

Agenda Trust Board – Open Session

Date	10/09/2026
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles, Steve Peacock, Natasha Watts (Louisa Green to deputise)
Observing	Trevor Smith, Chief Executive Officer Designate

- 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 9 July 2026**
 Approve the minutes of the previous meeting held on 9 July 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 Finance, Investment & Cash Committee**
 David Liverseidge, Chair
- 5.2**
 9:25 **Briefing from the Chair of the People and Organisational Development Committee**
 Jane Harwood, Chair
- 5.3**
 9:30 **Briefing from the Chair of the Quality Committee**
 Tim Peachey, Chair
- 5.4**
 9:35 **Chief Executive Officer's Report**
 Receive and note
 Sponsor: David French, Chief Executive Officer
- 5.5**
 10:05 **Performance KPI Report for Month 4**
 Review and discuss
 Sponsor: Andy Hyett, Chief Operating Officer

- 5.6 UHS Operating Plan 2026-27 and Board Assurance Statement**
10:35 Receive and approve
Sponsor: Andy Hyett, Chief Operating Officer
Attendee: Duncan Linning-Karp, Deputy Chief Operating Officer
- 5.7 Break**
10:50
- 5.8 Finance Report for Month 4**
11:05 Review and discuss
Sponsor: Ian Howard, Chief Financial Officer
- 5.9 People Report for Month 4**
11:15 Review and discuss
Sponsor: Steve Harris, Chief People Officer
- 5.9.1 NHS Staff Standards: Trust Response and Implementation Plan**
11:25 Review and discuss
Sponsor: Steve Harris, Chief People Officer
- 5.10 Safeguarding Annual Report 2025-26**
11:30 Receive and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Dannielle Honey, Head of Safeguarding
- 5.11 Annual Complaints Report 2025-26**
11:40 Receive and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Jenny Milner, Associate Director of Patient Experience
- 5.12 Learning from Deaths 2026-27 Quarter 1 Report**
11:50 Review and discuss
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience
- 5.13 Freedom to Speak Up Report**
12:00 Review and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian
- 5.14 Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance**
12:10 Receive and note the Annual Report. Approve the Statement of Compliance.
Sponsor: Paul Grundy, Chief Medical Officer
- 5.15 State of Maternity and Neonatal Services 2026/27: Strategic Position, Risks and Priorities**
12:20 Review and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Alison Millman, Midwifery Quality Assurance and Safety Matron/Jessica Bown, Midwifery Quality Assurance and Safety Matron/Hannah Mallon, Neonatal Quality Assurance and Safety Matron

- 6 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL**
- 6.1 Register of Seals and Chair's Actions Report**
 12:35 Receive and ratify
 In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
 Sponsor: Jenni Douglas-Todd, Trust Chair
- 7 Any other business**
 12:40 Raise any relevant or urgent matters that are not on the agenda
- 8 Note the date of the next meeting: 12 November 2026**
- 9 Items circulated to the Board for reading**
- 9.1 South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 1 Performance Report**
 Note the report
 Sponsor: Paul Grundy, Chief Medical Officer
- 10 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.
- 11 Follow-up discussion with governors**
 12:45
- 12 Maternity Appendices (*Ref Item 5.15*)**
- 12.1 Appendix A: MatNeo Safety 2025-26 Quarter 4 Report**
- 12.2 Appendix B: MatNeo Safety 2026-27 Quarter 1 Report**
- 12.3 Appendix C: MatNeo Workforce Report**
- 12.4 Appendix D: MatNeo Position Statement on 10 Point Plan**
- 12.5 Appendix E: National Maternity Triage Specification, UHS Readiness Statement, Gap Analysis Report**
- 12.6 Appendix F: Maternal Care Bundle Implementation Report**

Agenda links to the Board Assurance Framework (BAF)

10 September 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 30
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 30
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 4 16	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 26
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 4 20	5 x 2 10	Apr 31
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	TBD
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 30
5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.	Open (Technology & Innovation)	2 x 4 8	2 x 2 4	Dec 27

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.5	Performance KPI Report for Month 4	1a, 1b, 1c			x
5.6	UHS Operating Plan 2026-27 and Board Assurance Statement	1a, 5a	x		
5.8	Finance Report for Month 4	5a			x
5.9	People Report for Month 4	3a, 3b, 3c			x
5.9.1	NHS Staff Standards: Trust Response and Implementation Plan	3b	x		
5.10	Safeguarding Annual Report 2025-26	1b			x
5.11	Annual Complaints Report 2025-26	1b			x
5.12	Learning from Deaths 2026-27 Quarter 1 Report	1b			x
5.13	Freedom to Speak Up Report	3b			x
5.14	Medical Appraisal and Revalidation Annual Report	1b, 3c			x
5.15	State of Maternity and Neonatal Services 2026/27	1a, 1b, 3a, 4a, 5b, 5c			x

Minutes Trust Board – Open Session

Date	09/07/2026
Time	9:00 – 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd (JD-T)
Present	Jenni Douglas-Todd, Chair (JD-T) Diana Eccles, NED (DE) (9-10:00 / 11:30-13:00) 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) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 5.6) Julie Brooks, Deputy Director of Infection Prevention and Control (JB) (item 5.15) Martin de Sousa, Director of Strategy and Partnerships (MdS) (item 6.1) Lucinda Hood, Head of Medical Directorate (LH) (item 6.1) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.14) Julian Sutton, Clinical Lead, Department of Infection (JS) (item 5.15) 1 member of the public (item 2) 2 governors (observing) 8 members of staff (observing) 4 members of the public (observing)
Apologies	Steve Peacock, NED (SP)

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 Steve Peacock.

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

2. Patient Story

Terri was invited to speak to the Board about her experience at the Trust in relation to the end-of-life care provided to her stepfather in May 2026. It was noted that:

- The care provided by staff was described as being 'second-to-none', with Terri's stepfather being treated with dignity and respect.

- Facilities had also been provided to Terri's mother to enable her to stay with her husband, with staff ensuring that she was looked after.
- Terri thanked the staff of the hyper acute stroke unit.

3. Minutes of the Previous Meeting held on 14 May 2026

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 14 May 2026.

4. Matters Arising and Summary of Agreed Actions

There were no matters arising and no actions were due.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

Ian Howard was invited to present the Committee Chair's Report in respect of the meeting held on 18 May 2026, the content of which was noted. It was further noted that:

- The committee had received a report in relation to the National Cost Collection exercise for 2026.
- The committee received a report on waivers of competitive tendering between October 2025 and March 2026.
- The committee reviewed the progress against the internal audit plan and the output from an internal audit of the Trust's recruitment processes and controls.
- An update was received from the external auditors in relation to the Trust's annual report and accounts.
- The Trust's local counter fraud specialist provided an update in respect of progress against the annual plan and proactive exercises carried out.
- The committee reviewed the Board Assurance Framework (item 5.6), noting particular concern regarding quality-related risks.

5.2 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 1 June and 22 June 2026, the contents of which were noted. It was further noted that:

- There was a risk in relation to the Trust's financial position due to uncertainty around elective income (see item 5.10).
- The Trust's Cost Improvement Programme target for 2026/27 was £81m. The Trust had made good progress in terms of developing schemes, but there were still unidentified and not fully developed schemes representing a risk of c.£35m.
- The committee reviewed the Board Assurance Framework (item 5.6). It was noted that consideration should also be given to the financial investment needed to implement the actions required to reach the Trust's risk targets.

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

Jane Harwood was invited to present the Committee Chair's Report in respect of the meeting held on 22 June 2026, the contents of which were noted. It was further noted that:

- The Trust had reported that its workforce numbers were in line with its 2026/27 plan (see item 5.11). Appraisal rates and completion of statutory and mandatory training remained areas of challenge.

- The committee received an update in respect of consultant job planning, noting the progress made over the course of 2025/26. It was noted that national measures were now being used to ensure alignment with reporting to NHS England.
- A joint meeting of the People and Organisational Development Committee and Finance, Investment and Cash Committee was to be held to discuss the Trust's Cost Improvement Programme.
- The committee received an update in respect of a number of national matters, including industrial action, changes in the NHS Oversight Framework, and the review by Lord Mann into racism and antisemitism in the NHS.
- The committee was provided with an update on the action plan agreed to resolve the dispute with the portering team, noting that the majority of actions had been completed.

5.4 Briefing from the Chair of the Quality Committee

Tim Peachey was invited to present the Committee Chair's Report in respect of the meeting held on 1 June 2026, the content of which was noted.

- Clinical risk remained high within the Trust, but there were numerous initiatives underway, which would address these risks in the longer term.
- The roll out of the work to implement NatSSIPs 2 was proceeding well and already appeared to have had an impact.
- There were significant challenges as a result of the volume of work of the PALS/Complaints team. Use of artificial intelligence generated complaint letters was further increasing the team's workload and its complexity.
- The coroners had trialled a fast-track process, which would dramatically reduce the need for clinical involvement.

The committee received a detailed update in respect of Maternity and Neonatal services.

- It was noted that there were no matters to escalate arising from the Maternity and Neonatal Safety 2025/26 Quarter 4 Report.
- Following the publication of the report on the independent investigation into maternity and neonatal services in England by Baroness Amos, trusts would be required to implement a 10-Point Plan. Based on an initial review of the requirements, the Trust was partially compliant with seven out of ten areas, and guidance was expected from NHS England in relation to the three other areas
- The Ockenden Report published on 24 June 2026 had highlighted a number of cultural issues as well as racism, which had impacted maternity services. It was noted that Tim Peachey and Natasha Watts met regularly with the teams at Princess Anne Hospital and as a result were able to provide assurance that the cultural issues identified by the Ockenden Report did not exist at the Trust.
- A meeting with the Maternity & Newborn Safety Investigations body had provided a good level of assurance about the Trust's Maternity and Neonatal service.

5.5 Chief Executive Officer's Report

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

- Following the release of the report into Nottingham University Hospitals NHS Trust and building on the previous recommendations from the Fuller inquiry, NHS England required boards to complete a board assurance statement in respect of mortuary services by 31 July 2026.

- The Trust had declared a critical incident on 25 June 2026 as a result of the impact of the red and amber heat health alerts, significant operational pressure, and heat-related disruption. This period had been a difficult one for both staff and patients. It was not possible to make widespread use of additional air conditioning units due to electrical supply limits. There had been a higher number of deaths in the community which had placed significant pressure on the Trust's mortuary service. In addition, there had been a higher number of attendances at the Emergency Department. The Trust had also experienced reduced MRI capacity and theatres due to temperatures and humidity.
- The Trust was ready to launch its new Trust and Clinical Strategies following agreement by the Board in early 2026.
- NHS England had published the latest segmentation and league table rankings for the fourth quarter of 2025/26. The Trust was ranked 68 out of 134 and continued to be in segment 3 due to the impact of the financial override.
- The Government had reached a deal with the British Medical Association in order to resolve the long-running dispute with resident doctors. However, consultants had since voted in favour of industrial action.
- The Information Commissioner and NHS England Chief Executive had both addressed the trend of inappropriate access of patient records by NHS staff. A letter had been sent to all NHS trusts in England outlining expectations and providing national materials to support an awareness campaign. It was noted that the Trust had previously taken action against employees, including dismissal, in connection with inappropriately accessing patient records.
- The University of Southampton had announced the appointment of a new Vice Chancellor.
- The Trust's IT team had recently been commended in the Health Service Journal awards and had received an NHS England award for innovation.
- The Trust had taken over the tenancy of the Royal South Hants site and one theatre with a programme to take over the remaining theatres to provide a dedicated elective site.

5.6 Board Assurance Framework (BAF) Update

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

- The Board had previously reviewed the Board Assurance Framework in May 2026. All risks had since been updated following discussions with the relevant executive directors.
- Seventy-five per cent of risks were rated as 'critical' (i.e. 15 or above) and were outside of the Trust's stated risk appetite.
- The report included details of the target scores and their relation to the stated risk appetite as well as the intended progress toward the target score. It was noted that for some of the risks the route toward being within risk appetite and/or the target was less clear than for others.
- Work was ongoing to develop the BAF, including the incorporation of longer-term actions, linked to the Trust's strategy.
- The Trust's internal audit plan had been assessed against the BAF, and work was under way to review the coverage of the internal audit programme and other sources of assurance.

5.7 2026-27 NHS Oversight Framework Update

Ian Howard was invited to present the NHS Oversight Framework update, the content of which was noted. It was further noted that:

- The approach to the NHS Oversight Framework in 2026/27 was to be intentionally evolutionary with the addition of further metrics, and segmentation to be based on thresholds rather than quartiles. In addition, integrated care boards would also now be included.
- A financial override would remain in place, limiting organisations in financial deficit to segment 3.
- The metrics included a greater emphasis on staff-related measures in line with the NHS staff standards.
- Guidance was expected from NHS England in July 2026 in relation to the provider capability assessment.
- It was understood that no acute trusts in the south/south-east were in segments 1 or 2.
- The Trust would ensure that the metrics relevant to the NHS Oversight Framework were incorporated into its performance reporting.

5.8 Performance KPI Report for Month 2

Andy Hyett was invited to present the Performance KPI Report for Month 2, the content of which was noted. It was further noted that:

- The Trust's Referral To Treatment waiting list had continued to grow during April and May 2026. In addition, the Trust saw around 10,000 referrals each month, although this was not consistent growth across all services, with dermatology, ophthalmology, neurology and cardiology seeing the largest increases.
- The Trust's 18-week performance had improved to 65.7%. However, the growth in the overall size of the waiting list posed a risk to the Trust's performance target for 2026/27.
- The Trust's performance against cancer targets remained broadly positive, although there remained challenges in terms of urology, colorectal and sarcoma tumour sites.
- Although emergency care performance remained an area of challenge, the Trust had recorded performance against the four-hour Emergency Department standard above its planned trajectory.
- Diagnostic performance had also been strong. However, the recent critical incident and loss of diagnostic capacity was expected to impact performance in this area.
- The southeast had experienced its first and longest red weather warning, which had prompted the Trust to declare a critical incident (see item 5.5). The Trust had already developed an action plan in relation to potential future incidents. This plan focused both on mitigating the impact of heat and on how to avoid issues arising, with further work ongoing to develop longer-term solutions. Consideration also needed to be given at a system level as to how to prevent people needing to go to hospital in the first place.

The Board discussed the Performance KPI Report for Month 2. This discussion is summarised below.

- Concern was expressed in relation to the increase in negative scores in the Friends and Family Test in maternity. It was noted that there was an issue with partners being unable to stay with patients.

- The Trust's reduced endoscopy capacity and the inefficiency of the post-fire model had impacted the Trust's 28-day faster diagnosis cancer performance.
- The number of mental health patients spending more than 12 hours in accident and emergency appeared to be increasing. It was noted that there had been increasing number of complex patients and a lack of available complex care packages.
- The percentage of virtual appointments appeared relatively flat. It was noted that where virtual appointments were appropriate, use was increasing. In addition, some patients were now being addressed via patient initiated follow up, rather than as a virtual outpatient.
- The Trust was considering how to resource smoking cessation services. In addition, consideration was being given to making it mandatory to disclose smoking status on entry.

Action

Andy Hyett agreed to investigate what was being done to meet the 90% target for patients with a disability reporting additional needs and/or adjustments being met.

5.9 Break

5.10 Finance Report for Month 2

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

- The Trust continued to report in line with its 2026/27 plan, recording a deficit of £7.3m at Month 2. Cost Improvement Programme (CIP) savings were also in line with plan. However, there remained a significant challenge in terms of the Trust's CIP plan for the year.
- The Trust continued to develop CIP schemes and had reported 42% of schemes as being fully developed, noting that there was a target for trusts to have fully developed 80% of schemes by the end of Month 3. It was unclear at this point when the Trust would meet the 80% target.
- There was a risk in terms of the Trust's elective performance due to the impact of actual and threatened industrial action in April and June 2026, the critical incident, impact of the fire, and staffing levels in critical care.
- The number of patients having no criteria to reside had continued to increase since February 2026, with the loss of capacity following the fire placing additional pressure on the Trust.

5.11 People Report for Month 2

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

- The Trust continued to report that its workforce was in line with its 2026/27 plan. Whilst substantive workforce grew by 44 whole-time-equivalents (WTE) during the month, it was 43 WTE below plan. Bank staff use was 72 WTE above plan and agency staffing use was 28 WTE below plan.
- Appraisal completion rates were to be an area of focus, with an expectation that rates would increase.
- Lord Mann had published his review into racism and antisemitism in the NHS. There were a series of recommendations, which would be examined by the People and Organisational Development Committee. An area of particular challenge was expected to be in terms of policies in relation to badges and

other political or religious symbols. Publication of a national policy would be helpful.

- The review of Band 5 nursing roles was expected to be completed in 2028, with the Board required to submit a plan to NHS England by 31 July 2026.
- NHS England had published staff standards to set minimum employment requirements to improve staff experience. A gap analysis was to be reviewed by the People and Organisational Development Committee, although it was thought that the Trust was already focusing on many of the areas set out in the NHS staff standards. The staff standards would also form part of the NHS Oversight Framework.
- The Trust was reviewing its existing programmes against the expectations of the NHS Leadership and Management Framework.

5.12 Violence, Aggression and Abuse Policy

Steve Harris was invited to present the Violence, Aggression and Abuse Policy, the content of which was noted. It was further noted that:

- In September 2025 the Board supported the view that the Trust needed to do more in terms of violence, aggression and abuse, especially in the context of unrest in the country and increasing numbers of such incidents against NHS staff nationally.
- The Management of Violence, Aggression and Abuse: Acceptable Behaviour Policy introduced a new Trust-wide framework to prevent, manage and respond to violence, aggression and abuse towards staff, patients and visitors. It was a core component of the Safe@UHS programme.
- The revised policy established a four-stage framework, escalating from informal warnings to exclusion. A training needs analysis has been completed to support the effective roll out of the policy.
- In addition, the policy established a Violence, Aggression and Abuse Board, jointly chaired by the Chief Operating Officer and Chief People Officer, which provides for clear governance around decision-making, such as when exclusion would be appropriate.
- The Trust has already taken action against patients and members of the public, and staff who have interacted with the process have reported feeling well supported. It was considered to be important to ensure staff were kept informed about what had been done in this area to further increase confidence in the process.
- Gratitude was expressed to the former Director of Organisational Development, Ceri Connor, for her work on the programme.

Decision

The Board agreed to support and endorse the revised approach to violence, aggression and abuse, and noted that ongoing assurance regarding implementation of the policy would be provided through the People and Organisational Development Committee.

5.13 Learning from Deaths 2025-26 Quarter 4 Report

Paul Grundy was invited to present the Learning from Deaths 2025-26 Quarter 4 Report, the content of which was noted. It was further noted that:

- The Trust remained one of eight trusts nationally with a lower-than-expected death rate.
- 1,210 deaths had been reviewed during the quarter by the Medical Examiner Service, of which 37% had occurred in hospital.
- There had been a major review of the deaths of those with a learning disability.
- A module had been added to the Ulysses system to facilitate the capture and sharing of Morbidity and Mortality meetings. This module was undergoing testing.

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

Diana Hulbert was invited to present the Guardian of Safe Working Hours Quarterly Report and Update on 10-Point Plan, the content of which was noted. It was further noted that:

- Following the changes in exception reporting introduced in February 2026, the number of reports had increased to an average of 74.8 per month compared to 62 per month during the previous year. It was not possible at this stage to draw detailed conclusions regarding this increase, and national data would be helpful to determine the Trust's position relative to others.
- The Trust was expecting to be audited in terms of its compliance with the 10-Point Plan. The Trust reported that it was 91% compliant with the plan. The main areas of non-compliance related to annual leave reform and reimbursement of fees and expenses.

5.15 Infection Prevention and Control 2025-26 Annual Report

Julian Sutton and Julie Brooks were invited to present the Infection Prevention and Control Annual Report for 2025/26, the content of which was noted. It was further noted that:

- The Trust had reported that it had met annual targets in respect of two out of five national healthcare associated infection standards – C. difficile and Klebsiella BSI.
- The Trust had recorded eight cases of MRSA during the year. Six of these related to intravascular device management. As such this had been an area of particular focus during the year.
- The Trust had experienced lower than expected cases of influenza and respiratory syncytial virus and norovirus during the winter period, especially when compared to other local providers.
- The Trust had missed its target for reducing use of antibiotics, but was investigating the figures recorded for March 2026, as these seemed abnormally high.
- During the fire on 1 February 2026, there had been no reported cases of infections resulting from the evacuation of patients into areas with sub-optimal infection prevention controls.

- The Trust's performance in terms of infection prevention and control was good relative to peers, particularly where those peers had higher numbers of side-rooms to facilitate isolation of patients.
- In addition, there was good interaction between the infection prevention and control team and the teams in the Trust.

The Board discussed the Annual Report. This discussion is summarised below.

- The impact of the heat in recent weeks was not yet known. Any impact would potentially be seen in the next month or so.
- The importance of switching from intravenous antibiotics to oral antibiotics, even toward the end of a course of treatment, was emphasised as a means of reducing infection risk.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2026-27 Quarter 1 Update

Martin De Sousa and Luci Hood were invited to present the Corporate Objectives 2026/27 Quarter 1 update, the content of which was noted. It was further noted that:

- The Trust was making progress against the objectives linked to each strategic theme.
- Delivery against the Trust's 'Outstanding Care' objectives was broadly on track with significant progress being made in developing the Clinical Effectiveness dashboard.
- The launch of the new Violence, Aggression and Abuse Policy had been a significant achievement during the quarter.
- There had also been good progress against the Trust's research and development objectives with strong performance in terms of research delivery and securing future research infrastructure and capability.
- The Trust had seen good delivery across financial, digital and estates priorities despite a challenging environment.

6.2 Research and Development Plan 2026-27

Karen Underwood was invited to present the Research and Development Plan for 2026/27, the content of which was noted. It was further noted that:

- 2026/27 would be the third year of the Trust's five-year research strategy, Research for Impact.
- The priorities for 2026/27 were to complete the actions required for submission of the NIHR BRC infrastructure renewal bid, deliver national UKCRD performance metrics, secure the future of the Research Leaders Programme, and increase inclusive research engagement and participation.
- The importance of the impact of 'research champions' in the Trust was noted.

Decision

The Board approved the Research and Development Plan for 2026/27.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (CoG) Meeting 8 July 2026

Alison Tattersall presented a summary of the Council of Governors' meeting held on 8 July 2026. It was noted that the meeting had considered the following matters:

- Chief Executive Officer's Performance Report
- Medium Term Planning
- Corporate Objectives
- Governor attendance at Council of Governors' meetings
- Health Bill 2026 and Council of Governors' elections
- Membership engagement

7.2 Register of Seals and Chair's Actions Report

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

Decision:

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

7.3 Financial Undertakings – Self Assessment

Ian Howard was invited to present the paper 'Financial Undertakings – Self Assessment', the content of which was noted. It was further noted that:

- In June 2023, the Hampshire and Isle of Wight Integrated Care System entered into the Recovery Support Programme. As part of this, providers agreed formal undertakings in relation to financial recovery.
- It has been confirmed that the Trust had transitioned out of the Recovery Support Programme and into regionally led oversight and support.
- The Trust had been requested to provide self-assessment in respect of its compliance with the undertakings entered into in 2023. The Trust had previously provided a similar self-assessment in June 2024 and in January 2025.
- It was proposed whilst the Trust was compliant across most areas, the Trust would indicate partial compliance with the undertakings, noting that it continued to report a deficit and there was significant risk associated with the Trust's 2026/27 Cost Improvement Programme.

The Board discussed the proposed self-assessment. This discussion is summarised below.

- It was suggested that the Trust should record itself as being compliant against requirement 7.1.1.
- It was suggested that the commentary in respect of 7.1.1.4 should be broadened beyond reference to the 'Grip & Control' checklist.
- It was considered appropriate that Ian Howard and the Chair should speak with NHS England before the self-assessment was submitted.

Decision

Subject to the comments set out in the discussion above, the Board approved the submission of the self-assessment to NHS England.

8. Any other business

There was no other business.

9. Note the date of the next meeting: 10 September**10. Resolution regarding the Press, Public and Others**

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

The meeting was adjourned.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 09/09/2025 - 8 Any other business				
1286.	Organ donation	● Machell, Craig	08/10/2026	■ Pending
	<i>Explanation action item</i> Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session. Item scheduled for TBSS on 08/10/2026.			
Trust Board – Open Session 09/07/2026 5.8 Performance KPI Report for Month 2				
1357.	Patients with a disability	● Hyett, Andy	10/09/2026	■ Pending
	<i>Explanation action item</i> Andy Hyett agreed to investigate what was being done to meet the 90% target for patients with a disability reporting additional needs and/or adjustments being met.			

Agenda Item 5.1 i)

Committee Chair's Report to the Trust Board of Directors 10 September 2026	
Committee:	Finance, Investment and Cash Committee
Meeting Date:	27 July 2026
Key Messages:	• The committee received the Finance Report for Month 3, noting that the Trust had report a £2.9m in-month deficit (£10.2m year-to-date) in line with its plan. The Trust had experienced a period of sustained operational pressure, including a critical incident, theatre closures, reduced bed numbers, and increasing numbers of patients with no criteria to reside. As a result, the Trust's activity levels had been lower than planned, which represented a risk of £5m to the Trust's anticipated elective income. Coupled with the £35m of risk in the Trust's Cost Improvement Programme (CIP) and further income risk due to the ongoing impact of the fire, there was an overall risk to the achievement of the Trust's 2026/27 plan of £45m. • The committee received an update in respect of the Trust's CIP plan, noting that the £81m target had been fully identified to a minimum of 'opportunity' level, meeting the NHS England target of no unidentified CIP, and 60% of schemes were fully developed. Delivery of CIP was reported as being on plan, however, there remained significant risk in the Trust's ability to deliver the full year savings and the rate at which schemes are being developed is slowing. • The committee received an update on the work being undertaken by Nexus Consulting since February 2026 in relation to patients with no criteria to reside. The work so far had identified a lack of consistency in data across system partners and a lack of capacity in the system as being key issues. Whilst disappointed that recommendations and proposed actions were yet to be reported, the Committee looked forward to hearing from Nexus in the September meeting. • The committee received an update on the Urgent and Emergency Care transformation programme. The Trust had been successful in reducing average length of stay by 5.6% compared to the 2025/26 baseline. Whilst Emergency Department performance remained a challenge, there were a number of initiatives underway to improve the situation, including use of rapid assessment models, diagnostics tracking, and the opening of an urgent treatment centre later in 2026. In addition, the Trust was working with system partners to avoid admissions and to further reduce length of stay. • The committee discussed a report on cost movements since 2019/20, noting that the most significant cost increases had occurred during the COVID years, with the main areas of growth being the Emergency Department, Critical Care, Cardiovascular and Thoracic, and Women and Newborn. These areas would be further examined as part of the financial consultancy work being commissioned as well as via the Trust's transformation programmes. • The committee received a quarterly update from the Digital team, noting the alignment between the team's programmes and the Trust's transformation objectives. The Trust was investing capital to address the highest risks identified in-year. It was noted that whilst heat was identified as a risk, the Trust's network had demonstrated resilience during the recent hot weather. There were a number of major projects

	underway or planned, including migration to NHS.net, the NHS Future Workforce solution, and ambient voice technology. The Committee was assured that the Trust's maturity against Cyber risk was one of the strongest amongst peers and the longer term investment plan to address future risks would be presented at the next Quarterly update. - The Trust's cash position was reviewed. The committee noted that the Trust's cash balance was higher than anticipated and that the Trust's position had improved materially in recent months as part of the Cash Recovery Plan. Although no additional cash support was required, in the event that the risks identified in the Finance Report materialised, the Trust would be likely to require cash support in January 2027. - The committee supported a proposed operating model for the Genomic Medicine Service.
Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	N/A
Any Other Matters:	The committee invited members of the People and Organisational Development Committee to attend a joint session to discuss a joint finance and workforce report, in order to bring together the reporting positions and risks within the finance and people reports, ensuring triangulation of the position and a clear narrative on risks and potential mitigations. This enabled a consistent review of the financial and people challenge to be understood, however the mitigations to achieve plan, both for financial and WTE targets, were yet to be fully developed and it was agreed to hold a further such session in September or October 2026.

Assurance Rating:

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

Risk Rating:

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

Agenda Item 5.1 ii)

Committee Chair's Report to the Trust Board of Directors 10 September 2026			
Committee:	Finance, Investment and Cash Committee		
Meeting Date:	1 September 2026		
Key Messages:	- The committee received the Finance Report for Month 4 (see below). - The committee received an update on the Trust's financial improvement programme, noting that the Trust had fully identified the £81m Cost Improvement Programme target to a minimum of 'opportunity' level and had increased the percentage of fully developed schemes to 68% though pace of progress has slowed as opportunities become more difficult to crystalise. - The committee received a report from an external consultancy in relation to patients not meeting the criteria to reside, which contained a number of recommendations to address this issue, and which had been shared across system partners. Significant opportunities have been identified within UHS to improve the position as well as working in conjunction with our partners, however capacity to progress this is needed and will be addressed with urgency. - The committee reviewed an update on the Trust's Elective Transformation Programme, noting the work being undertaken to integrate local and national referrals systems and to introduce a single point of access. In addition, the focus for Quarter 3 would be to carry out a clinically-led review of templates, appointment lengths, new-to-follow-up ratios, booking rules, and follow-up pathways. The Trust was also working on automating administrative processes for booking patients. - The committee received a six-monthly report from UHS Estates Limited (UEL) and updates from the Estates, Facilities and Capital Development and Managed Healthcare Services teams. The work of the teams in ensuring that the Trust continued to function during the heatwave was noted. The Trust's capital programme was progressing well with over 40 schemes currently in design or construction. - The committee reviewed an updated Outline Business Case for the OneEPR programme and recommended its approval by the Board. - An update was provided in relation to the Trust's recovery from the fire on 1 February 2026. It was noted that the Trust expected to be able to re-open theatre capacity in November 2026 along with restoring access and functionality of three endoscopy rooms.		
Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	5.10 Finance Report for Month 2	Assurance Rating: Reasonable	Risk Rating: High
	- The Trust reported an in-month deficit of £2.42m, £12.65m year-to-date, which remained in line with its plan. The Trust had also delivered £15.2m of CIP savings in line with its plan, although the balance of non-recurrent savings was greater than planned - The CIP plan for the year requires a significant uplift in monthly savings achievement from October 2026 and the Committee did not gain assurance of specific step changes anticipated in savings from that point. This is a significant risk to achieving plan for the year.		

	- The underlying deficit had remained relatively flat at £4.6m per month. The Trust's costs were being examined in detail at a service level in order to identify and deliver improvements in the underlying deficit. - There was a significant risk to delivery of the Trust's plan related to elective income, which had been impacted by the fire, operational pressures, industrial action, and the heatwave. - The Trust's cash balance was £28m and it was not anticipated that there would be significant cash challenges until Quarter 4 as the Capital programme cashflow is weighted towards the end of the year.
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.

Agenda Item 5.2 i)

Committee Chair's Report to the Trust Board of Directors 10 September 2026	
Committee:	People & Organisational Development Committee
Meeting Date:	27 July 2026
Key Messages:	• The committee reviewed the People Report for Month 3. June 2026 had been a challenging month, which saw increased use of bank staff due to the opening of surge capacity. In addition, the hot weather had had impacted staff wellbeing. The sickness absence rate during the month had been higher than expected at 4%. Appraisals remained an area of challenge and, following discussion at the Trust Executive Committee, work was being carried out to understand the data held in terms of recording completion of appraisals. Increasing the rate of appraisal completion was a key priority for the year. The committee also noted the restrictions in terms of use of national CPD funding and the challenges in terms of availability of funding for developing staff. The Government had agreed a deal with resident doctors to end the long-running industrial dispute. This deal included changes in pay and progression as well as the continued implementation of the 10-Point Plan. • The committee reviewed the national requirement to produce an action plan for the job evaluation of all Band 5 nursing job descriptions by 2028. The committee supported the plan and approved its submission to NHS England. The plan had been agreed with the local RCN job evaluation lead and had been received positively. The main risk identified was in relation to uncertainty over what the outcome of the review would be and the financial impact. • The committee discussed the outputs of the review by Lord Mann into racism in the NHS, noting the recommendations set out in the review. The committee agreed in principle that the Trust should adopt the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government's definition of anti-Muslim hostility. In both cases, this adoption was to be subject to more detailed guidance being developed in relation to interpretation of the definitions. The committee also agreed that the Trust should sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles. • The committee received an update from the Employee Relations team, noting the key risks due to the Employment Rights Act 2025 relating to unfair dismissal eligibility periods and the Act's impact on fixed-term contracts. The complexity and number of disciplinary cases had increased since 2022, although the majority of cases were resolved either via a letter of concern or first written warning. One area of recent national attention had been in relation to inappropriately accessing patient records and it was noted that the Trust had taken action against staff members, including dismissal. The main areas of focus for the coming 12 months included a focus on sickness absence, training in relation to the Employment Rights Act, and increasing the Trust's in-house investigation capability and capacity. • The committee received an update in relation to the recently published NHS Staff Standards, noting that a gap analysis was being carried out, the results of which would be reported to the committee in due course.

Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	N/A
Any Other Matters:	Committee members were invited to attend a joint session with the Finance, Investment and Cash Committee to discuss the Trust's financial and workforce plans. It was agreed to arrange a further such session in September or October 2026.

Assurance Rating:

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

Risk Rating:

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

Agenda Item 5.2 ii)

Committee Chair's Report to the Trust Board of Directors 10 September 2026			
Committee:	People & Organisational Development Committee		
Meeting Date:	25 August 2026		
Key Messages:	- The committee reviewed the People Report for Month 4 (see below). - The committee noted that it had been a significantly challenging period for the Trust's workforce due to operational and staffing pressures owing largely to the extremely hot weather during July and August. - The committee reviewed a report in relation to the Trust's compliance with the NHS Staff Standards. These standards, published in July 2026, set national minimum employment requirements for NHS employees across six domains. The Trust's performance against these standards would form part of the Trust's rating under the NHS Oversight Framework. The committee noted that the Trust had strong foundations across the domains but needed to identify where there were gaps or potential improvements to achieve full compliance. A key consideration would also be where matters could be sensibly delegated to the committee, rather than being overseen by the whole Board. - The committee received an update in relation to national initiatives and programmes, noting that there had been a delay in the proposed roll-out of the future workforce solution and that the Trust was still awaiting the publication of NHS England's workforce plan. The latter was impacting the development of the Trust's updated people strategy to cover the next five years.		
Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	5.10 People Report for Month 4	Assurance Rating: Substantial	Risk Rating: Medium
	- The Trust's workforce had increased by 35 whole-time-equivalents (WTE), which had resulted in the Trust now being off-plan. Whilst the substantive workforce had fallen by 7 WTE and agency staff by 4 WTE, bank usage had been significantly higher and was now 184 WTE above plan. - A combination of higher admissions, increased acuity and staffing shortages had been a key driver of the increased bank usage. - Sickness rates had been higher than would ordinarily have been anticipated during the summer months, with the rolling sickness absence rate being reported as 4.2% and 4.1% in month. - Turnover had remained comparatively low at 10.4%. - Appraisal rates remained an area of concern with only 64.6% of staff having been recorded as having completed an appraisal. As such steps were being taken to ensure that where appraisals had been completed, but not recorded, that the system was updated to record the appraisal. - The Trust continued to record an increasing number of staffing incidents, with 126 having been recorded in July 2026. - The committee was concerned about a number of the metrics, including appraisal and training compliance, sickness absence rates, and staffing incidents. A report, looking in detail at these areas, is due		

	to be presented to the People Board on 7 September 2026, following which the committee will also examine these areas. Despite the challenges, the Trust continued to progress several significant workforce initiatives, including expansion of nursing apprenticeship starts to 51 places and preparations for the early adoption of the future workforce solution. In addition, preparations were underway for 'We are UHS' week between 12-16 October 2026.
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.

Agenda Item 5.3 i)

Committee Chair's Report to the Trust Board of Directors 10 September 2026			
Committee:	Quality Committee		
Meeting Date:	13 July 2026		
Key Messages:	- It was noted that there had been no new never events or patient safety incidents reported during the period. With regard to falls, the Trust was focusing on analysing data gathered from the neurological observations audit. - The committee received an update on the Fundamentals of Care Programme, noting that a new version of standards for outpatients was ready to be rolled out and the roll out of the 'What matters to me' boards continued. There were some concerns in relation to digital capacity and the impact on the programme. - The committee reviewed an assessment of the Trust's compliance with the 10-Point Plan issued following the publication of Baroness Amos' investigation into Maternity and Neonatal Services. It was noted that the Trust was in a relatively good position to respond. The main areas of risk were those related to workforce and estate. - The committee reviewed the Maternity and Neonatal Workforce Report, noting that the Trust had robust governance processes in place. There was a need for an increase in the obstetrics workforce due to the impact of the increasing rate of caesarean births. The most significant workforce gaps were in the neonatal team, although the Trust was in a better position than most amidst a national shortage. - The committee reviewed the Maternity Care Bundle Implementation Report, noting the plan for implementation by March 2027. - The committee received an update in respect of Mental Health, noting that there had been a significant reduction in the waiting time for mental health beds following changes in the processes in Hampshire and Isle of Wight. - The committee reviewed the Medicines Management Annual Report, noting that reporting had decreased slightly (but was still consistent with a good reporting culture), and that moderate to severe harm incidents had decreased as had the proportion of incidents causing harm. Work was ongoing to standardise selection of drugs. - The committee received an update on consultant job planning. The committee noted the significant progress which had been made during the year, with the Trust reporting 89% of job plans having been signed off at the end of 2025/26. - The committee received a summary of the key clinical outcomes as presented to CAMEO in January 2026. - The committee reviewed the quality risks in the Board Assurance Framework.		
Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	5.11 Annual Complaints Report 2025-26	Assurance Rating: Substantial	Risk Rating: Medium
	- The Trust recorded 8,726 PALS interactions during 2025/26. - The primary themes of complaints remained consistent with the previous year: clinical treatment (28%), communication (26%), and appointments (9%).		

	- The Trust had low numbers of referrals to the Parliamentary and Health Services Ombudsman compared to others. - The complexity of complaints was increasing, with AI being used to generate complaints. - Work was ongoing in terms of providing greater assurance around the follow up of actions generated by complaints. - The committee challenged the threshold applied to upholding complaints, noting that the proportion of complaints partially or fully upheld appeared low, although was now closer to the national average.
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.

Agenda Item 5.3 ii)

Committee Chair's Report to the Trust Board of Directors 10 September 2026			
Committee:	Quality Committee		
Meeting Date:	24 August 2026		
Key Messages:	• It was noted that there had been one case of MRSA reported during the month, but that the cause was still under investigation. There had also been an increase in the number of pressure ulcers reported. One never event in Dermatology had been recorded during the quarter. • The committee noted that the period had been challenging due to the heat. However, no specific patient harm had been identified following a review of heat-related alerts raised. • A peer review of the Trust's NatSSIPS implementation had identified areas of good practice and 12 improvement actions. • The committee noted that progress had been made in terms of reducing the backlog in PALS enquiries and the waiting time for responses. An additional complaint theme relating to admission and discharge had been identified. Work was ongoing to follow up on actions arising from complaints to ensure that there was greater visibility and oversight. • The committee reviewed the Maternity and Neonatal Safety 2026-27 Quarter 1 Report, noting that it had been a busy quarter with high demand and acuity. This was reflected in terms of the performance in areas such as post-partum haemorrhage rates, the friends and family test, and post-natal readmissions. The committee noted that a number of additional requirements had been received from NHS England following the publication of the Ockenden and Amos reviews. The most significant maternity and neonatal risks were those related to workforce and infrastructure/estates. • The committee noted that there had been an unannounced CQC inspection of the Trust's maternity service on 27-29 July 2026, which raised concerns relating to estates and security. • The committee noted an update regarding the Trust-hosted Maternity Triage Line and the Trust's compliance with a series of national standards in this area.		
Assurance: <i>(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</i>	5.11 Learning from Deaths 2026-27 Quarter 1 Report		Assurance Rating: Substantial
	• Based on SHMII data, the Trust continued to be one of eight trusts recording lower-than-expected numbers of deaths. • It was noted that the Trust had seen a more stable trajectory of deaths over the course of the year as opposed to spikes at particular times of the year. • The medical examiner service continued to be busy, with more than 50% of deaths examined being deaths in the community rather than in hospital. • The availability of side rooms remained an ongoing challenge.		Risk Rating: Medium

	5.14 Safeguarding Annual Report 2025-26	Assurance Rating: Substantial	Risk Rating: Medium
	- The Trust had seen an increase in the number and complexity of safeguarding referrals. This had significantly impacted the length of time each case remained open. - The committee noted the ongoing work to improve the availability of data to divisional and operational teams from the Safeguarding team in order to facilitate improved planning and operations. - Completion of mandatory training remained an area of challenge, although work was being undertaken to ensure that staff were required to undertake the correct level of training. - There had been a significant change in the law regarding Deprivation of Liberty following a Supreme Court case, which was expected to impact the Trust.		
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.

Agenda Item 5.4 Report to the Trust Board of Directors, 10 September 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 care	Pioneering research and innovation	Outstanding people	Foundations for the future
x	x	x	x
Executive Summary:			
The CEO's Report this month covers the following matters: - Heatwave - CQC Unannounced Inspection - Employment Rights Act - Secretary of State Appointment - Hampshire Orthopaedic Centre - Flu Jabs - Awards			
Contents:			
Chief Executive Officer's Report			
Risk(s):			
N/A			
Equality Impact Consideration:		N/A	

Chief Executive Officer's Report

Heatwave

Accident and Emergency demand hit a record high in July 2026 as the NHS faced a 'summer surge'. There were a record 2.5 million attendances in July amid multiple heatwaves, with the three busiest months ever all recorded between May and July.

Although the NHS normally experiences spikes in demand during the summer months, typically there is more trauma from falls, this summer has seen unprecedented pressure, with the heat contributing to a rise in admissions due notably to respiratory, stroke and cardiology, as well as a worsening of underlying medical conditions, particularly in the frail elderly population.

The Trust has therefore experienced a challenging few months, having declared a critical incident in June and managing through further periods of extremely hot temperatures. The Trust saw an increase in Emergency Department attendances, which was coupled with a higher-than-expected rate of staff sickness absence and reduced bed capacity. In response to capacity challenges, the Trust stood up incident management arrangements to focus its collective efforts on increasing discharges across the hospital.

The heat and humidity across much of the hospital, especially the G level wards where we care for our most vulnerable patients, created an environment at times incompatible with the care we want to provide. Electrical capacity constraints meant there was limited potential for additional air-conditioning in ward areas and on several occasions, we either lost, or chose to close, radiology and theatre estate to protect chilling equipment which was at risk of failure.

Our experience was not unique, with similar challenges faced elsewhere in hospitals and across the public estate such as in schools. With hotter summers likely to be more frequent, the need for a government-wide response is clear, although identifying a funding source will obviously be challenging. Absent a funded national programme, I have asked the estates team (UHS Estates Ltd) to develop some options to mitigate the heat impact ahead of next summer.

I would like to thank staff for their commitment and effort to provide the best care they could during a difficult period for the Trust and the wider NHS.

CQC Unannounced Inspection

A team from the CQC arrived on site unannounced and performed a two-day (28 and 29 July) inspection of maternity care at Princess Anne Hospital. They spoke to staff and women about their experiences, observed care being provided and inspected the physical estate. Their initial verbal feedback was that the care provided was good, with a strong team culture within and across the various professional groups, and that all the women spoken to were happy with their care. They also commented on the strong quality improvement work and that despite high workload pressures, staff felt well-supported. They highlighted some concerns around physical security arrangements, notably the potential risk of unauthorised people entering the labour ward and abducting a baby. The CQC followed this up in writing, requiring immediate improvements in security procedures and hardware. The Trust's response was to implement all those improvements (including a higher fence surrounding the garden, additional CCTV and changes to physical controls at building exits). The CQC have confirmed that they are content with our response and the changes we have made.

Since then, we have provided CQC with extensive documentation such as outcomes, policies and procedures etc. The next stage will be for CQC to issue a draft report, on which we will have opportunity to comment for factual accuracy. It is likely that the final report and rating will be confirmed in Q1 2027.

Employment Rights Act

The Employment Rights Act 2025 proposed significant reforms to 'zero' or low-hours employment terms. These include a right to a guaranteed contract reflecting the hours employees regularly work, requirements for employers to give reasonable notice of shifts, and payments where shifts are cancelled, cut short or moved at short notice.

The changes form part of the Government's attempts to crack down on 'exploitative' zero-hours contracts. However, the proposals will also apply to the use of bank staff in the NHS. The Government launched a consultation on these changes, which closed in August 2026. UHS provided feedback to the consultation through the Southeast Temporary Staffing Collaborative.

NHS Employers has also published its consultation position on implementation within the NHS. It has warned that the changes could reduce the number of bank workers available and undermine efforts to reduce spending on agency staff. NHS Employers has argued that bank arrangements differ from standard zero-hours arrangements because they offer two-way flexibility, noting that 85% of bank staff already hold a substantive contract.

NHS Employers is seeking an opt-out from guaranteed hours offers for staff who wish to retain their current arrangements, alongside exemptions for shifts covering emergency response, seasonal pressures, sickness and annual leave.

NHS Employers has estimated that, nationally, the reforms as currently set out would require around 800 additional administrative staff and 610 managers to implement and oversee. These additional staffing costs, combined with compensation for short-notice changes and upgrades to workforce and digital systems, are estimated to result in recurring annual costs of around £900m.

NHS Employers is calling on the Government to pause the process pending further engagement with health and social care representative bodies and to undertake a full impact assessment covering cost, equality and productivity for the NHS.

The changes remain subject to final legislative change, and the proposed implementation date has yet to be confirmed.

Alongside considering the impact of these proposals, UHS is updating its policies in response to changes introduced by the Employment Rights Act, including policies relating to probation periods and fixed-term contracts. The Chief People Officer will continue to appraise the People and Organisational Development Committee on the impact of these changes and advise the Board accordingly.

Secretary of State Appointment

On 20 July 2026, Yvette Cooper was appointed as Secretary of State for Health and Social Care, having previously served as Secretary of State for Foreign, Commonwealth and Development Affairs and as Secretary of State for the Home Department. She replaces James Murray, who served briefly as Secretary of State following the resignation of Wes Streeting in May 2026.

Yvette Cooper was first elected as a Member of Parliament in 1997 and served in various roles in the administrations of Tony Blair and Gordon Brown and in opposition between 2010 and 2024.

Initial interactions with the NHS CEO community suggest the goals and objectives of the previous Secretary of State, i.e. waiting list reduction, urgent and emergency care and the 10-year plan, will remain the focus of the new government.

Hampshire Orthopaedic Centre

The Hampshire Orthopaedic Centre celebrated an important milestone after treating its 1,000th patient.

Opened in September 2025, the Hampshire Orthopaedic Centre (HOC) is delivered in partnership between UHS and Hampshire Hospitals NHS Foundation Trust. Based at Royal Hampshire County Hospital in Winchester, this specialist facility has helped to increase access to planned orthopaedic surgery, reduce last-minute cancellations, and enable patients to receive treatment sooner. It has achieved a 41% day-case rate and 87% of hip and knee patients are home by the next day. We are currently exploring whether a broader cohort of patients can be treated at the HOC because the existing scope means there will be insufficient patients to utilise the capacity fully.

Flu Jabs

On 17 August 2026, NHS England announced the opening of its national booking system for those eligible to pre-book their flu vaccinations when vaccinations start on 1 September. This is ahead of local NHS services beginning to send invites to the first cohort of eligible people in September.

The chief nursing officer for England said: “The NHS is kicking off its preparations for winter earlier than ever, with millions of flu jab appointments for pregnant women and children available to book from today ahead of vaccinations next month... I’d encourage everyone who is eligible to come forward as soon as they are invited. By getting your flu jab, you’re not only protecting yourself, but also your loved ones, your community and helping the NHS prepare for winter.”

We have well-established procedures to manage the flu vaccine campaign and will look to increase the proportion of our staff receiving the vaccine over last year.

Awards

Members of the Trust’s paediatric intensive care (PICU) nursing team were recognised with the prestigious chief nursing officer silver award. Members of the team volunteered as clinical volunteers on an international humanitarian mission that brought children from Gaza to the UK for specialist medical treatment.

Two members of the Trust’s healthcare science team were recognised for their exceptional achievements at the Southeast Healthcare Science Awards, with one individual receiving the Research and Innovation Award and another receiving the Scientific Leadership Award.

I am sure the Board will join me in congratulating all our award winners.

Agenda Item 5.5 Report to the Trust Board of Directors, 10 September 2026			
Title:	Performance KPI Report 2026-27 Month 4		
Sponsor:	Andy Hyett, Chief Operating Officer		
Author:	Sam Dale, Associate Director of Data and Analytics Damien Flood, Elective Care Pathway Manager		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
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):			
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.			
Equality Impact Consideration:		NO	

Performance KPI Board Report

Covering up to
July 2026

Sponsor

Andy Hyett, Chief Operating Officer

Author(s)

Sam Dale, Associate Director of Data and Analytics

Damien Flood, Elective Care Pathway Manager

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 considers cancer performance, with particular focus on the Faster Diagnosis, 31-day and 62-day standards, the current cancer waiting list position, tumour-site pressures and the recovery actions underway.

The report highlights that: -

- Cancer performance remains mixed: UHS achieved 62-day performance of 74.0% in June 2026, above national and Wessex averages but below the 2026/27 expectation of 80%.
- Faster Diagnosis performance improved to 76.8% but remains below the revised 80% national standard, with delivery constrained by first outpatient capacity, diagnostic capacity and pathology turnaround times.
- The most significant immediate risk is the 31-day treatment standard, which fell to 81.2% against the 94% ambition, primarily due to radiotherapy disruption, CT-planning constraints and the resulting backlog.
- Referral demand remains high, with July 2026 reported as the second-highest monthly referral volume received by UHS. Recovery is focused on restoring radiotherapy and CT-planning capacity, improving diagnostic access and turnaround times, and reducing tumour-site backlogs.

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

1. Emergency care performance remains positive, with 80.7% of patients seen within four hours, ahead of the trust's 78.5% trajectory. Corridor-care episodes also reduced to 1,808 reflecting continued focus on alternatives to ED, escalation, discharge and patient flow.
2. Elective performance remains broadly stable, with 64.6% of patients waiting fewer than 18 weeks, marginally ahead of the 64.5% trajectory. However, the waiting list stands at 64,407 compared to 63,326 in June. There is a continual operational focus on reducing the 1,585 patients waiting over 52 weeks with all services exploring further waiting list initiatives, additional outsourcing contracts and opportunities for mutual aid. This is against a backdrop of continual manual and automated validation to ensure the waiting list is as accurate as possible.
3. Diagnostic services continue to manage significant demand, with 10,541 patients waiting and 21.0% waiting over six weeks, compared with the trust's 18.5% trajectory. Recovery plans remain focused on capacity, productivity and reducing waits in the most challenged modalities. CT services experienced significant pressures in the month of July predominantly within the cardiac CT service. The backlog has arisen because cardiac CT requires consultant-supervised scanning and the service has experienced consultant workforce pressures. Recovery plans are focused on increasing reporting and scanning capacity, and the forecast remains achievable.
4. The Trust reported 19 Red Flag staffing incidents in July, reflecting the operational challenges associated with maintaining safe staffing levels across services during periods of heightened demand and the opening of additional capacity. The incidents demonstrate the effectiveness of

real-time escalation processes in identifying and responding to staffing pressures, ensuring patient safety risks are recognised and managed promptly.

5. Pressure-ulcer performance has improved, with category 2 and category 3+ rates reducing to 0.30 and 0.38 per 1,000 bed days, respectively. Category 3+ performance remains above target, and prevention, review and shared learning continue across clinical teams.
6. Medicines safety remains an area of focus, with five moderate or severe medication errors reported in the latest month against a target of no more than three. Immediate clinical action and incident review support continued learning around prescribing, administration and checking processes.
7. Patient experience remains broadly positive, with inpatient and maternity negative FFT scores of 1.6% and 4.9%, both within the 5% threshold. A total of 88.0% of patients reported involvement in decisions, while 87.2% said their additional needs or adjustments were met.
8. Health inequalities measures show encouraging progress, with supported smoking-cessation referrals reaching 51.6% and ethnicity-data completeness improving to 80.6%. Continued work will focus on sustaining referral uptake and strengthening the quality of core inequalities data.
9. Research recruitment performance has improved to 12th place, moving closer to the trust's top-10 ambition. Maintaining a strong portfolio of open studies and supporting recruitment across clinical services remain priorities.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 17th August 2026, our average handover time was 14 minutes and 20 seconds across 732 emergency handovers and 16 minutes 31 seconds across 57 urgent handovers. There were 26 handovers over 30 minutes and 1 handover taking over 60 minutes within the unvalidated data. Across July 26, the average handover time was 16 minutes 17 seconds.

Spotlight: Cancer performance

1. Introduction and Key Messages

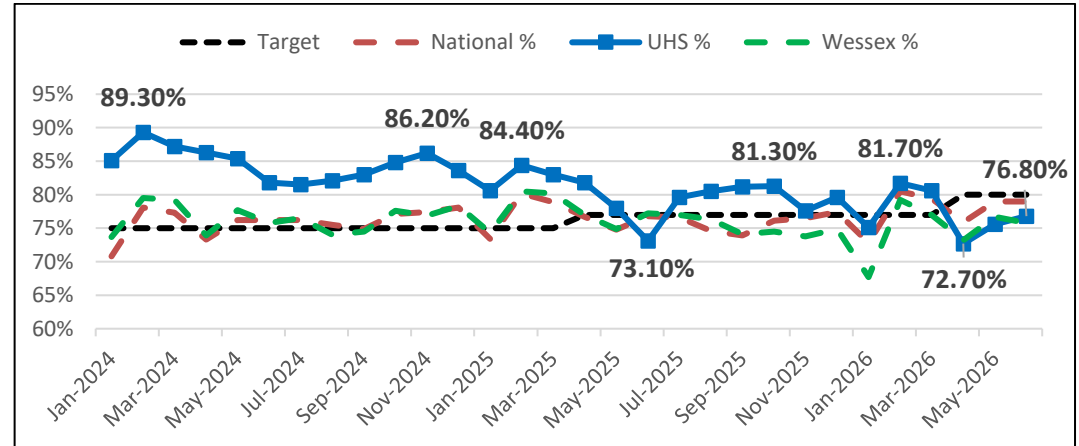
UHS cancer performance remains challenging. The Trust continues to report comparatively strong 62-day performance, achieving 74.0% in June 2026, above both national and Wessex averages, although still below the 2026/27 ambition of 80%. Faster Diagnosis performance improved to 76.8% but also remains below the revised 80% standard. The most significant immediate risk is the 31-day treatment standard, which fell to 81.2% in June, mainly due to radiotherapy capacity disruption and the resulting treatment backlog.

The Board is asked to note the current performance position, the principal risks to delivery, and the recovery actions underway, with particular focus on the 31-day treatment standard, radiotherapy recovery, diagnostic capacity and tumour-site backlog reduction.

2. UHS Waiting Time Performance Overview

The **Faster Diagnosis Standard** reflects a maximum 28-day wait for diagnosis from urgent GP referral and from NHS cancer screening programmes. In 2026/27 the national target rose from 77% to 80%.

UHS Faster Diagnosis performance declined from 81.7% in March to 72.7% in April 2026 following the increase in the national standard. Performance improved to 76.8% in June but remained below the standard. Delivery is constrained by first-appointment and diagnostic capacity, particularly in Head and Neck, Colorectal and Urology, including pathology turnaround times. UHS was below the June national average of 79.0% but above the Wessex average of 75.8%.

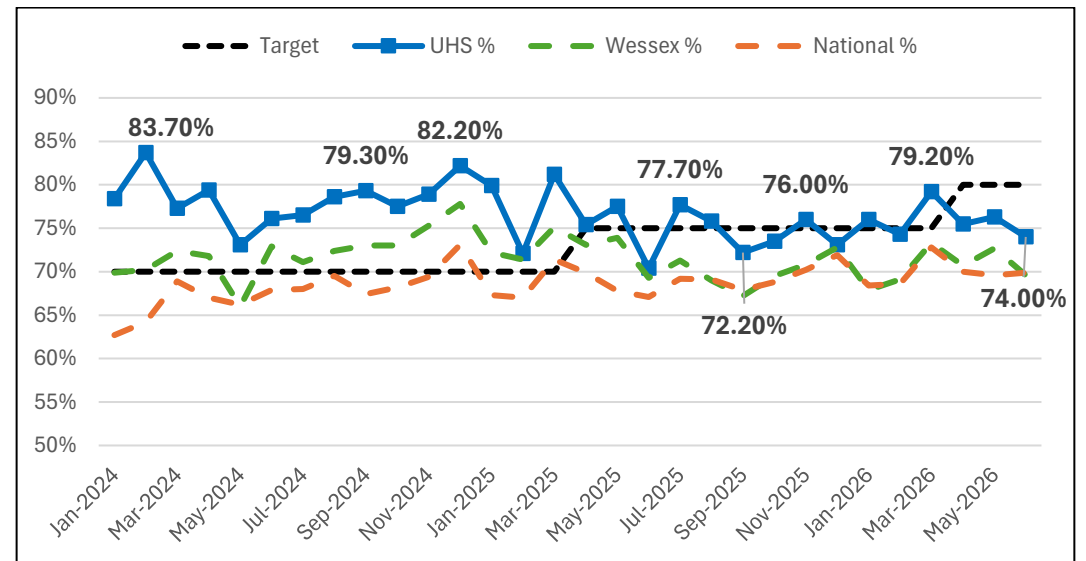


Graph 1: 28 Day Faster Diagnosis Performance Trend

The 62-day standard measures the time from urgent GP referral, cancer screening referral or consultant upgrade to first definitive treatment. The current target for compliance is 80%.

UHS reported 62-day performance of 74.0% in June 2026, down from 76.3% in May and below the 2026/27 expectation of 80%. Performance nevertheless remains above the national average of 69.9% and the Wessex average of 69.6%.

The services showing deterioration in performance since April are Breast, Head and Neck and Gynaecology although partially offset by improvement in Respiratory, Urology and Upper GI.

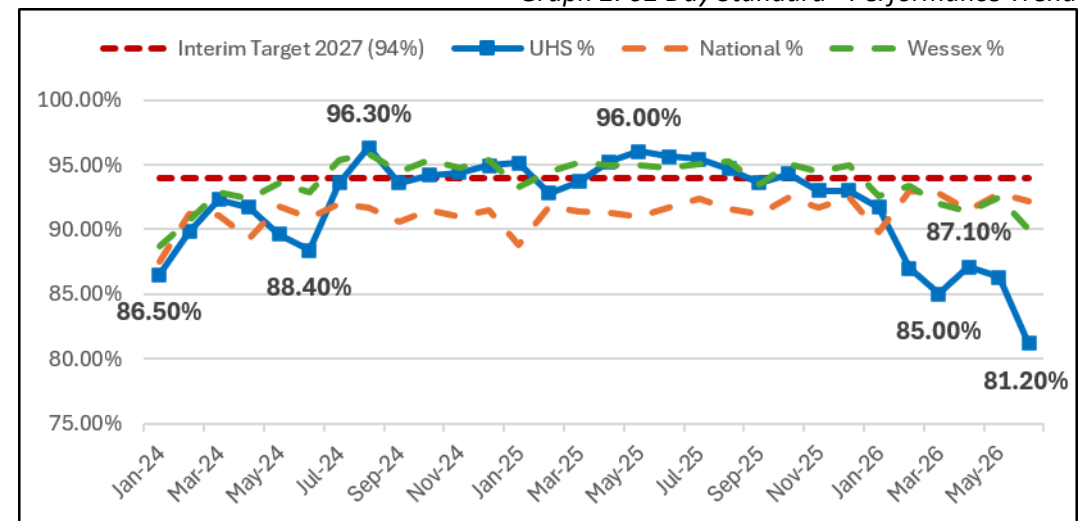


Graph 2: 62 Day Standard - Performance Trend

The 31-day standard refers to the time allowed from a registered decision to treat to the definitive treatment date associated with that plan - the national ambition is for Trusts to deliver this for 94% of patients.

The UHS 31-day position remains the most significant performance concern. Performance fell to 81.2% in June 2026 against the 94% ambition, compared with a national position of 92.2% and a Wessex average of 90.0%. The main driver was the backlog created during replacement and repair of the radiotherapy LINAC.

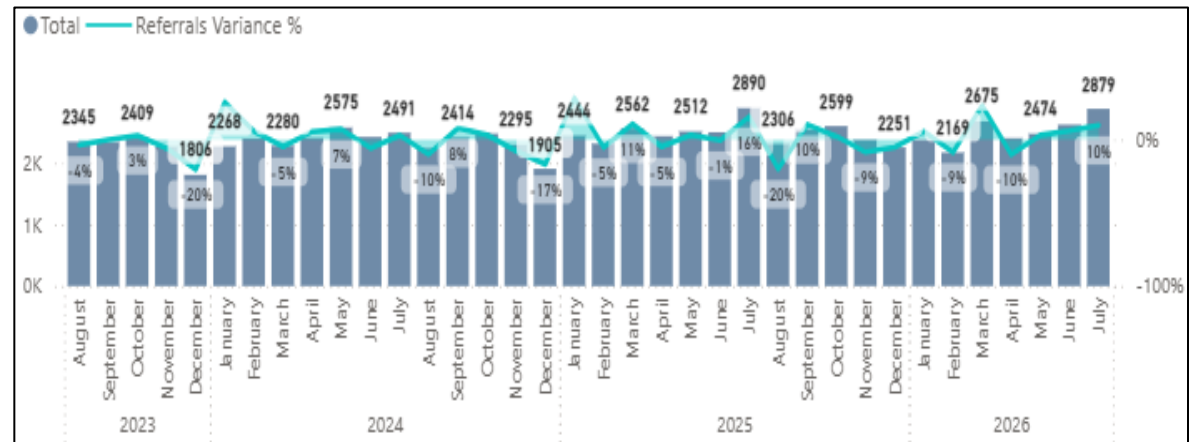
Although LINAC availability has improved, recovery of CT-planning capacity remains an important dependency. Breast and Urology account for the largest volumes of patients breaching the standard.



Graph 3: 31 Day Standard - Performance Trend

3. Cancer Referrals and Waiting List

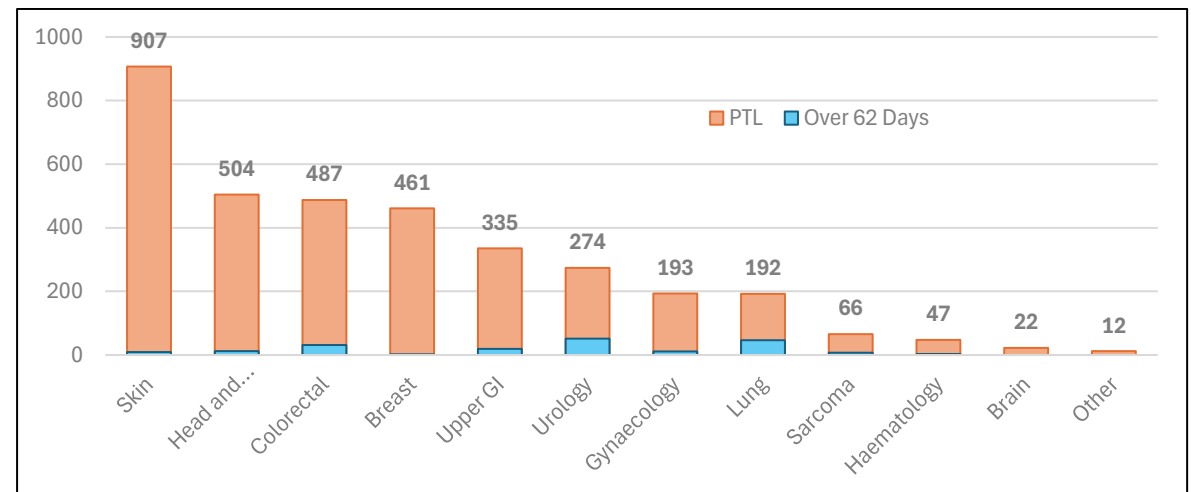
Several factors impact cancer referrals, influencing both the timeliness and appropriateness of patient pathways. Key determinants include primary care recognition of symptoms, patient awareness and willingness to seek medical advice, and the efficiency of referral systems. Delays can arise from workforce shortages, administrative bottlenecks, and variation in referral guidelines. Additionally, diagnostic capacity, such as access to imaging and pathology services, plays a crucial role in processing referrals efficiently at UHS. External pressures, including seasonal variations, pandemic-related backlogs, and socioeconomic disparities further contribute to fluctuations in referral volumes.



Graph 4: UHS two week wait (2WW) - referral volumes

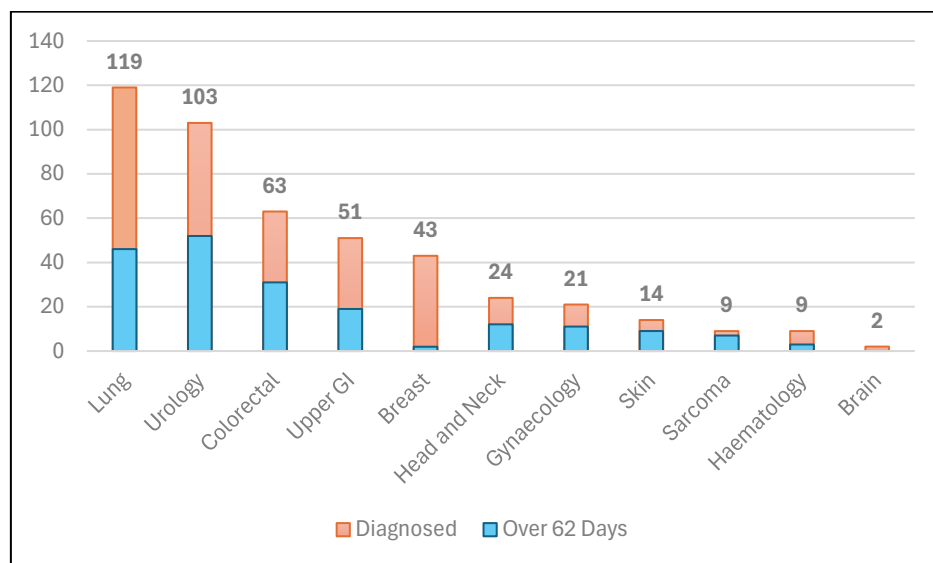
The Trust has continued to receive a high number of referrals through the 26/27 year so far, with early reports of July referrals peaking at the second highest ever number received into UHS in a month. The Trust has continued developing modelling for cancer referrals, treatment interventions and expected growth/reduction per month to better support annual planning, capacity modelling and business case development.

The total cancer PTL sits at 3,505, including 192 patients waiting more than 62 days. This represents 5% of the total PTL and an improvement from the previous report. Graph 5 reflects a breakdown of the entire PTL by tumour site and the recent backlog volumes illustrating the ongoing challenges in Urology and Lung services.

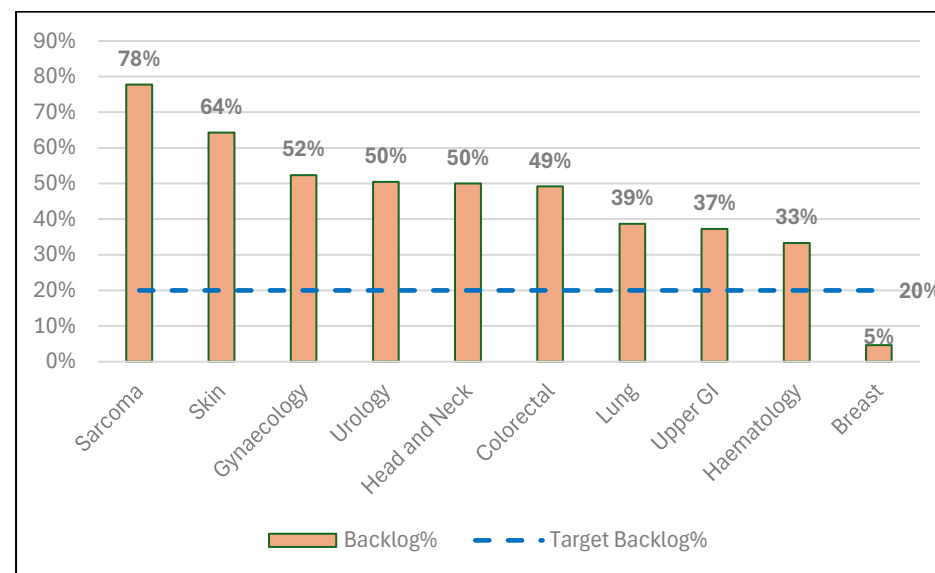


Graph 5: Cancer PTL by Tumour Site and Backlog (>62 day waits)

Among patients with a confirmed diagnosis, the greatest proportional pressures are in Sarcoma, Skin and Gynaecology, where more than half are already waiting over 62 days. This creates a material risk to future 62-day compliance. Graphs 6 and 7 show the number of patients with a confirmed diagnosis who are now part of the backlog, against a 20% target line (the amount that can breach and still hit 80% compliance).



Graph 6: Confirmed Diagnosis by Tumour Site and Backlog (>62 day waits)



Graph 7: Backlog as a percentage of Confirmed Diagnosis by Tumour Site

4. Tumour Site Summaries

Cancer performance is increasingly being determined by a small number of high-risk pathways where capacity constraints, workforce shortages and diagnostic delays are affecting timely diagnosis and treatment. Although the underlying issues vary between tumour sites, common themes include workforce resilience, diagnostic turnaround times and treatment-capacity pressures. The following summaries focus on the principal risks affecting performance delivery, the mitigating actions underway and the key milestones expected to support recovery during 2026/27. Detailed recovery plans are provided in Appendix A1.

4.1 Breast

The Breast service is experiencing significant workforce pressures across both Surgical and Breast Radiology teams, creating a constraint at the front of the pathway. First outpatient waits are impacting delivery of both the 31-day and 62-day standards, despite utilisation of available clinic capacity consistently exceeding 95%. Capacity is expected to improve from September 2026 through reduced planned leave and additional Waiting List Initiative activity, with service modelling indicating this should support performance recovery. In parallel, a Cancer Alliance-funded insourcing solution has been approved and is currently being developed. Once implemented, this is expected to significantly reduce waits for first appointment and diagnostic assessment.

The service is also assessing the wider operational impact of increased diagnostic capacity, including potential downstream effects on theatre demand should additional cancers be identified. While recruitment progress has been made within the surgical workforce, national shortages within Breast Radiology continue to present a risk to sustained recovery and will require ongoing monitoring. Existing recovery actions remain focused on restoring first appointments to within 14 days, maintaining Faster Diagnosis Standard performance and reducing downstream treatment delays.

4.2 Colorectal

Faecal Immunochemical Test (FIT) availability before first appointment has improved, although uptake remains inconsistent across GP practices. Deteriorating patient frailty and comorbidity is also increasing the requirement for consultant-led assessment. The service is reviewing its workforce model to maintain timely access to specialist expertise.

4.3 Head and Neck

Insourced ENT and Head and Neck capacity has commenced to address workforce-related diagnostic delays. Clearing long-waiting patients may initially reduce reported Faster Diagnosis performance before recovery benefits become visible, likely in Q4.

Maxillofacial services continue to experience workforce constraints affecting diagnostic and treatment capacity; these risks have been escalated through governance processes.

4.4 Dermatology

The Skin service has managed the seasonal increase in referral demand through the use of the single lesion clinic, although referral volumes are expected to remain elevated in the short term. The service is also progressing plans to transform the skin cancer pathway through the implementation of the Skin Analytics

DERM artificial intelligence platform. The proposed model will establish an in-house photographic hub where patients attend for clinical imaging, with photographs reviewed through the AI tool before consultant oversight.

The new pathway is expected to improve triage and pathway efficiency by identifying patients with benign conditions who may not require further investigation, while prioritising patients with suspected cancer for expedited clinical review. Consultant oversight will remain integral to the pathway, and patients will continue to have the option of a traditional face-to-face assessment should they prefer this approach.

Subject to implementation planning, rollout is currently scheduled from November 2026 and is expected to support improved utilisation of specialist clinic capacity and more timely assessment of urgent suspected cancer referrals.

4.5 Respiratory

The respiratory pathway has shown improvement but remains exposed to delays between confirmed diagnosis, molecular testing and treatment decision. The service is assessing opportunities to accelerate molecular diagnostics, with the aim of reducing the time patients spend between diagnosis and treatment planning. This is particularly important for lung pathways, where timely diagnostic confirmation and treatment stratification are key determinants of 62-day delivery.

4.6 Endoscopy

Endoscopy capacity remains a key enabler of Faster Diagnosis performance, particularly for colorectal and upper gastrointestinal pathways. Recovery has been supported through continued use of mobile provision and partnership working, which has helped maintain additional diagnostic capacity. Sustaining this capacity through 2026/27 will be important to prevent diagnostic waits from becoming a constraint on cancer pathway recovery.

4.7 Radiology

Radiology reporting capacity is an emerging risk to cancer pathway delivery, with vacancies and reporting workforce pressures having the potential to extend diagnostic turnaround times. The service has escalated these risks and is progressing workforce planning and mitigation actions. Continued monitoring will be required to ensure reporting delays do not adversely affect Faster Diagnosis performance or create downstream 62-day risk.

4.8 Pathology

Pathology turnaround remains an important dependency for cancer pathway recovery, particularly where diagnosis and treatment planning rely on timely histology or molecular results. The service is assessing a combination of workforce growth, digital improvement and AI-supported triage to improve diagnostic

flow. These developments are expected to support faster decision-making and reduce delays between diagnostic test, confirmed diagnosis and treatment planning.

4.9 Radiotherapy

Radiotherapy remains the principal driver of the current 31-day treatment risk following LINAC disruption and the associated backlog. LINAC availability has improved, but recovery remains dependent on restoring CT-planning capacity and sustaining treatment throughput. Continued focus is required to reduce the treatment backlog, recover 31-day performance and prevent delays from affecting wider cancer pathway delivery.

5. Conclusion

Cancer performance remains mixed. UHS continues to compare favourably with national and Wessex peers for the 62-day standard, but performance remains below the 2026/27 expectation. Faster Diagnosis performance is recovering but remains below the revised 80% standard. The 31-day standard presents the greatest immediate risk, principally owing to radiotherapy capacity disruption and the resulting treatment backlog.

Recovery activity is focused on three priorities: restoring Radiotherapy treatment capacity and reducing the 31-day backlog; improving diagnostic turnaround times and first appointment access through investment in Breast, Pathology, Radiology and Endoscopy services; and reducing diagnosed backlogs within tumour sites driving 62-day non-compliance. Key milestones include the Breast capacity uplift from September 2026 and implementation of the Skin Analytics AI pathway from November 2026. Recovery remains dependent on workforce resilience, particularly within Breast Radiology, Radiology and specialist diagnostic services.

Appendix

Appendix A1 summarises the key recovery actions supporting delivery of cancer performance.

Area	Key Challenge	Recovery Action	Milestone	Expected Impact
31-Day Standard / Radiotherapy	Treatment backlog following LINAC disruption.	Restore LINAC availability and recover CT planning capacity.	LINAC restored; CT planning recovery ongoing.	Reduction in treatment backlog and recovery of 31-day performance.
Breast	Significant workforce shortages across Surgical and Breast Radiology teams have created front-end pathway	Additional capacity scheduled from September through reduced leave and Waiting List Initiative activity. Cancer	Capacity uplift from September 2026; insourcing	Reduction in first appointment waits, improved Faster Diagnosis

Area	Key Challenge	Recovery Action	Milestone	Expected Impact
	constraints, resulting in increasing waits for first appointment and deterioration in 31 and 62-day performance despite clinic utilisation exceeding 95%.	Alliance-funded insourcing programme approved and being developed. Recruitment activity continues, although Breast Radiology shortages remain a national challenge.	mobilisation underway.	performance and improved 62-day pathway delivery.
Head & Neck	Diagnostic delays and workforce shortages impacting Faster Diagnosis performance.	Insourced ENT and Head & Neck capacity introduced to reduce waiting times and clear long waits.	Recovery benefits expected during the second half of 2026/27.	Improved diagnostic timeliness and recovery of Faster Diagnosis performance.
Dermatology	Sustained seasonal referral pressures and increasing demand.	Development of an AI-supported triage pathway (Skin Analytics DERM), including an in-house photographic hub and consultant-led review process to improve referral stratification and pathway flow.	Planned implementation from November 2026.	Improved utilisation of specialist clinic capacity, reduced unnecessary face-to-face appointments and faster assessment of patients with suspected skin cancer.
Pathology	Diagnostic turnaround times impacting pathway performance.	Cancer Alliance-funded developments, workforce investment and exploration of AI-supported triage solutions.	Phased implementation of funded initiatives underway.	Faster diagnostic turnaround times and improved pathway efficiency.
Radiology	Emerging reporting workforce pressures and vacancies.	Workforce planning and escalation to mitigate risks to reporting capacity.	Recruitment and mitigation plans in progress.	Reduced risk to cancer diagnostic turnaround times.
Endoscopy	Need for sustained diagnostic capacity to support cancer performance.	Continued use of mobile units and partnership working to expand capacity.	Additional diagnostic capacity maintained throughout 2026/27.	Supports Faster Diagnosis Standard recovery.
Respiratory	Delays between diagnosis and treatment planning.	Assessment of faster molecular diagnostic testing.	Evaluation and implementation planning underway.	Faster treatment decisions and improved pathway efficiency.

Area	Key Challenge	Recovery Action	Milestone	Expected Impact
62-Day Backlog Reduction	High diagnosed backlog in Urology, Lung, Skin, Sarcoma and Gynaecology creating ongoing risk to 62-day delivery.	Targeted tumour-site recovery plans alongside diagnostic and treatment capacity improvements.	Ongoing monitoring through monthly performance reviews.	Progress towards the 80% 62-day trajectory and reduction in backlog risk.

NHS Constitution - Standards for Access to services within waiting times

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

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

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

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

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

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

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

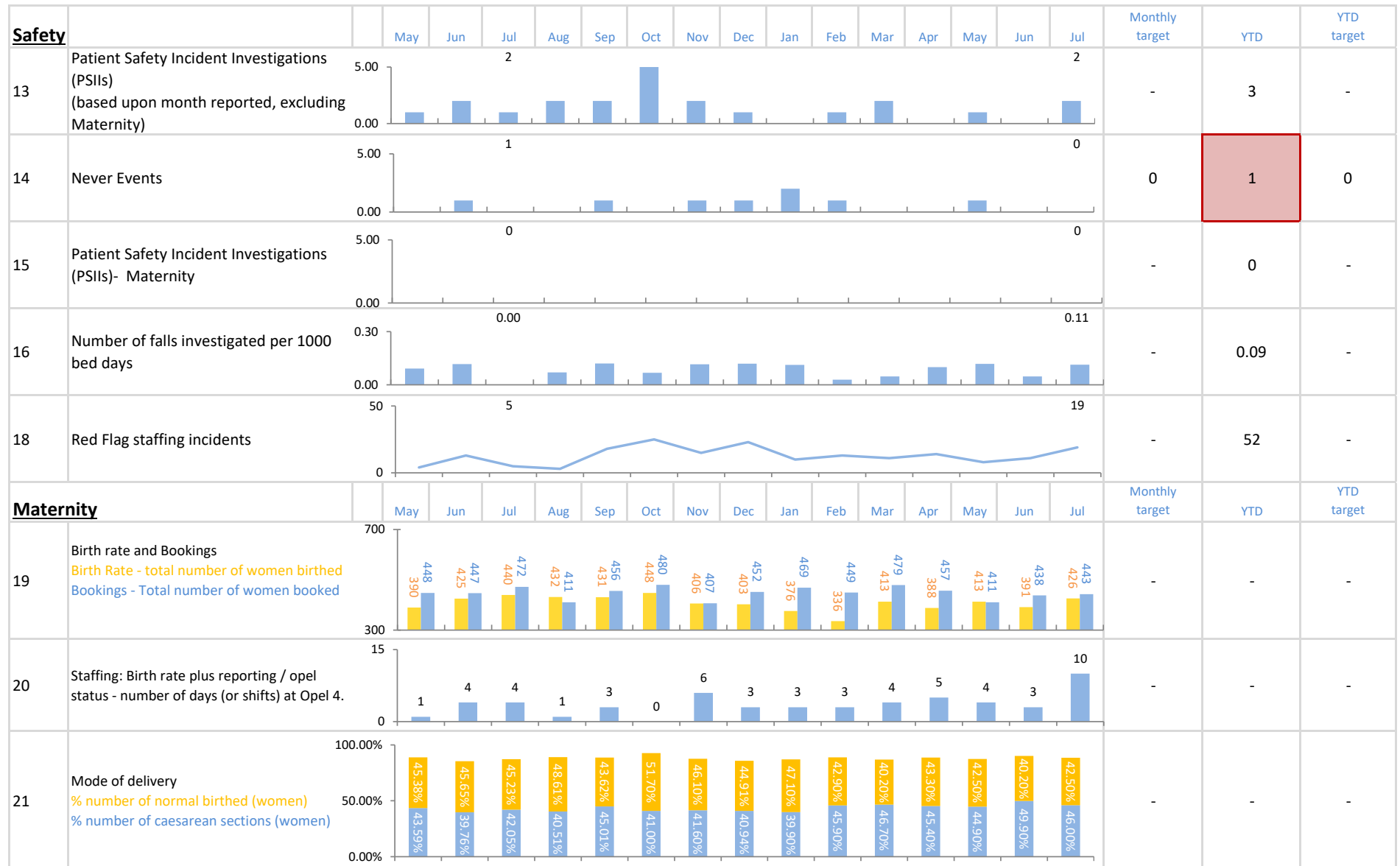
* <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

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

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	3	3	4	6	7	7	9	7	7	8	8	5	5	5	64.6%	≥64.5%	65.0%
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)	3	10	7	9	9	8	7	9	6	7	7	8	5	9	74.0%	≥75.2%	75.2%
30	Patients spending less than 4hrs in ED (All Types) UHSFT & Mapped Trusts Teaching hospital average (& rank of 20) South East average (& rank of 17)	9	10	9	2	4	9	6	3	3	2	2	4	3	3	80.7%	≥78.5%	80.7%
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	9	9	10	11	11	13	13	13	9	12	12	11	10	11	21.0%	≤18.5%	19.2%

Outcomes		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - UHS HSMR (Rolling 12 Month Figure) - SGH	91.3												98.6			≤100	99.6	≤100
2	HSMR - Crude Mortality Rate	2.3%												2.3%			<3%	2.3%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital	13.8%												12.6%			-	12.6%	-
		Q2 2025/2026		Q3 2025/2026		Q4 2025/2026		Q1 2026/2027		Q2 2026/2027		Quarterly target							
4	Cumulative Specialties with Outcome Measures Developed (Quarterly)	74	75	76	76	76	+1 Specialty per quarter												
5	Developed Outcomes RAG ratings (Quarterly)	33 90 311	34 93 309	36 107 321	35 105 327	37 109 311													
Red : below the national standard or 10% lower than the local target Amber : below the national standard or 5% lower than the local target Green : within the national standard or local target																			

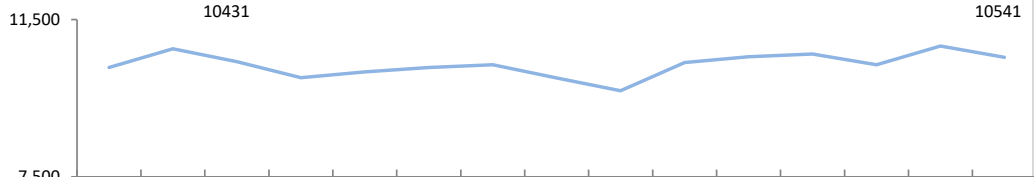
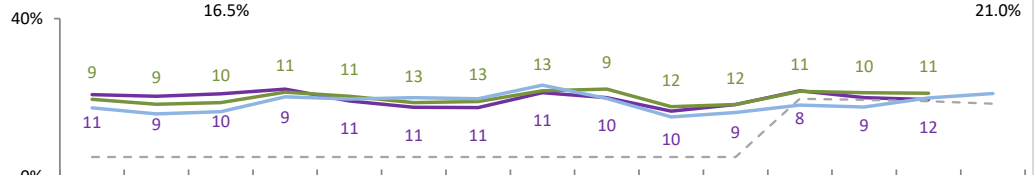
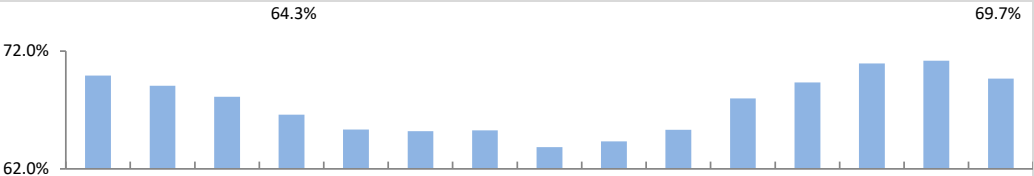
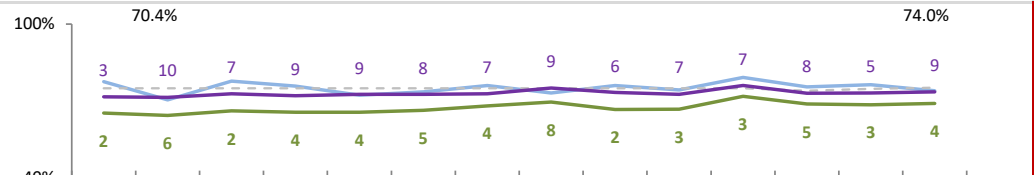
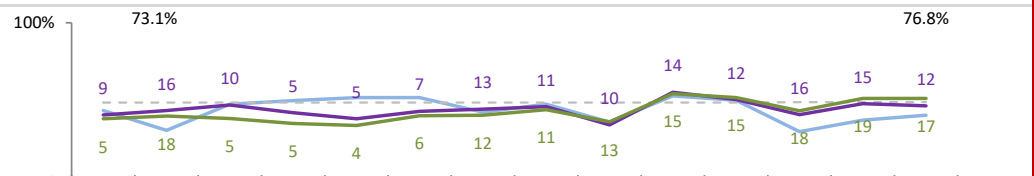
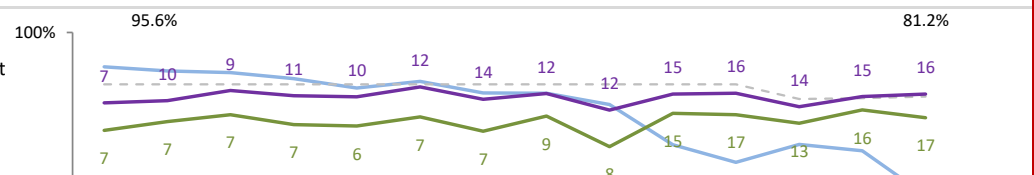
Safety		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile Most recent 12 Months vs. Previous 12 Months																≤7	31	≤28
7	MRSA bacteraemia																0	1	0
8	Gram negative bacteraemia																≤15	79	≤63
9	Pressure ulcers category 2 per 1000 bed days																<0.3	0.30	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days																<0.3	0.38	<0.3
11	Medication Errors (severe/moderate)																≤3	21	12
12	Watch & Reserve antibiotics, usage per 1,000 adms Most recent 12 months vs. Previous 12 months																<2506	2,516	<2541



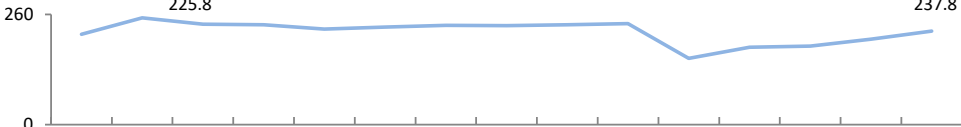
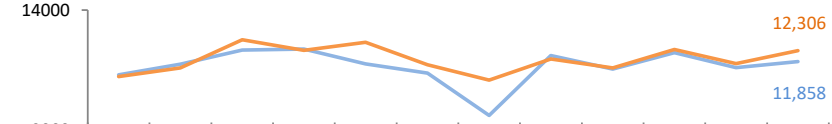
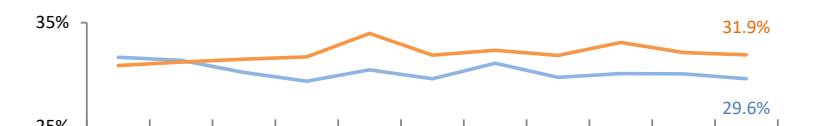
Patient Experience		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients			1.4%												1.6%	≤5%	1.2%	≤5%
23	FFT Negative Score - Maternity (postnatal ward)			2.2%												4.9%	≤5%	4.4%	≤5%
24	Total UHS women booked onto a continuity of carer pathway			14.8%												8.6%	≥35%	12.2%	≥35%
25	Total Global Majority women booked onto a continuity of carer pathway			19.3%												15.2%	≥51%	14.6%	≥51%
25 - metric renamed from "BAME" to "Global Majority"																			
26	% Patients reporting being involved in decisions about care and treatment			85.2%												88.0%	≥90%	88.0%	≥90%
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)			86.1%												87.2%	≥90%	87.3%	≥90%
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)			65												110	-	455	-
29	Number of mental health patients spending over 12 hours in A&E			48												24	-	114	-

Access Standards		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED (All Types) UHSFT & Mapped Trusts Teaching hospital average (& rank of 20) South East average (& rank of 17)																≥78.5%	80.7%	-
31	Average (Mean) time in Dept - non-admitted patients																≤04:00	03:32	≤04:00
32	Average (Mean) time in Dept - admitted patients																≤04:00	02:50	≤04:00
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year																-	95.4%	>97.9%
59	Patients who received corridor care for >45 minutes																-	-	-
60	Inpatient Length of Stay																-	-	-

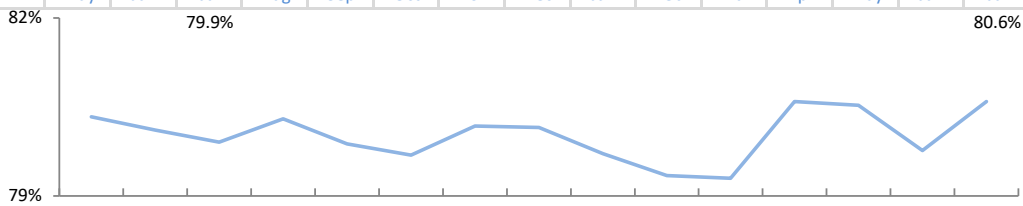
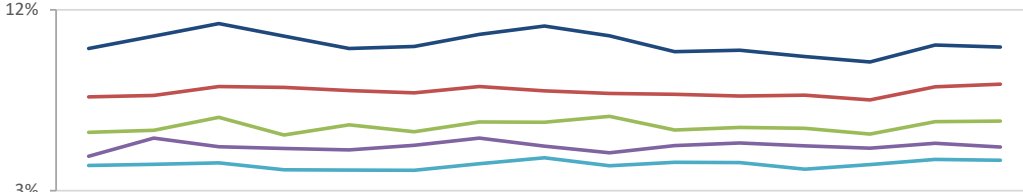
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	63.4%														64.6%	≥64.5%	65.0%	-
35	Total number of patients on a waiting list (18 week referral to treatment pathway)	63007														64407	-	64,407	-
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)	2.54%														2.46%	<1.3%	2.46%	-
37	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	1599														1585	<800	1585	-
38	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	173														222	0	222	-
39	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	12														17	0	17	-

		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
40	Patients waiting for diagnostics																-	10,541	-
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																≤18.5%	19.2%	-
42	% of patients waiting for a First OP appointment within 18 weeks																#N/A	69.7%	-
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)																≥75.2%	75.2%	-
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)																≥80.1%	75.1%	-
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)																≥92.6%	84.7%	-

R&D Performance		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
46	Recruitment performance ranking	7	7	5	5	6	7	7	10	9	8	8	10	19	18	12	Top 10	-	-
47	Performance in initiating clinical trials	53%	39%	67%	87%	55%	55%	67%	54%	57%	62%	38%	67%	56%	61%	50%	≥90%	-	-
48	Performance in delivering clinical trials	23%	35%	21%	21%	23%	21%	24%	27%	27%	44%	47%	44%	80%	33%	25%	≥90%	-	-
49	Proportion of sponsored studies open/on track	82%	84%	87%	87%	87%	88%	90%	88%	87%	87%	85%	84%	82%	84%	87%	80-90%	-	-

Local Integration		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																-	-	-
51	Emergency Department activity - type 1 This year vs. last year																-	0	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.9%	≥25%
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month																			

Digital		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target																																
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	<table border="1"><caption>My Medical Record - UHS patient accounts (cumulative)</caption><thead><tr><th>Month</th><th>Accounts</th></tr></thead><tbody><tr><td>May</td><td>253,862</td></tr><tr><td>Jun</td><td>265,000</td></tr><tr><td>Jul</td><td>275,000</td></tr><tr><td>Aug</td><td>285,000</td></tr><tr><td>Sep</td><td>290,000</td></tr><tr><td>Oct</td><td>295,000</td></tr><tr><td>Nov</td><td>298,000</td></tr><tr><td>Dec</td><td>299,000</td></tr><tr><td>Jan</td><td>300,000</td></tr><tr><td>Feb</td><td>301,000</td></tr><tr><td>Mar</td><td>302,000</td></tr><tr><td>Apr</td><td>303,000</td></tr><tr><td>May</td><td>304,000</td></tr><tr><td>Jun</td><td>305,000</td></tr><tr><td>Jul</td><td>298,653</td></tr></tbody></table>															Month	Accounts	May	253,862	Jun	265,000	Jul	275,000	Aug	285,000	Sep	290,000	Oct	295,000	Nov	298,000	Dec	299,000	Jan	300,000	Feb	301,000	Mar	302,000	Apr	303,000	May	304,000	Jun	305,000	Jul	298,653	-	298,653	-
Month	Accounts																																																		
May	253,862																																																		
Jun	265,000																																																		
Jul	275,000																																																		
Aug	285,000																																																		
Sep	290,000																																																		
Oct	295,000																																																		
Nov	298,000																																																		
Dec	299,000																																																		
Jan	300,000																																																		
Feb	301,000																																																		
Mar	302,000																																																		
Apr	303,000																																																		
May	304,000																																																		
Jun	305,000																																																		
Jul	298,653																																																		
54	My Medical Record - UHS patient logins (number of logins made within each month)	<table border="1"><caption>My Medical Record - UHS patient logins (monthly)</caption><thead><tr><th>Month</th><th>Logins</th></tr></thead><tbody><tr><td>May</td><td>38,000</td></tr><tr><td>Jun</td><td>37,000</td></tr><tr><td>Jul</td><td>38,000</td></tr><tr><td>Aug</td><td>37,000</td></tr><tr><td>Sep</td><td>37,500</td></tr><tr><td>Oct</td><td>38,000</td></tr><tr><td>Nov</td><td>36,000</td></tr><tr><td>Dec</td><td>37,000</td></tr><tr><td>Jan</td><td>37,500</td></tr><tr><td>Feb</td><td>37,000</td></tr><tr><td>Mar</td><td>38,000</td></tr><tr><td>Apr</td><td>36,000</td></tr><tr><td>May</td><td>36,000</td></tr><tr><td>Jun</td><td>37,000</td></tr><tr><td>Jul</td><td>36,597</td></tr></tbody></table>															Month	Logins	May	38,000	Jun	37,000	Jul	38,000	Aug	37,000	Sep	37,500	Oct	38,000	Nov	36,000	Dec	37,000	Jan	37,500	Feb	37,000	Mar	38,000	Apr	36,000	May	36,000	Jun	37,000	Jul	36,597	-	142,280	-
Month	Logins																																																		
May	38,000																																																		
Jun	37,000																																																		
Jul	38,000																																																		
Aug	37,000																																																		
Sep	37,500																																																		
Oct	38,000																																																		
Nov	36,000																																																		
Dec	37,000																																																		
Jan	37,500																																																		
Feb	37,000																																																		
Mar	38,000																																																		
Apr	36,000																																																		
May	36,000																																																		
Jun	37,000																																																		
Jul	36,597																																																		
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	<table border="1"><caption>Distribution of computers per age in years</caption><thead><tr><th>Age (years)</th><th>Count</th></tr></thead><tbody><tr><td>14</td><td>0</td></tr><tr><td>13</td><td>0</td></tr><tr><td>12</td><td>0</td></tr><tr><td>11</td><td>0</td></tr><tr><td>10</td><td>100</td></tr><tr><td>9</td><td>100</td></tr><tr><td>8</td><td>300</td></tr><tr><td>7</td><td>1800</td></tr><tr><td>6</td><td>2800</td></tr><tr><td>5</td><td>1800</td></tr><tr><td>4</td><td>2200</td></tr><tr><td>3</td><td>300</td></tr><tr><td>2</td><td>2800</td></tr><tr><td>1</td><td>0</td></tr></tbody></table>															Age (years)	Count	14	0	13	0	12	0	11	0	10	100	9	100	8	300	7	1800	6	2800	5	1800	4	2200	3	300	2	2800	1	0	-	-	-		
Age (years)	Count																																																		
14	0																																																		
13	0																																																		
12	0																																																		
11	0																																																		
10	100																																																		
9	100																																																		
8	300																																																		
7	1800																																																		
6	2800																																																		
5	1800																																																		
4	2200																																																		
3	300																																																		
2	2800																																																		
1	0																																																		
56	CHARTS system average load times - % pages loaded <= 3s	<table border="1"><caption>CHARTS system average load times - % pages loaded <= 3s</caption><thead><tr><th>Month</th><th>% loaded <= 3s</th></tr></thead><tbody><tr><td>May</td><td>99.3%</td></tr><tr><td>Jun</td><td>99.3%</td></tr><tr><td>Jul</td><td>99.3%</td></tr><tr><td>Aug</td><td>99.3%</td></tr><tr><td>Sep</td><td>99.3%</td></tr><tr><td>Oct</td><td>99.3%</td></tr><tr><td>Nov</td><td>99.3%</td></tr><tr><td>Dec</td><td>99.3%</td></tr><tr><td>Jan</td><td>99.2%</td></tr><tr><td>Feb</td><td>99.2%</td></tr><tr><td>Mar</td><td>99.3%</td></tr><tr><td>Apr</td><td>99.3%</td></tr><tr><td>May</td><td>99.3%</td></tr><tr><td>Jun</td><td>99.3%</td></tr><tr><td>Jul</td><td>99.3%</td></tr></tbody></table>															Month	% loaded <= 3s	May	99.3%	Jun	99.3%	Jul	99.3%	Aug	99.3%	Sep	99.3%	Oct	99.3%	Nov	99.3%	Dec	99.3%	Jan	99.2%	Feb	99.2%	Mar	99.3%	Apr	99.3%	May	99.3%	Jun	99.3%	Jul	99.3%			
Month	% loaded <= 3s																																																		
May	99.3%																																																		
Jun	99.3%																																																		
Jul	99.3%																																																		
Aug	99.3%																																																		
Sep	99.3%																																																		
Oct	99.3%																																																		
Nov	99.3%																																																		
Dec	99.3%																																																		
Jan	99.2%																																																		
Feb	99.2%																																																		
Mar	99.3%																																																		
Apr	99.3%																																																		
May	99.3%																																																		
Jun	99.3%																																																		
Jul	99.3%																																																		

Health Inequality		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Monthly target	YTD	YTD target
61	Ethnicity data capture completeness	 79.9% 80.6%															-	-	-
62	Outpatient DNA rate by IMD quintiles Quintile 1 (most deprived) Quintile 2 Quintile 3 Quintile 4 Quintile 5																-	-	-
63	Referrals to smoking cessation services on a supported pathway	 35.4% 51.6%															-	-	-

Agenda Item 5.6 Report to the Trust Board of Directors, 10 September 2026			
Title:	Operational Plan 2026-27 and Board Assurance Statement		
Sponsor:	Andy Hyett, Chief Operating Officer		
Author:	Duncan Linning-Karp, Deputy Chief Operating Officer		
Purpose			
(Re)Assurance	Approval	Ratification	Information
	x		
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			
Executive Summary:			
This paper presents the Trust’s annual operating plan to the Board for approval. The plan provides a summary of more detailed plans and policies, covering a range of operational themes from infection prevention to predicted capacity and demand. The plan shows that, including the demand management schemes led by the ICB, there is still likely to be a gap between predicted demand and capacity. The aim is to mitigate this gap through a further reduction in length of stay and patients not meeting the criteria to reside. Should this not prove successful there is a risk that the Trust will need to run at an occupancy level of above 95% and / or cancel some elective surgery. The plan outlines the Trust’s response to Operational Pressures Escalation Levels (OPEL), the system’s transformation schemes, infection prevention and control and a summary of plans for key areas of the hospital.			
Contents:			
This paper contains: 1. The Trust’s Operating Plan for 2026-27 2. A Board Assurance Statement.			
Risk(s):			
- Risk of overcrowding in the Emergency Department, and therefore a risk to patient safety and experience - Risk of cancelling elective surgery because of non-elective pressures, and therefore a risk to patient safety and experience - Risk of failing to deliver the Trust’s 2026-27plan for either (or both) performance and finance			
Equality Impact Consideration:		Attached	

UHS Operating Plan

**October 2026 - September
2027**

Contents

Chapter 1 Introduction and Scope.....	3
Introduction.....	3
Aims of the Operating Plan.....	3
Predicted Demand and Bed Proposal.....	4
Chapter 2 Planned Response.....	6
Infection Prevention & Control (IPC).....	6
Staff vaccination (COVID-19 and Influenza).....	7
Emergency Department.....	7
Ambulance Handover.....	8
Mental Health.....	8
Southampton Children's Hospital.....	9
Princess Anne Hospital (PAH).....	11
Level 1 Beds.....	11
Level 2 and 3 Beds.....	11
Surgery & Operating Theatres.....	12
Cancer.....	12
Mortuary Capacity.....	13
Nursing Staffing.....	13
Staff Support and Health & Wellbeing Plans.....	14
Personal Protective Equipment (PPE).....	14
Discharge.....	15
Inclement Weather.....	15
Partner Schemes.....	18
Communications.....	19
Digital.....	20
Chapter 3 Operating Frameworks and Industrial Action.....	22
Operating Frameworks and Escalation.....	22
Industrial Action.....	29
Data Driven Insights / Business Intelligence.....	34
Change Programmes.....	34
Chapter 4 Conclusion.....	36

Chapter 1 Introduction and Scope

Introduction

The Trust wide Operating Plan is intended to provide a summary of plans from October 2026 to September 2027. It is intended as a summary document and should sit alongside key policies including (but not limited to) infection prevention & control policies, the Pandemic Plan, Hot and Cold Weather Plans and the Major Incident Plan. It is also important to note that many of the issues in the hospital require dynamic management and the plan is subject to flux depending on the situation and competing priorities. The last few years have seen significant uncertainty with infectious diseases, industrial action and elective recovery. As in previous years, there are likely to be significant waves of infection associated with viruses, such as Norovirus, influenza/RSV, particularly over the winter. Other risks include potentially ongoing industrial action, including from the consultants who now have a mandate to strike, as well as more traditional concerns about the level of patients not meeting the criteria to reside, mental health patients, the need for financial improvement and ongoing rising demand. The organisation still faces significant disruption from the fire, some of which will continue over the next year.

This plan is also intended as the Trust's winter plan. Winter should be recognised as a period of increased pressure due to the increased clinical acuity of many patients combined with increased demand on services. In addition, the winter period often brings with it untoward events such as widespread infectious diseases including influenza and Norovirus.

Seasonal vaccination programme for NHS staff has yet to be confirmed. However, based on last year we are likely to offer staff the influenza vaccine, but the Covid-19 vaccine will not be offered as routine. Influenza vaccine reduces transmission of the virus and uptake will be strongly encouraged after reduced uptake, presumed to be vaccine fatigue, over recent years. Support from matrons and clinical leaders will be required to support inpatient vaccination due to the need for vaccine specific prescribing and nursing competencies. Patients with a length of stay over 21 days will also be offered the vaccine.

Significant work has taken place with Hampshire and the Isle of Wight Healthcare, including a joint investment to reduce hospital admissions. This is covered further in the plan.

Aims of the Operating Plan

UHS's Operating Plan prepares the organisation for 2026/27 with support from the Health and Care Community locally to:

- Manage available capacity to meet demand
- Achieve the targets laid out in the national operating plan, including 82% emergency access performance in March 2027, a maximum of 0 of patients waiting over 52 weeks, 78% RTT and the suite of cancer standards
- Reduce both the number of patients not meeting the criteria to reside and the number of patients who are waiting a mental health admission who remain in an acute bed
- Support the Trust's financial recovery

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

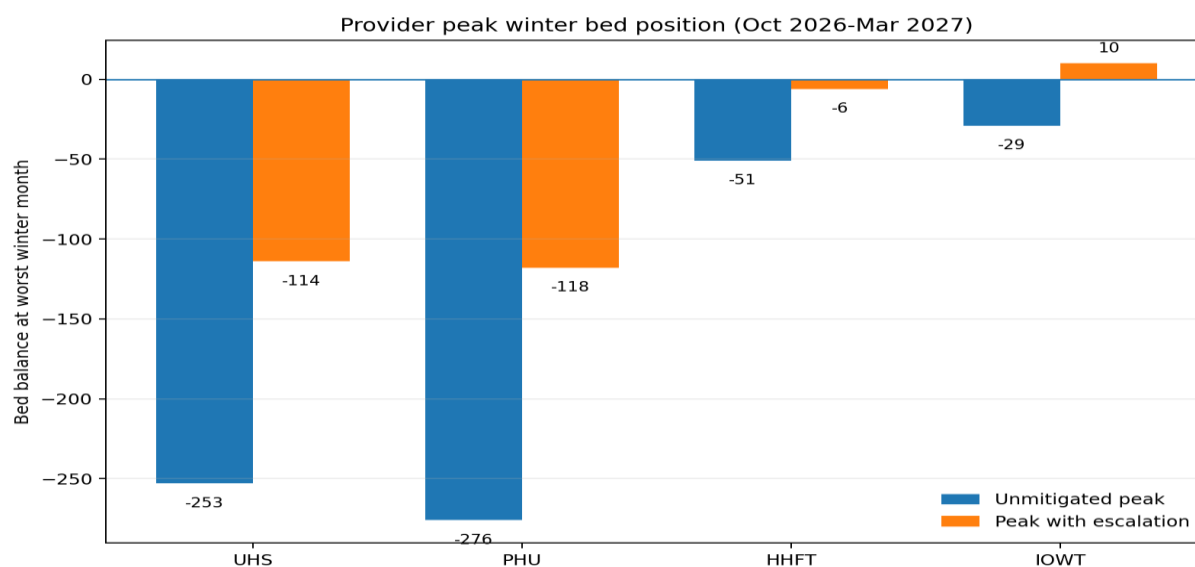
- Opening an Urgent Treatment Centre in November 2026
- The reduction of length of stay and the adoption of best practice through a renewed focus on improvements in internal process, via the UEC Transformation Programme

- The reduction and avoidance of admissions through partnership working, including joint investment with Hampshire and the Isle of Wight Healthcare and Hampshire and the Isle of Wight ICB
- Ensuring all bedded capacity remains *available*, although it may at times be unstaffed if it is not needed
- Closing all surge capacity where possible and maintaining closed wards in line with the year's financial and operational plans
- Continue to treat elective patients based on clinical priority, while also focusing on driving down waiting times
- Continuing to maintain and improve cancer waiting times
- Continuing to maintain and improve diagnostic waiting times
- Achieving 82% emergency access performance at a local system level by March 2027
- Continue to work with system partners to reduce the number of patients not meeting the criteria to reside who remain in hospital, leading the local system's revised and renewed discharge plan, including a robust plan to take the Nexus diagnostic work forwards
- Effective management and control of all infections including norovirus, COVID and influenza

Predicted Demand and Bed Proposal

2025/26 was very much a year of two parts. Until February the Trust saw consistently high occupancy, although the level of elective cancellations remained minimal. The fire and major incident in February 2026 dramatically changed things, leading to swathes of elective cancellations in the immediate aftermath, and a forced reconfiguration of the hospital. For 3 months UHS ran with 150 fewer beds, and 100 fewer patients not meeting the criteria to reside. However, this number has since returned to the *status quo ante* as the additional capacity put in post fire has been unwound. Despite this, we have maintained circa 90 beds closed, and one of the challenges will be to continue this throughout 2026/27.

GIRFT modelling suggests a gap of 114 beds in the worst week in January:



This gap would need to be managed by:

- Increasing occupancy (the modelling assumes 92% whereas in reality the Trust runs significantly higher). Running at 98% creates an extra 60 beds.
- Reducing admissions, length of stay and n-ctr
- Opening additional surge capacity (surge capacity outlined below)

- As a last resort cancelling elective surgery

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

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

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

- A need to protect our workforce
- Recognition from all that plans are fluid and will need to adapt as the situation develops. As an example, depending on the timing and size of non-elective demand we will need to review elective operating
- Recognition from all that all capacity is the Trust's. There needs to be a shift away from divisional or speciality 'ownership' of wards
- A starting principle that those who usually staff beds (nursing and junior doctor) will continue to do so even if other specialities' patients are in them. Clearly this may need to be flexed depending on skill set
- A need to keep beds closed to support financial recovery

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

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

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

Escalation beds.

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

Phase 1

Location	Hosting	Pt Group	Beds
SDU	Surgery	Low acuity surgical	26
AMU4	EM	Medical Flow	8
Cath lab day unit	CV&T	Low acuity / next day discharge	9
Neuro day unit	Neuro	Low acuity / next day discharge	3
C3	EM	Medical Flow	10
F7	Medicine	Medical Flow	20
			76

Chapter 2 Planned Response

Infection Prevention & Control (IPC)

The ability of infection to disrupt our capability to treat patients remains ever present, impacting our patients, staff and services. Focus on reducing the risk of transmission of infection and risk of outbreaks occurring remains a key priority for the organisation over the next year. Actions to support effective prevention, management and control of infections will continue to be maintained and integrated as standard measures and practices and will be subject to ongoing review.

Expected increases in winter viruses, such as Norovirus, influenza/RSV, along with a potential increase in other infections such as COVID-19, is likely to place additional pressure on the organisation this winter. An increase in patients presenting with winter viral illnesses, combined with in-patients developing infection, in-hospital transmission of infection and subsequent outbreaks is likely to result in an increased demand for single room isolation and bay/ ward closures.

Early identification, testing and robust management of patients with symptoms of infection or at high risk of infection will be key in reducing the risk of transmission and outbreaks occurring within our hospitals. Relevant infection specific IPC policies (e.g. respiratory virus, unexpected/unexplained diarrhea & vomiting policy) will be followed and the Trust outbreak of infection policy invoked where required to support management and control of outbreaks of infection.

Specific actions to support effective prevention, management and control of infection include:

- Use of local and national prevalence/incidence data and UHS surveillance data to facilitate early warnings of increased rates of infection in the local community, regionally, nationally and our own hospitals (enabling us to identify both outbreaks and clusters of infection amongst patients and staff).
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow for early recognition of patients with symptoms of infection or at high risk of infection.
- Use of rapid in-lab testing to test patients with symptoms suggestive of respiratory virus (October – April) or viral gastroenteritis (all year) to facilitate early identification and placement of positive cases.
- Isolation or cohorting of symptomatic patients who have a positive respiratory virus test (COVID-19 and influenza) or Norovirus and quarantine of patient contacts where required (Norovirus).
- Education, training and awareness activities, including incorporating IPC measures/messaging as part of a winter awareness campaign.
- Communications to staff regarding levels of infection, expected IP&C practices, situational updates.
- Proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Monitoring and focus on infection prevention and control practices in clinical areas.
- Active deployment of portable air-purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks.

Staff vaccination (Influenza)

Influenza vaccines are assumed to be offered to health and social care workers as part of an Autumn campaign. The Trust will offer the vaccine to all eligible staff, and encourage uptake, using a multicomponent approach in line with NICE guidance on increasing vaccination uptake. Currently we are waiting for details of the Autumn campaign

The government has accepted the advice of the JCVI to exclude frontline healthcare workers from the COVID-19 vaccination campaign in the autumn 2025 vaccination campaign, and we presume the same will be true for 2026.

Emergency Department

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

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

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

To support with the challenges identified above a number of new initiatives have started in 2025/26 and continued in 2026/27 to deliver better flow in and out of ED for both patients who require to be admitted but also those who can be turned around by the ED.

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

1. Continuing the ongoing work related to use of Same Day Emergency Care (SDEC) capacity and expand current pathways to increase patient numbers and improve flow.
2. Focus on the Inpatient Flow Programme and reducing length of stay across the Trust, to support flow from the Emergency Department.
3. Continue to embed the professional standards across the Trust as part of the "Who Goes Where" document
4. Use of external capacity to further avoid admission or reduced length of stay such as UHS @ Home service and virtual ward capacity.

5. Continue to implement new pathways across the Trust as an alternative to a long wait in the Emergency Department.
6. Further implement the Transformation workstreams as part of the Trust UEC Strategy led by the Clinical Director for UEC
7. Development of the co-located Urgent Treatment Centre which is due to be handed over late in Q3. This will support with re-direction of minor illness and injuries allowing the ED inside the hospital to re-focus on the patients who need emergency treatment.

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

ED Plan during surge

The plans for winter are described above; however, ED has plans should there be further waves in which the department could see a significant surge in patients. If required AMU will increase its bed capacity from 54 beds to a total of 62 by using the 'surge' area (10 beds - called AMU 5 in C3) within the ED which can be used either as an overflow for inpatient beds for a particular specialty. The use of these escalation beds comes with inevitable impact/risk on other parts of the service. When this space is not used for "inpatients" the function is used as an Acute Ambulatory Assessment Unit (AAU) to support flow out of ED for potential medical admissions.

Ambulance Handover

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

The Trust will continue to implement 'release to respond', staffing cohorts with UHS nurses, to release ambulances and crews. However, this does have a significant impact on staffing across the organization, as well as a cost.

Mental Health

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

- NHS 111 mental health Triage service to ensure appropriate mental health care away from ED (evidence of a 97% reduction in ED endpoints).
- SCAS/ Police seek NHS 111 support in decision making to avoid conveyance to ED.
- Mental Health response car providing emergency mental health care in the community.
- Community Psychiatric Liaison within 1hr Triage for all mental health ED attendances.
- Trusted assessment with liaison team being able to refer directly to home treatment services and informal admission without a second on site assessment.
- Adult / older adult Liaison Psychiatry emergency response to wards within 1 hour.
- Children and young people with self-harm presentations diverted from the standard overnight stay pathway to an assessment at home or a mental health base.

- ED Triage nurses can refer directly to adult /older adult liaison psychiatry prior to ED clinician review.
- Escalation process for children and young people remains in place
- Those with both a physical and mental health need will move upstream to AMU for on-going care.
- Reduced risk ligature room in AMU Enhanced Care Suite (ECA) to offer safer space for patients with high-risk mental health needs who need transfer to a s136 suite or in-patient mental health care. Patients should only come to UHS where a physical health need requires side by side treatment. A safe space is required to support those patients' mental health as well as physical health needs.
- Implementing the ICS wide escalation protocol for patients delayed while waiting for an admission to a mental health unit.

On-going planning.

- HIOW Community FT has provided assurance that the four s136 suites available is sufficient capacity for the needs of Hampshire. This will remain under constant review.
- HIOW Community FT Bed Escalation Policy for adult and older adults has in place with the aim of supporting more efficient flow.
- Monthly partnership meetings are now being held between HIOW Community FT and UHS to ensure the psychiatry provision is fit for purpose where KPIs are reviewed to support in this.
- Continued recruitment of the ICS approved additional investment to support increasing the HIOW Community FT compliance against CORE24 serving UHS although this is consequently under review due to the financial pressures.
- More work is required to improve escalation and bed flow to reduce the length of stay of this patient cohort.
- Ongoing discussions linked to the national strategy of creating specific Mental Health EDs to support individuals who present to ED in some form of mental health crisis with no physical health needs. UHS has been supported to the next stage (a business case) in its bid for a Mental Health ED, and planning will continue through 2026/27.

Southampton Children's Hospital

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

Emergency Pathways.

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

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

Surge capacity

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

Other aspects we would also be considering, in extremis are

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

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

Elective Work.

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

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

Paediatric Critical Care

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

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

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

Other Inpatient Areas.

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

RSV

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

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

Princess Anne Hospital (PAH)

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

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

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

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

Level 1 Beds

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

Level 2 and 3 Beds

The Trust has the following level 2 and 3 adult beds:

GICU 31 beds
Neuro ICU 13 beds
CICU 16 beds
SHDU 10 beds
RHCU 9 beds
CHDU 20 beds

TOTAL 99 beds

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

Surgery & Operating Theatres

The Trust is currently reviewing surgical capacity for the rest of the year, to try to balance both meeting our performance objectives and ongoing financial challenges. At the time of writing, it is not known how many additional sessions are planned for the rest of the year. Due to fire impacts two theatres (V&W) and a recovery area have been dedicated for Endoscopy use, reducing available theatre capacity on the SGH site.

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

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

Cancer

As in previous years, there will be a significant focus on cancer waiting times, and cancer patients are likely to be prioritised for elective surgery based on their clinical priority. The three-fold focus in 2026-27 will be ensuring the Trust achieves the 28-day Faster Diagnosis Standard and that the Trust improves upon and achieves the 31-day radiology and 62-day cancer targets.

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

Specialist Transfers & Major Trauma

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

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

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

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

Diagnostics

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

Mortuary Capacity

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

Nursing Staffing

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

The hub also coordinates cover for additional needs arising from the Release to Respond (R2R) agreement, ensuring there are designated nursing staff identified to support the emergency department when R2R is actioned.

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

Nurse staffing levels, oversight and review are robustly managed using the framework from the national quality board and implementation of the recommendations within NICE guidelines on safe staffing. This is reflected in the UHS Nursing Safe Staffing Policy (2025).

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

Clear and over-arching expectations are in place:

- Nursing professionals become flexible with what they do and adhere to The NMC Code - working within their scope of practice.
- Quality Impact assessments will be undertaken to support any changes in ward/department specialty and function and to underpin any adjustments to set staffing establishment levels
- Thresholds for training, competency attainment, assessment and supervision will be reviewed and adapted to move to a greater emphasis on local induction, on the job supervision and self-certification
- Registration options will be expedited to enable 'top of licence' working and increased contribution and capability of nursing trainees, nursing associates and overseas nurses (in line with national guidance).

- Ward staffing levels will be constantly reviewed and monitored with levels linked to minimum Care Hours per Patient Day and agreed staffing levels will be monitored as patient specialty, acuity, dependency, and care needs change.
- During periods of extremis, redeployment of staff will be facilitated to support areas of greatest need.
- All staff with pre-existing nursing skills will be provided with continued up-skilling opportunities either face to face or via online materials with guidance on the required level to return to practice.
- Non-ward-based staff across all services will be considered for re-assignment to ward areas based on a RAG rating linked to impact on existing service. Redeployment will occur at agreed escalation points and risk assessment will be noted for the impact on existing service.
- Health roster will be utilised to the maximum (supported by workforce systems) to enable the management and deployment of nursing staff.
- 'Red flags' raised via the 'safecare' system will be actively used in the staffing hub to capture pressures on care at ward level.

Staff Support and Health & Wellbeing Plans

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

Key elements include:

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

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

Personal Protective Equipment (PPE)

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

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

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

Discharge

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

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

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

Southampton and South West Hampshire system in conjunction with the ICB commissioned a diagnostic with Nexus consulting that reported in August 2026. Key recommendations were:

A 38-87 BED REDUCTION OPPORTUNITY IN UHS IS ACHIEVABLE IF ALL PROGRAMMES ACHIEVE THEIR STRETCH TARGETS

RECOMMENDATIONS

1. **Build operational clarity, consistency, and control** through a structured change programme, involving all system partners
2. **Invest in community services and relationships**, specifically in equipment services for Hampshire residents and maintenance of the Southampton bridging capacity
3. **Redesign the digital environment** to support flow, and reinforce behavioural changes

Opportunity	Summary	Indicative savings*
1. Operational grip	Review and restructure of ops control processes, supported by common language, definitions and a single source of truth	£1.5m–£3.5m
2. OCR redesign and training	Rapid process and digital development of the OCR	£0.5m–£0.7m**
3. Hampshire equipment investment	Short-term funding and/or expanded UHS peripheral stores until the new provider starts	Likely breakeven
4. Protect Southampton bridging	Increased bridging capacity due to end in September, needs ongoing commissioning	~£1.7m risk avoided
5. Future-state process and digital flow	Co-design of future pathways across clinical, ops and digital to create an evidenced develop-vs-replace decision	/
Total (excl. SCC bridging)		£2.0m–£4.2m

* We've taken a conservative approach to estimating opportunity, aiming at targets of 10-20% and costing the opportunity on realistic cash out values (£200 per day, instead of the £400 reference cost).

** The low targets cover risk of double counting opportunities

At the time of writing the local system was agreeing how to progress these. However, they will form a key basis of the discharge plan for 2026/27, supporting the aim to reduce patients not meeting the criteria to reside.

Inclement Weather

UHS maintains a Trust-wide Adverse Weather Plan (EPRR008) covering both hot and cold weather. The plan aligns the Trust response to UKHSA Weather-Health Alerts and provides a single framework for escalating action through yellow, amber and red alert levels. It applies across clinical services, Estates and Facilities, workforce, communications, logistics and operational command. The hot weather plan was refined after the heatwave in June 2026.

The plan sets out the alert cascade from EPRR through divisional and Care Group leadership to wards and departments. Level-specific action cards are available through StaffNet and translate national alerts into practical action at service level. These include measures to protect vulnerable patients, support staff welfare, maintain safe staffing, reduce avoidable infrastructure failure and sustain critical services.

Heat preparedness and operational controls

The Hot Weather Hub sets out how staff should respond where internal temperatures become uncomfortable or unsafe.

Where fixed air conditioning or ventilation is installed, faults or poor performance should be reported through the Maintenance Helpdesk or Planon. Where no fixed cooling is available, teams are expected to follow the local guidance on ventilation, fans and temporary cooling. Where Estates has no further intervention available, local temperatures should be recorded for risk-monitoring purposes and escalated through the relevant divisional route.

Temporary air-conditioning units are limited by the electrical capacity of the UHS estate and are allocated according to clinical and operational need by Site Operations, working with service leads. They are permitted only in clinical and critical-process areas. Staff must not bring in or independently purchase temporary air-conditioning units because of electrical and patient-safety risks.

The use of fans is governed by clear infection prevention and electrical-safety requirements. Fans must:

- be capable of being opened and cleaned;
- be cleaned at least weekly and between patients;
- have a current PAT test; and
- not be used where they could increase infection or contamination risk.

Fans must not be used during infectious outbreaks, during procedures with a risk of body-fluid splash, or during aseptic procedures. Bladeless or enclosed fans that cannot be cleaned internally are not permitted.

Local environmental controls include:

- keeping curtains and blinds closed during the day to reduce solar gain;
- keeping windows closed while the outside temperature is higher than the inside temperature;
- opening windows once the outside temperature falls below the internal temperature;
- turning radiators off or down;
- reporting failures of refrigeration or air conditioning promptly; and
- switching off unnecessary lights and electrical equipment.

Patient care during hot weather

Clinical teams are expected to take practical steps to keep patients comfortable and monitor for heat-related illness.

During hot weather, UHS works with Serco to support regular water rounds. Staff are asked to check and refill water jugs frequently. Water bottles are available for patients being discharged using patient transport.

Ice lollies and ice are available through the B-level kitchen using the agreed requisition process and collection times. These arrangements provide wards with a practical way to support hydration and comfort during prolonged periods of heat.

Staff are expected to monitor patients for signs of heat exhaustion or heatstroke and to take appropriate clinical action where concerns arise. Particular attention is required for frail patients, those with multiple comorbidities, people who cannot regulate their own environment, and patients whose treatment or medication may increase their vulnerability to heat.

Staff welfare

The Hot Weather Hub also provides guidance for staff working in clinical and non-clinical areas.

During hot weather, staff may wear smart, plain, knee-length shorts where these remain consistent with health and safety requirements and the Trust uniform policy. Clinical colleagues may wear their own scrubs where these are suitable, clean and maintained to the required infection prevention standard. Hired scrubs must not be used for this purpose.

Staff are encouraged to:

- drink water regularly rather than waiting until they feel thirsty;
- take breaks in cooler areas where operationally possible;
- wear loose, lightweight and breathable clothing; and
- raise concerns where the working environment may be affecting health, safety or service delivery.

The Trust's adverse-weather absence guidance remains clear that staff are expected to make every reasonable effort to attend work where it is safe and practical. Where travel disruption prevents attendance, employees must contact their manager promptly and agree the most appropriate arrangement.

Learning from the 2026 heat incident

The Trust's arrangements were tested extensively during the severe heat period in June and July 2026, when UHS declared a Critical Incident following significant operational and infrastructure impact. The incident affected urgent and emergency care, theatres, diagnostics, critical care, digital infrastructure, mortuary capacity, staff welfare and patient flow.

The incident confirmed that heat risk at UHS extends well beyond patient comfort. High temperatures can affect the availability of theatres, imaging equipment, network infrastructure, ward environments, medicines, refrigeration and staff capacity. Heat can therefore become a Trust-wide business continuity and patient-safety issue.

Following the incident, UHS strengthened its operational response through:

- a defined trigger and escalation approach linked to Heat-Health Alert levels and observed local impact;
- once-daily incident coordination meetings during significant amber and red alerts, with the ability to increase frequency;
- a live RAID process covering clinical, operational, workforce, digital, estates and system risks;
- clearer escalation routes through Site Operations and the Trust command structure;
- improved monitoring of heat-sensitive infrastructure;
- targeted review of vulnerable patients and high-risk clinical areas;

- strengthened staff-welfare arrangements; and
- earlier engagement with system partners where heat affects transport, discharge, mutual aid or capacity.

Cold-weather preparedness

Cold-weather readiness is delivered through a green, yellow, amber and red escalation model. The plan includes early action by Estates and Facilities, clinical services and operational teams before conditions cause service disruption.

Key measures include:

- proactive gritting, boiler checks and review of heating resilience;
- identification of vulnerable buildings, access routes and external areas;
- workforce travel contingencies and staffing contact arrangements;
- consideration of Local Resilience Forum support where normal transport arrangements are disrupted;
- safe discharge planning, including confirmation that vulnerable patients have heating, food, medication and appropriate follow-up;
- preparation for increased respiratory demand, falls and frailty-related admissions; and
- escalation of emergency and urgent care capacity through established operational-pressure arrangements.

Command, assurance and next steps

Weather alerts alone do not determine the UHS response. Escalation is based on the combined effect of the alert, local conditions, current operational pressure, infrastructure performance and actual or anticipated patient-safety impact.

Where disruption remains contained and can be managed through local workarounds, business continuity arrangements will be used. Where the Trust is losing the ability to maintain critical services safely, or requires significant system support and executive direction, escalation to a Critical Incident or Major Incident will be considered under the Trust Incident Response Plan.

The 2026-27 priorities are to:

- complete the formal review of EPRR008 using the findings from the 2026 heat incident;
- embed the Immediate Heat Action Plan into the wider adverse-weather framework;
- maintain and refresh the Winter Well and Hot Weather Hub content;
- confirm divisional and Care Group ownership of seasonal preparedness actions;
- strengthen reporting of heat-sensitive estate and equipment risks;
- improve assurance that actions at each alert level have been completed;
- exercise both cold-weather and heat-response arrangements; and
- ensure lessons are reflected in business continuity plans, capital priorities and operational escalation arrangements.

Partner Schemes

Immediately post the fire in February 2026 UHS, Hampshire and the Isle of Wight Healthcare (HIOWHC) and the ICB began working on schemes to support the 'left shift' and reduce demand on the acute hospital. A risk share to fund these schemes has been agreed and HIOWHC are currently recruiting to them. The five schemes, with launch dates, are:

Project No	Project name	Project Lead	Current Recruitment Status	Soft Launch Date	Soft Launch Impact	Full Launch date	Full Launch Impact
P1	Enhanced Care in the Community	Sybilla Stempel	Recruiting x 12, as at 23/7/26 there are 3/12 recruited, next interviews 28/7	05/10/2026 (4 - 6 WTE needed as critical mass)	80 nQr pm	02/11/2026	360 nQr pm
P2	Emergency Department Intervention Team	Sally MacKenzie	Recruiting x 4 - Interviews completed	N/A	No Soft Launch	30/11/26	526 nQr pm
P10	Rehab@Home	Louise Miness	Recruiting x 7 - Interviews completed	07/09/2026	Increasing by 18 nCTR cumulatively by week until full launch	12/10/2026	100 nQr pm
P8	Extra Care Facilities	Emma Coleman- Jones/ Sybilla Stempel	Recruiting x 2 - Interviews 4/8/26	14/9/2026	25 nQr pm	02/11/2026	50 nQr pm
P5	NEW - Community OPAT	Allison Morris	Funding agreed and confirmed by ICB, UHS and HIOWH - 27/07/26. Recruitment not commenced - no launch date yet agreed.	TBC	TBC	TBC	TBC

The success of the schemes will be kept under review, with the potential to divest if they prove less successful than planned.

Communications

The communications approach will support delivery of operational priorities through staff engagement, coordinated stakeholder communications, proactive external storytelling, supporting public health campaigns, and effective use of digital channels.

This will be a people-led approach internally with staff engagement prioritised within the organisational goals framework. The storytelling will support the organisational awareness and understanding of our goals. Externally the messaging with support changes that are benefiting patients, partnerships across the system to achieve ambitions of patients being treated in the right place and maintain public confidence during periods of operational pressure. We will join up stakeholder engagement with key partners and organisations across the HIOW and national system where appropriate to reflect system-working.

Our communications will use a range of digital channels including website, social media, and existing NHS patient-facing digital platforms, alongside

Staff engagement and recognition

Purpose: Ensure staff understand priorities, changes and expectations and that we celebrate outcomes and achievements that reflect our organisational goals and values

Examples:

- Regular leadership briefings and CEO updates.
- Board to ward cascade communications through managers.
- Staff spotlights, intranet updates and content for team briefings.
- Recognition and feedback mechanisms such as UHS Voices, Spotlight, UHS Champions and We Are UHS Week.
- Internal health campaigns e.g. flu vaccination, wellness/wellbeing.

Stakeholder Engagement

Purpose: Build support and alignment with partners.

Examples:

- Joined-up communications across the HIOW system engagement with local authorities, providers, ICS partners and voluntary sector organisations.
- Briefings for MPs, councillors

Public information and awareness

Purpose: Inform patients and communities about services and priorities.

Examples:

- Supporting campaigns promoting vaccination, screening or prevention.
- Reviewing approach to 'choose well' campaign to better target service users with behaviour change messaging that will improve access to care in the right place e.g. appropriate use of urgent and emergency care
- Targeted communications during winter or heat-related pressures Promoting self-care and digital-first services.
- Supporting healthier lifestyle choices.

Reputation and trust building

Purpose: Maintain confidence in UHS services and people and the NHS.

Examples:

- Proactive storytelling around patient outcomes and innovation.
- Media coverage that reflects our organisational goals and position as leading teaching university hospital Trust.
- Executive visibility and partnerships with organisations across the system
- Transparent communication about performance and challenges.

Crisis and incident communications

Purpose: Maintain clear communication during operational pressures or emergencies so that staff across the organisation understand their role in the response and that public confidence is maintained in the handling of the incident with clear and consistent public messaging.

Examples:

- Management of major incident communication protocols including both internal and external messaging that supports operational response.
- Winter and heat related resilience communications for internal and external audiences.
- Rapid media response processes.
- Public messaging during service disruptions, joined up with partners where appropriate including stakeholder briefings.

Digital

UHS continues to look at opportunities to further move from analogue to digital. We have invested in end user devices and infrastructure to give our teams the ability to work remotely – including clinical teams working at other sites. We will continue to expand digital tools across the Trust – for example, in the coming months we expect to expand out Inpatient Noting for Doctors, roll out electronic consenting, and other developments and improvements.

UHS Digital will continue to support the key transformation programmes in line with the Trust priorities. We work with clinical representatives to ensure that the work within the programmes is prioritised in line with the Trust's needs. This transformational work also includes looking at how we can further automation across the Trust to reduce administrative burden, leveraging technologies such as Robotic Process Automation, Agentic Artificial Intelligence, Ambient Voice, and other technologies. This workstream will also look at how we can redesign our existing processes to utilise automation as a default.

Our improvements in process will make it easier for patients to access our services. All patients can access their medical record through My Medical Record, which is fully integrated with the NHS App, and we are further expanding our paper-lite processes in most specialities. We will look to bring in further technological improvements for patients – for example, we expect to launch digital wayfinding in the coming months to help guide patients around the hospital.

We are engaging across a number of major national NHS programmes which will be of benefit to the Trust: we are working on migrating our email addresses across to the national NHS.net platform; we are one of the early adopters of the NHS Future Workforce Solution; and we are looking at expanding our use of the Federated Data Platform.

Finally, as the Trust moves to more digital processes, we are also investing more in digital infrastructure to ensure that we are able to provide a reliable and safe service. We are building a new data centre which will come online in the period, replacing a data centre which is 18 years past end of life. We are also increasing our capital investment in new hardware to replace end of life network infrastructure across all UHS sites.

Chapter 3 Operating Frameworks and Industrial Action

Operating Frameworks and Escalation

OPEL Framework and Metrics

UHS uses the national Integrated Operational Pressures Escalation Levels framework 2024-26 as the principal model for assessing and reporting operational pressure. The framework converts nationally defined indicators into a normalised score from 0-100, mapped to OPEL Levels 1-4. Provider assessments are submitted at least once each day, normally by 10:00, and contribute to the system, regional and national view of operational risk.

The national framework describes operational pressure. It does not replace the separate NHS arrangements for declaring a Business Continuity Incident, Critical Incident or Major Incident. Sustained OPEL 4 pressure does not therefore require an automatic incident declaration.

UHS uses Power BI, Emergency Department information, the live bed state and other operational data to maintain a shared Trust position. This supports reporting through SHREWD and into Hampshire and Isle of Wight system coordination arrangements.

Site Operations and Clinical Site Managers use the data alongside direct intelligence from divisions and Care Groups. The numerical OPEL score is considered with:

- current clinical risk;
- workforce pressures;
- estate and infrastructure constraints;
- diagnostic capacity;
- infection prevention and control issues;
- urgent and emergency care demand;
- critical care and theatre capacity;
- patient flow and discharge; and
- system dependencies.

The Trust position is therefore based on a common dataset supported by operational judgement. Where the reported score does not fully reflect the actual risk - for example, where a critical service is close to failure or an infrastructure problem sits beneath the operational pressure-the position is escalated through the Trust command structure.

Running Cycle of the Day

The UHS running cycle links live information to actions, owners and review points throughout the 24-hour period. It includes structured handovers, Site Operations reviews, divisional and Care Group coordination, bed and flow meetings, system reporting and scheduled opportunities to decide whether the Trust is recovering or requires further escalation.

Site Operations maintains the overall Trust picture. Working through named divisional and Care Group single points of contact, it brings together:

- expected admissions and emergency demand;
- current bed capacity and use of escalation areas;
- discharge opportunities and barriers;
- the forecast net bed position;
- workforce, diagnostics, estates and infection prevention constraints;

- repatriation and system dependencies;
- actions required to improve flow; and
- matters requiring Tactical, executive or system escalation.

SPOCs are expected to attend with a clear position and recovery plan, rather than solely reporting pressure. Divisions and Care Groups remain responsible for delivering actions within their control, keeping bed and discharge plans current and escalating barriers they cannot resolve locally.

The daily rhythm is intended to move from information, to decision, to delivery. Where recovery remains credible, the routine cycle continues. Where the position is deteriorating, agreed actions are not producing sufficient effect, or recovery is no longer credible, the chair considers activation of the UHS Level 3 or Level 4 framework.

Level 3 - Substantial Operational Pressure

The UHS Level 3 framework is used where pressure is substantial, recovery is uncertain and a tighter Trust-wide operating rhythm is required.

Indicators may include:

- high or rising bed demand;
- material pressure in ED, assessment units, theatres or critical care;
- escalation areas open or approaching capacity;
- insufficient discharge to meet forecast demand;
- workforce or support-service constraints affecting flow;
- loss or degradation of a significant operational dependency;
- repeated failure to deliver agreed recovery actions; or
- an OPEL 3 position trending towards OPEL 4.

Level 3 introduces a formal Site Operations-led coordination cycle, normally including reviews at 10:00, 12:30, 15:00 and 17:00. Each division or Care Group must provide an appropriately senior SPOC who:

- understands the whole Care Group position;
- has access to current bed, discharge and workforce information;
- can commit the Care Group to actions;
- can resolve or escalate barriers;
- and can remain accountable for delivery between meetings.

The required seniority should be proportionate to the pressure and decisions needed. Routine operational representatives may remain appropriate at the start of Level 3, but Care Group or divisional leadership should attend where:

- agreed actions have not been delivered;
- service restriction or prioritisation is being considered;
- significant workforce or clinical risk requires acceptance;
- support is needed from another division or the wider system; or
- the chair requires direct senior ownership.

At Level 3, Site Operations moves from routine coordination to active management of the Trust recovery plan. The chair confirms:

- the current position;
- the required effect before the next review;
- actions and named owners;

- completion times;
- matters requiring Tactical support;
- and the conditions for escalation or de-escalation.

The Site Operations response should cover four core functions:

- Site Operations Lead: chairs the cycle, maintains oversight and interfaces with the Tactical Commander;
- Flow and Capacity Lead: maintains the live demand, bed and escalation-area position;
- Discharge and System Interface Lead: coordinates discharge barriers, repatriations and external dependencies;
- Information, SitRep and Assurance Lead: maintains the common operating picture, decision and action record, and system reporting.

These functions may be combined where staffing is limited, but each must remain covered. Role-based Site Operations action cards will set out how the team works differently once Level 3 is activated, including meeting preparation, information requirements, action tracking, handover and escalation.

Tactical Command at Level 3

Level 3 does not automatically require a full Hospital Incident Management Team. The nominated Tactical Commander should, however, be clearly identified and available to:

- support the Site Operations Lead;
- resolve cross-divisional barriers;
- confirm priorities where competing risks exist;
- secure senior clinical or operational attendance;
- approve actions within delegated authority;
- escalate significant decisions to the COO or Strategic Commander; and
- determine whether the position requires Level 4 or formal incident command.

In hours, the Tactical function should normally sit within the established Operations leadership structure. Out of hours, the Tactical Commander or other nominated commander should understand whether they are:

- maintaining oversight;
- actively commanding the Level 3 response; or
- preserving the on-call command function for a separate sudden-onset incident.

Where operational pressure is planned or sustained, a specifically nominated Tactical lead may be used so that the routine on-call commander remains available for an unrelated emergency.

Level 4 - Severe Operational Pressure

Level 4 applies where pressure is severe, mitigations are being exhausted and there is a material risk that the Trust will be unable to maintain safe services without wider Tactical direction.

Indicators may include:

- ED, critical care, theatre or specialist capacity at or close to failure;
- no credible bed or discharge recovery plan;
- escalation capacity fully committed;
- major workforce gaps affecting safe delivery;

- significant diagnostic, digital, estates or infrastructure disruption;
- inability to maintain key pathways safely;
- requirement to restrict, defer or reprioritise services;
- significant dependence on ICB or partner support;
- failure of Level 3 actions to stabilise the position; or
- cumulative pressures that cannot be managed through routine escalation.

Level 4 requires formal Tactical oversight. The Tactical Commander determines the structure required, which may include:

- an enhanced operational meeting;
- a focused Hospital Incident Management Team;
- a wider multi-disciplinary HIMT;
- or activation of the Incident Coordination Centre (ICC).

The format should be proportionate to the risk and decisions required.

At Level 4, attendance should normally include sufficient senior representation from the affected divisions and services. Care Group SPOCs may continue to support the process, but they should not be expected to carry decisions that require divisional, clinical or executive authority.

The meeting should address:

- immediate patient-safety risks;
- ED, critical care, theatre and Trust capacity;
- discharge and patient flow;
- workforce and support services;
- infection prevention and control;
- estates, digital and diagnostic dependencies;
- service restriction or prioritisation;
- system support and mutual aid;
- communications;
- overnight and recovery arrangements;
- and actions with owners and review times.

Tactical Discharge Hub

The Tactical Discharge Hub (TDH) is available as an escalation response where discharge performance, pathway barriers or patient-level ownership require concentrated Trust-wide action. It is not required for every period of Level 3 or Level 4 pressure. Activation should be based on whether the normal divisional discharge arrangements are sufficient to deliver the required recovery.

Where activated, the TDH provides:

- one shared patient-level tracker;
- named pathway ownership;
- daily reconciliation of admissions and discharges;
- clear identification of barriers and required actions;
- escalation of capacity and system issues;
- direct oversight from the TDH Lead;
- and a route to the Associate Director of Operations for unresolved barriers.

The TDH should report into the wider Site Operations or HIMT structure rather than operate as a separate command system.

Learning from the 2026 TDH work will be used to clarify:

- activation and stand-down criteria;
- the minimum dataset required;
- responsibility for data quality;
- the role of pathway owners;
- escalation into divisions and the system;
- and how discharge actions are tracked through to completion.

Business Continuity and Incident Declaration

OPEL 4, UHS Level 4 escalation and formal NHS incident declaration are related but separate decisions. UHS may remain at Level 4 without declaring an incident where the risk remains measurable and manageable through the established escalation framework.

- A Business Continuity Incident should be considered where a disruptive event causes a service or dependency to fall below its acceptable operating level and contingency arrangements are required to maintain delivery.
- A Critical Incident should be considered where the Trust is losing the ability to deliver critical services safely, patients or staff are at material risk, or special measures and wider support are required to restore normal functions.
- A Major Incident should be considered where the scale, nature or impact of an event requires implementation of the Trust Major Incident arrangements and a coordinated response with partner agencies.

The practical test is whether the Trust can continue to manage the position through normal escalation and planned business continuity measures.

Further escalation should be considered where:

- local workarounds are failing or cannot be sustained;
- the impact has spread across several critical services;
- Tactical or Strategic decisions are required to balance competing risks;
- a formal HIMT and decision log are needed;
- the Trust requires significant system support or mutual aid;
- service restriction or prioritisation is required;
- there is no credible recovery plan within an acceptable period; or
- another incident occurs alongside the operational pressure.

Declaration is based on impact, consequence and required response - not the OPEL number alone.

Command Arrangements

During routine pressure, the Operations Centre and Site Operations teams coordinate the Trust position.

At Level 3:

- Site Operations leads the structured recovery cycle;
- the Tactical Commander is identified and available;
- divisional and Care Group accountability is strengthened;

- actions are tracked between review points;
- and barriers are escalated promptly.

At Level 4:

- the Tactical Commander provides Trust-wide direction;
- senior divisional and clinical representation is expected;
- a HIMT or ICC may be established;
- comparative risk and service-priority decisions are formally recorded;
- and the COO or Strategic Commander provides executive oversight.

The Strategic Commander or COO resolves matters beyond Tactical authority and agrees:

- significant service restriction;
- formal incident declaration;
- external requests for assistance;
- major changes to Trust operating priorities;
- and matters requiring Chief Executive or Board-level awareness.

A key principle is that the routine on-call command rota should remain available for sudden-onset incidents wherever possible. For planned or sustained pressure, separate or specifically nominated leadership may be used rather than automatically consuming the on-call Tactical and Strategic Commanders.

The ICC may operate in person, through Microsoft Teams or as a hybrid arrangement. This allows the Trust to scale the response to the risk without applying a full incident structure unnecessarily.

Handover and Continuity Across the 24-Hour Period

Level 3 and Level 4 arrangements must include a clear handover between daytime and out-of-hours teams.

The handover should confirm:

- current OPEL and UHS escalation level;
- main patient-safety and operational risks;
- open escalation areas;
- forecast demand and bed position;
- actions completed and outstanding;
- decisions already made;
- authority delegated to the out-of-hours team;
- thresholds for contacting Tactical or Strategic Command;
- system issues and mutual-aid requests;
- and the timing of the next formal review.

Where risk continues overnight, the handover should be recorded rather than relying solely on verbal communication.

Stand-down and Recovery

De-escalation should not be based solely on an improving OPEL score.

Level 4 may step down to Level 3 when:

- critical services are stable;
- the main risks can be managed through Site Operations;
- senior cross-divisional decision-making is no longer required;
- and a credible recovery plan is in place.

Level 3 may stand down when:

- recovery actions are delivering the required effect;
- normal divisional and Care Group arrangements can manage the remaining risk;
- escalation areas and exceptional controls are reducing;
- and outstanding actions have clear owners and governance routes.

Formal incident command should continue where senior decisions, system support, recovery tracking or cross-divisional coordination remain necessary, even where the immediate operational pressure has eased.

Learning and Further Development

The strengthened Level 3 and Level 4 framework was introduced in summer 2025 and has since been tested through:

- sustained operational pressure;
- industrial action;
- the TIE upgrade;
- LIMS planning and downtime arrangements;
- significant digital and infrastructure disruption;
- the February 2026 Major Incident;
- the June 2026 heat-related Critical Incident;
- and activation of the Tactical Discharge Hub.

This work has reinforced the need to distinguish clearly between:

- severe operational pressure;
- failure of a critical dependency;
- activation of business continuity arrangements;
- declaration of a Critical or Major Incident;
- and the need to continue command through recovery.

It has also been shown that effective escalation depends on having the right seniority, authority and information available at each level, rather than simply increasing the number of meetings.

Priorities for 2026-27

The priorities are to:

- review and formally align the Level 3 and Level 4 framework with the Trust Incident Response Plan and Business Continuity Management System;
- define the expected seniority, authority and attendance at each escalation level;
- complete Site Operations action cards setting out how the team operates differently at Level 3 and Level 4;
- clarify the in-hours and out-of-hours expectations of Tactical Command;
- protect the on-call command structure for concurrent incidents wherever possible;

- complete activation, escalation, stand-down and recovery criteria;
- strengthen written handover and information management across the 24-hour period;
- embed the Tactical Discharge Hub as a defined escalation option and incorporate the learning from its 2026 use;
- exercise the transition from OPEL escalation to Business Continuity, Critical Incident or Major Incident response;
- develop clearer measures for action completion, recovery and de-escalation;
- ensure that HIMT attendance is proportionate and includes people with the authority to make the decisions required;
- and embed learning from the February Major Incident, heat, industrial action and major system downtime within routine operational practice.

Industrial Action

Over the past 12 months, hospital services have been affected principally by repeated BMA resident doctor industrial action. National action took place from 25-30 July 2025, 14-19 November 2025, 17-22 December 2025, and 7-13 April 2026. A further period was announced for 15-19 June 2026, but was suspended shortly before it was due to begin while the BMA balloted members on a proposed agreement.

These rounds have tested hospitals in different circumstances: summer pressure, the approach to winter, the Christmas period, Easter holidays and, in June 2026, forecast hot weather. National expectations have increasingly moved from widespread cancellation towards maintaining urgent, emergency and as much planned care as can be delivered safely. During the November 2025 action, the NHS aimed to maintain around 95% of elective activity; during the April 2026 action, NHS England reported that previous arrangements had sustained approximately 95% of normal activity, although at significant cost to staff and services.

UHS has developed a repeatable planning and command model that protects critical services, maintains as much activity as is safely possible, supports patients and staff, and allows rapid recovery or stand-down if action changes at short notice.

Pre-action planning

Planning begins as soon as formal notice or credible intelligence of action is received. Executive oversight is provided through the COO, Medical Director and Director of Nursing, with EPRR coordinating the planning cycle and maintaining the central record of risks, decisions and actions.

The planning approach includes:

- completion of NHS England and Hampshire and Isle of Wight ICB assurance returns;
- workforce modelling by division, specialty, grade and shift;
- confirmation of expected participation and areas of greatest clinical risk;
- identification of services that must be protected;
- consultant, specialist doctor and advanced clinical practitioner cover;
- review of bank, agency and locally employed doctor capacity;
- assessment of theatre, anaesthetic, critical care, maternity, paediatric and diagnostic cover;
- review of mutual-aid and system dependencies;
- agreement of patient communications and media handling;
- establishment of command, escalation and reporting arrangements; and
- preparation for recovery of any activity that must be rescheduled.

A live RAID log is used to capture concerns and actions throughout the planning period. This supports a single Trust view and avoids risks being held separately within divisions or individual meetings.

UHS initially plans on the basis that no derogations or patient-safety mitigations will be agreed. Any mitigation subsequently requested or accepted is then incorporated into the plan rather than being assumed from the outset. NHS England provides a formal patient-safety mitigation route for circumstances where a service cannot otherwise be delivered safely.

Activity planning and patient safety

The Trust's starting position is to maintain urgent and emergency care and as much planned activity as can be delivered safely. Cancellation is not used simply to reduce pressure; services must assess whether activity can continue with safe clinical cover, supervision, diagnostics, beds and support services.

Protected or closely managed areas include:

- emergency and major trauma pathways;
- critical care;
- maternity and neonatal services;
- cancer and other time-critical pathways;
- emergency and urgent surgery;
- dialysis and other essential treatments;
- time-critical diagnostics and interventional services;
- paediatric emergency care; and
- services where interruption would create immediate patient harm.

Divisions are required to confirm:

- the activity they can safely maintain;
- the staffing model supporting that activity;
- any services requiring restriction or rescheduling;
- named clinical and operational decision-makers;
- safety-netting arrangements;
- how cancelled or deferred activity will be recovered; and
- the point at which further executive or system support is required.

Any decision to reduce activity is taken through the agreed clinical and operational governance route. NHS England expects changes required for patient safety to be discussed with the relevant regional team and for Trusts to retain the ability to reinstate activity quickly if action is suspended.

Seven-day and 72-hour assurance points

At approximately seven days before action, UHS moves from outline planning to confirmed delivery arrangements. Divisions provide their final workforce and activity assumptions, protected services are confirmed, clinical rotas are tested, and any material gaps are escalated.

By 72 hours before action, the Trust confirms:

- final consultant and senior clinical cover;
- overnight, weekend and handover arrangements;
- theatre, anaesthetic and recovery capacity;
- critical care and escalation-bed resilience;

- ED and acute assessment models;
- diagnostic and pharmacy support;
- divisional command contacts;
- patient notifications and safety-netting;
- reporting responsibilities and deadlines; and
- the meetings and decision points required during the action.

The Trust also prepares for the NHS England activity, workforce and rescheduled-activity SitRep collections. Acute Trusts are required to submit returns even where the position is nil, and reporting windows may open and close before industrial action begins.

Command and coordination during action

UHS uses a proportionate command structure rather than automatically establishing a full incident response for every period of action.

A senior operational planning group maintains oversight before the action. During strike periods, the Trust normally operates through:

- Strategic oversight: executive leadership, setting priorities and accepting significant organisational risk;
- Tactical coordination: Trust-wide management of staffing, activity, patient flow and competing risks;
- Operational delivery: divisional and service leads implementing the agreed plans and escalating exceptions.

Hospital Incident Management Team meetings are scheduled according to risk and operational need. Senior stakeholders represent divisions, clinical services, workforce, Site Operations, diagnostics, pharmacy, communications and other critical functions.

The HIMT:

- confirms the current workforce and participation position;
- reviews urgent and emergency care;
- assesses protected services and activity delivered;
- considers patient-safety concerns and service restrictions;
- manages flow, discharge, beds and escalation capacity;
- identifies support-service and system dependencies;
- agrees actions, owners and review times;
- confirms the reporting position; and
- decides whether further meetings or escalation are required.

An evening HIMT may be placed in diaries as a precaution but held by exception where daytime control has produced a stable and credible overnight plan. Where no further meeting is required, oversight continues through Site Operations, divisional command and the on-call executive and clinical structures.

Workforce deployment and professional safeguards

Resident doctors who are not participating may be redeployed where necessary to protect patient safety, but only with appropriate approval, induction, supervision and consideration of competence. NHS England guidance states that doctors should not be placed outside their area of competence and that those continuing to work should, where possible, remain in familiar clinical areas.

UHS planning therefore considers:

- competence and scope of practice;
- senior supervision;
- safe handover;
- fatigue and consecutive working;
- the effect on training;
- use of consultants and SAS doctors;
- advanced clinical practitioner contribution;
- locally employed doctors;
- bank and agency arrangements; and
- the sustainability of cover across the full action and recovery period.

Information, reporting and communications

A single source of truth is maintained for workforce assumptions, protected activity, cancellations, operational risks and actions. Divisions are expected to report changes promptly rather than waiting for the next scheduled meeting.

Patient communication follows the national principle: Patients should attend as planned unless UHS contacts them directly to rearrange their care.

This reduces avoidable non-attendance and supports the Trust's aim of maintaining activity. National communications during each recent round have continued to advise patients to use NHS services normally, including 111 for urgent but non-life-threatening needs and 999 or ED for emergencies.

Trust communications also cover:

- what services remain available;
- arrangements for patients whose care is changed;
- staff responsibilities and professional standards;
- escalation and reporting routes;
- internal operational updates; and
- stand-down or reinstatement where action is suspended.

Rapid stand-down and reinstatement

The suspension of the planned June 2026 action reinforced the need to plan simultaneously for the strike and for rapid reinstatement of normal activity. NHS England asked Trusts to stand down additional shifts and overtime where possible and recover cancelled appointments from the following working days.

UHS planning therefore identifies:

- decisions that can be delayed until participation is clearer;
- activity that can be reinstated safely at short notice;
- named owners for contacting patients;
- workforce changes that can be stood down;
- theatre and clinic lists that can be rebuilt;
- communication routes for confirming normal arrangements; and
- financial and workforce consequences of late cancellation.

This prevents the planning response itself creating avoidable harm where industrial action is amended or withdrawn.

Recovery following industrial action

Recovery starts during the action rather than after it ends. Divisions maintain a record of deferred activity and identify named owners for rebooking and clinical prioritisation.

The recovery process includes:

- clinical review of any same-day cancellation;
- reconciliation of cancelled and rescheduled activity;
- prioritisation according to clinical need and waiting time;
- confirmation of diagnostic and treatment dependencies;
- monitoring of patients whose care has been deferred repeatedly;
- restoration of training and normal staffing arrangements;
- management of accumulated discharge, pathway or administrative work;
- completion of national reporting; and
- review of patient complaints, incidents or harm.

The Trust uses a structured EPRR debrief to identify what worked well, what should change and what must be carried into the next planning cycle. Outputs are supported by workforce data, SitReps, incident and harm information, activity records, operational feedback and patient experience.

Current assurance position

UHS now has an established and repeatable industrial-action model. Recent rounds have demonstrated that the Trust can:

- mobilise planning quickly;
- provide senior clinical cover;
- protect critical services;
- maintain substantial planned activity;
- use proportionate command arrangements;
- meet national reporting requirements;
- respond to changing participation assumptions;
- stand down unnecessary meetings where the position is stable; and
- recover deferred activity through named divisional ownership.

The position nevertheless remains dependent on the nature, duration and staff group involved. Resident doctor action is now well rehearsed; simultaneous action by more than one professional group, prolonged action, or action combined with winter, heat, digital disruption or severe operational pressure would require a wider response.

Priorities for 2026-27

The priorities are to:

- retain a single Trust industrial-action planning framework that can be adapted to different staff groups;
- update the framework using learning from the July, November and December 2025 and April 2026 action;

- incorporate the learning from the suspended June 2026 action and rapid reinstatement requirement;
- maintain current workforce, activity and command templates;
- define minimum information required from divisions at each planning gate;
- strengthen recovery tracking and repeated-cancellation oversight;
- align industrial-action planning with OPEL, business continuity and incident-declaration arrangements;
- protect the routine on-call command structure for concurrent emergencies where possible;
- exercise a scenario involving action by more than one professional group; and
- continue to test whether scheduled HIMTs are necessary, retaining the ability to convene rapidly where risk changes.

Data Driven Insights / Business Intelligence

The data and analytics department will continue to provide trusted, timely and actionable intelligence to support decision-making at every level of the organisation. Through robust board reporting, performance management frameworks and alignment to national oversight requirements, we will ensure that leaders have clear visibility of operational, quality and performance information. We will further strengthen our use of internal and external benchmarking, enabling services to understand variation, identify opportunities for improvement and compare performance against peers, national standards and best practice.

We will continue to expand our self-service analytics capability through Power BI, developing a modern portfolio of dashboards and analytical products that support clinical, operational and corporate services. Our focus will be on moving beyond reporting towards delivering true insight—combining data, analysis and visualisation to identify trends, predict pressures, evaluate improvement initiatives and support proactive decision-making. Alongside ongoing automation and rationalisation of low-value reporting, we will prioritise the development of products that improve operational flow, support delivery of the Trust's strategic objectives and maximise the value of our data assets.

Change Programmes

The Trust's transformation agenda is a critical component of the FY26/27 plan, supporting improvements in operational performance, financial sustainability, workforce productivity and patient outcomes. The Trust has set 5 organisational goals for 26/27 that represent the key priorities for the year that are backed by transformation programmes focussed on Urgent and Emergency Care, Elective Care and Intelligent Automation. These programmes are clinically led with Executive sponsorship for each with an established programme board reviewing the delivery plans and metrics reporting into the Transformation Oversight Group (TOG) which is chaired by the Chief Executive Officer. To support these change programmes, the transformation team is deployed in a divisionally aligned model to support bespoke delivery of the change programmes across all areas of the trust and support teams to engage with change ideas that help them achieve the 5 goals.

Goal	Measured by
1. Get people home sooner	Length of Stay
2. Patients are seen the right place as soon as possible	4-hr ED performance
3. Reduce waits by treating more patients	#pts in theatre
4. Seeing more new Outpatients to reduce waits	RTT %
5. Engaged and motivated people	Staff survey results

Chapter 4 Conclusion

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

The next year will be challenging, with a need to balance operational and financial pressures, as well as the usual challenges of infection and winter.

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	No	Confirmed with ICB that they undertake this role	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes		
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes		
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes		
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes		
Capacity					
	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	No		
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		

3	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes		
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes		
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes		
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes		
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes		
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	No		
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes		
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes		
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes		
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes		
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		

	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

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

Trust / Provider Name:	University Hospital Southampton NHS Foundation Trust
Provider CEO name:	David French
Date reviewed:	
Provider Chair name:	Jenni Douglass-Todd
Date reviewed:	

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Andy Hyett, COO. Andy.Hyett@uhs.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
Yes

Please confirm date reviewed
17/08/2026

BAS Self-Assessment Dashboard

Trust		
Overall Assessment Rating: 4 - Substantial assurance		
Section B		Rating
	Prevention	4 - Substantial assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	4 - Substantial assurance
	UEC Flow	3 - Moderate assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	Awaiting assessment

UHS Equality and Quality Impact Assessment (EQIA) Tool										
Any queries, requests for support, and/or completed EQIAs which require review at the Trust's EQIA Panel, should be directed to EQIA@uhs.nhs.uk										
Section 1: To be completed by the EQIA author										
Reference number (allocated by EQIA panel):	Version:				1.1					
Title of proposal (scheme/project/change):	UHS Operational Plan including Winter 2026/27									
Division/Directorate/THQ Function:	Trustwide plan which has been developed and led by the Chief Operating Officer									
EQIA author:	Lauren Anderson, Corporate Governance & Risk Manager									
Accountable lead for proposal:	Duncan Linning Karp, Deputy Chief Operating Officer									
Brief description of proposal:	The University Hospital Southampton (UHS) Operational Plan has been developed to ensure continuity of operations, patient and staff safety, and sustained performance over the next 12 months. This plan also serves as the Trust's Winter Plan, recognising the seasonal pressures and heightened risks associated with this period. The plan is informed by predicted demand, potential risks, and lessons learned from previous years. It provides a framework for risk mitigation and supports responsive and informed decision-making in evolving circumstances. Through this approach, UHS aims to maintain high standards of care and operational resilience across all services. To support this, this EQIA has been completed as mandated by NHS England.									
Who has been involved in or consulted with in completion of this EQIA? (Staff, patients, system partners, committees, Staffside, unions etc..)	The plan has been developed in consultation with divisional managers, clinical and operational leads, the emergency preparedness, response and resilience team, the infection prevention team, communications, digital, and occupational health. Subsequent to this, the EQIA has been completed by the Deputy COO.									
Does this impact on delivery of the Trust's corporate strategy and objectives? Describe how if so.	Aims to support delivery of agreed performance standards and maintain a safe service.									
Describe any impact on other departments/functions within UHS outside of the primary area this EQIA applies to, if applicable: (e.g. support services)	The operational plan, and this EQIA, are applicable Trustwide.									
Describe any impact on the wider system and/or external partners if applicable:	Delivery of the UHS operational plan will impact on ICB led demand management schemes and systemwide NCTP plans. There will also be an impact on the ambulance service and discharge services - eventual aim collaborate throughout system.									
CLICK HERE TO ACCESS GUIDANCE ON RISK SCORING										
Quality: assess the impact of the proposal on each of the domains below:	IMPACT			INHERANT RISK SCORE (pre mitigations)			MITIGATIONS	RESIDUAL RISK SCORE (post mitigations)		
	Select if the net impact is positive, negative, or neutral:	Describe the impact:	How will you measure/evidence this?	Consequence	Likelihood	Score (C X L)	Please document the mitigations that will be put into place:	Consequence	Likelihood	Score (C X L)
Patient safety / prevention of harm (safe)	Positive	The operational plan is intended to produce a positive impact by supporting capacity and flow to ensure patients can receive the right care at the right time. It is recognised that without considered planning there would be a negative impact as the hospital would not be sufficiently prepared to meet demand, therefore harm could occur from insufficient capacity, overcrowding, delays, errors made/inadequate care under	AERs, performance metrics, elective activity cancellations, occupancy, infection rates, time to be seen in the emergency dept.	5 - Catastrophic	4 - Likely	20	The operational plan aims to mitigate the risk of a negative patient safety impact by facilitating sufficient capacity and optimal flow. This will be supported by proactive risk assessment and management in line with Trust policy. Additionally as specific changes are planned/occur, (such as closures of wards) individual EQIAs will be completed. Risk stratification will be used to inform waiting lists. Use of surge	3 - Moderate	2 - Unlikely	6
Clinical outcomes and effectiveness (effective)	Positive	As above, the operational plan is intended to support optimal patient outcomes and access to effective treatment in a timely manner. Without the plan patients could suffer worse outcomes as they would encounter delays to treatment and in some case this could result in changes to treatment plans if there has been disease progression in that time negating the benefits of the most effective first line treatment.	Outcome data and case reviews at M+Ms. Local and national audits. Adherence to guidance.	5 - Catastrophic	3 - Possible	15	The operational plan aims to mitigate the risk of negative patient outcomes. Risk stratification will be used to inform waiting lists. Individual EQIAs will be completed where specific changes to pathways are planned.	3 - Moderate	2 - Unlikely	6
Patient experience (caring)	Positive	The operational plan is intended to produce a positive patient experience impact by reducing waiting times. However it is recognised that in times of challenge non elective care will be prioritised which could result in cancellation of elective activity, which is not a good experience. Additionally during times of pressure, priority is given to maintaining safety so 'over and above' tasks can be dropped. There may also be the need to use mix sex wards in times of extreme pressure which can affect privacy and dignity.	PALS data - concerns and complaints. FFT. Elective activity cancellations.	3 - Moderate	4 - Likely	12	Through the operational plan, the Trust aims to reduce occupancy and enhance flow, reducing the possibility of elective activity being cancelled. Risk stratification will be used to inform waiting lists. Where cancellations cannot be avoided, or waiting lists effectively managed to reduce wait times, open and early communication with patients will be promoted. Individualised care promoted to meet patient needs and preferences as much as possible. Use of volunteers. Responsive patient experience team leading	3 - Moderate	3 - Possible	9

Workforce & leadership (well-led)	Neutral	There will be an impact to staff who will need to be responsive to demand, potentially resulting in moving staff between departments, particularly nursing staff. This could be stressful for some staff, whereas others may enjoy the change in pace/speciality etc..	Staff feedback, locally via 1:1s etc.. as well as through more formal routes such as staff survey. Sickness rates. Turnover. AERS, red flag data.	3 - Moderate	4 - Likely	12	Regular communications, both locally, and Trustwide such as Spotlight, Staffbriefing, Talk to David etc.. Utilisation of the staffing hub. Additional staffing through utilisation of bank and agency if necessary.	3 - Moderate	3 - Possible	9
Activity / performance	Positive	The operational plan is intended to support delivery of performance targets, however there is a risk that non elective pressures leads to cancellation of elective activity as described above.	Performance metrics. Cancellation rates.	4 - Severe	4 - Likely	16	Clinical prioritisation and risk stratification processes. Divisional performance reviews. Use of surge capacity and additional staffing to increase activity.	3 - Moderate	3 - Possible	9
Sustainability	Neutral	No specific impact identified.	N/A	1 - None	1 - Rare	1	N/A	1 - None	1 - Rare	1
Reputation	Neutral	Long waits and cancellations can negatively impact the reputation of the organisation, however the intention of the operational plan is to enhance capacity and reduce the likelihood of cancelled activity.	Patient feedback. Media reports.	2 - Low	3 - Possible	6	Standardised and proactive communication with patients and the media. Communications team.	2 - Low	3 - Possible	6
Other		N/A				0				0
Equality: assess the impact of the proposal on each of the characteristics below. Consider all individuals including patients, staff and visitors.	Select if the net impact is positive, negative, or neutral:	Describe the impact:	How will you measure/evidence this?	Consequence	Likelihood	Score (C X L)	Please document the mitigations that will be put into place:	Consequence	Likelihood	Score (C X L)
Age	Neutral	The elderly population are more likely to access healthcare than younger generations therefore are more likely to be impacted by provision (or lackof) of services.		1 - None	4 - Likely	4	N/A	1 - None	4 - Likely	4
Disability		Nil identified.				0				0
Gender reassignment	Negative	Side rooms are offered to patients who are undergoing/who have undergone gender reassignment. However the number of side rooms could reduce if/when wards are closed, or due to increased winter infections rates, therefore fewer side rooms may be available to offer to patients with gender recognition certificates.	Patient feedback.	3 - Moderate	3 - Possible	9	For those patients who have preferences around gender or are intersex, but have not undergone gender reassignment, we will take risk based decisions on accommodation availability and clinical need. We aim to meet patient preferences relating to individualised care where-ever possible and to prevent discrimination.The same sex accomodation policy is currently being reviewed and updated.	2 - Low	3 - Possible	6
Marriage and civil partnership		Nil identified.				0				0
Pregnancy and maternity		Nil identified.				0				0
Race		Nil identified.				0				0
Religion or belief		Nil identified.				0				0
Sex		When demand is excessive, more likely to mix sex beds as described within patient experience.	Monitor single sex breeches. Patient feedback.	3 - Moderate	3 - Possible	9	Daily site meetings and planning. Mixed sex acomodation policy to inform decision making.	3 - Moderate	2 - Unlikely	6
Sexual orientation		Nil identified.				0				0
Socio-economic factors		Nil identified.				0				0
Any other group of individuals (inc. staff and patients) that will be impacted inequitably		Nil identified.				0				0
Any additional comments? E.g. does the service have resilience?	It is noted that the operational plan will be subject to iterative review and planning/decision making will be responsive to patient need in real time.									
Monitoring arrangements										
Who will be responsible for monitoring the predicted impact and identifying any unintended impact?	COO, Deputy COO, Site / operations teams, directorate and divisional managers.									
Describe what will be monitored if there is anything additional to what has been entered in column D above:	As described above.									
Describe the ongoing review process including frequency and where this will take place (i.e. divisional/directorate governance group or board, or steering group).	Weekly performance meetings, real time site meetings multiple times per day, escalation process to DMTS and execs, embedded ward to board governance processes.									
Local sign off:										
Accountable Manager signatory:		Date:								
Divisional Management Team (DDO/DCD/DDN) or senior THQ Manager name and signatory:		Date:								
Section 2: to be completed by the EQIA panel										
Date to panel:										
Chair:										

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

Overview

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

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

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

<u>Quality Domains</u>	<u>Definition/Considerations</u>
Patient safety	This refers to the avoidance of unintended harm to people during the provision of their healthcare. Consider: the likelihood of patient harm/clinical risk, reliability of safety systems, duty to protect and safeguard children, young people and vulnerable adults, infection prevention and control, collaborative working, environment, other organisations/shared risk, workforce and the ability to deliver safe care.
Clinical outcomes and effectiveness	This refers to the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. The aim of clinical effectiveness is to use evidence to improve the effectiveness of clinical practice and service delivery. Consider: variations in care, care pathways - improvements and consequences delivery of positive outcomes, compliance with national guidance/best practice, mortality rates, readmission rates, etc.. clinical efficiency, clinical communication/handover, plans for monitoring outcomes.
Patient/carer experience	This refers to the way a patient feels about their care based on all their interactions, before, during and after delivery of care or how a carer or staff member may feel. Consider: the voice of the patient/carer/staff member, individual need inc. patient choice and self-care, privacy, dignity and respect, access, equity, perception of decision by patient/carers or staff, communication (undertaken or planned).
Workforce & leadership	This refers to staff and volunteers health and wellbeing, workforce and education training needs, including provision of workforce training placements linked to service delivery, and the impacts on recruitment and retention of staff. It also refers to the leadership and governance of the service.
Activity & performance	This refers to the impact on the services ability to meet national and local performance metrics and standards.
Sustainability	This refers to the sustainability of the proposal including the longevity and whether it offers value for money, as well as the environmental impact associated with the project/change.

Reputation	This refers to the impact on the organisation's/service's reputation, public trust, and relationships with stakeholders (including patients, healthcare providers, system partners and the local community).
------------	--

<u>Protected</u>	<u>Definitions</u>
-------------------------	---------------------------

<u>Characteristics</u>	
-------------------------------	--

Age	Protection against discrimination based on age.
Disability	Protection for individuals with physical or mental impairments.

Gender reassignment	Protection for those undergoing gender transition.
---------------------	--

Marriage and civil partnership	Protection for individuals who are married or in a civil partnership.
--------------------------------	---

Pregnancy and maternity	Protection for individuals during pregnancy and maternity leave.
-------------------------	--

Race	Protection against discrimination based on race, color, nationality,
------	--

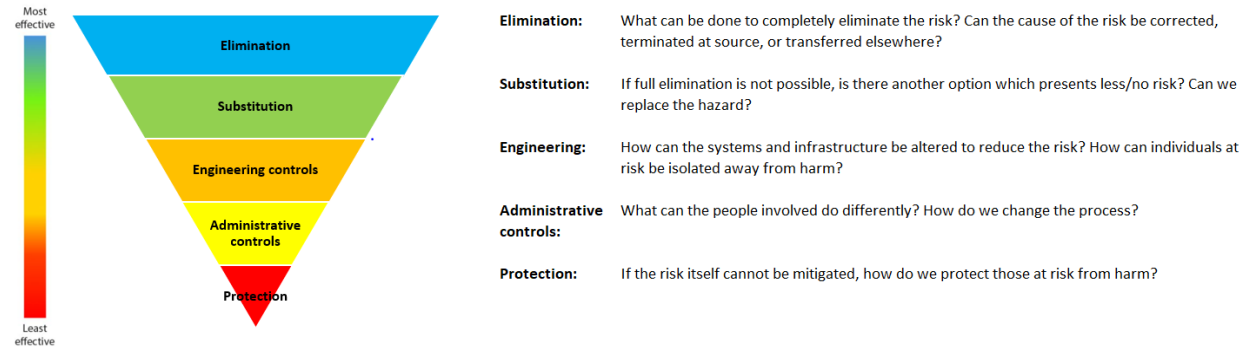
Religion or belief	Protection for individuals based on their religious beliefs or lack thereof.
--------------------	--

Sex	Protection against discrimination based on gender.
-----	--

Sexual orientation	Protection for individuals based on their sexual orientation.
--------------------	---

Risk mitigations

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



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

<https://staffnet.uhs.nhs.uk/TrustDocsMedia/DocsForAllStaff/GovernanceAndSafety/RiskManagementPolicy/Appendix-3-UHS-Risk-Scoring-Matrix-v2-Finalised-December-2024.pdf>

Additionally the 5 x 5 matrix is shown below:

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

Agenda Item 5.8 Report to the Trust Board of Directors, 10 September 2026			
Title:	Finance Report 2026-27 Month 4		
Sponsor:	Ian Howard, Chief Financial Officer		
Author:	Philip Bunting, DoOF and Vickie O’Leary, ADOF		
Purpose			
(Re)Assurance	Approval	Ratification	Information
			x
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
			x
Executive Summary:			
This report outlines the performance and financial position for the Trust. Note the updated report for M4 – covering a dashboard, focused on lead indicators and covering risks and mitigations.			
Financial Position			
M4 shows a deficit of £2.42m, in line with plan, £12.65m YTD. The CIP delivery is also on plan at £4.2m, £15.2m YTD. The 2026/27 underlying deficit position is flat from June to July at £4.6m deficit, with significant savings required over the remainder of the year to deliver our plan.			
Operational Context			
In operational terms, the Trust continued to be under sustained pressure, with net c90 beds closed for most of the month because of fire damage. Our plan is to maintain these bed closures through reduced NCTR and length of stay efficiencies. However, whilst NCTR numbers reduced from 239 to 156 in the aftermath of the fire, they have gradually increased thereafter to 238 in July, meaning the net pressure on beds has increased.			
The heatwave continued through July pushing the Trust into a critical incident. This created further pressure on beds with additional capacity opened, in addition to staffing challenges and equipment failures due to the extreme temperatures. This led to a loss of operational capacity (including operating theatres) and therefore activity which has translated into income risk.			
Elective Recovery Fund (ERF)			
Early indications are that the Trust is £8.3m below ERF targets for M1-4, linked to operational pressures, loss of theatre capacity from the fire (estimated at c£1m per month), industrial action and the heatwave. We are also seeing pressures relating to staffing in some high-cost areas (e.g., Critical Care), leading to cancellations.			
We are continuing to review our data, with significant estimates based on uncoded/unoutcomed data included within the assessment.			
Should the level of risk highlighted materialise in our final data, the Trust will need to identify recovery actions to mitigate the level of risk. This may include activity recovery plans, additional outsourcing/insourcing, and discussions with commissioners and insurers regarding the ongoing impact of the fire. Commissioners remain supportive that planned funding is earmarked for UHS, and at this time are not seeking to recover cash for underperformance.			

Risks and Mitigations

The below table gives an indication of the scale of financial risks and mitigations, noting that there is significant uncertainty when it comes to variables such as the potential for future industrial action and NCTR that has elements beyond the Trusts direct control.

Risks	Narrative	£m
Non Criteria to Reside	The Trusts plan was predicated on NCTR numbers being maintained at 160 releasing c100 beds when compared to 2025/26. The current trajectory suggests this could return to pre-fire levels without intervening action.	(6.5)
Cost Improvement Programme Delivery	A risk adjusted view of CIPs indicates risks due to scheme maturity of c£35m. Note the NCTR impact above has been removed avoiding a double count. This is supported by a top-down view of scheme risk (75% of high risk, 50% of medium risk, 25% of low risk).	(28.5)
Elective Recovery Fund (ERF) Income	ERF delivery for M1-4 has been estimated at c£8.3m below plan. £3m of this relates to non recurrent pressures (Industrial Action and Critical Incident) £5m of this relates to loss of capacity in theatres linked to the fire. Mitigation plans include recovering capacity during November. This risk has therefore been adjusted to £10m (8 months). The full year risk is therefore £13m if there is no run rate improvement.	(13.0)
Industrial Action	Senior doctors and consultants in England voted 'yes' in a ballot, securing a 12-month mandate for strike action. Although no dates are confirmed each IA day incurs costs and lost income. We would anticipate a greater impact than seen in the Resident Doctors industrial action.	Unknown
Total Risks		(48.0)

Mitigations	Narrative	£m
Deliver CIP as per plan	Accelerated improvement within the CIP programme driven by the July sprint, consultancy support and newly developed left shift projects.	35.0
Fire related mitigations	We are exploring multiple mitigations including reviewing our data, activity recovery plans including insourcing / outsourcing, and discussions with both commissioners and insurers regarding the ongoing impact from the fire.	13.0
Industrial Action Support	National funding support as per previous years to mitigate the costs/lost income related to industrial action.	Unknown
Total Mitigations		48.0

Net Risk	At present the net risk position is presented as breakeven. This is subject to ongoing review.	0.0
-----------------	---	------------

The overall level of risk is broadly consistent with a top-down assessment based on the current underlying financial position continuing. It should be noted that we have not incorporated potential clawback of Deficit Support Funding (£10m) into the risk assessment at this stage.

The Trust will continue to monitor both the underlying run rate and forecast position and highlight risks to plan financial deliverability as we move forward through the year. At present the Trust continues to forecast the achievement of a breakeven position with net risks after mitigations of zero.

With regards to mitigating the under delivery of the CIP programme the following should be noted:

- June was a 'sprint' month to significantly target transformation across the whole organisation, with refreshed core objectives feeding through the Trust. Whilst momentum progressed well in the early part of the month, the heatwave caused teams to be diverted to respond to the critical incident, which has continued throughout July. Next steps have therefore been delayed until August. There is still however confidence in the progress made.
- We continue to robustly manage the Trust's CIP progress, with further details as outlined in the CIP paper. We continue to see good progress on identification and progression on scheme maturity.
- The Financial Improvement Support consultancy procurement is progressing, with a preferred bidder anticipated to commence work by the end of September (subject to contract).
- Five new initiatives have been agreed with HIOW Healthcare and HIOW ICB to left-shift activity from UHS into the community provider setting, reducing attendances and admissions to UHS. These schemes have been entered into on a risk/gain share basis. These schemes are now in the recruitment and mobilisation stage.
- Continuous review of NCTR processes is ongoing, supported by consultancy support (see separate paper).
- We have brought additional resource into the CIP team, focussing on several savings projects, reporting into the Financial Improvement Group.

Capital Programme Update

Good progress continues to be made with the Trusts internal capital programme with expenditure of £8m YTD close to the trusts plan. As reported last month awards have now been made for £22.4m of external capital funding in 2026/27 (subject to business case sign off) with further confirmation expected for histopathology and frontline digitisation investments expected to follow shortly.

The main risk to highlight is the delivery of externally funded schemes within the required timeframes especially those which have high levels of project complexity or require Building Safety Regulator approval. We are currently undertaking a detailed forecast assessment with teams with a view to identifying risks and mitigations, potentially considering requests for funding adjustments to future years. A more detailed capital update, including financial forecast, will follow for next month's meeting for review and discussion.

Conclusion

Overall, the Trust delivered the M4 plan as expected. However, the Trust has several operational pressures, including managing the aftermath of the fire, periods of industrial action and the heatwave against a backdrop of increasing NCTR volumes. There is also a significant financial improvement journey required from this point to deliver the plan, particularly in the second half of the year.

Trust Board is asked to note the update.

Contents:

Finance Report

Risk(s):

5a

Equality Impact Consideration:

N/A

Agenda Item 5.9 Report to the Trust Board of Directors, 10 September 2026			
Title:	People Report 2026-27 Month 4		
Sponsor:	Steve Harris, Chief People Officer		
Author:	Workforce BI Team		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			x
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
		x	
Executive Summary:			
In July 2026, the total workforce position increased by 35 WTE to 13,228 WTE (168 WTE over plan). With substantive staff reducing by 7 WTE, and agency increasing by 4 WTE, this total increase is driven by bank staffing (+ 38 WTE) which is now 184 WTE over plan. Operational pressures cited in June (heatwaves, increased ED attendances, higher admissions, increased acuity, and staffing challenges in Critical Care and Theatres) have continued into July, contributing to further growth in temporary staffing utilisation. Key people indicators remain mixed: sickness was 4.1% in-month, and above target, with the rolling 12-month sickness at 4.2%; turnover remains comparatively low at 10.4% rolling 12-month (with 67 WTE leavers in July); appraisal completions for Agenda for Change staff remain materially below target at 64.6%, having reduced from June (65.0%). Statutory training compliance is also below target at 71% (against a target of 85%), with only four out of 16 measures meeting the target. Mandatory compliance stands at 81%, with two out of six measures above the 85% target. These metrics were discussed at People and OD Committee (POD). A deep dive is set to be undertaken at People Board on 7th September and then the POD will receive an update of the actions being taken at its September meeting. There were 116 staffing-related incidents reported in June, a substantial increase from May (67); this has increased again to 126 in July. There is also a continued upward trend in the grading of rating of incidents. Alongside these operational challenges, several significant workforce initiatives are progressing, including implementation of a new probation process, expansion of nurse degree apprenticeship starts from 46 to 51 places, and preparations for the future workforce solution (replacing ESR). Planning for 'We are UHS' week (12 – 16 October 2026) to celebrate staff achievements and showcase progress against organisational priorities has commenced. The Trust has launched plans for the annual We Are UHS Champions Awards, taking place on Thursday 26th November. The awards are closely aligned with the new corporate strategy and Trust values.			
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



**OUTSTANDING
PEOPLE**

UHS People Report

July 2026



Summary

PEOPLE REPORT OVERVIEW: 2026/27 M4 (July-26)



Sickness

In-Month: **4.12%**
Above target by 0.42%



Appraisal

Completion Rate:
64.6%
Below target by 20%



Turnover

Rolling 12M: **10.4%**
Below target by 3.2%



Substantive

In-Month: **12,419 WTE**
Under Plan by 8 WTE



Bank

In-Month: **779 WTE**
Over Plan by 184 WTE



Agency

In-Month: **30 WTE**
Under Plan by 8 WTE



Patient Safety Incidents

In-Month: **126**
Change from M2: +10

In July 2026, the total workforce position increased by 35 WTE to 13,228 WTE (168 WTE over plan). With substantive staff reducing by 7 WTE, and agency increasing by 4 WTE, this total increase is driven by bank staffing (+ 38 WTE) which is now 184 WTE over plan. Operational pressures cited in June (heatwaves, increased ED attendances, higher admissions, increased acuity, and staffing challenges in Critical Care and Theatres) have continued into July, contributing to further growth in temporary staffing utilisation.

Key people indicators remain mixed: sickness was 4.1% in-month, and above target, with the rolling 12-month sickness at 4.2%; turnover remains comparatively low at 10.4% rolling 12-month (with 67 WTE leavers in July); appraisal completions for Agenda for Change staff remain materially below target at 64.6%, having reduced from June (65.0%). Statutory training compliance is also below target at 71% (against a target of 85%), with only four out of 16 measures meeting the target. Mandatory compliance stands at 81%, with two out of six measures above the 85% target. These metrics were discussed at People and OD Committee (POD). A deep dive is set to be undertaken at People Board on 7th September and then the POD will receive an update of the actions being taken at its September meeting.

There were 116 staffing-related incidents reported in June, a substantial increase from May (67); this has increased again to 126 in July. There is also a continued upward trend in the grading of rating of incidents.

Alongside these operational challenges, several significant workforce initiatives are progressing, including implementation of a new probation process, expansion of nurse degree apprenticeship starts from 46 to 51 places, and preparations for the future workforce solution (replacing ESR). Planning for 'We are UHS' week (12 – 16 October 2026) to celebrate staff achievements and showcase progress against organisational priorities has commenced.

The Trust has launched plans for the annual We Are UHS Champions Awards, taking place on Thursday 26th November. The awards are closely aligned with the new corporate strategy and Trust values

Overall Position

WTE Movement (M3 to M4)

Total Workforce

The total workforce **increased by 35 WTE** to **13,228 WTE** from M3 (13,193) to M4.

During this period, the substantive workforce **decreased by 7 WTE**, and the total temporary staffing **increased by 38 WTE**.

As of M4, the Trust is **above the total plan (by 168 WTE)**.

Substantive WTE

Substantive WTE decreased by 7 WTE between end of June and end of July.

Despite notable growth in multiple staff groups (APST +18 WTE, A&C Div +11 WTE), reductions across other staff groups, particularly Resident Doctors (-31 WTE) ahead of the August rotation resulted in a net decrease in substantive staff.

Bank & Agency WTE

Total Bank and Agency use increased by 42 WTE in July 2026.

Bank increased by 5% (38 WTE) and

Agency increased by 13% (4 WTE) in July 26, compared with previous month.

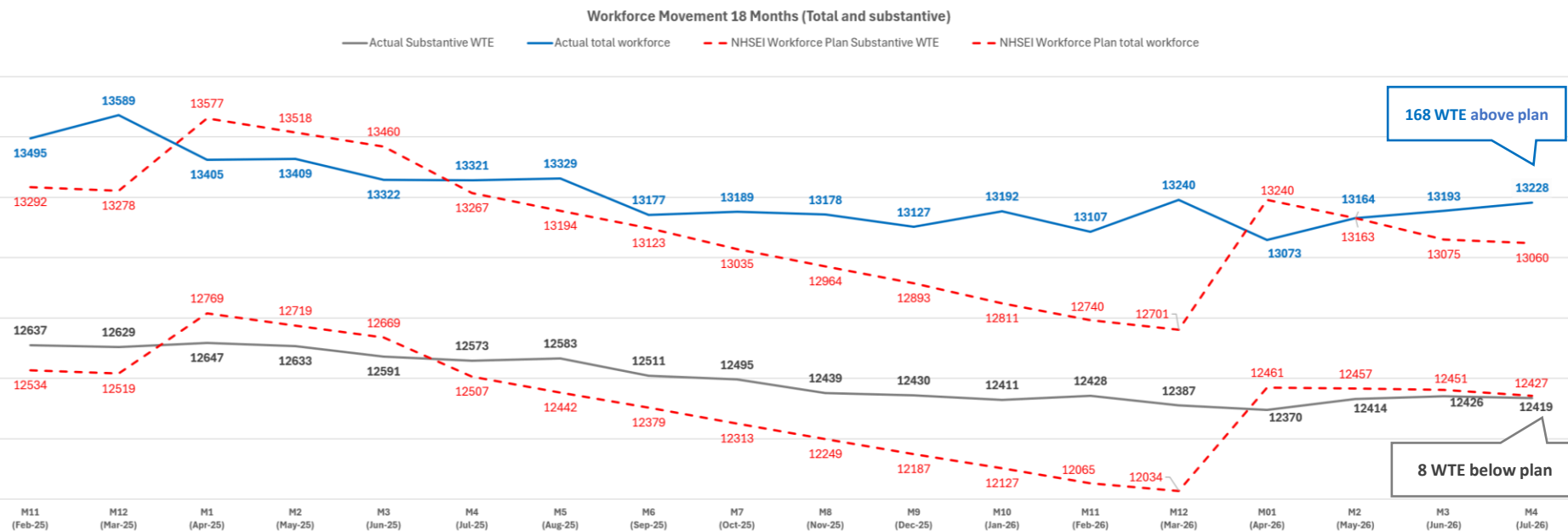
Pressures:

Continued heatwaves: substantial rise in A&E attendances, higher admission rates, increased patient acuity.

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

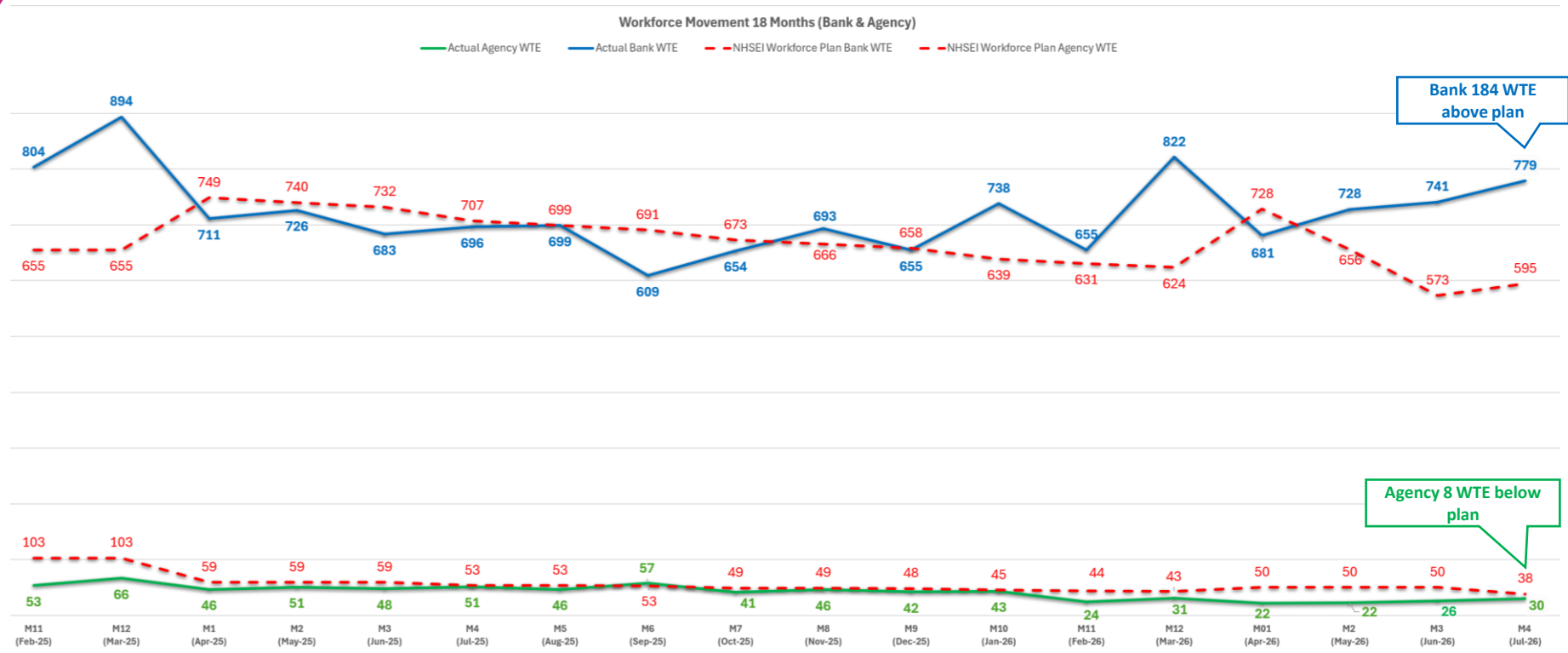
Staffing challenges in Critical Care and Theatres.

Workforce Trends: Total & Substantive



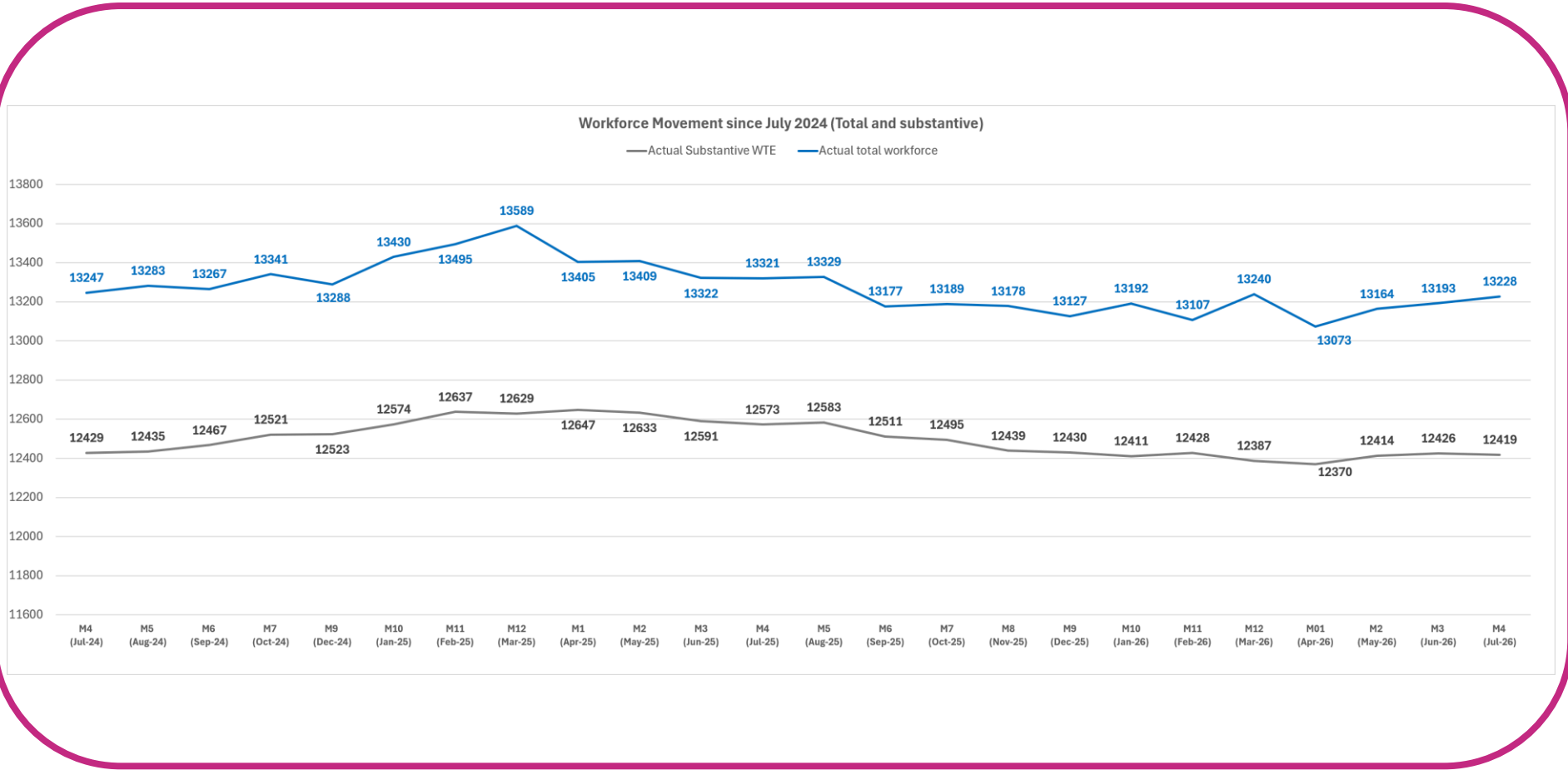
Source: ESR, THQ Medical Bank, NHSp and 247 Agency as of July 2026.

Workforce Trends: Bank & Agency



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

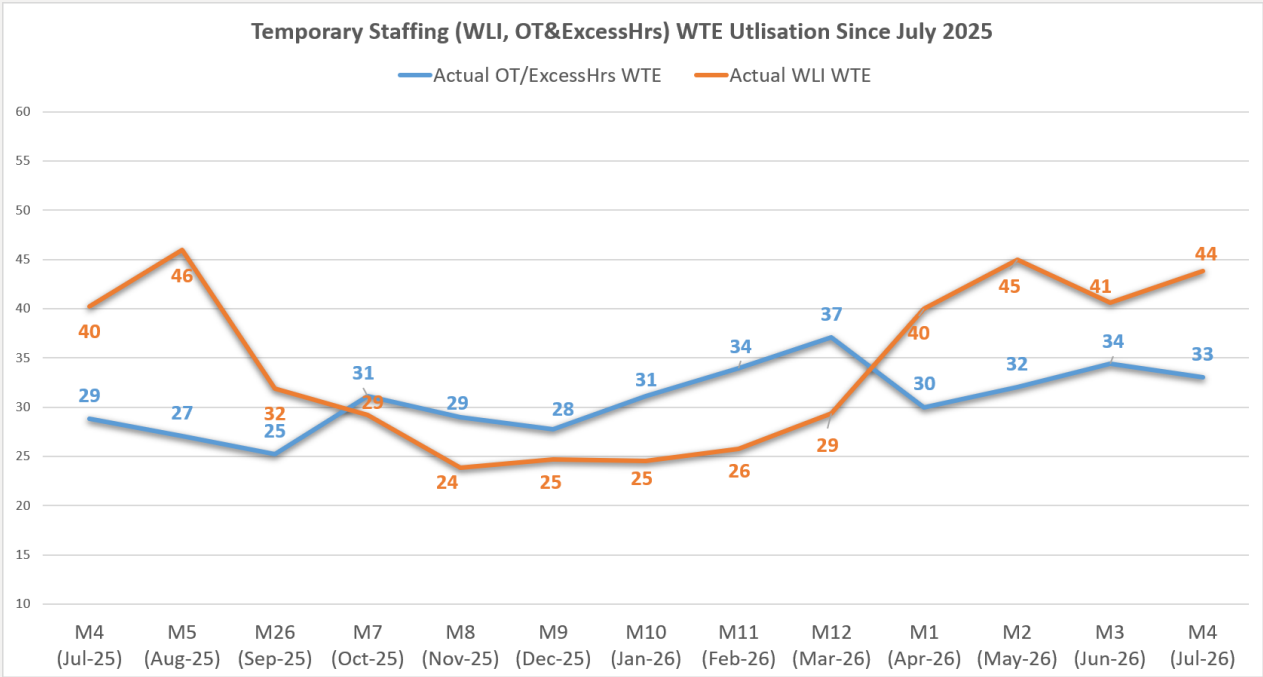
Total & Substantive Over Last 2 Years



Source: ESR, THQ Medical Bank, NHSp and 247 Agency as of July 2026.

Workforce Trends: WLI and Overtime

WLI Movement	M4- M5 2025	M5- M6 2025	M6- M7 2025	M7- M8 2025	M8- M9 2025	M9- M10 2026	M10- M11 2026	M11- M12 2026	M12- M1 2026	M1- M2 2026	M2- M3 2026	M3- M4 2026
	6	-14	-3	-5	1	0	1	4	11	5	-4	3



Source: Healthroster as of July 2026

Quarterly People Heatmap – 2026/27 Q1

	THRIVE			EXCEL			BELONG	
	AWL as of M12 (Jun 26)	% 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	12051	9.05%	697.0	64.7%	4.0%	46.9%	12.8%	11.1%
Division A Overall	4074	7.8%	191.4	65.7%	4.1%	39.1%	17.3%	13.1%
CV&T	950	6.2%	50.7	67.4%	4.2%	38.9%	18.7%	12.9%
Critical Care, Theatres and Anaesthetics	1575	7.4%	70.4	66.5%	4.3%	41.9%	100.0%	16.7%
Neuro	473	8.2%	24.8	62.1%	3.4%	22.2%	17.4%	10.5%
Surgery	616	8.7%	25.2	55.2%	3.6%	41.2%	14.1%	12.7%
T&O	461	7.8%	20.2	77.3%	4.1%	23.1%	21.2%	15.2%
Division B - Overall	3278	9.1%	114.2	62.4%	3.9%	48.2%	14.5%	15.5%
Cancer Care	735	8.7%	27.6	65.3%	4.1%	56.8%	17.1%	18.6%
Emergency Care	747	9.8%	20.4	57.3%	4.3%	60.0%	10.3%	18.7%
Medicine	840	10.7%	48.2	74.1%	4.4%	38.3%	26.5%	6.1%
H&IOWAA	0	5.9%	0.0	18.5%	1.0%	NA	0.0%	9.5%
Ophthalmology	315	9.9%	12.1	55.9%	4.1%	32.1%	14.3%	5.7%
Specialist Medicine	641	6.7%	6.0	56.7%	4.0%	35.7%	13.3%	16.7%
Division C - Overall	3754	9.1%	257.5	62.3%	4.1%	48.4%	10.4%	12.5%
Child Health	879	7.2%	43.6	66.6%	3.9%	30.6%	1.6%	12.2%
Clinical Support	931	10.8%	128.2	69.8%	2.6%	52.7%	14.0%	10.5%
Pathology	598	10.0%	38.2	55.9%	5.0%	53.3%	13.2%	16.7%
Radiology	483	8.2%	18.9	69.8%	3.0%	38.7%	9.8%	10.9%
Women & Newborn	862	8.2%	28.7	51.4%	4.9%	56.3%	6.9%	18.2%
THQ - Overall	944	10.4%	133.9	74.3%	4.1%	48.8%	11.8%	12.0%
Chief Finance Officer	104	11.4%	25.0	52.1%	2.9%	33.3%	11.5%	13.1%
Chief Operating Officer	174	16.5%	1.0	73.2%	7.0%	75.0%	17.1%	5.7%
Clinical Development	84	15.9%	4.8	79.2%	5.0%	17.6%	9.4%	24.5%
Informatics	236	3.0%	26.4	75.3%	2.7%	38.9%	16.5%	10.6%
People / HR	149	11.7%	20.0	78.1%	4.1%	40.0%	7.1%	12.9%
Research and Development	386	12.3%	19.7	80.1%	3.4%	61.7%	11.5%	8.3%
Training & Education	197	11.5%	37.0	89.1%	4.2%	66.7%	0.0%	11.1%

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

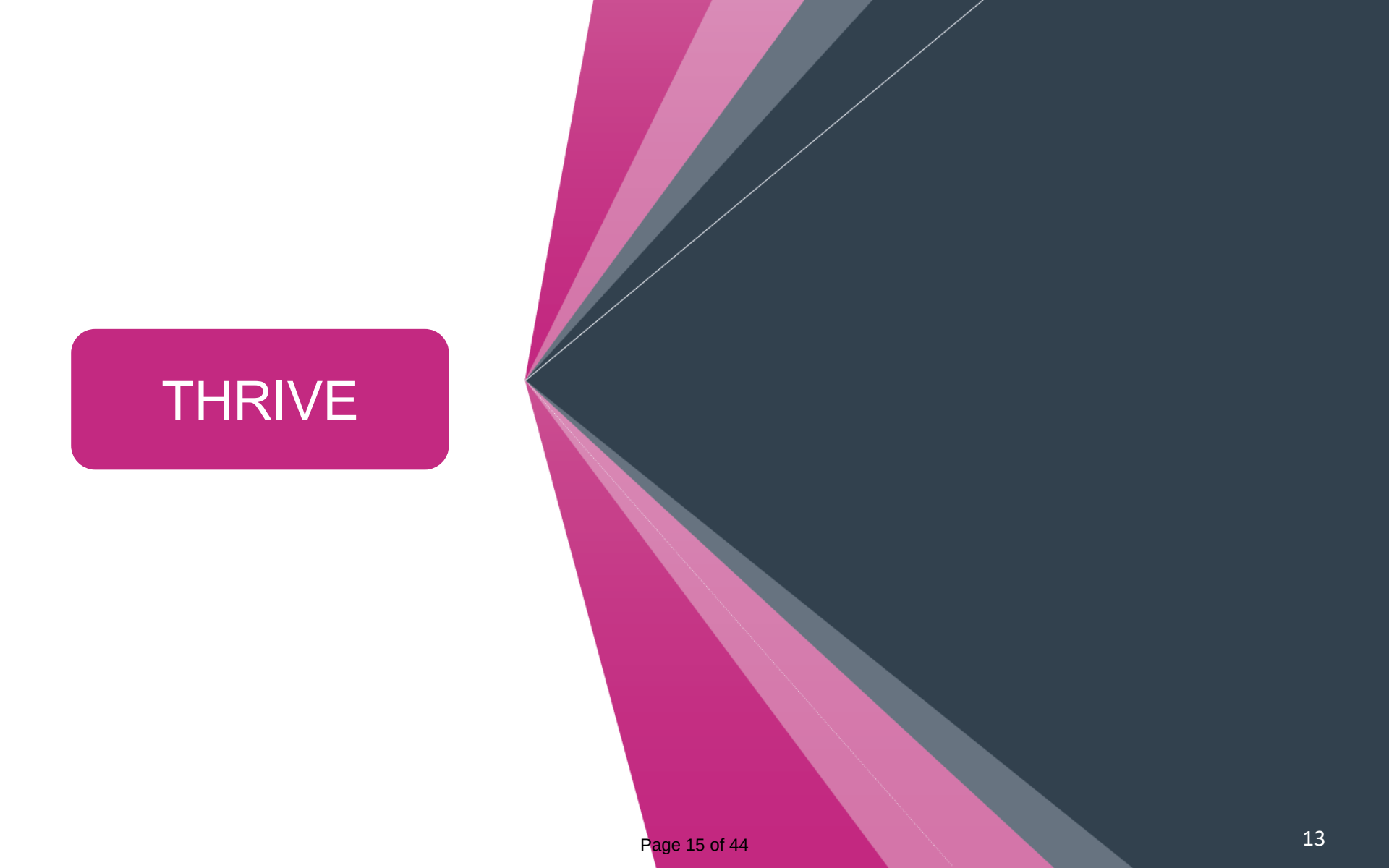
Substantive SIP by Staffing Group

Substantive Monthly Staff in Post (WTE) Last 18 Months																				
	24/25		25/26												26/27				Movement	
	M11 (Feb)	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)	M3 to M4	YTD
Add Prof Scientific and Technic	297	302	301	300	300	312	303	306	307	303	304	301	305	303	304	305	306	324	↑ 18	↑ 12
Additional Clinical Services	2104	2107	2121	2123	2134	2131	2117	2101	2074	2064	2059	2041	2033	2030	2018	2039	2041	2045	↑ 4	↓ -86
Administrative and Clerical (Divisions)	1348	1352	1352	1350	1327	1316	1298	1282	1273	1258	1257	1254	1246	1248	1248	1244	1249	1260	↑ 11	↓ -56
Administrative and Clerical (THQ)	900	902	899	893	879	874	859	826	822	808	805	800	799	796	794	797	800	799	↓ -1	↓ -75
Allied Health Professionals	821	817	823	822	832	831	839	842	849	849	849	846	847	846	852	858	849	851	↑ 1	↑ 20
Estates and Ancillary	415	416	414	409	407	403	398	392	387	387	413	408	406	404	401	403	405	404	↓ -1	→ 1
Healthcare Scientists	518	521	523	520	523	524	522	523	525	523	523	523	527	523	521	521	519	515	↓ -4	↓ -8
Consultant & Career Grade Doctor	983	984	990	983	982	986	991	989	989	985	984	986	983	982	987	991	992	990	↓ -2	↑ 3
Resident Doctor	1152	1146	1145	1140	1132	1125	1198	1194	1200	1185	1176	1178	1201	1192	1176	1176	1181	1151	↓ -31	↑ 26
Nursing and Midwifery Registered	4032	4013	4010	4024	4008	4003	3990	3990	4010	4024	4010	4025	4028	4012	4017	4030	4034	4031	↓ -3	↑ 27
Students	69	69	70	69	68	68	68	67	60	54	50	49	53	51	52	50	49	49	→ 0	↓ -19
Grand Total	12637	12629	12647	12633	12591	12573	12583	12511	12495	12439	12430	12411	12428	12387	12370	12414	12426	12419	↓ -7	↓ -154

Source: ESR substantive staff as of July 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 by Staffing Group

Total Monthly Workforce (WTE) Last 18 Months (Substantive, Bank and Agency)																				
	24/25		25/26												26/27				Movement	
	M11 (Feb)	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)	M3 to M4	YTD
Add Prof Scientific and Technic	298	303	302	303	303	315	305	307	310	306	307	303	306	305	305	307	309	329	↑ 20	↑ 14
Additional Clinical Services	2438	2475	2419	2430	2421	2432	2421	2379	2364	2365	2345	2342	2287	2341	2341	2336	2341	2361	↑ 20	↓ -71
Administrative and Clerical	2321	2330	2311	2296	2255	2241	2203	2149	2139	2107	2109	2104	2094	2106	2106	2100	2112	2128	↑ 16	↓ -112
Allied Health Professionals	844	845	844	843	849	850	855	858	862	862	864	861	862	862	862	874	866	867	↑ 2	↑ 17
Estates and Ancillary	442	443	439	437	434	418	410	414	410	411	438	436	432	433	433	433	431	433	↑ 1	↑ 15
Healthcare Scientists	528	532	532	529	531	532	531	532	534	533	533	533	537	534	534	530	531	525	↓ -6	↓ -8
Medical and Dental	2175	2174	2176	2162	2152	2165	2225	2211	2218	2209	2201	2203	2220	2211	2211	2203	2213	2187	↓ -26	↑ 22
Nursing and Midwifery Registered	4379	4418	4312	4341	4309	4300	4310	4259	4291	4331	4281	4359	4315	4396	4396	4330	4341	4349	↑ 8	↑ 50
Students	69	69	70	69	68	68	68	67	60	54	50	49	53	51	52	50	49	49	↓ 0	↓ -19
Grand Total	13495	13589	13405	13409	13322	13321	13329	13177	13190	13178	13127	13192	13107	13240	13240	13164	13193	13228	↑ 35	↓ -93

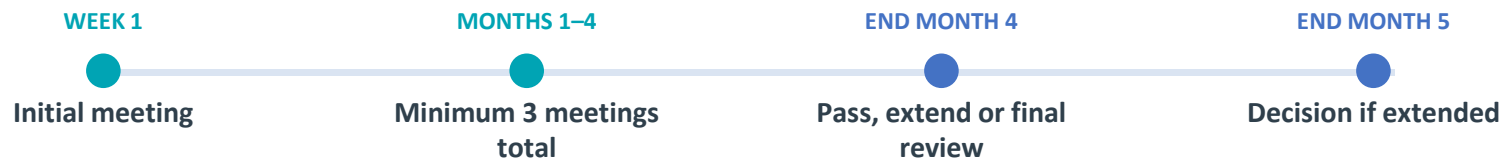


THRIVE

New probation policy at a glance

UHS has changed its probation policy for new starters joining on or after 1 July 2026 due to the Employment Rights Act giving all employees unfair and uncapped dismissal rights after 6 months employment from 1 January 2027

The new four-month process helps managers act early, document decisions and reduce legal, service and safety risk.



Manager essentials

- Set SMART objectives and measures.
- Record each discussion; review competencies and evidence.
- Address attendance, conduct, performance or safety concerns early.
- Seek Employee Relations advice before an extension or final review.

Decision discipline

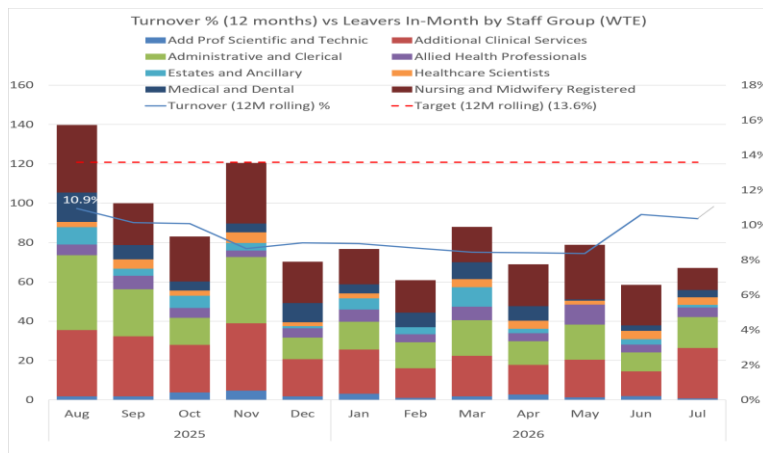
- FAIL** (Red dot) Use the final review process where evidence supports this.
- EXTEND** (Orange dot) Exceptional only; maximum one month and consult ER.
- PASS** (Green dot) Confirm when required standards and competencies are met.

WHY IT MATTERS Missed reviews or weak evidence can mean default passing of probation, unresolved under-performance and legal, operational and financial exposure.

Employee Relations: HREmployeeRelationsUnit@uhs.nhs.uk | Ext. 6525, option 4 | Mon–Fri, 08:00–18:00



Turnover



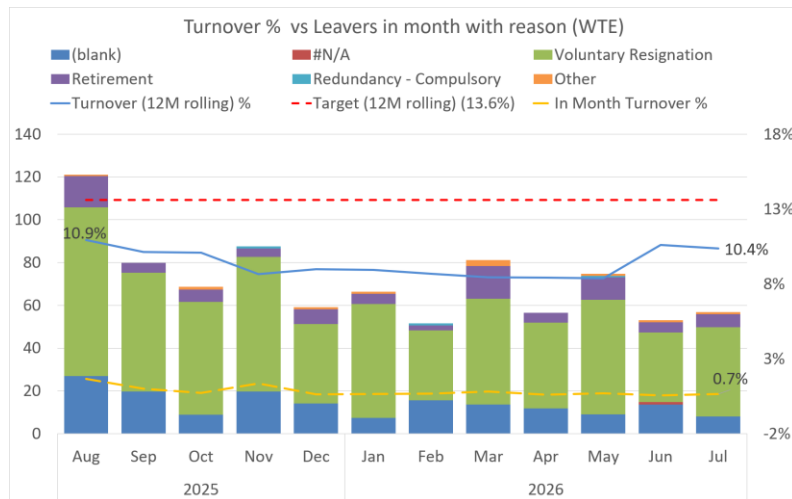
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	0.8	0.3%	8.8%
Additional Clinical Services	25.7	1.2%	12.9%
Administrative and Clerical	15.7	0.7%	10.6%
Allied Health Professionals	4.8	0.6%	7.8%
Estates and Ancillary	1.4	0.3%	20.0%
Healthcare Scientists	3.7	0.7%	7.4%
Medical and Dental	3.8	1.0%	13.2%
Nursing and Midwifery Registered	11.2	0.3%	6.7%
UHS total	67.2	0.7%	10.4%

In July 2026, there was a total of 67.2 WTE leavers, 12.7 WTE less than June 2026 (54.5 WTE). Division C recorded the highest number of leavers (23 WTE). Within Division C, Additional Clinical Services staff group had the highest number of leavers (12.8 WTE).

Divisions A and B had the next highest number of leavers (17.2 and 18.8 WTE respectively); with the largest number of leavers for Division A being the Nursing and Midwifery staff group (8.8 WTE). And the largest number of leavers for Division B being the Additional Clinical Services staff group (8.6 WTE)

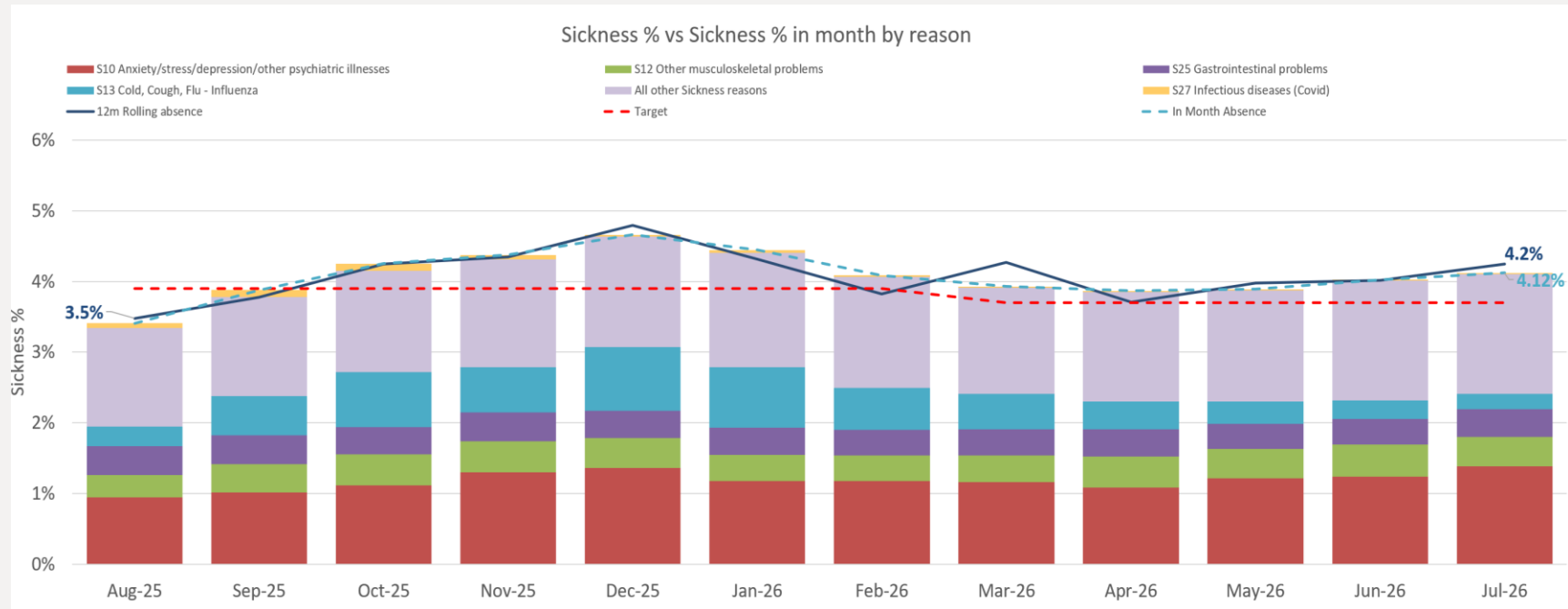
Total leavers by division are as follows:

- Division A: 17.2 WTE leavers
- Division B: 18.8 WTE leavers
- UEL: 2.4 WTE leavers
- Division C: 23 WTE leavers
- THQ: 5.8 WTE leavers



Sickness

Current in-month sickness: 4.12% | Rolling 12-month sickness: 4.20% | Year-to-date sickness 4.08%



Source: ESR – July 2026

Temporary Staffing

Qualified Nursing (WTE)

- Demand increased from 404 in July to 412 (+8)
- Bank fill increased from 289 to 297 (+8) from previous month.
- Agency filled increased 21 (+3 from the previous month).
- Unfilled shifts decreased: 94 remained unfilled (-3 on previous month).
- Year-on-year demand increased: 72 higher than July 2025

Healthcare Assistants (HCA) (WTE)

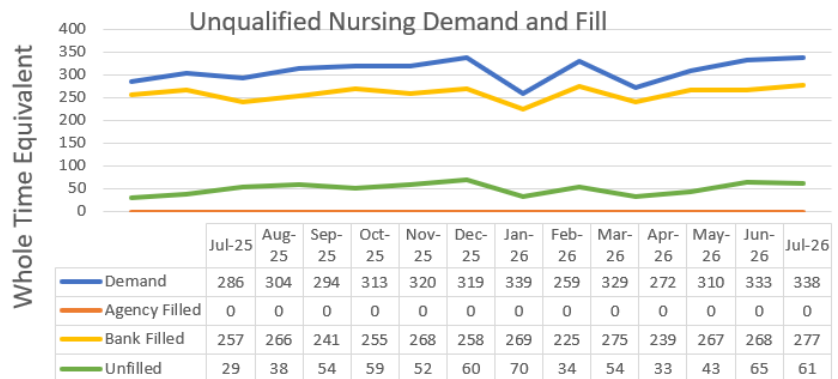
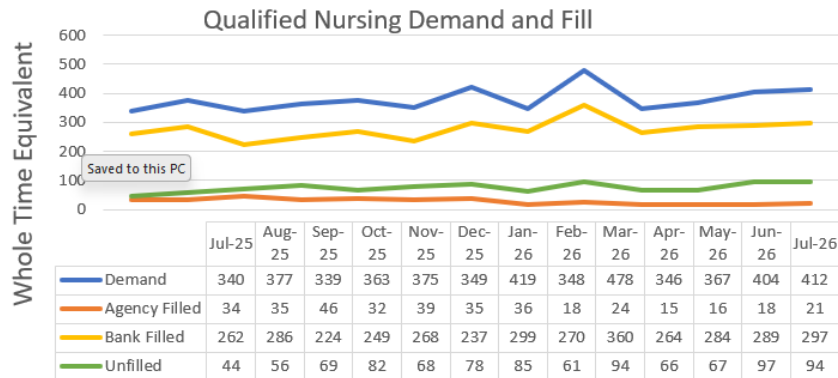
- Demand increased from 333 to 338 (+5).
- Bank filled increased from 268 to 277 (+9)
- Unfilled shifts decreased: from 65 to 61 (-4 on prior month)
- Year-on-year demand increased: 52 higher than July 2025.

Actions

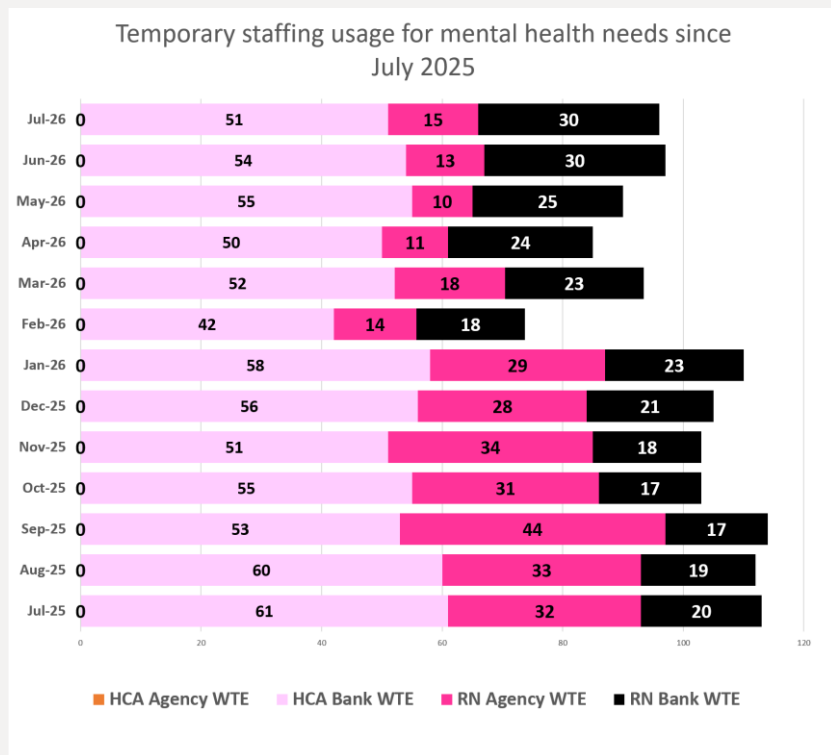
During July, there was a strong focus on Critical Care and Theatres due to ongoing staffing challenges. Agency workers were engaged to support service delivery and minimise the risk of cancelled procedures. This work continues in close collaboration with Matrons.

Demand increased compared with the previous month across both Registered Nurse (RN) and Healthcare Assistant (HCA) roles, resulting in an overall increase of 13 WTE in demand and 20 WTE in fill. Demand was also significantly higher than the same period last year, with an increase of 124 WTE.

Mental Health demand also increased compared with the previous month (+1 WTE).



Temporary Staffing: Mental Health



Mental Health Staffing Summary – July 2026

Total Temporary Staffing: 96 WTE (Whole Time Equivalent) -1 WTE compared to prior month.

Registered Mental Health Nurses (RMNs): 45 WTE (increase of 2 WTE), of which 15 WTE were agency (+2 WTE on previous month) and 30 WTE were bank staff (same as prior month).

Healthcare Assistants (HCAs): 51 WTE (decrease of 3 WTE on prior month).

Year-on-Year Comparison: 17 WTE decrease compared to July 2025 (+10 WTE increase in HCAs, -17 WTE decrease for agency RMN).

Key Challenges & Actions

1. Ongoing Pressures

Rising mental health demand continues to create significant safety, quality, and financial pressures. UHS is escalating concerns to the ICB. Collaborative work is in process with NHSE through the ETOC project to review the Enhanced Care strategy and delivery model. Regular project meetings are being held to discuss the ETOC project.

2. Transition from Agency to Bank Staff

Agency shift fill rates have reduced as part of the planned transition to Bank staffing. The strategy aims to improve workforce stability and strengthen governance. NHSP pay rates are currently higher than agency charges, increasing overall staffing costs. This cost impact has been escalated for review within the Southeast Collaborative. Bank staff can work across H1OWFT, reducing local availability for HCA Enhanced Care shifts at UHS.

3. Increased RMN Use for HCA Shortfalls

There are still instances where HCA shifts are not being filled and are subsequently backfilled with RMNs. Governance processes have been strengthened to ensure robust oversight and approval when RMNs are deployed to cover HCA shortfalls.

4. Band 2/3 Review of Enhanced Care HCAs

From 1 July 2026, all Enhanced Care HCAs will be paid at Band 3. To remain compliant with the requirements of this role, all Enhanced Care HCAs must ensure that they have completed all required training and competencies by 31 July 2026.

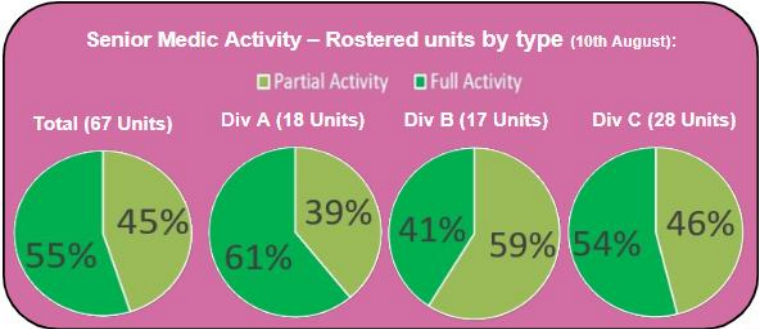
5. Temporary Workforce Quality

Ongoing work is focused on developing a workforce suitable for an acute hospital setting. Actions include: delivery of in-house Maybo PMVA and BILD Act-accredited training, training is bespoke to UHS and provided to all Bank staff, 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.

Workforce: Medical Rostering and Job Planning

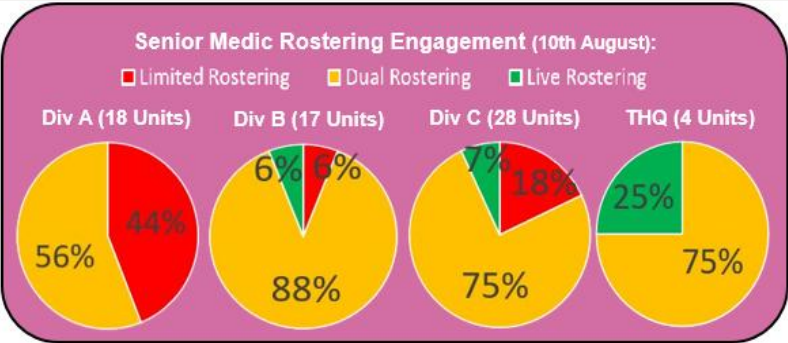
Rostering

Senior medical units set up with activity rostering, split between partial & full activity:



- 6% of units are using the HealthRoster system as a live rostering tool
- 73% of units are 'Dual Rostering' (rostered alongside other existing rostering tools)
- 21% of units are not using or have 'Limited Rostering'

Divisional breakdown for Rostering Engagement:



Job Planning

Job Plans signed off in the last 12 months:

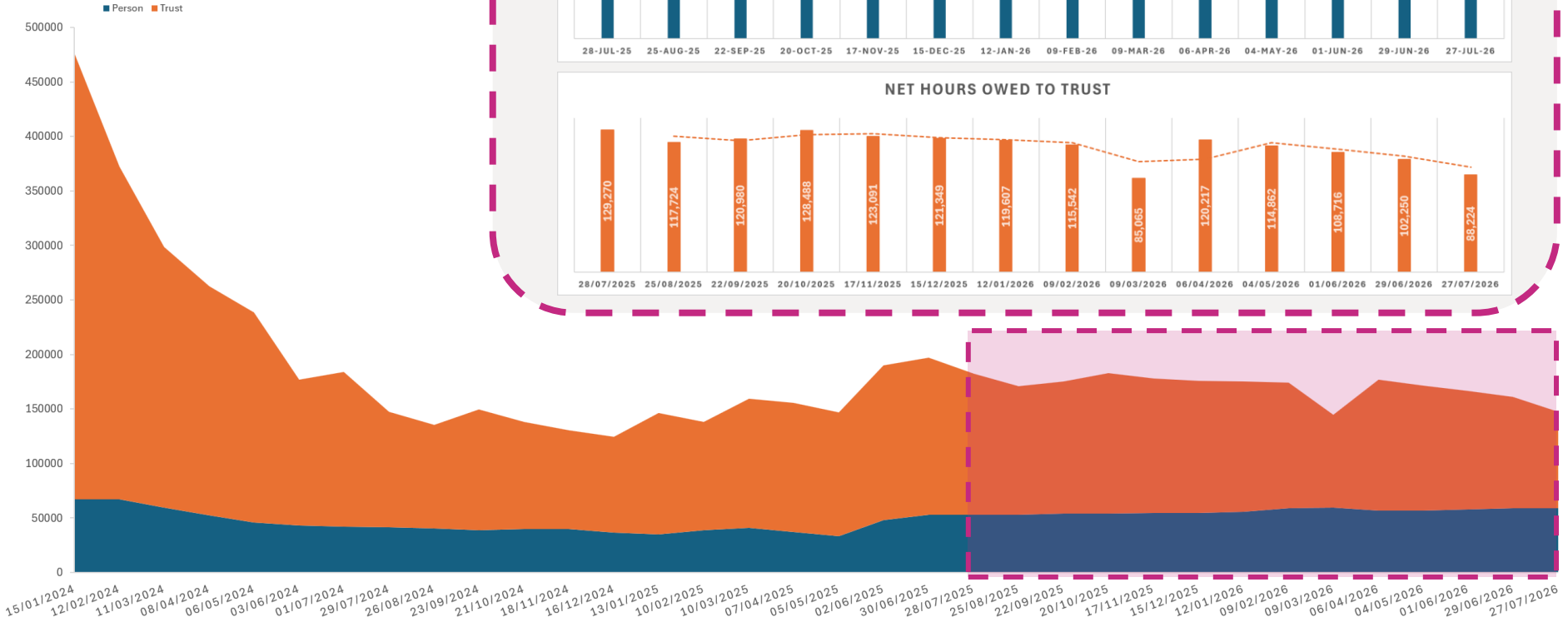
	NHS England / PWR Reporting (excludes non-substantive staff; clinical academics, locums or fixed term less than 6 months)
Consultants	83% 750 of 901
SAS Doctors	65% 59 of 91
Active Accounts	92% logged into during the last 12 months

Planned future activities:

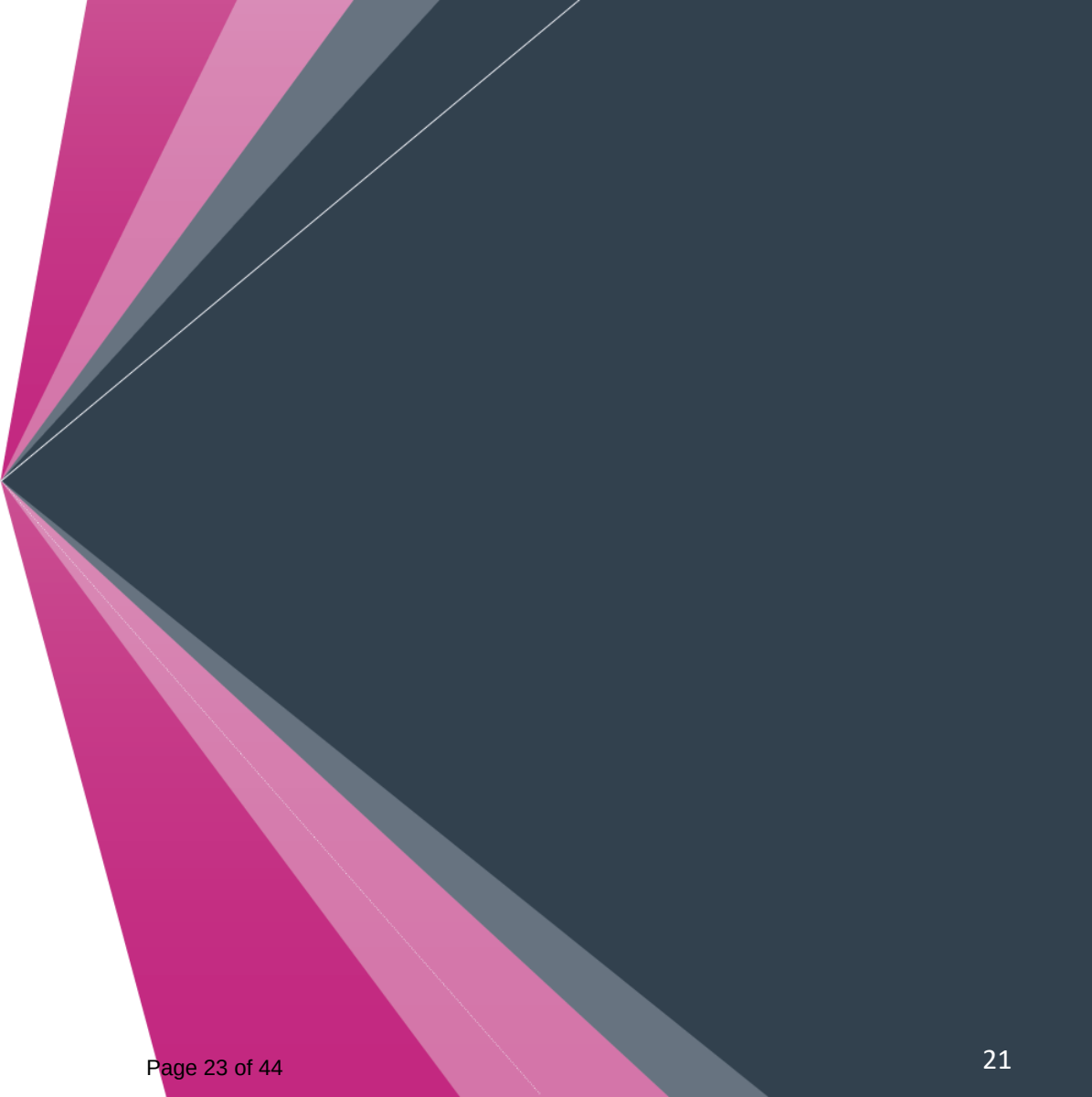
- Finalising job plan policy (in alignment with new trust policy template) for ratification
- Progressing service job planning for Cardiac Surgery, Cancer Care and the Emergency Department
- Identifying accounts that will be able to extend existing job plans
- Launch of individual job plan renewal
- Internal sign off for Job Plan Policy and Toolkit
- Share service job plan templates

Net Hours

TOTAL NET HOURS TREND



- Since the start of the net hours project in Jan 24, there has been a **12% reduction** in hours owed to staff, and a **78% reduction** in hours owed to the trust
- In comparison with this time last year, there has been a **11% increase** in net hours owed to staff, and a **32% decrease** in net hours owed to the trust



EXCEL

Apprenticeships

Following approval by TEC in May 2026 of 45 apprenticeship starts (with a run rate reduction of £214k), an additional six apprenticeship places have been approved, increasing the total to 51 starts for 2026/27 with a run rate reduction of £229k (as agreed by CFO). This is affordable due to NHS England backfill for ODP and Nurse Associate apprenticeships.

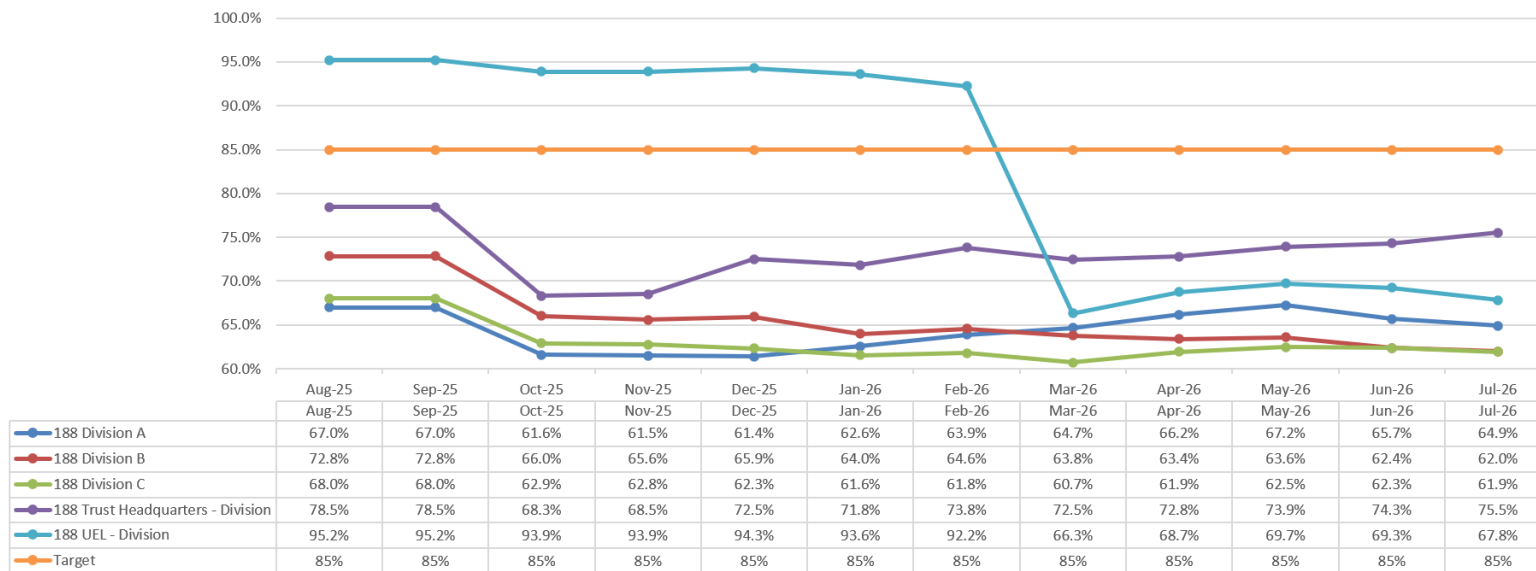
This prioritises clinical degree apprenticeship starts in 2026/27 and ensures that the trust maintains clinical degree apprenticeships in an affordable way to support the workforce and service requirements in three to four years' time.

	Original Plan	Revised Plan
Nursing	28	30
Occupational Therapy	2	2
ODPs	8	8
Diagnostic Radiography	2	2
Therapeutic Radiography	2	2
Healthcare Scientists	3	3
Additional Posts	-	4
Total Apprenticeship Starts	45	51

Appraisals – Agenda for Change Staff

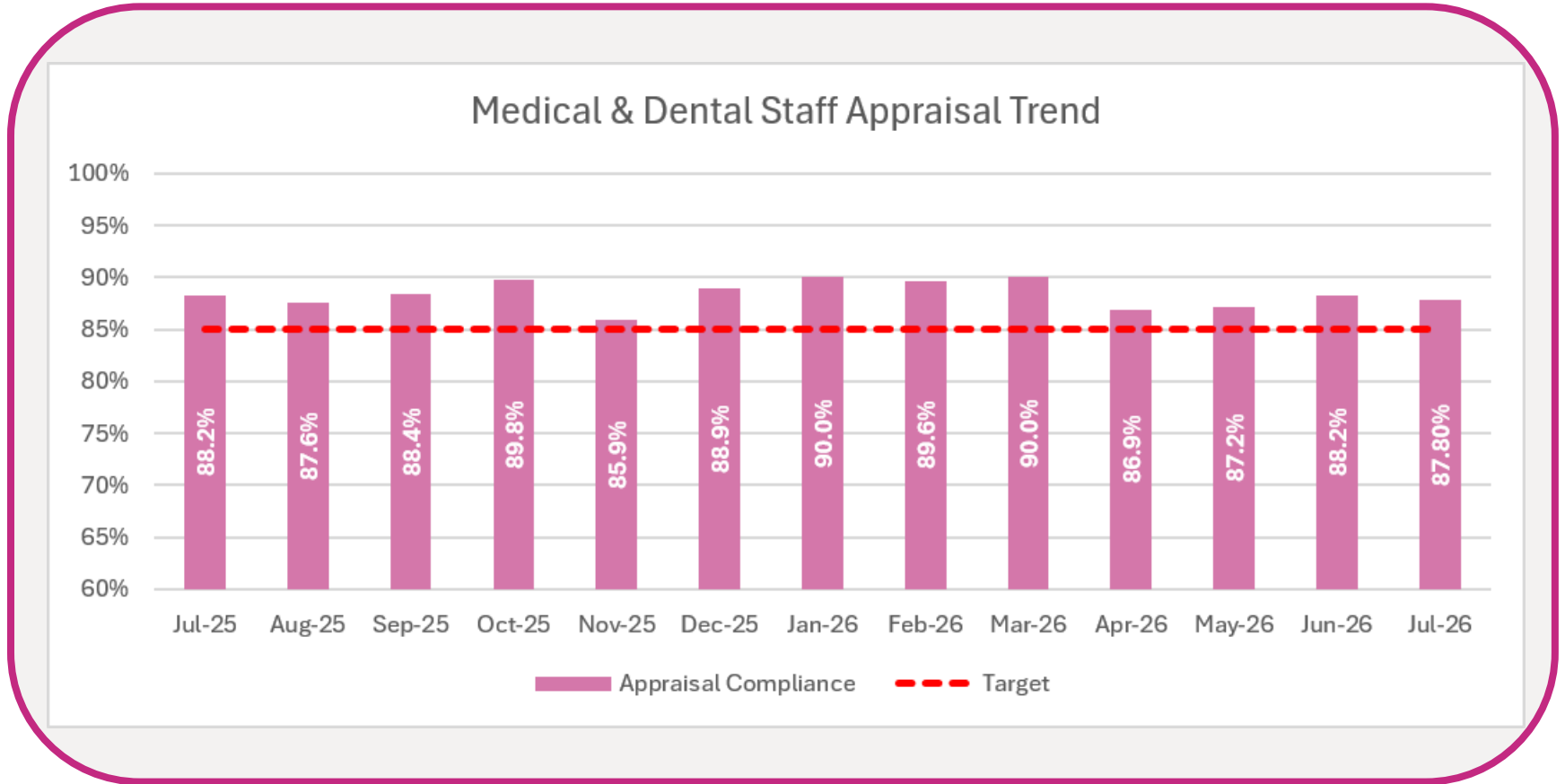
The Trust's appraisal completion rate is 64.6% as of July 2026, a decrease of 0.4% from June 2026

Divisional Appraisal Trend



UEL appraisal drops considerably in March 26, this reflects EFCD to UEL TUPE (1st April 25). By beginning as 'new' staff in the system, these staff members were automatically compliant until 31st March 26.

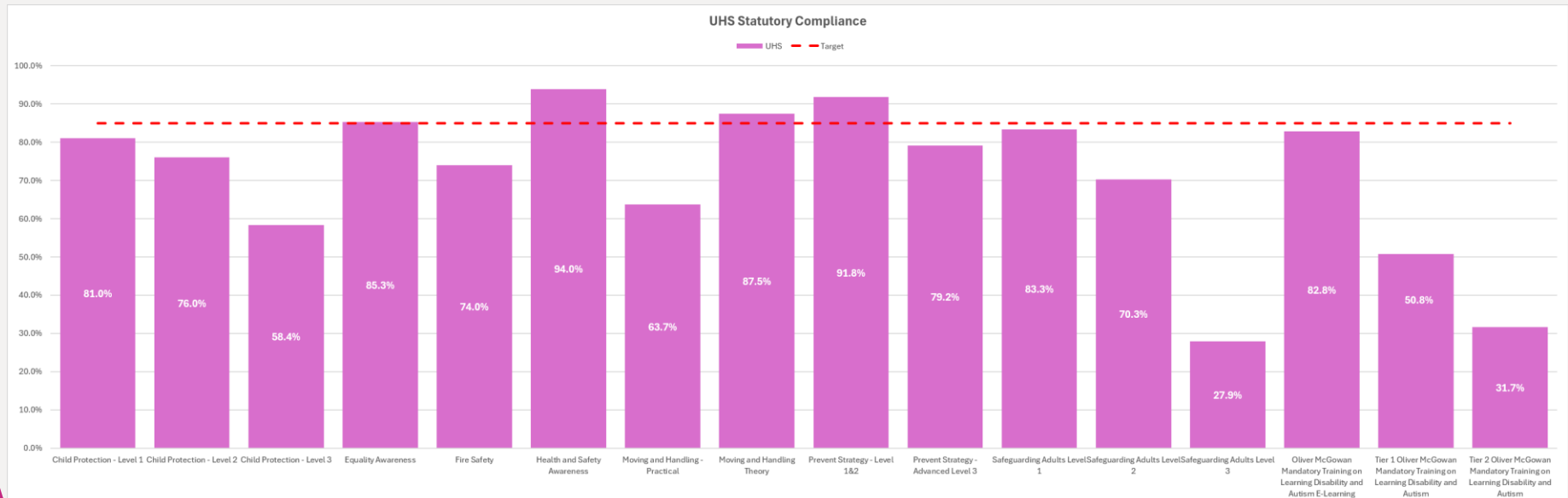
Appraisals – Medical & Dental Staff



Source: Medical HR. Appraisal data for Medical & Dental Staff Only.

UHS Statutory Compliance

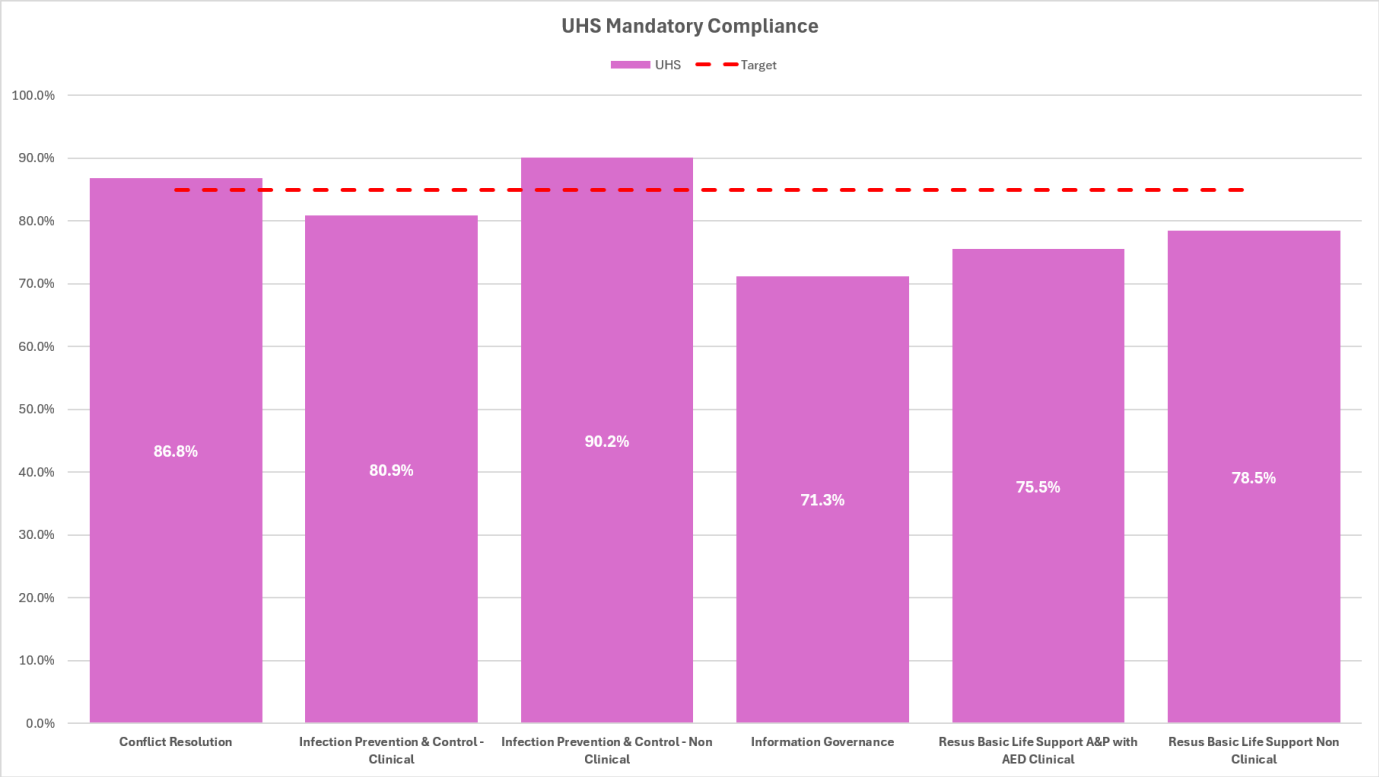
The Trust's average Statutory compliance rate for July 2026 is 71%, with 4 of 16 measures above the 85% target.



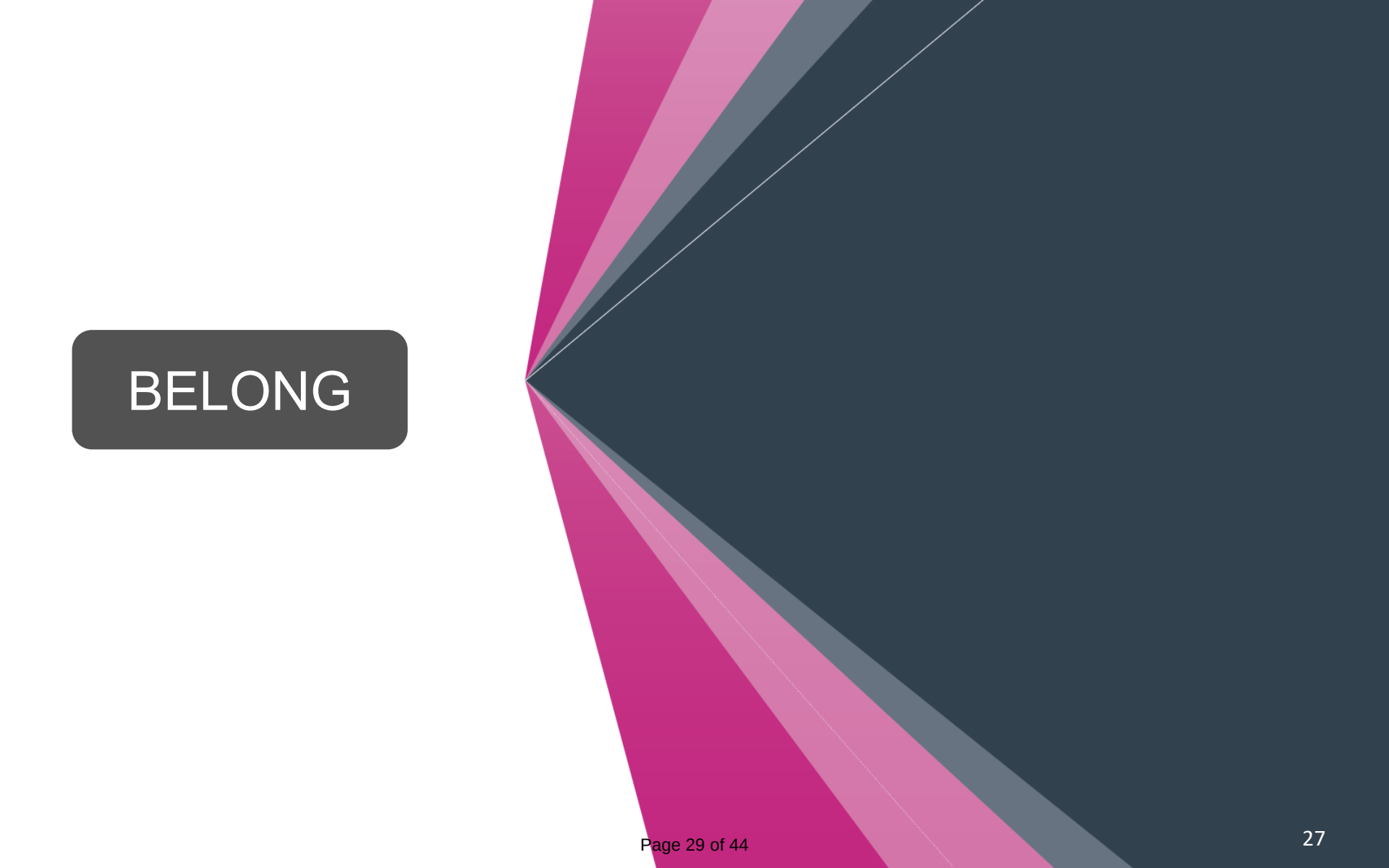
Source: Virtual Learning Environment (VLE).

UHS Mandatory Compliance

The Trust's average Mandatory compliance rate for July 2026 is 81%, with 2 of 6 measures above the 85% target.



Source: Virtual Learning Environment (VLE).



BELONG



‘We Are UHS’ Week – Celebrating Our People

12th – 16th October 2026



‘We Are UHS’ Week will be a week-long celebration and showcase of the incredible work taking place across UHS in support of our organisational goals being delivered by our people.

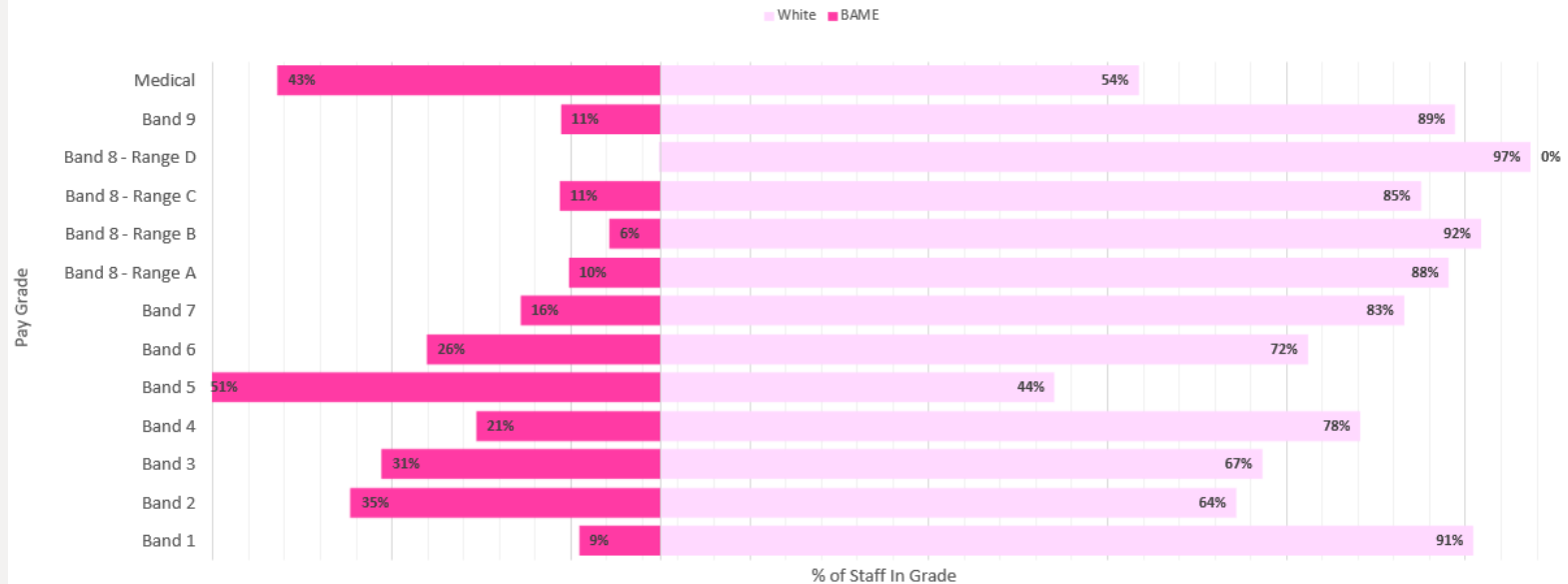
The week will provide an opportunity to:

- Celebrate and recognise the commitment, innovation and achievements of our people.
- Demonstrate the progress being made towards our organisational goals.
- Showcase the transformation and improvement work taking place every day for patients and staff.
- Highlight the role colleagues play in delivering meaningful change for the future of UHS.
- Create opportunities for staff to learn, connect, share ideas and recognise one another.
- Bring organisational priorities to life through visible, engaging activities across sites and departments.

The programme will combine recognition, engagement, learning and celebration, with each day themed around one of our organisational goals and supported by open-day style activities, departmental showcases, executive engagement and development opportunities. The week will use existing recognition mechanisms eg High5s/Spotlight/Voices along with a bespoke programme of engagement opportunities.

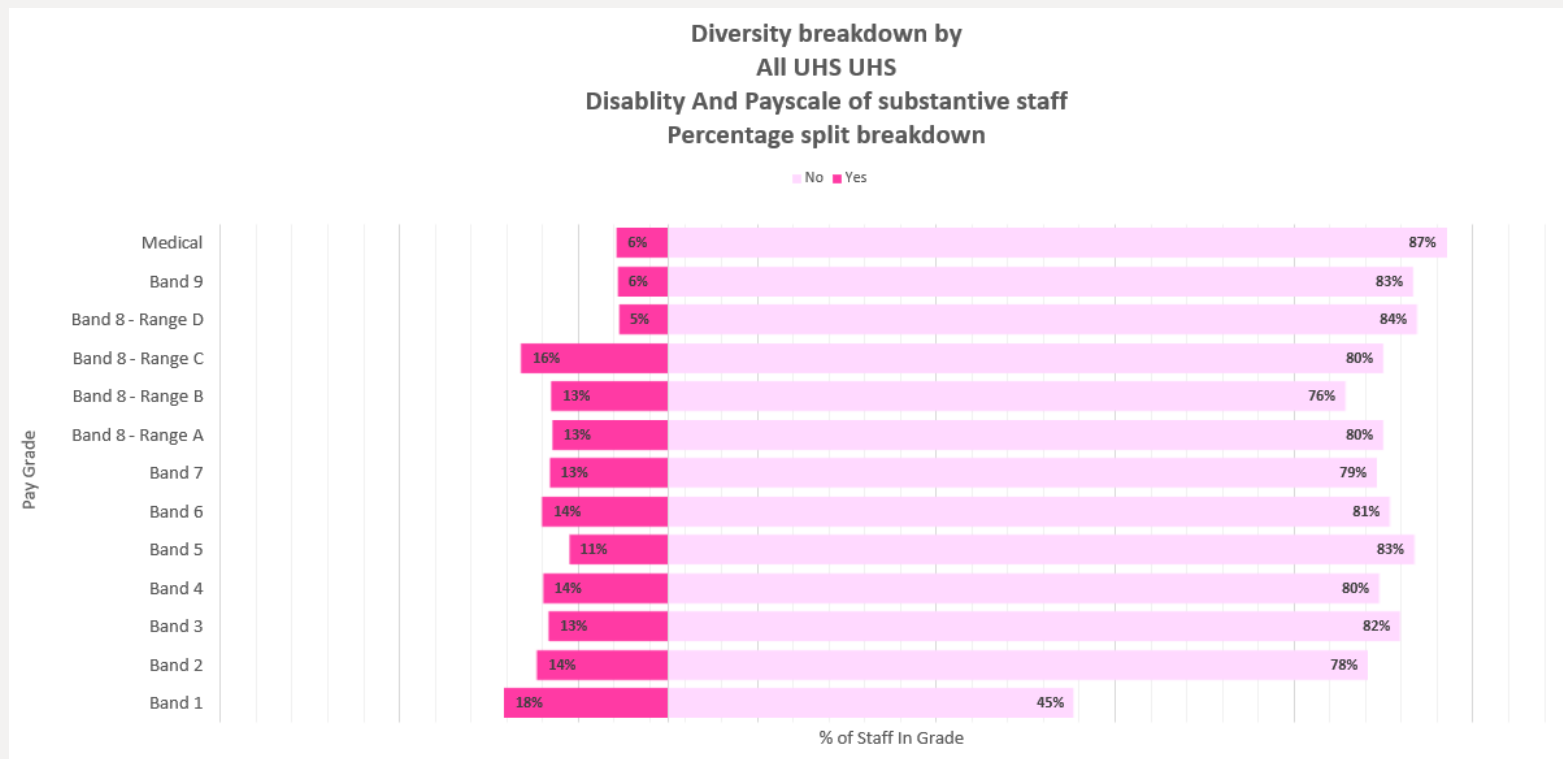
Staff in Post - Ethnicity

Diversity breakdown by
All UHS UHS
Ethnic Origin And Payscale of substantive staff
Percentage split breakdown



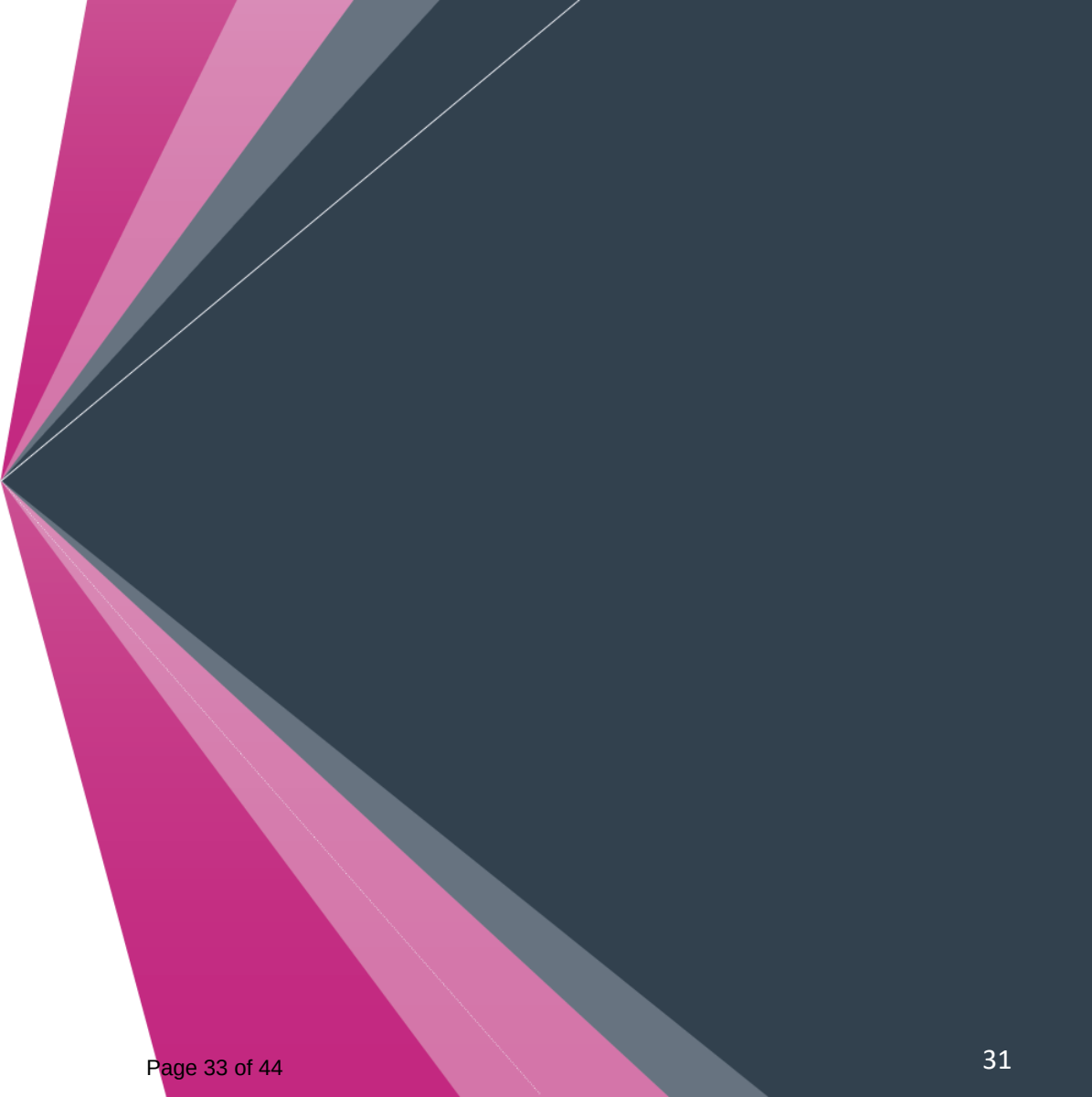
Source: ESR – July 2026

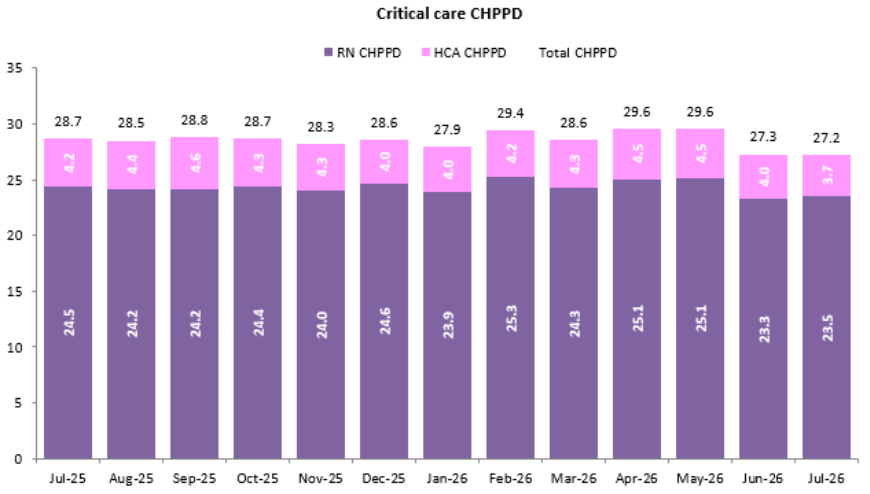
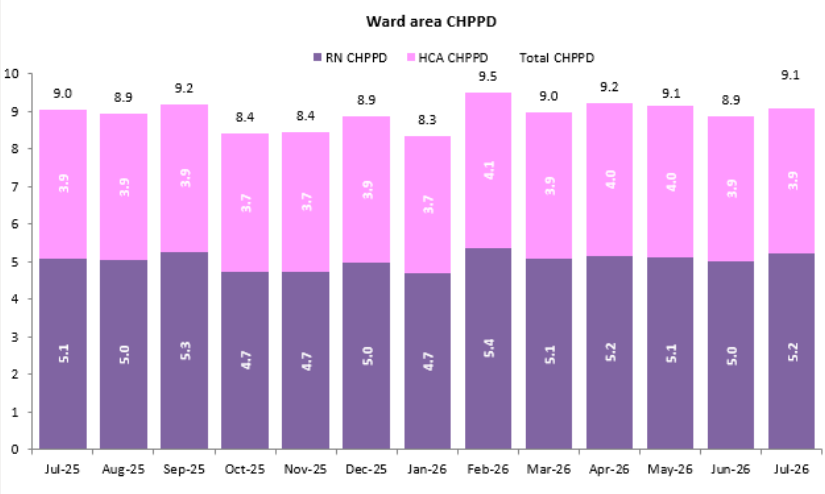
Staff in Post – Disability Status



Source: ESR – July 2026

Staffing Safety



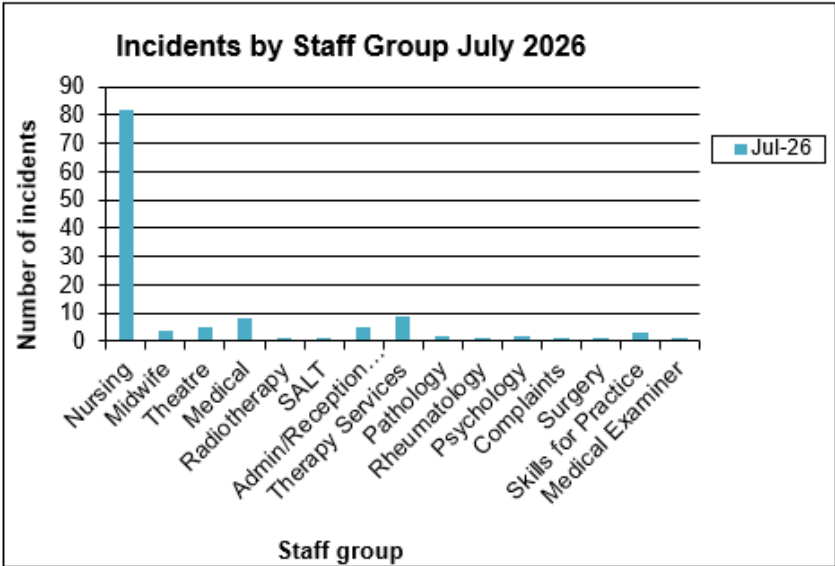


Patients continue to be cared for in different specialties/shared wards spaces as part of the recovery operation. This has continued into July 2026 with wards being repurposed or shared, and staff moving across areas to maintain staffing levels. As a result, data should be reviewed with caution as it will not accurately reflect all these arrangements as rosters and specialty codes have not always been changed in line with the ward moves and patient activity.

Source: HealthRoster, NHSP & eCamis – July 2026

Patient Safety – Staffing Incidents & Red Flags

In total 126 incident reports were received in July 2026 which cited staffing. This is an increase on the 116 reported in June. There is a continued upward trend in the severity rating of incidents.



Incidents by Division July 2026 vs June 2026

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
July 2026	44	42	35	5	126
Total	44 ↓ (46)	42 ↑ (36)	35 ↑ (29)	5 ↔ (5)	126 ↑ (116)

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
June 2026	46	36	29	5	116
Total	46 ↑ (26)	36 ↑ (21)	29 ↑ (19)	5 ↑ (1)	116 ↑ (67)

Source: Safeguard System July 2026

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

Div A:

Forty-four incidents reported in July, a slight decrease on the previous month (46). There were 9 red flags, an increase on the previous month (4).

Div B:

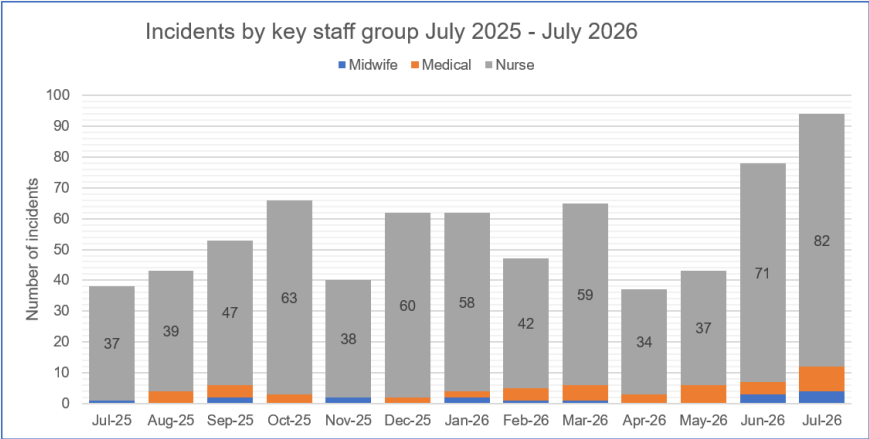
Forty-two incidents were reported in July (an increase on the 36 in the previous month). There were 12 red flags reported, an increase on the 7 reported in the previous month.

Div C:

Thirty-five incidents were reported in June (an increase on the 29 in the previous month). There were 0 red flags reported.

THQ:

Five incidents were reported in June (the same as the previous month). The incidents were reported from medical examiner's, skills for practice and complaints.



July 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	5	2	3	0
	Delay in pain relief	6	3	3	0
	Delay in observations	5	2	3	0
	Less than 2 registered	5	2	3	0
	Total	21	9	12	0

June 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	5	3	2	0
	Delay in pain relief	2	1	1	0
	Delay in observations	2	0	2	0
	Less than 2 registered	2	0	2	0
	Total	11	4	7	0

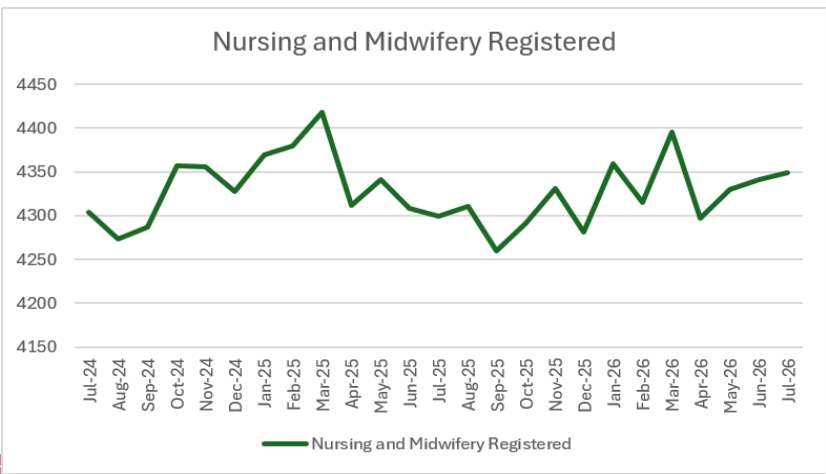
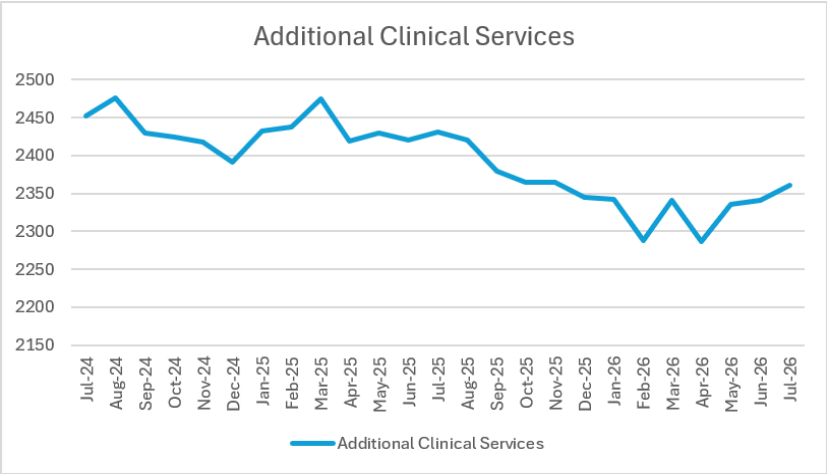
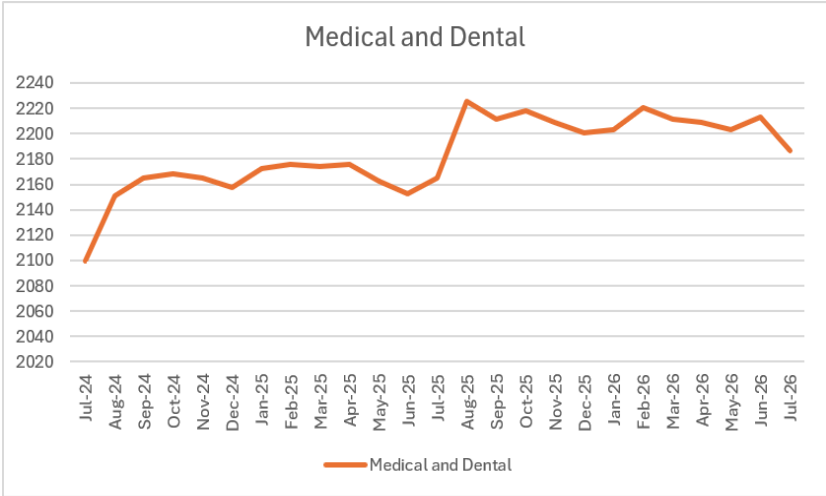
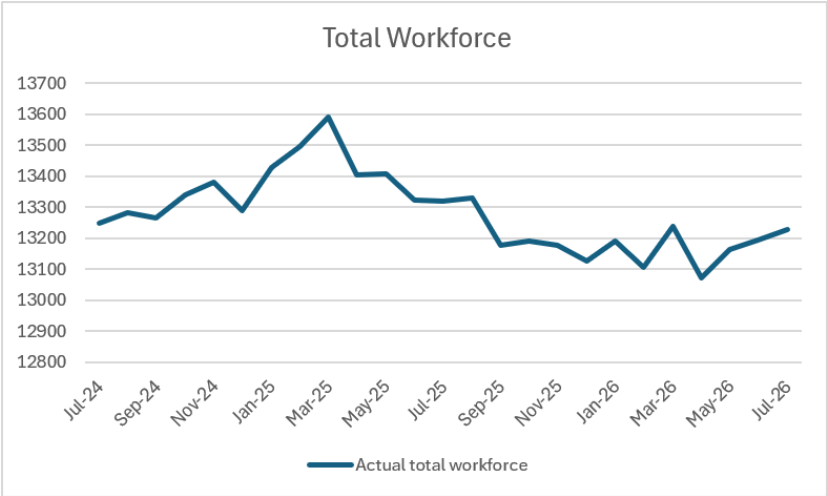
National & Regional Updates

Future NHS Workforce Solution - Programme Overview

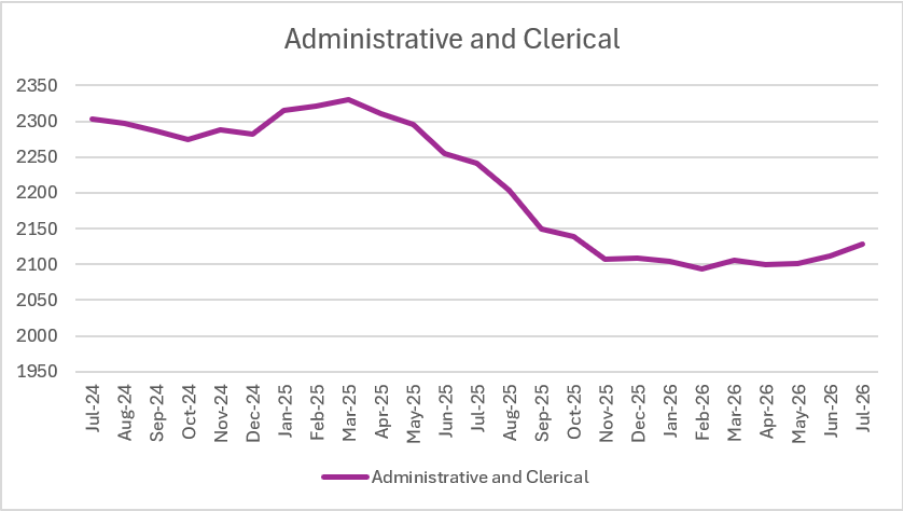
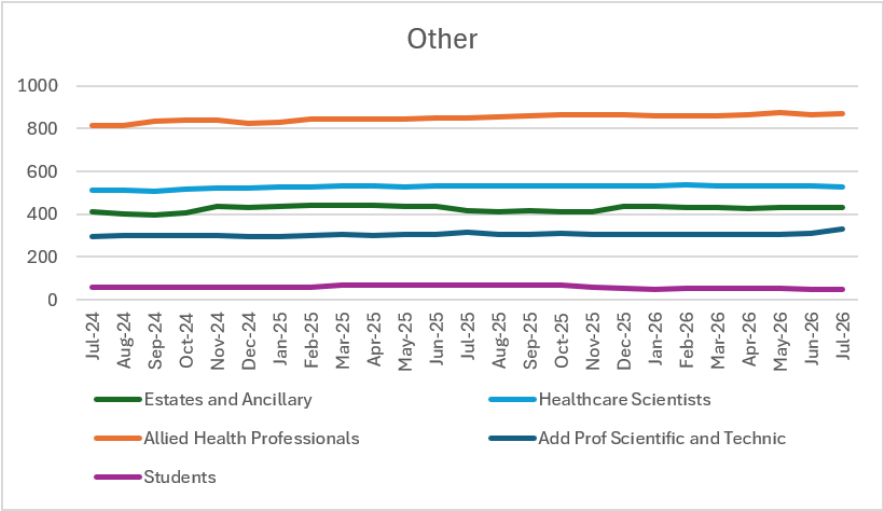
Programme Duration:	April 2026 – March 2028	Lead:	Brenda Carter	RAG status:	
Progress to date: (Apr 26 to Aug 26)				Next priorities: (Sep 26 to Nov 26)	
- UHS is an early adopter of the future NHS workforce solution to replace the incumbent ESR - The go-live date is planned to be March 2028 - A core UHS delivery team and project group have been established - A governance structure has been agreed, with key developments shared at People Board - Various tasks have been undertaken since the project’s inception: multiple introductory webinars (system landscape, integration, data cleansing / mapping), attendance at system community of practice; cleansing of high-priority data; interface / system landscape templates; identification of all shared service and third-party providers to support system integration - The domains of the future solution are listed as follows: Core HR Talent acquisition Career development Performance management Compensation and benefits Payroll Learning <td colspan="2"> - Draft job descriptions for key programme roles to support the programme - Attendance at domain walkthrough sessions and detailed process videos - Complete project plan submission, change impact assessments, exception requests to global template, complete templates for each domain (outlining how processes run in UHS and where details are captured), and sign Data Sharing Programme Agreement </td>				- Draft job descriptions for key programme roles to support the programme - Attendance at domain walkthrough sessions and detailed process videos - Complete project plan submission, change impact assessments, exception requests to global template, complete templates for each domain (outlining how processes run in UHS and where details are captured), and sign Data Sharing Programme Agreement	
Risks / Issues:				Decisions Required:	
Capacity of leads to undertake and complete core tasks				Proceed with full functionality in principle, subject to reviewing detailed functionality	
Resource requirements for data cleansing and mapping, and future activities					

Appendices

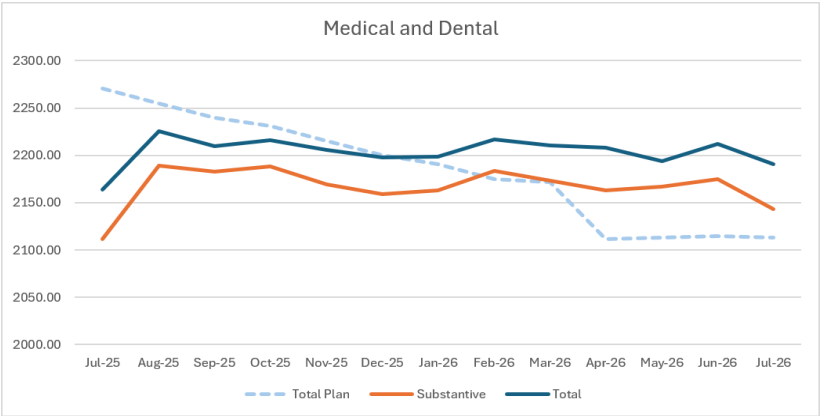
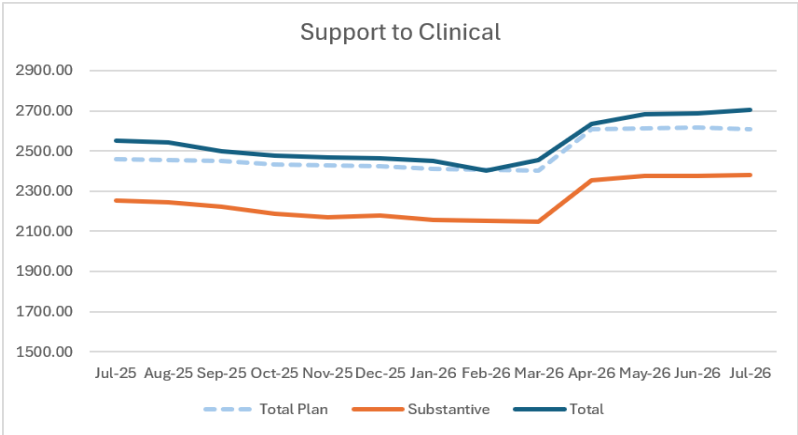
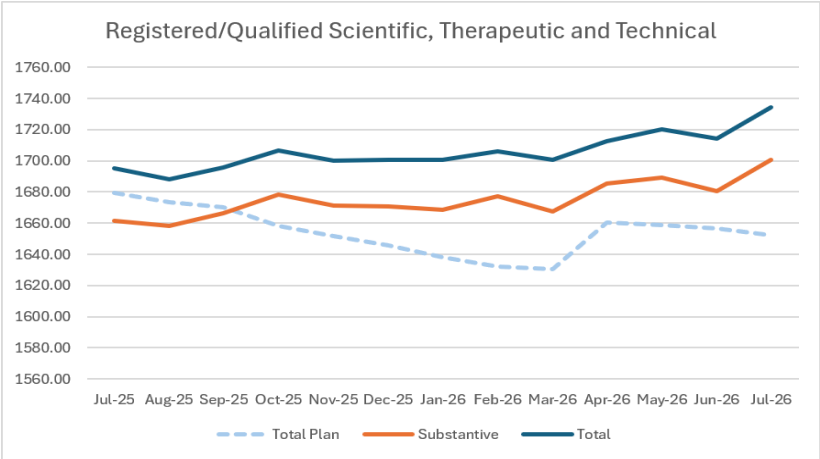
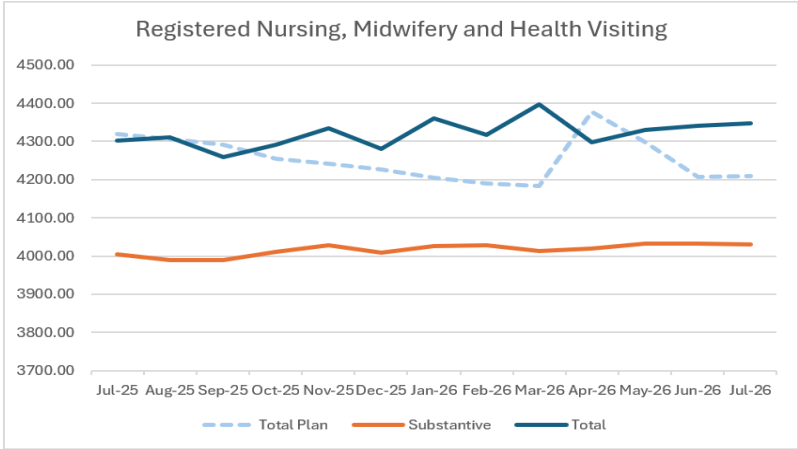
Total Workforce Graphs by Staff Group



Total Workforce Graphs by Staff Group



Progress Against Plan by Staff Group



Source: PWR– July 2026

Data Sources

Metric	Data Source	Scope
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; resident doctors' extra rostered hours)	For 26/27 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. Capital funded posts.
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	For 26/27 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions. Capital funded posts.
Temporary Staffing (WTE)	<u>Bank</u>: NHSP; MedicOnline <u>Agency</u>: Medical Locum Bank (for Medical) 24/7 (for Non-medical); all other framework and non-framework agencies	No exclusions
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/resident doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	VLE (Appraisals completed in-month and last 12 months) for AfC staff; Sard for medical appraisals	No exclusions
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



**OUTSTANDING
PEOPLE**

Agenda Item 5.9.1 Report to the Trust Board of Directors, 10 September 2026			
Title:	NHS Staff Standards: Trust Response and Implementation Plan		
Sponsor:	Steve Harris, Chief People Officer		
Author:	Katie Dunman, Senior HR Business Partner		
Purpose			
(Re)Assurance	Approval	Ratification	Information
			x
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
		x	
Executive Summary:			
This paper provides the Trust Board with an overview of the new NHS Staff Standards, published in July 2026 by the Department of Health and Social Care and NHS England. The standards set national minimum employment requirements for NHS employers across six areas that staff have identified as central to their experience at work: line management, health and wellbeing, violence prevention and reduction, championing sexual safety, tackling racism, and flexible working. Initial assessment indicates that many of the requirements of the NHS Staff Standards are already supported through existing policies, programmes of work and governance arrangements. Implementation will focus on strengthening assurance arrangements, addressing identified gaps and aligning existing activity with the national requirements. The Trust response and implementation approach were considered and approved by the People and Organisational Development Committee on 25 August 2026. The paper is now presented to the Trust Board for information and to provide visibility of the Board-level requirements within the standards.			
Contents:			
Appendix 1: Trust Response and Implementation Plan Appendix 2: What good looks like in year one Appendix 3: UHS benchmarking against the 2025 Staff Survey Appendix 4: Briefing slides on Staff Standards from NHSE			
Risk(s):			
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:		YES An equality impact assessment will be considered as part of implementation planning, particularly where actions relate to tackling racism, sexual safety, flexible working, health and wellbeing, and the experience of staff with protected characteristics.	

1. Introduction

- 1.1. This paper provides the Trust Board with an overview of the NHS Staff Standards and sets out the Trust's response and implementation arrangements. It also summarises the Trust's current position against the standards and the actions being progressed and the arrangements for ongoing oversight and assurance.

2. Background: NHS Staff Standards

- 2.1. The NHS Staff Standards were published by the Department of Health and Social Care and NHS England in July 2026 following the commitment in the 10 Year Health Plan to establish a set of staff standards to improve the experience of working in the NHS. The standards were developed with employers and staff representatives through the Social Partnership Forum and apply initially to secondary care organisations, including acute, mental health, ambulance and community healthcare providers.
- 2.2. The standards have been introduced in recognition that staff experience remains variable across the NHS and that good practice is not consistently implemented across all organisations. They are intended to raise the profile of staff experience so that it is considered with the same level of importance as other organisational priorities, including quality of care, patient safety, operational performance and financial sustainability. The standards establish a national minimum expectation for NHS employers and will be supported through the development of assurance, measurement and oversight arrangements over time.
- 2.3. The standards build on existing national workforce initiatives, including the NHS People Promise and the NHS Leadership and Management Framework, by providing a clearer and more consistent statement of what staff should be able to expect from their employer regardless of where they work in the NHS. They are intended to support organisations to improve staff experience, strengthen organisational culture and create environments where staff feel valued, supported, safe and able to perform at their best.

3. Summary of the Six Staff Standards

- 3.1. The NHS Staff Standards focus on six areas identified by staff as most important to their experience at work. Each standard describes the employer actions required and the experience staff should be able to expect as a result. A summary of each standard is provided below:
 1. **Line Management:** This standard recognises that high-quality line management is one of the most important factors in staff experience, performance, retention and wellbeing. Employers are expected to ensure line managers are appropriately trained, supported and given sufficient time to manage well. Staff should be able to expect supportive, fair, developmental and compassionate line management, with clear expectations, regular conversations, timely support and a focus on enabling staff to perform well and fulfil their potential.
 2. **Health and wellbeing:** This standard requires employers to take a proactive and evidence-based approach to protecting the physical and mental health and wellbeing of staff. This includes attention to the working environment, rest spaces, occupational health and wellbeing support, prevention of work-related ill health, and clear accountability for improving staff wellbeing. Staff should be able to expect an organisation that supports them to feel safe, cared for and able to perform well.
 3. **Violence prevention and reduction:** This standard sets an expectation that staff should feel safe and supported at work and that employers take meaningful action to prevent and reduce violence, aggression, intimidation and abuse. Employers should ensure clear reporting routes, timely and compassionate support after incidents, appropriate training, data-led improvement, and governance arrangements that enable risks, themes and hotspots to be identified and addressed.

4. **Championing sexual safety:** This standard requires employers to create and maintain a working environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviour. It places emphasis on prevention, clear behavioural expectations, accessible reporting routes, prompt and proportionate action, training, learning from incidents, and support for those affected. Implementation should be aligned with wider dignity at work, employee relations, safeguarding, professional standards and Freedom to Speak Up arrangements.
5. **Tackling racism:** This standard requires employers to take active steps to tackle racism and improve the experience of racially minoritised staff. It should be considered alongside existing work on equality, diversity and inclusion, WRES reporting, staff survey outcomes, speaking-up arrangements, employee relations data, staff networks and anti-racism commitments. Staff should be able to expect visible leadership, clear standards of behaviour, routes to raise concerns safely, fair and consistent handling of incidents, and evidence-led action to address inequalities and improve culture.
6. **Promoting flexible working:** This standard expects employers to promote and enable flexible working wherever possible, recognising its importance for recruitment, retention, wellbeing, inclusion and work-life balance. Staff should be able to expect that requests are considered fairly, consistently and transparently, with managers supported to explore options and balance individual, team, service and patient needs. Implementation should include clear policy expectations, manager capability, monitoring of access and outcomes, and consideration of how flexible working can be embedded across different staff groups and service area.

4. Trust Response and Action Plan

- 4.1. Initial assessment indicates that many of the requirements of the NHS Staff Standards are already supported through existing policies, programmes of work and governance arrangements. The implementation plan therefore focuses on strengthening assurance, addressing identified gaps and aligning existing activity with the national requirements. The Staff standards reflect many of the existing prioritised of focus at UHS reflected in the UHS People Strategy, Inclusion and Belonging Strategy and the People priorities for 25/26.
- 4.2. The table at Appendix 1 summarises the Trust's current position against each standard, the response, lead ownership, timescale and assurance route.
- 4.3. A number of key delivery areas are also linked to the appointments of new roles, such as the Head of OD (Commencing October), and the disability advisory post (currently advertising). The incoming head of OD has a background in leadership development which is a key staff standards priority.
- 4.4. NHS England has confirmed that delivery of the NHS Staff Standards will be assessed through the NHS Oversight Framework and wider assurance processes. Implementation will continue to be progressed in partnership with relevant leads, staffside colleagues, staff networks and existing governance groups. Progress will be monitored through existing governance arrangements, including People Board, POD and relevant specialist groups, and will contribute to wider assurance through the NHS Oversight Framework, NHS Staff Standards score, Provider Capability Assessment and other national assurance processes.
- 4.5. Appendix 3 provides an initial benchmark against relevant 2025 NHS Staff Survey indicators to support understanding of the Trust's current position and future assurance requirements.

5. Board-Level Actions and Governance Requirements

5.1. The NHS Staff Standards include a number of specific board-level requirements relating to leadership, accountability and assurance. The table below summarises the key board-level actions required by the standards.

Priority	Action	Details	Owner	Status and action required	Action required for Board
Line Management	Board oversight of line manager enablement	Ensure board-level oversight on how line managers are enabled by collecting and acting on feedback from line managers.	Chief People Officer	Whilst reporting regularly provided through People Report, new infrastructure is needed to fulfil this obligation.	People Report to include updates on line manager development actions at regular intervals.
Health & Wellbeing	Appoint Health and Wellbeing Guardian	Appoint a Health and Wellbeing Guardian at board level.	Chief People Officer	Complete - Jane Harwood (NED)	Complete – No further action.
Championing Sexual Safety	Implement sexual safety charter and assurance framework	Fully implement the sexual safety in healthcare organisational charter, assess progress using the assurance framework, and ensure board-level ownership and accountability.	Chief People Officer	Significant work already to date on Sexual safety – Review assurance framework and present to POD / Board	Board to receive updates from People and OD committee.
Tackling Racism	Board SMART objectives on tackling racism	Ensure every board member has a published SMART objective on tackling racism.	Chair	All Board members have an EDI objective. This has been an annual feature for a number of years Each executive is the sponsor of a staff network.	Chair to review all current EDI objectives with CPO and Chief Executive Collective revised objectives to be shared with Board
Promoting Flexible Working	Appoint board-level flexible working champion	Appoint a board-level flexible working champion responsible for promoting and leading improvements in flexible working.	Chief People Officer	Currently no Board Flexible working champion.	POD recommended the CPO take this role as a natural alignment to portfolio.
Promoting Flexible Working	Board-owned Flexible Working Action Plan	Implement a Flexible Working Action Plan using organisational workforce data, owned by the Board.	Chief People Officer	Significant work to date on flexible working (Agile, Flex NHS) - Review board oversight of flexible working though the People report.	People report to be used to monitor flexible working Action plan to be included in People Report to Board.

6. Next Steps

- 6.1. The Trust Board is asked to note the publication of the NHS Staff Standards, the Trust response, and the implementation and assurance arrangements set out in this paper.
1. Note the publication of the NHS Staff Standards and the introduction of national minimum employment standards across six areas identified as most important to staff experience.
 2. Note the Trust response to the NHS Staff Standards and the continued alignment of existing policies, programmes of work and governance arrangements with the national requirements.
 3. Note the progress already made against the NHS Staff Standards and the continued development and delivery of the Trust's implementation plan.
 4. Note that implementation will continue to be progressed in partnership with staffside colleagues, staff networks, managers and subject matter leads to ensure that actions remain aligned to operational requirements, staff experience priorities and national expectations.
 5. Note that delivery and compliance with the NHS Staff Standards will be monitored through existing governance arrangements, with POD and Board as required, receiving assurance on progress, risks and any resource implications arising from implementation.
 6. Note the principles of the staff standards will be included in the refreshed UHS People Strategy linked to the new UHS corporate strategy.
 7. Note that where additional capacity, investment or resource is identified as necessary to support delivery of the NHS Staff Standards, associated business cases will be developed and brought forward through the appropriate governance route for consideration.

Appendix 1: Trust Response and Implementation Plan

NHS Staff Standard	Current position	Proposed UHS response / action	Owner	Timescale	Assurance route	RAG	Status
1. Line management	Existing leadership and management development programmes are in place. Work is underway to align current arrangements with the NHS Leadership and Management Framework, including review of leadership development, appraisal arrangements and management capability. Appraisals compliance is currently below Trust target.	Continue implementation of the NHS Leadership and Management Framework, including alignment of leadership development programmes, appraisal arrangements, manager capability initiatives and consideration of manager self-assessment requirements. Review of appraisal performance being undertaken through People Board and POD.	Chief People Officer / Head of OD	2026/27 onwards	People Board; POD Board (Via People Report)	Amber	Refresh of line manager training and development to begin once Head of OD commences (October 2026) Appraisal monitoring to continue via People Board and POD.
2. Health and wellbeing	Occupational Health and wellbeing services are established, with ongoing work relating to workplace adjustments, menopause support, staff wellbeing, rest facilities and UHS health and wellbeing strategy has been in place since 2023. Trust built the Wellbeing Hub, roof garden, and refurbished over 50 staff rooms with	Develop and implement refreshed Health and Wellbeing Strategy in line with new staff standards and new people strategy. Continue delivery of actions relating to workplace adjustments, manager wellbeing capability, staff facilities and access to wellbeing support. Implement new role accessibility officer role (currently being advertised)	Chief People Officer / Head of OD / COO	2026/27 onwards	People Board; POD Board (Via People Report)	Amber	Established wellbeing resources in place. Absence has been higher than normal levels and is subject to review Staff facilities variable at local level across the Trust

	Banksy charitable donation in 2023.						
3. Violence prevention and reduction	The Trust has implemented a new VAA framework reflecting the Violence Prevention and Reduction Standard and has established governance, reporting, training and post-incident support arrangements. VAA board in place with regular meetings to oversee progress and case review	Continue implementation of the Violence Prevention and Reduction Standard, including annual improvement planning, development of reporting arrangements, staff training and strengthening partnership and staff voice arrangements. Continue to strengthen board reporting and monitoring	Chief People Officer / VAA Lead	2026/27 onwards	Violence and Aggression Steering Group; People Board; POD	Green	On track New framework launched and being embedded
4. Championing sexual safety	The Trust has already implemented many aspects of the sexual safety charter. Existing arrangements are supported through the Dignity at Work Policy, Freedom to Speak Up arrangements and employee relations processes. Work is ongoing to strengthen awareness, training and reporting arrangements.	Continue implementation of the Sexual Safety Charter and associated assurance framework, including development of training, awareness, reporting and investigation arrangements where required.	Chief People Officer / Head of OD	2026/27 onwards	People Board; POD Board (via People Report)	Amber	Good progress made to date and continued worked required under @Safe at UHS framework
5. Tackling racism	Trust has a well establishes including and Belonging Strategy. Existing Inclusion and Belonging, Equality, Diversity and Inclusion and	Continue delivery of existing anti-racism and Inclusion and Belonging priorities, including actions relating to staff voice, reporting arrangements,	Chief People Officer / Head of OD / VAA Lead	2026/27 onwards	People Board; POD	Amber	Significant work already under inclusion and belonging strategy and VAA

	anti-racism programmes support a number of the requirements within the standard. Workforce reporting, staff voice arrangements and policy frameworks are already established. Clear link also to the VAA framework and @safe at UHS work.	recruitment and career progression, policy development and board accountability. Revision of existing Board objectives on EDI to include anti racism. Trust is reviewing and implementing the actions from the Lord Mann review.					framework (@safe at UHS) Further specific work required in line with actions of staff standards
6. Promoting flexible working	Flexible working arrangements are supported through existing policies, workforce processes and manager guidance. Work is underway to align local arrangements with the requirements of the NHS Staff Standard, including workforce data, action planning, governance arrangements and manager capability.	Continue implementation of actions relating to flexible working governance, workforce data, policy alignment, manager capability, workforce planning and reporting arrangements, ensuring alignment with national requirements and existing workforce priorities.	Chief People Officer / Head of OD	2026/27 onwards	People Board; POD Board (via people report)	Green	Good progress to date on flexible working practices – further work needed to provide board visibility and assurance. Continued tension with flexible working and service provision

Appendix 2: NHSE guidance on what good looks like in year one

What Good Looks Like in Year One				
Theme	Good in year one means	Evidence / Products	Suggested Owner	Current status
Board leadership and accountability	Board has discussed the NHS Staff Standards and agreed alignment with staff experience priorities. Required Board-level roles and ownership are in place, with regular visibility and assurance on progress.	Board paper/minutes; named champions/owners; assurance schedule.	Chief People Officer	Discussed at the August People and OD committee and scheduled for the September 11 public Board.
Understanding current position	Clear baseline established across the six standards using existing data, staff feedback and NHS Staff Survey results; minimum expectations met and gaps understood.	Baseline assessment; data pack; gap analysis; staff feedback summary.	Chief People Officer	A baseline assessment has been completed and reported to the People and OD Committee and the Board.
Credible, prioritised action	Proportionate year-one action plan focused on minimum expectations and significant risks to staff experience. Actions are owned, time-bound and integrated with existing workforce and people plans.	Action tracker; risk alignment; workforce/people plan cross-reference.	Chief People Officer	The action plan has been reviewed by the People and OD Committee and has been with the Board.
Listening to staff and working in partnership	Staff and trade union representatives engaged through local partnership arrangements; staff voice shapes priorities and there is transparency about change.	Engagement plan; partnership minutes; staff network feedback; communications log.	Chief People Officer	Staff side and networks integrated into existing governance structures through People Board and other key committees Regular engagement with Staff side colleagues at formal partnership forum, We Are UHS voices sessions, Executive sponsorship of each network group.
Fit for purpose assurance	Organisation understands how delivery is assessed through NHS Oversight Framework. Leaders can explain position, drivers and response.	NHS Oversight Framework interpretation; assurance reports; committee papers; improvement narrative.	Chief People Officer	People NOF questions and current position shared with People and OD committee and Board. People Report used to track progress against NOF

Appendix 3: UHS benchmarking against the 2025 Staff Survey

Key:

>3 ppt above
<3 ppt below
In between

Below is data from the 2025 NHS staff survey measured against the average acute score and the best reported acute score. UHS is current broadly at average with three areas significantly higher (VAA reporting, flexible working, opportunity for development) and one significantly lower (Health and Wellbeing)

Area	Question code	Staff survey question	Measure direction	UHS 2025	Acute average 2025	Best acute 2025	UHS vs average (pp)	UHS vs best (pp)
Leadership & management	Q9d	My immediate manager takes a positive interest in my health and well-being.	Higher is better	71.8%	69.7%	77.4%	2.0	-5.6
Leadership & management	Q9f	My immediate manager works together with me to come to an understanding of problems.	Higher is better	71.0%	68.9%	75.5%	2.1	-4.5
Leadership & management	Q9i	My immediate manager takes effective action to help me with any problems I face.	Higher is better	68.5%	66.8%	73.9%	1.7	-5.4
Team working	Q7a	The team I work in has a set of shared objectives.	Higher is better	75.1%	73.5%	79.8%	1.6	-4.7
Team working	Q7h	I feel valued by my team.	Higher is better	70.0%	68.9%	75.3%	1.2	-5.3
Health & wellbeing	Q11a	My organisation takes positive action on health and well-being.	Higher is better	50.2%	53.2%	70.0%	-3.0	-19.8

Health & wellbeing	Q11c	During the last 12 months have you felt unwell as a result of work-related stress?	Lower is better	43.0%	42.3%	33.5%	0.8	9.5
Health & wellbeing	Q12b	How often, if at all, do you feel burnt out because of your work?	Lower is better	31.6%	32.1%	26.0%	-0.5	5.6
Violence prevention	Q13a	Experienced physical violence at work from patients/service users, relatives or public.	Lower is better	14.8%	14.7%	6.4%	0.1	8.4
Violence prevention	Q13b	Experienced physical violence at work from managers.	Lower is better	0.6%	0.8%	0.2%	-0.2	0.4
Violence prevention	Q13c	Experienced physical violence at work from other colleagues.	Lower is better	1.1%	1.8%	0.6%	-0.7	0.5
Violence prevention	Q13d	The last time you experienced physical violence at work, did you or a colleague report it?	Higher is better	76.0%	71.9%	85.7%	4.1	-9.7
Bullying, harassment & abuse	Q17b	In the last 12 months, have you been target of unwanted behaviour?	Lower is better	3.8%	3.4%	2.0%	0.4	1.8
Inclusion & belonging	Q15	Does your organisation act fairly with regard to career progression/promotion, regardless of protected characteristics?	Higher is better	55.7%	53.1%	65.6%	2.6	-9.9
Bullying, harassment & abuse	Q14a	Experienced harassment, bullying or abuse from patients/service users, relatives or public.	Lower is better	23.8%	24.6%	14.4%	-0.8	9.3

Bullying, harassment & abuse	Q14b	Experienced harassment, bullying or abuse from managers.	Lower is better	8.1%	9.2%	5.1%	-1.2	3.0
Bullying, harassment & abuse	Q14c	Experienced harassment, bullying or abuse from other colleagues.	Lower is better	16.5%	17.9%	10.9%	-1.4	5.6
Discrimination	Q16a	Experienced discrimination from patients/service users, relatives or public.	Lower is better	9.3%	8.6%	3.0%	0.7	6.3
Discrimination	Q16b	Experienced discrimination from managers / team leader or other colleagues.	Lower is better	8.1%	8.7%	4.5%	-0.6	3.6
Flexible working	Q4d	How satisfied are you with opportunities for flexible working patterns?	Higher is better	59.4%	55.9%	65.0%	3.5	-5.6
Flexible working	Q6b	My organisation is committed to helping me balance my work and home life.	Higher is better	47.6%	48.2%	58.5%	-0.6	-10.9
Flexible working	Q6d	I can approach my immediate manager to talk openly about flexible working.	Higher is better	72.8%	70.2%	77.6%	2.6	-4.8
Appraisal & development	Q23a	Had an appraisal, annual review, development review or KSF review in last 12 months.	Higher is better	82.2%	85.9%	95.6%	-3.7	-13.3
Appraisal & development	Q23c	Appraisal helped me agree clear objectives for my work.	Higher is better	35.1%	34.8%	46.0%	0.3	-10.9

Appraisal & development	Q23d	Appraisal left me feeling my work is valued by my organisation.	Higher is better	33.0%	33.0%	40.6%	-0.1	-7.6
Development	Q24d	I feel supported to develop my potential.	Higher is better	58.7%	54.1%	63.6%	4.7	-4.9
Development	Q24e	I am able to access the right learning and development opportunities when I need to.	Higher is better	59.4%	57.4%	69.9%	2.0	-10.4

NHS Staff Standards

Board Briefing Pack

July 2026

Contents and Guidance

To support you with updating your Board, this pack provides you with key information to help your organisation understand what is required to deliver and embed the new NHS Staff Standards.

Contents



Section	Description
Key Messages	This serves as a useful crib sheet to support your update and focus on the salient information, suitable for a Board-level audience.
Context	This section highlights the strategic imperative to adopt the NHS Staff Standards in full and the expected benefits it will deliver to the NHS.
Detail	This section outlines the NHS Staff Standards in greater detail to support Board-level conversations regarding operationalising the requirements.
Next Steps	This section describes suggestions for engagement to ensure your workforce understands what to expect from the NHS Staff Standards.

Guidance



- Trust Boards and Providers will have different successes and challenges when it comes to staff experience. Therefore, some sections of this pack will be more relevant for your update than others.
- For Boards engaging with the NHS Staff Standards for the first time, we recommend using the context slides so that Boards understand the rationale for their introduction.
- This pack is designed to give you a clear understanding of the NHS Staff Standards, what you need to do to deliver them and how they will be monitored.
- You are welcome to use these slides to support your presentation or share them with Board members who want more detail.

Next Steps

01

Speak to your Board about the NHS Staff Standards and discuss your implementation plan

02

Begin engagement with your workforce to help them understand the standards and how they can share their voice

03

Use the accompanying materials in whatever way is helpful to support communication of the NHS Staff Standards across your organisation.

NHS Staff Standards: Key Messages

A summary of the key information for the new NHS Staff Standards

Why?

There has been considerable focus on **improving staff experience** via the NHS People Promise with many organisations working hard to drive improvements, which is reflected in some of the 2025 NHS Staff Survey results. But this has been inconsistent across the NHS and more needs to be done to bring all organisations up to the required level and ensure staff experience is treated as a priority. In line with the 10 Year Health Plan's commitments, the NHS Staff Standards will, for the first time, set a national required standard which employers must meet.

What?

The new standards focus on six key areas for organisations to improve staff experience: **1) promoting flexible working; 2) line management; 3) health and wellbeing; 4) violence reduction and prevention; 5) tackling racism; and 6) championing sexual safety in the workplace.**

Who?

Acute trusts, ambulance trusts, and mental health and community trusts are in scope of the new standards. However, all organisations delivering NHS services should reflect on the new standards and seek to improve their staff experience in these key areas. The standards apply to NHS employed staff; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms.

How?

Regions and organisation boards should begin reviewing their existing staff experience provision and monitoring to ensure their policies, procedures and operational initiatives reflect the requirements of the new standards. Delivery against the standards will be measured with a new score that will be part of the NHS Oversight Framework.

The Bottom Line?

Employers are expected to implement the NHS Staff Standards from **within existing budgets**. The standards reflect minimum actions for employers which they should reasonably be expected to have in place, or be working towards already, to bring all organisations to the same national minimum expectation. This is about building on existing work rather than introducing new funded programmes.

NHS Staff Standards: What do they mean for senior leaders?

Prioritising staff experience

The standards are about making staff experience a core priority for your organisation – building on your existing initiatives to support continuous improvement.

Boards and executive teams are accountable for making sure the standards are understood, implemented and monitored.

A key aim is to see staff experience given the same level of focus and grip given to other organisational priorities such as finance, operational performance and quality of care.

Partnership with your workforce

Implementation should be done in partnership with staff, staff networks, trade unions and local partnership arrangements.

This partnership approach will be important for identifying what matters most locally, shaping practical actions, and providing assurance that the standards are being embedded in a way that reflects the needs of different staff groups and services.

Boards and leaders to drive

It is ultimately up to senior leaders to have a visible role in setting expectations for respectful, inclusive and supportive workplaces.

Leaders should ensure managers are equipped to lead well and facilitate them to help drive staff experience – as well as improving the experience of managers themselves.

Leaders should also make sure staff can raise concerns, share feedback and see that action is being taken in response.

Background: Transformation context for NHS Staff Standards

The 10 Year Health Plan committed to developing the NHS Staff Standards to ensure that staff experience is given increased priority in the NHS.

NHS Staff Standards in the 10 Year Health Plan:

“A positive experience of work and the workplace should not be a ‘nice to have’. We will work with the Social Partnership Forum to develop a new set of staff standards, which will for the first time outline minimum standards for modern employment. They will underpin the NHS Oversight Framework, and poor performance on staff-related outcomes will act as an early warning signal for CQC.”

Fit for the Future: The 10 Year Health Plan for England, Pg 105, July 2025

The 10 Year Workforce Plan will set out action to deliver a new workforce model, to support delivery of the 10 Year Health Plan. We will deliver that change by making sure that staff are better treated, have better training, more fulfilling roles, and hope for the future.

Case for Change

Why are the NHS Staff Standards needed?

Case for Change

Improvements to support staff experience have been inconsistently applied by organisations across the NHS.

Lack of mandation for existing frameworks means workforce benefits have been patchy and inconsistent across the NHS.

Better staff engagement is associated with improved experience and job satisfaction.

Staff burnout, stress and fatigue are consistently linked to patient safety incidents and adverse events.

Higher staff turnover is associated with higher patient mortality.

The productivity loss from absenteeism, presenteeism, lost capacity, and harm to staff is a serious issue across the NHS.

Scope

Staff in Scope

The standards apply to NHS employed staff in secondary care; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms

Organisations in Scope

- Secondary Care providers, including acute trusts, ambulance trusts, and mental health and community trusts
- All organisations delivering NHS services should consider the new standards
- Options for expanding the scope of mandating the standards across Primary Care and other NHS services will be considered

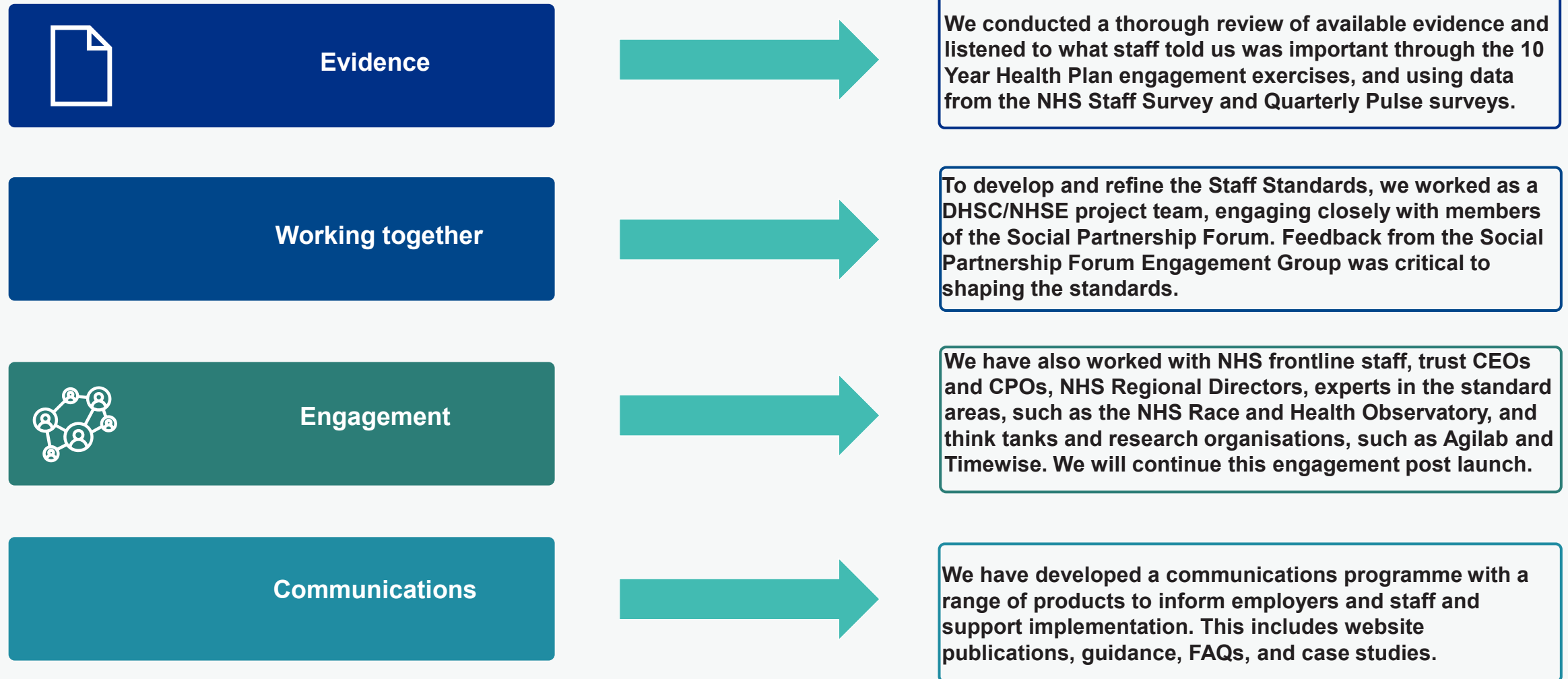
Objectives

It is intended that the NHS Staff Standards will achieve...

- 1 **Improvements in staff experience**
- 2 **Reductions in turnover and increased retention**
- 3 **Positive impact on service delivery**
- 4 **Increase the priority level organisations give to staff experience**

NHS Staff Standards – How we did it

Deliverables produced in this phase and how they will support regional provider preparedness.



Data, evidence and consultation

More detail on sources

Evidence

- NHS Staff Survey results
- NHS Pulse Survey results
- 10 Year Health Plan People Group engagement exercises
- Industrial Relations engagement
- Research from experts including the Race and Health Observatory and think tanks and research organisations such as Agilab and Timewise

Engagement

Close engagement with:

- Social Partnership Forum Engagement Group
- NHS England and DHSC policy and analyst leads
- CQC

Consultation with:

- NHS frontline staff
- NHSE Regional Directors and regional design leads
- Social Partnership Forum groups – wider group, Violence Reduction Oversight Group, regional co-chairs.
- Chief People Officers
- NHS CEOs
- Experts in standard areas

NHS Staff Standards – alignment to existing frameworks



The NHS Staff Standards do not replace existing guidance, policies or improvement programmes – rather they are complementary. They are also not intended to replace or cut across action already underway locally to drive improvements that are working well. Instead, they bring together and strengthen what is already in place, setting a clear national baseline for what all NHS employers are expected to deliver for staff and a clear framework to help Boards prioritise their efforts.

The NHS People Promise - as an example - can provide guidance and resources to support implementation of the standards and ensure continuous improvements in staff experience.

Unlike many previous initiatives, delivery of the standards is mandatory, and performance will be measured through national oversight and assurance processes, including the NHS Oversight Framework.

The NHS Staff Standards should complement and work alongside local programmes of change and improvement that organisations already have in place and that are working well.

The NHS Staff Standards

Line Management

Health & Wellbeing

**Violence Reduction &
Prevention**

**Championing
Sexual Safety**

Tackling Racism

**Promoting
Flexible Working**

The following slides give an overview of the actions for employers for each of these standards. Full detail of all the requirements is available in the supporting materials for the NHS Staff Standards online.

NHS Staff Standards – overview of the standards

LINE MANAGEMENT

Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support for line managers, to help staff to perform well, feel valued and fulfil their potential.

Actions for employers

Employers must:

- Embed the NHS Leadership and Management Framework across strategies, policies, training, appraisal and recruitment, and require all managers to complete the self-assessment tool
- Ensure line managers have access to comprehensive line management training through the NHS Leadership and Management Framework (with a focus on first-time managers) and monitor and address line management quality
- Ensure job plans accurately allocate sufficient time for line management responsibilities
- Ensure all role descriptions have clear, accurate and up-to-date job descriptions and review role changes promptly through agreed processes when requested, in accordance with the NHS Job Evaluation Scheme
- Ensure all line managers have appropriate supervision and mentoring for their own line managers and ensure that line management policies are accessible to enable timely and effective people management
- Ensure board-level oversight on how line managers are enabled by collecting and acting on feedback from line managers
- Work in partnership with trade unions through local arrangements to review workforce data, culture, health and safety risks and equality impacts

So that line managers are enabled to:

- Deliver high-quality appraisals, regular feedback and meaningful development and career support to their line reports
- Model inclusive, respectful behaviours, provide compassionate support, and foster psychologically safe teams that are well-led, connected and feel able to raise concerns or problems

NHS Staff Standards – overview of the standards

HEALTH & WELLBEING

Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for, and able to perform well.

Actions for employers:

- Appoint a Health and Wellbeing Guardian at board level
- Use the NHS Health & Wellbeing Framework to produce a localised Health & Wellbeing Strategy that is built on workforce data and provides needs-driven health and wellbeing support
- Take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods
- Ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. Alternatively, employers should ensure that there are safe options available for staff to store and prepare their own food
- Ensure all managers are supported to complete mandated competencies on safety, health and wellbeing so that all staff can expect health & wellbeing conversations to be embedded into 1-1s and appraisals
- Ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs
- Ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- Ensure all staff have access to Occupational Health and Wellbeing support and local services
- Work in partnership with trade unions through local arrangements to review data and monitor progress

NHS Staff Standards – overview of the standards

VIOLENCE PREVENTION & REDUCTION

Actions for Employers:

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

- Implement and embed the Violence Prevention Reduction (VPR) standard, as well as having a named Senior Responsible Officer for VPR with an annual VPR improvement plan
- Ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse, irrespective of a patient's circumstances or condition
- Accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- Staff who are subject to violence or abuse should have access to high quality post incident psychological and welfare support. Managers as well as HR policies and procedures should provide the right support following incidents and during investigations
- Ensure that all staff receive training appropriate to their role
- Ensure the appropriate Health and Safety Committee/Forum is engaged in VPR planning and monitoring
- Work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements

NHS Staff Standards – overview of the standards

CHAMPIONING SEXUAL SAFETY

Actions for employers:

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisation to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognise and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

- Fully implement the actions set out in the sexual safety in healthcare organisational charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- Ensure all staff to complete [Understanding sexual misconduct in the workplace e-learning](#)
- Ensure that investigators of sexual misconduct allegations receive specialist training
- Ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- Share concerns about employees with future employers and host organisations
- Ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- Work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

NHS Staff Standards – overview of the standards

TACKLING RACISM

Actions for employers:

Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace.

- Set consequential outcomes for misconduct at the individual level, from penalties for certain behaviours and/or repeated incidents to potential refusal of care for patients in non-emergency situations, and consequences for organisational performance and professional non-compliance
- Work with Trade Unions to ensure representation of the staff voice; ensuring policies are fair/proportionate; support staff to speak up; and support during formal procedures to ensure racism is taken seriously
- Ensure implementation and monitoring of the six High Level Impact Actions as part of the NHS EDI Improvement Plan
- Ensure every board member has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism
- Implement inclusive recruitment and talent management practices including recruitment and career progression plans for equity of opportunity
- Work to create inclusive cultures that encourage staff at all levels to report, and for employers to consistently work to root out racist behaviour
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice
- Update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments
- Update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice

NHS Staff Standards – overview of the standards

PROMOTING FLEXIBLE WORKING

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a “flexible first” culture, rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Actions for employers:

- Appoint a board level flexible working champion who is responsible for promoting and leading improvements in flexible working
- Implement a Flexible Working Action Plan using organisational workforce data which is owned by the Board
- Implement preference-based team e-rostering for all frontline workers (where operationally appropriate)
- Collect data on the number of flexible working requests which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic, staff groups / professions, bands and at department level
- Publish this data for staff and linked to the Flexible Working Action Plan set out what actions will be taken to improve areas of concern
- Work in partnership with Trade Unions through local partnership arrangements to assess progress
- Ensure that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams
- Include flexible working as an option in all job adverts, job interviews, pre-retirement conversations, and line manager conversations such as appraisals or regular one to one discussion
- Ensure your organisation is following the guidance set out in [The National Flexible Working People Policy Framework](#) and reference this within the local flexible working policy

NHS Staff Standards – Accountability & Assurance

In the first year (2026-27), the following accountability tools will be used to ensure organisations are embedding the NHS Staff Standards as a core element of their efforts to improve staff experience

NHS Oversight Framework (NOF)

NHS Staff Standards score

- New score based on delivery across the standards
Sub-scores for each of the standards will also be made available to organisations to view
- Will inform segmentation for the People & Workforce domain and overall

Engagement Score

- Existing score – will be used in conjunction with the new NHS Staff Standards score for increased understanding of staff experience.
- Also informs segmentation for the People & Workforce domain and overall

Provider Capability Assessment

When the existing framework is updated in 2026, it will include updates to look at how organisations are working to improve staff engagement

Organisation self assessment

- Updated guidance in the People & Culture section to request evidence of organisations' use of staff experience information
- NHS Staff Standards will be referenced in the indicative lines of inquiry

NHSE assessment

- Triangulate staff experience assurance received from the trust with any other information – e.g. what is its score, are there material staff concerns, do CQC well-led reviews highlight cultural issues? Concerns reflected in organisation's RAG rating

The new NHS Staff Standards NOF score

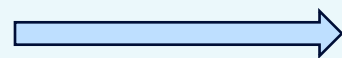
- ***The NOF is a key part of ensuring organisations are accountable for delivery of the NHS Staff Standards.***
- ***The new score contributes to an organisation's segmentation in both the People & Workforce domain and for the overall segmentation.***
- Introduced from Q1 2026/27 - initially based upon the 2025 NHS Staff Survey (NSS) data (Q1-3)
- Q4 will introduce the data from the upcoming 2026 NSS – ensuring opportunity for each organisation's score to be impacted in the first year of the new standards
- Detailed methodology will be available in the NOF Technical Guidance

NHS Staff Standards – accountability & assurance

The standards will be assessed using the following NHS Staff Survey questions:

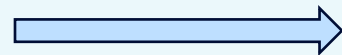
NHS Staff Survey Questions

Line Management



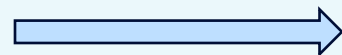
Q7a,h Q9d,f,i; Q23a,c,d; Q24d,e

Health & Wellbeing



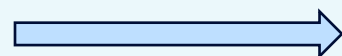
Q11a,c Q12b

**Violence Prevention
& Reduction**



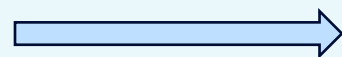
Q13a,b,c; Q13d

**Championing Sexual
Safety**



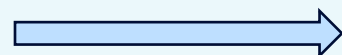
Q17b

Tackling Racism



Q14a,b,c; Q15; Q16a,b

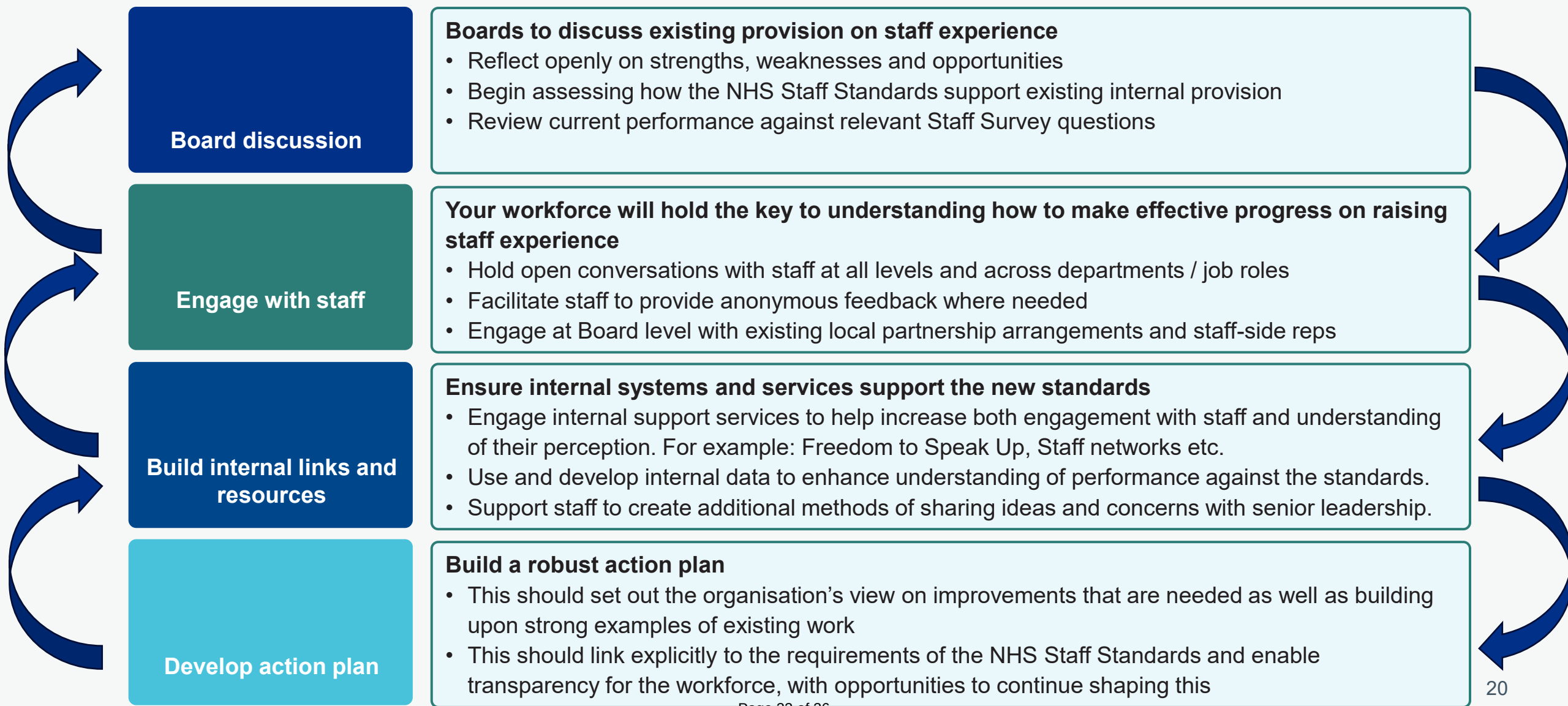
**Promoting Flexible
Working**



Q4d, Q6b,d

NHS Staff Standards: Suggested internal engagement

Key activities for organisations to begin embedding the new standards



NHS Staff Standards: Suggested internal engagement

Key activities for organisations to begin embedding the new standards



While the standards set clear expectations for employers, staff also have an important role to play in creating a positive culture and workplace. Organisations should ensure their staff voice shapes local improvements.

Organisations should ensure that their plans to embed the standards facilitate working with trade union representatives through their local partnership arrangements and provide ways for staff to engage with the Board to support application of the standards.

Visual resources

There is a pack of resources accompanying this slide deck. Please use these materials as you see fit to support internal awareness of the standards. We know that each organisation is different, so have created a number of different products with varying levels of detail to help communicate the NHS Staff Standards and what this means for staff. There is also an accompanying Q&A document.

NHS Staff Standards – What ‘good’ looks like in year one

In year one, good delivery means organisations have focus, grip and a clear direction of travel. Not everything will be fully embedded.

Board leadership and accountability

- The Board has discussed the NHS Staff Standards and agreed how they align with existing staff experience priorities.
- Required Board-level roles and ownership are in place, with regular visibility and assurance on progress.

Understanding current position

- Organisations have established a clear baseline across the six standards, drawing on existing data, staff feedback and NHS Staff Survey results and understand where minimum expectations are already being met and where gaps remain

Credible, prioritised action

- A proportionate year-one action plan is in place, focused on meeting minimum expectations and reducing the most significant risks to staff experience.
- Actions are clearly owned, time-bound and integrated with existing workforce and people plans.

Listening to staff and working in partnership

- Staff and trade union representatives have been engaged through local partnership arrangements.
- Staff voice is shaping priorities and there is transparency about what will change.

Fit for purpose assurance

- The organisation understands how delivery will be assessed through the NHS Oversight Framework.
- Leaders can explain their Staff Standards position, what is driving it, and how they are responding.

Agenda item 5.10 Report to the Trust Board of Directors, 1 September 2026			
Title:	Safeguarding Annual Report 2025-26		
Sponsor:	Natasha Watts, Acting Chief Nursing Officer		
Author:	Danielle Honey, Julie Davies		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x		x	x
Executive Summary:			
This report provides assurance regarding safeguarding arrangements across adults, children, maternity and transition safeguarding services, mental capacity and deprivation of liberty services during 2025/26. The service has continued to provide specialist advice, support, leadership, training and multi-agency engagement throughout a year of service transformation and workforce change. Activity has remained high across all areas of the service. The adult team received 2726 referrals with the children’s team seeing a 4% increase on the number of referrals. Maternity safeguarding saw an increase in notifications and a 13% increase in DoLS applications was seen. Notably, recognised neglect has increased in relation to children, with adult concerns being characterised by complexity and interconnected risks. Transitional safeguarding remains an area of growing importance, particularly for care experienced young people and those young people experiencing mental health, safeguarding and social complexity. UHS safeguarding has maintained strong partnership engagement locally, contributing to reviews, audits and strategic board work across Southampton and Hampshire routinely and supporting the ongoing driving and embedding of best practice in all areas of safeguarding. The service has undertaken significant transformation with the creation of new roles within leadership and operational workforces, aiming to improve sustainability, visibility, accessibility and career development whilst supporting organisational efficiency. Key areas of challenge remain safeguarding training compliance, MCA implementation and limitations within the digital systems which restrict reporting, oversight and progression of several improvement programmes. Throughout the workforce changes and operational challenges, the safeguarding arrangements remain effective, with statutory responsibilities met by a team which has maintained a resilient and responsive approach whilst supporting some of the trust’s most vulnerable patients and families.			
Contents:			
Annual report.			
Risk(s):			
N/A			
Equality Impact Consideration:		N/A	

Safeguarding Annual Report 2025/2026

Dannie Honey Head of Safeguarding

Julie Davies, Named Midwife Safeguarding

Sam Spreadbury Named Nurse Safeguarding Adults



SAFEGUARDING TEAM

Supporting you, supporting our patients

Tash Watts
Chief nurse

Louisa Green
Deputy Chief nurse

Danielle Honey
Head of Safeguarding

Sam Spreadbury
Named nurse safeguarding adults

Vacant
Named nurse safeguarding children

Julie Davies
Named Midwife Safeguarding Children

Ann Rodwell
MCA and DOLS specialist nurse

Richard Darch
adult safeguarding specialist nurse

Sheri Robson
adult safeguarding specialist nurse

Rachael Keeling
adult safeguarding practitioner

Donna Stafford
transition safeguarding specialist nurse

Berny Webster
children's safeguarding specialist nurse

Madeline Dyer
children's safeguarding specialist nurse

Nina Webb
children's safeguarding practitioner

April Hassett
paediatric liaison nurse specialist

Katy Durston
Maternity safeguarding specialist practitioner

Aleena George
Maternity safeguarding practitioner

Ildiko Nagy
PA to the safeguarding management team

Charlotte Bailey
adult safeguarding administrator
Sue Gunson
MCA/DOLS administrator

Franz Paredes
children's safeguarding administrator
Jacqueline Moody
PLNS administrator

Ria Burroughs
maternity safeguarding administrator
Emma Price
maternity safeguarding administrator

Introduction

This year's Safeguarding Annual Report summarises the key achievements, areas of work and activity for 2025/6 for Adults, Children and Maternity Safeguarding within UHSFT, including paediatric liaison, MCA and DoLS and transition safeguarding. This report has been written to provide high level assurance to the Executive Team in relation to the safeguarding arrangements within UHSFT and in line with required reporting against the NHS Contract.

Throughout the past year, the Safeguarding Team have continued to provide a robust, responsive and supportive service to both UHSFT colleagues and multi-agency partners to safeguard the most vulnerable patients who come into our care and their families. We have continued to utilise a hybrid method of working across the team but have maintained a daily onsite presence during core working hours. The team are working towards a member of the adults' team, the children's team, the maternity team and the senior leadership team, supported by at least one member of business support, on site each day.

This year has seen significant transformation work in the safeguarding structure, the expectations of team members and the culture of the team in working with wider trust colleagues and the multi agency network.

Progress updates – Safeguarding

Last year (24/25) we said we would:	We have achieved (25/26):
Continue to develop the joint Safeguarding Training Strategy including launching Safeguarding Adults Level 3, reviewing Safeguarding Children Level 3 with a view to increasing compliance, launching MCA Level 3 training and developing and delivering transitional safeguarding training.	Divisional Education leads are tasked with developing improvement plans with associated trajectories and updates, with monitoring to be overseen by Divisional Governance teams and reported to SGSG by Divisional Leaders.
Review of the Supervision offer and uptake within the Trust.	Ongoing work on the Safeguarding children supervision offer continues, with an increase in the offer and uptake seen in 2024/25. Maternity safeguarding continue to offer responsive supervision, one to one supervision and group supervision to targeted groups but are looking to increase this offer to universal caseload midwives.
Review of information sharing forms as part of ED migration to Miya	The number of ISFs coming through the team has dropped, and work has been done to cross reference with attendances that would be expected to generate an ISF. This review indicated that ISFs are being shared as required.
Review of Maternity Safeguarding Children in Maternity policy to include additional support around legal framework around the time of birth and police protection	This policy has been updated alongside associate police protection guidance and has been approved by SGSG
Launch a safeguarding champion's network covering an all age approach to safeguarding.	Work has commenced in this area, with mapping of clinical areas and requests for volunteers sent to ward leaders. This will be jointly undertaken by adults, children and maternity safeguarding teams to facilitate an all age, family approach to safeguarding across the trust.
Full review of safeguarding team structures.	This review has been undertaken, and transformation work has been commenced with vacant posts being re-banded, and a restructure of the senior workforce in progress.



Progress updates – Safeguarding

Last year (23/24) we said we would:	We have achieved (24/25):
SGSG processes to be improved and standardised.	Attempts to support divisional reporting have highlighted challenges with the UHS Apps visibility for divisions. Work to improve this continues and until completed, this workstream cannot progress.
Referrals at source to commence.	Attempts to identify one single and accurate dataset have been unsuccessful within UHS Apps. Work cannot progress on this until UHS Apps improvements are complete.
Development and roll out of MCA and DoLS training packages.	This work continues.
Develop a public facing webpage for MCA and DoLS.	This work continues.
Upskill the workforce in relation to 16 and 17 year olds placed outside of paediatric areas.	The transitional safeguarding nurse continues to support nursing and medical staff outside of paediatric areas to respond to the needs of this cohort of patients. Senior staff in clinical areas who admit 16 and 17 year olds are profiles to safeguarding children level 3 in order to provide support and oversight. A training package including the needs of this cohort, as well as care leavers and children with disabilities has been developed to support these areas.
Improve the response for 16 and 17 year old patients subject to child protection investigations and plans.	All S47 investigations are managed by the safeguarding children team, as opposed to the transition nurse specialist.
Redevelop and improve the safeguarding children policy	This is in draft form awaiting final comments and sign off.
Complete a suite of SOPs for individuals working within the safeguarding team to provide consistency and efficiency.	SOPs are in development across the safeguarding service. Approximately 60% are complete in the children's team with more work required in adults due to the prolonged period of reduced staffing.

Safeguarding Policy Updates

Safeguarding Policies approved 2025-26

- FGM Policy is approved
- Management of Risk Posed by Offenders Subject to Multi-Agency Public Protection Arrangements (MAPPA) Whilst on UHSFT Premises, updated and approved.
- DNA / WNB adults at risk.
- Safeguarding Children in Maternity.

Safeguarding policies under review, overdue for approval.

- Safeguarding children policy.
- Modern Slavery policy

Safeguarding Policies under review 2026-27:

- Safeguarding Adult policy
- Female Genital Mutilation policy (as new policy 1 year review)

Safeguarding risks

Risk Number	Summary	Risk Rating
172	Delays in individuals being assessed and followed up by the supervisory body with regards to applications for Deprivation of Liberty Safeguardings. This may result in patients being unlawfully deprived of their liberty.	12
307	The Mental Capacity Act (2005) may be misapplied in practice. Actions to mitigate: • For MCA champions to be supported to undertake spot audits in clinical areas • Develop MCAA and BI decision-making records training examples / guidance / feedback available to UHS staff. • Roll out level 3 MCA training.	9
173	Patients may not be safeguarded effectively if staff training compliance is below target levels for Safeguarding Adults and Mental Capacity. Actions to mitigate: • Divisional education leads have been tasked to develop improvement plans and feedback with updates and trajectories.	9
833	If safeguarding children training compliance remains below target levels, staff may not have the skills and knowledge to respond effectively to safeguarding children concerns. Actions to mitigate: • Divisional education leads have been tasked to develop improvement plans and feedback with updates and trajectories.	12
893	Information shared with GP surgeries via email may not be received by surgeries due to changes in email addresses used not being communicated to the paediatric liaison nursing service.	CLOSED – RISK MITIGATED
643	There is a risk that we cannot satisfy the CQC requirement for DOLs outcomes to be communicated to the CQC in a timely manner.	CLOSED – RISK MITIGATED



Adults Safeguarding



Adults Safeguarding

- **Review of structure:** The 3 whole time equivalent nurses working in the safeguarding adult operational team were all sitting at a band 7, with no management responsibilities and minimal exposure to strategic and partnership work. As part of a wider team restructure, the team will have 1 band 7 and 2 band 6 practitioners. The band 7 will have management responsibilities for the band 6s who will take ownership of day-to-day, simple safeguarding advice, guidance and case management. One vacancy has been recruited to as a band 6 and others will be through natural attrition.
- **Level 3 Safeguarding Adult Training.** Level 3 training is developing well, with 200-250 attendees most months. Despite this level of attendance, compliance has not significantly increased. The Safeguarding team education lead is working with workforce systems in relation to this.
- **Safeguarding Adult Reviews:** There were 14 scoping requests for Safeguarding Adult Reviews and 7 scoping requests for Domestic Homicide Reviews. 1 Safeguarding adult review and 2 domestic abuse related death reviews have closed. 4 completed and published reviews have ongoing action plans associated with them, and 5 newly commissioned reviews remain in progress.
- **Safeguarding Supervision.** Weekly drop-in safeguarding supervision session continues to be well attended. (Do we keep any records of who and to discuss what? And Advice given?)
- **Improved reporting and oversight.** Challenges in the use of UHS Apps to provide real time information for divisions, and to pull robust and accurate data have resulted in the pausing of a number of workstreams whilst improvement work is undertaken.

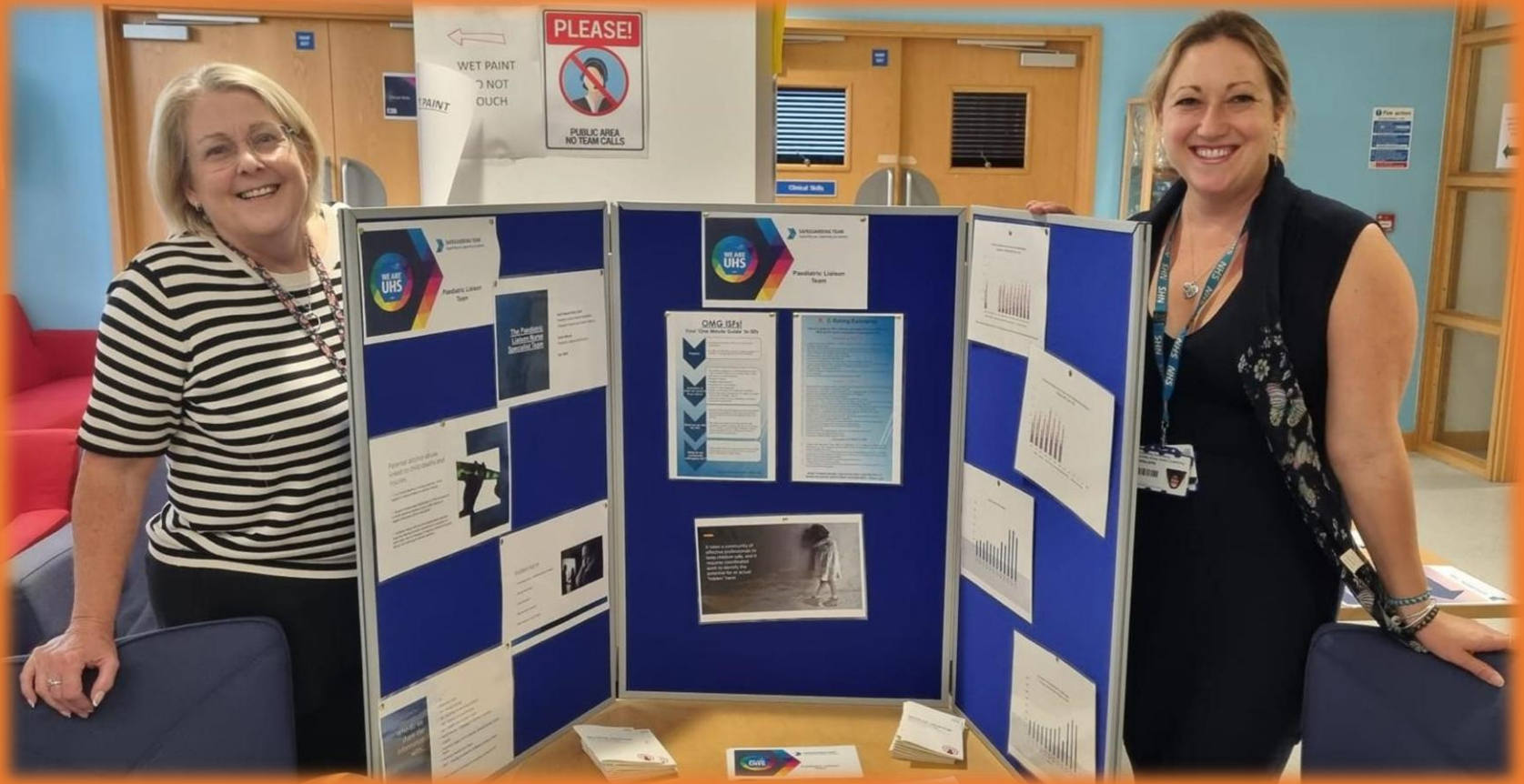
Adults Safeguarding

- **Review of Adult Safeguarding Concerns Pathway.** This piece of work is unable to be progressed until such a time as IT system amendments are completed. There is currently no way of assuring practice due to incomplete data sets and variation in visibility and the risk of implementing without a baseline is felt to be too great. The Safeguarding adult service is undertaking a deep dive into all amendments required to ensure UHS Apps provides the level of data insight required.
- **Staff Development.** The specialist team has been supported to engage in professional development opportunities including professional nurse advocate training, best interest assessor training and leadership training. This has supported the ongoing approach to maintaining and developing a high quality, professional workforce with clear opportunities for progression and development.
- **Multi agency work.** The team has worked closely with Southampton Safeguarding Adults and Children Partnership Board to support learning and development, case reviews and implementing organisational and system level learning. The team has supported an in depth review of the Multi Agency Risk Management (MARM) framework, an area which has been highlighted as lacking in multiple Safeguarding Adult Reviews.





Children's Safeguarding



Children's Safeguarding

- **Audits.** The team has provided input into multiple audits undertaken by the Safeguarding Children Partnerships and undertake an informal review into a reduced number of information sharing forms received since the implementation of the Miya ED system.
- **L3 Safeguarding Children Training.** Compliance for Safeguarding Children Level 3 has remained lower than required and alongside a trust wide review and cleanse of the data. The safeguarding education lead is working closely with divisional education leads and workforce systems to support continual improvement. In excess of 300 staff per month have attended training in recent months.
- **Technology.** The team relies on UHS Apps for record keeping, and has identified areas for improvement, both in terms of usability and case management, and reporting from the system. Requested changes remain in a development queue with the UHS Apps team.
- **Newsletters.** Newsletters have been developed and shared widely with updates on best practice and multi agency updates.
- **Operational Challenges.** The team was fortunate to bring a specialist nurse in for a 12-month secondment from the community workforce to support operational work and bring a new and exciting lens to the work undertaken. This is due to finish in Q1 2026/27 and will be replaced with a safeguarding practitioner role as part of ongoing structure revisions.
- **Statutory reviews.** There have been a low number of statutory scoping requests relating to children, and no local safeguarding child practice reviews commissioned in 2025/26.

Maternity and Neonatal Safeguarding



Maternity and Neonatal Safeguarding

- **Maternity Safeguarding Team Structure:** Although fully aligned with the corporate safeguarding team: the Team maintain close links with maternity: The Band 6 & 7 practitioners work from a dedicated safeguarding hub on Lyndhurst Ward. At this hub, the Band 6 duty midwife handles daily safeguarding inbox activities and telephone calls, provides responsive supervision, and supports the community midwife during MDT meetings and regular ward rounds. Additionally, the Perinatal Mental Health Midwife is based within this office, ensuring comprehensive safeguarding support across our services and effective liaison. Katy Durston was successful in a new substantive 22.5-hour Band 7 Senior Maternity Safeguarding Practitioner post. A Central part of Katy's role is providing senior operational support to the band 6 safeguarding practitioners. The team being available for staff during core hours is much valued by our midwifery and neonatal colleagues on the wards to avoid discharge delays, to help with ward flow and to support staff with challenging conversations
- **HIPS Unborn and Newborn Protocol:** As a team we have been actively involved in a all parts of the HIPS wide working group. Due to changes with the ICB this has been delayed until Autumn 2026. This review represents a welcome opportunity to address several challenges that have been identified within HIPS, including issues related to information sharing, the rigor of risk assessments, and the evaluation of parental mental capacity—a factor that significantly impacts the unborn. We view this process as a critical step toward enhancing our practices and ensuring better outcomes across the network and to ensure challenges that were within the old HIPS protocol have been addressed.
- **Southampton Mash Conversational Model:** This model has been in place for over a year. Feedback has been largely positive with some minor issues such as 'time to make the call' We have listened to midwife's feedback and worked with MASH to make a template for Midwives to send with information sharing requests when there are historic risks that would trigger a referral under the unborn protocol risk assessment but no new emerging risks to reduce risk of delays around information sharing. These referrals are shared with the parents to be awareness.
- **Hope Boxes:** This scheme was designed to help mothers capture important memories of their time with their baby prior to separation due to legal proceeding around the time of birth and to promote the ongoing connection between mother and baby.
- **Safeguarding Newsletters:** We continue to offer quarterly newsletters to maternity and neonatal colleagues. We use this to highlight topics in depth and to support learning from safeguarding reviews, audits, media topics and to provide signposting to services and information. This year's topics have included Support for Dad's, HIPS Neglect strategy, alcohol and baby safety and the Victoria Marten review.

Maternity and Neonatal Safeguarding

- **Complex Safeguarding and Parental Mental Health cases.** There has been a noticeable rise in complex safeguarding cases involving families with significant social vulnerabilities, particularly where unborn babies and wider family members are at risk. Some of these cases involve prolonged neonatal admissions, where maternal mental health, self-care challenges, and wider social issues directly affect fetal and newborn wellbeing. Maternity and Neonatal services are increasingly taking on the role of Lead Professional due to their consistent and ongoing involvement with these families. Case planning has highlighted strong multidisciplinary collaboration across the Trust: including inpatient teams, Nest Teams, Obstetricians, Site Managers, and the Learning Disabilities team — as well as effective partnership working with external agencies such as ICB Designated Nurses. However, this work has also highlighted gaps in wider community services and the need for additional resources and support pathways to meet the growing complexity and safeguard families effectively.
- **Psychological Supervision-** The team continues to access bi-monthly psychological supervision in partnership with Perinatal Mental Health colleagues, delivered by Beth George from the UHS Psychology Services. This provides a structured space to reflect on complex cases, decompress, and process the emotional impact of working with highly vulnerable families. Recognising the vicarious trauma experienced by staff, Beth also supporting the Nest teams is now also providing monthly psychological supervision specifically for the maternity safeguarding team, which has been very positively received.
- **Safeguarding Supervision:** Safeguarding supervision continues to be strengthened, and we are always looking at ways we can expand the current provision to ensure supervision is available to staffing groups within Maternity and Neonatal services. We offer targeted group/individual sessions to Nest teams which has been challenging in terms of numbers due to ongoing staffing pressures within the Nest team. We will always offer one to one safeguarding supervision if requested or if we identify a staff member may benefit from additional support. The Neonatal Unit provides bi-monthly supervision accessible both virtually and face-to-face, ensuring flexibility for staff. In addition, the NNU hosts weekly psychosocial meetings attended by neonatal and maternity teams. These meetings provide a structured forum to discuss inpatients with psychosocial needs, agree plans, and ensure timely updates are shared with Health Visiting teams.

Maternity and Neonatal Safeguarding

- Level Three Safeguarding Children Training. We have worked with our colleagues in maternity and health rostering to improve attendance at training sessions- this has seen a slow but steady improvements to attendance which is now 67% which compares favourably to other divisions. The team are reviewing the training offer in response to feedback from the wider service and following the recent updated Intercollegiate Document which places increased emphasis on competence over hours spent in training. The intention is to return to a hybrid model of training, increasing flexibility of access and opportunity whilst continuing to provide regular face to face updates, including drop ins and 'lunch and learn' sessions.
- The Neonatal Unit have added a Family Information Form to their admission processes which supports the staff in undertaking a more holistic approach to admissions with prompts around psychosocial assessments which enables staff to continue to have open and honest conversations about issues which may impact their family well-being and long-term planning.

Mental Capacity Team



Mental Capacity Team

- **CQC notifications.** A previous risk due to a significant delay in sharing of notifications has been closed with the backlog entirely resolved.
- **The DoLS policy** was reviewed and a DoLS priority tool was introduced.
- **MCA Champions Network.** The network continues to be well attended and supports clinical practice widely within the organisation.
- **Monthly drop-in sessions.** These are run quarterly in conjunction with specialist teams including Learning Disability and Autism and Delirium and Dementia teams.
- **Audits.** MCA and best interests decision making audit was undertaken in line with contractual reporting requirements. The audit found:

Mental capacity assessment records

- Documented the decision to be made.
- Were conducted at the right time.
- Documented the outcome of the assessment.
- Require improvement in evidencing functional test elements and assessing communication element correctly.
- Require improvement in clearly linking inability to make a decision with impairment/disturbance in functioning of mind/brain.

Best Interest Decision Making Process

- Appropriately consulted with relevant others.
- Used and weighed information available/gathered to make a best interest decision.
- Considered patients wishes/beliefs/cultures/values/lifestyle.
- Documented best interest decision in patients notes.
- Could be slightly improved evidencing consultation with family/significant others.



University Hospital Southampton
NHS Foundation Trust

The image shows a detailed display board for a Safeguarding Team. The board is divided into several sections, each with a different theme related to child protection and safeguarding. The left side features a poster on 'TYPES OF RISK AND POTENTIAL ABUSE' and another on 'HOW DO THEY SEE THE WORLD?'. The center has a poster about 'THE TEEN BRAIN' and a checklist for under-18s. The right side includes a poster about 16 and 17-year-olds, a poster on vulnerability factors, and a poster about asking three questions. A purple bucket of snacks is placed on a table in front of the board.

Transition Safeguarding

Service impact: transition service is at times required to cover absence in the SG Adults, SG Children and Paediatric Liaison teams due to wider operational service pressures. This can result in reduced skill mix across all areas of the service.

Transition specific training: about Under 18s in adult areas across the Trust has continued to be delivered this year. A package is in development covering children looked after, disabled children and care leavers which will also support this area.

Meeting attendance: Adult High Intensity Service User (HISU) group, Children's HISU group, Adults and Children Safeguarding meetings, MDTs, MARMs, Delayed Discharge Meetings, Professionals meetings, Patient Safety meetings, CAMHS/In-Reach CAMHS daily huddle.

Transition in-patient review continue to review the daily 16- & 17-year-old inpatient and the 18–25-year-old inpatient checklist. Direct support is provided to ward areas as required.

Transition as a local priority: transitional safeguarding has been identified in a theme in multiple domestic abuse related death reviews and safeguarding adult reviews. This will be an area of focus for safeguarding adult boards locally.



University Hospital Southampton
NHS Foundation Trust

Activity – Safeguarding Adults

Safeguarding Referrals to UHS Adult Safeguarding team= 2726 (2.5% decrease from 24/25)

Safeguarding referrals sent to the Local Authority = Unable to report

Prevent referrals: 1

DoLS = 1137 (13% increase from 24/25- 1041)

Number of Court of Protection / legal cases supported: 7 with support given to **9** further cases where applications were considered.

Total number of SAMA cases: 33 (43% decrease from 23/24)

Training delivered; adult sessions = 13 / joint adult & child sessions = 3

Statutory Activity: 21 scoping's for consideration of statutory review including safeguarding adult review and domestic abuse related death review. Panel member for **5 DARDs** and **4 SARs**.

Analysis of Safeguarding Adults data

- Whilst a decrease is noted in the number of referrals being shared with the safeguarding adult team, this does not reflect a reduction in the operational capacity required to respond to those concerns. Increasing complexity, alongside interconnected safeguarding risks and co-occurring vulnerabilities, continues to present challenges in resolving concerns and supporting patients effectively.
- The safeguarding team continues to see low levels of S42 enquiries caused by the local authority in relation to UHS related care. This averages at 6 S42 enquiries per quarter. This is likely to reflect both high-quality referrals with assurances provided to the local authority that reduce the requirement for a S42 enquiry, and a high level of changing process and structure within the local authority resulting in thresholds for enquiries to have raised.
- There has been a further **13%** increase in DoLS applications on previous years. There remains a delay, however, in authorisation by the Supervisory Body which is recognised and reflected on the Trust's Risk Register. This is a nationwide issue since the Cheshire West ruling in 2014 whereby the "acid test" provided additional clarity as to what constitutes a deprivation of liberty. The trust has a process in place to identify high risk patients and request urgent assessments where required and the expertise of the MCA / DoLS lead is utilised by clinical areas to support decision making.
- There has been a reduction in the number of SAMA cases, allegations in relation to staff whereby a safeguarding threshold is met or which require a safeguarding oversight. The change in the structure of the team has streamlined this process somewhat and the updated policy will be out for draft in 2026/27.
- The team continues to offer support to multiple areas in relation to complex discharge planning, liaising with local partner agencies and complaints. There are no complaints directly in relation to the work of the team.



Analysis of Safeguarding Adults data continued

- 13 training sessions were completed this year delivered by the team, with excellent feedback provided by attendees. There remains a challenge in demonstrating an increasing compliance rate for training despite up to 250 attendees per month attending and the safeguarding education lead will continue to work with workforce systems and divisional education leads to resolve this. Divisions have been asked to review and report their improvement plans and trajectories through safeguarding governance and steering group.
- One Prevent referral was made this year. Prevent data is collated quarterly and returned to the NHS Data Collection team on behalf of the Trust by the Safeguarding Adults team. Prevent referrals remain low, however the national landscape continues to evolve with increasing recognition of individuals presenting with mixed, unclear or unstable ideological influences, as well as those demonstrating a fixation on violence rather than adherence to a single extremist narrative.
- The safeguarding adult service continues to work alongside divisions and IT to attempt to resolve challenges in patient flow and length of stay, including upgrading UHS Apps safeguarding adults, adding safeguarding flags to the e-whiteboard which populate from UHS Apps, and visibility of both current and retrospective data in relation to safeguarding concerns at ward, care group and divisional level.
- An Independent Domestic Violence Advocate has been commissioned and funded by Southampton City Council to work with patients at UHS with a start date to be confirmed.

Activity – Transition Safeguarding

Safeguarding Referrals = 176 (16&17yr olds) + **190** (18 to 25yr olds) = **366** (495 in 23/24)

Training delivered = this data is included within adults and children's training figures

High levels of concerns are raised in relation to transition aged patients who have presented due to dysregulation or mental health difficulties, and where admission is requested to support with a place of safety. A number of these patients are highly challenging to discharge where the risks that they present to themselves are unable to be effectively mitigated by community services.

Joint working across the whole safeguarding team has enabled an increase in the knowledge of the transition team in responding to complex adult and child safeguarding scenarios, as well as providing the opportunity for the wider team to understand better the complexities of that this cohort of patients experiences.

Anecdotally, care leavers and care experienced young people are highly represented within this cohort of patients, and a gap review against the NICE guidance on transition is to be undertaken and fed into the safeguarding children partnerships in 2026/27.

Activity – Safeguarding Children

25/26 Safeguarding referrals to UHSFT Safeguarding Children Team = 1330 4% increase from 2024/25, and maintaining the increase seen from previous years.

104 of those relate to children subject to Child Protection Planning (111, compared with 111 in 2024/25, 87 in 23/24 and 55 in 22/23).

352 concerns identified relate to a parent who is the primary patient (compared with 304, 202 and 70 in previous years) indicate continued improvements in applying a think family approach when safeguarding children.

A reduction has been seen in the number of children experiencing actual harm (76 down from 87, 101 and 136 in previous years); but a steady rate of unexpected child deaths (16, compared with 20, 15 and 9 in previous years).

The number of concerns for which advice was provided but no further action required from the team reduced from 525, 530 and 592 in previous years to 486. This indicates that confidence in managing concerns within the wider organisation remains high and continues to increase.

Statutory Activity

- 7 requests for information to be provided from UHS to contribute to Rapid Reviews and Local Safeguarding Child Practice Reviews Of these contributions, 1 has moved forward to full statutory reviews.
- UHS provides input into multi agency audits led by both Hampshire and Southampton safeguarding children partnerships.

Published Child Safeguarding Practice Reviews

The Named Nurse or Deputy Named Nurse attends the appropriate rapid review or partnership subgroup to contribute to consideration for CSPR and identifies and shares learning where appropriate for UHS. There have been no published child safeguarding practice reviews to which UHS contributed in the year 2025/26.

Activity – Safeguarding Children

Total number of LADO cases = 26 Previous years: 19 29; 22 and 27. More concerns are progressed through LADO that would previously be managed under SAMA as recognition of regulated activity with children increases, particularly in clinical pathways that take patients from age 16.

Paediatric Liaison Nurse Specialist (PLNS) Team

Triaged **4673** Information sharing forms (ISF) in 2025/46. This represents a 12% decrease from 5315 forms completed in 2024/25. The PLNS team stopped reviewing all ED attendances for children in 2025/26 following an audit that showed that 98% of attendances had an appropriate ISF completed. An audit of the attendances that ought to trigger an ISF showed a correlated decrease in line with the reduction of ISFs.

PLNS attends operational MET (missing, exploited, trafficked) meetings in Hampshire and Southampton to share and receive information related to children who are at risk of being MET and / or habitual knife carriers and maintains flags on records in relation to these children.

PLNS handed over the dissemination of neonatal unit reports to the neonatal team in 2025/26.

Safeguarding Children Training:

Safeguarding Children Level 3 generic: 11 (one cancelled due to UHS Major incident.

Domestic abuse (adults and children): 2

Topic Specific Safeguarding Children Level 3: 10

Level 3 children's for Taplins nursery: 1

Other bespoke delivered at level 2: 17.

Summary and Analysis of Safeguarding Children data

- **Safeguarding referrals to UHSFT Safeguarding Children Team-** there has been a relatively static number of referrals into the Safeguarding Children team. The team was fortunate to have staffing supported by a secondment for 12 months of a band 7 safeguarding specialist nurse from a community trust, and following that has employed substantively a band 6 safeguarding practitioner to the team. This forms an element of the restructure of the team, providing improved escalation pathways and an improved career pathway for those wishing to develop a safeguarding career within UHS.
- The named nurse safeguarding children post will be rebanded to an 8A, with a band 8B Head of safeguarding providing oversight across the whole of safeguarding and MCA / DoLS. Consultations and recruitment in to these posts will progress into 2026/27.
- The highest recorded risk factor recorded within referrals to the UHSFT Safeguarding Children Team was poverty, with drug and alcohol use following closely. This is a contrast to 2024/25 where the drug and alcohol use featured more highly than poverty. This data is not robustly recorded and as such does not reflect the whole picture in relation to the experiences of children using our hospital.
- 623 children raised to the safeguarding team had experienced concerns within their own home.
- 132 referrals related to physical harm, with 109 cases of neglect; 24 cases of sexual abuse and 17 cases of emotional abuse being recorded. This data relates to the category of initial concern and do not reflect the final outcome of assessment and investigation. The significant increase in concerns of neglect may be associated with the increasing recognition of poverty.
- 30 SUI (Serious Untoward Incidents) were notified to the Named Nurse and wider Senior team in 2025/26. These reflect situations where children have been identified to have died or suffered significant harm believed to have been as a result of neglect or abuse.

Activity-Maternity Safeguarding

Number of maternity safeguarding notifications raised = **979 (+ 17.5 % % from 2024/25)**

Number of referrals sent to children social care = **482 (+ 37 % from 2024/25)**

Outcome of pre-birth plans

•Pre- birth plans commenced by children services (NB this includes 3rd party referrals e.g. police, health visiting) = **314 (+35 % from 2024/25)**

•No further action = **245 (+45 % from 23/24)**

•Newborns on Child protection plan at birth = **60 (+28 %)**

•Newborns on child in Need plan at birth = **109 (+ 7.0 %)**

•Interim care orders at birth=**15 (+ 7.0%)**

•Newborn police protected at birth = **0 (24/25= 2)**

•Number of cases that have been referred for child practice reviews which focus was maternity related = **1 cases**

General Data :

Teenagers & Pregnancy

Teenagers under the aged of 19 years = **97(+ 7 %)**

Teenagers under the age of 16 years = **14 (-21%)**

Reported FGM cases = **49 (-33%)**

Domestic Abuse

Current Disclosures 69 %(+ 18.9%)

Historic disclosed by pregnant person 363 (+8.6%)

Subject to MARAC/HRDA 29 (-24%)

Substance Misuse

Current Substance Misuse 52 (-8%)

Historic 11 (+7.8%)

Activity – Maternity safeguarding

Meeting activity

Number of meetings with children services attended by midwifery pre-birth (safeguarding or Nest Teams) = **450**

Number of post birth meetings attended = **49 (16.7%)**

Number of additional professional meetings including JAR, strategy meetings, MARM, neonatal psych-social meetings substance misuse meetings and MDT meetings = **186**

Total number of meetings covered by maternity services = **684 (+12% meetings -)**

421 (+19%) of these meetings were supported by the maternity safeguarding team

Total number of Supervision sessions facilitated by maternity safeguarding team = **29**

Telephone calls/liaison collected from April 2025/March 2026 = 795 calls (496 25/26)

Safeguarding Children Training Level 3 (including bespoke sessions delivered to NNU staff/ maternity staff) = **9 sessions**

Maternity Data Analysis

Safeguarding Notification and Referrals

Both the early identification and onward referrals/escalation of risks have increased. This upward trend reflects both increasing complexity within the population and strengthened practitioner confidence in identifying and onward referrals and escalating concerns.

Pre birth planning activity has increased with children services initiating 314 birth plans (+35%) alongside a notable increase in cases where no further action was needed, this suggesting improved quality and proportionality of assessments

A percentage of case closures occur during pregnancy, and this does not then reflect the work by safeguarding practitioners in attending meetings and follow ups related to the case and escalation if with disagree with this decision and then potential delays if a case needs to be re-referred to children services.

Pre and Post Birth Planning

More newborns were subject to CP plans (60,+28%) and child in need plans (109, +7%), indicating heightening risk levels in families. This is very important as we know newborns in family groups are the most vulnerable particularly in large family groups.

Interim care orders have remained stable and the reduction in police protection at birth demonstrates effective early intervention and reduced need for crisis response

.

Maternity Data Analysis

Meeting Activity

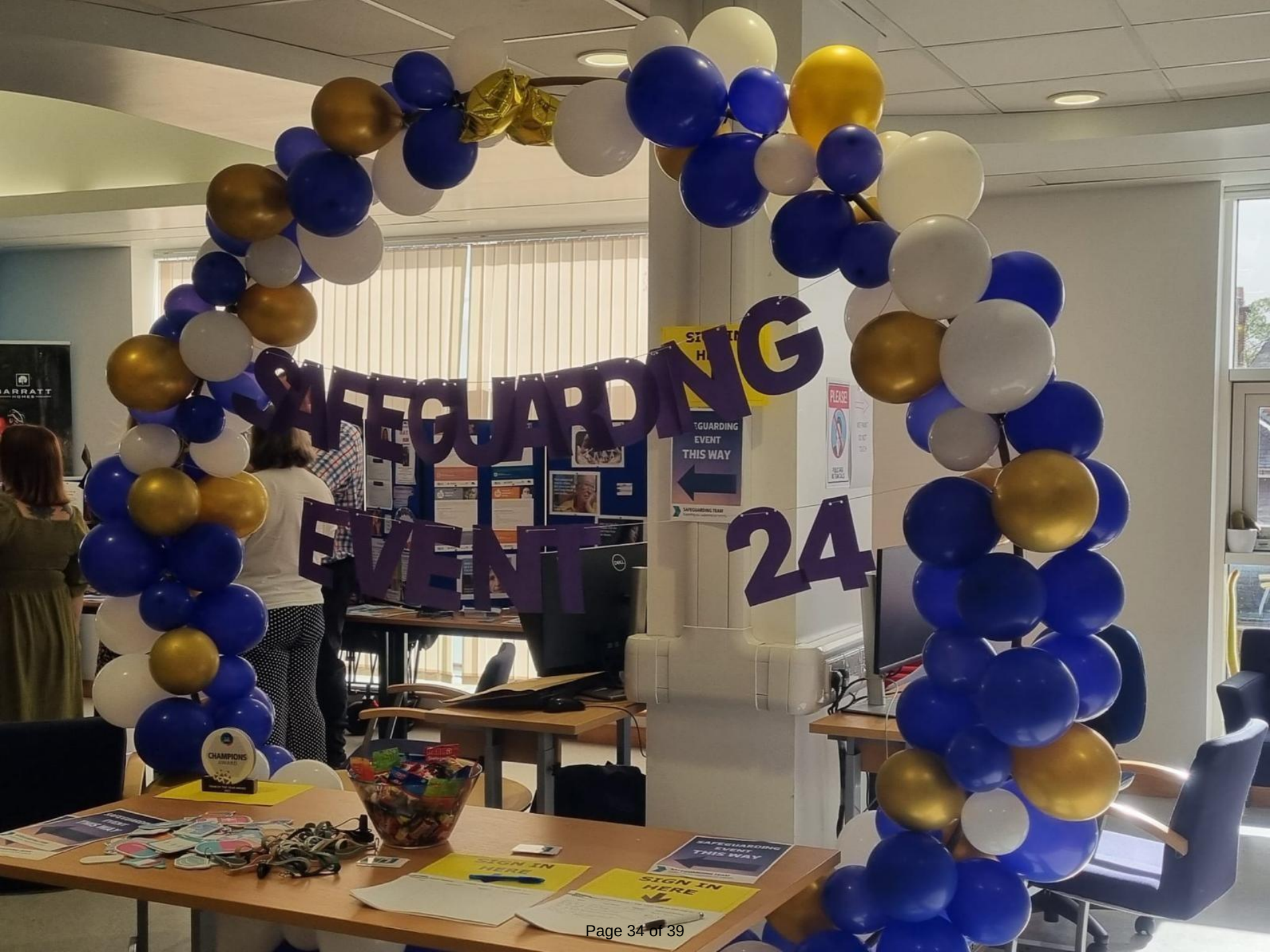
The increase in multi-agency meetings highlights a growing reliance on the maternity safeguarding team but this then reduces our availability for other activities such as supervision. This may be demonstrated by the rise in phone calls to the services which potentially demonstrates a reliance on immediate advice and potentially missed opportunities for early intervention

Supervision and Support

With only 29 supervision sessions delivered despite rising complexity there is a risk that staff may not receive sufficient reflective support, a reliance of calling the team for immediate advice and the potential to impact the quality of safeguarding assessments and practitioner well-being both for the team and maternity and neonatal staff.

Risk of delays in Discharge and Ward Flow

Although mitigations in place if activity levels increase the likelihood of delays in discharge planning, particularly if senior safeguarding support is not consistently available.



Mandatory training report

	Div. A % (Targeted audience)	Div B % (Targeted audience)	Div C % (Targeted audience)	Trust HQ % (Targeted audience)	Trust Wide % (Targeted audience)
Safeguarding Adults level 1	78.60%	65.00%	82.80%	87.60%	80.80%
	3435	2779	3569	900	10681
Safeguarding Adults level 2	75.30%	77.30%	73.00%	61.80%	73.30%
	3503	2588	3414	669	10173
Safeguarding Adults level 3	21.10%	34.90%	17.90%	0%	25.20%
	2394	2003	1479	20	5896
Mental Capacity Act level 1	80.10%	91.20%	80.80%	83.50%	82.20%
	884	457	1098	269	2708
Mental Capacity Act level 2	54.20%	55.10%	60.50%	45.40%	55.90%
	3602	2909	3040	547	10097
Prevent levels 1&2	84.50%	88.20%	92.50%	86.20%	89.30%
	2479	2064	3452	1399	9393
Prevent level 3	77.60%	76.70%	81.80%	63.00%	77.60%
	3821	2938	2815	667	10240
Child Protection level 1	73.30%	61.10%	84.10%	77.80%	77.00%
	500	651	1802	1191	4145
Child Protection level 2	74.50%	74.60%	85.40%	66.90%	76.20%
	3947	2919	3016	737	10618
Child Protection level 3	47.50%	49.80%	62.20%	28.00%	56.10%
	957	1605	1896	167	4624

Analysis of Training compliance

Level Three safeguarding training

Despite significant attempts to resolve the challenges in recording and reporting safeguarding children level 3 training compliance, improvements have not been realised.

A significant piece of work led by the education leads and supported by the safeguarding team created a new matrix model for a yearly reporting safeguarding children level 3 compliance which is live on VLE.

Despite the work undertaken, regular cohorts of staff are not identified as being mapped to this compliance and IT service desk tickets are requested on each of these occasions.

Improvement plans, showing improvement trajectories, have been created by divisional education leads and further work continues to support the increasing of compliance, including requesting that this be a standing agenda item at divisional and care group governance meetings for oversight.

41 sessions have been delivered, with 24 of these being at level 3, by the safeguarding children team.

Staff are able to achieve their compliance through attendance at a delivered session, completion of e learning for health level 3 training or case review, attendance at supervision, or self directed learning.

Maternity safeguarding continues to deliver bespoke training to the wider maternity workforce, together with perinatal mental health. Maternity roster managers support with attendance and actively roster staff to attend training in line with their compliance expiry.

Safeguarding adult level 3 compliance continues to cause similar challenges to those in safeguarding children with compliance not increasing in line with expectations, with in excess of 250 attendees per month at delivered sessions. Similar pathways to completion are available to those requiring this training.

Level 3 DoLS training is expected to be launched in 2026/27.

Key areas of work for 2026/27

Joint

- Joint Safeguarding Adults and Children Champions Network.
- Development of improved training offer in line with updated Intercollegiate Documents.
- Allegations management policy to be ratified.
- Training compliances to increase.
- Safeguarding supervision training to be created and embedded.

Adult specific

- IT system improvements to be made.
- Referrals at source to commence.
- Embedding of SOPs and divisional facing portfolios.

MCA Specific

- MCA / DoLS level 3 to be developed and rolled out.
- Development of a public facing webpage with information for patients and families

Transition specific

- Continue the upskilling of workforce providing care for 16- and 17-year-old patients outside of paediatric areas and celebrate the successes that are seen in practice.
- Transition gap analysis against NICE guidance.

Children specific

- IT system improvements to be made.
- Embed named nurse safeguarding children at 8A and create a new approach to escalation and oversight.
- Embed CP-IS across UHS
- Embedding S11 action plans.

Maternity specific

- To continue to embed changes in staffing, supporting the family approach to safeguarding including the UBB and the safeguarding of mothers in maternity.
- To review the offer NNU and identify whether the workforce is adequate to support the current process.

Patient and Family Story

- Destiny and Winnie
- Destiny presented to ED with abdominal pain and found to be 24/40. Destiny was previously unaware of pregnancy and identified to be active user of crack cocaine.
- Destiny was seen by VAST, the maternity safeguarding team were notified of her attendance, and she was admitted to Princess Anne Hospital to receive care.
- Discussions were held with UHS Legal team around patient's choices, including consideration of termination of pregnancy.
- A referral was made to the children's resource team for the unborn baby.
- Discussions were held between UHS MCA Team, UHS Adult Safeguarding team and UHS maternity safeguarding team.
- A referral was made to psychiatric liaison.

Patient and Family Story continued

- Discussions were focussed on recognising the risks to UBB and their needs, understanding Destiny's wishes and hearing her voice, and ensuring that she had choices in relation to her care and how it was to be delivered.
- The need to provide support, leadership and advice to staff on the ward was recognised by the safeguarding team.
- Multiple meetings and plans were supported by the wider UHS safeguarding team, throughout the remaining pregnancy and following the birth of Winnie, with exploration of support options and recognition that pregnancy can be a driver for change for some. Initial plans considered the likelihood of the removal of the baby at birth as quite high.
- Through the building of trusting relationships and ongoing multi-professional support, Winnie, after a period of inpatient care in NNU was discharged into the care of Destiny with ongoing intensive support by agencies to ensure that the family could continue to thrive.
- Destiny described her initial experience as one of being scared, feeling watched and judged and of having had previous negative experience. On discharge she described feeling grateful, seen, heard and understood and was pleased to have a happy ending and a new start.

Agenda Item 5.11 Report to the Trust Board of Directors, 10 September 2026			
Title:	Annual Complaints Report 2025-26		
Sponsor:	Natasha Watts, Acting Chief Nursing Officer		
Authors:	Jenny Milner, Associate Director of Patient Experience Debbie Watson, Head of Patient and Family Relations		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			
Executive Summary:			
Between 1 April 2025 and 31 March 2026, UHSFT recorded 8,726 PALS interactions, of which 503 progressed to formal ‘take a closer look’ complaints. This increase reflects sustained demand and the full implementation of PHSO reporting standards. The primary themes of complaints remain consistent with the previous year: clinical treatment (28%), communication (26%), and appointments (9%). Increased volumes have impacted performance, with average response times rising to 49 working days for formal complaints and 30 working days for early resolution. Recovery actions including new PALS leadership and an enhanced triage system are underway to reduce backlogs and improve timeliness. Overall, 46% of formal complaints were upheld or partially upheld, representing an increase on the previous year, though this remains below national benchmarks. Escalations to the PHSO remain low, suggesting confidence in local complaint handling processes. Learning from complaints continues to inform improvements in communication, documentation, consent, and overall patient experience. Insights are embedded through staff training, strengthened governance, and targeted service reviews. Priorities for 2026/27: ▪ Reduce response times and strengthen early resolution pathways ▪ Sustain backlog reduction ▪ Embed learning more consistently into frontline practice Despite rising demand, the Trust remains committed to transparent, responsive complaint management and continuous improvement. The report also explores the potential role of AI in complaint handling, including associated opportunities and risks.			
Contents:			
Annual Complaints Report 2025-26			
Risk(s):			
Risk 827: PALS Response time			
Equality Impact Consideration:		N/A	

Definition of terms

Everyday Conversation

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

Complaint – Early Resolution

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

Complaint – Taking a Closer Look

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

Parliamentary and Health Service Ombudsman (PHSO)

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

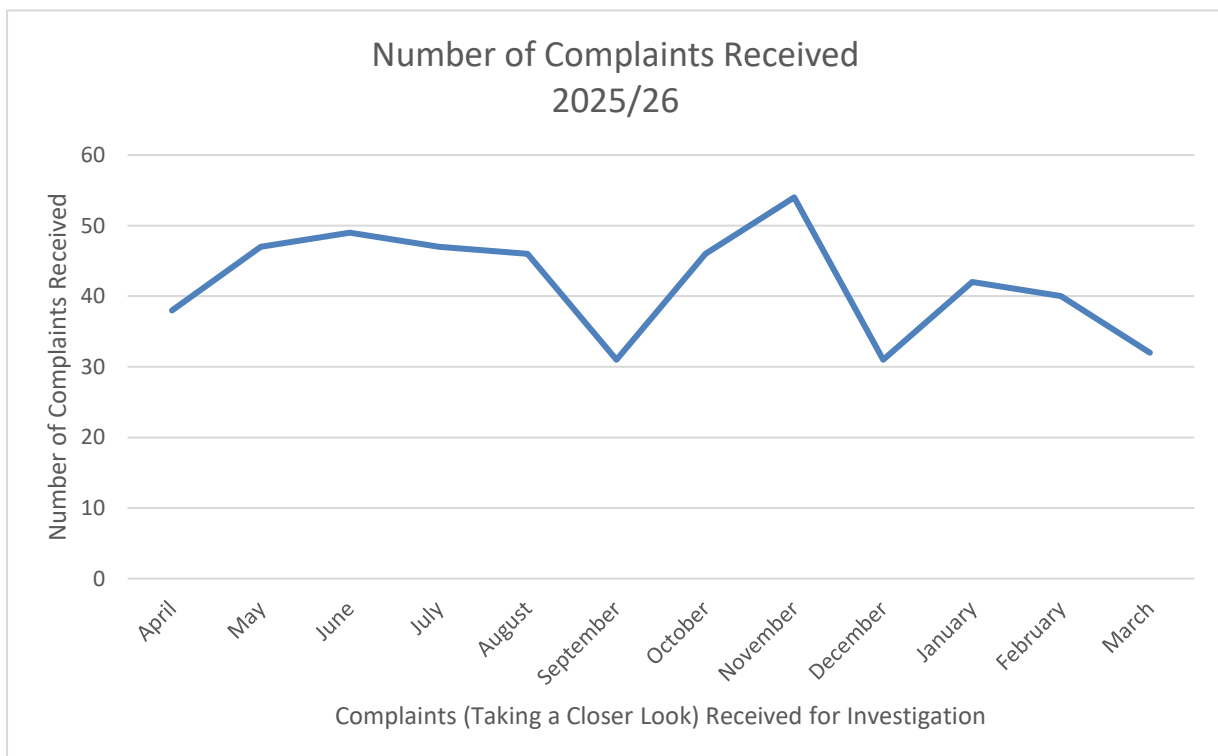
PALS

Patient Advice and Liaison Service.

1 Purpose of report

This report presents an overview of the complaints received by University Hospital Southampton NHS Foundation Trust (UHSFT) during the period from 01 April 2025 to 31 March 2026. It has been prepared in accordance with the requirements set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

2 Complaints activity



Over recent years, there has been an approximate 20% rise in ‘taking a closer look’ complaints. This increased demand has contributed to longer processing times, with average handling reaching 49 working days in March 2026.

Similarly, higher volumes of interactions within the PALS service have resulted in extended handling times, which reached 30 working days by March 2026. In response, a new Clinical PALS Manager was appointed towards the end of Q4 2025/26. The team has since undertaken a focused program of work to address a significant backlog, which had developed due to vacancies and sustained workload pressures.

Complaints received (please note does not include all enquires/interactions)

	2021/22	2022/23	2023/24	2024/25	2025/26
Complaints – Early Resolution*	2,434	2,048	1,546	265	451
Complaints – Taking a Closer Look	388	413	403	436	503
Total Complaints	2,822	2,461	1,949	701	959

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

The Parliamentary and Health Service Ombudsman (PHSO) introduced revised complaint standards requiring all expressions of dissatisfaction to be recorded as formal complaints. Full implementation and standardisation were achieved in October 2023, which explains the temporary reduction in 'Early Resolution' data prior to this point.

Although 'Everyday Conversations' are not analysed in depth within this report, it is important to recognise that the Trust recorded 7,957 informal interactions (including feedback and signposting) during the 25/26 reporting period. These interactions reflect ongoing engagement between patients, families, and staff, and provide valuable insight into the broader patient experience.

The number of formal complaints, as detailed in the 'Taking a Closer Look' section, has predominantly shown an increase.

Complaints (Taking a Closer Look) upheld

	2021/22	2022/23	2023/24	2024/25	2025/26
Complaints received	388	413	403	436	503
Complaints upheld	41	44	39	45	71
Complaints partially upheld	125	163	133	111	162
% complaints upheld or partially upheld	43%	50%	42%	36%	46%
National comparison for upheld	66%	60%	50%	67%	48%

In 2025/26, the proportion of complaints upheld (14%) or partially upheld (32%) by UHSFT increased to 46%, with both upheld and partially upheld cases increasing. Notably, UHSFT continues to benchmark below national averages for upheld complaints. While interpretation of this data may vary, further assurance is provided by the Trust's consistently low number of referrals to the PHSO.

During the same period, the PHSO also contacted UHSFT regarding two complaints, both of which were resolved locally through remedy payments in line with their recommendations.

Complaint themes

UHSFT	NHS (National)
Clinical treatment (28%)	Clinical treatment (26.5%)
Communications (26%)	Communications (17.6%)
Appointments (9%)	Patient care (12.8%)

National NHS data is drawn from the Data on Written Complaints in the NHS 2024/25 report, published in October 2025. At the time of writing, data for 2025/26 is not yet available. The Trust's top three complaint themes have remained consistent over the past five years. Clinical treatment continues to be the most frequent theme, followed by communication, and then either patient care or appointments.

As in previous years, identifying broader patterns within complaints remains challenging, as they often reflect individual patient experiences across one or more services. Complaints activity is routinely reported to divisional and care group governance teams, ensuring that emerging themes or any significant increases in cases are identified and addressed promptly.

3 Parliamentary and Health Standards Ombudsman (PHSO)

Review of PHSO cases

	2021/22	2022/23	2023/24	2024/25	2025/26
Complaints closed	2	1	2	3	6
Complaints upheld	0	0	0	0	0
Complaints partially upheld	1	1	2	3	2

There are currently 12 open complaints being reviewed by the PHSO.

In 2025/26, two cases were closed by the PHSO and were partially upheld; none were fully upheld. It should be noted that PHSO data reflects only cases that progress to preliminary investigation and excludes referrals that do not meet the threshold for investigation.

PHSO case 1

This case concerned a lack of clarity in communication between UHS and a partner organisation (Trust B). In response, a formal protocol has been introduced to enable Trust B to access a consultant directly when making future referrals.

It was also identified that a telephone referral from Neurologist was not documented in the patient's health record. While recognising the complexity of fully addressing this issue, documentation of incoming telephone referrals has been added to the Trust's risk register, and clinicians have been reminded of the importance of accurate record keeping.

In addition, elements of the complaint investigation did not fully align with NHS complaint handling standards. The PHSO requested that the Trust provide a formal apology to the patient and demonstrate evidence of service improvements.

PHSO case 2

This case is related to a patient undergoing neuromodulation surgery. It was found that the consenting process did not include discussion of the potential use of an alternative implant. Furthermore, the procedure proceeded with a change of implant during surgery, which should not have occurred.

It was also identified that sedation during the procedure was insufficient, negatively impacting the patient's experience and emotional wellbeing.

The PHSO requested a formal apology, a comprehensive action plan, and a financial remedy of £2,500 in recognition of the significant psychological impact on the patient.

4 Cases of learning from complaints

Case 1: Medicine

A patient with complex and advanced health needs experienced a deterioration in skin integrity during a hospital admission, resulting in a hospital-acquired pressure ulcer. There were concerns that this change in condition was not clearly communicated to the patient's family, and discharge documentation did not accurately reflect the severity of the injury.

Following discharge for end-of-life care, transport arrangements were not appropriate to the patient's condition, causing avoidable discomfort and distress. Subsequent involvement of community care providers highlighted the extent of the patient's condition to the family, which led to further distress and a formal complaint. The patient was later readmitted and subsequently transferred to hospice care, where they died.

A complaint resolution meeting was held with the family, where concerns were acknowledged and discussed openly. Key learning identified included:

Key learning identified the importance of clear, timely, and compassionate communication with patients and families regarding changes in condition.

Ensuring accurate and transparent clinical documentation, particularly at the point of discharge. The need for appropriate and individualised discharge planning, including safe and suitable transport arrangements.

Actions taken included reinforcing these principles with staff and developing targeted educational resources to support learning and improve practice. The organisation provided assurance to the family that their feedback had been heard and that steps had been taken to reduce the risk of recurrence.

Case 2: Children's Emergency Department (CED)

A young child presented with a high temperature; however, an appropriate diagnostic sample was not obtained to exclude potential infection in line with national guidance. This represented a missed opportunity for timely diagnosis. While recognising that sample collection in young children can be challenging, the investigation highlighted the importance of adhering to recommended assessment pathways. Clinical documentation indicated features that should have prompted consideration of a bacterial cause.

The case was reviewed with the clinician involved to support reflection and learning. Key learning points were shared within the department and communicated more widely to reinforce awareness and promote consistent adherence to clinical guidelines.

Case 3: Cancer Care

A patient with a complex mental health history experienced distress following an inaccurate clinic letter that referenced a procedure which had not been discussed. This error had an adverse impact on the patient's wellbeing.

The inaccuracy was acknowledged as unintentional. The clinician reflected on the impact of the error and reinforced the importance of careful review of correspondence. The letter was subsequently corrected and reissued to the patient.

Case 4: Surgery

During the reporting period concerns were raised regarding delays in urology treatment pathways which impacted patient experience and quality of life. Feedback also highlighted issues related to communication and clarity around appointment processes.

In response, the service undertook a review of waiting list management processes to identify and support individuals affected by delays. Actions included prioritising cases where appropriate, strengthening the routine monitoring of waiting lists, and improving communication with patients regarding expected timeframes and next steps.

This case reinforced the importance of providing timely updates, clear explanations, and appropriate apologies where delays occur. Ongoing improvements have been implemented to enhance transparency, manage expectations, and ensure a more consistent and person-centred approach to communication.

5 The use of artificial intelligence (AI)

The increasing public access to artificial intelligence tools is beginning to materially influence the nature and complexity of complaints received. Patients and families are now more frequently referencing specific NICE guidelines and NHS England (NHSE) policies within their concerns, often expecting detailed, evidence-based justifications in responses. While this reflects a more informed and engaged patient population, it also introduces additional layers of scrutiny and requires more comprehensive review, validation, and cross-referencing by teams. As a result, complaint handling is becoming more time-intensive, with a measurable impact on response turnaround times and overall service capacity.

Agenda Item 5.12 Report to the Trust Board of Directors, 1 September 2026			
Title:	Learning from Deaths 2026-27 Quarter 1 Report		
Sponsor:	Paul Grundy, Chief Medical Officer		
Author:	Jenny Milner, Associate Director of Patient Experience Louise Russell, Bereavement, Mortality and Data Insight Lead		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			
Executive Summary:			
This report ensures that mortality reporting in relation to deaths, reviews, investigations, and learning is regularly provided to the board. The report also provides an update on the development and effectiveness of the Medical Examiner Service (MES). The National Guidance on Learning from Deaths sets out expectations that: Boards must ensure robust systems are in place for recognising, reporting, reviewing, or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. This paper sets out a plan to meet these requirements more fully. 1. The Trust reduces avoidable deaths in our hospitals. 2. The Trust promotes learning from death by reviewing the quality of end-of-life care. 3. The Trust promotes an open and honest culture and support for the duty of candour.			
Contents:			
N/A			
Risk(s):			
▪ Risk 828: Bereavement Services Provision (closed February 2025) ▪ Risk 918: Clinical outcomes and patient safety could be compromised if learning from M&Ms is not effectively shared and embedded (moderate x likely = 12) ▪ Risk 919: Lack of adequate paediatric palliative care provision at UHS (moderate x possible = 9) ▪ Risk 958: Reduced staffing numbers within the Supportive and Palliative Care Service prevents the provision of a 7-day service which is a national standard for hospital based palliative care teams (moderate x likely = 12)			
Equality Impact Consideration:		Yes – EQIA completed	

1. Introduction

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

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

Morbidity and Mortality meetings (M&M) remain a key focus, with ongoing improvement in data quality and availability to enable organisational learning and Trust-wide dissemination.

2. Analysis and discussion

2.1 Deaths at UHS

Quarter	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27
Q1	483	504	512	466	500	449
Q2	591	526	471	446	435	
Q3	651	565	578	498	513	
Q4	537	489	558	552	504	
Total	2262	2084	2119	1962	1952	

During Q1 2026/27, 449 deaths were recorded across University Hospital Southampton (UHS) sites, representing an 11% decrease compared with Q4 2025/26, consistent with expected seasonal variation.

Of the deaths recorded in Q1 2026/27:

- 18 occurred in the Emergency Department.
- 431 occurred among inpatients.

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

The SHMI data measures the ratio between:

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

2.2.1 National context

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

- 13 trusts recorded a '*higher-than-expected*' number of deaths. This has increased from 9 in the last reporting period.
- 97 trusts recorded an '*expected*' number of deaths which is '*within range*'.

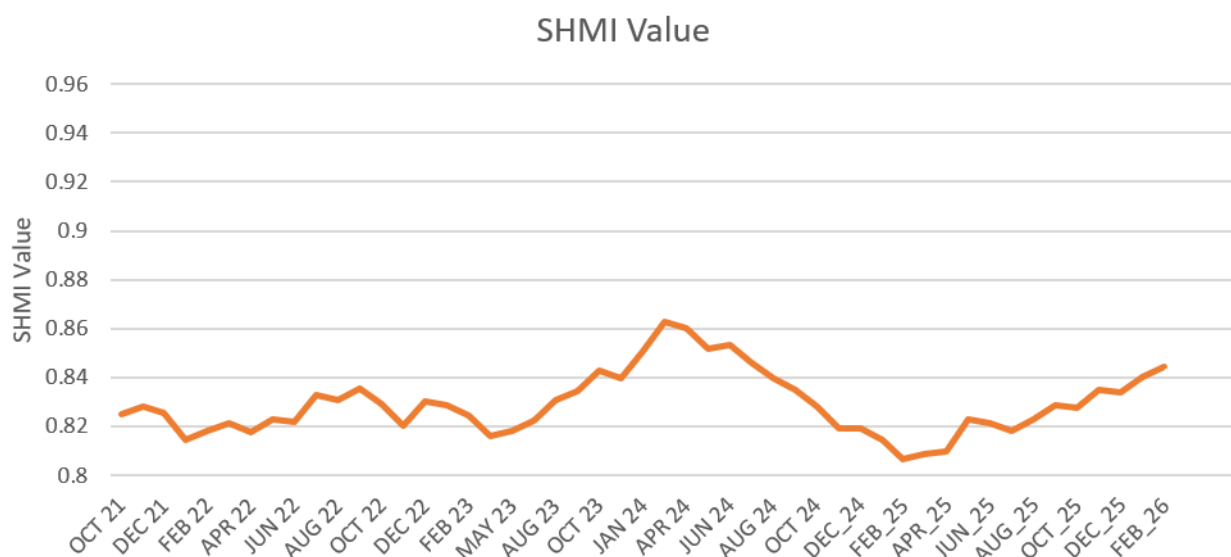
- 8 trusts recorded a '*lower-than-expected*' number of deaths, of which 7 also reported '*lower than expected*' number of deaths for the same period in the previous year and this includes UHS.

2.2.2 UHS performance

UHS has consistently remained in the '*lower-than-expected*' category throughout the reporting period. Key highlights include:

- A SHMI score of 0.8442 for the 12 months ending February 2026.
- This represents a less than a 1% increase on the previous figure reported for the 12 months ending November 2025 which was 0.8349.
- UHS is one of only 8 trusts nationally to achieve a '*lower-than-expected*' SHMI score.

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



SHMI values are calculated on a diagnosis level for the following diagnosis groups using the latest NHS England data published 09/04/2026 for 1 December 2024 to 30 November 2025.

Diagnosis Group	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	1.0398	As expected
Cancer of bronchus; lung	0.9462	As expected
Secondary malignancies	0.6658	Lower than expected
Fluid and electrolyte disorders	0.8107	As expected
Acute myocardial infarction	0.6255	Lower than expected
Pneumonia (excluding TB/STD)	0.9283	As expected
Acute bronchitis	0.5638	Lower than expected
Gastrointestinal haemorrhage	0.605	Lower than expected
Urinary tract infections	1.0355	As expected
Fracture of neck of femur (hip)	0.8928	As expected

During the 12-month period ending 28 February 2026, six diagnosis-level categories were classified within the '*as expected*' range, while four were identified as '*lower than expected*'. SHMI banding has changed for one diagnosis group from Q4 2025/26, as Gastrointestinal haemorrhage has improved from '*as expected*' to '*lower than expected*'. SHMI value has improved in five diagnosis groups.

2.3 Medical Examiner Reviews

In Q1, the MES reviewed a total of 1,229 deaths, including 458 deaths occurring on UHS sites and 771 within the community.

Of the 71 acute deaths referred to the Coroner during the reporting period, 44 underwent a post-mortem examination and 20 proceeded to inquest. Referral outcomes remain in line with historical patterns, with no significant deviation from previous reporting periods.

2.3.1 Referrals for Morbidity and Mortality (M&M) learning

During Q1, the MES referred eight deaths to specialty M&M meetings. Of these, two resulted in Patient Safety referrals and one was referred to the Learning from Lives and Deaths Review (LeDeR) programme. Referrals involved four care groups: MOP, Cancer Care, Critical Care, and Surgery, as well as two community-based cases.

2.3.2 Referrals to LeDeR

7 cases were reviewed under the LeDeR programme in Q1. Key learning points from these reviews include:

Areas of concern and action:

- Review of overnight bed moves involving vulnerable patients. Explored the feasibility of an e-CAMIS alert/flag, improve communication arrangements, taking the item to the Learning Disabilities Steering Group for discussion.
- Improve the consistency and quality of documentation on DNAR forms to ensure clear, comprehensive, and accurate recording of decisions and supporting discussions.

Areas of good practice:

- Early engagement with specialist support teams, including the Palliative Care Team, to support holistic care planning.
- Staff developed a strong understanding of the patient's individual needs and adapted care accordingly.
- Comprehensive inpatient discharge summary completion.

2.4 Learning from death via patient safety

New cases in Q1:

There was 1 PSII (patient safety incident investigations) and 1 NE (never event) reported in Q1. Neither was related to a patient's death.

Closed cases in Q1:

There was however one case closed in Q1:

- Patient was admitted to UHS following an intentional overdose and expression of suicidal ideation. He was admitted to AMU whilst awaiting allocation of an Older Persons Mental Health inpatient bed. He agreed to remain in hospital informally, meaning that he was not detained under any legal authority. He was assessed by mental health liaison services and deemed to require enhanced observation (one-to-one supervision). Patient accessed the bathroom in accordance with his enhanced care plan and following a short period without response to verbal checks was found with a ligature. Despite resuscitation efforts and transfer to intensive care he did not survive, having sustained a severe hypoxic brain injury.

Key learning:

A range of system-focused actions have been identified to address the learning from this investigation. These include:

- Improving the visibility and communication of enhanced care plans, standardising documentation and handover processes.
- Strengthening escalation pathways when RMN staffing is unavailable.
- Reviewing environmental safety arrangements.
- Enhancing training for staff providing one-to-one observations.
- Ensuring consistent staff well-being support following traumatic incidents.

2.5 UHS 'End of Life' incident reports

For Q1 2026/27, there were a total of 19 incidents reportedly relating to end-of-life care compared to 35 in Q4 2025/26. Overall, the main themes of the incidents were related to:

- **End of life care management:** These cases involved difficulties using the correct equipment and providing pain medication in a timely manner due to lack of availability and

lack of knowledge, resulting in avoidable suffering. In all cases ward discussions and training have ensued to avoid this occurrence in future.

- **Communication:** This accounted for more than half of the AERs. Themes identified include errors with 'movement to the mortuary', and human error in booking appointments and ensuring follow up.
- **Availability of services out of hours:** Specialist Paediatric Palliative Care not available for family on PICU when their child was deteriorating quickly overnight, impacting their choices and the morale of staff. Spiritual Care as well as Bereavement and Family Support were sought but not available when requested by a family on a Saturday.
- **Cryogenic Preservation request:** Sudden and urgent response required when presented with this request as family interfered with patient after death to reduce her temperature in the bay on the ward using bags of ice. Staff were unaware of these wishes and documentation produced appeared dubious. The situation was exacerbated by difficulties contacting the UHS legal team as this had never been requested before and as such there was no policy to follow. On this occasion, staff managed to balance the wishes of the family, and meet legal and ethical requirements, as due process was expedited to allow the patient to be released in accordance with her wishes. Learning involved a debrief for those involved and development of a new policy with urgent guidance to wards, along with TRiM support for those members of staff impacted.

2.6 Learning from UHS formal complaints relating to end-of-life care

In Q1 there were four cases closed relating to end-of-life care. Two cases are highlighted below:

Case 1

Patient was discharged without end-of-life-care provision at home. The family lacked understanding about fast-track application and anticipatory medicines regarding how and when they should be administered, and by whom.

Identified learning:

- Improve communication with patients and families regarding anticipatory medications to ensure they understand their purpose, appropriate use, and administration.
- The doctor has discussed this case with the ward team and resident doctors, reinforcing the importance of explaining anticipatory medication prescriptions to patients and families, including that these medications are provided for symptom management if required and are not intended for routine administration.

Case 2

There were communication shortcomings, including inaccurate information in the discharge summary, insufficient explanation and guidance regarding anticipatory medications, and a lack of referrals to palliative care, the GP, or community nursing services.

Identified learning:

- The importance of accurately documenting a patient's discharge destination was reinforced. Feedback was provided to the doctor responsible for completing the discharge summary.
- The need to strengthen communication with families was identified, with an emphasis on recognising effective communication as a core professional responsibility for all staff.
- Expectations for communication within the medical team should be clarified, including what constitutes a significant clinical update, such as an end-of-life discussion. Clear timeframes for communication and defined responsibilities should also be established.

3. M&M data capture & standardisation

During Q1 final enhancements were completed to the Ulysses module. However, the project was subsequently paused due to delays in Ulysses' planned system upgrades.

4. End of Life Patient and Family Support

During Q1 the Butterfly Friends service was supported by nine volunteers who delivered 115 hours of bedside support. They provided companionship to 405 people, including 205 patients across 304 visits.

Following successful recruitment and training, supported by positive television coverage, the service now has 14 volunteers moving into Q2. This increased capacity will enable us to meet all referrals Monday to Friday, 10am to 4pm, while also offering longer and repeat visits for those with the greatest need.

Feedback remains overwhelmingly positive. Families value the companionship and respite provided, particularly when they are unable to visit. Patients consistently report looking forward to these non-clinical visits, while staff express reassurance that patients are not left alone when wider clinical demands limit their availability.

Agenda Item 5.13 Report to the Trust Board of Directors, 10 September 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 care	Pioneering research and innovation	Outstanding people	Foundations for the future
x		x	
Executive Summary:			
Recent National Guardian's Office reviews exploring the experiences of temporary workers and overseas-trained workers highlighted the importance of psychological safety, inclusion, belonging and confidence to speak up within NHS organisations. Both reviews identified barriers relating to fear of detriment, discrimination, cultural factors and staff confidence that concerns raised would be listened to and acted upon. These findings align with themes identified through local Freedom to Speak Up activity at UHS and provide an opportunity to reflect on how the Trust continues to support an open and learning culture across all staff groups. This report outlines what we have learned nationally, what we have seen locally, and how UHS continues to respond through visible Freedom to Speak Up arrangements, staff engagement, organisational learning and leadership commitment.			
Contents:			
Paper			
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:		This report has equality, diversity and inclusion implications, particularly in relation to temporary workers, overseas-trained workers and staff who may experience additional barriers to speaking up. The Trust's response supports inclusive practice, psychological safety and equitable access to Freedom to Speak Up support.	

1. Executive Summary / Purpose

To provide the Board with an overview of key national learning from recent National Guardian's Office (NGO) reviews, local Freedom to Speak Up intelligence from UHS, and assurance regarding how the Trust continues to strengthen its speaking up culture following the closure of the National Guardian's Office in June 2026.

Key Issues

2. What We Have Learned Nationally

2.1 Future of Freedom to Speak Up

As noted in the previous Freedom to Speak Up report on the findings of the [Dash review](#) the National Guardian's Office closed in June 2026, the principles of Freedom to Speak Up remain fundamental to patient safety, workforce wellbeing and organisational culture. The national reviews emphasise the ongoing responsibility of NHS organisations to create environments where staff feel safe to raise concerns, contribute ideas and support organisational improvement.

2.2 Temporary Workers Review

The National Guardian's Office review found that temporary workers may experience additional barriers to speaking up, including fear of detriment, feelings of exclusion, discrimination and reduced confidence that concerns will be addressed. The review highlighted the importance of visible speaking up arrangements, inclusive cultures and supportive leadership.

2.3 Overseas-Trained Workers Review

The review of overseas-trained workers identified additional barriers associated with cultural differences, communication challenges, discrimination, immigration concerns and confidence in organisational processes. The review reinforced the importance of psychological safety, cultural competence, inclusive leadership and accessible Freedom to Speak Up support.

3. What We Have Seen Locally

3.1 Recent External Engagement and Freedom to Speak Up Activity at UHS

The Trust recently welcomed an external visit focused on speaking up culture, staff experience and organisational learning. This provided an opportunity to showcase the work being undertaken by the Freedom to Speak Up service both within Maternity Services and across the wider Trust.

Examples shared included:

- Proactive engagement with maternity teams to promote staff voice and psychological safety.
- Visibility and accessibility of the Freedom to Speak Up Guardian.
- Support provided to staff raising concerns.
- Collaborative working with maternity leaders and operational teams.
- Development and support of the Freedom to Speak Up Champion network.
- Ongoing ward walkabouts and staff engagement activities.
- Partnership working with Human Resources, Equality, Diversity and Inclusion teams, Staff Networks and senior leaders.

- Use of Freedom to Speak Up intelligence to identify themes, support organisational learning and inform improvement activity.

The work highlighted during the visit demonstrated how Freedom to Speak Up contributes to workforce wellbeing, inclusion, organisational learning and patient safety. It also provided an opportunity to showcase examples of good practice and the positive impact of ongoing engagement across the Trust.

The themes emerging through local engagement closely mirror those identified within the National Guardian's Office reviews, particularly around psychological safety, inclusive leadership, belonging, visibility and confidence to speak up.

4. How UHS Is Responding

UHS continues to strengthen its speaking up culture through:

- Promoting psychological safety across teams and services.
- Supporting staff who may experience additional barriers to speaking up.
- Strengthening inclusion, belonging and staff engagement.
- Maintaining a visible and accessible Freedom to Speak Up service.
- Supporting and developing the Freedom to Speak Up Champion network.
- Using Freedom to Speak Up intelligence to support organisational learning and improvement.
- Working collaboratively with HR, Equality, Diversity and Inclusion teams, Staff Networks and operational leaders.
- Embedding Freedom to Speak Up principles within workforce, governance, equality and quality improvement programmes.

Conclusion

The findings from the National Guardian's Office reviews, together with local Freedom to Speak Up intelligence and recent external engagement activity, reinforce the vital role that Freedom to Speak Up plays in promoting patient safety, workforce wellbeing, inclusion and organisational learning.

The work shared with external stakeholders regarding maternity services, the recent external visit and ongoing Trust-wide Freedom to Speak Up activity demonstrate our commitment to listening to staff, learning from concerns and creating an environment where all workers feel able to raise concerns, share ideas and contribute to improvement without fear of detriment.

The Board can therefore be assured that UHS remains committed to sustaining and strengthening a culture of openness, transparency and psychological safety, ensuring that speaking up continues to be recognised as a cornerstone of an inclusive, compassionate organisation that places both staff wellbeing and patient safety at the centre of everything it does.

Recommendation

Trust Board is asked to:

- **Note** the national learning from the National Guardian's Office reviews on temporary and overseas-trained workers.
- **Take assurance** from local Freedom to Speak Up activity, external engagement and examples of good practice across UHS.
- **Recognise** the importance of psychological safety, inclusion and speaking up in supporting staff wellbeing, organisational learning and patient safety.
- **Support** the continued development and integration of Freedom to Speak Up arrangements within Trust governance, workforce, equality and quality improvement programmes following the closure of the National Guardian's Office.

Agenda Item 5.14 Report to the Trust Board of Directors, 10 September 2026			
Title:	Medical Appraisal and Revalidation Annual Report including Board Statement of Compliance		
Sponsor:	Paul Grundy, Chief Medical Officer		
Author:	Liz Brown, Medical HR Operations Manager		
Purpose			
(Re)Assurance	Approval	Ratification	Information
	X		X
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
X			
Executive Summary:			
The framework published by NHS England is designed to allow the organisation to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement. The continued focus of the central appraisal teams has been on improving appraisal compliance rates, ensuring access to appraisal for all connected doctors and improving appraisal quality. The responsible officer (RO) has a statutory duty to ensure compliance with NHS England and GMC requirements for appraisal and revalidation. The Chief Medical Officer is the RO for the Trust. The Board is asked to note the summary information included in this report and approve the “Statement of Compliance” at Appendix A, confirming that the organisation, as a designated body, is compliant with the medical profession regulations.			
Contents:			
Paper (template outlined by NHS England), Appendix A – Statement of Compliance			
Risk(s):			
None, the Trust remains compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013) and related guidance.			
Equality Impact Consideration:		N/A	

Section 1 – General:

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

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Comments:	Yes, the chief medical officer.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Recruitment for the Trust appraisal lead, in preparation for one lead retiring in December 2025.
Comments:	Successful recruitment took place for the Trust appraisal lead, commencing the post in January 2026. The Deputy RO and Trust appraisal leads support the RO with the day-to-day responsibility for delivering medical appraisal. This includes the development of policy, appraiser training and quality assuring the process. The Medical HR team supports the RO with all associated administration and reporting.
Action for next year:	SARD contract renewal due at the end of 2026.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Maintain monthly review of connections and ensure communication between the responsible parties continues.
Comments:	The medical appraisals and revalidation officer sits as part of the wider medical HR team. Recruitment and management of connected doctors' contracts is carried out in partnership. All connections are reviewed and managed by the appraisals officer via the SARD platform.
Action for next year:	Continue to seek improvement to existing processes and ensure accurate connections are maintained.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Comments:	The appraisal and revalidation policy was reviewed and updated in line with GMC and Academy of Royal College recommendations.
Action for next year:	Policy review and renewal due in 2026.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Comments:	UHS has not had a further peer review. Internal process review and quality assurance exercises have been completed. The Trust uses this information to make changes and address any areas of concerns.
Action for next year:	Continue programme of process review and annual quality assurance exercise.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Comments:	Limited numbers of long-term locums and bank only doctors have meant as yet standalone appraisers for the group have not been established. The central appraisal team, care group appraisal leads, and the Trust appraisal leads support as required.
Action for next year:	None, will take appropriate action if required.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to enable access to appraisals, supporting individuals who find the appraisal process challenging.
Comments:	Central focus to identify and support individuals who have struggled with the appraisal process. This has included coaching from the appraisal leads, support arranging appraisal meetings and technical guidance. Good medical practice recommendations have been incorporated into SARD and the appraisal form updated. The appraisal conversation covers whole scope of practice including complaints and significant events.
Action for next year:	Maintain high appraisal compliance by providing targeted support for doctors who experience barriers to engagement, enhancing early intervention processes, and ensuring appraisals continue to demonstrate comprehensive review of whole scope of practice and all relevant fitness to practise information.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	Further work with DCDs and appraisal leads to manage non-compliance.
Comments:	Compliance rates have remained consistent across the appraisal year, with a current average of 88.59%. Doctors with overdue appraisals are contacted and reminded of their responsibility to complete their appraisal. Automated reminders via the appraisal system highlight approaching and overdue appraisals and remind doctors of their obligation. A list of doctors with an overdue appraisal of 3 months or more without an acceptable reason are reviewed regularly and escalated as appropriate. Appraisal leads offer support and coaching to appraisees that have not completed an appraisal. DCDs have oversight of individuals that do not have an agreed reason for a missed appraisal and take appropriate action. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process.
Action for next year:	Seek to further improve appraisal compliance rates through proactive monitoring, earlier engagement with doctors at risk of non-compliance, targeted support and coaching, and consistent escalation processes where participation requirements are not met.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Comments:	The Trust's Medical Appraisal and Revalidation policy is compliant with national policy and has incorporated several national recommendations. The policy has been approved via the central policy ratification group.
Action for next year:	The policy is due for review and renewal in 2026.

1B(iv) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Remain compliant with recommended ratio and continue to run courses for 2026.
Comments:	Consultant appraisers have increased by 8 to 201, two training courses for new appraisers are run each year. Trust appraisal leads and care group appraisal leads encourage others to become appraisers and it has been agreed that newly appointed consultants can attend the training if keen to be appraisers. We remain compliant with the recommended ratio. Ratio is currently 1:5.5
Action for next year:	Work with the Trust Appraisal leads to identify ways to increase appraiser numbers and succession plan.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Review training content when new Trust appraisal lead joins the team.
Comments:	Appraisers have access to regular training, bi-annual update sessions and appraiser feedback reports support professional development. Existing appraisers are reminded on the requirement to refresh their training as appropriate. Annual quality assurance exercise undertaken and detailed report shared with appraisal leads and the Decision-Making Group. 293 appraisals were reviewed, 99.3% scored between 75% and 100%, and increase of 2.8%. Two appraisals scored less than 75%, these were reviewed by the Trust appraisal leads and this will be shared with the department appraisal leads so a constructive conversation and feedback can be given to the appraiser to allow them to reflect on their outputs and provide additional training. NHS England recommends achieving at least 20% appraisee completion of feedback questionnaires each year, with the results being fed back to the appraiser annually. We achieved an overwhelmingly positive 79.5% response rate for our consultant appraisers. The qualitative data demonstrates a high level of skills among the appraisers. Doctors comment that they feel supported and motivated through discussions with appraisers.
Action for next year:	Training provisions to be reviewed and delivered over the next two-year cycle, with a focus on providing multi source feedback.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Annual programme of review and ongoing training.
Comments:	Action completed. In the 2025/265 QA review round: 293 ASPAT questionnaires were sent out, 2 for each of our trust consultant appraisers. • 291 out of 293 appraisals with a completed ASPAT questionnaire have scored between 75% and 100% • 2 out of 293 appraisals with a completed ASPAT questionnaire have scored between 50 % and 74% • 0 out of 293 appraisals with a completed ASPAT questionnaire have scored 49% or lower All doctors are asked to rate the quality of appraisal and the suitability of the appraiser. 98.3% of appraisees rated their appraiser as very good or good.

	Full report shared with the Decision-Making Group.
Action for next year:	Continue to deliver the annual quality assurance programme, using appraiser feedback and QA findings to support appraiser development, maintain appraisal quality, and provide assurance through reporting to the Decision-Making Group.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Comments:	The Trust's CMO, Deputy CMO and Associate Director of HR meet once a quarter with the GMC Employment Liaison Officer throughout the year to discuss cases.
Action for next year:	• GMC and UHS meetings will continue on a quarterly basis. • Advice will be sought for new and ongoing professional affair cases. • Referrals will be made if the threshold is met under Good Medical Practice.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Maintain proactive approach to managing recommendations and identify any missing requirements as early as possible.
Comments:	The review process begins well in advance of the revalidation recommendation date, and the appraisal team highlights the outstanding actions to the doctors, the DCD, Trust Appraisal Lead and the RO as appropriate. Where a deferral was recommended, the doctor was notified with confirmation of the actions required.
Action for next year:	Continue to strengthen the early review of revalidation recommendations, identifying and addressing outstanding requirements at the earliest opportunity to minimise avoidable deferrals and support timely positive recommendations.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Comments:	Complaint and serious incidents are discussed and reflected upon as part of the process. Local and Divisional governance reports are reviewed at the Quality Governance Steering group, the group reports to the Trust Executive Committee and the Board.
Action for next year:	None.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Comments:	Management teams monitor performance of teams and review complaints and incidents at monthly governance meeting. An annual report of any doctor with more than three complaints is presented to the CMO. In many areas activity data is available from divisional analysts at the request of doctors in advance of appraisal, this is more accessible in surgical areas where procedure data and length of stay information is tracked.
Action for next year:	None.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	No, technical limitations of the central Trust governance and complaints systems mean that doctors are not able to access and download a single report of all complaints or incidents in which they are named. However, all information is accessible to appraisees which can then be included in appraisal in line with the principles of good medical practice. This then allows for individual reflection, full discussion and identification of learning or improvements.
Comments:	The current governance systems for complaints, serious incidents and risk incidents are not easily searchable, and a total combined report is not accessible. For all complaints where a doctor is named, the individual is asked to respond. This should be captured in the annual appraisal and reflections undertaken. Sufficient information is available for appraisal was combined with self-reporting, reflection, and a probity statement.
Action for next year:	None, requirement to access information from existing systems.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

Y/N	Yes
Comments:	Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists Policy. Concerns are addressed accordingly with support from HR. The Trust has a lead for managing conduct and capability issues, the Deputy Chief Medical Officer, who is the NHSR trained case manager for UHS. A cohort of new case investigators has been trained, and the hope is to deliver a further NHSR Case Manager training course within the next 12 months.
Action for next year:	The above policy is due for review and renewal.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Comments:	All cases at UHS are stored on secure online software (CaseWorkER). Case level information is extracted from CaseWorkER into a report to be discussed at the monthly ER Performance Board. This group is chaired by the Associate Director of HR (ADHR), has a staff-side representative, the ER team, and the FTSU Guardian in attendance. All medical cases are discussed at this group, which looks at whether the case is being managed in a fair, timely, and proportionate way and in line with EDI principles. Following the meeting, a monthly ER report is compiled and distributed to key stakeholders (including the designated NED). An ER Performance Report is submitted to the People and OD Committee (a Trust Board sub-group) on an annual basis to appraise the board on ER activity and key themes. The designated NED for medical cases is sent a copy of the terms of reference (TOR) document for any new medical cases and meets with the ADHR on a quarterly basis to discuss all medical cases and provide oversight. Practitioners are able to contact the NED if they have any concerns with how a case is being managed. The Deputy CMO, Case Manager, and ADHR meet on a monthly basis to discuss all cases and meet regularly with NHS Resolution and the GMC.
Action for next year:	Continue to schedule ER Performance Board and submit assurance data to the People and OD Committee.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Comments:	A process is in place for transferring information and concerns between the RO and other ROs where UHS connected Doctors undertake regular work.
Action for next year:	None.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.

Y/N	Yes
Comments:	The UHS policy for Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists is in line with Maintaining High Professional Standards guidance. All policies are ratified by the relevant Trust 'expert' group following consultation with all applicable groups. This also applies to all clinical governance and safeguarding policies and processes.
Action for next year:	None.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture.

Y/N	Yes
Comments:	As part of the implementation of the updated SARD appraisal form aligned to <i>Good Medical Practice 2024</i>, the Trust has incorporated local governance prompts to support reflection on wider organisational and national learning. Within Domain 3, appraisees are prompted to consider and discuss relevant national reviews, guidance, inquiries, patient safety initiatives and governance developments, and how these relate to their scope of practice. This approach supports the integration of learning from external and internal governance sources into the appraisal process, encouraging reflection, professional development and continuous improvement.
Action for next year:	Continue to review appraisal prompts and supporting guidance to ensure relevant national, regional and local governance learning is incorporated into the appraisal process.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible.

Y/N	Yes
Comments:	Professional standards for regulated positions align with the Trust values. The overarching policies apply to all groups with professional registration and incorporate the standards expected by professional bodies.
Action for next year:	None.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Comments:	The medical HR team is responsible for undertaking pre-employment checks, in line with NHS Employers mandatory standards. Monthly compliance audits are carried out on a sample of new starters. The temporary resourcing team are responsible for ensuring that appropriate pre-employment documents are provided for any temporary workers, supplied via a locum agency.
Action for next year:	Update processes in line with mandated policy changes as necessary.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Comments:	At UHS we have “Always improving” as one of our core values. Our transformation team supports the trust leadership in delivering on continuous improvement supported by the medical lead, Kate Pryde. We run annual “We are UHS” weeks with poster presentations submitted for display at our mini-conference event.
Action for next year:	Continue to embed the link between effectiveness, outcomes, and improvement.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity, and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Comments:	At UHS we champion equality, diversity, and inclusion (ED&I), which is about being pro-active, practical and positive. As our Trust reflects wider society, we believe that a hospital that promotes equity from within creates a culture of belonging amongst staff and ultimately better health outcomes for patients. The Trust is committed to developing a culture that embeds the effective management of ED&I in all that we do, providing the necessary resources and leadership to make this happen.

	Our governance arrangements allow for our equality objectives to be externally regularly reviewed and our progress against them to be monitored nationally, regionally and locally.
Action for next year:	Continued focus on a culture of anti-racism and anti-discrimination. Development of the refreshed inclusion and belonging strategy.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Comments:	The CMO meets 1:1 all new consultant appointments to UHS to discuss our values and offer support in continuous improvement and in managing conduct and capability issues, as well as coaching and mentorship. We have embedded the patient safety incident response framework, focusing on effective learning and improvement. We have well established FTSU process with a guardian and multiple champions in every division.
Action for next year:	None.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Y/N	Yes
Comments:	There are several routes which support both informal and formal feedback. The Trust supports a culture of openness, honesty, and transparency. Concerns can be raised with line managers, directly to the Freedom to Speak Up Guardian, or a local champion, via the Raising Concerns (Whistleblowing) policy or through the incident reporting system.
Action for next year:	None.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Comments:	The ER Performance Board assesses the ethnicity of all staff involved in all types of formal HR process and the Trust's WRES data compares whether a staff member is more likely to enter into a formal disciplinary process if they are from a White / BAME background. The data does not currently assess the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristic.
Action for next year:	Look specifically at the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristic.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Comments:	Deputy RO and Trust appraisal leads attend RO network meetings and relevant training sessions.
Action for next year:	None.

Section 2 – metrics

Year covered by this report and statement: 1st April 2025- 31st March 2026.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	1512
Total number of appraisals completed	1125
Total number of appraisals approved missed	237
Total number of unapproved missed	150
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	200
Total number of late recommendations	2
Total number of positive recommendations	138
Total number of deferrals made	60
Total number of non-engagement referrals	0
Total number of trained case investigators	10
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer	7
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	307
Median duration of concerns processes closed (working days)	80
Total number of doctors excluded/suspended during the period	4
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation (inclusive of residents)	607
Total number of new employment checks completed before commencement of employment (inclusive of residents)	607
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld	0

Section 3 – Summary and overall commentary

General review of actions since last Board report:	
The majority of actions identified in the 2025/26 report have been completed. Throughout the year, the Trust has maintained a strong focus on improving appraisal compliance and quality, with positive progress demonstrated across both areas.	
Actions still outstanding:	
Look specifically at the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristic.	
Actions for next year:	
SARD contract renewal due at the end of 2026.	Working with the procurement team to secure a renewal of the software licence.
Continue to seek improvement to existing processes and ensure accurate connections are maintained.	Working with the medical HR team to capture starters and leavers and seeking greater improvements via reporting and system interfaces.
Appraisal policy review and renewal due in 2026.	Review work already commenced, will proceed through the required approvals committees.
Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists Policy review and renewal.	Review work already commenced, will proceed through the required approvals committees.
Continue programme of process review and annual quality assurance exercise.	Continue and look to expand our internal quality process reviews.
Continue to strengthen the early review of revalidation recommendations.	Achieved through good housekeeping of the system, identifying and addressing outstanding requirements, regular reporting and escalation, appraiser support and training. Trust appraisal leads to support RO with positive recommendations process.
Work with the Care Group Appraisal leads to identify ways to increase appraiser numbers and succession plan.	Trust appraisal leads to initiate work with the care groups via the bi-annual meeting. Encourage those undertaking new appraiser training to champion with colleagues.
Continue to review appraisal prompts and supporting guidance.	Ensure relevant national, regional and local governance learning is incorporated into the appraisal process as required.
Maintain high appraisal compliance.	Providing targeted support for doctors who experience barriers to engagement, enhancing early intervention processes, and ensuring appraisals continue to demonstrate comprehensive review of whole scope of practice and all relevant fitness to practise information.
Training provisions to be reviewed.	Trust appraisal leads to review materials and update, reinforcing training on providing multi source feedback.
Overall concluding comments:	
The Trust remains compliant with the requirements of The Medical Profession (Responsible Officers) Regulations 2010 and continues to demonstrate a robust and effective appraisal and revalidation system. Throughout 2025/26, significant progress has been made in strengthening	

appraisal quality, maintaining high levels of engagement and enhancing support for doctors participating in appraisal and revalidation processes.

Appraisal compliance remained stable at 88.59%, despite continued growth in the number of connected doctors. The Trust expanded its appraiser workforce to ensure sufficient capacity and accessibility of appraisal across all specialties. Quality assurance results provide strong assurance regarding the quality and consistency of appraisals, with 99.3% of appraisals reviewed through ASPAT achieving scores of 75% or above and 98.3% of appraisees rating their appraiser as good or very good. Feedback continues to demonstrate that doctors feel supported, challenged appropriately and motivated through the appraisal process.

Revalidation processes remain effective and well governed. The number of deferrals reduced significantly from 106 in the previous year to 60, reflecting the impact of earlier engagement and improved oversight of doctors approaching their revalidation recommendation date. Whilst this represents substantial progress, reducing avoidable deferrals remains a priority for the coming year.

Key priorities for 2026/27 include further improving appraisal compliance, reducing revalidation deferrals, maintaining high-quality appraisal standards through quality assurance and appraiser development, completing planned policy reviews, securing the future SARD platform contract, and progressing equality analysis relating to professional standards processes.

The Trust has effective arrangements in place to support medical appraisal, revalidation, clinical governance and professional standards, and that a culture of continuous improvement is embedded within these processes.

Section 4 – Statement of Compliance:

The Board of University Hospital Southampton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: University Hospital Southampton NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Agenda Item 5.15 Report to the Trust Board of Directors, 10 September 2026			
Title:	State of Maternity and Neonatal Services 2026/27: Strategic Position, Risks and Priorities		
Sponsor:	Natasha Watts, Acting Chief Nursing Officer		
Author:	Emma Northover, Director of Midwifery		
Purpose			
(Re)Assurance	Approval	Ratification	Information
x			x
Strategic Theme			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			x
Executive Summary:			
This report provides the Trust Board with an overarching assessment of the current state of Maternity and Neonatal Services and outlines the principal strategic issues requiring Board oversight. It draws together intelligence from recent: • MatNeo safety reporting from Q4 2025/26 and Q1 2026/27 (Appendix A and B) • MatNeo Workforce report, July 2026 (Appendix C) • NHS England Maternity and Neonatal 10-Point Plan assessment (Appendix D) • National Maternity Triage Specification review (Appendix E) • Maternal Care Bundle implementation programme (Appendix F). The service continues to demonstrate many areas of strength. Governance arrangements are well established, compliance with key national safety requirements remains broadly positive, multidisciplinary training compliance is strong, and there is evidence of a proactive and learning-focused culture. Significant progress has been made in responding to external scrutiny, implementing improvement programmes and maintaining oversight of quality and safety. However, the service is operating within a period of unprecedented change and increasing pressure. Demand for maternity and neonatal services continues to rise, women and birthing people are presenting with increasing complexity and acuity, and workforce constraints remain a significant challenge. Whilst the service remains safe, there is growing evidence that current models of care are becoming increasingly stretched and that further transformation will be required to meet both future demand and evolving national requirements. Nationally, maternity and neonatal services have become a major strategic priority following publication of the Amos Investigation, the Ockenden Review, the NHS England Maternity and Neonatal 10-Point Plan, the National Maternity Triage Specification and the revised NHS Resolution Maternity Incentive Scheme. Collectively, these developments place significant expectations on Boards to demonstrate visible leadership, active oversight and measurable improvement in outcomes, experiences and safety for women and birthing people, babies and families. Whilst assurance can be taken from the strength of governance arrangements and the progress made across multiple improvement programmes, the Board should note that workforce sustainability, clinical outcomes, maternity triage transformation, estate limitations and increasing national assurance requirements represent the principal strategic risks facing the service during 2026/27.			

Contents:

1. Current State of Maternity and Neonatal Services
2. National Context and Board Responsibilities
3. Workforce Sustainability and Service Resilience
4. Quality, Safety and Outcomes
5. Experience of Women and Birthing People
6. Maternity Triage and Urgent Care Transformation
7. Estates, Environment and Infrastructure
8. Equity and Reducing Inequalities
9. Strategic Priorities Requiring Ongoing Board Oversight
10. Principal Risks Requiring Ongoing Board Attention
11. Conclusion

Appendices:

- A. MatNeo Safety Report Q4, 2025/26
 - i. Report Appendices
- B. MatNeo Safety Report Q1, 2026/27
 - i. Report Appendices
- C. MatNeo Workforce Report
 - i. Report Appendices
- D. MatNeo Position Statement on 10 Point Plan
 - i. Submission Progress and Evidence Log for Ten Point Plan
- E. National Maternity Triage Specification, UHS Readiness Statement, Gap Analysis Report
 - i. Report Appendix
 - ii. Maternity Triage Specification Benchmarking Audit Tool
- F. Maternal Care Bundle Implementation Report
 - i. Report Appendix

Due to the size of some of the appendices, it has been agreed that the larger documents are placed in ibabs reading for Board members' reference.

Risk(s):

- 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.
- 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.
- We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
- 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.
- We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity.
- Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.

Equality Impact Consideration:

N/A

1. Current State of Maternity and Neonatal Services

Maternity and Neonatal Services continue to care for one of the most complex populations of women and birthing people in England. As a tertiary provider, UHS manages increasing numbers of women and birthing people with significant medical, obstetric, fetal and social complexity requiring specialist, multidisciplinary input. Demand remains high across both planned and unscheduled care pathways and continues to increase year on year. Within Quarter 1 2026/27 alone, the Maternity Day Assessment Unit managed more than 2,700 urgent assessments, highlighting the scale of activity managed through maternity urgent care services.

The recent Care Quality Commission inspection (July 2026) identified positive examples of compassionate care, strong staff engagement and visible commitment to service improvement. Whilst concerns were raised regarding security arrangements and aspects of the Maternity environment, the Trust's response demonstrated effective leadership and organisational agility, resulting in proposed enforcement action being withdrawn following implementation of immediate mitigating actions.

At the same time, increasing demand, rising acuity and workforce constraints are placing growing pressure across maternity and neonatal pathways. These pressures are increasingly evident within service-user feedback, workforce intelligence, safety reporting and emerging outcome trends. Whilst these challenges are not unique to UHS, the combination of increasing activity, rising acuity, workforce constraints and infrastructure limitations means that Maternity and Neonatal Services are operating within an increasingly narrow margin between capacity and demand. This is creating challenges not only for day-to-day operational delivery but also for the implementation of the significant transformation programmes now required nationally.

2. National Context and Board Responsibilities

The national context for maternity and neonatal services has changed significantly during 2026. Following publication of major national reviews, NHS England has established a clear expectation that maternity and neonatal services should be considered a strategic organisational priority requiring active Board engagement and leadership.

The focus has moved beyond traditional regulatory compliance. Boards are now expected to demonstrate clear oversight of workforce sustainability, organisational culture, service-user experience, safety, inequalities and quality improvement. There is an increasing expectation that organisations not only identify risks but can also demonstrate measurable improvements and sustainable change.

On 12 August 2026, NHS England issued formal guidance regarding implementation of the Maternity and Neonatal 10-Point Plan. This requires all Trusts to complete a Board-approved baseline assessment by 25 September 2026 and a further progress update by 31 December 2026. These returns are intended to demonstrate active Board ownership of maternity and neonatal improvement and will form an important part of future assurance discussions.

The publication of the National Maternity Triage Specification represents a further significant shift. For the first time, maternity triage has been formally recognised as a safety-critical urgent care service and the front door for urgent and unscheduled maternity care. Trusts are required to undertake Board-level audits and implement the national standard within twelve months.

The national direction of travel is clear. Maternity and Neonatal Services are now subject to increasing scrutiny from NHS England, regulators and the wider public, with a growing expectation that Trust Boards can demonstrate both understanding of the key risks facing services and oversight of actions taken to mitigate them.

3. Workforce Sustainability and Service Resilience

Workforce sustainability remains the most significant strategic challenge facing Maternity and Neonatal Services and is the common factor linking many of the issues highlighted throughout this report. Midwifery staffing remains below Birthrate Plus recommendations, Neonatal Services continue to experience nursing vacancies and challenges achieving Qualified in Specialty compliance, and there are increasing pressures within both obstetric and neonatal medical workforce models.

Workforce pressures increasingly influence the resilience of the service and affect the organisation's ability to deliver both current care and future improvements. During periods of high activity and acuity, staffing pressures frequently require redeployment of staff between clinical areas to maintain safety. Whilst these actions are clinically appropriate, they can have unintended consequences for continuity of care, patient experience and service delivery elsewhere within the system.

Importantly, many national improvement programmes are dependent upon workforce capacity and resilience. The successful implementation of the Maternal Care Bundle, National Maternity Triage Specification, equity programmes and wider NHS England improvement requirements will ultimately depend upon the availability of a sustainable and appropriately skilled workforce.

Workforce sustainability sits at the centre of almost every strategic issue described within this report. The ability to improve outcomes, enhance the experiences of women and birthing people, implement national programmes, respond to increasing demand and deliver service transformation is fundamentally dependent upon workforce capacity and resilience. As such, workforce should be considered the single greatest determinant of future service sustainability.

4. Quality, Safety and Outcomes

Recent reports demonstrate a number of emerging trends that require continued Board scrutiny.

Several key outcome measures have deteriorated, including postpartum haemorrhage, severe perineal trauma and maternal and neonatal readmissions. Whilst there is no evidence that these changes are attributable to a single cause, increasing demand, workforce challenges and service pressures are likely contributing factors. These trends require continued monitoring and targeted quality improvement activity.

The complexity of incidents managed by the service has also increased. Recent reporting includes maternal deaths, increasing numbers of moderate harm incidents and more complex investigations requiring multidisciplinary review. Recurrent themes arising from reviews include communication, documentation, guideline compliance, recognition of risk and escalation of care.

Whilst the service remains compliant with national reporting and investigation requirements and there is no evidence of systemic safety failure, the Board should recognise that sustained pressure creates an increasing risk that quality and outcome measures may deteriorate further if these underlying issues are not addressed.

Whilst these indicators require continued scrutiny, it is important to recognise that they sit within a wider context of increasing activity, increasing complexity and rising acuity. There is no evidence of a single systemic cause underpinning these trends; however, the consistency with which workforce pressures, operational challenges and delayed patient flow appear across multiple data sources suggests that these factors continue to influence overall performance.

5. Experience of Women and Birthing People

The experience of women and birthing people remains a key indicator of service quality and provides valuable insight into the impact of operational pressures across the service.

Feedback remains positive regarding the compassion, professionalism and commitment demonstrated by staff. However, recurring concerns continue to be identified regarding communication, feeding support, continuity of care, postnatal services and discharge processes. These themes are consistently reflected across Friends and Family Test data, complaints, PALS activity and wider service-user engagement.

Of particular concern is the deterioration in postnatal experience. Feedback increasingly suggests that staffing pressures and workforce redeployment are influencing the experiences of women and birthing people receiving postnatal care. Communication remains a persistent theme across multiple sources of intelligence and continues to represent a significant opportunity for improvement.

Importantly, the themes emerging from women and birthing people mirror those identified through complaints, incidents and investigations. This reinforces the importance of service-user feedback as a source of organisational learning and demonstrates that improvement in communication, continuity and responsiveness has the potential to strengthen both experience and safety outcomes.

6. Maternity Triage and Urgent Care Transformation

The National Maternity Triage Specification represents one of the most significant developments currently facing maternity services. The specification positions maternity triage as a safety-critical urgent care service and introduces substantial new expectations relating to workforce, performance, governance, estates, patient experience and equality.

The local assessment identified a number of strengths, including 24-hour access to MDAU, use of BSOTS, established maternity telephone triage arrangements and existing governance structures. However, all ten national principles were assessed as partially compliant, indicating that a significant programme of improvement is required.

This national shift also reflects a broader change in thinking about urgent maternity care. Across the NHS, some organisations are beginning to reposition maternity triage services as "Maternity Emergency Departments" or equivalent urgent care services to reinforce their role as the front door for emergency maternity care. Whilst terminology differs between organisations, the purpose is to support a shift in expectations amongst staff, women and birthing people and the wider organisation, recognising maternity triage as an urgent care service rather than simply an assessment area.

For UHS, the strategic importance lies not in the name of the service, but in recognising that maternity triage now requires the same level of organisational focus, governance and investment that would be expected of any other urgent and emergency care pathway.

The Board should recognise that implementation of the National Maternity Triage Specification is likely to have implications for future workforce requirements, performance management arrangements, organisational priorities and capital investment decisions.

7. Estates, Environment and Infrastructure

The suitability of the maternity estate remains one of the most significant strategic barriers to future development.

The current MDAU environment remains identified as a Red (16) risk and has previously been described as not fit for purpose. Physical limitations relating to space, privacy, dignity, capacity and patient flow increasingly affect service delivery and limit the organisation's ability to meet new national maternity triage standards.

These challenges are particularly important when caring for women and birthing people experiencing pregnancy loss, bereavement, safeguarding concerns or other highly sensitive situations requiring privacy and compassion. Progression of proposed estate developments therefore remains a critical enabler of future service sustainability and one of the most important factors influencing the Trust's ability to achieve compliance with the National Maternity Triage Specification and deliver a modern urgent maternity care model.

8. Equity and Reducing Inequalities

Reducing inequalities remains a significant national priority and is increasingly central to maternity improvement programmes.

The service has strengthened existing approaches to monitoring variation in outcomes and experiences for women and birthing people and has introduced targeted improvement activity to respond to identified disparities. Equity considerations are increasingly embedded within governance processes and quality improvement programmes.

As national equity and anti-discrimination programmes develop further, the Board should expect increasing scrutiny regarding how effectively organisations understand, monitor and reduce inequalities experienced by women and birthing people.

9. Strategic Priorities Requiring Ongoing Board Oversight

Over the next twelve months, five strategic priorities should remain the focus of Board oversight:

- **Workforce sustainability and service resilience**, recognising that workforce remains the single greatest determinant of the service's ability to deliver safe care and implement future improvements.
- **Improvement in clinical outcomes and patient safety**, with particular attention to postpartum haemorrhage, severe perineal trauma, maternal and neonatal readmissions and learning from investigations.
- **Improvement in the experience of women and birthing people**, particularly within postnatal services and around communication, continuity of care and responsiveness.
- **Delivery of national maternity and neonatal programmes**, including the NHS England 10-Point Plan, National Maternity Triage Specification, Maternal Care Bundle and NHS Resolution Year 8 requirements.
- **Long-term sustainability through estate development, service transformation and reduction of inequalities**, ensuring that infrastructure, service models and improvement programmes remain aligned to the future needs of women and birthing people, babies and families.

10. Principal Risks Requiring Ongoing Board Attention

The principal risks requiring Board attention are workforce sustainability, deterioration in selected clinical outcomes, implementation of the National Maternity Triage Specification, estate limitations and the increasing national assurance requirements associated with the NHS England Maternity and Neonatal 10-Point Plan. These risks are interconnected and collectively influence the organisation's ability to provide safe, effective and equitable care for women and birthing people, babies and families.

11. Conclusion

Maternity and Neonatal Services continue to demonstrate strong leadership, robust governance and a clear commitment to improving outcomes and experiences for women and birthing people, babies and families. However, the service is operating within a period of significant national reform and increasing operational pressure. Workforce sustainability, demand, clinical outcomes, patient experience, estate limitations and implementation of new national requirements now represent the principal strategic challenges facing the service.

The Board is therefore asked to take assurance from the progress achieved to date whilst maintaining active oversight of these strategic priorities and ensuring that sufficient organisational support, investment and leadership are in place to deliver the transformation required over the next 12 months.

In conclusion, Board members should be reassured that the service continues to benefit from highly committed clinical teams, strong governance arrangements and a culture of continuous improvement, providing a solid foundation from which to address these challenges.

Agenda Item 6.1 Report to the Trust Board of Directors, 10 September 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 care	Pioneering research and innovation	Outstanding people	Foundations for the future
			x
Executive Summary:			
This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification. The Board has agreed that the Chair may undertake some actions on its behalf. There have been no Chair's actions since the last report. The report provides compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.			
Contents:			
Report			
Risk(s):			
N/A			
Equality Impact Consideration:		N/A	

1 Signing and Sealing

- 1.1 **Supplemental Lease** between University Hospital NHS Foundation Trust (Landlord) and Alliance Medical Limited (Tenant) relating to the Modular Scanning Unit at Southampton General Hospital, Tremona Road, Southampton SO16 6YD. This supplemental lease is for a term of 1 year and 4 months, from 1 December 2025 to 31 March 2027 and is in line with and associated with the Supply of Services Contract between Alliance Medical Limited and University Hospital NHS Foundation Trust, which has been extended until 31 March 2027 in line with NHS England's revised procurement timetable for these services. Seal number 314 on 25 August 2026.

2 Recommendation

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

Agenda Item 9.1 Report to the Trust Board of Directors, 10 September 2026			
Title:	South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 1 Performance Review		
Sponsor:	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 care	Pioneering research and innovation	Outstanding people	Foundations for the future
x	x		
Executive Summary:			
This report provides a performance update for the National Institute of Health and Care Research (NIHR) South Central Regional Research Delivery Network (SC RRDN) region for the first quarter of the 2026/27 financial year. • Research Activity: Regional research delivery organisations recruited 10,952 participants across 624 studies and 112 research locations during quarter one. Organisations also supported identification, data collection and follow-up across 2,039 studies. • Portfolio Transition & Funding Impact: Non-commercial interventional trials increased to 55% of active recruiting studies, reflecting a shift toward higher complexity research. However, the transition to the new national funding model this financial year resulted in an £868,069 or 3.1% budget reduction for the region. • Commercial & Community Growth: Commercial trial delivery trended upwards with 1,046 participants recruited across 114 studies in quarter one in all care settings. Community care settings recruited 30% of total regional recruitment over the preceding twelve months - aligning with the NHS’ shift of care to the community. • Study Setup Performance: South Central achieved 69% compliance for opening research locations within sixty days, ranking eighth among English regions, alongside 43% for consenting the first participant within thirty days of site readiness, ranking twelfth nationally. • Portfolio size: South Central had the 4th-highest number of recruiting non-commercial studies and 5th-highest number of commercial studies among the twelve regions. • Participant Experience: Participant feedback remained positive across most indicators, while awareness of trial results among adult respondents increased to 61% in quarter one, from 39% in 2025/26.			
Contents:			
South Central Regional Research Delivery Network (SC RRDN) Quarter One 2026/27 Performance Review, 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	

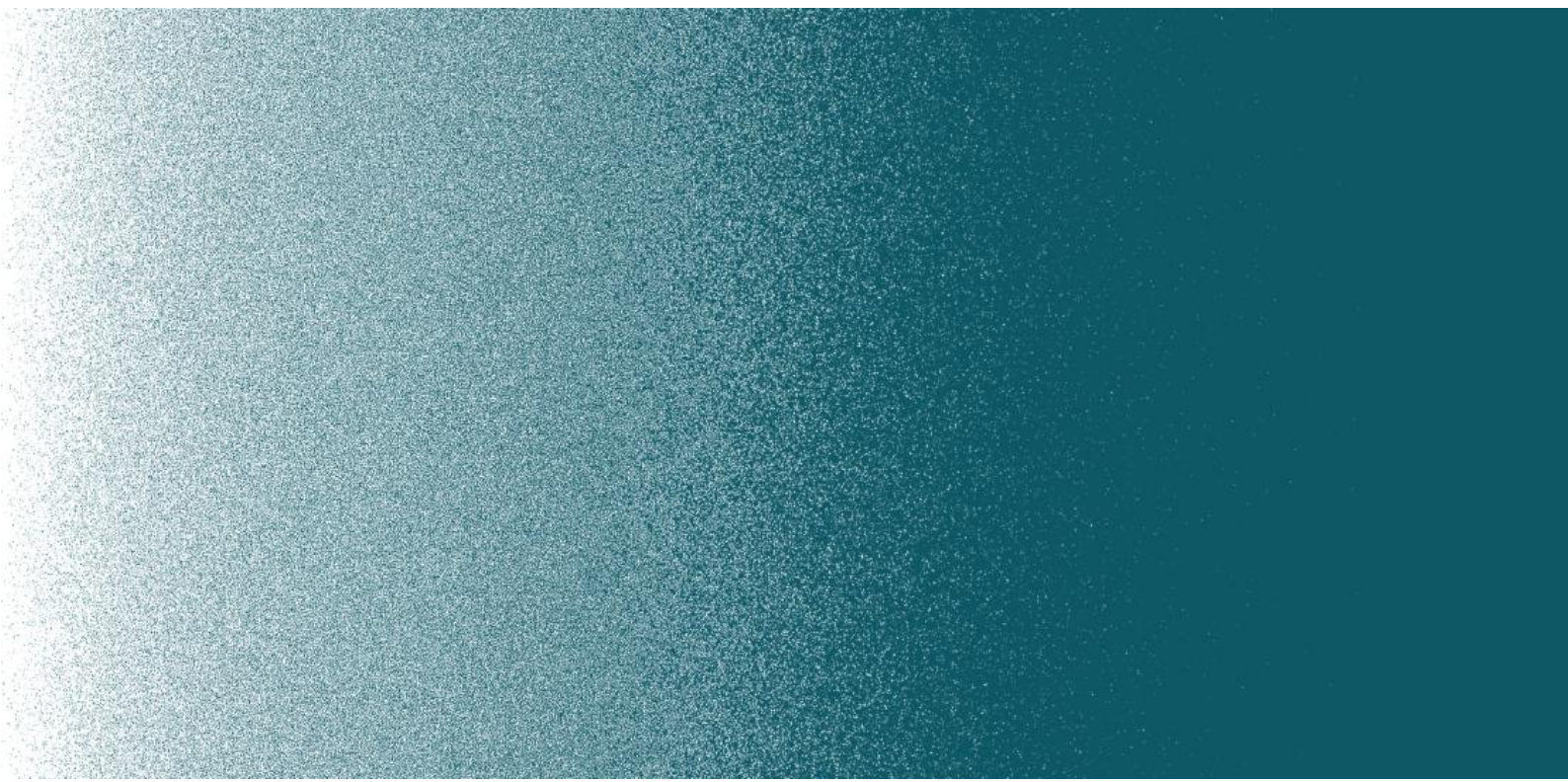
NIHR | Research Delivery Network

South Central Regional Research Delivery Network (SC RRDN) Quarter One 2026/27 Performance Review

Graham Halls, Data and Analytics Senior Manager

Clare Rook, Network Director

August 2026



Introduction

In addition to providing the Board with some key impact stories, 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 in the first quarter of the 2026/27 financial year (1 April 2026 to 30 June 2026). The report primarily presents performance against the measures included in the Research Delivery Network (RDN) funding models, which have been implemented from April 2026.

The RDN is funded by the Department of Health and Social Care to enable the health and care system to attract, optimise, deliver research across England. The primary purposes are to support the successful delivery of research as an active partner in the system, to increase the capacity of the delivery infrastructure for the future.

The network contributes to these goals through 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 more information about the wider projects that SC RRDN has delivered against the annual plan during 2025/26, view the [Annual Report](#).

Summary of the RDN funding models

A new funding model for research delivery was introduced for the 2026/27 financial year. This consisted of two sub-models, depending on the health and care setting in which research is delivered:

- 1. The Hospital Model:** This nationally calculated budget comprises of the historical allocation (50 per cent), activity based funding with a combination of recruitment and complexity weighted recruitment (30 per cent) and other performance elements (20 per cent).

2. The Wider Care Settings Model: This funding supports the strategic shift from hospital to community care outlined in the Government's [10 Year Health Plan](#). Organisations who deliver research at care homes, GP practices, pharmacies, schools and other community locations, access this funding via retrospective payments for delivered research and prospective payments to develop their research infrastructure. Agile Research Delivery Teams, employed by the regional delivery networks, also provide direct support to research delivery organisations.

The transition in funding model resulted in an £868,069 (3.1 per cent) reduction for the South Central region in 2026/27.

Impact of research in the South Central region

Taking part in liver disease research: Alan's story

A Hampshire man says he's been given his independence back after joining a research study into advanced liver disease that has resulted in him spending less time in hospital. Alan Prangnell, 76, from Totton, Southampton, experiences refractory ascites, caused by cirrhosis, a scarring of the liver which leads to a painful, recurrent build-up of fluid in the abdomen.

Treatment involves visiting the hospital every 10 to 14 days to have the fluid drained by inserting a tube into the abdomen for up to 6 hours. The procedure and fluid build-up can be painful and if large volumes of fluid are removed, patients may need to receive human albumin solution (HAS) to help maintain blood volume.



Figure 1 – Alan and Pam Prangnell

Alan, husband to Pam, was invited to participate in the REDUCe2 study, which is comparing draining the fluid at home to at the hospital. The trial randomly assigns patients to either home or hospital drainage. Alan was assigned to home drainage.

Alan is not eligible for a liver transplant or a procedure to improve blood flow in the liver, so he is receiving palliative care at the end stage of his disease.

The retired former support worker for people with learning disabilities said: “Living with ascites for this past year has been really difficult. The fluid build-up I get causes extreme breathlessness. Before taking part in this research I had to go to the hospital all the time, sometimes 2 or 3 times a week to have the fluid removed, which could take several hours. We were approached by the research team at the hospital. It was a walk into the unknown, but we were pleased to be part of the trial. I was spending so much time in the hospital which wasn’t good for me or my wife.”

Alan said: “At the start, I had a small operation to insert a tube into my abdomen with a tap to drain the fluid. Now, twice a week, the fluid is drained at home.”

The long-term drain allows fluid to be removed gradually at home over the course of the week, preventing large build ups. Community nurses trained Pam to manage the process – including draining the fluid, changing the bag and caring for the dressing without nursing support.

As part of the study, Alan had routine blood tests and completed questionnaires during the home visits from the NIHR's Agile Research Delivery Team to gather information about his quality of life, symptoms and use of NHS services. As his informal carer, Pam also completed a monthly questionnaire: "We were pleased to be asked to take part. I am in less pain and discomfort because the fluid can be drained more regularly."

He said: "It can all be done at home, rather than going into hospital which means we get back some of our lives again. It has been such a great trip back to independence for me and my wife. I have outside activities and to think I am able to continue with them is a bonus. I can now enjoy fishing again, something that I love and Pam has been able to catch up with her friends and family again. We have even managed a holiday to Weymouth."

Pam said: "I can now do all the things that you take for granted, like getting a haircut or going for an eye test. I always had to cancel them because Alan was too ill. Having the drain fitted has changed my life. I hope other people can benefit from me taking part in research."

World first for pancreas transplant preservation technique

University of Oxford researchers have performed the world's first perfused human pancreas transplant. The RDN-supported HOPP study evaluates pumping cold, oxygenated fluid through donor organs before surgery, replacing storage on ice. Standard ice storage damages organs, causing up to half to be discarded. This new preservation technique aims to improve organ quality, reduce complications and increase viable transplants for patients with severe diabetes.

To evaluate this intervention, the study will recruit 30 patients from the simultaneous kidney-pancreas transplant waiting list. During the clinical procedure, the donor pancreas is actively perfused for two hours while the recipient undergoes their concurrent kidney transplant. The clinical outcomes for these participants will be benchmarked against a control group of sixty recent patients whose organs were managed using conventional static cold storage, allowing researchers to objectively measure differences in organ function, surgical requirements, and the length of hospital stays.

Should the empirical data demonstrate improved organ viability, the findings will provide a verifiable evidence base for updating national preservation protocols, which could sustainably increase overall transplant capacity across the NHS. Further details on the trial and its operational delivery can be

accessed at: <https://oxfordbrc.nihr.ac.uk/world-first-perfused-pancreas-transplant-marks-major-milestone/>



Figure 2 - The research and surgical team who carried out the first case. From left to right: Dr Mohamed Elzawahry, Dr Patrick Jull, Mr Venkatesha Udupa, Professor James Hunter and Mr Dylan Barnett. Photo credit: Nuffield Department of Surgical Science.

Overview of research activity in the South Central region

Recruitment in South Central

During the first quarter of the 2026/27 financial year organisations in the region recruited **10,952 participants** to **624 studies** at **112 research locations** and across **all main clinical specialties**. During this period, the region's organisations recruited **6.3 per cent of the total participants in England**, with 7.8 per cent of the English population (Figure 3). Delivery organisations in the region have also supported the identification of participants, data collection and other follow up activities on **2,039 studies**.

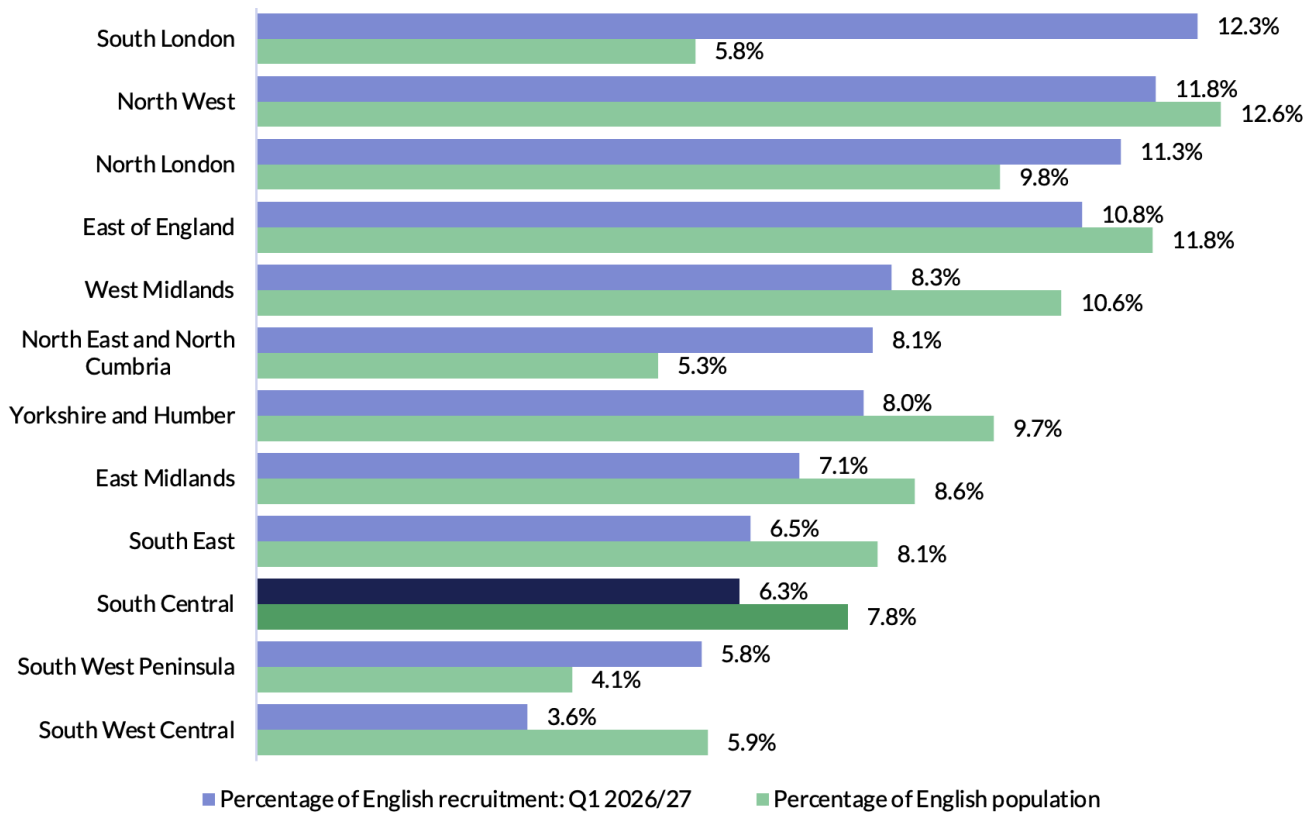
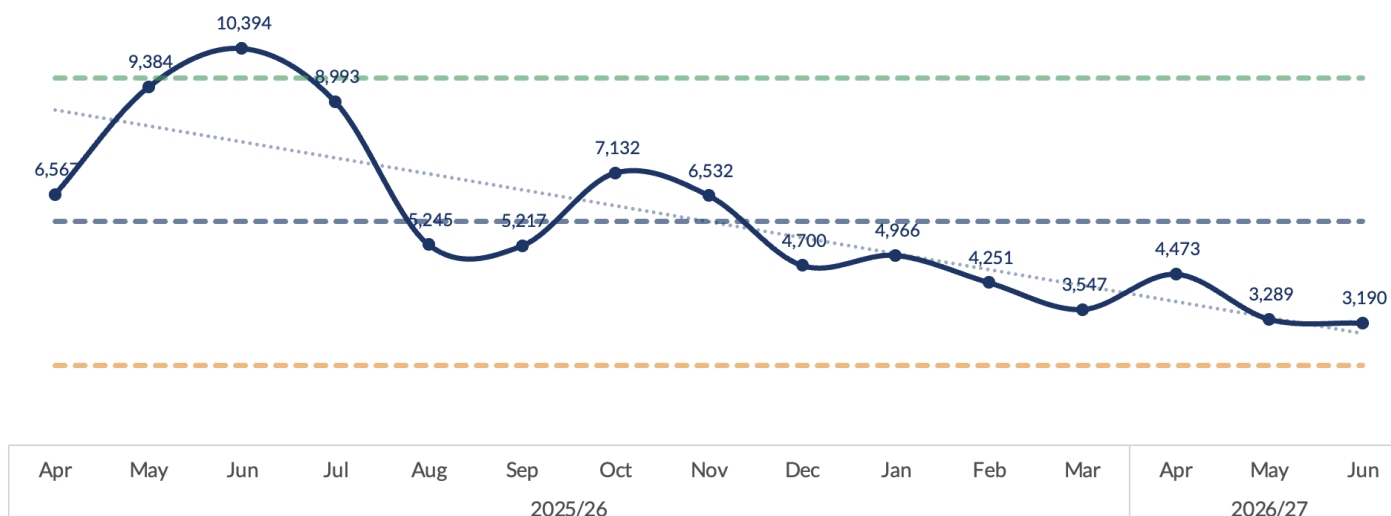


Figure 3 – Percentage of English recruitment compared to the percentage of the English population in each RRDN region during quarter one of the 2026/27 financial year

South Central



England

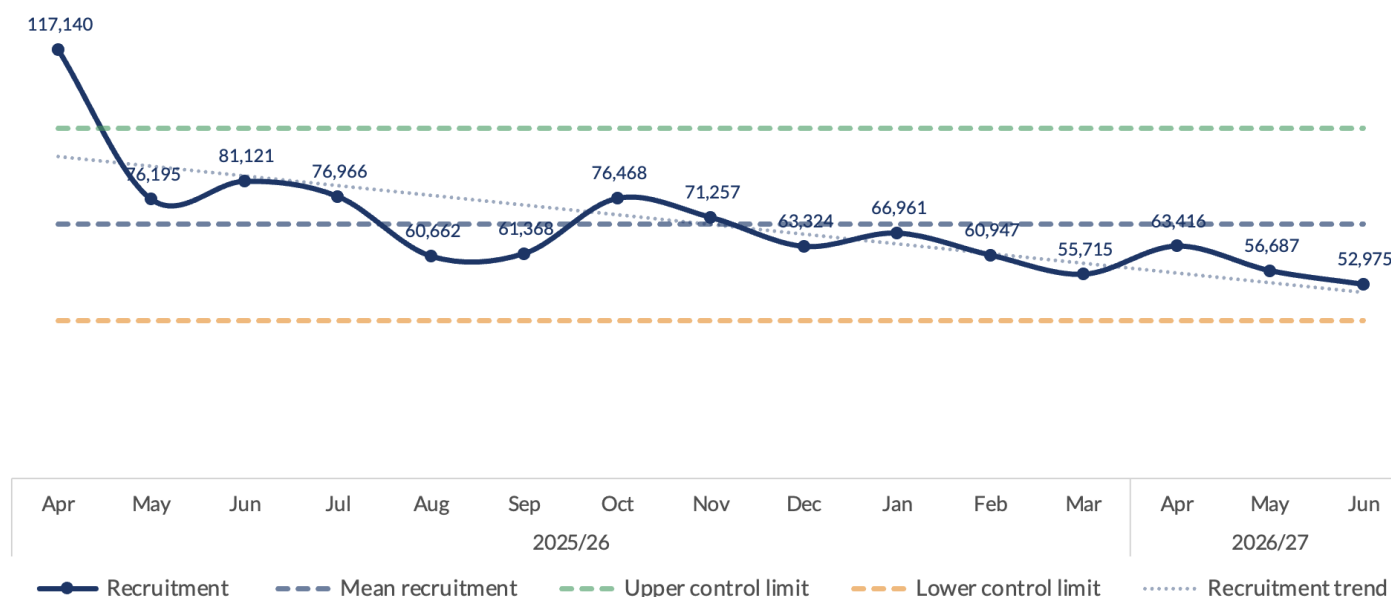


Figure 4 - Monthly recruitment in the South Central region benchmarked against England in the previous fifteen months

Clinical research recruitment across the South Central region and England demonstrated a downward trend between April 2025 and June 2026. In the South Central region, recruitment fell below the average for this period in December 2025 and remained below this for seven months. This indicates a statistically significant reduction in recruitment rather than normal monthly variation.

This sustained reduction likely reflects the NIHR RDN portfolio variability, rather than sustained underperformance. Research recruitment is primarily driven by observational, registry and diagnostic studies, which require lower resources per participant and can recruit faster than studies

with longer screening periods. As these studies meet their recruitment targets and stop recruiting, overall recruitment falls unless they are replaced by studies of an equivalent volume. Complex interventional studies, such as clinical trials of investigational medicinal products (known as ‘drug’ trials), involve additional clinical resources, stricter inclusion criteria and extended follow-up periods. This typically results in lower monthly recruitment.

To address the reduction in recruitment, South Central RRDN developed a recruitment action plan during the 2025/26 financial year. The network updated the plan during the final quarter to align with changing government priorities for the 2026/27 financial year. This introduced an approach that requests research delivery organisations discuss their local recruitment strategies during joint business planning meetings in the 2026/27 financial year.

The updated strategy aligns with the three core shifts outlined in the Government’s [10 Year Health Plan](#). Under this framework, the SC RRDN recommends research studies that are focusing on preventative medicine and early diagnostics, as well as those that include under-served populations within the region. Decision making is supported by a Regional Intelligence Tool dashboard, which combines demographic data with research activity across various geographies, to identify gaps in research delivery. A locally Specialty Overview dashboard also enables the SC RRDN team and delivery organisations to identify high impact studies not yet active in South Central, or with the potential to open at other regional organisations.

The plan prioritises the expansion of commercial research through earlier collaboration with life science sponsors, as well as supporting the [NIHR Life Sciences Industry Hub’s](#) work. The Hub acts as a single national interface for commercial research sponsors, streamlining study feasibility, costing, contracting as well as site identification to accelerate clinical trial setup across the NHS. Engaging with sponsors earlier in the study lifecycle supports delivery organisations to prepare for prospective studies, including addressing operational bottlenecks. Additional core work in the plan includes promoting enrolment through national registries, including [Be Part of Research](#) and [Join Dementia Research](#), while promoting flexible cross-organisation staffing models for less complex studies.

SC RRDN staff engage with the Research & Development management through monthly (R&D management) and quarterly (R&D Director) meetings to explore issues, share best practice and to provide workshop opportunities. Marie Nelson, the SC RRDN Health and Care Director for Nursing, Midwifery and Allied Health Professionals has also established a Clinical Delivery Leaders Group who

we will also be engaging with to develop the recruitment action plan and explore workforce challenges that may be impacting research delivery.

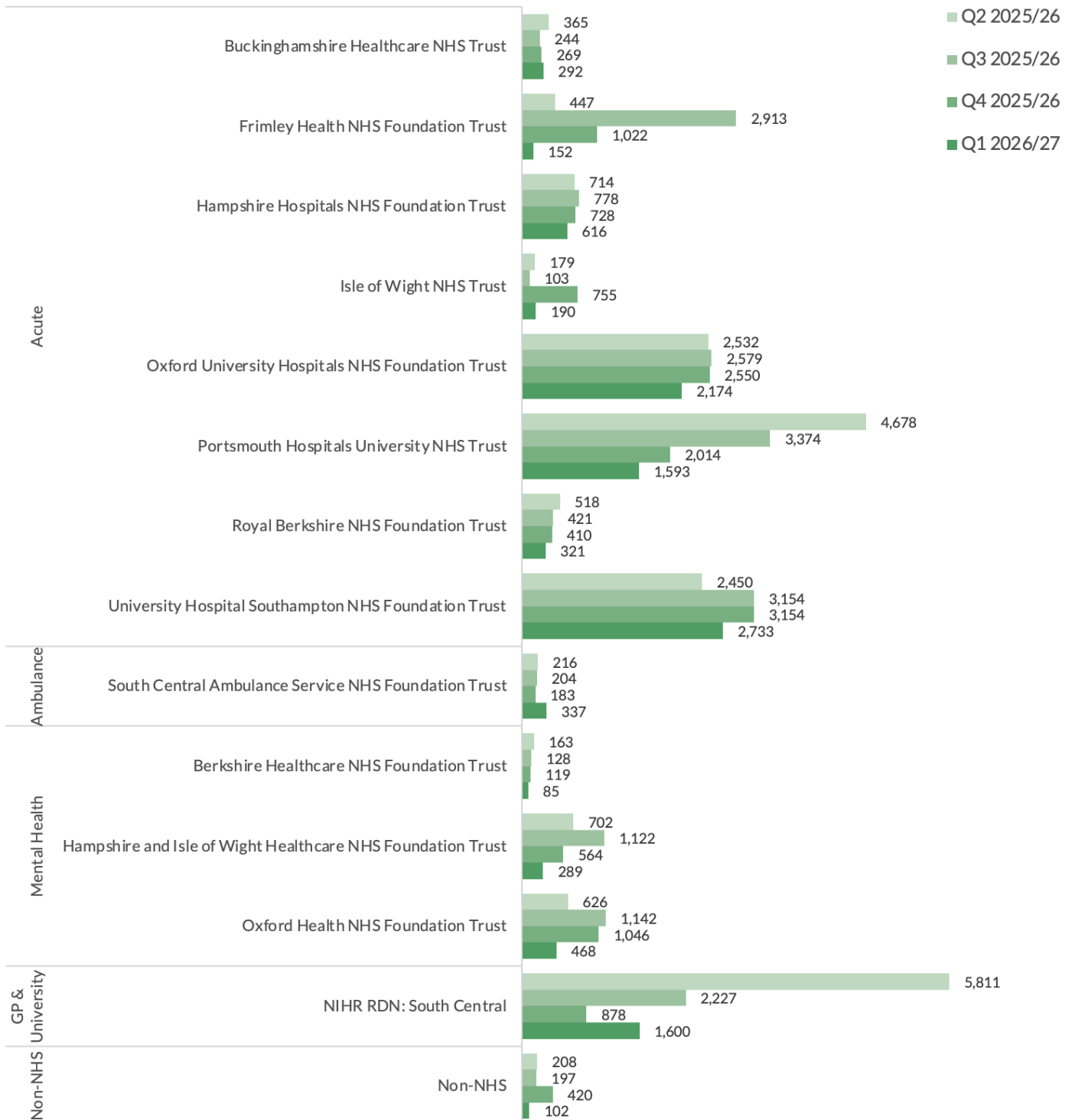


Figure 5 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

For reference, quarterly recruitment at delivery organisations within South Central is provided in Figure 5. 30 per cent of recruitment in South Central over the last twelve months has been in community organisations, supporting the shift to these settings.

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, but important data is collected to answer the research question. Studies also vary in the number of participants they intend to enrol and in the effort 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 for the 2026/27 funding model, based on an analysis of study data and feedback from stakeholders, is shown in the table below.

Type of research study	Study funder type	Study sample size (recruitment target)	Weighting per research 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 weighted zero because the funding for this research activity is paid directly from the life science industry partners.

During the fifteen-month period from April 2025 to June 2026, monthly complexity weighted recruitment across the South Central region had a downward trend (Figure 6). This represents an overall reduction of almost 32 per cent between April 2025 and June 2026. Across England, CWR

followed the same trend, with an overall decrease of 19 per cent over this period. The CWR shows a seasonal pattern, with reductions evident in holiday periods in August and December.

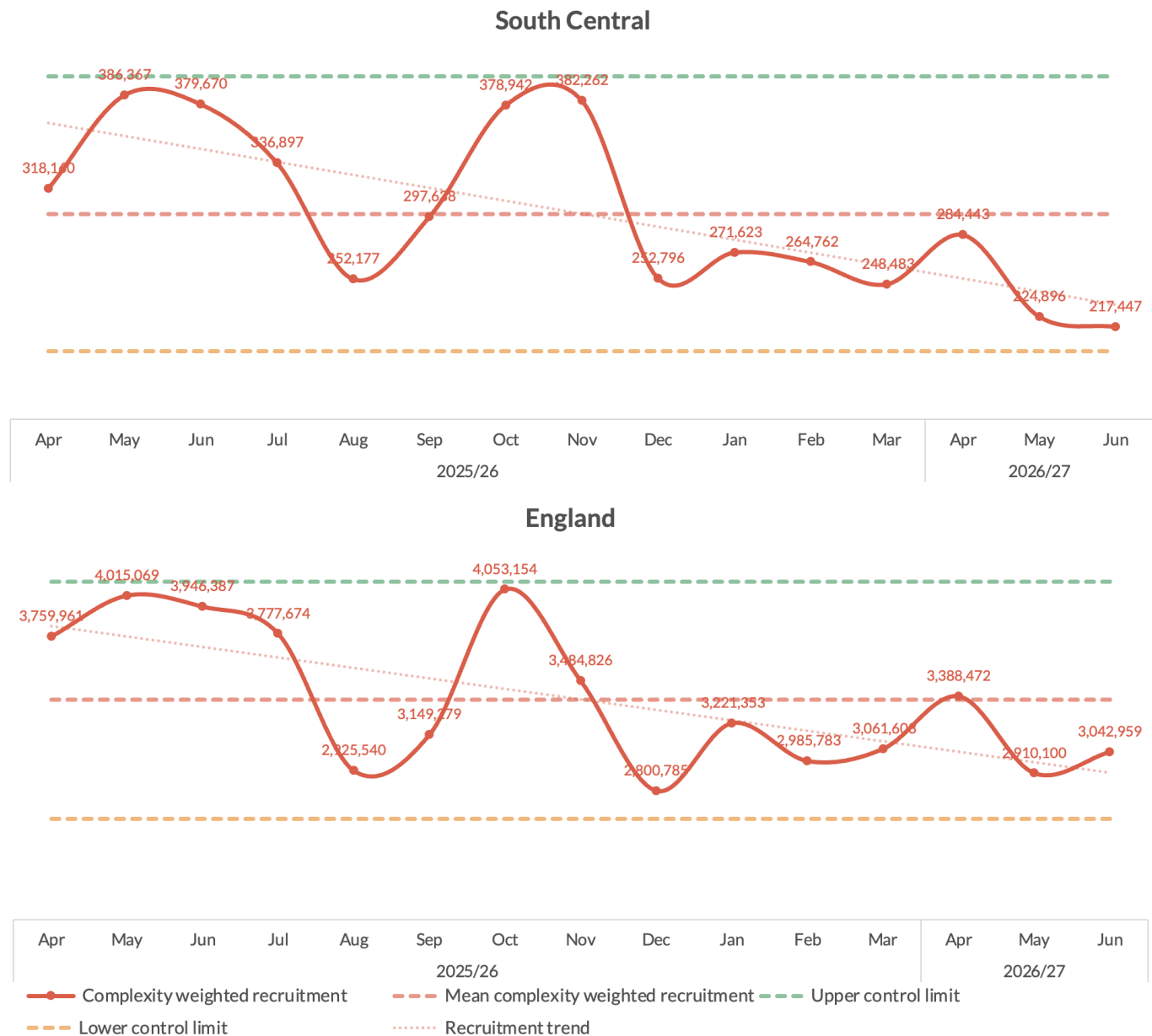


Figure 6 – Monthly complexity weighted recruitment in the South Central region benchmarked against England in the previous fifteen months

Under the RDN funding model, CWR is an important element used to calculate future delivery allocations for NHS trusts. This accounts for 21 per cent of the hospital funding model. A sustained downward trend in weighted activity relative to other English regions represents a potential financial risk to South Central’s delivery infrastructure. To mitigate this risk, it is recommended that delivery organisations:

- maintain their improved set-up timelines
- horizon scan for study opportunities using the NIHR RDN Open Data Platform
- consider whether staff from other specialties can be temporarily assigned to existing studies
- identify best practice for research delivery internally and at other organisations
- promote new research study development from within the organisation.

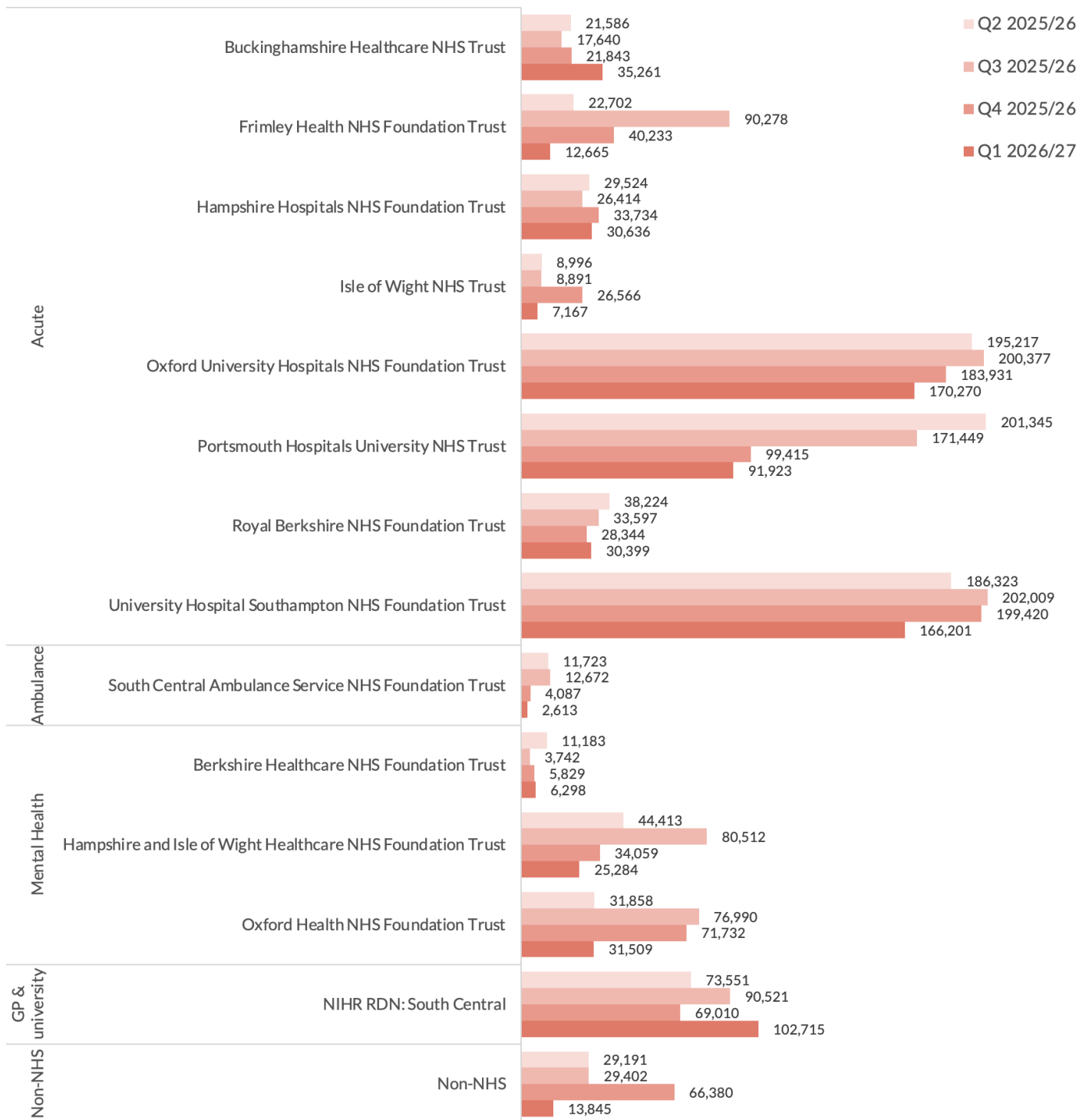


Figure 7 – Complexity weighted recruitment by organisation and organisation type in the South Central region in the previous four quarters

For reference, quarterly CWR at delivery organisations within South Central is provided in Figure 7.

Commercial recruitment in South Central

During quarter one of the 2026/27 financial year, delivery organisations in the South Central region have recruited **1,046 participants** across **30 research locations** on **114 commercial studies**.

Commercial research, funded and sponsored by the life sciences industry, remains a strategic priority for both the Department of Health and Social Care and the NIHR. Commercial trials provide South Central's local population with access to novel treatment options while supporting the expansion of regional research infrastructure and generating savings on treatment costs for participating organisations. Sustaining the growth in commercial activity is essential to maintain and expand South Central's delivery capacity and align with the recommendations of [Lord O'Shaughnessy's 2023 review](#) into commercial clinical trials in the UK.

Unlike the broader downwards trend observed for non-commercial research activity, commercial recruitment in South Central, as well as England, is trending upwards (Figure 8). Over 500 participants have been recruited within South Central in quarter one on Discover Me, a very large observational study analysing health as well as genetic data of primary care patients.

Commercial recruitment was distributed across all care settings in the first quarter of the 2026/27 financial year (Figure 9). The most recruitment occurred within primary care, with acute organisations broadly maintaining their historic recruitment in the first quarter. Berkshire Healthcare, a mental health NHS Trust, recorded its first commercial recruitment in the twelve-month period. Expanding commercial delivery into the community setting supports the RDN's objective to broaden research participation outside of hospitals.

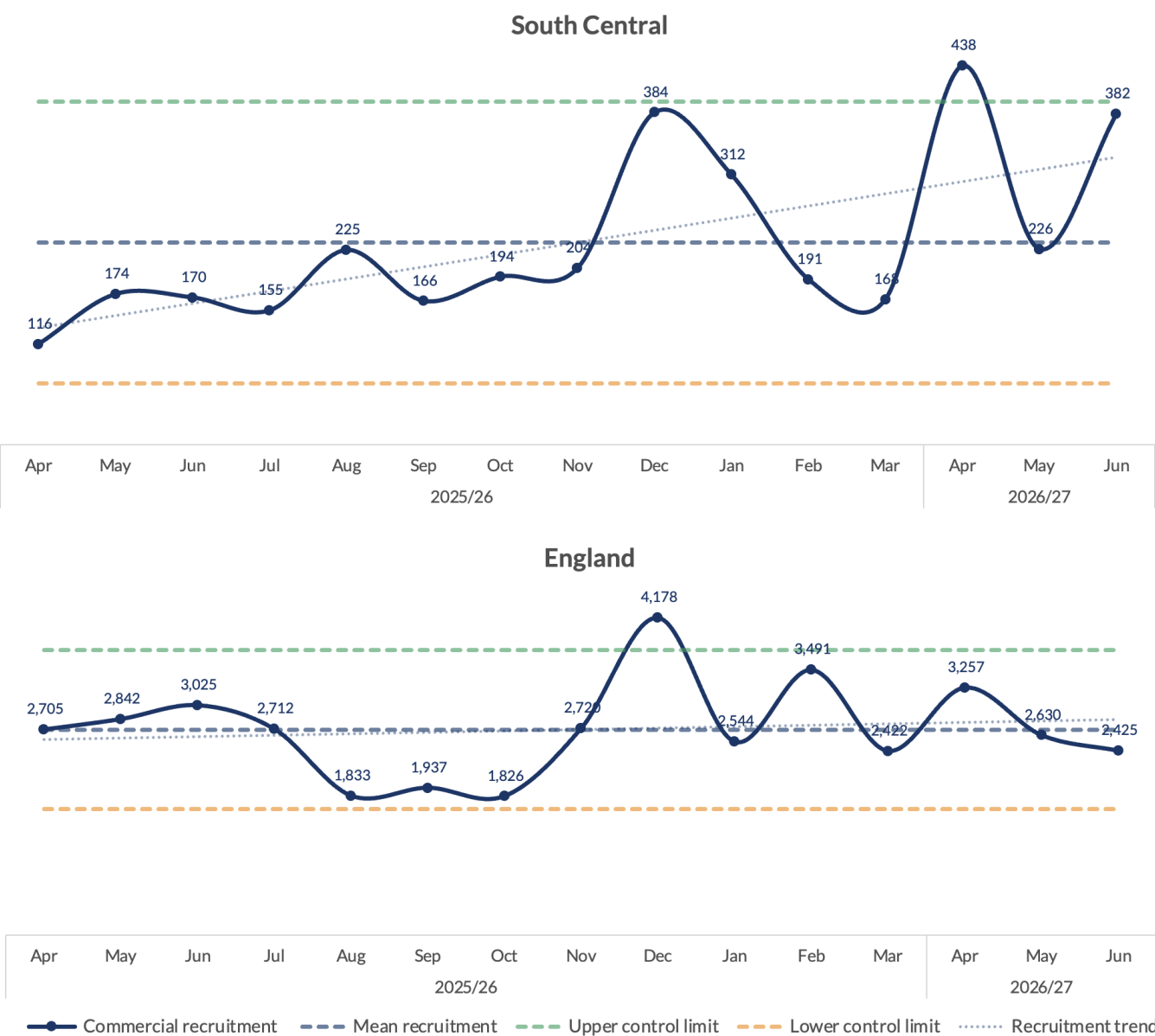


Figure 8 - Monthly commercial recruitment in the South Central region benchmarked against England in the previous fifteen months

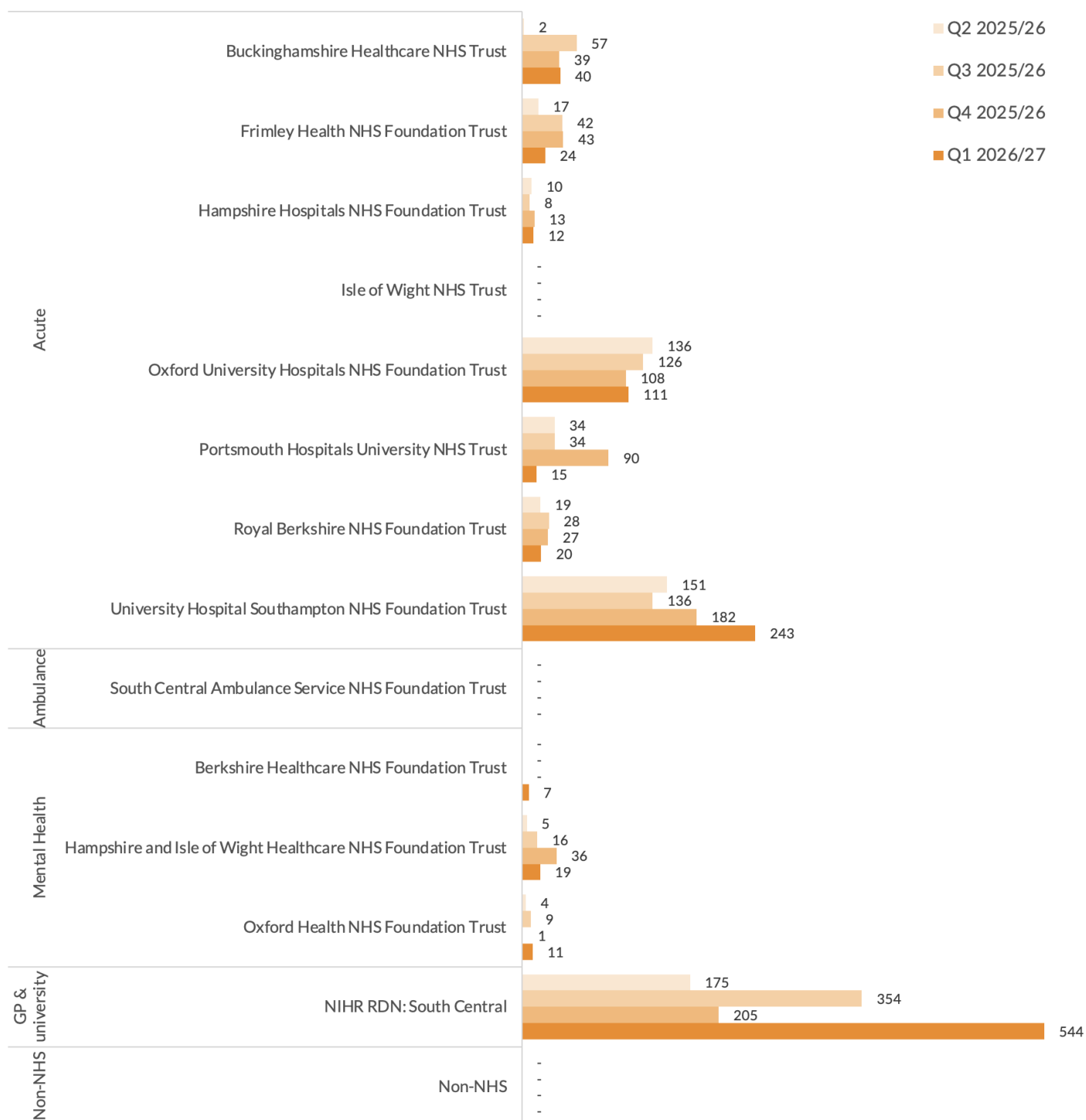


Figure 9 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

Summary of South Central research activity

The research activity in the South Central region, relative to all other RRDN regions in England has been provided in Figure 10 for information. For context, the South Central region has the eighth largest population.

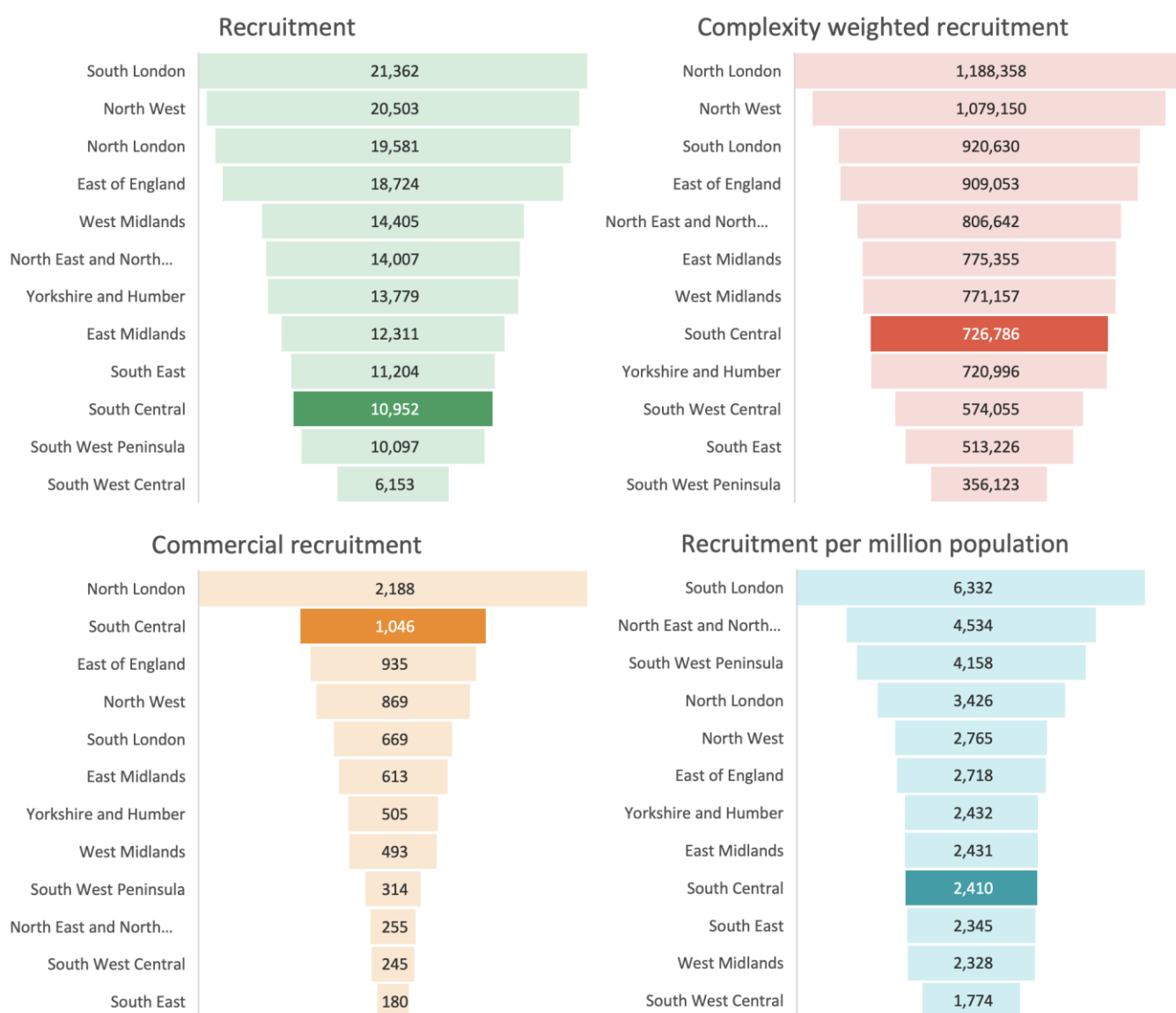


Figure 10 – Recruitment, complexity weighted recruitment, commercial recruitment and recruitment weighted per million population by RRDN region in quarter one of the 2026/27 financial year

Recruiting studies in South Central

South Central recruited to a total of **510 non-commercial studies** during quarter one of the 2026/27 financial year, following a financial year total of 879 in 2025/26 (Figure 11). The composition of the regional portfolio continues to transition toward higher complexity interventional trials. In quarter one, interventional and large interventional trials accounted for 54.5 per cent of the non-commercial portfolio within South Central. This is an increase from 50 per cent combined interventional activity in 2023/24 & 2024/25, followed by 52 per cent in 2025/26. This growth has been offset by a reduction in observational and large observational recruiting research studies. These now represent 45.5 per cent of non-commercial recruiting studies, down from a combined 51 per cent in 2023/24.

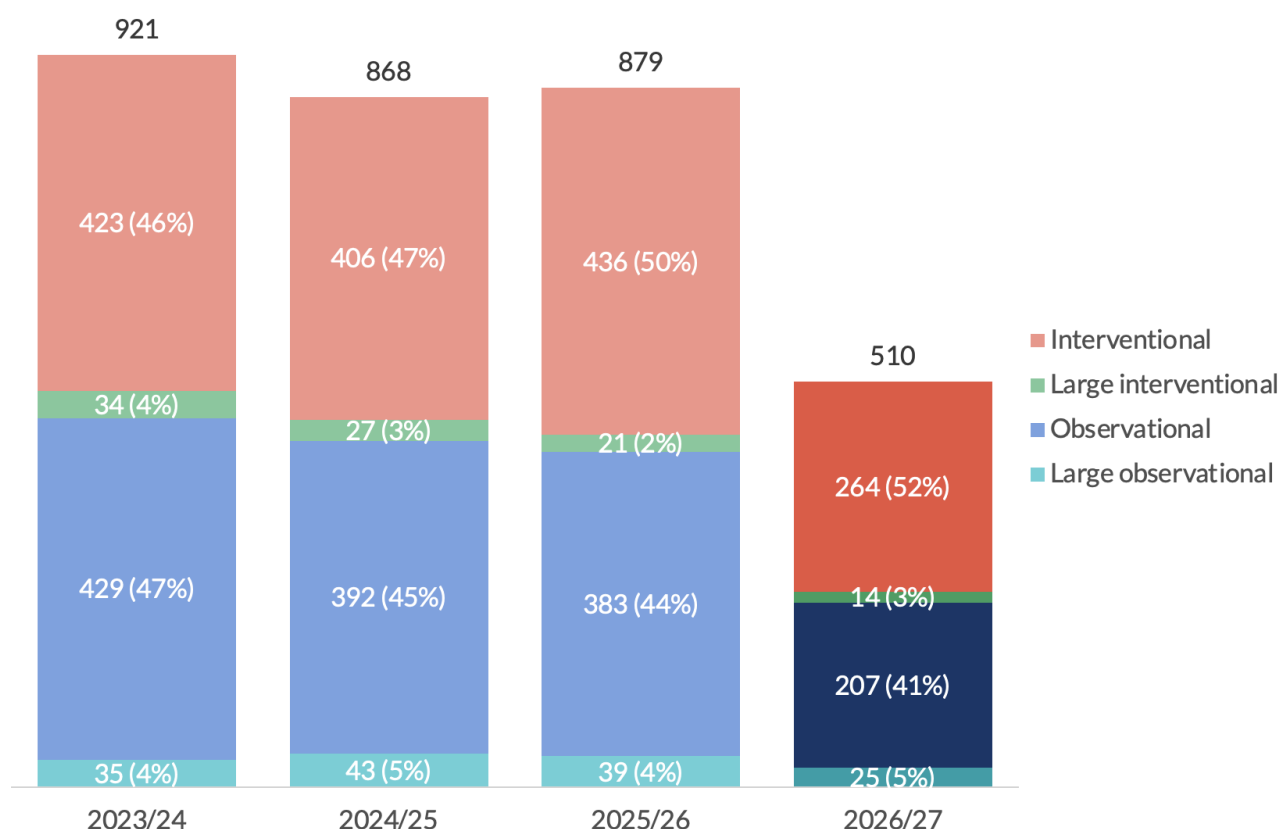


Figure 11 – Non-commercial recruiting studies by complexity within the South Central region since April 2023

The number of commercial recruiting studies rose to 270 in 2025/26 and during quarter one of 2026/27 the region has recruited to 114 studies so far (Figure 12). 77 per cent of these studies were interventional, down slightly from 82 per cent in 2025/26.

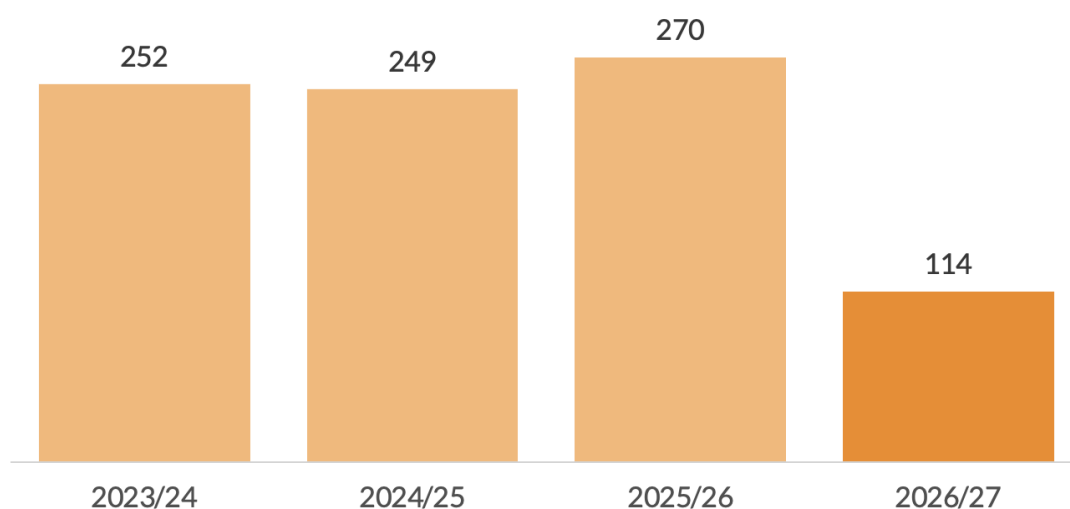


Figure 12 – Commercial recruiting studies within the South Central region since April 2023

In the first quarter of 2026/27, South Central had the fourth and fifth highest number of recruiting non-commercial and commercial studies, respectively, among the twelve RRDN regions in England (Figure 13).

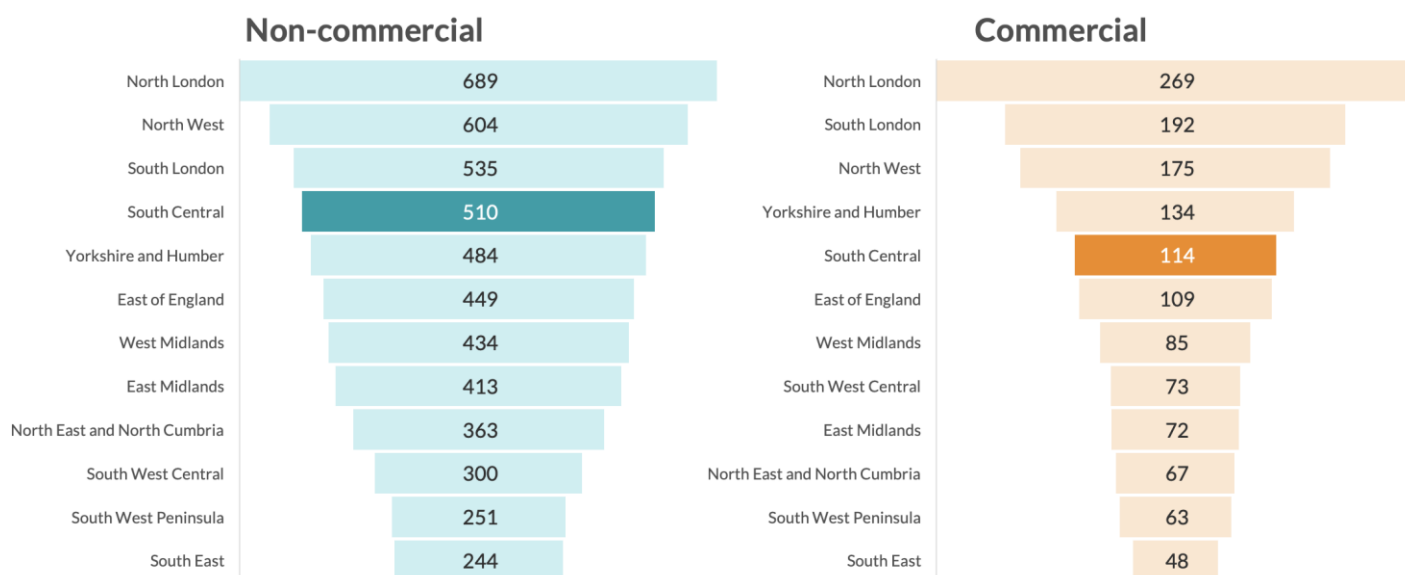


Figure 13 - Non-commercial and commercial recruiting studies by RRDN region in quarter one of the 2026/27 financial year

Study set-up

The NIHR RDN funding model allocates a portion of funding to research delivery organisations based on how efficiently they set-up studies. The first metric measures the proportion of study research locations opened within sixty days of Health Research Authority study approval or the location\’s selection date by the study sponsor, whichever date is later.

In quarter one of the 2026/27 financial year, South Central delivery organisations achieved 69 per cent of research locations meeting the target (Figure 14). Across the 2025/26 financial year, this performance was at 57 per cent. Nationally, South Central ranks eighth among the twelve English Regional Research Delivery Networks.

Performance varied across participating NHS trusts within the region during the first quarter. Seven delivery organisations achieved 100 per cent, where all open research locations met the sixty day target (Figure 15). However, performance on this metric was lower among some mental health organisations, as well as the largest acute organisations who have the highest set-up activity and burden. This impact of this is that the average performance across the region was lowered.

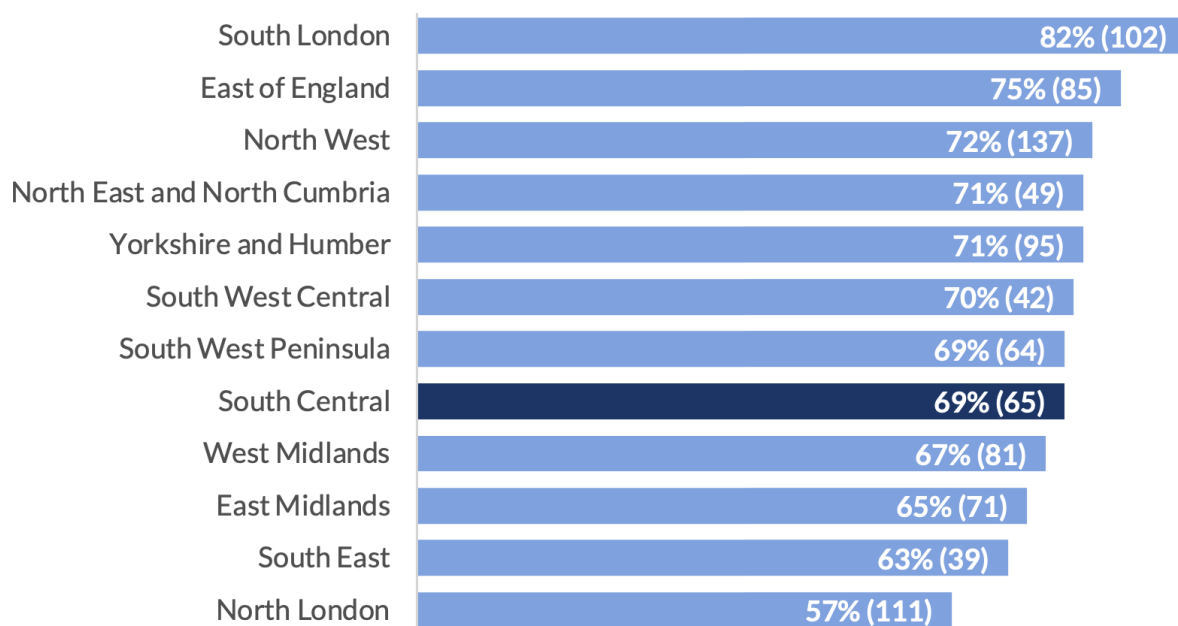


Figure 14 – Study locations open within sixty days of HRA approval or research location selection by RRDN region in quarter one of the 2026/27 financial year

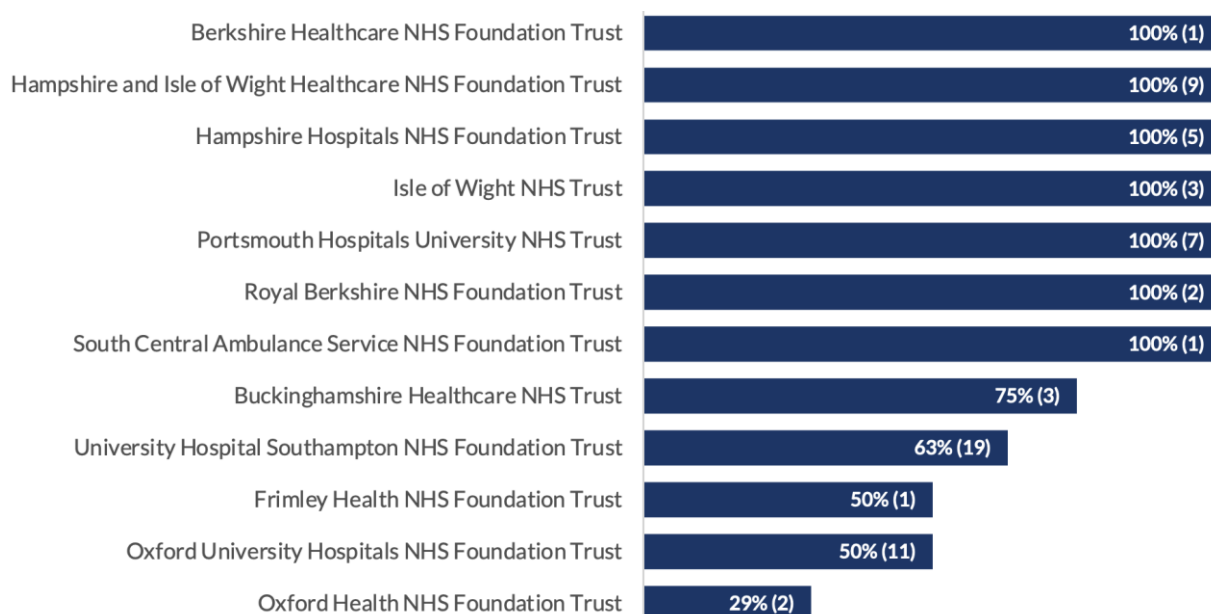


Figure 15 – Study locations open within sixty days of HRA approval or research location selection at South Central NHS Trusts in quarter one of the 2026/27 financial year

The funding model also includes a second set-up metric which measures percentage of studies achieving first participant's first visit (FPFV) at an organisation within thirty days of the delivery organisation readiness. In the 2025/26 financial year, 40 per cent of regional research locations achieved this metric. This has risen slightly to 43 per cent in the first quarter of this financial year, but delivery organisations in the South Central region are currently performing below the other English regions on this metric (Figure 16 and Figure 17).

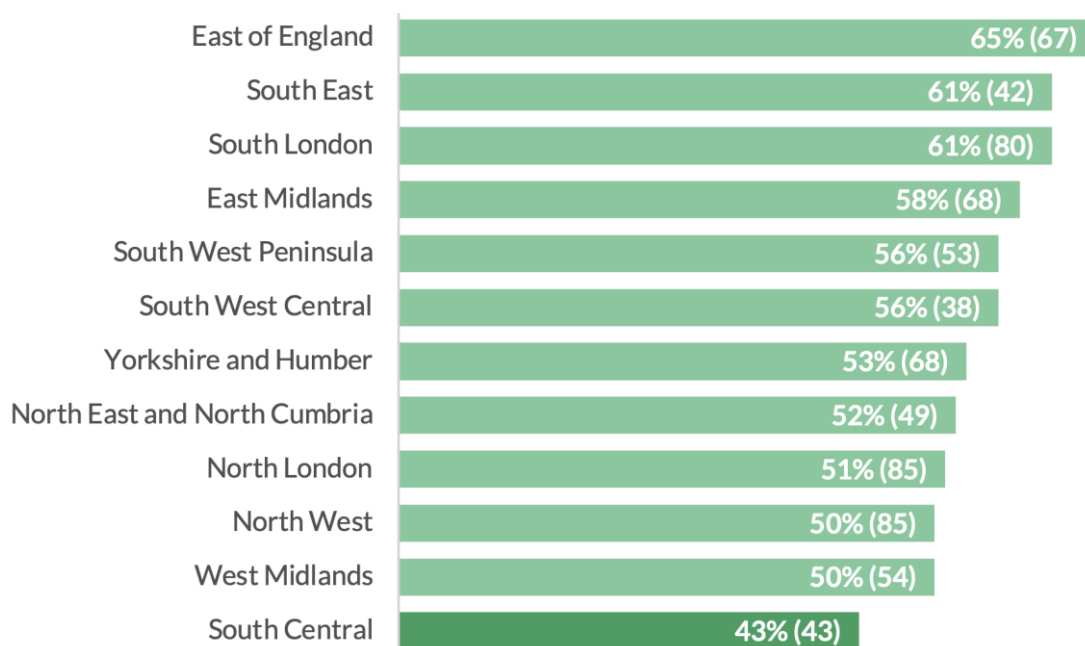


Figure 16 – Study locations achieving the first participant first visit within thirty days of research location readiness by RRDN region in quarter one of the 2026/27 financial year

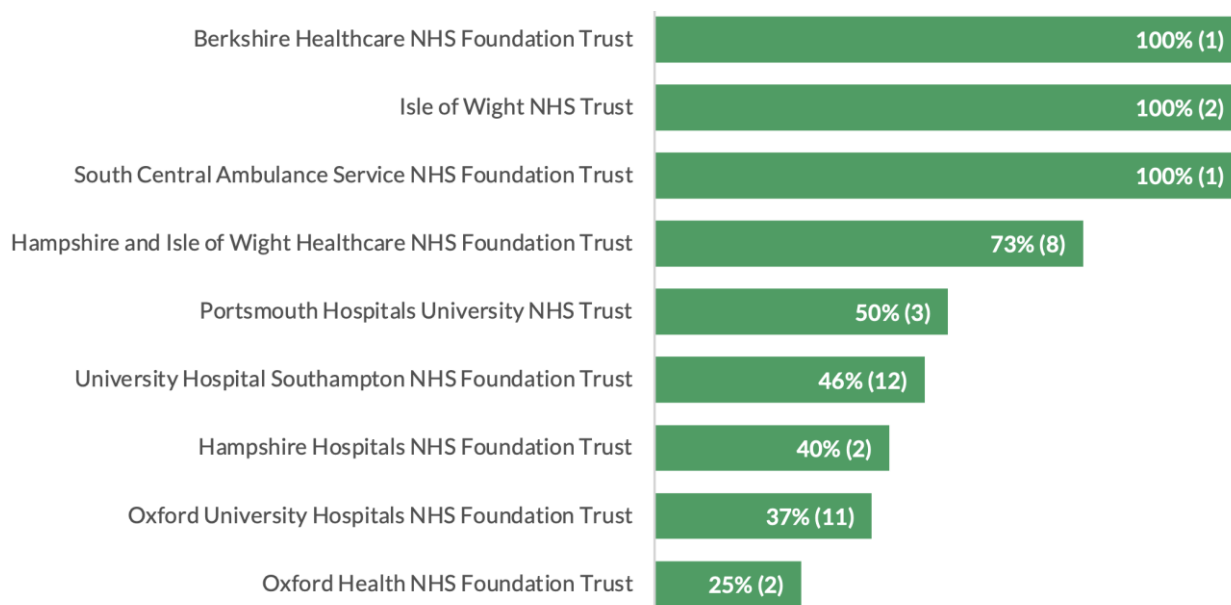


Figure 17 – Study locations achieving the first participant first visit within thirty days of research location readiness at South Central NHS Trusts in quarter one of the 2026/27 financial year

In response to the Government's 150 day set-up target from regulatory submission through to the first research participant visit, SC RRDN has supported research delivery organisations in several ways:

- Allocated strategic funding to support projects that refine set-up processes

- The Agile Research Delivery Team have made available clinical support for health and care organisations to reduce the time to recruit the first participant
- SC RRDN are monitoring the study set-up times and have implemented a regional escalation process that targets specific blockers to set-up, for example, resolution of costing queries.

By supporting faster set-up, this will optimise the opportunity to recruit participants by maximising the time available to identify them. For interventional studies, this supports the goal of bringing new treatment options to patients faster.

Participant experience

During quarter one of the 2026/27 financial year, South Central RRDN have monitored research participant feedback through the refreshed My Research Experience survey. Delivery organisations received **544 adult responses** across **91 studies** (Figure 18).

Adult feedback remained high for most questions, with 97 per cent of participants reporting being treated with courtesy and respect, 96 per cent feeling prepared for their study, 94 per cent rating their research experience positively as well as 91 per cent expressing willingness to participate in future studies. Questions relating to communication indicate that there is possibility for improvement, with 76 per cent responding that they understand their care arrangements at the end of the study and 61 per cent knew how they would receive the results. The latter has demonstrated progressive improvement, with 39 per cent recorded across the 2025/26 financial year. This metric may have been influenced by national regulations brought in on 28 April 2026 requiring clinical trial results to be distributed to participants within twelve months of study completion.

For the children and young people (CYP) version of the survey, only **four CYP responses** have been received across **two studies** (Figure 19). Because of this small sample size, there is currently not enough data available to draw conclusions. However, there are some concerning results for feeling valued, knowing how they would receive the results and feeling treated with courtesy and respect. This will be tracked in future months and raised with the affected delivery organisations if a pattern is observed. The delivery teams involved in these studies will have access to these responses in order to review the reasons behind them.



Figure 18 - Summary of the My Research Experience adult survey results in the South Central region in quarter one of the 2026/27 financial year



Figure 19 - Summary of the My Research Experience children and young person (CYP) survey results in the South Central region in quarter one of the 2026/27 financial year

Conclusion

During the first quarter of the 2026/27 financial year, delivery organisations within the South Central region recruited 10,952 participants across 624 studies and 112 research locations, representing 6.3 per cent of total recruitment in England. While overall recruitment continues a downward trend due to the completion of high-volume observational studies, delivery organisations within the region demonstrated a transition towards higher complexity interventional research. Non-commercial interventional studies now represent 54.5 per cent of recruiting studies so far this year, requiring greater clinical resources per participant.

The implementation of the new national Research Delivery Network funding model resulted in an £868,069 or 3.1 per cent funding reduction for South Central compared to the previous financial

year. This means that some NHS Trusts are operating under reduced funding for research activity compared to the 2025/26 financial year.

In contrast, commercial trial recruitment demonstrated sustained growth across the region. Delivery organisations recruited to 114 commercial studies in the first quarter, with 77 per cent focused of these interventional. Furthermore, regional initiatives to expand research delivery into non-hospital settings progressed successfully, with community organisations generating 30 per cent of total regional recruitment over the preceding twelve months.

Participant feedback collected through the My Research Experience survey remained strongly positive, with 97 per cent of adult respondents reporting being treated with courtesy as well as respect and 94 per cent rating their experience positively. Awareness regarding the communication of study results reached 61 per cent, reflecting progressive improvement following new national trial transparency regulations introduced in April 2026.

Study set-up efficiency remains an important area for improvement. During the first quarter, South Central organisations achieved 69 per cent compliance for opening research locations within sixty days, ranking eighth among the twelve English regional networks. However, South Central organisations achieved only 43 per cent for consenting the first participant within thirty days of site readiness, placing the region twelfth.

SC RRDN is responding to this issue through coordinated action with regional research leaders and delivery organisations. Monthly and quarterly engagement with Trust research leadership, alongside the new Clinical Delivery Leaders Group, will help realise the recruitment action plan and identify workforce challenges affecting delivery. The RRDN is also providing strategic funding and clinical support, monitoring study set-up times and providing a regional escalation process to address specific barriers.

South Central RRDN remains committed to supporting the NIHR's mission to improve the health and wealth of the nation through research and will continue to provide quarterly updates to the Board on South Central's progress and performance.

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 following completion of MOC process. Event: Staff we have invested in and developed to work in this Agile capacity leave or are absent 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 2. Wellbeing programme established for the team and delivered by the team 3. Ensure regular check-ins at 1:1 meetings with all staff 4. Continue to keep a close eye on any changes using all possible tools, e.g. 1:1s, team meetings, wellbeing surveys etc 5. 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 8. The agile band 7 management team are meeting weekly to support staff and review capacity and capability 10. HoRD and Director of Ops are 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. 12) review of team member's work load to ensure it is equitable, band appropriate, and manageable	Ongoing	1	3	3
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	Raised locally with DOs with examples requested. Raised nationally for advice on prioritisation of key activities/studies	Ongoing	3	2	6
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	SC RRDN R&D Leadership meeting on 24/3/2026 dedicated to sharing information about how DO R&D/R&I teams work with Pharmacy colleagues, including: structures, relationships, funding, and ways of handling pressures. This was followed up with a half day face-to-face meeting on the 8/6/2026 with R&D Managers and Directors, as well as Lead Pharmacists, invited. This meeting focussed on potential collaborative initiatives and innovations to increase capacity and efficiency in pharmacy and support services with the aim of reducing set up times. Ideas from other RRDN areas are also being investigated and shared. Funding specifically for pharmacy at OUH, UHS and RBH has been increased via CSS and contingency funding awards. The SC RRDN Imaging Specialty Lead, working with the SSS and Industry team, is continuing to engage with organisations to map capacity.	Ongoing	3	3	9
SCRRDN 006	19. Health and Care Services Engagement	Thames Valley ICB Engagement	Research engagement with TV ICB: TV ICB launched on 1st April 2026 and roles that include responsibility for research are not yet finalised	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) Link with TV ICB Executive Medical Director 3) leverage contacts already in place with the Hampshire and IOW ICB	Ongoing	3	2	6

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 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 at a senior level 3. Importance of high priority studies communicated to delivery organisations at a senior level	All ongoing	4	4	16
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 Pls 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	1	3	3
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	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	Workload regularly reviewed by the Strategic Director. Work closely in conjunction with the Study Support team who are supplying operational level input in the day to day challenges of the 150 days. Regularly discussed by the leadership team. Matrix management with Industry Hub leadership to provide clarity and direction.		5	4	20
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.		3	3	9

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 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 workstreams and action group - Regional strategic funding call with commissioned call for projects to support study set-up acceleration. Large awards funded. Total TBC.		4	4	16
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 commercial 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 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 in Autumn 2026. 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 been asked to extend their contracts into 2027/28. Update 7/1/2026: the procurement process has been extended nationally by six months. This would mean an implementation date of October 2027. Update 6/7/2026: Original procurement date is now targeted, with a functioning system due 1 April 2027 ready to transfer all data over a course of a year.	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	Allocation of strategic funding, wider care setting funding and contingency funding to support DOs. Potential use of use of any management team and wider care setting underspend to support DOs while also demonstrating strategic impact. Deployment of Agile team on a case by case basis to support short term requirements	Ongoing	4	4	16

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 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 have run two funding calls: Strategic Funding and Wider Care Settings. Ther amount requested from applicants to significantly exceeded the SC RRDN funding envelopes allocated for these calls.	Potential reputational risk to SC RRDN stakeholders relationships.	5	3	15	The RDN has met with numerous organisations to feedback and explain funding decisions seeking solutions which include support being supplied from other nearby Trusts and deployment or agile staff to support the organisations to build their portfolio. A limited number of discussions are still continuing. The WCS team has shared an update email to mitigate WCS research location concerns, GP experts have confirmed this was helpful. The network has several plans in place to learn from the challenges for the next year's (27/28) funding call due Autumn 2026	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 4) One to one meetings being offered to those who want to discuss their funding allocation outcome. 5) the SC RRDN HoRD is sharing feedback on several national groups including the funding model. 6) The SC RRDN HoRD is the national Communications lead for the next WCS Funding Call.	3	3	9
SCRRDN 030	20. Workforce Learning and Organisational Development	National industry short term projects/programmes	Industry hub mandate to mobilise 2 FTE to support industry activities at short notice and no consideration of individual teams situation/workload. No input request, impact assessment and lack of operationsl details.	Ability to deliver national SSS Potential HR issues/ staff burnt out.	5	3	15	Feedback to national team via Directors. SSS/Life Sciences team to design an strategy/ operations plan to mitigate impact on team members. In the absence of operationsl details, the following communication channels have been establish to review situation in a regular basis: - Weekly Operations/Strategy managers meeting to review progress and actions required. - Use established biweekly SSSM/Agile and IM meeting to review operations/needs - SC industry hub/NCVR chat / rota : SSS team members were brief about rapid response to industry requests and support for IM during new processes implementation. This chat enables prompt response and support to industry hub queries. SSSO rota for speedy triage of queries to relevant team members. - All SSS have been trained on industry operations as part of transition (CRN-RDN) to increase team's resilience. A refresher to be deliver once operational details are provided	Situation monitored weekly and to adjust response as needed	4	2	8



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
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

Agenda Item Report to the Quality Committee, 1 June 2026				
Title:	Maternity and Neonatal Safety Report 2025-26 Quarter 4			
Sponsor:	Natasha Watts, Interim 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 (type an 'x' in the appropriate box(es))				
(Re)Assurance	Approval	Ratification	Information	
X	X		X	
Strategic Theme (type an 'x' in the appropriate box(es))				
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 Maternity and Neonatal service remains broadly compliant with the NHS Resolution Maternity Incentive Scheme (Year 8), demonstrating strong performance in workforce standards, safety systems and progress with care bundle implementation. However, during Quarter 4 there is clear evidence that increasing clinical acuity and activity are beginning to impact both outcomes and experience of care. This is reflected in rising rates of postpartum haemorrhage, obstetric trauma and postnatal readmissions, alongside a deterioration in postnatal experience. The service has also managed several complex and significant incidents, including three indirect maternal deaths in Quarter 4, which remain subject to external investigation. Emerging learning highlights the impact of operational pressures and identifies areas where local clinical guidance requires alignment with national standards. In addition, system risks are developing, including the planned withdrawal of the BCG vaccination service in September 2026 and workforce and training risks within the homebirth service. The Committee is asked to take assurance from areas of compliance while maintaining scrutiny of emerging risks relating to clinical outcomes, experience of care, workforce capacity and service sustainability.				
Contents:				
This report provides an update on: 1. Current Position and key risks 2. NHSR Safety Actions (A–F): • Workforce and Capacity • Training and Education • Learning from Review and Investigations • Service User Voice and Equity • Care Bundles • Board Oversight, Culture and Leadership 3. System and strategic risks 4. Conclusion and Committee focus				

Risk(s):

The Maternity and Neonatal service continues to operate within a complex regulatory and governance framework, with clear expectations from NHS Resolution, the Care Quality Commission and NHS England. While these requirements are well established, the principal risks for the service at this time relate to sustaining compliance and managing the impact of increasing clinical demand and system pressures on quality and outcomes.

- There is an ongoing reputational and regulatory risk should current areas of concern, including clinical outcomes and experience, not demonstrate sustained improvement. These may attract external scrutiny from national bodies and impact public confidence in the service.
- A financial risk remains linked to delivery of the NHS Resolution Maternity Incentive Scheme. While the service is currently broadly compliant, any deterioration in performance against the safety actions could result in loss of financial incentive and increased oversight.
- In addition, there is a governance risk associated with the scale and complexity of incidents and investigations, including maternal deaths, which require robust oversight to ensure timely review, learning and assurance. Failure to demonstrate this may lead to escalation to regional or national bodies.
- Most significantly, there is a patient safety risk linked to increasing acuity, workforce pressures and identified areas of variation in clinical practice. These factors have the potential to impact outcomes and experience if not actively mitigated through focused quality improvement and operational management.

The Trust continues to address these risks through strengthened governance arrangements, continuous quality improvement activity and active engagement with staff, service users and system partners.

Equality Impact Consideration:

N/A

1. Current Position and Key Risks

Across all safety domains, the dominant theme during Quarter 4 is the impact of sustained high activity and clinical acuity.

There is a clear and consistent relationship between operational pressure and deterioration in both clinical outcomes and patient experience. Periods of peak demand have been associated with increased rates of postpartum haemorrhage and severe perineal trauma, alongside a rise in postnatal maternal and neonatal readmissions. (see Appendix 1 – UHS Maternity Services dashboard)

Workforce pressures have required redistribution of staff to maintain safety within higher-acuity areas, particularly labour ward. This has had a direct impact on postnatal services, where feedback and safety intelligence indicate a poorer experience of care.

In parallel, the volume and complexity of incidents, including maternal deaths, have increased the importance of timely investigation and demonstrable organisational learning. Emerging themes from these reviews further reinforce the relationship between capacity, workforce and outcomes. These cross-cutting issues underpin the position across all Safety Actions and require continued Committee oversight.

2. NHSR Maternity Incentive Scheme – Position

The Maternity and Neonatal service remains broadly compliant with the requirements of NHS Resolution Maternity Incentive Scheme (Year 8) (see Appendices 2 – 4 for the revised scheme).

Performance across the six safety actions is summarised in Chart 1, with the detailed position outlined within this report. While compliance is maintained in key areas such as workforce, safety systems and care bundle implementation, there are notable areas requiring continued focus.

Safety Action C (learning from investigations), Safety Action D (service user experience), and Safety Action F (culture and oversight) reflect the impact of sustained operational pressures and increased incident complexity during this period.

Chart 1:

NHSR Year 8 Assurance	RAG rating	Themes	Exceptions/Key concerns
Safety Action A: Workforce & Capacity	Green	High acuity, increased escalations to Opel 3	Birth rate + establishment = minimum requirement for safe staffing
Safety Action B: Training compliance	Green		Self declared touch point 30th June 2026 90% all staff groups
Safety Action C: Learning from reviews and investigations	Green	Communication Treatment/procedure delay Clinical Care	Global majority, in particular Black African overrepresented - CoC criteria review
Safety Action D: Service-user voice and equity	Green	Feeding support Communication Clinical Care	MNVP back from Maternity Leave
Safety Action E: Care Bundles	Yellow	Equipment/system issues and delays	Saving Babies Lives - Element 2 procurement issues with digital blood pressure monitors validated for use in pregnancy. Maternal Care Bundle - awaiting toolkit release
Safety Action F: Board oversight, governance, culture & leadership	Green	Staffing (medical staffing gaps) Safety critical tasks Dashboard/data	

The Committee is asked to consider this overview in conjunction with the detailed narrative within each Safety Action and maintain appropriate scrutiny of the identified areas of risk and improvement.

2.1. Safety Action A – Workforce and Capacity

The service remains fully compliant with workforce requirements, achieving 100% compliance with Royal College guidance in Quarter 4.

Notwithstanding this, periods of sustained high activity and acuity have required staff redeployment to maintain safe care in higher-risk areas. This has resulted in challenges maintaining continuity and quality within postnatal care, reflected in both safety intelligence and service user feedback.

Ongoing work is focused on strengthening workforce resilience and reviewing escalation processes to mitigate the wider impact of capacity pressures.

2.2. Safety Action B – Training and Education

Training requirements for multidisciplinary emergency training, neonatal life support and fetal monitoring remain in place, with compliance expected at defined points within the reporting period.

Training compliance is currently progressing as expected (see Appendix 5), with formal assessment points scheduled for 30th June and 30th November 2026 in line with NHS Resolution requirements. There are no current areas of concern; however, achievement of compliance at the Quarter 1 reporting point will be critical to maintain assurance.

2.3. Safety Action C – Learning from Review and Investigations

The service remains compliant with national requirements for incident reporting, investigation and review, including use of the Perinatal Mortality Review Tool and external panel involvement (see Appendices 6 – 8 for more detailed information on cases and triangulation of themes).

Quarter 4 has seen an increase in both the number and complexity of incidents, including three indirect maternal deaths. No investigations were closed during Quarter 4, reflecting their complexity, but this presents a risk in relation to the timeliness of learning and assurance. There were 3 moderate or above reported incidents. 2 of which were related to Maternity Services escalating to Opel 4 with the service opening within 24 hours. The other incident was a baby born and admitted to Neonatal Intensive Care Unit following a shoulder dystocia and requiring therapeutic hypothermia (see Appendix 7 for more information). There were no new Patient Safety Investigations.

Thematic review of incidents, complaints and feedback has identified key areas for improvement. This intelligence has demonstrated the need to realign our case loading criteria for maternity following a shift in outcomes that aligns with the national picture. This relates to poorer outcomes for Global Majority women and babies and specifically those of Black African origin and has prompted an urgent review and re evaluation for providing a higher support model for these groups. We are mindful of the impact of high acuity on outcomes and patient experience. A recent MNSI investigation has identified a specific misalignment between local clinical guidance and NICE recommendations relating to the assessment of proteinuria in pregnancy.

Actions are underway to address these findings, including guideline revision and targeted quality improvement work. Continued Committee oversight is required to ensure that learning is embedded and improvement is sustained.

2.4. Safety Action D – Service User Voice and Equity

Mechanisms remain in place to capture service user voice through the Maternity and Neonatal Voices Partnership (MNVP), Friends and Family Test, complaints, and direct feedback.

During Quarter 4, feedback has highlighted a deterioration in postnatal experience, closely associated with workforce pressures and staff redeployment. These findings align with themes identified through safety intelligence and incident review (see Appendix 9).

An action plan is being implemented to improve continuity of care and the quality of postnatal experience, ensuring that service user feedback drives targeted improvement.

2.5. Safety Action E – Care Bundles

Implementation of the Saving Babies' Lives Care Bundle (version 3.2) is largely complete, with only minor local variation remaining (see Appendix 10).

The service is preparing for implementation of the new Maternity Care Bundle, with further detail awaited through the national toolkit. Local planning is underway to ensure readiness for delivery and monitoring.

Neonatal pulse oximetry screening remains embedded within routine practice, with an audit planned in Quarter 1 to confirm ongoing compliance.

2.6. Safety Action F – Board Oversight, Culture and Leadership

Governance arrangements to support oversight of maternity and neonatal safety remain in place, supported by reporting through this Committee.

The Maternity Outcomes Signal System (MOSS) continues to function effectively, with no safety signals generated since implementation (see Appendix 11). A test exercise is planned to ensure system readiness.

The perinatal culture improvement plan is currently under review following changes in leadership, and Safety Champions activity is being re-established following recent disruption (see Appendix 12).

Overall, governance arrangements remain in place; however, leadership and culture development are currently in transition, and progress against improvement plans will require close monitoring by the Committee.

3. System and Strategic Risks

Three key system risks require ongoing oversight.

The first relates to the planned withdrawal of the BCG immunisation service for high-risk newborns in September 2026. This service is currently embedded within the TB service which is part of the service withdrawal. Work is ongoing with commissioners and system partners to determine a sustainable replacement model.

The Screening and Quality Assurance Service (SQAS) from NHSE reviewed our Antenatal and Newborn Screening Services to gain assurance that screening incidents were being consistently reported across the programmes. The evidential submission by the Trust resulted in this review to be downgraded to a table top review and 3 expected actions were delivered to the Trust to be completed within the next 12 months. (See Appendix 13). "These actions do not represent immediate risk but require ongoing monitoring to ensure sustained compliance.

The second relates to the homebirth service, where a recent review has identified risks relating to workforce, training and service provision. These have been escalated to the Trust risk register, and an action plan is in development.

The third involves the Occupational Entonox exposure testing which has continued to demonstrate higher than acceptable levels of exposure to staff. A capital funding bid has been submitted in relation to the works required.

In addition, digital implementation of the Maternity Early Warning Score (MEWS) remains in progress, with expected completion in Quarter 1 (see Appendix 14 for an update of progress against the 3 year delivery plan expectations).

4. Conclusion and Committee Focus

In summary, the service continues to deliver against national standards and demonstrates areas of strong assurance. However, increasing demand and acuity are beginning to impact both outcomes and experience, and several emerging risks require active management.

Committee members are asked to maintain focused oversight on deteriorating clinical outcomes, particularly postpartum haemorrhage and perineal trauma, alongside rising maternal and neonatal readmissions and the impact on postnatal experience. Continued scrutiny is required on workforce capacity and the effects of sustained high activity and acuity on care quality, as well as the timeliness and demonstrable impact of learning from investigations in line with Safety Action C. The Board should also ensure that service user feedback and equity considerations are effectively driving improvement (Safety Action D), while maintaining strong governance, oversight and safety culture (Safety Action F). In addition, attention is required on key system risks, including the future delivery of BCG vaccination services, sustainability of the homebirth service, and progress against critical programmes such as MEWS implementation.

Agenda Item			
Report to the Quality Committee, 24 August 2026			
Title:	Maternity and Neonatal Safety Report 2026-27 Quarter 1		
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 (type an 'x' in the appropriate box(es))			
(Re)Assurance	Approval	Ratification	Information
X	X		X
Strategic Theme (type an 'x' in the appropriate box(es))			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
X			
Executive Summary:			
The Maternity and Neonatal Service continues to deliver against national standards and demonstrates areas of strong assurance, including ongoing progress against the NHS Resolution Maternity Incentive Scheme and compliance with key workforce, training and governance requirements. However, increasing demand, patient acuity and sustained operational pressures continue to impact service delivery, clinical outcomes and service user experience, requiring ongoing oversight and focused improvement activity. During the reporting period, Maternity Services received an unannounced Care Quality Commission (CQC) inspection. Whilst feedback included positive observations regarding patient-centred care, staff engagement and commitment to improvement, significant concerns were raised regarding security arrangements within Maternity Services. Following an immediate Trust-wide response and implementation of mitigating actions, assurance was provided to the CQC and proposed enforcement action was subsequently withdrawn. Further work to strengthen security arrangements and the Maternity environment remains underway and is described within this report. The Committee is asked to maintain focused oversight of deteriorating clinical outcomes, particularly postpartum haemorrhage and perineal trauma, alongside rising maternal and neonatal readmissions and the impact of operational pressures on postnatal care and service user experience. Continued scrutiny is required in relation to workforce capacity and resilience, the impact of sustained activity and acuity on quality of care, and the effective implementation of learning arising from incidents, investigations and reviews. The Committee is also asked to maintain assurance that service user feedback and equity considerations continue to drive quality improvement, whilst ensuring robust governance, leadership, oversight and safety culture across Maternity and Neonatal Services. Particular attention is required in relation to delivery of the Maternity and Neonatal Services 10-Point Improvement Plan, actions arising from the recent CQC inspection, the future provision of BCG vaccination services for high-risk newborns and the ongoing occupational Entonox exposure risk.			

Contents:	
1. Current Position and Key Risks (Appendices 1 – 4) 2. NHSR Maternity Incentive Scheme – Position 2.1. Safety Action A – Workforce and Capacity (Appendix 5) 2.2. Safety Action B – Training and Education (Appendix 6) 2.3. Safety Action C – Learning from Review and Investigations (Appendices 7 – 10) 2.4. Safety Action D – Service User Voice and Equity (Appendices 11 – 13) 2.5. Safety Action E – Care Bundles 2.5.1. Saving Babies' Lives Care Bundle (Version 3.2) (Appendices 14 – 15) 2.5.2. Maternal Care Bundle (Appendix 16) 2.5.3. Neonatal Pulse Oximetry (Appendix 17) 2.6. Safety Action F – Board Oversight, Culture and Leadership 2.6.1. Maternity Outcome Signal System (MOSS) (Appendix 18) 2.6.2. Perinatal Culture Improvement Plan (Appendices 19 – 20) 2.6.3. Safety Champions (Appendix 21) 3. System and Strategic Risks (Appendices 22 – 24) 4. Conclusion and Committee Focus	
Risk(s):	
The Maternity and Neonatal Service continues to operate within a complex regulatory and governance framework, with clear expectations from NHS Resolution, the Care Quality Commission and NHS England. While these requirements are well established, the principal risks for the service at this time relate to sustaining compliance and managing the impact of increasing clinical demand and system pressures on quality and outcomes. - There is an ongoing reputational and regulatory risk should current areas of concern, including clinical outcomes and experience, not demonstrate sustained improvement. These may attract external scrutiny from national bodies and impact public confidence in the service. - A financial risk remains linked to delivery of the NHS Resolution Maternity Incentive Scheme. While the service is currently broadly compliant, any deterioration in performance against the safety actions could result in loss of financial incentive and increased oversight. - In addition, there is a governance risk associated with the scale and complexity of incidents and investigations, including maternal deaths, which require robust oversight to ensure timely review, learning and assurance. Failure to demonstrate this may lead to escalation to regional or national bodies. - Most significantly, there is a patient safety risk linked to increasing acuity, workforce pressures and identified areas of variation in clinical practice. These factors have the potential to impact outcomes and experience if not actively mitigated through focused quality improvement and operational management. The Trust continues to address these risks through strengthened governance arrangements, continuous quality improvement activity and active engagement with staff, service users and system partners.	
Equality Impact Consideration:	N/A

1. Current Position and Key Risks

This report is presented in the context of sustained operational pressures within Maternity and Neonatal Services during Quarter 1 2026/27 and a period of significant external scrutiny.

Maternity Services received an unannounced Care Quality Commission (CQC) inspection on 28 and 29 July 2026, with further interviews undertaken remotely in the days following the visit. Initial feedback was positive in relation to patient-centred care, staff engagement and the commitment of staff to service improvement. However, concerns were raised regarding security arrangements within Maternity Services, including aspects of baby abduction prevention and environmental security.

On 4 August 2026, the Trust received notification of proposed enforcement action relating to these concerns. An immediate and coordinated response involving Trust Board leadership, Estates, Security, Emergency Planning and Maternity Services resulted in the implementation of a range of mitigating actions and provision of assurance to the CQC. Following review of these actions, the proposed enforcement action was withdrawn on 5 August 2026. Further permanent and interim improvements remain underway, supported by ongoing oversight from the Interim Chief Nursing Officer, Deputy Chief Operating Officer, Estates and Security Teams. Further detail is provided in Section 3 of this report.

Across all safety domains, the predominant theme during Quarter 1 2026/27 remains the impact of sustained high levels of clinical activity and increasing patient acuity. This has been compounded by the publication of the Amos and Ockenden reports during the quarter, placing additional focus on maternity and neonatal safety, leadership, governance, workforce and service improvement.

Activity and operational pressure data captured through the daily National Maternity Situation Report (SitRep) is presented in Appendix 1 and provides an overview of Quarter 1 performance, including episodes of service escalation, service suspension and delays to planned activity. As this remains a relatively new reporting process, some data quality issues have been identified; however, these continue to be reviewed and validated by the Midwifery Leadership Team to support improvements in data accuracy and completeness.

This information should be considered alongside Appendix 2, which summarises the key safety themes and operational risks identified through daily Maternity and Neonatal safety walkarounds. Together, these datasets provide valuable insight into service pressures, workforce challenges and emerging safety concerns, enabling timely escalation, oversight and implementation of mitigating actions to support safe and effective care delivery. The service is also developing an acuity and activity dashboard to support trend analysis and proactive risk management.

Charts 1 and 2 highlight the principal areas of quality, safety and operational challenge requiring Committee oversight. Whilst these metrics are not new, they continue to require close monitoring and targeted improvement, supported by ongoing senior leadership oversight and assurance processes.

2. NHSR Maternity Incentive Scheme – Position

The Maternity and Neonatal Service remains broadly compliant and on track to meet the requirements of the NHS Resolution Maternity Incentive Scheme (Year 8).

Performance across the six safety actions is summarised in Chart 3, with the detailed position outlined within this report. Whilst assurance is demonstrated across workforce, training, safety systems and care bundle implementation, a number of areas continue to require focused attention.

Safety Action C (Learning from Reviews and Investigations), Safety Action D (Service User Voice and Equity) and Safety Action F (Board Oversight, Governance, Culture and Leadership) reflect the impact of sustained operational pressures, increasing service demand and the complexity of incidents managed during the reporting period.

The Committee is asked to consider this overview alongside the detailed narrative within each Safety Action and maintain oversight of the identified risks, mitigations and improvement actions.

Chart 3 – Progress to achieve NHSR, Maternity Incentive Scheme Year 8

	Assessment of compliance (met / partially met / not met)	Is there clear evidence to support compliance	Gaps requiring action
A – Workforce and Capacity	AMBER – On track	YES	No gaps – in progress
B - Training	AMBER – On track	YES	No gaps – in progress
C - Learning from reviews and investigations	AMBER – On track	YES	No gaps – in progress
D - Service User Voice and Equity	AMBER – On track	YES	No gaps – in progress
E - Care Bundles	AMBER – On track	YES	No gaps – in progress
F - Board Oversight, Governance, Culture and Leadership	AMBER – On track	YES	No gaps – in progress
What is going well	All areas on track with sufficient progress Touch point for training compliance achieved 30.06.26 		
What is of concern	- Limited MNVP engagement capacity due to the temporary absence of the MNVP Chair. - Maternal Care Bundle implementation, where a significant programme of work is required within challenging timescales.		
What are the top contributors for under/over-achievement	☐ Strong multidisciplinary team (MDT) working and collaboration. ☐ Limited clinical capacity and competing operational priorities.		

2.1 Safety Action A – Workforce and Capacity

The service remains compliant with workforce requirements, achieving greater than 80% compliance with Royal College guidance during Quarter 1 (Appendix 5).

However, periods of sustained activity and increasing patient acuity have required the redeployment of staff to maintain safe care within higher-risk clinical areas. Whilst necessary, this has impacted continuity of care and service delivery within some postnatal areas, which is reflected within safety intelligence and service user feedback.

Work continues to strengthen workforce resilience, optimise staffing deployment and review escalation processes to minimise the impact of ongoing capacity pressures.

2.2 Safety Action B – Training and Education

NHS Resolution Year 8 training requirements for multidisciplinary emergency training, neonatal life support and fetal monitoring remain key components of the Maternity Incentive Scheme. The Trust has achieved greater than 90% compliance across all relevant staff groups for these mandatory training requirements, meeting the required standard at the first reporting point. Supporting evidence is provided in Appendix 6.

Compliance will continue to be monitored throughout the reporting period, with the final compliance assessment taking place on 30 November 2026 at the end of the Maternity Incentive Scheme reporting year. Quarterly updates will be provided to the Committee, including any emerging risks, challenges or areas requiring remedial action to maintain compliance.

2.3 Safety Action C – Learning from Review and Investigations

The service remains compliant with national requirements for incident reporting, investigation and review, including use of the Perinatal Mortality Review Tool and external panel involvement (see Appendices 7 – 10 for more detailed information on cases and triangulation of themes).

Quarter 1 has seen an increase in reported moderate and above harm incidents. Four reported incidents relating to breaches of staff confidentiality were identified; however, these related to the actions of a single staff member who accessed the records of current and former employees. The matter has been escalated and is being managed through established HR processes. No new Patient Safety Investigations were commissioned during the reporting period.

Thematic review of incidents, complaints, claims, mortality and feedback has identified key areas for improvement. Women and birthing people from the global majority did not experience increased harm or poorer experiences within this reporting period. Actions are underway to address these findings, including guideline revision and targeted quality improvement work. Continued Committee oversight is required to ensure that learning is embedded and improvement is sustained.

2.4 Safety Action D – Service User Voice and Equity

During Quarter 1, service user feedback relating to postnatal care remained predominantly negative. Themes were largely associated with workforce pressures, staffing availability and staff redeployment.

Triangulation of intelligence from the Friends and Family Test (FFT), complaints, PALS contacts, and MNVP engagement (Appendix 11) identified three key areas for improvement: the review and standardisation of clinical guidelines, risk assessment and care planning, and communication with women, birthing people and families. The strongest themes emerging from FFT feedback between April and June 2026 are communication, feeding support, clinical care concerns, partner accommodation restrictions, and staffing/capacity pressures.

The service has developed an action plan to improve the review and standardisation of clinical guidelines (Appendix 12) and invested in the 'Eolas' clinical guidance system to improve access to up-to-date guidance, support consistency of practice, and enhance the quality and safety of care. Progress against these improvement actions continues to be monitored through the Maternity governance framework.

In response, a targeted improvement plan is being implemented to strengthen continuity of care and improve the overall postnatal experience, with ongoing monitoring through the Maternity governance structure. The Trust has also secured funding for MNVP engagement officers, and the return of the MNVP chair from maternity leave is expected in September 2026 to further support co-production and ensure service user feedback continues to inform quality improvement activity.

The service completed an audit of interpreter use during Quarter 1 2026/27 to assess equitable access to maternity care and support informed decision-making. The audit reviewed women and birthing people who identified a need for an interpreter at booking and found that six individuals accepted the offer of professional interpreting services. While some women declined interpreter support, others expressed a preference to use a family member or relative. The findings will be used to inform ongoing work to promote equitable access, person-centred care and effective communication for women and birthing people whose first language is not English (see Appendix 13 for the full audit report).

2.5 Safety Action E – Care Bundles

2.5.1 Saving Babies' Lives Care Bundle (Version 3.2)

Implementation of the Saving Babies' Lives Care Bundle (v3.2) remains largely compliant across the service. However, a small number of elements have demonstrated a recent decline in performance following review of Quarter 4 2025/26 data with the regional team. Targeted improvement actions have been implemented and continue to be monitored through the established governance framework.

Appendix 14 provides a detailed overview of Quarter 1 2026/27 compliance, areas of emerging concern and associated improvement activity. The Trust currently holds approved variances against Element 2: Fetal Growth Restriction (FGR), with further detail provided in Appendix 15. These variances have been reviewed and agreed through both the Maternal Medicine Network and Fetal Medicine Network and approved through the Trust's governance processes.

Ongoing audit and surveillance arrangements are in place to monitor compliance, clinical outcomes and any emerging concerns. The Committee is asked to review the supporting evidence, scrutinise the rationale for these variances and approve their continued application prior to formal submission of the agreed variances and Quarter 1 2026/27 data to the regional team.

2.5.2 Maternal Care Bundle

The service has commenced implementation of the Maternal Care Bundle through multidisciplinary stakeholder groups for each of the five elements. The implementation plan has been presented to the Quality Committee and Trust Board, with Appendix 16 outlining the baseline assessment and benchmarking results. The Trust has demonstrated partial compliance across all five elements, with improvement plans established and progress underway in each area.

Appropriate governance, leadership and oversight arrangements are in place, and engagement with the national programme team will support delivery of identified improvement priorities and progression towards full compliance.

Chart 4 – local RAG rating for Maternal care Bundle implementation Q1 26-27

Element	Progress
VTE	Partial compliance
Pre-Hospital & Acute care	Partial compliance
Epilepsy in pregnancy	Partial compliance
Maternal Mental Health	Partial compliance
Obstetric Haemorrhage	Partial compliance

2.5.3 Neonatal Pulse Oximetry

Neonatal pulse oximetry screening remains embedded within routine practice, with an audit completed in Quarter 1 to confirm ongoing compliance (see Appendix 17). A review of 10% of births demonstrated 95% compliance with screening completion. The service is developing a Power BI dashboard to review compliance in real time and to identify if there are any key themes or areas to focus on.

2.6 Safety Action F – Board Oversight, Culture and Leadership

Governance arrangements supporting effective oversight of Maternity and Neonatal safety remain well established, with assurance provided through regular reporting to the Committee and escalation through existing governance structures where required.

2.6.1 Maternity Outcome Signal System (MOSS)

The Maternity Outcomes Signal System (MOSS) continues to function effectively, with no safety signals generated since implementation (see Appendix 18). A test exercise is planned in Quarter 2 2026/27 to ensure system readiness.

2.6.2 Perinatal Culture Improvement Plan

The perinatal culture improvement plan has been updated following changes in leadership (see Appendix 19). A Quality Improvement project has commenced looking at psychological safety across the Maternity and Neonatal Service (see Appendix 20). The aim is to improve psychological safety by increasing staff confidence to model positive behaviours, challenge incivility constructively and contribute to a compassionate and inclusive working environment.

2.6.3 Safety Champions

The Maternity and Neonatal Safety Champions continued to provide independent safety oversight throughout Quarter 1 (Appendix 21). In July, the Safety Champions met with representatives from the Maternity and Newborn Safety Investigations (MNSI) programme to review themes, learning and recommendations arising from recent investigations. This quarterly review provided an opportunity to identify recurring safety issues, consider emerging risks and ensure local improvement activity aligns with national learning.

A summary of the discussions with MNSI, together with findings from recent Safety Champion walkarounds and bi-monthly Safety Champion meetings, is provided in Appendix 21. At the time of reporting, the Safety Champions have not identified any issues requiring escalation to the Quality Committee and remain assured that appropriate governance processes are in place to manage identified risks and improvement opportunities.

3 System and Strategic Risks

The Amos and Ockenden reports were published during Quarter 1. Appendix 22 provides an overview of the key themes for Boards and the implications for our service. Both reviews highlight the need for sustained focus on culture, leadership, workforce, health inequalities, listening to women, birthing people and families, and robust safety governance to improve maternity and neonatal outcomes.

They emphasise the critical role of Boards in providing assurance that these areas are subject to effective oversight, continuous monitoring and demonstrable improvement.

In response to the findings and recommendations arising from these national reviews, a Maternity and Neonatal Services 10-Point Improvement Plan has been developed and presented to the Quality Committee and subsequently to Trust Board. The plan has since been updated and is provided in Appendix 23. Progress against each action will continue to be monitored through established governance arrangements and reported quarterly.

An update on the Home Birth Review is provided in Appendix 24. Overall, the Trust can be assured that appropriate actions are being taken to strengthen the safety, sustainability and governance of the Home Birth Service, whilst continuing to support informed choice and personalised maternity care.

Maternity Services received an unannounced Care Quality Commission (CQC) inspection on 28 and 29 July 2026, with further engagement continuing remotely following the visit. Initial feedback included positive observations regarding patient-centred care, staff engagement and a culture of continuous improvement. Feedback highlighted positive examples of compassionate care, welcoming staff and a strong commitment to service improvement.

However, significant concerns were raised regarding security arrangements within Maternity Services, including controls designed to mitigate the risk of baby abduction, together with aspects of the Maternity environment.

On 4 August 2026, the Trust received notification of proposed enforcement action relating to these concerns. An immediate Trust-wide response was mobilised involving Trust Board leadership, Estates, Security, Emergency Planning and Maternity Services. Following implementation of immediate mitigating actions and the provision of assurance to the CQC, the proposed enforcement action was withdrawn on 5 August 2026. Further improvements remain underway, including environmental and security enhancements, implementation of revised security procedures, and ongoing monitoring through Trust governance processes.

The planned withdrawal of the BCG immunisation service for high-risk newborns in September 2026 remains a significant system risk. The service is currently delivered through the Tuberculosis (TB) Service, which is subject to planned withdrawal. Work is ongoing with commissioners and system partners to identify and implement a sustainable replacement model to ensure continuity of provision.

Occupational exposure to Entonox remains a significant risk for the service, currently rated as Red (15) on the Trust risk register. Funding approval is being sought for an Anaesthetic Gas Scavenging System (AGSS) as part of an ongoing business case; however, implementation will require significant planning and estates infrastructure work. As an interim mitigation, options to rent nitrous oxide conversion units for a 12-month period have been identified and are currently being progressed. The risk will continue to be monitored through the Trust's governance and risk management processes.

4 Conclusion and Committee Focus

In summary, the Maternity and Neonatal Service continues to deliver against national standards and demonstrates areas of strong assurance, including compliance with key NHS Resolution requirements, workforce standards, training expectations and established governance arrangements. However, increasing demand, patient acuity and sustained operational pressures continue to impact both clinical outcomes and service user experience, requiring ongoing oversight and targeted improvement activity.

The Committee is asked to maintain focused oversight of deteriorating clinical outcomes, particularly postpartum haemorrhage and perineal trauma, alongside rising maternal and neonatal readmissions and the impact of sustained operational pressures on postnatal care and service user experience. Continued scrutiny is required in relation to workforce capacity and resilience, the effect of increasing activity and acuity on quality of care, and the timely implementation and demonstrable impact of learning arising from incidents, investigations and reviews.

The Committee is also asked to ensure that service user feedback and equity considerations continue to inform quality improvement activity, whilst maintaining assurance regarding governance, leadership, oversight and safety culture across Maternity and Neonatal Services.

Particular attention is required in relation to key system and strategic risks, including delivery of the Maternity and Neonatal Services 10-Point Improvement Plan, ongoing actions arising from the recent CQC inspection, the future provision of BCG vaccination services for high-risk newborns and the management of occupational Entonox exposure risks.

Notwithstanding these challenges, the Committee can take assurance from the service's continued compliance with national safety requirements, the progress made against improvement programmes, and the timely response to concerns raised through external scrutiny. Continued monitoring and oversight will be required to ensure that improvements are embedded and sustained.

Agenda Item					Report to the Quality Committee, 13 July 2026				
Title:	Maternity and Neonatal Workforce 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 Sarah Walker, Consultant Obstetrician, Obstetric Patient Safety Lead Richard Isaacs, Consultant Anaesthetist, Obstetric Lead Felicity Oldman, Lead Neonatal Matron Neil Sabarre, Lead Matron (Women & Newborn Theatres)								
Purpose (type an 'x' in the appropriate box(es))									
(Re)Assurance			Approval		Ratification		Information		
X			X				X		
Strategic Theme (type an 'x' in the appropriate box(es))									
Outstanding patient outcomes, safety and experience		Pioneering research and innovation		World class people		Integrated networks and collaboration		Foundations for the future	
X									
Executive Summary:									
NHS Resolution (NHSR) requires the Maternity & Neonatal (MatNeo) Service to provide regular assurance to the Trust Quality Committee regarding workforce capacity and capability. This report is presented to demonstrate compliance with the NHSR Maternity Incentive Scheme (MIS) Year 8 Safety Action A. The report provides assurance that Maternity and Neonatal Services have established systems to monitor, review and respond to workforce capacity and staffing levels. These systems include the use of recognised workforce planning tools, oversight of staffing fill rates, escalation processes, workforce triangulation, and routine review of workforce data alongside safety, quality, patient experience and staff wellbeing indicators. Key workforce messages are: • Midwifery vacancy levels remain low; however, funded establishment remains 8.94 WTE below the Birthrate Plus® recommended requirement. • Obstetric medical staffing remains safe and compliant with national standards; however, workforce modelling identifies an underlying consultant deficit of 4.5 WTE which continues to impact workforce resilience. • Obstetric anaesthetic staffing is compliant with national standards and supported by robust governance and escalation processes. • Neonatal nursing workforce capacity remains the most significant workforce risk, with a vacancy of 21.99 WTE and qualified-in-specialty compliance below BAPM standards. • Neonatal medical staffing remains substantially compliant with national standards, with mitigations in place for identified risks.									

Workforce risks are actively managed through established governance arrangements, regular review through Women and Newborn governance structures and escalation through Trust workforce and quality assurance processes. Action plans are in place to strengthen workforce sustainability and support compliance with national standards.

Overall Assurance Assessment: Moderate Assurance

Whilst the service continues to provide safe care through effective escalation processes, governance oversight, flexible workforce deployment and multidisciplinary working, workforce gaps remain in several professional groups. The most significant risks relate to neonatal nursing workforce capacity and alignment of the funded midwifery establishment with Birthrate Plus® recommendations. Improvement plans are in place and continue to be monitored through established governance processes.

The Committee is asked to:

1. Note the workforce position across Maternity and Neonatal Services.
2. Take assurance from the workforce monitoring, escalation and governance arrangements described within this report.
3. Endorse the workforce improvement plans outlined.
4. Support continued organisational focus on achieving alignment with national workforce standards and recommendations

Contents:

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

1. Midwifery workforce
2. Obstetric workforce
3. Obstetric Anaesthetic workforce
4. Neonatal nursing workforce
5. Neonatal medical workforce
6. Perioperative teams

Appendices:

1. Midwifery (and Neonatal) workforce triangulation slides
2. Consultant sessions (Feb 2026)
3. Current Middle Grade Staffing rota May (2026)
4. Locum register
5. Obstetric Anaesthetic rota
6. Neonatal nursing workforce action plan June 2026

1. Midwifery Workforce

This report provides assurance to the Quality Committee that University Hospital Southampton (UHS) has effective systems in place to plan, monitor, and respond to Maternity workforce capacity in line with NHS Resolution Maternity Incentive Scheme (MIS) Year 8 Safety Action A. This is achieved through a systematic and triangulated approach, combining Birthrate Plus (BR+) methodology, validated workforce data, and continuous assessment of safety, acuity, patient experience, and staff wellbeing indicators, supported by robust governance and Board oversight arrangements.

A comprehensive BR+ review undertaken in July 2024 remains the baseline for determining midwifery establishment requirements. The current funded establishment remains below the BR+ recommended level, resulting in an ongoing shortfall. To date, the service has utilised professional judgement alongside the BR+ model to safely manage workforce requirements, taking account of local factors including high acuity case mix, sustained escalation activity, and service configuration across community, birth centres and tertiary pathways. However, in line with the strengthened expectations of NHSR MIS Year 8, there is recognition that full compliance will require alignment of funded establishment to BR+ recommendations, and this will necessitate a clear trajectory towards establishment uplift.

Clinical activity remains high across the service, with the Maternity Day Assessment Unit (MDAU) functioning as the primary front door for unscheduled care. Attendance levels are sustained, with a high proportion of women and birthing people requiring urgent or time-critical assessment, reflecting both the volume and acuity of demand. This is compounded by the complexity of the local case mix, with the Trust acting as a tertiary referral centre for both fetal and maternal medicine, resulting in a higher proportion of women and birthing people with complex medical and obstetric needs. This complexity is further evidenced by the operative delivery rate, with the current caesarean section rate at 48%, significantly above national averages and indicative of the high-risk population served. These factors contribute to sustained pressure on workforce capacity, increased care intensity, and the requirement for experienced clinical decision-making and senior midwifery oversight.

Following validation of workforce data, the funded midwifery establishment for clinical midwifery services is 199.90 WTE, with 197.42 WTE currently in post, resulting in a relatively small actual vacancy of 2.48 WTE. The Birthrate Plus® (BR+) review (July 2024) identified a requirement for an uplift of 8.94 WTE in establishment to ensure alignment with national workforce planning standards and the level of demand and acuity within the service. Whilst vacancy levels are comparatively low, the funded establishment remains below the BR+ recommended requirement. Consequently, staffing resilience is reduced and safe service delivery continues to rely upon escalation processes, flexible deployment and discretionary staff effort to maintain standards of care during periods of increased demand. This position reflects that, whilst vacancy levels are comparatively low, gaps persist in key staff groups, most notably at Band 7 level, alongside a significant shortfall in the maternity support workforce. This remains the most material midwifery workforce risk, impacting skill mix, patient flow and the capacity of registered midwives to consistently deliver care across all settings.

Triangulated evidence (See appendix 1 Midwifery & Neonatal workforce triangulation) demonstrates sustained operational pressure. High levels of activity and acuity are reflected in ongoing high dependency care demand and repeated periods of OPEL 3 and 4 escalations, indicating a continued mismatch between capacity and demand at peak times. Key safety indicators, including one-to-one care in established labour, supernumerary labour ward coordination, acuity levels, and workforce indicators such as missed breaks, are routinely monitored, with compliance maintained for core safety standards despite these pressures. This position is, however, reliant on continuous escalation, flexible deployment, and the discretionary effort of staff.

Patient experience data reflects the impact of these pressures, with a growing proportion of women and birthing people reporting concerns relating to communication, staffing capacity, delays in care, and discharge processes. Staff experience indicators further reinforce this position, with feedback highlighting missed breaks, late finishes, and increased stress and anxiety. This triangulated view confirms that, whilst headline vacancy remains relatively stable, workforce capacity is not yet fully aligned to the level, complexity, and unpredictability of service demand.

Midwifery workforce planning is considered alongside neonatal workforce capacity through shared governance structures, recognising the interdependencies across the perinatal pathway and ensuring a whole-system approach to workforce sustainability and safe care delivery.

A range of actions are in place to address identified gaps, including targeted recruitment within the maternity support workforce, development pathways to strengthen senior midwifery capacity, and continued work to improve workforce data accuracy. Workforce risks, performance, and mitigation plans are reviewed through established governance processes, with routine reporting to the Quality Committee. This report forms part of the Trust's Board assurance framework for MIS Year 8, providing oversight of compliance with Safety Action A and alignment with Safety Action A7 and Safety Action F governance requirements.

In summary, the Trust demonstrates a robust and maturing approach to workforce planning and assurance, with clear triangulation of data, responsive action, and strong governance oversight. Whilst the service has historically been able to safely manage workforce requirements through professional judgement, NHSR MIS Year 8 establishes a clear expectation for funded establishment to align with BR+ recommendations. As such, there is a recognised requirement to progress towards establishment uplift to ensure sustainable alignment between workforce capacity and the complexity, acuity, and demand of the population served. A clear trajectory is required to achieve full alignment between funded establishment and BR+ recommendations, and this will form part of ongoing workforce planning discussions within the Trust.

2. Obstetric Workforce

2.1 Obstetric Consultant Presence and Resident Staffing

The obstetric workforce includes 15 consultants on the non-resident on-call rota, two consultants resident and two not undertaking on-call duties. One consultant is on phased return, with gaps covered via internal locums. In total, 21 consultants (including one locum) deliver obstetric PAs, equating to 15.4 WTE. (Appendix 2 Consultant sessions)

Subspecialty provision includes 6 fetal medicine subspecialists (plus 2 with specialist interest), included within this are 5 maternal medicine subspecialists (plus 2 with specialist interest). Two consultants are currently on phased return. The obstetric physician post is vacant, with a new appointee due July 2026. Capacity and demand modelling identifies a 4.5 WTE consultant deficit. Despite this deficit, current arrangements provide safe consultant cover and compliance with national standards. However, delivery of the service remains dependent upon internal mitigation and additional programmed activity, limiting workforce resilience and flexibility. Active recruitment to a 0.8 WTE post is underway, with a business case required for the remaining gap.

Consultant job plans were revised (Feb 2026) to ensure resident labour ward presence Monday–Friday 08:30–17:30, aligned to RCOG guidance. Outside these hours, cover is provided by the non-resident on-call rota, with additional activity supported through extra PAs.

The current rota does not include compensatory rest, with increasing overnight and evening demand. Interim mitigation is in place; however, 11-hour rest compliance is not consistently achieved. A rota redesign is underway, proposing resident cover to 22:00 and formal compensatory rest, likely requiring further workforce expansion.

Consultant attendance aligns with RCOG (2022) and is embedded in induction and guidance. There have been no incidents of non-attendance, and this data is audited as part of NHSR reporting.

2.2 Middle Grade and Junior resident staffing

The service operates a two-tier resident rota (1:9). As of May 2026, staffing is 10.2 WTE (junior) with a 0.3 WTE gap (senior). Anticipated 1.8 WTE CCT turnover will be partially mitigated through internal progression (Appendix 3 Middle grade staffing rota May).

Gaps are managed through internal locums, with limited external use. All external locums undergo eligibility checks and structured induction in line with RCOG and NHSE guidance. (See Appendix 4 Locum register.) For long-term locum placements, mandatory training must remain up to date and fully compliant throughout the duration of employment.

3. Obstetric Anaesthetic Workforce

A compliant 24/7 consultant and trainee obstetric anaesthetic rota is in place (Appendix 5 Obstetric Anaesthetic rota). The Obstetric Anaesthetic Lead has dedicated job-planned time for service delivery, governance, and workforce planning.

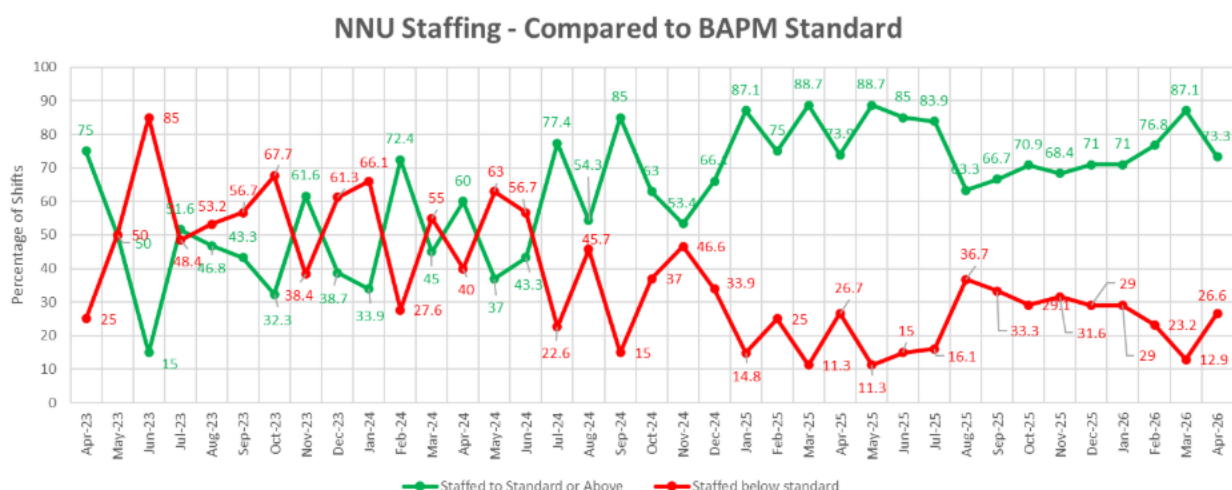
Two obstetric theatres are maintained, supported by a clear escalation pathway (v2.0, StaffNet), with exceptions monitored. Daily safety walkarounds provide forward oversight of theatre capacity and anaesthetic workforce over a 24-hour period, enabling timely escalation of delays or risks. Anaesthetic input is fully integrated into planned caesarean pathways and multidisciplinary working, with representation at governance forums. Regular, quorate attendance at Women and Newborn Governance meetings ensures oversight of workforce risks, incidents, and escalations. Current workforce arrangements provide a high level of assurance regarding compliance with national standards and support safe delivery of obstetric anaesthetic services.

4. Neonatal Nursing Workforce

The Neonatal Service currently operates 15 intensive care, 12 high dependency and 16 special care commissioned cots. To comply with BAPM standards, 21 nurses are required for every shift with at least 70% of registered nurses Qualified in Speciality (QIS). There is currently a vacancy of 21.99 WTE nurse and 55.9% of the current nursing workforce who provide direct patient care is QIS trained. At present, due to the inability to safely staff all cots, there are 4 cots flexed down. There is an aim to open all cots in Winter 2026.

Neonatal nursing workforce capacity remains the most significant workforce risk across maternity and neonatal services. Whilst mitigating actions continue to support safe service delivery, ongoing workforce shortages have necessitated the temporary flexing down of four cots and continue to affect progress towards full compliance with BAPM workforce standards.

The lack of suitably trained neonatal nursing staff to safely care for intensive care babies remains on the Trust Risk Register. There is an ongoing action plan to increase the number of qualified in speciality (QIS) nurses with inhouse training (see Appendix 6 Neonatal nursing workforce action plan). The objective is to increase the number of nurses holding the QIS qualification by 16 staff members annually. This has become achievable from 2025 onwards due to the Operational Delivery Network (ODN) delivering two QIS course cohorts each year, with cohorts commencing in November 2025 and February 2026. However, for the 2026/27 programme, the ODN has only agreed to fund five course places. The remaining 11 course places will need to be funded through any Continuing Professional Practice and Development (CPPD) funding allocated to the service. At present, the level of CPPD funding available is unknown. Should sufficient funding not be secured for these additional 11 places, alternative funding sources will need to be identified. Failure to fully fund all 16 places will reduce the number of staff able to undertake the QIS programme and will consequently slow progress towards achieving compliance with BAPM workforce standards. The service is aware that this risk is longstanding. The below graph demonstrates the improvement in staffing compared to BAPM standard.



Given the scale of the workforce gap and dependency upon future education funding, this risk continues to require close oversight through Trust governance arrangements and remains a priority area for workforce improvement.

5. Neonatal Medical Workforce

5.1 In 2025, Southampton Neonatal Services delivered 3269 intensive care (ITU) days. Medical staffing meets BAPM recommendations for units delivering 2500 – 4000 ITU care days across all areas, with one domain identified as partially compliant and subject to ongoing action.

- There are currently 11 WTE Neonatal consultants on the on-call rota with one available 24/7 for unit cover and a second 24/7 to support the transport service.
- All substantive consultants either have CCT in Neonatal Medicine or equivalent qualification from overseas, are dedicated only to the Neonatal Services and only have primary duties here. One substantive consultant and one locum consultant is in progress for CETR accreditation.
- On-site consultant cover is provided for more than 12 hours a day (0830-2300) Monday to Friday and 0830-2200 at the weekend.
- As a minimum on both day and night shifts there are two tier 1 doctors or ANNPs and two experienced resident doctors ST4-8 or appropriately trained specialty doctor or ANNP covering the Neonatal Unit.
- During normal working hours, there are 4 consultant-led teams between 0830-1500 and 3 consultant-led teams between 1500-1700 covering the Neonatal Service.

5.2 Current risks and mitigations

- Tier 2 cover reduces to one overnight if the second Tier 2 clinician goes out on a transfer. This is mitigated by the on-call consultant coming into the unit if required e.g. to support the remaining Tier 2 clinician due to acuity or due to skill mix requirements.
- Changes to Paediatric training curriculum – Tier 2 rotational Paediatric Trainees are no longer required to be able to intubate as a core competency. Mitigation – division of the Tier 2 rota into a more senior (able to intubate) and less senior (potentially not able to intubate) structure to ensure at least one Tier 2 doctor is competent to intubate overnight. However, this mitigation fails again if they go out on transport (see risk 1). Only mitigation in this circumstance is for the on-call consultant to be resident overnight.

- Cessation of the national MTI (Medical Training Initiative) program – a significant number of Tier 1 and Tier 2 clinicians have been recruited via the MTI scheme over the last 10 years with the unit having a track record of MTI doctors starting at Tier 1 and progressing to Tier 2 during their 2-year rotation. As this scheme has ceased (March 2026), no new recruitment is possible via this route. This has the potential to significantly impact our ability to safely staff the medical rota in the future. Mitigations in discussion include increasing the number of ANNPs working on the medical rota, continuing to recruit from overseas on an individual basis (i.e. outside the MTI scheme) and / or development of post-CCT specialist fellow posts to attract UK candidates to the unit for additional neonatal training / subspeciality skills in a pre-consultant role.

6. Perioperative Teams

Perioperative Overview – Anaesthetic Practitioners

Standard Requirement

A dedicated and appropriately trained anaesthetic assistant is required for all anaesthetic procedures (including sedation), across all settings and at all times, including emergency and out-of-hours activity. This aligns with national safety standards and supports safe perioperative care.

6.1 Current Position

All theatre settings are staffed with a dedicated Anaesthetic Practitioner (ODP or anaesthetic nurse equivalent).

Anaesthetic Practitioners are supernumerary to the surgical team and provide continuous support to the anaesthetist throughout procedures.

Continuous anaesthetic support is maintained across obstetric, elective, emergency, and out-of-hours services.

Workforce members are appropriately trained, competent, and professionally registered in line with NMC and HCPC regulatory requirements.

6.2 Capacity and Risk

There remains a recurrent capacity gap equating to approximately 4.5 obstetric theatre lists per month, impacting the consistent delivery of the two-theatre standard.

This is a recognised and recorded risk on the Trust Risk Register, with established oversight and routine review.

6.3 Mitigation and Assurance

Elective theatre activity is dynamically managed in response to operational pressures, ensuring prioritisation of obstetric emergency care.

This approach enables continued compliance with anaesthetic staffing standards and supports safe patient care delivery.

The risk is subject to ongoing monitoring through governance processes, with escalation in place where workforce constraints may affect service capacity or delivery.

Conclusion

This report demonstrates that robust workforce governance, monitoring and escalation arrangements are in place across maternity and neonatal services. Workforce data is routinely triangulated with safety, quality, patient experience and staff wellbeing indicators to support informed decision-making and organisational oversight. While current arrangements continue to support safe service delivery, significant workforce challenges remain, particularly in relation to neonatal nursing capacity and alignment of midwifery establishment with Birthrate Plus® recommendations. The overall assurance assessment is therefore rated as Moderate Assurance, with improvement plans and governance oversight in place to address identified risks and support sustainable compliance with national standards.

Risk(s):	
University Hospital Southampton (UHS) Maternity and Neonatal (MatNeo) Services operate within a complex regulatory and governance framework. The following key risks may impact service delivery, safety, and organisational performance: • Reputational Risk: Concerns relating to safety or quality may be escalated by service users or stakeholders to external bodies, including NHS Resolution and the Care Quality Commission (CQC), potentially impacting public confidence. • Financial Risk: Ongoing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) Year 8 is required. Failure to meet the required Safety Actions may result in loss of financial incentive and increased external scrutiny. • Governance Risk: Significant safety or quality concerns may trigger escalation to national and regional stakeholders, including CQC and NHS England, resulting in formal review or enhanced oversight. • Safety Risk: Non-compliance with national standards and recommendations may increase clinical risk, impact staff wellbeing, and adversely affect outcomes for women and babies. The Maternity and Neonatal Safety Improvement (MNSI) programme may initiate external review where concerns are identified. UHS MatNeo Services remain committed to mitigating these risks through robust governance, effective workforce and safety oversight, continuous quality improvement, and transparent engagement with stakeholders, in line with NHSR MIS Year 8 requirements.	
Equality Impact Consideration:	N/A

Agenda Item				
Report to the Quality Committee, 13 July 2026				
Title:	10-point plan for Maternity and Neonatal Services			
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 (type an 'x' in the appropriate box(es))				
(Re)Assurance	Approval	Ratification	Information	
X	X		X	
Strategic Theme (type an 'x' in the appropriate box(es))				
Outstanding patient outcomes, safety and experience	Pioneering research and innovation	World class people	Integrated networks and collaboration	Foundations for the future
X				
Executive Summary:				
On 30 June 2026, NHS England published Baroness Amos' Independent Investigation into Maternity and Neonatal Services alongside a national Maternity and Neonatal 10-Point Plan, setting out ten urgent actions for Trusts and systems in response to the Amos Investigation and Ockenden Review. This paper provides the Trust Board with an assessment of University Hospital Southampton NHS Foundation Trust's position against each of the ten actions. The assessment demonstrates that established governance, safety and quality improvement arrangements are in place across all domains, with active workstreams identified to support delivery. Seven actions are currently rated Amber and three are rated Grey. The Grey ratings reflect dependencies on forthcoming national programmes, frameworks and guidance rather than deficiencies in local governance or delivery arrangements. Preparatory work is underway in all three areas to support implementation once national requirements are published. The most significant risks relate to workforce sustainability across Maternity and Neonatal Services, including midwifery staffing against Birthrate Plus recommendations, Neonatal nursing vacancies, Qualified in Speciality (QIS) compliance and emerging medical workforce pressures. These risks remain subject to active oversight through established governance arrangements. The Board is asked to note the Trust's assessment against the NHS England Maternity and Neonatal 10-Point Plan, endorse the proposed implementation timeline and support ongoing oversight through existing governance arrangements.				

Contents:	
Following publication of the NHS England Maternity and Neonatal 10-Point Plan, an assessment has been undertaken of the Trust's position against each of the ten actions. This report provides the Board with assurance regarding current arrangements, identifies gaps requiring further action and highlights key risks requiring ongoing oversight.	
Risk(s):	
The most significant risks associated with implementation of the 10-Point Plan relate to workforce sustainability across Maternity and Neonatal Services. Midwifery staffing remains below Birthrate Plus recommendations and Neonatal Services continue to experience nursing vacancies and challenges in achieving Qualified in Speciality (QIS) compliance. Additional risks relate to implementation of forthcoming national requirements, including the Perinatal Equity and Anti-Discrimination Programme, new maternity triage standards and the national framework for responding to incidents and complaints with humanity and compassion. These risks are recognised through existing governance arrangements and will continue to be monitored through Quality Committee and Trust Board oversight. Mitigating actions and improvement plans are in place for all identified risks and progress will be monitored through existing maternity and neonatal governance structures, Quality Committee and Trust Board reporting arrangements.	
Equality Impact Consideration:	N/A

Background

The publication of Baroness Amos' Independent Investigation follows a series of national maternity reviews which have identified recurring concerns relating to safety, culture, leadership, workforce, listening to women, birthing people and families, inequalities and organisational accountability. In response, NHS England has issued a Maternity and Neonatal 10-Point Plan requiring Trusts to prioritise urgent actions while the National Maternity and Neonatal Taskforce develops a wider National Action Plan.

An assessment has been undertaken to determine the Trust's current position against each action and identify any gaps requiring further attention.

Trust Position Against the 10-Point Plan

<i>Action completed</i>	Compliant
<i>Ongoing actions, with workstreams identified</i>	Partial Compliance
<i>Actions required</i>	Non-Compliant
<i>Awaiting National Frameworks/guidance</i>	Awaited

Action	Current Position	RAG
Martha's Rule	Partial implementation in place with further work required to complete rollout.	Partial
Patient experience, outcomes and clinical audit data	Established arrangements with further work required to strengthen engagement and feedback mechanisms.	Partial
Dual board-level accountability	Existing governance arrangements in place with further alignment required.	Partial
Amos into Action staff listening exercise	Multiple engagement mechanisms established with further formalisation planned.	Partial
Addressing inequalities in maternity and neonatal outcomes	National programme not yet available and further implementation work required.	Awaited
Ensuring 24/7 safety and responsiveness	Workforce improvement plans in place but significant workforce challenges remain.	Partial
Homebirth services review	Dedicated workstream established and ongoing.	Partial
Responding to incidents, complaints and concerns with humanity and candour	Awaiting publication of national framework.	Awaited
Deliver safe and effective maternity triage	Awaiting national guidance and completion of required audit.	Awaited
Post-death care	Established arrangements with ongoing assurance actions.	Partial

Detailed Assessment

1. Listening to Women and Families Through Martha's Rule

RAG Rating: Amber (partial implementation)

Martha's Rule principles have been partially implemented across Maternity and Neonatal Services, including antenatal, intrapartum and postnatal inpatient settings, Maternity assessment areas and Neonatal Services.

Actions underway

- Implementation of the Maternity Early Warning System (MEWS).
- Formalisation of independent review arrangements for neonatal services.

2. Listening to Women and Families Through Real-Time Feedback and Outcomes

RAG Rating: Amber (partial implementation)

Friends and Family Test (FFT) data is routinely collected across Maternity and Neonatal Services and triangulated with complaints, incidents, claims and staffing information through governance processes. Maternity response rates consistently exceed Trust targets, and a comprehensive Maternity patient experience dashboard is in place. A Birth Reflections Service also provides valuable qualitative feedback and learning.

Actions underway

- Recruitment of an MNVP Engagement Lead.
- Improvement of Neonatal FFT response rates.
- Enhanced engagement with underserved communities.

3. Dual Board-Level Accountability

RAG Rating: Amber

The Trust has identified Board-level Maternity and Neonatal Safety Champions, and the Director of Midwifery attends Trust Board when Maternity and Neonatal matters are discussed.

However, the Amos Plan requires explicit joint accountability between Medical Directors and Chief Nursing Officers. Further review is required to ensure full compliance with national expectations and attendance arrangements for Maternity and Neonatal clinical leaders.

Actions underway

- Review of executive accountability arrangements.
- Consideration of attendance by maternity and neonatal Clinical Directors at Board discussions.

4. Amos Into Action Staff Listening Exercise

RAG Rating: Amber (partial implementation)

The Trust has a well-established Perinatal Culture and Leadership Programme informed by staff surveys, safety intelligence and engagement activities. Additional opportunities for listening include professional forums, executive walkabouts, student engagement events and senior leadership communications.

Actions underway

- Introduction of formal monthly maternity and neonatal listening events.

5. Addressing Inequalities in Maternity and Neonatal Outcomes

RAG Rating: Grey (awaited)

The Trust routinely reviews inequalities data alongside incidents, complaints, mortality, patient experience and clinical outcomes to identify and address disparities in care. Targeted improvements have been implemented in response to identified inequalities affecting women and birthing people from global majority backgrounds. Oversight is provided through the Trust's established Equality, Diversity and Inclusion (EDI) Working Group, which has delivered a number of key initiatives. Further progress remains aligned to emerging national requirements and guidance.

Reason for Rating

- Implementation is dependent upon release of the NHS England Perinatal Equity and Anti-discrimination Programme. Local monitoring of inequalities and targeted service improvement activity are already established.

Planned Actions

- Commence implementation of the national programme once released.
- Continue implementation of the Maternal Care Bundle.
- Maintain routine review of inequalities data through governance processes.

6. Ensuring 24/7 Safety and Responsiveness

RAG Rating: Amber (partial implementation)

Whilst workforce challenges are reflected within an Amber rating, this remains the most significant organisational risk to delivery of the 10-Point Plan. Workforce sustainability is therefore subject to ongoing review through the Trust's risk management processes and Workforce Committee alongside Quality Committee oversight.

Biannual workforce reports provide oversight of vacancies, turnover and sickness. Service escalation processes exist to support safe care during periods of increased demand and acuity.

Key challenges

- Midwifery staffing remains below Birthrate Plus recommendations.
- Neonatal nursing establishment remains below BAPM standards.
- Neonatal Services continue to carry approximately 20 WTE nursing vacancies.
- QIS compliance remains below required levels.
- Workforce risks exist relating to cessation of the Medical Training Initiative programme.
- Obstetric workforce redesign is underway to address increasing demand.

Actions underway

- Midwifery workforce review.
- Ongoing QIS recruitment and training.
- Obstetric rota redesign.
- Workforce mitigation planning.

7. Homebirth Services

RAG Rating: Amber (partial implementation)

A dedicated Homebirth Working Group has been established to review and enhance homebirth services. Risks associated with workforce and staff training have been recorded on the Trust Risk Register and improvement work is ongoing.

Actions underway

- Delivery of recommendations from the Homebirth Working Group.
- Continued monitoring of workforce and education risks.

8. Responding to Incidents, Complaints and Concerns with Humanity and Candour

RAG Rating: Grey (awaited)

The Trust has established Duty of Candour processes and robust maternity and neonatal governance arrangements that support open and transparent communication with families following incidents. Clinical incidents are reviewed through the multidisciplinary Clinical Events Group, with Quality and Patient Safety Partner (QPSP) involvement to ensure the patient voice informs incident review, learning, and service improvement

Reason for Rating

- NHS England has not yet published the national blueprint describing the required compassionate and trauma-informed approach to responding to incidents and complaints.

Planned Actions

- Review local processes against the national blueprint when published.
- Continue NHS Resolution Year 8 work relating to family engagement and accessibility of communication materials.

9. Deliver Safe and Effective Triage in Maternity Services

RAG Rating: Grey (awaited)

The Trust operates a dedicated Maternity Triage Line and a 24-hour Maternity Day Assessment Unit, supported by BSOTS and routine monitoring of performance metrics.

Reason for Rating

- National guidance has not yet been published.
- The required Board-level audit cannot be completed until the national standards and framework are released.

Planned Actions

- Undertake the Board-level audit following publication of national guidance.
- Incorporate triage quality and performance data within future Maternity and Neonatal safety reports.
- Implement actions arising from national requirements.

10. Post-Death Care

RAG Rating: Amber (partial implementation)

Established neonatal and stillbirth pathways are in place, supported by local and network guidance. Ongoing work is underway to strengthen assurance regarding post-death care processes.

Actions underway

- Completion of the Board Assurance Statement by 31 July 2026.
- Finalisation of the updated stillbirth pathway guidance.

Implementation Timeline

Period	Key Deliverables
July–September 2026	• Review Board accountability arrangements. • Recruit MNVP Engagement Lead. • Introduce monthly staff listening events. • Complete post-death care Board Assurance Statement. • Prepare for Martha's Rule implementation.
October–December 2026	• Complete maternity triage audit. • Implement identified improvements. • Progress workforce plans. • Strengthen QIS compliance. • Update Perinatal Culture Improvement Plan.
January–March 2027	• Implement Perinatal Equity and Anti-discrimination Programme (subject to national release). • Achieve Maternal Care Bundle milestones. • Implement emerging national guidance and frameworks.

Key Risks for Board Oversight

The principal risks associated with delivery of the 10-Point Plan are:

1. Midwifery staffing levels remaining below Birthrate Plus recommendations.
2. Neonatal nursing vacancies and QIS compliance.
3. Workforce risks associated with changes to national training programmes.
4. Delivery of national equity and anti-discrimination requirements and the Maternal Care Bundle.
5. Implementation of forthcoming NHS England guidance relating to triage and compassionate responses to incidents and complaints.

Conclusion

The Trust is well positioned to respond to the requirements of the NHS England Maternity and Neonatal 10-Point Plan. Established governance, safety, quality and patient experience arrangements provide a strong foundation for delivery. Whilst three actions remain dependent on forthcoming national programmes and guidance, active workstreams are in place across all ten domains. Continued Board oversight will primarily be required in relation to workforce sustainability, inequalities and implementation of emerging national requirements.

Action	Current position	Actions required	RAG rating
1. Listening to women and their families by rolling out Martha's Rule	Martha's rule has partially been rolled out across MatNeo Services. This includes all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings.	- Launch of MEWS (Maternity Early Warning System) - Formalise the route for staff to access an independent review in neonates	
2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	FFT is in place across MatNeo services. FFT data is triangulated alongside incidents, claims, complaints and staffing and reported on quarterly within the governance processes and to Quality Committee. Action plans are devised as required. Maternity FFT response rates are consistently over the Trust target of 20%. A maternity patient experience dashboard has been created which includes themes, comments, improvements and actions. This dashboard also captures ethnicity. Neonatal FFT response rates fluctuate above and below the Trust target of 20%. MNVP lead currently on maternity leave. Funding has been allocated to recruit MNVP engagement leads. A birth reflections service is well established and offered to those women and birthing people who want to discuss their experience. Feedback and themes from these discussions are shared quarterly to W&NB Governance.	- Recruit MNVP engagement lead to support with obtaining experiences of people from minority backgrounds. - Improve response rates within Neonatal Services.	

Action	Current position	Actions required	RAG rating
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	Chief Nurse and Non-Executive Director identified as Board level Maternity and Neonatal Safety Champions. The Director of Midwifery attends Trust Board when maternity or neonatal matters are discussed.	To review if the Clinical Directors leading maternity and neonatal services should be attending Trust Board when maternity or neonatal matters are discussed.	
4. 'Amos into action' staff listening exercise	There is a Perinatal Culture & Leadership team who are developing a Perinatal Culture Improvement Plan based on multiple sources, including staff surveys and safety intelligence. Updates on this plan will be reported quarterly to Quality Committee. Listening events have been completed within Neonatal Services to hear from each nursing band. Maternity staff attend a monthly professional day (as part of the Statutory and Mandatory training) which the senior leadership team attend and will respond to specific questions. A bi-monthly Safety Champions and QUAD walkabout is held, with staff invited to feedback their concerns during the walkabout. Student listening events also take place as required. Video messages have been shared from the Director of Midwifery to the MatNeo staff to support effective communication and provide key updates.	To implement formal monthly listening events for Maternity and Neonatal staff.	

Action	Current position	Actions required	RAG rating
5. Addressing inequalities in maternity and neonatal outcomes	Triangulation of incidents, staffing, feedback, mortality, complaints and claims data also include equity. This triangulation is reported quarterly via governance processes and to Quality Committee.	Perinatal Equity and Anti-discrimination Programme will be available by the end of 2026.	
	The MatNeo service has recognised that there was an increase in poor outcomes for those women and birthing people from the global majority. In response to this, the NEST (needing extra support team) criteria has been reviewed and revised, with ongoing service improvement.	Maternity Care Bundle to be fully implemented by March 2027.	
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	Bi-annual perinatal workforce reports will be presented to Quality Committee including information on vacancy and sickness. Midwifery staffing does not currently meet Birthrate+ recommendation. This has been highlighted to Trust Board. Neonatal staffing does not currently meet BAPM standard and there is an action plan in place to achieve this. There is a lack of qualified in speciality (QIS) nurses which has been recognised and is on the Trust risk register. Neonatal Services continue to hold a vacancy of approximately 20WTE with 55.9% of their registered nurses having completed the QIS course (the requirement is for at least 70%).	- To uplift the midwifery workforce budget to meet Birthrate+ recommendation. - Continue to advertise and recruit QIS nurses. - Continue to identify and allocate nurses onto the QIS programme. - An obstetric rota redesign is underway, proposing resident cover to 22:00 and formal compensatory rest, likely requiring further workforce expansion. - To review the mitigations in relation to the cessation of the national MTI program for the neonatal resident doctor rota.	

Action	Current position	Actions required	RAG rating
	MatNeo services have escalation policies in place which includes guidance on redeployment of those not directly supporting frontline delivery during periods of increased activity or acuity. There is Obstetric Consultant presence on Labour Ward Mon – Fri 08:30 – 17:30, aligned to RCOG guidance. The current rota does not include compensatory rest, with increasing overnight and evening demand. Interim mitigation is in place. Neonatal medical workforce meets BAPM recommendations, with one domain identified as partially compliant and subject to ongoing action. There is a risk to recruitment to Tier 1 and Tier 2 clinicians due to the cessation of the national MTI (Medical Training Initiative) program.		
7. Trusts to review their homebirth services	A dedicated Homebirth Working Group has been created to review and enhance homebirth provision. Two risks have been added to the risk register relating to home birth education for staff and home birth staffing / workforce.	This is an ongoing piece of work with a dedicated working group established.	
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	The Trust has a duty of candour policy in place. There is a MatNeo governance policy which includes guidance around duty of candour in specific situations, such as cases which meet criteria for referral to MNSI.	Await the blueprint for how organisations and leaders can response with more humanity and compassion when things go wrong with a patient's care.	

Action	Current position	Actions required	RAG rating
		As part of NHSR Year 8, review how to obtain parent feedback in relation to language, tone and accessibility of parent-facing materials given to those involved in MNSI and PMRT cases.	
9. Deliver safe and effective triage in maternity services (already committed by Government)	The Maternity Triage Line (MTL) was launched in 2022. Women and birthing people are directed to MTL via the Healthier Together app (this is shared with all women and birthing people as part of their antenatal appointments). Through MTL, they will be triaged by midwives and, if required, advised to attend their local Maternity Day Assessment Unit (MDAU) for further assessment. MDAU at UHS is available for women and birthing people to access 24/7. BSOTS is utilised to support with rapid assessment. The UHS Maternity Dashboard provides data on the rate of patients who were seen and triaged within 15 minutes on arrival. This data is presented through the governance processes. Over the last year, the rate of patients seen within 15 mins of arrival to MDAU has been falling slowly to around 85 – 92%. The service is reviewing MDAU data to ensure that relevant measures are being captured and shared.	Audit to be completed and shared with Trust Board following publication of new NHS England guidance (to be released early July).	
		Include triage quality and performance within the quarterly MatNeo Safety Reports to Quality Committee and Trust Board.	

Action	Current position	Actions required	RAG rating
10. Post death care (already committed by Government)	There is a Neonatal Death SOP in place which outlines the processes to follow before and after death of a neonate. This is to be used alongside the network guidance for palliative, end of life and spiritual care, which provides further information on the practical aspects following the death of a neonate. The stillbirth pathway is being updated as a formal guideline which will provide clarity around the post death processes, including care of the baby within the holding room at PAH.	Board assurance statement to be completed by 31st July in relation to the System letter following the Fuller and NUH reviews.	

10-Point Plan for Maternity & Neonatal Services

How to Use This Template



The adoption and implementation of the 10 point plan in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England is the responsibility of each organisation and trusts must demonstrate compliance with the 10 Point Plan.

The reporting template is a tool designed to support a baseline assessment against the 10 point plan and support reporting to region and national teams. It is ordered as per the 10 point plan and allows for evidence of compliance, gaps in compliance, mitigations and comments to be recorded in text format. This template is intended to be built around existing governance structures. The use of the reporting tool is compulsory and should be used by Trust Boards to assure against the actions.

Trust boards should complete tab 1. Submission A-Baseline once only and returned to regional teams by **Friday 25 September 2026**. Tab 2. Submission B-Progress Report, should be completed by **Thursday 31 December 2026**. Each return should be completed once and returned regionally for assurance. Regional teams will provide further detail on their submission process. Both submissions must be signed off by the trust board. Boards should provide visible ownership and scrutiny of the 10 Point Plan actions and should continue to use existing board or committee governance for detailed review of progress, evidence improvement and risk management, in line with the MIS. Regional teams will review returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalate significant concerns for discussion at national level.

Action 4 of the 10 point plan 'Amos into action' an NHS-wide open conversation for all our staff to help shape real and sustainable change in services will be led by the NHS England national team. Although this is not featured within the reporting template, Trust Boards should ensure staff are supported and enabled to engage with this work.

The Evidence Log should be used to reference or embed the evidence for each action. The location or link reference should clearly identify where the evidence can be found; assurance notes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may span more than one deliverable where appropriate.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant and compliant.

Source: <https://www.england.nhs.uk/long-read/publication-of-baroness-amos-independent-investigation-into-maternity-and-neonatal-services-in-england/>

- 1. Summary tab: Provides instructions for completion and an overview of the key metrics for 1. Baseline assessment and 2. Progress Report. Please note all tables are automated and the information should pull directly from the relevant tabs.
- 2. Submission A Baseline Assessment tab: Record the trust's starting position against each of the 10 actions before improvement work begins. To be completed once and returned **Friday 25 Sept 2026**
- 3. Submission B Progress Report tab: One row per deliverable/scoping prompt (24 in total); Baseline Compliance tab updated automatically, all other columns to be manually updated. To be completed once and returned **Thursday 31 Dec 2026**
- 4. Evidence Log tab: Log supporting evidence against each action number; reference the Evidence ID in the Baseline Assessment and Progress Tracker tabs as required.
- 5. Evidence examples: Provides some example areas of evidence submission to be considered.

Rating definitions:
RAG guide: Red = no route to compliance or immediate safety risk. Amber = plan in place but gaps/risks remain. Green = evidence confirms requirement met or on track.

The **baseline compliance / compliance ratings** should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission therefore 'Not applicable' would be apply.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Name of trust or organisation: University Hospital Southampton

Report prepared by:

Report date:

Reporting period covered:

Baseline Assessment		
Key Metrics		
Total deliverables		26
Compliance	0. Not applicable	0
	1. Non-compliant	0
	2. Partially compliant	0
	3. Compliant	0
Regional Match	Regional match - Yes	0
	Regional match - No	0

Summary by Action - Baseline		Compliance				
Action	Total	Not applicable	Non-compliant	Partially compliant	Compliant	
1. Listening to women and families by rolling out Martha's Rule	1	0	0	1	0	
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	3	0	
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	2	0	
5. Addressing inequalities in maternity and neonatal outcomes	3	0	1	2	0	
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	3	4	
7. Trust review of homebirth services	2	0	0	1	1	
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	3	0	
9. Deliver safe and effective triage in maternity services	3	0	0	3	0	
10. Post death care	2	0	0	1	1	

Submission A: Baseline Assessment (Starting Position Against the 10-Point Plan)



This template should be completed once and submitted on the **Friday 25th September 2026**. It is intended to provide a baseline assessment of delivery against the 10-point plan actions and is separate to the tab 2. Progress Report submission.

Columns K & L should be used by regional teams only to provide independent assessment against Trust Board assurance.

The RAG rating should describe delivery risk and confidence: red where there is no credible route to compliance or an immediate safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms the requirement is met or on track. A completed review alone should not result in a green rating if significant residual risk remains.

Baseline compliance definitions

The baseline compliance / compliance ratings should be used to provide a consistent assessment of the current level of compliance against each requirement. Ratings should be based on available evidence, professional judgement and the extent to which the requirement has been fully implemented, embedded and sustained.

Not applicable: The requirement does not apply to the service, pathway, function or organisation being assessed. *For example, trusts may not yet be eligible for onboarding onto the PEADP programme at the time of submission, therefore 'Not applicable' would be applied.*

Non-compliant: There is no, or very limited, evidence that the requirement has been met.

Partially compliant: There is evidence that some elements of the requirement have been met, but implementation is incomplete, inconsistent or not yet fully embedded.

Compliant: There is sufficient evidence that the requirement has been fully met and is being implemented consistently

Report signed off by Trust Board (named Exec):



Trust Board sign off date:

Trust Board Assurance Template						
No.	Deliverable / Scoping Prompt	Baseline Compliance Rating	Baseline Evidence Reference <i>Please input reference number as listed in 3. Evidence Log tab</i>	Gaps in Assurance <i>Please provide detail of any gaps in assurance</i>	Improvement Actions (Including Temporary Mitigations)	Comments
1. Listening to women and families by rolling out Martha's Rule						
1.1	Has the trust commenced rollout of Martha's Rule across maternity and neonatal services?	Partially compliant		Launch of MEWS Formalise the route for staff to access an independent review from NNU Training roll out under way - projected completion DEC 2026 Awaiting NHSE clarification Awaiting launch date for incorporation of MEWS from digital provider		
2. Listen to women and their families using real-time and transparently reported outcomes and experience, and clinical audit that are acted upon at board level.						
2.1	Has the trust established a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit and patient outcome & experience data representative of the local population, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Partially compliant		MNVP due back from Maternity leave Sept 2026 Recruit MNVP engagement leads		
2.2	Does the trust board receive and publish a regular summary report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Partially compliant		Further work required with MNVP for actions and escalations (MatNeo safety reports quarterly)		
2.3	Does the report identify variation in outcomes and experience by ethnicity and deprivation, including any important gaps or limitations in the available data, and can the board demonstrate how the trust is responding to the variation identified?	Partially compliant		Local EDI steering group, work required to ensure any identified variation in outcomes and experiences shared with the board.		
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care						
3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	Partially compliant		Active recruitment for CMO in progress. Once appointment is confirmed, the newly appointed CMO to be asked to become an Executive Maternity Safety Champion alongside CNO.		
3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are on the agenda?	Partially compliant		Governance review to be completed by October 2026 with recommendation to Trust Board regarding Clinical Director attendance at maternity and neonatal discussions.		
5. Addressing inequalities in maternity and neonatal outcomes						
5.1	Has the trust board ensured that provision is in place to allow staff to be released for the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Non-compliant		Awaiting National guidance		
5.2	Can the trust board demonstrate that the trust is regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	Partially compliant		Further work required with data feeding in from EDI steering group.		
5.3	Has the trust board approved a plan to implement the Maternal Care Bundle by March 2027?	Partially compliant		Implementation in progress - currently concerns with achieving by march 2027 - see Q1 overview in QC report		
6. Ensuring 24/7 safety and responsiveness of services						
6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8, is there a minimum ≥80% consultant presence in defined acute care situations?	Compliant				
6.2	Is the trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Compliant				
6.3	Does the trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	Compliant		Increase QIS compliance from 55.9% to 65% by March 2027, providing a trajectory to achieve the BAPM standard of 70% by September 2027.		
6.4	Does the trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? (In line with MIS Year 8)	Partially compliant		To uplift the midwifery workforce budget to meet Birthrate+ recommendation. Business case for Birthrate+ workforce gap to be concluded by Oct 2026.		

6.5	Do the trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2? (in line with MIS Year 8)	Compliant				
6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	Partially compliant		Further work required to ensure all requirements are met, current safety reports capture part of this.		
6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	Partially compliant		Safe staffing/escalation policy currently under review		
7. Trust review of homebirth services						
7.1	Has the trust board received, scrutinised and actioned an urgent review of homebirth services in line with the letter of the Chief Midwifery Officer and the regional chief midwife of 26 November 2025?	Compliant				
7.2	Where significant risks and mitigations have been identified, has an action plan with agreed timescales to mitigate and remove the risks been agreed and shared with the Regional NHSE team?	Partially compliant		Meeting organised between HRBP, CM and DoM at the end of August to discuss and formalise new ways of working and HB team structure.		
8. Responding to incidents, complaints and concerns with humanity and candour						
8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	Partially compliant		Await publication of the national blueprint outlining how organisations and leaders should respond with humanity, compassion and a trauma-informed approach when care has not gone as expected.		
8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	Partially compliant		Complaints triangulated but work required around improvement plans		
8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	Partially compliant		Work in progress (trauma informed approach) mirroring ITU model.		
9. Deliver safe and effective triage in maternity services						
9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	Partially compliant		Local benchmarking complete for TB sign off.		
9.2	Does the board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes with a focus on inequalities?	Partially compliant		Audit completed and due to be reported to Trust Board in September following publication of the NHS England Maternity Triage Specification. UHS has benchmarked compliance against all 10 domains, with actions identified and monitored through the Mattheo governance framework and will be reported quarterly to Trust Board.		
9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	Partially compliant		National Maternity Triage specification now released and UHS has benchmarked against this.		
10. Post death care						
10.1	Has the trust board completed an assurance statement and submitted it by 31 July 2026?	Compliant				
10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	Partially compliant		Board assurance statement completed, approved and submitted in August 2026 in response to the System letter following the Fuller and Nottingham University Hospitals reviews. Evidence retained for assurance purposes.		



baseline assessment. Where a deliverable has already been reported as achieved in the baseline
here any progress updates are required.

stability risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms

Current Status	RAG	Evidence ID <i>Please input reference number as listed in 3. Evidence Log tab</i>	Key Gaps / Risks	Improvement action required	Due Date(s)
In progress	Amber				
In progress	Amber				
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
In progress	Amber				

In progress	Amber				
In progress	Amber				
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
In progress	Amber				
In progress	Amber				
Complete	Green				
In progress	Amber				

In progress	Amber				
Complete	Green				
In progress	Amber				
In progress	Amber				
In progress	Amber				
In progress	Amber				
Complete	Green				
In progress	Amber				

Evidence Log - Supporting Evidence Submission

The evidence log should be used to list and reference the evidence for each action. The location or link reference should clearly identify the evidence. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support or contradict established governance documentation wherever possible. Trusts should use the minimum evidence necessary to demonstrate assurance.

Log each piece of supporting evidence here. Reference the Evidence ID against the relevant row in the Baseline Assessment and the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner
EV-01					
EV-02					
EV-03					
EV-04					
EV-05					
EV-06					
EV-07					
EV-08					
EV-09					
EV-10					
EV-11					
EV-12					
EV-13					
EV-14					
EV-15					
EV-16					
EV-17					
EV-18					
EV-19					

EV-20					
EV-21					
EV-22					
EV-23					
EV-24					
EV-25					
EV-26					
EV-27					
EV-28					
EV-29					
EV-30					



ify where the evidence can be found; assurance notes should explain what the evidence demonstrates. More than one deliverable where appropriate. Trusts are encouraged to use existing evidence and assurance.

Progress Report as needed. Please note the evidence submitted should be accessible externally (to

[illegible]

[illegible]

Evidence: examples



This section is designed to support trust boards in identifying appropriate evidence to support their assurance assessments. We encourage trusts to make use of existing data sources and processes wherever appropriate to support their assurance. There may also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The model board report is available for use on the Futures platform. Trusts not already using the model board report may wish to adopt this template.

It should be noted that Trusts are not required to provide all suggested evidence to evidence compliance. **Trust should use the minimum amount of information to demonstrate compliance.**

Action		Deliverable	Suggested evidence
Action 1	1.1	The trust continuing to make progress with rollout of Martha's Rule across maternity and neonatal services?	Trusts are not asked to submit any evidence for this action as data will be collected via the national Martha's rule programme team. It is however expected that providers attend the launch webinar to understand process and next steps and continue work with the Martha's rule team to commence roll out.
	2.1	The trust continued to operate a monthly cycle of collecting and analysing the latest available maternity and neonatal clinical audit, patient outcome and experience data, including but not limited to, FFT, CQC survey findings when available, local intelligence from MNVPs and targeted outreach?	Analytical reports
Action 2	2.2	The trust board continuing to receive and publish a regular report that brings these sources of intelligence together, and can it demonstrate the decisions, actions or escalation resulting from its scrutiny, including how progress and impact are tracked?	Board report and minutes
	2.3	The insight and audit data presented by ethnicity and deprivation and does the board scrutinise variation?	- Board report and minutes - Quarterly MIS thematic report
Action 3	3.1	Has the trust board established clear joint accountability for maternity and neonatal services with Medical Directors and Chief Nurses holding a shared responsibility?	- Board ToR - Job plans
	3.2	Do Directors of Midwifery and Clinical Directors leading maternity and neonatal services attend boards and take part in discussions when maternity and neonatal matters are discussed?	- Job plans - Minutes of Executive board meetings
Action 5	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?	Board report and minutes
	5.2	The trust board regularly reviewing and acting on trends identified by their inequalities data dashboards every 6 months?	- Board report - Quarterly MIS thematic report - Equity dashboard reports - Core20PLUS5 reporting - Maternity equity action plans
	5.3	Is the trust board reviewing and acting on (at the relevant delegated committee) quarterly reports on implementation of the Maternal Care Bundle?	- Maternal Care Bundle implementation plans. - Board Report - MIS return
	6.1	Is the trust complying with the RCOG "Roles and Responsibilities of the Consultant providing acute care" standard? In line with MIS Year 8 is there a minimum ≥80% consultant presence in defined acute care situations?	- Workforce plan - Biannual workforce papers - Staff experience survey - Cappuccini-style assurance exercise
	6.2	The trust ensuring locum certification and maintaining a local (trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas? (In line with MIS Year 8)	Database
	6.3	The trust have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation and the neonatal nursing workforce calculator output (2020)? (In line with MIS Year 8)	- Workforce plan - Biannual workforce papers - BAPM workforce standards compliance - Staff experience survey

Action 6	6.4	The trust have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline, with further adjustments based on the professional judgement of the Director and Head of Midwifery? <i>(In line with MIS Year 8)</i>	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey
	6.5	The trust's obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2?	• Workforce plan • Biannual workforce papers • Cappuccini-style assurance exercise
	6.6	Does the trust board oversee workforce acuity, service pressures and escalation activity across maternity and neonatal services, ensuring they can a) respond to periods of increased demand, reduced workforce availability or changing clinical risk; b) address local gaps and c) eliminate siloed working, so that services can consistently and safely respond to the needs of women, babies and families?	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
	6.7	Has the trust board undertaken a review of internal resource deployment, including consideration of a) whether roles not directly supporting frontline delivery can be redirected to strengthen service provision; b) where specialist posts exist (including in bereavement care and infant feeding), what education and training is required to ensure other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available; c) the impact of redeployment across the service.	• Board report and minutes • Biannual workforce papers • Cappuccini-style assurance exercise
Action 7	7.1	Is the board assured that any actions identified through the urgent review of homebirth services have been completed and services are safe and of high quality?	• Board report and minutes
	7.2	Where significant risks have been identified, have they been communicated with the Regional NHSE team?	• Correspondence
Action 8	8.1	Does the trust have the Patient Safety Incident Response Framework (PSIRF) embedded within Maternity and Neonatal Services through clearly defined governance processes? Is the learning, any actions and outcomes regularly reviewed, shared with women and families, and routinely monitored at trust board through board safety reporting?	• Board report and minutes • A Trust-wide SOP for PSIRF is implemented across Maternity and Neonatal Services • PSIRF implementation within Maternity and Neonatal Services, governance and review processes. • Process for sharing outcomes and learning from PSIRF reviews with women and families. • Mechanisms to identify, monitor and learn from positive practice and areas of improvement.
	8.2	Does the trust review complaints and concerns thematically, with learning actions and improvement plans monitored for impact? Are the themes and learning actions routinely reported to the trust board?	• Board report and minutes • Thematic reviews of complaints and concerns using a learning-focused and inquisitive approach. • Recommendations arising from thematic reviews are monitored, reviewed and acted upon.
	8.3	Does the Trust have embedded processes for open learning and compassionate debriefing, with staff supported to engage effectively with women and families, use feedback to inform practice, provide each family with a key contact, and ensure early duty of candour by a senior manager?	• Board report and minutes • Debrief guidance • Education and Training for Staff involved in debriefing women and families
Action 9	9.1	Has the trust board completed and reported to NHSE regions an audit, including dedicated staffing and clinical capacity with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced?	• Triage Benchmarking tool completed template
	9.2	Does the trust board have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes?	• Board paper
	9.3	Is the trust on track to implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS within 12 months?	• Plan and progress reports
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement
	10.2	Has the board assured itself that it is continuing regular oversight and implementations of national actions and recommendations around matters relating to mortuaries including review of incident records over the past 10 years?	• Board Report • Review report

[Agenda Item] Report to the Quality Committee, 24 August 2026			
Title:	National Maternity Triage Specification (July 2026): UHS Readiness Assessment, Gap Analysis and Implementation Requirements		
Sponsor:	Natasha Watts, Interim Chief Nursing Officer		
Author:	Emma Northover, Director of Midwifery		
Purpose (type an 'x' in the appropriate box(es))			
This report provides an overview of the NHS England National Maternity Triage Specification published in July 2026 and outlines the implications for University Hospital Southampton (UHS) Maternity Services. It presents the findings of an initial review of current maternity triage arrangements, highlights areas requiring further development, identifies associated risks, and outlines the next steps required to achieve compliance with national expectations. A local gap analysis is included in Appendix 1 and a further bench marking tool that has just been released by the national team will be presented to Trust Board at the 10 September meeting.			
(Re)Assurance	Approval	Ratification	Information
X			X
Strategic Theme (type an 'x' in the appropriate box(es))			
Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
			X
Executive Summary:			
The National Maternity Triage Specification establishes maternity triage as a safety-critical urgent care service and the front door for urgent and unscheduled maternity care throughout pregnancy and up to six weeks postnatally. Trusts are required to undertake a board-level audit of maternity triage services, complete a gap analysis within three months of publication and implement the specification within twelve months. UHS demonstrates strong alignment with several aspects of the specification. The Trust provides a 24-hour Maternity Day Assessment Unit (MDAU), utilises the Birmingham Symptom Specific Obstetric Triage System (BSOTS), has access to a dedicated Maternity Telephone Line (MTL), and has established governance processes to support oversight and quality improvement. However, the specification introduces significant new requirements relating to workforce, estates, patient experience, equality monitoring, performance reporting and organisational oversight. The review identifies several strategic risks including increasing levels of activity and complexity within MDAU, capacity constraints, challenges in accessing timely medical review, limitations of the current estate and the need for enhanced reporting and governance arrangements. Whilst no immediate patient safety concerns have been identified through the review, all ten principles of the specification have been assessed as Amber. A significant programme of work will be required over the next twelve months to achieve full compliance. Overall assurance is therefore assessed as Moderate (Amber).			

Contents:	
1. Background 2. Why this matters for UHS 3. Workforce Challenges 4. Current position at UHS 5. Findings from the initial gap analysis 6. Estates and environment 7. Patient privacy, dignity and experience 8. Equity, equality and governance 9. Data quality and reporting 10. Risks and mitigation 11. Next steps 12. Conclusion 13. Recommendations • Appendix 1 – Gap analysis	
Risk(s):	
Risks: • 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. • 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. • We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. • 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. • We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity. • Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.	
Equality Impact Consideration:	N/A

1. Background

The National Maternity Triage Specification was developed in response to a series of national reviews and investigations which highlighted variation in maternity triage services across England. Common themes included delays in assessment, inconsistent prioritisation processes, workforce challenges, variable access arrangements and differences in governance and oversight. The specification seeks to establish a nationally consistent framework for maternity triage and to provide greater assurance regarding the safety, accessibility and responsiveness of urgent maternity care services.

The specification defines maternity triage as the front door for urgent and emergency maternity care and clearly distinguishes maternity triage activity from planned assessment and surveillance services. NHS England expects organisations to recognise maternity triage as a safety-critical urgent care environment with equivalent governance, escalation and performance expectations to other urgent care services.

The specification sets out ten core principles covering:

- Access and Integration;
- Recognition as Urgent Care;
- Assessment and Care of Women;
- Clear Information for Women;
- Telephone Maternity Triage;
- Service User Voice and Experience;
- Facilities and Estates;
- Staffing;
- Equity and Equality; and
- Data and Measurement.

Collectively, these principles represent a significant shift in the way maternity triage services are viewed, governed and resourced. The specification introduces clear performance standards, workforce expectations, estate requirements and Board-level accountability. Several elements, including initial assessment within 15 minutes of arrival, dedicated triage staffing, routine reporting of delays and outcomes, and the monitoring of health inequalities mirror requirements more commonly associated with emergency care services.

2. Why this Matters for UHS

The publication of the National Maternity Triage Specification represents a significant development for maternity services and requires a fundamental refocus of maternity triage as a safety-critical urgent care service. Whilst UHS has invested significantly in the development of MDAU over recent years, the national specification raises expectations regarding workforce, estates, governance, performance measurement and organisational oversight.

Demand for urgent maternity assessment continues to increase. During Quarter 1 of 2026/27, 2,741 BSOTS assessments were undertaken within MDAU, representing an average of more than 900 attendances per month. Approximately one-third of women and birthing people attending the service required obstetric review following their initial assessment. This demonstrates both the scale of activity and the increasingly complex nature of presentations managed within the service. As a tertiary maternity centre, UHS cares for a population with a high proportion of complex medical, obstetric and social needs. MDAU routinely manages women and birthing people with significant co-morbidities, maternal medicine conditions, severe pregnancy complications, fetal concerns and specialist maternity requirements. The level of clinical acuity and risk within the service is therefore substantial and requires rapid access to senior clinical decision-making, timely review and responsive escalation processes.

Unlike planned outpatient activity, maternity triage demand is inherently unpredictable. Significant fluctuations in attendance can occur within short periods, creating challenges in maintaining patient flow and ensuring timely assessment and review. Whilst escalation arrangements are in place, the service continues to experience occasions where capacity pressures and competing demands across maternity services make achievement of national standards increasingly challenging. The requirement within the specification for all women and birthing people to receive an initial assessment within 15 minutes of arrival further highlights the importance of ensuring workforce, estate and governance arrangements remain aligned to future demand.

The specification therefore provides an opportunity to review whether current service arrangements remain fit for purpose and whether greater organisational support and investment are required to enable maternity triage to meet its role as a major urgent care service within the Trust.

3. Workforce Challenges

Workforce represents one of the most significant challenges associated with implementation of the National Maternity Triage Specification. The specification is clear that maternity triage should be supported by appropriately trained and dedicated staffing arrangements that enable timely assessment, rapid escalation and access to senior obstetric review at all times.

MDAU benefits from an experienced and highly skilled midwifery workforce who manage a complex and unpredictable caseload within a busy clinical environment. However, increasing attendance, rising acuity and wider workforce pressures across maternity services create challenges in sustaining timely review and flow through the service.

A particular challenge relates to access to designated medical staffing. Whilst consultant and obstetric support is available, there is currently no specifically designated medical workforce assigned solely to MDAU activity. During periods of high demand, competing priorities across the wider maternity service can result in delays to medical review and decision-making. The national specification introduces increased scrutiny of review times and associated outcomes, making this an important area for future development.

The specification also introduces the expectation that triage staffing is recognised as a dedicated resource and that redeployment from triage should be regarded as a formal escalation event subject to governance oversight. This represents a significant operational and cultural shift and may have implications for future workforce planning and service configuration.

A review of workforce models, escalation arrangements, consultant oversight and service capacity will therefore form a key component of the implementation programme.

4. Current Position at UHS

UHS is well positioned to respond to the requirements of the National Maternity Triage Specification. A number of key elements are already established and align closely with national expectations.

The MDAU provides a continuous twenty-four-hour service for women and birthing people requiring urgent maternity assessment. The service uses BSOTS, which is the nationally recommended triage methodology, ensuring women and birthing people receive structured assessment and prioritisation according to clinical need. Access to telephone triage is provided through the regional Maternity Telephone Line (MTL), with documentation recorded electronically within BadgerNet.

The service has access to the diagnostics required to support emergency maternity assessment, including fetal monitoring, laboratory investigations and ultrasound. MDAU activity is overseen through existing maternity governance structures, and work is already underway to strengthen data reporting through the development of an MDAU Power BI dashboard. This work will support delivery of the national measurement framework and enhance organisational visibility of service performance.

Whilst these foundations are positive, the review identified several areas that require further development before full compliance can be demonstrated.

5. Findings from the Initial Local Gap Analysis

The initial self-assessment has been undertaken against all ten principles contained within the specification. Detailed findings are included within **Appendix 1**.

The review identifies a number of strengths, including established access arrangements, implementation of BSOTS, dedicated telephone triage arrangements and existing governance oversight. However, no principle was assessed as fully compliant at the time of review and all ten principles have therefore been assigned an Amber rating. This reflects a service with strong foundations but requiring further development before full compliance can be demonstrated.

Key themes identified include the need to strengthen postnatal pathways, improve integration with emergency and primary care services, develop equality reporting, improve accessibility of information, strengthen service user feedback arrangements and enhance monitoring of key performance indicators. Additional work is required to ensure robust compliance with national standards relating to waiting times, staffing resilience and timely clinical review.

6. Estates and Environment

The National Maternity Triage Specification requires maternity triage services to be delivered within safe, accessible and purpose-designed environments that support timely assessment, patient flow, dignity, privacy and escalation of care.

Whilst MDAU benefits from close proximity to Delivery Suite and access to essential diagnostic services, the existing accommodation represents one of the most significant challenges to achieving full compliance with the specification.

The current MDAU footprint has previously been identified as not fit for purpose and remains recorded on the maternity risk register as a **Red (16) risk**. Limitations relating to space, capacity, patient flow and overall suitability of the environment were highlighted during the two most recent Care Quality Commission inspections.

The increasing activity and complexity managed within MDAU further exacerbates these challenges. The environment can become crowded and pressured, creating challenges for staff delivering care and for women and birthing people requiring assessment. Current accommodation limits flexibility and restricts the service's ability to meet the expectations described within the national specification.

A number of options have been explored to address these concerns. Following review of potential solutions, plans for a modular development within the Labour Ward garden area have progressed to Stage 4 and are currently awaiting approval through the Trust capital planning process. This proposal represents the preferred long-term solution and would significantly improve service capacity, patient flow, privacy, dignity and staff experience.

The current estate therefore remains one of the most significant strategic risks to delivery of the National Maternity Triage Specification and will require continued organisational focus and investment.

7. Patient Privacy, Dignity and Experience

The National Maternity Triage Specification places considerable emphasis on providing women and birthing people with care in environments that support privacy, dignity, psychological safety and compassionate care. The review asks services to proactively engage with service users and seek feedback on their experiences of triage and care. This should be informed by a clear understanding of the local population, including social, cultural, and geographical factors, to ensure services are equitable, accessible, and responsive to community needs.

Whilst staff work exceptionally hard to provide high-quality care, the current MDAU environment presents challenges in consistently delivering this standard of experience. The physical footprint frequently limits opportunities for confidential conversations, private clinical assessments and the separation of women and birthing people with significantly different clinical and emotional needs.

This is particularly important given the complexity of presentations managed within MDAU. Women and birthing people regularly attend with concerns relating to fetal wellbeing, severe pregnancy complications, pregnancy loss, safeguarding concerns, mental health crises and fetal anomalies. These presentations often require sensitive conversations and compassionate support within a protected environment.

Of particular concern is the experience of bereaved families. Women and birthing people may attend MDAU having experienced reduced fetal movements and subsequently receive a diagnosis of stillbirth or intrauterine fetal death. The current environment provides limited opportunity to protect families from the busy clinical setting or provide the privacy and dignity required at such a devastating time. This remains a significant quality-of-care concern and is not fully aligned with the ambitions of the National Maternity Triage Specification or wider bereavement care standards.

Improving patient privacy, dignity and experience should therefore be considered a key quality objective within any future redesign of maternity triage services and estate development.

8. Equity, Equality and Governance

The specification places a stronger emphasis on understanding variation in access, experience and outcomes than has previously been required within maternity triage services. Organisations are expected to routinely monitor activity and outcomes according to ethnicity, deprivation and language and to use this information to inform targeted improvement activity.

Whilst relevant demographic information is collected, further work is required to ensure routine reporting and analysis can be undertaken in a meaningful way. The implementation programme will therefore include development of equality reporting alongside strengthened engagement with service users and the Maternity and Neonatal Voices Partnership (MNVP).

9. Data Quality and Reporting

The national measurement framework represents one of the most significant changes introduced within the specification. Providers are expected to routinely collect and report information relating to attendance patterns, waiting times, delays in care, clinical review times, staffing pressures, service user experience and health inequalities.

Initial review of local data quality has identified opportunities to improve documentation relating to medical review times, management plans and completion of triage episodes. Whilst these findings do not necessarily reflect deficiencies in care delivery, they do limit the ability to provide assurance against several of the national standards and demonstrate compliance through governance processes.

The national team has developed a Maternity Triage Specification Benchmarking Audit Tool and has requested that all Trusts complete the assessment, secure Trust Board review and sign-off, and submit the completed tool to their regional team by 25 September 2026.

Development of the MDAU dashboard will be a key enabler in supporting future performance monitoring, service improvement and Board assurance.

10. Risks and Mitigation

Implementation of the National Maternity Triage Specification introduces a number of significant strategic risks.

- **Capacity and Demand Risk:** Increasing and unpredictable activity creates a risk of breaching national triage standards and review times. Mitigation includes enhanced performance monitoring, workforce review, escalation processes and ongoing oversight through the developing dashboard.
- **Workforce Risk:** Availability of designated medical support and delivery of timely review remain ongoing challenges. Mitigation includes workforce benchmarking, review of staffing models, escalation pathways and consultant oversight arrangements.
- **Data Quality Risk:** Incomplete documentation may limit the Trust's ability to demonstrate compliance with national standards. Mitigation includes audit, education, dashboard development and routine validation of performance metrics.
- **Patient Experience and Equality Risk:** Current processes may not fully capture variation in outcomes or experience. Mitigation includes enhancement of service user feedback mechanisms, equality reporting and partnership working with MNVP.
- **Estates Risk:** The current environment has been identified as not fit for purpose and remains a Red (16) risk. Mitigation includes maintaining oversight through the risk register, implementing local improvements where possible and progressing the modular build proposal through capital planning processes.
- **Regulatory Risk:** Failure to implement the specification within the required timeframe may result in increased external scrutiny. Mitigation includes establishment of a formal implementation programme with clear milestones, accountability and governance oversight.

Overall implementation risk is assessed as **Moderate to High (Amber)**.

11. Next Steps

The next phase of work will focus on completion of the formal maternity triage audit which will be presented to Trust Board 10 September 2026, further refinement of the gap analysis and development of a detailed implementation plan.

A multidisciplinary implementation group will be established with representation from MDAU, the Maternity Safety Team, governance, data and digital services, MTL, service user representatives and clinical leadership teams. The implementation plan will set out specific actions, timelines, responsibilities and success measures aligned to each of the ten principles.

Progress will be monitored through existing maternity governance structures and reported regularly to Quality Committee and Trust Board, with a progress update going to the regional team by 31 December 2026.

12. Conclusion

The National Maternity Triage Specification represents a significant change in the oversight and delivery of urgent maternity care. UHS has strong foundations, including a 24-hour assessment service, implementation of BSOTS, dedicated telephone triage arrangements and established governance processes.

However, the review demonstrates that achieving full compliance will require more than incremental operational change. The specification provides a clear national mandate for maternity triage to be recognised, resourced and governed as a safety-critical urgent care service. For UHS, the most significant challenges relate to increasing activity and complexity, workforce capacity, timely access to medical review, data reporting requirements and the limitations of the current MDAU estate.

A key challenge remains the current MDAU environment, which is subject to an existing Red (16) risk and has been highlighted during the previous two CQC inspections. Progression of the proposed modular development will be an important enabler in delivering the facilities, privacy, capacity and patient experience requirements described within the national specification.

Whilst no immediate patient safety concerns have been identified, all ten principles have been assessed as Amber and require further development before full compliance can be assured. Delivery will require sustained organisational focus, workforce planning, governance oversight and capital investment over the next twelve months.

13. Recommendations

The Quality Committee is asked to:

1. Note the publication of the National Maternity Triage Specification and its implications for maternity services.
2. Note the findings of the initial UHS readiness assessment and gap analysis.
3. Support completion of the formal maternity triage audit by September 2026.
4. Endorse development of a detailed implementation plan to achieve compliance within twelve months.
5. Receive a further progress report following completion of the audit and implementation planning process.

Appendix 1 National Principles for Maternity Triage Services

Local Gap Analysis Against Specification of 10 Principles

Red	Not in place
Amber	Partially in place
Green	Fully in place
	Not relevant

Principle	Actions Required	Trust Current Position	Actions Required	Key Metrics	RAG Rating
1. Access and integration	Clear, local 24/7 pathways so women and birthing people know where to go and are supported between services.	- MDAU now open 24/7 - Healthier Together web browser available in different languages - UHS staff/MTL use BSOTS for referrals into MDAU.	- Postnatal concerns (clarify process up to 6 weeks postnatal) - Primary care/emergency care referrals in (clarify process) - Postnatal pathways (postnatal toolkit) - Review accessibility (language and accessible formats).	- Rate of presentations per 1,000 births - Frequency of unplanned maternity triage service closures per month - Ethnicity, deprivation and language data for each presentation - Proportion of women and birthing people who attend without prior telephone triage. <i>Frequency of review: Monthly (? Weekly for rate of presentations)</i>	Amber
2. Recognition as urgent care	Maternity triage is the safety/critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	- Scheduled care daily - MDAU for unscheduled attendances.	- Ensure patients are aware of wait times, with real time updates where possible - Recognised as core part of the urgent and emergency care system – working with ambulance and emergency services (with a structured handover)	Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. <i>Frequency of review: Monthly</i>	Amber

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required	Trust Current Position	Actions Required	Key Metrics	RAG Rating
				Part of a system-wide network that supports neighbouring Trusts during periods of high demand.		
3.	Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	UHS uses BSOTs. This is well established and all MDAU core staff trained.	MDAU specific training – should recognise that Black and Asian women and birthing people are more likely to present with higher risk factors (address unconscious bias and support equitable escalation).	- Proportion of women and birthing people triages in each category of urgency - Proportion of women and birthing people for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency - Proportion of women and birthing people who experience a delay in assessment, review or onward care, with recorded outcome - Proportion of women and birthing people who leave without further reviews or care following initial triage, despite an identified need for further review or care. Frequency of review: Weekly/Monthly	Amber

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required	Trust Current Position	Actions Required	Key Metrics	RAG Rating
4.	Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	- Use of interpreters - On discharge patients are safety netted with the ability to ask questions if concerned/if they are happy to be discharged	- Ensure clear consistent guidance on how and when to contact maternity services and where to attend with concerns related to their pregnancy or postnatal concerns - Offer information/advice in accessible formats, including plan language and easy read materials, and culturally appropriate messaging (link with MNVP).	Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns. <i>Frequency of review: weekly/monthly</i>	Amber
5.	Telephone maternity triage (MTL based at SCAS)	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	- Dedicated MTL based at SCAS - Called documented in real time via BadgerNet, calls audio recorded and accessible if required.	Work with MTL/regionally to ensure key principles are met.	- Rate of calls per 1,000 births (breakdown specific to each Trust) - Proportion of women and birthing people who call triage but do not attend in person - Proportion of dropped or unanswered calls to MTL. <i>Frequency of review: Weekly/monthly</i>	Amber
6.	Service user voice and experience (As per 10-point plan for Mat/Neo services)	Women's feedback must shape and service design, improvement and experience.	Friends and family feedback captured, comments filtered to capture MDAU specific.	Proactively engage and seek feedback from service users using MTL – develop a deeper understanding of populations	Qualitative and quantitative data on the experience of women using maternity triage services should be collected using existing local feedback methods – use PREM one available	Amber

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required	Trust Current Position	Actions Required	Key Metrics	RAG Rating
				- Gather feedback regularly through multiple channels (via MTL and internally) - Present monthly data and quality improvement work in accessible patient-facing and staff-facing formats, using this information to improve the quality of the service - Ensure women and birthing people are clearly informed about how to raise concerns or seek further review if they are not satisfied with the outcome of a triage review, including access to local escalation routes and relevant safety processes – awareness of Martha's Rule - Adopt the Mat/Neo PREM when available (<i>being developed by NHS England and should be available Summer 2026</i>) - Use qualitative lived experience alongside quantitative data – work with MNVP.	- Frequency and diversity of feedback collected - Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. <i>Frequency of review: Quarterly/half year</i>	
7.	Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	Positioned on the delivery suite (albeit it small)	- Suitably sized waiting area visible to clinical staff - Reception area where staff are notified of women and	Clinical area where the woman/birthing person was admitted following triage (where relevant) – ongoing care.	Amber

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required		Trust Current Position	Actions Required	Key Metrics	RAG Rating
				- Access to essential diagnostics, including electronic fetal monitoring, blood tests, urine samples and USS - MDAU is physically separate from scheduled care appointments/space.	- birthing people's arrival and help can be accessed quickly (no ward clerk after 00:30 – 07:00) - Ensure appropriate facilities and space (currently space is small and limited) - Include a well-equipped office space within the clinical area to support clear and confidential handover and centralised oversight of the service workload - Review accessibility standards, including the provision of accessible WCs and clear signage. Designing spaces that provide quiet or private areas wherever possible, offer clear explanations of waiting processes and ensure systems to demonstrate that women and birthing people have been seen and are awaiting care - Design the physical environment to promote women and birthing people's sense of safety and comfort.	<i>Frequency of review: Monthly</i>	

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required		Key Metrics		RAG Rating
8.	Staffing		- MDAU has a dedicated team – appropriately skilled to work in fast paced environment. Shift patterns mean always >1 midwife (until 02.30-07.30) - Escalation pathway in place for when MDAU breaching (need to review SOP/policies) - In escalation staffing is adjusted in response to critical workload in wider maternity service (pull from LW etc where possible) - Low risk labourers are assessed on Broadlands Birth Centre and transferred to MDAU if risks arise/as appropriate.	- Maternity triage services must ensure appropriate staffing in line with recommended minimum standards (outlined in RCOG good practice paper) – review models regularly against local attendance data to ensure appropriately resourced, safe and responsive to demand - Escalations should incorporate locally agreed thresholds for senior consultant attendance beyond twice-daily ward rounds – ensuring timely access to senior input as required - Oversight of MDAU to be jointly maintained by the midwifery coordinator and most senior obstetrician on call for the labour ward – triage activity should be reviewed as part of consultant-led ward rounds.	- Proportion of women and birthing people assessed within the expected timeframes based on category of urgency - Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage <i>Frequency of review: Weekly/monthly</i>	Amber

Appendix 1 National Principles for Maternity Triage Services

Principle		Actions Required	Trust Current Position	Actions Required	Key Metrics	RAG Rating
9.	Equity and equality	Services must use data and targeted action to identify and reduce inequalities.		- Understand local population needs and service demand – align improvements with wider system work such as ICB-ed population mapping and blueprints - Demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements - Ensure all staff involved in maternity triage undertake training to support culturally safe care, including that develops cultural intelligence and addresses unconscious bias.	Refer to principle 1 where these metrics align to Principle 9 of Equity and Equality. <i>Frequency of review: As described for metrics in principle 4.</i>	Amber
10.	Data and measurement	Data must drive oversight, learning from incidents and continuous	- Power BI dashboard has been developed to collect MDAU specific data - MTL attendance at women & newborn governance, plans in place to review safety events through PSIRF.	- Establish processes that enable teams to frequently review their data - Be transparent with women and birthing people about why data is collected and how it will be used.	<i>No specific metrics for this principle.</i>	Amber

Maternity triage specification benchmarking audit tool

Please enter the name of your **trust** below:

University Hospital Southampton

Please enter the **trust site** below:

Princess Ann Hospital

Guidance for completion

Purpose

This benchmarking tool has been developed to support maternity services in assessing alignment with the Maternity Triage Specification and identifying opportunities for improvement. The tool should be used as both a self-assessment and quality improvement resource, enabling organisations to evaluate the effectiveness, safety, accessibility, equity and responsiveness of their maternity triage service.

The objective is not solely to determine compliance, but to support continuous service improvement through reflection, evidence review, gap analysis and action planning.

Principles for completion

The Benchmarking Audit Tool must be completed for **each site** within a Trust where maternity triage is operational. This ensures that benchmarking reflects local service delivery arrangements and enables site-specific identification of strengths, gaps and improvement opportunities.

Consider the maternity triage service as a whole, including telephone triage, face-to-face assessment, ongoing care, governance, workforce, environment, equity and measurement.

Base responses on evidence rather than individual opinion.

Dashboard

The Dashboard Tab brings together information from across the benchmarking audit tool into a single, easy-to-view summary. It provides an overview of implementation against each Maternity Triage Specification principle, displaying the number of standards assessed as Fully in Place, Partially in Place, Not in Place, Not Relevant, or where Data is Not Complete. It also includes the estimated cost to progress compliance against the specification standard, enabling organisations to quickly identify areas of strength, prioritise improvement activity, and monitor progress without having to review each individual principle tab separately.

Specification standard

The individual standards within the Maternity Triage Specification have been broken down into specific benchmarking criteria to support a structured assessment of your maternity triage service.

Benchmarking suggestions in line with the specification

This column outlines the minimum standards for benchmarking your maternity triage service against the Maternity Triage Specification. It supports consistent assessment, identification of good practice and improvement opportunities, and consideration of how standards are evidenced, embedded, monitored and continuously improved.

Benchmark rating

This column supports benchmarking against each standard within the Maternity Triage Specification. Each site within the Trust should consider the evidence available to demonstrate implementation, monitoring and continuous improvement, focusing on how standards are embedded in practice and contributing to improved outcomes for women and families.

There is a drop down menu incorporating the following:

Fully in place, evidenced and embedded

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

Not relevant to local pathway/context

Support required from Trust board to progress compliance

This column supports organisations in identifying local improvement needs and the actions, resources and support required to achieve compliance with the Maternity Triage Specification. It should be used to inform prioritisation, action planning and ongoing service development.

What happens if selecting:

Partially in place, but inconsistent or not fully evidenced

Not in place, significant gaps or limited evidence

There is automatic functionality built in that takes you to the Support required from trust board column.

Metrics

This column outlines the metrics for each standard within the Maternity Triage Specification, supporting performance monitoring, assurance and continuous improvement. Where metrics are not currently captured, organisations should identify actions required to enable future data collection.

Data captured per site

This column supports organisations in identifying gaps in data collection and reporting, and the actions required to enable future measurement and monitoring.

There is a drop down menu incorporating the following:

Site captures this data

Site partially captures this data

Site doesn't capture this data

Support required from Trust board to progress the metric

What happens if selecting:

Site partially captures this data

Site doesn't capture this data

There is automatic functionality that takes you to the support required to progress this metric column

Evidence requirements have not been prescribed within this tool to enable each site within the Trust to reflect on local arrangements and identify the most appropriate evidence to demonstrate implementation and compliance. Assessments should be based on documented evidence and demonstrated practice. Benchmarking should be undertaken as a multidisciplinary exercise to support continuous improvement, with actions identified where standards are not fully achieved.

Estimated financial requirements to support compliance

Where assessed as **Partially in place, but inconsistent and not fully evidenced** or **Not in place, significant gaps or limited evidence**, each site within the Trust should estimate the financial investment required to achieve compliance, including any workforce, training, digital, infrastructure or operational costs.

Principles Menu

This functionality will enable you to navigate between the principles tabs more easily.

Maternity Triage Specification Benchmarking Audit Tool Dashboard

Click below to link through to each principle

		Fully in place	Partially in place	Not in place	Not relevant	Data not complete	Estimated cost to progress compliance of specification standard
Principle 1: <u>Access and integration</u>	Clear, local 24/7 pathways so women know where to go and are supported between services.	0%	100%	0%	0%	0%	£0.00
Principle 2: <u>Recognition as urgent care</u>	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	20%	80%	0%	0%	0%	£0.00
Principle 3: <u>Assessment and care of women</u>	Every woman receives timely assessment, prioritisation and a clear plan of care.	20%	60%	0%	20%	0%	£0.00
Principle 4: <u>Clear information for women</u>	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	0%	100%	0%	0%	0%	£0.00
Principle 5: <u>Telephone maternity triage</u>	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	13%	88%	0%	0%	0%	£0.00
Principle 6: <u>Service user voice and experience</u>	Women's feedback must shape service design, improvement and experience.	0%	80%	20%	0%	0%	£0.00
Principle 7: <u>Facilities and estates</u>	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	0%	40%	60%	0%	0%	£0.00
Principle 8: <u>Staffing</u>	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	8%	92%	0%	0%	0%	£0.00
Principle 9: <u>Equity and equality</u>	Services must use data and targeted action to identify and reduce inequalities.	0%	100%	0%	0%	0%	£0.00
Principle 10: <u>Data and measurement</u>	Data must drive oversight, learning from incidents and continuous improvement.	0%	71%	29%	0%	0%	£0.00

Principle 1: Access and integration

Clear, local 24/7 pathways so women know where to go and are supported between services.

Dashboard

Principles menu

Previous

2

3

4

5

6

7

8

9

10

Next

Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.	1. Local guidance agreed by stakeholders is in place ensuring consistent, clearly defined referral pathways for women presenting 24/7 in care areas outside of acute maternity services 2. The pathway defines where women should present based on gestation, symptoms, urgency and clinical need and this is shared with women, healthcare professionals and partner services. 3. The guidance in place covers early pregnancy, antenatal, intrapartum concerns and the postnatal period, up to 6 weeks and includes clearly definition of handover procedures between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Provide clearly defined 24/7 access routes so women always know where to go with urgent concerns.	1. All access routes are clearly described including via telephone, walk-in and professional referral routes and that these are available and monitored 2. All information related to access routes is consistently applied to all areas of your organisation, including the Emergency Dept. 3. Clear information is provided to women identifying appropriate access routes for all gestations of pregnancy and postnatal period	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Agree the most appropriate place of care for women at different stages of pregnancy and with different clinical needs; share this with women, staff and partner services including primary care, ambulance services and NHS 111, supporting seamless care from early pregnancy to six weeks postnatal.	1. A documented, system-wide agreement exists defining the most appropriate place of care for women with differing clinical needs. 2. The agreed place of care guidance covers the entire maternity journey from early pregnancy to 6 weeks postnatal. 3. Criteria are clearly defined for escalation, transfer, and place of care decisions for different clinical need and pregnancy stages. 4. Pathways have been formally agreed between maternity providers, primary care, ambulance services, NHS111, and other relevant partner organisations	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure inclusive access arrangements so all women can use maternity triage safely and equitably, regardless of language, disability, race, ethnicity, socioeconomic status, digital literacy or GP registration; pathways should be clear and accessible to women with no prior system knowledge.	1. A documented policy exists to ensure equitable access to maternity triage for ALL women. 2. Professional interpretation and translation services are available and routinely used within maternity triage services. 3. Information about how to access maternity triage is available in multiple formats, including easy read, large print, audio, digital and translated versions. 4. Reasonable adjustments for women with physical, sensory, learning, cognitive or communication disabilities have been made 5. Triage pathways have been reviewed, and where necessary, amended to identify and reduce barriers related to race, ethnicity, culture, socioeconomic deprivation and inclusion health needs 6. Pathways in place identifying different access routes for women without digital access and literacy and women who have no known GP registration status, immigration status or previous engagement with maternity services. Clear self referral and direct access routes exist without requiring women to navigate complex healthcare systems 7. Information is designed to be understandable for women with no prior knowledge of maternity services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Support the digital and financial investment required to ensure equitable access to maternity information and services for women and families whose first language is not English, helping to reduce health inequalities and improve outcomes and experience across our diverse population.	
Maintain access routes such as telephone, walk-in and community referral, with an open-door policy for anyone attending with concerns or needing urgent care; initial assessment should be equitable regardless of route of access or previous attendance.	1. All access routes are clearly defined through pathway documents including telephone triage, walk- in, community referral, ambulance conveyance and professional referral. 2. A guideline is in place defining an open door policy, ensuring women are not turned away when presenting with concerns 3. A guideline is in place defining how women can access maternity assessment without unnecessary barriers or requiring appointment		Please outline what support you require from your trust board below	

	assessment must unnecessary barriers or requiring appointment. 4. A guideline is in place defining initial assessment processes are consistent regardless of route of access.	Partially in place, but inconsistent or not fully evidenced			
Provide accessible and consistent guidance and signposting for staff and service users, with onward referral and coordinated handover responsibility resting with healthcare professionals in the presenting service. Providing support for women to navigate between services.	1. The service has clearly defined pathways and guidance to support staff and service users in accessing the appropriate service 2. Information and signposting has been provided to staff and service users 3. Guidance is provided in all accessible formats required for your service. 4. Clear handover procedures are in place for effective handover of care between services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Define referral criteria across local maternity services including community midwifery, antenatal clinics and day assessment services.	1. Agreed referral criteria are in place across local maternity services, including community midwifery, antenatal clinics, maternity triage and day assessment services.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Establish communication and referral pathways between triage, primary care, emergency departments, ambulance services, perinatal mental health and safeguarding teams.	1. Documented communication pathways exist between maternity triage and key partner services - including those listed within the specification standard.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Plan ongoing care, including sufficient bed capacity to support timely and safe admission for women requiring inpatient care from maternity triage services.	1. Defined pathways are in place to support the ongoing management and care of women following maternity triage assessment. 2. Clear criteria are established for admission, observation, transfer, discharge and follow up care following triage assessment. 3. The service has a process to assess, monitor and manage maternity bed capacity to support timely admission from triage. 4. The service has provision in place for women requiring admission to be transferred to appropriate inpatient setting without avoidable delay. 5. Formal escalation processes exist when bed capacity is constrained, including operational and clinical escalation arrangements.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Financial support for staff time		
Share information and discharge summaries in a timely way with relevant care partners, including primary care and community midwifery, with clear accountability for communicating outcomes, actions and next steps to the woman's usual care provider.	1. A formal process exists for sharing discharge information and outcomes following triage attendance, tailored to the individual need. 2. A formal process exists for sharing discharge summaries/assessments and clinical outcomes to relevant care providers and to the women.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Financial support for staff time		
Provide a postnatal pathway to six weeks postnatal, including guidance on care of the baby where required; where the baby does not need separate neonatal or paediatric care, avoid separating baby from mother wherever possible.	1. A clearly defined pathways exists for women accessing maternity services from birth to 6 weeks postnatal. 2. The pathway describes ongoing assessment, follow-up, escalation and support requirements throughout the postnatal period 3. Guidance is available to support assessment and care of the baby where this is relevant to the reason for attendance.		Please outline what support you require from your trust board below		

	4. Processes are in place to support the needs of both the woman and baby during postnatal assessment and care. 5. Clear referral process are in place for babies requiring neonatal or paediatric review and ongoing care. 6. Guidance is in place to reflect a family centred approach to minimise separation of mother and baby.	Partially in place, but inconsistent or not fully evidenced		
--	---	---	--	--

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	
Metric: Rate of triage presentations per 1,000 births. Why: Helps services understand demand and plan capacity.	Site Partially captures this data	Please outline what support you require from your trust board below	Total estimated cost to implement this principle
			£0.00
Metric: Frequency of unplanned maternity triage service closures per month. Why: Tracks service resilience and identifies risks to 24/7 access, informing contingency planning and capacity improvements.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Ethnicity, deprivation and language data for each woman presenting, including English as a first language and need for interpretation services. Why: Identifies groups more likely to face access barriers or worse outcomes, supporting targeted action to reduce inequalities.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Proportion of women who attend without prior telephone triage. Why: Helps services understand use of different access routes and confirm open-door policies are working as intended.	Site Partially captures this data	Please outline what support you require from your trust board below	

FOR BOARD ASSURANCE
Not compliant and significant challenge
working towards but with significant challenge
working towards and confident around compliance
In place and can give assurance.
UHS Maternity narrative/progress for TB September 2027
Maternity Day Assessment Unit now open 24/7
Working towards a full process up to 6 weeks postnatal.
Healthier together app (with different languages in browser assists in signposting but requires GP details for registration)
Working on clarification of process around primary care and emergency referrals into service
Healthier together app (with different languages in browser assists in signposting. Current plans to include all pregnant people requiring interpreters to NEST (continuity of carer) care Discussions needed re signage (not consistent)
Working towards a full process up to 6 weeks postnatal.
HT app signposts women to access the most appropriate place of care
Working on clarification of process around primary care and emergency referrals into service
Interpreter policy well understood and pocket devices being made available Process described to avoid digital exclusion but more work to be done ie all of the BADgemet IT systems work in English only
New NEST criteria would include those with needs which make usual channels of communication challenging
Healthier together app does not support different languages- browser does. Both require literacy
Self referral process is open to all and does not require primary care registration or involvement
Access and service user feedback from harder to reach populations requires support from MNVP and engagement officer - one is on maternity leave and therefore not yet recruited.
Will require further review but no women are turned away at any time - requires input from MTL (Maternity Triage Line which is hosted by UHS based at SCAS)

Triage in MDAU SOP in place but needs review to include these specifics
Further work but much is in place. Self referral and Healthier Together app/browser give lots of information. Pivotal role of MNVP understood but will need to be back from maternity leave for impact.
Antenatally embedded but postnatal pathway s for concerns to be extended
Some will be captured as part of maternity care bundle regional working
Well understood escalation processes but bed capacity can be challenging during periods of high acuity Longer in patient stays due to higher acuity of population may compound this.
Documentation in maternity information systems not accessible by primary care or services outside of maternity currently. Will need to strengthen the process
Working towards a full process up to 6 weeks postnatal.
Women have access to MDAU until 6 weeks postnatally but the pathway needs review and clarification

Women are encouraged to attend with their babies - need clear process for neonatal care within MDAU

Referral processes for babies requiring neonatal or paed review lie outside maternity triage

Service is building a Power BI dashboard to capture these data metrics but currently there are some significant data quality issues which will need to be resolved . Key data captured is rate of triage presentations and time to initial triage assessment. Subsequent timings reliant on individual data entry . work ongoing

[illegible]

Principle 3: Assessment and care of women

Every woman receives timely assessment, prioritisation and a clear plan of care.

Dashboard

Principles menu

Previous 1 2 4 5 6 7 8 9 10 Next

Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	
Align the clinical model with RCOG Good Practice guidance and ensure every attending woman is assigned a clinical priority based on physical, mental and social wellbeing.	1.The maternity triage clinical model is aligned with current RCOG Good Practice Guidance and relevant national maternity standards.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure triage assessment and clinical prioritisation are carried out by staff trained in the specific triage method.	1. The service can evidence initial triage assessments and clinical prioritisation are undertaken only by staff who have completed training in the local maternity triage method. 2. A documented competency framework exists for staff undertaking maternity triage assessment and prioritisation. 3. The service can evidence staff complete a structured induction and training programme before independently undertaking triage assessments.	Partially in place, but inconsistent or not fully evidenced	Financial support for staff time Please outline what support you require from your trust board below	
Aim to adopt the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), as recommended by RCOG Good Practice Paper No. 17.	1. The service had adopted, or has a documented implementation plan to adopt, the Birmingham Symptom Specific Obstetric Triage System or an equivalent evidence based maternity triage methodology.	Fully in place, embedded and evidenced	Financial support for staff time & training No further action required	
If not using BSOTS, ensure any adaptation or alternative model is evidence-based, clinically evaluated or piloted, demonstrates equivalent outcomes through audit, and is formally agreed by the Trust Board.	1. Where BSOTS is not used, the Trust has adopted an alternative maternity triage model that is supported by evidence, local evaluation and has undergone testing prior to implementation. 2. The service can demonstrate through audit and performance monitoring that the model achieves outcome equivalent to, or better than, established triage standards 3. The alternative triage model has received formal approval through governance structures and the trust board.	Not relevant to local pathway/context	No further action required	
Ensure triage models and staff training address unconscious bias and support equitable escalation, recognising higher risk and later presentation patterns among Black and Asian women and ensuring timely, appropriate care based on clinical need.	1. The maternity triage model explicitly incorporates principles of equity and supports fair, consistent assessment and prioritisation for all women. 2. Staff undertaking maternity triage roles receive training on unconscious bias, cultural competence and equitable care. 3. Staff training includes awareness of know maternal inequalities and variation in outcome for different population groups.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Financial support for staff time & training	

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	Total estimated cost to implement this principle
Metric: Proportion of women triaged in each category of urgency. Why: Shows the spread of urgency levels, helping services understand case mix and plan staffing and escalation capacity.	Site Partially captures this data	Please outline what support you require from your trust board below	£0.00
Metric: Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency. Why: Measure time to initial assessment, waiting	Site Partially captures this data	Please outline what support you require from your trust board below	

Why: measures time to initial assessment, waiting times and review times, and whether urgent cases are escalated in line with triage standards, reducing the risk of harm.

Metric: Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded.

Why: Monitors the impact of delays on women's care and outcomes, supporting timely review, learning and targeted improvement where harm or increased risk is identified.

Metric: Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care.

Why: Helps understand patterns of incomplete assessment and address barriers that cause women to leave early, improving experience and outcomes.

Site Partially captures this data
Site Partially captures this data

Please outline what support you require from your trust board below

Please outline what support you require from your trust board below

[Dashboard](#)

Principles menu										
Previous	1	2	4	5	6	7	8	9	10	Next

FOR BOARD ASSURANCE SEPTEMBER 2026
Not compliant and significant challenge
working towards but with significant challenge
working towards and confident around compliance
In place and can give assurance.

Principle 3 carries lots of areas of compliance due to the established use of the BSOTS model.
Aligned in majority but important gaps such as obstetric staffing and estates
Every attendance assigned a clinical priority based upon BSOTS
All staff, midwifery and obstetric, have BSOTS training as part of their structured induction.
VLE update package aviable but not mandated
No current documented competency document
Core MDAU team
In place since Jan 2019
MDAU specific training needs more emphasis and recognition that Black and Asian women are more likely to present with higher risk factors. Current consultation in place to caseload these women to promote stronger continuity and advocacy
EDI working group at UHS - currently no national training packages available.

working towards a POWER BI solution to capture data

[Dashboard](#)

Principles menu										
Previous	1	2	3	5	6	7	8	9	10	Next

FOR BOARD ASSURANCE SEPTEMBER 2026

Not compliant and significant challenge

working towards but with significant challenge

working towards and confident around compliance

In place and can give assurance.

Currently postnatal concerns go through Broadlands birth centre
- pathway under review as per the postnatal tool kit

Requires support and input from MNVP and engagement officer when appointed to ensure appropriate representation

HT app not available in other languages, whilst browser format is

Most recent audit shows some active requesting of family members to interpret but with strong compliance with offer. Current review of caseloading intended to provide continuity model to those requiring interpreters.

Further training and work required. Limits with translation services currently as only phone and not face to face or 'zoom/teams'.

Informal process in place but requires audit and potential IT digital service input

Generally compliant and community coordinators support transfer of care between services.

Specific services follow self-referral process (women's health physio) although staff referral possible if support required
Process for referring women directly from ED/primary care needs review and strengthening

working towards a POWER BI solution to capture data

Principle 5: Telephone maternity triage

A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.

Dashboard

Principles menu

Previous 1 2 3 4 5 6 7 8 9 10 Next

Estimated cost to progress compliance of specification standard

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	Estimated cost to progress compliance of specification standard
Provide a well-publicised 24/7 single contact number, answered promptly by clinically active midwives trained and experienced in maternity triage; telephone maternity triage should not be diverted to labour wards where prompt response may not be possible.	1. A single, dedicated telephone number is available for maternity triage and advice services. 2. Telephone maternity triage service is available 24 hours a day, 7 days a week. 3. The contact number is well publicised and routinely shared with women, families, primary care, ambulance services, NHS111 and partner organisations. 4. Telephone triage is undertaken by clinically active midwives with responsibility for maternity triage assessment and advice. 5. Guidance is in place to support staffing arrangements to ensure telephone triage functions are delivered safely, including not diverting to labour ward due to unknown response times.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Encourage telephone triage use where appropriate but never make it the only route to care.	1. All access routes are clearly defined through pathway documents including telephone triage, walk-in, community referral, ambulance conveyance and professional referral. 2. A dedicated telephone triage service is available. 3. Communication is tailored to encourage women to contact telephone triage with clarity that telephone is not the only option available and they can access maternity triage via any route beneficial to them 4. Information provided to women consistently reinforces that telephone triage compliments not replaces direct care.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below Financial support for staff time Please outline what support you require from your trust board below	
Ensure all women have open access to face-to-face maternity triage; where a woman remains anxious or concerned after telephone triage, invite them to attend for in-person assessment.	1. All women and staff understand there is direct access to face to face maternity triage assessment regardless of previous telephone contact. 2. Women and staff are aware that if the woman remains anxious it is appropriate to encourage face to face attendance.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Operate telephone triage from a protected, quiet, confidential space away from the main clinical area and clinical office space; the midwife's sole responsibility during this time should be telephone triage.	1. Telephone triage is delivered from a dedicated space specifically designed to support safe, effective telephone triage. 2. The telephone triage area is sufficiently designed that it is located in a quiet area and in an environment that protects confidentiality. 3. The telephone triage area is located away from busy and noisy clinical areas and in a dedicated space, not a shared office environment.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Do not defer in-person attendance to manage service workload; give women clear information about clinical urgency of attending and operate a low threshold for attendance because telephone assessment is difficult and subjective.	1. Guidance is place to support the decision making around face to face attendance and based on the woman's need not service capacity. 2. The service has processes in place to ensure attendance to face to face is not discouraged or delayed based on awareness of service capacity and/or staffing pressures. 3. Processes are in place to ensure telephone triage promotes a low threshold for face to face review.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Do not allow telephone triage to provide definitive diagnosis, determine clinical priority before in-person assessment, make appointments for in-person triage, or manage or limit the number or timing of women attending.	1. The service has a documented policy in place defining the purpose and limitations of telephone triage. 2. There is a guideline in place acknowledging that telephone triage is used to assess concerns, provide advice and determine next steps, but not provide a diagnosis. 3. There is guidance in place ensuring telephone triage does not replace formal prioritisation of clinical need. 4. Telephone triage is not used to schedule appointments for maternity triage	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Maintain clear pathways so suspected threatened preterm or extreme preterm birth is signposted to in-person maternity triage without delay, where this is	1. The service has a documented pathway for the assessment of suspected preterm labour and extreme preterm birth. 2. The service has a process to ensure all women with suspected preterm or		Please outline what support you require from your trust board below	

the safest and most appropriate setting.	extremely preterm birth are directed to face to face maternity triage without delay. 3. Referral criteria is in place to action this. 4. There are agreed pathways and communication in place with primary care, NHS111, emergency departments and community midwifery services for suspected preterm and extremely preterm birth.	Partially in place, but inconsistent or not fully evidenced										
Document all calls in real time using a standardised template within the woman's electronic patient record where available; audio-record calls with consent to support accuracy and safety; document requests for hospital attendance including urgency and expected timeframe.	1. All telephone triage contacts are documented contemporaneously during or immediately after contact. 2. A standardised telephone triage template is used for all calls. Including documentation supporting request for attendance and anticipated time frame. 3. Where available, telephone triage assessments are recorded in the woman's Electronic Patient Record.	Fully in place, embedded and evidenced	No further action required									
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		How much does it cost to implement this principle								
Metric: Rate of calls to telephone triage per 1,000 births. Why: Helps services understand demand for telephone triage and plan staffing and resources effectively.	Site Partially captures this data	Please outline what support you require from your trust board below		£0.00								
Metric: Proportion of women who call telephone triage but do not attend in person. Why: Monitors the effectiveness of telephone triage in identifying urgent care needs and whether barriers may be preventing attendance when needed.	Site Partially captures this data	Please outline what support you require from your trust board below										
Metric: Proportion of dropped or unanswered calls to telephone triage. Why: Identifies service capacity issues and supports timely access for urgent concerns, reducing risk of harm.	Site Partially captures this data	Please outline what support you require from your trust board below										
Principles menu												
Dashboard		Previous	1	2	3	4	6	7	8	9	10	Next

FOR BOARD ASSURANCE SEPTEMBER 2026
Not compliant and significant challenge
working towards but with significant challenge
working towards and confident around compliance
In place and can give assurance.

MDAU remains open even when Opel 4. Women not turned away at presentation.
MTL number well-publicised and available via HT app or direct for more vulnerable women/ out of area who can't access HT app
When MTL unstaffed, diverted to alongside midwifery-led unit
Review of caseloading model to include women requiring interpreters to have continuity care - this enables them to contact their team directly and often text is preferred mode of initial contact.
Women on a continuity of care pathway are encouraged to contact their caseloading MW directly as their access routes
No women turned away if present directly but further work needed for SOP and guidance
Work required with MTL to ensure this standard is met - MTL do triage in and document on badger notes if patient attending due to anxiety and seeking reassurance.
MTL compliant with this specification however, non-compliant when MTL diverted to individual units - at UHS calls diverted to BRO birth centre
MTL not based on site, triage assessments non-biased when service high acuity. Work to ensure SOP/guidance clear on this.
Guidance requested from MTL
MTL telephone triage aligns with Wessex Antenatal Care Pathway for ppROM though require review

Healthier together information regularly reviewed and updated by clinical experts to support with triage

BSOTs telephone triage contact template on BadgerNet
used by MTL & community MWs when referring into MDAU

MTL calls recorded

Calls/data captured by MTL teams and audits in place to review calls.

Metrics	Data captured per site	Support required from Trust Boards to progress the metric	
Metric: Qualitative and quantitative data on the experience of women using maternity triage services, collected through existing local feedback methods and transitioning to the national maternity and neonatal Patient Reported Experience Measure when available. Why: Helps services understand women's experience, including whether they feel informed, respected and involved in their care, and target actions to improve experience.	Site Partially captures this data	Please outline what support you require from your trust board below	Total estimated cost to implement this principle £0.00
Metric: Frequency and diversity of feedback collected, including review by ethnicity to confirm feedback reflects the service population. Why: Ensures timely, representative feedback is available to support continuous improvement based on service user experience.	Site Partially captures this data	Please outline what support you require from your trust board below	
Metric: Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements. Why: Monitors whether identified issues lead to timely, measurable improvement actions, supporting continuous service improvement and accountability.	Site Partially captures this data	Please outline what support you require from your trust board below	

FOR BOARD ASSURANCE SEPTEMBER 2026
Not compliant and significant challenge
working towards but with significant challenge
working towards and confident around compliance
In place and can give assurance.

FFT feedback regularly captured and can be filtered to MDAU specific
Work required with MNVP once returns from leave

Patient experience report presented quarterly at Governance & FFT shared with Matrons and SLT monthly - any themes/concerns captured
Work required with MNVP once returns from leave

Further work required with MNVP
Don't go home unhappy posters in clinical areas - MDAU specific to ensure feedback.

Don't go home unhappy posters in clinical areas - MDAU specific to ensure feedback. Martha's rule implemented and posters in clinical areas.

PREM not available yet

Quarterly safety reports triangulate feedback/complaints with outcomes - work needed to ensure MDAU specific is captured and shared.
MNVP support required

MNVP currently on maternity leave - due back SEPT

Further work required with MNVP and Patient experience team to ensure data captured is used in a meaningful way.

Principle 8: Staffing

Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.

Specification standard	Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance	progress compliance of specification
Use dynamic staffing models informed by local activity data and aligned to the triage system used; consider unit size and activity levels so sufficient trained personnel are available.	1. The maternity triage service uses a staffing model informed by local activity and acuity information. 2. Staffing levels align to the maternity triage system in use.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure appropriate dedicated midwifery, medical and support staffing in line with RCOG Good Practice Paper No. 17 minimum standards, with capacity and escalation pathways at all times including nights and weekends; review staffing models regularly against local attendance data.	1. Dedicated maternity triage midwifery and obstetric staffing is provided in line with the RCOG Good Practice Paper No. 17. 2. Appropriate medical staffing is available to support timely assessment, review and escalation of clinical concerns 3. Staffing arrangements cover 24 hours 7 days a week 4. Staffing models are reviewed regularly utilising data relating to acuity, peak activity periods and service demand.	Partially in place, but inconsistent or not fully evidenced	Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below	
Ensure dedicated triage staffing is structurally independent of labour ward midwifery staffing; treat redeployment from triage to other maternity areas as a formal escalation event and document, review and monitor through governance processes.	1. Maternity triage has dedicated staffing establishment that is separate from labour ward staffing requirements. 2. A formal process defines circumstances in which triage staff may be redeployed and identifies associated escalation requirements and recorded as a formal escalation event. 3. Redeployment events and triage staffing pressures are reviewed regularly through maternity governance processes.	Partially in place, but inconsistent or not fully evidenced	Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below	
Where possible, have a minimum of one midwife responsible for initial triage assessment and at least one other midwife carrying out subsequent care, informed by local demand, service need and RCOG birth-rate modelling.	1. Staffing arrangements support separation of initial assessment and ongoing care requirements.	Fully in place, embedded and evidenced	Financial support for clinicians time to review policies/guidelines. No further action required	
Ensure initial triage assessment and telephone triage are undertaken by appropriately trained and experienced staff with clinical judgement to advise, assess urgency, escalate concerns and initiate urgent interventions.	1. Initial maternity triage assessment and telephone triage are undertaken only by staff who have completed training in the locally adopted maternity triage methodology.	Partially in place, but inconsistent or not fully evidenced	Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below	
Define competency requirements for triage functions so staff are well supported and supervised.	1. A documented competency framework defines the knowledge, skills and behaviours required for all maternity triage roles	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Ensure staff working in triage receive appropriate training including rapid assessment, with clear competency frameworks and governance, and maintain regular experience in this setting.	1. All staff undertaking maternity triage complete a structured training programme appropriate to their role and responsibilities.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Define escalation protocols and thresholds for peak activity and escalating midwifery and medical staffing when capacity is exceeded; base thresholds on attendance numbers and clinical urgency categories, embed in policies/governance and support with real-time activity monitoring.	1. A documented escalation framework exists for maternity triage, defining actions required during periods of increased activity, capacity pressures or workforce shortages.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below	
Where staffing is adjusted in response to critical workload and demand, make decisions carefully and promptly, balancing acuity and safety across the wider maternity service to maintain minimum safe staffing levels.	1. A documented policy defines how staffing adjustments are made during periods of critical workload, demand or capacity pressure, including wellbeing of staff needing to have regular breaks.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below 	

FOR BOARD ASSURANCE SEPTEMBER 2026

Not compliant and significant challenge
Working towards but with significant challenge
Working towards and confident around compliance
In place and can give assurance.

Staffing model in place - recently reviewed and changed to ensure 24/7 cover
No dedicated obstetric staffing as per RCOG min staffing standards Requirement for Consultant staffing on demand capacity model (10PAs/ week) Attempt to roster resident obstetric staff but only when other service capacity allows (such as staffing OT and on call service) Obstetric staffing provided by labour ward team and in place 24/7 24/7 midwifery staffing as per RCOG minimal MW staffing for unit size
Separate midwifery staffing for MDAU
Currently no process for reporting/reviewing redeployment - this is done via exception and service uses escalation policy.
Staffing model recently revised 2 midwives until 02:30am-07:30 am during this time 1 midwife rostered and would be supported by LW team if acuity in MDAU high - requires further review
Telephone triage undertaken by specifically trained MTL staff with exception of when MTL diverts to local units
All staff trained in BSOTs at induction with a core MDAU midwifery team
Need to review competency framework There are specific competencies for skills such as speculum examination & role specific requirements
Core MDAU midwifery staff BSOTs trained and work regularly to maintain experience Need to review competency framework MDAU shifts only available to staff familiar with working in area.
MDAU triage SOP details escalation process
Real-time activity monitoring based upon numbers awaiting initial triage assessment To review real-time monitoring for ongoing assessment/ clinical urgency category, currently escalate breaches as per escalation policy
Safe staffing policy under current review

Include locally agreed thresholds for senior or consultant attendance beyond twice-daily ward rounds to ensure timely senior input when required.	1. The maternity triage service has locally agreed criteria defining when senior midwifery, obstetric or consultant review is required in maternity triage. 2. Clear processes are in place for consultant attendance beyond the twice daily ward rounds.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		MDAU part of LW handover and consultant on call is senior obstetrician responsible for MDAU when on duty. MDAU staff supported to escalate direct to senior obstetric staff inc consultant due to either complexity or acuity though no specific agreed criteria
Ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of triage activity and escalation, with clear communication to neonatal teams where required; review triage activity during consultant-led labour ward rounds twice daily, seven days a week.	1. The maternity service has locally agreed criteria to ensure the most senior obstetrician on call for labour ward and the midwifery coordinator jointly maintain oversight of maternity triage including activity, capacity, acuity and escalation requirements. 2. Processes exist to ensure timely communication with neonatal teams where required. 3. Processes are in place to ensure triage activity is reviewed during consultant led labour ward rounds twice daily, seven days a week.	Partially in place, but inconsistent or not fully evidenced	Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below		Obstetric consultant on call has oversight of MDAU activity/ together with LW co-ordinator and maternity bleedholder
Restrict midwifery-led unit triage-type activity to low-risk term labour assessment; promptly transfer women who present with concerns requiring triage care to the appropriate obstetric unit with a designated maternity triage service.	1. Local policy clearly defines the role of Midwifery Led Units (MLUs) in assessing unscheduled attendances. 2. Clear guidance exists defining triage type activity within MLUs including inclusion and exclusion criteria. 3. A clear documented pathway exists to facilitate prompt transfer of women requiring maternity triage assessment to the designated obstetric unit.	Partially in place, but inconsistent or not fully evidenced	Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below		MDAU is part of LW handover, but aware of variable compliance Need to work on formal process for Neonatal teams input
			Financial support for clinicians time to review policies/guidelines. Please outline what support you require from your trust board below		All attendances to MDAU except low-risk term labour/ SROM assessments with prompt transfer to LW/ MDAU if concerns on face to face triage
					Only women low risk who are suitable to birth on BRO MLU can be assessed there, need to review guideline and process.
			Financial support for clinicians time to review policies/guidelines.		
Metrics	Data captured per site	Support required from Trust Boards to progress the metric		Total estimated cost to implement this initiative	
Metric: Proportion of women assessed, including initial triage and medical clinical review, within expected timeframes based on the category of urgency. Why: Monitors whether triage standards are met and flags delays linked to staffing or capacity, guiding targeted improvements.	Site Partially captures this data	Please outline what support you require from your trust board below		£0.00	Work needed to ensure reporting and data captured
Metric: Frequency of staff being redeployed from maternity triage to other maternity care areas within the unit. Why: Monitors how often triage staffing is compromised, supporting improvements to staffing plans.	Site Partially captures this data	Please outline what support you require from your trust board below			

Principle 9: Equity and equality

Services must use data and targeted action to identify and reduce inequalities.

Specification standard		Benchmarking suggestions in line with the specification		Benchmark Rating	Support required from Trust Boards to progress compliance		progress compliance of specification standard
Acknowledge and understand inequalities experienced by service users as a crucial first step.		1. The service formally recognises health inequalities and their impact on access, experience, safety and outcomes within maternity triage services.		Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Understand local population needs and service demand, including social, cultural and geographical factors, and align improvements with wider system work such as ICB-led population mapping and blueprints.		1. The service uses population health intelligence to understand the needs of the local maternity population, including demographic, clinical, cultural and socioeconomic factors.		Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Use demographic and outcome data to identify where poor outcomes are concentrated and use this to inform service design and improvements; map inequalities, for example by postcode, to visualise need and guide targeted interventions.		1. The service routinely analyses demographic data to understand variation in access, experience and outcomes across different population groups. 2. Findings from demographic and outcome data analysis informs the design of targeted interventions and improvement strategies to reduce inequalities and improve outcomes.		Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Work with local improvement initiatives and community-led organisations so lived experience meaningfully informs service improvements.		1. The service actively participates in local, regional and national improvement initiatives focussed on maternity safety, experience, equity and outcomes.		Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Ensure all staff involved in maternity triage undertake training supporting culturally safe care, including cultural competence, cultural safety, cultural intelligence and unconscious bias.		1. Staff have received training to understand and respond appropriately to diverse cultural beliefs, values, traditions and preferences that may influence care.		Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
					Financial support for clinicians time & training		
Metrics		Data captured per site		Support required from Trust Boards to progress the metric		Total estimated cost to implement this principle	
Note: Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.		Site Partially captures this data		Please outline what support you require from your trust board below		£0.00	
Metric: Equity and equality data should be captured as a defined subset of each primary dependent outcome measure, and reported both overall and stratified by ethnicity, deprivation (IMD) and spoken language.		Site Partially captures this data		Please outline what support you require from your trust board below			
Why: Helps identify variation and potential inequality in access, experience and outcomes.							

FOR BOARD ASSURANCE - SEPTEMBER 2026

Not compliant and awaiting assurance
Working towards but with significant challenge
Working towards and confident around compliance
In place and can give assurance.

Local EDI steering group in place - further work required to ensure data capture specific to MDAU Further work required with the return of the MNVP All data captured can filter to ethnicity/IMD etc.
Work underway with the EDI steering group but further work required with the return of the MNVP to engage with local communities.
Data is reviewed and analysed to understand variation in mortality case reviews/CER but further work is required to strengthen this. Further work required with MNVP and engagement officers to ensure patient voice captured and informs improvements and change.
Further work required with the MNVP and engagement officers to actively engage local communities.
EDI steering group awaiting national resources to be developed. Local utilising training packages available

Power BI dashboard under development but work required to capture patient voice

Principle 10: Data and measurement

Data must drive oversight, learning from incidents and continuous improvement.

Specification standard		Benchmarking suggestions in line with the specification	Benchmark Rating	Support required from Trust Boards to progress compliance		Estimated cost to progress compliance of specification
Collect and review all data outlined in the measurement strategy wherever feasible, ensuring a robust and representative sample; at minimum include attendance patterns, peak times and waiting times and examine inequalities for initial triage.		1. The service routinely collects and reviews all metrics identified in the measurement strategy, where feasible. 2. Processes are in place to ensure data are accurate, complete, timely and representative of maternity triage activity.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Where a metric cannot be captured, identify improvements needed to enable future capture, including timescales and whether the process is manual or automated.		1. The service has assessed all metrics within the maternity triage specification measurement strategy and identified those that cannot be currently captured. 2. Improvement plans are in place for all metrics that cannot currently be captured.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Review data at appropriate intervals—daily, weekly, monthly and quarterly—to identify trends, patterns and improvement areas.		1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Establish processes for teams to frequently review data, reflect on insights or changes, and respond to support continuous improvement.		1. The service has an agreed schedule for reviewing maternity triage data at daily, weekly, monthly and quarterly intervals. 2. The service has a process to utilise findings from data analysis to highlight areas for improvement.	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below		
Embed maternity triage within robust governance arrangements, including routine safety event review through the Patient Safety Incident Response Framework (PSIRF).		1. Maternity triage is explicitly included within the organisations maternity governance framework with defined leadership, accountability and reporting arrangements. 2. Maternity triage incidents and safety events are managed in line with the Trust's Patient Safety Incident Response Framework (PSIRF) policy and processes.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Include demographic variables such as ethnicity, language, deprivation and disability, as outlined in the measurement strategy, to understand local population needs and address inequalities in access and outcomes.		1. The service routinely collects demographic data for women accessing maternity triage in line with the measurement strategy. 2. The service can identify groups experiencing differences in access, timeliness, experience, escalation and outcomes. 3. Equity and demographic data are routinely reviewed through governance structures with clear accountability for improvement.	Partially in place, but inconsistent or not fully evidenced	Please outline what support you require from your trust board below		
Be transparent with women about why data is collected and how it will be used to improve care, especially in communities with lower trust in the healthcare system.		1. Women are provided with clear information about what data are collected, why they are collected and how they support care delivery and service improvement	Not in place, significant gaps or limited evidence	Please outline what support you require from your trust board below		

Dashboard

Principles menu

Previous123456789Next

Estimated cost to implement this standard

£0.00

FOR BOARD ASSURANCE SEPTEMBER 2026

Not compliant and significant challenge
Working towards but with significant challenge
Working towards and confident around compliance
In place and can give assurance.

Working towards a Power BI dashboard to represent all the required data metrics but this is work in progress requiring significant digital support and time

Data quality issues identified work to ensure re-training and education to staff using BSOTS form.

Working towards a Power BI dashboard to represent all the required data metrics but this is work in progress requiring significant digital support and time

System C change request made for areas that not currently captured

Key metrics are shared with Trust Board and Quality Committee via a detailed dashboard. This includes Power BI dashboards which are under development and those already created. Frequency of review would relate to how time critical the data is.

Work underway to ensure all data can be captured, this will then inform frequency.

Maternity triage incidents and safety events managed via Trust's PSIRF policy - awaiting national steer on maternity specific.

Clinical event review includes whole patient journey, including maternity triage

All data collected captures ethnicity/IMD etc - further work required for triangulation of MDAU specific data through the EDI steering group with MDAU team and MNVP.

Work required

Agenda Item Report to the Quality Committee, 13 July 2026				
Title:	Maternal Care Bundle Implementation Report			
Sponsor:	Natasha Watts, Acting Chief Nursing Officer			
Author:	Emma Northover, Director of Midwifery Sarah Walker, Consultant Obstetrician Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron			
Purpose (type an 'x' in the appropriate box(es))				
(Re)Assurance	Approval	Ratification	Information	
X	X		X	
Strategic Theme (type an 'x' in the appropriate box(es))				
Outstanding patient outcomes, safety and experience	Pioneering research and innovation	World class people	Integrated networks and collaboration	Foundations for the future
X				
Executive Summary:				
This report outlines the Maternal Care Bundle (MCB) in the context of the NHS Resolution Maternity Incentive Scheme (Year 8) Safety Action E (Care Bundles). The MCB supports the early recognition, escalation and management of maternal deterioration through structured assessment, use of early warning tools and clear escalation pathways. For NHS Resolution Year 8, there is an expectation of demonstrable implementation, robust governance and ongoing assurance. This includes evidence of staff competency, consistent application in practice and effective use of data to support learning and improvement. The report sets out the Trust's implementation plan, summarises current progress, highlights identified gaps and describes actions to strengthen delivery, with a focus on reducing maternal harm and addressing inequalities in outcomes for women and birthing people. The Quality Committee is asked to: 1. Note progress towards implementation of the Maternal Care Bundle. 2. Review the governance and assurance arrangements in place. 3. Consider the key risks and mitigation actions identified. 4. Support the implementation plan and associated improvement actions to achieve full compliance by March 2027.				
Contents:				
- Maternal Care Bundle Implementation - Appendix 1: Maternal Care Bundle Implementation Action Plan				

Risk(s):	
The implementation of the Maternal Care Bundle presents risks relating to workforce training and competency, variation in compliance during implementation, clinic and equipment capacity, and the availability of reliable data to demonstrate compliance and outcomes. Failure to address these risks may affect the Trust's ability to deliver consistent care, reduce maternal harm, meet NHS Resolution requirements and provide assurance to regulators and stakeholders. Mitigating actions are included within the implementation plan and will be monitored through established governance processes.	
Equality Impact Consideration:	N/A

Introduction

Maternal Care Bundle Implementation

Improving the recognition, escalation and management of maternal deterioration is critical to reducing avoidable harm and addressing inequalities in maternal outcomes.

The Maternal Care Bundle (MCB) forms part of NHS Resolution Maternity Incentive Scheme Year 8 Safety Action E (Care Bundles). This paper outlines the Trust's approach to implementation, with full delivery planned by March 2027, alongside proposed governance and assurance arrangements.

The bundle comprises five elements, each led by a designated Obstetric Lead, with overall oversight provided by the Obstetric Safety Lead and supported by the Maternity Quality and Safety Matron team.

Current Position

Initial review against the national implementation requirements has identified a number of areas of established practice within the Trust, including existing maternal deterioration pathways, escalation processes and governance structures.

A preliminary self-assessment has also identified areas requiring further development to achieve full compliance with all bundle requirements. These include:

- Completion of a detailed gap analysis against the national standards.
- Workforce training and competency assurance.
- Standardisation of documentation and clinical processes.
- Development of audit and compliance monitoring arrangements.
- Strengthening data collection and reporting mechanisms.

Progress against these areas will be monitored through the implementation plan detailed in Appendix 1.

Implementation

Appendix 1 details the Trust's implementation plan, which has been informed by learning from incidents, local reviews and national guidance.

Delivery is supported by the national Maternal Care Bundle implementation toolkit, enabling structured self-assessment, gap analysis and progress monitoring.

Following publication of the national implementation toolkit, work is ongoing to complete a comprehensive review of the Trust's current position against the bundle requirements and to identify any remaining actions required for full implementation.

Current self-assessment has identified areas of good practice alongside opportunities for improvement. Further work is required to achieve full compliance across all elements of the bundle, particularly in relation to workforce training, documentation, audit processes and data collection.

Quarterly updates will be provided through established governance arrangements, with the next update scheduled for July 2026.

Governance and Assurance

Assurance will be provided through:

- Quarterly implementation progress reports.
- Compliance audits against Maternal Care Bundle standards.
- Workforce training and competency monitoring.
- Review of incidents involving maternal deterioration and associated learning.
- Monitoring of process and outcome measures identified within the national implementation toolkit.
- Ongoing review of implementation risks and mitigating actions.

Oversight will be provided through the Women and Newborn Governance Committee, with escalation to the Quality Committee where appropriate.

Any significant risks, delays to implementation or concerns regarding compliance will be escalated through the Trust governance framework, including the Maternity Safety Champions and Trust Board as required.

Implementation progress and assurance metrics will be reviewed quarterly to ensure the Trust remains on track to achieve full compliance by March 2027.

Maternal Care Bundle (MCB) Implementation Plan
Aim: Full Implementation by March 2027

Recommendation complete	
Recommendation within timescale for completion	

Action		Action Owner	Target for Completion	Status
1. Establish stakeholder group for the Maternal Care Bundle.	- Obstetric Safety Lead (SEW) has oversight of the MCB, leads for each Element Identified. - Action – Review current guidance and practice and GAP analysis against each element of the MCB.	OBS Safety Lead & QAS Matrons	July 2026	
2. Education & Training	- Each of the leads to develop any MDT education as required. - Embed learning from incidents/reviews	MCB Leads	October 2026	
3. Data, Audit & Assurance	- Establish audit programme aligned to MBC - Use data/dashboards to monitor compliance and outcomes - Triangulate incidents, complaints & clinical outcomes	MCB Leads & QAS Matrons	September 2026	
4. Equity & Reducing inequalities	- Review data to identify variation in outcomes - Implement targeted improvement actions	OBS Safety Lead & QAS Matrons	October 2026	

Q1 26/27 update to be shared 24.08.26
Midpoint review: November 2026