University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	10/03/2026
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd
Apologies	Steve Peacock

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 13 January 2026** Approve the minutes of the previous meeting held on 13 January 2026
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 Audit and Risk Committee** Ian Howard, Chief Financial Officer, for Chair
5.2	9:25	**Briefing from the Chair of the Finance, Investment & Cash Committee** David Liverseidge, Chair
5.3	9:30	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.4	9:35	**Briefing from the Chair of the Quality Committee** including Interim Maternity and Neonatal Safety Report Tim Peachey, Chair
5.5	9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer

5.6 **Performance KPI Report for Month 10**

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

5.7 **Break**

10:40

5.8 **Finance Report for Month 10**

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

5.9 **ICB System Report for Month 10**

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

5.10 **People Report for Month 10**

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

5.11 **Freedom to Speak Up Report**

11:20 Review and discuss the report
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

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

11:35 Review and discuss the report and update
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2025-26 Quarter 3 Update**

11:50 Review and feedback on the corporate objectives
Sponsor: David French, Chief Executive Officer
Attendee: Martin de Sousa, Director of Strategy and Partnerships

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

12:00 Review and discuss the update
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

7.1 **Feedback from the Council of Governors' (CoG) Meeting 29 January 2026 (Oral)**

12:15 Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:20 Receive and ratify the report
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:25 Review and approve the Terms of Reference
Sponsor: Ian Howard, Chief Financial Officer, for Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.4 **Quality Committee Terms of Reference**

12:30 Review and approve the Terms of Reference
Sponsor: Tim Peachey, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

12:35 Review and approve the Terms of Reference
Sponsor: Jenni Douglas-Todd, Trust Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

8 **Any other business**

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

9 **Note the date of the next meeting: 14 May 2026**

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

10.1 **South Central Regional Research Delivery Network (SC RRDN) 2025-26 Q3 Performance Report**

Note the report
Sponsor: Paul Grundy, Chief Medical Officer

11 **Resolution regarding the Press, Public and Others**

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

12 **Follow-up discussion with governors**

12:45

University Hospital Southampton NHS
NHS Foundation Trust

Agenda links to the Board Assurance Framework (BAF)

10 March 2026 – 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)	4 x 4 16	3 x 2 6	Apr 27
5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.	Open (Technology & Innovation)	2 x 4 8	2 x 2 4	Dec 27

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.6	Performance KPI Report for Month 10	1a, 1b, 1c			x
5.8	Finance Report for Month 10	5a			x
5.9	ICB System Report for Month 10	5a			x
5.10	People Report for Month 10	3a, 3b, 3c			x
5.11	Freedom to Speak Up Report	3b			x
5.12	Guardian of Safe Working Hours Quarterly Report and Update on 10-Point Plan	3b			x

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	13/01/2026
Time	9:00 – 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd (JD-T)
Present	Jenni Douglas-Todd, Chair (JD-T) Keith Evans, Non-Executive Director (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 and Deputy Chair (JH) Ian Howard, Chief Financial Officer (IH) Andy Hyett, Chief Operating Officer (AH) David Liverseidge, NED (DL) Tim Peachey, NED (TP) Alison Tattersall, NED (AT) Natasha Watts, Acting Chief Nursing Officer (NW)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) James Allen, Chief Pharmacist (JA) (item 5.12) Julie Brooks, Deputy Director of Infection Prevention and Control (JB) (item 5.11) Blue Cunningham, Patient Engagement & Involvement Officer (item 2) John Mcgonigle, Emergency Planning & Resilience Manager (JMc) (item 6.1) Jenny Milner, Associate Director of Patient Experience (JM) (item 5.10) Julian Sutton, Clinical Lead, Department of Infection (JS) (item 5.11) 4 governors (observing) 5 members of staff (observing) 2 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.

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

2. Patient Story

Blue Cunningham was invited to present the Patient Story on behalf of Jade […], whose nine-year-old daughter, Lucy, had had a bowel resection at the Trust. It was noted that:

- Lucy was a very structured child, who relied heavily on planning and knowing outcomes as well as having sensitivities to lots of different sensory inputs.

- In their treatment of Lucy, staff paid particular attention to Lucy's needs and adapted their behaviour and took the time to make Lucy's stay in hospital as comfortable as possible.
- This Patient Story clearly demonstrated the Trusts' values and the time taken in the handling of Lucy by staff likely saved time and effort in the long run by not distressing the patient and then having to manage this situation.

3. Minutes of the Previous Meeting held on 11 November 2025

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 11 November 2025, subject to reassigning action 1296 to James Allen.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted.

- Action 1293: work had commenced on a broader MRI strategy. This work would be presented to the Quality Committee in due course – the action remained open.
- Action 1294: this formed part of a larger piece of work, which would be addressed through the planning cycle. The action could be closed.
- Action 1295: a solution had been developed, but the Trust was waiting on a third party to be able to implement the solution. The action could be closed.
- Action 1296 was addressed as part of item 5.12 below. It was explained that the metric was based on day cases and national statistics and was intended to show usage levels of the most critical antibiotics.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Finance, Investment & Cash Committee

David Liverseidge was invited to present the Committee Chair's Reports in respect of the meetings held on 24 November and 15 December 2025, the contents of which were noted. It was further noted that:

- The Trust had reported an in-month deficit of c.£5m and, at the end of November 2025, had reported a year-to-date deficit of £40m.
- The committee had received an update in respect of the Trust's theatres improvement plans, noting that there had been a 3% increase in utilisation and a 3% reduction in cancellations.
- The committee had received a report on the Trust's productivity based on the national framework and noted that further work was required to understand the metrics behind the national framework.
- The committee had reviewed the Trust's cash position and supported a proposal to request further cash support for January 2026.
- The committee noted that whilst the Trust's transformation plans were ambitious, they were nonetheless grounded in reality.
- In its review of the proposed capital plans for 2026/27-2029/30, the committee noted the challenge of having to balance the Trust's allocation of Capital Departmental Expenditure Limit (CDEL) with the cash available to the Trust.
- The committee reviewed the Trust's medium-term plan ahead of the first submission to NHS England on 17 December 2025. It was noted that the assumed reductions in patients with no criteria to reside and mental health

patients were those reasonably considered to be within the Trust's control rather than reductions which were dependent on third parties.
- The committee supported a proposal for transforming the Southern Counties Pathology network.

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

Jane Harwood was invited to present the Committee Chair's Reports in respect of the meetings held on 21 November and 15 December 2025, the contents of which were noted. It was further noted that:

- Whilst there had been reductions in the size of the substantive workforce, this had been offset by an increase in temporary staff due to a combination of demand, sickness absence, patients with no criteria to reside, and mental health patients.
- The committee noted changes with respect to statutory and mandatory training, which would facilitate 'passporting' between NHS organisations.
- The committee received an update in respect of the Trust's Inclusion and Belonging strategy, noting that progress had been slower than anticipated due to available resource. It was further noted that the external political environment had also created additional challenges in this area.
- The committee received an update regarding the Trust's refreshed approach to violence and aggression, noting a greater willingness to take action against violent/abusive patients and members of the public. It was further noted that the communications accompanying the new approach would be key.
- The committee reviewed the Trust's performance against the ten-point plan for resident doctors, noting that the Trust was, subject to a few exceptions, in a good position.
- Whilst the results of the Staff Survey were still under an embargo, early indications were that the participation rate was lower than hoped for.
- The Trust's seasonal vaccination campaign had been successful with over 50% of staff having been vaccinated against influenza.

5.3 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 24 November 2025, the content of which was noted. It was further noted that:

- The committee noted that the Trust's Complaints service, particularly Patient Advice and Liaison Service (PALS), was fragile. There was a backlog of c.500 emails due to resource constraints.
- The committee noted that despite the financial pressure the Trust was under, it had sought to maintain staff numbers to ensure patient safety. A significant proportion of the reduction in staff during the year had been from administrative staffing groups. Whilst the Trust had successfully reduced the size of the clinical administrative workforce, it had not been possible to transform how this service was delivered through technical or other means. Therefore, there was a risk of bottlenecks due to insufficient administrative staff with the high level of demand falling on a smaller number of staff.
- NHS England had launched changes to maternity care reporting with additional reporting requirements with the aim of developing national standards and approaches.
- The committee had reviewed the Trust's Maternity and Neonatal Safety report for the second quarter and noted that the Trust had demonstrated compliance with the requirements for the NHS Resolution Maternity Incentive Scheme.

5.4 Chief Executive Officer's Report

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

- NHS England had published latest segmentation and league tables under the NHS Oversight Framework for Quarter 2. The Trust had fallen slightly from 48 out of 134 to 51 out of 134. The Trust remained in segment 5 due to being in the Recovery Support Programme.
- The number of patients waiting over 65 weeks in October 2025 had resulted in the Trust entering Tier 1 for elective performance. However, since that time, the Trust had successfully reduced the number of patients waiting over 65 weeks to c.80, with a target to reduce this number to nil by the end of March 2026.
- The Employment Rights Bill received Royal Assent on 18 December 2025. The Act included a number of changes which would impact the Trust. These changes were to be reviewed in detail by the People and Organisational Development Committee.
- During further strike action by resident doctors between 17 December and 22 December 2025, the Trust had met the national target of maintaining 95% of activity. Roughly one-third of resident doctors had taken part in the industrial action, which compared favourably to other trusts – some had reported a participation rate of 80-90%.
- University Hospitals Sussex NHS Foundation Trust had been fined in connection with the death of a patient with severe mental health problems who had absconded from a ward at the trust and subsequently committed suicide. This case was pertinent for the Trust given the number of mental health patients currently being cared for at the Trust in the absence of a more appropriate setting. It was noted that the Trust's policy was clear on the approach to be taken in the event of a similar situation to that faced by University Hospitals Sussex NHS FT.
- On 2 January 2026, the Trust had been informed that its endoscopy service had had its accreditation renewed until 1 November 2026 following an annual review by the Royal College of Physicians' Joint Advisory Group on Gastro-Intestinal Endoscopy.
- Alison Tattersall had been appointed as the Trust's second Nominated Trustee on the board of the Southampton Hospitals Charity.
- The Trust's department of clinical law – a service established to deal with clinical questions relating to regulatory and legal principles within the Trust – had been in existence for 16 years.

5.5 Performance KPI Report for Month 8

Andy Hyett was invited to present the 'spotlight' report in respect of Cancer waiting time targets, the content of which was noted. It was further noted that:

- There had been an increase in referrals over recent years, but despite this increase, the Trust had maintained performance, particularly in respect of the 28-day faster diagnosis pathway.
- Consideration was being given in terms of demographic groups to be targeted in view of the success of the Targeted Lung Health Check programme and its efforts to target particular sections of the population.
- The main challenge in terms of improving performance was in terms of diagnostic capacity, including access to magnetic resonance imaging (MRI) and other imaging services. Improving the diagnostics services remained a key priority, including development of a longer-term strategy for imaging. It was noted that MRI and computed tomography (CT) scan capacity in the UK was lower than that in comparable nations such as those in the US and EU.

- The Trust maintained a good relationship with the Wessex Cancer Alliance, which was an effective route for obtaining additional funding for cancer care.

Action
Andy Hyett agreed to provide Jane Harwood with further data regarding the stage at which cancer was diagnosed by socio-economic group.

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

- The Trust's overall Referral To Treatment (RTT) waiting list for November 2025 had decreased by 0.9% and the Trust had made significant progress in reducing the number of patients waiting more than 65 weeks.
- The number of patients waiting for diagnostics marginally increased, but the Trust had maintained its previous performance with c.80% of patients waiting under six weeks for the fourth month in a row.
- The Trust's performance against the four-hour emergency department target had improved by 5.8% since October 2025, achieving 60.4% in November 2025, which was above its in-year performance plan submitted at the beginning of 2025/26.

The Board discussed the Performance KPI Report for Month 8. This discussion is summarised below:

- In terms of the Trust's RTT waiting list, it was forecast that there would be c.60,000 patients on this list by the end of March 2026 with performance against the 18-week target expected to be c.67%.
- The Trust's performance in respect of the number of mental health patients spending over 12 hours in accident and emergency was considered to be reflective of the need to admit mental health patients where there was no more appropriate venue available. This situation also gave rise to increased use of agency staff. A workshop had been held with Hampshire and Isle of Wight Healthcare NHS Foundation Trust (HIOWH) and an action plan had been agreed. It was noted that HIOWH was also experiencing challenges in terms of its ability to discharge patients.
- The reduction in the percentage of virtual appointments as a proportion of all outpatient consultations compared to 2024/25 was being looked at.
- As of 13 January 2026, there were 295 patients with no criteria to reside – equivalent to 12 wards – at Southampton General Hospital. Work was ongoing to create wards specifically for this cohort of patients. It was noted that Hampshire and Isle of Wight Integrated Care System was ranked 39 out of 42 in terms of its number of patients with no criteria to reside.

5.6 Break

5.7 Finance Report for Month 8

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

- The Trust had reported a £4.9m deficit for Month 8 (£40.8m deficit, year-to-date), which was in line with its Financial Recovery Plan. This in-month deficit had also been maintained for Month 9, with the year-to-date deficit increasing to £45.6m.
- The Trust's underlying deficit remained at c.£6m per month with continued high numbers of patients with no criteria to reside and mental health patients coupled with operational pressures.

- The Trust had carried out between £20m and £30m of unfunded work during the year and had incurred £10m-15m of costs associated with patients with no criteria to reside and mental health patients.
- The Trust expected to deliver £90m of savings under its Cost Improvement Programme against its target of £110m.
- The Trust had requested £8.4m of additional cash support for January 2026 and expected to require a further £3m of support in March 2026.

5.8 ICS System Report for Month 8

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

- The Hampshire and Isle of Wight Integrated Care System had reported a year-to-date deficit of £65m, which represented a variance of £36m from plan. It was noted that the Trust was a significant contributor to this variance, but that other organisations were also now reporting variances to plan.
- The Trust had achieved the best ambulance handover time performance in the system, but further work was ongoing across the system with South Central Ambulance Service (SCAS) to improve performance.

5.9 People Report for Month 8

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

- The overall workforce fell marginally during November 2025, with reduction in substantive staff of 52 whole-time-equivalents (WTE) being partially offset by an increase in temporary staff usage due to operational pressures and sickness absence.
- The Trust remained above its 2025/26 plan by 214 WTE despite a decrease of nearly 400 WTE since 31 March 2025. In order to meet its Financial Recovery Plan, the Trust's workforce needed to reduce by a further 137 WTE.
- Sickness absence continued to increase with 4.2% being reported during November and 4.8% being reported for December 2025.
- The 2025 Staff Survey had closed. It was noted that the results were expected to be challenging.
- The Trust had hit its target of 58% of staff having been vaccinated against flu, which placed the Trust in the top 15 nationally and second in the South East.
- There was a significant amount of work ongoing to refresh the Trust's approach and policies in respect of violence and aggression, including policy changes, training and communications.

5.10 Learning from Deaths 2025-26 Quarter 2 Report

Jenny Milner was invited to present the Learning from Deaths report for the second quarter, the content of which was noted. It was further noted that:

- The Trust continued to benchmark well against other organisations. It was one of only 11 trusts nationally with a lower than anticipated mortality rate based on its summary hospital-level mortality indicator (SHMI) score.
- The Medical Examiner Service had reviewed a total of 1,078 deaths, of which 36% had occurred at the Trust's sites.
- Patients with learning disabilities remained an area of concern, although progress was being made in this area. The Trust was one of only a few

organisations to hold separate meetings to discuss deaths of patients with learning disabilities.
- The Trust had procured a system to support organisation-wide learning from Morbidity and Mortality outcomes.

5.11 Infection Prevention and Control 2025-26 Quarter 2 Report

Julian Sutton and Julie Brooks were invited to present the Infection Prevention and Control report for the second quarter, the content of which was noted. It was further noted that:

- For the period covered by the report (July-September 2025), the Trust had exceeded all measures in terms of the annual limits for incidences of bacteraemia. The Trust was in a similar position to other organisations nationally.
- There had been two cases of Methicillin-resistant Staphylococcus aureus (MRSA) and 34 cases of Clostridioides difficile (C-diff) during the period.
- There had been a focus on invasive device care management (such as cannulas and catheters) and on hand hygiene.
- The Trust had successfully managed the Candidozyma auris outbreak, with only three new cases identified since the beginning of 2025, the last of which was identified in April 2025.

5.12 Medicines Management Annual Report 2024-25

James Allen was invited to present the Medicines Management Annual Report 2024/25, the content of which was noted. It was further noted that:

- The Trust's expenditure on medicines during 2024/25 was £215m, a 2% reduction compared to 2023/24 and was on track to spend only £207m during 2025/26. These reductions indicated that the strategy of using less expensive generic and biosimilar medicines had been effective in reducing costs.
- The number of approvals for clinical trials and research activity had continued to improve.
- The Trust had completed work to decommission nitrous oxide manifolds, which was expected to reduce the Trust's nitrous oxide emissions by 600,000 litres per year, equivalent to 354 tonnes of carbon dioxide emissions.
- An area of focus was the deployment of digital systems.

Action

Ian Howard agreed to look at the level of savings achieved in terms of medicines costs and how costs of medicines were budgeted for.

5.13 Ward Staffing Nursing Establishment Review 2025

Natasha Watts was invited to present the Ward Staffing Nursing Establishment Review 2025, the content of which was noted. It was further noted that:

- The report set out the results of the ward staffing review undertaken between July and October 2025.
- There was a renewed national focus on safe staffing.
- Overall, the Trust's staffing establishments remain appropriate and within recommended guidelines.

- Continued high levels of enhanced care demand, a significantly more junior workforce, managing additional surge areas, and the impact of financial controls had been highlighted as ongoing challenges.

6. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

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

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

- NHS England required all trusts to complete an annual self-assessment against a number of core standards. In its assessment against 62 applicable core standards, the Trust was fully compliant with 56 and not yet fully compliant with 6 standards.
- Of the areas where the Trust was not yet fully compliant, these related primarily to governance maturity, exercising and testing, workforce training consistency, and assurance evidence, rather than the absence of emergency response arrangements.
- Since an initial report had been submitted to the Trust Executive Committee in November 2025, the Trust had completed development and approval of the Business Continuity Management System, completed the consultation and adoption of Protective Security and Emergency Lockdown arrangements, and had commenced consultation and system engagement for Evacuation and Shelter.
- Training was scheduled to take place between February and May 2026 for on-call staff in charge. It was intended to hold a tabletop exercise during 2027.
- It was noted that it had been some time since the Trust had practised a major incident response with other partners.
- The Trust was on schedule to embed the 'protect' duty under the Terrorism (Protection of Premises) Act 2025 by March 2027.

Action

John Mcgonigle agreed to look at scheduling a major incident response exercise with other partners involved.

7. Any other business

It was noted that the Trust had declared a critical incident on 10/11 December 2025 due to an IT system failure.

It was noted that this was Keith Evans' final formal meeting, as his second three-year term as a non-executive director was due to expire on 31 January 2026. The Board expressed its thanks to Keith Evans for his service and support.

8. Note the date of the next meeting: 10 March 2026

9. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 11/11/2025 - 5.6 Performance KPI Report for Month 6				
1293.	MRI scanners and imaging	Hyett, Andy	10/03/2026	Pending
	Explanation action item Andy Hyett agreed to work on and present at either a future Board meeting or Trust Board Study Session the Trust's longer-term strategy with respect to MRI scanners and imaging. TB 13/01/26: work had commenced on a broader MRI strategy. This work would be presented to the Quality Committee in due course – the action remained open.			
Trust Board – Open Session 09/09/2025 - 8 Any other business				
1286.	Organ donation	Machell, Craig	16/04/2026	Pending
	Explanation action item Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session. Update: Item deferred to TBSS on 16/04/26.			
Trust Board – Open Session 15/07/2025 - 5.11 Freedom to Speak Up Report				
1267.	Data	Mbabazi, Christine	10/03/2026	Pending
	Explanation action item Christine Mbabazi to include data from other mechanisms for reporting concerns in future Freedom to Speak Up reports.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 13/01/2026 - 5.5 Performance KPI Report for Month 8				
1311.	Cancer diagnosis	Hyett, Andy	10/03/2026	Pending
	Explanation action item Andy Hyett agreed to provide Jane Harwood with further data regarding the stage at which cancer was diagnosed by socio-economic group.			
Trust Board – Open Session 13/01/2026 - 5.12 Medicines Management Annual Report 2024-25				
1312.	Medicines costs	Howard, Ian	10/03/2026	Pending
	Explanation action item Ian Howard agreed to look at the level of savings achieved in terms of medicines costs and how costs of medicines were budgeted for.			
Trust Board – Open Session 13/01/2026 - 6.1 Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)				
1313.	Major incident response exercise	Mcgonigle, John Hyett, Andy	10/03/2026	Pending
	Explanation action item John Mcgonigle agreed to look at scheduling a major incident response exercise with other partners involved.			

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.1

Committee Chair's Report to the Trust Board of Directors 10 March 2026			
Committee:	**Audit & Risk Committee**		
Meeting Date:	**27 January 2026**		
Key Messages:	• The committee considered the accounting policies and management judgements in respect of the 2025/26 annual accounts, noting the impact of the review of the Modern Equivalent Asset valuation estimation methodology. This review was to ensure that the valuation reflects specialised assets based on a modern, functionally equivalent facility at an alternative location, rather than simply replicating the current buildings and equipment. • The committee received an update in respect of the work on the Trust's interim accounts, noting that there had been significant improvements in terms of use and recording of manual adjustments, with an objective of further reducing the use of manual adjustments in future. • The committee noted the work undertaken to address the issues identified in the production of the 2023/24 and 2024/25 accounts. • The committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts, noting that the Trust was compliant in all areas or had appropriate explanations for areas of non-compliance, of which there were only a few. • The committee received a report on compliance with the Trust's Standards of Business Conduct Policy, noting that the level of declarations of interest had remained largely static and that further work would be required to review the Trust's approach in this area. • The committee received updates in respect of the internal audit programme, including the reports in respect of an audit of cyber security and the Trust's core financial systems. • An update was provided in respect of the work of the counter-fraud team. It was noted that the risk of temporary worker impersonation was a particular area of focus. In addition, the committee noted the work undertaken to review the Trust's compliance with the Economic Crime and Corporate Transparency Act 2023.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:* Substantial**	***Risk Rating:* N/A**
	• All risks had been reviewed with the relevant executive director(s). • There had been no significant changes in ratings or target dates since the BAF had been last reviewed in October 2025. However, the committee challenged how realistic some of the target dates were on the basis that many of the actions required were reliant on third parties. • The committee suggested that the rating for risk 5c should be reconsidered in view of the increasing cyber risk. • It was noted that the actions from the internal audit on the Trust's risk management maturity were on track.		

	7.4 Audit and Risk Committee Terms of Reference	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• The committee reviewed its Terms of Reference and no changes were proposed. • The committee recommended that the Board approve the revised Terms of Reference.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 i)

Committee Chair's Report to the Trust Board of Directors 10 March 2026	
Committee:	**Finance, Investment and Cash Committee**
Meeting Date:	**26 January 2026**
Key Messages:	• The committee received the Finance Report for Month 9. The Trust had reported an in-month deficit of £4.9m and continued to report in line with the Financial Recovery Plan. The Trust had also delivered £10.3m of savings under the Cost Improvement Programme during the month. The modern equivalent assets review had been completed, which delivered £3m of benefit during the month. • The committee carried out a deep-dive into the Trust's underlying financial position, noting that there had been £15.8m of one-off adjustments and that the underlying deficit was £61.4m year-to-date. The monthly underlying deficit continued to be c.£6m and therefore the 2025/26 exit position was assessed to be £72m. • The committee received an update on the Trust's medium term planning submission, noting that it was expected that the Trust would submit a non-compliant plan. There remained a significant gap between the level of performance required under the framework and the available funding and an absence of proposals from Specialised Commissioning. It was noted that the assumptions regarding non-criteria to reside numbers were based on factors within the Trust's control, rather than those dependent on third parties. • The committee received an update on financial improvement, noting that the Trust was £4m behind its CIP plan for 2025/26, expecting to deliver £88m of savings by year end compared to the £110m target. The Trust was targeting £50m of CIP savings for 2026/27. Based on national data, the Trust had the tenth smallest opportunity for productivity savings. • The committee considered the Trust's cash position as at 31 December 2025 and the forecast cash position for the remainder of the financial year. The Trust expected to require a further £2.9m of cash support in March 2026, which the committee supported. • The committee received an update in respect of the Trust's outsourced cleaning and catering services contract.
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 5.2 ii)

Committee Chair's Report to the Trust Board of Directors 10 March 2026	
Committee:	**Finance, Investment and Cash Committee**
Meeting Date:	**23 February 2026**
Key Messages:	• The committee received the Finance Report for Month 10 (see below). • The committee received an update in respect of the impact of the fire at Southampton General Hospital on 1 February 2026, including in respect of the actions being taken to restore the lost services and the Trust's claims under the NHS Resolution Property Expenses Scheme and under its commercial insurance policy. • The committee received an update following the submission of the Trust's medium term plan on 12 February 2026, noting that the Trust's current proposed deficit made it an outlier. There remained a significant gap between the level of funding available from commissioners and the performance required under the framework. The committee enquired as to the possible route to resolve and supported the view that pricing of activity needed to be set at a level which did not create an increasing deficit as it currently does in critical care areas. Following the external review recommendations, the committee look forward to a deeper dive into the drivers of the increases in the Trust's cost base over the past 5-6 years as this has increased at a greater rate than activity levels. This is planned for the March 2026 meeting. • The committee received an update in respect of the Always Improving programme, noting that the fire had prompted something of a re-think in terms of organisational and system fundamentals. It was noted that there had been changes in the Trust's risk appetite in terms of management of patients having no criteria to reside and outpatient appointments. Sustaining the improvements in these areas was considered to be a key priority. • The committee received a report on the roll out of the MIYA system in the Trust's emergency department, which went live on 8 October 2025. It was noted that whilst there had been some initial impact on performance during the first weeks, this had been expected, and the issues appeared to have been largely resolved. The system had delivered improvements in clinical management and in terms of data analytics. • The committee noted that the Trust had been awarded £39m in capital funding for 2025/26. It was noted that this was a significant amount of funding to be used during the final months of 2025/26 and that work was ongoing to secure this funding through placing of orders and other activity. • The committee received an update in respect of the Trust's proposed tender for car parking services. • The committee supported the proposals to obtain mobile endoscopy units to address the loss of the Trust's endoscopy service in the fire on 1 February 2026. • The committee noted proposals in respect of changes to NHS Property Services.

Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.8 Finance Report for Month 10**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The Trust had submitted a revised forecast to NHS England of a deficit of £49.9m following a request for an 'art of the possible' re-forecast. The Trust had since received additional funding, which reduced the 2025/26 forecast deficit to c.£45m. • The Trust had reported a year-to-date deficit of £44.8m, with the underlying monthly deficit remaining between £5.5-6m. The Trust expected additional one-offs during the final months, but there was significant risk associated with this. • The Trust was forecasting CIP delivery of £94m for 2025/26, with £78m achieved year-to-date. • Whilst there had been some increase in workforce numbers in December 2025 and January 2026, it was considered normal for this to occur during this period, however this was creating a deviation from the planned workforce numbers. This was explained as the result of the decision taken to address 65- and 52-week waits which had therefore impacted staff numbers. The resulting increased income from additional work had yet to register in the Trust's revenue numbers but was expected in February and March..		
	6.2 Board Assurance Framework (BAF) Update	***Assurance Rating:***	***Risk Rating:*** **N/A**
	• Risk 5a remained the Trust's highest-rated risk at 25 and the target date for reduction had been extended by six months due to continued uncertainty around the funding available during 2026/27 and the impact of the fire on 1 February 2026. • Risk 5b had been assessed following the fire, but it was considered that whilst there had been significant disruption, the event and subsequent activities had been well-managed and demonstrated the effectiveness of the Trust's evacuation and business continuity plans. Accordingly, no changes were proposed to the rating. • There had been an increase in the rating of risk 5c, largely due to risks surrounding the age of the Trust's digital infrastructure and uncertainty regarding the OneEPR programme.		
Any Other Matters:	The committee reviewed the Trust's cash position and forecast, and the committee supported the additional request to be submitted in February 2026 for cash support up to a maximum of £10m to be received in April 2026. The trajectory for cash support in 2026/27 was to be reviewed at the March 2026 meeting.		

Assurance Rating:

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

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.3 i)

Committee Chair's Report to the Trust Board of Directors 10 March 2026	
Committee:	**People & Organisational Development Committee**
Meeting Date:	**23 January 2026**
Key Messages:	• The committee reviewed the People Report for Month 9. Substantive workforce fell by 9 whole-time-equivalents (WTE) and the overall workforce fell by 51 WTE. The transfer of employees from Wessex Procurement Limited to UHS Estates Limited impacted the level of the overall in-month fall in workforce numbers. Use of temporary staffing, whilst high early in December 2025 due to operational pressures and seasonal illness, reduced toward the end of the month. • Additional recruitment activity had been carried out to support the Trust's work to address long-waiters. • December had been a challenging period due to seasonal illness and the committee would be reviewing residual sickness rates, particularly the rates of mental health-related absence. Flu vaccine uptake by the Trust's staff was 58%, which was the Trust's target for 2025/26. • The Trust continued to make progress toward the target of having 95% of job plans approved by the end of March 2026. • The committee reviewed the Trust's performance against the 10-Point Plan for Improving Resident Doctors' Lives, noting that the areas highlighted in the plan did not fully align to the known concerns of resident doctors at UHS. • It was noted that the participation rate in the Staff Survey was lower than in previous years and initial results indicated a decline in key engagement scores. • The committee received an update in respect of the workforce elements of the Trust's medium term plan submission, which was due to be submitted to NHS England on 12 February 2026. There were significant challenges around the performance expected under the framework and the funding available to achieve this. • The committee received an update in respect of the impact of the Employment Rights Act 2025. These impacts included a reduced notice period and increased mandate period (now up to 12 months) for industrial action as well as a reduced qualifying period for unfair dismissal claims and removal of the cap on damages. The Act had potentially significant implications for the use of temporary and fixed term staff by the Trust and wider NHS.
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 5.3 ii)

Committee Chair's Report to the Trust Board of Directors 10 March 2026			
Committee:	**People & Organisational Development Committee**		
Meeting Date:	**26 February 2026**		
Key Messages:	• The committee reviewed the People Report for Month 10 (see below). • The committee considered the workforce implications of the Trust's medium term plan submission, noting that the plan had been submitted on 12 February 2026. The plan submission was non-compliant largely due to the gap between available funding and the performance level required. The situation was currently unclear with respect to the affordability of the workforce required to deliver the required level of performance. It was noted that the Trust had maintained its current controls in respect of recruitment and the scrutiny given to new and replacement posts. • The committee received an update in respect of the support being provided to staff following the fire at Southampton General Hospital on 1 February 2026. It was noted that immediate wellbeing support had been provided to staff involved in the incident and that senior leaders (including non-executive directors) had delivered 'boost boxes' to staff. A single-point-of-access had been created to access welfare and wellbeing support. In addition, senior leaders had been open with the impact of the incident on them personally. The Trust was also considering what recognition could be given to staff. The needs of the endoscopy team in adapting to the new environment were also considered.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.10 People Report for Month 10**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The workforce had increased by 65 whole-time-equivalents (WTE) in January 2026, although the substantive workforce had fallen by 19 WTE. Temporary staffing rose during the month due to seasonal illness, the need for surge capacity, and the high numbers of patients having no criteria to reside. • The Trust had carried out some recruitment in connection with the work being carried out to address long-waiters. • The committee would be carrying out a deep dive into sickness absence in March 2026, with a particular focus on mental health. • Appraisal rates remained low, largely as a result of capacity constraints. • The Staff Survey results remained embargoed until 12 March 2026. It was agreed that the results would be reviewed in detail at a later date. • A new framework for statutory and mandatory training was expected to be rolled out from April 2026. • The Trust had made good progress against the 10-Point Plan for Improving the Lives of Resident Doctors. • The committee noted a slight increase in the number of 'red flag'/staffing incidents, which was to be reviewed by the Trust Executive Committee.		

	6.2 Board Assurance Framework (BAF) Update	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• Risks 3a, 3b and 3c had been reviewed by the relevant executive directors and included the impact of the fire on 1 February 2026. No changes had been proposed to the ratings and target dates. • Risk 3a remained the most critical people-related risk at a rating of 20. • It was agreed that additional operational risks should be created to cover the impacts of the fire, the Employment Rights Act 2025, and the changes required following the Supreme Court decision on gender recognition.		
Any Other Matters:	The committee will be reviewing the Trust's proposed transformation programmes to understand the impact on staff at its March 2026 meeting.		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda item 5.4

Committee Chair's Report to the Trust Board of Directors 10 March 2026			
Committee:	**Quality Committee**		
Meeting Date:	**26 January 2026**		
Key Messages:	• It was noted that there had been five patient safety incident investigations (PSII) in November 2025 and two new never events had been reported. The committee also noted the issues encountered with the initial roll out of the MIYA system in the emergency department, but further noted that the situation had since improved. • There had been theatre cancellations due to staffing shortages in critical care and an inability to fill bank shifts, but steps were being taken to address this issue. • The committee received a report on mental health, noting that there had been no significant improvements and that the risk remained the same. It was further noted that Hampshire and Isle of Wight Healthcare NHS FT (HIOWH) had changed their processes for bed management, but that it was not yet clear what impact this would have on the Trust. The committee expressed concern about the provision of service by HIOWH and the reduction in the number of community places. • The committee reviewed the Maternity and Neonatal Safety Report, noting that there was a national concern regarding the use of Intergrowth estimated foetal growth charts. The Trust would no longer be using these charts from 5 January 2026, adopting instead the Hadlock formula. A review was being conducted of the Trust's support to home births and whether a dedicated team was required. • The committee received an update in respect of the Fundamentals of Care programme, noting that discharge experience remained a key area of focus. In addition, there had been focus on management of cannulars (due to the link with MRSA risk) and on repositioning of patients to avoid pressure ulcers. • The committee noted that the Trust reported strong clinical outcome performance compared with national data. However, it was noted that several specialities had reported concerns regarding staffing pressures and reduced capacity was impacting the ability to report outcomes data.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** N/A	***Risk Rating:*** **N/A**
	• Risks 1a, 1b, 1c and 4a have been updated, following discussions with the respective Executive Director(s). • There had been no significant changes to the risk ratings or target dates since the committee reviewed these risks in October 2025.		
	7.5 Quality Committee Terms of Reference	***Assurance Rating:*** N/A	***Risk Rating:*** **N/A**
	• The committee reviewed its terms of reference and agreed to recommend the terms of reference to the Board for approval. • No changes were proposed.		

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 4.4	Report to the Quality Committee, 26 January 2026
Title:	Interim Maternity and Neonatal Safety Report
Sponsor:	Natasha Watts, Acting 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:

This interim report to the Quality Committee provides assurance and highlights key developments in advance of the full Quarter 3 report, scheduled for publication in March 2026.

The interim update supports timely oversight while allowing the full Q3 report to be comprehensive, data-rich, and underpinned by robust analysis.

The Committee is invited to continue its oversight and constructive scrutiny of Maternity and Neonatal Services, ensuring patient safety remains central to care delivery and improvement activity.

Contents:

This report provides an update in relation to the following areas:

Risk(s):

The University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Services operate 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, birthing people, 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. NHSR Year 7 Reporting and Submission

The MatNeo Service is declaring full compliance with all ten MIS Year 7 Safety Actions**.** Supporting evidence will be presented to the Trust Board on 13 January 2026**,** followed by sign-off at the LMNS Executive Board on 27 January 2026**,** prior to final submission to NHS Resolution on 3 March 2026.

1.1 UPDATE: Safety Action 7 The MatNeo Service has developed and implemented an action plan to meet the requirements of MIS Year 7 Safety Action 7**,** focused on listening to women, birthing people, parents, and families and co-producing Maternity and Neonatal Services with users. The action plan remains appropriate and sufficient to deliver compliance with this Safety Action. Further detail on agreed actions, timelines, and monitoring arrangements is provided in **Appendix 1**, which has been agreed with the Integrated Care Board (ICB).

1.2 Workforce Report: The Midwifery Workforce report can be found in **Appendix 2**. There is a requirement for bi-annual reporting as part of NHSR MIS Year 7. This is the second report for this year.

2. Intergrowth Chart Issue

Background

In December 2025, NHS England issued a national communication to all Trusts identifying a potential safety concern regarding the use of Intergrowth estimated fetal weight charts in maternity services and advising that immediate action was required.

Trust Response

The Obstetric Lead for the Small for Gestational Age (SGA) guideline has engaged with sonography and obstetric teams. It has been agreed that, with effect from 5 January 2026**,** the Trust has ceased use of Intergrowth charts for estimated fetal weight and CPR MoM (cerebroplacental ratio multiples of the median.

The Trust has adopted the Hadlock formula**,** in line with RCOG guidance**,** for fetal weight estimation. The Trust continues to use Intergrowth charts for symphysis fundal height (SFH) plotting. Work is underway to identify and implement an appropriate alternative SFH chart, with actions being progressed through the SGA guideline governance process.

Assurance

The Trust continues to monitor and audit the detection and management of babies born <10th centile and <3rd centile**,** in line with the Saving Babies' Lives Care Bundle. It is noted that the Intergrowth SFH chart extends beyond 40 weeks' gestation. This feature was previously advocated for by the Trust with System C following a Maternity and Newborn Safety Investigation (MNSI) case and will be considered as part of the evaluation of alternative SFH chart options.

3. AMOS Independent Investigation into Maternity and Neonatal Services Reflections and Initial Impressions

Background

The AMOS independent investigation reviewed maternity and neonatal services across 12 Trusts (reduced from an initial 14). The investigation's terms of reference focused on the following key lines of enquiry:

1. Local investigation processes, including quality and timeliness.
2. System-wide review, incorporating evidence from families, staff, previous reviews, academic experts, national healthcare leaders, and wider community engagement.

3. Inequalities, with a specific focus on the experiences of women, birthing people, families, and non-birthing partners from Black, Asian, and other seldom-heard communities.
4. Legal framework review, including the role of Coroners in stillbirths and the approach to compensation following harm due to clinical negligence.
5. Development of a single set of national recommendations to improve maternity and neonatal safety.

The AMOS final report is expected to be published in Spring 2026. The key emerging headlines and corresponding local assurance are summarised below:

Key Headline	Local Assurance
Slow progress on safety improvements	The Trust continues to respond to and report progress against national and regional requirements, with actions tracked through established governance arrangements.
Basic care failures	Service user feedback, including the Friends and Family Test (FFT), is reviewed monthly to identify themes and inform improvement actions.
Communication and respect	Monthly review of service user feedback (FFT) supports monitoring of communication, dignity, and respect, with learning shared across teams.
Discrimination and inequity	Ethnicity and Index of Multiple Deprivation (IMD) data are captured for all reviews and outcomes to enable triangulation, theme identification, and monitoring of inequity. A local Equity Steering Group meets regularly to identify gaps and address priority issues.
Staffing pressures	A recent Birthrate Plus® review has been completed. Workforce planning is overseen through NHS Resolution MIS Year 7 – Safety Action 5**,** with the Trust declaring full compliance with this safety action.

4. Homebirth service – Urgent review of homebirth services

Background
The Regional Chief Midwife has issued a national request for all Trusts to undertake an urgent review of homebirth services, following a Prevention of Future Deaths (PFD) report that identified concerns relating to the safety and quality of homebirth provision.

Trust Response
In response, the Trust has established a multi-disciplinary stakeholder working group to review current homebirth service arrangements, identify any gaps, and agree actions to strengthen safety and quality.

The review is focused on:

1. Training and education – ensuring staff have the appropriate skills, competencies, and ongoing training.
2. Operational delivery and staffing – including escalation processes, resilience, and contingency planning.
3. Support for staff and service users – particularly where requests fall outside established guidance.
4. Monitoring of incidents and outcomes – to identify themes, learning, and improvement actions.

A formal action plan will be developed and shared with the Committee, with regular progress updates provided. Any immediate or significant concerns identified through the review will be escalated through Trust governance arrangements to ensure timely action.

5. Antenatal and Newborn Screening

5.1 Quality Assurance Review

The Antenatal and Newborn Screening Service has been formally notified of a focused Quality Assurance (QA) review scheduled for March 2026, with a specific focus on governance and incident management pathways.

The review will be conducted virtually. Programme teams are awaiting requests for information to support the review. Correspondence confirming the review is provided in **Appendix 3**.

5.2 Annual Screening Report

In line with national requirements, screening services produce an annual report in arrears. The attached report covers the period 1 April 2024 to 31 March 2025 and includes all six Antenatal and Newborn Screening Programmes.

The report provides comprehensive assurance and will be shared with commissioners and the Screening Quality Assurance Service. The full report is included as **Appendix 4**.

Action Plan for NHS Resolutions Maternity Incentive Scheme Year 7 Safety Action 7

Timeline of MNVP activity within April – November 2025:

- **April 2025** – release of NHSR Year 7 guidance. MNVP role currently in place commissioned for 5 days per month.
- **May 2025** – case for change presented to LMNS Exec Board. Option agreed of 6 days per month MNVP Chair and 6 days per month MNVP engagement lead.
- **July 2025** – significant absence from key meetings and low levels of onsite input from MNVP chair. Verbally escalated to LMNS by UHS DOM.
- **August 2025** – case for change approved by LMNS and funding agreed.
- **August 2025** – MNVP met with DOM and LMNS to discuss workstreams and engagement.
- **August – October 2025** – strong improvement in engagement and attendance at meetings by MNVP chair.
- **October 2025** – MNVP contract expired and awaiting renewal. MNVP chair escalated to LMNS, who escalated to ICB internal processes of ECP. ECP paperwork submitted formal to ICB MNVP chair made the decision to not continue working until renewal of contract.
- **November 2025** – ECP outcome chased and MNVP chair communicated to
- **December 2025** – MNVP chair contract renewed for 12 months, back dated to October and formal communication to MNVP chair sent, and work resumed.

UHS position statement:

The MNVP infrastructure was commissioned from August 2025. However, UHS is declaring that there is evidence that the MNVP infrastructure was not commissioned and **functioning in full** as per national guidance due to the following reasons:

- There was poor attendance from the MNVP chair at key safety meetings from April – July 2025. This was escalated to the LMNS verbally and the DOM attended a 1:1 with the MNVP chair and LMNS in August 2025.

- The MNVP engagement lead post is currently vacant and therefore the MNVP chair is unable to attend all key safety meetings as required.
- The MNVP chair contract expired end of October 2025 and the MNVP chair therefore ceased all work until her contract was renewed.

Action plan:

Action	Review date	Lead	Progress
MNVP engagement lead funding approved and post to be advertised.	January 2026	MNVP chair	Job description written. Advert to be posted. UHS and LMNS to support MNVP in recruitment activities
MNVP chair contract requires renewal.	December 2025	LMNS	ECP was approved on 17 December 2025 for 12 months, effective from 21 October 2025 until 20 October 2026 and MNVP to receive backdated pay from 21 October 2025.
Terms of Reference for key safety meetings to be reviewed and updated to include MNVP chair or deputy as quorate member.	April 2026	UHS	TORs to be updated and include MNVP chair or deputy as quorate member once MNVP engagement lead is in post.

Appendix 2

Midwifery Workforce

This paper provides assurance to the Quality Committee and Trust Board regarding compliance with NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) Year 7 – Safety Action 5, which requires Trusts to demonstrate a systematic and effective approach to midwifery workforce planning.

The report confirms that:

- A recognised workforce review (Birthrate Plus®) was completed in July 2024
- The Trust is partially compliant with the BR+ funded establishment requirement, with a variance of -8.94 WTE
- The Trust remains fully compliant with:
  - One-to-one midwifery care in active labour, and
  - Supernumerary labour ward coordination
- Agreed actions are in place, subject to ongoing Board oversight, to address the remaining area of partial compliance
- This report fulfils the requirement for six-monthly Board-level oversight.

The Trust meets 4 of the 5 MIS Year 7 Safety Action 5 requirements.

Background:

MIS Year 7 Safety Action 5 requires Trusts to evidence:

- A recognised, evidence-based midwifery staffing review within three years
- A funded establishment aligned to the calculated requirement
- Compliance with national standards for intrapartum care and labour ward coordination
- Six-monthly Board reporting and oversight.

UHS uses Birthrate Plus®, the nationally endorsed workforce planning tool.

Assessment and Assurance:
1.1 Birthrate Plus® Review (Requirement a):
✅ *Compliant*

A full Birthrate Plus® assessment was completed in July 2024, based on a three-month casemix sample:

- Annual births: 4,993
- High-acuity casemix (Categories IV & V): 76.6%
- Recommended establishment: 257.76 WTE
  - Clinical: 230.14 WTE
  - Specialist/managerial: 27.62 WTE.
  -

1.2 Funded Establishment (Requirement b):
❌ *Partial Compliance*

The current funded establishment is 248.82 WTE, resulting in a variance of -8.94 WTE.

Workforce Group	Funded WTE	BR+ WTE	Variance
Clinical Midwives & MSWs	226.42	230.14	-3.72
Specialist / Managerial	22.40	27.62	-5.22
Total	248.82	257.76	-8.94

This variance has not resulted in non-compliance with intrapartum care standards or labour ward coordination requirements.

Agreed Actions and Oversight

- Ongoing recruitment to midwifery vacancies
- 16.6 WTE newly qualified midwives recruited in 2025/26:
  - 7.6 WTE commenced October 2025
  - 9 WTE commence January 2026 (clinical deployment from mid-February 2026)
- Recruitment approvals were based on predicted attrition; lower-than-expected leavers have resulted in an over-recruited position of 8.75 WTE (January 2026)
- While not currently funded, this position supports the BR+ recommended uplift
- Engagement with the NHSE newly qualified midwife expansion initiative, enabling conversion of MSW vacancies to Band 5 midwife posts
- Temporary staffing primarily delivered via substantive UHS midwives through NHSP, with minimal agency usage
- A live workforce dashboard, integrating ESR and e-rostering data, is maintained and available for audit
- Ongoing engagement with the LMNS and regional workforce groups.

1.3. Labour Ward Coordination (Requirement c): reporting period 02/04/25 to 30/11/25 – this report covers 01/07/25 – 30/11/2025

✅ *Compliant*

UHS maintains 100% supernumerary labour ward coordinator presence on all shifts, supported by:

- Rostered and actual presence validation
- Formal escalation process in the event of unavailability
- 1x Red Flag (RF10) was recorded inaccurately. This woman was being assessed in Maternity Day Assessment Unit (MDAU) prior to being admitted to Labour Ward for 1:1 care.

1.4. One-to-One Midwifery Care in Labour (Requirement d): reporting period 02/04/25 to 30/11/25 – this report covers 01/07/2025

✅ *Compliant*

The Trust continues to meet the requirement for 1:1 care in active labour. Supporting evidence includes:

- 100% compliance via acuity tool monitoring
- 1x Red Flag (RF9) was reported however this was established as a data input error following investigation
- OPEL escalation used appropriately (23 declarations YTD).

Number of Red Flags recorded

01/07/2025 to 30/11/2025

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	3	7%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	3	7%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	5	11%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	18	39%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	1	2%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	2%
RF10	Coordinator not able to maintain supernumerary/supervisory status	1	2%
RF11	Unable to facilitate women's choice of birth place	14	30%
TOTAL		46	

*The % is rounded to nearest whole number

1.5. Oversight Reporting (Requirement e):

✅ *Compliant*

This paper serves as the second of two required six-monthly oversight reports to the Trust Board during MIS Year 7.

Risks and Mitigations:

Risk	Impact	Mitigation
Understaffing	Potential impact on maternal/neonatal outcomes	Escalation protocols, temporary staffing, on-call cover
Financial	Risk to MIS incentive and increased bank/agency reliance	Recruitment pipeline and retention initiatives
Workforce sustainability	Risk of burnout, low morale, and reduced retention	Staff wellbeing, flexible working, career development
Reputational/Regulatory scrutiny	Non-compliance with BR+ recommendations	Transparent Board reporting; active commissioner engagement

Conclusion:
The Trust has in place a robust midwifery workforce planning and assurance framework that satisfies the majority of requirements under MIS Year 7 – Safety Action 5. Where full compliance has not yet been achieved, clear plans and mitigations are in place, with timelines agreed and shared with system partners.

Recommendation to the Trust Board:

The Board is asked to:

1. Note the completion of the Birthrate Plus® workforce review (July 2024)
2. Acknowledge the current shortfall of 8.94 WTE and partial compliance with the funded establishment requirement
3. Endorse the current recovery plan and workforce trajectory to address this shortfall
4. Confirm that UHS continues to provide safe care with full compliance in 1:1 labour care and supernumerary coordination
5. Approve this report as formal evidence for submission to NHS Resolution in line with MIS Year 7 – Safety Action 5 requirements.

David French
Chief Executive
University Hospital Southampton NHS Foundation Trust

By email

22 December 2025

Dear Mr French

Quality Assurance review to University Hospital Southampton NHS Foundation Trust Antenatal and Newborn Screening Service 17 March 2026

The Screening Quality Assurance Service (SQAS) is arranging a Quality Assurance (QA) review of University Hospital Southampton NHS Foundation Trust Antenatal and Newborn Screening Service on 17th March 2026.

The review will examine the governance structure and incident management pathways for the 6 antenatal and newborn screening programmes. It will be undertaken virtually through a series of interviews that will take place across one day with our professional clinical advisors.

The SQAS will liaise directly with the screening management team regarding organisational arrangements and requirements.

Following the review SQAS will share the findings and any recommendations with the service lead. We will notify you of any immediate concerns or urgent recommendations.

If you have any queries or concerns about this visit, please do not hesitate to contact Teresa Lardner, QA advisor on teresa.lardner@nhs.net.

Yours sincerely

Dr Helen Lewis-Parmar
Senior Clinical Lead
Antenatal and Newborn

cc.

Emma Northover, Director of midwifery

Francesca Finch, Screening Co-ordinator

Rachel Shipsides, NHSP local manager

Clare Simpson, Screening and immunisation lead

University Hospital Southampton NHS Foundation Trust

Annual Report 2024 – 2025 for Antenatal and Newborn Screening at University Hospital Southampton NHS Foundation Trust

Author Francesca Finch – Antenatal and Newborn Screening Specialist Midwife

Kathryn Payne – NIPE coordinator

Rachel Shipsides – Cover Lead Newborn Hearing

The purpose of the annual report is to give assurance up to Trust Board level that the commissioned Antenatal and Newborn screening programmes are performing in line with national standards. Our commissioners consider it imperative that there is an awareness of the successes, quality, and challenges within Antenatal and Newborn screening at UHSFT at this level. The timeframe for reporting in this report is April 1st, 2024 – 31st March 2025.

This report will be distributed to the following people and organisations after review by the Director of Midwifery and Neonatal Services.

Internally:

- The CEO at UHSFT
- The Medical director at UHSFT who has oversight of screening programmes within the trust.
- The DCD and DDO of Division C (Woman and Newborn)
- The CGM for Women and Newborn
- The QA matron who also line manages the screening team.
- The contracting manager at UHSFT
- The Ultrasound Lead
- The clinical lead for the Virology laboratory
- The laboratory manager and clinical lead for Sickle Cell and thalassaemia screening

Externally:

- The clinical lead for trisomy 13,18 and 21 screening at Portsmouth Hospital Trust
- The clinical lead for Newborn Bloodspot Screening at Portsmouth Hospital Trust
- The Screening and Immunisation Manager at NHS England Southeast Region (HIOW)
- The Screening and Quality Assurance team at NHS England

There are six antenatal and neonatal screening programmes. The standards for these are set by each programme team at a national level. The programmes are commissioned by NHS England. The programmes include:

Introduction

This report relates to the operations and performance of Antenatal and Newborn screening programmes from April 2024 to the end of March 2025.

Antenatal Screening Programmes

- **Infectious Diseases in Pregnancy Screening (IDPS)**
- **Sickle Cell and Thalassaemia screening (SC&T)**
- **Fetal Anomaly Screening Programme (FASP)**

Newborn Screening Programmes

- **Newborn Bloodspot screening (NBBS)**
- **Neonatal and Infant Physical Examination (NIPE)**
- **Newborn Hearing Screening Programme (NHSP)**

There are KPIs attached to all the screening programmes which are submitted quarterly and there is an annual data submission against the standards for the antenatal screening programmes.

In January 2025, UHSFT has received notification of an intended Quality assurance review to examine the governance structure and incident management pathways for the six antenatal and newborn screening programmes. This is scheduled for March 2026.
At UHSFT we have a strong governance structure and have also re-instated the Screening steering meeting which was paused during covid. The screening steering group always for additional focus over the individual programme standards and KPI's which cannot always be covered as thoroughly in divisional governance.

Antenatal screening programmes

Infectious Diseases in pregnancy screening (IDPS). Screening for HIV, Hepatitis B, and Syphilis

We continue to receive a robust, high level of service from our virology laboratory colleagues. Overall, our turn-around- times are met and our monthly multi-disciplinary team meeting over 'Teams' is still working well, and we continue to enjoy a very solid relationship with our Hepatology and Sexual Health colleagues.

During this time we have had issues with missing/not received virology samples. This was discussed at governance and completed a patient safety review. The cause is multifactorial, including errors at specimen reception due to illegible forms, blood going missing between labs and midwives only sending one yellow top bottle for two investigations. This results in the service users being rebled and a potential delay of diagnosis and treatment. The key factor in preventing further issues, is the introduction of electronic requesting which is hopefully going to be in place from February 2025.

The annual antenatal data submission for IDPS measured against the following standard submitted June 2025 for this reporting period:

Standard 4 Test Turnaround Time

The following standards are now submitted via the Integrated Screening Outcomes Surveillance Service (ISOSS):

Standard 5 Timely discussion of screen Results with women
Standard 7 Timely immunisation of babies whose mothers are Hepatitis B positive.

The standards were met and exceeded for all of these during the period of this report.

Quarterly Data (KPI's) is submitted against the following standards:

Standards 1,2 and 3 – these are coverage KPI's where the achievable standard for coverage of tests for these 3 conditions is 99%. We exceed 99% and have a very low decline rate for these tests.

Standard 6 Timely review by Hepatology of new and high infectivity Hepatitis B positive mothers within 6 weeks. Our trust exceeds this standard and offers all hepatitis B positive women a review within 6 weeks.

Sickle Cell and Thalassaemia Screening
Historically, UHSFT has struggled to achieve the timeliness of testing for sickle cell and thalassaemia by 10 weeks and 0 days. It is important to note that the rationale behind timely testing is to ensure that women can access prenatal diagnostic testing at a stage in their pregnancy which enables them to have 'reproductive choice'. However, with the changes made to the self-referral process and timing of booking appointment, we have seen a substantial improvement from Q1 (24-25) 37.2% to 74% in Q4. This is a significant improvement from our previous performance of around 10%. We are now not only meeting the acceptable threshold but are close to meeting the achievable threshold of 75%.

At UHSFT we have rapid referral into a CVS and amniocentesis service which overcomes any potential delay but, in line with other trusts regionally, we experience some variation in the length of time it takes to receive results. The samples must travel to the regional laboratory for preparation and are then sent to the national reference laboratory in Oxford.

Following monitoring and review by NHS England, UHSFT has been recommended to move to a high prevalence model for SCT screening. The SCT programme is delivered via two approaches according to the prevalence of haemoglobinopathy conditions in the geographical area of the trust. As a trust we now meet the high prevalence threshold with 2% or greater of our booking blood results screen positive. Following the high prevalence algorithm will mean our whole booking cohort must be offered screening for sickle cell, thalassaemia, and other haemoglobin variants irrespective of ancestry. We have not yet switched to this model, a business case has been submitted for additional funding, but due to the changes within NHS England, its review has been delayed. Even though we are still following our previous model, we have a strong robust joint failsafe/process with the haematology lab so are not concerned that we are missing any cases.

This year the SCT service across UHSFT, was peer reviewed and received positive feedback but particularly the Antenatal and Newborn screening provision.

Fetal Anomaly Screening Programme

Down's syndrome, Edwards' and Patau's syndrome Screening

Our relationship with the laboratory remains strong with turnaround times and national standards being met.

For FASP standard 7, which is timelines to information and support for higher chance screening results, our performance was 100% with all service users being contacted and counselled by a screening midwife within 3 working days of us receiving the result.

UHSFT was very proud to be one of the pilot centres for the trial of the new R445 NIPT pathway. We helped establish the process and educational/learning resources with the other centres. This pilot was the introduction of the offer of NIPT for service users who had previously had a pregnancy affected by Down syndrome, Edward's or Patau's syndrome. The pilot was successful and R445 has now launched as a national screening pathway. This allows the eligible cohort access to enhanced screening earlier in their pregnancy if they wish.

The 18+0 to 20+6 anomaly scan
Capacity in the Ultrasound Department has been pressured at times during this reporting period. This has been managed efficiently due to strong leadership in the ultrasound department with additional lists added. Scanning lists at the NFBC for first trimester and anomaly scans are now well established. This is alleviating capacity issues and receives positive reviews from service users regarding the setting and proximity for those living closer to the New Forest.
The coverage KPI for anomaly scanning was met throughout this reporting year with few issues. The national reporting system for fetal anomalies known as NCARDRs reports a year in arrears but there were no concerns raised in the most recently published report.

As part of the annual data submission for the Fetal Anomaly scan part of FASP we report against Standard 8 which is the time to referral within 3 working days from ultrasound to our Fetal Medicine service. This data showed that of 49 of the 52 women referred for one of the 11 key conditions were seen by 3 days. Two people were seen within 4 working days, with one person seen within 5 working days but that was due to patient choice.
The working relationships with the Fetal Medicine service are strong and effective.

Newborn Screening Programmes

Newborn Bloodspot Screening (NBBS)

This newborn screening programme is, currently, the only newborn programme coordinated by the screening team. All newborn screening programmes benefit from national fail-safes which flag babies who have not completed screening. The nature of our service, alongside the Children's Hospital mean that newborn screening programmes can be complex. However, the screening team have linked with the children's hospital and now have a regular slot on the PICU study days.

The KPI we report against for NBBS is for samples requiring a repeat for avoidable reasons. Our performance for Q1 was 1.7% but unfortunately declined to 2.6% in Q4 which is below the acceptable threshold on <2.0%. In response to this, the screening team have devised a new staff policy for management of rejected samples. The policy contains clear training pathways for staff following rejected samples including a new competency document.

We are also well established on the PICU study days and have recently started teaching on the NNU new starter and midwifery preceptor days.

Neonatal and Infant Physical Examination

This newborn screening programme (NIPE) has a Consultant Neonatologist as programme lead with a 0.6 WTE band 7 NIPE Screening Coordinator who runs the screening programme operationally. The Neonatal Safety and Quality Assurance Matron supports the programme. From April 24, 6.5 hours of the Failsafe Officer's hours were allocated to support NIPE.

The NIPE screening programme aims to identity congenital abnormalities of the eyes, heart, hips and testes (in males) within the neonatal period and again at 6-8 weeks.

As a regional provider of neonatal intensive care and specialist paediatric services, including cardiac care, the implementation of NIPE at UHS involves unique complexities due to patient acuity, inter-hospital transfers and clinical workload variability.

Despite service complexity, the NIPE programme aims to adhere to the programme standards expectations through the work of the NIPE screening Coordinator, with strong collaboration from the Failsafe officer, Data Team and Education Teams.

Key developments include:

The introduction of a new local failsafe process following a screening incident. This was introduced to flag hip risk factors identified within the electronic maternity record. This monthly report identifies any cases that were not referred at the time of the NIPE and allows for prompt action by the Screening Coordinator.

Governance and communication

There is regular communication with commissioners regarding incidents.

All learning is shared within the NIPE team and at Women and Governance meetings to promote continuous improvement.

Workforce Development

Standard operating procedures are now available on Staffnet to guide: Midwifery staff with a NIPE qualification on becoming registered NIPE practitioners at UHS and ongoing CPD compliance for existing practitioners.

A strong partnership between the Practice Education Team, Roster Team and Screening Coordinator supports preceptees with dedicated time in the NIPE clinic to build confidence and competence.

University Hospital Southampton NHS Foundation Trust

KPI's and comparison with National performance

Standard's and KPI's	Description	Acceptable threshold	Achievable threshold	UHS data
NP1	The proportion of babies eligible for the newborn physical examination who are tested for all 4 components (3 in female infants) of the newborn examination at ≤72 hours of age and have a conclusive result on the day of the report	≥95.0%	≥97/5%	**95.0%**
S02	The proportion of babies with a screen positive eye result on newborn physical examination who attend for clinical assessment by an Ophthalmology specialist ≤2 weeks of the examination.	≥95.0%	≥99.0%	**50%**
S03	The proportion of babies with a screen positive newborn hip result who attend for ultrasound scan of the hips within the designated timescale.	≥90/0%	≥95.0%	**80.7%**
NP4	The proportion of babies with a screen positive newborn hip result at newborn examination for whom an outcome decision was made within the designated timescale.	≥90/0%	≥95.0%	**67.6%**
S05	The proportion of babies identified with screen positive testes results requiring urgent review and who are seen for assessment by a consultant paediatrician or associate specialist ≤24 hours of the NIPE newborn examination.	100%	-	**100%**

NP1 – this is an improvement on last year (94.7%). There has been a huge drive within the neonatal unit to complete the NIPE when the baby is clinically well enough and not waiting until discharge is imminent. The NIPE midwifery clinic within Princess Anne continues to work well to ensure that all babies who are require a NIPE are offered and screened within the 72-hour KPI.

S02 – This KPI was not achieved due to 1 baby breaching the standard. The decision to delay the appointment came from the consultant team who already knew the family and delayed the

appointment slightly to bring it in line with the sibling's appointment to allow for easier access to the service for the family.

S03 – From April 2024 this standard was stood down as a KPI with the focus being on NIPE S04 as the new KPI. Our performance is comparable to the previous year but a huge improvement since the recruitment of the NIPE Screening Coordinator in Feb 23 (56.5%). The NIPE Screening Coordinator and failsafe officer continue to work with the Orthopaedic admin team to ensure appointments are offered within the correct timeframes.

NP4 – Performance greatly improved since 22/23 data where performance sat at 42.0%. The NIPE Screening Coordinator and failsafe officer continue to work with the Orthopaedic admin team to ensure appointments are offered within the correct timeframes. Most babies that don't achieve this KPI are due to the clinical decision to offer a rescan due to hip immaturity. 2% of the babies that required a rescan were treated after the target KPI. 30 babies were treated for DDH because of referral from the NIPE screening programme.

S05 – standard achieved.

Updates

In collaboration with the Paediatric Orthopaedic team, UHS has started collating data in relation to hip outcomes with the OUCH study programme. We are one of the selected sites to provide an enhanced data set within S4N in relation to hip diagnostic and treatment pathway this will then support the development of a programme to overcome unplanned variation in Children's Health.

The NIPE Screening coordinator was asked by the national team to support with testing of the updates to the Smart4NIPE national failsafe. This has provided a great opportunity for networking with other screening coordinators within England as well as enabling a greater depth of understanding of the S4N system.

UHS were notified in January 2025 that the Screening Quality Assurance Service (SQAS) would like to undertake a formal review of governance structures and processes for antenatal and newborn screening, no current date is set but this could occur anytime from September 2025. The NIPE Clinical lead, NIPE Screening Coordinator and Maternity and Neonatal quality assurance matrons are working hard to ensure that guidelines are up to date, failsafe processes are all documented and that appropriate governance structures are in place.

Newborn Hearing Screening

The newborn hearing screening service has continued to perform well throughout 24/25. The annual figures produced in June 2025 are as follows -

NH1 99.6% - (acceptable 98%)

NH2 93.2% - (acceptable 90%)

There has been a recent change in the management of babies moving in from other countries. All babies moving in under 12 weeks of age are now required to be added to the NHSP database. This may influence the KPIs for NH1 for all sites nationally.

Several staffing changes have occurred within the team in the last year. One screener retired in May and these hours have not been permanently replaced at present. We have been able to cover occasional shifts when needed with the retired screener working for NHSP and staff excess hours.

Christina Crouchman NHSP local manager commenced her maternity leave in July with Rachel Shipsides appointed as covering local manager.

In February 2026 our band 5 admin manger will be retiring, this role is planned to be replaced by a band 4 senior screener role as this will provide more flexibility in the team.

Our screening equipment has been identified as a risk due to its increasing age and unreliability. The planned replacement was awaiting the production of the new Senteiro screening devices. The development and testing of the new device has experienced lengthy delays with no clear production date. It has been decided to change to another provider and purchase 4 Accuscreens which will replace some of our current equipment before the end of our funding agreement in late March 2026.

A further funding bid has been requested for 3 devices through capital funding for screening services. This funding will be available for successful applicants in the next financial year.

Our relationship with the Audiology department remains strong and we have no current concerns regarding capacity for ongoing testing and diagnosis.

The service has continued to work hard to provide a family friendly service with 8 regular clinics providing good access for families attending outpatient appointments. Home visits are offered to families when needed and where possible, screeners attend existing postnatal visits within the hospital to offer hearing screens.

Conclusion

To conclude, the Antenatal and Newborn screening programmes are performing well and running effectively. Significant improvements have been seen in key areas such as ST2, SO3 and NP4. These improvements mean UHS is now in line with, or higher achieving within the SHIP network.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.5 Report to the Trust Board of Directors, 10 March 2026	
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:

- Fire at Southampton General Hospital
- Independent Investigation into Maternity and Neonatal Services
- NHS Waiting Lists and Performance
- Corridor Care Summit
- Supply of Bone Cement Products
- Agenda for Change Pay Award 2026/27
- Nursing Profession Changes
- Industrial Action
- National Cancer Plan for England
- GP Contract 2026/27
- HIOWAA CQC Report
- GICU Specialist Rehabilitation Facility
- Cardiac Intensive Care Unit awarded Centre of Excellence status

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

Fire at Southampton General Hospital

At approximately 05:30 on the morning of 1 February 2026 a fire broke out in the endoscopy department on E level in West Wing as a result of a localised electrical fault. Five hundred and two patients were moved out of West Wing to other areas around the hospital within the space of 40 minutes and nobody was seriously injured.

More than 110 firefighters from the Hampshire & Isle of Wight Fire and Rescue Service attended the blaze, bringing the fire under control by about 10:00.

The Trust declared a major incident and diverted patients away from its Emergency Department and cancelled planned elective activity and outpatient appointments. The Trust remained in major incident until 10 February 2026.

The Trust has lost seven endoscopy rooms and the associated equipment. However, steps have been taken to make alternative temporary provision via other providers and the private sector, and the Trust is procuring mobile endoscopy suites for deployment at Southampton General Hospital and at Adanac Park.

As a result of the fire, the Trust is working with 150 fewer beds than it would normally have. Local authorities and other local providers have greatly assisted the Trust by helping to reduce the number of patients having no criteria to reside from approximately 260 to 120 by opening additional capacity for community placements and enabling the Trust to transfer patients to other settings.

A thorough review of what happened, what went well and what opportunities exist to improve in case such an incident should happen again, here or elsewhere, is underway and will be shared widely once completed.

The Trust is also reviewing how the operation of the hospital changed in the days following the fire, for example increased discharges, and to 'bake in' some of those changes to our future business as usual.

The efforts of the Trust staff were truly remarkable and indeed courageous in the evacuation of patients. Staff have demonstrated the Trust's values in caring for patients in extremely challenging circumstances during and since the fire. I am proud of the way teams have responded, both on the day and throughout the recovery period.

The Trust has set up wellbeing support services for staff and will continue to support staff in need of wellbeing or welfare support.

Independent Investigation into Maternity and Neonatal Services

On 26 February 2026, the Independent Investigation into Maternity and Neonatal Services in England published its interim report. The investigation, chaired by Baroness Valerie Amos, was established in August 2025 to examine maternity and neonatal services in 12 NHS trusts with the aim of developing one set of national recommendations to drive improvements, reduce inequalities, and help affected families to receive justice and accountability.

More than 8,000 people have so far submitted evidence, with 400 families meeting with Baroness Amos.

The findings of the interim report include:

- Services depleted or stopped due to capacity pressures, with stretched antenatal wards and delivery units resulting in delays to admissions and the use of community midwives in delivery units impacting safety.
- Poor relationships between team members and racist and bullying behaviour.
- Structural racism and persistent inequalities leading to notably higher risk of adverse outcomes for women from black and Asian backgrounds and women from more deprived areas.
- A lack of compassion and transparency when baby loss and harm occurs.
- Care being delivered in outdated and dilapidated buildings, in some cases compromising clinical care.
- Staff reporting maternity units did not have enough personnel to provide safe care.

The interim report can be read at: https://www.matneoinv.org.uk/updates/independent-investigation-into-maternity-and-neonatal-services-in-england-interim-report/

The final report is expected in June 2026.

NHS Waiting Lists and Performance
On 12 February 2026, NHS England reported that, in 2025, the NHS delivered more elective activity than in any other year in its history, helping to cut the waiting list to its lowest level since February 2023. Staff delivered 18.4m treatments and operations in 2025, up from 18m in 2024. The overall NHS waiting list dropped to 7.29m.

In December 2025, 1.43m treatments were delivered despite five days of industrial action by resident doctors. It was also reported that the percentage of people waiting over 18 weeks for treatment has decreased slightly to 61.5%, while the percentage of those waiting over 52 weeks had fallen to 1.9% - the lowest since June 2020.

Demand for emergency services has continued to increase, with 2.3m accident and emergency attendances in January 2026 – 4.6% higher than in January 2025. However, despite this the number of people admitted, transferred or discharged in less than four hours was higher than the prior year. Four-hour performance has been at 73.5% during the winter – up from 72.1% last year.

The COO will update the Board on the current UHS performance levels during the meeting.

Corridor Care Summit
Some of the Trust's executive directors were among those from 30 trusts who were requested by NHS England to attend a summit on corridor care in London on 26 February 2026.

The purpose of the day was to hear from other organisations which have had some level of success in eradicating corridor care and for organisations to begin formulating a plan to achieve this. There was a very clear message that corridor care was unacceptable, as it poses risks to patient safety and experience as well as to the psychological wellbeing of staff.

The Trust has two weeks to submit its plan to regional leads setting out actions we intend to take to reduce the need for corridor care within the Emergency Department. Unlike other trusts in attendance last week, we do not board patients on wards or provide care in other corridors in other areas within the Trust such as in x-ray departments.

Supply of Bone Cement Products
Heraeus Medical, the supplier of approximately three-quarters of the bone cement needed in the NHS was forced to temporarily halt production at its main site following a packaging fault. The product is used in more than 1,000 operations a week, mostly knee replacements, but also in some hip and shoulder replacements.

Local inventory levels were reasonably strong however there were some initial national concerns, with trusts told to postpone treatments. It was announced on 25 February 2026 that the NHS had found a new supplier and an existing supplier had agreed to increase its deliveries.

Agenda for Change Pay Award 2026/27
On 12 February 2026, the Government announced the 2026/27 pay award for staff on Agenda for Change terms and conditions. Staff will receive a 3.3% consolidated uplift in April 2026 salaries.

As part of the 2026/27 pay package, the Department of Health and Social Care will begin discussions with trade unions and employers through the NHS Staff Council to agree funded improvements in the pay structure. Once agreed, reforms will provide some staff with additional pay increases backdated to 1 April 2026. Priorities include raising pay for the lowest paid and improving pay for graduates.

Nursing Profession Changes
In addition to wider Agenda for Change reforms, including graduate pay, the Government has announced a series of specific measures to recognise the significant value of the nursing profession. This will include a review of all Band 5 nurse job descriptions to make sure that every nurse is in the right band, which will be determined through the fair and proper application of the job evaluation scheme. Work commenced in 2025 to review nursing and midwifery job descriptions at the Trust following the recent publication of revised national profiles. This work will continue under this new national directive.

An update will be provided for staff ahead of 1 April 2026 – when this programme of work is expected to commence – once further detail has been received from NHS England.

Also announced was the planned launch of a single national nursing preceptorship standard. When more detail is available, it will be necessary to consider how this aligns with the established UHS preceptorship programme.

Industrial Action
Members of the British Medical Association (BMA) voted in favour of extending the current mandate for industrial action for a further six months in the long-running dispute with resident doctors. Approximately 93% of BMA members voted in favour of continuing industrial action on a turnout of 53%.

Industrial action by resident doctors commenced in spring 2023 and has led to 14 separate strikes.

The Government has suggested a 2.5% pay increase from April 2026 to the independent pay review body, which is now considering what to recommend.

National Cancer Plan for England
On 4 February 2026, the Department for Health and Social Care published its National Cancer Plan for England.

The plan reiterates the Government's commitment to meet cancer waiting time standards by the end of the current Parliament and to become a global leader on cancer survival by 2035. The plan includes:

- Delivery of 9.5m additional tests by 2029 through investment in diagnostics and ensuring as many community diagnostics centres as fully operational and open 12 hours a day, seven days a week.
- Prioritising improvement in the most challenged trusts through intensive support.
- Using data, artificial intelligence, genomics, robotics, and wearables to transform care pathways.
- Cutting unnecessary appointments by giving patients control over their care, through straight-to-test pathways, and implementing patient-initiated follow-up.
- Using technology to triage patients to make better use of diagnostic capacity.
- Rolling out the Lung Cancer Screening programme nationally by 2030.
- Passing the Tobacco and Vapes Bill.
- By 2028, the NHS App will be the front door for cancer care, allowing patients to manage screening invitations, appointments and treatment plans.
- More patients will be able to access genomic testing.
- Measures to shift more cancer care out of hospital and into local neighbourhoods.
- Improvements in cancer care for young people, including providing up to £10m per year to pay for travel costs for cancer care for children and young people.

The plan can be viewed at: https://www.gov.uk/government/publications/national-cancer-plan-for-england

GP Contract 2026/27
The contract for General Practitioners for 2026/27 was published on 24 February 2026. This was the first year that the negotiations included a wider stakeholder consultation beyond just the BMA.

The contract will be uplifted by £485m, representing a 3.6% total increase (1.4% in real terms). This growth assumes an assumption of a 2.5% pay uplift. In addition to this amount, £292m will be repurposed from the Capacity and Access Payment into a practice-level reimbursement scheme, which will be available to practices to increase capacity through extra sessions or recruiting additional staff.

Practices will be expected to provide a same-day response for urgent patient requests and new requirements have been introduced in respect of patient choice and practice-level communication with community pharmacy. In addition, primary care network responsibilities around vaccinations, cancer screening, continuity of care, and neighbourhood geography have been more clearly defined.

HIOWAA CQC Report
The Hampshire and Isle of Wight Air Ambulance Service (HIOWAA) has been rated ‘outstanding’ by the Care Quality Commission (CQC) following a comprehensive inspection by the independent regulator in October 2025.

The collaboration between the HIOWAA Charity and the Trust was formally established in November 2018 to further strengthen integration between the air ambulance charity and NHS services.

This is the first time that the CQC has rated the service.

GICU Specialist Rehabilitation Facility
In January 2026, the Trust celebrated the opening of a dedicated rehabilitation facility within its General Intensive Care Unit (GICU). This new space is equipped with a wide range of specialist kit to promote early mobilisation, recovery and independence as patients begin their journeys out of intensive care.

In addition, a new staff room has been created to enhance the wellbeing of GICU staff.

These developments complete the final phase of the wider GICU project.

Cardiac Intensive Care Unit awarded Centre of Excellence status

The Trust's Cardiac Intensive Care Unit (CICU) has been awarded Centre of Excellence status, recognising its dedication to patient safety, quality of care and outcomes for patients. The accreditation was awarded by Cardiac Advanced Life Support (CALS), the international body responsible for CALS training for cardiac surgical practitioners.

The Trust's purpose-built unit contains 16 beds and cares for around 1,400 patients each year, providing specialist one-to-one nursing and expert support from a team of cardiac specialists for patients across the south of England and the Channel Islands.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.6 Report to the Trust Board of Directors, 10 March 2026	
Title:	Performance KPI Report 2025-26 Month 10
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Sam Dale, Associate Director of Data and Analytics

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

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

Contents:

The content of the report includes the following:

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

Risk(s):

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

Equality Impact Consideration:	NO

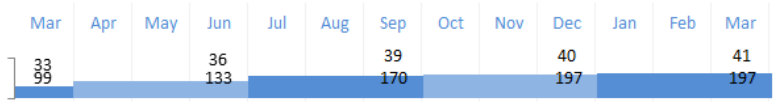
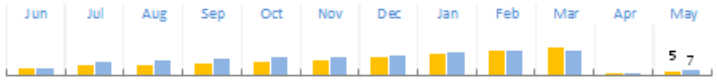
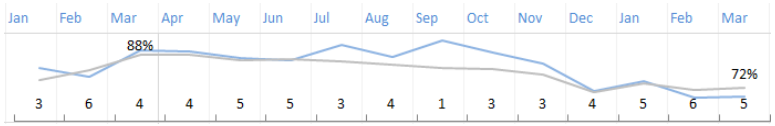
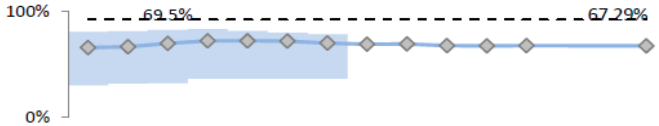
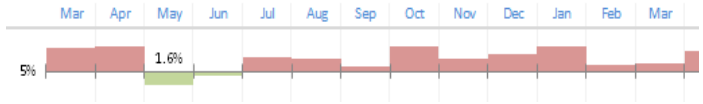
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
January 2026

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

Report guide

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

Introduction

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

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

The content of the report includes the following:

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

Summary

This month's spotlight report explores waiting list position and performance against 2025/26 referral to treatment waiting time targets.

The report highlights that: -

- The trust's waiting list has stabilised in recent months following month on month growth in the first half of the year. The January 2026 waiting list stands at 62,675 patients reflecting a 1.3% reduction on the December position. The 18 week performance stood at 60.2%.
- The trust is currently behind the 2025/26 plan submission for both 18 week performance and the percentage of patients waiting over 52 weeks, however the organisation has prioritised a number of workstreams in the remaining quarter as it seeks to recover the performance position on all key waiting list metrics.
- These workstreams are focussed around increased pathway validation including dedicated GIRFT support, expansion of insourcing services, waiting list initiatives, new outsourcing contracts and the exploration of mutual aid as part of the recovery cell.
- On 1st February 2026, the Trust declared a major incident following a significant fire in Southampton General Hospital West Wing. Whilst the major incident does not impact the reported positions described in this paper (January 2026), it is recognised in the forecast section as the trust attempts to protect its elective throughput and model the performance implications on its recovery plans.

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

1. Four hour performance for Type 1 attendances has improved for three months in a row reaching 63.3% for January 2026. Daily attendances to the department averaged 367 reflecting a 3% monthly reduction since December. Average time for patients in the department has remained consistent in recent months for both non-admitted (3 hrs 32 minutes) and admitted patients (5 hours 42 minutes). The key recovery workstreams being delivered in this period are focussed on improvement of CT diagnostic flows and faster decision making within the urgent care pitstop sections of the department.
2. At the time of writing, validated cancer data is available up until December 2025. It illustrates consistent month on month performance for the 31 day standard at 93%, an improved position for the 28 day faster diagnosis standard at 79.6% but a reduction in performance to 73.1% for the 62 day standard. Services below the national target for 62 days include urology, sarcoma and lung with the majority of delays categorised as diagnostic.
3. The volume of patients waiting for diagnostics has reduced for the second month in a row reporting 9,690 patients for January 2026 which is the lowest number since February 2025. The reduction over the last two months is predominantly within echocardiography, magnetic resonance scanning and dexa scans. The percentage of patients waiting less than six weeks increased to 80.2%.
4. The trust reported two never events and zero patient safety incident investigations in January 2026.

5. The percentage of patients over 65 who required admission after attending the emergency department has increased for two months in a row reaching 45.5% for January 2026. The trend and position are however in line with the previous year's position indicating seasonality is the main driver.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 23rd February 2026, our average handover time was 16 minutes 54 seconds across 793 emergency handovers and 16 minutes 23 seconds across 56 urgent handovers. There were 46 handovers over 30 minutes and 9 handovers taking over 60 minutes within the unvalidated data. Across February 26 the average handover time was 15 minutes 3 seconds.

Spotlight: Referral to Treatment Waiting Times

1. Introduction

The trust continues to operate in a challenging elective recovery environment, characterised by sustained referral demand, productivity restrictions and ongoing pressures across inpatient and outpatient services. Nationally, the elective waiting list has begun to stabilise, with reductions seen in some long wait cohorts; however, performance against the 18week standard remains significantly below national targets.

Within this context, the trust has advanced a comprehensive recovery programme, supported by strengthened PTL processes, increased insourcing and outsourcing, refined demand management arrangements, and ongoing work to improve data quality and scheduling efficiency.

This paper summarises the trust's current position, progress against national standards, and the expected trajectory over the remainder of the financial year. At the time of writing, validated waiting list data is only available up to January 2026.

On 1st February 2026, the Trust declared a major incident following a significant fire in Southampton General Hospital West Wing. The fire caused extensive damage to the endoscopy department on E level and impacted floors above and below, including a number of wards. The major incident does not impact the reported positions described in this paper, but is recognised in the forecast section as we assess the impact and our recovery plans.

2. National Context

The national elective waiting list continues to be a central indicator of NHS performance and system pressure. Over recent months, there has been cautious but notable progress in reducing the total number of patients waiting for planned treatment across England. Despite this improvement, the system remains significantly challenged, with performance against key constitutional standards still far below expectations. The following section summarises the current national position and highlights the emerging trends relevant to assessing local performance.

At a national level, the elective waiting list has fallen for the second consecutive month, reaching 7.29 million pathways at the end of December 2025, the lowest point since February 2023. This reduction represents a modest but symbolically important shift after a prolonged period in which waiting list growth had appeared entrenched. In terms of people rather than pathways, the backlog now corresponds to approximately 6.17 million individual patients, reflecting the scale of demand that continues to exceed system capacity.

A key feature of the national picture is the gradual improvement in long-wait performance. The proportion of patients waiting over a year for treatment has fallen meaningfully: around 140,000 patients remained on the list for more than 52 weeks in December, down from approximately 156,000 in November,

signalling ongoing focus on the longest waiters. More broadly, waits over 52 weeks now account for just 1.9% of the list, the lowest level recorded since June 2020, illustrating the impact of targeted national efforts and increased elective throughput.

Despite these gains, routine performance against the national 18-week Referral to Treatment (RTT) standard remains significantly off trajectory. In December 2025, 61.5% of patients were seen within 18 weeks, slightly down from 61.8% in November and still far short of the 92% constitutional target. Performance at this level reflects sustained operational pressure across the NHS and highlights the extent to which the pandemic-era backlog continues to influence system recovery.

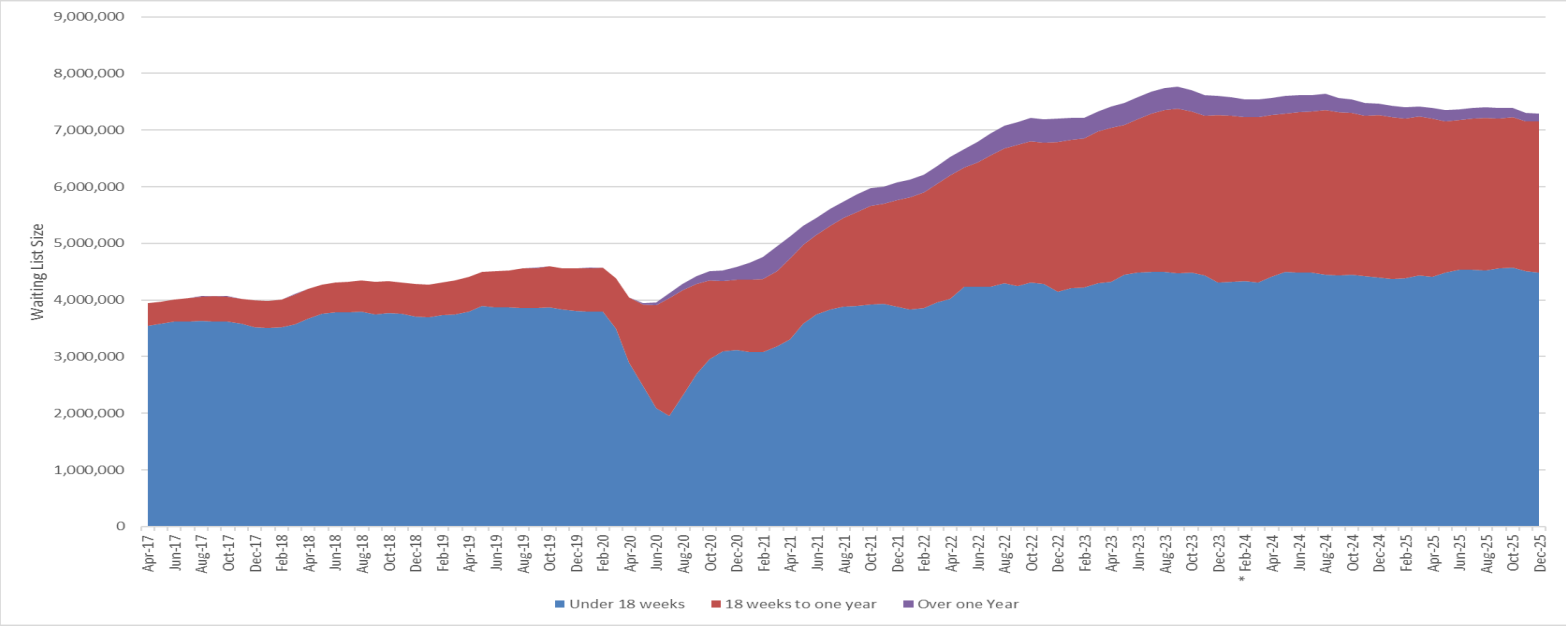


Chart 1: National NHS Waiting List Trend

The recent reduction in the waiting list is partly attributable to record levels of elective activity. Throughout 2025, the NHS delivered 18.4 million elective treatments and operations, the highest annual total in its history and a substantial increase from 18 million in 2024. This uplift in activity has been supported by national reforms such as expanded surgical hubs, additional theatre capacity, and extended operating hours. However, independent analysis suggests that some of the overall reduction in list size also reflects increased validation activity which is estimated to contribute around 15–17% of the

improvement. While this practice is long-standing and broadly consistent with historic patterns, it underscores the importance of interpreting list-size movements alongside underlying treatment activity.

Overall, the national elective picture is one of slow but genuine progress, supported by high levels of activity and targeted attention on the longest waiters. Yet recovery remains fragile: RTT performance is largely static, demand remains high, and any deterioration in urgent care flow risks constraining elective capacity. As a result, the national context continues to set a challenging baseline for local systems such as UHS as we work to sustain reductions in long waits and improve overall waiting list performance in the months ahead.

3. UHS Performance

3.1 Overview

The 2025/26 priorities and operational planning guidance cited three key metrics to measure success in the reduction of the time people wait for elective care. These targets and the latest UHS performance position is listed in table 2. It should be noted that the 18 week metrics have a national target for the NHS, but this would be delivered by all trusts delivering a 5% improvement against their November 24 baseline position, hence why local targets differ from the national target.

	Baseline	NHS Target	UHS Target	**UHS Current**
25/26 National Priority Measures	Nov-24	Mar-26	Mar-26	**Jan-25**
Patients waiting over 18 weeks (%)	62.4%	65.0%	67.4%	**60.2%**
Patients waiting over 18 weeks (%) for their first appointment	66.2%	72.0%	71.2%	**64.3%**
Patients waiting over 52 weeks (%)	1.9%	1.00%	1.00%	**2.4%**

Table 1: 2025/26 Key Performance Metrics

By January 2026, the trust's RTT position remains challenging, but has shown signs of stabilisation after several months of increase across the first half of the financial year. The total waiting list stands at 62,675 pathways of which 37,700 are waiting within 18 weeks, giving an overall RTT incomplete performance of 60.2%. Although this remains significantly below the national 92% standard, it is broadly consistent with the trust's position through late 2025 and continues to track close to the levels seen across the wider teaching hospital peer group.

Long waits remain an area of sustained operational focus. The trust currently has 1,529 patients waiting over 52 weeks which is a 26% improvement against the October 25 position (2,065) and 51 patients waiting more than 65 weeks compared 334 in October. Only 4 patients remain above 78 weeks with the trust maintaining full removal of 104week waiters. This reflects the cumulative impact of a series of targeted interventions across the second half of the year, including strengthened PTL oversight, improved validation, expanded outsourcing and insourcing capacity and improved sequencing of elective lists. The

3.2 Waiting List Size

The size of the UHS RTT (referral to treatment) waiting list has stabilised over the last quarter following monthly increases in the first half of the year which reached a peak of 63,960 in October 2025. January's position was 62,675 which is a 2.0% reduction since that October peak.

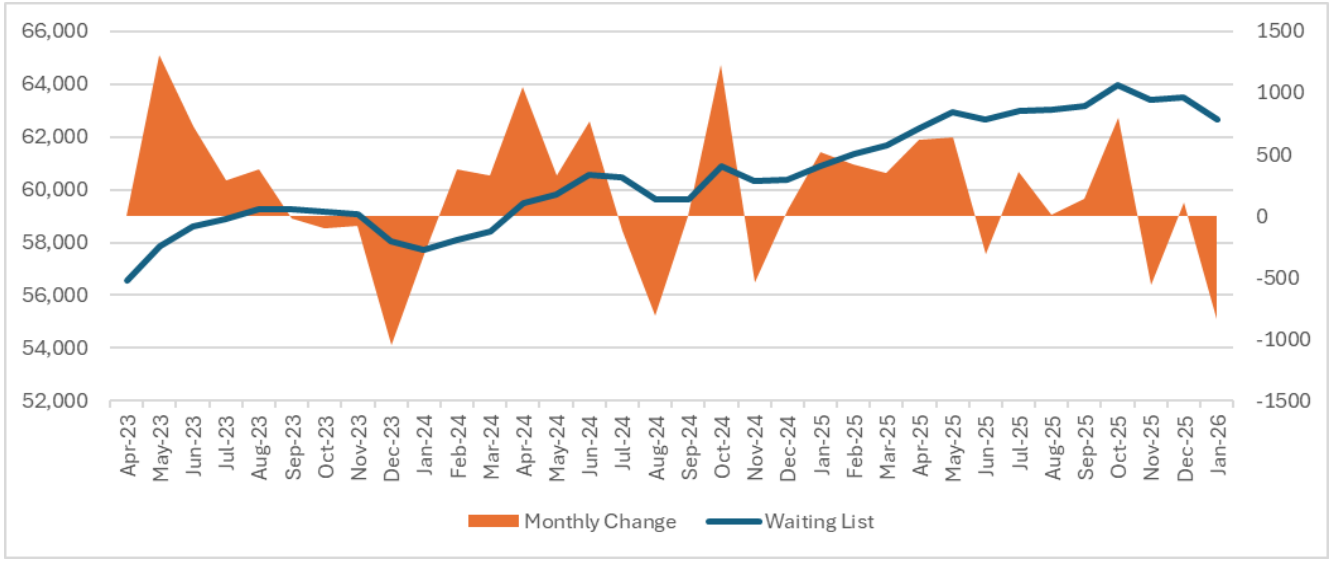


Chart 2: UHS waiting list trend and monthly change

The volatility of the waiting list is highly dependent on the number of referrals received across the trust and chart 3 illustrates the annual trend increases for all referral types and the volume of new pathways opened within the reportable waiting list. A key pressure earlier in the year has been the growth in referrals particularly within outpatient based services such as dermatology, neurology and clinical genetics where Southampton hospital is often the main regional provider or the trust absorbing the impact of service closures in the community.

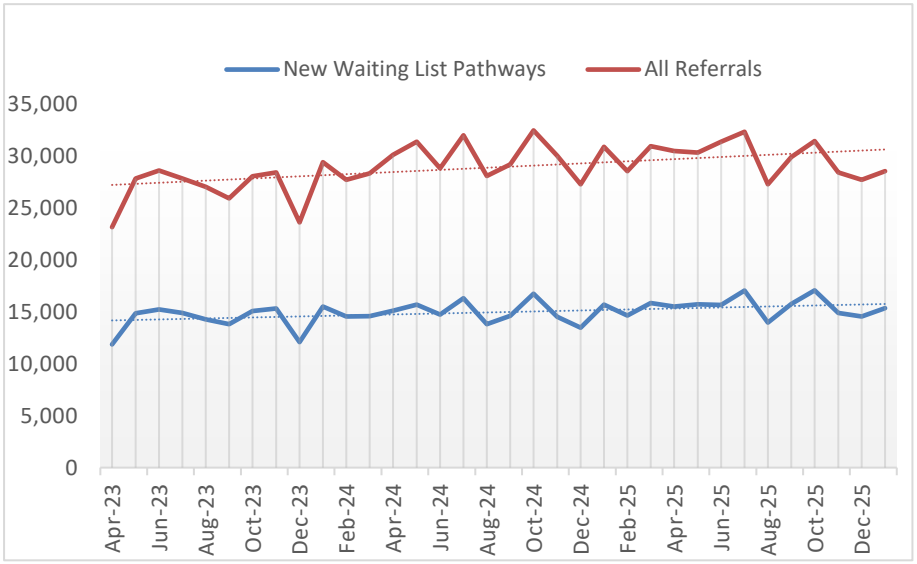


Chart 3: Additions to the UHS waiting list and referral volumes

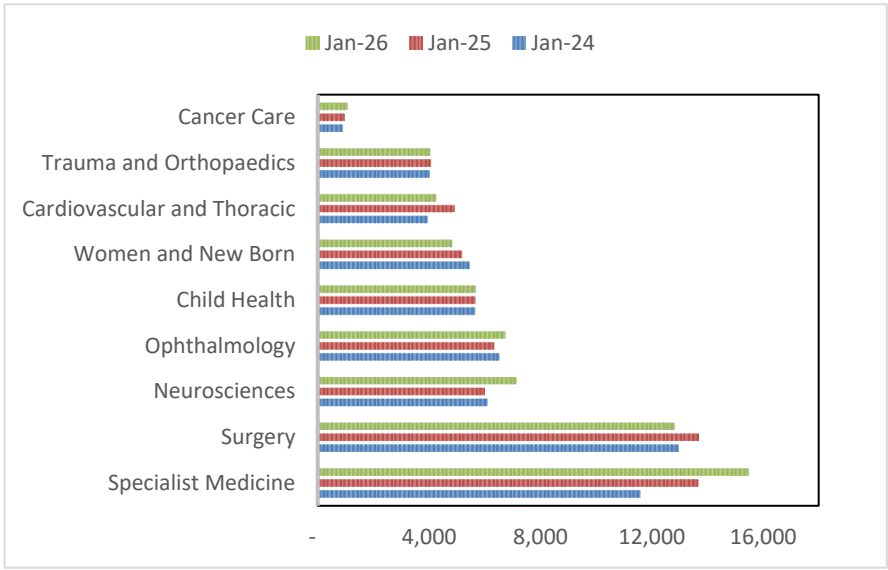


Chart 4: UHS waiting list annual comparison by caregroup

Improvements in virtual consultation utilisation, clearer clinical triage thresholds, and increased use of community and independent sector outpatient capacity have provided flexibility within admitted and non-admitted pathways. In parallel, GIRFT supported validation work has helped ensure the list reflects accurate clinical need, removing dormant or duplicate pathways and enabling specialties to target clearance where it is most impactful. Together, these actions have contributed to the relatively stable total waiting list seen in January.

3.3 18 week performance

18 week performance in January is **60.2%**, a slight reduction from the **60.8%** reported in December 2025 but consistent with the overall trend seen across the past six months. Benchmarking against the trust's teaching hospital peer group shows that, at the end of 2025, UHS was performing above the peer average, ranking 7th out of 19 organisations for RTT incomplete performance, compared with a peer mean of 59.6% and a median of 59.5%. Although January 2026 peer data is not yet available, the trust's month to month movement is small, and UHS is expected to remain broadly in line with the group once updated data is released.

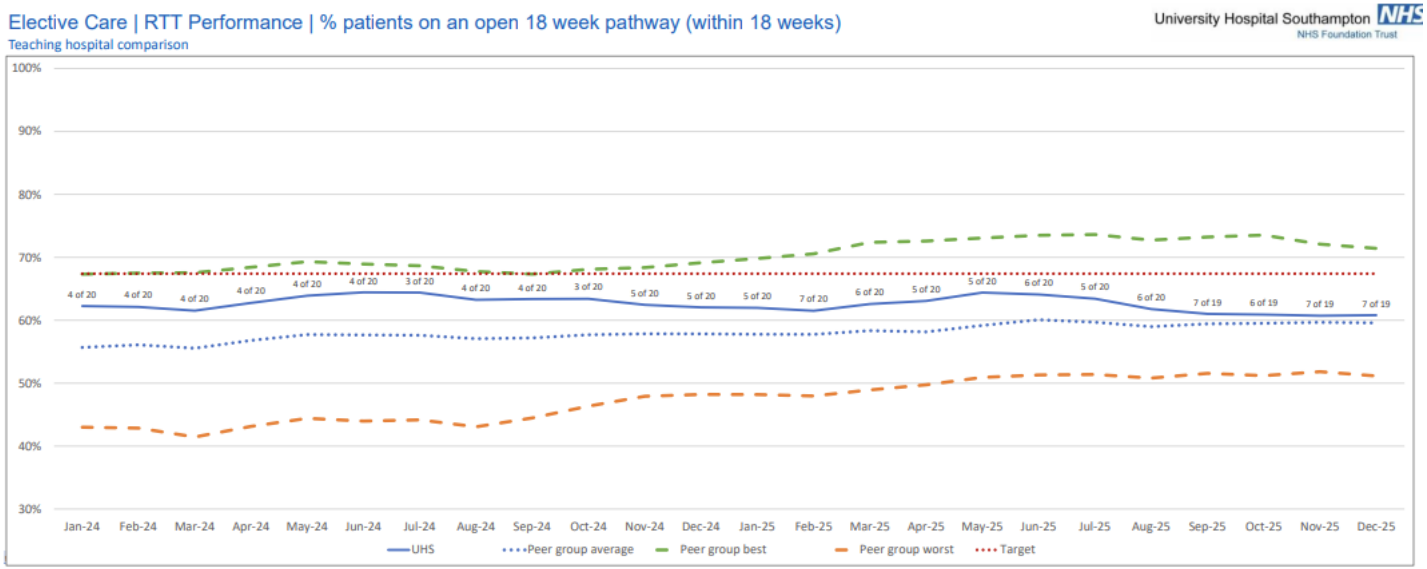


Chart 5: 18 week performance comparator to peer teaching hospitals

3.4 Long waiting patients

At January 2026, the trust reported 1,529 patients waiting over 52 weeks, 51 patients over 65 weeks and 4 patient over 52 weeks. The 1,529 patients waiting over 52 weeks represent a challenge to our original plan trajectories, and reductions in this cohort have been slower than planned due to ongoing constraints in high demand admitted specialties. However, the trust has made strong progress in reducing longer duration pathways in recent months: 65week waits have fallen to just 51 patients, and 78week waits have reduced to 4, with scheduled plans in place to clear the remaining cases over the coming weeks.

Long waiter management has remained a central focus of the trust's elective efforts throughout the 2025/26 financial year. The trust was unable to sustain the significant reduction in 65 week breaches seen across 2024/25 as prioritising financial stability and the in year funding mechanisms necessitated a reduction in the volume of elective treatments delivered through outsourcing and the independent sector. As part of the elective tiering support, the trust agreed to reinstate additional capacity in quarter three and this has been further supported through national quarter four sprint objectives ensuring additional funding is available to improve the position.

Peer comparisons show that, at the end of 2025, the trust remained behind many of its teaching hospital peers on long wait clearance. UHS ranked 11th out of 19 organisations for the proportion of >52week waits, was 13th for 65week pathways, and 17th for 104week waits. The progress made since December will improve the trust's position when new comparator data becomes available, however over 52week waits remain the most significant gap between UHS and higher performing peers.

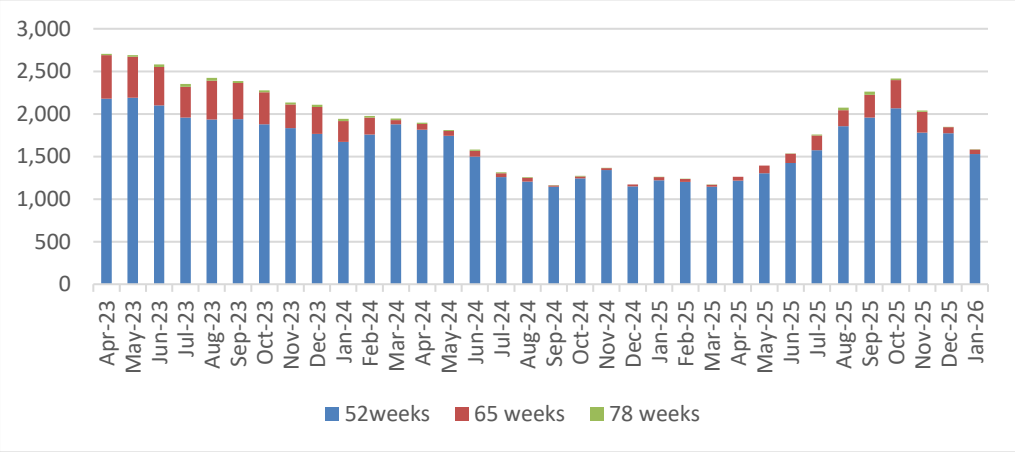


Chart 6: UHS long waiter patient cohort trend

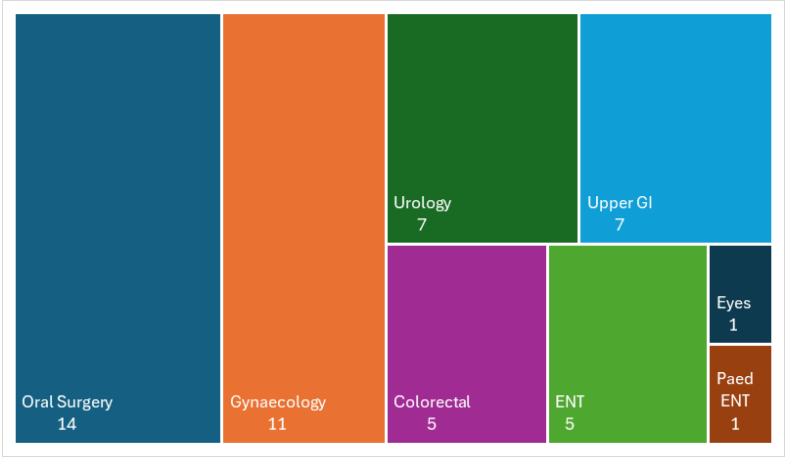


Chart 7: Over 65week patient volumes by specialty (Jan-26)

4. UHS Performance Forecast

The year end forecast is based on the trust's performance trajectory from January, the operational plans in place, and the anticipated impact of elective recovery actions across the remaining months. The fire and subsequent incident in February are expected to have significant impact on admitted elective capacity in the short term, particularly for bed dependent surgical pathways, although the trust has put in place a series of mitigating actions intended to protect as much elective throughput as possible. Under current assumptions, the trust has ambitions to improve waiting list performance to 65% by the end of the financial year alongside treatment of all patients over 65 weeks and significant progress towards the national target of just 1% of patients waiting over 52 weeks. However, there must be recognition that current capacity uncertainty, emergency service volatility and the clinically appropriate transfer of patients to other trusts and private providers has added a level of uncertainty to the year end forecast.

Overall, while the February incident introduces uncertainty into admitted capacity forecasts, the trust's strengthened governance, increased use of external capacity, and improved validation processes provide a level of resilience that should allow continued elective improvement through to year end. A range of

targeted actions are underway to support services experiencing the most significant challenges with long waiting patients. A strengthened approach to waiting list management has been introduced across these specialties, with an emphasis on rigorous validation activity and improvements to data quality. Alongside this, GIRFT is providing dedicated support to the organisation, including input into the development of more robust pathway administration to ensure waiting list accuracy and prioritisation are consistently applied.

To increase treatment capacity, several specialties are progressing insourcing arrangements, with active programmes already in place for Dermatology and Neurophysiology and further specialties being considered. Outsourcing continues to play an important role in the recovery plan. The trust is working closely with partners in the independent sector, making use of established clinical pathways and strong operational relationships. New partnerships are also being developed both within and beyond the ICB footprint to expand available capacity. While independent sector providers are beginning to release some ad-hoc activity, early indications suggest that the total volume of capacity offered is unlikely to meet the full scale of demand, prompting ongoing discussions about contractual mechanisms, including the potential for direct payment models.

In parallel, the trust is maximising its internal capacity where possible. Additional theatre activity, including the use of “super weekends,” is now being delivered. However, the ability to scale this further remains constrained by reduced bed availability and the ongoing impact of the recent fire and major incident on critical care capacity, particularly within ICU and HDU. These constraints continue to limit the number of patients who can be safely managed post-operatively, despite theatre teams being willing and able to deliver extra sessions.

Finally, the trust is exploring further opportunities for mutual aid through the elective recovery cell. This includes identifying where neighbouring providers may have spare capacity for specific procedures, enabling patients to be redirected where clinically appropriate. These collective efforts—internal, external, and system-wide—form a coordinated response to managing long waits and supporting sustainable improvement in elective recovery.

5. Conclusion

Throughout the financial year, the trust has faced challenges around capacity, funding and sustained demand growth, all of which slowed the pace of improvement during the first half of the year and constrained the organisation’s ability to strengthen RTT performance at the rate originally planned. However, the trust has significantly intensified its recovery programme during recent months, aligning with national sprint initiatives and pursuing all available options to increase elective throughput, expand external capacity, and accelerate long wait clearance. This renewed momentum has begun to deliver tangible improvements, particularly in the reduction of the longest waits. The major incident in February has, however, introduced new operational pressures at a critical point in the recovery cycle, and some time will be required to fully assess the extent of its impact on admitted activity and overall delivery trajectories. The trust remains committed to maintaining recovery progress in the remaining months of the year and to restoring the elective position as quickly and safely as possible.

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

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	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%	62.0%													60.2%	≥67.4%	62.0%
		4	4	4	4	3	3	3	3	4	6	7	7	9	7			
		5	5	5	7	6	5	5	6	5	6	7	6	7	7			
		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%	82.2%													73.1%	≥75%	74.6%
		4	4	2	10	4	10	3	10	7	9	9	8	7	9			
		1	2	2	4	2	3	2	6	2	4	4	5	4	8			
		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%	61.2%													63.3%	≥78%	60.2%
		12	15	9	16	14	10	14	15	15	7	8	14	11	8	4		
		9	12	6	12	12	7	15	13	17	5	6	17	9	8	5		
		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%	15.7%													19.8%	≤5%	18.79%
		6	6	6	6	7	9	9	9	10	11	11	13	13	13			
		9	8	9	6	7	10	11	9	10	9	11	11	11	11			
		0%																
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	100.0 87.8 86.2 80.0												93.5 91.5			≤100	94.7	≤100
2	HSMR - Crude Mortality Rate	3.0% 2.3% 2.0%												2.3%			<3%	2.2%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital	15% 13.6% 10%												12.3%			-	12.3%	-
		Q4 2024/2025			Q1 2025/2026			Q2 2025/2026			Q3 2025/2026			Q4 2025/2026			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80 75 70 76			77			74			75			76			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100% 75% 50% 36 75 318			36 93 306			33 90 311			34 93 309			36 107 321			-		

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		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**				97 112	105 120	12 8	19 20	29 28	36 41	49 53	59 62	69 69	79 76	88 81	94 85	≤9	85	≤82
7	MRSA bacteraemia				2	1	0	0	1	0	0	1	1	0	0	3	0	2	0	8	0
8	Gram negative bacteraemia				29	31	20	35	18	21	14	22	26	31	24	20	20	10	23	≤19	211	≤182
9	Pressure ulcers category 2 per 1000 bed days					0.30										0.31	<0.3	0.31	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days					0.33										0.33	<0.3	0.33	<0.3
11	Medication Errors (severe/moderate)					4										5	≤3	25	27
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent 12 months** vs. **Previous 12 months**														2,680	2,683	<2578	2,551	<2552

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

Safety		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)	0														0	-	18	-
14	Never Events		3													2	0	7	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity		0													0	-	0	-
16	Number of falls investigated per 1000 bed days			0.11												0.09	-	0.11	-
18	Red Flag staffing incidents			8												10	-	131	-

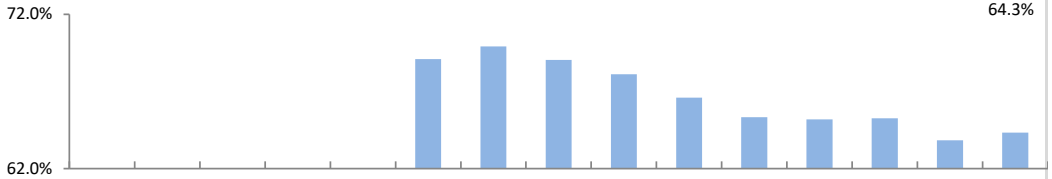
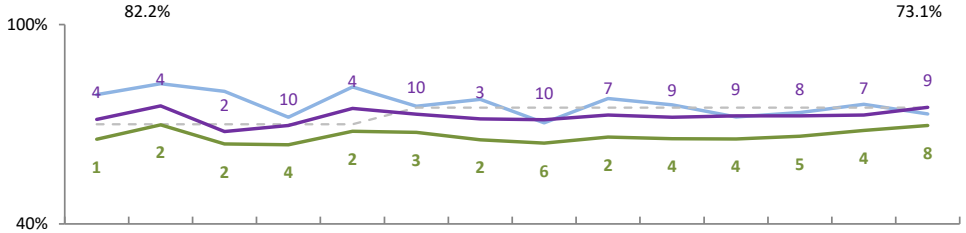
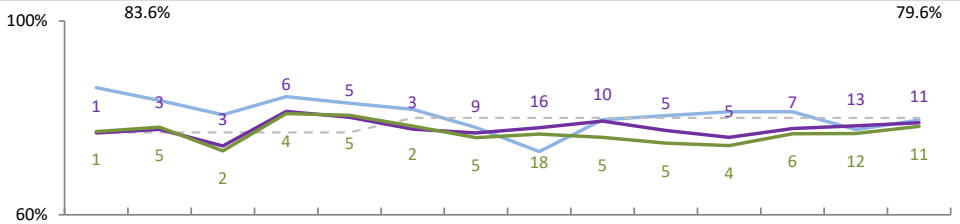
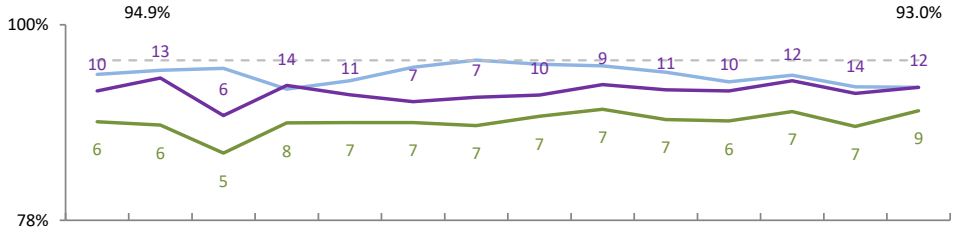
Maternity		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	392 / 451	396 / 467	395 / 496	372 / 466	410 / 494	390 / 450	390 / 448	425 / 447	440 / 472	432 / 411	431 / 456	448 / 480	406 / 407	403 / 452	376 / 469	-	-	-
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	1	0	1	1	1	1	1	4	4	1	3	0	6	3	3	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	46.68% / 41.07%	40.91% / 47.47%	47.85% / 42.03%	47.85% / 42.47%	48.54% / 40.98%	48.46% / 37.69%	45.38% / 43.59%	45.65% / 39.76%	45.23% / 42.05%	48.61% / 40.51%	43.62% / 45.01%	51.70% / 41.00%	46.10% / 41.60%	44.91% / 40.94%	47.10% / 39.90%	-	-	-

Patient Experience		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients	3%		1.5%												0.5%	≤5%	1.1%	≤5%
		0%																	
23	FFT Negative Score - Maternity (postnatal ward)	10%		0.9%												3.2%	≤5%	3.1%	≤5%
		0%																	
24	Total UHS women booked onto a continuity of carer pathway	30%		17.5%												12.6%	≥35%	13.7%	≥35%
		0%																	
25	Total Global Majority women booked onto a continuity of carer pathway	100%		21.6%												19.0%	≥51%	18.0%	≥51%
		0%																	
25 - metric renamed from "BAME" to "Global Majority"																			
26	% Patients reporting being involved in decisions about care and treatment	100%		85.5%												88.8%	≥90%	86.8%	≥90%
		80%																	
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%		87.5%												92.2%	≥90%	89.0%	≥90%
		80%	247	296	323	273	483	491	442	504	416	357	276	338	419	341	357			
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		76												97	-	806	-
		0																	
29	Number of mental health patients spending over 12 hours in A&E	100		35												22	-	0	-
		0																	

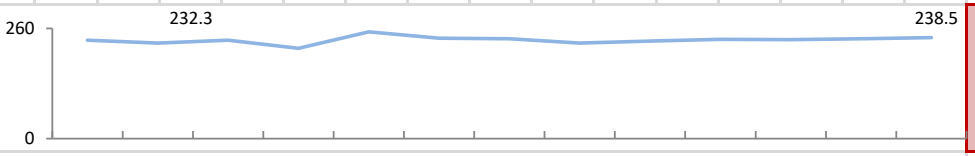
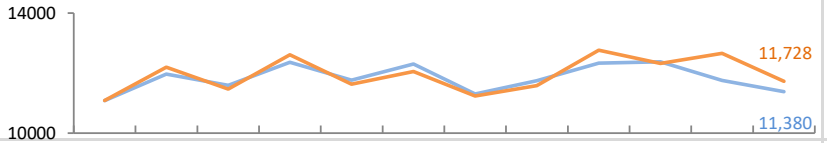
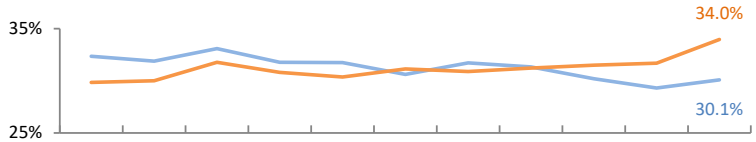
Access Standards		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	12 9	15 12	61.2% 9 6	16 12	14 12	10 7	14 15	15 13	15 17	7 5	8 6	14 17	11 9	8 8	63.3% 4 5	≥78%	60.2%	≥78%
31	Average (Mean) time in Dept - non-admitted patients			03:11												03:39	≤04:00	03:32	≤04:00
32	Average (Mean) time in Dept - admitted patients			05:31												05:42	≤04:00	05:19	≤04:00
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year															98.0% 96.0%	-	96.8%	>98.2%
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	4 5	4 5	62.0% 4 5	4 7	3 6	3 5	3 5	3 6	4 5	6 6	7 7	7 6	9 7	7 7	60.2%	≥67.4%	62.0%	≥67.4%
35	Total number of patients on a waiting list (18 week referral to treatment pathway)			60910												62675	-	62,675	-
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 7	6 7	2.00% 6 7	6 7	7 7	5 7	8 7	8 8	10 8	11 11	13 13	15 14	12 14	11 12	2.44%	1.0%	2.4%	1.0%

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	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)			1220												1529	0	1529	0
38	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			39												51	0	51	0
39	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			1												4	0	4	0
40	Patients waiting for diagnostics			9388												9690	-	9,690	-
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			15.7%												19.8%	≤5%	18.8%	≤5%

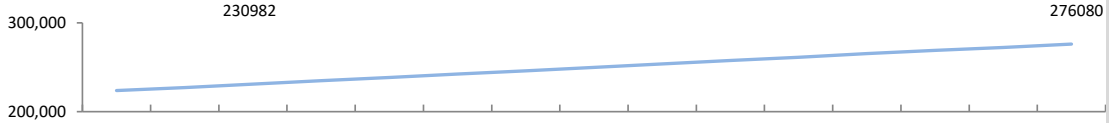
41 - As of **April 2024**, **YTD and Monthly Target** changed from **1% to 5%** to reflect latest guidance

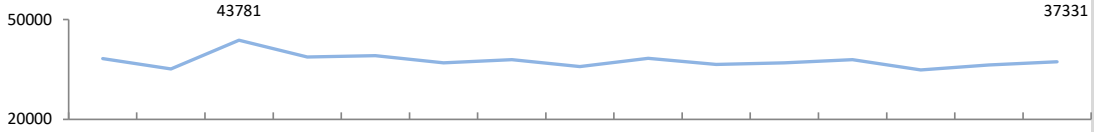
			Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks																	≥71.2%	64.3%	≥71.2%
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥75%	74.6%	≥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)																	≥80%	79.2%	≥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)																	≥96%	94.5%	≥96%

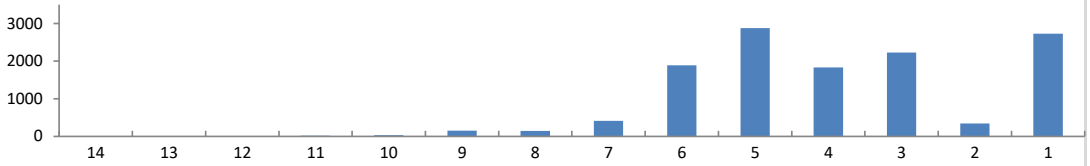
R&D Performance		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
46	Recruitment performance ranking	8	8	9	10	11	16	7	7	5	5	6	7	7	10	9	Top 10	-	-
47	Performance in initiating clinical trials	36%	70%	44%	47%	44%	40%	53%	39%	67%	87%	55%	55%	67%	54%	57%	≥80%	-	-
48	Performance in delivering clinical trials						23%	23%	35%	21%	21%	23%	21%	24%	27%	27%	≥80%	-	-
49	Proportion of sponsored studies open/on track						81%	82%	84%	87%	87%	87%	88%	90%	88%	87%	≥80%	-	-

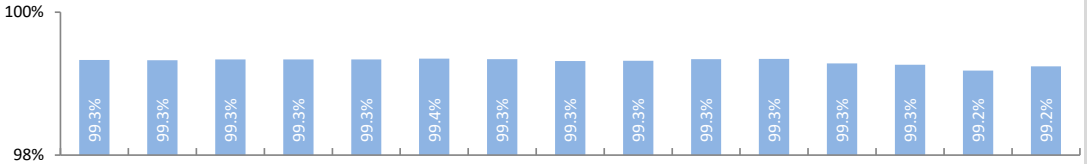
Local Integration		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	234	-
51	Emergency Department activity - type 1 This year vs. last year																-	118,924	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	31.1%	≥25%
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month																			

Digital		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			230982												276080	-	276,080	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			43781												37331	-	369,013	-
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		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted	50% 40%		45.8%												45.5%	-	44.5%	-
58	Percentage of under 18s attending emergency departments to be admitted	15% 5%		11.6%												11.5%	-	11.5%	-

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.8	Report to the Trust Board of Directors, 10 March 2026
Title:	Finance Report 2025-26 Month 10
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 January report are as follows:

- The Trust has reported a £0.8m surplus in M10 (£44.8m deficit YTD). This is in line with the updated Financial Recovery Plan trajectory for M10, but £4.7m below the original plan submitted to NHS England (£33.7m adverse to plan YTD). The Trust originally submitted a full year plan to achieve a breakeven position.
- In M10, an updated financial trajectory was agreed at £45.0m for the full year, revised down from the £54.9m initial Financial Recovery Plan trajectory.
- The M10 surplus predominantly results from two one-off non-recurring income flows including £2.9m industrial action funding and £2.0m from H&IoW ICB.
- The underlying deficit has improved to £5.6m in M10, compared to a restated £6.2m in M9. Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, non-criteria to reside patient volumes increasing, length of stay improvements not being sustained and inpatient mental health patient costs remaining high.
- WTEs continue to be on a downward trajectory overall yet increased by 65 in M10 to 13,192. Bank and agency costs increased by £0.5m with substantive costs decreasing by £0.5m.
- Whilst the trajectory is improving overall, it is not yet at the pace required to deliver the original plan. Cost improvements have been offset by other pressures.
- UHS continues to deliver significant levels of financial savings, £9.1m has been achieved in M10 and £78.0m YTD. This is however £6.4m behind plan. Transformation programmes centred around patient flow, theatre optimisation and outpatients remain core to this.
- Cash has decreased by £1.5m to £24.2m in month, and includes £9.5m advanced payments from H&IoW ICB which is repayable over the remainder of the year. The cash position remains a significant risk to the Trust (25 score on risk register).
- The fire major incident in the Endoscopy suite on 1 February will significantly impact on the financial position, however as this occurred in February, it will be form part of the financials from M11.

Contents:

Finance Report

Risk(s):

5a

Equality Impact Consideration:	N/A

University Hospital Southampton
NHS Foundation Trust

UHS Finance Report – M10

Financial Position

In M10, the Trust reported a £0.8m surplus, £4.7m adverse to the annual plan. The Trust's underlying position had a marginal improvement, to £5.6m deficit (when compared to the restated M9 position of £6.2m).

The YTD position is now £44.8m which is consistent with the updated financial recovery plan trajectory. The forecast variance from the trusts original plan is shown below.

	Full Year 2025/26			
	Plan	FRP Trajectory	Revised Trajectory	Revised Variance
Trust Deficit	(13.9)	(63.6)	(53.6)	(39.7)
Deficit Support Funding	13.9	8.6	8.6	(5.3)
Reported Deficit including DSF	0.0	(55.0)	(45.0)	(45.0)

M10 YTD 2025/26		
Revised Trajectory	Actuals	Variance
(53.4)	(53.4)	0.0
8.6	8.6	0.0
(44.8)	(44.8)	0.0

Key driving factors of the UHS position include:

- UHS were set an extremely challenging target of delivering a breakeven plan, noting pressures within the starting underlying position, with activity levels above contract funding levels, NCTR and MH pressures. The Trust signed up to deliver the plan, but highlighted significant levels of risk, including the reliance upon the Trust achieving £110m (9%) of real cash releasing savings.
- The plan relied upon a set of assumptions. Despite positive CIP delivery to date, a number of those assumptions have not held true – notably:
    - Activity levels are above contracted levels
    - NCTR has not improved, but has instead deteriorated
    - MH has not improved, but has instead deteriorated
    - The Trust has faced significant operational pressures in month with increased demand, and additional ward and surge bed capacity has been open
    - The improvements seen in length of stay in previous months have not been sustained.
    - New unexpected pressures have materialised, including the impact of industrial action and the income received for the pay award not covering the full costs
    - Workforce reduction targets have been challenging to deliver in full, with a reduced turnover rate and lack of funding to support cost of change (e.g., MARS programme costs were expected to be funded within plan assumptions)
    - The Trust has delivered less recurrent CIP than targeted, off-set by an increase in non-recurrent CIP, putting pressure on the monthly underlying run-rate.
    - The Trust has seen an unplanned reduction in income levels following the plan submission, including:
        - Unplanned cut in Genomics funding
        - Unplanned reduction in funded activity from Channel Islands (replaced by unfunded growth in NHS activity)
        - Unplanned loss of pathology income (contracts from other systems repatriating activity to their host system)
        - Reduction in private patient activity
- Our underlying financial position is improving on a monthly basis, with a reducing workforce trajectory following management actions including a recruitment freeze, MARS programmes and divisional restructure. However, the position has not improved quickly enough to keep pace with the plan.
- In M10 we have reported a £0.8m surplus (£4.7m adverse variance to plan). The M10 surplus predominantly results from two one-off non-recurring income flows including £2.9m industrial

action funding and £2.0m from H&IoW ICB. In addition £1.0m of non-recurring deferred income release, relating to prior years was recognised in M10.

- YTD UHS continues to accrue for ERF income for M1-10.
- Due to specific areas of operational pressure and clinical risk, our outsourcing expenditure is £4.4m adverse to plan at M10, driven by Cardiac and Dermatology activity. This is partially driving the ERF overperformance outlined above. In addition, activity has commenced for Orthopaedics, Gynaecology and Surgery to target the 65 week wait lists and improve on RTT (£0.4m in M10, £0.6m YTD).
- CIP is reporting below plan by £6.4m YTD to M10 with achievement of £78.0m reported. There is however an underachievement of £17.4m on recurrent CIP offset by an overachievement of £11.1m on non-recurrent CIP.
- The Trust is working hard to improve its financial recovery, with robust governance including a weekly Financial Improvement Group. We have taken difficult decisions around workforce and reducing expenditure on insourcing and outsourcing, which has started to impact performance.
- The underlying position is in part driven by the number of NCTR patients remaining in the Trust, meaning bed capacity is over optimal levels.
- A further challenge is the number of Mental Health patients attending the Trust. This creates a significant additional cost, including utilising specialist agency to ensure we have sufficiently skilled staff capacity to care for these patients safely often including additional security costs.
- The Trust remains committed to delivering significant financial improvements in-year; however, it remains an extremely challenging position, and we are unable to continue to absorb additional cost pressures.
- The fire major incident in the Endoscopy suite on 1 February will significantly impact on the financial position, however as this occurred in February, it will be form part of the financials from M11. Plans continue to be worked through to resume services as quickly as possible. Conversations with the insurers continue as loss adjusters survey the site. The finance teams remain vigilant to capture all fire related costs for insurance claim purposes.

Financial Improvement - CIP

The Trust continues to target month on month financial improvement from its savings and transformation programmes. Key highlights for M10 include the following:

- UHS has delivered £9.1m (>7% of addressable spend) of CIP in M10, which is £2.8m below the 25/26 plan. This brings the YTD achievement of CIP under plan by £6.4m with £78.0m delivered against a target of £84.4m.
- Workforce controls continue to be enacted, targeting reductions of 5% in divisions and 10% in corporate departments. The Trust is £17.2m adverse to the pay expenditure plan in M10 to date but has delivered additional workforce savings month on month.
- UHS is currently utilising agency for just 0.3% of the total workforce, significantly below the national target. Just 43 agency WTE were utilised in month mainly relating to the support of mental health patients.
- The Financial Improvement Group is established and meeting weekly. This group has approved initiatives across a number of different programmes and projects all targeting sustainable cost reductions and increased efficiency.

Workforce Expenditure

There has been an increase in the total workforce of 65 WTEs; workforce numbers are below average levels seen in 24/25 and strict workforce controls continue to be in place.

Total pay remained flat at £70.7m in month, however saw a decrease in substantive costs offset by an increase in bank. This was driven by high clinical needs, particularly due to the OPEL 4 operational status raised on 13 January. The pay award has been fully accounted for, generating a YTD pressure of £2.0m with an ongoing £0.2m per month pressure resulting from funding not covering costs in full.

The financial plan trajectory for the year requires significant month on month improvement which is a key focus for the newly formed Financial Improvement Group.

Corporate Services

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

UHS workforce controls and corporate non-pay savings target means the Trust is reviewing the position monthly, particularly with regards to capitalisation of time in corporate functions. The forecast is currently showing that UHS will be £1.2m over the target, however this is expected to reduce in the coming months. Expenditure to date is £40.4m in M1-10.

Net Risk Reporting / Financial Recovery Plan (FRP)

The Trust is currently reporting net risks of £45.0m consistent with the updated FRP trajectory. This includes the assumption that H2 deficit support funding of £5.3m will not be received.

The FRP has been shared within NHS England for regional oversight and review. This has led to an independent review being completed. The Board has approved the revised forecast this month.

Capital

Capital expenditure to M10 is £15.5m (£28.8m below plan) with delays across several projects suppressing expenditure. An internal capital forecast of £26.5m is proving challenging to achieve in 2025/26 with mitigation opportunities continuing to be explored given more than half the programme is still to be completed. Slippage has been reported across Strategic Maintenance, the Community Diagnostic Centre (CDC), and several other estates projects.

There has also been minimal spend on externally funded schemes at M10, as planning and designs are still being finalised to secure funding arrangements. Several new bidding opportunities have also recently been subject to review and response by the Trust. All relate to funding available for 2025/26 so would require delivery within this financial year.

Forecast capital expenditure for the year is currently projected at £54.7m, of which 52% (£28.2m) is externally funded and 48% (£26.5m) internally funded. The Trust is forecasting additional mitigations of £3.5m to ensure delivery to plan. Work is underway with project leads and system partners to maximise Q4 deliverability and reduce the risk of under-delivery.

Report To	Board meeting in Public		
Title of Paper	System Report 2025/26 (Month 10)		
Purpose of Paper	For information	**Date of Meeting**	4 March 2026
Author	Natasha Taplin, Director of System Performance Improvement	**Agenda Item**	Item no. will be added by Governance team
Executive Sponsor	James Lowell, Interim Chief Delivery Officer	**Clinical Sponsor**	If applicable

Prior Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
Executive Committee	24 February 2026	For information
Future Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
	Click or tap to enter a date.	

Executive Summary

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

Please note that Month 10 (M10) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 9 (M9), with some exceptions depending on reporting frequency.

Performance Overview

This report provides an overview of in-month performance against operating plan metrics based on latest published data and highlights 13 headline metrics currently performing worse than plan across the Hampshire and Isle of Wight system (no change on previous month). The metrics below plan in current month reporting are:

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M10)
- Access to Children and Young People's Mental Health Services (M9)
- Average length of stay for Adult Acute Beds (Mental Health) (M9)
- Adults in inpatient care who are autistic, with no learning disability (M9)
- Diagnostic 6 week waits (9 key tests) (M9)
- Cancer 28 day faster diagnosis (M9)
- Cancer 62 day referral to treatment (M9)
- Time to First Appointment (M10) – *unvalidated*
- RTT 52 week waits (M9)
- RTT waiting list within 18 weeks (M9)
- Emergency Department 4 hour performance (total mapped footprint) (M10)
- % of attendances in A&E over 12 hours (M10)
- Category 2 ambulance response times (M10)

Quality Overview

Quality overview can be found on pages: 9-15

Financial Overview

The purpose of the Month 10 (M10) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position for the ICS as at the end of January 2026.

The ICS position in month 10 is a deficit of £2.46m compared to a planned surplus of £8.45m, so £10.91m off plan in-month.

The ICS is reporting a year-to-date deficit of £78.12m, compared to a planned year-to-date deficit of £17.99m, so a £60.13m off plan year-to-date.

The ICS submitted a £0.468m surplus plan for 2025/26. At M10, following the NHS England forecasting protocol, the system is now reporting a forecast deficit of £89.71m, £90.18m worse than plan. £27.33m of the deterioration in the system forecast relates to lost Deficit Support Funding.

Workforce Insights

- **Total Workforce: 47,978 WTE**, which is **1,121 WTE** worse than nationally submitted plan. Compared to December 2025, the system saw a decrease of 20 WTE.
- Trusts **better than plan**: HIOWH (116 WTE).
- Trusts **worse than plan**: HHFT (325 WTE), IOW (129 WTE), PHU (356 WTE), SCAS (50 WTE), UHS (377 WTE).
- **Substantive**: 659 WTE worse than plan.
- **Bank**: 439 WTE worse than plan.
- **Agency**: 23 WTE worse than plan.
- Compared to March 2025 baselines in submitted Planning templates:
    - **Total Workforce**: Reduced by 1,316 WTE
    - **Substantive**: Reduced by 1,094 WTE
    - **Bank**: Reduced by 137 WTE
    - **Agency**: Reduced by 85 WTE.
- The ICB continues to work with providers to monitor their agreed workforce plans to reduce workforce costs, and working with our Regional People leads to support future transition.
- Workforce Recovery Action Plans for UHS, PHU, IOW & HHFT all forecast a M12 position that is worse than 25/26 submitted plans.
- Workforce performance and assurance will move to NHS England from 1 April 2026. HIOW ICB are working closely with NHS SE Regional team during this transitional period to form handover plans.
- Progress against plans monitored at System Workforce Oversight Committee (SWOC) for both weekly trends and month position.

Strategic Integrated Commissioning and Better Care Fund (BCF) Monthly Update

BCF update can be found on pages: 19-23.

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

Governance and Compliance Obligations

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

	☐ 5A) **System Workforce Capability and Sustainability** – There is a risk that the system workforce is not sufficient, sustainable, capable or affordable to meet current and future population needs or deliver strategic priorities.
Regulatory and Legal Implications	Standard Operating Framework Ratings, Regulatory Standards
Financial Implications	See Finance section of the report.
Communications and Stakeholder or Staff Engagement Implications	There are no specific communications and stakeholder/staff engagement implications from this report.
Patient or Staff Implications	Summarises Key Performance Indicators linked to Constitution and Regulatory Standards. Indicates pressures faced by NHS workforce.
Equality Impact Assessment	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	N/A
Appendices or Supporting Information	N/A

1. Introduction

This report serves as an overview of the Hampshire and Isle of Wight Integrated Care System's performance against the national priorities and success measures outlined in the NHS operational planning guidance for 2025/26 and financial, workforce and quality plans and indicators.

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 12 February 2026 – up to January 2026 for Urgent and Emergency Care metrics and up to December 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 February 2026, NHS Hampshire and Isle of Wight is ranked red against 13 headline operating plan metrics:

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M10)** – % of beds occupied by patients not meeting the criteria to reside remains significantly above the 12% target (no operating plans set in 25/26), decreasing marginally in M10 to 23.2% (compared to 23.6% in M9.

- **Access to Children and Young People's Mental Health Services (M9)** – below M9 plan with 25,105 vs 25,497 target, improvement on M8. The known data quality issue with a new Provider has been resolved and analysis is underway to determine where we are seeing under performance against planned figures with other Providers, and where existing data quality issues may still be affecting the rate.

- **Average length of stay for Adult Acute Beds (Mental Health) (M9)** – performance in December is 64 days, improvement on M8 although not achieving the M9 plan of 51 days.

- **Adults in inpatient care who are autistic, with no learning disability (M9)** – performance in M9 remains significantly above plan (38 vs 22 plan). There remains a shortage of admission alternatives for Autistic Adults (aged 25+) - in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Diagnostic 6 week waits (9 key tests) (M9)** – performance in M9 shows a deteriorating position for the diagnostic 9 key tests and remains above the in-month operating plan of 26.8%. However, total diagnostic activity achieved plan in M9.

- **Cancer 28 day faster diagnosis (M9)** – performance in M9 is 6.4% below plan at 73.8%. This represents a 1.3% improvement on previous month. Performance is 3.6% below national average of 77.4%, and NHS Hampshire and Isle of Wight rank 33 of 42 systems nationally (lowest quartile).

- **Cancer 62 day referral to treatment (M9)** – performance in M9 improved to 72.8% (compared to 71.4% previous month), not achieving plan. Performance is above national average of 71.9%, and NHS Hampshire and Isle of Wight rank 22 of 42 systems nationally (interquartile).

- **Time to First Appointment (M10) – *unvalidated*** – latest M10 position shows NHS Hampshire and Isle of Wight is 6.9% below plan, however, this is based on unvalidated data and is subject to change. M9 was 6.5% below plan.

- **RTT 52 week waits (M9)** – In M9, 4,991 patients are waiting over 52 weeks, representing a decrease on M8 (5,674) but not achieving plan. All providers are above plan in M9, with the largest variance seen at University Hospital Southampton (UHS).

- **RTT waiting list within 18 weeks (M9)** – Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has declined to 60.7% in M9 (compared to 61.4% previous month) – not achieving in-month plan by 2.1%.

- **Emergency Department 4 hour performance (total mapped footprint) (M10)** – Performance in M10 declined to 73.6% (compared to 75.2% previous month) – not achieving the 78% standard.

- **% of attendances in A&E over 12 hours (M10)** – Waits from decision to admit (DTA) increased significantly in M10 to 1,771 (compared to 1,212 previous month) and % over 12 hours from arrival increased significantly in M10 to 7.5% above M10 plan (e.g. not achieving).

- **Category 2 ambulance response times (M10)** – performance in M10 deteriorated to 37:46 (compared to 31:50 previous month), remaining above M10 plan and the 30-minute operating standard. Delivery against year-end target remains challenging.

The following metrics are national priorities for 2025/26, but are currently not achieving national target:

- **% of patients with hypertension treated according to NICE guidance (CVDP007HYP) (M6)** – latest published position for September 2025 shows 67.19% vs 70.5% local target (national target is 77%), representing a 2.74% increase on the September 2024 position. National average is 68.71%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased since September and there is now a difference of 5% between NHS Hampshire and Isle of Wight and the top performing ICB (North East and North Cumbria), with NHS Hampshire and Isle of Wight ranking 31 out of 42 systems, improving from a position of 4th worst nationally / historically. There has been consistent improvement in performance since March 2022. In terms of local data, the latest position in January 2026 shows an improving position to 70.51% in relation to the blood pressure treated to target measure, the highest percentage achieved to date.
- **% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy (CVDP003CHOL) (M6)** – latest published position for September 2025 shows 58.81% vs 60% national target, representing a 3.03% increase on September 2024 position. National average is 64.10%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased and there is now a difference of 10.94% between NHS Hampshire and Isle of Wight and the top performing ICB (South Yorkshire), with NHS Hampshire and Isle of Wight ranking worse nationally.
- **% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance (CVDP012CHOL) (M6)** – latest published position for September 2025 shows 47.17% vs 65% national target. National average is 49.00%. NHS Hampshire and Isle of Wight ranking 27 out of 42 systems.

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

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M10)** –)– NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their January performance with 601 patients with no CTR as at 15 February 2026, which is 20.83% of total G&A beds available. (Lowest quartile) (Lowest quartile)
- **Access to Children and Young People's Mental Health Services (M9)** – NHS Hampshire and Isle of Wight are ranked 11 of 42 Integrated Care Boards for their November performance. (Interquartile)

- **Diagnostic 6 week waits (9 key tests) (M9)** NHS Hampshire and Isle of Wight are ranked 34 out of 42 Integrated Care Boards for their December performance with 32.8% (Lowest quartile)
  The National average is 24.8%.

- **Cancer 28 day faster diagnosis (M9)**, NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their December performance with 73.9% (Lowest quartile)
  The National average 77.4%

- **Cancer 62 day referral to treatment (M9)**, NHS Hampshire and Isle of Wight are ranked 22 out of 42 Integrated Care Boards for their December performance with 72.8%. (Interquartile)
  The National average is 71.9%

- **RTT 52 week waits (M9)** – NHS Hampshire and Isle of Wight are ranked 40 out of 42 Integrated Care Boards for their December performance with 2.6% (Lowest quartile)
  The National average is 2.5%

- **RTT waiting list within 18 weeks (M9)** – NHS Hampshire and Isle of Wight are ranked 27 out of 42 Integrated Care Boards for their December performance with 60.7% (Interquartile)
  The National average is 60.6%

- **Emergency Department 4 hour performance (total mapped footprint) (M10)** – NHS Hampshire and Isle of Wight are ranked 18 out of 42 for their December performance with 73.6%. (Interquartile)
  The National average is 72.5%

- **% of attendances in A&E over 12 hours (M10)** – NHS Hampshire and Isle of Wight are ranked 10 out of 42 Integrated Care Boards for their January performance with 11.3% (Highest quartile)
  The National Average is 13.1%

- **Category 2 ambulance response times (M9)** – NHS Hampshire and Isle of Wight are ranked 7 out of 11 for their January performance with 31:54
  The National Average is 35:04

3 Quality

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

The intelligence from thematic analysis of system quality, safety and patient feedback and collaboration with system providers over the year has informed our 2026/27 quality contract development processes, which is highlighted in relevant points throughout this section.

3.1 Regulatory

3.1.1 Care Quality Commission – General Practice: there is currently one Hampshire and Isle of Wight GP Practices that has a published Care Quality Commission rating of outstanding; 122 are good; three require improvement and two remain unrated.

3.1.2 Care Quality Commission – Large System Trusts:

- **Hampshire Hospitals NHS Foundation Trust:** the Care Quality Commission conducted a responsive assessment of the Urgent and Emergency Services at Basingstoke and North Hampshire Hospital (BNHH) following concerns about staffing, safety culture, and the suitability of the environment for patients experiencing mental health crisis. Although the hospital's overall rating remains *Good*, the Emergency Department was rated *Requires Improvement*.

  The inspection found that staff continued to deliver kind, compassionate and highly individualised care. Patients consistently described positive interactions with staff, who were attentive, respectful, and responsive to diverse needs, including those of children, people with disabilities, travelling communities, and individuals in mental health distress. Clinical care was supported by strong multidisciplinary working, well-established pathways—particularly for frail and older patients—and the consistent use of evidence-based guidance.

- The Trust will report progress against their action plan as part of contract requirements.

Care Quality Commission Rating Improvement – Emergency Department Basingstoke and North Hampshire Hospital

Domain	Previous Rating		Current (new) Rating
Safe	Requires Improvement	→	Requires Improvement
Effective	Good	→	Good
Caring	Good	→	Good
Responsive	Requires Improvement	→	Good
Well-Led	Good	→	Requires Improvement

- **Isle of Wight NHS Trust - unannounced Care Quality Commission Inspection:** on 10 February 2026, the Care Quality Commission commenced an unannounced inspection of their Emergency Department and Urgent and Emergency Care

- **University Hospital Southampton NHS Foundation Trust - unannounced Care Quality Commission Visit and announced Well-led inspections:** as previously reported, the Care Quality commission undertook a two-day unannounced inspection at University Hospital Southampton NHS Trust on the 25 and 26 November 2025. The focus of the visit was the Children and Young People's Service, Learning Difficulties and End of Life care. Feedback from the visit remains awaited. The Care Quality Commission will commence their announced well-led review the week beginning 16 February 2026.

- **Hampshire and Isle of Wight Healthcare:** as previously reported, the outcomes of the Trust's unannounced inspections which took place during April and September 2025 and their well-led inspection in November 2025 remain awaited.

3.1.3 Quality Assurance and Improvement Surveillance Levels: in January 2026 all the large Hampshire and Isle of Wight NHS providers remained in routine quality assurance and improvement surveillance levels apart from one, University Hospital Southampton NHS Foundation Trust, that moved to enhanced surveillance for the number of Never Events reported over a two-year period with an associated improvement plan (all other areas for that Trust remained in routine surveillance). The enhanced surveillance supports the Trust's improvement plan and the assurances required on embedding of the learning.

3.2 Contract: Quality Schedules

3.2.1 2026/27 Quality contract elements: as previously reported, quality contract negotiations have continued during February 2026, and final negotiations are planned in March 2026. NHS Hampshire and Isle of Wight and providers have committed to agreeing the quality schedules by 16 March 2026. Quality contracts are developed in partnership with NHS and other providers to support strategic commissioning with the priorities focusing upon standards

3.3 Patient and Staff Experience

3.3.1 Friends and Family Test – December 2025: overall, Hampshire and Isle of Wight Friends and Family performance remains positive. From an Integrated Care Board (ICB) perspective, all areas apart from maternity (postnatal – ward and community) and mental health performed above or the same as the national rate for positive responses.

Areas to note include:

- **General Practice:** of note, in comparison to the previous month, there had been no changes in system performance. In December 2026, positive feedback was above the national rate and the same as the regional rate and performance for the negative rate was the same as both regional and national data. Positive feedback for General Practice was lower than that for Dental Practice, which mirrors the national and regional performance
- **Dental:** dental practices positive responses saw a slight decline but remained high (96%) although were lower than both the national and regional rate. As with GP Practices, the negative performance for Dental Practices was the same as both the regional and national data
- **Ambulance:** the Isle of Wight ambulance service results continue to perform better than the national rate for positive and negative feedback, although it is recognised numbers remain low (54 responses) and relate to one area
- **Acute providers:** system performance remained better than national positive and negative feedback performance for the month for emergency departments, inpatients outpatients, antenatal and birth setting. Key area to note:
    - **Emergency Department:** performance at University Hospital Southampton NHS Foundation Trust remained below the national rate, but some improvement in performance seen
    - **Maternity:** postnatal ward positive feedback has been reported as being below the national rate by one University Hospital Southampton NHS Foundation Trust, however, despite remaining below the national rate, this month saw an improvement in performance (85%). The Trust's postnatal community data remained below the national rate for positive feedback but performed better in relation to negative feedback
- **Mental Health:** the latest data shows performance at Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust to be better than the national rate for positive and negative feedback. All mental health categories reflected this positive position apart from secondary care community services
- **Community:** community (physical) services at Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust continue to perform better than the national rate for both positive and negative feedback, apart from specialist services, which perform just below the national rate at 93%, although it should be noted they did not receive any negative feedback.

Friends and Family Test performance is triangulated with other quality intelligence that captures the experience of those that use services, to inform contract monitoring and improvement. Areas of concern are escalated via Contract Review Meetings to enable further focus for improvement.

3.3.2 Mixed-Sex Accommodation breaches – December 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.

Despite a decline, NHS Hampshire and Isle of Wight's performance remained better than that of England and South East England with a November 2025 breach rate of 1.9 (110 cases).

3.3.3 NHS Hampshire and Isle of Wight – primary care complaints backlog: as of 18 February 2026, the backlog of 212 complaints transferred on 1 February 2025 from the South East Complaints Hub has reduced to 17 open cases.

3.3.4 NHS Hampshire and Isle of Wight Patient Experience and Complaint themes: in January 2026, the Patient Experience and Complaints Team received 389 contacts (December 330, November 339 and October 322) and closed 386 (December 363). Some complaints and queries the team manage via the contact are redirected to the providers, who have not received them directly and had the opportunity to explore the issues and resolve them with the complainant.

The team received feedback from patients:

- regarding the Procedures of Limited Clinical Value (PLCV)
- about Attention-deficit hyperactivity disorder/autism assessment following the Indicative Activity Plan for Right to Choose
- who have had their procedure postponed into next year – relating to the Independent Sector Activity Management Plan
- experiencing continued delays in starting new paediatric continence service
- regarding dental access and being unable to register with an NHS dentist.

All complaints are shared with the commissioning teams and feed into strategic commissioning of services.

3.4 Safety

3.4.1 On the morning of Sunday 1 February a fire broke out in the west wing of Southampton General Hospital. Due to the swift response of emergency services, hospital staff and system partners, the fire was put out and patients moved to safety. A system-wide major incident was stood up in response, allowing health and care partners to take extraordinary measures to support University Hospital Southampton NHS Foundation Trust, this has since been stood down.

NHS Hampshire and Isle of Wight will monitor any harm through normal governance routes and lessons of good practice and areas of concern will feed into Board reports, including any learning from the major incident debrief.

3.4.2 Infection Prevention and Control – January 2026: the NHS standard contract (Annex A, Service Conditions) requires providers to have zero cases of Methicillin-resistant Staphylococcus aureus and to perform within their individually assigned thresholds for Clostridium difficile and gram-negative bloodstream infections.

The Hampshire and Isle of Wight system has exceeded its annual threshold for Methicillin-resistant Staphylococcus aureus and is predicted to exceed the annual threshold for Clostridiodes difficile and Escherichia coli:

Key areas to note:

- **Methicillin-resistant Staphylococcus aureus (MRSA):** five cases of MRSA were reported in Hampshire and Isle of Wight during January 2026, raising the outturn for the year to be currently at 24 cases. The new cases are being investigated for new themes and learning; as previously noted themes during the year have been in associated with insertions and ongoing care on indwelling devices, compliance with Methicillin-resistant Staphylococcus aureus Screening and risk reduction policy.

- **Clostridium difficile:** two Trusts, Portsmouth Hospitals University NHS Trust and the Isle of Wight Trust, currently remain within their annual thresholds, and two acute Trusts have exceeded their monthly trajectory, one of these trusts has breached its annual threshold and the other trust is predicted to breach their annual threshold.

As part of the 2026/27 quality contract negotiations, a meeting was held at the beginning of February 2026 with Trust Infection Prevention and Control leads to ensure the contract supports providers in embedding learning from their infections during 2025/26 and in delivering the requirements of the National Action Plan for Antimicrobial Resistance.

3.4.3 Never Events: the total number of Never Events reported during 2025/26 (up to 18 February 2026) is 24. Of these, 21 relate to surgical incidents. During January 2026 two wrong site surgery incidents were reported (one of which occurred in December 2025) and to date, in February 2026, one retained foreign object has been reported, relating to an incident in December 2025.

Hampshire Hospitals NHS Foundation Trust undertook a Never Event summit in February 2026 to which NHS Hampshire and Isle of Wight and NHS England quality leads attended.

As part of their enhanced surveillance, University Hospital Southampton NHS Foundation Trust is considering holding a Never Event summit. It should be noted that the Trust is one of two Trusts in the system to have shown an improvement in the number of Never Events reported the others have seen an increase. In comparison to 2024/25:

- Hampshire Hospitals NHS Foundation Trust has seen a reduction of four Never Events
- University Hospitals Southampton NHS Foundation Trust has seen a reduction of two Never Events.

Thematic learning is shared across the system via the System Quality Group, ensuring that local insights and best practice are adopted more widely to prevent incidents and improve outcomes across all organisations and the population.

As part of the 2026/27 quality contract negotiations, discussions are taking place in relation to including an element in the schedules which supports providers in demonstrating their approach to embedding a safety culture.

3.5 Clinical Effectiveness

3.5.1 Fractured Neck of Femur Best Practice Tarriff – November 2025: the Best Practice Tariff percentages show how much of provider care delivered meets nationally agreed standards. Higher percentages assure that patients are more likely to receive care aligned with best outcomes.

Across the system, Portsmouth Hospitals University NHS Trust continues to exceed national performance in delivering care that meets the best practice criteria, with the other Trusts performing below the England average. However, despite remaining below England performance, University Hospitals Southampton NHS Foundation Trust and Hampshire Hospitals NHS Foundation Trust saw improvement in overall compliance in comparison to the previous month.

Best Practice Tariff improvement plans are monitored via usual contractual routes and quality oversight for improvement.

3.5.2 Summary Hospital Mortality Indicator (SHMI): SHMI is the ratio between the actual number of patients who die following hospitalisation at a Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. The latest data (up to 30 September 2025) published in February 2025 shows that no Hampshire and Isle of Wight provider had a higher-than-expected observed number of deaths within 30 days of discharge from hospital.

The SHMI guidance continues to highlight that there is a high percentage of invalid diagnosis codes for one Trust and therefore their values should be interpreted with caution. This has been escalated to the Trust who are in the processes of reviewing.

3.6 Quality Impact Assessments

NHS Hampshire and Isle of Wight has a weekly panel in place which reviews all Quality and Equality 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 and Equality Impact Assessments that meet the above criteria and makes recommendations based on the information presented.

During January 2025 no Quality and Equality Impact Assessments were moved from the NHS Hampshire and Isle of Wight panel to the next stage of decision-making.

4. Integrated Care System Financial Overview

4.1 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.

4.2 Background

The original agreed system plan for 2025/26 was 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 included £63.2m of non-recurrent Deficit Support Funding. Since completion of the 2025/26 planning round, NHS England announced that Deficit Support Funding 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.

The Hampshire and Isle of Wight system has received Q1 and Q2 Deficit Support Funding (M1 to M6). Deficit Support Funding for the period (M7 to M10) has been withheld by NHS England.

NHS England previously advised Hampshire and Isle of Wight organisations to assume that any Deficit Support Funding withheld could be earned back in Q4 (M10 to M12), but this will be conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

Following the movement in forecast at M10 to a deficit £89.71m, and noting the guidance issued by NHS England on financial performance, the forecast changes reported at M10 assume that no Deficit Support Funding for Q3 and Q4 would be received.

4.3 Financial Position

Table 2 below summarises the in-month and year-to-date financial position as at Month 10 (January) for all Hampshire and Isle of Wight organisations:

Table 2: Summary of M10 results (using original plan not adjusting for lost DSF)

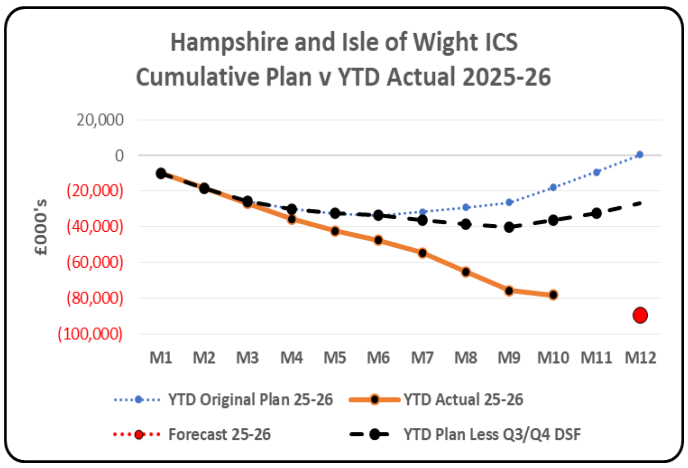
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	8,445	(2,460)	(10,905)	(17,987)	(78,118)	(60,131)	469	(89,711)	(90,180)

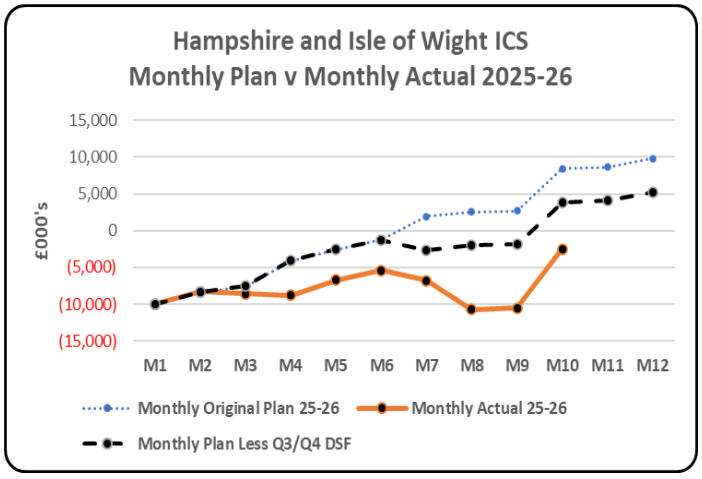
In January 2026 itself, the ICS reported a deficit of £2.46m against a planned surplus of £8.45m, so a £10.91m adverse variance to plan. Year-to-date the system has reported a deficit of £78.12m at Month 10 compared to a planned deficit of £17.99m, therefore a £60.13m adverse variance to plan.

Of the £60.13m adverse variance to plan year-to-date, £18.22m relates to withheld Deficit Support Funding.

The graphs below summarise the ICS position reported at month 10 (January) 2025/26.

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





4.4 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.

5. Workforce

Month 10 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is worse than plan by 1,121 WTE in Month 10 2025/26, broken down by Substantive (659 WTE), Bank (439 WTE) and Agency (23 WTE).
- Compared to the previous month (December 2025), the system has seen an overall decrease of 20 WTE.
- Trusts worse than plan are University Hospital Southampton (377 WTE), Portsmouth Hospitals University (356 WTE), Hampshire Hospitals (325 WTE), Isle of Wight (129 WTE), and South Central Ambulance Service (50 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 116 WTE.

Month 10 - Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 659 Substantive whole time equivalent (WTE) worse than plan.
- Trusts worse than plan are University Hospital Southampton (284 WTE), Hampshire Hospitals (248 WTE), Portsmouth Hospitals University (199 WTE), Isle of Wight (108 WTE) and South Central Ambulance Service (4 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 185 WTE.
- 'Support to Clinical' is better than plan by 101 WTE, as well as 'Any Other Staff' by 1 WTE, respectively. Whilst 'NHS Infrastructure Support' is worse than plan by 367 WTE, alongside 'Registered Qualified Scientific' at 179 WTE and 'Medical & Dental' at 170 WTE.

Month 10 - Bank & Agency Trajectories – Whole Time Equivalent (excluding Integrated Care Board)

- In Month 10, Total Temporary staffing (Bank & Agency) usage is 2,825 WTE and 463 WTE (19.6%) worse than the plan of 2,363 WTE.
- Bank use, worse than plan by 439 WTE (20.9%).
- Agency use is worse than plan by 23 WTE (8.9%).
- All Provider Trusts in Hampshire & Isle of Wight are worse than Temporary Staffing plan. Portsmouth Hospital University shows the most significant variation to plan by 157 WTE (46.0%), followed by University Hospital Southampton by 93 WTE (13.6%).

6. Strategic Integrated Commissioning and Better Care Fund (BCF) Monthly Update

6.1. Metrics Update

6.1.1 BCF Performance Summary (Latest Position): [Dec '25; Month 09 local data]

Local data (M09) is used for operational monitoring and provides the most up-to-date picture. Where available, the latest national validated data is also shown below for context. National data is typically 1–2 months behind and may not align precisely with local reporting periods. It should be noted that M09 reflects the assessment of performance against the revised Q3 and Q4 metric targets which was a condition across each of the four 25/26 BCF Place plans. *National M09 data is not yet available.*

For M09, all four Places met monthly targets for emergency admissions (65+) and the target for long-term care home admissions, reflecting strong prevention and community support. Discharge delays remain a challenge for all Places.

Metric	Southampton	Hampshire	Isle of Wight	Portsmouth
Emergency admissions to hospital for people aged 65+ per 100,000 population	**Plan:** rate:2207.8 admissions:785 **Performance *Local data:*** rate: 2157 admissions: 767	**Plan:** rate:1688 admissions:5482 **Performance *Local data:*** rate: 1496 admissions: 4857	**Plan:** rate:1582 admissions:665 **Performance *Local data:*** rate: 1572 admissions: 672	**Plan:** Rate: 2083.9 admissions:666 **Performance *Local data:*** rate:1752 admissions: 560
Average length of discharge delay for all acute adult patients	**Plan:** 1.34 **Performance *Local data:*** 1.56	**Plan:** 1.29 **Performance *Local data:*** 1.52	**Plan:** 1.33 **Performance *Local data:*** 1.42	**Plan:** 1.26 **Performance *Local data:*** 2.00
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population	**Q3 plan target:** rate: 140.6 admissions: 50 At end Q3, residential admissions remain on track to meet the 25/26 target. Latest full year position based on 12 month rolling data is	**Q3 plan target:** rate: 133.9 admissions: 435 Q3 admissions increased slightly; however, cumulative performance remains below the 2025/26 target.	**Q3 plan target:** rate: 140.4 admissions: 60 Q3 actuals (local data pending national verification): Q1 - 119.32 (51 admissions) - better than plan	**Q3 plan target:** rate: 156.4 admissions: 50 National Q3 data is not yet available. National data for Q1 and Q2 is indicating on track against plan. Local unvalidated data for October

	570.95 against target of 576.6		Q2 - 142.71 (61 admissions) - better than plan Oct - 28.07 - better than plan (on 1/3 basis) Nov / Dec not yet available	and November indicates on track against plan in Q3.
Emergency admissions to hospital for people aged 65+ per 100,000 population	**Plan:** rate:2207.8 admissions:785 **Performance** ***Local data:*** rate: 2157 admissions: 767	**Plan:** rate:1688 admissions:5482 **Performance** ***Local data:*** rate: 1496 admissions: 4857	**Plan:** rate:1582 admissions:665 **Performance** ***Local data:*** rate: 1572 admissions: 672	**Plan:** Rate: 2083.9 admissions:666 **Performance** ***Local data:*** rate:1752 admissions: 560
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6.2 Finance Summary

6.2.1 Headline Finance Overview

6.2.2 BCF Overall Summary Position – Month 10, 2025/26 – (source: ICB BCF Central Expenditure Report)

Place	Total BCF Value (£'000)	NHS Spend (£'000)				YTD Actuals (£'000)	YTD Variance (£'000)
		NHS Providers (£'000)	Local Authority (£'000)	Other (£'000)	Total NHS (£'000)		
Hampshire	178,686	73,234	47,075	2,104	122,413	102,011	0
IOW	30,732	7,028	8,933	1,181	17,142	14,475	190
Portsmouth	52,433	16,556	10,695	296	27,547	23,157	201
Southampton	41,925	12,023	11,512	2,065	25,601	21,118	-215
Total	303,777	108,842	78,214	5,646	192,703	160,762	176

(The table above summarises the total BCF value and associated NHS spend across the HIOW system by Place. The "Total BCF Value" column includes both NHS and Local Authority contributions. The breakdown under "NHS Spend" only reflects the portion of funding commissioned or managed by the ICB. This is split into: NHS Providers, Local Authority-commissioned services funded via NHS contributions, and Other ICB-commissioned services. The "YTD Actuals" column shows reported spend to date, while the "YTD Variance" column highlights any difference against planned NHS spend. Please note, Local Authority financial data is not centrally held.)

6.2.3 Key BCF Financial Highlights (Month 10):

- **Southampton:** the position reflects scheme-level adjustments within community wellbeing and prevention, reablement variance associated with discharge to assess (D2A) funding movements, and expected variability in the joint equipment service post-provider transition.
- **Isle of Wight:** there is a forecasted overspend on the equipment service. As this is a jointly funded service, the NHS HIOW proportion of the overspend is reflected in the BCF spend.
- **Portsmouth:** overspend relates to the Community Equipment Service, due to an unforeseen change in provider which incurs additional costs in comparison to the previous provider. The forecast remains variable due to the nature of this change in provider.
- **Hampshire:** spending in line with the financial plan for 2025-26.

6.3. Strategic Integrated Commissioning – Using BCF as the Driver

6.3.1 Workstream updates

Area	Performance Update	Key Issues/Actions	Next Steps & Milestones
Strategic Integrated Commissioning – BCF programme	• System priorities agreed at the BCF Planning Summit continue to provide a shared direction for BCF development beyond 2025/26, including strengthening Health & Wellbeing Board (HWB) leadership for neighbourhood delivery. • Local Government Association (LGA) support secured following successful expression of interest application. • Actions arising from the Summit are being progressed, with updates shared with stakeholders. • Planning assumptions reflect closer alignment between Neighbourhood Health and BCF, with the majority of narrative expected to sit within Neighbourhood Health.	• Progress actions from the BCF Planning Summit, including System Priority 3: strengthening governance and delivery accountability through HWBs. • Use the BCF Maturity Assessment to support targeted review of existing BCF schemes, as well as consideration of schemes operating outside the current BCF framework. • Finalise Section 75 deed of variations by the end of Q4.	• Develop and agree 26/27 BCF Plan in partnership with LA/ICB. • Use LGA support resource to inform HWB leadership discussions and Neighbourhood Health / BCF planning for 2026/27. • BCF Plan submission deadline is likely to be at least 12 weeks form date of guidance release. • Establish a system learning forum to share learning from Isle of Wight and Portsmouth National Neighbourhood Health Implementation Programme (NNHIP) activity. • Respond to joint Neighbourhood Health/BCF guidance (expected Feb). • Prepare for a second Neighbourhood Health submission (likely Sept 2026) to support further development.

6.4. Governance & Forthcoming Quarter Returns

6.4.1 Better Care Fund 25/26 Quarterly Reporting

Q3 report: The reporting template was released 15 December. Each Place submitted their return to NHS England ahead of the 30 January deadline.

6.4.2 Looking Forward - Better Care Fund 25/26 Quarterly Reporting

Quarter	Template Available to HWB Areas	Signed off HWB Submission Date
Quarter 1	16-Jun-25 ✅	15-Aug-25 ✅
Quarter 2	29-Sep-25 ✅	11-Nov-25 ✅
Quarter 3	15-Dec-25 ✅	30-Jan-26 ✅
End of Year	12-Mar-26	29-May-26

HWBs will be expected to submit a signed off report to the national Better Care Fund team.

7. Recommendations

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.10 Report to the Trust Board of Directors, 10 March 2026	
Title:	People Report 2025-26 Month 10
Sponsor:	Steve Harris, Chief People Officer
Author:	Workforce BI Team

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

The total workforce increased in January by 65 WTE. The substantive workforce continued to decrease, dropping by 19 due to ongoing workforce controls. Temporary staffing rose during the month, reflecting expected seasonal trends and higher surge capacity needed because of increased operational pressure. NCTR peaked at nearly 300 in January.

Although sickness absence slightly declined in January, it still contributed to elevated temporary staffing costs. TEC and POD have agreed to conduct an in-depth review in March, focusing specifically on stress and anxiety.

Resourcing strategies have prioritised substantive recruitment to achieve RTT targets, including targeted hiring in theatres and critical care to reduce reliance on temporary staff after the NHSP rate reduction. Recruitment also occurred in clinical administration areas to support RTT recovery, particularly where booking and patient management resources are necessary.

The Trust has exceeded 60% flu vaccination coverage among frontline staff, surpassing its NHSE target. UHS continues to benchmark well against other providers both regionally and nationally.

The national staff survey results remain embargoed until March 12. Significant financial controls, workforce reductions, and a series of challenging decisions are anticipated to negatively impact the final outcomes.

The fire in endoscopy has significantly affected the workforce. The People team has responded with strong support for employees' psychological well-being. Our staff will receive appropriate support and recognition as they demonstrate outstanding resilience and adaptability in restoring services. The Trust intends to use this experience to re-engage the workforce and secure positive transformation opportunities created by the rapid changes.

Contents:

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

Risk(s):

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

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

UHS People Report

WORLD CLASS PEOPLE

January 2026

THRIVE EXCEL BELONG

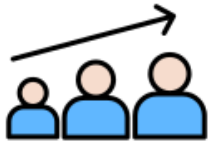
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M10 (January-26)

In-month sickness is currently 4.33%, 0.63% above target (3.7%).

Appraisal completion rate is currently 64.5% which is 20.5% below target (85%)

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



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

Bank usage increased and is now 99 WTE above plan.

Increase in agency staffing by <1 WTE. Agency is 2 WTE below plan.

Increase in patient safety incidents to 115 (93 in December)

Executive Summary

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Overall Position

WTE Movement (M9 to M10)

Total Workforce

The total workforce **increased by 65 WTE** to 13,192 WTE from M9 (13,127) to M10.

During this period, the substantive workforce **decreased by 19 WTE**, while the total temporary staffing **increased by 86 WTE.**

As of M10, the Trust is **above the total plan (by 381 WTE).**

Substantive WTE

Substantive WTE decreased by 19 WTE between end of December and end of January.

The biggest decrease in staff in post is within the Additional Clinical Services staff group (-19 WTE). All other staff groups showed a decrease or minimal increase (<2 WTE), except Nursing and Midwifery Registered which grew by 15 WTE.

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

Bank & Agency WTE

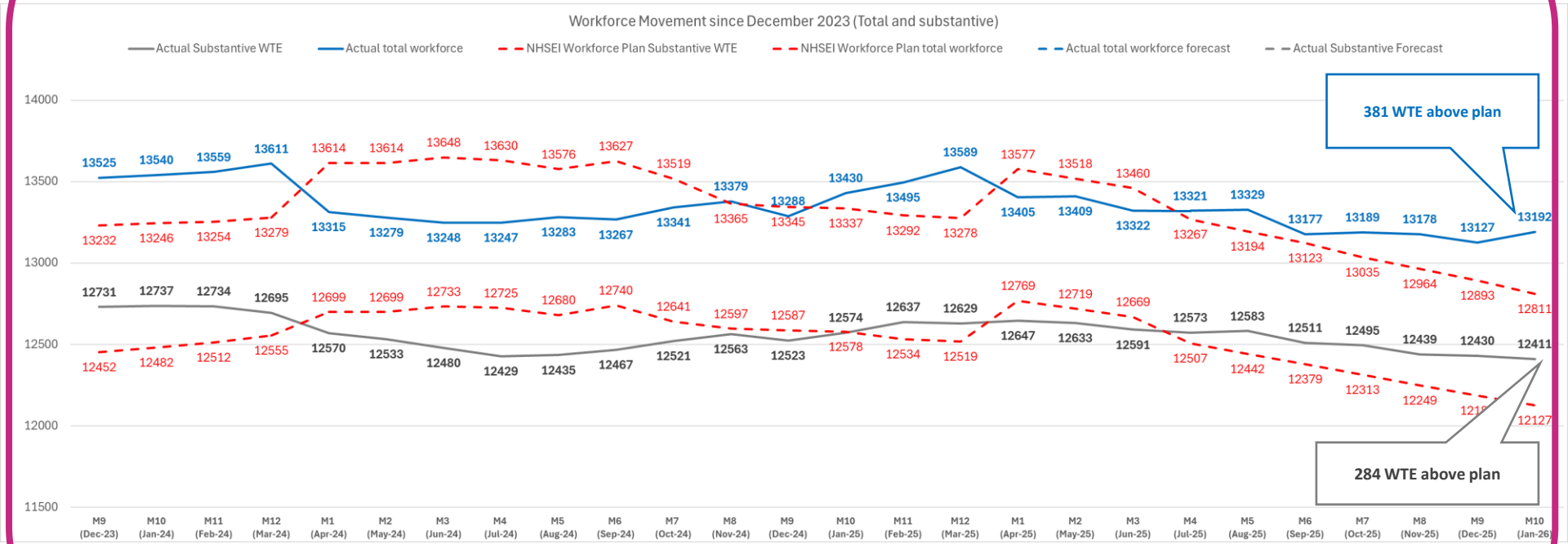
Total Bank and Agency usage increased by 86 WTE in January 2026.

Bank increased in January by **12%**, while
Agency increased in January by **1%**.

Ongoing Pressures
Mental health demand continues to present safety, quality, and financial pressures.

Unfilled shifts have risen significantly across the trust
Nursing & Midwifery showing a 47% year-on-year increase in unfilled shifts. Bank only unregistered workforce has significantly reduced compared to prior year.

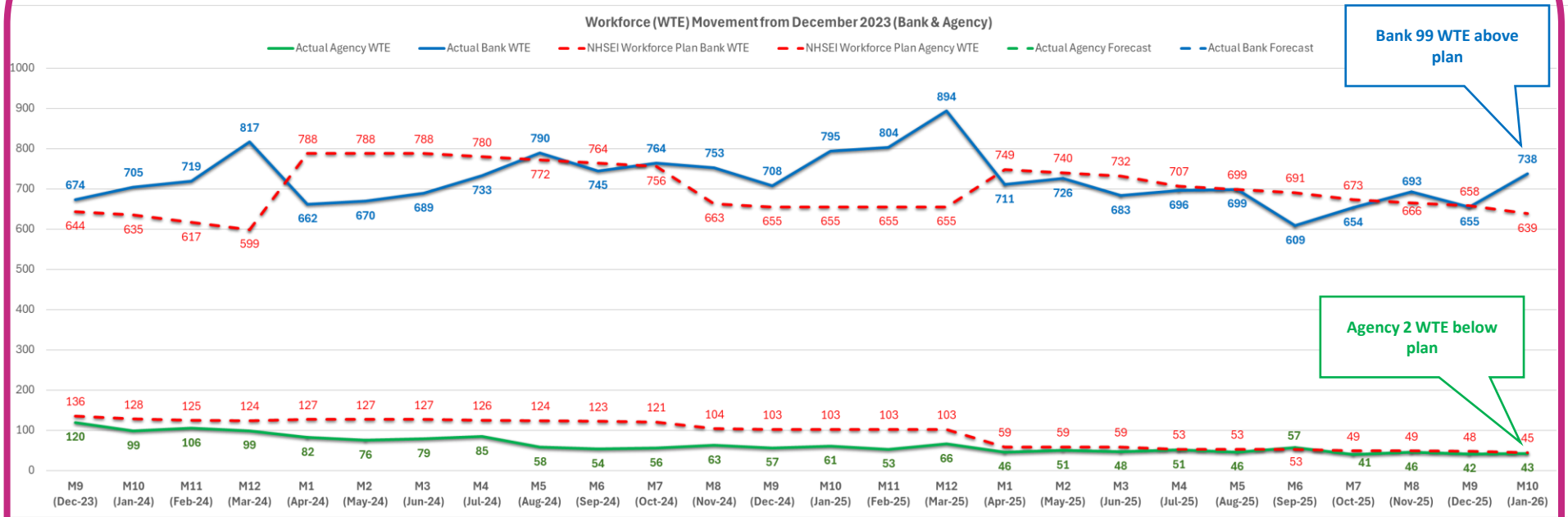
Workforce Trends: Total & Substantive



Source: ESR as of January 2026.

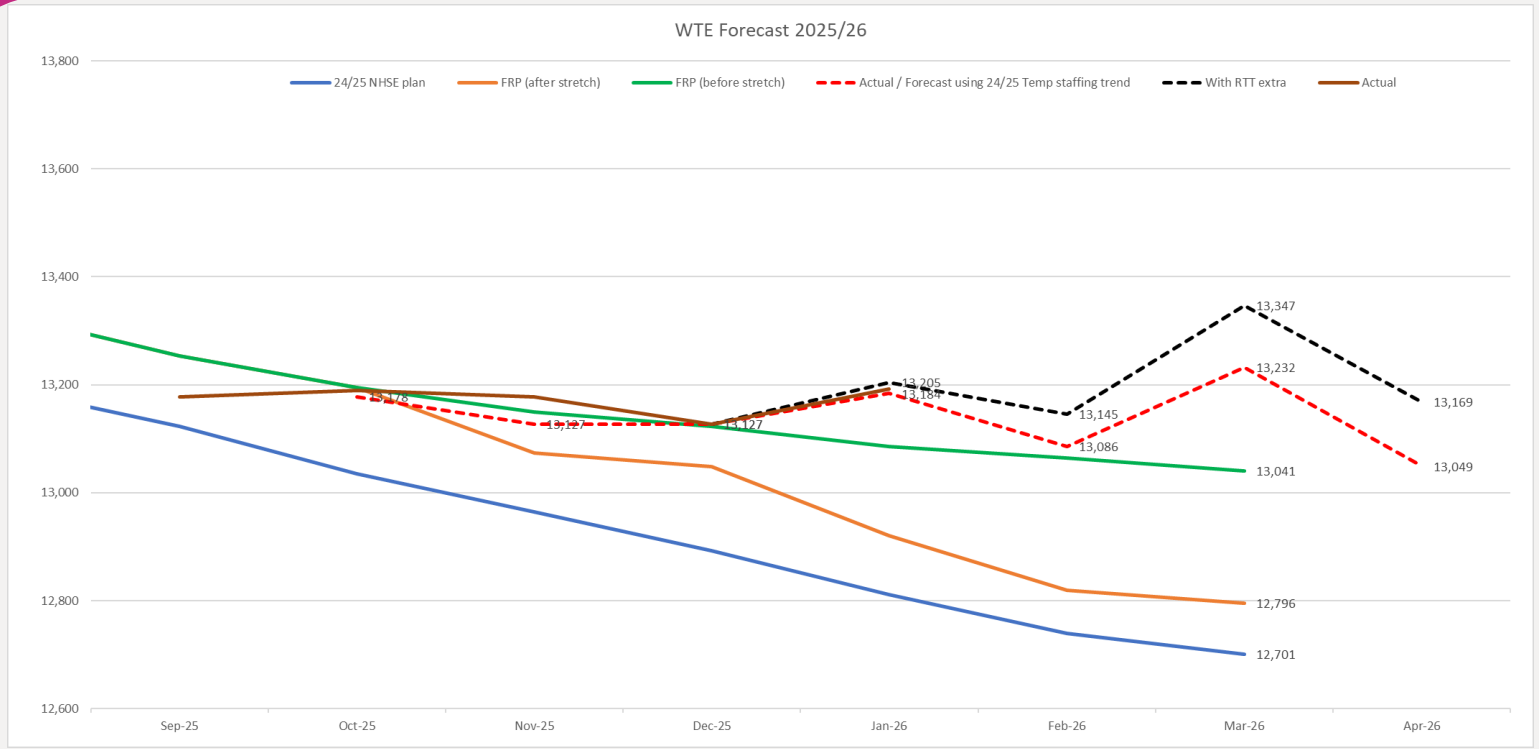
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



Source: NHSP Bank + THQ Medical Bank & Agency (NHSP Agency & 247 Agency) as of January 2026

Total WTE Workforce Forecast against FRP

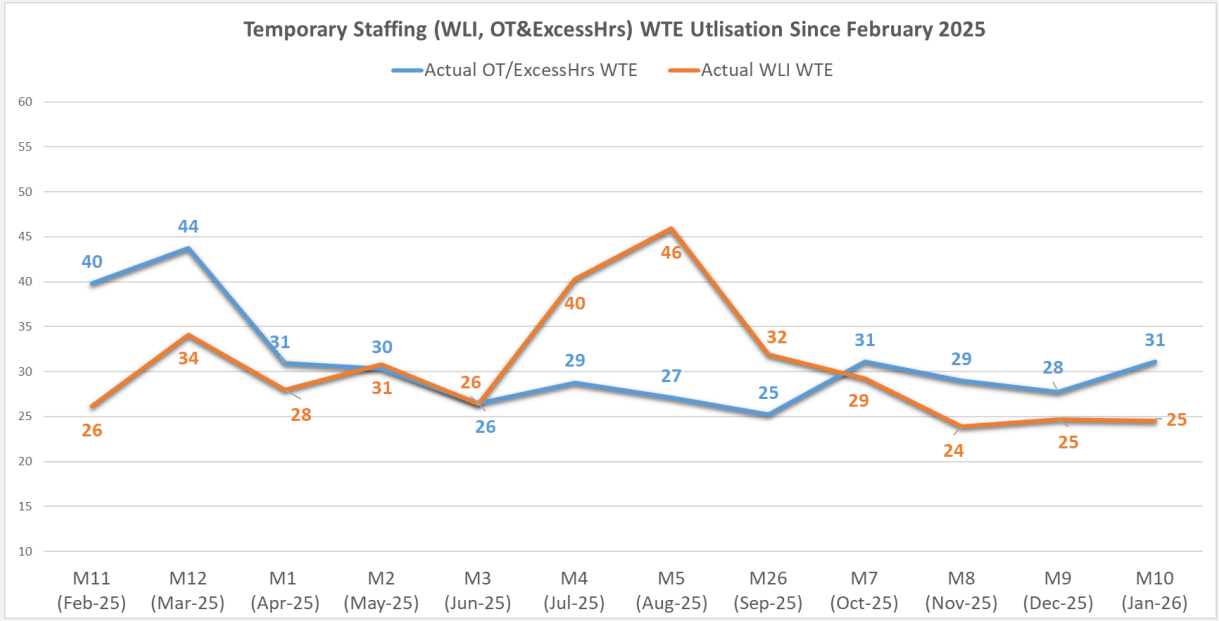


Assumptions on forecast:

- Red Forecast – based on continued limitation of starters and 24/25 bank and agency trends for the remainder of the year
- Black Forecast – Based on additional RTT recruitment (Admin, Clinical Posts) being brought forward. Includes also 24/25 Bank and agency trends
- Note drop expected in February bank usage due to the impact of the fire, resulting in fewer beds and less temporary staffing needed.
- Peak still expected in March as per normal seasonal trend

Workforce Trends: WLI and Overtime

WLI Movement	M11 - M12 2024	M12 - M1 24/25	M1 - M2 2025	M2 - M3 2025	M3 - M4 2025	M4- M5 2025	M5- M6 2025	M6- M7 2025	M7- M8 2025	M8- M9 2025	M9- M10 2026
	8	-6	3	-4	14	6	-14	-3	-5	1	0



Source: Healthroster as of January 2026

Quarterly People Heatmap – 2025/26 Q3

	THRIVE			EXCEL			BELONG	
	AWL as of M6 (Dec 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	**12181**	**10.1%**	**695**	**65.0%**	**4.8%**	**40.2%**	**12.4%**	**13.7%**
Division A Overall	3954	9.3%	188.2	61.4%	4.4%	29.0%	17.3%	13.9%
Cardiovascular And Thoracic	906	8.6%	45.1	54.2%	4.3%	24.4%	18.6%	14.5%
Critical Care	652	10.1%	22.8	66.5%	4.3%	18.3%	10.5%	10.5%
Division A Management	16	8.3%	1.0	40.0%	4.5%	100.0%	0.0%	9.1%
Division D Management	29	15.0%	1.0	46.7%	2.9%	0.0%	0.0%	22.2%
Neurosciences	459	8.9%	25.3	59.7%	4.0%	15.0%	18.2%	11.7%
Spinal Service	58	18.7%	2.9	70.0%	5.4%	0.0%	0.0%	50.0%
Surgery	562	10.4%	24.6	43.9%	4.1%	32.9%	12.1%	13.6%
Theatres And Anaesthetics	851	8.2%	44.6	60.8%	5.0%	37.1%	32.1%	17.9%
Trauma And Orthopaedics	421	8.8%	20.9	71.6%	4.4%	18.8%	21.2%	15.2%
Division B - Overall	3089	9.7%	119.0	65.9%	4.6%	42.5%	13.9%	15.6%
Cancer Care	716	10.3%	32.3	68.9%	4.6%	48.9%	16.5%	18.8%
Division B Management	-13	6.6%	5.6	39.6%	5.0%	33.3%	11.5%	23.1%
Emergency Care	707	9.7%	16.4	65.1%	5.3%	52.8%	10.0%	17.5%
Hampshire And low Air Ambulance	0	14.1%	45.2	4.2%	1.8%	75.0%	0.0%	4.8%
Medicine	778	8.6%	13.9	81.4%	4.3%	26.1%	24.5%	8.2%
Ophthalmology	297	13.9%	5.6	47.0%	5.0%	37.1%	17.9%	7.1%
Specialist Medicine	605	8.1%	5.4	55.4%	4.3%	40.2%	10.0%	16.3%
Division C - Overall	3833	10.5%	263.2	62.3%	4.3%	41.9%	10.3%	12.9%
Child Health	867	10.5%	47.4	66.2%	4.8%	17.6%	1.9%	13.7%
Clinical Support	898	11.4%	125.4	68.6%	2.8%	46.9%	14.0%	10.8%
Division C Management	188	15.3%	4.6	66.2%	5.2%	31.1%	12.2%	6.1%
Pathology	577	11.6%	37.7	53.9%	4.7%	41.0%	12.8%	14.9%
Radiology	481	8.5%	19.3	74.1%	3.4%	38.6%	7.9%	11.2%
Women And Newborn	822	8.3%	28.9	54.3%	5.6%	50.3%	6.9%	19.4%
THQ - Overall	1305	11.3%	119.9	72.5%	3.8%	45.8%	10.5%	14.2%
Chief Finance Officer	122	13.0%	18.0	35.8%	1.9%	30.8%	8.9%	12.5%
Chief Operating Officer	182	16.6%	1.0	70.8%	7.2%	40.9%	14.3%	7.1%
Digital	251	3.8%	27.1	77.0%	2.4%	48.4%	17.9%	17.6%
Human Resources	162	13.8%	19.2	83.6%	3.0%	18.2%	3.2%	11.6%
Research and Development	373	12.2%	17.1	79.4%	3.6%	57.1%	11.6%	7.1%
Training And Education	207	15.2%	18.8	82.8%	3.5%	76.5%	7.7%	7.7%

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

Key recruitment actions linked to elective work

Staff Group / Area	Issue	Vacancy gap	Action being taken
Clinical Administration	Significant reductions through ICB wide WF controls and plan have left some key RTT linked specialities vulnerable	Divisional Clinical administration has reduced by 100 WTE since March 2025. Targeted action to 50 WTE replacement	• Targeted additional NHSP to support in key areas • Conversion of NHSP staff to perm in key areas • Start dates expedited where possible • Targeted external recruitment to priority areas • Increased support to validation team
Critical Care Nursing (All areas)	Circa % vacancy in Band 5 nursing in Critical are and reduction in take up of NHSP shifts. Increased cancelation of elective cases (sickness, acuity, staffing)	Vacancy position in GICU against current establishment is 30 WTE. However reviewing budgets and establishment against future WF demands.	• Long lines of agency being pursued. Agency being used to support nights at no greater cost than Bank. • International recruitment of Band 5 CC experienced nurses. Relocation packages offered • Ongoing national / local recruitment has proven successful, however caveat : risk of affecting other key areas of UHS nursing e.g. ED, Theatres • Identification of all regular staff who also work NHSP shifts in critical care – offered secondments • General offer of internal 3-month secondments in critical care • Review of rostering and deployment to ensure most appropriate deployment of substantive staff • Revaluation of true capacity requirement to deliver RTT performance in 25/26 linked to medium term plan. Review of establishment / headroom / training pipeline. Recruit to requirement not AWL.
Theatres Scrub	Vacancy in key scrub areas of T&O, ENT OMF, Cardiac, Urology & Neuro	Overall vacancy position 86 WTE	• International recruitment – 10 offered qualified theatre scrub staff commencing started late Dec, 5 due late Feb (first arrival 17th). • Domestic recruitment including relocation packages where appropriate • Long lines of agency (at no greater cost than bank) • Review of rostering and deployment to ensure most appropriate deployment of substantive staff • Revaluation of true capacity to deliver RTT performance in 25/26 linked to medium term plan. Review of establishment / headroom / pipeline.
Perfusion	National shortage specialty	16 WTE in post against AWL of 19 WTE.	• Sustained recruitment and retention premia in place which has been working well • Successful recruitment of external perfusion from neighbouring centre (Oxford) started in January • Continuation of NHSP enhanced rate and bonus for multiple shifts worked • UHS representation on newly formed national action group on perfusion supply • 3 trainees due to complete between September and early 2027 – expect these to join full rota from March/April 2027 (need time to complete paeds / congenital competencies).

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

	23/24	24/25												25/26										Movement		
	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M8 to M9 movement	Mar24 to M9 Movement	Mar25 to M9 Movement
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	295	294	297	302	301	300	300	312	303	306	307	303	304	301	↓ -2	↓ -1	↓ -1
Additional Clinical Services	2136	2135	2134	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	2134	2131	2117	2101	2074	2064	2059	2041	↓ -19	↓ -96	↓ -67
Administrative and Clerical (Divisions)	1386	1399	1387	1374	1366	1363	1356	1347	1342	1328	1340	1348	1352	1352	1350	1327	1316	1298	1282	1273	1258	1257	1254	↓ -3	↓ -132	↓ -98
Administrative and Clerical (THQ)	902	904	902	875	864	860	859	852	875	888	897	900	902	899	893	879	874	859	826	822	808	805	800	↓ -5	↓ -102	↓ -101
Allied Health Professionals	796	803	800	799	788	786	808	815	814	806	807	821	817	823	822	832	831	839	842	849	849	849	846	↓ -3	↑ 51	↑ 29
Estates and Ancillary	380	374	372	373	376	373	370	373	407	405	407	415	416	414	409	407	403	398	392	387	387	413	408	↓ -5	↑ 28	↓ -8
Healthcare Scientists	498	499	495	498	496	497	495	504	510	509	512	518	521	523	520	523	524	522	523	525	523	523	523	→ 1	↑ 25	↑ 2
Consultant & Career Grade Doctor	949	947	946	949	948	951	964	965	971	971	976	983	984	990	983	982	986	991	989	989	985	984	986	↑ 1	↑ 37	↑ 2
Resident Doctor	1235	1103	1102	1099	1096	1150	1161	1164	1155	1147	1149	1152	1146	1145	1140	1132	1125	1198	1194	1200	1185	1176	1178	↑ 2	↓ -57	↑ 32
Nursing and Midwifery Registered	4053	4052	4039	4030	4025	3998	3998	4055	4041	4038	4039	4032	4013	4010	4024	4008	4003	3990	3990	4010	4024	4010	4025	↑ 15	↓ -28	↑ 12
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	50	49	↓ -2	↓ -9	↓ -20
Grand Total	**12695**	**12570**	**12533**	**12480**	**12429**	**12435**	**12467**	**12521**	**12563**	**12523**	**12574**	**12637**	**12629**	**12647**	**12633**	**12591**	**12573**	**12583**	**12511**	**12495**	**12439**	**12430**	**12411**	↓ -19	↓ -284	↓ -218
	Old	New Counting Criteria																								

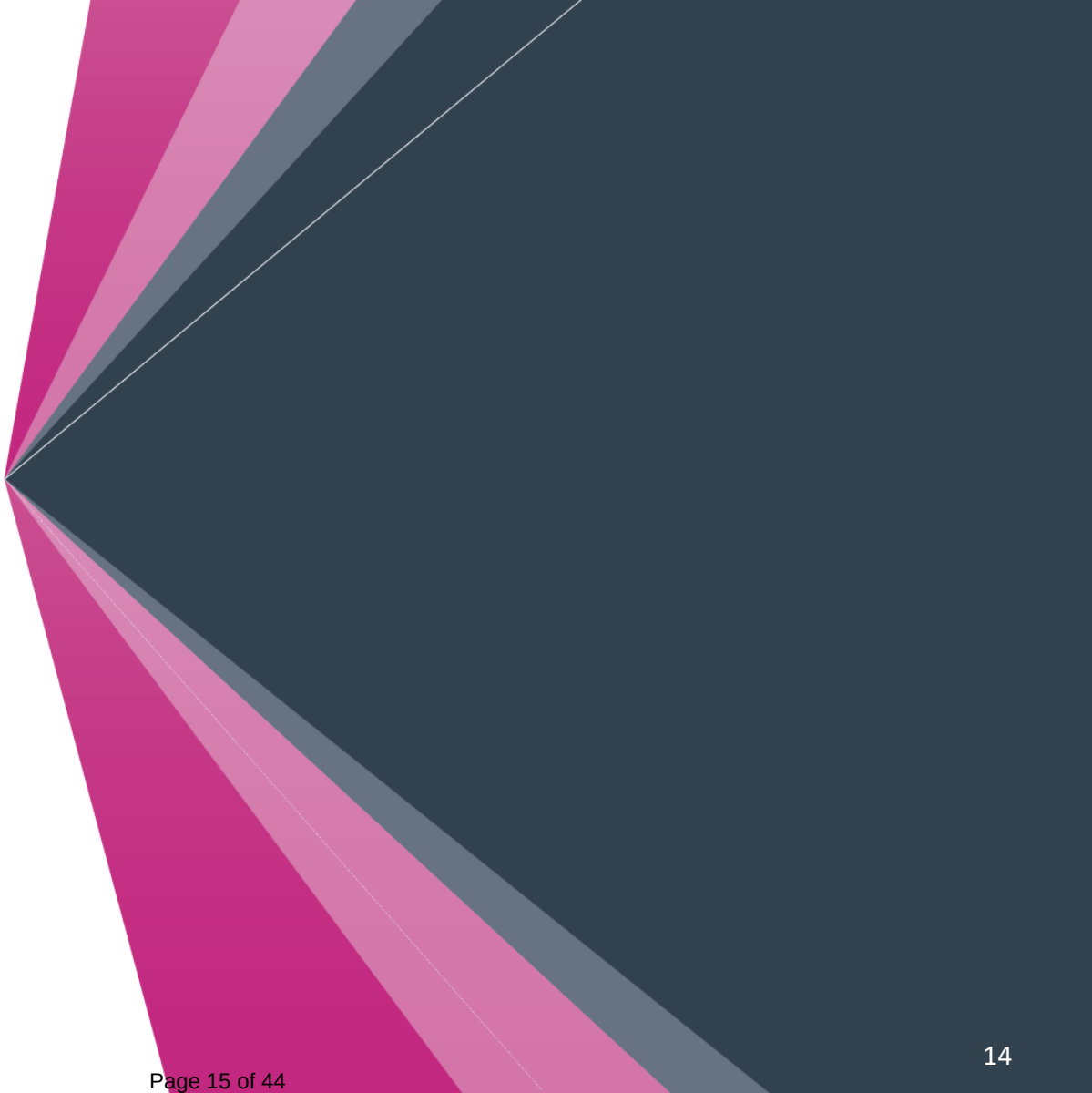
Source: ESR substantive staff as of January 2026; includes consultant APAs & Resident Doctors' Extra Rostered Hours, excludes CLRN, Wessex AHSN, WPL (revised criteria for 25/26). From September 2025, EPR Project posts are excluded due to capitalisation. Numbers relate to WTE, not headcount.

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

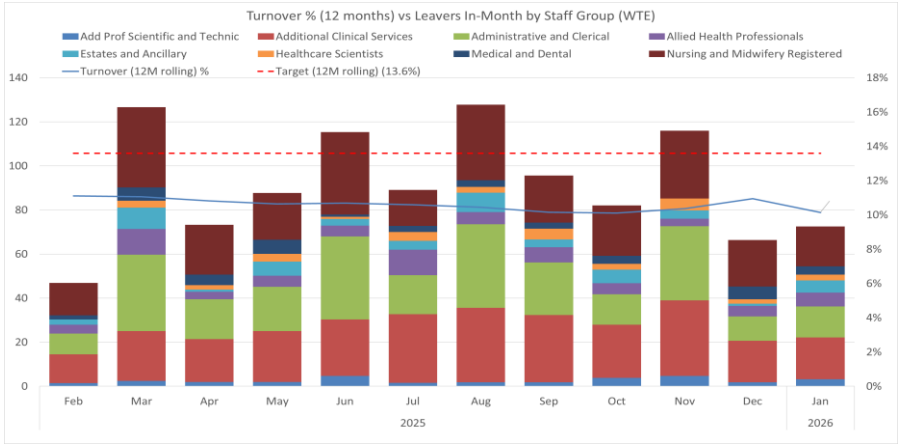
Total Monthly Workforce (WTE) for Since March 23 (Substantive, Bank and Agency)																										
	23/24	24/25												25/26									Movement			
	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M9 to M10 Movement	Mar24 to M10 Movement	Mar25 to M10 Movement
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	296	294	298	303	302	303	303	315	305	307	310	306	307	303	-4	1	0
Additional Clinical Services	2522	2464	2464	2449	2453	2476	2430	2425	2418	2391	2433	2438	2475	2419	2430	2421	2432	2421	2379	2364	2365	2345	2342	-3	-180	-132
Administrative and Clerical	2348	2356	2342	2304	2303	2297	2286	2274	2287	2282	2315	2321	2330	2311	2296	2255	2241	2203	2149	2139	2107	2109	2104	-5	-244	-226
Allied Health Professionals	826	825	824	822	816	813	834	839	837	825	828	844	845	844	843	849	850	855	858	862	862	864	861	-2	35	17
Estates and Ancillary	410	401	403	404	409	403	398	403	435	431	436	442	443	439	437	434	418	410	414	410	411	438	436	-2	25	-7
Healthcare Scientists	509	508	505	506	509	511	508	517	524	522	525	528	532	532	529	531	532	531	532	534	533	533	533	0	24	1
Medical and Dental	2231	2093	2092	2101	2100	2151	2165	2168	2165	2158	2172	2175	2174	2176	2162	2152	2165	2225	2211	2218	2209	2201	2203	2	-28	29
Nursing and Midwifery Registered	4404	4311	4292	4308	4304	4273	4287	4357	4356	4327	4370	4379	4418	4312	4341	4309	4300	4310	4259	4291	4331	4281	4359	78	-45	-59
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	50	49	-1	-9	-20
Grand Total	13611	13315	13279	13248	13247	13283	13267	13341	13379	13288	13430	13495	13589	13405	13409	13322	13321	13329	13177	13190	13178	13127	13192	64	-419	-397

Source: ESR substantive staff, NHSP Bank & Agency temporary staff, THQ Medical Bank staff & 247 Agency staff as of January 2026
Excludes CLRN, Wessex AHSN, WPL (revised criteria for 25/26). Numbers relate to WTE, not headcount.

THRIVE



Turnover



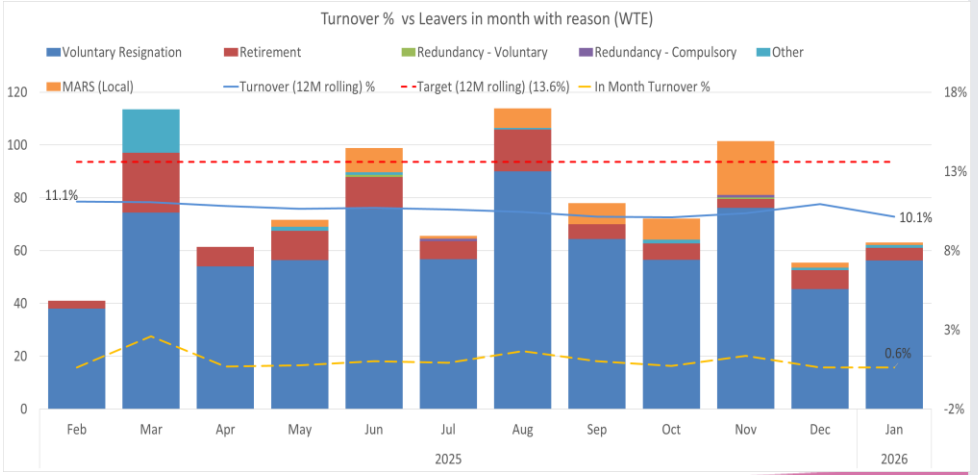
In January 2026, there was a total of 72.5 WTE leavers, 3.4 WTE more than December 2025 (69.1 WTE). Division C recorded the highest number of leavers (20.7 WTE). Within Division C, Allied Health Professionals staff group and Additional Clinical Services staff group both had the highest number of leavers (4.2 WTE).

Divisions A and Division B had the second and third highest number of leavers (20.3 and 14.9 WTE respectively); with the largest number of leavers for Division A being the Nursing and Midwifery Registered staff group (10.3 WTE), while in Division B Additional Clinical Services staff group accounted for 6.8 WTE leavers.

Total leavers by division are as follows:

- **Division A: 20.3 WTE leavers**
- **Division B: 14.9 WTE leavers**
- **Division C: 20.7 WTE leavers**
- **THQ: 11.8 WTE leavers**
- **UEL: 4.8 WTE leavers**

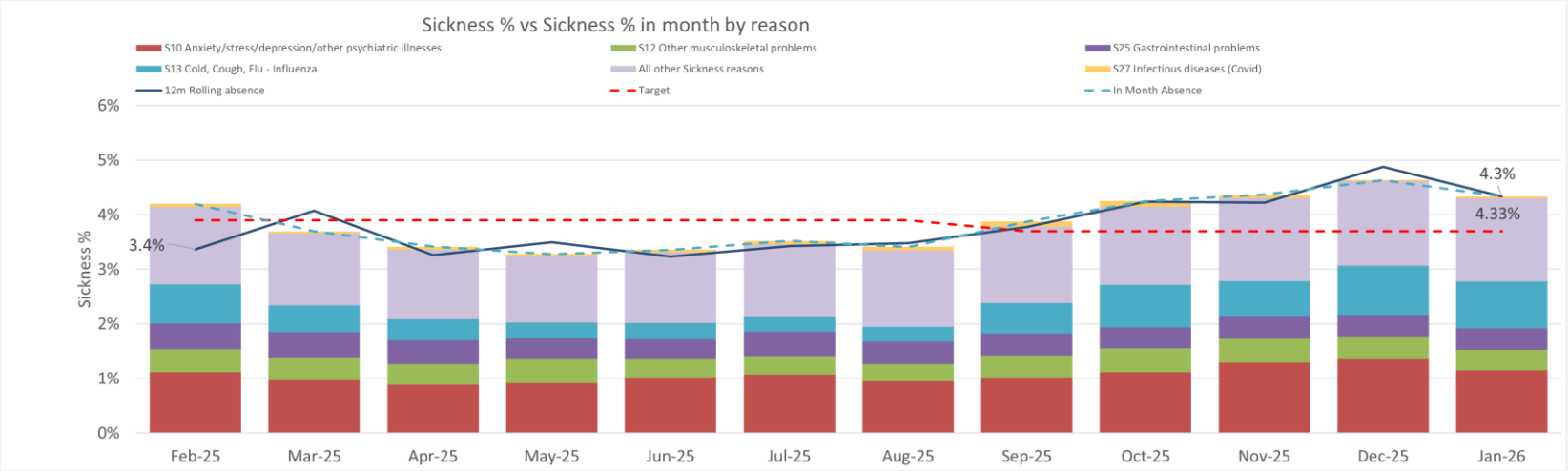
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	3.2	1.0%	10.4%
Additional Clinical Services	19.0	0.9%	14.2%
Administrative and Clerical	14.1	0.6%	15.1%
Allied Health Professionals	6.2	0.7%	8.6%
Estates and Ancillary	5.6	1.3%	52.5%
Healthcare Scientists	2.6	0.5%	6.4%
Medical and Dental	3.8	0.5%	13.2%
Nursing and Midwifery Registered	18.1	0.5%	7.6%
UHS total	**72.5**	**0.6%**	**10.1%**



Source: ESR – Leavers Turnover WTE, ESR Staff Movement Jan 26 (exc.resident doctors & hosted services, includes UEL)

Sickness

Current in-month sickness: 4.33% | Rolling 12-month sickness: 4.3% | Year-to-date sickness 3.89%



Source: ESR – January 2026

Temporary Staffing

Status

Qualified Nursing (WTE)

- **Demand increased** from 349 in December to 419 in Jan (+70).
- **Bank filled increased** from 237 to 299 (+62) from previous month.
- **Agency filled increased** from 36 WTE (+1 from the previous month).
- **Unfilled shifts increased**: 85 remained unfilled (+7 on previous month).
- **Year-on-year demand increased:** 32 WTE more than January 2025

Healthcare Assistants (WTE)

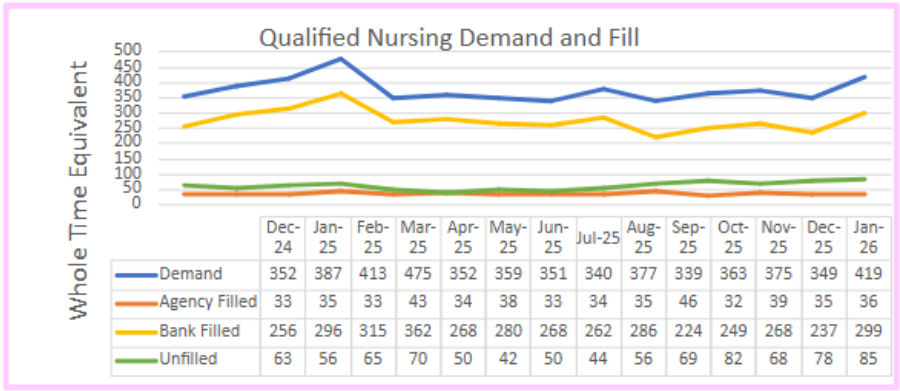
- **Demand increased** from 319 in December to 339 in January (+10).
- **Bank filled increased** from 258 to 269 (+11)
- **Unfilled shifts increased** from 60 to 70 (+10 on prior month)
- **Year-on-year demand decreased**: 9 WTE lower than January 2025.

Actions

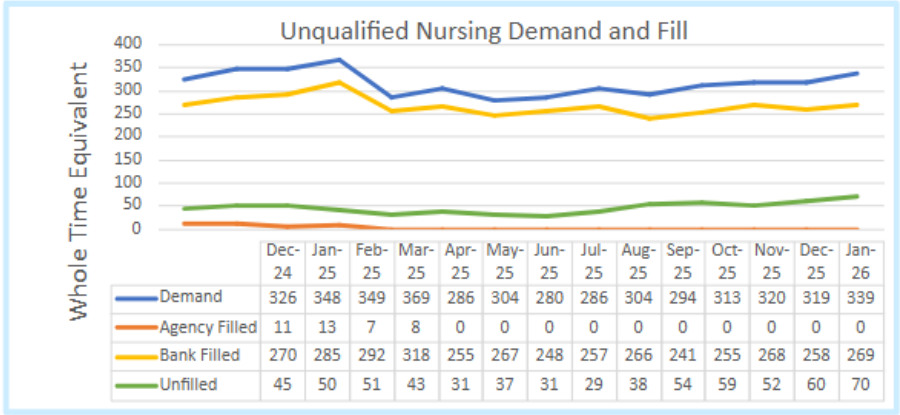
RMN use increase: Some RMN increased usage linked to shifts being released due to unfilled HCA shifts. Actions are being taken to ensure the correct governance processes are in place to address this, as we are seeing increased agency use across the trust driven by higher RMN reliance. Project is under way to review the HCA Mental Health role & align to band 3 payrates.

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

Unfilled shifts have risen significantly across the trust, with Nursing & Midwifery showing a 52% year-on-year increase in unfilled shifts. Bank only unregistered workforce has significantly reduced compared to prior year (106 less workers working) with an uptick of MPH working (17 additional workers). However, we have seen decreases in our Registered substantive workforce - the number of multi-postholders picking up shifts at UHS has decreased by 122 with an increase of bank only workers (+5)



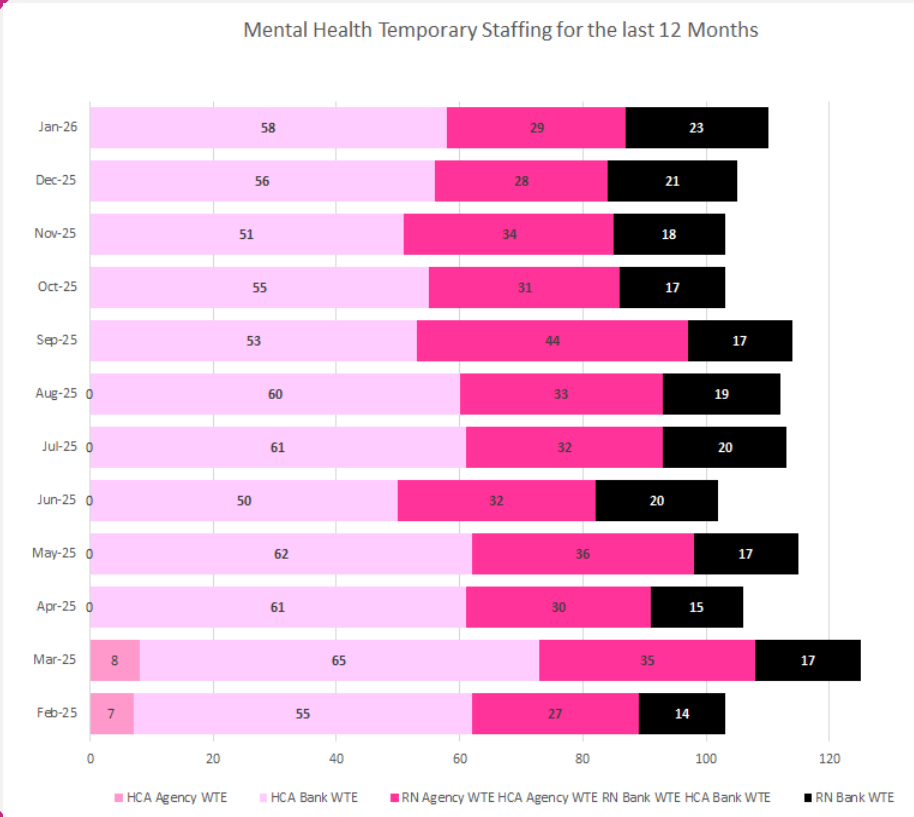
	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Demand	352	387	413	475	352	359	351	340	377	339	363	375	349	419
Agency Filled	33	35	33	43	34	38	33	34	35	46	32	39	35	36
Bank Filled	256	296	315	362	268	280	268	262	286	224	249	268	237	299
Unfilled	63	56	65	70	50	42	50	44	56	69	82	68	78	85



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Demand	326	348	349	369	286	304	280	286	304	294	313	320	319	339
Agency Filled	11	13	7	8	0	0	0	0	0	0	0	0	0	0
Bank Filled	270	285	292	318	255	267	248	257	266	241	255	268	258	269
Unfilled	45	50	51	43	31	37	31	29	38	54	59	52	60	70

Source: Temporary Resourcing – January 2026

Temporary Staffing: Mental Health



Mental Health Staffing Summary – January 2026

Total Temporary Staffing: 110 WTE (+5 WTE compared to Dec 25).
RMNs: 52 WTE (+3 on Dec 25), of which 29 WTE agency (+1 WTE Dec 25) and 23 WTE bank (+2 WTE on Dec 25).
HCAs: 58 WTE (+2 WTE on Dec 25).
Year-on-Year Comparison: 14 WTE decrease compared to January 2025 (-19 WTE HCAs, +8 WTE RMNs)

Key Challenges & Actions

Ongoing Pressures

- Rising mental health demand continues to create significant safety, quality, and financial pressures – escalated to ICB.
- ETOC project with NHSE to review the Enhanced Care strategy and delivery model. NHSE visited the Trust in January to meet with the project team, led by Suzy Pike.

Transition from Agency to Bank Staff

- Agency fill rates have reduced as part of the planned transition to Bank staffing, aiming to improve workforce stability and strengthen governance.
- NHSP pay rates are currently higher than agency charges, increasing overall staffing costs – escalated to SE Collaborative
- Bank staff can work across HIOWFT, reducing availability for HCA Enhanced Care shifts at UHS.

Increased RMN Use for HCA Shortfalls

- RMN usage has stabilised. After a 32% increase between December 2024 and December 2025, the rise seen in January 2026 was much lower, at only a 10% increase compared with January 2025.
- Increase in HCA fill in January 2026 has supported the trust backfilling less RMN's than previous months. Thanks to targeted work to attract HCA back to UHS.
- Governance processes are being strengthened to ensure robust approval when RMNs are deployed to cover HCA shortfalls.

Band 2/3 review of Enhanced Care HCA

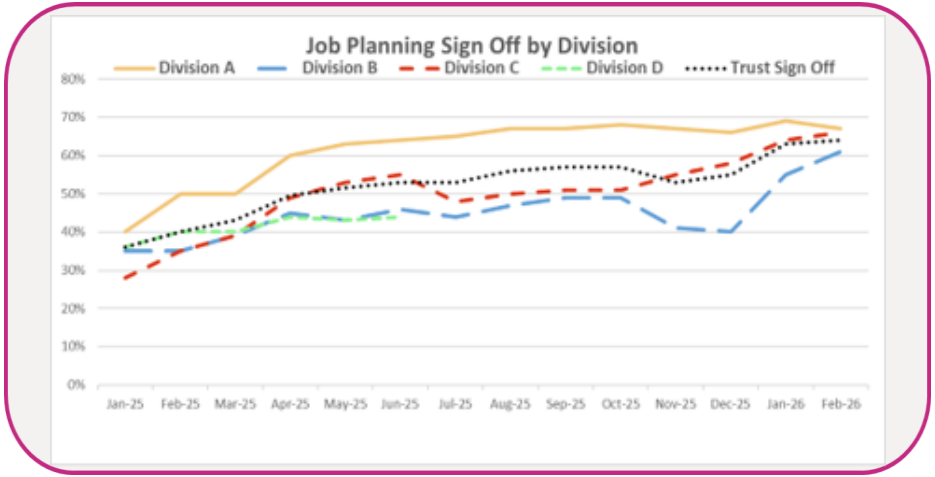
- A review is underway to consider moving Enhanced Care HCAs to Band 3 roles to improve day shift fill rates. Day shifts remain the highest staffing risk due to lower pay compared with unsocial hours.

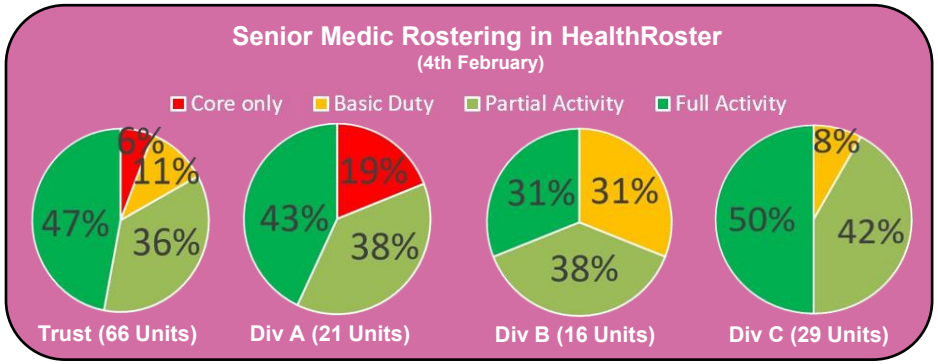
Temporary Workforce Quality

- Ongoing work is focused on developing a workforce suitable for an acute hospital setting.
- Actions: Delivery of in-house Maybo PMVA and BILD Act–accredited training, VLE overview for NHSP
- Additional focus on: Training, supervision, and ongoing support, Ensuring the Enhanced Care temporary workforce can safely and effectively meet patient needs

Source: Temporary Resourcing – January 2026

Workforce: Medical Rostering and Planning



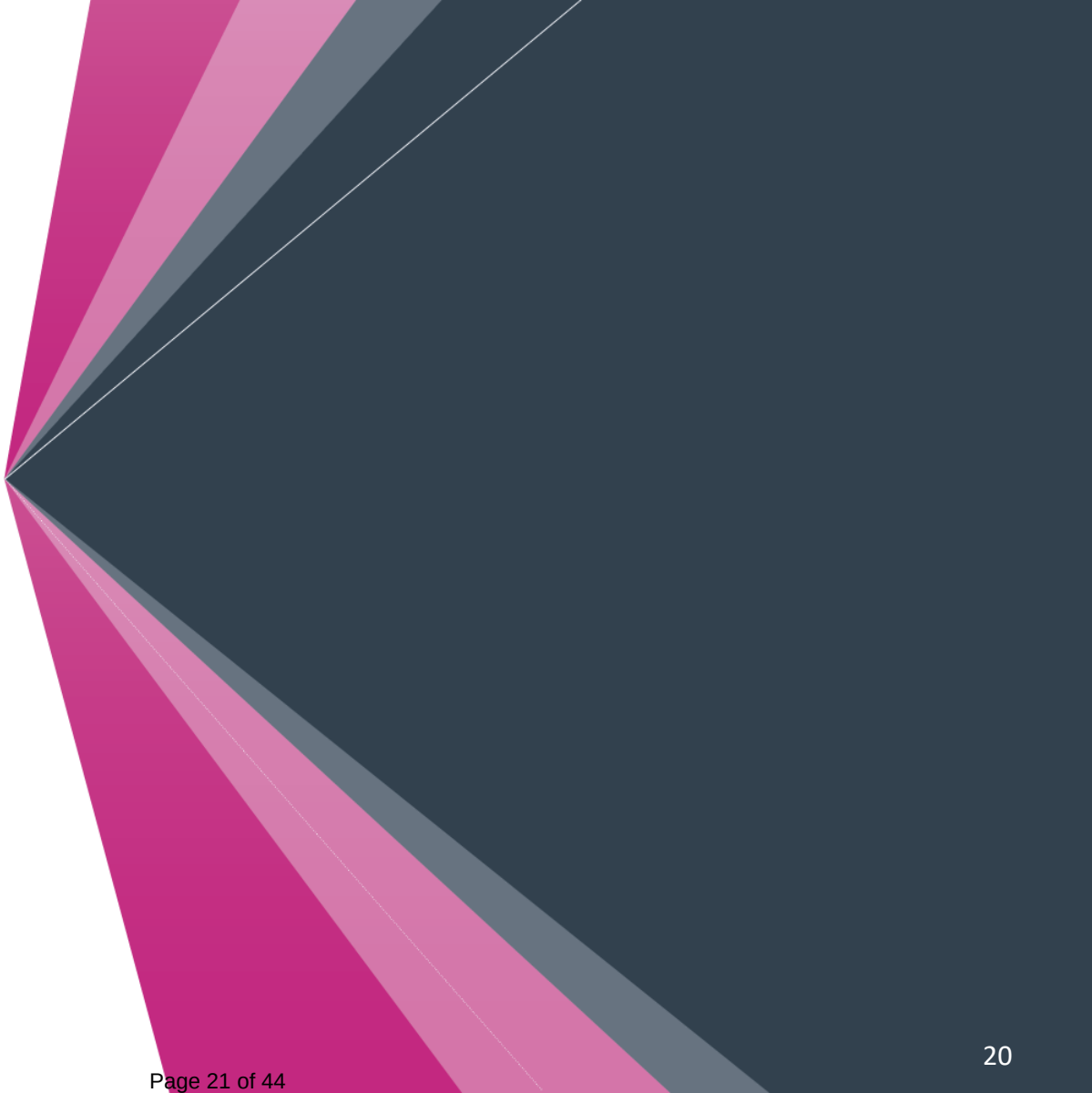


Source: Healthroster & Job Plan – Feb 2026

Medical Job Planning

- Signed off job plans increased 1% to a total of 64% (as of 02.02.2026)
- There are 407 Job Plans requiring sign off before the deadline of 31.03.2026
- Trust major incident impacted progress this month due to chasing put on hold.
- Actions:
  - Renewal timetable brought forward to facilitate sign off for all groups by 31.03.2026
  - Fortnightly detailed review of progress by Deputy CMO and DoE&W.
  - Escalation process established for republished job plans with no sign off after 2 weeks.
  - Regular meetings with DCDs for direct escalations of low sign off areas and lack of engagement by individuals. Action plans established with follow up meetings.
  - Job planning policy and guidance changes are being drafted following discussions with BMA and LCNC.
  - External consultant engaged to commence service level job planning in 3 pilot areas

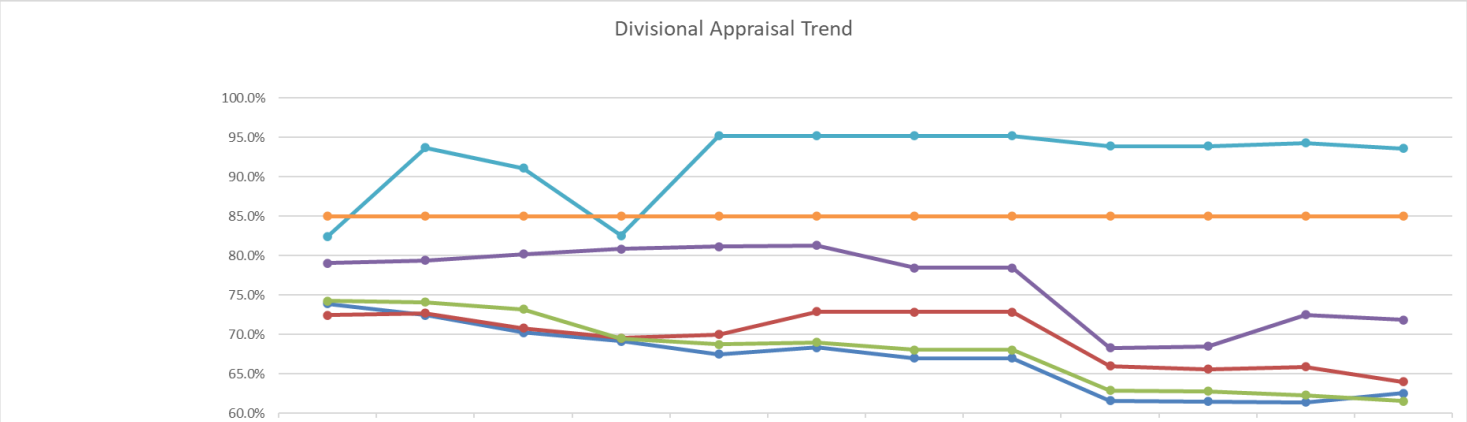
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 64.5% as of January 2026, a decrease of 0.5% from December 2026

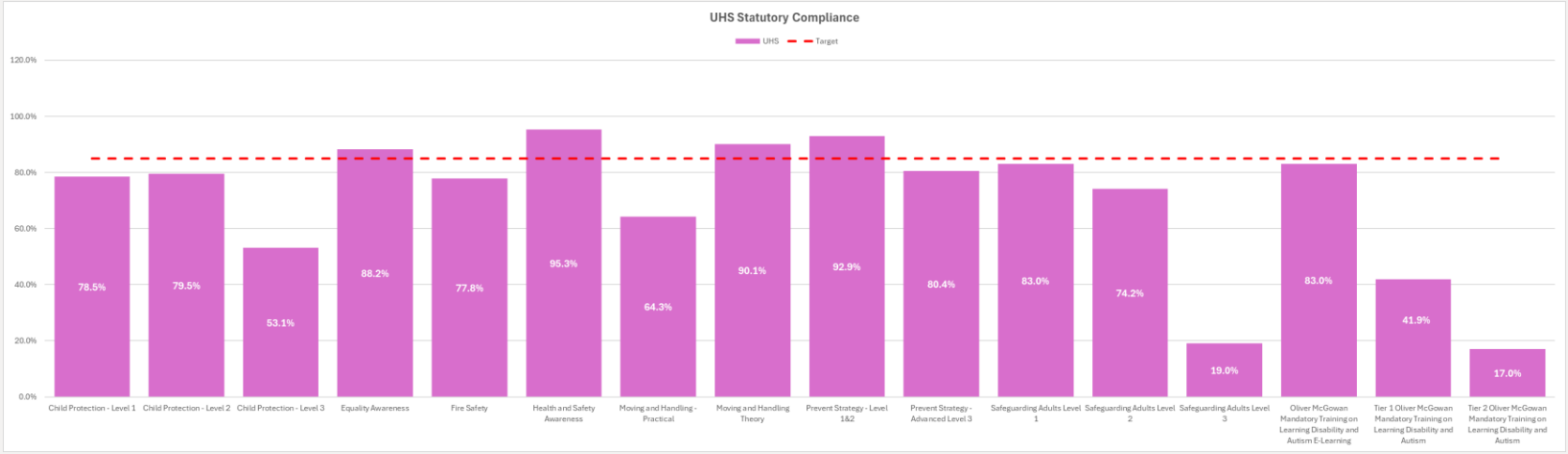


	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
188 Division A	73.9%	72.4%	70.3%	69.1%	67.5%	68.3%	67.0%	67.0%	61.6%	61.5%	61.4%	62.6%
188 Division B	72.4%	72.7%	70.8%	69.5%	70.0%	72.9%	72.8%	72.8%	66.0%	65.6%	65.9%	64.0%
188 Division C	74.3%	74.1%	73.2%	69.5%	68.8%	69.0%	68.0%	68.0%	62.9%	62.8%	62.3%	61.6%
188 Trust Headquarters - Division	79.0%	79.4%	80.2%	80.9%	81.1%	81.3%	78.5%	78.5%	68.3%	68.5%	72.5%	71.8%
188 UEL - Division	82.5%	93.7%	91.1%	82.5%	95.2%	95.2%	95.2%	95.2%	93.9%	93.9%	94.3%	93.6%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: ESR & VLE. Appraisal data for Div A, B, C & THQ only (exc. Medical & Dental group).

UHS Statutory Compliance

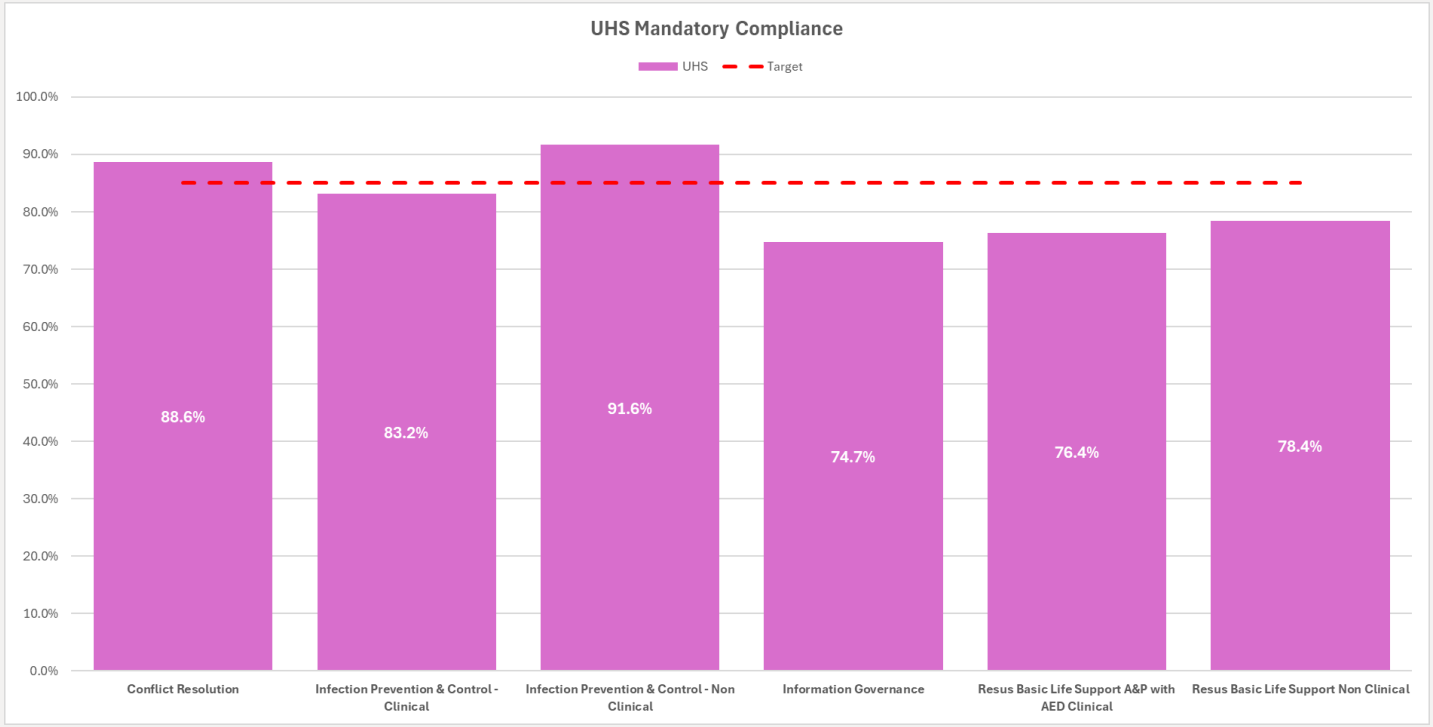
The Trust's average Statutory compliance rate for January 2026 is 70%, with 4 of 16 measures above the 85% target.



Source: Virtual Learning Environment (VLE).

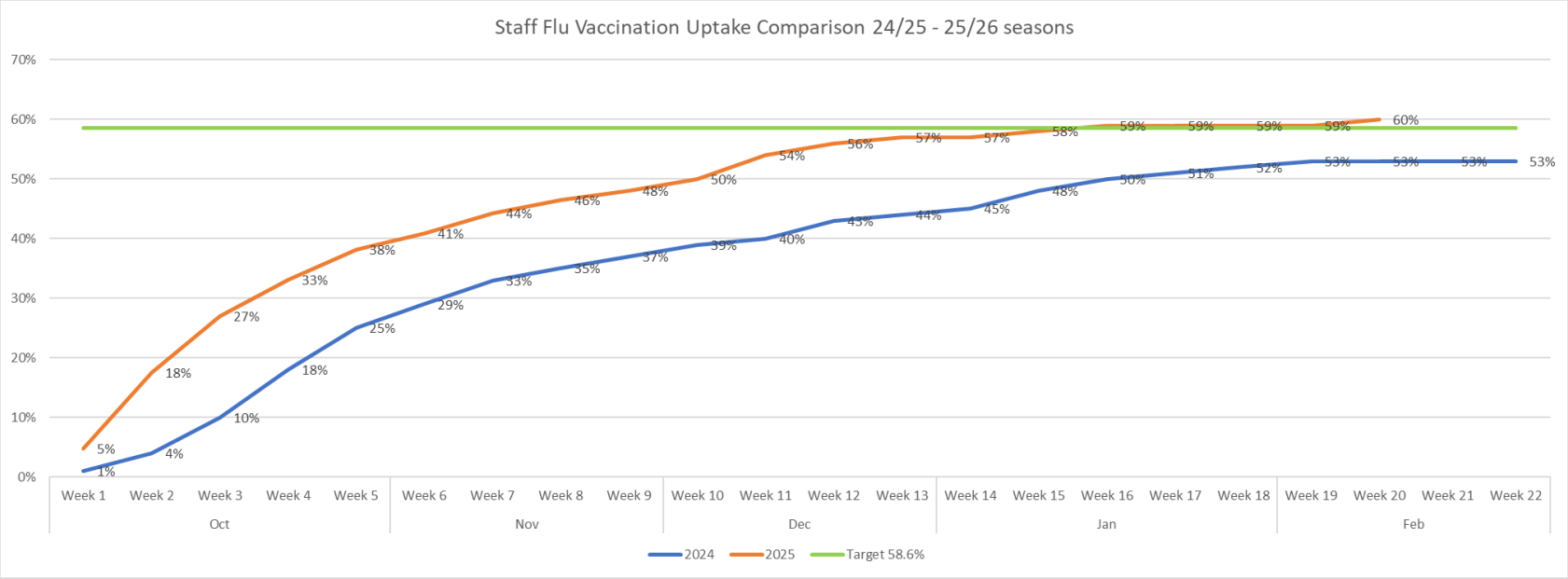
UHS Mandatory Compliance

The Trust's average Mandatory compliance rate for January 2026 is 82%, with 2 of 6 measures above the 85% target.



Source: Virtual Learning Environment (VLE).

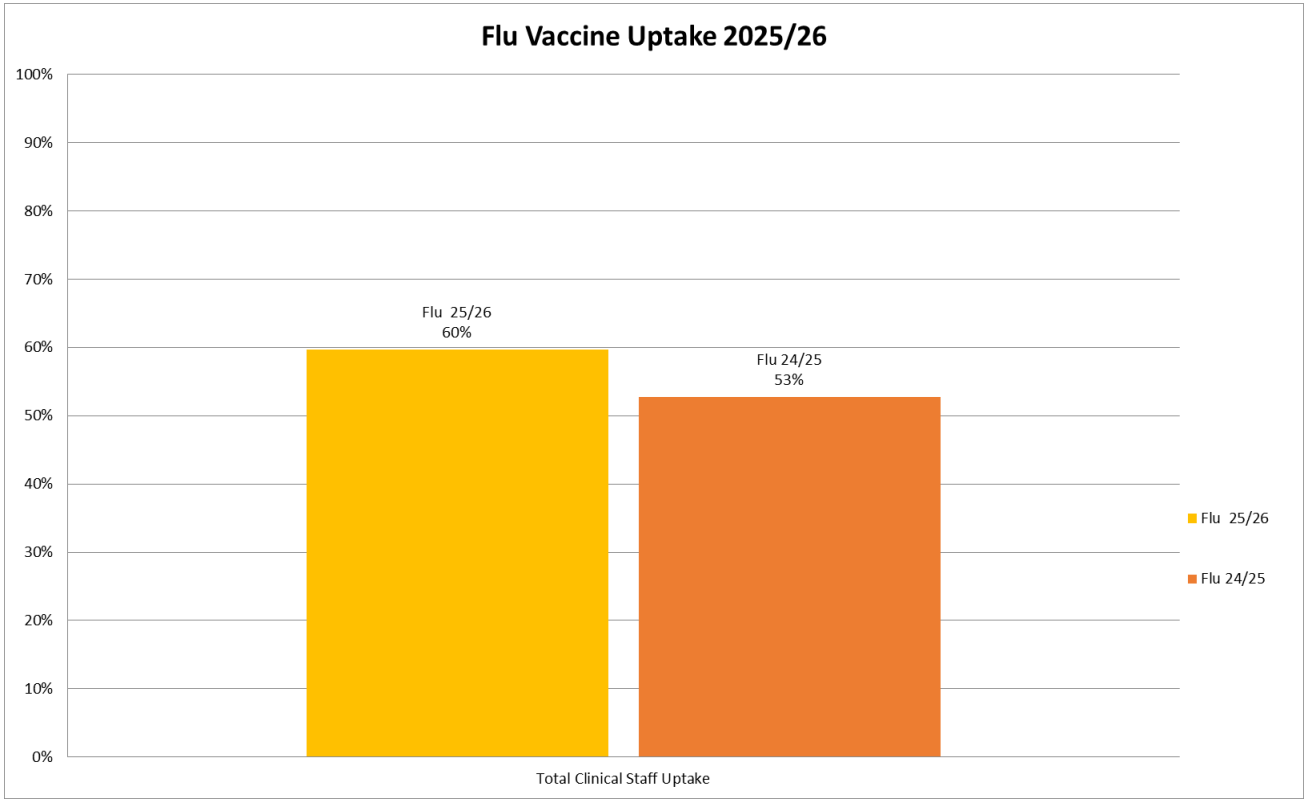
UHS Flu performance - 60% of frontline staff vaccinated



- UHS achieved a total flu uptake of 53% in 24/25
- UHS have passed the target set by NHS England of 58.6% and have reached 60%
- Change of approach this year – planned clinics across the Trust
- Much quicker uptake due to ease of access to vaccination
- Very similar uptake across all professions
- Drop-in clinics continue to be available at OH however very little activity now (only 20 staff vaccinated across the ICS between 6th Feb and 12th Feb)
- UHS declared 2nd highest performing Trust across SE Region and 13th nationally
- 0.5 months of the programme remaining

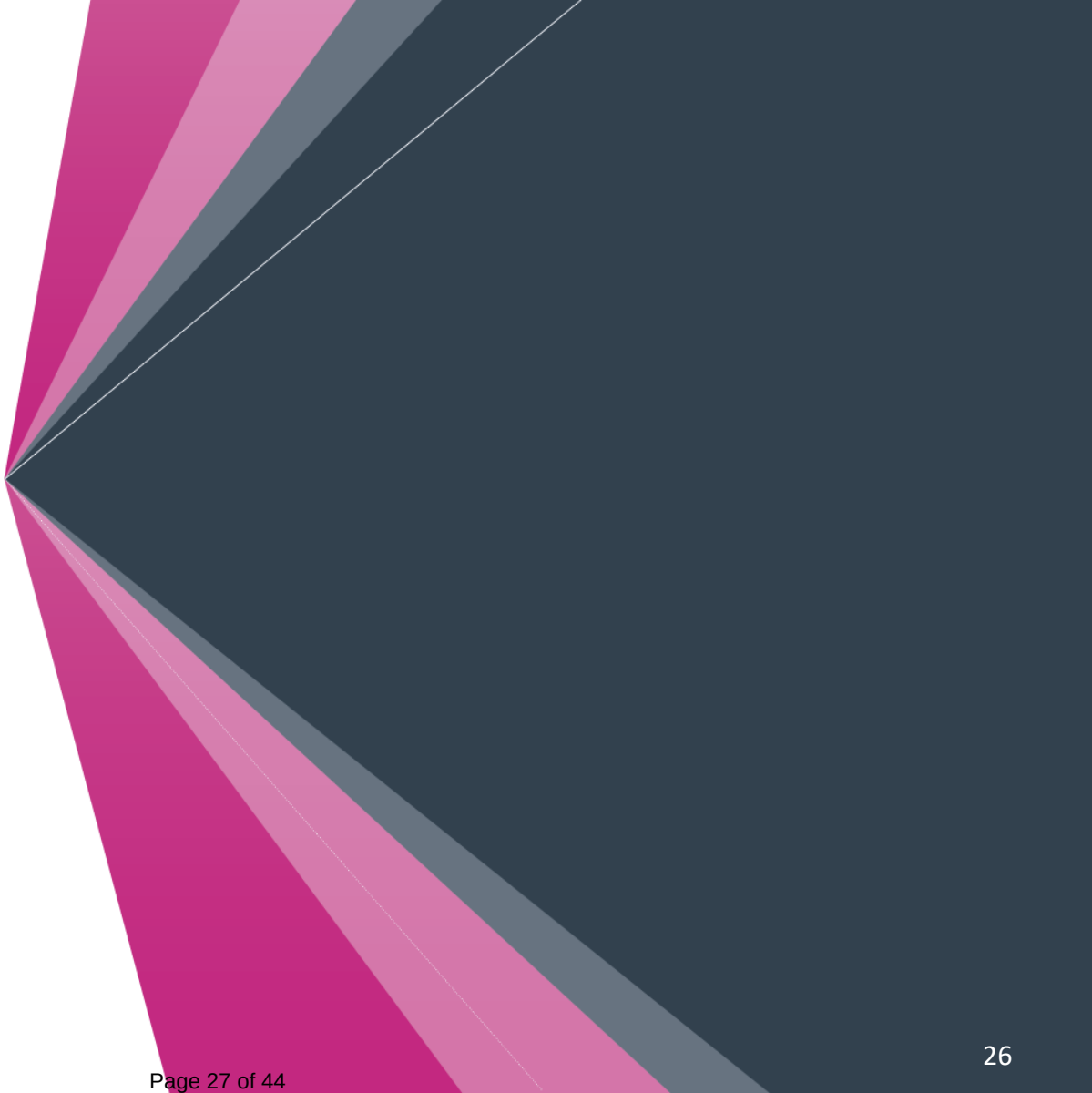
Source: Occupational Health.

2025-2026 Flu Programme Update



Source: Occupational Health.

BELONG



Impact of the fire on our People

Early on the morning of February 1, 2026, a fire at the Trust destroyed the endoscopy department. This led to one of the largest patient evacuations in NHS history, with over 500 patients—the entire west wing—safely relocated within 40 minutes. The Trust lost its entire endoscopy service, approximately 200 beds (around 20% of capacity), and 36 outpatient clinics.

A major incident was declared at UHS and across HIOW, prompting swift assistance from system partners that helped stabilise the Trust both on the day and in the following week. Measures included transferring and discharging patients to other facilities, significantly reducing elective procedures, and diverting emergency department services.

The response of leaders at levels and from staff on the day and afterwards was truly commendable, though the Trust remains concerned about the psychological effects of the incident.

Key concerns include:

•The mental health impact on those who quickly evacuated patients, including potential risks to their own safety
•The destruction of the endoscopy department, which served as a workplace and ‘home’ for staff, along with the loss of personal belongings
•The adaptability required from many staff working in new and unfamiliar settings as the Trust reorganises services within a smaller space

The People Team at UHS promptly established an incident response unit and adjusted wellbeing services to support staff throughout the Trust.

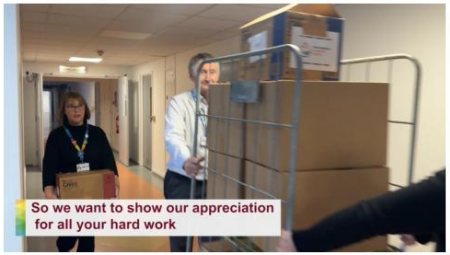
Impact of the fire on our People

Boost boxes rolled out to teams across the Trust

Boost boxes have been delivered across the site throughout this week, with support from Southampton Hospitals Charity, as a small, practical way to support our teams.

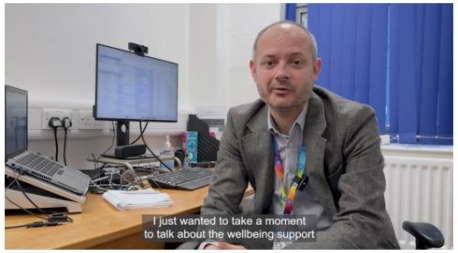
Each box contains practical items such as snacks and drinks, providing quick-access essentials that can be helpful during an exceptionally busy period.

In total, over 300 boxes have now been delivered to more than 150 areas across the site.



Wellbeing – supporting our staff

Steve Harris, chief people officer, has shared a video with staff to reinforce the importance of prioritising staff wellbeing following the incident, and to encourage colleagues to reach out for support if they need it. He outlines the range of services available, including local drop-in sessions being organised by leadership teams, trauma risk assessments, and psychology one-to-one sessions.



Our response:

- Rapid creation of a dedicated wellbeing support line (for the fire) triaging support
- TRiM (Trauma management) and psychology support intervention
- 2 TRiM debrief sessions led by our CEO marketed directly to all staff on duty
- Revision of Healthroster data to identify all individuals off sick as a result of the fire with personal follow ups for support
- Mutual aid offer with HIOW Healthcare for iTalk services to expand our psychology response.
- Rapid communication programme to manage internal dissemination and external media
- Daily rolling communication to our people through key channels
- Introduction of a pay policy to support staff who rapidly responded to the incident approved with staffside
- A policy on reclaim of belongings lost due to fire
- Delivery of over 300 ‘boost boxes’ by a range of senior leaders to areas across the trust
- Significantly increased senior visibility to ensure the wellbeing offer is known and to support staff
- Development of a process to collect learning, collect stories and continue to engage on personal wellbeing

Impact of the fire on our People – by the numbers

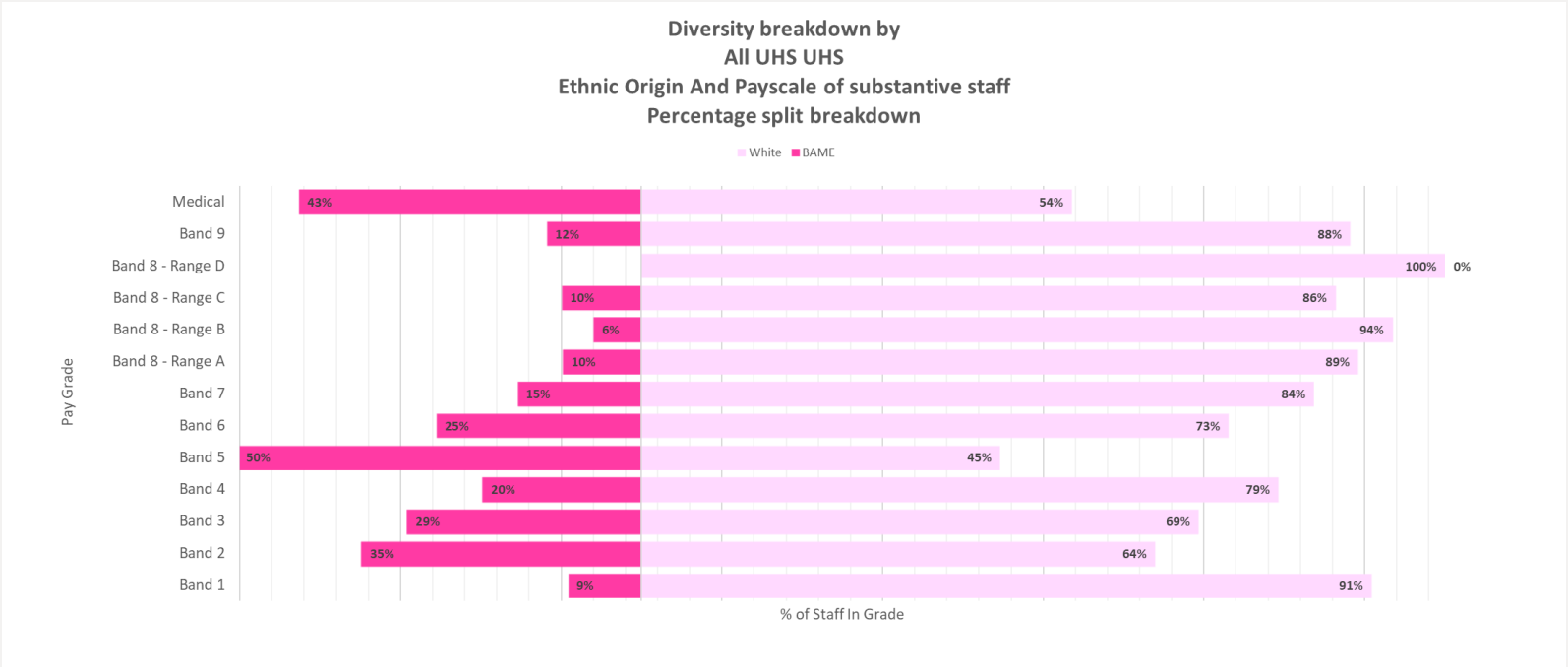
- 630 UHS employed staff on duty on night of 31 Jan / 1 Feb when the fire broke out
- No staff physically injured in the fire
- 16 staff subsequently reported off sick – personal follow up in each case
- Over 300 boost boxed distributed to local departments including partners (Serco etc)
- 168 staff attended CEO led TRiM debrief sessions (either online or in person)
- 2500 staff directly contacted with support briefing who were on duty on the night of the fire and the day and night following
- 40 individuals engaged in either group or individual TRiM sessions

Next Steps

The fire has presented an opportunity to seize on transformation and lock in positive benefits. The trust is refreshing its transformation priorities, objectives and work programmes for 26/27 and beyond. This includes:

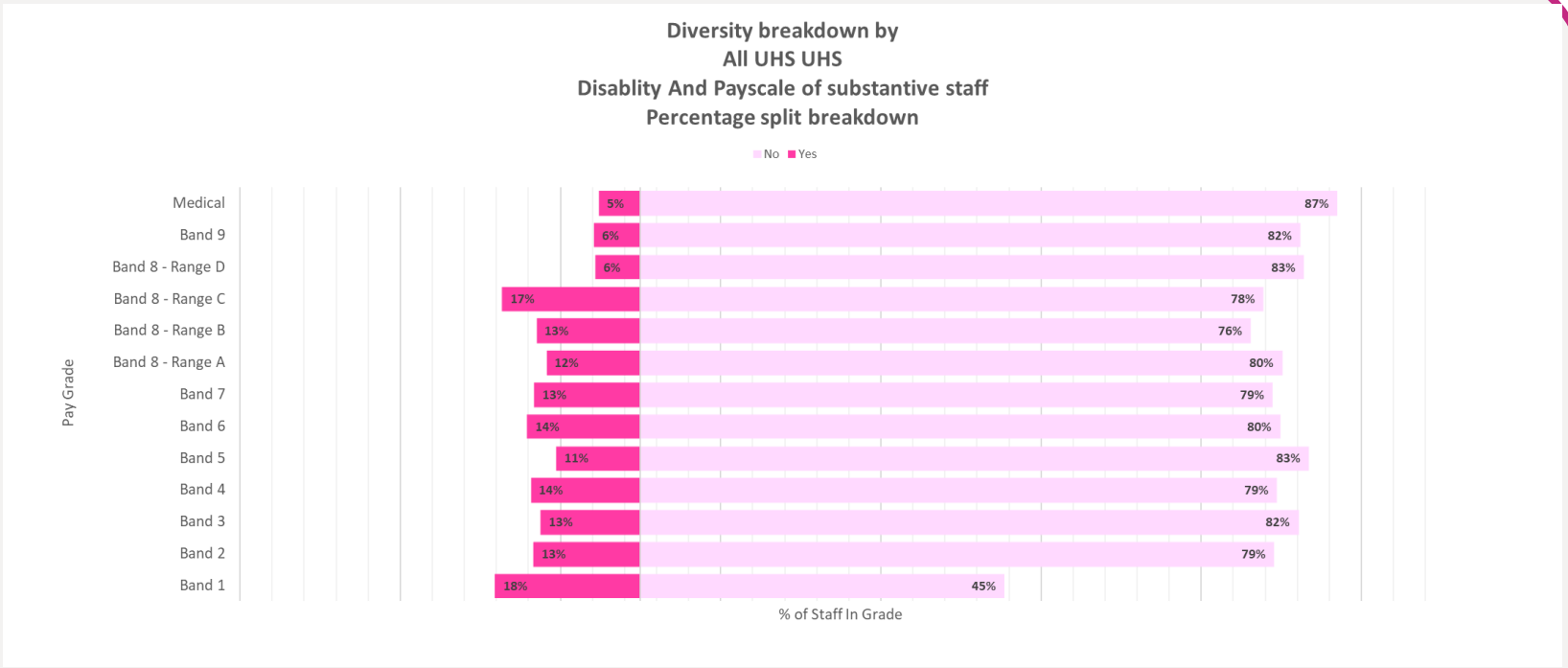
- A stronger partnership with Hampshire and Isle of Wight Healthcare to support acceleration of 'left shift' and pathway changes in mental health, rehab, and community management led by the CMOs of each organisation
- To work with partners to sustain the gains made on NCTR and cap future numbers to deliver workforce savings and patient experience improvements
- Increasing opportunities for Outpatient transformation with further use of virtual and digital mechanisms
- To re-imagine the endoscopy service, including a new build off-site with education and training space included. 4-stage plan being worked through
- Capitalising on the collective leadership, compassion, and sense of purpose through the fire to use as a catalyst for improving staff survey results, engagement and morale during 26/27
- Established a senior oversight committee for reward, celebration and thanks linked to the fire to ensure the heroic actions are marked accordingly.

Staff in Post - Ethnicity



Source: ESR – January 2026

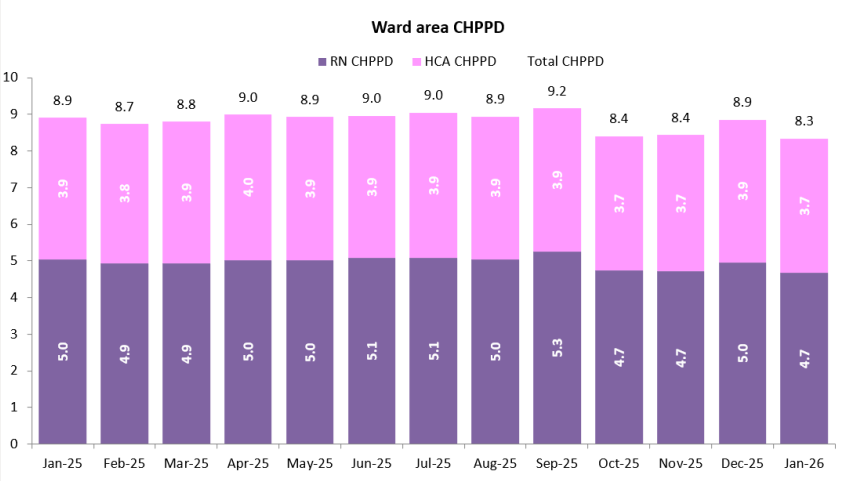
Staff in Post – Disability Status

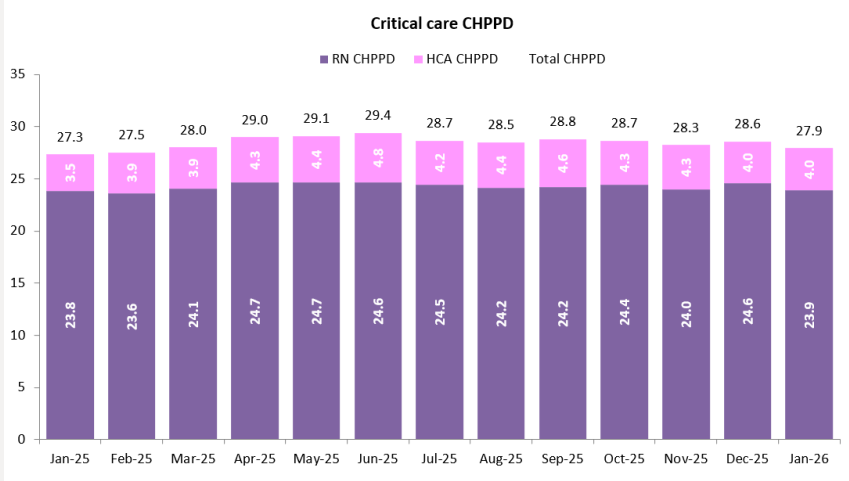


Source: ESR – January 2026

Staffing Safety Data

CHPPD





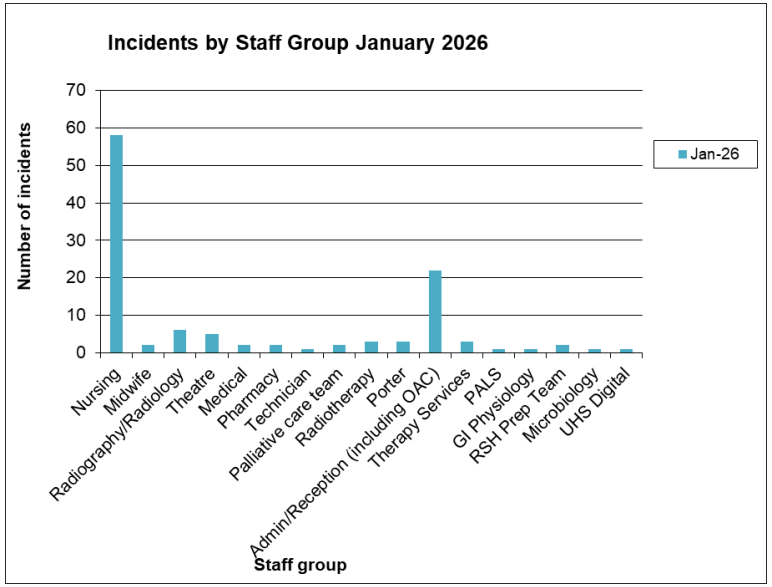
The Ward areas CHPPD rate in the Trust has decreased overall from last month. RN 4.68 (previously 4.95), HCA 3.66 (previously 3.99), overall, 8.34 (previously 8.85).

The CHPPD rate in Critical care has decreased overall from last month. RN 23.89 (previously 24.60), HCA 4.05 (previously 3.99) overall 27.94 (previously 28.59).

Source: HealthRoster, NHSP & eCamis – January 2026

Patient Safety – Staffing Incidents & Red Flags

In total 115 incident reports were received in January 2026 which cited staffing. This is an increase on the 93 reported in December.



Incidents by Division January 2026 vs December 2025

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
Jan-26	50	25	35	5	115
Total	50 ↑ (39)	25 ↓ (36)	35 ↑ (18)	5 ↑ (0)	115 ↑ (93)

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
December 2025	39	36	18	0	93
Total	39 ↑ 14	36 ↑ 21	18 ↓ 29	0 ↓ 4	93 ↑ 75

Source: Safeguard System January 2026

Patient Safety – Staffing Incidents & Red Flags cont.

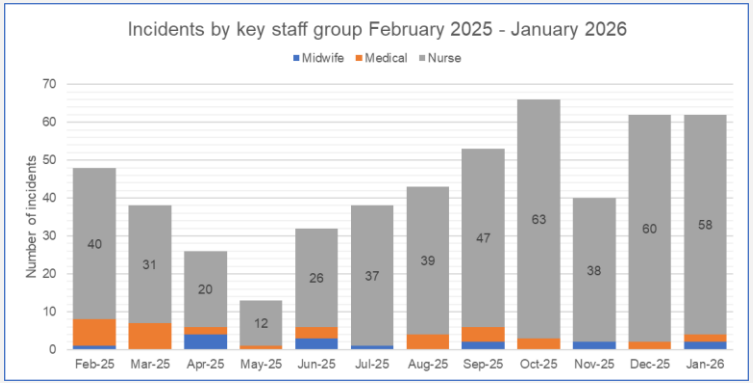
DIVISIONAL BREAKDOWN:

Div A (now including Div D):
Fifty incidents reported in January, up from 39 in the previous month. There were 8 red flags, same as previous month.

Div B:
Twenty-Five incidents were reported in December (significant decrease on the 36 in the previous month). There were 0 red flags reported, a significant decrease from the previous month December (13)

Div C:
Thirty-Five incidents were reported in January (significant increase from 18 in the previous month). There were 2 red flags reported, up on the previous month (0).

THQ:
Five incidents were reported in January (up from 0 in the previous month). There were 0 red flags reported.



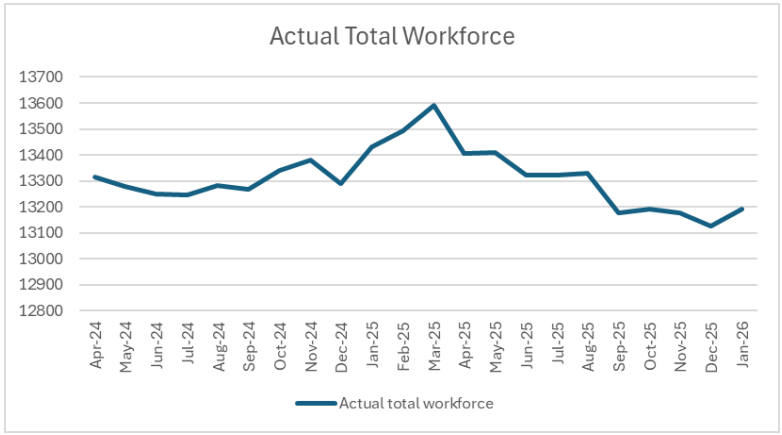
	Red flag category	Number of reports	Div A	Div B	Div C	THQ
Jan-26	Delay in medication	1	1	0	0	0
	Delay in pain relief	3	3	0	0	0
	Delay in observations	3	2	0	1	0
	Less than 2 registered	3	2	0	1	0
	Total	**10**	**8**	**0**	**2**	**0**

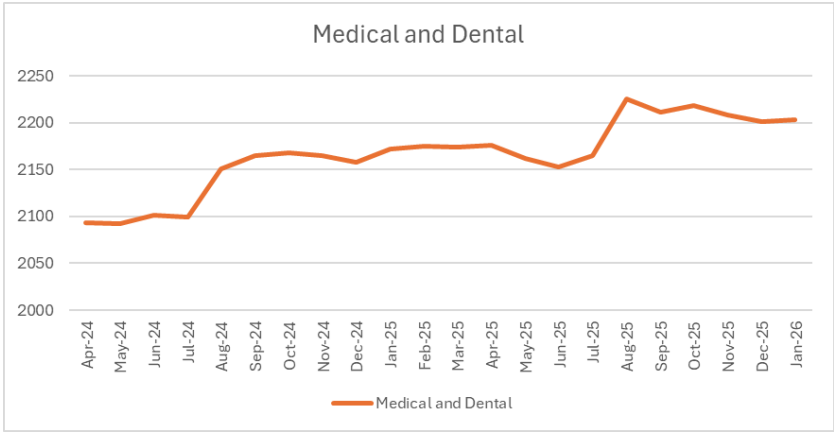
	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
Dec-25	Delay in medication	6	1	4	0	0	1
	Delay in pain relief	7	3	3	0	0	1
	Delay in observations	6	2	3	0	0	1
	Less than 2 registered	6	2	3	0	0	1
	Total	**25**	**8**	**13**	**0**	**0**	**4**

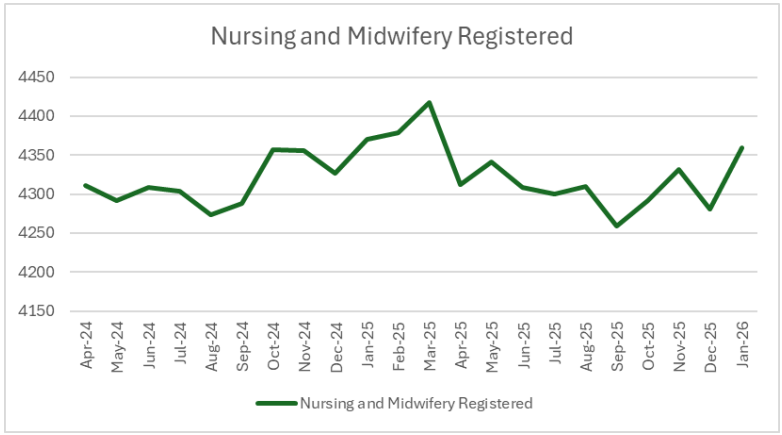
Source: Safeguard System January 2026

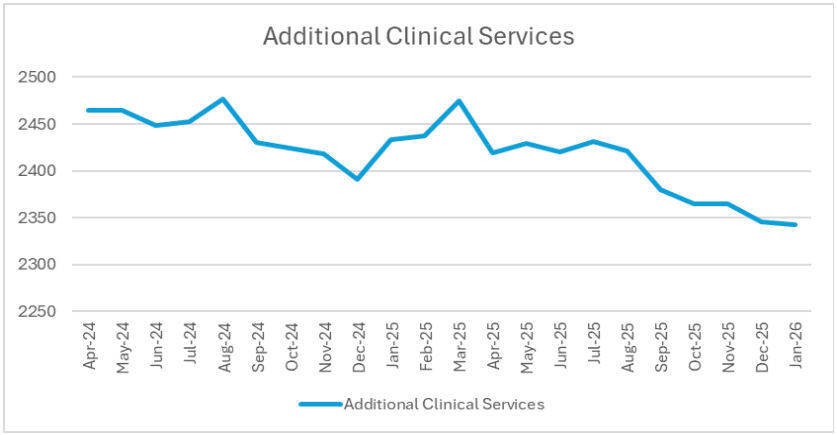
Appendices

Total Monthly Workforce (Substantive, Bank & Agency)



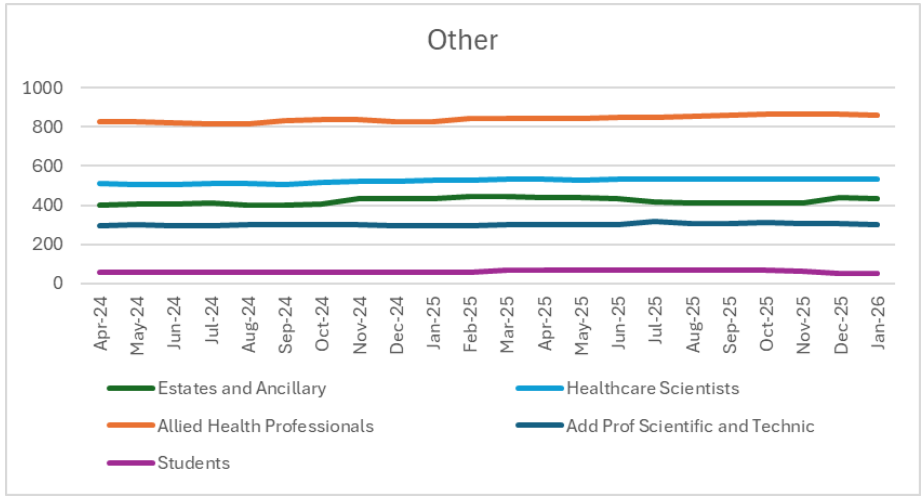


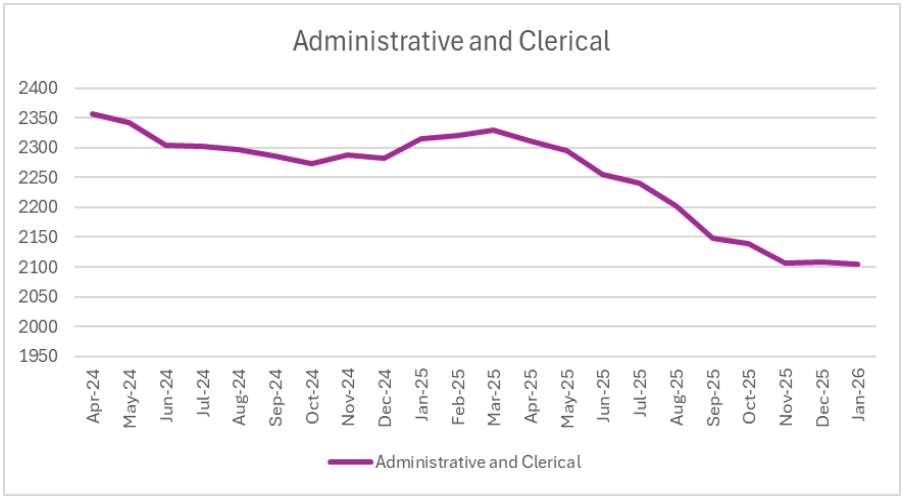




Source: ESR – January 2026

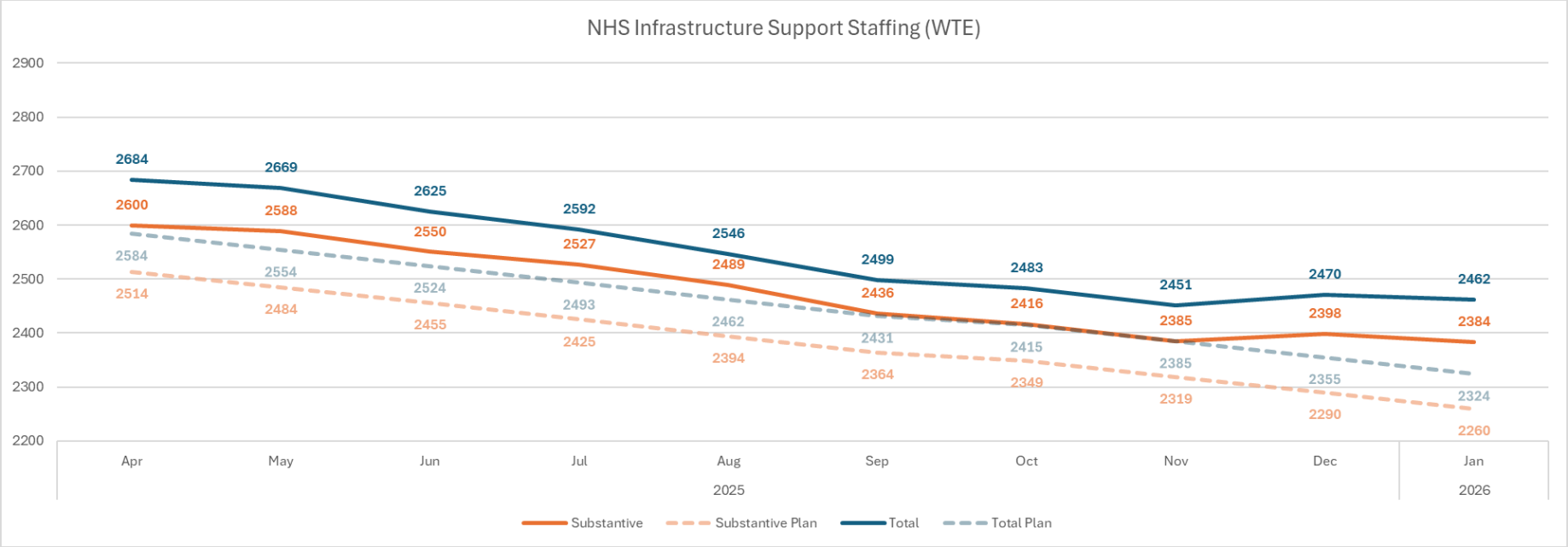
Total Monthly Workforce (Substantive, Bank & Agency)





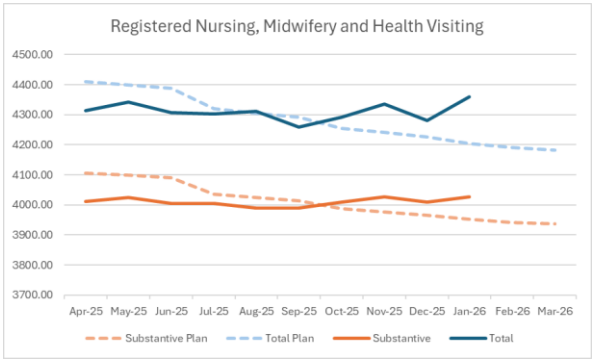
Source: ESR – January 2026

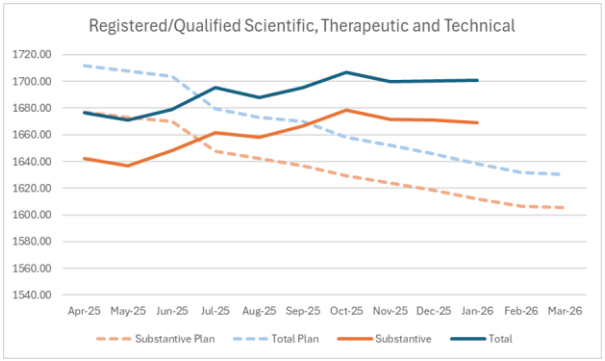
NHS Infrastructure Support Staffing

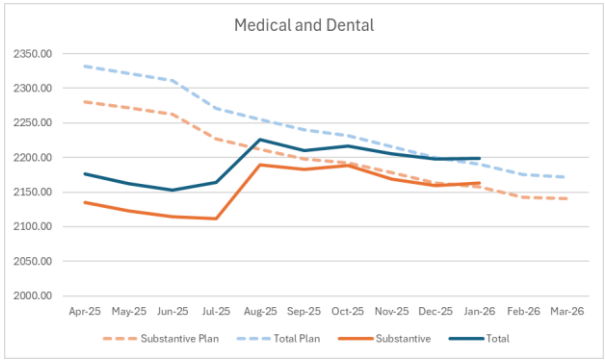


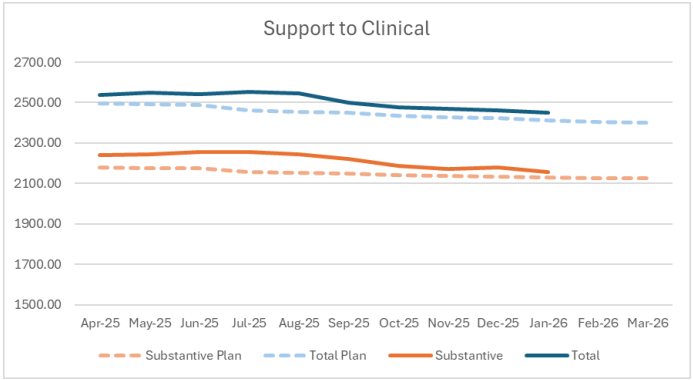
Source: PWR – January 2026

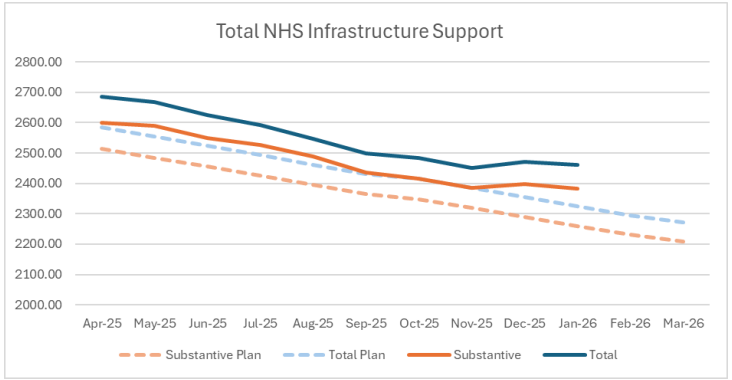
Progress Against Plan by Staff Group











Source: PWR– January 2026

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, 10 March 2026	
Title:	Freedom to Speak Up Report
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Christine Mbabazi, Freedom to Speak Up Guardian

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:

To provide an update on the Freedom to Speak Up (FTSU) agenda, cases, themes and actions taken and lessons learnt from the concerns raised.

1. Mechanism to support a culture where staff feel safe and can speak up about concerns.
2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust.
3. Compliance with the Public Interest Disclosure Act 1998.

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note update regarding the mechanisms of reporting.
- Note update on the future of Freedom to Speak Up: Engagement

Contents:

Appendix A

Risk(s):

1. Failure to keep improving services for patients and the working environment for staff.
2. Failure to support a culture based on safety, openness, honesty and learning.
3. Failure to comply with NHS requirements and best practice and commissioning contracts

Equality Impact Consideration:	N/A

1. Executive Summary / Purpose

To provide an update following the last report written in July 2025. This report provides an update on the Freedom to Speak Up (FTSU) agenda. In addition, it also makes note of the lessons learnt from concerns raised to the FTSU guardian.

2. Key Issues

2.1 Case Update

The Trust has received 62 FTSU cases from (July 25 – Jan 26) almost the same number of 64 cases received same time last year.

3.Progress on the FTSU Agenda

3.1Data from other mechanisms for reporting concerns.

Following the last FTSU report July 2025, the board requested that data from other mechanisms for reporting concerns to be included in future Freedom to Speak Up reports.

There are different ways that staff have been reporting concerns. The obvious and recommended way of reporting is contacting one's line manager and if that is not possible to follow the chain of command. The following ways below are other mechanisms staff can use to report concerns.

- Patient safety team: Any member of staff can report patient safety concerns to the patient safety team. The patient safety team supports divisions to manage and learn from incidents and significant incidents requiring investigation (SIRIs). Patient safety incidents and near misses are reported to the Learning from Patient Safety Events (LFPSE) system so that information can be reviewed nationally for trends or problems. For more information please use the link https://staffnet.uhs.nhs.uk/Patientfocus/Patientsafety/Learning-from-patient-safety-incidents/Duty-of-candour-Being-Open/BeingOpen.aspx. The graph below will indicate the annual number of patient safety concerns raised by staff incident system reporting. Further detailed information regarding patient safety is in the quarterly Trust board reports of Patient safety.

- The staff incident reporting system – Ulysses:

  Staff use the electronic incident reporting (eReporting) system. The eReport form is a web based incident form and is available for all staff within the trust to use to report incidents, accidents and near misses. All incidents are reported to the appropriate ward or department manager for the ward or area in which the incident occurred to ensure the collection of all relevant and significant facts. The forms are completed promptly by the member of staff who first becomes aware of the incident and can be reported immediately, if serious to the Patient Safety Team (in hours) or to the site coordinator or executive on call (out of hours)

- Key staff contacts:
  The other ways staff report concerns are by usually contacting Human resources directly, The Chief medical Officer, Chief Nursing Officer and the Chief People officer.

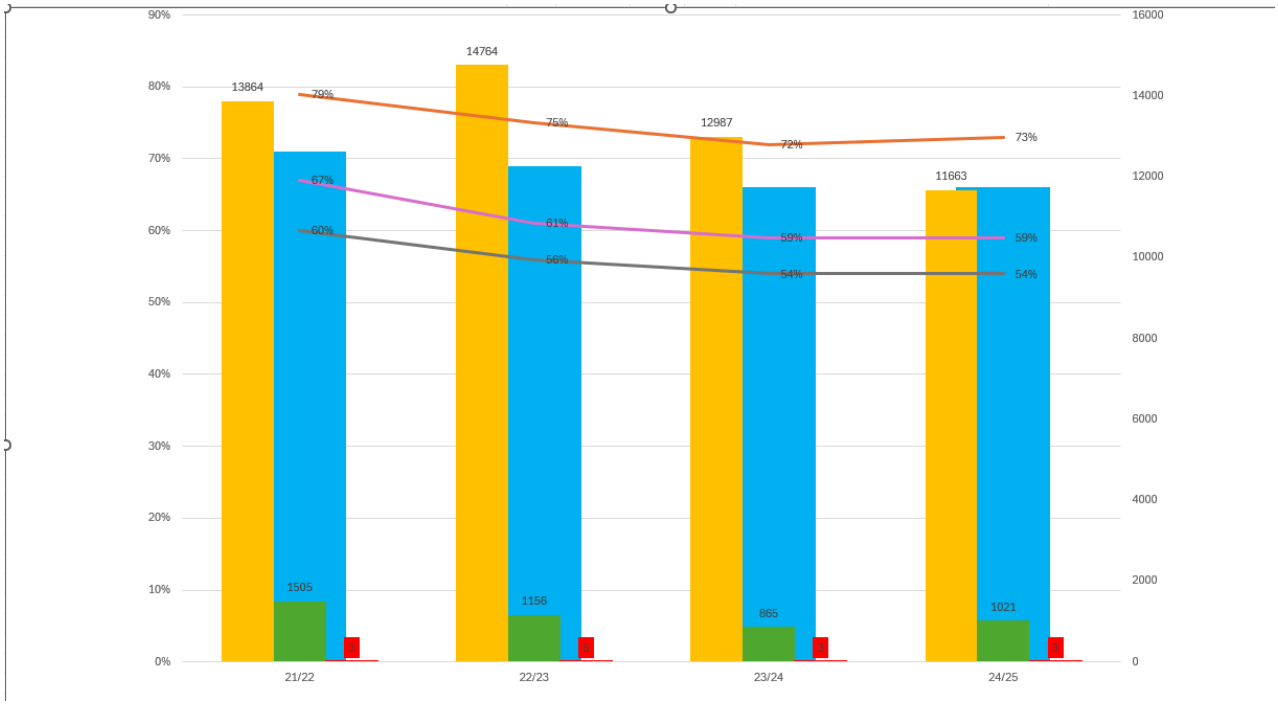
- Freedom to Speak Up Guardian and Freedom to Speak Up Champions
  The FTSU Guardian and Champion network continues to work with different teams to embed speaking up as business as usual. Concerns are received and recorded by the FTSU

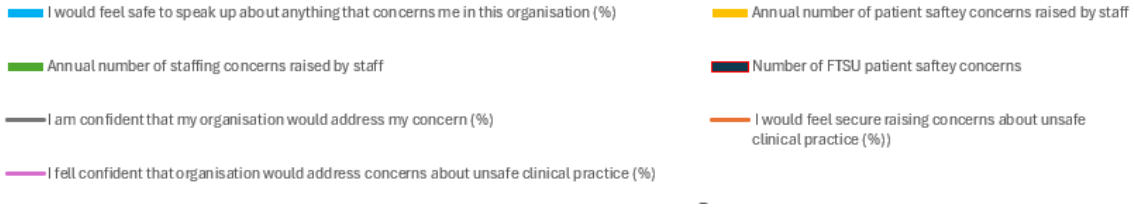
guardian. The importance of doing this is to ensure that we create a culture where patients and staff safety are at the centre of what we do.

- Staff Survey results: These are a good way of anonymously painting an overall picture of what is happening in different departments and divisions in the trust. The following questions are asked to address the speaking up culture and patient safety concerns.

  Key findings regarding patient safety and staff experiences
  a) I feel safe to speak up about anything that concerns me in this organisation (%).
  b) Feel organisation would address any concerns I raised (%).
  c) I would feel secure raising concerns about unsafe clinical practice (%).
  d) Would feel confident that organisation would address concerns about unsafe clinical practice (%)

	Year				
Data	21/22	22/23	23/24	24/25	Source
I am confident that my organisation would address my concern (%)	60%	56%	54%		Staff survey
I would feel secure raising concerns about unsafe clinical practice (%))	79%	75%	72%		Staff survey
I fell confident that organisation would address concerns about unsafe clinical practice (%)	67%	61%	59%		Staff survey
I would feel safe to speak up about anything that concerns me in this organisation (%)	71%	69%	66%		Staff survey
Annual number of patient saftey concerns raised by staff	13864	14764	12987	11663	Incident system
Annual number of staffing concerns raised by staff	1505	1156	865	1021	Incident system
Number of FTSU patient saftey concerns	3	5	3	3	FTSU Patient safety concerns





3.2 Update: Future of Freedom to Speak Up:

In July 2025, the Dash review of patient safety across the health and care landscape recommended that the responsibilities of the NG should be incorporated into providers, with functions aligned with other staff voice functions in NHS England. The review emphasised that ensuring these functions happen in all commissioners and provides should be a core function of CQC as the independent regulator.

Following the above report an engagement has been arranged setting out proposals for the future of Freedom to Speak Up (FTSU) as the National Guardian's Office prepares to close. Views were sought out with a deadline of 20th February. We now await for the proposed new arrangements that will go live in July 2026.

Key points were:

- The NGO will close by the end of June 2026 following the Dash review recommendations
- Essential FTSU functions will transfer to NHS England, the Department of Health and Social Care (DHSC), the Care Quality Commission (CQC) and providers.
- There is a commitment to maintaining the support for guardians and the FTSU agenda
- Engagement ran from January to February 2026.

3 Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the progress on the FTSU agenda.

Appendix A – FTSU CASES July 2025 – Jan 2026

Year	Qtr	Date Concern Raised	Month Raised	Department	Contact Method (Internal	Professions	Trust Board Summary
2025	Q2	03/07/2025	July	Division C	Internal	Allied Health professionals	Bullying and Harassment
2025	Q2	03/07/2025	July	Division A	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q2	16/07/2025	July	Division A	Internal	Unknown	Team Dynamics
2025	Q2	23/07/2025	July	Trust HQ	Internal	Administrative and clerical	Bullying and Harassment
2025	Q2	24/07/2025	July	Division B	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q2	24/07/2025	July	Division D	Internal	Medical and Dental	HR issue or process concerns
2025	Q2	24/07/2025	July	Division C	Internal	Unknown	Discrimination / Unfair Treatment
2025	Q2	31/07/2025	July	Division A	Internal	Unknown	HR issue or process concerns
2025	Q2	04/08/2025	August	Division A	Internal	Unknown	Team Dynamics
2025	Q2	04/08/2025	August	Division D	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q2	21/08/2025	August	Division D	Internal	Administrative and clerical	HR issue or process concerns
2025	Q2	26/08/2025	August	Division B	Internal	Administrative and clerical	HR issue or process concerns
2025	Q2	07/09/2025	September	Division A	Internal	Registered Nurses and Midwives	HR issue or process concerns
2025	Q2	11/09/2025	September	Division B	Internal	Registered Nurses and Midwives	Recruitment Concerns
2025	Q2	16/09/2025	September	Division C	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q2	17/09/2025	September	External	external	Healthcare Assistants	other
2025	Q2	22/09/2025	September	Trust HQ	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q2	25/09/2025	September	Division C	Internal	Healthcare Assistants	Bullying and Harassment
2025	Q2	25/09/2025	September	Division A	Internal	Registered Nurses and Midwives	Team Dynamics
2025	Q2	25/09/2025	September	Trust HQ	Internal	Registered Nurses and Midwives	Recruitment Concerns
2025	Q2	25/09/2025	September	Division B	Internal	Registered Nurses and Midwives	Discrimination / Unfair Treatment
2025	Q2	29/09/2025	September	Division A	Internal	Registered Nurses and Midwives	Patient Safety
2025	Q3	03/10/2025	October	Trust HQ	Internal	Administrative and clerical	Bullying and Harassment
2025	Q3	03/10/2025	October	Division A	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q3	03/10/2025	October	Division A	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q3	09/10/2025	October	Division A	internal	Registered Nurses and Midwives	Patient Safety
2025	Q3	12/10/2025	October	Division A	internal	Healthcare Assistants	Discrimination / Unfair Treatment
2025	Q3	14/10/2025	October	Division C	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2025	Q3	16/10/2025	October	Division B	Internal	Registered Nurses and Midwives	Team Dynamics
2025	Q3	17/10/2025	October	Division A	Internal	Registered Nurses and Midwives	HR issue or process concerns
2025	Q3	17/10/2025	October	Division B	Internal	Registered Nurses and Midwives	HR issue or process concerns
2025	Q3	23/10/2025	October	Division B	Internal	Registered Nurses and Midwives	Discrimination / Unfair Treatment
2025	Q3	30/10/2025	October	Division B	Internal	Medical and Dental	HR issue or process concerns
2025	Q3	31/10/2025	October	Division A	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q3	07/11/2025	November	Division A	Internal	Registered Nurses and Midwives	Bullying and Harassment
2025	Q3	07/11/2025	November	Division B	Internal	Administrative and clerical	Team Dynamics

Year	Qtr	Date Concern Raised	Month Raised	Department	Contact Method (Internal	Professions	Trust Board Summary
2025	Q3	07/11/2025	November	Division B	Internal	Administrative and clerical	Team Dynamics
2025	Q3	12/11/2025	November	Division A	Internal	Registered Nurses and Midwives	Patient Safety
2025	Q3	19/11/2025	November	Division C	Internal	Allied Health professionals	Team Dynamics
2025	Q3	28/11/2025	November	Division B	Internal	Healthcare Assistants	Discrimination / Unfair Treatment
2025	Q3	01/12/2025	December	Division B	internal	Medical and Dental	Team Dynamics
2025	Q3	01/12/2025	December	Division A	Internal	Medical and Dental	Discrimination / Unfair Treatment
2025	Q3	04/12/2025	December	Division C	Internal	Registered Nurses and Midwives	Other
2025	Q3	05/12/2025	December	Trust HQ	Internal	Unknown	other
2025	Q3	05/12/2025	December	Trust HQ	Internal	Administrative and clerical	Discrimination / Unfair Treatment
2025	Q3	10/12/2025	December	Division C	Internal	Registered Nurses and Midwives	Team Dynamics
2025	Q3	15/12/2025	December	Division A	Internal	Registered Nurses and Midwives	Team Dynamics
2025	Q3	16/12/2025	December	Division B	Internal	Healthcare Assistants	HR issue or process concerns
2025	Q3	17/12/2025	December	Trust HQ	Internal	Administrative and clerical	HR issue or process concerns
2025	Q3	18/12/2025	December	Division B	Internal	Administrative and clerical	HR issue or process concerns
2025	Q3	24/12/2025	December	Division A	internal	Healthcare Assistants	Bullying and Harassment
2025	Q3	29/12/2025	December	Division A	Internal	Registered Nurses and Midwives	Discrimination / Unfair Treatment
2026	Q4	08/01/2026	January	Division C	Internal	Registered Nurses and Midwives	Bullying and Harassment
2026	Q4	13/01/2026	January	Division A	Internal	Allied Health professionals	Discrimination / Unfair Treatment
2026	Q4	20/01/2026	January	Division C	Internal	Allied Health professionals	HR issue or process concerns
2026	Q4	26/01/2026	January	Division A	Internal	Allied Health professionals	Patient Safety
2026	Q4	26/01/2026	January	Trust HQ	Internal	Other	HR issue or process concerns
2026	Q4	28/01/2026	January	Division A	Internal	Registered Nurses and	HR issue or process concerns
2026	Q4	29/01/2026	January	Division A	Internal	Medical and Dental	Other
2026	Q4	29/01/2026	January	Division A	Internal	Healthcare Assistants	HR issue or process concerns
2026	Q4	30/01/2026	January	Division B	Internal	Registered Nurses and Midwives	HR issue or process concerns

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.12	Report to the Trust Board of Directors, 10 March 2026
Title:	Guardian of Safe Working Hours Quarterly Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Dr Diana Hulbert, Guardian of Safe Working Hours

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

The current fill rate for Resident Doctor posts at UHS is 93.14%.
The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing seen in all NHS trusts.
The Exception Reporting system illustrates the self-reported hours worked above those contracted and details missed breaks, missed educational opportunities and work patterns which suggest an immediate safety concern.
Following the implementation of the national changes to the Exception Reporting system in February 2026, we are adjusting to a new way of working and we shall be monitoring any changes in the pattern of Exception Reports.
NHS England has issued a Ten Point Plan to improve the working lives of Resident Doctors, and we are working to achieve the outcomes required at both local and regional levels.

Contents:

Risk(s):

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

Equality Impact Consideration:	N/A

Quarterly Report - Guardian of Safe Working Hours

Employment and Rotas

In February 2026, the vacancy rate for resident and locally employed doctor posts across the Trust is 6.86%. This is a clear improvement from a figure of 9.2% in November 2023. Recruitment continues for current approved vacancies, and Medical HR continues to work with departments to plan future gaps. (Appendix 1)

The present financial situation of the NHS remains a cause for concern; there is a recruitment freeze which will inevitably impact both directly and indirectly on the Resident Doctor workforce. The impact of staff sickness continues to be significant, particularly with flu, covid and norovirus cases, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on Residents' work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some Residents.

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

UHS continues to take clear steps to keep the Resident Doctors regularly informed of the situation and Executive members regularly attend the Resident Doctors Executive Forum to discuss the situation with the Residents and take questions; the Residents value these interactions very highly and excellent feedback is received.

Medical Locum Bank

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

At present there are only the premia agreed rates in place for Specialist Registrars in Emergency Medicine and Obstetrics and Gynecology. This is under regular review.

(Appendix 2 Locum Data)

Workforce Evolution

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

Exception reporting

Engagement with the exception reporting (ER) system remains variable and, whilst it has highlighted some areas that need to review, it is unlikely that this system reflects the situation with full accuracy. A better understanding of most of the areas of concern comes from direct discussion with the clinical teams. However, the ER system does allow us to see comparative data and trends.

NHS Employers and the BMA have issued changes to the ER system which came into force on 4th February 2026. (Appendix 3)

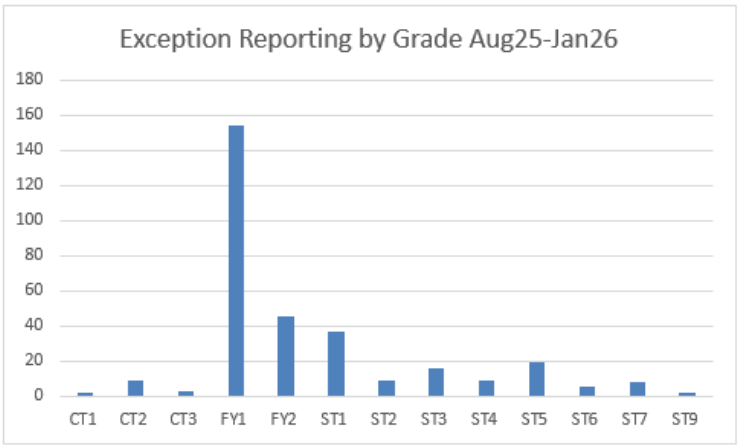
We have confidence that Becci Mannion and her team have set up an effective system which will meet the terms and conditions of service in England.

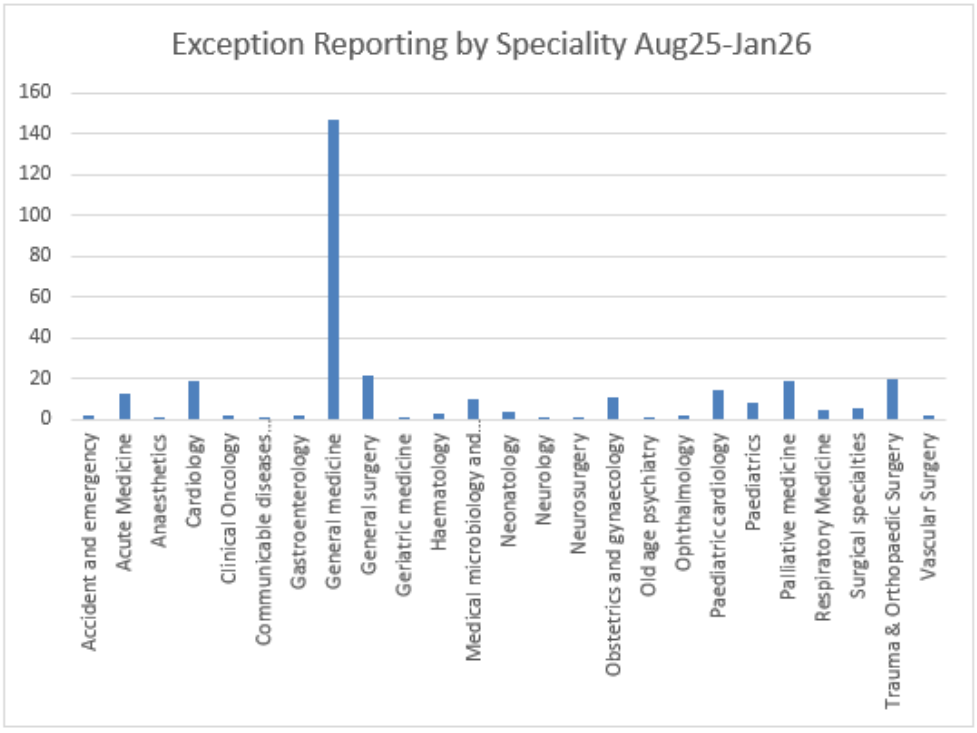
On average there were 62 Exception Reports (ERs) per month from August 2024 to July 2025; between August 2025 and January 2026 this figure was 58.

Since the implementation of the reform to date, there have been 89 exception reports submitted, and 4 were identified as 13hr breaches for which the departments have received a fine.

It is too early to know if this is a trend, but two aspects of the new system may be changing behaviour and practice: the confidential nature of the process and the ease of reporting ERs of less than two hours.

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





The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment for the additional hours worked. This may change with the reform being implemented.

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

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

UHS has always encouraged the use of the exception reporting mechanism to raise concerns when SDT has been missed on at least 25% of occasions over a 12-week period. This allows us to review and adjust rotas accordingly. The new changes to the system have formalised this process and these ERs go to the DME in addition to me and MW

From August 2024 to July 2025, we received 19 exception reports (1.6 per month) stating missed SDT. From August 2025 to January 2026, we received 17 (2.8 per month) and in February 2026 we received 6 in total.

Again, it is too early to draw any conclusion from these figures

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

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

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

I am delighted that UHS continues to support the Chief Resident role which is invaluable for Resident engagement and representation and to give our work perspective and credibility.
Dr Genevieve Southgate, a senior doctor in training in paediatric palliative care, is the present Chief Resident.
Genevieve is working on several projects during her year in post; these include the continuation of the project to provide a management teaching programme for the Registrars at UHS and an ongoing review of non-clinical space with a view to potential improvements. In addition, Genevieve has also been instrumental in the management of the 10 Point Plan at UHS and she is the named Resident Doctor Peer Lead in the working group.
Genevieve has been in post while the current Chief Resident, Guendalina Bonnifacio has been on maternity leave. I am delighted that UHS and the Deanery have agreed that Genevieve is able to stay until her CST date in July to provide continuity. Genevieve and Gwendalina will thus overlap during this rather intense period of change and reform in the working lives of resident doctors.

The planning has started for the next Doctors Awards Ceremony which will be held on 7th May 2026.

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

Industrial Action

There have now been 13 strike periods since the dispute between the residents and the government which began in March 2023. The recent talks centered on pay, pay erosion and job shortages.

UHS will ensure that there are appropriate communications to all parties around the strike periods and emphasise that residents are supported to take the actions they choose.

NHS England 10 Point Plan to Improve Resident Doctors' working Lives

In April 2024 NHS E sent a paper to all NHS Trusts outlining a plan to improve the working lives of Junior Doctors (now Residents)

All Trusts were required to rate their performance in three domains:

1) Increased choice and flexibility
2) Reduction of duplicative inductions and pay errors
3) Creating a sense of value and belonging for our doctors

We ensured wide representation in a working group which includes the Chief Resident and an F1 representative to ensure that we made progress in all three domains.
The area that required improvement was provision of non-clinical facilities, which has long been a area of concern for us.

In August, following this paper and resultant bench-marking exercise, NHS E issued the Ten Point Plan to improve Resident Doctors' working Lives. (Appendix 4)

This plan sets out clear expectations and has a short time frame; there is a 12-week delivery window for the initial actions (approximately mid-November) and there will be further actions required in the following weeks and into 2026.

The 10 Priority Areas are:

- Working environment and wellbeing
- Work schedules and rota information
- Annual leave
- Appointment of two leaders - one senior and one peer
- Statutory and Mandatory Training
- Exception Reporting
- Reimbursement of course-related expenses
- The impact of rotations on residents' lives
- The impact of changing employers when rotating

Following an initial benchmarking document there are actions for both Trusts and NHS E pertaining to each of these "deliverables"
We have re-convened the Improving Resident Doctors' Lives group and set up a programme of work to ensure that we meet the expectations of the directives we receive.
At present our rating is 91% and this will be measured and recalibrated regularly going forward.
In addition, I am part of a Southeast workstream which holds regular webinars and meetings to ensure that all the actions are completed.

This work is clearly a significant priority for NHSE and we aim to meet all the necessary requirements.

The Ten Point Plan seeks to address many of the issues we have discussed for the past three years; we have been cognisant for some time that there are unique challenges for Residents in 2025 which are very different from those which beset previous tranches of medical graduates. These challenges exist in the wider context of social change, financial complexity and an unstable international landscape.
Although true for all professional groups at UHS we have a specific opportunity to improve the working lives of our residents who will be the Consultant workforce of the future and we should grasp this moment.

I owe great thanks to Genevieve who is a highly effective, hard-working and compassionate Chief Resident and look forward to welcoming Gwendalina back when she does her KIT days this month.

A big thank you to the Executive team (particularly Paul and Steve) who continue to positively engage with the challenges facing these doctors and who remain consistently supportive in these complex times. The recent fire at UHS was an event of huge significance for so many UHS staff and Genevieve and I were very moved by David's eloquent words at a meeting held to offer support for the Resident doctors involved.

I would like to conclude by offering huge thanks to the Becci Mannion, Lynne Stassen and their team who work so hard to provide rotas, detailed support and in-depth knowledge, which is so effective for the Residents, and therefore crucial for all members of the multidisciplinary teams and the patients at UHS.
Following the ER reforms Becci and Lynne have taken on significant extra, complicated and time-critical work; they have done this entirely professionally and completely effectively. This has allowed UHS to make a smooth transition into a new way of working. We are very grateful for all their excellence.

Appendix 1 - Vacancy data

Division	Care Group	Cost centre	Aug-25	Fill rate as of 3/9/25	Fill rate as of 3/10/25	Fill rate as of 3/11/25	Fill rate as of 3/12/25	Fill rate as of 03/01/2026	Fill rate as of 03/02/2026	Fill rate as of Mar26
A	Critical Care	Anaesthetics	95.38%	96.92%	96.92%	92.31%	93.85%	89.23%	93.85%	93.85%
A	Critical Care	CICU	100.00%	90.91%	100%	100%	100%	81.82%	90.91%	100%
A	Critical Care	GICU	86.27%	90.20%	90.20%	92.16%	88.24%	86.27%	97.83%	97.83%
A	Critical Care	NICU	100.00%	100%	100%	100%	100%	100%	90.91	90.91%
A	Critical Care	SHDU	90.00%	90.00%	90.00%	90.00%	100.00%	90.00%	90.00%	90.00%
A	Surgery	ENT	100.00%	93.75%	100%	100%	100%	100%	100%	100%
A	Surgery	General Surgery	100.00%	98.04%	98.04%	94.12%	94.12%	94.12%	96.08%	98.04%
A	Surgery	OMFS	80.00%	100%	100%	100%	100%	100%	100%	100%
A	Surgery	Urology	100.00%	92.31%	100%	100%	100%	100%	100%	100%
A	CV&T	Cardiology	94.74%	94.74%	94.74%	94.74%	89.47%	92.11%	97.37%	97.37%
A	CV&T	Cardiothoracic Surgery	100.00%	100.00%	97.14%	100.00%	94.29%	94.29%	97.14%	97.14%
A	CV&T	Vascular Surgery	91.67%	91.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
A	Neurosciences	Neurology	86.96%	91.30%	91.30%	95.65%	95.65%	95.65%	100.00%	100.00%
A	Neurosciences	Neurophysiology	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
A	Neurosciences	Neurosurgery	100.00%	100.00%	100.00%	100.00%	95.83%	100.00%	95.83%	91.67%
A	Neurosciences	Stroke	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
A	T&O	Spinal Surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
A	T&O	T&O	96.49%	96.49%	96.49%	96.49%	91.23%	91.23%	96.49%	98.25%
B	Ophthalmology	Ophthalmology	85.71%	82.14%	82.14%	82.14%	82.14%	82.14%	82.14%	82.14%
B	Cancer Care	Clinical Oncology	100.00%	100.00%	94.74%	94.74%	94.74%	94.74%	94.74%	94.74%
B	Cancer Care	Haematology	100.00%	91.67%	91.67%	95.83%	83.33%	83.33%	87.50%	87.50%
B	Cancer Care	Medical Oncology	85.00%	90.00%	85.00%	95.00%	80.00%	85.00%	85.00%	95.00%
B	Cancer Care	Palliative Care	88.89%	88.89%	88.89%	88.89%	88.89%	88.89%	88.89%	77.78%
B	Cancer Care	Acute Oncology	33.33%	33.33%	33.33%	66.67%	100%	100%	100%	100.00%
B	Emergency	Acute Med	100.00%	100.00%	100.00%	100.00%	100%	100%	100%	95.65%
B	Emergency	Acute Med OOH	100.00%	100.00%	100.00%	100.00%	100%	100%	100%	100.00%

B	Emergency	ED	97.14%	97.14%	95.71%	97.14%	91.43%	91.43%	91.43%	90.00%
B	Emergency	PHEM	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.87%
B	MOP	MOP	50.00%	96.55%	100.00%	100.00%	100.00%	100.00%	100.00%	93.55%
B	Specialist Med	Allergy/Respiratory	100.00%	75.00%	75.00%	75.00%	75.00%	75.00%	100.00%	75.00%
B	Specialist Med	Clinical Genetics	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
B	Specialist Med	Dermatology	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	75.00%
B	Specialist Med	Endo/Diabetes	93.75%	100.00%	100.00%	100.00%	93.33%	93.33%	93.33%	100.00%
B	Specialist Med	General Medicine	100.00%	93.75%	93.75%	96.88%	96.88%	93.75%	96.88%	93.75%
B	Specialist Med	GI Renal	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
B	Specialist Med	Rheumatology	92.98%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
C	Pathology	Chemical Pathology	75.00%	66.67%	66.67%	75.00%	75.00%	75.00%	66.67%	75.00%
C	Pathology	Microbiology	96.55%	100.00%	100.00%	100.00%	92.31%	92.31%	92.31%	84.62%
C	Pathology	Histopathology	100.00%	98.25%	96.49%	96.55%	96.55%	96.55%	91.38%	93.10%
C	Child Health	Paediatric Cardiology	0.00%	100%	100%	100%	100%	100%	100%	100%
C	Child Health	Paediatrics	100.00%	100.00%	100.00%	87.50%	87.50%	90.00%	80.00%	70.00%
C	Child Health	Paeds ED	100.00%	88.89%	94.44%	100.00%	100%	100.00%	100.00%	94.44%
C	Child Health	PICU	82.14%	82.14%	96.43%	96.88%	96.88%	96.88%	90.63%	93.75%
C	W&N	Neonates	94.44%	94.44%	94.44%	91.67%	97.22%	100.00%	97.22%	97.22%
C	W&N	O&G	100.00%	100.00%	100.00%	100.00%	100%	100.00%	100.00%	100.00%
		Total	94.61%	94.61%	95.13%	95.58%	93.85%	93.45%	94.65%	94.27%

Appendix 2 - Locum data

Count of Unit	Column Labels		
Row Labels	Unfilled	Filled	Grand Total
CAN Clin Onc Med Staff	**16**	**9**	**25**
2025	**16**	**7**	**23**
Aug	5		5
Oct	1		1
Nov	3	5	8
Dec	7	2	9
2026		**2**	**2**
Jan		2	2
CAN Haem Onc Medical Staff	**41**	**164**	**205**
2025	**31**	**143**	**174**
Aug	1	27	28
Sep	10	13	23
Oct	1	44	45
Nov	2	39	41
Dec	17	20	37
2026	**10**	**21**	**31**
Jan	10	21	31
CAN Haematology Medical Staff	**17**	**19**	**36**
2025	**17**	**19**	**36**
Aug	6	13	19
Oct	1	2	3
Dec	10	4	14
CAN Medical Oncology Medical Staff	**9**	**30**	**39**
2025	**7**	**27**	**34**
Aug		6	6
Sep	3	5	8
Oct	4	5	9
Nov		6	6
Dec		5	5
2026	**2**	**3**	**5**
Jan	2	3	5
CAN Palliative Care Medical Staff	**8**	**11**	**19**
2025	**7**	**11**	**18**
Aug	1	3	4
Oct	2	7	9
Nov		1	1
Dec	4		4
2026	**1**		**1**
Jan	1		1
CAR Med Staff Vascular	**30**	**46**	**76**
2025	**26**	**44**	**70**
Aug		2	2
Oct	16	17	33
Nov	9	17	26

Dec	1	8	9
2026	**4**	**2**	**6**
Jan	4	2	6
CAR Medical Staff Cardiac Surgery	**167**	**290**	**457**
2025	**108**	**221**	**329**
Aug	6	24	30
Sep	14	33	47
Oct	23	53	76
Nov	18	48	66
Dec	47	63	110
2026	**59**	**69**	**128**
Jan	59	69	128
CAR Medical Staff Cardiology	**86**	**172**	**258**
2025	**72**	**127**	**199**
Aug	25	14	39
Sep	8	8	16
Oct	6	17	23
Nov	5	39	44
Dec	28	49	77
2026	**14**	**45**	**59**
Jan	14	45	59
CC CICU Medical Staff	**19**	**188**	**207**
2025	**15**	**162**	**177**
Aug	1	51	52
Sep	2	39	41
Oct	2	24	26
Nov	5	26	31
Dec	5	22	27
2026	**4**	**26**	**30**
Jan	4	26	30
CC GICU & SHDU Senior Medical	**1**		**1**
2025	**1**		**1**
Dec	1		1
CC GICU Medical Staff	**74**	**87**	**161**
2025	**72**	**67**	**139**
Aug	3	2	5
Sep	12	9	21
Oct	13	18	31
Nov	22	18	40
Dec	22	20	42
2026	**2**	**20**	**22**
Jan	2	20	22
CC NICU Medical Staff	**14**	**26**	**40**
2025	**10**	**23**	**33**
Aug	1	4	5
Sep		1	1
Oct		2	2
Nov	6	8	14

Dec	3	8	11
2026	**4**	**3**	**7**
Jan	4	3	7
CC SHDU Medical Staff	**3**	**38**	**41**
2025	**2**	**19**	**21**
Aug	2	12	14
Sep		2	2
Nov		3	3
Dec		2	2
2026	**1**	**19**	**20**
Jan	1	19	20
CHI CED Medical Staff Junior	**12**	**54**	**66**
2025	**12**	**51**	**63**
Aug	4	22	26
Sep	1	10	11
Oct	5	4	9
Nov	1	6	7
Dec	1	9	10
2026		**3**	**3**
Jan		3	3
CHI CED Medical Staff Senior	**2**	**46**	**48**
2025	**2**	**37**	**39**
Aug		1	1
Sep		1	1
Oct		14	14
Nov	2	12	14
Dec		9	9
2026		**9**	**9**
Jan		9	9
CHI Medical Staff Junior	**15**	**68**	**83**
2025	**13**	**54**	**67**
Aug	3	17	20
Sep	6	19	25
Oct	1	5	6
Nov	3	5	8
Dec		8	8
2026	**2**	**14**	**16**
Jan	2	14	16
CHI Medical Staff Paediatric Cardiology	**4**	**16**	**20**
2025	**4**	**13**	**17**
Aug	1	4	5
Sep	1	4	5
Oct	1	2	3
Nov	1	1	2
Dec		2	2
2026		**3**	**3**
Jan		3	3
CHI Medical Staff PICU	**11**	**9**	**20**

2025	**9**	**7**	**16**
Aug	2	1	3
Sep	6	4	10
Nov	1	2	3
2026	**2**	**2**	**4**
Jan	2	2	4
CHI Medical Staff Senior		**7**	**7**
2025		**7**	**7**
Dec		7	7
CHI Sleep Team	**1**		**1**
2025	**1**		**1**
Aug	1		1
ECM AMU Medical Staff	**41**	**144**	**185**
2025	**31**	**116**	**147**
Aug	4	23	27
Sep	5	7	12
Oct	1	15	16
Nov	4	28	32
Dec	17	43	60
2026	**10**	**28**	**38**
Jan	10	28	38
ECM ED ACPs	**2**		**2**
2025	**2**		**2**
Sep	1		1
Oct	1		1
ECM Emergency Dept Medical - Junior Doctors	**130**	**200**	**330**
2025	**104**	**151**	**255**
Aug	13	23	36
Sep	5	29	34
Oct	15	34	49
Nov	17	36	53
Dec	54	29	83
2026	**26**	**49**	**75**
Jan	26	49	75
ECM Out of Hours Medical Team	**4**	**48**	**52**
2025	**1**	**40**	**41**
Aug		10	10
Sep		6	6
Oct		5	5
Nov		10	10
Dec	1	9	10
2026	**3**	**8**	**11**
Jan	3	8	11
MED Medical Staff MOP		**3**	**3**
2025		**3**	**3**
Aug		3	3
MED Medical Ward Based	**86**	**168**	**254**
2025	**75**	**143**	**218**

Aug	12	44	56
Sep	15	13	28
Oct	7	24	31
Nov	9	30	39
Dec	32	32	64
2026	**11**	**25**	**36**
Jan	11	25	36
NEU HASU	**1**		**1**
2025	**1**		**1**
Dec	1		1
NEU Med Staff Neurology	**14**	**16**	**30**
2025	**13**	**15**	**28**
Oct	2	3	5
Nov	11	5	16
Dec		7	7
2026	**1**	**1**	**2**
Jan	1	1	2
NEU Med Staff Stroke		**2**	**2**
2025		**2**	**2**
Aug		2	2
NEU MedStaff Neurosurgery	**17**	**59**	**76**
2025	**16**	**55**	**71**
Aug		9	9
Sep	3	14	17
Oct	8	14	22
Nov	1	9	10
Dec	4	9	13
2026	**1**	**4**	**5**
Jan	1	4	5
OPH Medical Staff	**7**	**178**	**185**
2025	**5**	**151**	**156**
Aug		7	7
Sep		32	32
Oct	3	41	44
Nov		41	41
Dec	2	30	32
2026	**2**	**27**	**29**
Jan	2	27	29
RAD Wessex Registrars	**5**	**41**	**46**
2025	**4**	**35**	**39**
Aug		6	6
Sep		4	4
Oct	2	8	10
Nov		7	7
Dec	2	10	12
2026	**1**	**6**	**7**
Jan	1	6	7
RD Fellows	**1**	**6**	**7**

2025	**1**	**4**	**5**
Aug	1	4	5
2026		**2**	**2**
Jan		2	2
SME General Medicine Med Staff	**72**	**205**	**277**
2025	**72**	**158**	**230**
Aug	26	33	59
Sep	21	30	51
Oct	16	31	47
Nov	4	31	35
Dec	5	33	38
2026		**47**	**47**
Jan		47	47
SME MedStaff Dermatology	**4**	**12**	**16**
2025	**4**	**11**	**15**
Aug		1	1
Sep		1	1
Oct		3	3
Nov		3	3
Dec	4	3	7
2026		**1**	**1**
Jan		1	1
SME MedStaff GI/Renal		**1**	**1**
2025		**1**	**1**
Dec		1	1
SME MedStaff Rheumatology	**2**	**2**	**4**
2025	**2**	**2**	**4**
Aug	2	2	4
SUR Med Staff ENT	**17**	**83**	**100**
2025	**14**	**71**	**85**
Aug	6	23	29
Sep	2	9	11
Oct	1	9	10
Nov	4	14	18
Dec	1	16	17
2026	**3**	**12**	**15**
Jan	3	12	15
SUR Med Staff GI	**119**	**248**	**367**
2025	**97**	**219**	**316**
Aug	13	57	70
Sep	23	41	64
Oct	19	19	38
Nov	24	56	80
Dec	18	46	64
2026	**22**	**29**	**51**
Jan	22	29	51
SUR OMF Medics	**7**	**38**	**45**
2025	**6**	**35**	**41**

Aug		1	1
Sep	5	18	23
Oct		6	6
Nov	1	6	7
Dec		4	4
2026	**1**	**3**	**4**
Jan	1	3	4
T&O Medical Staff	**125**	**418**	**543**
2025	**80**	**334**	**414**
Aug	17	71	88
Sep	3	26	29
Oct	10	48	58
Nov	28	81	109
Dec	22	108	130
2026	**45**	**84**	**129**
Jan	45	84	129
THR Anaesthetics Medical Staff	**11**	**53**	**64**
2025	**11**	**45**	**56**
Aug	2	3	5
Sep	1	7	8
Oct	2	8	10
Nov		5	5
Dec	6	22	28
2026		**8**	**8**
Jan		8	8
W&N Med Staff Breast/Endo	**5**	**16**	**21**
2025	**1**	**9**	**10**
Aug		6	6
Sep	1	1	2
Dec		2	2
2026	**4**	**7**	**11**
Jan	4	7	11
W&N Med Staff Junior	**101**	**304**	**405**
2025	**91**	**269**	**360**
Aug	22	60	82
Sep	23	65	88
Oct	14	42	56
Nov	21	56	77
Dec	11	46	57
2026	**10**	**35**	**45**
Jan	10	35	45
W&N Neonatal Med Staff	**5**	**70**	**75**
2025	**5**	**62**	**67**
Aug	3	19	22
Sep		17	17
Oct		6	6
Nov	2	14	16
Dec		6	6

2026		**8**	**8**
Jan		8	8
Grand Total	**1306**	**3595**	**4901**

Appendix 3 - Exception Reporting Reform Update

- The Exception Reporting System (ERS) is confidential, and the Exception Reports (ERs) do not go to the Clinical Rota Leads.
- All ERs relating to missed educational opportunities will go to the director of medical education (DME) for approval.
- All ERs relating to total hours of work, difference in pattern of hours, inability to take breaks, inability to take SDT, will go to Medical Workforce (MW) for approval.
- The Guardian of Safe Working Hours (GoSWH) will retain oversight of all ERs and these will be reviewed to identify patterns to ensure reports are accurate, valid and adhere to the purpose of exception reporting.
- A three-tier system will be used to determine if hours were indeed worked.
- Residents will have their choice of time off in lieu (TOIL) or pay except when a breach of safe working hours mandates the award of TOIL.
- Employers must provide access to the ERS to Residents within 7 days of starting employment. If access is not provided there is a £250 fine per resident per week for an access and completion breach from 4/2/26 – 3/8/26 which increases to £500 from 4/8/26.
- Employers will be fined £500 per Resident for a proven information breach; these fines will be paid into a central fund which the GoSWH oversees. The resident can decide to have this paid into the local fund overseen by the GoSWH and a Residents' Representative.
- When a verified ER confirms a breach of contractual working time limits or rest requirements, a fine will be levied on the relevant division; the fines will be paid into the local fund.
- When a verified ER confirms that contractual breaks have been missed on at least 25% of occasions, a fine will be levied on the employer; the value of the fines will be paid into the local fund.
- The funds must be used to benefit the education, training and working environment of Residents and should prioritise wellbeing-focused initiatives.
- Residents will be required to submit ERs as soon as possible but not later than 28 days from the day they occurred.
- Until 4/8/26 MW have 10 calendar days from the submission of the ER to complete the investigation; from 4/8/26 this decreases to 7 calendar days.
- The GoSWH is required to oversee and conduct quarterly surveys on breaches of access and completion, information breach and actual or threatened detriment. These are to be reported on in the report to the Trust Board

Appendix 4 - 10 Point Plan Progress

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	Yes, <50%	Yes, <50%
Rest facilities	Yes, <50%	Yes
Designated on-call parking access	Yes	Yes
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes, <50%	Yes
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes	Yes
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes	Yes
Protected breaks?	Yes, <50%	Yes, >50%
Do you promote the Safe Learning Environment Charter?	Yes, <50%	Yes
Sexual safety/harassment training and awareness?	Yes, <50%	Yes

Appointing senior leads to take action on Resident Doctor issues	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	Yes	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	All
NETS survey	All	All
National Staff Survey		All
National Student Survey		Executive Team

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Plan to	Plan to
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)	Yes (internal rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	Yes	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes	Yes
Changes in payroll errors over the last 12 months?	No change	No change
Processing of course related expenses?	After attendance, plan to change	After course attendance, plan to change

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, both	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey 91% (Improvement of 7PP)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.

Agenda Item 6.1 Report to the Trust Board of Directors, 10 March 2026	
Title:	Corporate Objectives 2025-26 Quarter 3 Update
Sponsor:	David French, Chief Executive Officer
Author:	Martin de Sousa, Director of Strategy and Partnerships

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This paper provides an update regarding progress against our corporate objectives for Quarter 3 of 2025-26.

Our objectives were agreed at Trust Board in March 2025. This is the third progress report for this financial year. These updates represent progress to end of December 2025 so don't fully reflect the current position following the West Wing fire in February 2026 – this will be taken into account for the Q4 review.

A scoring summary of progress is below:

Ref	Corporate ambition	Leads	Number of Objectives for 2025/26	Q3 Green	Q3 Amber	Q3 Red
1	Outstanding patient outcomes, safety and experience	COO/CNO	4	2	2	0
2	Pioneering research and innovation	CMO	2	1	1	0
3	World class people	CPO	2	0	1	1
4	Integrated networks and collaboration	COO/CMO	1	0	1	0
5	Foundations for the future	CFO/CEO/CNO/CMO	3	0	2	1
Totals			12	3	7	2
		% against		25%	58%	17%

RAG Rating for corporate objectives updates	In Year Updates
Green	On track to be delivered in full
Amber	Minor Delays/or shortfall in target
Red	Significant delays/or shortfall in target

Contents:	
Summary of progress + Appendix 1-5: updates in full by strategic theme	
Risk(s):	
Objectives relate directly to all BAF risks.	
Equality Impact Consideration:	NO

Quarter 3 Update
The 2025/26 corporate objectives were approved by the UHS Board in March 2025. Twelve objectives were agreed, which reflected an attempt to focus priorities across our five strategic themes, whilst recognising the breadth and complexity of work that was ongoing in the Trust. Following agreement of the twelve objectives, quarterly milestones were set for each objective to measure progress against across the year, and reporting and RAG status reflects progress against these milestones. A narrative summary by strategic pillar is below, with further detail contained in the appendix.

Outstanding Patient Outcomes, Safety and Experience
There has been generally good progress against our four objectives in this pillar. Our objectives relating to Fundamentals of Care and the Quality Priorities were both green rated in terms of progress at the end of Q3. A full report will be presented to Quality Committee in March 2026 reviewing the detail of these schemes. Our transformation programmes were both amber rated at the end of Q3 – this reflects the fact that delivery of tasks within each programme has been successful but there remains further effort required to meet the metrics set for each programme.

Pioneering Research and Innovation
Progress with Year 2 of our five-year Research for Impact Strategy has been consistent and we remained on track at the end of Q3 with this objective. The main risk to progress in this pillar relates to the future of the Research Leaders' Programme which is awaiting a further decision on direction following discussion at Trust Board Study Session in December 2025.

World Class People
Delivery of our workforce plan remains red rated as we remained significantly above our workforce plan at the end of Q3. Work is ongoing to improve this position but also balance the need for targeted activity increases to meet performance targets and ensure correct workforce trajectory for 26/27. Staff experience work is ongoing through resource available - we are awaiting public release of annual staff survey results, although anticipating a deterioration in a number of key measures from previous years.

Integrated Networks and Collaboration
The objective for this area is amber rated at the end of Q3. Whilst there has been progress in some network discussions and agreement of our ICS acute clinical strategy we still recognise the need to make further progress as part of our overall strategy, particularly in terms of developing out-of-hospital pathways and making progress to reduce NCTR numbers with partners.

Foundations for the Future
Our financial position remains very challenged and subject to close Trust Board oversight. This objective remains red rated overall. We continue to make progress on the other objectives under this strategic pillar such as development of a Private Patient Unit, and an elective hub at Royal South Hants. Oversight of these objectives alongside other long-term strategic priorities is being reviewed as part of development of our 2026/27 corporate objectives, linked to the refresh of our overall Trust Strategy.

Summary
The Board is asked to note the overall position for delivering our objectives. The areas of challenge remain subject to specific recovery actions and external scrutiny, particularly the red-rated schemes relating to workforce and financial targets. The position reflected here at the end of Q3 is likely to change significantly in some areas following the West Wing fire in February 2026. The impact of this will be reflected more fully in the Q4/end of year update for our objectives. Work is also ongoing on the transition from our 25/26 to our 26/27 objectives which focus on recovery from the fire as well as a refreshed Trust Strategy, which will be subject to further consideration and discussion at Trust Board.

Appendix 1: Objectives Update

Outstanding Patient Outcomes, Safety and Experience

Ref	Lead	Objective	Q3 Milestone	Q3 Update
1(a)	CNO	Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme.	Evaluation of the deconditioning project including What Matters To Me and proposals for potential further roll put if KPIs demonstrate tangible patient experience improvements as well as effective 'cost' savings in 'time to care' and length of stay. The intention of this objective and project would be to support the 5% workforce reductions in clinical teams and maintain quality care	The Geriatric Rehabilitation and Care Enhancement (GRACE) was evaluated and the learning has been shared at a local and regional level. The project does support flow of patients to their discharge destination in a timely way but this intervention was not sustainable within the present therapy staffing model. Quality of documentation on inpatient noting remains a priority - A new working group is being set up and will be led by Grace McCutcheon (Ward Manager on F11), including clinical staff representation across the organisation to set clear standards and expectations of nursing team documentation within the body maps and daily assessment tools specifically. - We continue to monitor the quality of completion through matron's walkabout and clinical digital education team audits. Educational opportunities remain a priority and although no further formal training sessions have taken place in the last quarter, 1 day is planned for Q4 of 2025/26 and another has been postponed to Q2 2026/27 due to the major incident. - 58 members of staff have signed up either to a Learning Disability and Autism focussed day (Applying the FoC in practice) or the Fundamentals of Care Champion programme. - This includes staff from across the organisation in different roles and areas. - We aim to improve the day-to-day embedding of the FoC into practice through the network of champions - In the last two quarters, preceptees have received an enhanced level of FoC training, applying it to their multi-professional backgrounds and utilising simulated participants to achieve a more practical demonstration of the FoC in practice. This has been well received and several educators across the trust are being upskilled to deliver the training to each preceptee cohort. Overall: **Green**

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
1(b)	CNO	Deliver the quality priorities for 25/26. **1)Experience of Care** **2)Improving the care of the dying patient and those important to them** **3)Fundamentals of Care:** See above **4)Acuity and deteriorating patients:** **5)NATSSIPs Implementation** **6)Health Inequalities**	The following quality priorities are being implemented as per the oversight of the Quality Committee. 1)Experience of Care 2)Improving the care of the dying patient and those important to them 3)Fundamentals of Care: See above 4)Acuity and deteriorating patients: 5)NATSSIPs Implementation 6)Health Inequalities	**Green:** All quality priorities are on track and a final report is being prepared for Quality Committee and TEC for presentation in March 2026 (quarter 4).

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
1(c)	COO	Deliver the objectives of the elective programme, including achievement of national targets for RTT improvement.	- Elective front door platform procurement and phase 1 deployment planned - Clinic template standardisation underway in target specialties - DNA Reduction through six week partial booking - Reduction in referral demand through improved OOA management and referral triage processes using A&G - Pre-Assessment working group established with plan to standardise booking and treatment practices	**Amber:** eRS API being developed to integrate with eGrading instead of Elective Front door business case to enable greater A&G - Clinic templates being reviewed in multiple specialties with roll out plan continuing into 26/27 - Partial booking roll out progressing with completion expected by March 26' - GIRFT report in theatres has initiated new workstreams including external support for Pre-Assessment pathway. Work underway on automatic e-TCI referral into pre-assessment

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
1(d)	COO	Deliver the objectives of the UEC programme, including achievement of national target for ED performance improvement.	- Initiate phase 1 of the OPAT service - H&IOW discharge standards implemented - Implementation of place-based discharge plan	Amber: - Phase 1 of OPAT initiated in October with 15 patients on service (n.b. increased to 30+ in response to fire) - Diagnostic work undertaken by NEXUS consultancy to understand drivers of complex discharge performance and compliance with H&IOW discharge standards - P0 and P1 review process undertaken with the site office team to improve NCTR and discharge - Resources in place from all system partners to support S&SWH Complex Discharge group to deliver the place based plan

Pioneering Research and Innovation

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
2(a)	CMO	Deliver Year 5 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.	Panel outcome for RLP Cohort 6 - dependent upon securing budget for RLP in 26/27. Prepare and disseminate RLP evaluation report. Hold second annual SETT conference. Review ATIMP specialty increase. Develop joint UHS/UoS MedTech advisory group.	No panel has been convened for RLP cohort 6. Following the Trust Board study session in December, once a way forward for the RLP has been agreed, a call will follow. RLP evaluation report in progress. SETT conference successfully held in Q3 with good feedback from attendees. ATIMP specialties increasing with studies opening and in set up in additional specialties including ophthalmology. Development of joint MedTech advisory group is in progress with conversations underway to map regulatory expertise across the research landscape. Overall progress: **Amber**
Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
2(b)	CMO	Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.	Use new updated corporate framework to include consensus statement (published in Q3). Continued delivery of a senior leaders programme Deliver PI offering and project INSPIRE.	Corporate strategy remains in development. Senior Leaders programme continued, due to finish in Q4. PI Offering in development, due for presentation at RDSG in Q4 with project INSPIRE then to be launched. Overall progress: Green

World Class People

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
3(a)	CPO	Deliver a workforce plan for UHS for 2025/26 which meets the national planning requirements and is safe, sustainable, and affordable.	Implementation of HIOW resourcing hub. Supporting and embedding ongoing change. MARS reductions completed	Red: Total workforce fell in December by 51WTE. Trust remains above workforce plan by 234WTE YTD at the end of M9. The overall workforce has fallen by over 400 since March 25. With the focus on elective recovery in Q4 and placing ourselves in a positive position for 26/27 in line the NHSE medium term plan, some discrete targeted recruitment and resourcing is taking place. This will result in an increase in substantive starters during the later part of Q4 as UHS increase resource linked to elective activity. It also includes some discrete replacement of administrative and clerical staff in clinical areas focused on elective management. Medical job planning work ongoing, job plans signed off increased to 63% at end of Month 9. Sickness absence has risen during Q3 linked to seasonal trends placing additional pressure on workforce and temporary staffing. Flu campaign has gone well with UHS reaching 60% of staff vaccinated. UHS benchmarks well against other organisations. All MARS exits have now taken place in line with plan. HIOW resourcing hub project on hold due to viability of business case, being reconsidered as part of wider collaborative corporate service work

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
3(b)	CPO	Deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy.	Implementation of annual staff survey Implement cohort 2 of Senior Leadership Development Programme (revised content) Consultant Engagement	**Amber:** The national staff survey results remain under external embargo and are expected to be published in March. Full data is not yet available, however key details the Trust has been provided to date will be circulated to Divisional leaders. It is clear that the Trust results have deteriorated as was expected as a result of the many difficult decisions the trust has faced linked to its financial deficit. Planning and responding to this to take place in Q4. Senior leadership development programme remains on hold due to financial constraints We Are UHS week did take place during Q3, albeit scaled down. It was a good opportunity to connect with our people. We Are UHS voices has continued during Q3 with execs and senior leaders visiting departments and teams to connect about the key issues Progress on the resident doctors 10 point national plan has continued with good progress at UHS working with the Chief Resident and Guardian of safe working hours.

Integrated Networks and Collaboration

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
4(a)	CMO	Develop network relationships within our Integrated Care System, including progression of shared services work with partners.	• Support development of the ICS acute provider collaborative clinical strategy • Continue membership and support for the ICB acute provider collaborative board • Approve financial, operational and governance model for upper GI, breast DIEPs • Develop Pelvic floor full business case- provider review • Develop and deliver on collaboration plan with HHFT	ICS Acute Provider clinical strategy signed off at UHS Trust Board. Work ongoing in network groups on priority pathways. UGI work on hold awaiting further decisions from ICB and NHSE on next steps. Work with HHFT limited to specific pathway discussions (e.g. maxfax). Pelvic Floor case drafted, with pilot area identified (Gosport) and agreement in principle from partners. Awaiting sign off from ICB regarding funding for pilot. The ICB and councils have jointly funded a project team to focus on the process for discharge into the community, we have been collaborating with them on this with the aim of reducing NCTR. Overall: **Amber**

Foundations for the Future

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
5(a)	CFO	Deliver the financial plan for 25/26, supported by delivery of schemes within the Improving Value programme.	Target less than 10% of savings in opportunity phase or unidentified. Delivery of Q1-Q3 Savings Target = £72m Delivery of I&E Plan = £16.6m deficit YTD	**Red:** Trust is at £45.6m deficit YTD at the end of M9. UHS continues to deliver significant levels of financial savings, £10.3m has been achieved in M9 and £68.9m YTD. This is however £3.6m behind plan. Transformation programmes centred around patient flow, theatre optimisation and outpatients remain core to this. Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, non-criteria to reside patient volumes increasing, length of stay improvements not being sustained and inpatient mental health patient costs remaining high.

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
5(b)	CFO	Deliver the prioritised 2025/26 capital programme and set a prioritised capital plan for 2026/27, as well as setting aspirations for future year programmes.	Commence the capital prioritisation process for 2026/27 and beyond. Continue monitoring of 2025/26 capital plan including management of risks and mitigations via TIG with escalations to Trust Board where necessary.	**Amber:** Capital prioritisation process underway, with plan for sign off in Q4. Close monitoring remains for delivery of 25/26 capital schemes with review for schemes that will slip into 26/27 to ensure that spillage is clearly reflected in next year's capital plan. Despite limited remaining flexibility, the Trust continues to ensure: • Weekly scheme-level review of spend and approvals. • Close working with Estates to identify any acceleration opportunities. • Joint reviews with Digital team to confirm mitigation assumptions. • Review of capitalisation opportunities, including assessment of revenue expenditure against ccounting criteria.

Ref	Lead	Objective	Q3 Milestone	Q3 Milestone
5(c)	CNO	Progress key strategic objectives for this year, to include: a. Elective centre for UHS at RSH b. Progress towards onsite PPU c. Refresh for UHS strategy	a. Approved Business case / business plan for transitional period 26/27	**Amber:** RSH theatres Investment case developed for NHSE with initial priority specialties identified. Challenges around property negotiation between UHS, NHSPS and current provider being factored in to planning for start date. Currently aiming to mobilise for Q2 26/27.
			b. Release ITT documentation to successful Bidder early November 2025, Bidders submit first draft of proposal Dec 2025.	b. ITT release Jan 26, (Stage 2) Bidder Dialogue Sessions to complete Feb 26. Initial bid submissions received. Review of submission has started. Stage 3 dialogue and negotiations due to commence.
			c.Launch of new strategy	Strategic objectives discussed at Trust Board Study Session in December 2025. Finalised strategy document being drafted for March 2026 Board.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.2 Report to the Trust Board of Directors, 10 March 2026	
Title:	Board Assurance Framework (BAF) Update
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Lauren Anderson, Corporate Governance & Risk Manager Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

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

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

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

Contents:

Paper
Appendix A – The full Board Assurance Framework

Risk(s):

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

Equality Impact Consideration:	N/A

1. Purpose

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

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

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

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

2. Key updates

2.1. The board last received the BAF in November 2025. Since then, all risks have been reviewed and updated by the responsible executive(s) and their senior teams.

2.2. Additionally the sub committees of Board have received and reviewed the BAF risks contained within their portfolio, as follows:

- Quality Committee 26 January 2026
- Audit & Risk Committee 27 January 2026
- Finance & Investment Committee 23 February 2026
- People & Organisational Development Committee 26 February 2026

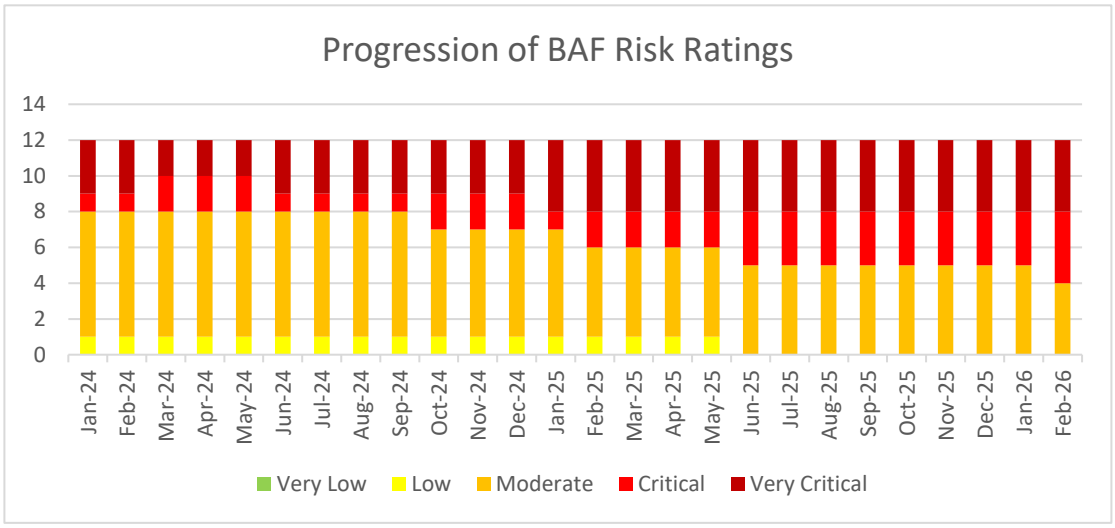
2.3. All risks have been reviewed both in the context of the standing risk we are aware of and continue to manage, but also in consideration of the recent significant fire which occurred at Southampton General Hospital on 01 February 2026, resulting in declaration of a major incident at organisation and system level. It is recognised that this introduced many operational risks, a number of which continue to be managed, and these are linked to strategic risks within the BAF including capacity, workforce and estate.

2.4. Key changes to individual strategic risks are shown within the current assurances and updates on each risk within the BAF, including updates on ongoing actions or mitigations.

2.5. The risk rating for one risk has increased. This is risk 5c – Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.

The rating of this risk has been increased from 12 (moderate x likely) to 16 (severe x likely) given the significant operational impact that may occur should this risk materialise. Key concerns which demonstrate this impact are reflected within the risk, such as the inability to digitally book patient appointments if the Trust is without a Patient Administration System (PAS) should the existing contract not be able to be renewed in 2028 and an alternate system has not been funded and secured prior to this. It is noted that the PAS is a component of the Electronic Patient Record (EPR) and there is currently no clear route to funding a new EPR at a local or national level. Further risk is associated with the aging digital infrastructure and insufficient funding to address this.

2.6. In total there are now 8 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.



2.7. Currently there are 8 risks (all critical risks) 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.

University Hospital Southampton NHS
NHS Foundation Trust

UHS Board Assurance Framework (BAF)

Updated February 2026

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

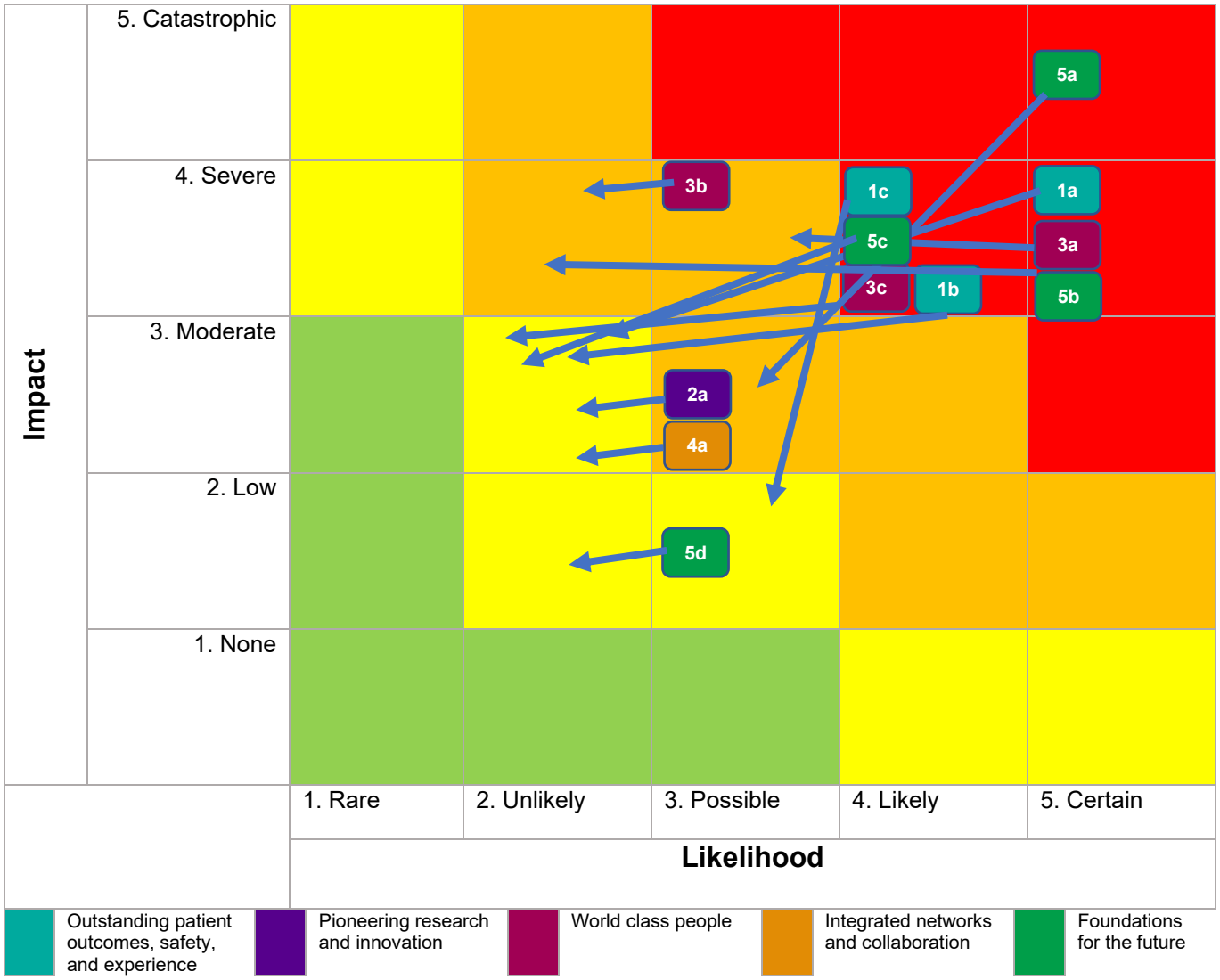
There are 8 critical strategic risks with a red risk rating above 15. These are:

- 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)
- 5c) Digital (4 x 4 = 16)

At present there are 8 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1b, 1c, 3a, 3c, 5a, 5b, and 5c. 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	February 2026	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	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 February 2026 with minor updates included to ensure the risk is current. The entry has been considered in the context of the standing risk, as well as in the context of the additional risk faced because of the recent significant fire which occurred at Southampton General Hospital 01/02/2026. The fire occurred in the endoscopy unit rendering this unusable for an ongoing prolonged period, and also affected a number of wards which had to be evacuated and remain closed reducing our bed count. This was initially reduced by 200, and around a 1/3 of these have now been brought back. In response, a major incident was declared at UHS and across the HIOW system, with a significant system wide effort made to safely manage patients and balance the reduced capacity against demand. Intensive efforts were made to discharge patients where this was safe to do so, and subsequently NCTR reduced by over 100, rebalancing the tension between available beds and need. It is however predicted that sustaining this will be a challenge and work is underway to identify lessons we can learn from how well this was managed, with the intent of informing future improvements. To facilitate this the Trust's transformation programmes for 2026/27 have been updated to include this.

Elective capacity remains a concern and contractual negotiations are underway to balance planned work and the pay envelope available for this. Meanwhile mitigations are embedded to regularly validate patients and prioritise them clinically, and additional resource is being secured for admin and clerical staff supporting these pathways. Service specific solutions are also being explored such as use of NHSP/agency and planning additional activity, although it is noted that some attempts at outsourcing have not been as successful as hoped as whilst other/private providers would require us to provide the surgeon. The intent remains to see all long waiters (over 65 weeks) by the end of the financial year.

Consistent and focussed effort also continues to manage emergency demand and previous trials in ED for an observation service and to utilise a dedicated named consultant in ambulatory care are both now embedded as business as usual. It is anticipated that the urgent treatment centre will open in June followed by the diagnostic hub in August 2026.

Key controls	Gaps in controls
Clinical Prioritisation Framework.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may

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. Winter/business planning which includes business continuity plans, such as the use of surge capacity should this risk be realised.	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 the previous 3 years has presented significant risk to the Trust's ability to meet ongoing demand on our services. This could continue into 26-27. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow. Lack of a clear capacity and demand plan to resolve cardiac capacity issues in the longer term. Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities, surgical skin services.
Key assurances	**Gaps in assurances**
Level One (Internal) Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Increase in advice & guidance referrals. **Level Two (Internal)** Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns.	Local system plans to reduce patients without a criteria to reside are emerging but will take time to evidence results.

Level Three (External) NHSE and NHS HIOW ICS supportive quality visits to ED.	

Key actions

Emergency Care

COO AH leading an ED improvement programme through 2025/26 and 2026/27 including key priority workstreams:

- Launch an acute assessment unit (AAU) – completed August 2025.
- Introduce minors appointments – completed August 2025.
- Improve CT efficiency including vetting of referrals and appropriate monitoring of scanning and reporting timeframes, with the intent of reducing scans required and reducing length of stay.
- Improve staff experience and culture, supported by the Trust's prioritisation and focus of the violence and aggression work stream.
- Implement an ED Observation Service (EDOS) – trial commenced September 2025 and is now embedded as BAU.
- Use of a dedicated named consultant in ambulatory ED to support earlier discharge of patients – trial commenced November 2025 and is now embedded as BAU.

Flow and Discharge

Deputy COO DLK is working with the wider system and leading the UHS elective and UEC transformation programmes to improve discharge and reduce NCTR through 2025/26 and 2026/27 including:

- Local NCTR delivery unit for the South West established in 2024/25 and remains underway.
- Monthly meetings between UHS, the ICB and social care directors.
- Implement and embed criteria led discharge process at UHS.
- Use of a bedded discharge lounge at UHS is underway.
- Develop a shared action plan across the system to improve mental health pathways following a 2025 workshop involving senior leadership teams from all partners, to be implemented and monitored through a monthly task and finish group.
- Joint improvement group across HIOW for mental health.

Elective Activity

COO AH to deliver on set activity targets for 2025/26:

- < 1% patients waiting over 52 weeks.
- > 72% of patients seen with 18 weeks.

Ongoing engagement in the NHSE Further Faster programme for elective care overseen by COO AH.

CMO PG leading a task and finish group through 2025/26 and 2026/27 to seek a sustainable solution for cardiac capacity including a demand and capacity plan, and supported by mutual aid.

UHS increasing capacity including use of outsourcing from Q3 2025/26.

Community Diagnostic Hub opening Q2 2026/2027 to provide additional diagnostic capacity. Previously scheduled for 2023/4 however this has been delayed following redesign and construction issues.

Urgent Treatment Centre to be opened in Summer 2026.

New theatres and MRI suites were opened in September 2025 including 5x new all day theatre lists.

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	2 x 3 = 6	3 x 2 = 6	31/10/2025
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	30/04/2026
259	Capacity and Demand in Maternity Services	4 x 4 = 16	2 x 2 = 4	31/03/2026
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 5= 20	2 x 2 = 4	31/01/2026
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 3= 12	2 x 3 = 6	30/06/2026
443	Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service.	3 x 4 = 12	3 x 2 = 6	31/10/2025
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/12/2025
671	Capacity within the melanoma and soft tissue cancer pathways.	4 x 4 = 16	3 x 2 = 6	27/02/2026
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	2 x 4 = 8	3 x 2 = 6	30/04/2026
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	31/03/2026
758	Urology stone service - including stent change delays & capacity challenges	4 x 4 = 16	3 x 2 = 6	31/03/2026
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	30/04/2026
767	HoLEP capacity issues	3 x 3 = 9	3 x 1 = 3	31/03/2026
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	31/03/2026
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	31/03/2026
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 2 = 8	30/06/2026
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2026
840	Paediatric haemodialysis capacity	4 x 4= 16	2 x 3= 6	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 2= 8	4 x 1 = 4	31/03/2026
850	Inability to effectively run the pelvic floor service due to staffing and capacity	3 x 3 = 9	2 x 2 = 4	31/05/2026
857	Prostate PIFU Capacity	4 x 3 = 12	3 x 2 = 6	31/03/2026
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
911	If there are no dedicated CAMHS facilities and insufficient CAMHS staff at Southampton's Children's Hospital, coupled with inadequate community and social support to facilitate timely discharge of children and young people with acute mental illness or behavioural disturbances, this may lead to an inability to effectively meet the needs of this patient group resulting in a poor experience, delayed care and discharge,	3 x 3 = 9	2 x 3 = 6	31/01/2026

	and harm; as well as adversely affecting the admitting and treating capacity in other paediatric specialities			
921	Ketogenic diet clinic capacity	3 x 4 = 12	2 x 2 = 4	28/02/2026
922	Increased waiting time for endocrine dynamic function tests (DFTs) could result in poor patient experience and potential patient harm to those waiting for treatment	3 x 3 =9	3 x 1 = 1	05/06/2026
937	Patients attending ASU/SDEC attend via multiple access pathways, leading to overcrowding. This has the potential for patient harm due to treatment delays, unwitnessed deterioration due to patient/staff ratio and environmental layout.	3 x 3 = 9	2 x 3 = 6	26/06/2026
972	Due to an electrical fire in our Endoscopy unit on Sunday the 1st of February 2026, we do not have provision for diagnostic and therapeutic endoscopy for patients. There is a risk of clinical harm due to delays, this may include patient restricted or reduced treatment options, impact patient outcomes and cause significant or catastrophic harm.	5 x 3 = 15	2 x 2 = 4	30/09/2026

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	February 2026	3 x 2 6	April 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	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 by the responsible executives and is agreed to remain an accurate reflection of the risk held 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. Updates on work to mitigate this are provided below:

- A review has been undertaken of our provision of Martha's Rule to consider how well it is working and if any amendments are needed. This is now being repiloted with a Specific Point Of Access who will then triage the call and direct it to the most appropriate service. Work is also underway to improve documentation, particularly in adults, and this includes trialling different documentation.
- Actions overseen by the NATSIPPS working group continue to progress well with an education day workshop recently held in Theatres and the minor procedures policy now written.
- Work continues to embed the M+M Ulysses module to ensure consistent, timely and accurate recording across the Trust. This has now been trialled in clinical areas with some usability improvement opportunities identified, that are in the process of being addressed.

Additionally promoting a positive patient experience and outcomes has been a significant priority in the management of the recent fire:

- EQIAs are being completed for all services relocated as a result of the recent fire, and these are scheduled for review at the Trust's EQIA panel chaired by the Acting Chief Nursing Officer and Chief Medical Officer.
- The patient support hub led a sizable effort to reunite patients with lost property when they were evacuated. Once it was deemed safe to enter evacuated zones, the team retrieved all salvageable property and in total have returned 932 bags to patients, prioritising essential items such as spectacles and dentures first.

- Psychological support has also been offered to all patients affected by the fire, including provision of a chaplain from spiritual care on the wards in the immediate aftermath.

Key controls	Gaps in controls
Trust Patient Safety Strategy and Experience of care strategy. Clinical strategy in development, this will cover priorities for demand management, including collaboration with partners and shift towards community care. The strategy will also cover delivering timely care and access. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews. Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of 23/24 and 24/25 Always Improving Programme aims, continuing into 25/26. Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Governance of this through role cards, allocation process, and annual reviews. Directory of 2000 patients who are willing to engage in projects and provide a patient voice. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with priorities and allocation of dedicated time across multiple roles in the clinical strategy and BI teams. Maternity safety champions. Listening events and community engagement. Equality & Quality Impact Assessment (EQIA) review group. Ward to Board governance and escalation route.	Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients once the Trust strategy is finalised in early 2026 in line with the 10 year plan. Patient safety strategy currently under review and refresh. Likely to be completed early 2026. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support. However, work across the system on value based care will feed into this. Cost of SMS surveys across the Trust is significant. Patient safety incidents reflect challenges in staffing.
Key assurances	**Gaps in assurances**
Level One (Internal) Matron walkabouts and executive led back to the floor. Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. **Level Two (Internal)** Monitoring of patient outcomes with QPSP input.	Ongoing industrial action through 22-23, 23-24 and 24-25, and into 25-26 presents risk to the Trust's ability to meet ongoing demand on our services.

Clinical accreditation scheme (with patient involvement).

Internal reviews into specialties, based on CQC inspection criteria.

Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits.

Performance reporting.

Governance and oversight of outcomes through CAMEO and M+Ms

Patient Safety Incident Investigation Oversight Meeting

Transformation Oversight Group (TOG) including TOG dashboard to oversee impact.

Health Inequalities Board

Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board) including AAA (Alert, Advise, Assure) reports.

Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints.

Level Three (External)

CQC inspection reporting: Good overall.

Feedback from Royal College visits.

Getting it right first time (GIRFT) reporting to Quality Committee.

External accreditations: endoscopy, pathology, etc.

Kitemarks and agreed information standards.

Current and previous performance against NHS Constitution and other standards.

Key actions

Introducing a robust and proactive safety culture:

Embed learning from deaths, and an M+M Framework, across the Trust throughout 2025/26 and 2026/27 (CMO PG, MD for Patient Safety CR, and AD for Patient Experience JM):

- Embed lead medical examiner roles.
- End of life strategy ratified and launched April 2025 and learning from death report embedded.
- M+M lead training – launched January 2025 with further training planned 2026/27.
- Implement Ulysses M+M module to record discussions and actions.
- Standardise directorate and divisional governance forums to include M+M learning.

Review of the clinical quality dashboard and how it reports up to Board – ACNO NW Q2 2026/2027.

Launch and implement PSIRF – completed.

Implement the second round of Ockenden recommendations – completed.

Always Improving programme (actions throughout 2025/26 and 2026/27 – COO AH and AD for Transformation JW)

Delivery of 23/24 and 24/25 aims of patient flow, outpatient and optimising operating services programmes and associated quality, operational and financial benefits (incl. outpatient follow-up reduction) completed with a 5% reduction in LOS and 81.7% YTD optimisation in theatres. 2025/26 projects realigned with national priorities and 2026/27 priorities being updated post fire at SGH.

(Emergency & Urgent Care (Flow), Improving Value, and Elective Care.)

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

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

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

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

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

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

Fundamentals of care programme roll out across all wards – ACNO NW.

Patient experience initiatives (actions throughout 2025/26 and 2026/27 – ACNO NW and AD for Patient Experience JM)

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

Experience of Care team to provide meaningful patient feedback to individual services through Div Gov and local level groups to disseminate and support service improvement through codesign and patient experience. This is ongoing work, limited by a 12% headcount reduction in the Experience of Care in the past 12 months, but with a renewed focus to provide divisional tailored reports at care group and divisional level.

We are listening events to be held with the local community areas to capture protected characteristic patients that may not explore traditional complaint routes into the Trust.

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

Health inequalities Programme (throughout 2025/26 and 2026/27 led by CMO PG and Head of the Medical Directorate LH)

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

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	30/04/2026
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	26/09/2025
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	01/10/2026
909	Patients may come to harm with vision loss due to reduced clinics at Lymington Hospital	3 x 2= 6	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	February 2026	2 x 3 6	April 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed with the Acting Chief Nurse and the Consultant Nurse for Infection Prevention in February 2026. The risk rating has been considered and agreed to remain accurate, particularly as the operational impact of closed wards/bays due to infections such as norovirus has increased following the recent fire due to overall reduced bed capacity, and reduced sideroom capacity in fire effected wards which remain closed. This exacerbates the existing challenge in provision of side rooms which impacts our ability to isolate and treat infections. This is caused by competing needs, for example an increased reliance on single rooms to support patients presenting with mental health. Whilst infectious patients are allocated side rooms when the need is identified, this is sometimes delayed whilst other patients are moved to accommodate this. This enforces the importance of strict adherence to IPC standards, particularly when caring for infectious patients.

It is noted that nationally there has been an increase in infection and this is also true locally therefore it is predicted that we will exceed national infection thresholds for 2025/26, for example MRSA BSIs and CDIFF, although we do not expect to be an outlier in this. 6 out of 8 MRSA BSIs at UHS are related to IV access devices so an IV access device improvement plan has been developed.

Further improvement work underway includes:

- Continued focus on hand hygiene with slow but consistent improvements evidenced in the most recent covert audit.
- Significant improvements in clinical cleaning with standards consistently met over the last 6-9 months.
- Workplan for 2026/27 developed including IPC practice in invasive devices – intravenous access devices and indwelling urinary catheters.

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities.	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections.

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, IV device management and care, and winter virus awareness. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission. Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need. Point of Care testing in AMU. Expedited laboratory testing facilities for respiratory and GI infections. CNO/CMO reviews with clinical teams for MRSA cases. Business continuity: up to date ratified pandemic plan reviewed annually as well as the infection outbreak policy.	Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced. 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
Level One (Internal) Hand hygiene, IP&C and cleanliness audits. **Level Two (Internal)** Infection Prevention Committee and IP&C Senior Oversight Group. Patient-Led Assessment of the Care Environment. Capital funding monitored by executive. Finance and Investment Committee oversight of estates and digital capital programme delivery. Internal audit annual plan and reports. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). **Level Three (External)** National Patient Surveys. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board.	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.

Key actions

- Head of IPC JB leading an ongoing review of IPC policies to ensure they are aligned to the national IPC manual for England, including launch, communication, education and monitoring. Completed policies include MRSA, outbreak of infection, and isolation with the following anticipated by the end of 2025/26: C Diff, candida auris, and urinary catheter care.
- Head of IPC JB and pharmacy leads launching a new antimicrobial 5 year strategy by the end of 2025/26. This combines stewardship and IPC and replaces the previously expired IPC strategy.
- Align UHS with the updated national mandatory IPC education packages by the end of 2026/27 – Head of IPC JB.
- Focussed IP&C education and awareness campaigns supported by internal and external communications plan, and monthly OPC newsletter, led by Head of IPC JB throughout 2025/26 and into 2026/27.
- Implement 2025/26 and 2026/27 workplans to guide improvements in practice and implement learning – Head of IPC JB.

Pioneering research and innovation

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

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 2 8	April 2022	3 x 4 12	February 2026	3 x 2 6	March 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	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 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

This risk has been reviewed by the responsible executive in February 2026 and the risk rating and targets are still considered accurate following the increase in August 2025. The reduction in headcount in R&D, and the wider workforce reductions across the organisation, are still having an impact on R&D Trust Board KPIs. Study recruitment levels (TB KPIs for national ranking) are still being met but our ranking has fallen again from 7 to 9 and we are still struggling to meet the national metrics for study set-up times and first patient recruited metrics. Capacity constraints across clinical support services are impacting on our ability to set-up new studies so we are prioritising opening studies based on known capacity constraints across the clinical delivery system. To support mitigation local actions from an EQIA have been implemented which are ensuring patient safety and data integrity are being maintained for open studies, and local research delivery team capacity is being managed in response to study pipeline demand.

New national NIHR Research Delivery Network funding model for 2026/27 has linked performance for a mix of historical and current performance national metrics to funding allocations – indicative funding allocations indicate a £500K reduction in funding for 2026/27 compared to 2025/26 – although UHS indicative funding allocation is still 4th highest nationally. Potential reduction in RDN budget for 2026/27 will be offset by strategic funding secured from the RDN, as well as pay spend reductions secured through the workforce reductions in 2025/26. NIHR / NHSE have also implied a link to delivery against national study set up and recruitment metrics (150 days) to future NIHR infrastructure funding (no further information available at this stage). The recent fire at Southampton General Hospital has had a limited impact on research study delivery; study endoscopy requirements are being mapped and potential mitigations for delivery capacity identified.

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded.	Operational pressures, limiting time for staff to engage in research & innovation.

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. Prioritisation of high-risk or high-impact studies when workforce capacity constraints impact through: Staffing capacity constraints are identified and managed to ensure an agile response to areas of high need Manage study set-up pipeline depending upon capacity constraints with a focus on national set-up metrics, high-risk or high-impact studies. Reduction in volume of new studies in set-up depending upon capacity constraints to maintain set-up times, protect study delivery capacity and ensure patient safety.	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. R&D have met their required workforce reduction allocation so some vacancies are now being filled, but R&D turnover still higher than Trust average. Reductions in research workforce and clinical support services are impacting on our delivery against national performance metrics. Knock on impact on NIHR RDN funding allocations for 26/27 (predicted £500k reduction against 25/26 £7.5m budget) as based on historical and current performance against national metrics. Potential reduction in RDN budget for 26/27 will be offset by strategic funding secured from the RDN, as well pay spend reductions secured through the workforce reductions in 25/26. UHS indicative funding allocation is still 4th highest nationally but we are moving to a national funding model where our comparative performance against other hospitals now impacts directly on our funding allocation. Funding will be confirmed by end February 2026. Patient safety and data integrity are being maintained for open studies, and local research delivery team capacity is being managed in response to study pipeline demand but this is having an impact on individual and team resilience.
Key assurances	**Gaps in assurances**
Level One (Internal) Monitoring research activity funding and impact at R&D steering group. Level Two (Internal) Governance structure surrounding University partnership. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint Innovations and Commercialisation Group – UHS/UoS. Level Three (External) Board to Council meetings. MHRA inspection and accreditation. CQC review of well-led criteria, including research and innovation. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In February 2026 our national recruitment ranking has declined from 7th in October 2025 to 9th in January 2026 and securing sustainable improvements in study-set up	Limited corporate approach to supporting innovation across the Trust. New national site metrics introduced around clinical trial set up and delivery will be introduced as Trust Board KPIs in 2026/27. NHSE have included a requirement in medium term planning framework that research income and R&D KPIs metrics are reported to TB at least 6 monthly so intention would be to 1) update TB KPIs to reflect national priorities (reported monthly), and 2) introduce a 6 monthly review against the R&D Annual Plan to meet the reporting frequency requirements.

and delivery metrics are proving challenging given workforce capacity constraints.	

Key actions

Deliver the 2025/26 Annual Plan, including the approved R&I Investment Case, with quarterly updates against progress submitted to the Trust Board through the corporate objectives. Largely on track with some actions delayed due to capacity. Karen Underwood

By March 2026, define and implement a UHS contribution plan to the Wessex Health Partners Annual Review, including agreed RoI metrics and resource commitments for the next 3-year term. On track. Karen Underwood

By March 2026, expand staff engagement initiatives presented to TBSS in February 2025, based on mapping outcomes and staff feedback. On track. Karen Underwood

Support at least three departments in piloting innovative R&D-linked roles by July 2026 and evaluate their impact on recruitment and retention by Q4 2026/27. On track. Marie Nelson

Implement new digital tools to streamline clinical research delivery by March 2026, aiming for a 10% improvement in recruitment efficiency compared to 2023/24 benchmarks. Capacity constraints and delays in development / identification of systems will impact on delivery. Laura Purandare

Launch the action plan to deliver the Joint Research Vision with UoS by March 2026, with quarterly progress reviews by the Joint Research Strategy Board starting end Q1 2026/27. On track. Karen Underwood & Diana Eccles.

Successfully initiate the NIHR Applied Research Collaboration Wessex programme (UHS host, with UoS – regional bid awarded £16.3m over 5 years) by April 2026, ensuring governance, staffing, and delivery plans are in place. On track. Catherine Bowen / Michale Boniface.

By July 2026 complete a staff survey on innovation engagement and understanding, and develop an implementation plan addressing the identified gaps.

Develop and formalise partnership processes between UHS and UoS by December 2026, laying the foundation for a long-term UHS Innovation Strategy to be launched in 2027. On track. Chris Kipps & Pete Baker

Complete a Trust-wide review of the corporate innovation approach by July 2026, and develop a draft UHS Innovation Strategy aligned with UHS/UoS partnership goals by December 2026. On Track. Chris Kipps, Pete Baker & Martin de Sousa

Secure at least one new external funding source through the International Development Centre to support staff-led innovation projects by September 2026. Pete Baker.

World class people

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

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

Cause	Risk	Effect
Nationally directed financial restraints limiting workforce size and growth pose a risk, and this is compounded in some hard to fill professions and specialities by national and international shortages;	This could result in an inability to recruit the number and skill mix of staff required to meet current demand;	This may result in a suboptimal patient care and experience and may be damaging to staff engagement and morale.
Category	**Appetite**	**Status**
Workforce	Open *The current risk rating is outside of the stated risk appetite. The target rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 4 16	April 2022	4 x 5 20	February 2026	4 x 3 12	March 2030

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	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 February 2026 in consideration of the ongoing risk factors, as well as the impact of the recent major incident whereby a significant fire occurred at Southampton General Hospital on 01/02/2026 resulting in loss of the endoscopy unit and initially 200 inpatient beds. It is recognised that the fire has resulted in a significant shift in workforce utilisation to respond to this, as well as a reduction in NHSP/agency usage due to the lost capacity. It is however expected that this usage will increase again in March as recovery efforts increase capacity, and substantive staff are using annual leave at year end. EQIAs are currently being completed for each ward/clinical service move and these will identify any specific impacts or risks to workforce in effected areas, both in terms of utilisation and wellbeing, to ensure mitigations can be considered and implemented.

Workforce controls, in mitigation of the Trusts financial risk, remain under close consideration and a decision has been taken to increase recruitment of admin and clerical staff responsible for bookings and RTT in key areas such as theatres and critical care to support efforts to increase elective capacity. It is also noted as we near year end that all leavers from two successful Mutually Agreeable Resignation Schemes have now exited the organisation, delivering a full year saving of £2m against a cost of £1m.

Workforce planning for 2026/27 is underway, including submission of the Medium Term Plan which outlined workforce capacity over the next 3 years. Job planning also remains a focus with an external expert engaged to support service level planning with a target date of 31st March 2026.

The Trust's HR team are also monitoring and responding to national developments such as the updates to the Employee Relations Act which received Royal Assent in December 2025. Both Trust Executive Committee (TEC) and People & Organisational Development Committee (POD) have been briefed on the key changes and impact of these, with an action plan now underway. The government have also made a commitment to nursing staff aimed at recognising the value of the profession and this includes re-evaluation of band 5 roles, and wider pay reform including graduate entry roles. Preceptorship standards are also to be overhauled to better support Newly Qualified Nurses, although it is noted that UHS do already hold an award winning preceptorship

programme. Once further detail on these plans is published a briefing will be prepared for TEC, POD, and Trust Board.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes. Workforce plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2025/26 submitted to ICB. Organisational change policy including management of redeployment. RCP (Recruitment Control Panel). Creation of an organisational change management group to govern the current restructure. Financial Improvement Group established with a supporting Equality and Quality Impact Assessment Review Group. Planned change management and wellbeing support for staff and managers. Continual joint working between finance and workforce to align data and improve forecasting. Established procedures for managing staffing deficits and maintain business continuity including escalation through the staffing hub and use of NHSP/agency where patient safety necessitates this.	Completion of objectives for South-East temporary collaborative for 2024/25, 2025/26, and beyond. Planned improvements for medical job planning to be implemented. Over reliance on NHSP.
Key assurances	**Gaps in assurances**
Level One (Internal) Fill rates, vacancies, sickness, turnover and rota compliance. **Level Two (Internal)** Review of implications for education and training infrastructure from national workforce plan. **Level Three (External)**	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.	

Key actions

2025/2026 and 2026/2027 led by CPO SH

Support the Trust's delivery of the financial recovery plan including delivering a plan of organisational change in a safe and sustainable manner to scale back workforce.

Refresh the Trust's People Strategy once the Trust's Corporate Strategy has been agreed.

Ensure accuracy of leave allocation and recording for medical staff via Health roster for all care groups. Increase use of Health roster across medical staff groups. Improve medical job planning.

Support the Trust's recovery efforts post fire including maximising transformation opportunities within the workforce.

Delivery of 2026/2027 planning, and Medium Term Planning, established for workforce.

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	01/03/2026
67	There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc.	2 x 4 = 8	3 x 2 = 6	27/02/2026
167	MRI physics staffing risk	4 x 2 = 8	2 x 1 = 2	31/03/2026
286	Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service	3 x 4 = 12	3 x 3 = 9	30/04/2026
458	Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input.	3 x 4 = 12	2 x 2 = 4	31/03/2026
604	Risk in epilepsy nursing service	3 x 3 = 9	3 x 1 = 3	31/12/2026
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 4 = 16	2 x 1= 2	01/03/2026
646	Reduced ACP Cover across Neurosciences care group	4 x 2 = 8	4 x 1 = 4	03/09/2025
661	Insufficient Medical staff to safely manage patient activity within cancer care	4 x 4 = 16	2 x 3 = 6	28/02/2026
662	Cellular Pathology Staffing and Capacity	4 x 5 = 20	4 x 2 = 8	30/06/2026
726	Ophthalmology clinical/AHP workforce	4 x 3 = 12	4 x 1 = 4	01/01/2027
730	Risk of patient harm due to lack of administrative support for clinical services in surgical care group.	4 x 4 = 16	2 x 2 = 4	28/02/2026
748	There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service	2 x 4 = 8	2 x 1 = 2	27/03/2026

776	Insufficient clinical pharmacy workforce	3 x 5 = 15	3 x 3 = 9	31/08/2026
791	Outpatients Administration Centre (OAC) - Staffing Risk	3 x 3 = 9	2 x 3 = 6	31/03/2026
837	Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs	3 x 5 = 15	3 x 2 = 6	31/06/2026
873	A&C Spinal Staffing	3 x 3 = 9	2 x 2 = 4	30/06/2025
879	IISS Programme (project management resource)	3 x 3 = 9	3 x 3 = 9	01/07/2025
881	Retention and Sustainability of Specialist Neurosciences CNS Workforce	3 x 2 = 6	3 x 1 = 3	31/12/2025
899	Trust recruitment pause, impact on staffing levels and service delivery (EFCD)	4 x 3 = 12	4 x 1 = 4	31/03/2026
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
923	Lack of Obstetric Physician Cover	3 x 3 = 9	2 x 2 = 4	31/07/2026
925	The provision of the congenital/adult cardiac theatre service is at risk due to the lack of ability to retain cardiac scrub practitioners.	3 x 5 = 15	5 x 1 = 5	30/09/2026
931	Insufficient capacity in the paediatric cardiology ACP team to manage current workload nor enable planned expansion of the service	2 x 5 = 10	2 x 2 = 4	31/03/2026
938	Lack of administrative support within Specialist Medicine	3 x 4 = 12	2 x 1 = 2	06/03/2026
942	Paused Recruitment/Head Count Reduction - Maintenance Apprentices	3 x 4 = 12	3 x 1 = 3	28/10/2026
943	Paused Recruitment/Head Count Reduction - Maintenance Chargehands	3 x 3 = 9	3 x 1 = 3	28/10/2026
944	Paused Recruitment/Head Count Reduction - Maintenance Technical Staff	3 x 4 = 12	3 x 1 = 3	28/10/2026
945	Perfusion Workforce Supply and Resilience	4 x 4 = 16	4 x 3 = 12	30/04/2028
948	Impact of recruitment pause on Waste Management Service delivery	3 x 3 = 9	3 x 2 = 6	28/10/2026
952	There is a concern that deteriorating adult patients are at a risk of increased harm due to a reduced Critical Care Outreach service within UHS.	4 x 4 = 16	2 x 2 = 4	31/03/2026
955	Risk to 24/7 microbiology service due to staffing vacancies	2 x 5 = 10	1 x 2 = 2	30/04/2026
958	Supportive and Palliative Care Service provision	3 x 4 = 12	1 x 2 = 2	30/07/2026
971	Risk to patient safety and patient experience due to reduced staffing within the paediatric cardiac nurse specialist team.	3 x 3 = 9	3 x 2 = 6	29/05/2026

World class people

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 3 12	February 2026	4 x 2 8	March 2030

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	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 Chief People Officer in February 2026 and agreed to be an accurate reflection on the current risk with key concerns noted as below:

- The emotional toll of the recent fire cannot be underestimated, and a comprehensive package of support has been implemented at pace. This includes additional offering of wellbeing resources such as psychology support and the Trauma Risk Management (TRiM) service, and CEO debriefs attended by 180+ staff. The people directorate have also formed a response cell to deliver practical support including processes for reimbursement of lost belongings and payment for additional work on the day of the fire. These measures have been directly marketed to individuals working in affected areas. These measures remain in place and the Trust are also working with external teams to ensure appropriate support is in place for individuals experiencing ongoing effects such as PTSD.

- Prevention and management of violence and aggression towards staff remains a key focus, with both the V&A task and finish group, and V&A executive board fully implemented. The revised policy, including a rapid route to exclusion/restrictions, has been drafted and will be circulated for consultation and then ratified imminently.

- Staff survey results are nationally embargoed until 12th March 2026 but, as per briefings to Board throughout the year, it is anticipated that our results will have deteriorated in comparison to previous surveys. This is as a result of the financial pressures and impact on the workforce morale. Actions in response will be considered, developed and communicated once the full results are available. Meanwhile measures to boost morale are underway such as a campaign throughout February and March to promote benefits available to staff through platforms such as Vivup, and all staff networks have now been sponsored by an executive director, as well as a non-executive director. Additionally a

deep dive is underway to understand increasing staff sickness during the recent winter months, with a particular focus on reported stress and anxiety.

- Following the 2025 Supreme Court ruling on the Equality Act 2010, which ruled that the term 'sex' only applies to biological sex and not acquired sex, the organisation are considering the varying impacts to its workforce and how to address these whilst awaiting national guidance. This is currently being risk assessed, and legal advice is being sought.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours. Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. Proud2BeAdmin & Proud2Bops campaigns and networks. Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing. Launch of digital appraisal process. Windows into Wellbeing. Leading through change' workshops to support and equip UHS leaders to manage and understand organisational change, lead people and teams through change, and create an environment which facilitates successful change. Regular communications for all staff including briefings and 'Talk to David' sessions, further complemented by targeted communications for specific staff groups such as 'Connect' for senior managers and leaders, and briefings for medical staff. This includes 'UHS Voice' with executives visiting individual teams to ensure this is accessible for all. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed – cohort 2. Cohort 3 advertised. Nurse specific positive action programme also launched.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks. Coverage of allyship training to increase to 80% compliance by 31/03/2026 (74% as at March 2025). Improving implementation of national improving working lives actions for junior doctors following national letter May 2024. Organisational capability and capacity to fully support LID, external support being sought.

All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake. A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments. Inclusive recruitment review undertaken. EQIA Panel.	
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of staff networks. Maturity of datasets around EDI, and ease of interpretation. Areas for improvement identified through the annual staff survey (March 2024) – remedial action reflected within the People objectives for 2024/25 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 and 2026/2027 led by CPO SH Continue implementation of the inclusion and belonging strategy within available financial and people resources. Delivery of Organisational Development support to complement organisational change. Ensure that equality impact assessments are completed and monitored through the EQIA review group. Establish a Violence & Aggression executive led board to oversee and expedite this workstream.	

World class people

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

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

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

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the organisations risk appetite however the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 4 16	February 2026	3 x 2 6	March 2029

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16	4 x 4 16

Current assurances and updates

This risk has been reviewed by the Chief People Officer in February 2026 with key updates noted below:

- As part of the refresh of the People strategy, the education team have reviewed the structure and resources available, and to identify what further capacity and capability is required to support the Trust's corporate strategy and national workforce plan once published. The quality of the estate remains a challenge with limited availability to deliver education. It is however noted that as the estate is rebuilt post fire, this may include delivery of services off site, and this may present opportunities to gain or maximise education space on site.
- Central funding for Oliver McGowan training is now nearing completion and consideration is being given to how this is now funded across the HIOW collective. This is likely to result in a cost pressure for the Trust,
- Appraisal rates have fallen due to increased operational pressures however a key priority for 2026/2027 will be to refocus and re-energise managers with targeted leadership training.
- Sadly the Trust has been informed that the long awaited partnership with Southampton University Technical College can no longer proceed. Wider education partnerships are under review to maximise opportunities available.

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 Access to CPD funding from NHSE WTE and other sources 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. £175k of charitable funds 2025/26 to support education for staff who do not qualify for national CPD funding.	Staff providing education being released to deliver education, and undertake own development Releasing staff to attend core training, due to capacity and demand 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**
<u>Level One (Internal)</u> Trust appraisal process Utilisation of apprenticeship levy. **<u>Level Two (Internal)</u>** Annual Trust training needs analysis reported to executive. Talent development steering group People Board reporting on leadership and talent, quarterly **<u>Level Three (External)</u>** GMC/NETs Survey Education review process with NHSE WTE.	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.
Key actions	
Actions are overseen by CPO SH with operational leads indicated where appropriate and will be carried out through 2025/26 and into 2026/27. To increase the proportion of appraisals completed and recorded to 85% and increase staff quality perceptions on appraisal. Ongoing specific targeted action to improve areas of low satisfaction in the GMC survey To continue to build the education strategic partnerships and capacity for delivery of the NHS workforce plan and UHS People Strategy including: • Continuing to develop our formal partnership with the new UTC • Developing a partnership agreement with South Hampshire Colleges Group	

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

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

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

A review has taken place within T&D to look at the infrastructure and longterm workforce plan and was presented to POD in Q2 2025/26.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
173	Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training.	3 x 3 = 9	3 x 1 = 3	31/12/2025
833	Safeguarding children Statutory Training Compliance Levels are below required.	4 x 3 = 12	4 x 1 = 4	31/07/2026
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	31/03/2026
965	Operational pressures and insufficient funding may prevent full compliance with statutory and mandatory training presenting a regulatory risk and a risk that staff will not be equipped with the correct knowledge and skills to fulfil their roles.	3 x 4 = 12	2 x 3 = 6	31/03/2027

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	February 2026	3 x 2 6	December 2026

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been reviewed with the executive lead in February 2026 and minor changes made to the controls, assurances, and actions, to ensure it is a current and accurate record. 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. Financial limitations can also hinder pace.

It is noted that current pressures and directive to reduce workforce spend across the NHS may impact on the ability and capacity to execute plans if these are not adequately resourced, however the requirement for savings and efficiency may also assist as a driver for working collaboratively. Additionally national direction is shifting accountability, drawing clearer lines in responsibilities between Trusts and commissioning bodies, which may empower organisations to engage in networking when there are clear benefits to be maximised.

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

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.	capacity at UHS is a challenge as evidenced on the operational risk register.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> • Friends and Family Test **<u>Level Two (Internal)</u>** • Outcomes and waiting times reporting. Included within cases for change being built for networks. • Integrated networks and collaborations board set up for regular meetings at executive level. **<u>Level Three (External)</u>** • CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys	• Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. • Ability to network is difficult and manifests in capacity challenges. • Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track.

Key actions

Business case for future working of the Southern Counties Pathology Network has been developed following a CFO/COO workshop Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment and is anticipated to be shared at all relevant Boards in Q4 2025/26. Once all Boards have approved this it will move into the first phase of implementation with appointment of management likely in Q2 2026/27. (CEO DF).

UHS took over the lease of the elective hub from April 2026 and plans to run theatres from July 2026. Funding has been approved and a letter of support from the ICB received. (CEO DF).

A high level options paper has been developed for Upper GI across UHS and UHD. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this. However there is not current alignment across the three organisations on how this will be delivered therefore this is now with the ICB for consideration of how this is commissioned. This is likely to be a longer term piece of work over the next few years led by the ICB. UHS and other providers are currently completing returns to support this decision and define what the service will look like.

Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. This will be worked up into a business case ahead of 2026/2027. Plastic leadership has also been strengthened within UHS to support this change. (COO AH)

Planning underway to increase performance supported by a common assumption across the system and leadership from David French for the ICS elective programme. Steps include increased outsourcing from UHS (Q3 2025/26), and ongoing negotiations for contract offers for 2026/27.

Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2037 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this. There will be a need to consider clinical reconfigurations to bridge this gap however a forum hasn't yet been established. UHS are keen to work closely with HHFT on this to ensure that we understand any need for redirection of emergency or urgent presentations in the South, which are likely to be the elderly or frail population, and maternity. This is a longer term aspiration.

Completed

NHSE has approved the business case, and funds have been received, for the Winchester Elective Hub which opened September 2025.

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

Urology Area Network plan was agreed however progress had stalled due to lack of programme management resource and the clinical lead stepping down, alongside challenges in aligning clinician availability across the organisations. This workstream has not come to fruition and is not currently being taken forward.

Foundations for the future

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

- **A reducing cash balance impacting the Trust's ability to meet payment terms for suppliers and staff, meet statutory requirements such as payments to HMRC, and invest in line with the capital plan.**
- **NHS England imposing additional controls/undertakings.**

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

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (including NCtR and mental health), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position and that our cash balance will significantly reduce resulting in an inability to make payments to suppliers and staff, and make payments in line with our statutory requirements.	This may directly impact the organisation's operational ability to provide care to patients if services or staffing are withdrawn due to failure to make required payments. Additionally it may impact on the organisation's ability to grow and transform due to limitations in investment.
Category	**Appetite**	**Status**
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the long term target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Interim & long term target (I x L)	
4 x 5 20	April 2022	5 x 5 25	February 2026	5 x 4 = 20 5 x 3 = 15	October 2026 April 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25

Current assurances and updates

This risk was reviewed with the Chief Financial Officer in February 2026. Following the reassessment in August 2025, when the risk rating was increased from 20 (severe × certain) to 25 (catastrophic × certain), it is confirmed that this rating remains accurate. This reflects the significant and sustained fiscal pressures currently facing the Trust, including the declining cash position and risk of operational impacts, as well as the ongoing tension between planned activity levels and insufficient associated income, both of which remain key concerns.

Further consideration has been given to the major incident declared at UHS and across the HIOW system following the substantial fire at Southampton General Hospital on 01/02/2026 and its financial implications. Work is underway to quantify the impact, including additional operational costs, capital requirements, and lost revenue, and to liaise with NHS Resolution and private insurers to secure all eligible insurance recoveries.

Actions to manage this risk continue to progress, with the latest updates summarised below:

- Following the external independent review of the Trust's financial position, the Board has met to consider the findings and has submitted a revised forecast to NHSE indicating a projected year-end deficit of £45m. The Trust is currently awaiting NHSE's formal response.
- Planning submissions for 2026/27 have been provided to NHSE; however, contracting discussions remain ongoing due to a substantial gap (approximately £76m) between planned activity and the payment envelope offered.
- A programme of financial improvement projects continues to advance, with a number scheduled for completion during Q4 2025/26. Oversight is being maintained through the Financial Improvement Group and the Finance & Investment Committee.

- The current Financial Improvement Director will leave the organisation in March 2026. However, a successor, funded by NHSE, is expected to be appointed and in post promptly minimising the risk of disruption.

It is noted that the target dates for reduction of this risk are planned to be reviewed early 2026/27 once contracting negotiations are complete and there is a clearer view of this position and the pace at which change is thought able to happen.

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. **Business Continuity** In the event of zero cash availability, national support to maintain payments for regulatory requirements such as HMRC, and staff payments of salary and pension. Should key resources become unavailable due to inability to pay suppliers, operational management would include established methods of escalation and	**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.

oversight including HIMTs and emergency Board meetings. This would include risk stratification to minimise impacts to patients as well as diversion of patients/mutual aid if we were unable to provide essential care.	
Key assurances	**Gaps in assurances**
Level One & Two (Internal) • Regular finance reports to Trust Board & F&IC. • Full financial report for the system to Trust Board. • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity. Monthly cash reporting to F&IC. **Level Three (External)** • Monthly CFO Meeting • Monthly ICB report on all provider positions • Regional scrutiny meetings.	• 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	
Ongoing Actions • Delivery of 2025/26 financial plans (CFO, IH). • Set programmes/projects for delivery as part of the Financial Improvement Group – underway and ongoing throughout 2025/26 and into 2026/27 (CFO, IH). • Workforce forecasting and delivery of workforce reduction schemes (CPO, SH). • Develop and implement a financial recovery plan throughout 2025/26 (CFO, IH). • Prepare and negotiate contracting arrangements ahead of 2026/27 (CFO, IH) • Maximise opportunities throughout 2025/26 to bid for national cash support and recover any outstanding cash due to UHS (CFO, IH). **Completed Actions** • Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete. • Reset CIP and transformation programmes based on 25/26 targets – complete. • Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway and established.	

Foundations for the future

5b) We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity

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

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services.	There is a risk that our estate will prohibit delivery and expansion of clinical services. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.	This would result in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		**Current risk rating (I x L)**		**Long term target (I x L)**	
4 x 4 16	April 2024	4 x 5 20	February 2026	4 x 2 8	April 2030

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed with the Chief Finance Officer, and Director of Estates, Facilities and Capital Development, in February 2026 with no revisions to the current or target risk ratings required. It has been considered whether the impact of the substantial fire at Southampton General Hospital on 01/02/2026, which was declared a major incident at UHS and across the HIOW system, increases the risk rating. However, whilst it is acknowledged that this has caused significant operational disruption, extensive damage to the estate, and required immediate risk management, it is also considered that the event and the resultant risk have been managed well and assurance should be taken that evacuation plans and business continuity plans have been effective. Therefore, whilst management of significant operational risk is still underway, it is not considered that the strategic risk articulated here needs to be increased at this time, although this position may be revisited dependent on the full results of the investigation into the fire.

The key concerns at present, as previously reported, are whether there is sufficient funding and staffing resource to manage this risk. In mitigation planning is underway for 2026/27, informed by the six-facet survey, with a currently anticipated budget of c.£5m although it is likely that this will reduce. It is also probable that this will be supported by £11m from the NHSE safety fund. Meanwhile prioritisation of maintenance continues, focussed on meeting statutory and mandatory requirements, and addressing priority one and two requests, to ensure that available staffing resource is used effectively.

Key controls	**Gaps in controls**
Multi-year estates planning, informed by clinical priorities and risk analysis Up-to-date computer aided facility management (CAFM) system – new system is in the process of procurement and implementation. Asset register (90% in place) Maintenance schedules	Scale of investment and funding is insufficient to fully address identified gaps in the critical infrastructure. 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.

Trained, accredited experts and technicians Asset replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Clear line of sight to Trust Board for all risks identified. ICB Infrastructure plan completed 2025/26. Review exercise of EFCD business continuity plans, and implementation of action cards, occurred 2024.	Lack of decant facilities. Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work. Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits.
Key assurances	**Gaps in assurances**
<u>Level One & Two (Internal)</u> 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 **<u>Level Three (External)</u>** Six Facet Survey NHSE Assurance Visits Authorised engineer audits	
Key actions	
<u>Ongoing Actions</u> Develop estates strategy following the finalisation and agreement of the estates masterplan and ICB infrastructure plan – March 2026, DJ. Update and renew the Trust's Green Plan which will support reduction in backlog – December 2025, DJ (Complete). Implement and embed the renewed Green Plan through 2026/2027 and beyond, DJ. Identify future funding options for additional capacity in line with the site development plan, throughout 2025/2026 and 2026/2027 – Executive team supported by DJ for delivery. Implement the HIOW elective hub in 2025/2026 - Executive team supported by DJ for delivery. Delivery of 2025/26 capital plan - DJ. Deliver £8.3m of critical infrastructure backlog maintenance in 2025/26 - DJ. Delivery of the Urgent Treatment Centre through 2026/2027, DJ. **<u>Additional actions to be agreed/progressed in the future</u>** 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	28/02/2026
157	Site wide electrical infrastructure resilience, HV and LV.	05/03/2019	4 x 3 = 12	4 x 1 = 4	31/12/2026
260	Insufficient space in the induction of Labour Suite.	28/10/2019	4 x 4 = 16	4 x 1 = 4	31/12/2026
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	31/12/2026
489	Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures	07/02/2021	5 x 3 = 15	5 x 1 = 5	31/03/2027
727	Black start electrical test	25/07/2023	5 x 2 = 10	5 x 1 = 5	31/12/2026
773	Impact of the Building Safety Act (2022) on Capital Project Delivery	24/01/2024	3 x 3 = 9	3 x 2 = 6	30/11/2026
817	Lack of UPS backup on power failure	28/05/2024	5 x 3 = 15	5 x 1 = 5	31/12/2026
846	PAH – General ward areas and Neonatal Unit air handling units beyond service life	11/10/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
851	Lab and Path Chiller 1 Aged and Not Operational	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
853	Lab and Path Chilled Water Pumps	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2026
854	P.M.S Computer room AC Chillers	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2026
855	West Wing SHDU AC Units - Beyond Service Life	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
856	Non-compliant & unmaintainable fire dampers in West wing	12/11/2024	5 x 3 = 15	5 x 1 = 5	31/12/2026
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	31/12/2026
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	31/12/2026
877	Poor condition of Car Park 5 (old section multi story)	11/02/2025	5 x 3 = 15	5 x 1 = 5	01/06/2026
897	Centre Block Vertical Extension Chilled Water Capacity	08/05/2025	3 x 3 = 9	3 x 1 = 3	31/12/2026

898	Obsolete fire alarm repeater panels	08/05/2025	5 x 2 = 10	5 x 1 = 5	01/04/2026
899	Trust recruitment pause, impact on staffing levels and service delivery	08/05/2025	4 x 3 = 12	4 x 1 = 4	31/03/2026
908	Non-Compliance with UHS EFCD Design Standards - Adanac Aseptic Suite	17/06/2025	3 x 4 =12	3 x 2 = 6	08/11/2026
942	Paused Recruitment/Head Count Reduction - Maintenance Apprentices	04/12/2025	3 x 4 = 12	3 x 1 = 3	28/10/2026
943	Paused Recruitment/Head Count Reduction - Maintenance Chargehands	04/12/2025	3 x 3= 9	3 x 1 = 3	28/10/2026
944	Paused Recruitment/Head Count Reduction - Maintenance Technical Staff	04/12/2025	4 x 3 = 12	4 x 1 = 4	28/10/2026
949	Neuro Theatre Block Cladding Defects	8/12/2025	5 x 2 =10	5 x 1 = 5	8/12/2026
951	Helipad structural concrete issues	8/12/2025	4 x 3 = 12	4 x 1= 5	31/03/2026
959	Potential Fire Spread via External Cladding	21/01/2026	5 x 3 = 15	5 x 3 = 15	01/04/2026
960	Lack of (suitable, or suitably functioning) fire-alarm activated door closer devices on some fire doors	21/01/2026	5 x 3 = 15	5 x 2 = 10	01/06/2026

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 4 16	February 2026	3 x 2 6	April 2030

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 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 was reviewed with the Chief Operating Officer and Chief Information Officer in February 2026. It was agreed that the risk rating should be increased from 12 (moderate × likely) to 16 (severe × likely), based on the following factors:

- **Electronic Patient Record (EPR) and PAS Risk:** Funding for the procurement of a new Electronic Patient Record (EPR) system has been withdrawn, and there is currently no clear organisational, system, or national plan route to funding. The existing Patient Administration System (PAS), a component of the EPR, remains under contract until 2028, however the supplier has ceased product development due to a change in business direction and a declining customer base. This creates an immediate risk that the system will not continue to meet UHS requirements, and a significant future risk that the Trust may be unable to renew the contract in 2028 without a replacement system in place. The impact of this is that UHS would cease to have digital ability to book and manage patient appointments. Securing and implementing a new PAS typically requires 18–24 months due to system complexity, therefore planning and identification of funding are now urgent.

- **Digital Infrastructure Risk:** The risk associated with aging digital infrastructure continues to increase following reduced capital investment, particularly over the last two years. A substantial proportion of hardware is now end-of-life, for example, the oldest network switch is 18 years old, far beyond the typical five-year lifespan. Hardware supporting Oracle databases, which underpin approximately half of Trust applications, is also end-of-life. This raises the likelihood of infrastructure failure and associated operational disruption. A seven-year rolling replacement programme has been proposed, subject to funding.

- **Cyber Security Risk:** Cyber security is also acknowledged as a continual risk for the organisation, although assurance of risk management is noted as the previously reported cyber security audits have now been completed with only minor findings which have all been actioned.

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. • The current Data Centre is end of life with the replacement data centre due to be built in 2026.	**Failure in physical network infrastructure** • 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. • NHS Board cyber security training (07/10/2025)	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover.	**Single points of failure in staffing** • Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry.
Implementation and sustainability of digital technology • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout trialled in cancer care, with tweaks being made before further rollout. • 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. • Single EPR business case has no visible route to funding.
Loss of access to critical IT systems & business continuity • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards (utilised in 2 recent incidents). • Robust system and regression testing completed on system developments. • Scenario testing completed. • All wards have a business continuity device in situ allowing access to patient records in system outages. • Separate telephone systems are set up in critical areas such as ED to facilitate communication in the event of phone lines being unavailable.	**Loss of access to critical IT systems & business continuity** • Digital can advise clinical teams on business continuity plans but do not own these.

Key assurances	Gaps in assurances
Level One & Two (Internal) Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed on UHS Digital leadership team call. UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams. UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc). Standardised change control, testing, and assurance processes implemented across the Development team. Regular Trust Board Study Sessions with digital updates. **Level Three (External)** KLAS clinician usability surveys every 3 years NHSE annual DPST assessment completed to highlight gaps in services. Annual digital framework capability assessment Cyber security audits	Funding to cover the development programme, improvements, and clinical priorities. Difficulties in understanding benefits realisation of digital investment.

Key actions

Recruitment

- Ongoing recruitment of key Digital resource to mitigate operational risk throughout 25/26 and 26/27 where recruitment controls allow – JT
- To support the above, leverage capital funding to bring in additional resource where appropriate – JT.
- Develop inpatient noting improvements post cancer care trial – 2026/27, JT.

Replacement of key clinical systems to more modern systems & future development

- Identify funding to procure and roll out a single EPR across HIOW, previously forecast to go live April 2029, but now subject to funding. JT.
- Continually identify opportunities for funding for digital transformation and programmes throughout 25/26 and 26/27 – opportunities tied to 10 year plan and medium term plan are now materialising (e.g. digital diagnostics capability programme, NHS 5 year capital plan). JT.

Completed

- Acceleration of cyber software upgrades completed 2024/25.
- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience.
- Implementation of MIYA in 2025/26 (complete – JT).
- Lessons learned from LIMS project were shared across UHS Digital, Estates, and other major project teams.
- Inpatient noting for doctors trial in cancer care complete in Q3 2025/26.

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
282	Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity.	3 x 4 = 12	2 x 2 = 4	31/03/2027
634	Accommodation / Infrastructure - Fibre optic cabling at the ONH	4 x 3 = 12	3 x 2 = 6	31/03/2026
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	31/03/2026
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	3 x 4 = 12	4 x 3 = 12	31/12/2026
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	31/03/2026
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	31/03/2026
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	01/06/2026
829	Cyber Security - Windows 11 Roll-out before Win10 EOL	4 x 3 = 12	2 x 2 = 4	31/03/2026
929	Current software version on our existing servers is not supported.	5 x 3 = 15	5 x 2 = 10	31/12/2026
930	Oracle Database Appliances (ODAs) are end of life and represent a risk to the estate.	5 x 3 = 15	4 x 3 = 12	31/12/2026
946	Accommodation / Infrastructure - the Trust may be unable to operate its core services due to not having an operational and supported Patient Administration System	5 x 3 = 15	2 x 2 = 4	31/12/2028

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	February 2026	2 x 2 4	December 2027

Risk progression: (previous 12 months)	Feb 25	Mar 25	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
	2 x 3 6	2 x 3 6	2 x 3 6	2 x 3 6	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8

Current assurances and updates

This risk has been reviewed in February 2026 by the responsible executive and Head of Sustainability with no significant changes. Resource and capacity to progress this workstream had reduced through part of the year due to vacancies, however the new Head of Sustainability is now in post and key actions are progressing such as updating of the Green Plan which was completed in October 2025 and ratified by Trust Board in November. This provides opportunity to drive this at a strategic level although resource at an operational level is still insufficient to progress this at pace. Recruitment for a Sustainability Manager is currently underway, to address part of this operational gap.

Key controls	**Gaps in controls**
Governance structure including Sustainability Board Clinical Sustainability Lead Head of Sustainability Energy Manager Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan 2025-2028.	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy 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 and approved, however recruiting to the roles hasn't yet occurred due to the recruitment controls in place. Do not have a fully funded plan to achieve the national targets set out. Future funding streams are uncertain.
Key assurances	**Gaps in assurances**
<u>Level One and Two (Internal)</u> Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones.

Sustainability Board **Level Three (External)** Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators.	

Key actions

All actions are planned throughout the remainder of 2025/26 and 2026/27 and are led by the Head of Sustainability AT with executive oversight by CMO PG.

Appointment of Sustainability Manager to support Green Plan delivery and clinical sustainability projects (spring 2026).

Develop KPI metrics in respect of the Trust's Green Plan and other related strategies.

Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore low carbon skills funding). This includes funding secured for LED lighting, BMS system improvements, and measures to adapt to climate change.

Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. This aims to increase the use of electricity, including solar panels, and phase out use of gas.

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED and repurpose cardiovascular catheters.

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

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED.

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.2	Report to the Trust Board of Directors, 10 March 2026
Title:	Register of Seals and Chair's Actions Report
Sponsor:	Jenni Douglas-Todd, Trust Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
		x	

Strategic Theme

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

Executive Summary:

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

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

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

Contents:

Report

Risk(s):

N/A

Equality Impact Consideration:	N/A

1 Signing and Sealing

1.1 **Agreement** between New Forest National Park Authority (the Authority), NHS Property Services Limited (the Owner), University Hospital NHS Foundation Trust (the Lessee) and Hampshire County Council (the County Council), Pursuant to Section 106 of the Town and Country Planning Act 1990 and all Enabling Powers relating to land at Ashurst Hospital, Lyndhurst Road, Ashurst, SO40 7AR (the Trust holds a lease for the New Forest Birth Centre, which is within the planning boundary, although no development will take place within the Trust's lease area). Seal number 308 on 20 January 2026.

1.2 **Section 106 Indemnity Agreement** between NHS Property Services Limited (NHS PS) and University Hospital Southampton NHS Foundation Trust (the Trust) relating to Ashurst Hospital Development. Under the indemnity, NHS Property Services will cover any losses the Trust incurs as a result of s106 obligations, including breaches by third-party purchasers of the development. Seal number 309 on 20 January 2026.

2 Chair's Actions

2.1 **Call-off Contract** under the Health Trust Europe LLP Framework for the Anatomical Pathology Automation for Histopathology Service Modernisation to Axlab Limited, for an initial term of 7 years at a total cost of £3,869,000 excluding VAT. Funding from NHSE National Histopathology Service Modernisation Grant covering capital costs, with the Trust incurring maintenance costs from year 2. Signed by the Chair on 23 February 2026.

2.2 **Award of Contract** for Outsourced Radiology Reporting to Medica Reporting Limited and DMC Imaging Limited for an initial term of 36 months, at a total cost of £5,485,054, VAT exempt. The contract includes 5 x 12-month extension options at a maximum contract cost of £14,626,811 (no VAT). Signed by the Chair on 23 February 2026.

3 Recommendation

The Board is asked to ratify the Chair's actions and application of the seal.

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.3 Report to the Trust Board of Directors, 10 March 2026	
Title:	Audit & Risk Committee Terms of Reference
Sponsor:	Ian Howard, Chief Financial Officer for Committee Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
	x		

Strategic Theme

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

Executive Summary:

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The Code of Governance for NHS Provider Trusts requires that Council of Governors is consulted on the terms of reference. The terms of reference are approved by the Board of Directors.

No changes are proposed to the current terms of reference.

The terms of reference have been reviewed by the Audit and Risk Committee on 27 January 2026.

The Council of Governors has been consulted on the proposal on 29 January 2026.

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

Contents:

Revised Terms of Reference (marked up)

Risk(s):

N/A

Equality Impact Consideration:	N/A

Audit and Risk Committee Terms of Reference

Version: 8

Date Issued:	~~11 March 2025~~ 10 March 2026
Review Date:	~~January 2026~~ January 2027
Document Type:	Committee Terms of Reference

Document Status

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

1. Role and Purpose

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

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

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

2. Constitution

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

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

2.3 In carrying out its role the Committee will primarily utilise the work of internal audit, external audit and other assurance functions. It is also authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

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

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be independent non-executive directors of the Trust (other than the chair of the Board). The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

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

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

3.3.1 representative(s) from the external auditor;

3.3.2 representative(s) from the internal auditor;

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

3.3.4 Chief Financial Officer;

3.3.5 Chief Nursing Officer; and

3.3.6 Associate Director of Corporate Affairs/Company Secretary.

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

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

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

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be two members. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

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

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

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

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members, or at the request of external or internal auditors if they consider it necessary.

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

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

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by

the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 *Integrated Governance, Risk Management and Internal Control*

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

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

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

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

7.2 *Internal Audit*

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

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

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

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

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

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

7.3 *External Audit*

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

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

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

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

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

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

7.4 ***Financial Reporting***

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

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

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

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

7.4.3.2 areas where judgment has been exercised;

7.4.3.3 appropriateness and adherence to accounting policies and practices;

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

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

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

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

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

7.5 ***Counter Fraud***

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

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

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

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

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

8. Accountability and Reporting

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

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

8.2.1 the fitness for purpose of the board assurance framework;

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

8.2.3 the integration of governance arrangements;

8.2.4 the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

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

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

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

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

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

10.2 Code of Governance for NHS Provider Trusts

10.3 NHS Foundation Trust Annual Reporting Manual

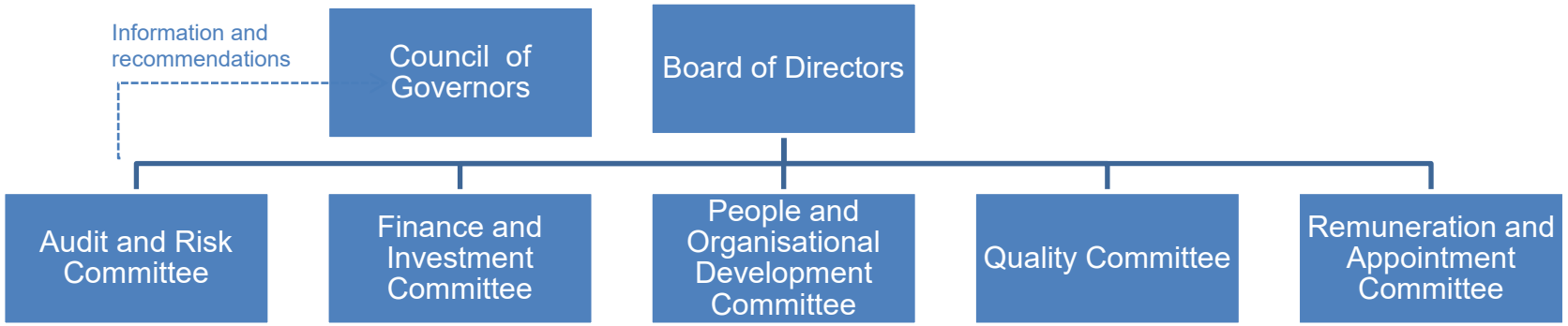
10.4 National Audit Office Code of Audit Practice

10.5 Public Sector Internal Audit Standards

10.6 NHS Counter Fraud Authority's counter fraud standards

10.7 NHS Improvement guidance on Freedom to Speak Up

Appendix A


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

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~11 March 2025~~ 10 March 2026
Responsible Committee:	Audit and Risk Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~January 2026~~ January 2027
Target audience:	Board of Directors, Audit and Risk Committee, NHS Regulators, Staff and Public
Key words:	Audit, Risk, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	No changes.
Consultation:	Council of Governors, Internal Audit, External Audit, Counter Fraud
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Agenda item 7.4 Report to the Trust Board of Directors, 10 March 2026	
Title:	Quality Committee Terms of Reference
Sponsor:	Tim Peachey, Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
	x		

Strategic Theme

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

Executive Summary:

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

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

No changes are proposed to the current terms of reference.

The Board of Directors is asked to approve the terms of reference following review and approval by the Quality Committee on 26 January 2026.

Contents:

Revised Terms of Reference (marked up)

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Quality Committee Terms of Reference

Version: ~~7~~ 8

Date Issued:	~~11 March 2025~~ 10 March 2026
Review Date:	~~January 2026~~ January 2027
Document Type:	Terms of Reference

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Document Status

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1. Role and Purpose

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

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

2. Constitution

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

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

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

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

3. Membership

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

3.1.1 at least three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating Officer.

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

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

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

3.4.1 Deputy Director of Nursing (Quality);

3.4.2 Medical Lead for Safety (Patient Safety Specialist); and

3.4.3 patient representative(s).

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

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

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or secretary of the Committee in advance.

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

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the year) and otherwise as required.

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.

7.5.4 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

7.5.5 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.6 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

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

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

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

7.7 ***Reporting***

7.7.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

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

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

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

10.2 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

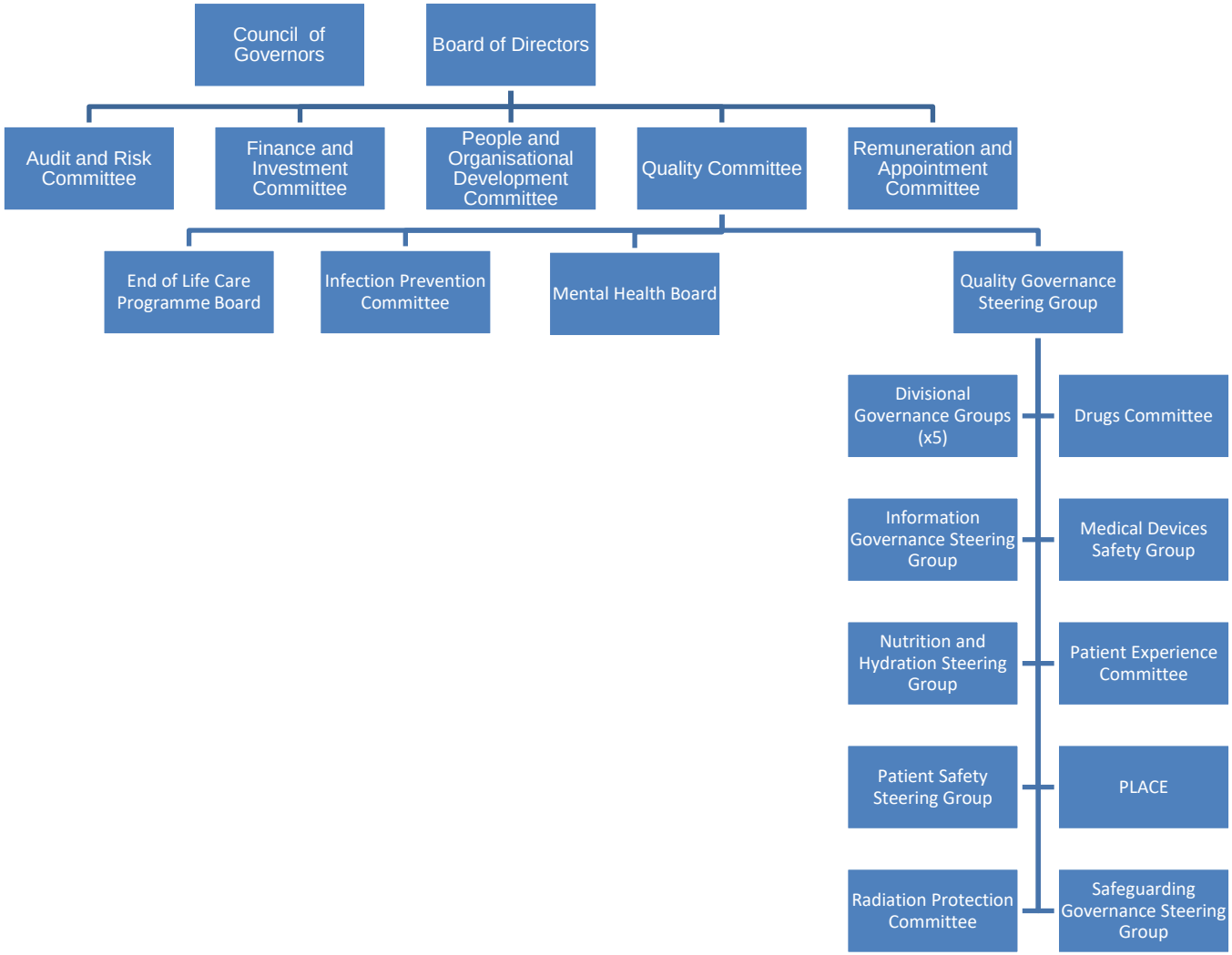
10.6 Code of Governance for NHS Provider Trusts

10.7 NHS System Oversight Framework

10.8NHS Foundation Trust Annual Reporting Manual

10.9NHS England and NHS Improvement’s requirements for quality accounts

Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

Quality Committee Terms of Reference	Version: ~~7~~8

Document Monitoring Information	
Approval Committee:	Board of Directors
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Responsible Committee:	Quality Committee
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Target audience:	Board of Directors, Quality Committee, NHS Regulators, Staff
Key words:	Quality, Governance, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Amendment of 10.6 to Code of Governance for NHS Provider Trusts and removal of Charitable Funds Committee from Appendix A~~ No changes
Consultation:	Chief Nursing Officer
Number of pages:	8
Type of document:	Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.5	Report to the Trust Board of Directors, 10 March 2026
Title:	Remuneration and Appointment Committee Terms of Reference
Sponsor:	Jenni Douglas-Todd, Trust Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
	x		

Strategic Theme

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

Executive Summary:

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

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

It is proposed to make a number of changes to the terms of reference, largely to reflect the updated NHS England Very Senior Manager Pay guidance issued in 2025. In addition, it is proposed to update 7.3.10 to reflect the requirement under the Code of Governance to discuss proposed severance payments with regional directors.

The Board is asked to approve the terms of reference.

Contents:

Draft Terms of Reference

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Remuneration and Appointment Committee Terms of Reference

Version: -7~~6~~8

Date Issued:	~~11 March 2025~~ 10 March 2026
Review Date:	March 202~~6~~7
Document Type:	Committee Terms of Reference

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Document Status

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1. Role and Purpose

1.1 The Remuneration and Appointment Committee (the **Committee**) is responsible for identifying and appointing candidates to fill all the executive director positions on the board of directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and for determining their remuneration and other conditions of service.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of remuneration and executive director appointments in accordance with relevant laws, regulations and Trust policies.

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

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

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

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

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

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be the non-executive directors of the Trust except as provided in paragraph 3.2 below.

3.2 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

3.3 The chair of the Board will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

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

3.4.1 Chief People Officer; and

3.4.2 Associate Director of Corporate Affairs/Company Secretary.

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

asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

4. Attendance and Quorum

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

4.2 The quorum for a meeting will be four members, including the chair of the Board (or the Deputy Chair in their absence). A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

5.1 The Committee will meet as required, which will usually be four times each year.

5.2 The Committee may establish a sub-committee for a specific purpose where it would be impractical for the Committee to be involved, for example the appointment of an executive director following agreement by the Committee of the process, job description and person specification.

6. Conduct and Administration of Meetings

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

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

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

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

7. Duties and Responsibilities

7.1 The Committee will carry out the duties below for the Trust.

Remuneration Role

7.2 The Committee will:

7.2.1 establish and keep under review a remuneration policy in respect of executive directors (as set out in Appendix A);

7.2.2 consult the Chief Executive Officer about proposals relating to the remuneration of the other executive directors;

7.2.3 in accordance with relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors, including salary, any performance-related pay or bonus, provisions for other benefits,

including pensions and cars, allowances, payable expenses and compensation payments;

7.2.4 adhering to all relevant laws, regulations and Trust policies:

7.2.4.1 establish levels of remuneration that are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level that is affordable to the Trust;

7.2.4.2 decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

7.2.4.3 make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the Trust, and take as a baseline for performance any competencies required and specified in the job description for the post;

7.2.4.4 consider all relevant and current directors relating to contractual benefits such as pay and redundancy entitlements;

7.2.4.5 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors while ensuring that increases are not made where Trust or individual performance do not justify them;

7.2.4.6 be sensitive to pay and employment conditions elsewhere in the Trust;

7.2.5 monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

7.2.6 on an annual basis monitor the remuneration of non-clinical senior leadership roles remunerated at levels above those specified in the NHS agenda for change terms and conditions;

7.2.7 approve the level of remuneration or any proposed change to remuneration for a senior leadership role referred to in 7.2.6 where the proposed remuneration for the role would exceed that of any executive director; and

7.2.8 consider issues of equality and diversity when evaluating and setting remuneration.

~~7.2.8~~7.2.9 Ensure decision making is consistent with NHS England guidance such as the NHS Very Senior Managers Pay Framework issued in June 2025.

Appointment Role

7.3 The Committee will:

7.3.1 regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board and the Governors' Nomination Committee, as applicable, with regard to any changes;

7.3.2 give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future;

7.3.3 keep the leadership needs of the Trust under review at executive director level to ensure the continued ability of the Trust to operate effectively in the health economy;

7.3.4 be responsible for identifying the and appointing candidates to fill posts within its remit as and when they arise;

7.3.5 when a vacancy is identified, evaluate the balance of skills, knowledge and experience of the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

7.3.6 ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation and monitor procedures to ensure that executive directors remain 'fit and proper' persons;

7.3.7 ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;

7.3.8 ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

7.3.9 carefully consider what compensation commitments (including pension contributions) the executive directors' terms of office would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing executive director's obligation to mitigate loss. Appropriate clawback provisions should be considered in the case of an executive director returning to the NHS within the period of putative notice; and

7.3.10 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. The Committee shall assure itself that any regulatory responsibilities of the trust relating to continuation of office of any executive director have been appropriately discharged. This includes notification of regulatory bodies such as NHSE where appropriate.

8. Accountability and Reporting

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

8.2 The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive directors and the process it has used in relation to the appointment of executive directors.

9. Review of Terms of Reference and Performance and Effectiveness

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

10. References

10.1 National Health Service Act 2006

10.2 Code of Governance for NHS Provider Trusts

10.3 ~~NHS England Guidance on pay for very senior managers~~ NHS Very Senior Managers Pay Framework

Appendix A
UHS Executive Director Pay Principles

1. **The importance of executive director pay**
   The delivery of the Trust's 5-year strategy and annual Trust objectives is predicated on ensuring talent is available at all levels of the Trust. Good senior leadership is vital, and therefore a key strategy for UHS must be to recruit and retain the best executive director talent into the Trust. This will be from a combination of both good internal succession planning, bringing top talent from the NHS and also seeking high calibre individuals from other sectors.

2. **Determination of pay levels of posts**
   Pay for executive director posts will be determined by:
   - Use of NHS England (NHSE) data on pay for executive director (Very Senior Manager – VSM) positions in comparable trusts (Figure 1).
   - Any other available NHSE frameworks for setting of executive pay
   - Use of other salary benchmarking exercises, particularly from comparable NHS organisations
   - Job evaluation as required.
   - The conditions required to attract suitably qualified individuals, particularly where commercial, financial or other niche business skills are required.

   Pay levels will be reviewed not less frequently than annually by the Committee in accordance with the Trust's pay review cycle to ensure that salary levels are both appropriate and provide value for money.

3. **Setting salary of executive directors**
   The following principles will apply:
   - UHS will aim to pay at a point consistent with the VSM pay framework that attracts suitable candidates~~at around mid-point of NHSE levels for trusts of a comparable nature and scale.~~
   - UHS will review pay based on performance, changes in the NHSE framework levels, comparable NHS Trust benchmarking and, in particular, the need to retain key individuals likely to be of interest to the external market.
   - UHS will not recognise relevant changes of NHSE framework levels in respect of individuals where this is not justified by individual performance.
   - UHS will be mindful of equality and diversity, particularly in relation to gender and ethnicity in pay levels.
   - UHS will ensure all VSM nationally applicable cost of living pay awards are reflected in executive director pay each year, as decided by the Committee. The committee may choose to withhold a national pay increase where individual performance has been unsatisfactory and where the guidance permits this.
   - Any decision to introduce performance-related pay, or bonuses, will be subject to decision by the Committee based on a sound business case and adherence to NHSE guidance on executive pay.

4. **Approval process**
   All decisions on pay for executive directors will be managed in line with the terms of reference for the Committee.

The Committee, supported by the Chief People Officer, will also ensure that the NHSE prevailing guidance on setting executive director pay, including any required approval process, will be followed as appropriate.

Figure 1 – ~~Current~~ NHS England Pay Thresholds 2025/26

~~Supra large acute NHS trusts and foundation trusts (£750m+)~~	~~Lower quartile~~	~~Median~~	~~Upper quartile~~
~~Chief executive~~	~~£236,000~~	~~£250,000~~	~~£265,000~~
~~Deputy chief executive~~	~~£185,500~~	~~£188,000~~	~~£195,500~~
~~Director of finance/Chief finance officer~~	~~£166,000~~	~~£172,500~~	~~£190,500~~
~~Director of workforce~~	~~£142,500~~	~~£155,000~~	~~£165,500~~
~~Medical director/Chief medical officer~~	~~£205,000~~	~~£214,000~~	~~£233,500~~
~~Director of nursing/Chief nursing officer~~	~~£150,000~~	~~£163,500~~	~~£168,000~~
~~Chief operating officer~~	~~£143,500~~	~~£162,500~~	~~£174,500~~
~~Director of corporate affairs/governance~~	~~£113,000~~	~~£117,500~~	~~£134,000~~
~~Director of strategy/planning~~	~~£135,000~~	~~£144,000~~	~~£152,500~~
~~Director of estates and facilities~~	~~£129,500~~	~~£137,000~~	~~£146,500~~

Pay Ranges for Organisations with Annual Turnover above £1bn			
Role	**Minimum**	**Operational Maximum**	**Exception Zone**
Chief Executive Officer	£245,663	£279,163	£308,976
Executive Directors (reporting to CEOs)	£156,331	£206,581	£227,667
Executive Directors (reporting to a board director)	£122,832	£150,749	£157,199

Note: The committee will use the latest published NHS England pay thresholds. The table above was correct as of the date of issue of these terms of reference for organisations with annual turnover above £1bn.

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~11 March 2025~~10 March 2026
Responsible Committee:	Remuneration and Appointment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	March 202~~6~~7
Target audience:	Board of Directors, Remuneration and Appointment Committee, NHS Regulators, Staff and Public
Key words:	Remuneration, Appointment, Nomination, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~No changes are proposed~~Updates to 7 to include reference to VSM Pay Guidance and role of third parties in 7.3.10. Update to Appendix 3 and to pay table based on latest NHSE VSM Pay Ranges and reference to the NHSE VSM pay framework in 10.3.~~-~~
Consultation:	Remuneration and Appointment Committee
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

Agenda Item 10.1	Report to the Trust Board of Directors, 10 March 2026
Title:	South Central Regional Research Delivery Network (SC RRDN) 2025-26 Q3 Performance Report
Sponsor:	Mr Paul Grundy, Chief Medical Officer
Author:	Clare Rook, Network Director, SC RRDN Graham Halls, Data and Analytics Senior Manager, SC RRDN

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

This report provides a performance update for the South Central Regional Research Delivery Network (SC RRDN) region for quarters one to three of the 2025/26 financial year.

- **Regional Performance**: SC RRDN continues to perform strongly when compared to other English regions, ranking 3rd nationally for recruitment when adjusted for population size.
- **Recruitment Trends**: Total recruitment has seen a downward trend since June 2025, mirroring a systemic decline across England. However, activity remains within expected statistical limits for the region when the normal variation in research study opportunities is considered.
- **Funding Transition**: There will be a transition to a new national funding model in April 2026 for research in hospitals and wider care settings. The move from a regional to a national funding model has resulted in an £868,069 (-3.1%) cut for our region year on year. However, high complexity-weighted recruitment positions the region's NHS Trusts well for future activity-based funding.
- **Commercial Research**: While commercial recruitment is currently trending down nationally, the region has seen an underlying upward trend this year when excluding a few exceptionally large historical studies. This trend continues into 2026.
- **Participant Experience**: Feedback from 1,285 participants is positive regarding research delivery. A key priority for the region is improving how we communicate study results back to participants.

Contents:

South Central Regional Research Delivery Network Q3 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 Three Performance Report

Clare Rook, Network Director

Graham Halls, Data and Analytics Senior Manager

February 2026

2

Introduction

This report informs the Board of the health and care research activities within the National Institute of Health and Care Research (NIHR) South Central Regional Research Delivery Network (SC RRDN) region during first three quarters of the 2025/26 financial year (April to December 2025). The report primarily presents performance against the measures included in the RDN funding model, which will be implemented from April 2026.

SC RRDN was formed in October 2024, with a change in geography to cover the area shown in Figure 1. This area aligns with the regions covered by NHS Buckinghamshire, Oxfordshire & Berkshire West, NHS Frimley and NHS Hamshire & Isle of Wight Integrated Care Boards. This report includes historical research activity from the organisations in the same region to allow performance to be tracked over a longer period.

Figure 1 - Map of the region covered by SC RRDN

About the NIHR Research Delivery Network (NIHR RDN)

The NIHR RDN is funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise and deliver research across England. The RDN consists of twelve RRDNs and a Coordinating Centre, working together as one organisation with joint leadership. The RDN contributes to NIHR's **mission** to improve the health and wealth of the nation through research.

RDN vision, mission and purpose

The RDN's **vision** is for the UK to be a global leader in the delivery of high quality research that is inclusive, accessible, and improves health and care.

The RDN's **mission** is to enable the health and care system to attract, optimise and deliver research across England.

The RDN has two primary **purposes**:

1. to support the successful delivery of high quality research, as an active partner in the research system
2. to increase capacity and capability of the research delivery infrastructure for the future.

This will:

- enable more people to access health and social care research where they live
- support changing population needs by delivering a wider range of research and deliver research in areas of most need
- provide support to the health and care system through research
- encourage research to become a routine part of care
- support economic growth by attracting investment to the UK economy.

NIHR RDN Strategic Plan – Launched in October 2025

The NIHR RDN developed a strategic plan for 2025 to 2030, after extensive collaboration across the research community. The plan sets out how the NIHR RDN will deliver on its primary purposes and focus its activities in supporting the government's health and growth missions by delivering on

the **'three shifts'** outlined in Fit for the future: Ten Year Health Plan for England. It will also support the delivery of the Life Sciences Sector Plan vision to be at the forefront of global innovation. The plan outlines how the NIHR RDN will work as a partner in the wider health and care system to deliver against commitments in the NIHR's **seven strategic priority areas**:

1. building on lessons from the COVID-19 response
2. strengthening preventative, public health, and social care research
3. improving care for people with multiple long-term conditions
4. expanding clinical research to under-served regions and communities
5. embedding equality, diversity, and inclusion
6. strengthening careers for research delivery staff
7. expanding collaboration with the life sciences industry.

For further information on the RDN Strategic Plan, please visit the NIHR RDN website.

Research funding model for the 2026/27 financial year

From April 2026, a consistent, nationally agreed funding distribution model will be adopted across England. A key **aim** is to enable a more transparent, fair, and predictable system of funding that supports the NIHR's strategic ambitions and the needs of the whole health and care system, including underserved areas and settings.

The nine guiding **principles** for the NIHR RDN Funding Model are:

1. **National Consistency:** A single national model will be adopted across all RRDNs to reduce regional disparities.
2. **Predictability:** Enable long-term planning through earlier notification of allocations.
3. **Adaptability:** Evolve the model in line with the research portfolio and wider system needs.
4. **Strategic Alignment:** Align the model to the NIHR's aims and the Government's strategic priorities.
5. **Support for Established and Emerging Delivery Organisations:** Protect existing capacity while building new infrastructure.
6. **Proportionate Oversight:** Streamline reporting to avoid duplication.

7. **Value and Impact:** Develop robust ways to assess value for money and return on investment.
8. **Collaboration and Integration:** Promote partnerships and shared accountability.
9. **Full Cost Recovery:** Ensure organisations can secure appropriate funding for research costs.

Funding for NHS Trust-based research (the 'Hospital' model)

The nationally calculated budget has three components:

Figure 2 – The three components of the Hospital funding model

The three components are explained further below:

1. **Historical Allocation (50% of the hospital delivery budget):** The NHS Trust's allocation from the previous financial year, which provides a base level of stability.
2. **Activity Based Funding (30% of the hospital delivery budget):**
    - **Weighted Recruits (70% of Activity-Based funding):** Tracking the number of recruits, weighted by study type.
    - **Number of Studies (30% of Activity-Based funding):** The count of non-commercial research studies conducted over the previous three financial years.
3. **Performance (20% of the hospital delivery budget):** distributed based on organisational performance against a range of setup, efficient study delivery and growth metrics. These align with the government priority areas.

The new funding model employs a tiered system for '**caps and collars**'. All organisations are protected by a 7% collar which is the maximum that funding can decrease year on year. The caps on funding increases vary based on the NHS Trust's RDN funding size:

- For NHS Trusts with more than £2.5 million in RDN funding, the cap is 7%.
- For NHS Trusts with £1-2.5 million in RDN funding, the cap is 15%.
- For NHS Trusts with less than £1 million in RDN funding, the cap is £150,000

This tiered approach is designed to protect stability for all organisations while enabling growth for emerging organisations.

The **Performance** section of the model is distributed through two mechanisms:

1. **Direct payments:** additional funding for excellent performance beyond the organisation's funding cap.
    - First UK site to open to recruitment within sixty days of Health Research Authority (HRA) approval.
    - First UK participant recruited within ninety days of HRA approval.
    - First European site to recruit (commercial studies only).
    - First global site to recruit (commercial studies only).
2. **Performance adjustments to the baseline:** subject to overall caps and collars.
    - Percentage of studies opened at the site within sixty days of HRA approval or site selection (commercial & non-commercial studies).
    - Percentage of studies achieving First Participant, First Visit (FPFV) at the site within thirty days of site readiness (commercial & non-commercial studies).
    - Percentage of commercial studies achieving Recruitment to Time and Target at the site.
    - Increase/decrease in recruitment to interventional commercial trials compared to the previous reporting period.
    - Increase/decrease in the number of interventional commercial trials recruiting compared to the previous reporting period.

The move from a regional to a national funding model has resulted in an £868,069 (-3.1%) cut for the South Central region year on year. However, high complexity-weighted recruitment positions the region's NHS Trusts well for future activity-based funding.

Funding for research outside of hospitals (the 'Wider Care Settings' model)

Funding allocations for wider care settings (WCS) will be managed at a regional level, with each Regional Research Delivery Network (RRDN) receiving a WCS allocation. In the 2026/27 financial year, each RRDN will receive additional funding to WCS to support the shift from hospital to community, as outlined in the Government's 10 Year Health Plan. A single distribution model will be applied to all wider care settings.

Organisations from wider care settings can access RDN funding in two ways, receiving both retrospective and prospective payments:

1. **Retrospective payments (activity-based):** Support costs are paid to any organisation in a wider care setting that has delivered research from the RDN portfolio, based on the confirmation of activity completed.
2. **Prospective payments:** These are awarded to organisations to help them develop their research delivery infrastructure, based on the submission of a nationally standardised application.

The Agile Research Delivery Teams, employed by each RRDN, will continue to deliver research support for WCS research. The RRDNs have flexibility to move funding between the regional wider care and strategic funding pots to respond to the availability of research.

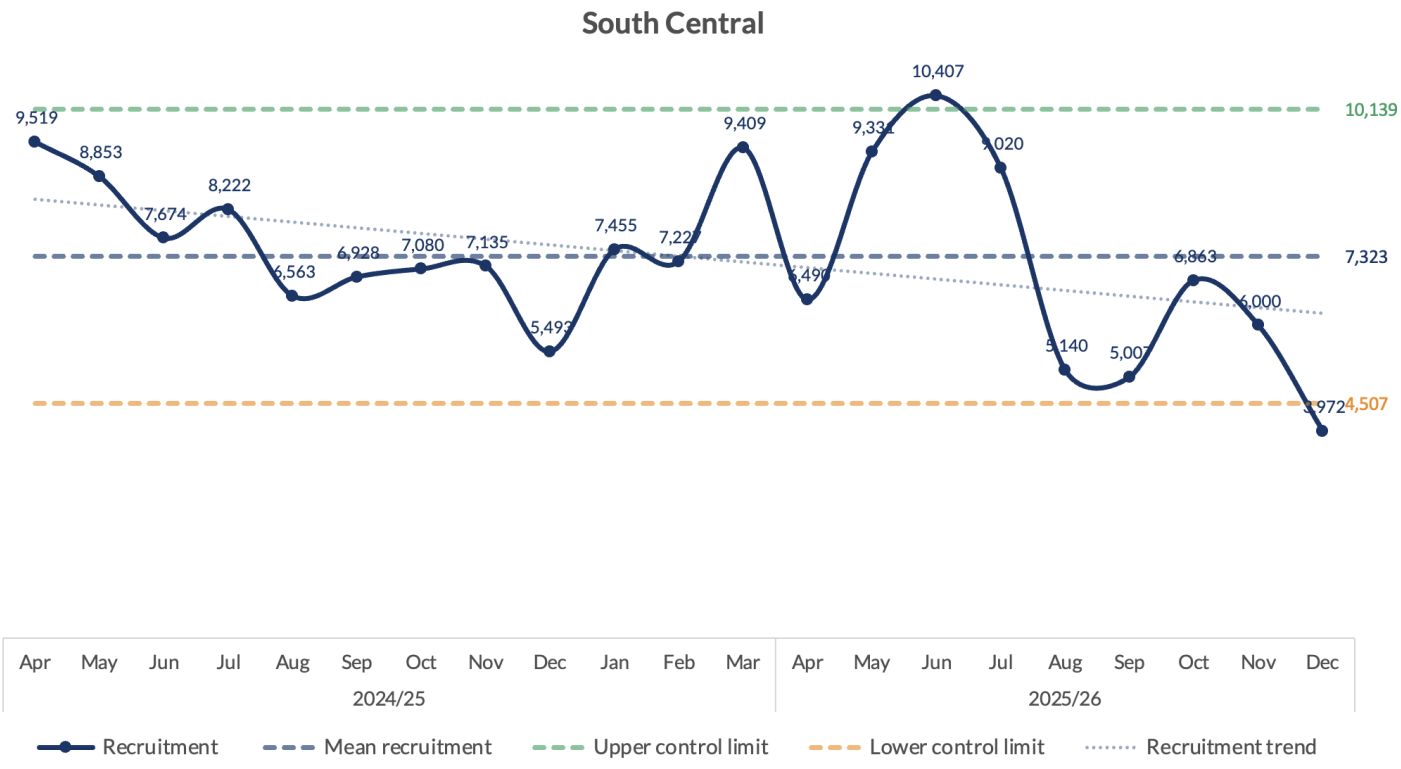
Overview of research activity in the SC RRDN region

Recruitment in South Central

During the first nine months of the 2025/26 financial year in the South Central region, **62,251 participants** were recruited to **983 studies** at **228 sites** and across **all main clinical specialties**.

After a peak of 10,407 participants recruited during June 2025, recruitment has since fallen in South Central (Figure 3). However, this activity hasn't left the lower and upper statistical limits for a period of greater than a month. This indicates that there is normal variation in the research activity. The pattern for recruitment activity is rarely linear because research studies open and close throughout a financial year, as well as seasonal fluctuations in staff availability due to holiday

periods. For comparison, the overall downwards trend in recruitment is also being experienced across England.



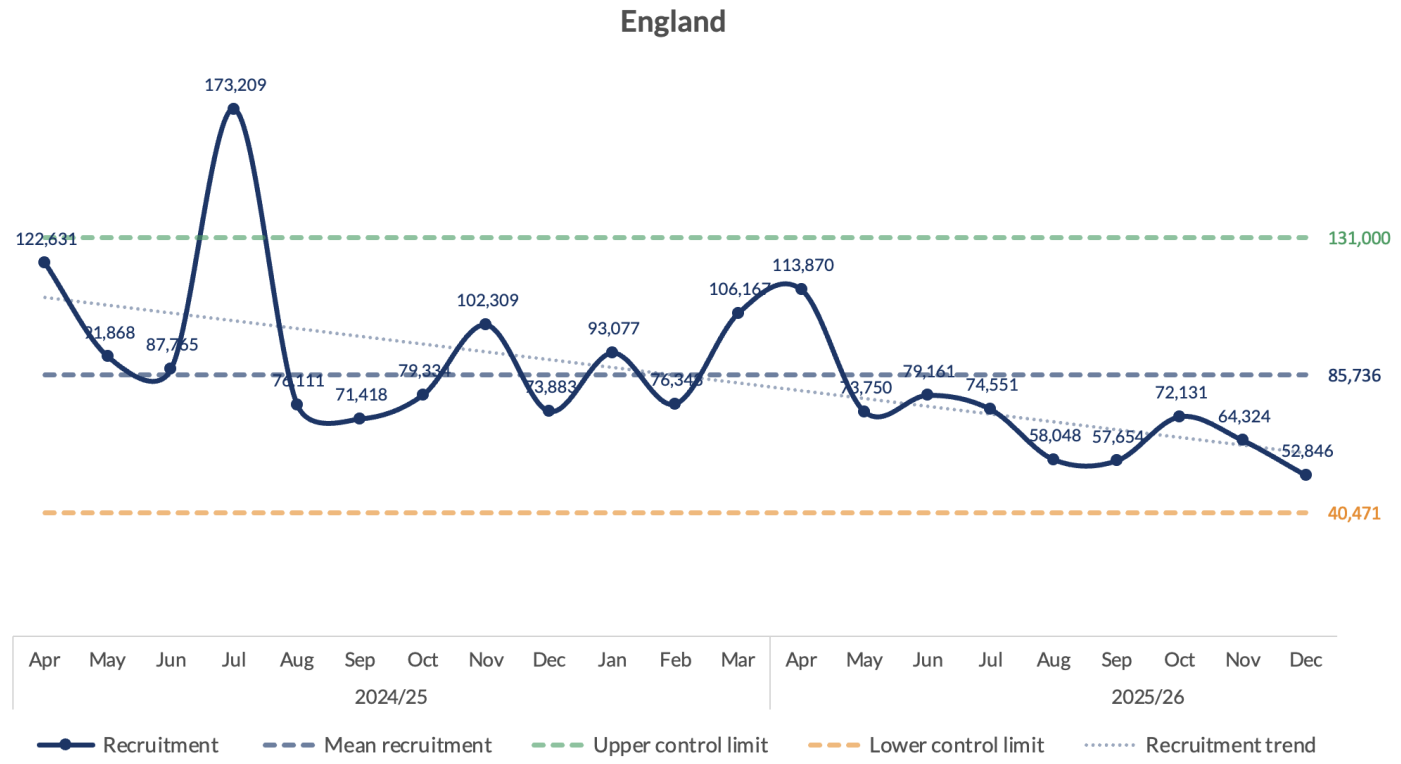


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Figure 3 - Monthly recruitment in the South Central region benchmarked against England since April 2024

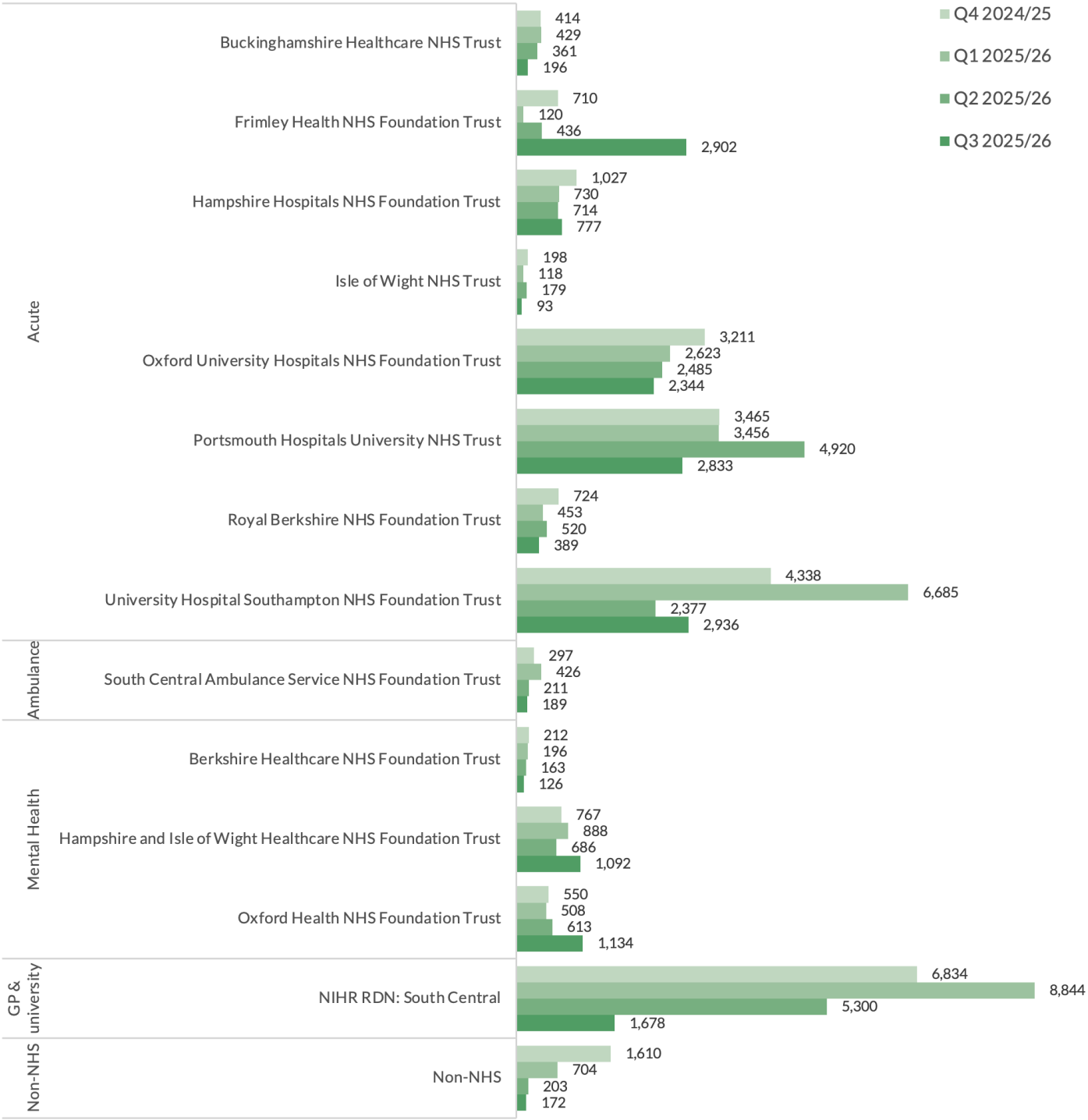

Figure 4 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

Research recruitment has happened in all NHS Trusts, as well as at over a hundred GP practices, care homes, pharmacies and other health and care settings in the South Central region (Figure 4). There has been a general decline over the last six months in primary care and university recruitment, as well as at some NHS Trusts, including the largest organisations. This trend has been reversed at Frimley Health, Oxford Health, Hampshire and Isle of Wight Healthcare and Hampshire Hospitals in the most recent quarter.

Complexity weighted recruitment in South Central

While recruitment is an important measure of the opportunities available to the population to participate in research, other important aspects are the design and complexity of the research that is delivered.

Research participation can either be **interventional**, where the patient's care pathway is affected, or **observational**, where there is no change. Studies also vary in the number of participants they intend to enrol and in the effort required to deliver the study's protocol - the set of instructions required to answer the research question. This concept is known as the study 'complexity'.

Regions and delivery organisations are expected to have a balanced portfolio of all types of study design and complexity. Each participant is therefore assigned a weighting to create a comparable figure known as **complexity weighted recruitment (CWR)**. The weighting for recruitment in different study types has been updated with the 2026/27 funding model based on an analysis of study data and feedback from stakeholders:

Type of research study	Study funder	Study sample size	Weighting per participant
Interventional	Non-commercial	Less than 5,000	175
Observational	Non-commercial	Less than 10,000	86
Large interventional	Non-commercial	5,000 or above	29
Large observational	Non-commercial	10,000 or above	1
Any commercial research	Commercial	Any sample size	0

Recruitment on commercial research studies is not weighted because the funding for this research activity is paid directly from the life science industry partners.

Like recruitment, CWR since April 2024 has been trending downwards in South Central and in England (Figure 5). This suggests that there has been a systemic change over time rather being a region-specific issue. There is also evidence of seasonal variation, with August and December showing the some of the largest drops in activity each year.

Figure 5 – Monthly complexity weighted recruitment in the South Central region benchmarked against England since April 2024

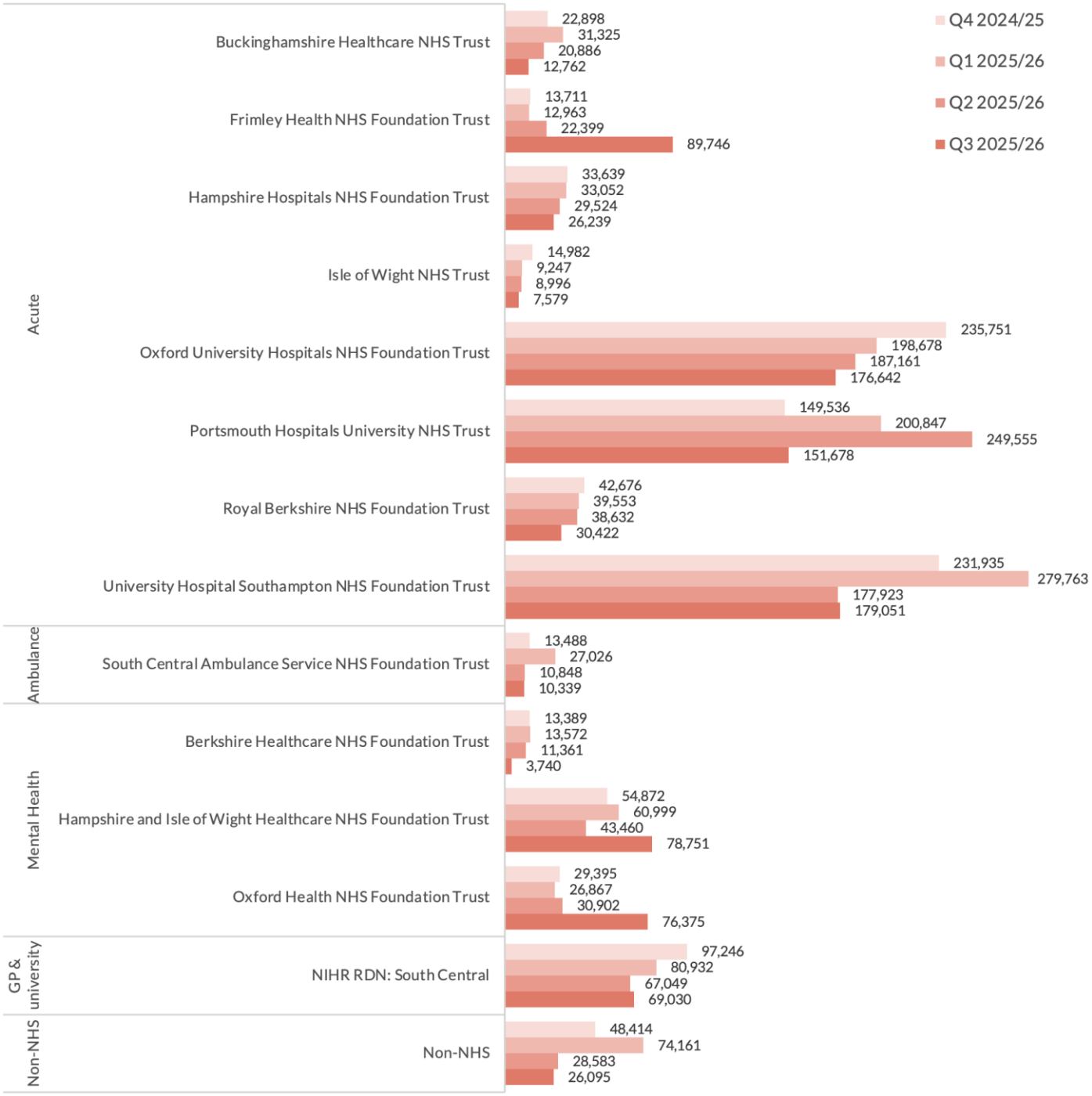

Figure 6 – Complexity weighted recruitment by organisation and organisation type in the South Central region in the previous four quarters

The ability to deliver highly complex studies is limited by the capacity and skills of the workforce that can deliver them, as well as the available infrastructure. Drug trials in particular require experienced clinical leadership and support departments that can dispense experimental drugs and perform investigational scans. For this reason, the most complex research generally requires the most resources and is therefore weighted higher in the funding model. This is also why most drug and device trials are delivered in a hospital setting, where these resources are centralised across limited locations.

Figure 6 shows how CWR is distributed across the South Central region by type of organisation. University Hospital Southampton, Oxford University Hospitals and Portsmouth Hospitals continue to have the highest CWR in this region, though each have seen a decline from their respective peaks.

Frimley Health and community organisations like Oxford Health and Hampshire and Isle of Wight Healthcare have each significantly increased their CWR in the third quarter of 2025/26. Each organisation increased their recruitment during this period and did so on higher complexity weighted studies.

Recruitment in the wider care settings, including GPs, universities and other non-NHS organisations collectively exceeds each of the largest NHS Trusts in the region (Figure 4). However, the complexity of the research delivered has been lower than hospital-based research (Figure 6). Wider care settings activity is independent from the hospital funding model for 2026/27. However, high recruitment in wider care settings means that research is reaching more people where they live, so this is a priority area of growth for the Government.

Commercial recruitment in South Central

Commercial research, funded and sponsored by the life sciences industry, is important to the South Central region and is also 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. Lord O'Shaughnessy's 2023 review of

commercial clinical trials in the UK also recommended substantial increases in commercial recruitment in the UK.

In the first three quarters of 2025/26, organisations in the South Central region have recruited **1,429 participants** across **30 sites** on **224 commercial studies**.

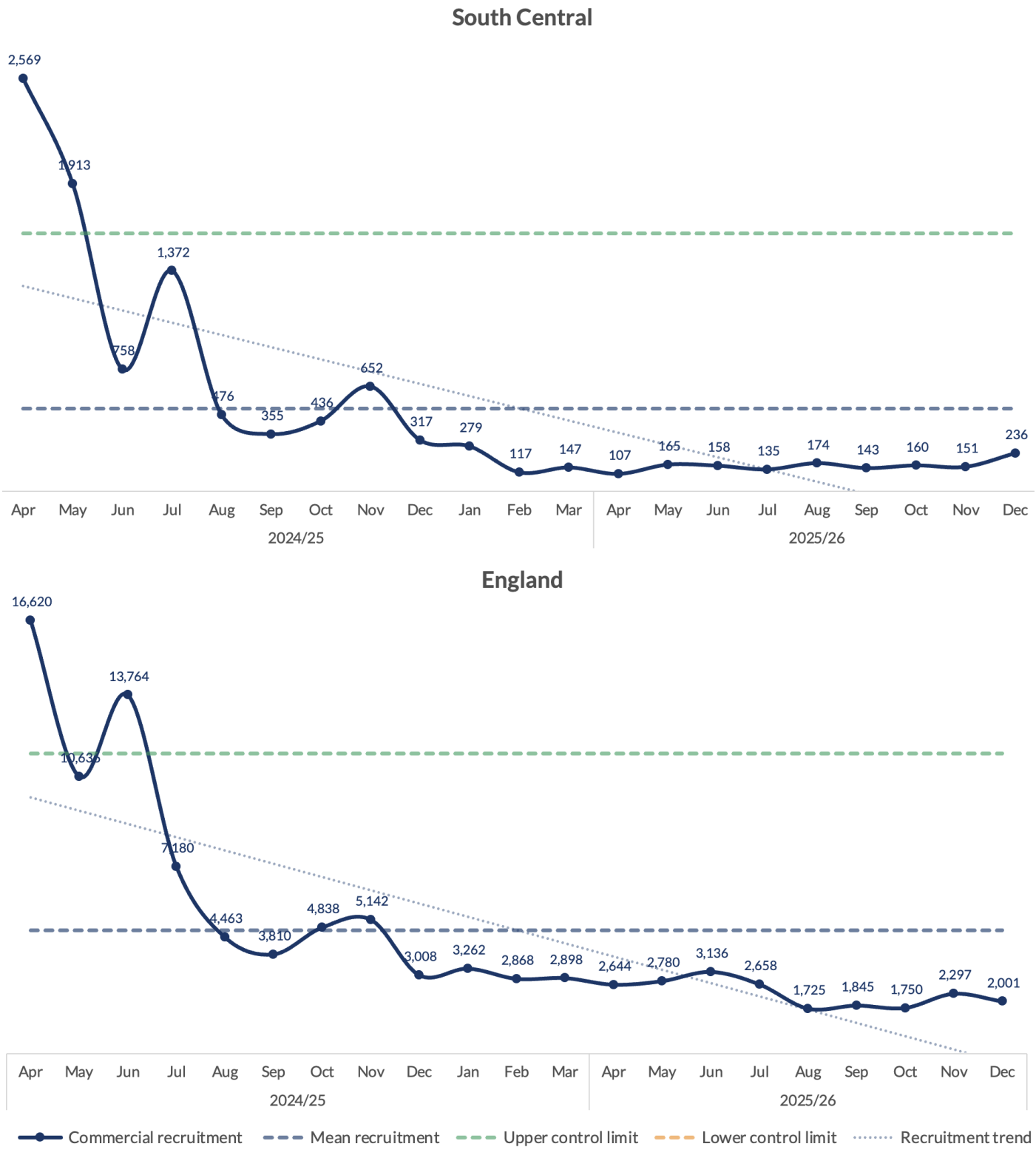

Figure 7 - Monthly commercial recruitment in the South Central region benchmarked against England since April 2024

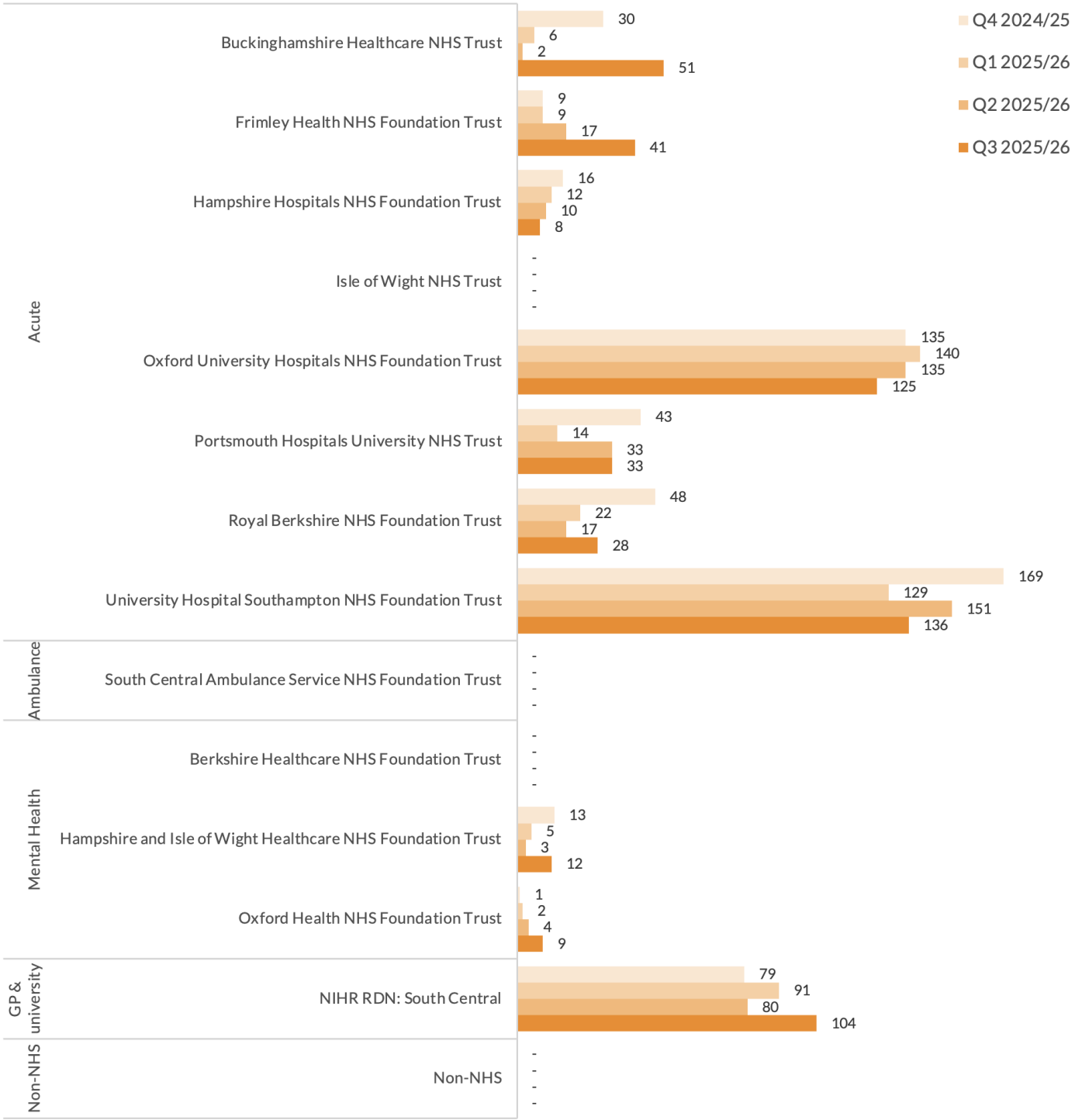

Figure 8 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

Figure 7 shows that commercial recruitment is trending downwards for both the South Central region and all regions in England. The peak evident at the beginning of 2024/25 is due to four studies with a national sample size of over 4,500 participants. When these are removed, monthly

commercial recruitment is trending upwards this financial year in the South Central region. In January 2026, this trend has continued with 318 participants recruited.

For reference, commercial recruitment by organisation and organisation type during the last four quarters is provided in Figure 8.

Summary of South Central recruitment

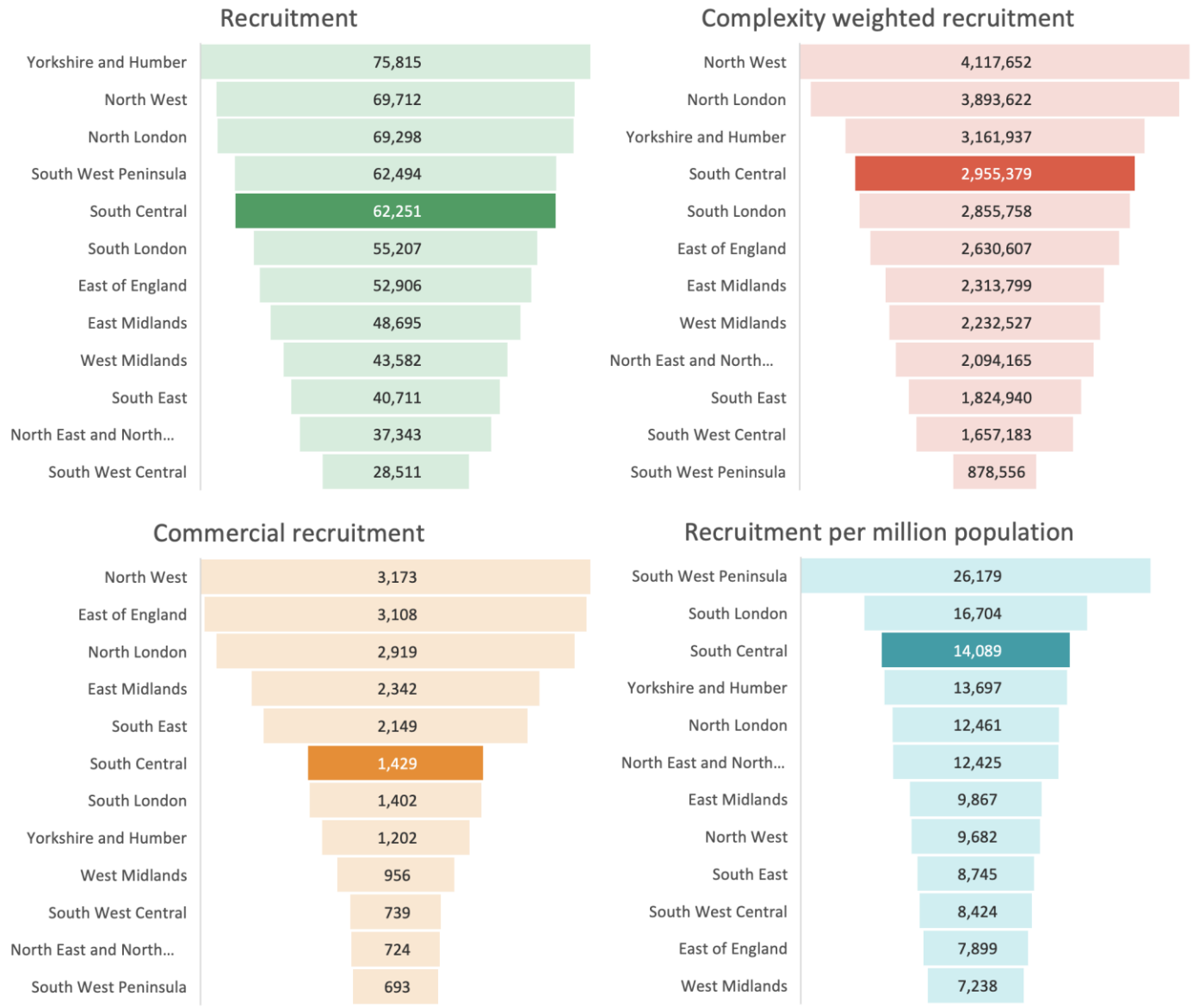

Figure 9 – Recruitment, complexity weighted recruitment, commercial recruitment and recruitment weighted per million population by RRDN region in quarters one to three of the 2025/26 financial year

The research activity in the South Central region, relative to all other RRDN regions in England has been provided in Figure 9.

South Central has the eighth largest population and so, excluding all other factors, might expect to be positioned low to middle in comparison to the other English RRDN regions. South Central ranked fifth for recruitment, fourth for complexity weighted recruitment, sixth for commercial recruitment and third when the population size of each region is accounted for. This suggests that South Central is not only recruiting well, relative to other regions, but that this activity is of a higher complexity. In terms of the hospital funding model, South Central organisations will receive a higher proportion of the funding linked to complexity weighted recruitment in 2027/28, should this performance continue during 2026.

Although commercial recruitment has showed signs of growth over the last twelve months, it appears to be a target for improvement, with a step change between South Central and the regions with higher activity. More commercial recruitment will lead to income that is in addition to the hospital and wider care settings funding models. This will give South Central organisations greater scope to expand capacity or account for any increased costs in research delivery.

Recruiting studies in South Central

Figure 10 shows the total number of recruiting non-commercial studies in South Central since April 2023. This is a factor in the hospital funding model, albeit with the timeline shifted six months to three calendar years (2023 to 2025). This chart indicates that this metric will be unlikely to be met in this region, however the 2025/26 total will appear reduced because this is for a partial year.

The increase in the proportion of interventional studies, the highest weighted study category, has been offset partly by a two per cent decrease in observational studies – the second highest weighted. This does not necessarily mean that there will be a reduction in complexity weighted recruitment, but that there are currently fewer studies on which to recruit in these highly weighted categories.

The number of commercial studies that have recruited has remained relatively stable over the same period (Figure 11). The 2025/26 total is reduced for the partial year but is expected to increase before the end of April 2026, based on the current pipeline of commercial studies in setup.

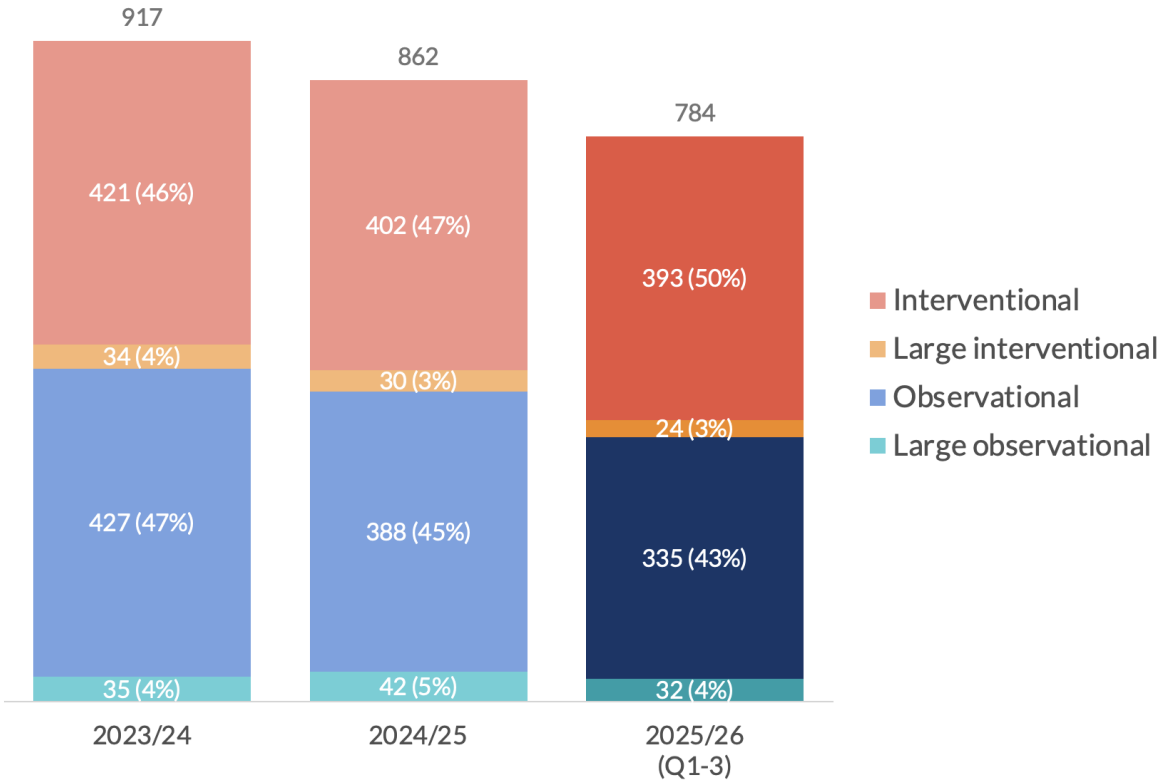

Figure 10 – Recruiting studies by complexity within the South Central region since April 2023

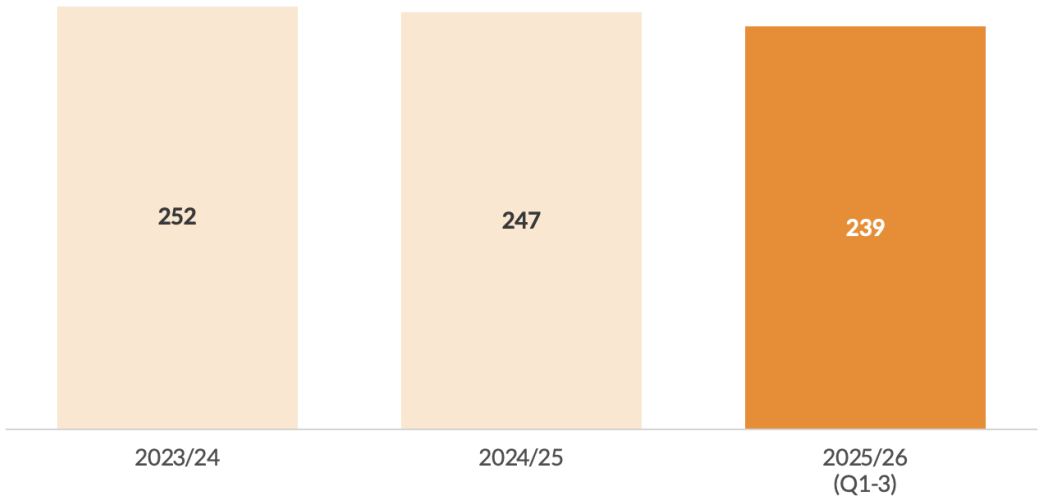

Figure 11 – Commercial recruiting studies within the South Central region since April 2023

In the first three quarters of 2025/26, South Central has the fifth and fourth highest number of recruiting non-commercial and commercial studies, respectively, among the twelve RRDN regions in England (Figure 12).

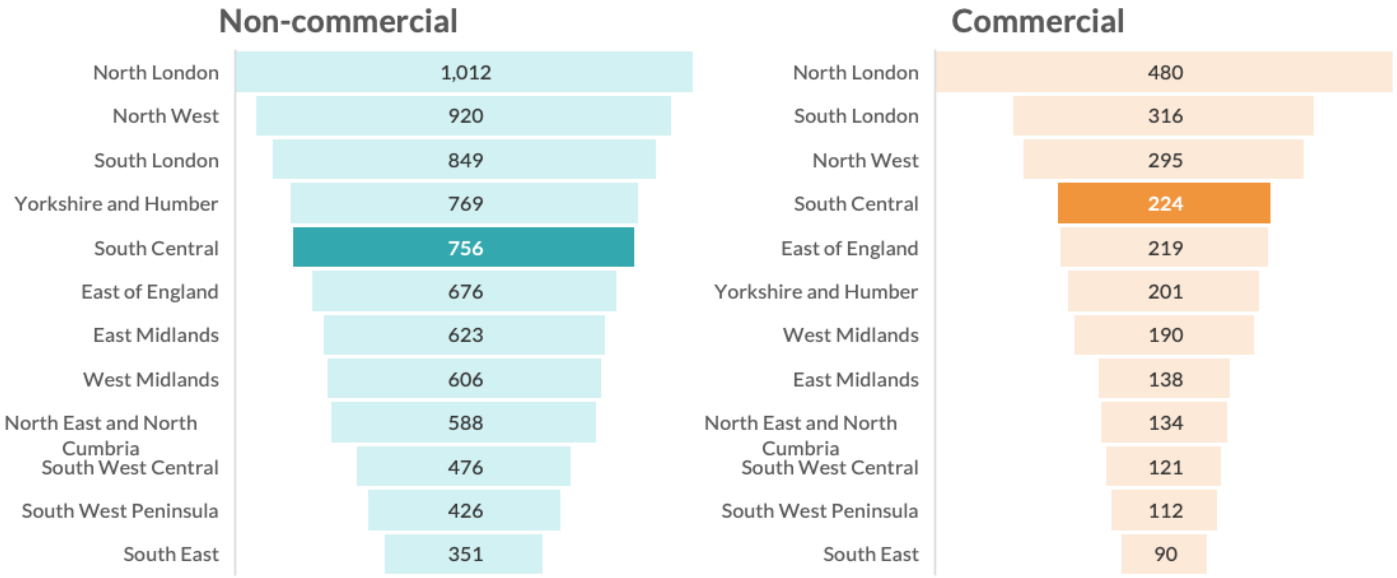

Figure 12 - Non-commercial and commercial recruiting studies by RRDN region since April 2025

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 **1,285** responses in the first three quarters (Figure 13).

Feedback was generally positive from participants, but a communications issue remains. This relates to being informed of the study results and being kept updated throughout their involvement in the study. These aspects are directly affected by the design of the study and whether contact points with participants have been included and approved by an ethics committee. The Health Research Authority requires researchers to state in their ethics application how they intend to inform participants of the results. Drug trials approved from 28 April 2026 will also be legally required in the UK to do so within twelve months of the trial ending, under a change in the legislation.

SC RRDN regularly share the survey results with research delivery organisations. Strategies to address identified issues are then discussed, monitored, and adjusted based on ongoing participant feedback.

Figure 13 - Summary of the Participant in research experience survey results in the South Central region in quarters one to three of the 2025/25 financial year

Other performance measures affecting funding for hospital-based organisations

The 2026/27 RDN hospital funding model introduced nine new measures under the 'Performance' section. This final section of the report includes each South Central research delivery organisations' performance on these measures and is provided for information only.

First UK site to open to recruitment within 60 days of HRA approval – Direct payment

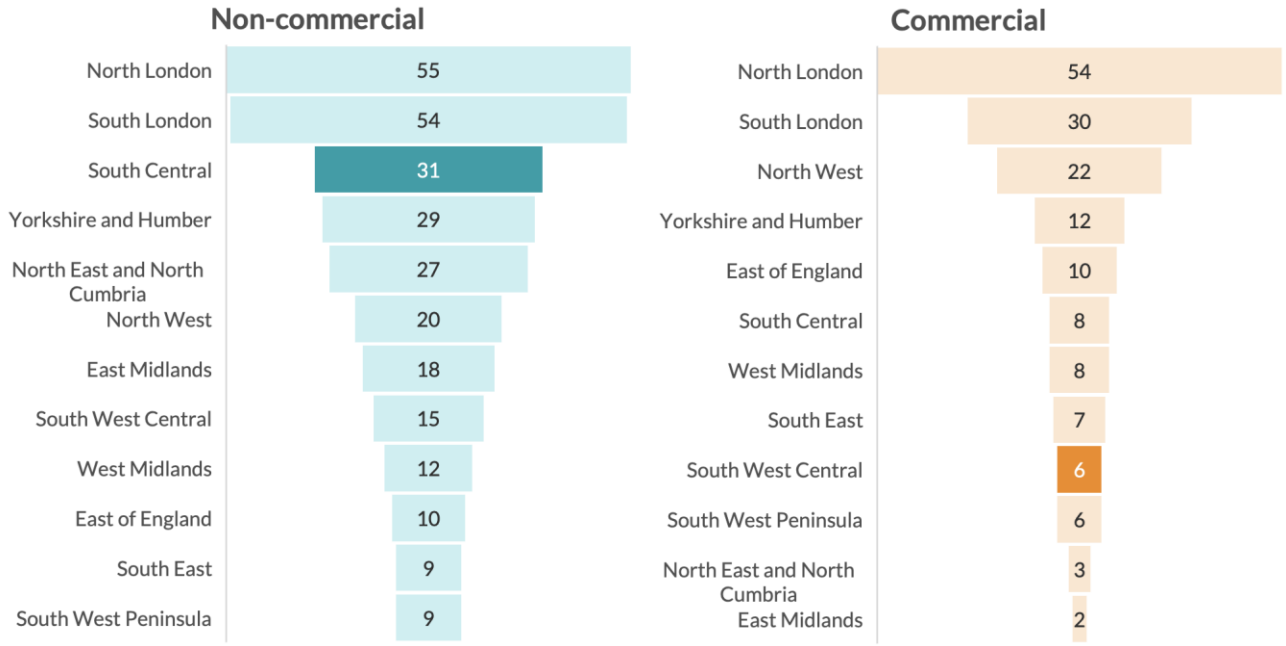

Figure 14 - First UK site to open to recruitment within sixty days of HRA approval on non-commercial and commercial studies by RRDN region since January 2025

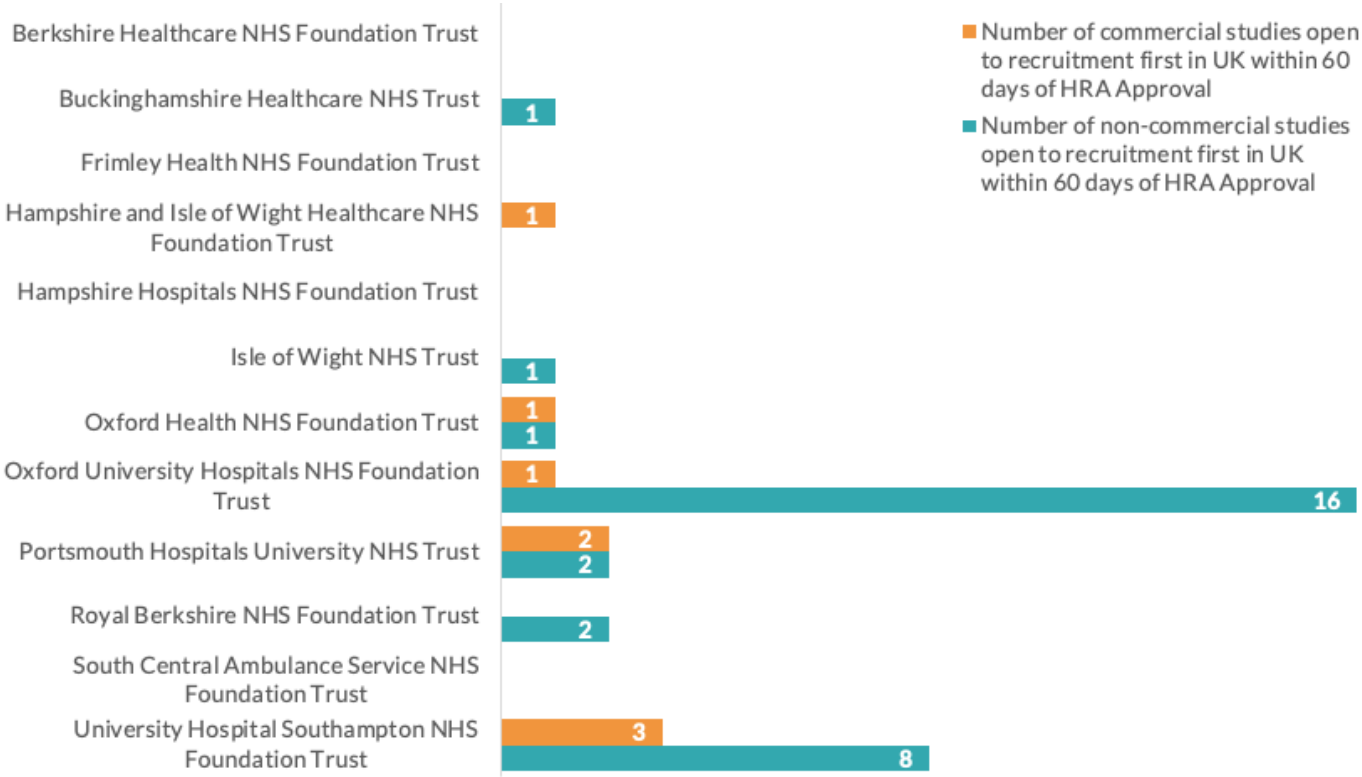

Figure 15 - First UK site to open to recruitment within sixty days of HRA approval on non-commercial and commercial studies at South Central NHS Trusts since January 2025

First UK participant recruited within 90 days of HRA approval – Direct payment

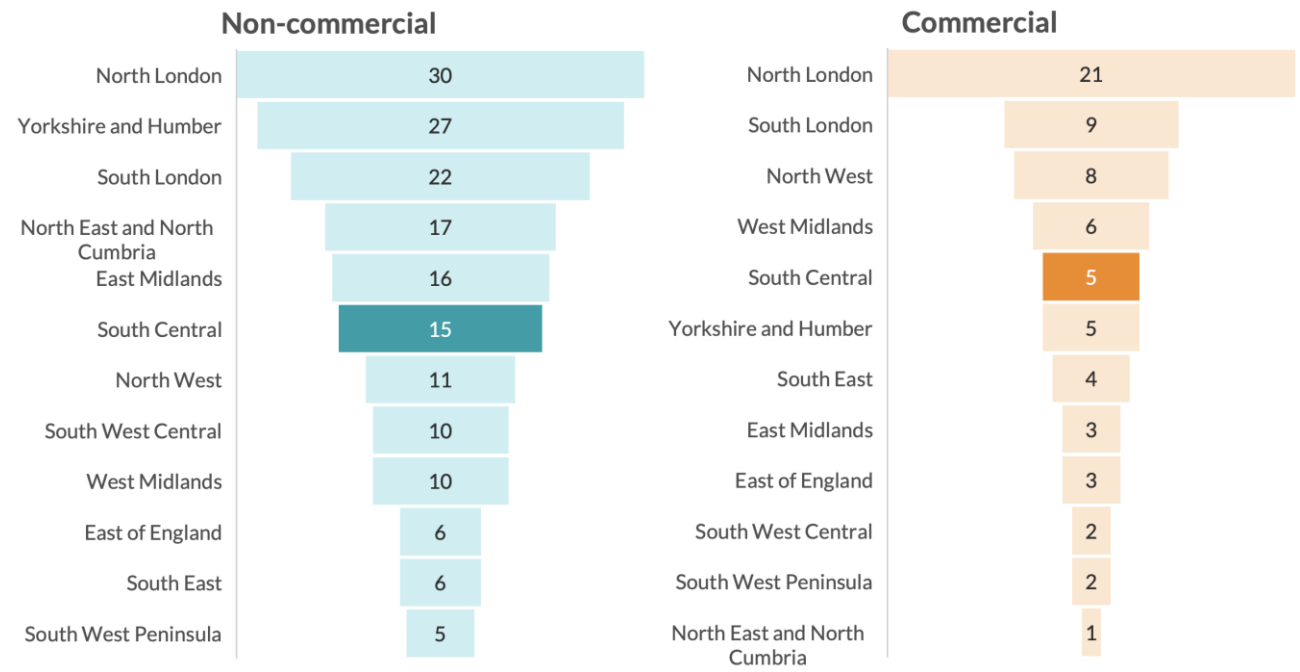

Figure 16 – Studies with first UK participant within ninety days of HRA approval on non-commercial and commercial studies by RRDN region since January 2025

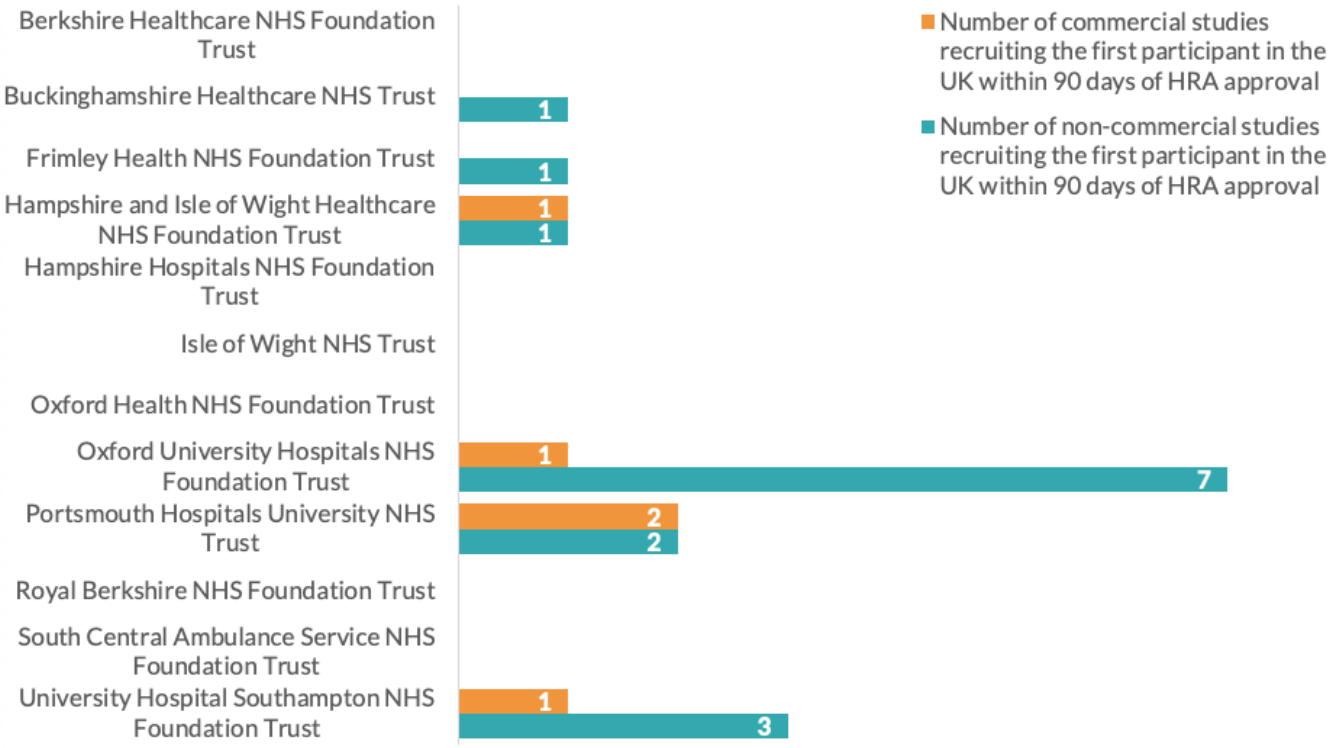

Figure 17 – Studies with first UK participant within ninety days of HRA approval on non-commercial and commercial studies at South Central NHS Trusts since January 2025

First European or global site to recruit – Direct payment, commercial studies only

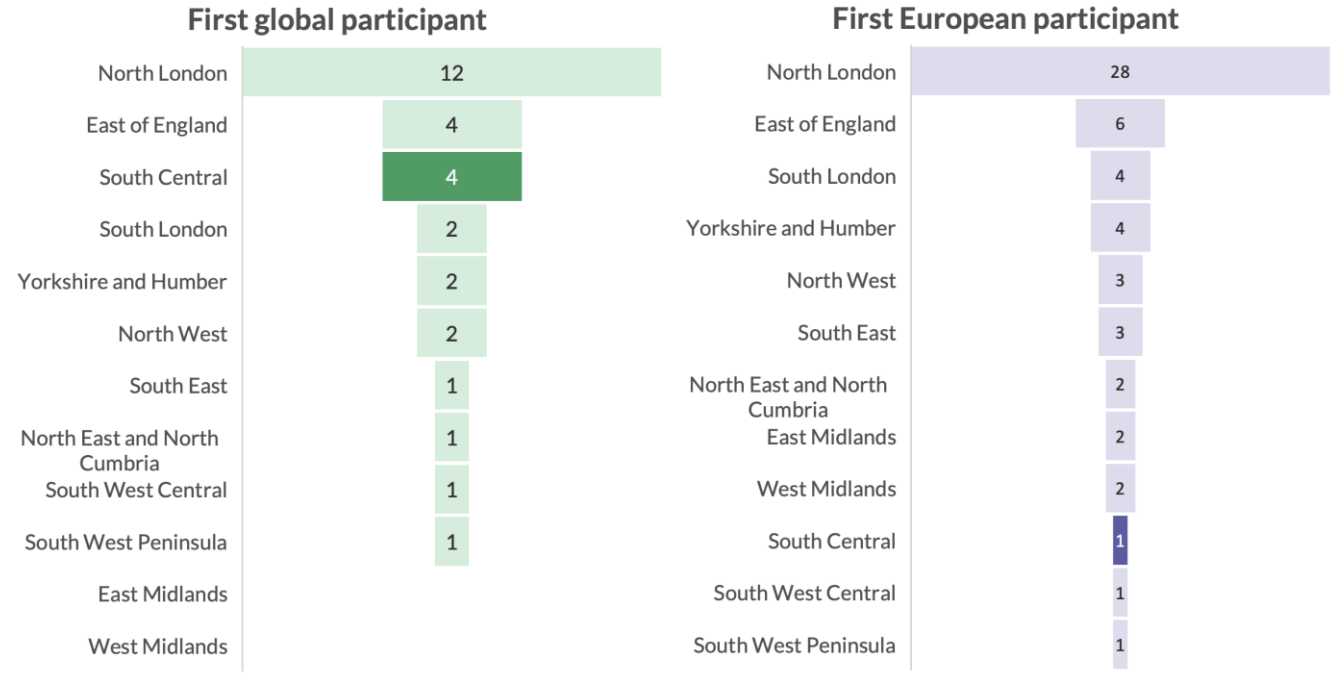

Figure 18 - Studies with the first site to recruit a participant by RRDN region globally or in Europe since January 2025

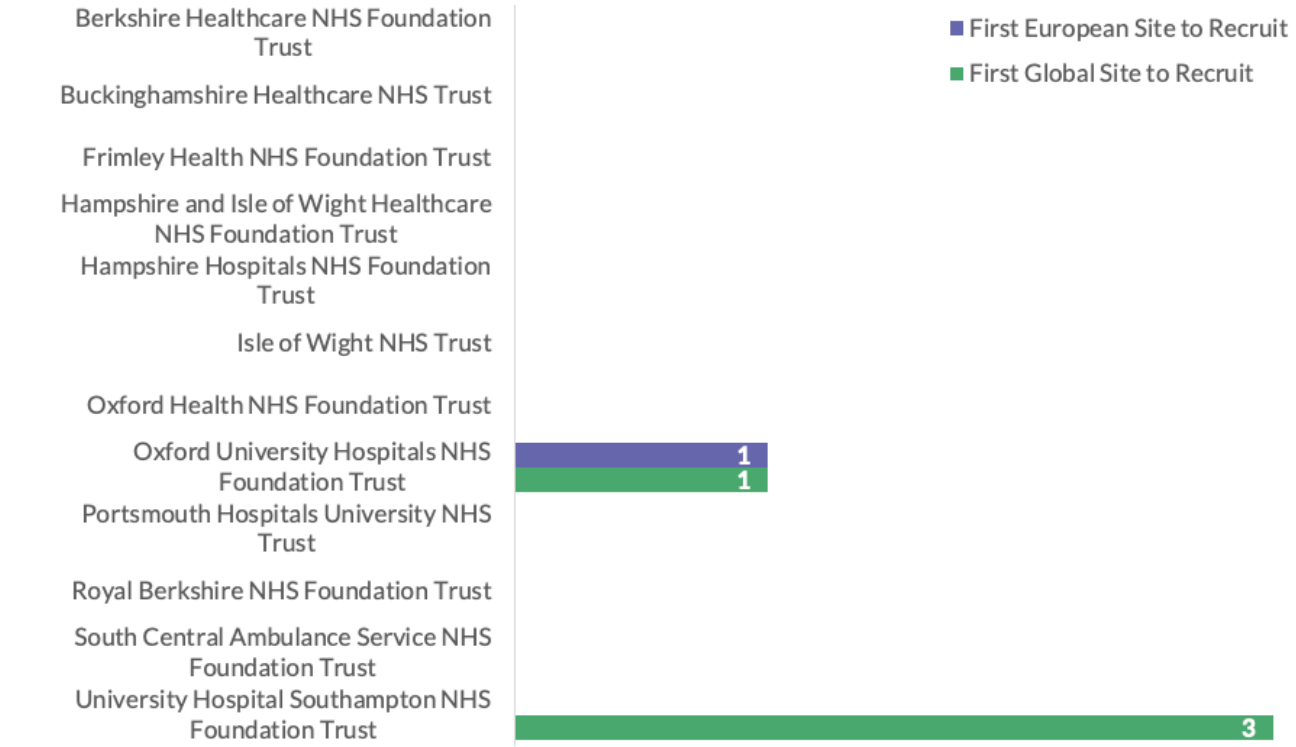

Figure 19 - Studies with the first site to recruit a participant at South Central RRDN NHS Trusts globally or in Europe since January 2025

25

Percentage of studies opened at the site within sixty days of HRA approval or site selection – Performance adjustment to the delivery organisation's baseline funding

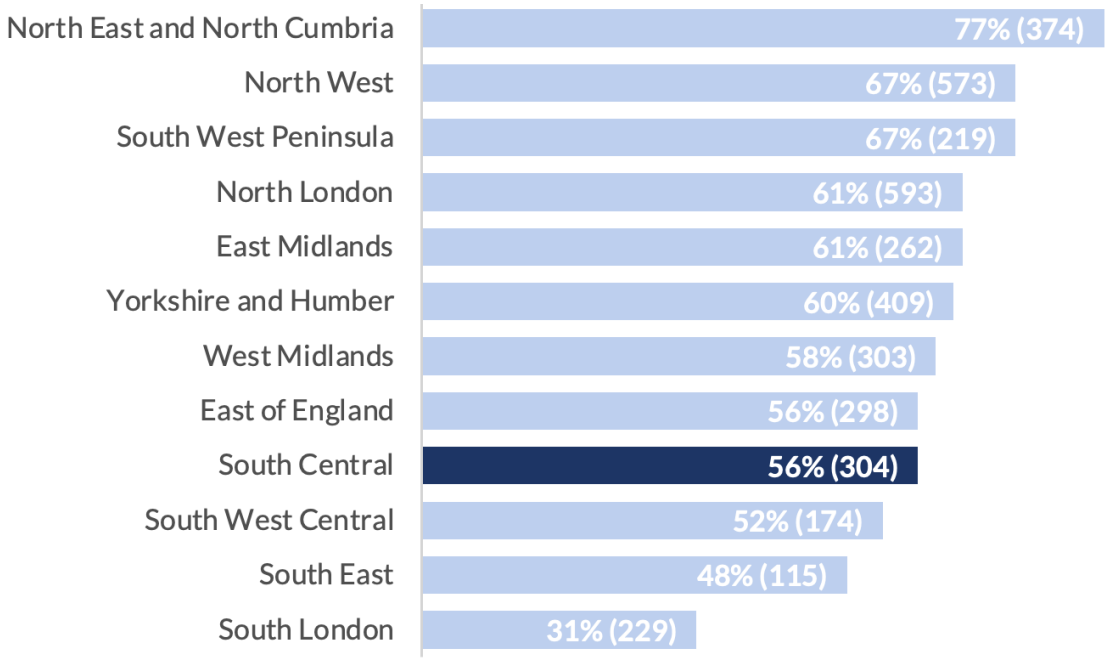

Figure 20 – Study locations open within sixty days of HRA approval or site selection by RRDN region since April 2025

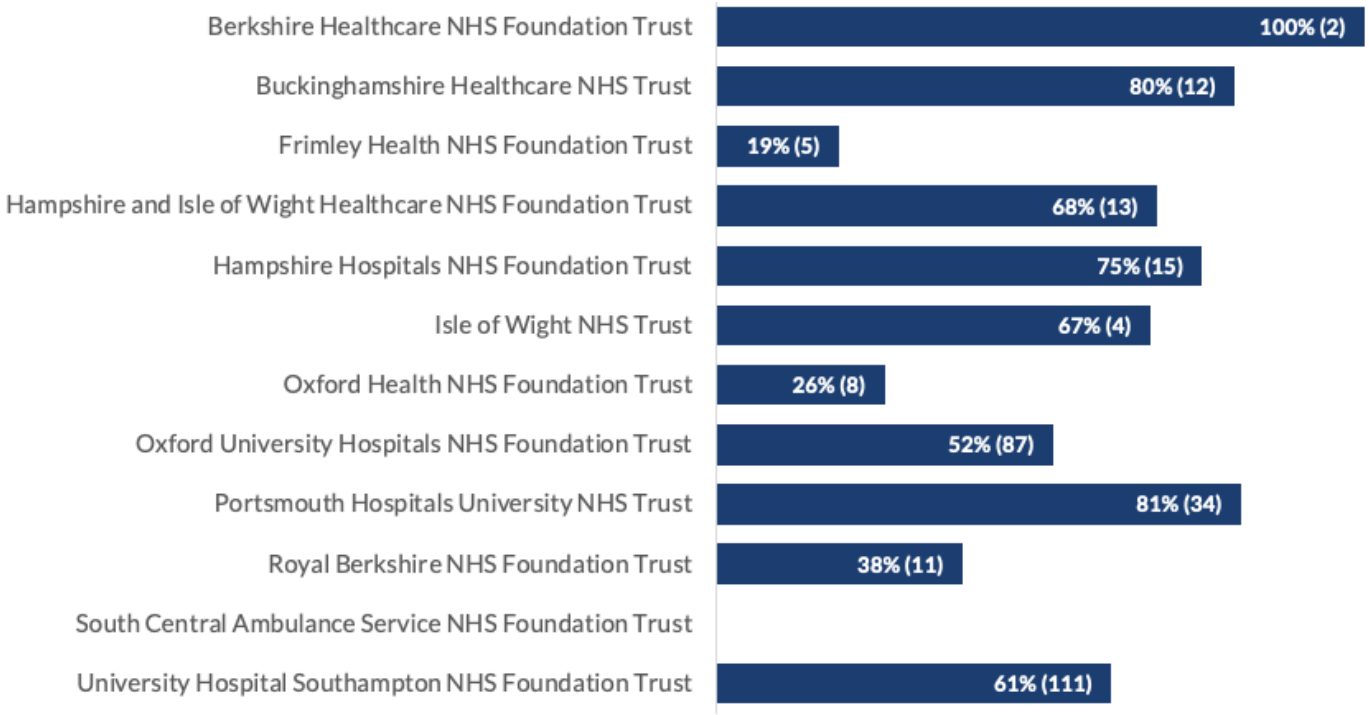

Figure 21 - Study locations open within sixty days of HRA approval or site selection at South Central RRDN NHS Trusts since April 2025

Percentage of studies achieving First Participant, First Visit (FPFV) at the site within thirty days of site readiness – Performance adjustment to the delivery organisation's baseline funding

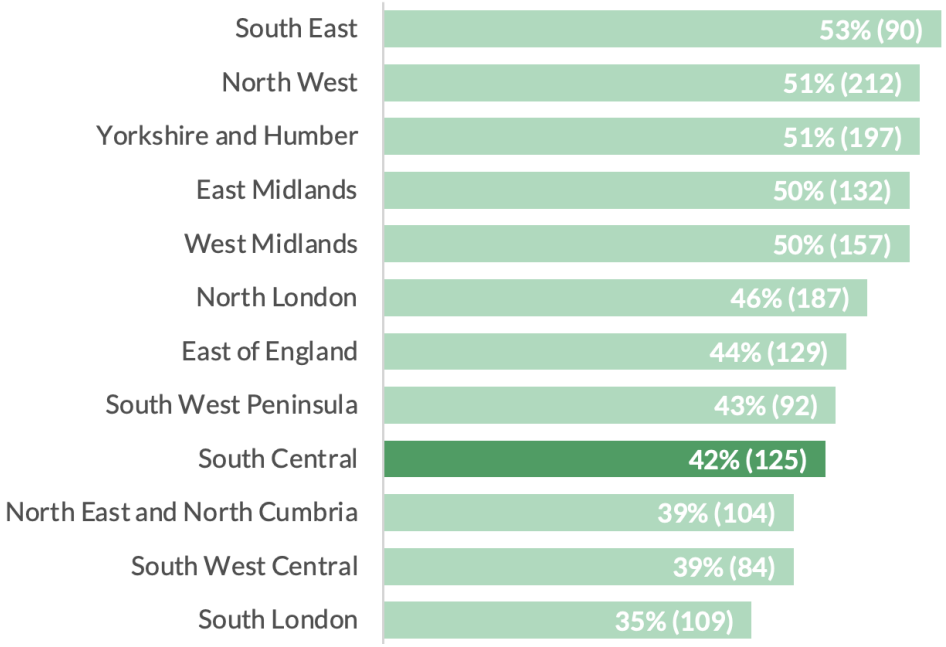

Figure 22 – Study locations achieving the first participant first visit within thirty days of site readiness by RRDN region since April 2025

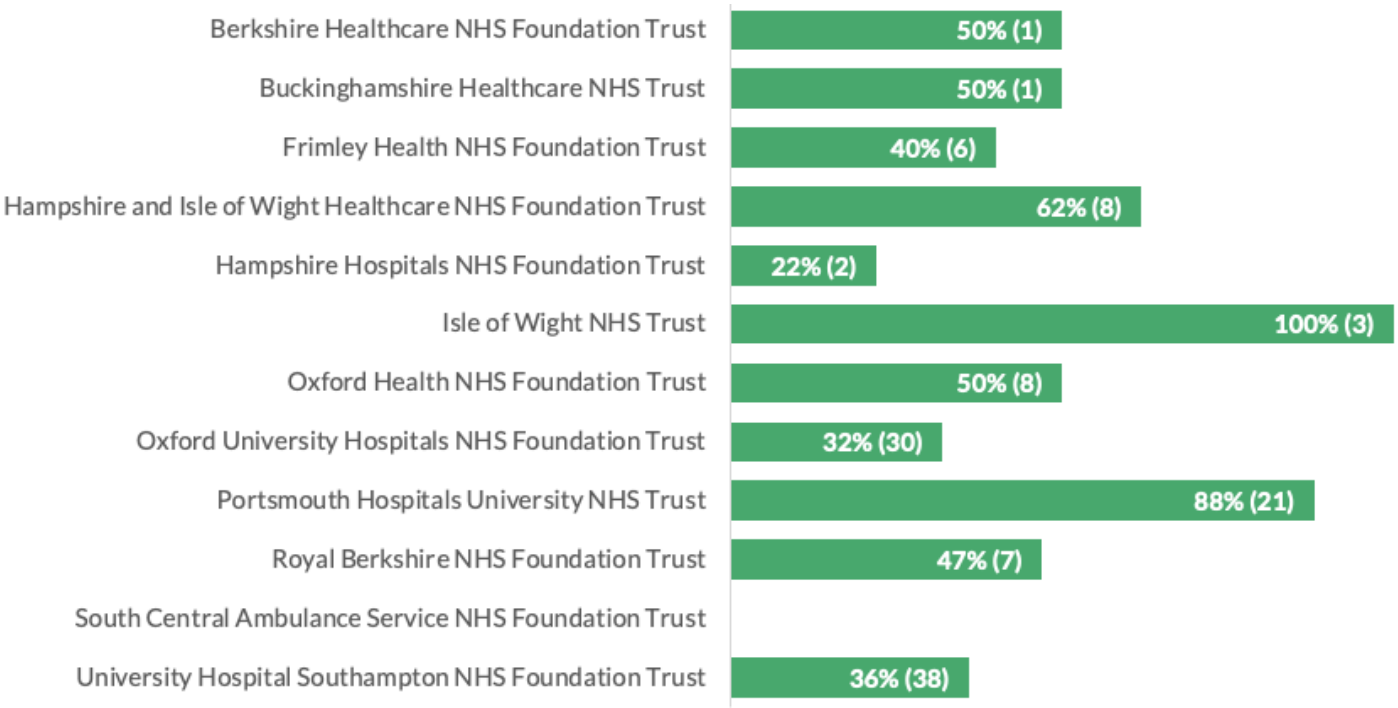

Figure 23 – Study locations achieving the first participant first visit within thirty days of site readiness at South Central RRDN NHS Trusts since April 2025

Percentage of commercial studies achieving Recruitment to Time and Target at the site – Performance adjustment to the delivery organisation's baseline funding

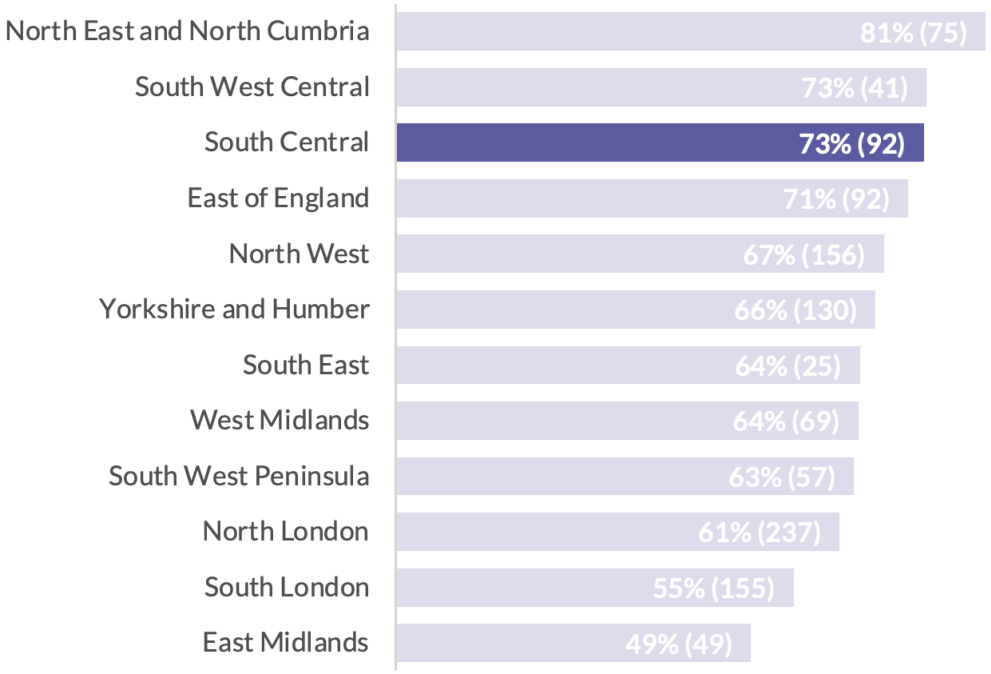

Figure 24 – Commercial study locations recruiting to time and target by RRDN region since January 2025

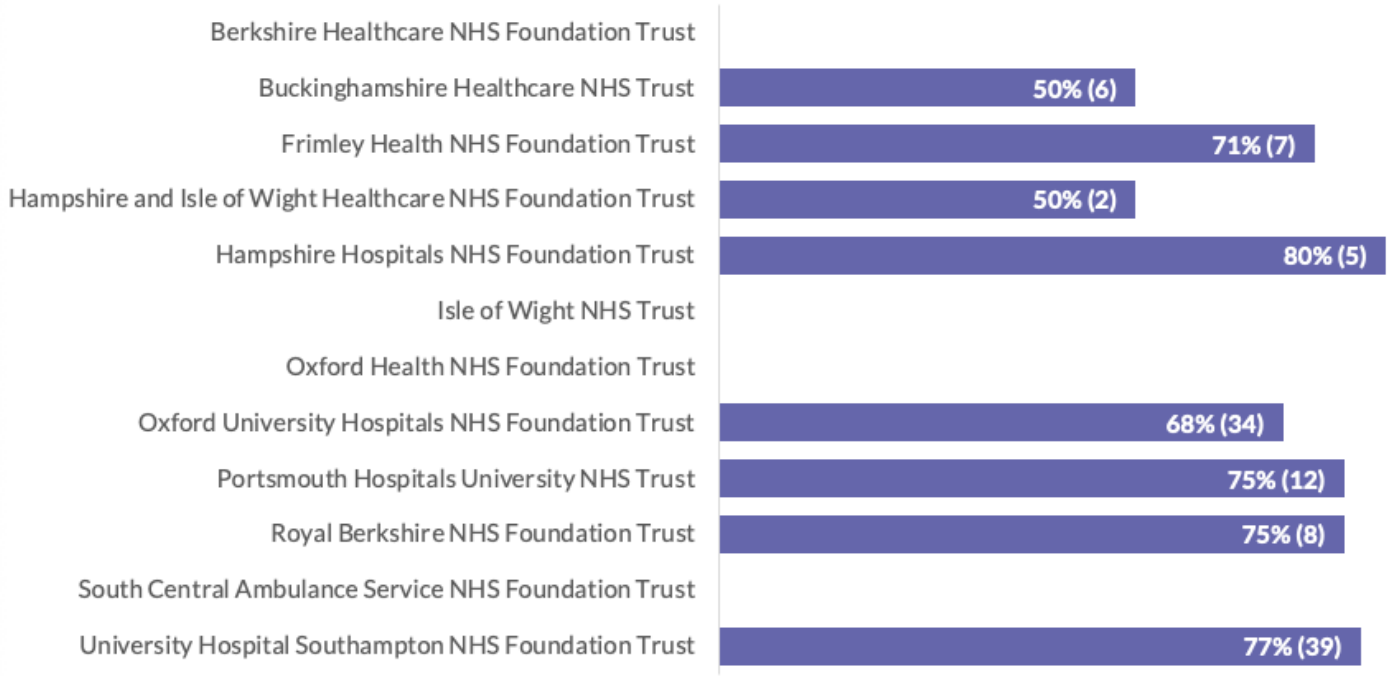

Figure 25 – Commercial studies locations recruiting to time and target at South Central RRDN NHS Trusts since January 2025

Increase/decrease in recruitment to interventional commercial trials compared to the previous reporting period – Performance adjustment to the delivery organisation's baseline funding

RRDN	Jan-Dec 2024: Recruitment to interventional commercial studies	Jan-Dec 2025: Recruitment to interventional commercial studies	Increase/Decrease in recruitment to interventional commercial studies
East Midlands	674	539	-135
East of England	1,949	1,859	-90
North East and North Cumbria	752	631	-121
North London	2,219	1,733	-486
North West	2,087	1,499	-588
South Central	1,444	1,041	-403
South East	626	457	-169
South London	1,378	1,217	-161
South West Central	845	558	-287
South West Peninsula	921	586	-335
West Midlands	804	707	-97
Yorkshire and Humber	1,537	1280	-257

Figure 26 - Increase/decrease in recruitment to interventional commercial trials between 2024 and 2026 by RRDN region

Organisation	Jan-Dec 2024: Recruitment to interventional commercial studies	Jan-Dec 2025: Recruitment to interventional commercial studies	Increase/Decrease in recruitment to interventional commercial studies
Berkshire Healthcare NHS Foundation Trust	0	0	-
Buckinghamshire Healthcare NHS Trust	69	15	-54
Frimley Health NHS Foundation Trust	33	19	-14
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	30	14	-16
Hampshire Hospitals NHS Foundation Trust	128	40	-88
Isle of Wight NHS Trust	2	0	-2
Oxford Health NHS Foundation Trust	5	17	12
Oxford University Hospitals NHS Foundation Trust	339	439	100
Portsmouth Hospitals University NHS Trust	106	102	-4
Royal Berkshire NHS Foundation Trust	63	31	-32
South Central Ambulance Service NHS Foundation Trust	46	0	-46
University Hospital Southampton NHS Foundation Trust	623	364	-259

Figure 27 - Increase/decrease in recruitment to interventional commercial trials between 2024 and 2026 at South Central RRDN NHS Trusts

Increase/decrease in the number of interventional commercial trials recruiting compared to the previous reporting period – Performance adjustment to the delivery organisation's baseline funding

RRDN	Jan-Dec 2024: Number of interventional commercial studies recruiting	Jan-Dec 2025: Number of interventional commercial studies recruiting	Increase/Decrease in number of interventional commercial studies recruiting
East Midlands	122	136	14
East of England	167	204	37
North East and North Cumbria	119	135	16
North London	455	476	21
North West	286	298	12
South Central	190	209	19
South East	66	82	16
South London	298	324	26
South West Central	86	100	14
South West Peninsula	85	99	14
West Midlands	148	173	25
Yorkshire and Humber	187	211	24

Figure 28 - Increase/decrease in the number of interventional commercial trials recruiting between 2024 and 2026 by RRDN region

Organisation	Jan-Dec 2024: Number of interventional commercial studies recruiting	Jan-Dec 2025: Number of interventional commercial studies recruiting	Increase/Decrease in number of interventional commercial studies recruiting
Berkshire Healthcare NHS Foundation Trust	0	0	-
Buckinghamshire Healthcare NHS Trust	10	5	-5
Frimley Health NHS Foundation Trust	7	7	-
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	10	5	-5
Hampshire Hospitals NHS Foundation Trust	5	4	-1
Isle of Wight NHS Trust	1	0	-1
Oxford Health NHS Foundation Trust	3	2	-1
Oxford University Hospitals NHS Foundation Trust	98	108	10
Portsmouth Hospitals University NHS Trust	21	22	1
Royal Berkshire NHS Foundation Trust	10	12	2
South Central Ambulance Service NHS Foundation Trust	1	0	-1
University Hospital Southampton NHS Foundation Trust	57	64	7

Figure 29 - Increase/decrease in the number of interventional commercial trials recruiting between 2024 and 2025 at South Central RRDN NHS Trusts

Conclusion

In the first three quarters of the 2025/26 financial year, the South Central region has demonstrated significant resilience and high-quality research delivery despite a challenging national environment. Although total recruitment has trended downwards since June 2025, mirroring a systemic decline across England, regional activity remains within expected ranges. Notably, the SC RRDN continues to perform strongly against other regions, ranking third nationally for recruitment when adjusted for population size.

The region's primary strength lies in its ability to deliver high-complexity research. The move from a regional to a national funding model has resulted in an £868,069 (-3.1%) cut for our region year on year. However, high complexity-weighted recruitment (CWR) positions the region's NHS Trusts well for future activity-based funding. While the largest hospital trusts continue to lead in CWR, recent growth in community organisations such as Oxford Health and Hampshire and Isle of Wight Healthcare highlights the region's expanding capability.

Moving forward, the SC RRDN will focus on two key strategic priorities:

- **Commercial Growth:** Although underlying commercial recruitment is trending upwards when historical outliers are removed, a focused "step change" is required to align with top-performing regions and secure additional income for infrastructure expansion.
- **Participant Experience:** While feedback from 1,285 participants remains largely positive, the network and delivery organisations must work together to encourage research sponsors to improve how study results are communicated back to participants.

By leveraging regional partnerships across both hospital and wider care settings, the SC RRDN is well-placed to meet the NIHR's mission of improving the health and wealth of the nation through inclusive and accessible research. The Board will continue to receive quarterly performance updates to monitor progress against these strategic goals.

Appendix

Appendix 1 – South Central Risk Register

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
SCRRDN Reference Number	Risk Category	Risk Title	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col KxL)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
SCRRDN 002	**20. Workforce Learning and Organisational Development**	Impact on Performance Network Agile Research Delivery Team (ARDT) Workforce	**Cause:** Staff exhaustion due to ongoing team vacancies and limited clarity about roles within the new SC regional processes and workstreams. Recruitment freeze remains in place due to the MOC process in its final stages. **Event**: Staff we have invested in and developed to work in this Agile capacity leave and we lose this capability without being able to recruit	Unable to deliver Government priority studies as DHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the separate organisational change processes of the ARDT and management team. Decrease in the number of studies that can be delivered.	4	4	16	1. Ongoing recruitment to the direct delivery team - PAUSED 2. Reinvestment of hud income to increase headcount - 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. 8. Agile working groups set up and communicated with Agile staff members with opportunities for them to be involved 9. The agile band 7 management team are meeting weekly to support staff and review capacity and capability 10. HoRD and Director of Ops is working with the Senior Agile Manager to support staff and workload as best as possible. 11) staff capacity and capability and well-being is regularly reviewed at agile management meetings on a weekly basis.	Recruitment paused, reinvestment of hub income paused, dependent on organisational change. The Agile team are now viewed as one regional team. This has allowed capacity to be reviewed and implemented more broadly. Resulting in increased capacity to meet contractual requirements including VIP studies.	3	4	12
SCRRDN 004	**15. Research Delivery**	NHS Pressures	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
SCRRDN 005	**15. Research Delivery**	Supporting departments capacity to support study set up (including 150d studies	Cause: Reduced access to PET scanning capacity and tracers (amyloid and tau) required for both clinical and research scans. Event: Limited access to PET scans for research purposes. Reduced opportunities for access to research for neurology and oncology patients. Cause: Limited capacity from Pharmacy to review/approve new studies. Event: WIthdrawn from commercial studies in set up."	Sites unable to set up and deliver interventional studies (including 150d). Threat to safety and data integrity if schedule of imaging events cannot be adhered to.	4	4	16	Raised at OMG and IOM/BDM meeting, to monitor. Discussed with COO and local escalation to ICBs via WHP. SSS Manager and Industry Manager engaging with providers and mapping capacity so that we have all offers available for the sites. Imaging Specialty Lead helping to engage with organisations to learn more about barriers and potential ways to provide support. Increase to pharmacy funding / capacity at OUH, UHS and RBH via CSS funding. Contingency funding awarded to OUH to increase pharmacy capacity.	Ongoing	3	3	9
SCRRDN 006	**19. Health and Care Services Engagement**	BOB and Frimley ICB Engagement	No research engagement at present due to the ICB is currently going through a merger and management of change process.	Failure to progress with work streams and opportunities missed.	4	2	8	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
SCRRDN 007	**17. Communications**	Low researcher usage of Be Part of Research volunteer service	Low awareness and usage of Be Part of Research volunteer service by researchers could see opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering. Details about trials using the service have been requested from CC.	Opportunities missed to enhance recruitment to trials. Could result in volunteers not being contacted about studies, leading to negative perception of service / volunteers de-registering	3	2	6	Promotion of service to researchers through study support service and other teams and wider promotion e.g. newsletters	Ongoing	3	1	3

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
SCRRDN Reference Number	Risk Category	Risk Title	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col KxL)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
SCRRDN 012	**18. Patient and Public Involvement and Engagement (PPIE)**	Relationship management - building and maintaining positive connections	**Cause:** Change of region/staff/uncertainty **Event:** Transition from Clinical Research Network to Research Delivery Network	Risk to relationship continuity with the following: 1. Organisations participating in Research Ready Communities initiative 2. Research Champions 3. Public Contributors	3	3	9	Maintain relationships through regular contact Stakeholder Group Public Partners identified National One Public Partner work ongoing in line with strategy	Ongoing	2	3	**6**
SCRRDN 013	**15. Research Delivery**	Delivery to RDN High Priority Studies - Lead Network (e.g. RECOVERY)	Failure to successfully deliver high priority studies led by SC RRDN	1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	2	4	8	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Agile delivery team resource allocated to support delivery in all RRDNs 3. Importance of high priority studies communicated to delivery organisations at a senior level 4. Supporting sponsor and sites with timely recruitment uploads to allow recruitment to be closely monitored and issues identified	All ongoing	2	3	**6**
SCRRDN 014	**15. Research Delivery**	Delivery to RDN High Priority Studies - Participating Site	Failure to successfully deliver high priority studies at delivery organisations within SC RRDN	1. Reputational damage to SC RRDN delivery organisations and to the UK as a place to deliver research 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	4	4	16	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Local Agile delivery team resource allocated to support delivery organisations. 3. Importance of high priority studies communicated to delivery organisations at a senior level	All ongoing	3	4	**12**
SCRRDN 016	**15. Research Delivery**	Agile team members working in new environments	Expectation for the Agile team to expand research delivery to wider community and out of hospital settings. This will include settings where SC RDN does not have prior experience of delivering research, which may present unfamiliar risks to the safety and well-being of staff members e.g. prisons and probation service, severe mental health services. There is a lack of national guidance for staff working in these new settings and current training may not sufficiently cover.	1) Potential threat to agile staff work place safety and well-being when working in new environments and participant groups. 2) Unforeseen safety considerations and risks that potentially prevent continuation of research delivery. 3) Additional time may be required during study setup to train staff in preparation for the study to be delivered.	4	3	12	1) Wider SC RRDN agile meeting 21/11/24 - agreed management plan. 2) Expand SC RRDN training where gaps are identified during study specific feasibility assessment. Training can can be sourced from in-house expertise, regional expertise and nationally available training resources. General training (e.g. de-escalation methods) to be provided as required to benefit staff who deliver research across settings and during engagement activities with patients, service users and the public. 3) Raised risk at national agile meeting to discuss, including how RDNs can collectively pool resources such as best practice, SOPS and training resources 4) Agile and primary care teams to adapt national/supra-regional resources and apply to SC RDN region when appropriate to do so. 5) Senior agile management to review study by study and agile training needs 6) studies will not commence if agile team are not adequately qualified and trained. 7) goverance framework being formed and plans in place for UHS to approve final guidance for RDN team members working at events.	Ongoing review	1	3	3

A	B	C	I	J	K	L	M	N	Q	R	S	T
	South Central Regional Research Delivery Network		**PENDING RISK DESCRIPTION**		**Pre Response Rating**			**Response**		**CURRENT (RESIDUAL) RATING**		
SCRRDN Reference Number	**Risk Category**	**Risk Title**	**Risk Description (to include cause/event)**	**Effect/Impact**	**Probability Value**	**Impact Value**	**Score (Col KxL)**	**Mitigation Actions**	**Mitigation actions Outstanding**	**Current Likelihood**	**Current Impact**	**Current Score**
SCRRDN 017	**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.	New studies not being approved to be delivered at OUH sites due to SC RDN organisational changes and expectation for the OUH based agile team withdrawal. Timeline not yet known. Risk to current studies on the portfolio not being delivered in their entirety.	1) studies not delivered at OUH due to workforce limitations. 2) SC RDN and OUH organisational reputational damage. 3) uncertainty regarding agile team availability for current and future study delivery.	4	4	**16**	1) Regular meetings held between senior management at OUH and RDN 2) Ongoing review the OUH SC RDN portfolio of studies on a regular basis and subsequent portfolio management including closing studies and stop recruiting to other studies 3) regular review by the senior agile, management team including at the bi-weekly agile management meeting. 4) Transitional arrangements agreed to ensure continuity of study delivery. 5) OUH R&D communication with OUH PIs are underway 6)Transitioning of studies from OUH agile team to OUH R&D with oversight from RDN senior agile management 7) OUH agile team are informed of progress and presenting as a unified RDN / OUH approach.	Ongoing discussions being held with OUH and closely managed to reduce risk likelihood.	3	3	9
SCRRDN 018	**14. RDN Specialties and Settings**	Limited funded time available to specialty and setting leads	Risk of specialty or settting leads not having time to fulfil duties / expectations of the role	Reduced strategic clinical oversight and leadership. Lack of local clinical engagement	3	2	6	Review ongoing situation with the leads Avoid unnecessary workload / use their time strategically Provide reasonable level of administrative support Keep meetings they are expected to attend to a minimum	Ongoing	**3**	**2**	6
SCRRDN 019	**21. Business Development and Marketing**	Redirection of senior strategic industry regional industry resources	Risk - The regional industry activities previously completed by the Industry Operations Manager in LCRNs do not have a consistently agreed position in the RRDN structure. Cause - Transition to mandated structure with national focus for LSKAM role and Band 7 Industry Manager role means senior regional industry activity does not have a natural fit in the structure. This includes engagement activity with DOs including challenging behaviours, increasing organisational capacity and capability through RDN led initiatives and regional business development, providing strategic direction as well as working with the MedTech and SME sector.	Effect - Reduction in regional ability to support life sciences activity as a key priority for RDN. Reduction in effectiveness of customer relationships built over 10 years and perception from DOs that senior regional industry support is no longer available. Loss of skilled and experienced industry staff across the network due to uncertainty.	5	4	**20**	Phased transition for staff previously in IOM roles who are now holding LSKAM roles agreed as part of GP3 project. *This does not mitigate the risk for regions who have appointed an LSKAM who was not an IOM, or do not have an LSKAM in post. This must also be balanced with the risk of KAM service failure, which also has significant pressure to succeed.* Comparison of Industry Manager, LSKAM and SSS job roles underway. Service design activities underway. Interim position to be drafted by small working group - Lauren Tough, Chris Smith, Fiona Halstead, Kelly Adams, Kaatje Lomme. Will invite Operations Director.		4	4	16
SCRRDN 021	**15. Research Delivery**	a) Requirements of "Head count" impacting the ability for Trusts to deliver. b) Research Registered NMAHPs shortage in partner organisations and job freezes in place.	a) 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 b) Cause: Lack of availability of registered NMAHPs. Event :Leading to a shortfall in registered staff qualified to deliver clinical trials	a) Effect - reduced R&D staff in partner Trusts impacting on Study delivery. b) Fewer clinical trials are delivered and/or quality of research conducted becomes reduced leading to reputational damage.	5	3	**15**	a) Regular Meetings with trusts to monitor situation. Raise issue at Operations Board b) To be aware of trusts with job freezes and implications of RRDN funded posts 5. Letter circulated to SC region R&D DIrectors to remind that RDN funding is ring fenced and posts funded through this stream should not be impacted by recruitment freezes, as per the RDN research delivery organisation contract. c) Partner organisations asked to provide examples of impact of staffing limitations on Research Delivery.		4	3	12

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SCRRDN 022	**21. Business Development and Marketing**	Study set up times for commercial studies	Risk - Slow set up times for commercial studies in the context of government led drive to reduce setup time to 150 day but March 2026	- Reputational damage to SCRRDN and SC delivery organisations. - Reduced selection of SC delivery organisations resulting in fewer opportunities for patients and decreased commercial income - Future reduction in commercial study opportunities - Performance against 150 day metric will impact performance element of RDN funding to DOs	5	4	**20**	- NIHR Joint Acceleration plan in place to provide enhance support to candidate studies - D&A app to provide real time setup data to DOs in line with UKCRD metrics - SC RRDN R&D managers meeting with focus on set up times - Support DOs to reduce duplication and streamline set up processes - Appropriate escalation of system wide issues, via industry hub, 150 day worksteams and action group - Contingency funding call for DOs to fund initiatives aimed at reducing set up times, 15 bids funded (£473k total) - Regional strategic funding call with commissioned call for projects to support study set-up acceleration. Large awards funded. Total TBC.		4	4	16
SCRRDN 023	**20. Workforce Learning and Organisational Development**	Resident doctor strikes	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	1	**3**	Regular Meetings with trusts to monitor situation. Raise issue at Operations Board		3	1	3
SCRRDN 024	**21. Business Development and Marketing**	Failure to see an increase or seeing a decrease in recruitment to commercial studies	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, reduction in both commerical contract and RDN funding at DOs Impact - reduction in commercial studies set-up in the UK, reduction in income	4	4	**16**	- Regular review of commercial recruitment performance at RRDN Management and Internal Contractor Governance Group. - Implementation of SC RRDN Recruitment Action Plan. - Renewed focus on SC RRDN Recruitment Action Plan with plan to be updated and shared with DOs. DOs to be asked to share their own recruitment action plans. - Recruitment patterns to be discussed at organisational business planning meetings in Spring 2026.		4	4	16
SCRRDN 025	**20. Workforce Learning and Organisational Development**	Statutory/Mandatory and Competency training - Oxford Agile team	Administration error as part of the tupe process for the OUH agile team. May prevent research activities from being performed until resolved.	Prevent some research activities being performed until training records updates and training provided.	4	3	**12**	UHS R&D education team working closely with agile team leads and Georgie Parsons. Marie Nelson is working with team members and Becky Croucher. Staff have been advised that anything that was expired, has subsequently expired or, is due to expire and for any new starters the UHS VLE should be used for completion of online training and for booking any that require F2F training. OUH Agile team members to complete their training profiles so we have a baseline and can identify what training is required. Training is being provided where needed. Agreed that staff are working safely and are covered by current training. Being followed up accordingly by Kirsty, Georgie and during 1:1s with line managers	Training provision	3	2	6

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SCRRDN 027	**16. Information and Knowledge**	LPMS re-tender process due to end just before the 2027/28 financial year will result in a period of disruption to research delivery at the affected organisations	Risk: That the national system due for delivery for March 2027 is delayed. In addition a complicating factor is SC RRDN uses two Local Portfolio Management Systems (LPMS). A re-tender process has begun, led by the NHS BSA, which is due to end with the selection of a single LPMS in England by April 2027. Cause: central NHS directives.	Effect: 1. Delivery organisations affected by the selection will go through a period of significant disruption involving their processes and data being migrated to a new system. 2. SCRRDN staff will have reduced visibility to portfolio information which will impact on processes	5	4	**20**	An existing LPMS exit plan is in place. RRDN Data and Analytics Senior Manager has raised with the RDN project leads the potential disruption in our region and the need for a significant period of time to transfer and test data, cascade training on the new system and troubleshoot issues. Both LPMS providers have confirmed that they can extend their contracts into 2027/28 if required. Update 7/1/2026: the process has been extended nationally by six months. This would mean an implementation date of October 2027.	Ongoing	5	3	**15**
SCRRDN 028	**15. Research Delivery**	Reduction in 2026-27 funding allocated to SC Delivery Organisations impacting on delivery of research	Cause: Following the application of the new NIHR RDN funding model, there has been a reduction in funding going to SC RRDN Delivery Organisations totalling just over £1.1m - the largest monetary impact nationally. Event: Most SC RRDN DOs (with the exception of Portsmouth Hospital University NHS Trust) have seen a reduction in funding with OUH and UHS losing £279,000 and just under £500,000 respectively and most other DOs at or close to the collar.	This will potentially have an impact on the ability of DOs to fund staff resulting in reduced workforce available to deliver NIHR Portfolio research.	4	4	16	Potential use of use of any management team and wider care setting underspend to support DOs while also demonstarting strategic impact. Potential use of Strategic, CSS and / or Contingency Funding.	Ongoing	4	4	16
SCRRDN 029	**17. Communications**	Relationship management due to the Strategic Funding and Wider Care Settings funding call outcomes for the financial year 26/27	The SC RRDN are running two funding calls: Strategic Funding and Wider Care Settings. There is a high likelihood for the total funding amount requested from applicants to exceed the SC RRDN funding envelopes allocated for these calls.	Potential reputational risk to SC RRDN stakeholders relationships.	5	3	15	The RDN will make best efforts to manage expectations via a range of accessible comms to applicants over the call's 6 week period including 1) 1:1 meetings 2) daily drop-in sessions staffed by experienced RDN staff from Monday to Thursday each week 3) written guidance 4) pre-recorded webinar 5) rapid response to email queries 6) Setting leads supoorting RDN messaging. The risk has further been factored into process planning and comms for both calls. Relevant members of the SMT are aware of the risk and involved in management discussions.	1) continue to actively manage expectations through the range of comms available to applicants. 2) SC RRDN Operation Director to flag at a national senior management level. 3) ongoing conversations between SMT members and Setting leads.			

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