University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	12/11/2026
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jane Harwood
Apologies	Jenni Douglas-Todd

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** 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 10 September 2026** Approve the minutes of the previous meeting held on 10 September 2026
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Audit and Risk Committee** Steve Peacock, Chair
5.2	9:25	**Briefing from the Chair of the Finance, Investment & Cash Committee** David Liverseidge, Chair
5.3	9:30	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.4	9:35	**Briefing from the Chair of the Quality Committee** Tim Peachey, Chair
5.5	9:40	**Chief Executive Officer's Report** Receive and note Sponsor: Trevor Smith, Chief Executive Officer

5.6 **Integrated Performance Report for Month 6**

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

5.7 **Fire Debrief**

10:25 Review and discuss
Sponsor: Andy Hyett, Chief Operating Officer
Attendees: Duncan Linning-Karp, Deputy Chief Operating Officer/
Sarah Swanton, Associate Director of Operations

5.8 **Break**

10:35

5.9 **Finance Report for Month 6**

10:45 Review and discuss
Sponsor: Ian Howard, Chief Financial Officer

5.10 **People Report for Month 6**

10:55 Review and discuss
Sponsor: Steve Harris, Chief People Officer

5.11 **Maternity and Neonatal Services - Thirlwall Inquiry Report**

11:05 Review and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Jessica Bown, Lead Matron - Maternity Services

5.12 **Scheduled Caesarean Birth Mapping Report**

11:20 Review and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Jessica Bown, Lead Matron - Maternity Services

5.13 **10-Point Plan for Maternity and Neonatal Services Progress Report**

11:35 Review and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Jessica Bown, Lead Matron - Maternity Services

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2026-27 Quarter 2 Review**

11:50 Review and discuss
Sponsor: Trevor Smith, Chief Executive Officer
Attendee: Martin de Sousa, Director of Strategy and Partnerships

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors' (CoG) Meeting 27 October 2026 (Oral)
12:00
Sponsor: Jenni Douglas-Todd, Trust Chair

7.2 Register of Seals and Chair's Actions Report
12:05
Receive and ratify
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 Health and Safety Services Annual Report 2025-26
12:10
Receive and discuss
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendee: Vickie Purdie, Head of Patient Safety

7.4 Review of Standing Financial Instructions
12:15
Review and approve
Sponsor: Ian Howard, Chief Financial Officer
Attendee: Phil Bunting, Director of Operational Finance

7.5 Audit and Risk Committee Terms of Reference
12:20
Review and approve
Sponsor: Steve Peacock, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.6 Finance, Investment and Cash Committee Terms of Reference
12:25
Review and approve
Sponsor: David Liverseidge, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.7 People and Organisational Development Committee Terms of Reference
12:30
Review and approve
Sponsor: Jane Harwood, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

7.8 Quality Committee Terms of Reference
12:35
Review and approve
Sponsor: Tim Peachey, Committee Chair
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

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

9 **Note the date of the next meeting: 14 January 2027**

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

10.1 **South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 2 Performance Report**

Note the report
Sponsor: Freya Pearson, Interim Chief Medical Officer

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

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

12 **Follow-up discussion with governors**

12:45

Minutes Trust Board – Open Session

Date	10/09/2026
Time	9:00 – 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd (JD-T)
Present	Jenni Douglas-Todd, Chair (JD-T) David French, Chief Executive Officer (DAF) Louisa Green, Interim Deputy Chief Nursing Officer (LW) (for N Watts) 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) Steve Peacock, NED (SP) Alison Tattersall, NED (AT)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Jessica Bown, Midwifery Quality Assurance and Safety Matron (JB) (item 5.15) Jillian Connor, Consultant Obsetrician (JC) (item 5.15) Danielle Honey, Head of Safeguarding (DH) (item 5.10) Duncan Linning-Karp, Deputy Chief Operating Officer (DL-K) (item 5.6) Hannah Mallon, Neonatal Quality Assurance and Safety Matron (HM) (item 5.15) Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian (CMb) (item 5.13) Jenny Milner, Associate Director of Patient Experience (JM) (items 5.11-5.12) Carly Springate, Head of Midwifery (CS) (item 5.15) Trevor Smith, Chief Executive Officer Designate (TS) (observing) 1 member of the public (item 2) 1 governor (observing) 4 members of staff (observing) 4 members of the public (observing)
Apologies	Diana Eccles, NED (DE) Natasha Watts, Acting Chief Nursing Officer (NW)

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

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

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

It was noted that Trevor Smith would be observing the meeting.

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

2. Patient Story

Vikki was invited to speak to the Board about her experience when she attended the Emergency Department in April 2026 with severe tonsilitis. It was noted that:

- Vikki had been triaged within 20 minutes and was referred to the Ear, Nose and Throat pathway. As a result, she was in ENT within 40 minutes and out of the hospital within four or five hours.
- Vikki reported feeling like she was treated as a human being and that she had made the right decision to come to the Emergency Department.
- The story highlighted the benefits of alternative pathways to the Emergency Department, noting that there were difficulties in sustaining some of these alternatives out-of-hours. It was also important to inform patients about these alternative pathways.

3. Minutes of the Previous Meeting held on 9 July 2026

The minutes of the previous meeting held on 9 July 2026 were approved subject to a minor amendment to item 5.11 on page 7.

4. Matters Arising and Summary of Agreed Actions

The matters arising and update in respect of the actions was noted. Action 1357 could be closed, noting that work was ongoing to improve reporting in this area.

5. QUALITY, PERFORMANCE and FINANCE

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

David Liverseidge was invited to present the Committee Chair's Reports in respect of the meetings held on 27 July and 1 September 2026, the contents of which were noted. It was further noted that:

- The committee had reviewed the Finance Report for Month 4 (item 5.8). The Trust had reported that it was on plan for the first four months of the year. However, going forward, there were risks to achievement of the plan associated with income and Cost Improvement Programme (CIP) delivery.
- The committee received a quarterly update from the Digital and Estates teams. It was noted that the committee intended to examine the longer-term risks associated with Digital.
- The committee received an update in respect of the Trust's transformation programmes. Whilst there had been some progress, a number of external factors had impacted delivery.
- The Trust's cash position had improved materially in recent months and there was no immediate need for additional cash support.
- The committee reviewed and supported business cases in relation to the OneEPR programme and the Genomic Medicine Service.
- The committee received an update on the implications of the fire in February 2026, noting that the impact on the Trust had been and continued to be significant both operationally and financially.

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

Jane Harwood was invited to present the Committee Chair's Reports in respect of the meetings held on 27 July and 25 August 2026, the contents of which were noted. It was further noted that:

- The committee had reviewed the People Report for Month 4 (item 5.9).

- The committee had, with delegated authority from the Board as agreed on 27 July 2026, reviewed and supported the Trust's plan for the job evaluation of all Band 5 nursing job descriptions and approved its submission to NHS England.
- The committee had, with delegated authority from the Board as agreed on 27 July 2026, discussed the outputs from the review by Lord Mann into racism in the NHS and had supported the adoption in principle by the Trust of the International Holocaust Remembrance Alliance's definition of antisemitism and the Government's definition of anti-Muslim hostility.
- The committee considered the implications for the Trust of the Employment Rights Act, including in terms of fixed-term contracts and the potential risk of increased numbers of Employment Tribunal claims. It was noted that the latter in particular was expected to place further pressure on the Employee Relations team.
- The committee had held a joint session with the Finance, Investment and Cash Committee on 27 July 2026 to discuss the workforce implications associated with the Trust's 2026/27 plan and its CIP plan.
- The committee considered a gap analysis against the recently published NHS Staff Standards, noting that whilst there were some gaps, the Trust was in a good position in relation to achieving full compliance with the standards (item 5.9.1).
- The committee expressed concern that a number of staff indicators appeared to be worsening.

5.3 Briefing from the Chair of the Quality Committee

Tim Peachey was invited to present the Committee Chair's Reports in respect of the meetings held on 13 July and 24 August 2026, the contents of which were noted.

- The committee received an update in relation to consultant job planning, noting the significant improvements achieved in this area. It was noted that the People and Organisational Development Committee received regular updates on job planning. Work was ongoing to develop service level job plans and to improve the consultant job planning process.
- The committee reviewed the Medicines Management Annual Report, noting that the report provided good assurance that the Trust was in a good position.
- The committee discussed the Trust's Maternity and Neonatal services in depth (item 5.15).
- The committee noted the impact of the implementation of the national safety standards for invasive procedures (NatSSIPS) and the reduction in the number of never events recorded.
- The committee also noted the improvements in infection prevention and control and the consequent impact on the number of cases of MRSA reported.
- The number of cases of pressure ulcers recorded was an area of concern, with work being undertaken to focus on this area.

5.4 Chief Executive Officer's Report

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

- The Trust had faced significant pressures over the summer period due to the impact of the heatwave, with increased demand on Accident and Emergency due to more admissions due to respiratory, stroke and cardiology as well as a worsening of underlying conditions, particularly in the frail elderly population.
- The temperatures had resulted in a challenging environment on the Trust's wards and high levels of humidity had caused sensitive equipment, such as MRIs, to stop working. The closure of local schools due to the heat had

resulted in further staffing challenges. Theatre closures had also been necessary in order to protect chilling equipment at risk of failure.

- The Trust faced additional challenges due to the constraints in the electrical supply to the Southampton General Hospital site, which meant that it was not possible to make extensive use of air conditioning units.
- There had been an unannounced inspection of maternity care at the Princess Anne Hospital by the Care Quality Commission on 28-29 July 2026. It was not believed that the inspection had been prompted by concerns raised about the service. Feedback from the inspection highlighted particular strengths in terms of the culture of the team, care, and focus on quality improvement. However, there were some concerns raised in relation to security. The concerns raised were addressed rapidly and the CQC had been satisfied with the Trust's response. The Trust had received a significant number of requests for documentation and data from the CQC as part of its inspection.
- Yvette Cooper had been appointed as Secretary of State for Health and Social Care on 20 July 2026. It was not expected that there would be a significant change in terms of the goals and objectives of the NHS, with waiting list reduction, urgent and emergency care, and the Ten-Year Plan remaining the focus.
- Members of the Trust's paediatric intensive care nursing team and members of the healthcare science team had received awards. The Board congratulated those who had received the awards.
- The Hampshire Orthopaedic Centre had treated its 1,000th patient. It was noted that consideration was being given to expanding the scope of this facility.

The Board discussed the matters raised in the Chief Executive Officer's Report. This discussion is summarised below.

- The Board acknowledged the support provided by the Southampton Hospital Charity and by the Trust's Human Resources team during the heatwave.
- It was noted that the Government had recognised the need to invest in the public estate in order to be able to manage in extreme temperatures. It was understood that funding would be sourced from that already forming part of the estates safety fund. Decisions to invest in estate improvements would form part of the Trust's capital prioritisation process based on the risk of not investing.
- The Trust had developed a plan to deal with future heatwaves and was liaising with national groups. There were significant challenges and limitations on the Trust's ability to reconfigure its estate due to the extant disruption due to the impact of the fire in February 2026.
- The Trust had developed a longer-term plan in conjunction with the National Grid and SSE to address the electrical supply issues for the Southampton General Hospital site and an electrical infrastructure risk was recorded on the Trust's risk register. This risk was overseen by the Finance, Investment and Cash Committee.
- The Board expressed its gratitude to the Trust's staff for their work during the heatwave.

It was noted that the Trust had declared a critical incident due to infrastructure failures and the high number of patients between 25 June and 2 July 2026. Andy Hyett, as Chief Operating Officer, had been the strategic commander for the duration of the incident.

5.5 Performance KPI Report for Month 4

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

- A task and finish group had met to discuss a proposed integrated performance report. It was noted that changes were to be introduced to the current report along with transformation-related metrics and the metrics relevant to the NHS Oversight Framework.
- In terms of the spotlight report on cancer care, there had been a decline in performance against the 31-day standard, largely due to a loss of scanning and diagnostic capacity across Hampshire and Isle of Wight. The Trust's performance against the 28-day faster diagnosis standard was reflective of the loss of diagnostic capacity due to the fire and the resultant inefficiencies due to the relocation of services. Performance against the 62-day standard had declined due in part to reduced theatre capacity. It was noted that health inequalities were tracked at the Integrated Care Board level and that the Trust had worked with charities in areas such as patient transport.
- The Trust's Emergency Department performance had been sustained and continued to be ahead of plan. Elective performance was broadly stable, and the Trust was focused on addressing patients waiting more than 52 weeks. However, it was noted that the need to address long-waiters whilst also managing clinically prioritised patients was a challenge. Diagnostic performance continued to be a challenge due to the heatwave and issues faced by the endoscopy service following the fire.
- The key areas of focus were corridor care and patients waiting longer than 52 weeks.

The Board discussed the Performance KPI Report for Month 4. This discussion is summarised below:

- The increase in the number of pressure ulcers was an area of concern. Meetings had been held with matrons and clinical leaders to promote engagement in relation to this issue.
- There had been an increase in the number of staffing incidents reported. It was noted that further investigation was being undertaken of the incidents reported. In addition, enhanced care arrangements were being monitored.
- The average length of stay for in-patients appeared to be increasing. It was noted that there were a number of complex patients, but that meetings were being held with local authorities to focus on the ten patients with the longest length of stay.
- The average length of time for a patient to be admitted via the Emergency Department had reduced significantly in the past six months. The Trust's focus had been on ensuring that only those who needed to be in the Emergency Department were in the department along with work to develop alternative pathways which avoided the Emergency Department.
- The urgent treatment centre was expected to open in November 2026. It would be important to ensure that the public is provided with appropriate guidance on when to use primary care, the urgent treatment centre, and the Emergency Department.
- The data for category 2 pressure ulcers per 1,000 bed days appeared to indicate a downward trend. However, it was noted that this data was being looked at.
- The number of mental health patients spending over 12 hours in Accident and Emergency appeared to have reduced. Although this represented a reduction in A&E, there was still a significant impact on wards due to this cohort of patients.

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- The number of patients having no criteria to reside continued to increase. It was noted that work had been undertaken by a third-party consultancy in conjunction with system partners. An initial report had been reviewed by the Finance, Investment and Cash Committee, which indicated that there were a number of actions the Trust could take to address this issue, however, there was a lack of capacity to deliver these improvements.

Action
Andy Hyett agreed to look at the apparent contradiction between the increasing number of My Medical Record accounts and the number of patient log ins.

5.6 UHS Operating Plan 2026-27 and Board Assurance Statement
Duncan Linning-Karp was invited to present the UHS Operating Plan 2026/27 and Board Assurance Statement, the content of which was noted. It was further noted that:

- The operating plan outlines the Trust's response to operational pressures over the winter months. It covered a range of operational themes, including infection prevention, capacity, and demand.
- The Board Assurance Statement indicated three areas where the Trust was unable to confirm the relevant statement.
- A regional exercise to test the plan was scheduled to take place in London on 14 September 2026.

The Board discussed the Operating Plan and associated Board Assurance Statement. This discussion is summarised below.

- The Board questioned the level of confidence in the number of patients having no criteria to reside.
- The Board noted that poor weather conditions impacted different communities in different ways, e.g. rural communities.
- The plan required surge capacity to be available and staffed. The Board challenged whether it could be fully assured of this, noting the challenges around staffing. However, it was further noted that there were an extensive number of mitigations in place, although the decline in People metrics was noted and the potential impact of these. It was suggested that further commentary should be added to the Board Assurance Statement to explain and/or qualify the points regarding surge capacity.
- The Board challenged the level of confidence in statement 3.4. It was noted that the trajectory had taken into account historical experience of winter. However, there remained a risk to non-urgent pathways. It was suggested that the commentary should be amended accordingly.
- With regard to 1.4 in the Board Assurance Statement, it was stated that this area was the responsibility of the Integrated Care Board. However, the Board challenged whether further assurance was required from the ICB, noting that work had not been completed in this area. It was suggested that the commentary should be amended accordingly.

Decision
Having discussed the Operating Plan for 2026/27 and Board Assurance Statements, the Board approved the plan and assurance statements, subject to the amendments outlined above.

5.7 Break

5.8 Finance Report for Month 4

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

- The Trust had reported an in-month deficit of £2.42m, £12.65m year-to-date, which was in line with the Trust's plan.
- There remained reasonable confidence that the Trust would continue to meet its plan during Months 5 and 6, but the main challenge would be the need to deliver a surplus from Month 7 onward.
- The main risks to achievement of the Trust's financial plan related to the loss of capacity, income, and inefficiencies due to the fire in February 2026. In addition, the increase in staff absence and patients with no criteria to reside, industrial action, and the heatwave placed further pressure on the Trust's ability to deliver its plan.
- Although the Trust had delivered £15.2m in savings in line with its plan, there had been a higher proportion of non-recurrent savings delivery than planned.
- Significant work was ongoing to address the number of patients having no criteria to reside with the support of a third-party consultancy and system partners. A key element of controlling the number of such patients was working on admission avoidance with partners. The challenge was being able to make the necessary changes in a reasonable timescale to deliver in-year financial benefits.

5.9 People Report for Month 4

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

- The Trust's total workforce had increased by 35 whole-time-equivalents (WTE) and the Trust was 168 WTE above its plan. This increase was driven by high levels of bank usage, which was 184 WTE above plan. This was due to operational pressures, including the heatwave, increased Emergency Department attendances, increased acuity, and challenges in Critical Care and Theatres.
- There were concerns about some of the metrics reported, including high levels of sickness absence for the time of year, and low levels of appraisal and statutory and mandatory training completion.
- In terms of sickness absence, there had been an increase in the number of mental health-related absences. The Trust had added more granular detail to the reasons for absence in order to be able to better target interventions.
- It was thought likely that the appraisal rate was low due in part to under-recording and the People Board had recently considered a recovery plan.
- The Trust was planning for 'We Are UHS Week', commencing on 12 October 2026, and which would be linked to the Trust's transformation goals. In addition, planning was underway for the annual We Are UHS Champions Awards, taking place on 26 November 2026.
- The Trust continued to implement its refreshed approach to Violence, Aggression and Abuse. The VAA Board continued to review cases and specific work was ongoing with the Emergency Department and children's services.

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5.9.1 NHS Staff Standards: Trust Response and Implementation Plan

Steve Harris was invited to present the paper 'NHS Staff Standards: Trust Response and Implementation Plan', the content of which was noted. It was further noted that:

- In July 2026, the Department of Health and Social Care had published NHS Staff Standards with the intention of levelling up standards in the NHS across six domains that staff had identified as being central to their experience at work. It was noted that the standards were mandatory and would form part of the NHS Oversight Framework.
- The Trust had undertaken a self-assessment against the standards. The Trust was in a positive position based on its existing policies and frameworks. However, work was required to strengthen assurance.
- In terms of benchmarking of its Staff Survey results, the Trust was broadly in line with the average. However, the intention was to improve these results to bring the Trust back to where it had been historically, with above-average indicators.
- The view of staff was crucial to achieving compliance with the Staff Standards.

5.10 Safeguarding Annual Report 2025-26

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

- Activity had remained high across the service with the adult team receiving 2,726 referrals and the children's team seeing a 4% increase. In addition, the level of complexity of cases had increased. This increase in demand had been seen across the region.
- A key area of focus had been transforming the service, including a restructuring of the team, review of policies, and multi-agency engagement.
- The psychological safety and wellbeing of the team was also an important area of focus.
- Work was ongoing to improve access to data by the Safeguarding team to enable better service planning and improved inter-connectivity between teams.
- The level of training compliance remained an area of challenge, with work being undertaken with education leads to better understand training requirements.
- There had been a 13% increase in the number of Deprivation of Liberty Safeguards applications. Following the recent decision by the Supreme Court, it was expected that the complexity of these applications would increase significantly.

5.11 Annual Complaints Report 2025-26

Jenny Milner was invited to present the Annual Complaints Report for 2025/26, the content of which was noted. It was further noted that:

- During 2025/26, the Trust had recorded 8,726 interactions with its Patient Advice and Liaison Service (PALS). This represented a 20% increase in demand.

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- The Trust had received 503 complaints, of which 46% had been fully or partially upheld. Six cases had been referred to the Parliamentary and Health Service Ombudsman, of these, two had been partially upheld.
- The primary themes of complaints were consistent with the previous year: clinical treatment, communication, and appointments.
- Complaints were of increased complexity with A/I being used in generating the complaint. The Trust was investigating the possibility of using A/I tools to assist with its responses.
- Learnings from complaints and tracking of the implementation of actions arising from complaints was an area of focus for 2026/27.

5.12 Learning from Deaths 2026-27 Quarter 1 Report

Jenny Milner was invited to present the Learning from Deaths Report for the first quarter of 2026/27, the content of which was noted. It was further noted that:

- The Trust continued to benchmark well and remained one of eight trusts reporting lower-than-expected numbers of deaths based on its Summary Hospital-level Mortality Indicator (SHMI) data.
- The Medical Examiner Service had reviewed 1,229 deaths during the period, of which 458 had occurred on UHS sites, the remainder of which had occurred within the community.
- Key areas of focus were the quality of deaths at UHS and on deaths of those with learning disabilities.
- Changes had been introduced following the death of a mental health patient in the Acute Medical Unit.
- One particular challenge of note during the period had been handling the death of a patient who had expressed a wish to be cryogenically frozen.

5.13 Freedom to Speak Up Report

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

- A national review had highlighted the concern that temporary and overseas-trained staff might experience additional barriers to speaking up. The Trust was taking steps to increase awareness of Freedom to Speak Up and support staff in these groups.
- The themes reported via Freedom to Speak Up remained similar to those set out in previous reports. There had been an increase in the number of reports, but it was unclear whether this was due to better awareness on the part of staff or an increase in incidents.

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

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

- The Trust had recorded a compliance rate of 89%.
- The Trust had trained 201 appraisers, an increase of eight.

- A quality assurance exercise was conducted during the year, which reviewed 293 appraisals, of which 99.3% scored between 75% and 100%.
- The only area of non-compliance set out in the Statement of Compliance was because the Trust had not completed a peer review.

Decision
Having reviewed the Medical Appraisal and Revalidation Annual Report, the Board approved the Board Statement of Compliance, confirming that the Trust, as a designated body, was compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended).

5.15 State of Maternity and Neonatal Services 2026/27: Strategic Position, Risks and Priorities

Tim Peachey, Jessica Bown, Carly Springate and Hannah Mallon were invited to present the paper 'State of Maternity and Neonatal Services 2026/27: Strategic Position, Risks and Priorities' and the associated appendices, the content of which was noted. It was further noted that:

- The report provided an overview of the Trust's position in the context of the increased scrutiny of maternity and neonatal services. The Trust's services demonstrated many areas of strength, including governance, compliance with key national safety requirements, multidisciplinary training compliance, and a proactive and learning-focused culture.
- In terms of its review of the National Triage Specification (Appendix E), it was noted that the Trust was doing well against the requirements. The main challenge concerned the Trust's estate, as the area was not suitable, as had been raised by the CQC, due to a lack of privacy and the space being inadequate for the demand. However, improvements were part of the Trust's four-year capital plan.
- The Trust should expect criticism from the CQC of its day assessment unit due to estates issues.
- It was expected that NHS England would mandate use of Birthrate+ numbers to determine workforce establishments. This would pose a challenge, as workforce numbers were currently nine below the Birthrate+ number.
- Demand for services continued to rise, with increasing levels of complexity and acuity. In addition, the increase in the number of births via caesarean section placed pressure on available theatre capacity.
- The Trust was able to maintain patient safety, but staffing numbers were having an impact on patient experience.
- The recent CQC unannounced inspection had provided assurance that the fundamentals of the service were good.

It was noted that the appendices had been reviewed in detail by the Quality Committee and that there was nothing requiring escalation to the Board from the Maternity and Neonatal Safety Reports from Quarter 4 of 2025/26 and Quarter 1 of 2026/27 (Appendices A and B) and from the Maternity and Neonatal Workforce Report (Appendix C).

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Post-Meeting Note: The Board approved the submission of its NHS England Maternity and Neonatal 10-Year Plan assessment and the Trust's National Triage Specification submission to NHS England on 25 September 2026.

6. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

6.1 Register of Seals and Chair's Actions Report

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

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

7. Any other business

It was noted that this would be the last formal meeting held in public for both David French and Paul Grundy. The Board expressed its gratitude to both David French and Paul Grundy for their services as, respectively, Chief Executive Officer and Chief Medical Officer.

8. Note the date of the next meeting: 12 November 2026

9. Items circulated to the Board for reading

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

10. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

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University Hospital Southampton
NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 10/09/2026 - 5.5 Performance KPI Report for Month 4				
1392.	My Medical Record	Hyett, Andy	12/11/2026	Pending
	Explanation action item Andy Hyett agreed to look at the apparent contradiction between the increasing number of My Medical Record accounts and the number of patient log ins.			

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.1

Committee Chair's Report to the Trust Board of Directors 12 November 2026	
Committee:	**Audit & Risk Committee**
Meeting Date:	**9 October 2026**
Key Messages:	• The committee reviewed the proposed changes to the Trust's Board Assurance Framework, noting the intention to align the BAF with the Trust's 2026-30 strategy, to incorporate longer-term milestones, revise risk appetite statements and to introduce assurance ratings. The committee provided feedback in respect of the proposed framework, particularly in terms of the proposed assurance ratings. • The committee received a report on 'lessons learned' from the 2025/26 accounts, noting the recommendations from the external auditor's report in relation to the Modern Equivalent Asset valuation, fixed assets accounting, lease accounting and other systems and controls. The committee noted the work being carried out to address the recommendations and that there was reasonable assurance that issues identified in 2025/26 would be addressed by the year end. The committee noted that the report only addressed the recommendations from the audit of the financial statements and not the Value For Money audit. • The committee noted the Trust Write Off Report, which reported that £1.3m had been written off as being irrecoverable. The vast majority of this amount related to historical debts owed by overseas patients when payment processes were less robust. • The committee discussed the Waivers of Competitive Tendering granted between 1 April and 30 September 2026. • The committee reviewed the Trust's National Cost Collection submission for 2026 and ratified the decision to submit the return to NHS England. The committee noted that the Finance, Investment and Cash Committee would undertake further detailed review of the data along with any outcomes or learnings. • The committee reviewed the progress of the 2026/27 internal audit programme and discussed the findings from audits of the Data Security and Protection Toolkit and Mental Health Pathways Governance. The committee noted that the Mental Health Pathways audit resulted in a 'moderate' design opinion and 'limited' effectiveness opinion. The Trust was participating in a national programme on enhanced care concluding in March 2027. Following the conclusion of this programme, the Trust expected that a number of changes would be required to policies/procedures. This work would be overseen by the Quality Governance Steering Group and Quality Committee. • The committee discussed the Trust's proposed internal audit plan covering the period 2026-2029, noting sources of assurance in addition to that provided by the internal auditor. The committee considered the breadth and scope of the proposed plans and agreed to discuss the plan further. • The committee received the annual report from the Trust's Local Counter-Fraud Specialist, noting that activity had generated an annual fraud prevention saving of £154,000. The committee noted the progress of the 2026/27 work plan, particularly the activities which had been undertaken in relation to the risk of imposter fraud.

Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**7.4 Review of Standing Financial Instructions 2026**	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• The committee reviewed the proposed changes to the Trust's Standing Financial Instructions and agreed to recommend the updated Standing Financial Instructions to the Board for approval. • It was noted that there were ongoing discussions in relation to changes to procurement approval thresholds. Once these discussions had been concluded, the committee would consider any further changes required.		
	7.5 Audit and Risk Committee Terms of Reference	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• The committee reviewed proposed changes to its terms of reference, noting that the most significant amendment was the introduction of an Appendix B setting out the committee's key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. • The committee approved the proposed changes and agreed to recommend the terms of reference to the Board for approval.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 i)

Committee Chair's Report to the Trust Board of Directors 12 November 2026	
Committee:	**Finance, Investment and Cash Committee**
Meeting Date:	**2 October 2026**
Key Messages:	• The committee received the Finance Report for Month 5, noting that the Trust had reported an in-month deficit of £1.9m, £14.6m year-to-date in line with the Trust's plan. Delivery under the Trust's Cost Improvement Plan was also in line with the Trust's plan. However, the Trust's underlying deficit had remained relatively static at c.£4.5m per month and workforce was also c.270 whole-time-equivalents above plan. • The number of patients having no criteria to reside had gradually increased since the fire to 232 in August 2026. In addition, the Trust had not experienced the expected reduction in bank staff utilisation following its investment in the substantive workforce. The committee noted a significant risk to the Trust's income due to the impact of the fire and consequent loss of elective capacity. • The committee noted that the Trust had submitted its financial route map for 2026/27 to NHS England. • The committee received an update on the Trust's productivity, noting that the Trust benchmarked well in terms of cost-weighted activity. However, there remained some areas where the Trust was not as efficient as it could be. The National Cost Collection Index indicated that the Trust achieved 5% lower-than-average costs overall, although productivity had declined during 2025/26 due in part to the fire. The Trust's corporate services all benchmarked in the first and second quartiles. • The committee received an update on the Trust's Intelligent Automation Transformation Programme, noting the work ongoing to improve patient administration processes and plans to introduce ambient voice tools. • The committee noted a proposed specification for third party assistance with cross-system work to address patients having no criteria to reside. • The committee discussed the impact of the fire on 1 February 2026 and the Trust's recovery efforts. The committee noted the ongoing disruption and the impact on the Trust's finances and operations. • The committee received an update in relation to the Trust's capital plan for 2026/27, noting that there was confidence that the Trust would be able to deliver its capital plan for the year.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**N/A**
Any Other Matters:	The committee received reports from UHS Pharmacy Limited and from Wessex Procurement Limited.

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 ii)

<table>
<tr><td colspan="3">Committee Chair's Report to the Trust Board of Directors
12 November 2026</td></tr>
<tr><td>Committee:</td><td colspan="2">Finance, Investment and Cash Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="2">2 November 2026</td></tr>
<tr><td>Key Messages:</td><td colspan="2">• The committee received the Finance Report for Month 6 (see below).
• The committee discussed the proposed changes to the Trust's Board Assurance Framework and provided feedback in terms of the articulation of the risks within the committee's remit and the proposed current and target ratings.
• The committee discussed the Trust's financial position and financial route map for 2026/27 at length.
• The committee considered the work carried out by PA Consulting in terms of service reviews and the development of a financial recovery plan.
• The committee received an update on the Trust's Urgent and Emergency Care Transformation Programme, noting that whilst length of stay had reduced in some areas, this had not yet significantly impacted the Trust as a whole. It was noted that the increasing number of patients having no criteria to reside represented the biggest risk to the Trust's achievement of its plans in this area.
• The committee received a quarterly update from the Digital team, noting continued progress in terms of the delivery of the Trust's plans.
• The committee reviewed the Trust's cash position at 30 September 2026 and forecast to 31 March 2027. It was noted that the Trust expected to require additional cash support prior to 31 March 2027 and the committee supported a proposal to request support from NHS England in January 2027 and in March 2027.
• The committee supported a proposal to open c.20 beds at the Western Community Hospital site for stroke rehabilitation.
• The committee noted an update in relation to the proposal to develop a Community Diagnostics Centre at the Royal South Hants Hospital.</td></tr>
<tr><td rowspan="2">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.9 Finance Report for Month 6</td><td>Assurance Rating:
Reasonable</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust had reported a year-to-date deficit of £28.3m, which was £12.3m adverse to plan. This variance was due to the under delivery of Elective Recovery Fund income due to loss of capacity due to the fire.
• The Trust's Cost Improvement Programme had delivered £24.4m of savings in line with plan.
• The Trust's underlying deficit had increased to £4.9m due to continued workforce pressures, as the Trust had not experienced the expected reduction in bank staff utilisation following its investment in its substantive workforce.
• The committee noted that there was £61m of risk to achievement of the Trust's 2026/27 plan. This included risks concerned with under-delivery of CIP, the direct and indirect costs of the fire (including loss of income), and possible loss of deficit support funding.</td></tr>
</table>

	7.6 Finance, Investment and Cash Committee Terms of Reference	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• The committee reviewed proposed changes to its terms of reference, noting that the most significant amendment was the introduction of an Appendix B setting out the committee's key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. • There were also a number of other minor amendments to the terms of reference. • The committee approved the proposed changes and agreed to recommend the terms of reference to the Board for approval.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.3 i)

Committee Chair's Report to the Trust Board of Directors 12 November 2026	
Committee:	**People & Organisational Development Committee**
Meeting Date:	**28 September 2026**
Key Messages:	• The committee reviewed the People Report for Month 5, noting that the total workforce position had increased by 148 whole-time-equivalents (WTE), which was 270 WTE above plan. There had been high levels of bank staff utilisation during August 2026 due to the heatwave and operational pressures. Whilst the Trust had taken steps to increase its substantive workforce, the expected reduction in bank staffing had not occurred. • The committee discussed the implications of the agreement between the British Medical Association and NHS England in relation to locally employed doctors. It was noted that whilst granting substantive contracts to such doctors would provide stability, there was a risk that this would reduce flexibility and limit promotion opportunities for this group. In addition, there would be a significant impact on certain schemes operated by the Trust such as its fellowship scheme. • The committee undertook a detailed review of appraisal completion and sickness rates. It was noted that whilst the in-month sickness rate had reduced to 3.8%, this masked some areas where there remained challenges. Work was ongoing to provide greater detail of the reasons for sickness to enable the Trust to provide more effective support and/or interventions. In addition, it was proposed to introduce a number of improvements in terms of occupational health provision. • It was noted that the Trust's appraisal completion rate was 64.6%. For Band 8a and above grades, only 52% of staff had an appraisal recorded in the system. However, it was considered that this did not reflect the true picture of appraisal completion rates, which was believed to be higher. The committee noted the action plan to address appraisal completion rates. • The committee noted that statutory training compliance was 71% and mandatory training compliance was 81%. The Trust was intending to undertake a number of actions to address this issue, including options for protected time, a data quality review, and training needs analysis. • The committee reviewed the results from the GMC National Training Survey of Deanery trainees. Sixty per cent of trainees and 34% of trainers had participated in the survey. Overall satisfaction was higher than the national average, but there remained areas where there were still concerns, including Surgery, Haematology and Histopathology.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	N/A
Any Other Matters:	N/A

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.3 ii)

Committee Chair's Report to the Trust Board of Directors 12 November 2026			
Committee:	**People & Organisational Development Committee**		
Meeting Date:	**2 November 2026**		
Key Messages:	• The committee reviewed the People Report for Month 6 (see below). • The committee received a presentation on Critical Care and Theatres Recruitment, noting the impact of vacancies in both teams and that this resulted in reduced elective capacity and theatre cancellations. It was noted that staffing levels were impacted by a combination of hard-to-recruit-to roles and sickness absence. An incentive had been agreed in order to encourage staff to fill additional bank shifts. There was confidence, however, that plans were in place to address the most pressing concerns by January and February 2027. • The committee received an update in relation to the Trust's measures to improve inclusion and its progress against its strategy. The Trust's positive action leadership programme had been successful, with the fourth cohort having recently completed the programme. There had been an increase in the number of staff having completed the Actionable Allyship training, with 80% having now completed it. The Trust's steps to enhance the effectiveness of its approach to violence, abuse and aggression was also a positive development. The Trust was taking steps to implement NHS England guidance following the Supreme Court decision in relation to sex and gender under the Equality Act. • The committee reviewed the proposed changes to the Trust's Board Assurance Framework and provided feedback in relation to the proposed articulation of the People-related risks and the proposed risk ratings and targets. • The committee noted the scheduled industrial action by consultants between 25 and 26 November 2026 and the likely impact on elective activity.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.10 People Report for Month 6**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **Medium**
	• The Trust had reported that its total workforce was above plan by 207 whole-time-equivalents (WTE). Whilst there had been a reduction in bank staffing since the peak in August 2026, bank utilisation was 139 WTE above plan. • The sickness absence rate remained above target at 4.07% and continued to be an area of focus. • The Trust's work to transition locally employed doctors onto substantive contracts following the agreement between NHS England and the British Medical Association continued, with all but a few doctors agreeing to the proposed change. The Trust had submitted requests for exemptions from this arrangement for certain specialist programmes and roles, but was still awaiting a response. • The Staff Survey 2026 had opened, with 33% of staff having completed the survey. • Thirty-three per cent of staff had received a flu vaccination, against a national target of 60%.		

	• The Trust expected that the most likely outturn at the end of the year was that the Trust would be 770 WTE above its workforce plan. The Trust had engaged PA Consulting to review opportunities to reduce the size of its temporary workforce.		
	7.7 People and Organisational Development Terms of Reference	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• The committee reviewed proposed changes to its terms of reference, noting that the most significant amendment was the introduction of an Appendix B setting out the committee's key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. • There were also a number of other minor amendments to the terms of reference. • The committee approved the proposed changes and agreed to recommend the terms of reference to the Board for approval.		
Any Other Matters:	N/A		

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.4

Committee Chair's Report to the Trust Board of Directors 12 November 2026			
Committee:	**Quality Committee**		
Meeting Date:	**12 October 2026**		
Key Messages:	• The committee received an update on progress against the Trust's 2026/27 Quality Priorities, noting that there had been good progress in areas such as engagement with carers, embedding of Call for Concern, the Fundamentals of Care programme, and health inequalities. • The committee noted that two new Patient Safety Incident Investigations had been reported, both linked to 'failure to rescue', and that pressure ulcers, infection prevention, and falls remained areas of focus. • The committee received a quarterly update on the Fundamentals of Care programme, noting that there were concerns regarding the perception by staff that there were insufficient staff and the impact of staffing levels on quality of care. Whilst most areas were running below establishment, a combination of bank staff utilisation and moving staff from other areas was used to mitigate this situation. There were also concerns regarding the availability of mental health staff and the increasing need for enhanced care provisions. • The committee received a quarterly report on Mental Health, noting that significant issues were being experienced with patients without a medical need being brought into the Emergency Department. It was noted that Hampshire and Isle of Wight was piloting a system to track all section 136 patients across the system. • The committee reviewed the Annual Clinical Audit Programme, noting that there were 75 audits on the national plan, with a plan to contribute to 67 of these.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.12 Scheduled Caesarean Birth Mapping Report**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **Medium**
	• The committee reviewed a report on Scheduled Caesarean birth capacity, noting that scheduled Caesarean rates had risen from 13.5% in 2022 to 18.4% in 2026. • The Trust had implemented a range of mitigating actions since a previous review conducted in 2021, including increasing planned Caesarean capacity. • The committee noted ongoing risks relating to the Trust's ability to meet demand for both elective and emergency obstetric theatre capacity and the impact on benign gynaecology services. • It was a requirement of the NHS Resolution Maternity Incentive Scheme that trusts demonstrate that capacity was sufficient to deliver timely elective and emergency maternity and neonatal care, which includes a need for the Trust to undertake annual demand capacity mapping for planned Caesarean birth lists.		

	7.8 Quality Committee Terms of Reference	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• The committee reviewed proposed changes to its terms of reference, noting that the most significant amendment was the introduction of an Appendix B setting out the committee's key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. • The committee approved the proposed changes and agreed to recommend the terms of reference to the Board for approval.		
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.
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No Assurance	There is a fundamental breakdown or absence of core internal controls such that the organisation cannot rely upon them to manage the risks to the continuous and effective achievement of the objectives of the process. Immediate action is required to improve the adequacy and effectiveness of controls.
Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.5 Report to the Trust Board of Directors, 12 November 2026	
Title:	Chief Executive Officer's Report
Sponsor:	Trevor Smith, 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:

- Budget
- NHS England Single-Sex Spaces Guidance
- Industrial Action
- Access to Patient Medical Records
- Martha's Rule
- Health Bill
- Hampshire County Council Budget Consultation

In accordance with the request from NHS England, the Board is requested to review the NHS England Single-Sex Space Guidance and to satisfy themselves that their organisation is prepared to respond appropriately.

Contents:

Chief Executive Officer's Report

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

Budget

The Chancellor of the Exchequer presented his first Budget on 28 October 2026, setting out the Government's tax and spending plans. The Budget included a number of announcements:

- One-off payments for up to 20m households to help deal with rising energy bills.
- A commitment to remove standing charges from electricity bills.
- An increase in tax on income from savings and property rental, and increases in the threshold at which businesses become subject to paying business rates.
- Increases in the state pension and legal minimum wage.
- Cuts to the capital budgets of government departments in order to fully fund a Defence Investment Plan.

The Chancellor also announced that the Government would introduce a new category of ring-fenced spending at the 2027 Spending Review – preventative departmental expenditure limits (PDEL).

In terms of the key announcements in relation to healthcare and the NHS, the Budget included:

- £190m of new funding in 2026/27 to help with winter pressures.
- An independent review on using AI to boost NHS productivity.
- Use of quantum technologies to cut NHS waiting lists through more effective health diagnostics.
- £100m to accelerate the adoption of robotically assisted surgery across England.

The Department for Health and Social Care's capital budget has been reduced in 2027/28 from £13.3bn to £13bn due to the need to identify areas where spending could be reduced to help fund the Defence Investment Plan.

NHS England Single-Sex Spaces Guidance

Following the decision by the Supreme Court in April 2025 that the terms 'man', 'woman' and 'sex' in the Equality Act 2010 refer to biological sex at birth, not acquired gender, NHS England has published the following guidance to support NHS organisations in the provision of single-sex services in line with the relevant legislation and statutory guidance:

- Privacy, dignity and safety in hospital accommodation
- Guidance on NHS staff facilities

The Privacy, dignity and safety in hospital accommodation guidance reaffirms the NHS Constitution's commitment to single-sex accommodation and sets out how providers should meet their responsibilities to all patients.

The new staff facilities guidance recommends that organisations review provision for toilets and changing, washing and shower facilities, as well as staff accommodation with shared facilities. Organisations must continue to ensure that all staff have access to facilities to protect their privacy, dignity and safety.

Boards have been requested to review both guidance documents and to satisfy themselves that their organisation is prepared to respond appropriately.

The guidance can be read at: https://www.england.nhs.uk/long-read/guidance-to-support-nhs-organisations-in-the-provision-of-single-sex-services-and-facilities/

The Trust has formed a Supreme Court Ruling Steering Group, chaired by the Chief People Officer. This group is due to meet on 10 November 2026 and regularly thereafter. The Trust recognises the sensitivities around this subject and the issues it addresses. Throughout its work, the Trust is committed to upholding NHS values by maintaining dignity, privacy, safety, and respect for all patients, staff and visitors. The Trust will also work with its staff network groups to use employee voice to shape its continued response.

Industrial Action
The British Medical Association (BMA) has announced further industrial action by consultants in a dispute over pay and working conditions. Consultants will strike on 25 and 26 November 2026, with consultants staffing emergency care only. This will be the first time consultants have taken industrial action since 2023.

In the strike ballot conducted in July 2026, 76% of consultants who took part voted in favour of strike action, with just over half of eligible BMA members voting.

The Trust annual UHS Champions awards was due to take place on 26 November. The trust has taken the difficult decision to postpone these awards until early in the new year,

Access to Patient Medical Records
NHS England wrote to trusts on 25 September 2026 setting out new measures in relation to inappropriate access of patients' medical records. NHS England states that staff suspected of improperly and unlawfully accessing patients' medical records will face immediate suspension and have their access to NHS computer systems cut off as part of a 'zero-tolerance' approach.

There have been a series of high-profile incidents where it has been found that healthcare workers have accessed patient records without a legitimate reason for doing so, and the Information Commissioner's Office warned healthcare organisations to get on top of this 'worrying trend' in June 2026.

The Trust has recorded and reported a number of incidents of inappropriate access of patient records. The trust has always taken a robust approach to management of these cases when they sadly arise. In some cases, this has led to dismissal or other sanction under the Trust's disciplinary policy. The Trust undertakes both proactive and reactive monitoring of patient records to identify instances of inappropriate access and is investigating what more it can do in this area.

The Trust has also publicised its approach to staff over the summer to remind our people of our responsibilities around the stewardship of sensitive patient data.

Martha's Rule
On 21 September 2026, NHS England wrote to all NHS trusts encouraging them to implement Martha's Rule in Emergency Department services, with implementation expected to be completed by the end of March 2028. Trusts have been encouraged to build on existing local escalation processes and governance structures, align with existing outreach escalation processes, and work across multidisciplinary teams to test and adapt approaches.

Martha's Rule, launched in May 2024, is a key patient safety initiative that enables patients, families, carers and staff to request a rapid review by an independent clinician if they are worried a patient is deteriorating and their concerns are not being listened to. Martha's Rule has been introduced into all NHS adult and/or paediatric acute inpatient services in England. Implementation is now being extended into maternity and neonatal services and into Emergency Departments. The Trust is rolling out this requirement via its Call for Concern initiative.

Health Bill
The Health Bill, introduced in May 2026, is currently in the committee stage in the House of Lords. The Bill seeks, among other things, to abolish NHS England and merge its functions into the Department of Health and Social Care. In addition, the Bill originally proposed to abolish Healthwatch England and to transfer its functions to integrated care boards and local councils. However, it was announced on 28 October 2026, that the Government has abandoned plans to abolish Healthwatch and will instead seek to expand its role.

There have been a number of changes in the Health Bill, including reversal of the proposal to abolish the Health Services Safety Investigations Body. A key area of debate as the Bill passes through the Houses of Parliament has been in respect of the apparent contradiction between the Government's broader pro-devolution stance and the proposals to centralise control over aspects of the NHS in England.

Healthwatch England is a statutory committee of the independent regulator, the Care Quality Commission. Its main statutory functions are: to provide leadership, guidance, support, and advice to local Healthwatch organisations; to escalate concerns about health and social care services which have been raised by local Healthwatch to the CQC; and to provide advice to the Secretary of State, NHS England and local authorities.

Hampshire County Council Budget Consultation
On 2 November 2026, Hampshire County Council launched its budget consultation, inviting residents, service users, partners, and stakeholders to share their views.

Hampshire County Council highlight the significant financial pressures faced by the Council, with increasing demand for services and increasing costs. The Council is forecasting a budget shortfall of almost £199m in 2027/28.

The consultation sets out a number of options for addressing the Council's budget gap, including:
- Delivering efficiencies
- Lobbying central government for additional funding and legislative changes
- Generating extra income
- Introducing and increasing charges for some services
- Reviewing service delivery models
- Reducing and stopping services
- Delaying spend
- Increasing Council Tax
- Using reserves or borrowing

The consultation and how to respond can be viewed at:
www.hants.gov.uk/budgetconsultation

The consultation runs until 13 December 2026.

Agenda Item 5.6 Report to the Trust Board of Directors, 12 November 2026	
Title:	Integrated Performance Report 2026-27 Month 6
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Sam Dale, Associate Director of Data and Analytics

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

Outstanding 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 overarching narrative summary highlighting any key changes to the monthly indicators presented and an overview of the trust position across the reported metrics
- Overview metrics from the most recent National Oversight Framework publication
- Latest position for key performance indicators across the Trust
- Underlying trend charts for all metrics
- Guide to the icons and charts used in the report

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

Integrated Performance Report

Board performance overview and statistical process control detail

Reporting period: September 2026

Glossary

A quick guide to the icons and charts used in this report.

Chart types

SPC charts

Chart type	What it shows
XmR chart	Tracks one result per time period and the change between consecutive results. It helps identify whether a pattern may reflect a real change in performance rather than routine variation.
X-bar/S chart	Tracks the average result and the spread of underlying cases within each period. It is useful when each month includes many cases, such as patient-level length of stay.
P chart	Tracks the proportion of cases with an outcome, such as the share meeting a standard. It uses numerator and denominator counts, so limits account for changing numbers of cases.
Laney p′ chart	A proportion chart for data with more variation than a standard P chart expects. Adjusted limits help distinguish a meaningful signal from extra routine variation.
C chart	Tracks event counts when the opportunity for events is stable in every period, such as the same population and reporting timeframe.
U chart	Tracks event rates when the amount of exposure can change, such as pressure ulcers per 1,000 bed days. The exposure count is included in the limits.
Laney u′ chart	An event-rate chart for data with more variation than a standard U chart expects. Adjusted limits help avoid over-interpreting routine variation.
T chart	Tracks the time between rare events. Each point is the time since the previous event; a longer interval means events are occurring less often.
G chart	Tracks the number of opportunities between rare events. More opportunities between events means the events are occurring less often.

Non-SPC charts

Chart type	What it shows
Trend	Shows the measure over time without statistical control limits. It is useful for seeing direction and broad patterns, but does not distinguish routine variation from a process change.
Bar chart	Compares values across categories or periods. It gives a straightforward view of size and differences, without SPC centre lines or control limits.
Variance column chart	Shows financial performance against plan. Columns display the difference between actual and planned values, making the size and direction of the variance clear.

Summary icons

Icon	Column	Meaning
▲	Improvement	Month-to-month performance is improving.
▼	Improvement	Month-to-month performance is deteriorating.
▶	Improvement	No month-to-month change is detected.
	Variation	Special cause signal: unusually high value indicates improvement (blue) when higher is better.
	Variation	Special cause signal: unusually high value is concerning (orange) when lower is better.
	Variation	Special cause signal: unusually low value indicates improvement (blue) when lower is better.
	Variation	Special cause signal: unusually low value is concerning (orange) when higher is better.
	Variation	No special cause signal; the change is consistent with routine process variation.

Icon	Column	Meaning
	Assurance	The metric will consistently meet its target.
	Assurance	The metric will sometimes meet its target.
	Assurance	The metric will never meet its target.
—	Assurance	SPC chart with no target.
N/A	Assurance / Variation	Not applicable - not an SPC chart.

Report summary

Introduction

The Trust has completed a full refresh of the Integrated Performance Report (IPR) to bring together operational performance, quality, safety, patient experience, workforce and finance metrics to provide the Board with a more integrated view of Trust performance. It incorporates the latest National Oversight Framework (NOF) measures and benchmarking, alongside statistical process control (SPC) charts that distinguish routine variation from meaningful changes in performance to indicate whether current processes can consistently deliver required standards. The redesign supports NHS England's recommended approach to Board assurance, moving beyond individual monthly results and RAG ratings towards a clearer understanding of trends, underlying causes and priorities for improvement. Supported by an overarching narrative, the report is intended to strengthen Board scrutiny, assurance and decision-making by making the connections between organisational pressures, improvement actions and outcomes more explicit. Future developments will include trajectories against operational standards and metrics for transformation programmes. The trust will continue to develop the IPR over time to support the needs of the Board.

National Overview

The latest National Oversight Framework (quarter one) placed UHS in adjusted segment 3 moving from segment 2 due to the financial override as the trust is receiving deficit support funding. The trust ranked 42nd out of 134 acute trusts with the strongest domain assessment in People at segment 1. The overall picture is one of important areas of organisational strength and quality assurance alongside sustained operational and financial pressures, particularly relating to capacity, patient flow and access.

Demand, capacity, flow and access

Operational performance continues to be significantly influenced by the interaction between capacity and patient flow. The elective waiting list remains just below 65,000, and although growth slowed across August and September, capacity and patient-flow constraints continue to limit consistent delivery of several elective waiting-time standards. Long waits remain concentrated in a number of specialties where complex surgery, non-elective demand and the prioritisation of cancer and urgent patients constrain elective capacity. All key specialties have developed recovery trajectories as the trust maintains its ambition to deliver the 26/27 annual plans.

Despite the challenges, there are encouraging signs within access performance. The latest 62-day cancer position of 78.3% is above target and ranks UHS second amongst peer teaching hospitals. This represents an improvement from 74.4% in July, despite continued constraints across diagnostics, specialist surgical capacity and some high-demand pathways. The Faster Diagnosis and 31-day standards remain areas for recovery, with underlying capacity issues including ENT, Breast, Endoscopy and Radiotherapy identified in recent months.

Urgent care also demonstrates the importance of considering absolute and comparative performance together. Four-hour performance remains marginally below trajectory at 80.3%, but UHS ranks first amongst teaching hospitals. This has been achieved in the context of continued pressure on the emergency pathway and does not remove the impact of crowding on patients, illustrated by more than 2,000 episodes of corridor care during September.

The underlying constraint continues to be flow through and out of the hospital. On average, around 236 medically optimised patients were awaiting discharge, while occupied beds and length of stay remain above plan. This reduces the capacity available to absorb emergency demand and support planned care. Mental health demand adds further complexity, with activity above plan and prolonged waits in ED. Improving discharge and flow therefore has benefits extending beyond urgent care, with the potential to release capacity, improve patient experience and support elective productivity. The Trust is now preparing for the opening of the Urgent Treatment Centre to ensure patients are treated in the most suitable environment and to reduce pressure on the main emergency department.

Quality, outcomes and experience

Importantly, the operational pressures have not translated into deterioration across the key measures of clinical outcome. Mortality continues to provide strong assurance, with a SHMI of 0.83 which is below the threshold. There were zero Never Events during September and maternity stillbirth performance remains within target. Following inspections earlier in the year, the CQC has now rated both end of life care and services for children and young people as 'good', with end of life care rated 'outstanding' for caring. This is a strong result reflecting the skill and dedication of teams across both services. A separate unannounced inspection of urgent and emergency care, surgery and outpatients took place in October. While the formal outcome is not expected for some time, initial feedback was positive, particularly in relation to the culture experienced by inspectors, the kindness and compassion of colleagues, strong teamwork, and patients' and families' experiences of care.

Patient experience metrics illustrate relative resilience. Inpatient FFT negative responses remain comfortably within target at 2.6%, with SPC indicating consistent achievement, while measures relating to involvement in decisions and meeting additional needs are close to, but below, the 90% target. These areas remain important given the continuing operational pressure and incidence of corridor care, overnight non-clinical ward moves and extended ED stays for some mental health patients.

There are, however, specific safety priorities where improvement needs to be sustained. Infection prevention, pressure damage, medication errors, falls and safe staffing remain areas of focus. Previous review of pressure ulcers identified good completion of screening tools and care plans but opportunities to strengthen positioning, intentional rounding, heel offloading and skin assessment, with a Trust-wide improvement plan in place. Learning from patient safety investigations is also driving changes to escalation, documentation and ownership of urgent imaging.

Outcomes continue to provide important assurance, while areas of preventable harm require continued attention to ensure that prolonged operational pressure does not undermine fundamental standards of care.

People, productivity and financial recovery

The workforce position also contains important strengths. Turnover is 9.6%, comfortably within target, and SPC provides assurance that the current process will continue to achieve the standard. The national framework similarly places People in segment 1, with UHS performing particularly strongly nationally for sickness absence and flu vaccination within the published NOF measures. Internally, sickness remains slightly above the Trust target and non-clinical appraisal compliance requires further improvement.

The principal workforce challenge is increasingly one of aligning capacity and cost with the operational model. At Month 6 workforce was 207 WTE above plan, with pay £1.8m above plan. The identified drivers include high emergency attendances, higher admission rates, increased acuity and staff sickness and leave. This reinforces the close relationship between operational recovery and financial recovery: reducing avoidable demand on inpatient capacity and improving flow should support more sustainable deployment of workforce as well as improvements in access and patient experience.

The Trust reported a year-to-date deficit of £28.3m at Month 6 which is £12.3m adverse to plan. The adverse variance reflects lost elective income, predominantly associated with the continuing impact of the fire on theatre capacity and patient flow, compounded by industrial action, heat-related disruption and cancellations in specialist pathways. Discussions with commissioners have not secured additional funding to offset this loss, and the Trust has been unable to reduce costs in line with the reduction in income. This highlights the financial consequences of constrained capacity: lower elective delivery reduces income while the costs of maintaining services and managing operational pressures remain.

Efficiency delivery provides a positive contribution, with £24.4m achieved by Month 6, in line with plan. However, greater reliance on non-recurrent benefits is masking a shortfall in recurrent savings. The priority is therefore to translate reported savings into sustainable changes in service delivery and cost, alongside restoring elective productivity.

Recovery actions bring together service reviews, tighter management of temporary staffing and supported development of the efficiency programme. Work to ensure activity is fully counted and coded is progressing alongside action to address under-delivery. A jointly commissioned discharge programme with system partners is also being pursued, recognising that improved flow is central to releasing capacity, reducing operational cost pressures and supporting elective recovery.

Closing Statement

Overall, September's position demonstrates important strengths in clinical outcomes, workforce retention and patient experience, alongside strong comparative performance in urgent care and encouraging progress in 62-day cancer performance. These provide a positive foundation for recovery, while recognising that prolonged waits, constrained capacity and financial pressures continue to affect services and patients.

The Trust's improvement priorities are closely connected: better discharge and patient flow can release capacity, support elective recovery and enable more sustainable use of staffing and resources. Work across these areas, alongside targeted quality improvements and the development of recurrent savings, is focused on translating organisational strengths into more consistent access, a better patient experience and sustainable financial improvement.

National Oversight Framework Summary

University Hospital Southampton NHS Foundation Trust

University Hospital Southampton NHS Foundation Trust (RHM) | Adjusted segment: **3** | Rank **42** out of 134 | Average score: **2.20**

Best Q1 | Q2 | Q3 | Worst Q4

National Oversight Framework measure	Direction	Assessment period	Latest performance RHM	Improvement needed to next quartile
Access to services			Domain score: **2.61**	Segment: **3**
Percentage of A&E patients admitted, transferred or discharged within four hours of arrival	Higher is better	Q1 26/27	**80.70%** Rank 24 of 123	
Percentage of cases meeting the 28 day faster diagnosis standard	Higher is better	Q1 26/27	**75.10%** Rank 88 of 116	0.06%
Percentage of cases treated within 62 days of referral	Higher is better	Q1 26/27	**75.23%** Rank 40 of 118	2.16%
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Higher is better	Jun-26	**65.29%** Rank 68 of 129	0.16%
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Lower is better	Jun-26	**2.21%** Rank 109 of 129	0.36%
Percentage of patients spending 12 hours or longer in an emergency department without being admitted, discharged or transferred	Lower is better	Q1 26/27	**4.20%** Rank 26 of 122	
Percentage of referrals where the patient is waiting six weeks or longer for a test or procedure	Lower is better	Jun-26	**19.91%** Rank 78 of 131	2.85%
Effectiveness of care and population health			Domain score: **1.98**	Segment: **2**
Delayed inductions rate	Lower is better	Q1 26/27	**45.60 per 1,000 deliveries** Rank 82 of 119	14.40 per 1,000 deliveries
Percentage of inpatients referred to and seen by an in-house tobacco treatment services who make a supported attempt to stop smoking	Higher is better	Q4 25/26	**39.90%** Rank 41 of 126	5.90%
Percentage of patients readmitted within 30 days of discharge	Lower is better	Jun-26	**2.00** (metric score) Rank not published by NHSE	
Summary Hospital Mortality Indicator	Lower is better	Apr 25 - Mar 26	**1.00** (metric score) Rank not published by NHSE	
Experience of care			Domain score: **2.10**	Segment: **2**
CQC inpatient survey satisfaction rate	Lower is better	2024	**2.00** (metric score) Rank not published by NHSE	
NHS staff survey advocacy sub-score	Higher is better	Dec-25	**6.74 out of 10** Rank 54 of 134	0.17 out of 10
Patient safety			Domain score: **2.15**	Segment: **2**
Clinical audit outlier (banded score)	Lower is better	Jun-26	**1.00** (metric score) Rank not published by NHSE	
NHS Staff survey - raising concerns sub-score	Higher is better	2025	**6.32 out of 10** Rank 71 of 134	0.00 out of 10
Number of cases of MRSA in the last 12 months	Lower is better	12 months to June 2026	**8.00 count** Rank not published by NHSE	
Rate of c-difficile	Lower is better	Q1 26/27	**2.00** (metric score) Rank not published by NHSE	
Rate of e-coli	Lower is better	Q1 26/27	**3.00** (metric score) Rank not published by NHSE	

National Oversight Framework measure	Direction	Assessment period	Latest performance RHM	Improvement needed to next quartile
People			Domain score: **1.83**	Segment: **1**
NHS staff standards sub-score	Higher is better	2025	**7.55 out of 10** Rank 57 of 134	0.10 out of 10
NHS staff survey engagement theme sub-score	Higher is better	2025	**6.74 out of 10** Rank 73 of 134	0.06 out of 10
National Education and Training Survey overall experience sub-score	Higher is better	2025	**76.58%** Rank 64 of 134	2.22%
Percentage of frontline healthcare workers to receive a flu vaccination	Higher is better	Feb-26	**61.60%** Rank 8 of 134	
Sickness absence rate	Lower is better	Mar-26	**4.16%** Rank 6 of 134	
Temporary staffing agency	Lower is better	Q1 26/27	**1.00** (metric score) Rank not published by NHSE	
Temporary staffing bank	Lower is better	Q1 26/27	**1.00** (metric score) Rank not published by NHSE	
Temporary staffing cost relative band	Lower is better	Q1 26/27	**1.00** (metric score) Rank not published by NHSE	
Finance, productivity and innovation			Domain score: **2.37**	Segment: **3**
Combined finance	Lower is better	Jun-26	**2.00** (metric score) Rank not published by NHSE	
Overall Data Quality Maturity Index	Higher is better	Apr-26	**93.00** Rank 62 of 134	2.00
Percentage of clinical trials set up within 90 days	Higher is better	Q1 26/27	**59.09%** Rank 54 of 121	10.91%
Planned surplus/deficit	Higher is better	2026/27	**-0.69%** Rank 74 of 134	0.31%
Relative cost difference (National Cost Collection Index)	Lower is better	2025	**94.70%** Rank 37 of 134	0.42%
Variance to plan year-to-date	Higher is better	Jun-26	**0.01%** Rank 28 of 134	

Source: NHS England published National Oversight Framework acute trust data, Q1 2026/27. Trust selected by code RHM.

Performance summary

NHS University Hospital Southampton NHS Foundation Trust

Metric	Tgt	Act	Imp.	Var.	Ass.	
OUTSTANDING CARE						
Access to Services						
Patients on an open 18 week pathway (total waiting list)	—	64,802	▼	H	—	View
Percentage patients on an open 18 week pathway (within 18 weeks)	≥ 65.6%	64.0%	▼	H	F	View
Percentage patients on an open 18 week pathway (waiting 52 weeks+)	≤ 1.0%	2.6%	▼		F	View
Patients on an open 18 week pathway (waiting 65 weeks+)	≤ 0	230	▼	H	F	View
Patients on an open 18 week pathway (waiting 78 weeks+)	≤ 0	6	▲		?	View
Waiting for first outpatient appointment (within 18 weeks)	≥ 71.2%	69.4%	▼	H	F	View
28-day cancer wait - faster diagnosis standard	≥ 79.6%	72.3%	▼	L	?	View
31-day cancer wait - decision to treat to first definitive treatment	≥ 92.1%	86.3%	▼	L	?	View
62-day cancer wait - urgent referral to first definitive treatment	≥ 76.2%	78.3%	▲		?	View
Patients waiting for diagnostics	—	11,331.0	▼	H	—	View
Percentage patients waiting over 6 weeks for diagnostics	≤ 17.7%	19.6%	▲	H	?	View
Emergency department (ED) attendances (type 1)	—	12,362	▼		—	View
Patients spending less than 4 hours in ED (all types + mapped trusts) (%)	≥ 82.2%	80.3%	▼	H	?	View
Patients spending less than 12 hours in ED (all types)	—	93.5%	▼	L	—	View
Corridor Care	—	2,114.0	▼		—	View

Metric	Tgt	Act	Imp.	Var.	Ass.	
OUTSTANDING CARE						
Effectiveness of Care						
Outpatient did not attend (DNA) rate gap (Core20 vs non-Core20)	≤ 0.0%	4.3%	▼	L	F	View
Referrals to smoking cessation services on a supported pathway	—	33.6%	▼		—	View
Ethnicity data capture completeness	—	80.8%	▲	H	—	View
Summary Hospital-level Mortality Indicator (SHMI)	≤ 1.00	0.83	▲	N/A	N/A	View
Percentage non-elective readmissions within 30 days of discharge	—	11.9%	▲	L	—	View
Percentage non-elective readmissions within 7 days of discharge	—	6.0%	▲		—	View
Daily average inpatients that were medically optimised for discharge	—	235.6	▼		—	View
Length of Stay	—	5d 18h 35m	▼	H	—	View
Patient safety						
Pressure ulcers category 2 per 1,000 bed days	≤ 0.3 rate	0.3 rate	▲	H	?	View
Pressure ulcers category 3 and above per 1,000 bed days	≤ 0.3 rate	0.4 rate	▼		?	View
Days since last never event	—	149 days	▲		—	View
Clostridium difficile cases	≤ 8	12	▼		?	View
Days since last MRSA	—	101 days	▲		—	View
Medication Errors (severe / moderate)	≤ 3	7	▼	H	?	View
Proportion of Access (WHO AWaRe) antibiotic defined daily doses	≥ 50.0%	50.0%	▲		?	View

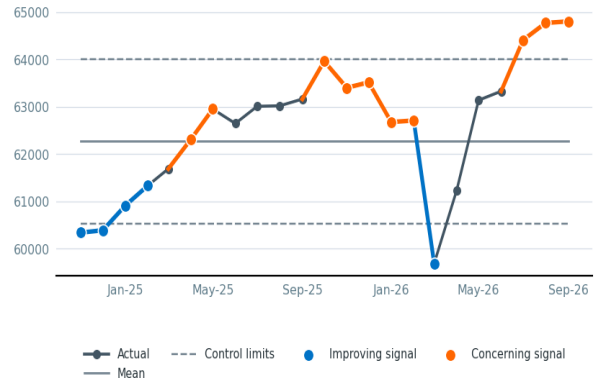
Performance summary - continued 1

University Hospital Southampton NHS Foundation Trust

Metric	Tgt	Act	Imp.	Var.	Ass.	
OUTSTANDING CARE						
Patient safety						
Days since last patient safety incident investigation (PSII)	—	17 days	▼		—	View
Number of falls investigated per 1,000 bed days	—	0.07 rate	▼		—	View
Red flag staffing incidents	—	53	▼	H	—	View
Stillbirth rate per 1,000 births	≤ 3.9	2.5	▲		?	View
Neonatal death rate per 1,000 liveborns	—	5.0	▲		—	View
Live births between encephalopathy cases (>34 weeks, moderate+)	—	1,147	▲		—	View
Days since last maternity and newborn safety investigation reportable case	—	46 days	▲		—	View
Experience of Care						
Friends and family test negative score - inpatients	≤ 5.0%	2.6%	▼		P	View
Patients reporting being involved in decisions about care and treatment	≥ 90.0%	88.3%	▲		?	View
Patients with disability/additional needs reporting needs met	≥ 90.0%	88.4%	▲		?	View
Overnight ward moves with a reason marked as non-clinical	—	117	▼	H	—	View
Number of mental health patients spending over 12 hours in ED	—	28	▶	L	—	View

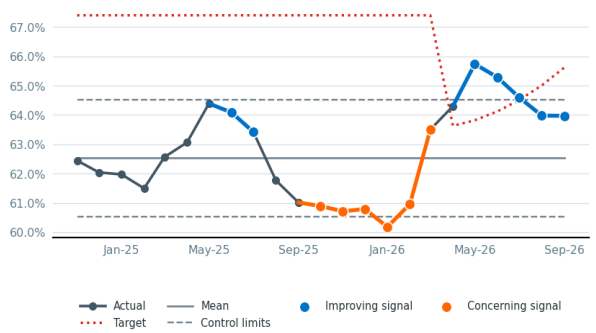
Metric	Tgt	Act	Imp.	Var.	Ass.	
OUTSTANDING PEOPLE						
People						
Staff sickness rate	≤ 3.9%	4.0%	▼		?	View
Staff turnover rate	≤ 13.6%	9.6%	▲		P	View
Non-clinical staff appraisals	≥ 85.0%	65.0%	▶	L	F	View
FOUNDATIONS FOR THE FUTURE						
Finance and productivity						
Income and expenditure - year to date variance to plan	—	-12.3 £m	▼	N/A	N/A	View
Cost improvement programme - year to date variance to plan	—	0.0 £m	▲	N/A	N/A	View
Capital - year to date variance to plan	—	-2.7 £m	▼	N/A	N/A	View
Cash – variance to working capital de minimis	—	23.8 £m	▲	N/A	N/A	View
Data quality maturity index (DQMI)	—	93.2	▲		—	View
My medical record - UHS patient accounts	—	305,478	▲	N/A	N/A	View
PIONEERING RESEARCH AND INNOVATION						
Innovation						
Recruitment performance ranking	≤ 10	17	▼	N/A	N/A	View
Performance in initiating clinical trials	≥ 90.0%	50.0%	▼		?	View
Performance in delivering clinical trials	≥ 90.0%	50.0%	▼		F	View
Proportion of sponsored studies open/on track	≥ 80.0%	90.0%	▶	H	P	View

Patients on an open 18 week pathway (total waiting list)



Latest: 64,802 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

Percentage patients on an open 18 week pathway (within 18 weeks)

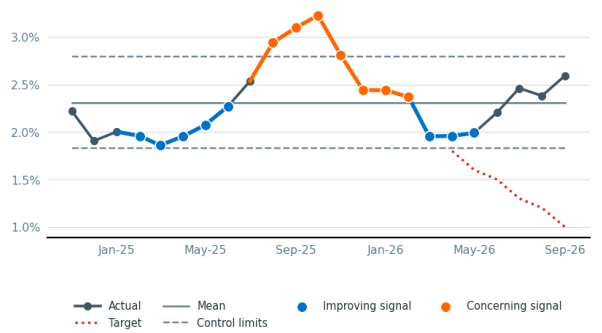


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
7	6	7	7	9	10	8	7	7	8	9	10

Latest: 64.0% **Target:** ≥ 65.6%
Period: Sep 2026 **Chart:** XmR chart

Percentage patients on an open 18 week pathway (waiting 52 weeks+)

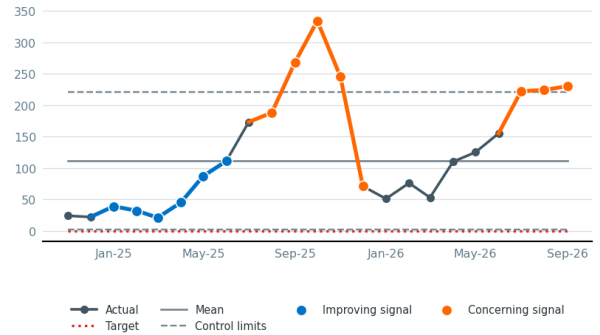


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
13	15	12	11	13	15	15	14	14	16	16	15

Latest: 2.6% **Target:** ≤ 1.0%
Period: Sep 2026 **Chart:** XmR chart

Patients on an open 18 week pathway (waiting 65 weeks+)

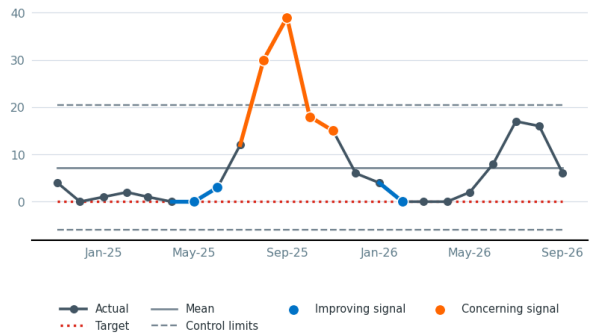


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
16	17	17	13	11	13	18	16	16	15	16	16

Latest: 230 **Target:** ≤ 0
Period: Sep 2026 **Chart:** XmR chart

Patients on an open 18 week pathway (waiting 78 weeks+)

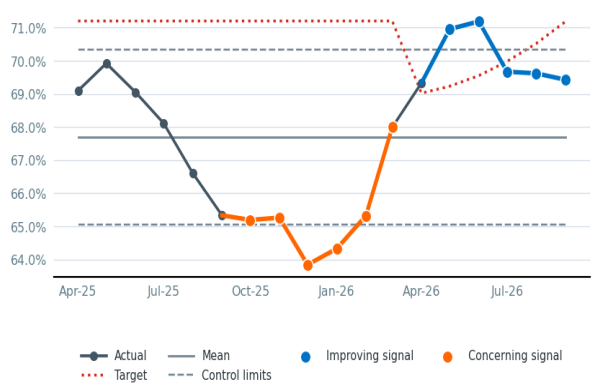


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
19	17	18	17	16	1	1	1	14	18	18	17

Latest: 6 **Target:** ≤ 0
Period: Sep 2026 **Chart:** XmR chart

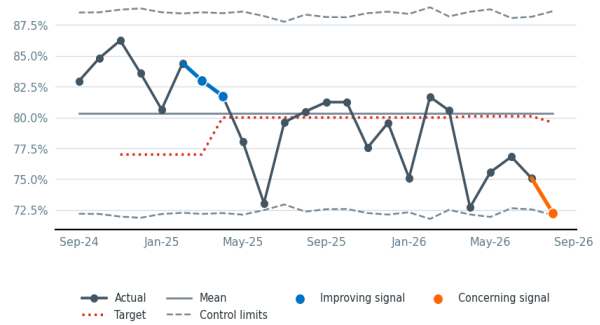
Waiting for first outpatient appointment (within 18 weeks)



Latest: 69.4% **Target:** ≥ 71.2%
Period: Sep 2026 **Chart:** XmR chart

Back to performance summary

28-day cancer wait - faster diagnosis standard

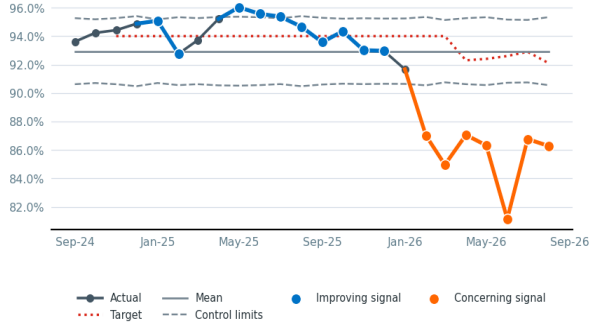


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
4	6	12	11	13	15	15	18	19	17	19	19

Latest: 72.3% **Target:** ≥ 79.6%
Period: Aug 2026 **Chart:** Laney p′ chart

31-day cancer wait - decision to treat to first definitive treatment

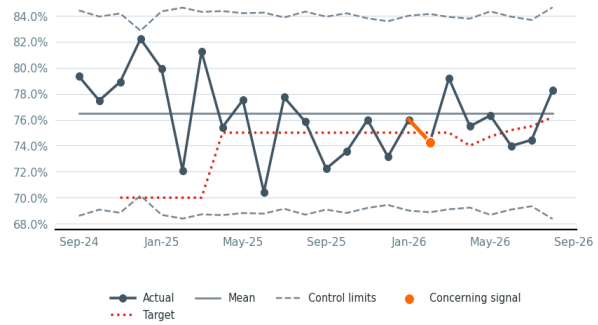


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
6	7	7	9	8	15	17	13	16	17	16	17

Latest: 86.3% **Target:** ≥ 92.1%
Period: Aug 2026 **Chart:** P chart

62-day cancer wait - urgent referral to first definitive treatment

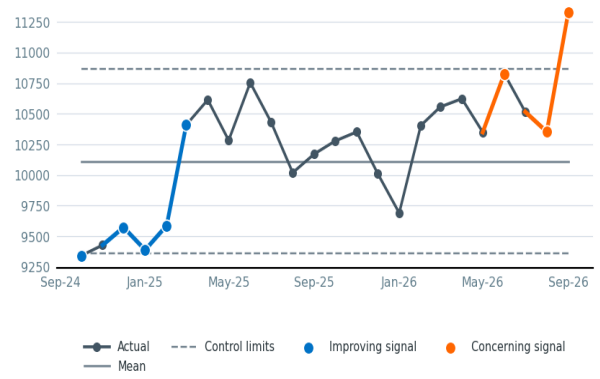


Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
4	5	4	8	2	3	3	5	3	4	6	2

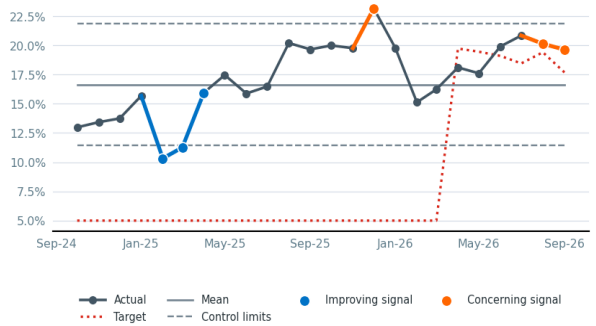
Latest: 78.3% **Target:** ≥ 76.2%
Period: Aug 2026 **Chart:** P chart

Patients waiting for diagnostics



Latest: 11,331.0 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

Percentage patients waiting over 6 weeks for diagnostics



Rank against teaching hospitals

Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
11	13	13	13	9	12	12	11	10	11	13	10

Latest: 19.6% **Target:** ≤ 17.7%
Period: Sep 2026 **Chart:** XmR chart

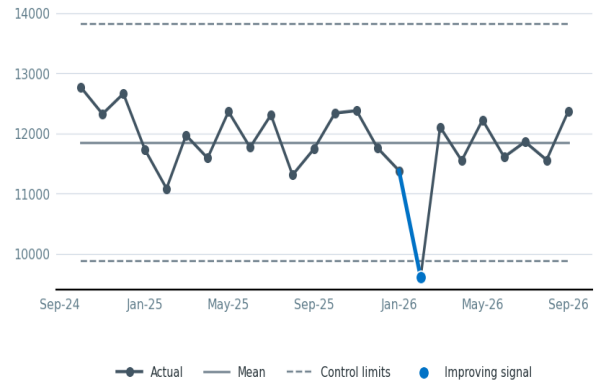
Back to performance summary

Access to Services - Urgent care

OUTSTANDING CARE

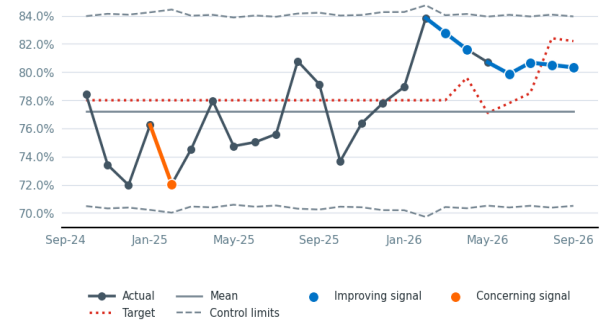
NHS University Hospital Southampton NHS Foundation Trust

Emergency department (ED) attendances (type 1)



Latest: 12,362 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

Patients spending less than 4 hours in ED (all types + mapped trusts) (%)

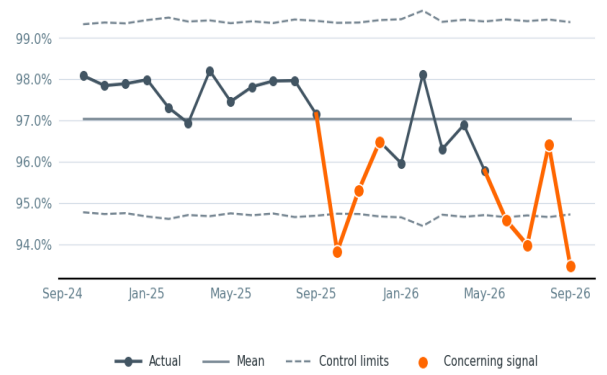


Rank against teaching hospitals

Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
7	4	3	1	1	2	3	2	1	2	4	1

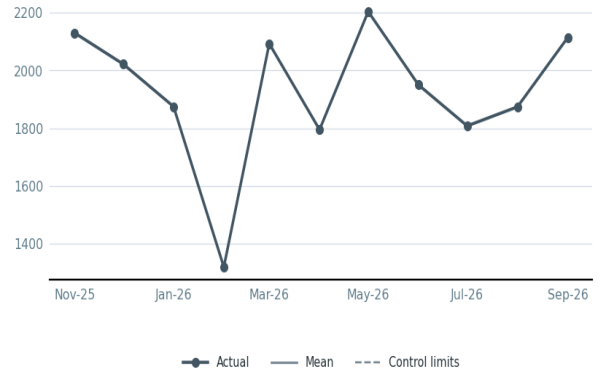
Latest: 80.3% **Target:** ≥ 82.2%
Period: Sep 2026 **Chart:** Laney p′ chart

Patients spending less than 12 hours in ED (all types)



Latest: 93.5% **Target:** -
Period: Sep 2026 **Chart:** Laney p′ chart

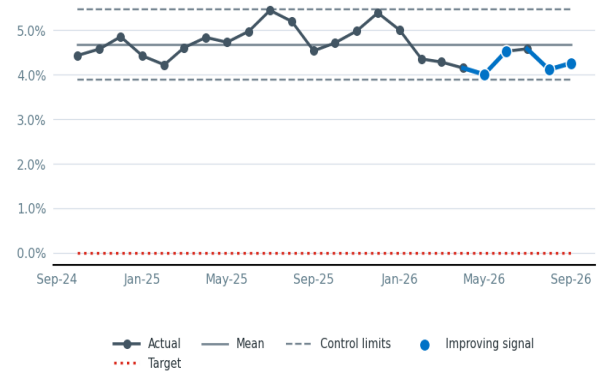
Corridor Care



Latest: 2,114.0 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

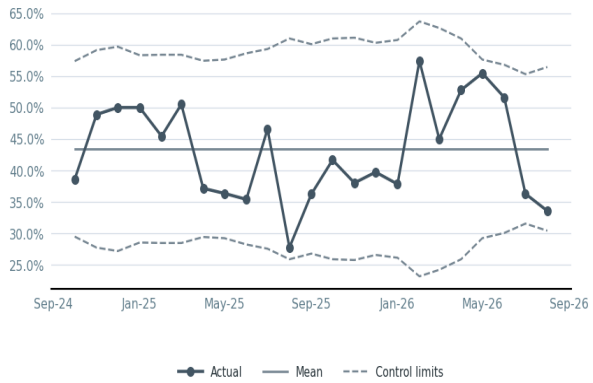
Back to performance summary

Outpatient did not attend (DNA) rate gap (Core20 vs non-Core20)



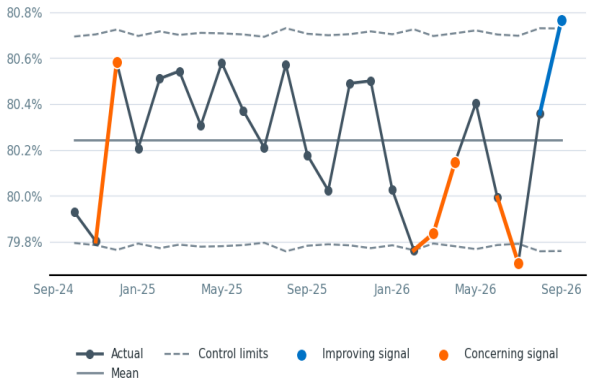
Latest: 4.3% **Target:** ≤ 0.0%
Period: Sep 2026 **Chart:** XmR chart

Referrals to smoking cessation services on a supported pathway



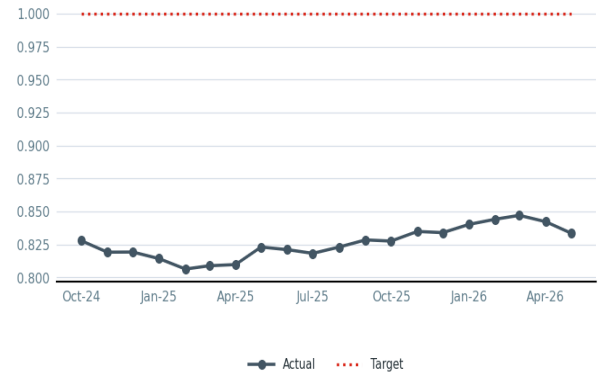
Latest: 33.6% **Target:** -
Period: Aug 2026 **Chart:** P chart

Ethnicity data capture completeness



Latest: 80.8% **Target:** -
Period: Sep 2026 **Chart:** P chart

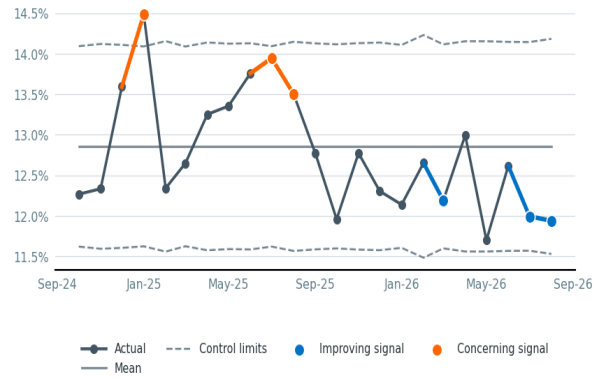
Summary Hospital-level Mortality Indicator (SHMI)



Latest: 0.83 **Target:** ≤ 1.00
Period: May 2026 **Chart:** Trend

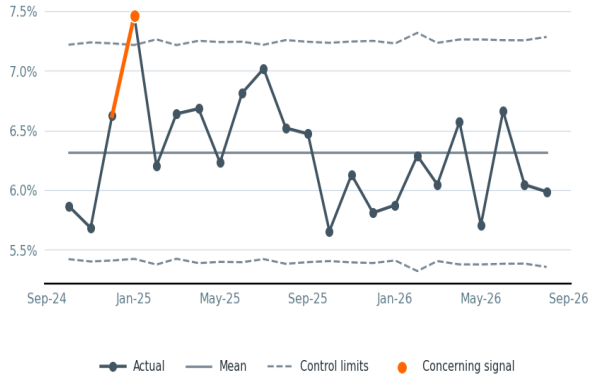
Back to performance summary

Percentage non-elective readmissions within 30 days of discharge



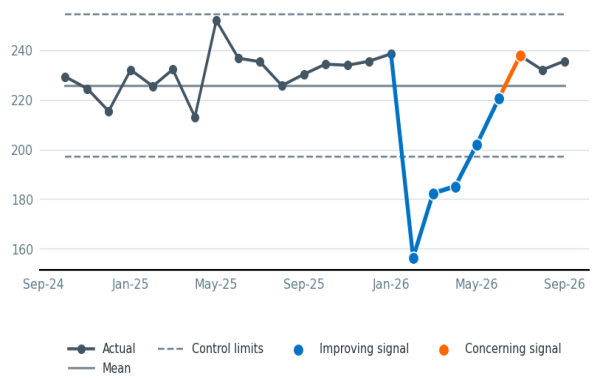
Latest: 11.9% **Target:** -
Period: Aug 2026 **Chart:** P chart

Percentage non-elective readmissions within 7 days of discharge



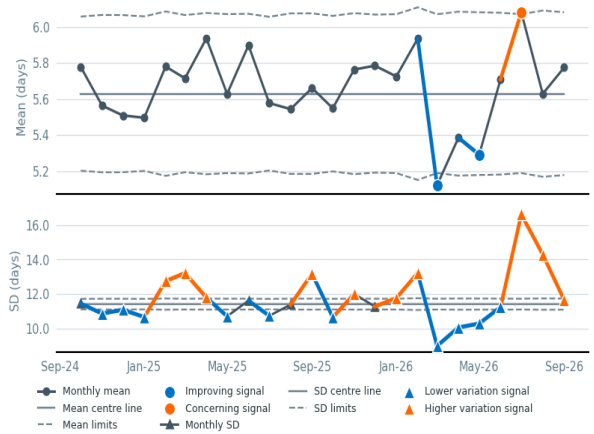
Latest: 6.0% **Target:** -
Period: Aug 2026 **Chart:** P chart

Daily average inpatients that were medically optimised for discharge



Latest: 235.6 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

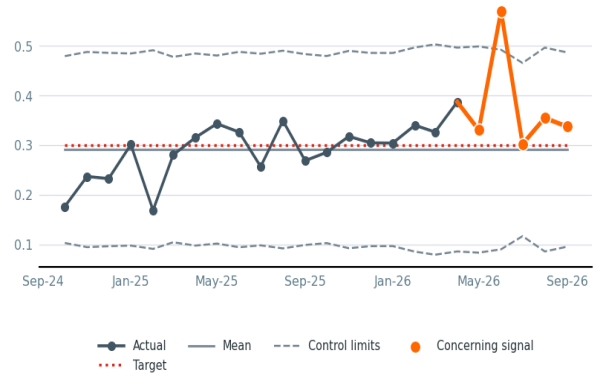
Length of Stay



Latest: 5d 18h 35m **Target:** -
Period: Sep 2026 **Chart:** X-bar/S chart

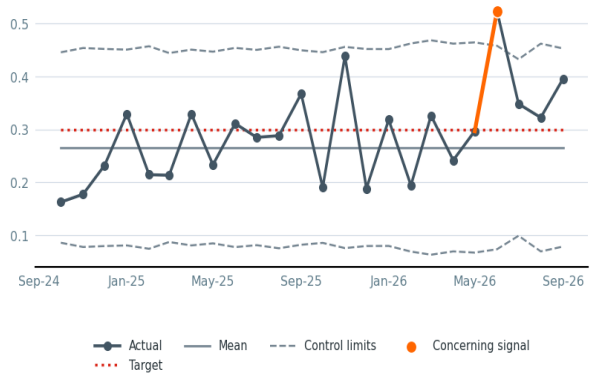
Back to performance summary

Pressure ulcers category 2 per 1,000 bed days



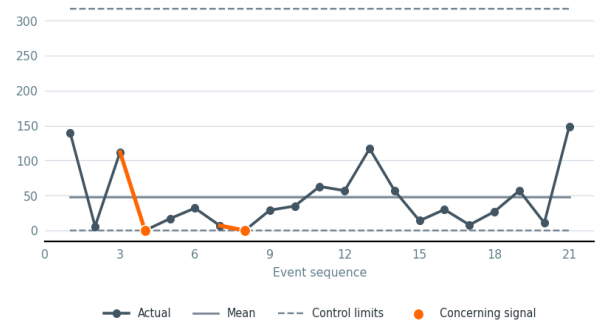
Latest: 0.3 rate **Target:** ≤ 0.3 rate
Period: Sep 2026 **Chart:** U chart

Pressure ulcers category 3 and above per 1,000 bed days



Latest: 0.4 rate **Target:** ≤ 0.3 rate
Period: Sep 2026 **Chart:** U chart

Days since last never event

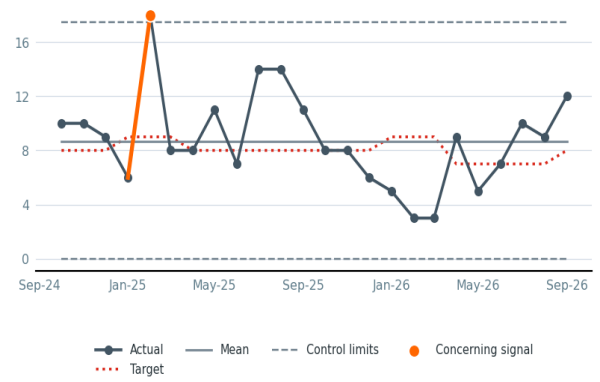


Monthly count

Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
1	0	2	2	1	0	1	1	0	0	0	0

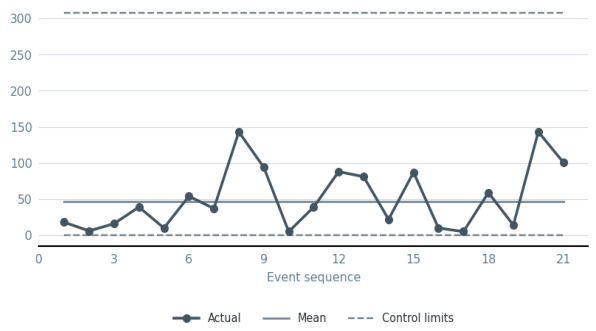
Latest: 149 days **Target:** -
Period: Sep 2026 **Chart:** T chart
Days since last event as of: 30 Sep 2026

Clostridium difficile cases



Latest: 12 **Target:** ≤ 8
Period: Sep 2026 **Chart:** C chart

Days since last MRSA

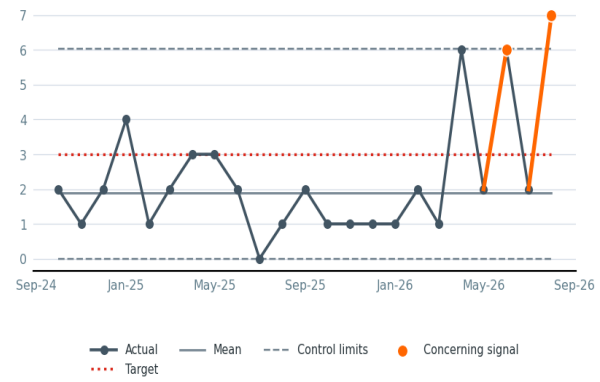


Monthly count

Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
0	3	0	2	0	0	0	0	1	0	0	0

Latest: 101 days **Target:** -
Period: Sep 2026 **Chart:** T chart
Days since last event as of: 30 Sep 2026

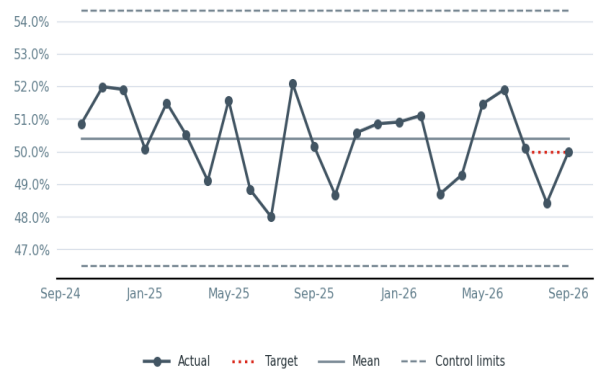
Medication Errors (severe / moderate)



Latest: 7 **Target:** ≤ 3
Period: Aug 2026 **Chart:** C chart

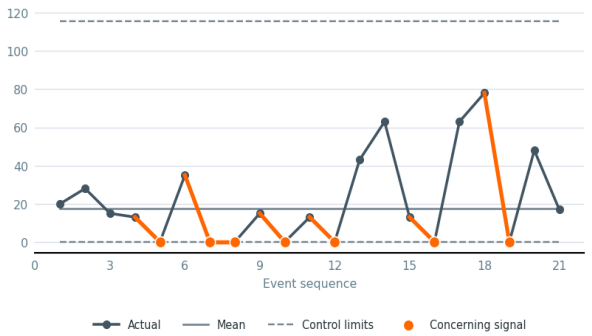
Back to performance summary

Proportion of Access (WHO AWaRe) antibiotic defined daily doses



Latest: 50.0% **Target:** ≥ 50.0%
Period: Sep 2026 **Chart:** XmR chart

Days since last patient safety incident investigation (PSII)

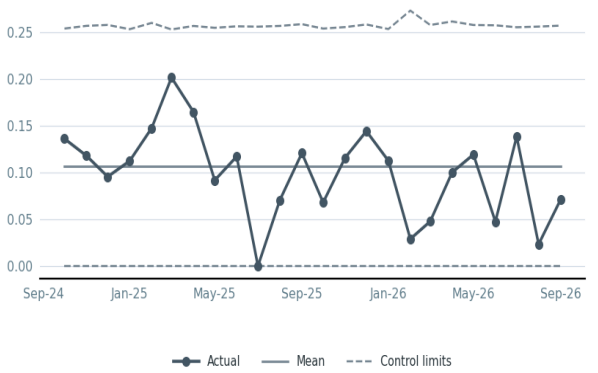


Monthly count

Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
5	2	1	0	1	2	0	1	0	2	0	1

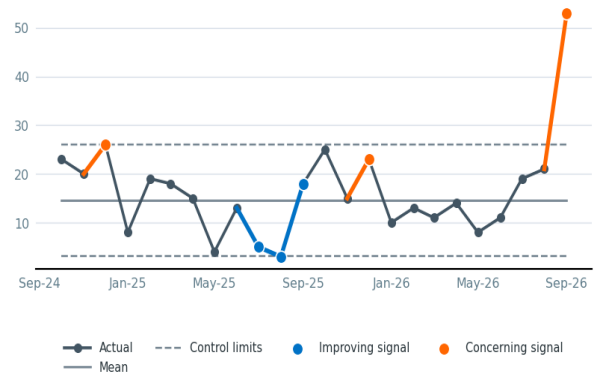
Latest: 17 days **Target:** -
Period: Sep 2026 **Chart:** T chart
Days since last event as of: 30 Sep 2026

Number of falls investigated per 1,000 bed days



Latest: 0.07 rate **Target:** -
Period: Sep 2026 **Chart:** U chart

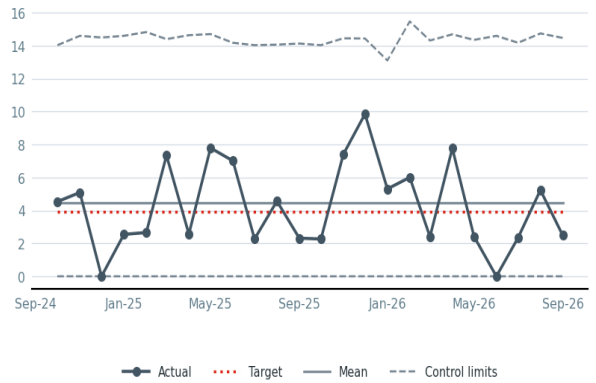
Red flag staffing incidents



Latest: 53 **Target:** -
Period: Sep 2026 **Chart:** C chart

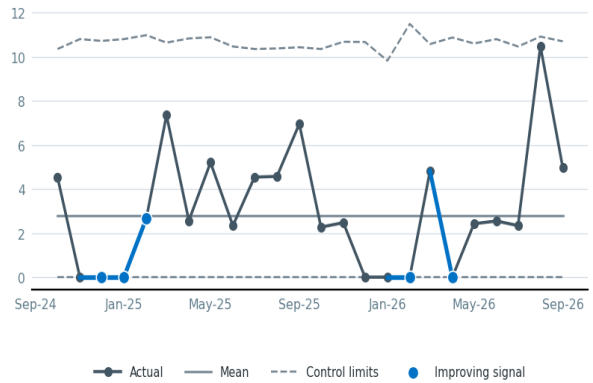
Back to performance summary

Stillbirth rate per 1,000 births



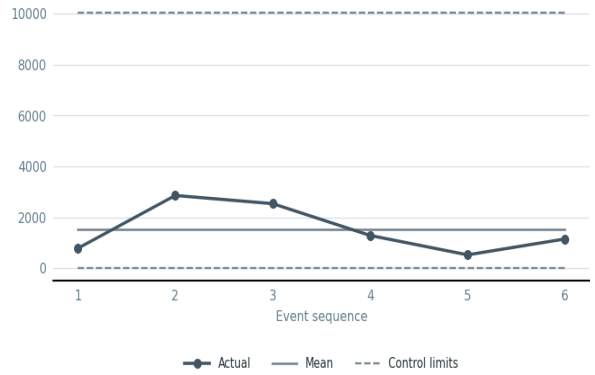
Latest: 2.5 **Target:** ≤ 3.9
Period: Sep 2026 **Chart:** U chart

Neonatal death rate per 1,000 liveborns



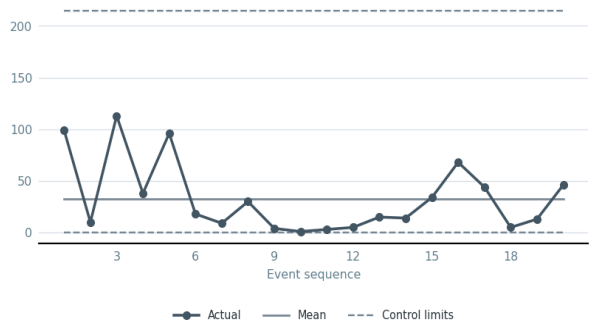
Latest: 5.0 **Target:** -
Period: Sep 2026 **Chart:** U chart

Live births between encephalopathy cases (>34 weeks, moderate+)



Latest: 1,147 **Target:** -
Period: Sep 2026 **Chart:** G chart

Days since last maternity and newborn safety investigation reportable case



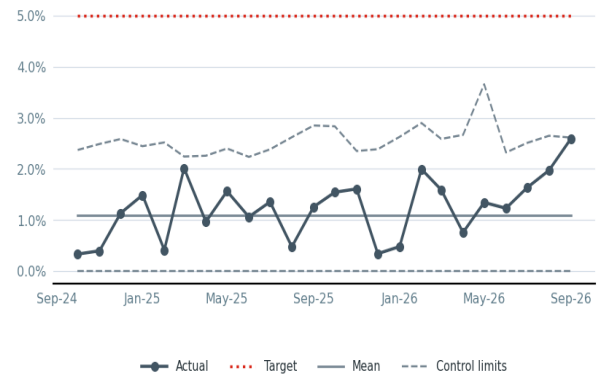
Monthly count

Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
0	1	2	4	2	1	1	0	1	1	2	0

Latest: 46 days **Target:** -
Period: Sep 2026 **Chart:** T chart
Days since last event as of: 30 Sep 2026

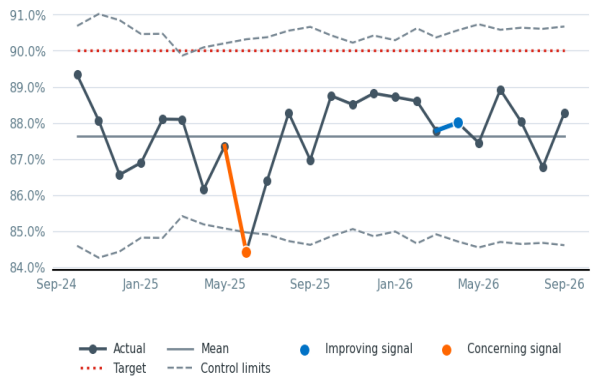
Back to performance summary

Friends and family test negative score - inpatients



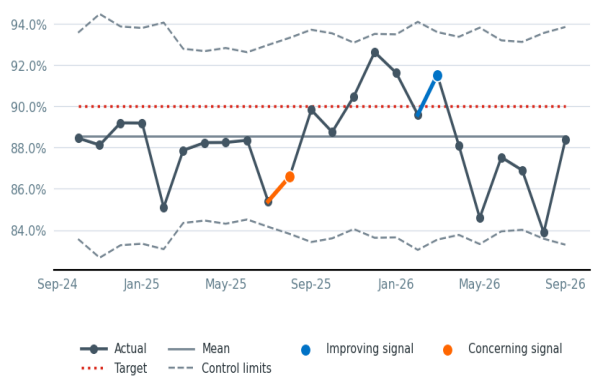
Latest: 2.6% **Target:** ≤ 5.0%
Period: Sep 2026 **Chart:** P chart

Patients reporting being involved in decisions about care and treatment



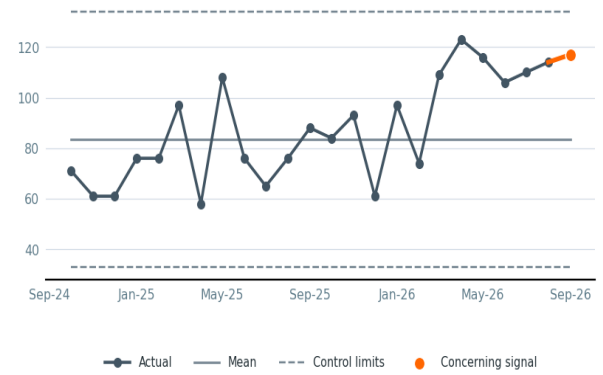
Latest: 88.3% **Target:** ≥ 90.0%
Period: Sep 2026 **Chart:** P chart

Patients with disability/additional needs reporting needs met



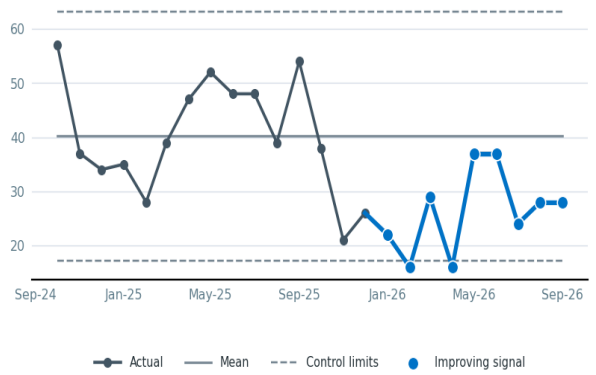
Latest: 88.4% **Target:** ≥ 90.0%
Period: Sep 2026 **Chart:** P chart

Overnight ward moves with a reason marked as non-clinical



Latest: 117 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

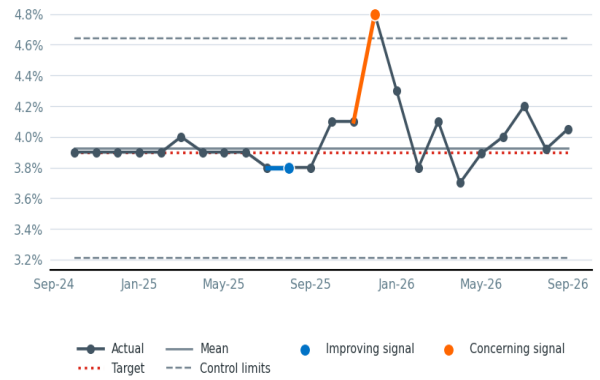
Number of mental health patients spending over 12 hours in ED



Latest: 28 **Target:** -
Period: Sep 2026 **Chart:** XmR chart

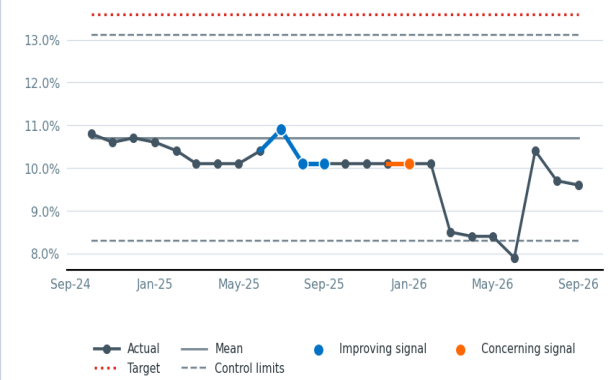
Back to performance summary

Staff sickness rate



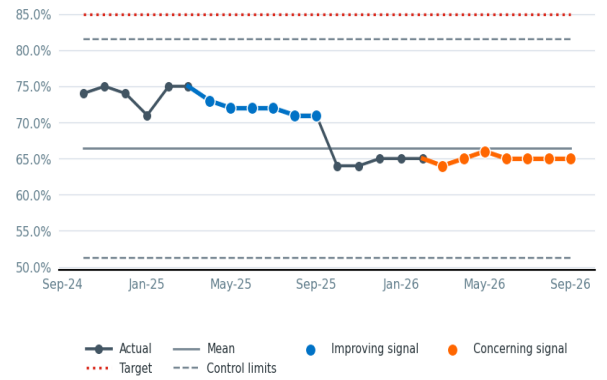
Latest: 4.0% **Target:** ≤ 3.9%
Period: Sep 2026 **Chart:** XmR chart

Staff turnover rate



Latest: 9.6% **Target:** ≤ 13.6%
Period: Sep 2026 **Chart:** XmR chart

Non-clinical staff appraisals

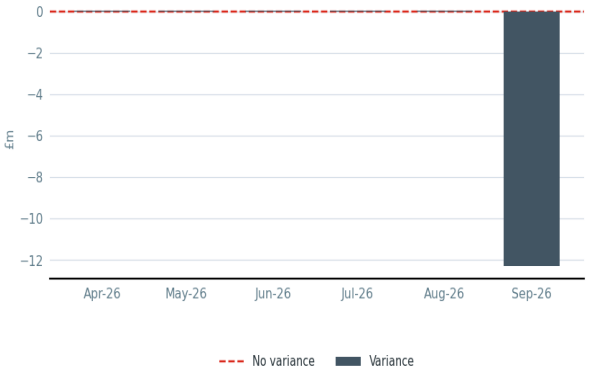


Latest: 65.0% **Target:** ≥ 85.0%
Period: Sep 2026 **Chart:** XmR chart

Back to performance summary

Income and expenditure - year to date variance to plan

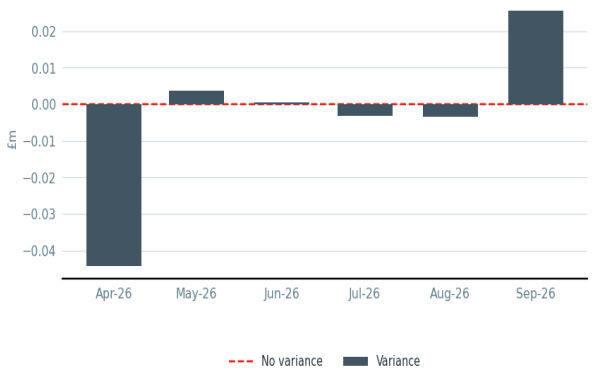
N/A N/A



Latest: -12.3 £m **Target:** -
Period: Sep 2026 **Chart:** Variance column chart

Cost improvement programme - year to date variance to plan

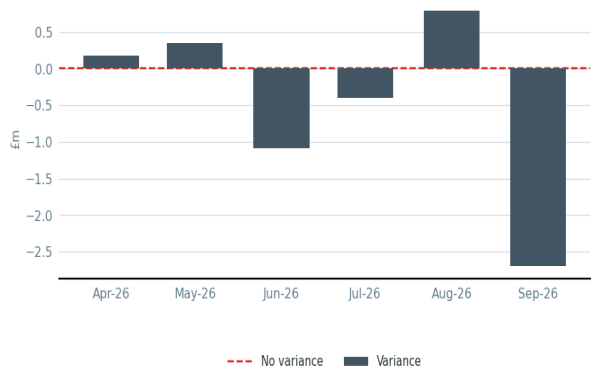
N/A N/A



Latest: 0.0 £m **Target:** -
Period: Sep 2026 **Chart:** Variance column chart

Capital - year to date variance to plan

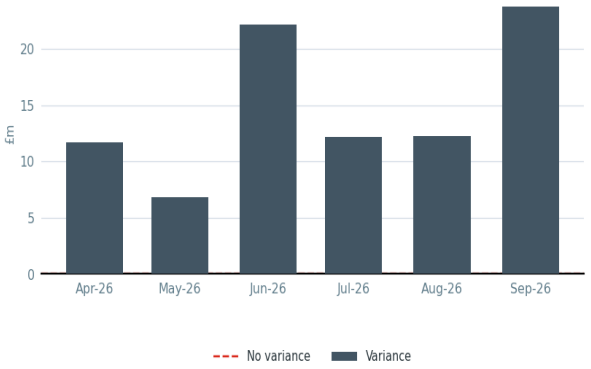
N/A N/A



Latest: -2.7 £m **Target:** -
Period: Sep 2026 **Chart:** Variance column chart

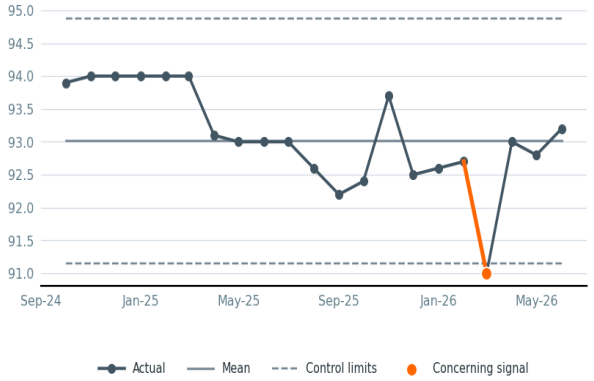
Cash – variance to working capital de minimis

N/A N/A



Latest: 23.8 £m **Target:** -
Period: Sep 2026 **Chart:** Variance column chart

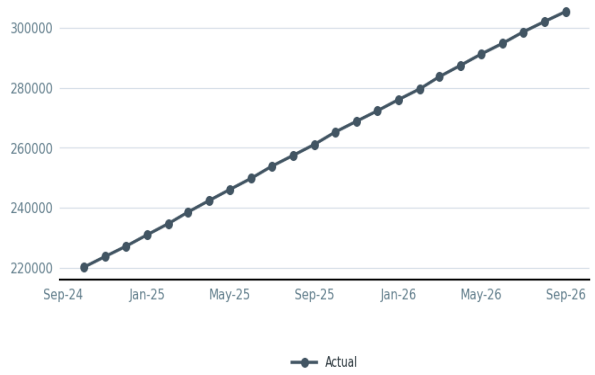
Data quality maturity index (DQMI)



Latest: 93.2 **Target:** -
Period: Jun 2026 **Chart:** XmR chart

My medical record - UHS patient accounts

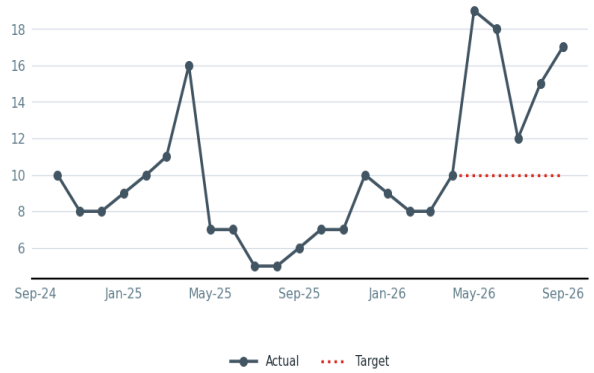
N/A N/A



Latest: 305,478 **Target:** -
Period: Sep 2026 **Chart:** Trend

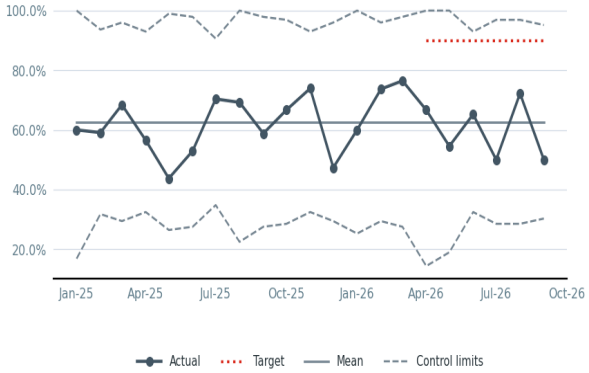
Back to performance summary

Recruitment performance ranking



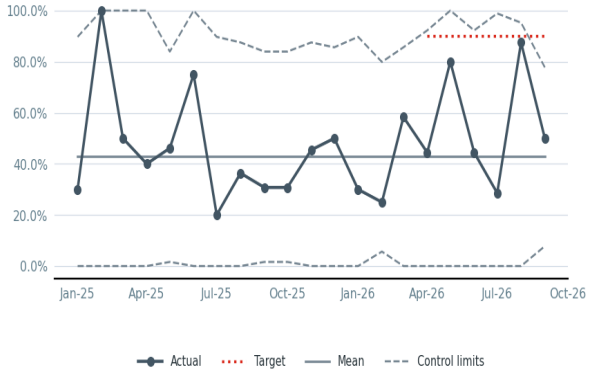
Latest: 17 **Target:** ≤ 10
Period: Sep 2026 **Chart:** Trend

Performance in initiating clinical trials



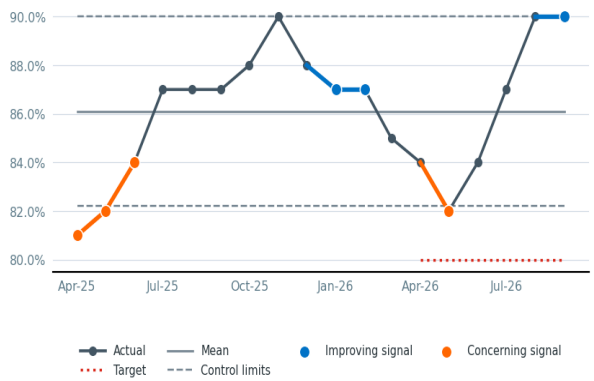
Latest: 50.0% **Target:** ≥ 90.0%
Period: Sep 2026 **Chart:** P chart

Performance in delivering clinical trials



Latest: 50.0% **Target:** ≥ 90.0%
Period: Sep 2026 **Chart:** P chart

Proportion of sponsored studies open/on track



Latest: 90.0% **Target:** ≥ 80.0%
Period: Sep 2026 **Chart:** XmR chart

Back to performance summary

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.7 Report to the Trust Board of Directors, 12 November 2026	
Title:	Summary Report on the Fire of February 2026 and Post-Fire Learning
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Duncan Linning-Karp, Deputy COO

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			

Executive Summary:

On 1 February 2026 a fire in the West Wing at Southampton General Hospital developed into a Major Incident. Later recovery reporting recorded approximately 500 patients evacuated within one hour. The immediate evacuation was followed by prolonged disruption to clinical capacity, patient movement and service delivery, with the Major Incident remaining in place until 10 February and recovery continuing beyond that point. The response showed strong clinical judgement, staff professionalism and practical problem-solving, but the subsequent review also found important areas where the Trust depended on individual experience and local workarounds rather than arrangements that were fully embedded and assured.

The response on 1 February protected patients in very difficult circumstances. Staff acted early, adapted quickly and sustained care despite a fast-moving fire, extensive displacement and prolonged loss of clinical capacity. That should be recognised clearly.

This paper provides the review's findings post-fire and key lessons learned.

Contents:

Appendix 1 – details of the report post fire

Risk(s):

BAF 1a, 1b, 3a, 5b and 5c. Corporate Risk Number 1037.

Equality Impact Consideration:	NO

Appendix 1

At 05:23:52 on Sunday 1 February 2026, the fire alarm system recorded the first detector activation in the Endoscopy footprint on West Wing Level E at Southampton General Hospital. Within minutes, reports of significant smoke changed the response from investigation of an alarm to management of a developing fire and an urgent threat to patients and staff. Local teams began moving patients before the full command structure had assembled. Hampshire and Isle of Wight Fire and Rescue Service attended, Tactical and Strategic command developed around the live incident, and UHS formally declared a Major Incident at 06:55.

The event quickly became more than a fire response. Patients were moved from several West Wing levels into safer parts of the hospital and then had to be cared for in corridors, lift lobbies, recovery areas and other temporary locations while the Trust created more sustainable arrangements. Emergency Department access was restricted, beds and clinical areas were lost, services were displaced and staff had to maintain urgent, specialist and tertiary care across a changing hospital footprint. The first 72 hours were therefore two connected problems: urgent life safety and evacuation, followed by prolonged stabilisation and continuity of care.

The response was effective in important respects. Early local judgement, rapid movement of patients, calm clinical leadership and staff professionalism materially reduced risk. Command became more structured as the morning progressed. Clinical and enabling teams created practical solutions for patient identification, medicines, equipment, digital access, property, family communication and movement. Emergency services, the Integrated Care Board, ambulance and patient transport services, receiving organisations, Adult Social Care and other partners provided important support.

The same evidence shows where arrangements placed too much burden on people. Patient tracking, dispersal, temporary holding, command support, notification, communications, infrastructure information, restricted-area control and some enabling functions relied heavily on manual work, personal knowledge and live problem-solving. Staff repeatedly made the response work, but they should not need to recreate essential systems during the next incident.

UHS protected patients and sustained critical services during an exceptionally demanding incident. The strongest feature of the response was the judgement and professionalism of staff. The main improvement need is to make the systems around them easier to activate, better prepared and more dependable under pressure.

What protected patients and services

- Local leaders acted on worsening conditions and began evacuation without waiting for a formal Major Incident declaration.
- Staff moved a complex and vulnerable inpatient population under severe time pressure and adapted routes and destinations to clinical need.
- Senior nurses, matrons, consultants and ward leaders restored order in temporary care areas using local lists, patient identification, prioritisation and floor-based oversight.
- Strategic, Tactical and Operational command developed around an incident already in progress and gained greater control through the day.

- The Emergency Department protected time-critical pathways while supporting wider hospital stabilisation and bed flow.
- Clinical and enabling teams built workable solutions quickly, including patient lists, digital workarounds, property processes, pharmacy support, volunteer and runner arrangements and temporary technical setups.
- Emergency services and health and care partners contributed to containment, movement, capacity and continuity.

Main learning

- A major hospital fire can become a whole-hospital continuity event within minutes. Fire response, evacuation, patient safety, bed capacity, infrastructure, command, communications and system support need to be planned as connected problems.
- Evacuation does not end when patients leave immediate danger. Temporary holding and stabilisation need the same level of planning as movement itself, including clinical leadership, oxygen, power, medicines, notes, infection controls, dignity, food, fluids, sanitation and family communication.
- Patient accountability must work while people are moving. Location alone is not enough: receiving teams and command also need clinical status, escort needs, medicines, notes, mobility aids and other continuity requirements.
- Command must be able to join a response that is already under way. Tactical command needs enough support to coordinate the wider hospital response, while a separate Joint Emergency Services Interoperability Principles (JESIP) Liaison Officer maintains the scene-facing emergency-service interface. Both functions need reliable communication, logging, action tracking and feedback to operational teams.
- Technical systems only help when their information can be understood and acted on. Fire detection, display, interpretation, relay and staff response should be tested as one end-to-end process.
- Mutual aid is most valuable when it reduces work for the organisation managing the incident. Offers of beds or transport only become operational relief when criteria, referral routes, clinical handover, documentation and transport are aligned.
- Plans and draft procedures do not by themselves create readiness. Staff need to know the arrangements, have the equipment and information available, and practise them under realistic conditions.

Improvement programme

The detailed working debrief generated a large number of actions across overlapping parts of the same response system. This report groups that learning into eight connected work packages rather than reproducing a long action list. The work packages cover command and incident support; evacuation and temporary care; patient accountability and family support; alerting and communications; site infrastructure and enabling services; patient dispersal and system coordination; stabilisation and recovery; and implementation, training and exercising.

Domain	Board-level outcome	Minimum evidence before assurance
1. Command and incident support	Clear authority, scene and ICC interface, handover, command support and scalable decision-making.	Approved aligned framework; action cards and packs available; trained role holders; exercise or live evidence; material issues corrected and retested.
2. Evacuation, shelter and temporary care	Clinical areas can choose and deliver the safest protective action while maintaining care.	Controlled procedure; local annex; usable pack and equipment; staff briefing; local drill; environmental and clinical exceptions owned.
3. Patient accountability, movement and family support	Every movement remains identifiable and reconcilable, with additional needs, family information and essential property controlled.	Movement and dispersal records; active reconciliation; family and property products; exercise evidence including unmatched and deferred patients.
4. Alerting and incident communications	The Trust can alert, brief and update staff and partners through resilient primary and fallback channels.	Graded cascade; Switchboard and fallback test; command communications test; accessible messages; acknowledgement and non-receipt process.
5. Site infrastructure, security and enabling services	Routes, utilities, access, equipment and enabling services can sustain the chosen protective action.	Technical Information Packs; local checks; Security / Estates / Portering / Pharmacy / IPC evidence; defects and interim controls tracked.
6. Patient dispersal, mutual aid and system coordination	UHS can coordinate demand, destinations, transport and receipt while retaining patient accountability.	PDC readiness; PDC and PDT interface agreed; transport and receiving assumptions tested; partner decisions recorded; multi-agency exercise.
7. Stabilisation, business continuity and recovery	Recovery begins during response and controls reoccupation, continuity, welfare, repatriation and prolonged service impact.	Recovery leadership / logs; technical and clinical reoccupation evidence; BCP updates; welfare arrangements; recovery exercise and debrief.
8. Implementation, training, exercising and assurance	Capability is sustained through controlled publication, competence, exercise, corrective action and retest.	Coverage dashboard; training records; exercise programme; evidence repository; named reviewers; action closure and periodic retest.

Conclusion

The 1 February 2026 Major Incident response demonstrated considerable resilience and protected patients under severe pressure. It also showed where the Trust was relying on individual adaptation rather than a sufficiently embedded operating system.

The design response is now substantially stronger. The important distinction for the Board is that design is not yet assurance. Draft 1.1 must be ratified, deployed, taught, exercised and evidenced; local areas must be able to use it; and partner interfaces must work across organisational boundaries.

Agenda Item 5.9	Report to the Trust Board of Directors, 12 November 2026
Title:	Finance Report 2026-27 Month 6
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Philip Bunting, DoOF and Anna Schoenwerth, ADOF

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

Outstanding 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.

Financial Position

The year-to-date position at M6 shows a £28.3m deficit, £12.3m adverse to plan. The variance is solely in relation to under delivery of Elective Recovery Fund (ERF) income due to loss of capacity linked to the fire. Without this, the Trust would be on plan YTD. CIP is on plan at £24.4m YTD, albeit supported by non-recurrent schemes above planned levels.

The 2026/27 underlying deficit position has marginally deteriorated from August to September at £4.9m deficit due to continued workforce pressures. The plan requires a £16m surplus in H2, supported by a significant increase in CIP delivery – meaning significant savings are required over the remainder of the year to deliver our plan.

Operational Context

In operational terms, the Trust continued to be under sustained pressure. Whilst NCTR numbers reduced from 239 to 156 in the aftermath of the fire, they have gradually increased, month on month, to 236 in September. This is now consistent with pre-fire levels and puts risk on the Trust's bed plan.

Sustained high attendances in September created prolonged pressure operationally, following several months of high temperatures which exacerbated the critical incident, beginning in July. Pressure on beds therefore also continued with additional capacity opened, in addition to staffing challenges. Workforce numbers have increased by 280 from 13,073 in April to 13,353 in September.

Impact of the Fire

The major fire on 1st February 2026 continues to have a significant impact on the Trust's financial position. The Trust has reduced theatre capacity (c2.5 theatres), loss of productivity, multiple service movements and closed bed capacity, as well as the significant impact on staff morale and increase in staff sickness. This position has also had an impact on the Trust's capacity to deliver transformational change and CIP programmes.

Elective Recovery Fund (ERF)

Current indications are that the Trust is £12.3m below ERF targets for M1-6, linked to operational pressures, loss of theatre capacity from the fire (estimated at c£2m per month), industrial action and the heatwaves. The Trust is also seeing pressures relating to staffing in some high-cost areas (e.g., Critical Care), leading to cancellations.

This risk has materialised into the reported position in M6. Up until M5, we had been in conversations with commissioners to request that the impact of the fire did not result in funding being withdrawn. However, the support requested has not transpired, with commissioners following normal contracting rules & funding completed activity to deliver performance targets only. Funding earmarked for UHS in the plan is being committed elsewhere to cover other activity & financial pressures. The Trust has not been able to reduce its costs in line with the loss of income.

Risks and Mitigations

The below table gives an indication of the scale of financial risks and mitigations, mirroring that used within the Trust's route map submission to NHSE. This includes a high-level management estimate of the impact of the fire on the 2026/27 financial position, noting that this is approximating the counter-factual of what would have been achieved if the fire had not occurred. It is therefore not a perfect analysis but intends to provide a broad indication of the scale of impact.

Fire-Related Risk/Mitigation	Description	Narrative	Total Risk £m	Of which: CIP risk £m
Risk	Fire-related loss of income (net of marginal cost reduction)	Due to the fire, Endoscopy capacity is being undertaken in UHS theatres - resulting in a loss of capacity of 2.5 theatres (Apr-Nov).	(12.0)	0.0
Risk	Fire-related direct costs	UHS has incurred direct costs in relation to the fire beyond the level of business interruption insurance - including additional bank staffing in Endoscopy & covering increased sickness & sub-optimal ward layouts, plus additional outsourcing.	(10.1)	0.0
Risk	Fire-related non-delivery of CIP	Trust assessment on the impact of the fire on CIP delivery - including theatres productivity, LOS schemes, private patients schemes, reduced insourcing/outsourcing etc. Link to the fire are around loss of capacity, inability to transact, loss of operational efficiencies and loss of managerial capacity.	(20.6)	(20.6)
Total Fire-Risk	**Total Risk associated with the fire**	**Trust assessment of the financial pressures as a result of the fire**	**(42.7)**	**(20.6)**

Other Risk/Mitigation	Description	Narrative	Total Risk £m	Of which: CIP risk £m
Risk	Cost Improvement Programme	Slippage / non delivery on CIP programme not related to the fire	(27.8)	(27.8)
Mitigations	Delivery of additional recurrent Cost Improvement Programme	Delivery of additional CIP above current run-rate in M6-M12	11.1	11.1
Mitigations	Delivery of additional non-recurrent Cost Improvement Programme	Delivery of additional non-recurrent CIP in M6-M12	5.6	5.6
Risk	Additional cost pressures - winter surge capacity	Allowance for expected winter costs	(3.2)	0.0
Mitigations	Other Interventions	Other underspends / non recurrent benefits offsetting cost pressures	6.1	0.0
Net Position	**Route Map Trajectory Risk**	**Risk scenario - submitted to NHSE**	**(50.9)**	**(31.7)**
Risk	Loss of Deficit Support Funding	Should risk position materialise, NHSE likely to claw back deficit support funding	(10.0)	0.0
Net Position	**Route Map Trajectory Risk**	**Risk scenario - including loss of DSF**	**(60.9)**	**(31.7)**

Best Case Risk/Mitigation	Description	Narrative	Total Risk £m	Of which: CIP risk £m
Mitigations	Stretch CIP Improvements	Stretch CIP improvements to deliver plan in full	31.7	31.7
Mitigations	Fire related mitigations	NHSE / ICB short term support for lost income due to the fire	16.0	0.0
Mitigations	Other Interventions	Further CIP or cost avoidance measures (offsetting winter pressures)	3.2	0.0
Mitigations	Return of Deficit Support Funding	Opportunity to re-earn DSF by returning to an on-plan trajectory	10.0	0.0
Total	**Route Map Trajectory (Best Case)**	**Mitigated (net risk) scenario**	**0.0**	**(0.0)**

The overall level of risk is broadly consistent with a top-down assessment based on the current underlying financial position continuing. 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.

The Trust continues to target delivery of the breakeven plan (best case); however, given the scale of financial pressures to date, the Trust remains anxious regarding the level of risk within the position. In September the Trust submitted a route map to NHSE showing a potential scenario of £50.9m deficit for the year, inclusive of £16m lost income due to the fire. This puts a further £10m of Deficit Support Funding at risk. Further to this there is a risk of industrial action particularly for consultants that could further impact activity and income.

We continue to focus on actions to mitigate the under delivery of the CIP programme. The Trust has appointed PA Consulting to support service reviews, including reviewing temporary staffing and CIP programmes. We are prioritising development of a route map to return to a financially sustainable position as soon as possible, with separate reports presented to the Finance Committee. We are also pursuing opportunities to improve discharges with a jointly commissioned programme with commissioners, local authorities and community providers.

Capital Programme Update

The Trust is on trajectory to deliver its capital plan in full. Further to this the Trust are also seeking to access additional NHSE funded capital with several key projects currently awaiting business case approval. A number of schemes are receiving additional scrutiny to ensure the Trust can afford the revenue consequences before receiving approval.

Cash Position

The Trust cash position has increased in September to £40.4m. The Trust's Cash Recovery Plan has been successful, with an improved position from plan and not requiring cash support to date. We are currently reviewing the cash forecast in line with the route map risks outlined above. We previously highlighted to Committee the likely requirement to submit a request to NHSE in November for cash support in January and believe that position is likely to prevail.

Conclusion

Overall, the Trust continues to be financially challenged, with significant risks materialising in relation to the major fire. This includes loss of capacity resulting in reduction of income from commissioners, additional costs of delivery above business interruption insurance levels, and the impact the fire has had across the organisation impacting ability to deliver CIP. The Trust also faces further operational pressures due to sustained attendances, against a backdrop of increasing NCTR volumes.

The Trust financial position has therefore deteriorated significantly from our original plan. We are now working with NHSE and consultants to create a route map to return to a sustainable financial position as soon as possible.

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

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.10 Report to the Trust Board of Directors, 12 November 2026	
Title:	People Report 2026-27 Month 6
Sponsor:	Steve Harris, Chief People Officer
Author:	Workforce 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:

September 2026 workforce performance remains mixed. Substantive staffing stands at 12,551 WTE, 78 WTE above plan. Temporary staffing pressures remain, with bank staffing at 774 WTE (139 WTE above plan), although agency usage remains controlled at 28 WTE, 10 WTE below plan, demonstrating ongoing efforts to reduce agency reliance.

People metrics show both strengths and challenges. Turnover remains low and favourable at 9.6% (rolling 12 months), well below the 13.6% target, indicating strong workforce retention. September recorded 93.6 WTE leavers, with the highest turnover within Nursing & Midwifery (35.0 WTE), Additional Clinical Services (25.6 WTE) and Administrative & Clerical staff (21.8 WTE).

However, sickness absence remains just above target at 4.07%. Rolling 12-month sickness is at 4.05% against a target of 3.9%. Anxiety/stress and other non-musculoskeletal conditions remain the main drivers of absence. Targeted actions continue to focus on improving attendance and staff wellbeing. Appraisal compliance at 65.1% continues to require improvement. Targeted action plans remain in place to address these areas.

There were 125 patient safety incidents reported during September, an increase of three from the previous month. Incident levels remain considerably higher than earlier in the year and continue to indicate significant workforce pressures across clinical services. Overall, staffing-related incidents increased from 122 to 125 (+3), driven primarily by increases in Divisions B and C, partially offset by a significant reduction in Division A.

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

NHS
University Hospital Southampton
NHS Foundation Trust

OUTSTANDING PEOPLE

UHS People Report

September 2026

THRIVE EXCEL BELONG

Summary

PEOPLE REPORT OVERVIEW: 2026/27 M6 (September-26)



September 2026 workforce performance remains mixed. Substantive staffing stands at 12,551 WTE, 78 WTE above plan. Temporary staffing pressures remain, with bank staffing at 774 WTE (139 WTE above plan), although agency usage remains controlled at 28 WTE, 10 WTE below plan, demonstrating ongoing efforts to reduce agency reliance.

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Overall Position

WTE Movement (M5 to M6)

Total Workforce

The total workforce **decreased by 23 WTE** to **13,353 WTE** from M5 (13,376) to M6.

During this period, the substantive workforce increased **by 28 WTE**, and the total temporary staffing **decreased by 51 WTE.**

As of M6, the Trust is **above the total plan (by 207 WTE).**

Substantive WTE

Substantive WTE increased by 28 WTE between end of August and end of September.

This was mainly driven by growth in Additional Clinical Services (15 WTE), Admin & Clerical (Divisions (10 WTE) and Allied Health Professionals (27 WTE).

Bank & Agency WTE

The total bank and agency use decreased by 51 WTE in M6.

Bank decreased by 6% (53 WTE) and **agency increased by 7%** (2 WTE) in September 2026, compared with August 2026.

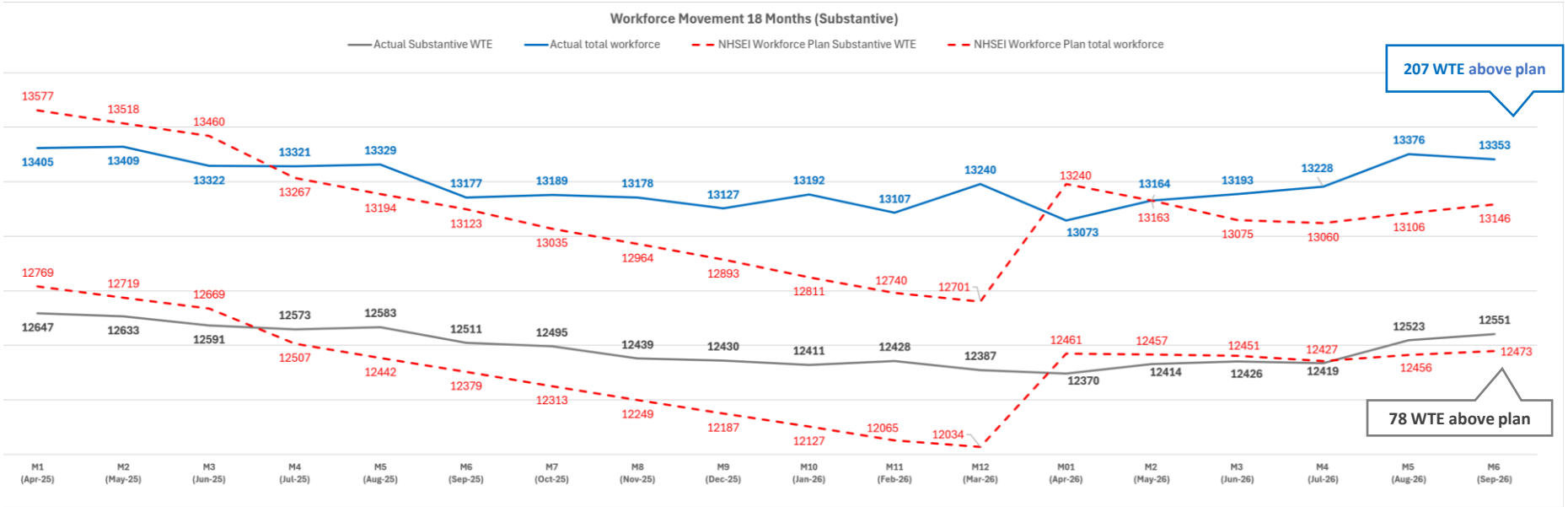
Pressures:

- High patient acuity
- Sustained temporary resourcing demand
- Sickness and vacancy gaps

Risks/Challenges:

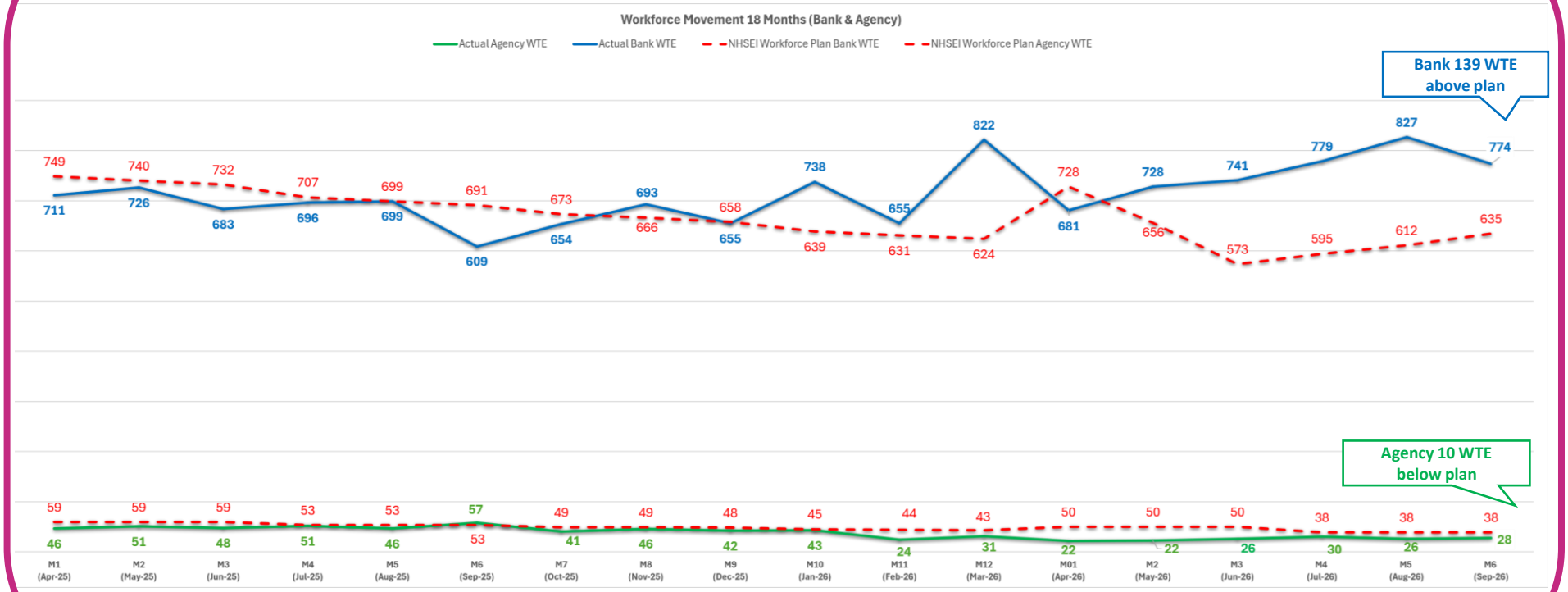
- Continued staffing pressure in Emergency Department and Critical Care
- Redeployment of staff from Research, Study Leave and Non-Clinical Time to support

Workforce Trends: Total & Substantive



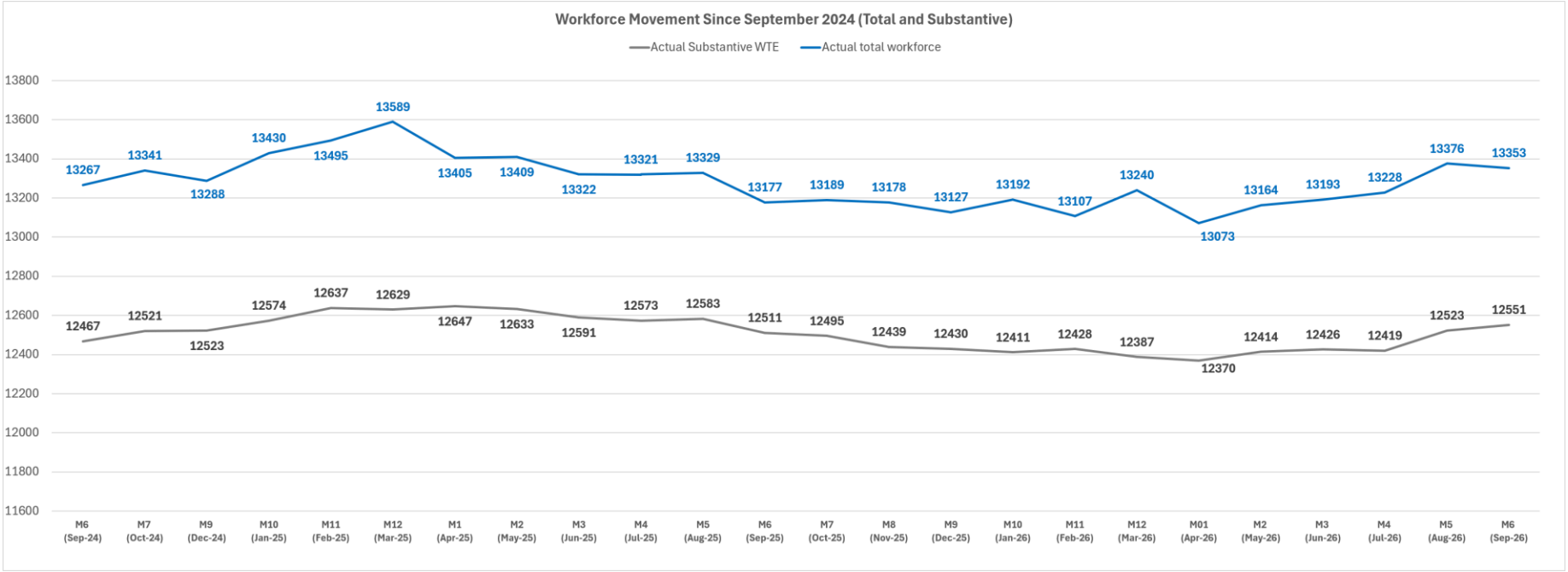
Source: ESR, THQ Medical Bank, NHSP and 247 Agency as of September 2026.

Workforce Trends: Bank & Agency



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

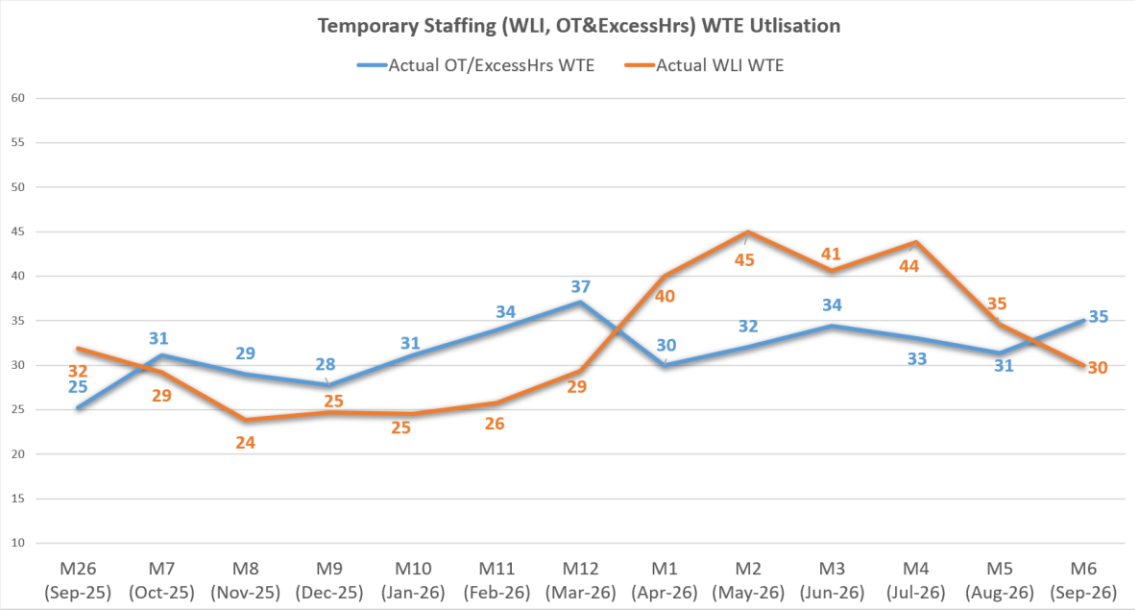
Total & Substantive Over Last 2 Years



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

Workforce Trends: WLI and Overtime

WLI Movement	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	M4- M5 2027	M5- M6 2027
	-3	-5	1	0	1	4	11	5	-4	3	-9	-5



Source: HealthRoster as of September 2026

Quarterly People Heatmap – 2026/27 Q2

	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	**12145**	**8.71%**	**438.4**	**65.3%**	**4.6%**	**40.0%**	**13.3%**	**11.1%**
Division A Overall	4002	7.3%	119.4	65.5%	4.9%	29.4%	18.4%	10.3%
CV&T	936	7.4%	32.2	68.5%	4.6%	23.7%	18.7%	9.5%
Critical Care, Theatres and Anaesthetics	1568	6.7%	44.4	67.0%	5.2%	30.4%	20.7%	9.8%
Neuro	463	6.3%	9.3	54.2%	4.5%	10.0%	21.5%	10.5%
Surgery	580	8.8%	20.6	57.2%	4.7%	34.0%	12.9%	10.2%
T&O	456	6.7%	12.9	75.9%	4.7%	22.0%	20.0%	12.8%
Division B - Overall	3088	9.5%	92.8	64.6%	5.0%	43.7%	14.9%	10.3%
Cancer Care	692	8.5%	12.4	65.3%	4.6%	42.1%	17.6%	11.6%
Emergency Care	694	10.6%	21.4	61.5%	5.0%	55.4%	11.7%	11.4%
Medicine	769	10.2%	35.8	72.9%	5.2%	39.2%	29.2%	8.4%
H&IOWAA	0	2.1%	0.0	19.2%	0.7%	NA	0.0%	6.1%
Ophthalmology	314	8.3%	11.4	61.4%	4.6%	25.6%	12.5%	9.4%
Specialist Medicine	618	10.1%	11.8	59.2%	5.7%	40.7%	13.1%	9.7%
Division C - Overall	3707	8.8%	149.0	61.3%	4.4%	41.9%	10.7%	13.4%
Child Health	837	8.6%	31.6	64.2%	5.3%	23.3%	1.1%	13.1%
Clinical Support	942	9.4%	47.9	68.5%	2.7%	47.9%	14.1%	12.7%
Pathology	596	9.9%	24.2	55.3%	5.3%	44.5%	14.4%	15.7%
Radiology	476	7.4%	14.8	66.0%	3.7%	28.9%	10.3%	11.2%
Women & Newborn	856	7.9%	30.5	53.2%	5.5%	50.4%	6.6%	13.2%
THQ - Overall	1348	9.4%	77.2	75.3%	3.9%	48.4%	12.2%	9.6%
Chief Finance Officer	104	11.9%	10.0	44.9%	3.1%	29.4%	10.9%	15.0%
Chief Operating Officer	184	12.7%	1.9	71.2%	6.2%	43.3%	13.8%	11.1%
Clinical Development	86	10.0%	2.3	81.4%	4.2%	32.0%	10.6%	24.3%
Informatics	233	4.2%	11.4	77.1%	3.2%	42.1%	15.3%	11.9%
People / HR	148	8.9%	11.0	81.4%	3.9%	40.7%	2.9%	14.3%
Research and Development	386	12.4%	3.6	85.1%	3.5%	57.4%	18.0%	15.2%
Training & Education	206	7.0%	37.0	85.3%	4.4%	82.4%	0.0%	7.8%

NB: Care groups & THQ departments with fewer than 50 WTE are excluded

Substantive SIP by Staffing Group

Substantive Monthly Staff in Post (WTE) Last 18 Months																			
	25/26												26/27						Movement
	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M5 to M6	YTD
Add Prof Scientific and Technic	301	300	300	312	303	306	307	303	304	301	305	303	304	305	306	324	336	339	↑ 4	↑ 33
Additional Clinical Services	2121	2123	2134	2131	2117	2101	2074	2064	2059	2041	2033	2030	2018	2039	2041	2045	2050	2066	↑ 15	↓ -35
Administrative and Clerical (Divisions)	1352	1350	1327	1316	1298	1282	1273	1258	1257	1254	1246	1248	1248	1244	1249	1260	1267	1277	↑ 10	↓ -5
Administrative and Clerical (THQ)	899	893	879	874	859	826	822	808	805	800	799	796	794	797	800	799	805	806	→ 0	↓ -21
Allied Health Professionals	823	822	832	831	839	842	849	849	849	846	847	846	852	858	849	851	860	887	↑ 27	↑ 45
Estates and Ancillary	414	409	407	403	398	392	387	387	413	408	406	404	401	403	405	404	402	398	↓ -3	↑ 7
Healthcare Scientists	523	520	523	524	522	523	525	523	523	523	527	523	521	521	519	515	523	517	↓ -5	↓ -6
Consultant & Career Grade Doctor	990	983	982	986	991	989	989	985	984	986	983	982	987	991	992	990	985	989	↑ 4	→ 1
Resident Doctor	1145	1140	1132	1125	1198	1194	1200	1185	1176	1178	1201	1192	1176	1176	1181	1151	1232	1226	↓ -7	↑ 32
Nursing and Midwifery Registered	4010	4024	4008	4003	3990	3990	4010	4024	4010	4025	4028	4012	4017	4030	4034	4031	4014	3998	↓ -17	↑ 8
Students	70	69	68	68	68	67	60	54	50	49	53	51	52	50	49	49	48	48	→ 0	↓ -19
Grand Total	**12647**	**12633**	**12591**	**12573**	**12583**	**12511**	**12495**	**12439**	**12430**	**12411**	**12428**	**12387**	**12370**	**12414**	**12426**	**12419**	**12523**	**12551**	↑ 28	↑ 41

Source: ESR substantive staff as of September 2026; includes consultant APAs & Resident Doctors' Extra Rostered Hours, excludes CLRN, Wessex AHSN, WPL (revised criteria for 26/27). 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)

	25/26												26/27						Movement	
	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M5 to M6	YTD
Add Prof Scientific and Technic	302	303	303	315	305	307	310	306	307	303	306	305	305	307	309	329	340	346	↑ 6	↑ 38
Additional Clinical Services	2419	2430	2421	2432	2421	2379	2364	2365	2345	2342	2287	2341	2341	2336	2341	2361	2395	2385	↓ -10	↑ 6
Administrative and Clerical	2311	2296	2255	2241	2203	2149	2139	2107	2109	2104	2094	2106	2106	2100	2112	2128	2143	2153	↑ 10	↑ 4
Allied Health Professionals	844	843	849	850	855	858	862	862	864	861	862	862	862	874	866	867	878	903	↑ 25	↑ 45
Estates and Ancillary	439	437	434	418	410	414	410	411	438	436	432	433	433	433	431	433	432	426	↓ -6	↑ 12
Healthcare Scientists	532	529	531	532	531	532	534	533	533	533	537	534	534	530	531	525	533	525	↓ -8	↓ -7
Medical and Dental	2176	2162	2152	2165	2225	2211	2218	2209	2201	2203	2220	2211	2211	2203	2213	2187	2255	2249	↓ -6	↑ 38
Nursing and Midwifery Registered	4312	4341	4309	4300	4310	4259	4291	4331	4281	4359	4315	4396	4396	4330	4341	4349	4351	4318	↓ -34	↑ 58
Students	70	69	68	68	68	67	60	54	50	49	53	51	52	50	49	49	48	48	↓ 0	↓ -19
Grand Total	**13405**	**13409**	**13322**	**13321**	**13329**	**13177**	**13190**	**13178**	**13127**	**13192**	**13107**	**13240**	**13240**	**13164**	**13193**	**13228**	**13376**	**13353**	↓ -22	↑ 176

Source: ESR substantive staff, NHSP Bank & Agency temporary staff, THQ Medical Bank staff & 247 Agency staff as of September 2026

Transition of Locally Employed Doctors and Dentists to substantive contracts

Under the national 2026 Government/BMA agreement, trusts must make permanent employment the default for most Locally Employed Doctors (LEDs). UHS has begun implementing the agreement by offering permanent contracts to eligible LEDs and reviewing all existing LED posts.

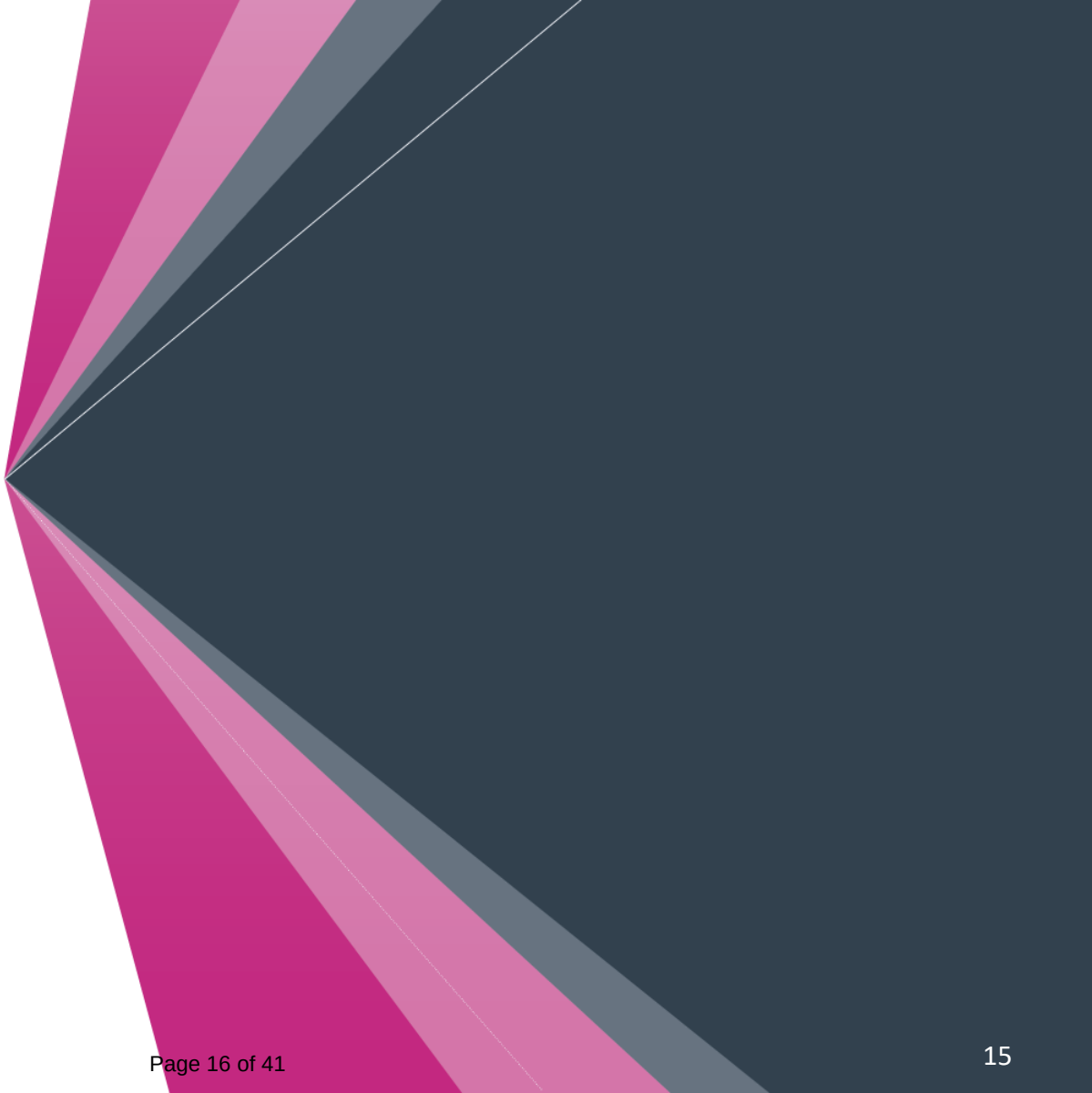
UHS implementation status

- UHS already applies the full national terms and conditions for resident doctors to its LEDs, meeting a key requirement of the agreement on parity of pay arrangements.
- Care Group and education leads have engaged well with the briefings.
- In collaboration with Care Groups, a UHS working group is reviewing all existing LED posts.
- UHS is offering substantive contracts to eligible LEDs.
- LED recruitment remains temporarily on hold pending completion of the review.
- Where appropriate, new LED appointments will normally be on permanent contracts.
- UHS and the BMA continue to discuss how the guidance applies to potentially exceptional cases.
- The focus is on strengthening recruitment and ensuring appropriate management of locally employed doctors as permanent appointments become the norm.

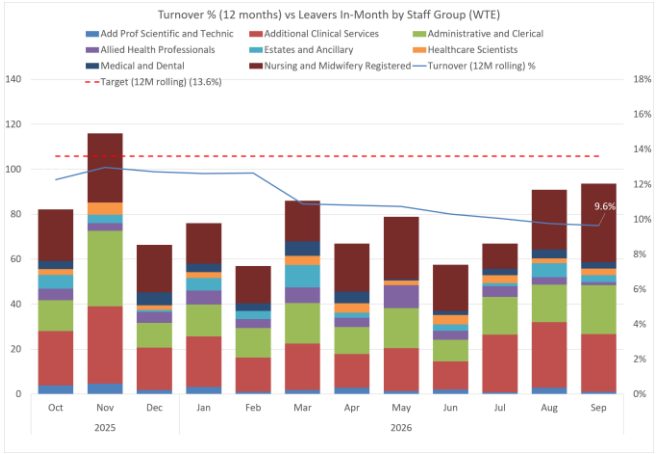
Law Changes October 2026

- **Employment Tribunal Claim Time Limits** – 1 October 2026: The time limit for bringing Employment Tribunal claims has increased from three to six months. ***Action:*** HR team have received training on the change in conjunction with the increased timeframe for ACAS Early Conciliation (this has increased from 4 to 12 weeks).
- **Public-Sector Outsourcing** – October 2026: The Employment Rights Act 2025 establishes a framework for a statutory code of practice and regulations intended to prevent two-tier workforces arising from public-sector outsourcing, where transferring public-sector employees and other supplier employees may receive different terms and conditions. The specific contractual requirements depend on the applicable code, regulations and commencement provisions. ***Action:*** Review relevant outsourcing, retendering and insourcing arrangements when the requirements are confirmed.
- **Trade Union Access and Protections** – 30 October 2026: Reforms will strengthen trade union workplace-access rights, introduce new rights and protections for union representatives, and extend protections against detriment for taking industrial action***. Action:*** The UHS Trade Union and Facilities Policy is being updated to reflect the new requirements.
- **Sexual Harassment and Third-Party Harassment** – 30 October 2026: Employers will be required to take "all reasonable steps" to prevent sexual harassment, with liability for third-party harassment where the statutory conditions are met***. Action:*** The Dignity at Work Policy was updated in 2024 to reflect the NHS Sexual Safety Charter and available support. The Violence and Aggression Group is progressing actions relating to NHS England requirements and incidents involving patients.
- **Right-to-Work Reforms** – October 2026 update: Under the Border Security, Asylum and Immigration Act 2025, right-to-work checking requirements are being extended to additional working arrangements, including specified workers engaged under worker's contracts, individual subcontractors and certain online matching services. These reforms are separate from the Employment Rights Act 2025. ***Action:*** HR reviewing existing arrangements and strengthen governance across right-to-work compliance, IR35 and insourcing

THRIVE



Turnover



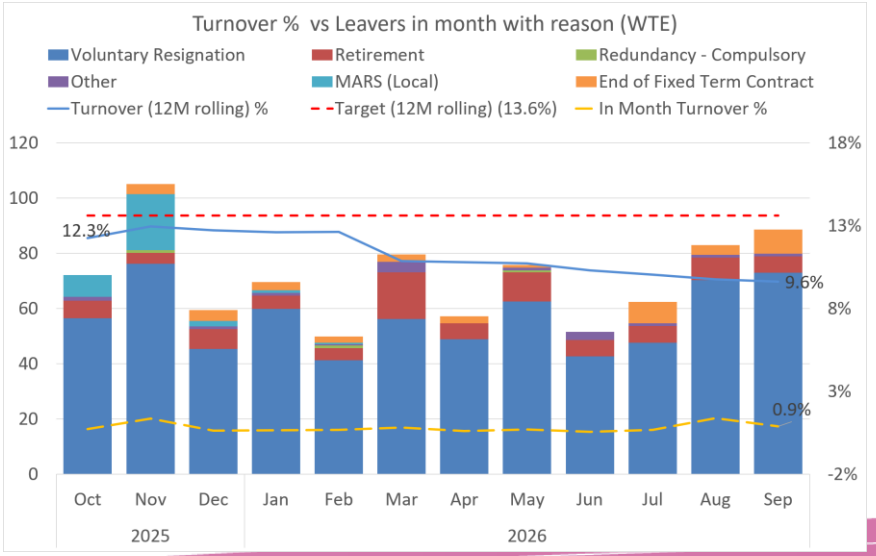
In Sep 2026, there was a total of 93.6 WTE leavers, 14.7 WTE less than August 2026 (108.3 WTE). Division C recorded the highest number of leavers (29.7 WTE). Within Division C, Additional Clinical Services staff group had the highest number of leavers (11 WTE).

Divisions A and B recorded the next-highest numbers of leavers, at 27.4 WTE and 22.8 WTE respectively. The largest staff-group movements were Nursing and Midwifery in Division A, at 14.2 WTE, and Nursing and Midwifery in Division B, at 10.3 WTE.

Total leavers by division are as follows:

- **Division A: 27.4 WTE leavers**
- **Division B: 22.8 WTE leavers**
- **Division C: 29.7 WTE leavers**
- **THQ: 10.7 WTE leavers**
- **UEL: 3 WTE leavers**

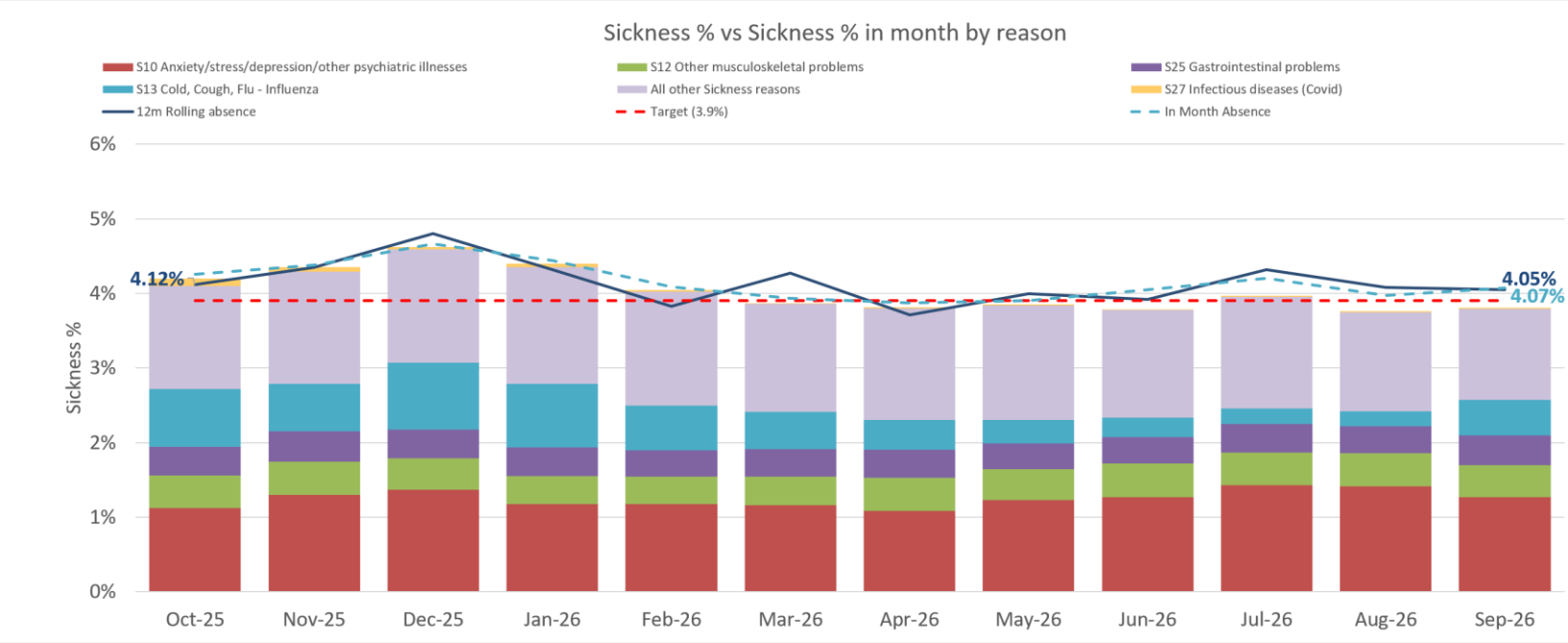
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.0	0.3%	8.3%
Additional Clinical Services	25.6	1.2%	12.6%
Administrative and Clerical	21.8	1.0%	9.6%
Allied Health Professionals	1.4	0.2%	6.8%
Estates and Ancillary	3.0	0.7%	19.0%
Healthcare Scientists	3.0	0.6%	7.0%
Medical and Dental	2.8	1.0%	12.6%
Nursing and Midwifery Registered	35.0	0.9%	6.8%
UHS total	**93.6**	**0.9%**	**9.6%**



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

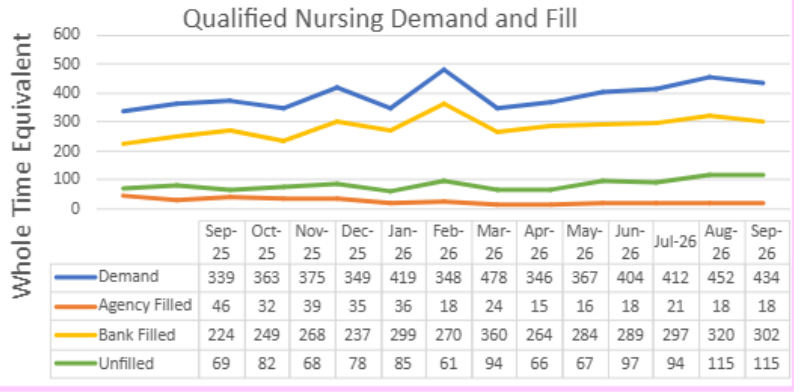
Sickness

Current in-month sickness: 4.07% | Rolling 12-month sickness: 4.05% | Year-to-date sickness: 4.15%

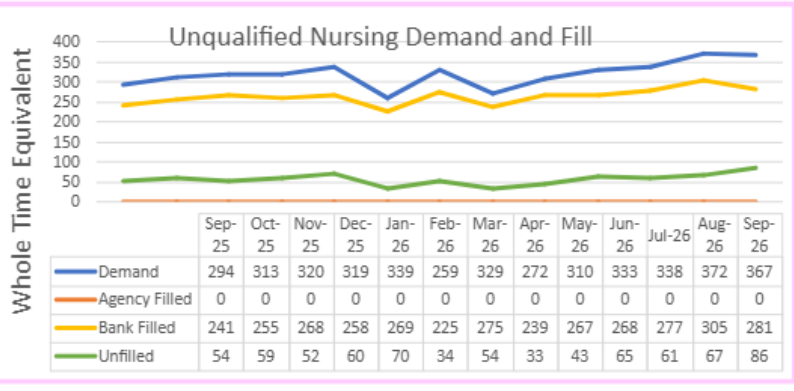


Source: ESR – Sep 2026

Temporary Staffing



	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Demand	339	363	375	349	419	348	478	346	367	404	412	452	434
Agency Filled	46	32	39	35	36	18	24	15	16	18	21	18	18
Bank Filled	224	249	268	237	299	270	360	264	284	289	297	320	302
Unfilled	69	82	68	78	85	61	94	66	67	97	94	115	115



	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Demand	294	313	320	319	339	259	329	272	310	333	338	372	367
Agency Filled	0	0	0	0	0	0	0	0	0	0	0	0	0
Bank Filled	241	255	268	258	269	225	275	239	267	268	277	305	281
Unfilled	54	59	52	60	70	34	54	33	43	65	61	67	86

Qualified Nursing (WTE)

- **Demand decreased from** 452 in August to 434 (-18)
- **Bank fill decreased** from 320 to 302 (-18) from previous month.
- **Agency filled remained the same** at 18.
- **Unfilled shifts remained the same** at 115
- **Year-on-year demand increased:** 95 higher than September 2025

Healthcare Assistants (HCA) (WTE)

- **Demand decreased from** 372 to 367 (-5).
- **Bank filled decreased from** 305 to 281 (-24)
- **Unfilled shifts increased**: from 67 to 86 (+19 on prior month)
- **Year-on-year demand increased**: 73 higher than September 2025

Demand decreased slightly across both Qualified Nursing and HCA workforce groups compared with August; however, bank fill also reduced, particularly for HCAs, leading to an increase in unfilled demand, while overall demand remained significantly higher than September 2025, increasing by 95 WTE for Qualified Nursing and 73 WTE for HCAs.

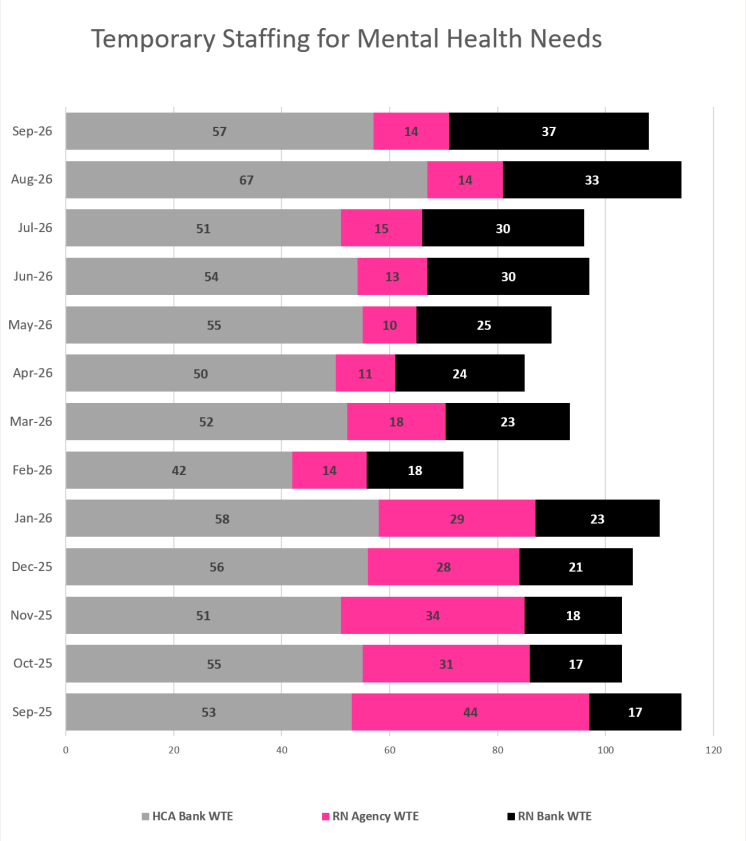
Emergency Care and Critical Care continued to experience significant staffing pressures throughout September. Ongoing nursing and midwifery workforce challenges limited the ability to support both the Emergency Department and additional staffing requests, including R2R requests. High patient acuity, sustained demand across the Trust, staff sickness, and vacancy gaps further exacerbated these pressures. To maintain safe staffing levels, services frequently relied on redeploying staff from research, study leave, and non-clinical time to provide frontline clinical support.

Mental Health and Enhanced Care services have significantly reduced agency reliance through conversion to bank staffing and implementation of the Band 3 Enhanced Care HCA model, improving workforce sustainability.

Registered bank workforce participation increased significantly in September compared with the previous year, with123 more registered nurses working bank shifts. This represents a notable improvement on the August position and has strengthened workforce flexibility and resilience across specialist services

Source: Temporary Resourcing – September 2026

Temporary Staffing: Mental Health



Mental Health Staffing Summary – September 2026

Total Temporary Staffing: 108 WTE, decrease of 6 WTE compared to prior month.
Registered Mental Health Nurses (RMNs): 51 WTE (increase of 4 WTE), of which 14 WTE were agency (same as previous month) and 37 WTE were bank staff (+4 WTE compared to prior month).
Healthcare Assistants (HCAs): 57 WTE (decrease of 10 WTE on prior month).
Year-on-Year Comparison: -6 decrease compared to September 2025 (+4 WTE increase in HCAs, -10 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 underway with NHSE through the ETOC project to review the Enhanced Care strategy and delivery model. An ETOC project team has been established, and the project aims have been agreed. NHS England visited the Trust in January to meet with the project team, led by Suzy Pike.

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 HIOWFT, 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.

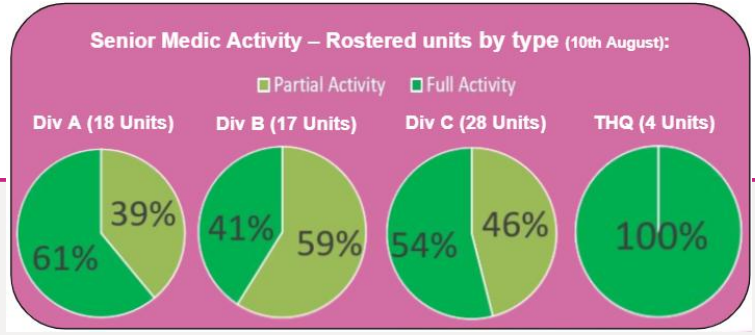
5. Temporary Workforce Quality
Ongoing work is focused on developing a workforce suitable for an acute hospital setting.

Source: Temporary Resourcing – September 2026

Workforce: Medical Rostering and Job Planning

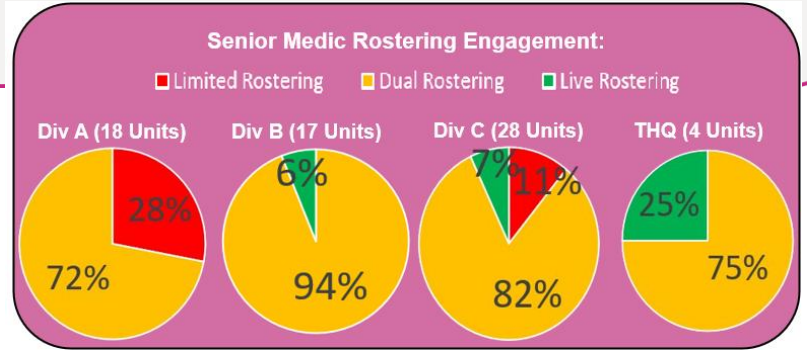
Rostering

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



- 12% of units are not using HealthRoster or have 'Limited Rostering'
- 82% of units are being rostered alongside other existing rostering tools as 'Dual Rostering'
- 6% of units are using HealthRoster as a 'Live Rostering' tool

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	74% 674 of 912
SAS Doctors	55% 56 of 92
Active Accounts	91% logged into during the last 12 months.

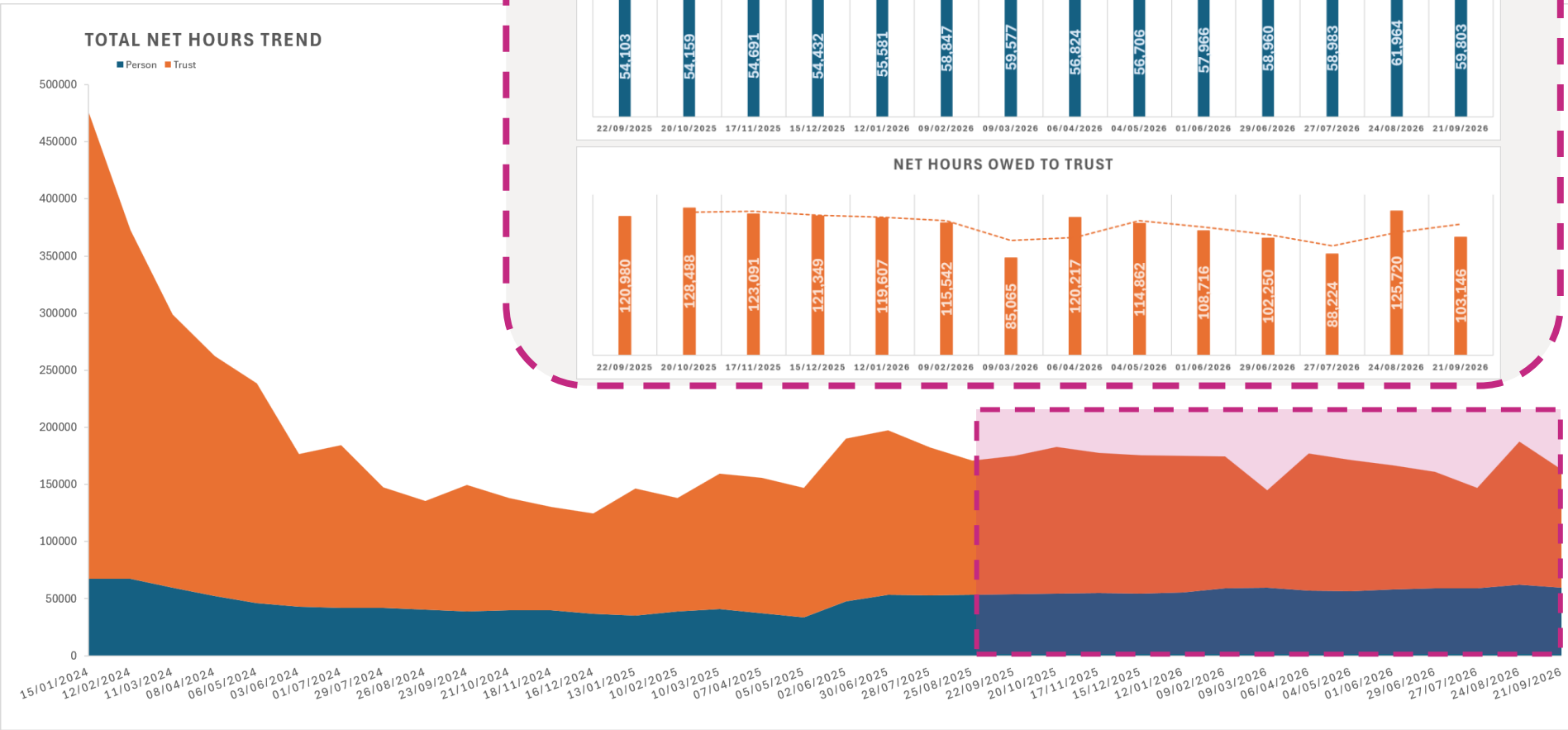
- Supporting meetings and progress with service job planning for Cardiac Surgery, Cancer Care and the Emergency Department
- Extensive streamlining of Non-DCC activity, for example SPA has reduced from 120+ activities to 40.
- Preparing Sharepoint, the 'Toolkit', site to be published.
- Option to Extend Job Plans has had very low uptake, around 10%.

Next month's planned activities:

- All job plans will be extended or republished by the end of October.

Source: Healthroster & Job Plan – Sept 2026

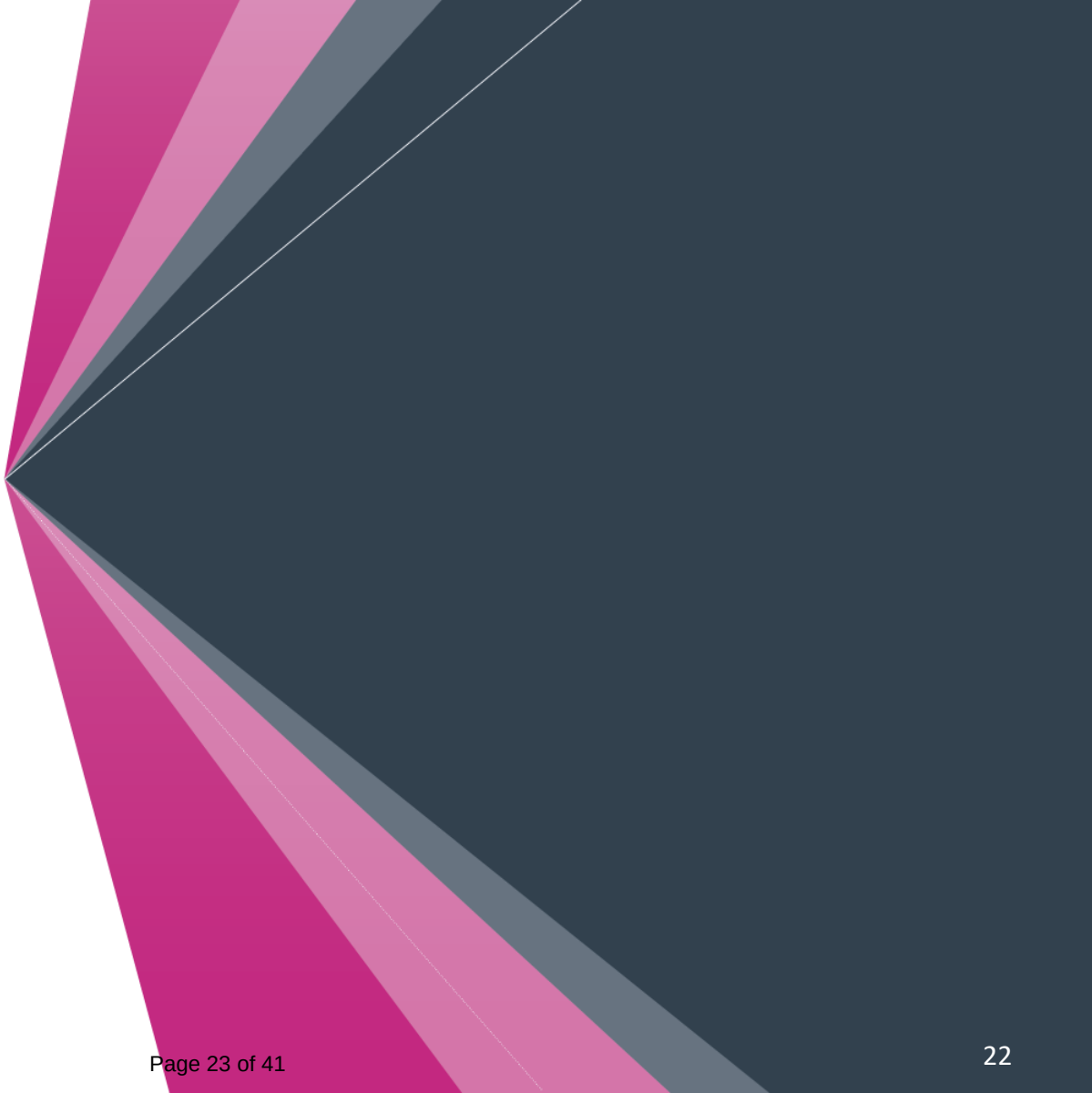
Net Hours



- **Since the start of the net hours project in Jan 24**, there has been an **11% reduction** in hours owed to staff, and a 75**% reduction** in hours owed to the trust
- **In comparison with September 2025**, there has been an **11% increase** in net hours owed to staff, and a **15% decrease** in net hours owed to the trust

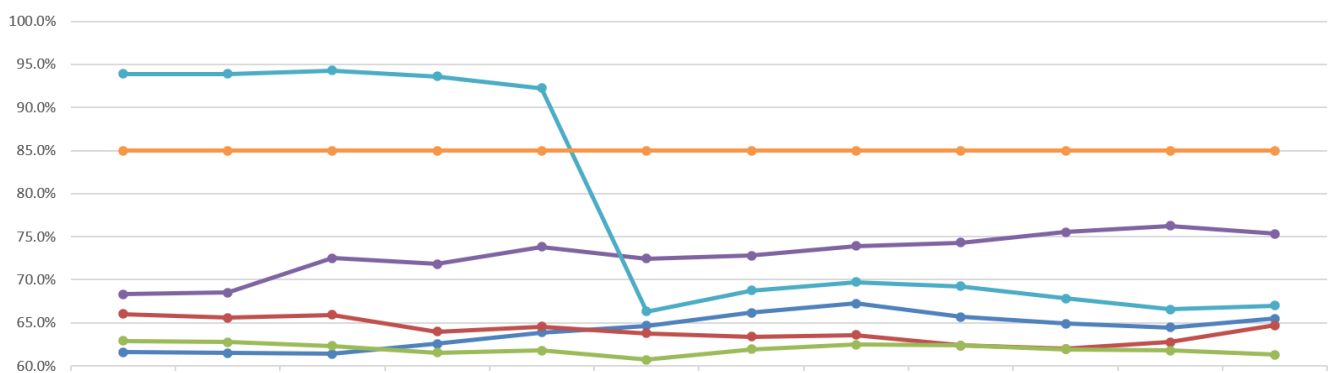
Source: HealthRoster September 2026

EXCEL



Appraisals – Agenda for Change Staff

The Trust's appraisal completion rate is 65.1% as of September 2026, a 0.5% increase on August 2026

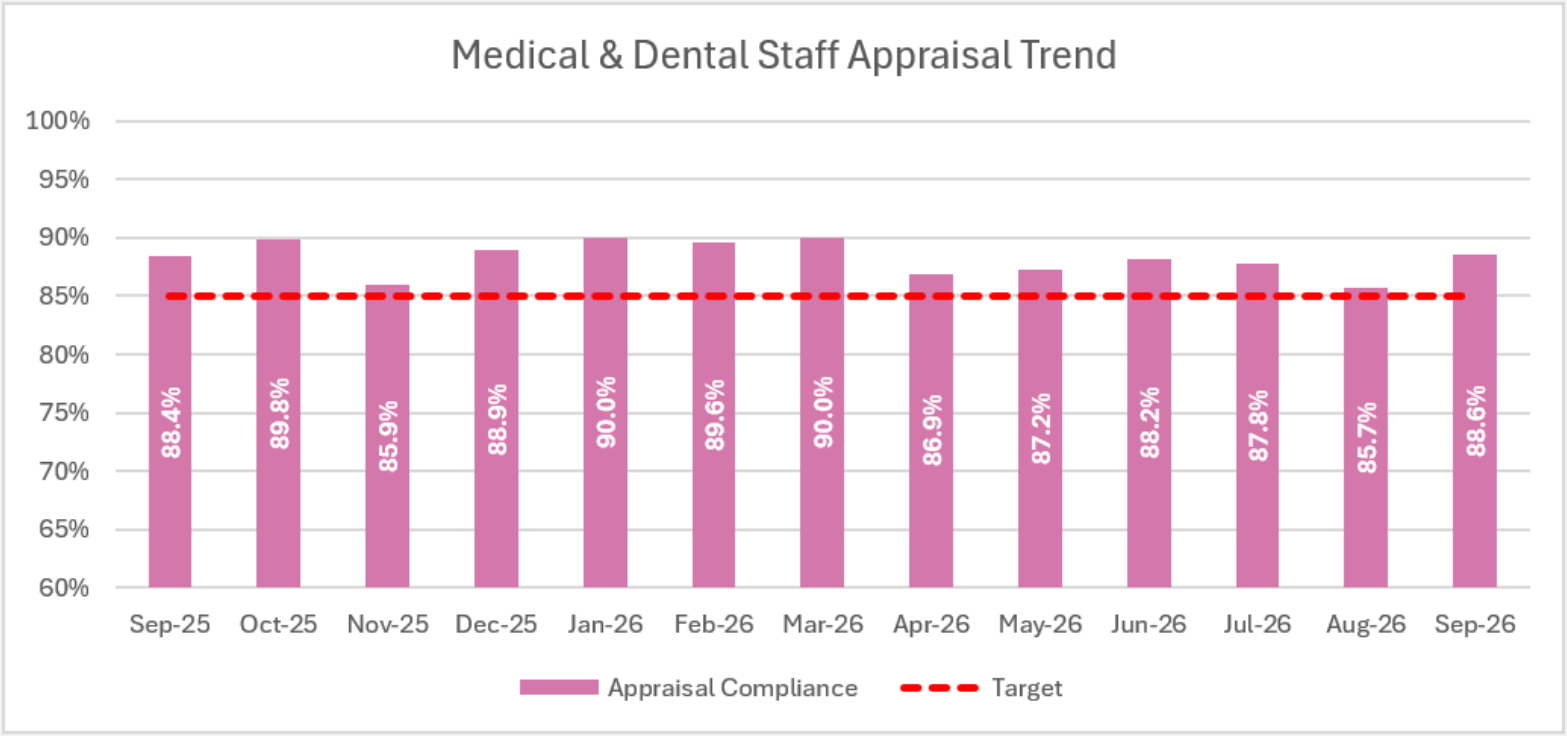


	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
188 Division A	61.6%	61.5%	61.4%	62.6%	63.9%	64.7%	66.2%	67.2%	65.7%	64.9%	64.5%	65.5%
188 Division B	66.0%	65.6%	65.9%	64.0%	64.6%	63.8%	63.4%	63.6%	62.4%	62.0%	62.7%	64.7%
188 Division C	62.9%	62.8%	62.3%	61.6%	61.8%	60.7%	61.9%	62.5%	62.3%	61.9%	61.8%	61.3%
188 Trust Headquarters - Division	68.3%	68.5%	72.5%	71.8%	73.8%	72.5%	72.8%	73.9%	74.3%	75.5%	76.3%	75.3%
188 UEL - Division	93.9%	93.9%	94.3%	93.6%	92.2%	66.3%	68.7%	69.7%	69.3%	67.8%	66.6%	67.0%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

UEL appraisal compliance dropped considerably in March 26; this reflects the EFCD to UEL TUPE (1st April 25). The transferred staff were treated as new starters in the system and therefore remained compliant until their first appraisal became due

Source: ESR & VLE. Appraisal data for Div A, B, C, THQ & UEL. Agenda for Change staff only.

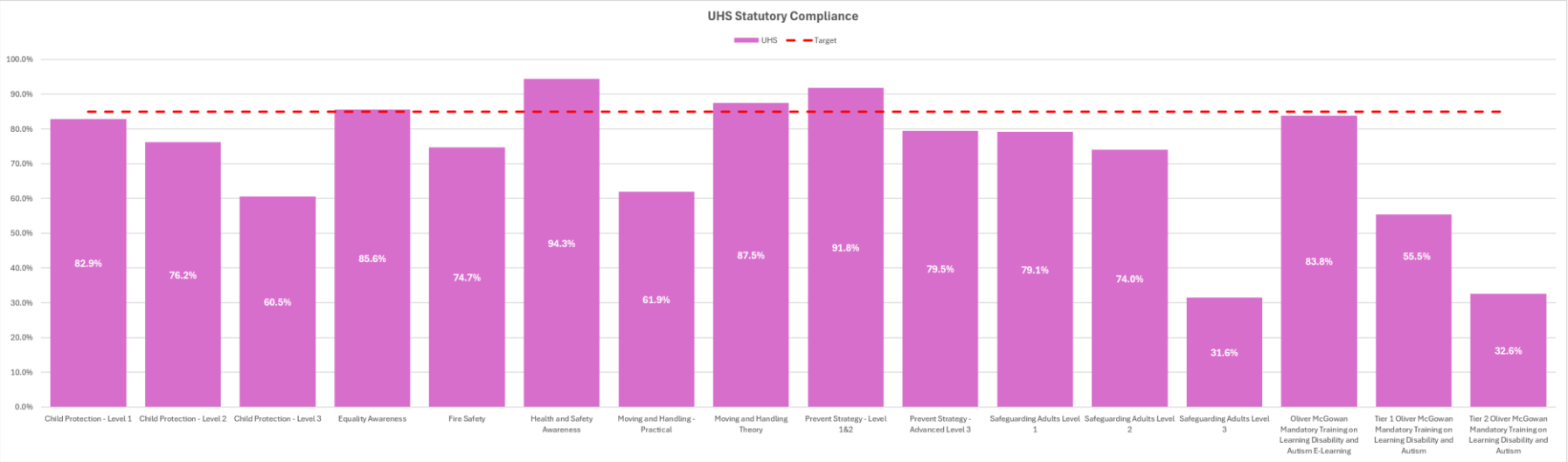
Appraisals – Medical & Dental Staff



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

UHS Statutory Compliance

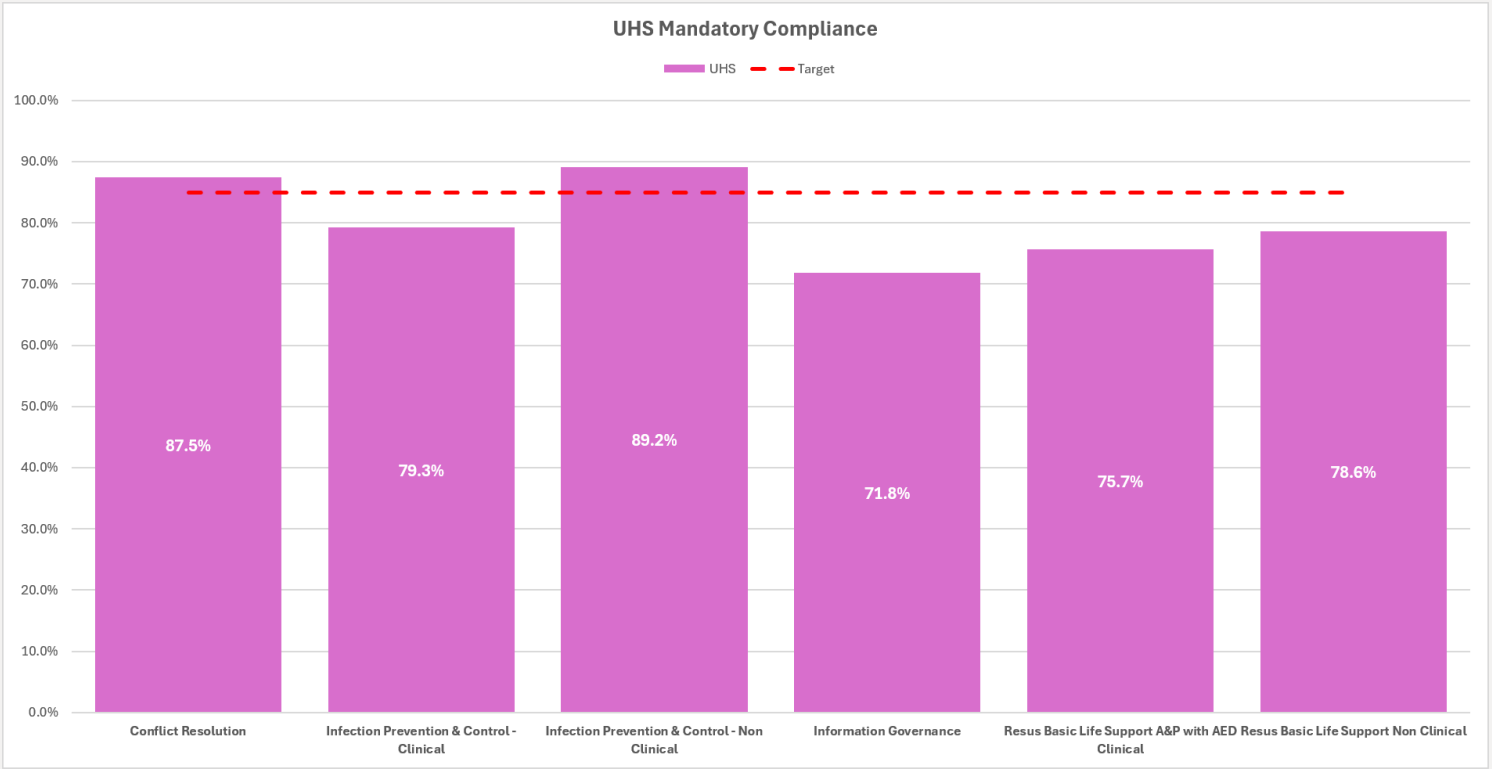
The Trust's average Statutory compliance rate for September 2026 is 72%, with 4 of 16 measures above the 85% target.



Source: Virtual Learning Environment (VLE).

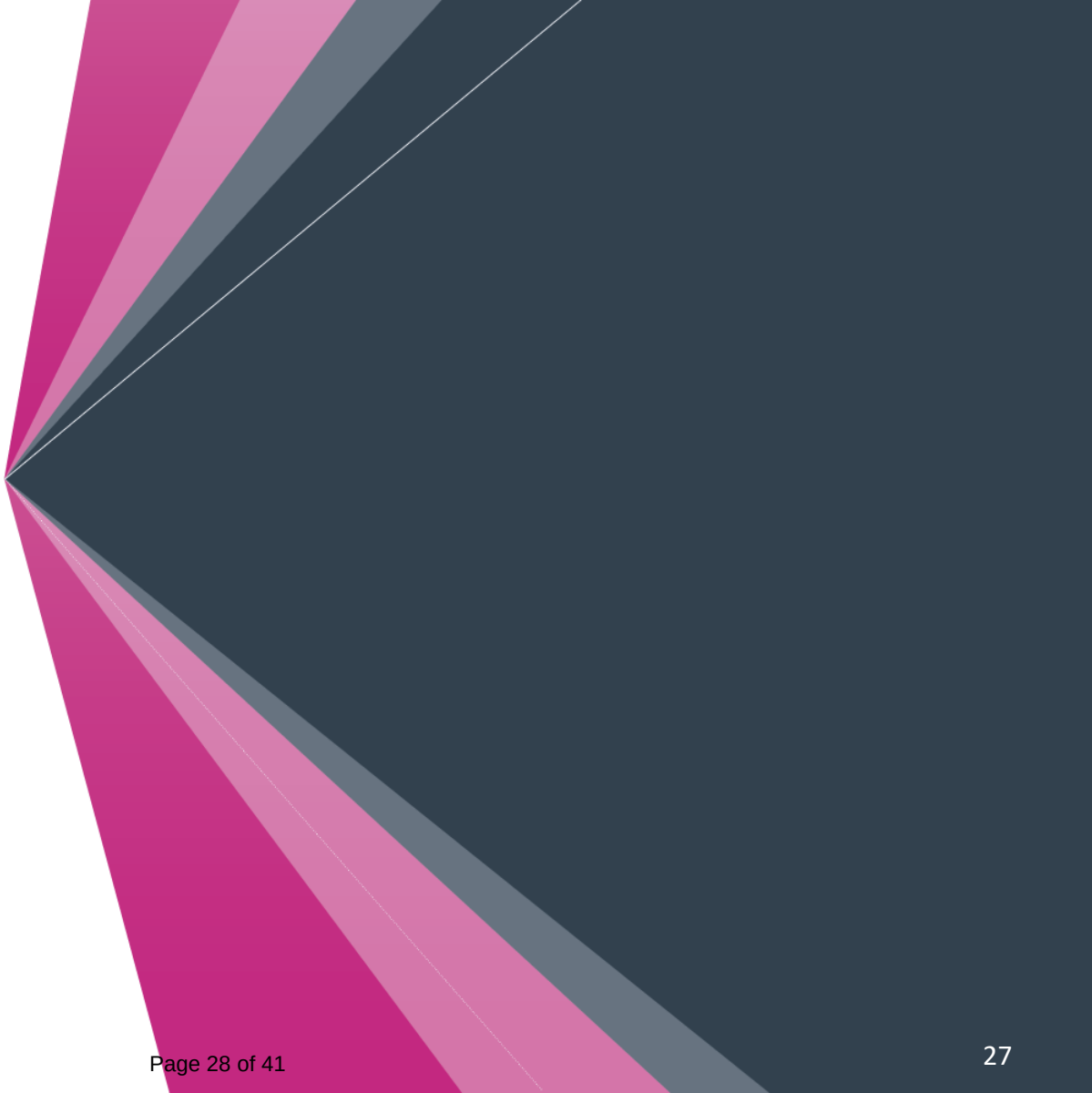
UHS Mandatory Compliance

The Trust's average Mandatory compliance rate for September 2026 is 80%, with 2 of 6 measures above the 85% target.

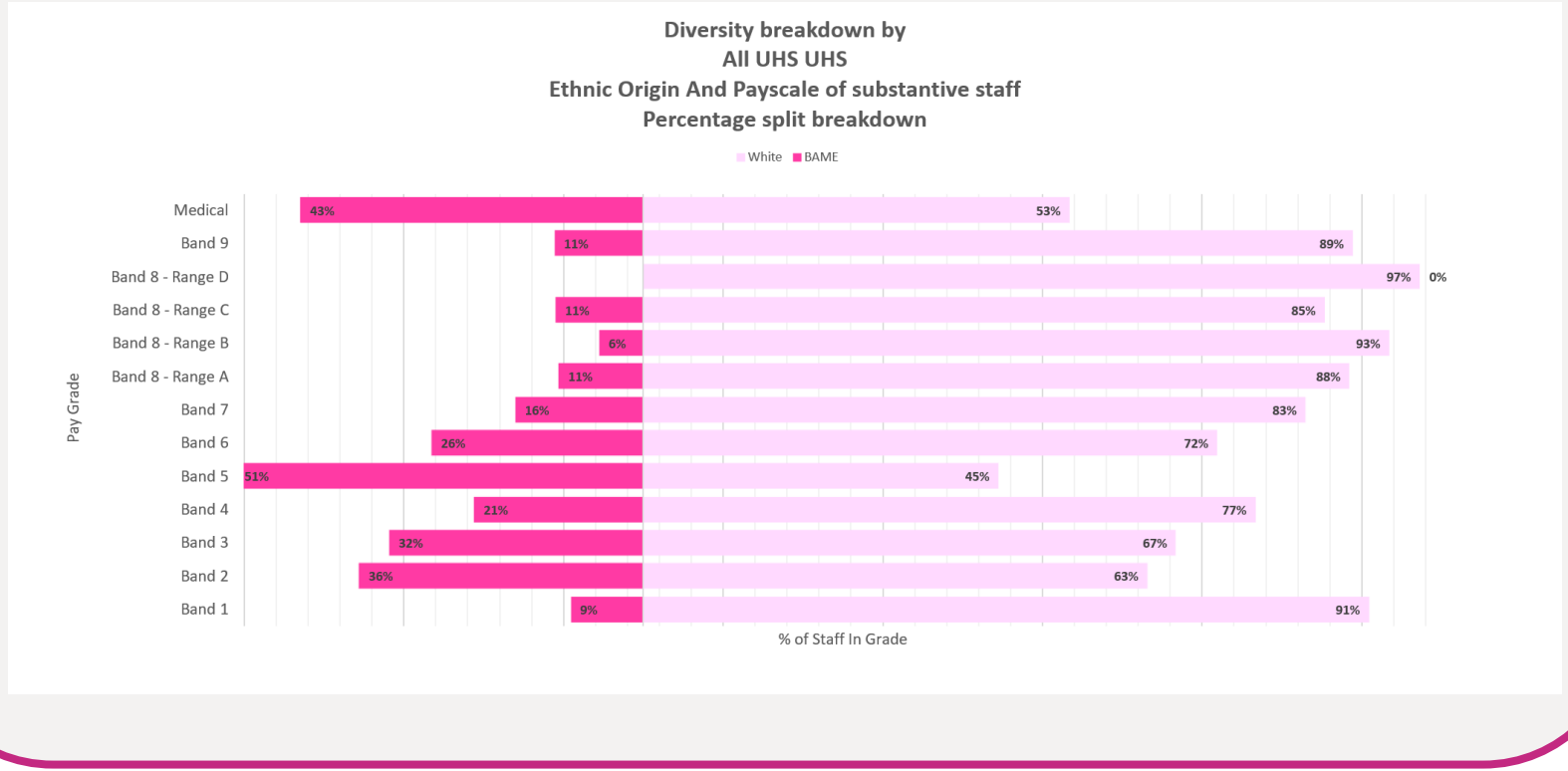


Source: Virtual Learning Environment (VLE).

BELONG

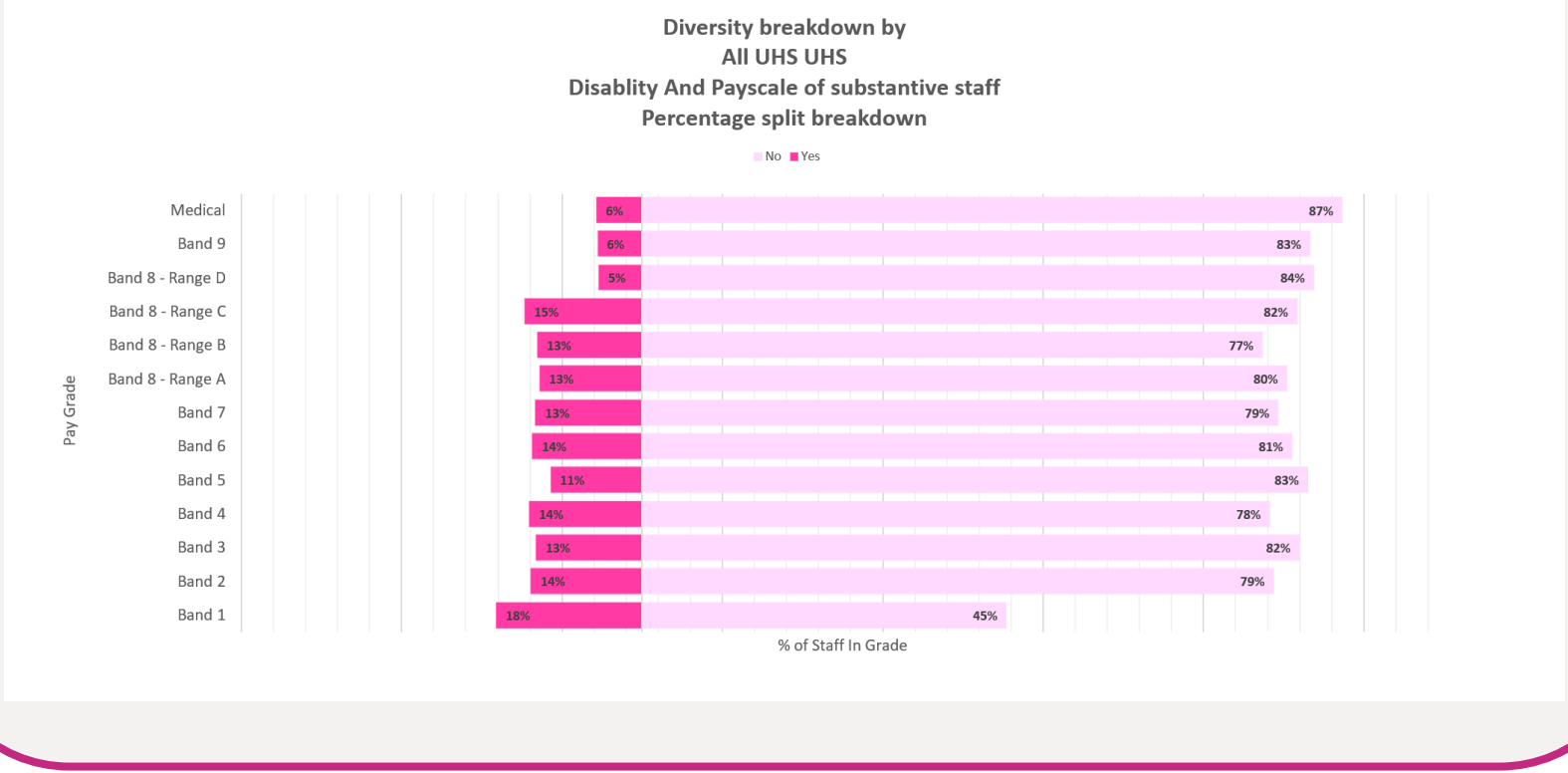


Staff in Post – Ethnicity



Source: ESR – September 2026

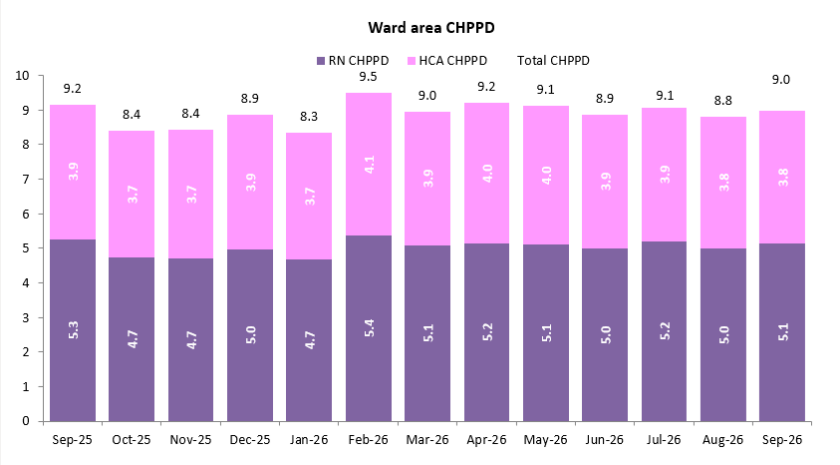
Staff in Post – Disability Status

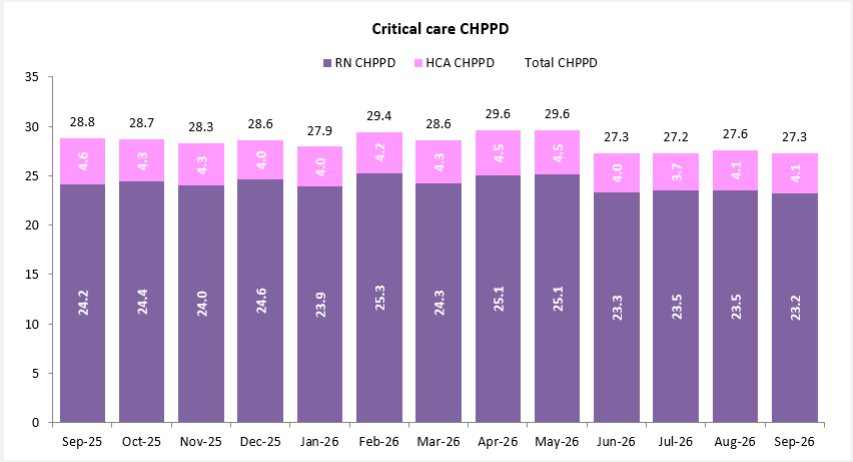


Source: ESR – September 2026

Staffing Safety

CHPPD



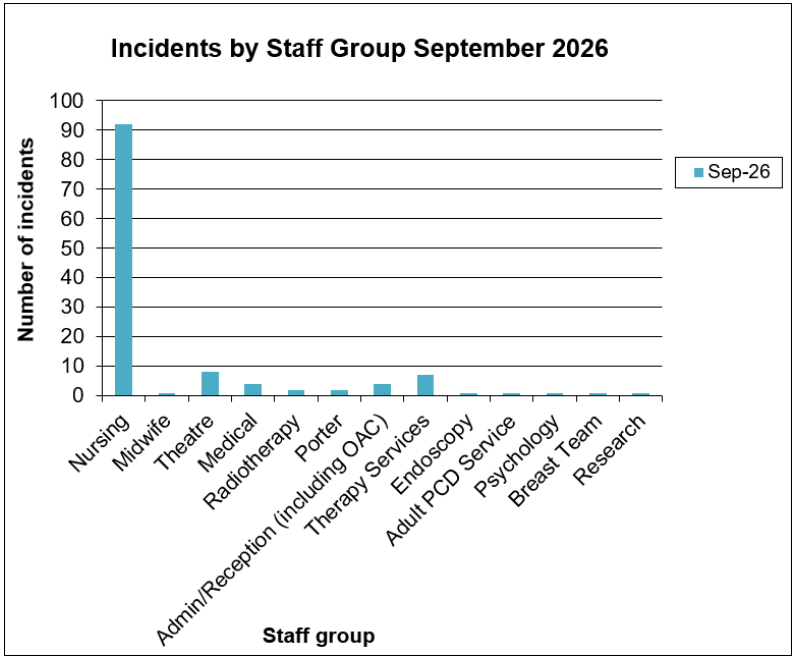


Patients continue to be cared for in different specialties/shared ward spaces as part of the recovery operation. This has continued into September 2026 with wards being repurposed or shared, and staff moving across areas to maintain staffing levels. As a result, data should be reviewed with caution as it may 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 – September 2026

Patient Safety – Staffing Incidents & Red Flags

In total 125 incident reports were received in September 2026 which cited staffing. This is a slight increase on the 122 reported in August 2026 and rises have been noted in clinical divisions B and C. THQ is slightly higher than the previous month.



Incidents by Division September 2026 vs August 2026

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
September 2026	37	54	31	3	125
Total	37 ↓ 50	54 ↑ 44	31 ↑ 26	3 ↑ 2	125 ↑ 122

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
August 2026	50	44	26	2	122
Total	50 ↑ (44)	44 ↑ (42)	26 ↓ (35)	2 ↓ (5)	122 ↓ (126)

Source: Safeguard System September 2026

Patient Safety – Staffing Incidents & Red Flags cont.

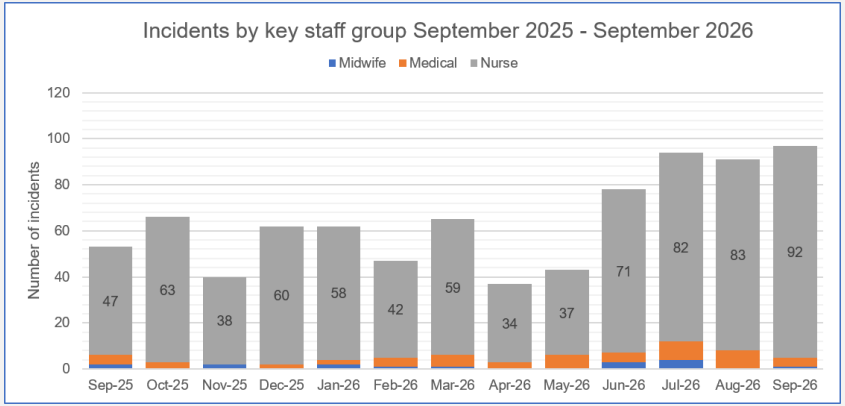
DIVISIONAL BREAKDOWN:

Div A:
Thirty-seven incidents reported in September, a slight decrease on the previous month (50). There were 31 red flags, a significant increase of 14 on the previous month.

Div B:
Fifty-four incidents were reported in September (an increase on the 44 in the previous month). There were 34 red flags reported, a significant increase on the 8 reported in the previous month.

Div C:
Thirty-one incidents were reported in September (an increase on the 26 in the previous month). There were 0 red flags reported a decrease on the previous month (2).

THQ:
Three incidents were reported in September (a slight increase from the previous month (2)). The incidents were reported from Portering and Research.



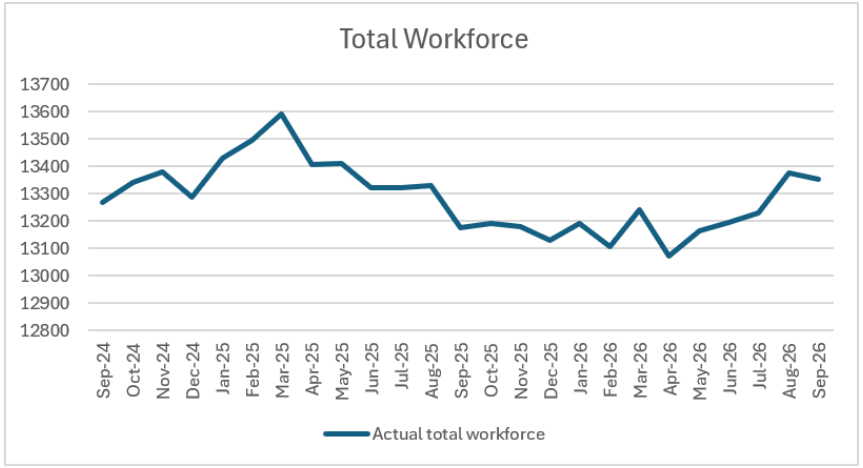
September 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	17	8	9	0
	Delay in pain relief	14	7	7	0
	Delay in observations	17	8	9	0
	Less than 2 registered	17	8	9	0
	Total	**65**	**31**	**34**	**0**

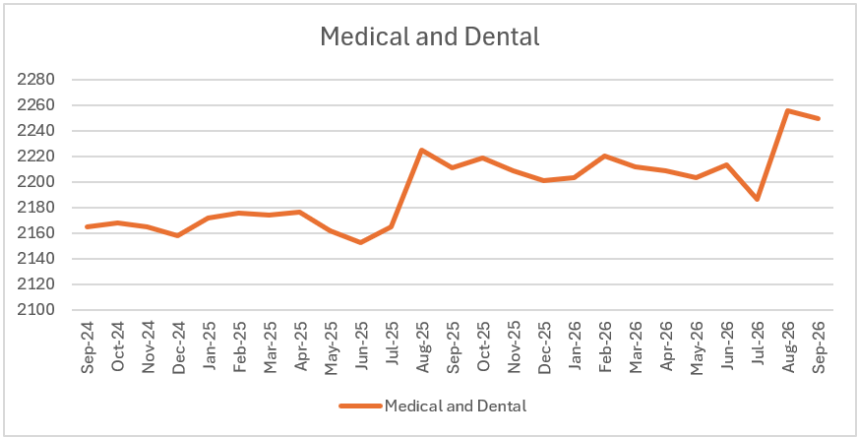
August 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	4	3	1	0
	Delay in pain relief	8	5	3	0
	Delay in observations	6	3	2	1
	Less than 2 registered	6	3	2	1
	Total	**24**	**14**	**8**	**2**

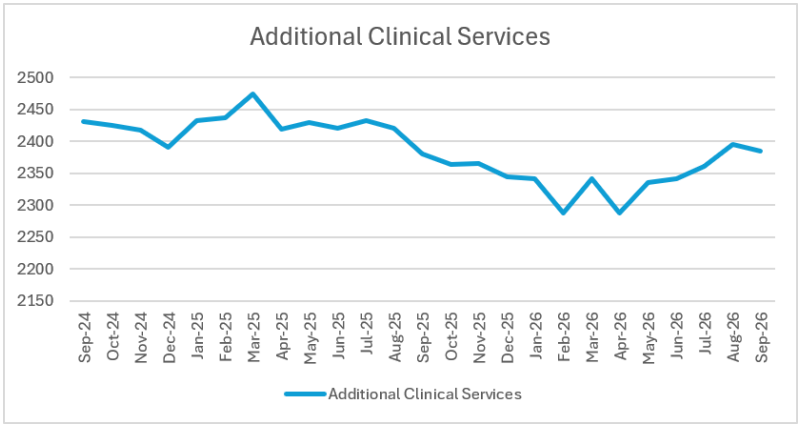
Source: Safeguard System September 2026

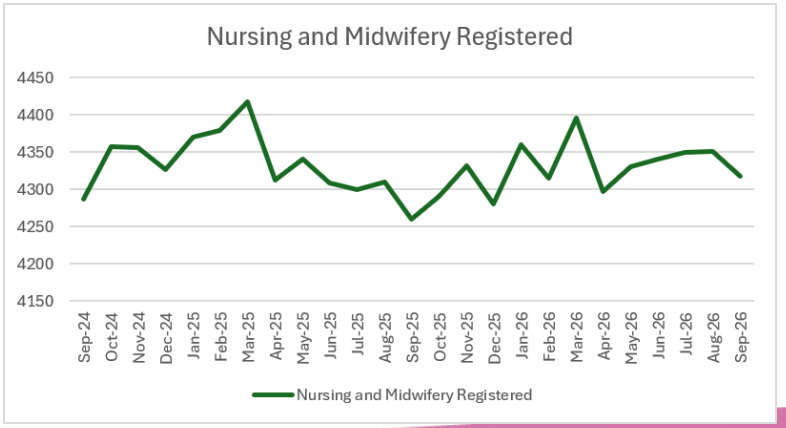
Appendices

Total Workforce Graphs by Staff Group



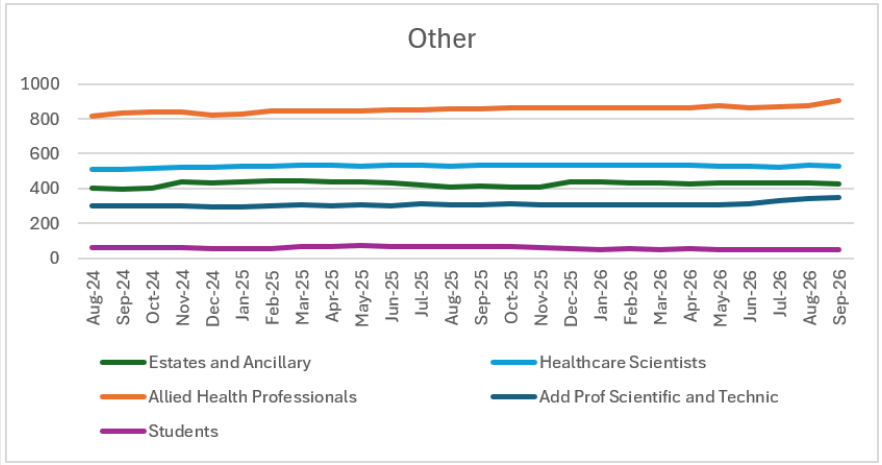


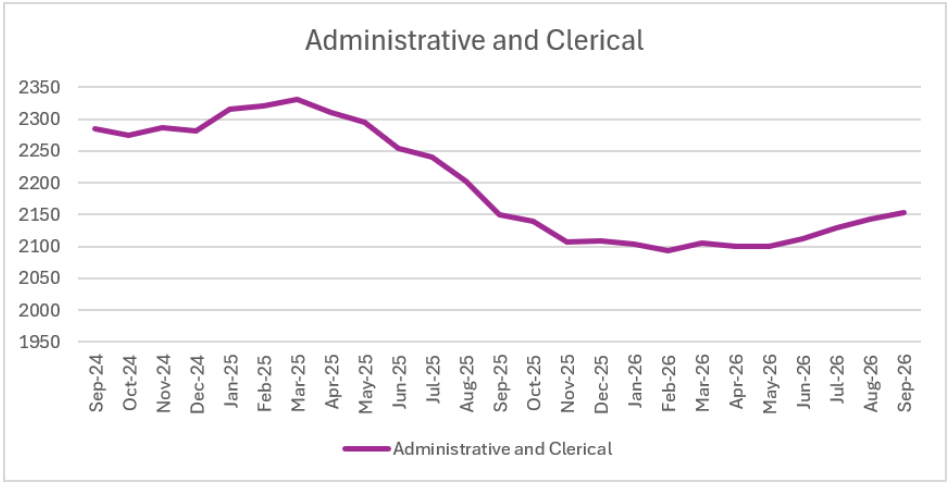




Source: ESR – September 2026

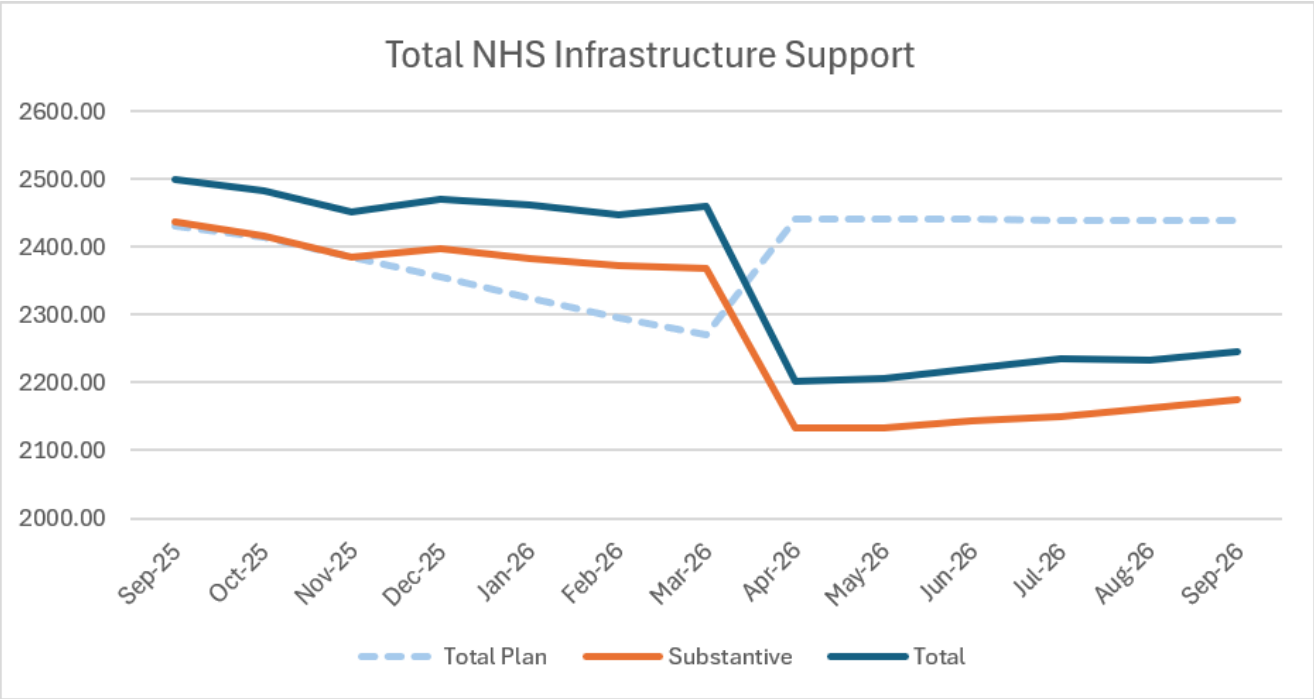
Total Workforce Graphs by Staff Group cont.





Source: ESR – September 2026

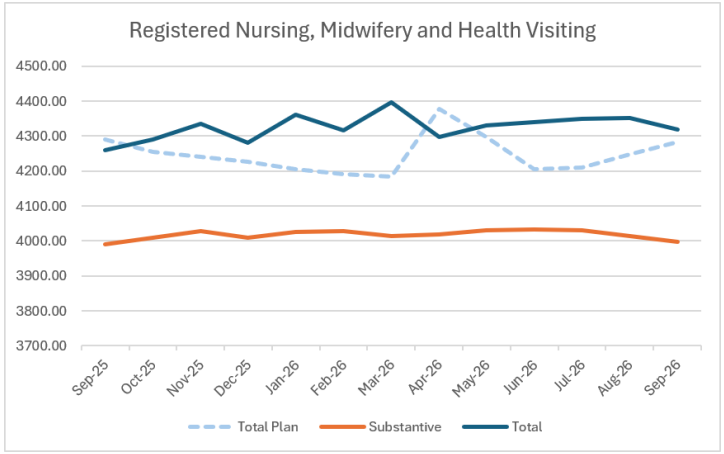
Progress Against Plan by Staff Group

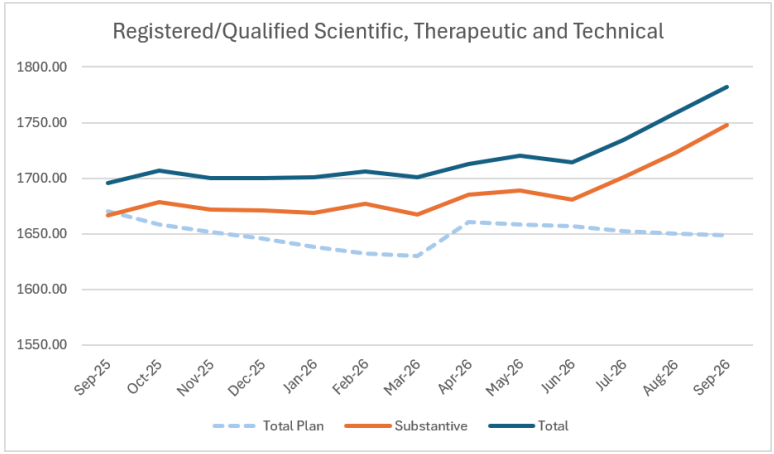


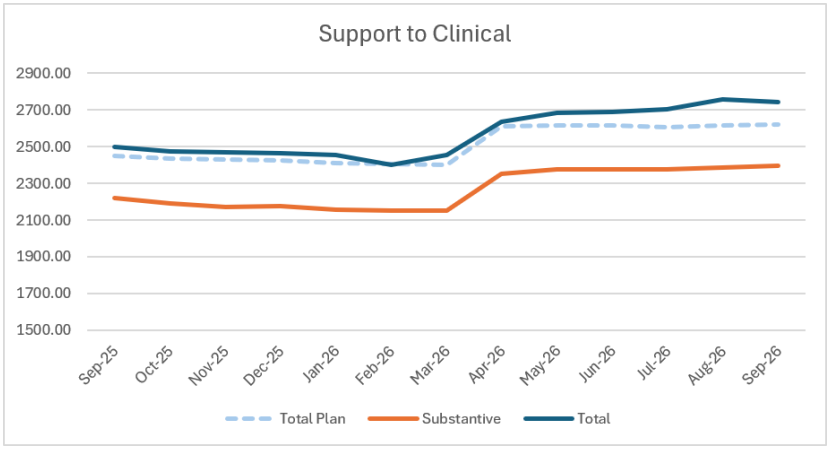
The steep decrease between March and April 2026 reflects changes in Provider Workforce Return criteria rather than genuine reduction.
In line with NHS England guidance for 26/27, Porters and Support Workers within Estates & Ancillary are now counted within 'Support to Clinical' rather than 'Infrastructure Support'.

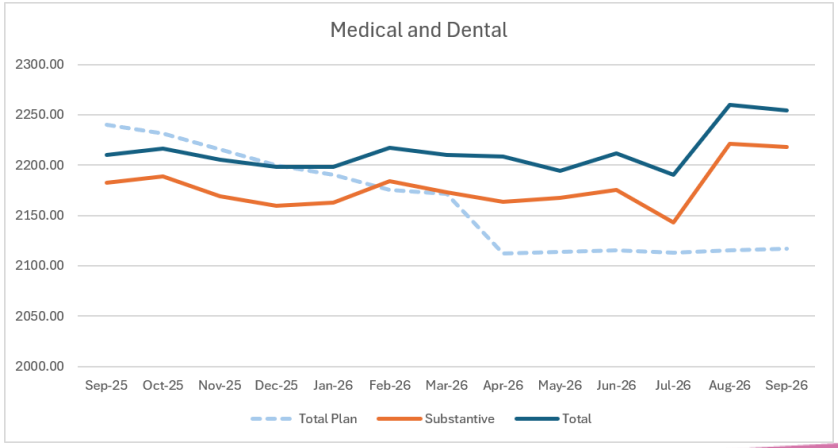
Source: PWR – September 2026

Progress Against Plan by Staff Group cont.









Source: PWR – September 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)	26/27 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and specified hosted networks within Divisions. Capital funded posts.
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	26/27 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and specified hosted networks within Divisions. Capital funded posts.
Temporary Staffing (WTE)	Bank: NHSP; THQ Medical Bank Agency: 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 Care Wards, and ED only


OUTSTANDING
PEOPLE

Agenda Item 5.11	Report to the Trust Board of Directors, 12 November 2026
Title:	Maternity and Neonatal Services – Thirlwall Inquiry Report
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Jessica Bown, Lead Matron – Maternity Services Alison Millman, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

Purpose

(Re)Assurance	Approval	Ratification	Information
x	x		x

Strategic Theme

Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			

Executive Summary:

The Thirlwall Inquiry examined the events at the Countess of Chester Hospital and the wider NHS systems that contributed to delays in recognising and responding to concerns. Its findings have significant implications for patient safety, safeguarding, organisational culture, mortality surveillance, escalation of concerns, governance and leadership accountability.

The Inquiry report was published in September 2026 and made 17 recommendations to the Government and the NHS. Five recommendations are specifically directed to NHS trusts, although the wider findings are relevant to all healthcare organisations. NHS England has also asked trusts to complete seven immediate actions.

UHS has undertaken an initial assessment against the Inquiry recommendations and the seven immediate NHS England actions. The detailed assessment is provided at Appendix 1, with the Trust response to the immediate actions at Appendix 2.

The assessment identifies areas where established UHS arrangements provide assurance, including:

- maternity, neonatal and paediatric mortality oversight;
- reporting through Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries, known as MBRRACE-UK;
- use of the Maternity Oversight Signal System;
- established maternity and neonatal governance and escalation routes; and
- communication of the immediate requirements relating to sudden and unexpected deaths in infancy and childhood.

The assessment has not assumed that the existence of an established process in itself demonstrates full compliance. Where the Inquiry introduces a more specific requirement, further review is being undertaken to confirm that local arrangements fully meet that requirement.

The principal areas requiring further action or assurance are:

- safeguarding training compliance and the inclusion of deliberate harm within relevant training;
- neonatal insulin storage, access controls and CCTV arrangements;
- implementation of the National Bereavement Care Pathway;
- Trust-wide escalation of concerning mortality data, trends or patterns;
- employment contract requirements;
- medical examiner processes; and
- implementation of recommendations that remain dependent on national guidance.

A Trust Task and Finish Group has been established to coordinate the response, maintain the action plan and monitor delivery. The group will meet every three weeks, with progress reported quarterly to Quality Committee. Matters requiring more immediate attention will be escalated through established Trust governance arrangements.

The Board is asked to:

1. Consider the applicability of the Thirlwall Inquiry findings and recommendations to UHS.
2. Note the initial UHS assessment, including the areas where existing arrangements provide assurance and those requiring further work.
3. Approve the proposed governance and oversight arrangements for delivery of the action plan.
4. Receive assurance that the seven immediate NHS England actions have been reviewed and are being progressed through named executive and operational leads.
5. Note that further assurance on delivery will be reported through Quality Committee.

Contents:

1. Background
2. UHS assessment and assurance position
3. Key areas requiring further action
4. Governance and oversight
5. Risks
6. Equality impact considerations
7. Conclusion and recommendations

Appendix 1: UHS assessment against the 17 Thirlwall Inquiry recommendations
Appendix 2: UHS response to the seven immediate NHS England actions

Risk(s):

Failure to implement the recommendations applicable to UHS within the required timescales may create patient safety, safeguarding, regulatory, governance and reputational risks.

The principal current risks relate to safeguarding training compliance, timely implementation of enhanced insulin security arrangements, and the need to confirm that Trust-wide mortality escalation and medical examiner processes fully meet the Inquiry requirements. Some actions are also dependent on national guidance or centrally determined arrangements.

These risks will be managed through the Trust action plan and Task and Finish Group, with named executive and operational leads, agreed target dates and escalation through the established governance structure where delivery is delayed or further support is required.

Equality Impact Consideration:	Yes

1. Background

The Thirlwall Inquiry was established in October 2023 following the trial and subsequent convictions of former neonatal nurse Lucy Letby for the murder and attempted murder of babies at the Countess of Chester Hospital.

The Inquiry considered the experiences of the families involved, the actions and responses of staff and leaders at the Countess of Chester Hospital, and whether concerns should have been recognised, escalated and investigated earlier. It also examined whether the Trust's culture, management, governance structures and processes contributed to the failure to protect babies.

The Inquiry considered the effectiveness of wider NHS management, governance, external scrutiny and professional regulation in maintaining patient safety. This included how concerns about possible deliberate harm should be managed and how the accountability of senior managers should be strengthened.

In 2015, eight babies out of 468 admissions died on the neonatal unit at the Countess of Chester Hospital. Two further babies born at the hospital were transferred to other hospitals, where they subsequently died.

The increase in neonatal deaths represented a significant alert signal within MBRRACE-UK surveillance data. However, the data analysis for 2015 was not reported until June 2017, by which time the police had been contacted. The Inquiry identified that the value of the alert signal was diminished by this delay.

This reinforces the importance of:

- timely and accurate mortality reporting;
- active review of available surveillance information;
- professional curiosity;
- clear and predetermined escalation routes;
- Board visibility of mortality data and safety signals; and
- a culture in which concerns are heard and acted upon.

The Inquiry report was published in September 2026. It made 17 recommendations covering areas including:

- CCTV and parental livestreaming within neonatal units;
- insulin access, storage and investigation;
- bereavement care;
- safeguarding training and employment contracts;
- digital interoperability;
- mortality monitoring and escalation;
- data reporting;
- sudden and unexpected deaths in infancy and childhood;
- concerns or suspicions of deliberate harm;
- access to independent clinical expertise;
- medical examiner arrangements;
- paediatric and perinatal pathology;
- accountability and regulation of managers;
- the role of the Care Quality Commission;
- whistleblowing; and
- national oversight of the implementation of statutory inquiry recommendations.

Five of the recommendations are specifically directed to NHS trusts, although the wider findings have relevance to all healthcare organisations. NHS England has also identified seven immediate actions for trusts.

UHS has undertaken an initial review of the recommendations and immediate actions. The detailed assessment is set out at **Appendix 1**, with the response to the seven immediate NHS England actions at **Appendix 2**. This paper focuses on the overall UHS assurance position, the areas requiring further action and the arrangements for oversight and delivery.

2. UHS assessment and assurance position

The initial UHS assessment identifies areas where established arrangements provide assurance, alongside areas where further work is required to confirm or strengthen compliance.

The assessment has considered whether:

- an established Trust mechanism meets the recommendation;
- an existing mechanism is in place but requires further assurance or strengthening;
- new work is required;
- implementation is dependent on national guidance; or
- the recommendation is directed to a national organisation rather than individual NHS trusts.

Importantly, the assessment has not assumed that the presence of an existing policy, process or governance route in itself demonstrates full compliance. Where a recommendation introduces a more specific requirement, further assurance or gap analysis is being undertaken.

2.1 Mortality oversight

UHS has established arrangements for maternity, neonatal and paediatric mortality review and reporting.

Information on reportable neonatal deaths is included within the quarterly Maternity and Neonatal Safety Report presented to Quality Committee and Trust Board. Deaths of non-viable babies are included within the UHS Maternity Dashboard.

Deaths of children are reviewed through the Child Death and Deterioration Group and reported quarterly through Children's Hospital governance arrangements. Work is continuing to consider how learning from the deaths of babies and children can be more explicitly represented within the Trust-wide learning from deaths report.

2.2 Maternity and neonatal safety surveillance

The Maternity Oversight Signal System was introduced at UHS in November 2025. It uses information relating to term stillbirths and term neonatal deaths up to 28 days after birth to identify potential maternity safety signals.

The system is reviewed and reported quarterly through the Maternity and Neonatal Safety Report. A signal prompts a service-led critical safety check. A standard operating procedure is in place and a critical safety check exercise is scheduled annually.

2.3 MBRRACE-UK reporting

The Maternity and Neonatal Quality Assurance Matron team has responsibility for MBRRACE-UK reporting. Reportable deaths are submitted and mortality information is monitored and reported through maternity and neonatal governance arrangements.

A further gap analysis is required to confirm whether existing arrangements fully meet the specific Inquiry requirement for at least weekly review of real-time data viewers. This will include consideration of the role, training and responsibilities of the identified lead reporter.

2.4 Sudden and unexpected deaths

Relevant staff were informed on 28 September 2026 that the process for sudden and unexpected deaths in infancy and childhood applies to babies who die suddenly and unexpectedly without having left hospital.

The Trust Neonatal Death Standard Operating Procedure and Child Bereavement Guideline will be reviewed when revised national guidance is published.

3. Key areas requiring further action

3.1 Safeguarding and responding to concerns

Safeguarding training is established and mapped to staff roles across UHS. However, current compliance does not provide the level of assurance required.

A safeguarding assurance improvement plan will be completed by 31 December 2026. This will set out how training compliance will be improved and how training will explicitly cover the response required where there are concerns or suspicions that a member of staff may have deliberately harmed a patient.

The plan will also consider safeguarding training requirements for Board members, including Non-Executive Directors.

UHS is reviewing its existing processes for managing allegations and concerns while awaiting publication of the national Suspicion of Deliberate Harm Protocol. A further assessment will be undertaken once the national protocol and supporting guidance are available.

3.2 Insulin security and access

A multidisciplinary review of neonatal insulin storage, access controls and monitoring arrangements is under way.

This work will assess compliance with the NHS England Getting It Right First Time guidance on safe insulin use. It will identify all neonatal insulin storage locations and confirm the requirements for digital access controls, CCTV coverage and retention of recordings for at least 28 days.

The review will also consider privacy, information governance and security requirements. The resulting improvement plan will identify any investment, estates or digital support required to demonstrate compliance within the required timescale.

3.3 Bereavement care

A gap analysis against the National Bereavement Care Pathway for stillbirth and neonatal death will be completed by 31 January 2027.

The review will assess whether bereaved families receive consistent, compassionate and high-quality care in line with the national pathway. Any gaps will be incorporated into a Bereavement Care Improvement Plan with named leads, target dates and evidence requirements.

3.4 Mortality surveillance and escalation

UHS has established maternity, neonatal, paediatric and Trust-wide governance arrangements for mortality oversight.

Further work is required to confirm that these arrangements collectively provide a clear and predetermined Trust-wide route for escalating concerning mortality data, trends or patterns to senior management and the Board.

An assurance review will be completed with the Trust Patient Safety Team. This will include the escalation of urgent concerns outside the routine quarterly reporting cycle. Any gaps identified will be incorporated into the Trust action plan.

3.5 Medical examiner arrangements

An assurance review will be completed with UHS Medical Examiner leads to confirm that local processes meet the relevant Inquiry recommendations.

The review will consider:

- how medical examiners ask direct questions about possible harm or safeguarding concerns;
- how those questions and the responses are recorded;
- how details of the healthcare professionals involved in a baby's care are retained where concerns arise;
- access to appropriate neonatal clinical advice; and
- how revised national requirements will be incorporated into local practice.

A local medical examiner development day focusing on child and neonatal death was held in October 2026. Further actions arising from the assurance review will be added to the Trust action plan.

3.6 Employment arrangements

Human Resources will review the employment implications arising from the Inquiry recommendations.

This will include the proposed requirement for employment contracts to contain an obligation to comply with relevant safeguarding guidance and the forthcoming Suspicion of Deliberate Harm Protocol.

The review will consider existing and new employees, as well as bank and agency workers. It will also identify any national employment, contractual or legal guidance needed before local implementation.

3.7 CCTV and parental livestreaming

UHS is awaiting the NHS England roadmap for cameras and parental livestreaming within neonatal services.

In preparation, an initial scoping exercise will assess:

- the current number and location of cots and incubators;
- camera requirements and coverage;
- Wi-Fi and digital infrastructure;
- cyber security and information governance;
- privacy and consent;
- parental access;
- estates implications;
- staffing and operational requirements; and
- likely capital and ongoing costs.

Future implementation will need to balance parental involvement with appropriate safeguards for babies, families and staff. A funded implementation plan will be developed once the national requirements and funding arrangements are confirmed.

4. Governance and oversight

A Trust Task and Finish Group has been established to coordinate the UHS response, maintain the detailed action plan and monitor delivery.

The group will meet every three weeks while the immediate actions and initial gap analyses are being completed. Its responsibilities will include:

- confirming executive and operational ownership;
- agreeing target completion dates;
- defining the evidence required to demonstrate completion;
- monitoring delivery and dependencies;
- identifying resource or investment requirements;
- reviewing new national guidance;
- escalating delayed or high-risk actions; and
- reporting progress through the appropriate governance routes.

Actions will not be treated as complete solely because a policy or process exists. Completion will require proportionate evidence that the relevant requirement has been implemented and is operating effectively.

Progress will be reported quarterly to Quality Committee. Reports will include:

- progress against the seven immediate NHS England actions;
- the outcome of the identified gap analyses and assurance reviews;
- overdue or high-risk actions;
- areas where assurance remains incomplete;
- national guidance received since the previous report;
- required investment or additional support; and

- the updated overall UHS assurance position.

Urgent patient safety concerns, material delivery delays or significant gaps in assurance will be escalated through established Trust governance arrangements without waiting for the quarterly reporting cycle.

This approach provides Trust Board with oversight of the overall organisational response, while enabling detailed scrutiny of delivery through Quality Committee.

5. Risks

Failure to respond effectively to the Inquiry findings could lead to missed opportunities to strengthen the protection of babies, children and other patients. It could also expose the Trust to patient safety, safeguarding, regulatory, governance and reputational risk.

The initial UHS review has deliberately identified areas where assurance remains incomplete. The most immediate areas are safeguarding training compliance, neonatal insulin security and the need to confirm that mortality escalation and medical examiner arrangements meet the specific Inquiry requirements.

There is a further delivery risk where local implementation depends on national guidance, protocols, funding or centrally agreed arrangements. These recommendations will remain under active review, with preparatory work undertaken where possible to support timely implementation.

Risks will be managed through the Trust action plan and Task and Finish Group. Any inability to meet a mandated timescale, or any requirement for significant additional investment, will be escalated to the appropriate Executive Director and governance forum.

6. Equality impact considerations

The Inquiry recommendations are intended to strengthen the safety and protection of all babies, children, patients and families.

Relevant equality considerations will be incorporated into implementation plans. These include:

- accessible communication and information;
- reasonable adjustments for disability;
- language and interpretation needs;
- digital access and digital exclusion;
- privacy and dignity;
- informed consent;
- equitable access to parental livestreaming technology; and
- the impact of any changes on staff and families with protected characteristics.

A full equality impact assessment will be completed where implementation of a recommendation results in a material change to Trust policy, practice or service delivery.

7. Conclusion and recommendations

The Thirlwall Inquiry has significant implications for NHS organisations. Its findings reinforce the importance of effective safeguarding, reliable mortality surveillance, professional curiosity, timely escalation of concerns and clear leadership accountability.

UHS has completed an initial assessment against the Inquiry recommendations and the seven immediate NHS England actions. The review identifies established arrangements across several areas, while also identifying where further assurance, improvement or national guidance is required.

The detailed assessment is set out at **Appendix 1**, with the Trust response to the seven immediate actions at **Appendix 2**.

The current position provides assurance that the Trust has undertaken a systematic review, has identified the principal areas requiring further work and has established a governance route to oversee delivery. It does not imply that all recommendations have been fully implemented or that assurance is complete in every area.

The Board is asked to:

1. **Consider** the applicability of the Thirlwall Inquiry findings and recommendations to UHS.
2. **Note** the initial UHS assessment and the areas where further assurance or action is required.
3. **Approve** the proposed governance and oversight arrangements.
4. **Receive assurance** that the seven immediate NHS England actions have been reviewed and are being progressed through named executive and operational leads.
5. **Note** that detailed scrutiny and further assurance on delivery will be provided through Quality Committee.

Appendix 1 – Thirlwall recommendations

Recommendations		Trust position	RAG rating
CCTV and monitoring			
1.	All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.	The Trust are awaiting national guidance as to how this will be implemented. Estates and security are conducting an initial scoping exercise for costings, including cameras and WIFI coverage.	Awaiting national guidance
Insulin			
2.1	Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, GIRFT Neonatology: Guide to safe insulin use.		
2.2	Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.		
2.3	The GIRFT Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.		
Bereavement care			
3.	The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.	A gap analysis will be completed against the National Bereavement Care Pathway (NBCP) for stillbirths and neonatal deaths. This is due to be completed by end of January 2027.	In progress
Safeguarding and contracts of employment			
4.1	All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.	The Trust has training in place with appropriate mapping, but various challenges have resulted in low compliance levels. A safeguarding assurance improvement plan is being formulated by end of December 2026. This will outline the plans to increase safeguarding training compliance across the Trust, as well as ensure that safeguarding	In progress

		training includes how to deal with concerns and suspicions about deliberate harm.	
4.2	By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.	To be explored within HR.	Not yet commenced
Operating systems (interoperability)			
5.	NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.	Action for NHS England.	National action
Monitoring deaths in hospitals			
6.1	By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board level monitoring of all deaths of children and babies.	Quarterly reports are presented to Quality Committee and Trust Board including dashboards and information on all reportable neonatal deaths which occur within the Maternity and Neonatal Service via the Maternity and Neonatal Safety Report. Deaths of non-viable babies are reported within the UHS Maternity Dashboard.	Mechanism already embedded
		Deaths of children are reviewed through Child Death and Deterioration Group. This is reported quarterly to Children's Hospital Governance, and any escalations will proceed through the usual escalation pathways. A quarterly learning from deaths report is presented to Trust Board which focuses on learning from deaths in adults. There is an ongoing action considering including learning from deaths of children and babies within this report.	In progress

6.2	By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.	To explore with Trust Patient Safety Team.	In progress
Data reporting			
7.1	All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.	The Maternity and Neonatal Quality Assurance Matron team are the lead reporters to MBRRACE. Data is inputted as required to MBRRACE (i.e. when a reportable death occurs). Data is monitored regularly and reported quarterly. Trends or concerns are reviewed and escalated through the maternity and neonatal governance routes.	Mechanism already embedded
7.2	Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise: a. whether any alerts or a need for investigation have arisen b. the investigation or action plan in place.	Quarterly reports are presented to Quality Committee and Trust Board including dashboards and information on all reportable neonatal deaths which occur within the Maternity and Neonatal Service via the Maternity and Neonatal Safety Report. The Maternity Oversight Signal System (MOSS) was introduced in November 2025 which produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days. MOSS is reviewed and reported quarterly via the Maternity and Neonatal Safety Report alongside mortality reporting. A signal prompts a service-led critical safety check. An SOP is in place for the MOSS process and a critical safety check drill is also scheduled to take place annually.	Mechanism already embedded
Sudden Unexpected Death in Infancy and Childhood (SUDIC)			
8.1	NHS England must: a. Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital. b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.	Relevant staff received communication sharing the process for managing and reporting unexpected deaths on 28/09/2026.	Completed

8.2	DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.	Awaiting national guidance which will then be updated within the Trust Neonatal Death SOP and Child Bereavement guideline.	Awaiting national guidance
8.3	SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.	Action for DHSC.	National action
Suspicion of Deliberate Harm Protocol and guidance			
9.1	By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient.	Action for NHS England. The Trust is currently reviewing our allegations processes in the interim and will further review to ensure alignment with the guidance once published.	National action
9.2	Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.	As per recommendation 9.1.	National action
9.3	Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.	The Trust is currently reviewing our allegations processes in the interim and will further review to ensure alignment with the guidance once published.	Awaiting national guidance
Panel of experts			
10	Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised.	Action for DHSC.	National action
Medical examiners			
11.1	The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.	Action for the National Medical Examiner. A local medical examiners away day was held in October 2026 with a focus on child and neonatal death.	National action

11.2	The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.	Action for the National Medical Examiner.	National action
11.3	Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.	To be explored with the UHS Medical Examiner leads as to how the Trust can be assured that this happens.	In progress
11.4	There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.	To be explored with the UHS Medical Examiner leads.	In progress
11.5	The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.	Action for DHSC.	National action
Paediatric and perinatal pathologists			
12	DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report.	Action for DHSC and NHS England.	National action
Accountability and regulation of managers			
13.1	DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.	Action for DHSC and NHS England.	National action
13.2	NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that: a. The move is not proposed because of the manager's lack of capability or misconduct. b. The manager meets the fit and proper person test.	Action for NHS England.	National action
13.3	In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.	Action for NHS England.	National action

13.4	The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first.	Action for NHS England.	National action
13.5	In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third).	Action for NHS England.	National action
Care Quality Commission (CQC)			
14.1	CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).	Action for CQC.	National action
14.2	Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value.	Action for CQC.	National action
14.3	Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety.	Action for CQC.	National action
Assessment of the performance of CQC			
15	There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.	Action for Health and Social Care Committee.	National action
Parliamentary and Health Service Ombudsman			
16	The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include: a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.	Action for PHSO.	National action
Implementation of recommendations			
17	A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.	Action for the National Audit Office.	National action

Appendix 2 – Immediate Actions as requested by NHSE

	NHS Immediate Action	Executive Lead	Action for implementation	Trust lead for implementation	Target date	RAG rating and status
1	Present the findings and recommendations of the Thirlwall Inquiry to Trust Board and obtain assurance that Board members have considered the applicability of the findings to UHS.	CNO / CMO	Assurance paper to be presented to Trust Board alongside an improvement plan.	CNO / CMO	12/11/2026	Completed
2	Communicate and implement the SUDIC protocol across relevant services, ensuring staff and Board members understand that the process applies to all sudden and unexpected infant and child deaths, including within neonatal units.	CNO / CMO	Trust-wide communication issued (see recommendation 8.1 above).	CNO / CMO	28/09/2026	Completed
3	Complete a gap analysis against the National Bereavement Care Pathway (NBCP) for stillbirth and neonatal death and implement improvements to ensure bereaved families receive consistent, compassionate and high-quality care in line with NHS England requirements.	CNO / CMO	NBCP gap analysis to be completed and Bereavement Care Improvement Plan approved (see recommendation 3 above).	Director of Midwifery EN / Neonatal Risk Lead VP	31/01/2027	In progress.
4	Establish local baseline of every cot/incubator; assess camera coverage, livestreaming, privacy, consent, cyber/security, estates, Wi-Fi and parental access; develop funded implementation plan aligned to national roadmap.	COO	Awaiting national guidance (see recommendation 1 above).	Director of estates, facilities and capital development DJ / Head of Security DW	31/03/2027	Waiting for national guidance.

5	Install CCTV monitoring for all neonatal insulin storage locations, including fridges, cupboards and storage units, with recordings retained for a minimum of 28 days.	CNO / CMO	CCTV to be installed and operational across all neonatal insulin storage locations with 28-day recording retention (see recommendation 2 above).	Chief Pharmacist JA / Director of Midwifery EN / Head of Security DW	30/11/2026	In progress
6	Review and implement access control, storage and monitoring arrangements for insulin within neonatal services to ensure compliance with the GIRFT Guide to Safe Insulin Use.	CNO / CMO	Neonatal insulin security improvement plan to implemented and GIRFT compliance confirmed (see recommendation 2 above).	Chief Pharmacist JA	31/03/2027	In progress
7	Ensure safeguarding arrangements for babies and children are strengthened through compliance with safeguarding training requirements, effective escalation processes, and enhanced Board oversight and assurance.	CNO / CMO	The Trust has training in place with appropriate mapping, but various challenges have resulted in low compliance levels. A safeguarding assurance improvement plan is being formulated by end of December 2026 (see recommendation 4.1 above).	Head of Safeguarding DH	31/12/2026	In progress

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.12 Report to the Trust Board of Directors, 12 November 2026	
Title:	Scheduled Caesarean Birth Mapping Report
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Sarah Walker, Consultant Obstetrician, Obstetric Patient Safety Lead Nazia Irshad, Consultant Obstetrician Rebecca Wiltshire, Consultant Obstetrician Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
x			

Executive Summary:

NHS Resolution Maternity Incentive Scheme (NHSR MIS) Year 8 states that Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity / neonatal care. Trusts must undertake annual demand-capacity mapping for planned Caesarean birth lists, covering the full pathway.

A detailed demand and capacity review of scheduled caesarean birth capacity was completed in 2021 with an options appraisal paper submitted to the divisional management team. Subsequently, the Maternity Service's demand and capacity have been continually reviewed via twice-weekly planning meetings involving obstetric, administrative, operational and midwifery teams. This paper outlines the Trust's current provision and planning processes with a plan for a review to be written annually summarising any changes in demand / need for change in capacity annually.

Contents:

1. Background
2. Current provision
3. Current risks
4. Improvement projects
5. Current monitoring
6. Conclusion and recommendations

Risk(s):

The risks associated with not anticipating required capacity for planned Caesarean Sections are:

- Safety
- Clinical
- Reputational
- Financial – as this is a requirement for the NHS Resolutions Maternity Incentive Scheme for Year 8.

Not planning capacity requirements for planned caesarean section birth would not reflect the current local, regional and national data trend towards this mode of delivery for an increasing

minority of our pregnant population. A non-proactive approach to the delivery of this elective workstream risks poor service user experience and additional uncertainty to those booked for an elective birth. Insufficient capacity moves elective caesarean sections into high-risk intrapartum areas, increasing the workload for these teams and risks causing delays in care and theatre availability for emergency interventions.	
Equality Impact Consideration:	N/A

1. Background

A detailed demand and capacity review of scheduled caesarean birth capacity was completed in 2021 with an options appraisal paper submitted to divisional management. At that time, the Trust's scheduled caesarean birth rate had increased from 7.7% in 2013 to 13.9%, mirroring national figures and experience and was not anticipated to reduce. The review confirmed our demand was consistent with work shared nationally (North Bristol NHS Trust 'Planned caesarean: A national survey of provision and staffing of lists') and identified the need for 7 planned sessions per week.

Subsequent actions included:

- Increased capacity to facilitate 6 (2021) and then 7 sessions/ week (January 2025), displacing planned gynaecology sessions
- Caesarean section Standard Operating Procedure introduced in 2022 to streamline booking and categorise caesarean complexity, ensuring appropriate case selection and maximising efficiency of lists, reducing risk of cancellations due to list overruns.
- Escalation from Women & Newborn Care Group Management (CGM) team to divisional team and Chief Medical Officer (CMO) Sept 2022 with alongside escalation via Maternity Safety Champions with agreement to start discussion with regional partners.
- Local Maternity and Neonatal System (LMNS) discussion regarding mutual aid across the region for scheduled caesarean births held in December 2022.

Scheduled caesarean rates have further risen from 13.5% in 2022 to 18.4% so far in 2026 (see Chart 1) with the primary reason being due to maternal request, followed by declined vaginal birth after caesarean (VBAC). Case complexity has also increased, and the service imports complex cases from the region due to advanced cardiac, maternal medicine and fetal medicine services. Between the end of March to end of August 2026, 37/451, (8.2%) of scheduled CS were performed out of hours. There has also been an overall rise in the CS rate since 2022 (see Chart 2).

Chart 1: Schedule CS rate from 2022 to 2026

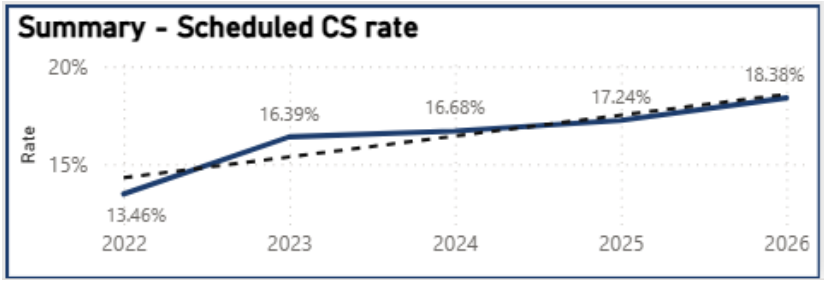
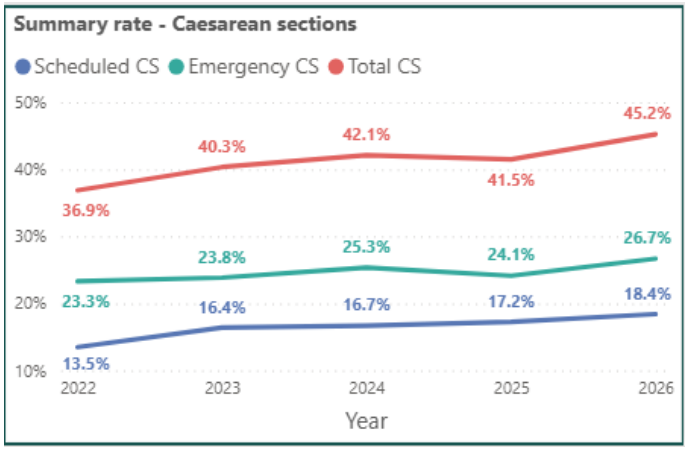


Chart 2: Caesarean section rates from 2022 to 2026



2. Current provision

From September 2026, there has been an increase to 8 regular weekly sessions with 1-2 flexible sessions. Twice-weekly planning meetings are held which allow for our demand and capacity to be continually reviewed. These meetings involve obstetric, administrative, operational and midwifery teams. In addition to oversight of demand, urgent requests are discussed and a live waiting list of patients who require a scheduled caesarean, but who do not currently have slots is reviewed and updated.

Pre-clerking slots have been increased to match capacity. Midwifery staffing templates require further review due to the additional strain on allocating 2 midwives to recovery on a day where there are 2 sessions per day. Nurses have been utilised via short-term agency usage to support the post-operative care within Labour Ward. There has also been recent employment of nurses on the postnatal ward to continue to support the postnatal journey.

If demand requires the flexible sessions to be utilised as scheduled caesarean sessions, these additional slots are 'opened'. Obstetric anaesthetic and theatre staffing match these flexible sessions. If there are still patients on the waiting list despite these additional sessions, to reduce and mitigate risk, the cases are reviewed to 'swap' complex cases into scheduled lists and allocate the remaining (ideally more basic) cases for the labour ward on call team to do. Midwifery staffing and known category 3 caesarean births are used to identify the most appropriate days for these additional caesarean births.

Where utilisation of these flexible sessions remains insufficient to meet demand and would require multiple cases for the on-call team to perform, this has been escalated to the care group management team and weekend sessions utilised for scheduled caesareans, often at the expense of gynaecology operating.

Delays in elective caesarean section are reported via the daily regional Maternity SitRep. Chart 3 provides data for Apr 2026 to 21st Sept 2026.

Chart 3: Number of women delayed >24 hrs for a scheduled elective c-section



Following planned caesarean birth, women are transferred to the high-risk postnatal ward and managed on the enhanced recovery pathway. Beds are allocated through daily operational planning and, where possible, women are cohorted to support consistent care and discharge planning. Capacity and patient flow challenges have been identified, reflecting increasing caesarean birth activity and demand for postnatal beds. A quality improvement initiative focused on earlier transfer has been implemented to improve flow and bed utilisation, with outcomes currently under evaluation.

3. Current risks

As highlighted above, the service has recognised that there are several risks relating to theatre capacity, theatre staffing and midwifery staffing, as well as the impact on other services within PAH. These risks have been escalated onto the Risk Register.

Risk number	Risk Title	Current score	Risk description
266	Obstetric Theatre Capacity is not able to meet demand and regulatory requirement at PAH	Red 20	Obstetric Theatre Capacity is not able to meet demand and regulatory requirement at PAH this includes elective and emergency C-section capacity alongside obstetrics emergency demand access to theatres on PAH site. The National Standard (Safer Childbirth, 2007) for any unit delivering more than 4000 babies per annum should have 2 operating theatres dedicated for obstetrics 24/7, so that simultaneous emergency procedures can be performed, elective procedures can be safely managed, women with infectious diseases can be appropriately managed and repairs and other obstetric interventions can be managed alongside the emergency pressures. There is currently access to 2 theatres each day excluding 1.5 sessions average weekly which we are unable to allocate due to clinical priority of W&N services that would be impacted
566	Lack of Gynaecology benign inpatient and outpatient capacity due to insufficient appropriate theatre and outpatient space	Red 20	Lack of Gynaecology benign inpatient and outpatient capacity due to insufficient appropriate theatre and outpatient space, resulting in extended waits and deterioration to conditions and negative impact to outcomes.
927	Out of hours theatre staffing – there is a risk that theatres at PAH may not be staffed for 2 emergency theatres out of hours as required by national guidance	Orange 8	Due to last minute sickness/absence/lack of NHSP fill there is a risk there may not be enough staff to effectively staff 2 out of hours theatres at PAH for obstetric emergencies. There is a vacancy rate of 15% across scrub and AP roles and 18% across HCA roles.
1033	Elective Caesarean Capacity & Midwifery Staffing	Orange 9	Increase in elective caesareans having a significant impact on midwifery staffing. Current midwifery staffing template is x 17 including HDU, IOL and all ward areas. Increasing double section lists requires x 2 RM's to facilitate and this is from our normal midwifery staffing template. The increase in elective sections also means that CAT III sections are often needed to be added for labour ward staff to facilitate.

4. Improvements projects

There is ongoing work in the following areas:

- Proposed improvements to the diary to auto populate complexity so slots are filled accordingly and prevent overbooked lists.
- Proposed changes to the categorisation of Caesareans to re define the basic, intermediate and complex groups. This will give a more realistic idea of how many slots are required and prevent over burdening of lists.
- Proposed improvements to diary so there is a version history, allowing an audit trail of changes to bookings.
- Caesarean booking team transferring to utilise the general theatre timetable for sessions to provide one source of accurate information and avoid duplication.
- Consideration to use the caesarean birth booking function on Badgernet.
- Ongoing challenge of last-minute transfers from other units at maternal request and of maternal request caesarean births and increasingly complex social/other considerations meaning a specific date/time is requested giving limited flexibility to accommodate.
- Formalising a SOP for cases that are cancelled on the day due to acuity so that can be rebooked in an appropriate timeframe.
- Earlier transfer following elective section of low-risk women to the postnatal ward as part of the enhanced recovery pathway.
- A discharge lounge is being created to support with flow within the service.

5. Current monitoring

Planned CS capacity has been a set agenda point for discussion at the monthly MatNeo Risk meeting since April 2025 following escalation from the CS team due to capacity challenges. This meeting includes representation from theatres, obstetrics and midwifery. In future, caesarean birth capacity will be a quarterly agenda point at the Intrapartum Care Committee, and an annual review will be written summarising any changes in demand and any associated requirement for changes in capacity.

6. Conclusion and Recommendations

In conclusion, demand for scheduled caesarean birth capacity has increased significantly and consistently over recent years, rising from 13.5% of births in 2022 to 18.4% in 2026. This trend mirrors national experience but has exceeded the capacity assumptions contained within the Trust's previous demand and capacity review. In addition to increased volume, the complexity of cases has also increased, with the service providing specialist regional support for women with complex maternal, cardiac and fetal medicine needs.

The Trust has implemented a range of mitigating actions since the original review, including increasing planned caesarean capacity from six to eight regular weekly sessions, introducing a Standard Operating Procedure to improve list efficiency, increasing pre-clerking capacity, utilising flexible theatre sessions, undertaking regular multidisciplinary capacity planning meetings, and using weekend operating where required. Despite these measures, demand continues to exceed available capacity at periods of peak activity, resulting in delayed procedures, out-of-hours operating, pressure on midwifery and theatre staffing, and displacement of gynaecology activity.

The current position presents ongoing risks relating to:

- The ability to meet demand for both elective and emergency obstetric theatre activity.
- Compliance with national recommendations regarding obstetric theatre provision.
- Sustainability of midwifery, theatre and recovery staffing models.
- Impact on benign gynaecology services and associated waiting times.
- Patient experience, delayed care and operational resilience.

While the introduction of additional regular and flexible theatre sessions from September 2026 provides further mitigation, current activity suggests demand will continue to require close monitoring and may necessitate further capacity expansion should trends continue.

Recommendations

1. **Note** the continued increase in scheduled caesarean birth demand and case complexity.
2. **Note** the current risk position and the impact on obstetric, midwifery, theatre and gynaecology services.
3. **Support** continuation of the current mitigation measures, including flexible theatre utilisation, enhanced capacity planning arrangements and weekend operating where clinically required.
4. **Support** completion of the identified improvement projects relating to booking processes, list categorisation, governance and patient flow.
5. **Approve** ongoing oversight through the MatNeo Risk Meeting, Intrapartum Care Committee and divisional governance structures.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.13 Report to the Trust Board of Directors, 12 November 2026	
Title:	10-Point Plan for Maternity and Neonatal Services B-Progress Report
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 paper provides the Trust Board with a mid-point assessment of progress against the national Maternity and Neonatal 10-Point Plan. It is intended to support Board scrutiny of delivery, evidence, residual risk and the credibility of the route to completion ahead of the mandatory regional progress submission by 31 December 2026.

26	12	14	0
National deliverables	Complete	In progress	Red-rated

Overall judgement: Progress is positive and there is a credible route to delivery. There are no Red-rated deliverables and no actions currently assessed as having no credible route to compliance or presenting an immediate safety risk. However, 13 deliverables remain Amber because implementation is incomplete, evidence is still being embedded or material dependencies remain.

Decision requested: The Board is asked to endorse the mid-point assessment and support finalisation and formal sign-off of Submission B before 31 December 2026.

Contents:

Appendices:

1. Board-level assurance dashboard
2. National Submission B progress return

Risk(s):

- Thirteen deliverables remain Amber, reflecting incomplete implementation, evidence gaps or material dependencies. There are no Red-rated deliverables and no immediate safety risks identified through this assessment. However, reputational, patient safety and patient experience risks remain if the Amber actions are not delivered within agreed timescales.

Equality Impact Consideration:	YES

Recommendations to the Board

- Note the progress made since the baseline assessment, including that 12 of 26 deliverables are complete and no deliverables are Red-rated.
- Receive reasonable assurance that credible improvement plans are in place for the 13 Amber-rated deliverables, while recognising that gaps and dependencies remain.
- Confirm continued Board oversight of workforce resilience, inequalities, maternity triage, and compassionate learning and response.
- Endorse the Trust mid-point assessment ahead of finalisation and formal Board sign-off of the national Submission B progress return for regional submission by 31 December 2026.

1. Purpose and national context

The 10-Point Plan brings together urgent national actions arising from Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and the Nottingham maternity review. Trusts are required to demonstrate organisational ownership, multidisciplinary delivery and clear Board oversight of the actions.

The national reporting tool is compulsory. The progress assessment asks Trusts to identify the current status and RAG rating for each deliverable, describe key gaps and risks, set improvement actions and due dates, and reference the evidence supporting the judgement. The regional team will review the return and may provide challenge, identify support requirements or escalate significant concerns.

Action 4, "Amos into Action", is led nationally and is not included within the reporting template. The Trust will nevertheless support and enable staff to engage in the national conversation as further arrangements are confirmed.

2. Overall mid-point position

The Trust assessment covers 26 deliverables. Twelve are complete and 14 remain in progress. Thirteen are rated Green and 13 Amber, with no Red ratings. This represents strengthened assurance since the baseline assessment, particularly in executive accountability, clinical workforce standards, Board reporting and thematic complaints oversight.

The rating is deliberately evidence-based. Green is used where evidence confirms that the requirement is met or delivery is on track. Amber is used where a plan is in place but gaps, delivery risks or dependencies remain. Completion of a review or establishment of a workstream has not, in isolation, been treated as sufficient for a Green rating.

3. Areas where assurance has strengthened

Executive accountability: Joint accountability for maternity and neonatal services is now established between the Chief Medical Officer and Chief Nursing Officer. The attendance and contribution of maternity and neonatal leaders when relevant matters are considered by the Board is also assessed as complete.

Listening, intelligence and Board oversight: The mechanisms for bringing together clinical audit, outcome and experience intelligence, and for reporting this through established governance, have strengthened. Two of the three deliverables under this action are now Green.

24/7 clinical safety standards: Consultant presence, locum assurance, neonatal establishment planning, midwifery establishment and 24/7 anaesthetic cover are assessed Green. These ratings do not remove the need for continued oversight of operational pressures and workforce sustainability.

Homebirth services: The urgent service review has been completed and the immediate safety and quality requirement is Green. Work continues on the sustainable future model, pending national guidance.

Complaints and post-death care: Thematic review of complaints and concerns is Green. The post-death care assurance statement has been completed, with continuing oversight of relevant national actions through established governance.

4. Areas requiring continued Board oversight

Assurance theme	Current position	Principal gap or risk	Next oversight point
Workforce and operational resilience	Amber	Integrated oversight of acuity, service pressure and escalation remains in progress. The safe staffing and internal deployment review is not yet fully embedded.	Integrated maternity and neonatal workforce report to Trust Board, January 2027; safe staffing policy review.
Equity and inequalities	Amber	National programme rollout, data quality and consistent use of inequalities intelligence remain developing. Maternal Care Bundle implementation continues.	Quarterly Maternity and Neonatal Safety Report and six-monthly inequalities review.
Maternity triage	Amber	Implementation against the national specification requires sustained work on workforce, clinical capacity, data quality, operational flow and estates.	Phased improvement programme, including capital works, performance reporting and quarterly governance oversight.
Compassionate learning and response	Amber	Patient safety response processes and the trauma-informed debrief model require further embedding and evidence of consistent impact.	Progress through maternity and neonatal governance, complaints review and quarterly safety reporting.
Listening and engagement	Amber	Monthly intelligence is established, but representative engagement and targeted outreach require further strengthening following the return of the MNVP lead.	Recruitment to engagement roles and renewed focus groups, including engagement with underserved communities.
Homebirth future model	Amber	A safe future model is being developed, but workforce sustainability and national guidance remain dependencies.	Final model following national guidance and continued regional engagement.

5. Board assurance judgement

The Trust's mid-point assessment provides reasonable assurance that there is a credible route to delivery against the 10-Point Plan. There are no Red-rated deliverables and no actions currently assessed as having no credible route to compliance or presenting an immediate safety risk. Thirteen deliverables remain Amber, reflecting areas where improvement plans are in place but gaps, dependencies or risks remain. Continued Board and executive attention is required, particularly for workforce resilience, inequalities, maternity triage, and compassionate learning and response.

6. Governance, evidence and reporting

Detailed oversight will continue through the established maternity and neonatal governance framework, with material risks and delivery exceptions escalated through the Maternity and Neonatal Safety Champions and the Quality Committee. The quarterly Maternity and Neonatal Safety Report will provide continuing visibility of progress, evidence of impact and any deterioration in delivery confidence.

The national evidence log will use the minimum evidence necessary to demonstrate assurance, drawing primarily on existing Board and committee papers, workforce reports, dashboards, audit outputs, policies, minutes and regional correspondence. Evidence quality and accessibility will be checked before the final regional submission.

7. Risks and dependencies

- Operational pressure and workforce availability may slow delivery or reduce the capacity available for improvement work.
- Triage improvement depends on coordinated workforce, digital, data, operational and estates delivery, including timely implementation of funded capital improvements.
- Some actions remain dependent on national guidance or programme rollout, particularly the Perinatal Equity and Anti-Discrimination Programme and the future homebirth model.
- Ratings may not withstand regional challenge if evidence is incomplete, inaccessible or does not demonstrate sustained implementation and impact.
- Reputational, patient safety and patient experience risks remain if Amber actions are not completed within agreed timescales.

8. Equality impact

The 10-Point Plan has a direct and positive equality focus, particularly through listening to women and families, representative engagement, review of outcomes and experience by ethnicity and deprivation, and implementation of the Maternal Care Bundle. The key assurance gap is the consistent use of reliable inequalities data to demonstrate that actions are improving access, experience and outcomes for women, birthing people, babies and families who experience the greatest disadvantage.

9. Conclusion

The mid-point position demonstrates good progress and improving organisational grip. The Trust can provide reasonable assurance that there is a credible route to delivery, while remaining transparent that half of the national deliverables are still Amber. Board endorsement of this balanced assessment will support finalisation of the mandatory national return and maintain clear organisational ownership of the remaining actions.

University Hospital Southampton NHS Foundation Trust

Appendix 1

Action: Maternity 10-point plan actions and assurance. **Progress update Q3 26-27**

Recommendation complete	
Recommendation within timescale for completion	

Action Plan	Assurance and Actions	Action Owner	Target for Completion	Status
1. Listening to women and their families by rolling out Martha's Rule	• The MEWS (Maternity Early Warning System) guideline is being updated. There is a training package ready with a rollout date from end of December 2026.	DOM / Birth Environments Matron	Q4 2026-27	Q3 update -MEWS training package ready -Plan to rollout MEWS from December
2. Listening to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level.	• The MNVP Lead returned from maternity leave in September 2026, with recruitment to engagement lead roles now a priority to strengthen service user involvement. FFT themes are reviewed routinely, with current improvement work focused on the postnatal pathway. • MNVP representation at Maternity Safety Champion meetings provides a mechanism for escalating service user feedback and emerging themes, supported by regular governance oversight. • The EDI Steering Group is being refreshed with a strengthened governance framework from Q2 2026/27 to enhance accountability and delivery. • Consultation on the NEST continuity model is underway, with agreed changes to improve equity of access and outcomes planned for implementation during Q3-Q4 2026/27.	DOM/QA Matrons/Consultant midwives	Q4 2026-27	Q3 update -MNVP lead is back and recruitment in progress for MNVP engagement leads. -MNVP has key meetings & is engaging with service users & has focus groups planned, focusing on equality. -NEST consultation remains in progress; new criteria have been approved through Governance structures.

Action Plan	Assurance and Actions	Action Owner	Target for Completion	Status
3.Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	• As of 28 September 2026, newly appointed Chief Medical Officer (CMO), Freya Person, has met with the Director of Midwifery (DOM). It has been agreed that she will provide joint executive accountability for Maternity and Neonatal Services and will undertake the role of Executive Safety Champion going forward.	CMO/DOM	Q3 2026-27	Q3 update Freya Pearson new CMO in post will be invited to be a Mat/Neo Safety Champion
4.'Amos into action' staff listening exercise	• There is a Perinatal Culture & Leadership team who have developed a Perinatal Culture Improvement Plan based on multiple sources, including staff surveys and safety intelligence. Updates on this plan are reported quarterly to Quality Committee. • Formal monthly listening events to be launched for Maternity and Neonatal staff.	DOM/Perinatal leadership team	Q3 2026-27	Q3 update -Recent completion of a psychological safety questionnaire across MatNeo.
5. Addressing inequalities in maternity and neonatal outcomes	• Ongoing work within the Continuity of Carer teams is ensuring service criteria reflect consultation findings and support equitable access to care. • An EDI focus is being embedded within maternity triage pathways to support fair and consistent access to services. • The Maternity and Neonatal EDI Working Group continues to oversee and drive delivery of the equity agenda. • Attendance at national Equity Programme onboarding sessions is planned for October and November to support implementation of best practice and strengthen local improvement plans.	DOM/D-DOM/Lead matron/Consultant midwives	Q3-Q4 2026-27	Q3 update -SLT booked to attend equity programme onboarding -MNVP working with service users from harder to reach communities.
6. Ensuring 24/7 safety and	• Maternity workforce risks have been escalated to the Executive Team, with approval sought for recruitment exemptions, removal of the current vacancy factor, and	DOM/D-DOM/OBS Lead/CD	Q3 2026-27	Q3 update

Action Plan	Assurance and Actions	Action Owner	Target for Completion	Status
responsiveness or services	recruitment towards the recommended Birthrate Plus establishment. • Out-of-hours escalation processes are being refreshed and aligned with Trust arrangements, alongside plans to adopt the National OPEL Framework to strengthen management of operational pressures. • The Trust has responded proactively to neonatal escalation, including temporary nursing support from Child Health services to maintain safe care delivery. • Workforce gaps within specialist midwifery roles remain under review as part of ongoing recruitment and workforce planning discussions. The redeployment of specialist midwives remains an active escalation action pending full resolution. • The second workforce report is on track for submission within NHS Resolution timeframes, providing further assurance regarding workforce planning and staffing sustainability. • Staff surveys recently reported, plans to review and ensure clear actions.			-Workforce reporting inline with NHSR Year 8 requirements,
7. Trust review of homebirth services	• A dedicated Homebirth Stakeholder Group has been established, with strong multidisciplinary engagement and oversight to support the future development of the service. • While national guidance is awaited, local planning is progressing to define a sustainable service model and delivery roadmap, with the aim of implementing the agreed service position by 2027.	Cons MW/DOM/D-DOM	Q3-4 2026-27	Q3 update -Homebirth working group in progress, training commences Nov 2026. -Awaiting National guidance.
8. Responding to incidents, complaints and concerns with	• A complaints process remains in place; however, a refreshed approach has been identified as a priority. A newly appointed Lead Matron will lead this workstream, with progress and outcomes to be reported in Q3.	D.DOM/Lead Matron/Lead PMA/Governance team	Q4 2026-27	Q3 update -Complaints process to be reviewed. -Governance policy going for consultation.

Action Plan	Assurance and Actions	Action Owner	Target for Completion	Status
humanity and candour	• The debrief workstream is progressing in partnership with the Lead PMA and Clinical Psychologist, with a longer-term ambition to develop a model aligned to the ITU service. In the interim, family mediation is well established and continues to provide a valuable mechanism for early engagement, resolution, and restorative conversations following concerns or adverse experiences. • The Maternity and Neonatal Governance Policy is currently under review to ensure governance arrangements remain robust, clearly defined, and aligned with current national and local requirements. The revised policy will support effective oversight, accountability, and assurance across all maternity and neonatal improvement workstreams.			
9. Deliver safe and effective triage in maternity services	• The Trust Board is sighted on the current position of maternity services, with particular focus on the estates challenges and opportunities required to support future service improvements. • Following the appointment of the new CEO, Trevor Smith, commencing on 19 October 2026, a request has been made for an early visit to maternity services to review current estate limitations, improvement opportunities, and potential investment requirements. • Plans are in place to establish a dedicated stakeholder working group to support the development of improvement proposals, ensuring multidisciplinary engagement and alignment with service needs. Progress and recommendations will be reported through Q3 governance arrangements.	CMO supporting with this.	Q3-Q4 2026-27	Q3 update -National triage specification went to TB sept 2026 -CEO has visit planned in Q3 2026-27, Maternity remains a key priority -Stakeholder working group under development, linking with ED leads.
10. Post death care	• Actions outlined within the Board Assurance Statement have been completed and progressed, with ongoing oversight through established governance arrangements.	DDO/DOM	Q3-Q4 2026-27	Q3 update -Thirwell report going to QC/TB in Q3, stakeholder working group.

Action Plan	Assurance and Actions	Action Owner	Target for Completion	Status
	• In response to the Thirwell Report, a review of bereavement services and current provision is underway to ensure services meet the needs of bereaved families and reflect emerging recommendations and best practice. • Plans are progressing to develop a Rainbow Clinic service model at UHS. A stakeholder working group is being established to support service design and implementation, with the ambition of introducing the service by 2027.			-Rainbow clinic progressing, service user focus group being set up by MNVP chair.

Appendix 2

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 a nd Neonatal Services in England is the responsibility of each organisation and ttrustrusts 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 l ine with the MIS. Regional teams will review returns and, where necessary, provide constructive challenge, identify where trusts might need additional support and escalat e 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 n otes should explain what the evidence demonstrates; and the evidence quality field should indicate whether the evidence is stro ng, adequate, limited or not available. Evidence may support 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. Pro gress 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 improveme nt 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 au tomatically, 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 c onfirms 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, emb edded 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 appl icable' 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 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.

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 *Please input reference number as listed in 3. Evidence Log tab*	Gaps in Assurance *Please provide detail of any gaps in assurance*	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 Awaitine 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 fFrom 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 (Matheo 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 CMD in progress. Once appointment is confirmed, the newly appointed CMD 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 QI 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 (2025)? *(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 Birtprate+ 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. LHS has benchmarked compliance against all 10 domains, with actions identified and monitored through the Matheo 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 LHS 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.		

NHS

st the baseline assessment. Where a deliverable has already been reported as achieved in the baseline cycle where any progress updates are required.

rte safety risk; amber where a plan is in place but gaps or risks remain; and green where evidence confirms area.

Current Status	RAG	Evidence ID *Please input reference number as listed in 3. Evidence Log tab*	Key Gaps / Risks	Improvement action required	Due Date(s)
In progress	Amber		MBRRA guideline awaiting an update. Short delay to rolling out training due to practice education capacity.	Training package ready with a fine rollout date from 31/12/26	
In progress	Amber		Power BI dashboards updated monthly to include agreed clinical outcomes. MNVP returned during September 2026 from maternity leave. Their primary focus on return is the recruitment into the funded engagement officer role to support the SBRVP and enable prioritisation of key meetings alongside newsletter/blog engagement.The focus groups have been paused due to the MNVP maternity leave. The Digital Midwife/ Extra Support Teams,I revised ways of working consultation continues with revised inclusion criteria now signed off through our governance process.		
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
In progress	Amber		We continue to await National Guidance at time of review of progress. This is expected in December 2026. Senior staff signed up for national training with one for rollout to workforce PLUS 3000 by	Awaiting guidance	31/12/2026
In progress	Amber		Maternity KSI working group meet monthly to discuss data and identify service gaps. This piece of work is ongoing and undergoing a rolling evaluation	Admin support for minutes and general support required to facilitate onward meetings. N	31/12/2026
In progress	Amber		The progress is reported to Quality Committee quarterly via the MatNeo Safety Review. Progress is ongoing.		31/12/2027
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
Complete	Green				
In progress	Amber		Current workforce review in progress - 2nd integrated workforce report to Trust Board scheduled for January 2027.	Birthrate Plus review due to be repeated in 2027	January 2027 for report related to integrated workforce. Birthrate Plus
In progress	Amber		Safe staffing policy remains under review - to incorporate the new Opel MP Framework		
Complete	Green				
In progress	Amber		Meeting and discussions during September 2026 regional Insight Visit. Summary of progress to date:Overall, good progress has been made during Q2 in strengthening the safety, sustainability and governance of the Maternity Service. Key improvements in risk management, workforce and equipment governance are now moving into implementation, with closure of Risk 978 marking an important milestone. Workforce sustainability remains the core area requiring focused attention, with ongoing work to develop a safe and sustainable future model for Ivern birth provision.	Awaiting national guidance expected by the end of 2026. Final model of care to be decided once this guidance is available.	31/12/2026
In progress	Amber		Awaiting mandate for specific around maternity incentives. Currently reporting incidents via Datix and Ulysses for external review. Learning from incidents shared at M and M meetings and via Theme of the week. PRICIMPT and Fetal Surveillance training. Triangulation slides shared at ward/dir, safety rewards to our Quality Committee and events discussed.		
Complete	Green				
In progress	Amber		Ongoing Trauma informed approach	26/11/26 - Trust psychologist and lead Professional Midwifery Advocate are recording a teaching video utilising the TBI model to represent this via a conversation which includes psychoeducation. This is intended to be circulated to staff mid December 2026	31/12/2026
In progress	Amber		Trust Board sign off of initial benchmarking. Recruitment of lead matron achieved with job planning in progress.	Capital funding secured for required improvements with planning in progress for phase 1.	31/07/2027
In progress	Amber			Work to discuss improving data quality in progress following a robust review of data requirements as part of the benchmarking exercise	31/03/2027
In progress	Amber		Availability of adequate capital funding		
Complete	Green				
In progress	Green			Board assurance letter describes regular reviews via safeguarding teams regarding compliance	

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 where the evidence can be found; assurance notes should explain what the evidence demonstrates. The evidence quality field should indicate whether the evidence is strong, adequate, limited or not available. Evidence may support more than one deliverable where appropriate. Trusts are encouraged to use existing evidence and 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 Progress Report as needed. Please note the evidence submitted should be accessible externally (to the trust).

Evidence ID	Action No	Evidence Type	Document / Meeting / Dataset	Date	Owner	Location / Link Reference	Assurance Notes	Evidence Quality
EV-01	2.1	Triangulation slides	Appendix to Quarterly Safety report	Q1 26-27	QA Matrons		Trinagulation from complaints, feedback and clinical outcomes	
EV-02	2.2	MatNeo safety report	Quarterly Mat/Neo safety report	Q1 26-27	EN/NW		MatNeo safety report with clear escalationd and actions to QC and TB	
EV-03	2.3	National picture report	EN report - National Maternity Landscape	01/04/2026				
EV-04	3.1 & 3.2							
EV-05	5.1	N/A						
EV-06	5.2	Q2 safety report						
EV-07	5.3	MCB implementation report	Report to TB as per NHSR with MCB implementation plan		EN/NW		Implementation plan	
EV-08	6.1	Workforce report	Obstetric workforce report					
EV-09	6.2	Locum log	Short term locum register					
EV-10	6.3	Workforce report	Neonatal workforce report					
EV-11	6.4	Birthrate plus report	Birthrate plus report	01/07/2024	EN/CS			
EV-12	6.5	Workforce report	Obstetric Anaesthetic report					
EV-13	6.6	MatNeo safety report	Quarterly Mat/Neo safety report	Q1 26-27	EN/NW			
EV-14	6.7							
EV-15	7.1	Homebirth response letter & Action plan	Homebiurth assurance documents x2		EN			
EV-16	7.2	?? N/A						
EV-17	8.1	Asked Governance team						
EV-18	8.2	Quarterly thematic review of complaints						
EV-19	8.3	Becky Fry and Beth George						
EV-20	9.1	National triage bench marking tool EN report	Triage benchmarking tool Safety report	01/09/2026	EN			
EV-21	9.2							
EV-22	9.3							
EV-23	10.1							
EV-24	10.2							
EV-25								
EV-26								
EV-27								
EV-28								
EV-29								
EV-30								

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 ma y also be instances where an individual item e.g. board report may account for evidence against multiple deliverables. The mode l 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.	
Action 2	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	
	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	?? is safety report enough
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	N/A roll out April 2027 Launch oct/nov 26
	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	Asked Amy B
	5.3	Is the trust board receiving 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	
Action 6	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	Staff experience survey
	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	Staff experience survey
	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? *(In line with MIS Year 8)*	• BR+ review and workforce plan • Biannual workforce papers • Staff experience survey	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 co sideration 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	Check AB
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.	Governance team
	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.	? Carly/Abby Green
	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	Becky Fry/Beth George
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	? next report/in progress
	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	? next report/in progress
Action 10	10.1	Board assurance statement completed and submitted by 31 July 2026	• Assurance statement	?? who did this
	10.2	Has the board assured itself that it is continuing regular overersight and implementations of national actions and reccomendations around matters relating to morturaries including review of incident records over the past 10 years?	•Board Report •Review report	??

Agenda Item 6.1 Report to the Trust Board of Directors, 12 November 2026	
Title:	Corporate Objectives 2026-27 Quarter 2 Review
Sponsor:	Trevor Smith, Chief Executive Officer
Author:	Martin de Sousa, Director of Strategy and Partnerships Luci Hood, Head of the Medical Directorate

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:

Delivery against our 2026/27 corporate objectives is mixed at Quarter 2. Care improvement and research programmes continue to progress, alongside strengthened education and organisational development capacity and important estates milestones. However, access, workforce affordability and financial sustainability remain material risks to delivery. Access performance improved but remains below target, while delayed discharge and fire-related capacity constraints continue to affect flow and elective recovery.

Research delivery is a relative strength, with 90% of open studies on track against an 80% target; the Biomedical Research Centre outline renewal application has been submitted, with the outcome awaited. Retention and agency control remain positive, but workforce levels, sickness absence and appraisal compliance require sustained action.

At Month 6, the Trust reported a financial deficit and work has been underway on actions to deliver an improved position for the end of the year. Quarter 3 priorities are to restore capacity and flow, accelerate recurrent productivity and workforce improvement, and convert digital and estates progress into sustainable benefits.

The Board is asked to note progress and the principal delivery risks.

Contents:

Strategy Delivery Progress:

- Summary by Strategic Theme
- Appendix i- Detailed Updates

Risk(s):

Objectives relate directly to all BAF risks.

Equality Impact Consideration:	NO

Progress Summary by Strategic Theme

Outstanding Care

Progress during the quarter has been positive in several areas of our Outstanding Care objectives, alongside some continuing delivery challenges. Clinical effectiveness, patient involvement and safety programmes are progressing, but implementation is stronger in some areas than others and access continues to be constrained by delayed discharge, workforce pressures and fire-related loss of capacity. The priority is to focus on improvement activity into consistent practice and measurable patient benefit.

Outcomes

The clinical outcomes dashboard and stronger links with divisional governance provide a good platform for evidence-led improvement. Additional funding for tobacco dependence and alcohol care have created opportunities to strengthen prevention and address health inequalities. Progress is constrained by data availability and the pace of Patient Reported Outcome Measures collection, which reached 13% of specialties against a 30% ambition. Quarter 3 will focus on embedding the dashboard in routine governance, improving outcome measurement and mobilising the funded prevention pathways.

Experience

The completed review of Patient Reported Experience Measures and approval of the Carers Support Package strengthen the foundations for more inclusive, person-centred care. The priority is now implementation: extending representative feedback, launching the carers offer in November and improving participation in ‘What Matters to Me’, where fewer boards were completed this quarter. Copilot is supporting PALS response drafting, but the complexity of individual concerns limits wider automation and requires continued professional oversight. Quarter 3 will focus on demonstrating how patient and carer feedback changes care and communication, alongside preparation for consistent documentation standards.

Safety

Safety improvement continues through incident learning, invasive-procedure standards and greater involvement of Quality and Patient Safety Partners. Level 1 patient safety training compliance exceeded target and no NatSSIPs-linked Never Events were reported in Q2 which was a positive story. Martha’s Rule is fully implemented in Southampton Children’s Hospital, although adult deteriorating-patient work has been delayed by limited leadership capacity. Quarter 3 priorities are to strengthen reliable safety practice, embed patient and family involvement in learning, progress adult deterioration work and implement improvements to enhanced therapeutic observations and care.

Access

Access performance improved during Q2 but remains below ambition: 18-week referral-to-treatment performance reached 64% against 72%, and four-hour emergency department performance reached 80.3% against 82%. Patients with no criteria to reside increased to again during the quarter reinforcing the continuing challenge to flow and capacity. UHS continues to work actively with external partners to jointly address some of the capacity and demand challenges. As part of this the Trust is developing a work programme jointly with local authority and community health teams around discharge from hospital. The Trust is also part of the Home Is Best programme which has been launched across Hampshire and Isle of Wight- this brings together acute, community, primary care and local authority teams with the aim of managing high risk cohorts of patients through targeted intervention to reduce hospital admissions.

Outstanding People

Progress against the Quarter 2 People objectives is variable at this stage in the year. Workforce retention remains strong, with sustained low turnover. Agency use also continue to remain low, reflecting strong oversight. However, the total workforce was 207 WTE above plan at Month 6, driven by substantive staffing 78 WTE above plan and bank use 139 WTE above plan. The latest forecast indicates a material risk to delivery of the year-end workforce plan without further workforce cost improvement and substitution of temporary staffing.

Sickness absence and appraisal compliance remain key areas for improvement. September in-month sickness was 4.07% and rolling 12-month sickness was 4.05%, both above the 3.9% target, with anxiety, stress and other non-musculoskeletal conditions the main drivers. Appraisal compliance was 65.1%, materially below the 85% target. Targeted action plans remain in place but this has to be balanced with ongoing clinical staffing pressures.

There were a number of other areas of positive progress in the quarter. The continued implementation of the new Violence, Aggression and Abuse policy has been positively received by staff. There has been a continued trend in increased reporting of incidents, which is a positive reflection of increased awareness of new process and provides opportunities for intervention to support our people. Work has begun on updated People and Education Strategies, supported by the new Heads of Organisational Development and Education. A further cohort of the Positive Action Leadership Programme have been undertaking the programme in the quarter, building diverse future leadership capacity for the organisation. staff.

The annual Staff Survey launched at the end of the quarter and continues into Q3 – this will provide a temperature check of overall progress when results are received.

Pioneering Research and Innovation

Research and innovation made progress during Q2, with the Biomedical Research Centre outline renewal application submitted by the September deadline. The outcome remains awaited, so renewal funding is not yet secured. Preparation for the next application stage is a strategic priority, subject to invitation and the national timetable.

Research delivery remains a relative strength: 90% of open studies were on track against an 80% target, compared with 85% in Q1. Multidisciplinary oversight, escalation and learning from comparable trusts are supporting improvements in study set-up, with further process and digital changes planned. Community-based research engagement and routine training to improve participant data quality are progressing. However, the sustainable Research Leaders Programme model remains under discussion.

Quarter 3 priorities are to prepare for the potential full BRC application, embed faster and more reliable study set-up, and progress sustainable clinical academic career and research leadership arrangements.

Foundations for the Future

Delivery against Foundations for the Future objectives is mixed, with financial sustainability the principal strategic concern. At Month 6, the £28.3m year-to-date deficit was £12.3m adverse to plan, reflecting under-delivery of Elective Recovery Fund income associated with lost capacity. Cost improvement delivery was on plan at £24.4m, but greater reliance on non-recurrent measures and continuing workforce pressures increase the challenge of second-half recovery. Restoring capacity and accelerating recurrent productivity improvements are central to recovery. Capital delivery remains on trajectory, but external cash support may be required in the final quarter.

Digital transformation is strengthening the platform for operational improvement through the Digital First Outpatients business case, AI governance and the Automation Hub. The strategic priority is to convert these developments into measurable improvements in access, administrative efficiency and productivity. Delivery remains dependent on business-case approval, testing and funding; in particular, withdrawal of national funding requires the Ambient Voice Technology financial case and funding route to be reassessed before procurement progresses.

Strategic estates delivery has achieved important milestones, including mobilisation of the first Southampton Elective Hub theatre, finalisation of the Chilworth long-term lease and progress towards a sustainable endoscopy solution. These developments support service resilience and future capacity, alongside West Wing recovery. Further delivery remains dependent on procurement, licensing, funding and approvals, including the Private Patient Unit and Adanac Park programmes.

The priority for the remainder of the year is to align financial recovery, workforce productivity, digital transformation and estates delivery around a credible route to sustainability. Maintaining safe services while restoring capacity, securing recurrent benefits and managing investment and cash dependencies will require sustained oversight.

Appendix i- Strategy delivery progress report- Q2 2026/2027

OUTSTANDING CARE
Outcomes **2026/27 ambitions:** • **Build the internal Clinical outcomes dashboard** • **Increase collection and use of PROMs** • **Increase integration of Clinical effectiveness data into divisional governance** • **Improve clinical outcomes in high impact Health Inequalities specialties**
Q2 progress update and assessment of delivery against plan: - Workshops were held with clinical effectiveness leads in October. These covered key areas of our strategic plan including launching the clinical outcomes dashboard, increasing the collection and use of PROMs, clarifying asks linked to the new audit policy and understanding current feelings around integration into divisions and opportunities to support. - The Clinical outcomes dashboard was received positively as an intervention to support the identification of outcome data within the trust. Conversations also highlighted additional metrics for ongoing development. - The divisional model within the clinical effectiveness team and increased opportunities to link into divisional governance were also well received. No new concerns were raised on this theme. - Focused work continues on developing pathways for health inequality and prevention priorities (tobacco, alcohol, obesity and hypertension). In this quarter we have been successful in agreeing further funding into tobacco and alcohol services. For tobacco, we have agreed a 1 year pilot with Southampton City and Hampshire County Council public health teams to introduce smoking cessation support in pre-operative pathways, this was recognised as a missed opportunity. We have also had a proposal approved against the HIOW ICB's 'left shift' funding, which will see investment in identification of alcohol support needs in the emergency department, investment in the alcohol care team and focus on tobacco dependence support in respiratory outpatients. This funding will be available until April 2028. - Overall achievement against ambitions remains steady, some developments on the dashboard have stalled due to identification of data sources, but new opportunities have been discussed. Pace with the development of PROMs collection is an ongoing challenge. **Q3 priorities** - Start integrating the use of the clinical outcomes dashboard and build on metrics available - Continue to work with clinical teams to highlight the importance of PROMs and identify opportunities to support increased collection and use within services. - Review asks from the latest CQC visit and identify opportunities for improvement in documentation and sharing of clinical effectiveness data - Set up enhanced service options for tobacco dependence and alcohol care achievable via new funding routes. - Explore how National Consultant Information Programme (NCIP) can be incorporated to improve access to surgical outcome data

Experience

2026/27 ambitions:

- **Grow the patient 'voice' through our involved patient & draw together PREMs to strengthen feedback**
- **Develop the focus on 'What Matters To Me' & improve communication quality through documentation standards**
- **Increase recognition and support of 'unpaid' carers, in a non-clinical setting and the Patient & Family Support Hub**
- **Transform PALS processes, considering the role of AI**

Q2 progress update and assessment of delivery against plan:

- A review of Patient Reported Experience Measures (PREMs) has been completed, with work continuing to expand collection, improve inclusion, strengthen analysis, and use feedback to drive improvements.
- The new Carers Policy, Carers Pass and Unpaid Carers Support booklet have been approved and will launch in November alongside Carers Rights Day, supported by Southampton Hospital Charity.
- The 'What Matters to Me' trial has moved into Medicine for Older People. Reduced volunteer availability over the summer contributed to fewer boards being completed this quarter.
- The Corporate Nursing Team is reviewing proposed body map standards to support implementation aligned with wider Fundamentals of Care priorities.
- Exploration of AI solutions within PALS has not identified any radical opportunities for automation, largely due to the complex, nuanced and highly variable nature of patient concerns and complaints, which do not follow a standardised or "cookie-cutter" format. Each case typically requires careful consideration of individual circumstances, judgement and empathy, limiting the scope for end-to-end automation. However, Microsoft Copilot has been successfully introduced to support the drafting of responses, helping to improve consistency in tone and structure, reduce administrative burden, and expedite the response process, while ensuring that professional oversight and personalised handling remain central to each case.

Q3 priorities

- Implement the PREMs Expansion Plan to increase feedback participation, improve representation of seldom-heard groups, strengthen analysis, and drive service improvements.
- Continue rollout of the 'What Matters to Me' initiative in Medicine for Older People, improving accessibility, participation and person-centred care.
- Finalise the Trust-wide rollout plan for documentation standards (eg. Body map) to support implementation in Quarter 4 and alignment with the Fundamentals of Care programme.
- Prepare for the launch of the Carers Policy, Carers Pass and Unpaid Carers Support booklet, focusing on awareness, staff engagement and promotion of support for carers.

Safety

2026/27 ambitions:

- **Continue to embed Patient safety incident response programme (PSIRF) and the National Safety Standards for Invasive Procedures (NATSSIPs) programmes in culture, using learning tools and staff and patient support**
- **Define and embed the Quality patient safety partners (QPSP) programme to increase patient voice**
- **Clinical pathway focus on enhanced Therapeutic observations and care, and deteriorating patients**
- **Embed the Morbity and Mortality (M&M) framework and guidance**

Q2 progress update and assessment of delivery against plan:

- Rapid response huddle approach (Swarm tool) pilot planned and awaiting final approval before roll-out in recovery (theatres)
- Cohort of never events reviewed in theatres by those involved to support the learning and embedding of best practice
- QPSPs are now involved in the NatSSIPs workstream
- VLE training update on safety checks and NatSSIPs is ongoing
- Checklists for invasive procedures outside of theatres are being reviewed in the cardiac cath labs
- Continuous development of how to incorporate the patient and family voice within M&M discussions
- Deteriorating patients- Organisational oversight has been supported by monthly acuity data across all adult and paediatric in-patient areas. Good progress has been made in Child health, where Martha's rule has been fully implemented and monthly data analysis continues. Adult workstreams have been delayed due to long term sickness of acuity lead.
- Enhanced therapeutic observations and care (ETOC)- This quarter the ETOC project involved virtual visits to 6 other acute providers to understand their models and identify practice improvement for UHS.; Plus the completion of the external ETOC governance audit.

Q3 priorities

- Ensure approval for the roll-out of Swarm huddles in theatres and Trustwide dissemination
- Continue implementation of the role descriptor for QPSPs
- Implement a standardised feedback process for those affected by patient safety investigations (both families and staff)
- Review checklists and supportive information to create a shared understanding of professional responsibilities for NatSSIPs
- Review main theatres/PAH safety checklists and devise a new implementation plan
- Continue to develop the work around M&M and patient involvement
- Deteriorating patients- The next quarter will focus on implementation of the Adult patient wellness questionnaire, as well as commencing the monthly NHSE data submission on Martha's Rule for Maternity and Neonates. The Adult deteriorating patient policy review will also be commenced.
- Enhanced therapeutic observations and care- Focus in the next quarter will be on engagement, training and implementation plan for ETOC paperwork on inpatient noting, and revise ETOC Policy.

Access

2026/27 ambitions:

- **Urgent and Emergency Care (UEC) Transformation Programme**
- **Elective Transformation Programme**
- **Service Configuration (Elective Hub/UTC)**
- **Improving equitable access**

Q2 progress update and assessment of delivery against plan:

- UEC transformation has progressed across front door, admission avoidance and discharge workstreams. ED-focused pilots have shown early impact, including reduced length of stay through the Majors Pitstop rapid assessment triage pilot and the Eye Casualty urgent access clinic pilot, with further testing planned for the Joint Assessment Model.
- Patient discharge work has continued through daily P0 discussions, with over 11,000 patients reviewed since inception and 47% confirmed as discharged on the same or following day. P1 and P2 meetings continue jointly with Transfer of Care Hub and Social Care colleagues.
- Elective transformation has delivered progress on referral management and outpatient productivity, including trust-wide rollout of referral grading to 57 specialties, development of the eRS API integration with CHARTS, eConsent procurement, partial booking rollout and continued growth in PIFU pathways.
- Access delivery remains at risk in key areas. NCTR has risen above the planning assumption, reaching 227 in early June against an ambition of 160 or fewer, creating a risk to flow, bed reductions and the UEC CIP target. Theatre productivity also remains constrained by estate, critical care workforce and bed capacity pressures following the fire.

Q3 priorities

- Continue the June Sprint follow-through by supporting divisions and care groups to translate the five organisational goals into local access improvement plans, with clear measures and review through TOG.
- Scale and evaluate UEC front door and admission avoidance pilots, including the Joint Assessment Model, SCAS call-before-conveyance work, UTC planning, Who Goes Where review and continued development of SDEC and alternatives to ED attendance.
- Progress the elective programme milestones, including technical integration for eConsent, preparation for the eRS API go-live, further referral grading onboarding, partial booking expansion and continued work to streamline single points of access for primary care.

Measures:

Pillar	Domain	Measure	Target	Q1	Q2	Q3	Q4
Outstanding care	Outcomes	Surgical + medical metrics tracked trust wide on CE dashboard	10	9	9		
	Outcomes	Specialties capturing and reporting PROMs (known to CE team)	30%	11%	13%		
	Outcomes	Increase smoking quit rate (% of patients who were referred to the in house tobacco dependence team, who quit)		29%	21%		
	Outcomes	Increase no. patients who quit smoking		34	26		
	Experience	Inpatients within pilot areas will have completed WMTM boards within 48 hours of admission	Increasing Number	211	181		
	Experience	Body maps and daily assessments will meet the set expected quality standards (starting Q3)	80%				
	Experience	Patients with a Learning Disability &/or Autism will have a completed WMTM board within 24 hours of admission (starting Q3)	100%				
	Safety	Increase in feedback from those involved in Patient Safety Incident Investigation		0	0		
	Safety	% staff compliant with L1 Patient Safety Syllabus	85%	82.3%	86.63%		
	Safety	Reduction in Never Events linked with NatSSiPs	0	1	0		
	Access	Referral to Treatment performance- 18 weeks	72%	62.1%	64%		
	Access	4-hr Emergency Department	82%	75.5%	80.3%		
	Access	Number of NCTR patients	130	206	236		

OUTSTANDING PEOPLE
26/27 Priorities:
Safety of our People at UHS - Roll out and embed the new Violence, Aggression and Abuse (VAA) Policy. **Deliver the Trust's transformation and workforce plan for 2026/27** **Voice of our People** - Strengthen the voice and engagement of our people from Board to ward through a compelling narrative of the Trust, immediate priorities for transformation, and our new long-term strategy and vision. **Developing our People** - Develop a new Education Strategy; reinstate leadership development offerings; refocus on appraisal and career development; strengthen inclusion and belonging within training; and provide skills to support local transformation **Inclusion and Belonging of our People** - Re-energise staff networks supported by new Executive Sponsorship; transform the experience of staff with long-term illness and disabilities; and deliver a further cohort of the Positive Action Leadership Programme.
Detailed Q2 Updates

Safety of our people

Creating a safe and supportive working environment remains central to the Trust's ambition to be an outstanding employer. During Quarter 2, work continued to embed the Violence, Aggression and Abuse Policy and strengthen the associated governance and response arrangements. This provides the foundation for a more consistent organisational approach to preventing and responding to incidents, supporting colleagues and taking proportionate action where unacceptable behaviour occurs. Further work is taking place to strengthen data intelligence, reporting and thematic analysis in Q3.

Delivering a sustainable workforce

The Quarter 2 position demonstrates continued strength in retention, with rolling 12-month turnover at 9.6%, but also a significant challenge in aligning workforce capacity and cost with the Trust's operational and financial plans. At Month 6, the total workforce was 207 WTE above plan. Agency use remained below plan, but substantive and bank staffing were above planned levels, and the latest forecast indicates that further action will be required to achieve the year-end workforce trajectory. The strategic priority is therefore to reduce reliance on temporary staffing, improve workforce productivity and ensure that workforce decisions support service transformation rather than short-term cost reduction alone. This will require coordinated delivery across workforce, finance and operational teams, with sustained executive and divisional oversight.

Workforce capacity, wellbeing and patient safety

Workforce pressures continue to have implications for staff wellbeing, service resilience and patient safety. Sickness absence remains above target, with anxiety, stress and other non-musculoskeletal conditions the principal drivers. Staffing-related patient safety incidents also remained elevated during the quarter, particularly in Emergency Care and Critical Care. These indicators reinforce the need for targeted action that connects workforce planning, retention, health and wellbeing, safer staffing and operational redesign. The Trust's response will focus on the areas of greatest risk, while ensuring that improvement action addresses underlying causes and supports sustainable staffing models.

Developing our people and organisational capability

Progress in developing organisational capability is mixed. Appraisal compliance was 65.1% at Month 6 against the 85% target, and statutory and mandatory training performance remains below the required level in a number of areas. This demonstrates the challenge in ensuring that all colleagues receive consistent development, career and performance conversations and maintain essential capabilities. Leadership capacity was strengthened towards the end of the quarter with the new Heads of Education and Organisational Development taking up their roles. Initial work is now underway to refresh the People Strategy and develop the Education Plan, focusing first on the immediate priorities and the foundations required for longer-term delivery. Alongside targeted recovery action on core compliance, work has continued to strengthen medical job planning, investigation capability and employee-relations practice. The strategic focus for Quarter 3 is to convert this strengthened leadership capacity into an integrated and measurable programme that equips colleagues and leaders to deliver transformation and the Trust's wider strategic goals.

Voice, inclusion and belonging

The objectives for staff voice, inclusion and belonging are important enablers of the Trust's wider strategy. A further cohort of the Positive Action Leadership Programme has been underway during Quarter 2, with positive uptake, supporting the development of a more diverse and inclusive leadership pipeline. This provides positive evidence of progress, although fuller assurance is still required on the impact of staff engagement, staff networks and work to improve the experience of colleagues with disabilities and long-term health conditions. The refreshed People Strategy should bring these strands together with clear outcomes and measures, enabling the Board to assess whether activity is translating into improved staff experience, stronger involvement in change and a more inclusive organisational culture.

Priorities for Q3

- Deliver further workforce cost improvement and reduce reliance on bank staffing, with clear trajectories against the year-end workforce plan.
- Improve sickness absence and appraisal compliance through targeted divisional action plans and oversight.
- Address clinical staffing pressures in Emergency Care and Critical Care, including unfilled nursing and healthcare assistant demand and staffing-related safety incidents.
- Continue progress on data oversight and thematic analysis to support VAA work
- Agree the initial priorities, delivery milestones and outcome measures for the refreshed People Strategy and Education Plan, building on the new leadership capacity

PIONEERING RESEARCH AND INNOVATION
26/27 Priorities:
Submit and secure BRC infrastructure renewal award - Submit renewal narrative & evidence pack - Align themes to Southampton/NIHR/government priorities - Agree internal governance and timelines **Deliver national UKCRD performance metrics – 150 days, open/on track and recruitment to time & target** - Use digital enablers (e.g. R&D performance reports) to identify and address bottlenecks - Implement actions with support services - Streamline processes to create efficiencies **Inspire research leaders - Secure the future of the Research Leaders Programme as a sustainable ongoing engagement initiative to harness talent within Southampton** - Secure the future of RLP: - Confirm post-investment model; - Embed career frameworks/job planning; - Agree funding route & decision points **Engage with our communities - Increase inclusive research engagement & participation** - Set annual engagement targets, - Agree data capture for participation & socioeconomic variables; - Monitor through quarterly SCREI-to-RDSG report
Progress in Q2 and assessment of delivery against plan:

- **Submit and secure BRC infrastructure renewal award**
  Ambition: Attend in-person collaboration event on 7th July. Online outline applications to be submitted by 17th September.
  Progress: Outline application submitted for the deadline and awaiting outcome.
- **Deliver national UKCRD performance metrics – 150 days, open/on track and recruitment to time & target**
  Ambition: Next multidisciplinary workshop for digital enablers to take place in July with recommendations taken forward.
  Feasibility/Expression of interest processes and internal meeting schedules to be reviewed and streamlined. Actions arising from study set up workshop to be complete including changes to processes. Huddles and 150-day report to be refined. Clear escalation rules and single points of contact to be defined and embedded. Revised pathways to be utilised for all new studies with review at the end of Q2 for evidence of impact.
  Progress: In progress. Weekly multidisciplinary study huddles continued throughout the quarter, with Director-level attendance each week, supporting timely escalation and resolution of issues. The huddles provide a regular mechanism to identify barriers affecting individual studies while also highlighting recurring themes requiring wider organisational or, in some cases, national improvement. During the summer, the Taskforce engaged with other NHS Trusts with comparable research portfolios to understand their study set-up processes and identify transferable best practice. Learning from these discussions has informed a number of local process changes, supporting adoption of proven approaches rather than developing solutions in isolation. Further changes are planned for implementation during Q3.
- **Secure the future of the Research Leaders Programme as a sustainable ongoing engagement initiative to harness talent within Southampton**
  Ambition: Present post-investment model to TB (through appropriate approval routes).
  Progress: In progress
- **Engage with our communities - Increase inclusive research engagement & participation**
  Progress: In progress. Raising voices in research (RViR) work continues with a focus on Research Friendly Spaces (RFS) work which looks at working with researchers and community groups to support research delivery in the move from hospital to community.
  Ambition: Alongside delivery of RViR, work will develop the inclusive recruitment staff link role model, whereby research nurses are developed and supported to engage communities about current studies and research participation. Research Nurse training on better capturing diversity data among participants is being delivered to improve completeness and quality of data monitoring the impact of our community engagement.
  Progress:
  Training for research nurses has become BAU with good feedback and data quality is improving

Priorities for Q3

- **Submit and secure BRC infrastructure renewal award**
  Prepare for invite for full application (due December 2026)
- **Deliver national UKCRD performance metrics – 150 days, open/on track and recruitment to time & target**
  - Embed and refine the study set-up pathway, implementing learning from weekly huddles, workshops and engagement with comparable NHS Trusts.
  - Continue weekly multidisciplinary huddles
  - Implement Edge improvements identified through the July workshop, including clearer data standards and user responsibilities, streamlined forms and workflows, improved guidance, and greater visibility of study status and key milestones.
  - Deliver a dedicated R&D Finance workshop
  - Deliver an Expression of Interest and feasibility workshop
  - Implement transferable best practice from other research-active Trusts and strengthen early engagement with sponsors, including confirmation of escalation contacts, contract quality-control arrangements and expected turnaround times.
  - Progress the Pharmacy and Digital agentic AI pilot,
- **Secure the future of the Research Leaders Programme as a sustainable ongoing engagement initiative to harness talent within Southampton**
  Continue long term planning for clinical academic careers, increase UoS PhD and fellowship opportunities, launch joint mentoring and career development schemes.
- **Engage with our communities - Increase inclusive research engagement & participation**
  - Deliver mass engagement programme events for quarter (anticipated to include Soton Freshers Fair and BBAM)
  - Progress actions arising from Staff Link Roles Pilot
  - Provide responsive support to recruiting studies and capture volume, efficacy metrics; incorporate and facilitate study recruitment/awareness activities into extant UHS and partner communications, community and public engagement opportunities/platforms;
  - Start engagement/exploration with UHS VS re. Research Volunteer roles to aid study recruitment and Commercially Sensitive study PPIE.

Measures:

Pillar	Measure	Target	Q1	Q2	Q3	Q4
Pioneering research and innovation	Secure existing infrastructure awards with financial uplift at renewal (metric to be defined)	Achieved (2 x new)				
	Proportion of open studies on track, delivering recruitment to time and target	80%	85%	90%		
	Establish the RLP as a sustainable, on-going programme by 2028 (metric to be defined)					
	Annual increase in UHS patients approached and recruited	Tbc				
	Diversity of participants mapped to local population data by 2028 (metric to be defined)					

FOUNDATIONS FOR THE FUTURE

26/27 priorities

Financial Stability

- Deliver our 2026/27 financial plan

Digitally Enabled

- Deliver year 1 of our Intelligent Automation digital transformation programme
- Deliver the digital portfolio plan for 26/27

Improving Estate

- Deliver year 1 milestones for our strategic estate priorities

Detailed Q2 Update

Financial Plan Delivery (to M6)

Financial sustainability remains a significant strategic challenge at the mid-year point, with performance affected materially by the operational and income consequences of the fire. At Month 6, the Trust reported a £28.3m year-to-date deficit, £12.3m adverse to plan, reflecting under-delivery of Elective Recovery Fund income associated with lost capacity. Excluding this impact, the Trust would be on plan year to date. Cost improvement delivery remains on plan at £24.4m, although with greater reliance on non-recurrent measures than planned.

The underlying financial position remains challenging, particularly given continuing workforce pressures and the requirement to deliver a substantial second-half improvement, including increased recurrent CIP delivery. The Trust continues to target its breakeven plan as the best-case position, while its route map to NHS England identifies a potential full-year deficit of £50.9m, including £16m of income impact associated with the fire.

The fire continues to constrain theatre and bed capacity and wider productivity, contributing alongside other operational pressures and industrial action to reduced elective activity and income. Further industrial action therefore represents an ongoing risk to the recovery trajectory.

Management focus remains on restoring operational capacity, accelerating sustainable cost improvement and developing the route back to financial sustainability. This is being supported by targeted external review of temporary staffing and CIP opportunities. Capital delivery remains on trajectory, while the cash position has performed better than plan to date. However, the cash forecast is being reviewed against the revised financial scenarios and external cash support may be required during the final quarter.

Deliver year 1 of our Intelligent Automation digital transformation programme

- **Digital First Outpatients:** Development of the business case progressed during Q2, bringing together end-to-end pathway digitisation, automation of routine administration, patient self-service and greater standardisation across specialties. The model is intended to improve appointment slot utilisation and reduce administrative workload.
- **Copilot and AI readiness:** Copilot training was delivered to TEC, alongside development and ratification of the Trust's AI policy.
- **Automation Hub:** Further developed during the quarter to strengthen the Trust's infrastructure and governance for safe and effective adoption of AI and automation.
- **Ambient Voice Technology (AVT):** Procurement proposals were supported at Trust Investment Group. Withdrawal of national funding has subsequently required the financial case and alternative funding route to be reassessed.
- **Partial booking automation:** Work continued towards testing and approval of the automated process.

Q3 priorities: Progress the Digital First Outpatients business case towards procurement; commence AVT procurement, subject to resolution of the funding route; and complete testing and approvals for partial booking automation.

Deliver year 1 milestones for our strategic estate priorities

Progress has continued across the Trust's strategic estates programme during Quarter 2, with important milestones achieved across a number of programmes. This includes mobilisation of the first theatre at the Southampton Elective Hub, finalisation of the long-term lease arrangements at Chilworth, and progress in developing the longer-term solution for endoscopy capacity. Several programmes remain dependent on procurement, licensing, external funding and approvals, with work continuing to secure these during the remainder of the year.

- **Chilworth Testing Facility** – Planning continues for pathology and genomics services at Chilworth, with work aligned to the regional pathology network and associated funding opportunities. Agreement has now been finalised with the University of Southampton for the long-term lease arrangements for Chilworth/IMI, and work is progressing to agree the mobilisation and handover plan.
- **Private Patient Unit** – Procurement remains underway, with continued engagement with bidders. Best and Final Offers (BAFO) are expected by the end of 2026, with the programme currently aiming to commence in Q1 2027/28, subject to successful completion of the procurement and associated approvals.
- **Adanac Park: Aseptics and Sterile Services** – Work is progressing to complete the licensing requirements for the Aseptics facility and enable commencement of commercial services. Construction of the new Sterile Services facility remains on track for completion by the end of the calendar year. In parallel, a potential new industry partnership to develop biologics capability is being explored between UHS, the University of Southampton and Hampshire County Council.
- **Southampton Elective Hub** – The first theatre at the Royal South Hants Hospital has now been mobilised and is providing additional elective capacity. Work is underway to agree the future phases of the service and the longer-term operational model.

- **NHS Property Services Estate** – Discussions continue with Hampshire and Isle of Wight ICB and NHS England regarding the future oversight of NHS Property Services facilities within the region. An NHS England business case is expected during Q3.
- **Endoscopy Capacity** – RIBA Stage 1 design work has been completed for the proposed longer-term endoscopy facility. Agreement has been reached with NHS England to fund further design work and land purchase to facilitate the development. The aim is to complete the initial stages of this work during the current financial year.
- **West Wing Redevelopment** – Planning for the redevelopment of E Level West Wing following the fire continues, with the programme being developed in conjunction with the longer-term plans for endoscopy capacity.

Priorities for Q3

- **Financial sustainability:** Restore operational capacity and elective income, accelerate recurrent cost improvement and workforce productivity, and refresh the recovery trajectory and cash forecast, including any requirement for external cash support.
- **Digital transformation:** Progress the Digital First Outpatients business case towards procurement, resolve the AVT funding route before procurement proceeds, and complete testing and approvals for partial booking automation.
- **Service capacity and recovery:** Agree the next phases and operating model for the Southampton Elective Hub, progress endoscopy design and land purchase, and align West Wing redevelopment with longer-term capacity plans.
- **Strategic estates delivery:** Progress the Chilworth mobilisation and handover plan; progress Private Patient Unit procurement towards Best and Final Offers by the end of 2026; and advance Aseptics licensing and Sterile Services construction milestones, subject to the required approvals.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.2 Report to the Trust Board of Directors, 12 November 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.

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 **Deed of Assignment** of Intellectual Property Rights between University Hospital Southampton NHS Foundation Trust (UHS and Assignee), UHS International Development Centre Limited (Assignor), Prehab4life Limited (Company Number 15254579 and Assignor), Addaptive Group Holdings Limited (Assignor) and Mr Jason Mawer (Assignor). The parties have entered into a settlement agreement pursuant to which, among other things, the Assignors have agreed to assign the Company Number 15254579 Intellectual Property Rights and the UHS Intellectual Property Rights to UHS. Seal number 215 on 11 September 2026.

1.2 **Deed of Gift** between University Hospital NHS Foundation Trust (Donor) and UHS International Development Centre Limited (Donee) of 490 ordinary shares of £1.00 each. Seal number 316 on 11 September 2026.

1.3 **Deed of Gift** between University Hospital NHS Foundation Trust (Donor) and Prehab4life Limited (Donee) of 20 ordinary shares of £1.00 each. Seal number 317 on 11 September 2026.

1.4 **Agreement** between University Hospital Southampton NHS Foundation Trust (the Employer) and E W Beard Limited (the Contractor) relating to the Building Contract for a UHS Data Centre, involving demolition of 89 Laundry Road, Southampton, SO16 6AQ and construction of a new single storey masonry building with flat roofing system, fit out of new data room, switchgear room, workshops and amenity facilities along with external hard and soft landscaping and incoming services (the Works). Seal number 318 on 6 October 2026.

2 Chair's Actions

2.1 **Award of Sub-Contract** for Gynaecology and Trauma and Orthopaedics Outsourcing to Nuffield Health Wessex Hospital, for 12 months, at a cost of £2,525,060 (no vat). This sub-contract covers the outsourcing of elective surgical services, designed to tackle surgical backlogs and deliver timely elective care. This is an interim arrangement, backdated to 1 February 2026 until 31 January 2027, whilst a full procurement process is undertaken. Approved by the Chair on 14 September 2026.

3 Recommendation

The Board is asked to ratify the application of the seal and Chair's action.

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.3 Report to the Trust Board of Directors, 12 November 2026	
Title:	Health and Safety Services Annual Report 2025-26
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Spencer Scott, Health and Safety Advisor

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 outlines the key H&S activities and issues to be highlighted by the corporate team over the last financial year. The H&S Services deliver occupational health and safety compliance, moving and handling (M&H) functions and FFP3 Resilience for the Trust.

Members of QGSG are asked to review and note the contents of the report. QGSG are also asked to continue to support the following key staff safety matters contained in the report which help to maintain the safety culture at UHS. Issues to highlight during 2025/26 include:

- The number of serious incidents to staff, RIDDOR notifiable incidents which UHS has a duty to report to the Health and Safety Executive (HSE), has dropped to 59 from 68 in the previous year;
- The H&S AERs across the Trust was on a downward trend over the previous three years, but the reporting have stayed at levels similar to 2024/25. AERs raised for Violence and Aggression incidents have also remained at levels similar to last year;
- M&H issue: #843 Corporate Risk Register issue is unresolved, see Alert section;
- Staff exposed to infectious respiratory diseases and/or are involved in aerosol-generating procedures are required to be fit tested to two models of FFP3 mask (or a PeRSo/ equivalent respirators) where appropriate. Improvements are required across some areas of UHS to ensure more staff have been tested to two FFP3 masks, refreshed every two years. There continues to be the need for local CG Fit Testers to be given suitable time to undertake this role & ensure good quality communications to colleagues when appointments are available;
- The H&S Service undertake investigations into reported accidents to staff and others, making recommendations/ actions plans to local management to follow up. Local managers should feedback through their governance meetings to highlight progress made on the actions;
- There are 5 issues highlighted in the **Alert section** which have been escalated by the H&S Team or others.

The Health & Safety Services Team continues to provide advice, guidance, training and support to staff, managers and senior leaders to ensure that the Trust's statutory duties are met with regard to staff health and safety in the workplace; this supports the Trust values so that a positive health and safety culture is embedded into all of the Trust's activities. It should be noted that there has been changes to personnel in the H&S Team during 2025/26, and this will continue in 2026/27, which has affected capacity, e.g. the ability to deliver audits and projects. For the majority of 2025/26 there were four members in the team.

NHS Employers have produced a *Workplace Health and Safety Standards* document (2023) which provides the basis of effective healthcare health and safety management, to support staff and ensure organisations are compliant with legislation, link below:
https://www.nhsemployers.org/publications/workplace-health-and-safety-standards

Contents:	
Paper Appendix 1 Graphical information on RIDDORs and H&S AERs for 2025/26 Appendix 2 Annual Health and Safety self-assessment audit report Appendix 3 Radiation Protection 2025/26 annual report	
Risk(s):	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles. 3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff. 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.	
Equality Impact Consideration:	N/A

ALERT	
Risk Register; changes, escalations	RR #843: There is no flat lifting kit at the Royal South Hants Hospital and no flat lift kit available for the main public entrance at Southampton General Hospital. If staff need to deal with someone who has fallen and is at risk of spinal injury/ #NOF they do not have the correct equipment for flat lifting of the patient – so there is a risk of MSK injury if lifting is attempted. At the RSH this may lead to a lengthy wait for the injured party for an ambulance to arrive.
HSE Interventions	There have been several contacts/ communications from the Health and Safety Executive over the year, although the majority of these were simply asking for evidence to be provided on the H&S measures local managers take to protect staff from specific occupational hazards, e.g. Harm Arm Vibration. There has been no enforcement action taken.

Information on health and safety escalations:

The following issues have been raised as actionable issues in the Corporate Health and Safety Team reports to CHSC and other governance meetings.

1. Entonox surveillance of the maternity staff

The most recent staff Entonox exposure monitoring was undertaken in March 2026 by Workplace Exposure Ltd (Occupational Surveillance Consultancy) as part of UHS duties under Control of Substances Hazardous to Health Regulations - Entonox used by birthing mothers is known to have health risks to staff with long-term exposure. The Health and Safety Executive (HSE) set a national *Workplace Exposure Limit* for Entonox (Nitrous Oxide) which the monitoring undertaken detailed was exceeded for three members of staff, and high levels for other staff were recorded (similar to the previous exposure sampling undertaken). Actions need to be taken to lower the workplace exposure levels with the preferred option being the use of gas scavenging equipment; a business case is being worked on so capital funding can be provided for these works.

A steering group has been set up to look at the actions that can be taken to reduce the staff exposure from nitrous oxide and will report into the Medical Gases Committee and Corporate Health and Safety Committee (CHSC). Of interest is the Basildon Hospital case of workplace Entonox exposure which hit *national headlines* in 2025/26.

2. Display Screen Equipment (DSE) compliance

UHS has seen an increase in e-noting and laptop use in recent years which has increased the focus on ensuring staff can work comfortably with this equipment. The ergonomics of staff who use laptops was audited in 2024 following feedback from staff, and a report was presented to the Corporate H&S Committee due to concerns about compliance with the Health and Safety (Display Screen Equipment) Regulations 1992. The issue was raised again in a 2025 CHSC meeting.

A review of Therapies staff workstations set up and practices identified DSE posture concerns, with an action plan being drawn up between H&S and local manager to focus on

improvements. The Therapies team audits identified the need for a project to look at laptop use on wards to highlight how the risks of poor posture, which can lead to musculoskeletal pain and increased absence, is being managed. The H&S Team undertook further visits to wards where observations were undertaken and those staff who were laptop or tablet users were asked to complete a short survey. This survey highlighted concerns on the standards across the hospital, focused on wards, as there was an inconsistency in the workstations staff have to use.

Care Groups and Departments should review DSE workstations and ensure staff annually complete the VLE DSE self-assessment module and review the work activities of their staff who are required to use laptops on ward and follow up on any actions identified in the self-assessment. It has been agreed that following a corporate group meeting on this subject that a Trust wide policy on DSE compliance is needed.

3. Pharmacy Goods-In Store, SGH loading bay

Both the Trust H&S Adviser and Fire Safety Officer have raised concerns with non-compliances identified with the building structure situated within the SGH loading bay: fire door replacement has now been completed, however the concerns about the size of structure for activities undertaken is unresolved. The pharmacy logistic activities in the storage and distribution of goods store, which including sterile bottles, has outgrown the unit. Fundamentally the store is not big enough to take the increasing levels of goods being received and the use of a powered pallet truck in the restricted space creates H&S risks which need to be managed and resolved. This issue has been recorded on the Divisional risk register. Local management actions cannot mitigate all the risks identified, and alternative measures have not yet been identified. Senior managers need to be aware of this risk.

4. Workplace Temperatures

During the warmer months the health and welfare issue which is most regularly raised as a staff and patient concern with the H&S Team directly or via AERs is the *high workplace temperatures*. Some of these areas across UHS are able to take appropriate action and have temporary mobile aircon units provided, but not all (electrical capacity does not allow mobile aircon units everywhere). This is an issue which has also been regularly raised by the Staff Side/ Unions over the years.

Guidance to staff on hot workplace temperatures is held on Staffnet – Hot Weather Hub. However, increasing summer temperatures is an issue which is predicted to only get worse over the coming years and has a significant impact on staff (and patients) during the warmer months. UHS needs to have measures in place to protect staff health and welfare from the hazards of high temperatures in the workplace.

5. DSEAR Inspection of LB80 Chemical Store

Inspections and an audit followed on from a chemical leak in the LB80 store in 2024 which highlighted concerns about the H&S Management of the room and the need to confirm roles and responsibilities of those using the store (shared with University).

An external consultancy was brought in to undertake a Dangerous Substances Explosive Atmosphere Regulations (DSEAR) audit in 2025 due to the concerns raised, and the standards which needed to be met. The audit report was provided in October 2025 with

seven actions marked as a *high priority*. Firefighting equipment has been provided for the store but a number of other actions are outstanding: electrical upgrade; & ventilation repairs. It is not clear to the Health and Safety Adviser who in EFCD is managing this improvement process. Update needs to be chased. (The H&S Service has not been directly involved in the West Wing Endoscopy Fire investigation or action plan, so this issue will be reported on elsewhere).	
Escalations for action by Divisional Management Team	The five items detailed for escalation above have all been raised at Divisional Governance, CHSC, and other meetings.

ADVISE

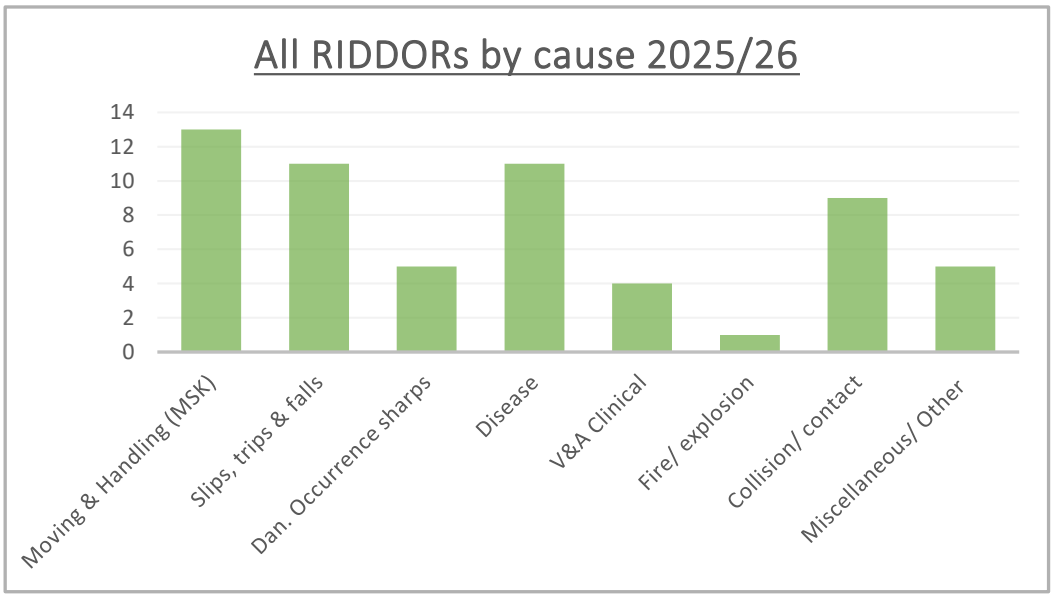
Summary of significant H&S-related incidents and RIDDORs

RIDDOR Reportable Incidents

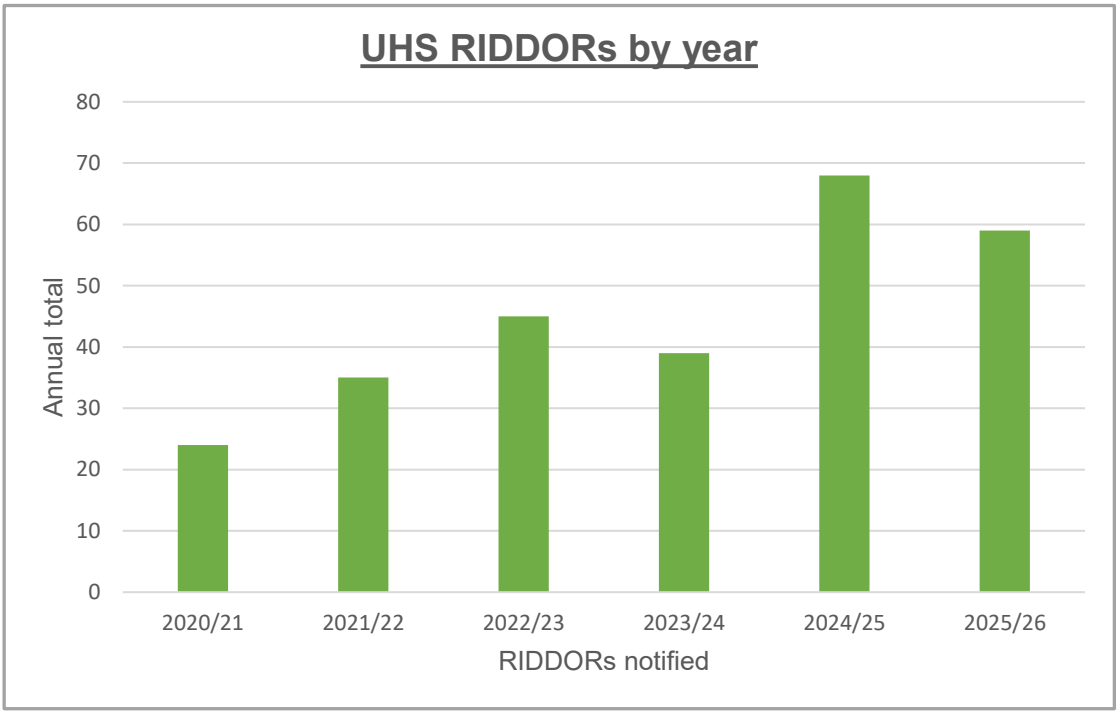
The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) is a statutory requirement; RIDDOR incidents are reported to the Health and Safety Executive by the Health and Safety Services Team, following investigations conducted locally in wards/departments and followed up by the H&S Adviser and M&H Adviser. Internal notifications are also made by Occupational Health Team for sharps and contamination incidents.

Monthly RIDDOR Panel meetings continued to review reportable incidents/cases and involved the Trade Union Representatives. The review panel ensures investigations have been carried out appropriately, any outstanding actions are followed up and the lessons learnt to help prevent recurrence are shared. A total of fifty-nine incidents were reported under RIDDOR, cause type detailed in the graph below.

Graph 1. RIDDORs by Cause 2025/26



When drilling into the data the *cause type* accounting for most incidents is Moving and Handling (M&H) which includes pushing and pulling movements which led to a staff injury. The big 5 causes as identified in the historic AERs

	received are, *V&A, Sharps, Moving and Handling, Collision's, Slips and Trips, which* are all represented in the figures. Graph 2. RIDDORs by year comparison  Graph 2 demonstrates that RIDDORs have had an upwards trajectory since 2020/21 (Covid year) but has plateaued in the last two years. Total numbers have dropped to 59 compared to last year's high of 68.

ASSURE	
Proactive Monitoring; inspections/ audits	Daily proactive monitoring of H&S AERs is undertaken to identify incidents which require further investigation or highlighting to Care Groups/ Divisional Governance.
H&S issues	The Corporate Health & Safety Committee (CHSC), chaired by the Chief Nursing Officer (CNO), have met quarterly in line with the Terms of Reference; the group monitors the Trust's activities in relation to staff health and safety, moving and handling and FFP3 resilience, receiving quarterly reports from all three services. The Committee also receives quarterly reports from Divisional Risk and Governance Groups and key supporting departments (EFCD compliance, Security & Occupational Health) and an annual report of non-clinical claims from the Claims & Insurance Department. However, it should be noted that there are *no regular health and safety metrics or key performance indicators* which are reported on regularly basis to any UHS groups by H&S Service Team. There is occasional verbal feedback reporting will be through People Board and will commence no later than Q3 in 2025/26.

Appendix 1 provides graphical summaries of the staff-related adverse event statistics from 1st April 2025 to 31st March 2026.

Section 2: summary of the Moving & Handling Service

The **Moving and Handling Team** advises and supports the Trust to ensure staff are *Happy, Healthy and Here*, while enabling the organisation to meet its statutory duties relating to moving and handling activities.

Members are asked to highlight the following key matters to senior management and operational teams to continue strengthening the safety culture at UHS.

Key Achievements and Activity Over the Past Year

- **Mobile Endoscopy Units Support** — The Trust Moving and Handling Adviser worked closely with the project team to support the successful launch of the Mobile Endoscopy Units at UHS. This included specialist guidance on evacuation chair use, equipment selection, and delivery of training. **A FERF was awarded in recognition of the Adviser's dedication, flexibility, and timely support throughout the project.**
- **RIDDOR Reduction** — RIDDOR incidents increased to thirteen (13), an increase of one (1) from the previous year. Moving and handling incidents now account for 22% of Trust-reportable RIDDORs.
- **Flat Lifting Kit Risk** — The non-availability of flat lifting kit at the Royal South Hants Hospital, and the absence of suitable outdoor flat lifting kit at Southampton General Hospital, has been added to the Trust Risk Register with a red rating of 15 (Risk #843).
- **Statutory & Mandatory Training** — The team delivered one hundred and seven (107) face-to-face clinical training events at Princess Anne Hospital, training five hundred and seventy-three (573) staff. Attendance has broadened to include consultants, nurses, and other clinical groups. Non-attendance resulted in a loss rate of 26% (227 staff).
- **Training Capacity** — The Lead Moving and Handling Trainer is currently at full capacity and unable to take on additional statutory or mandatory training for divisions, care groups, or wards.
- **Complex Workstation Assessments** — Fifty (50) complex workstation assessments were completed. Equivalent external provision would cost £395.00 plus VAT per assessment, resulting in a Trust cost saving of £23,700.00 (inclusive of VAT). Staff are typically contacted or assessed within three weeks—significantly faster than EDNA and DWP services, which currently have an eight-month backlog.
- **Ward Engagement** — Three hundred and eighty-six (386) ward visits were undertaken across the Trust.
- **Plus Size Patient Masterclasses** — In response to increased admissions of plus-size patients, masterclasses have been delivered since May 2024. Between 1 April 2025 and 31 March 2026, eight (8) courses trained forty-six (46) staff. Since launch, fourteen (14) courses have trained ninety-two (92) staff.

- **Fire Incident Support** — Following the fire incident on 1 February, the Moving and Handling Adviser has played a key role in supporting the Trust's ongoing response and recovery actions.
- **Evacuation Chair Provision** — The team supported the implementation of evacuation chair provision and associated training. Nine (9) staff have now completed the trainer-level course and are qualified to deliver evacuation chair training to Trust staff.

Training over the past year

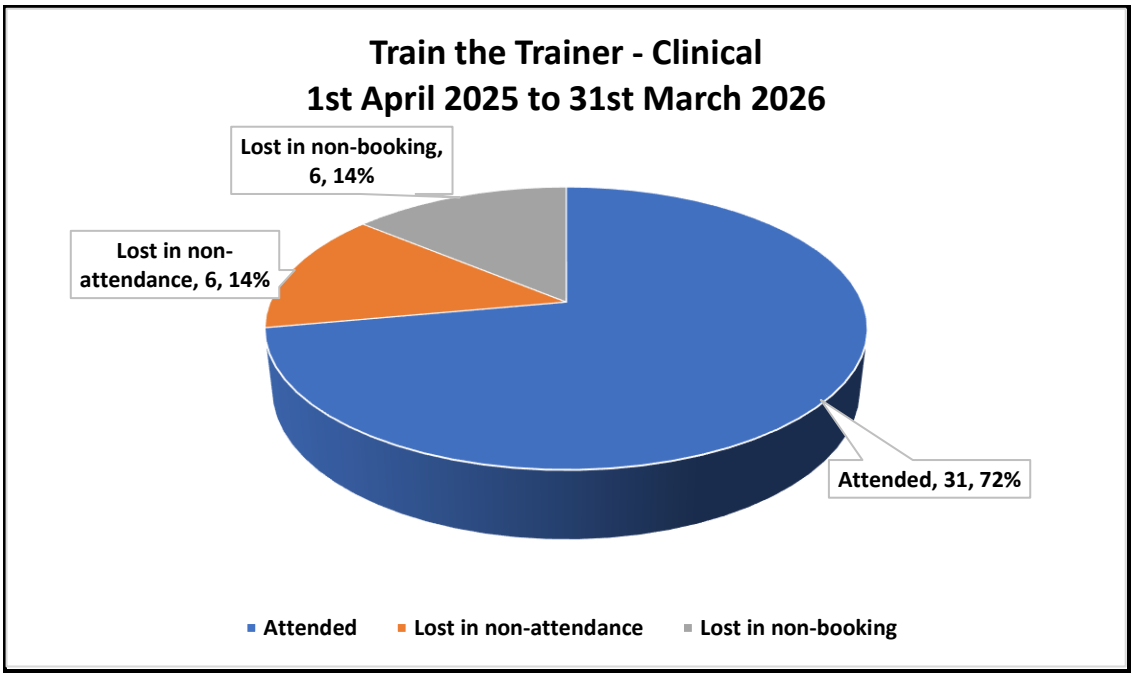
Training Capacity, Competency and Development

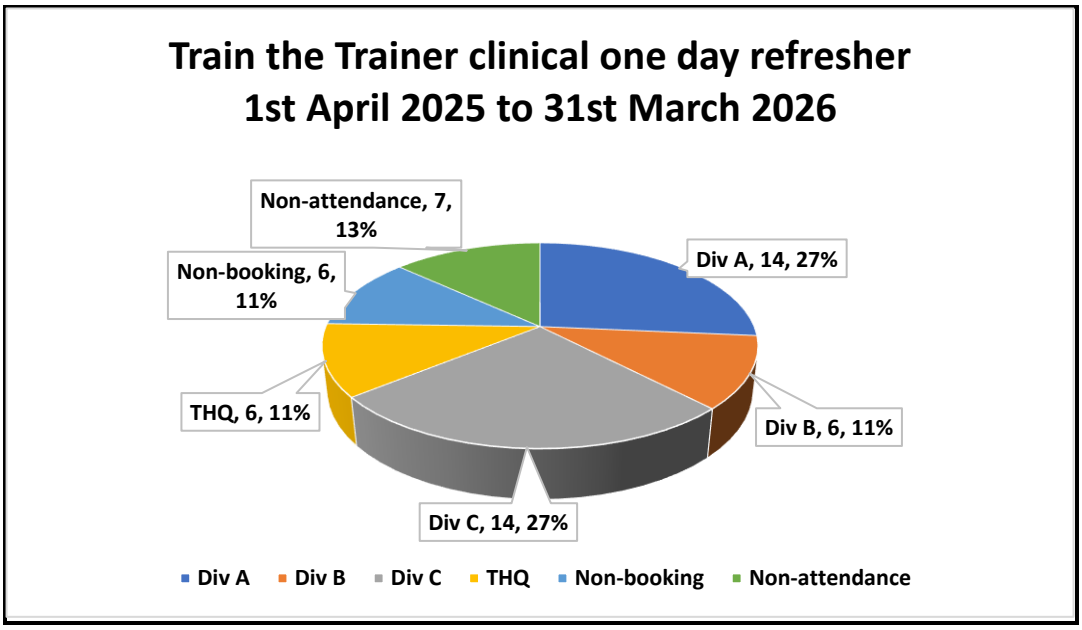
- There are one hundred and eight (108) competent Moving and Handling Trainers across divisions and care groups. Between April 2025 and March 2026, thirty-one (31) additional ward-based trainers completed the Train-the-Trainer course and peer reviews.
- Collaboration with the University of Southampton continues, with eight (8) university trainers trained in 2025/26. This ensures consistent standards for student nurses, midwives, and allied health professionals on placement within the Trust.
- Trainers who do not complete their **peer review**—either within two months of the course or at the two-year refresher point—are deemed not competent, and their training skill designation is removed from HealthRoster. Currently, twelve (12) care group trainers are overdue or have not completed a peer review; engagement is ongoing.
- Promotion of Train-the-Trainer courses via VLE and newsletters has increased demand from divisions for additional clinical trainers.
- The future aim is to ensure **two trainers per ward/care group**, providing resilience and peer support.
- The **refresher course** continues with improving uptake. It includes statutory and mandatory technique updates and reflective practice peer review. Trainers must attend every two years to remain competent, and completion signs off their own Level 2 training. Staff feedback has been positive, noting the course is useful and informative.

Trainer Clinical Course Attendance – Required Senior Support

The **clinical trainer course**—essential for maintaining competency—has been increasingly difficult to fill. Staff are **not booking onto the course**, creating additional workload for the Moving and Handling Team, who must contact individuals directly.

To maintain safe, compliant, and up-to-date Moving and Handling standards across the Trust, **senior managers are asked to actively release staff and promote attendance**. Ensuring trainers complete this course on time is vital so that the staff they train receive competent, legally compliant instruction.



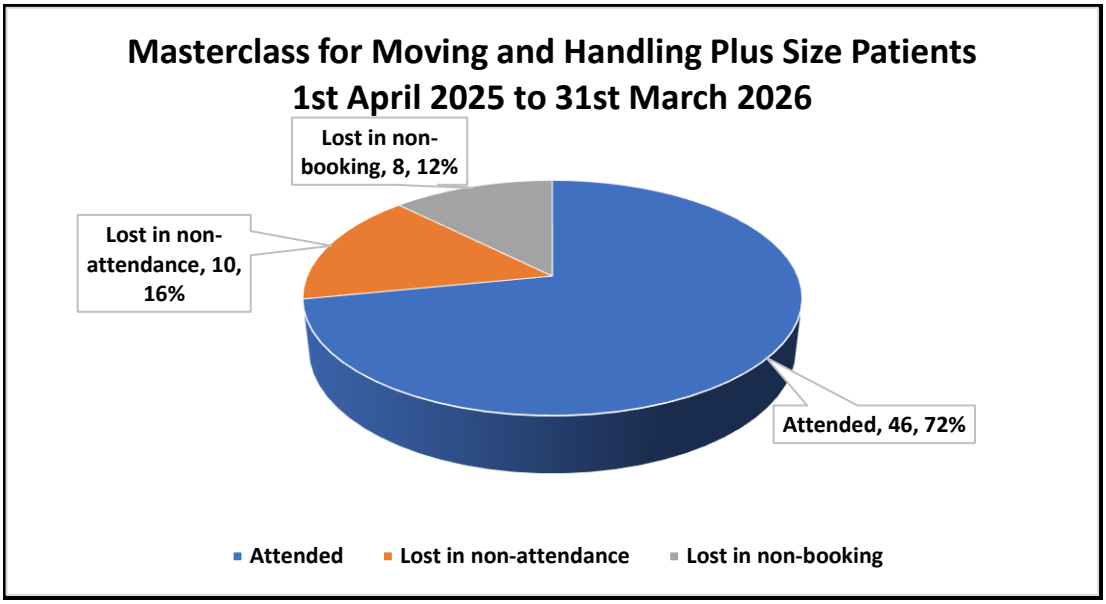


Train-The-Trainer non-clinical

- There are currently **nineteen (19)** non-clinical moving and handling trainers.
- One courses have been undertaken from 1st April 2025 to 31st March 2026.

Masterclasses for Moving and Handling Plus Size Patients

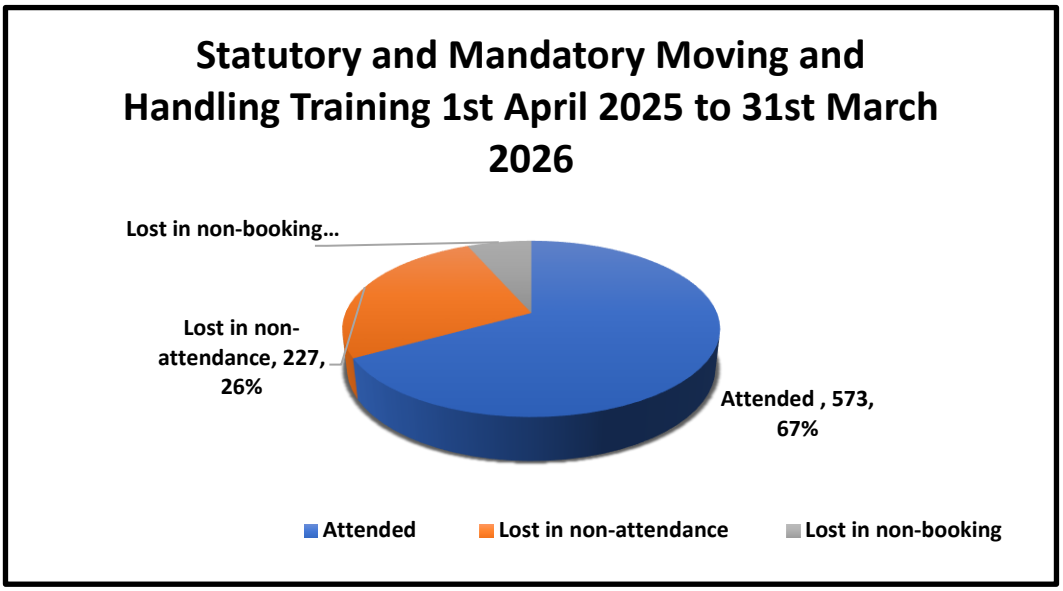
Between 1st of April 2025 and 31st March 2026 eight (8) courses were run and forty-six (46) staff trained.



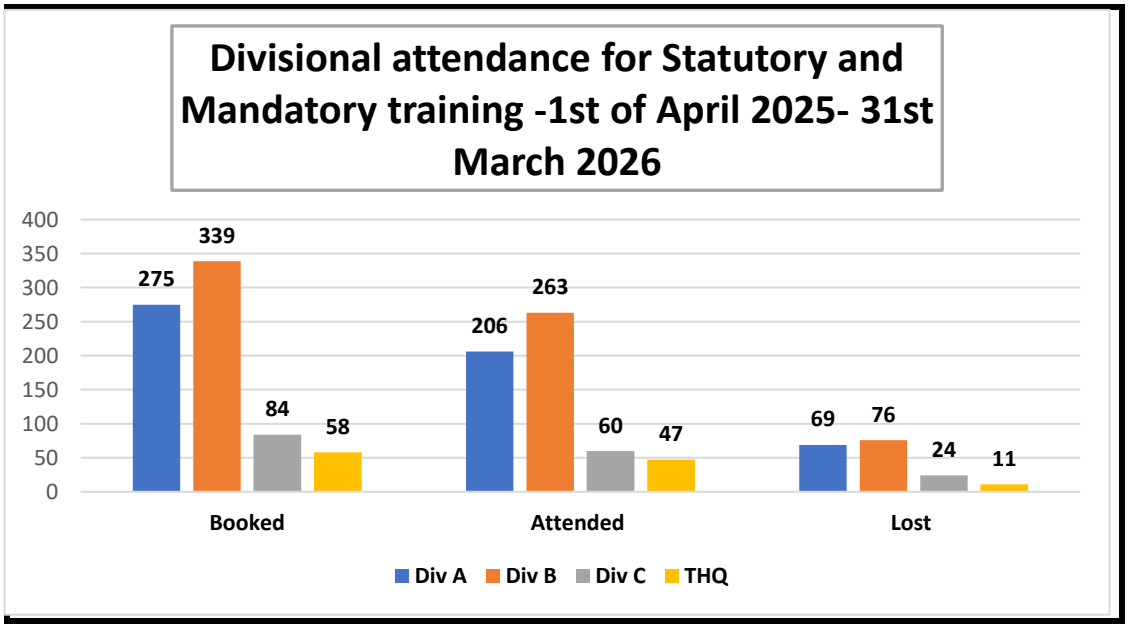
Statutory and Mandatory Moving and Handling Training for Clinical Staff

A total of **856 training places** were offered across the year, with **800 places booked** and **573 staff attending**. This resulted in **227 non-attendances**, equating to a **26% loss rate**, and **56 places lost due to non-booking**.

- Four (4) courses were cancelled due to attendance falling below the minimum requirement of four delegates. Three (3) courses were cancelled due to the **major incident** following the fire; affected staff were re-booked onto additional dates in March. Two (2) courses were cancelled to accommodate other essential training, including bariatric bed training for porters and a **Train-the-Trainer Evacusafe chair** session.
- Despite cancellations and operational pressures, **573 clinical staff** were trained between 1 April 2025 and 31 March 2026 by the Lead Moving and Handling Trainer. Attendance overall remains strong, demonstrating continued engagement with statutory and mandatory requirements.
- Non-attendance remains a significant challenge, particularly within **Divisions A and B**. To address this, the team has worked with the VLE team to implement a **non-attendance notification email** sent automatically to both the delegate and their line manager. This ensures visibility of missed training and supports improved accountability.
- Continued support from senior managers is essential to reduce non-attendance, ensure staff are released for training, and maintain safe, competent **Moving and Handling practice** across the Trust.



The M&H Team continue to provide a range of training courses, held regularly on site at Princess Anne Hospital. Courses are advertised via various media, such as walk and chat visits on the wards, workplace posters, our newsletter, Staffnet and the weekly Education Huddle.
Although we are now seeing significant changes in training uptake by staff, we continue to explore different ways of communicating our service and links within the Trust.



Bespoke and Specialist Training/Support over the past year

The Moving and Handling Team has continued to provide specialist support across the Trust, particularly in areas managing complex patients or requiring bespoke advice, training, and risk-based guidance.

- The **Moving and Handling Adviser** continues to act as the Trust's subject matter expert and is working closely with **NHS England** on proposed changes to **Statutory and Mandatory training**.
- The Trust delivered **eight (8) plus-size patient masterclasses** this year in response to rising admissions of plus-size patients. These sessions have become an invaluable resource for staff who support complex bariatric care. If you want to expand this section beyond September, you could add: *"Demand for plus-size patient training continues to increase, and additional masterclass dates are planned beyond September to ensure staff remain confident and competent in supporting this patient group."*
- Ongoing support has been provided to the **mortuary,** including updated risk assessments and annual specialist training. Mortuary staff received their annual update in **February 2026**, recognising the unique complexity of their moving and handling requirements.
- The Adviser has facilitated **monthly meetings with DHG**, the Trust's bariatric equipment supplier, to manage the bariatric rental contract. The Trust has been significantly exceeding its allocated monthly rental budget. This has been escalated, and **restriction measures** were implemented from **November 2025**. These continue to be monitored to reduce unnecessary expenditure and promote efficient equipment use.
- The **refresher course for Clinical and Non-Clinical Trainers** has now been running for over two years. Attendance is mandatory to maintain competence, but uptake has declined. Trainers are reminded that failure to attend may result in their competency being marked out of date and removal from training duties until refreshed.
- In response to concerns raised by the **Portering Service** regarding the **Benmore Aurum** bariatric bed, the Lead Moving and Handling Trainer—working with DHG—delivered targeted training for key portering staff and managers. This included classroom teaching, demonstrations of bariatric beds used across the Trust, and hands-on practical sessions. Trained staff will now cascade this training across the wider Portering Department to ensure consistent and safe practice.
- The team has supported several **non-clinical areas** with bespoke risk assessments and SOP development, including **Pharmacy, HEMS, and Radiotherapy**.
- The Adviser continues to contribute specialist input to the **Fundamentals of Care** project, supporting both the mobility and independence group and the communication and information group.
- Concerns remain regarding the **quality of electronic inpatient noting** for patients requiring mobility support. Reviews have shown inaccuracies in many cases. The team is now involved in a Trust-wide review of inpatient moving and handling documentation to ensure safe practice and reduce risk of injury to staff and patients.
- Work is ongoing to develop a **Trust-wide Moving and Handling lesson plan**, though progress has been delayed due to limited staffing and time.
- The team has supported and contributed to numerous **meetings and steering groups**, providing specialist expertise across multiple programmes of work.
- Following the **fire incident on 1 February,** the Moving and Handling Adviser has played a key role in supporting the Trust's response and

recovery. This has included attendance at multidisciplinary meetings, providing expert guidance on safe patient movement and evacuation in areas with restricted access, and advising on the most appropriate **evacuation equipment** to mitigate risks associated with limited escape routes.

- The Adviser has supported decision-making on the **selection and purchase of new equipment**, ensuring all recommendations align with Trust policy and patient needs.
- The Adviser has been heavily involved in the project to install **mobile endoscopy units**, ensuring operational and patient safety requirements were fully met. This included advising on emergency equipment, evacuation procedures, and delivering comprehensive equipment training for all staff working in the units prior to go-live.
- The team has provided bespoke moving and handling risk assessments for staff returning to work following injury or illness, with referrals initiated by line managers or Occupational Health.
- The team organised and delivered **a one-day event for National Back Care Week in October 2025**, themed *"SOS – Save Our Spines."* The event showcased DSE solutions (including support for neurodivergent staff), ergonomic seating, a Moving & Handling risk assessment app, physiotherapy input, and demonstrations from Linet and Winncare. Attendance was lower than in 2023 and 2024, and this will be reviewed to identify barriers and improve engagement for future events.

Proactive and reactive monitoring over the past year

- The team continues to maintain proactive compliance monitoring across the Trust through **ward visits**, equipment checks, close collaboration with **Moving and Handling Trainers,** Education Leads and their teams, participation in Trust-wide groups, liaison with equipment suppliers and manufacturers, and sharing best practice with other specialists.
- Reactive monitoring includes following up on **adverse events** where staff have been injured, investigating **RIDDOR-reportable incidents**, and using lessons learned to improve practice and reduce future risk.
- The team conducted **three hundred and eighty-six (386)** ward visits over the past year. These visits included reviewing patients (including plus-size patients), sourcing specialist equipment advising staff on equipment availability and correct use, undertaking **AER investigations,** reviewing care plans, and delivering bedside training to nursing, therapy, and medical staff.
- The team continues to support staff with **complex moving and handling advice and guidance,** ensuring safe practice in challenging clinical and non-clinical environments.
- The annual **self-audit** was transitioned to a Microsoft Forms-based audit in June 2026, distributed to all wards and Moving and Handling Trainers. Results will be presented in the October 2026 reporting period. Throughout the year, the team has been working on audit outcomes to drive improvements in practice.

Workstation / Display Screen Equipment (DSE) over past year

- The team carries out **complex DSE, and workstation assessments** for staff across the Trust, delivering positive outcomes and ensuring a safer, ergonomic working environment. **Complex DSE assessments** remain a key part of supporting staff health, wellbeing and productivity.
- Between **1 April 2025 and 31 March 2026**, the team completed **fifty (50)** complex DSE assessments. Based on an external provider cost of £395.00 plus VAT per assessment, this work generated a **Trust saving of £23,700.00** for the year.

- In previous years, the team saved **£42,200.00**, giving a combined saving of **almost £66,000.00 over three years**—a significant financial benefit alongside improved staff safety and comfort.
- The current waiting time for a complex DSE assessment is **three weeks**, which remains substantially faster than external providers. At the time of completing this report, **four (4**) outstanding DSE referrals have crossed into the next financial year.

Equipment

Risks and Equipment Availability

- **Increase in damage to flat lifting equipment** has reduced the number of safe working flat lifting kits available across the Trust.
- The **only kit suitable for outdoor use is currently affected**, impacting service resilience.
- A potential solution has been identified by the M&H Team but requires **capital investment**.
- Due to the lack of a safer alternative system of work, this issue has been **escalated to the Trust Risk Register #834**.

Financial Impact

- **Six HoverJack systems successfully replaced** with Winncare flat lifting kits as part of the rolling replacement programme.
- **Five additional Winncare kits planned for 2026 have been removed from the replacement programme** due to financial constraints.
- This may further impact future availability and resilience of flat lifting equipment.

Staff Engagement and Equipment Innovation

- The M&H Team delivered **two successful equipment showcase events** during the year.
- Events were supported by clinical staff, Clinical Engineering, Tissue Viability and Infection Prevention teams.
- Positive feedback has resulted in a commitment to **continue these events**, supporting equipment evaluation and staff engagement.

Patient and Staff Safety

- An **AER was raised in December 2025** following failures of retaining clips on Prism A320 hoists.
- A full investigation was completed and findings disseminated via **Field**

Safety Notice UHS/2025/016.

- **All identified hoists have now had the retaining clips replaced**, mitigating the safety risk.

Other activities

Regional Collaboration and Professional Development

- The team continues to actively participate in the **Somerset, Avon and Gloucester Back Exchange network**, providing opportunities to share best practice, discuss complex Moving and Handling challenges, review emerging equipment and innovations, and learn from other healthcare organisations.
- Participation supports **continuous professional development**, strengthens the team's expertise, and ensures that learning from across the region is translated into improvements in Moving and Handling practice at UHS.
- This engagement contributes to ongoing improvements in **staff safety, patient care, and service quality**.

In Summary

The Moving and Handling Team has experienced a significant increase in demand over the past year, delivering enhanced training programmes, increasing training capacity, undertaking a growing number of complex workstation and Display Screen Equipment (DSE) assessments, and supporting numerous Trust-wide projects and service developments.

Key Achievements:

- Increased delivery of Moving and Handling training across the Trust.
- Expanded support for complex workstation and DSE assessments.
- Continued provision of specialist Moving and Handling advice to staff and patients.
- Worked collaboratively with clinical and non-clinical teams to develop safer systems of work and address complex moving and handling challenges.
- Contributed to improvements in staff safety, patient care, and compliance with Moving and Handling best practice.

Strategic Impact

- The team's work delivers clear benefits to the Trust through improved staff safety, reduced risk, enhanced patient care, and the development of safer working practices.
- Achievements over the past year demonstrate the value of the service and highlight the importance of continued investment in Moving and Handling resources to meet future demand.

Section 3: FFP3 Resilience Service Report

To provide an Assurance Framework, assurances and compliance with legal requirements and standards set by CQC, NHS and Trust Policies.

Recommendations:
Members are asked to support and highlight the following key matters to their senior management and operational teams to improve the safety culture at UHS.

- Ensure there are enough local fit testers in care groups/wards to support clinical staff who need to be fitted with FFP3 respiratory protective equipment; those wards in high-risk pathways should have their own, local competent fit tester.
- Support local, ward/departmental Fit Testers with protected time to carry out their role.
- Ensure staff who are nominated to be a fit tester are given the protected time to attend all aspects of the training and competency assessment.
- Ensure all staff who care for patients with infectious respiratory diseases and/or are involved in aerosol-generating procedures (AGPs) are fitted to at least TWO appropriate FFP3 masks.
- Ensure that non-clinical staff who meet respiratory sensitisers (i.e. dusts, fumes, gases) are fit tested for FFP3 respiratory protective equipment, as detailed in the relevant risk assessments.
- Support staff to take responsibility for their own health and safety; staff must be aware of their fit testing requirements and fit testing history/records.

Introduction

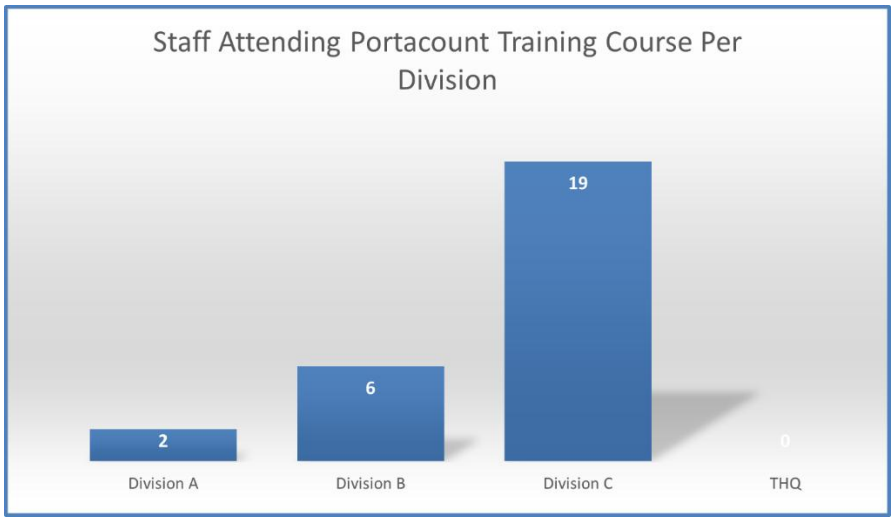
The FFP3 Resilience Service has continued to deliver the Central FFP3 mask fit testing service, Fit Tester Portacount training, assessment of fit tester competencies and the servicing and distribution of PeRSo equipment as well as now providing the Trust Portacount training courses for local trust fit testers
Portacount FFP3 Fit Testing training courses are now run in house, training the Trusts local fit testers. This both allows more Fit Testers to be trained per Division as well as saving the Trust over £10,000 per year in training costs. Training includes signing off local Divisional fit testers for their competencies with the Portacount machine. This should enable Divisions / Care Groups to be more self-sufficient in fit testing their staff. This is especially important now Fit Testing requirements are part of the Role Specific Mandatory Training on VLE and so has put pressure on the amount of fit testing required within the Trust. This pressure should be able to be partly absorbed by the Local Fit Testers. The inclusion of this on VLE will also ensure staff are informed when they need to renew their fit test and help with their safety and the Trust to have records on the number of staff fit tested.

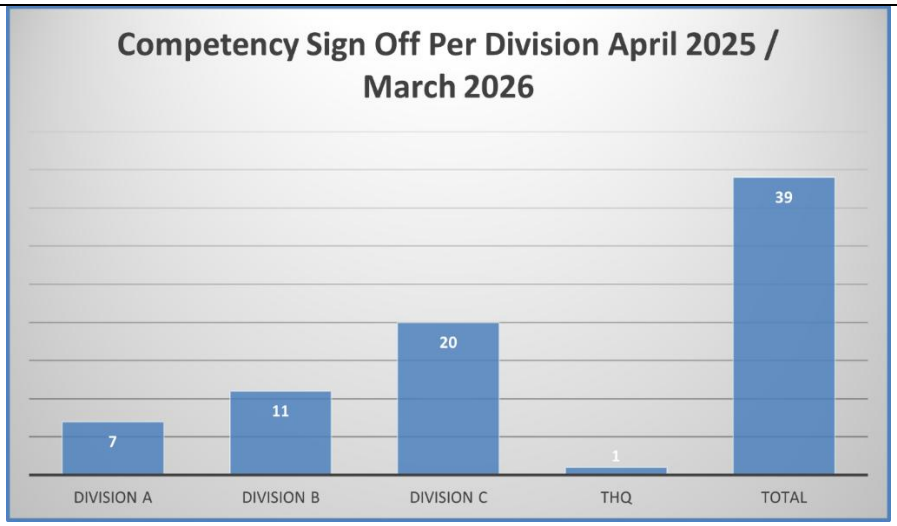
Fit Tester Training

We have run Nine (9) Portacount Fit Testing Training Courses April 1st, 2025, to March 31st, 2026. There are now twelve (12) further training courses available to book on VLE throughout the rest of 2026. As the need for hiring of outside companies to run the training courses has been removed, the Trust can run more courses to meet the needs of Fit Testing within the Trust, and we can be more flexible in providing courses where they are needed. In completing the nine courses we have trained a further forty-two (42) Divisional Fit Testers.



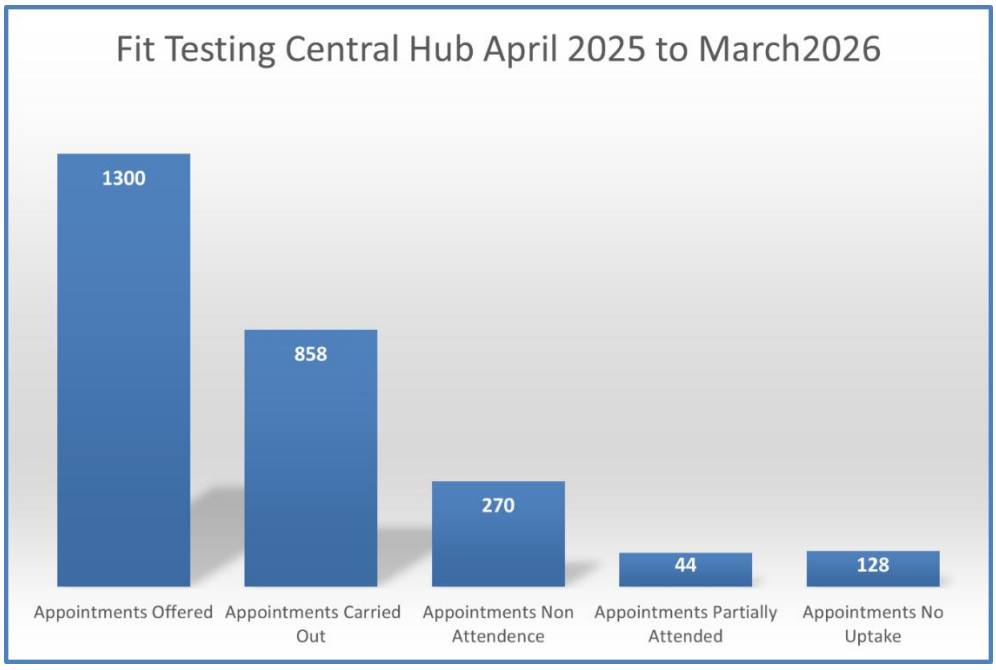
Staff do still seem to find it very difficult to be spared to complete their training, but they cannot fit test staff until they have had their competencies signed off. If staff are allowed to attend Day One of the course to be trained on Portacount Fit Testing, then they are also required to attend Day Two to complete the training course.
The introduction of the Fit Testers 3-Way agreement in 2025 has helped focus staff on completing their training.





Summary of FFP3 Mask Fit Testing in 2025 /2026

Managers should note that staff still need to read the email they are sent the day before their fit test as this has important information regarding the requirements of the fit test, as well as directions to the Fit Test Hub and the code to let them through the doors. In addition, some staff members miss the fact that they should be clean shaven when attending for a Fit Test.



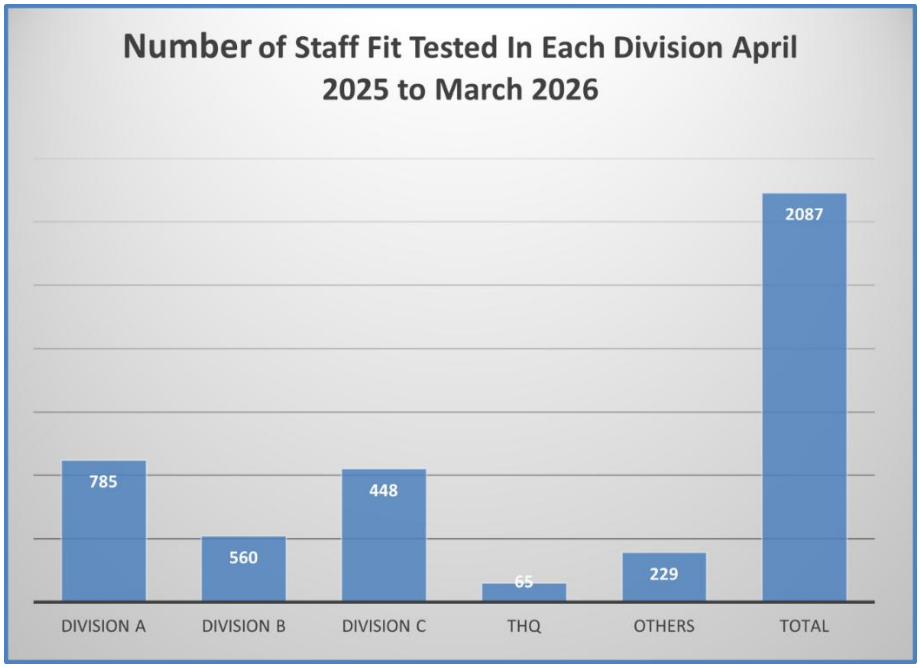
<u>Fit Testing completed in the Central Fit Testing Hub.</u>

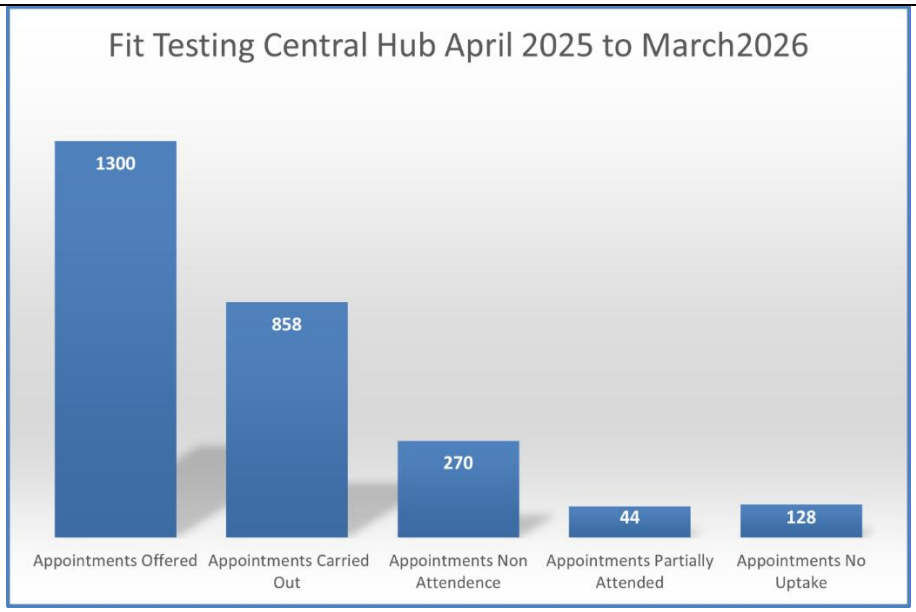
The Central Fit testing Hub has delivered over 32% of the total number of fit tests carried out within the Trust in the months April 2025 through to the end of March 2026.

The 'no-shows', 'no uptake' and partial attendees (Staff attend but have beard, stubble, have eaten or drunk, or have health issues) of appointments have accounted for 34% of the appointments offered this year. This was a drop annually over quarter 3 by 7%, but it is still frustrating that a third of the appointments go to waste. This is especially important as the FFP3 fit test is now on VLE as Role Specific Training and so has put even further pressure on the Central Fit Testing Hub where appointments can be booked up to 9-10 weeks ahead.
We are continuing to help reduce this number by using the VLE system to send email reminders to staff with the details and instructions for their fit test appointment the day before their appointment is due. This now appears to be now having an effect in reducing the number of staff coming to their appointments having eaten or having had a drink but is **still not helping in staff being released from their departments to attend their Fit Test appointments.**

It is appreciated that in a large, acute hospital members of staff cannot always leave their ward/department due to unforeseen pressures. However, mask fit testing is a key element of staff safety; line managers are asked to ensure that their staff are fit tested and are allowed to attend their appointments as a priority wherever possible.

Divisional / Care Group Fit Testers contributed to the fit testing of staff and a TOTAL of Two Thousand and Eighty (2087) staff were fit tested in the Trust in the months April 2025 through to March 2026. This is a great contribution to the safety of their colleagues. THANK YOU!
The following numbers of staff have been fit tested in each division.
Division A – 785, Division B – 560, Division C – 448, THQ – 65 and others (NHSP, students – medical and nursing etc) - 229





The continued training of local Fit Testers will have a further positive impact on staff safety. This is the most important aspect of allowing the Care Group Fit testers time to use the additional skills they have gained in undergoing their Fit Tester Training.

Further Projects

VLE has been updated in mid-December, to reflect the agreed FFP3 position of staff members. So, it is now part of many staffs Role Specific Mandatory Training. This does now put even greater pressure on the Central Fit Testing Hub as there are now large numbers of Trust Staff who are non-compliant on their mandatory FFP3 Training. This means local Fit Testers will be requested more frequently by colleagues for fit testing as this will increase the numbers of staff required to be fit tested to comply with the Trust FFP3 policy. **Team Leaders and Managers are asked to allow their local fit testers more time to fit test their colleagues where operational pressures allow.**
This project will enable the Trust to have more accurate records of fit testing compliance and support staff to keep themselves safe from infectious respiratory diseases.

PeRSo Usage
In the short term the FFP3 Resilience Service continues to offer PeRSo powered respirators to staff who cannot be fit tested to any disposable FFP3 masks; this equipment enables staff to continue to work in the event of them requiring protection against infectious respiratory diseases.

Current records indicate that over 500 PeRSo are still allocated to staff as follows.

- used as a back-up where a second FFP3 mask cannot be fitted.
- staff who wear the hijab and find it easier to use a PeRSo rather than the disposable FFP3 masks.
- staff with beards or do not wish to shave and those staff who are unable to shave for medical or religious reasons.

- staff in the Intensive Care Units use PeRSo equipment as either their main respiratory protection or as their secondary FFP3 option.
- The use of the PeRSo will cease at the end of August 2026

Perso Respirators Continuation

The Trust has not made a definitive decision reference which PAPRs will replace the use of PeRSo respirators yet. The questionnaire has been completed by PeRso users, and a showcase event was held in May with 7 Manufacturers attending with their powered respirators, so staff could attend and give feedback. This was collated with the questionnaire and as a result a paper has been written to be presented to the Trust Board with recommendations and options for the replacement Powered Respirators. Currently no decision has been made. Procurement will be involved in sourcing the alternative Respirators required. All Divisions will be updated when there is further progress and decisions have been made. This is expected to be before the end of August 2026.

Summary

The Lead Fit Test Trainer will now provide the Portacount Training courses for FFP3 testing. The Lead Fit Test Trainer will also continue to support and answer all queries about the use of FFP3 masks (including PeRSo powered respirators) across the Trust, as well as providing advice, guidance and support for managers and the local care group fit testers with regards to FFP3 masks, equipment queries and especially troubleshooting for the Portacount machines.

It should be noted that the situation of the “single point of failure” in the FFP3 Resilience Service remains. With only one member of staff managing and delivering the service, this adds to the long waiting time for appointments in the central fit testing hub -there is currently an 8 to 10 week wait.

Table 1 Corporate H&S Courses attendance 2025/26

	Division Attendees				
H&S Courses Q3	A	B	C	D	THQ/ WPL
H&S Leads intro	11	14	12	4	3
H&S Risk Assessment	10	16	13	3	6
COSHH Risk Assessment	5	6	7	2	2

Annual H&S Self-assessment Survey

There was a good level of engagement with the **Annual H&S self-assessment audit form** this year with 129 returns received, with headline results captured for the Corporate Health and Safety Committee (*see Appendix B*). One area of improvement identified is the need for local H&S Leads, staff champion in the

relevant ward/ workplace, to increase the number of local monthly inspections undertaken – which has decreased compared to the previous year's figures.

Dangerous Goods Transportation and Packaging

The dangerous goods safety audit programme was completed by the contracted external company who act as the Trust's Dangerous Goods Safety Adviser (DGSA), in line with legislation. Recommendations for actioning were forwarded to each relevant department.

Table 2 H&S AERs by year

Year	H&S AERs	V&A AERs	Total
2020/21	1441	605	2046
2021/22	1455	733	2188
2022/23	1279	764	2043
2023/24	949	1043	1992
2024/25	864	997	1861
2025/26	915	997	1912

Comparing incident numbers over recent years, the standout feature was a marked drop in health and safety AERs from 2020 to 2024. This pattern of AER reductions has changed in 2025/26 with a small rise in AERs, which may be attributed to the communications by the H&S Team during training course and meetings attended over the year.

Staff Radiation Incidents

Staff incidents caused by ionising or non-ionising radiation are either reported on Ulysses Safeguard at the time of the incident or discovered after the fact by occupational radiation dose monitoring (dose badges relevant staff wear); they are investigated and managed by the Radiation Protection team, led by Ben Johnson (RPA, RWA, MPE). Further details are included in Appendix 3.

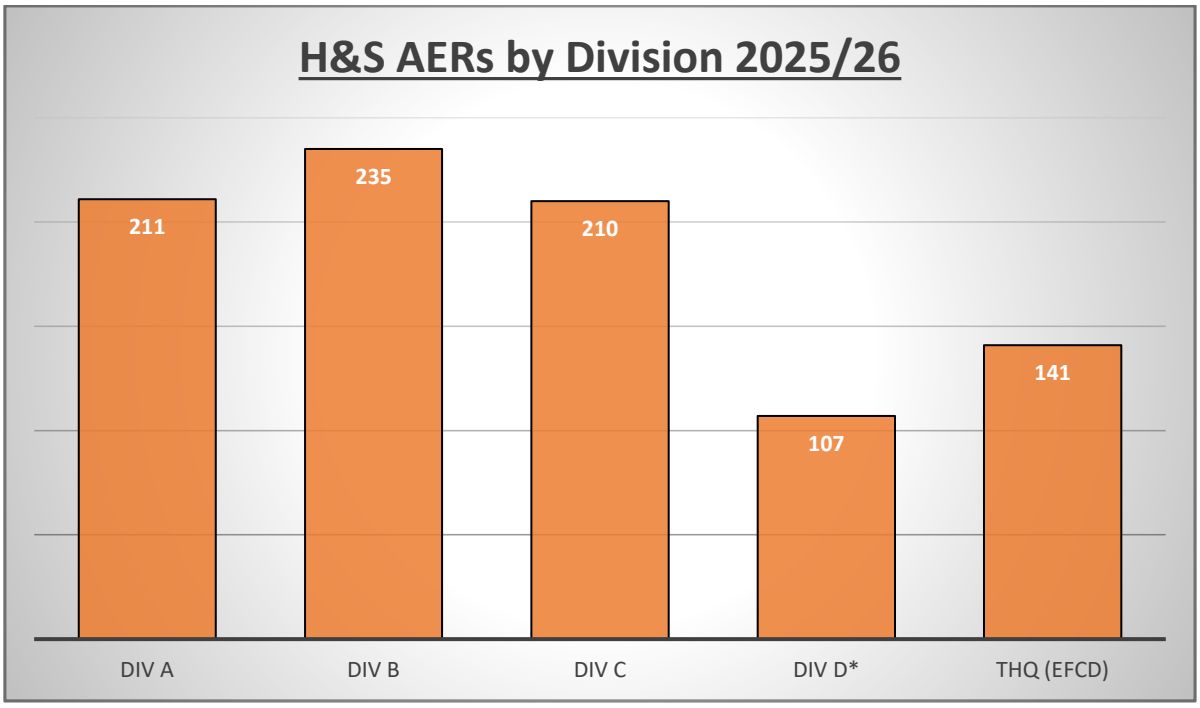
UHS Policies, Procedures, Guidance	Two policies were created/ reviewed during 2025/26: Control of Substance Hazardous to Health (v10), & Dangerous Goods Transport Security Plan. Both were required to ensure UHS continues to meet compliance standards with H&S Legislation.

Appendix other supporting documents:-

1. Graphical information on RIDDORs and H&S AERs for 2025/26;
2. Annual Health and Safety self-assessment audit report;
3. Radiation Protection 2025/26 annual report.

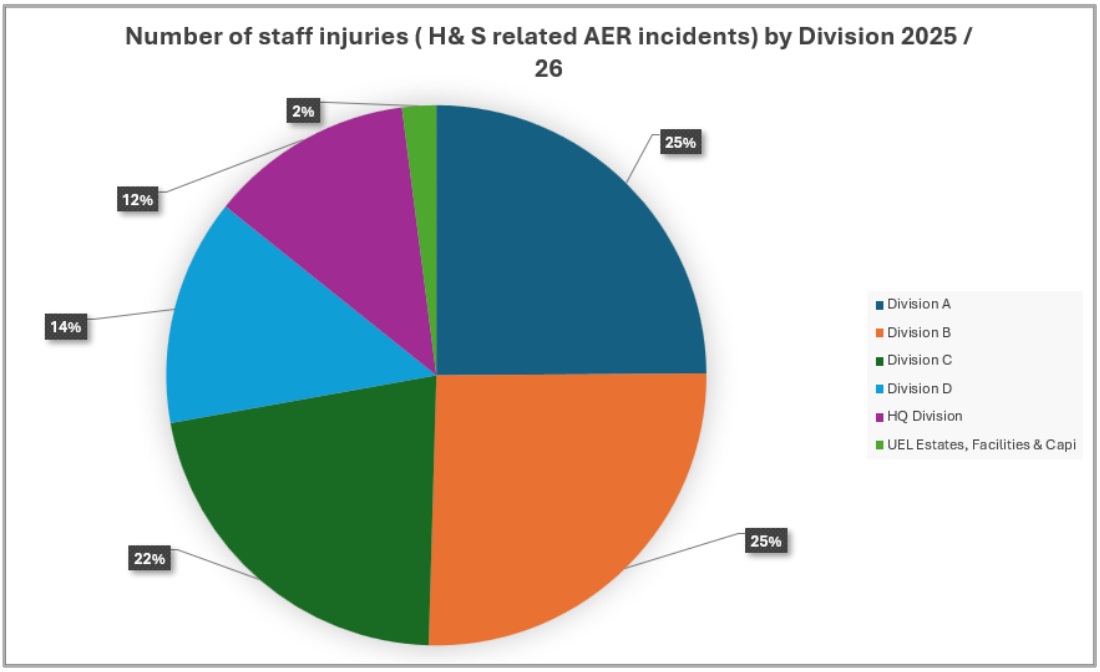
Appendix 1: Graphical Summaries of H&S Data 2025/26

Graph 1: H&S AERs by Division for 2025/26

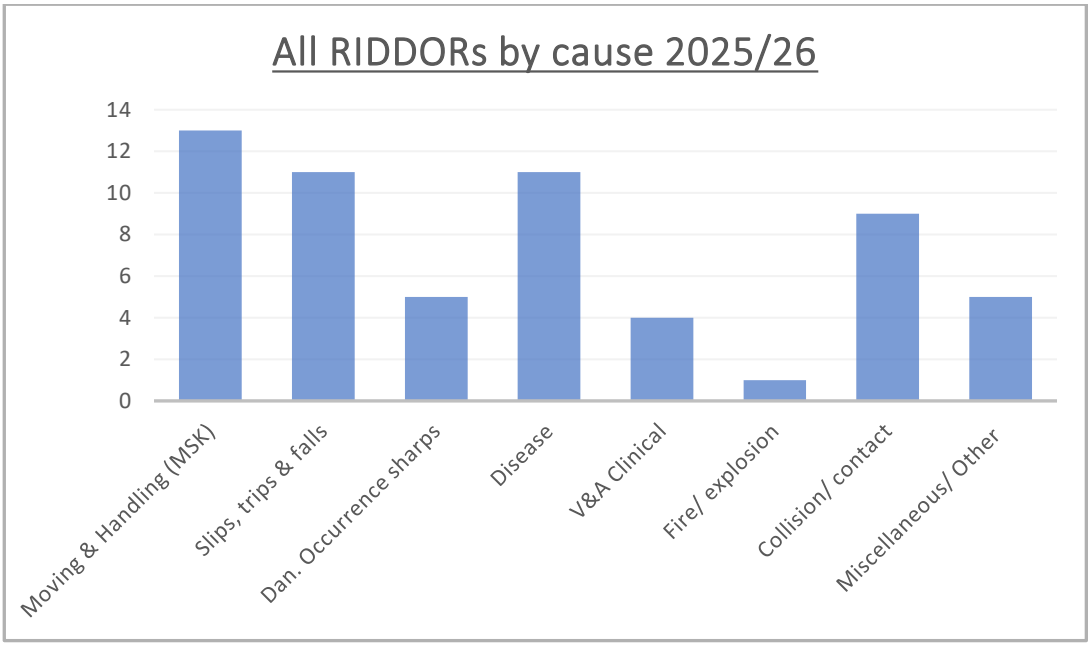


(Graph above excludes V&A and Challenging Behaviour AERs. * Div D was merged with the other Divisions in July 2025)

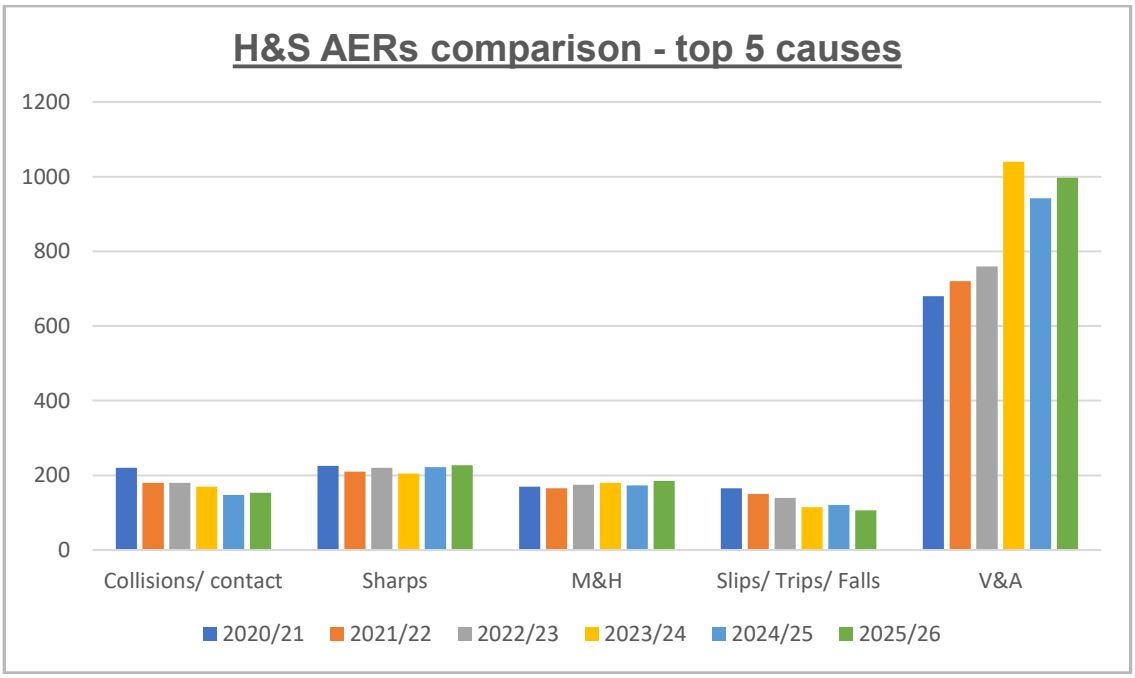
Graph 2: Number of staff injuries, H&S-related AER incidents, by Division 2025/26



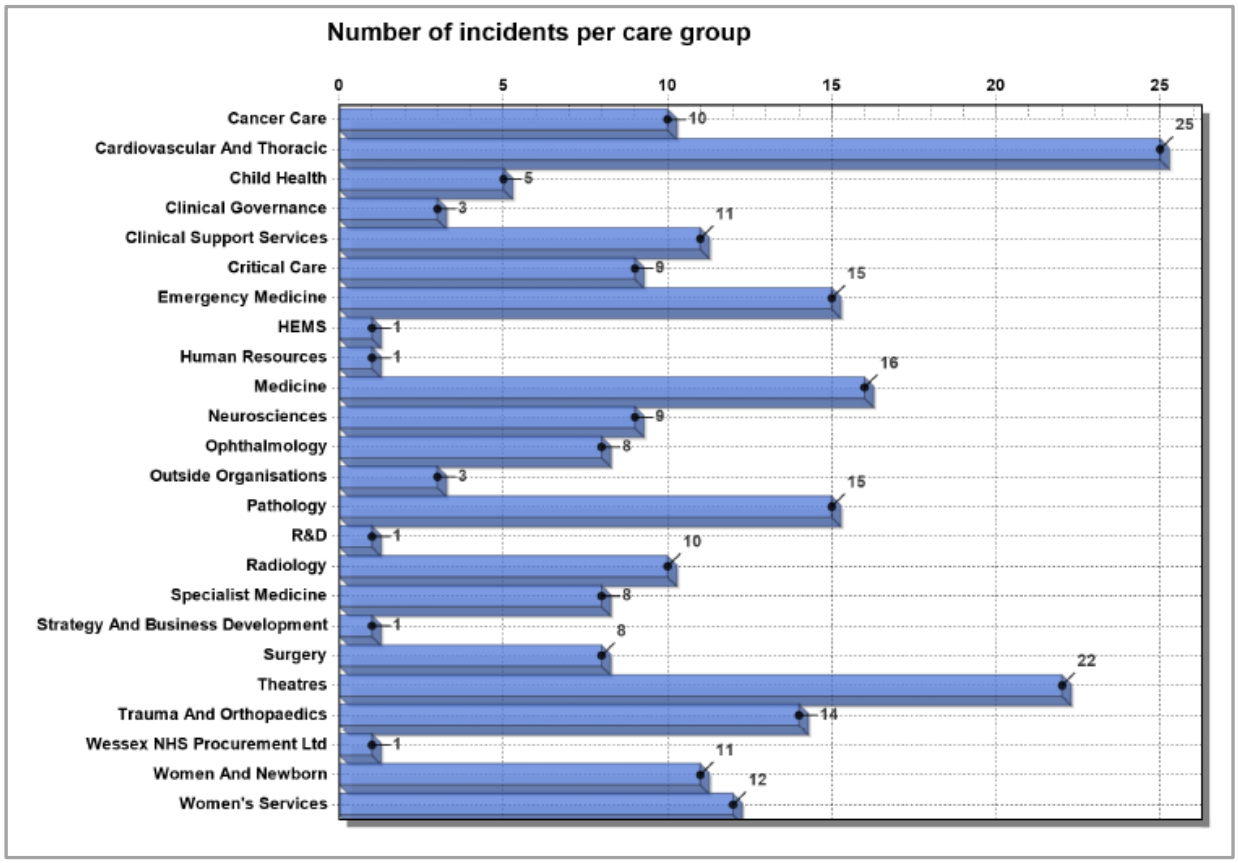
Graph 3: RIDDORs 2025/26 by Cause



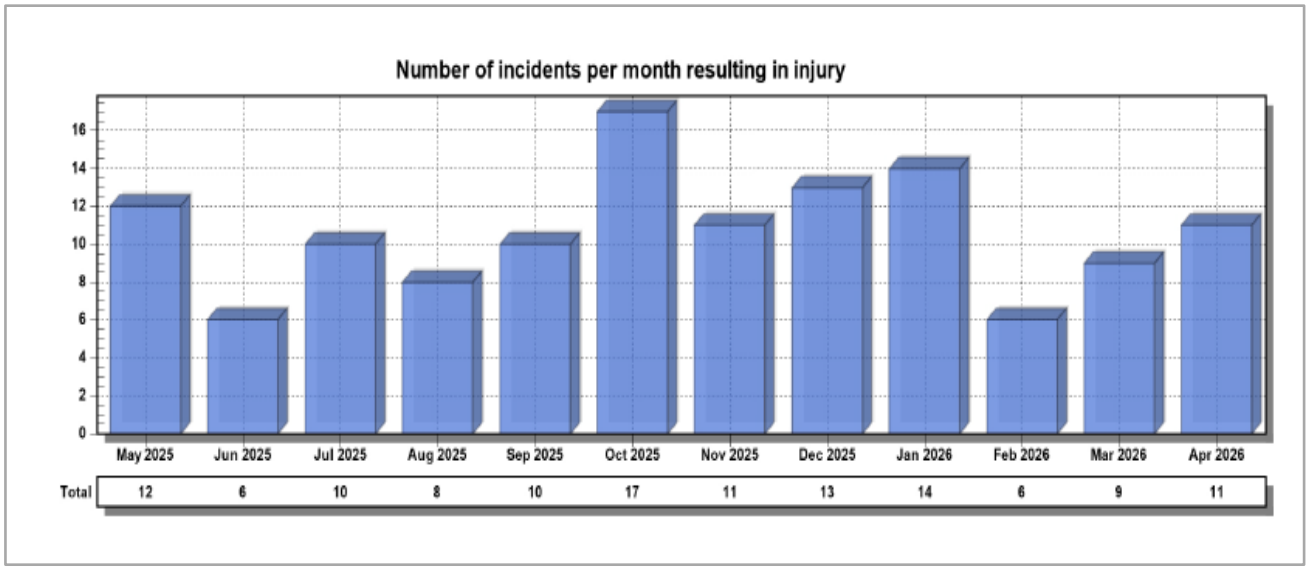
Graph 4: H&S AER top causes for last 6 years



Graph 5: Sharp incidents by care group 2025/26

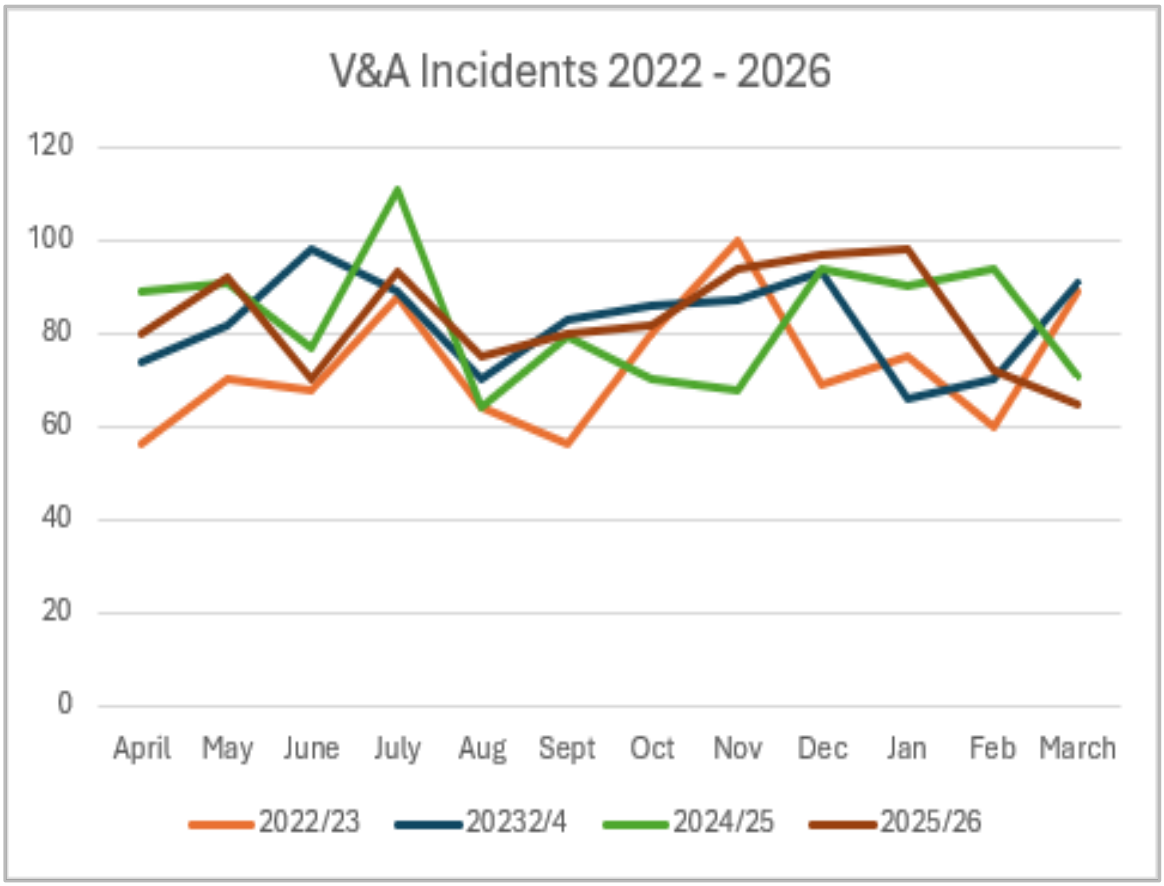


Graph 6: Sharp incidents by month 2025/26



Violence and Aggression AER Data

Graph 7: Trust-wide monthly V&A AERs 2022 to 2026



Appendix 2

University Hospital Southampton
NHS Foundation Trust

Annual Health and Safety Self-Assessment Audit returns 2025/26

The annual health and safety self-assessment audits were sent out to H&S Leads/ Ward Leaders on 14th May, with final deadline on 8th June. The data provided from the survey provides a snapshot of the health and safety compliance levels across the Trust for 2025/26. The self-assessment audit is undertaken using a Microsoft Forms format, which is easy to distribute, complete, return and analyse. It must be accepted that there are biases by those completing the survey form which should be taken into account*.

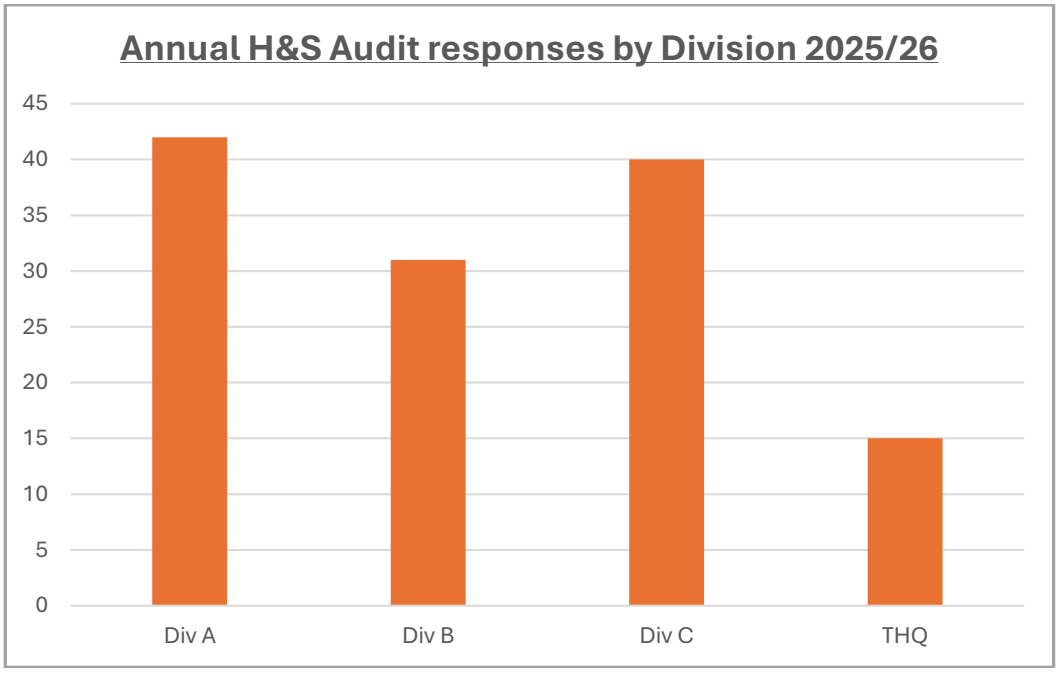
The question set was the same used for 2024/25, just below 50 questions, so to make completions easier and quicker - than those surveys previously circulated by H&S Team. The focus of questions is weighted to those healthcare based areas (wards, theatres, OPD's, etc). Not all questions are relevant to all responders.

129 responses were received by the end of the deadline (once duplications were removed), which is up on the 103 received last year. The better response rate was helped by learning lessons from last year, with appropriate reminders sent out. *Workplace Temperatures* (heat) was the most significant issue raised by responders for the Trust to resolve to improve health and safety.

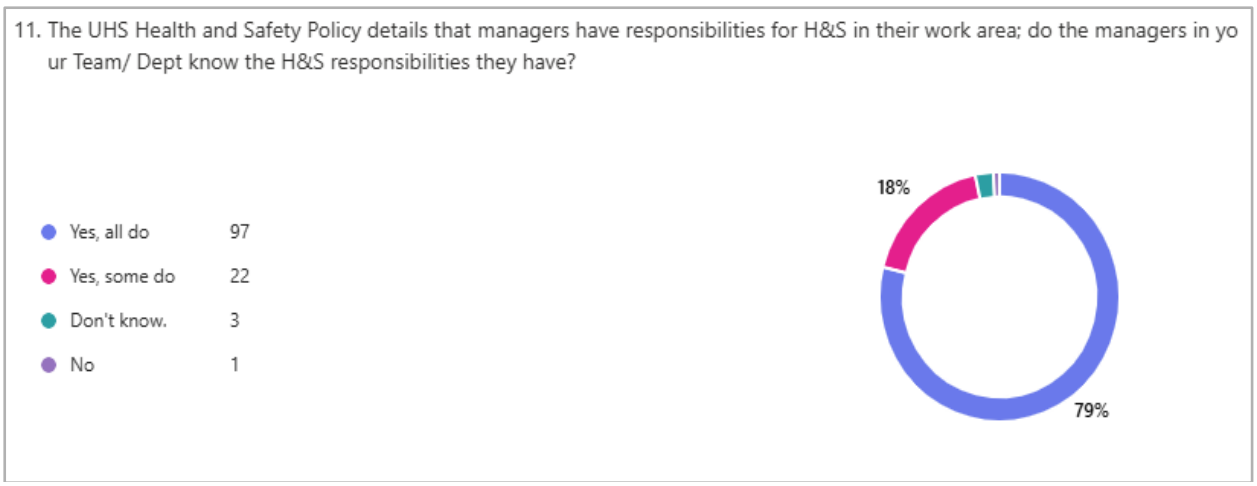
The MS Forms survey needed to be adapted due to the changes in Divisional Structure over the last 12 months – *removal of Division D*.

* When reviewing this data, the reader needs to be mindful of the inherent biased responses which can be received from this type of survey: *social desirability, acquiescence and recall bias* to name just three.

Graph 1 Responses by Division

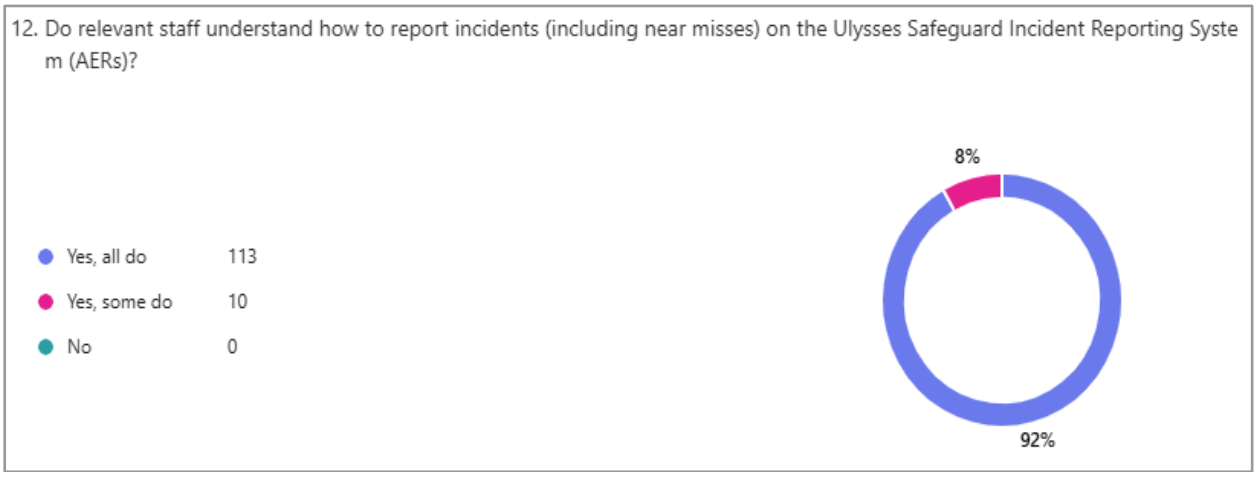


Management Health and Safety Responsibility



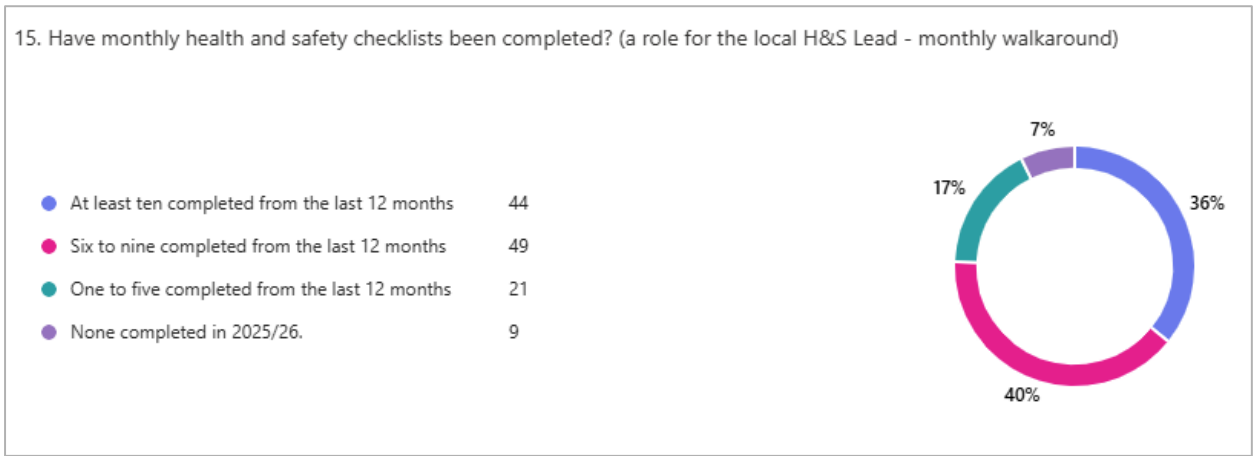
There was an increase in responders selecting the *Yes, some (managers) do* know their responsibilities, going up from 10% last year to 18% this year. This response highlights the need for ongoing communication and training with all managers across the Trust, and potentially the need for *tailored Management H&S Training* being delivered, which currently isn't provided.

Health and Safety incident reporting system



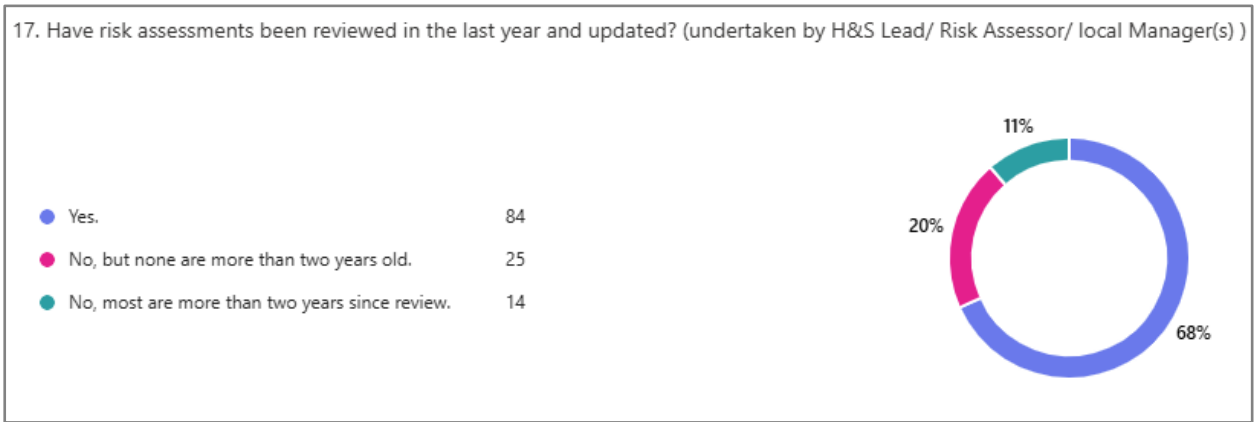
There was a small (positive) increase in responders detailing staff who know to use the Ulysses Safeguard system, up 2%. It is important that UHS has a *reporting culture* which will allow near misses to be investigated and potentially stop a future accident resulting in staff injury.

Monthly H&S Inspections of the workplace

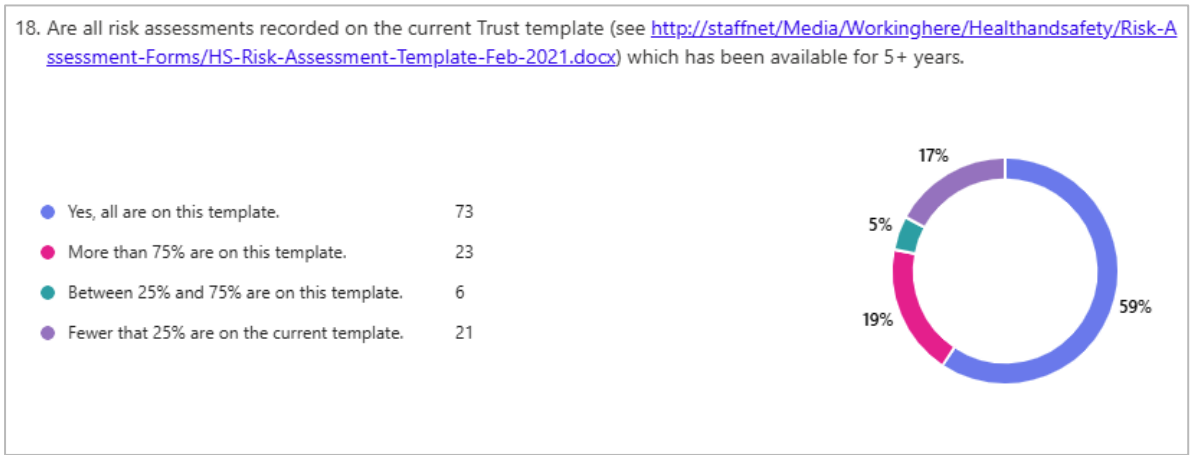


There was a *significant drop* in the workplace inspections being undertaken compared to last year: *10 or more monthly inspections* dropped to 36% from last year's 50%. This is a concern as a significant part of the local H&S Lead role is to undertake a monthly workplace inspection using the UHS checklist provided (which can be adapted) and identify actions/ remediations. If a target was being set by H&S Team it would be set at **90%** of H&S Leads completed 10 or more monthly inspections during the year – we are a long from this (*gap of 54%*!).
Anecdotally the feedback is that the H&S Leads are not being given enough protected time to complete this task.
There is a need for this regular workplace inspection culture to be driven by senior management - there may be the need to communicate this issue with Matrons/ Clinical Leaders.

Risk Assessment

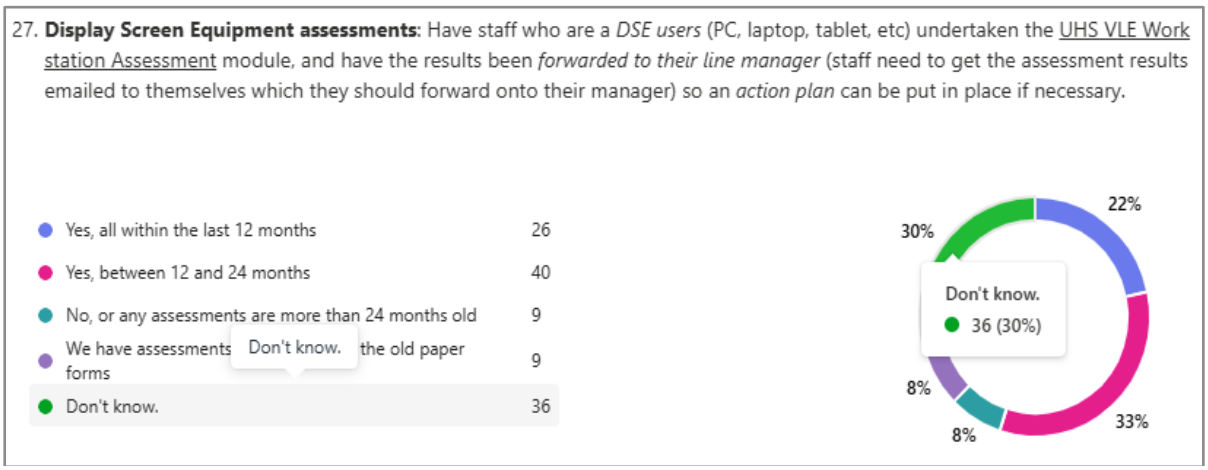


At 68% of an annual local reviews being undertaken (of the risk assessments), detailed by those responding, this shows a *5% improvement* on last year. However, these better results do not match with the experiences of the Trust H&S Adviser when they had reviewed risk assessments (although risk assessment reviews are sporadic). The H&S Team provide Risk Assessor training for staff (book on VLE), but resources do not allow regular audits of H&S competency or documentation to be undertaken



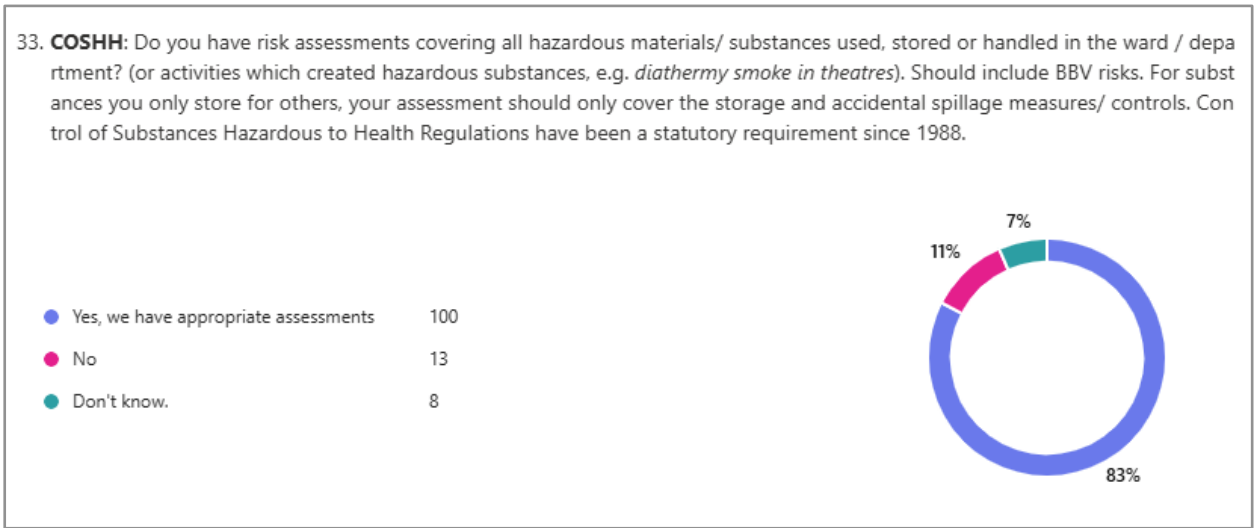
Risk Assessment: The responses to this question continues to raise concerns, with 59% of responders confirming that the correct UHS risk assessment format is used (last year it was 60%). The UHS Corporate template was introduced in 2021 so 41% of responders still have the out-of-date formats being used. With the HSE recommending annual reviews, and also in the UHS guidance it was anticipated that transfer of risk assessment to the newer format would be embraced & completed much more quickly.

Display Screen Equipment (DSE) assessments



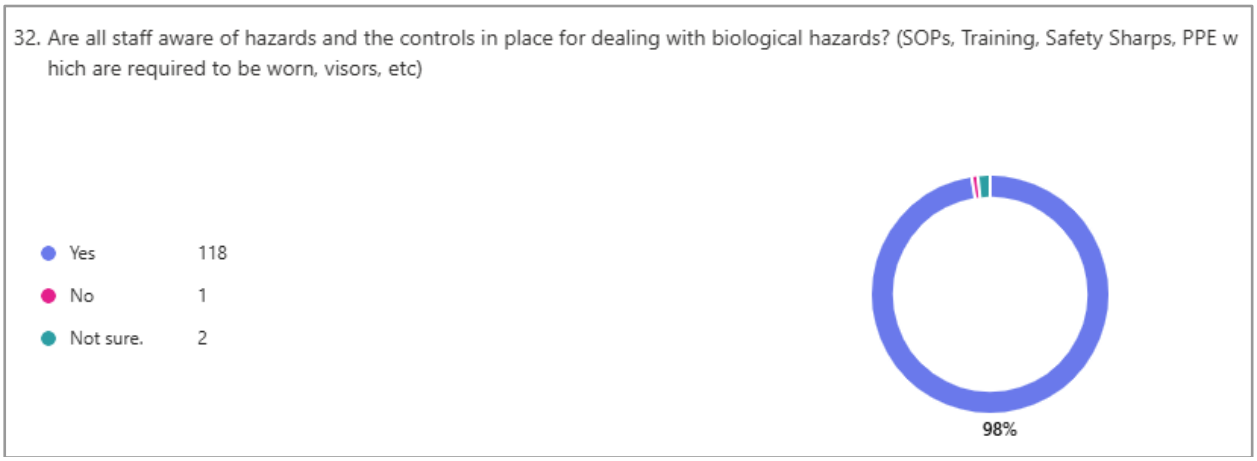
There has been a reduction in compliance in this year's figures, with annual assessments dropping to 22% (from 40% last year). Following previous audits of specific Teams (Therapy) which demonstrated poor ergonomics was a cause of absence (neck pain, back ache, etc), and also ward areas audits demonstrating poor design/ poor planning of workstations, the need for better DSE Regulation compliance and ergonomic set-ups in the wards & some offices(hot desk areas) has been flagged up at Corporate H&S Committee meetings. Currently there is no UHS Policy on DSE unlike most other NHS Trusts. With the increasing use of computers and e-noting for patient records in recent years this safety topic is becoming more relevant.

Control of Substances Hazardous to Health (COSHH)



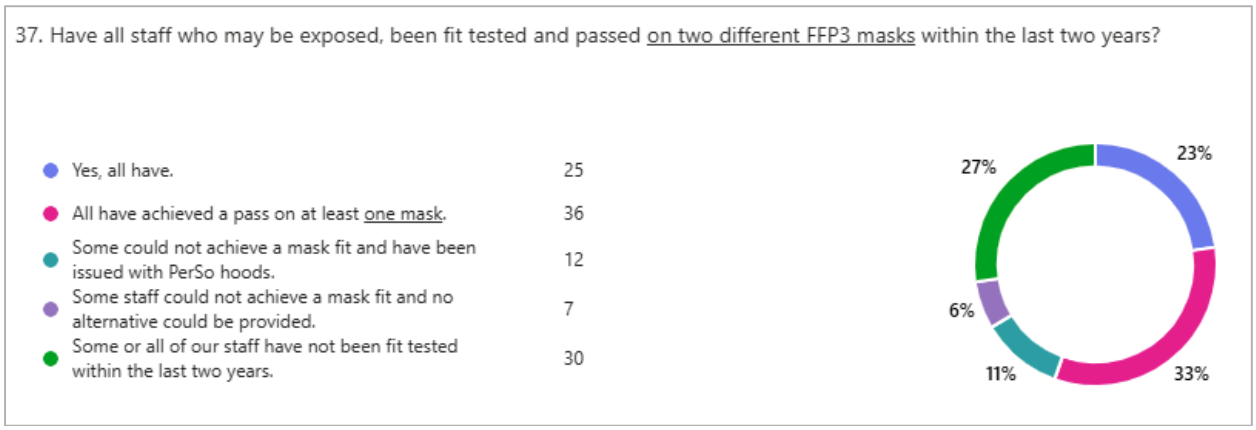
The responses on the COSHH risk assessment question has shown a small (negative) decrease (down from 86%). Although there is a reasonable knowledge of COSHH amongst UHS managers, transferring that knowledge into good quality risk assessments is still not at the levels required - from the interactions the H&S Adviser, and Occ Health Team feedback, focus on staff health risks needs improvement.

Biological hazards



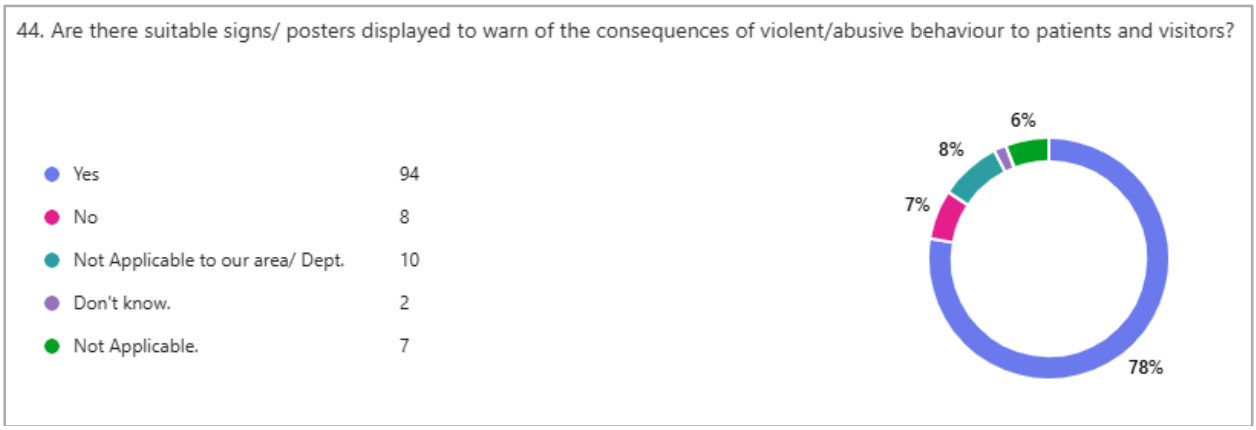
The responses showed a small increase, up from 93%. The H&S Team and Occ. Health Team have recently worked together to improve communications on the proper assessment of health risks to staff – with the production of new guidance aimed at managers (which will be presented to CHSC).

Face Fit testing responses



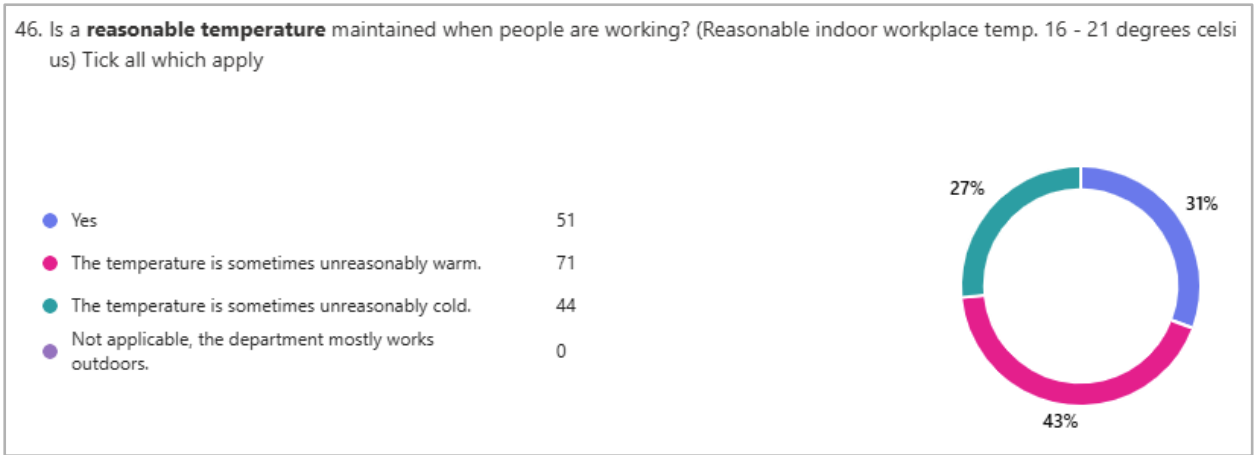
Protecting our staff from *respiratory infections* is an important function of H&S Management in an acute hospital. This question resulted in similar responses to last year, albeit with a significant increase in number of returns this year. There is regularly significant demand for the central fit testing provided by the H&S Team, which should be better supported by the Care Group fit testers. Of those responding the data indicates that **27%** of relevant staff have not been fit tested in the last 2 years in line with UHS requirements, this figure is a concern.

Violence and Aggression Feedback



Over the last 12 months there has been a focus on the procedures and practices for managing *violence, abuse and aggression* across the trust (through the Violence Aggression Abuse Steering Group). The responses show that there has been improved signage to patients and visitors – 61% rising to 78% this year. Other questions demonstrate an increased awareness of staff to the actions being taken across the hospitals.

Workplace Temperatures



Unreasonably warm temperatures during the warmer months is the most regular raise H&S AER across the Trust raised which the H&S Team are copied into. The results above show similar results to last year - these warm temperatures have a negative effect on staff and patients. There has been an increase in unreasonable cold workplaces (17% to 27%).

Other results to note

- 97% of responders reported having a local H&S Lead – the survey is sent out to H&S Leads, Ward Leaders and other hospital management, it is probable that those areas/ teams without a lead may not have completed the survey;
- 10% of responders stated they do not have a local H&S team induction;
- 66% of responders stated there is a New Mothers (vulnerable person) risk assessment in place;
- 79% of responders confirmed that the local risk assessor has attended UHS training (delivered by H&S Team) – *21% have not attended the training*;
- Only 50% of responders confirmed that DSE (workstation) risk assessments are reviewed by a line manager – this figure needs to increase;
- 69% of responders detailed that lone are not being undertaken in their workplace. 25 of those who completed the survey gave specific information on how lone working risks are being managed locally;
- 86% of those completing the survey stated there was a Blood Borne Virus (BBV) risk in their work area, and of those 98% confirmed appropriate controls were in place for staff;
- PPE: only 88% confirmed that appropriate PPE was in place for the hazards staff encountered at work – although a good response this issue should be tracked;
- 74% of responders stated that safety sharps are always used where they are available;
- Violence & Aggression: 79% of responders confirmed that procedures were in place for V&A incidents. 18% stated V&A was not relevant to their workplace;

- Within the survey was a free text question asking "*What 3 things could the Trust do to improve H&S at the hospital?*". This question received allot of responses most of which were focused on local issues, but there were some patterns in the responses, as follows: ***workplace temperatures*** (heat) was the most regular issues raised; closely followed by the need for **more storage**; *building and estate issues* were also regularly mentioned including the need for a prompt response to issues; storage of items (clutter) in corridors, was also a concern raised by many - & also has emergency evacuation concerns; the need for having **protected time** was also regularly detailed – obviously in this case for H&S Leads to undertake their duties; H&S training (refreshers & videos) and need for easily accessible H&S template documents was raised several times (& the need for H&S bulletins); & personal reminders for staffs annual DSE assessments was also raised.

END.

Appendix 3

Staff radiation incidents report - 1st April 2025 to 31st March 2026

Staff incidents caused by ionising or non-ionising radiations are either reported on Safeguard at the time of the incident or discovered after the fact by occupational radiation dose monitoring. Ionising radiation dose monitors are worn for 1 or 3 months and usually reported within a month of the end of the wear period. No occupational exposures in excess of the legal radiation dose limit or statutory dose investigation levels were reported on Safeguard or detected through monitoring in this period. Occupational dose limits are applied to calendar years. The legal radiation limit is 20mSv per annum to the body, 20mSv to the eye and 500mSv to the skin or extremities. Since January 2021, Radiation protection group have been collating all staff radiation incidents for trend analysis.

Ionising Radiations

During the period, there were 24 non-patient radiation incidents reported on Ulysses Safeguard. 5 incidents related to control of radioactive materials; 8 incidents involved an actual staff exposure to ionising radiation. The number and type of incidents are consistent with the trends reported last year. The following trends were identified:

Radioactive materials: Incidents related to potential loss of control of safety systems or loss of radioactive material or waste. These were from C4 ward, Nuclear Medicine and Radiopharmacy. Incidents were spills of radioactive material, leaking containers, radioactivity not disposed according to SOP. In each case an investigation of the causes was carried out and the potential radiation effects were calculated. An extremity dose of 12mSv resulted from clean up of a radioactive spill. This was a low dose.

Unauthorised access or inappropriate PPE: On several occasions staff or visitors were irradiated when radiographers had given insufficient warning of radiography occurring, had not fully checked the safety exclusion zone for occupants, or staff were inside the controlled radiation area without PPE. The highest radiation dose as a result was approximately 0.1µSv to the body. This was a negligible dose.

There were four instances of contingency plans being enacted (spill of radioactivity, unauthorised entry to radiation controlled area) which were recorded on Ulysses Safeguard. It is a formal requirement of the Ionising Radiation Regulations that such events are recorded and analysed.

There were 42 occupational radiation doses recorded on body, finger or eye dose monitors that were above the investigation level for high doses in a single monitoring period (monthly or quarterly) and five instances where an annual dose investigation level was exceeded.

All investigations from 2024-25 are now closed with action plans or dismissed as non-occupational doses or the subject of longer term observation of safety practices. Delays to closing investigations occurred due to insufficient information returned by

the badge wearer, their manager or local radiation protection supervisor. The majority of cases were from Interventional Radiology and relate to use of appropriate eye protection or extremity doses due to case mix. There were many false positives due to non-occupational exposures thus year. The most common cause of false doses was from irradiation of luggage at airports or monitoring badges left accidentally in radiation controlled areas.

Non-Ionising Radiations

During the period, there have been no staff incidents reported on Safeguard related to Laser/UV Light Safety.

The routine annual laser safety audit of ENT Theatres, on the 29th of May 2025, identified that the department had not conducted a multidisciplinary team rehearsal of their contingency arrangements for a patient fire during laser surgery since 2022. This is an annual requirement, as per their laser risk assessment and the Trust's Laser Use in Surgical Theatres Standard Operating Procedure. The training deficiency was escalated to the Trust's Radiation Protection Committee in December 2025, and the department was able to conduct training for the nursing team on the 26th and 27th of March 2026. A further training date, on the 14th of May 2026, has been identified for the Anaesthetic Practitioners. Ideally, this should be included in the Stat and Mand requirement for all theatre and medical staff working in the department (also applicable to the Cardiothoracic Theatre Team) to ensure annual rehearsals are carried out.

Ben Johnson
Head of Radiation Protection

Ben Inglis-Smith
Lead for Non-Ionising Radiation
Protection

23rd April 2026

Agenda Item 7.4 Report to the Trust Board of Directors, 12 November 2026	
Title:	Standing Financial Instructions Review
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Vickie O'Leary, Assistant Director of Operational Finance

Purpose

(Re)Assurance	Approval	Ratification	Information
	x		

Strategic Theme

Outstanding care	Pioneering research and innovation	Outstanding people	Foundations for the future
			x

Executive Summary:

Standing Financial Instructions set out the Trust's financial governance and controls, supporting accountability, compliance, sound decision-making and the effective use of public funds. They are reviewed annually to ensure they remain up to date and relevant.

The SFIs have been reviewed, and the updated document is included in the body of this report. The following people have reviewed and provided updates to the SFIs where required:

- Chief Finance Officer
- Director of Operational Finance
- Director of Estates, Facilities and Capital Development
- Chief Procurement Officer
- Assistant Director of Operational Finance
- Local Counter Fraud Specialist (LCFS)

The main areas of change are:

- 2.4 Fraud, Bribery and Corruption, updated by LCFS
- 7. Tendering & Contracting Procedures, updated by Chief Procurement Officer
- 8.1.9-12 Contracts for the provision of services, updated by LCFS
- 18.2 Standards of business conduct, updated by LCFS
- Annex 2, Section 1 Capital approval Trust Board and NHSE, to reflect change in approval limits based on National Oversight Framework
- Annex 2, Section 3, combining Financial Limits for Goods, Services and Works
- Annex 2, Section 4, including a table for PSR Healthcare Services

The Audit and Risk Committee reviewed the changes and recommended approval by the Board at the meeting on 9 October 2026.

The Board are asked to review the changes and approve the updated SFIs.

Contents:

Paper

Risk(s):

5a

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Standing Financial Instructions
University Hospital Southampton FT
For avoidance of doubt Subsidiaries have separate SFIs

Version:	**October 2026**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	**Jenni Douglas-Todd, Trust Chair**
Ratification Committee (Category 1 documents):	**N/A**
Date of Ratification (Category 1 documents):	**N/A**
Signature of ratifying Committee Group/Chair(Category 1 documents):	**N/A**
Lead Job Title of originator/author:	**Chief Financial Officer**
Name of responsible committee/individual:	**Ian Howard**
Date issued:	**-**
Review date:	**30 September 2027**
Target audience:	**All Divisions/Directorates**
Key words:	**Trust powers; Trust Board; Chair; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; fraud; bribery; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Divisions/Directorates**
Consultation:	**Audit and Risk Committee Trust Executive Committee**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**51**
Type of document:	**Level 1**
Trust Reference	**FIN003**

Standing Financial Instructions

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STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 University Hospital Southampton NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st October 2011, following authorisation by NHS Improvement (formerly Monitor), the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England, which this document represents).

1.1.3 The *NHS Oversight Framework* details how NHS England oversees and supports all NHS Trusts. Additional financial guidance is included in *National Audit Office – Code of Audit Practice,* NHS Foundation Trust Annual Reporting Manual and the *Department of Health and Social Care Group Accounting Manual (DHSC GAM)*, all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust and its hosted organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the CFO must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the Council of Governors).

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal. Where non-compliance involves suspected fraud, bribery, theft, dishonesty or other unlawful conduct, this may also result in referral for criminal investigation and, where appropriate, criminal proceedings.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit and Risk Committee

for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the CFO, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such Executive Directors in the Scheme of Delegation, Subsidiary Boards or committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive Officer (CEO), Chief Financial Officer (CFO)

1.2.4 The Chief Executive Officer and Chief Finance Officer will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

The Chief Executive Officer

1.2.5 Within the SFIs, it is acknowledged that the CEO is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health and Social Care, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The CEO has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the CEO to ensure that Members of the Board, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

1.2.7 In the event of absence of the CEO, the Deputy Chief Executive will temporarily be delegated the authorisation limits outlined within this document.

The Chief Financial Officer

1.2.8 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.9 In the event of the absence of the CFO, the Director of Operational Finance will temporarily be delegated the authorisation limits outlined within this document.

Board of Directors and Employees

1.2.10 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS England, the conditions of the NHS provider licence, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.11 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the CEO to ensure that such persons are made aware of this.

1.2.12 For all directors and employees who carry out a financial function, the form in which financial records are kept and the way directors and employees discharge their duties must be to the satisfaction of the CFO.

2. AUDIT

2.1 Chief Financial Officer

2.1.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit

function. An internal audit function is required by NHS England's "NHS Foundation Trust Accounting Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS England's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit and Risk Committee. The report(s) must cover:

   i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSC, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Statement of Internal Control" and provides assurances to the Audit and Risk Committee;

   ii) Any major internal financial control weaknesses discovered;

   iii) Progress on the implementation of internal audit recommendations;

   iv) Progress against plan over the previous year;

   v) A detailed work-plan for the coming year.

e) Ensuring that there is effective liaison with the Trusts appointed LCFS on counter fraud, bribery and corruption measures, all suspected cases of fraud and corruption and all anomalies which may indicate fraud or corruption before any action is taken.

2.1.2 The CFO, designated auditors and the Local Counter Fraud Specialist (LCFS) are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the CEO, the Audit and Risk Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the LCSF)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations/project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's Annual Governance Statement and Assurance Framework;

i) The Trust's compliance with the Care Quality Commission's fundamental standards.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Specialist (LCFS) must be notified.

2.2.4 The Head of Internal Audit (or equivalent title) will normally attend Audit and Risk Committee meetings and has a right of access to Audit and Risk Committee members, the Chair and CEO.

2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum".

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit and Risk Committee.

2.3.2 The Audit and Risk Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The responsibilities of the External Auditor are prescribed in National Audit Office Code of Audit Practise

2.3.5 Should there appear to be a problem with the external audit service being provided, then this should be raised with the external auditor and escalated appropriately within the external audit firm to ensure that the issue is resolved promptly and to the satisfaction of the Audit and Risk Committee

2.3.6 All additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors must be approved by the Audit and Risk Committee. Competitive tendering is not required, and the CFO is required to authorise expenditure.

2.4 Fraud, Bribery and Corruption

2.4.1 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.2 In line with their responsibilities, the CEO and CFO shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate counter-fraud, bribery and corruption arrangements, having regard to the NHS Counter Fraud Authority counter-fraud requirements and guidance (informed by Government Functional Standard GovS 013: Counter Fraud).

2.4.3 The Bribery Act 2010 creates offences relating to bribery, including offences applicable to individuals and the corporate offence of failure of a commercial organisation to prevent bribery. All staff, contractors and other individuals acting on behalf of the Trust must comply with the requirements of the Act. Any suspected or actual breach may result in disciplinary action and/or criminal proceedings.

2.4.4 The Economic Crime and Corporate Transparency Act 2023 (ECCTA) introduced a corporate criminal offence of failure to prevent fraud. The offence applies to qualifying large organisations (which includes the Trust) and makes an organisation criminally liable where a specified fraud offence is committed by an employee, agent, subsidiary undertaking or other associated person for the organisation's benefit, unless the organisation can demonstrate that it had reasonable fraud prevention procedures in place.

2.4.5 The Crime and Policing Act 2026 has further strengthened corporate criminal liability. Section 250 provides that, where a senior manager of a body corporate or partnership commits a criminal offence while acting within the actual or apparent scope of their authority, the organisation may also be guilty of that offence, subject to the statutory provisions and exceptions. This provision applies to criminal offences generally and is no longer limited to economic crime offences. Section 250 replaced the corresponding corporate liability provisions previously contained in sections 196–198 of the ECCTA.

2.4.6 All staff, contractors and other individuals acting on behalf of the Trust must be aware of and comply with the requirements of the Bribery Act 2010, the Economic Crime and Corporate Transparency Act 2023 and the Crime and Policing Act 2026, together with the Trust's policies and procedures for preventing and detecting fraud, bribery and corruption. Financial decisions, transactions, procurement activity and the use of Trust resources must be undertaken with due regard to these requirements and the principles of probity, transparency and accountability. The CFO is responsible for ensuring that adequate procedures and controls are in place to mitigate the Trust's corporate risk in relation to fraud, bribery and corruption, and that there is an appropriate programme of ongoing review to ensure that such procedures and controls remain effective and proportionate.

2.4.7 Further information and guidance are contained within the Trusts's Counter Fraud, Bribery and Corruption Policy, which should be read in conjunction with these Standing Financial Instructions.

2.4.8 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist (“LCFS”), to conduct the full range of counter-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Authority counter-fraud requirements and guidance.

2.4.9 The CFO shall ensure that the Trust appoints a Counter Fraud Champion in accordance with the NHS Counter Fraud Requirements. The Counter Fraud Champion shall act as a conduit between the Trust, its staff and the LCFS, supporting the promotion of counter-fraud

awareness, facilitating appropriate engagement and communication, and supporting the effective implementation of the Trust's counter-fraud arrangements.

2.4.10 Any Officer discovering or suspecting a fraud loss of any kind must either immediately inform the CEO and the CFO or the LCFS (who will then inform the CFO and/or CEO). Where a criminal fraud, bribery or corruption offence is suspected, the LCFS will investigate in accordance with relevant legislation and the Fraud, Bribery and Corruption Policy. If determined proportionate and necessary by the CFO and LCFS after an investigation, further criminal, civil, regulatory and/or disciplinary action will be pursued.

2.4.11 The LCFS shall report to the CFO and shall work with staff in the NHS Counter Fraud Authority, in accordance with the NHS Counter Fraud Authority counter-fraud requirements, the Government Functional Standards; Counter Fraud (GovS 013) and the NHS Counter Fraud Manual.

2.4.12 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. submitting a case to the Crown Prosecution Service, or a referral to the police or NHS Counter Fraud Authority.

2.4.13 The LCFS will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit and Risk Committee.

2.4.14 The LCFS will ensure that measures to mitigate identified risks are included in an annual organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit and Risk Committee.

2.4.15 The LCFS shall be afforded the opportunity to attend Audit and Risk Committee meetings and other meetings of the Board of Directors, or its committees, as required, but shall usually be required to attend at least two meetings of the Audit and Risk Committee annually.

2.4.16 The CFO will ensure that the LCFS:

a) keeps full and accurate records of any instances of fraud and suspected fraud;
b) reports to the Board of Directors any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;
c) has all necessary support to enable him/her to efficiently, effectively and promptly carry out their functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of their work;
d) receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and
e) participates in activities which the Department for Health and Social Care and/or NHS England directs, or in which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

2.4.17 The CFO must, subject to any contractual or legal constraints, require all Trust staff to co-operate with the LCFS and, in particular, that those responsible for human resources to disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

2.4.18 In accordance with the Raising Concerns (Whistleblowing) Policy, the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by the NHS Counter Fraud Authority.

2.4.19 The Trust will report annually on how it has met the Government Functional Standard Counter Fraud iGovS 013: in relation to counter-fraud, bribery and corruption work and the CFO and Audit and Risk Committee Chair will sign-off the annual return and authorise its submission to the NHS Counter Fraud Authority. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 The CEO has overall responsibility for the safety and security of employees, patients and visitors of the Trust, as part of the Trust's role as an employer and healthcare provider and for keeping the Trust's premises secure. However, the management of security risks within the Trust has delegated to the Chief Operating
Officer and to the appointed Local Security Management Specialist ("LSMS") in line with Trust policies and procedures.

2.5.2 Any prosecution of other offences relating to fraud, bribery or corruption against the Trust not involving the LCFS should be authorised by the CFO and will be reported to the Audit and Risk Committee.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Operational Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the CEO will compile and submit to the Board of Directors and to the Council of Governors the annual "Operational Plan" which takes into account financial targets and forecast limits of available resources. The Trust Operational Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in workload, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS England.

3.1.2 The annual Operational Plan must be submitted to NHS England in accordance with NHS England's requirements.

3.1.3 The CFO will, on behalf of the CEO, prepare and submit an annual budget for approval by the Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Operational Plan;

b) Accord with demand, workforce and capacity plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the regulatory framework for FTs.

3.1.4 The Trust Operational Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.5 The CFO shall monitor financial performance against budget, and report to the Board of Directors.

3.1.6 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.7 The CFO has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage their budgets successfully.

3.2 Operational Plan and Budget Setting Process

3.2.1 The CFO will submit to the Board of Directors a paper outlining the annual budget setting process for the year. This will include a baseline formed from a set of clearly defined assumptions.

3.2.2 Each Division and Director will be enabled to submit a list of proposed Business Cases and cost pressures for consideration in budget setting. Only approved requests will be incorporated into delegated budgets. Business cases will require approval as per the Trust Approval Framework in Annex 2, section 1.

3.2.3 The CEO and CFO will set an annual process for approving cases to be incorporated into the budget and Operational Plan. Approval of revenue-only business cases will follow the approval routes and limits outlined in the Trust Approval Framework in Annex 2.

3.2.4 The delivery of revenue schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than 5%, whichever is greater, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.

3.2.5 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:

a) An option appraisal of potential benefits compared with known costs;

b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and

c) An analysis of the project's discounted cash flow, based on an agreed rate of return.

3.2.6 The Trust Investment Group will report on major issues to the Trust Executive Committee, Finance, Investment & Cash Committee and Trust Board as required.

3.2.7 The Trust's 'Production Plan' (NHS clinical income plan) will be set utilising internal data sources, approved UHS business cases, and after consultation with service managers alongside external data sources including Commissioner and Integrated Care Board plans. This will be aligned to all other elements of the business plan.

3.2.8 The CFO will set a Cost Improvement Programme (CIP) savings target, delegated to each budget holder, and reduce the delegated expenditure budgets accordingly.

3.2.9 The CFO may set reserves to cover potential cost pressures and risks at the planning stage, which may then subsequently be delegated in-year.

3.3 In-Year Adjustments to Budgets

3.3.1 The CFO may authorise budget virements in the following circumstances:

a) To reflect an in-year business case approved by the relevant committee;

b) To utilise reserves;

c) To reflect where the distribution of income and expenditure has materially changed from the original plan, where this is net neutral for the Trust.

3.3.2 Budget virements for in-year business cases can only be allocated on an overall neutral basis, to ensure the budget remains balanced to the Operational Plan. Additional expenditure would require funding via additional income assumptions, release of reserves or additional savings above the required plan in another part of the budget.

3.4 Budgetary Delegation

3.4.1 The CEO, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

d) Achievement of planned levels of service;

e) The provision of regular reports.

3.4.2 Except where otherwise approved by the CEO, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.4.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.4.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the CEO or the CFO.

3.4.5 Budget Holders are expected to sign their acceptance of their annual expenditure budget.

3.5 Budgetary Control and Reporting

3.5.1 The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Board of Directors in a form approved by the Board of Directors, containing sufficient information to allow the Directors of the Board to ascertain the financial performance of the Trust. This may include the following:

i) Income and expenditure to date, showing trends and the forecast year-end position;

ii) Movements in working capital;

iii) Movements in cash;

iv) Capital project spend and projected outturn against plan;

v) Explanations of any material variances from budget;

vi) Details of any corrective action where necessary and the CEO's and/or CFO's view of whether such actions are sufficient to correct the situation

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial and workforce budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.5.2 Each Budget Holder is responsible for ensuring that:

a) all expenditure is lawful (in accordance with Managing Public Money) and is incurred in accordance with the No Purchase Order, No Payment protocol, see section 10.2.4;

b) all expenditure is incurred or committed in accordance with the SFIs, including the appropriate levels of internal and external approval;

c) planned and actual expenditure takes full account of the need to achieve value for money in terms of economy, efficiency and effectiveness;

d) all employees are appointed within the budgeted workforce establishment. Any planned expenditure beyond budgeted establishment will require prior approval in accordance with these SFIs;

e) they meet with the designated Finance Business Partner regularly;

f) forecasting of expenditure against budget is robust and where a budget allocation is no longer fully needed or where there is a risk of overspending this is reported to the Finance Business Partner; and

g) information can be supplied to the CFO as required to enable budgets to be compiled.

3.5.3 The CEO is responsible for identifying and implementing cost improvement programmes (“CIPs”), and income generation initiatives, in order to deliver a budget that will enable compliance with NHS England’s Use of Resources regime.

3.5.4 The CEO will incorporate a Recruitment Control Panel, responsible for approving recruitment as per Terms of Reference agreed by the Trust Executive Committee. Proposed recruitment will be considered by the Recruitment Control Panel where within scope of the criteria contained within the Terms of Reference.

3.5.5 All new Clinical consultant appointments will require the approval of the Trust Executive Committee.

3.6 Capital Expenditure

3.6.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the DHSC Group Accounting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.7 Performance Monitoring Forms and Returns

3.7.1 The CEO is responsible for ensuring that the appropriate monitoring forms and returns are submitted to NHS England. The performance figures reported to the Board of Directors should reflect the same figures, though not necessarily presented in the same format.

3.8 In-Year Business Cases

3.8.1 It is expected that most business cases will be identified and prioritised in principle during the setting of the Trust Operational Plan and therefore Budget Setting Process for the financial year ahead. These cases will then be prepared for approval at an appropriate point during the year.

3.8.2 Any case with a capital implication will be considered in section 12 and outlined in Annex 2, section 1.

3.8.3 Revenue cost only business cases will be subject to the approval as outlined in Annex 2, section 1.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS England and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS England as to their technical accounting content and information/data shown therein, before submission to NHS England.

4.2 The Associate Director of Corporate Affairs will prepare the Annual Report in accordance with the guidance in the NHS Foundation Trust Annual Reporting Manual.

4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHS England must be audited by the external auditor in accordance with appropriate international auditing standards.

4.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors, or by the Audit and Risk Committee (when specifically delegated the power to do so, under the authority of the Board of Directors).

4.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.7 The Chief Nursing Officer will prepare the Annual Quality Account in the format prescribed by NHS England and the Care Quality Commission and in accordance with the NHS Foundation Trust Annual Reporting Manual incorporating the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

4.8 The CEO and Chair shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Account".

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts in accordance with these SFI's and the Treasury Management Policy.

5.1.2 The Audit and Risk Committee or the Board of Directors will review banking arrangements annually as part of the Treasury management policy review.

5.1.3 The Audit and Risk Committee will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.1.4 All bank accounts used solely for the purposes of Trust activity must be in the name of the Trust and overseen by the Trust Finance team.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/NatWest accounts do not exceed the amount credited to the account except where arrangements have been made;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

e) Monitoring compliance with NHS England or DHSC guidance on the level of cleared funds;

f) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES, CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the financial regime as determined by NHS England where applicable. The CFO may agree alternative payment mechanisms with Commissioners or the Integrated Care Board.

6.2.2 The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by legislation. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and operational plans of the Trust and shall be approved according to the limits specified at SFI Annex 2, section 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits.

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £1,000	Assistant Director of Operational Finance, or Assistant Director of Finance for Workforce
Up to £10,000	Director of Operational Finance
Up to £100,000	CFO
£100,000 plus	Audit and Risk Committee

The limits apply to individual items.

6.3.4 A schedule of written off debt and salary overpayments that haven't been recovered shall be presented to the Audit and Risk Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit and Risk Committee should be presented to the Trust board for noting.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss and written and signed "declarations of indemnity" must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

7.1.1 The Procurement and Contracting Procedures provide a corporate framework for the procurement of all goods, services and works for the Trust. The Procedures are designed to ensure that all procurement and contracting activity is conducted with openness, probity and accountability, delivering value for money (VfM), appropriate quality and performance, and compliance with applicable legislation and regulatory requirements.

7.1.2 All contracts for the purchase of goods, services or works entered into by the Trust must be procured, awarded and managed in accordance with these Procedures.

7.1.3 Failure to comply with Trust SFIs will be reported to the Audit and Risk Committee and could result in disciplinary action.

7.1.4 Procurement services for University Hospital Southampton NHS Foundation Trust are provided by Wessex NHS Procurement Limited (WPL). WPL shall undertake procurement activities on behalf of the Trust in accordance with these Standing Financial Instructions.

7.2 Legislation Governing Public Procurement

7.2.1 All procurement activity shall be undertaken in accordance with UK procurement legislation and statutory guidance. WPL shall advise on the legislative requirements relevant to each procurement, having regard to, where applicable:

a) the Public Contracts Regulations 2015 (PCR 2015)
b) the Procurement Act 2023 (PA 2023) and the Procurement Regulations 2024
c) the Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) and associated statutory guidance
d) the Public Services (Social Value) Act 2012
e) any amendments to the above and/or successor legislation

7.2.2 The PSR Regulations apply only to the procurement of certain healthcare services, referred to within these Procedures as “healthcare services”. Services that fall outside the scope of PSR shall be procured in accordance with the applicable procurement legislation and regulations and are referred to within these Procedures as “non-healthcare services”.

7.2.3 Government legislation, policy, and guidance setting out procedures and requirements for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust’s SFIs. In the event of any conflict between what is contained within legislation and the Trust SFIs, the former shall prevail.

7.3 Procurement & Contracting Procedures Exemptions

7.3.1 The Procurement and Contracting Procedures do not apply in a limited number of circumstances:

a) If a partnership / joint venture contract exists that precludes the requirement for a competitive tendering process. This should be subject to confirmation by the Managing Director of WPL and Trust’s Chief Financial Officer.

b) If a single supplier is mandated by NHS England or the contract is intra-NHS and not open to competition.

c) as part of a pay over agreement to another government entity.

d) The CFO will maintain and monitor the list of exemptions, including:

i) Pay overs i.e. HMRC, Pensions, child voucher schemes, court fees
ii) Intra NHS Recharges
iii) NHS Litigation Services (NHS Resolution)
iv) NHS Pensions Authority
v) Transactions between UHS Group entities e.g. WPL, UEL, UPL
vi) University of Southampton shared service provisions i.e. consultant medical staff with joint contract”
vii) Complete Fertility Ltd (as commissioned by the ICB, UHS acts as payment agent, service has now transferred)
viii) Payments to charitable bodies
ix) Defence Business Services (covering payments for military doctors operating within UHS)
x) Payments to NHS Professionals (NHSP) for temporary resourcing (bank and agency staffing)
xi) CQC fees

7.3.2 These exemptions are subject to periodic review and amendment by the Trust's Chief Financial Officer.

7.3.3 Whilst the above contract types are exempt from the Procedures, Trust Departments must still ensure value for money is achieved where relevant.

7.4 Procurement Principles and Contract Signature

7.4.1 Where the required goods, services, or works are not available through an existing contractual arrangement, including Trust-approved catalogues, the procurement procedures set out in Annex 2 Section 4 must be followed.

7.4.2 The contract value is defined as the total potential lifetime value of the contract, including all contractual options and extensions, excluding VAT.

7.4.3 Contracts must not be artificially divided, disaggregated or otherwise structured with the intention or effect of avoiding the requirements of the Procurement and Contracting Procedures. Repeated engagements with the same supplier for similar goods, services, or works should be treated as a single procurement requirement for the purpose of determining the estimated contract value.

7.4.4 Quotations or tenders need not be invited where the goods, services or works can be sourced through an appropriate compliant framework agreement, provided that a value for money assessment has determined that the framework represents the best route to market, having regard to the optimum combination of whole-life cost, quality, operational timescales, delivery requirements and risk.

7.4.5 WPL will undertake all tenders using its e-sourcing solution in accordance with the WPL Procurement Manual, unless the procurement exercise is being run on their behalf by a framework provider. In such cases, WPL shall obtain assurance that the framework provider has conducted the procurement in accordance with the applicable legal requirements.

7.4.6 Appropriate records shall be maintained by WPL for all procurement activity to provide a complete audit trail, demonstrating compliance with applicable legislation and these Standing Financial Instructions.

7.4.7 All quotations and tenders should be treated as confidential.

7.4.8 Where the specified number of quotations or tenders detailed in Annex 2 Section 4 cannot be obtained, the reason for proceeding with fewer quotations or tenders must be documented.

7.4.9 The relevant UK public procurement legislation must be followed. Contracts above specified thresholds must be advertised, awarded, and managed in accordance with these rules. Transparency requirements must be met.

7.4.10 Where tenders are returned above the estimated total value / approved budget, then the additional budget must be approved by the Trust Finance team prior to governance documents being circulated.

7.4.11 Where free of charge goods or services are made available to the Trust, WPL must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity, to ensure that the Trust does not unintentionally commit itself to a single provider or longer-term commitment.

7.4.12 Contracts funded in whole or in part through grants are not exempt from UK public procurement legislation. WPL shall be consulted at the earliest opportunity to ensure that procurement requirements are identified, and appropriate procurement timescales can be achieved.

7.4.13 The estimated contract value (exclusive of VAT) must be used to determine the required level of authorisation. It is the responsibility of the Trust Department to ensure that the correct governance process is followed and that the necessary authorisation is obtained prior to the award of the contract.

7.4.14 Subject to the limits outlined in Annex 2 section 2, the Chief Information Officer, Divisional Directors of Operations, Director of Operational Finance, Director of R&D, Chief Pharmacist, Chief Financial Officer and Chief Executive Officer may sign contracts on the Trust's behalf, providing the required governance document has been signed by the relevant Trust authorised signatories.

7.5 Procurement Process: Goods, Non-Healthcare Services and Works

7.5.1 The required procurement procedure for placing contracts for goods, non-healthcare services or works is dependent on the contract value (inclusive of VAT) and set out in Annex 2 Section 4. Where the estimated contract value is unknown then an Above Threshold procurement process must be followed.

7.5.2 The most economically advantageous quotation for goods, non-healthcare services and works will be accepted by the Trust unless there are good and sufficient reasons to the contrary.

7.5.3 All tenders for goods, non-healthcare services and works with an estimated value at or above the applicable procurement threshold shall be evaluated and awarded on the basis of the Most Advantageous Tender (MAT), in accordance with the published tender evaluation methodology and weightings. For procurements below the applicable threshold, the evaluation methodology shall be proportionate to the value, complexity and risk of the procurement and shall demonstrate that the selected supplier offers value for money

7.5.4 Where appropriate, pharmacy orders will be placed against Regionally/Divisionally agreed Pharmacy Contracts, which should cover most orders placed by the Pharmacy Department.

7.5.5 The Chief Information Officer is authorised to place contracts for UHS Digital Contracts only.

7.5.6 The authorisation framework for entering into goods, services and works contracts is outlined in Annex 2 section 3. The values listed also apply to disposals (SFI 14).

7.5.7 When contracting with subsidiary companies and companies where UHS are shareholders, the Trust will follow the goods and services authorisation framework. In examples where there is a conflict of approving personnel, due to individuals holding multiple directorships within each entity, the approval level will escalate to the next appropriate person in the hierarchy.

7.5.8 Where the contract value is £25,000 (exclusive of VAT) or greater, appropriate authorisation prior to contract award must be sought utilising the Procurement Approval Document (PAD) in accordance with Annex 2 Section 3.

7.5.9 Where no tenders, or no suitable tenders, are received under a tendering process WPL may advise that the waiving of this process takes place and propose a "Switch to Direct Award". A Competitive Procedure Waiver (CPW) will need to be completed in this instance. Authorisation prior to contract award must be received in line with Annex 2 Section 3.

7.5.10 Waiving of Tendering/Quotation Procedure:

(a) The procurement of goods, non-healthcare services or works with a contract value of

£25,000 (exclusive of VAT) or greater should be competed, or a framework utilised, subject to the exemptions detailed in 7.3. This requirement may, following receipt of advice from WPL, be waived in the following specific circumstances:

i) Prototypes and development
ii) Single supplier - intellectual property or exclusive rights
iii) Single supplier - technical reasons
iv) Additional or repeat goods, services or works - extension or partial replacement
v) Additional or repeat goods, services or works - further goods, services or works following a competitive procedure
vi) Extreme and unavoidable urgency
vii) Switch to Direct Award: On advice from WPL following a failed competitive process.
viii) To protect life etc: Where the Minister of the Crown has made Regulations, under the Procurement Act 2023 Section 3, to allow certain specified contracts to be awarded. The scope of permitted contracts and time period it covers will be specified.

(b) Where the contract value is £25,000 (exclusive of VAT) or greater, appropriate authorisation prior to contract award must be sought utilising a CPW in line with Annex 2 Section 3. This requirement may, in exceptional circumstances, be set aside by the Chief Executive Officer or Chief Financial Officer.

(c) The waiving of competitive quotations/tendering should not be used to avoid competition, or for administrative convenience, or to award further work to a provider originally appointed through a competitive procedure.

(d) The waiving of tendering/quotation procedures shall be reported to the Audit and Risk Committee retrospectively on a six-monthly basis highlighting all CPWs over £25,000 (excl VAT).

7.6 Procurement Process: Healthcare Services

7.6.1 Relevant healthcare services must be procured in accordance with the Provider Selection Regime (PSR), as established under the Health and Care Act 2022.

7.6.2 In the case of mixed procurements, those involving both healthcare and non-healthcare elements, the Procurement Act 2023 (PA 2023) will apply where the elements can reasonably be procured under separate contracts. Where the elements cannot be separated, the applicable procurement regime shall be determined based on the main subject matter of the contract, identified by the highest value element.

7.6.3 WPL will advise on the most appropriate and proportionate procurement process as set out under the PSR guidance and detailed in Annex 2 Section 4.

7.6.4 Legislation, policy, and guidance setting out procedures for awarding all forms of PSR regulated contracts shall have effect as if incorporated into the Trust's SFIs.

7.6.5 Where the contract value is £25,000 (exclusive of VAT) or greater, appropriate authorisation prior to contract award must be sought utilising either the PSR Procurement Approval Document (PSR PAD) or the PSR Direct Award Approval Document (PSD DAAD) as detailed in Annex 2 Section 3.

7.7 Contract Requirements

7.7.1 Contracts between the supplier and the Trust under agreed terms and conditions should include clear specifications and key performance indicators (KPIs) where appropriate.

7.7.2 Where a formal contract document is required (see Annex 2 Section 4) it must contain the

following as a minimum:

- A clear description of the goods, services or works to be supplied/specification
- Supplier details (name, address etc)
- Price and payment terms
- Contract start and end dates
- Delivery date(s) where appropriate
- The provision of liquidated damages if appropriate
- Appropriate insurance where relevant
- Signatures and signature dates

7.7.3 The aim is that that contract terms, conditions, scope, and deliverables, KPI reporting, and relationship management are clearly established in the signed contract and understood by all parties.

7.7.4 Where the proposed contract has a value of over £5m it must contain a minimum of 3 KPIs. This obligation does not apply if it is considered the supplier's performance could not appropriately be assessed in this manner (for example where the contract is for a one-off delivery of goods). Please note this requirement does not apply to "light touch regime" contracts.

7.7.5. Performance against the KPIs must be monitored regularly and data published for those contracts over £5m in accordance with relevant UK public procurement legislation. Legal advice may need to be sought prior to publication this should there be a serious breach of contract/poor performance.

7.7.6 Any contracts for pilots, non-recurrent investments or short-term projects are to be for a maximum of 1 year.

7.7.7 The Trust does not allow for contracts that have no defined end date (for example rolling contracts).

7.7.8 Where the service provided requires access to/processes Trust/patient data, the Trust Data Protection Team must be consulted, and necessary information sought from the supplier.

7.7.9 Where the contract value is £25,000 (excluding VAT) or greater, contract signature and the issue of purchase orders shall be subject to all required authorisations having been obtained through the appropriate governance approval process.

7.7.10 Each party must ensure that the contract is signed by an officer with the appropriate delegated authority. Authorised Trust contract signatories are detailed in Annex 2 section 3.

7.7.11 A copy of the signed contract may be required to be published in certain circumstances under UK public procurement legislation. WPL will advise when this is required and complete the necessary steps to publish to the central digital platform.

7.8 Contract Management

7.8.1 Staff with contract management responsibilities must ensure contractual obligations are met at the agreed cost and quality by monitoring the contract throughout its lifecycle. This may extend beyond the term of the contract if there are ongoing obligations associated with maintenance agreements, warranties and guarantees.

7.8.2 Contract management activity should maximise business benefit realisation and ensure value for money is achieved.

7.8.3 Price adjustments may only be made in accordance with the agreed mechanism included within

the contract, following the involvement of WPL.

7.8.4 Staff are responsible for managing contracts in a manner that is appropriate for the contract complexity, value, and risk.

7.8.5 A regular process of evaluating supplier performance within the terms of the contract may be required. Performance matters should be discussed in an open, professional and transparent manner with the supplier.

7.8.6 It is the responsibility of the Contract Manager to ensure that appropriate meeting and performance monitoring records are retained.

7.8.7 Where possible performance management should focus on continuous improvement and delivering improved outcomes. Should poor performance be identified the appropriate escalation processes must be followed. WPL will support with any contractual disputes relating to existing issues or an exit plan.

7.8.8 It is the responsibility of the Contract Manager to ensure that all risks associated with the contract are understood, assessed, and managed.

7.8.9 Any concerns regarding supplier fraud or potential for fraud must be identified and reported to the Local Counter Fraud Specialist.

7.8.10 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc. If there is no such provision WPL will advise with regards to what is permissible under the relevant UK public procurement rules and the associated transparency requirements.

7.8.11 Should contract modifications of £25,000 (exclusive of VAT) or greater be required robust change control mechanisms must be in place, and appropriate approvals must be sought utilising the relevant Contract Change Approval Document (CCAD) as advised by WPL.

7.8.12 In all cases where optional extensions to a contract are outlined at the time of quoting/tendering, the user wishes to exercise the option(s), and the extension value is £25,000 (exclusive of VAT) or greater, appropriate approval must be sought utilising the relevant Contract Change Approval Document (CCAD) as advised by WPL.

7.8.13 Subject to the limits set out in Annex 2 Section 2, and following approval of the required governance documentation by the Trust's authorised signatories, contract variations, extensions and modifications may be executed on behalf of the Trust by the Chief Information Officer, Divisional Directors of Operations, Director of Operational Finance, Director of Research & Development, Chief Pharmacist, Chief Financial Officer or Chief Executive Officer. For the purposes of applying the delegation limits, the relevant value shall be the value of the proposed variation, extension or modification.

7.9 Contract Exit or Termination

7.9.1 Contracts may only be terminated before the end of their contractual term following engagement with WPL. Legal advice may need to be sought depending on the termination grounds to ensure the correct procedure is followed.

7.9.2 Contractual notice periods must be followed. Options upon termination/expiry of an existing contract must be evaluated prior to this to allow for appropriate decision making regarding the provision of existing services.

7.9.3 Contract Managers are responsible for managing the exit strategy, ensuring a smooth transition to a new supplier(s).

7.10 Non-Disclosure Agreements

7.10.1 Non-disclosure agreements (also referred to as NDAs or confidentiality agreements) may be entered into by the Trust when it is developing a new product, service or process with someone else. The agreement will restrict the way in which any confidential information shared by the Trust and the other party can be used and ensure that this information and the fact that the parties are working together are kept confidential. These agreements are entered into at the outset of the process and will not generally have a financial value associated with them.

7.10.2 Legal advice should be sought when the Trust is asked to enter into a non-disclosure agreement or the agreement entered into should follow the format of the template non-disclosure agreement used by the Trust. Non-disclosure agreements must be authorised and signed by any Executive Director, the Chief Information Officer, the Managing Director of Wessex Procurement Limited, Head of Innovation or the Commercial and Enterprise Director.

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The CEO, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Integrated Care Boards and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of Health and Social Care or NHS England are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the CEO should consider:

a) Costing and pricing (in accordance with the NHS England financial regime or any alternatively agreed payment mechanism) and the activity / volume of services planned;

b) The standards of service quality expected;

c) The relevant national service framework (if any);

d) Payment terms and conditions;

e) Amendments to contracts and non-contractual arrangements; and

f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 The CFO shall produce regular reports detailing actual and forecast income.

8.1.7 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

8.1.8 The authorisation limits for signing service contracts are set out in Annex 2.

8.1.9 All Service Contracts and other contracts entered by the Trust shall include appropriate provisions to protect the Trust against fraud, bribery, corruption and other financial crime. Where appropriate, contracts shall include provisions enabling the Trust to terminate or cancel the contract and recover any resulting loss, in accordance with the terms of the contract and applicable law, where the contractor or any person acting on its behalf has engaged in conduct that constitutes, or may constitute, fraud, bribery or corruption.

8.1.10 The responsible officer shall ensure that appropriate due diligence and contractual controls are undertaken when entering into contracts with suppliers, commissioners and other organisations, proportionate to the nature, value and risk of the contractual relationship.

8.1.11 Any concerns or allegations of suspected fraud, bribery or corruption involving a contractor, supplier or other contracting party shall be reported promptly to the CFO and LCFS in accordance with the Trust's Counter Fraud, Bribery and Corruption Policy. The matter shall be assessed and, where appropriate, investigated in accordance with the Trust's counter-fraud arrangements and may be referred to the relevant enforcement or regulatory authority where there are grounds to do so

8.1.12 The CFO shall ensure that appropriate procedures and controls are in place to mitigate the Trust's corporate risk arising from fraud, bribery and corruption in relation to its contractual activities, and that such procedures and controls are subject to a programme of ongoing review to ensure they remain effective and proportionate.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the CEO to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where UHS is a competing body)

8.3.1 Where UHS participate in a tendering exercise (whether in competition with others or not) for a health-related service, approval must be sought according to the delegated authority limits. This includes bidding for external sources of capital or revenue funding.

8.3.2 Delegated authority limits associated with tendering are outlined in Annex 2.

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the stated financial limits as per the Trust Authorisation Framework. All tender decisions will be reported to the Trust Executive Committee for noting.

8.3.4 Staff who participate in a tendering exercise must notify the Planning and Business Development team and/or commercial team and follow processes in accordance with the "Bidding for Contracts" policy (available on Staffnet).

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration and Appointment Committee

9.1.1 The Trust Board shall establish a Remuneration and Appointment Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and some Senior Manager posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director posts above the salary of the Prime Minister (currently circa £180k) must be referred to NHS England and onward opinion from the Secretary of State.

9.2 Staff Appointments, Terminations and Changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees or hire agency staff subject to any approval that may be required by the Recruitment Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees after consultation with their Human Resources Business Partner and job evaluation has taken place in accordance with Trust policy; subject to the Recruitment Control Panel Terms of Reference.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short-term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off-payroll engagements must be compliant with IR35 legislation and approved by the CFO prior to contract signature.

9.2.3 All contracts of employment including recruitment, promotions and terminations will be transacted via ESR (Electronic Staff Record) by Self Service or where applicable through the appropriate HR team.

9.2.4 All staff employed by the Trust will be issued a contract of employment. All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place. Engagement of agencies should also be in line with prevailing NHS England / NHS Improvement requirements and rules.

9.2.5 A termination of employment form must be submitted by the employee's line manager through manager self-service on ESR before the termination date.

9.2.6 Any appointments should follow the Trust Recruitment and Selection Policy found on Staffnet.

9.2.7 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.8 In the event that redundancy cannot be avoided the Trust shall:

i) Develop selection criteria based upon the agreed Trust Organisational Change Policy which includes affordability, and

ii) Complete the Trust redundancy approval form (RAF) and submit to the HR Business Partner. The form must be approved by the Chief People Officer and CFO. The approval process must be completed and agreed prior to any consultation commencing.

9.2.9 Changes to, and / or the creation of, local terms and conditions require approval by Pay Steering Group. Where necessary, for major changes, it may be appropriate for this to be authorised by either the Trust Board's Remuneration and Appointment Committee or Trust Board.

9.3 Processing Payroll

9.3.1 The Chief People Officer shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with current agreements.

9.3.2 The CFO is responsible for the agreement to and management of the Payroll Contract with outside providers.

9.3.3 Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contractual) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.4 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under / overpayments is contained in the Trust's Pay Policy.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the CEO will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The CFO will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services, via an approvals hierarchy; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 2.

10.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of Wessex

Procurement Limited shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.2.3 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition.

10.2.4 The Trust operates a "No Purchase Order No Pay" policy. All orders require a Purchase Order prior to being placed. The CFO will maintain and monitor a list of exemptions, including:

a) Pay overs i.e. HMRC, Pensions, child support, court fees, salary sacrifice schemes;

b) Patient reimbursements, such as travel Intra NHS recharges;

c) Transactions between UHS Group entities e.g. WPL, UEL, UPL

d) Patient voucher schemes (eg opticians) Out of scope of the above are payments via purchase cards, expense claims and invoices processed in JAC for Pharmacy.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.2 The CFO will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees able to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- where appropriate, the expenditure is in accordance with regulations, and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking they shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have

placed orders and negotiated prices and terms and that such checks are evidenced;

- in the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except where a prepayment is agreed).

10.3.3 Prepayments are only permitted where the financial advantages outweigh the disadvantages. In such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.4 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

b) The following contracts should be submitted to the Finance department for review prior to seeking approval as they are likely to need submission to Trust Investment Group under revised accounting standard IFRS16:

- Equipment leases
- Property leases (including those with peppercorn rents)

- Other contracts which include the supply of equipment which include separate charges for that equipment (embedded leases)
- Other contracts which include the supply of equipment which do not include separate charges for that equipment (as the charging mechanism may need apportioning between the supply of goods or services and the supply of equipment as an embedded lease)
- Other property guarantees

c) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the relevant approval body outlined in Annex 2;

d) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

e) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

f) Petty cash records are maintained in a form as determined by the CFO;

g) Contracts above specified thresholds are advertised and awarded in accordance with UK legislation and World Trade Organisation rules on public procurement; and

h) All requisitions must be approved in line with the Trust Authorisation Framework.

i) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one-off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Purchase Cards

10.4.1 Purchase Cards may be issued to employees only when specifically approved by the CFO. Managers and staff must ensure that they comply fully with the guidance regarding the use of cards as specified within the Purchase Card Policy.

10.5 Employee Expenses

10.5.1 The Trust's Reimbursement of Staff Expenses Policy is available on StaffNet to ensure all employees are aware of their responsibilities regarding the claiming of business travel expenses and other forms of subsistence and authorisation of related claims. The primary purpose of travel and subsistence allowances is to reimburse employees the cost incurred for meals, accommodation and travel in the performance of their duties. The Trust has an expenses system for staff related expenses. No expenses should be claimed outside of this system.

10.4.2 Staff expenses claims should be approved by Care Group Manager (for Clinical Divisions) or by the Director for Trust Headquarters. They may, however, be delegated to suitable deputy senior manager (minimum band 8a) at the discretion of the Care Group Manager or THQ director.

10.6 Management Consultants

10.6.1 Consultancy contracts over £50,000 require approval by NHS England in line with National guidance.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS England's NHS Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Operational Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 The Trust will comply with the guidance on dividend payments contained in the DHSC Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Audit and Risk Committee.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS England and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Audit and Risk Committee on an annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held to the Board through the Audit and Risk Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury Management Policy, with no investment made which would be outside the laid-down

parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Audit and Risk Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Trust Investment Group comprising at least two Executive Directors and chaired by the CFO to oversee its allocation of capital investment. The CFO will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Operational Plan and the Capital Investment Plan.

12.1.2 The Investment Group will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year.

12.2 Approval of Capital Business Cases

12.2.1 Approval of capital business cases will follow the approval limits outlined in the Trust Approval Framework in Annex 2. NHS England have based capital business case approval limits on the National Oversight Framework.

12.2.2 All expenditure should be within the program budget as agreed by Trust Board on an annual basis. Program reporting is required by Trust Investment Group (TIG) on a periodic basis

12.2.3 Delegated capital limits refer to overall contract values, regardless of the form of funding (e.g. lease, capital up-front, bullet payment or managed service contract).

12.2.4 The delivery of capital schemes within approved budgets will be the responsibility of a named officer within the business case. Where costs are reasonably foreseeable to exceed the approved budget by more than £150k or more than 5%, whichever is greater, then further approval from the authorising body will be required. In extremis, where this threshold is reached and it is not possible to obtain the necessary approval in a timely manner, the Chair of the authorising body will be informed and may exercise Chair's action to approve the additional expenditure with subsequent reporting to the authorising body at its next meeting. In situations where the additional expenditure increases the cost of the scheme beyond the approval limit of the original authorising body, that authorising body may approve the additional expenditure but will report such to the body with which the approval limit for the revised total scheme cost resides.

12.2.5 The Trust Investment Group will set out and periodically review and update the format and minimum required content of business cases. This will typically include:

a) An option appraisal of potential benefits compared with known costs;

b) Ensuring an appropriately detailed analysis of expenditure and income flows is undertaken, including documented responses from purchasers as appropriate and risk analysis testing the assumptions made; and

c) An analysis of the project's discounted cash flow, based on an agreed rate of return.

12.2.6 The Trust Investment Group will report on major issues to the Trust Executive Committee and Trust Board via the capital section of the monthly Finance Report and within the quarterly capital update.

12.2.7 The Southampton Hospital Charity, or other charities, may choose to donate assets to the Trust. The governance outlined in Section 17 (Charitable Funds Held on Trust) shall apply. Any financial consequences on the Trust must be approved by the appropriate body as outlined in the Trust Authorisation Framework (Annex 2).

12.2.8 Once capital is approved, the CFO is responsible for choosing the most appropriate source of finance, aligned to the Trust Treasury Management Policy.

12.2.9 Finance leases reaching the end of their contractual term are included as Capital expenditure. The Trust Investment Group has authorised the Leasing Sub-Committee to manage and approve the buy-out and/or direct replacement of leases. Where new equipment is required, a business case needs to go to Trust Investment Group for approval before a decision on whether to lease or direct purchase can be made.

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Trust Investment Group for approval or review prior to request for approval by Trust Board if required.

12.4 Asset Registers

12.4.1 The CEO is responsible for the maintenance of registers of assets, taking account of advice from the CFO concerning the form of any register and the method of updating. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to the associated senior service user/owner and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the CEO.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for:

a) Equipment on loan;

b) All contents of furnished lettings.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;
b) Acquisition of freehold property over £2.5 million (excluding VAT); and
c) Acquisition of property where the total value of the agreement is over £2.5 million (excluding VAT) by means of a lease, whether it is deemed to be capitalised or not under IFRS 16.

12.6.3 Property purchases, licences and leases up to £150,000 each (excluding VAT) may be authorised by the CFO and those at or above this value but not exceeding £2.5 million each (excluding VAT) may be authorised by the Trust Investment Group, provided in each case that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation. Licences connected with existing leases or other transactions previously authorised by the CFO, Trust Investment Group and Trust Board will not require separate authorisation provided that these do not result in significant changes to the Trust's Estate.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with Department of Health and Social Care guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the CEO.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £2.5 million (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets require the approval of NHS England.

12.6.11 Material or Significant Transactions, as defined in NHS England's transactions guidance, may require the approval of NHS England.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is more than £2.5 million.

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First In First Out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Managing Director of Wessex Procurement Limited. The day-today responsibility may be delegated by them to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Deputy Chief Pharmacist; and the control of fuel oil the responsibility of the Director of Estates, Facilities & Capital Development. The control of stock within UHS subsidiaries shall be the responsibility of subsidiary directors and their respective Boards.

13.1.3 The CFO, in conjunction with the Managing Director of Wessex Procurement Limited, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer, and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.4 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.5 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.6 The Managing Director of Wessex Procurement Limited shall be responsible for a system approved by the CFO for a review of slow-moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.7 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.8 Inventory that has deteriorated or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the CFO and recorded.

13.1.9 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the CEO shall identify those authorised to requisition and accept goods from the store.

13.1.10 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice where appropriate. The highest possible disposal value will be realised, considering potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued at over £100k (higher of either market value or net book value) must be approved by the CEO.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DHSC Group Accounting Manual and prepare a register. Approval limits where approval is required from NHS England and HM Treasury are defined in Annex 1.

14.2.2 Any Director or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the CEO and/or the CFO or inform an Officer charged with responsibility for responding to concerns involving loss. This Officer will then appropriately inform the CFO and/or CEO. Where a criminal offence is suspected, the CFO must immediately inform the police if theft or arson is involved. In

cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the CFO must inform the relevant LCFS.

14.2.3 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the CEO in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.5 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.6 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.7 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register. Losses and special payments are defined at Annex 1.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The CEO, supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible for accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and the UK General Data Protection Regulation; ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment, ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out to ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage and ensure that appropriate technical and organisational measures are in place to achieve compliance. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate

controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisitions, developments and maintenance are in line with the Trust's Information Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on Trust equipment or infrastructure (e.g. PCs, laptops, tablets, servers, cloud computing infrastructure) should be purchased without the approval by the UHS Digital department. Any quotes to purchase software or contract for cloud hosted services should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the UHS Digital department.

The Trust's Digital Board has an approval limit of £300k for projects where within budgetary limits. It will be at the discretion of the Chief Information Officer or other senior UHS Digital managers whether a case requires discussion at Digital Board.

15.1.7 The Trust shall maintain appropriate controls to prevent, detect and respond to fraud, cyber fraud, unauthorised access and other cyber security threats that may result in financial loss, compromise of data or disruption to services.

15.1.8 All staff and authorised users must comply with the Trust's information security, cyber security and counter-fraud policies and promptly report any suspected fraud, cyber fraud, unauthorised access or other security incident through the Trust's established reporting arrangements.

15.1.9 Suspected fraud, bribery or corruption shall be reported to the LCFS, with cyber security incidents reported through the Trust's established Digital reporting arrangements. Appropriate controls and reporting arrangements shall be regularly reviewed to ensure they remain effective and proportionate to the risks faced by the Trust.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead-on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions. This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The CEO is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept

responsibility or liability for patients' property brought into health service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Work and Pensions instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 The Trust no longer administers any Charity, including the Southampton Hospital Charity which is a wholly separate entity.

17.2 The Southampton Hospital Charity is the main vehicle for the collection and administration of charitable funds. All other charitable engagements need to be approved by the Charity oversight group and dealt with in line with the Managing Associated and Partner Charities policy. No Trust department may collect or administer funds without prior authorisation from the Charity team. For the avoidance of doubt, it is prohibited to set up bank accounts for Charitable purposes without Board approval.

17.3 The Southampton Hospital Charity acts as an independent grant awarding body. Grants awarded to UHS should be spent in line with the grant award guidance and records should be maintained to document that this is adhered to.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The CEO shall ensure that all staff, volunteers, and any other person associated with the activities of the Trust are made aware of, and comply with, the Trust's Standards of Business Conduct Policy. This policy details the conduct and behaviour expected of individuals regarding:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships and loyalties which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made in accordance with the Trust's Standard of Business Conduct Policy (available on Staffnet) for inclusion in the Register of Interests.

18.2 Staff, volunteers, contractors and other persons acting on behalf of the Trust must ensure that their conduct does not give rise to, or reasonably appear to give rise to, improper influence, favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised by gifts, hospitality, financial or other advantages.

All staff must comply with the requirements of the Bribery Act 2010 and the Trust's Standards of Business Conduct Policy, Counter Fraud, Bribery and Corruption Policy and Raising Concerns (Whistleblowing) Policy.

Any concerns or suspicions relating to fraud, bribery or corruption must be reported promptly to the LCFS in accordance with the Trust's reporting arrangements.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The CEO shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS England/DHSC guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	**Held By**
Property Deeds	Director of Estates, Facilities & Capital Development
Building & Engineering Contracts	Director of Estates, Facilities & Capital Development
Estate Maintenance Contracts	Associate Director of Estates
Maintenance Contracts	WPL
Clinical Contracts	Director of Operational Finance
WPL Contracts	WPL Associate Director of Corporate Affairs
Contracts for goods and services other than the above	

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be

held by other Managers must be reported to the Associate Director of Corporate Affairs for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS England/DHSC guidance (Records Management Code Of Practice 2023) shall only be destroyed before the specified guidance limits at the express authority of the CEO or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The CEO shall ensure that the Trust has a sound system of risk management and internal control set out in strategy, policy, and procedural documentation. The functioning and efficacy of the system of internal control and risk management shall be monitored and assessed for suitability by the Board of Directors and its duly established committees.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers regarding managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including internal audit, external audit, counter fraud, clinical audit and health and safety reviews.

The existence, integration and evaluation of these elements will provide a basis to make the Annual Governance Statement within the Annual Report and Accounts as required by current NHS guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether to continue with current arrangements

20.2.2 The Associate Director of Corporate Affairs shall act as the Trust's lead contact on insurance matters and ensure Insurance Brokers are liaised with over queries and negotiating renewal terms.

20.2.3 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents against insurance provision on the third-party liability scheme.

20.2.4 The Associate Director of Corporate Affairs shall ensure timely reporting of losses and the submission of claims against insurance provision on the third-party liability scheme in line with the agreed limits set in these SFIs.

20.2.5 The Associate Director of Corporate Affairs shall ensure timely reporting of incidents and losses and the submission of claims against insurance provision.

20.3 Clinical Risk Management/Clinical Negligence Scheme for Trusts (CNST)

20.3.1 The Chief Nursing Officer shall:

a) Provide a central point of contact within the Trust for NHS Resolution/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where NHS Resolution, in joint agreement with the Associate Director of Corporate Affairs, considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the Trust within the excess of £3k will be notified and approved by the Trust Legal Services Facilitator and Head of Claims and Insurance.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the University Hospital Southampton NHS Foundation Trust as the defendant.

Up to £500k	Divisional Clinical Director, Divisional Director of Nursing or Divisional Director of Operations
£501k - £1.5m	Divisional Clinical Director and Divisional Director of Nursing and shared with an Executive Director (usually Medical or Nursing)
£1.5m+	Divisional Clinical Director and Divisional Director of Nursing and shared with at least two Executive Directors and the CEO for final review and approval then reported to Trust Board

The DHSC must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made against legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care (Community Health and Standards) Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). If any NHS charges are payable these will be met in full by the compensator i.e. any other NHS trust. In the event the compensator is University Hospital Southampton NHS Foundation Trust the act provides that UHS is exempt from repaying their “own” costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the CFO. In certain cases, additional approval should be sought from NHS England and/or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer advises it to be prudent so to do and only after considering the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £50,000	Chief People Officer and Chief Financial Officer
£50,001 - £100,000	Chief Executive Officer
£100,000+	Trust Board

22.4 NHS England must be consulted before making any special payments that are novel, contentious or repercussive. The Chief People Officer, in the case of any compromise agreements, shall submit a business case to be approved by HM Treasury. Any payments made against legal advice must be approved by the Trust Board.

23. SUBSIDIARIES, SHAREHOLDINGS, HOSTED BODIES, PARTNERSHIPS AND COLLABORATIONS

23.1 Subsidiaries and Shareholdings

23.1.1 Subsidiary companies and companies where UHS are joint shareholder (e.g. WPL) are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, subsidiaries and shareholdings are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable, with the exception of where the group position is directly impacted (e.g. Group CDEL limit for capital). Reference to the subsidiary's documentation will need to be made.

23.1.2 Whilst subsidiaries operate independently, their SFIs include a schedule of changes where prior written approval of the Shareholder is required. This includes alteration of any constitutional documents of the company. Any changes to the schedule of prior Shareholder approval will require approval of Trust Board, following review and recommendation by the Audit and Risk Committee.

23.2 Hosted Bodies, Partnerships and Collaborations

23.2.1 Hosted bodies are organisations for which UHS provide services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Commercial Development Team. UHS also works in partnership and collaboration with other organisations under service level agreements, memoranda of understanding or similar documents.

23.2.2 Dependent on the terms of the SLA, memorandum of understanding or equivalent, these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding or equivalent should be referred to on a case-by-case basis.

24. FORCE MAJEURE

24.1 In the event of a force majeure, such as a Pandemic, the existing Standing Financial Instructions and Scheme of Delegation should be followed as normal where possible.

24.2 If compliance with Standing Financial Instructions (SFIs) and Schemes of Delegation (SODs) is expected to generate delays to the procurement of goods (either revenue or capital expenditure) and such delay causes unacceptable detriment to patients and / or staff, the SFIs and SODs may be waived on the written authority of either the CFO or Director of Operational Finance. If neither the CFO nor Director of Operational Finance is available, the CFO may delegate the authority to waive SFIs / SoD to another Executive Director.

24.3 If the value of the transaction exceeds £2.5m, the written authority of the Chair, or another Non-Executive Director nominated by the Chair, will also be required.

24.4 A schedule showing transactions where SFIs / SoD have been waived shall be maintained to include the date of waiver, name of supplier, description of goods ordered, name of approving officer and why the waiver was approved. This schedule shall be reported regularly to Trust Board and to each Audit and Risk Committee.

24.5 The Audit and Risk Committee are responsible for ratifying decisions made under force majeure.

24.6 The Trust Board and / or Audit and Risk Committee need to confirm when Force Majeure arrangements can come into force and when they are terminated.

24.7 The CFO or Director of Operational Finance can also waive section 10.3.3 of Trust SFIs relating to prepayments, where this is in line with HM Treasury policy regarding payments to Suppliers during a force majeure (for example “Procurement Policy Note 02: Supplier relief due to coronavirus”).

Annex 1

Losses, Gifts and Special Payments

LOSSES:

1. Losses of cash due to:
   a. theft, fraud etc.
   b. overpayment of salaries etc.
   c. other causes
2. Fruitless payments
3. Bad debts and claims abandoned in relation to:
   a. private patients
   b. overseas visitors
   c. other
4. Damage to buildings, property etc. due to:
   a. theft, fraud etc.
   b. other

SPECIAL PAYMENTS:

5. Compensation under legal obligation
6. Extra contractual to contractors
7. Ex gratia payments in respect of:
   a. loss of personal effects
   b. clinical negligence with advice
   c. personal injury with advice
   d. other negligence and injury
   e. severance payments on termination of employment
   f. other employment payments
   g. patient referrals outside the UK and EEA Guidelines
   h. other
   i. maladministration, no financial loss
8. Extra statutory and regulatory

Type	Approval thresholds by NHSE and HMT
Special severance payments	All non-contractual payments
Special payments	£95k+
Losses	£95k+
Gifts	£300k+
Anything novel, contentious or repercussive	All must be approved

Annex 2 – Trust Authorisation Framework

Section 1 – Authorisation Bodies and Limits

Expenditure limits refer to per annum budget thresholds.

Group	Revenue (Annual Gross Cost)	Capital
Divisional Management Boards	Utilisation of approved expenditure budget only.	Up to £150k where this is within the annual capital allocation for all Divisions. All capital expenditure to be reported to TIG.
Defined groups	N/A	Up to £150k where this is within annual capital allocation: • Director of EFCD – backlog maintenance / Infrastructure / Advanced design fees. • Leasing sub-committee – replacement leases / buy-outs. • Medical Equipment Panel • UEL Board • IISS Investment Committee Up to £300k where this is within annual capital allocation: • Digital Board
Recruitment Control Panel	As per Terms of Reference, reporting into TEC	N/A
People Board	As per Terms of Reference, reporting into TEC	N/A
Pay Steering Group	As per Terms of Reference, reporting into People Board	N/A
Payroll Approvals Group	As per Terms of Reference, reporting into Pay Steering Group	N/A
DoOF or COO	Up to £50k – exceptional circumstances only.	Up to £50k – exceptional circumstances only. All capital expenditure to be reported to TIG.
CEO or CFO	Up to £150k	Up to £150k. All capital expenditure to be reported to TIG.
TIG (Trust Investment Group)	Up to £2.5m additional expenditure budget. Schemes over £2.5m and/or of significant strategic importance should include a recommendation from TIG to FI&CC.	Up to £5.0m. Schemes over £5.0m and of significant strategic importance should include a recommendation from TIG to FI&CC.
TEC (Trust Executive Committee)	Receive minutes and note decisions from TIG. • Business cases relating to staff recruitment / training programmes. • New consultant business cases • Replacement consultant business cases – for noting.	Receive minutes and note decisions from TIG.

FI&CC (Finance, Investment & Cash Committee)	£2.5m+ and schemes of significant strategic importance for commercial review and recommendation to Trust Board.	£5.0m+ schemes of significant strategic importance for commercial review and recommendation to Trust Board.
Trust Board	£2.5m+ and: • schemes judged of significant strategic importance • major schemes with compliance arrangements	NOF Segment 1-2 £5.0m - £100m NOF Segment 3-4 £5.0m - £50m Above NOF Segment limits and recommendation to NHSE and: • schemes judged of significant strategic importance • major schemes with compliance arrangements
NHS England	Major schemes with compliance arrangements	NOF Segment 1-2 £100m+ NOF Segment 3-5 £50m + Major schemes with compliance arrangements All centrally funded business cases

Annex 2 – Trust Authorisation Framework

Section 2 – Non-Pay Authorisation Framework

Authorised Non-Pay Expenditure Limits	
	Limit £
All Staff	
Band 1-4	£0k
Band 5-7	£1k
Band 8a-8b	£10k
Band 8c-8d	£75k
Band 9	£250k
Trust Board/Directors	
Chief Executive Officer	Unlimited
Chief Financial Officer	Unlimited
Chief Operating Officer	£1m
Chief Information Officer	£1m
Other Executive Director	£1m
Pharmacy	
Chief Pharmacist	£250k

The expenditure limit is in respect of total contract/tender value. E.g. a three-year contract with an annual value of £26k has a total value of £78k and must follow protocol for signing off up to £250k.

Annex 2 – Trust Authorisation Framework

Section 3 – Contracting – Financial Limits

Total Contract Value (exc VAT)	Type of Contract	Authorisation to place/sign Contract
Nil	Non-Disclosure Agreements	Executive Director, Chief Information Officer, Director of R&D, , Head of Innovation, Commercial and Enterprise Director
Up to £0.5m	Goods, Services & Works	Chief Information Officer, Chief Pharmacist, Commercial Director, Director of Operational Finance, Director of R&D, DDO
£0.5m - £1.0m	Goods, Services & Works	Chief Financial Officer
£1.0m - £2.5m	Goods, Services & Works	Chief Executive Officer
£2.5m+	Goods, Services & Works	Trust Board, Chair

Ensuring Procurement and Tender limits also comply with

Up to £0.5m	Non-NHS Income	DDO, Commercial Director, Director of Operational Finance, Director of R&D
£0.5m - £1.0m	Non-NHS Income	Chief Financial Officer
£1.0m - £2.5m	Non-NHS Income	Chief Executive Officer
£2.5m+	Non-NHS Income	Trust Board, Chair

Up to £10m	NHS Income	Director of Operational Finance
£10m - £200m	NHS Income	Chief Financial Officer
£200m+	NHS Income	Chief Executive Officer

Up to £0.5m	Bidding for Tenders	DDO, Commercial Director, Director of R&D, Director of Planning
£0.5 - £10m	Bidding for Tenders	Tender Steering Group, Chief Financial Officer
£10m - £20m	Bidding for Tenders	Chief Executive Officer
£20m+	Bidding for Tenders	Trust Board

Based on gross expenditure, not offset with income

Annex 2 – Trust Authorisation Framework

Section 4 – Procurement Process

Goods, Services, Works & Consultancy (Non-Property)

Minimum Procurement Process	Form of Contract / Governance Requirement	Contract Value excl VAT			
		Up to £25,000	£25,001-£75,000	£75,001 – UK Threshold Values	Above UK Threshold Values
Trust Catalogue, or Compliant Framework, or 1 Written Quotation	• Purchase Order	Yes			
Compliant Framework, or 3 Written Quotations	• Purchase Order • PAD		Yes		
Compliant Framework, or Local Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD			Yes	
Compliant Framework, or Above Threshold Compliant Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD				Yes

Building and Estates Engineering

Minimum Procurement Process	Form of Contract / Governance Requirement	Contract Value excl VAT				
		Up to £25,000	£25,001-£75,000	£75,001-£499,999	£500,000 - UK Threshold Values	Above UK Threshold Values
Trust Catalogue, or Compliant Framework, or 1 Written Quotation	• Purchase Order	Yes				
Compliant Framework, or 3 Written Quotations	• Purchase Order • PAD		Yes			
Compliant Framework, or Local Tender Exercise (minimum 3 invited) *WPL to Lead*	• Purchase Order • Contract • PAD			Yes		
Compliant Framework, or Local Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD				Yes	
Compliant Framework, or Above Threshold Compliant Tender Exercise (minimum 4 invited) *WPL to Lead*	• Purchase Order • Contract • PAD					Yes

The contract values above represent the contract's lifetime value e.g., a 5-year contract of £25,000 per year requires £125,000 method and authorisation.

For current UK Threshold Values please refer to the WPL Procurement Manual.

The Authorisation Framework for a Procurement Approval Document (PAD) or Change Control Approval Document (CCAD) is detailed in Annex 2, Section 3.

PSR Healthcare Services

The procurement process to be followed will be dictated by circumstances, not contract value. Governance Requirement / Form of Contract applies to any contracts with a contract value of £25,000 (exclusive of VAT) and above. For those below this value a purchase order will suffice.

Process Name	Description	Governance Requirement /Form of Contract
Direct award process A	Where the nature of the service means the existing provider is the only capable provider	• PSR DAAD • Purchase Order • Signed Contract
Direct award process B	Where patients have a choice of providers, and the number of providers is not restricted by the relevant authority	• PSR DAAD • Purchase Order • Signed Contract
Direct award process C	Where the existing provider is satisfying the existing contract and likely to satisfy the proposed contract to a sufficient standard, and where the proposed contracting arrangements are not changing considerably	• PSR DAAD • Purchase Order • Signed Contract
Urgent situations	Where there is an award, or a contract modification to address an urgent and unforeseen situation	• PSR DAAD • Purchase Order • Signed Contract
Most suitable provider process	Identifying the most suitable provider without a competitive tendering exercise	• PSR PAD • Purchase Order • Signed Contract
Competitive process	Competitive tendering	• PSR PAD • Purchase Order • Signed Contract
Framework Agreements	Awarding a contract based on a framework agreement without competition (i.e. using a direct award process in accordance with the terms of that framework agreement)	• PSR PAD • Purchase Order • Signed Contract
Framework Agreements	Awarding a contract based on a framework agreement using the Competitive Process (in accordance with the terms of that framework agreement	• PSR PAD • Purchase Order • Signed Contract

Annex 2 – Trust Authorisation Framework

Section 5 – Authorisation Framework/Financial Limits for Competitive Procedure Waiver (CPW)

Goods, Services, Works, Consultancy & Building and Estates Engineering

Authorisation to place/sign Contract	Contract Value excl VAT		
	£25,000 to £1m	£1m - £2.5m	£2.5m+
Director of Estates, or Managing Director of WPL, or Chief Information Officer, or Head of Estates Maintenance, or Divisional Director of Operations	Yes		
Chief Executive Officer, or Chief Financial Officer		Yes	
Chair on behalf of Trust Board			Yes

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.5 Report to the Trust Board of Directors, 12 November 2026	
Title:	Audit and Risk Committee Terms of Reference
Sponsor:	Steve Peacock, Committee 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:

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The Code of Governance for NHS Provider Trusts requires that Council of Governors is consulted on the terms of reference. The terms of reference are approved by the Board of Directors.

The terms of reference were last reviewed in March 2026 with no amendments proposed.

The most significant proposed change to the terms of reference is to introduce an Appendix B, which summarises the key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. The introduction of this additional Appendix is intended to address one of the recommendations from the Well-Led Review carried out by The Value Circle: "The Trust should undertake a targeted review of committee TORs to explicitly state assurance responsibilities, define expected assurance outputs using a consistent framework, strengthen alignment to strategic priorities, and clarify inter-committee relationships and risk oversight expectations." Similar appendices will be included in the terms of reference of the other Board committees.

In addition, a number of minor amendments are proposed, including those to correct minor typographical errors.

The Audit and Risk Committee approved the proposed changes on 9 October 2026 and agreed to recommend the updated terms of reference to the Board for approval. The Council of Governors were consulted on 27 October 2026 about the changes and supported the proposed amendments.

The Board is requested to approve the proposed changes to the terms of reference.

Contents:

Terms of Reference

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

Version: ~~8~~9

Date Issued:	~~10 March~~[12] November 2026
Review Date:	~~March~~November 2027
Document Type:	Committee Terms of Reference

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1. Role and Purpose

1.1 The Audit and Risk Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and the external and internal audit functions.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the annual governance statement.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below. A summary of the Committee's key assurance responsibilities, expected assurance outputs, inter-committee relationships, and risk oversight expectations can be found in Appendix B. In case of any conflict between Appendix B and the main body of these terms of reference, the main body of the terms of reference shall prevail.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee will primarily utilise the work of internal audit, external audit and other assurance functions. It is also authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be independent non-executive directors of the Trust (other than the chair of the Board). The Committee will consist of not less than three members, at least one of whom will have recent and relevant financial experience, ideally with a qualification from one of the professional accountancy bodies.

3.2 The Board will appoint the chair of the Committee from among its members (the **Committee Chair**).~~The Committee Chair may be the deputy chair of the Board. However, in the event that the deputy chair must act as chair of the Board for an extended period of time, the deputy chair will resign as Committee Chair.~~ In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.3.1 representative(s) from the external auditor;

3.3.2 representative(s) from the internal auditor;

3.3.3 representative(s) from the local counter fraud service;

3.3.4 Chief Financial Officer;

3.3.5 Chief Nursing Officer; and

3.3.6 Associate Director of Corporate Affairs~~/~~ (**Company Secretary**~~.~~).

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3.4 The Chief Executive Officer will be invited to attend meetings of the Committee, at least annually, to discuss with the Committee the process for assurance that supports the annual governance statement.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee as observers, subject to the agreement of the Committee Chair.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be two members. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least four times each year and otherwise as required.

5.2 At least once each financial year the Committee will meet with representatives of the external and internal auditors without management being present to discuss their remit and any issues arising from their audits.

5.3 Outside of the formal meeting programme, the Committee Chair will maintain a dialogue with key individuals involved in the Trust's governance, including the chair of the Board, the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the external audit lead partner and the head of internal audit.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the ~~secretary of the Committee~~Company Secretary at the request of the Committee Chair or any of its members, or at the request of external or internal auditors if they consider it necessary.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer and the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 ~~The secretary of the Committee~~The Company Secretary (or a nominated deputy) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Integrated Governance, Risk Management and Internal Control***

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy and effectiveness of:

7.1.1.1 all risk and control related disclosure statements (in particular the annual governance statement), together with the head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;

7.1.1.2 the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of annual disclosure statements; and

7.1.1.3 the policies and arrangements for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reviews, reporting and self-certifications, including the NHS Constitution, the Trust's NHS provider licence, registration with the Care Quality Commission, and the Trust's constitution, standing orders and standing financial instructions and management of conflicts of interest.

7.2 ***Internal Audit***

7.2.1 The Committee will ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accounting Officer and Board. This will be achieved by:

7.2.1.1 considering the provision of the internal audit service and the costs involved;

7.2.1.2 reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in any risk assessment;

7.2.1.3 considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;

7.2.1.4 ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust; and

7.2.1.5 monitoring the effectiveness of internal audit and carrying out an annual review.

7.3 ***External Audit***

7.3.1 The Committee will review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

7.3.1.1 considering the appointment and performance of the external auditors, including providing information and recommendations to the council of governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the council of governors and the Committee;

7.3.1.2 discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan;

7.3.1.3 discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;

7.3.1.4 reviewing all external audit reports, including reports addressed to the Board and the council of governors, and any work undertaken outside the annual external audit plan, together with any significant findings and the appropriateness and implementation of management responses; and

7.3.1.5 ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.

7.4 ***Financial Reporting***

7.4.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.4.2 The Committee will ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.

7.4.3 The Committee will review the annual report and financial statements before these are presented to the Board in order to determine their completeness, objectivity, integrity and accuracy and will review the letter of representation addressed to the external auditors from the Board. This review will cover but is not limited to:

7.4.3.1 the annual governance statement and other disclosures relevant to the work of the Committee;

7.4.3.2 areas where judgment has been exercised;

7.4.3.3 appropriateness and adherence to accounting policies and practices, including whether accounts should be prepared on a 'going concern' basis;

7.4.3.4 explanation of estimates or provisions having material effect and significant variances;

7.4.3.5 the schedule of losses and special payments, which will also be reported on separately during the financial year;

7.4.3.6 any significant adjustments resulting from the audit and unadjusted audit differences; and

7.4.3.7 any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.4 The Committee will provide advice, where requested by the Board, on whether the annual report and accounts, taken as a whole, are fair, balanced and understandable, and provide the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy.

7.5 ***Counter Fraud***

7.5.1 The Committee will review the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud

Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service.

7.6 ***Raising Concerns/Freedom to Speak Up***

7.6.1 The Committee will review the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns and possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently with appropriate follow-up action and safeguards in place for those who raise concerns.

7.6.2 The Committee will ensure that the Trust's policy reflects the minimum standards for raising concerns set out by NHS ~~Improvement~~England and that the arrangements in place are regularly audited.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on:

8.2.1 the fitness for purpose of the board assurance framework;

8.2.2 the completeness and maturity of risk management in the Trust;

8.2.3 the integration of governance arrangements;

8.2.4 the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 The Trust's annual report will include a section describing the work of the Committee in discharging its responsibilities including:

8.3.1 the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;

8.3.2 an explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and

8.3.3 if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval in consultation with the council of governors.

10. References

~~10.1~~ National Health Service Act 2006
~~10.2~~ Code of Governance for NHS Provider Trusts
~~10.3~~ NHS Foundation Trust Annual Reporting Manual
~~10.4~~ National Audit Office Code of Audit Practice
~~10.5~~ Public Sector Internal Audit Standards
~~10.6~~ NHS Counter Fraud Authority's counter fraud standards

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~~10.7~~ NHS Improvement guidance on Freedom to Speak Up

Appendix A


Information and recommendations
Council of Governors
Board of Directors
Audit and Risk Committee
Finance, Investment and Cash Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee

Appendix B

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Key Assurance Responsibilities

The committee's key assurance responsibilities are:

Integrated governance, risk management and internal control	Reviewing whether effective systems of integrated governance, risk management and internal control are established and maintained across all Trust activities.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Committee Terms of Reference
Financial reporting	Monitoring the integrity of financial statements and formal financial announcements, including judgements, accounting policies, material estimates, losses and special payments, audit adjustments and unresolved audit issues.
	Reviewing the annual report and accounts before Board approval and advise whether they are fair balanced and understandable and that it is appropriate they be prepared on a going concern basis.
	Scrutinising risk and control disclosure statements, particularly the Annual Governance Statement.
Relevant Reports/Papers:	• Annual Report and Accounts • Accounting Policies and Management Judgements • Annual Report and Accounts Going Concern Assessment
Board Assurance Framework and Risk	Reviewing the fitness for purpose of the Trust's Board Assurance Framework and the maturity of risk management.
Relevant Reports/Papers:	• Trust Board Assurance Framework • Risk Strategy and Policy
Legal, regulatory and constitutional compliance	Reviewing arrangements for compliance with relevant legal, regulatory and code of conduct requirements, including the NHS Constitution, the Trust's provider licence, registration with the CQC, the Trust's constitution, standing financial instructions and management of conflicts of interest.
	Reviewing the effectiveness of the arrangements in place for allowing staff and contractors to raise (in confidence) concerns and possible improprieties in financial, clinical or safety matters.
	Reviewing the effectiveness of arrangements in place for counter fraud, anti-bribery and corruption.
Relevant Reports/Papers:	• Standards of Business Conduct Reports • Information Governance Updates • National Cost Collection Reports and Process • Waivers of Competitive Tendering Reports • Losses and Special Payments Reports • Treasury Management Reports and Policy • Cyber Security Reports • Fraud, Bribery and Corruption Annual Programme and Reports • Code of Governance for NHS Provider Trusts Compliance Self-Assessment
Internal Audit	Ensuring that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance.
Relevant Reports/Papers:	• Internal Audit Progress Reports • Annual Internal Audit Plan • Internal Audit Reports
External Audit	Reviewing and monitoring the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process.

Relevant Reports/Papers:	• External Audit Plan and Progress Reports • External Audit Report on the Trust's Accounts • Evaluation of the effectiveness of the External Auditor

Expected Assurance Outputs

The committee's expected assurance outputs are:

Integrated governance, risk management and internal control	Reporting concerns regarding the effectiveness of systems of integrated governance, risk management and internal control via the committee Chair.
Financial reporting	Providing the Board with assurance that accounting policies and judgements are appropriate.
	Recommendation to the Board that the annual report and accounts are fair, balanced and understandable and should be prepared on a going concern basis.
Board Assurance Framework and Risk	Reporting to the Board on the fitness for purpose of the Trust's Board Assurance Framework and the maturity of risk management.
Legal, regulatory and constitutional compliance	Reporting concerns regarding non-compliance with relevant legal, regulatory and code of conduct requirements via the committee Chair.
Internal Audit	Approving an annual internal audit plan and reporting any concerns arising from internal audits to the Board via the committee Chair.
External Audit	An annual assessment of the effectiveness of the Trust's external auditor.

Inter-Committee Relationships

The Quality Committee shall report to the Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality account and the appropriateness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

Risk Oversight Expectations

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

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.	Y
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	Y
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.	Y
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.	Y

Note: the Committee has responsibility for oversight of the Trust's risk management processes and frameworks and whilst it receives updates in respect of the risks set out above, oversight of the individual risks is carried out by the other Board committees.

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Audit and Risk Committee Terms of Reference	Version: ~~8~~9

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~10 March~~[12] November 2026
Responsible Committee:	Audit and Risk Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~March~~November 2027
Target audience:	Board of Directors, Audit and Risk Committee, NHS Regulators, Staff and Public
Key words:	Audit, Risk, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Appendix A – Finance, Investment and Cash Committee name change.~~Minor amendments to 1.3, 3.2, 3.3.6, 3.6, 4.1, 4.3, 6.1, 6.3, 7.1.1.3, 7.4.3, 7.6.2 and Appendix A. Addition of Appendix B
Consultation:	Council of Governors, Internal Audit, External Audit, Counter Fraud
Number of pages:	~~8~~11
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.6 Report to the Trust Board of Directors, 12 November 2026	
Title:	Finance, Investment and Cash Committee Terms of Reference
Sponsor:	David Liverseidge, Committee 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:

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference were last reviewed in September 2025 with a number of amendments to reflect the expanded remit of the committee vis a vis cash.

The most significant proposed change to the terms of reference is to introduce an Appendix C, which summarises the key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. The introduction of this additional Appendix is intended to address one of the recommendations from the Well-Led Review carried out by The Value Circle: "The Trust should undertake a targeted review of committee TORs to explicitly state assurance responsibilities, define expected assurance outputs using a consistent framework, strengthen alignment to strategic priorities, and clarify inter-committee relationships and risk oversight expectations." Similar appendices will be included in the terms of reference of the other Board committees.

The previous 7.3 has been updated to reflect the committee's role in terms of the Trust's savings and transformation programmes. Sections 7.5 and 7.6 have also been amended to reflect the committee's oversight of Digital and Estates, beyond annual plans in these areas. In addition, a new 1.3 has been inserted and there are amendments to 3.4 along with certain other minor updates to correct typographical errors, update references or provide clarity. There are also a number of proposed changes to update language to reflect current usage within the Trust.

At its meeting held on 2 November 2026, the Finance, Investment and Cash Committee agreed to the proposed changes to the terms of reference and to recommend their approval to the Board.

The Board is requested to approve the updated terms of reference.

Contents:

Terms of Reference

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Finance, Investment and Cash Committee Terms of Reference

Version: ~~11~~12

Date Issued:	~~7 October 2025~~[12] November 2026
Review Date:	~~October 2026~~November 2027
Document Type:	Committee Terms of Reference

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1. Role and Purpose

1.1 The Finance, Investment and Cash Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the stewardship of the Trust's finances, investments and sustainability of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including planning, financial performance, cash management, capital expenditure and the delivery of the ~~informatics~~digital and estates, facilities and capital development ~~annual~~ plans.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's financial position and capital and revenue investments to enable ~~world-class~~outstanding people to deliver ~~world-class~~outstanding care.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph ~~0~~7 below. A summary of the Committee's key assurance responsibilities, expected assurance outputs, inter-committee relationships, and risk oversight expectations can be found in Appendix C. In case of any conflict between Appendix C and the main body of these terms of reference, the main body of the terms of reference shall prevail.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 three non-executive directors of the Trust, at least two of whom should be independent, including the chair of the Audit and Risk Committee;

3.1.2 the Chief Executive Officer;

3.1.3 the Chief Financial Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). The Committee Chair will not be the chair of the Audit and Risk Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves (but not the chair of the Audit and Risk Committee) to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance/Deputy Director of Finance;

3.4.2 Director of Planning, Performance and Productivity; ~~and~~

3.4.3 Associate Director Always Improving; ~~.~~

~~3.4.3~~3.4.4 Associate Director of Corporate Affairs (**Company Secretary**).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee as observers.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors (one of whom must be either the Committee Chair or the chair of the Audit and Risk Committee) and either the Chief Financial Officer or Chief Operating Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the ~~secretary of the Committee~~Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The ~~secretary of the Committee~~Company Secretary (or a nominated deputy) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by

the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

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~~7. Duties and Responsibilities~~

~~The Committee will carry out the duties below for the Trust.~~

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Financial planning and performance***

7.1.1 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives, and consider the adequacy and effectiveness of any corrective action proposed:

7.1.1.1 the Trust's long-term financial model;

7.1.1.2 the Trust's long-term and annual financial plans encompassing income, expenditure and capital;

7.1.1.3 the capital plan including any changes in the Trust's performance that may impact on the delivery of the long-term capital plan;

7.1.1.4 financial performance and forecasts and projections including achievement of the control total and other targets;

7.1.1.5 performance against revenue budgets at both Trust and divisional level;

7.1.1.6 capacity, activity and productivity including any significant variation and the impact on income;

7.1.1.7 cash, liquidity and working capital;

7.1.1.8 the use of any working capital facilities; and

7.1.1.9 performance of the Trust's subsidiaries and any joint ventures against agreed performance indicators.

7.2 ***Cash Management***

7.2.1 The Committee shall review and monitor the Trust's overall cash position, including:

7.2.1.1 review of cash forecasts, the reasons for the Trust's cash position, and performance against cash key performance indicators;

7.2.1.2 reviewing and monitoring of the management of financial risk and the availability of cash to meet operational requirements;

7.2.1.3 ensuring that the Trust settles with its creditors in accordance with the Government's Better Payment Practice Code;

7.2.1.4 reviewing the level of funds owed to the Trust is minimised through effective credit control;

7.2.1.5 oversight of the cash impact of capital investments;

7.2.1.6 reviewing a monthly cash report from the Operational Cash Group. The terms of reference for the Operational Cash Group are set out in Appendix B;

7.2.1.7 reviewing the management of any surplus cash in line with the Trust's treasury management policy.

7.2.2 The Committee shall make recommendations to the Board in respect of applications for revenue public dividend capital from NHS England.

7.3 ***~~Always Improving Value for Money~~Transformation and Cost Improvement Programme***

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7.3.1 The Committee will ~~ensure~~ seek assurance that there is a~~n Always Improving: Value for Money (**AIVFM**) programme~~Cost Improvement Programme (**CIP**) in place each financial year that aligns with the Trust's annual plan.

7.3.2 The Committee will seek assurance that a recovery plan is in place and being implemented where any ~~AIVFM~~ CIP schemes are at risk of delivery.

~~7.3.2~~7.3.3 The Committee will seek assurance that there is a Transformation programme in place which aligns with the Trust's strategic objectives and will monitor delivery of this programme.

7.4 ***Investment***

7.4.1 The Committee will review business cases of £2.5 million or more in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.4.2 The Committee will review capital business cases over £5 million in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.4.3 The Committee will review all business cases identified by the Trust Executive Committee as being of significant strategic importance regardless of value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.4.4 The Committee will assess benefits realisation through post-implementation reviews, ensuring any learning is shared.

7.5 ***~~Informatics annual plan~~Digital***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's ~~annual plan for IT~~Digital plans including funding and ongoing alignment with the Trust's objectives, including alignment with the Trust's transformation programmes.

7.6 ***Estates, facilities and capital development ~~annual plan~~***

7.6.1 The Committee will monitor and oversee the delivery of the Trust's ~~estates~~Estates, ~~facilities~~ Facilities and ~~capital~~ Capital ~~development~~ Development ~~annual plan~~plans including funding and ongoing alignment with the Trust's objectives.

7.7 ***Risk***

7.7.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.7.2 The Committee will establish and maintain an overview of the Trust's financial risks and risks to delivery of the Trust's Transformation, ~~informatics~~ Digital or ~~estates~~Estates, ~~facilities~~ Facilities and ~~capital~~ Capital ~~development~~ Development plans and ensure the effectiveness and implementation of controls for financial risks and actions to mitigate risks to the delivery of the Trust's informatics or estates, facilities and capital development plans.

7.7.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.7.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.8 ***Reporting***

7.8.1 The Committee will review any key financial submissions to national bodies before these are presented to the Board for approval.

7.8.2 The Committee will review the National Cost Collection Index for the purposes of benchmarking the Trust's performance.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the financial statements and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

~~10.1~~ National Health Service Act 2006

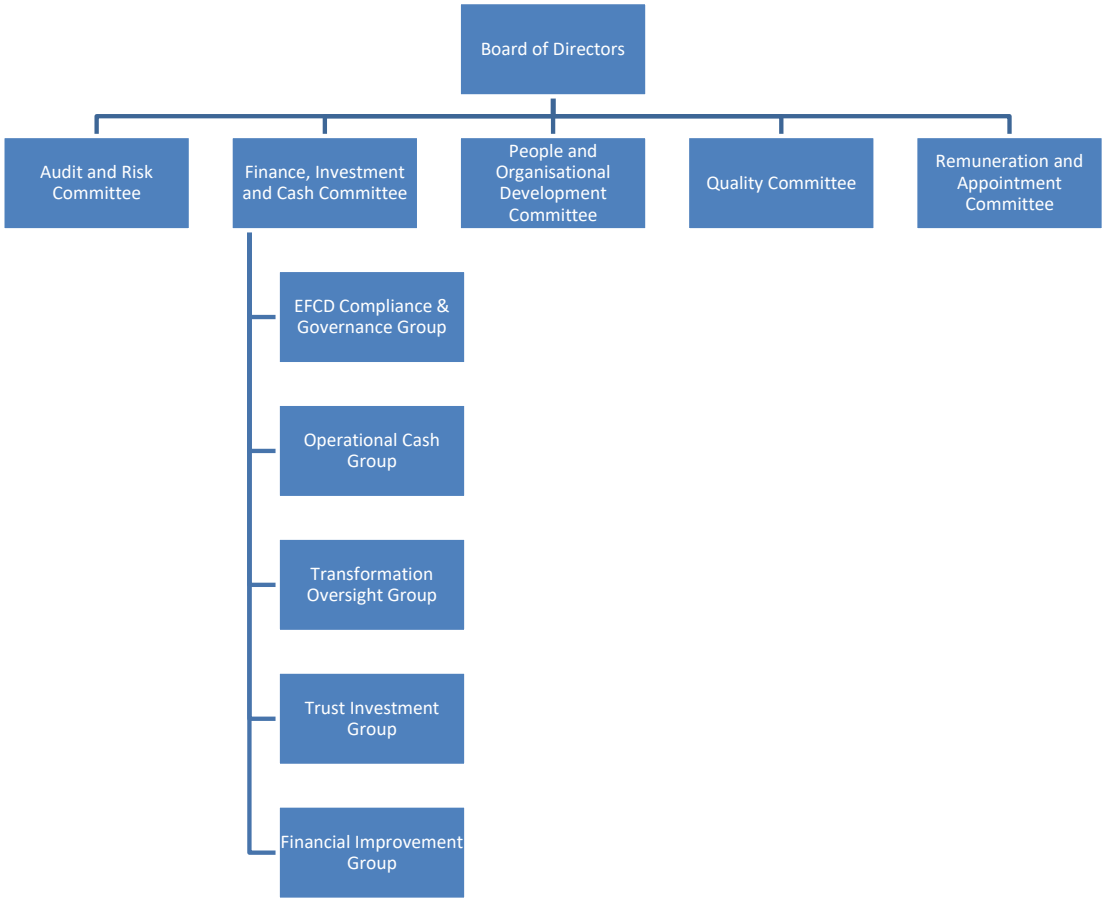
~~10.2~~ NHS ~~System~~ Oversight Framework

~~10.3~~ NHS Improvement and Care Quality Commission Use of Resources: assessment framework

~~10.4~~ Standing Financial Instructions

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Appendix A


Board of Directors
Audit and Risk Committee
Finance, Investment and Cash Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
EFCD Compliance & Governance Group
Operational Cash Group
Transformation Oversight Group
Trust Investment Group
Financial Improvement Group

Appendix B

Operational Cash Group Terms of Reference

1. Role and Purpose

1.1 The Operational Cash Group (the **Group**) is responsible for overseeing, monitoring and reviewing cash related matters for University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) as set out in more detail in paragraph 7.

2. Constitution

2.1 The Group has been established by the Finance, Investment and Cash Committee (the **Committee**). The Group has no executive powers other than those set out in these terms of reference.

2.2 The Group is authorised by the Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Group.

3. Membership

3.1 The members of the Group will be appointed by the Committee and will be:

3.1.1 the Director of Operational Finance;

3.1.2 the Associate Director of Operational Finance;

3.1.3 the Financial Services Manager; and

3.1.4 members of the finance team responsible for Accounts Receivable, Accounts Payable, Capital and Management Accounts (as required).

3.2 The Group shall be chaired by the Director of Operational Finance, or in his absence, by the Associate Director of Finance (the **Chair**).

3.3 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary.

4. Attendance and Quorum

4.1 The quorum for a meeting will be two members, including one of either the Director of Operational Finance or the Associate Director of Operational Finance. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Group.

4.2 When a member is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Group will meet weekly and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Group will be convened at the request of the Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Chair.

6.3 The Chair shall ensure that there is a record of the proceedings of all meetings of the Group, including recording the names of those present and in attendance and any declarations of interest.

7. Duties and Responsibilities

7.1 The Committee will carry out the duties below

7.1.1 reviewing the Trust's actual cash position against previous forecasts and the assumptions used;

7.1.2 reviewing the trend and change over time of cash balances;

7.1.3 identifying when cash pressures will arise and suggesting mitigating actions;

7.1.4 escalating actions to the Chief Financial Officer, where appropriate;

7.1.5 reviewing the cash impact and timing of investments;

7.1.6 reviewing the Trust's accounts receivable position, targeting timely payments to the Trust;

7.1.7 reviewing the Trust's accounts payable position and compliance with the Government's Better Payments Practice Code;

7.1.8 producing a monthly report to the Chief Financial Officer and Finance, Investment and Cash Committee;

7.1.9 reporting on performance against cash key performance indicators;

7.1.10 producing cash management plans for approval by the Chief Financial Officer.

8. Accountability and Reporting

8.1 The Group Chair will report to the Chief Financial Officer following each meeting, drawing his attention to any matters of significance or where actions or improvements are needed.

8.2 The Group Chair will report to the Finance, Investment and Cash Committee in accordance with the Committee's schedule of meetings.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Group will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Finance, Investment and Cash Committee for approval.

Appendix C

Key Assurance Responsibilities

The committee's key assurance responsibilities are:

Financial planning and performance	Reviewing whether the Trust's longer-term and annual financial and capital plans support the achievement of the Trust's objectives, and whether any corrective action proposed is adequate and effective.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Integrated Delivery Plan Reports • Finance Reports • Capital Programme Updates • Productivity, Cost Base and Benchmarking Reports • Budget Setting, Annual and Medium-Term Plans • UHS Pharmacy Limited Annual Assurance Report • Wessex Procurement Limited Performance Reviews • Reports from External Consultants • Reports from the external or internal auditors • Committee Terms of Reference
Cash Management	Reviewing and maintaining oversight of the Trust's overall cash position.
Relevant Reports/Papers:	• Cash Forecasts • Better Payment Practice Code
Transformation and Cost Improvement Programme	Reviewing the effectiveness of the Trust's Cost Improvement Programme and ensuring that the programme aligns with the Trust's annual financial plan.
	Reviewing the effectiveness of the Trust's Transformation programme in place and ensuring that the programme aligns with the Trust's strategic objectives.
Relevant Reports/Papers:	• Financial Improvement Updates • Transformation Programme Updates
Investment	Reviewing whether the outcomes and benefits are clearly defined in business cases and that these are measurable and support achievement of the Trust's objectives.
	Conducting post-implementation reviews to assess benefits realisation.
Relevant Reports/Papers:	• Business Cases • Standing Financial Instructions
Digital	Reviewing and overseeing the delivery of the Trust's plans for Digital funding to ensure that they align with the Trust's objectives.
Relevant Reports/Papers:	• UHS Digital Quarterly Reports
Estates	Reviewing and overseeing the delivery of the Trust's plans for Estates, Facilities and Capital Development to ensure that they align with the Trust's objectives.
Relevant Reports/Papers:	• Estates, Facilities and Capital Development Quarterly Reports • UHS Estates Limited Assurance Reports
Risk	Monitoring the Trust's financial risks and risks to the delivery of the Trust's digital or estates, facilities and capital development plans, and reviewing effectiveness of the controls and mitigations.
Relevant Reports/Papers	• Board Assurance Framework
Reporting	Reviewing key financial submissions prior to Board approval.
	Reviewing the National Cost Collection Index.

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Relevant Reports/Papers	• Annual and Medium-Term Plans • Productivity and Benchmarking Reports

Expected Assurance Outputs

The committee's expected assurance outputs are:

Financial planning and performance	Reporting on the Trust's progress against its annual and longer-term financial and capital plans.
	Reporting concerns in relation to the Trust's long-term and annual financial and capital plans via the Committee Chair.
Cash management	Reporting on the Trust's cash position and making recommendations to the Board in relation to any requirement to apply for additional cash support.
Transformation and Cost Improvement Programme	Reporting to the Board on the Trust's progress against its Cost Improvement Programme and Transformation programmes and highlighting any concerns in relation to delivery of these.
Investment	Making recommendations to the Board as to whether to approve business cases.
Digital	Making recommendations to the Board as to whether to approve proposed investments in Digital.
	Reporting concerns in relation to the Trust's Digital plans via the Committee Chair.
Estates	Making recommendations to the Board as to whether to approve proposed investments in Estates. Facilities and Capital Development.
	Reporting concerns in relation to the Trust's Estates, Facilities and Capital Development plans via the Committee Chair.
Risk	Reporting to the Board in respect of the effectiveness of the controls and mitigations in relation to the risks within the Committee's remit.
Reporting	Making recommendations to the Board in relation to financial submissions to national bodies.

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Inter-Committee Relationships

The chair of the Audit & Risk Committee shall be a member, but not chair, of the Finance, Investment and Cash Committee.

The Finance, Investment and Cash Committee shall report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the financial statements and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

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Risk Oversight Expectations

Board Assurance Framework Risk	Oversight
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.	N
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.	N
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.	N
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	N

portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	N
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.	N
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.	N
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.	N
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.	Y
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	Y
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.	Y
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.	N

Finance, Investment and Cash Committee Terms of Reference	Version: ~~11~~12

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~7 October 2025~~[12] November 2026
Responsible Committee:	Finance, Investment and Cash Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~October~~ November 202~~6~~7
Target audience:	Board of Directors, Finance, Investment and Cash Committee, Staff
Key words:	Finance, Investment, Cash, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Amendments to remit of Committee to include enhanced cash management role and renaming of Committee. Amendments to Appendix A. Addition of Operational Cash Group terms of reference in Appendix B~~Amendments to 1,3, 6, and 7. Addition of Appendix C.
Consultation:	Chief Financial Officer
Number of pages:	1~~4~~0
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.7 Report to the Trust Board of Directors, 12 November 2026	
Title:	People and Organisational Development Committee Terms of Reference
Sponsor:	Jane Harwood, Committee 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:

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference were last reviewed in September 2025 with the only amendment being to remove a reference to the Charitable Funds Committee.

The most significant proposed change to the terms of reference is to introduce an Appendix B, which summarises the key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. The introduction of this additional Appendix is intended to address one of the recommendations from the Well-Led Review carried out by The Value Circle: "The Trust should undertake a targeted review of committee TORs to explicitly state assurance responsibilities, define expected assurance outputs using a consistent framework, strengthen alignment to strategic priorities, and clarify inter-committee relationships and risk oversight expectations." Similar appendices will be included in the terms of reference of the other Board committees.

A new section 3.3 has been inserted to ensure that independent non-executive directors will always maintain a majority on the committee if the committee has to vote on a given matter. In addition, 3.4 has been updated to include a list of regular attendees. The previous 7.5 has been moved to 7.1.3 under the Culture section. To reflect the incorporation of Appendix B, a new 1.3 has been inserted and there are certain other minor updates to correct typographical errors, update references or provide clarity.

At its meeting held on 2 November 2026, the People and Organisational Development Committee agreed the proposed changes to the terms of reference and recommended their approval to the Board.

The Board is requested to approve the updated terms of reference.

Contents:

Terms of Reference

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

People and Organisational Development Committee Terms of Reference

Version: 8~~7~~

Date Issued:	~~9 September 2025~~[12] November 2026
Review Date:	~~August 2026~~November 2027
Document Type:	Committee Terms of Reference

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1. Role and Purpose

1.1 The People and Organisational Development Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the development and implementation of the people and organisational development strategies and operational plans for University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the three areas of culture, capacity, and capability and skills ~~and skills and the Trust's response to specific workforce issues arising from the coronavirus pandemic and the recovery of the organisation~~.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's culture, capacity, and capability and skills in support of the provision of ~~world-class~~outstanding care for all.

~~1.2~~1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below. A summary of the Committee's key assurance responsibilities, expected assurance outputs, inter-committee relationships, and risk oversight expectations can be found in Appendix B. In case of any conflict between Appendix B and the main body of these terms of reference, the main body of the terms of reference shall prevail.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least two non-executive directors of the Trust;

3.1.2 the Chief Executive;

3.1.3 the Chief Nursing Officer;

3.1.4 the Chief Medical Officer; and

3.1.5 the Chief People Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the non-executive director members present to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief People Officer and Chief Nursing Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.
~~3.2~~

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance/Deputy Director of Finance;

3.4.2 Deputy Chief People Officer;

3.4.3 Director of Education and Workforce;

3.4.4 Head of Workforce and Workforce Planning; and

3.4.5 Associate Director of Corporate Affairs (**Company Secretary**).

~~3.3~~3.5 Other individuals may be invited for one of more topics to be present depending on the nature of the agenda item.

~~3.4~~3.6 Governors may be invited to attend meetings of the Committee as observers.

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4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of two-thirds of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or ~~secretary~~ Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief People Officer or the Chief Nursing Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting, they should appoint a deputy to attend on their behalf. A deputy for an executive director will not count towards quoracy.

5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) and otherwise as required~~The Committee will meet at least six times each year and otherwise as required~~.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the ~~secretary of the Committee~~Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief People Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The ~~secretary of the Committee~~Company Secretary (or a nominated deputy) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust whilst making reference to the People Strategy and in particular the three pillars of Thrive, Excel and Belong

7.1 ***Culture***

7.1.1 The Committee will ensure that there are robust policies, systems and procedures for the development and monitoring of an inclusive culture with the Trust.

7.1.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.1.2.1 staff and team engagement;

7.1.2.2 compassionate and inclusive leadership;

7.1.2.3 quality improvement;

7.1.2.4 equality, diversity and inclusivity;

7.1.2.5 bullying and harassment;

7.1.2.6 staff sickness and wellbeing

7.1.2.7 Freedom to Speak Up and raising concerns; and

7.1.2.8 people aspects of the corporate and clinical strategy.~~; and~~

~~The Committee will also receive assurance on the organisation's compliance against the refreshed CQC quality statements that relate to culture, including equality diversity and inclusion.~~

~~7.1.2.8~~7.1.3

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7.2 ***Capacity***

7.2.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of workforce planning and recruitment and retention of staff.

7.2.2 The Committee may review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.2.2.1 strategic workforce planning;

7.2.2.2 recruitment and retention;

7.2.2.3 staffing levels;

7.2.2.4 reports from the Guardian of Safe Working Hours;

7.2.2.5 talent management;

7.2.2.6 reward including pensions;

7.2.2.7 Coverage, Quality, and ~~UIN~~Impact Networks (CQUINs);

7.2.2.8 bank and agency staff; and

7.2.2.9 volunteers.

7.3 ***Capability and Skills***

7.3.1 The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of staff appraisal and development.

7.3.2 The Committee will review and monitor the following ensuring these support the achievement of the Trust People Strategy and Trust's objectives. It will identify areas for action at a corporate and local level, ensuring follow up takes place:

7.3.2.1 appraisals;

7.3.2.2 education and training;

7.3.2.3 mandatory training;

7.3.2.4 gaps to meet the long-term corporate and clinical strategy;

7.3.2.5 the annual staff survey;

7.3.2.6 the 'fit and proper persons' requirements;

7.3.2.7 the Staff Friends and Family Test; and

7.3.2.8 flu vaccinations and other national vaccination programmes.

7.4 ***Risk***

7.4.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.4.2 The Committee will establish and maintain an overview of the Trust's people risks and ensure the effectiveness and implementation of controls for people risks and actions to mitigate these risks.

7.4.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.4.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

~~7.5 *CQC Quality Statements*~~

~~7.5.11.1.1 The Committee will also receive assurance on the organisation's compliance against the refreshed CQC quality statements that relate to culture, including equality diversity and inclusion.~~

~~7.6~~7.5 ***Reporting***

~~7.6.1~~7.5.1 The Committee will advise the Trust Board on the appropriate key performance indicators, measures and benchmarks in the three areas of culture, capacity and capability and skills.

~~7.6.2~~7.5.2 The Committee will ensure robust supporting data quality for any key performance indicators, measures and benchmarks within the areas of culture, capacity and capability and skills.

~~7.6.3~~7.5.3 The Committee will review any submissions to national bodies before these are presented to the Board for approval.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the staff report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive the minutes of those meetings and at least an Annual Report of their work.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

~~10.1~~ Employment Rights Act 1996

~~10.2~~ Equality Act 2010

~~10.3~~ Public Interest Disclosure Act 1998

~~10.4~~ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

~~10.5~~ NHS Constitution

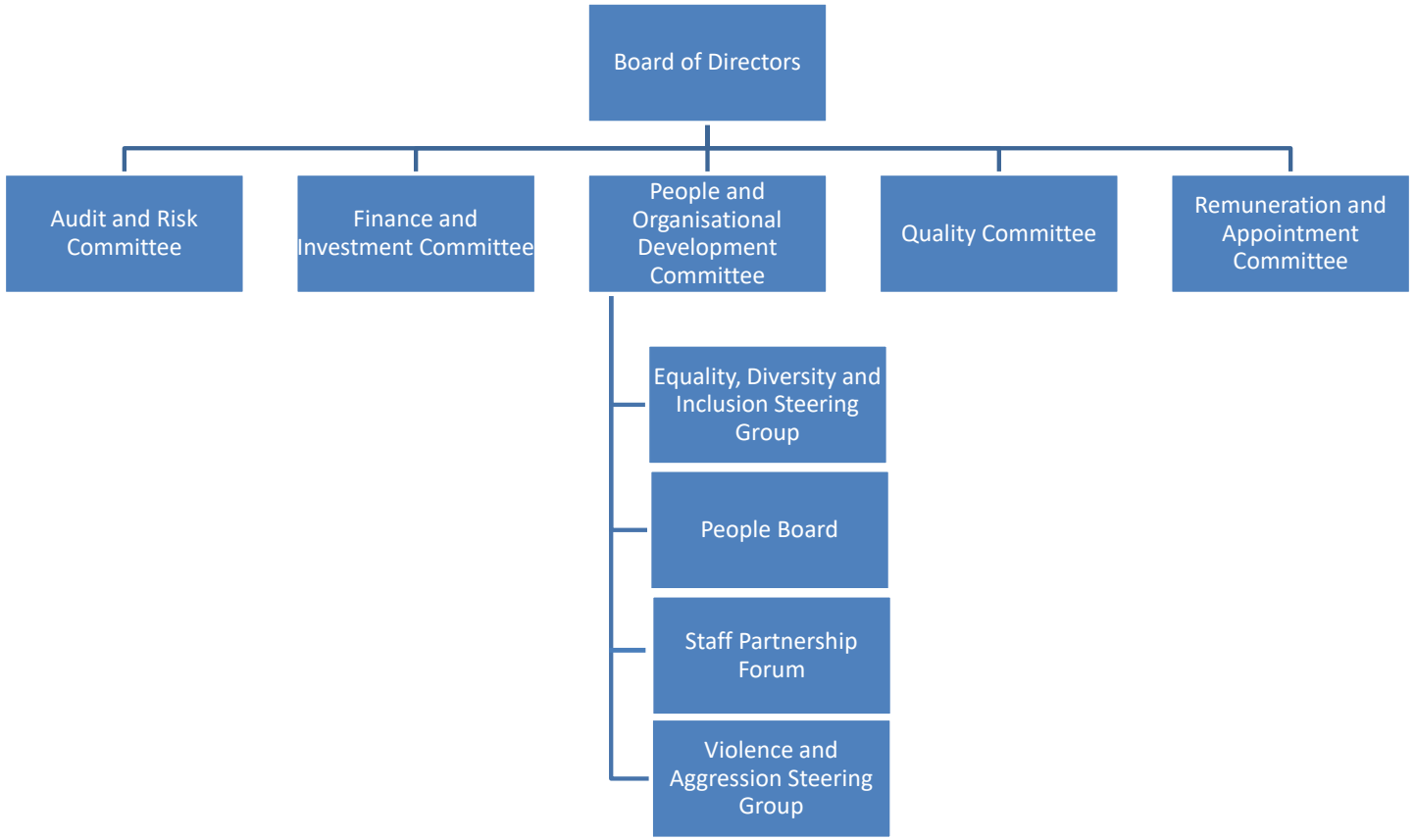
Terms and conditions of service for doctors and dentists in training (England) 2016 - December 2019

~~10.6~~ NHS England Staff Standards

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Appendix A


Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
Equality, Diversity and Inclusion Steering Group
People Board
Staff Partnership Forum
Violence and Aggression Steering Group

Appendix B

Key Assurance Responsibilities

The committee's key assurance responsibilities are:

Culture	Reviewing the effectiveness of policies, systems and procedures for the development of an inclusive culture within the Trust.
	Reviewing and monitoring key indicators of culture and ensuring that these support achievement of the Trust's strategy and objectives.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Committee Terms of Reference • People Reports • GMC National Training Survey Results • Staff Survey • NHS 10-Point Plan to Improve Resident Doctors' Working Lives updates • Employee Relations updates • People Priorities • Violence, Aggression and Abuse Policy • NHS England Staff Standards
Capacity	Reviewing the effectiveness of policies, systems and procedures for workforce planning, recruitment, and retention of staff.
	Reviewing and monitoring key workforce indicators and ensuring that these support achievement of the Trust's strategy and objectives.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Committee Terms of Reference • People Reports • Consultant Job Planning reports • Annual Workforce Plan • Medium-Term Plan
Capability and Skills	Reviewing the effectiveness of policies, systems and procedures for appraisal and development of staff.
	Reviewing and monitoring key education, training and staff development indicators and ensuring that these support achievement of the Trust's strategy and objectives.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Committee Terms of Reference • People Reports • People Priorities • GMC National Training Survey Results • Staff Survey
Risk	Monitoring the Trust's people risks and reviewing effectiveness of the controls and mitigations.
Relevant Reports/Papers:	• Board Assurance Framework
Reporting	Ensuring the robustness of data quality for any key performance indicators, measures and benchmarks within the areas of culture, capacity, and capability and skills.
	Reviewing any submissions to national bodies in respect of people-related matters before these are presented to Board for approval.
Relevant Reports/Papers:	• Committee Chair's Report to the Board • Committee Terms of Reference

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Expected Assurance Outputs

The committee's expected assurance outputs are:

Culture	Reporting on the Trust's performance against its key indicators of culture and progress against the Trust's strategy and objectives.
	Reporting concerns in relation to the Trust's culture, the key indicators, and the effectiveness of policies, systems and procedures via the Committee Chair.
Capacity	Reporting on the Trust's performance against its key workforce indicators and progress against the Trust's strategy and objectives.
	Reporting concerns in relation to the Trust's workforce and the effectiveness of policies, systems and procedures via the Committee Chair.
Capability and Skills	Reporting on the Trust's performance against its key education, training and staff development indicators and progress against the Trust's strategy and objectives.
	Reporting concerns in relation to the education, training and staff development, and the effectiveness of policies, systems and procedures via the Committee Chair.
Risk	Reporting to the Board in respect of the effectiveness of the controls and mitigations in relation to the risks within the Committee's remit.
Reporting	Reporting concerns in relation to data quality for any key performance indicators, measures and benchmarks.
	Recommending for approval any submissions to national bodies.

Inter-Committee Relationships

The People and Organisational Development Committee shall report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the staff report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

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Risk Oversight Expectations

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

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.	N
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.	N
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	N
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation,	N
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.	N

People and Organisational Development Committee Terms of Reference	Version: ~~7~~8

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~9 September 2025~~[12] November 2026
Responsible Committee:	People and Organisational Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~September 2026~~November 2027
Target audience:	Board of Directors, People and Organisational Development Committee, Staff
Key words:	People, OD, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Removal of Charitable Funds Committee, now defunct, from Appendix A~~Amendments to 1,2, 3, 4, 5, 6 and 7, addition of Appendix B.
Consultation:	Chief People Officer
Number of pages:	12~~8~~
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton
NHS Foundation Trust

Agenda Item 7.8 Report to the Trust Board of Directors, 12 November 2026	
Title:	Quality Committee Terms of Reference
Sponsor:	Tim Peachey, Committee 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:

The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference are approved by the Board of Directors.

The terms of reference were last reviewed in March 2026 with no amendments proposed.

The most significant proposed change to the terms of reference is to introduce an Appendix B, which summarises the key assurance responsibilities, expected assurance outputs, any formal inter-committee relationships, and risk oversight expectations. The introduction of this additional Appendix is intended to address one of the recommendations from the Well-Led Review carried out by The Value Circle: "The Trust should undertake a targeted review of committee TORs to explicitly state assurance responsibilities, define expected assurance outputs using a consistent framework, strengthen alignment to strategic priorities, and clarify inter-committee relationships and risk oversight expectations." Similar appendices will be included in the terms of reference of the other Board committees.

In addition, a new 1.3 has been inserted and there are amendments to 3.4 along with certain other minor updates to correct typographical errors, update references or provide clarity.

At its meeting held on 12 October 2026, the Quality Committee reviewed and agreed to the proposed changes to the terms of reference and to recommend the updated terms of reference to the Board for approval.

The Board is requested to approve the proposed changes to the terms of reference.

Contents:

Terms of Reference

Risk(s):

N/A

Equality Impact Consideration:	N/A

University Hospital Southampton NHS
NHS Foundation Trust

Quality Committee Terms of Reference	Version: 89
Date Issued:	~~10 March~~[12] November 2026
Review Date:	~~March~~November 2027
Document Type:	Terms of Reference

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1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below. A summary of the Committee's key assurance responsibilities, expected assurance outputs, inter-committee relationships, and risk oversight expectations can be found in Appendix B. In case of any conflict between Appendix B and the main body of these terms of reference, the main body of the terms of reference shall prevail.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and the other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 at least three independent non-executive directors of the Trust, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Deputy ~~Director of~~Chief Nursing ~~(Quality);~~Officer;

3.4.2 ~~Medical Lead~~Clinical Director for Patient Safety~~(~~;

3.4.3 Associate Director of Patient Experience;

3.4.4 Director of Midwifery;

3.4.5 Head of Clinical Quality Assurance;

3.4.6 Head of Patient Safety ~~Specialist);~~;

~~3.4.2~~3.4.7 Head of Medical Directorate; and

~~3.4.3 patient representative(s).~~

3.4.8 Associate Director of Corporate Affairs (**Company Secretary**).

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or ~~secretary of the Committee~~Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least eight times each year (at regular intervals throughout the year) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the ~~secretary of the Committee~~Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Nursing Officer and the Chief Medical Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 ~~The secretary of the Committee~~The Company Secretary (or a nominated deputy) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including patient safety incident investigations (PSII) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback ~~(including local Healthwatch)~~ on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive reports on Trust-wide clinical outcomes presented to clinical assurance meeting for effectiveness and outcomes (CAMEO) meetings including patient outcomes and compliance with the other aspects of clinical effectiveness activity.

7.3.3 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

~~7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.~~

~~7.5.4~~7.5.3 The Committee will seek to identify potential evidence and areas of health inequalities between different groups of people.

~~7.5.5~~7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

~~7.5.6~~7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

~~7.6~~ ***Risk***

~~7.6.1~~7.5.6 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

~~7.6.2~~7.5.7 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

~~7.6.3~~7.5.8 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

~~7.6.4~~7.5.9 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

~~7.7~~7.6 ***Reporting***

~~7.7.1~~7.6.1 The Committee will review the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

~~7.7.2~~7.6.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

8.1 The Committee Chair will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality accounts/quality report and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

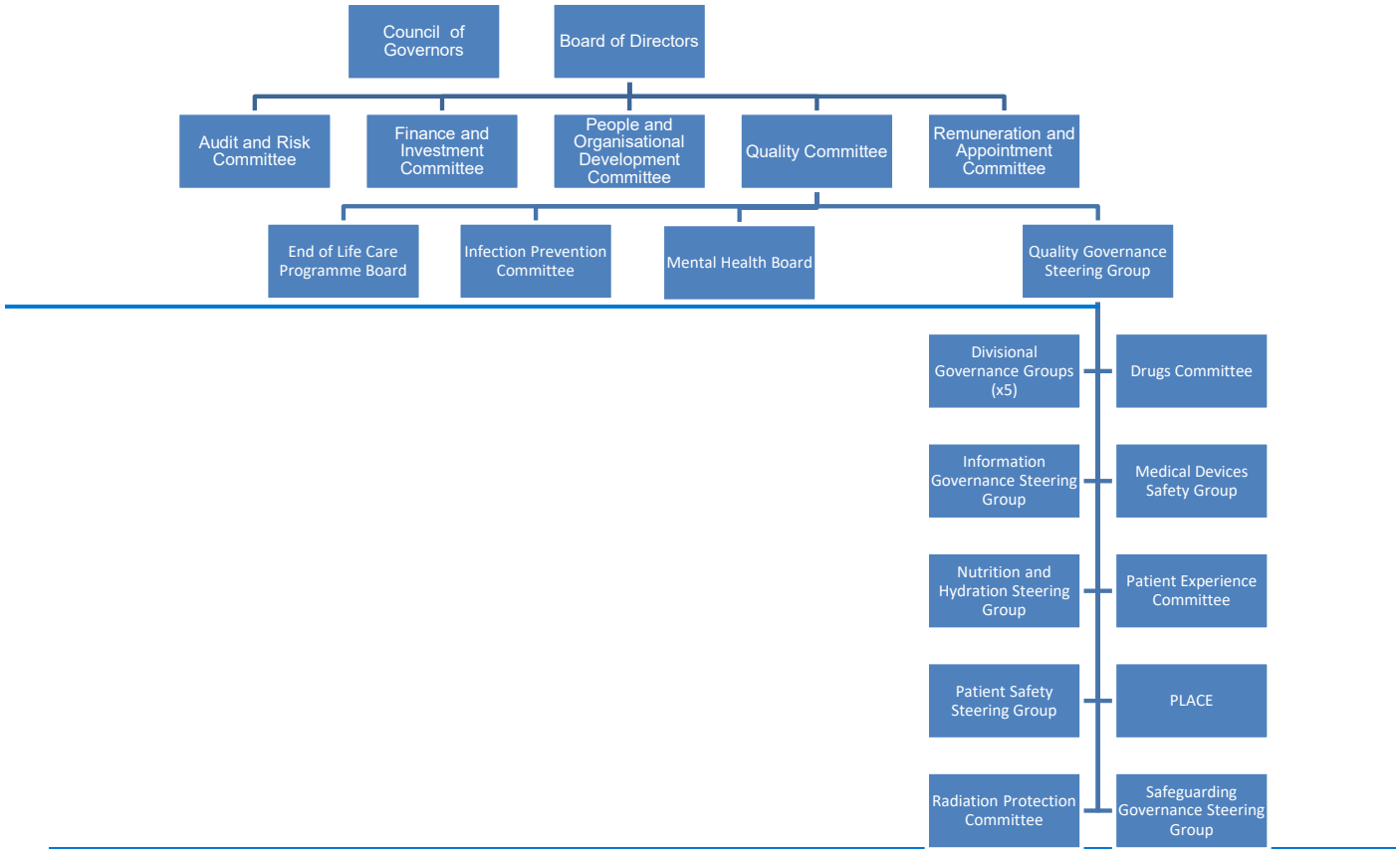
10. References

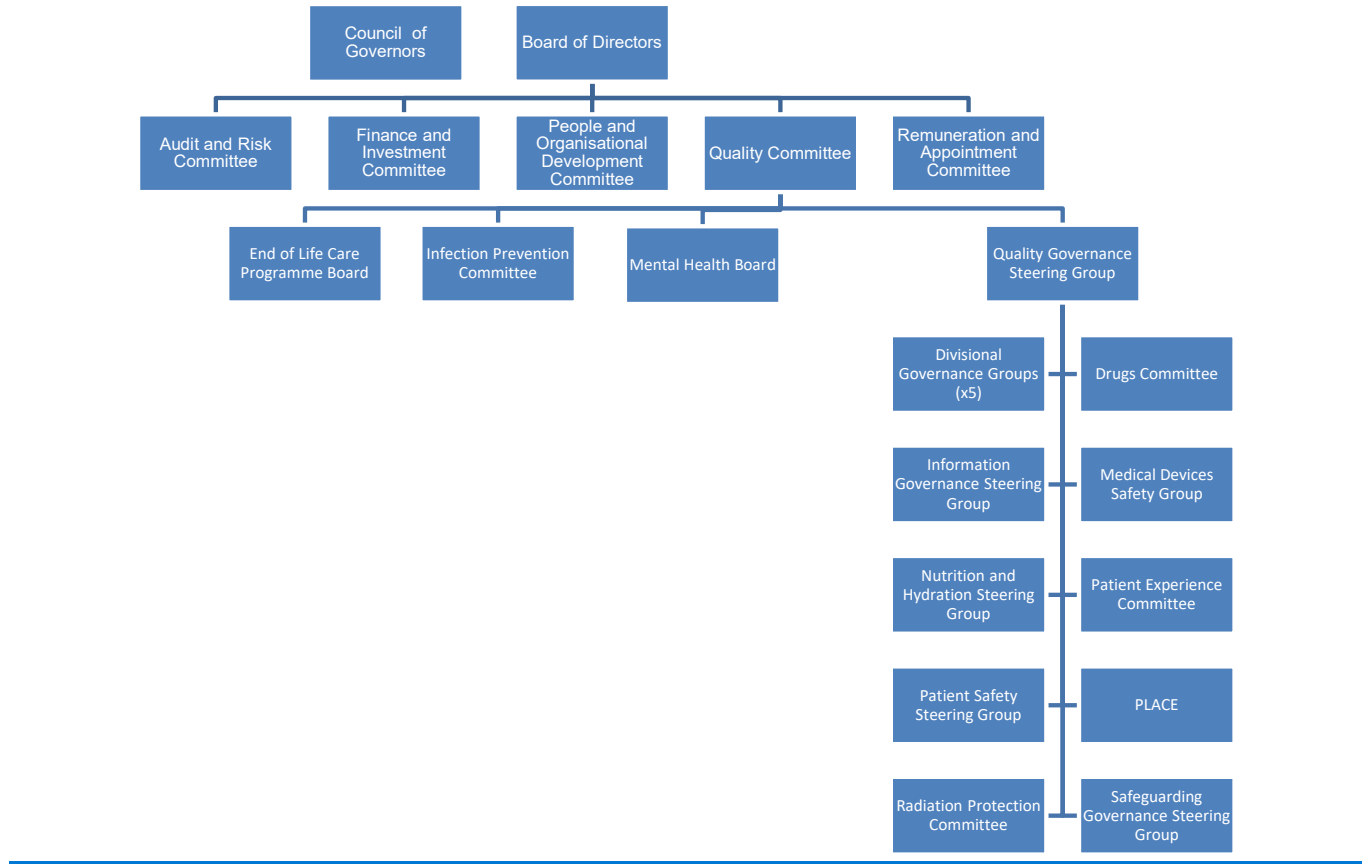
~~10.1~~ National Health Service Act 2006
~~10.2~~ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission
~~10.3~~ Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission
~~10.4~~ Health Act 2009
~~10.5~~ National Health Service (Quality Accounts) Regulations 2010
~~10.6~~ Code of Governance for NHS Provider Trusts
~~10.7~~ NHS System Oversight Framework
~~10.8~~ NHS Foundation Trust Annual Reporting Manual
~~10.9~~ NHS England and NHS Improvement's requirements for quality accounts

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Appendix A


Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group


Council of Governors
Board of Directors
Audit and Risk Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
End of Life Care Programme Board
Infection Prevention Committee
Mental Health Board
Quality Governance Steering Group
Divisional Governance Groups (x5)
Drugs Committee
Information Governance Steering Group
Medical Devices Safety Group
Nutrition and Hydration Steering Group
Patient Experience Committee
Patient Safety Steering Group
PLACE
Radiation Protection Committee
Safeguarding Governance Steering Group

Appendix B

Key Assurance Responsibilities

The committee's key assurance responsibilities are:

Clinical governance	Overseeing the systems, controls and risk management arrangements supporting safe, high-quality, patient-centred care.
Relevant Reports/Papers:	• Messages from the Quality Governance Steering Group • Board Assurance Framework • Fundamentals of Care Reports • Mental Health Reports • NatSSIPS Reports • Infection Prevention and Control Annual Report • Consultant Job Planning Reports • Committee Chair's Report to Board • Committee Terms of Reference
Patient safety	Reviewing themes and trends from adverse incidents, never events, complaints, claims, and inquests.
	Obtaining assurance on safeguarding systems and considering internal audit findings relating to quality and safety.
Relevant Reports/Papers:	• Maternity and Neonatal Safety Reports • Maternity and Neonatal Workforce Reports • Patient Safety Reports • Safeguarding Annual Report • Medicines Safety Annual Report
Patient Experience	Reviewing reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service, and other sources of feedback on all formal and informal patient feedback.
Relevant Reports/Papers:	• Experience of Care Reports • Learning from Deaths Reports • Annual Complaints Report
Clinical outcomes and effectiveness	Reviewing the annual clinical audit programme and monitoring its delivery.
	Overseeing Trust-wide outcomes and national audit findings.
Relevant Reports/Papers:	• Annual Clinical Audit Programme • Audit Findings Reports • Clinical Effectiveness Outcomes Reports
Performance and data quality	Advising on quality and safety indicators, benchmarks and supporting data quality.
	Identifying potential evidence and areas of health inequalities and seeking assurance that these are being addressed.
	Seeking assurance that improvement targets are supported by achievable action plans.
Relevant Reports/Papers:	• Quality Indicators Updates • Quality Priorities
Regulatory and compliance	Reviewing the Quality Account and other key non-financial governance submissions before Board approval.
	Reviewing CQC reports, compliance with fundamental standards and delivery of actions arising from regulatory findings.
Relevant Reports/Papers:	• Quality Account • CQC Reports and Action Plans

Expected Assurance Outputs

The committee's expected assurance outputs are:

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Clinical governance	Reporting concerns regarding the systems, controls and risk management arrangements supporting safe, high-quality, patient-centred care via the Committee Chair.
Patient safety	Reporting on themes and trends from adverse incidents, never events, complaints, claims, and inquests and escalating concerns to the Board as appropriate.
	Providing the Board with assurance on safeguarding systems and reporting internal audit findings relating to quality and safety as appropriate.
Patient Experience	Reporting feedback from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service, and other sources and escalating concerns as appropriate.
Clinical outcomes and effectiveness	Providing the Board with assurance regarding the annual clinical audit programme and reporting any concerns arising from clinical audits as appropriate.
Performance and data quality	Providing the Board with assurance in relation to reported quality and safety indicators, benchmarks and supporting data quality.
	Providing the Board with assurance in relation to the Trust's activities to identify and address health inequalities.
	Providing the Board with assurance that improvement targets are supported by achievable action plans.
Regulatory and compliance	Recommending that the Quality Account and other key non-financial governance submissions be approved.
	Reviewing CQC reports, compliance with fundamental standards and delivery of actions arising from regulatory findings and escalating matters to the Board as appropriate.

Inter-Committee Relationships

The Committee shall report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the quality account and the appropriateness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

Risk Oversight Expectations

Board Assurance Framework Risk	**Oversight**
Outstanding patient outcomes, safety and experience	
1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.	Y
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.	Y
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.	Y
Pioneering research and innovation	
2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.	N
World class people	
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	N
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.	N
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.	N

Integrated networks and collaboration	
4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.	Y
Foundations for the future	
5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.	N
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	N
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.	N
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.	N

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	10 March 2026
Responsible Committee:	Quality Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	March 2027
Target audience:	Board of Directors, Quality Committee, NHS Regulators, Staff
Key words:	Quality, Governance, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~No changes~~ Amendments to 3.4, 4, 6, 7.2, 7.5 and addition of 1.3 and Appendix B. Deletion of 7.5.3.
Consultation:	Chief Nursing Officer
Number of pages:	~~8~~11
Type of document:	Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

Agenda Item 10.1	Report to the Trust Board of Directors, 12 November 2026
Title:	South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 2 Performance Report
Sponsor:	Freya Pearson, 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 impact stories and 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 two quarters of the 2026/27 financial year.

- Research Impact Stories: Regional achievements include an NIHR20 Impact Prize awarded to University Hospital Southampton for co-leading the global HARMONIE study that reduced infant respiratory syncytial virus hospitalisations by 83%, alongside a trial participant in Slough whose chronic liver disease progression was halted through an innovative therapeutic study.
- Lower Recruitment & Remedial Plan: While recruitment fell below average to 22,244 participants (6% of the national total) due to the planned completion of large observational studies across England, delivery teams contributed to 2,176 ongoing studies and are supporting a regional plan to increase recruitment.
- Complexity Weighted Recruitment: South Central organisations delivered 1.54 million complexity weighted recruits (7.6% of England's weighted activity; closely matching the region's 7.8% population share), which will support the region's performance under the current national funding model.
- Commercial Trial Delivery: SC RRDN ranked third nationally for commercial recruitment with 1,479 participants recruited across 174 studies, representing 9.8% of England's total commercial recruitment.
- Portfolio Size & Balance: The region had the 5th highest number of recruiting studies of the 12 English regions, with higher-intensity interventional trials expanding to 43% of the portfolio to deliver novel clinical treatments across all specialities.
- Study Setup Improvements: Set-up efficiency in the region improved across national metrics; however, performance remains below the average across all regions.
- Participant Experience: Feedback from 989 adult respondents remained highly positive, with 97.4% reporting being treated with courtesy and respect and 94.3% rating their overall research experience positively.

Contents:

South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 2 Performance Report, Appendix 1 - South Central RRDN Risk Register, Appendix 2 - Glossary.

Risk(s):

1b, 2a (for full details, please see the SC RRDN risk register in Appendix 1)

Equality Impact Consideration:	N/A

1

University Hospital Southampton
NHS Foundation Trust

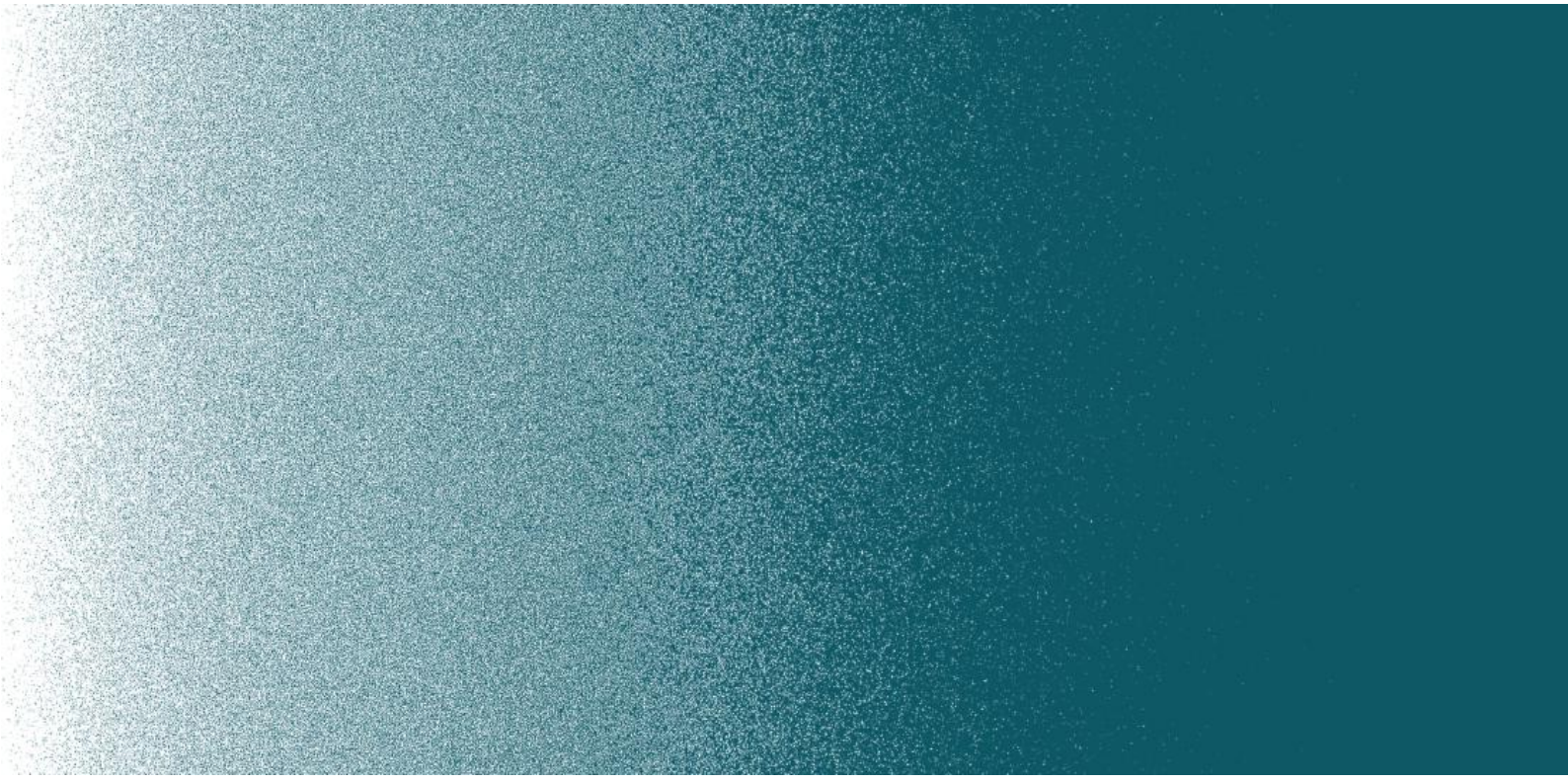
NIHR | Research Delivery Network

South Central Regional Research Delivery Network (SC RRDN) 2026-27 Quarter 2 Performance Report

Graham Halls, Data and Analytics Senior Manager

Clare Rook, Network Director

November 2026



Introduction

In addition to providing the Board with key impact stories, this report informs the Board about health and care research activity within the National Institute for Health and Care Research (NIHR) South Central Regional Research Delivery Network (SC RRDN) during the first two quarters of the 2026/27 financial year (1 April 2026 to 30 September 2026). It primarily presents performance against the measures included in the Research Delivery Network (RDN) funding models, which were implemented in 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. Its primary purposes are to support the successful delivery of research as an active partner in the system and 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 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 the historical allocation (50%), activity-based funding combining recruitment and complexity-weighted recruitment (30%), and other performance elements (20%).
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 that deliver research in care homes, GP practices, pharmacies, schools and other community locations

access this funding through 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%) reduction for the South Central region in 2026/27.

Impact of research in the South Central region

"I've not looked back since." - Lorna's life-changing choice to take part in research

A retired dental practice manager from Berkshire speaks about taking part in research. By joining a clinical trial, Lorna successfully halted her silent liver disease and eradicated her worry.

In 2008, Lorna was diagnosed with primary biliary cholangitis (PBC), a chronic autoimmune liver condition, following a routine blood test.

Lorna, 72, from Slough, said: "Although I didn't have any symptoms, I've since discovered that the disease can lead to overwhelming exhaustion that sleep cannot fix and a relentless skin itch caused by toxins leaking into the blood. It was scary that if left untreated, it could have led to liver failure."



Figure 1 – Lorna and family

It is often called a silent condition because the immune system slowly damages the liver's tiny bile ducts long before a patient feels ill. When bile cannot flow out of the liver normally, it accumulates

and acts as a toxin, causing inflammation that eventually leads to irreversible scarring. Lorna was prescribed the standard medication, ursodeoxycholic acid. But she said: “The initial medication didn't change anything, and my blood levels were showing that it was not getting any better; it was getting worse. I was so worried as I was hopeful the standard medication would be enough.”

In 2021, her consultant suggested she take part in a clinical trial. The trial was evaluating a new medication designed to reduce liver inflammation and bile acid build-up. Lorna, a grandmother-of-three, said: “I was dubious because I don't take drugs easily but the blood levels were just getting higher and higher, so I thought, ‘I’ve got to do something’. There was the unknown of what would have happened to my liver if I hadn't gone on it. I was thinking it’s going to give up altogether.”

She therefore decided to take part in the 6 year long trial. For Lorna, taking part involves taking a single tablet daily at home. She also attends hospital every 6 months, so the research team can monitor and take blood tests. She also has regular liver scans.

“In the first year of the trial my blood tests showed that my liver markers were improving and the peace of mind I felt was immense. It has continued to improve to now being told I have a healthy liver. It was definitely the right decision to take part. I’ve not looked back since. I am full of admiration for the staff. The doctor and wonderful nurse who takes my blood every 6 months now are so lovely and kind; they watch over me. I am so looked after; it has been absolutely life-changing. Now, I'm sort of a different person; when I first found out I had PBC I was so worried about my liver failing, but now that worry has been taken away. I would recommend people to give these trials a go wholeheartedly. For me, it's been absolutely wonderful and quite honestly one of the best decisions I have made.”

NIHR20 Impact Prize recognises study for protecting millions of babies worldwide

An international study co-led by University Hospital Southampton has been awarded an NIHR20 Impact Prize.

The national honour recognises how the HARMONIE trial has transformed protection against a common virus for babies around the world. Respiratory Syncytial Virus (RSV) is one of the leading reasons babies are admitted to hospital. The study has helped change policy and clinical practice globally. More than 11 million children have now received the winter jab and the treatment is approved in more than 50 countries.

Before the HARMONIE trial, preventative options were limited, costly and available only to a small number of babies at highest risk. The trial provided the first large-scale, real-world evidence that a single-dose immunisation could protect healthy babies throughout the RSV season. The study was co-led by experts at UHS, the University of Southampton, St George's University Hospital and University of Nottingham Health Service.

Researchers and delivery teams from the NIHR Clinical Research Facility: Southampton and NIHR Biomedical Research Centre: Southampton played a leading role in the design and delivery of the study.



Figure 2 - NIHR20 Impact Prize awards ceremony

This is one of 11 NIHR20 Impact Prizes to mark the 20th anniversary of the National Institute for Health and Care Research (NIHR). They celebrate researchers and teams whose work has improved health and care outcomes across the UK and internationally.

Professor Saul Faust, Director of the NIHR Clinical Research Facility: Southampton and co-lead investigator for the HARMONIE trial, said: "This award recognises the dedication of an extraordinary team effort. HARMONIE brought together multiple parts of the NIHR research infrastructure to work alongside NHS organisations, academic partners and industry collaborators to design and deliver a large, pragmatic trial at unprecedented speed and scale. Seeing this research translate into policy

change and protection for millions of babies around the world is an achievement shared by everyone involved."

The study recruited more than 8,000 babies across the UK, France and Germany. This included over 4,000 babies through the NIHR Clinical Research Network. The research demonstrated that a single dose of the long-acting antibody nirsevimab can reduce RSV-related hospitalisations in infants by 83%. The findings from HARMONIE have already informed RSV immunisation programmes internationally. Last winter, the NHS rolled out nirsevimab to thousands of babies born before 32 weeks.

Mr Paul Grundy, previously the Chief Medical Officer at University Hospital Southampton, said: "Research matters because of the difference it makes to patients, families and healthcare systems. We are proud that research led from Southampton is making such a significant difference to lives around the world. We are also incredibly grateful to the thousands of families who chose to take part in the study. Their contribution has helped generate evidence that is now influencing healthcare policy internationally, reducing serious illness in babies and helping to ease pressure on health services."

Professor Lucy Chappell, Chief Executive Officer of the NIHR and Chief Scientific Adviser to the Department of Health and Social Care, said: "I offer my warmest congratulations to all the excellent winners and commended teams of this year's NIHR Impact Prizes, who have all made a crucial contribution to changing lives through research."

Overview of research activity in the South Central region

Recruitment in South Central

In the first two quarters of the 2026/27 financial year organisations in the region recruited **22,244 participants** to **833 studies** at **143 research locations** and across **all main clinical specialties**. During this period, the region's organisations recruited **6% of the total participants in England**, compared to 7.8% of the English population. Delivery organisations in the region have supported the identification of participants, data collection and other follow up activities on **2,176 studies**.

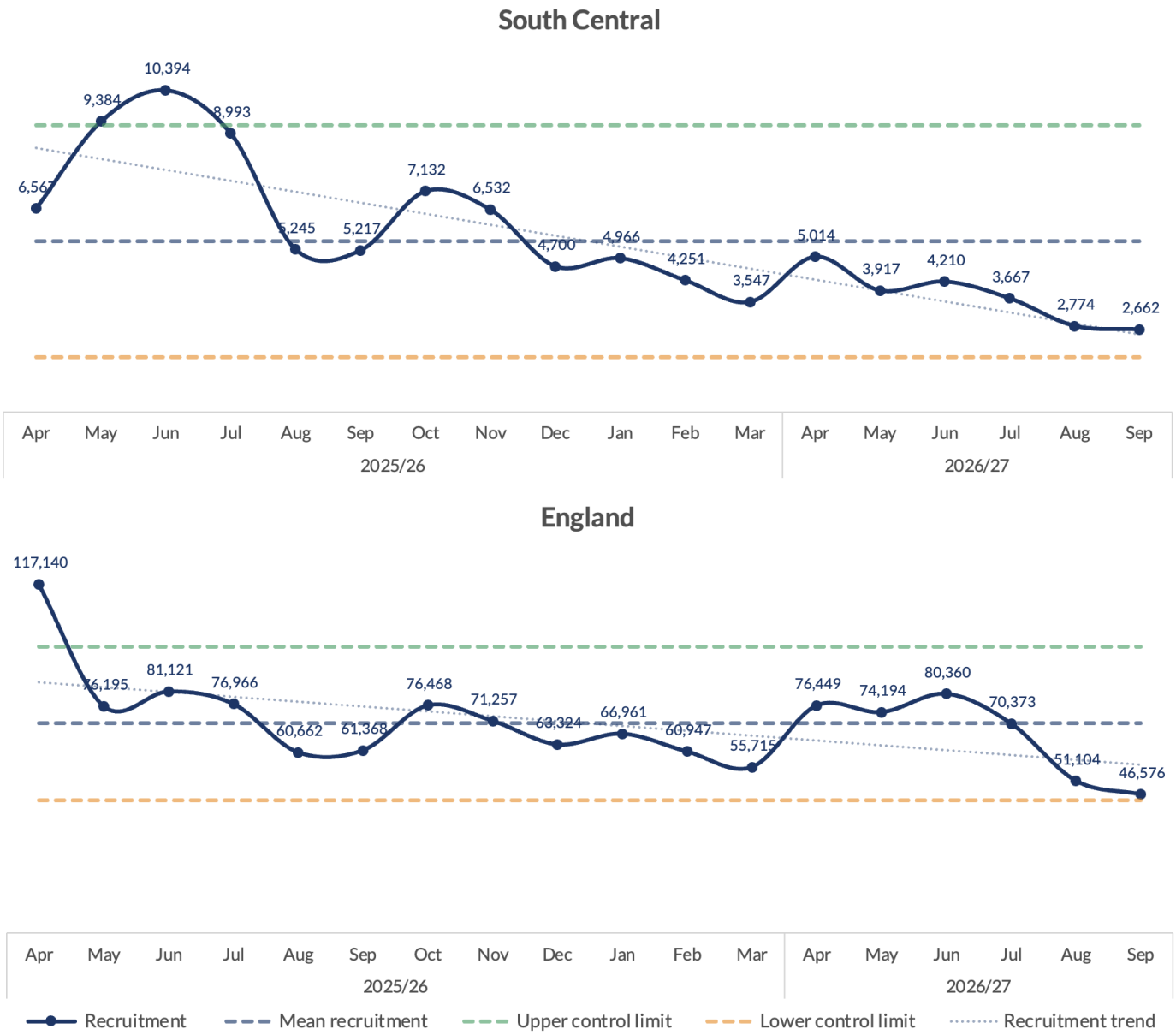


Figure 3 - Monthly recruitment in the South Central region benchmarked against England since April 2025

When recruitment is assessed using a statistical process control methodology to track performance and variability over time (Figure 3), South Central has maintained a continuous ten-month period below the average recruitment. Recruitment has also fallen recently across the whole of England.

This downward trend in recruitment is primarily due to variability in the national NIHR RDN Portfolio of research studies. Studies that are comparatively simpler to deliver are opening and recruiting relatively quickly, causing peaks in activity followed by drops when they finish recruiting. More recently, studies delivered in South Central have had smaller recruitment targets and have been more resource intensive. This has coincided with the closure to recruitment of the larger-scale

studies that were open earlier in the period. Ongoing support for more than 2,100 studies, including participant visits and associated data collection, also affects the ability to screen and recruit new participants.

To begin to address the reduction in recruitment, SC RRDN updated a regional recruitment action plan for this financial year to align with national health priorities, including preventative medicine, early diagnostics and under-served populations. RRDN teams are working with delivery organisation leadership to review these plans during business planning meetings and other regular meetings.

In the short to medium term, RRDN actions have included:

- Identifying studies that are currently paused to recruitment with the potential to re-open.
- Looking for opportunities for organisations to act as participant identification centres (PICs) to refer potential participants to delivery organisations that are already open to recruitment.
- Working with specialty and settings leads to identify studies that are likely less complex to deliver.
- Targeting studies that are already open, behind on their recruitment expected timelines and due to close within one year.
- Promoting the Associate Principal Investigator Scheme as a way to develop new researchers and also support the recruitment and delivery of existing studies.
- Working with regional sponsors to register their studies with Be Part of Research, a research volunteer registry where people can express their interest in taking part.

Future RRDN actions will include:

- Identifying the largest studies that are open to new research locations on the NIHR RDN Portfolio and sharing this intelligence with South Central delivery organisations.
- Building into the early costing review a check for studies that may meet the national health priorities and have high potential for enrolling participants.
- Meeting with the region's Clinical Trials Units to strengthen the RRDN's relationship and gather intelligence on the upcoming research pipeline.
- Understanding the reasons for any reluctance to register studies on the NIHR RDN Portfolio.

For reference, quarterly recruitment at delivery organisations within South Central is provided in Figure 4.

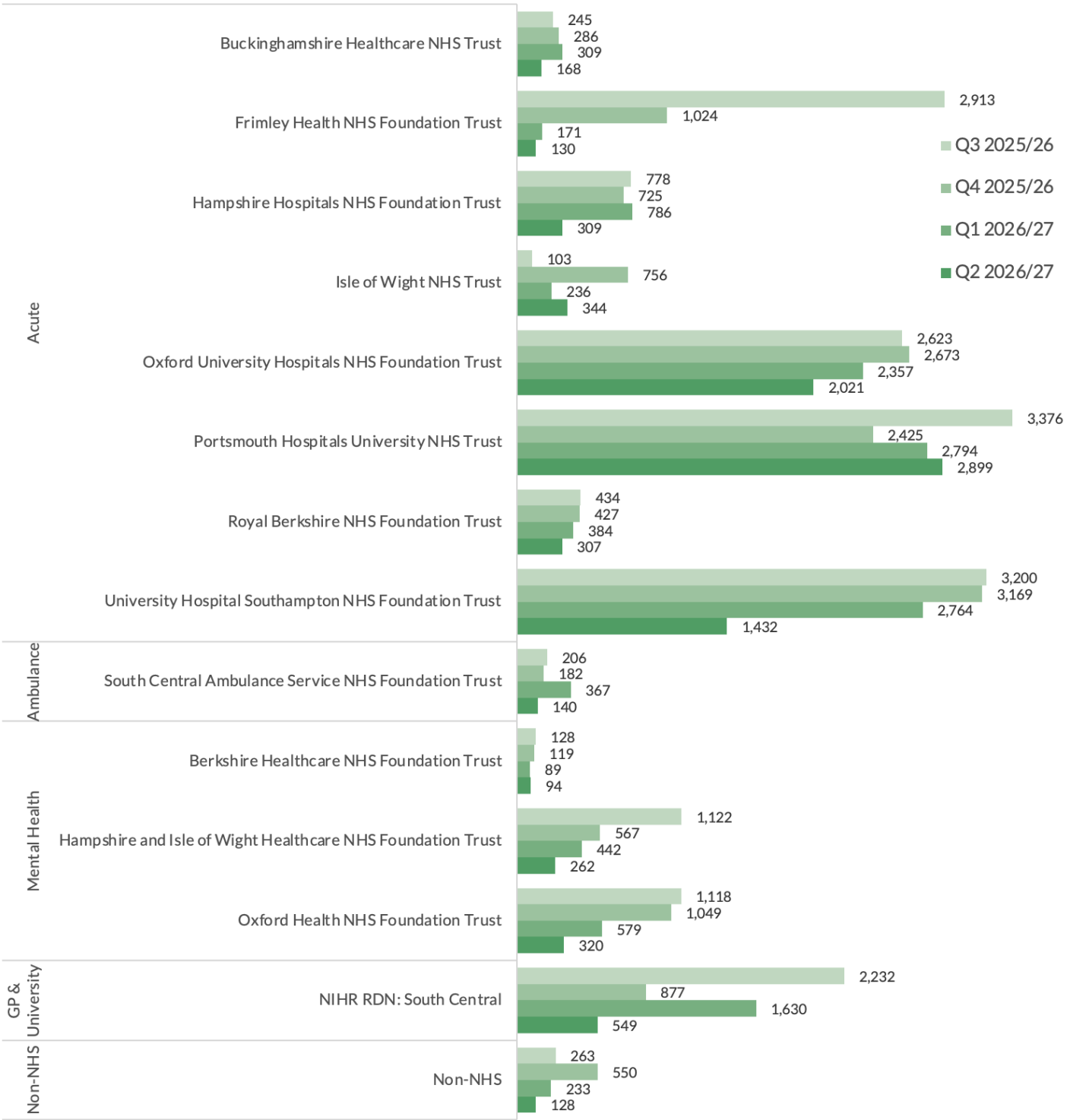


Figure 4 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

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

10

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)**. To account for these operational variations, the RDN uses CWR to establish a normalised measure of delivery activity across regions. The weighting for recruitment in different study types has been updated for the 2026/27 funding model and 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 eighteen-month period from April 2025 to September 2026, monthly CWR across the South Central region had a downward trend (Figure 5). Across the first half of the 2026/27 financial year, South Central delivered 1.54 million CWRs, representing 7.6% of the national total. This rose from 7.1% of England's weighted activity in the first quarter to 8.2% in the second quarter, exceeding the region's 7.8% population share. Weighted activity across both South Central and England moved below historical averages in the second quarter while remaining within the expected variation limits throughout. Under the hospital funding model, the impact of reduced recruitment by the region's delivery organisations is likely to be offset to some extent by this increased share of English CWR.

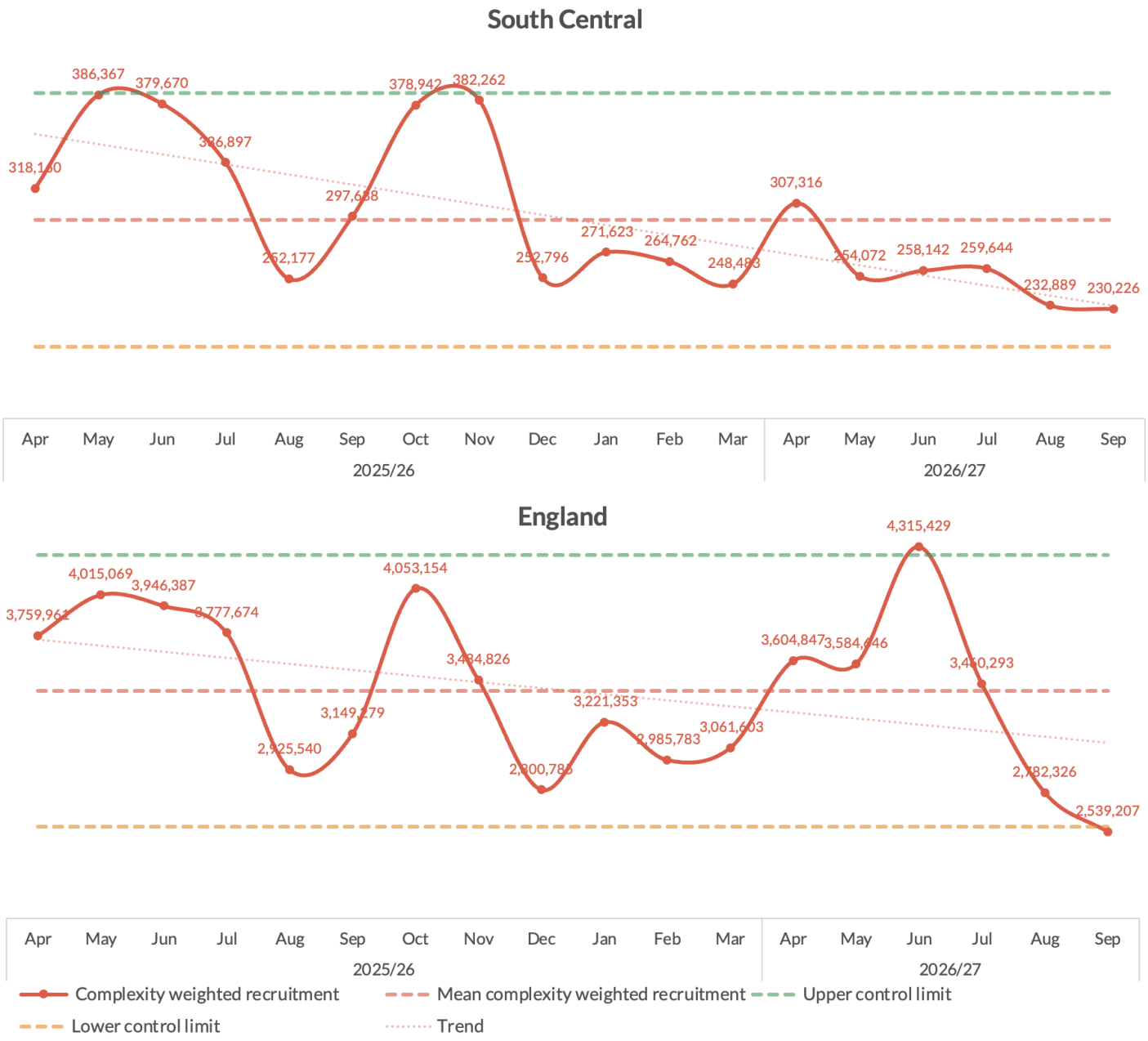


Figure 5 – Monthly complexity weighted recruitment in the South Central region benchmarked against England since April 2025

For reference, quarterly CWR at delivery organisations within South Central is provided in Figure 6.

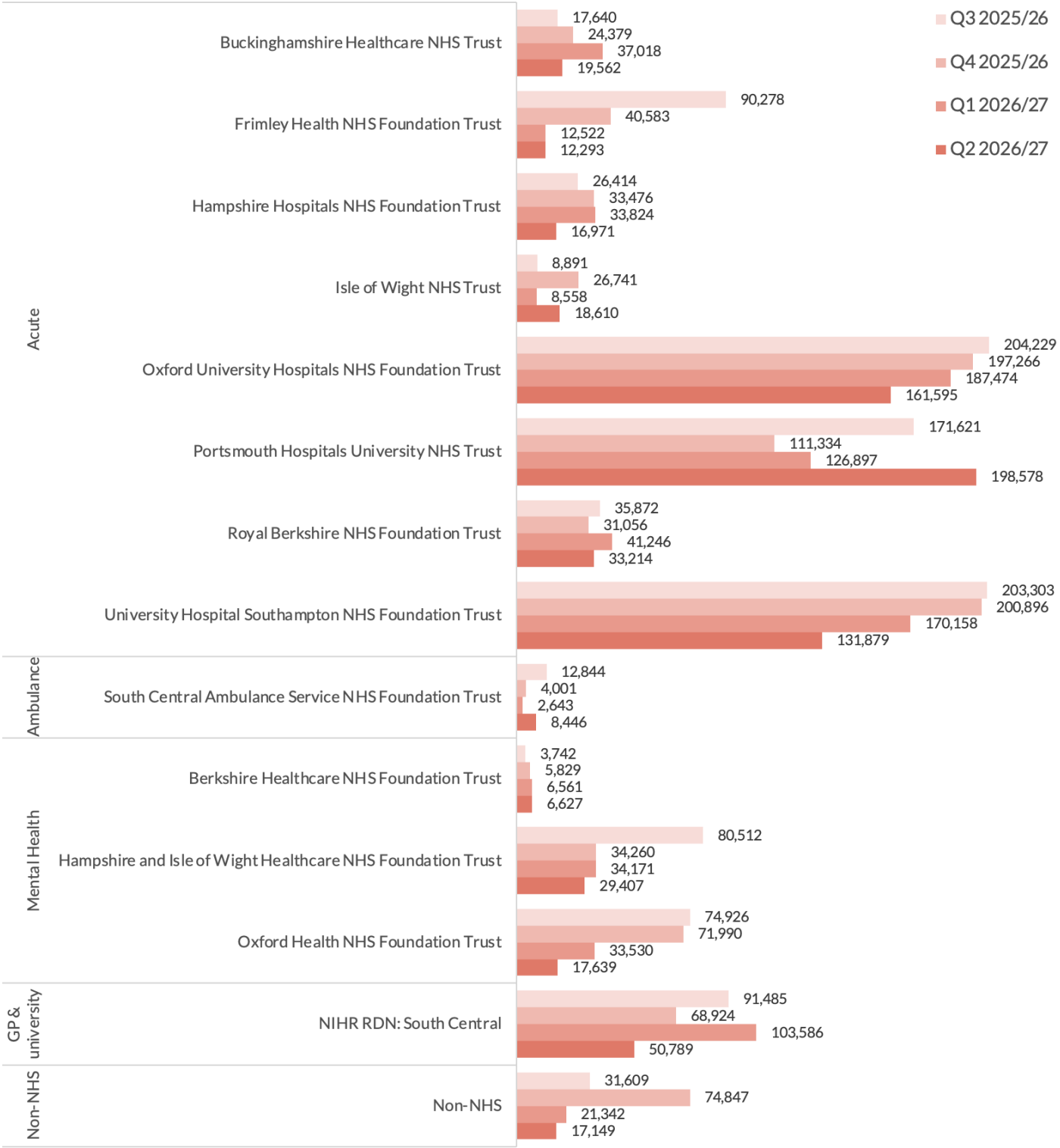


Figure 6 – Complexity weighted recruitment by organisation and organisation type in the South Central region in the previous four quarters

Commercial recruitment in South Central

During the first two quarters of the 2026/27 financial year, delivery organisations in the South Central region have recruited **1,479 participants** across **37 research locations** on **174 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.

Recruitment has slowed since the first quarter, during which a large and simple to deliver genetics testing study (Discover Me) was open in primary care and recruited over 500 participants (Figure 7). This resulted in the upper limits of variability being exceeded in April and June. However, the trend is upwards over the last 18 months and recent recruitment has been within normal limits.

Across England, commercial recruitment totalled 15,099 participants in the first two quarters of this financial year and is trending slightly downwards over the full 18 month period. South Central accounted for 9.8% of total commercial recruitment across England during this period. This performance exceeds South Central's 7.8% share of the English population.

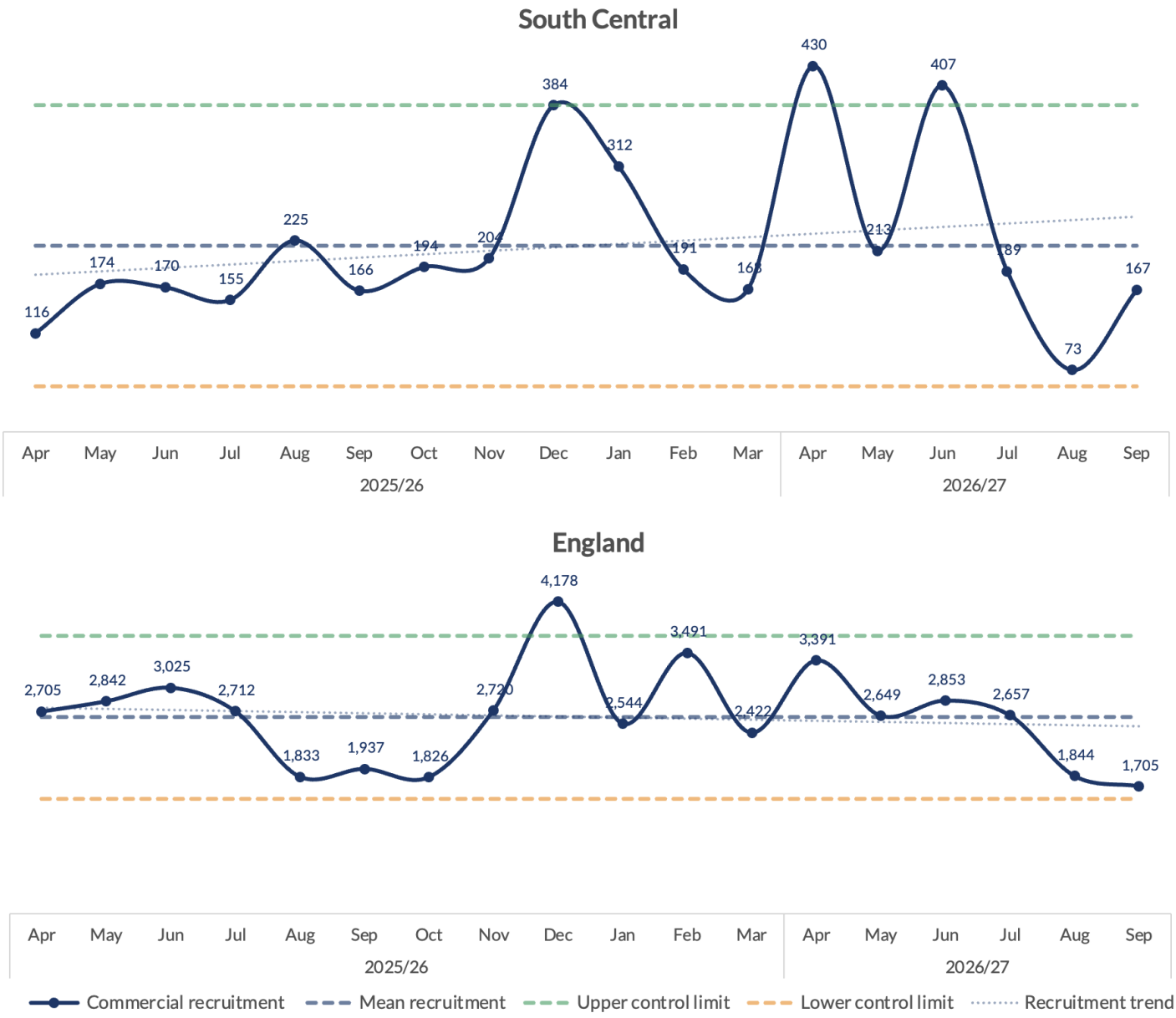


Figure 7 - Monthly commercial recruitment in the South Central region benchmarked against England since April 2025

For reference, quarterly commercial recruitment at delivery organisations within South Central is provided in Figure 8.

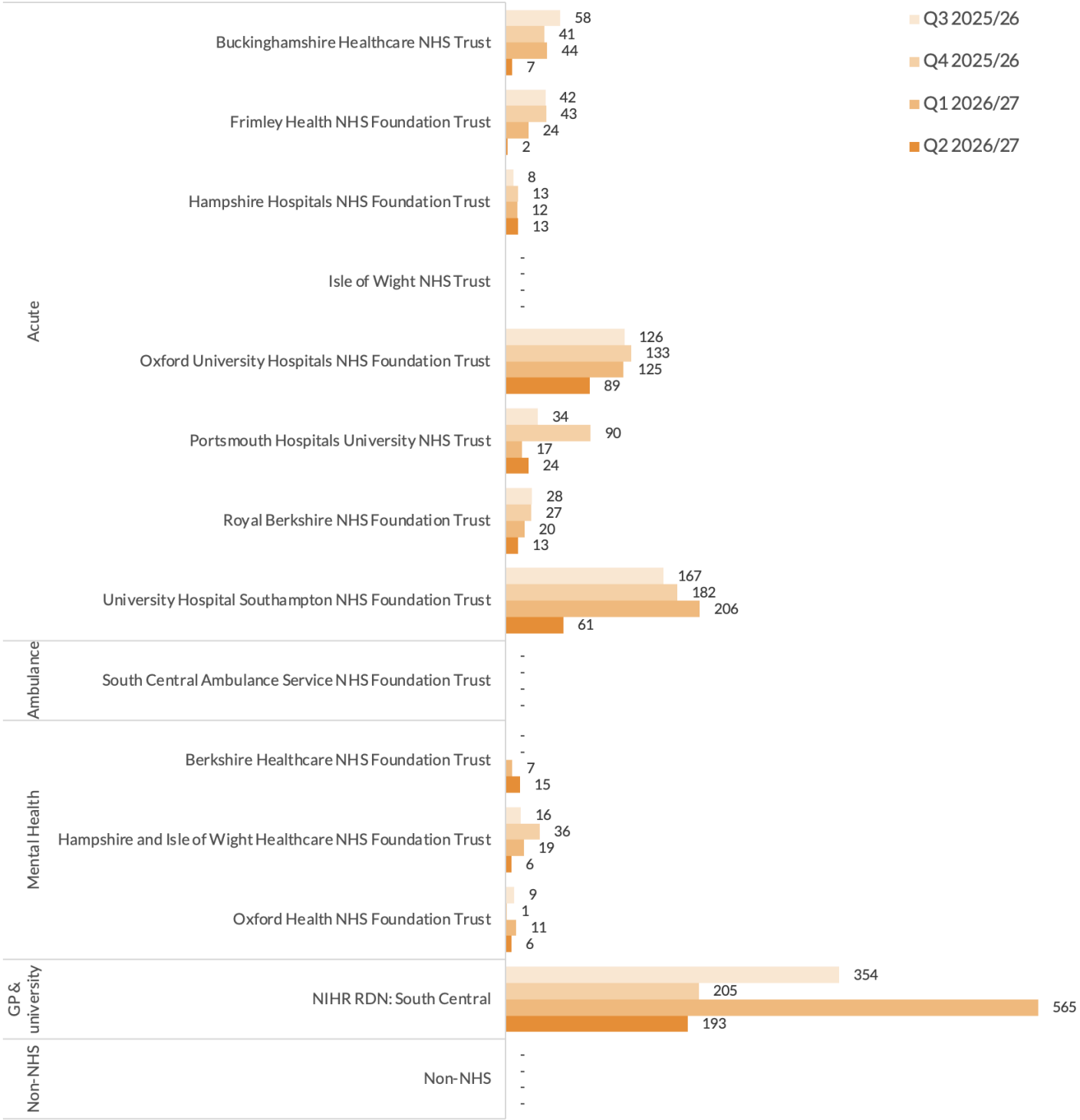


Figure 8 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

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 9 for information. For context, the South Central region has the eighth largest population.

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Relative to the first quarter, South Central's position has improved for all but commercial recruitment on these four metrics. For recruitment, South Central moved from 10th to 9th position compared to quarter one, and for complexity weighted recruitment, from 8th to 7th. The region's rank for recruitment per million population also increased from 9th to 8th. Conversely, the rank for commercial recruitment fell by one place.

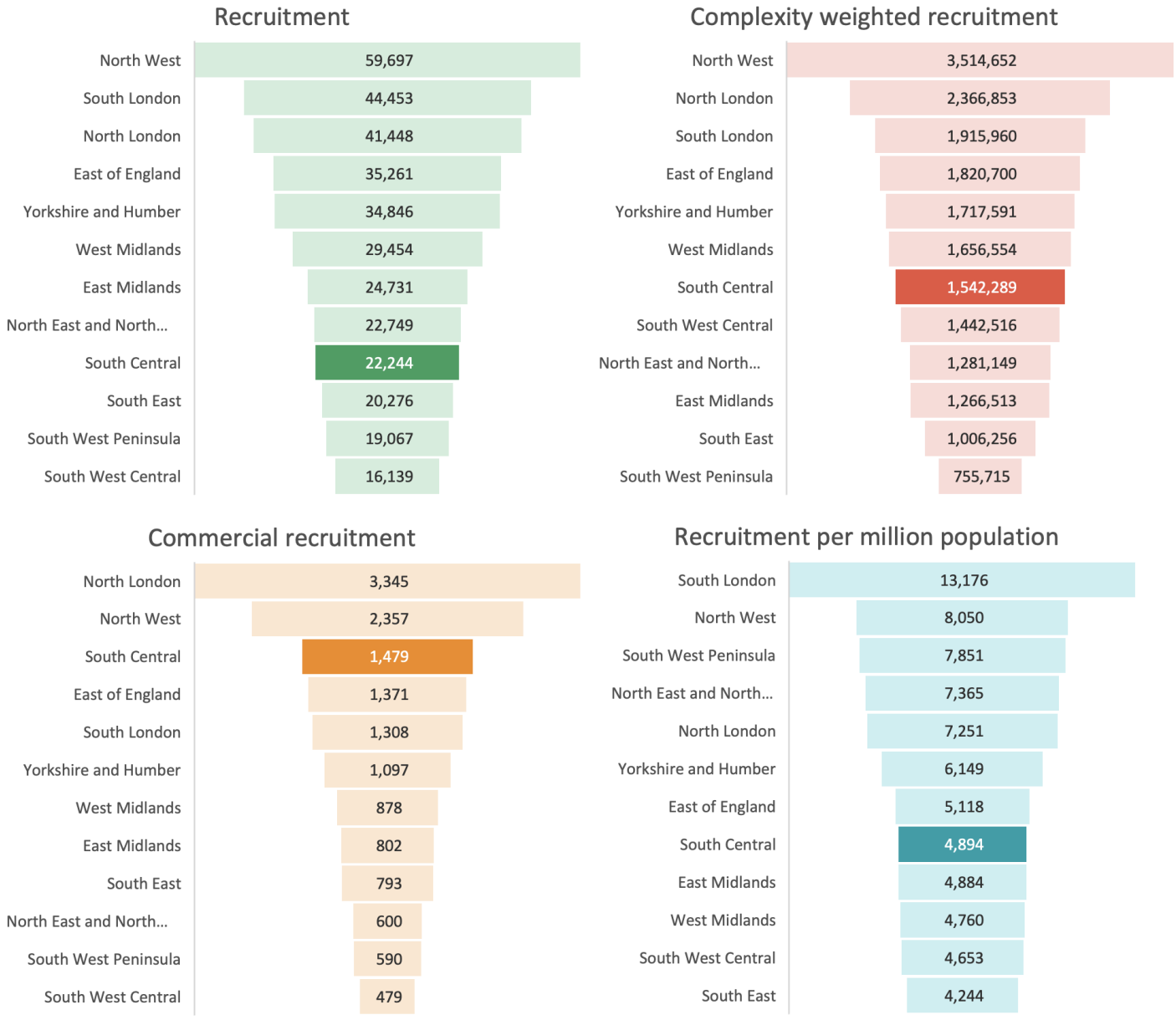


Figure 9 – Recruitment, complexity weighted recruitment, commercial recruitment and recruitment weighted per million population by RRDN region in the first two quarters of the 2026/27 financial year

Recruiting studies in South Central

South Central recruited to a total of **833 studies** during the first two quarters of the 2026/27 financial year, with steady progression towards exceeding the 2025/26 financial year total of 1,149 (Figure 10).

The proportion of non-commercial interventional studies has increased further to 43%, representing an imbalance compared to non-commercial observational research. This change in the structure of the region's portfolio is leading to higher stability for complexity weighted recruitment, while unweighted recruitment reduces. The proportion of commercial studies has reduced compared to the 2025/26 financial year, although the region is on track to exceed the total number of recruiting studies this year.

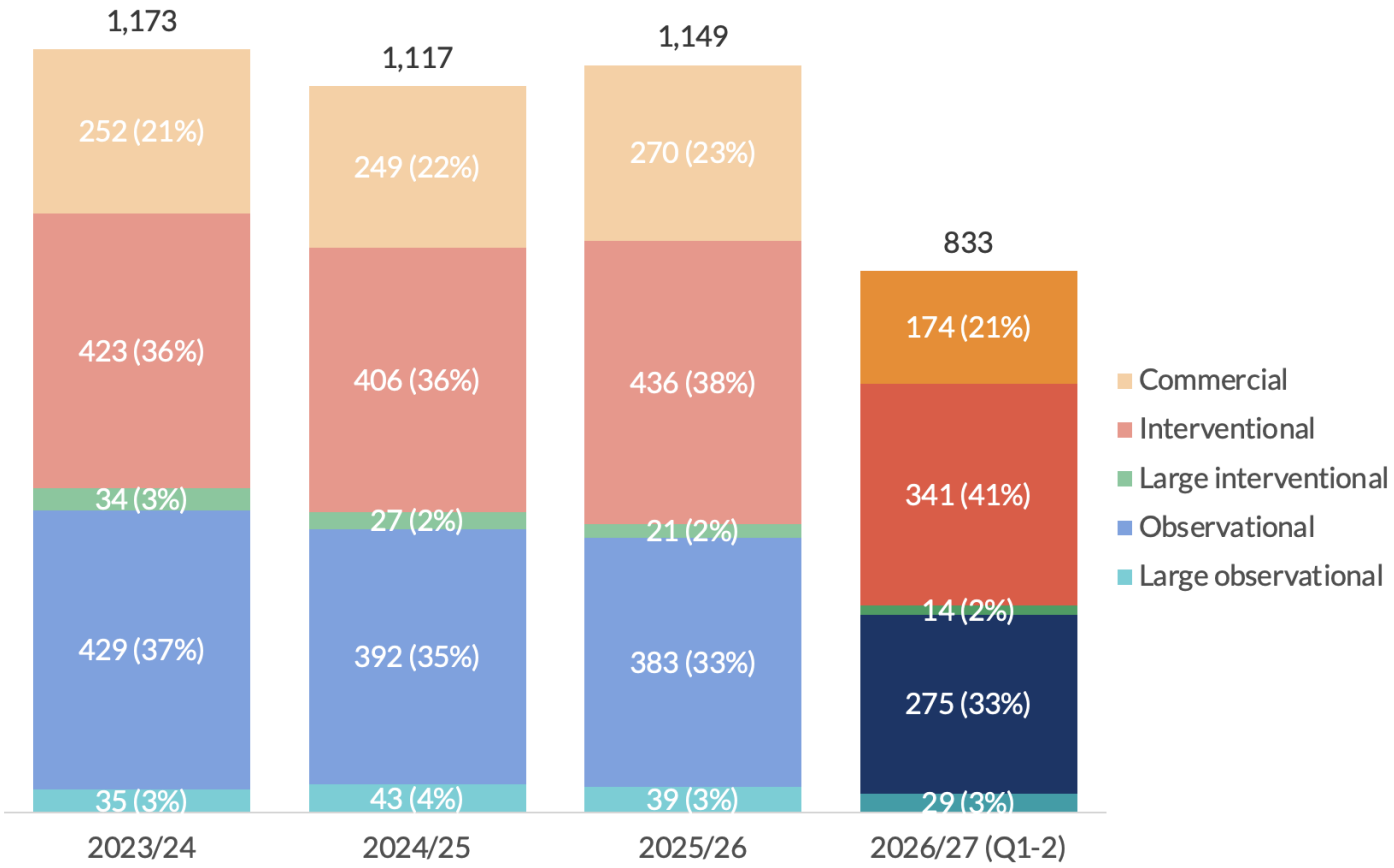


Figure 10 – Recruiting studies by complexity within the South Central region since April 2023

In the first six months of 2026/27, South Central maintained the 4th-highest number of recruiting non-commercial studies compared to quarter one, among the twelve RRDN regions in England (Figure 11). South Central dropped one place to 6th for the number of recruiting commercial studies, with one fewer study than the East of England region.

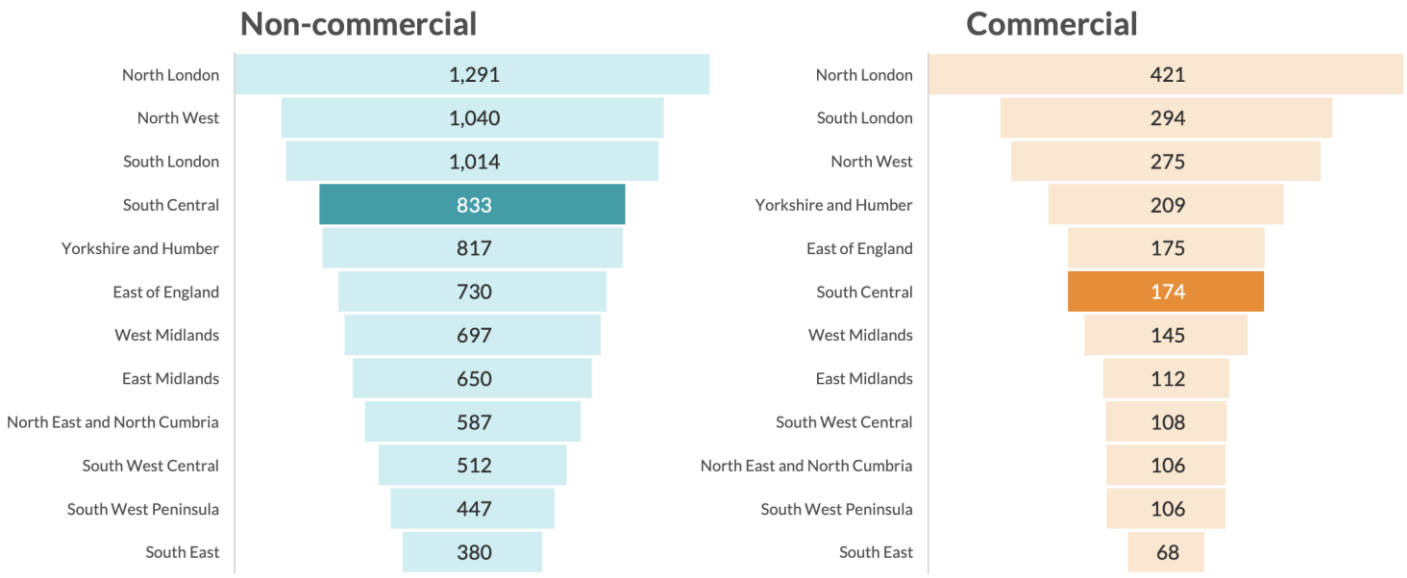


Figure 11 – Non-commercial and commercial recruiting studies by RRDN region in the first two quarters of the 2026/27 financial year

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 60 days of the Health Research Authority's study approval or the location's selection date by the study sponsor, whichever date is later.

In the first two quarters of the 2026/27 financial year, research delivery organisations across the South Central network opened 71% of study locations within the 60-day target (Figure 12). This was a two percentage point improvement over the 69% recorded at the end of quarter one and is a significant increase on the 57% performance during the 2025/26 financial year.

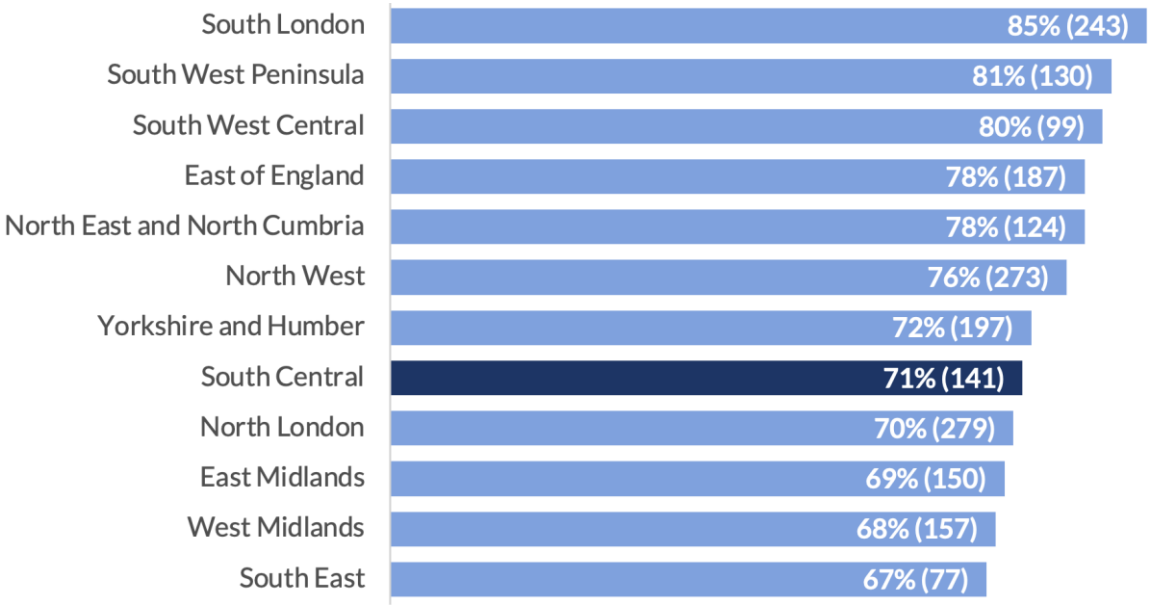


Figure 12 – Study locations open within sixty days of HRA approval or research location selection by RRDN region in the first two quarters of the 2026/27 financial year

Performance has varied by South Central delivery organisation, with five achieving 100% performance and a further two above 80% (Figure 13). The region's performance on this metric is primarily determined by its largest acute NHS trusts, Oxford University Hospitals and University Hospital Southampton, which account for more than half of the region's set-up research locations. Southampton maintained its performance between the end of quarter one and the end of quarter two, whereas Oxford improved substantially from 50% in quarter one to 64%.

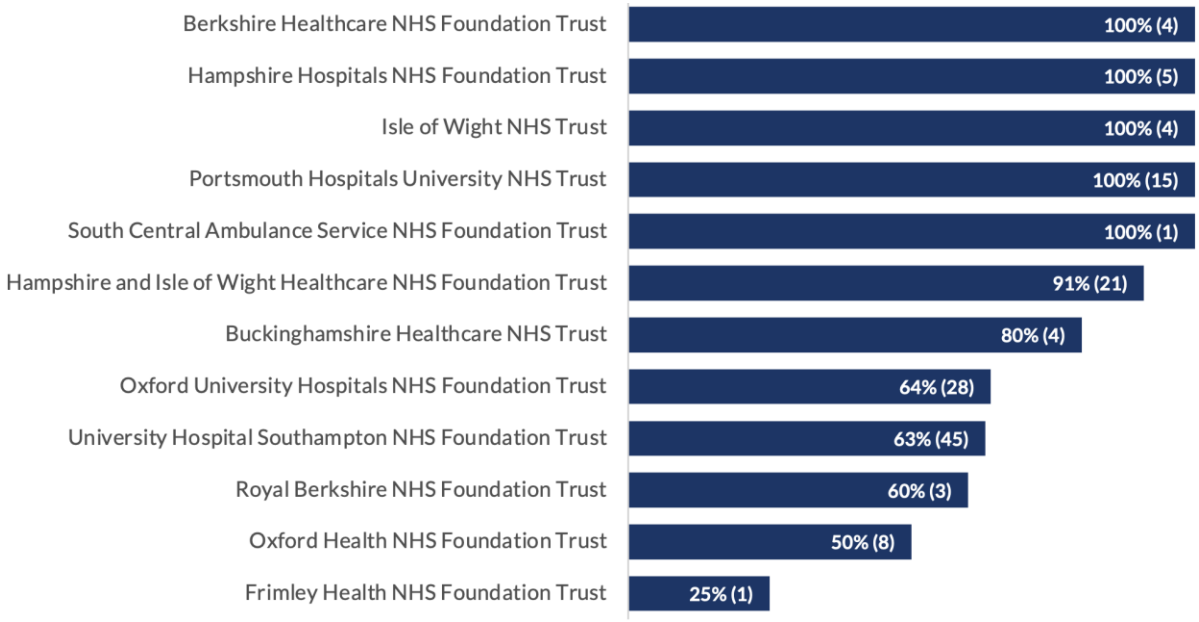


Figure 13 - Study locations open within sixty days of HRA approval or research location selection at South Central NHS Trusts in the first two quarters of the 2026/27 financial year

The funding model also includes a second set-up metric, which measures the percentage of studies in which the first participant completes their first research visit within 30 days of that organisation being ready to start. Across South Central, 52% of research locations achieved this metric, compared with a national average of approximately 58% (Figure 14). Although lower, this represents a regional improvement on South Central's performance of 40% in the 2025/26 financial year and 43% in quarter one. To produce this increase, 60% of South Central research locations recruited within 30 days during the second quarter. This suggests that set-up activity has accelerated, although other factors, such as the types of studies being opened, may also have influenced the improvement.

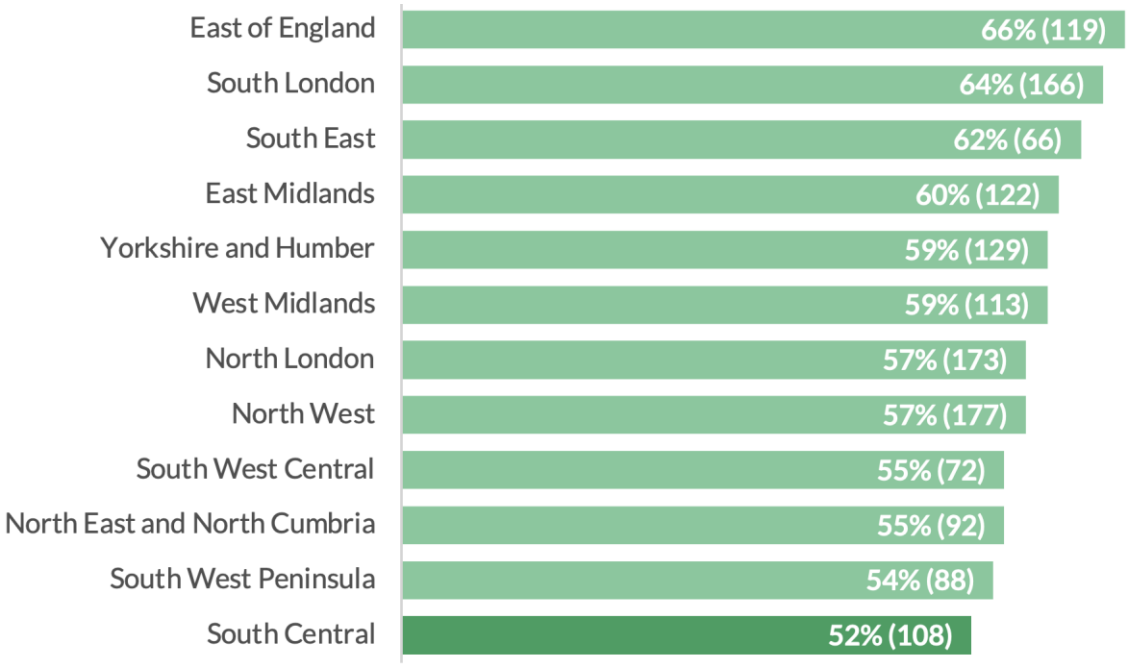


Figure 14 – Study locations achieving the first participant first visit within thirty days of research location readiness by RRDN region in the first two quarters of the 2026/27 financial year

South Central delivery organisation performance on this metric is included in Figure 15.

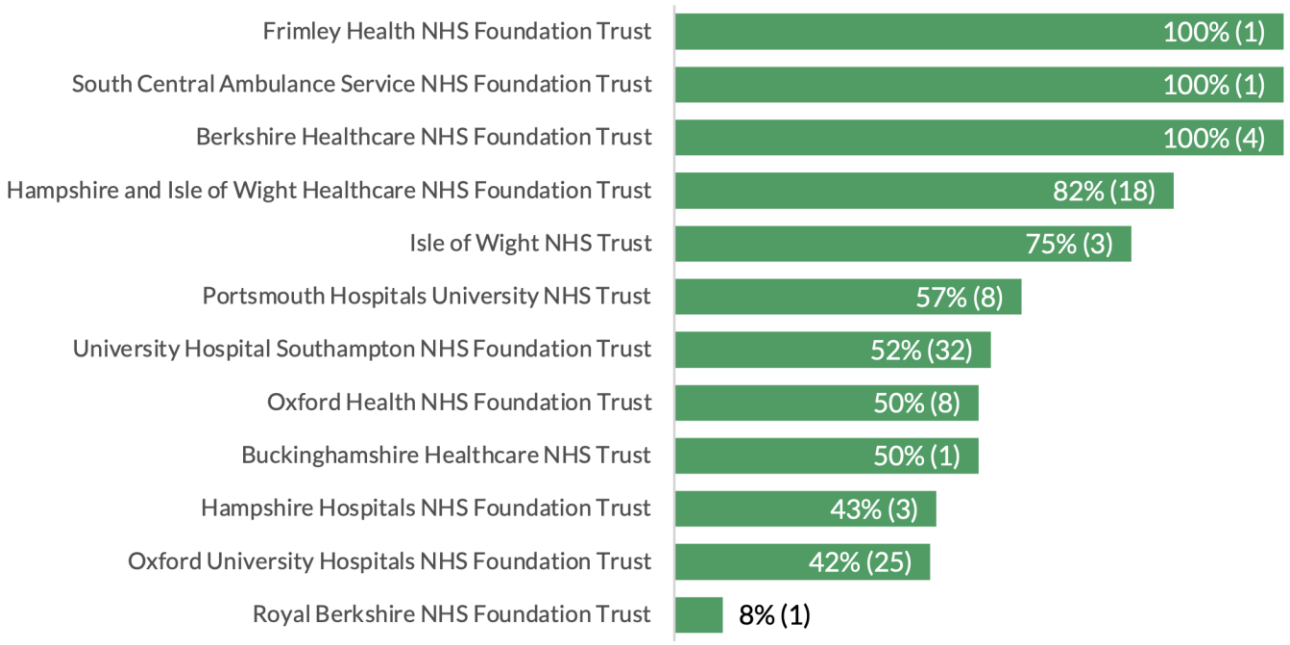


Figure 15 – Study locations achieving the first participant first visit within thirty days of research location readiness at South Central NHS Trusts in the first two quarters of the 2026/27 financial year

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 has made clinical support available to health and care organisations to reduce the time taken to recruit the first participant.
- SC RRDN monitors study set-up times and has implemented a regional escalation process that targets specific barriers to set-up, such as resolving costing queries.

Faster set-up maximises the time available to identify study participants, meaning the research question can be answered faster. For interventional studies, this supports the goal of bringing new treatment options to patients sooner.

Participant experience

During the first two quarters of the 2026/27 financial year, South Central RRDN monitored research participant feedback through the refreshed My Research Experience survey. Delivery organisations received **989 adult responses** across **142 studies** (Figure 16).

Patient experience remains generally positive, with 97.4% of adult respondents reporting that they were treated with courtesy and respect, 95.6% feeling prepared and 94.3% rating their overall

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research experience positively. In addition, 89.6% of adult participants expressed a willingness to take part in future clinical studies. Since quarter one, positive responses have dropped slightly for how participants understand their ongoing care arrangements and knowing how they would receive the survey results.

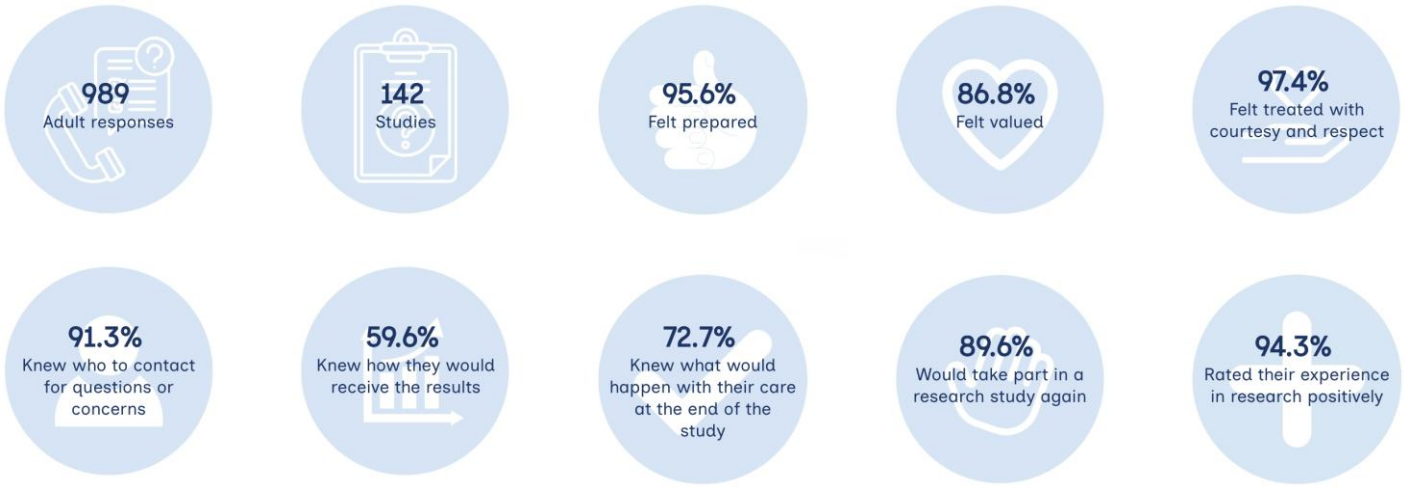


Figure 16 – Summary of the My Research Experience adult survey results in the South Central region in the first two quarters of the 2026/27 financial year

In quarter one, there were only four responses to the children and young people (CYP) version of the survey. This has not increased significantly, with **11 CYP responses** received across **5 studies** (Figure 17). Because of this small sample size, the results are still not considered representative of the service. However, the responses received in quarter two were more positive than with the quarter one group. Research delivery organisations receive all results and use them to make changes to improve their research service.

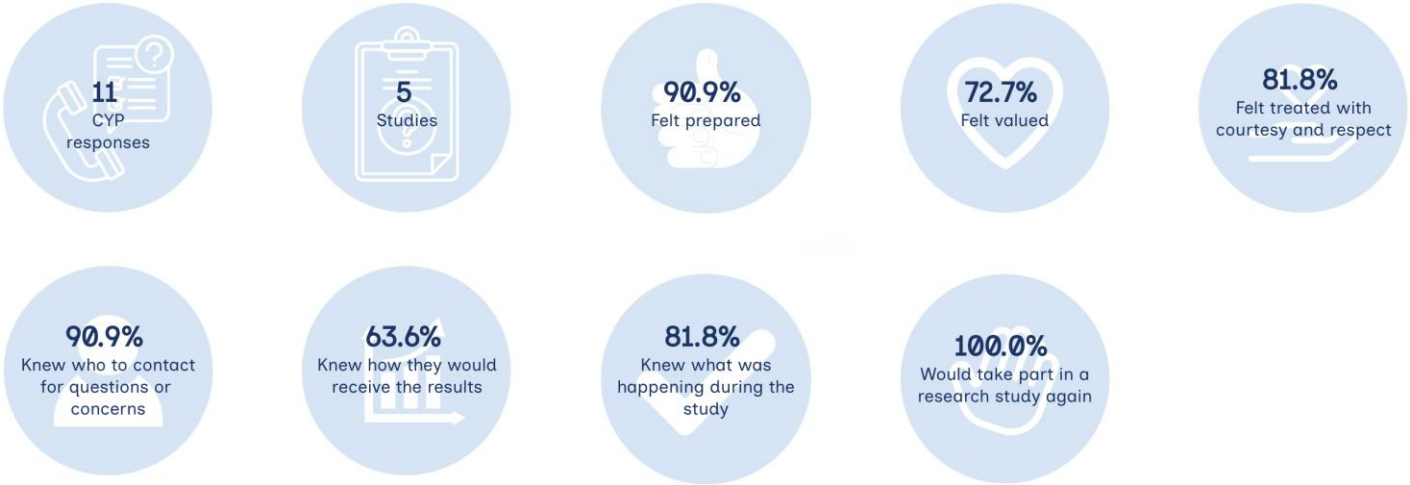


Figure 17 – Summary of the My Research Experience children and young person (CYP) survey results in the South Central region in the first two quarters of the 2026/27 financial year

Conclusion

During the first two quarters of the 2026/27 financial year, healthcare organisations within the South Central region recruited 22,244 participants across 833 studies and 143 research locations, accounting for 6% of total clinical research recruitment in England. However, during 2026, monthly recruitment has remained below the 18-month average of 5,510 participants. This reduction is attributed to national portfolio changes rather than a regional reduction in capacity. High-recruiting observational studies have reached their planned end date while research delivery staff continued follow-up, participant identification and data collection across 2,176 ongoing studies. A similar trend has happened across England, with an overall reduction in monthly recruitment.

The region's research portfolio has continued moving towards higher-complexity interventional clinical trials. These studies have an impact on the participant's care pathway and usually require more resources. Interventional protocols accounted for 43% of all active recruiting studies (355 studies). When the complexity of the studies is considered, South Central delivered 7.6% of the national total activity. This aligns with the region's population share of 7.8% and ranks South Central 7th of the 12 RRDN regions nationally.

Commercial contract research, funded directly by life science industry partners, maintained a high level of regional delivery. South Central delivery organisations recruited 1,479 commercial participants across 174 studies during the first half of the year, delivering 9.8% of total commercial activity in England and ranking 3rd of all regions. Following an initial peak in quarter one, primarily from one large study, monthly commercial recruitment adjusted within expected statistical limits in quarter two.

To increase overall recruitment, SC RRDN is collaborating with the region's delivery organisations to deliver a recruitment action plan. This includes, but is not limited to, finding studies that can potentially open at other locations, reopening paused studies, establishing Participant Identification Centres and reviewing study pipelines with the region's Clinical Trials Units.

The ability to set up studies with delivery organisations has shown some improvement. The proportion of research locations opening within the 60-day target from regulatory approval or site selection rose to 71%, compared to 69% in the first quarter and 57% in 2025/26. For the set up metric measuring first participant first visit within 30 days of the site being ready to start, regional performance was 52%, up from 43% in the first quarter and 40% in 2025/26. Aggregate regional set-up performance continues to be weighted by University Hospital Southampton and Oxford University Hospitals NHS Foundation Trusts, which accounted for over half of all set-up activity.

Participant feedback collected through the My Research Experience survey remained positive overall, with 97.4% of 989 adult respondents reporting being treated with courtesy and respect and 94.3% rating their experience positively. Feedback from children and young people improved, though with only 11 responses, a larger sample size is required to reliably report the results.

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 completed of team member's workload to ensure it is equitable, band appropriate, and manageable 13) recruitment into new roles underway	Workload is being spread equally across the team to ensure ensure it is equitable, band appropriate, and manageable. Recruitment into new roles underway. Well being is central to all 1:1 meetings with line management.	3	2	6
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.	5	4	20	SC RRDN R&D Leadership meeting on 24/3/2026 dedicated to sharing information 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 pharacy 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	4	4	16
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
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

	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 014	**15. Research Delivery**	Delivery to RDN High Priority Studies - Participating Site	Failure to successfully deliver high priority studies at delivery organisations within SC RRDN	1. Reputational damage to SC RRDN delivery organisations and to the UK as a place to deliver research 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	4	4	**16**	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Local Agile delivery team resource allocated to support delivery organisations. 3. Importance of high priority studies communicated to delivery organisations at a senior level	All ongoing	3	4	**12**
SCRRDN 017	**15. Research Delivery**	Risk of studies not being delivered at OUH sites due to the withdrawal of the SC RDN agile team based in Oxford and Horton.	New studies not being approved to be delivered at OUH sites due to SC RDN organisational changes and expectation for the OUH based agile team withdrawal. Timeline not yet known. Risk to current studies on the portfolio not being delivered in their entirety.	1) studies not delivered at OUH due to workforce limitations. 2) SC RDN and OUH organisational reputational damage. 3) uncertainty regarding agile team availability for current and future study delivery.	4	4	**16**	1) Regular meetings held between senior management at OUH and RDN 2) Ongoing review the OUH SC RDN portfolio of studies on a regular basis and subsequent portfolio management including closing studies and stop recruiting to other studies 3) regular review by the senior agile, management team including at the bi-weekly agile management meeting. 4) Transitional arrangements agreed to ensure continuity of study delivery. 5) OUH R&D communication with OUH PIs 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	3	2	6
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.		2	3	6
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 or less.	- Reputational damage to SCRRDN and SC delivery organisations. - Reduced selection of SC delivery organisations resulting in fewer opportunities for patients and decreased commercial income - Future reduction in commercial study opportunities - Performance against 150 day metric will impact performance element of RDN funding to DOs	5	4	**20**	- NIHR Joint Acceleration plan in place to provide enhance support to candidate studies - D&A app to provide real time setup data to DOs in line with UKCRD metrics - SC RRDN R&D managers meeting with focus on set up times - Support DOs to reduce duplication and streamline set up processes - Appropriate escalation of system wide issues, via industry hub, 150 day worksteams and action group - Regional strategic funding call with commissioned call for projects to support study set-up acceleration. Large awards funded. Total TBC.		4	4	16

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
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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. - Updated recruitment action plan shared with DOs for feedback. Face to face R&D Managers meeting in Sept 2026 to focus on DO plans to increase recruitment.		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. Update: 9/9/2026: Procurement has been extended to an unspecified date. SC RRDN will continue to support the SBA's procurement process as needed in the interim.	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
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 operational 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 operational details, the following communication channels have been established 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

	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 031	**17. Communications**	Relationship management due to the Strategic Funding call outcomes for the financial year 27/28	**The SC RRDN run an annual Strategic Funding Call:** -The amount requested from applicants previously significantly exceeded the SC RRDN funding envelopes allocated for this call. -Delivery organisations are able to put forward 3 applications and 4 if leading a collaborative application; delivery organisations will conduct their own processes for deciding which bids to put forward. It is important applicants do not think this screening is part of the RRDN process	Reputational damage	4	4	16	**Pre launch** - SFC showcase event - July 2026 - showcased previous funding requests v funding available setting expectations ,examples of good practice, promoted and enabled collaborative working - SFC drop in sessions and some 1:1s with organisations wanting a steer	**Call Launch - October 6th - 17th November** - Launch including webinar showcasing previous funding requests v funding available, number of bids per delivery organisation and need for internal processes and being clear and transparent re advisory and decision making panel processes including scoring criteria - Regular Drop in's throughout and 1:1s **Call close** -Validation process checking eligibility -Advisory and Decision making panel with external representative commenting and	3	2	6
SCRRDN 032	**17. Communications**	Relationship management due to the Wider Care Settings call outcomes for the financial year 27/28	The SC RRDN run an annual Wider Care Settings research infrastructure funding call. This was newly implemented for the financial year 2026/27. SC RRDN funding allocations did not previously meet all funding requests from applicants due to the funding envelope available and regional research	Further reputational risk to the SC RRDN. Some research locations may chose not to contract with the RDN as a research location and delivery NIHR portfolio research.	4	4	16	1) The SC RRDN are representing the region's concerns at national working groups relating to the WCS funding call to influence the national approach 2) RDN discussions underways to support applicant expectations and understanding of the funding call/application process 3) working closely with the applicable specialty and settings leads to provide support to the RDN and	Ongoing	4	3	12

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