 PDC Funding. Continue monitoring of 2025/26 capital plan including management of risks and mitigations via TIG with escalations to Trust Board where necessary.	**Amber:** Capital plan delivery behind plan YTD with £9.3m of capital expenditure v £16m plan. Slippage risks have been highlighted on several notable schemes such as the Community Diagnostics Centre and Biplane Angio upgrade. The forecast position remains under review with mitigations being explored such as bringing forward spend from 26/27 into 25/26 as internal CDEL cannot be carried forward. There are also delivery risks around £44m of externally funded capital due to Buildings Safety Act delays plus complexities of mobilising schemes at the required pace to draw down funds compliant with RIBA stage 4 completion. Discussions are taking place with NHSE with regards to carrying funding forward.
Ref	Lead	Objective	Q2 Milestone	Q2 Update

5(c)	CNO	Progress key strategic objectives for this year, to include: a. Elective centre for UHS at RSH b. Progress towards onsite PPU c. Refresh for UHS strategy	a. Initial service planning for the provision of UHS services at RSH	**Amber:** Service planning within UHS well underway with identified specialties. However production of detailed evidence to support NHSE investment case in Q3 is a challenge due to incomplete or unobtainable 3rd party records on the condition of the RSH building. Further clarification of level of detail of NHSE business case is sought, and new condition surveys have been urgently commissioned.
			b.PPU Tender Release for PSQ Receive PSQ responses Evaluate and score PSQ responses Shortlist Bidder to next stage (2)	**Green:** Released UK4 Tender Notice and Procurement Specific Questionnaire (PSQ) and Conditions of Participation (COP) in July 25, for bidders to respond. Stage 1 PSQ of the procurement has been scored and completed and 4 bidders have been notified informing them of their success to the next stage (2).
			c.Drafting of new strategy	**Green**: New strategy draft in progress, with aim to present at Trust Board Study Session in December 2025

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.2 Report to the Trust Board of Directors, 11 November 2025	
Title:	Board Assurance Framework (BAF) Update
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Lauren Anderson, Corporate Governance & Risk Manager Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

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

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

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

Contents:

Paper
Appendix A – The full Board Assurance Framework

Risk(s):

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

Equality Impact Consideration:	N/A

1. Purpose

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

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

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

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

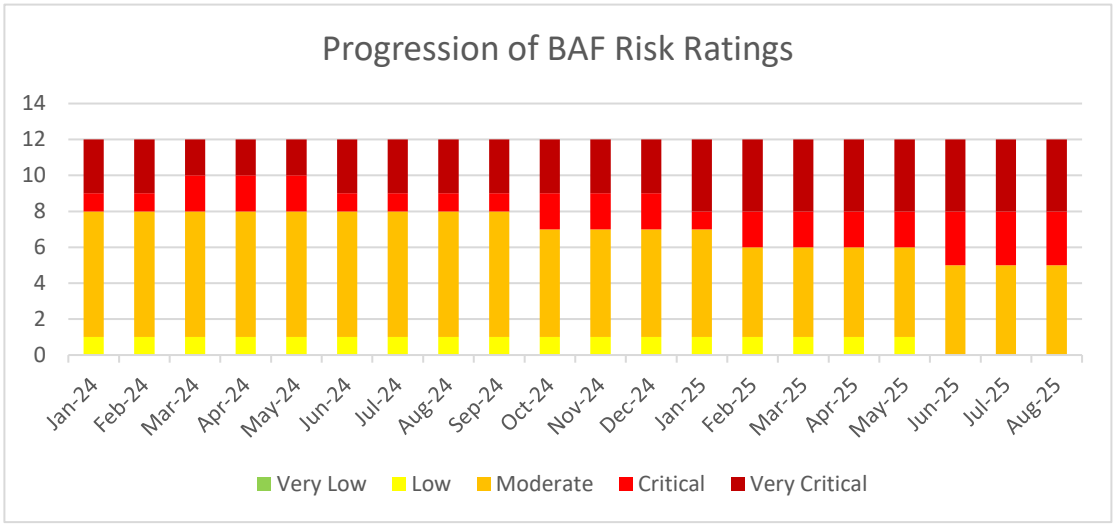
2. Key updates

2.1. The board last received the BAF in September 2025. Since then, all risks have been reviewed and updated by the responsible executive(s).

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

2.3. No risk ratings or target dates have been amended, but changes have been made to controls, assurances and action plans as required to ensure they are up to date and accurate.

2.4. In total there are now 7 critical risks recorded on the BAF, which accounts for 60% of the total risks. The graph below provides a visual demonstration of how this has increased, evidencing the continued and growing tension between clinical and operational pressures, and the constraints of available resources and finances.



2.5. Currently there are 7 risks (60%) with a risk rating outside of the organisation's risk appetite. Each of these articulate a clear intent to reduce the risk and align it with the risk appetite, and include actions to demonstrate how this will be delivered. It is recognised that this will take some time with all risk reductions anticipated to be successful between 2027 and 2030.

2.6. When reviewing and updating the BAF this month, consideration has been given to findings of the recent internal risk maturity audit undertaken by BDO. The final report has now been received with ratings shown overleaf. Overall, the findings are positive with particular strengths described as the organisation's Board Assurance Framework which is noted to be detailed and proactive, the risk appetite statement which is well embedded at a strategic leadership level, the organisation's governance structure, and the knowledge and competency of risk professionals in the Trust. Some areas of development were identified, primarily in relation to how operational risks are articulated as these do not always simply describe the cause / risk / effect, and do not accurately define the controls, assurances, and gaps. Additionally, actions are not always recorded in a SMART format and it is recommended that risks reflect business continuity plans where available to inform management if risks do materialise. The audit also recommended a formal education package be implemented and that risks be linked to Business Continuity Plans where applicable to enable a quick and effective response should a risk be realised.

Where areas of improvement have been identified, appropriate actions have been identified and are in progress. It is the opinion to the auditors that successful completion of these would facilitate the Trust meeting the 'enabled' criteria in all domains (the highest level of maturity).

Maturity Level					**Domain**	**Description**
Naïve	Aware	Defined	**Managed**	Enabled	Risk Governance	Risk management objectives are defined and management are trained in risk management techniques. Risk management is written into the performance expectations of managers. Management and executive level responsibilities for key risks have been allocated.
Naïve	Aware	Defined	**Managed**	Enabled	Risk Assessment	There are clear links between objectives and risks at all levels. Risk information is documented in a risk register. The organisation's risk appetite is used in the scoring system for assessing risks. All significant projects are routinely assessed for risk.
Naïve	Aware	**Defined**	Managed	Enabled	Risk Mitigation	Management in some parts of the organisation are familiar with, and able to distinguish between, the different options available in responding to risks to select the best response in the interest of the organisation.
Naïve	Aware	Defined	**Managed**	Enabled	Reporting & Review	The board reviews key risks, emergent and new risks, and action plans on a regular basis, e.g. quarterly. It reviews the risk management strategy, policy and approach on a regular basis, e.g. annually. Directors require interim updates from delegated managers on individual risks which they have personal responsibility.
Naïve	Aware	Defined	Managed	**Enabled**	Continuous Improvement	The organisational performance management framework and reward structure drives improvements in risk management. Risk management is a management competency. Management assurance is provided on the effectiveness of their risk management on a regular basis.

UHS Board Assurance Framework (BAF)

Updated October 2025

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

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

1. Outstanding patient outcomes, safety, and experience

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

2. Pioneering research and innovation

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

3. World class people

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

4. Integrated networks and collaboration

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

5. Foundations for the future

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

Executive Summary

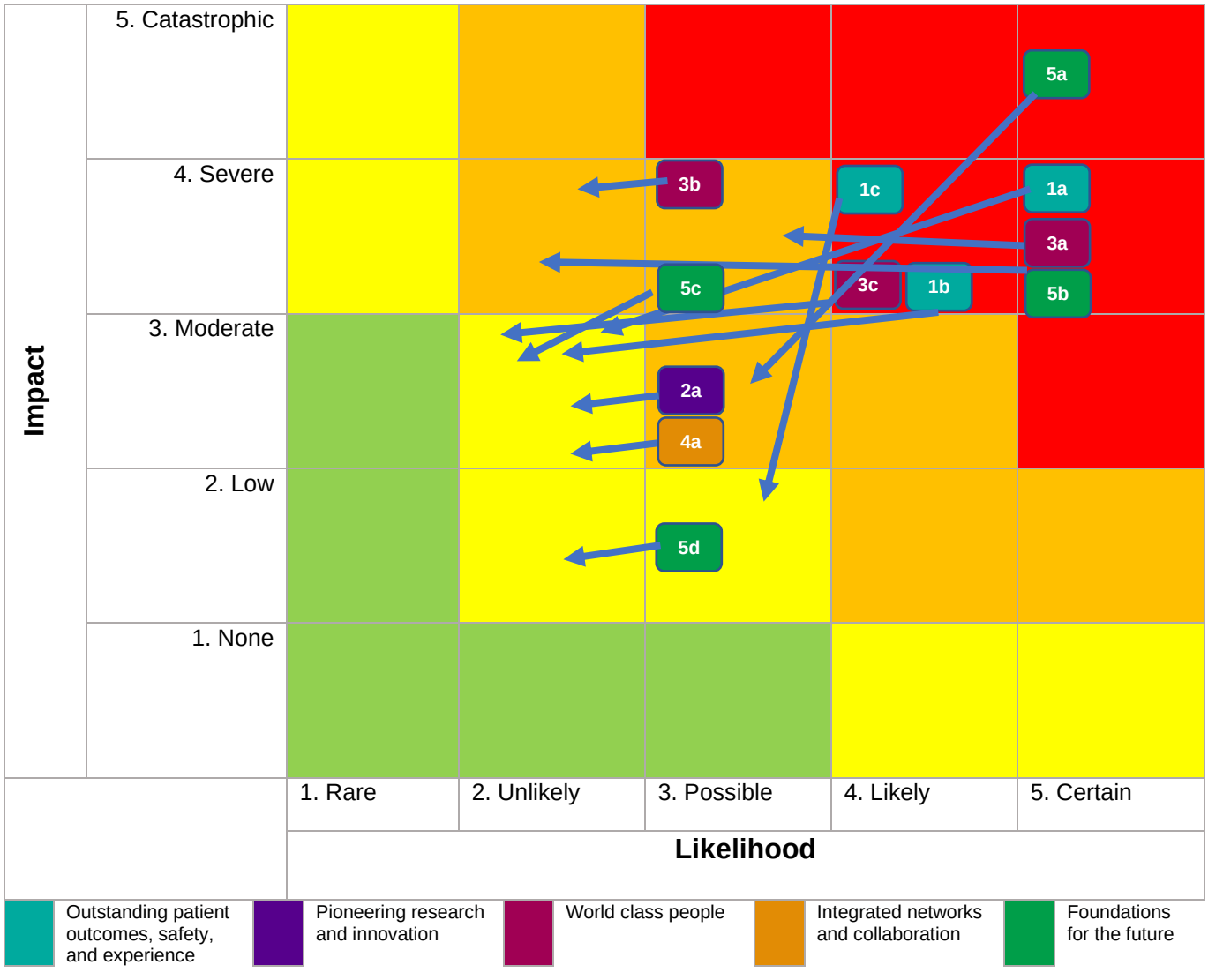
There are 7 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1b) Outcomes & Experience (4 x 4 = 16)
- 1c) Infection Prevention (4 x 4 = 16)
- 3a) Staffing (4 x 5 = 20)
- 3c) Future Workforce Planning inc. Training & Development (4 x 4 = 16)
- 5a) Finances (5 x 5 = 25)
- 5b) Estates (4 x 5 = 20)

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

Trajectory

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



Outstanding patient outcomes, safety, and experience

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

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 5 20	April 2022	4 x 5 20	August 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

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

Capacity remains a live challenge considering increasing seasonal infections, increased attendances and ambulances at ED, and ongoing difficulties with discharge particularly now that we have received confirmation that community capacity for domiciliary care has reduced. To address this concerns have been escalated to the ICB and region, and UHS are engaging in the discharge workstream led by the CEO at Portsmouth Hospital. Alongside this the system flow programme has been reinvigorated and our CEO is leading our ED improvement programme. Consistent and focussed effort also continues into both the NCTR and mental health workstreams.

To address patient safety and performance risks in relation to elective capacity, the Board have agreed to increase capacity to ensure that long waiters are seen as soon as possible. By doing so the intention is that there will be no long waiters over 65 weeks by the end of December 2025.

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

underpinning the objectives include criteria led discharge and discharge lounge use. Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand. Limited use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board. Rapid Improvement Plans to support improvements across cancer pathways. Winter/business planning which includes business continuity plans, such as the use of surge capacity should this risk be realised.	discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure. Ongoing industrial action through 23-24 and into 24-25 has presented significant risk to the Trust's ability to meet ongoing demand on our services. This could continue into 25-26. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow. Lack of a clear capacity and demand plan to resolve cardiac capacity issues in the longer term. Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities, surgical skin services.
Key assurances	**Gaps in assurances**
Level One (Internal) Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Increase in advice & guidance referrals. **Level Two (Internal)** Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns. **Level Three (External)** NHSE and NHS HIOW ICS supportive quality visits to ED.	Local system plans to reduce patients without a criteria to reside are emerging but will take time to evidence results.
Key actions	
Emergency Care CEO AH leading an ED improvement programme through 2025/26 and into 2026/27 including key priority workstreams: • Launch an acute assessment unit (AAU) – complete August 2025. • Introduce minors appointments – completed August 2025.	

- Improve CT efficiency including vetting of referrals and appropriate monitoring of scanning and reporting timeframes, with the intent of reducing scans required and reducing length of stay.
- Improve staff experience and culture, supported by the Trust's prioritisation and focus of the violence and aggression work stream.
- Implement an ED Observation Service (EDOS) – trial commenced September 2025 and is ongoing.
- Use of a dedicated named consultant in ambulatory ED to support earlier discharge of patients – trial commencing November 2025.

Flow and Discharge

Deputy CEO DLK is working with the wider system and leading the UHS elective and UEC transformation programmes to improve discharge and reduce NCTR through 2025/26 and into 2026/27 including:

- Local NCTR delivery unit for the South West established in 2024/25 and remains underway.
- Monthly meetings between UHS, the ICB and social care directors.
- Implement and embed criteria led discharge process at UHS.
- Trial of a bedded discharge lounge at UHS is underway.
- Develop a shared action plan across the system to improve mental health pathways following a 2025 workshop involving senior leadership teams from all partners, to be implemented and monitored through a monthly task and finish group.

Elective Activity

CEO AH to deliver on set activity targets for 2025/26:

- < 1% patients waiting over 52 weeks.
- > 72% of patients seen with 18 weeks.

Ongoing engagement in the NHSE Further Faster programme for elective care overseen by CEO AH.

CMO PG leading a task and finish group through 2025/26 and into 2026/27 to seek a sustainable solution for cardiac capacity including a demand and capacity plan, and supported by mutual aid.

UHS increasing capacity including use of outsourcing from Q3 2025/26.

Community Diagnostic Hub opening Q4 2025/26 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign.

New theatres and MRI suites were opened in September 2025 including 5x new all day theatre lists.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	2 x 3 = 6	3 x 2 = 6	31/10/2025
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	31/12/2025
259	Capacity and Demand in Maternity Services	4 x 4 = 16	2 x 2 = 4	30/09/2025
266	There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity	4 x 4 = 16	2 x 2 = 4	30/11/2025
395	This risk is related to the cardiac surgical patients who are on our waiting list that may come to harm whilst they wait for their surgery.	4 x 5 = 20	2 x 3 = 6	30/06/2025
443	Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service.	3 x 4 = 12	3 x 2 = 6	31/10/2025

610	Insufficient capacity to provide a safe and effective Out of Hours medical and ANP service across Div B	4 x 2 = 8	3 x 2 = 6	29/01/2026
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/12/2025
671	Capacity within the melanoma and soft tissue cancer pathways.	4 x 4 = 16	3 x 2 = 6	31/12/2025
681	Adult inpatient pain service is struggling to deliver a robust service - demand is exceeding the current capacity in the pain service.	3 x 2 = 6	3 x 1 = 3	31/12/2025
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	2 x 4 = 8	3 x 1 = 3	30/10/2025
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	30/10/2025
758	Urology stone service - including stent change delays & capacity challenges	4 x 4 = 16	3 x 2 = 6	31/12/2025
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	31/10/2025
767	HoLEP capacity issues	3 x 3 = 9	3 x 1 = 3	31/12/2025
775	Patients with kidney cancer may experience worse outcomes and survival due to capacity issues and delays in their treatment pathways	4 x 3 = 12	4 x 1 = 4	31/12/2025
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	30/09/2025
816	Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity	5 x 4 = 20	3 x 2 = 6	31/03/2026
822	Ophthalmology Glaucoma Capacity	4 x 4 = 16	4 x 4 = 16	30/06/2026
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2025
840	Paediatric haemodialysis capacity	4 x 2 = 8	2 x 2 = 4	31/10/2025
845	There is a risk that the obstetrics service will be compromised due to excess levels of demand and unmatched capacity within the consultant team	4 x 4 = 16	4 x 1 = 4	31/12/2025
850	Inability to effectively run the pelvic floor service due to staffing and capacity	3 x 3 = 9	2 x 2 = 4	31/05/2026
857	Prostate PIFU Capacity	4 x 3 = 12	3 x 2 = 6	31/12/2025
890	Risk of Patient Harm and Increased Admissions Due to Heart Failure Service Capacity Issues	4 x 3 = 12	4 x 1 = 4	31/12/2025

Outstanding patient outcomes, safety and experience

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	October 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

Focussed work is underway to

Following the increase to the risk rating in June, this is agreed to remain accurate in consideration of the impact we understand some patients are already experiencing due to the tension between clinical/operational demand and the financial resource available, as well as the likelihood that this will continue throughout the coming months. Examples of this impact are:

- An increase in pressure ulcers including grade 4 pressure ulcers which have a long-lasting impact to a patient's quality of life. An audit and deep dive thematic analysis has been undertaken to understand the increase and how this can be mitigated, and this has been presented to QGSG, Clinical Leaders, and Quality Committee. Further work is underway to plan mitigating actions.
- An increase in patient falls, with a deep dive review also being undertaken and presented to quality committee.
- A poorer patient experience as evidenced through complaints and the evolving themes within: for the first time 'staff compassion' has featured as a top three common theme. Complaints continue to be investigated individually, and reviewed collectively, to identify and implement learning.

Further actions underway to manage this risk are the development of a new quality paper to TEC and Quality Committee to support oversight, as well as targeted sessions at clinical leaders group with matrons and ward

leaders to reset and refocus our quality expectations and response. Additionally, previously reported actions to embed NATSIPPS2 remain underway with further training planned at the upcoming Theatres half day.

Key controls	Gaps in controls
Trust Patient Safety Strategy and Experience of care strategy. Clinical strategy in development, this will cover priorities for demand management, including collaboration with partners and shift towards community care. The strategy will also cover delivering timely care and access. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews. Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of 23/24 and 24/25 Always Improving Programme aims, continuing into 25/26. Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Governance of this through role cards, allocation process, and annual reviews. Directory of 2000 patients who are willing to engage in projects and provide a patient voice. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with priorities and allocation of dedicated time across multiple roles in the clinical strategy and BI teams. Maternity safety champions. Listening events and community engagement. Equality & Quality Impact Assessment (EQIA) review group. Ward to Board governance and escalation route.	Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients once the Trust strategy is finalised in early 2026 in line with the 10 year plan. Patient safety strategy currently under review and refresh. Likely to be completed early 2026. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support. However, work across the system on value based care will feed into this. Cost of SMS surveys across the Trust is significant. Patient safety incidents reflect challenges in staffing.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Matron walkabouts and executive led back to the floor. Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. **<u>Level Two (Internal)</u>** Monitoring of patient outcomes with QPSP input.	Ongoing industrial action through 22-23, 23-24 and 24-25, and into 25-26 presents risk to the Trust's ability to meet ongoing demand on our services.

Clinical accreditation scheme (with patient involvement).

Internal reviews into specialties, based on CQC inspection criteria.

Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits.

Performance reporting.

Governance and oversight of outcomes through CAMEO and M+Ms

Patient Safety Incident Investigation Oversight Meeting

Transformation Oversight Group (TOG) including TOG dashboard to oversee impact.

Health Inequalities Board

Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board) including AAA (Alert, Advise, Assure) reports.

Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints.

Level Three (External)

CQC inspection reporting: Good overall.

Feedback from Royal College visits.

Getting it right first time (GIRFT) reporting to Quality Committee.

External accreditations: endoscopy, pathology, etc.

Kitemarks and agreed information standards.

Current and previous performance against NHS Constitution and other standards.

Key actions

Introducing a robust and proactive safety culture:

Embed learning from deaths, and an M+M Framework, across the Trust throughout 2025/26 and 2026/27 (CMO PG, MD for Patient Safety CR, and AD for Patient Experience JM):

- Embed lead medical examiner roles.
- End of life strategy ratified and launched April 2025 and learning from death report embedded.
- M+M lead training – launched January 2025 with further training planned 2026/27.
- Implement Ulysses M+M module to record discussions and actions.
- Standardise directorate and divisional governance forums to include M+M learning.

Review of the clinical quality dashboard and how it reports up to Board – ACNO NW Q4 2025/26.

Launch and implement PSIRF – completed.

Implement the second round of Ockenden recommendations – completed.

Always Improving programme (actions throughout 2025/26 and 2026/27 – COO AH and AD for Transformation JW)

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

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

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

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

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

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

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

Fundamentals of care programme roll out across all wards – ACNO NW.

Patient experience initiatives (actions throughout 2025/26 and 2026/27 – ACNO NW and AD for Patient Experience JM)

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

Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience. This is ongoing work, limited by a 12% headcount reduction in the Experience of Care in the past 12 months, but with a renewed focus to provide divisional tailored reports at care group and divisional level.

We are listening events to be held with the local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust.

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

Health inequalities Programme (throughout 2025/26 and 2026/27 led by CMO PG and Head of the Medical Directorate LH)

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

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	31/12/2025
765	Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS	4 x 4 = 16	4 x 2 = 8	31/12/2025
805	Clinical harm and never events may occur if NATSIPPS2 cannot be embedded due to insufficient resource	4 x 4 = 16	3 x 1 = 3	31/03/2026
904	Quality of patient care and treatment may be compromised due to the significant financial challenges faced within the NHS	4 x 3 = 12	4 x 2 = 8	01/04/2026
909	Patients may come to harm with vision loss due to reduced clinics at Lymington Hospital	3 x 3 = 9	2 x 2 = 4	30/06/2026

Outstanding patient outcomes, safety and experience

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

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

Cause	Risk	Effect
If there are gaps in compliance with IPC measures and policy, either due to increased working pressures, or a lack of awareness or understanding,	Patients may acquire a new infection whilst in hospital and there may be nosocomial outbreaks of infection,	Resulting in patient harm, longer lengths of stay, a detrimental impact to patient experience if visiting restrictions are necessitated, and an operational impact as bays and wards are closed.
Category	**Appetite**	**Status**
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	October 2025	2 x 3 6	April 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed with the Acting Chief Nurse and the Head of Infection Prevention in October 2025. The risk rating and targets have been considered and agreed to remain accurate, particularly in consideration of increasing infection rates as we move into the Winter period. It is noted that nationally there has been an increase in infection and this is also true locally therefore it is likely that we will exceed national infection targets for 2025/26, for example MRSA BSIs and CDIFF, although we do not expect to be an outlier in this. As well as seasonal infections, another challenge is the increased pressure on single rooms in the organisation which impacts our ability to isolate and treat infections. This is caused by competing needs, for example an increased reliance on single rooms to support patients presenting with mental health. Whilst infectious patients are allocated side rooms when the need is identified, this is sometimes delayed whilst other patients are moved to accommodate this. This enforces the importance of strict adherence to IPC standards, particularly when caring for infectious patients, and focussed work to improve and maintain this is underway including:

- Increased focus on hand hygiene with slow but consistent improvements evidenced in the most recent covert audit.
- Significant improvements in clinical cleaning with standards consistently met over the last 6-9 months.
- Workplan for 2026/27 developed including IPC practice in urinary and catheter care, which is supported by local clinical initiatives such as a drive to reduce use of catheters in MOP.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme.	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g.

Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, 'Give up the gloves' winter virus. campaigns. PPE requirements, specifically the requirement for use of gloves, updated in the Trust Isolation policy (published June 2024) to support the 'give up the gloves' campaign. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission. Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need. Point of Care testing in AMU. Expedited laboratory testing facilities for respiratory and GI infections. CNO/CMO reviews with clinical teams for MRSA cases.	Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced. Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped although currently there are no extraordinary requirements for contact tracing.

Business continuity: up to date ratified pandemic plan reviewed annually as well as the infection outbreak policy.	
Key assurances	**Gaps in assurances**
Level One (Internal) Hand hygiene, IP&C and cleanliness audits. **Level Two (Internal)** Infection Prevention Committee and IP&C Senior Oversight Group. Patient-Led Assessment of the Care Environment. Capital funding monitored by executive. Finance and Investment Committee oversight of estates and digital capital programme delivery. Internal audit annual plan and reports. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). **Level Three (External)** National Patient Surveys. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board.	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.

Key actions

- Head of IPC JB leading an ongoing review of IPC policies to ensure they are aligned to the national IPC manual for England, including launch, communication, education and monitoring. Completed policies include MRSA, outbreak of infection, and isolation with the following anticipated by the end of 2025/26: C Diff, candida auris, and urinary catheter care.
- Head of IPC JB and pharmacy leads launching a new antimicrobial 5 year strategy by the end of 2025/26. This combines stewardship and IPC and replaces the previously expired IPC strategy.
- Align UHS with the updated national mandatory IPC education packages by the end of 2026/27 – Head of IPC JB.
- Focussed IP&C education and awareness campaigns supported by internal and external communications plan, and monthly OPC newsletter, led by Head of IPC JB throughout 2025/26 and into 2026/27.
- Implement 2025/26 and 2026/27 workplans to guide improvements in practice and implement learning – Head of IPC JB.

Pioneering research and innovation

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

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 4 12	October 2025	3 x 2 6	March 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 12	3 x 3 12

Current assurances and updates

This risk has been reviewed by the responsible executive in October 2025 and the risk rating and targets are considered accurate following the increase in August. The reduction in headcount in R&D, and the wider workforce reductions across the organisation, are starting to have an impact on R&D Trust Board KPIs. Previous improvements in study recruitment levels (TB KPIs for national ranking) are currently being maintained but we are seeing a reduction in the national metrics for study set-up times and we are struggling to improve on our first patient recruited metrics. We are starting to see capacity constraints, in particular in clinical support services, impact on our ability to set-up new studies. To support mitigation an EQIA has been completed to ensure plans and potential impact are fully considered, with local actions to reduce negative impact identified where possible.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology. Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Some vacancies are being filled, but R&D turnover us still higher than Trust average. It is anticipated that the impact of the current financial and

Local ownership of development priorities, supported by the transformation team. Prioritisation of high-risk or high-impact studies when workforce capacity constraints impact through: Staffing capacity constraints are identified and managed to ensure an agile response to areas of high need Manage study set-up pipeline depending upon capacity constraints with a focus on national set-up metrics, high-risk or high-impact studies. Reduction in volume of new studies in set-up depending upon capacity constraints to maintain set-up times, protect study delivery capacity and ensure patient safety.	workforce pressures will worsen our national position. New national site metrics introduced around commercial clinical trial setup and delivery will be introduced as Trust Board KPIs in 2026/27 once confirmed.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Monitoring research activity funding and impact at R&D steering group. <u>Level Two (Internal)</u> Governance structure surrounding University partnership. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint Innovations and Commercialisation Group – UHS/UoS. <u>Level Three (External)</u> Board to Council meetings. MHRA inspection and accreditation. CQC review of well-led criteria, including research and innovation. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In September 2025our national recruitment ranking has improved from 10th in March 2025 to 6th; but securing sustainable improvements in study-set up and delivery metrics are proving challenging given workforce capacity constraints.	Limited corporate approach to supporting innovation across the Trust. New national site metrics introduced around commercial clinical trial set up and delivery will be introduced as Trust Board KPIs in 2026/27 once confirmed.

Key actions

Deliver the 2025/26 Annual Plan, including the approved R&I Investment Case, with quarterly updates against progress submitted to the Trust Board through the corporate objectives. Karen Underwood

By March 2026, define and implement a UHS contribution plan to the Wessex Health Partners Annual Review, including agreed RoI metrics and resource commitments for the next 3-year term. Karen Underwood

By March 2026, expand staff engagement initiatives presented to TBSS in February 2025, based on mapping outcomes and staff feedback. Karen Underwood

Support at least three departments in piloting innovative R&D-linked roles by July 2026, and evaluate their impact on recruitment and retention by Q4 2026/27. Marie Nelson

Implement new digital tools to streamline clinical research delivery by March 2026, aiming for a 10% improvement in recruitment efficiency compared to 2023/24 benchmarks. Laura Purandare

Launch the action plan to deliver the Joint Research Vision with UoS by March 2026, with quarterly progress reviews by the Joint Research Strategy Board starting end Q1 2026/27. Karen Underwood & Diana Eccles.

Successfully initiate the NIHR Applied Research Collaboration Wessex programme (UHS host, with UoS – regional bid awarded £16.3m over 5 years) by April 2026, ensuring governance, staffing, and delivery plans are in place. Catherine Bowen / Michale Boniface.

By July 2026 complete a staff survey on innovation engagement and understanding, and develop an implementation plan addressing the identified gaps.

Develop and formalise partnership processes between UHS and UoS by December 2026, laying the foundation for a long-term UHS Innovation Strategy to be launched in 2027. Chris Kipps & Pete Baker

Complete a Trust-wide review of the corporate innovation approach by July 2026, and develop a draft UHS Innovation Strategy aligned with UHS/UoS partnership goals by December 2026. Chris Kipps, Pete Baker & Martin de Sousa

Secure at least one new external funding source through the International Development Centre to support staff-led innovation projects by September 2026. Pete Baker.

World class people

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

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

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	October 2025	4 x 3 12	March 2030

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

- This risk has been reviewed and updated with the Chief People Officer in October 2025. The risk rating is considered to still be an accurate reflection of the risk present within the organisation, particularly considering the financial challenges and necessary recruitment controls.

- As above, extensive recruitment controls are in place presently which have been necessary to slow overall headcount growth in light of nationally directed financial pressures. However, this continues to result in a tension between current clinical and operational demand, and the workforce available. To manage this a workforce plan has been agreed to reduce the size and scale, and actions to implement and support this are underway:
  - ICB wide recruitment controls are ongoing including a freeze on non-clinical recruitment (limited internal recruitment approved), and reduced levels (70%) of clinical recruitment.
  - Additional internal recruitment controls are also in place, such as increased internal recruitment prior to external advertisement of posts.
  - The planned organisational restructure from 4 clinical divisions to 3 went live as of 01st July 2025 and the majority of structural changes have now been implemented. Divisional teams are actively implementing plans which will achieve a 5% reduction in pay costs, and THQ are implementing plans to achieve a 10% reduction.
  - To support this corporate function reductions, CEOs across the system collaborating on a vision for shared services across Hampshire and Isle of Wight.
  - UHS initiated two rounds of the Mutually Agreeable Resignation Scheme (MARS) earlier this year which has now concluded with agreed exits being managed. The Trust has thoroughly evaluated each case for financial viability and operational impact, rejecting cases where appropriate.
  - Reductions to UHS premium rates for temporary staffing were implemented September 2025 to align payment with Agenda For Change. DDNs and Operational teams are monitoring any changes to fill rates and implementing mitigations when and if necessary. The RCN have submitted a collective dispute which was heard by the Executives 15th October 2025 and is pending outcome early November.
  - The Trust has addressed concerns regarding NQN recruitment over the past quarter and is phasing the recruitment of more NQNs with the approval of senior nursing colleagues. The additional NQNs should

lead to necessary reductions in bank costs to keep expenditures cost-neutral. UHS acted ahead of the letter received from NHSE following the Secretary of State's guaranteed job promise.

- A robust EQIA process has been implemented to support decisions made through the Financial Improvement Group, which supports the organisation in identifying potential impact to the workforce as a result of changes, and prompts consideration and scrutiny of mitigations where the impact is likely to be negative.

As above, the impact of recruitment controls is being assessed and monitored thoroughly and the continued pressure not only on clinical staff, but on admin & clerical staff is recognised particularly in light of corporate reductions. The Trust is currently considering ways to actively mitigate this including consideration of support from the OAC as well as recruitment where this is necessary.

It is also noted that further industrial action by resident doctors is planned nationally from the 15th to the 19th of November 2025. Planning is underway to mitigate and minimise operational impact, and impact to patients.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes. Workforce plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2025/26 submitted to ICB. Organisational change policy including management of redeployment. RCP (Recruitment Control Panel). Creation of an organisational change management group to govern the current restructure. Financial Improvement Group established with a supporting Equality and Quality Impact Assessment Review Group. Planned change management and wellbeing support for staff and managers. Continual joint working between finance and workforce to align data and improve forecasting. Established procedures for managing staffing deficits and maintain business continuity including escalation through the staffing hub and use of NHSP/agency where patient safety necessitates this.	Completion of objectives for South-East temporary collaborative for 2024/25, 2025/26, and beyond. Planned improvements for medical job planning to be implemented. Over reliance on NHSP.

Key assurances	Gaps in assurances
Level One (Internal) Fill rates, vacancies, sickness, turnover and rota compliance. **Level Two (Internal)** Review of implications for education and training infrastructure from national workforce plan. **Level Three (External)** NHSI levels of attainment criteria for workforce deployment. Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Temporary staffing collaborative diagnostic analysis on effectiveness. A system wide rostering audit has taken place across Hampshire and Isle of Wight, and UHS have now received the findings which provides strong, positive, assurance of our practice with continued opportunities around medical rostering and job planning.	Universal rostering roll out including all medical staff.

Key actions

2025/2026 led by CPO SH

Support the Trust's delivery of the financial recovery plan including delivering a plan of organisational change in a safe and sustainable manner to scale back workforce.

Refresh the Trust's People Strategy once the Trust's Corporate Strategy has been agreed.

Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. Improve medical job planning.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
20	Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection	3 x 4 = 12	1 x 5 = 5	01/02/2026
67	There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc.	2 x 4 = 8	3 x 2 = 6	31/10/2025
167	MRI physics staffing risk	4 x 2 = 8	2 x 1 = 2	31/10/2025
286	Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service	3 x 4 = 12	3 x 3 = 9	31/12/2025
458	Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input.	3 x 4 = 12	2 x 2 = 4	21/12/2025
604	Risk in epilepsy nursing service	3 x 2 = 6	3 x 1 = 3	18/06/2025
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 4 = 16	2 x 1= 2	01/03/2026
646	Reduced ACP Cover across Neurosciences care group	4 x 2 = 8	4 x 1 = 4	03/09/2025

661	Insufficient Medical staff to safely manage patient activity within cancer care	4 x 4 = 16	2 x 3 = 6	30/11/2025
662	Cellular Pathology Staffing and Capacity	4 x 5 = 20	4 x 2 = 8	31/03/2026
726	Ophthalmology clinical/AHP workforce	4 x 3 = 12	4 x 1 = 4	01/01/2026
730	Risk of patient harm due to lack of administrative support for clinical services in surgical care group.	4 x 4 = 16	2 x 2 = 4	28/02/2026
748	There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service	2 x 4 = 8	2 x 1 = 2	31/10/2025
776	Insufficient clinical pharmacy workforce	3 x 5 = 15	3 x 3 = 9	31/08/2026
785	The provision of the congenital cardiac service in theatres may be affected due to high vacancy and slow throughput of learners	3 x 2 = 6	3 x 1 = 3	30/10/2025
791	Outpatients Administration Centre (OAC) - Staffing Risk	3 x 3 = 9	2 x 3 = 6	31/03/2026
837	Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs	3 x 5 = 15	3 x 2 = 6	31/03/2026
844	Patients may not receive lifesaving emergency cardiac surgery due to a lack of cardiac trained staff.	3 x 3 = 9	4 x 1 = 4	30/10/2025
872	Lack of administrative support within cancer care	3 x 5 = 15	2 x 1 =2	31/12/2025
873	A&C Spinal Staffing	3 x 3 = 9	2 x 2 = 4	30/06/2025
879	IISS Programme (project management resource)	3 x 3 = 9	3 x 3 = 9	01/07/2025
881	Retention and Sustainability of Specialist Neurosciences CNS Workforce	3 x 2 = 6	3 x 1 = 3	31/12/2025
883	Lack of dedicated ophthalmology pharmacy support	3 x 3 = 9	2 x 2 = 4	05/09/2025
891	Risk of Paediatric Neurosurgical Care Being Delivered by Non-Specialists Due to Staffing Shortages	4 x 2 = 8	4 x 1 = 4	01/07/2025
896	There is a risk that patients could come to harm if there is not sufficient staffing and support for the Breast PIFU Service	3 x 4 = 12	3 x 2 = 6	31/12/2025
899	Trust recruitment pause, impact on staffing levels and service delivery (EFCD)	4 x 3 = 12	4 x 1 = 4	31/03/2026
900	Concern regarding insufficient, unfunded critical care education provision to meet service need and direct impact on staff and patient safety.	3 x 5 = 15	2 x 2 = 4	31/12/2025
903	If admin and clerical vacancies cannot be recruited to there is a risk that operational efficiency may be compromised effecting performance, patient safety/experience, and staff wellbeing.	4 x 3 = 12	3 x 2 = 6	31/03/2026

World class people

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

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

Cause	Risk	Effect
If longstanding societal and NHS wide challenges surrounding inclusion and diversity and current operational pressures on the NHS post covid are not mitigated, and necessary system and organisational change is not managed safely, sustainably, and equitably;	There is a risk that we will not recruit a diverse workforce with a range of skills and experience, and that we will not develop and embrace a positive and compassionate working culture where all staff feel valued;	Resulting in a detrimental impact to staff morale, staff burnout, higher absence and turnover, and the potential for reputational risk and possible litigation. This in turn has an impact on our patients when staff capacity cannot match clinical requirements, as we need to look after our staff to enable them to look after our patients.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	October 2025	4 x 2 8	March 2030

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12

Current assurances and updates

This risk has been reviewed by the responsible executive in October 2025 and updated as required. The risk rating has been considered and agreed to remain accurate. A key priority at present is refreshing and reinvigorating the violence and aggression workstream to ensure staff are physically and psychologically safe at work. To facilitate this a new executive led V&A board has been established which will oversee work undertaken by the V&A task and finish group. Specific actions underway include reconfirmed zero tolerance commitment, and review and update of the V&A policy including a rapid route to exclusion/restrictions to ensure that appropriate consequences can be implemented where violent or aggressive behaviours are displayed. With community tensions rising the Trust is also ensuring that it is clear that it is proud of its diverse workforce, through displays near the entrance which highlight and celebrate our workforce which is comprised of over 100 different nationalities.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. Proud2BeAdmin & Proud2Bops campaigns and networks.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2026 (74% as at March 2025). Improving implementation of national improving working lives actions for junior doctors following national letter May 2024. Organisational capability and capacity to fully support LID, external support being sought.

Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing. Launch of digital appraisal process. Windows into Wellbeing. Leading through change' workshops to support and equip UHS leaders to manage and understand organisational change, lead people and teams through change, and create an environment which facilitates successful change. Regular communications for all staff including briefings and 'Talk to David' sessions, further complemented by targeted communications for specific staff groups such as 'Connect' for senior managers and leaders, and briefings for medical staff. This includes 'UHS Voice' with executives visiting individual teams to ensure this is accessible for all. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed – cohort 2. Cohort 3 advertised. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake. A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments. Inclusive recruitment review undertaken. EQIA Panel.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks.	Maturity of staff networks. Maturity of datasets around EDI, and ease of interpretation.

Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25 and beyond. NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area. An independent external review has highlighted issues relating to culture, capability, and capacity within the UHS portering service. Work is underway to address these concerns including negotiations with the Unite union.
Key actions	
2025/2026 led by CPO SH Continue implementation of the inclusion and belonging strategy within available financial and people resources. Delivery of Organisational Development support to complement organisational change. Ensure that equality impact assessments are completed and monitored through the EQIA review group. Establish a Violence & Aggression executive led board to oversee and expedite this workstream.	

World class people

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

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

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

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the organisations risk appetite however the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 4 16	October 2025	3 x 2 6	March 2029

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 3 12	4 x 3 12	4 x 3 12	4 x 3 12	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed in October 2025 by the responsible executive. No significant changes have been made as the national long term workforce plan is still awaited and UHS has engaged with the call for evidence which is currently underway to inform this.

Key controls	Gaps in controls
Education Policy	Quality of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development
Access to CPD funding from NHSE WTE and other sources	Releasing staff to attend core training, due to capacity and demand
Executive succession planning	Releasing staff to engage in personal development and training opportunities
VLE relaunched to support staff to undertake self-directed learning opportunities.	Limited succession planning framework, consistently applied across the Trust.
TNA process completed for 2025/26.	Areas of concern in the GMC training survey
Escalation to NHSE with offer to assist in identifying future solutions.	National CPD guidance for 2025/26: scope of application is limited by rigid national rules.

£175k of charitable funds 2025/26 to support education for staff who do not qualify for national CPD funding.	New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included. Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships.
Key assurances	**Gaps in assurances**
Level One (Internal) Trust appraisal process Utilisation of apprenticeship levy. **Level Two (Internal)** Annual Trust training needs analysis reported to executive. Talent development steering group People Board reporting on leadership and talent, quarterly **Level Three (External)** GMC/NETs Survey Education review process with NHSE WTE.	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.

Key actions

Actions are overseen by CPO SH with operational leads indicated where appropriate and will be carried out through 2025/26 and into 2026/27.

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

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

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

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

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

- Deliver a second year of leadership development framework including Strategic and Senior Leaders programmes, Operational Leaders and Implement Team Leaders Programmes – complete.

- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes – complete.
- Roll out of a targeted programme of development for Care Group Clinical Lead – complete.

A review has taken place within T&D to look at the infrastructure and longterm workforce plan and was presented to POD in Q2 2025/26.

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
173	Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training.	3 x 3 = 9	3 x 1 = 3	31/12/2025
833	Safeguarding children Statutory Training Compliance Levels are below required.	4 x 3 = 12	4 x 1 = 4	31/10/2025
894	Delivery of training and development for staff may be compromised if funding is not available due to national restrictions	4 x 3 = 12	2 x 2 = 4	31/03/2026
900	Concern regarding insufficient, unfunded critical care education provision to meet service need and direct impact on staff and patient safety.	3 x 5 = 15	2 x 2 = 4	31/12/2025

Integrated networks and collaboration

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

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

Cause	Risk	Effect
Historical structures and culture have not encouraged or enabled collaborative networked pathways. Additionally, and more acutely, NHS organisations are challenged by capacity and financial constraints at present, limiting the ability to network and grow strategically, as available resource is directed to managing current issues instead.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.

Category	Appetite	Status
Effectiveness	Cautious *The current risk rating sits within the tolerable risk appetite and the target risk rating sits within the optimal risk appetite.*	Treat

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

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been continually reviewed and updated with the executive leads throughout 2024/25 and 2025/26 and minor changes made to the controls, assurances, and actions, to ensure it is up to date. Significant work is underway to advance integrated and networked care and progress continues to be made. There is an expectation that this will take time to establish and embed as it is a complex workstream due to the number and nature of stakeholders and the need to engage and negotiate with them, both internally and externally.

It is noted that current pressures and directive to reduce workforce spend across the NHS may impact on the ability and capacity to execute plans if these are not adequately resourced, however the requirement for savings and efficiency may also assist as a driver for working collaboratively. Additionally national direction is shifting accountability, drawing clearer lines in responsibilities between Trusts and commissioning bodies, which may empower organisations to engage in networking when there are clear benefits to be maximised.

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

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

Key actions

Business case for future working of the Southern Counties Pathology Network has been developed following a CFO/COO workshop Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment and is anticipated to be shared at all relevant Boards in November/December 2025. Once all Boards have approved this it will move into the first phase of implementation. (CEO DF).

UHS to take over the lease of the elective hub from April 2026 and run theatres from July 2026. Funding has been approved and a letter of support from the ICB received. (CEO DF).

A high level options paper has been developed for Upper GI across UHS and UHD. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this. However there is not current alignment across the three organisations on how this will be delivered therefore this is now with the ICB for consideration of how this is commissioned. This is likely to be a longer term piece of work over the next few years led by the ICB. UHS and other providers are currently completing returns to support this decision and define what the service will look like.

Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. This will be worked up into a business case ahead of 2026/2027. Plastic leadership has also been strengthened within UHS to support this change. (COO AH)

Planning underway to increase performance supported by a common assumption across the system and leadership from David French for the ICS elective programme. However, the Indicative Activity Plan (IAP) is lower than our current run rates resulting in termination of outsourcing in most specialities. A demand reduction plan is required before 2026/2027 and UHS are engaging with ICBs and Specialised Commissioning who are leading this.

Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2037 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this. There will be a need to consider clinical reconfigurations to bridge this gap however a forum hasn't yet been established. UHS are keen to work closely with HHFT on this to ensure that we understand any need for redirection of emergency or urgent presentations in the South, which are likely to be the elderly or frail population, and maternity. This is a longer term aspiration.

Completed

NHSE has approved the business case, and funds have been received, for the Winchester Elective Hub which opened September 2025.

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

Urology Area Network plan was agreed however progress had stalled due to lack of programme management resource and the clinical lead stepping down, alongside challenges in aligning clinician availability across the organisations. This workstream has not come to fruition and is not currently being taken forward.

Foundations for the future

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

- **A reducing cash balance impacting the Trust's ability to meet payment terms for suppliers and staff, meet statutory requirements such as payments to HMRC, and invest in line with the capital plan.**
- **NHS England imposing additional controls/undertakings.**

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

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (including NCtR and mental health), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position and that our cash balance will significantly reduce resulting in an inability to make payments to suppliers and staff, and make payments in line with our statutory requirements.	This may directly impact the organisation's operational ability to provide care to patients if services or staffing are withdrawn due to failure to make required payments. Additionally it may impact on the organisation's ability to grow and transform due to limitations in investment.
Category	**Appetite**	**Status**
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the long term target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Interim & long term target (I x L)	
4 x 5 20	April 2022	5 x 5 25	October 2025	5 x 4 = 20 5 x 3 = 15	April 2026 April 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	3 x 5 15	3 x 5 15	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 25	4 x 5 25

Current assurances and updates

This risk was reviewed by the Chief Finance Officer in October 2025. Following reassessment in August when the risk rating was increased from 20 (severe x certain) to 25 (catastrophic x certain) it is confirmed that this is still accurate in recognition of the significant and sustained fiscal pressures currently facing the Trust, with the declining cash balance and associated operational impact the most immediate concern.

The financial recovery plan continues to be implemented and monitored, with an improving trajectory and midyear deficit reported of £31m. However, it is acknowledged that as operational pressures increase in the coming winter months, likely resulting in increased NHSP usage and surge capacity, this does pose a risk.

As referenced above, the most significant risk is in relation to the availability of cash and the controls within this risk have been updated to reflect business continuity should this risk be realised, and the action plan updated to reflect proactive steps underway to manage and reduce this risk.

Key controls	Gaps in controls
Internal • Financial strategy and Board approved financial plan. • Financial recovery plan. • Newly (2025/26) established Financial Improvement Group supported by the Financial Improvement Director.	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels.

• Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits. • Implementation of revised recruitment controls, including revised Affordable Workforce Limits (AWLs), reduction in clinical recruitment, and a freeze on non-clinical recruitment. • Robust business planning and bidding processes • Robust controls over investment decisions via the Trust Investment Group and associated policies and processes • Monthly VFM meetings with each Care Group • Monthly cash flow forecast review. Improving Value transformation programme. • Mutually Agreed Resignation Scheme. • Time managed payments to control cash flow. **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved "grip and control" measures with consistent application across all organisations. **Business Continuity** In the event of zero cash availability, national support to maintain payments for regulatory requirements such as HMRC, and staff payments of salary and pension. Should key resources become unavailable due to inability to pay suppliers, operational management would include established methods of escalation and oversight including HIMTs and emergency Board meetings. This would include risk stratification to minimise impacts to patients as well as diversion of patients/mutual aid if we were unable to provide essential care.	• Funding for further rounds of the Mutually Agreed Resignation Scheme. **System wide/external** • Elements of activity growth unfunded via block contracts. • Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance.
Key assurances	**Gaps in assurances**
Level One & Two (Internal) • Regular finance reports to Trust Board & F&IC. • Full financial report for the system to Trust Board. • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability.	• Current short-term nature of operational planning • Lack of assurance in ability to deliver system wide plans focussing on reduction in NCTR, and mental health. • Concern over any further industrial action not incorporated into plan.

• Regular reporting on movements in overall productivity. Monthly cash reporting to F&IC. **Level Three (External)** • Monthly CFO Meeting • Monthly ICB report on all provider positions • Regional scrutiny meetings.	

Key actions

Ongoing Actions

- Delivery of 2025/26 financial plan (CFO, IH).
- Set programmes/projects for delivery as part of the Financial Improvement Group – underway and ongoing throughout 2025/26 and into 2026/27 (CFO, IH).
- Workforce forecasting and delivery of workforce reduction schemes (CPO, SH).
- Develop and implement a financial recovery plan throughout 2025/26 (CFO, IH).
- Prepare and negotiate contracting arrangements ahead of 2026/27 (CFO, IH)
- Maximise opportunities throughout 2025/26 to bid for national cash support and recover any outstanding cash due to UHS (CFO, IH).

Completed Actions

- Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete.
- Reset CIP and transformation programmes based on 25/26 targets – complete.
- Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway and established.

Foundations for the future

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

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

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services.	There is a risk that our estate will prohibit delivery and expansion of clinical services. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.	This would result in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 4 16	April 2024	4 x 5 20	October 2025	4 x 2 8	April 2030

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed with the Chief Finance Officer, and Director of Estates, Facilities and Capital Development, in October 2025 with no revisions to the current or target risk ratings required.

Plans to address backlog maintenance remain on track although it is acknowledged that there is an increased risk of delivery due to the recent reduction in headcount of 10% and reduction of non-PAYE spend of 10%, alongside the recognised risk of adequate funding. To maintain safety prioritisation is given to statutory and mandatory work, as well as any helpdesk inquiries risk assessed as priority one or two.

Planning for 2026/27 is underway, informed by the six facet survey, with a currently anticipated budget of c.£5m although it is likely that this will reduce.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Scale of investment and funding is insufficient to fully address identified gaps in the critical infrastructure.
Up-to-date computer aided facility management (CAFM) system – new system is in the process of procurement and implementation.	Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain.
Asset register (90% in place)	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
Maintenance schedules	Lack of decant facilities.
Trained, accredited experts and technicians	Reactive system requires re-prioritisation review.
Asset replacement programme	Planned maintenance will drop out of the asset register work.
Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)	Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits.

Six Facet survey of estate informing funding and development priorities Clear line of sight to Trust Board for all risks identified. ICB Infrastructure plan completed 2025/26. Review exercise of EFCD business continuity plans, and implementation of action cards, occurred 2024.	
Key assurances	**Gaps in assurances**
Level One & Two (Internal) Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors **Level Three (External)** Six Facet Survey NHSE Assurance Visits Authorised engineer audits	
Key actions	
Ongoing Actions Develop estates strategy following the finalisation and agreement of the estates masterplan and ICB infrastructure plan – March 2026, DJ. Update and renew the Trust's Green Plan which will support reduction in backlog – December 2025, DJ. Identify future funding options for additional capacity in line with the site development plan, throughout 2025/2026 and 2026/2027 – Executive team supported by DJ for delivery. Implement the HIOW elective hub in 2025/2026 - Executive team supported by DJ for delivery. Delivery of 2025/26 capital plan - DJ. Deliver £8.3m of critical infrastructure backlog maintenance in 2025/26 - DJ. **Additional actions to be agreed/progressed in the future** Agree plan for remainder of Adanac Park site. Site development plan for Princess Anne hospital.	

Linked operational risks					
No.	**Title**	**Initial Date**	**Current risk rating**	**Target risk rating**	**Target Date**
16	Estates Maintenance PPM Programme	26/06/2019	4 x 2 = 8	4 x 1 = 4	28/11/2025
157	Site wide electrical infrastructure resilience, HV and LV.	05/03/2019	4 x 3 = 12	4 x 1 = 4	30/11/2025
260	Insufficient space in the induction of Labour Suite.	28/10/2019	4 x 4 = 16	4 x 1 = 4	31/12/2025
421	There is a risk that the Trust does not appropriately manage or maintain its assets.	28/08/2020	4 x 3 = 12	4 x 1 = 4	30/12/2025
489	Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures	07/02/2021	5 x 3 = 15	5 x 1 = 5	31/03/2027
727	Black start electrical test	25/07/2023	5 x 2 = 10	5 x 1 = 5	31/12/2025
773	Impact of the Building Safety Act (2022) on Capital Project Delivery	24/01/2024	3 x 3 = 9	3 x 2 = 6	30/11/2025
817	Lack of UPS backup on power failure	28/05/2024	5 x 3 = 15	5 x 1 = 5	31/12/2025
818	Centralised Chilled water system - power supply resilience	28/05/2024	5 x 2 = 10	5 x 1 = 5	31/07/2026
846	PAH – General ward areas and Neonatal Unit air handling units beyond service life	11/10/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
851	Lab and Path Chiller 1 Aged and Not Operational	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
853	Lab and Path Chilled Water Pumps	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2025
854	P.M.S Computer room AC Chillers	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2025
855	West Wing SHDU AC Units - Beyond Service Life	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
856	Non-compliant & unmaintainable fire dampers in West wing	12/11/2024	5 x 3 = 15	5 x 1 = 5	31/12/2025
875	John Atwell ward, Single means of fire escape, non-compliant to HTM 05:02, Fire safety legislation.	11/02/2025	5 x 2 = 10	5 x 1 = 5	31/12/2025
876	Fire-fighting dry riser water supply accessibility to Urology Centre, Day surgery unit, is non compliant to HTM 05:02, current Fire legislation.	11/02/2025	5 x 2 = 10	5 x 1 = 5	31/12/2025

Foundations for the future

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

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	4 x 3 12	October 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

This risk has been reviewed with the Chief Operating Officer, and Chief Information Officer, in October 2025 with no revisions to the current or target risk ratings required.

Further assurance in relation to cyber security is noted:

- Following the previous reported cyber security incident whereby the Ivanti Endpoint Manager Mobile equipment was accessed by unauthorised users, the ICO have confirmed that they do not have any concerns and no further action is required.
- Two cyber security audits are underway, one as part of the internal audit schedule, and the other via NHSE.
- The UHS Board completed the NHS Board Cyber training on 07th October, and this contributes to our DPST scoring.
- Implementation of MIYA went live on 08th October with no significant issues reported. This also enhances cyber security as it removes a soon to be unsupported alternate system, replacing it with a cloud based system enhancing reliability.

There is also assurance that the upgrade to Windows 11 is now complete for the majority of Trust devices. Those outstanding are unable to be upgraded at this time as medical devices are reliant on them running older versions of Windows, therefore Microsoft have now released an Extended Security Update to maintain usability for a further year.

Key controls	Gaps in controls
Failure in physical network infrastructure • All Digital UPS tested. • Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this. • Replacement of key infrastructure on a case-by-case basis once it fails.	**Failure in physical network infrastructure** • The current Data Centre is end of life and requires a capital plan for replacement. • There is currently no phased replacement of switch and network equipment due to absence of funding.
Cyber Risk • Cyber security infrastructure refreshed and in place. • Staff training on cyber risks, with regular refreshers and clear policies. • Key cyber roles recruited to, with one remaining outstanding.	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover.	**Single points of failure in staffing** • Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry.
Implementation and sustainability of digital technology • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout planned for 2025/26. • Single EPR business case via NHS England EPR Investment Board.	**Implementation and sustainability of digital technology** • Funding to cover the development programme, improvements, and clinical priorities.
Loss of access to critical IT systems & business continuity • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Scenario testing completed. • All wards have a business continuity device in situ allowing access to patient records in system outages. • Separate telephone systems are set up in critical areas such as ED to facilitate communication in the event of phone lines being unavailable.	**Loss of access to critical IT systems & business continuity** • Time to fully stress test business continuity plans. • Digital can advise clinical teams on business continuity plans but do not own these.

Key assurances	Gaps in assurances
Level One & Two (Internal) Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed weekly on UHS Digital leadership team call. UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams. UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc). Standardised change control, testing, and assurance processes implemented across the Development team. Trust Board Study Session digital update (June 2025). **Level Three (External)** KLAS clinician usability surveys every 3 years NHSE annual DPST assessment completed to highlight gaps in services. Annual digital framework capability assessment	Funding to cover the development programme, improvements, and clinical priorities. Difficulties in understanding benefits realisation of digital investment. ICS digital strategy yet to be agreed. UHS digital strategy to be reviewed (runs until 2026 but requires prior review).

Key actions

Recruitment

- Ongoing recruitment of key Digital resource to mitigate operational risk throughout 25/26 and 26/27 where recruitment controls allow – JT
- To support the above, leverage capital funding to bring in additional resource where appropriate – JT.
- Inpatient noting for doctors scheduled for 2025/26 (currently testing in a live environment of cancer care, to be rolled out further Q4 2025/26). JT.

Replacement of key clinical systems to more modern systems & future development

- Implementation of MIYA in 2025/26 (complete – JT).
- Roll out of single EPR across HIOW, forecast to go live April 2029. JT.
- Lessons learned from LIMS project were shared across UHS Digital, Estates, and other major project teams.
- Continually identify opportunities for funding for digital transformation and programmes throughout 25/26 and 26/27 – opportunities tied to 10 year plan and medium term plan are now materialising (e.g. digital diagnostics capability programme, NHS 5 year capital plan). JT.

Completed

- Acceleration of cyber software upgrades completed 2024/25.
- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
282	Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity.	3 x 4 = 12	2 x 2 = 4	31/12/2025
634	Accommodation / Infrastructure - Fibre optic cabling at the ONH	4 x 3 = 12	3 x 2 = 6	29/09/2025

650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	29/09/2025
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	4 x 4 = 16	4 x 3 = 12	31/12/2025
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	30/05/2025
679	Accommodation / Infrastructure - Single point of failure on the UHS network (external connections)	4 x 3 = 12	4 x 1 = 4	31/03/2026
736	Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps	3 x 4 = 12	1 x 2 = 2	29/09/2025
757	Cyber Security – If there are unsupported server operating systems this could expose the Trust to cyber attack.	4 x 2 = 8	2 x 1 = 2	28/03/2025
829	Cyber Security - Windows 11 Roll-out before Win10 EOL	4 x 3 = 12	2 x 2 = 4	14/10/2025

Foundations for the future

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 4 8	October 2025	2 x 2 4	December 2027

Risk progression: (previous 12 months)	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8

Current assurances and updates

This risk has been reviewed in October 2025 by the responsible executive and Head of Sustainability with no significant changes. Resource and capacity to progress this workstream had reduced through part of the year due to vacancies, however the new Head of Sustainability is now in post and key actions are progressing such as the Green Plan which is being submitted to Board for ratification. This provides opportunity to drive this at a strategic level although resource at an operational level is still insufficient to progress this at pace.

Key controls	**Gaps in controls**
Governance structure including Sustainability Board Clinical Sustainability Lead Head of Sustainability and Energy Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan 2022-2025.	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy Communications plan. Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change. A proposal for champions has been submitted to TIG ad approved, however recruiting to the roles hasn't yet occurred due to the recruitment controls in place. Do not have a fully funded plan to achieve the national targets set out. Future funding streams are uncertain.
Key assurances	**Gaps in assurances**
<u>Level One and Two (Internal)</u> Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones.

Sustainability Board **Level Three (External)** Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators.	

Key actions

All actions are planned throughout the remainder of 2025/26 and 2026/27 and are led by the Head of Sustainability AT with executive oversight by CMO PG.

Ratify the 2025-2028 Green Plan in Q3 2025/26 and then implement this.

Develop KPI metrics in respect of the Trust's Green Plan and other related strategies.

Recruit a sustainability Manager to provide operational leadership – by the end of 2025/26.

Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore low carbon skills funding). This includes funding secured for LED lighting.

Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. This aims to increase the use of electricity, including solar panels, and phase out use of gas.

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED and repurpose cardiovascular catheters.

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

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED.

University Hospital Southampton
NHS Foundation Trust

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

Purpose

(Re)Assurance	Approval	Ratification	Information
		x	

Strategic Theme

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

Executive Summary:

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

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

There have been no actions since the last report.

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

Contents:

Report

Risk(s):

N/A

Equality Impact Consideration:	N/A

1 Signing and Sealing

1.1 **Retrospective Licence** for Works relating to part of Main Entrance Retail Area, Southampton General Hospital, Tremona Road, Southampton, SO16 6YD, between University Hospital Southampton NHS Foundation Trust (Head Landlord), Akzo Nobel CIF Nominees Limited (Landlord), Compass Contract Services (UK) Limited (Tenant) and Compass Group Holdings Public Limited Company (Tenant's Guarantor), for works carried out by Compass Contract Services UK Limited (trading as Costa) for the refurbishment of Unit 1. Seal number 305 on 12 September 2025.

1.2 **Compound Licence and Licence to Carry Out Works** between University Hospital NHS Foundation Trust (Superior Landlord), Just Retirement Limited (Landlord), Prime Infrastructure Management Services 4 Limited (Licensor) and IHSS Limited (Licensee) relating to Ground and First Floor Sterile Services Unit and Offices at Adanac Drive, Adanac Park, Southampton. Seal number 306 on 10 October 2025.

2 Recommendation

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.3 Report to the Trust Board of Directors, 11 November 2025	
Title:	Health and Safety Services Annual Report 2024-25
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Spencer Scott, Health and Safety Advisor

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This report outlines the key activities carried out by the corporate team, delivering the services of health and safety (H&S), moving and handling (M&H) and FFP3 Resilience from 1st April 2024 to 31st March 2025.

Members of Trust Board are asked to continue to support the following key staff safety matters contained in the report which help to maintain the safety culture at UHS. Issues to highlight during 2024/25:

- The number of serious incidents to staff, RIDDOR notifiable incidents which UHS has a duty to report to the Health and Safety Executive (HSE), has significantly increased to 68 from 39 in 2023/24;
- The H&S AERs across the Trust is on a downward trend over the last three years, with the rise in RIDDORs this is a concern. AERs raised for Violence and Aggression incidents remain at levels similar to last year;
- M&H issue: #843 Corporate Risk Register issue, see Alert section;
- Staff exposed to infectious respiratory diseases and/or are involved in aerosol-generating procedures are required to be fit tested to two models of FFP3 mask (or a PeRSo respirators) where appropriate. Improvements are required across some areas of UHS to ensure more staff have been tested to two FFP3 masks, refreshed every two years;
- The H&S Service undertake investigations into reported accidents to staff and make recommendations/ actions plans to local management to follow up. Local managers should feedback through their governance meetings to highlight progress made;
- There are four areas highlighted in the Alert section which have been escalated by the H&S Team or others.

Graphical summaries are provided of the top five causes of adverse events relating to staff health and safety, which are: violence and aggression, moving and handling, slips, trips and falls, sharps incidents and collision/contact with objects.

The Health & Safety Services Team continues to provide advice, guidance, training and support to staff, managers and senior leaders to ensure that the Trust's statutory duties are met with regard to staff health and safety in the workplace; this supports the Trust values so that a positive health and safety culture is embedded into all of the Trust's activities.

NHS Employers have produced a Workplace Health and Safety Standards document (2023) which provides the basis of effective health and safety management to support staff and ensure organisations are compliant with legislation, link below:
https://www.nhsemployers.org/publications/workplace-health-and-safety-standards

Contents:	
Paper Appendix 1 - Graphical Summaries of H&S Data 2024-25 Appendix 2 - Staff Radiation Incidents 2024-25	
Risk(s):	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.	
Equality Impact Consideration:	N/A

ALERT	
Risk Register; changes, escalations	RR #843: There is no flat lifting kit at the Royal South Hants Hospital and no flat lift kit available for the main public entrance at Southampton General Hospital. If staff need to deal with someone who has fallen and is at risk of spinal injury/ #NOF they do not have the correct equipment for flat lifting of the patient without risk of MSK injury. At the RSH this may lead to a lengthy wait for an ambulance.
HSE / CQC Interventions	An HSE Specialist Inspector undertook an inspection of the Containment Level 3 laboratory at SGH on 5th June 2024. The inspection resulted in a formal letter being sent to the Chief Executive (dated 13th June), which required a management review of staff lone working and a review of recording staff training to demonstrate competencies. Following the response made by the local management no further actions were undertaken by the inspector.

Information on health and safety escalations:

The following issues have been raised as alerts in the Corporate Health and Safety Team reports to other governance meetings.

1. <u>Entonox surveillance of the maternity staff</u>

The most recent staff Entonox exposure monitoring was undertaken on 18/19 March by Workplace Exposure Ltd (Occupational Surveillance Consultancy) as part of UHS duties under Control of Substances Hazardous to Health Regulations - Entonox used by birthing mothers is known to have health risks to staff with long-term exposure. The Health and Safety Executive (HSE) set a national *Workplace Exposure Limit* for Entonox (Nitrous Oxide) which the report on the monitoring undertaken detailed was exceeded for two members of staff, and high levels for other staff were recorded. Actions need to be taken to lower the exposure levels, which could include either: scavenging equipment; cracking equipment; or extract ventilation for all rooms where Entonox is used.

A working group has been set up to look at the actions that can be taken to reduce the staff exposure from nitrous oxide and will report into the Medical Gases Committee. Also, a report has been requested to be presented at the October Corporate Health and Safety Committee (CHSC). Further personal exposure monitoring is to be undertaken in 2025/26 by the W.E. Ltd Consultancy.

2. <u>Display Screen Equipment (DSE) compliance</u>

UHS has seen an widespread use of DSE and laptops linked to an increase use of electronic record keeping including E noting. This was investigated in 2024 following feedback from staff, and a report was presented to the Corporate H&S Committee due to concerns about compliance with the Health and Safety (Display Screen Equipment) Regulations 1992. The issue was raised again in the July CHSC meeting.

A review of Therapies staff workstations set up and practices identified DSE posture concerns, with an action plan being drawn up between H&S and local manager in

December. The Therapies work identified the need for a project to look at laptop use on wards to highlight how the risks of poor posture, which can lead to musculoskeletal pain and increased absence, is being managed. The H&S Team undertook visits to wards in Q4 where observations were undertaken and those staff who were laptop or tablet users were asked to complete a short survey.

Care Groups and Departments should review DSE workstations and ensure staff annually complete the VLE DSE self-assessment module and review the work activities of their staff who are required to use laptops on ward and follow up on any actions identified in the self-assessment. A corporate working group on DSE standards will meet in September to review practices across UHS.

3. Pharmacy Goods-In Store, SGH loading bay:

Both the Trust H&S Adviser and Fire Safety Officer have raised concerns, with non-compliances identified with the building structure situated within the SGH loading bay: fire door replacement required, and size of structure for activities undertaken needs review. The pharmacy logistic activities and demands in this area, the storage and distribution of goods (including sterile bottles) has outgrown the unit. Fundamentally the store is not big enough to take the increasing levels of goods being received and the use of a powered pallet truck in the restricted space creates H&S risks which need to be managed and resolved. This issue has been recorded on the Divisional risk register. Local management actions cannot mitigate all the risks identified, and alternative measures have not yet been identified. Senior managers need to be aware of this risk.

4. Workplace Temperatures

During the warmer months the health and welfare issue which is most regularly concern raised with the H&S Team directly during visits, via AERs or during the H&S meetings is the high workplace temperatures. Some of these areas across UHS are able to take appropriate action and have temporary mobile aircon units provided, but not all. This is an issue which has also been regularly raised by the Unions over the year.

The Estates Team have been open and responded by having thermometers fitted to a number of wards across Southampton General Hospital and Princess Anne Hospital. A further 50 thermometers are being distributed to the workplaces which haven't previously been provided. Guidance to staff on hot workplace temperatures is held on Staffnet

Unions have provided temperature charts to some wards to assist with them monitoring indoor temperatures.

Escalations for action by Divisional Management Team	The four items detailed for escalation above have all been raised at Divisional Governance meetings.

ADVISE

Summary of significant H&S-related incidents and RIDDORs

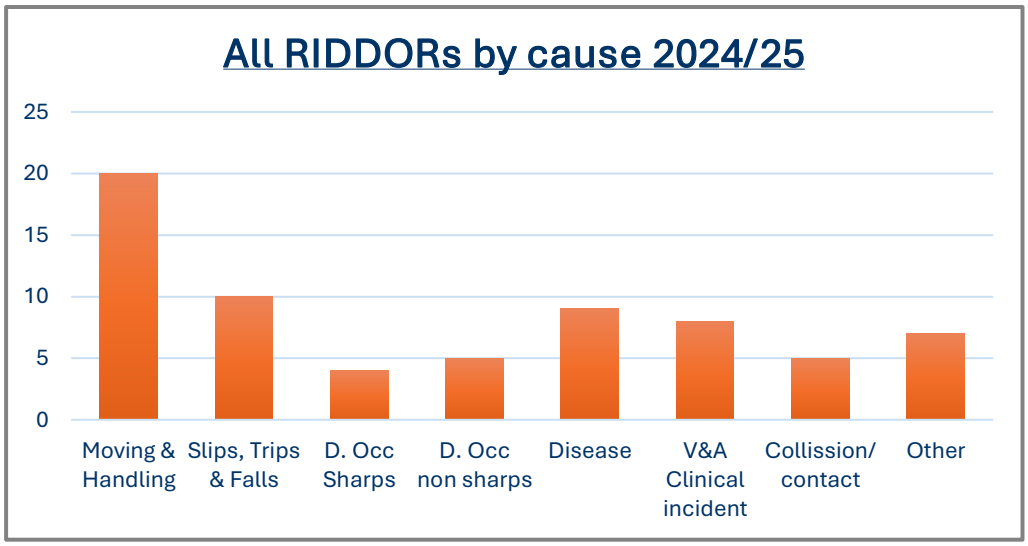
RIDDOR Reportable Incidents

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

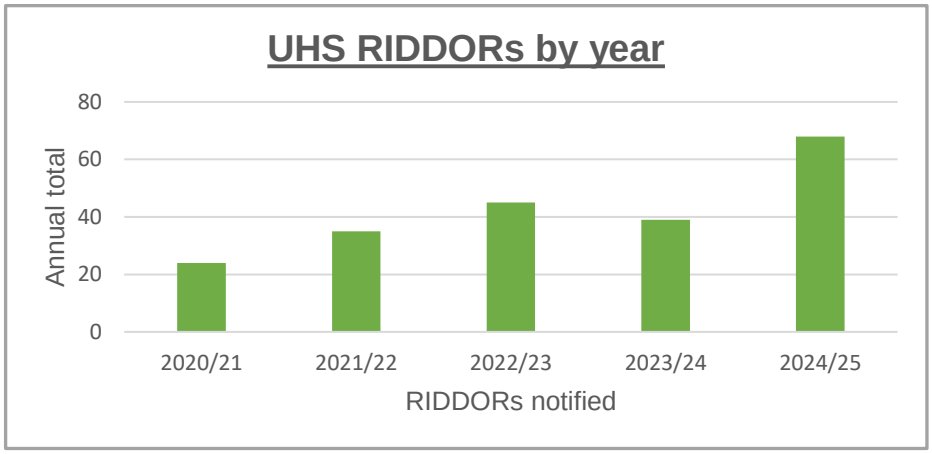
Monthly RIDDOR Panel meetings continued to review reportable incidents/cases and involves the Trade Union Representative. The review panel ensures investigations have been carried out appropriately, any outstanding actions are followed up and the lessons learnt to help prevent recurrence are shared.

A total of sixty-eight incidents were reported under RIDDOR, cause type detailed in the graph below.

Graph 1. RIDDORs by Cause 2024/25



Graph 2. RIDDORs by year comparison



	Graph 2 demonstrates that RIDDORs are up across the Trust in 2024/25 compared to previous years. When drilling into the data there is no one *cause type* which can be attributed for the significant increase, although M&H has doubled, more an increase of the normal H&S causes across the board. The big 5 causes as identified in the historic AERs received are, *V&A, Sharps, Moving and Handling, Collision's, Slips and Trips* are all represented in the figures.

ASSURE	
Proactive Monitoring; inspections/audits	Daily proactive monitoring of H&S AERs is undertaken to identify incidents which require further investigation or being highlighted to Care Groups/ Divisional Governance. Audits and inspections have been raised elsewhere in the report.
H&S issues	The Corporate Health & Safety Committee (CHSC), chaired by the Chief Nursing Officer (CNO), have met quarterly in line with the Terms of Reference; the group monitors the Trust's activities in relation to staff health and safety, moving and handling and FFP3 resilience, receiving quarterly reports from all three services. The Committee also receives quarterly reports from Divisional Risk and Governance Groups and key supporting departments (EFCD, Occupational Health) and an annual report of non-clinical claims from the Claims & Insurance Department. However, it should be noted that there are *no regular health and safety metrics or key performance indicators* which are reported on regularly basis to any UHS groups by H&S Service Team. It has subsequently been agreed that reporting will be through People Board and will commence no later than Q3 in 2025/26. Appendix 1 provides graphical summaries of the staff-related adverse event statistics from 1st April 2024 to 31st March 2025. **Summary of the Moving & Handling Service** The Moving and Handling Team (M&H) advises and supports the wards to ensure staff are "Happy, Health and Here" and to ensure statutory duties are met with a focus on the clinical environments. Members are asked to review the matters below and continue to support the work the team completes: • M&H RIDDOR's have increased over the year compared to the previous period, rising to twenty, which is 30% of the total RIDDOR's reports; • There is still no flat lifting kit at the Royal South Hants Hospital and no flat lift kit available for the main public entrance at Southampton

General Hospital. These concerns are captured in the Corporate Risk Register #843;

- 124 Statutory and Mandatory clinical face to face training events has been delivered in our training room. For the training provided there is a no-show rate of 20%, this is in line with other training within the Trust;
- The team undertook 53 complex workstation assessments. Independent providers would charge £395 for an equivalent assessment, which demonstrates the benefit of having this function in-house;
- The have been 370 ward visits undertaken over the year;
- A new plus size patient masterclass was run for Trust during the year, with 46 staff attending.

Train-The-Trainer clinical resources on wards:

- There are ninety-nine trainers in date and competent to undertake moving and handling training within their divisions and care groups. From April 2024 to March 20245 thirty more ward-based moving and handling trainers completed the Train-the-Trainer course and peer reviews. Five trainers have been discontinued, and one member of staff failed their peer review.
- We work closely with the University of Southampton and provide Train the Trainer clinical moving and handling courses to the University trainers. Twelve trainers were trained by the Moving and Handling Adviser in 2024/25. They provide training for the student nurses, midwives, and other allied professionals who have placements within our Trust. This provides a continuous competent standard across both organisation's.
- The Train-the-Trainer courses have been advertised on VLE and in our new Newsletters there has been an increase from the divisions for more moving and handling clinical trainers to be trained.
- The focus for the future is to have at least two trainers per ward/care group to support each other.
- The refresher course for moving and handling clinical trainers has continued and uptake is now improving the course includes statutory and mandatory moving and handling technique updates and a reflective practice peer review event, so staff learn from each other. Staff are being invited to attend as their HealthRoster skill expiries. Trainers have to attend every two years to remain competent, and it signs off their own level 2 training. Staff have commented they have found the course useful and informative.

Summary of the FFP3 Resilience Service

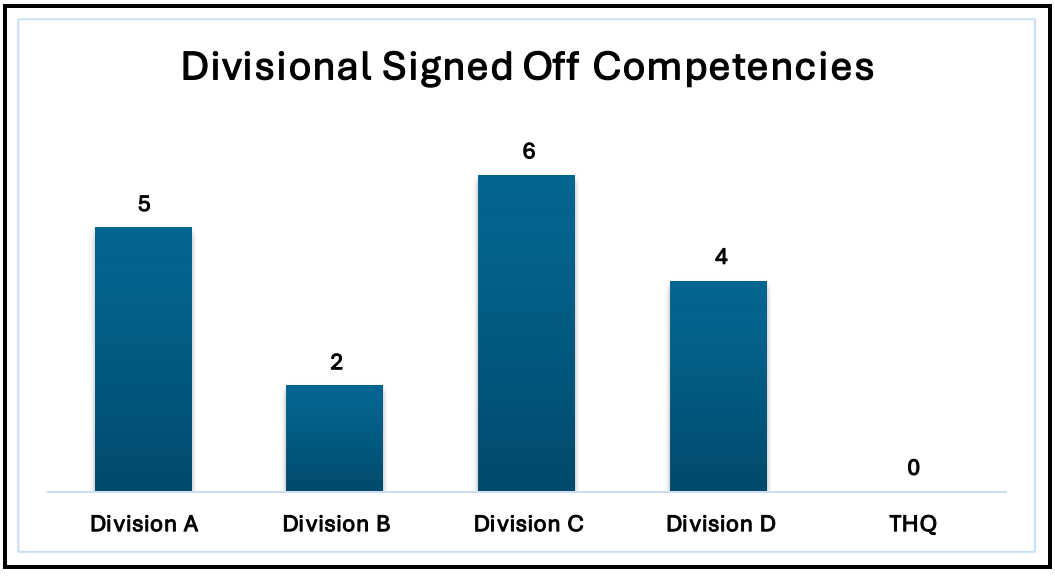
The delivery of the mask fit testing service is undertaken by Ian Peach.

The FFP3 Resilience Service has continued to deliver the central mask fit testing service, management of fit tester training, assessment of fit tester competencies and the servicing and distribution of PeRSo equipment.
The emphasis for this year was a return of the Central Fit testing Service and to train and sign off as many local fit testers as possible so that care groups could be self-sufficient in fit testing their staff. Another objective is to ensure all Fit Testing equipment was serviced and maintained as necessary and plans put in place to allow this to continue, particularly the servicing of the Portacount machines.

Fit Tester Training

In 2024/2025 we have continued to engage an accredited, external training provider and delivered twelve courses: Eighty eight staff have been trained as Fit Testers using the Portacount machine.

Fifty-one staff had their competencies signed off in the 2024/2025 and are competent to fit test. More will be signed off this year, but staff seem to find it very difficult to be spared time to complete their training, but they cannot fit test staff until they have had their competencies signed off. The introduction of the Fit Testers 3-Way agreement in 2025 has helped focus staff on completing their training.



Fit Testing Equipment

The loan agreement introduced earlier in June seems have made a difference to equipment being returned with items missing or damaged. The machines do seem to still be a little fragile on occasions so a 'Best Practice' Guide for Fit Testers will be being produced in 2025.

The first group of Portacount machines have now been sent to TSI as the servicing plans begin for 2025. This will ensure the Trust will have Portacount machines available for use by the Care Group Fit Testers when needed.

Fit Testing completed in the Central Fit Testing Hub

Total of Fit Tests Offered = 915
Number of Staff Fit Tested = 612
No-Shows = 220
No Uptake = 83

The Central Fit testing Hub has delivered over 20% of the total number of fit tests carried out in the last year. The 'no-shows' and no uptake of appointments have accounted for 33% of the appointments offered this year. Quarter 4 was a large improvement over Quarter 3 but is still frustrating that a third of appointments go to waste over 2024/2025.

We are continuing to help reduce this number by using the VLE system to send email reminders to staff with the details and instructions for their fit test appointment the day before their appointment is due. This now appears to be now having an effect in reducing the number of no-shows. It is appreciated that in a large, acute hospital members of staff cannot always leave their ward/department due to unforeseen pressures. However, mask fit testing is a key element of staff safety; line managers are asked to ensure that their staff are fit tested and are allowed to attend their appointments as a priority wherever possible.

The *Annual H&S Self-assessment Audit* completed by Ward Leaders and H&S Leads indicated that approximately 27% of relevant staff do not have an up-to-date mask fit.

PERSO Hoods
The Trust own a number of PERSO hoods which are currently stored on site. We are working with Estates to identify how many are stored and whether they are in working order before seeking a decision whether these are stored off site releasing parking spaces and reducing the cost of the container hire or whether the hoods are disposed of.

Corporate Health and Safety Training

The three corporate in-house health and safety courses were run during the year The *H&S Leads*, *H&S Risk Assessment*, and *COSHH Risk Assessment* courses These are booked on VLE. Other ad hoc training was provided to specific groups of staff including: PAH Theatres; Midwifery students; & microbiology staff. The candidate no shows across the three courses were 15%. There was a pause between June to November for the courses run, when the new H&S Adviser took up the training. The following table details attendance by staff, split by Division:

Table 1 Corporate H&S Courses attendance

	Division Attendees				
H&S Courses Q3	A	B	C	D	THQ/ WPL
H&S Leads intro	12	11	8	9	3
H&S Risk Assessment	8	14	12	11	5
COSHH Risk Assessment	4	6	6	5	2

There was a good level of engagement with the **Annual H&S self-assessment audit form** this year; a summary of the returns data from the H&S audit was presented to the CHSC in July. One area of improvement identified is the need to increase local monthly inspections undertaken.

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

Table 2 H&S AERs by year

Year	H&S AERs	V&A AERs	Total
2020/21	1441	605	2046
2021/22	1455	733	2188
2022/23	1279	764	2043
2023/24	949	1043	1992
2024/25	864	997	1861

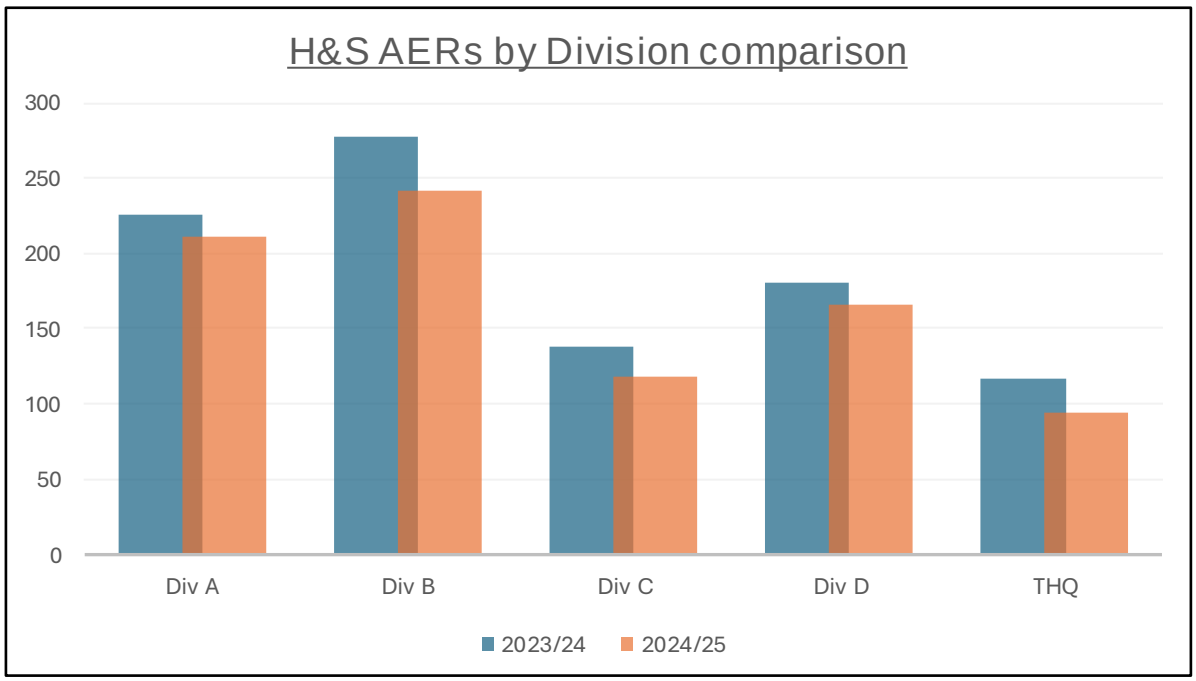
	Comparing incident numbers over recent years, the standout feature is a marked drop in health and safety AERs, a reduction of a third in H&S AERs in the last 2 years. This is of concern when considering the RIDDOR notifications to the Health and Safety Executive have increased to 68 – a 43% increase on the previous year. This is a pattern which will need to be monitored by Corporate Health & Safety Committee and other corporate groups. **Staff Radiation Incidents** Staff incidents caused by ionising or non-ionising radiations are either reported on Ulysses Safeguard at the time of the incident or discovered after the fact by occupational radiation dose monitoring; they are investigated and managed by the Radiation Protection team. Further details are included in Appendix 2.
UHS Policies, Procedures, Guidance	The Violence and Aggression at Work Policy was reviewed and updated:

Appendix other supporting documents:-

1. Graphical information on RIDDORs and H&S AERs;
2. Radiation Protection 2024/25 annual report.

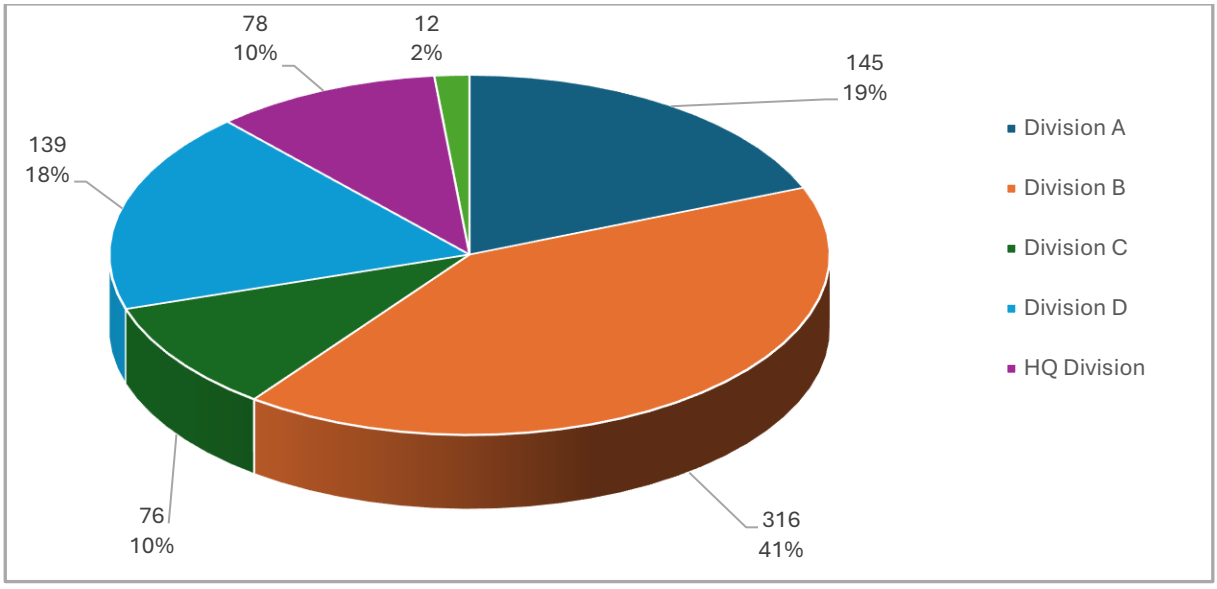
Appendix 1: Graphical Summaries of H&S Data 2024/25

Graph 1: H&S AERs by Division for 2023/24 and 2024/25

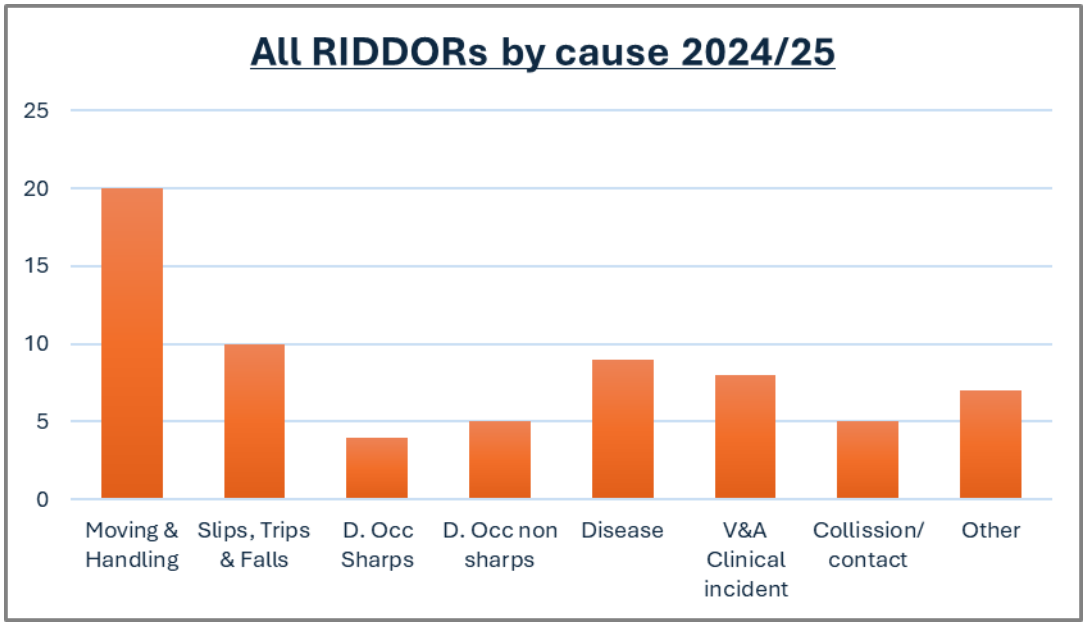


(Graph above excludes V&A and Challenging Behaviour AERs)

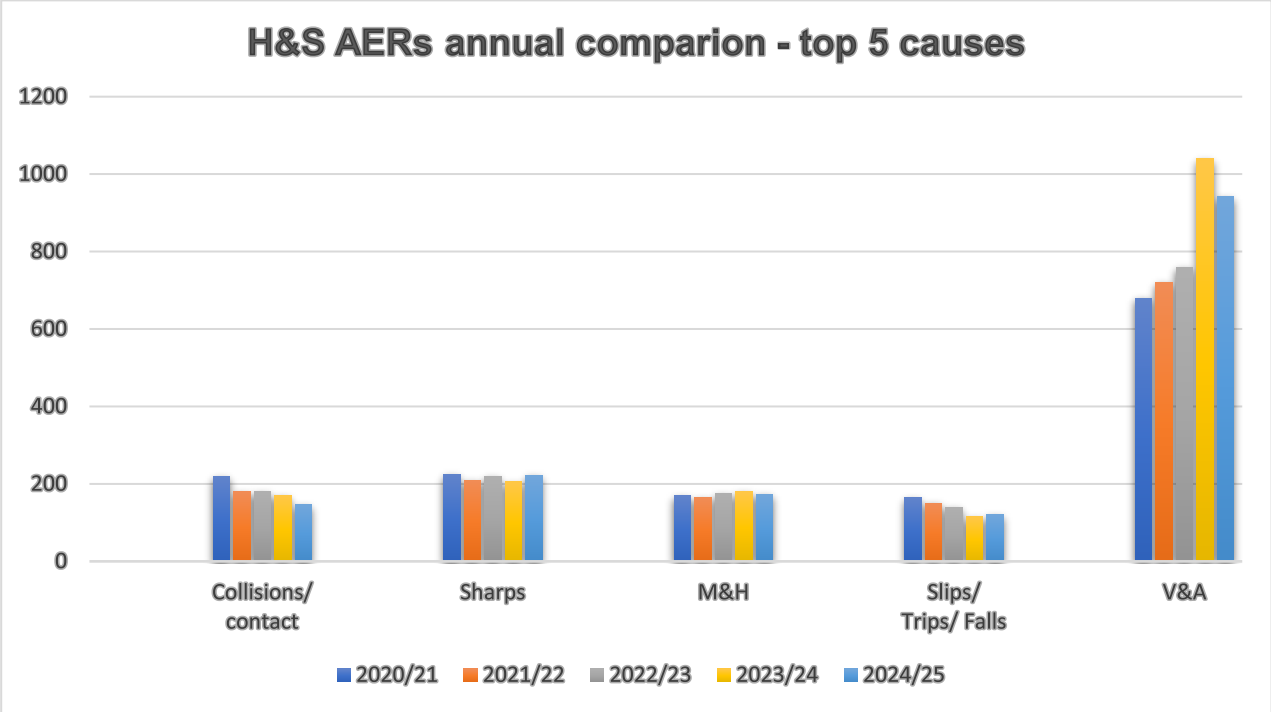
Graph 2: Number of staff injuries (H&S-related AER incidents) by Division 2024/25



Graph 3: RIDDORs 2024/25 by Cause



Graph 4: H&S AER top causes for last 5 years

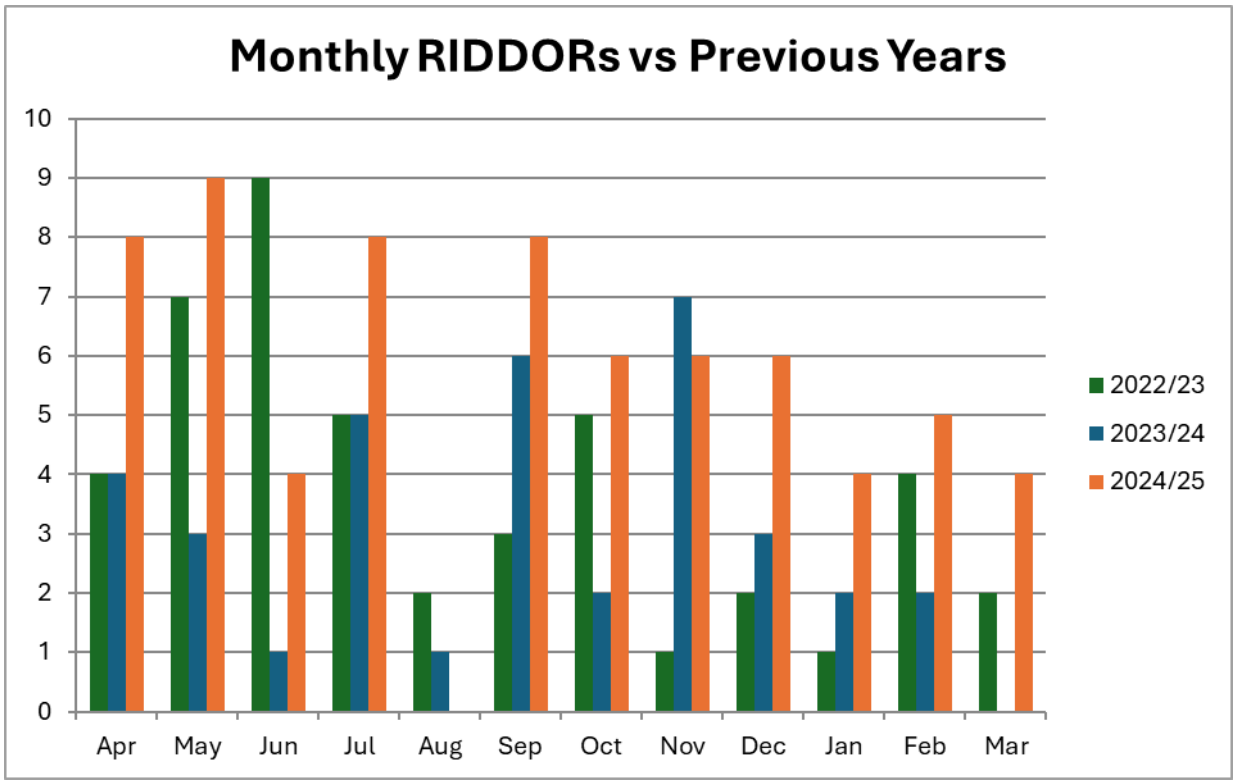


Health and Safety Leads for Divisions

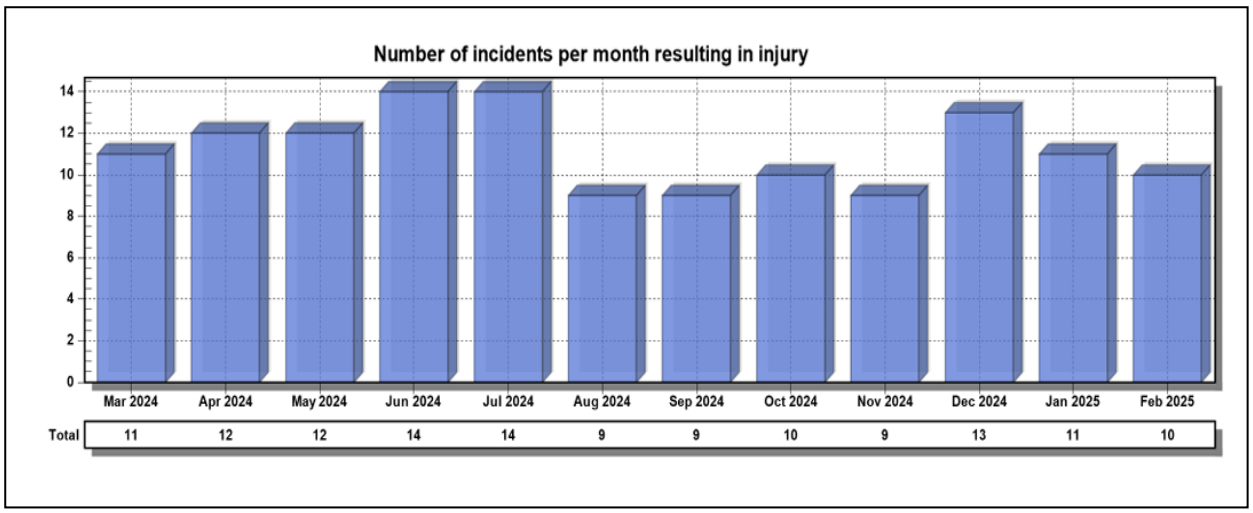
At the heart of the UHS approach for consulting with staff on health and safety matters are the *H&S Leads*, who's role is to feedback relevant safety, health and welfare information to staff and assist managers with risk assessments. Numbers across the Divsions is detailed in the table below, correct on 31/3/2025.

UHS H&S Leads		
Division	H&S Leads 2025 (March)	H&S Leads 2024
A	22	17
B	33	31
C	31	22
D	35	31
THQ	27	23

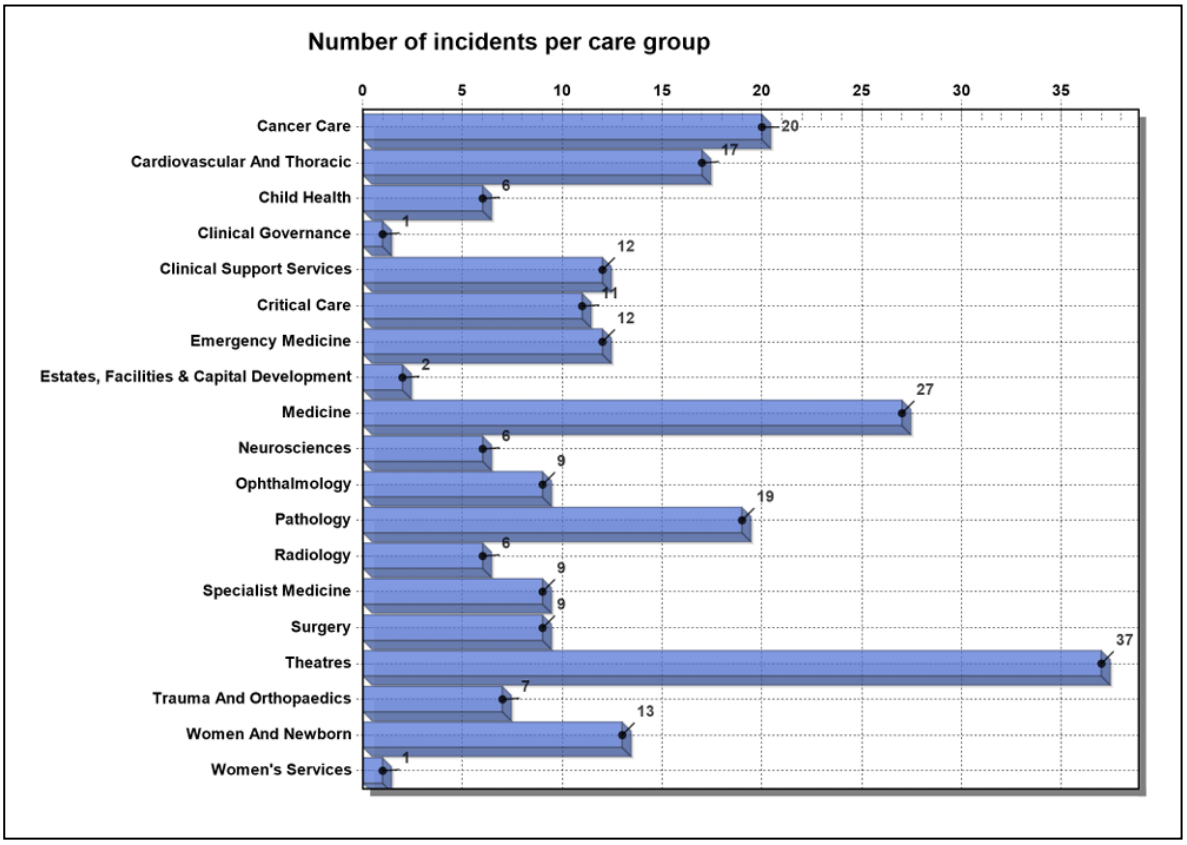
Graph 5: RIDDORs report by month comparison over 3 years.



Graph 6: Sharp incidents by month 2024/25

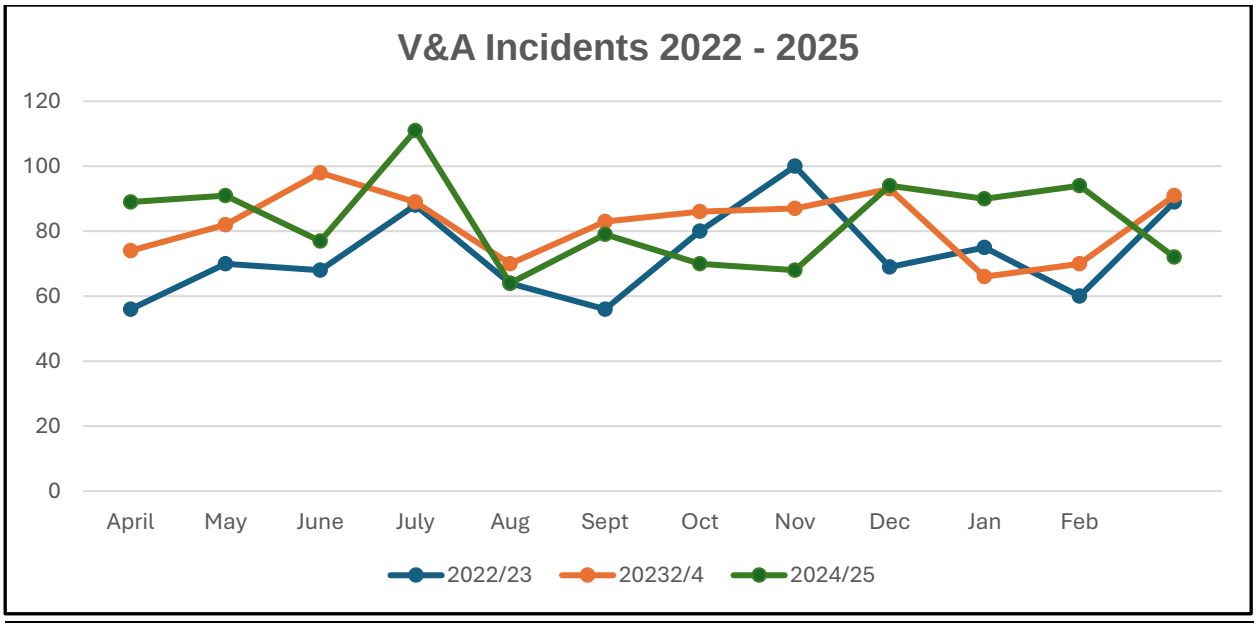


Graph 7: Sharps Incidents by Care Group in 2024/25



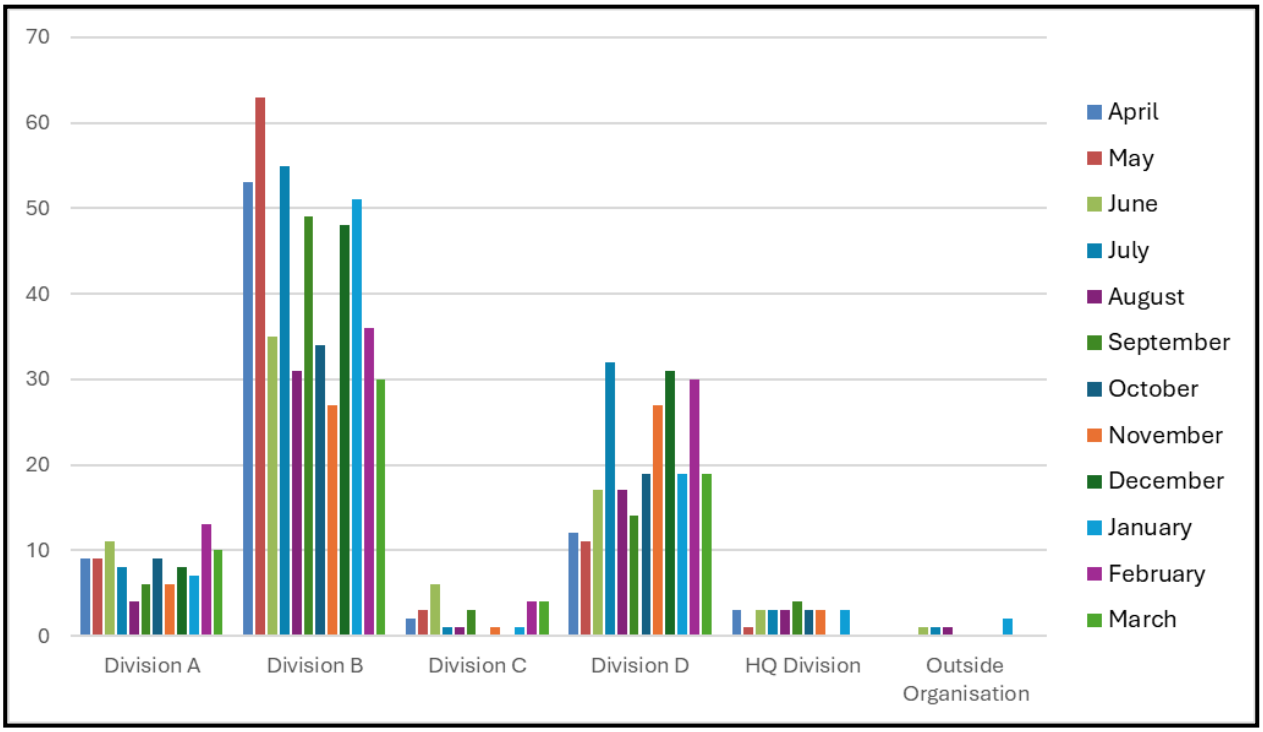
Violence and Aggression AER Data

Graph 8: Trust-wide V&A AERs 2022 to 2025



(All V&A AERs by month, excludes Challenging Behaviour AERs)

Graph 9: V&A AER data by Division by month for 2024/25



(Data above excludes Challenging Behaviour category)

Appendix 2

Staff radiation incidents – 1st April 2024 to 31st March 2025

Staff incidents caused by ionising or non-ionising radiations are either reported on Safeguard at the time of the incident or discovered after the fact by occupational radiation dose monitoring. Ionising radiation dose monitors are worn for 1 or 3 months and usually reported within a month of the end of the wear period. No occupational exposures in excess of the legal radiation dose limit or statutory dose investigation levels were reported on Safeguard, or detected through monitoring in this period. Occupational dose limits are applied to calendar years. The legal radiation limit is 20mSv per annum to the body, 20mSv to the eye and 500mSv to the skin or extremities. Since January 2021, Radiation protection group have been collating all staff radiation incidents for trend analysis.

Ionising Radiations

During the period, there were 26 non-patient radiation incidents reported on Ulysses Safeguard. 9 incidents related to control of radioactive materials; 13 incidents involved a staff exposure to ionising radiation. Of the staff exposure events, 12 incidents were actual events and 1 was classed as a near miss. This is significantly greater than the 14 incidents reported last year.

The following trends were identified:

- Radioactive materials: Incidents related to potential loss of control of safety systems for radioactive materials were most prevalent. These were from C4 ward, Nuclear Medicine and Radiopharmacy. Incidents were spills of radioactive material, leaking containers, radioactive patients transferred to wards without supporting advice, radioactivity not disposed according to SOP. In each case an investigation of the causes was carried out and the potential radiation effects were calculated. Two events resulted in extremity doses of 30mSv-40mSv.
- Unauthorised access or inappropriate PPE: On several occasions staff or visitors were irradiated when radiographers had given insufficient warning of radiography occurring, had not fully checked the safety exclusion zone for occupants, or staff were inside the controlled radiation area without PPE. The highest radiation dose as a result was approx 0.1mSv to the body.

There were some notable events of concern during the period:

1. There was a spill of radioactivity during different a novel P32 radionuclide therapy which resulted in actual radiation doses to staff. The contamination was not detected immediately and resulted in hand doses to several members of staff. A few other spills and leaks during administrations of radioactivity have occurred. Typically these occur when staff are rushing or are distracted and

these have also been seen as contributory factors in a number of other incidents.

2. A number of events have involved incorrect disposal or transfer processes for radioactivity, such as using the wrong container, not keeping records up to date, delivery of radioactivity to the wrong location. These are all actual incidents which demonstrate non-compliance with the law but did not result in a radiation dose to staff as they were detected soon after occurring. Lack of training or supervision are noted as contributory factors alongside those noted above.
3. A number of carers have been irradiated when supporting patients without the use of appropriate radiation PPE. Doses for these incidents are typically very low. These tended to occur in situations where a carer would not normally be present so their presence was overlooked. The contributory factor was unfamiliarity with the process.
4. A radiographer irradiated a colleague's hand during a quality control procedure. This was due to a lapse of attention at the time.

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

There were 45 occupational radiation doses recorded on body, finger or eye dose monitors that were above the investigation level for high doses in a single monitoring period (monthly or quarterly) and three instances where an annual dose investigation level was exceeded.

All investigations from 2024-25 are now closed with action plans or dismissed as non-occupational doses. Delays to closing investigations occurred due to insufficient information returned by the badge wearer, their manager or local radiation protection supervisor. The majority of cases were connected to an increase in an individual's workload or were false positives due to non-occupational exposures or incorrect wearing of dosimeters. The most common cause of false doses was from irradiation of luggage at airports or monitoring badges left accidentally in radiation controlled areas.

Non-Ionising Radiations

During the period there have been no staff incidents reported on Safeguard related to Laser/UV Light Safety.

Ben Johnson
Head of Radiation Protection

Ben Inglis-Smith
Lead for Non-Ionising Radiation Protection

16 July 2025

Agenda Item 10.1	Report to the Trust Board of Directors, 11 November 2025
Title:	South Central Regional Research Delivery Network (SC RRDN) 2025-26 Q2 Performance Report
Sponsor:	Mr Paul Grundy, Chief Medical Officer
Author:	Clare Rook, Network Director, SC RRDN Graham Halls, Data and Analytics Senior Manager, SC RRDN

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

This report informs the Board of the health and care research activities within the South Central Regional Research Delivery Network (SC RRDN) region during the first two quarters of the 2025/26 financial year (April to September 2025).

During this period, the region ranked fourth nationally for total recruitment and third when adjusted for the regional population. **43,044 participants were recruited to 803 studies at 205 sites and across all main clinical specialties. Recruitment is however trending downwards across South Central and all other English regions.** SC RRDN has a recruitment action plan underway to reverse this trend.

Feedback from participants has been very positive, with **95 per cent saying that they would take part in research again** and **96 per cent feeling valued**. However, SC RRDN is working with delivery organisations on improving communication with research participants both during and after the study.

Contents:

South Central Regional Research Delivery Network Q2 2025/26 Performance Report,
Appendix 1 – South Central RRDN Risk Register,
Appendix 2 - Glossary.

Risk(s):

1b, 2a (for full details, please see the SC RRDN risk register in Appendix 1)

Equality Impact Consideration:	N/A

1

University Hospital Southampton
NHS Foundation Trust

NIHR | Research Delivery Network

South Central Regional Research Delivery Network

2025/26 Quarter Two Performance Report

Clare Rook, Network Director

Graham Halls, Data and Analytics Senior Manager

October 2025

2

Introduction

This report informs the Board of the health and care research activities within the National Institute of Health and Care Research (NIHR) South Central Regional Research Delivery Network (SC RRDN) region during first two quarters of the 2025/26 financial year (April to September 2025).

SC RRDN was formed in October 2024, with a change in geography to cover the area shown in Figure 1. This report includes historical research activity from the research active organisations in the same region to allow performance to be compared over time.

Figure 1 - Map of the region covered by SC RRDN

About the NIHR Research Delivery Network (NIHR RDN)

The NIHR RDN is funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise and deliver research across England.

The RDN consists of twelve RRDNs and a Coordinating Centre, working together as one organisation with joint leadership. The RDN contributes to NIHR's **mission** to improve the health and wealth of the nation through research.

RDN vision, mission and purpose

The RDN's **vision** is for the UK to be a global leader in the delivery of high quality research that is inclusive, accessible, and improves health and care.

The RDN's **mission** is to enable the health and care system to attract, optimise and deliver research across England.

The RDN has two primary **purposes**:

1. to support the successful delivery of high quality research, as an active partner in the research system
2. to increase capacity and capability of the research delivery infrastructure for the future.

This will:

- enable more people to access health and social care research where they live
- support changing population needs by delivering a wider range of research and deliver research in areas of most need
- provide support to the health and care system through research
- encourage research to become a routine part of care
- support economic growth by attracting investment to the UK economy.

NIHR RDN Strategic Plan – New for October 2025

The NIHR RDN has developed a strategic plan for 2025 to 2030, after extensive collaboration across the research community.

The plan sets out how the NIHR RDN will deliver on its primary purposes and focus its activities in supporting the government's health and growth missions by delivering on the **'three shifts'** outlined in Fit for the future: Ten Year Health Plan for England. It will also support the delivery of the Life Sciences Sector Plan vision to be at the forefront of global innovation.

The plan outlines how the NIHR RDN will work as a partner in the wider health and care system to deliver against commitments in the NIHR's **seven strategic priority areas**:

1. building on lessons from the COVID-19 response
2. strengthening preventative, public health, and social care research
3. improving care for people with multiple long-term conditions
4. expanding clinical research to under-served regions and communities
5. embedding equality, diversity, and inclusion
6. strengthening careers for research delivery staff
7. expanding collaboration with the life sciences industry.

For further information on the RDN Strategic Plan, please visit the NIHR RDN website.

Overview of research activity in the SC RRDN region

All recruitment in South Central

During the first six months of the 2025/26 financial year in the South Central region, **43,044 participants** were recruited to **803 studies** at **205 sites** and across **all main clinical specialties**.

After a period of increased recruitment in the first four months of the financial year, recent activity has dropped below the monthly average since April 2024 (Figure 2). A seasonal dip is expected during the summer for recruitment, due to the increase in holidays for both participants and research staff. However, this reduction in recruitment has been compounded by the closure of two of the most active studies in the region this year. Recruitment in the first two quarters is approximately 4,400 (eight per cent) below the same period last year.

For comparison, recruitment across England is also trending downwards, with a 33 per cent decrease for the first two quarters year on year. All RRDN regions have experienced a reduction in recruitment in quarter two. This may suggest that the challenges impacting recruitment across the country are systemic.

A recruitment action plan is underway in South Central, with details provided later in this report. While the action plan includes the identification of high recruiting studies, choices about studies

supported by the region are also based on patient needs and strategic goals e.g. increasing industry funded research.

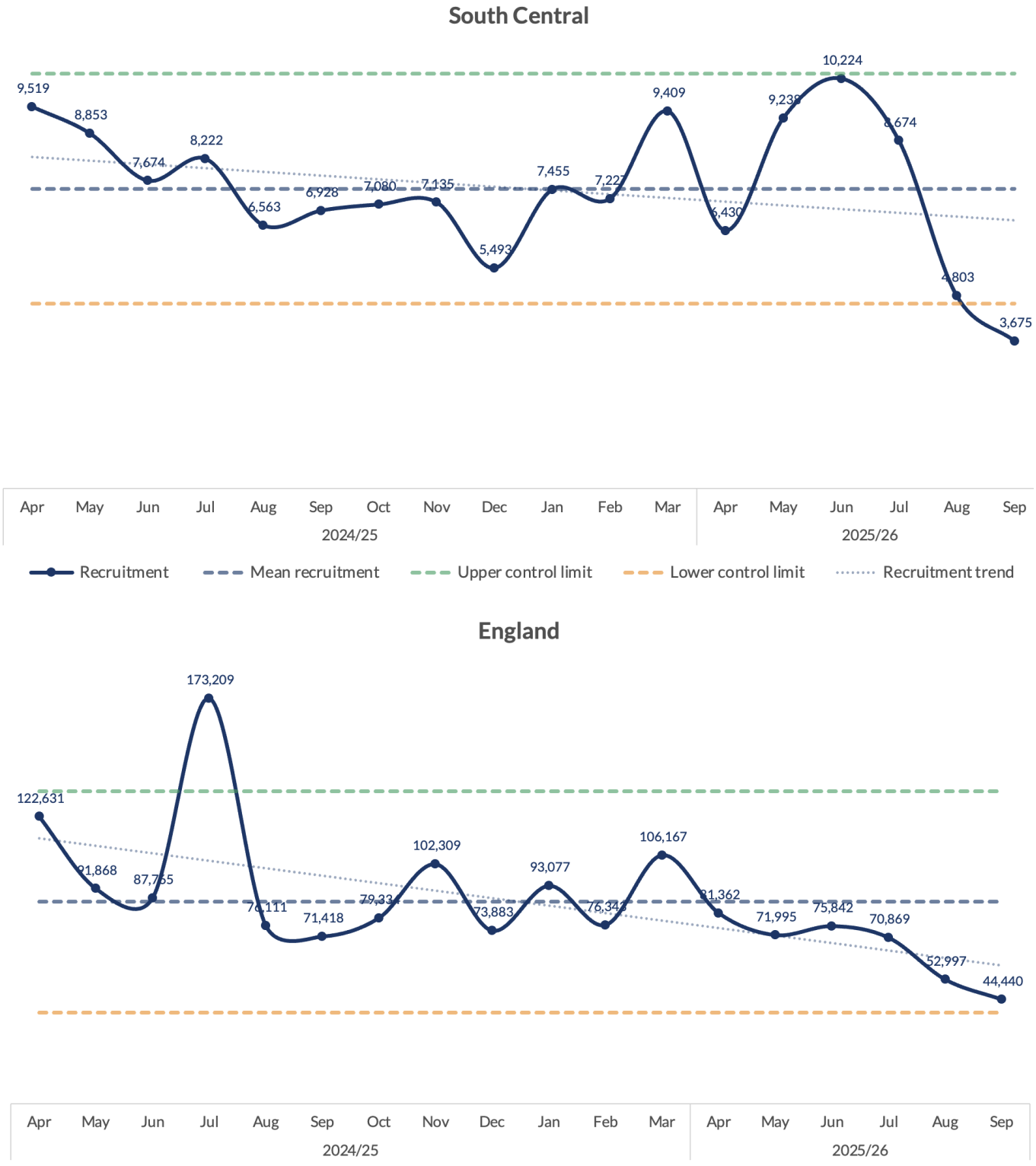


Figure 2 - Monthly recruitment in the South Central region benchmarked against England since April 2024

6

Research studies can be classified as having an 'observational' or 'interventional' design. Observational studies require no change to a participant's care pathway and may include data collection, surveys or interviews only. Interventional studies, including the majority of those that are funded by the life sciences industry, typically have more intensive requirements. These can include frequent visits and additional procedures. The type of research that takes place within an organisation has a direct effect on the capacity for recruiting additional participants.

Figure 3 shows that there is more observational recruitment taking place in the region on average, but that the split between designs is relatively balanced.

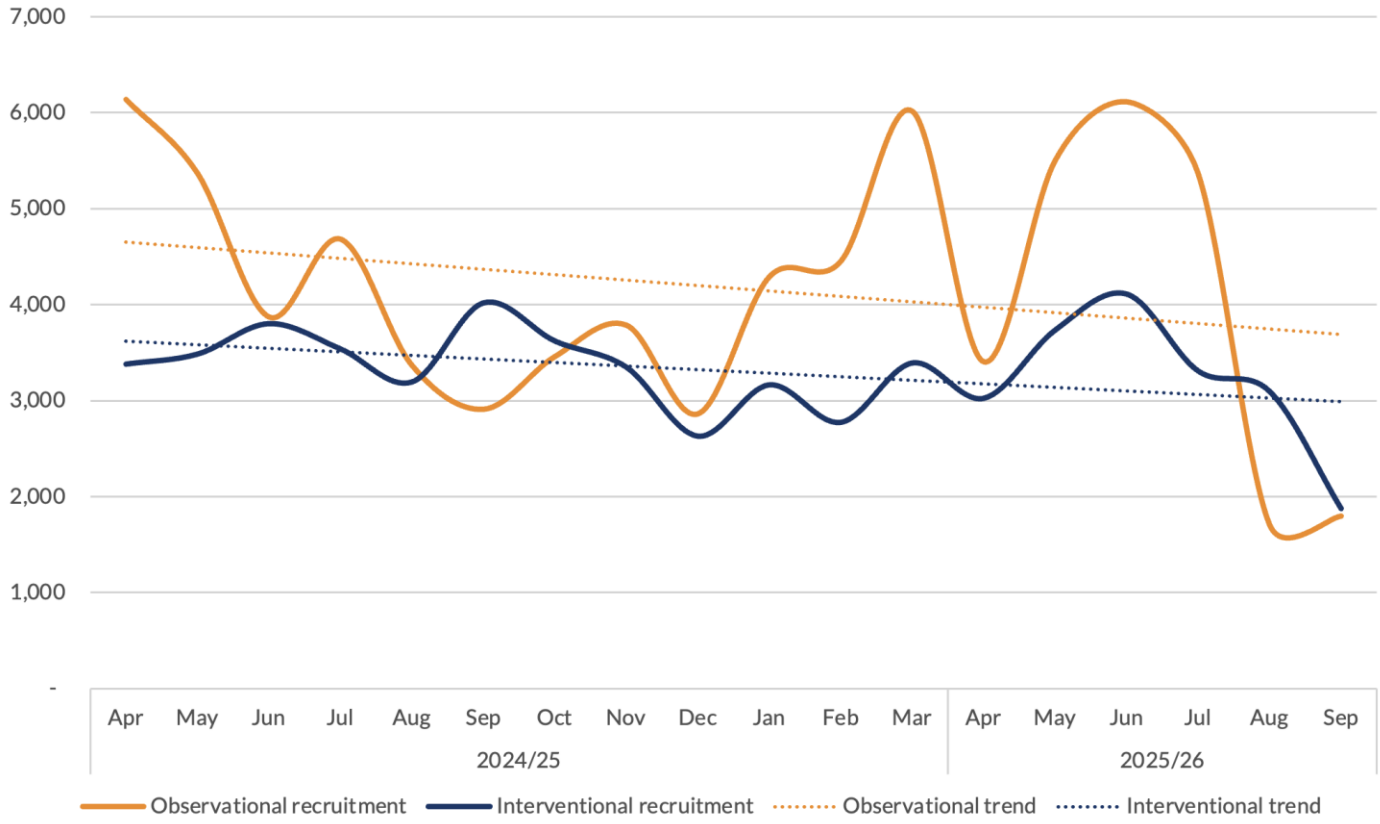


Figure 3 – Recruitment by study design within the South Central region since April 2024

South Central was the fourth highest recruiting region in the first two quarters (Figure 4). The region has the eighth largest population of the twelve in England. When the size of the population is factored in, South Central had the third highest proportion of the public participating in research.

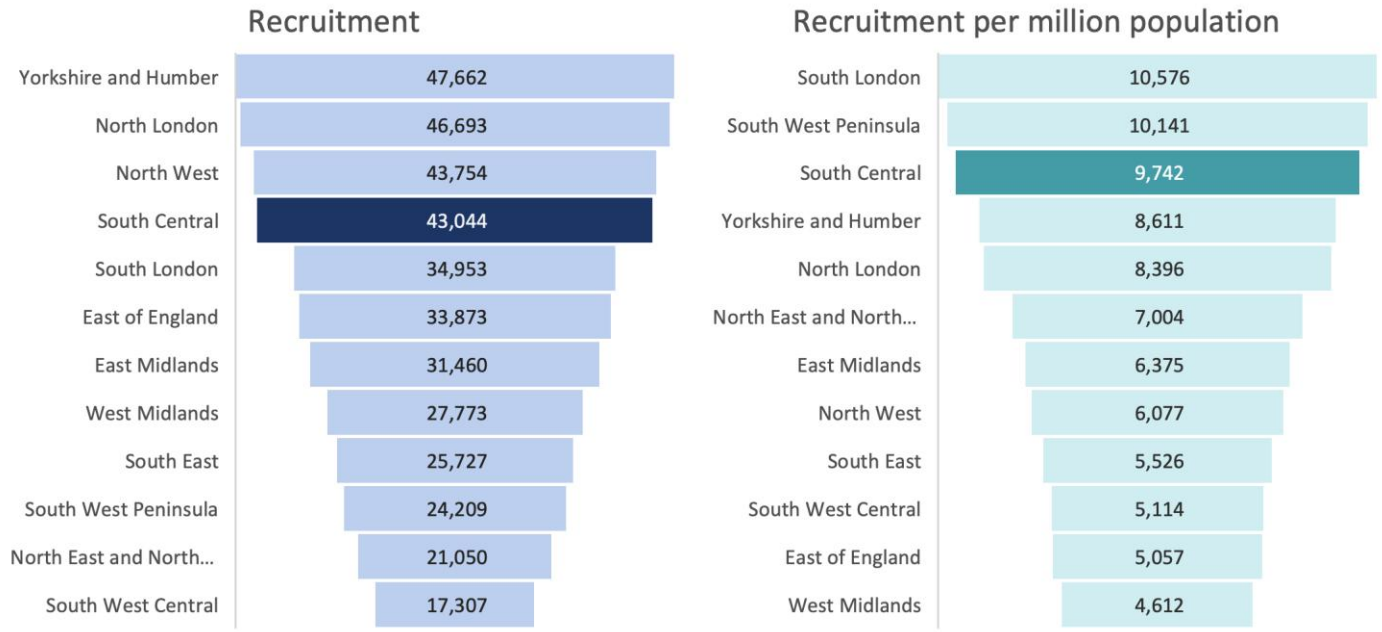
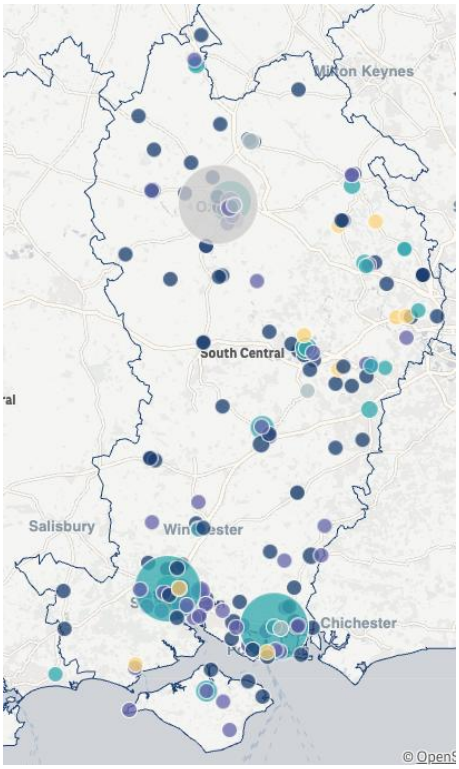


Figure 4 - Recruitment and recruitment weighted per million population by RRDN region in quarters one to two of the 2025/26 financial year



Organisation type	Trusts	Recruiting sites	Recruitment	Recruiting studies
Acute	8	29	25,020	664
Ambulance	1	8	434	5
Mental Health	3	61	2,809	78
Non-NHS	-	10	837	24
Primary care and university	-	97	13,944	38

Table 1 - Research activity in the South Central region by organisation type in quarters one to two of the 2025/26 financial year

Table 1 shows how research activity is distributed across the South Central region by type of organisation. Acute organisations typically support a higher number of studies, given the variety in specialist services they provide across a smaller number of locations. Other types of organisations recruit from a wider geography, including in more rural locations. 25 per cent of general practices have recruited in the first two quarters, with others providing support by referring patients to studies that are being delivered by larger organisations. For reference, recruitment by organisation and organisation type during the last four quarters is provided in Figure 5. Organisation acronyms are available in the Glossary in Appendix Two.

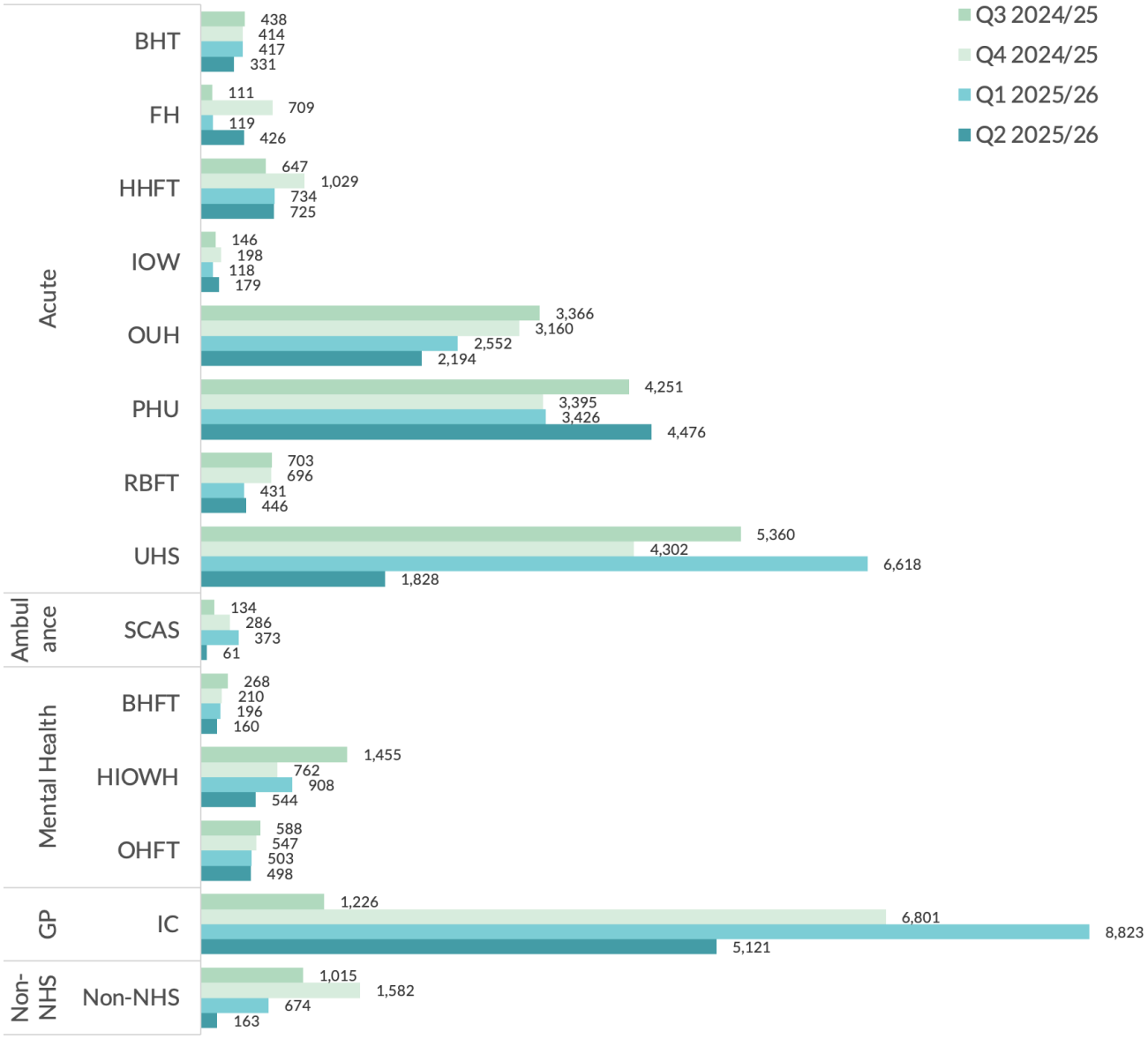


Figure 5 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

Recruiting studies in South Central

Figure 6 shows the total number of recruiting studies in South Central since April 2021. Large scale studies have a national recruitment target of over ten thousand participants and are usually designed to be simpler to deliver e.g. online surveys. Commercial research is funded and sponsored by the life sciences industry and may be observational or interventional.

The number of recruiting studies for quarters one to two in 2025/26 will appear reduced because this total is for a partial year. The composition of these studies has changed over time, with an increase in the proportion of interventional trials, which are often focused on developing new treatments.

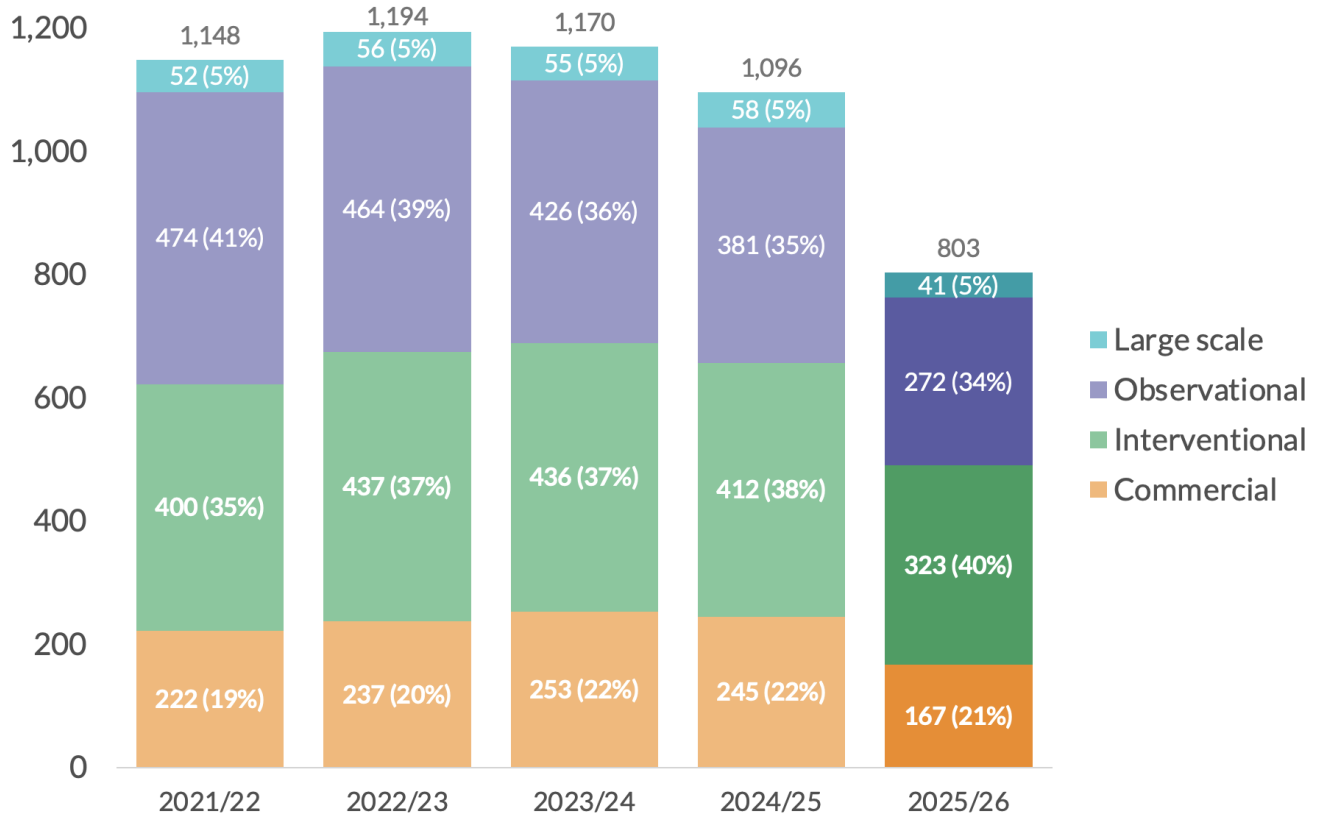


Figure 6 – Recruiting studies by complexity within the South Central region since April 2021

Commercial recruitment in South Central

Commercial research, funded and sponsored by the life sciences industry, is important to the South Central region and is a priority area for the DHSC and the NIHR. It provides novel treatment options for patients, supports the expansion of research infrastructure and often generates savings

on treatment costs for participating organisations. This supports the NIHR's mission to increase the health and wealth of the nation through research (NIHR website). Lord O'Shaughnessy's review of commercial clinical trials in the UK also recommended substantial increases in commercial recruitment in the UK (Lord O'Shaughnessy review).

In the first two quarters of 2025/26, organisations in the South Central region have recruited **847 participants** across **21 sites** on **158 commercial studies**. South Central was the **seventh highest recruiting RRDN region in England**.

Figure 7 shows that commercial recruitment is trending downwards for both the South Central region and all regions in England. The peak seen at the beginning of 2024/25 is due to three studies with national recruitment targets (sample size) of over 10,000 participants. When these are removed, monthly commercial recruitment is relatively stable in South Central since the end of the 2024/25 financial year.

For reference, commercial recruitment by organisation and organisation type during the last four quarters is provided in Figure 8. Organisation acronyms are available in the Glossary in Appendix Two.

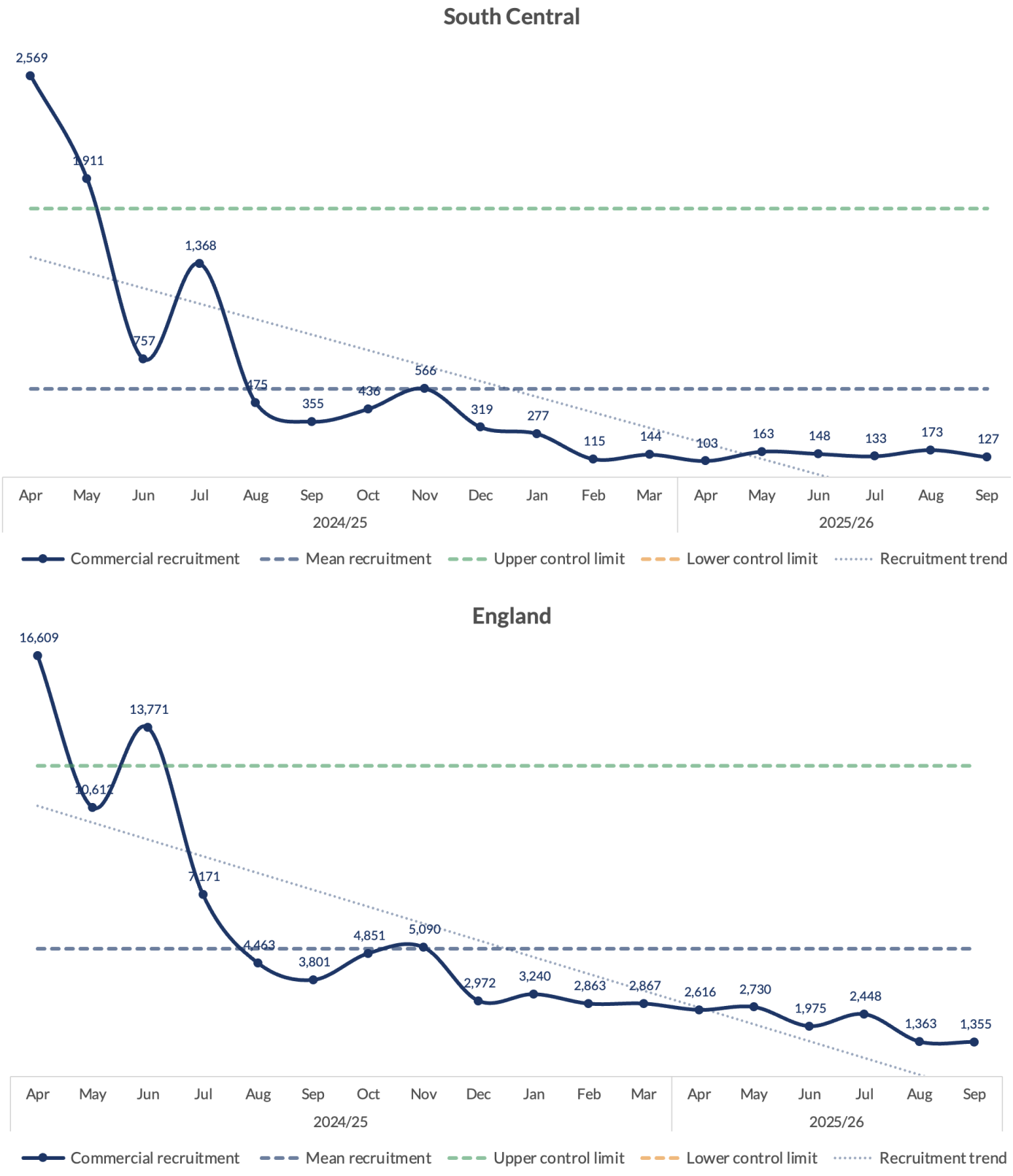


Figure 7 - Monthly commercial recruitment in the South Central region benchmarked against England since April 2024

12

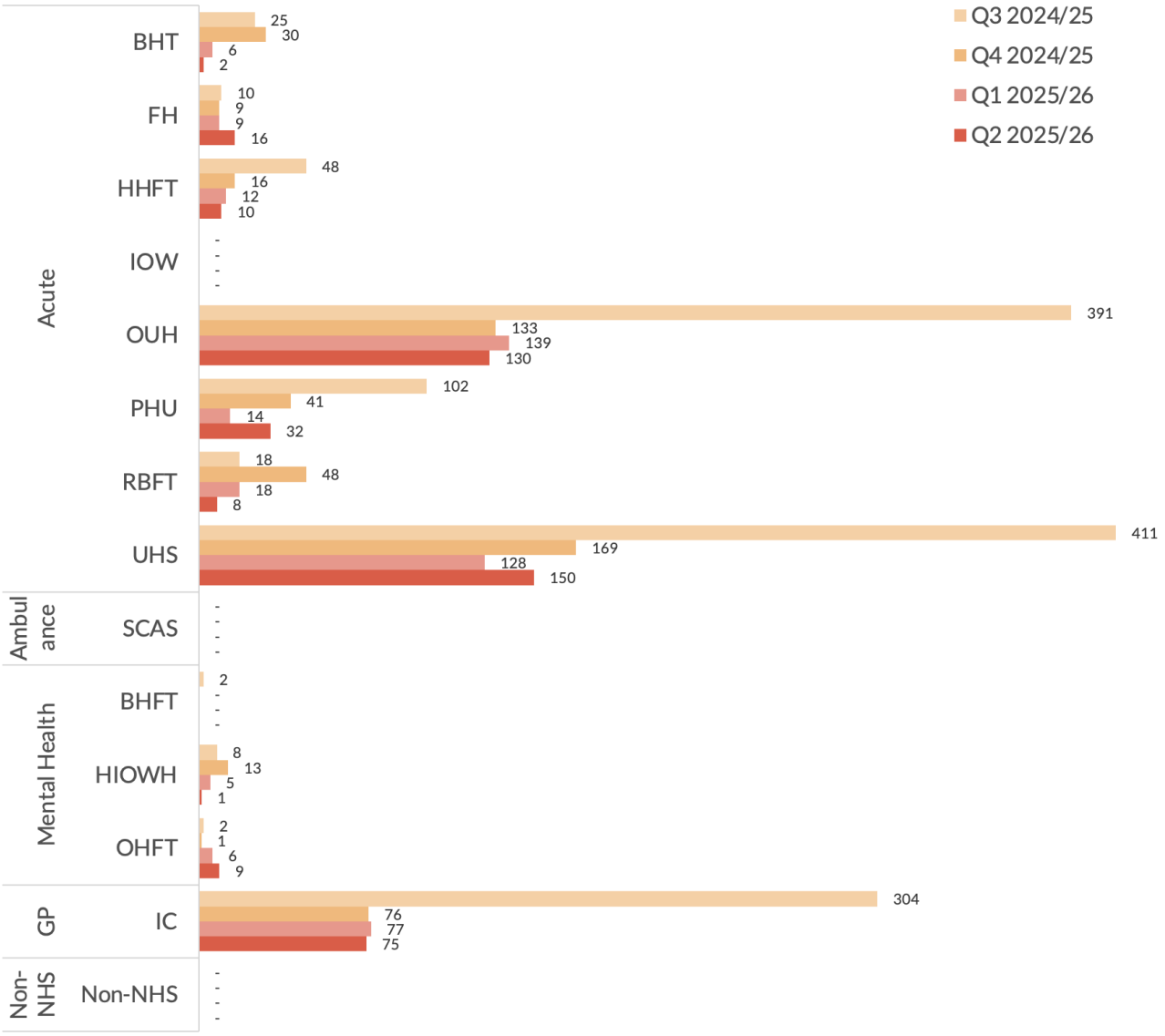


Figure 8 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

Recruitment action plan for 2025/26 onwards

The downwards recruitment trend for all studies, but particularly for commercial research, is occurring in an environment with fewer new studies available on the national NIHR RDN Portfolio. Given the UK Government's strong emphasis on research delivery, SC RRDN decided that strategic measures were necessary to reverse this trend, which are outlined in a recruitment action plan.

The plan calls upon SC RRDN to recommend new research opportunities to delivery organisations that are considered strategically important. In addition, greater emphasis is being placed on studies

that may support the three shifts in the UK Government's 2025 NHS 10 Year Plan (for example, increasing preventative medicine).

To enable the review of available studies, a dashboard has been updated to share intelligence about the national research portfolio, including the ability to identify new studies that the region isn't yet supporting.

Further actions include:

- **Participant Registries:** promoting national participant registries like "Be Part of Research" with the public and increasing community outreach and communications through events, testimonials, and digital engagement.
- **Relationships:** building relationships with sponsors and life science companies has been prioritised so that SC RRDN and delivery organisations have better awareness of their upcoming portfolios.
- **Recruitment strategies:** innovative recruitment strategies from the region, such as flexible approaches to less complex study delivery managed by general skilled staff, are also being explored.
- **Sourcing reasons for delays:** identifying bottlenecks in study setup and delivery through workshops with NHS Research & Development leadership are helping the region understand barriers and how SC RRDN can assist.

Participant Experience (PRES)

The experience of participants while supporting a research study is measured using a national 'Participant in Research Experience Survey' (PRES). There were 886 responses in the first two quarters (Figure 9).

Overall, feedback is positive on research operations, showing that South Central delivery organisations are creating generally positive experiences for research participants. The main areas for improvement are around communications. Specifically, only 41 per cent of participants knew

how they would receive the study results, and 79 per cent felt they were kept updated. There have been marginal increases in both aspects since quarter one.

SC RRDN regularly share the survey results with research delivery organisations. Strategies to address identified issues are then discussed, monitored, and adjusted based on ongoing participant feedback.

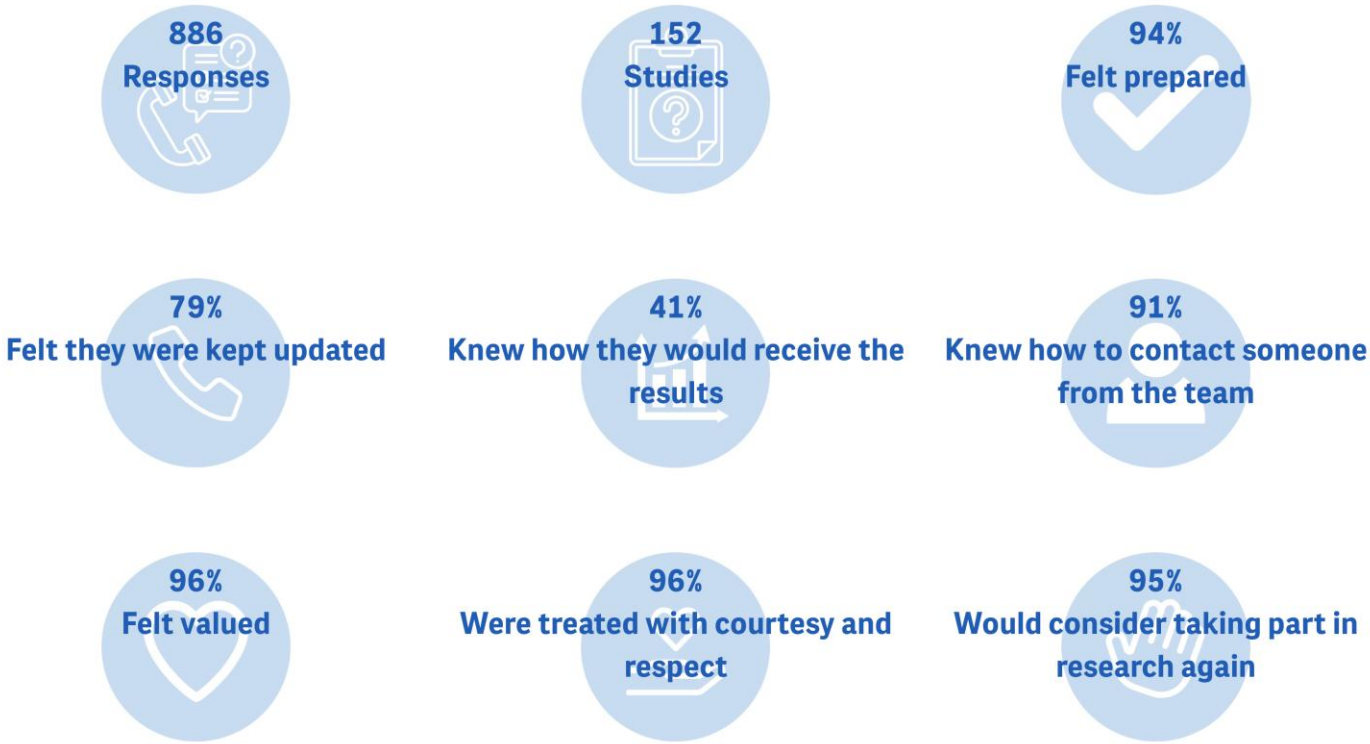


Figure 9 - Summary of the Participant in research experience survey results in the South Central region in quarters one to two of the 2025/25 financial year

Conclusion

In the first six months of the 2025/26 financial year, SC RRDN has continued to demonstrate strong performance, ranking highly nationally for participant recruitment and especially when considering population size. The region delivers research across all NHS Trusts and in wider care settings, including within a quarter of GP practices.

There is however a downward trend in recruitment, particularly in commercial studies, mirroring a national pattern. In response to this trend, SC RRDN has initiated a recruitment action plan. This

plan focuses on strategic study selection, fostering collaboration among delivery organisations, and enhancing engagement with both industry sponsors and the public to reverse this trend.

Participant feedback remains positive, highlighting the quality of research delivery and the positive experiences of those donating their time to research. While communication about study results has been identified as an area for improvement, SC RRDN is collaborating with research delivery organisations to ensure participants are kept well-informed.

SC RRDN will continue to provide quarterly performance updates to the Board.

Appendix

Appendix 1 – South Central Risk Register

South Central Regional Research Delivery		PENDING RISK DESCRIPTION			Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
Risk Category	**Risk Title**	**SCRRDN Reference Number**	**Risk Description (to include cause/event)**	**Effect/Impact**	**Probability Value**	**Impact Value**	**Score (Col JxK)**	**Mitigation Actions**	**Mitigation actions Outstanding**	**Current Likelihood**	**Current Impact**	**Current Score**
20. Workforce Learning and Organisational Development	Research Registered NMAHPs shortage in partner organisations and job freezes in place.	SCRRDN 001	**Cause:** Lack of availability of registered NMAHPs. **Event** :Leading to a shortfall in registered staff qualified to deliver clinical trials	Fewer clinical trials are delivered and/or quality of research conducted becomes reduced leading to reputational damage.	3	3	9	1. Recruit band 3 CTAs and train up to band 4 level to relieve existing nursing staff of some duties 2. Recruit CRPs to relieve existing nursing staff of some duties 3. Recruitment campaign to attract graduates to research delivery careers. 4. to be aware of trusts with job freezes and implications of RRDN funded posts 5. Letter circulated to SC region R&D DIrectors to remind that RDN funding is ring fenced and posts funded through this stream should not be impacted by recruitment freezes, as per the RDN research delivery organisation contract	all Ongoing	2	2	4
20. Workforce Learning and Organisational Development	Impact on Performance Network Agile Research Delivery Team (ARDT) Workforce	SCRRDN 002	**Cause:** Staff exhaustion due to ongoing workload and uncertainty. Recruitment Freeze pending organisational change. **Event**: Staff we have invested in and developed to work in this Agile capacity leave and we lose this capability without being able to recruit	Unable to deliver Government priority studies as DHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the separate organisational change processes of the ARDT and management team. Decrease in the number of studies that can be delivered.	4	4	16	1. Ongoing recruitment to the direct delivery team - PAUSED 2. Reinvestment of hub income to increase head count - PAUSED 3. Wellbeing programme established for the team and delivered by the team 4. Ensure regular check-ins at 1:1 meetings with all staff 5. Continue to keep a close eye on any changes using all possible tools, e.g. 1:1s, team meetings, wellbeing surveys etc 6. Encourage regular taking of annual leave throughout the year, limiting the accrual of TOIL wherever possible. 7. Encourage all staff to take regular breaks during the working day and consider the use of walking meetings etc as a way of stepping away from screens, encouraging interactions.	Recruitment paused, reinvestment of hub income paused, dependent on organisational change. The Agile team are now viewed as one regional team. This has allowed capacity to be reviewed and implemented more broadly. Resulting in increased capacity to meet contractual requirements including VIP studies.	3	4	12
15. Research Delivery	NHS Pressures	SCRRDN 004	Impact of NHS pressures on clinical services impacting on delivery of Research	Thus causing research staff to be redeployed to clinical services. Impact is reduced workforce to deliver NIHR Portfolio research.	4	4	16	1. Raise locally and nationally for advice on prioritisation of key activities/studies	Ongoing	4	4	16
15. Research Delivery	PET Scanning Access	SCRRDN 005	Cause: Reduced access to PET scanning capacity and tracers (amyloid and tau) required for both clinical and research scans Event: Limited access to PET scans for research purposes. Reduced opportunities for access to research for neurology and oncology patients.	Threat to safety and data integrity if schedule of imaging events cannot be adhered to.	4	4	16	1. Raised at OMG and IOM/BDM meeting, to monitor. 2. Discussed with COO and local escalation to ICBs via WHP	Ongoing	3	3	9
19. Health and Care Services Engagement	BOB and Frimley ICB Engagement	SCRRDN 006	Difficulties engaging with ICS organisations that cover the South Central Region. Slow establishment of BOB ICS compared with other regions.	Failure to progress with work streams and opportunities missed.	3	2	6	1) Liaise with RDN CC and with fellow RRDNs to align work. 2) Leverage relationships already in place with the BOB ICS (eg OUHFT and AHSN) 3) ICS-focussed Stakeholder Day was held in January 2025	Ongoing	3	2	6
17. Communications	Low researcher usage of Be Part of Research volunteer service	SCRRDN 007	Low awareness and usage of Be Part of Research volunteer service by researchers could see opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering. Details about trials using the service have been requested from CC.	Opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering	3	2	6	Promotion of service to researchers through study support service and other teams and wider promotion e.g. newsletters	Ongoing	3	1	**3**

South Central Regional Research Delivery		PENDING RISK DESCRIPTION			Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
Risk Category	**Risk Title**	**SCRRDN Reference Number**	**Risk Description (to include cause/event)**	**Effect/Impact**	**Probability Value**	**Impact Value**	**Score (Col JxK)**	**Mitigation Actions**	**Mitigation actions Outstanding**	**Current Likelihood**	**Current Impact**	**Current Score**
17. Communications	Low awareness of branding guidelines	SCRRDN 008	Low awareness of name change to RDN and inappropriate use of South Central RRDN name with external stakeholders could result in negative impact on perception of the RDN as one network	Could result in negative impact on perception of the RDN as one network	3	2	6	Promotion of branding guidelines and files to RRDN staff and delivery organisations, responses to queries via shared inbox	Ongoing	3	1	3
18. Patient and Public Involvement and Engagement (PPIE)	Relationship management - building and maintaining positive connections	SCRRDN 012	**Cause:** Change of region/staff/uncertainty **Event:** Transition from Clinical Research Network to Research Delivery Network	Risk to relationship continuity with the following: 1. Organisations participating in Research Ready Communities initiative 2. Research Champions 3. Public Contributors	3	3	9	Maintain relationships through regular contact Stakeholder Group Public Partners identified National One Public Partner work ongoing in line with strategy	Ongoing	2	3	6
15. Research Delivery	Delivery to RDN High Priority Studies - Lead Network	SCRRDN 013	Failure to successfully deliver high priority studies led by SC RRDN	1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	2	4	8	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Agile delivery team resource allocated to support delivery in all RRDNs 3. Importance of high priority studies communicated to delivery organisations at a senior level 4. Supporting sponsor and sites with timely recruitment uploads to allow recruitment to be closely monitored and issues identified	All ongoing	2	3	6
15. Research Delivery	Delivery to RDN High Priority Studies - Participating Site	SCRRDN 014	Failure to successfully deliver high priority studies at delivery organisations within SC RRDN	1. Reputational damage to SC RRDN delivery organisations and to the UK as a place to deliver research 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	4	4	16	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Local Agile delivery team resource allocated to support delivery organisations. 3. Importance of high priority studies communicated to delivery organisations at a senior level	All ongoing	3	4	12
20. Workforce Learning and Organisational Development	Non-patient facing staff role security during the SC RDN organisational change process.	SCRRDN 015	Risk to role security for non-patient facing roles within ARDT during the RRDN agile organisational change process.	1) Negative impact on staff moral and well-being. 2) Disruption during the organisational changes and potential resulting impact on research support and delivery. 3) Reputational risk of damage if changes impact on study delivery and external comms.	5	4	20	1) Continuous monitoring of staff morale through line management, 1:1s and team meetings. 2) standing agenda item on the senior agile management team meeting that happens bi-weekly. 3) regularly discussed at SC RDN meetings including the SMT. 4) SC RDN Senior management to review regularly and respond appropriately. 5) SC RDN well-being leads involved in key discussions. 6) increased senior management team comms	Ongoing	1	2	2
15. Research Delivery	Agile team members working in new environments	SCRRDN 016	Expectation for the Agile team to expand research delivery to wider community and out of hospital settings. This will include settings where SC RDN does not have prior experience of delivering research, which may present unfamiliar risks to the safety and well-being of staff members e.g. prisons and probation service, severe mental health services. There is a lack of national guidance for staff working in these new settings and current training may not sufficiently cover.	1) Potential threat to agile staff work place safety and well-being when working in new environments and participant groups. 2) Unforeseen safety considerations and risks that potentially prevent continuation of research delivery. 3) Additional time may be required during study setup to train staff in preparation for the study to be delivered.	4	3	12	1) Wider SC RRDN agile meeting 21/11/24 - agreed management plan. 2) Expand SC RRDN training where gaps are identified during study specific feasibility assessment. Training can can be sourced from in-house expertise, regional expertise and nationally available training resources. General training (e.g. de-escalation methods) to be provided as required to benefit staff who deliver research across settings and during engagement activities with patients, service users and the public. 3) Raised risk at national agile meeting to discuss, including how RDNs can collectively pool resources such as best practice, SOPS and training resources 4) Agile and primary care teams to adapt national/supra-regional resources and apply to SC RDN region when appropriate to do so. 5) Senior agile management to review study by study and agile training needs 6) studies will not commence if agile team are not adequately qualified and trained.	Ongoing review	1	3	3

South Central Regional Research Delivery		PENDING RISK DESCRIPTION			Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
Risk Category	**Risk Title**	**SCRRDN Reference Number**	**Risk Description (to include cause/event)**	**Effect/Impact**	**Probability Value**	**Impact Value**	**Score (Col JxK)**	**Mitigation Actions**	**Mitigation actions Outstanding**	**Current Likelihood**	**Current Impact**	**Current Score**
15. Research Delivery	Risk of studies not being delivered at OUH sites due to the withdrawal of the SC RDN agile team based in Oxford and Horton.	SCRRDN 017	New studies not being approved to be delivered at OUH sites due to SC RDN organisational changes and expectation for the OUH based agile team withdrawal. Timeline not yet known. Risk to current studies on the portfolio not being delivered in their entirety.	1) studies not delivered at OUH due to workforce limitations. 2) SC RDN and OUH organisational reputational damage. 3) uncertainty regarding agile team availability for current and future study delivery.	4	4	**16**	1) Regular meetings held between senior management at OUH and RDN 2) Ongoing review the OUH SC RDN portfolio of studies on a regular basis and subsequent portfolio management including closing studies and stop recruiting to other studies 3) regular review by the senior agile, management team including at the bi-weekly agile management meeting. 4) Transitional arrangements to be agreed to ensure continuity of study delivery. 5) OUH R&D communication with OUH PIs. 6)Transitioning of studies from OUH agile team to OUH R&D with oversight from RDN senior agile management.	Ongoing discussions being held with OUH and closely managed to reduce risk likelihood.	3	3	9
14. RDN Specialties and Settings	Limited funded time available to specialty and setting leads	SCRRDN 018	Risk of specialty or settting leads not having time to fulfil duties / expectations of the role	Reduced strategic clinical oversight and leadership. Lack of local clinical engagement	3	2	6	Review ongoing situation with the leads Avoid unnecessary workload / use their time strategically Provide reasonable level of administrative support Keep meetings they are expected to attend to a minimum	Ongoing	**3**	**2**	6
21. Business Development and Marketing	Redirection of senior strategic industry regional industry resources	SCRRDN 019	Risk - The regional industry activities previously completed by the Industry Operations Manager in LCRNs do not have a consistently agreed position in the RRDN structure. Cause - Transition to mandated structure with national focus for LSKAM role and Band 7 Industry Manager role means senior regional industry activity does not have a natural fit in the structure. This includes engagement activity with DOs including challenging behaviours, increasing organisational capacity and capability through RDN led initiatives and regional business development, providing strategic direction as well as working with the MedTech and SME sector.	Effect - Reduction in regional ability to support life sciences activity as a key priority for RDN. Reduction in effectiveness of customer relationships built over 10 years and perception from DOs that senior regional industry support is no longer available. Loss of skilled and experienced industry staff across the network due to uncertainty.	5	4	**20**	Phased transition for staff previously in IOM roles who are now holding LSKAM roles agreed as part of GP3 project. *This does not mitigate the risk for regions who have appointed an LSKAM who was not an IOM, or do not have an LSKAM in post. This must also be balanced with the risk of KAM service failure, which also has significant pressure to succeed.* Comparison of Industry Manager, LSKAM and SSS job roles underway. Service design activities underway. Interim position to be drafted by small working group - Lauren Tough, Chris Smith, Fiona Halstead, Kelly Adams, Kaatje Lomme. Will invite Operations Director.		3	4	12
20. Workforce Learning and Organisational Development	Lack of clarity over roles and responsibilities of the Clinical Educator position, impacting recruitment to vacant positions in SC RRDN Workforce team.	SCRRDN 020	Risk - The Clinical Educator position is a Band 6 1.0 WTE within Workforce teams. The job description has been highlighted for review at the RRDN National board to ensure there is a better understanding of the roles and responsibilities of this position. Cause - Clinical Educator recruitment currently frozen due to national review of job description and personal specification. Learning and Development role (0.8-1.0 WTE) currently vacant. Recruitment to position on hold until clarity provided about Clinical Educator role.	Effect - Reduced service offered by the Workforce team, impacting training offered and future development of training opportunities for SC RRDN staff.	4	3	**12**	Pause recruitment to the Workforce team until further guidance on Job description and personal specification available. Train current Learning and Development facilitator to support Workforce training offer. Utilise facilitator community to ensure training continues. Receive regular updates about Clinical Educator role development from Workforce and People national lead.	Prepare a draft recruitment strategy for Learning and Development (0.8-1.0 WTE) and Clinical Educator role.	3	3	9
15. Research Delivery	Requirements of "Head count" impacting the ability for Trusts to deliver	SCRRDN 021	Risk: The imperative for Trusts to decrease the head count is impacting on the ability for Trusts to recruit new R&D staff. Cause: central NHS directives	Effect - reduced R&D staff in partner Trusts impacting on Study delivery	5	3	**15**	Regular Meetings with trusts to monitor situation. Raise issue at Operations Board		5	3	15

South Central Regional Research Delivery		PENDING RISK DESCRIPTION			Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
Risk Category	Risk Title	SCRRDN Reference Number	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col JxK)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
21. Business Development and Marketing	Study set up times for commercial studies	SCRRDN 022	Risk - Slow set up times for commercial studies in the context of government led drive to reduce setup time to 150 day but March 2026	- Reputational damage to SCRRDN and SC delivery organisations. - Reduced selection of SC delivery organisations resulting in fewer opportunities for patients and decreased commercial income - Future reduction in commercial study opportunities - Performance against 150 day metric will impact performance element of RDN funding to DOs	5	4	**20**	- Working group to be form to collect reason in LPMS for set up >150 days - D&A app to provide real time setup data to DOs in line with UKCRD metrics - SC RRDN R&D managers meeting with focus on set up times - Support DOs to reduce duplication and streamline set up processes - Appropriate esculation of system wide issues - Contingency funding call open to DOs to fund initiatives aimed at reducing set up times		4	4	16
20. Workforce Learning and Organisational Development	Resident doctor strikes	SCRRDN 023	Risk - Resident doctor strikes have an ongoing impact on medical cover required for research studies.	Effect - reduced capacity to deliver essential medical review required for research studies. Impact - Increase in protocol deviations and potential serious breaches. Reduced capacity to screen and recruit participants. Safety and reputational damage.	3	2	**6**	Regular Meetings with trusts to monitor situation. Raise issue at Operations Board		3	2	6
21. Business Development and Marketing	Failure to see and increase or seeing a decrease in recruitment to commercial studies	SCRRDN 024	Risk - Poor commercial set-up and recruitment performance causes either a drop in commercial recruitment or failure to increase commercial recruitment activity.	Effect - reputational damage Impact - reduction in commercial studies set-up in the UK	4	4	**16**	- Regular review of commercial recruitment performance at RRDN Management and Internal Contractor Governance Group. - Implementation of SC RRDN Recruitment Action Plan		4	4	16
20. Workforce Learning and Organisational Development	Statutory/Mandatory and Competency training - Oxford Agile team	SCRRDN 025	Administration error as part of the tupe process for the OUH agile team. May prevent research activities from being performed until resolved.	Prevent some research activities being performed until training records updates and training provided.	4	3	**12**	UHS R&D education team working closely with agile team leads and Georgie Parsons. Marie Nelson is working with team members and Becky Croucher. Staff have been advised that anything that was expired, has subsequently expired or, is due to expire and for any new starters the UHS VLE should be used for completion of online training and for booking any that require F2F training. OUH Agile team members to complete their training profiles so we have a baseline and can identify what training is required. Training is being provided where needed. Agreed that staff are working safely and are covered by current training. Being followed up accordingly by Kirsty, Georgie and during 1:1s with line managers	Training provision	3	2	6
15. Research Delivery	Lack of sufficient oversight for agile incident reporting	SCRRDN 026	Clarification required for OUH incident reporting, with oversight by the senior research nurse manager.	Slower process and increased chance for error in the oversight of incident reporting	4	3	**12**	Teams are reporting incident reports directly to the agile team senior research nurse lead at OUH - out of the system. In the meantine, the lead is arranging an honorary contract to have access to the OUH system and can oversee historical and new incident reports. Marie Nelson involved in discussions. Kirsty Gladas has taken over as the lead for incident reporting at OUH alongside Sandie Wellman. Kirsty to be added to the OUH system. Rebecca Croucher and Marie Nelson to act as an escalation point. Flow diagram for incident reporting has been created for wider Agile team, including those based at OUH, and being shared to clarify the process. Managers to discuss and support direct reports as required. A google form has been created for all incidents to be reported to Kirsty and Rebecca at a regional level across multiple settings so there is regional oversight.	Incident report flow diagram and spreadsheet to be implemented with the wider agile team and training provided as required.	2	2	4
16. Information and Knowledge	LPMS re-tender process due to end just before the 2027/28 financial year will result in a period of disruption to research delivery at the affected organisations	SCRRDN 027	Risk: That the national system due for delivery for March 2027 is delayed. In addition a complicating factor is SC RRDN uses two Local Portfolio Management Systems (LPMS). A re-tender process has begun, led by the NHS BSA, which is due to end with the selection of a single LPMS in England by April 2027. Cause: central NHS directives.	Effect: 1. Delivery organisations affected by the selection will go through a period of significant disruption involving their processes and data being migrated to a new system. 2. SCRRDN staff will have reduced visibility to portfolio information which will impact on processes	4	4	**16**	An existing LPMS exit plan is in place. RRDN Data and Analytics Senior Manager has raised with the RDN project leads the potential disruption in our region and the need for a significant period of time to transfer and test data, cascade training on the new system and troubleshoot issues. Both LPMS providers have confirmed that they can extend their contracts into 2027/28 if required.	Ongoing	4	3	**12**

20

Appendix 2 - Glossary

South Central research delivery organisation acronyms:

Delivery organisation	Acronym
Berkshire Healthcare NHS Foundation Trust	BHFT
Buckinghamshire Healthcare NHS Trust	BHT
Frimley Health NHS Foundation Trust	FH
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	HIOWH
Hampshire Hospitals NHS Foundation Trust	HHFT
Isle of Wight NHS Trust	IOW
Independent contractors (primary care)	IC
Non-NHS organisations in the South Central region	Non-NHS
Oxford Health NHS Foundation Trust	OHFT
Oxford University Hospitals NHS Foundation Trust	OUH
Portsmouth Hospitals University National Health Service Trust	PHU
Royal Berkshire NHS Foundation Trust	RBFT
South Central Ambulance Service NHS Foundation Trust	SCAS
University Hospital Southampton NHS Foundation Trust	UHS

NIHR Regional Research Delivery Network abbreviations and their population:

NIHR Regional Research Delivery Network (RRDN)	Acronym	Population
East Midlands	EM	4,934,939
East of England	EoE	6,697,937
North East and North Cumbria	NENC	3,005,519
North London	NL	5,561,092
North West	NW	7,199,831
South Central	SC	4,418,268
South East	SE	4,655,433
South London	SL	3,305,088
South West Central	SWC	3,384,367
South West Peninsula	SWP	2,387,206
West Midlands	WM	6,021,653
Yorkshire and Humber	YH	5,535,065