University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	09/09/2025
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd
Apologies	David French, Tim Peachey

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 15 July 2025** Approve the minutes of the previous meeting held on 15 July 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	9:20	**Briefing from the Chair of the Finance and Investment Committee** David Liverseidge, Chair
5.2	9:25	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.3	9:30	**Briefing from the Chair of the Quality Committee** including Maternity and Neonatal Safety 2025-26 Quarter 1 Report Tim Peachey, Chair
5.4	9:35	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5	10:00	**Performance KPI Report for Month 4** Review and discuss the report Sponsor: David French, Chief Executive Officer

5.6 **UHS Operating Plan 2025-26 and Board Assurance Statement**

10:30 Receive and approve the Plan
Sponsor: Andy Hyett, Chief Operating Officer
Attendee: Duncan Linning-Karp, Deputy Chief Operating Officer

5.7 **Break**

10:40

5.8 **Finance Report for Month 4**

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

5.9 **ICS Operational Delivery Report for Month 4**

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

5.10 **People Report for Month 4**

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

5.11 **Learning from Deaths 2025-26 Quarter 1 Report**

11:20 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

5.12 **Annual Complaints Report 2024-25**

11:30 Receive and discuss the report
Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

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

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

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

11:50 Receive and discuss the report and strategy
Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Corinne Miller, Named Nurse for Safeguarding Adults/ Dannielle Honey, Named Nurse for Safeguarding Children

6 **STRATEGY and BUSINESS PLANNING**

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

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

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

7.1 **Feedback from the Council of Governors' (CoG) Meeting 16 July 2025 (Oral)**
12:20
Sponsor: Jenni Douglas-Todd, Trust Chair

7.2 **People and Organisational Development Committee Terms of Reference**
12:30
Review and approve
Sponsor: Steve Harris, Chief People Officer

8 **Any other business**
12:35
Raise any relevant or urgent matters that are not on the agenda

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

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

10.1 **South Central Regional Research Delivery Network (SC RRDN) 2025-26 Quarter 1 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
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Agenda links to the Board Assurance Framework (BAF)

9 September 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
5.5	Performance KPI Report for Month 4	1a, 1b, 1c			x
5.6	Operating Plan October 2025 – September 2026	1a, 1b, 1c	x		
5.8	Finance Report for Month 4	5a			x
5.9	ICS Operational Delivery Report for Month 4	5a			x
5.10	People Report for Month 4	3a, 3b, 3c			x
5.11	Learning from Deaths 2025-26 Quarter 1 Report	1b, 3b			x
5.12	Annual Complaints Report 2024-25	1b, 3b			x
5.13	Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance	3b, 3c			x
5.14	Safeguarding Annual Report 2024-25 and Strategy 2025-26	1b			x

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NHS Foundation Trust

Minutes Trust Board – Open Session

Date	15/07/2025
Time	9:00 – 13:00
Location	Conference Room, Heartbeat/Microsoft Teams
Chair	Jenni Douglas-Todd (JD-T)
Present	Gail Byrne, Chief Nursing Officer (GB) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Duncan Linning-Karp, Interim Chief Operating Officer (DL-K) David Liverseidge, NED (DL) Tim Peachey, NED (TP) 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) (shadowing CM) Julie Brooks, Deputy Director of Infection Prevention and Control) (JB) (item 5.12) Phil Bunting, Director of Operational Finance (PB) (item 7.2) Martin De Sousa, Director of Strategy and Partnerships (MDeS) (item 6.1) Christopher Kipps, Clinical Director of R&D (CK) (item 6.2) Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian (CMb) (item 5.11) Laura Purandare, Deputy Director of R&D (LP) (item 6.2) Julian Sutton, Clinical Lead, Department of Infection (JS) (item 5.12) Karen Underwood, Director of R&D (KU) (item 6.2) 1 members of the public (item 2) 4 governors (observing) 3 members of staff (observing) 1 members of the public (observing)
Apologies	Diana Eccles, NED (DE)

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

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

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

2. Patient Story

Verity Elbro-White was invited to present her experience of the birth of her second child at Princess Anne Hospital. The mother was diabetic, and the pregnancy was complex. It was noted that:

- Both the community midwife and diabetic team had been excellent. The midwife had advised that the patient go to hospital because she was feeling unwell, following which she underwent a caesarean section.
- The patient felt valued and listened to, with the care patient-centred.
- The surgical and neonatal intensive care teams were also excellent and compassionate.
- Attention was also paid to family members.

3. Minutes of the Previous Meeting held on 13 May 2025

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 13 May 2025.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted. It was noted that action 1247 could be closed.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

Keith Evans was invited to present the Committee Chair's Report in respect of the meeting held on 9 June 2025, the content of which was noted. It was further noted that:

- There had been a delay in the production of the Trust's Annual Report and Accounts due to issues with reconciling information from the Trust's ledgers into the accounts. NHS England had been notified, and it had been agreed that the Trust would submit its accounts by 21 July 2025.
- The committee had reviewed the internal auditor's report for 2024/25 and noted that out of the six reviews undertaken during the year, the results were good overall.
- The committee received an update from the Trust's external auditor and noted that it was necessary for the Trust to simplify its processes in order to prevent a repeat of the delay in producing end-of-year accounts.

5.2 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 2 June 2025 and 23 June 2025, the content of which was noted. It was further noted that:

- The committee reviewed the Finance Reports for Month 1 and Month 2 (item 5.8), noting that the Trust's reported deficit remained in line with its plan.
- The Trust's underlying deficit remained at c.£7m per month.
- The committee reviewed the Trust's Cost Improvement Programme, noting that the Trust was targeting £110m of savings for 2025/26. It was further noted that even with full delivery of the Trust's workforce plans, there would still be a shortfall.
- The committee received an update on the contracting process for 2025/26, noting that there was a risk that there would be £20-30m of unfunded activity during the year based on the current position.
- The committee also continued to monitor the Trust's cash position.

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

Jane Harwood was invited to present the Committee Chair's Report in respect of the meeting held on 25 June 2025, the content of which was noted. It was further noted that:

- The committee reviewed the People Report for Month 2 (item 5.10), noting that the Trust was on track in terms of its plan to reduce its workforce by c.700 and had received more than 220 applications under the Mutually Agreed Resignation Scheme.
- The committee received an update on organisational change and the support being given to staff on managing change.
- An update was provided in respect of the Trust's education programmes, noting that there was a risk due to a lack of resource.
- The committee would be reviewing the recently published 10-Year Plan in detail, particularly in terms of the organisational development elements and the plan's implications for the Trust.

5.4 Briefing from the Chair of the Quality Committee

Tim Peachey was invited to present the Committee Chair's Report in respect of the meeting held on 2 June 2025 and to provide an update following the meeting held on 14 July 2025, the content of which was noted. It was further noted that:

- There had been a further never event, although no harm had resulted.
- The committee received a report on pressure ulcers and noted some concerns with respect to the regular turning of patients.
- An update on the Fundamentals of Care programme was received and it was noted that improvement in general standards was limited in the absence of sufficient staff.
- The committee noted an update in respect of job planning and that this provided good assurance of the process.
- The committee reviewed the Maternity and Neonatal Safety Report for Quarter 4 and confirmed that there was nothing requiring escalation to the Board.

Tim Peachey was invited to present the Maternity and Neonatal Workforce Report, the content of which was noted. It was further noted that:

- The Trust expected to be compliant with the requirements of the NHS Resolution Maternity Incentive Scheme for 2025/26.
- Although the Birthrate Plus assessment indicated a reduction in the birth rate, the acuity was, however, higher.
- According to assessment, the Trust was approximately nine midwives below the required level. However, there was a plan in place to address this shortfall using the existing workforce.
- There was a national shortage of neonatal nurses, although the Trust was attempting to address this issue through its in-house training programme.
- In terms of the obstetrics workforce, there remained an issue with the number of trainees.

5.5 Chief Executive Officer's Report

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

- The Trust had opened a new Neonatal ICU facility on 11 July 2025 as part of its work to improve the quality of the environment in the department.
- The Government had published its 10-Year Health Plan for the NHS in England, which was based on reforming the NHS through three shifts: hospitals to community; analogue to digital; and sickness to prevention.

- NHS England had published the NHS Oversight Framework for 2025/26 under which organisations would be segmented based on their performance against a range of metrics. Whilst the Trust was one of the best performing trusts, the impact of a financial override and being in the Recovery Support Programme meant that the Trust would be placed in segment 5, the lowest category of performance.
- Whilst the NHS waiting list nationally had fallen, the Trust's waiting list has continued to grow. This was partially due to the impact of the cap on elective funding which had caused the Trust to cease outsourcing some procedures on the basis that it was not financially viable.
- Notification had been received from the British Medical Association that resident doctors would embark on a five-day strike commencing on 25 July 2025. There was a risk of industrial action by other staffing groups, as both the Royal College of Nursing and Unite were conducting consultative ballots in respect of the 2025/26 pay award and other matters.

5.6 Performance KPI Report for Month 2

Duncan Linning-Karp was invited to present the Performance KPI Report for Month 2, the content of which was noted. It was further noted that:

- In the spotlight on Referral To Treatment, despite the Trust treating more patients, its waiting list had grown by 1%. Certain services accounted for much of this growth, with other services seeing flat or reducing waiting lists. The increase had also been driven by the decision to cease outsourcing some specialities due to the impact of the elective recovery funding cap.
- There were three ways to address the increasing size of the waiting list: refusing referrals, validation, and treating more. The 'patient choice' agenda made refusing out-of-area referrals difficult.
- The Trust's performance across the constitutional standards indicated that the Trust was operating in a challenging environment and was delivering at activity levels far in excess of pre-COVID-19 levels.
- Attendances at the Emergency Department remained high, averaging 433 attendances per day across March, April and May 2025. The Trust's performance against the four-hour standard was 56.2%, a reduction of 4.5% compared to April 2025.
- There had also been a reported increase in the number of Category 2 Pressure Ulcers (per 1,000 bed days) to 0.37 in May 2025, above the target of 0.3.
- The Trust continued to benchmark in the top quartile when compared to peer teaching organisations against the national cancer performance targets.
- Pressure on flow had caused an increase in overnight ward moves.

5.7 Break

5.8 Finance Report for Month 2

Ian Howard was invited to present the Finance Report for Month 2, the content of which was noted. It was further noted that:

- The Trust had reported an in-month deficit of £3.8m, which was consistent with the Trust's annual plan. The underlying monthly deficit remained at £7.2m.
- There had been a number of 'one-offs' during the month which had reduced the underlying deficit to meet the planned level of deficit. The Trust continued to target recurrent savings.
- Whilst the Trust remained on an improving trajectory, there was some concern regarding the pace of improvement.

- The Trust was involved in a number of contractual disputes in respect of currently unfunded or insufficiently funded services.
- The Trust's cash position remained an area of concern and continued to be closely monitored. The Trust had five operating days of expenditure, although this was supported in month by holding c.£13m of payments. There remained a significant risk that the Trust's cash balance would reduce to close to zero in the first half of 2025/26.

5.9 ICS Operational Delivery Report for Month 2

Ian Howard was invited the present the ICS Operational Delivery Report for Month 2, the content of which was noted. It was further noted that:

- The previous ICB Finance Report had been expanded to now include operational and performance information across the system.
- The Hampshire and Isle of Wight Integrated Care System had reported that it was on plan for Month 2 with a reported deficit year-to-date of £18.25m against a planned deficit of £18.3m.
- All organisations in the system would receive deficit support funding for Quarter 1 and Quarter 2. Whilst there was no clear national picture, it was believed that other organisations were in a similar position.
- The South East region's plan for 2025/26 was for a deficit of £95m at Month 2.

5.10 People Report for Month 2

Steve Harris was invited to present the People Report for Month 2, the content of which was noted. It was further noted that:

- In May 2025, the workforce grew by 19 whole-time-equivalents (WTE), although was still below plan by 107 WTE. In addition, in June 2025, there had been a reduction in the overall workforce size of 99 WTE driven by the closure of surge capacity and higher turnover during the month.
- There had been a freeze on hiring for administrative and clerical roles since March 2025 and only 70% of clinical leavers were being replaced. However, patient demand was not reducing.
- The Trust had carried out a divisional restructure, reducing its clinical divisions from four to three.
- Even full delivery of the Trust's Cost Improvement Programme workforce reduction schemes would still produce a shortfall in terms of the Trust's achievement of its 2025/26 plan. Whilst the Trust was currently on plan in terms of its workforce numbers, it was expected that it would deviate from this later in the year.
- The Trust had accepted 42 applications under the Mutually Agreed Resignation Scheme and a number of others were under consideration. The majority of accepted applicants were from clinical administration teams,
- The Trust was carrying out work to benchmark its temporary pay rates against others.
- Transparency about the changes was key to mitigate against the anxiety in the workforce. A number of engagement activities were taking place, including regular 'Talk To David' sessions.
- An Equality and Quality Impact Assessment process was in place and was undertaken in respect of decisions. The impact of decisions would be monitored through the Quality Governance Steering Group. It was also

necessary to ensure that there was a strategic view of decisions rather than just individual cases.

The Board discussed the controls on recruitment. The content of the discussion is summarised below:

- It was questioned whether a complete freeze on non-clinical recruitment could be sustained for the full year, and that shortages in administrative staff were already having an impact. It was noted that there had already been restrictions on recruitment for these staff groups during the previous year.
- It was noted that decisions made by providers in isolation could impact other providers. However, chief medical officers across the system had agreed to discuss plans collectively.

5.11 Freedom to Speak Up Report

Christine Mbabazi was invited to present the Freedom to Speak Up Report, the content of which was noted. It was further noted that:

- The Trust had received 37 Freedom to Speak Up cases between December 2024 and June 2025, compared to 64 cases during the same period in 2023/24. There had also been a lower number of patient safety and health and safety reports.
- Although there had been fewer reports via Freedom To Speak Up, there were other routes for raising concerns and Freedom To Speak Up was meant to provide a route where other options were unavailable or not possible.
- It had been reported that the National Guardian Office function was to be abolished.

The Board discussed the report, the key points from which are summarised below:

- The Freedom to Speak Up framework was designed to facilitate reporting of patient safety related concerns. However, there had been few such reports through this route, with the mechanism being used more as a conventional 'speak up' method to report matters such as bullying and harassment.
- Moreover, it was not clear whether the lack of such reports via Freedom to Speak Up was an indicator whether the more conventional reporting mechanisms were working effectively and hence there was no requirement to use Freedom to Speak Up.
- It was agreed that it would be helpful to have data from the other means of reporting patient safety concerns included in the report in order to provide greater assurance.

Action

Christine Mbabazi to include data from other mechanisms for reporting concerns in future Freedom to Speak Up reports.

5.12 Infection Prevention and Control 2024-25 Annual Report

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

- The Trust had exceeded the threshold for Clostridioides Difficile and Methicillin-resistant Staphylococcus aureus (MRSA) cases during the year. However, the Trust had been successful in improving antimicrobial stewardship by 1%.
- There had been a surge in respiratory infections in early 2025, which the Trust had managed well due to the use of its rapid testing diagnostic tool. The Trust had also successfully mitigated outbreaks of norovirus.
- The measures taken to prevent the spread of Candida auris had been successful with only four acquisitions since September 2024.
- Only 59% of areas had achieved the accreditation scheme standard, but there were actions in place to address this and improve standards as well as support through the Fundamentals of Care programme.

5.13 Guardian of Safe Working Hours Quarterly Report

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

- There was a resident doctor vacancy rate of 8%, which was good compared with others.
- Exception reports had decreased since the winter months. 711 exception reports had been received over the past 12 months, an average of 59 per month.
- The People and Organisational Development Committee would continue to receive updates in respect of work being carried out to improve the lives of resident doctors.
- The main challenge in terms of steps required to improve working conditions remained the Trust's estate and the limited options for providing office space.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2025-26 Quarter 1 Review

Martin de Sousa and Kelly Kent were invited to present the Corporate Objectives 2025/26 Quarter 1 Review, the content of which was noted. It was further noted that:

- Twelve objectives had been agreed for 2025/26.
- The Trust was on track with 75% of objectives recorded as 'green' and the balance being 'amber'.
- The main risks to achieving the Trust's objectives related to availability of people and financial constraints.

6.2 Research and Development Plan 2025-26

Karen Underwood and Chris Kipps were invited to present the Research and Development Plan 2025/26, the content of which was noted. It was further noted that:

- 2024/25 had been a challenging year, but despite this there had been a number of significant successes. These included an award to host a new Commercial Research Delivery Centre, launch of the South Central Regional

Research Delivery Network, and securing funding for a secure data environment.
- There remained challenges in terms of available capacity to set up and deliver studies.
- Key Performance Indicators were to be focused on national priorities.
- The plan for 2025/26 would focus on efficiency and working regionally.
- The Trust had increased the size of its commercial portfolio. However, there needed to be a balance with non-commercial studies to support the Trust's wider strategy.

Decision
Having considered the proposed Research and Development Plan for 2025/26, the Board approved the plan.

6.3 Board Assurance Framework (BAF) Update and Risk Appetite Statement
Lauren Anderson was invited to present the Board Assurance Framework (BAF) Update, the content of which was noted. It was further noted that:
- All risks had been reviewed by the relevant executive(s) and by the Board's committees since the Board Assurance Framework was last presented to the Board.
- The risk ratings had been increased for three risks. This was broadly due to the tension between the Trust's finances and increasing demand. As a result, 60% of BAF risks were now at the 'critical' level.
- The risk descriptions indicated crossover in terms of mitigations, demonstrating a holistic approach to risk management.

Lauren Anderson was invited to present the Trust's Risk Appetite Statement, the content of which was noted. It was further noted that:
- The Trust's Risk Appetite Statement had been updated following the Trust Board Study Session held on 3 June 2025.
- Due to the current environment, the Trust was required to tolerate a higher level of risk.
- The main changes in terms of risk appetite were to reflect the need to make decisions that might adversely impact patient experience and a lower appetite for financial risk.

Decision:
The Board agreed the Risk Appetite Statement tabled to the meeting.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

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

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

7.2 Review of Standing Financial Instructions 2025

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

- There were two main changes proposed: an additional section on employee expenses and reducing non-pay approval limits for certain bands.
- The Standing Financial Instructions had been benchmarked against others to address differences of approach.
- The proposed changes had been reviewed and supported by the Audit and Risk Committee at its meeting held on 9 June 2025.

Decision:
The Board approved the proposed changes to the Standing Financial Instructions tabled to the meeting.

8. Any other business

There was no other business.

9. Note the date of the next meeting: 9 September 2025

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

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List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 13/05/2025 - 5.6 Performance KPI Report for Month 12				
1246.	Virtual outpatients appointments	Linning-Karp, Duncan	09/09/2025	Pending
	Explanation action item Duncan Linning-Karp agreed to investigate why the number of virtual outpatients appointments had reduced.			
Trust Board – Open Session 15/07/2025 - 5.11 Freedom to Speak Up Report				
1267.	Data	Mbabazi, Christine	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.			

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Agenda Item 5.1 i)

Committee Chair's Report to the Trust Board of Directors 9 September 2025	
Committee:	**Finance and Investment Committee**
Meeting Date:	**21 July 2025**
Key Messages:	• The committee reviewed the Finance Report for Month 3, noting that the Trust had reported a £4.5m in-month deficit. This was £1.1m above the plan submitted to NHS England. The Trust's underlying deficit was £6.5m in month and income had been lower than expected. • Whilst the Trust's financial trajectory was improving, it was not improving at the rate required to deliver the plan. • The committee received an update in respect of the Trust's cash position, noting that the Trust had received additional cash from the ICB during the month. However, the Trust expected to record a negative cash balance in December 2025. Accordingly, the Trust was investigating further measures to manage its cash position. There was also a risk due to any unfunded elements of the pay award and additional costs due to industrial action. • The committee reviewed the Trust's CIP performance, noting that whilst the Trust was close to full achievement, there had been fewer recurrent schemes delivered than anticipated with a greater proportion of savings being delivered through non-recurrent savings. • The committee received an update in respect of the Trust's productivity, noting that this would be one of the metrics to be included in the new NHS Oversight Framework. • The committee received an update regarding the Outpatient Transformation Programme. • The committee reviewed Wessex NHS Procurement Limited's performance, including its delivery of CIP. • The committee received the quarterly UHS Digital report. • The committee received an update on the proposed Hampshire and Isle of Wight elective hub and on a possible Urgent Treatment Centre at Southampton General Hospital.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	N/A
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 5.1 ii)

Committee Chair's Report to the Trust Board of Directors 9 September 2025			
Committee:	**Finance and Investment Committee**		
Meeting Date:	**2 September 2025**		
Key Messages:	• The committee reviewed the Finance Report for Month 4 (see below). • The committee reviewed and discussed a draft of the Trust's Financial Recovery Plan, which was to be reviewed by the Board on 9 September 2025. The committee requested some clarifications and proposed some additions to ensure that long-term implications were understood. These changes would be incorporated into the paper to go to the Board. Suggestions for further action were also raised, but some of these had been discounted due to the impact on operations and detriment to the short-term position. • The committee received an update in respect of the Trust's cash position, noting that the Trust had received cash advances in June and July and that the ICB had agreed to provide additional cash in August and September. In addition, the process for requesting cash support from NHS England had now been published, although this would likely require some adjustments to the Trust's governance to establish a 'cash committee' – it was considered appropriate to review the terms of reference for the Finance and Investment Committee and possibly to separate out the cash monitoring activities. • It was further noted that NHS England had published guidance which suggested that trusts should have a minimum of four days' operating expenditure in cash. • The committee supported the submission of a request for cash support from NHS England, noting that the consequences of not receiving such support would be extremely serious (see also BAF review below). • The committee received an update in respect of ongoing and recent contracting disputes, noting that a number of significant disputes had been closed and two remain in dispute and have been escalated.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.8 Finance Report for Month 4**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The Trust had recorded a year-to-date deficit of £19.5m, which was £5.8m above its 2025/26 plan. • There had not been the one-off benefits seen in previous months during Month 4, which meant that the Trust's position had worsened. However, its underlying month-on-month deficit was improving with £6.5m being recorded in month (previous months had been c.£7m). • The Trust had also received less income than anticipated from areas such as the Channel Islands, genomics, pathology, and CAR(T). There was also a risk that the Trust would not be fully paid for its over performance in terms of elective work, but this was being pursued with the relevant commissioners. • The Trust was also above its workforce plan by 55 whole-time-equivalents and the unfunded element of the pay award amounted to £2.4m per annum, of which £1.4m related to the training and		

	education contract and the balance being as a result of the settlement not accurately reflecting the Trust's staffing mix. • However, the Trust was on track in terms of its CIP delivery, albeit there had been higher non-recurrent delivery than expected.		
	6.1 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). • It had been agreed to increase the rating of risk 5a from 20 to 25 on the basis that the Trust did not, currently, have an agreement for the provision of cash support, and that the Trust was reliant on third parties to resolve many of the underlying issues. It was also noted that the need to reduce activity and spending now would likely require increased expenditure in future years in order to recover the Trust's position. • It was agreed that the target risk ratings should be amended to show a rating of 20 at April 2026 and 15 at April 2027.		
Any Other Matters:	The committee noted new guidance in respect of strengthening financial management and supporting delivery in 2025/26.		

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.
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Risk Rating:

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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 9 September 2025	
Committee:	**People and Organisational Development Committee**
Meeting Date:	**21 July 2025**
Key Messages:	• The committee reviewed the People Report for Month 3 and noted that the size of the workforce had reduced during June 2025. There had been 110 whole-time-equivalent (WTE) staff who left during the month and the Trust was phasing new starters. In addition, the Trust had been able to close surge capacity and was closing wards, which had led to a reduction in bank staff use. • Based on the forecast, the Trust expected to be c.350 WTE short of its 2025/26 plan based on the delivery of the 'green' and 'amber' rated CIP programmes. The Trust continued to experience increased demand and there had been an increase in the number of patients having no criteria to reside. In addition, new resident doctors and newly qualified nurses would impact the Trust's workforce numbers and the forecast made no assumptions regarding industrial action. • The committee noted that administrative and clerical staff had been hardest hit by the recruitment restrictions over the past two years, which was causing difficulties in some areas. • The committee discussed the potential intake of newly qualified nurses, noting the difficulty of balancing the Trust's short-term concerns of needing to reduce its workforce with the longer term need for qualified staff. • The committee received an update on the organisational change activities underway, including the proposed divisional restructure and MARS programme. • The committee received an update in respect of the planned industrial action by resident doctors. • The committee reviewed the National Education and Training Survey for 2024, which covered all staff in training posts in the NHS.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	N/A
Any Other Matters:	• The committee reviewed five draft Equality and Quality Impact Assessments relating to the measures required to deliver the Trust's 2025/26 plan.

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.
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Not Applicable	Where risk rating is not relevant.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 ii)

Committee Chair's Report to the Trust Board of Directors 9 September 2025			
Committee:	**People and Organisational Development Committee**		
Meeting Date:	**1 September 2025**		
Key Messages:	• The committee reviewed the People Report for Month 4 (see below). • The committee noted the recent announcement by the Government of a 'graduate guarantee' for nurses. It was noted that, prior to this announcement, the Trust had decided to increase the level of offers to newly qualified nurses, but to phase start dates in line with predicted turnover and anticipated vacancies in nursing posts. • The committee noted that there were significant challenges across the organisation with staff impacted by multiple factors, including: increased car parking rates, building work requiring temporary relocation of 300-400 car park users to Adanac (Park and Ride), a reduction in enhanced bank rates back to standard Agenda for Change levels, and a decision to no longer offer free tea and coffee in theatres for staff (in line with other areas of the Trust). This coupled with the ongoing financial environment and workforce controls would impact staff engagement and satisfaction with the Staff Survey due to launch at the end of September 2025. • The committee also expressed its concern for staff – particularly those from overseas – in view of the recent political climate regarding immigration. • The committee reviewed the workforce related elements of the Trust's proposed recovery plan, noting that the Trust was dependent on a number of material assumptions in order to be able to meet its 2025/26 plan. These included: availability of funding for further restructuring, reductions in mental health and no criteria to reside numbers, and reduction in overall activity levels. • The committee received an update in respect of the industrial action undertaken by resident doctors in July 2025 and noted that about one third of staff eligible took part in the strike and that most clinical activity continued. It was also noted that F1 doctors were to be balloted separately by the BMA with the focus more on pay and availability of training places. The Trust has been required to produce a self-assessment of ten actions relating to doctors' working conditions and to determine how to achieve these actions which will be presented to committee and to Board through the update by the Guardian of Safe Working at UHS.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.10 People Report for Month 4**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The overall workforce had increased by 10 whole-time-equivalents (WTE) in July 2025. Whilst the substantive workforce had decreased by 18 WTE, increased numbers of mental health cases, coupled with industrial action, had led to an increase in use of temporary staff. • Accordingly, the Trust was above the NHSE 2025/26 workforce plan by 55 WTE. • 65 applications under the Mutual Agreed Resignation Scheme (MARS) had been approved with all successful applicants due to leave		

	by the end of November 2025. This would deliver a recurrent saving of £2.2m based on the whole-year saving, albeit at a one-off cost of £1.1m, which meant that it was broadly cost neutral for 2025/26. • The Trust completed its divisional restructure on 1 July 2025, which was expected to deliver a saving of £700k and 12 WTE		
	7.2 People and Organisational Development Committee Terms of Reference	***Assurance Rating: N/A***	***Risk Rating: N/A***
	• The committee reviewed its terms of reference and recommended that the Board approve the updated terms of reference. • Only one minor change was proposed – to remove reference to the Charitable Funds Committee on the basis that this committee no longer existed.		
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.
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Not Applicable	Where risk rating is not relevant.

Agenda Item 5.3

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
9 September 2025</td></tr>
<tr><td>Committee:</td><td colspan="3">Quality Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">18 August 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• It was noted that there were concerns in respect of the staff reaction to the intended removal of enhanced NHS Professionals rates from September 2025. However, it was further noted that these enhancements were originally intended to be temporary.
• The committee received the Experience of Care Quarter 1 Report, noting that the trend of staff attitudes featuring as a reason for a complaint seen in Quarter 4 had continued. A number of complaints had also been recorded regarding outpatient appointments, which was under investigation to identify any common themes. The committee also questioned the proportion of complaints 'not upheld' and whether this was in line with that at other organisations.
• The committee reviewed the Maternity and Neonatal Safety Report for Quarter 1, noting that there had been a formal escalation in respect of the Maternity Triage Line regarding its governance. However, an action plan had been developed with local partners and the ICB and the concern had been addressed.
• The committee noted that there had been two further Never Events during Quarter 1.
• The committee received an update in respect of the roll out of NatSSIPS
• The committee received the Medicines Safety Annual Report, noting that reported incidents were at pre-pandemic levels. Ten NHS patient safety alerts had been received, of which nine related to shortages of medicines.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.11 Learning from Deaths 2025-26 Quarter 1 Report</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
Medium</td></tr>
<tr><td colspan="3">• The Trust remained one of only 11 trusts out of 119 with a lower-than-expected death rate during the Quarter.
• The Trust had agreed to purchase an additional module for the Ulysses system to facilitate the sharing of learning from Mortality and Morbidity meetings as well as improve tracking and analysis of outputs.
• It was noted that the sharing of learning, especially where there were wider implications beyond the directly impacted team, could be improved. However, where there was a patient safety related concern, this learning was disseminated widely.
• The committee reviewed the Annual Clinical Audit Programme 2025/26.</td></tr>
<tr><td>5.14 Safeguarding Annual Report 2024-25 and Strategy 2025-26</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
Medium</td></tr>
<tr><td colspan="3">• The committee noted the Safeguarding Annual Report 2024/25, noting that activity levels remained consistent with prior years, but that the complexity of cases had increased and noting that overall numbers had increased in the post-COVID period.</td></tr>
</table>

	• There had also been an increase in the number of adult safeguarding referrals. • The team had seen improved levels of training across the Trust, although noting that there was further work to do.
Any Other Matters:	• The committee noted clinical claims activity for 2024/25 and a summary of legal matters.

Assurance Rating:

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Not Applicable	Where risk rating is not relevant.

Agenda Item 4.3	Report to the Quality Committee, 18 August 2025
Title:	Maternity and Neonatal Safety 2025-26 Quarter 1 Report
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

Purpose

(Re)Assurance	Approval	Ratification	Information
x	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				

Executive Summary:

In line with NHS Resolution (NHSR) requirements, the Maternity & Neonatal (MatNeo) Service submits a quarterly safety report to the Trust Quality Committee. This Quarter 1 (Q1) 2025–26 report continues to reflect an adaptive and responsive approach to emerging safety concerns within our service, while providing assurance regarding ongoing improvements that impact the safety and experience of families, service users, and staff.

The report is intended to offer both assurance and reassurance, fulfilling the requirements of NHSR's Maternity Incentive Scheme (MIS) Year 7. It highlights key safety improvement initiatives, learning from incidents and investigations, and progress in alignment with the Patient Safety Incident Response Framework (PSIRF).

We ask Committee members to continue supporting the MatNeo Service through appropriate monitoring, oversight, and constructive scrutiny, ensuring that safety remains a priority across all levels of care.

Contents:

This report provides an update in relation to the following areas for Quarter 1 2025/26:

1. Perinatal Quality Surveillance – 1a. UHS Maternity Dashboard - Q1 2025 26.xlsx
   Key red flags:
   1.1. Post Partum Haemorrhage (PPH) – OBS UK 7-month summary **(Appendix 1.1)**
   1.2. 3rd and 4th degree perineal tears OASI **(Appendix 1.2)**
   1.3. Apgar scores less than 7 at 5 minutes **(Appendix 1.3)**
   1.4. Smoking at time of delivery **(Appendix 1.4)**
2. Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases **(Appendix 2**)
   PSIRF learning slides:
   Appendix 2.1 MNSI case
   Appendix 2.2 PSII case
3. Maternity Triage Line (MTL) MNSI concerns escalation letter & action plan **(Appendix 3)**
4. Perinatal Mortality Review Tool learning and themes **(Appendix 4)**
5. ATAIN update **(Appendix 5)**
6. Triangulation of incidents and complaints **(Appendix 6)**
7. 3 Year Delivery Plan Benchmarking **(Theme 1) Personalisation and choice (Appendices 7.1 and 7.2)**

8. SCORE survey **(Appendix 8)** PCL Team update
9. Patient voice and progress with MNVP **(Appendix 9)**

Risk(s):

The University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Service operates within a complex regulatory and governance framework. Several key risks have been identified that may impact service delivery, organisational performance, and the safety of women, babies, and staff:

- **Reputational Risk**: Any concerns relating to safety or quality of care may be raised by service users or stakeholders to external regulatory bodies such as NHS Resolution and the Care Quality Commission (CQC), potentially affecting public confidence in our services.
- **Financial Risk**: Ongoing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) remains essential. Failure to meet all ten required Maternity Safety Actions could result in the loss of financial incentives and increased scrutiny.
- **Governance Risk**: Significant concerns regarding safety or quality can be escalated to a range of national and regional stakeholders, including the CQC, NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, and the Regional Chief Midwife. This may lead to formal reviews or additional oversight.
- **Safety Risk**: Non-compliance with national requirements, standards, or recommendations can have serious consequences, including increased clinical risk to women and babies, reduced staff morale and wellbeing, and ultimately poorer outcomes. The Maternity and Neonatal Safety Improvement (MNSI) programme has the authority to raise formal concerns and trigger external reviews where safety is questioned.

UHS remains committed to proactively addressing these risks through robust governance processes, continuous quality improvement, and transparent engagement with our staff, service users, and external partners.

Equality Impact Consideration:	N/A

1. Perinatal Quality Surveillance – Maternity & Neonatal Dashboard (Including PQSM)

The red flag exceptions for this quarter are detailed in **Appendix 1a**, UHS Maternity Dashboard Q1 2025/26. Most exceptions are already known to the Quality Committee, and no new exceptions have been identified during this period. Key areas of note are outlined below.

1.1 Post Partum Haemorrhage (PPH) >1500ml

Appendix 1.1 summarises the first seven months of an ongoing quality improvement initiative aimed at reducing the number of red cell transfusions associated with significant postpartum haemorrhage. This work focuses on the implementation of a robust care bundle that supports early identification, effective management, and timely escalation of PPH cases. Initial findings are being used to inform current clinical practice and support ongoing improvements in the management of obstetric haemorrhage.

The Quality and Safety team are continuing to explore this measure in greater depth and are working with our LMNS partners, who currently report lower PPH rates. By reviewing their approaches and outcomes, we aim to identify areas of potential learning or improvement that can be incorporated locally.

1.2 3rd and 4th Degree Perineal Tears (OASI)

Appendix 1.2 provides an update on progress with the rollout of the OASI Care Bundle. Audit activity remains ongoing and is being supported by thematic learning reviews to better understand contributing factors and target improvement. We are pleased to report that a newly appointed pelvic health lead midwife is now in post. They are actively working in collaboration with regional colleagues to help strengthen and drive this important area of safety work.

1.3 Apgar Scores Less Than 7 at 5 Minutes

Concerns regarding babies with Apgar scores below 7 at five minutes have previously been escalated through internal reporting systems and discussed at Safety Champion Meetings. **Appendix 1.3** provides further detail, particularly focusing on fetal monitoring practices and escalation protocols.

From a review of cases, it was noted that antenatal CTGs were not consistently subject to hourly peer review. Of the 21 intrapartum cases reviewed, 19 had CTG concerns that were appropriately escalated. All five elective LSCS cases involved general anaesthesia. Two cases experienced delays in accessing theatre due to capacity and acuity challenges, these have been escalated for further review.

In response, a dedicated working group is being established to undertake a more detailed thematic review of these cases. The aim is to identify recurring issues, support targeted learning, and embed improvement across this critical aspect of care.

1.4 Smoking at Time of Delivery (SATOD)

During Quarter 1, SATOD rates showed fluctuations, in part due to temporary staffing gaps in the tobacco dependency advisor (TDA) team, which affected the timely provision of cessation support. Encouragingly, the service has now received approval to recruit 1.8 WTE TDAs following the confirmation of recurrent national funding. Recruitment is currently underway, and with this expansion in capacity, we anticipate greater support for service users and improved outcomes over the coming quarters. There are also plans to align the service more closely with national incentive schemes, which will offer further benefit to women and their families. Further detail on this workstream is provided in **Appendix 1.4**.

2. Maternity and Newborn Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases

Appendix 2 provides assurance to Committee Members that appropriate reporting and governance processes have been followed in Quarter 1, in line with national and Trust wide expectations. During this period, there were no new MNSI referrals. One PSII case was initiated and closed, and two MNSI cases were concluded, with key learning captured and shared.

As part of our commitment to transparency, the report also includes information on new and closed perinatal mortality cases, even where no concerns regarding the quality or safety of care were identified. This approach ensures continued visibility and offers ongoing learning opportunities across our Maternity and Neonatal service.

A summary of all moderate harm incidents reported in Q1 is also included in **Appendix 2**, with analysis of contributory factors and emerging themes that may inform future safety improvement work. **Appendices 2.1** and **2.2** describe the learning identified from the two closed cases: one investigated externally by MNSI (involving a cooled baby) and one investigated internally by UHS through a PSII process (involving a retained vaginal swab).

Thematic reviews/learning informed by PSIRF

In line with the Patient Safety Incident Response Framework (PSIRF), the Risk and Governance Team has undertaken thematic reviews of both PPH and OASI. These reviews have enabled a more structured approach to identifying trends and opportunities for improvement across these key areas of care.

In relation to PPH, themes emerging include issues with theatre capacity and delays, the importance of pre-conception optimisation of haemoglobin levels, and the potential to enhance debrief processes to improve patient experience and reduce formal complaints.

For OASI, 3a tears were found to be the most frequently recorded injury. A noteworthy trend is that 37% of cases occurred over the weekend period. Additionally, in 70% of cases, women were in a semi-recumbent position during birth, and 77% had a normal vaginal delivery. These insights are being used to inform both clinical education and care pathway adjustments.

3. Maternity and Neonatal Safety Improvement Programme – Formal Escalation: Maternity Triage Line (MTL)

The Maternity and Neonatal Safety Improvement (MNSI) programme has formally escalated concerns relating to the Maternity Triage Line (MTL), following the identification of repeated issues during investigations where the MTL was cited as a contributing factor. While none of the incidents involved UHS patients directly, the Trust acknowledges its hosting role and the responsibility this brings.

In response, UHS has developed a comprehensive action plan designed to strengthen the safety, governance, and operational delivery of the MTL. This includes a full review of current triage processes, enhanced oversight and monitoring, and the implementation of immediate and longer-term mitigation strategies.

UHS remains fully engaged with MNSI and other relevant stakeholders to ensure the risks associated with the MTL are addressed effectively and transparently. Further information is available in **Appendix 3**, which outlines the actions taken to date and the next steps.

4. Perinatal Mortality Review Tool learning and themes

Appendix 4 outlines the service's progress against the required standards for Safety Action 1 of the NHS Resolution Maternity Incentive Scheme (MIS) Year 7.

The appendix details the actions taken to meet compliance requirements and highlights key themes and learning identified through this process. These insights are being used to inform ongoing quality improvement and strengthen maternity safety governance. The themes and learning have been shared with our LMNS at the Perinatal Quality and Safety forum.

5. ATAIN update

Quarter 1 of 2025/26 has seen a further reduction in term neonatal admissions, with 26 admissions recorded, down from 34 in the previous quarter. **Appendix 5** provides further detail. Poor perinatal adaptation continues to be the leading cause of admission, accounting for 69% of cases.

Several recurring themes have been identified, including inconsistent or delayed clinical escalation, incomplete documentation, variation in jaundice management, and challenges in interpreting fetal monitoring accurately. These areas are being addressed through targeted audit, multidisciplinary education sessions, and ongoing review. The service remains focused on improving early recognition and timely response to neonatal deterioration.

6. Triangulation of incidents, claims and complaints

Appendix 6 consolidates recurring themes across multiple data sources, including reported incidents (AERs), MNSI recommendations, formal complaints, service user feedback (FFT), and legal claims.

Thematic analysis has identified key areas for improvement, notably communication, staffing and capacity challenges, and delays or gaps in clinical care and observations. These findings have been shared with the Maternity and Neonatal Voices Partnership (MNVP), with whom we are working collaboratively to identify actionable changes and develop responsive quality improvement plans.

7. MatNeo 3 year delivery plan local update

We are currently in the second year of the national Three Year Delivery Plan for Maternity and Neonatal Services. The service has undertaken a benchmarking exercise to assess our position against the plan's expectations. Progress against Theme 1 is detailed in **Appendices 7.1** and **7.2**, including the Personalisation of Care pilot, which represents a key workstream. Evaluation of the pilot will inform plans for wider rollout to our full maternity population.

As a Trust, we remain fully committed to delivering the ambitions set out in the national plan. From Q1, reporting has been structured around each of the four thematic areas, with one theme covered per quarter. Risks to delivery are escalated through appropriate governance routes, including to this Committee. At year end, we will provide a comprehensive summary of progress across all themes.

Patient experience improvement work

The Wessex Maternal Medicine Network, in collaboration with UHS, UHD, and service users requiring ICU care, has developed a virtual learning environment (VLE) training session. This work addresses the impact of mother–baby separation and aims to improve ITU staff's understanding of maternity care needs during critical illness and the early transition to parenthood.

Three women have shared their lived experiences in ICU, which have been incorporated into the training and made accessible via the Healthier Together website. Supporting guidance has also been developed to provide compassionate and consistent care to mothers admitted to ICU while breastfeeding or formula feeding. This work has been adopted by all units across our network and will be showcased at the ITU Network Conference in November.

8. SCORE Survey and Safety Culture update

Appendix 8 summarises the latest update from the Perinatal Culture Leadership Team, shared during the recent Safety Champions Meeting. It outlines progress against the agreed action plan, including ongoing workstreams and future priorities.

Key developments include the launch of the "Cultivating Kindness" civility campaign, development of the 2026 training programme (including escalation pathway training), and completion of Moments training, all of which contribute to the creation of a more inclusive and supportive culture.

9. Patient Voice (MNVP update)

During Quarter 1, our MNVP Chair, Frankie Snow, continued to engage with service users through a series of listening and engagement events. These sessions are proving vital in capturing authentic user feedback and highlighting opportunities for improvement.

The MNVP's 2025/26 work plan prioritises enhancing engagement, particularly among underrepresented communities, and improving visibility through ongoing listening events and service walkabouts. Emerging themes include positive feedback on the BadgerNet app and Continuity of Carer teams, alongside a noted need for more time and support in the postnatal period. This feedback is being used to inform quality improvement activity and shared with relevant teams for consideration.

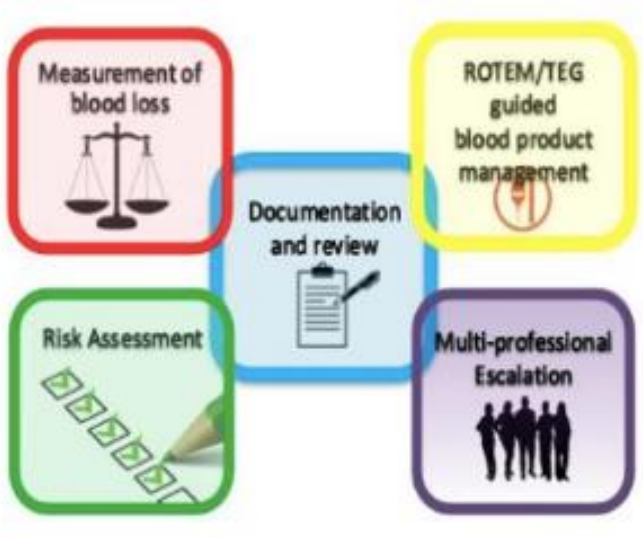
UHS OBS UK Study Update

Appendix 1.1

OBS UK
Obstetric Bleeding Study UK

NHS
University Hospital Southampton
NHS Foundation Trust

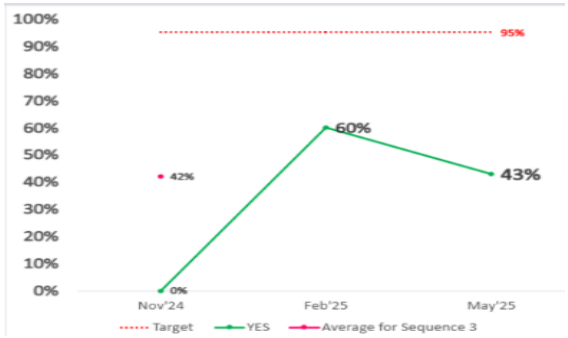
Aims:



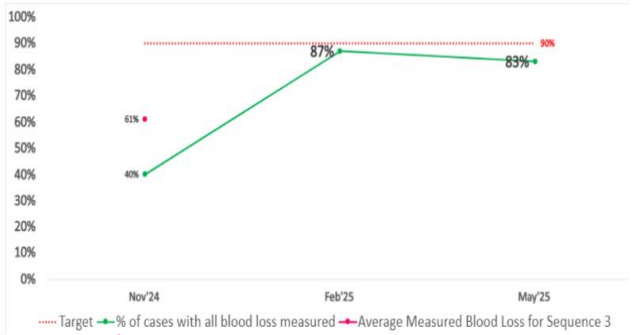
Month 7 Audit findings:

- Snapshot of 30 women
- Births between 7th-9th May 2025
- Types of birth: 10 EMCS, 8ELCS, 12 SVD, 0 instrumental births
- Location: 18 theatre, 8 in delivery suite room, 3 MLU, 1 pool
- 14 cases of ≥ 500mls blood loss

PPH risk assessments performed:



Measured blood loss:



Cumulative blood loss:

Documented evidence of cumulative blood loss measurements improved from 20% to **30%**

Escalation when ≥ 1L blood loss:

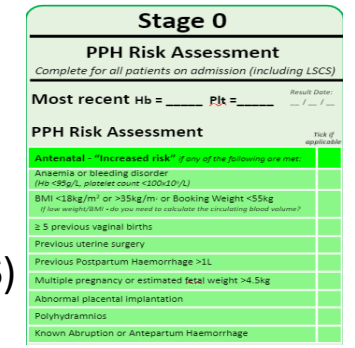
Band 7 involvement: 5/10
Resident obstetrician involvement: 8/10
Resident anaesthetist involvement: 6/10

TEG taken when ≥ 1L blood loss:

4/10 (3/3 MOH's)

Going forward:

1. Use the OBS UK Proforma for all births in all areas (including theatre and EILSCS)
2. Record PPH risk assessment for all patients admitted on LW (including EILSCS)
3. Cumulative weighing and record as **measured** blood loss.
4. Use proforma to ensure appropriate escalation and documentation of this.


Stage 0

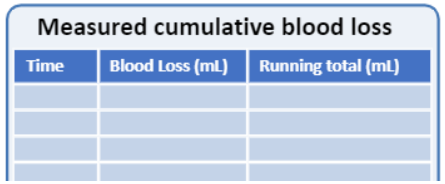
PPH Risk Assessment

Complete for all patients on admission (including LSCS)

Most recent Hb = _____ Plt =_____ Result Date: __ / __ / __

PPH Risk Assessment — Tick if applicable

Antenatal - "Increased risk" if any of the following are met:	
Anaemia or bleeding disorder (Hb <95g/L, platelet count <100x10⁹/L)	
BMI <18kg/m² or >35kg/m² or Booking Weight <55kg (if low weight/BMI - do you need to calculate the circulating blood volume?)	
≥ 5 previous vaginal births	
Previous uterine surgery	
Previous Postpartum Haemorrhage >1L	
Multiple pregnancy or estimated fetal weight >4.5kg	
Abnormal placental implantation	
Polyhydramnios	
Known Abruption or Antepartum Haemorrhage	


Measured cumulative blood loss

Time	Blood Loss (mL)	Running total (mL)

Feedback from Obs UK Team

The UHS site is embracing the study and made fantastic efforts with implementation. Now pushes are needed to continue this progress

OASI Update

On 25th March 2025 the OASI TWO CARE BUNDLE was launched at UHS

The OASI 2 Care bundle includes 4 elements, which have been dynamically rolled out:

1. **Antenatal discussion** – *New staff resources*
2. **Manual perineal protection** - *Practical training element*
3. **Mediolateral episiotomy** – *Practice training element*
4. **Systematic examination** – *Education material*

OASI TWO CARE BUNDLE

Training

- Face to Face OASI training for all midwives and doctors is ongoing, Currently **36%** are trained.
- There are plans in place for training with community teams on 'away days' and team meetings.
- RCOG level 1 training (free online) recommended

Communications

- OASI Stats posters are now in the birthing areas and will be updated monthly
- Posters for 'warm compress' and 'finish grip' are being circulated to support and remind staff in clinical areas
- Staff information sheets are being circulated for approval to support the antenatal 34week conversations

Perinatal Pelvic Health Service

AUDIT

- There is an ongoing Audit capturing local OASI incidence, aiming to review themes in line with national criteria

Coming soon!

- New referral pathway for LMNS referrals to Pelvic Health Physio
- Launch of Antenatal education classes

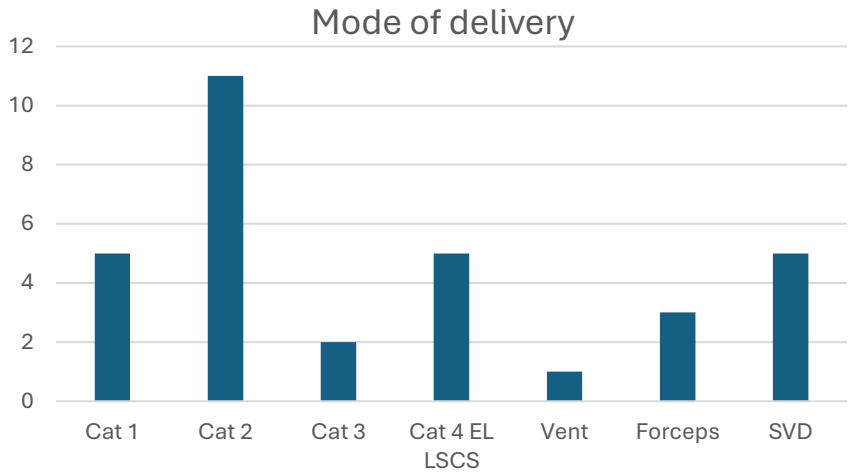
Author: Rebecca Juffs – Perinatal Pelvic Health Midwife | Data: Stephanie Meys | Version: 1.0 | 23.07.2025

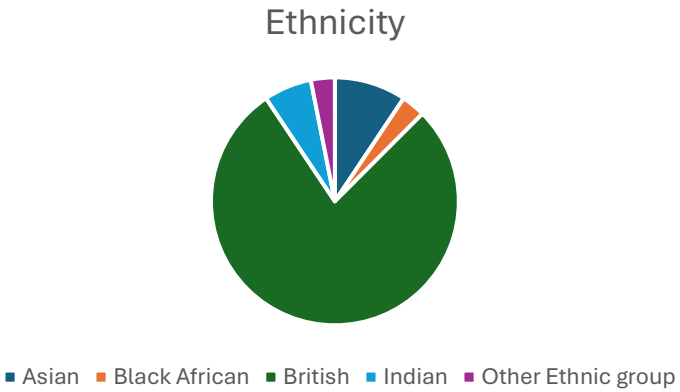
Apgar's <7 at 5 mins in relation to Fetal Monitoring

Jessica Bown

Summary

- 32 cases reviewed
- **All 5 Cat 4 EL LSCS had a GA**
- Gestation ranged from 26-41 weeks
- 19 cases clearly had CTG concerns that were escalated appropriately.
- Average compliance for hourly Peer reviews on the Intrapartum *(21 total)* CTG's **70%**
- **3 AN CTG's – did not have hourly reviews**
- Fetal monitoring labour review form not always used, compliance variable





<u>Themes</u>

- AN CTG's not having regular reviews
- Dr's when reviewing not always documenting a full CTG review
- 2x cases delays going to theatre due to capacity
- 3 cases identified for **Clinical Events Review**
- **13 babies admitted to NNU –** 3 expected due to extreme preterm/NN abnormality.
- Average length of labour:

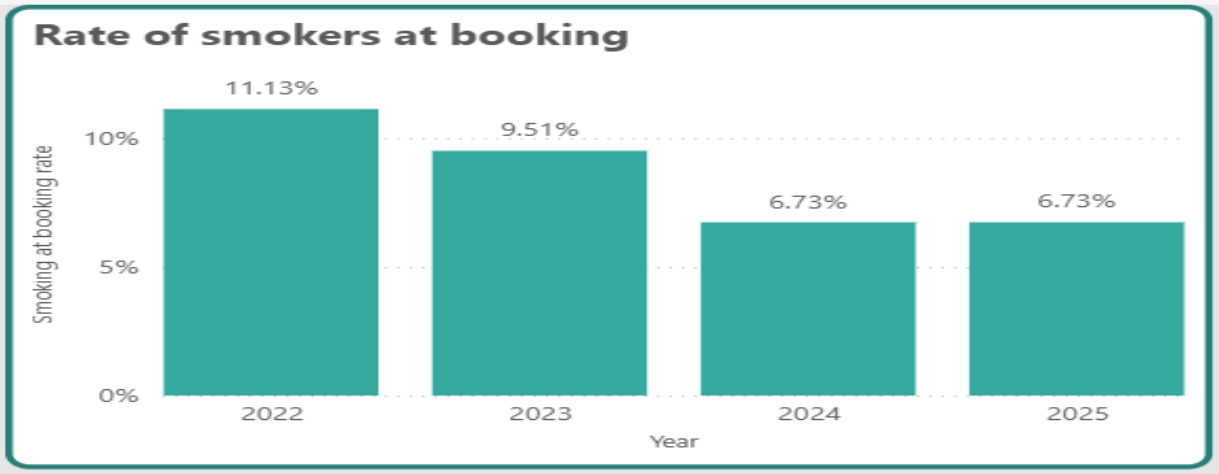
First stage: 8.5 hours

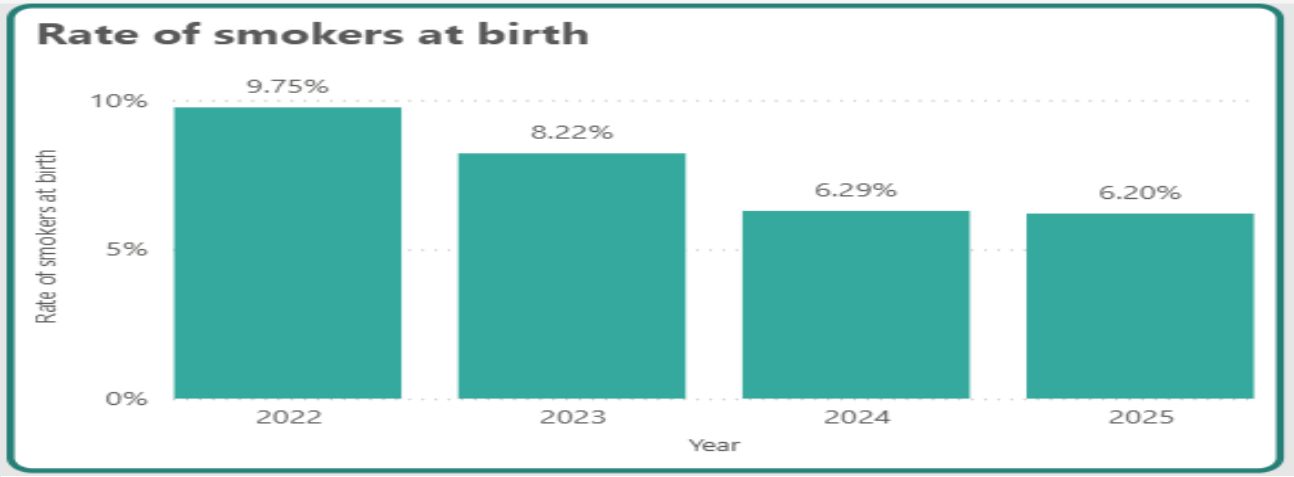
Second stage: 1.5 hours.

Smoking summary

Appendix 1.4

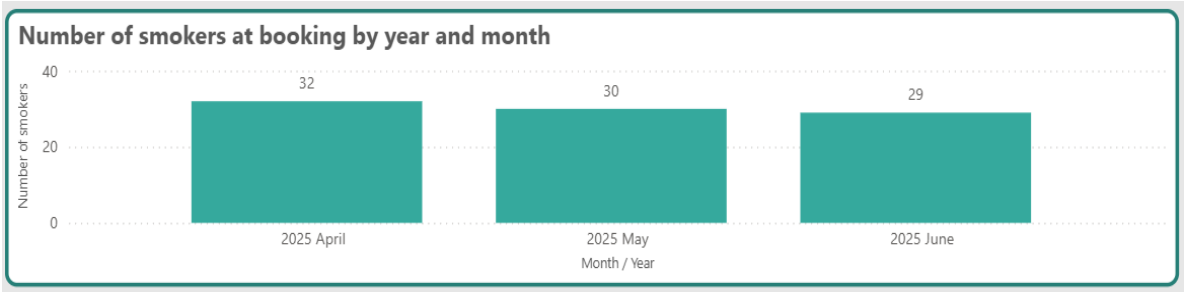
University Hospital Southampton NHS Foundation Trust

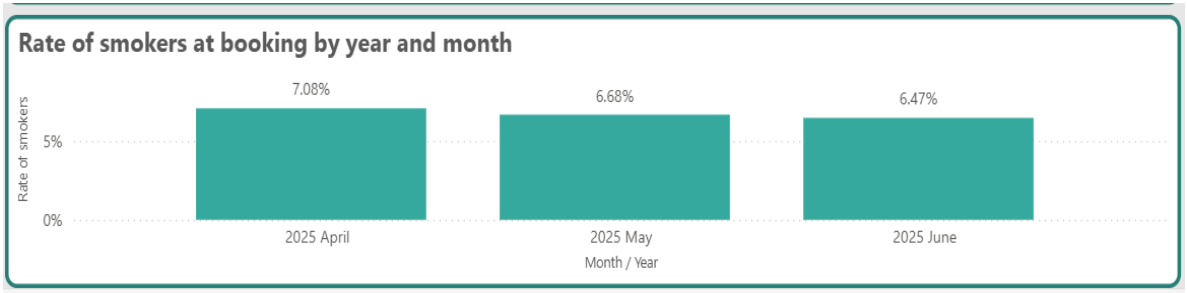




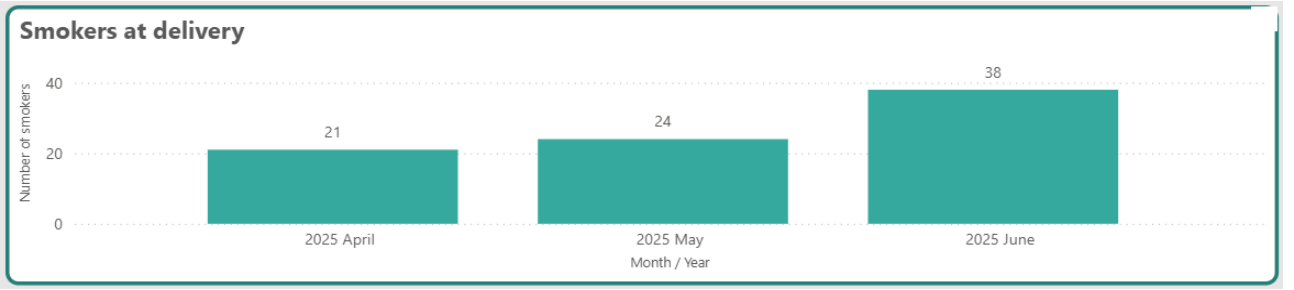
Smoking summary – Q1 (April to June) 2025/26

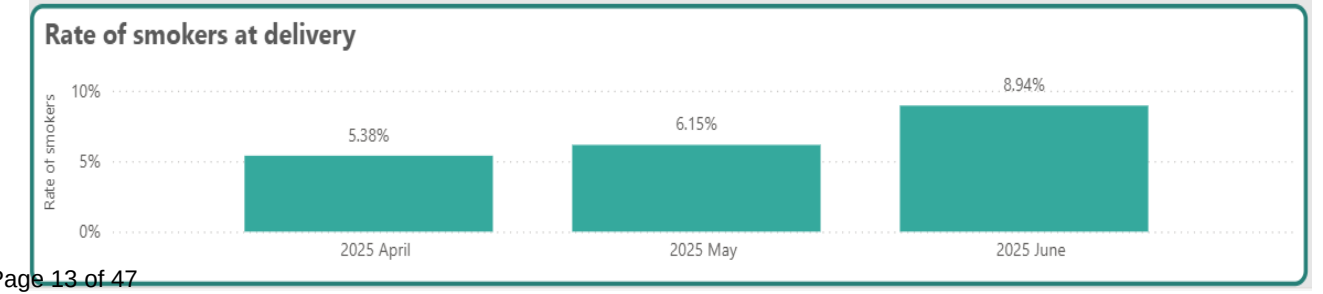
Antenatal booking – During Q1, 91 women/people disclosed smoking at booking

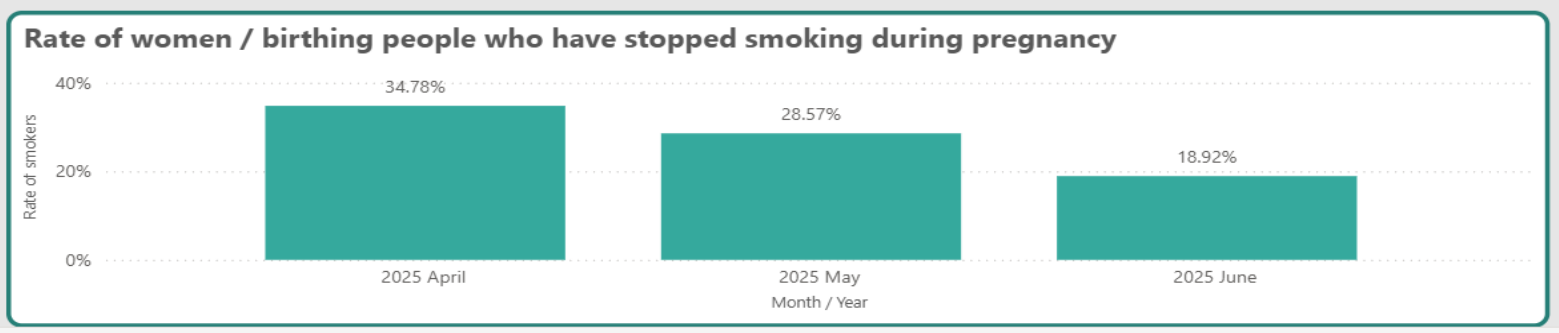




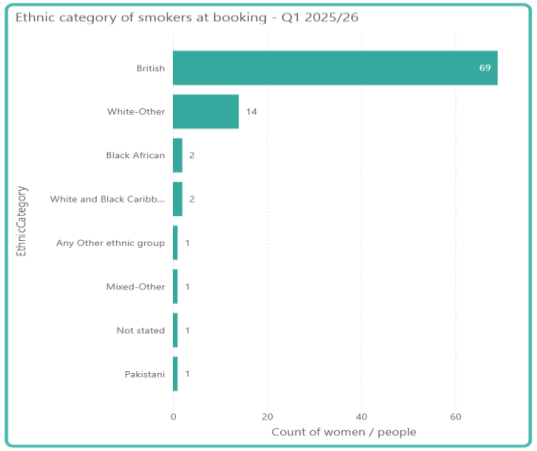
Births – During Q1, 83 women/people disclosed smoking at birth

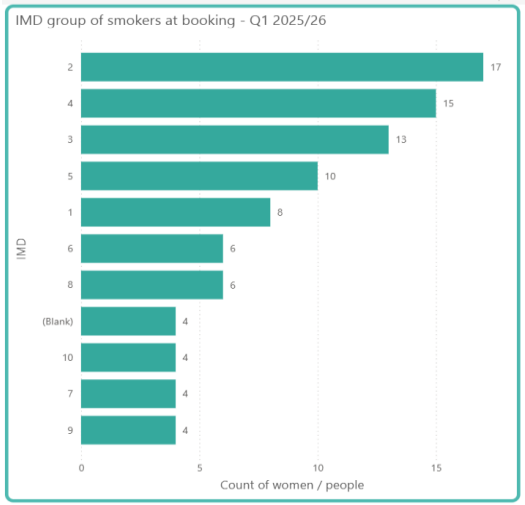


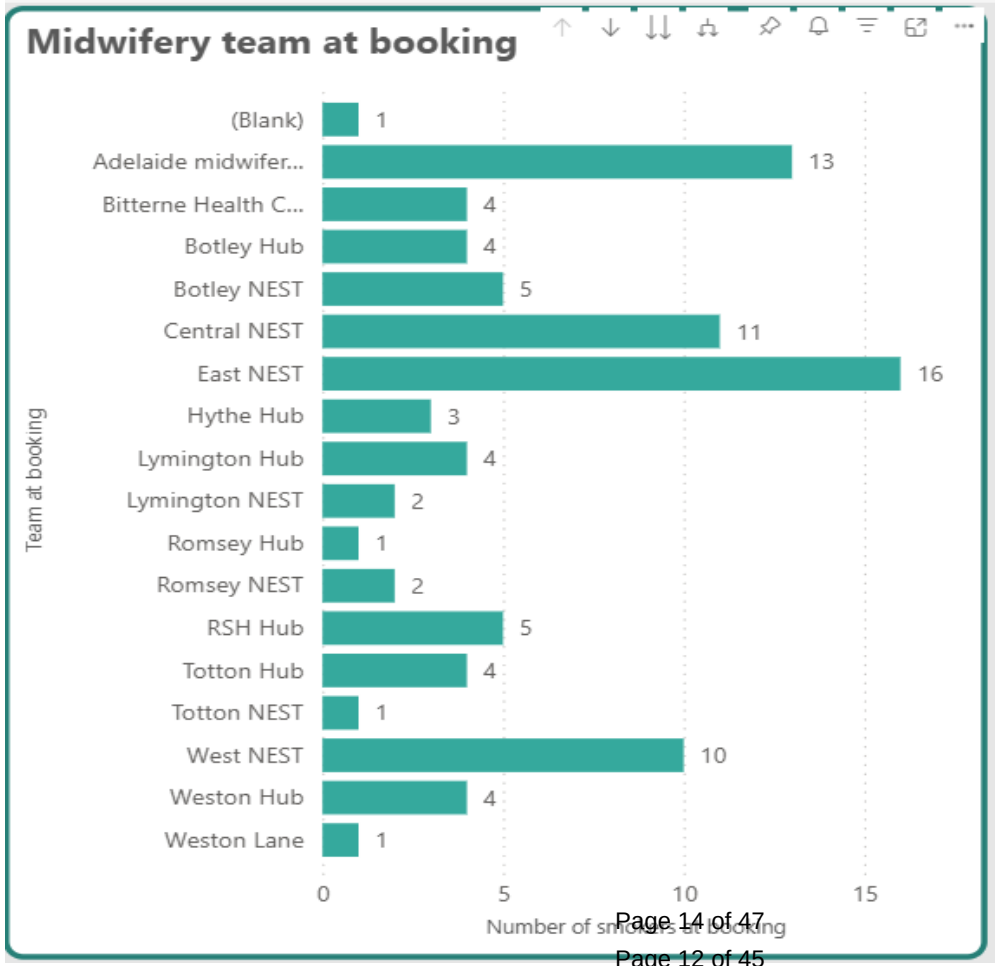




Demographics – Q1 (April to June) 2025/26 – smokers at booking







Q1 - Progress

- Governance approval of maternity Vaping SOP
- Agreement to offer permeant TDA role
- Interim support form Smokefree Solutions during interim period

Q1 - Quality improvements

- Continued targeted emails to improve Smoking documentation
- Work to improve 36-week CO status

Q1 - Risks / issues

- TDA vacancies mean increased pressure on community midwives
- Lack of space in community for TDA see women/ pregnant people

Q1 - Next steps

- Exploring community spaces for TDAs
- TDA Interviews
- Joint planning for Stoptober with Acute site
- Visit to Portsmouth Smoking Cessation team for shared learning
- Launch Swap to Stop scheme prioritising NEST women

Appendix 2

Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases – 1st April 2025 – 30th June 2025

New Patient Safety Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
Patient Safety	9997470	16/04/2025	Pressure Ulcer	Left ear folded in half and indented with either the edge of the clamp or the ties. Ear was dark with bruising and the edge was crusty with what appeared to be yellow serous fluid and appeared to be starting to break down. Reviewed by TVS and graded as category 3 PU (hospital acquired).	For After Action Review (AAR) to be completed. Initial meeting held with Tissue Viability. Report to be completed and shared at Division C Governance.
MNSI	9984393	07/10/2024	NND (Term)	MNSI referral due to tightening's Attended MDAU with absent FM, for IOL later that day. Pathological CTG - NND	CER, PMRT, Patient complaint, decision to refer to MNSI.MNSI are now investigating.
HRT (Opel 4)	10002513	06/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Harm review tools sent to RH to complete Operational Matron
HRT (Opel 4)	10002240	19/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Harm review tools sent to RH to complete Operational Matron
HRT (Opel 4)	10001060	26/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Harm review tools sent to RH to complete Operational Matron

New PMRT cases

(to note some cases have been opened and closed in this time period)

PMRT number	Log Date	Incident Trigger	Summary of incident	Outcome of incident
98028	03/04/2025	Early Neonatal Death	Baby boy born at 23+0 weeks with a background of previous pregnancy loss at 20 weeks and cervical suture in this pregnancy. No steroids or magnesium sulphate given prior to delivery. He was born as	Reported to PMRT 24/03/2025 Discussed at CDRM on 19/05/2025 07/07/2025 Awaiting PP's from Maternity Bereavement team.

			soon as the suture was released. Intubation attempts with some challenges. Heartbeat no longer heard at 16 mins of age. Due to gestation, it was agreed not for cardiac massage and drugs. Decision to stop life sustaining attempts at 29 mins of age.	Graded as B/B Antenatal- B Counselling in relation to steroids in high-risk women NNU- B Intubation challenges Bereavement care - Unable to grade as awaiting feedback from the bereavement midwives. Awaiting Closure.
98058	07/04/2025	Antepartum stillbirth	Attended MDAU with history of RFMs at 30+5 and IUD confirmed. Baby girl delivered at 31+2 weeks. Delivery was complicated with a uterine rupture and PPH.	Reported to PMRT. To be closed as A, B. Reviewed at CER and through Perinatal Mortality Review Group (PMRG). Learning identified relating to appropriate review prior to postnatal discharge to ensure appropriate information and support is given.
98456	05/05/2025	Late Neonatal Death	Antenatal diagnosis of exomphalos. This was a very large defect with small hole. She was managed between NICU and PICU.	Reported to PMRT. Reviewed through Neonatal Child Death Review Meeting. To be closed as A, A, A.
98477	07/05/2025	Late Neonatal Death	Twin 1 DCDA twins. Born at 23+6 weeks in North Hampshire Hospital, Basingstoke. Had 1 dose of steroids and magnesium sulphate was commenced prior to delivery. Transferred to PAH for ongoing care. She had a complex neonatal course with an umbilical catheter extravasation which required a laparotomy, she had several episodes of sepsis, a dislodged peripheral arterial line, she developed a left sided chylothorax and developed acute renal failure. Conservations were had with her parents and care was redirected. She died at 40 days of age.	Reported to PMRT. Reviewed through Neonatal Child Death Review Meeting. To be closed as C, C, A. An AAR is ongoing within the local unit. To note, all cases that are graded as C or D for antenatal or neonatal care that was provided by UHS will be presented to the Patient Safety New Cases Group to decide whether further investigation is required.
98532	09/05/2025	Antepartum stillbirth	Presented at 31+1 weeks with severe abdominal pain. IUD confirmed on scan. Cat 2 section under GA confirmed placental abruption.	Report to PMRT and ongoing within timescale. Reviewed at CER. There was an issue with the blood bank due to blood track issues and therefore she had to have O negative blood. Reviewed at CER and PMRG in June graded as A+B due to not being given the opportunity to take baby home.

98704 (being led by the Children's Hospital)	22/05/2025	Early Neonatal Death	Born via vaginal delivery at 41+0 weeks at Dorset County Hospital. Discharged home but represented with concerns over feeding and sleepiness. Neonatal collapse on day 2 of life. Diagnosed with subdural haemorrhage. Transferred by SORT to PICU and care was redirected as it was felt that the haemorrhage was un-survivable.	Reported to PMRT and ongoing within timescale. Reviewed through Child Death and Deterioration (CDAD), with no learning identified. To note, this case has been reported to MNSI by Dorset County Hospital.
98722	26/05/2025	Antepartum stillbirth	26+ weeks attended MDAU with RFM's and IUD confirmed	Reported to PMRT and ongoing within timescale. To be reviewed through CER and at PMRG June. Graded as A/B
98756	30/05/2025	Antepartum stillbirth	Presented at 40+0 with no FMs for 2 days. IUD confirmed on scan. Delivered at 40+3 weeks.	Reported to PMRT and ongoing within timescale. Reviewed through CER and at PMRG in June. Graded as : Antenatal -C due to lack of RFM guidance /No GTT/Follow up for raised glucose. No PN Anti D. Bereavement –B due to issues with Anti D –now resolved had appropriate Anti D antenatally to cover this period –May now be graded as an A
98772 (being led by the Children's Hospital)	24/05/2025	Late Neonatal Death	Antenatal diagnosis of hypoplastic aortic arch and muscular VSD. Booked in Milton Keynes and delivered at Oxford. Transferred to E1 for ongoing cardiac care on 26/12/2024. Developed cardiac NEC post initial cardiac repair. Baby died from complications from cardiac NEC at 5 months of age.	Report to PMRT and ongoing within timescale. Reviewed at CDAD, with no learning identified. Reviewed at PICU CDRM.
98852 (being led by the Children's Hospital)	02/06/2025	Late Neonatal Death	Born at 39+6 weeks at Horton General Hospital with thick meconium. Transferred to Oxford NICU due to her oxygen requirement. ECHO performed showed intracardiac total anomalous pulmonary venous drainage (TAPVD) with ASD and PDA. Transferred to PICU. TAPVD repair completed on day 1 of life. Required surgical revision on day 6. She had an ongoing AKI and chylothorax. She developed sepsis and continued to deteriorate despite maximal support. Care was directed with parents. She died at 30 days of age.	Report to PMRT and ongoing within timescale. Reviewed at CDAD, with no learning identified. Reviewed at PICU CDRM.

98917	06/06/2025	Antepartum stillbirth	Antenatal diagnosis of T18. Multiple cardiac anomalies also diagnosed on scan. Planned scan by fetal medicine and sadly confirmed IUD at 35+0. Baby girl delivered at 35+2.	Reported to PMRT and ongoing within timescale. To be reviewed through CER and at PMRG in July.
99073	20/06/2025	Antepartum stillbirth	24+3 wks Attended MDAU with 2/7 history of RFM's IUD confirmed	Reported to PMRT and ongoing within timescale. To be reviewed through CER and at PMRG in July.
99121	24/06/2025	Antepartum stillbirth	23/06/2025 Seen by CMW for routine ANC -Unable to find FH therefore asked to attend MDAU for further investigation. 16.25 Attended MDAU for further auscultation of FH Seen by NAB Scan performed and confirmation by 2nd Obstetrician re no FH present.	Reported to PMRT and ongoing within timescale. To be reviewed through CER and at PMRG July.
99133	24/06/2025	Early Neonatal Death	Born at 23+ 3 weeks following a significant APH	Reported to PMRT on 24/0/2025.Initial data input to PMRT 24/06/2025 Update- For review at CDRM in September
99132	25/06/2025	Early Neonatal Death	Attended MDAU in Poole for raised BP, however CTG concerns therefore had LSCS at 30+4. Baby transferred to PAH	Reported to PMRT on 24/06/2025.Initial data input to PMRT /06/2025 Update For review at CDRM in September

Closed Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
Patient Safety	9988433	18/12/2024	Retained swab	Patient delivered her baby on 20/11/2024 via vaginal delivery. She had an episiotomy and second-degree tear and was sutured following delivery. She presented on 06/12/2024 with a retained vaginal swab which was removed.	Patient Safety Incident Investigation completed and closed at PSIIOG in June 2025. Learning slide to be shared.
Patient safety	9994045	15 – 17/02/2025	Maternity Services on Opel 4 alert >24 hours	Maternity Services was on Opel 4 alert from 15 – 17/02/2025.	Harm tool completed and closed at Patient Safety Steering Group (PSSG) 10/06/25.
PMRT	95987 (being led by the Children's Hospital)	10/11/2024	Neonatal death	Born at 39+4 weeks gestation. Out of hospital arrest at home. Retrieved by SORT. Sadly, died on PICU on day 5 of life. Coroners case & JAR.	Reported to PMRT and closed with grading B, C, A. Reviewed jointly with Royal Berkshire Hospital (where the mother delivered) who have completed a local AAR. No learning identified for UHS.
PMRT	96024	09/11/2024	Antepartum stillbirth	Presented at 36+1 weeks to MDAU with RFM. Under care in Falklands (arrived in UK on 06/11/24) - was receiving twice weekly CTGs as concerns with growth. Delivered at 36+2 weeks.	Reported to PMRT and closed with grading C, A. Learning relates to liaison and transfer to the UK. This process is now under scrutiny and being updated.
PMRT	96475	16/12/2025	Neonatal death	NND .Booked in Tameside (Manchester) then was in holiday in Poole when she went into labour at 22+4 weeks Transferred to UHS pre-delivery.	Case reviewed at CDRM and closed. Graded as A/B/C Antenatal - A-No concerns NNU -B -Baby got cold following admission. Some Incidental findings around the care received No equipment ready for delivery. Delayed intubation/More active respiratory management Bereavement -C SERCO staff were uncivil to parents on the ward post delivery.

PMRT	96731	04/01/2025	Antepartum stillbirth	AP IUD placental abruption	Case reviewed at PMRG and closed initially on 06/05/2025 Re-opened to add further detail s to the case .Awaiting PM also .Grading B/A Antenatal -B due to concerns re FGR clinic referral -Although this would not have affected the outcome to the baby . We appreciate that if Debbie had been referred to the FGR clinic, then she would have been given an explanation of the scan findings which would have given a her a better understanding of the scan results and subsequent management. Re-scan was performed at 36 weeks which she had, however the placental abruption happened later the same day, prior to her referral to FGR clinic (which had been arranged following 36 week scan). Following the 36 week scan all care provided was within guidance. Bereavement - A -No concerns
PMRT	97324	15/02/2025	Neonatal death	Postnatal complications of 1a. Total ischaemic necrotic bowel and cloacal anomaly 1b. Anorectal malformation with stoma, obstructive uropathy, cystic end stage renal disease	Case reviewed at CDRM and closed. Graded Antenatal-B Antenatal B (neonatal counselling , identified suspicion of antenatal cloacal NNU- C- Missed imperforate anus, Early PD catheterisation, Confirmation bias antenatal diagnosis/postnatal care, renal surgical patient without nasogastric tube Bereavement care- B Issues with PM consent
PMRT	97495	26/02/2025	Antepartum stillbirth	DCDA twins Review: Seen with Dr Walker in UHS Transferred via ambulance From Winchester with TPTL? abruption? chorioamnionitis Twin 2 Demised <20 weeks	Case reviewed at PMRG and closed Grading of care was as follows: Antenatal -B due to lack of understanding of women using HTA and MTL Criteria for being booked under NEST team. Bereavement - A No concerns.
PMRT	99702/1	11/03/2025	Neonatal death	MCDA Twins Laser ablation at 18weeks at St Georges Inpatient on Lynd with RFM's at 27+1 and Twin	Case reviewed at CDRM and closed. Grading B/A/B Antenatal -B Learning: There needs to be some feedback to the SpR regarding his reluctance to go and scan a 2nd time, although this was escalated higher fairly promptly. Learning: we will introduce a formal echo for all MC twins post-

					laser at 24-28 weeks in view of higher chance of evolving cardiac differences. Learning: feedback will be given to staff re: need for repeating scan to obtain adequate CTG monitoring in context of absent FMs. Learning: we will feed back to the relevant teams and to maternity staff in general about handing over bereavement details to non-maternity areas e.g. CT and ensure domestic staff on Lyndhurst understand about the Butterfly room. NNU-A Bereavement -B Learning: we will feed back to the relevant teams and to maternity staff in general about handing over bereavement details to non-maternity areas e.g. CT and ensure domestic staff on Lyndhurst understand about the Butterfly room.
PMRT	99702/2	11/03/2025	Antepartum stillbirth	MCDA Twins Laser ablation at 18weeks at St Georges Inpatient on Lynd with RFM's at 27+1 and Twin	Case reviewed at PMRG and closed. Antenatal -B Learning: There needs to be some feedback to the SpR regarding his reluctance to go and scan a 2nd time, although this was escalated higher fairly promptly. Learning: we will introduce a formal echo for all MC twins post-laser at 24-28 weeks in view of higher chance of evolving cardiac differences. Learning: feedback will be given to staff re: need for repeating scan to obtain adequate CTG monitoring in context of absent FMs. Learning: we will feed back to the relevant teams and to maternity staff in general about handing over bereavement details to non-maternity areas e.g. CT and ensure domestic staff on Lyndhurst understand about the Butterfly room. Bereavement-B we will feed back to the relevant teams and to maternity staff in general about handing over bereavement details to non-maternity areas e.g. CT and ensure domestic staff on Lyndhurst understand about the Butterfly room.
PMRT	97659	08/03/2025	Neonatal death	Booked at DCH. PPROM. Attended MDAU with bleeding Transferred to QAH for ongoing care due to NNU facilities.	Case reviewed at CDRM and closed. Grading Antenatal Care - C. PTB clinic referral could have made a difference. Case and learning

				Delivered in QAH at 23 weeks then was transferred to PAH 0n 16/02/2025 Preterm with evolving CLD PHVD with gross hydrocephalus Klebsiella ESBL colonisation	will be shared with Dorset LMNS and PMRT quarterly report to DCH Trust Board and DCH Maternity Governance meeting. Neonatal Care - A- No Care concerns Bereavement Care - A- No Care concerns
PMRT	97777	15/03/2025	Neonatal death	Known Cardiac Anomaly diagnosed at xx weeks IOL followed by Cat 1 LSCS for FTP and CTG concerns	Case reviewed at PMRG and closed Antenatal -A no care concerns although the group reflected that they may change practice in the future. NNU - C related to timing of delivery and access to a septostomy. Bereavement -B - Paperwork not given to the family before discharge.
PMRT	97898	24/03/2025	Antepartum stillbirth	Abruption /Intrapartum stillbirth	Case reviewed at PMRG and closed Antenatal -A No concerns Bereavement- A no concerns. Reported to MNSI, however parents declined investigation.

Moderate or above incidents

Incident Date/Number	Type of Incident	Summary of incident	Outcome of incident
16/04/2025 9997470	Moderate	Left ear folded in half and indented with either the edge of the clamp or the ties. Ear was dark with bruising and the edge was crusty with what appeared to be yellow serous fluid and appeared to be starting to break down. Reviewed by TVS and graded as category 3 PU (hospital acquired).	For After Action Review (AAR) to be completed. Initial meeting held with Tissue Viability. (see new cases section above).
03/05/2025 9998553	Moderate	Attempt to sample from arterial line for gas and bloods at 02.00. Difficult to sample and blood clot drawn into syringe. Hand became white so line removed immediately and GTN patch applied. Some return of perfusion to fingers but 4 hours later they remain discoloured with sluggish CRT.	Reviewed through Neonatal Risk Meeting. Incident closed as moderate due to the impact that this would have had on her fingers. (see PMRT case 98477)
12/05/2025 9999156	Severe / major	Peripheral arterial line right posterior tibial. Had been sampling well and tracing well with toes similar colour to other foot. After attempt at sampling blood gas foot went white. Line removed and GTN patches applied. Initial review foot looked blue and to be re-perfusing. Overnight foot deteriorated with dark toes and sole. Line of demarcation heading up leg by the morning.	Reviewed through Neonatal Risk Meeting. Incident closed as severe / major due to the long term impact of this injury. DoC completed with the family. No immediate learning identified. Neonatal services will review peripheral arterial line access due to this incident and incident 9998553.
30/05/2025 10000866	Moderate	Maternity documentation system, BadgerNet, declared critical incident involving loss of clinical narrative and inability to save narrative on some devices.	Closed as moderate incident.
07/06/2025	Moderate	38+4 baby born on the 7th of June by C-section 38+4, born at 18:37 Issues after delivery - Low temperature requiring heat pad - Hypoglycaemia 1.7 (initial glucose 3.2) - Maternal antibodies - Low Kaiser and no known RFFS	Revie.wed at CER then downgraded to low minor and closed

		First baby Cat 2 LSCS due to fetal HR concerns Required ventilation breaths and PEEP in FiO2 up to 100%. PEEP continued for 50 mins. Low temp whilst on resuscitaire. Cord gases ok Low kaiser, no BC or abx unless clinical illness DAT negative Baby was feeding ok and wet nappies. Decreased feeds after midnight and was not looking well so parents decided to bring him straight to the labour ward as they were not aware about ED. SGA, birth weight 2.5 kg (4th centile) Maternal antibodies - FBC, group and DAT sent at birth from cord. This early morning, around 4:30 am, parents brought baby to labour ward very concerned about baby. Midwife bleeped to tell us to review him. On arrival, baby was on rescusitaire, looking very mottled. Baby was very cold to touch. Made sure the rescusitaire in on maximum heat. Checked temperature. Was 36.1 degrees. Sats were not reading as peripheries were very cold. Baby had low respiratory effort. Started him on PEEP but saturations were in the 60-70 when it was reading. O2 increased to 50% but still did not maintain his saturations. Ended up with 100% O2.	
09/06/2025 10001060	Moderate	Maternity services escalated to Opel 4 due to capacity, acuity, activity and staffing.	Closed as moderate incident.
10/06/2025	Moderate	Maternity Services escalated to Opel 4 at 20:00 on 10/06/25 due to activity and staffing.	

19/06/2025	Moderate	High acuity in MDAU overnight. Roughly 10-15 women within first few hours of the shift with 2x midwives. Escalated to MIC, unable to provide another midwife to support. Breeching on both doctors reviews as well as midwife triaging. Some women in MDAU who needed immediate transfer to labour ward which was not able to be facilitated (pre-term labour, meconium-stained liquor, multip in labour). These women should have been red 'immediate transfer' but LW acuity was high and not able to accept. This led to delays in triaging as well as transferring for 1:1 care. Escalated to op-co who escalated to manager on call, subsequently escalated unit to OPEL 4. Delay in doctor review as awaiting ward round to be complete and multiple women still awaiting review for several hours (yellows waiting >3 hours). Escalated to MIC + op-co who facilitated senior reg to attend to assist in performing timely reviews.	Closed
26/06/2025	Moderate	UHS maternity has declared opel 4 due to very high activity,acuity, challenges with capacity and a significant number of Inductions of labour who cannot currently be progressed. In addition - activity was so high that no staff managed more than 1/2 an hour break many of whom were very late in their busy shifts (one of these was a diabetic member of staff) and one midwife had no break at all.	Closed
29/06/2025	Moderate	Night shift started with insufficient nursing staffs. 17 babies, with 6 intubated patients. on Opel 3, 1 admitting bed, 1 emergency bed. 3 QIS staff that is absent 2 band 6 (1 in charge of the unit, 1 in charge of an ITU room), 1 band 5 qis (in charge of the other ITU room) 2 PICU nurse (as pulled out) 2 band 5 QIS trainee	Closed

		5 band 5 non-QIS trainee, 1 band 4 The unit acuity was high but the staffing was too insufficient to support all the staff and the workload. Each room has a QIS trainee which needs supporting given that they have to take 1 ventilated to be able to adhere to BAPM standards. PICU nurse was given a ventilated patient but also needs support as they are in unfamiliar unit and work routine. The Band 5 QIS also needs support as she haven't been incharge of an ITU room before and she needs to support the PICU nurse, QIS trainee on top of having 1 ventilated baby and another intensive care patient. the non QIS has been allocated with 2 intensive care patients. I feel the situation is "unsafe" as I (being the coordinator) and transport nurse can do much to support the whole unit. The staffing is unbalanced which can compromise patient care and safe practice.	
30/06/2025	Moderate	When looking at patient's most recent chest x-ray which had been done on 24/6/26 6 days previously, in order to make decision on weaning resp support, I noticed there were multiple healing rib fractures on the left. I did not think this had been noticed previously. Not on handover sheet & consultant unaware. Looked back at previous x-rays & seemed to be an abnormal looking rib on XR on 12/6/25. Since then there were 3 other chest XR on 20th & 21st June with evidence of healing fractures on the left. As we were looking at these we received a message from the neonatal coordinator that an urgent finding had been called through to their office from the radiology department.	Awaiting closure

Appendix 2.1 - Enc Cii

The Patient Safety Incident Response Framework (PSIRF) Learning Slide

The Mother, was 32 years old when she booked in her 1st pregnancy. She was working abroad and had USS's at 8 +12 weeks. On her return to the UK, the Mother booked and had an ultrasound scan was performed at 17+1 weeks calculating a different EDD (6 days ahead). She alternated her antenatal care between the two countries during the pregnancy.. During an obstetric review at term +, the discrepancy with the EDD was revisited and risks of going beyond her due date were discussed; she was keen to avoid induction of labour especially using her UK EDD. At 42+3 weeks (UK dates), at 42+3 ((UK dates)the Mother suspected that her waters had broken at 22:00 hours, she received telephone advice the following morning (42+4 weeks), was invited in for assessment and she opted to decline this. She attended the labour ward at 00:30 hours when she was 42+5 weeks and it was confirmed that her waters had broken. She returned to the maternity unit at 00:29 hours when her labour had established. The Baby's heartbeat was monitored in labour and, when concerns arose, a ventouse birth was undertaken. A shoulder dystocia occurred, requiring multiple manoeuvres and the Baby was delivered 13 minutes later. The Baby required resuscitation and received ongoing care in the neonatal intensive care unit including 72 hours of therapeutic hypothermia . The Baby weighed 4.9kg (99th centile) and LGA . An MRI scan of the Baby's brain reported no features of moderate or severe acute profound hypoxic ischaemic injury and some degree of chronic partial hypoxic ischaemic injury.

Questions from family

Parental engagement was sought however there was no response from the family

Organisation Learning

Audit of data for women who book outside of the dating window

Audit of women who decline IOL, including identification of risks and women's wishes. Documentation of appropriate discussion.

Development of process to support staff caring for women who want to birth outside of guidance

External Learning

Use of correct charts on Badgernet

Local Learning

The Trust to amend electronic records to support all maternity staff to plot symphysis fundal height measurements beyond 40 weeks of pregnancy, so that significant accelerations or decelerations in symphysis fundal height trajectory can be noted and escalated appropriately

Tools & Technology Learning

Badgernet update with new charts will be in place by 18/03/2025

Task Learning

None

Person Learning

Ensure the use of correct charts post term

Escalate any growth concerns

The Patient Safety Incident Response Framework (PSIRF) Learning Slide

On 20/11/2024 Ms JW was in her first pregnancy and had a normal delivery of a baby girl on Labour Ward She needed to have an episiotomy to expedite the delivery progress and had an estimated total blood loss of 800mls. During the episiotomy and the suturing afterwards, several gauze swabs would have been used. At some point after Ms JW 's baby was born, a gauze swab was placed inside her vagina, during the suturing procedure, which was accidentally left there. Following the routine suturing, she was transferred to the postnatal ward for ongoing care prior to being discharged home the following day.

Ms JW attended her GP's surgery on 3rd December 2024, as her sutures had become more painful and felt infected. She was examined by her GP who commenced her on oral Flucloxacillin. Since her visit to the GP, she had experienced some increasing pressure and felt that there was "something coming out of her vagina." She was then reviewed on 6th December 2024 in the Maternity Day Assessment Unit (MDAU) in PAH by a midwife, who performed an internal examination, which identified a retained swab, and this was subsequently removed. Her observations were within normal limits at this point. As a result, her medication was changed from Flucloxacillin to Co-amoxiclav. Bloods were taken for FBC/CRP AN HVS was also taken. A further appointment was made for 2 weeks' time, for a follow up Ms JW was then seen by Dr RW for a follow up appointment on 15th January 2025, complications), for some further advice/care.

Questions from the family

What was the swab used for and specifically why was it placed inside my vagina?

Were there any protocols in place aimed at avoiding retained swabs?

If so were these protocols followed?

Organisation Learning

Review the guidelines (Labour care/perineal repair/assisted birth) to ensure STOP POINTS FOR SAFETY (NatSSIP's) included

Improve compliance with appropriate staff group training for the organisation wide NatSSIPs review.

Service improvement for women who require extra support for medical issues postnatally and need to be assessed at MDAU

Local Learning

Improved use of Whiteboards for documentation of swab/needle counts and blood loss.

Planned Quality Improvement project to 're-launch' the role of a second staff member

Staff to watch the swab counting video, highlighting what the process for swab checking is

Task Learning

Use of green wristbands to identify if there has a swab left internally as part of an ongoing care management plan.

Tools & Technology Learning

Introduction of the NatSSIP's boards in every birthing room to facilitate adherence to the stops points for safety measures.

New guidance to be introduced to assist staff re the correct process for swab counts

Personal Learning

- The LW Co-Ord/Op Co to exception report via AER if whiteboards / pens not available in intrapartum areas.
- Decrease the barriers to safe swab/needle counts and improve the escalation for support if barriers are present

Appendix 3

University Hospital Southampton NHS
NHS Foundation Trust

Action plan for: Escalation of a concern from MNSI investigations with maternity Triage Line Involvement
UHS as host provider

Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion	Status
1. Review of MNSI Cases	Complete review of all MNSI cases involving the Maternity Triage Line (Oct 2024–present).	Quality & Safety Assurance Matrons	Completed	July 2025
2. Escalation Through Governance	Escalate findings via the Women & Newborn Governance Framework.	Governance Leads	Completed – noted as part of risk/MNSI update	July 2025 (update to follow)
3. Report to Quality Committee	Include findings/learning in the Q2 2025 Quality Committee report as part of the Perinatal Quality Surveillance Dashboard.	Quality & Safety Assurance Matrons	Q1 25-26 QC Mat/Neo safety report August submission	
4. Ongoing Case Monitoring	Monitor all future MNSI investigations for MTL involvement and flag emerging safety recommendations. NB. This will be done with any safety concerns/incidents that have MTL involvement.	Quality & Safety Assurance Matrons	Ongoing	
5. Strengthened Oversight Process	Collaborate regionally to develop a robust oversight pathway including: • Incident identification • Factual accuracy process	Quality & Safety Assurance Matrons/ MTL Matron	In progress	

	• Safety action implementation • Dissemination of learning			
6. Review Governance Agreement	Review and, if required, revise the Agreement for the Governance and Management of the MTL to ensure alignment with current oversight needs.	UHS Governance Leads + Regional Stakeholders	In progress	
7. Communication & Transparency	Maintain open communication with stakeholders and MNSI leads, offering updates and outcomes.	Director of Midwifery / Quality & Safety Matrons	In progress	

Appendix 4

PMRT update

1st Dec 2024 – 30th June 2025

Standard a): Notify all eligible deaths (reportable to MBRRACE – incl TOP) within **7** working days.

22 deaths notified in reporting period within the timescale, with 17 eligible for PMRT.

Standard b): Seek parents views for at least **95%** of the deaths of babies eligible for PMRT review.

Parents views have been sought for 82% of the deaths of babies eligible for PMRT review in this reporting period.

Standard ci): Start the reviews for **95%** of the deaths of babies who were born and died in our Trust within **2 months.**

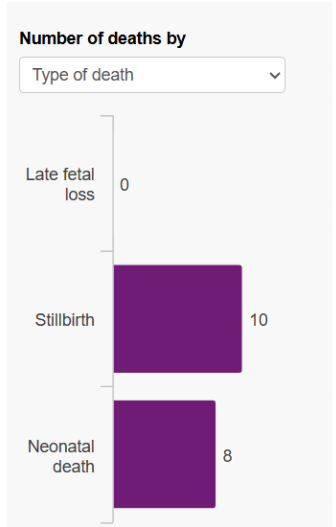
Reviews were started for 100% of cases within 2 months.

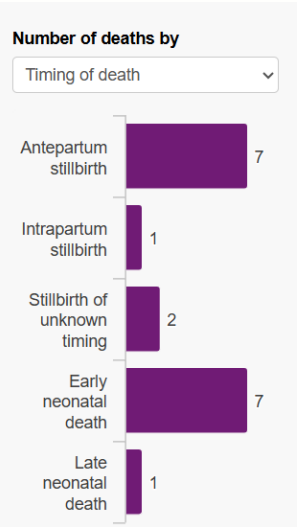
Standard cii): Complete and publish the reviews for **75%** of the deaths of babies who were born and died in our Trust within **6 months.**

Reviews have been published for 100% of cases within 6 months.

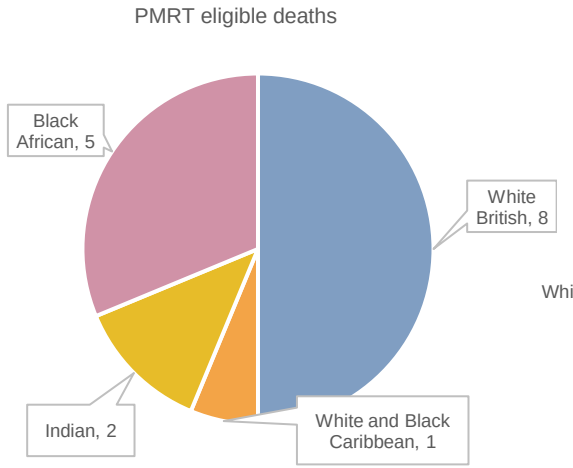
Standard ciii): An external member should be present at the multi-disciplinary review panel meeting for **50%** of the deaths reviewed, of babies who were born and died in our Trust.

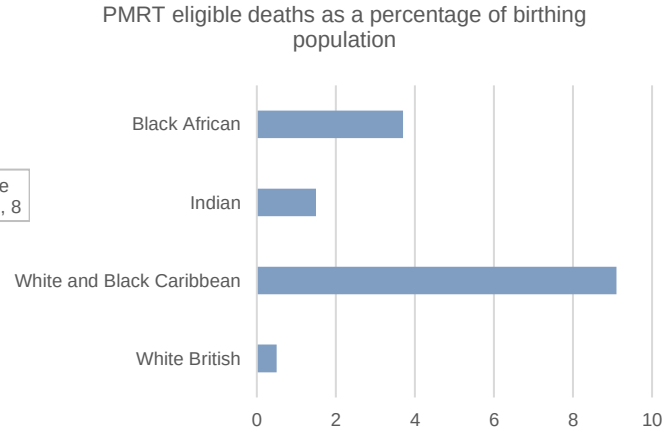
An external member was present in 67% of cases.



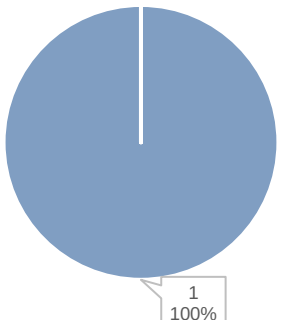


Ethnicity of women / birthing people of the MBRRACE reportable deaths eligible for PMRT





IMD deciles of women / birthing people of the MBRRACE reportable deaths eligible for PMRT



Themes identified in Q1 25-26 PMRT reviews

- 7 cases – All **antepartum SB/IUD's** gestation ranging from 24-40 weeks
- 1 cases had an abruption (1 confirmed on arrival with IUD 31/40), 1 case uterine rupture (following IOL for IUD)
- 1 known abnormalities - likely T18
- 3 full PM, 2 Histology & cytogenetics & 2 external (1 + histology)
- 4 cases have had a review

Saving Babies Lives

- 1 identified issues with RFM management - ? Info not clearly given (patient booked late, new to county at 31/40)

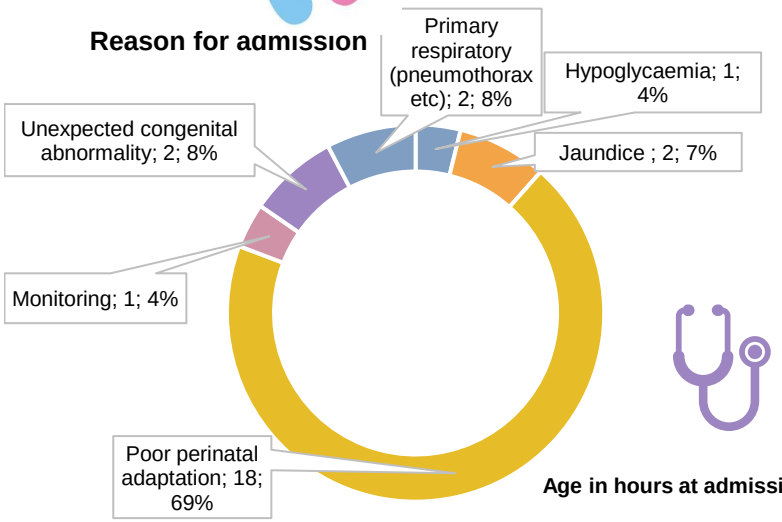
ATAIN

Appendix 5

Qtr. 1 2025/26 – 26 unexpected term admissions

University Hospital Southampton NHS Foundation Trust

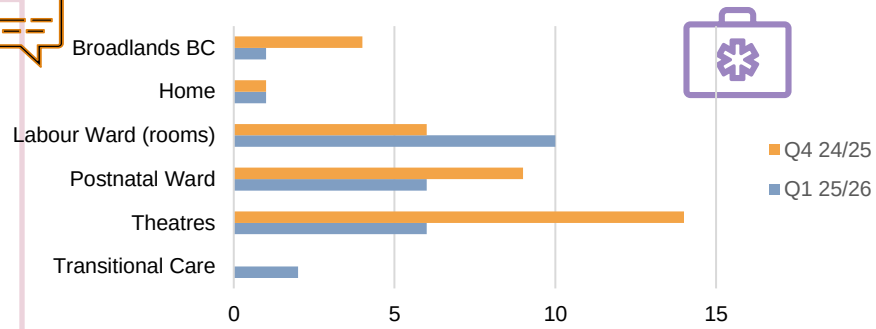
Reason for admission



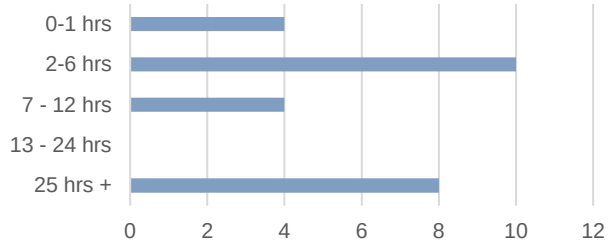
Learning identified

- 14 cases identified for review
- 11 reviews completed
- 2 cases deemed avoidable admissions
- Themes/issues highlighted:
  - Escalation
  - Documentation
  - Jaundice management
  - Fetal monitoring interpretation

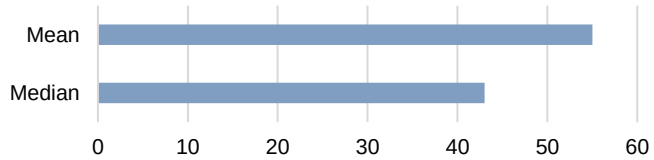
Admission from

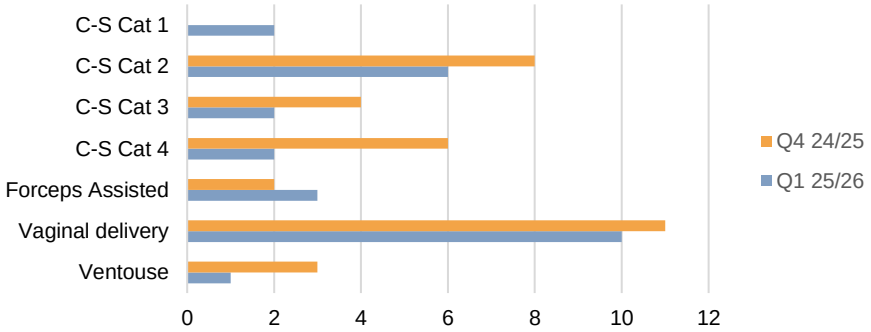


Age in hours at admission

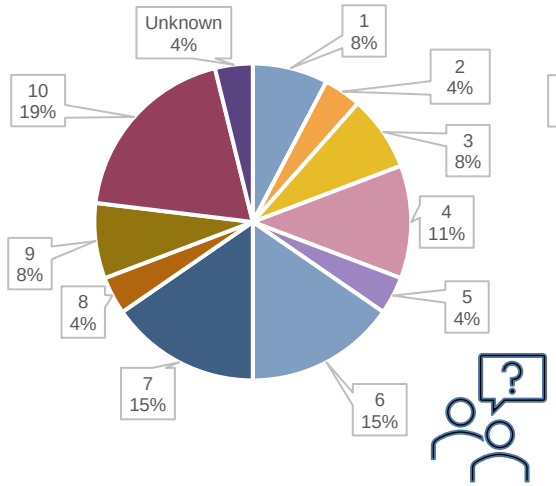


Average length of stay in hours



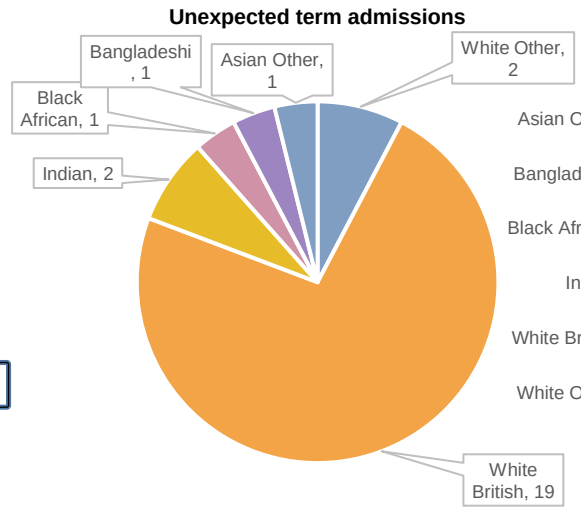


IMD deciles of women / birthing people

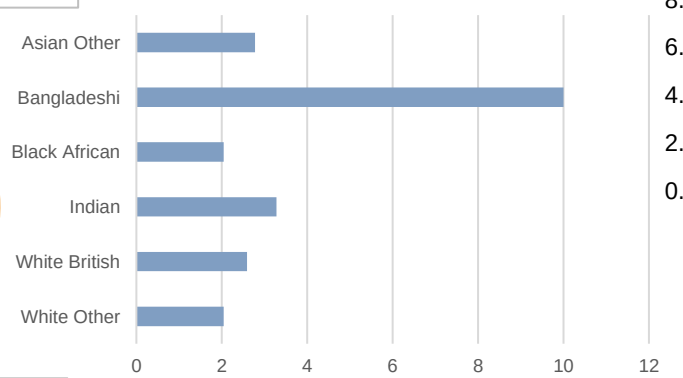


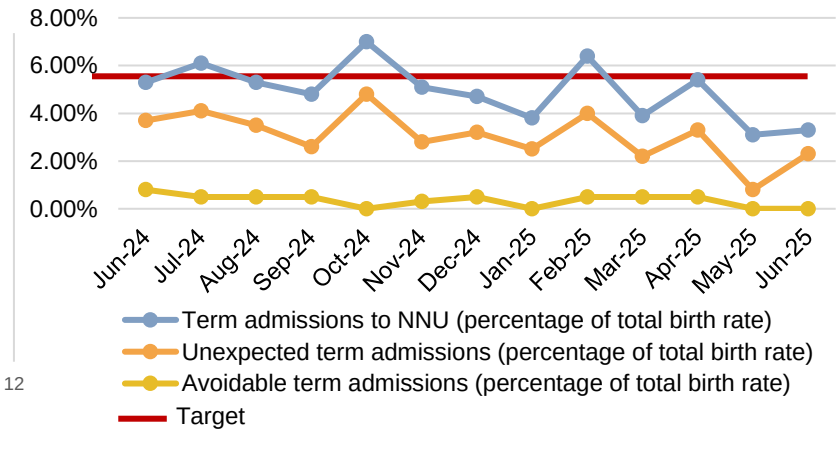
Ethnicity of women / birthing people

Unexpected term admissions



Unexpected term admissions as a percentage of term livebirths





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UHS Maternity/Obstetric Triangulation of claims, incidents and complaints data Q1 25-26

Appendix 6

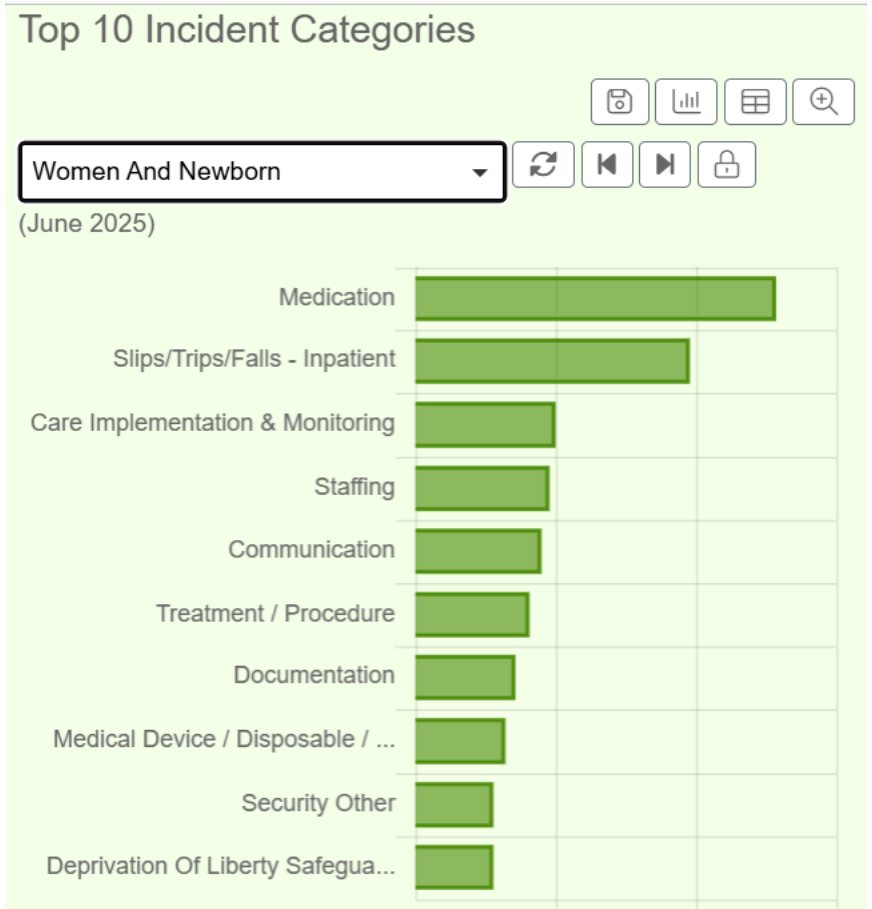
PMRT Supporting high quality local perinatal reviews

2 New claims in Q1 25-26 (No obvious themes)
3 Closed claims in Q1 25-26 (No obvious themes)

Themes & learning identified from PMRT in Q1 25-26

7 cases – all antepartum Stillbirths/IUD's
1 abruption & 1 uterine rupture
1 known abnormalities

Themes from Mat/Neo reported incidents (AER's)



MNSI report recommendations

2024/25

- Clinical Assessment
- Fetal Monitoring
- Guidance
- Training
- Medical Records

- 3 report with no recommendations
- 4 reports with recommendations

Mat Neo complaints Q1 25-26

9 complaints (5 ongoing, 1 resolved, 1 upheld, 2 partially upheld)
5 ongoing
3 – Antepartum IUD 1, 2 NND (PMRT review)
Theme: **Communication** & **Delay/failure in observation/treatment.**

Patient Voice/feedback Q1 25-26

Constructive themes from FFT:
Communication
Staff attitude
Staffing/capacity

Commonalities

1. Communication
2. Staffing/capacity
3. Care/observations & monitoring

NHS
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Theme 1 – Listening to and working with women and families with compassion	
Objective 1 – Care that is personalised	Progress and Evidence
Empower maternity and neonatal staff to deliver personalised care so that they have the time, training, tools and information to deliver the ambition as above	• New regional project. Personalisation of care pilot being launched in the maternity service on 1st August 2025 (see slide (appendix 10.2) Initially via case loading teams but intention is to dynamically evaluate to ensure needs are met and plan to roll out more widely to all groups • Consultant midwifery team engage with any service users seeking care outside of guidance and agree, create and communicate personalised care plans • Significant recruitment drive by neonates to increase staffing with action plans in place to move staff through the QIS model. • Family and Psychology support team in neonates working with families to individualise care for differing needs • Following feedback, the NNU have strengthened the MDT working for complex cases to ensure needs of families with long term admissions for their babies are met • The family support and psychology teams work to identify individual families' support needs to ensure their care and support is bespoke with vulnerabilities and any safeguarding needs being shared and escalated via daily huddles and weekly psychosocial meetings • Completed refurbishment of family facilities for neonatal parents to provide a 'haven' and 'home from home' environment to support and release them from intensive care environments • New Woodland ward has pull down beds by cots to enable parents to continue to have ownership of their babies' care in line with their own emotional and physical needs. Staff work alongside parents to empower them to be active participants in their babies' care • The NNU expansion has increased space around cots to better facilitate early

University Hospital Southampton NHS Foundation Trust

	postnatal visits for those still requiring to be in a hospital bed and to give families more room when they are visiting their baby.
Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents	• FFT – continue to show good response rates with both maternity and neonates working hard to maximise responses to enable the services to be reactive to user and family feedback. Feedback is shared with staff • MNVP now in post and actively engaging with users and seeking and delivering feedback. • Birth Reflections service remains highly valued by service users and feedback given following these reviews. • Increasing use of face-to-face resolution meetings when service user feedback demonstrates a shortfall of care versus expectation • New neonatal preterm optimisation role currently out to EOI to further support improvement in neonatal delivery standards • Regular audits around key outcomes such as ATAIN demonstrate the success of interventions designed to keep mothers and babies together • A quiet room is now available on the NNU to enable a more peaceful environment with the options for prayer. •
Consider the roll out of midwifery continuity of carer in line with the principles NHS England set out in September 2022	• Current Continuity of care teams will be initial phase of personalisation of care pilot. Current case loading model identifies all IMD1 women to be case loaded with global majority women being prioritised for case loading if they present as non IMD1 but with any additional social, cultural,physical,emotional or safeguarding need.
Achieve the standard of the UNICEF Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative by March 2027	• Stages 1 and 2 now completed. New Infant Feeding lead appointed to cover maternity leave of existing maternity lead and work towards level 3 and full accreditation on track.

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	• NNU have recently appointed a Band 7 BFI identified nurse to move their accreditation plans forward. • New BFI guardian prioritising equipment for milk expressing across the neonatal areas and increasing equipment supplies by 30 additional Spectra pumps to support this for families staying with sick babies locally. A successful charity bid will also see a further 20 Spectra breast pumps to support service users who do not have their baby with them to support families across the mat/neo setting

Objective 2 – Improve Equity for Mothers and Babies	
Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information standard in maternity and neonatal settings	• Our MNVP is working hard to form links with different ethnic and faith groups and is keen to involve a wide variation around 15 steps visits – these are likely to occur in the autumn • The personalisation of care pilot will be involving and evaluating informed decision making around exercising choice in the antenatal, intrapartum and post-natal periods • Our maternity service is already demonstrated to be high users of the interpreting service, but the LMNS have achieved some funding for a pocket interpreter tool which we are keen to trial soon at PAH
Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.	• Our digital team can generate specific reports using power BI to ensure that we are aware and able to react in relative real time to outcomes and ensure we have early awareness of any different outcomes for specific groups. We also capture ethnicity as part of our FFT to ensure that our responses are reflective of our different groups and that feedback is not specifically lower for any harder to reach groups. We interrogate our data to ensure that there are no

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	themes for complaints or poorer outcomes amongst any specific members of our service user population • We are engaged with the LMNS EDI lead and benchmark our progress against a standardised gap analysis while seeking regional solutions when able.

Objective 3 – Work with service users to improve care	
Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services	• Our MNVP is part of the quorum for our W and N governance meetings and aims to provide user feedback and hear and contribute to service change. The MNVP also has lived professional experience with working with vulnerable or hard to reach groups. We are aiming to involve a variety of ethnic groups to provide 15 steps input and we see service user involvement as a high priority when designing or delivering new services • The upgraded NNU family facilities have helped to provide a home from home environment for families visiting babies and this especially applies to those visiting within an intensive care environment. • We monitor outcomes within both neonates and maternity to ensure that we are meeting expected quality thresholds and increasingly meet with services users who express concern regarding their care as we have found that face to face resolution of concerns is frequently much more helpful for families • We use tools such as the CQC survey and outcomes of complaints and Birth Reflections to use feedback when improving services.

Appendix 7.2 Q1 update 3-year delivery plan – Maternity Personalisation of care pilot 2025

Ref No:	Theme & Objective	Trusts
	Theme 1: Listening to and working with women and families with compassion	
	Objective 1: Care that is personalised	
1.1	Empower maternity and neonatal staff to deliver personalised care so they the time, training, tools, and information, to deliver the ambition above.	✓
1.2	Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.	✓
1.3	Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022	✓
1.4	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.	✓

Purpose

National ask – All women & pregnant people to have a personalised care and support plan in a digital format (with a non-digital option if required)

This should be reviewed at every contact and forms part of the management plan

SHIP LMNS Working group creating supporting document with choices/options/advice before implementation March 2025

Pilot required of Badgernet offering to see if fit for purpose or changes required

Ask of Pilot Team

Encourage your caseload to use the Antenatal Support Conversations, Birth Plan, and Postnatal Support Conversations to record their thoughts and feelings about their management plan and pregnancy. This is also somewhere concerns (non-urgent) and worries can be recorded

Pilot team to use this resource to have meaningful discussions with your caseload about their thoughts/feeling and incorporate those into their management plan, which should be personalised and updated at every contact (outside of this project)

What feedback do we need?

NHS Hampshire and Isle of White

We will create some feedback surveys for service users, and for Midwives about how they found the process, as well as functionality and ease of use. We will also want to know about the additional time it takes to complete this and if you feel you could have benefitted from additional training.

We will use this to inform any required changes from Badgernet.
We appreciate at the moment the system and process is 'clunky' so really need some feedback about how to make it better and more streamlined (like being able to see the PSCP at the same time as the management plans etc)
Also is it useable in its current format whilst we wait for changes.

Start date with continuity teams August 1st 2025

NHS University Hospital Southampton NHS Foundation Trust

Women and birthing people information

SHIP LMNS

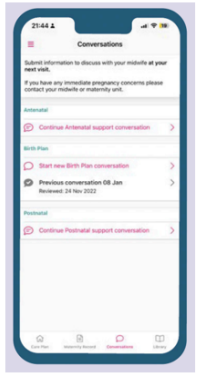
Personalised Care and Support Planning

NHS Hampshire and Isle of Wight

What is it?
In Hampshire & Isle of Wight we want every pregnant person to experience safe and personalised care.
This means that the care and your plan is centred around your needs, thoughts and feeling.

Why is it important?
It means you can tell us how you would like your care based on your preferences, past experiences and your family circumstances.
By telling us this we can use this information to plan your care with you and your family.

How?
Using your BadgerNotes app – Select 'Conversations' from the bottom navigation bar.



There are 3 conversations available;
- Antenatal
- Birth Plan
- Postnatal

You can use the questions to guide you to complete your preferences for each conversation.

You can do this as many times as you like, as things may change in your pregnancy.

Your midwife will discuss these with you at every appointment.

Thank you for your support in this pilot phase, with your permission we will contact you for feedback.

Next Steps –

- Implement pilot
- Gather feedback and evaluate
- Make changes if required
- Roll out to **all** community teams to enhance personalisation of care

NHS Hampshire and Isle of Wight

UHS Perinatal Culture & Leadership Team (PCL)

Emma Northover
Director of Midwifery

Bala Thyagarajan
Consultant Neonatologist

SCAN ME

Hannah Kedzia
Care Group Manager W&N

SCAN ME

Ganga Verma
Maternal Fetal Medicine Consultant

SCAN ME

Marie Cann
Consultant Midwife

SCAN ME

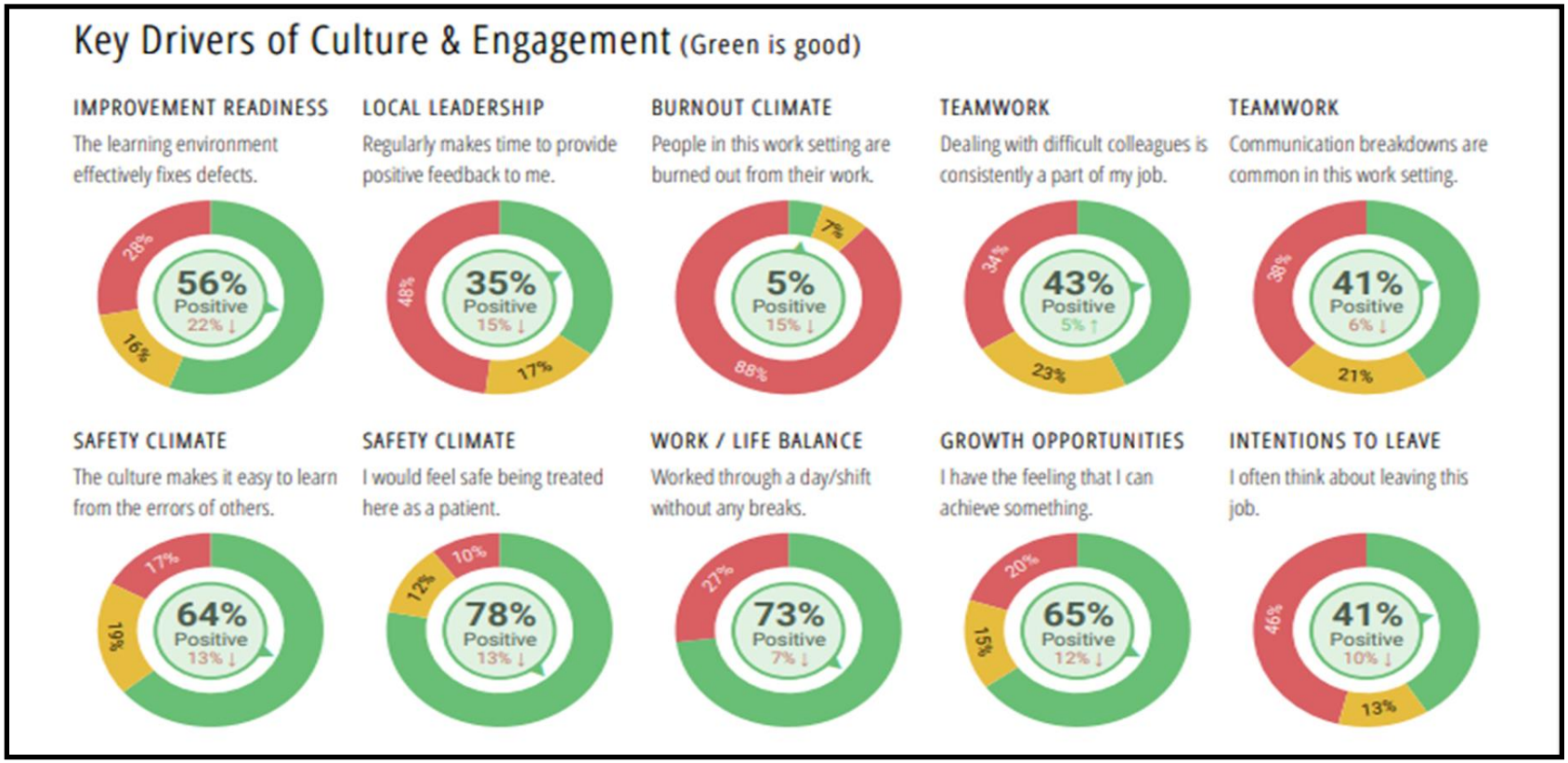
QUAD Survey

The PCL Team supports:

1. Nurture a positive safety culture.
2. Enable psychologically safe working environments.
3. Build compassionate leadership to make work a better place to be.

Please feel free to contact us

Mat/Neo SCORE Culture Survey - findings



The PCL Team Improvement Actions:

1. To promote efficient & effective use of technology
2. To empower staff to role model positive behaviours & compassionately challenge incivility
3. Create environments for constructive feedback to support continuous improvement

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Mat/Neo SCORE Culture Survey – Technology Improvement Plan

Recommendation	Action / Improvement	Who will be responsible	Current Compliance	Completion	Comments
To promote efficient & effective use of technology	Make use of Digital innovations wherever possible.	Digital lead & Digital team	Amber	eWhiteboards installed in key ward areas awaiting go live	
	Continue regular review of IT equipment replacing or updating as able.	Digital lead & Digital team	Amber	Continual upgrading	
	Use of QR Codes	Digital lead & Digital team		QR codes used throughout the MatNeo service	
	Use of Ipads	Digital lead & Digital team	Amber		
	Use of business Intelligence tools	Data lead	Amber		

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Mat/Neo SCORE Culture Survey – Culture - Improvement Plan

Recommendation	Action / Improvement	Who will be responsible	Current Compliance	Completion	Comments
To empower staff to role model positive behaviours & compassionately challenge incivility	Incorporate Civility sessions in all training	Practice Education team & Clinical leads		Training contains civility	Forms part of PROMPT
	Involve Q&S Partners in MatNeo work streams	Governance team QA matrons	Amber		
	Project & transformation teams to focus on civility	PCL team	Amber	Cultivating Kindness work stream	Launched June 2025
	Revisit Teach or Treat approach	Practice Education team	Amber	Developing training & education programmes for 2026	
	Hold QUAD walkabouts/focus sessions	Safety Champions PCL team MNVP Sub teams i.e. PMA		Walkabouts in place	
	'Moments' training	AHSN		1st session delivered in June	July 2025 next session

Mat/Neo SCORE Culture Survey – Quality Improvement - Improvement Plan

Recommendation	Action / Improvement	Who will be responsible	Current Compliance	Completion	Comments
Create environments for constructive feedback to support continuous improvement	Relaunch of the MatNeo QI sessions	Consultant MW NNU QI lead PMA	Amber	Ongoing planning	Re launched in April 2025
	Review of MatNeo dashboard indicators for improvement	QA Matrons Consultant MW	Amber		PPH 3rd /4th degree tears APGER scores

Appendix 9

University Hospital Southampton
NHS Foundation Trust

Q1 25-25 MNVP Update

SOUTHAMPTON
Maternity & Neonatal Voices
Working in partnership to improve maternity & neonatal services

Analysis of feedback

- Service users reported excellent care on the labour ward and at Broadlands Birth Centre, highlighting compassionate and professional staff. Many found BadgerNet easy to use, supporting accessible and clear maternity records.
- Antenatal care feedback was mixed, with continuity of care cited as a key factor in positive experiences those who saw the same midwife consistently reflected positively on this experience.

- Postnatal care was generally viewed as good, though some users felt it was too brief. A recurring theme was the need for more breastfeeding support before discharge, with several families expressing a desire for more time and guidance in this critical area.

- *"The care after birth was really good, but I felt like we were discharged too quickly. I hadn't quite got the hang of breastfeeding and would have appreciated a bit more time and support before going home."*

Next steps

Hampshire and Isle of Wight

Planned Activities for the Next Quarter

Our focus for the next quarter will be on enhancing service user engagement. These initiatives aim to create a more inclusive and responsive service, ensuring that all voices are heard and valued.

Key action steps include:

1. Increasing Service User Participation & Feedback

- Encouraging greater service user involvement.
- Expanding feedback opportunities to ensure diverse voices are heard.

2. Strengthening Community Engagement

- Working closely with communities, particularly those experiencing higher health inequalities.
- Hosting a **face-to-face engagement event** within the community.
- Organising community feedback listening events

3. On-the-Ground Outreach

- Setting up **"Walk the Patch"/ "15 Steps" engagement visits** to interact directly with service users.
- Attending **drop-in community events** at centres such as breastfeeding support groups and family hubs.
- Representing MNVP at **parent coffee mornings** for Neonatal service users at Ronald McDonald House.

4. Enhancing Digital Engagement & Feedback Processes

- Improving engagement on social media platforms.
- Evaluating the current feedback form to ensure it effectively captures service user experiences - looking to add to FFT to capture more involvement for MNVP.
- Expanding engagement opportunities to reach a broader audience.

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Agenda Item 5.4	Report to the Trust Board of Directors, 9 September 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:

- NHS Oversight Framework
- Industrial Action
- Elective Care Capital Incentive Scheme
- 'Graduate Guarantee' for Nurses and Midwives
- Violence and Aggression
- Winter Improvement Guides
- Local Council Reorganisation

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

NHS Oversight Framework

Following publication of the NHS Oversight Framework 2025/26 in June 2025, NHS England has announced that it will use an assessment of provider capability alongside providers' segmentation to judge what action or support are appropriate at each trust.

As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across six areas derived from the domains set out in *The Insightful Provider Board*. These areas are:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

Trusts will have eight weeks to carry out a self-assessment and then return this to their region, which will then carry out a review of the return and assign a capability rating. As such, the Board will need to review and approve the proposed submission during October 2025.

Trusts will be assigned a rating of green, amber-green, amber-red, or red. Oversight teams may also use third party information (such as that from the CQC and similar regulatory/oversight bodies) and compare this to the organisation's self-assessment submission in determining the rating of an organisation.

This rating will be used to inform whether trusts go forward to apply for new Foundation Trust status (as announced in the 10-Year Plan) or are considered for the National Provider Improvement Programme (NPIP) (the replacement for the Recovery Support Programme).

It is intended that ratings will be in place by the end of November 2025 in order to identify candidates for the NPIP in December.

The self-assessment template and accompanying guidance can be viewed at: https://www.england.nhs.uk/publication/assessing-provider-capability-guidance-for-nhs-trust-boards/

The segmentations under the NHS Oversight Framework are due to be published on 8 September 2025.

Industrial Action

Resident doctors undertook strike action between 25 and 30 July 2025 following a ballot of British Medical Association (BMA) members for a six-month strike mandate, which expires on 6 January 2026.

Based on data published by NHS England, more care was delivered during the July 2025 strike than during the five-day walkout in June 2024. NHS analysis estimates that an additional 11,071 appointments and procedures went ahead compared to June 2024. UHS lost very little activity (385 outpatient appointments, 11 surgical patients, and nine endoscopies) and ranked positively against other teaching hospitals in terms of lost activity (26th out of 29).

Staff absence due to industrial action was lower during this latest strike with around 1,243 fewer staff absent each day on average compared to June 2024 – a 7.5% drop.

At UHS approximately one third of resident doctors took part in industrial action. Consultant cover was provided at previously agreed pay rates with no escalated rates. The hospital ran very well with flow and discharges positively impacted.

The Trust is making good progress towards the 'improving resident doctors' lives' standards and has a task and finish group in place, which will now address the new 10-point plan to improve resident doctors' working lives.

The Secretary of State and BMA agreed to continue to engage throughout the summer.

Following its rejection of the proposed 2025/26 pay deal, there remains a risk that the Royal College of Nursing will seek a mandate for industrial action later in the year.

Elective Care Capital Incentive Scheme
NHS England announced the criteria and timelines for the first funding round under the Elective Care Capital Incentive Scheme on 19 August 2025. The scheme aims to incentivise and to reward providers which make significant improvements to their Referral to Treatment (RTT) position, whilst also ensuring continued progress is made towards reducing waiting lists.

A £40m uplift in capital departmental expenditure limit (CDEL) is being divided into two rounds of £20m, with the first round being allocated to providers during the first quarter of 2026/27 based on performance between April and September 2025.

In the first round the scheme will reward the ten most improved providers which make the greatest improvements towards meeting the RTT standards. These providers must also be on track to deliver the waiting list reductions they committed to in their planning submissions, including meeting their targets for reducing patients waiting over 52 weeks.

Successful providers will be able to request to spend some or all the incentive in the final quarter of 2025/26.

The CDEL uplift associated with this incentive scheme is not automatically cash backed. If a provider has insufficient cash, they will be able to apply to NHS England and to the Department of Health and Social Care for system capital support public dividend capital financing. This request will remain subject to the normal tests on operational capital allocations and CDEL affordability, as well as an assessment of the purpose of funding and the organisation's ability to finance the expenditure from its own cash reserves or depreciation.

'Graduate Guarantee' for Nurses and Midwives
On 11 August 2025, the Government announced a 'graduate guarantee' for newly qualified nurses and midwives, confirming that all newly qualified nurses and midwives in England will have the opportunity to apply to join the health and social care workforce. This followed discussions with the Royal College of Midwives and the Royal College of Nursing to provide more certainty for graduates and to fill vacant posts.

NHS providers are encouraged to recruit newly qualified nurses before vacancies formally arise and to adopt a time-limited approach to utilise existing vacant healthcare support worker roles to create time-limited registered nursing posts.

NHS England has reprioritised £8m of non-recurrent funding for 2025/26 to support the temporary conversion of vacant maternity support worker posts to band 5 registered midwifery roles to create opportunities for newly qualified staff.

It is intended that increasing recruitment of newly qualified nurses and midwives will enable organisations to significantly reduce reliance on high-cost agency staffing.

UHS had already committed to increasing the number of nursing graduates hired this autumn, following conversations with university education partners and recognising the importance of ensuring the viability of the UK educated nursing pipeline, supporting nurses the Trust has helped to train and maintaining an age diverse workforce.

Violence and Aggression
On 12 August 2025, the Royal College of Nursing (RCN) published the results of its analysis of violence and aggression against nursing staff in accident and emergency departments in England. The RCN made a request under the Freedom of Information Act to all acute trusts across England asking for the total number of incidents of physical violence carried out towards staff by patients reported each year between 2019 and 2024 in the organisation's largest accident and emergency department. Eighty-nine organisations responded, including UHS.

The RCN found that across the trusts which responded there had been 2,093 incidences of physical violence recorded against staff in 2019 compared to 4,054 in 2024. The Trust recorded 41 incidents in 2019 and 32 in 2024, with an average of 37 incidents per year over the period (peaking at 59 in 2022).

Winter Improvement Guides
NHS England has published a series of urgent and emergency care improvement guides designed for providers and systems to consider embedding as good practice to reduce ambulance handover delays.

These guides have been drawn from the Winter Improvement Collaborative which was established to identify solutions to problems over the winter period. Members of the collaborative were asked to co-design a series of plans and potential improvement measures to be adapted and trialled at a local level.

The guides can be viewed at: https://www.england.nhs.uk/nhsimpact/improvement-resources/winter-improvement-guides/

Local Council Reorganisation
As part of national plans to create unitary councils in place of existing county and district/borough councils, public engagement was launched about different options within Hampshire and Isle of Wight.

Hampshire County Council propose a model of four unitary authorities which groups Southampton in a single authority with New Forest, Eastleigh and Test Valley.

Southampton City Council (along with the majority of other councils in Hampshire and IOW) propose an alternative model of five authorities, with Southampton and Eastleigh being separated from the rural areas of New Forest and Test Valley.

UHS did not respond formally to the consultation.

The proposal for five authorities would more closely align one unitary authority with the Trust's secondary activity referral population, which might make discussions around health and wellbeing and discharge easier to focus. However, given the nature and spread of services at UHS there will always be a need to be interacting with the other authorities, whatever decision is reached regarding the final configuration.

Following the close of this engagement, a recommendation is due to be made to government at the end of September 2025, with the current timetable aiming that structures are agreed by March 2026 and implemented by May 2028.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.5 Report to the Trust Board of Directors, 9 September 2025	
Title:	Performance KPI Report 2025-26 Month 4
Sponsor:	David French, Chief Executive Officer
Author:	Sam Dale, Associate Director of Data and Analytics Gavin Hawkins, Divisional Director of Operations (Division B)

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

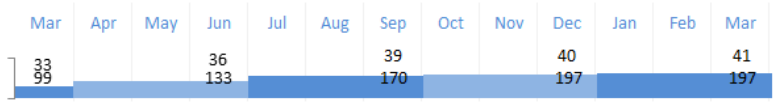
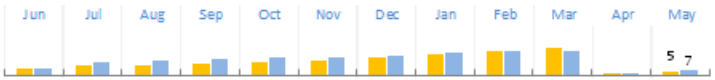
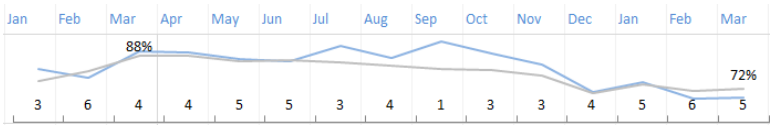
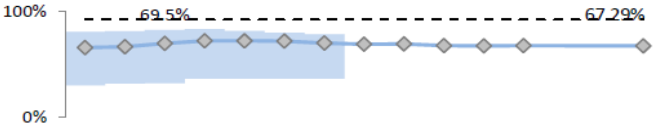
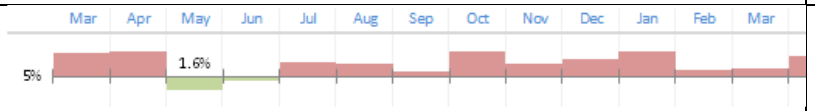
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
July 2025

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

Report guide

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

Introduction

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

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

The content of the report includes the following:

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

Summary

This month's spotlight report describes activity and waiting time performance within the Emergency Department.

The report highlights that:-

- Performance against the four hour target for all attendances (type 1 and type 2) for the latest reported month (July 2025) was 61.0%. The national target is 78% with expectation that trusts achieve this by March 2026.
- The trust has been placed in Tier 1 escalation due to the gap between the trust's current position and the performance plan submitted at the start of the year.
- The trust is working with the Emergency Care Improvement Support Team (ECIST) to implement recommendations alongside an internal action plan which has been developed by operational teams and the Clinical Director for Urgent and Emergency Care.
- The key actions include the establishment of an acute assessment unit and an ED specific SDEC, reduction of the number of inappropriate attendances, offering appointments to minor patients at certain times of the day and improving decision making and patient flow through the hospital.
- The unvalidated August position indicates some early signs of improvements but recognises this has also been supported by fewer attendances to the department.

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

1. The organisation reported an increase in the number of patients waiting over 52, 65 and 78 weeks in July 2025 alongside a small increase in the overall waiting list (63,007 for July 2025). The trust has entered Tier 2 escalation for RTT (referral to treatment) performance due to the variance from the trust's original waiting list performance plan for the financial year. It is working closely with the regional team to describe the key variance drivers and opportunities for immediate and long term improvement.
2. Key drivers for the waiting list and waiting time increases are the volume of referrals in a handful of specialties but capacity and resource challenges of delivering cost reductions whilst continuing to treat more patients year on year. Intervention success is being seen within several transformation programmes designed to drive efficiency and increased capacity through cancellation reductions, improved theatre utilisation and the appropriate management of referrals through advice and guidance schemes. The hospital continues to prioritise patients based on clinical urgency.
3. The trust is modelling forecast trajectories for all key waiting time metrics alongside intervention options. The monitoring of these revised plans will be shared in future board papers.
4. The latest validated position (June 2025) evidences a challenging month for cancer waiting times reflected in performance of 73.1% for the 28 day faster diagnosis standard. Performance is primarily impacted by ongoing capacity issues in dermatology, maxillo-facial and ENT (including head and neck service). Unvalidated data shows recovery in July and plans are in place to improve staffing levels in ENT and capacity levels via improvements

in one stop clinics in Dermatology. The trust is also working with the Cancer Alliance on short term non-recurrent support available to reduce waiting times.

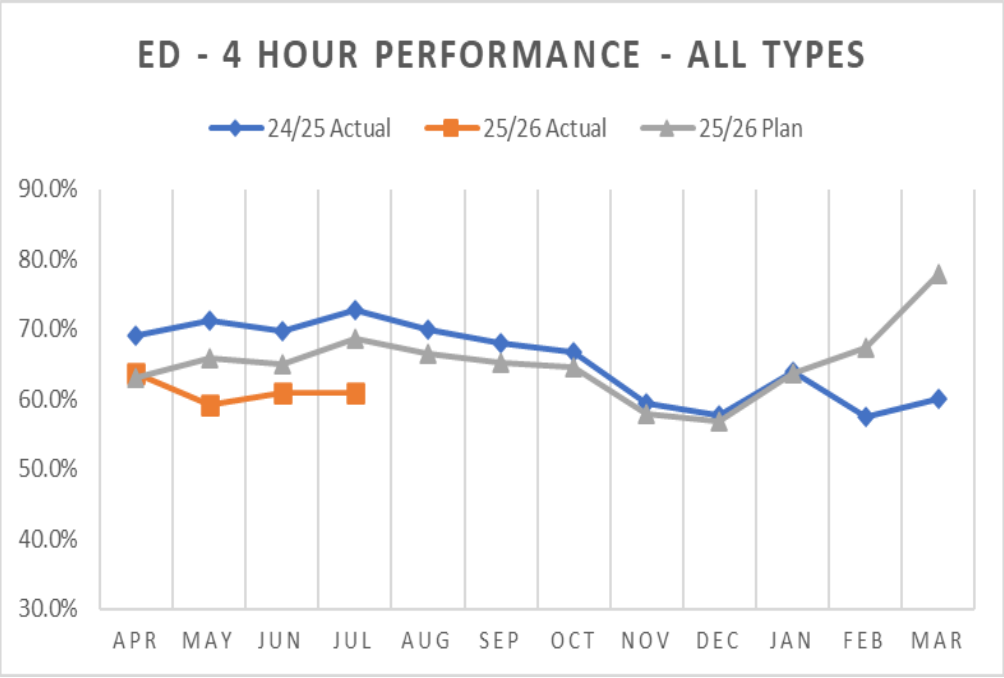
5. Despite the performance challenges within the overall waiting list, the number of patients waiting for diagnostics decreased to 10,431 in July 2025 and performance against the six week waiting time standard remained consistent at 16.5%
6. The trust reported one case of MRSA in July 25, zero never events and one Patient Safety Incident Investigation (PSII).
7. There was a reduction in the number of falls investigated (per 1000 days) to just 0.02 and a reduction to the red flag staffing incidents.
8. The volumes of pressure ulcers (category 2 and category 3) per 1000 days has now reduced to below the monthly target indicating early success following the education improvements that have been previously outlined.
9. The organisation has remained consistent in the volumes of outpatient consultations delivered virtually achieving the national expectation of 25% every month over the last 12 months.

Spotlight: Emergency Department (ED) Performance

Four hour standard, from arrival to admission, transfer, or discharge from the Emergency Department

The national ED target for 2025/26 is for 78% of all patients to be seen and admitted, transferred or discharged within 4 hours of arrival, as a system position. The expectation is that this milestone is achieved in March 2026. This is unchanged from 2024/25.

Our 2025/26 plan submission for our UEC performance is captured in graph 1.



Graph 1: ED four hour performance vs plan (all types)

This is for all 4hr performance types which UHS directly control i.e. type 1 & 2 but not type 3. In previous years, the end of March performance calculation has included the two Urgent Treatment Centres local to UHS, at the Royal South Hants Hospital and Lymington. We expect this to still be the case.

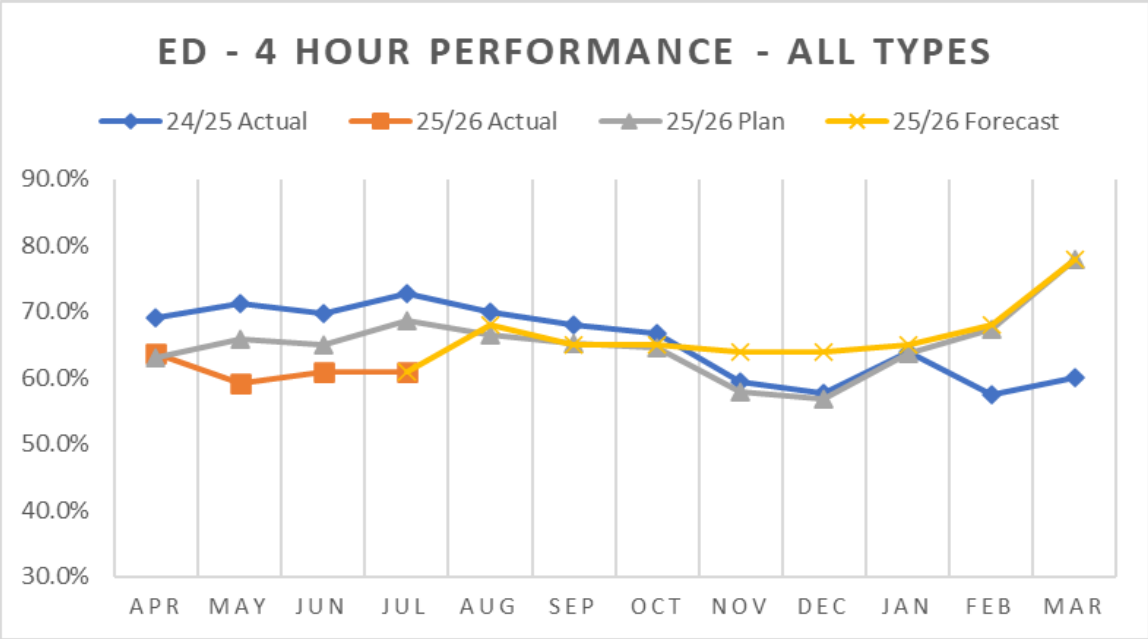
From the graph you will see up from May 25 to July 25 we have been off plan, 7.7% for July'25.

This triggered UHS being placed in tier one escalation for our UEC performance to which we were notified of in August.

Note our entry into tier one was due to our performance against plan not due to our actual 4hr performance although this has reduced relative to other organisations.

To date we are still awaiting confirmation as to what this means for UHS although the guidance states we will be in contact with the Emergency Care Improvement Support Team (ECIST). Fortunately UHS had already invited ECIST back to the Trust to talk through further ideas to support our current position.

Our draft position for August 25 has been better against the plan of 66.5%, with our 4hr performance expected to be close to 69% evidencing some positive signs of improvement from the current initiatives being implemented by the ED team.



Graph 2: ED four hour performance vs plan (all types)

Graph 2 highlights the plan for 25/26 with a forecast trajectory added to our August25 position to the end of March26.

The submission for 2025/26 assumed we would be in a position for our Urgent Treatment Centre to have been agreed and open in March26. At this time this is not looking likely.

The ED team working alongside the Trust are focussing on several initiatives to maintain August's improvement and to continue this further.

It must be recognised attendances to ED are still higher than they should be, so achieving 78% 4hr performance in March26 remains a significant challenge.

The August 25 combined performance is still being validated and whilst UHS type 1 & type 2 was below plan for July 25 our combined UEC performance including the Urgent Treatment Centres stood at 75.6%.

Graphs 3 & 4 in the appendices show the type 1 performance and attendance trend over the last 5 years. Our performance against 12hr waits remain better than plan for 25/26, better than actuals in 24/25 and in the top 10 nationally of all type 1 ED providers.

ED - Hospital Performance Comparison

The trust benchmarks ED performance against other organisations across the country and the table below shows our ranking against 20 peer teaching organisations and the 17 providers within the South East region clearly illustrating the decline in performance since quarter 4 of 2024/25:-

Comparator Position	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Teaching Organisations (20)	5	5	7	7	7	5	2	3	2	5	2	4	5	6	4	4	9	12	6	12	12	7	15	13	17
South East Providers (17)	8	8	12	10	11	8	4	4	4	9	6	8	6	10	6	6	12	15	9	16	14	10	14	15	15

Top Quartile
Top Half
Bottom Half

The operational pressures raised in previous reports to Trust Board remain and in summary are:-

- Attendance growth - 23% increase in attendances since pre-covid year (19/20)
- Continued rise in patients with enhanced care needs and mental health attendances and the associated length of stay in ED but also the knock-on impact on assessment areas and downstream wards. A 9.5% rise in patients attending ED in July25 vs June25 whose attendances is mental health related.
- Flow through the Emergency Department despite efforts from downstream specialties. Some of this challenge is highlighted by the Trust's non-criteria to reside (NCTR) numbers which have risen consistently since covid and on some days take up 25% of the level one bed stock of the Trust.

What are we currently doing about these challenges?

ECIST (Emergency Care Improvement Support Team) returned to UHS on the 26th of June and spent an afternoon with our ED, Same Day Emergency Care (SDEC) and Acute Medicine teams. Their review was led by Jim McDonald and Natalie King and subsequent feedback focussed on the following themes:-

Internal to ED

1. Developing an Urgent Treatment Centre (UTC) covering primary care and minor injuries and streaming up to 50% of walk-in activity to it.
2. Redesigning CDU to accommodate high volume but low complexity patients who currently breach before being discharged.
3. Prioritise early streaming and referral of patients to appropriate specialist teams.
   This would be supported by:
   a. Consistent Emergency Medicine Consultant support in pit-stop.
   b. Improved access to all SDEC and assessment areas to decongest the Emergency Department.

External to ED

4. Improved medical assessment space and staffing profile which would be supported by:
   a. A dedicated Acute Assessment Area.

b. A demand and capacity analysis on the medical team, especially out-of-hours.

5. Better use of SDEC to bring down length of stay

Since the beginning of August the ED team, Care Group, Division B Management Teams and the Clinical Director for UEC have established a list of initiatives to take forward in the short term to improve the four hour emergency access performance. These UHS initiatives do also address the feedback received from the ECIST visit.

The top six initiatives are:

i. Review of the CT head pathway to reduce time taken and time spent in ED;
ii. Establishment of an Acute Assessment Unit to support those patients where an admission decision has been made but waiting for a downstream bed to become available;
iii. Offering appointments to minor patients at certain times of the day to reduce attendance surge allowing an easier management of patient numbers according to the resources available;
iv. Embedding redirection of patients at the front door to reduce the number of inappropriate attendances into ED;
v. Establishing an ED specific SDEC to support the management of patients on an ambulatory pathway
vi. Review and change use of Clinical Decisions Unit (CDU) in ED.

Each of these initiatives has an individual project plan linked to milestones and metrics. The aim from these initiatives is to reduce four hour breaches by 30 per day to improve four hour performance but also ensure the patient experience is not impacted. A further 10 short-focussed schemes are also being worked on but not at the expense of this top six schemes.

External to ED, all specialties are fully engaged and remain focussed on challenging themselves to ensure they can best manage their non-elective patients.

Particular areas of focus include:-

- SDECs - space constraints have slowed down the inception of downstream SDECs but this is still a focus for all teams. An 8% increase in patients being seen in an SDEC facility was reported in July25.
- Continued focus on patients to be transferred out of the ED post downstream bed being requested, 3% increase in this target in July25.
- The “Who Goes Where” document is still being used with specialties feeding back to Care Group Clinical Leads and ED team to support with updates.

- Better management information from Radiology to support with diagnostics demand and waits.
- Reduction in length of stay – a further 5% is the Trust ambition for 25/26.
- Roll-out of Pharmacy First as this has not fully embedded so far.
- Trialling of a bedded discharge lounge to support bringing forward the time of discharge to increase available beds earlier in the day.
- Constant internal communications to bed managers and Single Point of Contacts (SPOCs) regarding the importance of 4hrs and timely flow out of ED.
- Setting up Task & Finish Groups to tackle NCTR numbers and MH/enhanced patient care demand.
- Specialty priorities which care groups are working to support UEC:-
    - Trauma & Orthopaedics (T&O) - Optimising operating services, UEC pathways, and Virtual Fracture Clinic (VFC).
    - Neurosciences - Spinal Rapid Access Pathway, Angiography for Subarachnoid Service, and length of stay (LoS) optimisation for spinal services.
    - Cardiovascular & Thoracic (CVT) - Criteria-Led Discharge, Discharge Lounge optimisation, eWhiteboard integration.
    - Emergency Medicine & Medicine for Older People - Electronic handover pilots, board rounds, push/pull models in AMU, and SMDU optimisation
    - Surgery - Improving EDD and LoS compliance, criteria-led discharge, and therapy-supported board rounds.
    - Cancer Care - Consultant-led triage, streamlined ambulatory pathways, reducing avoidable ED attendances.

These initiatives are discussed at Urgent & Emergency Care Board which has representation from all care groups from medical, nursing and operational teams which in turn then feeds into Transformation Oversight Group (TOG).

The Trust has notionally been awarded capital to complete two projects which should have a positive benefit to improving our 4hr emergency access performance and supporting patient care. To receive the capital (and cash) we are finalising the internal and external facing business cases.

The funding is to provide:

1. Urgent Treatment Centre to be built on site to be co-located with our ED;
2. Re-develop the previous Paediatric ED space which has been used over the last 5 years as a Respiratory Assessment Unit (RAU), ambulance holding area, plus medical surge.

The intention from both capital bids is to support demands on our ED, however the challenges will be for these schemes to remain cost neutral from a revenue perspective when we know certainly with the UTC there is a risk of increasing attendances.

Ambulance Handover Performance Target - "All handovers must take place within 15 minutes with none waiting more than 30 minutes"

Ambulance Handovers remain a focus area for UHS & SCAS as is a key national target. UHS has constantly performed very well in relation to measures of timely ambulance handover and continues to do so compared to peers. In quarter 4 of 24/25 UHS ED came under extreme pressure and as a result our ambulance handover performance worsened. With a slight reduction in attendances and an increase in downstream bed availability our position has since improved.

Graph 5: Total Ambulance handovers per week (unvalidated)

The graphs above continue to highlight total handovers covering January 2023 to the end of July 2025 by week, performance (%) and number of handovers over 30mins and 60mins. It should be noted that the increase in the number of handovers from January 25 is constantly over the 810 average and the dip in % performance although this has since recovered well.

We are currently linking in with SCAS to perform a “perfect week” to better implement dual sign off with the emergency department, to ensure more accurate data quality, agreeing a ‘capacity full’ protocol with SCAS and the wider system, and work between SCAS and the emergency department to review best practice.

Conclusion

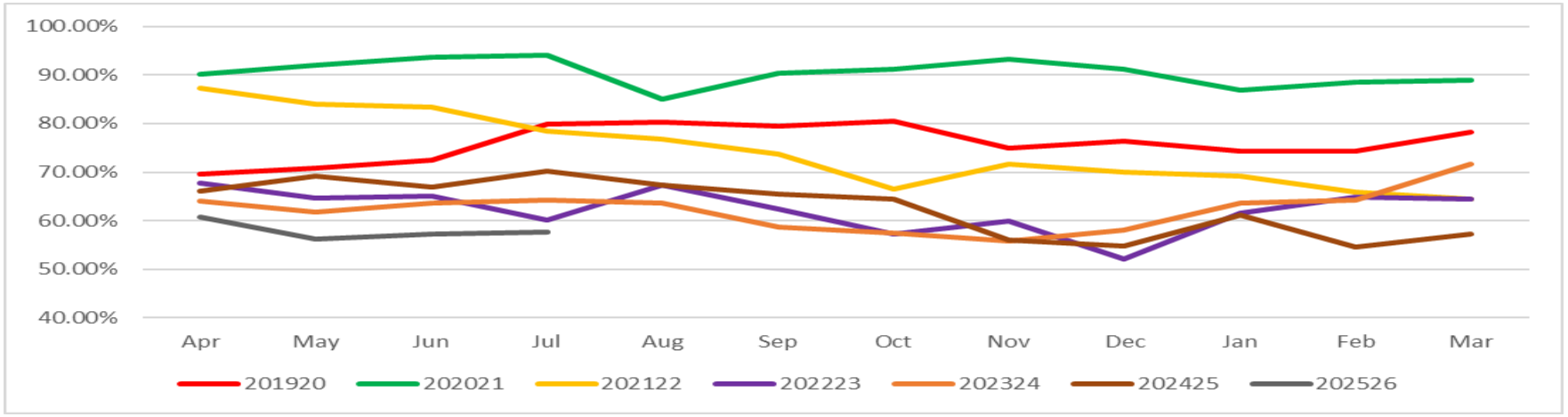
UHS remains in a challenged position from a 4hr performance perspective compared to peers. Nationally this is seen by our performance being off plan recognising comparisons are difficult to be drawn due to many Trusts having an Urgent Treatment Centre shown in their denominator as explained in this report.

We have made good progress in August 2025 setting up new initiatives at pace which have translated into improved performance against plan and our peers. We recognise this has been helped by fewer attendances in the ED in the month.

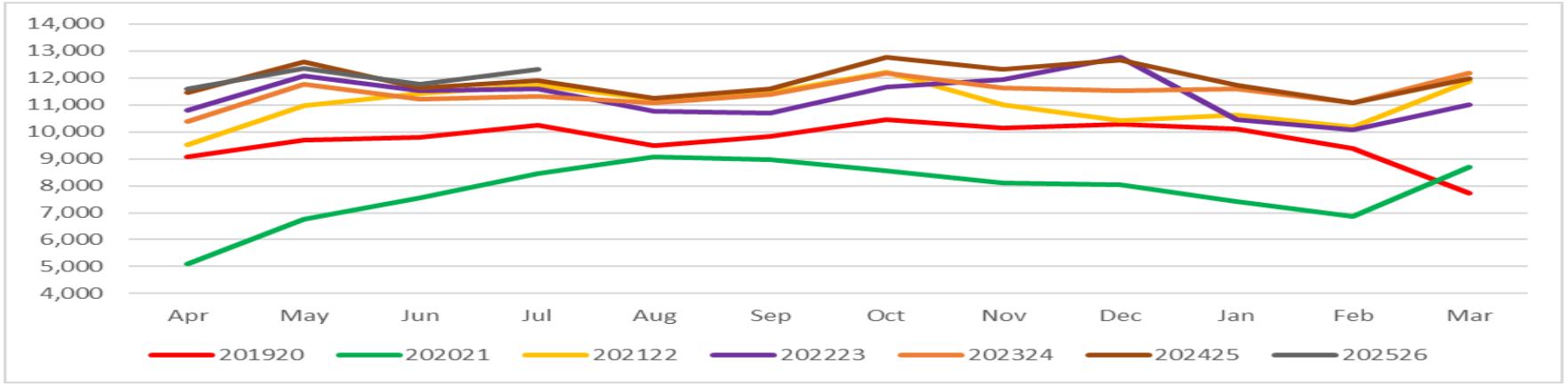
The intention is to continue with this more consistent 4hr performance position via working on the initiatives as part of our ED action plan as well as following up on the recommendations from the ECIST Report. As a result of this we are striving to be removed from Tier 1 escalation as soon as appropriate.

The challenge Trustwide will be maintaining performance going into the winter months.

Appendices:



Graph 3: Trended ED 4 hour performance – Type 1 only



Graph 4: Trended ED attendances – Type 1 only

NHS Constitution - Standards for Access to services within waiting times

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

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

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

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

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

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

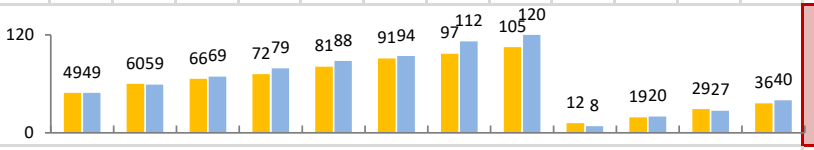
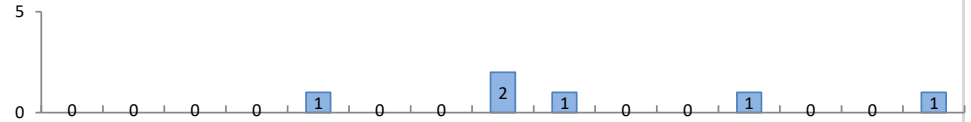
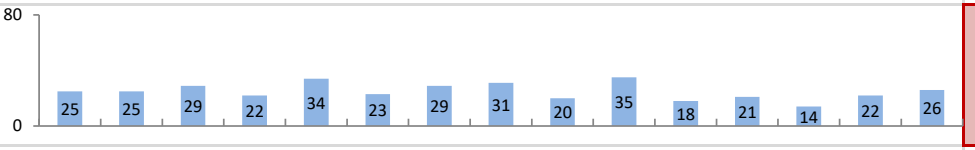
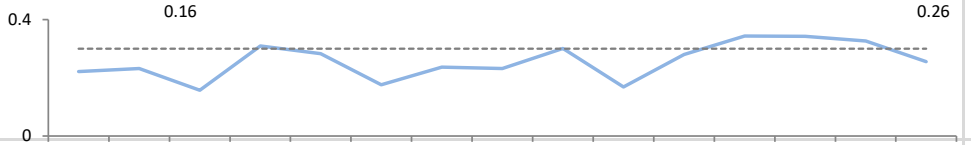
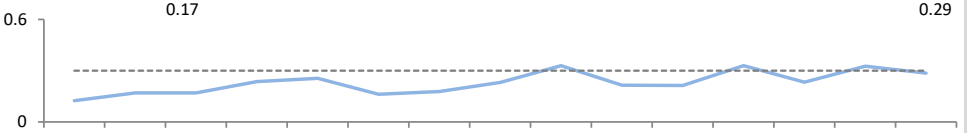
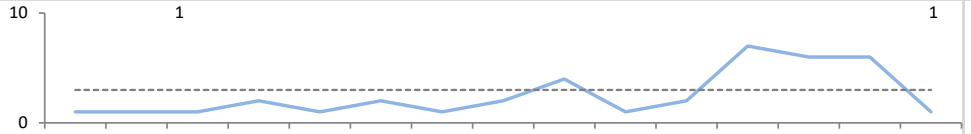
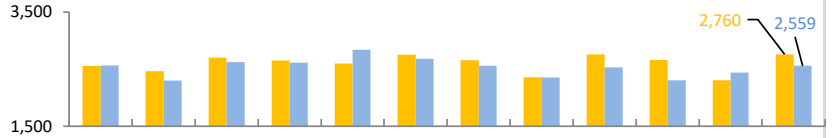
Performance against the NHS rights, and a range of the pledges, is summarised below. Further information is available within the Appendix to this report.

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

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD
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%	64.4%													63.4%	≥67.4%	63.7%
		4	4	4	4	4	4	4	4	4	4	3	3	3	3			
		4	4	3	4	4	3	5	5	5	7	6	5	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%	76.1%													70.4%	≥75%	74.5%
		6	5	5	4	3	5	4	4	2	10	4	10	3	10			
		4	3	3	2	2	2	1	2	2	4	2	3	2	6			
		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%	70.6%													57.6%	≥78%	57.9%
		6	8	6	10	6	6	12	15	9	16	14	10	14	15	15		
		2	4	5	6	4	4	9	12	6	12	12	7	15	13	17		
		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%	11.6%													16.5%	≤5%	16.43%
		4	5	5	5	5	6	6	6	6	6	7	9	9	9			
		5	5	6	6	6	8	9	8	9	6	7	10	11	9			
		0%																
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	100.0 90.1 88.4 80.0												91.3 89.5			≤100	94.7	≤100
2	HSMR - Crude Mortality Rate	3.0% 2.6% 2.2%												2.3%			<3%	2.2%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital	15% 11.6% 10%												12.6%			-	13.6%	-
		Q1 2024/2025			Q2 2024/2025			Q3 2024/2025			Q4 2024/2025			Q1 2025/2026			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	78 76 74 76			76			76			76			77			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100% 75% 50% 36 77 342			39 79 319			36 76 317			36 88 309			35 90 309			-		

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

Safety		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**																≤8	40	≤32
7	MRSA bacteraemia																0	2	0
8	Gram negative bacteraemia																≤18	83	≤68
9	Pressure ulcers category 2 per 1000 bed days																<0.3	0.26	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days																<0.3	0.29	<0.3
11	Medication Errors (severe/moderate)																≤3	20	12
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent 12 months** vs. **Previous 12 months**																<2578	2,459	<2552

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

Safety		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)			0												1	-	6	-
14	Never Events			1												0	0	2	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity			0												0	-	0	-
16	Number of falls investigated per 1000 bed days			0.09												0.02	-	0.10	-
17	% patients with a nutrition plan in place (total checks conducted included at chart base)			90.9%												91.8%	≥90%	92%	≥90%
				973	977	930	869	826	964	961	828	901	989	965	895	945	1,074	981	
18	Red Flag staffing incidents			33												5	-	37	-
Maternity		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	415	379	390	400	410	438	392	396	395	372	410	390	390	425	440	-	-	-
		633	517	501	480	403	523	451	467	496	466	494	450	448	447	472			
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	3	8	8	2	12	6	1	0	1	1	1	1	1	4	4	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	46.51%	53.03%	44.80%	44.25%	43.90%	41.10%	46.68%	40.91%	47.85%	47.85%	48.54%	48.46%	45.38%	45.65%	45.23%	-	-	-
		39.04%	35.88%	44.40%	43.00%	42.44%	48.40%	41.07%	47.47%	42.03%	42.47%	40.98%	37.69%	43.59%	39.76%	42.05%			

Patient Experience		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients	3%	0.9%													1.4%	≤5%	1.2%	≤5%
		0%																	
23	FFT Negative Score - Maternity (postnatal ward)	10%	3.1%													2.2%	≤5%	2.4%	≤5%
		0%																	
24	Total UHS women booked onto a continuity of carer pathway	30%	13.3%													14.8%	≥35%	14.2%	≥35%
		0%																	
25	Total BAME women booked onto a continuity of carer pathway	100%	19.2%													19.3%	≥51%	16.4%	≥51%
		0%																	
26	% Patients reporting being involved in decisions about care and treatment	100%	89.4%													85.2%	≥90%	85.1%	≥90%
		80%																	
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%	89.9%													86.1%	≥90%	87.9%	≥90%
		80%	340	280	258	317	221	353	247	296	323	273	483	491	442	504	416		
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	47													65	-	307	-
		0																	
29	Number of mental health patients spending over 12 hours in A&E	100	36													48	-	195	-
		0																	

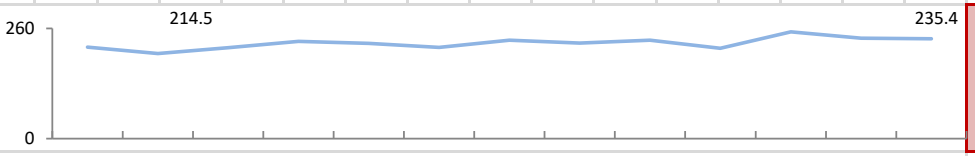
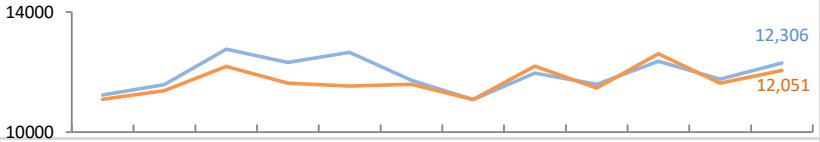
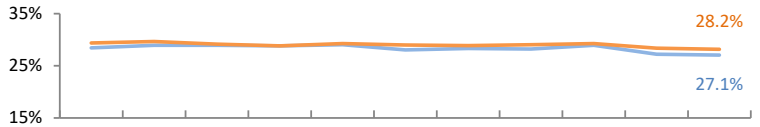
	Access Standards	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED (Type 1) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 16)**	80%	70.6%													57.6%	≥78%	57.9%	≥78%
		6	8	6	10	6	6	12	15	9	16	14	10	14	15	15			
		2	4	5	6	4	4	9	12	6	12	12	7	15	13	17			
		40%																	
31	Average (Mean) time in Dept - non-admitted patients	05:00		03:03												03:24	≤04:00	03:22	≤04:00
		02:00																	
32	Average (Mean) time in Dept - admitted patients	07:00		05:00												05:47	≤04:00	05:50	≤04:00
		03:00																	
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year	100%														98.0% 99.1%	-	97.9%	>98.4%
		95%																	
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%		64.4%												63.4%	≥67.4%	63.7%	≥67.4%
		4	4	4	4	4	4	4	4	4	4	3	3	3	3				
		4	4	3	4	4	3	5	5	5	7	6	5	5	6				
		50%																	
35	Total number of patients on a waiting list (18 week referral to treatment pathway)	65,000		60461												63007	-	63,007	-
		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%		2.08%												2.54%	1.0%	2.5%	1.0%
		6	5	3	3	3	4	6	6	6	6	7	5	8	8				
		9	8	6	6	6	6	7	7	7	7	7	7	7	8				
		1%																	

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	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)	1260														1599	0	1599	0
		5,000	3	2	2	2	2	2	3	3	3	3	2	2	2	4			
		0	10	9	9	8	9	8	9	9	10	9	9	9	9	10			
38	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	44														173	0	173	0
		1,500	2	2	1	1	2	1	2	2	1	2	2	4	8	12			
		0	5	4	4	4	6	4	5	6	7	7	9	10	13	15			
39	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	11														12	0	12	0
		250	10	11	9	9	4	8	8	1	5	5	6	1	1	10			
		0	10	11	7	6	6	7	8	1	4	6	7	1	1	14			
40	Patients waiting for diagnostics	11,500	9132													10431	-	10,431	-
		7,500																	
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	11.6%														16.5%	≤5%	16.4%	≤5%
		40%	4	5	5	5	5	6	6	6	6	6	7	9	9	9			
		0%	5	5	6	6	6	8	9	8	9	6	7	10	11	9			

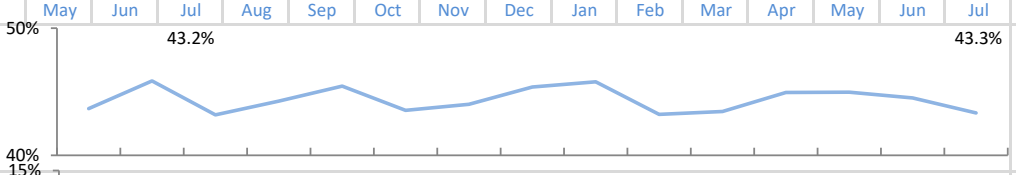
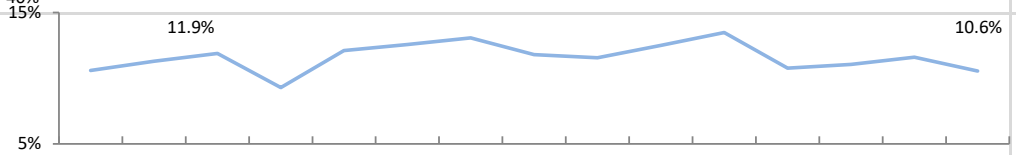
41 - As of **April 2024**, **YTD and Monthly Target** changed from **1% to 5%** to reflect latest guidance

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks															68.1%	≥71.2%	68.1%	≥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)															70.4%	≥75%	74.5%	≥75%
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)															73.1%	≥80%	77.5%	≥80%
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)															95.6%	≥96%	95.6%	≥96%

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

Local Integration		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	234	-
51	Emergency Department activity - type 1 This year vs. last year																-	48,022	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	27.8%	≥25%
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month																			

Digital		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			209848												253862	-	253,862	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			37311												38347	-	149,081	-
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		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted																-	44.4%	-
58	Percentage of under 18s attending emergency departments to be admitted																-	11.0%	-

Agenda Item 5.6 Report to the Trust Board of Directors, 9 September 2025	
Title:	Operating Plan 2025-26 and Board Assurance Statement
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Duncan Linning-Karp, Deputy Chief Operating Officer

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 presents the Trust's annual operating plan to the Board for approval. The plan provides a summary of more detailed plans and policies, covering a range of operational themes from infection prevention to predicted capacity and demand.

The plan shows that, including the demand management schemes led by the ICB, there is still likely to be a gap between predicted demand and capacity. The aim is to mitigate this gap through a further reduction in length of stay and patients not meeting the criteria to reside. Should this not prove successful there is a risk that the Trust will need to run at an occupancy level of above 95% and / or cancel some elective surgery.

The plan outlines the Trust's response to Operational Pressures Escalation Levels (OPEL), the system's transformation schemes, infection prevention and control and a summary of plans for key areas of the hospital.

Contents:

This paper contains:

1./ The Trust's Operating Plan for 2025-26.
2./ A Board Assurance Statement.
3./ An Equality and Quality Impact Assessment.

Risk(s):

- Risk of overcrowding in the Emergency Department, and therefore a risk to patient safety and experience
- Risk of cancelling elective surgery because of non-elective pressures, and therefore a risk to patient safety and experience
- Risk of failing to deliver the Trust's 2025-26 plan for either (or both) performance and finance

Equality Impact Consideration:	Attached

University Hospital Southampton
NHS Foundation Trust

UHS
Operating Plan

October 2025 – September 2026

Contents

Chapter 1 Introduction and Scope

Introduction

The Trust wide Operating Plan is intended to provide a summary of plans from October 2025 to September 2026. It is intended as a summary document and should sit alongside key policies including (but not limited to) infection control policies, the Influenza Plan, and the Major Incident Plan. It is also important to note that many of the issues in the hospital require dynamic management and the plan is subject to flux depending on the situation and competing priorities. The last few years have seen significant uncertainty with infectious diseases, industrial action and elective recovery. While COVID-19 is less of a risk than previous years there are likely to be significant waves of infection, particularly over the winter. Other risks include potentially ongoing industrial action, as well as more traditional concerns about the level of patients not meeting the criteria to reside, mental health patients, the need for financial reset and ongoing rising demand.

This plan is also intended as the Trust's winter plan. Winter should be recognised as a period of increased pressure due to the increased clinical acuity of many patients combined with increased demand on services. In addition, the winter period often brings with it untoward events such as widespread infectious diseases including influenza and Norovirus. This winter there will also be the added pressure of COVID-19, ongoing financial challenges and the need to achieve elective, cancer and non-elective targets (more detail below).

Seasonal vaccination programme for NHS staff has been confirmed for influenza for the 2025/26 campaign; only those in specified at-risk groups will be eligible for COVID-19 vaccination. Influenza vaccine reduces transmission of the virus and uptake will be strongly encouraged after reduced uptake, presumed to be vaccine fatigue, over recent years. Support from matrons and clinical leaders will be required to support inpatient vaccination due to the need for vaccine specific prescribing and nursing competencies. The Trust remains a holding centre for mpox vaccine and support the ICB to respond in the event of a case locally.

Aims of the Operating Plan

UHS's Operating Plan prepares the organisation for 2025/26 with support from the Health and Care Community locally to:

- Manage available capacity to meet demand
- Achieve the targets laid out in the national operating plan, including 78% emergency access performance in March 2026, a maximum of 1% of patients waiting over 52 weeks, a 5% improvement on RTT and the suite of cancer standards
- Reduce both the number of patients not meeting the criteria to reside and the number of patients who are waiting a mental health admission who remain in an acute bed
- Support the Trust's financial recovery

The top interventions to deal with the expected increased demand throughout this year (both elective and emergency) are: -

- Reviewing what more can be done to support the Emergency Department, including implementing the Unscheduled and Emergency Care (UEC) recovery plan

- The reduction of length of stay and the adoption of best practice through a renewed focus on improvements in internal process, via the UEC Transformation Programme
- The reduction and avoidance of admissions through partnership working
- Ensuring all bedded capacity remains *available,* although it may at times be unstaffed if it is not needed
- Closing all surge capacity where possible
- Continue to treat elective patients based on clinical priority, while also focusing on driving down waiting times
- Continuing to maintain and improve cancer waiting times
- Continuing to maintain and improve diagnostic waiting times
- Achieving 78% emergency access performance at a local system level by March 2026
- Continue to work with system partners to reduce the number of patients not meeting the criteria to reside who remain in hospital, leading the local system's revised and renewed discharge plan
- Effective management and control of all infections including norovirus, COVID and influenza

Predicted Demand and Bed Proposal

In 2024/25 UHS saw consistently high occupancy, and a degree of elective cancellations to support non-elective flow. Elective cancellations were kept comparatively low by the use of surge capacity, including Surgical Day Unit (SDU), Cath Labs, Neuro Day Case AMU 4 and AMU5.

The Trust's 2025/26 plan assumed a reduction in bedded capacity through a combination of reducing the number of patients not meeting the criteria to reside and a reduction in overall length of stay. While the number of patients not meeting the criteria to reside has remained static, last year's improvements in length of stay have allowed beds to be closed over the summer. This has been two wards (D7 and E2), as well as largely keeping surge capacity closed. The aspiration is to maintain this throughout the winter. However, there remains a risk and modelling based on the status quo suggests a bed gap at the height of winter:

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Average G&A capacity (per op plan)	1115	1121	1107	1090	1072	1062	1032	1031	1030	1032	1026	1035
Less elective beds reqd (ave @ 92% occ)	-235	-226	-225	-225	-225	-225	-225	-225	-225	-225	-225	-225
Balance for NEL available	880	895	882	865	847	837	807	806	805	807	801	810
Target NEL occupancy	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Theoretical NEL capacity	836	851	838	822	805	795	767	766	765	767	761	770
Unmitigated NEL demand	810	831	829	818	819	849	872	865	874	898	888	880
Unmitigated bed deficit	**26**	**20**	**9**	**4**	**-14**	**-54**	**-105**	**-99**	**-109**	**-131**	**-127**	**-110**
demand management impact	4	6	13	20	25	31	74	76	74	74	82	74
Potential net bed surplus / (deficit)	**30**	**26**	**22**	**24**	**11**	**-23**	**-31**	**-23**	**-35**	**-57**	**-45**	**-36**

Without further reductions in patients not meeting the criteria to reside or length of stay the predicted gap will have to be mitigated by running at more than 95% occupancy and / or cancelling elective surgical patients.

All capacity will still need to be managed dynamically to support both elective and non-elective fluctuations in demand.

There are a number of over-arching principles that will inform how we approach this year:

- A need to protect our workforce
- Recognition from all that plans are fluid and will need to adapt as the situation develops. As an example, depending on the timing and size of non-elective demand we will need to review elective operating

- Recognition from all that all capacity is the Trust's. There needs to be a shift away from divisional or speciality 'ownership' of wards
- A starting principle that those who usually staff beds (nursing and junior doctor) will continue to do so even if other specialities' patients are in them. Clearly this may need to be flexed depending on skill set
- A need to keep beds closed to support financial recovery

As in previous years, non-elective peaks will be managed by:

1. Working closely with system partners to support a reduction in patients not meeting the criteria to reside, while recognising the limited success achieved to date
2. Working on our internal flow and discharge programme to reduce length of stay and ensure patients only remain in hospital when truly clinically necessary
3. Effective use of discharge lounges
4. Opening additional capacity where possible and necessary
5. Outlying medical patients into surgical wards
6. Cancelling elective surgical cases to free-up beds for non-elective patients where unavoidable
7. As a last resort patients may queue in the Emergency Department, or there may be limited boarding on AMU

This document will **not** outline the plan for every ward. For the avoidance of doubt, unless explicitly stated otherwise the presumption is that wards remain the responsibility of their current Care Groups.

Escalation beds.

In the event of escalation beds being needed, the following areas would be considered:

Phase 1

Location	Hosting	Pt Group	Beds
SDU	Surgery	Low acuity surgical	24
AMU4	EM	Medical Flow	6
Cath lab day unit	CV&T	Low acuity / next day discharge	9
Neuro day unit	Neuro	Low acuity / next day discharge	3
AMU 5	EM	Medical Flow	8
			50

Chapter 2 Planned Response

Infection Prevention & Control (IPC)

The Trust has a formal outbreak of infections policy to guide outbreak management. Expected increases in winter viruses, such as Norovirus, influenza/RSV, along with a potential increase in other infections such as COVID-19 , is likely to place significant pressure on the organisation this winter and it is therefore essential to ensure that effective strategies are in place to minimize the impact of this as much of as possible.

Actions to support effective management and control of infections will continue to be maintained and integrated as standard measures and practices. Lessons learnt from previous outbreaks of Norovirus, influenza and COVID-19 will be used to inform and support planning and management during the winter period. Early identification, testing and robust management of patients presenting with symptoms of infection or at high risk of infection will be key in reducing the risk of transmission and outbreaks occurring within the hospital. Relevant infection specific IP&C policies (e.g. respiratory virus, unexpected/unexplained diarrhea policy) will be followed and the outbreak of infection policy invoked where required to support management and control of outbreaks of infection.

Actions and strategies to reduce the risk of in-hospital transmission of respiratory viruses (including COVID 19) and Norovirus, along with planning for a potential increase in cases remain in place and under ongoing review. Ongoing monitoring, review and consideration of IP&C measures will also remain in place, led by Director of IPC/IP&C Senior Oversight Group.

Specific actions to support effective management and control of all infections include:

- Use of local and national prevalence/incidence data to facilitate early warnings of increased rates of infection in the local community, regionally and nationally
- The ongoing use of local UHS surveillance data to facilitate early warnings of increased rates of infection enabling us to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff
- Ongoing close liaison between the Infection Prevention Team, Occupational health & clinical and non-clinical teams to support identification, investigation, and management of increased incidence of infection
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection
- Testing of patients with symptoms suggestive of respiratory viruses and viral gastroenteritis to facilitate early identification and placement of positive cases
- Isolation or cohorting of symptomatic patients who have a positive respiratory virus test (COVID--19 and influenza) or Norovirus and quarantine of patient contacts where required.
- Ongoing focus on effective management and optimal use of single room capacity to facilitate rapid isolation of patients with suspected/confirmed infections
- Ongoing proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation
- Limiting patient movement as far as possible
- Ongoing review of IP&C guidance/control measures and implementation of additional measures, where required, in response to rising levels of infection/outbreaks within the hospital

- Working with partners regarding admission avoidance where appropriate e.g., hydration management in care homes/the home
- Use of trust wide communications prior to and during outbreaks – communication cascades/alerts relating to rising levels of infection, expected IP&C practices, situational updates.
  Ongoing monitoring and focus on implementation of robust IP&C practices in clinical and non-clinical areas

Staff vaccination (COVID-19 and Influenza)

Influenza vaccines will again be offered to health and social care workers as part of an Autumn campaign. The Trust will offer the vaccine to all eligible staff, and encourage uptake, using a multicomponent approach in line with NICE guidance on increasing vaccination uptake. Currently, the autumn campaign is scheduled to start in early October 2025 and run until late December.

The government has accepted the advice of the JCVI to exclude frontline healthcare workers from the COVID-19 vaccination campaign in the autumn 2025 vaccination campaign, therefore eligible staff will be encouraged to access COVID-19 vaccination from community providers.

Emergency Department

More than ever, there is an imperative to move patients swiftly through the Emergency Department (ED) to improve patients' experience and outcomes and prevent over-crowding to support safer service delivery. Based on feedback from an Emergency Care Intensive Support Team (ECIST) visit in early 2024, the Trust has set the twin aspirations of both not queueing ambulances and not queueing in corridors. Significant work is taking place both within the Emergency Department and across the Trust to support this stretching aspiration.

Over the next year, the emergency department is likely to see:

- An increase in frail elderly patients, many of whom experience difficulties in winter months. The likely return of more common viruses seen particularly throughout the winter such as Influenza as well as those viruses' requiring isolation and full PPE.
- A continued increased pressure on the whole system, as other healthcare organisations and GPs struggle to cope with rising demand.
- A potential increase in patients not meeting the criteria to reside, as social care continues to struggle with staffing and capacity.
- Reduced flow and inpatient bed availability due to demand on both non-elective and elective services as well as ongoing pressure on isolation beds throughout the organisation.
- Increased presentations and lengths of stay for Mental Health patients requiring both formal and informal admissions to mental health beds, as well as presentations of those under a section 136.
- A potential increase in admitting areas seeking to flow their admissions through the Emergency Department due to capacity constraints.

To support with the challenges identified above a number of new initiatives have started in 2025/26 to deliver better flow in and out of ED for both patients who require to be admitted but also those who can be turned around by the ED.

The list below provides an example of some of these initiatives:

1. Continuing the ongoing work related to use of Same Day Emergency Care (SDEC) capacity and expand current pathways to increase patient numbers and improve flow.
2. Focus on the Inpatient Flow Programme and reducing length of stay across the Trust, to support flow from the Emergency Department.
3. Continue to embed the professional standards across the Trust.
4. Use of external capacity to further avoid admission or reduced length of stay such as UHS @ Home service and virtual ward capacity.
5. Continue to implement new pathways across the Trust as an alternative to a long wait in the Emergency Department.
6. Further implement the Transformation workstreams to come out of the ECIST follow-up visit linked to supporting flow in and out of ED.
7. Development of the co-located Urgent Treatment Centre which is due to be handed over late in Q4. This will support with re-direction of minor illness and injuries allowing the ED inside the hospital to re-focus on the patients who need emergency treatment.

Improvements in Emergency and Unscheduled Care will be monitored via the Urgent and Emergency Care Board, chaired by the COO and also regular oversight meetings with the Executive. This will join up internal improvement plans and the wider system plans, providing a single point of oversight.

ED Plan during surge

The plans for winter are described above; however, ED has plans should there be further waves in which the department could see a significant surge in patients. If required AMU will increase its bed capacity from 54 beds to a total of 62 by using the 'surge' area (8 beds - called AMU 5) within the ED which can be used either as an overflow for inpatient beds for a particular specialty. The use of these escalation beds comes with inevitable impact/risk on other parts of the service.

Ambulance Handover

The Trust continues to work closely with SCAS to ensure that handover delays are minimized. This does, at times, mean patients queue in corridors to release ambulances back to the community. However, this is less of a risk than holding ambulances, meaning prolonged waits for undifferentiated patients in the community without paramedic care. A Single Point of Access (SPOA) has been established for specific pathways for SCAS to refer patients directly into SDEC avoiding an ED attendance altogether.

UHS has a documented procedure to support ambulance release via cohorting of patients at times of pressure working with SCAS, ED and the hospital clinical site team.

Mental Health

The overarching aim is to ensure that patients with mental health needs are only attending ED where there is also a physical health need. The following continue to be in place to include:

- NHS 111 mental health Triage service to ensure appropriate mental health care away from ED (evidence of a 97% reduction in ED endpoints).
- SCAS/ Police seek NHS 111 support in decision making to avoid conveyance to ED.
- Mental Health response car providing emergency mental health care in the community.
- Community Psychiatric Liaison within 1hr Triage for all mental health ED attendances.

- Trusted assessment with liaison team being able to refer directly to home treatment services and informal admission without a second on site assessment.
- Adult / older adult Liaison Psychiatry emergency response to wards within 1 hour.
- Children and young people with self-harm presentations diverted from the standard overnight stay pathway to an assessment at home or a mental health base.
- ED Triage nurses can refer directly to adult /older adult liaison psychiatry prior to ED clinician review.
- Escalation process for children and young people remains in place
- Those with both a physical and mental health need will move upstream to AMU for on-going care.
- Reduced risk ligature room in AMU Enhanced Care Suite (ECA) to offer safer space for patients with high-risk mental health needs who need transfer to a s136 suite or in-patient mental health care. Patients should only come to UHS where a physical health need requires side by side treatment. A safe space is required to support those patients' mental health as well as physical health needs.
- Implementing the ICS wide escalation protocol for patients delayed while waiting for an admission to a mental health unit.

On-going planning.

- HIOW Community FT has provided assurance that the four s136 suites available is sufficient capacity for the needs of Hampshire. This will remain under constant review.

- HIOW Community FT Bed Escalation Policy for adult and older adults has in place with the aim of supporting more efficient flow.

- Ongoing Quarterly service review meetings have now been established between UHS, HIOW Community FT as provider and also reps from the ICB. Fortnightly meetings are also progressing work on defining the local Mental Health strategy to include service provision at the front door and as an inpatient covering both psychology and psychiatry services.

- Continued recruitment of the ICS approved additional investment to support increasing the HIOW Community FT compliance against CORE24 serving UHS although this is consequently under review due to the financial pressures.

- More work is required to improve escalation and bed flow to reduce the length of stay of this patient cohort.

Southampton Children's Hospital

This plan assumes that seasonal variations in conditions which affect children (primarily respiratory viruses) follow an expected pattern.

Emergency Pathways.

Non-elective admissions will be admitted to the appropriate specialty ward area. An RSV surge plan exists within the children's hospital that includes outlying medical patients to surgical wards as required to cope with emergency demand. This plan takes into account the need to isolate/cohort certain respiratory viruses.

With regards to the Children's Emergency and Trauma Department (CETD), the presumption is that it continues to operate in the standard format with the Paediatric Short Stay in place. Work is ongoing to ensure most effective use of this footprint.

Surge capacity

Within the children's hospital, we will use surge capacity to support peaks in emergency admissions within our specialty ward footprint, set out in the table below. This would be taking into account relevant speciality skills required for the children at the time and available staffing. As well as any infection control requirements.

Other aspects we would also be considering, in extremis are

- 16–17-year old's that may be suitably cared for in the adult settings, if available
- Children awaiting transfer to their local hospital and how UHS can support them
- Paediatric Short Stay Unit surge provision, based on types of children and their needs

	Standard	Surge (total)
E1	16	+4 (=20)
G2N	6	+1 (=7)
G3	16	+1 (=17)
PHDU g-level space	0	+ 6
	TOTAL	**12 additional beds**

Elective Work.

John Atwell Day Ward will continue as the paediatric day unit with inpatients managed across the appropriate wards (primarily G3 and G4). The elective plan is to run a full programme, including occasional weekend operating, throughout winter and to assess admissions based on bed capacity.

Cross-divisional planning and oversight of the paediatric cardiac congenital surgical pathway will continue to ensure sufficient capacity and throughput and safe management of this patient group.

Paediatric Critical Care

The Paediatric Intensive Care Unit (PICU) will flex up from its commissioned 14 beds as required within the existing PICU footprint. Additional funding from NHS England has been confirmed to support the nursing staffing costs of running an additional 2 PICU beds from October to March. This funding has now been confirmed on a recurrent basis specifically to support maintaining paediatric cardiac surgical activity over winter. PICU will continue to work collaboratively across the region and beyond in accordance with existing regional surge/escalation protocols.

The Paediatric High Dependency Unit (PHDU) remains adjacent to PICU on D level. This allows PHDU to run at 7 beds (an increase of 1 bed compared with G level location). It also allows PHDU to take higher acuity patients due to the proximity of the PICU medical and nursing teams to support, thereby supporting flow out of PICU. Additional funding from NHS England has been confirmed to support the development of increased level 2 capacity. NHS England has also directly funded a post at UHS to work across the region focusing on timely repatriation of level 2 patients.

Should either PICU or PHDU need to surge outside of their existing physical footprint, this will need to be in accordance with a joint critical care surge plan, agreed in advance with adult critical care. This surge plan will need to be flexible depending on demands for both adults and children over winter.

Other Inpatient Areas.

Piam Brown, E1 and G2N will continue to operate at normal full capacity, with these beds protected as far as possible for relevant specialty admissions.

RSV

No national surge planning yet, similar plans to the previous year likely.

This includes prioritising children in the Emergency Dept into the cubicles within the Acute area and the deployment of air filters, in conjunction with the UHS Infection Prevention team. Consideration would also be given for the re-direction of children requiring admission but with speciality needs (non-RSV) to other parts of the Children's Hospital, to allow the Emergency Dept to focus on any RSV surge in admissions.

Princess Anne Hospital (PAH)

PAH will continue to manage four theatres of elective and emergency capacity between Obstetrics, Gynaecology and Breast Surgery. Gynaecology theatre lists will also continue to run in Southampton General Hospital, Lymington Hospital. Significant obstetric demand is likely to continue to impact on gynaecology capacity.

In maternity, we will stand up a two tier on call framework again as per normal practice during times of operational pressure to provide an additional layer of senior midwifery support. We would activate our contingency framework utilising support staff / specialist midwives to additional provide clinical input as required. Once we have exhausted all available staffing resources internally then our mutual aid will be sought from our external maternity partners within the LMNS in accordance with existing Opel surge/escalation protocols.

The Neonatal Unit expansion is now complete, with the addition of 5 extra cots and redevelopment of existing space.

The PAH transfer team will support timely transfer of patients between PAH and SGH in emergency situations.

Level 1 Beds

Level 1 bed stock will be used flexibly. In November there will be a review of current occupancy levels and capacity needs, with a view to pro-actively identifying cohorted areas for medical outliers from January – March. There will remain real-time assessment of the balance of elective and non-elective pressures, the prevalence infection and split of emergency demand by speciality.

Level 2 and 3 Beds

The Trust has the following level 2 and 3 beds:

GICU 31 beds
Neuro ICU 13 beds
CICU 16 beds
SHDU 10 beds
RHDU 9 beds
C5 – formally 0 but potential to use for Level 2 subject to staffing (although this is unfunded as L2)
CHDU 20 beds

TOTAL 99 beds (or 101 including C5)

The expectation is that we flexibly use GICU/CICU/Neuro ICU beds to ensure maximum efficiency and maintain at least one emergency admitting bed (as a major trauma centre) at all times with the need to have 3-4 admitting beds overnight. Key to maintaining flow in or out of the unit is the importance of prioritising discharges out of ICU to level 1 or 2 beds in a timely manner. This increases the likelihood that all elective patients needing a critical care bed post operatively are given the go ahead at the 7.45 critical care bed meeting overseen by the site team. It is recognised that should flow out of ICU is not optimised there may be occasions where post operative patients requiring an ICU bed may be held in recovery for a slightly extended period to ensure that we complete their operation / rather than their operation being cancelled.

Surgery & Operating Theatres

The Trust is currently reviewing surgical capacity for the rest of the year, to try to balance both meeting our performance objectives and ongoing financial challenges. At the time of writing, it is not known how many additional sessions are planned for the rest of the year or if one (or more) theatres will be closed.

However, we will continue to prioritise theatre capacity based first on clinical urgency and then on waiting times. We will continue to use capacity flexibly and where needed seek additional non-elective capacity to improve flow through the hospital and reduce waiting times.

In times of significant pressure, the elective programme may have to be reviewed to reduce hospital occupancy and support non-elective flow.

Cancer

As in previous years, there will be a significant focus on cancer waiting times, and cancer patients are likely to be prioritised for elective surgery based on their clinical priority. The three-fold focus in 2025-26 will be ensuring the Trust achieves the 28-day Faster Diagnosis Standard and that the Trust improves upon and achieves the 31-day radiology and 62-day cancer targets.

There is a detailed improvement plan that is managed via the Trust's Cancer Performance Meeting, chaired by the COO and reported to the Board by through the Cancer Spotlights.

Specialist Transfers & Major Trauma

The Major Trauma Centre (MTC) is a core part of UHS. The presumption is that we always remain open to major trauma. The centre would only consider closure in the event of a significant incident at which point there would be discussion with the Major Trauma Network and the regional on call directors.

Specialist transfers are managed daily by the relevant clinical teams and the site team are kept informed.

In the event of a critical bed shortage, time critical transfers may require discussion between the relevant clinical teams. Decisions on transfer will be made on a risk assessment basis. Repatriation of patients to their local hospital remains an ongoing challenge and a key work stream for the system.

A clear policy is in place for specialist transfers to UHS.

Diagnostics

Diagnostic modalities will continue to manage demand and capacity as required in order to ensure timely access for inpatient and urgent scans, whilst continuing to manage waits for non-urgent patients.

Mortuary Capacity

Current storage capacity 180 spaces with 40 Surge capacity spaces, in addition for winter pressures there is an agreed mutual aid arrangement via the ICB with other Hampshire Trusts, this facilitates the department responding effectively to surge in demand. Daily monitoring of occupancy, clear escalation thresholds, and close coordination with Funeral Directors, Medical Examiners and Bereavement Services support timely release and appropriate management of the deceased.

Nursing Staffing

The staffing hub was established at the start of the initial surge phase of COVID-19 and following evaluation, the hub has been permanently commissioned and the role strengthened to ensure the real-time focus on the staffing situation and metrics can be retained. This model will continue with strong links maintained to the operational site management function. The hub manages safe staffing across the organisation 7 days a week, ensuring staff are allocated appropriately for patient load and where necessary re-allocated to cover for sickness, or to support increased acuity or dependency on certain wards. They also co-ordinate all additional staffing requirements arising from enhanced care needs.

The hub also coordinates cover for additional needs arising from the Release to Respond (R2R) agreement, ensuring there is always an identified registered and unregistered nurse available to support the emergency department when R2R is actioned.

The staffing hub is supported by a staffing matron of the day rota and an allocated hub role 7 days a week.

Nurse staffing levels, oversight and review are robustly managed using the framework from the national quality board and implementation of the recommendations within NICE guidelines on safe staffing.

These recommendations will also be adapted (as appropriate and with robust risk assessment) to support pressures arising during Winter.

Clear and over-arching expectations are in place:

- Nursing professionals become flexible with what they do and adhere to The NMC Code - working within their scope of practice.
- Quality Impact assessments will be undertaken to support any changes in ward/department specialty and function and to underpin any adjustments to set staffing establishment levels
- Thresholds for training, competency attainment, assessment and supervision will be reviewed and adapted to move to a greater emphasis on local induction, on the job supervision and self-certification
- Registration options will be expedited to enable 'top of licence' working and increased contribution and capability of nursing trainees, nursing associates and overseas nurses (in line with national guidance).
- Ward staffing levels will be constantly reviewed and monitored with levels linked to minimum Care Hours per Patient Day and agreed staffing levels will be monitored as patient specialty, acuity, dependency, and care needs change.
- During periods of extremis, redeployment of staff will be considered to support areas of greatest need.
- All staff with pre-existing nursing skills will be provided with continued up-skilling opportunities either face to face or via online materials with guidance on the required level to return to practice.
- Non-ward-based staff across all services will be considered for re-assignment to ward areas based on a RAG rating linked to impact on existing service. Redeployment will occur at agreed escalation points and risk assessment will be noted for the impact on existing service.
- Health roster will be utilised to the maximum (supported by workforce systems) to enable the management and deployment of nursing staff.
- 'Red flags' raised via the 'safecare' system will be actively used in the staffing hub to capture pressures on care at ward level.

Staff Support and Health & Wellbeing Plans

The impact of staff mental health and wellbeing cannot be underestimated; both in the event of a future wave but also as a reaction to the past few years. Staff support is integral to our plans over the coming year.

Key elements include:

- Staff line – telephone support designed to be a confidential, front door to the psychology department. It is for all staff who feel they need a bit of support, whether that's individually, for a team or for another person
- Onsite, targeted psychological support for teams in areas particularly in need of additional interventions e.g., ED, Critical Care, Medicine for Older People
- Wellbeing rooms to enable staff to get away from their working environment for a break
- The Wellbeing Hub, offering staff an on-site facility to use flexibly, including a café and gym
- Occupational Health
- Live Well and Inspire suite of wellbeing tools

A key element of the UHS appraisal process is a wellbeing review and this will continue to be an important part of this conversation.

Personal Protective Equipment (PPE)

PPE supplies are now managed at local ward/department/care group level as per pre-pandemic arrangements. All wards/departments must have sufficient PPE supplies to ensure that staff have access to the correct PPE, including respiratory protection e.g. FFP3 masks and eye protection. PPE will be worn in accordance with the agreed current trust policies and guidance.

Staff who are required to assess/care for patients with a suspected or confirmed infection transmitted via the airborne/droplet route (including respiratory viral infections) and thus wear an FFP3 respirator mask, must be fit tested and trained in their use. Divisions/Care Groups will ensure that relevant staff working in clinical areas are fit tested.

The Wessex Procurement Limited Supply Chain Manager will maintain oversight of supply and demand of PPE products and will ensure any issues are resolved or escalated.

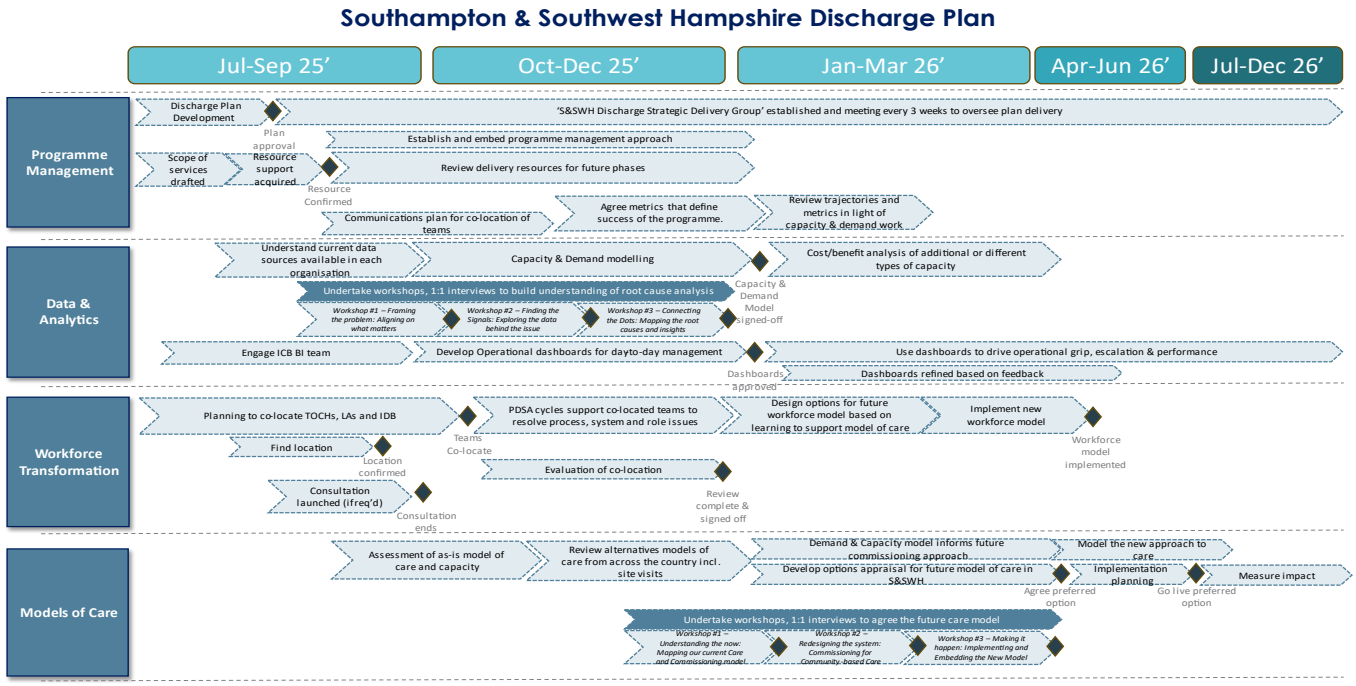
Discharge

Complex discharge remains a significant area of challenge. Despite system trajectories, the number of patients not meeting the criteria to reside remains >200. This puts significant pressure on the Trust and directly affects our ability to reduce queueing in the Emergency Department and continue to treat elective patients.

Internally the Trust continues to focus on its Inpatient UEC Transformation Programme, focussed on reducing length of stay primarily for simple discharges. The programme is focussed on:

- Embedding internal discharge standards
- Expanding access to / use of Same Day Emergency Care
- Scaling criteria led discharge
- Improving use of discharge lounges
- Starting an Outpatient Parenteral Antimicrobial Therapy service
- Improving use of virtual wards
- Care group and divisionally led initiatives

Less progress has been made reducing the number of patients who do not meet the criteria to reside. The local delivery system's discharge programme was re-started in June 2025, and a new discharge plan has been developed.



Inclement Weather

UHS's Adverse Weather Plan (EPRR008) is a trust-wide, controlled policy that merges the former heatwave and cold-weather plans into one framework aligned to the UKHSA Adverse Weather and Health Plan (AWHP). It adopts the impact and likelihood-based Weather-Health Alerts (WHA) (yellow / amber / red), defines a clear cascade (EPRR team -> divisional leaders -> wards), and issues level-specific action cards via Staffnet so clinical and estates actions are triggered consistently across sites.

The plan sits within EPRR governance and signposts incident response if service risk emerges (for example, overheating of theatres or increased ED attendances). This approach directly reflects national guidance: the 2025 - 26 AWHP sets the overall strategy for the health sector, while the WHA user guide defines the alert seasons (Heat-Health Alerts 1st June - 30th September; Cold-Health Alerts 1st November - 31st March) and emphasises proportionate actions at all levels.

Cold-weather readiness is operationalised through a GREEN -> YELLOW -> AMBER -> RED ladder with practical steps for clinical services, estates and logistics. Examples include proactive gritting and boiler checks; business-continuity measures (staffing lists, travel contingencies, LRF 4×4 support requests); discharge planning that verifies heating, food and follow-up at home; and ED surge management through a dedicated "Code White" protocol. These measures line up with national provider expectations in the AWHP and WHA materials - namely that alerts are cascaded through the ICB / NHS system and that providers act early for vulnerable groups even at yellow.

Hot-weather preparedness includes estates servicing of chillers / critical refrigeration, IPC-compliant use / cleaning of fans, assured supply routes for water / ice, and staff-welfare steps (flexible working, additional breaks, relaxed dress within policy). Amber / red actions emphasise shading and ventilation sequencing (curtains / blinds closed while outside is hotter; windows opened once cooler), targeted review of high-risk inpatients, and Staffnet-wide alerts with practical self-care advice.

Partner Schemes

The ICB has led on the development of three demand reduction schemes.

Cardio-vascular disease

Targeting 40,000 patients with hypertension, with an aim to offer them lifestyle modifications to reduce untreated high blood pressure. Impact from Month 7 onwards, forecast reduction of 247 ED attendances, 247 non-elective admissions and 1,978 occupied bed days.

Frailty

Procurement and implementation of digital remote monitoring platform and mobilisation of remote monitoring team to remotely monitor patients at risk of deterioration. 8,000 patients to be monitored, with projected 10% reduction in GP appointments, 19% reduction on ED attendances and 27% reduction on non-elective admissions in the cohort.

Single Point of Access

Trial the implementation of a single point of access model based with SCAS to support crews to manage patients without conveying them, or to convey them to alternative locations.

Communications

The communications team at UHS is constituted of a central corporate team with the aim of providing communications to engage and inform staff, support the executive and Trust Board in delivering the ambitions and strategy of the Trust and protecting the reputation of UHS within the wider environment of the NHS.

- Promotes the Trust's values, ambitions, specialities, innovations and outcomes
- Protects our reputation during periods of increased pressure, challenge and crisis
- Tailors approaches and messages for specific audiences to maximise engagement and impact

Specifically, over the next year communications will be focused on:

- Supporting the messaging around navigating the current challenged environment whilst showcasing quality and highlighting innovative and improvement.
- Supporting both the ten-year-plan and the urgent and emergency care recovery plan with a 'show don't tell' approach lead by patient stories.
- Supporting the wellbeing of our people through challenges, upweighting recognition opportunities and highlighting innovation and improvement

In summary, key comms activities for 25/26 will include but not be limited to:

- External media and social coverage, proactively showcasing innovation and outcomes that sit within context of wider NHS environment, reactively managing issues and crisis.
- Align output to ten-year plan and urgent and emergency care recovery plan using people and patient stories along with outcomes to demonstrate quality care and trust in services
- Focus on 'board to ward' communications that seeks to further engage staff in Trust-wide ambitions
- Revamp internal We Are UHS week to support recognition of workforce
- Deliver communications with a narrative that supports navigating challenges and reshaping of NHS, engaging staff and the public in this effort.

Digital

The Trust now regularly utilises agile working on a regular basis for its staff – both administrative and clinical, and UHS Digital will continue to ensure that the tools that support remote working will be maintained such as “soft” phones, Microsoft Teams, Microsoft 365 applications, etc. We have invested in increased internet capacity and a more modern and robust Virtual Private Network (VPN).

UHS Digital will continue to support the key transformation programmes of outpatients, flow and theatres. We work with clinical representatives to ensure that the work within the programmes are prioritised in line with the Trust’s needs. This transformational work also includes the launch of a new, modern Emergency Department (ED) system – Alcidion Miya – in September 2025, ahead of Winter pressures.

We will continue to digitise the patient experience in line with the 10 Year Plan. We offer the technology for clinicians to provide remote video consultations, and Patient Initiated Follow Up (PIFU) services through digital technology. We are running small-scale trials of Ambient Voice technology to look to reduce the clinical administration processes.

All patients can access their medical record through My Medical Record, which is fully integrated with the NHS App, and we have rolled out a paper-lite process in most specialities. We also have chatbots enabled on the UHS website to provide alternative methods of patient communication with the Trust.

As the Trust moves to more digital processes, we have revised our business continuity plans to ensure that we are able to maintain a reliable safe service. This has included improvements in our change control process to bring them more in line with ITIL standards, and revisions in our service desk provision to improve the support to staff if there are any service availability issues.

Chapter 3 Operating Frameworks and Industrial Action

Operating Frameworks and Escalation

OPEL Framework and Metrics

The Integrated OPEL framework (2024–26) is the single, mandated escalation model for providers and ICSs; it uses a normalised 0 - 100 score mapped to Levels 1 - 4, requires at least one assessment by 10:00 daily, and promotes digital automation so data flows consistently. UHS derives our score from nationally defined core parameters, which are then aggregated at ICS, regional and national levels to give a unified, near-real-time view of risk and trigger the corresponding actions. UHS uses its PowerBI, ED and bed-state view to maintain a live site picture which also feeds SHREWD / reports to the ICB. Site Operations Managers / Clinical Site Managers monitor PowerBI and SHREWD ensuring our OPEL status and command protocols are driven by a single, shared dataset.

Running Cycle of the Day

UHS daily rhythm links real-time data to clear decisions. Operations Centre Manager / Tactical Commander lead coordination through regular reviews throughout the 24-hour period that update the trust position, trigger EPRR reporting to the ICB, and drive de-escalation actions.

Working through the SPOCs, Site Operations Manager's turn the national OPEL parameters into a Care-Group plan covering arrivals, capacity, discharges, the net bed position and constraints. SPOCs are expected to come prepared, work closely with bed management, and expedite time-critical moves. Where recovery is uncertain, a decision is made whether to invoke the escalation framework (Level 3 / Level 4). Otherwise, the routine cadence maintains situational awareness and supports safe, steady de-escalation. Divisions and Care Groups, via their SPOCs, are responsible for producing and delivering the plans that improve flow.

Escalation Framework: Level 3 (substantial pressure) / Level 4 (severe pressure)

Level 3 is invoked when there are high bed requests, surge areas at capacity and no assured recovery, typically with an OPEL 3 trending towards OPEL4. UHS has a formalised an Operations Department led cadence (10:00, 12:30, 15:00 hours) where each Care Group SPOC attends prepared with a flow plan, activates local escalation, and keeps bed plans current. Level 4 is declared at severe pressure.

Escalation to HIMT is at the discretion of the L3 Chair where recovery is not credible. A HIMT, chaired by the Head of Operations, COO or Gold / Strategic Commander (if out of hours) leads the agenda and response (ED risks, trust capacity / flow, constraints / service prioritisation, IPC, workforce, patient-safety / recovery actions, system interdependencies and ICB engagement, with clear owners and review points.

This strengthened L3 / L4 construct and escalation model was introduced and embedded in summer 2025.

Industrial Action

UHS is well prepared for industrial action (IA) in 2025, drawing on lessons from previous years and the latest NHS England guidance to protect critical services, keep patients informed, and recover activity quickly.

Pre-action readiness (4–2 weeks out, then rolling)

With COO (Chief Operating Officer) / DoN (Director of Nursing) oversight, UHS completes NHS England's pre-action self-assessment via HIOW ICS / Region, plan on a "no-derogations" baseline and incorporate any agreed derogations (not relevant for recent Resident Doctor IA). A critical-services matrix is locked with senior sign-off. In parallel, UHS scenario-plans for resident-doctor (and potential nursing action), stand up consultant-delivered rotas and advanced-practice cover, map bank / agency capacity, confirm mutual aid, and set Gold / Silver / Bronze structures with escalation triggers. SitRep and assurance submissions, workforce participation and rescheduled activity via SDCS, are timetabled so returns land to schedule.

The 7-day and 72-hour gates

At T-7 days, UHS publishes the protected activity (cancer pathways, time-critical diagnostics, dialysis and maternity), moves non-urgent electives to recovery lists with named rebook owners, locks consultant-of-the-day models in acute medicine / surgery, and confirms theatre / anaesthetic cover for protected lists. At T-72 hours, UHS confirms safety-netting, issues clear patient updates, briefs staff on professional standards and escalation routes, stand ups and test command protocols. UHS prepares for delivery of SitRep definitions, so workforce-participation and rescheduled-activity returns are complete.

Strike days and recovery (control, protect, restore)

On the day(s), UHS runs a clear command-and-control rhythm. Gold (COO / DoN) reviews a critical-services dashboard at set intervals while Silver (Head of Site Operations) executes mitigations (consultant redeployments, theatre replans, extra recovery beds, diagnostic ring-fencing). The COO / DoN convenes the Hospital Incident Management Teams (HIMT) with senior stakeholders representing Divisions and key services. The HIMT performs dynamic risk assessment and mitigation in real time, keeps a live decision / action log, confirms derogations and safety nets, and unblocks flow (e.g., discharge acceleration, mutual aid). An evening HIMT is always scheduled, but our plans and daytime control have been robust enough that we hold evening HIMT by exception only; when not required, oversight continues through Silver / Bronze with on-call executive and senior clinical support.

UHS runs live harm reviews for any same-day cancellations, maintain a single source of truth for protected lists, and keep public messaging simple: attend as planned unless contacted. Data submissions (workforce and rescheduled activity) are returned within SDCS windows. UHS posture mirrors the operational levers highlighted in recent national updates - ring-fenced theatre lists, senior cover, anticipatory clinics and firm comms - used nationally to sustain a high proportion of planned care. UHS closes with a formal EPRR debrief, triangulating SitReps, "what went well / even better if," and patient-experience feedback, and feed improvements straight into the next readiness cycle.

Data Driven Insights / Business Intelligence

Business Intelligence will continue to support the organisation over the next year by ensuring that relevant and reliable information is made available to inform decision making, and for reporting to key internal and external stakeholders.

Where possible, we will automate reporting, and will shut down underutilised reports, redeploying the capacity and capability to other analytical priorities. We will continue to support self-serve analytics through PowerBI – our long-term strategic analytics tool. There have been several key developments

made within this product, with a range of applications now available for use, many beyond the BI team available in departmental workspaces.

Change Programmes

The Trust has three major change programmes in 25/26, focused on Urgent & Emergency Care, Outpatient transformation and Theatre transformation. The over-arching aims of each programme are to improve quality, safety and experience for patients, drive productivity improvements ensuring the most effective and efficient use of assets to mitigate performance and financial challenges. The progress of these programmes against the key metrics and aims is reviewed by Transformation Oversight Group which is chaired by the Chief Nursing Officer. To support these change programmes, the transformation team is deployed in a divisionally aligned model to support bespoke delivery of the change programmes across all areas of the trust.

Chapter 4 Conclusion

As always, there is a high degree of uncertainty. The Trust will need to respond to unexpected pressures and plans will change. There are significant financial and performance challenges against a backdrop of ongoing industrial action in some staff groups and uncertainty regarding infections. While the organisation has robust plans, infection, industrial action or higher than planned non-elective demand all have the potential to affect the elective programme.

The next year will be challenging, with a need to balance operational and financial pressures, as well as the usual challenges of infection and winter. Further uncertainty is likely with plans for a multi-year planning round that is likely to start in the Autumn of 2025. This plan is intended to provide a summary of the year, while more detailed polices exist for infection, incidents, digital, bed management and many other areas.

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	At Trust Board on 10/9/25
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	At Trust Board on 10/9/25
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Including via the local delivery group and wider ICB workstreams
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	On 8/9/25
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Partial	See Section B
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Partial	A risk to delivering elective trajectories based on current over-performance against IAP and inability to manage performance adequately through validation and referral management, as outlined in the planning guidance.

Provider CEO name	Date	Provider Chair name	Date

Provider:	Double click on the template header to add details

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Plan going to Trust Executive Committee.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Modelling via the ICB. Extreme surges may impact on elective capacity.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Currently exceeding national standards for patients discharged on P0 and P1.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Partial	A risk to delivering elective trajectories based on current over-performance against IAP and inability to manage performance adequately through validation and referral management, as outlined in the planning guidance.
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on	Partial	Fit testing is recorded on Healthroster not ESR.

	ESR, and all relevant PPE stock and flow is in place for periods of high demand.		Current compliance for relevant staff groups at 71%.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Policy for cohorting in ED and AMU
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	On call rotas in place
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

UHS Equality and Quality Impact Assessment (EQIA) Tool

Any queries, requests for support, and/or completed EQIAs which require review at the Trust's EQIA Panel, should be directed to EQIA@uhs.nhs.uk

Section 1: To be completed by the EQIA author

Reference number (allocated by EQIA panel):		Version:	1.1
Title of proposal (scheme/project/change):	UHS Operational Plan including Winter 2025/2026		
Division/Directorate/THQ Function:	Trustwide plan which has bee developed and led by the Chief Operating Office		
EQIA author:	Lauren Anderson, Corporate Governance & Risk Manager		
Accountable lead for proposal:	Duncan Linning Karp, Deputy Chief Operating Officer		
Brief description of proposal:	The University Hospital Southampton (UHS) Operational Plan has been developed to ensure continuity of operations, patient and staff safety, and sustained performance over the next 12 months. This plan also serves as the Trust's Winter Plan, recognising the seasonal pressures and heightened risks associated with this period. The plan is informed by predicted demand, potential risks, and lessons learned from previous years. It provides a framework for risk mitigation and supports responsive and informed decision-making in evolving circumstances. Through this approach, UHS aims to maintain high standards of care and operational resilience across all services. To support this, this EQIA has been completed as mandated by NHS England.		
Who has been involved in or consulted with in completion of this EQIA? (Staff, patients, system partners, committees, Staffside, unions etc..)	The plan has been developed in consultation with divisional managers, clinical and operational leads, the emergency preparedness, response and resilience team, the infection prevention team, communications, digital, and occupational health. Subsequent to this, the EQIA has been completed by the Deputy COO.		
Does this impact on delivery of the Trust's corporate strategy and objectives? Describe how if so.	Aims to support delivery of agreed performance standards and maintain a safe service.		
Describe any impact on other departments/functions within UHS outside of the primary area this EQIA applies to, if applicable: (e.g. support services)	The operational plan, and this EQIA, are applicable Trustwide.		
Describe any impact on the wider system and/or external partners if applicable:	Delivery of the UHS operational plan will impact on ICB led demand management schemes and systemwide NCTR plans. There will also be an impact on the ambulance service and discharge services - eventual aim collaborate throughout system.		

CLICK HERE TO ACCESS GUIDANCE ON RISK SCORING

Quality: assess the impact of the proposal on each of the domains below:	IMPACT			INHERANT RISK SCORE (pre mitigations)			MITIGATIONS	RESIDUAL RISK SCORE (post mitigations)		
	Select if the net impact is positive, negative, or neutral:	Describe the impact:	How will you measure/evidence this?	Consequence	Likelihood	Score (C X L)	Please document the mitigations that will be put into place:	Consequence	Likelihood	Score (C X L)
Patient safety / prevention of harm (safe)	Positive	The operational plan is intended to produce a positive impact by supporting capacity and flow to ensure patients can receive the right care at the right time. It is recognised that without considered planning there would be a negative impact as the hospital would not be sufficiently prepared to meet demand, therefore harm could occur from insufficient capacity, overcrowding, delays, errors made/inadequate	AERs, performance metrics, elective activity cancellations, occupancy, infection rates, time to be seen in the emergency dept.	5 - Catastrophic	4 - Likely	20	The operational plan aims to mitigate the risk of a negative patient safety impact by facilitating sufficient capacity and optimal flow. This will be supported by proactive risk assessment and management in line with Trust policy. Additionally as specific changes are planned/occur, (such as closures of wards) individual EQIAs will be completed. Risk stratification will be used to inform waiting lists. Use of surge	3 - Moderate	2 - Unlikely	6
Clinical outcomes and effectiveness (effective)	Positive	As above, the operational plan is intended to support optimal patient outcomes and access to effective treatment in a timely manner. Without the plan patients could suffer worse outcomes as they would encounter delays to treatment and in some case this could result in changes to treatment plans if there has been disease progression in that time negating the benefits of the most effective first line	Outcome data and case reviews at M+Ms. Local and national audits. Adherance to guidance.	5 - Catastrophic	3 - Possible	15	The operational plan aims to mitigate the risk of negative patient outcomes. Risk stratification will be used to inform waiting lists. Individual EQIAs will be completed where specific changes to pathways are planned.	3 - Moderate	2 - Unlikely	6
Patient experience (caring)	Positive	The operational plan is intended to produce a positive patient experience impact by reducing waiting times. Howere it is recognised that in times of challenge non elective care will be prioritised which could result in cancellation of elective activity, which is not a good experience. Additionally during times of pressure, priority is given to maintaining safety so 'over and above' tasks can be dropped. There may also be the need to use mix sex wards in times of extreme pressure which can affect privacy and dignity.	PALS data - concerns and complaints. FFT. Elective activity cancellations.	3 - Moderate	4 - Likely	12	Through the operational plan, the Trust aims to reduce occupancy and enhance flow, reducing the possibility of elective activity being cancelled. Risk stratification will be used to inform waiting lists. Where cancellations cannot be avoided, or waiting lists effectively managed to reduce wait times, open and early communication with patients will be promoted. Individualised care promoted to meet patient needs and preferences as much as possibe. Use of volunteers.Responsive patient experience team leading	3 - Moderate	3 - Possible	9

Workforce & leadership (well-led)	Neutral	There will be an impact to staff who will need to be responsive to demand, potentially resulting in moving staff between departments, particularly nursing staff. This could be stressful for some staff, whereas others may enjoy the change in pace/speciality etc..	Staff feedback, locally via 1:1s etc.. as well as through more formal routes such as staff survey. Sickness rates. Turnover. AERs, red flag data.	3 - Moderate	4 - Likely	12	Regular communications, both locally, and Trustwide such as Spotlight, Staffbriefing, Talk to David etc.. Utilisation of the staffing hub. Additional staffing through utilisation of bank and agency if necessary.	3 - Moderate	3 - Possible	9
Activity / performance	Positive	The operational plan is intended to support delivery of performance targets, however there is a risk that non elective pressures leads to cancellation of elective activity as described above.	Performance metrics. Cancellation rates.	4 - Severe	4 - Likely	16	Clinical prioitisation and risk stratification processes. Divisional performance reviews. Use of surge capacity and additional staffing to increase activity.	3 - Moderate	3 - Possible	9
Sustainability	Neutral	No specific impact identified.	N/A	1 - None	1 - Rare	1	N/A	1 - None	1 - Rare	1
Reputation	Neutral	Long waits and cancellations can negatively impact the reputation of the organisation, however the intention of the operational plan is to enhance capacity and reduce the likelihood of cancelled activity.	Patient feedback. Media reports.	2 - Low	3 - Possible	6	Standardised and proactive communication with patients and the media. Communications team.	2 - Low	3 - Possible	6
Other		N/A				0				0
Equality: assess the impact of the proposal on each of the characteristics below. Consider all individuals including patients, staff and visitors.	**Select if the net impact is positive, negative, or neutral:**	**Describe the impact:**	**How will you measure/evidence this?**	**Consequence**	**Likelihood**	**Score (C X L)**	**Please document the mitigations that will be put into place:**	**Consequence**	**Likelihood**	**Score (C X L)**
Age	Neutral	The elderly population are more likely to access healthcare than younger generations therefore are more likely to be impacted by provision (or lackof) of services.		1 - None	4 - Likely	4	N/A	1 - None	4 - Likely	4
Disability		Nil identified.				0				0
Gender reassignment	Negative	Side rooms are offered to patients who are undergoing/who have undergone gender reassignment. However the number of side rooms could reduce if/when wards are closed, or due to increased winter infections rates, therefore fewer side rooms may be available to offer to patients with gender recognition certificates.	Patient feedback.	3 - Moderate	3 - Possible	9	For those patients who have preferences around gender or are intersex, but have not undergone gender reassignment, we will take risk based decisions on accommodation availability and clinical need. We aim to meet patient preferences relating to individualised care where-ever possible and to prevent discrimination.The same sex accomodation policy is currently being reviewed and updated.	2 - Low	3 - Possible	6
Marriage and civil partnership		Nil identified.				0				0
Pregnancy and maternity		Nil identified.				0				0
Race		Nil identified.				0				0
Religion or belief		Nil identified.				0				0
Sex		When demand is excessive, more likely to mix sex beds as described within patient experience.	Monitor single sex breeches. Patient feedback.	3 - Moderate	3 - Possible	9	Daily site meetings and planning. Mixed sex acomodation policy to inform decision making.	3 - Moderate	2 - Unlikely	6
Sexual orientation		Nil identified.				0				0
Socio-economic factors		Nil identified.				0				0
Any other group of individuals (inc. staff and patients) that will be impacted inequitably		Nil identified.				0				0

Any additional comments? E.g. does the service have resiliance?	It is noted that the operational plan will be subject to iterative review and planning/decision making will be responsive to patient need in real time.
Monitoring arrangements	
Who will be responsible for monitoring the predicted impact and identifying any unintended impact?	COO, Deputy COO, Site / operations teams, directorate and divisional managers.
Describe what will be monitored if there is anything additional to what has been entered in column D above:	As described above.
Describe the ongoing review process including frequency and where this will take place (i.e. divisional/directorate governance group or board, or steering group)	Weekly performance meetings, real time site meetings multiple times per day, esclation process to DMTS and execs, embedded ward to board governance processes.

Local sigh off:			
Accountable Manager signatory:		Date:	
Divisional Management Team (DDO/DCD/DDN) or senior THQ Manager name and signatory:		Date:	

Section 2: to be completed by the EQIA panel	
Date to panel:	
Chair:	
Outcome:	
Comments for FIG:	
If there is a positive impact, is there an opportunity to deliver at scale?	
Does this EQIA need to be shared with QGSG?	
Does this EQIA need to be shared with POD?	
Does this EQIA need to be shared with the ICB EQIA panel?	

Overview

The Equality & Quality Impact Assessment (EQIA) process looks at the project, function or change as a whole and considers how it will impact a number of quality domains including how we provide safe and effective care, and how patient or staff experience may be impacted. It also looks at whether groups of individuals with specific or protected characteristics will be disproportionately affected.

Where negative impact or risk is identified consideration must be given to if and how this can be mitigated.

This is a continuous process and an EQIA should be completed before a project commences, and then reviewed throughout the duration of the project and again upon completion.

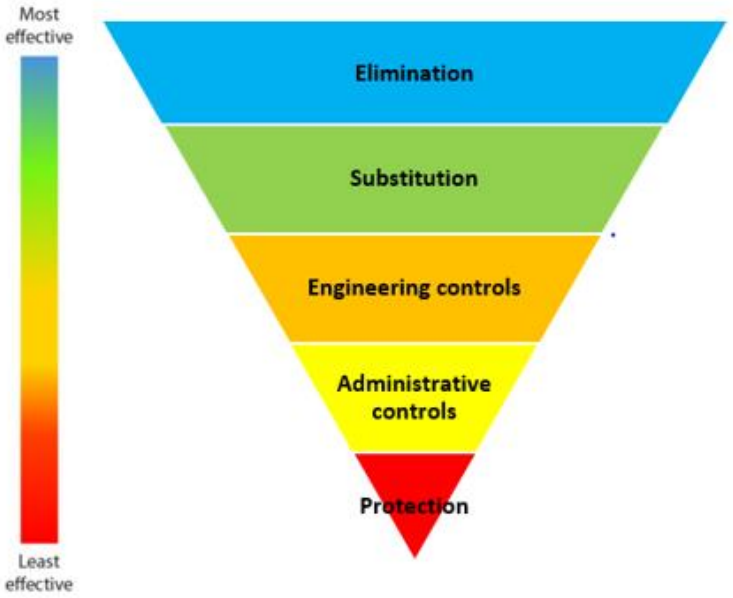
Quality Domains	**Definition/Considerations**
Patient safety	This refers to the avoidance of unintended harm to people during the provision of their healthcare. Consider: the likelihood of patient harm/clinical risk, reliability of safety systems, duty to protect and safeguard children, young people and vulnerable adults, infection prevention and control, collaborative working, environment, other organisations/shared risk, workforce and the ability to deliver safe care.
Clinical outcomes and effectiveness	This refers to the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The aim of clinical effectiveness is to use evidence to improve the effectiveness of clinical practice and service delivery. Consider: variations in care, care pathways - improvements and consequences delivery of positive outcomes, compliance with national guidance/best practice, mortality rates, readmission rates, etc.. clinical efficiency, clinical communication/handover, plans for monitoring outcomes.

Patient/carer experience	This refers to the way a patient feels about their care based on all their interactions, before, during and after delivery of care or how a carer or staff member may feel. Consider: the voice of the patient/carer/staff member, individual need inc. patient choice and self-care, privacy, dignity and respect, access, equity, perception of decision by patient/carers or staff, communication (undertaken or planned).
Workforce & leadership	This refers to staff and volunteers health and wellbeing, workforce and education training needs, including provision of workforce training placements linked to service delivery, and the impacts on recruitment and retention of staff. It also refers to the leadership and governance of the service.
Activity & performance	This refers to the impact on the services ability to meet national and local performance metrics and standards.
Sustainability	This refers to the sustainability of the proposal including the longevity and whether it offers value for money, as well as the environmental impact associated with the project/change.
Reputation	This refers to the impact on the organisation's/service's reputation, public trust, and relationships with stakeholders (including patients, healthcare providers, system partners and the local community).

Protected Characteristics	**Definitions**
Age	Protection against discrimination based on age.
Disability	Protection for individuals with physical or mental impairments.
Gender reassignment	Protection for those undergoing gender transition.
Marriage and civil partnership	Protection for individuals who are married or in a civil partnership.
Prgenancy and maternity	Protection for individuals during pregnancy and maternity leave.
Race	Protection against discrimination based on race, color, nationality,
Religion or belief	Protection for individuals based on their religious beliefs or lack thereof.
Sex	Protection against discrimination based on gender.
Sexual orientation	Protection for individuals based on their sexual orientation.

Risk mitigations

When identifiying risk mitigations (controls) consider the hierarchy below with prioritisation of the most effective mitigations.



Elimination:	What can be done to completely eliminate the risk? Can the cause of the risk be corrected, terminated at source, or transferred elsewhere?
Substitution:	If full elimination is not possible, is there another option which presents less/no risk? Can we replace the hazard?
Engineering:	How can the systems and infrastructure be altered to reduce the risk? How can individuals at risk be isolated away from harm?
Administrative controls:	What can the people involved do differently? How do we change the process?
Protection:	If the risk itself cannot be mitigated, how do we protect those at risk from harm?

The organisation's risk scoring matrix and guidance can be found in full using the link below:

https://staffnet.uhs.nhs.uk/TrustDocsMedia/DocsForAllStaff/GovernanceAndSafety/RiskManagementPolicy/Appendix-3-UHS-Risk-Scoring-Matrix-v2-Finalised-Decembe

Additionally the 5 x 5 matrix is shown below:

Risk Scoring Matrix Multiply the impact by the likelihood to generate a predicted risk score and rating					
	1. Negligible	2. Minor	3. Moderate	4. Severe	5. Catastrophic
5. Certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5

Agenda Item 5.8 Report to the Trust Board of Directors, 9 September 2025	
Title:	Finance Report 2025-26 Month 4
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 August report are as follows:

- The Trust has reported a £6.8m deficit in M4. This is £4.8m above the plan submitted to NHS England. The Trust has a full year plan to achieve a breakeven position.
- The underlying deficit is showing improvement reducing to £6.6m in M4 (after adjusting for the monthly pay award additional pressure of £0.2m).
- Whilst the trajectory is improving, it is not yet at the pace required to deliver the plan. Cost improvements have been offset by other pressures, such as reductions to income levels in a number of areas.
- Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, non-criteria to reside patient volumes and inpatient mental health patient costs with regards to enhanced care requirements.
- 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.
- The development of a formal financial recovery plan is now underway to consider improvement actions given the adverse variance to plan.
- UHS continues to deliver significant levels of financial savings (£9.4m has been achieved in M4, £0.3m ahead of the plan), from UHS transformation programmes on patient flow, theatres and outpatients.
- Cash has increased to £40.2m in month. This represents 10 operating days of expenditure. This has however been supported by a further £15m of additional cash from HIOW ICB that needs to be repaid. There is a significant risk that the Trust will require cash support from NHSE.
- WTEs continue to be on a downward trajectory, however increased by 10 in M4, with decreases in substantive -18 to 12,573, offset by an increase in temporary staffing +15 to 698 for bank and +13 to 51 for agency.

Contents:

Finance Report

Risk(s):

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

Equality Impact Consideration:	N/A

UHS Finance Report – M4

Financial Position

In M4, the Trust reported a £6.8m deficit, £4.8m adverse to the annual plan. The Trust's underlying position has decreased into M4 and is now at £6.6m.

	Apr-25	May-25	Jun-25	Jul-25	YTD
Plan	(4.39)	(3.76)	(3.43)	(2.09)	(13.67)
Actual	(4.39)	(3.76)	(4.50)	(6.85)	(19.50)
Actual Variance to Plan	0.00	(0.00)	(1.08)	(4.75)	(5.83)
Underlying	(7.78)	(7.75)	(6.94)	(6.63)	(29.09)
Underlying Variance to Plan	(3.38)	(3.99)	(3.51)	(4.53)	(15.42)

Key driving factors of the UHS position include:

- We set a challenging plan that required £110m real cash-out savings.
- 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, our underlying position has not improved quickly enough to keep pace with the plan.
- M4 YTD we have delivered £5.8m variance to plan; however, this has only been achievable due to £3m of net non-recurrent benefits.
- We have included an assumption that £6.6m of ERF overperformance income from M1-4 will either be funded, or an Activity Management Plan received from commissioners to reduce activity later in the year. This is not included in the underlying position due to the risk.
- CIP is reporting consistent with plan at M4 YTD with achievement of £28.8m reported. There is however an underachievement of £8m on recurrent CIP offset by an overachievement of £8m on non-recurrent CIP.
- Income pressures are a key deficit driver. The Trust has faced an unplanned cut in Genomics funding from NHSE plus noticeable reductions in Channel Islands activity (£1.2m under plan at M4), and a loss of pathology income linked to contracts from other healthcare systems repatriating activity to their host system.
- These unplanned hits on our income are offsetting the challenging decisions we have made to support CIP delivery.
- 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 of the Trust remains driven by overtrading (whereby we are not paid for all of the activity we are undertaking).
    - Our contract values are set at circa £30m below the value required to fully fund the planned level of activity.
    - We are overperforming those contract values by £6.6m YTD, relating to elective overperformance.
    - We are attempting to take measures to reduce activity levels particularly with other healthcare systems; however, all routes are challenging as demand for our services continues to increase.
- The underlying position is also driven by the number of NCTR patients remaining in the Trust, meaning additional unfunded bed capacity remains open. The Trust has not been able to close as many wards as planned as a result.

- 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.
- 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 is now being 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 achievements for M4 include the following:

- UHS has delivered £9.4m (>5% of addressable spend) of CIP in M4, which is £0.3m above the 25/26 annual plan.
- New workforce controls have been embedded, targeting reductions of 5% in divisions and 10% in corporate departments. The trust is in line with the pay expenditure plan in M4.
- UHS is currently utilising agency for just 0.4% of our total workforce, significantly below the national target of 3.2%. Just 51 agency WTE were utilised in month mainly relating to the support of mental health patients.
- Decisions have been made to reduce high-cost insourcing and outsourcing unless considered a significant clinical priority. This is expected to save c£0.5m per month from August onwards.
- 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 and Pay Awards

There has been an increase in the total workforce of 10 WTEs although workforce numbers are below average levels seen in 24/25 and strict workforce controls continue to be in place. Total pay increased in month from £70.0m to £77.6m which is due to agreed backdated payments and accounting for the pay award (£3.2m for which £2.4m was offset by income). The remaining increase in month stems from the five days of industrial action in July (£0.3m), MARS payments being made (£0.2m) as well as pressures from enhanced care and mental health patients (£0.3m).

The pay award has been fully accounted for in month 4 generating a YTD pressure of £0.8m with an ongoing £0.2m per month pressure resulting from funding not covering costs in full. In addition, there is a £0.2m pressure in relation to the recurrent impact of a pay agreement re. HCAs.

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.

Capital

Capital expenditure to M4 is £4.4m below plan due to timing across all key projects. The forecast is currently projected to be delivered in full however there are emergent risks around several schemes which will be explored at the Trust Investment Group meeting in September. Slower progress than plan is noted on

Strategic Maintenance, the Diagnostic Centre, and other Estates projects. There has been minimal spend on externally funded schemes at M4, as planning and designs are still being finalised to secure funding arrangements.

Due to a reduction in the ICB capital allocation, the Trust is forecasting to contribute £3 million of its internal CDEL to support balancing the wider system position. The UEC Incentive Funding of £2m will in effect be moved into our 2026/27 financial envelope by HIOW ICB with a further £1 million added to slippage requirements. This means the internal CDEL allocation is now £29.5m for UHS.

Forecast capital expenditure for the year is currently projected at £65.9m, of which 55% (£36.4m) is externally funded and 45% (£29.5m) internally funded.

Report To	Board meeting in Public		
Title of Paper	System Report 2025/26 (Month 4)		
Purpose of Paper	For information	**Date of Meeting**	Click or tap to enter a date.
Author	Natasha Taplin, Director of System Performance Improvement	**Agenda Item**	
Executive Sponsor	James Lowell, Interim Chief Delivery Officer	**Clinical Sponsor**	Not applicable

Prior Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
Executive Committee	26 August 2025	For information
Future Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**

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 4 (M4) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 3 (M3), 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 12 headline metrics currently performing worse than plan across the Hampshire and Isle of Wight system:

- Cancer 28 day faster diagnosis (M3)
- Cancer 62 day referral to treatment (M3)
- Diagnostic 6 week waits (9 key tests) (M3)
- Time to First Appointment (M4) – *unvalidated*
- RTT 52 week waits (M3)
- Reliance on inpatient care for adults with a Learning Disability (M3)
- Reliance on inpatient care for children with a Learning Disability and/or autism (or both) (M3)
- Access to Children and Young People's Mental Health Services (M3)
- Emergency Department total mapped performance (M4)
- % of attendances in A&E over 12 hours (M4)
- % of beds occupied by patients not meeting the Criteria to Reside (M4)
- Category 2 ambulance response times (M4)

Financial Overview
At M4, the Hampshire and Isle of Wight system in-month position is a deficit of £8.80m compared to a planned deficit of £4.06m, so an adverse variance to plan of £4.74m.

The ICS is reporting a year-to-date deficit of £35.59m at the end of July 2025, compared to a planned year-to-date deficit of £29.88m, so a £5.71m adverse variance to plan.

The ICS is forecasting achievement of its combined £0.468m surplus plan for 2025/26.

Workforce Insights
Overview provided on pages 9.

Quality Overview
Overview provided on pages 10-13.

Recommendations	Notes the detail of this report and escalations for awareness and management of these.

Governance and Compliance Obligations	
Relation to Strategic Objectives	This paper addresses the following objectives: 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
Risk or Board Assurance Framework	No new risks to escalate. This paper relates to BAF risk 3C.
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	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.
Quality Impact Assessment	
Data Protection Impact Assessment	All the data contained herein is in the public domain.
Appendices or Supporting Information	

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 14 August 2025 – up to July 2025 for Urgent and Emergency Care metrics and up to June 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 August 2025, NHS Hampshire and Isle of Wight is ranked red against 12 headline operating plan metrics:

- **Cancer 28 days Faster Diagnosis Standard:** M3 performance is 1.6% below plan, with only Isle of Wight NHS Trust (IOW) and Hampshire Hospitals Foundation Trust (HHFT) achieving plan in month. Current position is 77.4% vs 79% plan.

- **Cancer 62 days referral to treatment** – performance in M3 dropped significantly to 69.6% (compared to 75.3% in M2) and is 3.4% below plan. Although NHS Hampshire and Isle of Wight is below plan, performance is 2.8% above national average. Only IOW achieved plan in M3, with the largest variance against plan at HHFT (9.7%) and University Hospital Southampton Foundation Trust (UHS) with 5.6% negative variance.

- **Diagnostic waits:** The end of June 2025 position shows 29.3% of patients waiting over 6 weeks for the 9 key diagnostic tests, which is 2.1% above the M3 plan, representing a 0.8% improvement on previous month. Main areas of concern include: MRI and CT scans, and Echocardiography.

- **Percentage of patients waiting less than 18 weeks for their first appointment:** current performance is 2% below M4 plan (unvalidated). However, this is based on unvalidated data and may be subject to change. Performance has not achieved plan since M2.

- **52 week waits:** The end of June 2025 position shows 5,460 patients are waiting over 52 weeks, representing a decrease on the previous month of 5,551 but not achieving plan. Only Portsmouth Hospital University Trust (PHU) achieved M3 plan. The number of patients waiting over 65 weeks deteriorated in M3 to 328 (compared to 260 previous month). NHS Hampshire and Isle of Wight also continues to report patients waiting over 78 weeks with 15 in M3 (improvement compared to 19 in M2).

- **Adults in inpatient care who are autistic with no learning disability** – not achieving M3 plan with 35 vs 30 target.

- **Children in inpatient care who are autistic, have a learning disability or both** – not achieving M3 plan with 10 vs 7 target.

- **Access to Children and Young People Mental Health Services** – not achieving M3 plan with 25,350 vs 25,371 target.

- **Accident and Emergency attendances:** performance in M4 is below plan for all 3 operating plan metrics (e.g. Type 1, All Types and Other attendances). NHS Hampshire and Isle of Wight also remains below the 78% national target for total mapped Emergency Department footprint with 76%, no change on previous month.

- **Percentage of attendances in Accident and Emergency (A&E) over 12 hours** – M4 performance (unvalidated) is 1.2% above plan, with only HHFT achieving plan. The number of 12 hour waits from decision to admit has increased further to 1,551 breaches in M4 (against a zero national standard) – representing the highest number on record, with 979 breaches recorded at PHU (vs 838 previous month).

- **Percentage of beds occupied by patients not meeting the Criteria to Reside (NCTR)** – M4 performance remains significantly above the 12% target with 23.9%.

- **Category 2 ambulance response times:** As predicted last month, performance in M4 deteriorated and did not achieve M4 plan or the 30-minute operating plan ambition.

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

- **Access to General Practice – number of available appointments:** performance in M3 is 1.1% above plan.

- **Units of Dental Activity:** performance in M1 is 5.8% above Q1 plan.

- **Average Length of Stay in Adult Acute MH beds** – performance for NHS Hampshire and Isle of Wight in June 2025 is 52 (a reduction on the 63 recorded previous month). Currently below plan of 57 for M3.

- **Adults in inpatient care who have a learning disability (and may also be autistic)** – achieving M3 plan with 37 vs 40 target.

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:

- For **28 day Faster Diagnosis Standard**, NHS Hampshire and Isle of Wight are ranked **22nd out of 42** Integrated Care Boards for their June performance with 77.4% (**Interquartile**)
  The National average is 76.8%.

- For **62 day Cancer Referral to Treatment**, NHS Hampshire and Isle of Wight are ranked **14th out of 42** Integrated Care Boards for their June performance with 69.6% (**Interquartile**)
  The National average is 67.1%.

- For **Diagnostic 6+ weeks**, NHS Hampshire and Isle of Wight are ranked **35th out of 42** Integrated Care Boards for their June performance with 31.9% (**Lowest quartile**)
  The National average is 21.3%.

- For **Percentage seen within 18 weeks**, NHS Hampshire and Isle of Wight are ranked **18th out of 42** Integrated Care Boards for their June performance with 62.7% (**Interquartile**)
  The National average is 61.5%.

- For **Percentage of 52+ weeks**, NHS Hampshire and Isle of Wight are ranked **29th out of 42** Integrated Care Boards for their June performance with 2.8% (**Interquartile**)
  The National average is 3%.

- For **Access to Children and Young People Mental Health Services** – NHS Hampshire and Isle of Wight are ranked 9th out of 42 Integrated Care Boards for their June performance with 25,350 (**Highest quartile**)

- For **Type 1 A&E performance**, NHS Hampshire and Isle of Wight are ranked **26th out of 42** Integrated Care Boards for their July performance of 60.6%. (**Interquartile**)
The National average is 63.1%.

- For **all Type A&E performance**, NHS Hampshire and Isle of Wight are ranked **21st out of 42** Integrated Care Boards for their July performance of 76%. (**Interquartile**)
The National average is 76.4%.

- For **Percentage of attendances in A&E over 12 hours**, NHS Hampshire and Isle of Wight are ranked **9th out of 42** Integrated Care Boards for their July performance (unvalidated) of 6.3%. (**Highest quartile**)
The National average is 8.3%.

- For **Category 2 ambulance response times**, South Central Ambulance Service are ranked **11th out of 11** Ambulance Trusts for their July performance 35:03. (**Lowest quartile**)
The National average is 28:40.

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 M4 the Hampshire and Isle of Wight system has received Q1 and Q2 of the DSF (M1 to M6). With Q3 and Q4 (M7 to M12) conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

Table 1 below summarises how the DSF is phased across the financial years

Table 1: Deficit Support Fund Phasing

M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
£7,388	£7,388	£7,388	£4,555	£4,555	£4,555	£4,555	£4,555	£4,555	£4,555	£4,555	£4,555	£63,161

3.3 Financial Position

Table 2 below summarises the in-month and year-to-date financial position as at Month 04 (July) for all Hampshire and Isle of Wight organisations:

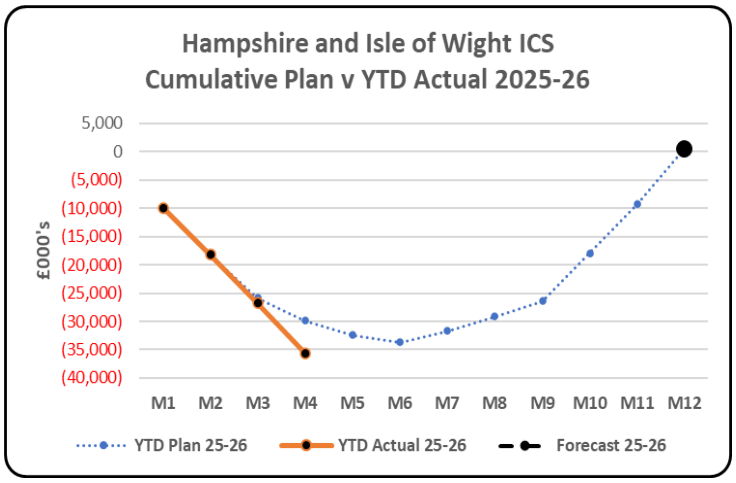
Table 2: Summary of M04 results

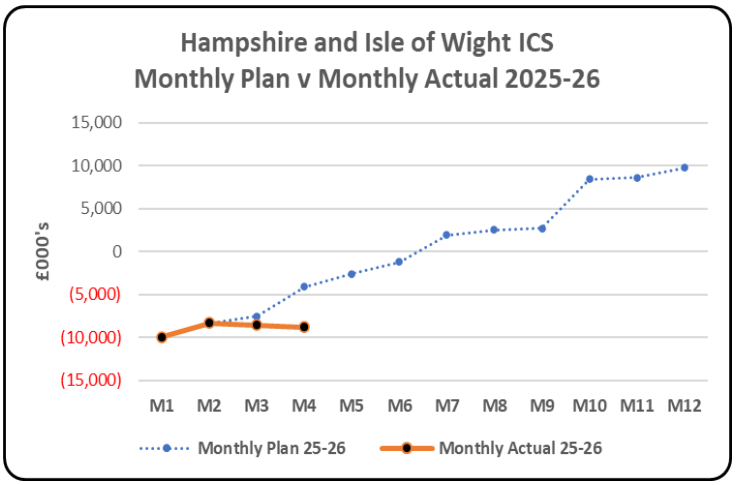
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	(4,063)	(8,800)	(4,737)	(29,883)	(35,595)	(5,712)	468	469	1

In July 2025 itself, the ICS reported a deficit of £8.80m against a planned deficit of £4.06m, so £4.74m adverse variance to plan. Year-to-date the system has reported a deficit of £35.59m at Month 04 compared to a planned deficit of £29.88m, therefore £5.71m adverse variance to plan.

The graphs below summarise the ICS position reported at month 04 (July) 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

4.1 System Oversight

The system has a weekly System Workforce Oversight Committee in place to ensure grip and control of the system workforce plan. This includes provider data review against plan and course correction actions required.

4.2 M4 System Performance

Month 4 - Whole Time Equivalent (excluding Integrated Care Board)

- The Total Provider Workforce Plan is £124.4m, equating to 3,945wte (Plans are made up of 1-Vacancy Management Establishment Reduction (£35.7m/1216wte) + 2- Workforce submitted Substantive plans to NHSE (-1913wte) + 3- Workforce submitted Temporary Staffing plans to NHSE (c£50m/-816wte))
- Hampshire & Isle of Wight system is 528 whole time equivalent (WTE) worse than Total Provider Workforce Plan in 2025/26.
- Trusts worse than plan are University Hospitals Southampton (368 WTE), South Central Ambulance Service (235 WTE), Portsmouth Hospitals University NHS Trust (97 WTE) & Isle of Wight (110 WTE).
- Hampshire Hospitals and Hampshire & Isle of Wight Healthcare are better than plan by 191and 91 WTE respectively

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.

5.1 Regulatory

5.1.1 Care Quality Commission: during July 2025, seventeen Care Quality Commission inspection outcomes were reported relating to providers within Hampshire and the Isle of Wight. One was an independent hospital provider that received an overall *Good* rating and two related to primary care services, one of which received an overall *Good* rating and the other a *Requires Improvement* rating.

5.1.2 Care Quality Commission – General Practice: 124 of the 129 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*. Two practices remain unrated.

5.1.3 Quality Assurance and Improvement Surveillance Levels: at the July 2025 Hampshire and Isle of Wight System Quality Group in July 2025, it was agreed that all the large NHS providers should 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 Patient Experience – Friends and Family Test – May 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.

- **General Practice:** 39,137 Friends and Family Test responses were received for General Practice across Hampshire and the Isle of Wight in June 2025, with a total GP registered list size of 1,970,452 for that period. Hampshire and Isle of Wight Performance was better than the national rate, seeing 93% positive feedback (national 92%) and 3% negative (national rate of 4%).

The Hampshire and Isle of Wight Friends and Family Test results which were below the national positive rate in June 2025, were:

- **Maternity Postnatal Community:** system performance for positive feedback was just below the national rate at 94.4% (national rate 94.5%). Although only one Trust in Hampshire and Isle of Wight had this data published for June 2025

- **Mental Health:** system performance reflected 88.8% positive feedback (national rate 89.6%). However, on review not all results included in the May and June 2025 published data related to mental health, this will require provider follow-up with the national Friends and Family Test team to ensure data accuracy.

5.2.2 Mixed-Sex Accommodation Breaches (up to April 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.

Across NHS Hampshire and Isle of Wight, in May 2025 there were 61,515 finished consultant episodes (an increase on the previous month) and 127 mixed-sex accommodation breaches (rate 2.1) - this represents an improvement in performance in comparison to the April 2025 data and the rate is lower than that of England (rate 2.4). Breaches were reported by two of our large providers which represented an improvement.

One Trust saw a slight increase in their breach rate in comparison to the previous month (rate 0.3 – previous 0.2) whereas, whilst still having the highest rate of breaches, another Trust saw a decline in their rate (rate 5.8 – previous 6.0).

The Trust with the highest breach rate cites capacity impacting patient flow as their main reason for mixed sex accommodation breaches. The Trust's Quarter 1 2025/26 data demonstrates that the breaches average one to two days with the longest being three days. Each breach is discussed at their internal bed meeting to see if actions can be taken to stop the breach.

As previously reported, Trusts manage their breaches, aiming to rectify them as soon as possible and ensuring patient privacy and dignity. The hospital estate has an impact on breaches, for examples those estates with bays including en-suite facilities are less likely to incur breaches.

5.3 Safety

5.3.1 Infection Prevention and Control – June 2025: key areas to note include:

- Methicillin-resistant Staphylococcus aureus: the threshold for Methicillin-resistant Staphylococcus aureus is zero. All acute providers have reported one case, apart from Hampshire Hospitals NHS

Foundation Trust. Despite breaching the zero threshold, the data for Quarter 1 2025/26 represents an improvement from 2024/25 where there were six cases.

5.3.2 Never Events: four Never Events occurred in Quarter 1 2025/26 across two providers. All related to surgical incidents – three wrong site surgery incidents and one wrong prosthesis incident. June and July 2025 have seen two medication Never Event incidents reported by two providers. All incidents are being investigated, and relevant learning will be shared across the System.

Actions: actions remain as previously reported -

- in response to provider surgical Never Event performance, thematic analysis of provider incidents and feedback during 2024/25, and through collaboration with providers, one of the key 2025/26 system quality priorities is to improve patient safety, team-working and efficiency in settings that undertake invasive procedures. All providers have agreed this as part of their 2025/26 quality contract (Schedule 4c).
- raised through joint assurance meetings with NHS England (Sout East) – deep dive presentations from providers to gain assurance regarding provider plans
- contract progress via System Quality Group
- system review of 2024/25 Never Events to further support learning and improvement.

5.3.3 Prevention of Future Deaths Report – Courts and Tribunals Judiciary – July 2025: one Trust in the Hampshire and Isle of Wight System received a Prevention of Future Death Report. The Trust will submit a response to the coroner by 18 September 2025.

5.4 Clinical Effectiveness

5.4.1 Standardised Hospital-level Mortality Indicator (SHMI) – up to February 2025: all providers are reporting 'as expected' (band 2) mortality rates apart from University Hospital Southampton NHS Foundation Trust who is showing 'lower than expected' (band 3).

5.4.2 National Hip Fracture database – hours to operation (June 2025): early surgery for hip fractures has been shown to reduce mortality rates and surgical complications. The national target is for patients to have surgery within 36 hours; this is because delays beyond this are shown to have increased mortality. In July 2025, only one Trust in the Hampshire and Isle of Wight system met the time to surgery standard.

As part of the contractual requirements, quality commissioners are in the process of reviewing fractured neck of femur best practice tariff performance

with providers, which also includes time to surgery. Assurances and improvement plans are being sought for those areas flagging.

5.5 Quality Impact Assessments

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

During July 2025, six Quality Impact Assessments were reviewed at the NHS Hampshire and Isle of Wight weekly panel, of which four 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.

Agenda Item 5.10 Report to the Trust Board of Directors, 9 September 2025	
Title:	People Report 2025-26 Month 4
Sponsor:	Steve Harris, Chief People Officer
Author:	Farid Khalil, Workforce Specialist

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, the workforce increased by 10 WTE in July. While the substantive workforce decreased by 18 WTE, a rise in mental health cases and industrial action led to an increase in bank and agency staff, resulting in a net rise in WTE. This has pushed UHS above its NHSE plan by 55 WTE.

The Trust is developing a comprehensive financial recovery plan for the ICB and NHSE, including strategies for restoring the workforce to target levels. A new forecasting model, built from bottom-up finance data, has been implemented and will be updated as part of the workforce recovery effort at the end of August. In addition, the Financial Improvement group continue to review items related to workforce, such as temporary staffing expenditure identifying opportunities for further improvement. Rate changes to NHSP premium pay for some areas are due to go live in September following discussions directly with staff.

The Trust has addressed concerns regarding NQN recruitment over the past month 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'.

The Trust has continued with its recruitment controls in place since March but has also now included additional elements. This has included increased internal advertising of clinical roles prior to advertising externally and limiting and phasing of external starters each month. All roles continued to be reviewed through the Trust recruitment control panel (RCP).

65 MARS applications have been approved and are being processed (51 WTE). The Trust has thoroughly evaluated each case for financial viability and operational impact, rejecting cases where appropriate.

The Trust is about to embark on its annual staff flu vaccination campaign and plans were approved through People Board and Trust Executive Committee in August.

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

July 2025

THRIVE EXCEL BELONG

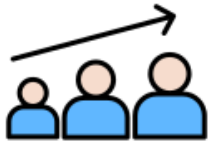
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M4 (July-25)

In-month sickness is currently 3.5%, 0.2% below target (3.7%).

Appraisal completion rates remained the same in July at 72%

R12m turnover rate (10.9%), which is below target (13.6%).



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

Bank usage increased from prior month and is now 9 WTE under plan.

Increased in agency staffing usage. Agency is 2 WTE under plan.

Decrease in patient safety incidents from 81 to 72 in July

Pulse Survey for Q2 shows a stable engagement score

Executive Summary

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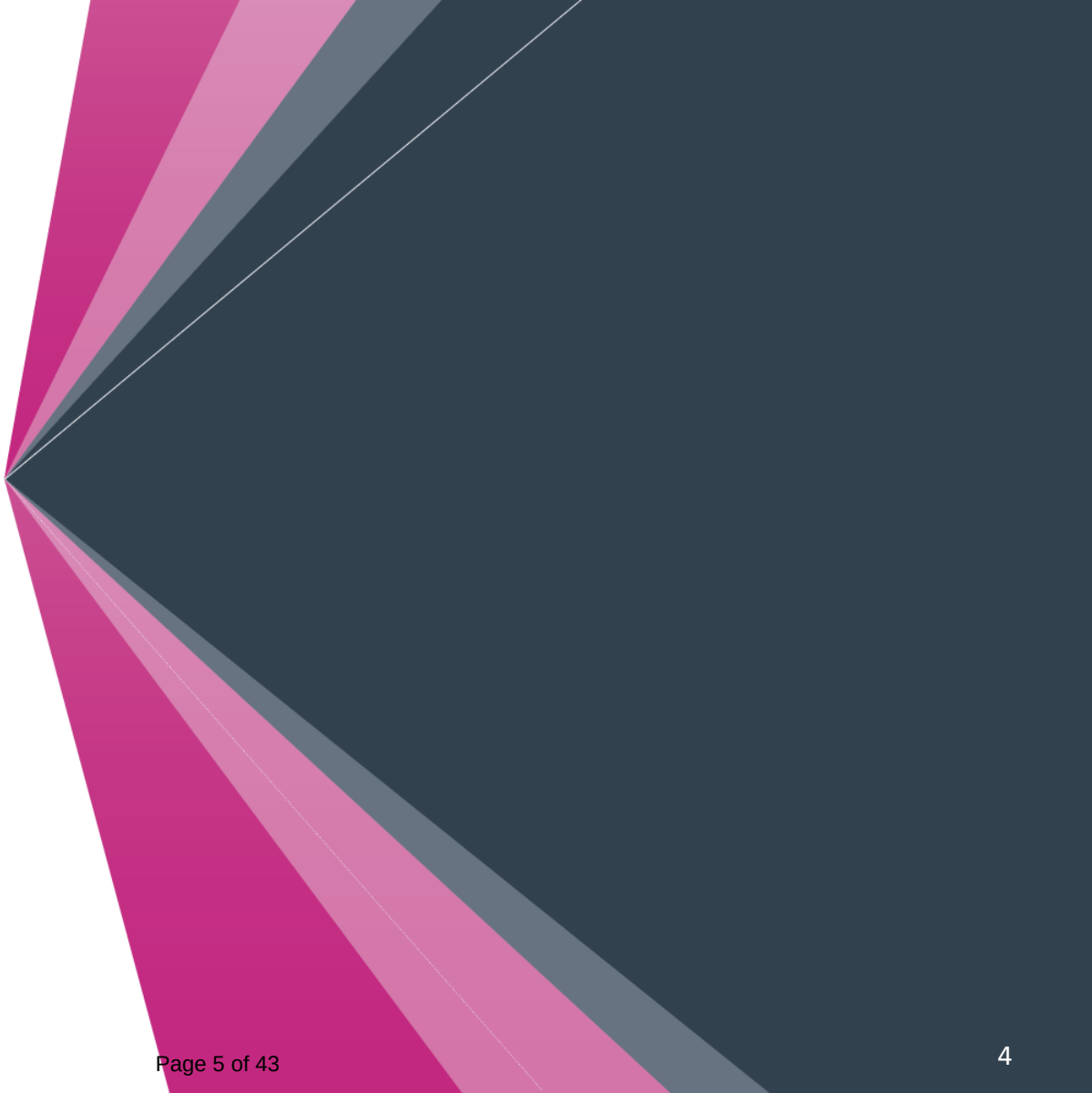
Overall Position



WTE Movement (M3 to M4)

Total Workforce

The total workforce **increased by 10 WTE** to 13,322 WTE from M3 (13,312) to M4.

During this period, the substantive workforce decreased by **18 WTE**, while the total temporary staffing increased by **28 WTE.**

As of M4, the Trust is **above the total plan** (by 55 WTE).

Substantive WTE

Substantive WTE decreased by **18 WTE** between end of June and end of July.

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

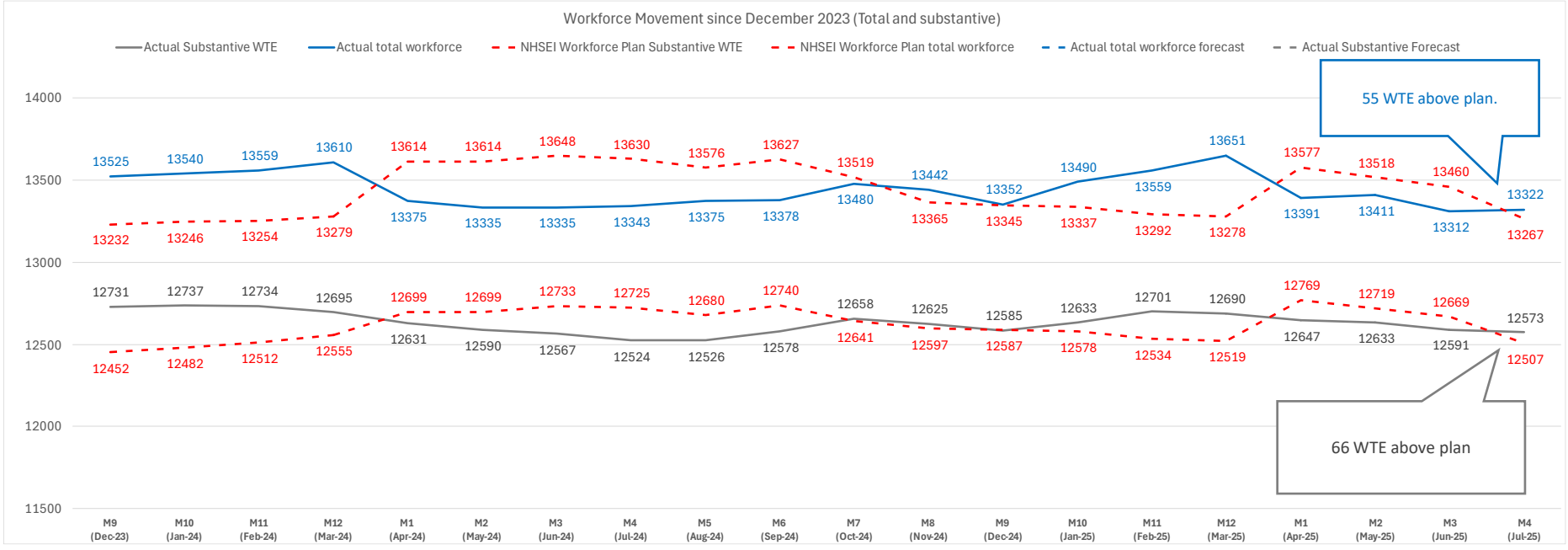
Total Bank and Agency usage increased by 28 WTE in July 2025.

Bank usage **increased** in July by 2%, while **Agency** usage **increased** in by 8%.

Ongoing Pressures
Shift from Agency to Bank Staff
Agency shift fill rates have declined from 45% in June 2024 to 31% in June 2025, reflecting the ongoing efforts to transition mental health workers from agency contracts to Bank roles. 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.

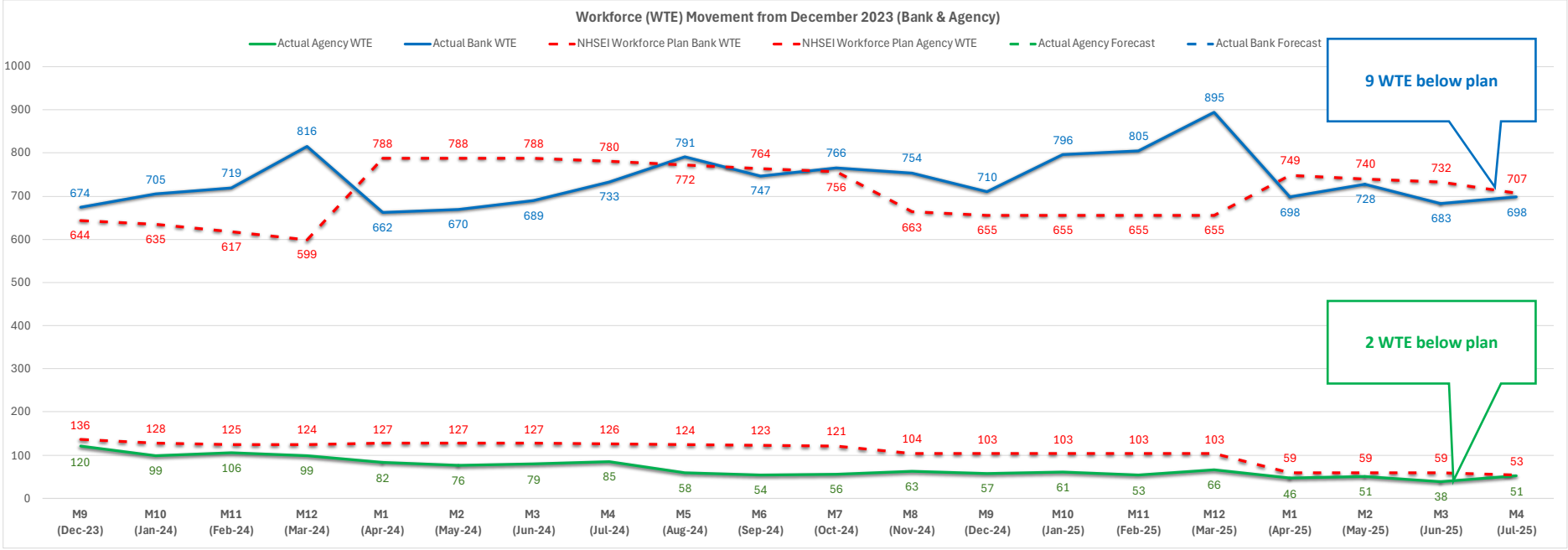
Rising Numbers of Detained Patients
There is a month-on-month increase in patients detained under Section 2 of the Mental Health Act. This is driving higher demand for 1:1 RMN-prescribed enhanced care.

Workforce Trends: Total & Substantive



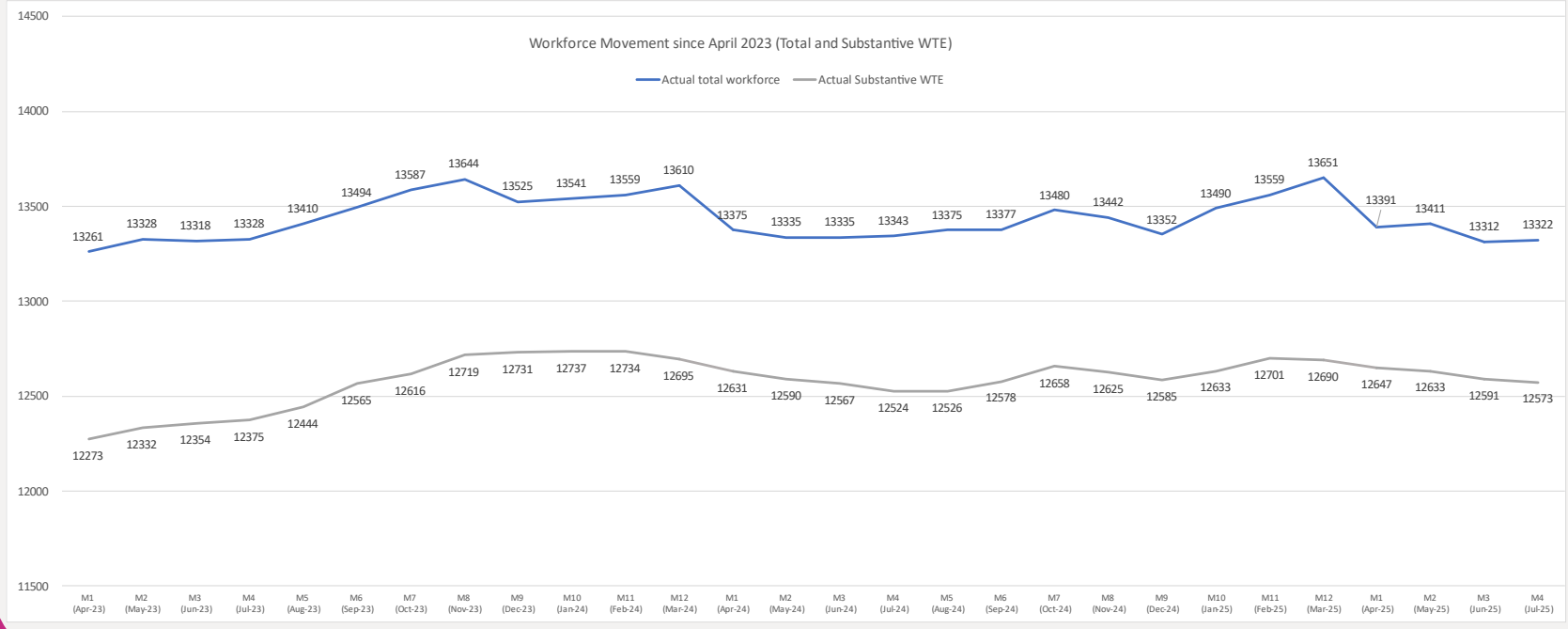
Source: ESR as of July 2025.
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



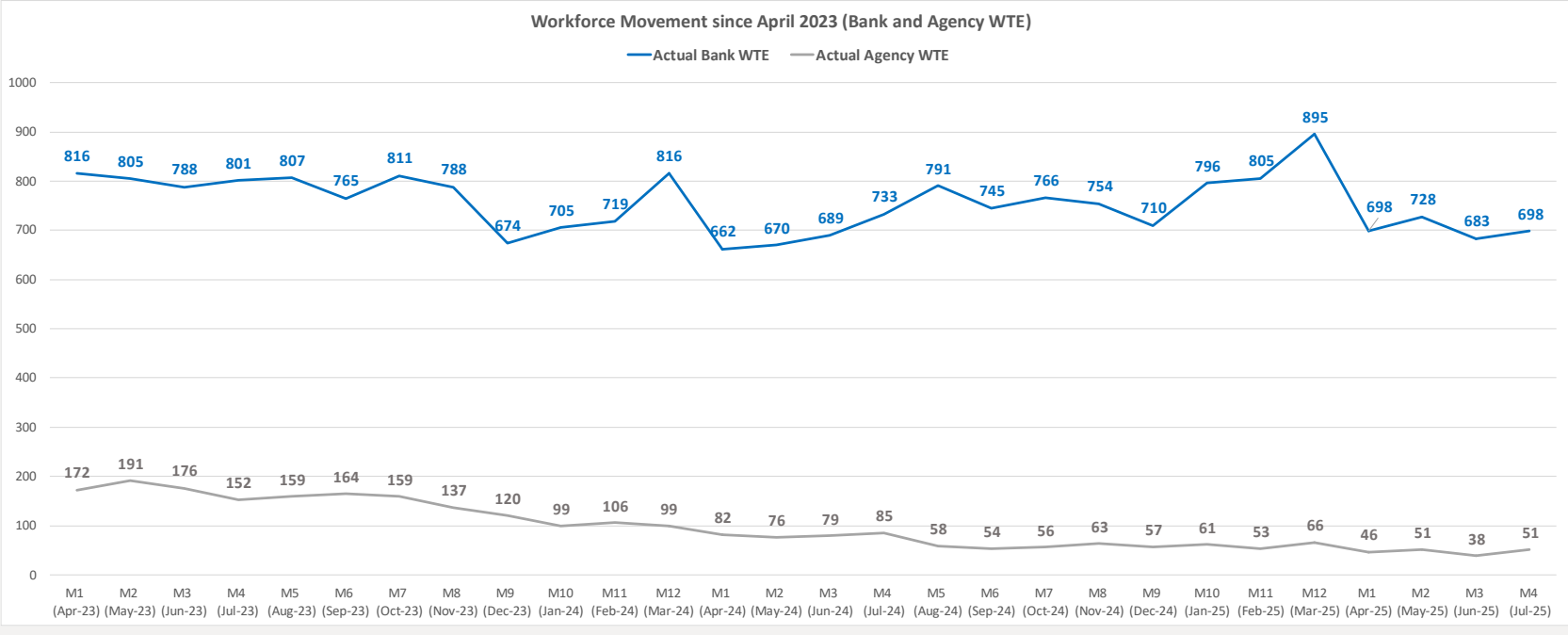
Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of July 2025
Forecast for bank is based on average past performance over the last 3 years for May, June, July, and August.

Workforce Trends: Total & Substantive over 2 years



Source: ESR as of July 2025.

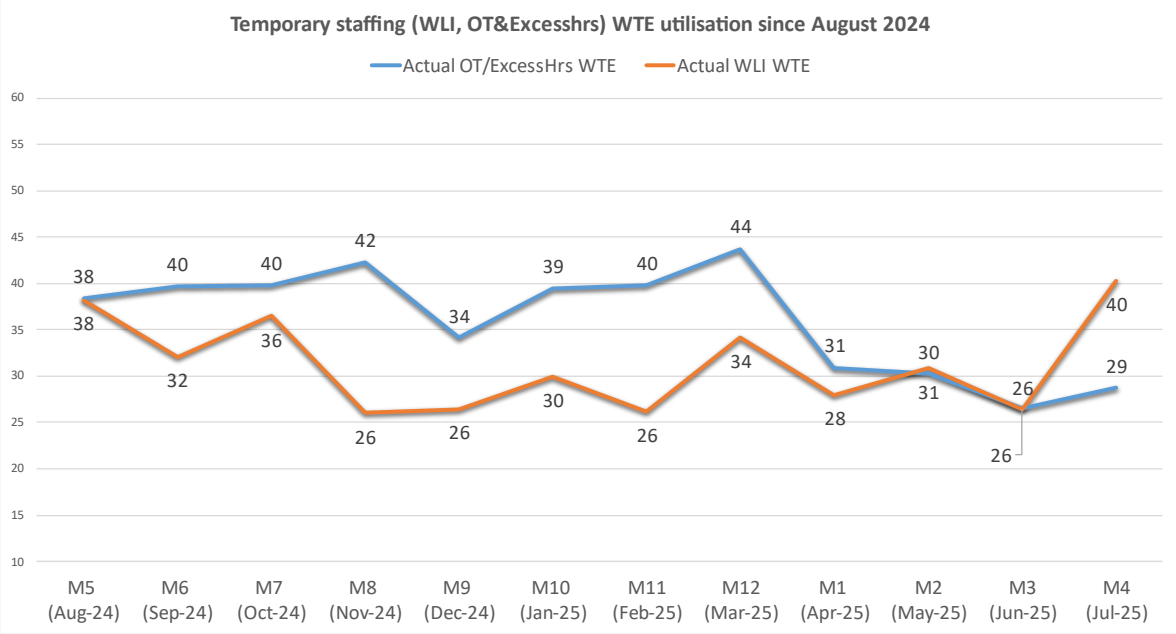
Workforce Trends: Bank & Agency over 2 years



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of July 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
	-7	-10	4	0	4	-4	8	-6	3	-4	14



Source: Healthroster as of July 2025.

Quarterly People Heatmap – 2025/26 Q1

THRIVE EXCEL BELONG

	AWL as of M3 (Jun 25)	% Turnover	Apprentice 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	**12614**	**10.4%**	**702.2**	**71.5%**	**3.2%**	**39.3%**	**12.1%**	**13.4%**
Division A Overall	2444	9.4%	104.2	67.5%	3.1%	28.1%	15.3%	11.9%
Critical Care	664	8.9%	24.1	71.3%	2.9%	6.7%	10.4%	9.1%
Ophthalmology	307	13.1%	12.9	78.3%	4.0%	31.3%	13.8%	6.9%
Surgery	580	9.2%	24.7	68.9%	2.5%	9.1%	10.1%	14.5%
Theatres & Anaesthetics	876	8.6%	41.5	60.1%	3.4%	50.0%	30.4%	16.1%
Division B - Overall	3449	9.6%	150.5	70.0%	3.3%	37.3%	12.6%	14.7%
Cancer Care	731	11.8%	33.1	66.5%	3.0%	42.9%	16.3%	16.3%
Emergency Care	723	10.2%	19.8	70.7%	3.7%	54.1%	10.0%	18.8%
Medicine	801	9.0%	47.2	81.4%	3.8%	15.8%	23.4%	8.5%
H&IOWAA	0	19.7%	0.0	29.6%	8.4%	0.0%	0.0%	8.3%
Pathology	604	8.0%	39.3	61.2%	3.4%	25.0%	10.9%	13.0%
Specialist Medicine	620	8.6%	5.4	71.3%	2.8%	23.1%	9.2%	13.2%
Division C - Overall	2815	11.7%	165.0	68.8%	3.5%	41.5%	10.3%	13.1%
Child Health	893	11.8%	41.0	68.3%	3.3%	12.5%	2.5%	14.4%
Clinical Support	904	13.2%	90.3	71.2%	2.4%	28.1%	14.4%	10.9%
Women & Newborn	837	8.2%	29.1	67.2%	4.5%	66.7%	6.4%	19.9%
Division D - Overall	2407	10.7%	122.9	74.2%	2.6%	52.8%	15.1%	13.4%
CV&T	925	11.5%	49.3	71.8%	2.7%	33.3%	20.1%	14.6%
Neuro	469	12.4%	27.1	65.7%	2.0%	0.0%	17.1%	10.5%
Radiology	490	8.5%	19.3	83.1%	2.8%	60.0%	6.4%	10.6%
T&O	438	10.1%	22.1	77.1%	2.9%	0.0%	21.2%	15.2%
THQ - Overall	1498	10.4%	159.6	81.1%	3.3%	41.7%	10.6%	13.4%
Chief Finance Officer	119	13.1%	17.0	80.5%	1.9%	33.3%	7.9%	12.7%
Chief Operating Officer	187	13.6%	1.0	64.9%	7.2%	100.0%	14.8%	7.4%
Clinical Development	90	12.6%	4.0	72.4%	4.4%	20.0%	8.5%	23.4%
Digital	259	4.2%	27.1	86.2%	1.7%	50.0%	17.1%	11.0%
People / HR	167	16.0%	19.1	86.7%	2.9%	0.0%	0.0%	16.2%
R&D	138	10.4%	16.3	85.3%	2.9%	61.5%	13.5%	11.2%
Training & Education	210	8.6%	39.4	84.3%	3.7%	100.0%	6.3%	6.3%

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

Substantive SIP by Staffing Group
2025-26 Counting Criteria

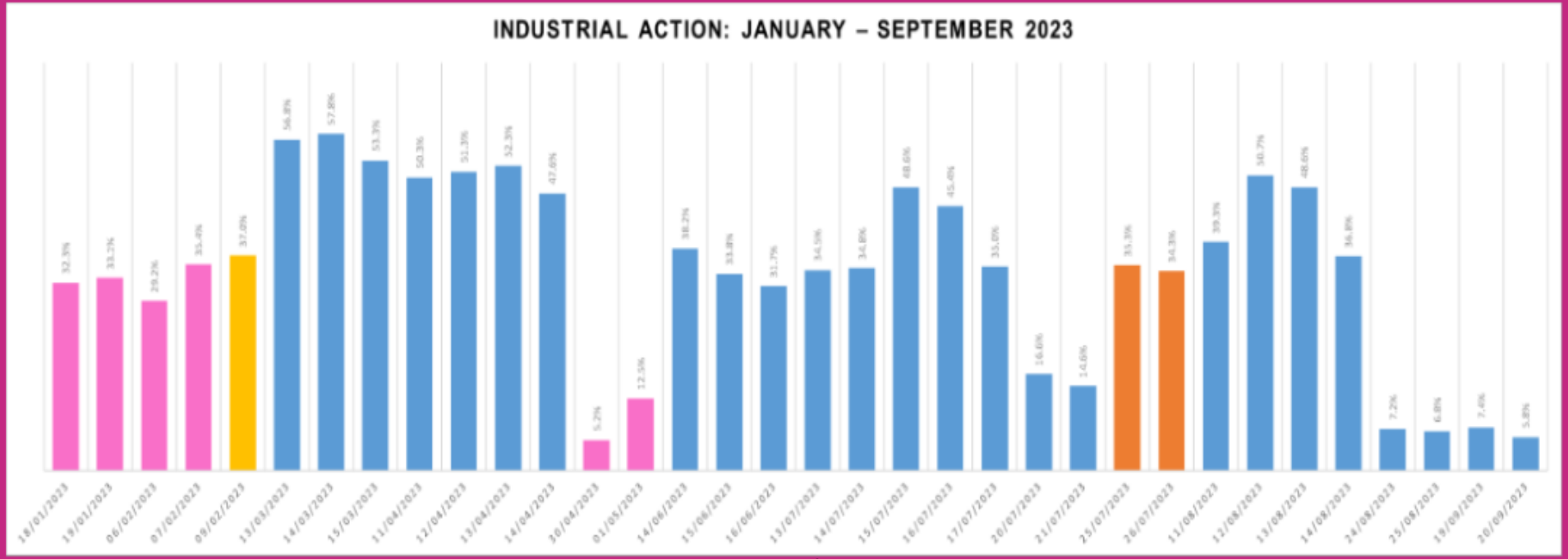
Substantive Monthly Staff in Post (WTE) for last 12 months																		
	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	2024/25 M5 (Aug)	2024/25 M6 (Sep)	2024/25 M7 (Oct)	2024/25 M8 (Nov)	2024/25 M9 (Dec)	2024/25 M10 (Jan)	2024/25 M11 (Feb)	2024/25 M12 (Mar)	2025/26 M1 (Apr)	2025/26 M2 (May)	2025/26 M3 (Jun)	2025/26 M4 (Jul)	M3 to M4 movement	Mar24 to Mar25 Movement
Add Prof Scientific and Technic	402	397	400	396	396	401	301	301	300	295	294	297	302	301	300	300	312	**12**	**-100**
Additional Clinical Services	2136	2135	2134	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	2134	2131	**-3**	**-29**
Administrative and Clerical (Divisions)	1386	1399	1387	1374	1366	1363	1356	1347	1342	1328	1340	1348	1352	1352	1350	1327	1316	**-11**	**-34**
Administrative and Clerical (THQ)	902	904	902	875	864	860	859	852	875	888	897	900	902	899	893	879	874	**-5**	**0**
Allied Health Professionals	696	703	700	699	688	686	808	815	814	806	807	821	817	823	822	832	831	**0**	**121**
Estates and Ancillary	380	374	372	373	376	373	370	373	407	405	407	415	416	414	409	407	403	**-4**	**36**
Healthcare Scientists	498	499	495	498	496	497	495	504	510	509	512	518	521	523	520	523	524	**1**	**23**
Medical and Dental	2184	2165	2163	2161	2155	2217	2240	2244	2127	2118	2125	2135	2130	2135	2123	2114	2111	**-3**	**-54**
Nursing and Midwifery Registered	4053	4052	4039	4030	4025	3998	3998	4055	4041	4038	4039	4032	4013	4010	4024	4008	4003	**-4**	**-40**
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	**-1**	**11**
Grand Total	**12695**	**12685**	**12649**	**12593**	**12540**	**12550**	**12583**	**12635**	**12563**	**12523**	**12574**	**12637**	**12629**	**12647**	**12633**	**12591**	**12573**	**-18**	**-66**

Source: ESR substantive staff as of July 2025; includes consultant APAs and junior doctors' extra rostered hours, excludes CLRN, Wessex AHSN, and WPL (revised criteria for 25/26). Numbers relate to WTE, not headcount.

Industrial Action: January – September 2023

This summary provides an overview of the workforce impact of several cohorts of industrial action at UHS since January 2023

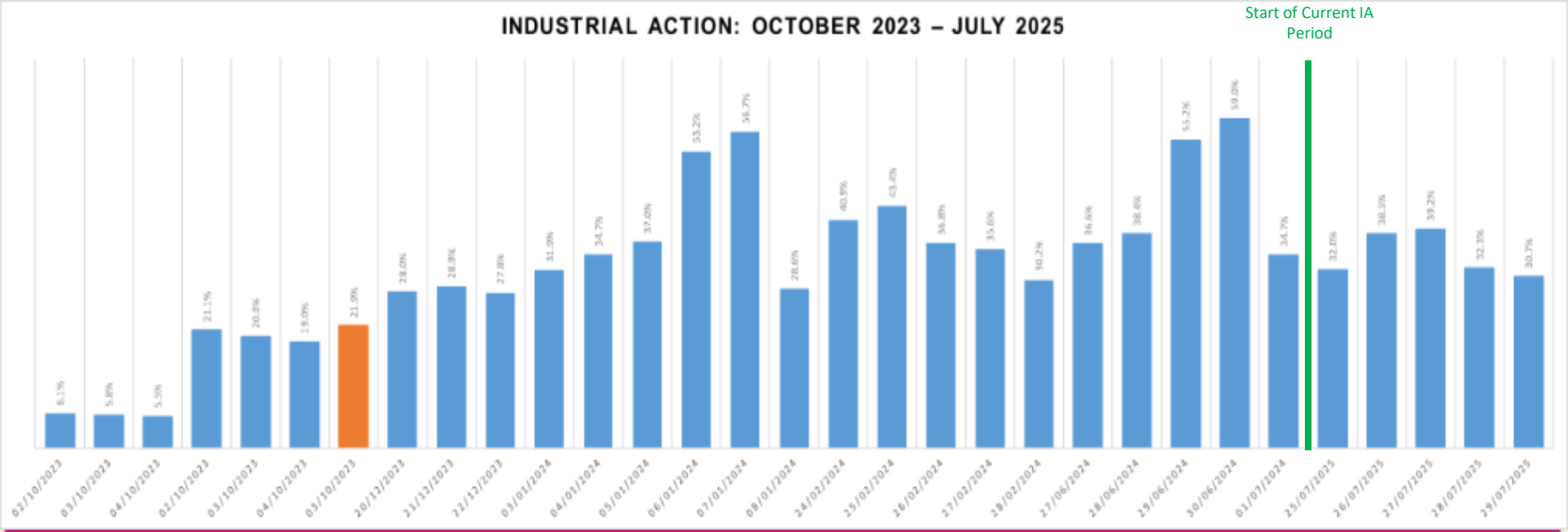
RCN CSP BMA SOR



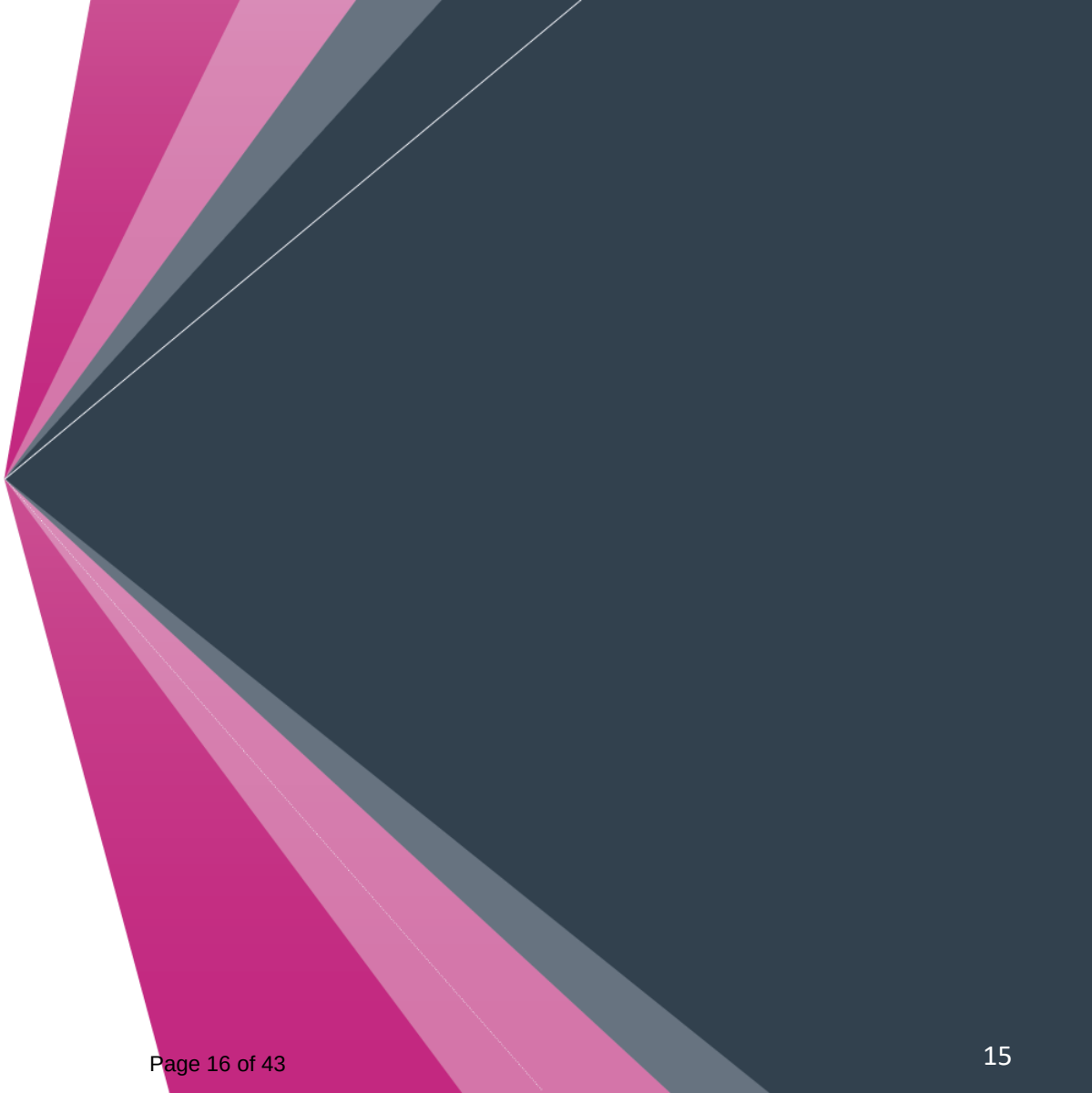
Industrial Action: October 2023 – July 2025

This summary provides an overview of the workforce impact of several cohorts of industrial action at UHS since January 2023

RCN CSP BMA SOR



THRIVE



NQN 2024 – 2025 Autumn intake Comparison

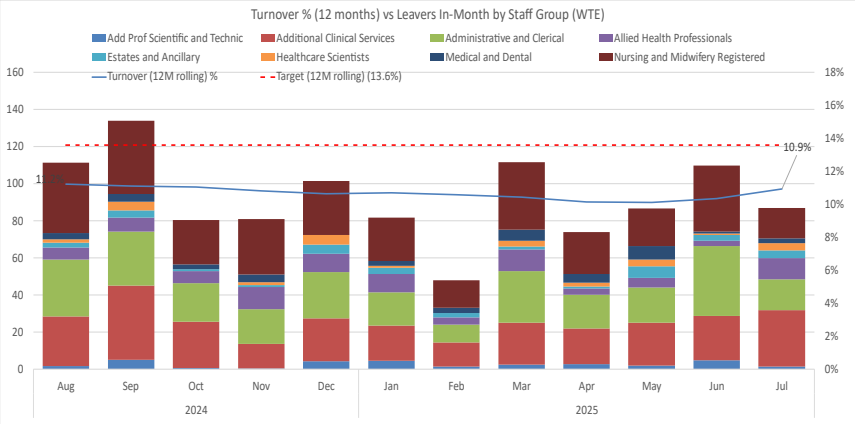
Updated 18th August 2025

An improved picture following the recent release of NQN allocations from Divisions

	Autumn Intake					
2024			2025	Sept - Oct	Jan - March	Total
Adult NQN starters external	55		Adult NQN offers external	21	57	78
Child NQN Staters external	41		Child NQN offers external	32	8	40
BPPs apprentices	34		BPPs apprentices			42
Total	130		Total	54	65	161
NQM	40			9	6	15

- Adult allocations up **41%** on last year.
- BPP allocations up **23%** on last year.
- **119** external Autumn onwards allocations, up by **23%** on last year
- Only **24** Adult NQN candidates have not received an offer.
- **All** appointable Child NQNs received offers.
- Midwifery NQs dropped from 18 to 15 due to withdrawals, replacement offers in progress

Turnover



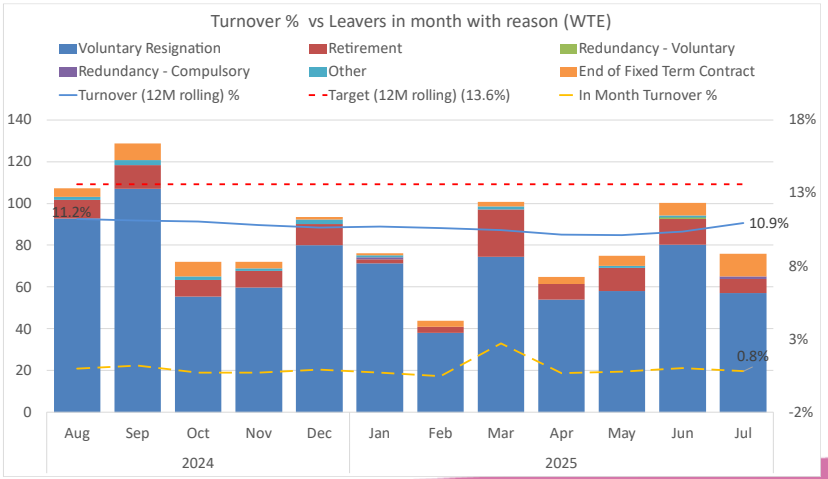
In July 2025, there was a total of 87 WTE leavers, 23 WTE less than June 2025 (110 WTE). Division C recorded the highest number of leavers (32 WTE). Within Division C, Additional Clinical Services staff group had the highest number of leavers (13 WTE).

Divisions A and B had the second and third highest number of leavers (20 and 19 WTE respectively); with the largest number of leavers for Division A being the Nursing and Midwifery Registered staff group (7 WTE), while in Division B Additional Clinical Services staff group accounted for 9 WTE leavers.

Total leavers by division are as follows:

- **Division A: 20 WTE leavers**
- **Division B: 19 WTE leavers**
- **Division C: 32 WTE leavers**
- **Division D: 1 WTE leavers**
- **THQ: 13 WTE leavers**
- **UEL: 2 WTE leavers**

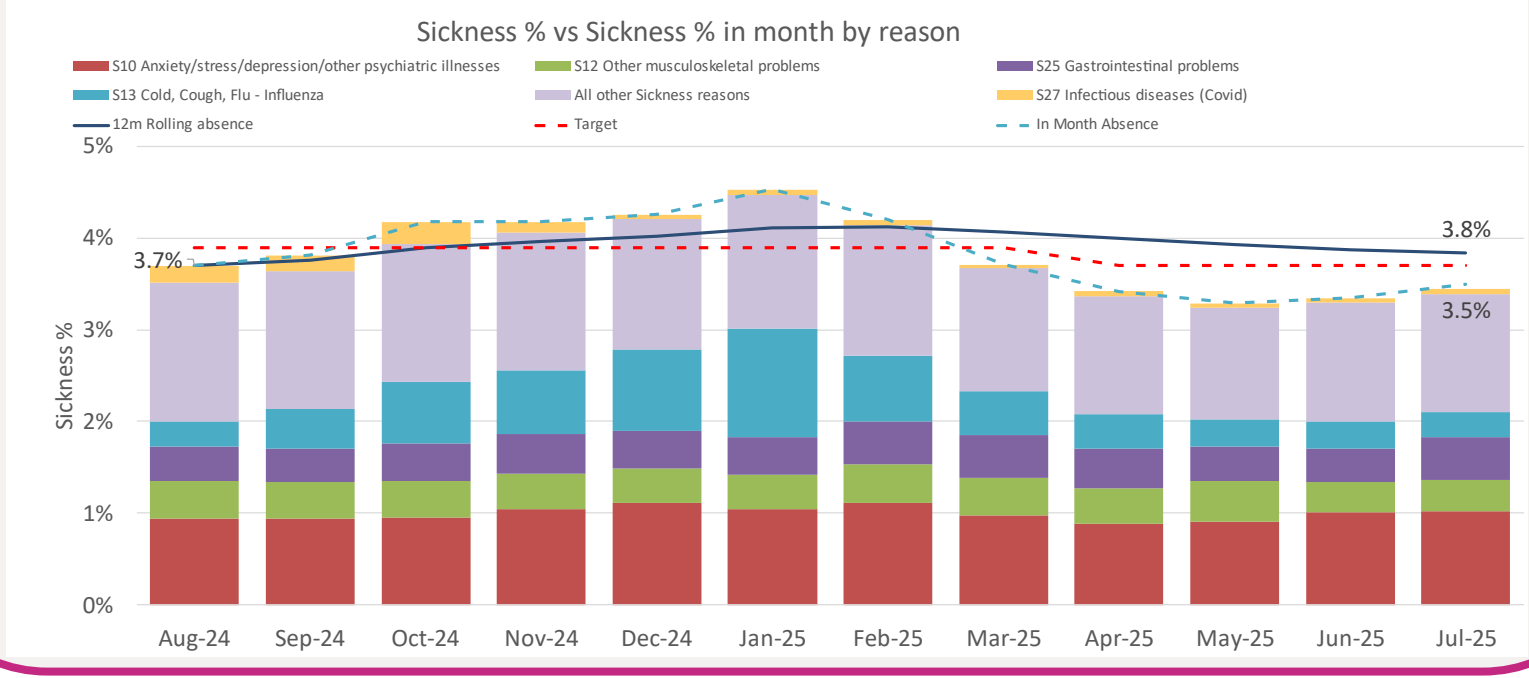
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.5	0.5%	10.3%
Additional Clinical Services	30.2	1.4%	13.4%
Administrative and Clerical	16.7	1.0%	11.9%
Allied Health Professionals	11.5	1.4%	11.0%
Estates and Ancillary	4.0	0.9%	8.3%
Healthcare Scientists	4.0	0.8%	5.2%
Medical and Dental	2.6	0.3%	14.6%
Nursing and Midwifery Registered	16.3	0.4%	8.3%
UHS total	**86.9**	**0.8%**	**10.9%**



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

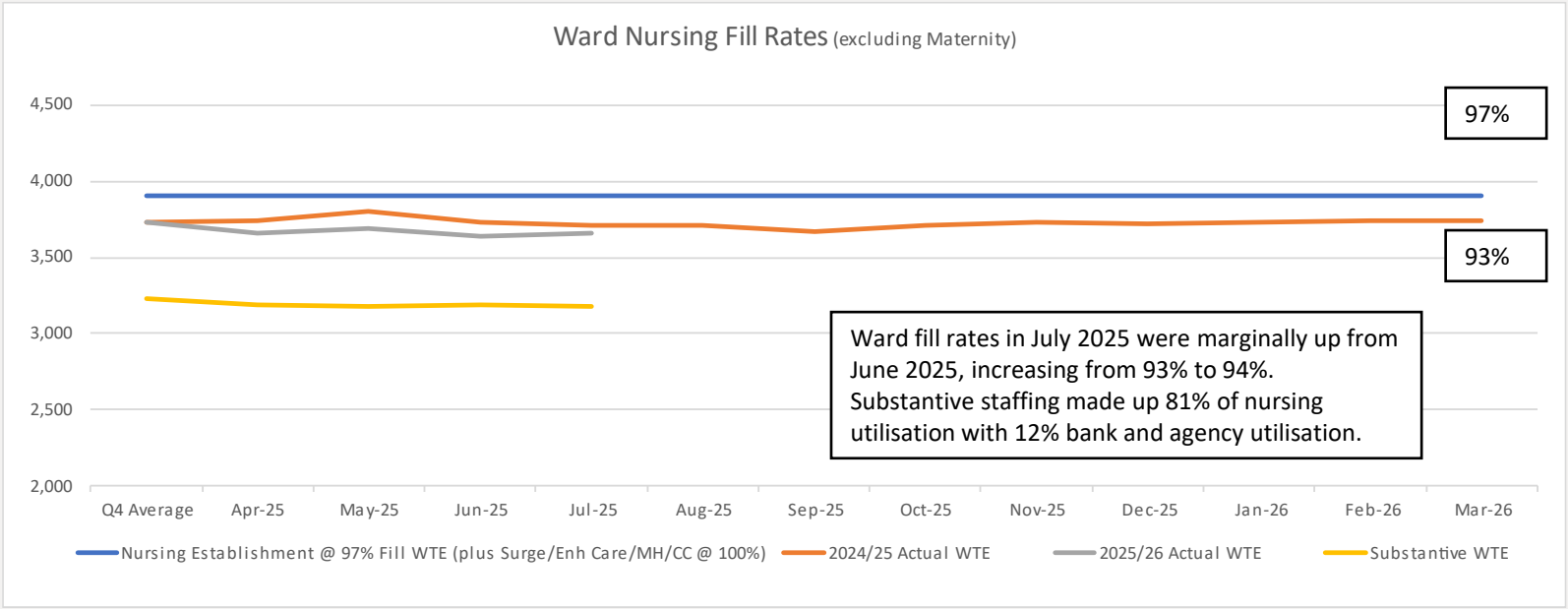
Sickness

Current in-month sickness: 3.5% | Rolling 12-month sickness: 3.8% | Year-to-date sickness 3.4%



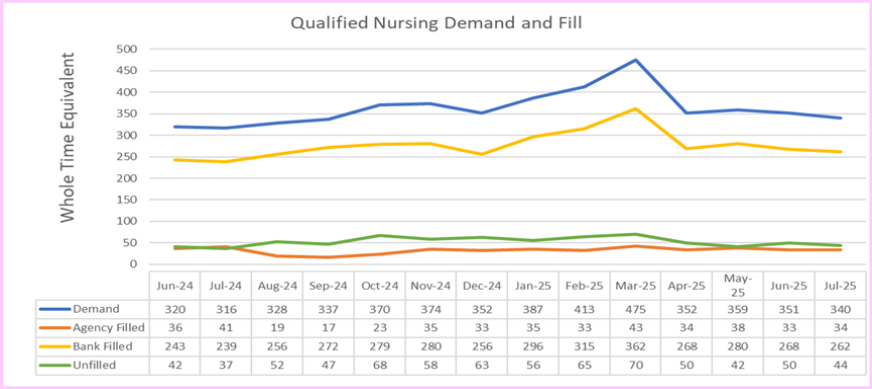
Source: ESR – July 2025

Ward Nursing Fill Rates (excluding Maternity)

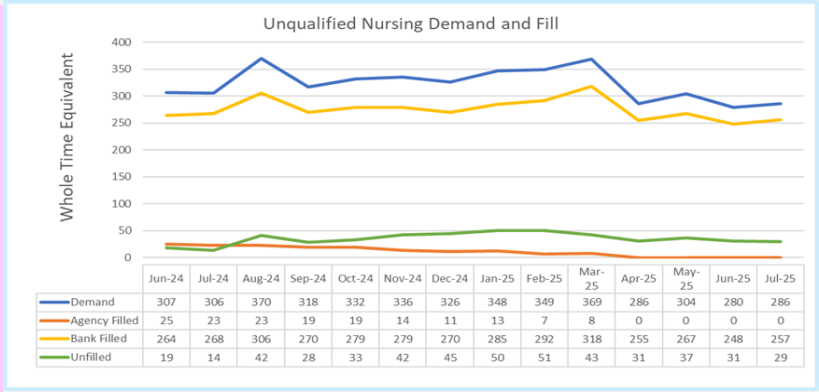


Source: Finance - July 2025

Temporary Staffing



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Demand	320	316	328	337	370	374	352	387	413	475	352	359	351	340
Agency Filled	36	41	19	17	23	35	33	35	33	43	34	38	33	34
Bank Filled	243	239	256	272	279	280	256	296	315	362	268	280	268	262
Unfilled	42	37	52	47	68	58	63	56	65	70	50	42	50	44



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Demand	307	306	370	318	332	336	326	348	349	369	286	304	280	286
Agency Filled	25	23	23	19	19	14	11	13	7	8	0	0	0	0
Bank Filled	264	268	306	270	279	279	270	285	292	318	255	267	248	257
Unfilled	19	14	42	28	33	42	45	50	51	43	31	37	31	29

Status

Qualified Nursing (WTE)

- **Demand decreased** from 351 WTE to 340 WTE in July (-11).
- **Bank fill decreased to** 262 WTE(-6 from previous month).
- **Agency filled** 34 WTE (+1 from the previous month).
- **Unfilled shifts decreased** : 44 WTE remained unfilled (-6 on previous month).
- **Year-on-year demand increased: 24** WTE higher than 2024 (+6 WTE bank filled).

Healthcare Assistants (HCA) (WTE)

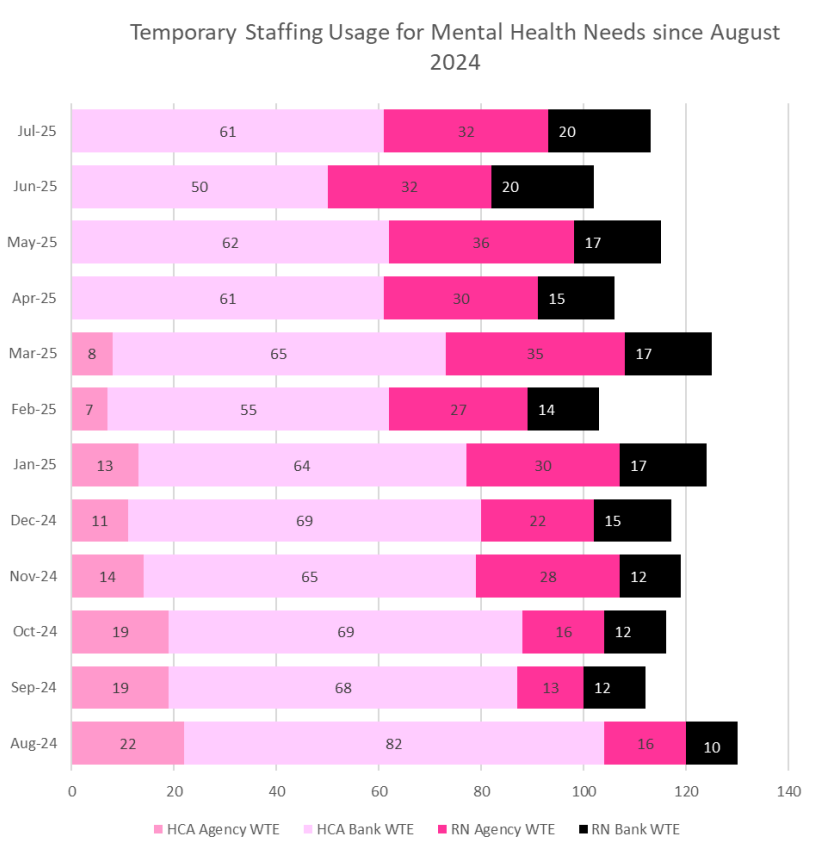
- **Demand increased** from 280 to 286 in June (+6).
- **Bank filled increased** from 248 WTE to 257 WTE (+9)
- **Unfilled shifts increased**: 29 remained unfilled (-2 on prior month)
- **Year-on-year demand increase**: 20 WTE lower than July 2024.

Actions

- **RMN Agency-to-Bank Migration;-** Review agency spend vs. bank costs for Mental Health staff, with a focus on potential savings. Action to include reducing unsocial hours payments to the bottom of the band and reinstating the agency-to-bank migration plan from a quality and governance perspective.
- **Enhanced Bank Rate Reduction;** Face-to-face sessions have been held with all affected wards, engaging both workers and NHSP. NHSP has also issued formal letters. Ongoing work is taking place with DDNs to **monitor fill rates** and ensure continuity of care.
- **Bank 2/3 Transition;** The transition project is complete for bank shifts, with a go-live date of 4th August. Rosters for all in-scope areas have been updated, enabling all relevant shifts to be released using the Band 3 code.
- **Agency Reduction**;- Reduce agency rate card for specialist areas down to SE caps in line with September SE ratecard.

Source: Temporary Resourcing – July 2025

Temporary Staffing: Mental Health



Mental Health Staffing Summary – July 2025

Total Temporary Staffing: 113 WTE (Whole Time Equivalent), increase of 11 WTE from the previous month.
Registered Mental Health Nurses (RMNs): 52 WTE (same as prior month), of which 32 WTE were agency and 20 WTE were bank staff.
Healthcare Assistants (HCAs): 61 WTE (increase of 11 WTE on prior month).
Year-on-Year Comparison: 12 WTE decrease compared to July2024 (32 WTE decrease in HCAs, 14 WTE increase in RMN requests).

Key Challenges & Actions

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

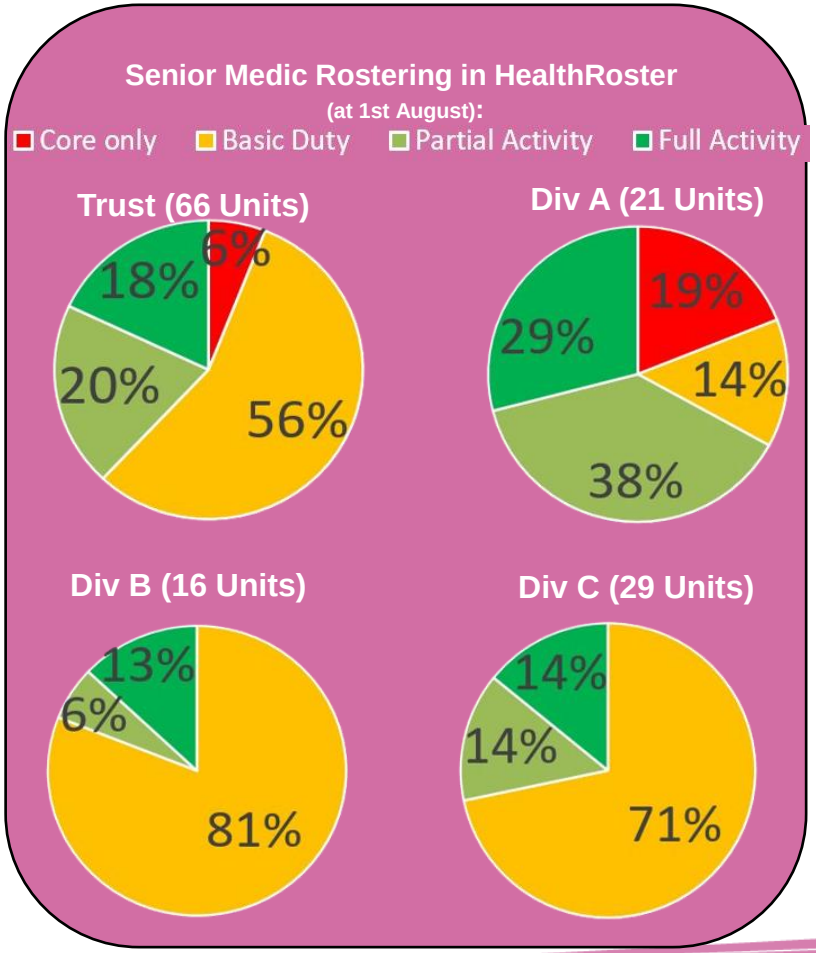
Active Workforce Management
The staffing hub team keeps detailed records of 1:1 Enhanced Care staffing requests. To improve data quality, a Microsoft Form has been introduced into the process to ensure consistent and accurate data collection.

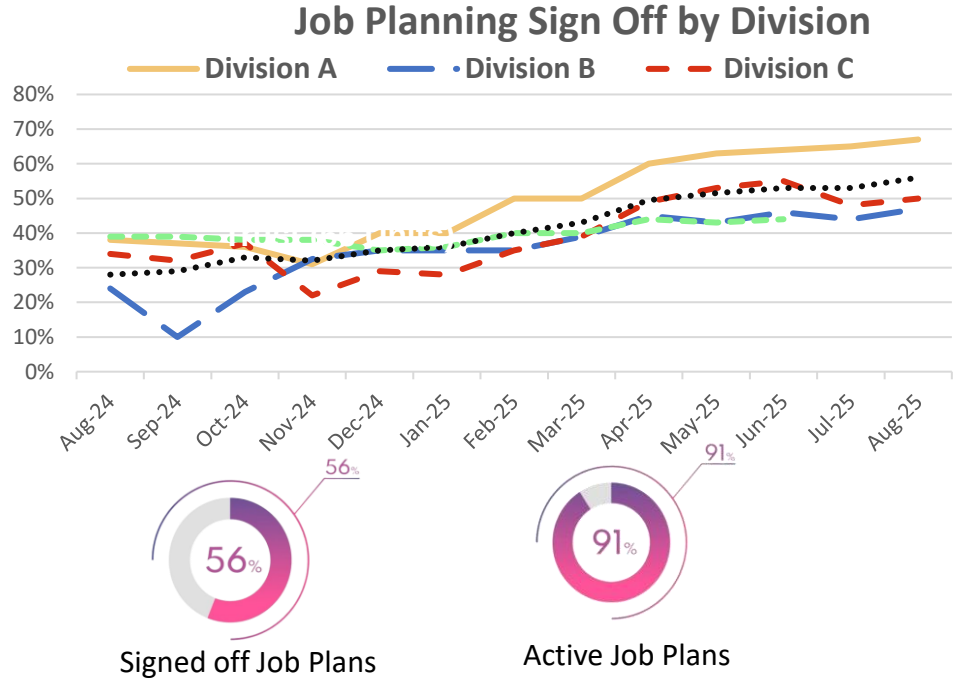
Shift from Agency to Bank Staff
Agency shift fill rates have declined, reflecting the ongoing efforts to transition mental health workers from agency contracts to **Bank** roles. This strategic shift aims to strengthen governance and workforce stability. However, it is important to note that current 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
There is 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.

Source: Temporary Resourcing - July 2025

Workforce: Medical Rostering and Planning



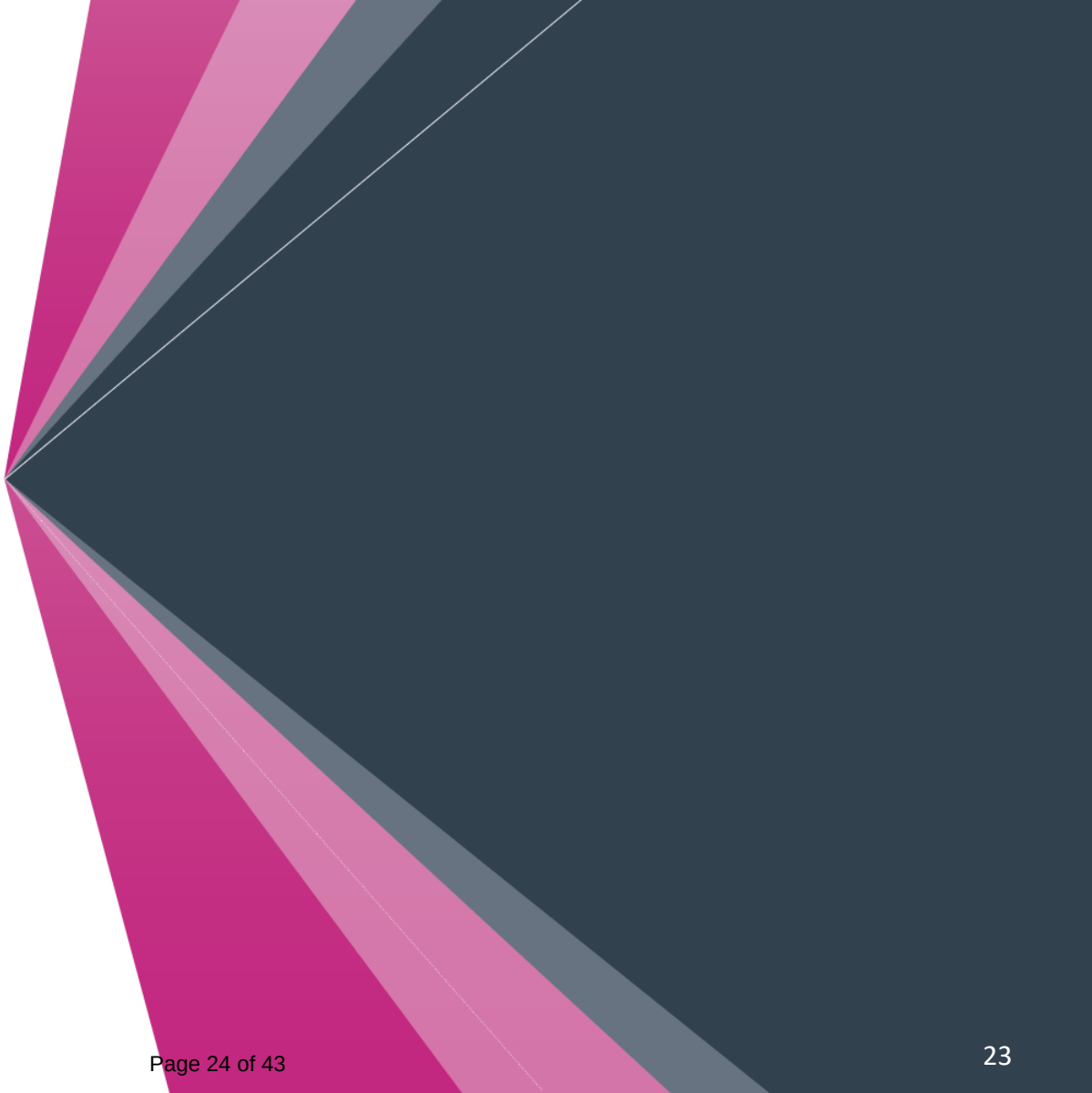


Signed off Job Plans

Active Job Plans

- Sign Off up 3% at 56%
- Active Job Plans steady at 91%
- Paper to improve Job Planning governance and progress supported by FIG
- Demand Planning
- Comprehensive review of activity choices across groups to improve data quality

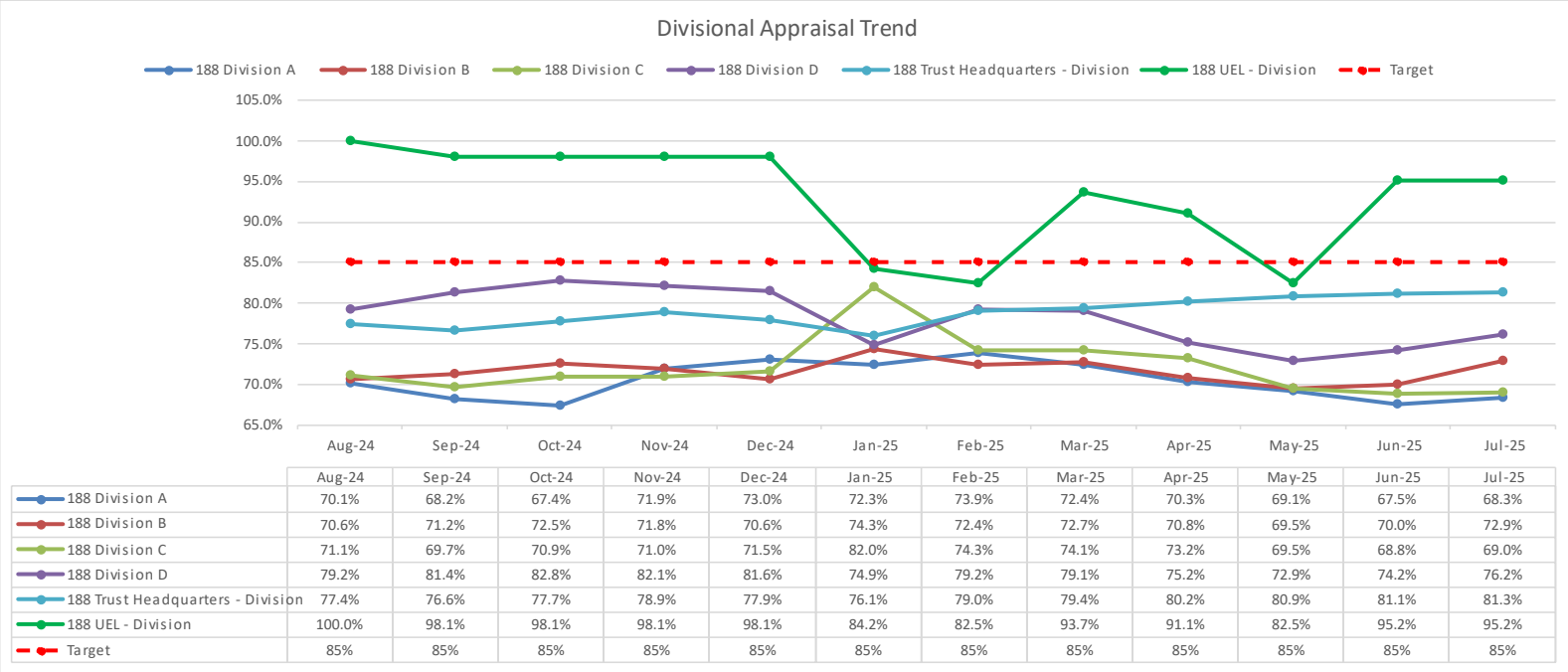
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 72% as of July 2025, same level as June 2025 (72%).

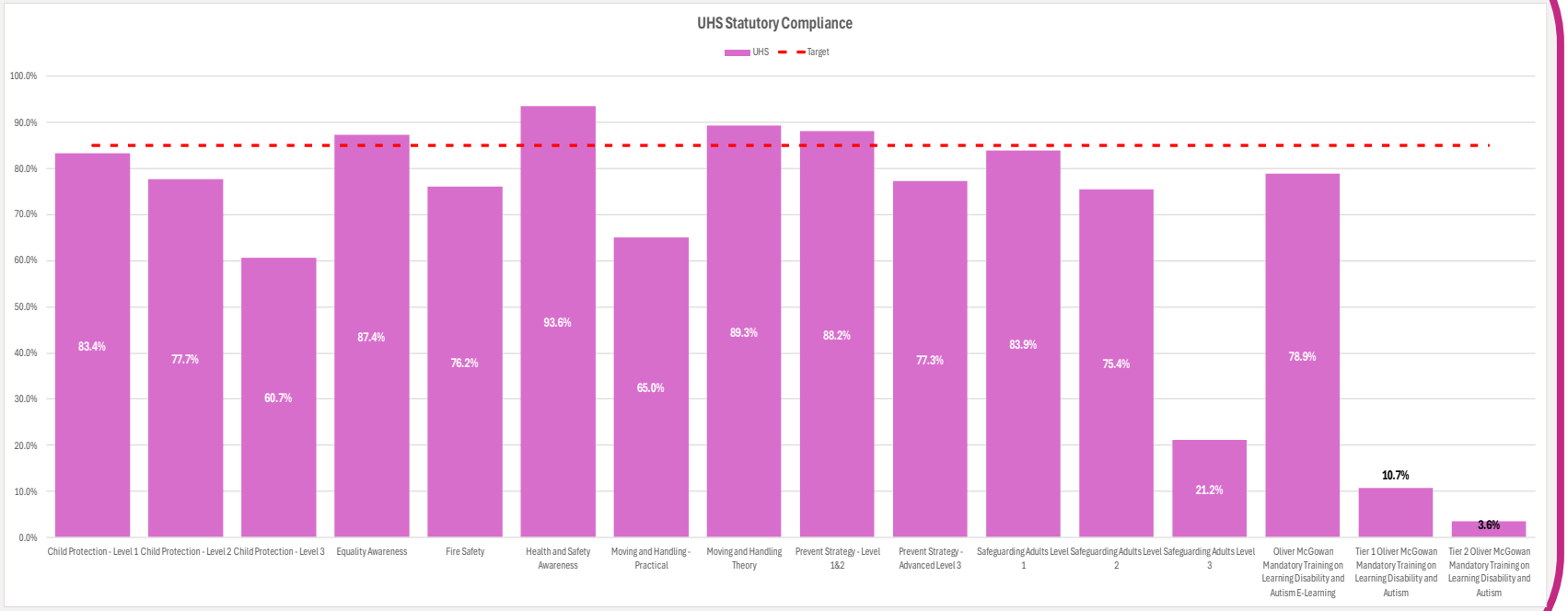


	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
188 Division A	70.1%	68.2%	67.4%	71.9%	73.0%	72.3%	73.9%	72.4%	70.3%	69.1%	67.5%	68.3%
188 Division B	70.6%	71.2%	72.5%	71.8%	70.6%	74.3%	72.4%	72.7%	70.8%	69.5%	70.0%	72.9%
188 Division C	71.1%	69.7%	70.9%	71.0%	71.5%	82.0%	74.3%	74.1%	73.2%	69.5%	68.8%	69.0%
188 Division D	79.2%	81.4%	82.8%	82.1%	81.6%	74.9%	79.2%	79.1%	75.2%	72.9%	74.2%	76.2%
188 Trust Headquarters - Division	77.4%	76.6%	77.7%	78.9%	77.9%	76.1%	79.0%	79.4%	80.2%	80.9%	81.1%	81.3%
188 UEL - Division	100.0%	98.1%	98.1%	98.1%	98.1%	84.2%	82.5%	93.7%	91.1%	82.5%	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 and THQ only (excluding Medical and Dental staff group) July 2025

UHS Statutory Compliance

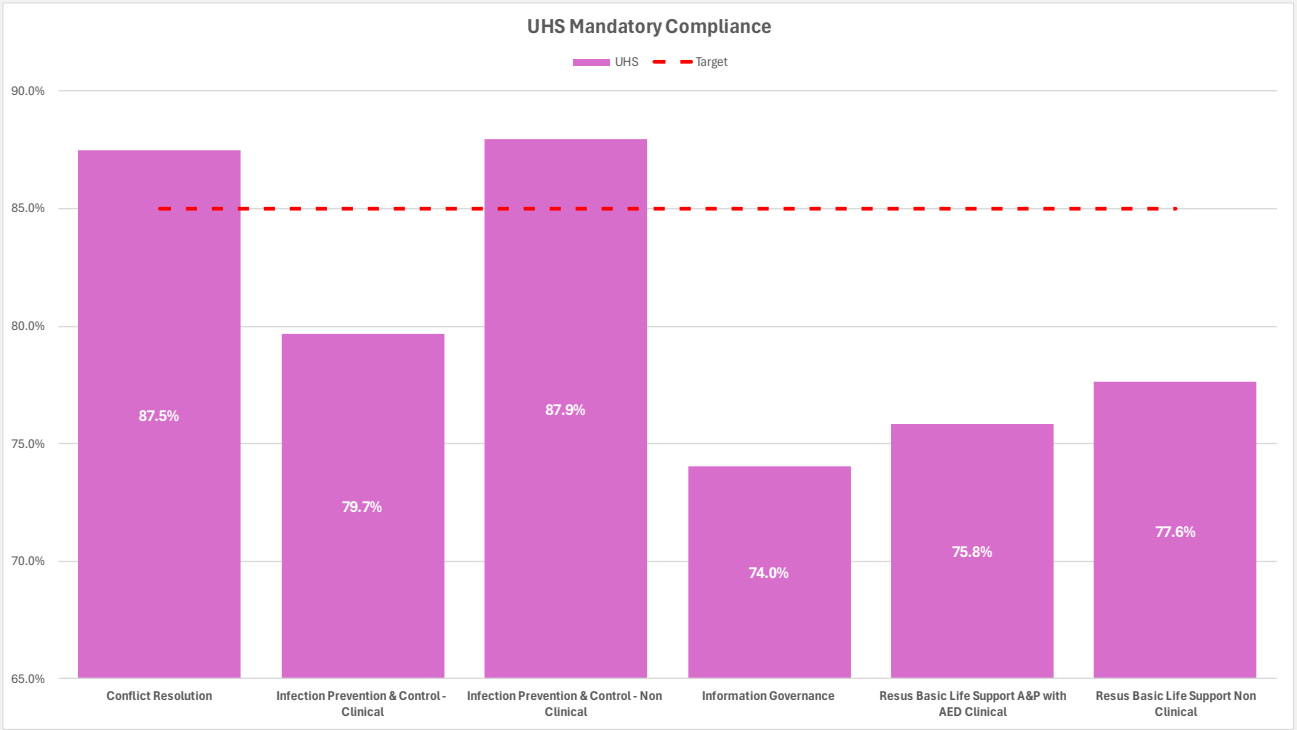
The Trust's average Statutory compliance rate for July 2025 is 67%, with 4 of 6 measures above the 85% target.



Source: Virtual Learning Environment (VLE) July 2025

UHS Mandatory Compliance

The Trust's average Mandatory compliance rate for July 2025 is 80%, with 2 of 6 measures above the 85% target.



Source: Virtual Learning Environment (VLE) July 2025

2025-2026 Staff Flu Vaccine Plan Summary

To address challenges faced in previous campaigns and to provide a multi-component approach as recommended by NICE, the following plans have been agreed through UHS People Board and TEC to aim to surpass the NHSE target of improving uptake by 5%:

- **Mobile clinics** – Pause all non-essential OH work and prioritise 56 mobile clinics in clinical areas for the initial stages of the campaign enabling frontline staff to be vaccinated without having to leave their department. OH will open fixed location drop-in clinics around the Trust later in the campaign.

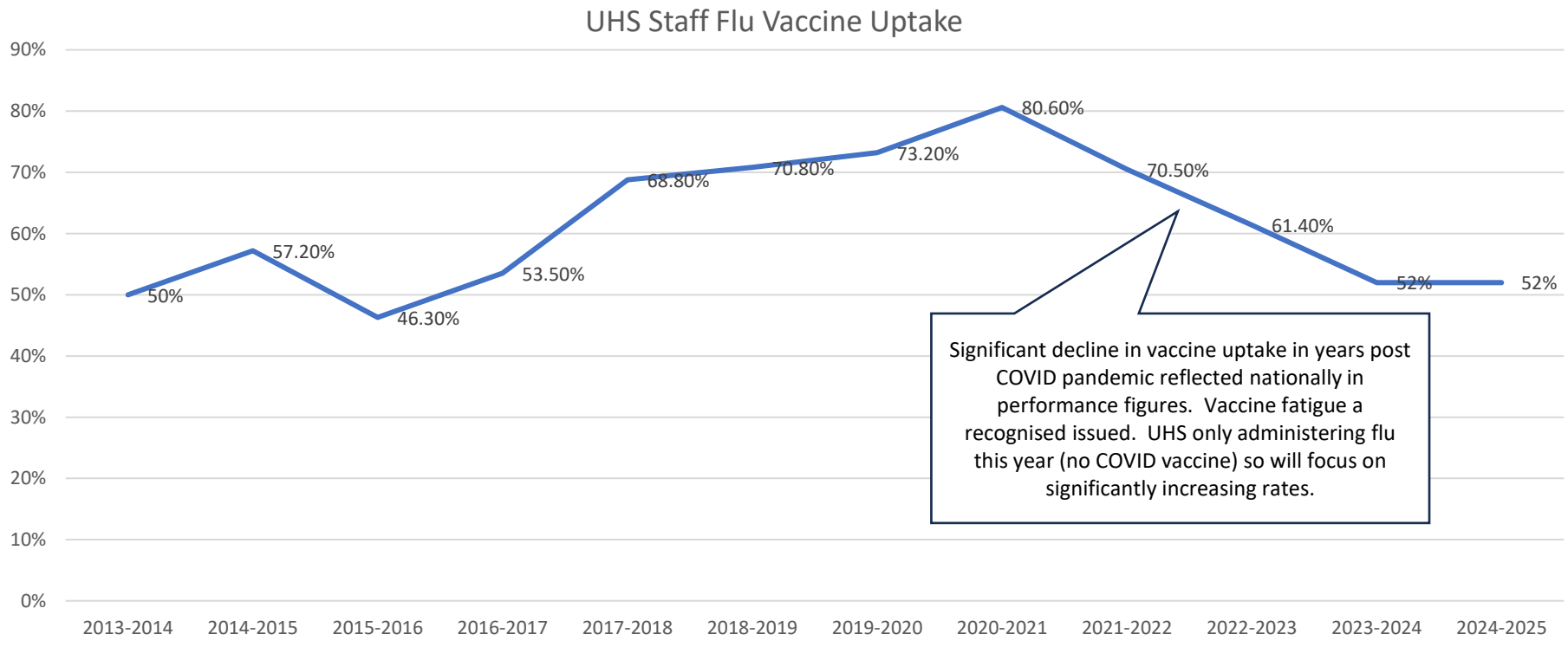
- **Senior support** – Clinical leaders are booking time with the vaccine team to join mobile clinics for positive advocacy. Plans in place for photo & video comms to address common vaccine misconceptions.

- **Communications** – Early and more regular communications to maintain momentum of the campaign and make clinics more visible to those particularly based away from the main hospital site. Targeted communications with those yet to be vaccinated encouraging attendance or to report if vaccinated elsewhere.

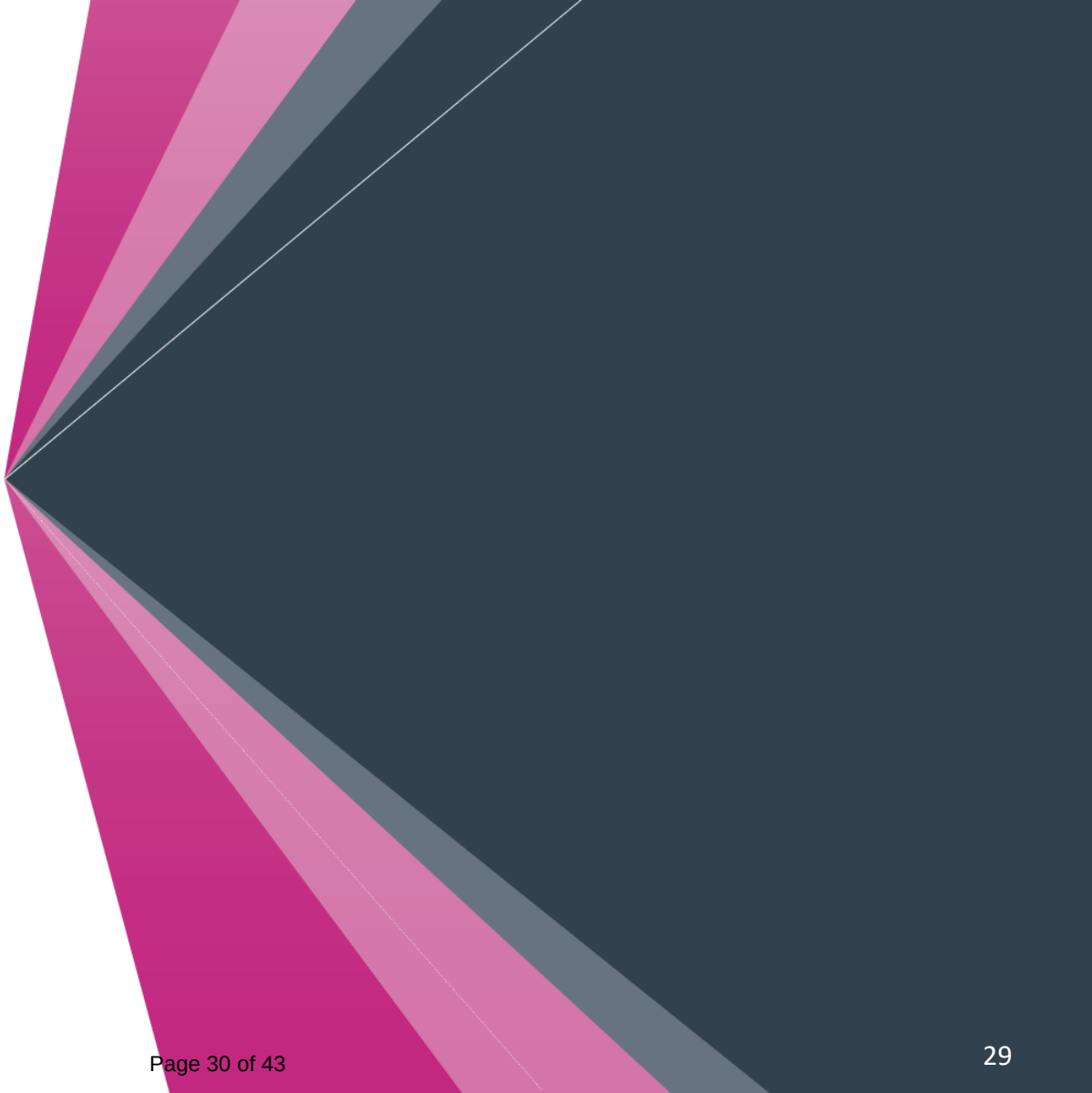
- **Peer vaccinators** – Employ the skills of our peer vaccinators and maintain regular contact with them to encourage more activity.

- **Reciprocal support** – A reciprocal agreement signed with Trusts in the ICB to vaccinate each other's staff if working away from the main site and on different premises.

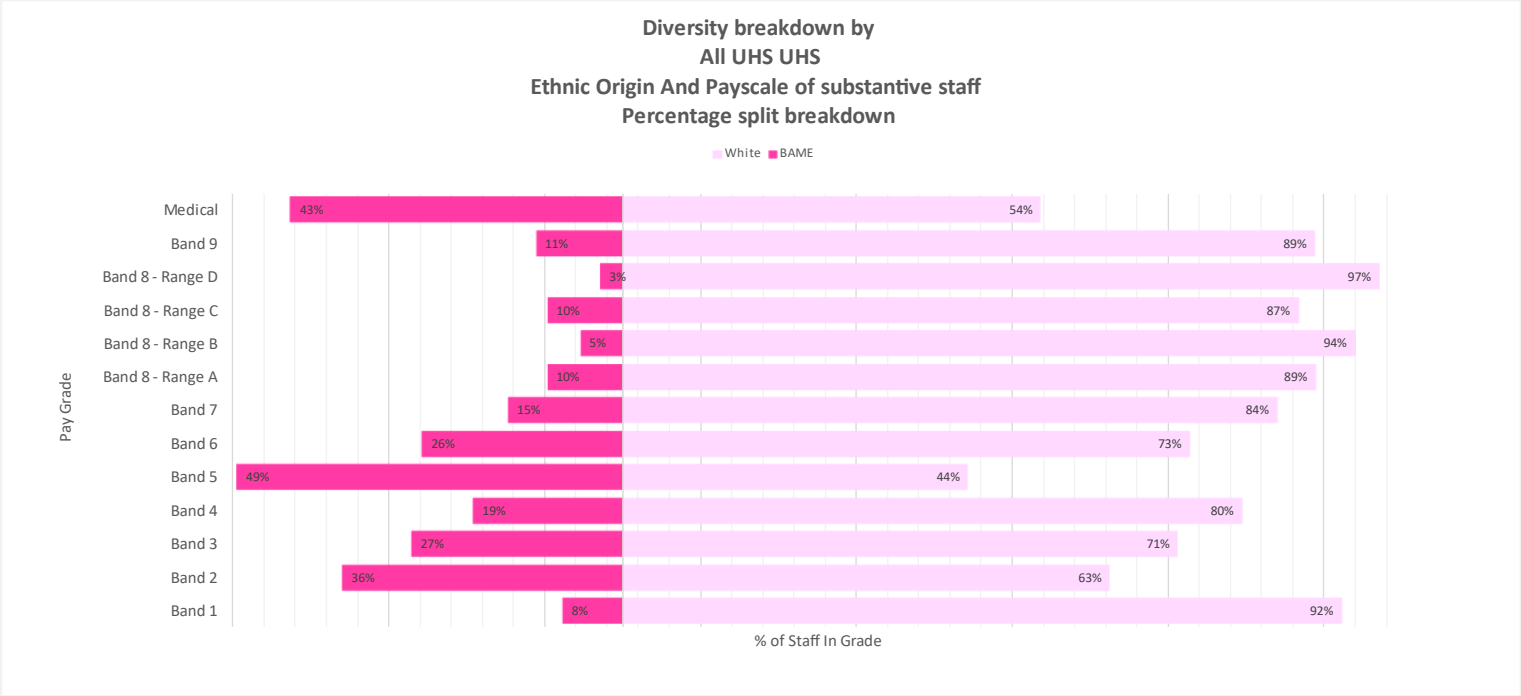
Clinical Staff Flu Vaccine Uptake over the last 10 years



BELONG

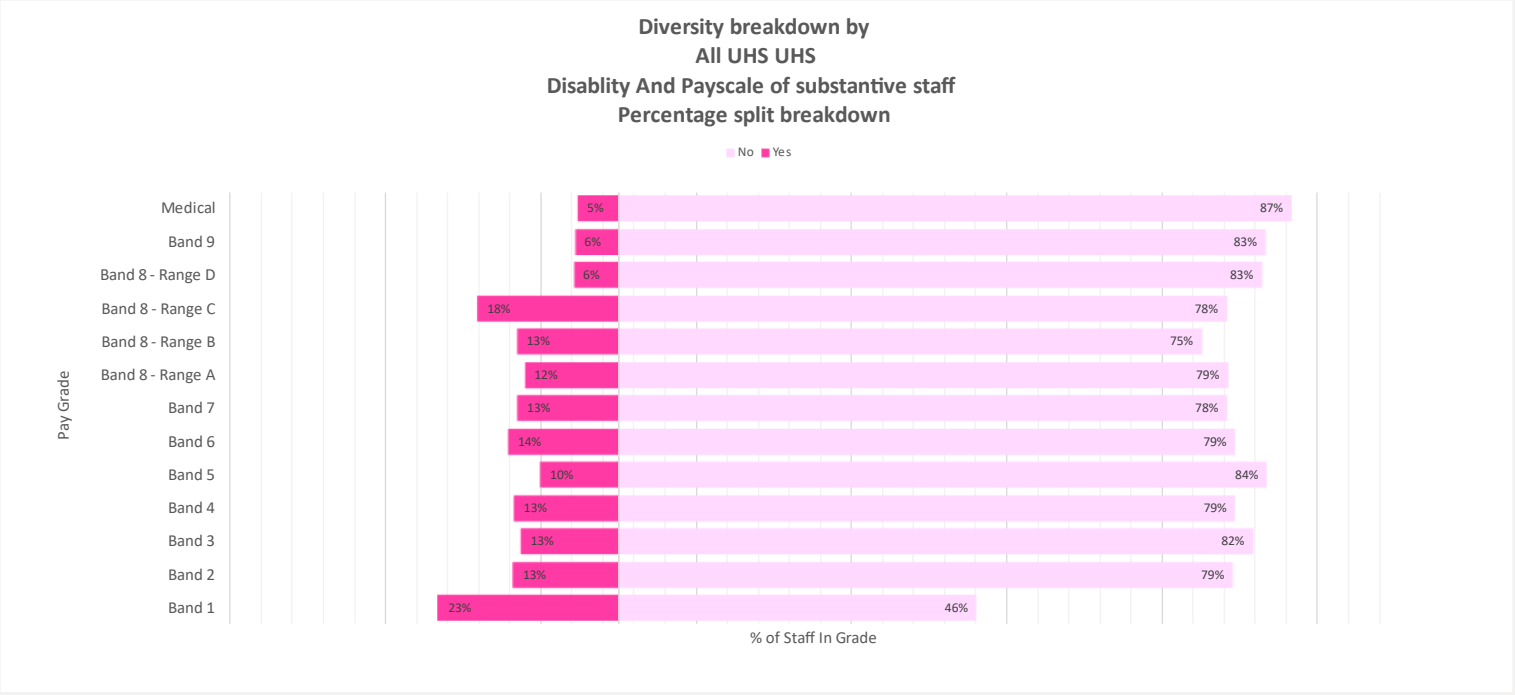


Staff in Post - Ethnicity



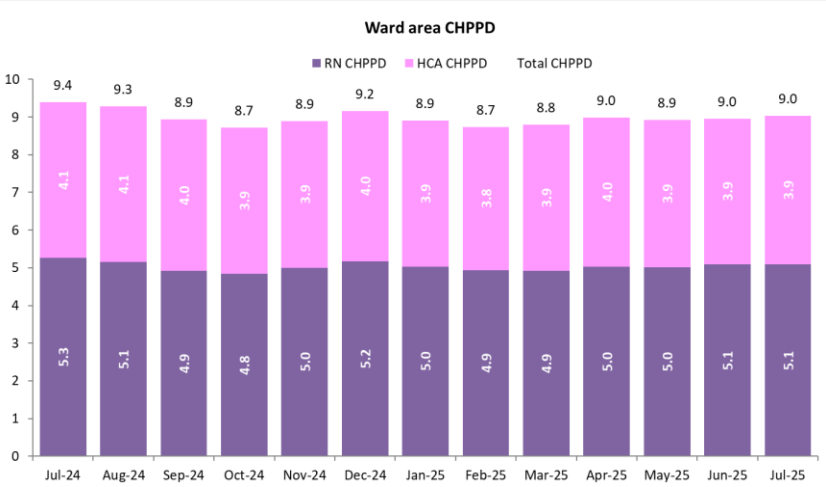
Source: ESR – July 2025

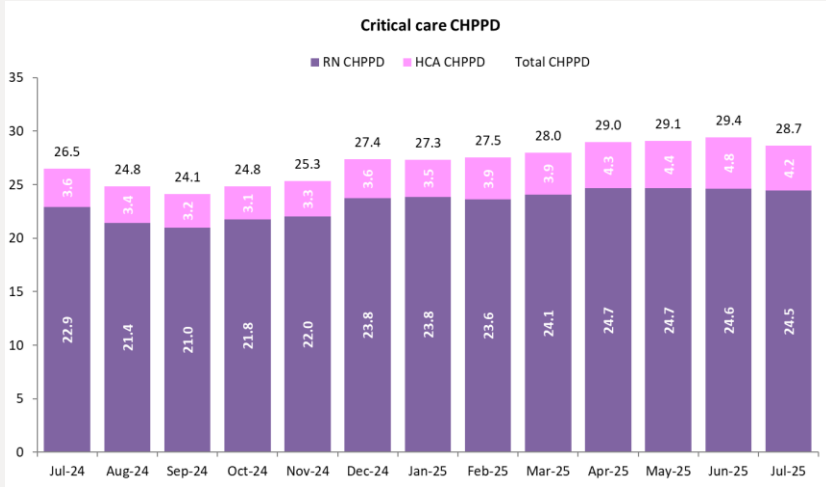
Staff in Post – Disability Status



Source: ESR – July 2025

CHPPD





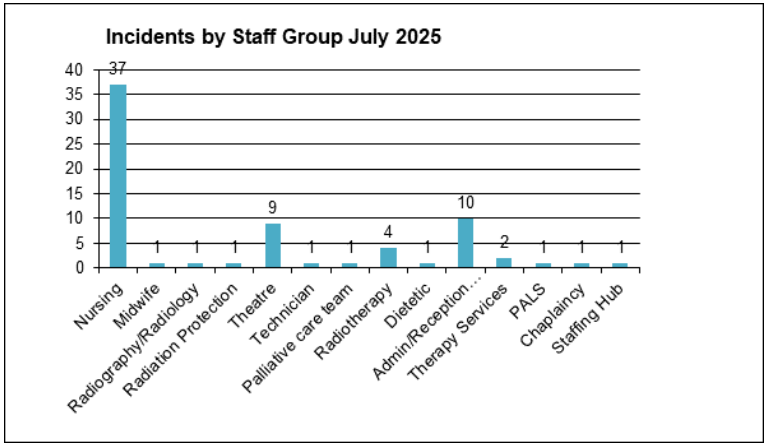
The Ward areas CHPPD rate for remained the same last month RN 5.1 (previously 5.1), HCA increased marginally from 3.87 to 3.95 overall, 9.0.

The CHPPD rate in Critical Care decreased overall last month from 29.4 to 28.7. RN decreased last month 24.5 (previously 24.6), while HCA decreased from 4.8 to 4.2.

Source: HealthRoster, NHSP & eCamis – July 2025

Patient Safety – Staffing Incidents & Red Flags

In total 72 incident reports were received in July 2025 which cited staffing. This is a slight decrease on the 81 reported in June.



Incidents by Division July 2025 vs June 2025

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
July 2025	17	14	25	12	3	72
Total	**17 ↑ (15)**	**14 ↓ (19)**	**25 ↓ (29)**	**12 ↓ (13)**	**3 ↓ (5)**	**72 ↓ (81)**

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
June 2025	15	19	29	13	5	81
Total	**15 ↑ (11)**	**19 ↓ (22)**	**29 ↑ (21)**	**13 ↑ (1)**	**5 ↓ (6)**	**81 ↑ (61)**

Source: Safeguard System July 2025

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

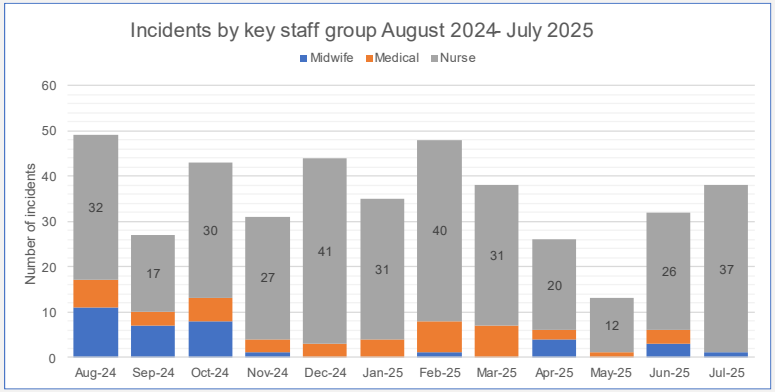
Div A:
Seventeen incidents reported in July 2025, up from 15 in the previous month. Red Flags were at the same level as last month.

Div B:
Fourteen incidents were reported in July 2025 (down slightly on the 19 in the previous month). There were 0 red flags reported compared to 10 in the previous month.

Div C:
Twenty-five incidents were reported in July 2025 (lower than the 29 in the previous month). There were 0 red flags reported.

Div D:
Twelve incidents reported in July (down from the 13 reported in the previous month). There were 3 red flags raised.

THQ:
Three incidents reported in July (5 in the previous month).



June 2025	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
	Delay in medication	4	1	3	0	0	0
	Delay in pain relief	6	0	5	1	0	0
	Delay in observations	2	0	1	1	0	0
	Less than 2 registered	2	0	1	1	0	0
	Total	**14**	**1**	**10**	**3**	**0**	**0**

May 2025	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
	Delay in medication	1	0	1	0	0	0
	Delay in pain relief	1	0	1	0	0	0
	Delay in observations	2	0	1	0	0	1
	Less than 2 registered	2	0	1	0	0	1
	Total	**6**	**0**	**4**	**0**	**0**	**2**

Source: Safeguard System July 2025

Delivery of the Workforce Plan

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 a number of key risks to the delivery of the plan which have been discussed and 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 including 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 £700k	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.	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) to complete between now and November. • Rejections on the basis of critical posts / affordability	Final exit November 2025
Temporary staffing	• FIG review of temporary staffing premium rates for A4C with proposals to consider actions made • Premium NHSP nursing rates in key areas are reducing in September. Discussions with staff affected have taken place during August. • Review of WLI and Bank expenditure for medical staff targeting high-cost areas • Introduction of additional controls on approval of bank shifts (2nd approval) within Allocate for all areas, including medical staff. • Detailed review of WLI / EDC at FIG and review of overtime.	Autumn
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

Leading through change workshops

The OD team have pivoted resources to focus on supporting our leaders and people through a difficult period of change:

- 323 delegates since May plus 146 delegates on the Operational Leaders in June including same content.
- Workshop dates to be booked via VLE up to Nov 25 - all with spaces.
- Piloting online workshops in August to make use of usual downturn plus 3 bespoke online workshops for a specific team.
- OD creating a bank of other resources for leaders to approach change and other team development interventions.
- New Wellbeing through Change workshop – For all - designed to focus on practical ways to deal with change impacting wellbeing. 2 pilot workshops in Aug/Sept bookable via VLE
- Most delegates so far from more junior/middle layer of leaders .
- Most common feedback is "waiting to know the impact to their team" with lots of discussions about a kind of “change limbo”. Also, lots of feedback about the impact of the recruitment pause on Admin roles and the wider clinical teams.
- Setting up a teams channel for all attendees to share messages and resources.

Appendices

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, 9 September 2025	
Title:	Learning from Deaths 2025-26 Quarter 1 Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Jenny Milner, Associate Director of Patient Experience

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 report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board.

The report also provides an update on the development and effectiveness of the medical examiner service.

The National Guidance on Learning from Deaths sets out expectations that:

Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced.

This paper sets out a plan to meet these requirements more fully.

1. The Trust reduces avoidable deaths in our hospitals.
2. The Trust promotes learning from deaths, including relating to avoidable deaths and reviews quality of end-of-life care.
3. The Trust promotes an open and honest culture and support for the duty of candour.

Contents:

N/A

Risk(s):

Risk 828 – Bereavement Services (reduced risk rating to 9 due to successful recruitment)

Equality Impact Consideration:	N/A

1. Introduction

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

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

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

2. Analysis and discussion

2.1 Deaths at UHS

Quarter	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Q1	540	483	504	512	466	500
Q2	516	591	526	471	446	
Q3	599	651	565	578	498	
Q4	644	537	489	558	552	
Total	2299	2262	2084	2119	1962	

During the first quarter of 2025/26, a total of 500 deaths were recorded across University Hospital Southampton (UHS) sites. This represents a 7.2% increase compared to 466 deaths in the same period of 2024/25.

Of the deaths recorded in Q1 2025/26:

- 21 occurred in the Emergency Department.
- The remaining 479 were among inpatients.

2.2 Summary Hospital-level Mortality Indicator (SHMI) *Calculated by NHSE*

The Summary Hospital-level Mortality Indicator (SHMI) measures the ratio between:

- The actual number of patient deaths following hospitalisation at a trust (or within 30 days post-discharge), and
- The expected number of deaths, based on national averages and adjusted for patient characteristics.

National context

Among the 118 NHS trusts included in the SHMI dataset for this period:

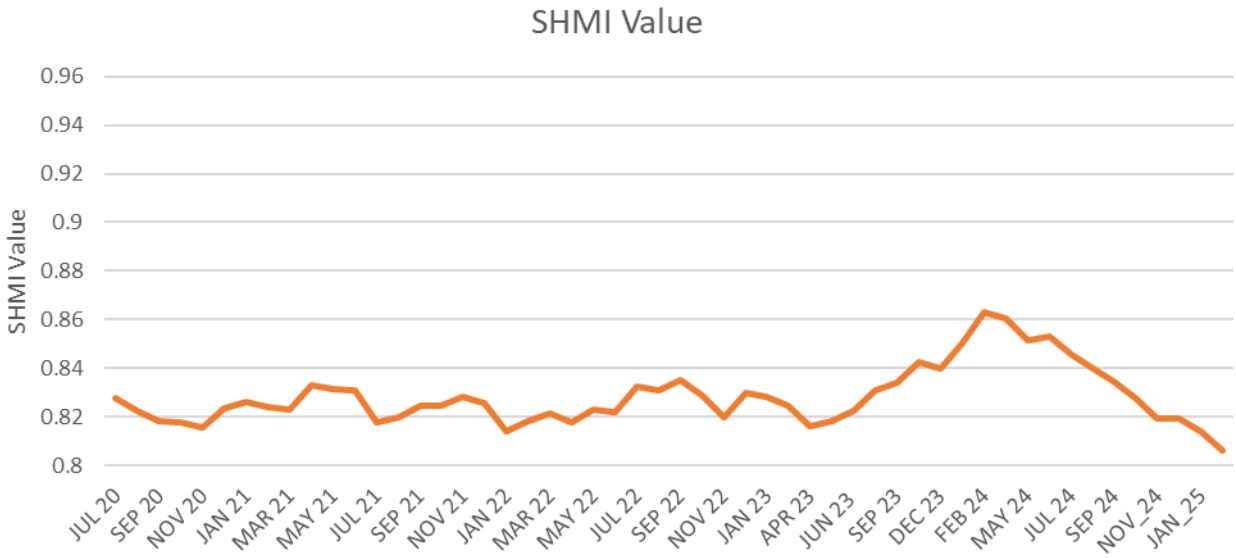
- 8 trusts recorded a higher-than-expected number of deaths.
- 99 trusts recorded an expected number of deaths.
- 11 trusts recorded a lower-than-expected number of deaths.

UHS performance

University Hospital Southampton (UHS) has consistently remained in the '*lower than expected*' category throughout the reporting period. Key highlights include:

- A SHMI score of 0.8064 for the 12 months ending February 2025.
- This represents a continued downward trajectory and is the lowest SHMI value recorded since the January 2018 – December 2018 period.
- UHS is one of only 11 trusts nationally to achieve a lower-than-expected mortality rate.

Note: As stated by NHS England (2025), the SHMI "should not be interpreted as indicating satisfactory or good performance."



SHMI values are calculated on a diagnosis level for the following diagnosis groups using the latest NHSE data published 10/07/25 for March 2024 to February 2025.

Diagnosis Group	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	0.9145	As expected
Cancer of bronchus; lung	0.8379	As expected
Secondary malignancies	0.7616	Lower than expected
Fluid and electrolyte disorders	0.5371	Lower than expected
Acute myocardial infarction	0.7586	Lower than expected
Pneumonia (excluding TB/STD)	0.8638	As expected
Acute bronchitis	0.4847	Lower than expected
Gastrointestinal haemorrhage	0.9045	As expected
Urinary tract infections	0.6109	Lower than expected
Fracture of neck of femur (hip)	0.7864	As expected

During the 12-month period ending February 2025, five diagnosis-level categories were classified within the 'as expected' range, while five were identified as 'lower than expected'.

Importantly, no diagnosis groups were classified in the 'higher than expected' band during this reporting period.

2.3 Medical Examiner Reviews

During Q1, the Medical Examiner Service reviewed a total of 1,137 deaths. Of these, 461 (41%) occurred at University Hospital Southampton (UHS) sites, while 676 (59%) were community deaths. This represents a 13% decrease compared to the 1,301 deaths reviewed in Q4 2024/25, which is consistent with expected seasonal variation.

A total of 67 acute deaths at UHS were referred to the Coroner, accounting for 14% of all UHS deaths. Of these referrals, 43% proceeded to further investigation via Coroner post-mortem or inquest, compared to 56% in the previous quarter. These figures remain broadly consistent with historical trends.

2.3.1 Referrals for Morbidity and Mortality (M&M)

During Q1, six deaths were referred by the MES to specialty M&M meetings, an increase from three referrals in the previous quarter. The referrals were distributed across the following specialties: Neuro ICU (2), D Neuro (1), D6 (1), and PICU (2).

Neuro ICU: One referral involved a significant post-operative surgical site infection. The M&M discussion did not identify specific areas for improvement. However, learning points included the importance of early discussions regarding treatment escalation plans that reflect the patient's wishes. In this case, the patient's deterioration was sudden, and decisions were made in their best interest.

Renal Patient (D6): Key learning focused on the management of diabetes in end-of-life care and renal failure. A proposal was made for the diabetes team to provide targeted education to ward staff. This action will be followed up by the M&M lead in collaboration with the Inpatient Diabetic Outreach Team. Additionally, concerns were raised about the patient being outlied to a medical ward (D6) instead of being placed in the appropriate renal ward (E12), an ongoing issue that continues to be addressed.

2.3.2 Referrals to LeDeR (Learning from Lives and Deaths – People with a Learning Disability and Autistic People)

During Quarter 1, the MES referred two deaths to the Patient Safety team for LeDeR reviews. While no concerns were identified regarding the quality of care provided, several commendable aspects were noted:

- Effective collaboration within the multidisciplinary team (MDT) and meaningful engagement with the family in end-of-life care discussions.
- Smooth and compassionate transition of care, allowing families to spend valuable and uninterrupted time with their loved one.

As highlighted in the Q4 2024/25 Learning from Deaths report, a significant case involving a patient with a learning disability remains under active review. The family continues to receive support throughout this process. This case has contributed to a broader Trust-wide initiative aimed at auditing all aspects of care provided to individuals with learning disabilities.

During Q1, a targeted audit was launched to examine key components of care, with a particular focus on the identification and response to 'soft signs of deterioration'—a nationally recognised theme in the review of deaths among patients with learning disabilities.

2.3.3 Patient Safety Referrals:

In Quarter 1, the Medical Examiner Service (MES) made three direct referrals to the Patient Safety team, alongside the initiation of a new Patient Safety Incident Investigation (PSII) involving a patient death. The open cases are summarised below:

- PSIRF Category: Failure to rescue.
  39-year-old patient with urosepsis and learning disabilities, concerns raised by the patient's mother regarding unrecognised and untreated pain and deterioration.

- PSIRF Category: Failure to rescue.
  Patient presented to ED with suspected femoral fracture, there were significant delays in gaining IV access due to high departmental acuity and multiple trauma cases, patient died in ED due to hypokalaemia.

- PSIRF Category: Failure to rescue / fall.
  Patient stumbled or sustained a fall, injury mechanism unclear, transferred to Trauma and Orthopaedics but not optimised for surgery, patient then palliated.

No PSIIs involving patient deaths were closed during Quarter 1. As a result, no new learning was identified during this period.

2.4 UHS 'End of Life' incident reports

For Q1, there were a total of 29 incidents reported relating to end-of-life care. Overall, the main themes of the incidents were related to:

- Privacy in death. 13 incidents were reported in which patients died in multi-bed bays rather than in private side rooms. These occurrences were primarily due to limited availability of side rooms and constraints related to infection control. The issue has been escalated to both care group and Trust-level management, and clinical teams have been instructed to report such incidents as they occur.

  Of the 13 cases, nine occurred within the Cancer Care service. Over half of these incidents resulted in significant distress for both families and other patients in the bay, many of whom required additional emotional support. Cancer Care has formally recorded the limited side room capacity on their care group risk register, with the associated risk currently scored at 16.

- Communication. Themes identified include inadequate guidance regarding body viewings, delays in communicating the time of death, and miscommunication surrounding DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions.

- Lack of Commissioned Specialist Paediatric Palliative Care On-Call Service. Over two separate weekends, the absence of a commissioned specialist paediatric palliative care on-call service impacted two cases. In both instances, oncology advice was provided by staff

members who were not officially on-call. These individuals intervened out of concern that, without their input, the patients' conditions and deterioration would not have been optimally managed.

Both Adverse Event Reports (AERs) highlighted that paediatric symptom management was 'complex and beyond the expertise of the oncology consultant team'. Following review, the care group's risk score has been increased. A visit to the local hospice is planned to explore a potential joint cover initiative. Due to current financial constraints, the care group has not yet committed to developing a formal business case.

- Improper management of implants. On two separate out-of-hour incidents, wards were unable to deactivate implantable devices, resulting in dying patients receiving inappropriate shocks intended to prolong life. This caused significant distress for families.

  Upon investigation, one incident revealed that an established care plan had not been followed, while the other highlighted a lack of awareness regarding out-of-hours device management. In response the Clinical Practice Educator for Palliative and End of Life Care has implemented targeted interventions including individual training, rapid-response simulations (trolley dashes), and broader communication efforts to prevent recurrence. Initial feedback from Ward D12 indicates that these measures have already led to improved practice in recent cases.

2.5 Learning from UHS complaints relating to End-of-Life care

During the first quarter, three cases were subject to formal investigation. The primary learning identified across these cases highlighted the critical importance of conducting sensitive conversations with families in designated quiet rooms. This practice supports a more compassionate and respectful environment, ensuring privacy and emotional safety. Furthermore, the investigations underscored the need to avoid creating a sense of urgency or time pressure during these interactions, allowing families adequate time to process information and ask questions.

3. Morbidity and Mortality (M&M) data capture & standardisation

The preferred system for capturing data to support Trust-wide learning from M&M outcomes is currently in the procurement phase. The associated cost is minimal, as the system is an add-on to the existing Ulysses platform already in use across the Trust for recording adverse events.

The next phase will focus on implementation. To support this, the Trust-wide Clinical Lead for M&M will be conducting a survey of all M&M Clinical Specialty Leads. The aim is to identify any barriers to standardising processes and developing a consistent framework that all M&M reviews can broadly follow.

Agenda Item 5.12	**Report to the Trust Board of Directors, 9 September 2025**
Title:	Annual Complaints Report 2024-25
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Jenny Milner, Associate Director of Patient Experience

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:

- Our three most frequently reported complaint themes are clinical treatment, communication, and patient care which are consistent with national trends.
- The volume and nature of complaints received demonstrate seasonal variation, in line with historical patterns.
- The proportion of complaints that are fully upheld remains significantly below the national average, providing assurance of overall complaint service quality.
- Learning and improvement is demonstrated with examples where service improvements have been implemented directly as a result of learning from complaints.

Contents:

Annual Complaints Report 2024-25

Risk(s):

Risk 827: PALS Response time

Equality Impact Consideration:	N/A

Definition of terms

Everyday Conversation

This terminology is used for the general enquiries / low levels of dissatisfaction that come into the PALS team, they are classed as low-level immediate resolves or general enquiries.

Complaint – Early Resolution

This is classified as successful intervention between PALS and the relevant UHS teams, in which the resolve has avoided progression to the formal complaints process. It is a complaint that can be managed more quickly and less formally by PALS.

Complaint – Taking a Closer Look

This is classified when PALS are unable to offer a resolve and / or the complaint is complex and needs a formal review and action plan or response. The closer look allows for teams to formally contribute to a response letter. These are managed by the Complaints team.

Parliamentary and Health Service Ombudsman (PHSO)

The PHSO will investigate complaints that the complainant feels have not been resolved by the Trust.

PALS

Patient Advice and Liaison Service.

1 Purpose of report

This report presents an overview of the complaints received by University Hospital Southampton NHS Foundation Trust (UHSFT) during the period from 01 April 2024 to 31 March 2025. It has been prepared in accordance with the requirements set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

2 Complaints activity

A seasonal trend in complaint volumes is evident, with an increase typically observed during the winter months and a lower volume in July. In December 2024, the PALS team undertook a focused effort to address a backlog of early resolution cases, some of which progressed to formal complaints. This activity contributed to the upward trend in complaint volumes recorded between January and March.

Complaints received

	2021/22	2022/23	2023/24	2024/25
Complaints – Early Resolution*	2,434	2,048	1,546	265
Complaints – Taking a Closer Look	388	413	403	436
Total Complaints	**2,822**	**2,461**	**1,949**	**701**

**Complaints – Early Resolution* previously known as Concerns prior to March 2023*

The Parliamentary and Health Service Ombudsman (PHSO) introduced new complaint standards requiring that all expressions of dissatisfaction be recorded as formal complaints. Full implementation and standardisation of this approach was not achieved until October 2023, which accounts for the reduction in 'Early Resolution' data during that period. The data presented for 2024/25 represents the first complete year under the new PHSO standards and provides an accurate reflection of the early resolution activity undertaken by PALS.

Although 'Everyday Conversations' are not analysed in depth within this report it is important to note that the Trust recorded a total of 8,096 informal interactions during the reporting period. These engagements represent ongoing dialogue between patients, families, and staff, and provide valuable insights that contribute to a broader understanding of the patient experience. This includes cases that were previously recorded as concerns but are no longer recorded as early resolution under PHSO guidance, which is indicative of the significant drop in early resolution cases.

The number of formal complaints, as detailed in the Complaints – Taking a Closer Look section, has remained broadly consistent with previous reporting periods, indicating a stable trend in the volume of concerns formally raised.

Complaints (Taking a Closer Look) upheld

	2021/22	2022/23	2023/24	2024/25
Complaints received	388	413	403	436
Complaints upheld	41	44	39	45
Complaints partially upheld	125	163	133	111
% complaints upheld or partially upheld	43%	50%	42%	36%
National comparison	66%	60%	50%	67%

In 2024/25, the proportion of complaints upheld or partially upheld by UHSFT decreased to 36%, with 16 fewer upheld cases compared to 2023/24 despite a year-on-year increase of 33 total complaints. Notably, UHSFT continues to benchmark below national averages for upheld complaints. While interpretation of this data may vary, further assurance is provided by the Trust's consistently low number of referrals to the PHSO.

A total of 3 cases were closed and partially upheld in 2024/25 by the PHSO, and none were fully upheld. The PHSO data only reflects where a preliminary investigation has been launched. Cases that are referred to PHSO but do not meet the threshold for an investigation are not reported.

Complaint themes

UHSFT	NHS (National)
Clinical treatment (28%)	Clinical treatment (27%)
Communications (20%)	Communications (17%)
Patient care (14%)	Patient care (12%)

The national NHS data is sourced from the 'Data on Written Complaints in the NHS 2023–24' report, published in October 2024. At the time of writing, data for 2024/25 has not yet been released.

The three complaint themes from the Trust this year have been consistent for at least the past five years. As per previous years, it is difficult to extrapolate patterns within complaints as complaints typically concern a very personal experience within a service, or services. The Complaints team regularly report to both divisional and care group governance teams on complaints activity, ensuring that any themes or disproportionate rises in cases would be discovered promptly and addressed.

3 Parliamentary and Health Standards Ombudsman (PHSO)

Review of PHSO cases

	2021/22	2022/23	2023/24	2024/25
Complaints closed	2	1	2	3
Complaints upheld	0	0	0	0
Complaints partially upheld	1	1	2	3

There are currently 8 open complaints being reviewed by the PHSO

Of the 3 complaints investigated and closed by the PHSO in 2024/25, all 3 were partially upheld:

- A complaint regarding a patient fall (patient without memory who was not in the line of sight of his 1:1 carer whilst using the toilet). Graded as 'Partially Upheld' (UHS graded as 'Not Upheld'). PHSO requested an action plan for the clinical area and financial remedy to complainants' family of £200.

- A complaint regarding a diagnosis that could have been six days sooner. This did not happen because red flag symptoms were not properly recognised and the two weeks wait pathway was not appropriately followed. Graded as 'Partially Upheld' (in line with UHS grading). PHSO requested an action plan and financial remedy to the family of £500.

- A complaint regarding failure to obtain an accurate weight of a patient and subsequently leading to an inaccurate prescription of an anticoagulation medication. This was graded as 'Partially Upheld' (in line with UHS grading). PHSO requested an action plan and financial remedy to complainant of £900.

It is important to note that escalation of a complaint to the PHSO may not completely align with the complaint made to UHS, such as when the complainant is satisfied with some of the complaint response by UHS but wishes to escalate any areas they are dissatisfied with. As a result, how UHS grades the complaint and how the PHSO grades it may not always be fully aligned.

4 Examples of learning from complaints

Identifying learning from a patient or family complaint is a vital component in the complaints and feedback process.

Patient Weight Recording – Quality/Safety Improvement Initiative
Following the closure of a case by the Parliamentary and Health Service Ombudsman (PHSO) and a thematic review of patient safety incidents, an emerging concern was identified regarding the inaccurate documentation of patient weights. In response, a Trust-wide initiative was launched in Q4 2024/25 to enhance the accuracy of patient weight measurements.

As part of this initiative, Matron Walkabouts in February 2025 included a focused audit on weight recording practices. This audit encompassed 39 clinical areas and reviewed 160 sets of patient notes. The findings led to the development of targeted, actionable improvements. The outcomes and key learning points from this audit have been disseminated across multiple clinical forums to support shared learning and drive sustained improvement in clinical documentation standards.

End-of-Life Care: Complaint and Learning Summary

A formal complaint was received concerning the quality of end-of-life care provided to a patient, highlighting three key areas of concern:

- Unmet care needs
- Inadequate pain management
- Poor communication with the patient's relatives

Following a thorough review, several areas for improvement were identified and actions implemented:

Key Learning and Actions Taken:

- Timely Family Communication: Emphasis placed on prompt and proactive contact with families when a patient's condition deteriorates.
- Infection Prevention Education: Targeted education sessions introduced to reinforce best practices in infection prevention.
- Manual Handling Audits: Matron-led audits initiated to assess and improve manual handling practices specific to end-of-life care.
- Compassionate Care Feedback: Constructive feedback shared with the clinical team regarding compassionate care. This has led to the development of a new infographic for families and carers, outlining how to escalate concerns directly to ward leaders.

Governance and Oversight:

This improvement work is being led by the Chief Nursing Officer and is governed through the End of Life Programme Board. The initiatives are currently being rolled out Trust-wide to ensure consistent, compassionate, and high-quality end-of-life care.

Agenda Item 5.13 Report to the Trust Board of Directors, 9 September 2025	
Title:	Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Liz Brown, Medical HR Operations Manager

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				

Executive Summary:

(a) The framework published by NHS England is designed to allow the organisation to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement.

(b) The focus of the central appraisal teams has been on improving appraisal compliance rates, ensuring access to appraisal for all connected doctors and continuing to improve appraisal quality. The responsible officer (RO) has a statutory duty to ensure compliance with NHS England and GMC requirements for appraisal and revalidation. The Chief Medical Officer is the RO for the Trust.

(c) The Board is asked to note the summary information included in this report and approve the "Statement of Compliance" at Appendix A, confirming that the organisation, as a designated body, is compliant with the medical profession regulations.

Contents:

Paper (template outlined by NHS England), Appendix A – Statement of Compliance

Risk(s):

None, the Trust remains compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013) and related guidance.

Equality Impact Consideration:	N/A

Appendix A

Section 1 – General:

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

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

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

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

Y/N	Yes
Action from last year:	Renewal of appraisal software licence.
Comments:	The SARD licence was successfully renewed. Three full appraisal cycles have now been completed on the electronic appraisals system, compliance rates have continued to remain over 87% and evidence for revalidation recommendations can be easily accessed. The Deputy RO and Trust appraisal leads support the RO with the day-to-day responsibility for delivering medical appraisal. This includes the development of policy, appraiser training and quality assuring the process. The Medical HR team supports the RO with all associated administration and reporting.
Action for next year:	Recruitment for the Trust appraisal lead, in preparation for one lead retiring in December 2025.

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

Y/N	Yes
Action from last year:	Maintain monthly review of connections and ensure communication between the responsible parties continues.
Comments:	The medical appraisals and revalidation officer sits as part of the wider medical HR team. Recruitment and management of connected doctors' contracts is carried out in partnership. All connections are reviewed and managed by the appraisals officer via the SARD platform.
Action for next year:	Continue to seek improvement to existing processes and ensure accurate connections are maintained.

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

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

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

Y/N	No
Comments:	UHS has not had a further peer review. Internal process review and quality assurance exercises have been completed. The Trust uses this information to make changes and address any areas of concerns.
Action for next year:	Continue programme of process review and annual quality assurance exercise.

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

Y/N	Yes
Action from last year:	Continue to monitor and if it is identified that this group are struggling to access support and appraisal a review will be taken, and remedies implemented.
Comments:	Limited numbers of long-term locums and bank only doctors have meant as yet standalone appraisers for the group have not been established. The central appraisal team, care group appraisal leads, and the Trust appraisal leads support as required.
Action for next year:	None, will take appropriate action if required.

1B – Appraisal

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

Y/N	Yes
Action from last year:	Continue to focus on managing annual compliance rates.
Comments:	Good medical practice recommendations have been incorporated into SARD and the appraisal form updated. The appraisal conversation covers whole scope of practice including complaints and significant events.
Action for next year:	Continue to enable access to appraisals, supporting individuals who find the appraisal process challenging.

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

Action from last year:	Continue to focus on managing annual compliance rates.
Comments:	Compliance rates have continued to rise across the appraisal year, with a current average of 88.88%. Doctors with overdue appraisals are contacted and reminded of their responsibility to complete their appraisal. Automated reminders via the appraisal system highlight approaching and overdue appraisals and remind doctors of their obligation. A list of doctors with an overdue appraisal of 3 months or more without an acceptable reason are reviewed regularly and escalated as appropriate. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process.
Action for next year:	Further work with DCDs and appraisal leads to manage non-compliance.

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

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

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

Y/N	Yes
Action from last year:	Work with the Trust Appraisal leads to identify ways to increase appraiser numbers and succession plan.
Comments:	Consultant appraisers have increased by 17 to 193, two training courses for new appraisers are run each year. Trust appraisal leads and care group appraisal leads encourage others to become appraisers and it has been agreed that newly appointed consultants can attend the training if keen to be appraisers. We remain compliant with the recommended ratio. Ratio is currently 1:6
Action for next year:	Remain compliant with recommended ratio and continue to run courses for 2026

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

Y/N	Yes
Action from last year:	Training course feedback to move to an online collection mechanism to support improved development.
Comments:	Action completed; all training courses have electronic feedback mechanisms which supports continued improvement. Appraisers have access to regular training, bi-annual update sessions and appraiser feedback reports support professional development. Existing appraisers are reminded on the requirement to refresh their training as appropriate. Annual quality assurance exercise undertaken and detailed report shared with appraisal leads and the Decision-Making Group. 287 appraisals were reviewed, 96.5% scored between 75% and 100%. Those scoring less than 75% were reviewed by the Trust appraisal leads and this will be shared with the department appraisal leads so a constructive conversation and feedback can be given to the appraiser to allow them to reflect on their outputs and provide additional training. NHS England recommend achieving at least 20% appraisee completion of feedback questionnaires each year, with the results being fed back to the appraiser annually. We achieved an overwhelmingly positive 80% response rate for our consultant appraisers. The qualitative data demonstrates a high level of skills among the appraisers. Doctors comment that they feel supported and motivated through discussions with appraisers.
Action for next year:	Review training content when new Trust appraisal lead joins the team.

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

Y/N	Yes
Action from last year:	Trust appraisal leads to review further appraisal output forms for the 5 appraisers who scored between 50% and 74%. Outcomes to be shared with the department appraisal leads which will allow for a constructive conversation and feedback session to take place.
Comments:	Action completed. In the 2024/25 QA review round: 287 ASPAT questionnaires were sent out, 2 for each or our trust consultant appraisers. • **275 out of 287** appraisals with a completed ASPAT questionnaire have scored between 75% and 100% • **8 out of 287** appraisals with a completed ASPAT questionnaire have scored between 50 % and 74%

	• **2 out of 87** appraisals with a completed ASPAT questionnaire have scored 49% or lower All doctors are asked to rate the quality of appraisal and the suitability of the appraiser. 98% of appraisees rated their appraiser as very good or good. Full report shared with the Decision-Making Group.
Action for next year:	Continue with annual programme of review and ongoing training.

1C – Recommendations to the GMC

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

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

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

Y/N	Yes
Action from last year:	Further improvement of non-compliant rates. • Implementation of bi-monthly report to care group appraisal leads. • Leads to then offer support and guidance to minimise missed appraisals.
Comments:	Action completed, full review of individuals with multiple missed appraisals undertaken and support provided by appraisal leads. DCDs involved as required. Improvements made with those individuals and overall compliance rate improvements which supports prompt recommendations. The review process begins well in advance of the revalidation recommendation date and the appraisal team highlights the outstanding actions to the doctors, the DCD and the RO. Where a deferral was recommended, the doctor was notified with confirmation of the actions required.
Action for next year:	Maintain proactive approach to managing recommendations and identify any missing requirements as early as possible.

1D – Medical governance

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

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

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

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

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

Y/N	No, all information is accessible but not compiled into a single report.
Action from last year:	Trust appraisal leads to explore improved reporting opportunities with the governance team.
Comments:	Action completed; improvements explored but without a replacement system improvements are limited. The current governance systems for complaints, serious incidents and risk incidents are not easily searchable and a total combined report if not accessible. For all complaints where a doctor is named, the individual is asked to respond. This should be captured in the annual appraisal and reflections undertaken. CMO and Appraisal Leads have met with governance teams before to discuss and review systems limitations. Sufficient information is available for appraisal was combined with self-reporting, reflection, and a probity statement.
Action for next year:	None, requirement to access information from existing systems.

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

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

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

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

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

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

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

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

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

Y/N	Yes
Action from last year:	Appraisal leads to look at appraisal guidance with specific mention of 'response to national reports and reviews'.
Comments:	Action completed. As part of the move to 'new' appraisal form in SARD (GMC GMP 2024) we have been able to incorporate our own prompts. In domain 3 this prompts appraisees to reflect and comment on this area as applied to their area of practice and appraisers to discuss at the appraisal meeting.
Action for next year:	None.

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

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

1E – Employment Checks

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

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

1F – Organisational Culture

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

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

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

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

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

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

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

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

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

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

1G – Calibration and networking

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

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

Section 2 – metrics

Year covered by this report and statement: 1st April 2024- 31st March 2025.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	1499
Total number of appraisals completed	1103
Total number of appraisals approved missed	265
Total number of unapproved missed	131
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	387
Total number of late recommendations	0
Total number of positive recommendations	281
Total number of deferrals made	106
Total number of non-engagement referrals	0
Total number of trained case investigators	10
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer	7
Total number of concerns processes completed	5
Longest duration of concerns process of those open on 31 March (working days)	525 working days
Median duration of concerns processes closed (working days)	84 Working days
Total number of doctors excluded/suspended during the period	3
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	356
Total number of new employment checks completed before commencement of employment	356
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld	0

Section 3 – Summary and overall commentary

General review of actions since last Board report:	
All actions from the 2024/25 report have been completed in year.	
Actions for next year:	
Move to electronic multi-source feedback only	Access to electronic feedback mechanisms is well established. A move away from paper will improve efficiency, support the Trust environmental agenda and reduce costs.
Recruitment for the Trust appraisal lead, in preparation for one lead retiring in December 2025.	Job-share partnership to continue, this will support consistency. Interviews planned for October.
Continue to seek improvement to existing processes and ensure accurate connections are maintained.	Working with the medical HR team to capture starters and leavers and seeking greater improvements via reporting and system interfaces.
Continue programme of process review and annual quality assurance exercise.	Continue and look to expand our internal quality process reviews.
Continue to enable access to appraisals, supporting individuals who find the appraisal process challenging.	Care group appraisal leads to receive regular reports highlighting those that have not completed an appraisal without approval. This will prompt a conversation to ensure that appraisees know how to access an appraisal and can seek support and guidance regarding any aspect they find challenging.
Further work with DCDs and appraisal leads to manage non-compliance.	Compliance rates have continued to rise but the focus has moved from those with multiple missed appraisals to ensuring all undertake annual appraisals.
Review training content when new Trust appraisal lead joins the team.	The new TARL will begin delivering training in early 2026. A personnel change within the team is an opportunity to review all content and seek further improvement.
Continue with annual programme of review and ongoing training.	Ensure quality appraisal through annual ASPAT review, regular appraiser update meetings and the refresher training.
Maintain proactive approach to managing recommendations and identify any missing requirements as early as possible.	Appraisals officer has an established process to escalate to RO and Deputy RO, also reviews individual status as each appraisal is completed in the cycle, highlighting missing areas to appraisees.
Overall concluding comments:	
Appraisal compliance rates have continued to rise across the appraisal year, with a current average of 88.88%. The number of prescribed connections has increased by 60 this year, appraiser numbers have continued to increase to support the expanding workforce and ensure that appraisals are readily accessible. The number of unapproved missed appraisals decreased increased by 50% to 8%.	

Deferrals reduced slightly this year from 29% to 27%. While this is still higher than the Trust considers acceptable, improvements are continuing to be made and previously deferral rates ranged between 33 and 37%.

There continues to be a focus on quality appraisals, 98% of appraisees rated their appraiser as very good or good. Survey results demonstrated high levels of staff satisfaction in the process and doctors commented that they feel supported and motivated through discussions with appraisers. The expanded ASPAT exercise gave further assurance that appraisals were being carried out in line with national guidance and local policy.

Good medical practice 2024 recommendation have been fully incorporated into the electronic appraisal system, a wide range of communications were sent to users confirming the changes and the appraisal leads took the opportunity to review and update the guidance within SARD to continue to make the process as user friendly as possible.

Section 4 – Statement of Compliance:

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

Signed on behalf of the designated body

Chief executive or chairman

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

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

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

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.14 Report to the Trust Board of Directors, 9 September 2025	
Title:	Safeguarding Annual Report 2024-25 and Strategy 2025-26
Sponsor:	Gail Byrne, Chief Nursing Officer
Author:	Danielle Honey and Corinne Miller

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:

The Safeguarding annual report summarises the activity, key achievements and challenges for the corporate safeguarding service in 2024-25.
The Safeguarding service has contributed to reviews of 56 patients where a statutory review has been considered, of those UHS has joined panels for 5 Safeguarding Adult Reviews, 3 Domestic Abuse Related Death Reviews and 3 Child Safeguarding Practice Reviews.
The number of S42s caused by Southampton City Council has reduced significantly following the implementation of their new processes – this does not reflect a reduction in the number of UHS referrals, nor of the complexity that the service responds to.
A reduction in the number of allegations relating to people in positions of trust has been seen, and the service is working to review the allegations management policy.

Key areas of success include:

- Maternity safeguarding incorporated into the corporate safeguarding team.
- Safeguarding event held in September 2024.
- Training compliance slowly increasing following a large effort to ensure that the data is accurate and reflecting the appropriate mapping of staff to levels.

Key areas of focus for the upcoming year:

- Safeguarding team structure review including a focus on individual and team psychological wellbeing and resilience.
- Safeguarding supervision practice review across all areas of the organisation and service.
- Engagement and education within the organisation.
- Moving towards a “referral at source” model of raising safeguarding adult concerns from clinical areas.
- Improving engagement opportunities for the organisation.

The Safeguarding Strategy ratified through SGSG aims to support the underpinning direction of the team, in order to focus its activity through the year.

Contents:

Annual Report
Strategy

Risk(s):

N/A

Equality Impact Consideration:	N/A

Safeguarding Annual Report 2024/2025

Dannie Honey Named Nurse Safeguarding Children

Corinne Miller, Named Nurse Safeguarding Adults

Julie Davies, Named Midwife Safeguarding

Katy Durston Deputy Named Professional Safeguarding Adults and Children

NHS
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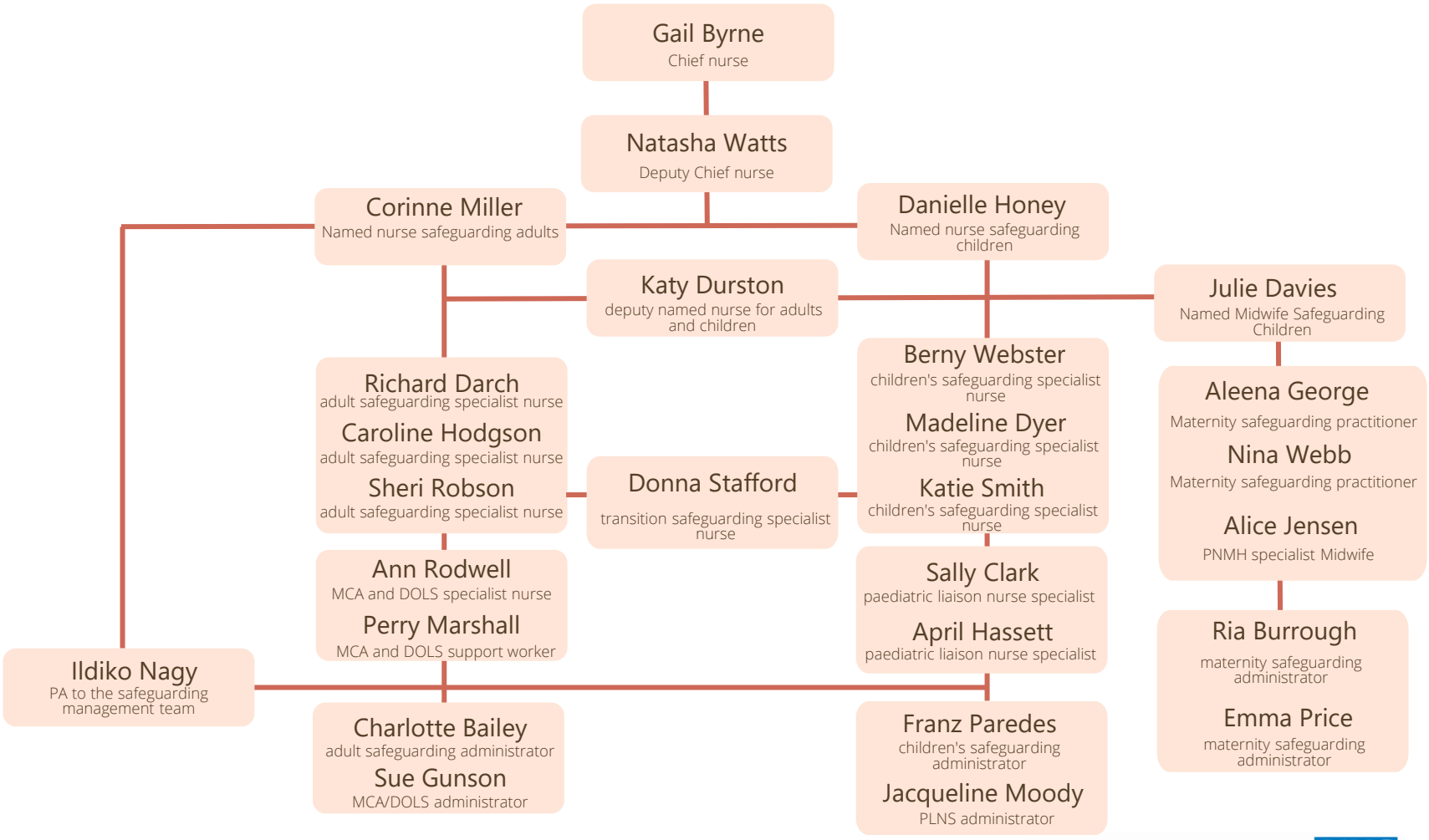
SAFEGUARDING TEAM

Supporting you, supporting our patients



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Introduction

This year's Safeguarding Annual Report summarises the key achievements, areas of work and activity for 2024/25 for Adults, Children and Maternity Safeguarding within UHSFT. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT and in line with required reporting against the NHS Contract.

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

This year has seen a further increase in activity and staff sickness. Following a successful recruitment process, the Named Nurse for Safeguarding Children post was filled with the current postholder joining the team in May 2024.Positive progress has been made with most work streams, however due to operational demands, some workstreams have been paused at points throughout the year. This will be reflected in this year's report.

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Progress updates – Safeguarding

Last year (23/24) we said we would:	We have achieved (24/25):
Continue to develop the joint Safeguarding Training Strategy including launching Safeguarding Adults Level 3, reviewing Safeguarding Children Level 3 with a view to increasing compliance, launching MCA Level 3 training and developing and delivering transitional safeguarding training.	Safeguarding Training compliance across UHS has remained at levels below those we aspire to reach and below the 85% compliance set out in the NHS contract. More detail on this priority area is provided at slides 34-35.
Launch of the new Domestic Abuse policy	This policy was ratified at Safeguarding Governance and Steering Group in July 2024 and amendments made to bring in line with best practice.
Further development and strengthening of links across maternity, children and adult safeguarding to deliver a cohesive safeguarding team Think Family approach	Throughout the year, the maternity safeguarding service has been brought into the safeguarding budget, bringing its management and oversight in line with the wider safeguarding service. Alongside this, the maternity safeguarding team vacated their office in Princess Ann Hospital (PAH) and is now co-located with the wider service, with an office available within the clinical area in PAH for increased accessibility and visibility for midwives.
Planning and launch of Safeguarding Event for UHS staff during Q3 2024.	This highly successful event took place on 26 September 2024 and was attended by in excess of 140 members of staff, with excellent feedback received. Plans are in place for this to become an annual fixture in the safeguarding calendar
In partnership with SCC and HCC, launch of new review process for safeguarding adult concerns.	This process has now been embedded within UHS and reviews with Local Authorities remain in place, with further work to move towards a model of referral at source from clinical and non-clinical areas.

Progress updates – Safeguarding

Last year (23/24) we said we would:	We have achieved (24/25):
Launch of new pressure ulcer/safeguarding adult's pathway in partnership with TVN and Patient Safety teams.	The Trust Prevention and Management of Pressure Ulcers Policy was updated in December 2024. The updated version includes the adult safeguarding assessment guide and direction on the requirement to complete this as part of the AAR process.
Relaunch of Safeguarding Adults Engagement Group.	Due to the reconfiguration of the safeguarding team, to include maternity colleagues, the Safeguarding Adults Engagement Group will be discontinued, and frontline engagement prioritised through the recruitment of frontline safeguarding champions across the Trust.
Review of MCA and DoLS Policy	This policy has been reviewed and amended with improvements made to increase the ease with which clinicians can meet their duties to patients. Most recent updates were approved by SGSG in March 2025.
Audits: Best Interests decision making documentation (Q2), staff knowledge re role of IMCA (Q3), weekly DoLS spot audits for inpatient areas	The Best interests Decision Making and IMCA audit were completed in line with safeguarding contract requirements. Due to staffing challenges and high levels of complexity and acuity within the MCA team, the spot audits have not been completed as frequently as anticipated.
Awareness raising of the Transition Safeguarding Service across the Trust footprint.	Multiple training sessions have been delivered over the past year on safeguarding care of 16-17-year-olds in adult inpatient areas. Transitional safeguarding is also routinely covered in preceptorship study days as part of generic safeguarding training. The safeguarding transition nurse had a stand at the Safeguarding Event held in September 2024 and has spoken at an external conference to raise awareness to external agencies.
Review of information sharing forms as part of ED migration to Miya	Information sharing forms will be digitised as part of the migration to Miya which has been delayed until September 2025. Changes to the management of the forms remains an area to improve and remains in a development queue with UHS Apps.

Progress updates – Safeguarding

Last year (23/24) we said we would:	We have achieved (24/25):
Review and relaunch of Safeguarding Champions network	Planning work has been completed around this, however due to operational challenges, the launch has been delayed until Q1 2025/26.
Review of the Supervision offer and uptake within the Trust.	Ongoing work on the Safeguarding children supervision offer continues, with an increase in the offer and uptake seen in 2024/25. Maternity safeguarding continue to offer responsive supervision, one to one supervision and group supervision to targeted groups but are looking to increase this offer to universal caseload midwives.
Increasing the visibility and profile of Safeguarding within the Trust.	Increased on site working alongside a continued effort to engage with a variety of trust forums has worked to increase the accessibility and profile of the safeguarding team. Embedding maternity safeguarding within the clinical area and the Duthie building has supported increased accessibility for midwives.
Completion of safe sleep and ICON audit	The Safe sleep and Icon audit has been further delayed due to operational pressures. However, we aim to complete by Q3, supported by the temporary Band 7 staffing from the SG children's team
Audit of Safeguarding referrals	This audit was completed and presented, with recommendations, to SGSG in March 2025.
Review of Maternity Safeguarding Children in Maternity policy to include additional support around legal framework around the time of birth and police protection	Due to operational pressures the Safeguarding Children in Maternity Policy has been further delayed but this is currently in progress with a completion plan by July 2025.
Introduction of Undetermined Mark Pathway in partnership with Solent and Southampton children services	This work has been completed, and the pathway is available on the HIPS website

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Safeguarding Strategy 2025 – 2026

The UHS Safeguarding service has identified 4 strategic objectives to focus on over the coming two years which align with the trust strategic themes.

Communication, engagement and education

Self assessment and continuous improvement

Integration and partnership working

Empowerment

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Safeguarding Policy Updates

Safeguarding Policies approved 2024-25

- FGM Policy is completed and awaiting approval at SGSG in Q1 2025/26
- Domestic Abuse Policy was ratified at SGSG.
- Management of Risk Posed by Offenders Subject to Multi-Agency Public Protection Arrangements (MAPPA) Whilst on UHSFT Premises (New Policy document)
- Mental Capacity Act and DoLS Policy
- Prevent Policy

Safeguarding Policies under review 2025-26

- Allegations Management Policy
- Safeguarding Children Policy
- Modern Slavery Policy
- DNA/WNB Adults at Risk Policy
- Safeguarding Children in Maternity Policy

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Safeguarding risks

Risk Number	Summary	Risk Rating
172	Delays in individuals being assessed and followed up by the supervisory body with regards to applications for Deprivation of Liberty Safeguardings. This may result in patients being unlawfully deprived of their liberty.	12
307	The Mental Capacity Act (2005) may be misapplied in practice.	9
173	Patients may not be safeguarded effectively if staff training compliance is below target levels for Safeguarding Adults and Mental Capacity	9
833	If safegaurding children training compliance remains below target levels, staff may not have the skills and knowledge to respond effectively to safeguarding children concerns.	12
893	Information shared with GP surgeries via email may not be received by surgeries due to changes in email addresses used not being communicated to the paediatric liaison nursing service.	12
643	There is a risk that we cannot satisfy the CQC requirement for DOLs outcomes to be communicated to the CQC in a timely manner.	8

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Adults Safeguarding

Adults Safeguarding

- **Level 3 Safeguarding Adult Training.** Level 3 training is available to staff via the e-learning for health module which is accessible via VLE. The planned launch of Safeguarding Adults Level 3 training as part of the statutory and mandatory matrix was delayed to April 2025. A new landing page was developed on VLE to support those wishing to access training.

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

- **Newsletter.** Publication of Safeguarding Adults Matter newsletter has continued and is widely disseminated across the Trust. The newsletter contains information on both local and national issues and learning from Safeguarding Adult Reviews.

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

- **ICB Adult Safeguarding Supervision Strategy.** The strategy has continued to be rolled out and the year 1 target has been met with all members of the Adult Safeguarding team having regular access to both individual and group safeguarding supervision.

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

Adults Safeguarding

- **Safeguarding Adult Engagement Group.** Due to operational pressures, meetings have not recommenced. Going forwards, we are supporting development of an integrated frontline safeguarding champions role to include both adults and children's safeguarding. This will mirror the highly successful development and expansion of the MCA Champions role and network.

- **Review of Adult Safeguarding Concerns Pathway.** A new process for sharing concerns with the local authority was launched in August 2024 and is under ongoing review with partners. This will feed into a move to referrals at source, from clinical and non-clinical areas who identify concerns for patients.

- **UHS Champions Awards.** This year 2 individual practitioners were shortlisted for a UHS Champions Award.

- **Integrated Homelessness Forum.** This new forum has been established this year to promote shared understanding of roles and responsibilities and multi-agency working arrangements across Southampton for one of our most vulnerable patient groups.

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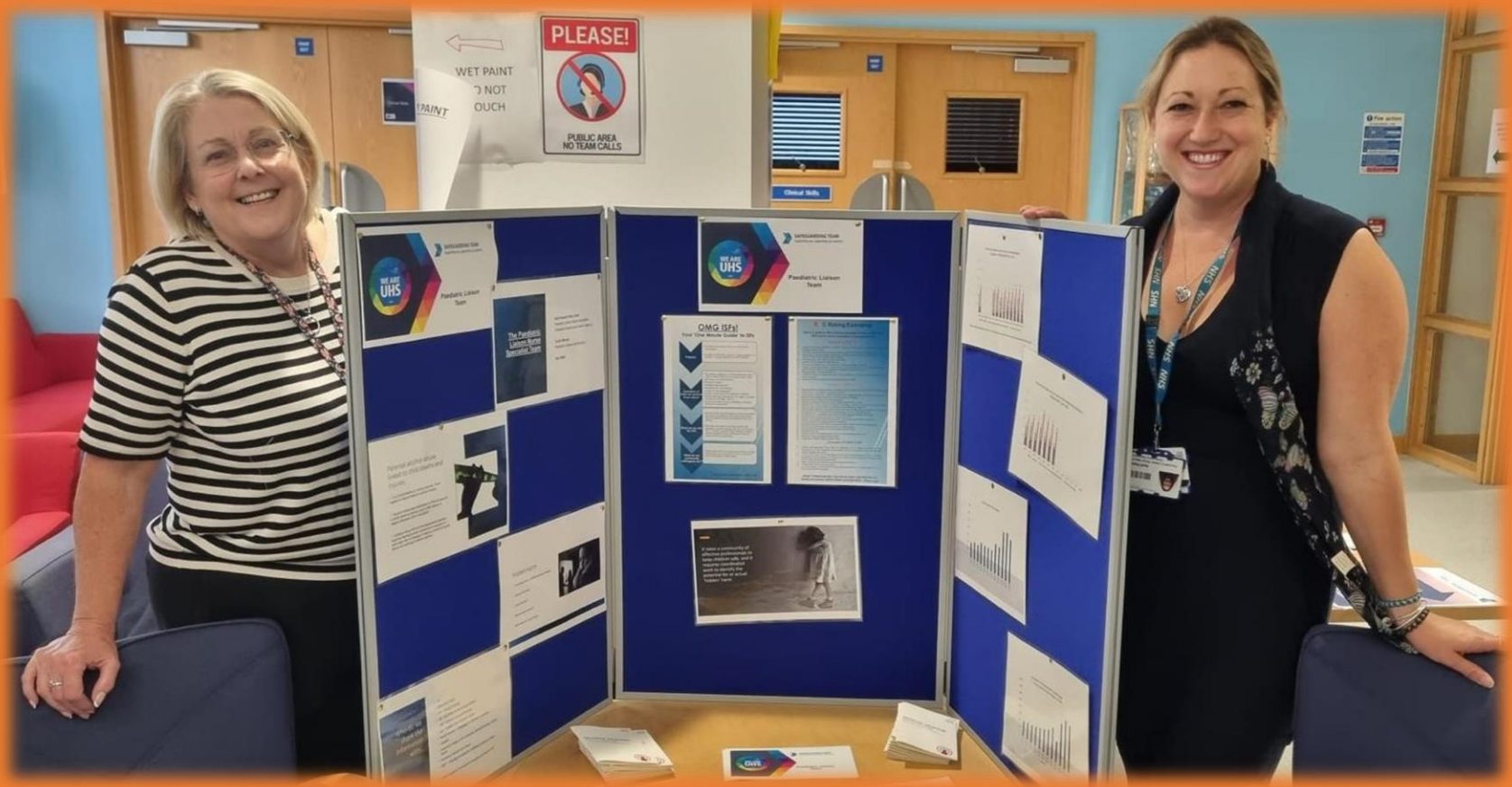
Children’s Safeguarding



Children's Safeguarding

- **Audits.** The team has provided input into multiple audits undertaken by the Safeguarding Children Partnerships and has developed Terms of Reference and plans for an audit into the recording of the Voice of the child and use of the Safeguarding Proforma. This is a re-audit of one undertaken in 2022/23 and reported in 2023/24. The team is planning to undertake a Was Not Brought audit alongside a redevelopment of the policy.

- **L3 Safeguarding Children Training.** Compliance for Safeguarding Children Level 3 has remained lower than required and alongside a trust wide review and cleanse of the data, a working group is being established to review the content and delivery of the packages available for staff to attend. See Slide 39.

- **Technology.** The team relies on UHS Apps for record keeping, and has identified areas for improvement, both in terms of usability and case management, and reporting from the system. Requested changes remain in a development queue with the UHS Apps team.

- **Newsletters.** Newsletters have not been established this year, and plans are in place for this workstream to be fully allocated once staffing has reached optimal levels.

- **Safeguarding Champions.** Work has progressed on planning for the relaunch of the champions' network; the launch has not yet been completed due to operational challenges and is planned for 2025/26.

- **Operational Challenges.** Delays in recruiting into post have resulted in a longstanding vacancy within the team however all posts are expected to be filled in Q1 2025/26. A decision to recruit to fixed term / secondments was made with a view to reviewing the structure of the team in 2025/26.
- Despite the challenges, the team has worked well to ensure that a service to the organisation was maintained at all times.

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Children's Safeguarding

- **Safeguarding Supervision.** The team has continued to deliver supervision to a number of clinical teams. A supervision model within the team has been developed to ensure that all practitioners have access to group as well as individual supervision, a vital aspect of maintaining wellbeing and resilience within the role.

- **Safeguarding Ward Rounds.** Despite staffing challenges within the team, face-to-face ward rounds have continued alongside an increase in attendance at internal trust meetings. As staffing levels have returned to normal, this has been an area of focus.

- **Leadership.** The Named Nurse for Safeguarding Children commenced in post in May 2024, and since that time has created strong and positive relationships within the team, the organisation and the external network of agencies and partnerships. The Deputy Named Nurse was appointed to a secondment opportunity within the Nursing and Midwifery Council, opening an opportunity for another member of the team to take up this role for a 12-month period, developing their leadership and management skills. This will support ongoing progression planning within the wider service.

Maternity and Neonatal Safeguarding

Maternity and Neonatal Safeguarding

- **Maternity Safeguarding Team Structure:** The Maternity Safeguarding Team is now aligned with the Corporate Safeguarding Team and operates from the Duthie Building. To maintain close links with maternity: we have maintained a dedicated safeguarding hub on Lyndhurst Ward. At this hub, the duty midwife handles daily safeguarding inbox activities and telephone calls, provides responsive supervision, and supports the community midwife during MDT meetings. Additionally, the Perinatal Mental Health Midwife is based within this office, ensuring comprehensive safeguarding support across our services. There has been some changes to staffing within the team because of promotion and some temporary secondments: we have welcomed two new safeguarding professionals and a temporary Band 7 from the children's team who have come with fresh ideas and backgrounds which has been very positive.
- **HIPS Unborn and Newborn Protocol**: The protocol is currently under review across the HIPS network, with a targeted completion by Autumn 2025. This review represents a welcome opportunity to address several challenges that have been identified within HIPS, including issues related to information sharing, the rigor of risk assessments, and the evaluation of parental mental capacity—a factor that significantly impacts the unborn. We view this process as a critical step toward enhancing our practices and ensuring better outcomes across the network.
- **Southampton Mash Conversational Model**: was launched in January 2025. Prior to its implementation, meetings were held with children's services and Midwifery to assess the potential impact on referrals. Feedback has been largely positive, though some challenges have arisen. We have maintained regular contact with children services to address these issues and develop responsive plans.
- **Hope Boxes:** This scheme was designed to help mothers capture important memories of their time with their baby prior to separation due to legal proceeding around the time of birth and to promote the ongoing connection between mother and baby. The pilot for this scheme is now complete and it has been rolled out across the LMNS.
- **Safeguarding Newsletters:** We continue to offer quarterly newsletters to maternity and neonatal colleagues. We use this to highlight topics in depth and to support learning from safeguarding reviews, audits, media topics and to provide signposting to services and information.

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Maternity and Neonatal Safeguarding

- **Maternal Mental Health service and trauma informed care:** This year we have observed an increase in complex mental health cases that fall outside the criteria for Perinatal Mental health Team but involve significant social complexities and vulnerabilities, impacting both maternal self-care and fetal wellbeing. In a many of these cases, maternity services have assumed the role of Lead professional due to our consistent involvement with the families. Case planning has showcased excellent multidisciplinary collaboration within the trust including inpatient teams, Nest Teams, Obstetricians, Site managers and the LD team- as well as external agencies such as the Designated Nurses in the ICB. However, it has also revealed where gaps in within the wider community services and the need for more resources and support services.
- **Psychological Supervision**- in recognising the vicarious trauma from working with complex families the psychologist who has been supporting our Nest teams is now facilitating psychological supervision to the maternity safeguarding team monthly- this has been well received
- **Safeguarding Referral Audit:** An audit of maternity safeguarding referrals was conducted in November 2024 and finding published in Feb 2025 : following two AER in maternity, both linked to incidents where referrals lacked oversight from the maternity safeguarding team. The audit aimed to determine whether these were isolated cases or indicative of broader process issues. A total of 80 referrals were reviewed across universal and Nest caseloads. The findings are informing our 2025/26 workplans, including enhancements to supervision, structural changes within the Hampshire Nest teams and initiatives to strengthen confidence in information sharing and consent processes for referrals to children social care.
- **Unscheduled Attendances:** because of the above audit we will also be reviewing the Maternity Missed Appointment Policy to capture the importance of recognising that an increase in unscheduled attendances at Maternity Day Unit and ED can indicate an increase in risk factors such as domestic abuse, emotional dysregulation or as a cry for help. We would like practitioners to take a moment when they see a pregnant person who is a frequent unscheduled attendances to take a moment to ask a pregnant people whether they are okay and whether they feel safe at home as well as sending an update to maternity safeguarding so we can review the case.

Maternity and Neonatal Safeguarding

- **Safeguarding Supervision**: We continue to strengthen our supervision offer which is currently targeted and despite staffing challenges we have continued to offer group supervision to Nest teams and drop in's/responsive for all staff The neonatal unit offers Bi-monthly supervision to all staff which is accessible via teams or face to face. In addition, the NNU hosts a Weekly psychosocial meetings attended by the neonatal and maternity staff - Inpatients are discussed regarding any psychosocial needs, plans made, and updates sent to the health visiting teams.
- **Safer discharge for neonatal unit babies Project.** This is an IT project focusing how we collect and share sensitive data about family's psychosocial needs. The document is written from a baby's perspective to help us to think about the baby will need to thrive in hospital and after their discharge. The aim is to encourage more open conversations with our families with the aim to highlight psychosocial issues and safeguarding issues earlier and all information will be kept in one place.
- **Safe Sleep and ICON training**- This continues to be a focus for midwifery and neonatal staff. Hayley Taylor continues to deliver the 'Rolling ICON & Safer Sleep training offered to all UHS staff and this is well attended, receiving positive feedback.

Mental Capacity Team

Mental Capacity Team

- **MCA Champions Network.** The network has continued to grow with representation from the majority of clinical areas across the Trust. The 8 weekly meetings are chaired by the Lead Practitioner and are an opportunity for MCA Champions to make positive links across the Trust, learn from each other and access specialist support from the MCA team.

- **Monthly drop-in sessions.** These are run quarterly in conjunction with specialist teams including Learning Disability and Autism and Delirium and Dementia teams.

- **DoLS focus.** A focus on DoLS across the Trust and daily ward rounds in core working hours has seen a continued rise in DoLS applications, evidencing that staff are accurately identifying when patients are being deprived of their liberty.

- **Audits.** IMCA and BI decision-making audits have been completed in line with contract requirements.

- **DoLS Spot Audits.** The audit involves a review of patient records and identification of potential gaps where DoLS applications should have been considered but where patients are not detained at UHS under a legal framework. Due to operational service demand, these audits have not taken place as regularly as anticipated.

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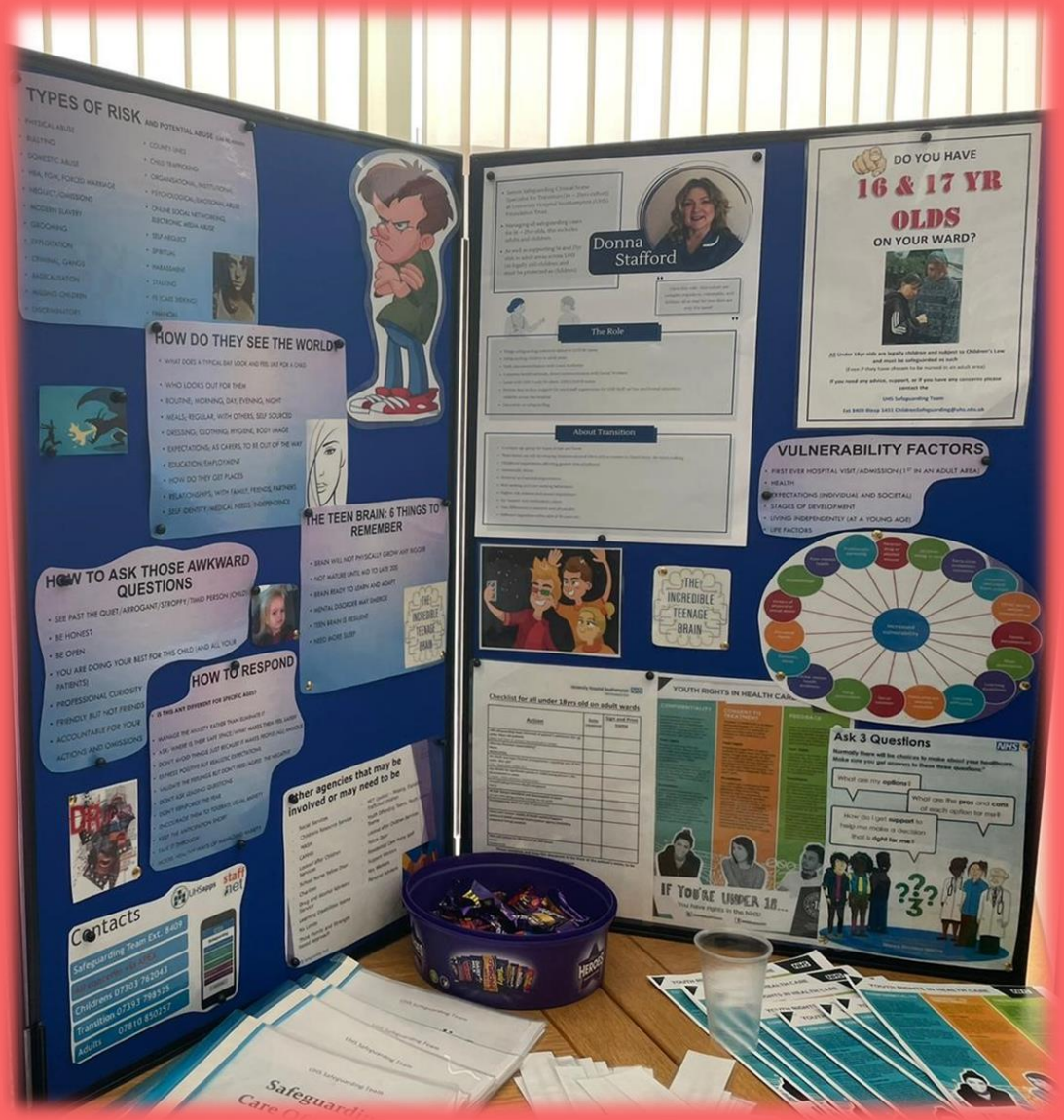
Transition Safeguarding



Transition Safeguarding

Service impact transition service is at times required to cover absence in the SG Adults, SG Children and Paediatric Liaison teams due to wider operational service pressures. This has impacted at times Transition service workstreams delivery.

Onsite ward rounds have continued which include visits to wards where there are safeguarding concerns/cases. This is to gain and receive case updates and to offer support, education and ad hoc safeguarding supervision to staff and speak directly to children/young people. Visits/contact to adult areas where under 18s (children) are admitted are prioritised to offer guidance, education and support to the ward as the patient is still legally a child. Support is also provided to clinical staff with raising any new safeguarding concerns to the UHS Apps system.

Transition specific training about Under 18s in adult areas across the Trust has continued to be delivered this year.

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

Transition in-patient review continue to review the daily 16- & 17-year-old inpatient and the 18–25-year-old inpatient checklist. Direct support is provided to ward areas as required.

Activity – Safeguarding Adults

Safeguarding Referrals to UHS Adult Safeguarding team= **2465** (2% decrease from 23/24 = 2521)

Safeguarding referrals sent to the Local Authority = 693 (from 01.08.2024)

Prevent referrals: **0** (3 23/24)

Safe and Well Referrals = **227**

DoLS = **1181– 24/25** (13% increase from 23/24- 1041)

Number of Court of Protection cases supported: 3 with support given to **8** further cases where applications were considered.

Total number of SAMA cases: 57 (23% decrease from 23/24 - 72)

Complaints screened: 4 (decrease from 23/234- 5)

Training delivered; adult sessions = 13 / joint adult & child sessions = **3**

LeDeR Reviews Deaths reviewed: **13**

Statutory Activity: 26 scoping's for consideration of SARs. Panel representation for 5 SARs. 4 scoping's for consideration of DARDRs. Panel representation for 3 DARDRs.

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Analysis of Safeguarding Adults data

- There has been a **2%** decrease in referrals into the Safeguarding Adults team. The referral numbers, however, do not recognise the complexity of many of the referrals which are multi-faceted, and the time taken to manage these complex cases in conjunction with Local Authority and other multi-agency colleagues. The decrease in part can be attributed to the implementation of the new Safeguarding Adults protocol in relation to pressure ulcers which means that the number of pressure ulcers requiring referral to the Local Authority has decreased.

- For 2024/2025 **33** referrals to the Safeguarding Adults team met statutory safeguarding criteria, a significant decrease from the previous year. This is a significant reduction from previous years. It is possible that this is due to restructuring of the safeguarding team within Southampton City Council and higher thresholds for causation of S42 enquiries. This discrepancy has been highlighted to the designate safeguarding team in the ICB who are exploring this issue further.

- There has been a **13%** increase in applications relating to DoLS referrals. There remains a delay, however, in authorisation by the Supervisory Body which is recognised and reflected on the Trust's Risk Register. This is a nationwide issue since the Cheshire West ruling in 2014 whereby the "acid test" provided additional clarity as to what constitutes a deprivation of liberty. The daily presence of the MCA team in clinical areas has potentially increased the recognition of DoLS across the UHSFT footprint.

- There has been a **23%** decrease in SAMA referrals (concerns in relation to members of staff who are in a position of trust) in the past year. There has been an increase though in relation to agency workers contracted to support mental health patients and cases requiring joint SAMA/LADO oversight. The Allegations Management (Adults at Risk) Policy is currently under review and safeguarding allegations management processes in respect of staff who work with children will be included in the new document in line with an all age/think family approach to safeguarding and to reflect the current picture of joint SAMA/LADO oversight.

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

Analysis of Safeguarding Adults data continued

- The safeguarding and LDA teams reviewed **18** deaths as part of the internal LeDeR process this year. The dedicated Teams module centralise LeDeR activity enables data in relation to themes and trends to be compiled and analysed more comprehensively and allows for targeted dissemination of learning across the Trust.

- **16** training sessions were completed this year, both solely in relation to safeguarding adults and alongside Safeguarding Children's Team colleagues, thus promoting the Family Approach ethos. A further **5** scheduled sessions were cancelled by clinical areas.

- No Prevent referrals were made this year. 3 referrals were made the previous year. Prevent data is collated quarterly and returned to the NHS Data Collection team on behalf of the Trust by the Safeguarding Adults team.

- **227** Safe and Well referrals were recorded as being made this year by UHSFT however the number is likely to be higher. This is due to the online referral form whereby staff can select "other" or "agency" as a referral source instead of UHSFT. Safe and Well referrals are routinely considered where concerns around self-neglect , hoarding or other fire risk indicators are noted.

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Activity – Transition Safeguarding

Safeguarding Referrals = **311** (16&17yr olds) + **184** (18 to 25yr olds) = **495** (503 in 23/24)

Training delivered = this data is included within adults and children's training figures

16 & 17yr old inpatients at UHS per day = average of **15-20** per day with an average of **4** nursed in adult inpatient areas.

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

8 Scoping's completed for Transition Safeguarding age group (0 in 2023/24)

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Analysis of Transition Safeguarding Data

- Referral figures are comparable to the previous year. A significant number of transition age safeguarding cases continue to relate to mental health however the majority are multi-faceted concerns.

- As in previous years, referral numbers do not reflect the complexity of many of the referrals which take significant time to manage and ensure staff and patient safety and include contact with external agencies and organisations.

- Safeguarding concerns for this age group are frequently complex in nature due to the developing brain, exposure to early trauma, hormones, individual and societal expectation, contextual safeguarding (may or may not be known), complex or lack of support networks and level of current risk.

- This year 7 young people aged 18-25 years and known to the UHS Safeguarding team have died. This is an increase from previous years.

- Lack of recognition of under 18s in adult areas may lead to a lack of Professional Curiosity or knowledge /recognition of Safeguarding concerns. This continues to be addressed through transition specific safeguarding training alongside the wider safeguarding training offer.

Activity – Safeguarding Children

24/25 Safeguarding referrals to UHSFT Safeguarding Children Team = 1277 this is almost static – 1.5% increase from 2023/24, and maintaining the increase seen from previous years.
An increase in the numbers of children subject to Child Protection Planning (111, compared with 87 in 23/24 and 55 in 22/23) and concerns identified relating to a parent who is the primary patient (304 compared with 202 and 70 in previous years) indicate continued improvements in applying a think family approach when safeguarding children. Alongside this, a reduction has been seen in the number of children experiencing actual harm (87 down from 101 and 136 in previous years); but an increase in unexpected child deaths (20, increased from 15 and 9 in previous years.
The number of concerns for which advice was provided but no further action required from the team reduced from 530 and 592 in previous years to 525. This indicates that confidence in managing concerns within the wider organisation remains high.

Statutory Activity

- **22** (10 in 23/24) requests for information to be provided from UHS to contribute to Rapid Reviews, Local Safeguarding Child Practice Reviews and Domestic Abuse Related Death Reviews. These requests are predominately from Southampton, Hampshire and Portsmouth Safeguarding Children Partnerships however due to the nature of UHS, have also included Bournemouth, Christchurch and Poole SCP; Portsmouth SCP, Dorset SCP, West Berks SCP and West Sussex SCP.
- Of these contributions, 3 have moved forward to full statutory reviews.

Published Child Safeguarding Practice Reviews

1 Child Safeguarding Practice Review was published in the HIPS (Hampshire, Isle of Wight, Portsmouth and Southampton) area in 2024/25 by Portsmouth Safeguarding Children Partnership.
The Named Nurse or Deputy Named Nurse attends the appropriate rapid review or partnership subgroup to contribute to consideration for CSPR and identifies and shares learning where appropriate for UHS.

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Activity – Safeguarding Children

Total number of LADO cases = 19 This is lower than previous years, 29; 22 and 27.

Paediatric Liaison Nurse Specialist (PLNS) Team

Triaged **5315** Information sharing forms (ISF) in 2023/24. This represents a 4.5% decrease from 6184 forms completed in 2022/23.

Other Specific ISF data related to children

Deliberate self-harm 2024/35 -779 – a light increase but not back to previous high levels seen in 2022/23

Drugs and Alcohol 2024/25 -**180** – relatively static compared with 175 last year.

Assaults 2024/25- 219 – an increase from **183 in 2023/24.**

NNU reports The Princess Anne Neonatal Unit (NNU) is one of the largest units in the country caring for up to 23 intensive and high dependency beds and 14 special care cots; The PLNS Team have been responsible for disseminating 1379 NNU Reports (new admissions and updates) in 2023/24 a slight decrease from previous years.

Safeguarding Children Training Level 3 –

27 sessions delivered (24 sessions delivered in 23/24). This includes both planned and bespoke training. These take place primarily online via Microsoft Teams.

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Summary and Analysis of Safeguarding Children data

- **Safeguarding referrals to UHSFT Safeguarding Children Team-** there has been a relatively static number of referrals compared with 2023/24 into the Safeguarding Children team. Throughout the year there has been some turbulence in terms of resource and staffing, with one member of the team leaving to take up a new post outside of UHS and backfill plans taking some time to implement. As work to complete a budget and establishment review commenced, the decision was made to use temporary options for backfilling vacancies.

- The Deputy Named Nurse was successful in applying to an external secondment opportunity and this role is further backfilled with a temporary member of staff.

- The highest recorded reason for referrals to the UHSFT Safeguarding Children Team was drug and alcohol use, with poverty recorded as a complicating factor highly. This data is not robustly recorded and as such does not reflect the whole picture in relation to the experiences of children using our hospital.

- Almost one half of concerns arose in the child's own home (600); with a further 450 recorded as "other".

- 115 referrals related to physical harm, with 39 cases of neglect; 21 cases of emotional abuse and 20 cases of sexual abuse being recorded. This data relates to the category of initial concern and do not reflect the final outcome of assessment and investigation.

- **Serious Incident forms** 26 SUI (Serious Untoward Incidents) were notified to the Named Nurse and wider Senior team in 2024/25. These reflect situations where children have been identified to have died or suffered significant harm believed to have been as a result of neglect or abuse.

Summary and Analysis of Safeguarding Children data continued

- **Telephone/email advice.** 730 requests for advice and information were recorded in 2024/25, a 26% increase from 2023/24. This is likely to reflect both a strong confidence in teams undertaking actions as advised by the safeguarding team and an improvement in recording of data around advice provision.
- 140 referrals did not require further action, and 14 did not constitute a concern following review of the records.

- **ISF's.** A 4.5% decrease has been recorded overall from the number of ISFs completed in 2023/24 following a 10% decrease from the previous year. An ISF is required when it is identified there are possible safeguarding concerns- this can range from a safety issue where a child swallows a tablet to a child presenting with suspected/actual harm.
- Alongside reviewing ISFs the Paediatric liaison nurses review all ED attendances and liaise with ED where an ISF would have routinely been required. This process is in review and the implementation of Maya in 2025/26 is expected to see this workstream discontinued.

- **Statutory Activity.** The number of scoping requests seen has increased to be in line with previous years, following a decrease in 2023/24. The Southampton Multi Agency Safeguarding Arrangements are in the process of being redesigned to combine adults and children safeguarding arrangements to Southampton Safeguarding Children and Adults Partnership. This will ensure that learning is more widely understood looking at the whole of life course and capturing the impact of childhood experiences on adult outcomes. Both Named Nurses are represented through these arrangements and continue to contribute the voice of the Acute hospital in understanding opportunities to improve care and support.

Activity-Maternity Safeguarding

Number of maternity safeguarding notifications raised **= 833 (+ 1.9% % from 2023/34)**
Number of referrals sent to children social care **= 352 (+ 3.5 % from 2023/24)**

Outcome of pre-birth plans
•Pre- birth plans commenced by children services (NB this includes 3rd party referrals e.g. police, health visiting) = **232 (+1.9 % from 2023/24)**
•No further action = **137 (-4.2% from 23/24)**
•Newborns on Child protection plan at birth = **47 (-2.9 %)**
•Newborns on child in Need plan at birth = **102 (+ 1.3 %)**
•Interim care orders at birth= **14 (-24.0%)**
•Newborn police protected at birth = 2 **(23/24= 5)**
•Number of cases that have been referred for child practice reviews which main focus was maternity related = 1 **cases**

Number of:
Teenagers under the aged of 19 years **= 75(+5.2 %)**
Teenagers under the age of 16 years **= 17(2023/24= 18)**
Reported FGM cases **= 65 (+1.2%)**

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Activity – Maternity safeguarding

Meeting activity
Number of meetings with children services attended by midwifery pre-birth (safeguarding or Nest Teams) **= 450**
Number of post birth meetings attended **= 15**
Number of additional professional meetings including JAR, strategy meetings, MARM, neonatal psych-social meetings substance misuse meetings and MDT meetings **= 186**
Total number of meetings covered by maternity services **= 684 meetings -**
340 of these meetings were supported by the maternity safeguarding team
Total number of Supervision sessions facilitated by maternity safeguarding team = **62**

Telephone calls/liaison collected from Sep 24 = 486 calls

Safeguarding Children Training Level 3 (including bespoke sessions delivered to NNU staff/ maternity staff**) = 9 sessions**

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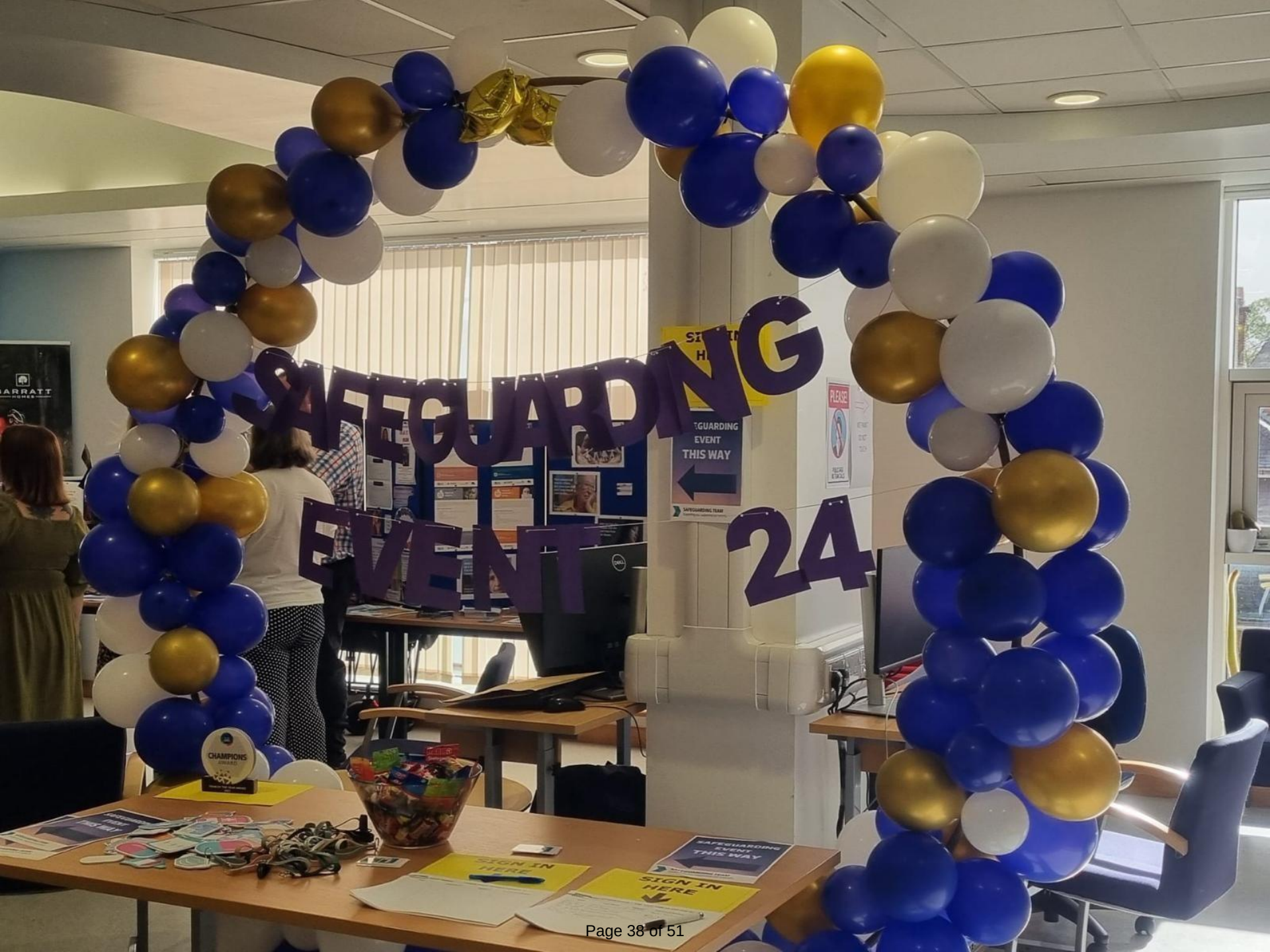
Maternity Data Analysis

- The maternity data is comparable with previous annual reports with a few notable exceptions. The number of Unborn's of on CP plans continues to reduce but we are noting that there are families who have significant risk factors being managed on CP plans -if families are demonstrating good engagement and change. This is both across Hampshire and Southampton. As a team we will escalate if we have concerns with this threshold and we feel there is drift in the pre-birth planning. We do hold concerns that a CIN plan is voluntary and if a case moves to legal planning it feels like the step between CIN and Legal I.E. CP Planning to ensure there is a framework for professionals and parents to work to a plan is miss.
- The number of ICO and police protection has also decreased by a small amount. The reduction of police plans has reflected some professional conversations around supervision of parents with their newborn baby, when they are subject to legal proceedings which has prompted some changes to pre and post birth plan to ensure a safe plan are made that allows parents to continue to care for their baby with supervision when safe to do so.
- As highlighted in maternity and safeguarding update we have had several very complex families that have delivered this year requiring multi-disciplinary team approach and complex pre and post birth planning which have required additional meetings and escalation with the support from the Senior Safeguarding Leadership team and the ICB Designated Safeguarding Nurses.
- Meeting activity has remained high with additional data collected this year on supervision sessions and telephone contacts.
- The number of FGM cases as plateaued this year following the very large increase in reporting for 23/24


SAFEGUARDING
EVENT 24
THIS WAY
PLEASE
CHAMPIONS
SIGN IN HERE
SIGN IN HERE
SAFEGUARDING EVENT THIS WAY

Mandatory training report by Staffing Groups as of 15.05.25

	Div. A % (Targeted audience)	Div B % (Targeted audience)	Div C % (Targeted audience)	Div D % (Targeted audience)	Trust HQ % (Targeted audience)	Total Trust% as of 21/05/2025	Trust Target
Safeguarding Adults level 1	**82.3%** 1530	**87.4%** 2634	**90.6%** 2753	**87.9%** 2261	**82.3%** 639	**87.2%** **9853**	>85%
Safeguarding Adults level 2	**75.3%** 1371	**84.8%** 863	**82.7%** 1154	**81.6%** 2144	**75.6%** 451	**80.2%** **5968**	>85%
Safeguarding Adults level 3	**5.6%** 751	**10.6%** 1748	**32.9%** 85	**0.0%** 31	**43.8%** 144	**12.5%** **2601**	>85%
Mental Capacity Act level 1	**80.7%** 119	**89.7%** 243	**88.2%** 356	**80.5%** 681	**83.0%** 118	**84.4%** **1518**	>85%
Mental Capacity Act level 2	**61.0%** 2240	**61.3%** 2564	**65.7%** 2367	**56.6%** 1540	**52.8%** 430	**61.1%** **9167**	>85%
Prevent levels 1&2	**88.3%** 290	**93.0%** 1178	**93.4%** 1189	**87.8%** 403	**92.7%** 1218	**92.5%** **4281**	>85%
Prevent level 3	**76%** 2258	**78.1%** 2535	**85.4%** 2065	**76.4%** 2177	**73%** 540	**78.5%** **9599**	>85%
Child Protection level 1	**73.7%** 175	**84.4%** 752	**86.6%** 507	**88.6%** 266	**88.6%** 966	**85.6%** **2667**	>85%
Child Protection level 2	**76.7%** 2095	**80.7%** 2160	**82.4%** 1162	**79.2%** 2187	**74.9%** 446	**79.1%** **8080**	>85%
Child Protection level 3	**54.9%** 690	**50.2%** 1397	**61.4%** 1448	**40.1%** 177	**0.0%** 1	**55.1%** **3849**	>85%

Analysis of Training compliance

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

- **Level Three safeguarding children training**

Training compliance has remained low throughout the year, and it became clear on analysis that the dataset was not robust. This had resulted from both a complicated matrix which was flawed in its logic rules, and a 3 yearly reporting cycle which excluded those with proportionate compliance from being considered as compliant.
The response to this has been a stepwise one, with a final aim to transfer to yearly reporting for the correct cohort of staff.
A VLE compliance has been created on an annual reporting cycle.
A list of all staff has been created and shared with clinical divisions to review against the ICD guidance and identify the appropriate levels of training for all staff groups.
This has created challenges for the divisional teams in relation to the admission of 16- and 17-year-old patients into adult care areas and the requirements for medical teams and final agreements remain outstanding.
Staff groups on the same position title who undertake subtly different roles, causing a challenge in identifying the most appropriate level of training.
Agreement of assurance mechanisms for non-substantive UHS staff remains in discussion.
Once complete, the confirmed compliance will be launched on the yearly compliance system giving a full and robust dataset around compliance and enable action plans to be developed with areas to support the improvement of compliance.
This has and continues to be a highly complex piece of work, requiring support and input from each of the divisions and the team recognises and is grateful for this ongoing support in ensuring that the output is correct.

Analysis of Training Compliance

- **Maternity Safeguarding Level 3 Training :** Due to staffing challenges within maternity services some planned level three training were cancelled in 2024. Additionally, as of January 2025, we have transitioned from three yearly reporting to annual reporting, which has contributed to a reduction in compliance to 53%. We are currently collaborating with the Practice Education and Maternity Senior Leadership team to improve compliance and delivery of training. Any new starters in maternity, newly qualified midwives and neonatal nurses have had bespoke additional one day level 3 training session which has continued throughout this period.
- **Adults Training** Safeguarding Adult Level 3 training has been soft launched in 2024/25. Following completion of role profiling it will be added to VLE matrices on the 1st April 2025. Additional live training sessions have been scheduled for the remainder of the year to support reaching the mandated compliance level of 85%.
- Safeguarding Adults Levels 1 and 2 training compliance levels have increased from last year although Level 2 remains a little below the target compliance level.
- **MCA Training** MCA Level One compliance level has increased to 84.4% which is nearly at target compliance level. Level 2 remains at a similar level to the previous year. Work is continuing to refresh the MCA training offer over the coming year with a specific focus on decision making in relation to healthcare interventions and practical application of DoLS.
- **Prevent** Compliance with Prevent Level 1 & 2 training remains stable at 92.5% with Level 3 standing at 78.5% which is slightly below the target compliance level.

Key areas of work for 2025/26

Joint

- Joint Safeguarding Adults and Children Champions Network.
- Development of improved training offer in line with updated Intercollegiate Documents when finalised.
- Full review of Safeguarding team structures.
- Allegations management policy to be ratified.
- SGSG processes to be improved and standardised.
- Embedding of development documents to support new into post staff members, and those wishing to develop and progress.
- Support joint working with external teams to further support career progression and knowledge development for team members.
- To create an action plan from the recommendations arising from the Safeguarding team Trust Wide Survey.
- Safeguarding Event Day

Adult specific

•Referrals at source to commence.
•Launch of mandated L3 Safeguarding adults training for staff profiled to complete this in line with the Intercollegiate document.
•Further development of SOP.

MCA Specific

- Development and roll out of training packages in respect of DoLS and completion of MCA for clinical decisions on VLE.
- Continued work with Divisions to improve MCA training compliance.
- Development of a public facing webpage with information

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Key areas of work 2025/26 continued

Transition specific

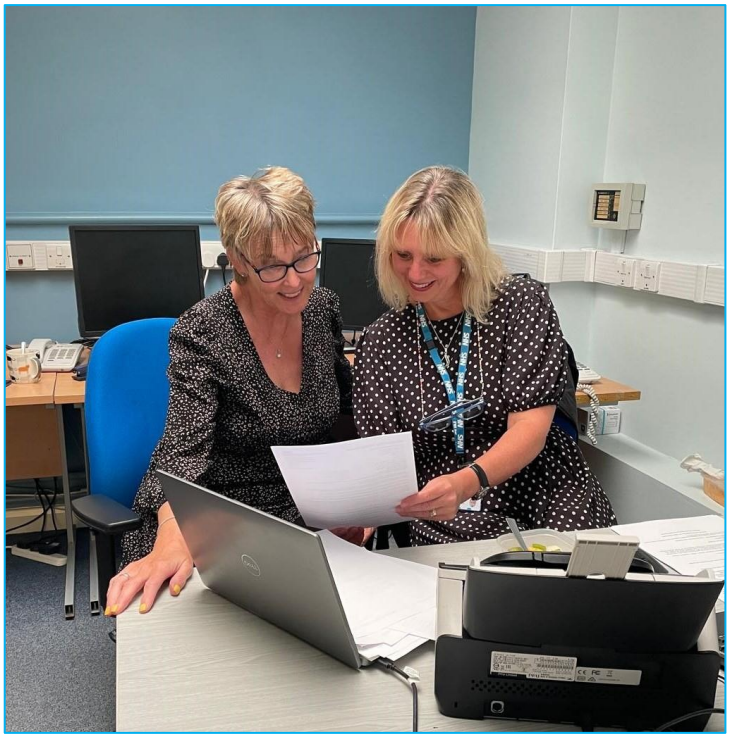
- Upskilling of workforce providing care for 16- and 17-year-old patients outside of paediatric areas.
- Improved response for 16- and 17-year-old patients subject to Child Protection concerns.

Children specific

- Increased efficiency of processes including improvements in the use of UHS systems.
- Work with Divisions on improving Safeguarding children training compliance.
- Redevelopment of Safeguarding Children policy and development associated SOPs.
- Full audit programme to be developed and embedded.

Maternity specific

- To continue to integrate with the Trust Safeguarding Team
- To increase supervision and access to these sessions throughout maternity and the neonatal unit
- To complete planned audits and to embed the recommendations from the safeguarding referral audit completed Feb 2025



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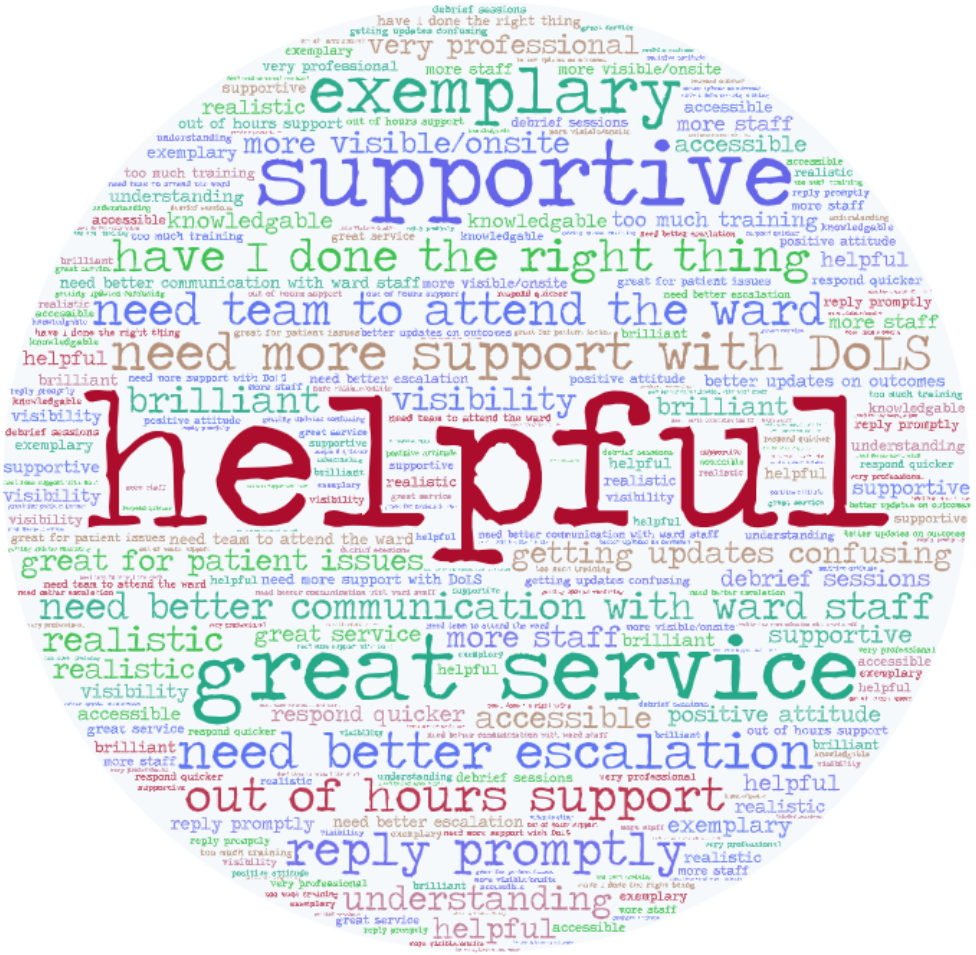
Safeguarding Team Feedback (2024/25)
This word cloud has been generated from staff feedback received through the survey completed in October 2024.



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Patient and Family Story

- A 17 year old patient, previously unknown to agencies was admitted to UHS following a very brief period in Foster care.
- The patient was identified to be a non-UK national, the child of parents who had applied for and been granted UK right to remain.
- The patient had been in the UK for up to 6 years, having been removed illegally from the care of the state in their home country.
- As the history of the patient became better understood it was evident that they had been admitted due to refusing to eat in placement, and had been the victim of significant neglect both prior to and following entry to the UK.
- The patient had no recourse to public funds in the UK and the Local Authority held no responsibility to them post their 18th birthday, which was a matter of weeks away at the point of admission. The patient was made a “ward of the court” as a Care Order was inappropriate due to the proximity of their 18th birthday at the time of the hearing. This was due to expire on the patient’s 18th birthday.

Patient and Family Story continued

- The patient had no networks available to them having lived in complete isolation with their parents prior to the intervention of the Authority.

- As the patient rapidly approached 18, and engaged well with therapeutic care – there was a strong recognition that the normalcy that they required to recover from their experiences and build a positive future was not achievable in an acute hospital, and a place of discharge was urgently required. The patient did not require admission to a mental health facility, although had been detained whilst in UHS, partly in line with the Manchester Ruling .

- Through strong escalation and challenge up to and including the Chief Nursing Officer and Executive Lead for Safeguarding within UHS to the Local Authority Chief Executive and ICB Chief Nurse, barriers were overcome, and a place of discharge was facilitated for the patient, post her 18th birthday with a support and financial package in place to enable them to begin to live a fulfilling life in the UK.

- Support was offered by partners for the patient to engage with their embassy and the Home Office to resolve their immigration status to enable ongoing support.

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Safeguarding Strategy 2025 – 2026

The UHS Safeguarding service has identified 4 strategic objectives to focus on over the coming two years which align with the trust strategic themes.

Communication, engagement and education

Self assessment and continuous improvement

Integration and partnership working

Empowerment

Communication, education and engagement

We will improve engagement with partner agencies, boards, partnerships, staff and patients.

We will increase our training compliance trust wide.

We will increase our visibility and engagement with teams.

To do this we will:

- Develop our Safeguarding training plan
- Develop our safeguarding supervision plan
- Review our SOPs and arrangements for presence within the organisation.
- Review our team structure and identify and areas for increased efficiency and availability.

Self-assessment and continuous improvement

We will identify areas of strengths and areas for improvement in all areas of our safeguarding practice.

We will engage with all multi-agency opportunities for learning and ensure that opportunities for improvement are utilised to their fullest.

To do this we will:

- Develop and embed our safeguarding improvement and learning framework.
- Share the results of all audits and action plans.
- Celebrate our successes.

Integration and Partnership Working

We will have the right person in the right place at the right time to give the right advice

We will be represented at operational meetings, partnerships and boards by the right person.

We will be a valued and valuable contributor to our organisation and our partners.

To do this we will:

- Have a team structure that provides the most effective and cost-effective service.
- Embed a culture of collaboration at all levels of the organisation.
- Be purposeful, meaningful and efficient

Empowerment

We will ensure that all staff are able to respond to a safeguarding concern in real time.

We will ensure that staff are able and supported to challenge and escalate where necessary.

We will ensure that our patient's voices are heard.

To do this we will:

- **Embed our training plan and support teams to increase their compliance with statutory training.**
- **Review our SOPs and processes, along with feedback from our teams to ensure that they support best practice.**
- **Embed a high challenge high support culture in relation to safeguarding practice.**

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Agenda Item 6.1 Report to the Trust Board of Directors, 9 September 2025	
Title:	Board Assurance Framework (BAF)
Sponsor:	Gail Byrne, 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 July 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.

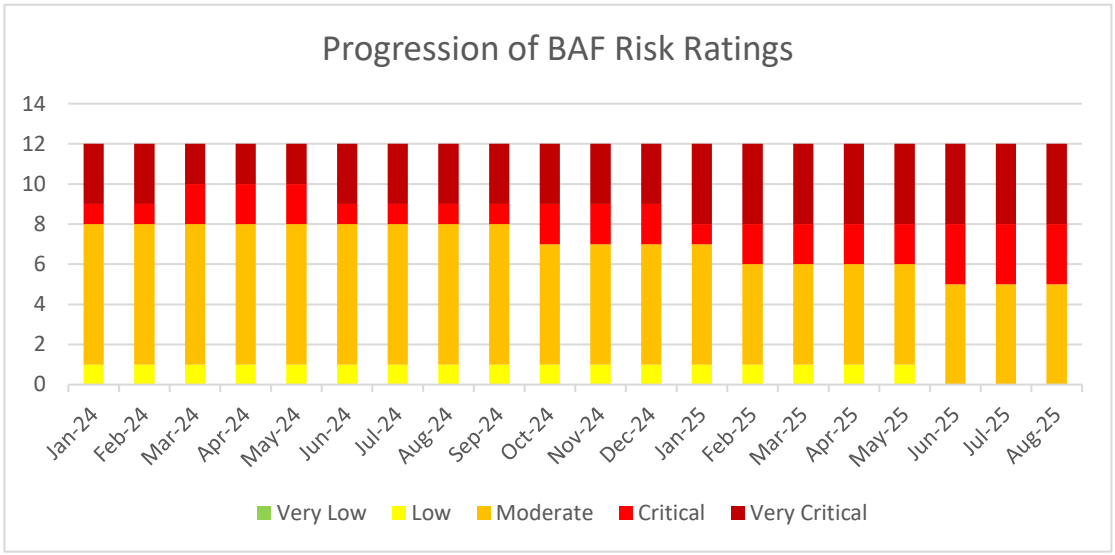
2.3. The risk rating for one risk has increased:

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

- a reducing cash balance impacting on 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.

The current risk rating has been reassessed and increased from 20 (severe x certain) to 25 (catastrophic x certain) in consideration of the deteriorating cash balance and the continued financial pressures within the organisation and across the system. Consideration has also been given to the target risk rating and this has been updated to reflect incremental risk reduction over the course of the next two financial years. The ultimate intent remains to reduce the risk in line with our risk appetite.

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.

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UHS Board Assurance Framework (BAF)

Updated August 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

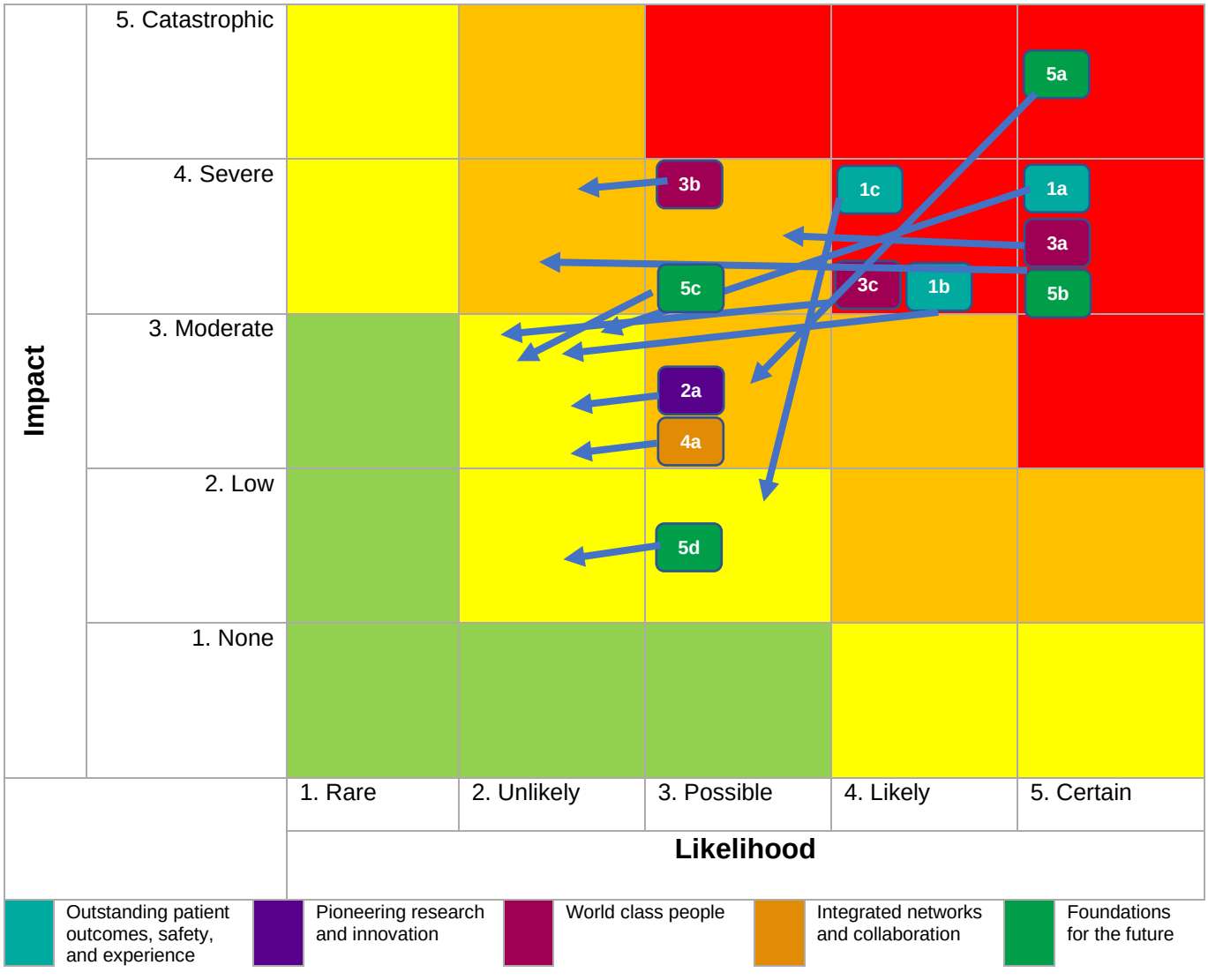
There are 7 critical strategic risks with a red risk rating above 15. These are:

- 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)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 August 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 as evidenced through deteriorating targets, for example at present only 54% of suspected cancer referrals are achieved within 2 weeks. To manage this capacity is being prioritised within oncology and P2 patients (those who should be treated within one month) and the organisation's transformation programmes aligned to this continue to be a key focus. Patients are being supported to make informed decisions when choosing where to be treated through transparency about wait times, particularly when we are not the closest or quickest option for the patient. Additionally work progresses to reduce procedures of limited clinical value to redirect capacity to more urgent and higher risk patients. Limited outsourcing continues for some high risk and high demand specialities such as urology/prostate, and some mutual aid is still being sought for cardiac patients. Despite this though, demand continues to grow and the organisation continues to deliver more elective work than commissioned for which is untenable in the current financial climate. Negotiations are underway with ICBs with the intent of addressing these gaps with partial success thus far, for example allocation of increased funding from BSW ICB, and some additional funding for Dermatology following withdrawal of the tier 2 service. More broadly, withdrawal of other tier 2 services presents a risk that our services could become overwhelmed with referrals, and this will need to be monitored and managed carefully. Operational planning for the winter season is underway with mitigations planned to use 16 surge beds if required.

In addition to the challenges around elective capacity described above, mental health also remains a challenge, as does capacity in ED. The refurbishment of the ambulatory majors corridor has now been completed, facilitating a better line of sight of patients which may reduce the number of admissions. Funding for an Urgent Treatment Centre at Southampton General Hospital has been confirmed and it is anticipated that this will be opened in March 2026. Additionally, funding for phase 2 of the Same Day Emergency Care is confirmed with an expected opening of March 2026 as well. It is hoped that this will aid urgent and emergency capacity once completed. It is noted that the second Emergency Care Intensive Support Team (ECIST) visit has now occurred and recommendations and governance arrangements are being reviewed.

30% of resident doctors at UHS took part in nation wide industrial action in July and this was managed well at UHS, with the Trust ranked 4th lowest of acute teaching hospitals in relation to cancelled activity (11 surgeries, 9 endoscopies/colonoscopies, and 350 outpatient appointments were cancelled).

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern. Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use. 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.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside. Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. However emerging NHS HIOW transformation programmes are focussed on discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure. 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**
Clinical Assurance Framework, reported quarterly to the executive. Reported bi-weekly via CPRP. Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. 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	Local system plans to reduce patients without a criteria to reside are emerging but will take time to evidence results.

from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns. NHSE and NHS HIOW ICS supportive quality visit to ED (September 2024). Increase in advice & guidance referrals.	

Key actions

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

Deliver ERF targets for 2024/25 to secure additional funding and address waiting lists - complete. Activity targets for 2025/26 set:

- < 1% patients waiting over 52 weeks
- > 72% of patients seen with 18 weeks

Pursue significant improvement in cardiac wait times through development of a demand and capacity plan and mutual aid.

Community Diagnostic Hub opening in 2025/26 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign.

New theatres and MRI suite scheduled to open in September 2024 - complete. 5 new all day theatre lists opened.

Engagement in the NHSE Further Faster programme for elective care.

Continued delivery of improvement work in 2024/25 and 2025/26 on patient flow and optimising operating services and outpatients through the elective and UEC transformation programmes.

An external visit from the Emergency Care Intensive Support Team (ECIST) took place in February 2024 and we have now received their report with findings and recommendations to review and implement. The Emergency Department Team have clear actions to take forward as well as some Trust wide schemes. Revised pathways have been trialled in ambulatory majors and pitstop both demonstrating improved safety and more timely access. Pilot is being reviewed and implemented further. A further ECIST visit is planned in June 2025.

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

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
95	Delays in discharge of children and young people with acute mental illness or behavioural disturbance may impact on capacity within the Children's hospital.	3 x 5 = 15	2 x 3 = 6	30/06/2025
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	30/04/2025
266	There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity	4 x 4 = 16	2 x 2 = 4	06/01/2025
395	This risk is related to the cardiac surgical patients who are on our waiting list that may come to harm whilst they wait for their surgery.	4 x 5 = 20	2 x 3 = 6	30/06/2025
443	Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service.	3 x 4 = 12	3 x 2 = 6	31/07/2025
470	Risk to reputation and patient safety due to insufficient theatre capacity across Child Health, resulting in long waiting times for surgery.	4 x 4 = 16	3 x 2 = 6	16/12/2024

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	31/08/2025
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/08/2025
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 3 = 9	3 x 1 = 3	30/10/2025
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	3 x 4 = 12	3 x 1 = 3	30/09/2025
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	30/09/2025
758	Urology stone service - including stent change delays & capacity challenges	4 x 4 = 16	3 x 2 = 6	31/10/2025
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	31/08/2025
767	HoLEP capacity issues	3 x 3 = 9	3 x 1 = 3	31/07/2025
775	Patients with kidney cancer may experience worse outcomes and survival due to capacity issues and delays in their treatment pathways	4 x 3 = 12	4 x 1 = 4	31/07/2025
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	30/09/2025
814	Inability to provide a safe pleural service	4 x 1= 4	2 x 2 = 4	01/09/2025
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	01/04/2025
850	Inability to effectively run the pelvic floor service due to staffing and capacity	3 x 3 = 9	2 x 2 = 4	31/08/2025
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	August 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed with the Deputy Chief Nurse for Quality in August 2025. 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.	Patient experience strategy is out of date and now not in keeping with national and local objectives. New

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 sponsors for priorities, health inequalities liaison role sitting within patient experience, and allocation of dedicated time across multiple roles in the clinical strategy and BI teams. Maternity safety champions. Listening events and community engagement. Equality & Quality Impact Assessment (EQIA) review group. Ward to Board governance and escalation route.	strategy to be co-designed with involved patients once the Trust strategy is finalised in 2025. 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.
Key assurances	**Gaps in assurances**
Monitoring of patient outcomes with QPSP input. CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Current and previous performance against NHS Constitution and other standards. Matron walkabouts and executive led back to the floor. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits.	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.

Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Strategy Oversight Committee Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Health Inequalities Board Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board). Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints. Divisional and committee AAA (Alert, Advise, Assure reports).	

Key actions

Introducing a robust and proactive safety culture:

Implement plan to enable launch of PSIRF in Q3 2023/24 and continued implementation and embedding into 2024/25 and beyond.

Embed learning from deaths lead & lead medical examiner roles (primary and secondary care) and develop objectives and strategy: end of life strategy was signed off and launched April 2025. Learning from death report embedded.

Introduce thematic reviews for VTE.

Implement the second round of Ockenden recommendations – completed.

Review of the clinical quality dashboard and how it reports up to Board.

Always Improving programme

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

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

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

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

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

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

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

Fundamentals of care programme roll out across all wards.

Patient experience initiatives

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

a wider demographic of patients. 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, there have been several vacancies in the Experience of Care, but with the recruitment of a new Head of Patient Experience there is now a renewed focus to provide divisional tailored reports at care group and divisional level.

We are listening events to be held 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

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

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

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
440	Children and young people with acute mental illness or behavioural disturbance will be at increased risk of harm if there are no dedicated CAMHS facilities and insufficient CAMHS staffing at Southampton Children's Hospital; this risk will be exacerbated if there are also delays in their discharge.	4 x 5 = 20	2 x 3 = 6	30/06/2025
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	29/08/2025
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	August 2025	2 x 3 6	April 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25
	3 x 3 9	3 x 3 9	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

The risk has been reviewed by the Deputy Chief Nurse for Quality in August 2025 with no alterations to the risk rating or target required at this time. It is understood that a high level of risk is still present and this can be evidenced through infection rates, practices and audits; for example through continued poor hand hygiene surveillance scores. To help mitigate this work is in process to empower ward IPC link nurses to challenge staff and promote basic practices, and to review low scoring audits in conjunction with the CNO.

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

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. 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.	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.
Key assurances	**Gaps in assurances**
Infection Prevention Committee and IP&C Senior Oversight Group. Hand hygiene, IP&C and cleanliness audits. Patient-Led Assessment of the Care Environment. National Patient Surveys. Capital funding monitored by executive. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board. Clinical audit reporting. Internal audit annual plan and reports. Finance and Investment Committee oversight of estates and digital capital programme delivery. Digital programme delivery group meets each month to review progress of MMR. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). Ongoing focus on hand hygiene by the IPT and Divisions/Care groups – improvements starting to be seen in hand hygiene practice (as demonstrated in	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.

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

Key actions

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

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

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

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

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

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

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

Pioneering research and innovation

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

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

Cause	Risk	Effect
If there is: • 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	August 2025	3 x 2 6	March 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 reviewed by the responsible executive in August 2025 and the risk rating and targets are considered accurate. It is still anticipated that the planned reduction in headcount in R&D, as part of the workforce reduction across the organisation, may have an impact on national Trust Board KPI rankings later in the year. With a reduced workforce previous improvements may be difficult to sustain and slippage may be encountered. To support mitigation of this EQIAs are being 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. Local ownership of development priorities, supported by the transformation team.	Operational pressures, limiting time for staff to engage in research & innovation. Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. Impact of recruitment processes on vacancy rates in research workforce and clinical support services is impacting performance, with vacancy rates having a particular impact in R&D office and clinical trials pharmacy. Vacancies being filled, but R&D turnover still higher than Trust average. It is anticipated that the impact of the current financial and 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.
Key assurances	**Gaps in assurances**
Governance structure surrounding University partnership. Board to Council meetings. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint Innovations and Commercialisation Group – UHS/UoS. Monitoring research activity funding and impact at R&D steering group. MHRA inspection and accreditation. Strategy and transformation process. CQC review of well-led criteria, including research and innovation. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In 24/25 we saw the impact of the focus on our recruitment with improvement in our national performance: recruitment rankinghad improved from 16th in 23/24 to 10th in March 2025, and weighted recruitment had improved from 13th in 23/24 to 10th in September 2024, but has since slipped back to 12th in March 2025.	Limited corporate approach to supporting innovation across the Trust. National benchmarking: previously ranking was below optimal although improvements are being seen since September 2023. Action plan underway. Now meeting Trust Board KPI for recruitment ranking (improvement from 16th in 2023/2024 to 10th 2024/2025) and weighted recruitment had improved (from 13th in 23/24 to 10th September 2024) but has now slipped to 12th for overall 2024/2025 weighted recruitment. New national site metrics introduced around commercial clinical trial set up and delivery will be introduced as Trust Board KPIs.
Key actions	
Staff survey to test staff engagement and understanding of innovation at UHS. Deliver R&I Investment Case. Annual Plan for 25/26 will be taken to TB which includes investment RoI evaluation. Established mechanisms to capture RoI on investment are now built into annual planning process. International Development Centre, attracting external funding to support staff in pursuing innovation. Maximise the benefits of the newly established Wessex Health Partnership as a founding member. WHP Annual Review starting to identify RoI, UHS has committed to supporting next 3 year term. Supporting departments in increasing recruitment and retention through work with R&D to create innovative roles. Staff engagement initiatives were presented to TBSS in February 2025. Review the Trust's approach to corporate-wide innovation. Processes being streamlined and new digital tools being adopted to increase clinical research delivery efficiency. On-going improvement programme, but impact being felt as we saw an improved recruitment ranking in 24/25 Joint Research Vision, developed with University of Southampton, went to Senior Operational Group in June 2024, and was finalised by the Joint Research Strategy Board in Q4 2024/25. UHS led on a regional bid for an NIHR Commercial Clinical Research Delivery Centre supported by all Wessex NHS Partners, Dorset and HIOW ICBS, Wessex Health Partners and Heath Innovation Wessex. Funding £4.7m over 7 years awarded, to start 1st April 2025. UHS as host have submitted regional bid in partnership with UoS for renewal of the NIHR Applied Research Collaboration (ARC) Wessex. Application for £16m (uplift from £9m from previous award). Notified through to second stage of the application. Funding application from Wessex Health Partners to take forward outputs from Innovation workshop unsuccessful but funding secured from the NHSE Secure Data Environment To develop processes for UHS/UoS partnership and in the longer term a UHS innovation strategy. Links to review of corporate wide innovation approach above.	

World class people

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

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

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	August 2025	4 x 3 12	March 2030

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 August 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. The first planned shared service is recruitment services and this will be launched at the start of Q4 2025/26.
  - UHS initiated a Mutually Agreeable Resignation Scheme (MARS) earlier this year which has now concluded with agreed exits being managed. A further MARS was initiated in May 2025, open to a wider pool of candidates, and this closed 15 June 2025. From the second scheme 65 MARS applications have been approved and are being processed (51 WTE). 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 are being implemented September 2025 and this will 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 Trust has addressed concerns regarding NQN recruitment over the past month 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.

It is also noted that 30% of resident doctors at UHS took part in nationwide industrial action in July and this was managed well at UHS, with the Trust ranked 4th lowest of acute teaching hospitals in relation to cancelled activity (11 surgeries, 9 endoscopies/colonoscopies, and 350 outpatient appointments were cancelled).

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.	Completion of objectives for South-East temporary collaborative for 2024/25, 2025/26, and beyond. Planned improvements for medical job planning to be implemented.
Key assurances	**Gaps in assurances**
Fill rates, vacancies, sickness, turnover and rota compliance .	Universal rostering roll out including all medical staff.

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. Review of implications for education and training infrastructure from national workforce plan.	

Key actions

2025/2026

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.

Plan and deliver shared corporate services across Hampshire and the Isle of Wight, commencing with a shared recruitment resource hub planned to be implemented October 2025.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
20	Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection	3 x 4 = 12	1 x 5 = 5	01/10/2025
67	There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc.	2 x 4 = 8	3 x 2 = 6	31/10/2025
167	MRI physics staffing risk	4 x 2 = 8	2 x 1 = 2	31/03/2025
180	Lack of pathology staff and inappropriate skill mix	3 x 4 = 12	3 x 2 = 6	31/07/2025
286	Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service	3 x 4 = 12	3 x 3 = 9	31/12/2025
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	30/08/2025
604	Risk in epilepsy nursing service	3 x 2 = 6	2 x 2 = 4	18/06/2025
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 4 = 16	2 x 1= 2	24/06/2025
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	31/10/2025
662	Cellular Pathology Staffing and Capacity	4 x 5 = 20	4 x 2 = 8	31/08/2025
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	31/08/2025
748	There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service	2 x 4 = 8	2 x 1 = 2	31/08/2025

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	31/07/2025
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 4 = 12	3 x 2 = 6	31/03/2026
844	Patients may not receive lifesaving emergency cardiac surgery due to a lack of cardiac trained staff.	4 x 3 = 12	4 x 1 = 4	30/09/2025
859	Reduced Portering workforce (volume and skill/knowledge) due to industrial action may affect the operational ability of UHS to provide safe and efficient patient care	3 x 2 = 6	3 x 1 = 3	30/09/2025
872	Lack of administrative support within cancer care	3 x 5 = 15	2 x 1 =2	31/08/2025
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	2 x 2 = 4	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	31/07/2025
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	30/07/2025
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	31/10/2025
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

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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	August 2025	4 x 2 8	March 2030

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 August 2025 and updated as required. The risk rating has been considered and agreed to remain accurate. It is noted that a significant level of organisational change is underway and that this may impact on staff experience, therefore a comprehensive range of measures have been implemented to support staff through this. This includes:

  - '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.
  - Creation of an Equality & Quality Impact Assessment (EQIA) review group to support the Trust's Financial Improvement Group (FIG) in making informed decisions. Where operational and organisational changes are proposed at FIG, an EQIA will be completed and reviewed at the group, focussing on the impact to both patients and staff. This will help to mitigate the risk of discrimination where changes are proposed.
  - The established 'Windows into wellbeing' Staffnet page which promotes access to a range of services such as occupational health, chaplaincy, and the employee assistance programme. Further dedicated resources have been added in relation to wellbeing and managing change.
  - Indicators such as absence and sickness are being closely monitored at a local and Trustwide level.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks.

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. Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing. Launch of digital appraisal process. **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.	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.
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board.	Maturity of staff networks. Maturity of datasets around EDI, and ease of interpretation.

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 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.	

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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	August 2025	3 x 2 6	March 2029

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 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 August 2025 by the responsible executive and no significant changes were required as the risk was extensively reviewed in February 2025 when the risk rating was increased. At present there is still a lack of national directive, although a longer term plan is expected in Spring and new workforce plans will be published, which will help to guide direction. The NHS Long Term Plan has now been published and we do expect that the workforce plans will follow this next quarter. It is noted that the T&D review of the infrastructure and long term workforce plan has now been completed and presented to People and Organisational Development Committee (POD) with next steps under consideration.

To support education for staff who do not qualify for national CPD funding, £175K of charitable funds have been secured, and divisions are participating in allocation of 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	

VLE relaunched to support staff to undertake self-directed learning opportunities. TNA process completed for 2025/26. Escalation to NHSE with offer to assist in identifying future solutions.	Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust. Areas of concern in the GMC training survey National CPD guidance for 2025/26: scope of application is limited by rigid national rules. New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included. Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships.
Key assurances	**Gaps in assurances**
Annual Trust training needs analysis reported to executive. Trust appraisal process GMC/NETs Survey Education review process with NHSE WTE. Utilisation of apprenticeship levy. Talent development steering group People Board reporting on leadership and talent, quarterly	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.

Key actions

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

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 is underway within T&D to look at the infrastructure and longterm workforce plan and will be 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	31/10/2025

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	August 2025	3 x 2 6	Dec 2025

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 into 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.

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

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	• Potential for diluted influence at key discussions • Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local.

• Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes. • Establishment of UHS Integrated Networks and Collaboration Board • Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner organisations 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.	• 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 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**
• CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys • Friends and Family Test • Outcomes and waiting times reporting. Included within cases for change being built for networks. • Integrated networks and collaborations Board set up for regular meetings at executive level.	• Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. • Ability to network is difficult and manifests in capacity challenges. • Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track.

Key actions
Urology Area Network plan agreed. Progress had stalled due to lack of programme management resource and clinical lead stepping down. This programme has now picked up again and new workstreams have been agreed. Challenges to moving forward related to aligning clinician's availability across multiple organisations.
Business case for future working of the Southern Counties Pathology Network 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 September/October 2025.
Business case for a Southampton elective hub has been written and approved at TIG and Trust Board, with a letter of support provided by the ICB as well. Capital funding has been set aside and plans have been sent to NHSE for approval, with the aim of opening this in April 2026.
NHSE has approved the business case, and funds have been received, for the Winchester Elective Hub which is due to be 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.
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.
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 the next financial year. Plastic leadership has also been strengthened within UHS to support this change.
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 and UHS are engaging with ICBs and Specialised Commissioning.
Once networks have been established, define a core set of KPI metrics to be monitored. INC board has been disbanded therefore ownership and oversight will sit within the Acute & Community Provider Collaborative with engagement from UHS.
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.

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 20	August 2025	5 x 4 = 20 5 x 3 = 15	April 2026 April 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25
	3 x 5 15	3 x 5 15	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

Current assurances and updates

This risk was reviewed by the Chief Finance Officer in August 2025. Following reassessment, the risk rating has increased from 20 (severe x certain) to 25 (catastrophic x certain). This escalation reflects the significant and sustained fiscal pressures currently facing the Trust, including a declining cash balance and the associated operational impact. The target risk rating has also been considered by the Finance & Investment Committee and has been updated to reflect incremental reduction anticipated over the next two years, with eventual risk reduction in line with risk appetite remaining the ultimate objective. This will be managed alongside risks to performance and increasing activity which will directly impact financial risk.

The increase in risk rating is supported by negative assurance regarding the effectiveness of current mitigations, as evidenced by deviations from the financial plan in months 3 and 4. In response, several additional mitigations are being implemented:

- A cash advance from the Integrated Care Board (ICB) has been secured.
- A financial recovery plan is under development.
- Efforts are underway to address the imbalance between payment and activity, including:
  - A formal dispute with BSW ICB, which has resulted in an increase in payment.
  - A further dispute with Dorset ICB, currently in arbitration with NHS England (NHSE).

Further measures under consideration include reducing activity and workforce beyond current reduction targets, though these must be carefully weighed against potential impacts on quality, staff wellbeing, and performance. Local mitigations are also being progressed, including the Make It Count campaign and a reduction in temporary staffing payment rates.

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. • 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.	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. • 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**
• 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. • Regular reporting on movements in overall productivity. • Monthly cash reporting to F&IC.	• 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.
Key actions	
• Delivery of 2025/26 financial plan. • 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.
- Set programmes/projects for delivery as part of the Financial Improvement Group – underway and ongoing.
- Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway and established.
- Workforce forecasting and delivery of workforce reduction schemes.
- Develop and implement a financial recovery plan.

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	August 2025	4 x 2 8	April 2030

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 in August 2025 with no revisions to the current or target risk ratings required. There are no new concerns and plans to address the backlog maintenance are on plan, however adequate funding remains the limiting factor in mitigation of this overall risk.

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.
	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment.
	Lack of decant facilities.
	Reactive system requires re-prioritisation review.
Asset register (90% in place)	Planned maintenance will drop out of the asset register work.
Maintenance schedules	Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits.
Trained, accredited experts and technicians	Lack of Estates strategy for the next 5 years.
Asset replacement programme	
Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.)	

Six Facet survey of estate informing funding and development priorities Estates masterplan 22-23 approved. Clear line of sight to Trust Board for all risks identified.	
Key assurances	**Gaps in assurances**
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	The annual six facet survey has recently been completed and is being used to facilitate risk-based prioritisation of funding through the Trust Investment Group (TIG). This has highlighted 17 new operational risks which are being assessed ahead of addition to the operational risk register.
Key actions	
Commence work on the estates strategy following the finalisation and agreement of the estates masterplan, including engagement with all clinical and non-clinical divisions. Being developed alongside the ICB infrastructure plan. Currently paused as funding has been withdrawn, but this is currently under consideration as to how to move this forward. Identify future funding options for additional capacity in line with the site development plan. Delivery of 2025/26 capital plan. Implement the HIOW elective hub. Deliver £3.5m of critical infrastructure backlog maintenance in 2025/26. 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	30/11/2024
260	Insufficient space in the induction of Labour Suite.	28/10/2019	4 x 4 = 16	3 x 1 = 3	31/12/2025
421	There is a risk that the Trust does not appropriately manage or maintain its assets.	28/08/2020	4 x 3 = 12	4 x 1 = 4	30/06/2025
489	Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures	07/02/2021	5 x 3 = 15	5 x 1 = 5	31/03/2027
727	Black start electrical test	25/07/2023	5 x 2 = 10	5 x 1 = 5	31/08/2025
773	Impact of the Building Safety Act (2022) on Capital Project Delivery	24/01/2024	3 x 3 = 9	3 x 2 = 6	30/05/2025
817	Lack of UPS backup on power failure	28/05/2024	5 x 3 = 15	5 x 1 = 5	31/06/2025
818	Centralised Chilled water system - power supply resilience	28/05/2024	5 x 2 = 10	5 x 1 = 5	31/07/2025

846	PAH – General ward areas and Neonatal Unit air handling units beyond service life	11/10/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
851	Lab and Path Chiller 1 Aged and Not Operational	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2025
853	Lab and Path Chilled Water Pumps	06/11/2024	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	31/08/2025
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	August 2025	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 in August 2025 with no revisions to the current or target risk ratings required.

It was previously noted that UHS had a cyber issue whereby the Ivanti Endpoint Manager Mobile equipment was accessed by unauthorised users. The UHS cyber team worked with the NHS England Cyber Security Operations Centre and the National Cyber Security Centre to address these issues, and there has been no evidence of data being stolen. Patient data was not included within this ring fenced system. In response, further to the recent cyber security Trust Board Study Session, an additional session is being set up for the Board to participate in the NHS Board Cyber training which contributes to our DPST scoring. An internal audit into cyber security is also scheduled for September 2025.

Development and roll out of key actions continue. This includes implementation of MIYA which is anticipated to go live early September 2025 providing the remaining issues can be resolved to ensure stability of the system. There is the risk of short term slippage if a resolution cannot be found in time, however safe and sustainable implementation is a key priority. Additionally the UHS digital strategy has been drafted and is due for consultation with key stakeholders.

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. • Penetration testing contract pulled forward to 2024/25.
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 • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards. • Robust system and regression testing completed on system developments. • Scenario testing completed.	**Loss of access to critical IT systems** • Time to fully stress test business continuity plans.
Key assurances	**Gaps in assurances**
Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed weekly on UHS Digital leadership team call.	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).

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. NHSE annual DPST assessment completed to highlight gaps in services. Business Continuity Plans in place for clinical areas in the event of IT outages. Trust Board Study Session digital update (June 2025).	Digital team provide guidance to clinical services developing BCPs but the team do not review these at service/ward level due to time and capacity.

Key actions

- Ongoing recruitment of key Digital resource to mitigate operational risk.
- Inpatient noting for doctors scheduled for 2025/26.
- Replacement of key clinical systems to more modern systems: Alcidion previously scheduled in April 2025, now deferred to October 2025.
- Lessons learned from LIMS project were shared across UHS Digital, Estates, and other major project teams.
- Procurement of Single EPR across HIOW to provide a more modern EPR.
- Identify opportunities for funding for digital transformation and programmes.
- Acceleration of cyber software upgrades completed 2024/25.
- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience. The air conditioning for the A-Level communications room is also now under review.

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	30/05/2025
556	Workforce Resourcing - Risk to provision of Pathology test results (all departments) if there are delays or errors in the implementation of the new Path IT system	4 x 3 = 12	4 x 1 = 4	31/08/2025
634	Accommodation / Infrastructure - Fibre optic cabling at the ONH	4 x 3 = 12	4 x 3 = 12	29/09/2025
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	29/09/2025
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	4 x 4 = 16	2 x 3 = 6	31/12/2025
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	30/05/2025
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	August 2025	2 x 2 4	December 2027

Risk progression: (previous 12 months)	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 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 3 6	2 x 3 6	2 x 4 8	2 x 4 8

Current assurances and updates

This risk has been reviewed in August 2025 by the responsible executive and updates provided as below:

- Following previous temporary gaps in leadership, these have now been filled including a shared leadership model with HHFT. This provides opportunities to align plans and share learning, and work is now progressing to review and update the Green Plan.
- However, the lack of clinical speciality leads remains a challenge. Although the business case for these roles was approved, the recruitment controls have meant that these posts cannot be appointed to.
- A £19m bid to Salix to support the heat recovery programme of work has been approved. Whilst this is positive news, it is noted that due to government restrictions in funding, this is now likely to be the last grant secured in the foreseeable future, therefore future funding opportunities are currently unclear.

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.

Key assurances	Gaps in assurances
Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators. Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board. Sustainability Board	Definition of and reporting against key milestones.

Key actions
Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore Low carbon skills funding) Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. Continue to further develop metrics and establish governance processes in respect of the Trust's Green Plan and other related strategies. Finalise energy performance contract to deliver a responsive and progressive energy plan. 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, 9 September 2025	
Title:	People and Organisational Development Committee Terms of Reference
Sponsor:	Steve Harris, Chief People Officer
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
	x		

Strategic Theme

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

Executive Summary:

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

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

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

No other changes are proposed.

The Board of Directors is asked to approve the terms of reference following review and approval by the People and OD Committee on 1 September 2025.

Contents:

Revised Terms of Reference (marked up)

Risk(s):

N/A

Equality Impact Consideration:	N/A

People and Organisational Development Committee Terms of Reference

Version: ~~6~~ 7

Date Issued:	~~10 September 2024~~ 9 September 2025
Review Date:	August ~~2025~~ 2026
Document Type:	Committee Terms of Reference

Contents

Document Status

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1. Role and Purpose

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

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

2. Constitution

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

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

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

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

3. Membership

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

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

3.1.2 the Chief Executive;

3.1.3 the Chief Nursing Officer;

3.1.4 the Chief Medical Officer; and

3.1.5 the Chief People Officer.

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

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

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

4. Attendance and Quorum

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

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

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

5. Frequency of Meetings

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

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

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

7.1 ***Culture***

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

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

7.1.2.1 staff and team engagement;

7.1.2.2 compassionate and inclusive leadership;

7.1.2.3 quality improvement;

7.1.2.4 equality, diversity and inclusivity;

7.1.2.5 bullying and harassment;

7.1.2.6 staff sickness and wellbeing

7.1.2.7 Freedom to Speak Up and raising concerns;

7.1.2.8 people aspects of the corporate and clinical strategy; and

7.2 ***Capacity***

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

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

7.2.2.1 strategic workforce planning;

7.2.2.2 recruitment and retention;

7.2.2.3 staffing levels;

7.2.2.4 reports from the Guardian of Safe Working Hours;

7.2.2.5 talent management;

7.2.2.6 reward including pensions;

7.2.2.7 CQUINs;

7.2.2.8 bank and agency staff; and

7.2.2.9 volunteers.

7.3 ***Capability and Skills***

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

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

7.3.2.1 appraisals;

7.3.2.2 education and training;

7.3.2.3 mandatory training;

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

7.3.2.5 the annual staff survey;

7.3.2.6 the 'fit and proper persons' requirements;

7.3.2.7 the Staff Friends and Family Test; and

7.3.2.8 flu vaccinations and other national vaccination programmes.

7.4 ***Risk***

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

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

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

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

7.5 ***CQC Quality Statements***

7.5.1 The Committee will also receive assurance on the organisation's compliance against the refreshed CQC quality statements that relate to culture, including equality diversity and inclusion.

7.6 ***Reporting***

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

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

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

8. Accountability and Reporting

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

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

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 Employment Rights Act 1996

10.2 Equality Act 2010

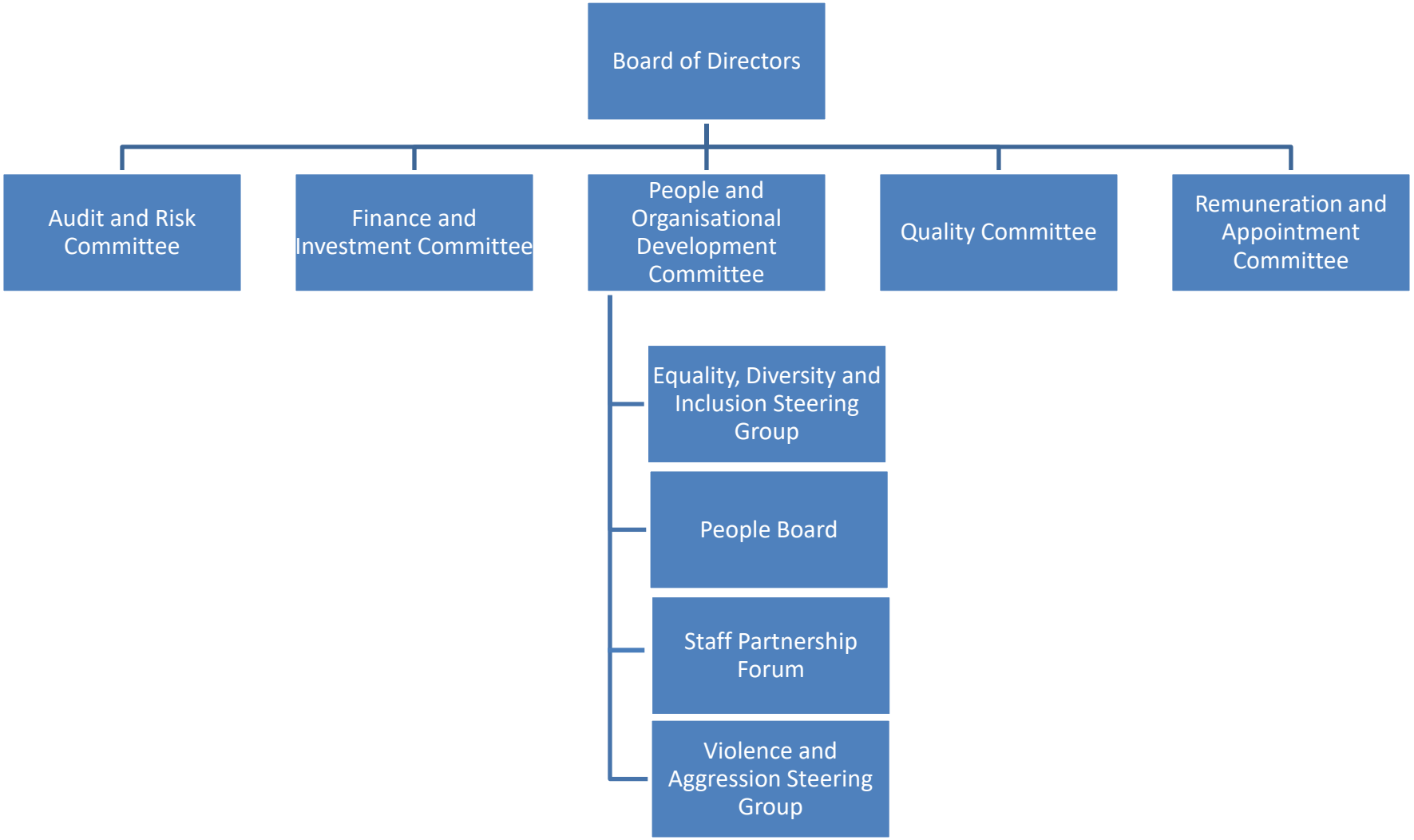
10.3 Public Interest Disclosure Act 1998

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

10.5 NHS Constitution

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

Appendix A


Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Equality, Diversity and Inclusion Steering Group
People Board
Staff Partnership Forum
Violence and Aggression Steering Group

People and Organisational Development Committee Terms of Reference	Version: ~~6~~ 7

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~10 September 2024~~ 9 September 2025
Responsible Committee:	People and Organisational Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	September ~~2025~~2026
Target audience:	Board of Directors, People and Organisational Development Committee, Staff
Key words:	People, OD, Committee, Board, Terms of Reference
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Summary of most recent changes if applicable:	~~Addition of paragraph 7.5 CQC Quality Statements~~ Removal of Charitable Funds Committee, now defunct, from Appendix A
Consultation:	Chief People Officer
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Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

Agenda Item 10.1	Report to the Trust Board of Directors, 9 September 2025
Title:	South Central Regional Research Delivery Network 2025-26 Quarter 1 Performance Report
Sponsor:	Mr Paul Grundy, Chief Medical Officer
Author:	Clare Rook, Network Director, SC RRDN and 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 quarter of the 2025/26 financial year (April to June 2025).

The SC RRDN region demonstrated strong performance in the first quarter of 2025/26, ranking second nationally for total recruitment and first when adjusted for population. The region recruited 24,874 participants across 627 studies across all care settings and main specialties.

While overall recruitment and specifically commercial recruitment have experienced a downward trend, which mirrors the national picture, the network has implemented a comprehensive action plan to reverse this. This plan focuses on sharing information, strategically selecting high-impact studies, fostering greater collaboration, and improving engagement with industry and the public.

Feedback from research participants remains positive, with 95% willing to participate in research again. The network has, however, identified a key opportunity to improve how the results of studies are communicated back to participants.

Contents:

South Central Regional Research Delivery Network Q1 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 One Performance Report

Clare Rook, Network Director

Graham Halls, Data and Analytics Senior Manager

August 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 the first quarter of the 2025/26 financial year (April to June 2025).

SC RRDN was formed in October 2024, with a change in geography to include 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**:

- to support the successful delivery of high quality research, as an active partner in the research system
- 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.

Overview of research activity in the SC RRDN region

All recruitment in South Central

During the first three months of the 2025/26 financial year in the South Central region, **24,874 participants** were recruited to **627 studies** at **168 sites** and across **all main clinical specialties**. Regional recruitment since April 2023 has averaged around eight thousand participants per month, with there being a slight downwards trend over this period (Figure 2). This downwards trend is

evident across the whole of England. SC RRDN has developed a recruitment action plan to reverse this downwards trend in our region and this is detailed later in this report.

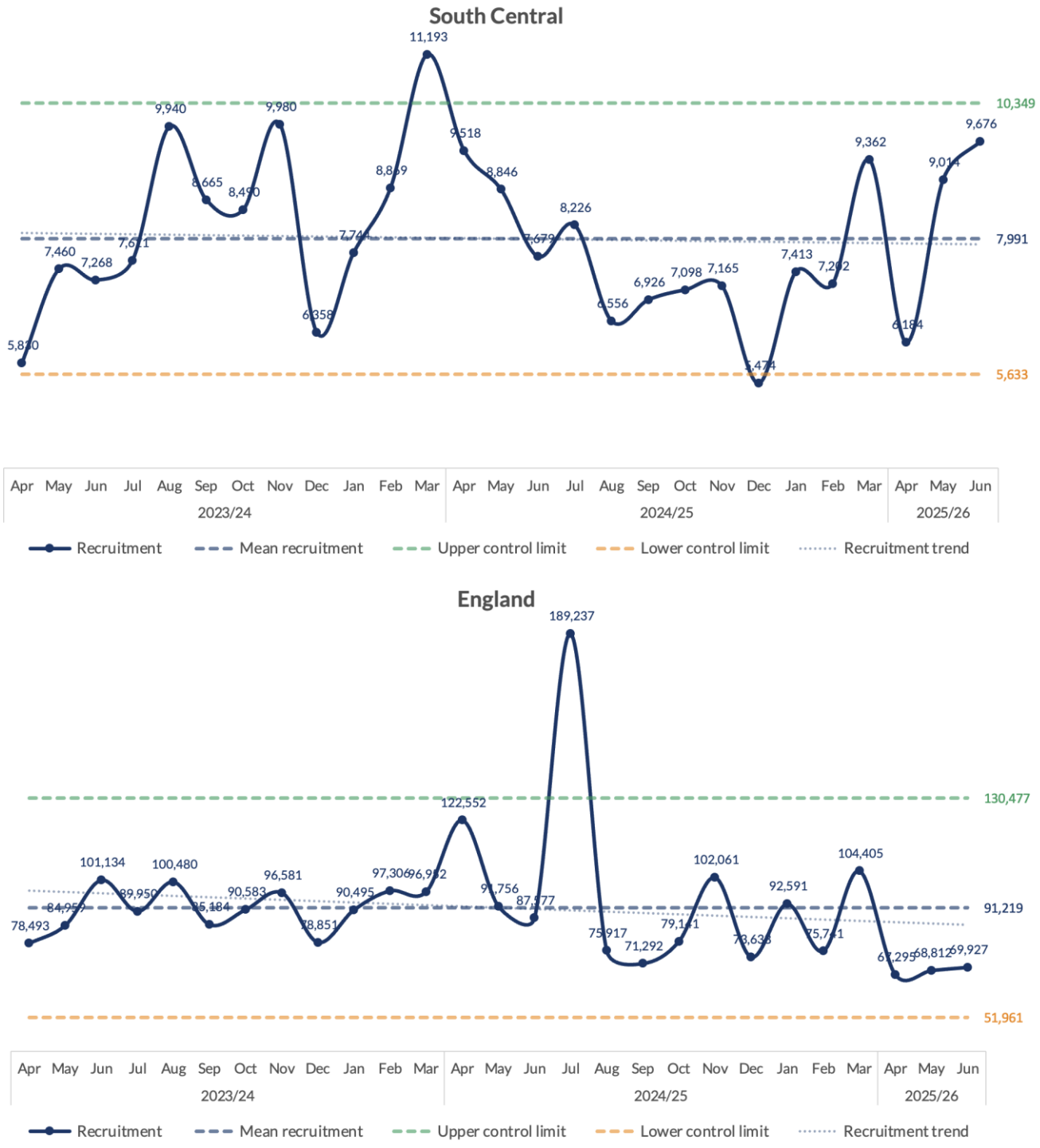

Figure 2 - Monthly recruitment in the South Central region benchmarked against England since April 2023

Over the same period, the type of studies that have recruited has been changing, with an increase in 'interventional' studies, where the patient's care is affected by participation, and a reduction in 'observational' activity (Figure 3). This trend can be greatly affected by only a few high recruiting studies, which was the case during the 2023/24 financial year. However, having approximately equal participation in both observational and interventional research is an indicator of a balanced portfolio of research currently being delivered in the region.

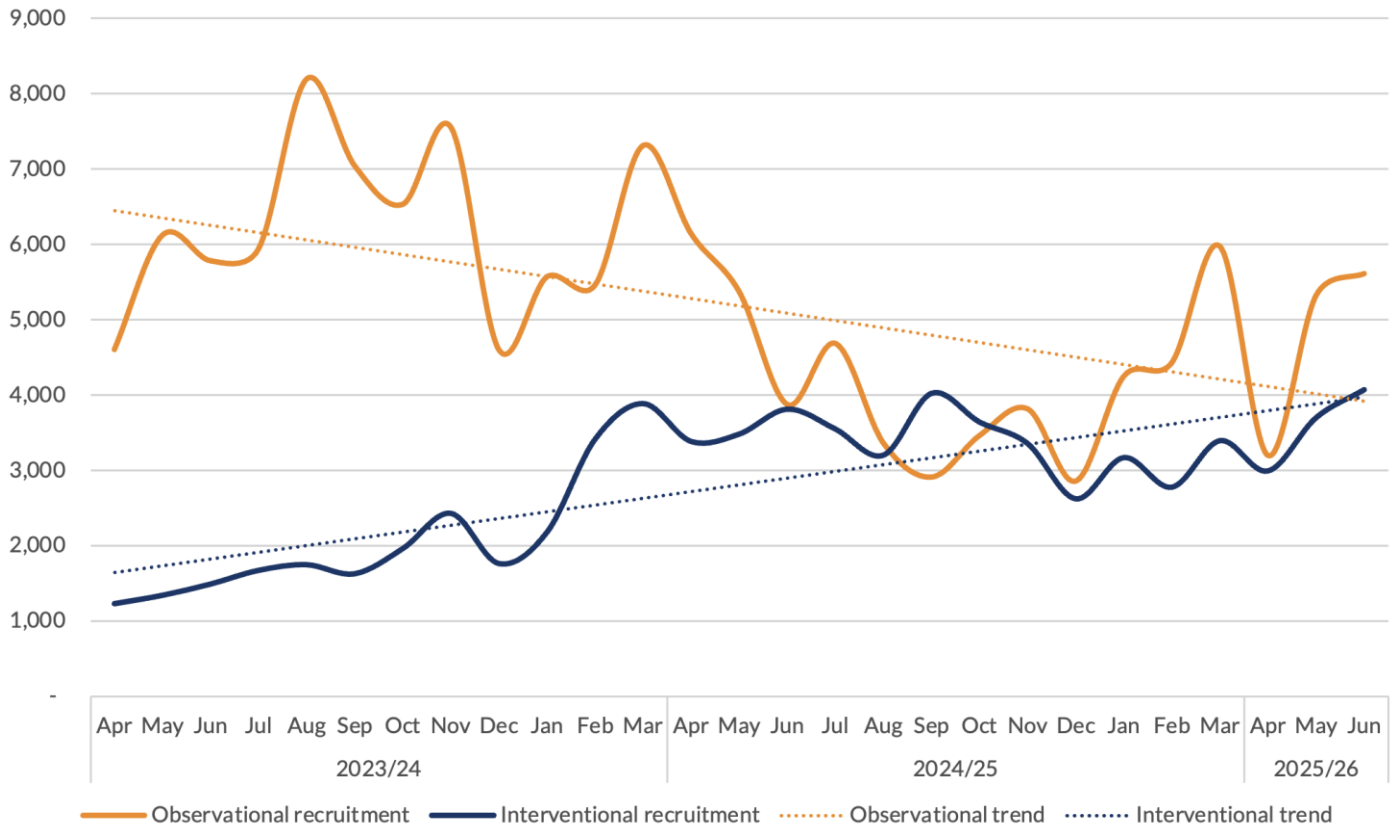

Figure 3 – Recruitment by study design within the South Central region since April 2023

South Central was the second highest recruiting region in the first quarter (Figure 4), despite the region having the eighth largest population among the twelve regions in England. When the size of the population is factored in, South Central had the highest proportion participating in research.

Figure 4 - Recruitment and recruitment weighted per million population by RRDN region in quarter one of the 2025/26 financial year

Organisation type	Trusts	Recruiting sites	Recruitment	Recruiting studies
Acute	8	28	14,173	533
Ambulance	1	8	338	5
Mental Health	3	51	1,415	64
Non-NHS	-	5	230	17
Primary care	-	77	8,718	32

Table 1 - Research activity in the South Central region by organisation type in quarter one of the 2025/26 financial year

Table 1 shows how research activity is distributed across the South Central region by type of organisation. Acute trusts, which primarily recruit from hospitals, were the largest contributors to recruitment and had the highest number of recruiting studies. Over 10,000 participants have been recruited from wider care settings by primary care, mental health, ambulance and non-NHS

organisations. Around twenty per cent of general practices have recruited in quarter one, with other practices providing support through complementary activities such as patient identification and referrals.

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.

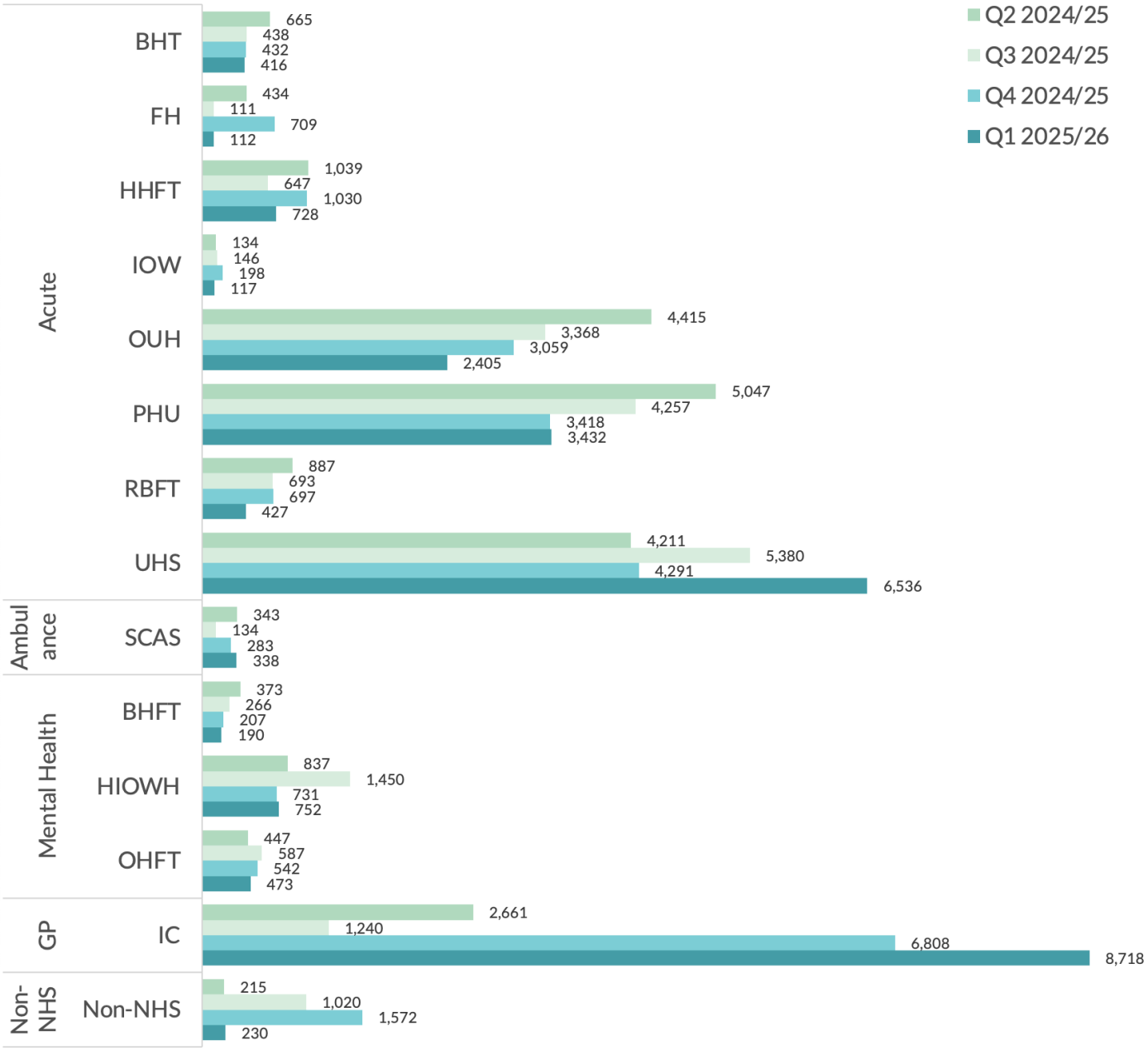

Figure 5 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

Recruiting studies in South Central

The total number of recruiting studies has remained relatively stable at around 1,100 to 1,200 annually, however there has been a change over time in their composition (Figure 6). The number of recruiting studies for quarter one in 2025/26 will appear reduced because this total is for a partial year only.

Large scale studies have a national recruitment target of over ten thousand participants and are usually designed to be simpler to deliver. Observational studies require no change to a participant's care pathway and may include data collection, surveys or interviews only. Interventional studies and the majority of those that are commercially funded and sponsored typically have more intensive requirements, including frequent visits and additional procedures.

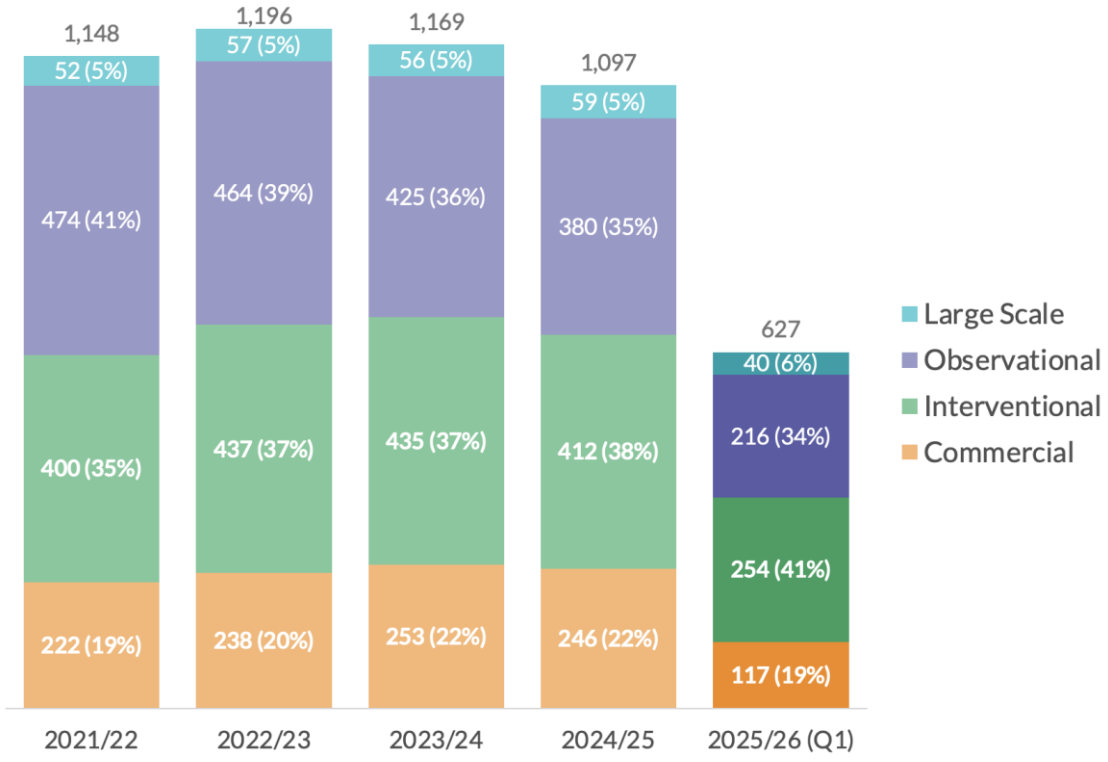

Figure 6 – Recruiting studies by complexity category within the South Central region since April 2021

The number of recruiting observational studies has been declining, from 474 in 2021/22 to 380 in 2024/25. This trend has continued into the first quarter of 2025/26, with 216 studies, representing a smaller proportion of the total (34 per cent). Conversely, the proportion of

interventional studies, which are often focused on developing new treatments, has been growing steadily and has increased again in the first quarter.

There has been a small decrease in the proportion of commercial recruiting studies in quarter one. However, the region's organisations are demonstrating a continued ability to attract industry-funded research. Large Scale studies have also remained consistent and accounted for 58 per cent of the region's recruitment in quarter one.

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 quarter of 2025/26, organisations in the South Central region have recruited **428 participants** across **18 sites** on **117 commercial studies**. South Central was the **seventh highest recruiting RRDN region in England** (sixth when weighted per million population).

Figure 7 shows that the overall trend line in commercial recruitment is downwards for both South Central and England, indicating a general decline in commercial recruitment over the period. The peak seen in the region and across England during 2023/24 and the beginning of 2024/25 are due to three very large observational studies with national recruitment targets between 19 and 146 thousand participants. When these are removed, monthly commercial recruitment is relatively stable in South Central since April 2023. However, quarter one recruitment is below the new average of 239 participants per month. The recent reduction highlights the need to focus on this area, and this has been included in the region's recruitment action plan.

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.

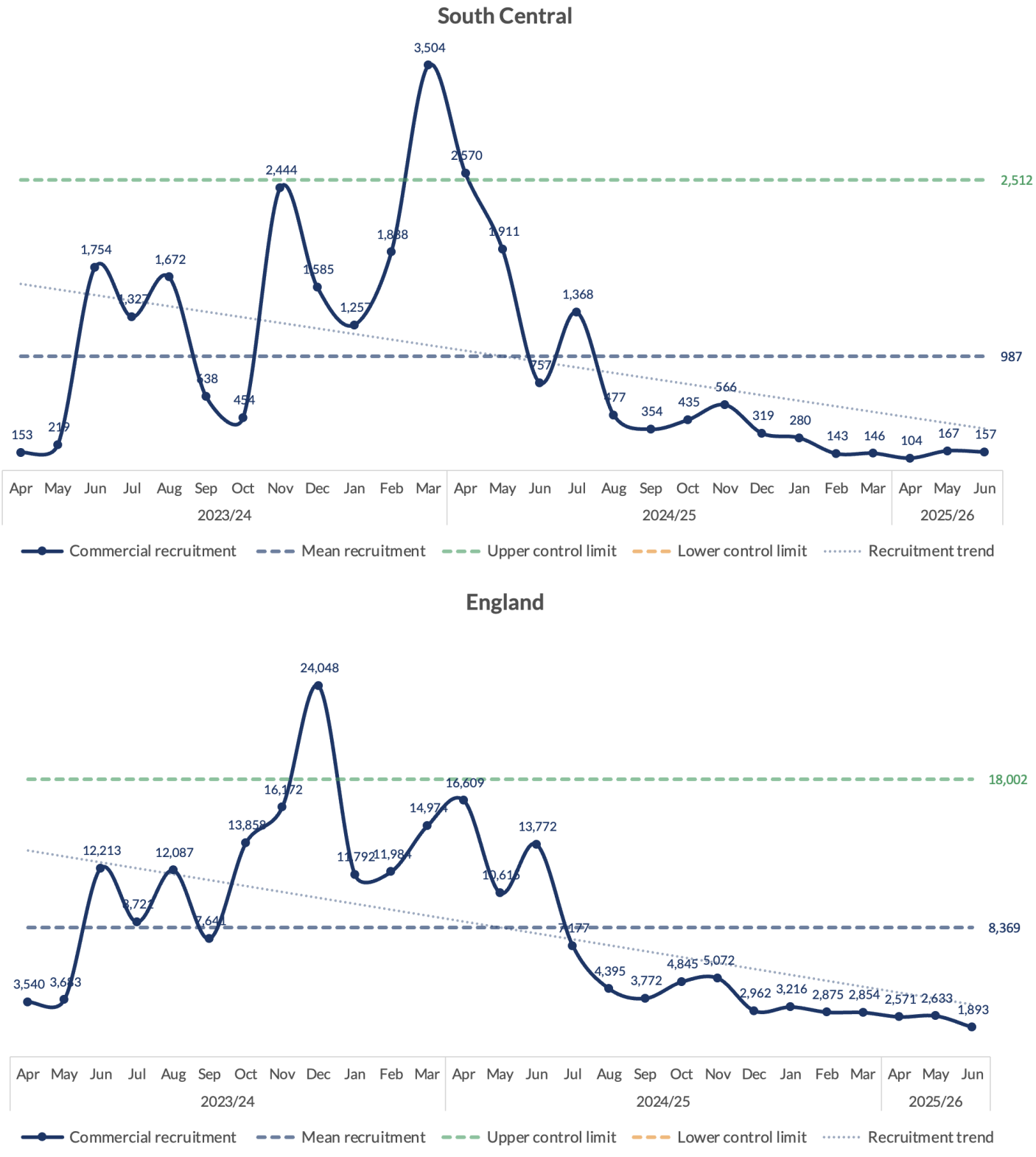

Figure 7 - Monthly commercial recruitment in the South Central region benchmarked against England since April 2023

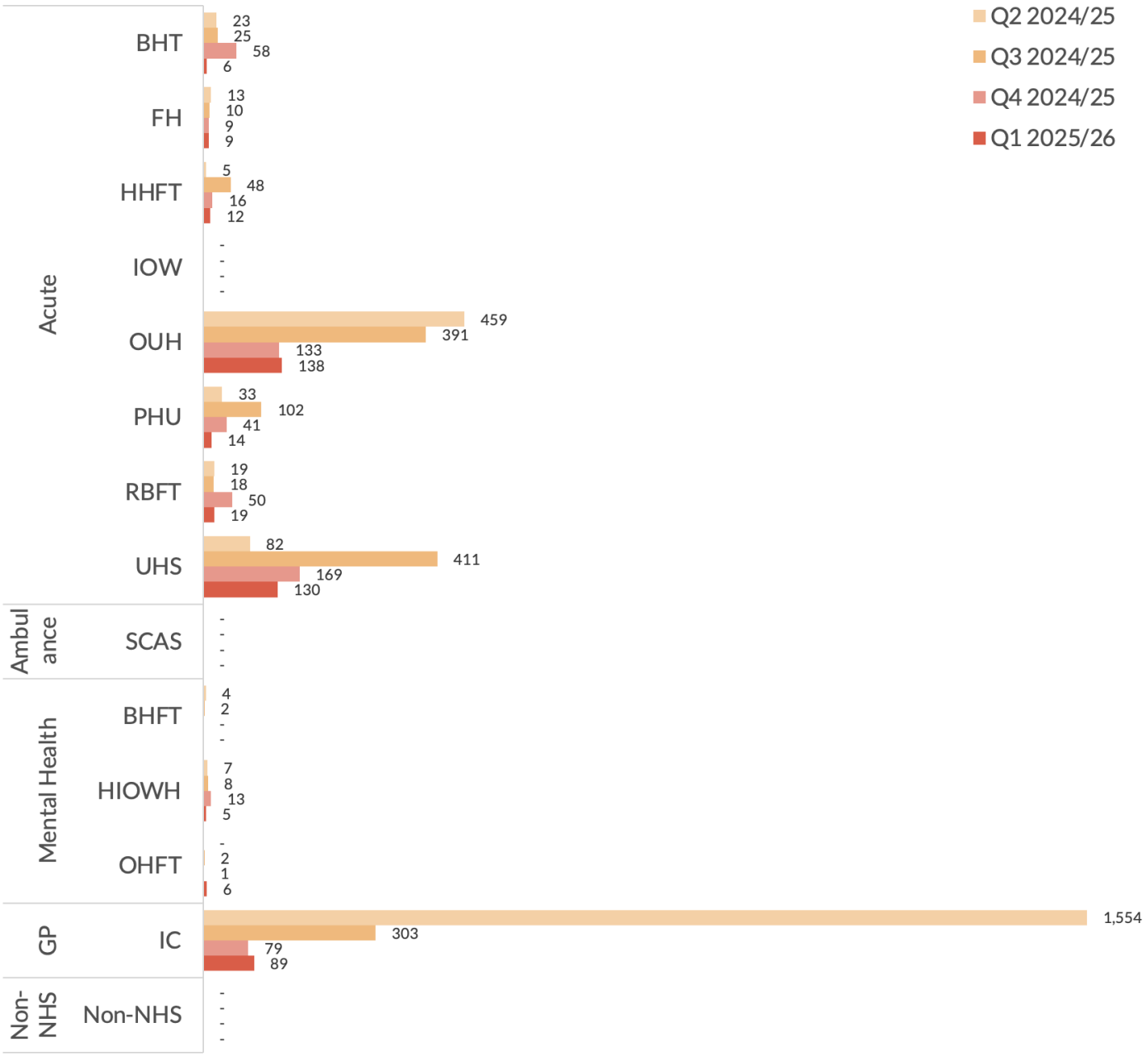

Figure 8 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

Recruitment action plan for 2025/26 onwards

There is a downwards trend in recruitment within the South Central in recent years, particularly for commercial studies. This trend is occurring in an environment with fewer new studies available through the NIHR RDN Portfolio. Given the UK Government's strong emphasis on research

delivery, especially for commercial studies, SC RRDN decided that strategic measures were necessary to reverse this trend, which are outlined in a recruitment action plan.

The plan calls upon the SC RRDN team, including specialty and care settings leads, to recommend new research opportunities to delivery organisations that are considered strategically important. **The criterion for selecting recommended studies includes:**

- **High-Impact Research:** Prioritising high-profile commercial studies and those highlighted as nationally important, such as those related to the Vaccine Innovation Pathway (NIHR website).
- **Local Relevance:** Selecting studies that are highly relevant to our local patient population and contribute to a balanced portfolio across different specialties and settings.
- **Recruitment Potential:** Focusing on studies that are open to new sites, have ambitious recruitment targets, and are likely to recruit successfully over the long term.
- **Inclusive Research:** Making a concerted effort to include studies that recruit from communities currently under-served by research, thereby ensuring the studies benefit the entire population.
- **Professional Development:** Supporting research by a broad range of healthcare professionals, including nurses and allied health professionals, by enabling them to take on leadership roles as Principal Investigators.
- **Collaborative Partnerships:** Fostering collaboration and enabling recruitment across a wider range of healthcare settings to expand our reach and impact.

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 through generally skilled staff, are also being explored.
- **Sourcing reasons for delays:** identifying bottlenecks in study setup and delivery through workshops with NHS Research & Development leadership will help understand barriers and how SC RRDN can assist.

Many of these actions outlined in the plan are already underway and their impact will be assessed over the 2025/25 financial year and beyond.

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 501 responses in the first quarter, which was below the quarterly target of 850 (Figure 9).

The summary shows generally positive feedback. 94 per cent of participants felt well-prepared to take part in the research. Most participants felt they were treated with courtesy and respect (97 per cent) and felt valued for their contribution (97 per cent). 95 per cent of participants indicated they would consider taking part in research again in the future and 94 per cent of participants knew how to contact the research team if they had questions. These responses show that South Central delivery organisations are creating positive experiences for research participants.

However, only 40 per cent of participants knew how they would receive the results of the research and 78 per cent felt that they were kept updated. These communications aspects are significantly lower than the other areas and presents a clear opportunity for improvement for both study

sponsors and delivery organisations. Ensuring participants are informed of the outcomes of the research they contributed to is a key part of our commitment to ethical and patient-centred research.

The results of the survey are shared regularly with representatives of the South Central research delivery organisations and strategies to address issues are discussed and monitored through the responses of participants, on an ongoing basis.

Figure 9 - Summary of the Participant in research experience survey results in the South Central region in quarter one of the 2025/25 financial year

Conclusion

This quarter has demonstrated a mixed but promising picture of research performance in the South Central region. The region has maintained a strong position nationally, ranking as the second-highest region for total recruitment and the top-performing region when adjusted for population size. South Central organisations are offering diverse studies, at locations across the region, in all care settings, to patients and the wider population. The South Central portfolio is becoming more balanced, with a positive shift towards a higher proportion of interventional studies.

However, a downwards trend in overall recruitment is evident, particularly for commercial studies. While this mirrors a national trend, SC RRDN have developed and are now implementing a comprehensive action plan to reverse this. This plan focuses on strategically selecting high-impact studies, increasing collaboration between delivery organisations, and improving our engagement with both industry sponsors and the public.

Finally, feedback from research participants remains positive regarding their experience, with high scores for feeling valued, respected, and willing to participate again. This is a foundation for the region's future sustainability and growth and demonstrates the quality of research delivery happening in the region. South Central RRDN have identified necessary improvements in how delivery organisations communicate research results to participants, and this will be a continued focus.

South Central RRDN remains committed to supporting the NIHR's mission to improve the health and wealth of the nation through research and will provide regular updates to the Board on our progress and performance.

Appendix

Appendix 1 – South Central Risk Register

South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION			Pre Respone 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	Notes
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 repuational 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 ringfenced 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	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 Goverment priority studies as DHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the seperate 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, reinvestiment of hub income paused, dependent on organisational change .	4	4	16	
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	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 workstreams and opportunities missed.	3	2	6	1) Liaise with RDN CC and with fellow RRDNs to align work. 2) Leverage relationships already in place with the BOB ICS (eg OUHFT and AHSN) 3) ICS-focussed Stakeholder Day was held in January 2025	Ongoing	3	2	6	
17. Communications	Low researcher useage of Be Part of Research volunteer service	SCRRDN 007	Low awareness and useage of Be Part of Research volunteer service by researchers could see opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering. Details about trials using the service have been requested from CC.	Opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering	3	2	6	Promotion of service to researchers through study support service and other teams and wider promotion e.g. newsletters	Ongoing	3	1	3	
17. Communications	Low awareness of branding guidelines	SCRRDN 008	Low awarness of name change to RDN and inappropriate use of South Central RRDN name with external stakeholders could result in negative impact on perception of the RDN as one network	Could result in negative impact on perception of the RDN as one network	3	2	6	Promotion of branding guidelines and files to RRDN staff and delivery organisations, responses ot queries via shared inbox	Ongoing	3	1	3	

South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION			Pre Respone 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	Notes
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	Ongoing	2	3	6	
15. Research Delivery	Delivery to RDN High Priority Studies - Lead Network	SCRRDN 013	Failure to succesfully deliver high priority studies led by SC RRDN	1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations 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 priorty 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 succesfully deliver high priority studies at delivery organisations within SC RRDN	1. Reputational damage to SC RRDN delivery onrganisations 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	3	4	12	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 priorty studies communicated to delivery organisations at a senior level	All ongoing	2	3	6	
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.	All ongoing	4	3	12	
15. Research Delivery	Agile team members working in new environments	SCRRDN 016	Expectation for the Agile team to expand research delivery to wider commmunity and out of hospital settings. This will include settings where SC RDN does not have prior experiece of delivering research, which may present unfamiliar risks to the safety and well-being of staff members e.g. prisons and probation service, severe mental health services. There is a lack of national guidance for staff working in these new settings and current training may not sufficently cover.	1) Potential threat to agile staff work place safety and well-being when working in new environments and participant groups. 2) Unforseen safety considersations and risks that potentially prevent continuation of research delivery. 3) Additional time may be required during study set up to train staff in preperation 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) Nancy to raise risk at the next national agile meeting to discuss, including how RDNs can collectively pool resources such as best practice, SOPS and training resources 4) Agile and primary care teams to adapt national/supr-regional resources and apply to SC RDN region when appropriate to do so.	All ongoing	3	3	9	

South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION			Pre Respone 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	Notes
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) Meeting held between RC, MD and Sandie Wellman 11.4.25 2) Meeting to be set up between MM, RC, MD, Sandie Wellman and Chris Bray to review the OUH SC RDN portfolio of studies on a regular basis during the RDN organisational change process, this will include new studies requesting agile to support. 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 Meeting held between MD, CR, SW, CB, KA (24/5/25), Ongoing meetings occuring, Studies that could potentially close identified to be ratified by group. Communication to be sent out to OUH PIs	All ongoing	4	3	12	
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 unecessary workload / use their time strategically Provide reasonable level of administrative support Keep meetings they are expected to attend to a minimum	Ongoing				
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	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.		5	4	20	Working group paper taken to Strategy Board in April 2025 and recommendations outlined in paper approved to proceed with
20. Workforce Learning and Organisational Development	Lack of clarity over roles and responsibilities of the Clinical Educator positon, impacting recriutiment to vacant positions in SC RRDN Workforce team.	SCRRDN 020	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 responsiblities 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	Effect - Reduced service offered by the Workforce team, impacting training offered and future developement of training opportunities for SC RRDN staff.	4	3	12	Pause recruitment to the Workforce team until further guidance on Job description and personal sepcification available. Train current Learning and Development facilitator to support Workforce training offer. Utilise facilitator community to ensure training continues. Recieve 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	
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 goverment led crive to reduce set up 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	5	4	20	- Working group to be form to collect reason in LPMS for set up >150 days - D&A app to provide realtime set up 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		4	4	16	

South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION			Pre Respone Rating			Response		CURRENT (RESIDUAL) RATING			
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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	Failing to 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	

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