University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	13/01/2026
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd
Apologies	Diana Eccles

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 11 November 2025** Approve the minutes of the previous meeting held on 11 November 2025
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Finance, Investment & Cash Committee** David Liverseidge, Chair
5.2	9:30	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.3	9:40	**Briefing from the Chair of the Quality Committee** including Maternity and Neonatal Safety 2025-26 Quarter 2 Report Tim Peachey, Chair
5.4	9:50	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.5	10:20	**Performance KPI Report for Month 8** Review and discuss the report Sponsor: Andy Hyett, Chief Operating Officer

5.6 **Break**

11:00

5.7 **Finance Report for Month 8**

11:15 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.8 **ICB System Report for Month 8**

11:25 Receive and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.9 **People Report for Month 8**

11:30 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

5.10 **Learning from Deaths 2025-26 Quarter 2 Report**

11:45 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

5.11 **Infection Prevention and Control 2025-26 Quarter 2 Report**

11:55 Review and discuss the report
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Julian Sutton, Clinical Lead, Department of Infection/Julie Brooks, Deputy Director of Infection Prevention and Control

5.12 **Medicines Management Annual Report 2024-25**

12:05 Receive and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: James Allen, Chief Pharmacist

5.13 **Annual Ward Staffing Nursing Establishment Review 2025**

12:15 Discuss and approve the review
Sponsor: Natasha Watts, Acting Chief Nursing Officer

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

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

12:25 Review and discuss the report
Sponsor: Andy Hyett, Chief Operating Officer
Attendee: John Mcgonigle, Emergency Planning & Resilience Manager

7 **Any other business**

12:35 Raise any relevant or urgent matters that are not on the agenda

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

9 **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.

10 **Follow-up discussion with governors**

12:45

University Hospital Southampton NHS
NHS Foundation Trust

Agenda links to the Board Assurance Framework (BAF)

13 January 2026 – Open Session

Overview of the BAF

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

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.5	Performance KPI Report for Month 8	1a, 1b, 1c			x
5.7	Finance Report for Month 8	5a			x
5.8	ICB System Report for Month 8	5a			x
5.9	People Report for Month 8	3a, 3b, 3c			x
5.10	Learning from Deaths 2025-26 Quarter 2 Report	1b			x
5.11	Infection Prevention and Control 2025-26 Quarter 2 Report	1c			x
5.12	Medicines Management Annual Report 2024-25	1b			x
5.13	Annual Ward Staffing Nursing Establishment Review 2025	1b, 3a			x
6.1	Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	1b			x

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	11/11/2025
Time	9:00 – 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd (JD-T)
Present	Diana Eccles, NED (DE) Keith Evans, Deputy Chair and NED (KE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director (JH) Ian Howard, Chief Financial Officer (IH) Andy Hyett, Chief Operating Officer (AH) David Liverseidge, NED (DL) Tim Peachey, NED (TP) Alison Tattersall, NED (AT) Natasha Watts, Acting Chief Nursing Officer (NW)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Lauren Anderson, Corporate Governance and Risk Manager (LA) (item 6.2) Martin de Sousa, Director of Strategy and Partnerships (MdS) (item 6.1) Lucinda Hood, Head of Medical Directorate (LH) (item 5.13) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.12) Vickie Purdie, Head of Patient Safety (VP) (item 7.3) Kate Pryde, Clinical Director for Improvement and Clinical Effectiveness (KP) (item 5.13) Scott Spencer, Health and Safety Advisor (SS) (item 7.3) 4 governors (observing) 2 members of staff (observing)

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 no apologies had been received.

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

2. Patient Story

Item deferred to the next meeting.

3. Minutes of the Previous Meeting held on 9 September 2025

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 9 September 2025, subject to a minor correction at 5.10.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted.

- Actions 1281, 1283 and 1284 were closed.
- Action 1282 was to be addressed through item 5.6 below.
- In respect of action 1285, the Quality Committee would monitor progress on complaints response times.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

Keith Evans was invited to present the Committee Chair's Report in respect of the meeting held on 13 October 2025, the content of which was noted. It was further noted that:

- In terms of the internal audit reports, which had been received by the committee, whilst there were a number of points for the Trust to address, no areas of significant concern had been identified.
- There was a focus on 'imposter fraud' whereby individuals who had turned up to carry out a shift were not who they claimed to be. Whilst there had been no reported incidents at the Trust, the Trust had implemented controls at the ward level, which would be subject to testing during 2025/26.

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

David Liverseidge was invited to present the Committee Chair's Reports in respect of the meetings held on 22 September and 3 November 2025, the contents of which were noted. It was further noted that:

- In September 2025, the Trust had reported that it was in line with its Financial Recovery Plan. Of the £110m Cost Improvement Programme (CIP) target, 76% had been fully developed.
- The committee had reviewed the Finance Report for Month 6 (item 5.8), noting that the Trust had reported an in-month deficit of £5.4m, which was in line with the Financial Recovery Plan.
- The committee had expressed concern that 17% of the CIP target was not fully developed and that the Trust was £2.5m off-track in terms of delivery of the target at Month 6.
- Whilst progress had been made in terms of addressing patients with no criteria to reside and mental health patients, this remained an area of concern.
- The committee considered the NHS England Medium Term Planning Framework, noting that the first submission by the Trust was due prior to Christmas 2025.

5.3 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 22 September and 3 November 2025, the contents of which were noted. It was further noted that:

- There continued to be little improvement in terms of the number of patients with no criteria to reside or mental health patients, which impacted staffing numbers.
- The Trust was adopting a harder line in respect of its approach to violence and aggression, which included a greater willingness to exclude individuals.
- The current participation rate in the Staff Survey was lower than the national average, which was likely indicative of staff morale and engagement.

- The Trust's workforce numbers remained above plan, with limited options available to address this issue, especially in the absence of funding for restructuring costs.

5.4 Briefing from the Chair of the Quality Committee

Tim Peachey was invited to present the Committee Chair's Report in respect of the meeting held on 13 October 2025, the content of which was noted. It was further noted that:

- The committee received an update in respect of mental health patients, noting that although there were significant issues in the Emergency Department, the whole pathway for these patients remained a problem.
- The committee carried out a six-monthly review of the Trust's progress against its Quality Priorities, noting that good progress had been made on four of the six priorities and two were slightly behind.

5.5 Chief Executive Officer's Report

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

- NHS England had published the Medium Term Planning Framework, which was intended to encourage organisations to think beyond a 12-month time horizon and to progress the NHS 10-Year Plan. The Trust was expected to provide its first submission prior to Christmas 2025, but the detailed planning assumptions had yet to be received from NHS England. It was noted that a more detailed report on the Medium Term Planning Framework was to be received as part of the closed session of the meeting.
- The Strategic Commissioning Framework had been published by NHS England, which provided welcome clarifications about the future role of integrated care boards.
- The Trust had been placed into Tier 1 for both Urgent and Emergency Care and for Elective performance. There was a national expectation that trusts would have no patients waiting over 65 weeks for elective care by 21 December 2025. Where organisations had more than 100 such patients at the end of October 2025, they had been placed into Tier 1. The Trust was taking steps, including mutual aid, to attempt to address the number of long waiters, but there was insufficient capacity in the system.
- Resident doctors were due to strike for a further five-day period commencing on 14 November 2025, having rejected the Government's latest offer to resolve the ongoing dispute with the British Medical Association.
- The Hampshire and Isle of Wight Integrated Care Board and NHS England South East Region had carried out a visit to the Trust's paediatric hearing services in May 2025. The report, received in October 2025, had been positive about the service.
- The Trust and the University of Southampton had been awarded £16.3m by the National Institute for Health and Care Research. The Trust was one of only four organisations out of 15 applications to receive an award.
- The NHS Business Services Authority had announced the award of a £1.2bn contract to Infosys to deliver a new and enhanced workforce management system for the NHS to replace the existing Electronic Staff Record system. The 2030 target date for implementation was considered ambitious. Further details would be considered by the People and Organisational Development Committee when available.

5.6 Performance KPI Report for Month 6

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

- Diagnostics performance was a key element of the pathway, as delays in diagnosis had a consequential impact on the overall length of pathways such as those for cancer and patients on a Referral To Treatment pathway.
- Although there were some concerns with Diagnostics in the Trust, the Trust, generally, performed better than other organisations.

The Board discussed the matters raised in the Diagnostics 'spotlight'. This discussion is summarised below:

- There had been a long-standing issue with waiting times for cystoscopy due to insufficient capacity. However, a plan was being developed to improve the situation, although it was considered appropriate that the plan should also address broader issues with urology as a whole.
- There was concern regarding the availability of magnetic resonance imaging (MRI) scanners, particularly as two scanners were out-of-action. It was noted that the current set-up in terms of MRI scanners was not fit for the longer term and a strategy for the future needed to be developed.
- There was a disparity between capacity and demand in respect of the neurophysiology service, as this service had previously relied on outsourcing.
- Generally, activity was increasing, but overall performance appeared to be declining. There was also the additional financial challenge that Diagnostics was funded under a 'block' contract arrangement which did not fully take into account the demand for these services.
- There were concerns about the electrical supply capacity at the Southampton General Hospital site and the ability of the Trust to expand its Diagnostic capacity with this limitation. It was considered that a better longer-term model would be for scanners at local community diagnostics centres.

Actions

Andy Hyett agreed to work on and present at either a future Board meeting or Trust Board Study Session the Trust's longer-term strategy with respect to MRI scanners and imaging.

Andy Hyett agreed to develop a longer-term plan for cystoscopy/urology and to report back to the Board during Quarter 4.

Andy Hyett agreed to develop a long-term solution to the neurophysiology service.

Andy Hyett was invited to present the Performance KPI Report for Month 6, the content of which was noted. It was further noted that:

- The Trust's Emergency Department had recorded performance of 67.6% against the four-hour standard during September 2025. The department remained busy with c.450 patients and 120 ambulance attendances per day.
- There had been some initial performance impacts with the roll out of the MIYA system in the Emergency Department, but this appeared to have now been addressed with performance up to previous levels.
- A number of initiatives were being introduced into the Emergency Department in order to improve performance. These included the layout of the service, pathway re-designs, having General Practitioners in the department, and arranging with non-urgent patients to attend at a scheduled time rather than waiting in the department.

- In October 2025, the Trust had recorded 363 patients waiting over 65 weeks on a Referral To Treatment pathway against a national target of no such patients by the end of December 2025.
- The Trust was making use of the independent sector, weekend working, and was requesting capacity from other providers to address the number of patients waiting over 65 weeks.
- The planned industrial action by resident doctors posed a challenge, noting that the national expectation was that trusts maintain 95% of their capacity during this period. It was noted that, in contrast to previous instances of industrial action, resident doctors were apparently less forthcoming in terms of whether they intended to participate in the industrial action.
- The Trust continued to report one of the lowest Hospital Standardised Mortality Rates in England.
- The Trust's cancer performance, based on a BBC article, was 21 out of 121 trusts. It was noted that whilst the number of patients being referred on a cancer pathway had increased significantly, the number of patients diagnosed with cancer had not materially changed.
- There appeared to have been an increase in the number of pressure ulcers and 'red flag' incidents. Work was ongoing to address the findings of the pressure ulcer audit which had been presented to the Quality Committee on 2 June 2025.
- The number of patients having no criteria to reside and mental health patients remained high.

Actions
Andy Hyett agreed to clarify the basis of the calculation of the 'Watch & Reserve antibiotics usage per 1,000 adms' metric.

5.7 Break

5.8 Finance Report for Month 6
Ian Howard was invited to present the Finance Report for Month 6, the content of which was noted. It was further noted that:

- The Trust had submitted its Financial Recovery Plan to NHS England in August 2025, which committed to an additional £23m improvement in the Trust's financial position to deliver a full-year position of a £54.9m deficit. In the absence of these additional improvements, the Trust had been forecasting a year-end position of a £78m deficit. The revised target was subject to a number of assumptions, including the need for demand management and improvements in non-criteria to reside and mental health patient numbers.
- There were a number of risks to the achievement of the Financial Recovery Plan, including whether there would be improvements in mental health and non-criteria to reside and/or steps taken to manage demand, high levels of activity, and whether it would be possible to reduce the workforce and close theatres. The need for the Trust to focus on achieving the 65-week wait target in particular could impact the Trust's ability to close capacity.
- The Trust had reported an in-month deficit of £5.4m (£30.8m year-to-date), which was in line with the trajectory set out in the Financial Recovery Plan. The Trust's underlying deficit had seen some marginal improvement during the period.
- The Trust's cash position remains an area of significant concern. Cash requests had been made to NHS England, but the latest request for November 2025 had been rejected. It was therefore likely that the Trust would need to manage its supplier payments in accordance with its available cash.

5.9 ICS System Report for Month 6

Ian Howard was invited to present the ICS System Report for Month 6, the content of which was noted. It was further noted that:

- The Hampshire and Isle of Wight Integrated Care System had reported a year-to-date deficit of £48m.
- A significant improvement in the run-rate would be required for the system to be able to deliver its 2025/26 plan.
- The system was one of the worst in England in terms of the number of beds occupied by patients having no criteria to reside with approximately 23% of beds being occupied by such patients compared with a national average of 12%.
- The system was also below plan in terms of its targets for access to General Practitioners and targets relating to mental health patients. It was noted that the performance in these areas had a consequential impact on the Trust's performance in areas such as urgent and emergency care performance.

5.10 People Report for Month 6

Steve Harris was invited to present the People Report for Month 6, the content of which was noted. It was further noted that:

- The overall workforce fell by 73 whole-time-equivalents (WTE) during September 2025 and was reported as being 54 WTE above the Trust's 2025/26 plan. The reduction in workforce had been driven through a combination of the impact of the recruitment controls, mutually agreed resignation scheme (MARS) leavers, and a significant drop in use of temporary staff during the month.
- On 15 October 2025, the Trust had heard the collective grievance brought by the Royal College of Nursing in respect of the removal of enhanced NHS Professionals rates. It was decided not to reverse the decision in order to maintain equity with the rest of the workforce and consistency across other local providers. A number of actions had been agreed following the hearing.
- Sickness rates had increased to 3.8%, although the Trust still benchmarked well against peers.
- There were concerns about the potential impact of influenza during the winter period and therefore the Trust was taking a number of actions to promote vaccination of staff. The Trust was currently third in terms of uptake in the Region.
- The level of participation in the national Staff Survey remained a challenge with only 32% of staff having completed the survey compared with a national average of 38%. It was considered likely that the recent difficult decisions taken and the impact on staff was impacting staff experience and engagement.
- The People and Organisational Development Committee would be examining statutory and mandatory training levels together with the latest proposed national changes.

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

Natasha Watts was invited to present the NHS England audit and review of 'Developing Workforce Safeguards' (2018), including the Trust's Self-Assessment Return, the content of which was noted. It was further noted that:

- 'Developing Workforce Safeguards' was published in October 2018 and included a range of standards to assure safe staffing across the workforce. NHS England had initiated an audit, review and improvement plan amidst concern about a national reduction in compliance.
- The Trust had submitted a self-assessment as part of this NHS England review. This assessment showed that the Trust continued to comply with the majority of the standards.
- The audit exercise has been used as an opportunity to identify opportunities for improvement. Twelve recommendations have been developed, of which nine were assessed as 'green' and three as 'amber'.

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

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

- Resident doctors were due to strike for five days from 14 November 2025. This would be the thirteenth strike in recent years. It was noted that, in addition to pay, the dispute also concerned working conditions and the shortage of posts and consequent risk to resident doctors of unemployment.
- The Trust had performed a self-assessment against the 10-Point Plan and it was noted that the majority of the plan's contents had been considered by the Trust for some time. There were also a number of dependencies on the part of NHS England in areas such as lead employer models.
- A national review of statutory and mandatory training was expected to enable portability of training records to facilitate staff moving between NHS organisations.
- There had been significant improvements in respect of gaps in rotas.

5.13 Annual Clinical Outcomes Summary

Luci Hood and Kate Pryde were invited to present the Annual Clinical Outcomes Summary Report, the content of which was noted. It was further noted that:

- The paper provided an overview of the clinical outcomes reviewed by the Clinical Assurance Meeting for Effectiveness and Outcomes (CAMEO) over the 12-month period to September 2025.
- The majority of specialities provide reports to CAMEO, although outcome data can be more difficult in some areas to capture than in others.
- The outcomes reviewed by the CAMEO and outputs from this body were also influencing the development of the Trust's clinical strategy.
- The strains on the capacity of services posed a risk to clinical outcomes.

- There was potential that a ‘quality’ override could form part of the NHS Oversight Framework in the future, operating in a similar manner to the ‘financial’ override by limiting the segmentations available to an organisation.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2025-26 Quarter 2 Review

Martin De Sousa was invited to present the review of Corporate Objectives 2025/26 for the second quarter, the content of which was noted. It was further noted that:

- Of the 12 objectives agreed for 2025/26, six were rated ‘green’, four were ‘amber’ and two were ‘red’.
- The ‘red’ rated risks were that relating to the Trust’s financial performance and that relating to the Trust’s achievement of its workforce plan for 2025/26.

6.2 Board Assurance Framework (BAF) Update

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

- BDO had completed its audit of the Trust’s risk maturity and had presented its report to the Audit and Risk Committee on 13 October 2025. The audit had highlighted a number of strengths including the Board Assurance Framework, risk definition, and use of risk in decision-making. In terms of opportunities for improvement, the audit report suggested some improvements in articulation of operational risks and use of ‘SMART’ methodology for actions.
- The Board Assurance Framework had been reviewed by relevant executive directors and committees since it was last presented to the Board. There had been no changes to the ratings or target dates.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Feedback from the Council of Governors’ (COG) Meeting 28 October 2025

The Chair presented a summary of the Council of Governors’ meeting held on 28 October 2025. It was noted that the meeting had considered the following matters:

- Chief Executive Officer’s Performance Report
- Governor attendance at Council of Governors’ meetings
- Review of the Council of Governors’ Expenses Reimbursement Protocol
- Appointment of Jane Harwood as Deputy Chair with effect from 1 October 2025
- Membership engagement
- Feedback from the Governors’ Nomination Committee

It was noted that the Trust’s work on violence and aggression received particular attention from the Governors.

7.2 Register of Seals and Chair’s Action Report

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

It was further noted that one further item had been sealed on 7 November: Deed of Guarantee between University Hospital Southampton NHS Foundation Trust (Guarantor) and CHG-Meridian UK Limited (Beneficiary) regarding the payment and due performance obligations of UHS Estates Limited (UEL) under the Guaranteed Contract and specifically the Stryker Power Tools delivered to UEL under the pre-contract open build period with CHG. Seal number 307 on 7 November 2025.

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' and to the additional document referred to above.

7.3 Health and Safety Services Annual Report 2024-25

Spencer Scott was invited to present the Health and Safety Services Annual Report 2024/25, the content of which was noted. It was further noted that:

- The number of incidents reportable pursuant to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) had increased substantially to 68 such incidents compared to 39 in 2023/24. The majority of these incidents related to moving and handling or exposure to infectious diseases.
- There was a concern that there had been a reduction in the number of health and safety related reports and escalations whilst at the same time the number of RIDDORs had increased.
- Four areas of concern were highlighted: Entonox surveillance of maternity staff, display screen equipment compliance, the Southampton General Hospital loading bay, and workplace temperatures during the summer.

8. Any other business

There was no other business.

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

10. Items circulated to the Board for reading

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

11. Resolution regarding the Press, Public and Others

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

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 15/07/2025 - 5.11 Freedom to Speak Up Report				
1267.	Data	Mbabazi, Christine	10/03/2026	Pending
	Explanation action item Christine Mbabazi to include data from other mechanisms for reporting concerns in future Freedom to Speak Up reports.			
Trust Board – Open Session 09/09/2025 - 8 Any other business				
1286.	Organ donation	Machell, Craig	03/02/2026	Pending
	Explanation action item Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session. Update: Scheduled for TBSS on 03/02/26.			
Trust Board – Open Session 11/11/2025 - 5.6 Performance KPI Report for Month 6				
1293.	MRI scanners and imaging	Hyett, Andy	13/01/2026	Pending
	Explanation action item Andy Hyett agreed to work on and present at either a future Board meeting or Trust Board Study Session the Trust's longer-term strategy with respect to MRI scanners and imaging.			
1294.	Cystopscopy/urology	Hyett, Andy	13/01/2026	Pending
	Explanation action item Andy Hyett agreed to develop a longer-term plan for cystoscopy/urology and to report back to the Board during Quarter 4.			

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 11/11/2025 - 5.6 Performance KPI Report for Month 6				
1295.	Neurophysiology	Hyett, Andy	13/01/2026	Pending
	Explanation action item Andy Hyett agreed to develop a long-term solution to the neurophysiology service.			
1296.	Watch & Reserve antibiotics usage	Hyett, Andy	13/01/2026	Pending
	Explanation action item Andy Hyett agreed to clarify the basis of the calculation of the 'Watch & Reserve antibiotics usage per 1,000 adms' metric.			

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.1 i)

Committee Chair's Report to the Trust Board of Directors 13 January 2026	
Committee:	**Finance, Investment and Cash Committee**
Meeting Date:	**24 November 2025**
Key Messages:	• The committee received an update in respect of the Trust's commercial activities, noting that the Trust had robust systems in place to maximise cost recovery for private patient and overseas visitor income. The Trust's private patient unit project continued to progress. The Trust was also seeking a partner to manage its parking provision. • The committee received the Finance Report for Month 7. The Trust had reported a £5.1m in-month deficit (£35.9m year-to-date), which was in line with the trajectory contained in the Financial Recovery Plan. The underlying deficit remained flat at £6.4m. Whilst there had been a slight reduction in the number of mental health patients, there were c.240 patients having no criteria to reside at any point during the period. There was an increased level of scrutiny in respect of non-pay expenditure. • The committee reviewed an update on the Trust's measures for financial improvement, noting that the Trust was forecasting achievement of £85-95m against its target of £110m Cost Improvement Programme delivery for 2025/26. • The committee noted the Trust's approach and the timelines associated with the Medium Term Planning submission. It was noted that the framework set ambitious financial and performance targets. • The committee received an update in respect of the Trust's Theatre Experience Programme, noting that there had been a 3% increase in utilisation and a 3% reduction in cancellations. • The committee reviewed the Trust's productivity, noting that the Trust's productivity had fallen by 3.3% compared to the prior year due to high-cost growth. • The committee received an update in respect of the Trust's cash position and forecast and supported a proposal to request further cash support for January 2026. • The committee received an update on Capital Planning for 2026/27-2029/30. It was noted that it was expected that the Trust would be allocated c.£40m per annum, although there were concerns about the impact of the Trust's cash position and the ability of the Trust to meet this level of expenditure.
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	N/A
Any Other Matters:	N/A

Assurance Rating:

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

Risk Rating:

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

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.1 ii)

Committee Chair's Report to the Trust Board of Directors 13 January 2026			
Committee:	**Finance, Investment and Cash Committee**		
Meeting Date:	**15 December 2025**		
Key Messages:	• The committee received the Finance Report for Month 8 (see below). • The committee discussed the Trust's future transformation programmes, noting that the areas of focus would be: urgent and emergency care, elective care, and automation of administrative processes. The committee was assured that the programmes were felt to be suitably 'bold and ambitious' and were grounded in realistic opportunities, rather than 'blue sky' ideas. • The committee reviewed the draft capital plan for 2026/27 – 2029/30, noting that the Trust had been allocated c.£40m of capital departmental expenditure limit (CDEL) per year. It was noted that the Trust's cash position could place constraints on the Trust's capital programme. The opportunity to secure funding from national programmes outside of CDEL should be pursued vigorously. The plan was to be discussed in a Trust Board Study Session prior to submission in February 2026. • The committee reviewed, challenged and discussed the Trust's medium-term plan ahead of the first submission to NHS England on 17 December 2025. The committee provided feedback in respect of the proposed submission noting that some of the assumptions within the 2025/26 plan had not materialised with regard to matters such as reductions in non-criteria to reside numbers and the committee sought assurance that learnings had been applied to the development of the medium-term plan submission. The committee was assured that such assumed reductions within the 2026/27 plan were based purely on actions which were deemed to be within the Trust's control. The committee suggested some changes with regard to the plan, particularly around growth assumptions in the cost base, and agreed to recommend the revised plan to the Board for approval. It was noted that more detail and reviews would be required prior to the final submission date in February 2026. • The committee received an update in respect of the Trust's cash position and supported a proposal to make a further request for cash support from NHS England for January 2026. • The Trust reviewed and supported a proposal for transforming the Southern Counties Pathology network.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.7 Finance Report for Month 8**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The Trust had reported an in-month deficit of £4.9m (£40m year-to-date), which was consistent with the Trust's Financial Recovery Plan. • November 2025 had been a challenging month due to costs associated with industrial action, patients with no criteria to reside and mental health patients. • The Trust had received c.£3m of income out of £6.1m for elective over-performance. • There had been a slight improvement in the Trust's underlying deficit.		

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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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 13 January 2026	
Committee:	**People & Organisational Development Committee**
Meeting Date:	**21 November 2025**
Key Messages:	• The committee reviewed the People Report for Month 7 including progress against the workforce plan. During October 2025, the overall workforce grew by 14 whole-time-equivalents (WTE). Although the substantive workforce had reduced by 15 WTE, there had been lower-than-expected turnover and increased temporary staffing usage due in part to high sickness levels. The Trust remained on track, however, with respect to its Financial Recovery Plan trajectory. There were concerns about the response rate to the Staff Survey, which was below the national average. The Trust's vaccination campaign for staff had started well with the uptake rate for the flu vaccine amongst staff at 43%. • The committee considered the outputs of the review by NHS England of statutory and mandatory training and the implications for UHS. It was noted that a revised framework would facilitate passporting of training between NHS organisations. The Trust was aligned to the Core Skills Training Framework across six out of eleven areas and ten out of eleven areas for the Utilising E-Learning for Health material. • The committee received an update in respect of the Trust's Inclusion and Belonging strategy. It was noted that resource constraints and the impact of the current financial and operational environment on staff morale had impacted progress towards achievement of the objectives set out in the strategy. • The committee reviewed the People risks contained within the Trust's Board Assurance Framework.
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.
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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.

Agenda Item 5.2 ii)

Committee Chair's Report to the Trust Board of Directors 13 January 2026			
Committee:	**People & Organisational Development Committee**		
Meeting Date:	**15 December 2025**		
Key Messages:	• The committee reviewed the People Report for Month 8 (see below) including progress against the workforce plan and Financial Recovery Plan. • The committee considered the workforce implications of the Trust's medium term plan submission, noting that there were a number of national expectations and targets, such as those relating to sickness rates and elimination of agency spend. In addition, the committee noted the risks associated with the plan, including those where the Trust was reliant on progress with respect to non-criteria to reside and mental health numbers. • The committee received an update regarding the Trust's Violence and Aggression workstream, noting that the Trust had adopted a revised approach to violence, aggression and abuse directed at staff with a greater willingness to take action against violent/abusive patients and members of the public. A violence and aggression board had been established to provide executive oversight and leadership, and the Trust's policy was being revised. This work would be accompanied by a comprehensive communication plan for both staff and members of the public. • The committee reviewed the Trust's progress against its objectives for Year 4 of its People Strategy.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.9 People Report for Month 8**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **High**
	• The overall workforce fell during November 2025, with substantive numbers falling by 52 whole-time-equivalents (WTE). However, temporary staffing use had increased during the month due to increased sickness and operational pressures, which offset much of the reduction in substantive numbers. • The Trust was over its original plan by 214 WTE despite a decrease of nearly 400 WTE since 31 March 2025. In order to hit the Trust's Financial Recovery Plan target, the overall workforce would need to fall by a further 137 WTE (including a 72 WTE reduction in temporary staffing) by the end of March 2026. • A forecast based on the previous year's temporary staffing usage for the remaining months of the year indicated that the Trust would end the year approximately 500 WTE above the Trust's 2025/26 plan. • The Trust had submitted a baseline assessment against the 10 Point Plan to improve Resident Doctors' working lives in August 2025, which indicated that the Trust compared favourably against other organisations in the South East. The main issues concerned space available for doctors to work in and timeliness of reimbursement of course-related expenses. • The Trust was expected to meet a target of 95% of job plans having been signed off prior to 31 March 2026. At the start of December 2025, 55% of job plans had been signed off.		

	• Sickness absence had increased in November 2025 to 4.2% in month due to seasonal illnesses. • The staff survey closed on 28 November 2025. The completion rate for the staff survey had been lower than in previous years. It was noted that the low participation rate had been predicted to be lower than in previous years owing to a number of factors, including staff time available to complete the survey, capacity to support staff completing the survey, and feelings of disengagement due to operational demands and ongoing change within the organisation. • The Trust had been successful in terms of vaccination uptake amongst staff, with 50% of staff having been vaccinated against flu, compared to a total uptake of 53% by February 2025.
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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Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

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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

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
13 January 2026</td></tr>
<tr><td>Committee:</td><td colspan="3">Quality Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">24 November 2025</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• It was noted that there had been a new Never Event reported in Dermatology, involving a case of wrong site surgery. A patient safety investigation into patient referrals into Dermatology which had been rejected and then had to be triaged again when re-referrals were sent.
• During the second quarter there had been 1,791 recorded Patient Advice and Liaison Service (PALS) interactions, which had impacted response timeframes and had led to a backlog of approximately 500 unanswered emails.
• The Invasive Procedures Committee, which oversees implementation of the national standards for surgical procedures 2 (NatSSIPS 2) was up and running and was working on harmonising checklists.
• NHS England had concluded a consultation on changes to the Never Event framework. The key change is that the Trust is able to choose how to investigate incidents proportionately focussing on learning and improvement, rather than completing a mandatory patient safety incident investigation in all cases.
• Matron-led end of life care walkabouts had been positive with high levels of staff engagement. There remained, however, a lack of available side rooms and the high level of acuity impacted on prioritisation of care for dying patients.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.10 Learning from Deaths 2025-26 Quarter 2 Report</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
Medium</td></tr>
<tr><td colspan="3">• The Trust remained in the 'lower than expected' category throughout the reporting period based on its Summary Hospital-level Mortality Indicator (SHMI), one of only 11 trusts nationally.
• During the period, the Medical Examiner Service reviewed 1,078 deaths, which represents a 5.2% decrease compared to the previous quarter.
• There remained concerns about patients with learning disabilities and/or austism.</td></tr>
<tr><td>5.11 Infection Prevention and Control 2025-26 Quarter 2 Report</td><td>Assurance Rating:
Reasonable</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust had exceeded national thresholds set by NHS England for recorded incidences of bacteraemia. This was a national issue in common with many other organisations.
• Some improvements in hand hygiene had been noted following a series of audits carried out by the infection prevention team.
• There were concerns about the Trust's capacity to screen for respiratory cases.</td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">The committee reviewed the Maternity and Neonatal Safety 2025-26 Quarter 2 Report, noting that a new Perinatal Quality Oversight Model was being implemented, with the intention of strengthening safety through continuous improvement, data-driven decision-making, and proactive risk management.</td></tr>
</table>

	A concern was raised in respect of newborn bloodspot screening performance, which appeared to be linked to a change in lancet equipment.

Assurance Rating:

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

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Medium	There is some concern that the Trust might not be able to fully meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
High	There is a significant risk that the Trust will not be able to meet its stated objectives and/or plans based on the information contained in the report considered by the committee.
Not Applicable	Where risk rating is not relevant.

University Hospital Southampton NHS Foundation Trust

Agenda Item 4.3 Report to the Quality Committee, 24 November 2025	
Title:	Maternity and Neonatal Safety 2025-26 Quarter 2 Report
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery Alison Millman, Quality Assurance and Safety Midwifery Matron Jessica Bown, Quality Assurance and Safety Midwifery Matron Hannah Mallon, Quality Assurance and Safety Neonatal Matron

Purpose

(Re)Assurance	Approval	Ratification	Information
x	x		x

Strategic Theme

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

Executive Summary:

In accordance with NHS Resolution (NHSR) requirements, the Maternity and Neonatal (MatNeo) Service submits a quarterly safety report to the Trust Quality Committee. This Quarter 2 (Q2) 2025–26 report reflects our continued commitment to a responsive and adaptive approach to emerging safety concerns, while providing assurance of sustained improvements that positively impact the safety and experience of families, service users, and staff.

This report fulfils the requirements of the NHSR Maternity Incentive Scheme (MIS) Year 7 and aims to provide both assurance and reassurance. It outlines key safety improvement initiatives, shares learning from incidents and investigations, and details progress aligned with the Patient Safety Incident Response Framework (PSIRF).

Committee members are invited to continue their support for MatNeo Services through active oversight, constructive scrutiny, and sustained focus on safety at all levels of care.
Please note: This is a comprehensive report reflecting the depth of information required for NHSR submission. The reporting period concludes on 30 November 2025 and incorporates the new requirements of the Perinatal Quality Oversight Model, detailed within the report and in Appendix 1.

Contents:

This report provides an update in relation to the following areas for Quarter 2 2025/26:

Risk(s):
The University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Services operate within a complex regulatory and governance framework. Several key risks have been identified that may impact service delivery, organisational performance, and the safety of women, birthing people, babies, and staff: • **Reputational Risk**: Any concerns relating to safety or quality of care may be raised by service users or stakeholders to external regulatory bodies such as NHS Resolution and the Care Quality Commission (CQC), potentially affecting public confidence in our services. • **Financial Risk**: Ongoing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) remains essential. Failure to meet all ten required Maternity Safety Actions could result in the loss of financial incentives and increased scrutiny. • **Governance Risk**: Significant concerns regarding safety or quality can be escalated to a range of national and regional stakeholders, including the CQC, NHS England, the NHS Improvement Regional Director, the Deputy Chief Midwifery Officer, and the Regional Chief Midwife. This may lead to formal reviews or additional oversight. • **Safety Risk**: Non-compliance with national requirements, standards, or recommendations can have serious consequences, including increased clinical risk to women and babies, reduced staff morale and wellbeing, and ultimately poorer outcomes. The Maternity and Neonatal Safety Improvement (MNSI) programme has the authority to raise formal concerns and trigger external reviews where safety is questioned. UHS remains committed to proactively addressing these risks through robust governance processes, continuous quality improvement, and transparent engagement with our staff, service users, and external partners.

Equality Impact Consideration:	N/A

1. New Perinatal Quality Oversight Model (PQOM)

In August 2025, the **Perinatal Quality Oversight Model (PQOM)** replaced the previous Perinatal Quality Surveillance Model (PQSM). The PQOM aims to strengthen maternal and neonatal safety through continuous improvement, data-driven decision-making, and proactive risk management. It promotes collaboration, accountability, and early identification of safety threats to improve outcomes and reduce inequalities.

Perinatal Quality Oversight Model – Summary of Key Changes
The move from PQSM to PQOM represents a shift from monitoring to active accountability and intervention. Trust Boards now hold statutory responsibility for perinatal oversight, ensuring safe care delivery and adequate staffing and resources, while addressing health inequalities.

Aspect	Previous PQSM	New Oversight Model
Focus	Monitored data to identify risks.	Proactive oversight to ensure timely action and improvement.
Data & Reporting	Periodic reviews, some data lag.	More frequent, timely data and dashboards for rapid response.
Governance	Less formal escalation routes.	Clear escalation pathways and regular Board-level scrutiny.
Escalation	Action sometimes delayed or inconsistent.	Defined triggers, SMART action plans, and formal escalation.
Support	Limited structured improvement support.	Linked to national improvement programmes and resources.

Local actions:

- Increase frequency of Board-level review of perinatal data.
- Ensure risk registers and escalation processes reflect defined triggers.
- Engage with national support programmes where gaps are identified.

PQOM dashboard
To support the new model, MatNeo is developing a dedicated PQOM dashboard aligned to oversight requirements. This dashboard, structured around the delivery plan's key themes, supports compliance with NHSR MIS Safety Action 9. A draft working copy of the dashboard can be seen in **Appendix 1** or via this link.

2. UHS Maternity Services dashboard

Previously reported red flags:

- Post Partum Haemorrhage (PPHs) >500mls & >1500mls
- 3rd and 4th degree tears (OASI)
- Apgar's less than 7 at 5 minutes
- Smoking at time of delivery

These remain under active monitoring, with targeted improvement initiatives ongoing. No new updates are reported this quarter.

New red flag: *Newborn Bloodspot Screening Performance*
The avoidable repeat rate should be ≤2%. Current performance is 2.6%, making UHS a regional outlier. This decline coincides with a change in lancet equipment. Historical data show similar trends following previous equipment changes. The lancets were reverted on 1 November 2025, and improvement is anticipated. During this period, performance will continue to be monitored and reported as a safety measure.

3. Birth outcomes

As mentioned above, the MatNeo Service is reviewing the current dashboards that are in use. A PowerBI dashboard has been created looking at birth outcomes, which include type of delivery, 3rd and 4th degree tears as well as blood loss rates. A screenshot of the current summary is within **Appendix 2**.

4. NHSR Early Notification Scheme (ENS) review

In October 2025, NHS Resolution informed MatNeo of a review of cases from the past five years. A local review, supported by the legal team, has been completed to provide assurance that recommendations have been implemented.

NHSR ENS criteria
Babies born at ≥37 weeks with potentially severe brain injury within 7 days of birth (including Grade III HIE, therapeutic cooling, or seizures).

Themes identified include blood-stained liquor *and* placental histology. Guidance on these areas is under review, with plans to introduce electronic placental histology requests. See **Appendix 3**, for a breakdown of patient demographic and case thematics.

A regional comparison confirms UHS is not an outlier. (Note: regional data include babies ≥34 weeks.)

5. Claims scorecard and triangulation of claims, incidents and complaints

Appendix 4 presents the Claims Scorecard (2015–2025). UHS ranks in the bottom five for open and closed obstetric claims by volume. Top injury codes – brain damage, pain, psychological injury, and unnecessary operation – align with regional trends. **Appendix 5** triangulates these data with incident and complaint themes for Q2.

6. Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases

Appendix 6 outlines the cases reported by the MatNeo Service in Q2 25-26 and cases closed, with key themes and learning.

6.1. Mortality overview Q2

The stillbirth rate in Q2 was 3.8 per 1,000 births—below the national average (<4.2) and improved from Q1. The YTD rate (5.0 per 1,000) remains elevated due to Q1 data.

Key themes:

- NEST Continuity Teams: Cases involving families under NEST prompted review of how additional support needs intersect with outcomes.
- Placental Abruption: An upward trend is under thematic review by the Consultant Midwifery Team – see **Appendix 7**.

6.2. MNSI 9rocess review – term stillbirths

A retrospective review of 2024 referrals confirmed appropriate MNSI processes. Going forward, all ≥37-week stillbirths will be discussed with MNSI for shared learning. The MNSI team will attend the next LMNS Perinatal Quality and Safety Meeting to share findings regionally.

7. New MatNeo rapid review – PSIRF learning and capturing the patient voice

The Quality and Safety Team has redesigned the clinical event review process in line with PSIRF principles, embedding the voices of both staff and patients.

Key features:

- Daily rapid review walkarounds to identify and discuss incidents proactively.
- Weekly MDT reviews for amber cases, with Quality Patient Safety Partners ensuring representation of the patient voice.

Staff feedback indicates improved engagement and ownership in the safety review process. Emerging themes and learning will be reported in Q3.

8. Emergency theatre capacity 2nd obstetric theatre

Following escalations in July, an executive decision confirmed that two obstetric theatres must remain available at all times.

Key issues:

- Current gaps in Tuesday PM, Wednesday PM, and Friday PM capacity
- Increasing Category 3 CS and elective backlog pressures
- Staffing constraints due to NHSP rate reductions
- Concerns about overnight second theatre availability.

NHSE Southeast has requested confirmation of 24/7 access to a second emergency theatre as part of a regional review.

9. NMPA report 2025

The 2025 National Maternity and Perinatal Audit highlights improved risk identification and management of high-risk pregnancies, though outcome variation remains. UHS is acting on key recommendations **(Appendix 8),** focusing on risk assessment, early detection, and better integration between maternity and neonatal teams.

10. NNAP temperatures

The 2024 NNAP identified UHS as an outlier for the “normal temperature” metric (64.2% vs. 77.6% nationally). A QI project is underway, showing unvalidated improvement to 76.8%. See **Appendix 9** for the action plan.

11. ATAIN update

The “Think 60” QI project was presented to Safety Champions and LMNS in October. Although unexpected term admissions rose (35 in Q2 vs. 26 in Q1), rates remain below 5%. Admissions for jaundice increased (5 vs. 2); neonatal jaundice guidance is being updated. See **Appendix 10.**

12. 3 Year delivery plan benchmarking (theme 2)

Q2 focuses on Theme 2 – Supporting Our Workforce. Progress updates are detailed in Appendix 11. The plan aims to make maternity and neonatal care safer, more personalised, and more equitable.

13. SCORE / culture workstream updates

Current initiatives include:

- Cultivating Kindness Campaign
- Civility Champions **(50+ staff trained)**
- Happiness in the Workplace Programme

These MDT initiatives promote civility, restorative supervision, and psychologically safe conversations to address unprofessional behaviour constructively.

14. NHSR evidence/sign off

The MatNeo Service is nearing completion of NHSR MIS Year 7 requirements, with final reporting due 30 November 2025.

Key dates:

- Trust Board Declaration: 13 January 2026
- ICB Executive Review: post–Board declaration
- Submission to NHS Resolution: by 3 March 2026

Safety Action	Brief Description	Status prior to Nov 30th
1	Perinatal Mortality Tool and Reporting	Ongoing and on track
2	Maternity Services Data Set Standards	Met
3	Transitional Care Services	Met
4	Obstetric, Anaesthetic, Neonatal workforce	Ongoing reporting
5	Midwifery Workforce	Ongoing reporting
6	Saving Babies' Lives Care Bundle	Ongoing and on track
7	Listening to Service Users	Ongoing and on track
8	Multi professional emergency training	Ongoing and on track
9	Oversight of Mat/Neo Quality and Safety	Ongoing reporting
10	MNSI and EN Scheme reporting compliance	Ongoing and on track

Appendix 1

UHS Maternity - Perinatal Quality Oversight Model

Introduction to PQOM dashboard

In August 2025, the Pregnancy Quality Oversight Model (PQOM) replaced the previous Pregnancy Quality Safety Model (PQSM). The PQOM aims to improve maternal and neonatal safety by focusing on continuous quality improvement, data-driven decision-making, and proactive risk management. It promotes collaboration and accountability among healthcare providers, ensuring better health outcomes through early identification of safety threats and adherence to best practices. In response, our MatNeo service has updated its dashboard to align with the new oversight requirements, ensuring compliance and enhanced care delivery.

Listening to women and families	Workforce	Culture of learning, safety and support	Structures and standards underpinning safer, more personalised, eqitable care
Friends and Family Test	Education	Maternity Safety Support Programme	Maternity Dashboard
Not linked - Maternity Safe...	Workforce	Incidents	National Neonatal Audit...
Complaints	Birth Rate +	PMRT	
		MNSI	
		Not linked - PSII	

Listening to women and families - Friends and Family Test

Return to main menu

Maternity FFT

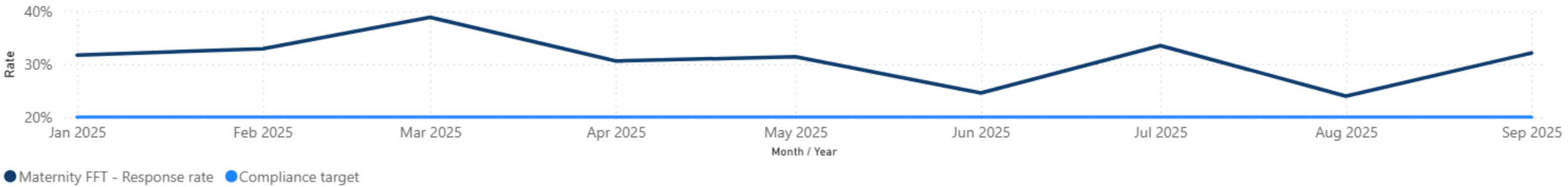
Neonatal FFT

Date range

2025

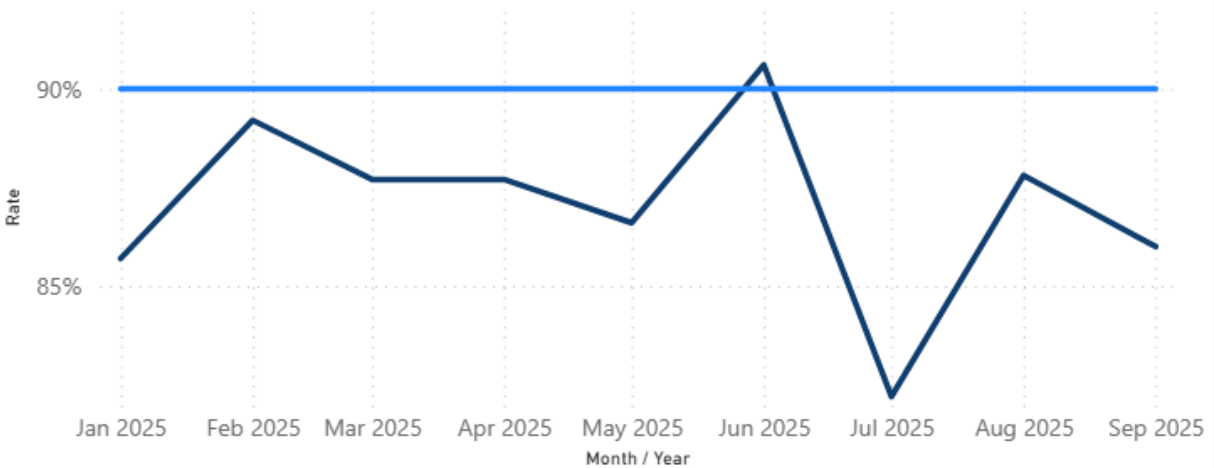
Maternity FFT - Response rate

Trust compliance target - 20% or greater



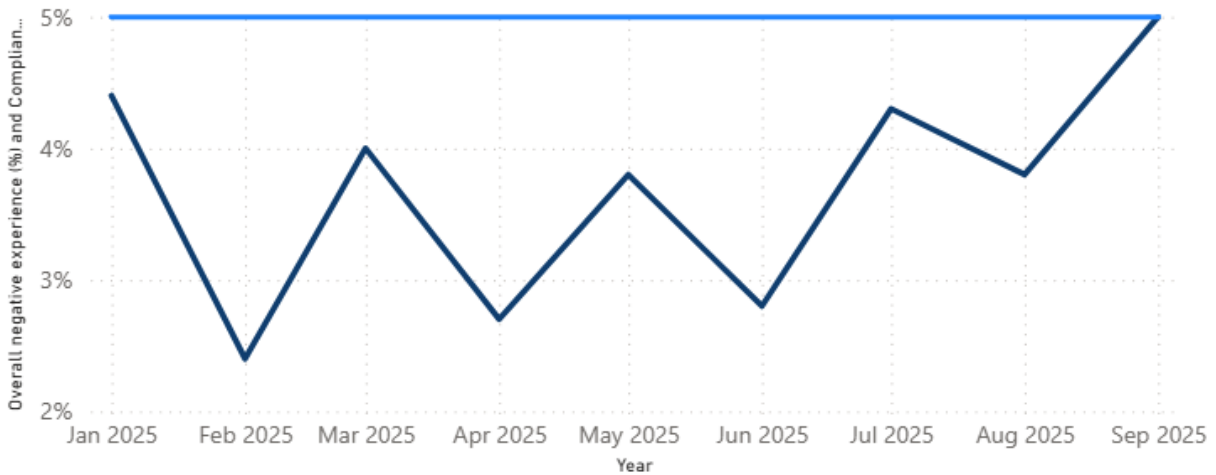
Maternity FFT - Overall positive experience rate

Trust compliance target - 90% or greater



Maternity FFT - Overall negative experience rate

Trust compliance target - 5% or less



Listening to women and families - Friends and Family Test

Return to main menu

Maternity FFT

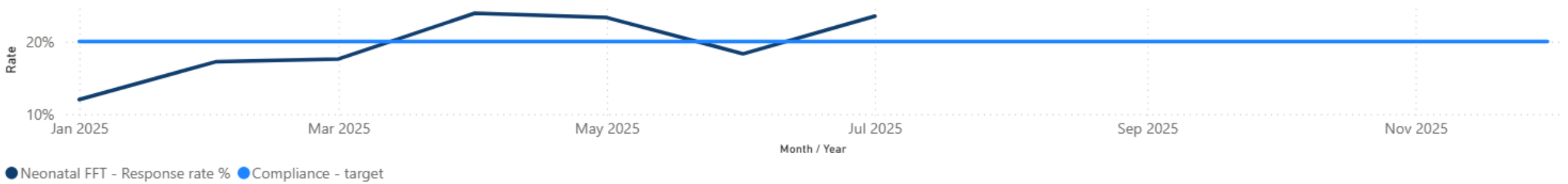
Neonatal FFT

Date range

All

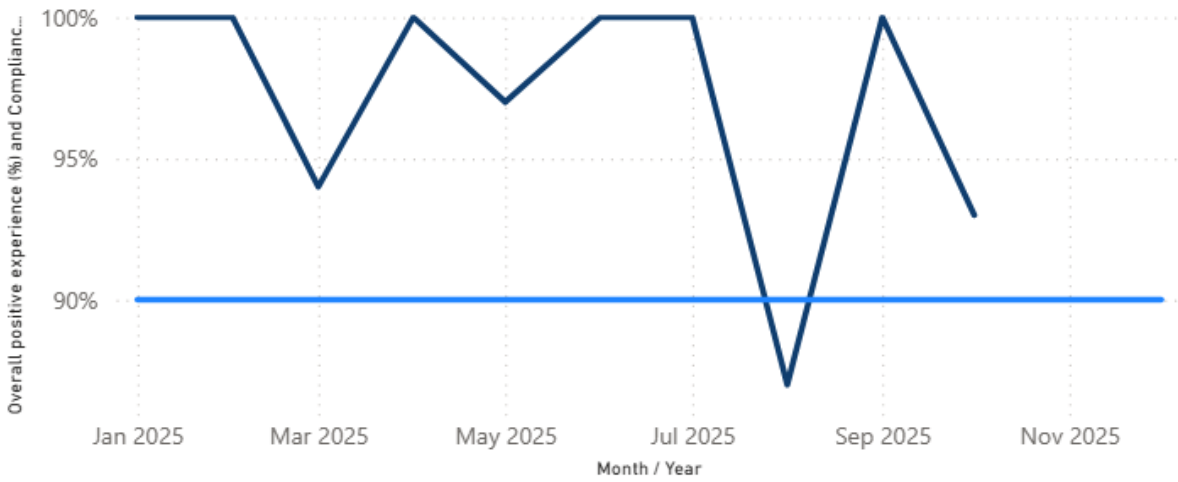
Neonatal FFT - Response rate

Trust compliance target - 20% or greater



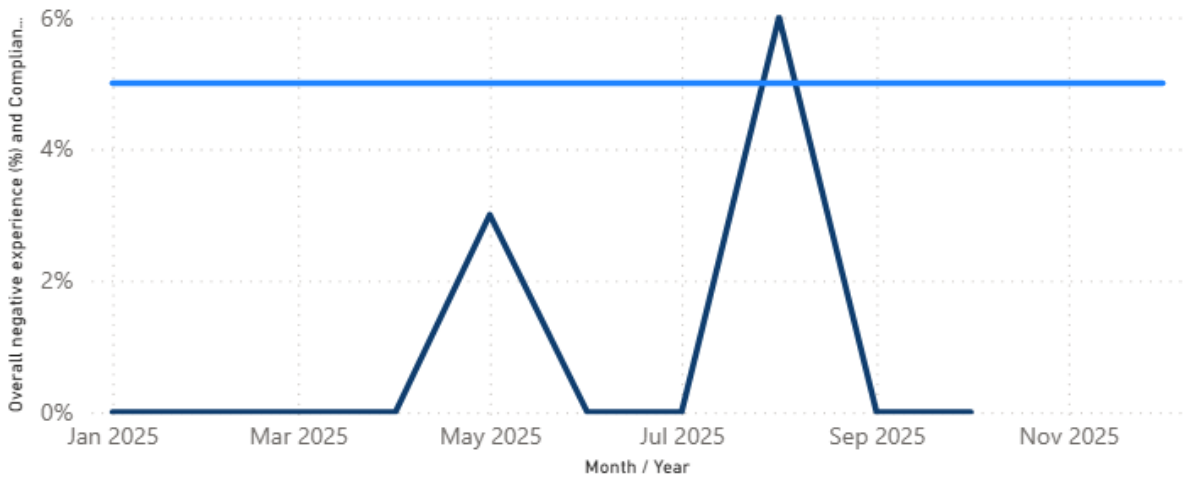
Neonatal FFT - Overall positive experience rate

Trust compliance target - 5% or less



Neonatal FFT - Overall negative experience rate

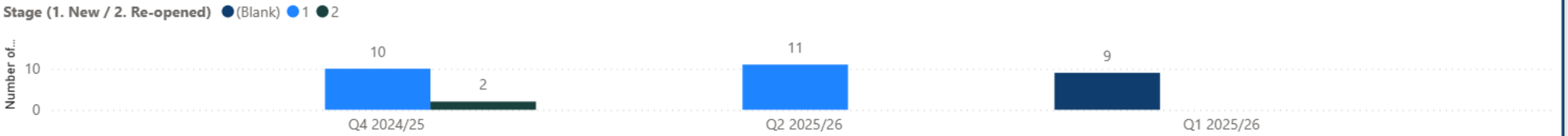
Trust compliance target - 5% or less



Listening to women and families - Complaints

Return to main menu

Number of complaints received



Quarter opened (to change to date received)

Q2 2025/26

Department

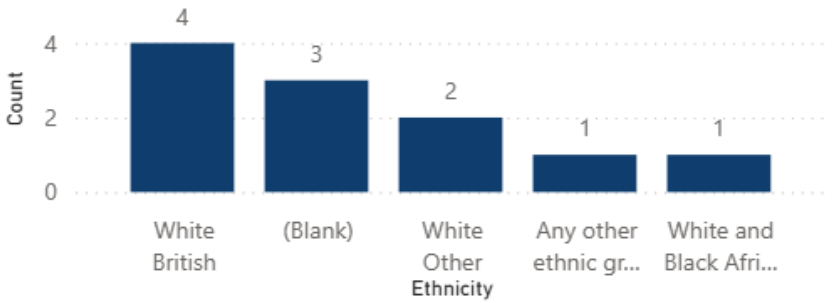
All

Stage (1. New / 2. Re-opened)

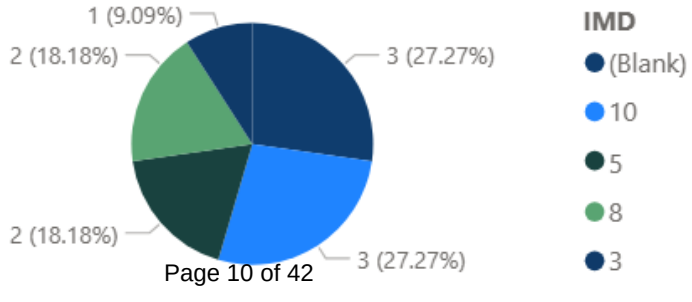
All

Count of Case ref. by Category

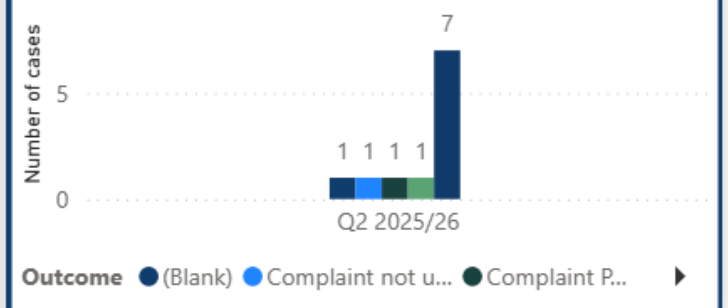
Ethnicity of mother



IMD



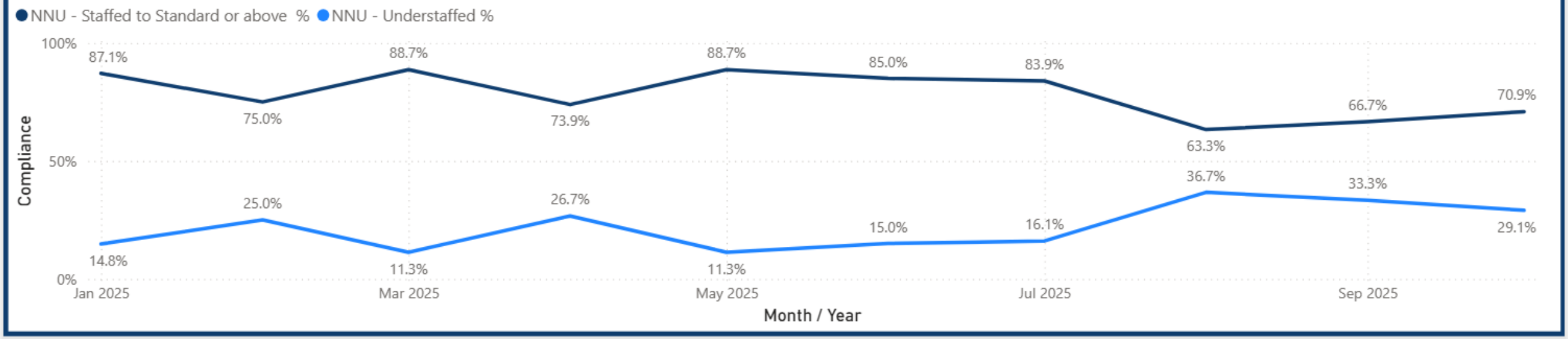
Outcome of complaints



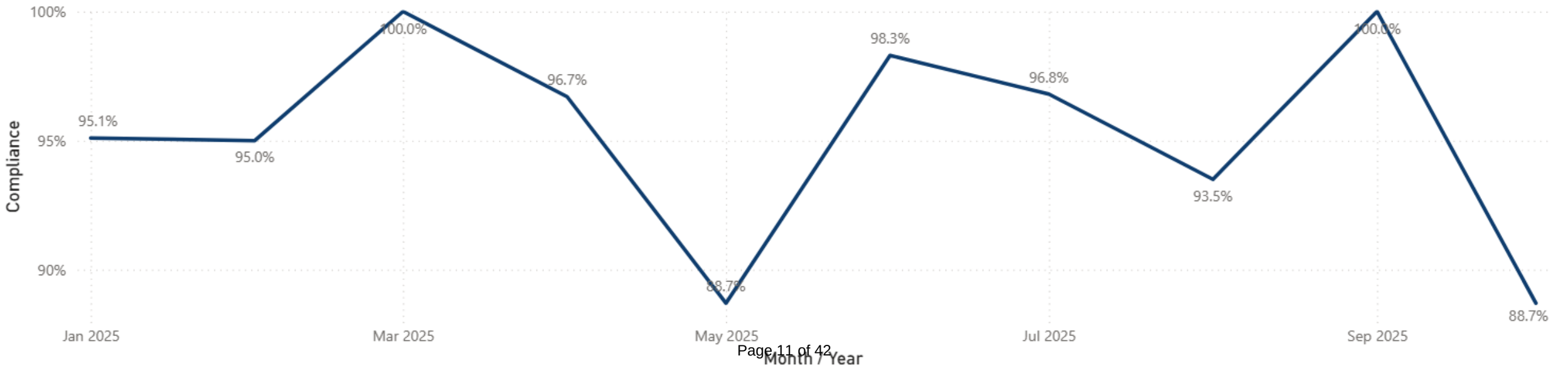
Workforce - Neonatal Staffing

Return to main menu

Neonatal staffing



Transitional Care % of Shifts Staffed to BAPM Standard (1:6) or Above



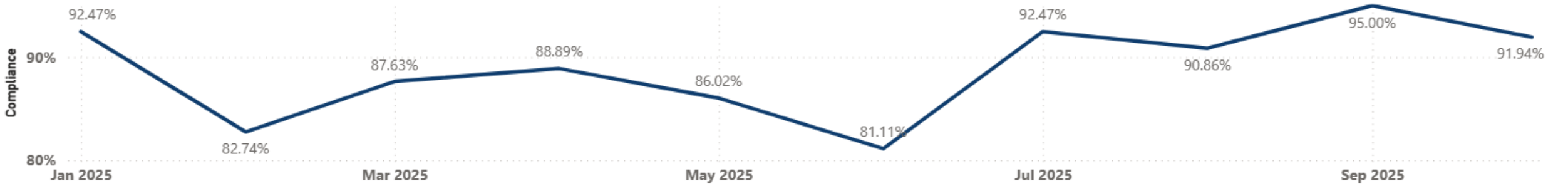
Workforce - Birth Rate Plus Acuity Tool

Return to main menu

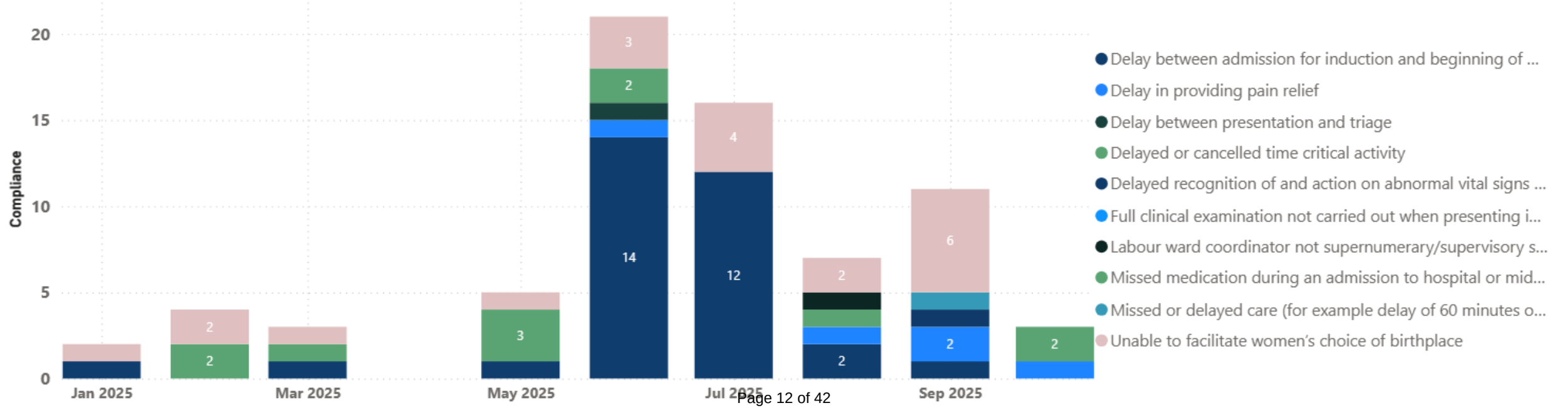
Birth Rate + Labour ward

Birth Rate + Broadlands ward

Birth Rate Plus - Labour ward completed assessments (all)



Labour ward red flags



Workforce - Birth Rate Plus Acuity Tool

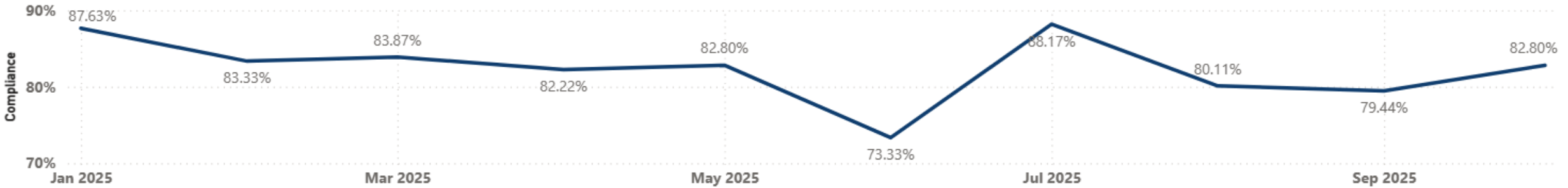
Click here to follow

Return to main menu

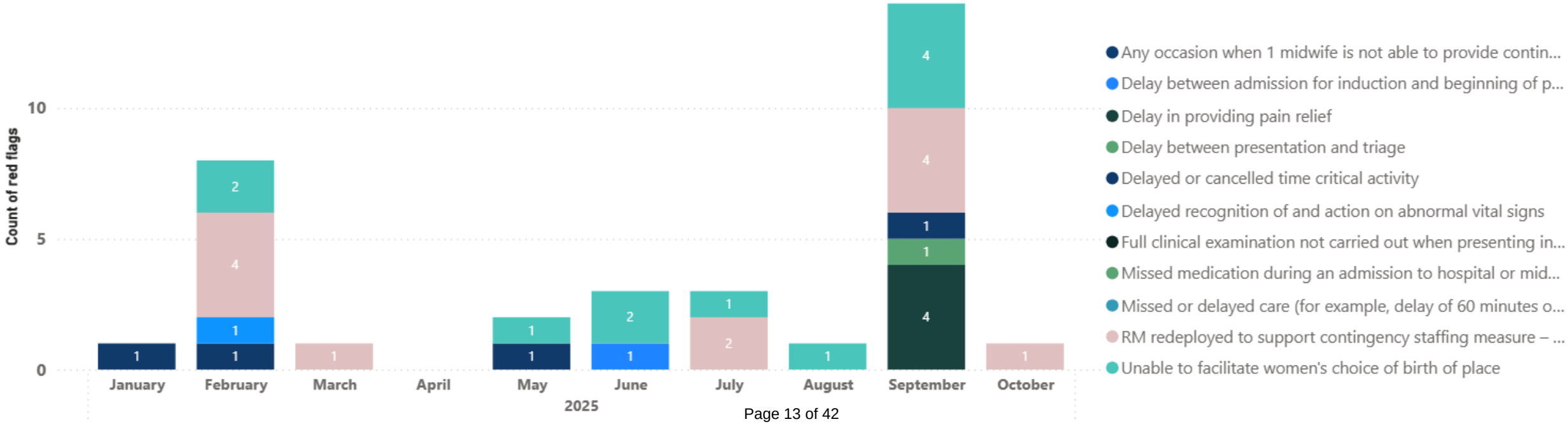
Birth Rate + Labour ward

Birth Rate + Broadlands ward

Birth Rate Plus - Broadlands ward completed assessments (all)



Broadlands ward red flags



Culture of learning, safety and support - MSSP and Incidents

Return to main menu

Entry onto the Maternity Safety Support Programme

Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025
No	No	No	No	No	No	No	No	No

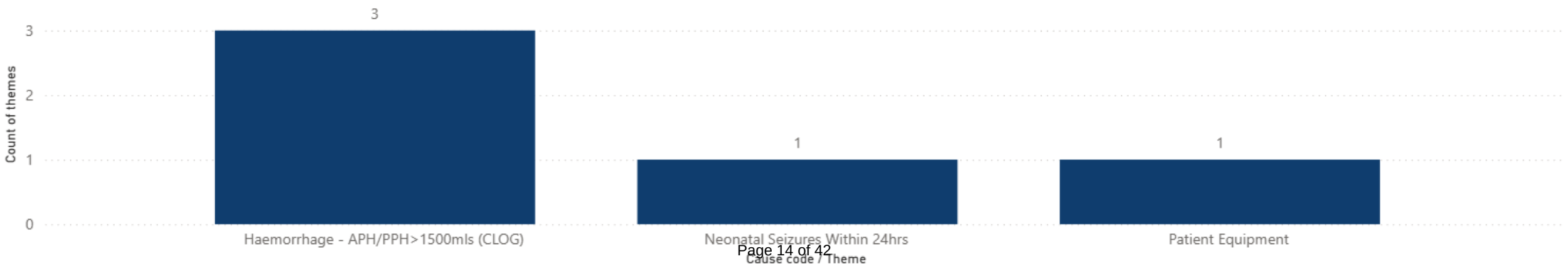
Number of moderate or above incidents reported within Maternity and Neonatal Services

Year: 2025

Month: October

Actual Impact: All

Reported themes of moderate or above incidents



Culture of learning, safety and support - PMRT

Return to main menu

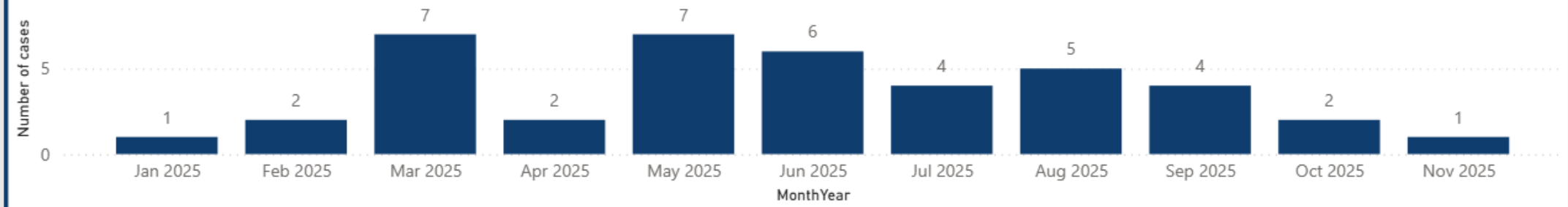
Date of death

All

Category of case

All

Number of reportable PMRT cases

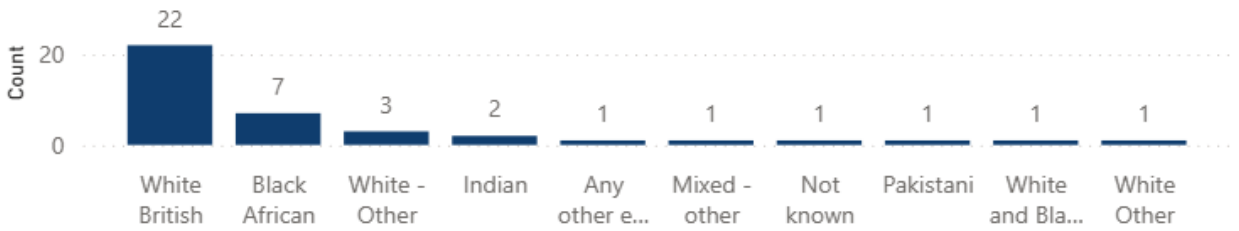


PMRT cases

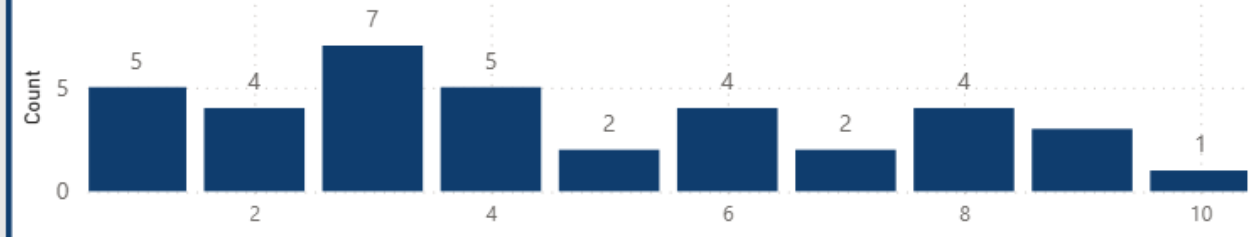
Reset table

PMRT ref.	Date of death	Category (Stillbirth / Neonatal Death)	Inborn / outborn	Ethnicity	IMD
96731	03 January 2025	Antepartum SB	Inborn	White British	4
97324	14 February 2025	Early NND	Inborn	Black African	9
97495	25 February 2025	Intrapartum SB	Inborn	White and Black Caribbean	4
97659	08 March 2025	Late NND	Outborn	Black African	6
97702	08 March 2025	Antepartum SB	Inborn	White British	10
97702	10 March 2025	Early NND	Inborn	White British	10
97770	10 March 2025	Antepartum SB	Inborn	Indian	7

Ethnicity of mother



IMD



Coroner's regulation 28 made directly to Trust

Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025
No	No	No	No	No	No	No	No	No

Culture of learning, safety and support - MNSI

Return to main menu

MNSI - Date of incident

- Select all
- (Blank)
- 07/10/2024
- 14/03/2025
- 15/07/2025
- 22/08/2025
- 24/03/2025

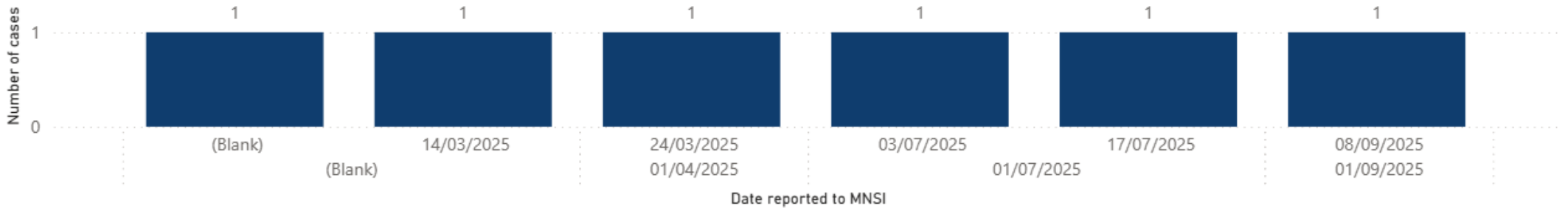
Number of cases submitted to MNSI

5

Number of cases accepted by MNSI

4

MNSI cases

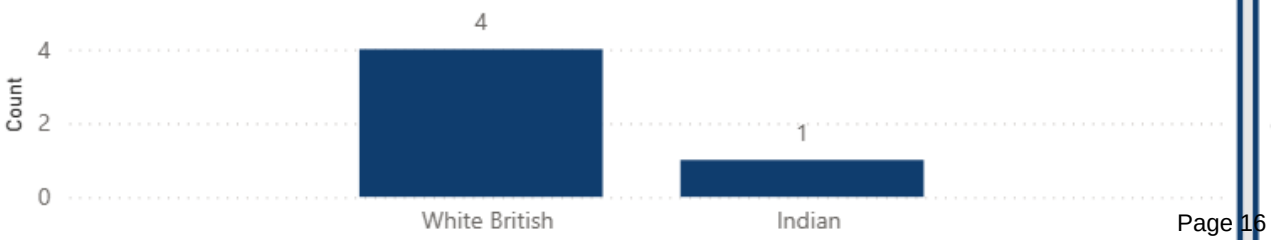


MNSI reportable cases

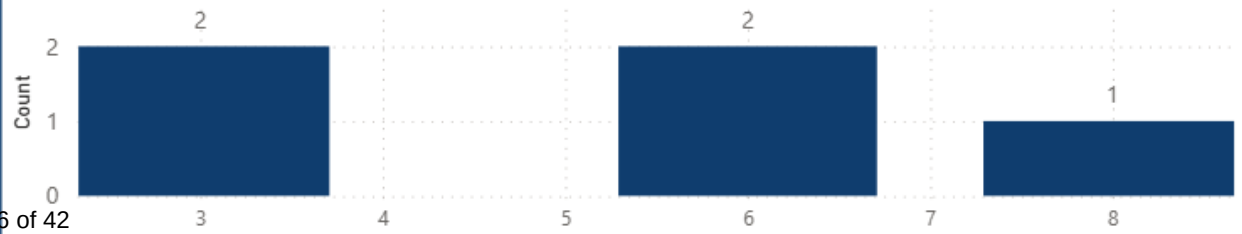
Reset table

Date of incident	MNSI ref.	Type of incident	Ethnicity	IMD	Date reported to MNSI	MNSI accepted (Y/N)	Accepted date Formatted
07/10/2024	MI-043787	Neonatal death	White British	6	03/07/2025	Yes	Jul 2025
14/03/2025	MI-040754	Neonatal death	Indian	3	14/03/2025	No	
15/07/2025	MI-044334	Therapeutic Cooling	White British	8	17/07/2025	Yes	Jul 2025
22/08/2025	MI-046163	Intrapartum stillbirth	White British	3	08/09/2025	Yes	Sep 2025
24/03/2025	MI-040825	Intrapartum stillbirth	White British	6	24/03/2025	Yes	Apr 2025

Ethnicity of mother



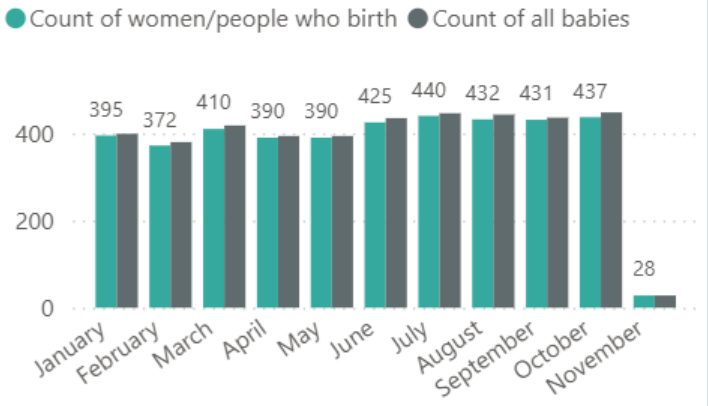
IMD



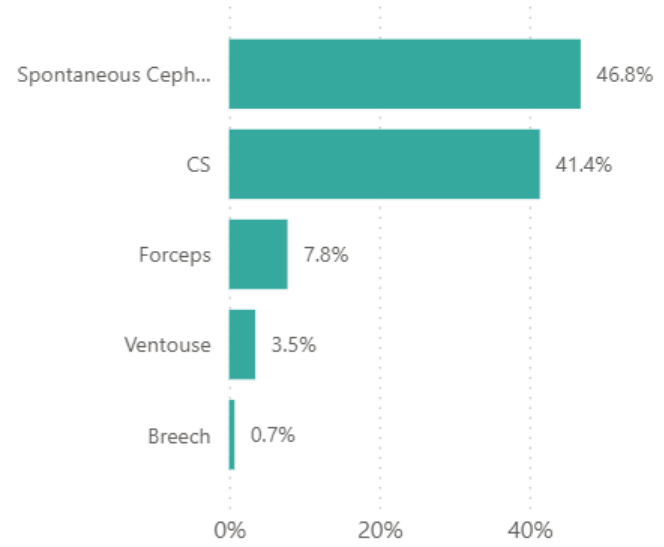
Appendix 2

UHS Maternity Services - Birth outcomes - 2025 summary

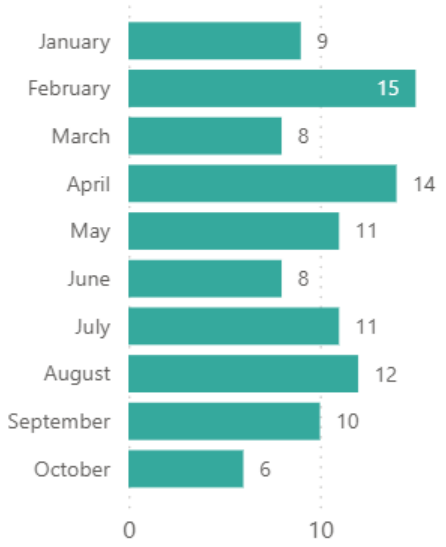
2025 birth rate



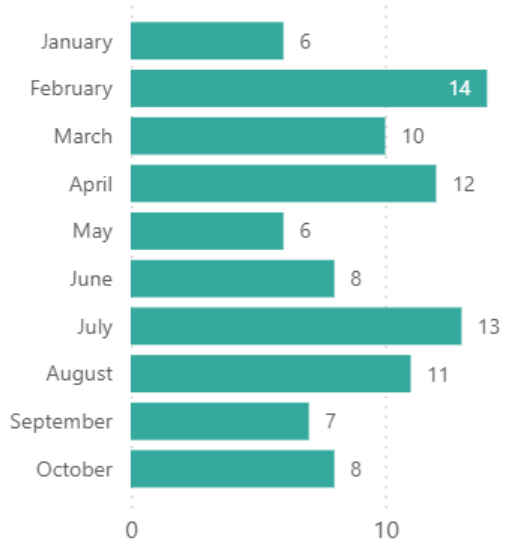
2025 Type of delivery



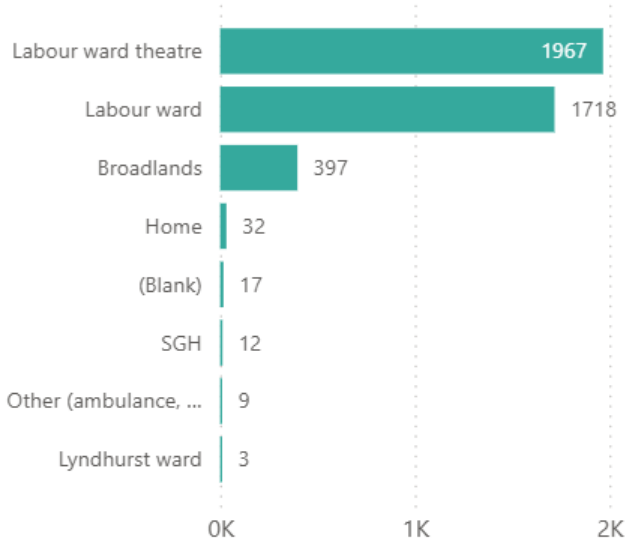
Number of 3rd/4th degree tear



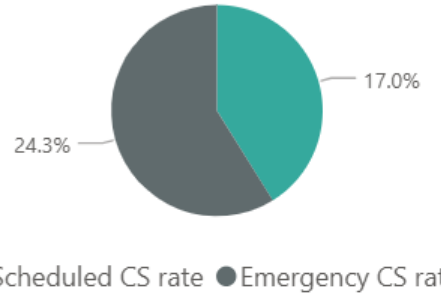
Apgar score less at 7 at term



2025 Place of birth



2025 CS rates

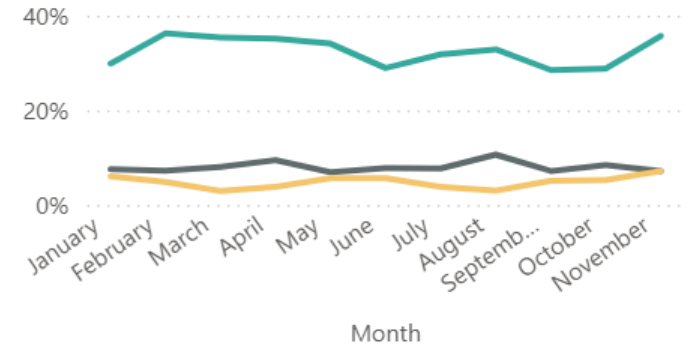


Rate of 3rd/4th degree tears

Stillbirths

22

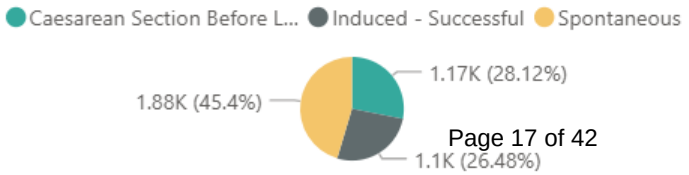
Blood loss rates



Late fetal losses

38

Onset of labour



Neonatal deaths

Total inborn deaths recorded on Badger

16

BBA

20

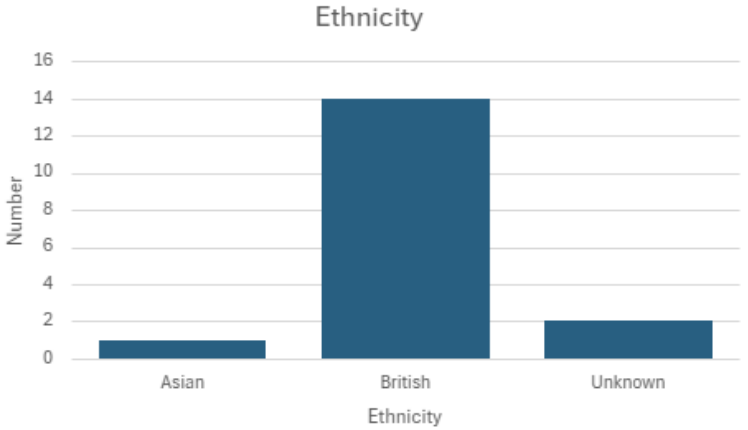
Attended homebirth

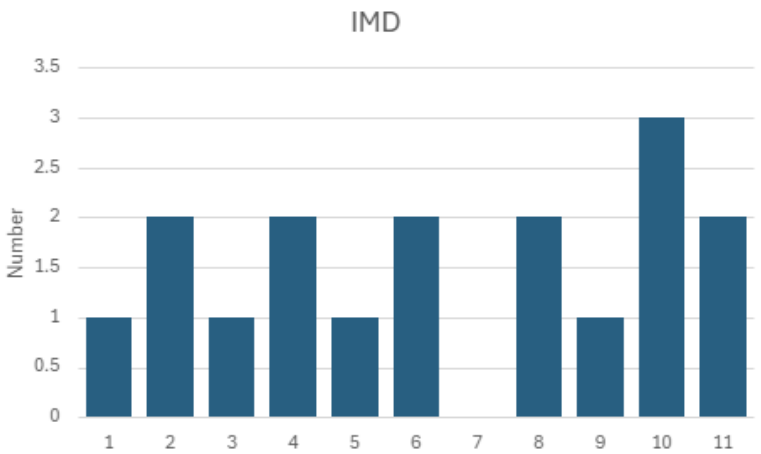
23

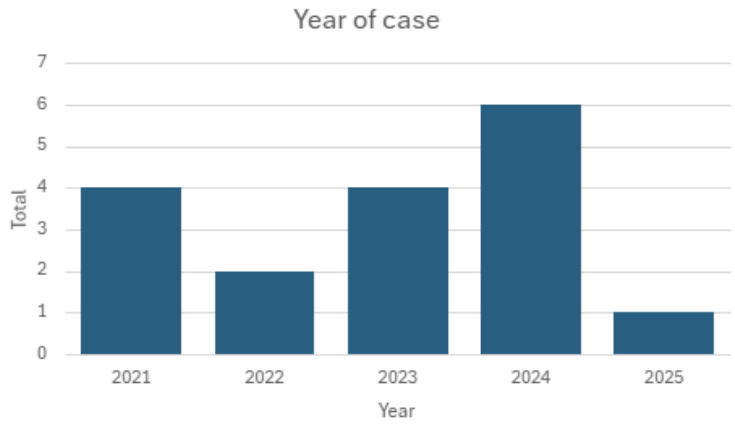
NHSR ENS review (1st Jan 2021 – 30th sept 2025)

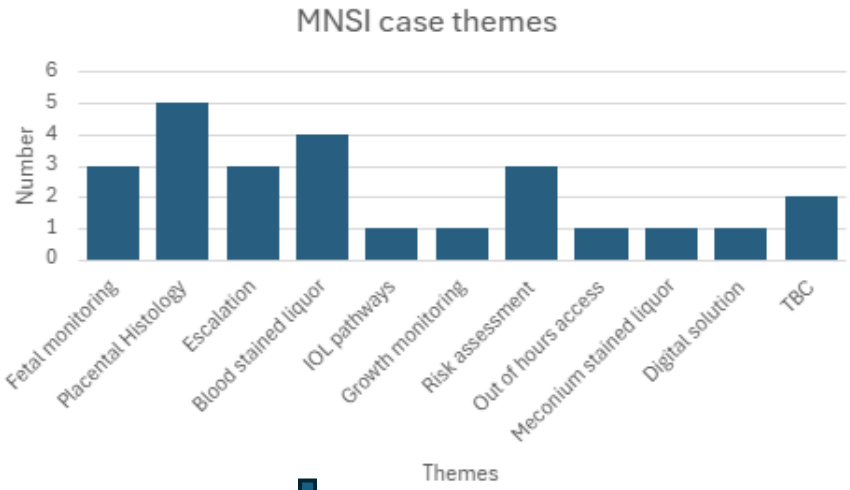
17 cases

All cases baby went for therapeutic cooling – 2 of the cases the baby subsequently died (Days 8 & 9)









NB. Some cases more than 1 theme.

Summary

- No obvious patient demographic themes
- Spike in cases in 2024
- Top themes:
  - Placental histology
  - Bloodstained liquor

UHS vs ODN rates of HIE

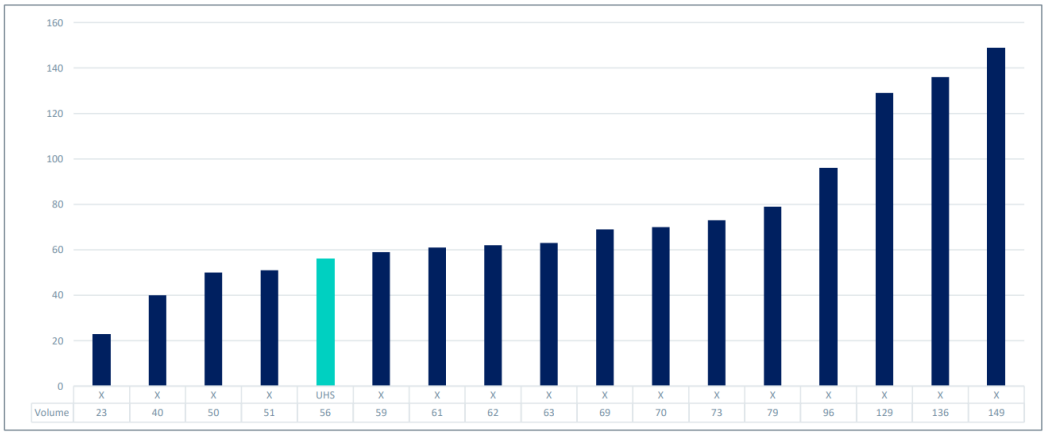
Level of NNU		NIC	NIC	NIC	LNU	LNU	LNU	LNU	LNU	LNU	SCU	SCU	SCU	SCU	SCU	
Live Births		7,280	4,820	4,885	3,841	4,517	4,564	4,279	3,668	2,009	2,411	2,067	2,149	1,665	917	49,072
HIE: babies identified with possible HIE		10	2	8	5	3	3	6	1	1	0	3	2	1	0	45
HIE rate per 1000 births		1.37	0.41	1.64	1.30	0.66	0.66	1.40	0.27	0.50	0.00	1.45	0.93	0.60	0.00	0.92
3 year: Babies identified with possible HIE		30	15	24	11	15	24	14	6	7	9	9	9	4	0	177
3 year: HIE rate per 1000 births		1.37	1.04	1.64	0.95	1.11	1.75	1.09	0.55	1.16	1.24	1.45	1.40	0.80	0.00	1.20

NB. This includes babies >= 34 weeks gestation

UHS Claims Score Card Summaries and Benchmarking 2024/2025

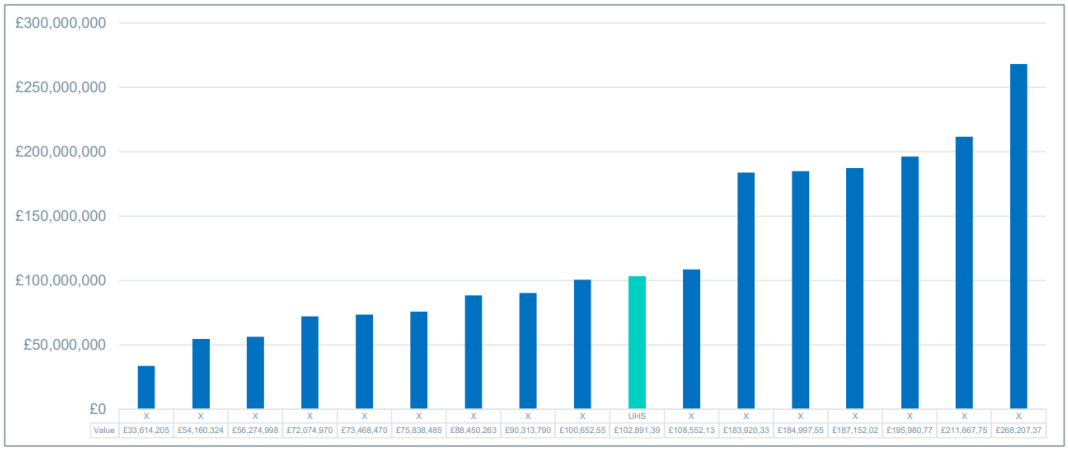
Appendix 4

SE regional maternity services: All open & closed obstetric claims by volume 2015/16 to 2024/25



*Data correct as of 30.06.2025 & by clinical incident date

SE regional maternity services: All open & closed obstetric claims by value 2015/16 to 2024/25



*Data correct as of 30.06.2025 & by clinical incident date

University Hospital Southampton NHS Foundation Trust

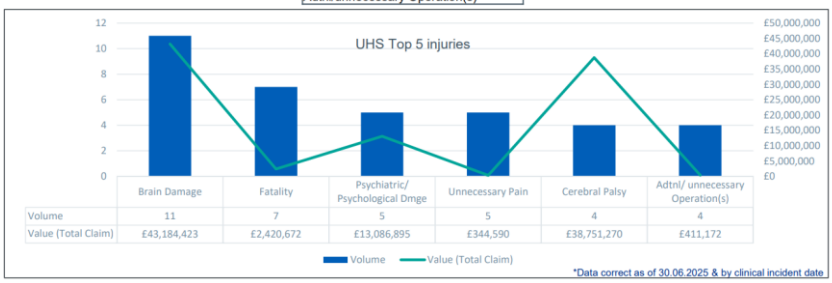
UHS Claims Score Card Summaries and Benchmarking 2024/2025

Appendix 4

National & UHS – Top injury codes from all open & closed Maternity claims 2015/16 to 2024/25

NHS Resolution

National Top 5 Injuries for Obstetrics
Stillborn
Unnecessary Pain
Psychiatric/Psychological Dmge
Brain Damage
Adtnl/unnecessary Operation(s)



	Brain Damage	Fatality	Psychiatric/ Psychological Dmge	Unnecessary Pain	Cerebral Palsy	Adtnl/ unnecessary Operation(s)
Volume	11	7	5	5	4	4
Value (Total Claim)	£43,184,423	£2,420,672	£13,086,895	£344,590	£38,751,270	£411,172

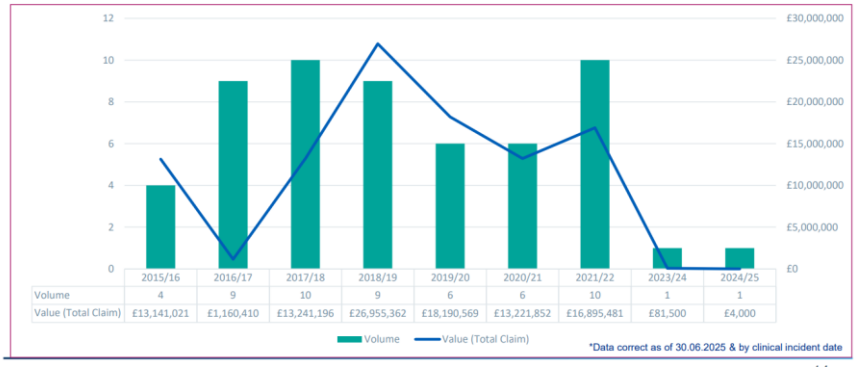
UHS – Top 10 Specialities for clinical claims 2015/16 to 2024/25

NHS Resolution

	Orthopaedic Surgery	Emergency Medicine	Obstetrics	Neurosurgery	General Surgery	Gynaecology	Neurology	Ophthalmology	Cardiology	Cardio Surgery
Volume	65	56	56	44	34	27	25	24	23	20
Value (Total claim)	£10,257,365	£19,946,027	£102,891,391	£18,145,110	£5,685,880	£3,082,564	£8,748,174	£6,714,802	£14,489,023	£3,122,125

UHS – All open & closed maternity claims year on year 2015/16 to 2024/25

NHS Resolution



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2023/24	2024/25
Volume	4	9	10	9	6	6	10	1	1
Value (Total Claim)	£13,141,021	£1,160,410	£13,241,196	£26,955,362	£18,190,569	£13,221,852	£16,895,481	£81,500	£4,000

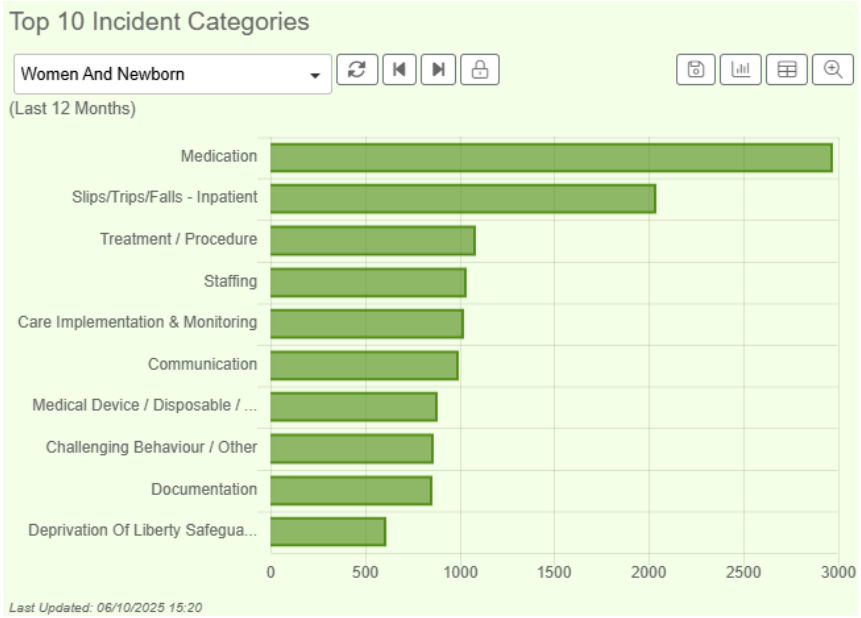
University Hospital Southampton NHS Foundation Trust

PMRT Supporting high quality local perinatal reviews

UHS Maternity/Obstetric Triangulation of claims, incidents and complaints data Q2 25-26

Status of claim	Volume	Value (Total claim)
Closed	37	£1.99M
Open	17	£87.7M
Incidents	2	£13.2M
Grand Total	56	£102.9 M

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



MNSI report recommendations

Themes & learning identified from PMRT in Q2 25-26

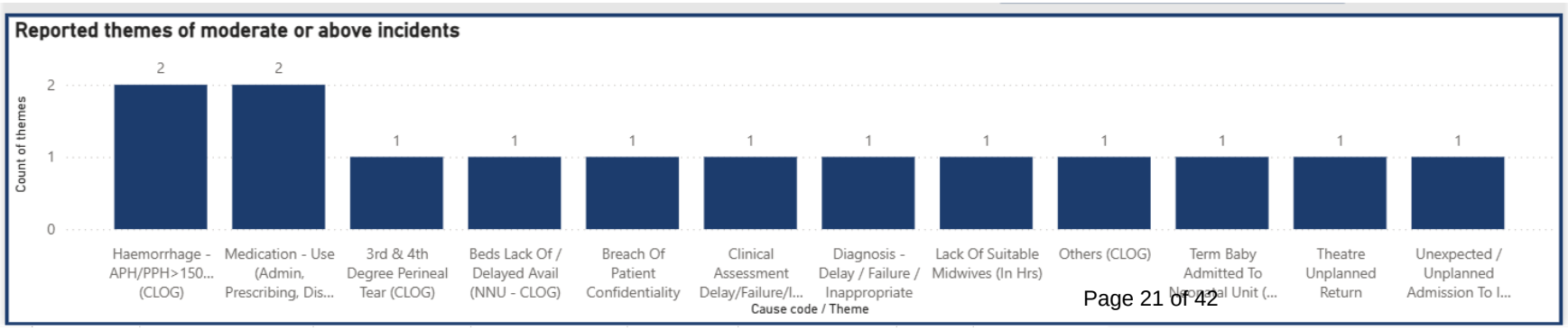
Management of smoking (CO monitoring)
? Missed opportunity for growth USS
NEST/CoC team

Mat Neo complaints Q2 25-26 (11 Total)

8 Outstanding
1 Upheld
1 Partially upheld
1 Not upheld
Themes: Communication, Clinical treatment & Patient care

Constructive FFT Patient Voice/feedback Q2 25-26

- Communication
- Basic care/clinical support/feeding support
- Staff attitude



Common Themes

1. Communication
2. Clinical treatment
3. Care/observations & monitoring

Appendix 6

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

New Patient Safety Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
MNSI / PMRT	MI – 043787	03/07/2025	Early Neonatal Death	Incident occurred in October 2024. Term baby at 41+5. Due to come in for IOL at 6pm. Presented with absent fetal movements for approx. 18 hours. On admission to MDAU, CTG commenced, and decision made for Cat 1 Section. Baby girl born in poor condition requiring resuscitation. ROSC at 22mins of age. Admitted to NICU however cranial ultrasound scan showed severe HIE. She developed multi organ failure despite maximal treatment. Decision made with parents to redirect care. Died on day 1 of life.	PMRT completed and closed as A / B / A. Case referred to MNSI in July following receipt of a complaint from the family which led us to re-review the case.
MNSI / PMRT	MI – 044334 / 10003583 / 99516	22/07/2025	Early Neonatal Death	Low risk pregnancy. Patient presented in labour at 40+3 weeks gestation. Baby girl born at 40+4 weeks via Cat 1 C section following a sudden bradycardia. She was born in very poor condition with no signs of life ?following placental abruption. She was admitted to NICU for ongoing care and therapeutic hypothermia commenced. She developed multi organ dysfunction and had extensive changes on MRI. Care was redirected to comfort care following discussions with parents. She died on day 7 of life.	PMRT reported and ongoing within timescale. Case reviewed through Clinical Events Review and reviewed at Neonatal CDRM in September. Initial learning identified relating to blood-stained liquor. Concerns raised by the family regarding to missed dosages of pain relief and postnatal care. This has been reported to MNSI and the investigation is ongoing. Provisionally graded as C, B and D, however waiting for completion of the MNSI report before finalising the grading.
MNSI / PMRT	MI – 046163 / 99935	22/08/2025	Intrapartum stillbirth	Phone call to Maternity Triage Line concerned and reduced fetal movements at 39+6 weeks. She reported niggles but no other concerns. She presented to MDAU and an IUD was confirmed. Baby boy stillborn at 40+0 weeks.	PMRT reported and ongoing within timescale. Reviewed through Clinical Events Review. Learning identified relating to a potential missed opportunity for referral for a growth scan due to

					static fundal growth. PMRT reported and ongoing within timescale. As the patient reported that she had niggles, this has been referred to MNSI as an intrapartum stillbirth. The case has been accepted for investigation.
Patient Safety Cases	10004442	25/07/2025	Moderate incident	An infant was antenatally diagnosed with an abdominal cyst but this was not identified on a postnatal ultrasound. After the ultrasound report, the infant was being cared for on the postnatal ward and experienced a large brown vomit which was felt to look like old blood by maternity staff. The baby was also noted to look grey. The neonatal SHO was informed immediately and reviewed the baby within an hour (although the exact time of this review and the nature of the review was not documented). The infant then had a further similar vomit. She was reviewed by the neonatal registrar and admission to the neonatal unit was arranged (she was admitted just over three hours after the first abnormal vomit). After admission to the neonatal unit, there was a further two-hour delay before an abdominal radiograph was requested and then a further 90-minute delay between the radiographer being bleeped and attending to perform the x-ray. In total, there was a 6-hour delay between the first vomit and the x-ray. The x-ray diagnosed a volvulus, which is a surgical emergency, and an emergency operation was performed. Sadly, the patient needed a significant gut resection and is expected to need parenteral nutrition for a prolonged period of time.	Reviewed through Patient Safety Case Review. For a Patient Safety Incident Investigation (PSII).

				The neonatal unit was very busy during this shift and every effort was being made to avoid admissions to the neonatal unit.	
Harm review tool	10004448	25 – 26/07/2025	Moderate incident	Neonatal Services escalated to Opel 4 at 0500 hours on 25/07/2025 to 1600 hours on 26/07/2025.	Harm tool completed. To be closed at Patient Safety Steering Group (PSSG) in October.

New PMRT cases

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

PMRT number	Log Date	Incident Trigger	Summary of incident	Outcome of incident
99409/2	15/07/2025	Early Neonatal Death	MCDA twins with antenatal diagnosis of megacystis in twin 2. Counselled antenatally by the MDT. Referred to palliative care team antenatally and ACP in place. There were CTG changes in twin 1 at 30+6 weeks gestation, therefore a decision was made to deliver the twins. Twin 2 died shortly after delivery.	PMRT reported and reviewed through Neonatal CDRM. To be closed A, A, A. Good practice was identified supporting bereavement and end of life care with both babies together.
99448	16/07/2025	Antepartum stillbirth	High risk patient with serial growth scans on diabetes pathway. Under the care of West NEST. Seen at for routine community midwifery appointment at 35+5 weeks gestation. Community midwife unable to auscultate fetal heart and she was referred to MDAU. IUD confirmed and baby by delivered stillborn at 35+6 weeks.	PMRT reported and ongoing within timescale. To be closed C and A due to a missed opportunity for a referral for a growth scan when there was static growth at 33+4 weeks.
99516	22/07/2025	Early Neonatal Death	Low risk pregnancy. Patient presented in labour at 40+3 weeks gestation. Baby girl born at 40+4 weeks via Cat 1 C section following a sudden bradycardia. She was born in very poor condition with no signs of life ?following placental abruption. She was admitted to NICU for ongoing care and therapeutic hypothermia commenced. She developed multi organ dysfunction and had extensive changes on	This has been reported to MNSI (see new patient safety cases section) and the investigation is ongoing.

			MRI. Care was redirected to comfort care following discussions with parents. She died on day 7 of life.	
99644	29/07/2025	Early Neonatal Death	Patient presented in labour at local unit at 38+6 weeks gestation. Baby girl born shortly after arrival in poor condition with no signs of life following a placental abruption. Resuscitation commenced and heart rate detected around 26 minutes of life. She was transferred to PAH for therapeutic cooling. There was evidence of multiorgan hypoxic injury and had recurrent seizures. Her MRI and EEG showed evidence of extensive catastrophic hypoxic ischaemic injury and care was redirected to comfort care following discussions with parents. She died on day 8 of life.	PMRT reported and ongoing within timescale. Reviewed at Neonatal CDRM in September with local unit involvement. Case has been reported to MNSI by the local unit and the investigation is ongoing. Provisionally graded as B, B and C, however waiting for completion of the MNSI report before finalising the grading.
99795	11/08/2025	Early Neonatal Death	Under care of Central NEST. Antenatal diagnosis of multiple anomalies including thoracic spina bifida, congenital diaphragmatic hernia and deviated cardiac axis. An advanced care plan was in place for comfort care post-birth. Mother presented in labour at 30+4 weeks gestation and baby boy born via Cat 3 C section. He died at approximately 20 minutes of age.	PMRT reported and ongoing within timescale. To be reviewed at Neonatal CDRM in October.
99796	11/08/2025	Early Neonatal Death	Under care of Central NEST. Baby boy born via breech delivery at home at 34+6 weeks gestation. Paramedics present for delivery of the baby's head. Resuscitation commenced and HEMS attended. Baby transferred to the Emergency Department and resuscitation stopped on discussion with the parents.	PMRT reported and ongoing within timescale. To be reviewed at Neonatal CDRM in October with attendance from HEMS and SCAS.
99935	22/08/2025	Intrapartum stillbirth	Phone call to Maternity Triage Line concerned and reduced fetal movements at 39+6 weeks. She reported niggles but no other concerns. She presented to MDAU and an IUD was confirmed. Baby boy stillborn at 40+0 weeks.	As the patient reported that she had niggles, this has been referred and accepted by MNSI as an intrapartum stillbirth (see new cases section above).

99994	26/08/2025	Antepartum stillbirth	Presented to the Emergency Department at 32+3 weeks with UTI symptoms. New to the country and had not yet booked in the UK. Admitted to MDAU and IUD confirmed. Baby boy stillborn. Bloods taken confirm maternal syphilis.	PMRT reported and reviewed at PMRG. Closed with gradings A, A. No learning identified.
100000	26/08/2025	Early Neonatal Death	Patient seen by Fetal Medicine Unit (FMU) due to severe IUGR and abnormal doppler studies. There were CTG concerns at 26+5 weeks, therefore baby girl born via Cat 2 C Section. She required maximal respiratory / ventilator support and was found to have a large VSD and dysplastic aortic arch. She developed an extensive left intraparenchymal haemorrhage and discussions were held with the family. A decision was made to move to comfort care. Genetic testing returned showing Trisomy 18 (Edwards syndrome).	PMRT reported and ongoing within timescale. To be reviewed at Neonatal CDRM in October.
100142	05/09/2025	Antepartum stillbirth	Under care of West NEST. Presented with an antepartum haemorrhage (APH) at 31+3 weeks. She had a Cat 1 Caesarean Section for placental abruption. Resuscitation was attempted however her baby girl showed no signs of life. She was confirmed stillborn.	PMRT reported and ongoing within timescale. Reviewed through Clinical Events Review. Learning identified relating to a missed opportunity for an obstetric referral. There is an ongoing review of the smoking cessation support to ensure that this followed Trust guidance. Case to be reviewed at PMRG in October.
100275	13/09/2025	Early Neonatal Death	Antenatal diagnosis of cardiac anomaly with small left ventricle and hypoplastic aortic arch. Baby girl born at 41+0 weeks. After extensive MDT discussion, it was felt that the only surgical option would be for a stage univentricular repair, and that comfort care would also be supported if the family didn't wish to continue with the difficult surgical route. Following discussions with the various teams, the family opted for comfort care. They were discharged home with palliative care support where she died on day 8 of life.	PMRT reported and ongoing within timescale. To be reviewed at Neonatal CDRM in November.

100361/1	18/09/2025	Early Neonatal Death	MCDA twins with twin-to-twin transfusion syndrome (TTTS). Laser ablation at 06/08/2025. Selective fetal reduction by cord occlusion 21/08/25. Twin 1 born and admitted to NICU. She had persisting high oxygen requirements and had recurrent left pneumothorax. She continued to deteriorate and became bradycardic. CPR was commenced but she showed poor response to this. After discussions with her parents, she was compassionately extubated and died at 5 hours of age.	PMRT reported and ongoing within timescale. To be reviewed through Clinical Events Review and at Neonatal CDRM in November.
100442	25/09/2025	Early Neonatal Death	Baby boy born at 38+0 weeks. Mum was under the care of East NEST due to previous safeguarding concerns. He had an out of hospital cardiac arrest at home on day 19 of life after a few days of being unwell. Paramedics attended and took him to the Emergency Department where resuscitation was stopped.	PMRT reported and ongoing within timescale. Joint Agency Response (JAR) initiated. For Coroner's PM. Reviewed at CDAD, no learning identified. For review at PICU CDRM.
N/A	13/09/2025	Late Neonatal Death	Twin born at 37+2 weeks gestation. Under Totton NEST. Did not receive any neonatal care. Presented to ED at 10 weeks of age following out of hospital cardiac arrest.	This case does not meet PMRT requirements, however, has been included for awareness.

Closed Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
PMRT	95426 (being led by the Children's Hospital)	03/10/2024	Neonatal death	Term birth at 38+2. Represented to QAH on day 1 and retrieved by PICU. Died on PICU on day 2 of life. Blood cultures grew Strep pneumoniae.	Heard through Child Death and Deterioration (CDAD) meeting and PICU Child Death Review Meeting (CDRM). No learning identified for UHS. Reported to MNSI by local Trust. Final report received. PMRT closed with gradings A, A, A.
PMRT	97700	10/03/2025	Antepartum Stillbirth	Antenatal diagnosis of complete congenital heart block. Attended pre-assessment for elective C section at 35+6 weeks gestation. Reported reduced fetal movements (RFMs) for 12 hours. Cat 1 section called. Baby girl born with no heart rate and unable to be resuscitated.	PMRT closed and reviewed at PMRG. Closed with gradings B and A due to communication issues antenatally when attending for pre-clerking.
PMRT	97874 / 2	22/03/2025	Neonatal death	DCDA twin. Twin 2 antenatal diagnosis of complex limb body wall difference. Extensive counselling with advanced care plan (ACP) in place. Baby girl born at 33+5 weeks gestation and died at 4 hours of age.	PMRT closed and reviewed at Neonatal CDRM. Closed with gradings A, A and A.
PMRT	98028	03/04/2025	Early Neonatal Death	Baby boy born at 23+0 weeks with a background of previous pregnancy loss at 20 weeks and cervical suture in this pregnancy. No steroids or magnesium sulphate given prior to delivery. He was born as soon as the suture was released. Intubation attempts with some challenges. Heartbeat no longer heard at 16 mins of age. Due to gestation, it was agreed not for cardiac massage and drugs. Decision to stop life sustaining attempts at 29 mins of age.	PMRT closed and reviewed at Neonatal CDRM. Closed with gradings B, B and A. Learning related to counselling for steroid in high-risk women and intubation challenges.

PMRT	98772 (being led by the Children's Hospital)	24/05/2025	Late Neonatal Death	Antenatal diagnosis of hypoplastic aortic arch and muscular VSD. Booked in Milton Keynes and delivered at Oxford. Transferred to E1 for ongoing cardiac care on 26/12/2024. Developed cardiac NEC post initial cardiac repair. Baby died from complications from cardiac NEC at 5 months of age.	Reviewed at PICU CDRM on 21/08/2025. Case closed as B, B and A. It was felt by the review group that it would have been beneficial to introduce the palliative care team to the family sooner based on the complex cardiac diagnosis to support the family at an earlier stage.
PMRT	98756	30/05/2025	Antepartum stillbirth	Presented at 40+0 with no FMs for 2 days. IUD confirmed on scan. Delivered at 40+3 weeks.	PMRT closed and reviewed at PMRG. Closed with gradings C and B. Learning related to lack of reduced fetal movements guidance, no GTT and follow up for raised glucose.
PMRT	98917	06/06/2025	Antepartum stillbirth	Antenatal diagnosis of T18. Multiple cardiac anomalies also diagnosed on scan. Planned scan by fetal medicine and sadly confirmed IUD at 35+0. Baby girl delivered at 35+2.	PMRT closed and reviewed at PMRG. Closed with gradings A and A.
PMRT	99133	24/06/2025	Early Neonatal Death	IUT from Bournemouth at 23+3 weeks. Fully optimised prior to delivery. Delivered following small APH - likely abruption. Died at 8 days of age.	PMRT reported and ongoing within timescale. Reviewed through Neonatal CDRM in September. To be closed with gradings B, B and A. Learning related to poor documentation during labour, consideration of aspirin, lack of use of translator and reviewing screening for ducts prior to extubation.
PMRT	99132	25/06/2025	Early Neonatal Death	Antenatal diagnosis of achondroplasia. Born at 30+4 in Bournemouth due to CTG concerns. Transferred to PAH. Also thought to be likely oesophageal atresia. Complex neonatal course. Developed NEC and laparotomy was required, though no bowel resection needed. She continued to be difficult to ventilate despite maximal medical therapy. Discussions took place	PMRT reported and ongoing within timescale. Reviewed through Neonatal CDRM in September. To be closed with gradings A, B and A. Learning identified for the local team relating to initial stabilisation and multiple attempts at intubation.

				with the family and care was redirected. She died at 45 days of age.	
HRT (Opel 4)	10002513	06/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Closed at PSSG in September.
HRT (Opel 4)	10002240	19/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Closed at PSSG in September.
HRT (Opel 4)	10001060	26/06/2025	Maternity OPEL 4 Alert	Maternity services were on OPEL 4 alert	Closed at PSSG in September.

Moderate or above incidents

Incident Date/Number	Type of Incident	Summary of incident	Outcome of incident
03/07/2025 10002684	Severe / major incident	Patient admitted to obstetrics with new onset severe pre-eclampsia and HELLP syndrome. Known background of APS and was on prophylactic enoxaparin 20mg BD antenatally. Known background of fetal growth restriction with abnormal dopplers and absent EDF. Underwent classical caesarean section at 25+6 for severity of PET on biochemical markers and raised BP. EBL 263ml and uncomplicated. Was recovering well at morning ward round but saw increase in BP to around 210/110, therefore was started on MgSO4 and IV labetalol. BP began to stabilize when started experiencing RUQ pain. 1 hour after anti-hypertensives saw sudden hypotensive episode. Became haemodynamically unstable and obstetrician called on call HPB surgeon who advised CT angio, which revealed ruptured liver capsule. Sent for CEPOD - midline laparotomy for R liver with large subcapsular and intraparenchymal haematoma. Following this admitted to ICU. Now for transfer to KCH	Reviewed through Patient Safety Case Review. For no further investigation.
15/07/2025 10003583	Catastrophic incident	Low risk pregnancy. Patient presented in labour at 40+3 weeks gestation. Baby girl born at 40+4 weeks via Cat 1 C section following a sudden bradycardia. She was born in very poor condition with no signs of life ?following placental abruption. She	Reported to MNSI and PMRT as per sections above.

		was admitted to NICU for ongoing care and therapeutic hypothermia commenced. She developed multi organ dysfunction and had extensive changes on MRI. Care was redirected to comfort care following discussions with parents. She died on day 7 of life.	
20/07/2025 10003835	Moderate incident	Maternity services escalated to Opel 4 due to acuity and staffing.	
25/07/2025 10004442	Moderate incident	An infant was antenatally diagnosed with an abdominal cyst but this was not identified on a postnatal ultrasound. After the ultrasound report, the infant was being cared for on the postnatal ward and experienced a large brown vomit which was felt to look like old blood by maternity staff. The baby was also noted to look grey. The neonatal SHO was informed immediately and reviewed the baby within an hour (although the exact time of this review and the nature of the review was not documented). The infant then had a further similar vomit. She was reviewed by the neonatal registrar and admission to the neonatal unit was arranged (she was admitted just over three hours after the first abnormal vomit). After admission to the neonatal unit, there was a further two-hour delay before an abdominal radiograph was requested and then a further 90-minute delay between the radiographer being bleeped and attending to perform the x-ray. In total, there was a 6-hour delay between the first vomit and the x-ray. The x-ray diagnosed a volvulus, which is a surgical emergency, and an emergency operation was performed. Sadly, the patient needed a significant gut resection and is expected to need parenteral nutrition for a prolonged period of time. The neonatal unit was very busy during this shift and every effort was being made to avoid admissions to the neonatal unit.	Reviewed through Patient Safety Case Review. For a PSII to be written (see new cases section).
25/07/2025 10004276	Moderate incident	OPEL 4 declared in Maternity Services due to NN capacity. No admitting or stabilisation cots in NNU.	Closed as moderate incident.

25 – 26/07/2025 10004448	Moderate incident	Neonatal Services escalated to Opel 4 at 0500 hours on 25/07/2025 to 1600 hours on 26/07/2025.	Harm tool completed. To be closed at Patient Safety Steering Group (PSSG) in October.
01/08/2025 10005268	Severe / major incident	Term admission of a baby from the community for high TCB and jaundice.	Reviewed through Clinical Events Review. Learning identified relating to jaundice and feed management. Ongoing review of jaundice guideline and use of TCB within the community and postnatal ward.
20/08/2025 10005760	Moderate incident	Baby with TOF-OA postnatal diagnosis – repaired 02/08. Anastomotic leak / oesophageal breakdown reanastomosis day 8/9. Day 9 post oesophageal anastomosis repair post leak – increased WOB requiring intubation. Impression is anastomotic leak – plan for emergency reexploration.	To be reviewed through Surgical M&M.
26/08/2025 10006228	Moderate incident	Whilst looking at a chest X-ray taken for another reason, air was noticed air under the diaphragm indicating an intestinal perforation. On review of imaging previously, this was evident but had not been picked up on the previous CXRs x 2 in previous days. Once perforation seen - quickly escalated to surgical team and laparotomy performed.	This was reviewed at the Neonatal Risk meeting and closed as moderate incident. The medical team report that this was missed at the 1st opportunity due to high acuity on the Neonatal Unit and being unable to provide full care to all babies. Neonatal Unit at the time was OPEL 4 due to capacity and staffing levels.
30/08/2025 10007146	Moderate incident	Baby born via elective C section due being breech. Documented by the obstetric team as being a difficult extraction and the obstetrics SpR heard a crack of the left leg when pulling her out. This was communicated to the parents and advised the neonatal team would review the baby for any concerns to the left leg. A hip Xray and femur X ray were undertaken which were NAD. The baby was reviewed by the neonatal team on a few occasions and the family was discharged home. The family returned for their D5 check and the healthcare professional they saw agreed that the leg seemed abnormal. They therefore presented to Children's ED and a fractured tibia was confirmed.	Reviewed through Clinical Events Review. Closed as moderate incident and Duty of Candour completed.

Appendix 7

Q2 2025 mortality

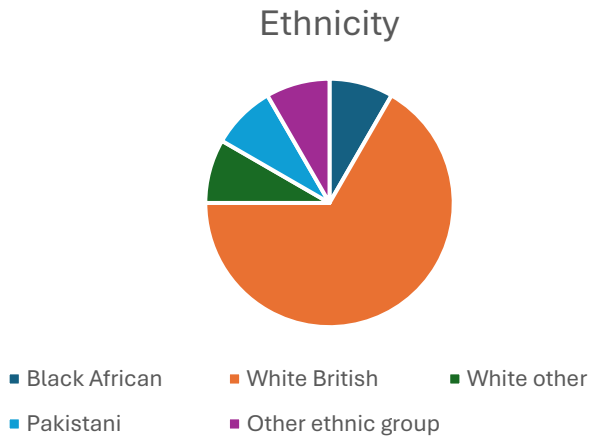
University Hospital Southampton NHS Foundation Trust

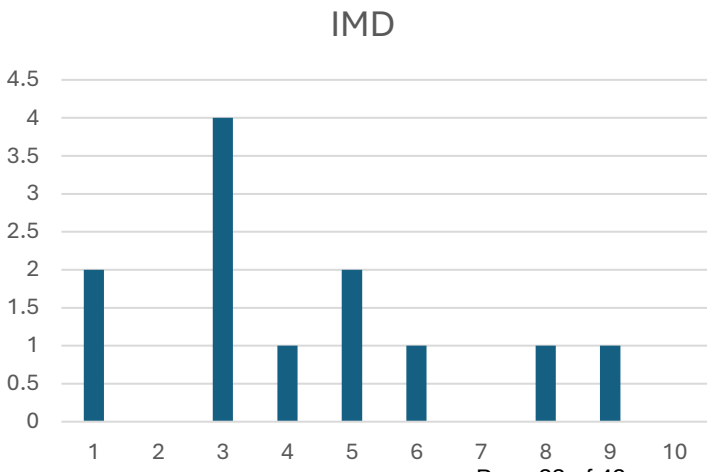
(*2024: stillbirths 4.44 per 1,000 births*) **2025 YTD stillbirth rate: 5.00per 1,000 births**
Q2 stillbirth rate: 3.8 per 1,000 births ⬇ (Q1 5.79 per 1,000 births)
National target (2021) <4.2 per 1,000 births

Case Overview *(1 delivered OOA and transferred to PAH NICU, 1 born at home 34+6 BBA)*
15 babies (14 patients) (3 were transfers into our service for Fetal Medicine)

- Antepartum stillbirths = **4 (1 selective reduction MCDA twins TTTS)**
- Intrapartum stillbirth = **1 (MNSI classifying 1 SB as Intrapartum – referral accepted as reported tightening's)**
- NNDs = **10 (9 Early, 1 Late NND >28 days)**
- Non registerable births = **0** *(4x MTOP's 22-24)*

Fetal Medicine Involvement 3x cases (21%)
Extreme Preterm (<28 weeks) 3x (21%)





NEST (CoC team) See DEEP DIVE
2 Antepartum stillbirth (1 APSB no AN care new to country)
4 NND (1 planned palliation, 1 BBA at home & 1 early NND 19 days, 1 late NND 10 weeks HANTS NEST)

Themes

- 6 cases were under NEST CoC teams (+1 new to country who had not received any AN care in the UK)
- 1 abruption

2025 community mortality cases

University Hospital Southampton NHS Foundation Trust

Q2 2025 – All 3 NEST CoC care team

1. **NND 19 days old** (Cause of death Ecoli sepsis – cardiac arrest at home) -> JAR
SVD 38+0 precipitate birth
EAST NEST – **IMD 2**
British – English speaking
Former smoker
27 yrs old, 3rd baby

2. **NND 8 days old** (Cause of death potential overlay) -> JAR
Cat 3 LSCS DCDA Twins (started IOL) 37+2
TOTTON NEST (Under multiples clinic – DCDA Twins) **IMD 4**
CIN plan as a child
British – English speaking
Former smoker
21 yrs old, 1st pregnancy

3. **BBA Breech birth 34+6 – NND (Prolonged resuscitation) ->** Coroner referral
CENTRAL NEST **IMD 1**
British – English
Nonsmoker
37 yrs old, 1st pregnancy

Appendix 8

NMPA 2025 Report UHS Response

Data from 2023.

University Hospital Southampton NHS Foundation Trust

National Key Findings and Recommendations

1. Timely Pregnancy Booking

- Booking by 10+0 – targeted intervention locally 2024.

Progress (NICE bookings by 9+6)
2023 – **9.90%** 2024 – **46.92%** ⇧
2025 to date – 74.58% ⇧

- Audit of late bookers in line with SBL to identify any barriers.

2. Impact of changing trends in Maternity care & Outcomes

- Local workforce review (ensuring the right staff in the right place with the right skill mix)
- Using power BI dashboards to review data, birth predictions and respond to variations.

3. Unwarranted Variation

- Using power BI dashboards to review data, birth predictions and respond to variations.
- Working with service users/local communities to actively understand and identify care gap needs.

4. Data definitions & data capture

- Digital teams working to better understand gaps.
- Data cleansing/education

5. Optimise data quality

- Digital teams working to better understand gaps.
- Data cleansing/education

NMPA Data

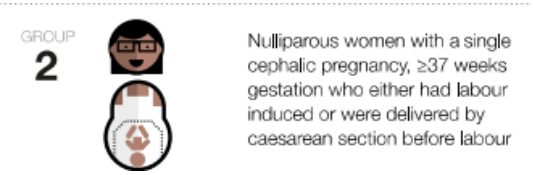
2023 data Outliers:

- *Unplanned maternal readmissions within 42 days* ⇧
- Apgar's <7 at 5mins
- SGA babies born at or >40 weeks
- Robson 2 – Caesarean birth
- Late antenatal booking

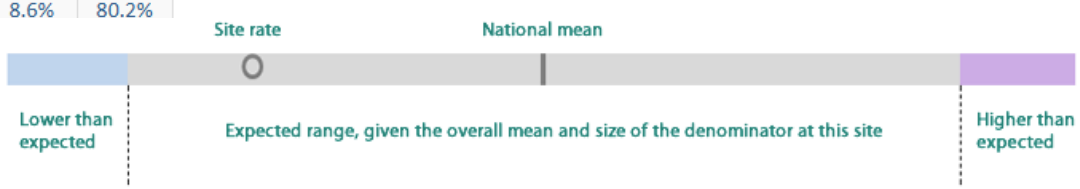
2025 data:

⇧ Oversight of coding
⇔ Targeted improvement work

⇧ Focused Quality Improvement work



University Hospital Southampton NHS Foundation Trust				All Trusts/Health boards included		
Measure	**Counts**	**Trust/Health board adjusted mean**	**Range**	**Mean**	**Lowest**	**Highest**
Unplanned maternal readmission within 42 days	253 / 4396	5.8%		3.1%	0.1%	9.1%
Induction of labour	1001 / 4130	24.5%		33.9%	12.0%	48.3%
Episiotomy (Overall)	758 / 2674	27.5%		24.4%	7.0%	38.4%
Caesarean birth (overall)	1857 / 4711	38.7%		39.6%		
Vaginal birth after primary caesarean section	88 / 489	17.9%		14.2%	3.3%	70.9%
3rd and 4th degree tears (Overall)	107 / 2732	3.7%		3.3%	1.2%	6.7%
Postpartum haemorrhage of 1500ml or more	182 / 4318	4.0%		3.4%	0.7%	6.6%
Preterm birth rate (Overall)	363 / 4823	7.5%		6.3%	3.5%	10.1%
Small-for-gestational-age babies born at or after 40 weeks	134 / 238	56.3%		42.6%	20.9%	82.1%
Term babies with a 5-minute Apgar score of less than 7	125 / 4663	2.7%		1.5%	0.4%	4.3%
Skin to skin contact (Overall (34+0 to 42+6 weeks))	3220 / 4708	68.7%		73.4%	9.4%	96.2%
Caesarean birth (In Robson Group 1, overall)	187 / 951	19.0%		18.0%	8.5%	33.1%
Caesarean birth (In Robson Group 2, overall)	540 / 843	63.2%		56.0%	35.4%	78.8%
Caesarean birth (In Robson Group 5, overall)	574 / 731	78.8%		81.8%	54.9%	91.6%
Skin to skin contact (Overall (24+0 to 33+6 weeks))	8 / 104	7.8%		10.8%	4.0%	66.2%
Vaginal birth, with or without the use of instruments (Overall)	2854 / 4711	61.4%		60.4%	50.4%	69.6%
Late antenatal booking (Overall)	3387 / 4819	70.6%		26.7%	8.6%	80.2%



Recommendation complete	
Recommendation within timescale for completion	

Recommendation	Action Plan	Action Owner	Target for Completion	Status
1) Raise awareness about the result in various platforms (in real time) – Clinical governance meetings, Joint Consultant/ANNP/Co-ordinator meeting, Risk meetings	Raise awareness about the result in various platforms (in real time).	RB	Completed	
2) Education and awareness through Departmental Induction for the new residents and simulation teaching.	Share at Departmental Induction and simulation teaching.	RB	Completed	
3) Continued education through Neonatal Education Newsletter (NEST), Theme of the Week (TOTW) both for neonates and maternity	1) Share via TOTW.	RB / KF	Completed	
	2) Consider sharing on a 6 monthly basis.	RB / KF	Ongoing	
4) Data report being shared as a presentation/discussion on World Patient Safety Day meeting	Presentation at WPSD re. periprem measures.	RJ / DWS	Completed	
5) Periprem Deep Dive: Results showed that the extreme preterms often were hyperthermic. Action plan about robust monitoring of temperature whilst in the theatre/delivery room having DCC, cuddles, being stabilised etc and taking action accordingly.	1) QI project launched focusing on monitoring temperatures and acting accordingly.	DWS	Completed	
	2) Review environmental ranges in theatres and whether the temperature should be amended to 22^{o}C with preterm deliveries.	RB	Dec 2025	
6) Shared learning with and from the Network on SONeT M&M for ideas.	Shared learning with and from the Network on SONeT M&M for ideas.	RB	Completed	

7) Nominating a named person to oversee and audit practice.	Nominating a named person to oversee and audit practice.	HW	Completed	
8) Clipboards with documentation paperwork for periprem/stabilisation after birth to assist monitoring temperature.	1) Paper documentation launched as part of QI project.	DWS	Completed	
	2) To review if new fields can be added to MetaVision.	HM / CP	Dec 2025	
9) Board game to increase involvement in thermal management	Board game to increase involvement in thermal management.	DWS	Dec 2025	
10) Regular Q&A sessions on the resident doctors'/ANNP group to increase awareness about the national audit measures and benchmarking process	Adding to resident doctors / ANNP group to share awareness.	RB	Ongoing	
11) Consider writing an incident report for every breach of NNAP thermal management target to develop a deeper and wider understanding of the issue	To discuss with the Neonatal Coordinators and Neonatal Risk Lead.	HM	Dec 2025	

ATAIN

Appendix 10

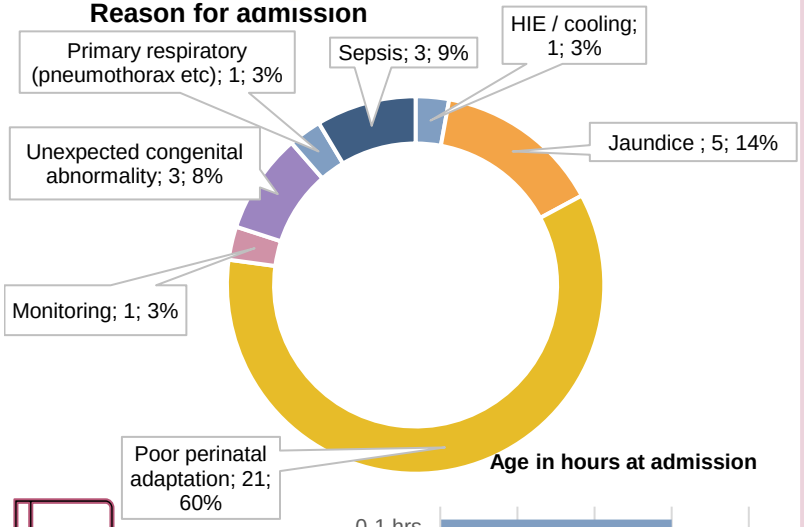
Qtr. 2 2025/26 – 35 unexpected term admissions

University Hospital Southampton NHS Foundation Trust

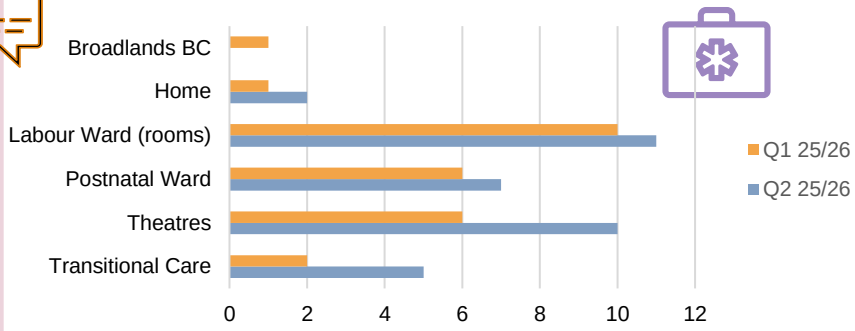
Learning identified

- 17 cases identified for review and all reviews completed
- 3 cases deemed potentially avoidable admissions
- Issues highlighted:
  - Fetal monitoring interpretation
  - Documentation
  - Management of sepsis
  - Postnatal acknowledgement of results
  - Thermoregulation
  - Jaundice management

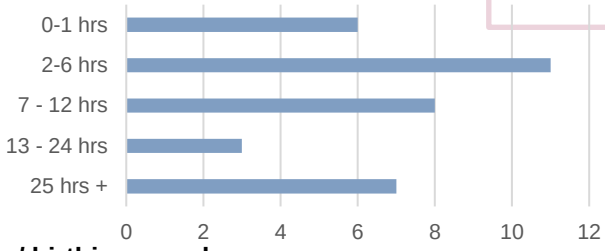
Reason for admission



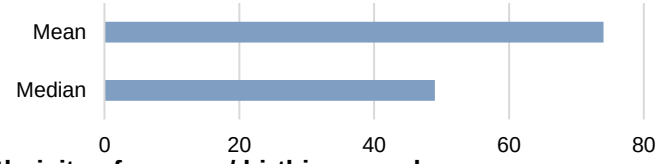
Admission from

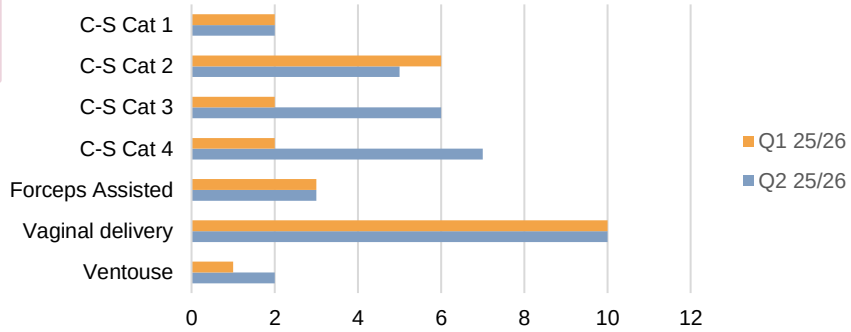


Age in hours at admission

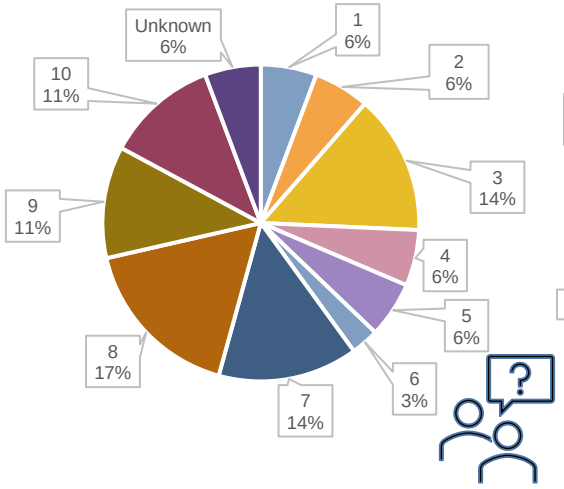


Average length of stay in hours

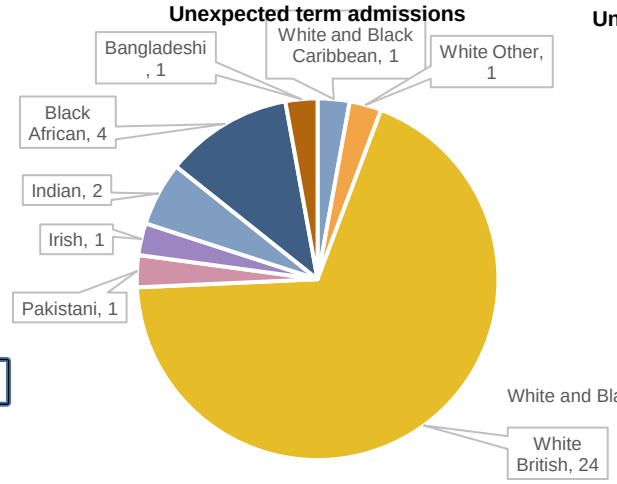




IMD deciles of women / birthing people

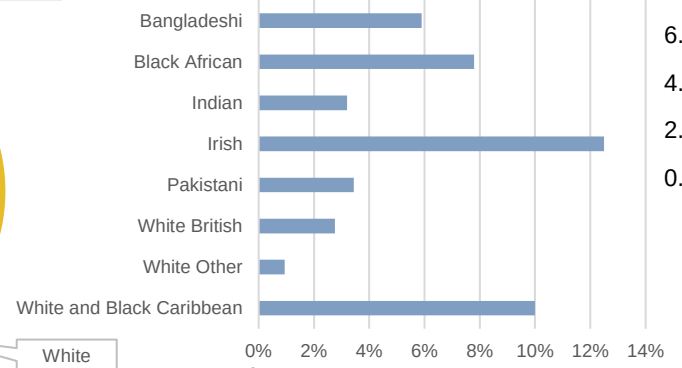


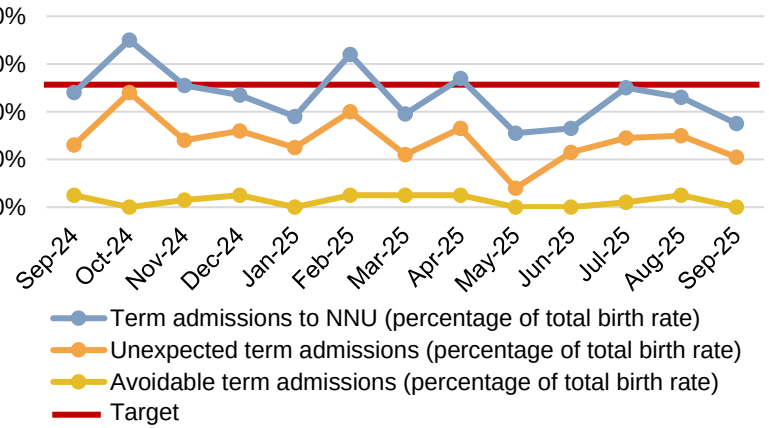
Ethnicity of women / birthing people



Unexpected term admissions

Unexpected term admissions as a percentage of term livebirths





University Hospital Southampton NHS Foundation Trust

Theme 2: Growing, retaining, and supporting our workforce

Theme 2: Growing,retaining and supporting our workforce	
Objective 4: Grow our Workforce	Progress and Evidence
• Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.	Full Birthrate Plus Assessment completed in July 2024 The Trust is currently not fully compliant with the BR+ recommended establishment, with a total variance of 8.94 WTE.
• Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice	A workforce recovery plan is in place and actively monitored through a live dashboard and strategic recruitment programme. Ongoing recruitment activity, 34 WTE band 5 midwives joined the maternity team in November 2024 / January 2025, and a further 16.6 WTE newly qualified midwives with conditional offers in the pipeline to offset forecasted leavers between January and November 2025.
• Provide administrative support to free up pressured clinical time	Administrative support is carefully targeted
Objective 5: Value and Retain our Workforce	
• Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.	The maternity service is seeking to offer internal development opportunities for our current Band 6 workforce. This includes an active plan to train 2 internal midwives at PG Cert level for 3rd Trimester Ultrasound.
• Implement equity and equality plan actions to reduce workforce inequalities	Working closely with the LMNS around EDI to ensure local plans align with the regional approach

Appendix 11

• Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource	Our service is ethnically diverse, especially within our medical teams. Our service responds actively and appropriately to any racist or inappropriate behaviour. We try to include as much diversity as we can during recruitment.
• Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey	Concerns raised are communicated by central learning environment team, and discussed at regular clinical link meetings with our linked Universities. Maternity Learning environment lead also attends the regular Student and Staff Liaison committee (SSLC) meeting to ensure direct communication from student voice. Learning environment lead for maternity runs twice yearly 'Keeping In Touch' days for each cohort of student midwives, which involve practical skills training but also clinical supervision sessions from the PMA lead and a student forum with Education Quality and Learning Environments lead for UHS.
• Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor	All band 5 newly registered midwives receive a 6 week induction period, followed by a 4 month 'provisional' period, where they receive supernumerary time in each area, followed by set time working in a 'provisional' capacity, alongside a senior midwife to increase confidence and competence. The Preceptorship programme has achieved the National Gold standard quality mark and consists of protected study days over an 18 month period, with protected time for review meetings. Band 6-8 receive personalised induction dependant on role and will have a period of support form an allocated mentor or buddy.
• Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce	LMNS Rising Tides Programme aims to promote and support this
• Objective 6: Invest in skills	
• Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.	Guidance around maternity specific training is clearly set out in the Specialist Training for Maternity services policy, due to be updated in 2027, alongside the UHS Statutory and Mandatory Role Specific Matrix. Training highlighted in the core competency framework is reviewed on a yearly basis. Rose Specific TNA last completed in 2023, due to be updated on a 3 year rolling pattern. Staff are rostered automatically onto

	mandatory role specific training (for example requirements of Saving Babies lives). Extended role training such as NLS certification is offered by UHS as a host Trust, however places are limited and the number of staff required to be released from clinical duties to maintain 4 yearly compliance is currently not feasible.
• Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively • Ensure temporary medical staff covering middle grade rotas in obstetric units for 2 weeks or less possess an RCOG certificate of eligibility for short term locums	

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.4 Report to the Trust Board of Directors, 13 January 2026	
Title:	Chief Executive Officer's Report
Sponsor:	David French, Chief Executive Officer
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

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

- NHS Oversight Framework League Tables
- UHS Tiering
- Employment Rights Bill
- Industrial Action
- Advanced Foundation Trusts
- NHS Trust Fined
- Royal College of Physicians – Joint Advisory Group Review
- Southampton Hospitals Charity – Nominated Trustee
- Department of Clinical Law

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

NHS Oversight Framework League Tables

On 11 December 2025, NHS England published the latest segmentation and league tables under the NHS Oversight Framework for Quarter 2.

At the national level there has been limited change in overall aggregate performance. The average metric score for Quarter 2 is 2.37, which is 0.01 points higher than Quarter 1. The median metric score has increased marginally from 2.32 to 2.34. This indicates that it is likely that slightly fewer trusts met their objectives in Quarter 2, in particular:

- Fewer acute trusts achieved their 18-week elective waiting list plan.
- More trusts were considered significantly off-track against their financial plan.

Thirty-eight trusts have seen a change in segment since Quarter 1, broken down as follows:

- Six are as a result of a financial override being applied or removed: four have improved segment, two have deteriorated.
- Eight are as a result of significant changes in average metric score: four have improved, four have deteriorated.
- The remaining 24 segment changes do not meet the current threshold to be considered significant. These trusts will be reviewed individually.

In Quarter 1, 120 trusts were identified as triggering the financial override. Seven of these trusts are no longer determined to trigger the override. However, six new trusts are now triggering the override. It should be noted that only two of the new trusts now triggering the financial override saw a deterioration in their segmentation, as the others were already in segments 3 or 4.

Based on the published league table for acute trusts, UHS is ranked 51 out of 134 with a score of 2.22. The Trust was previously ranked 48 out of 134 with a score of 2.13. The Trust remains in segment 5 due to being in the Recovery Support Programme.

UHS Tiering

The Trust entered Tier 1 for elective performance in October 2025 due to its forecast number of patients waiting over 65 weeks by 21 December 2025. In addition, the Trust has entered Tier 1 for its urgent and emergency care performance, particularly in terms of its performance against the four-hour target of 78%.

Employment Rights Bill

On 27 November 2025, the Government announced that it had held a series of discussions between trade unions and business representatives regarding proposed amendments to the Employment Rights Bill.

The discussions concluded that the qualifying period for unfair dismissal should be reduced from 24 to six months. Originally, the Bill proposed that there should be no qualifying period for unfair dismissal, but that there would be a nine-month 'probation period' during which it would have been procedurally simpler to dismiss an employee. The proposed changes to unfair dismissal also include a removal of the cap for damages (currently, 52 weeks' salary or a statutory cap, whichever is lower).

In addition, the Bill will provide 'day one' rights to sick pay and paternity leave and will establish the Fair Work Agency, which will oversee the enforcement of employment rights in the United Kingdom.

The Bill received Royal Assent on 18 December 2025 having been reviewed in both the House of Commons and the House of Lords. It is expected to come into force in a phased approach from April 2026 to 2027.

A report will be provided to the People and Organisational Development Committee to assess the detail and impact for the Trust.

Industrial Action

Resident doctors conducted further strike action between 17 and 22 December 2025. In addition, the British Medical Association announced a ballot on extending its strike mandate until August 2026. The ballot opened on 8 December 2025 and will run until 2 February 2026.

NHS England has published data which showed that the NHS met its goal to maintain 95% of planned care during the strike by resident doctors in November 2025. UHS maintained 100% of planned care (outpatient appointments and elective procedures) during the November strike action and 95% during the December period.

There were on average 17,236 resident doctors absent from work each day during November 2025 – slightly higher than the 16,162 average during the previous set of strikes. However, it was thought that this higher figure was due in part to the fact that more resident doctors would have been rostered to work during winter than in summer. An average of 35.62% of resident doctors at UHS participated in the strike during November 2025 (ranging from 30.3% to 42% dependent on day). During the December strike action, an average of 32% took part at UHS.

The Government has also announced its intention to overhaul the way it decides the terms of the General Practitioner contract in England. The Government will, from 2026/27, consult a group of stakeholders – effectively ending the British Medical Association's (BMA) role as sole negotiator of contract terms. NHS England will instead consult the Royal College of General Practitioners, the National Association of Primary Care, Healthwatch England, National Voices, and NHS Confederation alongside the BMA's GP Committee England.

Advanced Foundation Trusts

On 12 November 2025, NHS England published its guide for applicants to the Advanced Foundation Trust Programme and announced that eight trusts had been selected to be assessed under the programme.

The NHS 10-Year Plan stated that it would 'reinvigorate and reinvent the NHS [foundation trust] model for a modern, integrated health system' and set an ambition that, by 2035, every NHS provider should be a foundation trust.

The best performing organisations will be eligible to apply to become 'advanced foundation trusts', which will benefit from additional freedoms and autonomy compared to 'ordinary' foundation trusts, including:

- Strategic and operational autonomy: characterised by a different relationship with the centre and regions, including a more strategic approach to annual planning.
- A capability-based regulatory approach with more time given to address performance issues where they arise.
- Financial flexibilities: capital flexibility, ability to retain and reinvest aggregate revenue surplus, excluding deficit support funding, in capital projects. Capital autonomy, with business case approval not required for up to £100m CDEL spend. Revenue flexibility, limited to non-recurrent spending to support implementation costs linked to capital investment and transformation.

In addition, only advanced foundation trusts will be able to apply for Integrated Health Organisation contracts, whereby a provider will additionally take on a commissioning role in a local area or for a particular service across multiple localities.

In order to be eligible to become an advanced foundation trust, an organisation must demonstrate that:

- They are in the top two segments of the NHS Oversight Framework for two consecutive quarters.
- They have a 'good' or 'outstanding' rating from the Care Quality Commission with no site or service rated inadequate.
- They have a provider capability assessment score of at least amber-green.
- They have support from the local integrated care board and NHS region.

Advanced foundation trust status will be subject to regular re-assessment and can be lost.

In addition, the 10-Year Plan announced that foundation trusts would cease to have council of governors with the powers currently exercised by governors reverting to the Secretary of State/Department of Health and Social Care.

It is expected that the legislative changes necessary to introduce advanced foundation trusts and changes to existing foundation trust governance will be included in a Bill to be presented to Parliament in April 2026, with implementation by April 2027.

The NHS England guidance can be read at: https://www.england.nhs.uk/long-read/advanced-foundation-trust-programme-guide-for-applicants/#assessment-criteria

NHS Trust Fined

University Hospitals Sussex NHS Foundation Trust has been fined £200,000 in connection with the death of Ellame Ford-Dunn who suffered with severe mental health problems. Ellame, aged 16, committed suicide on 20 March 2022 when she absconded from the Bluefin acute children's ward at Worthing hospital.

The supervising agency nurse had watched Ellame leave the ward, but did not follow her because she said that she had been instructed not to leave the ward if patients absconded. In addition, the trust's policy on missing patients 'did not provide any meaningful guidance on what to do when a vulnerable patient is seen to be absconding'.

The trust pleaded guilty to a failure to provide safe care and treatment resulting in avoidable harm. In mitigation, the trust said that the acute ward was not equipped to deal with vulnerable mental health patients, but the trust had accepted the patient because of a 'growing crisis nationally' over the shortage of mental health beds for children and adolescents. The trust's counsel stated that: 'The decision to admit Ellame to the Bluefin ward placed the trust in an invidious position. It didn't have the resources or skill to care for her but the alternative was a refusal to admit.'

Royal College of Physicians – Joint Advisory Group Review

On 2 January 2026, the Trust was informed that its endoscopy service had had its accreditation renewed until 1 November 2026 following its annual review by the Royal College of Physicians' Joint Advisory Group on Gastro-Intestinal Endoscopy having met all the required accreditation standards. This is a necessary accreditation for our endoscopy service and meeting all the requirements is a great outcome for the team.

Southampton Hospitals Charity – Nominated Trustee
Alison Tattersall has been appointed as the second Nominated Trustee on the board of the Southampton Hospitals Charity.

Under the charity's articles of association, the Trust has the right to nominate one trustee where the board comprises five or fewer co-opted trustees and a right to nominate two trustees where the board comprises six or more co-opted trustees.

Department of Clinical Law
Between 2009 and 2013, the then medical director supported the establishment of an ad hoc referral service dealing with clinical questions relating to the application of General Medical Council and Nursing and Midwifery Council and legal principles within the Trust. It was made clear at the time that the service would not be providing legal advice, but rather would translate legal principles into clinical advice. The establishment of the department of clinical law was approved by the Trust Board in 2013.

The department currently comprises two individuals - a Consultant Surgeon and a Consultant Respiratory Physician. The latter is also chair of the Trust's Clinical Ethics Committee.

To date, 1,621 referrals have been received, and clinical advice has been provided in each case. In addition, 148 bulletins have been published on StaffNet and on the Trust's website. The bulletins can be read at: https://www.uhs.nhs.uk/whats-new/clinical-law-updates

The department remains unique within the United Kingdom, but there are indications that colleagues around the country intend to emulate the service.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.5 Report to the Trust Board of Directors, 13 January 2026	
Title:	Performance KPI Report 2025-26 Month 8
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Sam Dale, Associate Director of Data and Analytics

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

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

Contents:

The content of the report includes the following:

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

Risk(s):

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

Equality Impact Consideration:	NO

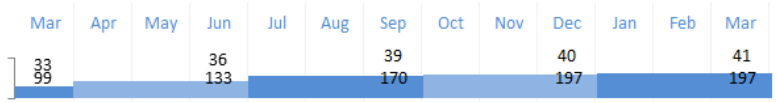
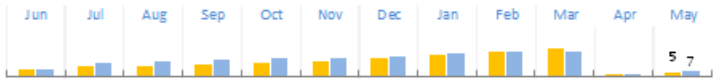
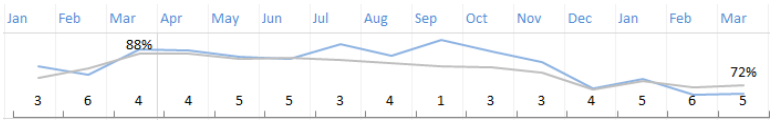
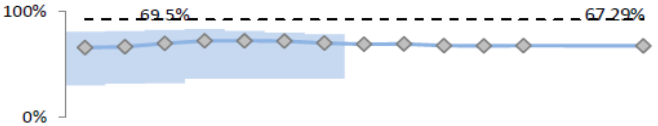
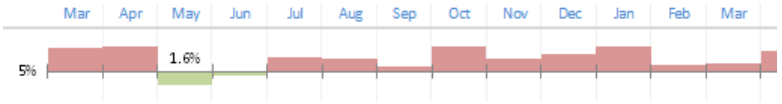
University Hospital Southampton NHS
NHS Foundation Trust

Performance KPI Board Report

Covering up to
November 2026

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

Report guide

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

Introduction

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

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

The content of the report includes the following:

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

Summary

This month's spotlight report explores UHS recent performance against the national cancer waiting time targets. The report highlights that:-

- Across the 2025/26 calendar year, the Trust has received on average 2,499 referrals per month which is a 3% increase on 2024/25 and a 6% increase on 2023/24.
- The trust has maintained strong performance for the 28 day faster diagnosis pathway element achieving 81.3% for the latest validated month (October 2025). Performance for the 31day metric (94.3%) and 62 day metric (73.5%) are both marginally short of the national targets, but all services are committed to maximising capacity, appropriately managing referrals and optimising pathways to achieve the performance ambitions set at the start of the year.
- The number of patients waiting over 62 days from the date of receipt currently sits at 236 patients (9% of total PTL).
- Challenges have emerged throughout the financial year, but services have maintained flexibility through insourcing and weekend working to ensure cancer patients are appropriately prioritised. In some areas this has been supported through funding from the Cancer Alliance.

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

1. The trust's overall RTT waiting list decreased to 63,399 for November 2025 which is a decrease of 0.9% or 561 patients since October 2025. Waiting time performance against the 18 week target for November was 60.7%. The reduction in the waiting list was within the cohort of patients waiting for their first appointment and those who were waiting for surgical treatment reflecting additional outpatient clinics and theatre utilisation.
2. The trust made significant progress in managing our longest waiting patients in November which is reflected in a 27% reduction in the number of patients waiting over 65 weeks from 334 in October to 245 at the end of November. Additional capacity has been achieved within the UHS footprint but also via appropriate outsourcing to private providers. This sits alongside existing validation processes to ensure the waiting list is maintained accurately and patients are regularly contacted and all changes in clinical urgency or patient choice reflected.
3. In November 12,376 patients arrived at the trust's main emergency department which aligns to the volume seen in November 2024 (12,376). 60.4% of patients spent less than four hours in the department which is a significant improvement of 5.8% since October 2025 and above our in year performance plan submitted at the start of the year. The key focus area in November was the redesign of urgent care areas into a same day emergency care service for ambulatory and minors' pathways. This is part of a series of planned pathway improvements designed to drive improvements towards the national target of 78% by March 2026.
4. The volumes of patients waiting for diagnostics marginally increased to 10,253 for November 2025, however the percentage of patients waiting under six weeks remaining at 80% for the fourth month in a row.
5. The hospital continues to report a reduction in non elective readmissions within 30 days of discharge down to 11.9% for November 2025.
6. There have been three cases of MRSA Bloodstream infection (BSI) across quarter three against a national performance threshold of zero. All cases underwent a detailed concise review led by the Infection Prevention Team, an after-action review (AAR) with the clinical team to identify learning and areas for improvement and a final HCAI review with Chief Nursing Officer and Chief Medical Officer.

7. The trust reported one never event, two Patient Safety Incident Investigations and zero medication errors across the organisation in November 2025.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 8th December 2025, our average handover time was 17 minutes 4 seconds across 852 emergency handovers and 20 minutes 50 seconds across 44 urgent handovers. There were 40 handovers over 30 minutes and 9 handovers taking over 60 minutes within the unvalidated data. Across November the average handover time was 18 minutes and 8 seconds.

Spotlight: Cancer performance

1. Introduction

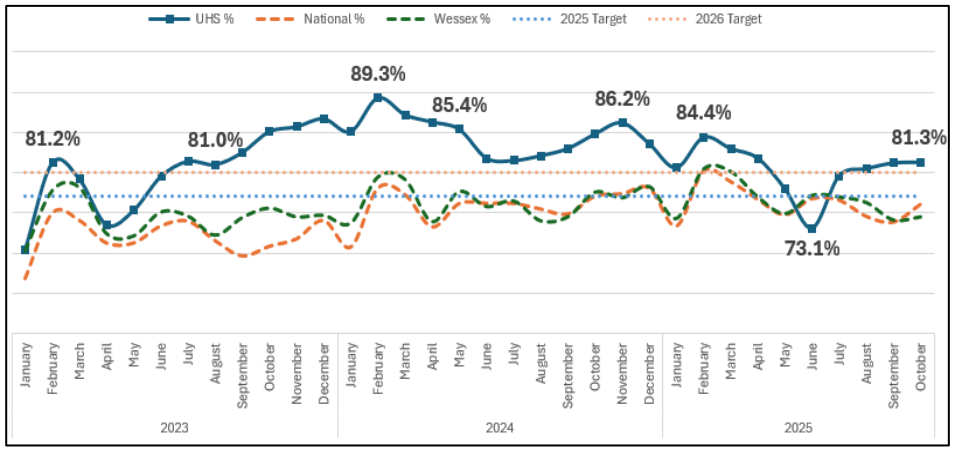
Cancer waiting times are a crucial measure of NHS performance, indicating how efficiently cancer care is delivered from referral through diagnosis to treatment. Ensuring patients receive timely cancer care is vital, as early detection and swift treatment greatly enhance patient experience and outcomes, improving survival prospects and quality of life. Despite national initiatives to optimise cancer pathways, both the NHS and UHS continue to struggle to meet waiting time targets, highlighting ongoing pressures related to service capacity, rising demand, and workforce shortages. Demand has continued to rise year on year within UHS and wider NHS Trusts; despite this, recent initiatives to optimise cancer pathways have started to take effect, and UHS has seen an improved and sustained position against national waiting time targets over the past year.

Today's waiting time standards are designed to reflect contemporary cancer care, placing greater emphasis on achieving a confirmed diagnosis or initiating treatment rather than simply tracking process milestones such as first appointments. These standards promote fair access to care by monitoring waiting times for all patients, regardless of how they entered the cancer diagnostic or treatment pathway. They also provide clinicians with greater flexibility to use remote testing and streamlined pathways. The NHS focuses on three principal cancer waiting time measures and, at the time of writing, validated data is available up to October 2025.

2. UHS Waiting Time Performance

The **Faster Diagnosis Standard** reflects a maximum 28-day wait for diagnosis from urgent GP referral and from NHS cancer screening programmes. In October 2025, UHS reported 81.3% of patients met the standard, against a current national target of 77% and an internal ambition to achieve 83% by March 2026. In April 2026 the national target is set to rise to 80% which UHS is consistently achieving.

The Trust has consistently maintained this standard, however, success is reliant on ensuring that front end capacity and diagnostics are available and that patients are appropriately informed of the importance of attending. There has been an increase in October's two weeks wait to first seen performance



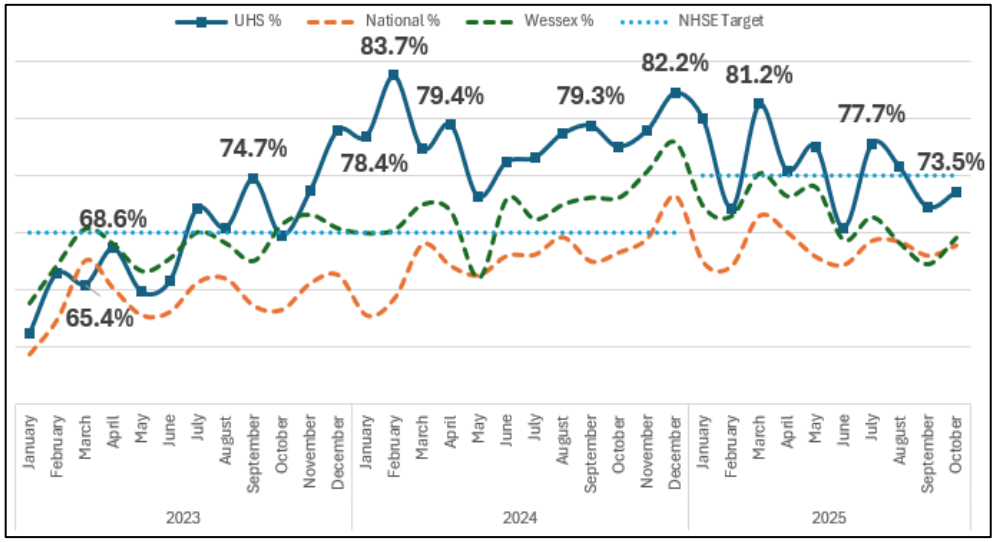
Graph 1: 28 Day Faster Diagnosis Performance Trend

which will have had a positive effect on the 28-day target. This is largely due to an increase in Breast referrals and timely first outpatient appointments delivered within this service.

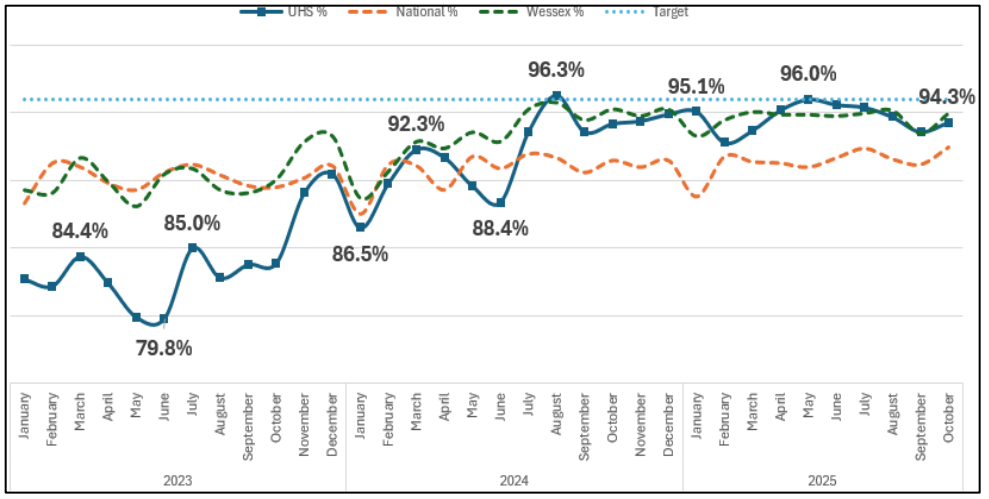
There is a known challenge to boost compliance in areas such as Head and Neck, Sarcoma and Urology (Bladder), especially with diagnostic pathology turnarounds, which is placing pressure on achieving the end of year planning target. UHS performs well against the average national NHS position (76.1% for October) and peer hospitals across Wessex who averaged 74.5% for October.

The 62-day standard measures the time from urgent GP referral, cancer screening referral or consultant upgrade to first definitive treatment. The national standard is for 85% of patients to meet this target, but recognition has been given to the current national picture of cancer wait times and a medium-term plan has been set by NHSE for all Trusts to improve their position incrementally by 5% year on year, starting from an expectation of 70% in 2024/25 and ending at 85% in 2028/29. For the financial year 2025/26, the Trust submitted an ambition of 77% by March 2026.

The Trust reported 73.5% for October 25 which was an increase on September's performance of 72.2%, but still a substantial reduction from the 81.2% reported in March 25. The UHS 62-day position continues to be challenged with dips in performance in Gynaecology (-5.2% vs. September), Haematology (-15.6% vs. September) as well as Head and Neck (-13.7% vs. September). Overall, the Trust continues to perform well against the national average of 68.8% and leads performance over Wessex peers who averaged 69.5% in October; the next highest scoring of which being Dorset Trust with 72.2%.



Graph 2: 62 Day Standard - Performance Trend



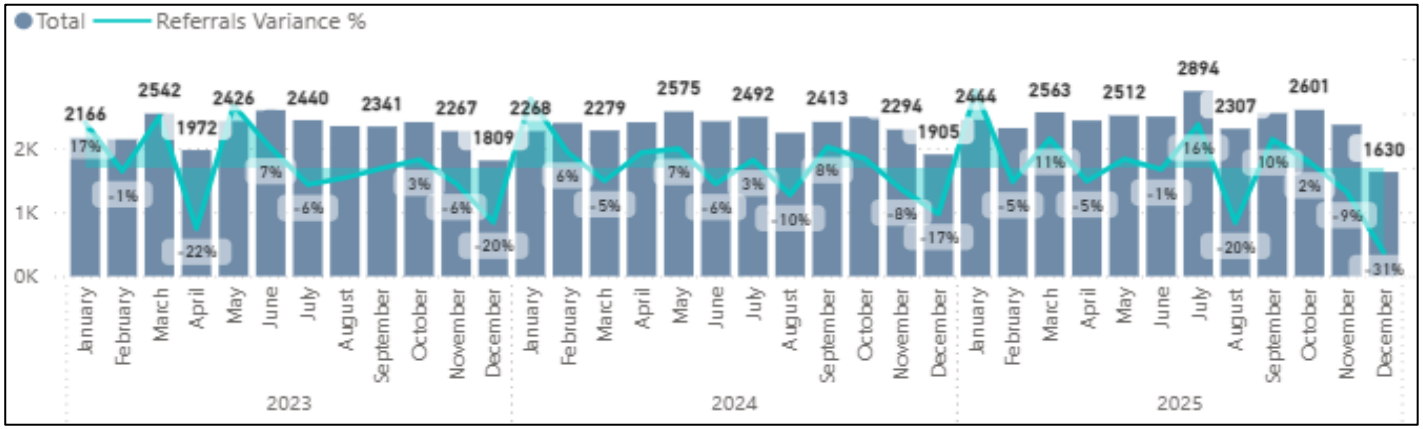
Graph 3: 31 Day Standard - Performance Trend

Some areas have improved significantly over previous months, such as Respiratory (+9.3% vs. September 25) and Urology (+8.6% vs. September 25). It is recognised that the 62-day position needs focus and improvement in order to push towards 85% by 2028/29, and the Cancer Alliance have primed funding which will be crucial to support plan implementations for achieving and maintaining this target, including support for pathology insourcing in quarter four to reduce turnaround times (which will also support the 28 day standard).

The 31-day standard refers to the time allowed from a registered decision to treat to the definitive treatment date associated with that plan - the national ambition is for Trusts to deliver this for 96% of patients. The UHS has recently made a huge step forward in terms of performance against this target, managing to surpass the 96% threshold for the first time since April 2021, in August 2024 when we reached 96.3%. We have since hit the target again only once, in May 2025, but have consistently reported over 95% until September and October, where we have dipped to 94.3%. The urology service continues to be the main area to have an impactful volume of breaching patients. The organisation has consistently benchmarked well compared to our peer organisations in Wessex, though the trust fell slightly below the average of 95.0% for October. The national NHS position for October is 92.5%.

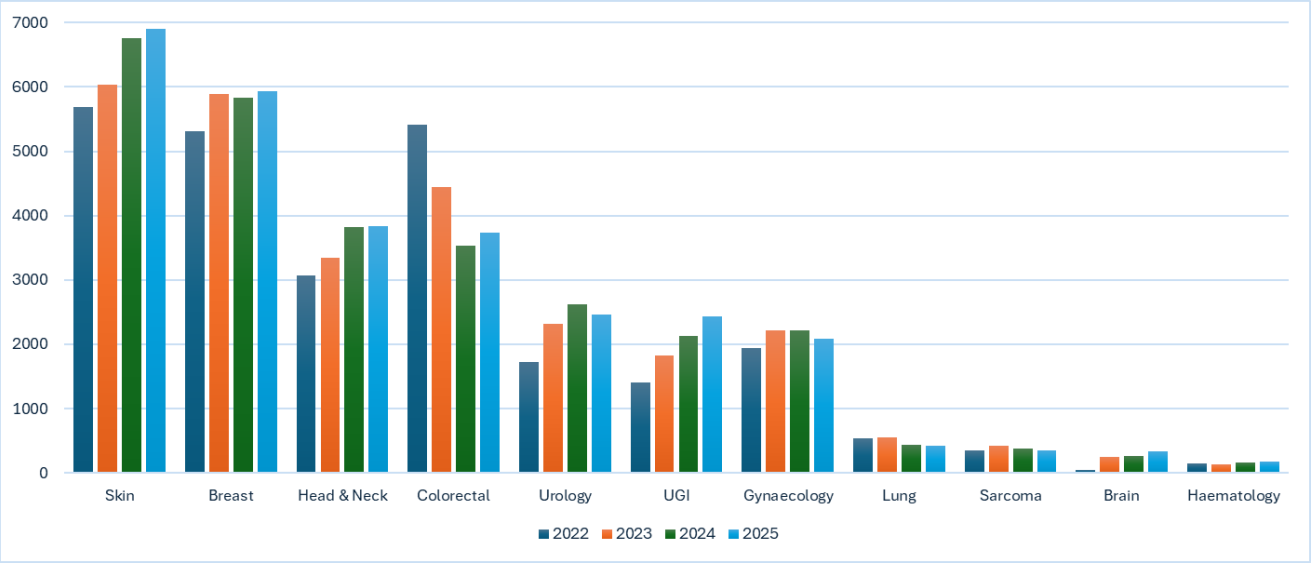
3. Cancer Referrals and Waiting List

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



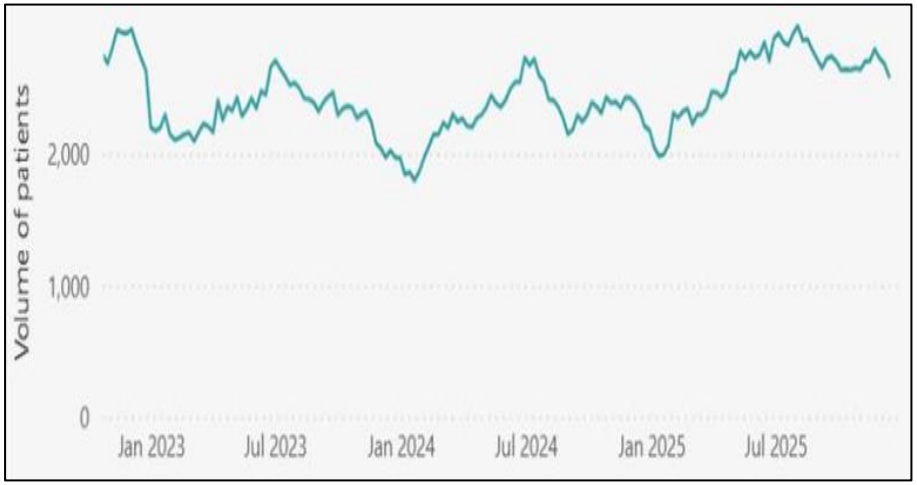
Graph 4: UHS two week wait (2WW) - referral volumes by month (N.B December is incomplete)

Across the 2025/26 calendar year, the Trust has received on average 2,499 referrals per month which is a 3% increase on 2024/25 and a 6% increase on 2023/24. The trust has developed modelling for cancer referrals and expected growth/reduction per month to better support annual planning, capacity modelling and business cases development. Graph 5 illustrates how most UHS cancer services have experienced a growth in referrals compared to 2024, but predominantly in Skin, Breast, Colorectal and Upper GI.

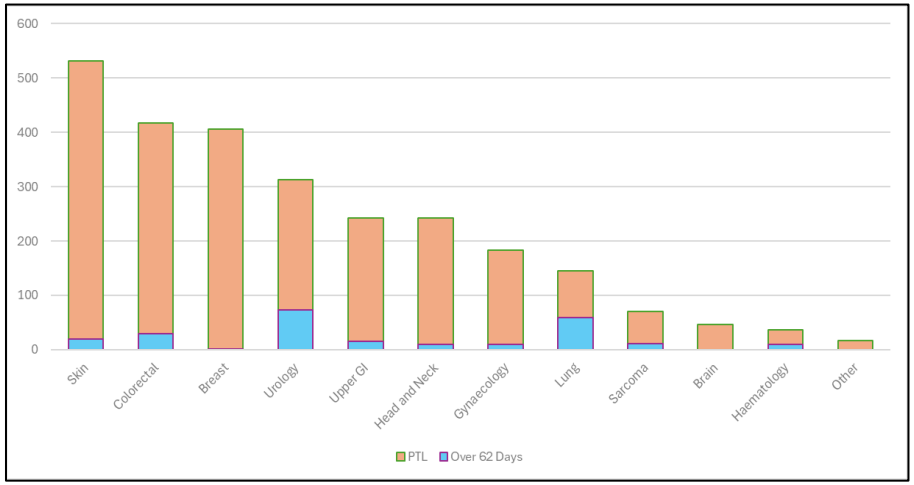


Graph 5: Annual Referral Volumes by Tumour Site

The overall waiting list size is heavily dependent on the number of urgent suspected cancer referrals and the speed of booking these patients in for an initial appointment or diagnostic procedure, as most patients will leave the waiting list due to a non-cancer diagnosis. At the time of writing, the cancer patient treatment list (PTL) is 2,651 which reflects some stability since the peaks reached in June, which was predominantly due to the seasonal volatility in skin cancer referrals. The number of patients waiting over 62 days from the date of receipt of referral is the subset of the PTL known as the backlog. At the time of writing, this currently sits at 236 patients (9% of total PTL). Graph 7 reflects a breakdown of the entire PTL by tumour site and the recent backlog volumes, illustrating the challenges in Urology and Lung services.



Graph 6: UHS overall PTL trend line



Graph 7: Latest Cancer PTL by Tumour Site and Backlog (<62 day waits)

4. Tumour Site Summaries

The section below describes some of the key challenges being faced by specific cancer services and the actions being taken to address them.

4.1 Breast Service

Referrals into the breast service remain steady but with some month on month variance. The backlog has been well managed and remained consistently low. Weekly PTL review meetings including members of the MDT continue to support the early escalation of any delays in a patient's pathway and the reallocation of patients to other consultants depending on capacity and suitability. The breast service overall has excellent turnaround times from referral to diagnostic biopsy but are often delayed by the reporting of pathology which can take up to five weeks. This puts greater strain on the later stages of the pathway for those patients who receive a cancer diagnosis and need to go on for first definitive treatment.

4.2 Gynaecology Service

There has been a steady referral rate into the gynaecology service. Capacity for first outpatient appointments is consistently reviewed against demand and additional clinics are stood up when needed to ensure the waiting time is maintained at around 14-days. Weekly PTL review meetings with clinical input

continue to support the early escalation of any delays in patient's pathway and the reallocation of patients to other consultants depending on capacity and suitability. This has supported regular compliance around 85% for 62-day performance over the last four months and a reduced backlog.

The gynaecology service remains consistent with its performance against the three cancer targets across the majority of the year, but a level of risk should be noted around their complex gynaecology theatre lists, as these are often taken down to make capacity for other urgent cases in other specialties, and can have a knock on effect to the service in terms of being able to rebook these patients back in ahead of breach without displacing others in the backlog. Gynaecology is often impacted by delayed pathology turnarounds earlier in the pathway, which makes improving their 28-day compliance a challenge, and tightens their window to book patients for treatment within 62-days.

4.3 Head and Neck Service

A single symptom low risk ENT pathway has been setup to run out of Romsey which looks to diagnose patients who have only been referred with short spell symptoms of a sore throat. Of the 150 patients seen thus far, only one has resulted in a cancer diagnosis, proving good efficacy for the expected findings of patients sent through this service, which has allowed more capacity to be freed up at UHS for higher risk referrals. There is a desire to expand this service out to include a list of other symptoms that may be considered low risk.

The backlog of 62-day pathways has reduced even further since last year, down to nine patients at the time of writing. However, from mid-December the locum consultant has left which will potentially have an impact on two week wait and 28-day targets due to the amount of front end-work that is covered by this role. The service has developed plans to mitigate while recruiting.

A pathway change for the management of demand for neck lump imaging is being worked through with Radiology; if a cohort of neck lump patients could go straight to test (scan) then they would not need to be seen in clinic prior to this, which would help with Head and Neck resource management.

There are also triage tools available which are being explored to help assess the percentage risk of these patients having cancer, which could help to manage capacity demands more intelligently. However, these will need to have a level of sign-off in order to be approved for clinical use, which the Chief Medical Officer is exploring.

4.4 Urology Service

The urology service continues to face challenges with 28-day performance at 61.2%, and 31-day performance at 86.9% - the lowest for the Trust and below target. Work has continued on the flexible cystoscopy service, including insourcing to clear the backlog of 600 patients by the end of December 2025.

There is new increased demand on robot capacity, as robotic treatment options have expanded to include bladder and renal as well as previously offered prostate procedures. Demand and capacity work has been instigated in order to properly plan how to effectively manage the shared usage of this equipment.

4.5 Lung Service

The respiratory 62-day position has started improving over previous months, however capacity for thoracic surgery remains a challenge and the Division are currently working up plans to sustain the position and improve it going forwards. A further risk is the expansion of the lung screening service in the Salisbury cohort which could further pressure the lung service, and though thoracic are exemplary at managing their pathways effectively, the service is reaching a limit to capacity.

4.6 Neurology

Neurology performs well across all three cancer metrics, frequently having 100% performance against 31 and 62-day targets and a more fluctuating 28-day performance that often exceeds targets but can drop below the 75% threshold at times.

4.7 Dermatology

Within the skin/plastics service, wide-local sentinel lymph node biopsies for potential melanoma patients have an extended wait due to a lack of access to regular theatre capacity for the service. The clinical team are under regular discussion with the theatres team to explore additional capacity, but consistent capacity has yet to be identified. There are ongoing discussions about a sustainable model of care, including where patients should be treated in the future.

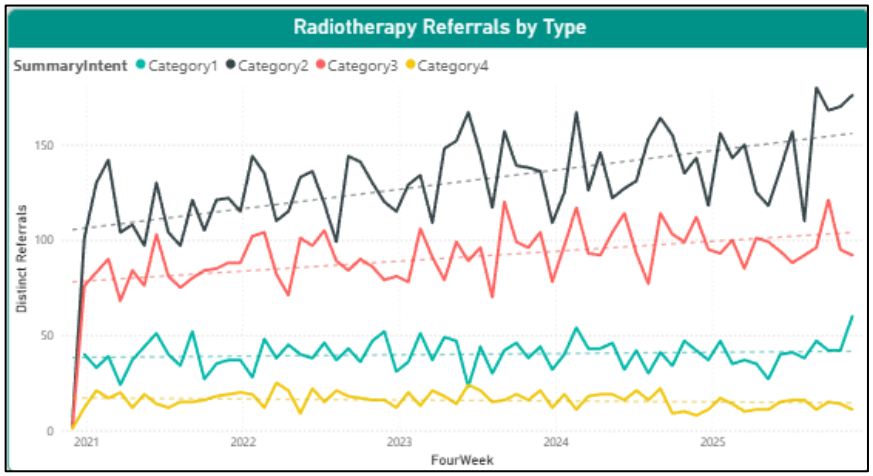
4.7 Pathology

Pathology provides a centralised service for the entire Trust, both for cancer and non-cancer specimens. With the ongoing pressures this year on the reduction of long waiters, as well as the continued pressures on cancer targets, the workload on pathology has increased and turnaround times for pathology specimens to be reported has also increased.

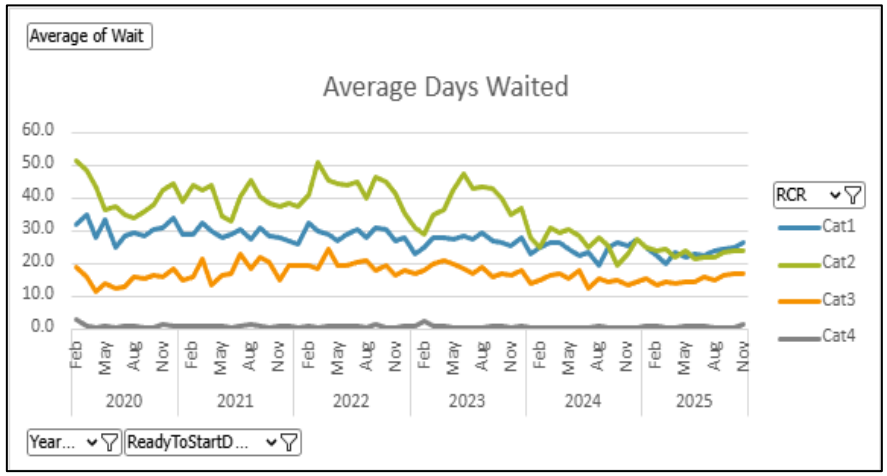
In order to support the delivery of 28, 31 and 62-day cancer targets, timely specimen reporting is essential in order to provide early diagnoses and create treatment plans earlier in the pathway. In light of this, several bids were made to the Cancer Alliance in order to fund potential solutions. The Cancer Alliance has provided additional funding to support insourcing in Quarter 4, with the goal of reducing turnaround times in pathology. They have also approved capital funding to buy additional equipment, which will reduce the processing time for samples.

4.8 Radiotherapy Service

Radiotherapy referrals have continued to increase with sustained high referral rates since September 2025, demonstrating an ongoing upward trend. Referrals of category 1 patients, those with fast growing disease and the highest priority treatments, have also seen a large peak in November and continuing into December. This is the largest volume of category 1 patients referred in the last 5 years having been relatively constant for the last 18 months.



Graph 8: Radiotherapy referrals by category



Graph 9: Radiotherapy average wait times by category

- Category 1 (fast growing, curative) – Target 31 Day.
- Category 2 (other curative) – Target 31 Day.
- Category 3 (palliative) – Guidance 14 days.
- Category 4 (emergency) – Treated within 24 hours.

This peak in referrals has coincided with a reduction in available equipment, with both planned and unplanned replacements. In September 2025 the second CT scanner on the UHS site failed. The unavailability of this CT has reduced the flexibility of the service to CT plan patients in a timely way. The service has been able to maintain capacity by increasing the clinical operating hours on the remaining CT at UHS, however this is limited by IV contrast patients needing to be scanned within core hours. Additionally, the radiotherapy CT at the Basingstoke site has been fully utilised with specialist CT staff travelling to Basingstoke from UHS.

The Linac at Basingstoke was due for replacement having reached the end of its clinical life in Spring 2024 and received central funding to be replaced which is being managed by HHFT. The Linac went out of service at the end of November 2025 with the new Linac due to go live clinically treating patients at the end of May 2026. This has put a large strain on the remaining 6 Linacs with the sustained and high levels of referrals becoming challenging to manage within the cancer targets. Waiting times throughout the year have been consistently within the 31 day target, however, it is looking likely that December will present a challenge due to the difficulties with CT availability and Linac H being out of clinical use.

Radiographer recruitment has been strong this year with the service having previously had a high vacancy rate. This improvement has allowed the weekday hours of clinical delivery to be increased, alongside a service regularly being provided on a Saturday and some Sundays. The first cohort of Therapeutic Radiographer Apprentices are due to graduate and gain registration, with the next cohort moving into their second year. Agency usage has been reduced to zero, with three temporary workers that were previously high-cost agency now working on NHSP.

In Spring 2025, the DXR unit which treats superficial skin lesions was replaced. The new unit has an extended range of treatment energies and is now fully integrated with our Mosaiq oncology information system and electronic health record and verification software.

Following the announcement of the Radiotherapy planning system Pinnacle's end of life, the department initiated the transition to RayStation as the primary treatment planning system. UHS is currently in the process of commissioning the system for clinical implementation. Clinical go-live is planned for mid-January, starting with prostates, then pelvic sites, and gradually all others. This phased migration is expected to improve planning efficiency and streamline departmental workflows.

Finally, Radiotherapy introduced liver SABR treatments for oligometastatic disease, hepatocellular carcinoma and prostate. This service uses advanced planning and delivery techniques to achieve high precision for hypo-fractionated treatments, reducing the number of treatments each patient needs.

5 Conclusion

The trust continues to benchmark well against all three national cancer standards but has ambitions to be compliant on all three targets as we start a new calendar year. Referrals have continued to steadily increase this year, and services are looking for more sophisticated ways to streamline pathways and plan effectively for the correct case mix within demand and capacity.

Challenges have continued to emerge throughout the year, but teams remained flexible and worked hard to meet demand. The support from Alliance funding has helped to bolster services and allowed some areas with larger backlogs to start to work through these at a positive rate bringing more activity earlier in the pathways to aid with target achievement. There are continuous, positive planning conversations which have a lot of potential to support the cancer service going forward into the next calendar year.

NHS Constitution - Standards for Access to services within waiting times

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

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

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

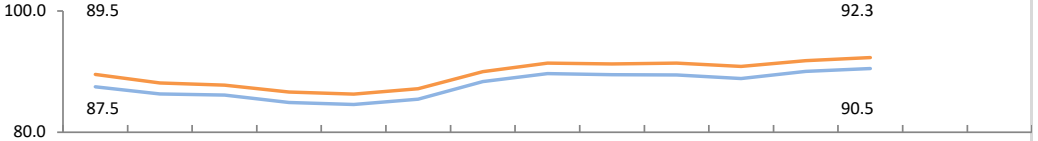
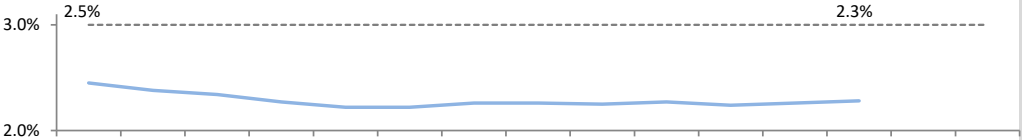
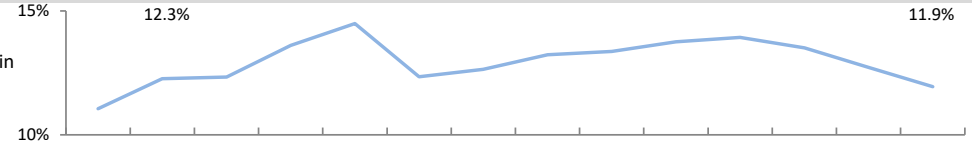
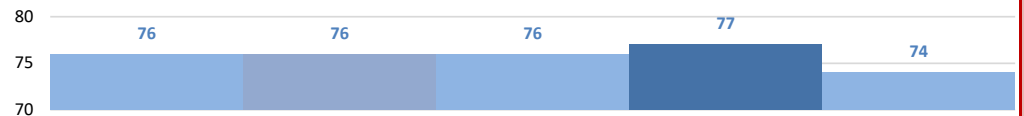
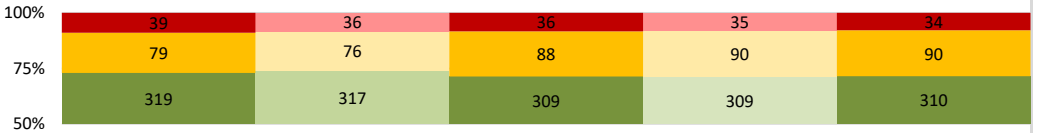
- All patients should receive high-quality care without any unnecessary delay.
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly.

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

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

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

		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	70% 62.4% 60.7% 50%															≥67.4%	62.4%
		4	4	4	4	4	4	3	3	3	3	4	6	7	7			
		4	3	5	5	5	7	6	5	5	6	5	6	7	6			
34 - As of April 2025, YTD and **Monthly target changed to local target (67.4%)**. N.B. new national target of 65%																		
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	100% 77.5% 73.5% 40%															≥75%	74.7%
		3	5	4	4	2	10	4	10	3	10	7	9	9	8			
		2	2	1	2	2	4	2	3	2	6	2	4	4	5			
43 - As of April 2025, YTD and **Monthly targets changed from 70% to 75%** in line with latest operational guidance																		
30	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	80% 56.1% 60.4% 40%															≥78%	59.6%
		6	6	12	15	9	16	14	10	14	15	15	7	8	14	11		
		4	4	9	12	6	12	12	7	15	13	17	5	6	17	9		
30 - As of April 2025, YTD and **Monthly target changed from 95% to 78%** in line with latest operational guidance																		
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	40% 13.4% 19.8% 0%															≤5%	18.14%
		5	6	6	6	6	6	7	9	9	9	10	11	11	13			
		6	8	9	8	9	6	7	10	11	9	10	9	11	11			
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**																≤100	93.8	≤100
2	HSMR - Crude Mortality Rate																<3%	2.2%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital																-	11.9%	-
			Q2 2024/2025			Q3 2024/2025			Q4 2024/2025			Q1 2025/2026			Q2 2025/2026		Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)																+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green																-		

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

Safety		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	81	88	91	94	97	112	105	120	12	8	19	20	29	28	36	41	49	53	59	62	69	69	79	76	≤8	76	≤64
7	MRSA bacteraemia	1	0	0	2	1	0	0	1	0	0	1	1	0	0	3	0	6	0
8	Gram negative bacteraemia	34	23	29	31	20	35	18	21	14	22	26	31	24	20	20	≤19	178	≤144
9	Pressure ulcers category 2 per 1000 bed days	0.24														0.34	<0.3	0.34	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.18														0.49	<0.3	0.49	<0.3
11	Medication Errors (severe/moderate)	1														0	≤3	0	0
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent 12 months** vs. **Previous 12 months**	2,613														2,423	<2578	2,514	<2552

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

Safety		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)			2												2	-	17	-
14	Never Events			2												1	0	4	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity			0												0	-	0	-
16	Number of falls investigated per 1000 bed days			0.09												0.16	-	0.15	-
17	% patients with a nutrition plan in place (total checks conducted included at chart base)			96.7%												94.3%	≥90%	93%	≥90%
				826	964	961	828	901	989	965	895	945	1,074	981	870	878	757	767	
18	Red Flag staffing incidents			20												15	-	98	-

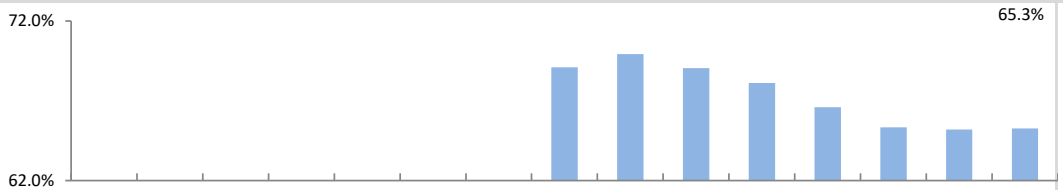
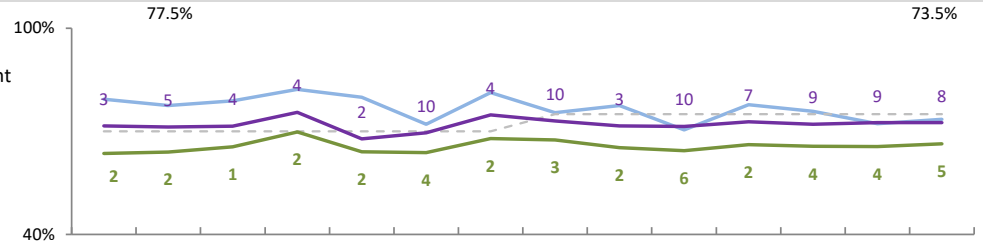
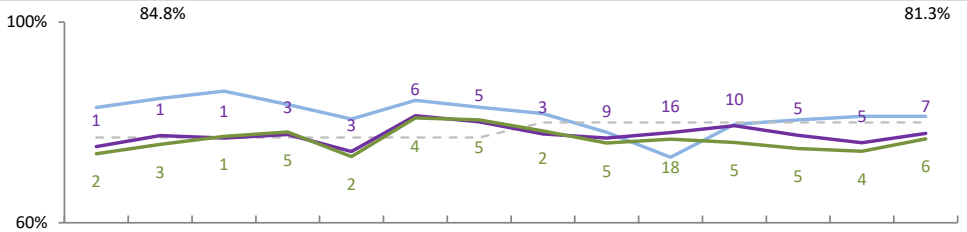
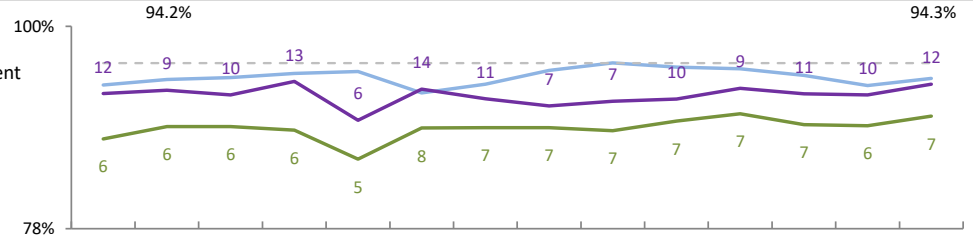
Maternity		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	410	438	392	396	395	372	410	390	390	425	440	432	431	448	406	-	-	-
		403	523	451	467	496	466	494	450	448	447	472	411	456	480	407			
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	12	6	1	0	1	1	1	1	1	4	4	1	3	0	6	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	43.90%	41.10%	46.68%	40.91%	47.85%	47.85%	48.54%	48.46%	45.38%	45.65%	45.23%	48.61%	43.62%	51.70%	46.10%	-	-	-
		42.44%	48.40%	41.07%	47.47%	42.03%	42.47%	40.98%	37.69%	43.59%	39.76%	42.05%	40.51%	45.01%	41.00%	41.60%			

Patient Experience		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients			0.4%												1.9%	≤5%	1.2%	≤5%
23	FFT Negative Score - Maternity (postnatal ward)			3.2%												4.2%	≤5%	3.1%	≤5%
24	Total UHS women booked onto a continuity of carer pathway			16.0%												13.3%	≥35%	14.1%	≥35%
25	Total Global Majority women booked onto a continuity of carer pathway			15.6%												22.7%	≥51%	17.9%	≥51%
25 - metric renamed from "BAME" to "Global Majority"																			
26	% Patients reporting being involved in decisions about care and treatment			87.3%												87.9%	≥90%	86.3%	≥90%
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)			88.5%												88.5%	≥90%	88.2%	≥90%
		221	353	247	296	323	273	483	491	442	504	416	357	276	338	419			
27 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
28	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)			61												93	-	648	-
29	Number of mental health patients spending over 12 hours in A&E			37												21	-	0	-

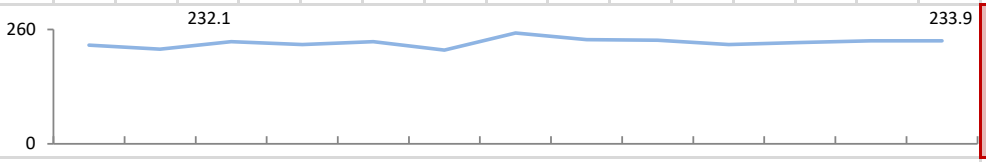
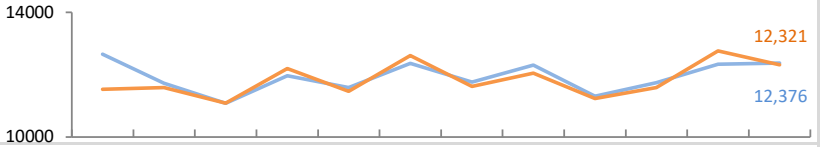
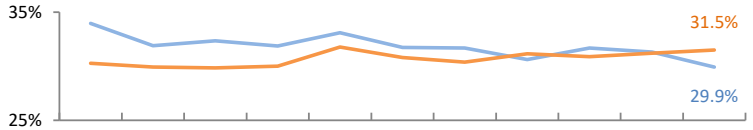
	Access Standards	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
30	Patients spending less than 4hrs in ED (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	6 4	6 4	56.1% 12 9	15 12	9 6	16 12	14 12	10 7	14 15	15 13	15 17	7 5	8 6	14 17	60.4% 11 9	≥78%	59.6%	≥78%
31	Average (Mean) time in Dept - non-admitted patients			03:33												03:53	≤04:00	03:29	≤04:00
32	Average (Mean) time in Dept - admitted patients			05:40												05:01	≤04:00	05:41	≤04:00
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year															97.8% 95.3%	-	96.9%	>98.3%
34	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	4 4	4 3	62.4% 4 5	4 5	4 5	4 7	4 6	3 5	3 5	3 6	3 5	4 6	6 7	7 6	60.7% 7	≥67.4%	62.4%	≥67.4%
35	Total number of patients on a waiting list (18 week referral to treatment pathway)			60338												63399	-	63,399	-
36	Percentage of patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	3 6	4 6	2.22% 6 7	6 7	6 7	6 7	7 7	5 7	8 7	8 8	10 8	11 11	13 13	15 14	2.81%	1.0%	2.8%	1.0%

		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
37	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			1340												1780	0	1780	0
38	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			24												245	0	245	0
39	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			4												15	0	15	0
40	Patients waiting for diagnostics			9428												10352	-	10,352	-
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)			13.4%												19.8%	≤5%	18.1%	≤5%

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

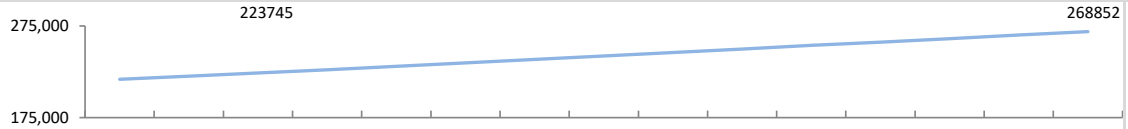
			Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks																	≥71.2%	65.3%	≥71.2%
43	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥75%	74.7%	≥75%
44	Cancer 28 day faster diagnosis Percentage of patients treated within standard UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥80%	79.4%	≥80%
45	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)																	≥96%	95.0%	≥96%

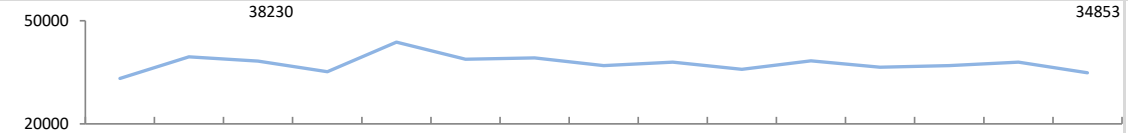
R&D Performance		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
46	Recruitment performance ranking	8	10	8	8	9	10	11	16	7	7	5	5	6	7	7	Top 10	-	-
47	Performance in initiating clinical trials	38%	78%	36%	70%	44%	47%	44%	40%	53%	39%	67%	87%	55%	55%	67%	≥80%	-	-
48	Performance in delivering clinical trials								23%	23%	35%	21%	21%	23%	21%	24%	≥80%	-	-
49	Proportion of sponsored studies open/on track								81%	82%	84%	87%	87%	87%	88%	90%	≥80%	-	-

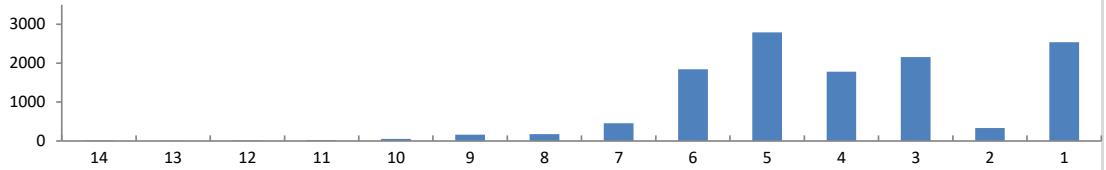
Local Integration		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	233	-
51	Emergency Department activity - type 1 This year vs. last year																-	95,786	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	31.4%	≥25%

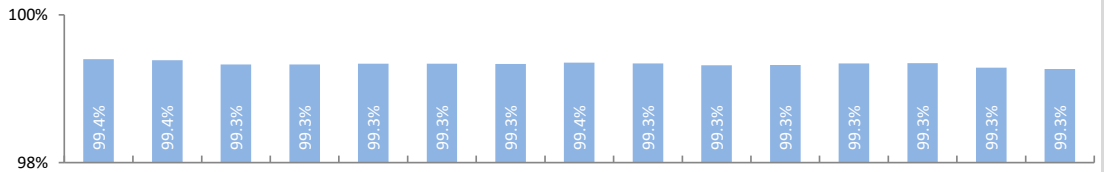
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month

Digital		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			223745												268852	-	268,852	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			38230												34853	-	295,310	-
54 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
55	Average age of IT estate Distribution of computers per age in years																-	-	-
56	CHARTS system average load times - % pages loaded <= 3s																		
56 - From **April 2024** , metric was changed from % loading time**s under 5s** to % loading times **under 3s**																			









Health Inequality		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted	50% 40%		44.0%												42.8%	-	44.4%	-
58	Percentage of under 18s attending emergency departments to be admitted	15% 5%		13.1%												14.0%	-	11.2%	-

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.7 Report to the Trust Board of Directors, 13 January 2026	
Title:	Finance Report 2025-26 Month 8
Sponsor:	Ian Howard, Chief Financial Officer
Author:	Philip Bunting, DoOF and Anna Schoenwerth, ADOF

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

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

The headlines for the November report are as follows:

- The Trust has reported a £4.9m deficit in M8 (£40.8m deficit YTD). This is in line with the FRP trajectory for M8, but £4.9m above the original plan submitted to NHS England (£24.1m adverse to plan YTD). The Trust originally submitted a full year plan to achieve a breakeven position.
- The underlying deficit has improved in M8, reducing to £5.7m. This is as a result of ERF overperformance delivered at marginal costs.
- WTEs continue to be on a downward trajectory overall and decreased by 11 in M8 to 13,178. Bank and agency costs increased by £0.5m due to industrial action and continued operational pressures. Substantive increased due to a M7 reclassification totalling £1.0m.
- Whilst the trajectory is improving overall, it is not yet at the pace required to deliver the original plan. Cost improvements have been offset by other pressures. In-month operational pressures including increased beds and surge capacity offset additional savings delivered.
- Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, non-criteria to reside patient volumes increasing, length of stay improvements not being sustained and inpatient mental health patient costs remaining high.
- Additional rigour continues to be applied around financial grip and governance ensuring strong controls are in place. This includes a weekly FIG (Finance Improvement Group) supported by the Financial Improvement Director and chaired by the Chief Executive Officer. This includes an additional weekly non-pay review panel.
- UHS continues to deliver significant levels of financial savings, £7.5m has been achieved in M8 and £58.6m YTD. This is however £4.7m behind plan. Transformation programmes centred around patient flow, theatre optimisation and outpatients remain core to this.
- Cash has decreased to £20.8m in month, due to increased payment to suppliers and £18.2m of ICB advanced payment being repaid. The cash position remains a significant risk to the Trust (25 score on risk register).

Contents:

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

University Hospital Southampton
NHS Foundation Trust

UHS Finance Report – M8

Financial Position

In M8, the Trust reported a £4.9m deficit, £4.9m adverse to the annual plan. The Trust's underlying position had a notable improvement, albeit remaining at a £5.7m deficit.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	YTD
Plan 25/26	(4.39)	(3.76)	(3.43)	(2.09)	(1.68)	(1.27)	0.00	0.00	**(16.62)**
Actual 25/26	(4.39)	(3.76)	(4.50)	(6.85)	(5.86)	(5.43)	(5.06)	(4.92)	**(40.75)**
Actual Variance to Plan	(0.00)	0.00	(1.07)	(4.75)	(4.18)	(4.15)	(5.06)	(4.92)	**(24.13)**
Underlying Position 25/26	(7.28)	(6.95)	(6.99)	(6.96)	(5.93)	(6.28)	(6.36)	(5.65)	**(52.41)**
Underlying Variance to Plan	(2.89)	(3.19)	(3.56)	(4.87)	(4.25)	(5.01)	(6.36)	(5.65)	**(35.79)**

Key driving factors of the UHS position include:

- UHS were set an extremely challenging target of delivering a breakeven plan, noting pressures within the starting underlying position, with activity levels above contract funding levels, NCTR and MH pressures. The Trust signed up to deliver the plan, but highlighted significant levels of risk, including the reliance upon the Trust achieving £110m (9%) of real cash releasing savings.
- The plan relied upon a set of assumptions. Despite positive CIP delivery to date, a number of those assumptions have not held true – notably:
    - Activity levels are above contracted levels
    - NCTR has not improved, but has instead deteriorated
    - MH has not improved, but has instead deteriorated
    - The Trust has faced significant operational pressures in month with increased demand, and additional ward and surge bed capacity has been open
    - The improvements seen in length of stay in previous months have not been sustained.
    - New unexpected pressures have materialised, including the impact of industrial action and the income received for the pay award not covering the full costs
    - Workforce reduction targets have been challenging to deliver in full, with a reduced turnover rate and lack of funding to support cost of change (e.g., MARS programme costs were expected to be funded within plan assumptions)
    - The Trust has delivered less recurrent CIP than targeted, off-set by an increase in non-recurrent CIP, putting pressure on the monthly underlying run-rate.
    - The Trust has seen an unplanned reduction in income levels following the plan submission, including:
        - Unplanned cut in Genomics funding
        - Unplanned reduction in funded activity from Channel Islands (replaced by unfunded growth in NHS activity)
        - Unplanned loss of pathology income (contracts from other systems repatriating activity to their host system)
        - Reduction in private patient activity
- Our underlying financial position is improving on a monthly basis, with a reducing workforce trajectory following management actions including a recruitment freeze, MARS programmes and divisional restructure. However, the position has not improved quickly enough to keep pace with the plan.
- In M8 we have reported a £4.9m deficit (£4.9m adverse variance to plan).
- YTD UHS continues to accrue for ERF income for M1-8.

- Due to specific areas of operational pressure and clinical risk, our outsourcing expenditure is £3.4m adverse to plan at M8, driven by Cardiac and Dermatology activity. This is partially driving the ERF overperformance outlined above. In addition, activity has commenced for Orthopaedics and Gynaecology to target the 65 week wait lists and improve on RTT (£0.2m in M8).
- CIP is reporting below plan by £4.7m YTD to M8 with achievement of £58.6m reported. There is however an underachievement of £16.8m on recurrent CIP offset by an overachievement of £12.1m on non-recurrent CIP.
- The Trust is working hard to improve its financial recovery, with robust governance including a weekly Financial Improvement Group. We have taken difficult decisions around workforce and reducing expenditure on insourcing and outsourcing, which has started to impact performance.
- The underlying position is in part driven by the number of NCTR patients remaining in the Trust, meaning bed capacity is over optimal levels.
- A further challenge is the number of Mental Health patients attending the Trust. This creates a significant additional cost, including utilising specialist agency to ensure we have sufficiently skilled staff capacity to care for these patients safely often including additional security costs.
- The Trust remains committed to delivering significant financial improvements in-year; however, it remains an extremely challenging position, and we are unable to continue to absorb additional cost pressures.
- A Financial Recovery Plan (FRP) is in implementation in response to the scale of challenge faced in year.

Financial Improvement - CIP

The Trust continues to target month on month financial improvement from its savings and transformation programmes. Key highlights for M8 include the following:

- UHS has delivered £7.5m (>5% of addressable spend) of CIP in M8, which is £1.3m below the 25/26 plan. This brings the YTD achievement of CIP under plan by £4.7m with £58.6m delivered against a target of £63.2m.
- Workforce controls continue to be enacted, targeting reductions of 5% in divisions and 10% in corporate departments. The Trust is £10.0m adverse to the pay expenditure plan in M8 but has delivered additional workforce savings month on month.
- UHS is currently utilising agency for just 0.3% of our total workforce, significantly below the national target. Just 46 agency WTE were utilised in month mainly relating to the support of mental health patients.
- The Financial Improvement Group is now established and meeting weekly. This group has approved initiatives across a number of different programmes and projects all targeting sustainable cost reductions and increased efficiency.

Workforce Expenditure

There has been a decrease in the total workforce of 11 WTEs; workforce numbers are below average levels seen in 24/25 and strict workforce controls continue to be in place.

Total pay increased by £0.4m to £70.9m in month driven by temporary staffing increases. The pay award has been fully accounted for, generating a YTD pressure of £1.6m with an ongoing £0.2m per month pressure resulting from funding not covering costs in full.

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

Corporate Services

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

UHS workforce controls and corporate non-pay savings target means the Trust are on track to deliver against this target, with expenditure of £31.3m in M1-8.

Net Risk Reporting / Financial Recovery Plan (FRP)

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

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

Capital

Capital expenditure to M8 is £12m (£16m below plan) with delays across several projects suppressing expenditure. An internal capital forecast of £26.5m is proving challenging to achieve in 2025/26 with mitigation opportunities continuing to be explored given more than half the programme is still to be completed. Slippage has been reported across Strategic Maintenance, the Community Diagnostic Centre (CDC), and several other estates projects.

There has also been minimal spend on externally funded schemes at M8, as planning and designs are still being finalised to secure funding arrangements. Several new bidding opportunities have also recently been subject to review and response by the Trust. All relate to funding available for 2025/26 so would require delivery within this financial year.

Forecast capital expenditure for the year is currently projected at £53.5m, of which 51% (£27m) is externally funded and 49% (£26.5m) internally funded. We are however currently in discussion around a number of externally funded schemes and brokerage across years hence the externally funded value is subject to change.

Report To	Board meeting in Public		
Title of Paper	System Report 2025/26 (Month 8)		
Purpose of Paper	For information	**Date of Meeting**	14 January 2026
Author	Natasha Taplin, Director of System Performance Improvement	**Agenda Item**	Item no. will be added by Governance team
Executive Sponsor	James Lowell, Interim Chief Delivery Officer	**Clinical Sponsor**	If applicable

Prior Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
Executive Committee	23 December 2025	For information
Future Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
	Click or tap to enter a date.	

Executive Summary

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

Please note that Month 8 (M8) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 7 (M7), with some exceptions depending on reporting frequency.

Performance Overview

This report provides an overview of in-month performance against operating plan metrics based on latest published data and highlights 14 headline metrics currently performing worse than plan across the Hampshire and Isle of Wight system. This represents an increase against previous month (12 metrics). The metrics below plan in current month reporting are:

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M8)
- Access to Children and Young People's Mental Health Services (M7)
- Average length of stay for Adult Acute Beds (Mental Health) (M7)
- Adults in inpatient care who have a learning disability, and may also be autistic (M7)
- Adults in inpatient care who are autistic, with no learning disability (M7)
- Diagnostic 6 week waits (9 key tests) (M7)
- Cancer 28 day faster diagnosis (M7)
- Cancer 62 day referral to treatment (M7)
- Time to First Appointment (M8) – *unvalidated*
- RTT 52 week waits (M7)
- RTT waiting list within 18 weeks (M7)
- Emergency Department 4 hour performance (total mapped footprint) (M8)
- % of attendances in A&E over 12 hours (M8)
- Category 2 ambulance response times (M8)

Quality Overview

Quality overview can be found on pages:10-17

Financial Overview
The purpose of the Month 08 (M8) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position for the ICS as at the end of November 2025.

The ICS position in month 8 is a deficit of £10.72m compared to a planned surplus of £2.56m, so a £13.28m adverse variance to plan in-month.

The ICS is reporting a year-to-date deficit of £65.15m, compared to a planned year-to-date deficit of £29.16m, so a £35.99m adverse variance to plan.

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

Workforce Insights
Month 8 Workforce Performance Overview (November)

- Total Workforce: 48,146 WTE, which is 753 WTE worse than nationally submitted plan. Compared to October 2025, the system saw a decrease of 84 WTE.
  - Trusts better than plan: HIOWH (135 WTE).
  - Trusts worse than plan: HHFT (200 WTE), IOW (114 WTE), PHU (321 WTE), SCAS (42 WTE), UHS (211 WTE).
  - Substantive: 515 WTE worse than plan.
  - Bank: 248 WTE worse than plan.
  - Agency: 10 WTE better than plan.
- Compared to March 2025 baselines in submitted Planning templates:
  - Total Workforce: Reduced by 1,148 WTE.
  - Substantive: Reduced by 843 WTE.
  - Bank: Reduced by 204 WTE.
  - Agency: Reduced by 100 WTE.

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

Governance and Compliance Obligations	
Relation to Strategic Objectives	Please select which of the following strategic objectives this paper addresses: ☒ 1) Improve outcomes and reduce inequalities for the people of Hampshire and Isle of Wight ☒ 2) Work with partners to transform the local NHS into an effective and sustainable system ☒ 3) Continuously improve the quality of and access to services for the people of Hampshire and Isle of Wight ☒ 4) Make best use of our resources by living within our means ☐ 5) Be an organisation that is a meaningful and fulfilling place to work.

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

Patient or Staff Implications	Summarises Key Performance Indicators linked to Constitution and Regulatory Standards. Indicates pressures faced by NHS workforce.
Equality Impact Assessment	This paper provides an aggregated overview of performance in Hampshire and Isle of Wight. Equality and Quality Impact Assessments are carried out across commissioners and providers; these are reported through organisational Boards. The System Quality Board maintains oversight of Quality. The Prevention & Health Inequalities Board maintains oversight across health and care and the People Board maintains oversight across the workforce. Systemic measurement and reporting of equality objectives is being developed, building on public sector equality duty and NHS standards. NHS Hampshire and Isle of Wight will need to set new equality objectives. The measures in future iterations of this report will allow the Board to track progress against equality measures at that aggregate level, although this report does not replace any regular assurance reports from those domains or any deep dive reports requested by the Board.
Quality Impact Assessment	
Data Protection Impact Assessment	N/A
Appendices or Supporting Information	N/A

1. Introduction

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

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

This report is based on data published on 11 December 2025 – up to November 2025 for Urgent and Emergency Care metrics and up to October 2025 for Planned Care, Local Care, Primary Care, Mental Health / Learning Disability and Autism metrics.

2. Operating Plan Summary

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

In December 2025, NHS Hampshire and Isle of Wight is ranked red against 14 headline operating plan metrics:

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M8)** – % of beds occupied by patients not meeting the criteria to reside remains significantly above the 12% target (no operating plans set in 25/26), increasing in M8 to 23.7% (compared to 23.4% in M7).

- **Access to Children and Young People's Mental Health Services (M7)** – below M7 plan with 25,105 vs 25,455 target, improvement on previous month. The known data quality issue with a new Provider has been resolved and analysis is underway to determine where we are seeing under performance against planned figures with other Providers.

- **Average length of stay for Adult Acute Beds (Mental Health) (M7)** – performance for NHS Hampshire and Isle of Wight in October is 58 days (deterioration on M6) and not achieving the M7 plan.

- **Adults in inpatient care who are autistic, with no learning disability (M7)** Although M7 shows an improving position, performance remains marginally above plan (34 vs 32 plan).There remains a shortage of admission alternatives for Autistic Adults (aged 25+) – in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Adults in inpatient care who are autistic, with no learning disability (M7)** Although M7 shows an improving position, performance remains significantly above plan (39 vs 25 plan). There remains a shortage of admission alternatives for Autistic Adults (aged 25+) - in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Diagnostic 6 week waits (9 key tests) (M7)** – Performance in M7 shows an improving position for the diagnostic 9 key tests, but remains above the in-month operating plan of 27.67%.

- **Cancer 28 day faster diagnosis (M7)** – Performance in M7 is 6.2% below plan at 73.9%. This represents a 1% decline on previous month. Performance is circa 2% below national average of 76.1%.

- **Cancer 62 day referral to treatment (M7)** – Performance in M7 improved to 70.3% (compared to 68% in M6), not achieving plan. Performance is above national average of 68.8%,

- **Time to First Appointment (M8) – *unvalidated*** – l Latest M8 position shows ICB is 4.5% below plan, however, this is based on unvalidated data and is subject to change. M7 was 4.4% below plan.

- **RTT 52 week waits (M7)** – in M7, 6,293 patients are waiting over 52 weeks, representing a decrease on M6 (6,429) and not achieving plan. All providers are above plan in M7

- **RTT waiting list within 18 weeks (M7)** – Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has declined marginally to 61.5% in M7 (compared to 62% previous month) – not achieving in-month plan by 1.4%.

- **Emergency Department 4 hour performance (total mapped footprint) (M8)** – Performance in M8 improved to 75.1% (compared to 73.4% previous month) – not achieving the 78% standard.

- **% of attendances in A&E over 12 hours (M8)** – Waits from decision to admit (DTA) decreased significantly in M8 to 1,453 (compared to 2,852 (compared to previous month) and % over 12 hours from arrival decreased in M8 to 8.9% (compared to 10.4% previous month), remaining above M8 plan (e.g. not achieving).

- **Category 2 ambulance response times (M8) -** Performance in M8 deteriorated to 32:27 (compared to 31:58 previous month), remaining above M8 plan and moving further away from the 30-minute operating standard. Response times have increased over two consecutive months, with delivery against year-end target at risk.

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

- **Primary Care Access** – performance in M7 is 1.6% below a national plan (e.g. not achieving). However, it should be noted that NHS Hampshire and Isle of Wight GP Practices provided 54,696 more appointments in October 2025 compared to the same period in 2024.

- **Units of Dental Activity** – performance in Aug 25 (latest published data) shows 84.7% vs 80.9% Q2 plan (e.g. currently achieving).

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

- **% of patients with hypertension treated according to NICE guidance (CVDP007HYP) (M3)**– latest published position for June 2025 shows 66.2% vs 70.5% local target (national target is 77%), representing a 2.1% increase on the June 2024 position. National average is 68.34%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased since June and there is now a difference of 6.03% between NHS Hampshire and Isle of Wight and the top performing ICB (North East and North Cumbria), with NHS Hampshire and Isle of Wight ranking 35 out of 42 systems. There has been consistent improvement in performance since March 2022. In terms of local data, the latest position in November 2025 shows an improving position to 69.27%, so moving in the right direction.

- **% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy (CVDP003CHOL)** – latest published position for June 2025 shows 58.7% vs 60% national target, representing a 1.07% increase on June 2024 position. National average is 63.84%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has increased since June and there is now a difference of 11.39% between NHS Hampshire and Isle of Wight and the top performing ICB (North-East London), with NHS Hampshire and Isle of Wight ranking worse nationally.

- **% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance (CVDP012CHOL)** – latest published position for June 2025 shows 45.96% vs 65% national target. National average is 47.67%. NHS Hampshire and Isle of Wight ranking 26 out of 42 systems.

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

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M8)**– NHS Hampshire and Isle of Wight are ranked 39 out of 42 Integrated Care Boards for their November performance with 748 patients with no CTR as at 11 December 2025, which is 23.69% of total G&A beds available. (Lowest quartile)
  The National average is approximately 14%

- **Access to Children and Young People's Mental Health Services (M7)** – NHS Hampshire and Isle of Wight are ranked 11 of 42 Integrated Care Boards for their October performance. (Interquartile).

- **Diagnostic 6 week waits (9 key tests) (M7)** NHS Hampshire and Isle of Wight are ranked 32 out of 42 Integrated Care Boards for their October performance with 28.6% (Lowest quartile)
  The National average is 21.3%.

- **Cancer 28 day faster diagnosis (M7)**, NHS Hampshire and Isle of Wight are ranked 29 out of 42 Integrated Care Boards for their October performance. (Interquartile)
  The National average 76.1%

- **Cancer 62 day referral to treatment (M7)**, NHS Hampshire and Isle of Wight are ranked 16 out of 42 Integrated Care Boards for their October performance. (Interquartile)
  The National average is 68.8%

- **RTT 52 week waits (M7)** - NHS Hampshire and Isle of Wight are ranked 39 out of 42 Integrated Care Boards for their October performance with 3.2% (Lowest quartile)
  The National average is 2.7%

- **RTT waiting list within 18 weeks (M7)** – NHS Hampshire and Isle of Wight are ranked 15 out of 42 Integrated Care Boards for their October performance with 61.5% (Interquartile)
  The National average is 61.3%

- **Emergency Department 4 hour performance (total mapped footprint) (M7)** – NHS Hampshire and Isle of Wight are ranked 19 out of 42 for their November performance with 75.1%. (Interquartile)
  The National average is 74.2%

- **% of attendances in A&E over 12 hours (M8)** – NHS Hampshire and Isle of Wight are ranked 9 out of 42 Integrated Care Boards for their November performance with 5.9% (Highest quartile)
  The National Average is 7.2%

- **Category 2 ambulance response times (M8)** – NHS Hampshire and Isle of Wight are ranked 7 out of 11 for their performance in November with 32:39 *The National Average is 32:46*

3 Quality

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

3.1 Regulatory

3.1.1 Care Quality Commission – General Practice: there is currently one Hampshire and Isle of Wight GP Practices that has a published Care Quality Commission rating of *outstanding*; 121 are *good*; one *requires improvement*, one is inadequate and four remain unrated.

3.1.2 Care Quality Commission – Large System Trusts:

- **Hampshire Hospitals NHS Foundation Trust:** in November 2025, following their inspection in July 2025, the Care Quality Commission upgraded the rating of maternity services at two of the Hampshire Hospitals NHS Foundation Trust sites (Basingstoke and North Hampshire Hospital and the Royal Hampshire County Hospital) from *requires improvement* to *good*. Both maternity departments were upgraded in the safe and well-led ratings from *requires improvement* to *good*. The domains of effective, caring and responsive were re-rated as *good*.
- **South Central Ambulance NHS Foundation Trust:** in December 2025 the Care Quality Commission published two reports covering the Trust's 999 control room and field operations. The emergency operations centre service was given an overall rating of *good* which represented an upgrade from *requires improvement* and the emergency and urgent care service received an overall rating of *requires improvement*, an upgrade from *inadequate*. The Trust's overall rating will not change until after a Trust-wide well-led inspection is completed in January 2026.

3.1.3 Quality Assurance and Improvement Surveillance Levels: members of the November 2025 System Quality Group agreed that all the large Hampshire and Isle of Wight NHS providers should remain in routine quality assurance and improvement surveillance levels. This will be reviewed at the next System Quality Group in January 2026.

3.2 Contract: Quality Schedules

3.2.1 2026/27 Quality Contract Framework: the intelligence from thematic analysis of system quality, safety and patient feedback and collaboration with system providers over the year has informed our 2026/27 quality contract development processes.

The *quality contract development and negotiation 2026/27 framework* was developed and socialised with providers including with the Integrated Care System Chief Nursing Officers during Autumn 2025. The framework

describes how the quality schedules will be developed to support reducing the gap in health life expectancy across Hampshire and the Isle of Wight which links with our quadruple aim, focused on reducing inequalities and improving population health through the delivery of better health outcomes, improved patient and staff experience and better value (i.e. effectiveness and efficiency).

Providers were given the opportunity to share their key areas of quality focus for 2026/27 to enable this to feed into local quality indicator development. Building on the success of the quality contract development workshops held in 2024/25 and following discussion and agreement with the Integrated Care System Chief Nursing Officers, quality contract development workshops have been organised to start in January 2025.

A meeting with provider Chief Pharmacists took place in December 2025 to collaboratively review the medication requirements included in Schedule 2J (Transfer from and Discharge from Care Schedule).

3.3 Patient and Staff Experience

3.3.1 Friends and Family Test – October 2025:

- **Acute providers – inpatient:** three of the four acute providers achieved over 95% positive response scores for inpatient care, exceeding the national rate of 94%.
  One Trust's positive feedback performance remains below the national rate, though showed slight improvement in comparison with the previous month.
- **Acute providers – Emergency Department:** one Trust demonstrated strong performance in Emergency Department positive feedback (94%), while two Trust's showed a marginal decline in positive Friends and Family Test performance when compared to September 2025.
- **Acute providers – Maternity:** response rates for antenatal care were very low for three out of four providers, with two Trust's performance based on only five responses and another based on seven). While most scores remain high overall—particularly for care at birth and postnatal ward—antenatal results vary significantly – two Trust's achieved 100%, whereas one Trust dropped to 60%.
  One Trust's postnatal ward scores were notably lower (79%), and one Trust's results showed a decline in care at birth (75%). Community postnatal data is incomplete, with several providers reporting no data. Of note, maternity services use multiple methods to gather patient feedback. The Maternity and Neonatal Voice Partnership provides a rich source of insight that supports service improvement.
- **Community and Mental Health:** performance highlighted mixed satisfaction trends; physical health services consistently above national average.

3.3.2 Mixed-Sex Accommodation breaches – October 2025:

the NHS has a policy of eliminating mixed-sex accommodation except in cases where it is deemed clinically necessary. This is to create a more comfortable, safe, and

dignified environment for all patients, ultimately contributing to a better overall healthcare experience.

NHS Hampshire and Isle of Wight's breach rate for October was 2.0 which was better than the England breach rate of 2.4. In October 2025, across NHS Hampshire and Isle of Wight, there were 63,685 finished consultant episodes and 128 mixed-sex accommodation breaches.

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

The NHS Hampshire and Isle of Wight quality team has asked providers to clarify their application of the national mixed-sex accommodation guidance. Responses have been received and are currently being reviewed.

3.3.3 Adult Inpatient Survey 2024: the Care Quality Commission undertake an annual survey of inpatients. The survey explores the experience of people who have stayed at least one night in hospital in November 2024 and looks at the experiences of 62,444 people across 131 NHS Trusts. The results were published on 9 September 2025 and for Hampshire and Isle of Wight acute providers demonstrated a generally positive picture, with consistently strong performance in areas of patient care that matter most to individuals' personal experiences. Patients continue to report very high levels of kindness, compassion, and respect, with scores ranging from 8.9 to 9.3. These results are in line with those from 2023 and demonstrate a sustained culture of dignity and compassion across all providers. Similarly, doctors and nurses received strong ratings, with one Trust performing marginally better than their peers. Cleanliness of hospital environments was also highlighted positively across all four providers.

In line with provider contracts, Trust improvement plans will be monitored. Providers will be encouraged to share good practice with each other. As strategic commissioners, intelligence from the survey will be used to inform 2026/27 contract development.

3.3.4 National Care at the End-of-Life Audit: the National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Jersey. As part of the provider contracts NHS Hampshire and Isle of Wight have now received all provider data from them.

Within Hampshire and the Isle of Wight a number of positive practices were highlighted and included:

- all sites provided face-to-face specialist palliative care service 8 hours/day, 7 days/week (100%)

- there was high compliance with sharing end-of-life care quality improvement plans with three Trust's performing at 100%
- one Trust demonstrated exceptional performance across most metrics, including spiritual/cultural needs (97%) and individualised care plans (100%).

Opportunities for improvement included:

- there were low documentation of spiritual, religious, and cultural needs nationally (41%) which were also noted at one Trust within Hampshire and the Isle of Wight (38%)
- staff training completion rates required improvement
- personalised care planning conversations remained low nationally (44%) including at one Trust within Hampshire and the Isle of Wight (30%).

Actions and improvements will now be monitored as part of contract review (Schedule 6d) and will inform 2026/27 contract development.

3.3.5 National Cancer Patient Experience Survey (published July 2025): within Hampshire and the Isle of Wight, the survey showed strong performance in clinical care and hospital experience, with a 56% response rate (above the national average of 50%) and an overall care rating of 9.0/10.

Patients reported high confidence in care coordination (90%), respect and dignity (88%), and clear information before treatment, particularly for surgery (91%), chemotherapy (86%), and radiotherapy (88%). Most had a main contact (92%) and found advice helpful (97%).

However, gaps remain in holistic support. GP involvement was low, with only 44% feeling supported and 21% receiving a cancer care review. Emotional support after treatment was limited (30%), and long-term side effect management scored 61%. Community care during treatment (52%) and financial advice (72%) required improvement, despite recent progress.

Trends from 2021–2024 show stability in high-scoring areas and incremental improvements in care planning and financial advice, but persistent low scores in GP engagement and emotional support.

Overall, the survey demonstrated strong performance in hospital-based care and communication, but improvements in post-treatment support and community engagement are required.

Actions and improvements will now be monitored as part of usual commissioning processes.

GP complaint handling workshop: the NHS Hampshire and Isle of Wight Patient Experience and Complaints team led a GP complaint handling workshop on 13 November 2025, with training delivered by the NHS England Strategic Complaints Lead. Over 60 people attended across two sessions. Feedback was very positive. Further guidance will be shared with primary

care colleagues regarding updating their complaints pages on Practice websites.

NHS Hampshire and Isle of Wight – primary care complaints backlog: of the 212 complaints transferred from the South East Complaints Hub to the NHS Hampshire and Isle of Wight Patient Experience and Complaints Team on 1 February 2025, 24 remain open as of 15 December 2025.

NHS Hampshire and Isle of Wight Patient Experience and Complaint themes: during November 2025 there have been:

- a continued rise in contacts from patients relating to access to attention deficit hyperactivity disorder (ADHD)/autism assessments
- contact from patients regarding Procedures of Limited Clinical Value (PLCV)
- themes in relation to dental access and registering with an NHS dentist.

NHS Hampshire and Isle of Wight have extended access to routine dentistry over the last two years. In 2024/25, there was a 10% increase in units of dental activity (UDAs) commissioned, and this year to date there is circa 5% increase on last year. An additional 125,000 UDAs are in the process of being commissioned and 34,000 urgent dental appointments have just been made available. The mobile dental unit continues to be commissioned and provides circa 20,000 appointments a year often in the areas of highest need and healthcare inequalities.

3.4 Safety

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

- **Methicillin-resistant Staphylococcus aureus:** in November 2025, within Hampshire and Isle of Wight, four cases were reported (outturn for the year is currently 19 cases). Nine cases remain under review. Five of the cases have identified a lapse in care and two identified incidental learning. While the number of cases is the same for the November 2024; there has been a change in allocation with 15 of the cases in 2025 being Healthcare Associated, compared to nine in April to November 2024.

  Current themes are associated with insertions and ongoing care on indwelling devices, compliance with Methicillin-resistant Staphylococcus aureus Screening and risk reduction policy. Only one case has been identified as a contaminated sample, this is a reduction on this theme from last year. NHS Hampshire and Isle of Wight infection prevention and control team continue to review themes to support System learning and prevention.

- **Clostridium difficile infections:** forty-seven cases were reported in November 2025 across Hampshire and Isle of Wight leading the system to be 70 cases above planned trajectory but remaining below the annual threshold.
- **Escherichia coli:** 110 cases were reported across Hampshire and the Isle of Wight in November 2025 with performance 170 cases above trajectory but remaining below the annual threshold.

  NHS Hampshire and Isle of Wight infection prevention and control team have distributed *Hydrate to Feel Great* resources with all local authorities and practices in the Isle of Wight, presentations have been given at varying forums including System Quality Group, and a dedicated webpage has been developed and shared.

  The Hampshire Clostridium difficile project won the PrescQIPP 2025 award for patient safety and addressing overprescribing. 14 Hampshire Primary Care Networks successfully finished their projects under the NHS Hampshire and Isle of Wight leads for the Infection Prevention and Control and Medicines Optimisation teams and funded by the Hampshire County Councils Contain Outbreak Management Fund (COMF). On average, the Primary Care Networks that undertook the project reduced their cases by 7.2% in 12 months compared to an average increase of 27.7% in the non-project group. All of the project materials are available on the NHS Hampshire and Isle of Wight webpage.

  The 2026/27 quality elements of the contract are being developed to support providers in embedding learning from infections during 2025/26 and to develop and deliver an action plan to safely reduce overall antibiotic use and increase the proportion of antibiotic use from the Access Category, in accordance with the requirements of the National Action Plan for Antimicrobial Resistance.

3.4.2 **Never Events:** the total number of Never Events reported during 2025/26 (to 12 December 2025) is 20, of which 19 have occurred during 2025/26. During November, three surgical incidents were reported.

All incidents are being investigated by the relevant organisations and improvement actions taken in response. Providers continue to embed the National Safety Standards for Invasive Procedures (NatSSIPs) as per the quality schedules in their contracts.

As previously reported, one Trust undertook a risk summit in response to their rise in Never Events. NHS Hampshire and Isle of Wight are encouraging providers who have not yet done so, to also adopt an internal risk summit approach to further develop learning for improvement. In response, an additional two providers have said they will explore this approach.

Over the past two years, the local quality elements of the contract have supported providers in embedding the National Safety Standards for Invasive Procedures. During 2026/27, it is expected that Boards will be assured that

these procedures are fully embedded. Compliance will be monitored as part of the contract through regular provider audit and reporting with evidence of Board oversight.

Sharing learning and escalation: at the December 2023 meeting of the Hampshire and Isle of Wight System Quality Group, concerns were raised about a digital risk identified in the electronic prescribing and medicines administration (EPMA) system. Reported local incidents from an acute Trust and triangulation of intelligence from another region highlighted that the system's software was defaulting to 'penicillamine' instead of 'penicillin' when auto-populating allergy information, creating a risk of incorrect allergy assignment. As this had the potential to be national safety concern, this was escalated to the NHS England South East regional team in January 2024 with a request to share nationally.

In November 2025, a National Patient Safety Alert was issued by the NHS England National Patient Safety team, in collaboration with the Royal Pharmaceutical Society, Royal College of Physicians and Royal College of General Practitioners, on the risk of harm from healthcare staff incorrectly recording patients' penicillin allergies as penicillamine allergies in electronic prescribing systems.

3.5 Clinical Effectiveness

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

Compliance with Best Practice Tariff standards is highly variable across providers, ranging from 0% to above national benchmarks. Two providers are significantly below national performance, with one reporting no compliance and another at 3.6%.

Time to surgery is a recurring issue, cited by some providers as a result of demand, theatre capacity and operational issues.

Nutritional assessment and delirium assessment show strong compliance in most organisations (often near or at 100%). Physiotherapy assessment is also showing strong performance with some providers achieving 100% compliance.

Delirium assessment remains a concern for one provider despite targeted interventions.

Best Practice Tariff improvement plans will be monitored via usual contractual routes and Quality oversight.

3.6 Quality Impact Assessments

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

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

4 Integrated Care System Financial Overview

4.1 Purpose

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

4.2 Background

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

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

The Hampshire and Isle of Wight system has received Q1 and Q2 Deficit Support Funding (M1 to M6). Deficit Support Funding for Q3 (M7 to M9) has been withheld by NHS England.

NHS England have advised Hampshire and Isle of Wight organisations to assume that any Deficit Support Funding withheld in Q3 will be earned back in Q4 (M10 to M12), but this will be conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

4.3 Financial Position

Table 2 below summarises the in-month and year-to-date financial position as at Month 08 (November) for all Hampshire and Isle of Wight organisations:

Table 2: Summary of M08 results

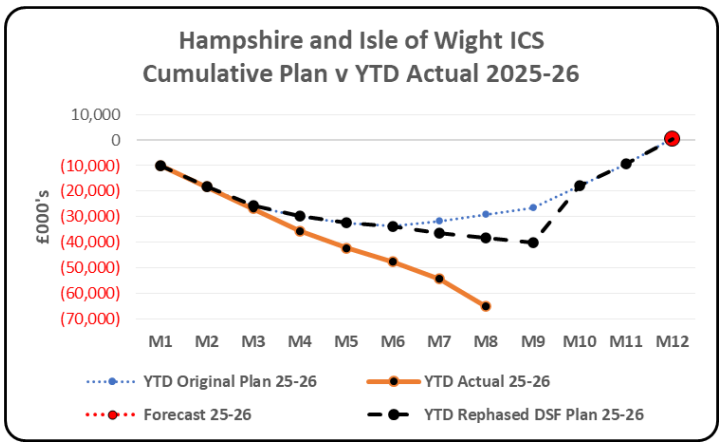
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	2,560	(10,717)	(13,277)	(29,163)	(65,153)	(35,990)	468	469	1

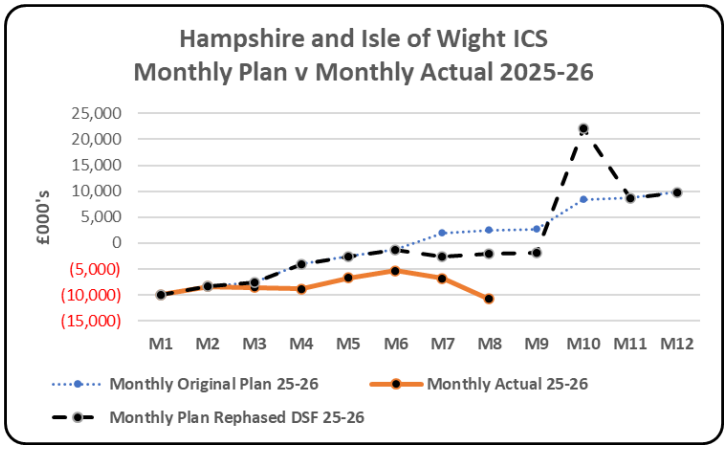
In November 2025 itself, the ICS reported a deficit of £10.72m against a planned surplus of £2.56m, so a £13.28m adverse variance to plan. Year-to-date the system has reported a deficit of £65.15m at Month 08 compared to a planned deficit of £29.16m, therefore a £35.99m adverse variance to plan.

Of the £35.99m adverse variance to plan year-to-date, £9.11m relates to withheld Deficit Support Funding.

The graphs below summarise the ICS position reported at month 08 (November) 2025/26.

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





4.4 System Actions to Support Financial Recovery

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

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

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

5. Workforce

Month 8 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is worse than plan by 753 WTE in M8 2025/26, broken down by Substantive (515 WTE), Bank (248 WTE) and Agency (-10 WTE).
- Compared to the previous month (October 2025), the system has seen an overall decrease of 84 WTE.
- Trusts worse than plan are Portsmouth Hospitals University (321 WTE), University Hospital Southampton (211 WTE), Hampshire Hospitals (200 WTE), Isle of Wight (114 WTE) and South Central Ambulance Service (42 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 135 WTE.

Month 8 - Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 515 Substantive whole time equivalent (WTE) worse than plan.
- Trusts worse than plan are Hampshire Hospitals (183 WTE), Isle of Wight (101 WTE), Portsmouth Hospitals University (201 WTE) and University Hospital Southampton (190 WTE). Trusts better than plan are Hampshire & Isle of Wight Healthcare (151 WTE) and South Central Ambulance Service (9 WTE).
- 'Support to Clinical' and 'Any Other Staff' staff Groups are better than plan by 109 and 1 WTE. Whilst 'NHS Infrastructure Support' is worse than plan by 277 WTE, alongside 'Registered Qualified Scientific' (153 WTE), 'Medical & Dental' (179 WTE), and ' Registered Nursing and Midwifery' (16 WTE) staff groups

Month 8 - Bank & Agency Trajectories – Whole Time Equivalent (excluding Integrated Care Board)

- In Month 8, Total Temporary staffing (Bank & Agency) usage is 2,743 WTE and 238 WTE (9.5%) worse than the plan of 2,505 WTE.
- Bank use is worse than plan by 248 WTE (11.1%).
- Agency use is better than plan by 10 WTE (3.5%).
- All Provider Trusts in Hampshire & Isle of Wight are worse than Temporary Staffing plan. Portsmouth Hospitals University shows the most significant variation to plan which is 120 WTE (33.7%) worse than plan.

.6. Recommendations

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

University Hospital Southampton
NHS Foundation Trust

Agenda item 5.9 Report to the Trust Board of Directors, 13 January 2026	
Title:	People Report 2025-26 Month 8
Sponsor:	Steve Harris, Chief People Officer
Author:	Workforce BI Team

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

The overall workforce fell marginally during November. The substantive workforce reduced by 52 WTE. This included MARS planned exits. Recruitment controls and capping of new starters remains in place. However, temporary staffing expenditure in bank increased in month. This was driven by increased sickness and operational pressures. Temporary staffing is now above the original NHSE plan, and UHS is over its original plan by 214 despite a decrease in nearly 400 WTE since 31March 2025.

To hit our financial recovery plan (FRP) the overall workforce needs to fall by a further 137 WTE. This includes a reduction in temporary staffing of 72 WTE. Substantive workforce will continue to fall subject to recruitment controls and normal levels of turnover. There will be continued pressures on temporary workforce as the winter progresses placing this target at risk. The Trust is also asked to work to mitigate impact of a spike in bank through annual leave utilisation in March. Mitigations should include planning of annual leave in line with the rostering policy.

Sickness absence has again risen during November to 4.2% in month. This is attributed to seasonal viruses causing additional short-term absence. The Trust is currently at 50% vaccination update of front-line workers (11% better than last year). Our target is 58% by the end of February. There is continued promotion of the flu vaccine including writing to all individuals where Occupational Health hold no vaccination status. The Trust has also launched its 'Winter Well' campaign, which includes promotion of vaccination for our people and the public.

Contents:

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

Risk(s):

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

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

UHS People Report

WORLD CLASS PEOPLE

November 2025

THRIVE EXCEL BELONG

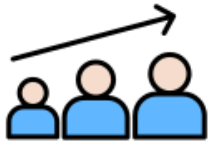
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M8 (November-25)

In-month sickness is currently 4.2%, 0.5% above target (3.7%).

Appraisal completion rate remains at 64.4%

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



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

Bank usage increased from prior month and is now 27 WTE above plan.

Increase in agency staffing. Agency is 3 WTE below plan.

Decrease in patient safety incidents to 75 (115 in October)

Executive Summary

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Overall Position

WTE Movement (M7 to M8)

Total Workforce

The total workforce **decreased by 11 WTE** to 13,178 WTE from M7 (13,189) to M8.

During this period, the substantive workforce **decreased by 56 WTE**, while the total temporary staffing **increased by 44 WTE.**

As of M8, the Trust is **above the total plan (by 214 WTE).**

Substantive WTE

Substantive WTE decreased by 56 **WTE** between end of October and end of November.

All staff groups (except Nursing and Midwifery registered) have shown a decrease in substantive staff. Largest reduction is seen in Admin & Clerical (30 WTE total, 15 WTE decrease in both divisions and THQ respectively).

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

Bank & Agency WTE

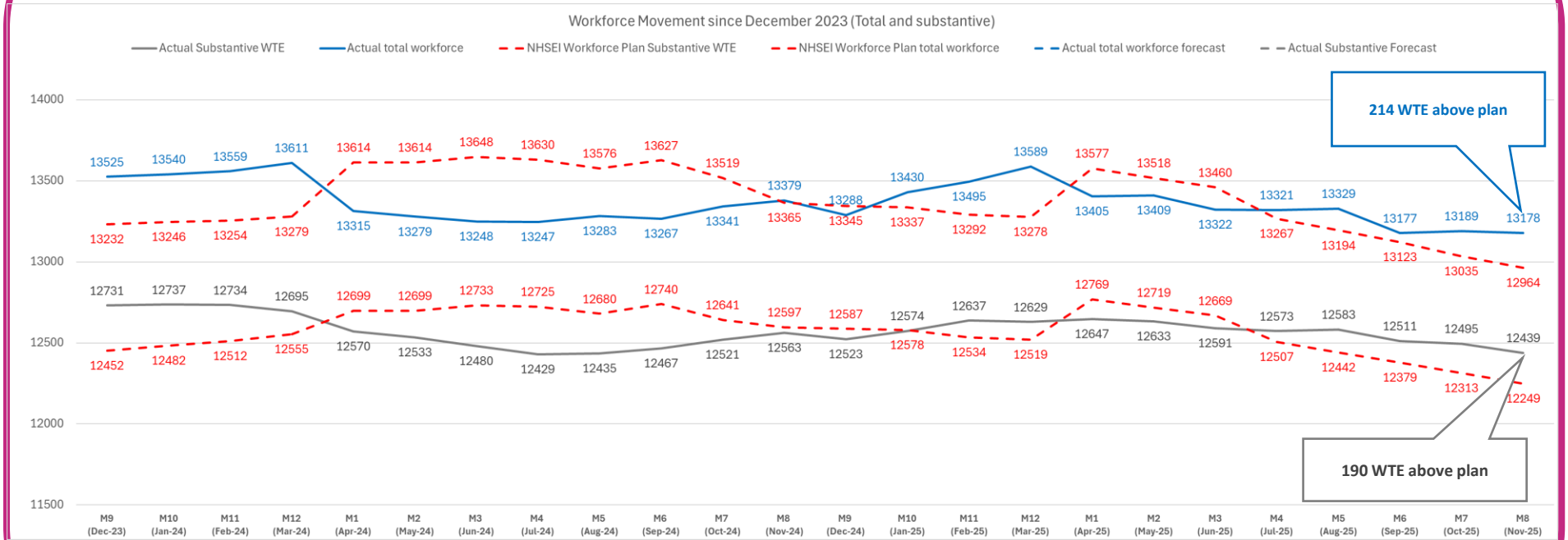
Total Bank and Agency usage increased by 44 WTE in November 2025.

Bank increased in November by **6%**, while
Agency usage **increased** in November by 1**2%**.

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

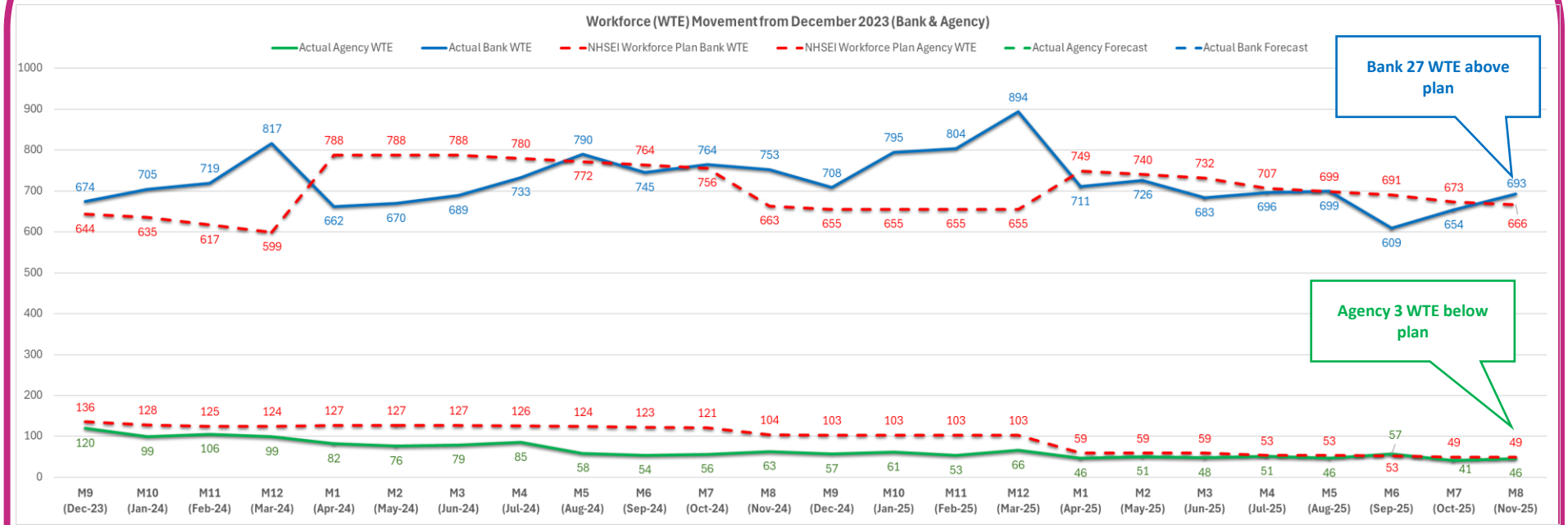
Increased RMN Usage
RMN usage continues to increase and is primarily driven by a 35% year-on-year reduction in HCA shift fill. As HCA shifts go unfilled, additional RMN shifts are released. Contributing to higher agency reliance across the trust.

Workforce Trends: Total & Substantive



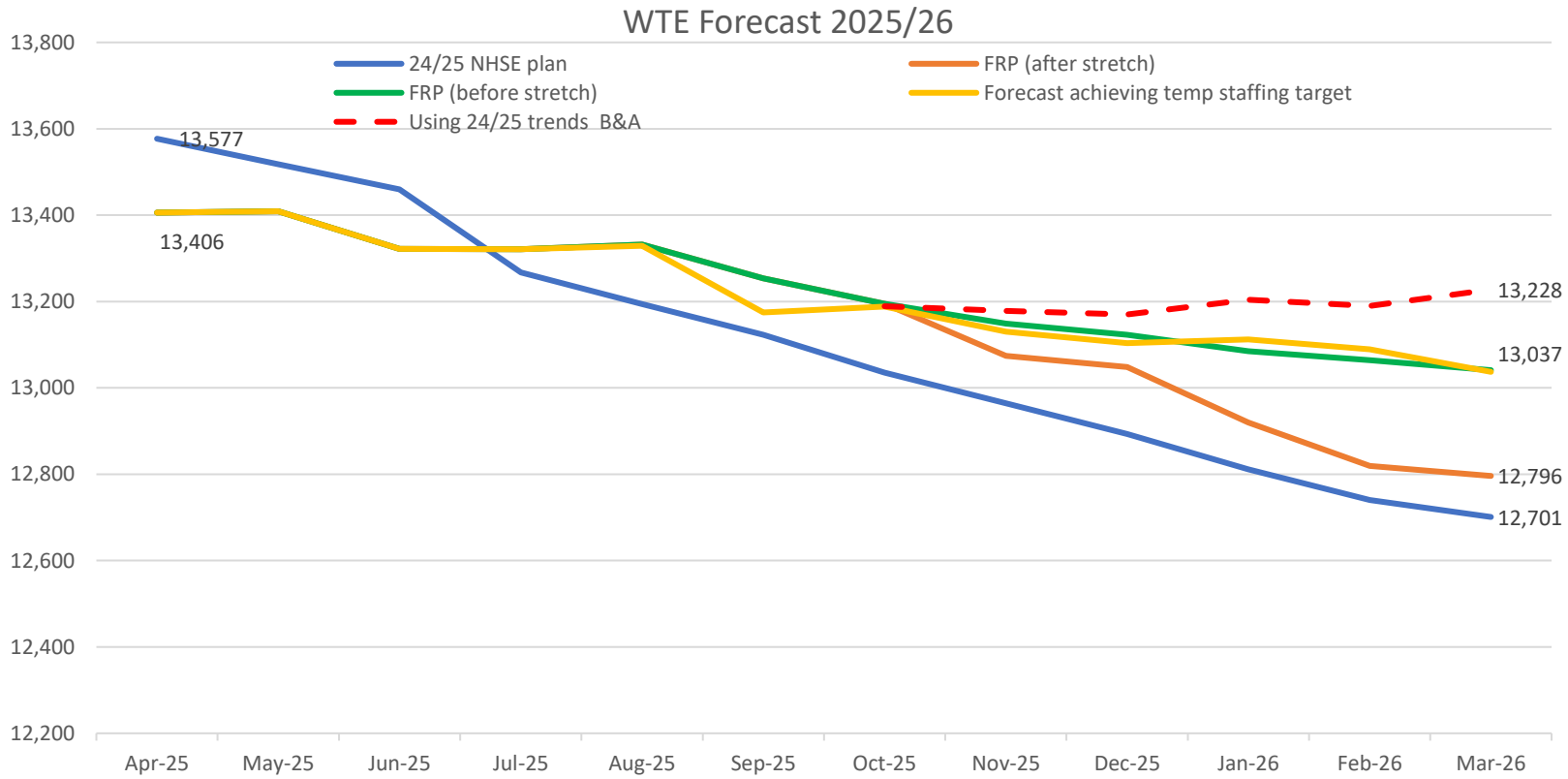
Source: ESR as of November 2025.
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



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

Total WTE Workforce Forecast against FRP



Assumptions on FRP forecast:

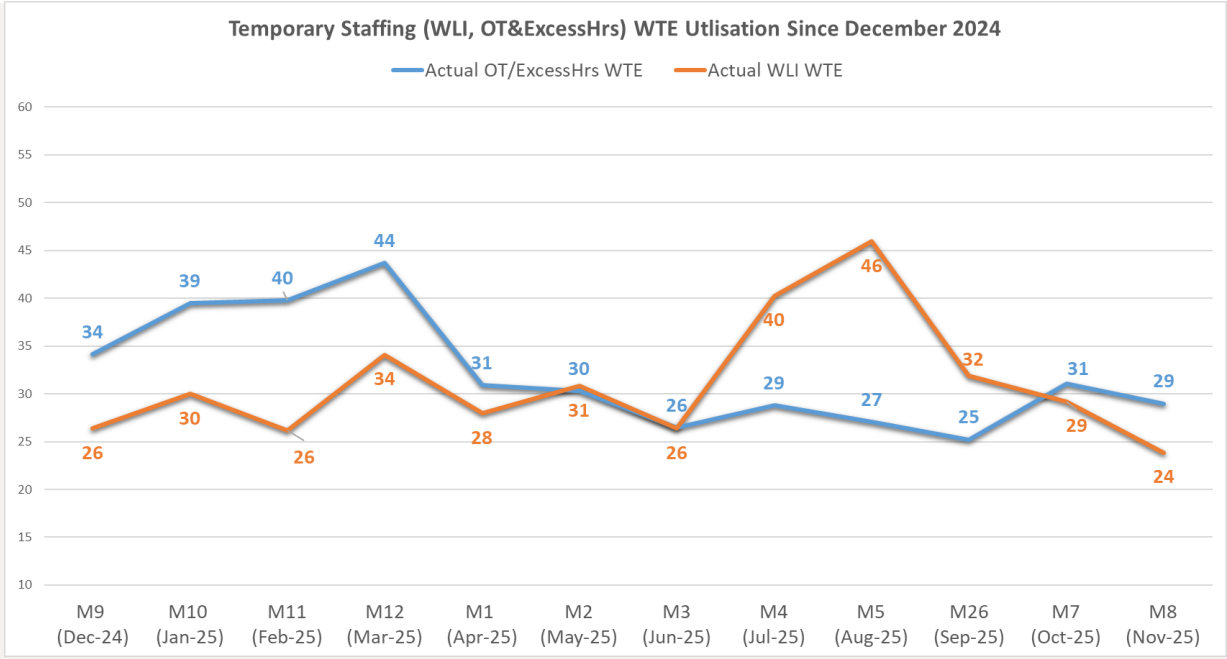
- Capped recruitment with some limited exceptions
- Achievement of Temp staffing targets with stretch
- Turnover at 95 WTE per month.
- Stretch FRP target includes 120 linked to NCTR, 15 to mental health, 30 linked to Theatres, 80 substantive linked to additional exits contingent on severance payments from external source.

Assumptions on the red line forecast

- Assumes continued controlled substantive recruitment with some limited exceptions
- Assumes stable turnover at 95 WTE
- Assumes temp staffing track against 24/25 levels for the remainder of the financial year. Takes into account we are operating a lower level of temp staffing each month during 25/26

Workforce Trends: WLI and Overtime

WLI Movement	M5 - M6 2024	M6 - M7 2024	M7 - M8 2024	M8 - M9 2024	M9 - M10 2024	M10 - M11 2024	M11 - M12 2024	M12 - M1 24/25	M1 - M2 2025	M2 - M3 2025	M3 - M4 2025	M4- M5 2025	M5- M6 2025	M6- M7 2025	M7- M8 2026
	-7	-10	4	0	4	-4	8	-6	3	-4	14	6	-14	-3	-5



Source: Healthroster as of November 2025.

Quarterly People Heatmap – 2025/26 Q2

		THRIVE			EXCEL		BELONG	
	AWL as of M6 (Sep 25)	% Turnover	Apprentice numbers (WTE)	Appraisals completed	Sickness absence	% Flexible working requests approved	% of staff at Band 7 and above (BAME)	% of staff band 7 and above LID
UHS Overall	**12181**	**9.9%**	**675**	**65.5%**	**3.8%**	**40.8%**	**14.3%**	**12.9%**
Division A Overall	3924	9.3%	190.9	62.0%	3.8%	28.2%	19.8%	13.2%
Cardiovascular And Thoracic	906	9.7%	46.9	61.8%	3.8%	30.6%	21.8%	14.9%
Critical Care	652	9.4%	23.8	65.4%	3.8%	20.0%	11.2%	9.0%
Division A Management	16	14.4%	1.0	48.0%	2.4%	100.0%	11.1%	1.2%
Neurosciences	459	10.9%	25.3	65.1%	3.4%	21.1%	22.2%	11.6%
Spinal Service	58	17.0%	4.0	72.7%	4.2%	16.7%	0.0%	55.6%
Surgery	562	9.0%	24.4	59.2%	3.3%	33.3%	13.0%	13.9%
Theatres And Anaesthetics	851	8.2%	42.5	57.6%	4.0%	32.0%	32.1%	15.3%
Trauma And Orthopaedics	421	8.3%	23.1	65.5%	4.1%	17.6%	21.9%	15.7%
Division B - Overall	3089	9.6%	121.8	66.6%	4.0%	44.4%	16.3%	15.4%
Cancer Care	716	11.7%	32.2	66.2%	3.9%	55.6%	18.8%	16.4%
Division B Management	-13	4.1%	5.6	43.1%	4.8%	40.0%	18.4%	25.3%
Emergency Care	707	9.5%	18.1	63.5%	4.5%	55.7%	11.0%	20.8%
Hampshire And low Air Ambulance	0	19.5%	0.0	15.4%	2.5%	75.0%	0.0%	7.4%
Medicine	778	8.2%	45.5	80.3%	3.9%	24.7%	28.1%	8.4%
Ophthalmology	297	12.8%	14.9	61.8%	4.7%	31.4%	15.8%	7.7%
Specialist Medicine	605	7.0%	5.4	56.7%	3.1%	41.1%	13.2%	14.6%
Division C - Overall	3833	9.8%	246.6	63.6%	3.9%	44.0%	12.3%	12.6%
Child Health	867	9.6%	42.4	63.8%	3.3%	22.2%	3.5%	15.0%
Clinical Support	898	12.2%	113.7	68.2%	2.9%	51.4%	16.8%	9.8%
Division C Management	188	17.2%	4.6	59.8%	5.5%	38.3%	15.8%	8.9%
Pathology	577	7.6%	38.4	52.8%	4.3%	37.9%	13.8%	14.1%
Radiology	481	7.5%	18.3	73.3%	2.7%	39.5%	10.4%	9.2%
Women And Newborn	822	8.0%	29.4	61.2%	5.2%	52.7%	6.3%	20.7%
Division D - Overall	29	9.8%	1.0	47.4%	1.2%	0.0%	0.0%	16.3%
Division D Management	29	9.8%	1.0	47.4%	1.2%	0.0%	0.0%	16.3%
THQ - Overall	1305	10.6%	114.9	70.7%	3.5%	40.0%	12.0%	14.2%
Chief Finance Officer	122	11.0%	17.0	28.6%	1.9%	27.3%	8.4%	12.3%
Chief Operating Officer	182	13.8%	1.0	60.5%	6.1%	50.0%	14.1%	9.8%
Digital	251	3.9%	27.1	81.9%	2.4%	50.0%	17.3%	10.9%
Human Resources	162	15.6%	17.7	78.0%	3.0%	23.5%	3.2%	18.2%
Research and Development	373	11.4%	15.3	80.7%	3.0%	41.7%	14.1%	13.1%
Training And Education	207	10.2%	36.8	80.0%	3.6%	73.3%	7.7%	7.7%

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

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

Substantive Monthly Staff in Post (WTE) for last 12 months																									
	23/24	24/25												25/26								Movement			
	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M7 to M8 movement		Mar24 to M8 Movement		Mar25 to M8 Movement	
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	295	294	297	302	301	300	300	312	303	306	307	303	↓	-3	↑	1	→	1
Additional Clinical Services	2136	2135	2134	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	2134	2131	2117	2101	2074	2064	↓	-10	↓	-73	↓	-43
Administrative and Clerical (Divisions)	1386	1399	1387	1374	1366	1363	1356	1347	1342	1328	1340	1348	1352	1352	1350	1327	1316	1298	1282	1273	1258	↓	-15	↓	-128	↓	-94
Administrative and Clerical (THQ)	902	904	902	875	864	860	859	852	875	888	897	900	902	899	893	879	874	859	826	822	808	↓	-15	↓	-95	↓	-94
Allied Health Professionals	796	803	800	799	788	786	808	815	814	806	807	821	817	823	822	832	831	839	842	849	849	↓	-1	↑	53	↑	32
Estates and Ancillary	380	374	372	373	376	373	370	373	407	405	407	415	416	414	409	407	403	398	392	387	387	↓	-1	↑	7	↓	-29
Healthcare Scientists	498	499	495	498	496	497	495	504	510	509	512	518	521	523	520	523	524	522	523	525	523	↓	-2	↑	25	↑	2
Consultant & Career Grade Doctor	949	947	946	949	948	951	964	965	971	971	976	983	984	990	983	982	986	991	989	989	985	↓	-4	↑	36	↑	1
Resident Doctor	1235	1103	1102	1099	1096	1150	1161	1164	1155	1147	1149	1152	1146	1145	1140	1132	1125	1198	1194	1200	1185	↓	-15	↓	-50	↑	39
Nursing and Midwifery Registered	4053	4052	4039	4030	4025	3998	3998	4055	4041	4038	4039	4032	4013	4010	4024	4008	4003	3990	3990	4010	4024	↑	15	↓	-28	↑	11
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	↓	-6	↓	-4	↓	-15
Grand Total	12695	12570	12533	12480	12429	12435	12467	12521	12563	12523	12574	12637	12629	12647	12633	12591	12573	12583	12511	12495	12439	↓	-56	↓	-256	↓	-190
	Old	New Counting Criteria																							

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

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

Total Monthly Workforce (WTE)

(Substantive, Bank and Agency)

	2023/24 M12 (Mar)	2024/25 M1 (Apr)	2024/25 M2 (May)	2024/25 M3 (Jun)	2024/25 M4 (Jul)	2024/25 M5 (Aug)	2024/25 M6 (Sep)	2024/25 M7 (Oct)	2024/25 M8 (Nov)	2024/25 M9 (Dec)	2024/25 M10 (Jan)	2024/25 M11 (Feb)	2024/25 M12 (Mar)	2025/26 M1 (Apr)	2025/26 M2 (May)	2025/26 M3 (Jun)	2025/26 M4 (Jul)	2025/26 M5 (Aug)	2025/26 M6 (Sep)	2025/26 M7 (Oct)	2025/26 M8 (Nov)	M7 to M8 movement	Mar24 to M8 Movement	Mar25 to M8 Movement
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	296	294	298	303	302	303	303	315	305	308	310	306	-4	4	3
Additional Clinical Services	2522	2464	2464	2449	2453	2476	2430	2425	2418	2391	2433	2438	2475	2419	2430	2421	2432	2421	2379	2364	2365	1	-157	-110
Administrative and Clerical	2348	2356	2342	2304	2303	2297	2286	2274	2287	2282	2315	2321	2330	2311	2296	2255	2241	2203	2149	2139	2107	-32	-241	-223
Allied Health Professionals	826	825	824	822	816	813	834	839	837	825	828	844	845	844	843	849	850	855	858	862	862	0	36	17
Estates and Ancillary	410	401	403	404	409	403	398	403	435	431	436	442	443	439	437	434	418	410	414	410	411	1	1	-32
Healthcare Scientists	509	508	505	506	509	511	508	517	524	522	525	528	532	532	529	531	532	531	532	534	533	-1	24	1
Medical and Dental	2231	2093	2092	2101	2100	2151	2165	2168	2165	2158	2172	2175	2174	2176	2162	2152	2165	2225	2211	2219	2209	-10	-22	35
Nursing and Midwifery Registered	4404	4311	4292	4308	4304	4273	4287	4357	4356	4327	4370	4379	4418	4312	4341	4309	4300	4310	4259	4291	4331	40	-73	-87
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	-6	-4	-15
Grand Total	**13611**	**13315**	**13279**	**13248**	**13247**	**13283**	**13267**	**13341**	**13379**	**13288**	**13430**	**13495**	**13589**	**13405**	**13409**	**13322**	**13321**	**13329**	**13177**	**13189**	**13178**	**-11**	**-433**	**-411**

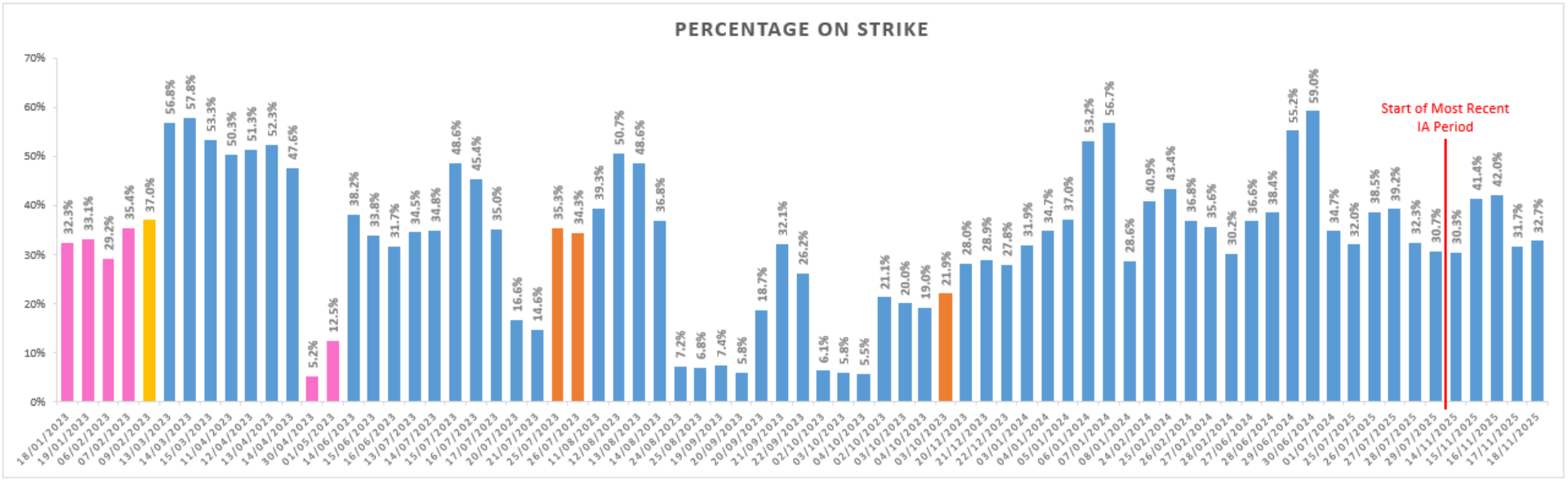
Source: ESR substantive staff, NHSP Bank & Agency temporary staff, THQ Medical Bank staff & 247 Agency staff as of November 2025.
Excludes CLRN, Wessex AHSN, WPL (revised criteria for 25/26). Numbers relate to WTE, not headcount.

THRIVE

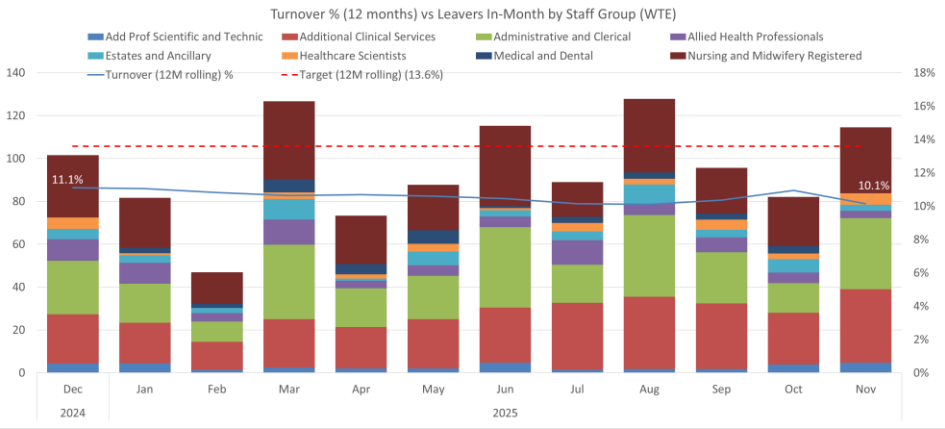
Industrial Action: 2023-2025

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

RCN CSP BMA SOR



Turnover



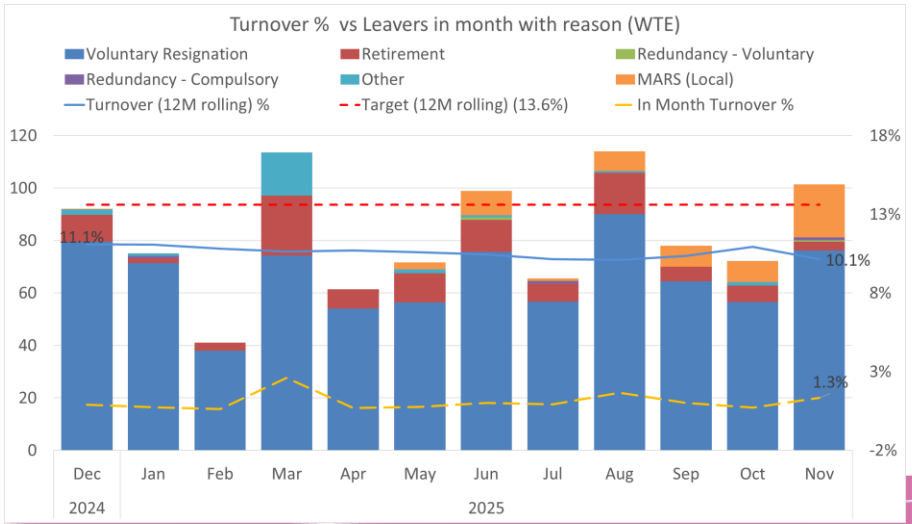
In November 2025, there was a total of 114.5 WTE leavers, 34.3 WTE more than October 2025 (80.2 WTE). Division C recorded the highest number of leavers (44.8 WTE). Within Division C, Additional Clinical Services staff group had the highest number of leavers (15.3 WTE).

Divisions A and THQ had the second and third highest number of leavers (28.5 and 24.6 WTE respectively); with the largest number of leavers for Division A being the Nursing and Midwifery Registered staff group (10.3 WTE), while in Trust Headquarters Admin & Clerical staff group accounted for 14.5 WTE leavers.

Total leavers by division are as follows:

- **Division A: 28.5 WTE leavers**
- **Division B: 15.6 WTE leavers**
- **Division C: 44.8 WTE leavers**
- **THQ: 24.6 WTE leavers**
- **UEL: 1 WTE leavers**

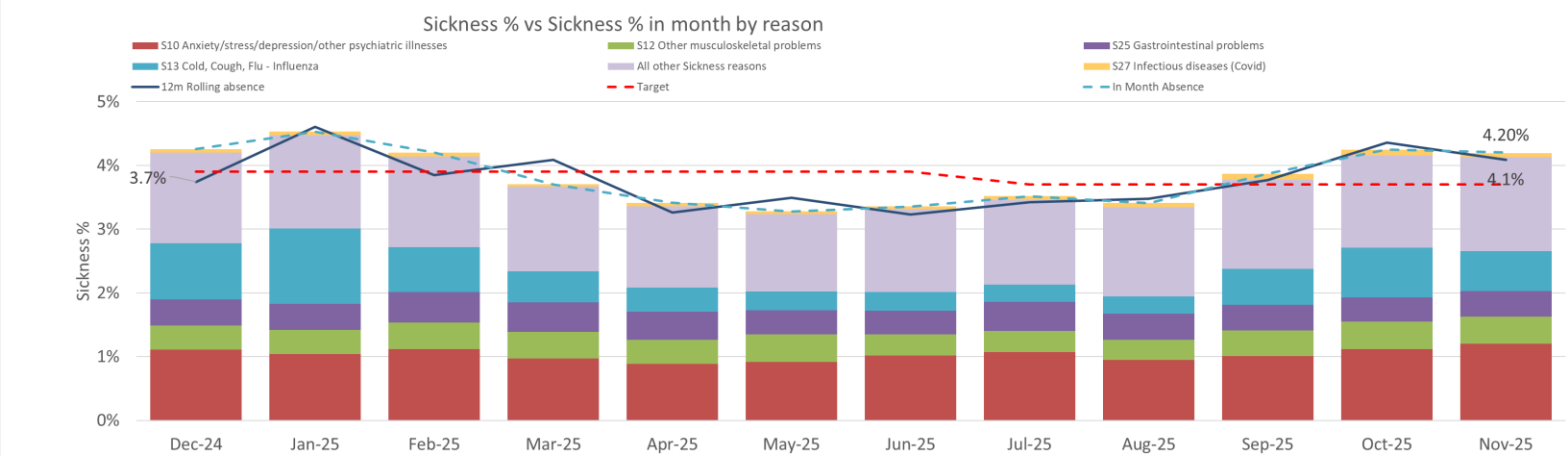
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	4.7	1.5%	11.5%
Additional Clinical Services	34.4	1.7%	14.5%
Administrative and Clerical	33.2	1.7%	12.5%
Allied Health Professionals	3.4	0.4%	9.4%
Estates and Ancillary	2.8	8.2%	8.6%
Healthcare Scientists	5.4	1.0%	6.7%
Medical and Dental	0.0	0.8%	4.1%
Nursing and Midwifery Registered	30.8	0.8%	8.4%
UHS total	**114.5**	**1.3%**	**10.1%**



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

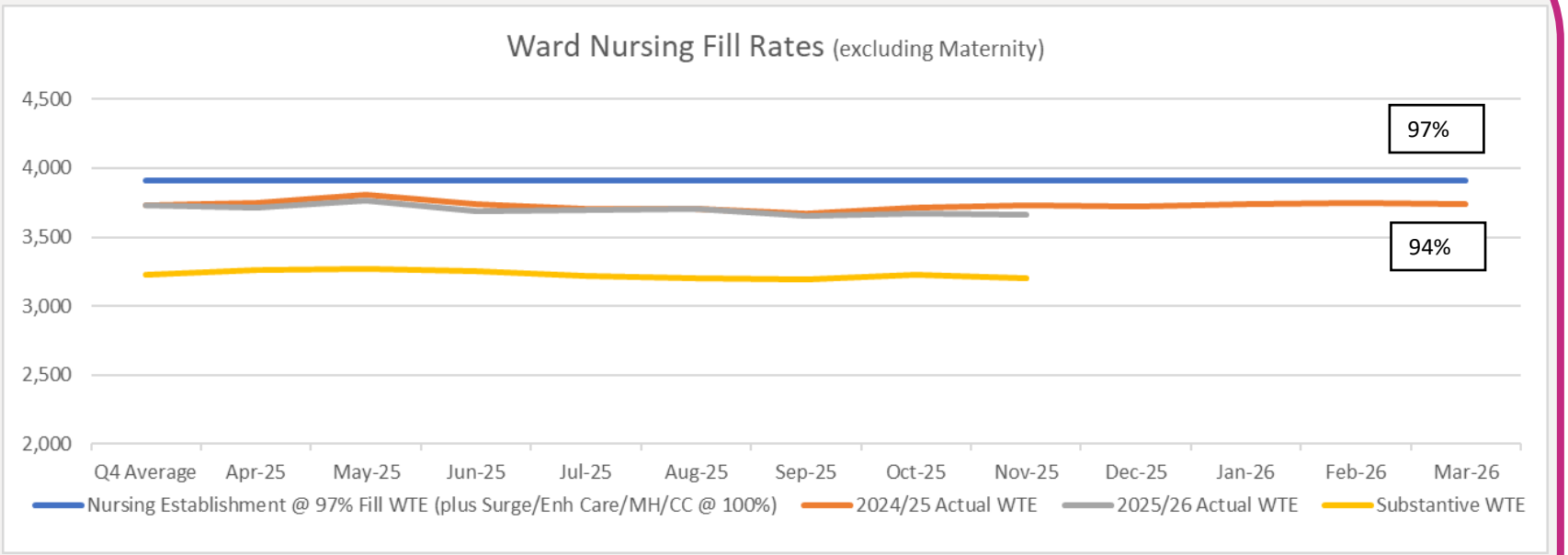
Sickness

Current in-month sickness: 4.2% | Rolling 12-month sickness: 4.1% | Year-to-date sickness 3.69%



Source: ESR – November 2025

Ward Nursing Fill Rates (excluding Maternity)



Source: Finance – November 2025

Temporary Staffing

Status

Qualified Nursing (WTE)

- **Demand increased** from 363 in October to 375 in November (+12).
- **Bank fill increased** from 249 to 268 (+19) from previous month
- **Agency filled** 39 WTE (+7 from the previous month).
- **Unfilled shifts decreased**: 68 WTE remained unfilled (-14 on previous month).
- **Year-on-year demand increased:** 1 WTE lower than November 2024

Healthcare Assistants (HCA) (WTE)

- **Demand increased** from 331 in October to 320 in November (+7).
- **Bank filled increased** from 255 WTE to 268 WTE (+13)
- **Unfilled shifts increased**: 52 WTE remained unfilled (-7 on prior month)
- **Year-on-year demand decrease**: 16 WTE lower than November 2024.

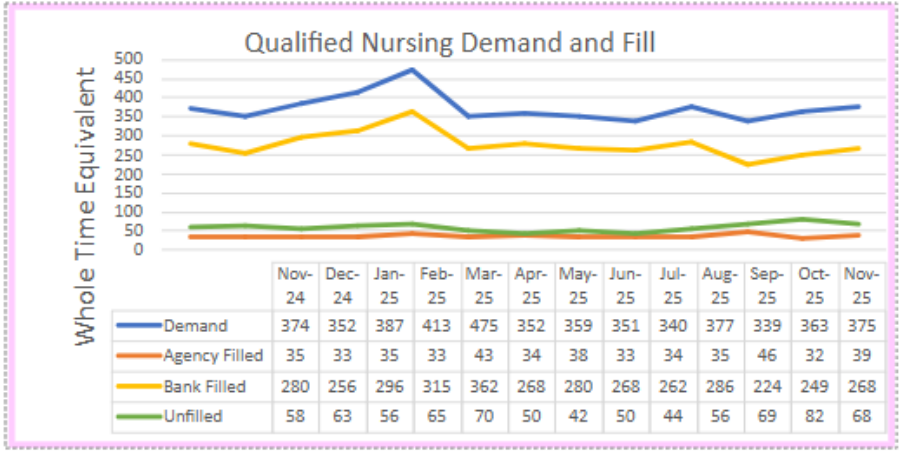
Actions

RMN Usage; has continued to increase, primarily driven by a 35% year-on-year reduction in HCA shift fill. As HCA shifts go unfilled, additional RMN shifts are being released, which is contributing to higher agency reliance across the Trust. Governance processes are being strengthened to ensure appropriate oversight and escalation to manage this trend.

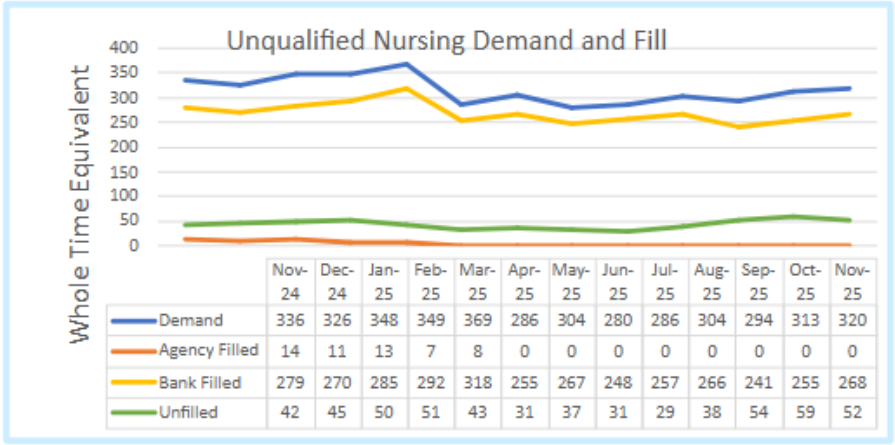
Bank 2/3 Transition; The Bank 2/3 transition project is now fully implemented and live, but some in-scope Band 3 shifts are still being advertised incorrectly. In addition, a number of bank workers have not yet completed the process to obtain their Band 3 code, which continues to affect bank shift fill rates. A review is underway to assess the remaining risks and will imminently remove the CSW00 code.

Theatre Agency Use

Agency usage within theatres has increased to prevent the cancellation of patient lists. Workforce gaps caused by reduced specialist bank rates have led to long lines of agency cover, particularly within Cardiac, CEPOD and Urology scrub theatres. These pressures continue to drive overall agency spend upward, with work ongoing to stabilise staffing levels in these critical areas.



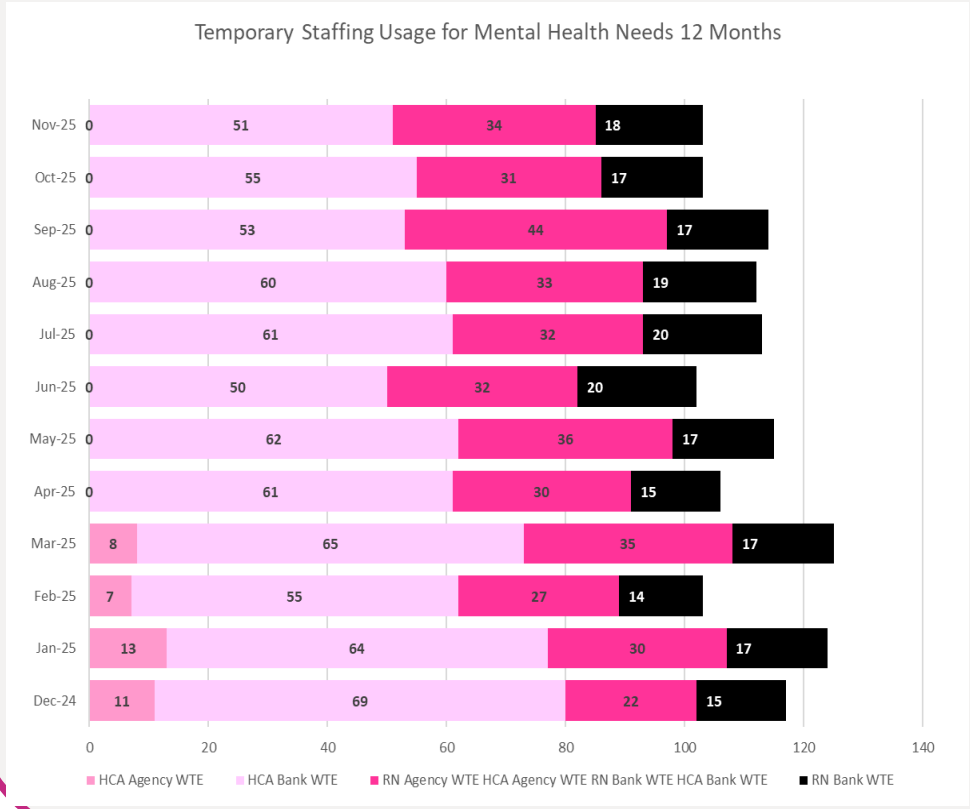
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Demand	374	352	387	413	475	352	359	351	340	377	339	363	375
Agency Filled	35	33	35	33	43	34	38	33	34	35	46	32	39
Bank Filled	280	256	296	315	362	268	280	268	262	286	224	249	268
Unfilled	58	63	56	65	70	50	42	50	44	56	69	82	68



	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Demand	336	326	348	349	369	286	304	280	286	304	294	313	320
Agency Filled	14	11	13	7	8	0	0	0	0	0	0	0	0
Bank Filled	279	270	285	292	318	255	267	248	257	266	241	255	268
Unfilled	42	45	50	51	43	31	37	31	29	38	54	59	52

Source: Temporary Resourcing – November 2025

Temporary Staffing: Mental Health



Mental Health Staffing Summary – November 2025

Total Temporary Staffing: 103 WTE, same as previous month.
Registered Mental Health Nurses (RMNs): 52 WTE (+4 WTE on prior month), of which 34 WTE were agency (+3 WTE on previous month) and 18 WTE were bank staff (same as previous month).
Healthcare Assistants (HCAs): 55 WTE (+1 WTE on prior month).
Year-on-Year Comparison: 16 WTE decrease compared to November 2024 (28 WTE decrease in HCAs, 12 WTE increase in RMN requests).

Key Challenges & Actions

Ongoing Pressures

- Mental health demand continues to present safety, quality & financial pressures.
- UHS is actively escalating concerns to the ICB and collaborating with NHSE on the ETOC project to enhance care strategy and delivery.

Transition from Agency to Bank Staff

- Agency shift fill rates have decreased as part of the strategy to move workers to Bank roles, aiming to improve workforce stability and governance.
- NHSP pay rates are higher than agency charges, increasing overall staffing costs. This has been escalated for review within the SE Collaborative.
- Bank staff can also work across HIOWFT, limiting HCA Enhanced Care fill locally.

Increased RMN Use to Cover HCA Shortfalls

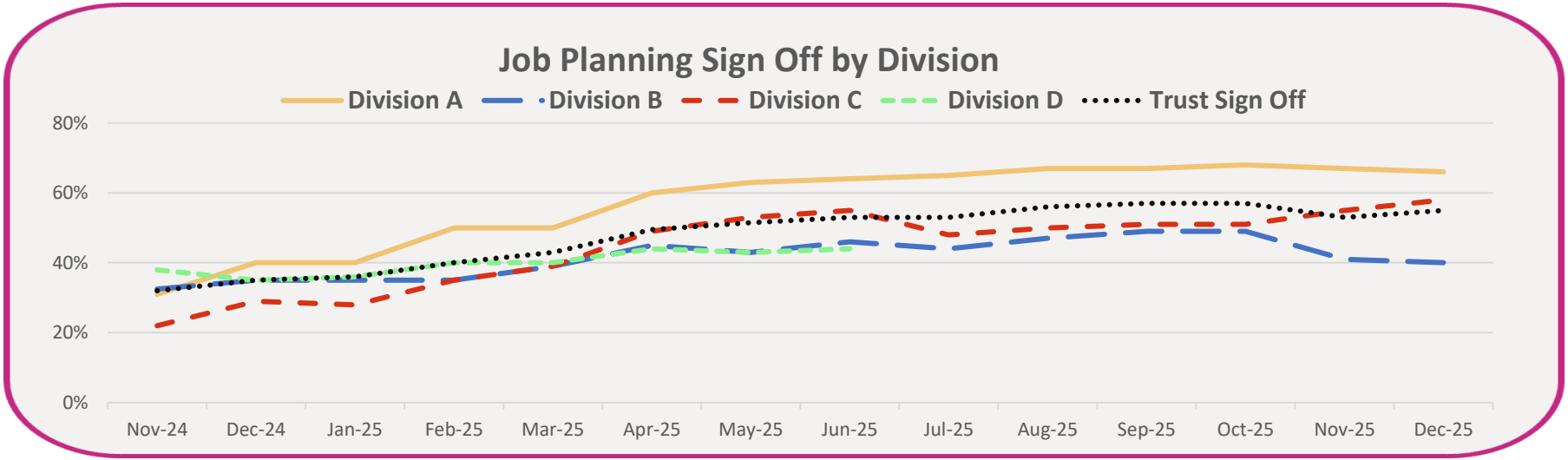
- RMN usage has risen by 30% due to a 35.4% reduction in HCA fill rates compared with November 2024. HCA shortfall and higher patient acuity account for this change.
- Governance processes are being strengthened for approvals when RMNs replace HCAs.

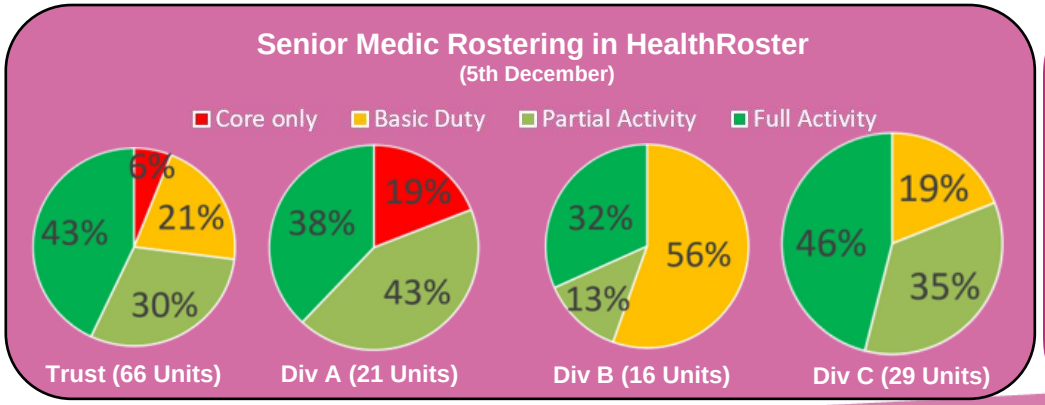
Band 2/3 review of Enhanced Care HCA

- A review will consider moving Enhanced Care HCAs to Band 3 to improve Day Shift fill, which remains the greatest staffing risk due to lower pay compared with unsocial hours.

Source: Temporary Resourcing – November 2025

Workforce: Medical Rostering and Planning





Medical Job Planning

- Sign Off down from a peak of 58% during Nov, to 55% at start of Dec
  - All remaining teams have been renewed before the 31st March 26 target
- ED job plans have expired, so new more detailed plans are to be shared with individuals wc. 8th Dec. Normally these are agreed and signed off soon after.
- Extending job plans has been very popular, with 92% of Gynaecology and over 60% of other groups taking the option, when available.
  - Following extending job plan sign off, W&N renewed all job plans at an impressive 70% signed off.
- Escalation process agreed for job plans that have been republished but no sign off after 2 weeks, escalation to CGCL/DCD.

Signed Off Job Plans

Resident Doctors' working lives

Department of Health & Social Care

NHS England

10 Point Plan to improve Resident Doctors' working lives

NHSE Baseline Assessment

Provider: **UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST**

Amenities

Access to Lockers	Yes, but not all
Rest facilities	Yes, but not all
Designated on-call parking access	Yes
Access to hot and cold food 24/7	Yes
Access to cold food 24/7	Yes
Access to inductions specifically designed to meet the needs of Resident Doctors	Yes
Beds/sleeping pods available free of charge	Yes, but not all
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes
Is there access to free psychological support treatment?	Yes
Are there positive feedback mechanisms in place to reward and promote staff?	Yes
Are there protected breaks?	Yes, but not all
Do you promote the Safe Learning Environment Charter?	Yes, but not all
Offer sexual safety/harassment training and awareness?	Yes, but not all

Annual Leave

Do you have a local policy to encourage good annual leave management which explicitly includes reference to resident doctors?	Planning to introduce (6 months)
Is good annual leave practice covered at resident doctor induction?	Yes
Do you allow resident doctors to carry over annual leave between rotations?	Yes (internal rotations)
How much leave can Resident Doctors carry over?	5 days
Do your rostering systems for Resident Doctors allow for self/preferential rostering?	Yes

Payroll and Expenses

Have you implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Yes
Have there been changes in payroll errors over the last 12 months?	No change
How do you process course related expenses?	After course attendance, planning to change (3 months)

Appointing senior leads to take action on Resident Doctor issues

Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes
If yes, please provide their name and role.	Dr Diana hulbert Guardian of Safe Working
Do you have a peer representative Resident Doctor who your Board consults with on local issues relating to Resident Doctors?	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (Executive team, Trust Board, People Committee or All)	
GMC Training survey	All
NETS survey	All

Mandatory Training & Learning

Do you accept mandatory training completed by resident doctors elsewhere, in line with the Recognition of Statutory and Mandatory Training Memorandum of Training AND do you adhere to the People Policy Framework for Mandatory Learning agreed on 1 May 2025?	Yes, both

* Baseline assessment score 84%

- National programme launched Aug 2025
- Make rapid progress on getting the basics right for resident doctors
- Baseline data submission
- Regular progress submissions
- Compliance and progress to feature in NHS Oversight Framework
- Baseline assessment data submitted Sept 2025

NHS England Code of Practice Compliance Data Submission for Resident Doctors:

- Data submitted 6 November regarding August 25 work schedules and duty roster compliance.

	Work Schedules (8 weeks)	Duty Rosters (6 weeks)
Resident Doctors (438)	90.41%	92.92%
Lead Employer (171)	92.98%	95.32%

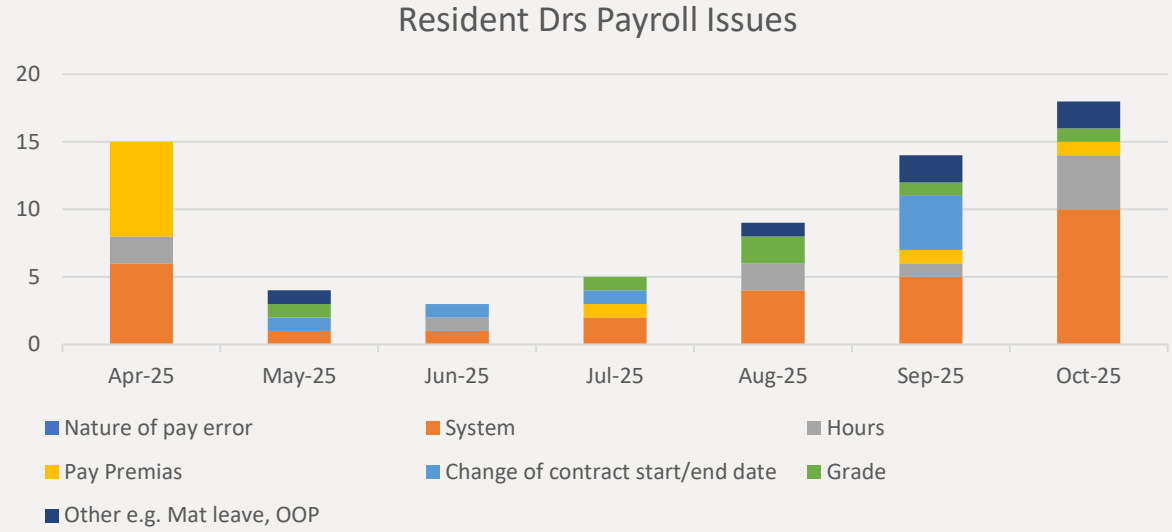
- Next submission March 26 regarding February 26 work schedules and duty rosters.

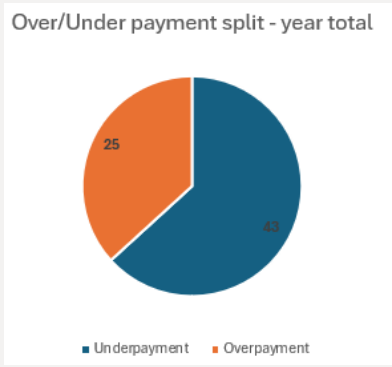
Resident Doctors' working lives

Department of Health & Social Care

NHS England

10 Point Plan to improve Resident Doctors' working lives





	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
In month % of resident doctors affected (Drs in post today 809)	1.85%	0.49%	0.37%	0.62%	1.11%	1.73%	2.22%

Note: % figure of residents affected using the doctors in post as of 11/11/25 (809), broadly numbers remain static.
A yearly running average percentage isn't possible due to constant movement, so would give a false number.

Resident Doctors' working lives

Department of Health & Social Care

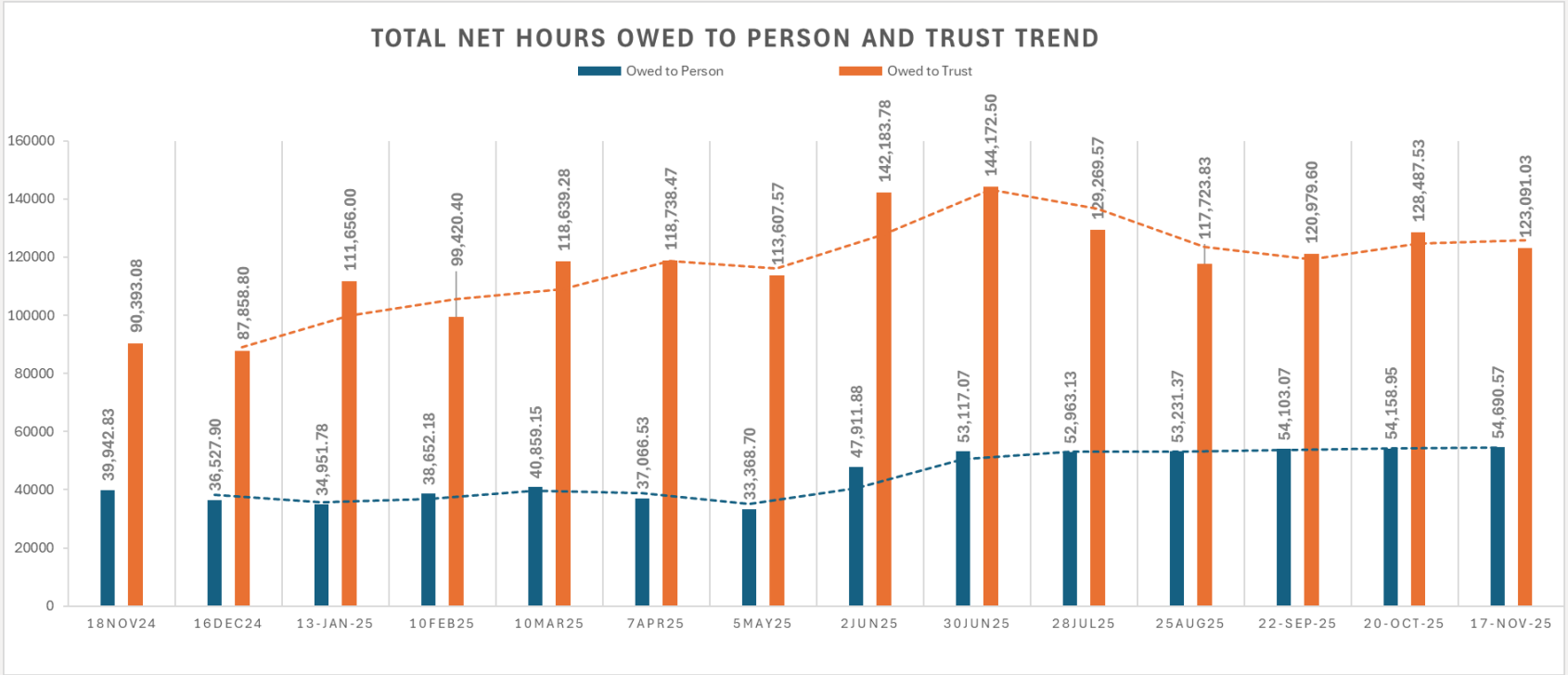
NHS England

10 Point Plan to improve Resident Doctors' working lives

Improvement Plan

10 Point Plan	Actions	Owner and timescale
1. Improve the working environment and wellbeing of resident doctors	Promote Safe Learning Charter, Attend Sexual Safety Workshop (Date TBC),	DME – completed baseline survey questions 12/11/25
2. Resident doctors must receive work schedules and rota information in line with code of practice	To be monitored via the GOSW network, report compliance	Baseline data submitted GOSW – ongoing.
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing	This point is currently being addressed by a NHSE working group.	Await national development
4. All Trust Boards should appoint senior leader and peer representative	Senior leader responsible for resident doctor issue Paul Grundy; paul.grundy@uhs.nhs.uk Peer representative Genevieve Southgate; Genevieve.Southgate@uhs.nhs.uk.	Contact details shared
5. Resident doctors should never experience payroll errors due to rotations.	Implement monitoring of payroll errors including Board level governance. Trust should sign up to attend the NHSE Payroll Processes Improvement Webinar	Payroll errors already been monitored and under board level governance Webinar attended
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.	**Passporting and MoU has been signed and implemented, no significant challenges have been identified**	**MoU signed and implemented; no significant challenges identified**
7. Resident doctors must be enabled and encouraged to exception report to better support doctors working beyond their contracted hours.	The Trust Guardian of Safe Working should join the SE GOSW network. 2. All Trusts to provide last GOSW Board report	GOSW – is a member of SE network Board report shared
8. Resident doctors should receive reimbursement of course-related expenses as soon as possible.	Ongoing meetings with regional PDU team regarding SL reimbursement at point of incurring expenditure vs. course attendance,	Ongoing meetings with regional PDU team
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery.	NHSE rotations workstream	NA
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate.	NHSE rotations workstream.	NA

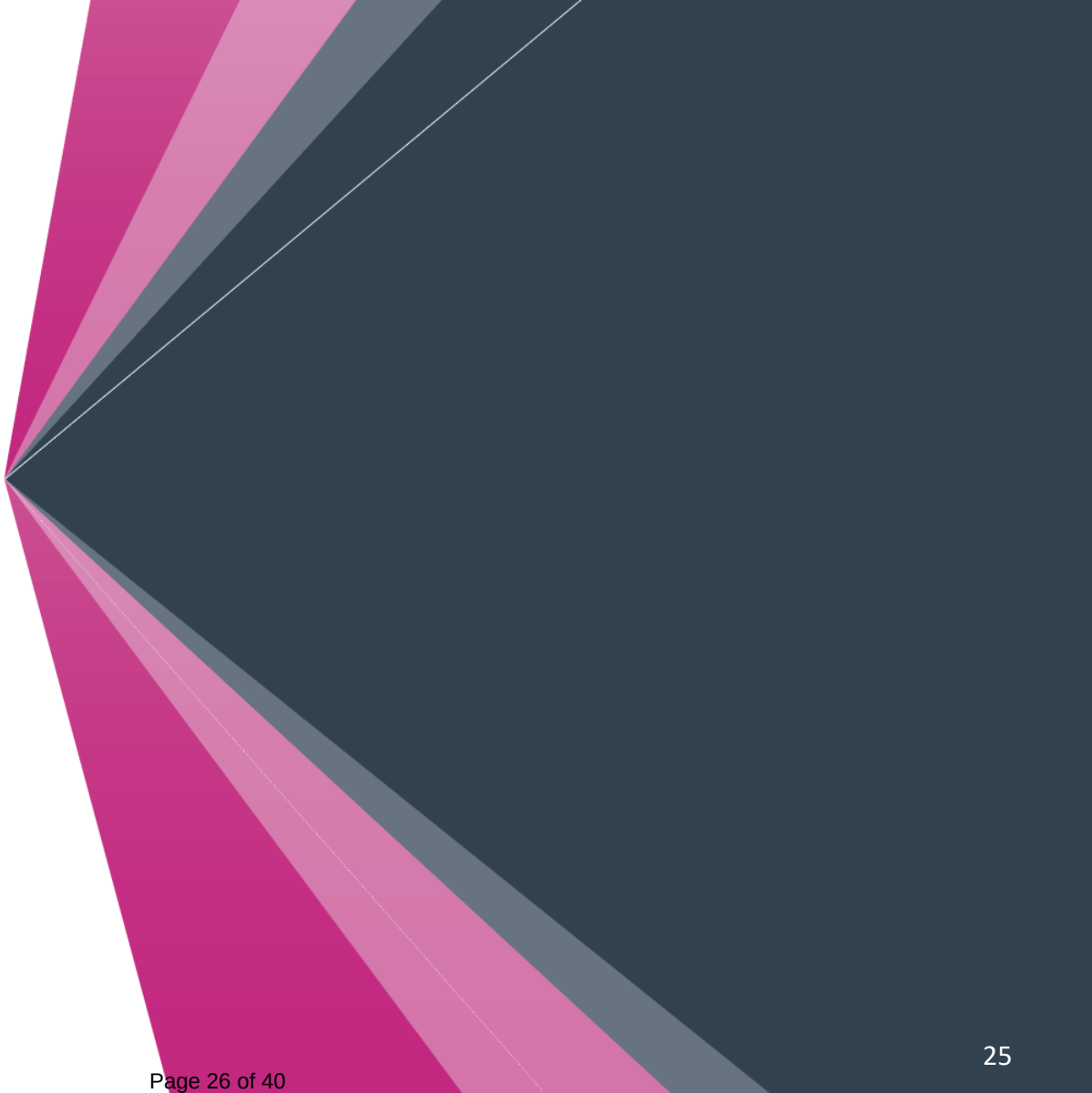
Net Hours



- **Over the last year**, there has been a **37% increase** in net hours owed to staff, and a **31% increase** in net hours owed to the trust
- **Since Jan 2024**, there has been a **19% reduction** in hours owed to staff, and a **70% reduction** in hours owed to the trust

Source: Healthroster as of November 2025,extracted on last working day before new roster period. Data covers AfC staff. From 02/06/25 data includes balances as a running total. Balances within FIG agreed thresholds (12 hrs clinical, 0 hrs A&C) are not excluded.

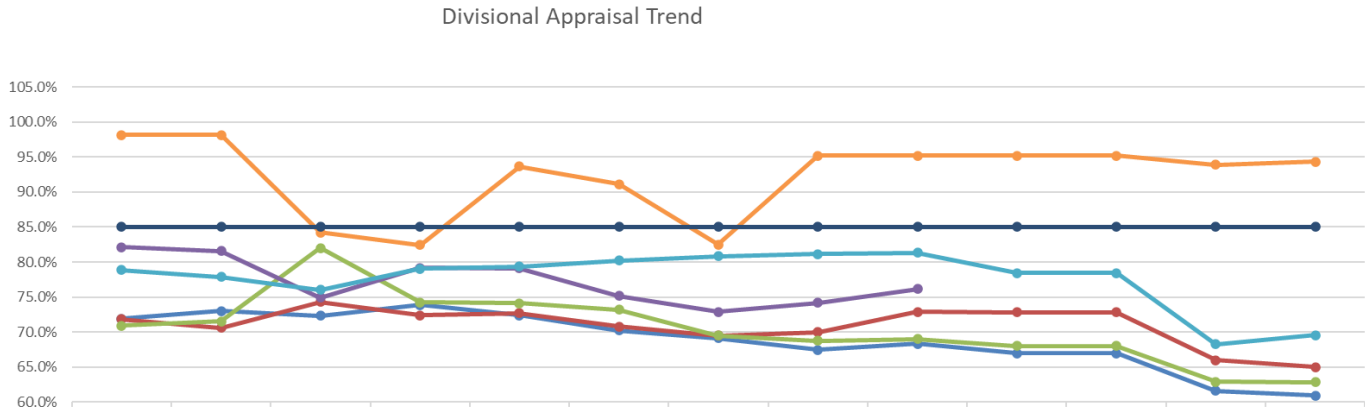
EXCEL



Appraisals

Summary

The Trust's appraisal completion rate is 64.4% as of November 2025, the same as October 2025

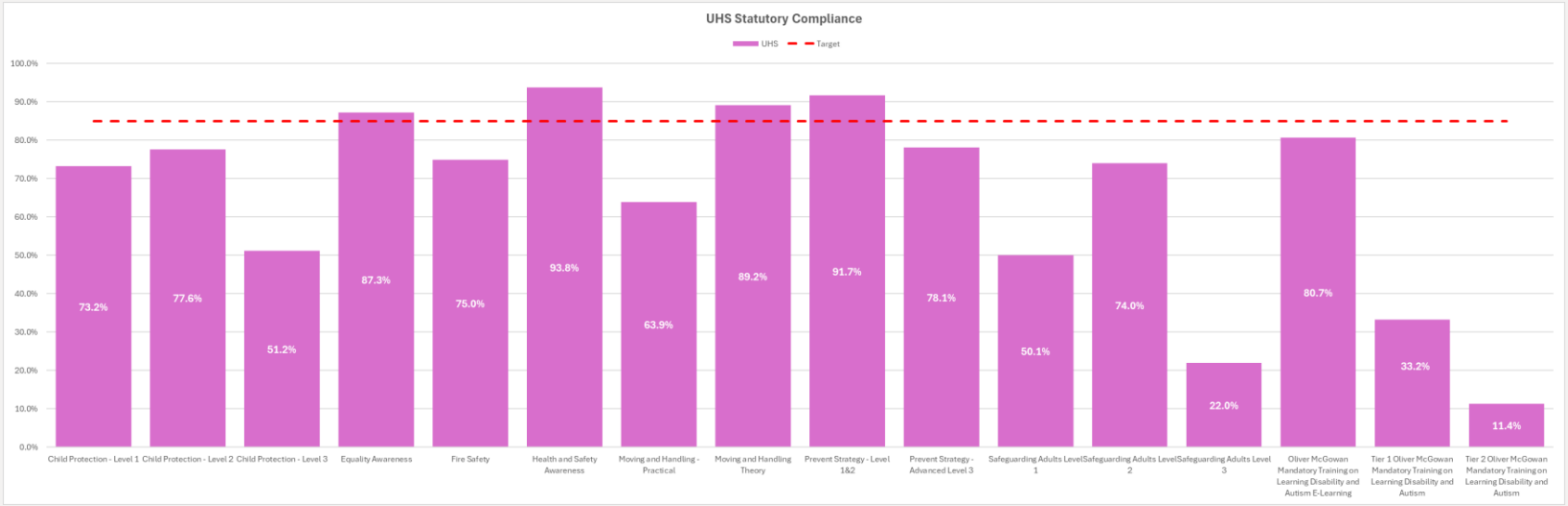


	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
188 Division A	71.9%	73.0%	72.3%	73.9%	72.4%	70.3%	69.1%	67.5%	68.3%	67.0%	67.0%	61.6%	60.9%
188 Division B	71.8%	70.6%	74.3%	72.4%	72.7%	70.8%	69.5%	70.0%	72.9%	72.8%	72.8%	66.0%	65.0%
188 Division C	71.0%	71.5%	82.0%	74.3%	74.1%	73.2%	69.5%	68.8%	69.0%	68.0%	68.0%	62.9%	62.8%
188 Division D	82.1%	81.6%	74.9%	79.2%	79.1%	75.2%	72.9%	74.2%	76.2%				
188 Trust Headquarters - Division	78.9%	77.9%	76.1%	79.0%	79.4%	80.2%	80.9%	81.1%	81.3%	78.5%	78.5%	68.3%	69.6%
188 UEL - Division	98.1%	98.1%	84.2%	82.5%	93.7%	91.1%	82.5%	95.2%	95.2%	95.2%	95.2%	93.9%	94.4%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

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

UHS Statutory Compliance

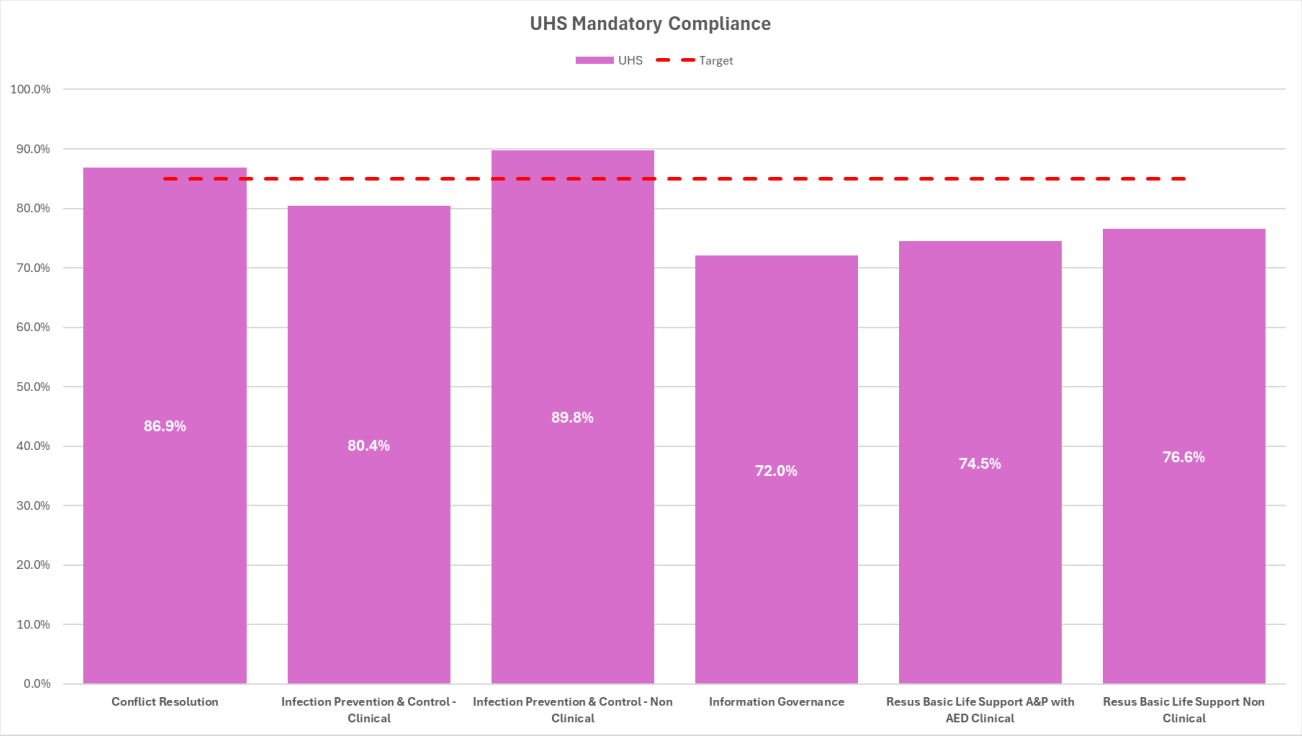
The Trust's average Statutory compliance rate for November 2025 is 66%, with 4 of 16 measures above the 85% target.



Source: Virtual Learning Environment (VLE) November 2025

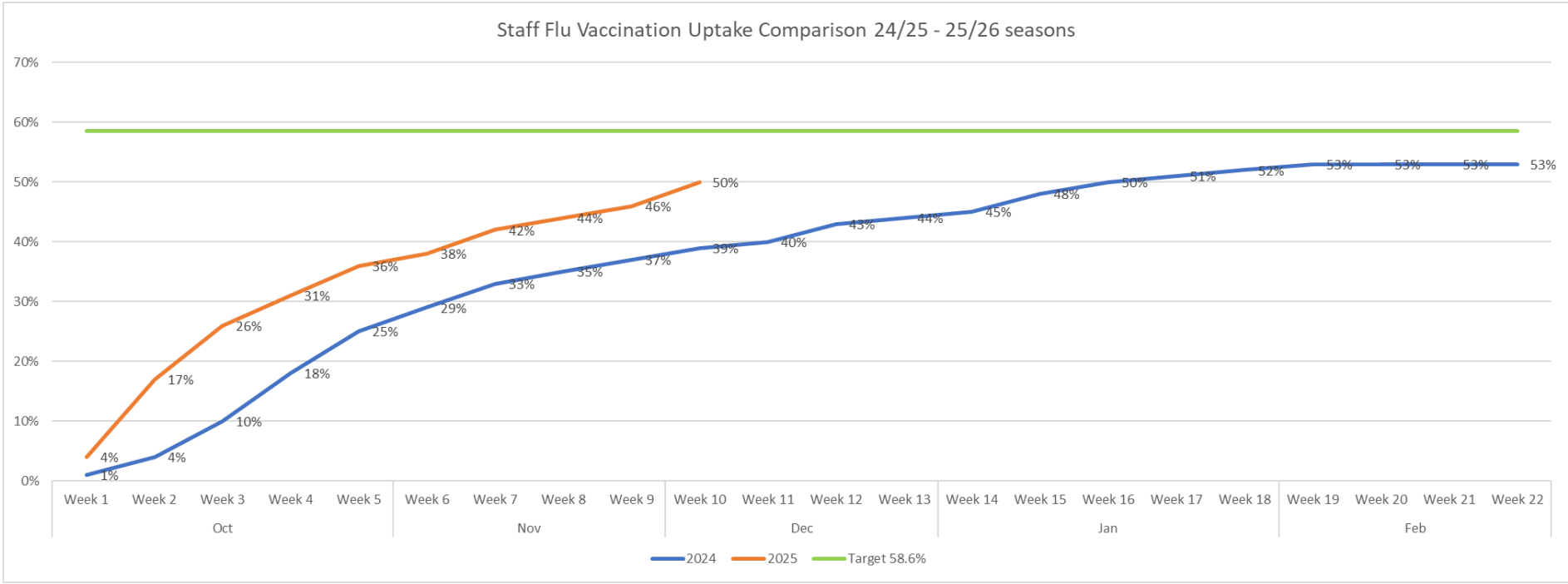
UHS Mandatory Compliance

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



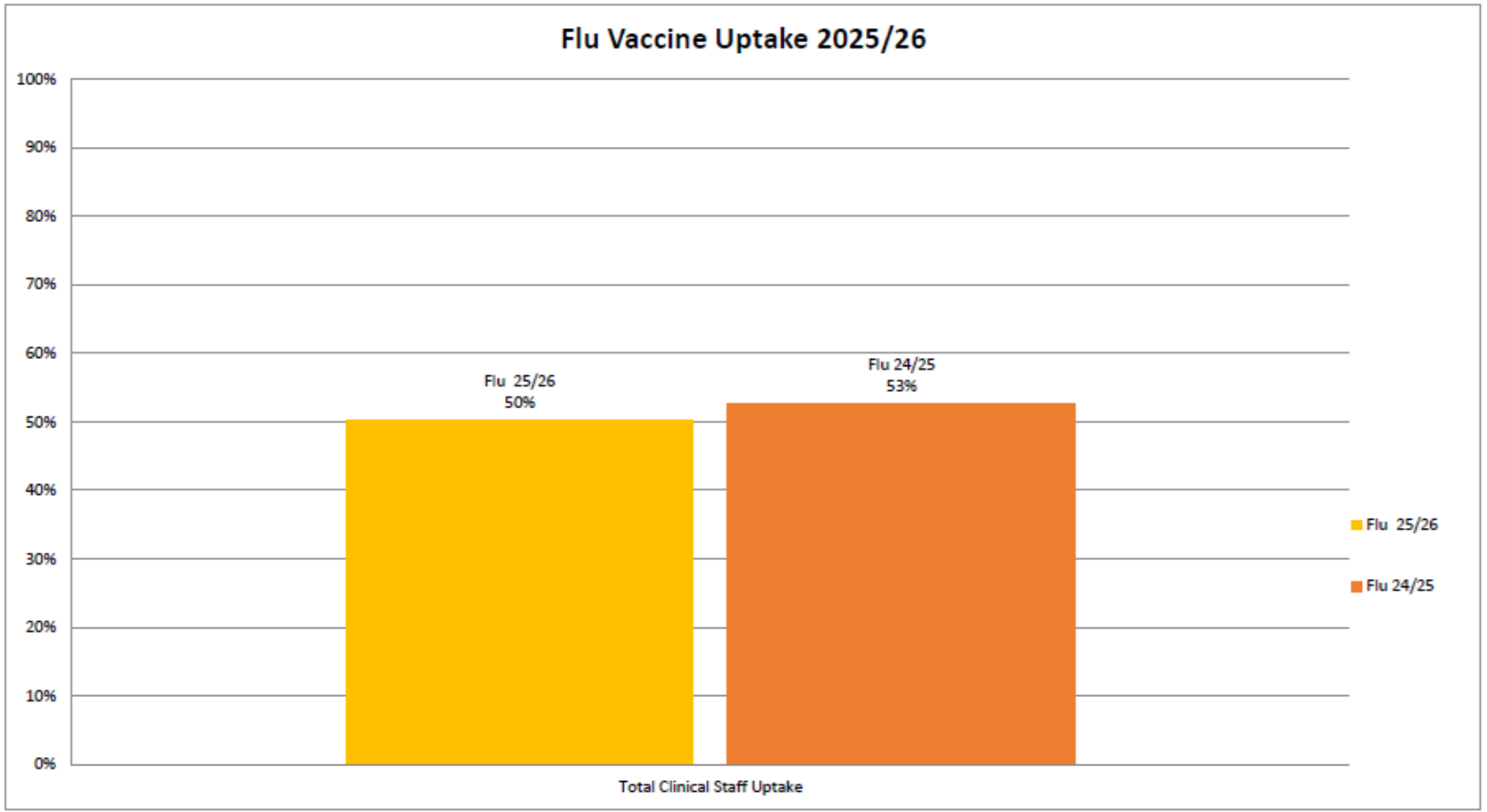
Source: Virtual Learning Environment (VLE) November 2025

UHS Flu performance - % of frontline staff vaccinated

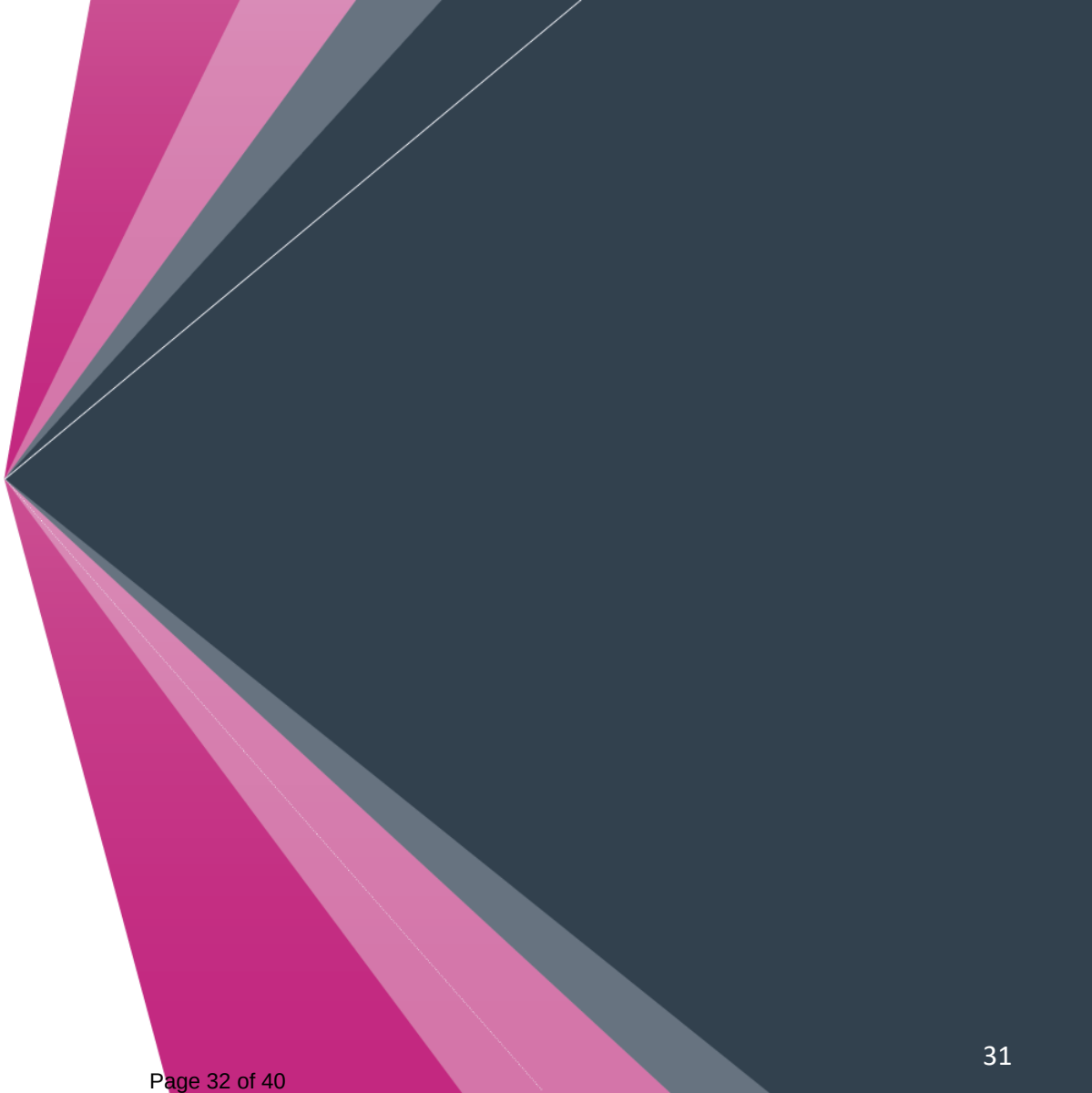


- UHS achieved a total flu uptake of 53% in 24/25
- Change of approach this year – planned clinics across the Trust
- Much quicker uptake due to ease of access to vaccination
- Very similar uptake across all professions
- Drop-in clinics available at OH and ongoing clinics across Trust
- UHS declared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

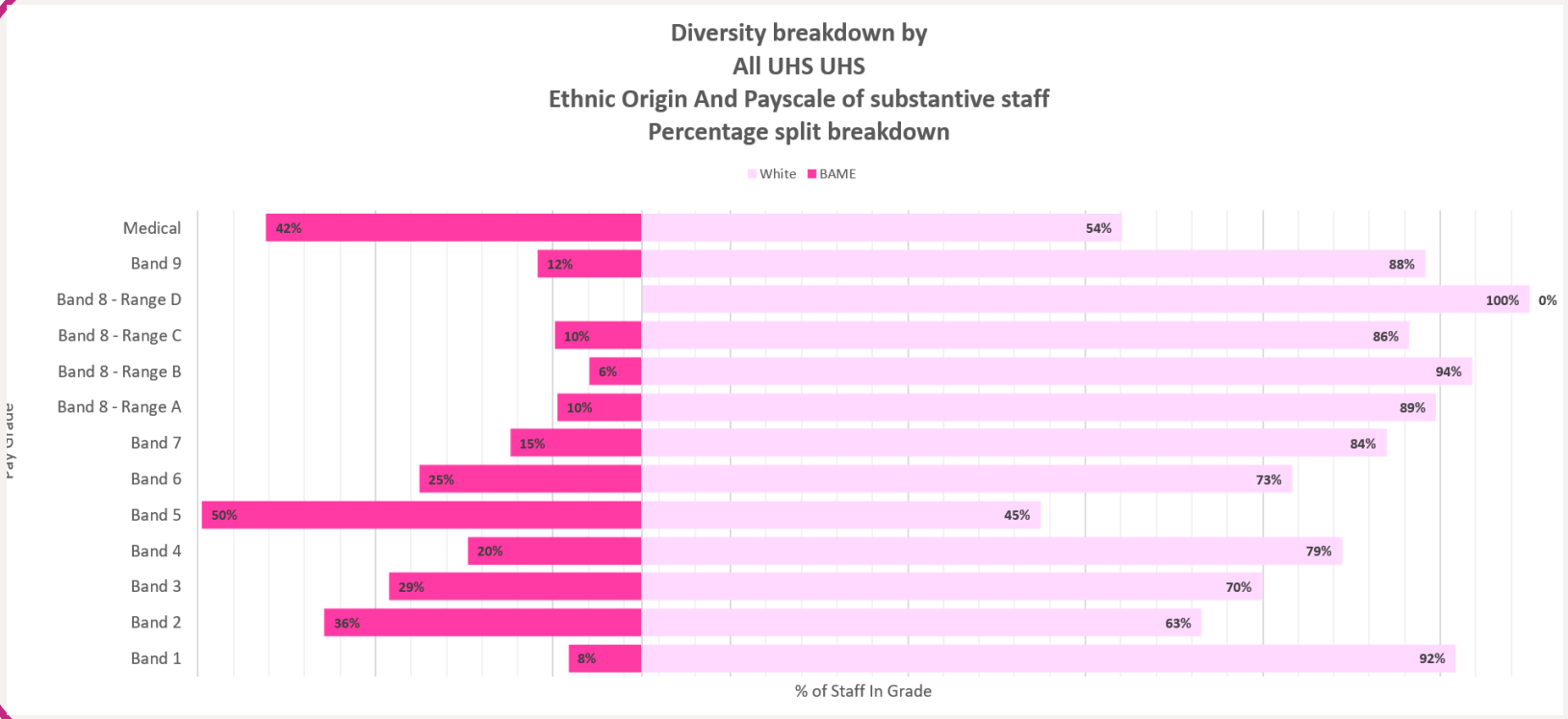
2025-2026 Programme Update



BELONG

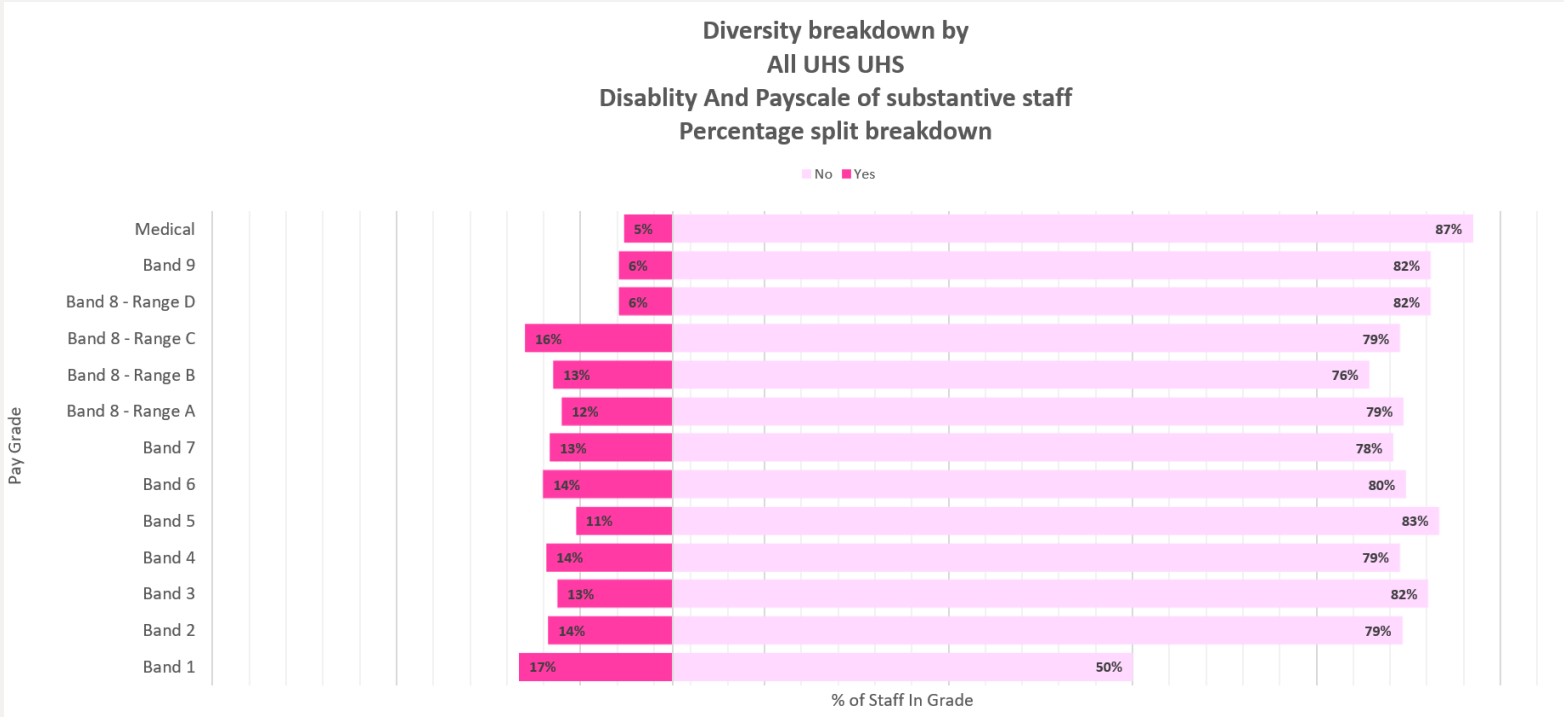


Staff in Post - Ethnicity



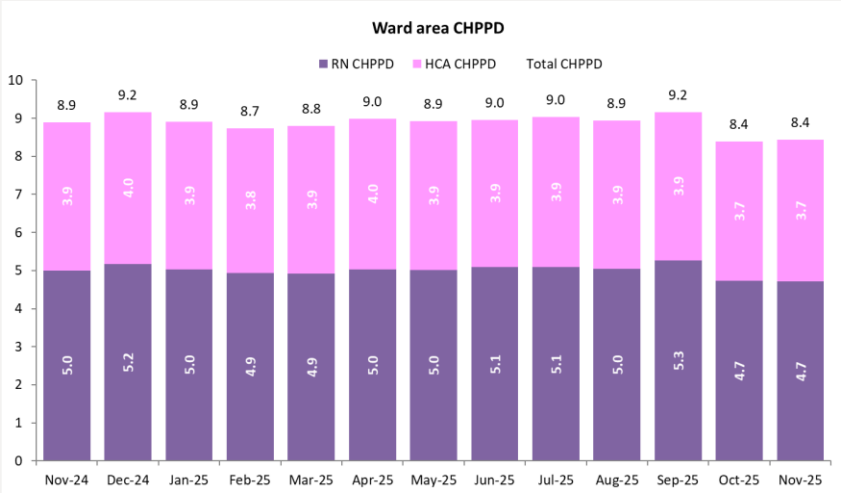
Source: ESR – November 2025

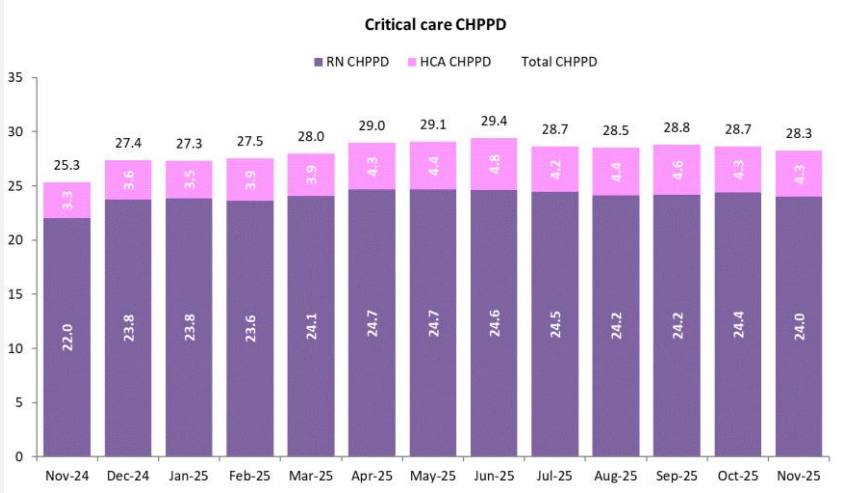
Staff in Post – Disability Status



Source: ESR – November 2025

CHPPD





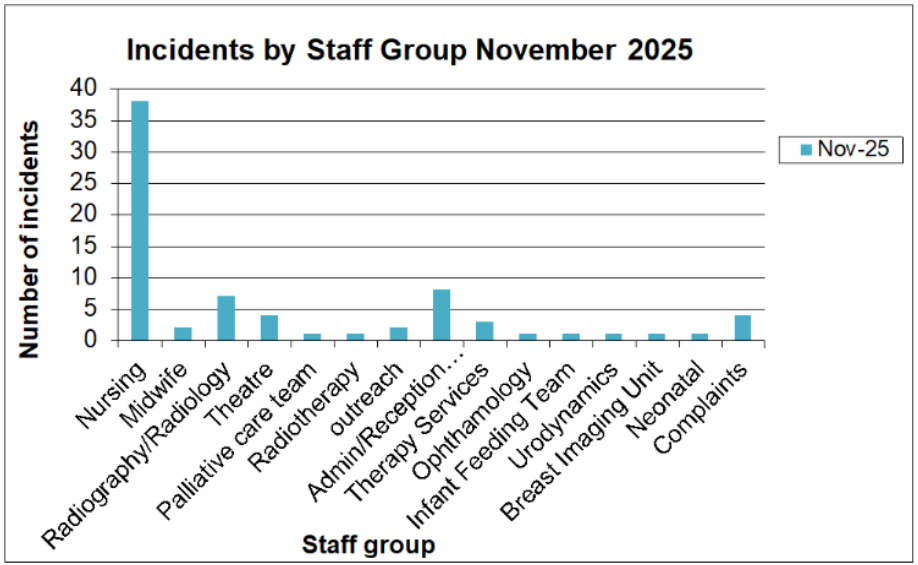
The Ward areas CHPPD rate in the Trust has increased overall from last month. RN 4.71 (previously 4.74), HCA 3.72 (previously 3.66), overall 8.43 (previously 8.40).

The CHPPD rate in Critical care has decreased overall from last month. RN 23.99 (previously 24.41), HCA 4.26 (previously 4.26) overall 28.25 (previously 28.66).

Source: HealthRoster, NHSP & eCamis – November 2025

Patient Safety – Staffing Incidents & Red Flags

In total 75 incident reports were received in November 2025 which cited staffing. This is a decrease on the 115 reported in October.



Incidents by Division November 2025 vs October2025

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
November 2025	14	21	29	7	4	75
Total	14 ↑ 12	21 ↓ 44	29 ↓ 34	7 ↓ 19	4 ↓ 6	75 ↓ 115

Month Incident occurred	Division A	Division B	Division C	Division D	THQ	Trust total
October 2025	12	44	34	19	6	115
Total	12 ↓ 28	44 ↑ 29	34 ↑ 33	19 ↑ 4	6 ↑ 4	115 ↑ 98

Source: Safeguard System November 2025

Patient Safety – Staffing Incidents & Red Flags cont.

DIVISIONAL BREAKDOWN:

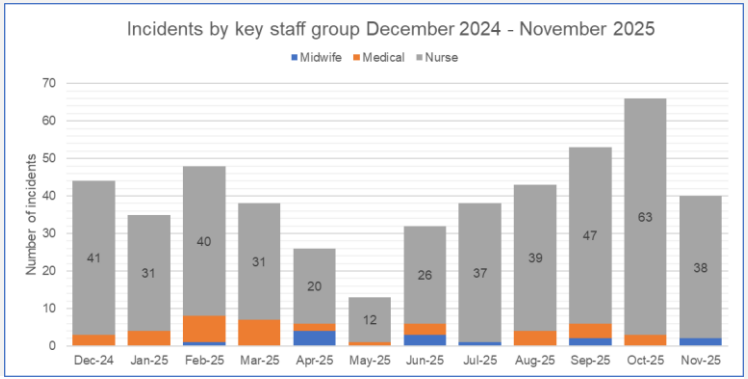
Div A:
Fourteen incidents reported in November, up from 12 in the previous month. Red Flags remained the same at 0.

Div B:
Twenty-one incidents were reported in November (significant decreased on the 44 in the previous month). There were 14 red flags reported, a decrease from the previous month (19).

Div C:
Twenty-nine incidents were reported in November (down slightly from the 34 in the previous month). There were 0 red flags reported, same as previous month

Div D:
Seven incidents reported in November (significant decrease from the 19 reported in the previous month). There were 2 red flags raised, down from the 4 reported in the previous month.

THQ:
Four incidents reported in November (down from 6 in the previous month).



	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
November 2025	Delay in medication	2	0	2	0	0	0
	Delay in pain relief	4	0	4	0	0	0
	Delay in observations	5	0	4	0	1	0
	Less than 2 registered	5	0	4	0	1	0
	Total	**16**	**0**	**14**	**0**	**2**	**0**

	Red flag category	Number of reports	Div A	Div B	Div C	Div D	THQ
October 2025	Delay in medication	5	0	3	0	1	1
	Delay in pain relief	9	0	6	0	1	2
	Delay in observations	8	0	5	0	1	2
	Less than 2 registered	8	0	5	0	1	2
	Total	**30**	**0**	**19**	**0**	**4**	**7**

Source: Safeguard System November 2025

Workforce Plan and Recovery Forcast

Data Sources

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


WORLD CLASS PEOPLE

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.10 Report to the Trust Board of Directors, 13 January 2026	
Title:	Learning from Deaths 2025-26 Quarter 2 Report
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	Jenny Milner, Associate Director of Patient Experience Louise Russell, Bereavement, Mortality and Data Insight Lead

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

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

The report also provides an update on the development and effectiveness of the Medical Examiner Service.

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

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

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

1. The Trust reduces avoidable deaths in our hospitals.
2. The Trust promotes learning from death by reviewing the quality of end-of-life care.
3. The Trust promotes an open and honest culture and support for the duty of candour.

Contents:

N/A

Risk(s):

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

Equality Impact Consideration:	N/A

1. Introduction

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

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

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

2. Analysis and discussion

2.1 Deaths at UHS

Quarter	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Q1	540	483	504	512	466	500
Q2	516	591	526	471	446	383
Q3	599	651	565	578	498	
Q4	644	537	489	558	552	
Total	2299	2262	2084	2119	1962	

During the second quarter of 2025/26, a total of 383 deaths were recorded across University Hospital Southampton (UHS) sites. This represents a 2.7% decrease compared to 446 deaths in the same period of 2024/25.

Of the deaths recorded in Q2 2025/26:

- 17 occurred in the Emergency Department.
- The remaining 417 were among inpatients.

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

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

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

National context

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

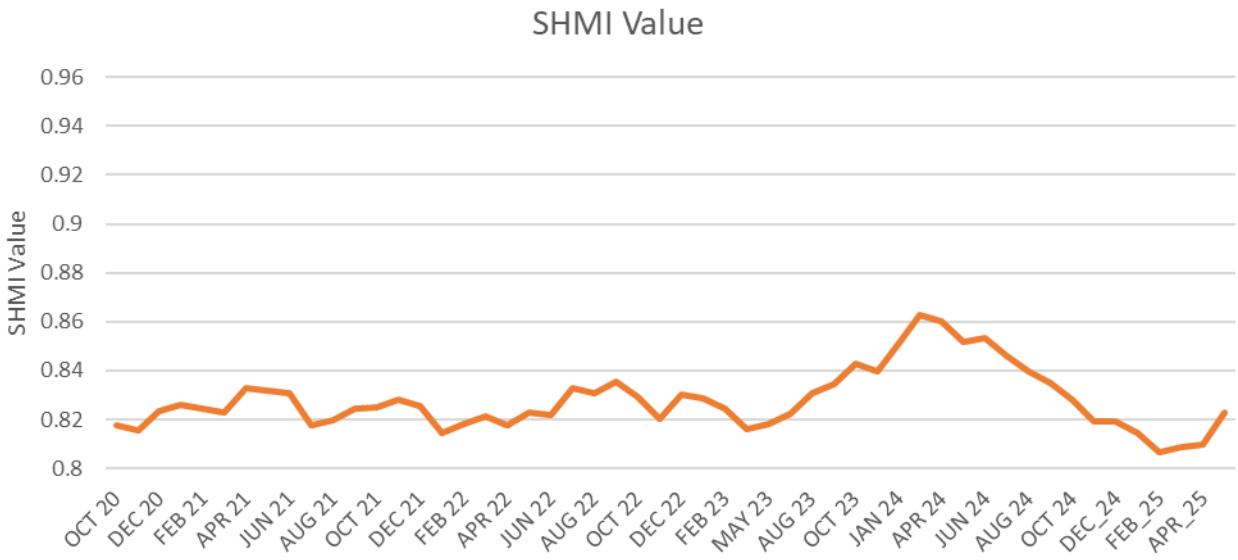
- 10 trusts recorded a higher-than-expected number of deaths (compared to 8 in Q1).
- 97 trusts recorded an expected number of deaths (compared to 99 in Q1).
- 11 trusts recorded a lower-than-expected number of deaths.

UHS performance

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

- A SHMI score of 0.8231 for the 12 months ending May 2025
- This represents a small increase in the previous downward trajectory, back to a level last seen in October 2024.
- UHS is one of only 11 trusts nationally to achieve a lower-than-expected mortality rate.

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



SHMI values are calculated on a diagnosis level for the following diagnosis groups using the latest NHSE data published 9/10/2025 for 1 June 2024 to 31 May 2025.

Diagnosis Group	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	0.903	As expected
Cancer of bronchus; lung	0.7976	Lower than expected (improved)
Secondary malignancies	0.7683	Lower than expected
Fluid and electrolyte disorders	0.5289	Lower than expected
Acute myocardial infarction	0.7063	Lower than expected
Pneumonia (excluding TB/STD)	0.8968	As expected
Acute bronchitis	0.5426	Lower than expected
Gastrointestinal haemorrhage	0.7775	As expected
Urinary tract infections	0.8398	As expected (deteriorated)
Fracture of neck of femur (hip)	0.9065	As expected

During the 12-month period ending May 2025, five diagnosis-level categories were classified within the 'as expected' range, while five were identified as 'lower than expected'. This is the same as Q1 except that Cancer of the Bronchus has improved to 'lower than expected' and Urinary Tract Infections moved to 'as expected' (from 'lower than expected').

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

2.3 Medical Examiner Reviews

During Q2, the Medical Examiner Service (MES) reviewed a total of 1,078 deaths. Of these, 383 (36%) occurred at University Hospital Southampton (UHS) sites, while 695 (64%) were community deaths. This represents a 5.2% decrease compared to the 1,137 deaths reviewed in Q1 2025/26, which is consistent with expected seasonal variation.

During the reporting period, 38 acute deaths at UHS were referred to the coroner, representing 9.9% of all deaths at the Trust. Of these referrals, 47% progressed to further investigation through either a Coroner's post-mortem or inquest. These figures are broadly in line with historical patterns and do not indicate any significant deviation from previous years.

2.3.1 Referrals for Morbidity and Mortality (M&M)

During Q2, 17 deaths were referred by the MES to specialty M&M meetings. The referrals were distributed across 6 care groups at UHS and 2 community referrals.

This quarter, gathering information on the dissemination and outcomes of Morbidity and Mortality (M&M) reviews has presented challenges as previously reported. Several cases remain unreviewed, and delays have occurred due to incorrect consultant referrals. Additionally, changes in M&M Leads have further impacted the process.
However, a new mechanism for collating this information is being introduced in Q3 via a dedicated 'bolt on' application to the current Ulysses IT platform used by the Trust for adverse incident reporting. This is expected to streamline and standardised data collection. Concurrently, work is underway in several areas to enhance the inclusivity of the M&M process for both staff and families. These developments aim to support sustainable improvements and enable more effective identification of Trust-wide themes.

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

4 cases were reviewed under the LeDeR programme during Q2. Key learning points from these reviews include:

Areas of concern and action:

- Concern has been raised regarding delays in the patient being reviewed by the cardiac surgery team in clinic, which subsequently led to a delay in potential surgical intervention. This case has undergone a patient safety scope and will be formally investigated as a Patient Safety Incident Investigation (PSII), under the category of 'failure to rescue'.

- Delays in completing discharge summaries and signing the Medical Certificate of Cause of Death (MCCD) were identified. Actions were taken to ensure that all individuals involved were made aware of the impact these delays had particularly on the mortuary services and, most importantly, on bereaved families. This issue has also been highlighted to the Medical Lead for Learning Disabilities.

Examples of good practice:

- Positive engagement with patients and their families around individual preferences was recognised, with exceptional examples of personalised end-of-life care delivery identified. One such example has been selected to be showcased as a case study for the upcoming 'Fundamentals of Care' study sessions.

2.3.3 Learning from death via patient safety

- One case was closed during Q2 with identified learning from death. The case related to a categorised 'failure to rescue' in which a patient died post discharge from an acute admissions area. This case was referred to the CQC. The key learning points identified are:

  - To develop and improve the current UHS discharge checklist and process across the Trust. The revised checklist has received approval from Divisions A and B and is pending final approval from Division C.
    Upon full approval, the updated checklist will be published on eDocs for Trust-wide implementation.

  - A bespoke education programme to be developed to comprehensively address all aspects of the discharge process. It will include training on: APEX, the roles and responsibilities of the nurse-in-charge, effective handover procedures, and the establishment of clear communication pathways. Additionally, it covers key areas such as the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The programme also ensures that all staff within the affected area are up to date with their mandatory MCA training requirements.

  - Updates to the UHS Discharge Policy and Taxi Booking Policy to insure that next of kin and care providers are notified of discharge plans.

  - Updates to the Medicines Prescribing, Acquisition, Storage and Administration Policy to include assessment of patients own medicines.

- An exemplary case was observed in which the Bereavement Care Team appropriately escalated family concerns regarding the death of their child. The Patient Safety Team reviewed the newly received information, prompting the Child Death and Deterioration (CDAD) Panel to reopen the case for further investigation.

2.4 UHS 'End of Life' incident reports

For Q2, there were a total of 16 incidents reported relating to end-of-life care. Overall, the main themes of the incidents were related to:

Privacy in death: Four incidents were reported in which patients died in multi-bed bays rather than in private side rooms. These occurrences were primarily due to limited availability of side rooms and constraints related to infection control. There was considerable distress caused to families and neighbouring patients.
The issue has been escalated to care group and Trust-level management. Clinical teams have been instructed to report such incidents as they occur.

- **Communication:** Themes identified include errors with 'movement to the mortuary', miscommunication and lack of knowledge surrounding DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions and paperwork.
- **Lack of commissioned specialist paediatric palliative care on-call service:** This is a recurrent concern, now formally recorded on the Trust's Risk Register and regularly

discussed at the End-of-Life Programme Board. A specific AER related to a paediatric patient experiencing significant pain and distress due to the lack of access to specialist palliative care support over the weekend. The absence of palliative paediatric out of hours cover availability resulted in avoidable suffering for the patient and considerable emotional distress for their family.

2.5 Learning from UHS formal complaints relating to end-of-life care

In Q2 a new case was opened following concerns from a family who felt insufficiently supported during their relatives' final weeks. They expressed distress over lack of flexibility over visiting hours, a perceived lack of privacy, and the overall experience of suffering during end-of-life care. Due to the complexity of the issues raised, a complaint resolution meeting has been scheduled with the family to capture key learning from this case and identify actions to improve future care delivery.

In Q2, no cases were closed where end-of-life care was identified as the primary concern. While end-of-life care may be referenced within a complaint, it is not always the principal issue.

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

The preferred system for capturing data to support organisation-wide learning from Morbidity and Mortality (M&M) outcomes has now been procured. The system is currently undergoing a bespoke design phase to ensure it aligns with the specific requirements of the M&M clinical leads. A pilot implementation of the new system is planned for Quarter 3.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.11	Report to the Trust Board of Directors, 13 January 2026
Title:	Infection Prevention & Control 2025-26 Quarter 2 Report
Sponsor:	Natasha Watts, Acting Chief Nursing Officer/Director of Infection Prevention & Control
Author:	Julie Brooks, Consultant Nurse and Deputy Director of Infection Prevention & Control Dr Julian Sutton, Lead Infection Control Doctor.

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection in UHS including:

- Performance against key infection indicators.
- Assurance of infection prevention standards, practices and processes.
- Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.

Focus on improving performance in relation to HCAIs has continued in Q2 through ongoing delivery of actions/interventions to ensure that the fundamental standards of infection prevention and control practice are consistently applied by all staff to reduce risk of transmission of infection and risk of antimicrobial resistance. Improvements in some elements of IP&C practice have been noted in Q2, particularly hand hygiene. Target thresholds were exceeded in 5 out of the 5 HCAI indicators during the quarter.

Members of the Trust Board are asked to review the report and the actions identified to support improvements in performance and note the following actions requested of Divisions/care Groups:

1. Divisions/Care Groups to ensure that the identified findings/learning and actions detailed in each section are shared and addressed via the Divisional Governance processes, with relevant teams and staff groups.
2. Divisions and Care Groups to ensure that processes and plans remain in place within Divisions/Care groups and are subject to ongoing review to improve IP&C practice standards, including hand hygiene, cleanliness of equipment, glove use, management and care of invasive devices and measures to reduce the risk of colonisation and infection with key organisms such as MRSA, CPE (multidrug-resistant gram negative bacteria) and *Candidozyma* (formerly *Candida*) *auris*.

Contents:

Risk(s):

Strategic: Board Assurance Framework Risk number 1c

Operational: Risk No. 489 inadequate ventilation in in-patient facilities. High risk (risk score:15)

quality Impact Consideration:	N/A

Category		Q2	Annual Limit	Action /Comment
National Thresholds (as set by NHSE)	MRSA bacteraemia (Threshold = 0)	R	R	2 MRSA BSI attributable to UHS in Q2 2025/26 (3 cases YTD)
	Clostridioides difficile infection (Threshold = 100)	R	R	34 cases in Q2 2025/26 against an internal limit of 25 (62 cases YTD)
	E. coli Bacteraemia (Threshold = 141)	R	R	51 cases in Q2 2025/26 against an internal limit of 35 (86 cases YTD)
	Pseudomonas Bacteraemia (Threshold = 23)	R	R	8 cases in Q2 2025/26 against an internal limit of 6 (17 cases YTD)
	Klebsiella Bacteraemia (Threshold = 56)	R	R	20 cases in Q2 2025/26 against an internal limit of 14 (32 cases YTD)
Other	MSSA			16 cases in Q2 2025/26 (31 cases YTD)
	VRE			4 cases in Q2 2025/26 (6 cases YTD)
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	G	National AMR 5-year plan target: reduction of 5% overall human antibiotic use (compared to a baseline of calendar year 2019) = 1% reduction per year.
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	R	R	Analysis of Q1&2 IP&C audits show 51% of areas are currently not meeting requirements needed to achieve full accreditation at year end in March 2026

1.Introduction

2. Analysis

2.1 Healthcare Associated Infection

Summary of progress in reducing risk of healthcare associated infection in UHS.

MRSA Bloodstream infection (MRSA BSI)

2 cases of Hospital Onset Healthcare Associated (HOHA) MRSA BSI attributed to UHS in Q2.

3 cases year to date against a nationally set annual threshold of 0.

The cases underwent a detailed concise review led by the Infection Prevention Team, an after-action review (AAR) with the clinical team to identify learning and areas for improvement and a final HCAI review with Chief Nursing Officer and Chief Medical Officer.

July 2025 (Maternity)	29 year old female re-admitted to hospital 5 days post emergency caesarean section. Blood culture taken on admission as part of a full septic screen grew MRSA. The patient was not known to have a previous history of MRSA and did not meet the criteria for MRSA screening antenatally/on admission (e.g. no risk factors). The likely source of BSI was considered as genito-urinary (evidence of colonisation of GU tract in a positive sample taken as part of septic screen) and the case was considered as likely unavoidable. Review of the case identified that although the patient did not have any risk factors to initiate MRSA screening, there was no documentation that MRSA risk factor questions were asked at antenatal appointments. Badgernet does not prompt to ask patient questions regarding MRSA or travel history.
August 2025 (Child Health)	10 month old transferred from Dorset Hospital to UHS for Haemolytic Uraemic Syndrome management. A blood culture taken 8 days after admission as part of a septic screen grew MRSA. Likely source of BSI considered as PICC line. Review of the case identified gaps in practice relating to MRSA screening and management/care/documentation of PICC line. No MRSA screen was taken on admission to UHS following transfer from Dorset. The PICC line was inserted in theatres and the monitoring form was not completed on insertion and for daily reviews.

Reporting trusts are now asked to provide information relating to prior healthcare exposure -whether patients had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases. Cases are split into one of five groups:

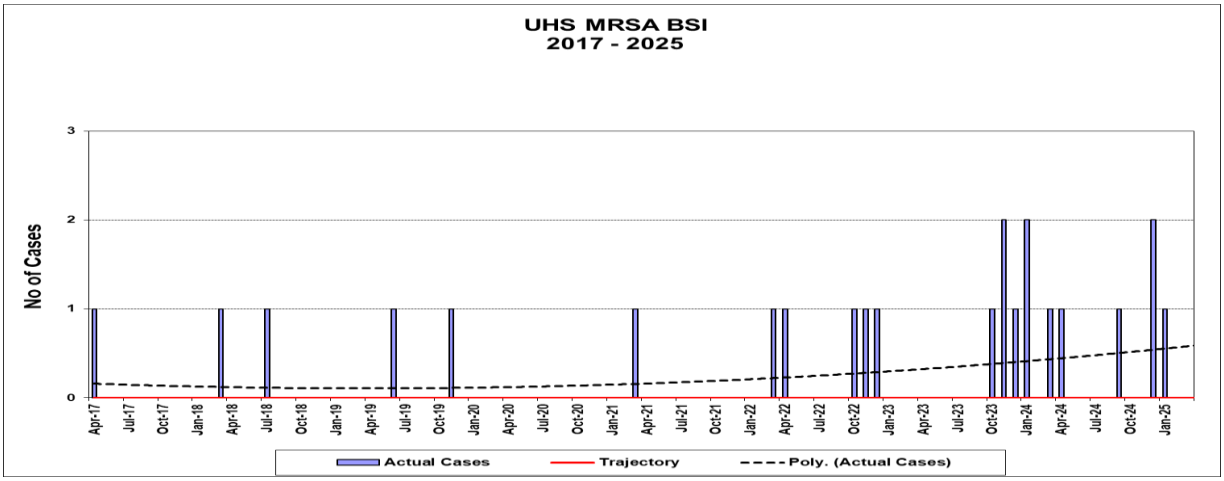
**Hospital-onset, healthcare associated (HOHA) - Specimen date is ≥3 days after the current admission date (where day of admission is day 1)*

**Community-onset healthcare-associated (COHA) - Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)*

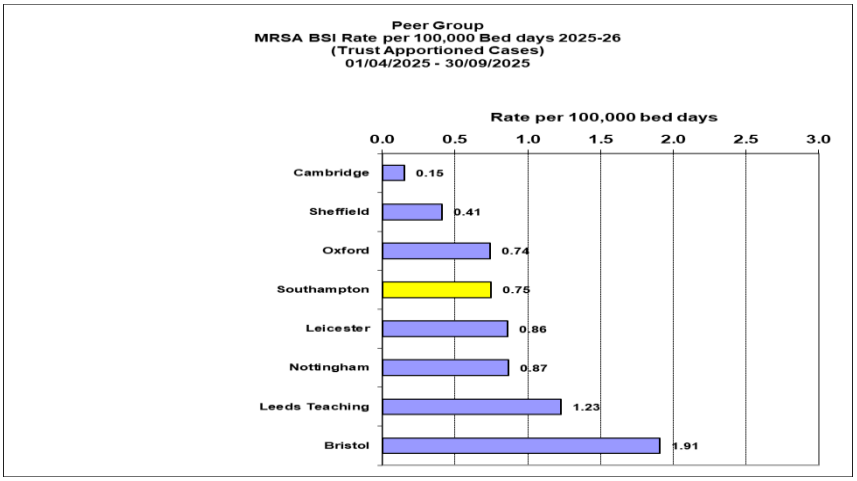
**Community-onset, community associated (COCA) - Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 28 days prior to the specimen date (where day 1 is the specimen date)*

** Unknown - The reporting trust answered "Don't know" to the question regarding previous discharge in the month prior to the MRSA case.*

** No information - The reporting trust did not provide any answer for questions on prior admission.*

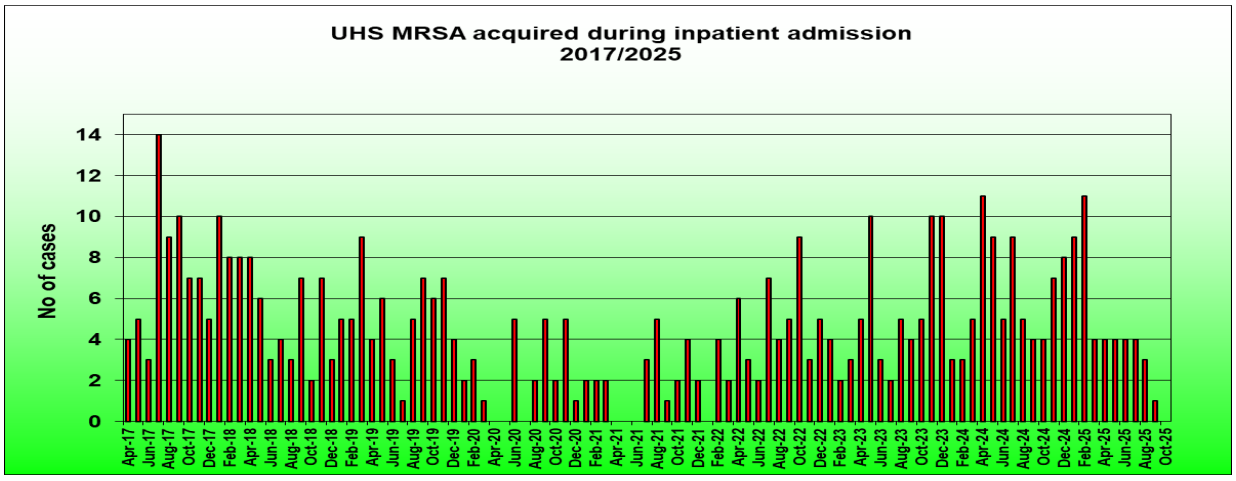


UHS has an attributable MRSA BSI rate of 0.75 cases/100,000 bed days and ranks fourth best of 8 self-selected peer hospitals.



Acquisition of MRSA colonisation in UHS

8 patients acquired MRSA (colonisation or infection) in UHS in Q2 2025/26.



Infection Prevention & Control (IP&C) MRSA practice reviews were undertaken by the Infection Prevention Team (IPT) on 103 patients in Q2 (July & August) to ensure that all expected measures were undertaken as per UHS policy. Reviews were undertaken on patients who were newly colonised with MRSA (18) and patients admitted who were known to be MRSA positive (85).

Whilst key themes/learning from IP&C MRSA practice reviews remain similar to Q1 2025/26 and Q4 2024/25, improvements in a number of the practice standards has been noted.

Of the patients who were found to be newly colonised with MRSA

- 33% did not have documented evidence that they had received MRSA risk reduction washes on or prior to admission, compared to 34% in Q1 and 50% in Q4 2024/25.
- 33% of patients did not have MRSA topical decolonisation therapy prescribed following confirmation of positive MRSA result, compared to 34% in Q1 and 17% in Q4 2024/25.

Of the patients who were known to be colonised with MRSA on admission:

- 42% patients did not have MRSA positive status documented in their medical/nursing records, compared to 54% in Q1.
- 90% of patients did not have MRSA topical decolonisation therapy prescribed on/following admission, compared to 86% in Q1.

Actions and interventions have remained ongoing in Q2 to support improvements in relation to MRSA practice standards including:

- Ongoing education/training and awareness activities provided by the IPT following the Infection Prevention & Control (IP&C) MRSA practice reviews.
- Finalisation and approval of a revised MRSA policy (adults, paediatrics/neonates and maternity) in August 2025, followed by initial communication activities and education at the infection prevention link staff meeting.
- Focused IPT follow-up (commenced September 2025) of patients of who are newly admitted and known to be colonised with MRSA, to communicate the requirement for MRSA decolonisation to reduce the risk of MRSA infection.
- Ongoing focus on improving IP&C practice standards including hand hygiene and care of invasive devices (as outlined later in this report).

Additional actions and interventions planned for Q3 include:

- Enhanced focus on improving staff knowledge of the revised MRSA policy via formal launch of the policy, production of policy summary guides, further communication activities and focused IPT education/awareness activities during October/November.

Clostridioides difficile (C. difficile)

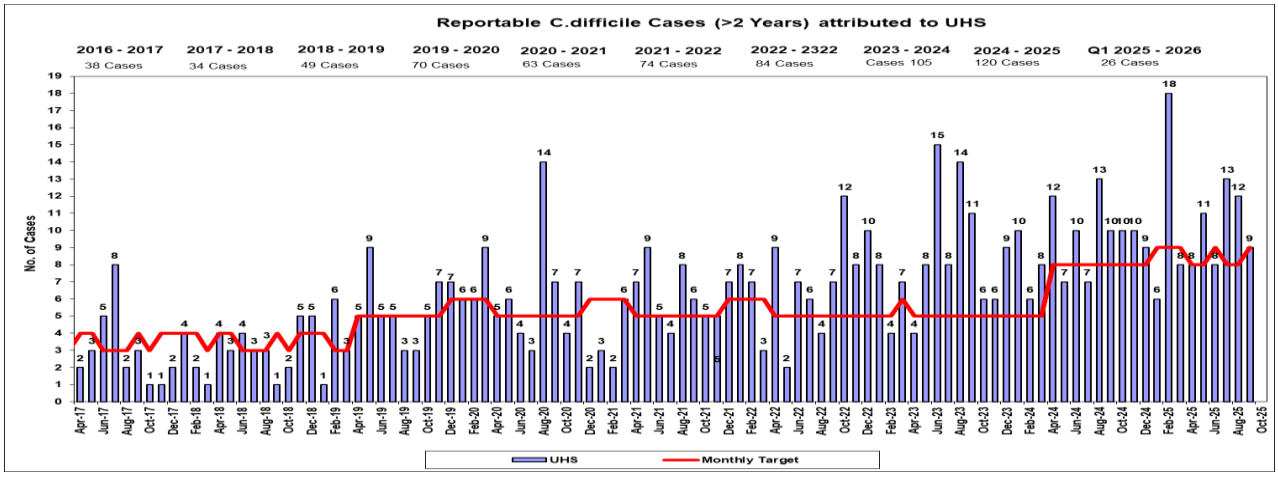
Trusts are required to minimise rates of *C. difficile* so that they are no higher than the threshold levels set by NHS England and Improvement. Trust-level thresholds comprise total healthcare-associated cases i.e. Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

2025/26 progress:
34 cases in Q2. 62 cases year to date against a nationally set annual threshold of 100.

Q2 cases:

- 22 Hospital Onset – Healthcare associated (HOHA)
- 12 Community Onset – Healthcare associated (COHA)

2025/26	Jul	Aug	Sept	Total
HOHA	10	8	4	**22**
COHA	3	4	5	**12**



The number of cases in Q2 2025/26 was slightly higher than the same period last year with 34 cases compared to 30 cases in 2024/25.

Twice weekly *C.difficile* ward rounds have continued in Q2 (undertaken by the anti-infectives pharmacists and Infection Prevention Nurses) to follow up in-patients with a new diagnosis of *Clostridium difficile* (toxin positive and negative) to ensure appropriate management, to reduce risk of complications and onward transmission, and to support improvements in practice where required.

75 patients were reviewed on the *C. difficile* ward rounds in Q2.

92% of patients were found to have one or more risk factors for developing *C.difficile* diarrhoea including

- Current or prior exposure to antibiotics - 61% of the patients were on antimicrobials when the specimen was taken, 49% had received antimicrobials in the preceding 7 days and 57 % in the preceding 28 days.
- Advanced age – 57% of the patients were over 65 years of age and of these 37% were over the age of 80.
- Prior history of *C.difficile* diarrhoea - 25% of the patients had previous episodes of confirmed *C.difficile* in the previous 13 months.
- Other risk factors – proton pump inhibitors (42%), anti-cancer chemotherapy in the 28 days prior to the specimen date (25%), laxatives (17%), enteral nutrition (12%), other high-risk medications (7%), gastrointestinal/ bowel surgery (9%), inflammatory bowel disease (6%) and other gastrointestinal infections (3%).

Of those patients who had received antibiotics, the majority had received courses of broad-spectrum antibiotics. In most cases prescribing was appropriate and in line with UHS prescribing guidelines. Of the 61% of patients that were on antimicrobials when the specimen was taken, 96% of these were prescribed in accordance with antimicrobial prescribing guidelines or were clinically justified and reasonable.
Of the 49% who had received antibiotics in the preceding 7 days, 70% of these were prescribed in accordance with antimicrobial prescribing guidelines or were clinically justified and reasonable.

Review of patient management post confirmation of the positive result including treatment choice and IP&C practices identified:

- 87% patients had commenced treatment for *C.difficile* at the time of the review and treatment choice was considered appropriate in 76% of cases.
- 93% of patients had a documented medical review in relation to diarrhoea and positive *C.difficile* result.
- 85% patients had a C.difficile care pathway commenced.
- 97% of patients were isolated as per the isolation policy for the management of patients with infectious conditions; correct isolation signage was displayed in 94% of cases; contact precautions were implemented in 97% of cases; and waste/linen was being correctly managed in 97% of cases.

- The correct cleaning (chlorine-based cleaning) had been implemented in isolation rooms in 97% of cases.

Key elements requiring improvement included:

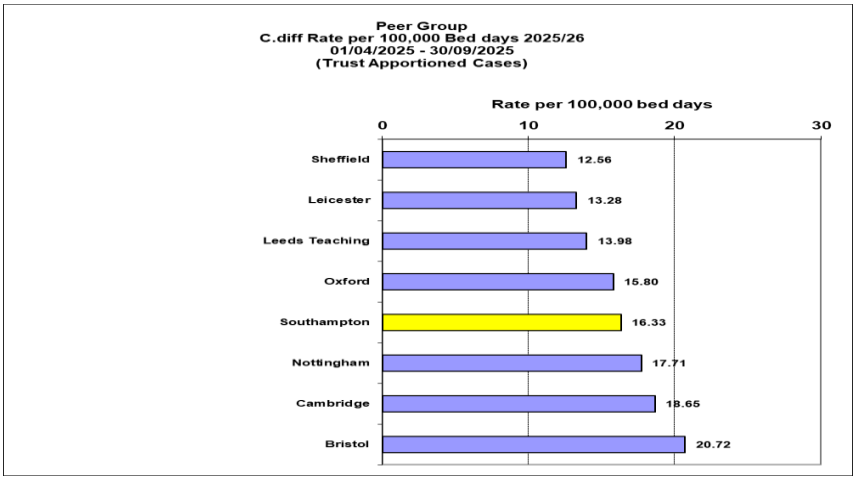
- 14% of commodes that were checked were not visibly clean.
- 28% of patients reviewed did not have the trust *C.difficile* care pathway completed daily.
- 24% of patient's reviews found the patient/relative was not supplied with a copy of the trust information leaflet/factsheet.
- 28% of patients reviewed did not have an isolation risk assessment completed.
- 28% of commodes that were found to be clean were not signed and dated as clean.

During Q2 2025/26, 4 periods of increased incidence (PII) were declared (two or more new cases of *C. difficile* on a ward in a 28-day period). Actions were implemented in response which included enhanced cleaning of the whole ward with Sochlor/Actichlor plus; increased activity on the ward by the IPT (including a formal weekly review of the ward/observations of practice); review of isolation procedures; review of antibiotic usage and enhanced communications with staff.

Actions and interventions remain ongoing to support improvements in practice and reduction of *C.difficile* including:

1. Focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing including review and update of antimicrobial prescribing guidelines.
2. Ongoing focus on improving IP&C practice standards including equipment cleanliness, hand hygiene practices, appropriate glove use, care and management of patients requiring isolation.
3. Participation in the sentinel surveillance programme of *Clostridioides difficile* infection (CDI) by WSG which will provide both C. *difficile* ribotyping data and further information on potential genetic relatedness of a sample our CDI cases.

In Q2 UHS ranked fifth best out of 8 self-selected peer acute trusts, with a rate of 16.33 *C. difficile* cases / 100,000 bed days. Comparative data need careful interpretation because of differences in test selection, methodology and reporting criteria between trusts.



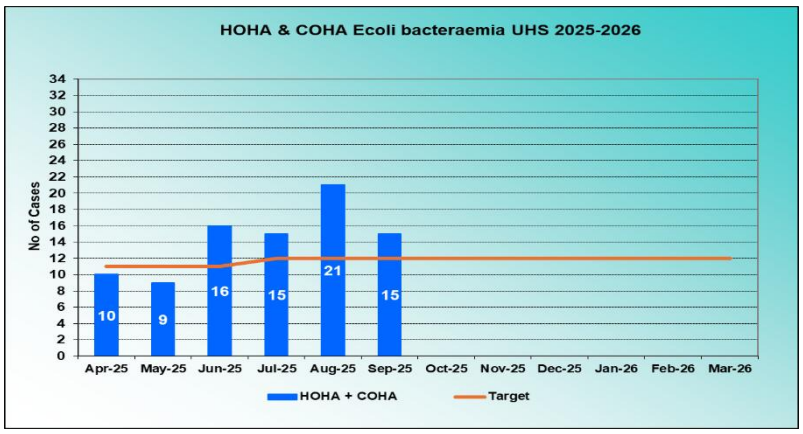
Healthcare Associated Bloodstream infections (excluding MRSA)

Trusts are required to minimise rates of Gram-negative bloodstream infections (BSI) so that they are no higher than the threshold levels set by NHS England. Trust-level thresholds comprise total healthcare-associated cases i.e., Hospital-onset healthcare associated (HOHA) and Community-onset healthcare associated (COHA).

Post-48h BSI	Q1 & 2 2025-26	2024-25	2023-24	2022-23	2021-22
E. coli	86 (141)	200 (141)	147 (120)	154 (127)	138 (151)
Pseudomonas	17 (23)	36 (22)	24 (33)	35 (36)	30 (34)
Klebsiella	32 (56)	81 (56)	58 (56)	51 (73)	64 (64)
MSSA	31	53	59	45	43
VRE	6	10	12	4	9

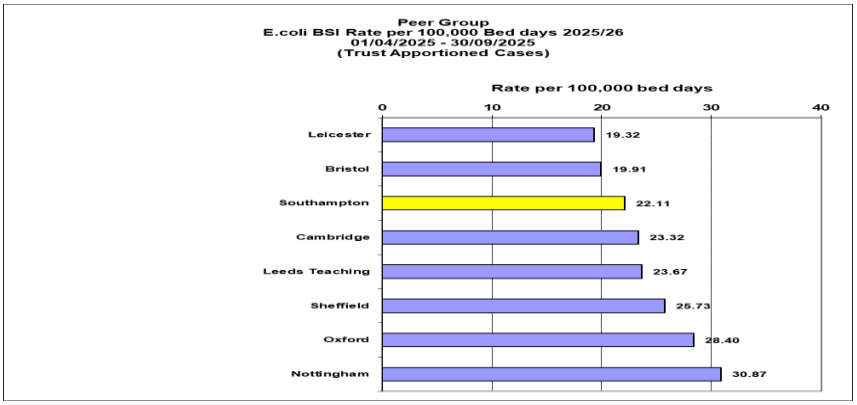
(Annual National thresholds in bracket

E. coli BSI: 86 cases year to date against a nationally set annual threshold of 141 cases for the year



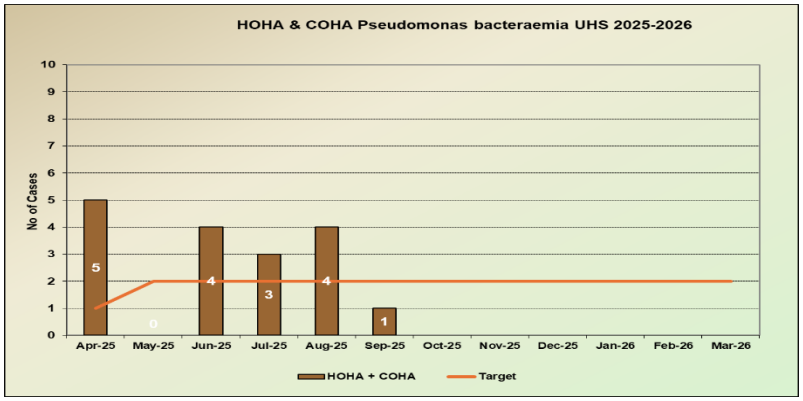
Q2 Progress:
51 cases

- 23 Community Onset – Healthcare Associated (COHA)
- 28 Hospital Onset – Healthcare Associated (HOHA)



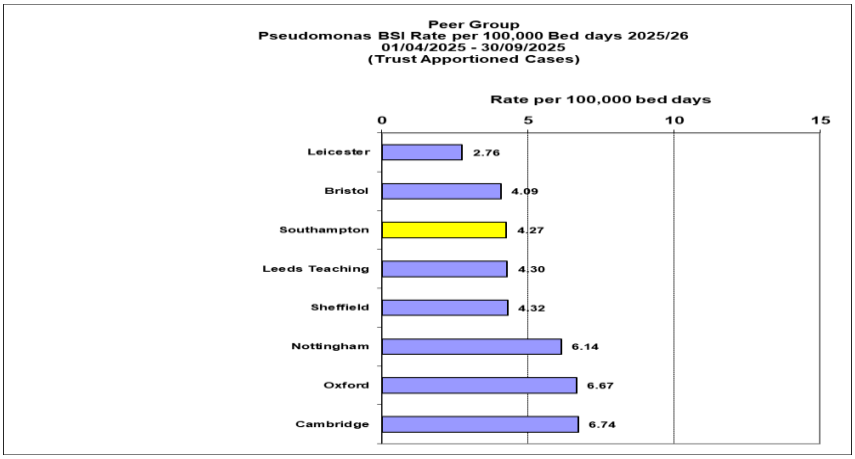
UHS ranks third out of 8 self-selected peer acute trusts for *E. coli* bloodstream infection (BSI) with a rate of 22.11 cases per 100,000 bed days.

Pseudomonas BSI: 17 cases year to date against a nationally set annual threshold of 23 cases for the year.



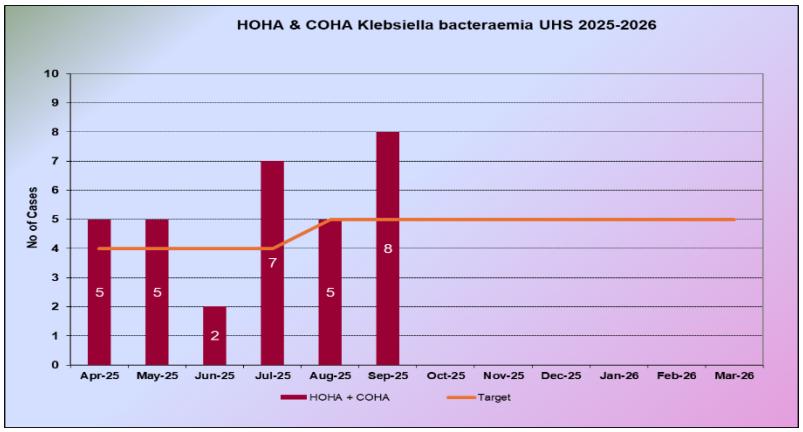
Q2 Progress:
8 cases:

- 1 Community Onset – Healthcare Associated (COHA)
- 7 Hospital Onset – Healthcare Associated (HOHA)



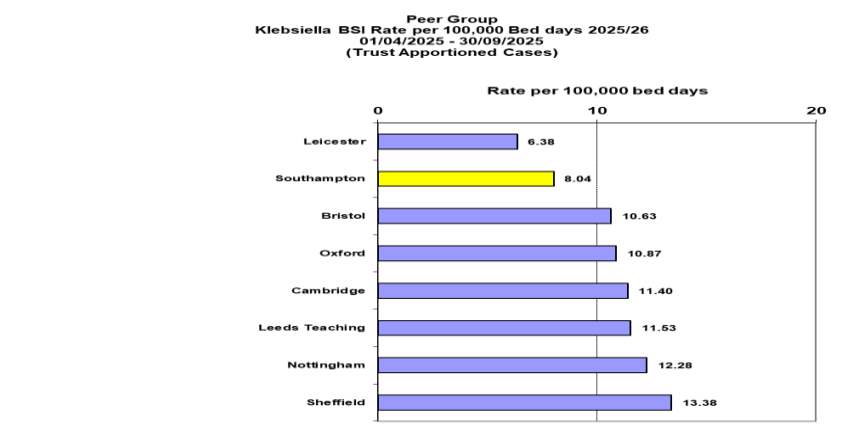
UHS ranks third out of 8 self-selected peer acute trusts for Pseudomonas bloodstream infection (BSI) with a rate of 4.27 cases per 100,000 bed days.

Klebsiella BSI: 32 cases year to date against a nationally set annual threshold of 56 cases for the year.



Q2 Progress
20 cases:

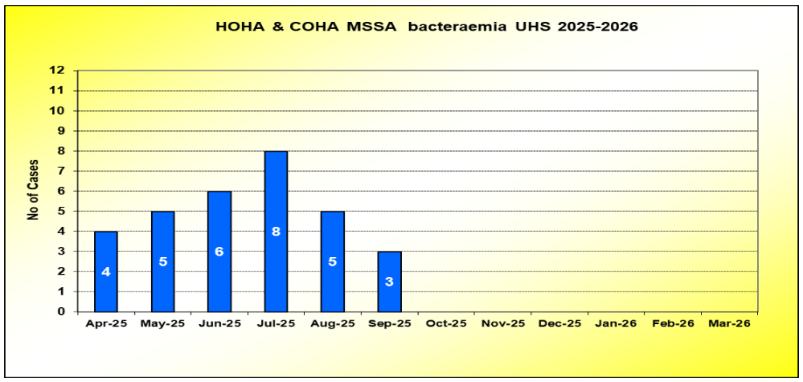
- 6 Community Onset – Healthcare Associated (COHA)
- 14 Hospital Onset – Healthcare Associated (HOHA)



UHS ranks second out of 8 self-selected peer acute trusts for Klebsiella bloodstream (BSI) infection with a rate of 8.04 cases per 100,000 bed days.

MSSA BSI

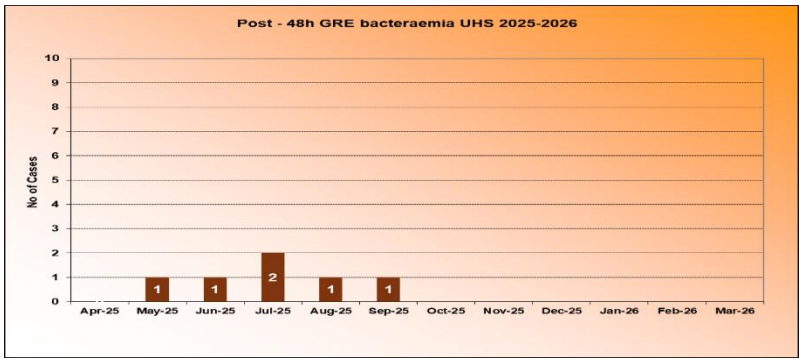
31 cases year to date. No nationally set threshold level but ongoing focus to minimise MSSA bloodstream infections.



Q2 Progress:
16 cases:

- 4 Community Onset – Healthcare Associated (COHA)
- 12 Hospital Onset – Healthcare Associated (HOHA)

VRE BSI: 6 cases year to date. No nationally set threshold level but ongoing focus to minimise VRE bloodstream infections.



Q2 Progress:
4 cases:

- 4 Hospital Onset – Healthcare Associated (HOHA).

Summary of bloodstream infections

A total of 99 cases of healthcare associated BSI (gram negative, MSSA & VRE) were reviewed by a Senior Infection Prevention Practitioner in Q2. The likely source of infection was determined as:

Source Unclear	23.24% (n=23)
Hepatobiliary	18.18% (n=18)
Intravascular Device (including Pacemaker/ ICD or CVC)	8.08% (n=8)

Lower Respiratory Tract (Pneumonia, VAP, Bronchiectasis, exacerbation COPD etc)	8.08% (n=8)
Lower Urinary Tract	8.08% (n=8)
Lower Urinary Tract (Catheter Associated)	8.08% (n=8)
Upper Urinary Tract (Pyelonephritis/Abscess)	5.05% (n=5)
Gastrointestinal or Intraabdominal collection (excluding Hepatobiliary)	4.04% (n=4)
Gut Translocation	4.04% (n=4)
Neutropenic Sepsis	4.04% (n=4)
Bone and Joint (No Prosthetic Material)	3.03% (n=3)
Skin or Soft Tissue (including Ulcers, Cellulitis, Diabetic Foot Infections without OM)	3.03% (n=3)
Bone and Joint (With Prosthetic Material)	1.01% (n=1)
Cardiovascular or Vascular (without prosthetic material, including Fistula Infection)	1.01% (n=1)

Focus for 2025/26 has been on addressing themes/learning from invasive device associated BSI reviews undertaken in 2024/25, specifically improving the management and care of indwelling urinary catheters and intravascular access devices

Management and care of intravenous access devices (specifically intravenous cannulas)

IPT ward reviews of peripheral intravenous cannula (PVC) care were undertaken in Q4 2024/25 and Q1 2025/26 where 313 patients with peripheral intravenous cannulas were reviewed across 75 clinical areas to assess management and care of the cannula and staff knowledge of expected practice standards. Focus in Q2 has been on continuing to address the key findings from the reviews:

- 59% of patients did not have a visual infusion phlebitis (VIP) score for the cannula recorded 8 hourly.
- 31% of cannulas reviewed did not have the date of insertion recorded.
- 16% of patients had cannulas that were no longer required.
- Staff knowledge of some critical aspects of cannula care was variable in some areas including frequency of observation of the cannula site and when cannula removal should be considered.

Activities/interventions to support improvements in practice have included:

- Ongoing targeted education/awareness and support activities by the IPT to clinical areas related to their specific findings/needs.
- Ongoing promotion and use of training materials/videos produced by the trust clinical digital educators relating to invasive device documentation on inpatient noting.
- Quarterly IV newsletter with feedback of findings from PVC ward reviews and key messages and reminders on IV device care.
- Observations/audits and support in defined areas by company clinical advisers regarding use of products e.g. skin preparation.

A review of the current policy standard for frequency of observation of the cannula site (8 hourly) is planned for Q3 and the policy will be updated accordingly.

Management and care of indwelling urinary catheters

IPT ward reviews of indwelling urinary catheter management and care were undertaken in Q1 where 260 patients with urinary catheters were reviewed across 61 clinical areas to assess the management and care of indwelling urinary catheters including catheter documentation within inpatient noting (or other systems like metavision), ANTT principles, terminology, catheter care practices and strategies for preventing urinary catheter-related infections. Focus in Q2 has been on continuing to address the key findings from the reviews:

- Catheters were inserted for appropriate indications in the majority of cases with the most common reasons for insertion being acute urinary retention (24%), urine output monitoring (26%), surgery and post-operative care (17%).
- 89% of patients had the catheter insertion date recorded, 11% did not.
- 69% of patients had no documented plan for removal of the catheter.
- 54% of patients had no documentation of daily review of their catheter, potentially contributing to delay in its removal.
- 68% of the catheters reviewed had urine meters but only 26% of patients required any kind of urine output monitoring.
- 45% of urinary catheters did not have a securing device in place.

Activities/interventions to support improvement in practice have included:

- Ongoing targeted education/awareness and support activities by the IPT to clinical areas related to their specific findings/needs.
- Ongoing promotion and use of training materials/videos produced by the trust clinical digital educators relating to invasive device documentation on inpatient noting.
- Focus on urinary catheters, including feedback from IPT ward reviews and key messages, at the bi-monthly infection prevention link staff meeting.
- Agreement to make amendments to the in-patient noting urinary catheter form to improve the documentation and daily review of need for catheter (changes effective from next release).

Quality improvement initiatives in defined areas remain ongoing, including the 'A-void' catheter project, a nurse led project to reduce the use of urinary catheters, on ward G9, with work ongoing to explore how the project can be extended to other wards within the trust.

Focus on promoting continence, avoiding use of urinary catheters/facilitating early removal of catheters remains a key component of the fundamentals of care project (bladder and bowel care commitment).

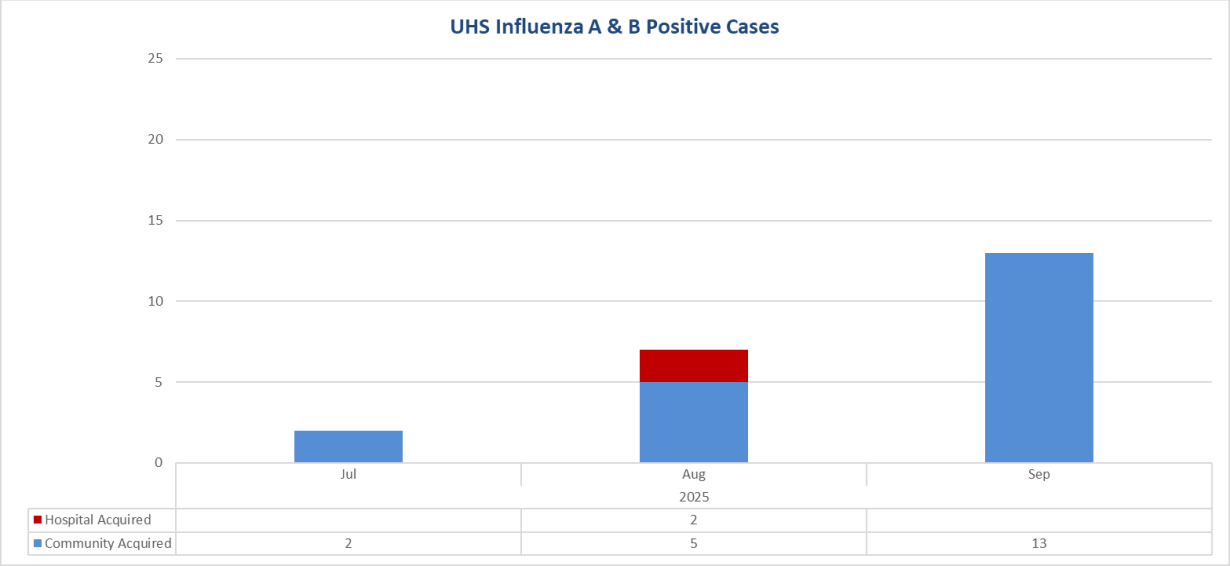
Work is planned in Q3 on reducing the inappropriate use of urine meters (urometers) which will have a positive financial and environmental impact. Uromoters cost approx. £4.91 each and their bulky/rigid plastic components generate more waste, compared to a 2 litre drainage bag which costs approx. £0.28 and has less plastic and therefore less waste.

2.2 Respiratory Viruses

Influenza & RSV

Prevalence of influenza and RSV in UHS was low in Q2 2025/26, in line with expected seasonal trends, with 0 cases of RSV and a small number of influenza cases.

Of the cases of influenza seen within UHS, 24 were community acquired/community onset and 2 cases (2 adults) were categorised as healthcare associated (samples taken from inpatients after 5 days of admission to UHS).

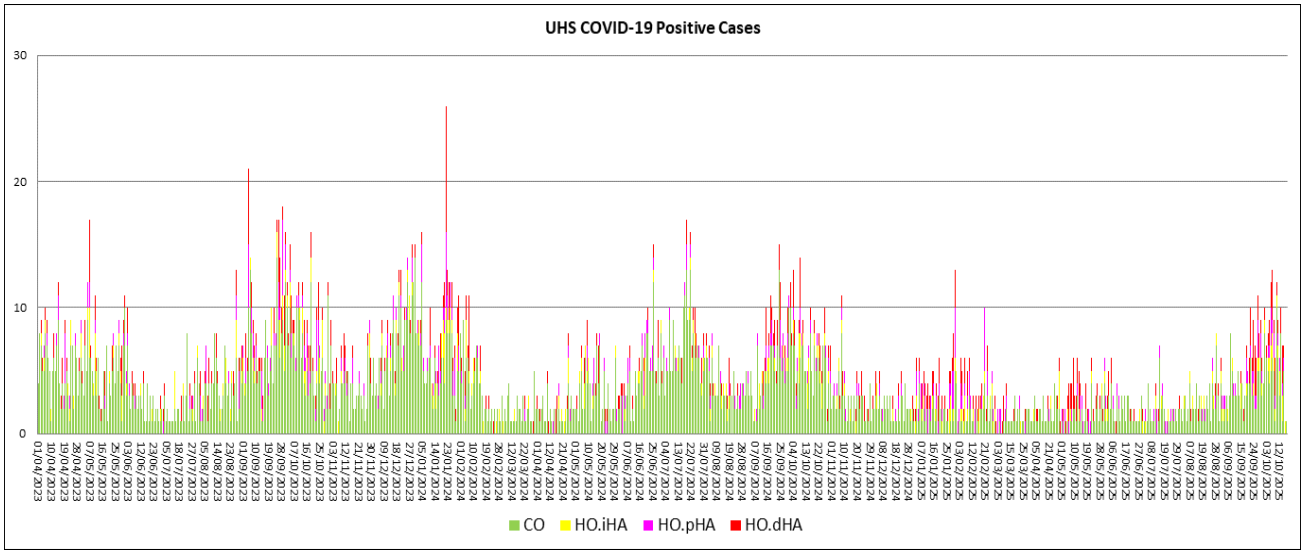


Source	Number of Cases	Number Admitted
ED	11	10
Admission Areas (AMU, MAOS,TAU)	12	
Inpatients	2	
Outpatients / Clinics	1	
Total	26	

COVID-19

Prevalence of COVID-19 increased in Q2 compared to Q1 (300 cases in Q2 compared to 205 in Q1) but was significantly lower than the same period last year (569 cases in Q2 2024/25). This coincided with a reported increase in community and national prevalence.

The increasing case numbers seen within UHS in the later part of September 2025 were associated with an increasing prevalence in the community, in-hospital transmission and a number of small outbreaks occurring.



Cases identified in UHS: July 2025 to September 2025

	Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
Q2	206	25	34	35

Definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals.
Definite (HO.dHA): *hospital-onset definite healthcare-associated first positive specimen date 15 or more days after admission to Trust (RCA required)*
Probable (HO.pHA)*: hospital-onset probable healthcare-associated – first positive specimen date 8–14 days after admission to Trust (RCA required)*
Indeterminate (HO.iHA): *hospital-onset indeterminate healthcare-associated – first positive specimen date 3–7 days after admission to Trust*
Community Onset (CO*) - positive specimen date <=2days after hospital admission or hospital attendance.*

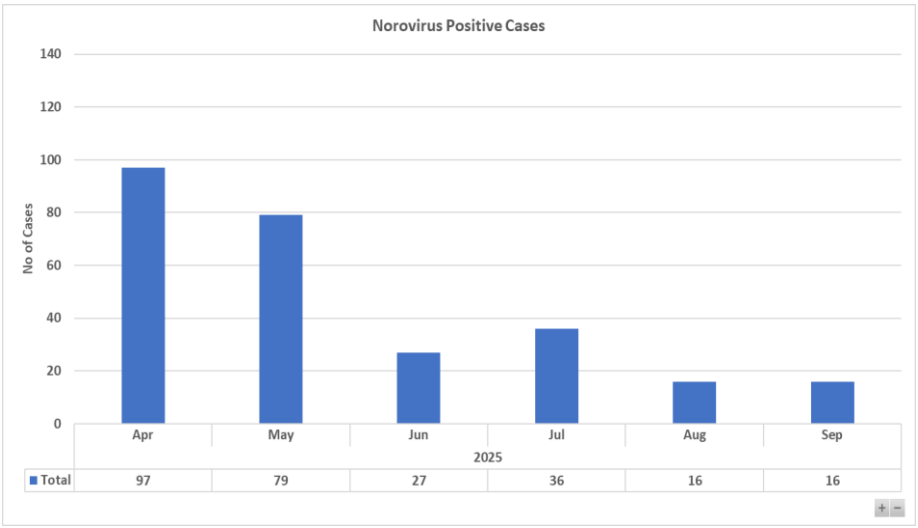
Respiratory Virus Outbreaks

	Number of Outbreaks	Total Number of Positive Patients
COVID-19	5	27
Influenza	0	0
RSV	0	0

Outbreaks continued to be managed by the Infection Prevention Team, with targeted control measures implemented as required and ongoing monitoring until 14 days following the last confirmed case.

2.3 Viral Gastroenteritis including Norovirus.

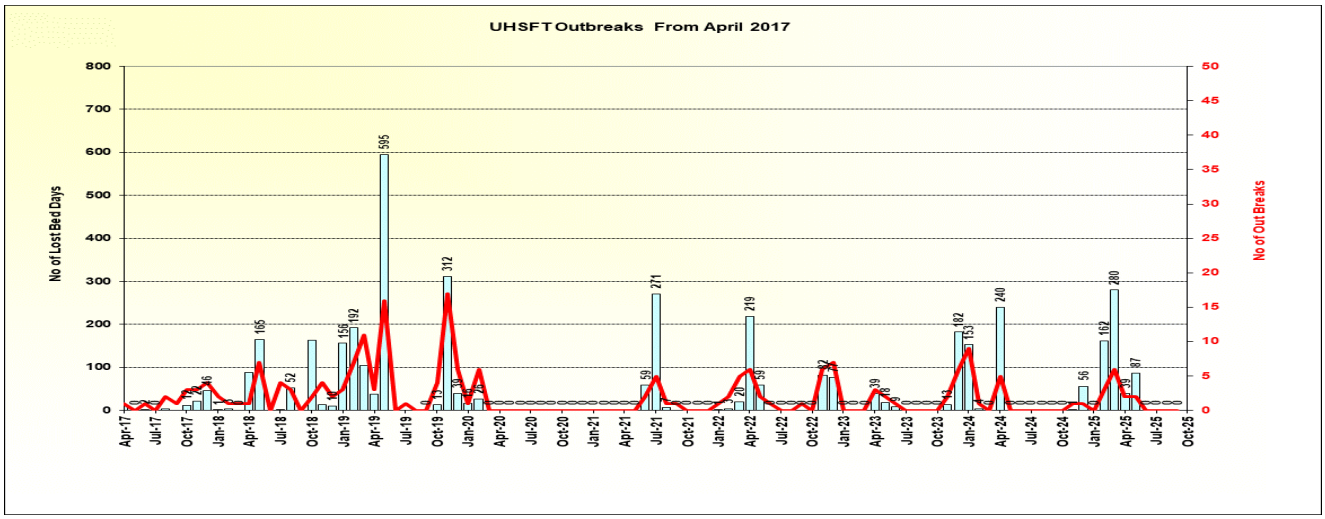
Prevalence of Norovirus was low during Q2 2025/26, compared to Q1 and the same period last year.
A total of 68 patients tested positive for Norovirus in Q2, significantly lower than levels seen in Q2 2024/25 (167 cases).



Source	Number of Cases
ED	31
Admission Areas (AMU, MAOS,TAU)	19
Inpatients	15
Outpatients / Clinics	3
Total	68

The majority of the Norovirus positive cases were identified through use of rapid in-lab diagnostic testing for gastrointestinal (GI) pathogens for symptomatic patients (those with potentially infective diarrhoea) either on admission (in agreed admission pathways in ED and AMU) or, within ward bays throughout the hospital.

0 Norovirus outbreaks were recorded in Q2



Year	Bed days lost due to bay/ward closures
2021-2022	361
2022-2023	503
2023-2024	477
2024-2025	769
Q1 & 2 2025-2026	126

UHS continues to be at risk of Norovirus outbreaks due to the limited single room capacity and limited toilet/bathroom facilities in some of the wards.

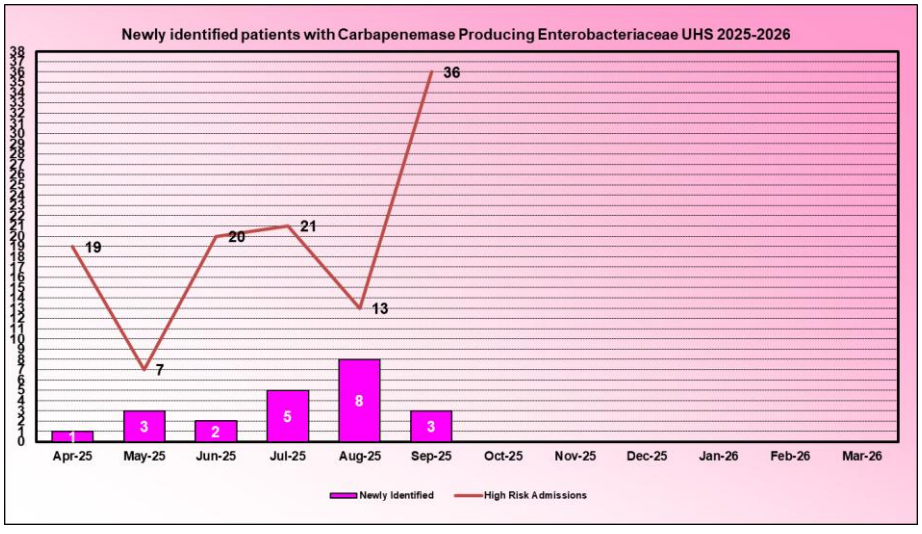
2.4 Actions to support prevention and control of respiratory viruses and Norovirus.

Actions and strategies to support prevention and control of respiratory viruses (including COVID-19) and Norovirus and reduce risk of in-hospital transmission and associated outbreaks, along with planning for potential increases in cases, remain in place and under ongoing review. Planning for winter 2024/25 has commenced in Q2.

2.5 Carbapenemase-producing Gram-negative bacteria (likely to be multidrug resistant).

Carbapenemase-producing *Enterobacterales* (CPE) continues to be an increasing risk for UHS and early identification of patients at risk and appropriate management is the key to reducing risk of transmission.

Antimicrobial resistance including CPE, continues to be a major public health risk as identified by the World Health Organisation and as outlined in the UK's updated five-year national action plan, (published in May 2024) for tackling antimicrobial resistance (Confronting antimicrobial resistance 2024-2029).



- 16 new CPE cases (from any sample site, including rectal screens and clinical samples) were identified in Q2 2025/26 compared to 15 in Q2 2024/25.
- 70 high risk patients were admitted to UHS in Q2 compared to 49 in Q2 2024/25.

Key actions to reduce risk and transmission from CPE remain ongoing including focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics especially carbapenem group of antibiotics; screening of patients for CPE including those admitted that meet the high-risk criteria for CPE carriage ensuring consistent application of high standards of infection prevention practices; regular review of

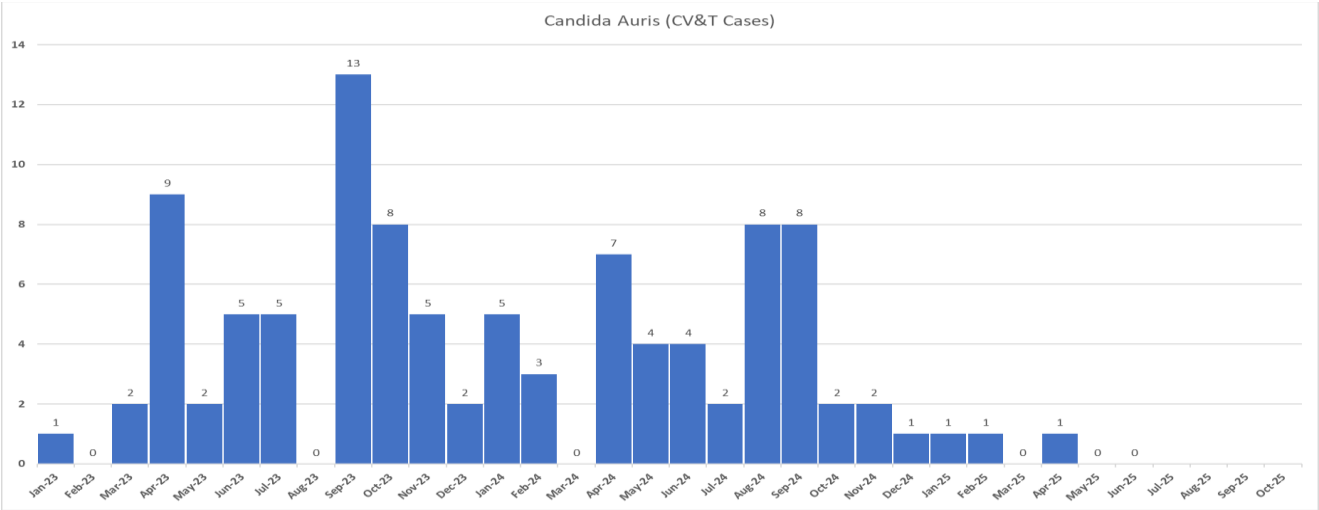
inpatient cases of CPE by the IPT for assurance that correct IP&C precautions are in place to reduce minimise risk of transmission to other patients. The UHS CPE Policy is currently under review.

2.6 *Candidozyma auris* outbreak

The outbreak of *Candidozyma auris* (previously known as *Candida auris*) centred on D4 Vascular ward at UHS, but also impacting on Trusts within the region whose patients access the UHS Vascular service, has continued into 2025/26. Control measures have remained in place and subject to ongoing review, with guidance and support from regional and national colleagues from UKHSA and other expert colleagues with experience of managing *C. auris* outbreaks.

Since the beginning of the outbreak in January 2023 to date (end of June 2025), 107 cases of *C.auris* have been confirmed within UHS with 100 of the cases specifically linked to the vascular outbreak (first declared in March 2023). However, there is clear evidence that the ongoing high-level focus and implementation of control measures, including extensive surveillance screening and enhanced IP&C and cleaning practices, is having a positive impact in controlling the outbreak with only 3 new cases identified since the beginning of 2025, the last of which was identified in April 2025.

Outbreak/incident meetings have continued to review the situation and control measures, with representation from HHFT, PHU, IOW, HIOW ICB, UKHSA, SCAS, HIOW NHS Trust, University Hospitals Dorset, and Dorset County Hospital NHSFT. A further meeting is scheduled for October 2025 where, if no further cases are reported, a view will be taken regarding closure of the outbreak and ongoing control measures.



2.7 Other Infections

Within UHS, we continue to see a wide range of infections (single cases, clusters and outbreaks), outside of those already detailed in the report. These have been identified through laboratory reporting, UHS surveillance systems, national notifications, notifications from clinical teams. All have required a combination of investigation, implementation of infection prevention and control measures, and ongoing monitoring and assurance.

2.8 Surgical Site Infections (SSI)

Continuous surgical site infection (SSI) surveillance (using UKHSA SSI modules) continues to be undertaken for elective hip and knee replacement surgery. The UHS surveillance system process includes the monitoring of SSIs before discharge, use of 30-day post discharge patient questionnaires and on readmission.

Hip Replacement

Year and Period	No. operations	Patient questionnaire No. Given	Patient questionnaire % complete	Inpatient & readmissions No.	Inpatient & readmissions %	Post discharge confirmed No.	Post discharge confirmed %	Patient reported No.	Patient reported %	All SSI * No.	All SSI * %
2025 Q1	90	87	90.0	1	1.1	0	0.0	0	0.0	1	1.1
2025 Q2	89	86	94.4	1	1.1	0	0.0	0	0.0	1	1.1

There were 2 (179) reported infected cases in Q1 & Q2 2025. As part of the UHS surveillance process, a root cause analysis of the infected cases was undertaken. A multidisciplinary meeting was held to review the 2 infected cases, with the aim of identifying patient risk factors, compliance to the NICE guidance for the prevention of SSIs, any learning and to agree on whether the SSI was avoidable or non-avoidable. Both cases were deemed as unavoidable.

Knee Replacement

Year and Period	No. operations	Patient questionnaire No. Given	Patient questionnaire % complete	Inpatient & readmissions No.	Inpatient & readmissions %	Post discharge confirmed No.	Post discharge confirmed %	Patient reported No.	Patient reported %	All SSI * No.	All SSI * %
2025 Q1	68	68	85.3	0	0.0	0	0.0	0	0.0	0	0.0
2025 Q2	73	73	94.5	0	0.0	0	0.0	0	0.0	0	0.0

There were no SSI reported in the knee category that met the UKHSA SSISS reportable classification in Q1 & Q2 2025.

2.9 Assurance of Infection Prevention & Control Practice standards, including environmental cleaning

Infection Prevention Practice standards

The Trust annual infection prevention audit programme remains in place for 2025/26 to monitor infection prevention and control practice standards in clinical and non-clinical areas.

In addition to the formal audits, ongoing monitoring of infection prevention and control practices continues through a range of avenues including as part of IPT visits and reviews of clinical areas and Ward leader/Matron walkabouts & spot checks.

High Impact Intervention Audits (care processes to prevent infection) - self-assessed audits:

	Month	Element	% Standards met
Preventing Surgical Site Infection	August 2025	Pre-Operative	97%
		Peri-Operative	91%
		Post-Operative	99%
Care of Ventilated Patients	August 2025		94%
Urinary Catheter Care	September 2025	Insertion	100%
		Ongoing	86%

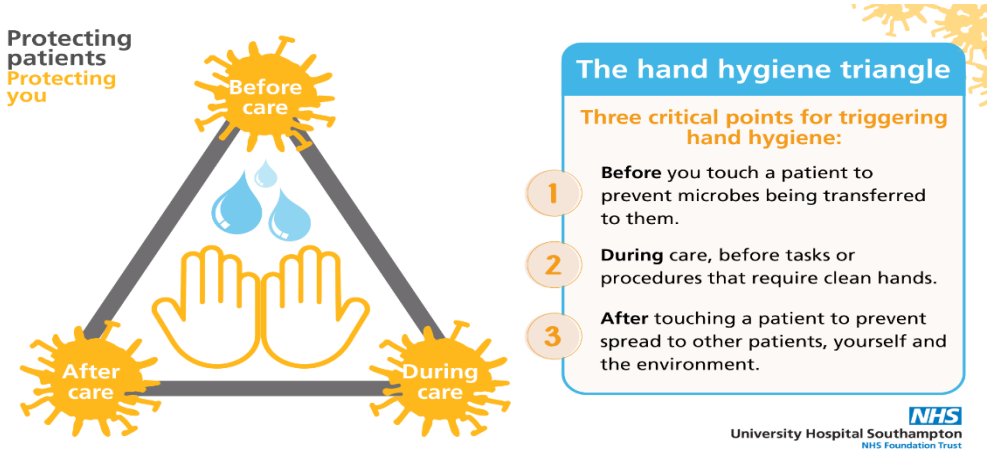
Miscellaneous Audits (all self-assessed)

Audit	Month	% Standards met
Personal Protective Equipment	July 2025	97%

Occupational Safety: Prevention of exposure (including sharps injuries)	July 2025	95%
Safe Management of Equipment	September 2025	97%

Hand Hygiene

Improving standards of hand hygiene practice remains an ongoing area of focus in 2025/26 in order to achieve consistent practice. In order to support ongoing improvement the Infection Prevention Team have adopted and launched a simplified framework for hand hygiene (the hand hygiene triangle) that communicates the critical points for hand hygiene in preventing the transfer of micro-organisms. The hand hygiene triangle reflects a number of the World Health Organisation 5 moments for hand hygiene (moments 1, 2 and 5) but in a way that clearly relates to how care is delivered with the aim that this simplified approach will be easier for staff to understand.



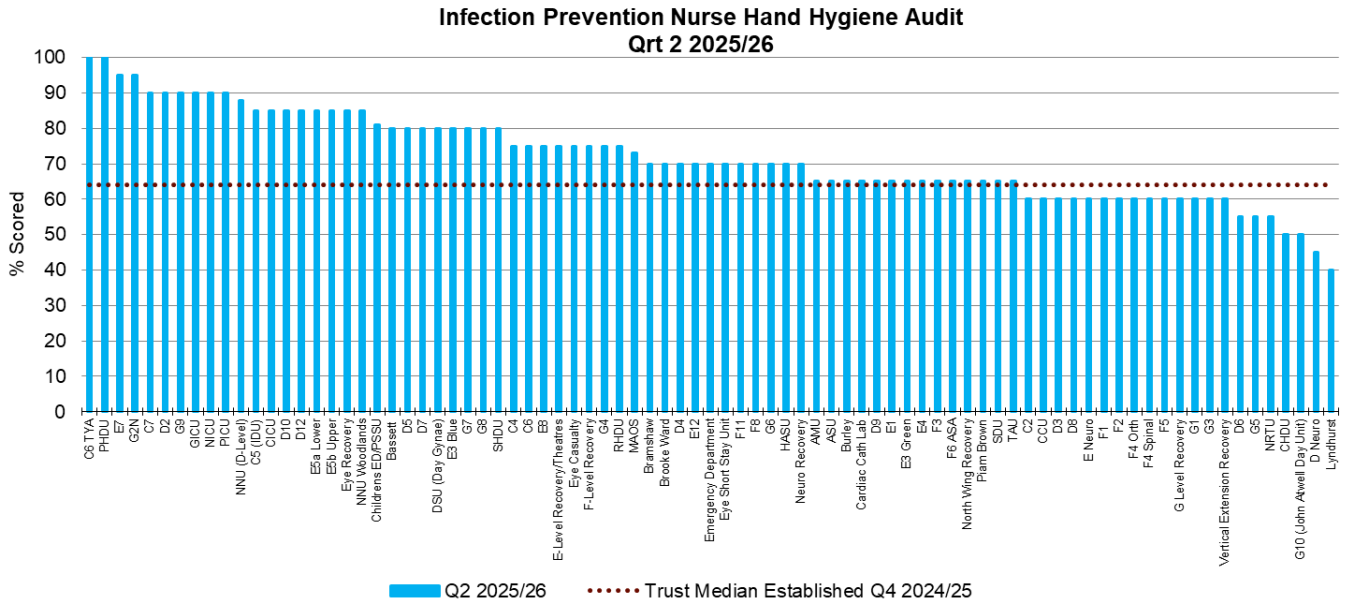
Covert hand hygiene audits carried were undertaken in Q2 by the IPT using an updated observation tool based on the hand hygiene triangle. In addition, the observations of hand hygiene practice were completed over a number of occasions in order to observe a wider range of staff (not on one visit to an area, as per audits in previous years).

Within the hand hygiene performance improvement framework (non-self-assessed audits) inpatient areas are measured against a performance improvement target with all areas expected to improve performance to score above the trust median score of 64% (the median score achieved in Q4 2025/26 audits).

Audit type	Month	% Standards met	
Inpatient areas (covert audit undertaken by Infection Prevention Nurses)	Quarter 2 2025	Overall trust median score = 72%	Against a performance improvement target of 64% (the trust median score established following Q4 2024/25).

Of the 83 inpatient areas audited in Q2 2025/26:

- 62 areas (75%) achieved on or above the Trust median score of 64% an increase of 17 areas compared to 45 areas (54%) in Q4 2024/25.
- 21 areas (25%) achieved below the Trust median score of 64%, compared to 39 areas (46%) in Q4 2024/25.
- 0 areas achieved equal to or below 30%, compared to 3 areas in Q4 2024/25.



Areas not achieving expected standards are required to implement actions to improve practice. The Infection Prevention Team continue to work with ward leaders and matrons to improve hand hygiene practice. Additional focus is also required to improve standards of hand hygiene practice amongst medical staff and other staff groups.

Infection Prevention Accreditation – Mid Year Review April 2025 – Sept 2025

Target**:** All areas to achieve full accreditation at year end 2025/26.

Accreditation status for each clinical area is calculated based on self-reported performance in audits undertaken as part of the Infection Prevention Audit Programme (self-assessed audits: high impact intervention audits, hand hygiene, miscellaneous audits), IPN Hand Hygiene Audits and clinical cleaning scores as detailed below:

- Self-assessed Audits: scores achieved across all audits. Non submission of an audit scores 0.
- IPN hand hygiene audits -score achieved across both audits in the year.
- Clinical cleaning scores: scores consistently achieved against national cleaning standards.

Progress: Trust overall performance (150 areas):

April to September 2025 midyear review (based on self-assessed audit scores only) a total of 73 areas were fully accredited (49%) and 20 areas partially accredited (13%).

56 areas did not achieve full or partial accreditation (38%).

- 16 areas in Division A
- 17 areas in Division B
- 23 areas in Division C

Non-submission of audits continues to be the main reason as to why areas are not achieving full accreditation.

Summary of actions to improve accreditation status:

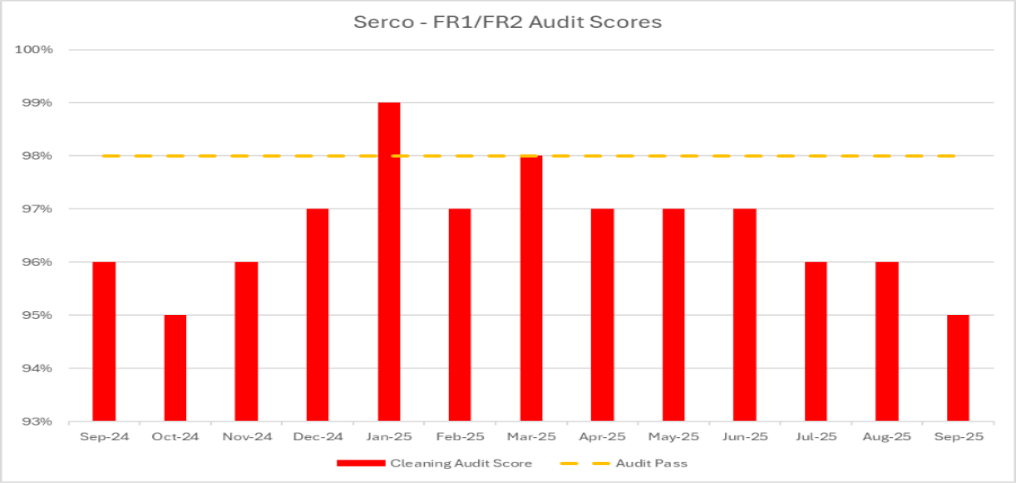
1. Divisions and Care Groups to review and take action in order to address those areas not meeting required standards, including ensuring that required audits are submitted as per the annual infection prevention audit programme.
2. The Infection Prevention Team to continue to work with areas to support achievement of full accreditation by the end of 2025/26.
3. Performance for individual clinical areas is subject to review by the IPT as part of a continual improvement process.

Environmental Cleaning

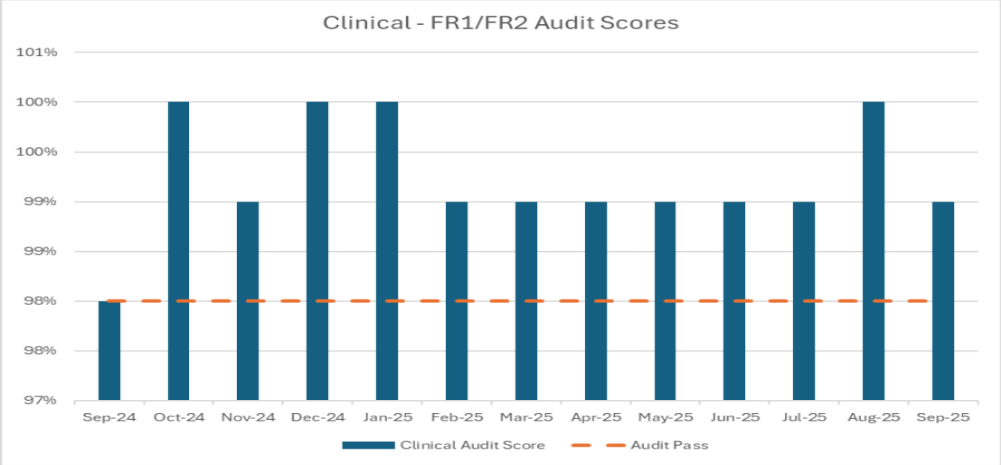
Monitoring of environmental cleaning standards (domestic and clinical) continues to be undertaken by the environmental monitoring team and Serco in Q2.

During this period, the EMT continue not to be operational at full capacity due to the vacant position of the clinical auditor and educator role within the team. The focus has remained to meet the requirements of the national cleaning standards with the levels of audits being consistent across all areas of the hospital. Ensuring star ratings are being updated and sitting at 5* across the entire trust.

The average score of Serco domestic audits per month is 99%. There has been a decline in the monthly pass percentage with the national target of 98%, not being achieved during Q2. Serco management have implemented a formal action plan to rectify this, which UEL EFCD are supporting Serco with. Updates on the action plan are presented and discussed with the Trust at fortnightly operational meetings as well as monthly overview meetings.



Clinical cleaning has seen consistent scores, with an average score sitting at 99% and clinical pass rates of 99% in July and September as well as 100% in August. This is a significant improvement from 12 months ago. The work completed by the clinical auditor & education lead prior to leaving has continued to demonstrate improvements in clinical cleaning across the site.

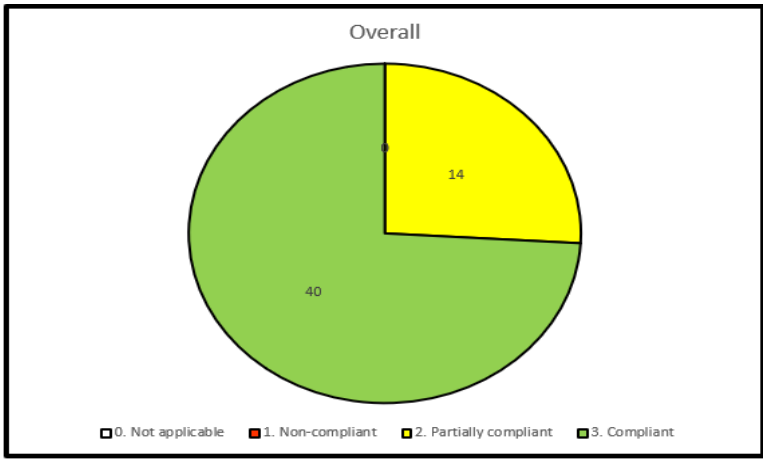


Infection Prevention and Control Board Assurance Framework.

The National IP&C Board Assurance framework was updated by NHSE in April 2025. The framework enables organisations to self-assess compliance with measures set out in the National Infection Prevention and Control Manual (NIPCM) for England, the Health and Social Care Act (2008) Code of practice on the prevention and control of infections, and other related disease specific infection prevention and control guidance issued by UKHSA.

The UHS self-assessment against the 10 key lines of enquiry within the framework was reviewed and updated in Q2 2025/26 and will be presented to the Infection Prevention Committee in November 2025.

Gaps in assurance have resulted in a number of elements being assessed as partially compliant, with either mitigating actions in place or actions identified to meet assurance.



2.9 Antimicrobial Stewardship.

Antimicrobial stewardship, along with the focus on infection prevention and control, is a key component in reducing antimicrobial resistance and is a key requirement within the Health and Social Care Act 2008 : Code of Practice for health and adult social care on the prevention and control of infections and related guidance (updated 2022), with a requirement for registered healthcare providers to demonstrate appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance The UK 5-year national action plan (NAP) for antimicrobial resistance

2024 to 2029 sets a target to reduce overall human antibiotic use by 5% by 2029, using calendar year 2019 as the baseline. This equates to a 1% reduction per year.

Appendix 1 provides a full report on antibiotic usage/consumption within UHS and performance against the NAP.

Key items to highlight:

Completion of HAPPI Audits

Mandatory requirement to monitor prescribing of antimicrobials in line with Health and Social Care Act 2008. At UHS this takes the form of 5 Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits per month per ward completed by ward pharmacists. Due to operational pressures the number completed falls short at less than 25% of what is expected. The results from the audits submitted demonstrate good documentation at initiation and review but over half are submitted by child health, we need to widen data capture across all clinical areas. AST team to explore increasing uptake and other methods to meet statutory requirements for monitoring antimicrobial usage.

Focus on IV to oral switch of Antimicrobials

Despite best efforts, education and raising awareness, we have not been able to change the proportion of IV to oral antimicrobial use. Therefore, benefits of reducing IV use have not been achieved.

Use of Broad-Spectrum Antibiotics

The use of broad-spectrum antibiotics – as proportion of Watch and Reserve to Access category – continues to be higher than targets outlined in the National Action Plan for antimicrobial resistance 2024-2029. Broader spectrum antibiotics are associated with higher *C. difficile* rates, increased adverse effects, and promoting antimicrobial resistance for the individual and public.

Administrative Support for Guidelines

Trust antimicrobial guidelines are the cornerstone of AMS (antimicrobial stewardship). Clinically these are updated by specialist pharmacists in conjunction with microbiologists and speciality teams. However, the administrative side to ensure these are available for clinicians to guide patient management is also undertaken by specialist pharmacists which represents a poor use of skill-mix and diverts from other clinical activity as well as introducing delay to updates as clinical activity takes priority.

OPAT service delivery

Current underutilisation of Out-Patient Parenteral Antimicrobial Therapy (OPAT) delivery as a method to free up bed capacity. Funding approved for a 9-month trial to increase and improve service provision, resulting in initiation of the Adult OPAT service in November.

Infection Advice

Microbiologists and specialist pharmacists continue to provide individualised advice for patients with infection via structured ward rounds, ad hoc advice and microbiologist led duty service.

2.10 Estates & the Built Environment

The design, planning, construction, refurbishment and ongoing maintenance of the healthcare facility has an important role to play in the prevention and control of infection. The physical environment should assist, not hinder, good practice.

Concerns continue to be highlighted in relation to the existing environment in many areas of our hospital sites (e.g. lack of mechanical ventilation, limited toilet/bathroom facilities, limited isolation facilities (side rooms), general repair of ward/outpatient environments) and the impact on preventing & controlling infection. Reviews undertaken by the IPT and other walkabouts continue to highlight a range of issues associated with the general fabric/repair of the environment which can have an impact on the ability to effectively prevent and control infection e.g. damage to the fabric of the environment which can provide a reservoir for micro-organisms and cannot be cleaned effectively. Whilst some progress continues to be made in addressing some of these issues funding remains a limiting factor.

The UHS EFCD team continue overall to have effective processes in place to ensure that consideration of IPC practices occurs throughout the planning, design, construction and refurbishment phases of a project, including regular consultation with the IPT.

Water Quality

The focus on water quality remains a priority for UHS due to the high number of augmented care units and immunocompromised patients. Waterborne infections such as *Pseudomonas* can cause significant morbidity and mortality to vulnerable patients, can delay discharge, and increase length of stay in addition to increasing the need to use broad spectrum antibiotics.

The Trust Water Safety Group has continued to meet quarterly with a remit to:

- Provide clear direction and oversee the strategic and operational implementation of water safety and hygiene management throughout the Trust.
- Support and steer action on water safety and hygiene to meet Trust objectives and local and national targets and statutory compliance.
- Ensure action is taken across the Trust to minimise the risk of infection emanating from water and ‘wet’ systems, e.g. legionella and pseudomonas, supporting the improvement in patient safety and the patient experience.
- Review of the programme and outcomes of monitoring of sampling for *Legionella* and *Pseudomonas*; review of risks and actions required/taken; review of water safety risk assessments for *Legionella/Pseudomonas*.
- Oversee delivery of actions identified in the annual water safety audit.

A sub-group is also in place with the remit to focus on key operational topics at each meeting, e.g. use of point of use filters, sampling. Focus of the subgroup in Q1/Q2 has been on the actions identified from the *Pseudomonas* risk assessments that were undertaken in all augmented care areas in March 2025.

Progress continues to be made in addressing *Pseudomonas* in our water systems (as demonstrated by a continued reduction in positive water samples) and in completing remedial works required to improve water hygiene.

Air Quality/Ventilation

Providing a clean environment, including fresh air, is considered essential to the healthcare environment. Good ventilation is an important line of defence for controlling transmission of infection.

General ventilation across UHS wards, outpatient areas and offices is variable, with only a small number of areas having good ventilation. Many of the general inpatient wards within the SGH & PAH sites have no mechanical ventilation or do not meet the current standard for inpatient areas of 6 air changes per hour. Many areas where ventilation is poor also experience high temperatures which affects both patient and staff wellbeing.

Ventilation remains on the estates risk register (Risk 489) and is identified as one of estates highest priorities for addressing. It continues to be included in the backlog maintenance replacement programme but requires funding. Long term solutions to improve/install mechanical ventilation in existing inpatient wards will require a large scale of work with potential disruption and significant investment. Long term

solutions to install ductwork will be scheduled in line with future ward refurbishment programmes and any newly built inpatient wards will be designed with mechanical ventilation.

The use of portable air purification units to wards/bays deemed to be at high risk of respiratory virus transmission/outbreaks and in high-risk areas such as admission units have continued to be used to address the risk relating to poor/lack of ventilation.

3.0 Operational and financial impact of Healthcare Associated Infection

Outbreaks of infection e.g. Norovirus, Influenza, COVID-19 can result in significant impact on operational capability/capacity of the Trust resulting in cancellation of elective procedures and staff absence. The increased length of stay and treatment costs associated with healthcare associated infection e.g. C. difficile, *C. Auris*, bloodstream infections, contributes further to decreased operational productivity. A recent study has estimated the total annual cost of healthcare associated infection in the UK to be 774 million pounds.

4.0 Appendices

Appendix 1: Pharmacy Anti-infectives Team Report: Q2 2025/26
Appendix 2: Division A Matron Report for Q1&Q2 2025/26
Appendix 3: Division B Matron Report for Q1&Q2 2025/26
Appendix 4: Division C Matron Report for Q1&Q2 2025/26

Appendix 1: Pharmacy Anti-infectives Team Report: Q2 2025/26

Pharmacy Anti-infectives Team Report to IPC
November 2025: Q2 2025/26

Introduction

Anti-Microbial Resistance (AMR) is an emerging crisis threatening health outcomes across all healthcare settings. The Health and Social Care Act 2008 outlines responsibilities for antimicrobial stewardship (AMS) activity to ensure appropriate antimicrobial use to optimise patient outcomes whilst reducing the risk of adverse events and antimicrobial resistance. AMS functions well when there is strong leadership across clinical specialities and when adequate resources are deployed to allow effective change to occur. At UHS oversight is provided by the antimicrobial stewardship team (AST) reporting via this medium to TEC. Whilst there are no set quality improvements linked to AMS in FY 25/26; the second UK government AMS policy paper National Action Plan (NAP) 'Confronting antimicrobial resistance' 2024 to 2029 was published in May 2024 and sets out targets relating to antimicrobial stewardship.

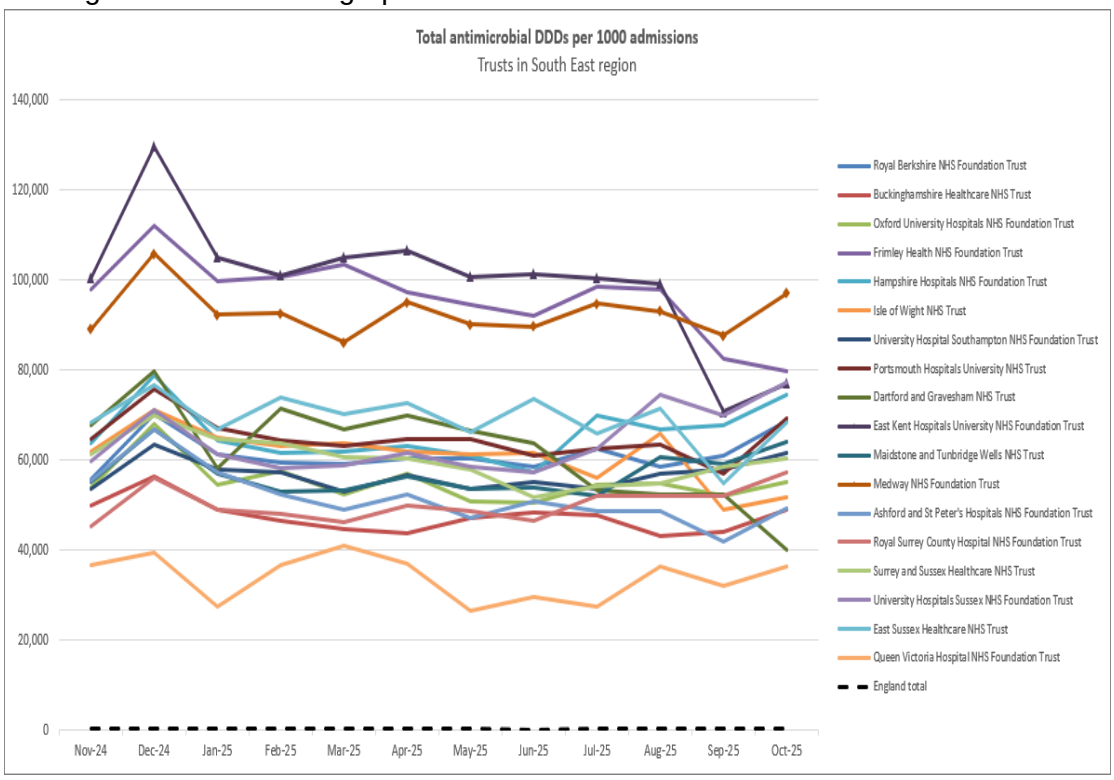
On average, 40% of inpatients at UHS are prescribed one or more antimicrobials at any one time. Current approaches to support better antimicrobial usage are being directly impacted by operational pressures and lack of time available for ward based clinical staff to focus on antimicrobial prescribing and review. This has been demonstrated by the failure to change prescribing practice relating to switching from IV to oral antibiotics and failure to meet statutory obligations for monitoring of antimicrobial prescribing.

1. Antibiotic Usage

1a. Total Antibiotic Consumption

The NAP sets a target to reduce overall human antibiotic use by 5% by 2029, this equates to a 1% reduction per year, so a 2% reduction in 2025/26 compared to 2019 baseline. Unfortunately, the RX Info system used to provide usual metrics is not functioning fully so we are using graphs provided by our Regional AMR data analyst. The graph below shows total antibiotic use (based on dispensing records) adjusted for activity in comparison with other trusts in the SE region. We will report next quarter on overall use as we expect antibiotic use to increase in the winter respiratory infection season, an uptick is

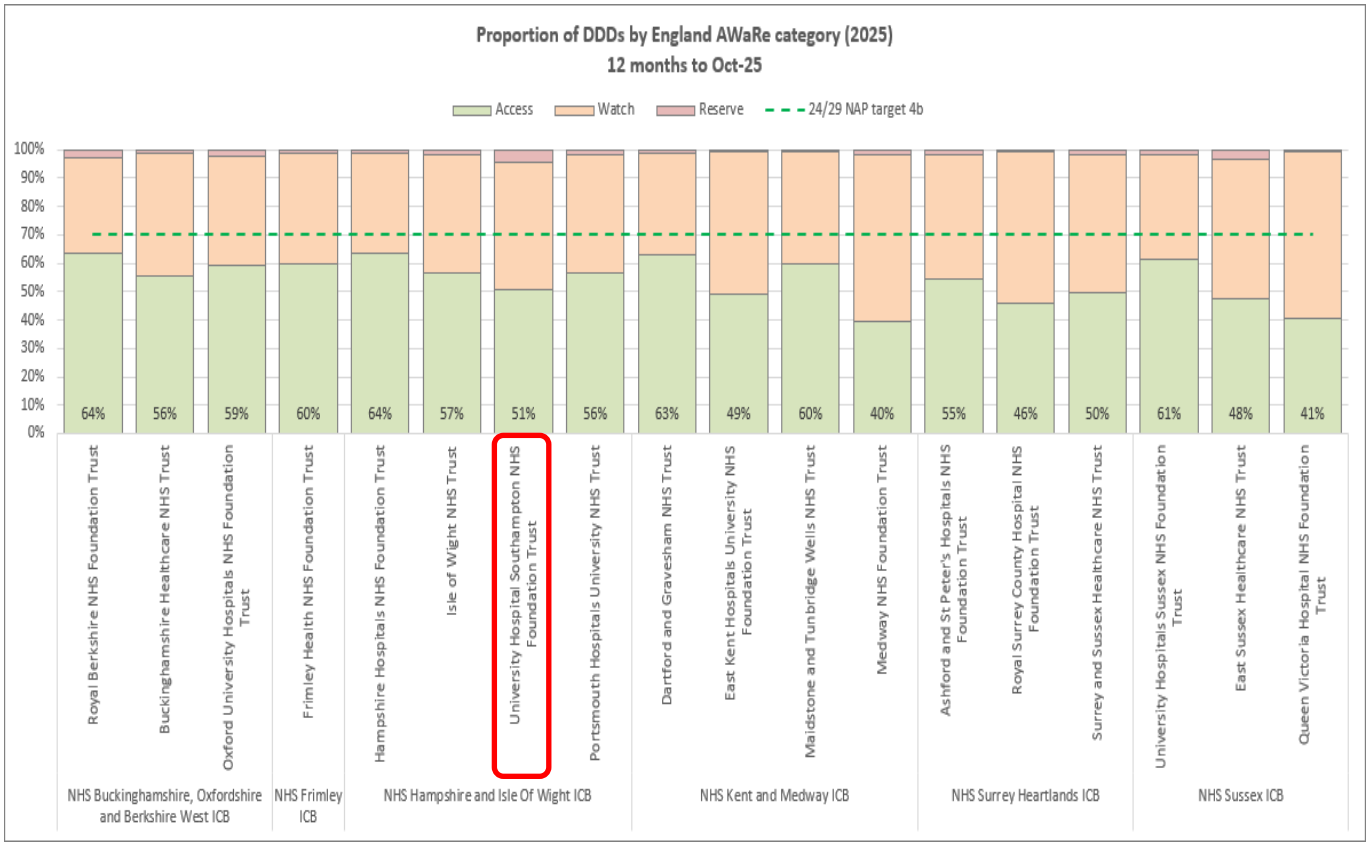
starting to be seen in this graph.



1b. Type of Antibiotic Prescribed

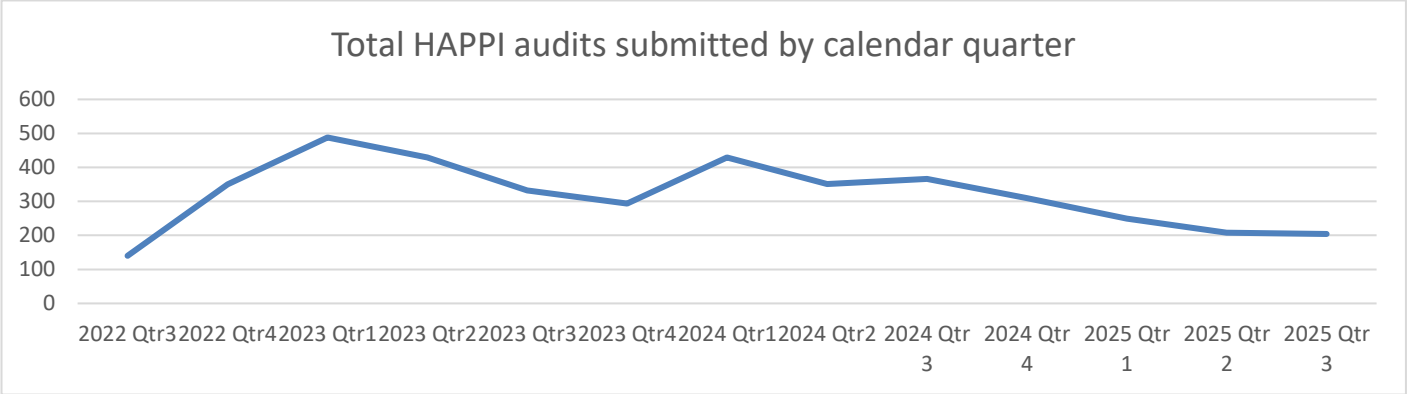
The NAP requires that the proportion of antibiotics from the Access category of the UK adapted WHO AWaRe antibiotic classification should increase to 70% of total human usage by 2029. In the AWaRe antibiotic classification system antibiotics are classified into three groups: Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms and their use should be limited. Watch and Reserve antibiotics tend to carry a higher risk of *C. difficile* infection and causing AMR.

The chart below shows UHS proportion use by antibiotic category in comparison to other trusts in the SE region. Further work is needed to ensure when antibiotic guidelines are updated access category antibiotics are chosen when possible. Our high use of reserve antibiotics when compared to other trusts has historically been assumed due to our cystic fibrosis population. However, given the advent of newer disease modifying drugs reducing the need for prolonged antibiotic courses further work is needed to look at UHS high use.

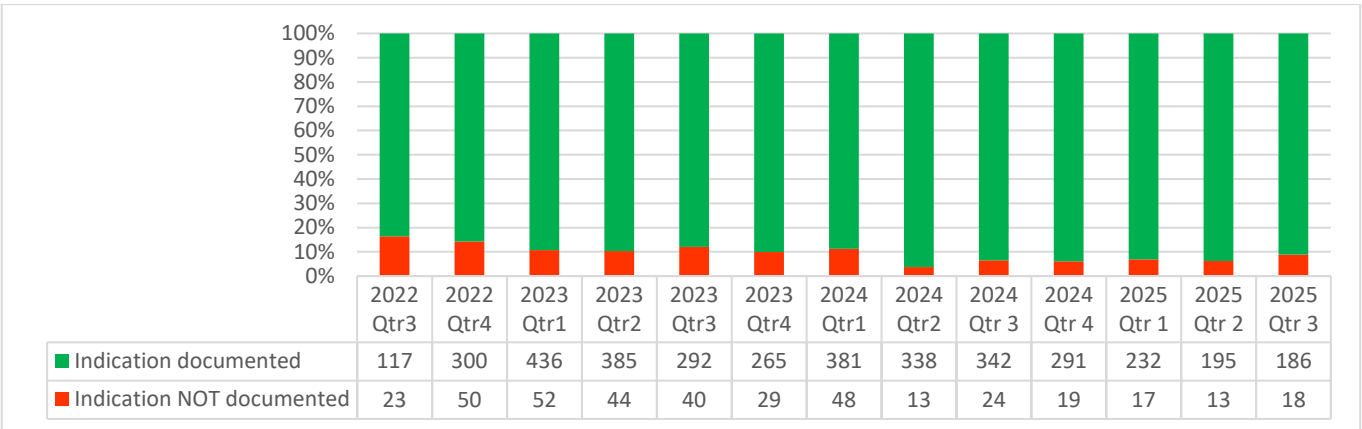

Proportion of DDDs by England AWaRe category (2025)
12 months to Oct-25
Access
Watch
Reserve
24/29 NAP target 4b
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
64%
56%
59%
60%
64%
57%
51%
56%
63%
49%
60%
40%
55%
46%
50%
61%
48%
41%
Royal Berkshire NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Oxford University Hospitals NHS Foundation Trust
Frimley Health NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Isle of Wight NHS Trust
University Hospital Southampton NHS Foundation Trust
Portsmouth Hospitals University NHS Trust
Dartford and Gravesham NHS Trust
East Kent Hospitals University NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Medway NHS Foundation Trust
Ashford and St Peter's Hospitals NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
University Hospitals Sussex NHS Foundation Trust
East Sussex Healthcare NHS Trust
Queen Victoria Hospital NHS Foundation Trust
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
NHS Frimley ICB
NHS Hampshire and Isle Of Wight ICB
NHS Kent and Medway ICB
NHS Surrey Heartlands ICB
NHS Sussex ICB

1c. Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) Audits

These are rolling audits of 5 patients per ward per month to assess appropriateness of antimicrobial prescribing. This chart shows the number of audits carried out per month, which continues to show a decline due to bed pressures and focus on discharge is diverting pharmacists from inpatient care.



Documenting the indication for an antibiotic is part of the national Start Smart then Focus antimicrobial stewardship toolkit. The audits continue to show this occurs with over 90% of audited prescriptions having a documented indication in the medical notes.



The number of times guidelines were followed (or justifiably deviated from) remains high (85.4%). Revision and updates to the antimicrobial guidelines in the Eolas system is an ongoing workstream, with significant administrative burden, currently undertaken by clinical pharmacists.

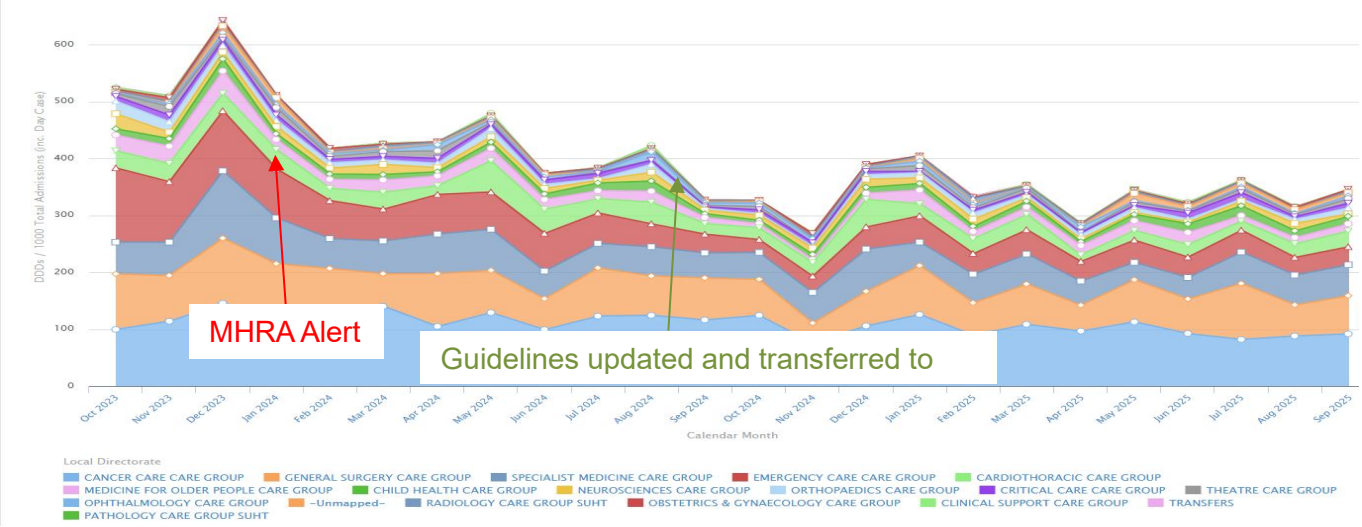
	Q4 24/25	Q1 25/ 26	Q2 25/26
On guideline	72.30%	75.6%	64.3%
Off guideline justified	15.7%	13.6%	21.1%
Off guideline not justified	2%	2.3%	6.6%
N/A no indication documented	1.6%	0.9%	1.4%
N/A no guideline available	8.4%	7.5%	6.6%

2. Stewardship Targets

2a. Reduction in Fluoroquinolone use

Following the updated MHRA alert in January 2024 mandating that this class of antibiotics (including ciprofloxacin, levofloxacin, moxifloxacin and delafloxacin) should only be prescribed when other commonly recommended antibiotics are inappropriate, work has been done to update guidelines and inform prescribers. Guideline updates to minimise fluoroquinolone use were published in August 2024. Overall use has reduced over the last 24 months, but we need to remain vigilant and ensure they are only used when there is no alternative option.

Total Fluoroquinolone issues (DDDs per 1000 admissions) at UHS for each directorate October 2023 to September 2025



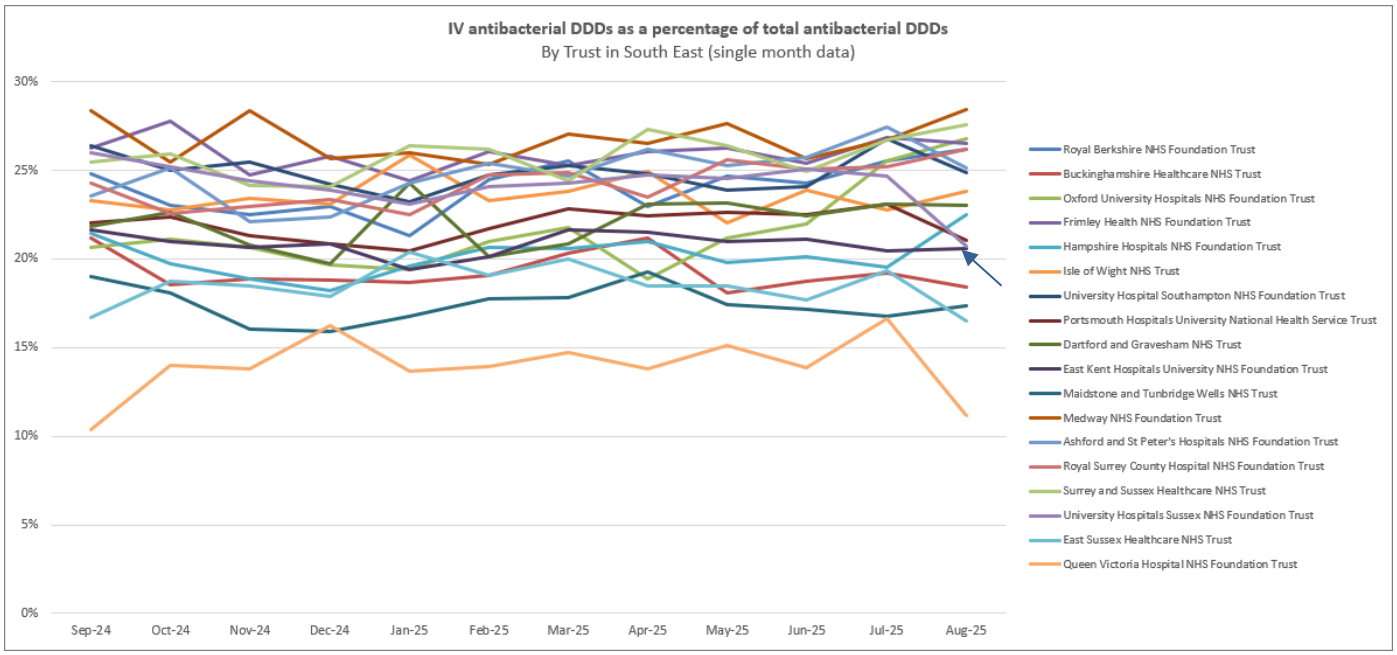
Ref: Internal reporting; source data from Rx info(Refine)

Ensuring patients are counselled on the risks associated with fluoroquinolones remains an important focus. A HIOW wide patient information leaflet is being developed by the ICB AMS group for local adoption. This is in the process of being implemented and will hopefully be completed by the end of the year.

2b. Timely IV to Oral switch

Switching antibiotics from intravenous (IV) to oral offers several benefits including: reduced nursing time, shortened length of hospital stay, fewer healthcare-associated infections, and lower plastic waste. This initiative was a 2023–24 quality improvement CQUIN and remains a key focus moving forward. Estimates suggest that 20% of patients on IV antibiotics at UHS could be switched to oral therapy—potentially saving £250k–300k annually in drug costs and freeing nursing capacity equivalent to 15 WTE. This remains a stewardship target due to the obvious benefits it provides.

The graph below outlines the % of antibiotic doses administered as IV from the total compared with other trusts in the SE region over the last year. UHS hovers just over the 20% proportion meaning that just under a quarter of all antibiotic doses given at UHS are via the intra-venous route, the goal is to reduce this. We can also see that the line remains fairly static indicating no real change in practice. This will remain a priority stewardship focus for the remainder of the year however it must be noted that engagement is required from the wider MDT and responsibility for antimicrobial review and prescribing needs to be acknowledged by clinical teams caring for patients.



2d. Targets for the remainder of 2025/26

- Continue to work on programme of guideline updates
- Develop stronger governance and educational links to encourage collaborative working with clinical specialities to raise profile of AMR and highlight how antimicrobial prescribing supports the aims of AMS
- Continue with work on IVOS to promote switch and initiation of oral antimicrobials
- Work with pharmacists to increase HAPPI audit completion and explore new methods to meet statutory monitoring requirements

Implement new adult Outpatient Parenteral Antimicrobial Therapy (OPAT) service delivery to support home administration of intravenous antimicrobials to free up hospital beds

Appendix 2: Division A Matron Report for Q1&Q2 2025/26

Care Groups: Cardiovascular and Thoracic, Critical Care, Neurosciences, Spines, Surgery, Theatres and Anaesthetics, Trauma and Orthopaedics.

Matrons: Jenny Dove, Sonia Webb, Jean-Paul Evangelista, Tracy Richards, Simon Jacobs, Linda Monk, Charlie Harding, Beverly-Ann Harris, Rebecca Tagg, Kerry Rayner, Kate Stride, Jack Bower, Mitzi Garcia, Claire Liddell, Jude Salas, Kaylee Osborn, Sam Woodward, Tracy Mahon.

Clinical Lead: Edwin Woo, Sanjay Gupta, Andy Cowan, Poppy Mackie, Wai Wakatsuki, Boyd Ghosh, Jonathan Hempenstall, John Knight, Eleni Balabanidou.

Date of Report: October 2025

Author: Colette Perdrisat – Divisional Director of Nursing and Professions

MRSA BSI Cases	
April 2025	MRSA BSI on F2 78-year-old male admitted due to fall in the community, striking left side of face on kerb, sustaining a wound on right thumb with left maxillary and orbital fractures. Cannula on right hand was inserted by ambulance staff on accident scene and removal was documented 6 days later. UHS VIP Score chart partially completed. Patient tested negative for MRSA on admission.
Key Learning / Actions / Improvements	
Critical care: **CV&T**: Nil cases Q1/2 **Neuro:** **Surgery**: Nil cases **Theatres:** **T&O** -VIP scoring and care- audits conducted by ward team, on the spot learning delivered. Previous cases which linked- prescribing of correct washes.	

Incidents / Outbreaks of Infection and Periods of Increase Incidents	
Cardiac Theatre Instruments	Cardiac theatres instruments are disintegrating with loose particulates present - some instruments in cardiac surgical packs were contaminated and rusty.
C.difficile period of increase incidence in C2	2 cases of healthcare associated C.difficile in C2 with a 28-day period.
Cardiology TOE Probe Decontamination	2 TOE probes were water damaged via the washer disinfector process when the vault box leaked
C.difficile period of increase incidence in F3	2 cases of healthcare associated C.difficile in F3 with a 28-day period.

F5 & E5U C-Diff cases	1 patient on F5 Sept 2025 1 patient on E5U Sept 2025
Key Learning / Actions / Improvements	
GICU	**MRSA** IP&C patient review x 7 between April-August. Lack of documentation acknowledging MRSA status, isolation risk assessment forms not completed/ updated, PPE not always worn, lapses in hand hygiene compliance, risk reduction/ decolonisation prescriptions incorrect (Octenisan prescribed rather than chlorhexidine 4% washes). Learning: information cascaded via email, newsletter and face to face discussions on unit. Spot checks continue to ensure/ educate necessity for MRSA risk reduction measures, to check isolation risk alerts as part of the daily safety checks and other standard IPC measures are adhered to. **C.Difficile** 9 cases between April-October. Issues raised where hand hygiene and PPE lapses, missing documentation on integrated care pathway (frequent) and isolation risk assessment forms, antibiotic prescriptions x1 not started following positive rapid biofire result and x1 not documented justification for antibiotic prescription. Commode not always found to be clean. Learning: information cascaded via email, newsletter and face to face discussions on unit, prompt added to task section on CIS to complete integrated care pathway if patient develops CDiff. – but further reminders are required to complete. Education on medical team study session to discuss learning from CDiff cases. Spot checks by GICU senior nursing team on ward cleanliness including commode checks. All key learning is shared via email and in local IP newsletters and MSD across critical care.
NICU (review also took place on F4 Spinal)	**MSSA BSI** August 2025 related to peripheral cannulas. Cannula x2 inserted in ambulance with no documented evidence of ANTT adherence. The cannula remained in situ with TDS assessment (1 x 5 days, 1 x 4 days) The cannula inserted in ED where ANTT was used, remained in situ 6 days. Documentation indicated the arms appeared ‘red, swollen and hot’. Incorrect assessment recorded on Metavision of insertion site with a recorded 0 score but there were observations of erythema, swelling and colour. There were undated dressings on the cannula from NICU, there was some confusion with which date to be recorded (insertion or date of dressing change). Correct hand hygiene was observed, correct dressing was applied, ANTT was adhered to on observations of other patients, Learning: Staff have been reminded to remove cannulas within 24 hours if placed in emergency e.g. ambulance where there is no evidence of ANTT use as per UHS guidelines and have been refreshed on correct documentation of VIP scoring and to date the dressing with the day it was changed. All key learning is shared via email and in local IP newsletters and MSD across critical care.

Infection Prevention and Control Mandatory Training Compliance:

Critical Care:

CV&T:

Neuro:

Surgery:

Theatres: Infection prevention and control- clinical (2 yearly) 81.2%

Infection prevention & Control – non clinical (3 yearly) 83.2%

Hand hygiene (once only) 96.7%

ANTT (once only) 79.3%

Managing stat and mandatory against service delivery – especially difficult in current time due as result of NHSP rate reduction and recent spike in sickness.

T&O: IP conference attended by IP ward links and lead

Progress and Success:

Critical care: Environmental monitoring audits – clinical cleaning 98%-100%; most IP audits 100%.

External waste audit in October seemed generally positive but awaiting formal report, learning shared with the teams via local IP newsletter.

We have begun to recycle enteral feeding and supplement bottles in agreement with the waste management team as we are generally compliant with our waste management following the success of the segregation work carried out to come off high incineration in the last quarter. Ongoing monitoring and spot checks to maintain this with support of our waste ambassadors and nurses who have an enthusiasm for sustainability. Other sustainability with associated cost saving measures are being investigated and will hopefully begin in November.

More patients receiving HIPEC have been admitted to **SHDU and GICU**. Actions and learning have been required to manage the patients' body fluid waste and correct PPE (ie disposal in purple lidded bins). We are continuing to liaise with the medical consultants regarding processes, there are plans for a SOP/ guidance to be written to support the teams caring for these patients in these areas. Nursing and medical colleagues have been informed of current practice requirements.

CV&T:

Neuro:

Some good compliance with hand hygiene audits although struggling with consistency as most recent audits =

- D Neuro : 45%
- E Neuro : 60%
- F4 Spinal : 60%
- F8 : 70%
- HASU : 70%
- NRTU : 55%

Good compliance with personal protective equipment

Surgery:

188 SUR E8 Ward	Infection Prevention &	4	100.00%	0.00%
188 SUR Education	Infection Prevention &	1	100.00%	0.00%
188 SUR F11 IF	Infection Prevention &	33	78.80%	21.20%
188 SUR F11 IF	Infection Prevention &	3	100.00%	0.00%
188 SUR F5 Ward	Infection Prevention &	39	84.60%	15.40%
188 SUR F5 Ward	Infection Prevention &	4	100.00%	0.00%
188 SUR GI Nurse Specialist	Infection Prevention &	25	92.00%	8.00%
188 SUR GI Nurse Specialist	Infection Prevention &	4	75.00%	25.00%
188 SUR Maxilofacial Surgery	Infection Prevention &	7	100.00%	0.00%
188 SUR Med Staff ENT	Infection Prevention &	36	47.20%	52.80%
188 SUR Med Staff GI	Infection Prevention &	91	55.00%	45.00%
188 SUR Med Staff Urology	Infection Prevention &	33	45.50%	54.50%
188 SUR OMF Medics	Infection Prevention &	23	34.80%	65.20%
188 SUR Outpatient Services	Infection Prevention &	18	94.40%	5.60%
188 SUR Surgery Discharge Loun	Infection Prevention &	1	100.00%	0.00%
188 SUR Urology Day Surgery Uni	Infection Prevention &	36	72.20%	27.80%
188 SUR Care Group Manager	Infection Prevention &	9	66.70%	33.30%
188 SUR Urology Admin	Infection Prevention &	15	86.70%	13.30%
188 SUR OMF Admin	Infection Prevention &	5	80.00%	20.00%
188 SUR Urology Day Surgery Uni	Infection Prevention &	3	100.00%	0.00%
188 SUR Surgery Discharge Loun	Infection Prevention &	3	100.00%	0.00%
188 SUR GS Admin	Infection Prevention &	11	81.80%	18.20%
188 SUR Admin	Infection Prevention &	5	100.00%	0.00%
188 SUR ENT Admin	Infection Prevention &	12	75.00%	25.00%

Theatres: Theatre clinical and Serco cleans improved position with all audits >97% compliance rates.

T&O: QI project with SSI nurse lead and FY1 regarding peri operative temperature recording. (particular link to infection post operatively if not treated when out of required range). Lots of actions and discussion across theatres, recovery & wards. Phase 2 now in progress. Further work shared at T&O elective promotion week

Ongoing Challenges:

Critical care: GICU and CICU: Continue to remind medical team to prescribe chlorhexidine washes for MRSA positive patients rather than the usual Octenisan. The pharmacy team are supportive with amending prescriptions during their reviews.

GICU: Some domestic cleaning EMT audit failures, Serco have written action plans with signs of improvement in weekly reviews by EMT and ambassadors. Senior nursing team monitoring cleanliness of environment including commodes and beds as they have been found to be unclean.

GICU: Hand hygiene audit 90% May & June improvements in July, ongoing reminders to adhere to policy.

Critical Care: Eye protection not worn when inserting CVADs or for some nursing staff during risk of splash, encouragement and reassessment showed improvements, but continuous reminders required for most medical staff across CC to wear for CVC insertions despite reminders and having a variety of options available and forms part of the audit.

We continue to see dirty beds and stained mattresses arriving to **GICU, CICU and SHDU** from the wards, supposedly clean and the bed made up with linen. We endeavour to check the beds and mattresses on arrival and complete AERs when able, otherwise they are identified during our spot checks by IP link nurse and EMT during their audits. We are frequently having to clean the beds as there is obvious body fluids on the frame and rails, and teletrack the mattresses back to stores for replacements due to severe staining and offensive odours.

CV&T: Unable to recruit to care group IFC lead due to financial position. Non elective vascular admissions being transferred to UHS with undeclared infections

Theatres: Financially issues with replacing rusty wheel on trolley and waste bins- working with UEL. Issue picked up in recent audit of T&O theatres.

Lack of designated isolation areas in F level recovery. Managing the risk with mitigation in place

Pressure on SDU side room capacity especially with the need to support IR with admitting and post procedure spaces

Neuro:

Some improvement required on C Neuro decontamination audit

Increased incidence of C Diff declared on E Neuro – now resolved

COVID outbreak declared on F8 twice – now resolved

Surgery: Hosted patients infection status not always being handed over correctly and there have been a few incidents of patients moved who have then required isolating.

T&O: -Side rooms within T&O are very commonly required for patients with behavioural concerns who cannot be within a larger bay for protection of others (V&A) and there are also patients who benefit from a quieter environment (such as those with autism/LD) where a side room provides that for them, this therefore lessens the options for infection.

Summary of Action since Last Report, Current Focus and Action Plan:

CV&T: Focused on reduction in candidozyma auris within care group specifically vascular patient cohort. Oversight and responsibility for staff training for IFC reverted to ward leaders.

Critical care: HCID emergency boxes and kit have been updated and are available in GICU if required. Lead IP link sister has had HCID training alongside IPT and is booked onto the HCID trainer course due in April. Education is now planned for the GICU medical teams, CCOT, resus, CC tech teams and GICU senior nursing teams, starting in November.

Critical Care IP link sister continues to support the care group, completing observations of practice, surveillance to ensure staff are following policy and providing assurance that infection prevention practices are adhered to. Information is cascaded via newsletter, emails and one to one education whilst in the clinical areas.

Theatres: Continue to work with IHSS and UEL on theatre instruments- monitoring closely with clear escalation, refurbishment of several cardiac sets have been undertaken.

Review of Lymington sets being actioned.

New theatres scrubs to be launched on 1st of December.

Neuro:

Action plans written for cannula care per ward and actions shared at governance. Learning taken especially around how to care for regional patients that arrive with a cannula

Action plans written for catheter care per ward and actions shared at governance

Surgery:

T&O:

Any Other Issues to Bring To the Attention of TEC and Trust Board:

CV&T: Nil

Critical care:

Theatres:

Neuro:

Cleaning audits:

C Neuro – 4 x audits all 5 star

D Neuro – 4 x audits all 5 star

E Neuro – 5 x audits all 5 star

Neurophysiology – 1 x 5 star audit

Neuro Outpatients – 3 x audits all 5 star

Neuro public areas – 2 x audits both 5 star

Surgery:

T&O:

Date this report will be an agenda item at Care Group Governance Meeting	Date this report will be an agenda item at Divisional Governance Meeting

Appendix 3: Division B Q1&2 Matron and CGCL Report

Care Groups: Cancer Care, Emergency Medicine, Helicopter Emergency Medical Services, Medicine/Medicine for Older People (MOP), Ophthalmology, Specialist Medicine.

Matrons: Steph Churchill, Matt Payne, Julia Tonks, Carole Spratt, Sandra Souto, Claire Smith, Susie Clarke, Steve Hicks, Malanie Ivory, Gillian Lambert, Raquel Domene Luque, Kirsty Turner, Samatha Brownsea, Nat Kinnaird, Gemma Hobson, Kat Black

Clinical Lead: Mathew Jenner, Jas Bhullar, Paddy Dennison, Julian Sutton, Aris Konstantopoulos, Serafeim Antonakis

Date of Report: October 2025

Author: Suzy Pike – Divisional Director of Nursing and Professions

MRSA BSI Cases
None
Key Learning / Actions / Improvements
N/A

Incidents / Outbreaks of Infection and Periods of Increase Incidents	
CPE Outbreak in D6	CPE positive patient identified on D6. Contact screened positive for CPE - identical on typing.
COVID 19 Outbreak in E7	3 COVID 19 positive patients across two bays and 2 staff members off sick with respiratory symptoms
Suspected Avian Influenza HCID no identified in ED	Patient had recent travel to Pakistan but was not identified for many hours that could be at risk of having an airborne HCID there was not isolated.
COVID 19 Outbreak in G5	3 COVID 19 positive patients in G5 across two bays
COVID 19 Outbreak in D12	3 COVID 19 positive patients in D12 across two bays
Key Learning / Actions / Improvements	
AMU Flow coordinator team and admin team working to improve review and identification of known infections by checking any alerts and isolate promptly. **Spec Med**- Nil in response to incidents listed above.	

Infection Prevention and Control Mandatory Training Compliance:

Ophthalmology

- Infection Prevention & Control - Clinical [2 Years] 79.80%
- Infection Prevention & Control - Non-Clinical [3 Years] 86.70%

AMU
Monthly report reviewed by Matron and any outstanding staffed prioritised- IPC training 99% in September 2025.

Spec Med
Not included in IPT hand hygiene audit in Q2.

Progress and Success:

Ophthalmology:
•All areas are working through the accreditation framework to ensure high standards.
•Improved Cleaning Standards audit results across the Unit.

Audit results

- **Safe Management of Equipment Audit**

Ward	Overall Score		Ward	Overall Score		Ward	Overall Score
ESSU	100		Eye Casualty	95		Eye OPD	100
Eye Theatres	100						

- **Hand Hygiene Practice Audit**

Ward /Area	Total No of Obs.	IPN HH Audit Q2 2025/26
Eye Casualty	20	75
Eye Recovery	20	85
Eye Short Stay Unit	20	70

- **Preventing Surgical Site Infection**

PERI-OPERATIVE

Ward	Overall Score	
Eye Theatres	100	

- **Use of Personal Protective Equipment Audit**

Ward	Overall Score		Ward	Overall Score		Ward	Overall Score
ESSU	100		Eye Casualty	100		Eye Theatres	100

AMU
AAU opened and air scrubber in place to facilitate safer IPC.

Spec Med- 100% in all reporting areas for Mgt of equipment audit, exc Managed Care/Infusion unit- to complete
2024/2025- Full IPT accreditation received for listed areas.

Specialist Medicine

Full Accreditation

Ward	2024 2025 %	Ward	2024 2025 %	Ward	2024 2025 %
Cystic Fibrosis	99	Dermatology	100	Endoscopy	100
Victoria House Managed Care Infusion Unit	100				

Ongoing Challenges:

Ophthalmology:

- There have been an increase in Endophthalmitis Cases in May and Septembers. Cases have been investigated and no common factors have been reviewed.

May	4- Escalated. IPC review. No common factors found
September	4-Investigated. IPC review. No common factors found

AMU
Visiting teams non-compliance with correct PPE and hand hygiene processes.
isolation of infections delayed due to limited cubicle capacity and flow out of AMU.

Spec Med- Ongoing challenges with sharps management in Derm- reported by teams that the amount of sharps bins for different items is confusing (in the surgery rooms specifically). New poster generated and taken through local governance. Escalated- no other areas reporting the same challenges.

Mattress 'audit' on pause in Derm due to absence of HK (held in recruitment controls). Individuals are checking the trolley mattresses regularly and the weekend HK does a thorough check weekly. This has continued to identify mattress issues which are reported and replaced accordingly so we have assurance that checks are still occurring.

Infection prevention ward accreditation and audit: Partial accreditation for TRC/D level. No accreditation for PFT and sleep. **Action:** Sam and Gemma have linked with team leads to obtain assurance on future compliance with infection prevention audits and action plans to be shared at local governance

Summary of Action since Last Report, Current Focus and Action Plan:

Ophthalmology:

- Close monitoring of Endophthalmitis cases.
- Endophthalmitis Outbreak Management SOP under development.

Any Other Issues to Bring To the Attention of TEC and Trust Board:

None

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
October 2025	October 2025

Appendix 4: **Division C Q1&2 Matron and CGCL Report**

Care Groups: Child Health, Clinical Support, Maternity, Pathology, Radiology, Trust Outpatients, Women and Newborn

Matrons: Catherine Roberts, Sarah Owen, Jenna Burchmore, Helen Rogers, Lorna St John, Lucy Price, Rachel Hanley, Isabella Byrne, Sarah Stacey, Rebecca Tagg, Katie McAuley, Karen Rendall, Felicity Oldman, Laura Campbell, Hannah Mallon, Ronilo Ramos, Kaite Symcox Green

Clinical Lead: Charlie Keys, Charlotte Lane, Jan Patel, Balamurugan Thyagarajan

Date of Report: October 2025

Author: Louisa Green – Divisional Director of Nursing and Professions
Emma Northover – Director of Maternity

MRSA BSI Cases	
July 2025	MRSA BSI in Maternity 29 year old Patient admitted to MDAU due to fetal distress and had a cat 1 C-section under regional for abnormal antenatal CTG. Cannula and urinary catheter inserted. Not known to have MRSA. Does not meet the criteria for an MRSA screen, but no record of MRSA questions asked on admission. Re-admitted to MDAU due to feeling unwell since 15/07 with hot/cold shivers, intermittent abdo pain and offensive PV discharge. C-section wound healing well. Full septic screen including HVS. 17/07 MRSA positive in blood culture/HVS. 18/07 MRSA negative in CNG. MC&S negative in urine. 19/07 MRSA positive in groin. Negative in nose
August 2025	MRSA BSI in G4 10-month-old male admitted to Dorset County Hospital with lethargy due to D&V. Stool sample positive for Shiga-like toxin producing E.coli causing Haemolytic Uraemic Syndrome (STEC HUS), Vertoxigenic E.coli and Throbocytopenia. History of travel to Romania. 01/08 transferred from Dorset Hospital to UHS for HUS management, admitted directly into a side room on G4. Not screened for MRSA on admission. 05/08 PICC inserted in theatres. PICC monitoring form was not completed on insertion and for daily reviews. 08/08 spiked a temperature and had a septic episode. BC sample result MRSA positive attributed to PICC line, which was subsequently removed. 10/08 MRSA positive in PICC line insertion site. 11/08 N&G MRSA negative following several days of antibiotic treatment. 14/08 Discharged home with topical treatment

Key Learning / Actions / Improvements

2 cases of MRSA Bloodstream infection (BSI) in Q2 against a national performance threshold of 0. Both cases underwent a detailed concise review led by the Infection Prevention Team, an after-action review (AAR) with the clinical team to identify learning and areas for improvement and a final HCAI review with Chief Nursing Officer and Chief Medical Officer.

Maternity
The MRSA BSI case was actioned by recognising the limitations of the electronic documentation system, BadgerNet, which does not prompt MRSA or travel history questions on admission. Staff awareness is being increased to ensure MRSA risks are considered despite system constraints.

Blood culture taken as part of a full septic screen on re-admission to hospital 5 days post emergency caesarean section. Likely source of BSI considered as genito-urinary (evidence of colonisation of GU tract).

Child Health
On G4, an MRSA bloodstream infection (BSI) was identified, prompting staff education on the new MRSA policy, updates to the CVC/PICC and cannula policy, CVC/PICC Line spot checks, and ANTT refreshers, with plans to extend training to all Children's wards.

The 10-month-old infant transferred to UHS from a district general hospital for management of Haemolytic Uraemic Syndrome. Blood culture taken 8 days after admission as part of a septic screen grew MRSA. Likely source of BSI considered as PICC line. Concise/AAR review identified gaps in practice relating to MRSA screening and management/care/documentation of PICC line.

Improvement actions include:
•Launch of a revised Trust MRSA policy supported by a communication, education and improvement campaign.
•Continued focus on improving IP&C practice standards including hand hygiene and care of invasive devices. Continue regular auditing.
•Review, update and reinforcement of the paediatric intravenous access policy/guidelines.

Incidents / Outbreaks of Infection and Periods of Increase Incidents	
MRSA Outbreak	2 identical cases of MRSA associated with the NNU
Shingles on PICU	A member of staff has been confirmed as having shingles, they have been working on PICU.
MRSA period of increase incidence in PICU	2 cases of healthcare associated MRSA in PICU within a 28-day period.
Pseudomonas period of increase incidence in PICU	4 cases of healthcare associated Pseudomonas in PICU with a 28-day period.
C.difficile period of increase incidence in G4	2 cases of healthcare associated C. difficile in G4 with a 28-day period.
C.difficile period of increase incidence in Piam Brown	3 cases of healthcare associated C. difficile in Piam Brown with a 28-day period.
Key Learning / Actions / Improvements	
Neonates	The trust Infection Prevention (IP) team visited the ward, with learning points including monitoring the dusty fan in the decontamination room and identifying one mattress for condemnation. No further actions were required on the unit. The MRSA cases were linked to parental colonisation, and parents completed decolonisation following GP

	advice. The Trust Infection Prevention team conducted a spot check of hand hygiene practices among staff caring for neonates, with no concerns identified. Awareness of hand hygiene has been reinforced across the neonatal unit, and MRSA cases have been highlighted at every staff meeting and during daily huddles.
PICU	**Shingles –** No further cases of Shingles or Chicken Pox developed. Staff member followed sickness policy and sort appropriate medical treatment. **July 2025 – MRSA (PII):** Two hospital-acquired MRSA cases identified; one typed identical to a November 2024 case. Four-weekly Infection Prevention monitoring completed, no further cases, and enhanced cleaning discontinued. Action plan submitted. **July 2025 – Pseudomonas (PII):** Four hospital-acquired Pseudomonas cases, confirmed unrelated by typing. Monitoring completed, no further cases, enhanced cleaning stopped. Action plan submitted. **To Note:** **September 2025 – Sternal Wound Infections:** Three post-operative sternal wound infections under review. Data requested from PICU consultants; ongoing review and practice developments to follow. **Salmonella Montevideo – PICU:** No further cases. IPT-led follow-up meeting held 08/10/25; plan in place and PICU Matron informed. Hand hygiene and cleaning awareness continues.
Child Health	C. difficile PII monitoring is complete with no further cases, though the PII period has been extended 28 days due to an additional case, with enhanced cleaning continuing until 11/10/25. Environmental observations noted good hand hygiene and PPE use, clean surfaces, completed stool charts and IRAs, but issues included a broken macerator, waste build-up in the sluice, a stained pillow in clean linen, a ripped reclining chair, and an unlabelled commode. Volunteers were reminded to follow the “Nothing Below the Elbows” policy. Weekly IPT visits provided reports and suggested actions for the improvement plan.

Infection Prevention and Control Mandatory Training Compliance:

Area	Clinical Compliance	Non-Clinical Compliance
Child Health	82.9% ↑	90.7% ↑
Maternity	82.1%	91.2%
Neonates	84.9%	92.3%
PICU	90.6%	83.3%
Therapies	>95%	>85%
Women’s Health	78–100%	75–100%

Progress and Success:

Child Health
Hand hygiene audit results are improving, with five wards passing; only G3 and PICU required reaudit within a month. PICU have introduced new cubicle signage to support correct PPE use. Mould identified in eight G3 mechanical ventilation heat recovery units has been resolved. The ward successfully passed the waste audit. The plan is to re-audit is planned in 10 months, with ongoing spot checks and continued education.

Maternity
Consistently good environmental cleaning scores across Maternity Wards.

Neonates
The new decontamination room is operational, restoring a dedicated sluice, and Room 4 has been refurbished to maintain 2 meters between cot spaces. Bin collections have increased with an extra overnight pickup to prevent overfilling. Recruitment of new staff is underway, improving coverage despite ongoing shortfalls, particularly in Qualified in Specialty nurses (QIS). A new monitoring process for incubator filter changes has been implemented, and paper bags are now used for nappy changes to reduce faecal contamination. Infection prevention measures include a neonatal isolation quick reference guide, bedspace precaution signage, good compliance with IP audits, and regular infection prevention update emails to the neonatal team.

PICU
Clinical cleaning audit scores have consistently remained 98–100% since June 2024, with continued focus on high standards and individualised bedside cleaning. Mask fit testing compliance is improving and is ongoing. Ventilator associated prevention (VAP), oral hygiene education continues, with updated VAP bundle forms in Metavision and increased use of continuous cuff pressure monitoring supported by the education team. A new PPE chart and cubicle signage has improved staff awareness. Transmission-based precautions have been added to Metavision for visibility. Hand hygiene compliance has increased from 60% to 90% in quarter 2. A new PICU-specific infection prevention newsletter has been launched, focusing on monthly topics such as winter preparedness, PPE compliance, and VAP. Following the recent Pseudomonas PII, under-sink panels at beds 7 and 17 have been repaired in coordination with Estates as part of the action plan.

Therapies
All on call competent respiratory physiotherapists compliant for suctioning and undertaken by the competency completion.

Women's Health
Consistently good environmental cleaning scores across Inpatient and Outpatient areas. Vast Improvement over Q1 -2 in Gynae Theatres.

Ongoing Challenges:

Child Health
Cubicles
High demand continues across Child Health. Allocation managed through individual patient risk assessments. On open wards (e.g., G2N), neuro patients should be individually assessed—reallocate nurse and patient to a cubicle elsewhere if safe, considering skill mix and ward acuity.

Rapid Respiratory Swabs
During summer, ED respiratory patients were not rapid-swabbed before ward transfer (temporary measure). This affected E1 bed use for symptomatic patients without results. Oncology patients

remained exempt. Symptomatic children were placed in bays if no cubicles available. For winter, symptomatic patients are now swabbed in ED; results may return before bed allocation, but patients are not to be held in ED awaiting results. Bed allocation decisions to be made case by case.

JADW MRSA
Three MRSA-positive patients admitted for surgery—policy allows this, but proximity to immunocompromised patients is under review to find an acceptable solution.

Training and PPE
Staff fit-testing often limited to one mask type due to time constraints; issues arise when that mask is unavailable. Fit testing required every two years — additional sessions will be needed soon (18 months since regular testing began). Training on donning and doffing PPE has commenced on PMU for staff potentially working on C5

Maternity
Housekeeping compliance has decreased due to staff vacancies. A digital QR code system is being introduced to help staff track and complete duties. Mould is reappearing on walls and window seals in areas not replaced during the PAH window scheme, despite previous remedial work.

Neonates
The computer keyboard was found to be gathering dust however, IT have confirmed there is no funding currently available to replace it with washable keyboards, however this is being explored locally within care group. The unit is awaiting installation of a new hopper in the sluice. Woodlands Ward continues to operate without its own sluice and is sharing facilities with Broadlands Ward. Ongoing staff shortages are creating increased workload and pressure, making consistent compliance with infection control practices more challenging.

PICU
Cleaning Audit
Follow-up with SERCO after failed audit (02.09.25) due to unclean floors. Deep cleaning completed; re-audit (11.09.25) scored 99%. Promoting teamwork between nursing and domestic staff to ensure deep cleaning even during busy periods.

Perso Hoods
Nine staff require Perso hoods (7 pending testing, 2 received). Discussions ongoing about charging and storage, as PICU lacks a designated space.

PPE Education
Ongoing PPE education to improve mask and eye protection use. Reinforced during Band 6/7 days; PPE chart remains in use and reviewed by IP team. Monthly IP newsletter focuses on PPE compliance and updates on mask fitting for winter.

CVC Insertion & Eye Protection
No CVC insertion observations in June; care compliance 100%. Eye protection use remains low due to visibility issues during procedures. Liaising with IP and ANP teams for education and support to improve compliance.

Estates/Leaks
Leaks noted near bed 15, corridor, parents' kitchen, and sluice room. Temporariy diverter in place; awaiting roof repair. Estates/IPT to update if bed closures are needed.

Documentation
Challenges with completing daily forms, especially isolation risk assessments. Awareness raised

through training, bedside teaching, and email updates. Education and PICU IV Leads supporting improvement.

Waste Management
Continuing education on correct waste segregation and labelling for traceability. Request for waste management walkaround to support staff education.

Mattress Checks
Three mattresses condemned due to contamination; replacements ordered (4-week delay). IP advised staggered checks. Further education planned on mattress cleaning, inspection, and replacement procedures.

Therapies
Hand Hygiene Update – Planned update for the therapy team delivered during core brief. Previous inpatient ward audits had highlighted some missed key points; these have now been addressed and completed.

Winter Virus Preparedness – MOP therapists have reported an increase in COVID-19 and D+V cases. An update on preparing for winter viruses is planned for the next core brief.

GICU Gym – The new gym is not yet open for patient use. Once operational, it will be included in upcoming audit areas for service users.

Summary of Action since Last Report, Current Focus and Action Plan:

Child Health
Current focus is on mask fit testing, MRSA policy rollout, winter pressures, and cohorting, alongside continued staff education and infection prevention monitoring.

Neonates
The priority is to maintain best cleaning and nursing practices, improving isolation risk guideline compliance, escalating equipment risks to the risk register and IT, continuing staff recruitment, completing sluice hopper replacement, and ongoing staff education on infection prevention.

PICU
Current focus remains on staff education of PPE compliance, mask fit testing, and documentation, with ongoing improvements supported through newsletters, emails, direct feedback, and close collaboration with the Infection Prevention team and multidisciplinary colleagues to sustain high standards of infection prevention.

Maternity
Current focus on increasing staff awareness of MRSA risks despite system limitations, improving housekeeping compliance via a QR code tracking system, and managing recurring mould in older window areas. Environmental cleaning remains high, and ongoing staff education supports Infection Prevention and Control compliance, with clinical staff currently 82.1% compliant.

Any Other Issues to Bring to the Attention of TEC and Trust Board:

NONE

Date this report will be an agenda item at Care Group Governance Meeting	**Date this report will be an agenda item at Divisional Governance Meeting**
October 2025	October 2025

Agenda Item 5.12	Report to the Trust Board of Directors, 13 January 2026
Title:	Medicines Management Annual Report 2024-25
Sponsor:	Paul Grundy, Chief Medical Officer
Author:	James Allen, Chief Pharmacist

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

This paper informs the TEC and Trust Board about progress, strengths and weaknesses within UHS medicines management systems. It includes updates on progress with the UHS Medicines Management Strategy and recommends strategies and improvements where appropriate. The report primarily focuses on 2024/25 with reference to key strategic updates and recommendations through the first half of 2025/26.

Key points:

- UHS expenditure on medicines was £215m. This is a 2% decrease on the £218m in 2023/24. At present, UHS is on track to spend £207m on medicines in 25/26.
- A combination of procurement savings and new generic and biosimilar opportunities were used to deliver £1.8m of in year medicines savings.
- The number of approvals for clinical trials and department research activity continues to improve following continued focus throughout 24/25.
- UHS aseptic units continue to meet regulator requirements; the Adanac aseptic unit is close to launch in 2026 and will provide significant improvements in capacity and aseptic resilience. It is expected to play a key role in the production of products to support our outpatient antimicrobial (OPAT) programme and in supporting the oncology pharmacy department's capacity demands.
- A new digital assessment process has been implemented to capture the operational and financial pressures associated with new NICE TAs. To date, 36 NICE TAs have been reviewed using this process.
- The primary Trust Medicines Policy and Controlled Policies have both been refreshed and updated.

Improvement focuses:

- Work to deploy digital system upgrades to streamline and improve uptake of electronic prescribing in outpatients.
- Improve technician training and recruitment to reduce the vacancy rate in our ward-based technician teams.
- Continue to explore sustainability projects and funding opportunities linked to sustainability interventions.
- Work with colleagues in infection prevention and infectious diseases to develop a robust and measurable action plan to address the requirements of the national antimicrobial resistance action plan.

The committee is requested to note the report's contents and raise any questions or concerns to support the Medicines Management Strategy and Action Plan.

Contents:

Risk(s):

1. Outstanding patient outcomes, safety, and experience – 1a, 1b, 1c
2. Pioneering research and innovation – 2a
3. World class people – 3a
4. Integrated networks and collaboration – 4a
5. Foundations for the future – 5a, 5b, 5c, 5d

Equality Impact Consideration:	N/A

1. Summary introduction

1.1.1 Medicines are the most commonly used healthcare intervention. Virtually all UHS patients will receive medicines while in hospital, upon discharge, as outpatients, and/or via homecare. Organisational use of medicines is associated with significant risks related to patient safety, compliance with statutory regulations, and financial risk. This report seeks to appraise executive and board members on the key areas of progress and risk in medicines management at UHS.

1.1.2 At UHS, approximately 2.7 million prescriptions are written, and 8 million doses are administered annually. In total, medicines cost UHS £215m in 2024/25, a modest 2% decrease from the previous year.

1.1.3 In 2024/25, 2,975 safety incidents involving medicines were reported, of which 30% resulted in some level of harm. The rate of moderate to severe harm has reduced slightly from 32%.

1.1.4 This paper informs the Trust Executive Committee about progress, strengths and weaknesses within UHS medicines management systems. It includes updates on progress with the UHS Medicines Management Strategy and recommends appropriate strategies and improvements. The report primarily focuses on 2024/25 with reference to key strategic updates and recommendations through the first half of 2025/26.

1.1.5 A medicines management summary action plan is included (Appendix A).

Analysis and Discussion

2. Key areas of good practice, progress and improvement

2.1 Leadership

2.1.1 UHS continues to be active in transferring medicines-related information to patients' community pharmacies. The ward-based pharmacy team referred around 2,000 patients in 24/25 to their community pharmacists for follow-up and support with their medicines after discharge. The NHS Discharge Medicines Service is an essential service within the community pharmacy contract. This has given further incentive to continue these referrals with greater reassurance that patients will be followed up in the community. Work continues with community colleagues to ensure that community pharmacies submit claims for undertaking this service. The next steps include reviewing the referral process to align with other acute Trusts across the ICS, training pharmacy support workers to submit referrals to prevent further readmissions, and extending the referral system to local care homes to support the transfer of care and medicines optimisation.

2.1.2 Regular antimicrobial stewardship ward rounds delivered by consultant microbiologists and specialist pharmacists continue within the key specialities, although gaps are acknowledged in key areas such as cancer care and medicine. In addition, the ward-based pharmacy teams continue to monitor and audit antimicrobial prescriptions monthly, in line with our legal obligations under the Health and Social Care Act 2008. The team has focused on antimicrobial stewardship and antimicrobial guideline updates, including managing the entry of new formulary antimicrobials, with an increasing focus on the WHO AWaRe (access, watch, reserve) classification of antibiotics. Additional antimicrobial focused activity included developing and supporting the Outpatient Antimicrobial Therapy (OPAT) case proposal, educational activities for all staff groups, and World Antimicrobial Resistance Awareness Week activities. Collaborative working has been a focus, including new ward rounds for *C.difficile* infection (with IP&C), new antiviral stewardship MDT meetings (with consultant virologists), and work with colleagues from the ICS to develop a peer review tool as part of the national AMR workstream.

2.1.3 The Chief Pharmacist continues as the designated Controlled Drugs Accountable Officer (CDAO). The Trust's CDAO is responsible for the safe and effective use and management of controlled drugs and has a statutory responsibility to provide quarterly occurrence reports to the NHS England (South) CDAO. These reports detail any concerns regarding the management or use of controlled drugs across the Trust or other organisations/agencies involved. All occurrence reports have been completed and submitted for 24/25 as required. The CDAO is also a member of the NHS England (South) Local Intelligence Network (LIN).

2.2 Medicines Finance

2.2.1 In 2024/25, UHS expenditure on medicines was £215m. This is a 2% reduction from the £218m in 2023/24. This reflects the implementation of several medicine savings opportunities, which resulted in a reduction in medicine spend in the following areas:

- Several pass-through medicines used in the management of cancer and neurology conditions became generic, leading to a £2.6m saving. This was offset by £1.4m of newly commissioned pass-through medicines.
- A range of biosimilar biologic medicines were launched for rheumatology and gastroenterology, leading to £1.3m savings
- Procurement of generic in-tariff medicines resulted in a £0.5m reduction.

At present, UHS remains on track to deliver a further reduction in overall medicines spend in 25/26.

2.2.2 Data from the national medicines data repository (Rx-Info) continues to place UHS just outside the top 25% of similar-sized trusts for total medicines spent. Given the range and depth of specialist services, this is to be expected and aligned with peer organisations as described in the table below. UHS appears to be one of the few organisations nationally to see a reduction in medicines spend in 24/25 and in our projected spend for 25/26.

	Spend (£ millions)			
Trust	2022/23	2023/24	2024/25	2025/26 (projected)
UHS	210	218	215	207
Peer Trust 1	167	190	209	216
Peer Trust 2	184	195	215	232
Peer Trust 3	158	171	179	188
Peer Trust 4	215	236	258	263
Peer Trust 5	315	327	377	372

2.2.3 Throughout 24/25, UHS clinicians and pharmacy continued to deliver essential savings in a range of schemes that released UHS capacity and promoted best value medicines usage. For this period, these savings (with direct financial impact to UHS) equated to £3.4m of which £1.8m of savings were realised. Under delivery was driven by higher than historical activity across several medicines, deferred invoice payments (from 23/24), and shortages of the best-value products. Over £5m of impactful medicine savings have been identified in 25/26, with delivery to date at £2.3m. The key areas of opportunity are new biosimilar medicines in ophthalmology and gastroenterology.

2.3 Workforce and Training

2.3.1 High-quality training and development remain a mainstay of the pharmacy department, with a 100% success rate for trainees in 24/25. NHSE WTE South East continue to provide a proportion of funding for trust led foundation trainee pharmacist training. The team are working with other providers across Hampshire and the Isle of Wight to collaborate in the delivery of local learning set study days. The University of Southampton commissions the pharmacy team to deliver teaching for medical, nursing and AHP students. We continued to build our trainee pharmacy technician numbers through the new apprenticeship, with two intakes per year now in September and February, both funded by NHSE WTE.

2.3.2 In 28-29, it will become mandatory that foundation trainee pharmacist posts be multi-sector, ensuring that pharmacy, as a profession, develops a flexible and adaptable workforce. UHS has offered cross-sector training since 2021, recognising that it is one of the most popular national schemes consistently attracting high-calibre candidates. Cross-sector partnerships are being increased for 25/26 and 26/27 with trainees in community pharmacy, primary care, and South Central Ambulance Service placements.

2.3.3 The new undergraduate pharmacy course includes prescribing; students graduating in 2025 will be qualified as independent prescribers when they register in 2026. A working group within UHS and across HIOW ICS is developing the training programme for Trainee Pharmacists, aligning with GPhC and NHSE requirements. A prescribing framework for newly qualified prescribers, learning hours guidance and scope of practice documents have been produced to support trainee pharmacists, Designated Supervisors and Designated Prescribing Practitioners. It is expected this work will enable the smooth transition of our trainee pharmacists qualifying in 25/26. Once embedded, work will focus on prescribing pharmacists formally supporting pathways (e.g. admission and discharge prescribing)

2.3.4 The number of non-medical prescribers (NMPs) within UHS continues to rise. Currently, 404 (353) active NMPs are recorded on the live register, an increase of 51 since last year. Of these, 78 are pharmacists, 33 are AHPs, and the remaining 293 are nurses. The new advanced practice pathways for nurses and AHPs can include prescribing. There are 47 NMPs in training, 21 nurses, 10 pharmacists, 14 trainee pharmacists and 2 AHPs.

2.4 Research & Development

2.4.1 The pharmacy team's clinical trial activity has largely recovered after implementing the key elements of the pharmacy R&D action plan. Several elements continue to play a critical role in the consistent delivery of studies; in particular, ring-fenced, dedicated RDN-funded resources aligned with aseptic and cancer activity have realised significant improvements in both cancer and advanced therapy studies. The next focus is on the time taken to approve studies in UHS aligned with the new national 150 day targets.

	2022/23	2023/24	2024/25	2025/26 (M8)
Cancer	33	10	23	20
Non-Cancer	51	43	56	48
Advanced Therapy	1	6	4	2
Total	85	59	83	70

2.4.2 Advanced Therapeutic Medicinal Products (ATMP) outputs have remained stable, with six additional studies opened since the previous report. This is a highly specialist area, and a significant long-term expert pharmacy vacancy continues to constrain our aspirations to progress this area at scale. All areas of medicine will likely see the emergence of AT(I)MP therapies in the next few years, with pharmacy working closely with Research and Development to deliver the objectives outlined in the emerging therapies unit strategy.

2.4.3 The department welcomes Professor Cathy McKenzie as the first UK Professor of Intensive Care Pharmacy. In addition, Professor McKenzie has been awarded a £2.7m grant to research whether giving intravenous thiamine to patients at very high risk of delirium reduces the risk of delirium occurring when they are severely unwell. The study is one of the first of its kind to be led by a UK pharmacist. It is a collaboration between University Hospital Southampton, the University of Southampton, the NIHR Southampton Biomedical Research Centre and the Intensive Care National Audit & Research Centre (ICNARC).

2.4.4 Three pharmacy team members have successfully applied for research awards with BRC and ARC internships and are being supported to apply for further awards. The number of research active staff increased from 16 to 28 in 24/25 and is already at 21 staff members in 25/26. Peer-reviewed publications also increased from 13 to 26.

2.4.5 The UHS Consultant Pharmacist for Genomic Medicine will support an approved NIHR-funded research project assessing pharmacogenetic-guided prescribing using routinely collected healthcare data. It is expected that the learning generated from this study will be able to directly support the work within UHS to develop pharmacogenomic testing capacity for Wessex.

In addition, they have applied to study the Our Future Health genomic cohort and their linked dispensing records as part of the national Pharmacogenomic Network of Excellence 2.0 project, working with Oxford University health epidemiologists. The results from this study will help support equitable access to pharmacogenetic testing and provide evidence for the use of these results in patients of non-European ancestry, a known and problematic gap in the existing data.

The UHS Consultant Pharmacist for Genomic Medicine, working with UHS Critical Care pharmacists and Infection pharmacists, will support the implementation of the Respiratory Metagenomics pilot at UHS, as well as building and supporting a new network of specialist pharmacists working at the 30 identified sites for expansion of this project across the UK. This project is now additionally funded by the UK Office of Life Sciences. It is seen as critical for the early identification of pathogens during a future pandemic, as well as for speeding up diagnosis and appropriate treatment of respiratory infections in critically ill patients locally.

Another genomic-related project, PRIMO (Pharmacogenomics Research for Individualised Medicine in Older people), has passed the first stage of NIHR assessment for a Programme Grant. The Consultant Pharmacist supports this work and brings together the Central and South Genomic Medicine Service, the Universities of Southampton, Oxford and Aston, and Health Improvement Wessex to deliver a pharmacogenomics testing trial to reduce polypharmacy in the elderly in Dorset and Birmingham. This will inform the use of pharmacogenomics across the local Health Systems and provide much-needed evidence for the implementation of pharmacogenomic testing services in Wessex.

2.5 Medication Incidents

2.5.1 The number of medication incidents reported in 24/25 increased from 2827 to 2975 primarily because of more no-harm incident reports, indicating a good reporting culture. The proportion of incidents resulting in harm has decreased, but not significantly, from 32% to 30%. The medicines safety team reviews all incidents and provides learning on a weekly basis via Workplace. Further details can be found in the annual Medicines Safety Officer report.

2.5.2 A medication-related never event was reported in 25/26. An oral formulation was incorporated into a syringe and subsequently infused subcutaneously. The issue was spotted very quickly, the patient received a very small amount of the incorrect solution (~0.1ml) and did not come to any harm. The incident has been subject to a full investigation at Divisional level and reviewed at the medication safety group. Contributory factors identified were a lack of knowledge of the preparation of syringe drivers, perceived pressure to treat the patient's pain, interruptions and cognitive bias in relation to double checks.

2.5.3 Demand for the patient Medicines Helpline remains high at around 140 calls per month during 2024/25. Often, calls are for clinical advice or follow an error or oversight relating to the discharge process. The helpline team can intervene to prevent patient harm and avert potential complaints or the need to see another health professional. The lead pharmacist for the Helpline works with the Medication Safety Group to identify and address the causes of the most common types of error and has provided data to inform the trustwide Discharge Checklist and improvements to the Trust discharge paperwork. The Helpline is widely advertised across various media, including My Medical Record, enabling rapid access to medication-related advice through this patient portal.

2.5.4 The Southampton Medicines Advice Services (SMAS) continues to develop its national training website, the Medicines Learning Portal, and has secured NHSE funding to write a chapter on Pharmacogenomics, with contributions from the Consultant Pharmacist Genomic Medicine. The Medicines Learning Portal teaches clinical problem-solving skills to hospital pharmacists, is used across the whole NHS, and continues to thrive, with more than 1 million visits.

2.6 Operational & Infrastructure

2.6.1 Medication shortages remain an enormous and growing national primary and secondary care issue. National data published by the Department of Health and Social Care indicates that formal notifications of impending shortages have increased each year since 2020. The UHS pharmacy team work closely with clinical teams across all specialities to mitigate the risks of medication shortages, and systematic processes to improve the early identification and communication of shortages remain in place. An increased proportion of medication shortages are now circulated to trusts as national patient safety alerts. The coordination and oversight of these alerts is led by the trust's Medication Safety Officer, with support from the Deputy Chief Nursing Officer and Head of Clinical Engineering.

2.6.2 Annual aseptic unit inspections continue with a focus on facilities, equipment, and process validation. The pharmacy aseptic unit (TSU) has now been closed; however, a proportion of the activity at the new Adanac aseptic hub will fall within the remit of this inspection team (rather than the MHRA). As such, a planned inspection is scheduled for Jan 26 to enable production under this regulatory framework to begin. This will be a key milestone for the pharmacy aseptic team as the first products can be prepared and several longstanding risks relating to supply resilience and aseptic unit contingency can be resolved while we develop our MHRA license.

The on-site Platinum house aseptic unit was inspected in Nov 25. This unit will complement our Adanac aseptic hub, supporting the delivery of short expiry, complex and clinical trial medicines. The unit was rated as low risk, with all but one major deficiency rectified since the last inspection. The remaining major inspection deficiency concerns the capacity and workforce challenges the unit faces until Adanac opens in 2026.

2.6.3 Improvements in the operational performance of the oncology pharmacy remain a significant focus. In recent months, maintaining the unit's performance has become challenging given the increasing volumes of work and the higher proportion of complex items the unit is preparing. The unit has a finite capacity, which is now likely at or near its limit until capacity from Adanac Park can be utilised. The team has been working on digital methods to support treatment schedulers and ensure capacity is available before patient booking. It is hoped this will improve patient experience while maximising capacity. A revised capacity plan and service level agreement have now been developed with cancer care to aid KPI monitoring and support future service development opportunities.

Category	Oct-21	Mar-22	Sep-23	Mar-24	Aug-24	Jun-25	Oct-25
Prepared in advance	21.5%	34.2%	40.6%	32.7%	41.0%	33.0%	32.5%
On Time	12.1%	28.4%	45.7%	42.1%	34.9%	29.2%	20.6%
0 - 1 hr delay	40.4%	29.7%	11.7%	22.2%	20.0%	23.9%	36.8%
1 - 2 hrs delay	18.5%	6.1%	1.0%	2.0%	2.8%	9.3%	7.9%
2 - 3 hrs delay	5.6%	0.9%	0.6%	0.4%	0.8%	2.8%	1.7%
3 - 4 hrs delay	1.3%	0.3%	0.1%	0.2%	0.3%	0.9%	0.3%
Over 4hrs delay	0.6%	0.4%	0.2%	0.3%	0.3%	0.9%	0.2%
Item Total	2107	2184	2197	2468	2788	2566	2910

2.6.4 The UHS pharmacy department and leadership team have continued to work with UPL to develop plans for additional, mutually beneficial programmes of work. At present, these include:

- Developing a digital automated stock management dashboard to improve efficiencies and reduce stock interruptions.
- Piloting the use of UPL as a homecare provider, including the provision of repeat prescription reminders. This releases established homecare service capacity and realises a modest saving for UHS vs the cost of homecare services.
- Piloting and expansion of their weekend service provision to improve access for patients and enable the current weekend pharmacy service to focus on inpatient discharges
- Developing a ‘pharmacy first’ service to take minor ailments directly from ED, supporting ED capacity.

2.6.7 The electronic system for wards to request discharge medicines using eWhiteboards has continued to support planning of safe discharges. The transformation, pharmacy and digital teams have continued to promote this system and make regular improvements, with a view to improving communication about discharge between the wards and pharmacy. A Power BI dashboard has been developed to facilitate targeted training for wards with low utilisation rates. The pilot ward demonstrated that consistent use of this communication method reduced the time to discharge and shortened the length of stay, supporting Trust operational targets.

2.7 Medicines Policy & Governance

2.7.1 The Trust Medicines policy and Controlled Drug policies both underwent significant updates and complete refreshes since the last report. Divisional governance and nursing leadership teams continue to support the refinement and implementation of these policies. The pharmacy department is now focusing on updating and clarifying the supporting appendices.

2.7.2 The increased volume and acuity of mental health inpatients have presented challenges regarding medication security. The security of patients' own medicines in transit between ward areas has been identified as a particular weakness, and our risk assessments for medication self-administration pay minimal attention to the risks of neighbouring or ward patient inappropriate access. The pharmacy team have supported an update to the medicines policy and plans to address these concerns and has sourced tamper-evident bags. It is expected that the implementation of these tamper-evident bags for the storage and transport of patients' own medicines will provide a suitable initial barrier to mitigate self-administration.

2.7.3 The UHS Drugs Committee met monthly throughout 24/25, undertaking the following activities:

- approved the addition of 69 items to the formulary, of which 35 were because of published NICE guidelines.
- removed 8 items from the formulary
- reviewed and approved 86 policies and procedures/clinical guidelines

2.7.4 Patient Group Directions (PGDs) allow specific healthcare professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without needing a prescription or instruction from a prescriber. The pharmacy team have worked hard to get all the Trusts PGDs in date, and has put a rolling process in place to help ensure this remains so. Future developments include implementing a national PGD audit tool to improve local governance. The PGD committee has:

- reviewed and approved 17 PGDs
- reviewed and approved 10 occupational health work instructions for staff vaccination
- removed a further 3 unnecessary PGDs from use

2.7.5 Free of Charge (FOC) and individual compassionate use schemes provide early access to or compassionate use of medicines that would otherwise be unavailable to patients. FOC schemes can present as NHSE instigated Early Access to Medicines Schemes (EAMS) or pharmaceutical manufacturer led early access schemes, both aimed at cohorts of patients. All schemes are carefully considered for clinical, ethical, and financial risks, with a recent increase in focus on operational impact and offset costs to UHS. The Drugs Committee continues to provide governance and oversight to these schemes using newly updated policy guidance based on national guidance released in Aug 2023. The Drugs Committee reviewed 13 individual patient compassionate use schemes and 1 manufacturer led early patient access scheme (declined due to operational impact) for suitability for use in UHS in 24/25.

2.7.6 Individual Funding Requests (IFRs) are requests for medicines for patients that are not routinely commissioned. All requests are carefully considered for clinical, ethical, and financial risks, with a recent increase in focus on operational impact and offset costs to UHS. In 2024/25, the frequency of applications broadly returned to pre-pandemic levels. However, a proportion of this relates to the volume of NHSE policies that need updating, particularly regarding paediatrics. A summary of the applications throughout 2024/25 and the first half of 25/26 is below:

	Total			ICB		NHSE	
	2022-23	2024/25	M6 25/26	2024/25	25/26 M8	2024/25	25/26 M8
Submitted	17	32	18	21	10	11	8
Approved	12	29	12	19	10	0	2

2.7.7 During 24/25, the UHS IFR panel, comprising the requesting clinician, the Chief Pharmacist, the Medical Director and the Director of Finance, considered 5 unique rejected cases for non-commissioned medicines indications. Four of these cases were approved based on clinical need and an assessment of offset benefits to UHS (admissions, ITU length of stay etc) at a total medicines cost risk of £274k. This resulted in a £100k in year additional medicine spend following funding approval from NICE and NHSE for two of the cases.

2.7.8 In early 2025, a new process was developed for the approval of drugs with positive recommendations in NICE technology appraisal (TA) guidance. The primary focus of this development was to ensure that the operational, clinical and financial considerations for all newly commissioned medicines were considered before implementation. The process is fully automated, capturing feedback from clinical, pharmacy and care group operational teams. It ensures UHS now has a streamlined, robust process that provides evidence of adherence to the NICE-mandated timescales for implementing new TA guidance (usually 30 or 90 days post-publication). To date, 36 NICE TA's have been reviewed via this new process.

2.8 Digital

2.8.1 The pharmacy digital team continues to support the organisation in deploying and improving its digital architecture concerning medicines. Throughout 2024 and 2025 to date, the team have:

- In March 2025, upgraded to the latest version of CareFlow Medicine management software, used for Trust wide ePrescribing and pharmacy stock management. The new version mitigated several risks associated with Electronic Prescribing and Medicines Administration (EPMA) and provided benefits for pharmacy contract management. The EPMA and medication safety team are continuing to review the impact of the upgrade and managing any new risks identified.
- Continued the collaborative ICS EPMA group, looking at supporting sites together with upgrades and optimisation of the EPMA system and convergence on pharmacy workflows. Specific projects have included supporting IOW with the deployment of EPMA to Maternity services in May 25 and developing eSigning of Homecare prescriptions at UHS from workflows developed at PUH.
- UHS have taken the core EPMA Lead role in Q2 2025, for the OneEPR programme, leading the review of process flows for medicines across the four acute Trusts and identifying convergence and transformation opportunities before OneEPR system deployment.
- Continued the deployment of ward direct digital ordering of stock medicines across PAH and other areas across UHS. This service development reduces paper use, ordering errors, and staff time by providing a secure digital mechanism for ordering stock medicines.
- Creating a new drug savings dashboard to support monthly reporting of the medicines saving programme across UHS.
- Supported the dispensary pharmacy prescription tracker upgrade project and the new functionality to record delivery to wards. This project, in conjunction with the

whiteboard discharge referrals, enables a complete discharge journey to be assessed, mapped and improvements tested.
- Worked with First Data Bank, CareFlow and the regional Genomic Medicine Service on integration of pharmacogenomic data and decision support into EPMA

2.8.2 The pharmacy digital Team have supported UHS digital in the development of the UHS EPR functionality with the following:

- Infection viewer app – allowing users to monitor antibiotic prescribing & administration during admissions.
- Developed a contextual link to EPMA Outpatient prescribing functionality, which is awaiting deployment to support extension of EPMA OP digital prescribing.
- Created a new Drug Chart View app, which provides a clearer view of medicines prescribing and administration during admission.
- Continued to support the medicine component of the Openeyes project, validating the new version and reviewing functionality, to develop new digital medicine workflows.
- Supported the development of allergy recording in the new Miya ED system, to ensure it is compliant and ready for integration once other downstream systems are compliant with data sharing standards (FHIR). Validated and deployed Miya integration with Omnicell medicine dispensing cabinets for patients' registration, to allow the timely removal of medicines for patients in ED.

2.8.3 NHSE digital medicine First of Type scheme bids have been successfully won by Pharmacy Digital to lead on the development of integration and a new user interface between the automated dispensing cabinets in AMU. This project, which resulted in £353k of NHSE capital funding, will support closed-loop administration on AMU, with an expected reduction in medication administration errors and improvements in ward drug administration efficiencies. In addition, UHS has been awarded a further £166k (capital) to support Buckingham Healthcare NHS Trust in developing a bi-directional interface between GP Connect and the EPMA system, enabling the transfer of medication data on admission and the direct communication of medication information at discharge.

2.8.4 The Varian Aria chemotherapy prescribing and scheduling system urgently needed an upgrade to the latest cloud-based software, as its current version had become unstable and remains outside the routine support period (although Varian will support the system while the upgrade is planned). The plan to establish a new BT fibre-optic connection by mid-December has been completed, with plans for data migration to the cloud environment scheduled for Mar 26. If everything proceeds on schedule, the system is expected to go live by May 2026. The UHS pharmacy oncology team is managing the upgrade programme across the relevant sites in the network.

2.9 Integrated Care Board and Regional Medicines Optimisation

2.9.1 The UHS Chief Pharmacist continues to chair the HIOW ICS system leadership group for Pharmacy. This group's primary strategic objective is developing and delivering the Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme for the HIOW Integrated Care Board (ICB). The plan covers key workstreams for medication safety, digital, workforce, medicines savings, and sustainability.

2.9.2 The planned development of an off-site aseptic unit at Adanac Park remains on track for commissioning in quarter 4 of 25/26. The build and equipment installation were completed in Mar 25, with the team relocating from UHS to begin the validation and testing phases in Jun 25. A significant focus over the past 6 months has been building the workforce needed to enable the unit to deliver the required volumes of aseptic products, alongside building the necessary portfolio of evidence for an MHRA license application. A strategic investment case for additional aseptic hubs (building on UHS and PUH as baseline capacity) is being developed by NHSE South East. At this stage, Adanac remains on track to be the first national aseptic pathfinder hub to license and deliver much-needed aseptic resilience to the local and neighbouring systems.

2.9.3 The ongoing work to prevent harm to unborn babies from the use of sodium valproate continues and is led by the UHS Medication Safety Officer via an ICB working group. The group reviews action across each provider, ensuring this remains within the medicines safety priorities for 25/26, which include improving the primary care records of hospital only medicines, time-critical medicines and reducing harm from oral methotrexate and emollients

2.9.4 The UHS Digital Pharmacy team are now integrated with PUH and IOW to ensure we realise the benefits of a shared EPMA system across the ICS. Continual cross-site collaboration supports projects such as the EPMA upgrade and the OpenEyes system deployment by reducing duplication of validation and system build work.

2.9.5 In collaboration with Health Innovation Wessex, leaders from the Acute Pain Team, Clinical Pharmacy and UHS Digital launched an update to discharge prescriptions to clarify the clinical intention for all opioid prescriptions. Prescribers are required to state the indication for the opioid and the expected duration. The hope is that this will reduce the number of prescriptions for opioids, which are continued in primary care, particularly when originally intended for short-term use, and therefore reduce the overall opioid prescribing across the region.

2.10 Sustainability and UHS Green Plan

2.10.1 In May 2025, work was completed to decommission the nitrous oxide (N_2O) manifolds in UHS. Funding was secured from NHS England (£29K), which enabled the purchase of regulators and brackets for portable N_2O cylinders in various theatres, enabling continued use in limited areas. In previous work, the anaesthetic team had shown up to 89% of N_2O leakage from current manifolds, consistent with results from other trusts. Estates, portering, pharmacy, anaesthetics and clinical engineering worked closely together to complete the project. It is estimated that this will reduce our N_2O emissions by 600,000 litres per year, equivalent to 354 tonnes of eCO_2.

2.10.2 The trust drugs committee are supporting the use of methoxyflurane (Penthrox) as an alternative to Entonox for short-term pain relief for a variety of procedures. Methoxyflurane has a lower carbon footprint while maintaining similar or greater efficacy.

2.10.3 A small project to recycle blister packs has been piloted on G8; the outcome of this is eagerly awaited before we consider deploying across a wider footprint of wards.

3. Key areas requiring action/improvement

3.1 Medicines Policy & Governance

3.1.1 The medicines management focussed matron walkabout programme, established in 24/25, highlighted several areas that still require additional actions. While policies have been updated, some key elements, such as fridge checks and medicine security, remain inconsistent, especially during periods of sustained operational pressure. The pharmacy team continues to audit and report incidences of unlocked cupboards and medicines not stored securely for each ward that receives a pharmacy-led stock top-up. These data have improved from 67% compliance when audited in Nov 24 to an average of 95% over the last 12 months. Results will soon be included in the ward clinical accreditation programme to highlight where improvements are needed and to support wards in improving practice.

3.1.2 1.2 In March 2023, NHSE issued guidance on reducing time-weighted exposure to nitrous oxide (N_2O) in healthcare environments. Initial measures have been implemented, and environmental monitoring is underway. The findings from an external exposure audit in Feb 25 indicated that a small number of staff were occasionally exposed to higher than recommended N_2O levels. Mitigation measures have been strengthened in the maternity ward. As part of the project, visits were made to Salisbury and Winchester to observe the scavenging and cracking units in operation. The medical gases committee and care group leadership teams are now reviewing and developing proposals for the use of scavengers across the acute trusts in the ICS. They will prepare a case for their purchase and implementation in UHS over the coming months.

3.1.3 National leads wrote to Trusts in November 2025 outlining their expectations regarding actions that must be taken to prevent antimicrobial resistance. The letter notes that while overall antibiotic prescribing is decreasing, prescribing in secondary care is rising. Rates of Gram-negative bloodstream infections are increasing and already exceed the 2028/29 targets in most areas. These are signals of concern that are also reflected in UHS data. There are actions related to baseline assessment required in the first quarter of 2026, culminating in the need to develop three priority areas for AMR improvement within UHS, which must be routinely reported to the Board. The pharmacy, infectious disease, microbiology, and infection prevention teams have already begun developing the UHS AMS strategy and plan to incorporate these measures and requirements.

3.2 Digital

3.2.1 The uptake and utilisation of electronic prescribing in outpatients remains low (12,500 prescriptions in the last 6 months). A link between the outpatient module in CHARTs and the outpatient prescribing module has been built and is in the final stages of testing and validation. Once released, the focus will shift to deploying OpenEyes for outpatient prescribing to support their paper-light programme.

3.2.2 The 10-year plan to shift from analogue to digital brings an expectation of trusts to deploy the Electronic Prescription service (EPS), allowing outpatient prescriptions FP10s to be digitally sent to a patient's community pharmacy of choice. A business case is being developed with the ICB to reach the strategic benefits. This is particularly pertinent with the recent changes in the OneEPR programme.

3.2.3 Prescription transfer between systems remains a risk when patients move between clinical areas that have CareFlow Medicine Management, MetaVision ePrescribing systems and ED paper prescribing. Several process-driven mitigations are currently adequately managing the risk. However, there remains a concern that as operational pressure increases, these processes may fail. The OneEPR programme was expected to reduce this risk in the future. It may still offer the opportunity to resolve this risk if EPMA is chosen as the priority for systemwide collaboration.

3.2.4 A new contractual requirement begins in January 2025 to provide NHSE with secondary care ePrescribing data - DAPB 4005. All customers of our EPMA supplier (System C) must upgrade to the next version, expected in Q1/2 26/27, to remain contractually compliant. UHS plans to upgrade in Q3 26/27 to enable data collection and reporting compliance by Q4 26/27.

3.2.5 The current fridge monitoring at ward level is retrospective and does not record how long a fridge has been out of range. There is currently no escalation of a fridge alarm at ward level. A digital fridge monitoring system for wards would provide cost savings from reduced stock wastage, added assurance for the CQC, and improve the hospital's quality/storage of our medicines. The trust-wide asset tracking project has developed some processes that have been successfully deployed in the PAH. So we plan to collaborate further to deliver a solution for UHS.

3.2.6 The use of physical controlled drug record books continues to limit opportunities to deliver improved oversight and monitoring of controlled drugs across UHS. In trusts with digital systems, there is a closed loop between the prescribing, recording and ordering process. Additionally, these systems maintain stock balances and enable usage triangulation to improve identification of cases of diversion. In addition, there are opportunities to save significant nursing time in relation to record-keeping and stock control of controlled drugs. Several complete digital systems are now available, and demonstrations have been provided to the ICS Chief Pharmacist groups. A key target for 25/26 and early 26/27 is to develop a case to deploy a digital solution across the acute trusts in UHS and, potentially, across the ICS.

3.3 Operational and Infrastructure

3.3.1 The homecare service for medicines has continued to increase, releasing critical UHS capacity and moving care closer to home for our patients. Patient numbers will have increased to over 9,000 by the end of 2025. The pharmacy homecare and clinical pharmacy teams received additional critical investment at the start of 2024 to ensure we can meet the organisation's demands and quality requirements. However, with the continued increase in workload, this investment is now insufficient to meet the required homecare capacity. The Pharmacy homecare service has been working closely with Trust/Pharmacy IT to develop electronic transmission of homecare prescriptions to providers, streamlining the service. It is expected that further digital, robotic process automation (RPA) will need to be explored throughout 25/26 to ensure this service can meet the needs of clinical services.

3.3.2 Despite the use of remote working, there is insufficient space within the pharmacy footprint to accommodate the team. Furthermore, expanding clinical trials and storing larger numbers of investigational medicinal products pose challenges. The pharmacy team continues working closely with the estates team to shape the 10-year master plan and provide a vision for re-using the space released when the TSU relocates to Adanac Park.

3.4 Workforce and Development

3.4.1 The recruitment status for pharmacy technicians provides the most significant recruitment challenge. Over 24/25, the combination of new primary care roles and reduced training numbers in 22/23 led to a significant shortfall in this critical workforce. In particular, the most impacted team is the ward-based pharmacy technicians, resulting in significant reductions in key medicines management metrics, such as medicines reconciliation. Pharmacist vacancies have significantly reduced throughout 24/25 and are somewhat mitigating the risks of this shortfall. However, this remains an inefficient use of skill mix, and a key target throughout the remainder of 24/25 is to improve the job satisfaction and flexibility of our pharmacy technician roles to reduce the appeal of primary care roles.

3.4.2 The Pharmacy workforce strategy needs to be updated and aligned to the trust workforce strategy while addressing the aforementioned areas of fragility in service provision. While key areas like aseptics have been covered the broader plan for pharmacy has been deferred while we navigate the current workforce focus and to ensure alignment with the expected 10-year workforce plan. The UHS pharmacy team expects to play a significant role as a training centre over the coming years, both for prescribing practitioners and for the regional aseptic workforce.

3.5 Sustainability and UHS Green Plan

3.5.1 The Greener Pharmacy Toolkit was launched by the Royal Pharmaceutical Society (RPS) in April 25. The toolkit is a pioneering digital self-assessment tool designed to help hospital pharmacy teams take practical action to reduce the environmental impact of pharmacy services, pharmaceutical care and medicines, while supporting patient care. The toolkit outlines three levels of accreditation—bronze, silver, and gold—based on various actions that pharmacy staff can voluntarily take to make their pharmacies more sustainable. Commissioned by NHS England and supported by Greener NHS, the toolkit is free and open access, available for use by hospital and community pharmacy teams throughout Great Britain. At present, UHS falls within the bronze category with a clear aspiration to work toward gold status over the next year. The toolkit will form the basis of our plan to formalise a programme of work to consider and implement evidence-based interventions to reduce the organisation's carbon footprint concerning medicines.

4. Conclusion

4.1.1 The actions required to address the concerns raised in section 3 above are listed in the action plan (Appendix A). The action plan also includes innovation initiatives to support the Trust's values and deliver efficiencies in the handling, management, and oversight of medicines.

4.1.2 The senior pharmacy managers will periodically review progress against the action plan, escalating through Division C management as required. This progress will be reported formally in the 2025/26 Medicines Management Report.

5. Recommendation

5.1.1 The Trust Executive Committee and Trust Board are requested to acknowledge the report and support the UHS Medicines Management Strategy and Action Plan.

6. Appendices

7. Appendix A – UHS Medicine Management Strategy and Action Plan

UHS strives to be at the leading edge of excellence in all aspects of medicine management and medicines optimisation. The UHS medicines management strategy has three themes: -

1. Best practice in the use of medicines.
2. Improving patient experience.
3. Best value from resources.

The components of each theme are aligned to the Trust's values: -

Medicine Management Theme	Component	Alignment to Trust Values		
		Patients First	Working Together	Always Improving
Best practice in the use of medicines	Excellence in all drug use processes, procurement, storage, prescribing dispensing, administration, monitoring, disposal	✓	✓	✓
	Evidence-based formulary and guidelines	✓		
	Medication error monitoring and learning	✓		✓
	Education and training		✓	✓
	Implementation of national guidance	✓		✓
	Research and quality improvement	✓	✓	✓
	Clinical audit	✓		✓
	Regulatory compliance and strong governance	✓	✓	✓
Improving patient experience	Medicines optimisation – maximising patient benefit from medicines	✓	✓	✓
	Patients as partners in selection of treatment	✓		
	Optimising transfer between care settings		✓	
	Implementing alternative care pathways	✓	✓	✓
	Provision of information, advice and support	✓	✓	
	Timely intervention – access to medicines when and where they are needed seven days a week	✓		

	Promoting self-care and healthy living	✓		
Best value from resources	Develop and support the medical, nursing and pharmacy workforce and explore new ways of working		✓	✓
	Integrate technology and innovation and use data effectively			✓
	Medicine procurement for value and safety	✓	✓	
	Evaluate and measure to improve effectiveness and productivity	✓		✓
	Partnership working with other organisations		✓	

Summary of medicines management actions

Actions completed, closed or paused due to dependencies

	Action	Outcome	Additional information
1	Implement e-prescribing to ED.	Paused	A scoping exercise undertaken in early 2020 identified that e-prescribing was only part of a much larger digitisation project within the ED. As such, the implementation of e-prescribing has been delayed until a full digitisation project can be fully explored. ED EPR system deployed October 2025 and EPMA not included until Phase 2 26/27.
2	Submit Medcura for national consideration as part of the newly formed National Aseptic Review panel	Paused	The five pathfinder sites are not at a stage to consider their aseptic preparative management systems. The UHS Pharmacy team plan to concentrate on the build and the MHRA validation of the Adanac Hub with a view to developing Medcura once the unit is operational.
3	Upgrade JAC system to - Achieve the complete safety and operational benefits from Omnicell Implementation - Respond to concerns raised in the Klas survey undertaken in 2021 regarding the system usability.	Complete	Omnicell benefits to be realised through NHSE First of Type project, expected to be delivered by Jan 2027.
4	Refresh Medicines Management policies and safe storage audit programme. Ensure these are aligned with the relevant CQC and regulatory frameworks and include formal reporting arrangements within the organisation.	Complete	The Trust Medicines Policy and Controlled Drug Policy have been updated. The pharmacy team are now working through the standalone appendices.
5	Update the pharmacy workforce strategy in light of the new NHS Long-Term Workforce Plan and regional workforce programmes.	Paused	Pending national 10 year workforce plan. Plans for aseptics are already in place.

Ongoing Action Plan

RAG Status:

	No progress or significantly delayed (>6 months)
	Progress is underway but delayed or slower than plan (< 6 month delay)
	On track, no significant concern

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
1	21/22	Ensure the new aseptic unit based at Adanac Park delivers on the organisation's investment and strategic requirements.	Phase 1 workforce recruitment is on track. Equipment in place and validation underway. Initial inspection planned for Jan 26 to enable production of UHS patients. MHRA licensing inspection planned for Mar/Apr 26 with a view to license production beginning for 26-27.		Q4 25/26	Chief Pharmacist – James Allen & Head of Pharmacy Aseptic Production - Amy Hill
2	21/22	Embed the discharge checklist in adult discharge pathways. Develop the nurse discharge checklist for paediatric areas & work with nurse leaders to improve utilisation in adult ward areas.	A new version has been deployed across UHS for adult patients, and we are currently collating data on the impact. This new checklist is significantly less time-consuming for nursing teams to complete. A paediatric version is still to be developed, and lessons from pharmacy helpline reports are being assessed to inform its development.		Complete Q1 25/26	Deputy Chief Pharmacist - Nicola Howarth

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
3	21/22	Formalise a programme of work to consider and implement evidence-based interventions to reduce the organisation's carbon footprint concerning medicines.	Carbon footprint is now routinely considered for new medicines reviewed as part of the regional formulary process. Formal plans to reduce desflurane from UHS have been completed. The pharmacy team are actively supporting the development of new plans and national bids to support the sustainable use of medicines. Nitrous Oxide manifolds decommissioned May 2025. Baseline assessment against the RPS Greener Pharmacy Toolkit completed April 25		Q1 2024/25	(New) Deputy Chief Pharmacist - Andy Fox
4	22/23	Upgrade the regional electronic chemotherapy prescribing (Aria) to ensure to ensure ongoing stability for chemotherapy provision and cancer scheduling	Upgrade planned underway with expected system availability from May/June 2025		Q1 25/26	Chief Pharmacist – James Allen
5	23/24	Develop and deliver an action plan to reduce Nitrous Oxide exposure to staff	Initial mitigation is in place. Environmental monitoring has commenced. Funding is being sought for personal monitoring in Feb 25. Exploring the use of scavengers in the ICB. Work to assess the risks across the wider trust footprint is also underway. Risk register entry in place with associated action plan		Q1 2025/6	Deputy Chief Pharmacist - Andy Fox

	Identified	Actions	Progress / Update	RAG Status	Timeline	Lead
6	Restarted 24/25	Electronic outpatient prescribing – objectively increase the proportion of outpatients prescribed digitally from baseline (~10%).	A new outpatient jump-through from CHARTs has been built and is being validated. This functionality will mean that prescribers can seamlessly transition to outpatient prescribing during clinic, reducing one of the most frequently cited barriers to increasing electronic outpatient prescribing uptake.		Q4 25/26	Chief Pharmacist – James Allen
7	24/25	Work with pharmacy and nursing leaders across HIOW to assess and procure a digital system for the stock control and ordering of controlled drugs.	Initial demonstrations have identified several limitations in the available systems. Additional scoping is required to identify a suitable product that can deliver the expected benefits.		Q3 25/26	Chief Pharmacist – James Allen
8	Restarted 25/26	Implement digital homecare management system to reduce administrative burden and improve contingency arrangements.	Initial scoping suggests no suitable systems are available, although pilot sites are testing electronic prescription transfer using EPS. Homecare eSign project being developed with UHS Digital to eliminate the need to transfer paper prescriptions. Expected delivery Q1 26/27.		Q2 26/27	Deputy Chief Pharmacist – Mark Pepperrell
9	New 25/26	Develop and publish the Trust Antimicrobial Resistance (AMR) strategy and 3 year AMR action plan. Including baseline assessment against required frameworks and alignment to the national action plan for AMR.	UHS AMR Strategy already developed, review and realignment with these new strategic targets is expected in Dec 25.		Q4 25/26	Chief Pharmacist – James Allen

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.13 Report to the Trust Board of Directors, 13 January 2026	
Title:	Ward Staffing Nursing Establishment Review July 2025 – October 2025
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Rosemary Chable, Head of Nursing for Education, Practice and Staffing

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

a) The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from July 2025 – October 2025.

Recommendations in this report link to the statutory responsibilities arising from the National Quality Board (2016) expectations on ensuring safe, sustainable, and productive staffing, the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021 refreshed 2025) assessed as part of CQC 'safe' and 'well-led' domain.

The report outlines UHS progress in meeting the 38 recommendations included in the NICE guideline (2014) on safe staffing for in-patient wards and provides an update on the action – plan to achieve the recommendations in the national staffing levels guidance published by the National Quality Board in July 2016 (a key requirement of the NHSI 'Developing workforce safeguards' guidance October 2018).

b) To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:

- Overall, the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations or service model changes – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

- UHS nursing establishments for the 55 areas reviewed are set to achieve a range of 1:1 to 1:9 registered nurse to patient ratio in most areas during the day with the majority (40) set between 1:4 to 1:8. Differences relate to specialty and overall staffing model.
- The majority of wards (31) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (22 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (2) are both higher intensity cancer care areas requiring a higher registered skill. 31 wards (down from 33 last year but remaining up significantly from 25 in 2019) are below the 60:40 ratio.
- Total (RN and unregistered) Planned Care Hours Per Patient Day (CHPPD) range from 4.4 – 19.2 and average at 7.8.

- Continued high levels of enhanced care demand, a significantly more junior workforce, managing additional surge areas and impact of financial controls have been highlighted as ongoing challenges for mitigation to ensure safe staffing.

  The paper is presented for DISCUSSION.

  a) The report is presented in full to Trust Board as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board on all aspects of the staffing reviews.

Contents:

Paper;
Appendix 1: National Quality Board (NQB Expectations for safe staffing Safe, Sustainable, and productive staffing;
Appendix 2: NQB Safe Staffing Recommendations – UHS action plan;
Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan;
Appendix 4: Ward by Ward staffing review metrics spreadsheet;
Appendix 5: Specific Divisional issues emerging;
Appendix 6: RCN Workforce Standards;
Appendix 7: RCN Revised Nursing Workforce Standards – May 2025 - UHS summary and assessment

Risk(s):

1b – Due to the current challenges we fail to provide patients and families/carers with a high-quality experience of care and positive patient outcomes.
3a – We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.

Equality Impact Consideration:	NO

1.0 Introduction or Background

1.1 The purpose of this paper is to report on the outcomes of the review of ward staffing nursing establishments undertaken from July 2025 – October 2025. This 6-monthly review forms part of the Trust approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs.

1.2 This paper focuses specifically on a review of nursing levels for in-patient ward areas. Areas such as maternity, critical care, theatres and the emergency department are reviewed separately.

1.3 Divisional 'light touch' 6 monthly staffing reviews took place in March/April 2025 for 3 of the clinical divisions (at the time) and were reported to their relevant divisional boards and Nursing and Midwifery Staffing Review Group. Emergent themes have been incorporated into this review. Division A did not complete a light touch review for their inpatient areas and a full annual review has been completed as part of this cycle.

1.4 Following a recent national review of the workforce safeguard standards (paper received at trust board in November 2025), as a key action, these light touch reviews will now be reported directly to trust board to ensure the board receives a 6 monthly update on nurse staffing establishments.

1.5 The ward staffing review this year has again taken place against the backdrop of financial recovery measures, some of which came into effect in Q4 of 2024/25 after the last annual staffing review with increasing measures being introduced in 2025/26. Discussions at the staffing review meetings focussed on impacts arising from the close monitoring and management of establishment levels (including temporary resourcing) and identification of any mitigations/adjustments needed to continue to assure the delivery of safe care in each area.

1.6 It should also be noted that there were some key ward reconfigurations, some ward moves and ward/bed closures since the last annual review and these changes have now been fully included in the annual cycle.

1.7 The report also includes an update on the NICE clinical guideline 1 – Safe Staffing for nursing in adult inpatient wards in acute hospitals, issued in July 2014 and details progress with the action plan for adopting this guideline within UHS.

1.8 This report fulfils expectation 1 and 2 of the National Quality Board requirements for Trusts in relation to safe nurse staffing and fulfils a number of the requirements outlined in the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. This review also meets recommendations outlined in the RCN Nursing Workforce Standards (May 2021 refreshed in 2025). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains.

2.0 Analysis and Discussion

2.1 Ward staffing review methodology

2.1.1 In 2006 UHS established a systematic, evidence based and triangulated methodological approach to reviewing ward staffing levels on an annual basis linked to budget setting and to staffing requirements arising from any developments planned in-year. This was aimed to provide safe, competent and fit for purpose staffing to deliver efficient, effective and high-quality care and has resulted in consistent year-on-year review of the nursing workforce matched by investment/disinvestment where required.

2.1.2 Following the National Quality Board expectations in 2014 and the refresh in 2016, a full review of ward establishments is now undertaken annually (with a light touch review at 6 months reporting to Divisional boards to ensure ongoing quality). As outlined previously, these light touch reviews will now be reported directly to Trust Board, in addition to the annual reporting to Trust Board in October/November. This is in response to the Developing Workforce Safeguards Standards.

2.1.3 The approach utilises the following methodologies:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool). Now incorporated into the Healthroster Safecare system
- Care Hours Per Patient Day (CHPPD)
- Professional Judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Health System data
- Review of eRostering data
- Review of ward quality metrics

2.2 National guidance

2.2.1 In 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) *'How to ensure the right people, with the right skills, are in the right place at the right time.'* This guidance was refreshed, broadened to all staff, and re-issued in July 2016 to include the need to focus on safe, *sustainable and productive* staffing. The NQB further reviewed this document and issued an updated recommendations brief in July 2017. The expectations outlined in this guide are presented in Appendix 1.

These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) has been updated with progress towards achieving compliance with the 37 recommendations that make up the 3 over-arching expectations.

2.2.2 The latest 4 monthly review of the action plan (November 2025) shows maintenance of compliance levels despite the ongoing activity and financial challenges. UHS remains compliant with 35 of the 37 recommendations. The following 2 outstanding areas require further action before being signed off:

Allocated time for the supervision of students and learners: *Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.* Whilst there is some allowance within the 23% headroom, requirements for supervision are growing with revised initiatives around preceptorship, staff wellbeing and student supervision. Learner numbers (including undergraduate students, apprentices and preceptees) are increasing with limited additional supervisory support available. It is also important to note that the Ward Leader Supervisory allowance is used flexibly and has at times been put on hold to support the staffing position with ward leaders being included regularly in the safe staffing numbers.

Equality and diversity: *The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.* Ongoing action through Equality & Diversity Group which is reported to Board separately.

2.2.3 In July 2014 NICE published *Clinical Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals.* This guideline is made up of 38 recommendations. A detailed action plan was developed within UHS and is reviewed 4 monthly by the Nursing and Midwifery Staffing review group. The current assessment (November 2025) shows UHS has maintained compliance in 37 of the 38 recommendations.

The 1 remaining recommendation is:

Escalation actions taken to address deficits on one ward should not compromise another. Management of trustwide staffing deficits and thrice daily reviews of staffing via the staffing hub, as well as an improved recruitment situation, have reduced the incidents of this however these have climbed again recently as we manage the ongoing capacity and management of surge areas specifically. The close management and maintenance of minimal staffing levels and regular redeployment of staff, does not enable assurance that wards are not compromised by staff movements in extremis.

The ongoing action plan is included at Appendix 3 detailing the recommendations and the UHS compliance position and actions in progress.

2.2.4 In October 2018 NHS Improvement published 'Developing Workforce Safeguards' guidance which sets out to support providers to deliver high quality care through safe and effective staffing. It includes many of the actions identified in both the NICE guidance and the National Quality Board recommendations broadened to all staff groups.

2.2.5 In July 2025 a national audit and self-assessment process was launched by NHSE to review trust compliance with the recommendations included in the Developing Workforce Safeguards guide. A separate paper was presented to board in November 2025 outlining the self-assessment for UHS and the actions required to assure compliance, including the development of a comprehensive safe ward staffing policy.

2.2.6 In May 2021 the Royal College of Nursing published their Nursing Workforce Standards (Appendix 6), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trustboard. Self-assessment undertaken by the Nursing and Midwifery Staffing Review Group (NMSRG) showed UHS was compliant with these standards.

2.2.7 During 2024 these standards were refreshed and a revised set of standards was published in May 2025. NMSRG completed a self-assessment (Appendix 7) which confirmed that UHS remain compliant with the majority of standards. One key standard that has changed is the recommendation that headroom should be set at a minimum of 27% as a realistic assessment of the requirement. UHS level is currently set at 23% and is consistently exceeded in most areas, particularly in specialty areas such as ED and Critical Care.

2.2.8 In September 2022 a key research study was published (Zaranko B, Sanford NJ, Kelly E et al. BMJ Quality and Safety Epub) which highlights the link between higher registered nurse numbers and seniority and improved patient outcomes. Additionally in August 2024 an additional follow-up article (Griffiths, P; Saville C; Ball, J JAMA

Network open) identified that substitution of registered gaps with temporary staff does not necessarily significantly lower the risks for patients.

2.2.9 In late 2023 NIHR published an evidence based Professional Judgement Framework to support the application of professional judgement in nurse staffing reviews. Rosemary Chable and Natasha Watts from UHSFT were contributors to this guidance and are acknowledged in the authorship. This framework has been used as the basis for professional judgement throughout the staffing reviews and is being used as part of the NHSE refreshed drive on safe staffing.

2.3 6 monthly Ward Staffing review July 2025 – October 2025 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2025 – October 2025 with initial review meetings taking place with each Division (attended by DDN, Matrons, Ward Leaders, Finance representatives, workforce representatives and facilitated by the Head of Nursing for Education, Practice and Staffing). The same triangulated methodology was used as in previous reviews. An update on the latest guidance and reporting requirements in relation to staffing were also included in the divisional review meetings.

2.3.2 The detailed spreadsheet with ward-by-ward findings is included at Appendix 4. This provides information on the current establishment data broken down by shift and assessing against registered/unregistered ratios; CHPPD; nurse to patient ratios by registered and total nurse staffing and acuity information from Safecare where appropriate. Following key changes within the data team in workforce systems, the processes for capturing and reporting this information, and linking it accurately to finance data, are being reviewed with the Head of Nursing to ensure it remains fit for purpose.

2.3.3 It should be noted that a number of wards continue to be regularly reconfigured in response to the changing capacity and service pressures or increase footprint to respond to surges in activity. Several rostering template reviews were therefore instigated as a result of the discussions, so some figures may have changed for individual wards since the review.

2.3.4 Other staff groups (e.g Housekeepers, administrative staff, Allied Health Professionals (AHP's), Enhanced and Advanced Practitioners) also provide vital support to the ward areas, and these are taken into consideration in setting the establishment levels.

2.3.5 The ***staffing hub*** which was established in April 2020 to co-ordinate and oversee the real-time nurse staffing levels across the hospital in support of the clinical site function has continued to operate and adapt. It now maintains a strong role in the daily deployment of staff and the ongoing management of additional temporary resourcing bookings, whilst maintaining the strong clinical focus on safe and effective care and appropriate escalation. This is particularly evident in the review and deployment of staff to support enhanced care needs.

The hub activity is led by a daily designated staffing matron who takes responsibility for leading the continuous review and reassignment of the nurse staffing resource throughout the day.

2.3.6 ***Nurse to patient ratios by registered and total nursing***

2.3.6.1 The ward establishments across UHS allow for registered nurse to patient ratios **during the day** to range from 1:1 (Piam Brown – Children) to 1:9 (Bassett, D6, D7 G6, G8, E7 and E12) depending on specialty and overall staffing model. This is a slight decrease in the number of wards with lower RN: patient ratios (down from 8 to 7

with all areas in medicine). It should be noted that medicine has this lower base than other areas.

2.3.6.2 The average level is set to achieve 1:4 to 1:8 registered nurse to patient ratio in most areas during the day (40 wards, previously 43) with 36 wards set between 1:4 to 1:7 (down from 42). 16 wards are set to achieve 1:1 to 1:3 ratios, these are all speciality areas such as cancer, and children or direct admission areas, that require a higher level of registered nurse intervention.

2.3.6.3 The areas on or above 1:7 (20 previously 22 wards) include the medicine wards, Medicine for Older People wards, some Trauma and Orthopaedic wards, including Brooke and the Acute Stroke Unit. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:4. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established and these wards with lower RN to patient ratios are working on their minimum safe levels.

2.3.6.4 Planned staffing ratios at **night** require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours.

- In areas that are working on lower staffing ratios, managing the workload at night has again emerged as an area that still requires action in a number of ward areas.
- Wards are piloting different twilight shift patterns (within existing budget) to continue to support the demands at night.
- Rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource at night.
- This also highlights the importance of supernumerary bleep-holders in supporting the ward areas. During 2025/26 to support measures to reduce temporary staffing demand and also to support the new 'Release to Respond' initiative or surge activity, supernumerary bleep-holders have been increasingly removed on a shift basis. Staff reported the impacts of this on support to the wards particularly at night as well as on maintaining patient flow.
- There is now 1 remaining in-patient ward area (F7) with ratios of 1:11 (RN to patient) at night. This is offset by a total nurse to patient ratio of 1:6 with the utilisation of support staff.

2.3.7 ***Registered to unregistered ratios***

2.3.7.1 UHS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should ideally not fall below unless planned as the model of care.

2.3.7.2 15 wards are now rostered at between 60:40 and 70:30.

2.3.7.3 31 wards are below the 60:40 ratio. An improvement on the 32 in the previous year but still remaining up significantly from 25 in 2019. These wards are utilising band 4 staff as a key contribution to the model of care and are areas where there is a wider multidisciplinary team contributing to care (e.g., MOP, T & O, Medicine, Acute Stroke). It should be noted however that with changing acuity and dependency of patients, these areas need to be kept under close review against other metrics to ensure safe, quality care can be provided within the establishments. As mentioned previously, recent research highlights the impact on patient outcomes in areas with reduced registered nurse cover.

2.3.7.4 9 wards (1 more than 2024) are above the 70:30 ratio reflecting the increased specialism of our regional specialties where the intensity of the patient needs requires a higher ratio of registered staff (Child Health, CV&T, Neurosciences, and Cancer Care areas).

2.3.7.5 The support of band 4 roles continues to be supported as part of a model of care in a number of areas linked to the further development of apprenticeship opportunities. This has also provided a role in which to appoint the emerging cohorts of nursing associates who have qualified and registered with the NMC from January 2019 onwards.

2.3.7.6 During 2025 a re-banding exercise was also completed moving our ward-based band 2 support staff to band 3 in the majority of cases and creating the progressive band 2/3 role for new starters. This has provided more robust support to clinical care, backed up by clear competencies.

2.3.7.7 In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision.

2.3.7.8 Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes and are accompanied by appropriate quality impact assessment and evaluation.

2.3.8 ***Assessment against the Safer Nursing Care Tool (acuity/dependency model***

2.3.8.1 The Safer Nursing Care Tool (SNCT - acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all the areas. Within UHS this is integrated into the health roster system as part of the safe-care tool and provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into recommended care hours per patient day.

2.3.8.2 Where the predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the speciality and number of beds.

2.3.8.3 The recent review and self-assessment of the Workforce Safeguards has highlighted the need to review the use of the SNCT within the trust and to undertake a separate focussed review in clinical areas to support establishment setting. A programme of work to support this is planned for 2026/27 to support next year's staffing reviews.

2.3.8.4 There is also ongoing education and support work taking place to ensure all areas are using the tool in line with the recommendations to ensure consistency.

2.3.9 ***Care Hours Per Patient Day***

2.3.9.1 Planned total Care Hours Per Patient Day (CHPPD) range from 4.4 (E7) rising to 19.2 (Piam Brown) and average at 7.8. The average is the same level as the previous year

2.3.9.2 Planned Registered care hours per patient day range from 1.9 (G5) rising to 14.5 (Piam Brown) and average at 4.5. This average is slightly lower this year.

2.3.9.3 Planned Unregistered care hours per patient day range from 1.3 (C6 TYA) – 8.7 (G2 Neuro) and average at 3.2. This average is slightly lower than last year.

2.3.9.4 Actual CHPPD fluctuate significantly across the year and are strongly linked to patient numbers and changes in patient acuity. For example, additional staffing for patients requiring enhanced care will increase the overall CHPPD numbers attributed to a ward whilst not really increasing the hours assigned for each patient, giving a false confidence around overall levels. For these reasons, an aggregated Trust-wide average, whilst useful to review month by month and annually for a trend, are less meaningful than the granular review of each ward CHPPD.

2.3.10 ***Allowance for additional headroom requirements and supervisory ward leader model***

2.3.10.1 All areas have 23% funding allocated to allow for additional headroom requirements arising from non-direct care time. It is recognised that in a number of areas this percentage is too low to cover all of the indirect requirements in an area, particularly related to speciality and supervisory and training needs. There remains significant pressure on maintaining staffing within the allowed headroom. This is due to high training levels (resulting from the more junior workforce) and maternity/paternity levels that consistently exceed the allowance. As highlighted previously the RCN now recommend an uplift of 27% as a minimum to cover all requirements as one of their safe staffing recommendations.

2.3.10.2 New national initiatives and requirements of the NHS contract such as the implementation of Professional Nurse Advocacy for all staff and Preceptorship support for all new registrants has further increased the pressure on this set level of headroom.

2.3.10.3 A discussion around management of headroom was included in each of the ward staffing reviews which took place with clear actions for the ward leaders to implement.

2.3.10.4 UHS has an established Ward Leader Supervisory model which means the Ward Leader is not included in the established numbers required to deliver safe care per shift. This enables them to focus more time on supervising and leading the ward team whilst supporting clinical care. This proved particularly important during recent years with developing the junior workforce.

2.3.10.5 This model has been paused intermittently in areas as part of the financial recovery plan and Ward Leaders were rostered directly to support shifts. This impacted a range of indicators including appraisal completion, sickness reviews, roster management and learner development. The model is used flexibly whilst the priority is always to ensure safe staffing levels on the wards. Ward Leaders clearly articulated the personal and professional impact of losing this protected time to undertake the wider aspects of their role.

2.3.11 ***Specific Divisional issues emerging***

Specific Divisional issues highlighted in the review are contained in Appendix 5.

2.4 Trust wide risks and issues considered in the review

2.4.1 ***Establishment monitoring and controls in line with financial recovery***

2.4.1.1 The staffing reviews took place against the backdrop of ongoing financial recovery. During the review period inpatient areas have been working to 97% of establishments (with identified exceptions) as a control measure and this is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards. Issues arising from these measures were openly discussed at the staffing reviews.

2.4.2 ***Increasing patient acuity/dependency***

2.4.2.1 The ongoing development of our defining services continues to result in an evidenced increase in the complexity, acuity and dependency of the patients cared for in our general ward beds, also linked to reducing length of stay.

2.4.2.2 Since Covid-19 it is clear that our patients are definitely presenting with a higher level of both acuity and dependency, and this has been highlighted by ward leaders across a number of specialties including cancer care and neurosciences.

2.4.2.3 Information on the acuity and dependency of our patients is available via the 'Safe Care' functionality in health roster and is used in real time as part of our daily staffing meetings. The information is also used at the 6 monthly reviews as part of the professional judgment assessment.

2.4.3 ***Increasing enhanced care needs***

2.4.3.1 Trust wide we have continued to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements.

2.4.3.2 We have also seen a significant rise in the episodes of violence and aggression experienced in our clinical areas which creates additional needs for staffing support.

2.4.3.3 This continues to have an impact on the ability to support the additional enhanced care needs that arise for these groups of patients particularly across key specialties (MOP, Medicine, Child Health, Neurosciences, T & O and Surgery).

2.4.3.4 Division B retain the Trustwide overview for enhanced care, specifically mental health support, and provide an advice service, supporting clinical areas in their decision making around the need for additional support.

2.4.3.5 Divisions have then developed enhanced care bays on wards and/or a local pool of staff to deploy to support enhanced care needs. Ward leaders report that this has made a major difference to the management of patients with these enhanced needs and has reduced the reliance on last minute agency to support.

2.4.3.6 The numbers however remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing.

2.4.3.7 The management of additional enhanced care needs extends beyond the definition of patients requiring formal mental health support. Increased numbers of patients with challenging behaviour or needing 1:1 presence brings additional pressures to ward establishments but are necessary to keep the environment safe for all patients.

2.4.3.8 During 25/26 the staffing hub has increased its role in co-ordinating and deploying the requests for additional staff with additional mental health needs specifically linked to the mental health support team. Whilst this has shown key improvements in the management of staffing resource, the demand and increase in patients presenting has continued.

2.4.3.9 In October 2025 UHS joined a cohort of the NHSE ETOC (Enhanced Therapeutic Observations and Care) programme. This programme will support the ongoing improvements around the provision of enhanced care.

2.4.4 ***Supervising and supporting the junior workforce***

2.4.4.1 The professional judgement discussions with all the Ward Leaders again highlighted the additional challenges posed to the staffing models, of appropriately supervising and supporting the increasing range of learners with placements on the ward areas. This includes the ability to meet the supervisory standards with an increasingly junior workforce.

2.4.4.2 National standards and a quality mark for preceptorship was established in October 2022 and implemented within UHS during 2023 with additional requirements in relation to the provision for all staff new to registration. Protected time for both preceptors and preceptees is now an expectation for organisations. In 2025 UHS was awarded the quality mark for preceptorship – one of the first trusts in the Southeast region to attain this.

2.4.4.3 The robust retention and recruitment strategies across the Trust and the strong vision to 'grow our own' nurses for the future have been sustained this year. This means that wards continue to support a range of learners including undergraduate students, trainee nursing associates, nurse degree apprentices and newly registered staff undergoing preceptorship.

2.4.4.4 Education teams across the trust have proved key to supporting the development and learning into the wards and particularly in continuing to train and support learners to full registration and into preceptorship.

2.4.4.5 The capacity and capability within the education and support teams is being further reviewed for 25/26 and beyond to ensure they can continue to support the further increase in numbers which will be required for UHS to meet the challenging workforce targets likely to emerge from the revised 10 year workforce plan.

2.4.5 *Benchmarking using the Model Health System*

2.4.5.1 UHSFT provides data monthly to the national Model Hospital System (MHS) detailing the actual CHPPD provided (based on patient numbers) for all clinical areas including critical care.

2.4.5.2 An overall average of total CHPPD is available to review via peer group and this is used as part of the staffing review. (Table 1)

2.4.5.3 Hospitals with a high volume of critical care beds (providing 1:1 care) will have a higher CHPPD.

2.4.5.4 Information from MHS of some general specialties is also included for information, however it is noted that category descriptions and case mix on wards can vary across organisations and therefore caution should be shown when making any direct comparison. (Table 2)

Table 1

Organisation/Group	Total CHPPD	Registered CHPPD	Unregistered CHPPD
UHS excl. Critical Care	8.7	4.8	3.9
UHS with Critical Care	10.5	6.7	3.8
Shelford Group	9.8	6.7	3.2
MHS Peer Group	9.56	5.7	3.4
Region	8.9	5.6	3.3
National	8.7	5.1	3.5

All data submissions (registered and unregistered) are averaged so will not necessarily equal the total CHPPD)

Data is from the MHS July 2025 (latest figure) and includes nursing and midwifery and ward AHP staffing. The UHS excluding critical care is UHS reporting July 2025 figure from People Report just for nursing.

Table 2

Speciality grouping	Total CHPPD - UHS	Total CHPPD – MHS Peer group
General Surgery	7.16	8.27
Trauma and Orthopaedics	9.21	8.96 (not trauma centres)
Cardiovascular	10.74	13.28
Neurosciences (specialty)	8.54	8.47
Medicine for Older People	6.05	8.49
General Medicine	7.04	8.13
Child Health	10.73	8.01

2.4.6 ***Review of quality metrics and staffing incidents***

2.4.6.1 The NICE guidance outlines some key quality metrics that should be considered as part of the staffing reviews. The safety metrics defined are patient falls, pressure ulcers and medicine administration errors. These metrics, along with a range of other UHS defined quality indicators are already monitored through our internal clinical quality dashboard and are discussed ward by ward as part of the professional judgement methodology in the reviews.

2.4.6.2 In addition, there is ongoing review of red flags raised as part of the adverse event reporting system and on 'safecare'. These elements are now also all brought together in the new quality report that is presented to trust board quarterly.

3.0 Conclusion

3.1 A robust ward staffing establishment review was undertaken using a mixed methodology of approaches and in line with recommendations from the National Quality Board, NICE guidance, Developing Workforce Safeguards and the RCN Nursing Workforce Standards.

3.2 Overall the staffing establishments remain appropriate and within recommended guidelines. These levels are however severely stretched when there is a requirement to support additional needs arising from enhanced care, opening of surge areas and Release to Respond.

3.3 There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip the nursing ratios, coupled with the impact of ward reconfigurations – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

4.0 Recommendations

4.1 To discuss the report at Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

4.2 To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.

4.3 To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing.

4.4 To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards.

4.5 To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels and to agree the continuous monitoring of this with the introduction of any additional financial recovery measures.

4.6 To support the continued Trust wide commitment and momentum on actions to fill clinical nursing vacancies and further reduce the reliance on temporary resourcing agency against the backdrop of rising acuity and emergency and elective recovery.

4.7 Systematic ward staffing reviews now to be reported to trust board 6 monthly. The Spring, 6-monthly light touch review reported through Divisional Boards and the next full staffing review to be presented to Trust Board in December 2026.

5.0 Appendices

Appendix 1: National Quality Board (NQB Expectations for safe staffing
Safe, Sustainable, and productive staffing
Appendix 2: NQB Safe Staffing Recommendations – UHS action plan
Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospital - UHS action plan
Appendix 4: Ward by Ward staffing review metrics spreadsheet
Appendix 5: Specific Divisional issues emerging
Appendix 6: RCN Workforce Standards
Appendix 7: RCN Revised Nursing Workforce Standards – May 2025 – UHS summary and assessment

Appendix 1

National Quality Board Expectations for safe staffing - Safe, Sustainable, and productive staffing (July 2016)

Expectation 1: Right staff	• Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. • Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. • This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. • There should also be a review following any service change or where quality or workforce concerns are identified. • Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. • Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.
Expectation 2: Right skills	• Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi professional team approach. • Decisions about staffing should be based on delivering safe, sustainable, and productive services. • Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.
Expectation 3: Right place and time	• Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. • Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

NATIONAL QUALITY BOARD - JULY 2016

Appendix 2

Supporting NHS Providers to deliver the right staff with the right skills, in the right place at the right time - safe sustainable and productive staffing - NURSING & MIDWIFERY

	Descriptor	No.	Recommendation	Current measures in place	Assessed UHS rating (Nov 2025) C = compliant A = Actions required	Identified actions required and notes on compliance	Timescale	Lead
Expectation 1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	**1.1 Evidence-based workforce planning**						
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).	Triangulated approach to staffing establishments well embedded. Shelford SNCT used and embedded in 'safecare' as part of eRostering. NICE guidance systematically reviewed 3 x per year.	C	Continue with current approach and strengthen with the use of CHPPD and safecare. Nov. 2025 refreshing use of SNCT as a result of the Workforce Safeguards review. To introduce more formal programme in Q1/Q2 2026/27	complete	Head of Nursing - staffing/DMT
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	C	Need to ensure there is corporate rigour on adapting SNCT while rolling out 'safecare'. Monitor the impact on the inclusion of 'enhanced care' scoring. Participate in the national NIHR research. Nov. 2025 refreshing use of SNCT as a result of the Workforce Safeguards review. To introduce more formal programme in Q1/Q2 2026/27	complete	Head of Nursing - staffing/DMT
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training and supervision requirements.	23% included in all direct care in-patient areas. Compliance monitored as part of healthroster reporting suite	C	Ongoing compliance monitored as part of healthroster reporting suite. Increased headroom requirement due to COVID-19. Acknowledgement that 23% headroom is not adequate in many settings. Discussed as part of staffing reviews.	complete	DoF/Chief Nurse
		1.2 Professional judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/DDN/Matron/ward leaders as well as workforce systems and finance. Professional judgement key part of the reviews.	C	Continue with current approach and strengthen with the use of CHPPD and safecare. Senior UHS team invovled in the authorship of the national professional judgement guide	complete	Head of Nursing - staffing/DMT
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.	As above. Professional judgement also used as part of the daily staffing review meetings through site control.	C	Continue with current approach. Professional judgement remains the ultimate measure of safe staffing. Key part of the staffing hub discussions.	complete	Head of Nursing - staffing/DMT/site team
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous ad hoc benchmarking included through AUKUH network and targeted at specific services under development. Need to strengthen and formalise	C	Build on the current benchmarking capabilities included in the Model Hospital and N&M Dashboard. Work with eRoster provider to introduce reporting that includes benchmarking data	complete	Head of Nursing - staffing/workforce systems team
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews	C	Model hospital benchmarking now being used routinely. All services benchmark with other areas where appropriate	complete	Head of Nursing - staffing/DMT
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Clinical Quality Dashboard (CQD) includes all staffing and quality metrics. Used as part of the systematic clinical accreditation scheme reviews	C	Build the model hospital work into the CQD	complete	Head of Quality and Clinical Assurance

Expectation 2: Right skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.	**2.1 Mandatory training, development and education**						
		2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	All frontline leaders skilled to manage staffing agenda. Included in competencies for ward leaders	C	Continue to maintain competence, skills and knowledge through master classes and staffing review meetings	complete	Head of Nursing - staffing/DMT
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	23% headroom allowance and provision of supervisory ward leader role covers most aspects of time identified but not fully assured around adequate time for supervision of all learners. Backfill provided for some roles in development - degree apprenticeships but does not cover release for all staff	A	23% headroom is included in all nursing establishments as well as an allowance in all areas for the Ward Leader to be supervisory. A number of additional requirements e.g. increased student numbers and supervision, increased numbers of junior staff needing more supernumerary training time, preceptorship support and professional nurse advocacy have led to the 23% allocation falling short of the needs in a number of areas. This is particarly notable in critical care and ED where the training needs outstrip the provision in the 23% headroom. Important to note that the Ward Leader Supervisory allowance was put on hold in Q4 2023/24 and reinstated slowly from Q1 2024/25 as part of the trust recovery plan. This impacted short term on some of the non-direct activities and KPI's eg appraisal. rates/progression/HR actions. Reviewed against the revised RCN workforce standards which recommend 27% headroom. Critical Care staffing review also highlighted a shortfall in allowances to account for ensuring staff are qualified in specialty (QuIS). Paper being developed to outline the need.	Unable to identify an expected date for compliance. Mitigations in place	Head of Nursing - staffing/DDN's/Divisional Education Leads/Education Quality Lead
		2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	C	Monitored as part of ongoing HR key performance metrics	complete	Associate Director of People/DMT
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Annual training needs analysis process well embedded within the annual cycle for the trust	C	Continue with current approach with review in 2026 to further streamline priorities to staffing needs and match to changed CPD arrangements .	complete	Divisional Education Leads/Education Quality Lead/DMT
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads//DMT
		2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time provided in all inpatient direct care areas.	C	Continue to review % of time achieved as supervisory linked to ongoing vacancy position	complete	Head of Nursing - staffing/DMT/workforce systems
		2.2 Working as a multiprofessional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed and evaluated within the organisation.	C	Further strengthen the trustwide approach to service by service workforce development	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department	C	Continue with current approach and strengthen integration	complete	Director of TD&W/Divisional Education Leads//DMT
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector.	C	Continue with current approach and strengthen partnership working through STP projects	complete	Director of TD&W/Divisional Education Leads//DMT

		2.3 Recruitment and retention						
		2.3.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Full action plan in place to address equality and diversity within trust linked to WRES data	A	Detailed in separate ED&I action plan. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan	ongoing through E & D	Chief Nurse/People Director
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Full retention and recruitment programme of work ongoing and a workforce project management office established to maintain the focus	C	Confident that there are effective strategies in place and remains an area for ongoing action. Continued focus and evaluation of the wide ranging streams of work in place to support retention and recruitment	ongoing through R & R steering group	People Director /DMT
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically around preceptorship.	C	Research partnership with Burdett and Birmingham to review self rostering. Flexibility sub group established as part of R & R actions to review different approaches to flexibility for generational needs. Joined RePAIR work on flexibility and NHSI retention collaborative	ongoing through R & R steering group	Associate Director of People/Director of TD&W/DMT
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	**3.1 Productive working and eliminating waste**						
		3.1.1	The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.	Transformation work incorporates lean techniques and productive ward techniques applied as appropriate including reviews of care hours, safety crosses, knowing how we're doing boards and patient status at a glance	C	Lean techniques used systematically as part of transformation	complete	Head of transformation/DMT
		3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated into all service redesign	C	Clear focus on flow and avoiding bottle-necks in service design.	complete	Head of transformation/DMT
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	Chief Nurse/DMT
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct care	C	Continue with current approach	complete	Chief Nurse/DMT
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register and AER system used to record, review and learn from any staffing issues	C	Continue with current approach and monitor ongoing trends with staffing risks	complete	Chief Nurse/DMT

Expectation 3: Right place and time		**3.2 Efficient deployment and flexibility**					
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systemetically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways inlcuded as part of the systematic review of staffing levels	C	Continue with current approach	complete	Chief Nurse/DMT
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Regular reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily stafifng meetings linked to site	C	Continue to strenghten the daily staffing meetings and utilise safecare information	complete	Head of Nursing - staffing/DDN/Matrons/Site
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared trustwide when required	C	Continue ot strengthen the information into site around staffing resource	complete	Head of Nursing - staffing/DDN/Matrons/workforce systems team
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Best practice guidance included in UHS poilicies around application of eRostering. Use of eRoster systematically reviewed and managed through the management team structure	C	Continue to strenthen the use of eRoster by utilising report function and reviewing compliance levels - specifically for: Approvals, unused hours, safecare	complete	Head of Nursing - staffing/DDN/Matrons
		3.3 Efficient employment, minimising agency use					
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	Currently undertake 6 monthly staffing reviews that take account of all of the recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use (NHSP) and reduce agency	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	Chief Nurse/Associate Director of People/DMT
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.	UHS fully engaged in development of STP workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/DoE
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.	Strong systems in place to idetnfiying palcement capacity and monitor student allocation and quality across all staff groups	C	Continue with current model. Work with universities to constantly review the placement models for students in line of developing undergraduate programmes and apprenticeships	complete	DoE/Education leads

37 recommendations: 35 compliant 2 require further action

Appendix 3

Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals : 38 recommendations

UHS FT self-assessment and action plan

	No.	Recommendation	NICE category Must (M) Should (S) Consider (C)	Current measures in place	Initial Assessed UHS rating (July 2014) C = compliant A = Actions required	Identified actions required (24 compliant, 14 action)	Timescale	Lead	November 2025 compliance	November 2025 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations	1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance.
	1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DDN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance	Maintain	Chief Nurse/Head of Nursing - staffing/ DDN	C	6 monthly light touch review not completed in all divisions in March due to COVID-19 but all establishments reviewed regularly during crisis and as part of restart. Full reviews scheduled for July/Aug 2020
	1.1.3	Ensure final ward establishments developed with registered nurses responsible and approved through chief nurse and trust board	M	6 monthly establishments reviews in place led by DoN team with DDN/Matron/ward leaders as appropriate. Reported and discussed through board	C	Strengthen involvement of ward sisters through supervisory competencies	Maintain	Chief Nurse/Head of Nursing - staffing/ DDN	C	6 monthly reviews involve ward leaders
	1.1.4	Ensure senior nursing managers are accountable for nursing rosters produced	M	Reflected in job descriptions for DDN/Matrons/Ward Leader and included in ward leader competencies Hierarchy in eRoster reinforces requirements	C	Strengthen the monitoring and follow up of roster KPI's	Maintain	Chief Nurse/Head of Nursing - staffing/DDN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles.
	1.1.5	Ensure inclusion of adequate 'uplift' to support staffing establishment	M	23% uplift included in all inpatient nursing establishments	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's	Maintain	DDN/Matron/Ward Leaders	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's.
	1.1.6	Include seasonal variation/fluctuating patient need when setting establishments	M	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews		Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.1.7	Establishments should be set appropriate to patient need taking account of registered/unregistered mix and knowledge and skills required	S	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.1.8	Ensure procedures in place to identify differences between on the day requirements and staff available	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily	C	Further strengthen the daily review processes through site. Strengthen the matron out of hours model to provide further oversight for staffing through to site		Head of Nursing - staffing/DDN/Matrons/Site	C	Staffing hub model now in place which provides the ongoing assurance and review of staffing.
	1.1.9	Hospital to have a system in place for nursing red flag events to be reported by nursing teams, patients, relatives to registered nurse in charge (see separate tab)	M	eReporting of incidents becoming embedded. Staff informally include red flag information	A	Formalise 'red flag' inclusions on e incident reporting. Educate staff on 'red flag' events through safe staffing master classes and local care group/divisional updates. Review 'red flags' on all quality review visits to ward areas.	Maintain	Head of Nursing - staffing/DDN/safety team	C	Red flag information now routinely captured through safecare (real-time) and reviewed through staffing hub. AER's also capture red flag information and this is reviewed systematically monthly and reported to board for trends. Included in staffing establishment reviews.
	1.1.10	Ensure procedures in place for effective response to unplanned variations in patient need - including ability to increase/decrease staffing	M	Clear escalation processes and review of staffing actioned through bleep holding arrangements in Divisions	A	Continued monitoring of effectiveness of escalation and staffing status	Maintain	Head of Nursing - staffing/DDN	C	Escalation clear and embedded through to the staffing hub function. Enhanced care requirements specifically flagged and linked to the policy and staff deployment co-ordinated through staffing hub.
	1.1.11	Actions to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards	S	Escalation processes include the need to review other wards/departments. All ward normal staffing included on trust wide spreadsheet daily	A	Continued monitoring of effectiveness of escalation and staffing status	Unable to identify a time when the organisation will be able to assure this. Mitigations in place.	Head of Nursing - staffing/DDN	A	Management of trustwide staffing deficits via the staffing hub have minimised the risk of this however the recruitment position, the dilute skillmix, the additional workforce controls in place and the capacity situation does not enable assurance that wards are not compromised by staff movements. Important to note that due to improved staffing levels, episodes of staffing in extremis to balance deficits have reduced however still unable to assure fully. Particularly noting challenges (November) with covering enhanced care needs and 'Release to Respond' necessitating staff moves to cover shortfalls.
	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	Head of Nursing - staffing/DDN	C	Escalation processes clear. Policy updated in 2022
	1.1.13	Consider implementing approaches to support flexibility such as adapting nursing shifts, skill mix, location and employment contracts	C	Variety of shift patterns worked within the trust and flexibility within rostering policy allows for variation	C	Continue to review as part of professional judgement element of staffing reviews	Maintain	Head of Nursing - staffing/DDN	C	Continue to review as part of professional judgement element of staffing reviews
	1.1.14	Ensure procedures in place for systematic ongoing monitoring of safe nursing indicators and formal review of nursing establishments twice a year	M	Nursing indicators monitored through incident reporting, ongoing monitoring and through CQD. Twice yearly formal staffing reviews embedded and managed through DON team	C	Continue to strengthen the process	Maintain	Head of Nursing - staffing/DDN	C	Included at establishment reviews

	1.1.15	Make appropriate changes to ward establishments as a response to reviews	M	Establishments amended as result of staffing reviews. Staffing review linked to budget setting process. Evidenced increases noted through trust board reporting	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DDN	C	Continue to strengthen and evidence the process
	1.1.16	Enable nursing staff to have appropriate training for the care they are required to provide	M	Strong track record of training within Trust. Individual care group education teams support ongoing development needs	C	Continue to strengthen and evidence the process	Maintain	Head of Nursing - staffing/DDN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DDN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DDN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DDN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual wards or shifts	**Principles for determining nursing staffing requirements -** Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements									
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Staffing hub has strengthened the understanding of staff at different levels
	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Continuous review of emerging national guidance	Head of Nursing - staffing	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into safe care module.
	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models. Stregnthened through the staffing hub
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DDN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models
Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment	**Setting the ward nursing staff establishment -** Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward									
	1.3.1	Setting ward establishments should involve designated senior registered nurses at ward level experienced and trained in determining nursing staff requirements using recommended tools	S	Ward sisters already involved in ward establishment reviews but approach needs strengthening. Competency for establishment review included in ward leader competencies	A	Strengthen involvement and training of ward leaders and other nurses through staffing master classes	Maintain	Head of Nursing - staffing/DDN/Workforce Systems	C	Current staffing review has full representation from ward leaders
	1.3.2	Routinely measure the average amount of nursing time required throughout a 24 hour period for each patient expressed as nursing hours per patient.	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016. reviewed as a metric in the staffing hub
						Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain	Head of Nursing - staffing/Workforce Systems	C	Safe care rollout complete
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016
	1.3.4	Multiply the average number of nursing hours per patient by the average daily bed utilisation	S	Methodologies currently based on using 100% bed occupancy - bed utilisation considered as part of the professional judgement	A	Introduce bed utilisation into the staffing review methodology for November 2014	Maintain	Head of Nursing - staffing/Workforce Systems	C	Bed utilisation discussed as part of the staffing review sonce July - Sept 2015 particularly in admission areas. Continue to calculate on 100% bed occupancy
	1.3.5	Add an allowance for additional nursing workload based on the relevant ward factors such as turnover, layout and size and staff factors	S	Already included in professional judgment considerations	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.3.6	Identify appropriate knowledge and nursing skill mix required - registered to unregistered - reviewing appropriate delegation	S	Trust baseline registered: unregistered 60:40 - no inpatient ward establishment drop below this. Assessed as part of professional judgement	C	Continued consideration at establishment reviews	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews
	1.3.7 and 1.3.8	Ensure planned uplift included in the calculation on average patients nursing needs	S	Trust baseline to include 23% on all ward establishments to cover uplift. Additional 0.8 wte uplift being rolled out for supervisory ward leader model	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	Maintain	Head of Nursing - staffing/DDN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering
Assessing if nursing staff available on the day meet patients' nursing needs - Recommendations for registered nurses in charge of individual wards or shifts	**Assessing if nursing staff available on the day meet patients' nursing needs -** Recommendations for registered nurses on wards who are in charge of shifts									
	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DDN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role. Oversight from the staffing hub now enhancing the 24 hr view

Assessing if nursing staff available o patients' nursing needs - Recommendati nurses on wards	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	Monitoring of red flags on ongoing basis and key metric considered at staffing hub huddles. Reflected in AER reporting
	1.4.3	If a nursing red flag occurs it should prompt an immediate escalation response by the registered nurse in charge - with potential to allocate additional nursing staff	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting and noted in bleep-holder logs
	1.4.4	Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning or establishments	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DDN	C	On the day records maintained and all red flag events captured through AER. Information used as part of the annual staffing reviews for each area to inform establishment changes. Examples at budget setting of changes as a result.
Monitor & evaluate ward nursing establishments - Recommendations for senior management and matrons	**Monitor and evaluate ward nursing staff establishments -** Recommendations for senior management and nursing managers or matrons to support safe staffing for nursing at ward level									
	1.5.1	Monitor whether the ward nursing staff establishment adequately meets patients nursing needs using safe nursing indicators. Consider continuous data collection of these nursing indicators	S	Majority of safe nursing indicators already included as part of the clinical quality dashboard	A	Expand the clinical quality dashboard to include the identified safe nursing indicators	Maintain	DDN/Head of Nursing - staffing/Head of Quality and Clinical Assurance	C	Clinical Quality Dashboard reviewed and relaunched September 2015. Review of indicators included as part of clinical accreditation scheme completed
	1.5.2	Compare results of safe nursing indicators with previous results over 6 month period	S	Review as part of monitoring of clinical quality dashboard	A	Include review of safe nursing indicators as part of staffing reviews from 2015 onwards	Maintain	Matrons	C	Review of indicators included as part of clinical accreditation scheme and annual matron reviews completed
	1.5.3	Monitor all of the nursing red flags and safe nursing indicators linked to wards exceeding 1 RN to 8 patients during the day	S	1:8 indicator included in daily staffing spreadsheet as a trigger to review staffing	A	Matrons to review all safe nursing indicators routinely for all ward areas	Maintain	Matrons	C	Matrons review all safe nursing indicators routinely for all ward areas. Retrospective review of red flag/AER incidents included as part of staffing discussions.

Appendix 4

Staffing figures extracted from healthroster for September 2025

Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

Safe care assess + is higher than recommended - is lower

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	Care Group	Unit Name	Shift	Total Beds	Budgeted Total Nursing Establishment (WTE)	Budgeted Registered Staff (WTE)	Budgeted Unregistered Staff (WTE)	Demand Registered (Count)	Demand Unregistered (Count)	Total nurse per shift	Skill Mix (RN:URN)	Patients RN Ratio (RN: Patient)	Patients Nursing Ratio (Total Nurse: Patient)	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD	Total Actual Demand CHPPD	Total Actual CHPPD
Division A	Surgery	SUR E5 Lower GI	Early	18	24.3	14.8	9.5	4	3	7	58 : 42	1 : 5	1 : 3	4.1	3.3	7.4	8.1	7.0
		SUR E5 Lower GI	Late	18				4	2	6	67 : 33	1 : 5	1 : 3					
		SUR E5 Lower GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
		SUR E5 Upper GI	Early	18	24.9	15.4	9.5	4	3	7	55 : 45	1 : 5	1 : 3	3.8	3.2	7.0	8.3	7.0
		SUR E5 Upper GI	Late	18				4	3	6	56 : 44	1 : 6	1 : 3					
		SUR E5 Upper GI	Night	18				2	2	4	52 : 48	1 : 9	1 : 5					
		SUR E8 Ward	Early	26	48.1	25.6	22.5	6	3	9	67 : 33	1 : 5	1 : 3	4.9	2.7	7.6	7.2	7.8
		SUR E8 Ward	Late	26				4	3	7	57 : 43	1 : 7	1 : 4					
		SUR E8 Ward	Night	26				4	3	7	57 : 43	1 : 7	1 : 4					
		SUR F11 IF	Early	17	31.8	22.8	9.0	4	2	6	67 : 33	1 : 5	1 : 3	5.0	2.8	7.7	10.4	7.6
		SUR F11 IF	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
		SUR F11 IF	Night	17				2	2	4	51 : 49	1 : 9	1 : 5					
		SUR Acute Surgical Unit	Early	12	24.1	15.1	9.0	4	2	6	67 : 33	1 : 3	1 : 3	4.8	4.1	8.9	10.3	11.4
		SUR Acute Surgical Unit	Late	12				4	2	6	67 : 33	1 : 3	1 : 3					
		SUR Acute Surgical Unit	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
		SUR Acute Surgical Admissions	Early	30	38.5	19.8	18.7	6	3	9	66 : 34	1 : 6	1 : 4	3.1	2.0	5.1	7.5	7.3
		SUR Acute Surgical Admissions	Late	30				6	2	8	70 : 30	1 : 6	1 : 4					
		SUR Acute Surgical Admissions	Night	30				3	3	6	50 : 50	1 : 11	1 : 6					
		SUR F5 Ward	Early	28	36.6	19.4	17.2	6	2	8	75 : 25	1 : 5	1 : 4	3.8	2.0	5.7	6.7	6.1
		SUR F5 Ward	Late	28				6	2	8	75 : 25	1 : 5	1 : 4					
		SUR F5 Ward	Night	28				3	2	5	61 : 39	1 : 10	1 : 6					
	Cancer Care	CAN Acute Onc Services	Early	12	24.3	19.2	5.2	5	3	8	63 : 37	1 : 3	1 : 2	4.9	4.3	9.2	#N/A	12.7
		CAN Acute Onc Services	Late	12				2	0	2	100 : 0	1 : 6	1 : 6					
		CAN Acute Onc Services	Night	12				2	2	4	50 : 50	1 : 7	1 : 4					
		CAN C4 Solent Ward Clinical Oncology	Early	23	35.3	22.1	13.2	5	3	8	63 : 38	1 : 5	1 : 3	3.9	2.4	6.4	8.0	7.9
		CAN C4 Solent Ward Clinical Oncology	Late	23				5	3	8	63 : 37	1 : 5	1 : 3					
		CAN C4 Solent Ward Clinical Oncology	Night	23				3	2	5	60 : 40	1 : 8	1 : 5					
		CAN C6 Leukaemia/BMT Unit	Early	21	40.2	39.1	1.1	8	2	10	80 : 20	1 : 3	1 : 3	7.6	1.5	9.2	6.5	9.4
		CAN C6 Leukaemia/BMT Unit	Late	21				8	2	10	80 : 20	1 : 3	1 : 3					
		CAN C6 Leukaemia/BMT Unit	Night	21				6	1	7	86 : 14	1 : 4	1 : 4					
		CAN C6 TYA Unit	Early	10	11.8	10.7	1.1	3	1	4	75 : 25	1 : 4	1 : 3	5.7	1.4	7.1	6.6	9.8
		CAN C6 TYA Unit	Late	10				3	1	4	74 : 26	1 : 4	1 : 3					
		CAN C6 TYA Unit	Night	10				2	0	2	100 : 0	1 : 6	1 : 6					
		CAN C2 Haematology	Early	27	35.6	23.2	12.4	8	3	11	73 : 27	1 : 4	1 : 3	5.5	2.6	8.1	9.3	9.5
		CAN C2 Haematology	Late	27				8	3	11	73 : 27	1 : 4	1 : 3					
		CAN C2 Haematology	Night	27				6	3	9	67 : 33	1 : 5	1 : 4					
		CAN D12	Early	24	31.8	22.9	8.9	5	3	8	62 : 38	1 : 5	1 : 4	4.3	2.3	6.6	6.8	8.8
		CAN D12	Late	24				5	3	8	63 : 37	1 : 5	1 : 4					
		CAN D12	Night	24				4	2	6	67 : 33	1 : 7	1 : 5					
Division B	Medicine	MED D5 Ward	Early	28	38.7	19.0	19.7	4	5	9	44 : 56	1 : 7	1 : 4	3.0	2.8	5.7	7.2	7.6
		MED D5 Ward	Late	28				4	4	8	50 : 50	1 : 7	1 : 4					
		MED D5 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
		MED D6 Ward	Early	24	34.0	14.7	19.3	3	5	8	38 : 62	1 : 9	1 : 4	2.9	3.4	6.3	9.1	8.5
		MED D6 Ward	Late	24				3	5	8	38 : 62	1 : 9	1 : 4					
		MED D6 Ward	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					
		MED D7 Ward	Early	16	23.7	12.0	11.7	2	3	5	40 : 60	1 : 9	1 : 4	2.9	3.7	6.5	9.6	0.0
		MED D7 Ward	Late	16				2	3	5	40 : 60	1 : 9	1 : 4					
		MED D7 Ward	Night	16				2	2	4	50 : 50	1 : 9	1 : 5					
		MED D8 Ward	Early	24	39.5	20.7	18.8	3	5	8	38 : 63	1 : 8	1 : 3	2.9	3.1	6.0	9.7	8.6
		MED D8 Ward	Late	24				3	4	7	43 : 57	1 : 8	1 : 4					
		MED D8 Ward	Night	24				3	3	6	50 : 50	1 : 8	1 : 4					
		MED D9 Ward	Early	28	39.3	19.0	20.3	4	5	9	45 : 55	1 : 8	1 : 4	2.8	2.7	5.5	#N/A	8.0
		MED D9 Ward	Late	28				4	4	8	50 : 50	1 : 8	1 : 4					
		MED D9 Ward	Night	28				3	3	6	50 : 50	1 : 10	1 : 5					
		MED E7 Ward	Early	26	31.5	15.5	16.1	3	5	8	38 : 63	1 : 9	1 : 4	2.3	2.1	4.4	11.0	7.8
		MED E7 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED E7 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED F7 Ward	Early	20	17.0	1.0	16.0	3	3	6	50 : 50	1 : 7	1 : 4	3.4	3.4	6.8	9.5	1.7
		MED F7 Ward	Late	20				3	3	6	50 : 50	1 : 7	1 : 4					
		MED F7 Ward	Night	20				2	2	4	50 : 50	1 : 11	1 : 6					
		MED C5 Isolation Ward	Early	14	26.4	15.2	11.2	2	4	6	34 : 66	1 : 8	1 : 3	3.5	4.9	8.4	10.5	16.2
		MED C5 Isolation Ward	Late	14				2	4	6	34 : 66	1 : 8	1 : 3					
		MED C5 Isolation Ward	Night	14				2	2	4	50 : 50	1 : 8	1 : 4					
		MED D10 Isolation Unit	Early	18	32.1	15.5	16.7	3	4	7	43 : 57	1 : 7	1 : 3	3.3	3.8	7.2	7.2	13.2
		MED D10 Isolation Unit	Late	18				3	4	7	43 : 57	1 : 7	1 : 3					
		MED D10 Isolation Unit	Night	18				2	2	4	51 : 49	1 : 9	1 : 5					
		MED G5 Ward	Early	28	39.2	15.5	23.8	4	5	9	44 : 56	1 : 7	1 : 4	2.6	2.8	5.3	8.9	6.5
		MED G5 Ward	Late	28				4	5	9	44 : 56	1 : 7	1 : 4					
		MED G5 Ward	Night	28				3	2	5	60 : 40	1 : 10	1 : 6					
		MED G6 Ward	Early	26	38.9	15.5	23.4	3	5	7	39 : 61	1 : 9	1 : 4	2.5	3.0	5.5	9.1	6.0
		MED G6 Ward	Late	26				3	5	7	39 : 61	1 : 9	1 : 4					
		MED G6 Ward	Night	26				3	2	5	59 : 41	1 : 10	1 : 6					
		MED G7 Ward	Early	14	32.2	12.4	19.9	2	3	5	40 : 60	1 : 7	1 : 3	3.2	3.3	6.5	10.3	7.9
		MED G7 Ward	Late	14				2	3	5	40 : 60	1 : 7	1 : 3					
		MED G7 Ward	Night	14				2	2	4	50 : 50	1 : 7	1 : 4					
		MED G8 Ward	Early	26	36.8	15.5	21.4	3	5	8	38 : 63	1 : 9	1 : 4	2.5	2.9	5.4	No measure	6.1
		MED G8 Ward	Late	26				3	5	8	38 : 62	1 : 9	1 : 4					
		MED G8 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED G9 Ward	Early	26	38.2	15.5	22.8	3	5	8	38 : 63	1 : 9	1 : 4	2.6	3.0	5.6	7.5	6.1
		MED G9 Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED G9 Ward	Night	26				3	2	5	60 : 40	1 : 9	1 : 6					
		MED Bassett Ward	Early	26	28.8	12.4	16.4	3	6	9	33 : 67	1 : 9	1 : 3	3.0	4.4	7.4	12.3	7.0
		MED Bassett Ward	Late	26				3	5	8	38 : 63	1 : 9	1 : 4					
		MED Bassett Ward	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
		MED E12	Early	24	0.0	0.0	0.0	3	5	8	38 : 62	1 : 9	1 : 4	2.4	3.4	5.7	10.9	4.4
		MED E12	Late	24				2	5	7	29 : 71	1 : 13	1 : 4					
		MED E12	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					
Division C	Child Health	CHI Paed Medical Unit	Early	18	40.7	28.6	12.2	6	2	8	75 : 25	1 : 4	1 : 3	7.9	2.4	10.4	8.2	12.0
		CHI Paed Medical Unit	Late	18				6	2	8	75 : 25	1 : 4	1 : 3					
		CHI Paed Medical Unit	Night	18				6	2	8	75 : 25	1 : 4	1 : 3					
		CHI Plam Brown Unit	Early	12	38.3	37.3	1.0	13	3	16	83 : 17	1 : 1	1 : 1	14.5	4.7	19.2	9.5	18.0
		CHI Plam Brown Unit	Late	12				5	2	7	71 : 29	1 : 3	1 : 2					
		CHI Plam Brown Unit	Night	12				4	2	6	67 : 33	1 : 5	1 : 3					
		CHI Ward E1 Paed Cardiac	Early	16	36.5	28.9	7.6	7	2	9	79 : 21	1 : 3	1 : 2	9.2	2.2	11.4	8.5	13.2
		CHI Ward E1 Paed Cardiac	Late	16				6	2	8	75 : 25	1 : 3	1 : 3					
		CHI Ward E1 Paed Cardiac	Night	16				5	1	6	83 : 17	1 : 4	1 : 3					
		CHI Ward G2 Neuro	Early	6	12.1	12.1	0.0	2	2	4	50 : 50	1 : 4	1 : 2	7.9	8.5	16.5	8.4	10.8
		CHI Ward G2 Neuro	Late	6				2	2	4	50 : 50	1 : 4	1 : 2					
		CHI Ward G2 Neuro	Night	6				2	2	4	50 : 50	1 : 4	1 : 2					
		CHI Ward G3	Early	16	43.7	30.5	13.2	6	4	10	60 : 40	1 : 3	1 : 2	8.2	5.3	13.5	8.2	14.0
		CHI Ward G3	Late	16				6	4	10	60 : 40	1 : 3	1 : 2					
		CHI Ward G3	Night	16				5	3	8	63 : 38	1 : 4	1 : 3					
		CHI Ward G4 SUN	Early	18	50.2	38.6	11.6	6	3	9	68 : 32	1 : 3	1 : 3	7.3	3.5	10.7	8.2	12.5
		CHI Ward G4 SUN	Late	18				6	3	9	68 : 32	1 : 3	1 : 3					
		CHI Ward G4 SUN	Night	18				5	2	7	71 : 29	1 : 4	1 : 3					
	Women & Newborn	W&N Bramshaw Womens Unit	Early	18	33.3	17.9	15.3	3	2	5	62 : 38	1 : 7	1 : 4	3.5	2.2	5.7	#N/A	9.9
		W&N Bramshaw Womens Unit	Late	18				3	2	5	61 : 39	1 : 7	1 : 4					
		W&N Bramshaw Womens Unit	Night	18				2	2	4	57 : 43	1 : 8	1 : 5					
	Cardiovascular & Thoracic	CAR Ward D3 Cardiac	Early	22	49.2	28.6	20.6	7	2	9	75 : 25	1 : 4	1 : 3	5.6	2.2	7.8	8.8	8.1
		CAR Ward D3 Cardiac	Late	22				6	2	8	72 : 28	1 : 4	1 : 3					
		CAR Ward D3 Cardiac	Night	22				4	2	6	67 : 33	1 : 6	1 : 4					
		CAR Ward D4 Vascular	Early	22	34.3	19.3	14.9	5	3	8	63 : 37	1 : 5	1 : 3	4.6	3.1	7.7	8.3	8.5
		CAR Ward D4 Vascular	Late	22				5	3	8	62 : 38	1 : 5	1 : 3					
		CAR Ward D4 Vascular	Night	22				3	3	6	50 : 50	1 : 8	1 : 4					
		CAR Ward E2 YACU	Early	17	28.1	18.8	9.2	4	2	6	67 : 33	1 : 5	1 : 3	5.3	3.3	8.5	#N/A	0.0
		CAR Ward E2 YACU	Late	17				4	2	6	67 : 33	1 : 5	1 : 3					
		CAR Ward E2 YACU	Night	17				2	2	4	51 : 49	1 : 9	1 : 5					
		CAR Ward E3 Green	Early	24	53.3	27.5	25.8	5	3	8	64 : 36	1 : 5	1 : 4	4.0	2.0	6.0	7.9	7.0
		CAR Ward E3 Green	Late	24				5	2	7	75 : 25	1 : 5	1 : 4					
		CAR Ward E3 Green	Night	24				3	2	5	60 : 40	1 : 9	1 : 5					

Appendix 4

Staffing figures extracted from healthroster for September 2025

Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

Safe care assess + is higher than recommended - is lower

					Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)			Actual demand average(In Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	**Care Group**	**Unit Name**	**Shift**	**Total Beds**	**Budgeted Total Nursing Establishment (WTE)**	**Budgeted Registered Staff (WTE)**	**Budgeted Unregistered Staff (WTE)**	**Demand Registered (Count)**	**Demand Unregistered (Count)**	**Total nurse per shift**	**Skill Mix (RN:URN)**	**Patients RN Ratio (RN: Patient)**	**Patients Nursing Ratio (Total Nurse: Patient)**	**Planned Registered (CHPPD)**	**Planned Unregistered (CHPPD)**	**Total Planned CHPPD**	**Total Actual Demand CHPPD**	**Total Actual CHPPD**
Division A		CAR Ward E3 Blue	Early	18	0.0	0.0	0.0	4	2	6	68 : 32	1 : 5	1 : 4	4.3	2.5	6.8	7.9	7.6
		CAR Ward E3 Blue	Late	18				4	2	6	67 : 33	1 : 5	1 : 4					
		CAR Ward E3 Blue	Night	18				2	2	4	50 : 50	1 : 10	1 : 5					
		CAR Ward E4 Thoracics	Early	20	40.4	24.9	15.6	6	2	8	76 : 24	1 : 4	1 : 3	5.9	2.8	8.7	7.1	9.8
		CAR Ward E4 Thoracics	Late	20				6	3	9	67 : 33	1 : 4	1 : 3					
		CAR Ward E4 Thoracics	Night	20				4	2	6	66 : 34	1 : 6	1 : 4					
		CAR Ward D2 Cardiology	Early	15	30.4	16.9	13.5	3	2	5	61 : 39	1 : 5	1 : 4	4.5	3.0	7.5	10.1	8.1
		CAR Ward D2 Cardiology	Late	15				3	2	5	60 : 40	1 : 6	1 : 4					
		CAR Ward D2 Cardiology	Night	15				2	2	4	51 : 49	1 : 8	1 : 4					
		NEU Acute Stroke Unit	Early	28	61.6	23.6	38.1	4	6	10	40 : 60	1 : 8	1 : 3	2.9	4.0	6.9	11.3	7.0
		NEU Acute Stroke Unit	Late	28				4	6	10	40 : 60	1 : 8	1 : 3					
		NEU Acute Stroke Unit	Night	28				3	4	7	43 : 57	1 : 10	1 : 5					
		NEU Regional Transfer Unit	Early	10	30.0	22.5	7.5	3	1	4	75 : 25	1 : 4	1 : 3	5.9	3.0	9.0	9.8	13.0
		NEU Regional Transfer Unit	Late	10				3	1	4	75 : 25	1 : 4	1 : 3					
		NEU Regional Transfer Unit	Night	10				2	2	4	54 : 46	1 : 6	1 : 3					
	Neurosciences	NEU ward E Neuro	Early	26	48.0	30.3	17.7	5	3	8	59 : 41	1 : 6	1 : 4	4.0	3.0	7.0	8.7	7.3
		NEU ward E Neuro	Late	26				5	3	8	59 : 41	1 : 6	1 : 4					
		NEU ward E Neuro	Night	26				4	3	7	54 : 46	1 : 7	1 : 4					
		NEU HASU	Early	13	30.6	22.6	8.0	4	1	5	79 : 21	1 : 4	1 : 3	7.2	1.8	8.9	15.4	10.4
		NEU HASU	Late	13				4	1	5	79 : 21	1 : 4	1 : 3					
		NEU HASU	Night	13				4	1	5	79 : 21	1 : 4	1 : 3					
		NEU Ward D Neuro	Early	27	60.6	30.3	30.3	5	5	10	51 : 49	1 : 6	1 : 3	3.9	4.0	7.8	10.8	10.6
		NEU Ward D Neuro	Late	27				5	5	9	51 : 49	1 : 6	1 : 3					
		NEU Ward D Neuro	Night	27				4	5	9	45 : 55	1 : 7	1 : 4					
	Spinal Service	SPI Ward F4 Spinal	Early	22	42.2	22.7	19.5	4	3	7	57 : 43	1 : 6	1 : 4	3.8	3.1	6.9	8.6	8.0
		SPI Ward F4 Spinal	Late	22				4	3	7	57 : 43	1 : 6	1 : 4					
		SPI Ward F4 Spinal	Night	22				3	3	6	50 : 50	1 : 8	1 : 4					
	Trauma & Orthopaedics	T&O Ward Brooke	Early	18	25.4	17.4	8.0	3	3	6	50 : 50	1 : 7	1 : 4	3.3	3.7	7.0	10.9	6.4
		T&O Ward Brooke	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
		T&O Ward Brooke	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					
		T&O Trauma Admissions Unit	Early	8	26.1	13.2	13.0	3	2	5	58 : 42	1 : 4	1 : 2	6.5	5.7	12.2	#N/A	19.7
		T&O Trauma Admissions Unit	Late	8				2	2	4	50 : 50	1 : 5	1 : 3					
		T&O Trauma Admissions Unit	Night	8				2	2	4	50 : 50	1 : 5	1 : 3					
		T&O Ward F1 Major Trauma Unit	Early	32	66.2	36.8	29.4	6	5	11	55 : 45	1 : 6	1 : 4	4.1	3.5	7.6	11.6	9.1
		T&O Ward F1 Major Trauma Unit	Late	32				6	5	11	55 : 45	1 : 6	1 : 4					
		T&O Ward F1 Major Trauma Unit	Night	32				5	5	10	50 : 50	1 : 7	1 : 4					
		T&O Ward F2 Trauma	Early	26	51.8	23.6	28.2	4	5	9	44 : 56	1 : 7	1 : 3	3.3	3.9	7.2	11.2	8.4
		T&O Ward F2 Trauma	Late	26				4	5	9	44 : 56	1 : 7	1 : 3					
		T&O Ward F2 Trauma	Night	26				3	4	7	43 : 57	1 : 9	1 : 4					
		T&O Ward F3 Trauma	Early	24	50.6	21.6	29.0	4	6	10	40 : 60	1 : 7	1 : 3	3.5	5.0	8.5	11.2	8.8
		T&O Ward F3 Trauma	Late	24				4	5	9	44 : 56	1 : 7	1 : 3					
		T&O Ward F3 Trauma	Night	24				3	5	8	38 : 63	1 : 9	1 : 4					
		T&O Ward F4 Elective	Early	18	33.2	21.3	11.9	4	2	6	67 : 33	1 : 5	1 : 4	3.6	3.4	7.0	7.9	7.0
		T&O Ward F4 Elective	Late	18				3	3	6	50 : 50	1 : 7	1 : 4					
		T&O Ward F4 Elective	Night	18				2	3	5	40 : 60	1 : 10	1 : 4					

Specific Divisional issues emerging - Ward Staffing Review 2025

Division A

The establishment staffing levels are appropriate in most wards areas. Relatively low trained nurse vacancy but high untrained vacancy up to 40% in some areas. Recruitment and retention remain a challenge, for untrained nurses.

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the ongoing financial position is being monitored by the matron teams via staffing AERs, quality indicators and red flags.

Ward lead supervisory time has been impacted throughout the year, these shifts have often been cancelled to support safe staffing on the ward areas. This leads to a direct impact on leadership and development of more junior staff, and managing the HR workload such as sickness and absence. Most ward areas have a junior workforce and at times the skill mix is not adequate. With pipeline recruitment focused on newly qualified nurses this is set to continue.

Surge areas continue to open when there is a high demand on beds. There is no funding for the workforce in SDU (above 6 inpatient beds), Cathlab Day Unit (overnight patients) and Neuro day case (overnight patients). Staffing these areas continues to put strain on the existing staff resource.

Enhanced care and patients requiring 1:1 staffing due to mental health conditions continues to be a challenge for inpatient ward areas. There is very little allocated funding for this workforce. Allocation has improved with the staffing hub leading on the booking of registered mental health nurses but we have seen a decrease in fill for unregistered mental health nurses. There have been shifts that have remained unfilled, necessitating a risk assessment to be made by the matron team as to which patient is allocated the health care support worker. This is often done with the help of the mental health team.

Violence and aggression incidents continue to remain a concern across ward areas. Orthopaedics and Neurosciences seem to be the areas affected most. This group of complex patients can be very time consuming and place significant demands on resources, particularly the security team, who are often required to de-escalate situations where staff are potentially put at risk. Private security firms have been used for several incidents this year, to protect staff and other patients. Staff wellbeing is affected when they have been involved in these incidents, with an increase in sickness, and low morale.

E2 cardiac ward was closed for 4 months over the summer, due to low bed occupancy and reduced operating. All staff were deployed within the cardiac ward footprint reducing the usage of bank and agency.

Supernumerary bleep holders remain unfunded in most areas. When there is opportunity to allocate to this role, they are often required to fill the R2R (release to respond) role in the Emergency Department. They are, however often needed to work clinically which means that they are both unable to support the Emergency Department and their own Care Groups with flow.

Areas to be put forward at budget setting post 2025 review – Division A:

- Review of supernumerary bleep holder funding to care groups.
- Enhanced care budget allocated to high using areas.

Division B

The established staffing levels are appropriate in most wards and registered nurse vacancy levels are low, however healthcare assistant vacancies remain challenging.

The ask for inpatient areas to work to 97% of establishments as a control measure in response to the ongoing financial position is being monitored weekly to ensure any impact on quality indicators and staff wellbeing are flagged and responded to in a timely way to ensure safe staffing in line with NQB standards.

Lack of Ward leader supervisory time is impacting on workload and wellbeing amongst this group. Particularly in their ability to effectively manage a team, such as absence management and appraisals. Supervisory time is inconsistent and often cancelled to support achieving safe staffing levels across the division, which is something we are monitoring to ensure balance.

In medicine for older persons - G5 and G7 wards the alignment with other inpatient wards improved their CHPPD position slightly and this change has been positively noted by staff to be making a difference. Overall, across Medicine and MOP their nurse: patient ratios and CHPDD planned remain lower than the rest of the trust.

Enhanced care including mental health remains a significant challenge for medicine inpatient wards and AMU. Cancer care, similar but less impacted by mental health. Recognition of this and agreement to fund this in addition to our establishments as part of the affordable workforce limit has continued to be a positive step forward, though the unpredictability of demand, and complexity of some cases has at times exceeded this limit. At times there has also been a need to fund private security to protect staff and patients. There is an ongoing need to work collaboratively with partners to ensure this patient group are receiving care in the right setting, as many do not have a criteria to reside in an acute hospital setting.

Violence and aggression incidences remain a concern across the division and particularly within AMU and medicine inpatient ward areas. Many nursing hours are lost in managing and de-escalating these incidences and time needed for debriefing and sign-posting staff to support wellbeing. We are engaged in the work the wider trust is doing around violence and aggression and monitoring closely.

Medicine/MOP

The temporary closure of ward F7 has supported a reduction in vacancy across the medicine/mop footprint and we have seen a link to reduced bank usage.
A reduction in NHSP fill rate, particularly for enhanced care has been challenging across the care group and impacting on fundamentals of care and staff wellbeing. Quality metrics are being closely monitored through our governance processes and escalations through to Divisional board.

AMU

Requirement to support escalation beds continues (AMU 4/5). This significantly increases the number of patients across the AMU footprint and stretches the clinical leadership model. The impact on quality and safety continues to be closely monitored through our governance processes and escalations through divisional board.

Cancer Care

Cancer care has seen a rise in the number of patients outside the cancer care footprint who require administration of chemotherapy, and this is currently being supported by releasing registered nurses from ward-based establishments impacting at times on achieving safe staffing levels.
This is currently under review and may lead to an ask through budget setting 2025/26.

Areas to be put forward at budget setting post 2025 review – Division B:

- D12 ward has continued to see a significant rise in their acuity on the ward and this has been further impacted by changes to pathways and the geography of the ward resulting in a requirement for an additional registered nurse on the early and late shift to ensure safe staffing levels. This is currently being achieved through use of bank when required. This will be highlighted through budget setting again.

- Enhanced care, including mental health, remains challenging, likely ask through budget setting to maintain funding for this separate to establishments.

- Medicine care group still have a proportion of Band 4 nurses as part of a mitigation when band 5 vacancies were high, likely ask through budget setting to convert remaining posts back to band 5 model.

Division C (excluding Midwifery)

There is increasing acuity and complexity across paediatric services, the following summarises the current staffing position in Division C, highlighting the impact on safe staffing and service delivery.

Paediatric services within Division C encompass a wide spectrum of care needs, ranging from day cases to high-dependency and level 2 critical care. These services are delivered within integrated clinical environments, requiring a highly adaptable and skilled nursing workforce. The diversity of acuity across wards necessitates dynamic staffing models that can flex in response to patient needs while maintaining safety and quality of care.

NHSP shift demand and fill had significantly decreased in Q1 and Q2. Since spring 2025 Child Health have been flexing down bed capacity overnight and at weekends to achieve financial savings. This approach has had no adverse effect on elective activity and performance and Child Health has remained underspent in nursing YTD.

As of month 6, the substantive fill rate stood at 82%, with an overall fill rate of 85%. While the persistently low overall fill has been managed by flexing down bed capacity, this approach is no longer sustainable to meet increasing operational demand as we move into winter.

To meet the demands of winter pressures, we have implemented a robust strategy to achieve staffing levels above 90%. This required a coordinated approach that combined targeted recruitment (28 newly qualified nurses are on staggered start between October 2025 and Feb 2026) with renewed efforts to enhance NHSP engagement, ensuring bank shifts are both attractive and accessible to staff, with particular attention given to recognising specialist skills and providing appropriate financial incentives where higher levels of expertise are required and the skills required are recognised appropriately.

PICU

There is a recognised national shortage of paediatric critical care capacity, with demand increasing year-on-year. The Children's Hospital is funded for 14 beds, with NHSE surge funding enabling flex to 16 beds, and occasionally up to 18 beds in exceptional circumstances to maintain elective flow and respond to increased emergency demand (e.g., congenital cardiac and spinal cases). Appropriate skill mix is required to manage this safely.

PHDU

PHDU routinely flex from 6 beds to 7 beds to meet demand, enabled by the unit's relocation and additional NHSE funding. However, as the 7th bed is only partially funded, there are constraints on the

ability to operate at full capacity around the clock. This has a direct impact on step-down flow from PICU, contributing to pressure points within the paediatric critical care pathway.
To establish a sustainable 7-bed model and ensure consistent support for critical care flow, an uplift of 3.0 WTE registered nurses is required.

E1 Ward

E1 Children's Cardiac Ward has successfully expanded from 4 HDU beds to 6. To ensure continual improvements, the ward is planning to open a dedicated day case bay within the inpatient ward footprint. This initiative is designed to ease patient flow and reduce pressure on inpatient beds by streamlining care for patients requiring short-stay procedures. The bay will support improved throughput and enhance the ward's ability to manage acuity more effectively. Embedding the day unit within the existing ward footprint is expected to reduce the scale of additional staffing required, compared to establishing a separate standalone area, though some increase in workforce will still be necessary to ensure safe and effective service delivery

PB Ward

Piam Brown are experiencing increased demand for both inpatient and day case activity. The existing footprint is insufficient to manage current and projected demand. We are reviewing the potential need for a satellite area to accommodate overflow and maintain patient flow. Workforce planning and uplift to support a satellite staffing model will be required, to ensure safe and sustainable care delivery.

Paediatric Medical Unit (PMU)

Transitioning patients and beds to Robbie's Rehabilitation (RR) as part of service redesign. This development has released a bay that could serve as a satellite area for oncology overflow or additional day case capacity to improve patient flow and reduce pressure on inpatient beds. This will have implications for staffing and require resource modelling to support dual-function and ensure safe staffing levels.

Neonates

The current Neonatal footprint at UHS comprises 43 cots:

15 ICU cots

12 HDU cots

16 SCBU cots

Neonatal services continue to face significant workforce pressures despite recent expansion efforts, including the commissioning of three additional cots and a 13 WTE uplift in establishment.

As of March 2025, high vacancy levels have limited operational capacity to 20 cots, with seven remaining closed or flexed. Recruitment has gained momentum, with 22 nurses appointed across experience levels, and a continued focus on developing existing staff to achieve Qualified in Specialty (QIS) status. Rising acuity and ongoing vacancies have created operational challenges, with the service frequently operating at OPEL 3 or 4, there is a clear requirement for sustained investment to safely open the remaining cots over the next 18 months.

Bramshaw (Breast and Gynaecology)

The established staffing levels within Bramshaw, at Princess Anne Hospital (PAH) are deemed appropriate to support the acuity of patients. The recent reduction in gestational age for baby loss has

positively influenced staffing acuity, enabling the team to maintain safe and effective care within the current establishment

Areas to be put forward at budget setting post 2025 review – Division C:

- Division C's paediatric and neonatal services are under increasing pressure due to rising acuity, demand for flexible bed capacity, and persistent workforce gaps. AWL and fill data shows the need for targeted nursing investment to safeguard care quality and sustainability. Strategic funding will be key to maintaining patient flow, minimising delays, supporting critical care pathways, and promoting staff wellbeing and retention.

- While further work is required to fully scope the additional staffing requirements, it is recognised that progressing this ahead of budget setting is essential. This should be undertaken with careful consideration of the current financial climate, ensuring that any proposed investment across PICU, HDU, E1, PB, and PMU is both targeted and sustainable. The aim is to future-proof paediatric care, uphold safety standards, and support the delivery of key performance requirements across the division.

Appendix 6

Royal College of Nursing

NURSING WORKFORCE ACADEMY

NURSING WORKFORCE STANDARDS

Supporting a safe and effective nursing workforce

RCN INSTITUTE OF NURSING EXCELLENCE

This document has been designed in collaboration with our members to ensure it meets most accessibility standards. However, if this does not fit your requirements, please contact **corporate.communications@rcn.org.uk**

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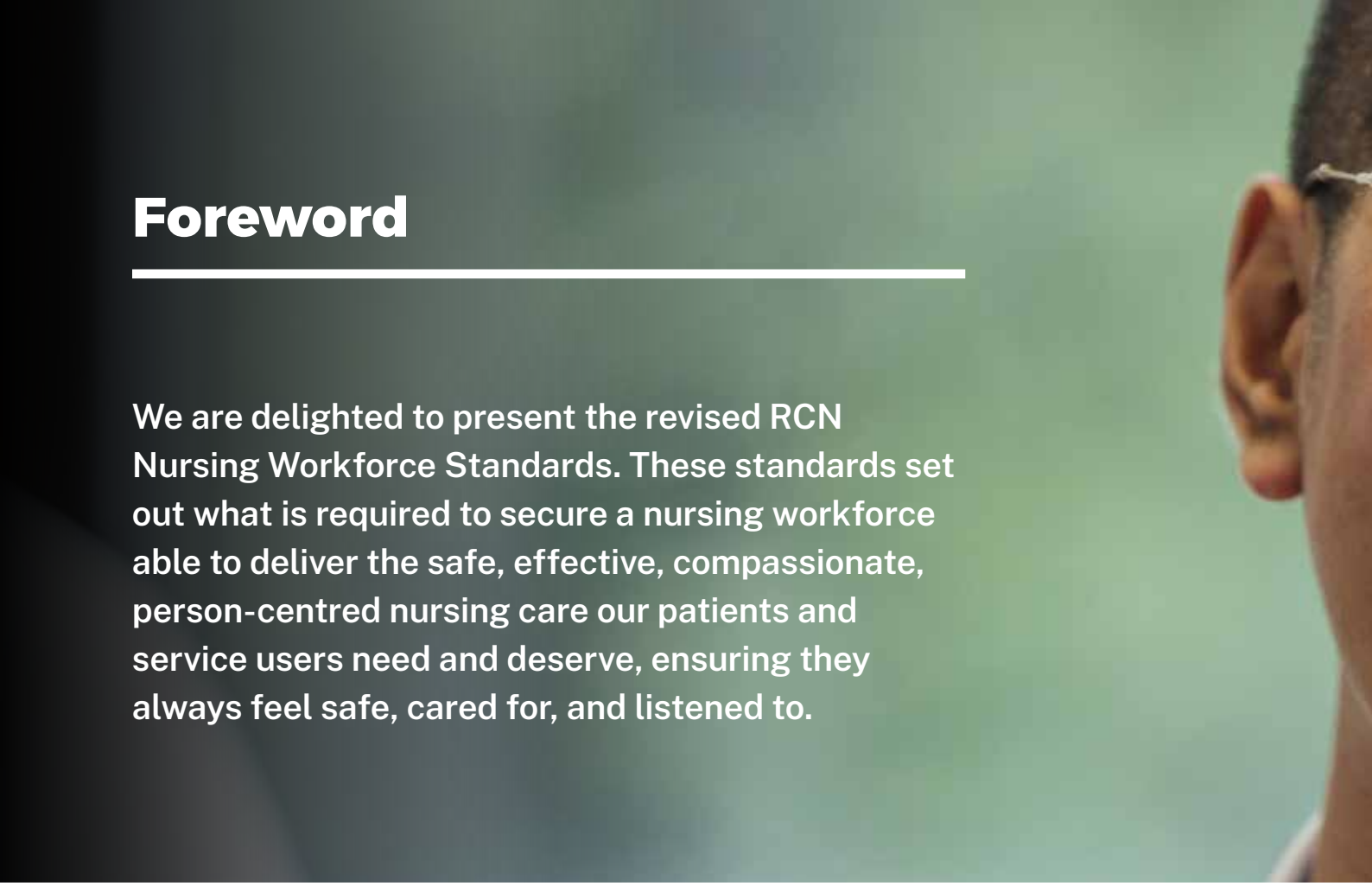


Foreword

We are delighted to present the revised RCN Nursing Workforce Standards. These standards set out what is required to secure a nursing workforce able to deliver the safe, effective, compassionate, person-centred nursing care our patients and service users need and deserve, ensuring they always feel safe, cared for, and listened to.

The RCN's *Nursing Workforce Standards* were originally introduced in 2021 and were backlit by the effects of the COVID-19 pandemic. They were the first national blueprint for addressing nursing shortages, setting out the standards we expect of a nursing workforce in all health and care settings across the UK.

Since then, and in the face of government inaction across the UK, the nursing workforce crisis has deepened. It is therefore vital that we equip our profession with this revised set of standards, ensuring they remain relevant, incorporate feedback from our members, and reflect new evidence and policies.

They must be ready to empower the nursing profession to tackle the challenges it is facing today.

While the environment we work in has changed, the need for quality care remains. The COVID-19 pandemic's significant impact on health and care services is still being felt today. The nursing profession continues to face many challenges, and a strong focus on recruitment and retention is essential. Health and social care services are in urgent need of investment and reform. So, the Nursing Workforce Standards have now been revised to update, clarify, and strengthen our position to meet the scale and urgency of the current challenge.

Nursing is the largest safety critical profession in health care. Getting the right numbers of nursing staff with the right skills in place is, quite literally, a matter of life and death.

Working with our members and listening to their professional nursing expertise, we've made evidence-based changes.

Our standard on the setting of workforce establishments now states that nurse staffing must always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Setting the right establishment must inform budget setting, not be driven by financial constraints. We have updated our standard on the calculation of the uplift (or headroom) in a

nursing establishment to stipulate that this must be a minimum of 27% to maintain safe and effective staffing during planned and unplanned leave. This should help to ensure that patients and service users always have access to continuous high-quality nursing care.

We have strengthened our standards on access to continuing professional development, and the right to work in healthy and safe environments.

The standards are for all nursing staff and alongside them, we offer practical tools to support you in your workplace. So, no matter where you work or your nursing role, these standards are for you. They set out our expectations of employers in providing a safe and effective nursing workforce which in turn will have a positive impact of the care patients and service users receive.

The changes we have made are important and necessary. They include new information about tackling racism and discrimination in the workplace and preparing for future health and climate emergencies. There is new guidance on the right to ask for reasonable adjustments during pregnancy, and for those with a disability.

As the Voice of Nursing, it is our responsibility to stand up for the profession across the UK. We believe that strong, visible nursing leadership is needed at board level, and that all nursing staff can make a real difference to influence the shape of service provision and the quality of nursing care. Investment in the nursing workforce provides evidenced benefits in the health and wealth of the nation.

Nicola Ranger
RCN General Secretary and Chief Executive

Rachel Hollis
FRCN Chair of RCN Professional Nursing Committee

Introduction

These standards apply across all settings in which nursing care is provided, and across the whole of the United Kingdom. The standards are designed to support a safe and effective nursing workforce alongside each nation's legislation.

They are to be used by:

- those responsible for funding, planning, contracting, commissioning, designing and providing services which require a nursing workforce in any setting
- nurse leaders involved in workforce planning and setting nurse staffing establishments
- all members of executive/corporate boards who are accountable and responsible for ensuring the safety and effectiveness of nursing services
- employers responsible for improving the health, wellbeing and safety of the nursing workforce
- local, regional and national organisations seeking to effect positive change for the nursing workforce
- regulators of health and care services
- professional regulators, for example, the Nursing and Midwifery Council (NMC)
- universities delivering courses for pre- and post-registration nursing students
- the nursing workforce to understand their rights and the support needed to deliver safe and effective care.

The standards are aligned to and may be used alongside the *RCN Employment Standards for Independent Health and Social Care Sectors.*

Key references to support the standards have been included for the first time. They can be found on pages 34-38.

Robust workforce planning is fundamental to the standards, although they do not define specific models or tools of nursing workforce planning. Nursing establishments should be set to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Where there is established practice or setting specific guidance, this should be followed, and the nursing workforce standards are to be used alongside such guidance.

When setting establishments a 27% minimum uplift or headroom must be implemented to support safe and effective staffing during planned and unplanned absences.

The recommendation of 100% supervisory or supernumerary status for registered nurse leads such as ward, department or nursing home managers will promote strong, visible nursing leadership to support and supervise the delivery of high-quality nursing care for patients and service users.

The standards support continued professional development for the nursing workforce. They promote the emotional, psychological, mental, and physical health and wellbeing of all nursing staff. The nursing workforce should work in environments that are safe, just and inclusive, this must be a priority for all employers.

The nursing workforce as defined in this resource is intended to include registered nurses, and nursing support workers (including registered nursing associates). It does not include supernumerary students, volunteer staff or others such as housekeeping and clerical staff. Midwifery is not included as they have their own guidance.

The 14 workforce standards are grouped into 3 key themes:

Responsibility and accountability

These 4 standards outline where the responsibility and accountability lie within an organisation for setting, reviewing and taking decisions and action regarding the nursing workforce.

Clinical leadership and safety

These 6 standards outline the need for registered nurses with lead clinical professional responsibility for teams, their role in nursing workforce planning and the professional development of that workforce.

Health, safety and wellbeing

These 4 standards outline the health, safety, dignity, respect and inclusive values of the nursing workforce to enable them to provide the highest quality of care.

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.

The nursing workforce should be recognised and valued through fair pay, terms and conditions.

Key Definitions

Executive level registered nurse
A registered nurse who has executive responsibility on the corporate board and is ordinarily responsible for assuring the board in nursing workforce issues. Executive level registered nurses have a pivotal and transformational role in an organisation. They navigate a complex set of stakeholders and partners in the service of organisational values and must use their influence at board level to guide nursing priorities for their organisation.

Designated senior registered nurse lead
A nurse leader in smaller organisations where there is no executive nurse who has authority to make decisions about setting nursing establishment. They will report directly to the responsible board or senior management team.

Registered nurse lead
Each clinical team or service that provides nursing care must have a registered nurse lead. This function may be fulfilled by registered nurses holding different titles, but the requirement of the role is set out in the descriptor for Standard 5.

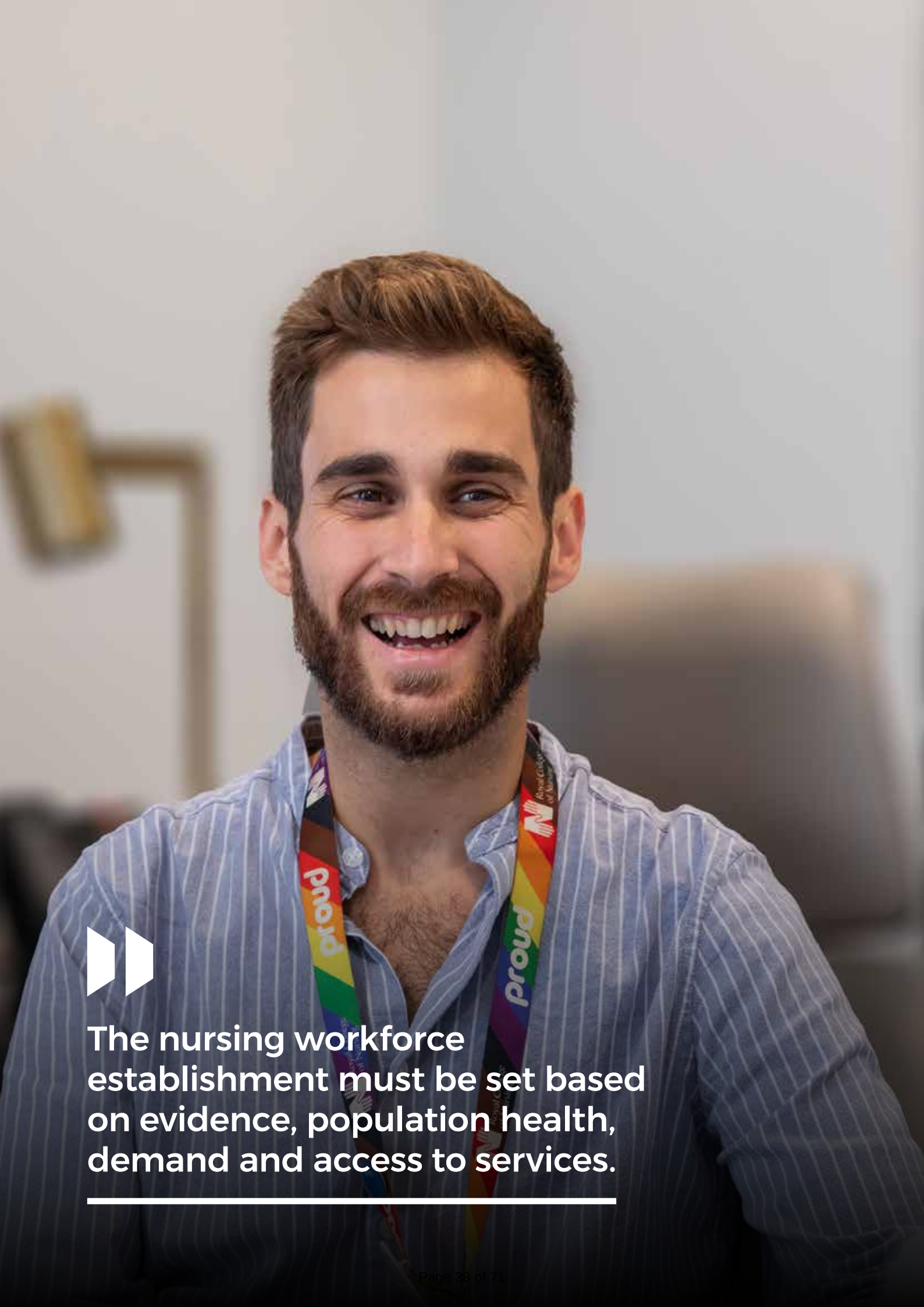
Staffing for safe and effective care
Having the right number of registered nurses and nursing support workers with the right knowledge, skills and experience in the right place at the right time is critical to the delivery of safe and effective care for all those who use health and care services.

Nursing support workers
Support the registered nurse in the provision of nursing care. This term encompasses a wide range of roles and titles which may include registered nursing associates, assistant practitioners, health care assistants, health care support workers and nursing assistants.

Corporate board
The body with the ultimate governance responsibility for any organisation providing health and care services.

Patients/service users
In these standards, this refers to those who use or are affected by the services of professionals within the nursing workforce. This umbrella term also covers clients, residents, children, and other common terms.

Pre-registration nursing students
Any individual enrolled onto an NMC-approved education programme whether full-time or part-time. This also includes student nursing associates and student nurse apprentices.



The nursing workforce establishment must be set based on evidence, population health, demand and access to services.

Responsibility and Accountability

Standard 1

All organisations providing, contracting, or commissioning nursing services must have an executive level registered nurse on the board who is responsible for setting the nursing workforce establishment and the standards of nursing care. All members of the board are accountable for the provision of a nursing workforce that will ensure the safety and effectiveness of service provision.

a. The executive level registered nurse gives assurance to the board. They must be accessible to the nursing workforce and provide strong, visible nursing leadership. The duty placed on registered nurses by the Nursing and Midwifery Council (NMC) Code to raise concerns to protect the public must be upheld.[1]

b. In smaller organisations such as general practices, care homes, and some third sector organisations, there may not be an executive level registered nurse. This exception must be recognised within the documented organisational structure. The organisation must evidence the use of nursing expertise within their commissioning body/partner organisation. A designated senior registered nurse lead with the authority to make decisions must be identified. They are responsible for reporting to the board, senior management team or a named individual accountable for safe nurse staffing.

c. The executive level nurse (or designated senior registered nurse lead) is responsible for providing professional, strategic, and operational advice and assurance to boards and commissioners on nurse staffing.[2] This is to ensure that those accountable fully understand nursing workforce demands, and this must be recorded and visible in board papers and minutes. The board are accountable for the decisions they make and the actions they do, or do not take in response to information, advice and recommendations. Any such decisions and actions must also be recorded.

d. Safe and effective nurse staffing should be a standing item at every board meeting. The record of this discussion and any decisions made will allow for scrutiny of staffing decisions by patients and service users, the public, staff, commissioners, board of governors, regulators and staff representatives.

e. Each organisation should have a board-approved risk management and escalation process in place to enable real-time nurse staffing risk escalation and mitigation, with a clear and transparent procedure to address severe and recurrent risks.

Responsibility and Accountability

Standard 2

The nursing workforce establishment must be set based on evidence, population health, demand and access to services. This should be reviewed, recorded and reported regularly and at least annually by the board.

a. Workforce planning and setting the nursing establishment and skill mix, using appropriate data and methodologies,[3] should be led by the professional nursing knowledge and experience of the executive registered nurse, who should sign off that establishment on behalf of the board.

b. Setting the nursing workforce establishment at safe and effective levels should explicitly inform the organisation's financial planning and budget setting, rather than being driven by financial constraints.

c. A continuous quality improvement approach to setting nurse staffing establishments should be taken to ensure the nurse staffing for each unit/service is sufficient to meet predicted levels of need. A triangulated approach is required and will include (but is not limited to):

   - evidence-based workforce planning tools
   - patient/service users' dependency, acuity and complexity
   - professional judgement[4]
   - clinical quality indicators
   - benchmark data from matched comparators
   - minimum 27% uplift or headroom (see Standard 8).

d. Establishments should be set in such a way as to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio).[5] Where a registered nurse-to-patient ratio has been set (through legislation or evidence-based guidance supported by professional consensus), employers must ensure that establishments are sufficient to always exceed the minimal level.

e. When planning and setting the nursing establishment the right skill mix must be deployed to meet the needs of patients/services users and services. Nursing is a safety-critical profession and evidence has shown that having more registered nurses with degree level education offers patients and service users better outcomes, including reduced mortality rates.[6]

f. A sustainable nursing educator workforce must be in place to support and develop nursing staff and students to deliver evidence-based, high-quality, and compassionate nursing care.

g. A framework should be in place that enables regular review of the nursing establishment, and whether safe staffing levels are achieved or not. This framework should include the metrics to be considered (quality of care, patient outcomes and workload) as well as the trigger points for when a review should take place, for example, when serious concerns have been raised about quality of care, never events, increased incident reporting, sickness levels or a change in service provision.

h. Once any review is completed, the findings and any recommendations must be presented to the board accountable for decision making on resourcing service provision and workforce. An action plan should be created to address any issues identified and decisions taken.

i. Workforce data should be reviewed at least monthly, alongside care quality data,[7] by the executive nurse (or designated senior registered nurse lead) and red flags must be investigated and reported with transparency. Workforce red flags include (but are not limited to):

   - high vacancy rate
   - when substantive staff are less than 80% (see Standard 9)
   - inability to meet the agreed skill mix
   - increased temporary staffing
   - increased staff redeployment
   - increased overtime/unpaid breaks
   - high sickness and turnover rates
   - increased staff disciplinaries
   - negative staff and patient feedback.

j. Where registered nurses such as advanced nurse practitioners work in inter-disciplinary or medical rosters, they must not also be counted as part of the nursing establishment.

k. Essential support staff such as clerical, housekeeping and catering staff, should not be considered as part of the nursing workforce when determining the nursing establishment to meet clinical need.

l. All pre-registration nursing students must be 100% supernumerary whilst on placement. Protected supernumerary time must be given as stipulated within their education programmes. All students must be supported to raise concerns when supernumerary time is not protected whilst on placements.

Responsibility and Accountability

Standard 3

Up-to-date business continuity plans must always be in place to enable staffing for safe and effective care during critical incidents or events.

a. Business continuity plans need to be developed with nursing leadership, taking into consideration:
    - the ability to manage and react to critical incidents, pandemics and climate emergencies
    - situations in which the nursing workforce is compromised, understaffed or redeployed
    - that contingency plans should align to the organisational risk management and escalation processes.
b. Partnership working and staff-side engagement with recognised trade unions on the principles, development and outcomes of business continuity planning and review is vital to accurately reflect nursing, foster collaboration and build organisational cohesion.[8]
c. The business continuity plan should be reviewed and tested at least annually.
d. Serious concerns and/or incidents affecting safety and/or quality of care must also trigger a review of the business continuity plan.
e. The nursing workforce must be supported and encouraged to raise concerns and report incidents or near misses that negatively impact on patients or service users, services and the nursing workforce.[9]
    - Staff must be supported to raise concerns in ways that feel safe and in which they have confidence, without fear of detriment. This may include using their trade union staff representatives, trusted impartial individuals within organisations, and Freedom to Speak Up Guardians/champions.[10]
    - Local processes must be in place and used to raise concerns. These processes must be developed in partnership with staff and representatives to encourage more reporting and to make the process easy, fast and reliable.
    - All concerns raised must be documented, appropriately investigated and responded to. Boards and senior managers must have oversight of the different concerns raised across their organisations.
    - Effectively using duty of candour will further develop trust in nursing by patients, servicer users, families and carers.
    - Appropriate follow up, action, and response by accountable managers creates psychologically safe environments, just and learning cultures.[11]

Standard 4

The nursing workforce should be recognised and valued through fair pay, terms and conditions.

a. Employers should have a transparent pay policy which sets out pay structures, pay progression and the criteria for how pay is increased annually to reflect changes in the cost of living. Pay should reflect the experience, expertise and level of nursing practice at which individuals are working.

b. All nursing staff require a written contract of employment issued before the first day of their new employment. On commencement of employment, pay scales must be built upon the Real Living Wage.[12]

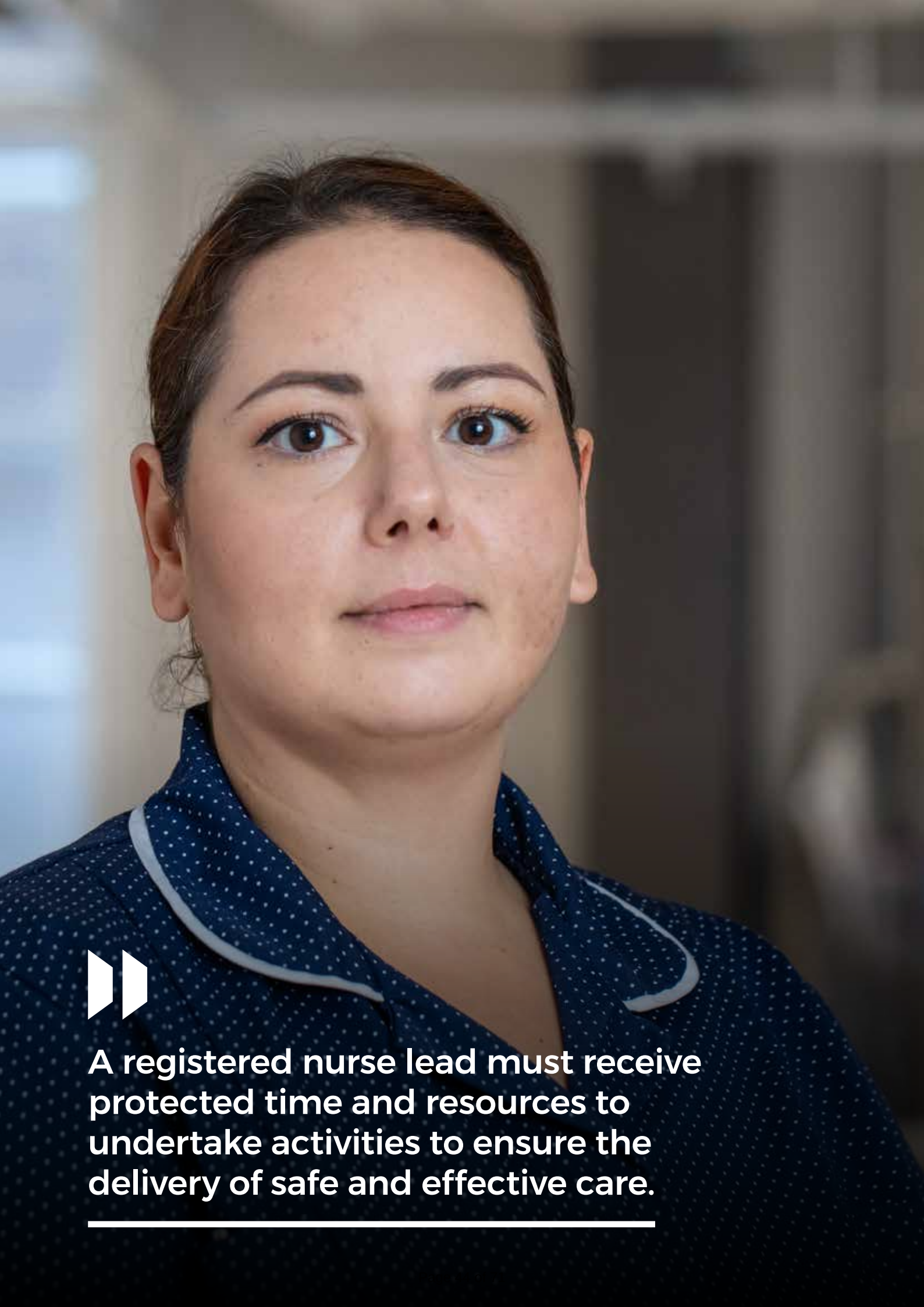
c. All members of the nursing workforce:

- must be compensated for any additional costs of working including unsocial or additional hours worked
- should have access to good quality, sustainable pension provision beyond the statutory minimum
- should have contractual sick pay, parental leave and annual leave beyond the statutory minimums
- should have a fair and transparent process to request a grading/banding review or job evaluation review if they believe that their role has changed beyond their current job description.[13]

d. Fair and equitable pay, terms and working conditions are achieved by engaging directly with the nursing workforce, through the RCN and any other recognised trade unions/ professional organisations.

e. The right to membership of a trade union and/or professional body should be presented to and/or discussed with all new employees at their induction.[14]

f. Employers have vicarious liability for their nursing staff and therefore employers are required to have employer indemnity insurance to insure employees' work.



A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.

Clinical Leadership and Safety

Standard 5

Each clinical team or service that provides nursing care must have a registered nurse lead.

a. The registered nurse lead provides visible nursing leadership, knowledge, skills and expertise and is responsible for the maintenance of the standards of nursing care within the team or service.[15, 16]

b. The registered nurse lead will have the responsibility to identify the nursing workforce required to provide safe, effective, high quality and compassionate care.[17]

c. They will respond to real time and recurrent risks to nurse staffing levels and take actions to mitigate risks to patients/service users and to nursing staff.

d. If risk mitigation such as reducing caseloads or bed closures cannot be achieved, the registered nurse lead will escalate the risk in line with the organisational policy. Risk escalation and response must be documented.

e. The escalation and reporting line should lead to the executive level nurse (or the designated senior registered nurse lead) and hence the accountable board (See Standard 1).

f. Where the registered nurse lead does not have another (senior) registered nurse as a direct line manager they must have a clear professional line to alternative nursing leadership.[18]

Clinical Leadership and Safety

Standard 6

A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.[19]

a. Their role in the leadership team as the senior voice of nursing in the workplace must be reflected and incorporated into role descriptions and job plans.

b. The registered nurse lead will be 100% supervisory/supernumerary and not counted in the numbers as part of the nursing workforce allocation.[20] Exceptions to this should be considered as a red flag and a clear rationale must be documented, agreed by the board, highlighted and made accessible to commissioners, regulators, staff representatives and/or recognised trade unions.

c. The registered nurse lead provides strong visible leadership across the 4 pillars of nursing: clinical, research, education and leadership.[21, 22] Time and resource are required for (but not limited to):

- leading and managing the team
- improving and monitoring the safety and quality of care delivered
- improving and monitoring patient and service-user experience
- improving and monitoring workforce experience and wellbeing
- workforce planning, monitoring, recruitment and retention
- budget management
- clinical and regulatory audits
- initiating quality improvement programmes
- research and innovation
- clinical supervision, staff development and succession planning
- monitoring health and safety data from adverse incidents and near misses involving staff and people who use services
- listening, supporting and engaging with families, carers and relatives of patients/service users, as appropriate.

d. Organisations must invest in the leadership and management skills and capabilities of all their nursing leaders through personal and professional development.

Standard 7

All members of the nursing workforce must have access to high quality, contractually funded continuing professional development (CPD) with protected (paid) time to undertake it.

a. Workforce planning and setting of the nursing establishment should include a learning needs analysis to inform the commissioning and provision of education and training.

b. All education and training must align to the needs of those using services, the practice setting, and the professional development needs of the nursing workforce.[23]

c. The delivery of high quality, evidence-based care requires nursing staff to undertake CPD beyond mandatory and/or statutory training and to be supported to engage in lifelong learning.[24]

d. Provision should be made for (but not be limited to) the following:
   - support with revalidation (for NMC registrants)[25]
   - supervision (clinical/restorative) and reflective practice
   - assessment, supervision, and teaching
   - coaching and mentorship
   - access to formal education and research opportunities
   - personal and professional development plans and reviews, including annual appraisal
   - careers support and succession planning
   - leadership training for all the nursing workforces.

e. The nursing workforce has a right to complete all their statutory, mandatory and CPD training within working time/hours or given time back in lieu.

f. Resources, including protected time for regular professional reflection, should be in place to support ongoing learning and evidence-based practice development.[26] The nursing workforce must have access to nursing educators and professional development teams to support evidence-based nursing, lifelong learning and CPD.

g. Organisations should monitor, report on and record the number of training sessions cancelled due to staffing shortages and how much CPD is undertaken outside working hours, to make meaningful improvements.

Clinical Leadership and Safety

Standard 8

When calculating the nursing workforce establishment whole time equivalent, a minimum uplift (or headroom) of 27% will be applied that allows for the management of planned and unplanned absence.

a. An agreed tool for calculating uplift/headroom should be used which must consider each of the following (as a minimum):[27]
    - annual leave – reflective of length of service
    - study leave/continuing professional development (CPD) – this must meet or exceed the statutory requirements for NMC registrants
    - sickness absence – which should reflect the actual sickness level in an organisation rather than the target level
    - parental leave – for staff with children under 18 years old
    - other leave, which includes (but is not limited to): carer's leave, jury service, and compassionate leave
    - maternity, paternity or adoption leave – the level of uplift should reflect the fact that nursing remains an almost 90% female profession.[28]
b. Professional judgement considerations for nursing workforce establishment and uplift/headroom should include (but not be limited to):[29]
    - environmental issues, for example, single rooms, layout
    - geographical issues, for example, travel requirements for community-based staff
    - shift patterns/length of the working day/flexible working
    - patient/service user acuity, complexity and dependency
    - high enhanced observation/1:1 requirement
    - patient/service user high turnover
    - professional regulatory requirements
    - staffing skill mix, levels of registered nurse required (enhanced/advanced/consultant)
    - time required to support/mentor students
    - time required to support staff, for example, phased return, clinical/restorative supervision, capability support, time to access nurse advocates/clinical psychologists, team building/meetings.

Standard 9

If the substantive nursing workforce falls below 80% for a department/ team, this should be an exception, a red flag. It must be escalated, recorded and reported to the board/senior management and shared with staff representatives/trade unions.[30]

a. All vacancies in the nursing workforce should be recruited to as soon as they arise.

b. If redeploying nursing staff, their knowledge, skills and competence must be considered to protect both patients/service users and the nursing workforce.[31]
   - Redeployed staff must always have an induction, orientation and handover.
   - Redeployed staff should never be expected to take charge of the area to which they are redeployed.
   - Redeployed staff should be supported to raise concerns when asked to work outside their limits of competence.
   - All staff redeployment must be done fairly, with support, and consideration of psychological safety and staff wellbeing.
   - The frequency and extent of staff redeployment must be monitored, recorded and reported by all organisations for transparency, accountability and review (See Standard 2i).

c. Bank and agency nursing work provides services and nursing staff with flexibility on both an individual and an organisational level. When using nursing staff from bank or agency, the service must be assured that they are competent and confident to work in the role or setting to which they are allocated. Staff skill mix should be matched to the acuity and dependency of patients/service users, within approved guidelines.

d. The bank or agency workforce must follow approved employment practices and clearance. The host organisation and employer must co-operate and communicate on the management of the health and safety risks to the temporary worker.

e. All staff from bank or agency will be provided with orientation and local induction which must include access to incident reporting systems and how to escalate concerns. A welcoming and supportive work environment offers psychological safety and can ensure the quality and safety of the care provided.[32]

Clinical Leadership and Safety

Standard 10

All members of the nursing workforce must be appropriately prepared and work within their scope of practice and (for registrants) in accordance with the NMC Code.[33]

a. The nursing team is diverse and includes registered nurses, nursing support workers and nursing students. All members of the nursing team must work within the limits of their competence and have access to the right education, training, development and supervision in keeping with their level of practice and the setting in which they work.[34]

b. A registered nurse must never be substituted with a nursing support worker (which includes registered nursing associates) or any other health care professionals.[35]

c. The work of the registered nurse increases in its complexity beyond the point of registration. Employers should recognise the level of nursing practice required within the workforce to meet nursing care needs in the services they provide[36] (See Standard 7).

d. The registered nurse lead will ensure that:

- all newly appointed members of the nursing workforce are allocated a period of supernumerary time and structured induction
- newly registered nurses have a period of structured preceptorship[37]
- individuals with no or limited previous experience in an area have tailored preceptorship periods, which includes structured inductions and close supervision, until specialty competence and confidence are achieved
- for more senior/experienced staff taking on additional or different roles, including promotions, management and leadership, a preceptorship period is still needed until competence and confidence are achieved
- all nursing students must have support and supervision whilst on placement (see Standard 2l)
- practice learning supervisors and assessors must have access to professional development specific to these roles and time and resource to liaise with the approved education institution
- there is an up-to-date NMC placement audit to support students in placement.[38]

e. Fostering leadership capability is integral to all members of the nursing workforce throughout their careers, to embed just and psychologically safe cultures and strengthen the nursing voice.

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.

Health, Safety and Wellbeing

Standard 11

Working patterns for the nursing workforce must be based on best practice and safe working. Working patterns must be agreed in consultation with staff, and their trade union representatives.

a. Where longer working hours may be preferred, the risk must be recognised and steps taken to mitigate fatigue-related incidents and errors and potential burnout. Best practice advice on mitigating fatigue risks from organisations such as the Health and Safety Executive should be followed, including adequate rest breaks, limits to the number of back-to-back long days and nights, avoidance of shifts longer than 8 hours, and time to recuperate after a stretch on night shifts or on-call shifts.[39]

b. Employers should support opportunities for nursing staff to work flexibly, with the criteria for doing so set out in a policy that is applied fairly to everyone. All posts should be included for consideration of flexible working, including for example, more senior roles. Self or team rostering and internal rotations can also be considered.[40]

c. Flexibility with annual leave should be considered to support the diverse needs of the nursing workforce. Annual leave must never be used to manage sickness absence.

d. The nursing workforce should have timely access to work schedules/rotas. A minimum of 8 weeks in advance will support staff to plan and have improved life-work balance.

e. All work schedules/rotas must ensure that that the right skill mix is in place to meet the needs of patients/services users and services (See Standard 2).

f. Any member of the nursing workforce with a disability is entitled to reasonable adjustment to support them at work.[41]

g. The nursing workforce must always be supported to take breaks during their working hours. Staffing levels and rotas/schedules should allow for staff to have uninterrupted breaks. Any breaks missed must be a red flag and be visible on schedules/rotas.[42]

Standard 12

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.[43]

a. Employers should be able to demonstrate sustained investment and improvement in ensuring that their workplaces are fully inclusive in culture and are anti-discriminatory and anti-racist.

b. Employment policies, practices, processes and cultures, as well as leadership styles, must intentionally support and nurture psychological safety to create inclusive workplaces for all. This includes freedom from all forms of bias, discrimination, bullying, incivility, sexism, and inequity.[44]

c. The nursing workforce must be treated with dignity by their employers, managers, colleagues, patients/service users, and the public.

d. Employers should support and facilitate access to training that supports inclusive workplaces, such as the RCN Cultural Ambassador Programme. Training should include engaging with a variety of groups to understand the full range of different people's needs, cultures and risk factors.[45]

e. Employers should promote and encourage the development of support networks or groups which offer a sense of belonging, safe spaces, and additional support for their staff with protected characteristics.[46]

f. All organisations must monitor, record and publish data on their workforce's protected characteristics.

g. Employers must abide with the 2010 World Health Organization (WHO) *Global Code of Practice on the International Recruitment of Health Personnel* when recruiting staff from outside the United Kingdom (UK).[47]

h. The nursing workforce recruited from outside the UK must be recognised for their prior skills, knowledge and expertise and supported in their career development and career progression.

i. Equitable access to continued professional development (CPD) should be in place to reduce underrepresentation of minoritised groups in nursing leadership roles and increase opportunities for career progression.

Health, Safety and Wellbeing

Standard 13

The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

a. Employers must meet their legal duties and put measures in place to reduce risks to health and safety, including (but not limited to):[48]
   - violence and aggression
   - back and musculoskeletal disorders
   - work-related stress
   - occupational infections
   - exposure to chemical and biological hazards
   - hazardous work environments, for example, overcrowding and "corridor care", wet floors, presence of mould and reinforced autoclaved aerated concrete (RAAC).

b. The employer must identify additional risks to new and expectant mothers and put measures in place to reduce those risks.

c. The nursing workforce have a professional responsibility to create healthy environments that improve health and wellbeing, and their employers must support them in this. Health, safety and wellbeing is more than just the absence of work-related disease or injury, rather, an emphasis on achieving good physical and mental health.[49]

d. The Health and Safety Regulations require the provision of safe and well-maintained buildings with adequate welfare facilities, for example, break/rest rooms, changing facilities and personal lockers. Where indicated by a risk assessment there must be access to suitable and sufficient, well-maintained resources (eg PPE, moving and handling equipment).

e. The risks to members of the nursing workforce working in people's homes or community settings should be assessed and managed by their employer. The nursing workforce must be given adequate information and training to undertake a dynamic risk assessment when carrying out home visits and know what steps to take if they feel in danger.

f. Nursing staff who are lone workers must have suitable means of raising the alarm and access to appropriate safety equipment, such as (but not limited to) lone worker devices, mobile phones, high-vis jackets, torches, GPS safety devices, SOS/panic alarms, and prompt access to support and advice.[50]

g. To prevent fatigue, safe driving rules must be adhered to when nursing staff drive as part of their work, for example, taking at least a 15-minute break after every 2 hours of driving. Therefore, enough time must be allocated between patient/service user visits for the nursing workforce working in communities. Access to safe parking is needed for staff safety and wellbeing.[51]

Standard 14

Employers must actively protect, promote and support the wellbeing of the nursing workforce.

a. Utilising the working environment as a place for promoting health and wellbeing is vital to enable a healthy and safe workforce. Meeting core wellbeing needs is non-negotiable. Nursing staff must always have access to drinking water alongside comfortable and relaxing spaces, away from working areas to take their breaks, eat, and drink.[52]

b. The nursing workforce, regardless of where and when they work must have access to healthy eating options. As a minimum, staff should have access to a fridge, microwave, kettle and/or access to food, canteens, shops and/or restaurants. Where staff work in 24-hour and 7-day services, all staff, especially those working nights, weekends or in the community must have 24/7 access to facilities.[53]

c. The psychological health and wellness of nursing staff must be a priority for all employers. Acknowledging the nature of nursing work, employers should proactively support the emotional wellbeing of the workforce. Good practice anticipates and expects the need for support with emotional and psychological wellbeing. Support should be planned for and a normalised component of practice.[54, 55]

d. Employers should provide opportunities for participation in health and wellbeing initiatives and facilitate access to proactive sessions that promote physical and mental good health. Team building and social interactions can be beneficial for staff wellbeing.

e. The nursing workforce must have access to occupational health services or employee assistance programmes. All recommended occupational health screening, vaccines and immunisations and physical/psychological support must be made easily accessible by employers.

f. The nursing workforce must be given manageable workloads to be able to deliver care safely and effectively (using Standards 2 and 3) and to protect staff wellbeing and reduce risk of moral injury, associated work-related stress and burnout. Nurses who are well, deliver safer and more compassionate care.[56]

The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

Glossary

Absences
Agreed and non-agreed non-attendance at a workplace. Absenteeism is habitual absence from work.

Corridor care
Corridor care is a term which has gained widespread usage to describe the provision of care in non-designated areas (including corridors). This is usually due to overwhelming demand or lack of available resources. Other terms include, temporary escalation areas, ‘fit to sit’, 'one upping', or 'boarding'.

Direct care
Care provided personally by a member of staff. May involve any aspect of health care including treatments, counselling and education regarding people who use services.

Duty of candour
Is a legal and ethical obligation for health and social care providers to be open and transparent with patients, service users and their next of kin when things go wrong with their care or treatment.

Indirect care
Nursing interventions that are performed to benefit people who use services but do not involve direct contact with these individuals and communities.

Independent employer
Any independent contractor, employer organisations that may or may not be commissioned by the public sector. This will include private employer health care providers, most social care providers; GP practices; out of hours/call centres; social enterprises and community interest companies; charities, private surgical, mental health and learning disability hospitals; independent treatment centres; public/private schools; private industry.

Missed care
Required care for people who use or need services that is omitted in part or fully, or care that is delayed.

Nurse retention
A strategy which focuses on preventing nurse turnover and keeping nurses in an organisation’s employment.

Nursing establishment
The total number of staff needed to provide sufficient resource to deploy a planned roster, which will enable registered nurses and nursing support workers to provide care to people who need or use services and that meets all reasonable requirements in the relevant situation. This includes adding an allowance when calculating staffing numbers for planned and unplanned staff absence.

Never events
Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all health care providers.

Nurse staffing
Rota and whole time equivalent (WTE) for a nursing team. The nurse staffing level refers to both the required establishment and the actual staffing level per shift/allocated workday. The maintenance of the nurse staffing level should be funded from the organisation's revenue allocation.

Nursing workforce
The total number of nursing staff (registered nurses and nursing support workers) working within an organisation, sector or country.

Patient/service user acuity
This refers to how ill the patient is, their increased risk of clinical deterioration and how complex their care needs are. This term is sometimes used interchangeably with the terms 'patient complexity' and 'nursing intensity'. An acuity-based staffing system regulates the number of nurses in a nursing service according to the individual's needs and not according to numbers of people who use or need services.

Patient/service user dependency
The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care, hygiene and mobilisation.

Patient/service user safety
Patient safety is the prevention of errors and adverse effects to patients and service users associated with health care. It is closely correlated to safe staffing levels.

Public sector
Refers to employers that are publicly funded – either as an arm's length body of the Department of Health and Social Care, or via another government department or directorate such as education, home office, and criminal justice. Examples include local authorities, statutory agencies such as inspectorates and regulators.

Protected time
'Protected learning time' is time spent by students on pre-registration programmes in a health, care or other setting during which students are learning and are supported to learn.

Real Living Wage
The Real Living Wage is a voluntary hourly wage rate in the UK, calculated based on the actual cost of living. It is higher than the government-mandated National Minimum Wage and National Living Wage.

Red flag
Warning signs or indicators that something might be wrong or problematic. Recognising these red flags can help in making informed decisions and to protect from potential harm.

Registered nurse-patient/service user ratios
Number of people who need or use services assigned to an individual registered nurse; based upon the acuity and/or dependency of the patient/service user for nursing care.

Seasonal variation in nursing workload
Variations and fluctuations in demands for care by people who need or use services, such as differing attendance rates.

Shift patterns
The organising of shifts to ensure patients have continued access to nursing care whatever the day or time of day. The shifts could be rotational between day, night and weekend working, or fixed or a continuous working pattern.

Skill mix
Percentage of different health care personnel involved in provision of care, for example, between registered nurses and nursing support workers, or between different health care professions.

Social care
Health, care and practical support services provided to individuals to support with activities of living (which may include nursing care) in their own homes, residential homes, nursing homes and communities. Most of the UK residential care (with or without nursing) and domiciliary care is provided by independent employers, which include charities and private care management companies, however most social care services are delivered by independent sector home care and residential care providers.

Staff rotas/schedules/rosters
A list of staff and associated information such as working times, responsibilities and locations for a given time period.

Substantive position
An employee's permanent position of employment.

Supernumerary (nursing students)
Is when students in practice or work placed learning are supported to learn without being counted as part of the rostered staffing establishment.

Supernumerary/supervisory (registered nurse lead)
The registered nurse lead is not counted in the regular staffing numbers. They oversee and manage others. They are responsible for guiding, directing, and evaluating the performance of employees or team members in delivering safe and effective nursing care.

Team
A group of staff brought together to achieve a common goal. Often associated with an inter-disciplinary approach to care for people who use services.

Understaffing
A situation where there are insufficient numbers of staff to operate effectively, with an impact on patient/service user and staff safety.

Uplift/headroom
Adding an allowance when calculating staff numbers for planned and unplanned staff absence.

Vacancies
Paid posts which are newly created, unoccupied, or about to become vacant and the employer is actively searching for suitable staff. Temporary staff may be able to fulfil posts during the recruitment of permanent staff.

Whole time equivalent
Also known as full time equivalent (FTE), is a standardised measure that represents the workload of an employee. It is commonly used in workforce planning and budgeting to standardise the working hours of part time employees into the equivalent of full time employees.

Workforce planning
The process of analysing the current workforce and determining future needs, including identifying any gaps between current and future provision. This should be based on the demand for the services the workforce will provide.

Employers must actively protect, promote and support the wellbeing of the nursing workforce.

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Each clinical team or service that provides nursing care must have a registered nurse lead.

011 930 | May 2025

RCN Revised Nursing Workforce Standards – May 2025
UHS Self assessment – June 2025

Standard	Description – Responsibility and Accountability	Assess
1	All organisations providing, contracting or commissioning nursing services must have an executive level registered nurse on the board who is responsible for setting the nursing workforce establishments and the standard of nursing care. All members of the board are accountable for the provision of a nursing workforce that will ensure the safety and effectiveness of service provision.	Yes Chief Nurse and scheduled board reports/ approvals
2	The nursing workforce establishment must be set based on evidence, population health, demand and access to services. This should be reviewed, recorded and reported regularly and at least annually to the board.	Yes Annual cycle
3	Up to date business continuity plans must be in place to enable staffing for sage and effective care during critical incidents or events.	Yes Included in MI planning
4	The nursing workforce should be recognised and valued through fair pay, terms and conditions.	Yes – clear links to pay review group

RCN Revised Nursing Workforce Standards – May 2025

Standard	Description – Clinical Leadership and Safety	Assess
5	Each clinical team or service that provides nursing care must have a registered nurse lead – accountable for workforce requirements and linked into the executive nurse lead	Yes ward leaders/ Matron/DDN
6	A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care	Yes Ward leaders (WLS) /Matron/DDN
7	All members of the nursing workforce must have access to high quality, contractually funded continuing professional development (CPD) with protected (paid) time to undertake it.	Yes Headroom LNA Induction
8	When calculating the nursing workforce establishment whole time equivalent, a minimum uplift (headroom) of 27% will be applied that allows for the management of planned and unplanned absence.	NO 23% uplift WLS
9	If the substantive nursing workforce falls below 80% for a department this should be an exception, a redd flag. It must be escalated, recorded and reported to the board/senior management and shared with staff representatives/trade unions	Yes Board reporting CHPPD
10	All members of the nursing workforce must be appropriately prepared and work within their scope of practice and (for registrants) in accordance with the NMC code.	Yes Induction/CPD

RCN Revised Nursing Workforce Standards – May 2025

Standard	Description – Health, Safety and Wellbeing	Assess
11.	Working patterns for the nursing workforce must be based on best practice and safe working. Working pattens must be agreed in consultation with staff and their trade union representatives.	Yes Roster policy/rules Team roster
12	The nursing workforce should be treated with dignity and respect and work in environments where equality, diversity and inclusion are embedded in the workplace culture.	Yes AER reporting EDI FTSU
13	The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety	Yes H&S Staff facilities PNA
14	Employers must actively protect, promote and support the wellbeing of the nursing workforce.	Yes Wellbeing OH and EAP PNA

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.1 Report to the Trust Board of Directors, 13 January 2026	
Title:	Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2025
Sponsor:	Andy Hyett, Chief Operating Officer / Accountable Emergency Officer
Author:	John McGonigle, Emergency Planning

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

1. Purpose

This report provides the Trust Board of Directors with an overview of University Hospital Southampton's (UHS) Emergency Preparedness, Resilience and Response (EPRR) assurance position for 2025, the organisation's current resilience risks, and the improvement actions underway to achieve full compliance with NHS England's Core Standards.

The report highlights specific vulnerabilities relating to patient experience and outcomes (Board Assurance Framework Risk 1b) and outlines the actions being taken to strengthen Business Continuity Management, Protective Security and Emergency Lockdown, and Evacuation and Shelter arrangements.

Overall, the Trust has established and operational emergency response arrangements in place and is able to respond to incidents using those arrangements, while continuing to strengthen governance, consistency, training, exercising and assurance across these critical areas.

2. National Context and Assurance Requirement

Under the Civil Contingencies Act (2004), NHS organisations, including UHS, are required to plan for and respond to a wide range of emergencies. These include extreme weather, infrastructure and utilities failure, digital and cyber disruption, infectious disease outbreaks, and major accidents, to ensure the continuity of safe patient care.

NHS England requires all Trusts to complete an annual self-assessment against the EPRR Core Standards, providing assurance that proportionate and effective arrangements are in place. The Accountable Emergency Officer (AEO) is responsible for ensuring compliance and for reporting the Trust's assurance position to the Board.

For 2025, UHS assessed itself against 62 applicable Core Standards, achieving:

- 56 Fully Compliant
- 6 Not Yet Fully Compliant

This results in an overall rating of Substantially Compliant (90%).

This rating reflects strong overall compliance, with a small number of development areas subject to active improvement plans and formal governance oversight. The Trust's assessment is consistent with the 2024 position but is supported by a more robust evidence base, clearer

governance arrangements, and a defined forward trajectory. All improvement actions are currently scheduled for completion by July 2026, subject to delivery assurance, operational dependencies and ongoing Board oversight.
Contents:
Appendix 1 - Annual Assurance Report for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2025
Risk(s):
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.

Equality Impact Consideration:	Yes. Equality impacts have been considered within the associated policies and procedures for Business Continuity Management, Protective Security and Emergency Lockdown, and Evacuation and Shelter. These include considerations for patients, staff and visitors with protected characteristics, including mobility, cognitive impairment, sensory needs and communication barriers. No additional adverse impacts have been identified beyond those mitigated through reasonable adjustments and existing safeguarding arrangements.

Appendix 1 - Annual Assurance Report for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) 2025

3. Progress since the November 2025 Assurance Submission

This initial report was submitted to the Trust Executive Committee in November 2025 as the Trust's annual assurance position against the NHS EPRR Core Standards. At that point, the assessment accurately reflected an organisation with clear strategic intent and emerging delivery activity, but limited evidence of embedded, system-wide capability and assurance.

Since submission of the assurance return, material progress has been made across several priority EPRR domains. This includes the development and approval of the Business Continuity Management System (BCMS), the completion of consultation and adoption of Protective Security and Emergency Lockdown arrangements, and the consultation and system engagement underway for Evacuation and Shelter. Collectively, these developments represent a significant strengthening of policy clarity, governance arrangements and workforce engagement.

However, it is important to note that these advances do not invalidate the November 2025 assurance judgement, nor do they materially alter the Trust's overall compliance rating. The progress described below reflects foundational delivery and the establishment of controls, rather than sustained operational maturity, embedded practice, or evidenced assurance outcomes at Trust or system level.

The six standards assessed as not yet fully compliant relate primarily to governance maturity, exercising and testing, workforce training consistency, and assurance evidence, rather than the absence of emergency response arrangements.

The Trust therefore remains appropriately assessed as Substantially Compliant, with Amber-rated development areas that continue to require implementation, testing, exercising and cultural embedding through 2026.

4. Key Areas of Focus and Assurance Gaps

Business Continuity Management System (BCMS)

The Trust currently holds a wide range of departmental Business Continuity Plans (BCPs). While these provide basic compliance, they do not constitute a fully functioning, governed system and do not meet the full assurance expectations of NHS England. The 2025 review confirmed UHS is currently operating at Maturity Level 2 (Developing), characterised by inconsistent exercising, variable plan quality, and limited assurance mechanisms.

Key issues include:

- Lack of systematic testing and exercising across services
- No mature reporting or performance framework
- A predominantly bottom-up model, lacking coordinated governance

These weaknesses directly increase the risk of avoidable impact on patient experience and outcomes (Risk 1b) during periods of disruption.

A Trust-wide BCMS aligned with ISO 22301[1] has now been endorsed, with a 12-month implementation roadmap established, targeting:

- Completion of all Business Impact Assessments (BIAs) and updated BCPs
- Deployment of ward-level Emergency Planning Posters (in-development)
- Establishment of run-books for all functions, incorporating digital and estates responses
- A full testing and exercising programme
- A BCMS evidence library and Key Performance Indicator (KPI) dashboard (in-development)

This roadmap is intended to move the Trust to Maturity Level 3 (Established) within 12 months, and Level 4 (Embedded) within 24 months, subject to delivery assurance and governance oversight.

Protective Security and Emergency Lockdown

Improvement in this domain is achievable through strengthened governance, targeted estates actions, and workforce training, building on existing operational arrangements. Identified gaps relate primarily to governance, training and environmental security measures, rather than digital infrastructure.

Immediate actions underway include:

- Establishment of a Security Management Group (SMG), chaired by the Office of the Chief Operating Officer, reporting into EPRR governance
- A joint estates audit to identify priority physical security measures

[1] ISO 22301 is the international standard for Business Continuity Management Systems (BCMS). It sets out best-practice requirements for identifying critical services, understanding risks and impacts, and establishing proportionate plans, governance and assurance to ensure organisations can continue to deliver essential functions during disruption.

- Introduction of Virtual Learning Environment (VLE) protective security and lockdown training
- Implementation of visible deterrence measures (signage and posters) and local lockdown drills as part of the exercising programme

These measures strengthen the Trust's ability to contain and control security-related incidents, reducing patient and staff safety risks, particularly in scenarios requiring rapid protection of clinical areas (Risk 1b).

Evacuation and Shelter

The revised UHS Evacuation and Shelter Policy and supporting Procedure have been developed and issued for consultation. Engagement is underway internally and with Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) partners, with consultation closing on 31 January 2026.

Existing evacuation arrangements remain in place and are used operationally; the revised policy, procedure and training programme are intended to strengthen consistency, assurance and system alignment.

Training can commence immediately following approval. While a Trust-wide live evacuation exercise is logistically complex, it remains essential to provide assurance of genuine readiness.

Key actions include:

- Circulation and implementation of the updated policy and procedure
- Development of short, practical training packages for clinical and non-clinical teams
- Capability-based exercising, including partial and localised evacuations
- Monitoring of anticipated changes in regional and national guidance

Effective evacuation capability directly mitigates Risk 1b, ensuring safe movement and continuity of care during fire, infrastructure loss, or internal environment failures.

5. Assurance Position by Theme

Across EPRR thematic areas, and taking account of the progress made since November 2025, the organisation demonstrates good practice in partnership working, integration with Trust operations, and alignment of EPRR inputs, outputs and outcomes with UHS values and divisional governance structures.

However, full assurance remains dependent on systematic delivery of the BCMS roadmap, strengthened physical security controls, and validated evacuation capability through implementation, testing and exercising.

Detailed operational and security-sensitive information relating to protective security and emergency response arrangements is held separately and reviewed through appropriate governance routes, including closed sessions where required, to ensure effective oversight without increasing risk.

6. Risk 1b - Patient Experience and Outcomes

Potential impact:

- Delayed care or deterioration during business disruption (for example digital loss, utilities disruption, or loss or denial of building access)
- Uncoordinated whole-Trust evacuation
- Inadequate lockdown affecting patient and staff safety

Mitigations underway:

- BCMS rollout, with BIAs and BCPs designed around maximum tolerable disruption periods
- A structured training and exercising programme covering clinical pathways and command roles
- Updated evacuation arrangements and ward-level readiness tools
- A strengthened protective security posture