University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	14/05/2026
Time	9:00 - 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd

1	9:00	**Chair's Welcome, Apologies and Declarations of Interest** Note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
2		**Patient Story** The patient story provides an opportunity for the Board to reflect on the experiences of staff within the Trust and understand what the Trust could do better.
3		**Minutes of Previous Meeting held on 10 March 2026** Approve the minutes of the previous meeting held on 10 March 2026
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:20	**Briefing from the Chair of the Audit and Risk Committee** Steve Peacock, Chair
5.2	9:25	**Briefing from the Chair of the Finance, Investment & Cash Committee** David Liverseidge, Chair
5.3	9:30	**Briefing from the Chair of the People and Organisational Development Committee** Jane Harwood, Chair
5.4	9:35	**Briefing from the Chair of the Quality Committee** including Maternity and Neonatal Safety 2025-26 Quarter 3 Report Tim Peachey, Chair
5.5	9:40	**Chief Executive Officer's Report** Receive and note the report Sponsor: David French, Chief Executive Officer
5.6	9:55	**Performance KPI Report for Month 12** Review and discuss the report Sponsor: Andy Hyett, Chief Operating Officer

5.7 **Break**

10:25

5.8 **Finance Report for Month 12**

10:35 Review and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.9 **ICB System Report for Month 12**

10:45 Receive and discuss the report
Sponsor: Ian Howard, Chief Financial Officer

5.10 **People Report for Month 12**

10:50 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer

5.11 **Staff Survey Results 2025 and People Priorities 2026-27**

11:00 Review and discuss the report
Sponsor: Steve Harris, Chief People Officer
Attendee: Ceri Connor, Director of OD and Inclusion

5.12 **Learning from Deaths 2025-26 Quarter 3 Report**

11:10 Review and discuss the report
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Jenny Milner, Associate Director of Patient Experience

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

11:20 Review and discuss the report and update
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant

5.14 **Maternity and Neonatal Services National Picture Report**

11:30 Review and discuss the report
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Emma Northover, Director of Midwifery/Alison Millman, Midwifery Quality Assurance and Safety Matron

5.15 **Antimicrobial Resistance Report**

11:40 Review and discuss the report
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Julian Sutton, Clinical Lead, Infection Control/Julie Brooks, Deputy Director of Infection Prevention and Control/Jackie Swabe, Lead Pharmacist Anti-infectives

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2025-26 Quarter 4 Review**

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

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

11:55 Review and discuss the update
Sponsor: Natasha Watts, Acting Chief Nursing Officer
Attendees: Craig Machell, Associate Director of Corporate Affairs and Company Secretary/Lauren Anderson, Corporate Governance and Risk Manager

6.3 **South Central Regional Research Delivery Network (SC RRDN) 2025-26 Annual Performance Review**

12:05 Receive and note the annual performance review
Sponsor: Paul Grundy, Chief Medical Officer
Attendee: Clare Rook, Network Director, SC RRDN

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

7.1 **Feedback from the Council of Governors' (CoG) Meeting 22 April 2026 (Oral)**

12:20 Sponsor: Jenni Douglas-Todd, Trust Chair

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

12:25 Receive and ratify the report
In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Jenni Douglas-Todd, Trust Chair

7.3 **Trust Executive Committee Terms of Reference**

12:30 Review and approve the Terms of Reference
Sponsor: David French, Chief Executive Officer
Attendee: Craig Machell, Associate Director of Corporate Affairs and Company Secretary

8 **Any other business**

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

9 **Note the date of the next meeting: 9 July 2026**

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

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

11 **Follow-up discussion with governors**

12:45

University Hospital Southampton NHS
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Agenda links to the Board Assurance Framework (BAF)

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Overview of the BAF

Risk	Appetite (Category)	Current risk rating	Target risk rating	
1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.	Minimal (Safety)	4 x 5 20	4 x 2 6	Apr 30
1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.	Cautious (Experience)	4 x 4 16	3 x 2 6	Apr 30
1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.	Minimal (Safety)	4 x 4 16	2 x 3 6	Apr 27
2a: We do not take full advantage of our position as a leading University teaching hospital with a growing, reputable, and innovative research and development portfolio, attracting the best staff and efficiently delivering the best possible treatments and care for our patients.	Open (Technology & Innovation)	3 x 4 12	3 x 2 6	Mar 27
3a: We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.	Open (workforce)	4 x 5 20	4 x 3 12	Mar 30
3b: We fail to develop a diverse, compassionate, and inclusive workforce, providing a more positive staff experience for all staff.	Open (workforce)	4 x 4 16	4 x 2 8	Mar 30
3c: We fail to create a sustainable and innovative education and development response to meet the current and future workforce needs identified in the Trust's longer-term workforce plan.	Open (workforce)	4 x 4 16	3 x 2 6	Mar 29
4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.	Cautious (Effectiveness)	3 x 3 9	3 x 2 6	Dec 26
5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.	Cautious (Finance)	5 x 4 20	5 x 2 10	Apr 31
5b: We do not adequately maintain, improve and develop our estate to deliver our clinical services and increase capacity.	Cautious (Effectiveness)	4 x 5 20	4 x 2 8	TBD
5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation,	Open (Technology & Innovation)	4 x 4 16	3 x 2 6	Apr 30
5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.	Open (Technology & Innovation)	2 x 4 8	2 x 2 4	Dec 27

Agenda links to the BAF

No	Item	Linked BAF risk(s)	Does this item facilitate movement towards or away from the intended target risk score and appetite?		
			Towards	Away	Neither
5.6	Performance KPI Report for Month 12	1a, 1b, 1c			x
5.8	Finance Report for Month 12	5a			x
5.9	ICB System Report for Month 12	5a			x
5.10	People Report for Month 12	3a, 3b, 3c			x
5.11	Staff Survey Results 2025 and People Priorities 2026-27	3b, 3c	x		
5.12	Learning from Deaths 2025-26 Quarter 3 Report	1b			x
5.13	Guardian of Safe Working Hours Quarterly Report and Update on 10-Point Plan	3a, 3b			x
5.14	Maternity and Neonatal Services National Picture	1a, 1b			x
5.15	Antimicrobial Resistance Report	1c	x		
6.3	SC RRDN 2025-26 Annual Performance Review	1b, 2a			x

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	10/03/2026
Time	9:00 – 13:00
Location	Conference Room, Heartbeat Education Centre
Chair	Jenni Douglas-Todd (JD-T)
Present	Jenni Douglas-Todd, Chair (JD-T) Diana Eccles, NED (DE) David French, Chief Executive Officer (DAF) Paul Grundy, Chief Medical Officer (PG) Steve Harris, Chief People Officer (SH) Jane Harwood, NED/Senior Independent Director and Deputy Chair (JH) Ian Howard, Chief Financial Officer (IH) Andy Hyett, Chief Operating Officer (AH) David Liverseidge, NED (DL) Tim Peachey, NED (TP) Alison Tattersall, NED (AT) Natasha Watts, Acting Chief Nursing Officer (NW)
In attendance	Craig Machell, Associate Director of Corporate Affairs and Company Secretary (CM) Martin de Sousa, Director of Strategy and Partnerships (MdS) (item 6.1) Diana Hulbert, Guardian of Safe Working Hours and Emergency Department Consultant (DH) (item 5.12) Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian (CMb) (item 5.11) Amanda Callow, The Value Circle (Well-Led Review) (observing) 1 member of the public (item 2) 3 governors (observing) 4 members of staff (observing) 5 members of the public (observing)
Apologies	Steve Peacock, NED (SP)

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

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

It was noted that apologies had been received from Steve Peacock.

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

2. Patient Story

Ty Whitlock was invited to present his experience as a patient of the Trust in late December 2025. It was noted that:

- He had been hospitalised when on holiday in Egypt, including being placed in intensive care, following suffering a bite on his leg. On return to the United Kingdom, Ty Whitlock was admitted to the General Intensive Care Unit (GICU) at Southampton General Hospital.

- The facilities and approach undertaken at the Trust was in complete contrast to that by the Egyptian hospital with significantly more patient involvement in decisions.
- Whilst there had been some slightly negative experiences with some consultants, the care provided by GICU staff was good. There were also some opportunities for improvement in communications between Southampton General Hospital and GPs.
- The story highlighted the importance of communicating with patients and patient choice.

3. Minutes of the Previous Meeting held on 13 January 2026

The draft minutes tabled to the meeting were agreed to be an accurate record of the meeting held on 13 January 2026.

4. Matters Arising and Summary of Agreed Actions

The matters arising and actions were noted.

- Actions 1267 and 1311 were closed.
- Action 1313 had been superseded by events so could be closed.
- Action 1293 would be considered by the Quality Committee and could be closed.
- Action 1312 would be reported as part of Cost Improvement Programme reporting to the Finance, Investment and Cash Committee, and the action could be closed.

5. QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Audit and Risk Committee

Ian Howard was invited to present the Committee Chair's Report in respect of the meeting held on 27 January 2026, the content of which was noted. It was further noted that:

- The committee considered the Trust's accounting policies and judgements with respect to the 2025/26 accounts and, in particular, the impact of the Modern Equivalent Assets valuation.
- The committee noted that there had been significant improvements in the Trust's processes as had been demonstrated through production of the Trust's interim accounts.
- The committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts and with its Standards of Business Conduct Policy.
- The committee also reviewed the Board Assurance Framework (item 6.2) and the work carried out by the Trust's local counter-fraud specialist 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 26 January and 23 February 2026, the contents of which were noted. It was further noted that:

- The committee received an update following the fire on 1 February 2026.
- The committee reviewed the Finance Report for Month 10, noting that the Trust's target for year-end was a deficit of £45m. The Trust was anticipating a number of one-off receipts to enable it to meet its year-end target.

- It was noted that there had been an increase in workforce numbers during Month 10, which reflected the decision to take steps to reduce the number of patients waiting over 65- or 52-weeks. It was expected that the Trust would receive income from the additional work to offset the additional costs incurred.
- The Trust's latest submission of its Medium Term Plan still included a significant deficit for 2026/27 owing to the gap in funding for the required level of activity and insufficient prices paid in areas such as critical care.
- The committee received a report on the roll out of the MIYA system in the Emergency Department, noting that whilst there had been an initial dip in performance, these initial issues appeared to have been resolved.
- The committee supported a proposal to deploy mobile endoscopy units as a temporary measure to replace the equipment lost in the fire on 1 February 2026.
- The committee reviewed the Trust's cash position and supported a request for additional cash support to be paid in April 2026.

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 23 January and 26 February 2026, the contents of which were noted. It was further noted that:

- The committee reviewed a detailed overview of the Employment Rights Act 2025, noting the potentially significant implications for the use of temporary and fixed term staff by the Trust and NHS in general. It was further noted that HR was carrying out work proactively in this area to understand and mitigate the potential impact.
- The committee reviewed the People Report for Month 10 (item 5.10) and noted the progress being made against the 10-Point Plan for Improving the Lives of Resident Doctors and the new framework for statutory and mandatory training.
- The committee received an in-depth report on the impact of the fire on 1 February 2026 on the Trust's staff, noting the immediate wellbeing support provided to staff and the provision for support to staff in the longer term.
- The committee noted that Diana Eccles had joined the committee as a member.

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 26 January 2026, the content of which was noted.

Tim Peachey provided additional commentary in respect of the interim Maternity and Neonatal Safety Report. This is summarised below:

- The Board should be assured that the Trust was meeting the requirements in this area, including those required under the NHS Resolution Maternity Incentive Scheme.
- Following the publication of the interim report by the Independent Investigation into Maternity and Neonatal Services in England on 26 February 2026, it was noted that the findings were similar to those from previous reviews in terms of concerns regarding communication with families, the importance of the culture within maternity units, workforce numbers, and basic care failures. The Trust regularly reviewed its workforce numbers and would be seeking proactive assurance in respect of the maternity/neonatal standards. In addition, the Trust intended to review its processes regarding continuity of care, which was

especially important for patients from minority backgrounds and those from deprived areas.
- The Trust had been expecting a visit to its maternity services as part of a review of screening services. However, this visit had been cancelled, as the national team had already obtained assurance based on the data supplied by the Trust.
- The general staffing level of the Trust's maternity and neonatal services was good and recruitment cycle for new midwives had already commenced. Whilst there had been difficulties in some areas, work had been undertaken to improve the position.

The Board discussed the impact of the fire on 1 February 2026 on mental health patients and those having no criteria to reside. This discussion is summarised below:

- There was concern regarding the lack of progress in respect of mental health patients and patients having no criteria to reside over the previous 24 months. However, it was noted that there had been positive engagement with partners in the immediate aftermath of the fire, which saw a substantial reduction in the number of patients having no criteria to reside.
- It was noted that a number of executive and working groups had been established jointly with Hampshire and Isle of Wight Healthcare NHS Foundation Trust in order to work on maintaining and building on the improvements seen in the aftermath of the fire on 1 February 2026.

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.

David French provided an overview of the fire on 1 February 2026, which was discussed by the Board. This discussion is summarised below:

- The Trust had suffered a major fire on 1 February 2026, which had resulted in the loss of seven endoscopy rooms and associated equipment and c.150 beds. Five hundred and two patients were moved to other areas of the hospital within the space of 40 minutes, and nobody was seriously injured. All patients were in a place of safety by 22:00 on 1 February 2026.
- As a result, the Trust declared a major incident at 06:55 on 1 February 2026, which was stood down on 10 February 2026. The immediate management of the incident was undertaken by Jo Ince, Divisional Director of Operations – Division C, following which Andy Hyett took over command of the incident. Patients were diverted from the Emergency Department until the evening of 2 February 2026.
- The Board recorded its thanks to its staff who went above and beyond both during the incident and in the aftermath.
- In addition, the Board thanked the Hampshire and Isle of Wight Fire and Rescue Service, Mitie, Serco, local providers and partners, local authorities, and those from the charitable sector, all of whom had been personally written to by the Chief Executive Officer thanking them for their actions and support.
- Work was ongoing to ensure that the Trust understood how the operation of the hospital changed in the days following the fire, especially in terms of the discharge of patients having no criteria to reside, and how to maintain this going forward.
- The Trust was currently working with two fewer theatres and 137 fewer beds, of which c.80 were unlikely to be available until rebuilding of the damaged

areas was completed. As a result of the need to relocate staff and services, Southampton General Hospital was also running less efficiently.
- The Trust was progressing property damage and business interruption claims through NHS Resolution and its commercial insurers.
- A key priority for the Trust was ensuring staff wellbeing, and an offer had been made by NHS England during a visit by the NHS England Chief Executive Officer, Jim Mackey, to provide access to national psychological support resources.
- The Trust was in the process of capturing the experiences of its staff and was considering how to recognise staff members.
- In addition, the Trust was compiling any lessons arising from the incident and would be sharing these with other organisations.

5.6 Performance KPI Report for Month 10

Andy Hyett was invited to present the Performance KPI Report for Month 10, the content of which was noted. It was further noted that:

- It was noted that there was an error on page 12 of the report – the reference to four patients under 3.4 referred to those waiting over 78 weeks. This would be corrected and the report reissued.
- It was noted that the data contained within the report, particularly in terms of the Trust's forecast performance, reflected the position at the end of January 2026 and therefore did not take into account the impact of the fire on 1 February 2026.
- The Trust's waiting list was beginning to reduce, particularly in terms of the number of patients waiting more than 52 and 65 weeks. Following the decision made by the Board in late 2025, the Trust had taken steps to increase capacity for elective work through a combination of insourcing, outsourcing (including use of the independent sector), and running additional lists.
- The Trust's performance against the four-hour Emergency Department target had improved for three months in a row, reaching 63.3% for January 2026.
- The Trust had seen a reduction in the volume of patients waiting for diagnostics to the lowest number since February 2025 and the percentage of patients waiting less than six weeks increased to 80.2% in January 2026.
- The Trust was maintaining its performance against the 31-day and 28-day cancer standards, but had experienced a reduction in performance against the 62-day standard. It was noted that the loss of the Trust's endoscopy capacity in the fire on 1 February 2026 was expected to impact diagnostic and cancer performance in March and April 2026.
- The age of much of the Trust's IT equipment was an area of challenge. It was noted that this issue was to be discussed as part of capital prioritisation discussions at the Trust Board Study Session scheduled to take place in April 2026. It had been intended to consider this matter in February 2026, but the Trust Board Study Session had been cancelled as the Trust was still in major incident at the time.

The Board discussed the Trust's performance against national standards. This discussion is summarised below:

- Two never events had been recorded in January 2026. Such events were always reviewed and one theme from previous reviews appeared to be failure to strictly follow checklists.
- There were concerns regarding the number of bacteraemia incidents. It was noted that a number of these related to use of intravenous cannulas and that a

programme was being rolled out by the Trust's Infection Prevention and Control team concerning proper management of cannulas.
- There appeared to be an upward trend in terms of the Trust's Hospital Standardised Mortality Ratio (HSMR), which was being kept under review.
- Five medication errors had been reported during January 2026, all of which had been investigated, but no particular themes had been flagged as a result.

5.7 Break

5.8 Finance Report for Month 10

Ian Howard was invited to present the Finance Report for Month 10, the content of which was noted. It was further noted that:

- The Trust had reported a £0.8m surplus in month and a £44.8m deficit year-to-date. The Trust expected to break even in Month 11 and remain on track for a year-end deficit of £45m.
- The underlying deficit had improved from £6.2m in Month 9 to £5.6m in Month 10, with the drivers of the deficit remaining the same as previously, i.e. demand in excess of block funded levels of activity, patients having no criteria to reside, and inpatient mental health costs.
- Although the Trust had delivered significant levels of savings, it remained behind in terms of its Cost Improvement Programme plan.
- The Trust had received £28.4m of additional cash support from NHS England during 2025/26.
- The cost impact of the fire on 1 February 2026 remained unclear, but the incident was expected to have a significant impact on the Trust's financial position. Detailed reports would be reviewed by the Finance, Investment and Cash Committee.

5.9 ICS System Report for Month 10

Ian Howard was invited to present the ICS System Report for Month 10, the content of which was noted. It was further noted that:

- The Hampshire and Isle of Wight Integrated Care System (ICS) was forecasting a year-end deficit of £89.71m, which was £90.18m worse than its 2025/26 plan. This deficit was primarily driven by UHS and Portsmouth Hospitals University NHS Foundation Trust.
- Workforce numbers across the ICS had reduced by c.1,300 whole-time-equivalents (WTE), but the ICS remained c.1,100 WTE above plan.
- There had been complaints from patients regarding procedures of limited clinical value no longer being funded, which indicated that further patient education was required.
- There was an error on page 10 of the report, where it indicated that the Care Quality Commission had commenced a Well-Led review of the Trust, whereas this review was an externally facilitated review conducted by a consultancy specialising in board development reviews.

5.10 People Report for Month 10

Steve Harris was invited to present the People Report for Month 10, the content of which was noted. It was further noted that:

- Total workforce increased by 65 WTE during the month. Whilst the substantive workforce fell by 19 WTE, this was offset by use of temporary staffing due to the level of increased operational pressure, including numbers of patients with no criteria to reside peaking at nearly 300 in January 2026.

- It was anticipated that there would be higher-than-normal use of bank staff during March 2026 as staff take annual leave before the end of the leave year, as has been seen in previous years.
- Whilst the full Staff Survey results were under embargo until 12 March 2026, it was expected that the results would have been impacted by the challenges experienced during 2025/26.
- The Trust had carried out some recruitment to support its decision to increase elective activity. Other areas where there were challenges, including where bottlenecks existed due to shortages of administrative staff, were being reviewed on a regular basis.

5.11 Freedom to Speak Up Report

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

- Between July 2025 and January 2026, the Trust had recorded 62 cases reported via Freedom to Speak Up compared to 64 during the same period in 2024/25.
- The report set out the methods through which staff could raise concerns in the organisation. It was noted that most concerns were raised through these routes, rather than through the Freedom to Speak Up process. The Freedom to Speak Up process was intended to be used where normal routes were inappropriate or ineffective for raising concerns.
- Based on the data contained in previous Staff Surveys, it was noted that a significant proportion of staff did not feel comfortable raising concerns. There were also concerns about a lack of feedback once an issue had been raised, although this was a complicated area due to the need for confidentiality.
- The Freedom to Speak Up team had a good working relationship with HR teams, often acting as a 'critical friend', noting also that the majority of concerns raised through Freedom to Speak Up related to matters that would otherwise be dealt with through HR processes.

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:

- There was a low vacancy rate for resident and locally employed doctor posts across the Trust at 6.86%, an improvement from 9.2% reported in November 2023. Use of the internal medical locum bank had also enabled more efficient coverage of short-term rota gaps.
- Changes had been introduced to the exception reporting system in February 2026. There had been an increase in the number of exception reports since the changes compared to previous months. It was unclear whether this represented a trend, but there may have been some changes in behaviour and practice.
- The Trust was 91% compliant against the areas in the Ten Point Plan to Improve Resident Doctors' Working Lives. The Trust was also looking at

addressing areas outside of the plan, such as office space, which were known to be of concern to the Trust's resident doctors.

Actions
Diana Hulbert agreed to review the vacancy data presented for Rheumatology.

6. STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2025-26 Quarter 3 Review

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

- At the end of December 2025, of the Trust's 12 corporate objectives for 2025/26, three were 'green', seven were 'amber', and two were 'red'.
- The main challenges in terms of achievement of the objectives related to workforce capacity and the Trust's financial situation.
- Work was ongoing to explore opportunities within the system to share resources and deliver services jointly – for example in areas such as recruitment.

6.2 Board Assurance Framework (BAF) Update

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

- All risks had been reviewed by the respective executive directors since the Board Assurance Framework had last been presented to the Board in November 2025. In addition, the risks had been reviewed by the Board's committees during January and February 2026.
- It was further noted that all risks had been reviewed in the context of the fire on 1 February 2026. It was suggested that risk 5b should be reviewed to ensure that the risk of a serious event was properly captured.
- The rating of risk 5c had been increased from 12 to 16 on the basis of the risk posed by the age of the Trust's IT estate and the uncertainties surrounding the OneEPR programme.
- It was noted that the target date for the reduction in rating of risk 5a had been moved from April to October 2026. The Board challenged whether assumptions when determining target dates were too optimistic.
- It was noted that the Quality Committee would consider the rating of risk 1a and whether this continued to be appropriate.

7. CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

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

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

- Appointment of Steve Peacock as a non-executive director with effect from 9 February 2026
- Chair and non-executive director appraisal process for 2026
- Governor attendance at Council of Governors' meetings
- Governors' Nomination Committee and Audit and Risk Committee terms of reference
- Membership engagement

7.2 Register of Seals and Chair's Actions Report

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

Decision:

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

7.3 Audit and Risk Committee Terms of Reference

Craig Machell was invited to present the proposed changes to the Audit and Risk Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Audit and Risk Committee had reviewed its terms of reference at its meeting on 27 January 2026, following which input had been sought from the Council of Governors at its meeting held on 29 January 2026.
- It was proposed to update the name of the Finance, Investment and Cash Committee in Appendix A.

Decision

Having considered the proposed amendment to the Audit and Risk Committee's Terms of Reference, the Board approved the changes.

7.4 Quality Committee Terms of Reference

Craig Machell was invited to present the Quality Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Quality Committee had reviewed its terms of reference at its meeting on 26 January 2026.
- No changes were proposed.

Decision

Having considered the Quality Committee's Terms of Reference, the Board approved the terms of reference.

7.5 Remuneration and Appointment Committee Terms of Reference

Craig Machell was invited to present the Remuneration and Appointment Committee's Terms of Reference, the content of which was noted. It was further noted that:

- The Remuneration and Appointment Committee had reviewed its terms of reference at its meeting on 10 March 2026.

- A number of changes were proposed, largely to reflect the updated NHS England Very Senior Manager Pay guidance issued in 2025 and to update 7.3.10 to reflect the requirement under the Code of Governance for NHS Provider Trusts to discuss proposed severance payments with regional directors.

Decision
Having considered the Remuneration and Appointment Committee's Terms of Reference, the Board approved the terms of reference.

8. Any other business
There was no other business.

9. Note the date of the next meeting: 14 May 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 09/09/2025 - 8 Any other business				
1286.	Organ donation	Machell, Craig	08/10/2026	Pending
	Explanation action item Craig Machell agreed to add organ donation to the agenda of a future Trust Board Study Session. Update: Item deferred to TBSS on 08/10/2026.			
Trust Board – Open Session 10/03/2026 - 5.12 Guardian of Safe Working Hours Quarterly Report and Update on 10-Point Plan				
1325.	Rheumatology	Hulbert, Diana	14/05/2026	Pending
	Explanation action item Diana Hulbert agreed to review the vacancy data presented for Rheumatology.			

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.1

Committee Chair's Report to the Trust Board of Directors 14 May 2026			
Committee:	**Audit and Risk Committee**		
Meeting Date:	**16 March 2026**		
Key Messages:	• The committee considered the going concern assessment for the 2025/26 accounts and agreed that the accounts should be prepared on a 'going concern' basis. In the update from the External Auditor, the committee noted the impact of the revised methodology employed under the Modern Equivalent Assets valuation and that this would be a particular area of focus for the External Auditors. • The committee reviewed the Losses and Special Payments report for the period between March 2025 and February 2026, noting that there had been a significant reduction in the number of payments made compared to the previous year. • The committee reviewed the Trust's Treasury Policy and confirmed the current bank mandate. • The committee received detailed updates in respect of the impact of the fire on 1 February 2026 and in respect of the Trust's Medium Term Plan. • An update was received in respect of Information Governance. It was noted that the Trust was facing challenges in terms of disclosures backlogs and that a plan was to be developed to address this. The committee also noted an update regarding the Data Protection and Security Toolkit for 2026/27. • The committee received an update on the progress of Internal Audit against the Internal Audit Plan for 2025/26 and discussed the proposed Internal Audit Plan for 2026/27. • The committee reviewed progress against the Trust's Fraud, Bribery and Corruption workplan for 2025/26, noting that the plan was on target. The risk of imposter fraud by temporary workers was a particular area of focus. In addition, the committee agreed the Fraud team's work plan for 2026/27.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**6.2 Board Assurance Framework (BAF) Update**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **N/A**
	• All risks had been reviewed with the relevant executive director(s). In addition, the Committee Chair and the Associate Director of Corporate Affairs had discussed the BAF and risk in a general sense and had agreed a number of potential improvements, which would be examined and implemented in due course. • The committee noted that the general level of risk was increasing. • The rating of risk 5c had increased to 16 to reflect the uncertainties around the OneEPR programme, and the risk posed by the age of the Trust's IT estate. • The committee discussed the BAF and challenged whether the target ratings and dates for the risks were realistic, noting that many of the actions to fully mitigate the risks were outside the Trust's control.		
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 14 May 2026	
Committee:	**Finance, Investment and Cash Committee**
Meeting Date:	**23 March 2026**
Key Messages:	• The committee received the Finance Report for Month 11. The Trust had reported an in-month deficit of £0.2m and continued to report in line with the Financial Recovery Plan, targeting an end-of-year deficit of £45m. There had been a reduction in income during February 2026 due to the fire and the full financial impact of the fire was still being assessed. • The committee received an update in respect of the Trust's Medium Term Plan, noting that a submission had been made on 18 March 2026. The committee also received an update in respect of contracting discussions with commissioners. • The committee reviewed a report on the Trust's cost base and productivity, noting that the Trust's workforce had grown relative to activity since 2019/20, which had been highlighted by NHS England and indicated a potential productivity gap. The committee noted that further work was required to understand the basis of the NHS productivity data and where there were material opportunities (if any). The committee requested that the productivity opportunities, CIP programme development and Workforce plans need to come together to provide very clear short- and medium-term targets to track against. These also need to align to or incorporate the intended outcomes of the Transformation programmes proposed. • The committee considered an update in respect of the Trust's transformation programmes and the recalibration undertaken following the fire on 1 February 2026, noting in particular the creation of two additional programmes in respect of service reconfiguration and service re-design. • The committee received an update in respect of the Trust's cash position, noting that the Trust had received £28.4m of cash support during 2025/26. The committee approved the submission of a request for further cash support to be received in May 2026 based on its assessment of the Trust's expected cash position. • The committee considered and supported a business case for additional funding from the Public Sector Decarbonisation Scheme and recommended some changes for areas to be clarified before being progressed for Board review. Specifically, the sensitivity of the case in response to current energy price volatility needs to be included. • The committee received an update in respect of a business case and was provided with an overview of the process required to obtain Cabinet Office approval. • The committee reviewed and supported a paper recommending the initiating of a re-procurement process for new Imaging Infrastructure support service in advance of the current extension ending in September 2027.

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.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.2 ii)

<table>
<tr><td colspan="4">Committee Chair's Report to the Trust Board of Directors
14 May 2026</td></tr>
<tr><td>Committee:</td><td colspan="3">Finance, Investment and Cash Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">27 April 2026</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee received the Finance Report for Month 12 (see below).
• The committee reviewed the Integrated Delivery Plan, which represented the narrative to accompany the Trust's Medium Term Plan setting out more detail around the delivery of the Trust's plan. It was noted that the most significant areas of risk in respect of delivery included: Cost Improvement Programme (CIP) delivery; maintaining the reduced number of beds; workforce numbers; non-criteria to reside numbers; and delivery of elective activity.
• The committee reviewed a draft of the Trust's CIP programme for 2026/27, which was intended to provide assurance regarding work ongoing to fully identify CIP by 30 June 2026.
• The committee received an update in respect of the Trust's cash position, noting that the Trust's cash balance at year end had been £46m, which was slightly higher than forecast. However, the Trust was expected to require cash support in July 2026.
• The committee received and discussed an update in respect of the OneEPR programme.
• The committee reviewed and approved proposed heads of terms in respect of the Institute of Medical Innovation (IMI) and Merck building exchange with the University of Southampton.</td></tr>
<tr><td rowspan="4">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.8 Finance Report for Month 12</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The Trust had reported a year-end deficit of £45m which was in line with its revised forecast.
• The underlying deficit for Month 12 had worsened marginally to £5.3m, but this was considered to be as a result of a combination of distorted costs in Month 11 due to the fire and the increased bank staff usage typically seen in March as staff use up annual leave.
• The Trust had been successful in meeting its capital expenditure target for 2025/26.
• The Trust had reported achieving £95.1m of savings against its CIP programme for 2025/26, although this was £14.6m behind its target.
• There were concerns that the number of patients having no criteria to reside were beginning to increase following the significant reduction seen in the aftermath of the fire on 1 February 2026. This posed a risk to the achievement of the Trust's Medium Term Plan.</td></tr>
<tr><td>6.2 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:
N/A</td><td>Risk Rating:
N/A</td></tr>
<tr><td colspan="3">• Risk 5a had reduced from 25 to 20 following clarity in respect of the contracting arrangements for 2026/27 and the Trust's improved cash position at the end of 2025/26 and confidence in terms of being able to obtain additional cash support. However, the target date had been extended to 2031.</td></tr>
</table>

	• Risk 5b remained at 20 with a target of 16 by 2030. However, this remained outside of appetite, but the timescales and route to meet the Trust's appetite remained unclear. • Risk 5c remained rated at 16, having increased from 12 in February 2026 due to uncertainties around the future of the Trust's PAS and the OneEPR programme.
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.
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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
14 May 2026</td></tr>
<tr><td>Committee:</td><td colspan="3">People and Organisational Development Committee</td></tr>
<tr><td>Meeting Date:</td><td colspan="3">28 April 2026</td></tr>
<tr><td>Key Messages:</td><td colspan="3">• The committee reviewed the People Report for Month 12 (see below).
• The committee received an update in respect of the NHS Future Workforce Solution, which was to replace the Electronic Staff Record system, noting that the Trust had been selected as an early adopter of the new system with implementation due to commence in August 2027.
• The committee discussed the Trust's People Priorities for 2026/27, noting that the priorities focused on five core areas: safety of our people (particularly violence, aggression and abuse), delivery of the workforce plan and transformation priorities, strengthening the voice and engagement of staff, reinstating leadership and people development, and progressing inclusion and belonging. The committee noted the importance of effective leadership in particular in terms of delivering the Trust's plans.</td></tr>
<tr><td rowspan="5">Assurance:
(Reports/Papers reviewed by the Committee also appearing on the Board agenda)</td><td>5.10 People Report for Month 12</td><td>Assurance Rating:
Substantial</td><td>Risk Rating:
High</td></tr>
<tr><td colspan="3">• The workforce was reported as having been 539 whole-time-equivalents (WTE) above plan at the end of March 2026. Whilst the substantive workforce had fallen by 41 WTE during March 2026, this was offset by increased temporary staffing use as staff used up annual leave prior to year end.
• The Trust's total workforce at year end aligned with the opening position for the Trust's 2026/27 plan. This plan included some growth in workforce in particular areas, but there remained a significant Cost Improvement Programme (CIP) target. However, it was noted that the emphasis was to be placed on transformation to deliver CIP.
• The Trust had reported that 89% of consultant job plans had been signed off at year end. Whilst this was below the NHS England target of 95%, it was a significant improvement on the position at the beginning of the year.</td></tr>
<tr><td>6.2 Board Assurance Framework (BAF) Update</td><td>Assurance Rating:
N/A</td><td>Risk Rating:
N/A</td></tr>
<tr><td colspan="3">• Risks 3a, 3b and 3c had been reviewed by the relevant executive directors.
• Risk 3b had been reassessed and the rating had increased from 12 to 16 due to the current challenges around staff morale, wellbeing and motivation.
• All three People risks were now rated as 'critical' (i.e. 15 or above).</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Any Other Matters:</td><td colspan="3">N/A</td></tr>
</table>

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
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Not Applicable	Where 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 5.4 i)

Committee Chair's Report to the Trust Board of Directors 14 May 2026			
Committee:	**Quality Committee**		
Meeting Date:	**16 March 2026**		
Key Messages:	• It was noted that management of intravenous cannulas had emerged as a theme in cases of MRSA. It was further noted that an improvement plan was in place to address this issue. • In addition to the impact of the fire on 1 February 2026, the committee noted that three never events had been reported since January 2026 and there had been an IT critical incident declared following a network upgrade in December 2025. The committee also noted that Synnovis, a provider of pathology services testing, had suffered a cyberattack. • The committee reviewed the Trust's progress against its quality priorities for 2025/26, noting that the Trust had achieved all six priorities. In addition, the committee reviewed the proposed quality priorities for 2026/27. These quality priorities include: strengthening involvement and support of unpaid carers; enhanced therapeutic observations and care; fully embedding 'Martha's Law'; Fundamentals of Care; developing the approach to reducing the impact of health inequalities; and development of a new clinical quality dashboard. • The committee received an update in respect of the Always Improving programme, noting the challenges posed by available resources to deliver the programme. • The committee reviewed the Maternity and Neonatal Safety 2025/26 report for Quarter 3, noting that there had been an increase in the rate of still-births during the period and that three indirect maternal deaths had occurred in January 2026. • The committee reviewed the Experience of Care 2025/26 report for Quarter 3, noting the current response times for interactions with PALS and the status of the backlog. • The committee reviewed the output of a thematic review of Never Events, which had occurred during 2025, noting that key themes included the result of interruptions or distractions of staff. It was further noted that no patient had come to severe harm.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.12 Learning from Deaths 2025-26 Quarter 3 Report**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **Medium**
	• The Trust benchmarked well against other Trusts, with mortality rates either 'as expected' or 'lower than expected'. • During the period, the Medical Examiner Service had reviewed a total of 1,208 deaths, of which 458 had occurred at the Trust's sites. • The Trust had added a module to the Ulysses system to assist in the data capture and standardisation of Morbidity and Mortality meetings. • People with a learning disability and autistic people remained an area of focus with the palliative care and bereavement teams being involved in Learning from Lives and Deaths (LeDeR). • The key themes for incidents reported relating to end-of-life care concerned privacy in death, communication, a lack of commissioned specialist paediatric palliative care on-call service, and end of life care management.		

Any Other Matters:	N/A

Assurance Rating:

Substantial Assurance	There is a robust series of suitably designed internal controls in place upon which the organisation relies to manage the risk of failure of the continuous and effective achievement of the objectives of the process, which at the time of our review were being consistently applied.
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Not Applicable	Where assurance is not required and/or relevant.

Risk Rating:

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

University Hospital Southampton NHS Foundation Trust

Agenda Item 4.6 Report to the Quality Committee, 16 March 2026	
Title:	Maternity and Neonatal Safety 2025-26 Quarter 3 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 & Neonatal (MatNeo) Service submits a quarterly safety report to the Trust Quality Committee. This Quarter 3 (Q3) 2025/26 report reflects our commitment to a responsive and adaptive approach to emerging safety concerns, while providing assurance on sustained improvements that positively influence the safety and experience of families, service users, and staff. This report covers Q3 data and any live or urgent safety matters, as the reporting period is one quarter in arrears.

This report fulfils the requirements of NHSR's Maternity Incentive Scheme (MIS) Year 7 and is designed 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).

We invite Committee members to continue supporting the MatNeo Service through ongoing monitoring, oversight, and constructive scrutiny, ensuring that safety remains central at every level of care delivery.

Contents:

This report provides an update in relation to the following areas for Quarter 3 2025/26:

9. MOSS – **Appendix 8**
10. SQAS Screening Quality Assurance Service – Screening QA visit
11. BCG immunisation service update
12. New Maternity Care Bundle summary

Risk(s):

The University Hospital Southampton (UHS) Trust and Maternity and Neonatal (MatNeo) Service 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, babies, and staff:

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

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

Equality Impact Consideration:	N/A

1. Perinatal Quality Oversight Model (PQOM)

The Perinatal Quality Oversight Model (PQOM) has now replaced the previous Perinatal Quality Safety Model (PQSM). A revised dashboard has been developed, structured around the key themes outlined in the national Delivery Plan. A working version is available via *UHS Maternity – Perinatal Quality Oversight Model*, with screenshots included in **Appendix 1**.

The PQOM remains in development as we continue refining the dataset to ensure information is timely, reliable, and meaningful for ongoing quality oversight.

Key areas of focus highlighted in this report include:

- MNSI cases: A recent increase has been observed; further detail is provided in Section 4.
- PMRT cases: A similar rise has been noted; see Section 4 for full analysis.

2. UHS Maternity Services Dashboard

A working version of the UHS Maternity Dashboard is available via UHS Maternity Dashboard with screenshots provided in **Appendix 2.**

Previously reported red flags and continued areas of focus

- **Postpartum Haemorrhage (PPH) >500ml and >1500ml**
  PPH remains a key area of focus. A thematic review is currently underway to identify contributory factors and improvement opportunities. This work aligns with the implementation of the new Maternity Care Bundle; further detail is provided in Section 12.

- **3rd- and 4th-degree tears (OASI)**
  The RCOG OASI Care Bundle has now been fully implemented and is well established. OASI rates were significantly lower in October and November, with a small increase in December. Overall, 2025 ended with fewer OASI cases compared to 2024, indicating a sustained positive trend associated with the care bundle.

- **Apgar score <7 at 5 minutes**
  A local Apgar Working Group has been established to review this metric in detail and identify opportunities for improvement.

  The 2025 year-to-date rate was 2.48%, a slight improvement from 2.57% in 2024. This metric is multifactorial and reflects the specialist nature of the service, which supports some of the highest-risk mothers and babies across the region.

  Ongoing monitoring and targeted learning will continue through the working group.

New red flags / notable fluctuations in data

- **Increase in preterm births**
  An increase in local preterm birth rates has been observed; however, this does not in itself indicate a safety concern. In line with the Saving Babies' Lives Care Bundle (Element 5: Preterm Birth), the focus remains on:
  - Optimisation of preterm care.
  - Ensuring babies are born in the appropriate setting (e.g., <28 weeks in a Level 3 NICU).

  HSJ recently requested comment regarding the rise. The Trust provided assurance that all preterm births undergo routine review by the PTB leads. No systemic issues or concerning trends have been identified.

- **ITU transfers – 4 cases in Q3 2025–26**
  All unexpected ITU admissions are reviewed through the Clinical Events process with multidisciplinary involvement, including input from an ITU consultant.

Summary of Q3 admissions:
- Sepsis following twin loss at 18 weeks (admitted via ED).
- Complex maternal medicine case with significant cardiac history; admission related to underlying condition and medication needs.
- Secondary PPH on Day 6 – haemodynamically unstable on presentation.
- Acute kidney injury requiring filtration – assessed as unavoidable.

Outcome: Reviews confirmed appropriate clinical management and timely escalation in all cases.

- **Hysterectomy – 2 cases in Q3 2025–26**
  - One planned/expected case due to known Placenta Accreta Spectrum (PAS).
  - One case associated with a known uterine anomaly; the patient had consented to sterilisation and hysterectomy as part of elective caesarean care planning.

- **Escalations to OPEL 4 – 10 occurrences in Q3 2025–26**
  The service escalated to OPEL 4 on 10 occasions, primarily due to:
  - Increased activity and clinical acuity.
  - Concurrent short- and long-term staff sickness.

  All escalation pathways were followed appropriately, ensuring safe staffing, clinical oversight, and flow during periods of heightened operational pressure.

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

Appendix 3 summarises the claims, incidents and complaints received in Quarter 3 (Q3) 2025/26. The main themes identified during this period were:
- Communication: Variability in the information and advice provided to women and families.
- Clinical Treatment: Missed or delayed elements of care.
- Fetal Monitoring and Escalation: Delays in recognising concerning CTG features and escalating appropriately.

During Q3, the Maternity Service appointed a new matron, resulting in full matron cover across all ward areas. This strengthened senior clinical presence is expected to positively impact:
- Oversight and visibility.
- Escalation and responsiveness.
- Patient experience.

This is particularly relevant for the antenatal and postnatal wards (F level), where feedback and complaints had previously highlighted areas for improvement.

The fetal monitoring lead midwife continues to lead a quality improvement project reviewing escalation barriers and contributory factors in CTG related incidents. Findings from this work will inform targeted actions to strengthen escalation pathways and enhance safety across the service.

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

Appendix 4 outlines the cases reported by the MatNeo Service in Q3 2025/26 and those closed during this period, including key themes and learning.

In Q3, the Trust reported three new MNSI cases. For two cases accepted by the MNSI team as intrapartum stillbirths, the Trust's local review concluded they more accurately met *antepartum* criteria (i.e., not in labour at the time of fetal demise). This discrepancy was escalated to the ICB, who have involved regional colleagues and are supporting a facilitated review to ensure correct categorisation and accurate reporting of intrapartum stillbirth rates both locally and nationally.

Themes identified in cases open and closed during Q3:
- Management of proteinuria in the absence of hypertension (guideline review underway).
- Location of care (right place/right time).
- Timely access to genetic testing and diagnosis.

4.1 Mortality Overview – Q3
In Q3 2025, the Trust reported a stillbirth rate of 6.37 per 1,000 births, an increase compared with the previous two quarters and remaining above the national target of <4.2 per 1,000 births.

- The year-to-date (YTD) rate for 2025 was 5.82 per 1,000 births.
- The current 2026 rate stands at 6.37 per 1,000 births.

The Quality and Safety Team continues to maintain close oversight of all cases, ensuring robust review processes are in place to identify themes, contributory factors, and improvement opportunities.

Key themes identified:
- Two cases of placental abruption, both reviewed in detail with no emerging recurrent themes.
- Higher gestational ages among antepartum stillbirths.
- 10 stillbirths reviewed:
    - 2 intrapartum (classified under MNSI criteria).
    - 8 antepartum.
- A small cluster of late bookers/new-to-country patients, although numbers remain very low.

These findings continue to inform targeted improvement work, and learning is shared with clinical teams and system partners to support safe, high-quality maternity and neonatal care.

See **Appendix 4.1** for full detail.

4.2 Urgent Update – Maternal Deaths
In January 2026, the Trust experienced three maternal deaths, all classified as indirect maternal deaths. Further detail is provided in **Appendix 4.2.**

Key information:
- None of the cases met criteria for direct maternal deaths.
- One case involved a woman who died three weeks postnatally due to complications from a recurrence of cancer.
- Two cases involved women at very early gestations who were not booked for maternity care and experienced out-of-hospital cardiac arrests.

All required reporting processes—internal reviews, external notifications, and national reporting routes—have been initiated. Each case is undergoing detailed review to identify contributory factors, system learning, and any actions required to strengthen safety and support high-quality maternity care.

4.3 APH / Abruption Thematic Review
A cluster of antepartum haemorrhage (APH), suspected abruption, and associated mortality cases was identified in Q3 2025. In response, a thematic review was undertaken, examining cases across the whole of 2025 to identify patterns and contributory factors.

Key themes identified:
- A higher proportion of Black African women/birthing people affected (3 out of 9), although numbers remain small, limiting statistical significance.
- All cases occurred after 30 weeks' gestation.
- A slight trend towards lower deprivation (IMD 6–8), though this is not statistically significant due to small numbers.

- TEG (Thromboelastography) use was identified as a *positive* aspect of care, supporting timely coagulation assessment and helping prevent maternal deterioration.

The review concluded that clinical escalation and management were appropriate, with no evidence of systemic safety concerns. Learning has been shared with relevant teams and presented at the LMNS safety meeting and the local morbidity and mortality (M&M) meeting.

See **Appendix 4.3** for full detail.

5. Patient Experience and MNVP

UHS continues to collect and review patient feedback through the Friends and Family Test (FFT). As previously reported to the Committee, the service has experienced contractual challenges with the Maternity and Neonatal Voices Partnership (MNVP), whose Chair is currently on maternity leave. In the interim, we are exploring alternative mechanisms to ensure that service user voices continue to inform quality improvement and are embedded within patient safety discussions.

This includes strengthened engagement with our Quality Patient Safety Partners (QPSPs), who are supporting ongoing patient experience work and contributing to relevant review processes.

Friends and Family Test (FFT) – F Level Wards

Feedback for F Level (antenatal and postnatal wards) has improved significantly.

- The "would not recommend" score reduced from 15.8% in October to 4.2% in January 2026, which is below the Trust target of 5%.

Further detail on the results and associated improvement actions is provided in **Appendix 5**.

6. ATAIN update

There has been a continued increase in unexpected term admissions to the Neonatal Unit in Q3, rising to 52 admissions**,** compared with 35 in Q2**.** Despite this increase in numbers, the rate remains below the network target of 5%**,** providing continued assurance regarding overall performance against the ATAIN standard.

There has also been a noted rise in admissions for neonatal jaundice**,** increasing from 5 cases in Q2 to 9 cases in Q3**.** The neonatal jaundice guidance is currently being updated**,** and this work is expected to support greater consistency in assessment, escalation and management.

An increase has also been observed in the average length of stay for term admissions. Further detail, including trend analysis and contributing factors is provided in **Appendix 6**.

7. 3 Year delivery plan benchmarking (theme 3)

The 3 year delivery plan for Maternity and Neonatal Services aims to ensure that care is safer, more personalised, and more equitable. As part of our quarterly Quality Committee reporting cycle, we provide an update on one of the four national themes each quarter.

For Quarter 3**,** we are reporting progress against Theme 3 – Supporting Our Workforce**.**

This theme focuses on strengthening the Maternity and Neonatal workforce through:

- Improved staffing models.
- Enhanced education and training.
- Stronger leadership and compassionate cultures.
- Better staff experience and wellbeing.
- Targeted support for areas under operational or safety pressure.

The benchmarking review summarises progress to date, identifies areas requiring further development, and outlines next steps aligned with national expectations and local workforce transformation priorities.

Further detail is provided in **Appendix 7**.

8. SCORE / culture workstream update

The Maternity and Neonatal (MatNeo) Service has developed a Cultivating Kindness Guide for staff, designed to support the wider rollout of this culture and compassion focused workstream. This resource aims to embed behaviours that promote psychological safety, mutual respect and supportive team dynamics.

Martha's Rule will be launched across MatNeo on 23 February 2026. This initiative strengthens escalation pathways for clinical deterioration and provides families with a clear route to request a second opinion when they have concerns about their own or their baby's condition. Preparatory work is underway, including staff training, communication materials and alignment with Trust wide implementation plans.

An internal review of the Safety Champions and QUAD membership is currently in progress. Once this review is complete, the service will proceed with a broader evaluation of the SCORE and wider culture workstreams, ensuring:

- Alignment across all culture-improvement initiatives.
- Clarity of roles and responsibilities.
- Effective governance.
- Consistency with national expectations for safety culture programmes.

9. Maternity Outcomes Signal System (MOSS)

The Maternity Outcomes Signal System (MOSS) is a safety management tool launched in November 2025. It identifies potential safety concerns by generating statistical "signals" that prompt a locally led critical safety check. This enables early recognition of emerging issues and supports timely assessment of whether a true safety concern exists.

Appendix 8 includes the cumulative sum (CUSUM) chart, which produces signals of potential safety issues arising during labour and birth using the following indicators:

- Term stillbirths.
- Term neonatal deaths up to 28 days of life.

Trends are plotted according to the accumulation of events against a national reference rate.

Interpreting MOSS signals

Signals are generated when there is evidence of a doubling in the rate of events. Signal colour reflects statistical confidence:

- Amber signal (Level 1): System is *95% confident* the rate has doubled.
- Red signal (Level 2): System is *99% confident* the rate has doubled.
- Following a red Level 2 signal, the CUSUM chart *resets* to ensure continued sensitivity to future events.

Local context

As UHS is a site with NICU and cardiac surgery, the case mix is more complex and more frequent signals may be generated.

Work is planned for 2026 to explore potential adjustments to account for these case mix differences.

Access to MOSS

In line with NHS England recommendations, access has been provided to:

- Perinatal leadership team (QUAD).
- Maternity and Neonatal Safety Champions.
- Chief Nurse.
- Chief Medical Officer.
- Chief Executive.

This ensures the appropriate visibility and oversight at all levels of senior leadership.

10. Screening QA visit

The Screening Quality Assurance Service (SQAS) will conduct a focused virtual review of UHS on 17 March, examining governance and incident management processes across all six antenatal and newborn screening programmes.

The review will include one day of interviews with clinical advisors and relevant members of the screening management team. SQAS will liaise directly with the screening leadership throughout the process and will provide formal feedback outlining findings and recommendations following the review.

Any immediate concerns or urgent recommendations identified during the visit will be escalated promptly to the Trust Board.

11. BCG immunisation of high-risk newborns

Maternity Services are the commissioned providers for BCG immunisations for high-risk newborns. At UHS, this service has historically been subcontracted to HIOW Healthcare, where it is delivered alongside the TB service based at the Royal South Hants Hospital (RSH).

HIOW Healthcare has given notice to end their BCG vaccination service by the end of Q4 2025/26, while the TB service has given notice to cease their service delivery by September 2026. As these services are designed to operate in parallel, HIOW Healthcare has offered to extend the BCG service so that both services withdraw at the same time.

This extension is timely given the complexity of BCG delivery, which requires close coordination across several providers, including:

- Child Health.
- Primary Care.
- Maternity Services.
- TB Services.

To support a safe and seamless transition later this year, the current provider has requested that a multi-agency working group be established, involving all key stakeholders. This group will oversee planning, risk mitigation, communication pathways, and handover arrangements.

12. New Maternity Care Bundle

NHS England published the Maternal Care Bundle (MCB) in January 2026 with the aim of reducing maternal mortality, morbidity, and inequalities. The bundle sets out national best practice standards across five key areas of clinical care that all NHS maternity providers are expected to implement.

The five elements of the Maternal Care Bundle are:

1. Venous Thromboembolism (VTE).
2. Pre-hospital and acute care.
3. Epilepsy in pregnancy.
4. Maternal mental health.
5. Obstetric haemorrhage.

Expectations for Maternity Services

Maternity providers are expected to:

- Implement all five elements consistently across maternity, emergency, ambulance, mental health and primary care pathways, reflecting the whole system approach required to support early recognition and escalation.
- Update local guidelines, escalation processes, referral pathways and training packages to ensure alignment with national standards.
- Prioritise early identification of clinical risk, timely escalation, and equitable access to specialist care.

Implementation and monitoring

The expectation is that services will implement the required changes over the next year. NHS England is currently delivering a series of webinars for clinicians during February and March 2026 to support rollout. Further information and resources are anticipated to be available on the Futures platform following this programme.

Monitoring and reporting of progress against each element of the Care Bundle must be submitted to Trust Boards (or equivalent committees). Unlike the Saving Babies' Lives Care Bundle, which was previously monitored by ICBs oversight, for the Maternal Care Bundle will remain within the Trust.

We intend to use these quarterly reports to provide progress updates at both local and regional levels.

UHS Maternity - Perinatal Quality Oversight Model

University Hospital Southampton NHS Foundation Trust

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	MSSP and Coroners regulations	UHS Maternity Dashboard
Maternity Safety Champions	Workforce	Incidents	National Maternity Dashboard
Complaints	Birth Rate +	PMRT	National Neonatal Audit Programme (NNAP)
Maternity & Neonatal Voice Partnership		MNSI	National Maternity and Neonatal Equalities Dashboard
		PSII / Harm Tools / After Actions Reviews	

Friends and Family Test

University Hospital Southampton NHS Foundation Trust

Maternity FFT compliance

Date range - Maternity FFT

2025

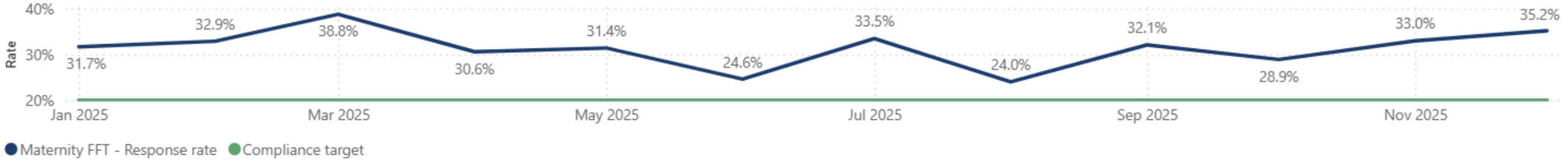
Neonatal FFT compliance

Date range - Neonatal FFT

All

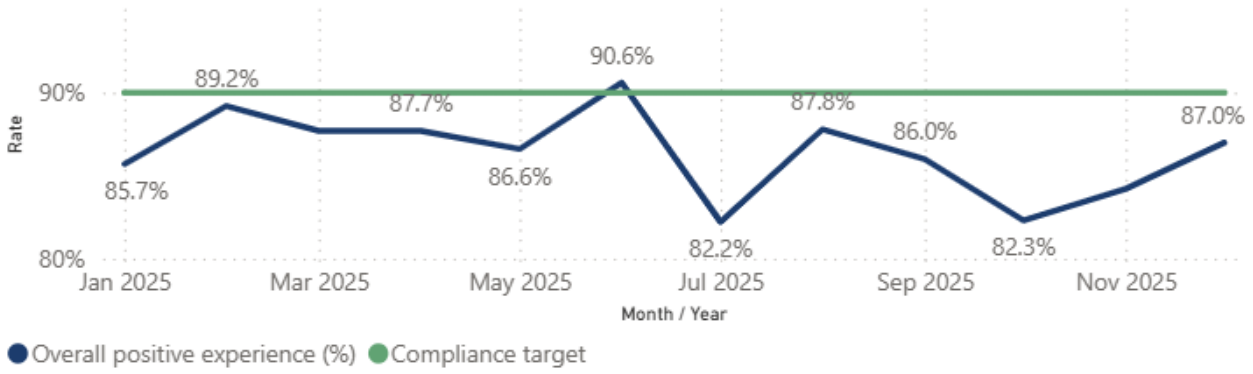
Maternity FFT - Response rate

Trust compliance target - 20% or greater



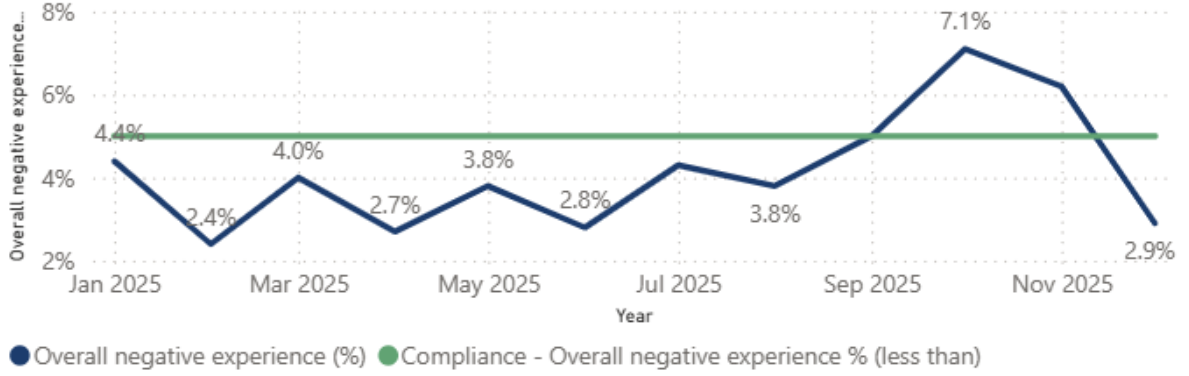
Maternity FFT - Overall positive experience rate

Trust compliance target - 90% or greater



Maternity FFT - Overall negative experience rate

Trust compliance target - 5% or less

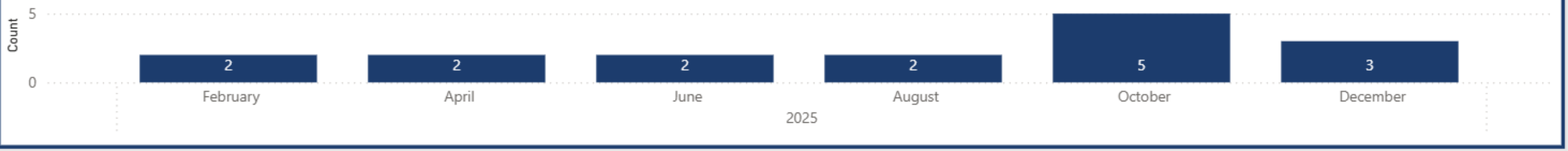


Maternity patient feedback dashboard - under development

Maternity Safety Champions

Return to main menu

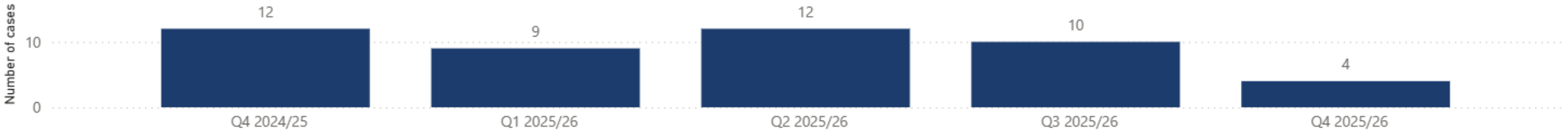
Number of concerns raised at the Maternity Safety Champion Meetings



Complaints

University Hospital Southampton NHS Foundation Trust

Number of complaints received

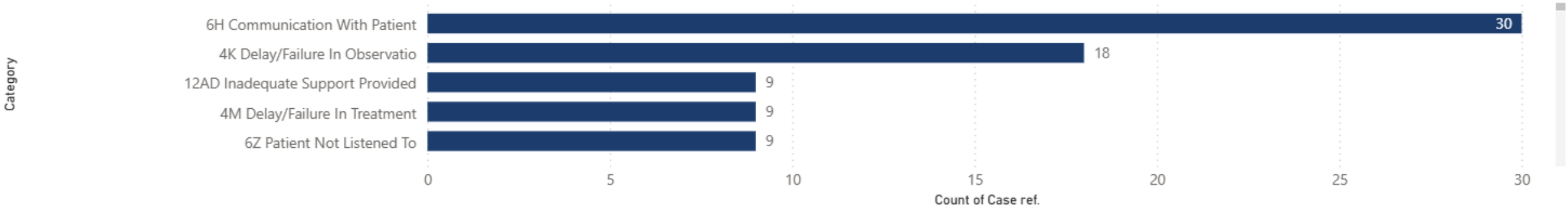


Month opened: All

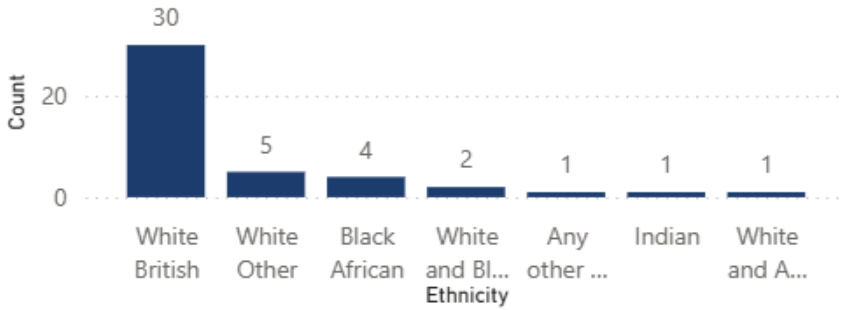
Department: All

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

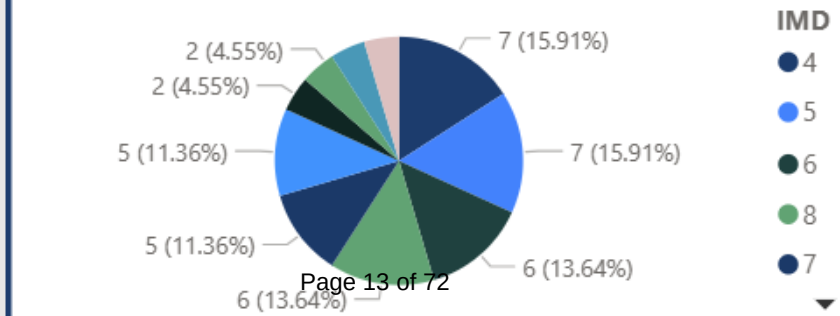
Count of Case ref. by Category



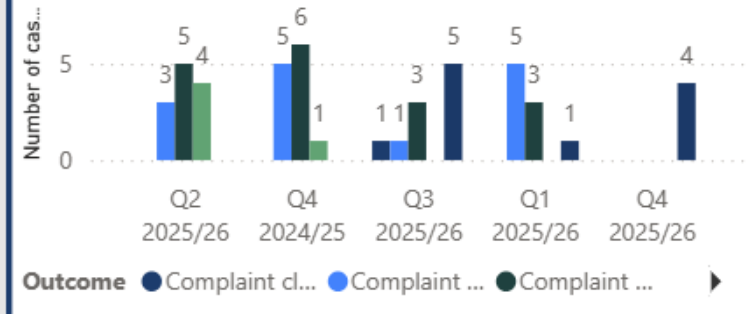
Ethnicity of mother



IMD



Outcome of complaints

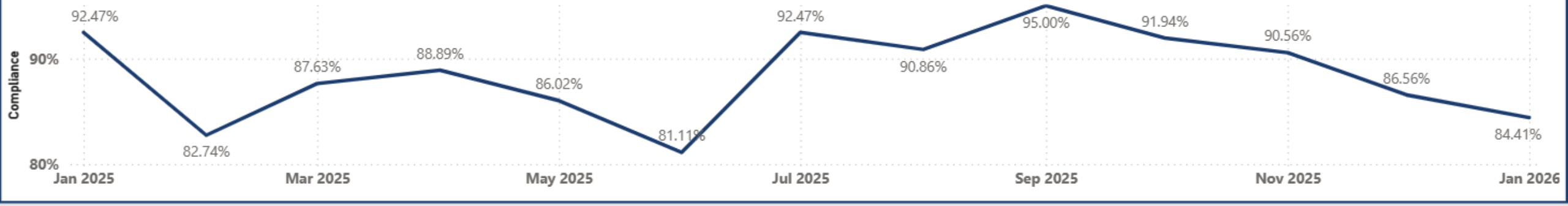


Birth Rate Plus Acuity Tool

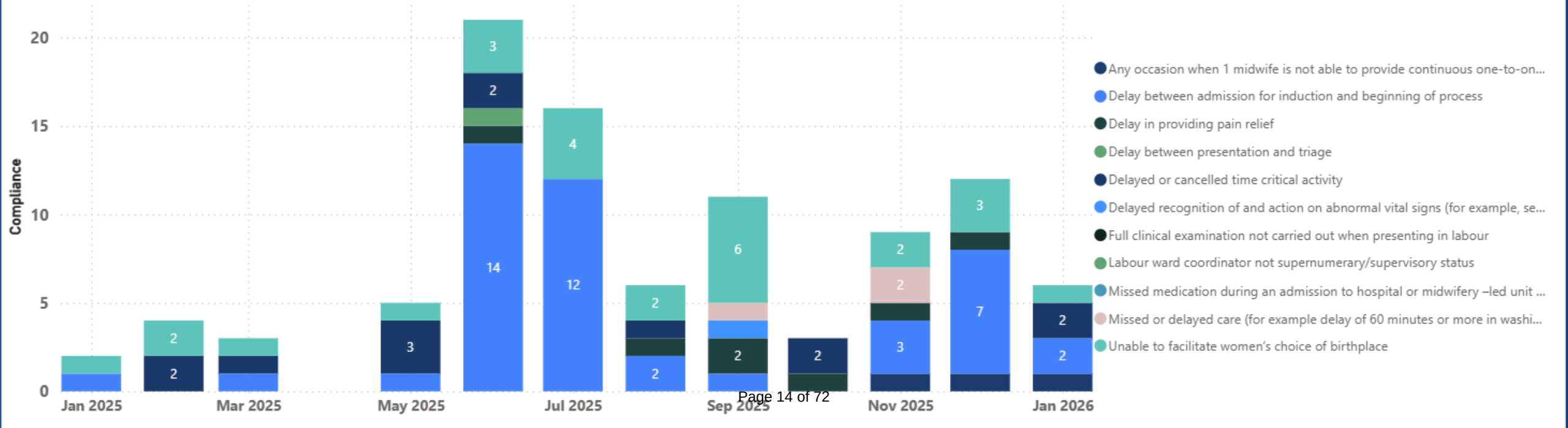
University Hospital Southampton NHS Foundation Trust

Labour ward | Broadlands ward | Burley ward | Lyndhurst ward

Labour ward - compliance summary (all completed assessments)



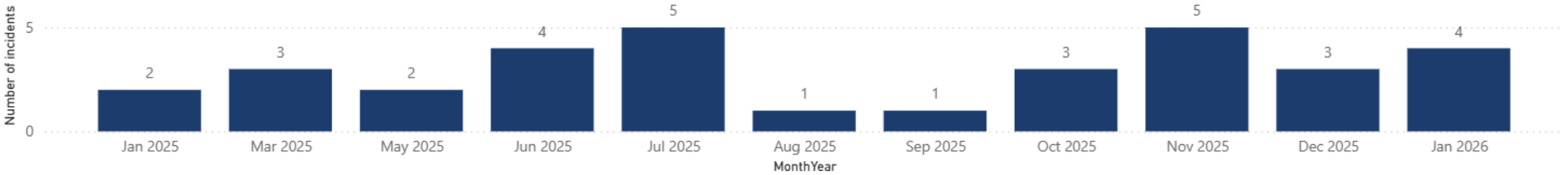
Labour ward red flags



Incidents

University Hospital Southampton NHS Foundation Trust

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

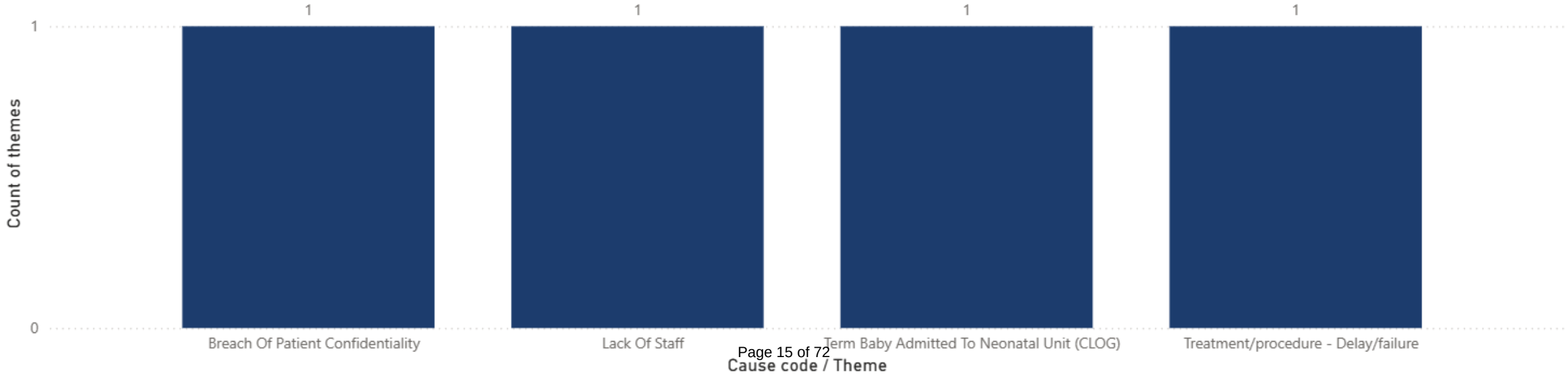


Year: 2026

Month: All

Actual Impact: All

Reported themes of moderate or above incidents



Maternity Safety and Support Programme / Coroner's regulation

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026
No	No	No	No	No	No	No	No	No	No	No	No	No

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	Oct 2025	Nov 2025	Dec 2025	Jan 2026
No	No	No	No	No	No	No	No	No	No	No	No	No

PSII / Harm Tools / After Action Reviews

University Hospital Southampton NHS Foundation Trust

PSII | Harm tools | After action review

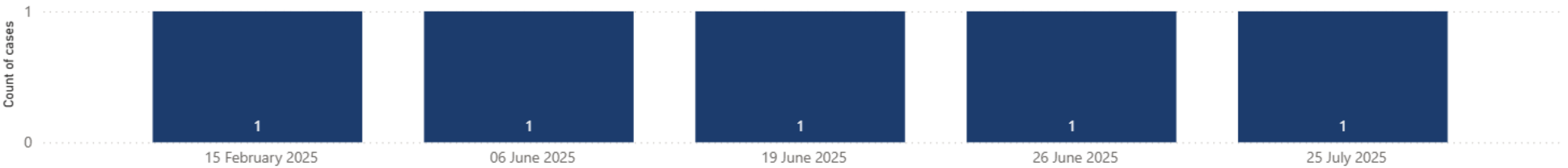
Number of PSII cases

PSII / Harm Tools / After Action Reviews

Return to main menu

PSII | Harm tools | After action review

Number of Harm Tools completed



Reset filters

PMRT

University Hospital Southampton NHS Foundation Trust

Date of death

Multiple selections

Category of case

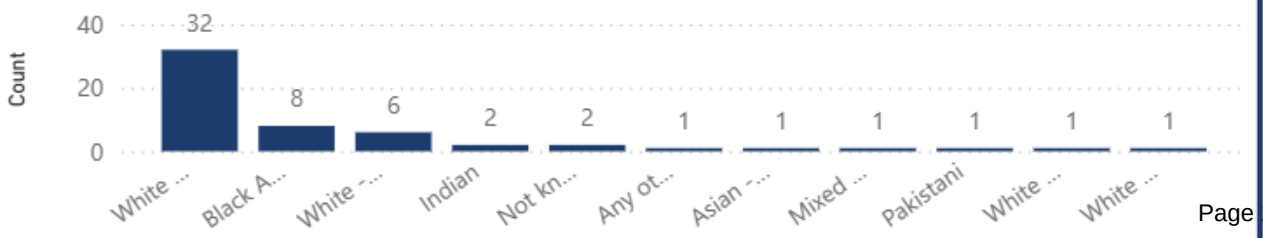
All

Number of reportable PMRT cases

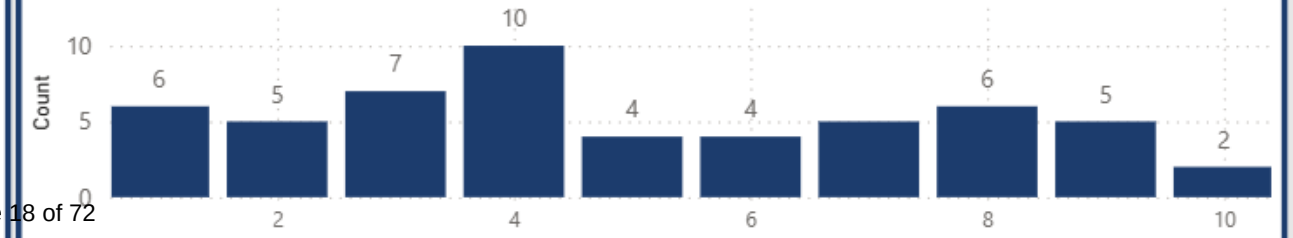
PMRT cases

Case ID	Date of death	Type of death	Timing of death	Location of Birth	Location of Death	Mother's ethnicity	IMD decile
96731	03 January 2025	Stillbirth	Antepartum SB	PAH	PAH	White British	4
97324	14 February 2025	Neonatal death	Early NND	PAH	PAH	Black African	9
97495	25 February 2025	Stillbirth	Intrapartum SB	PAH	PAH	White and Black Caribbean	4
97659	08 March 2025	Neonatal death	Late NND	QAH, Portsmouth	PAH	Black African	6
97702	08 March 2025	Stillbirth	Antepartum SB	PAH	PAH	White British	10
97702	10 March 2025	Neonatal death	Early NND	PAH	PAH	White British	10
97770	10 March 2025	Stillbirth	Antepartum SB	PAH	PAH	Indian	7
97777	14 March 2025	Neonatal death	Early NND	PAH	PAH	Indian	3
97874	22 March 2025	Neonatal death	Early NND	PAH	PAH	White British	3
97898	24 March 2025	Stillbirth	Intrapartum SB	PAH	PAH	White British	6
98028	03 April 2025	Neonatal death	Early NND	PAH	PAH	White Other	Unknown
98058	07 April 2025	Stillbirth	Antepartum SB	PAH	PAH	Black African	2
98456	05 May 2025	Neonatal death	Late NND	PAH	PAH	White British	9
98477	07 May 2025	Neonatal death	Late NND	BNHH, Basingstoke	PAH	White British	Unknown

Ethnicity of mother



IMD



Reset filters

MNSI

University Hospital Southampton NHS Foundation Trust

Number of cases submitted to MNSI

13

Number of cases accepted by MNSI

11

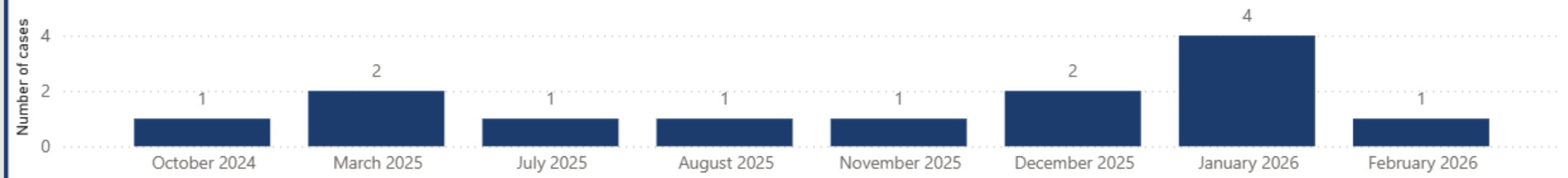
Date of incident

All

Type of incident

All

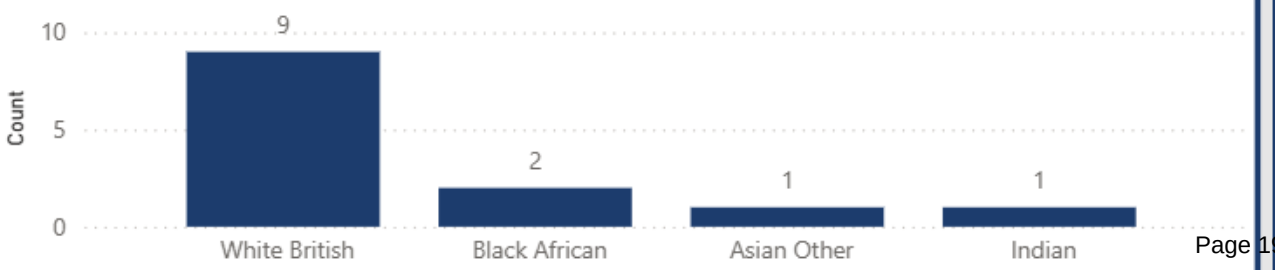
MNSI cases



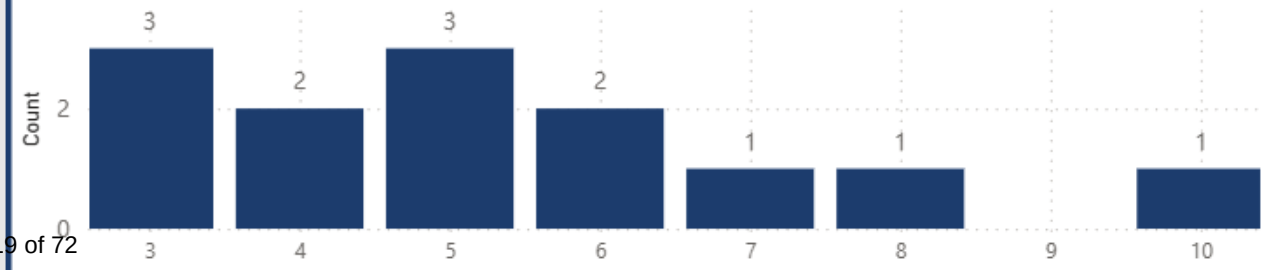
MNSI reportable cases

Date of incident	MNSI ref.	Type of incident	Ethnicity	IMD	Date reported to MNSI	MNSI accepted (Y/N)	Date accepted by MNSI
04/02/2026	MI-052808	Intrapartum stillbirth	Asian Other	5	2/4/2026	Yes	2/4/2026
30/01/2026	MI-052981	Maternal death	White British	7	2/9/2026	Yes	2/9/2026
27/01/2026	MI-052401	Maternal death	White British	5	1/27/2026	Yes	1/28/2026
26/01/2026	MI-052366	Maternal death	White British	10	1/27/2026	Yes	1/27/2026
22/01/2026	MI-052265	Therapeutic Cooling	Black African	3	1/23/2026		
23/12/2025	MI-051031	Therapeutic Cooling	White British	4	12/23/2025	Yes	1/8/2026
14/12/2025	MI-050751	Intrapartum stillbirth	Black African	4	12/17/2025	Yes	1/6/2026
26/11/2025	MI-049946	Intrapartum stillbirth	White British	5	11/27/2025	Yes	11/27/2025

Ethnicity of mother



IMD



University Hospital Southampton NHS Foundation Trust

UHS Maternity Dashboard

The maternity services dashboard provides the leadership team with oversight of key maternity outcome measures, this PowerBi dashboard replaces the previous excel based dashboard.
This dashboard should be used in conjunction with the Maternity PQOM dashboard to provide monitoring and assurance of a safe and effective service.

Booking/Antenatal measures

- Antenatal bookings
- Continuity of Carer

Birth outcomes - mothers

- Numbers of births
- Unwell women
- IOL / Type of birth / Place of birth

Birth outcomes - babies

- Numbers of babies
- Outcomes
- Neonatal outcomes

External monitoring

- NMPA
- CQIMs
- Ockenden

UHS Dashboard Links

- PQOM
- Antenatal Bookings
- Birth Outcomes
- 3rd and 4th degree tears

Areas for continuous monitoring

- Tears / PPH / APGARs

Other outcome measures

- MDAU
- Antenatal and Newborn Screening

Public health

- Infant feeding
- Smoking in pregnancy

Service monitoring

- Opel status

External links

- National Maternity Dashboard
- National Maternity and Neonatal Equalities Dashboard

Return to main menu

Antenatal Bookings

University Hospital Southampton NHS Foundation Trust

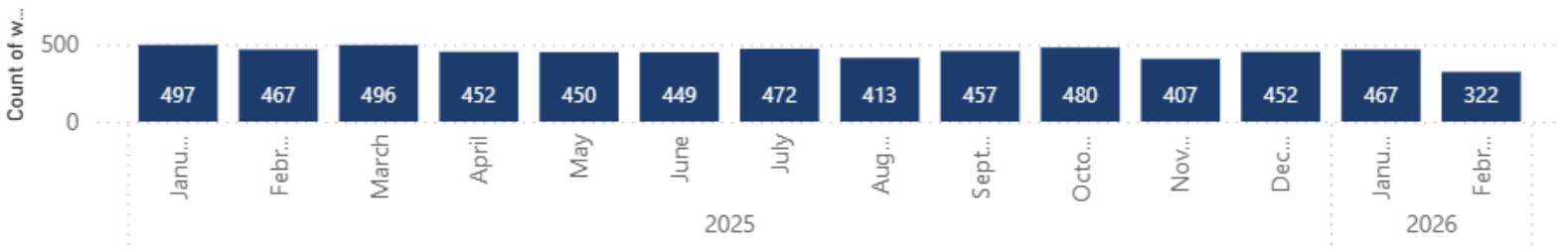
Year

Multiple selections

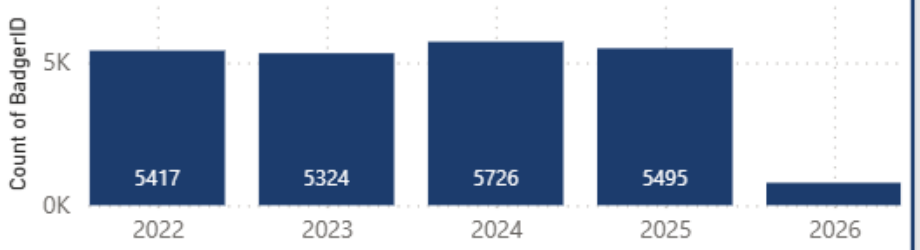
Month

All

Total number of antenatal bookings

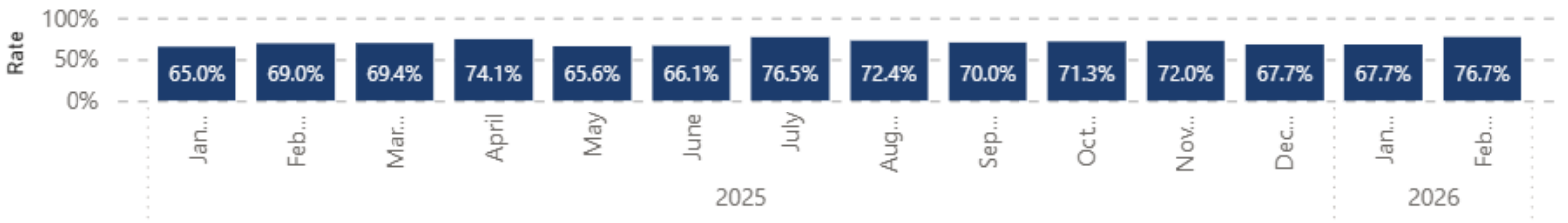


Summary - Antenatal bookings

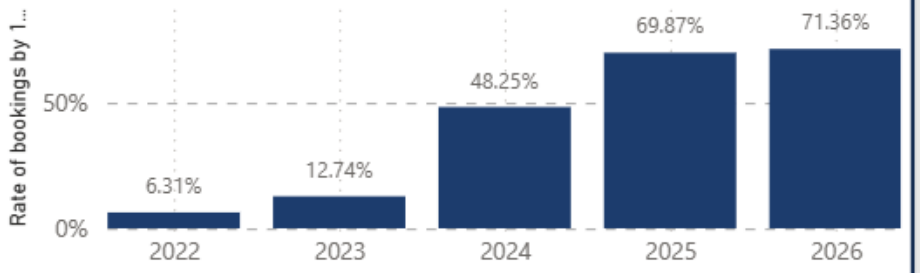


Rate of bookings completed by 9+6 weeks gestation (NICE recommendation)

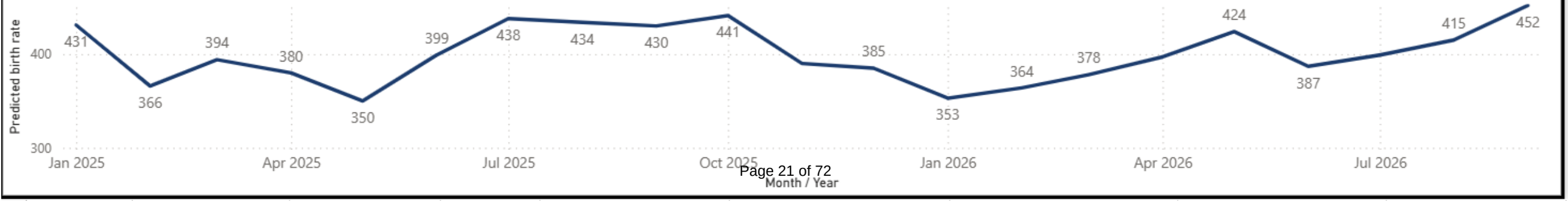
Acceptable level >50% Achievable level >75%



Summary - Rate of bookings by 9+6 weeks



Predicted birth rate



Return to main menu

Continuity of Carer at booking

University Hospital Southampton NHS Foundation Trust

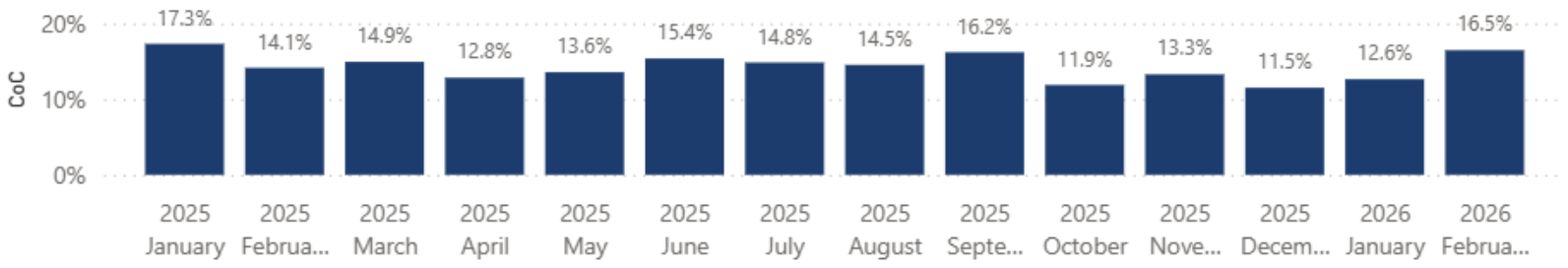
Year

Multiple selections

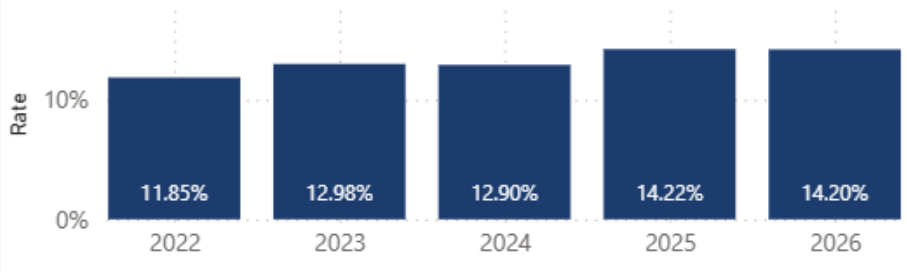
Month

All

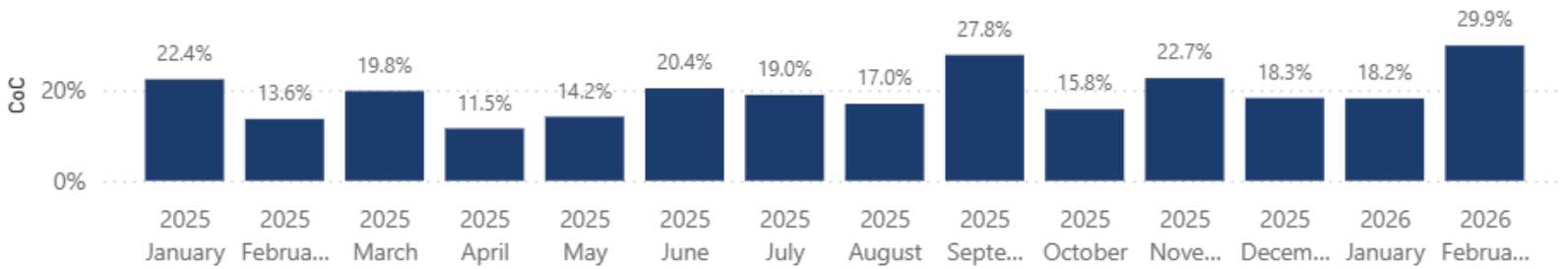
Continuity of Carer - Total women booked for Southampton NEST care



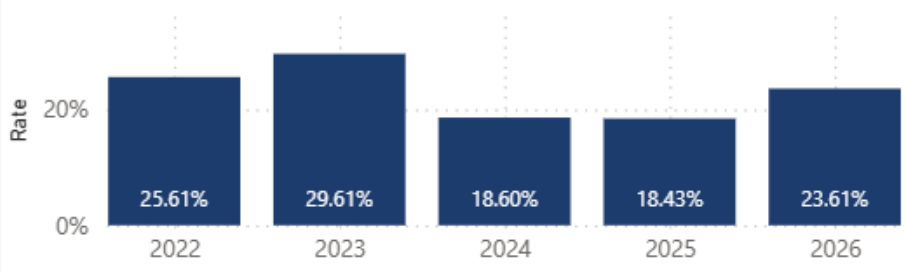
Summary - CoC all women



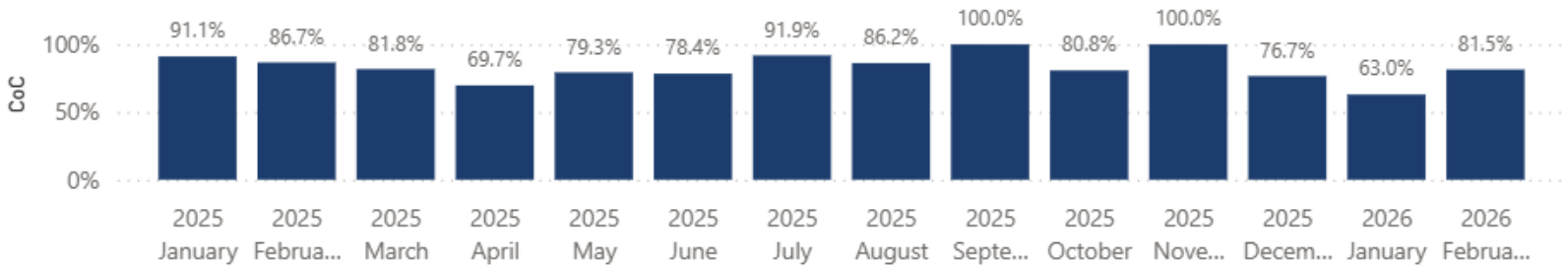
Continuity of Carer - Global majority



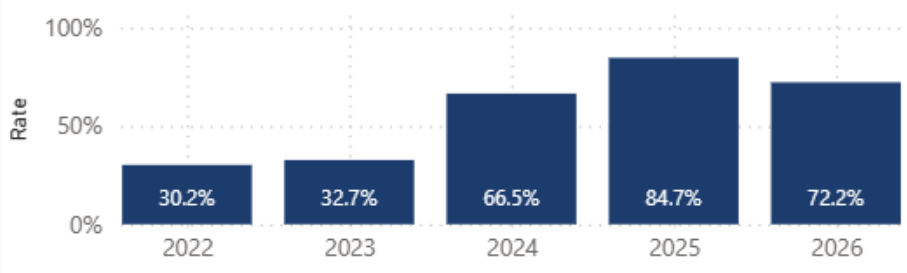
Summary - CoC global majority women



Continuity of Carer - IMD-1



Summary - CoC IMD-1 women - 2019



IMD data relating to antenatal bookings between 2021 and 2025 uses the IMD-2019 dataset. Antenatal bookings from 2026 onwards uses the IMD-2025 dataset

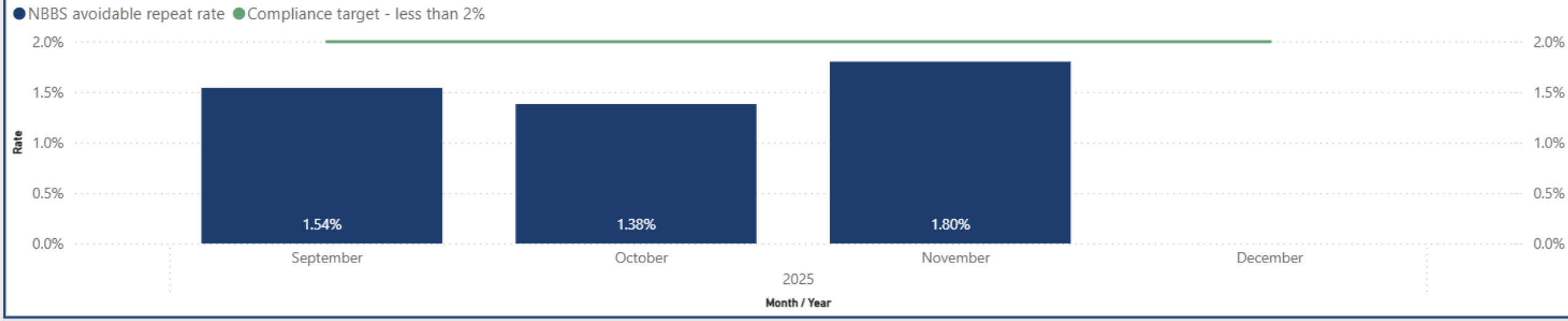
Return to main menu

Newborn Blood Spot Screening - Avoidable repeats

Reset all filters

Newborn blood spot screening - avoidable repeat rate

September 2025 figure is the final compliance for quarter 2 2025/26



Return to main menu

Birth outcomes - Mothers

NHS
University Hospital Southampton
NHS Foundation Trust

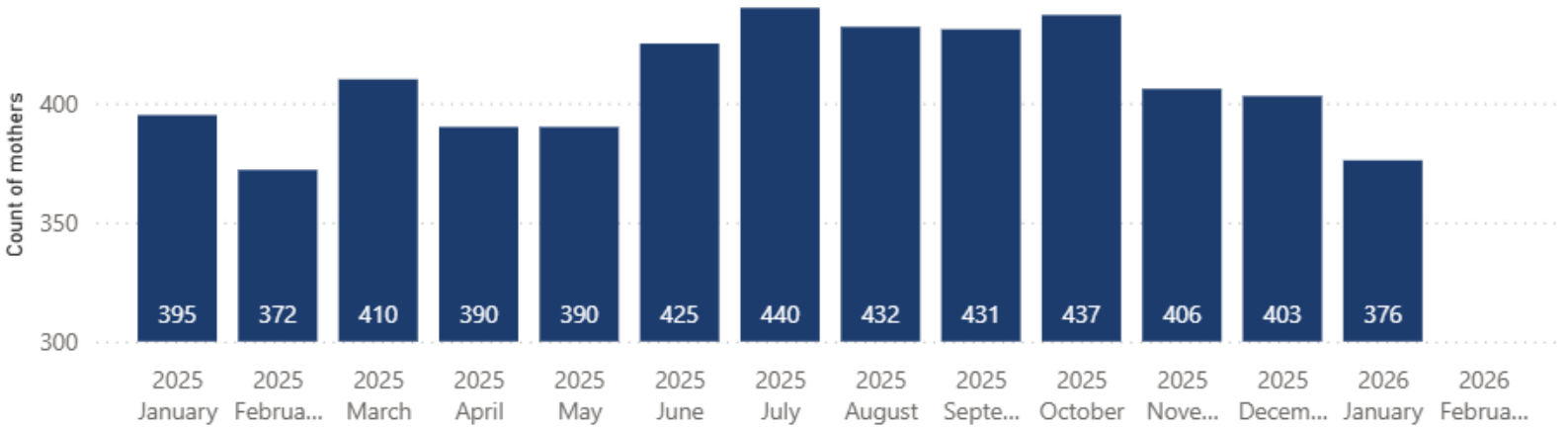
Year

Multiple selections

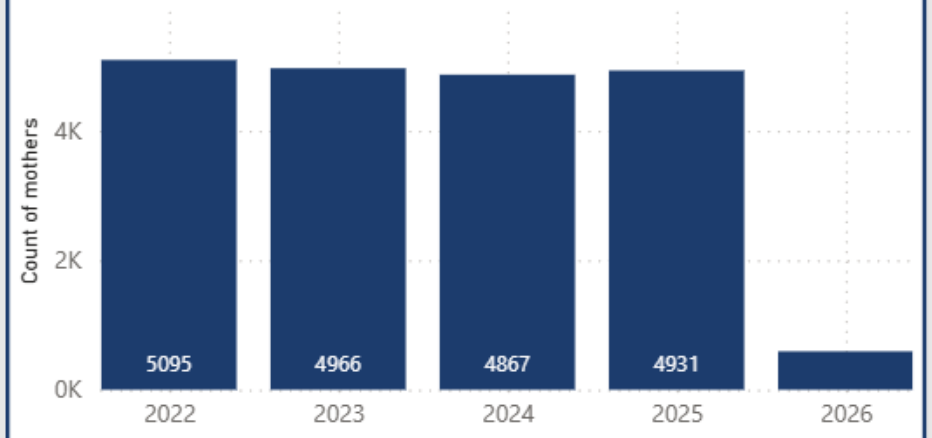
Month

All

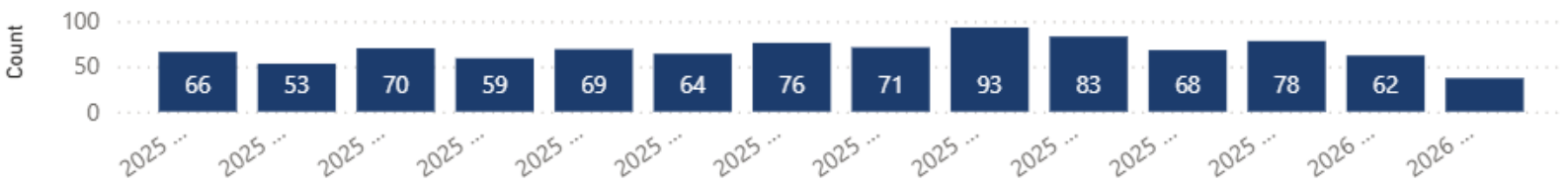
Total number of births (mothers)



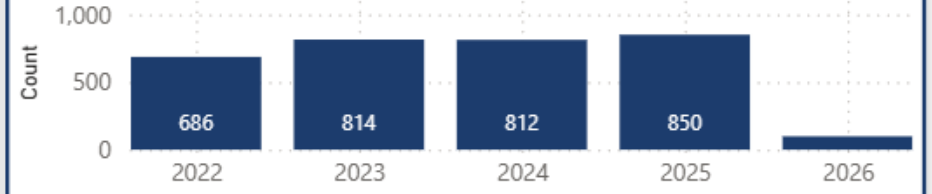
Summary - Mothers



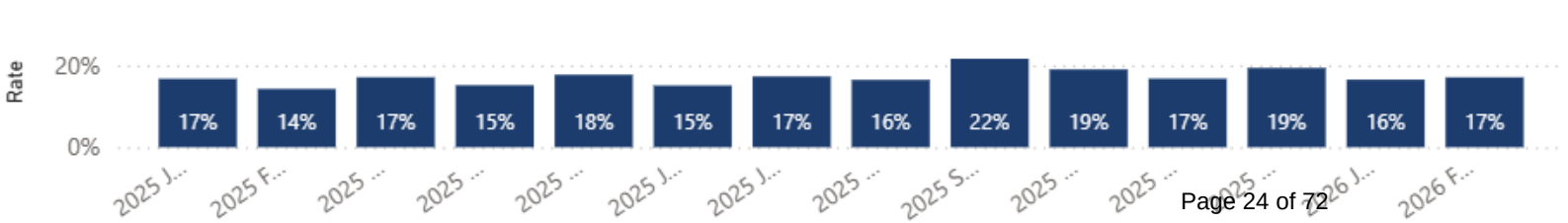
Scheduled caesarean section capacity - count of mothers



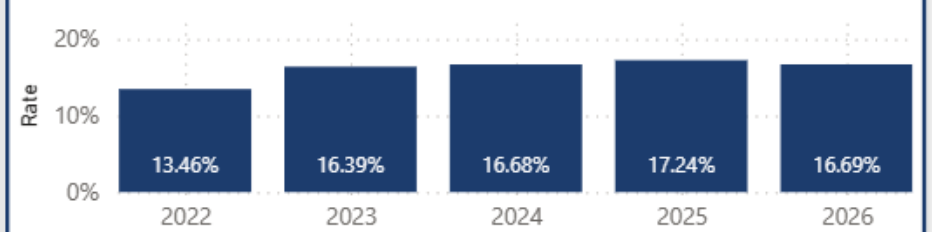
Summary - Count of scheduled CSs



Scheduled caesarean section capacity - rate



Summary - Scheduled CS rate



Return to main menu

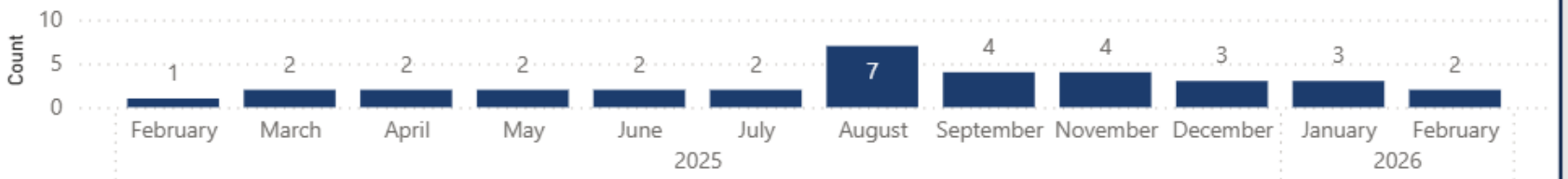
Birth outcomes - Mothers

University Hospital Southampton NHS Foundation Trust

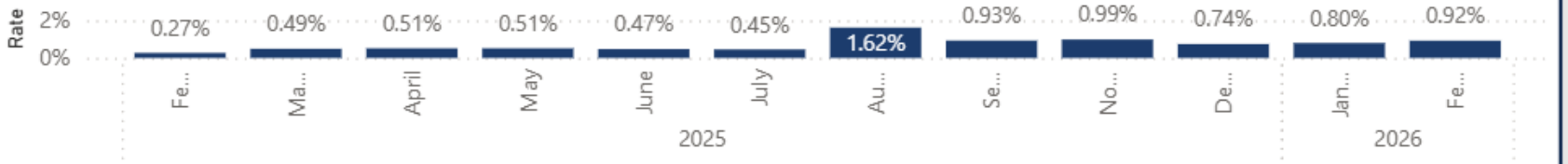
Year: Multiple selections

Month: All

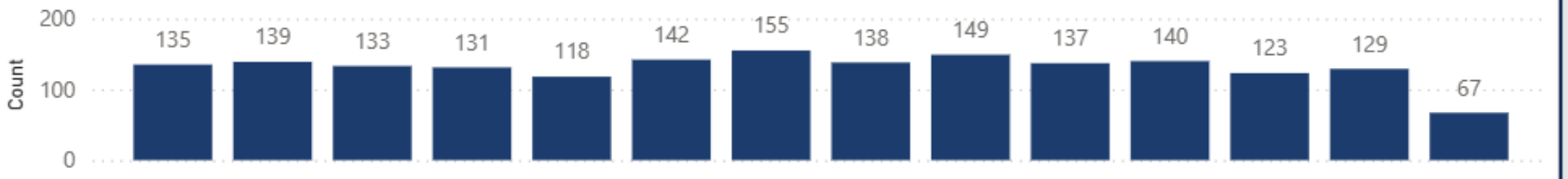
Total number of attended homebirths



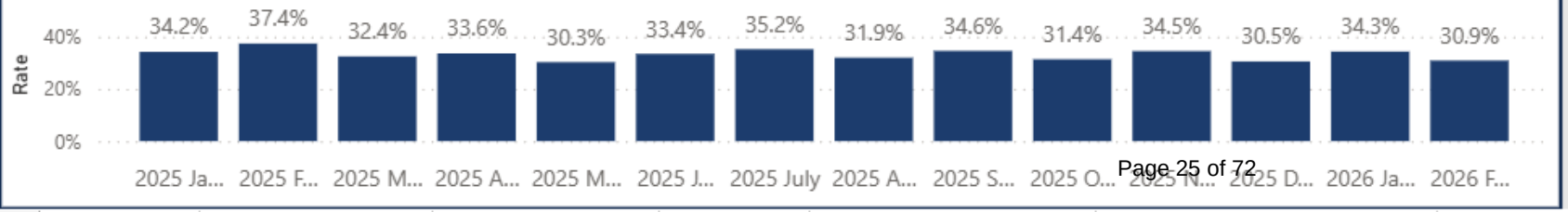
Home birth rate



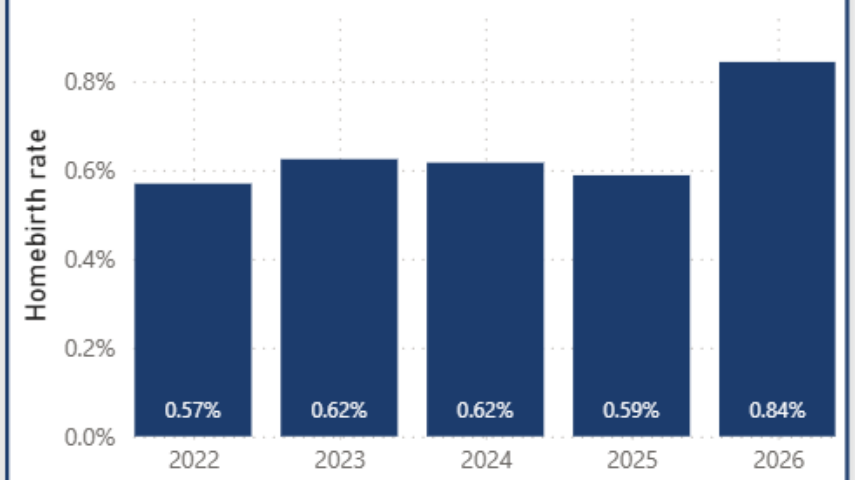
Number of women having an Induction of Labour



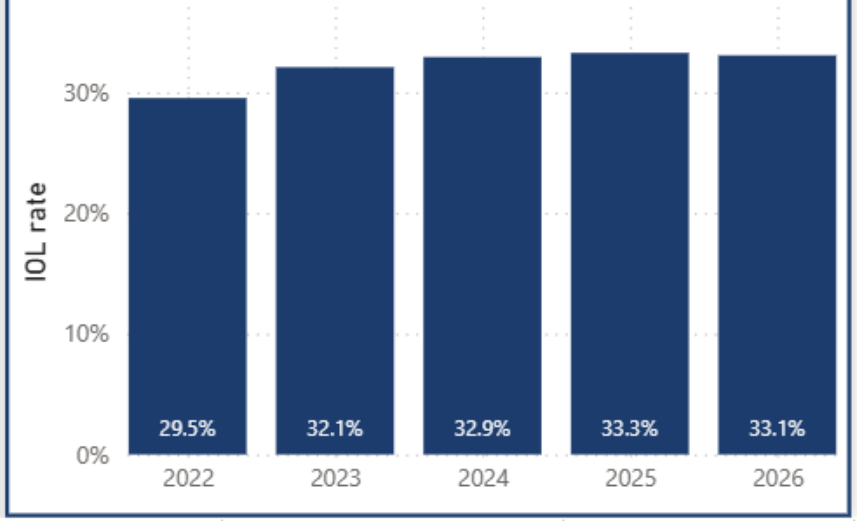
Induction of labour rate



Summary - Home birth rate



Summary - Induction of labour rate



Return to main menu

Birth outcomes - Mothers

University Hospital Southampton NHS Foundation Trust

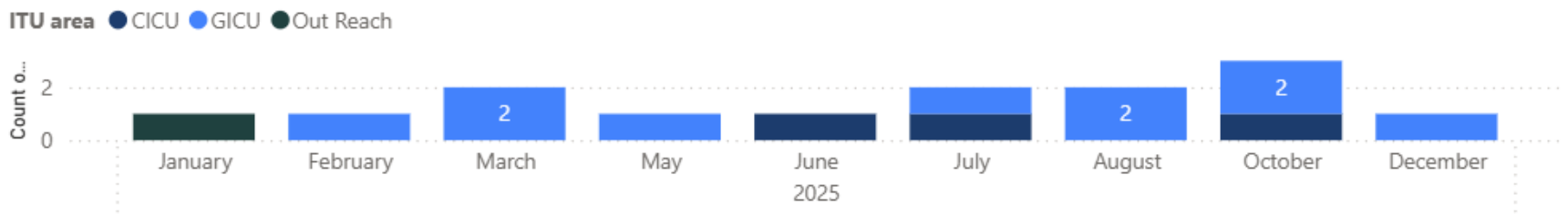
Year

2025

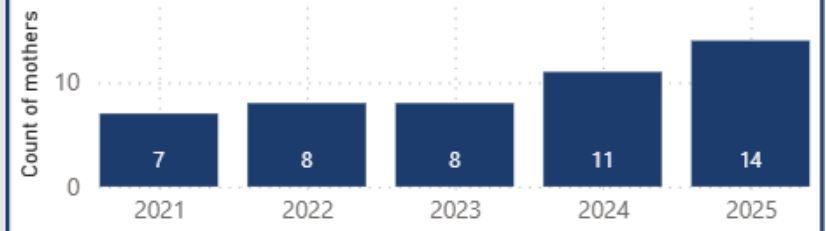
Month

All

Admissions or transfers to General, Neuro or Cardiac ICU



Summary - Admissions / transfers to ITU



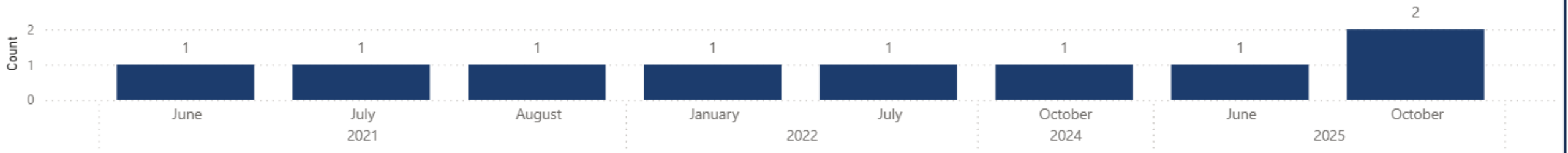
Year

All

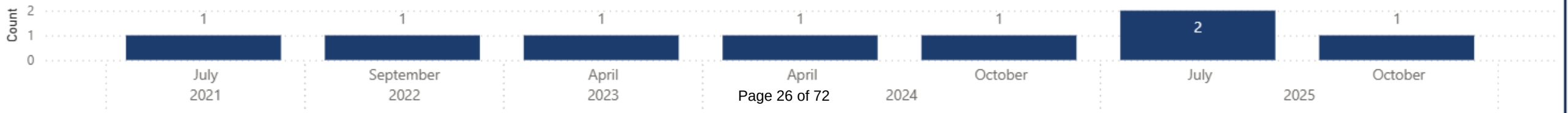
Month

All

Hysterectomy



Eclampsia - number of recorded cases



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Birth outcomes - Key outcomes for continuous monitorin

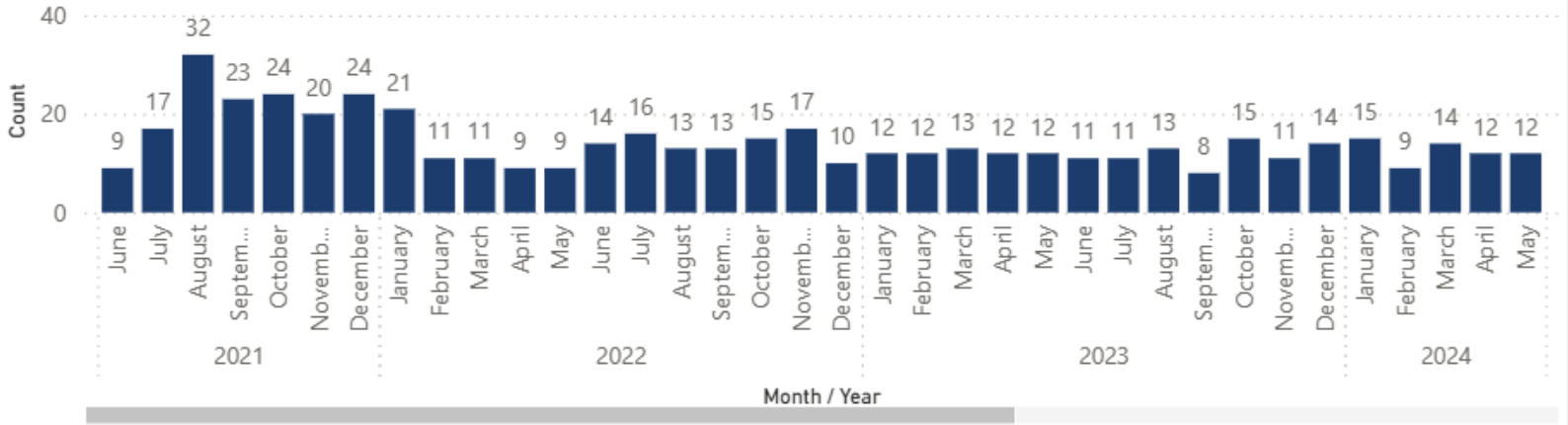
University Hospital Southampton NHS Foundation Trust

Third and forth degree tears | Postpartum Haemorrhage >1500mls | APGAR score < 7 at 5 minutes of age

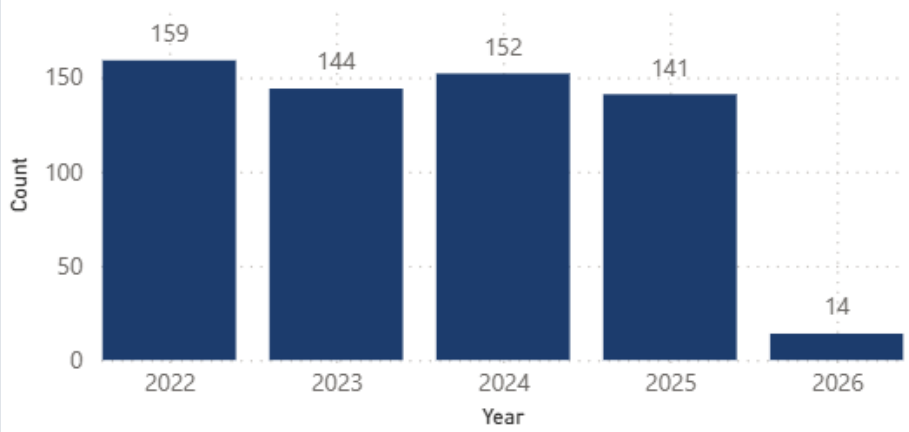
Year: All

Month: All

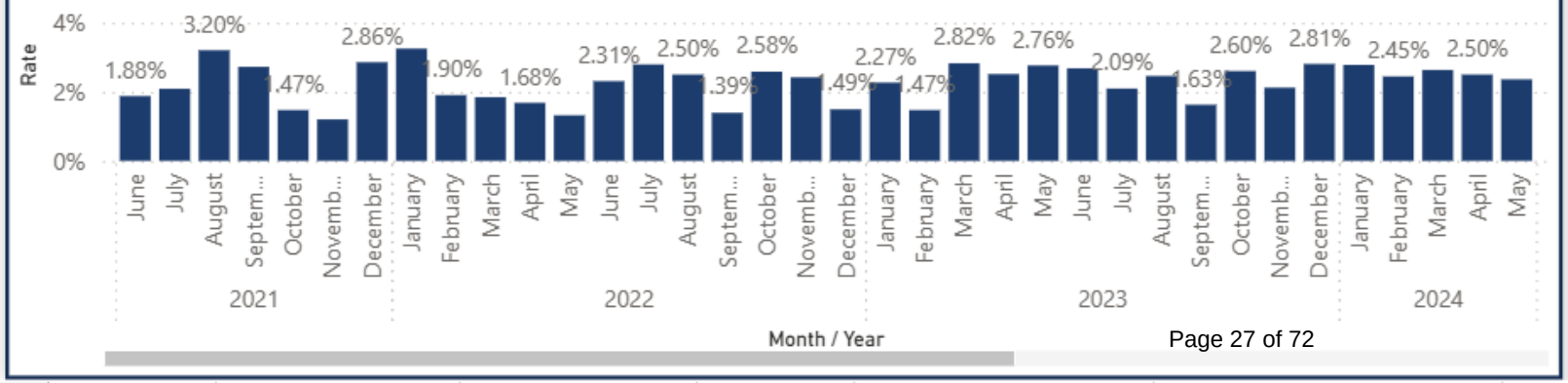
APGARS - term babies born with an APGAR score less than 7 at 5 minutes of age



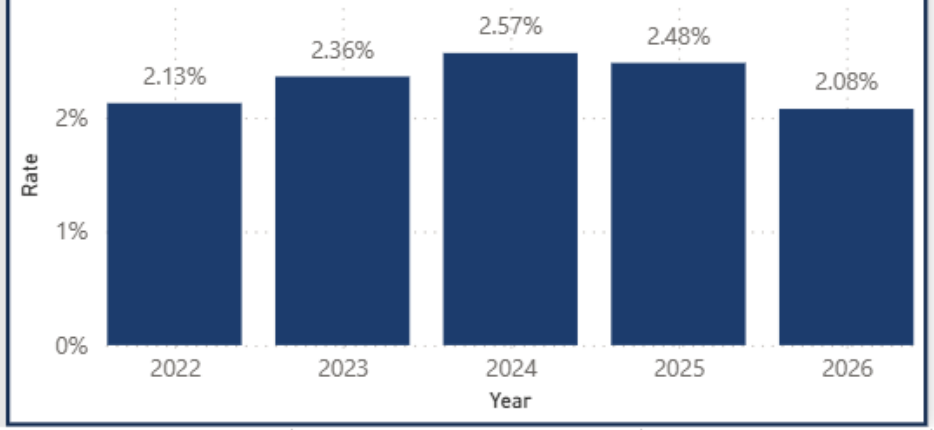
Summary - APGARS < 7



APGAR rate - term babies born with an APGAR score less than 7 at 5 minutes of age



Summary - APGAR <7 rate



Return to main menu

Birth outcomes - Key outcomes for continuous monitorin

University Hospital Southampton NHS Foundation Trust

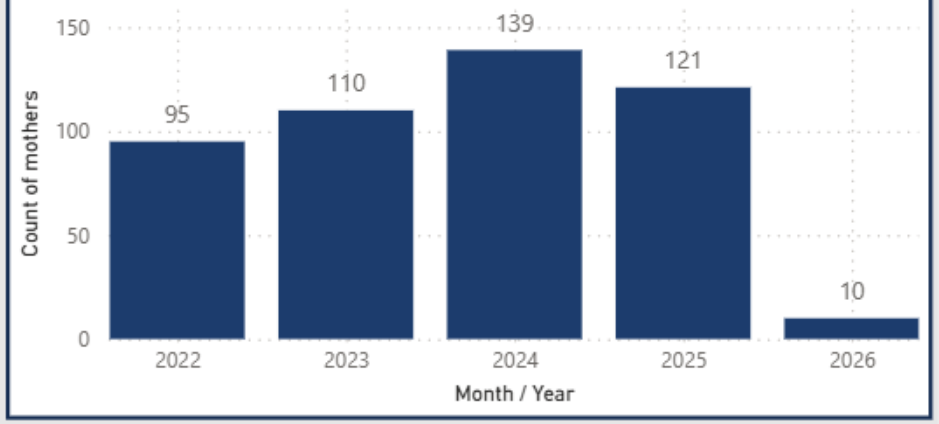
Third and forth degree tears | Postpartum Haemorrhage >1500mls | APGAR score < 7 at 5 minutes of age

Year: 2025

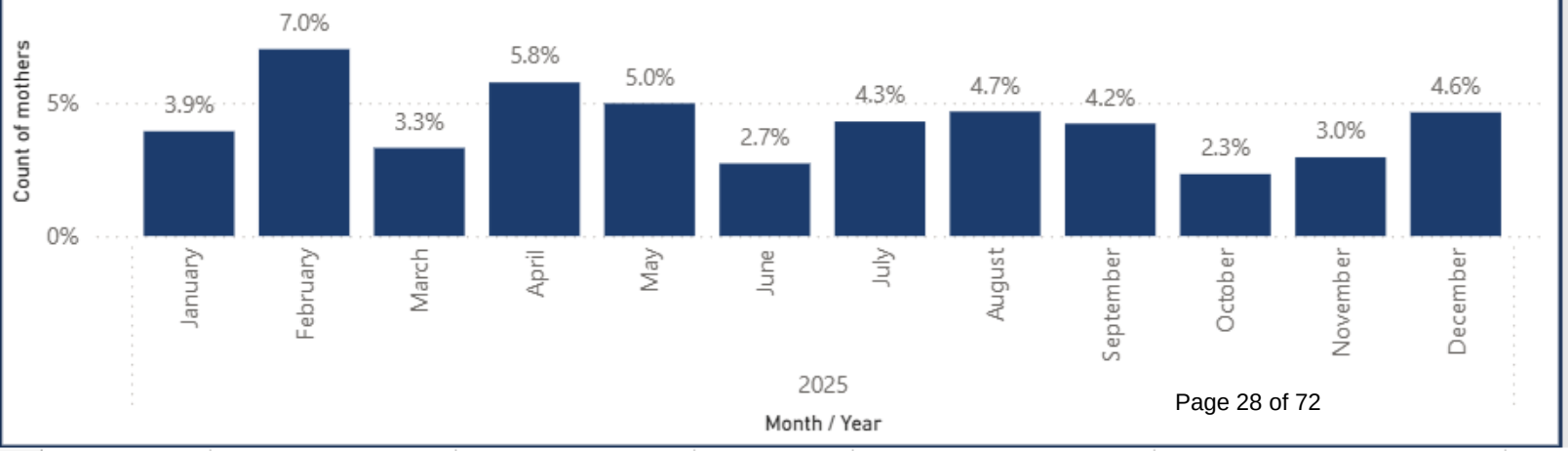
Month: All

Count of women sustaining a third or forth degree tear

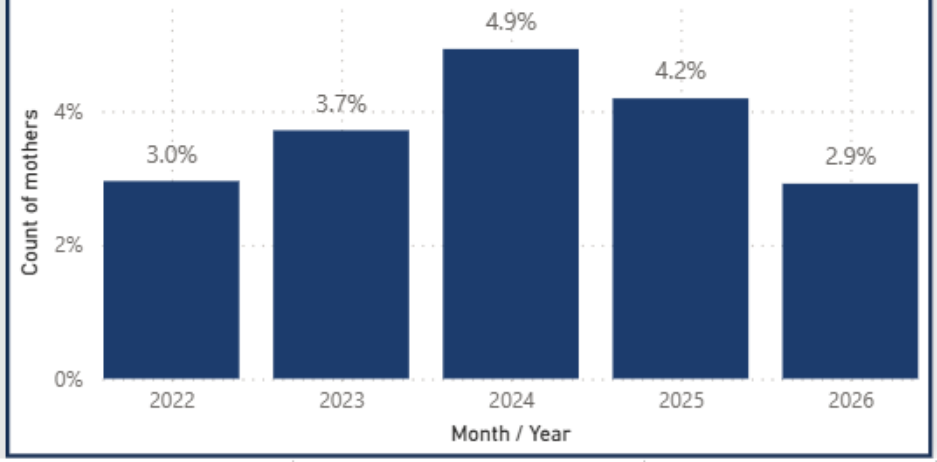
Summary - count of 3rd/4th degree tears



Rate of women sustaining a third or forth degree tear



Summary - rate of 3rd/4th degree tears



Return to main menu

Birth outcomes - Key outcomes for continuous monitoring

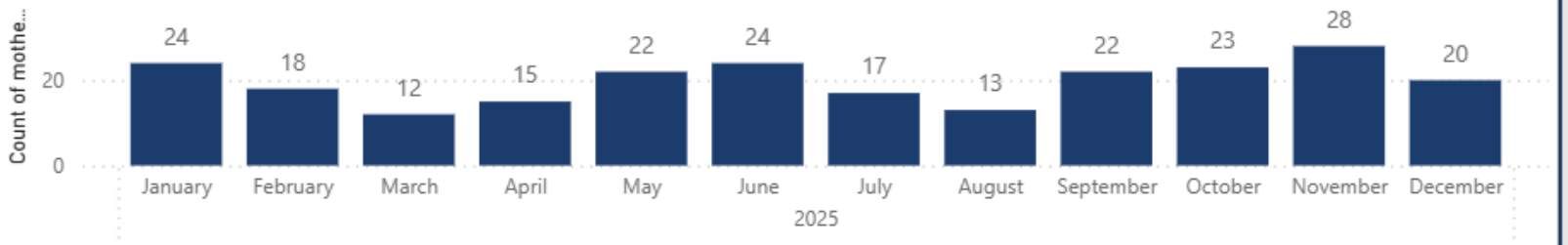
NHS University Hospital Southampton NHS Foundation Trust

Third and forth degree tears | Postpartum Haemorrhage >1500mls | APGAR score < 7 at 5 minutes of age

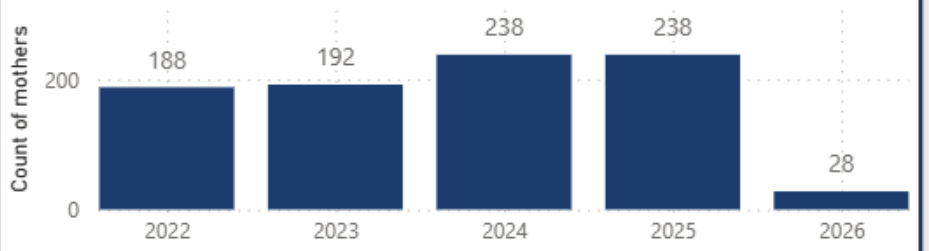
Year: 2025

Month: All

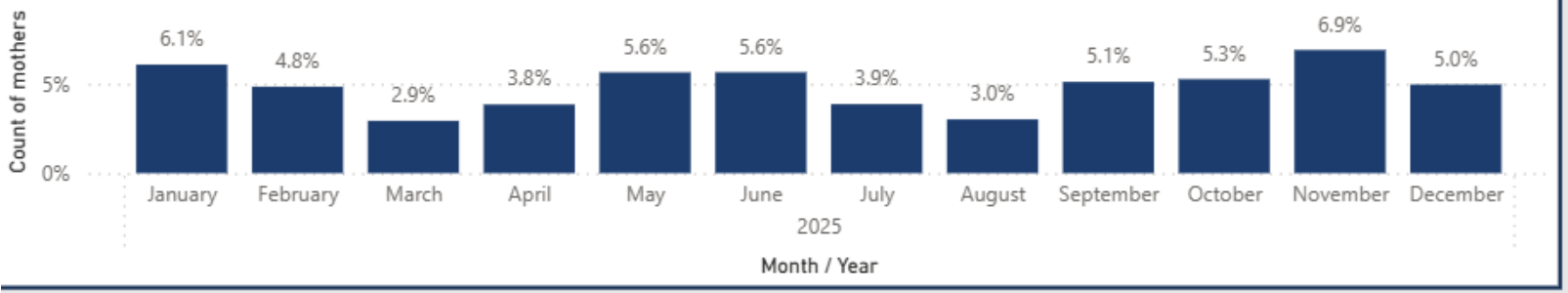
Count of women with a blood loss greater than 1500mls



Summary - PPH >1500mls count

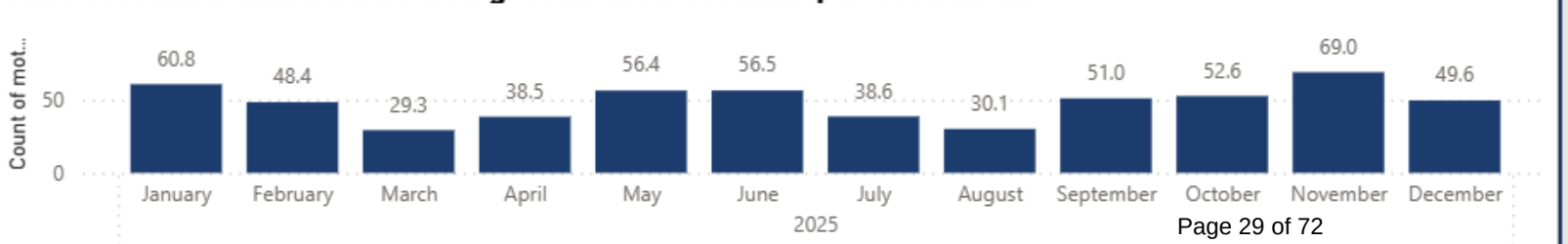


Rate of women with a blood loss greater then 1500mls

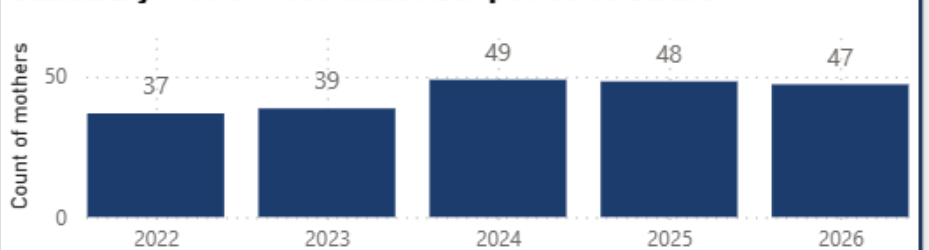


Summary - PPH >1500mls rate

Rate of women with a blood loss greater then 1500mls per 1000 births



Summary - PPH >1500mls rate per 1000 births



Return to main menu

Birth outcomes - Babies

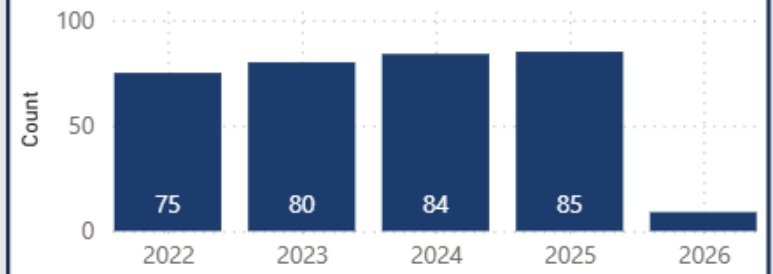
NHS
University Hospital Southampton
NHS Foundation Trust

Year: Multiple selections

Month: All

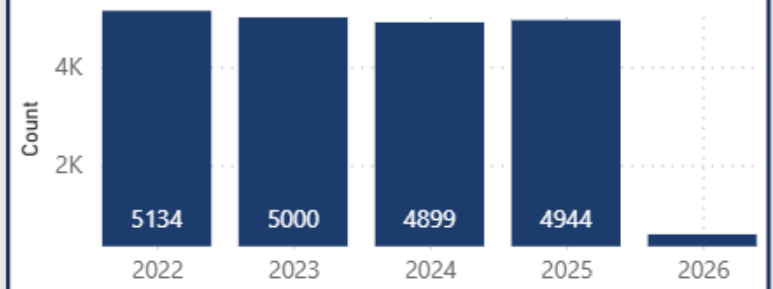
Sets of multiples - count of mothers

Summary - Sets of multiples



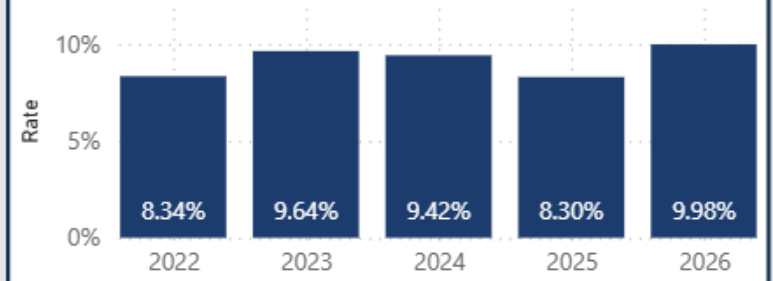
Total number of liveborn registerable babies

Summary - Liveborn registerable babies



Preterm birth rate (registerable babies)

Summary - Preterm birth rate

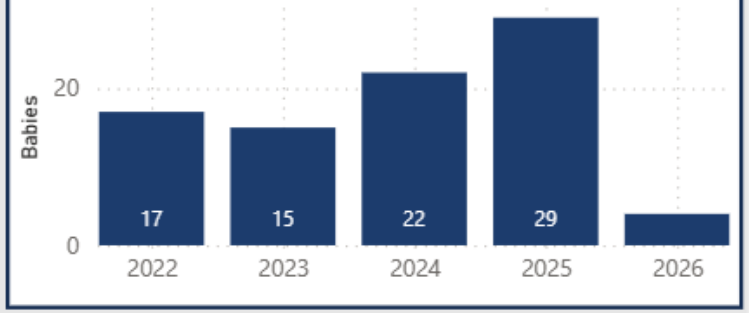


Year: Multiple selections

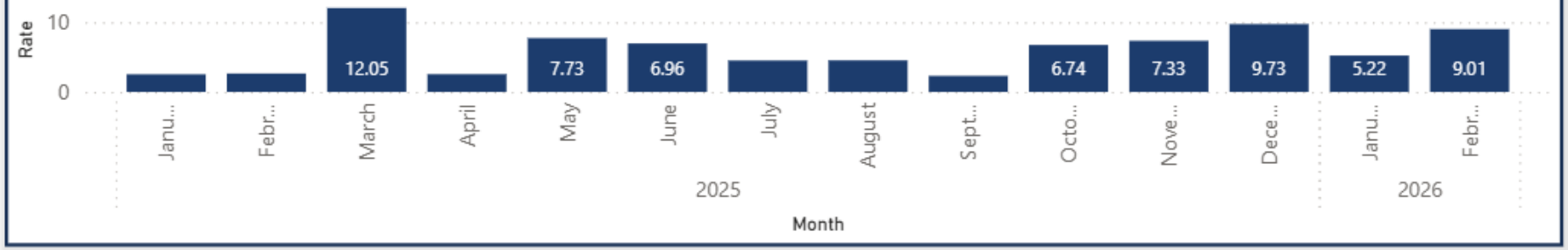
Month: All

Number of stillbirths

Summary - Number of stillbirths

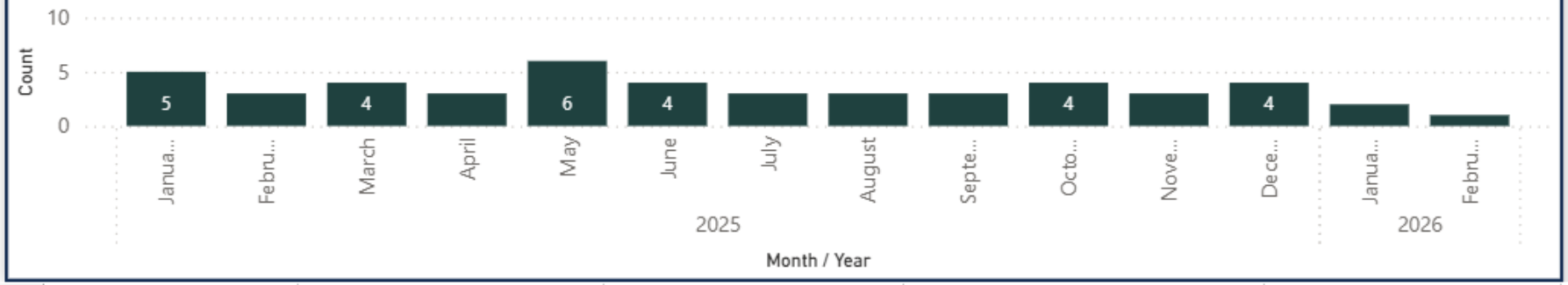


Stillbirth Rate per 1000 births by Year and Month

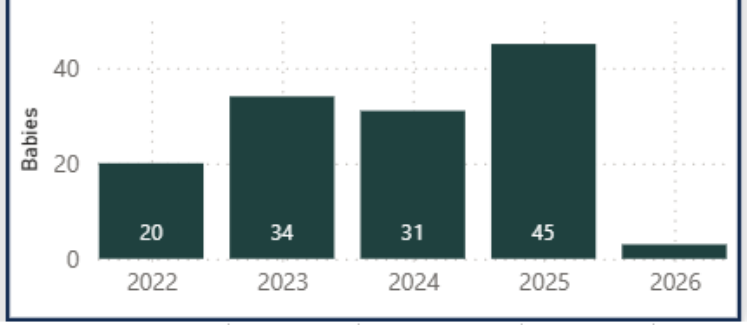


Summary - Stillbirths per 1000 births

Number of non-registerable births (late fetal losses)



Summary - Number of non-registerable births



Return to main menu

Birth outcomes - Saving Babies Lives - Element 2

University Hospital Southampton NHS Foundation Trust

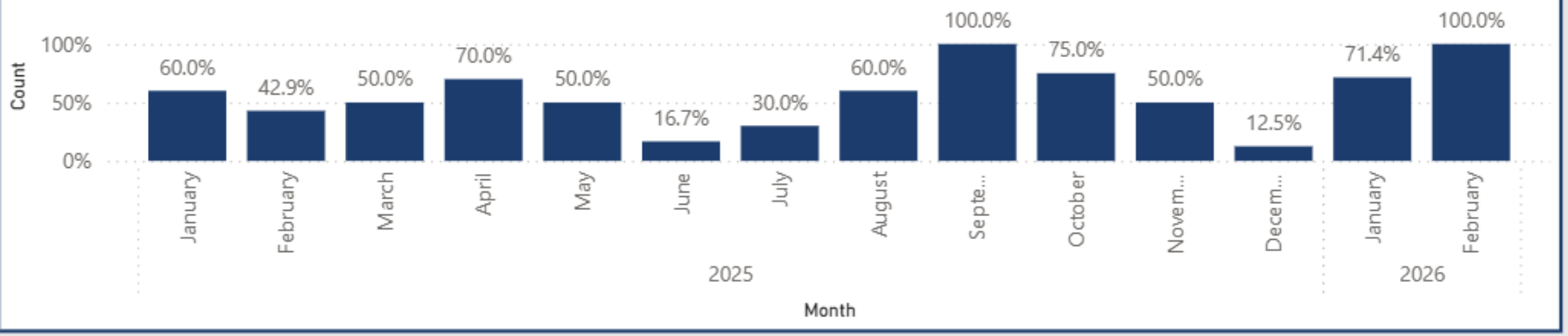
Year

Multiple selections

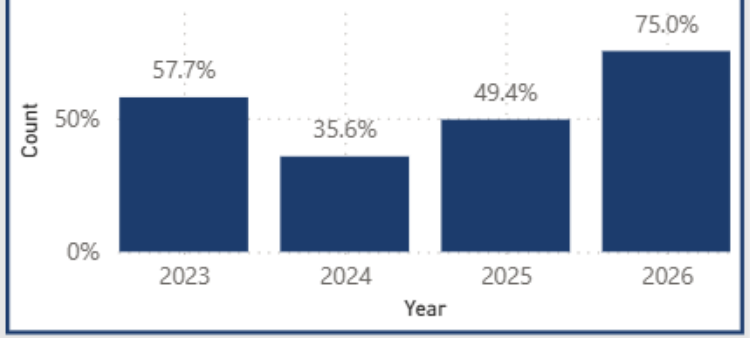
Month

All

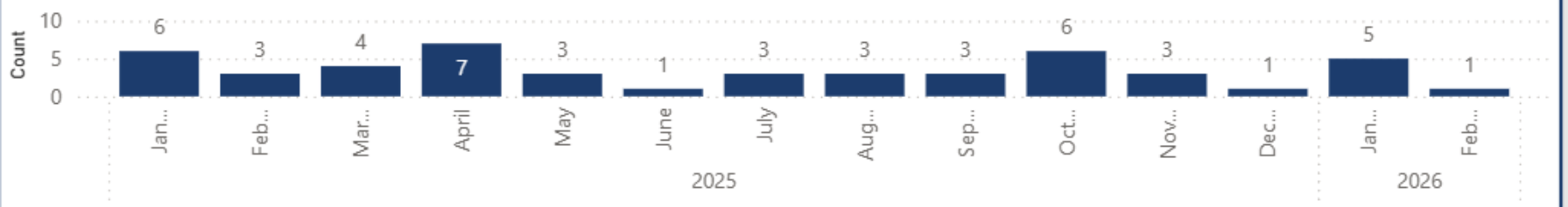
Percentage of babies born <3rd centile >37.6 weeks gestation



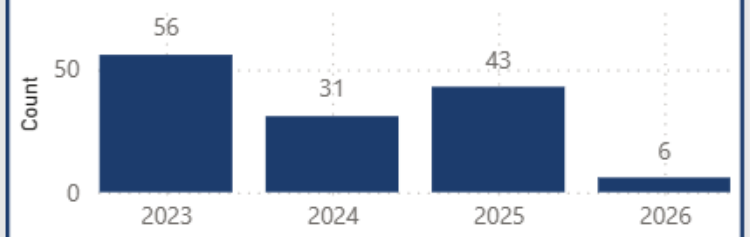
Summary - babies <3rd centile >37.6 weeks gestation



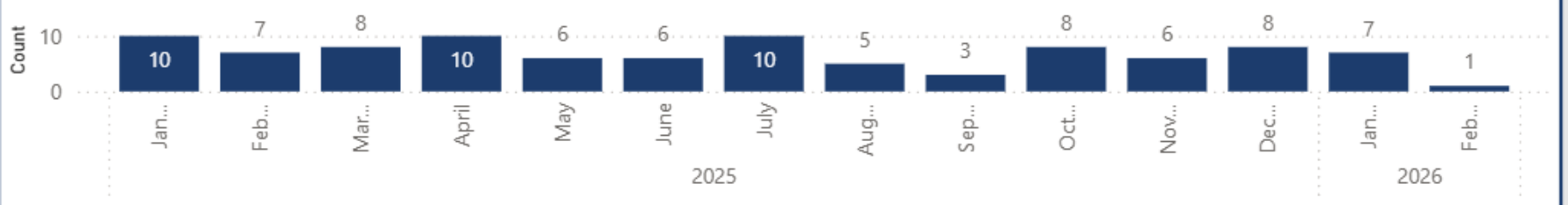
Numerator - Total number of babies born <3rd centile >37.6 weeks gestation



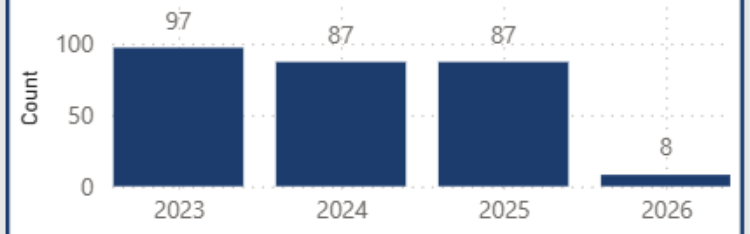
Summary - Numerator



Denominator - Total number of babies born <3rd centile



Summary - Denominator



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Public Health - Smoking in Pregnancy

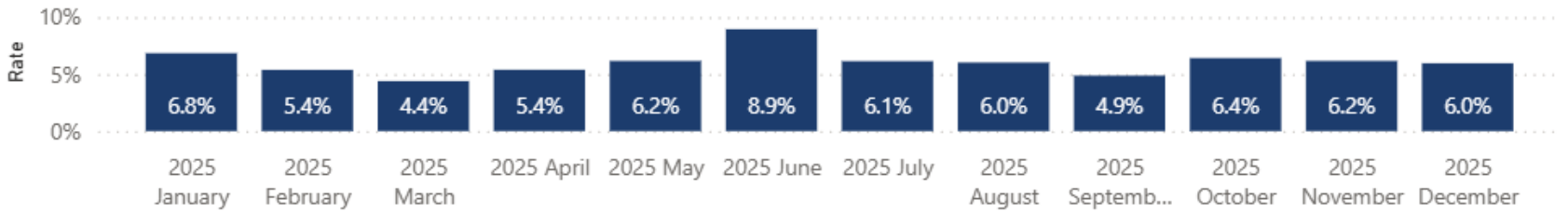
University Hospital Southampton NHS Foundation Trust

Smoking at booking | Smoking at birth | Southampton City data

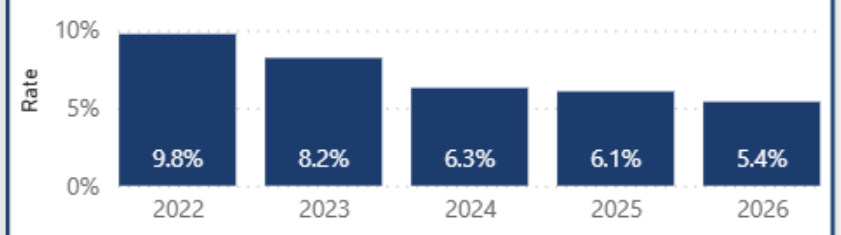
Year of delivery: 2025

Month of delivery: All

Smokers at birth - rate



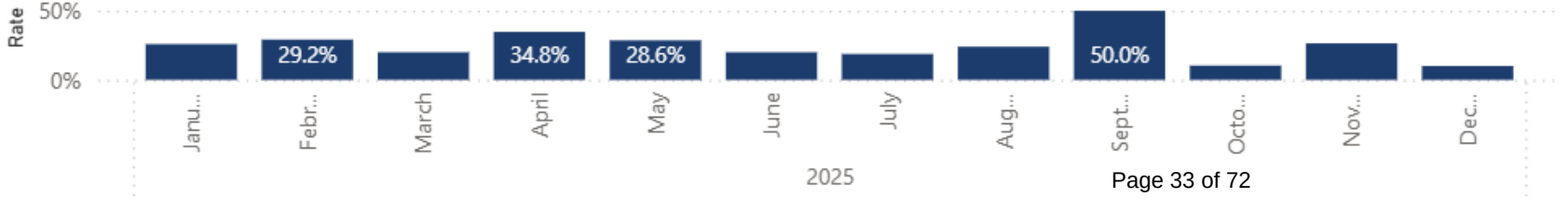
Summary - Smokers at birth - rate



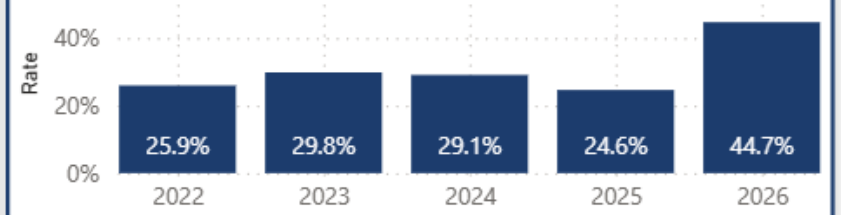
Number of delivered women who gave up smoking during pregnancy

Summary - quit during pregnancy

Rate of delivered women who were smoking at booking who are smoke free at delivery



Summary - quit during pregnancy rate



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Public Health - Infant feeding

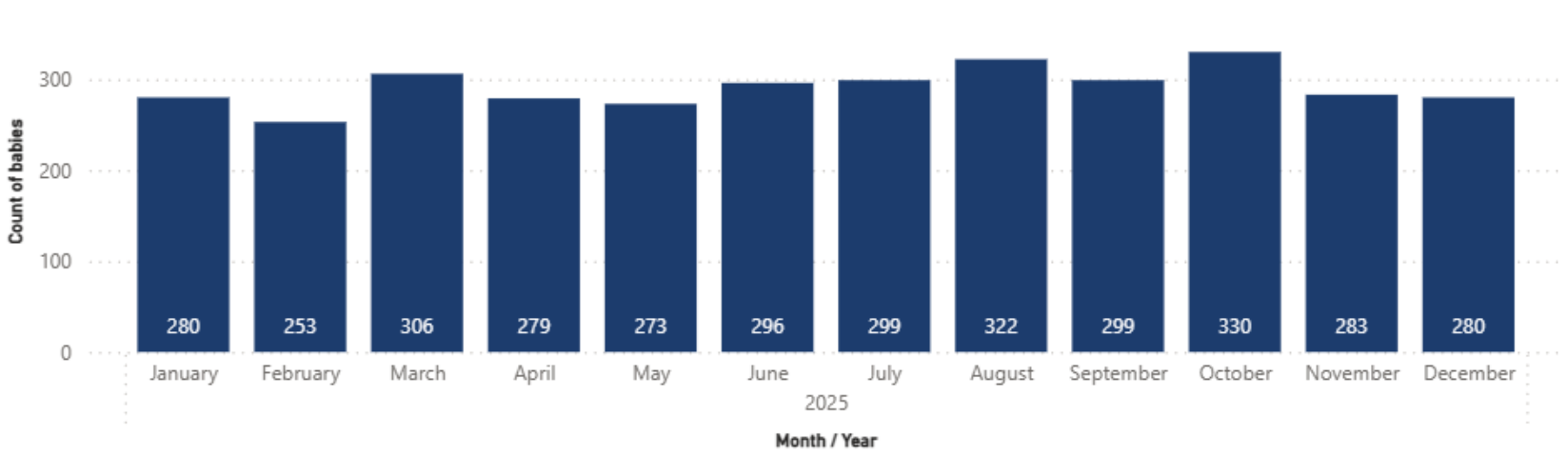
University Hospital Southampton NHS Foundation Trust

Breast feeding initiation | Breast milk at first feed | Breast milk at discharge to the community

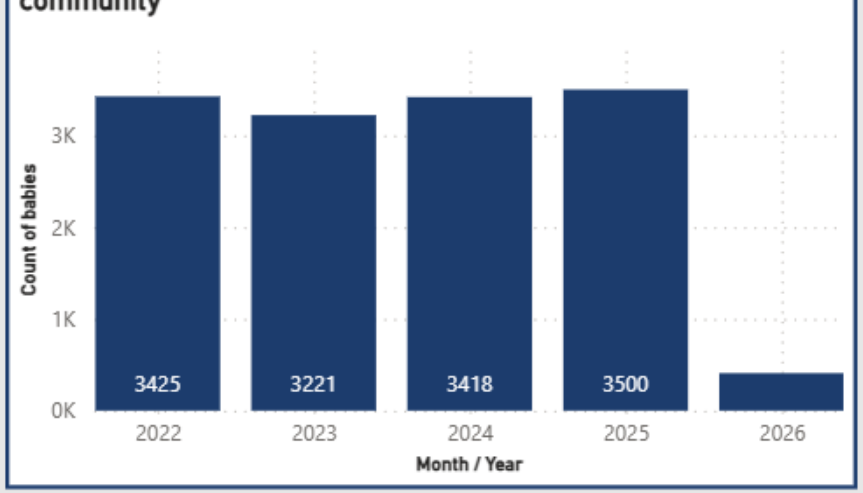
Year: 2025

Month: All

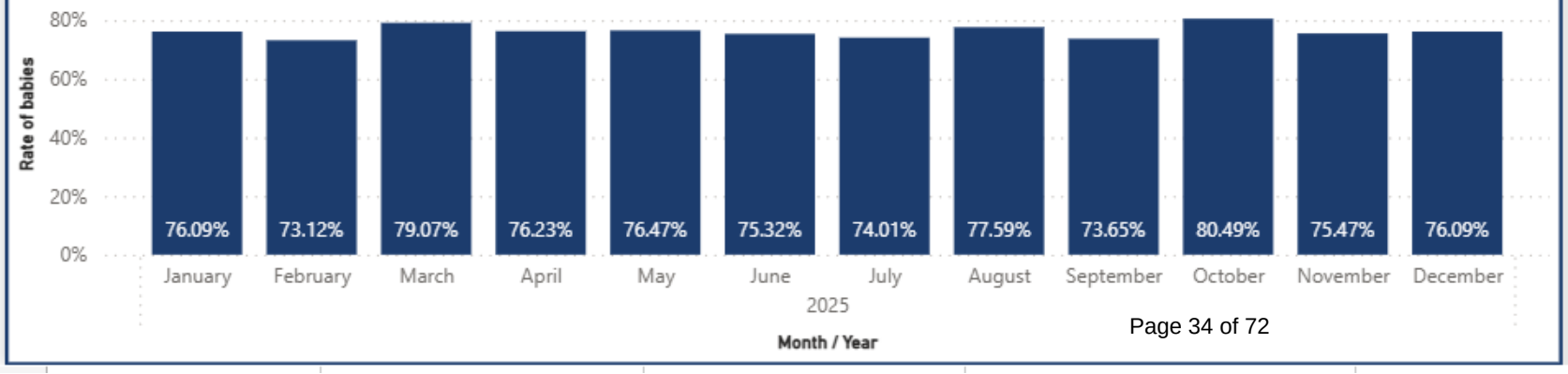
Count of babies receiving breast milk at discharge to the community



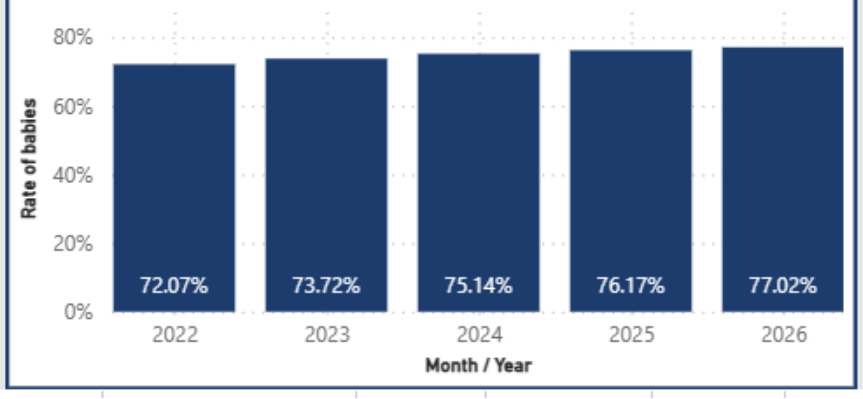
Count of babies receiving breast milk at discharge to the community



Rate of babies receiving breast milk at discharge to the community



Rate of babies receiving breast milk at discharge to the community



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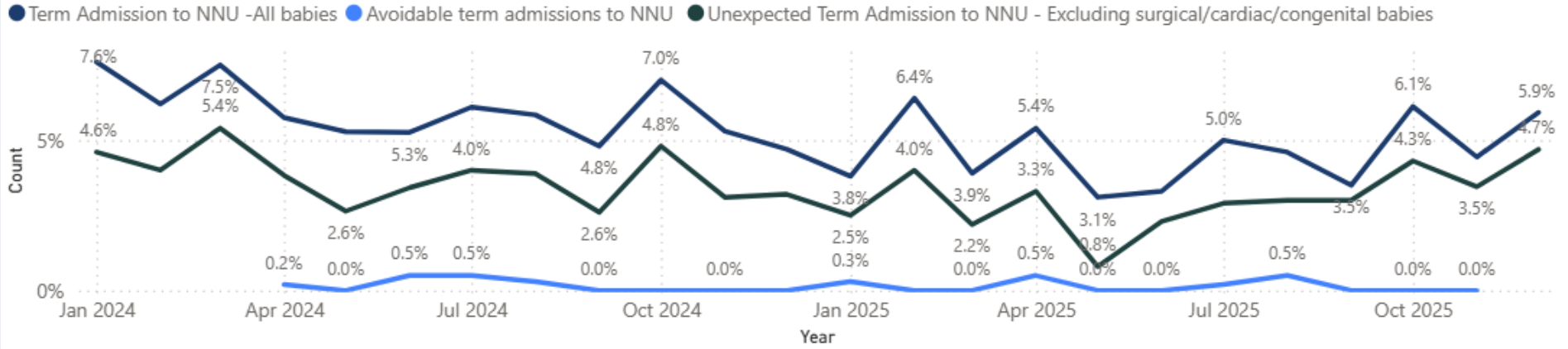
UHS Maternity Dashboard - Neonatal Outcomes

University Hospital Southampton NHS Foundation Trust

Year
All

Month
All

Term Admission to NNU -All babies, Avoidable term admissions to NNU and Unexpected Term Admission to NNU - Excluding surgical/cardiac/congenital babies by Year and Month



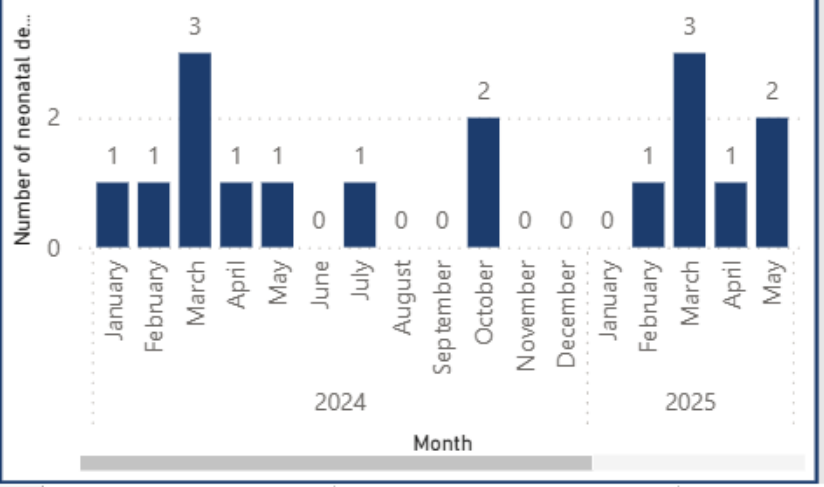
Appropriate place of birth

Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 20
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.00%	100.00%	100.00%	100.00%	100.0(

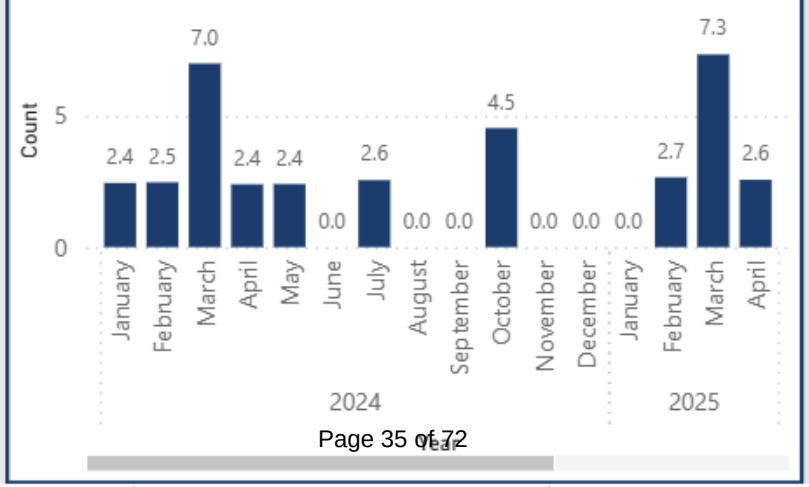
Number of Encephalopathy cases > 34 weeks (inborn babies, graded moderate and above)

Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2
3	1	1	0	0	1	0	0	0	1	

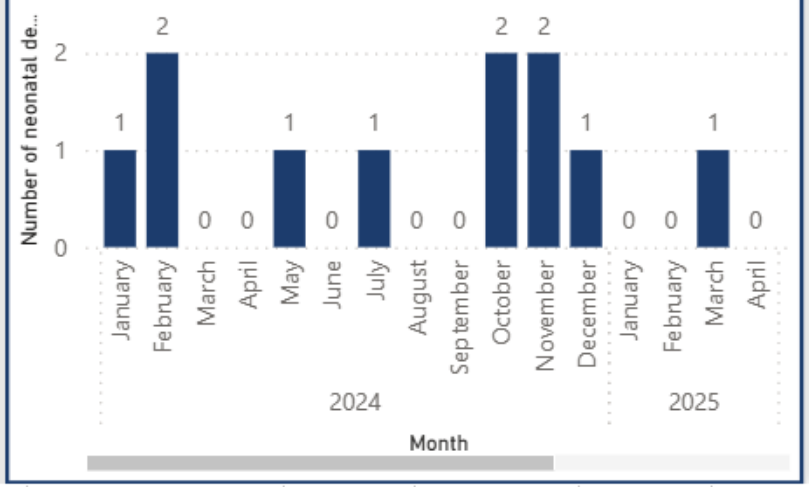
Neonatal Deaths - Inborn



Inborn NND rate per 1000 livebirths by Year and Month



Neonatal Deaths - Outborn



Return to main menu

MDAU

Reset all filters

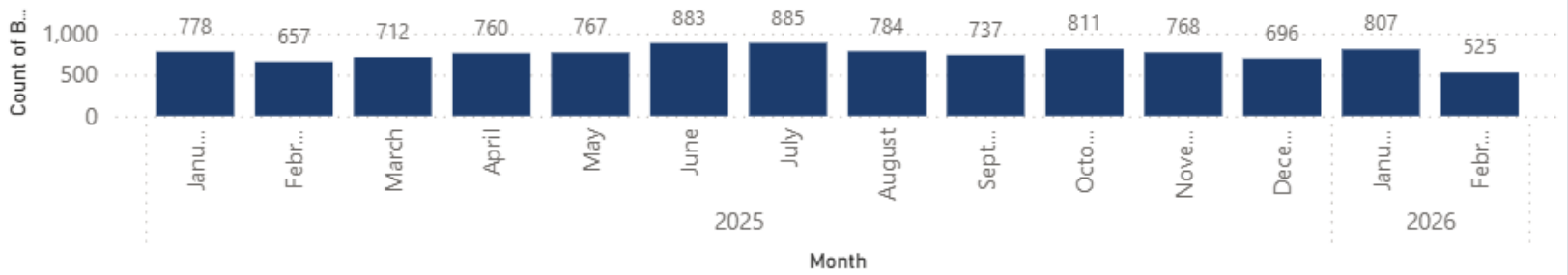
Year

Multiple selections

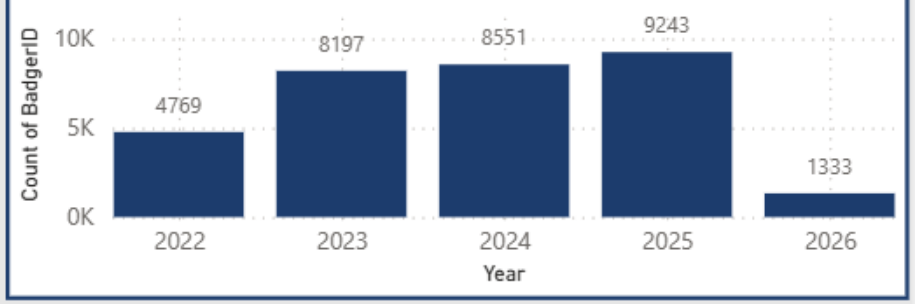
Month

All

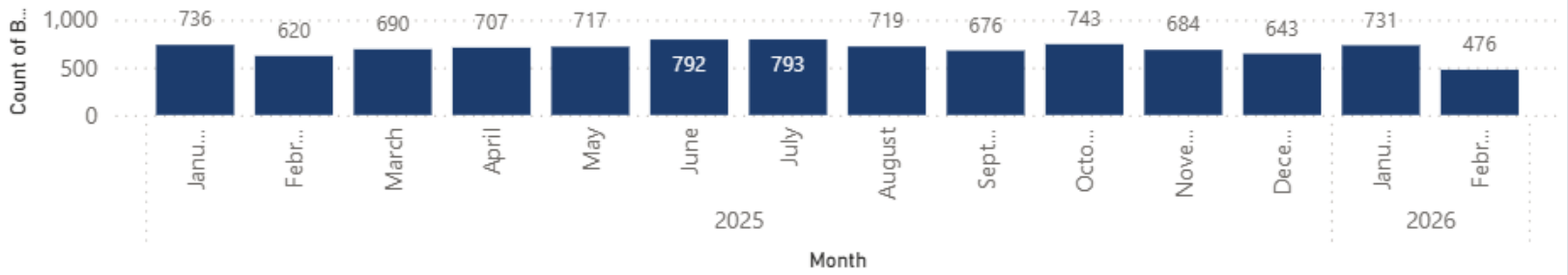
Number of patient visits to MDAU



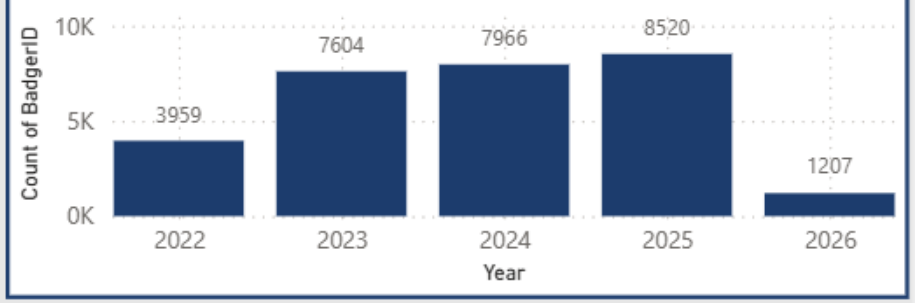
Number of patient visits to MDAU



Number of patients attending MDAU who were triaged within 15 minutes of arrival



Summary - triage within 15 minutes of arrival



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Opel Status

NHS
University Hospital Southampton
NHS Foundation Trust

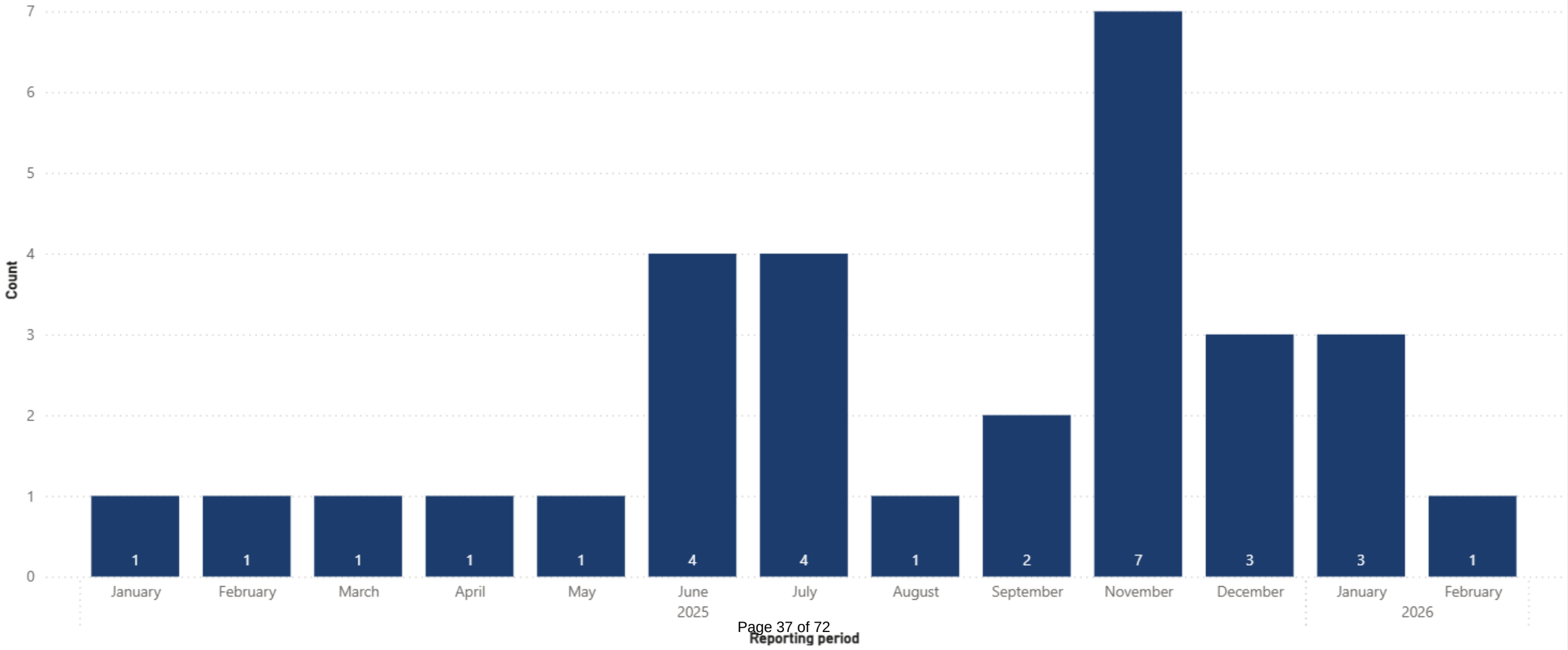
Year of escalation

All

Month of escalation

All

Number of times UHS Maternity has escalated to Opel 4 each month



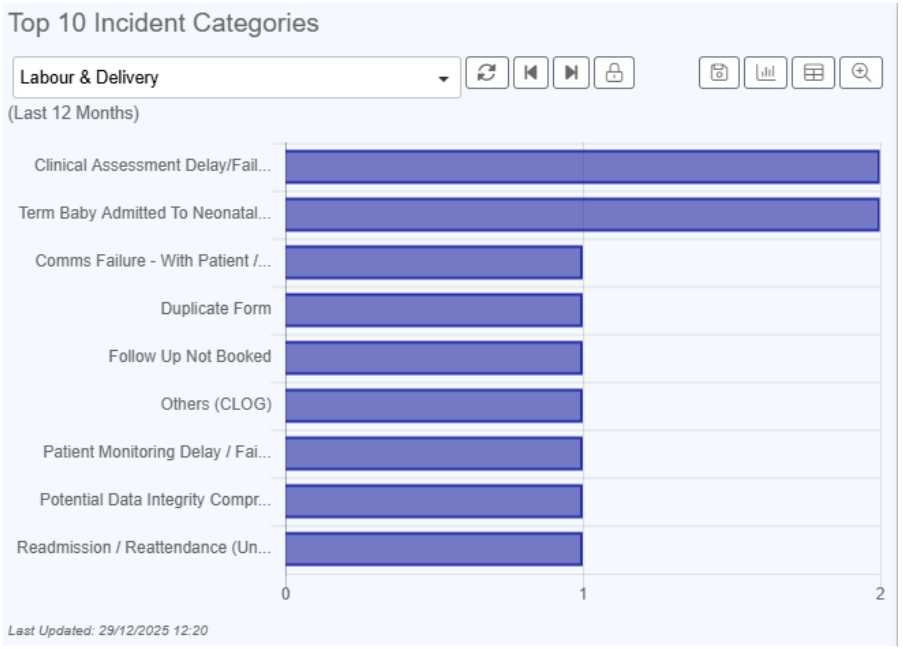
University Hospital Southampton NHS Foundation Trust

UHS Maternity/Obstetric Triangulation of claims, incidents and complaints data Q3 25-26

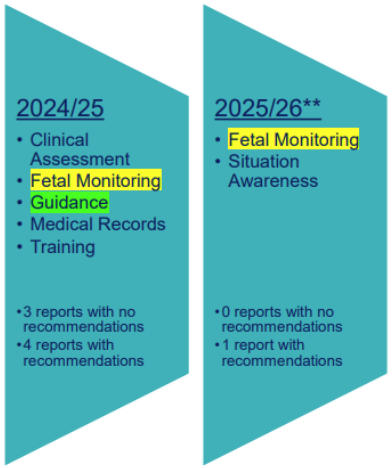
Appendix 3

PMRT Supporting high quality local perinatal reviews

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



MNSI report recommendations



Themes & learning identified from PMRT in Q3 25-26 (10 cases)

(2 cases have had a review)

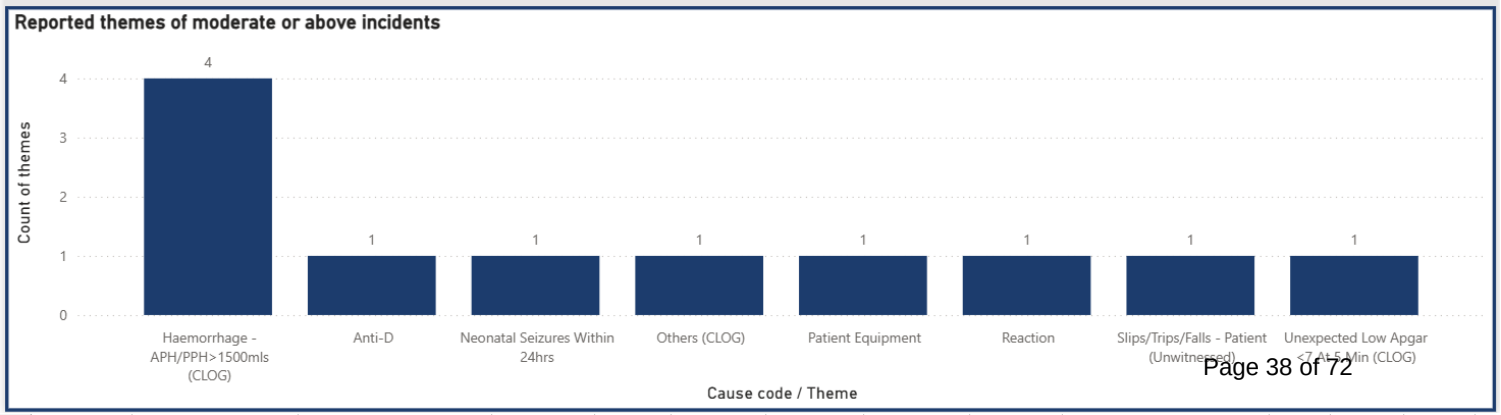
- 1x RFM – did not attend and ? No follow up NEST patient
- ? CTG/fetal monitoring failed to escalate (did normalise)

Mat Neo complaints Q3 25-26 (10 Total)

8 Outstanding
1 Upheld
1 Partially upheld
Themes: Communication, Clinical treatment & Patient care

Constructive FFT Patient Voice/feedback Q3 25-26

- Staffing/capacity – postnatal ward
- Discharge process
- Partners staying



Common Themes

1. Communication
2. Clinical treatment
3. Fetal monitoring/delayed escalation

University Hospital Southampton NHS Foundation Trust

Maternity and Newbon Safety Investigations (MNSI), Patient Safety Incident Investigations (PSII) and PMRT cases – 1st October – 31st December 2025 (Quarter 3 25/26)

New Patient Safety Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
MNSI / PMRT	MI – 049946 / 101371	26/11/2025	Intrapartum stillbirth	Under NEST criteria due to history of PTSD< anxiety and depression as well as tokophobia / birth anxiety. Presented at 39+0 weeks with absent fetal movements. IUD confirmed on arrival to MDAU. Baby boy stillborn at 39+0.	Case referred to MNSI due to experiencing mild period cramps. However, it was noted that there was marked maceration of the baby at delivery and therefore may not have met criteria for referring. Case also reported to Perinatal Mortality Review Tool (PMRT) and ongoing within timescale. Initial review of care through Clinical Events Review (CER) identified learning relating to proteinurea in the absence of high blood pressure and growth surveillance.
MNSI / PMRT	MI – 050751 / 101598	14/12/2025	Intrapartum stillbirth	Presented at 37+2 weeks with vaginal bleeding – suspected placental abruption. IUD confirmed on arrival to MDAU. Baby girl stillborn at 37+3.	Case referred to MNSI due to experiencing abdominal pain. Case also reported to PMRT and ongoing within timescale. Initial review of care through CER identified learning relating to proteinurea in the absence of high blood pressure.
MNSI	MI – 051031 / 10013941	23/12/2025	Therapeutic hypothermia	High risk woman under consultant led care. IOL at 37+4 weeks due to pelvic girdle pain and large for gestational age. Artificial rupture of membranes completed. Approximately 1 hour later, she had a cord prolapse. Baby girl delivered via Cat 1 section. She initially needed inflation and ventilation breaths as she was born with poor respiratory effort. She was admitted to Neonatal Intensive Care Unit (NICU) and underwent therapeutic hypothermia. She was subsequently discharged home on day 6 of life.	Case referred to MNSI. Initial review of care through CER identified no learning.

PMRT / Patient safety	100972 / 10010360	02/11/2025	Early neonatal death	Baby girl born at 33+4 weeks due to abnormal antenatal CTG after presenting with reduced fetal movements. Born in poor condition and required resuscitation. She was treated with therapeutic hypothermia. Her MRI confirmed profound HIE and care was redirected to palliation with family agreement. She died on day 4 of life.	Reported to PMRT and ongoing within timescale. Following review at Neonatal CDRM in December 2025, it was agreed for this case to progress as a Patient Safety Incident Investigation (PSII). Initial review highlights some concerns regarding management prior to delivery and therefore this has been referred to the Coroner for an inquest. The family have also raised concerns and submitted a formal complaint.

New PMRT cases

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

PMRT number	Incident Date	Incident Trigger	Summary of incident	Outcome of incident
100873	24/10/2025	Antepartum stillbirth	Under Central NEST due to social circumstances. Minimal English. 8th pregnancy (5 previous vaginal births and 2 TOPs). Presented at 34+5 with absent fetal movements (for over 12 hours). IUD confirmed. Baby girl born stillborn 35+1.	Reported to PMRT and closed at PMRG. Closed with gradings B / A. This was due to smoking cessation support for the mother and her partner.
100969 (being led by the Children's Hospital)	31/10/2025	Early neonatal death	Baby boy born at 39+4 weeks via elective section in his local unit. Initially good cry but then deteriorated. Required inotropes and nitric oxide. Retrieved by SONeT and taken to PICU. Commenced VV ECMO. Cardiac cath showed TAPVD with no operable solution. MDT discussion agreed to redirect to palliative care. Baby boy died at 2 days of age.	Reported to PMRT and closed at PICU CDRM. This does not fit MNSI criteria due to the fact that the mother did not labour and the baby died from a congenital anomaly. Closed with gradings B / B / C. This was due to no clear key worker being identified for the family which resulted in an un-coordinated response to the mother and a delay in meeting her needs.
100972	02/11/2025	Early neonatal death	Baby girl born at 33+4 weeks due to abnormal antenatal CTG after presenting with reduced fetal movements. Born in poor condition and required resuscitation. She was treated with therapeutic hypothermia. Her MRI confirmed profound HIE and care was redirected to palliation with family agreement. She died on day 4 of life.	See new patient safety cases section above. The case was reported to PMRT and reviewed at Neonatal CDRM. It has been closed with provisional gradings of D / B / C. These will be reviewed following completion of the PSII and amended as required.
101084	09/11/2025	Early neonatal death	Baby boy born at 30+0 weeks due to APH and vasa praevia in his local unit. Antenatal diagnosis of megacystis, urinary ascites, genital and spine differences. He had postnatal diagnosis of renal dysplasia, ambiguous genitalia and imperforate anus. Multiple discussions were held with his family and the different teams involved in his care and an agreement was made to support a re-orientation of care to palliation. He died on day 3 of life.	Reported to PMRT and ongoing within timescale. Reviewed at Neonatal CDRM in January 2026 and to be closed with gradings A / B / B. Learning identified relating to postnatal ward experience and lack of postnatal analgesia.

101086	08/11/2025	Early neonatal death	Baby girl born at 29+2 weeks following abnormal antenatal CTG in her local unit. She had a complex neonatal course with multiorgan failure, diagnosis of T21 and concerns about additional dysmorphic features and abnormal neurology out of keeping with T21. She had an increasing oxygen requirement, hypotension and metabolic acidosis. She had a sudden deterioration with a bradycardia which led to an asystolic arrest. There was a previous plan for a ceiling of care, and she was not for CPR or escalation of care. She was compassionately extubated into her parents' arms. She died on day 15 of life.	Reported to PMRT and ongoing within timescale. Reviewed at Neonatal CDRM in January 2026 and to be closed with gradings B / B / A. Learning related to a delay in diagnosis of T21 and recognition of the clinical picture.
101091	10/11/2025	Early neonatal death	Baby girl born at 23+6 weeks. Her mother had premature rupture of membranes at 23+2 weeks. Following counselling with the obstetric and neonatal teams, she made the decision that she did not want active management for her baby and was planned for feticide on 10/11/25. She went into labour prior to this and as agreed with her, comfort focussed care was provided to her baby following birth. Baby girl died at 1 hr of age.	Reported to PMRT and closed at Neonatal CDRM. Closed with gradings A / A / A. No learning identified.
101144	12/11/2025	Antepartum stillbirth	Under East NEST due to mental health diagnosis and previous social service involvement. 8th pregnancy (6 previous vaginal births and 1 miscarriage). PPROM at 34+4 weeks and oligohydramnios. Gestational diabetes requiring insulin. Inpatient on Lyndhurst with a plan for elective CS on 18/11/25. Routine morning CTG unable to find fetal heart rate. IUD confirmed and she delivered baby girl stillborn via C Section at 36+2 weeks.	Reported to PMRT and closed at PMRG. Closed with gradings B / A. Learning related to escalation processes from the antenatal ward in periods of high acuity.
101145	12/11/2025	Antepartum stillbirth	Presented at 35+2 weeks with placental abruption. IUD confirmed. Baby boy stillborn at 35+2 weeks.	Reported to PMRT and closed at PMRG. Closed with gradings C / B. Learning related to aspirin being

				indicated and may have made a difference to the outcome for the baby, given the low birth weight.
101371	26/11/2025	Intrapartum stillbirth	Under NEST criteria due to history of PTSD< anxiety and depression as well as tokophobia / birth anxiety. Presented at 39+0 weeks with absent fetal movements. IUD confirmed on arrival to MDAU. Baby boy stillborn at 39+0.	See new MNSI case section above. This case has been reported to PMRT and closed through PMRG. It has been closed with provisional gradings B / B. These will be reviewed following completion of the MNSI investigation and amended as required.
101379	26/11/2025	Early Neonatal Death	Antenatal diagnosis of ventriculomegaly. An MRI was performed at 22+1 weeks, however before this result could formally be discussed with her in clinic, she presented at 23+0 weeks with a significant APH. Discussions were held with her about challenges of survival and outcomes at 23+0 weeks, complicated by the MRI findings. An MDT was held and the consensus was for conservative management. Her baby girl was born and died shortly after.	Reported to PMRT and closed at Neonatal CDRM. Closed with gradings A / A / A. No learning identified.
101501/1	03/12/2025	Antepartum stillbirth	MCDA twin pregnancy. Attended a routine ultrasound scan at 31+6 weeks, however it was confirmed that twin 1 had sadly died. Both twins were born via emergency caesarean birth as there was a concern that twin 2 was having a bradycardia on scan. Twin 1 was born stillborn.	Reported to PMRT and closed at PMRG. Closed with gradings A / A. No learning identified.
101502	07/12/2025	Antepartum stillbirth	Under West NEST due to social history. She was a sex worker with a history of homelessness. She presented at 24+6 weeks gestation due to spontaneous rupture of membranes and contractions. Her baby girl was born immediately after arrival on Labour Ward. However, she was born with no signs of life. She was assessed by the neonatal team who confirmed that she had already	Reported to PMRT and closed through PMRG. Closed with gradings A / A. No learning identified.

			died and therefore resuscitation attempts were not undertaken.	
101566	10/12/2025	Antepartum stillbirth	Presented at 35+4 weeks gestation with reduced fetal movements to MDAU. The fetal heartbeat was unable to be found and an IUD was confirmed. Baby girl was born stillborn at 35+5 weeks.	Reported to PMRT and ongoing within timescale. Initial review undertaken through Clinical Events. No learning identified.
101598	14/12/2025	Intrapartum stillbirth	Presented at 37+2 weeks with vaginal bleeding – suspected placental abruption. IUD confirmed on arrival to MDAU. Baby girl stillborn at 37+3.	See new MNSI case section above.
101711	22/12/2025	Late Neonatal Death	Baby girl born at 25+2 weeks gestation in her local unit. Transferred to UHS for ongoing care. She had a stormy course with a spontaneous intestinal perforation on day 6 of life. She required a 2nd laparotomy for adhesions a month later. Feeds were restarted post operatively uneventfully. She was repatriated back to her local unit at 32 weeks corrected gestational age. She vomited following arrival. She developed abdominal distension and SONeT was contacted for advice. SONeT attended to support. Extensive resuscitation was required. There was an extensive discussion with the parents, SONeT, the UHS surgical team and local team. A decision was made to transfer back to UHS in case of opportunity for surgical procedure. On arrival to UHS, she was in peri-arrest with widespread discolouration of abdomen and lower limbs. It was discussed with the family, and she was palliated and died with her parents.	Reported to PMRT and ongoing within timescale. Reviewed at Neonatal CDRM and to be closed with gradings B / B / B. This was due to potential opportunity for an in-utero transfer, multiple intubation attempts, PICC line breakage, sodium supplements not given in 24 hr volume of feed and not stopping feeds after initial deterioration.

Closed Cases

Case type MNSI / PMRT etc	Incident form	Log Date	Incident Trigger	Summary of incident	Outcome of incident
Patient safety	9994802	07/03/2025	Major incident	Baby abducted from Woodland Ward by her parents. The missing baby policy was followed, and the police contacted. The baby was found by the police and returned to the hospital. The parents were arrested at the time and bailed. The baby has since been discharged home with both parents under supervision with family members with social services involvement and assessment.	PSII completed and closed at Patient Safety Incident Investigation Oversight Group (PSIIOG) in October. Learning and actions included below.
Patient Safety	9997470	16/04/2025	Pressure Ulcer	Left ear folded in half and indented with either the edge of the clamp or the ties. Ear was dark with bruising and the edge was crusty with what appeared to be yellow serous fluid and appeared to be starting to break down. Reviewed by TVS and graded as category 3 PU (hospital acquired).	After Action Review completed and signed off at Division C Governance Steering Group. Actions to look at launching a focus on back to basic nursing skills and review documentation on MetaVision and skin/wound checks.
PMRT	98852 (being led by the Children's Hospital)	02/06/2025	Late Neonatal Death	Born at 39+6 weeks at Horton General Hospital with thick meconium. Transferred to Oxford NICU due to her oxygen requirement. ECHO performed showed intracardiac total anomalous pulmonary venous drainage (TAPVD) with ASD and PDA. Transferred to PICU. TAPVD repair completed on day 1 of life. Required surgical revision on day 6. She had an ongoing AKI and chylothorax. She developed sepsis and continued to deteriorate despite maximal support. Care	PMRT reviewed and closed in PICU CDRM. Closed with gradings A / B / A. There was no learning identified for UHS.

				was directed with parents. She died at 30 days of age.	
PMRT	99073	20/06/2025	Antepartum stillbirth	Attended at 24+1 with RFMs for 48 hours. IUD confirmed.	PMRT reviewed and closed in PMRG. Closed with gradings B / C. Learning was identified relating to blood tests to have confirmed previous exposure to parvovirus, however it was not possible to determine whether this would have altered the outcome.
PMRT	99121	24/06/2025	Antepartum stillbirth	Attended routine community midwife appt at 31+0. No FH heard on sonic aid. Fetal movements reported as normal, felt slightly different but same pattern. Attended MDAU and confirmed IUD. Baby boy delivered 31+2.	PMRT reviewed and closed in PMRG. Closed with gradings B / A.
PMRT	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 reviewed and closed in Neonatal CDRM. Closed with gradings A / A / C. This was due to issues with genetic cord blood being taken / sent and the fact that the mother was cared for in a non-sound proofed room. Learning to be shared with the neonatal and maternity team around genetic testing. Personalised care, supportive neonatal care in delivery room and rapid review / release for faith burial.
PMRT	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 closed D, B, B. Due to missed opportunities to identify that she was pregnant (including initial 111 call and PHL call) and then once this was known, a missed opportunity to escalate / redirect to MTL. There were also multiple discussions round location of care and whether the baby should have been brought to maternity / neonates rather than ED. There were also delays in postnatal care and delays in suturing her urethral trauma.

PMRT	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 reviewed and closed in Neonatal CDRM. Closed with gradings A, C, B. Due to the fact that an earlier diagnosis could have been made as there were delays in sending and processing the genetic samples taken at birth. Timing of the trisomy diagnosis, could have been made earlier to avoid unnecessary invasive neonatal intensive care, and enable earlier conversations with family re care redirection.
PMRT	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 closed with gradings B and A. Due to a missed opportunity for an antenatal obstetric referral.
PMRT	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 closed with gradings A, A and A.
PMRT	100361/1	18/09/2025	Early Neonatal Death	MCDA twins with twin-to-twin transfusion syndrome (TTTS). Laser ablation at	PMRT reviewed and closed at Neonatal CDRM. Closed with gradings C / B / A. The C grading is

				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.	related to learning at another Trust including no documentation of risk discussion regarding TTTS during antenatal appointments.
PMRT	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 reviewed and closed at PICU CDRM. Closed with gradings A / A / A. No learning identified.

Moderate or above incidents

Incident Date/Number	Type of Incident	Summary of incident	Outcome of incident
23/10/2025 10010037	Moderate incident	SONeT transport team unable to dispatch to time critical uplift with required equipment due to equipment unavailability. Baby had PPHN and had prolonged period of hypoxia in local centre. Local team had used all appropriate methods to stabilise baby but nitric oxide was needed. Baby was in 100% oxygen and triggered time critical uplift at 08:00 phonecall. SONeT team were out on another uplift Basingstoke to Portsmouth and had all equipment on board that ambulance. At 08:30 SONeT had a full team available and an ambulance but were unable to dispatch as there is not a second rig with an appropriate monitor and no second nitric oxide transport kit. Requested SORT team to help which was agreed and they retrieved the baby. They arrived in Bournemouth just after 10am. The baby immediately responded to nitric oxide with a rise in oxygen saturations. The baby spent approx 1.5 hours with low oxygen saturations.	Reviewed through Patient Safety Case review in November. For further discussion through a local learning tool.
26/10/2025 10010132	Moderate incident	Patient arrived form Woodlands ward feeling unwell. Diagnosed secondary PPH. Taken to theatre for EUA - total MBL 2600mls. Required vaginal pack and Bakri balloon. Taken to ITU for recovery care.	Reviewed through CER. It was felt that this was a well-managed case with a good outcome. There was appropriate use of point of care testing, close liaison across the 2 sites and there was very clear documentation.
29/10/2025 10010360	Catastrophic incident	Baby admitted to the Neonatal Unit - decision made to initiate therapeutic hypothermia. Preterm 33+4 weeks.	Please see new PMRT cases section above – PMRT case 100972.
03/11/2025 10010772	Moderate incident	Fetal medicine team received email from the lab regarding Anti D being returned unused. The patient was RhD negative and cffDNA predicts at least one baby is RhD positive. Birthed on 31/10 and now >72 hours post birth and Anti D not given within the recommended timescale.	Anti D was given at 81 hours following birth. The patient was full informed regarding the incident and the possible side effects. The Anti D was documented as being ordered when the patient was on Labour Ward. However, it isn't clear why it was not given after the patient transferred to the postnatal ward. Duty of candour completed.

05/11/2025 10010890	Moderate incident	Patient had 5.6 litre haemorrhage during MTOP at 18/40. Taken to theatre during massive ongoing APH, and laparotomy performed to deliver baby as vaginal delivery not imminent. Gynae consultant present and assisting, blood products given. Bakri and pack in situ. Art line in situ. Transferred to theatre recovery at PAH.	Reviewed through CER. Concerns highlighted regarding split site issues which have been escalated and shared with the Maternity and Neonatal Safety Champions.
06/11/2025 10010958	Moderate incident	Maternity services escalated to Opel 4 for capacity, acuity and activity.	To be closed as moderate incident. The Opel 4 was less than 24 hours.
10/11/2025 10011203	Moderate incident	Maternity services escalated to Opel 4 for staffing.	To be closed as moderate incident. The Opel 4 was less than 24 hours.
27/11/2025 10012230	Moderate incident	Preterm infant born at 34+2 weeks, breech in the presence of thick meconium and PPROM from 32+2 weeks. Baby born in poor condition. Passive cooling commenced at 30 mins of life in view of poor gases and baby being floppy and not moving much.	This was discussed at CER on 09/12/25. On review, it was thought that the mother should have been transferred to LW 2 hours earlier. There was a potential to have put in an iGel prior to 3rd intubation attempt for the baby (the medic shouldn't have had 3 attempts) and the use of a video laryngoscope could have helped. It was identified that there were issues with the resuscitaire and learning has been shared regarding this and what the sounds mean. It will also be shared that if staff are concerned that the resuscitaire is not delivering pressure, an ambu bag can be used to deliver pressure if needed. This was graded as minor suboptimal (different management may have resulted in a different outcome) x satisfactory outcome for the baby.
11/12/2025 10013182	Moderate incident	Longline dressing lifting off the baby's arm. On review, it was noticed that the dressing was wet and oozy and white colour fluid was present. It was suspected that there was a fractured line. On removing the dressing, the line was fractured at 10cm. The rest of the line was unable to be visualised. It was confirmed via imaging that the line has remained insitu.	Multiple incidents related to lines breaking have been reported recently and these have all been reported to the company for further review. A decision has been made to leave the line in situ due to the size of the baby and complexity of removal at her current age. Learning relating to the management of lines has been circulated to all neonatal staff.

14/12/2025 10013342	Moderate incident	Poor perfusion to right foot third toe noticed that right buttocks had broken down skin, poor perfusion to area. This was originally handed over as bruising. Escalated on ward round and the Consultant agreed and removed UAC.	A clot was identified in her iliac artery which led to ischaemia of the limb / buttock and necrosis. It was difficult to have identified bruising or ischaemia earlier. The line was in for an appropriate length of time. When bruising was noted it was thought to be a coagulation issue as a result of her sepsis and appropriate action was taken following this. There were some errors in documentation (confusion between right and left buttock). There was appropriate escalation and referral to the tissue viability team.
23/12/2025 10013941	Moderate incident	High risk woman under consultant led care. IOL at 37+4 weeks due to pelvic girdle pain and large for gestational age. Artificial rupture of membranes completed. Approximately 1 hour later, she had a cord prolapse. Baby girl delivered via Cat 1 section. She initially needed inflation and ventilation breaths as she was born with poor respiratory effort. She was admitted to Neonatal Intensive Care Unit (NICU) and underwent therapeutic hypothermia. She was subsequently discharged home on day 6 of life.	See MNSI new cases section above.

Missing Baby incident

Learning:

- **Adherence to policy:** While most of the Missing Baby Policy was followed, a 2222 call to initiate a Hospital Incident Management Team (HIMT) was not made. Instead, contact was established directly with the site team, and relevant personnel were contacted separately.
- **Policy Availability:** The Missing Baby Policy should have been accessible in a folder located at the Operational Command (Op Co) office, the designated muster point. However, it was not readily available and had to be printed before proceeding to the muster point.
- **Security Measures:** Parents are permitted entry to the ward through staff authorisation via a buzzer system but can exit freely. This differs from other Neonatal Units within the ODN. A walkthrough has been conducted with Estates and Security teams to assess potential improvements to exit security measures, with cost estimates under review.
- **Use of Personal Devices:** The coordinator's mobile phone was used to contact the parents and relatives. This resulted in relatives obtaining the coordinator's contact number and contacting them directly post-incident.
- **Signage Issues:** Limited signage for Woodland Ward contributed to a delay in police arrival at the muster point. However, this did not impact the overall response in locating the infant.

Missing Baby incident

Actions:

- Add bespoke training on mental health to the monthly neonatal Statutory and Mandatory study days, including indications to signpost to other services.
- Missing baby policy guideline to be reviewed and updated to include guidance about informing the safeguarding team.
- Missing baby policy to be made available in the muster point. Flow charts to be available as quick reference guides for NICU and WW co-ordinators.
- Review the exit security measures across Maternity and Neonatal services.
- Review the signage for WW.
- Ask Travelwise about whether registration details are kept and can be accessed out of hours.

Q3 25-26 Mortality

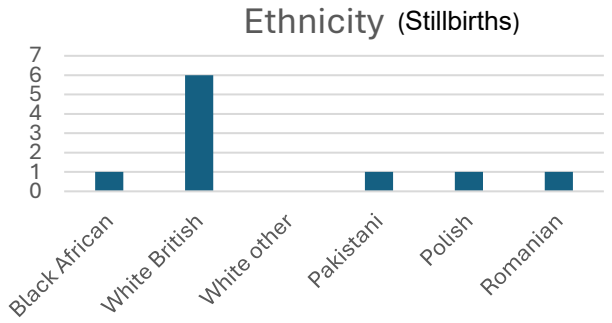
NHS
University Hospital Southampton
NHS Foundation Trust

(*2024: stillbirths 4.44 per 1,000 births*) **2026 YTD stillbirth rate: 6.37 per 1,000 births**
Q3 stillbirth rate: 7.92 per 1,000 births (Q2 3.8 per 1,000 births)
National target (2021) <4.2 per 1,000 births

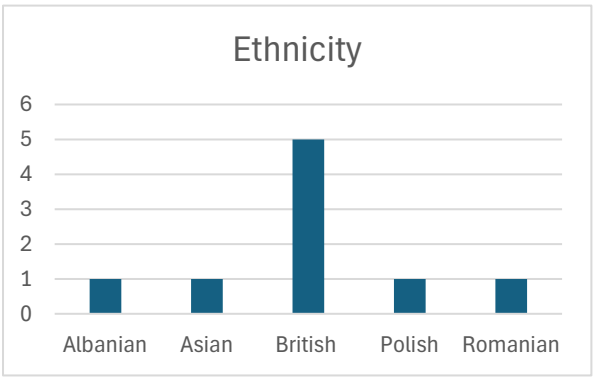
Case Overview

19 babies

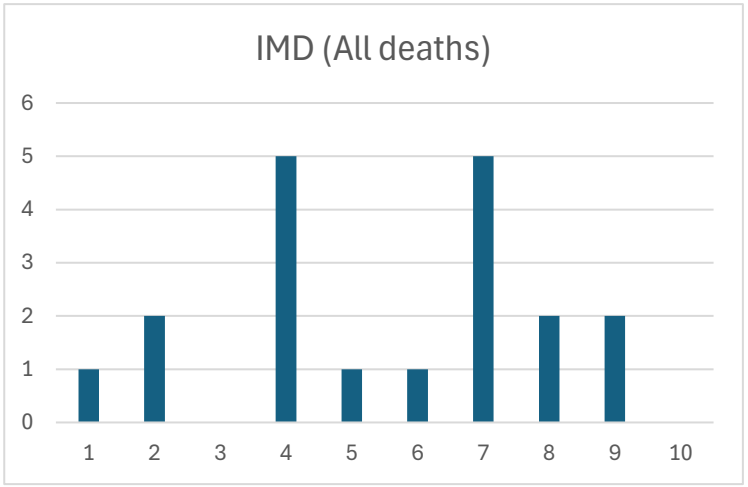
- Antepartum stillbirth = **8** ↑ **(1 was an MTOP)** Q2 25-26 4 cases
- Intrapartum stillbirth = **2** ↑ Q2 25-26 1 case *(Defined by MNSI criteria – 1 case was an abruption & 1 case attended with RFM and reported Braxton hicks)*
- NND's = **9** (all <28 days) ↓ (3 cases <24 weeks)



(Neonatal Deaths)



Extreme Preterm 7 **(37%)** <28 weeks



Themes

- Abruptions x2 (see APH/abruption review) ↑ *Q2 25-26 1 case*
- Higher gestations for APSB
- Late bookers/new to country – although numbers small

NEST – Continuity Team (XX)
3 under NEST ↓ *Q2 25-26 6 cases*

2x APSB (1 only booked 1 week prior)
1x IPSB (MNSI criteria)

Case reviews/reports

Type of loss	Gestation	Review
IPSB	37+3	CER + MNSI
APSB	35+5	CER + PMRG
APSB	24+6	CER + PMRG
APSB	31+6	CER + PMRG
IPSB	39+0	CER + MNSI
APSB	35+2	CER + PMRG
APSB	36+2	CER + PMRG
APSB	35+1	CER + PMRG
MTOP/APSB	25+4	CER
APSB	27+5	CER + PMRG
NND	23+0	CER + CDRM
NND	23+6	CER + CDRM
NND	39+4	CER + CDRM
NND	33+4	CER + CDRM
NND	29+2	CER + CDRM
NND	30+0	CER + CDRM
NND	25+2	CER + CDRM
NND	33+5	CER + CDRM
NND	21+6	CER

UHS Maternal Deaths (Jan 2026)
Indirect maternity deaths

Case 1: RH, IMD 10
White British, 36 years old, Not booked ? Previous cardiac arrest.
3x previous children (15,14 & 9)
Known social history – 2x younger children removed, previous drug history +ve toxicology for Benzo's.
Witnessed collapse / seizure out of hospital. Patient in asystole. Intubated in ED. Positive urine pregnancy test on admission to ED (unknown if patient or family were aware). MRI was performed which showed HIE. Extubated and was non-responsive. Following legal and ethical discussions and involving the family, the decision was to move to palliative care.
Died 26/01/2026

Case 1: MM, IMD 7
White British, 23 years old, OOA (Dorchester)
P1 31+2 when delivered – transferred to SGH 4 days Post delivery, died 3 weeks post delivery.
Past medical history of Ewings sarcoma and congenital unilateral kidney. CS at 31+2 weeks under GA. Complex and multi organ problems. Pulmonary hypertension with significant right ventricle dysfunction. PET/CT indicated enlarged avid nodes in abdomen. Planned to start chemotherapy and clinical improvement following dexamethasone. Acute deterioration overnight with increasing oxygen need. Cardiac arrest in the early hours of the morning 27/01/2026.

Case 1: AS, IMD 7
White British, 38 years old, Not booked, self referred to P/mouth QA 8-year-old son.
Had evidence of left bundle branch block on ECG earlier in January 2026 at a health check up ? related to this episode.
Further information outstanding currently.
26/01/2026 Collapse at home during intercourse. Reported to be 10 weeks pregnant by relative and we have now been informed that Amie had self referred into Portsmouth Hospitals maternity service and was due to be booked on 3/2/26. . CPR - x8 episodes of defibrillation and adrenaline administered. Intubated and ventilated. Admitted to GICU. Viable intrauterine pregnancy noted on dating and viability ultrasound performed on GICU on 28/1/26 = Fetal heart seen - Crown Rump length = 25mm compatible with a 9 week and 2-day fetus. - noted to have an abnormal ECG with ?left bundle branch block. Head imaging showed coning - deemed likely not to survive. Died 30/1/26.

- All x3 indirectly related to Maternity & did not die in Maternity unit (SGH site)
- All x3 White British, English speaking.
- IMD 7 x2 & IMD 10 x1
- 1x Social/drug use
- 2x OOH Cardiac arrests, 1x In hospital Cardiac arrest – being treated for cancer.

All 3 cases referred and accepted by MNSI – awaiting family consent in 1 case.
Patient safety team involved and supporting with scoping meetings

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UHS APH/Abruption case review 2025

Summary 2025 (to date 15.12.25)
2024 =

9 cases of significant APH & likely abruption

7 presented with significant APH/abruption from home

2 inpatients

1- IOL for fetal cardiac anomaly was on AN ward

1- Labouring on LW with CEFM and acute Brady (MNSI investigation and this case was likely vasa praevia)

Sadly in 5 cases IUD was confirmed on arrival

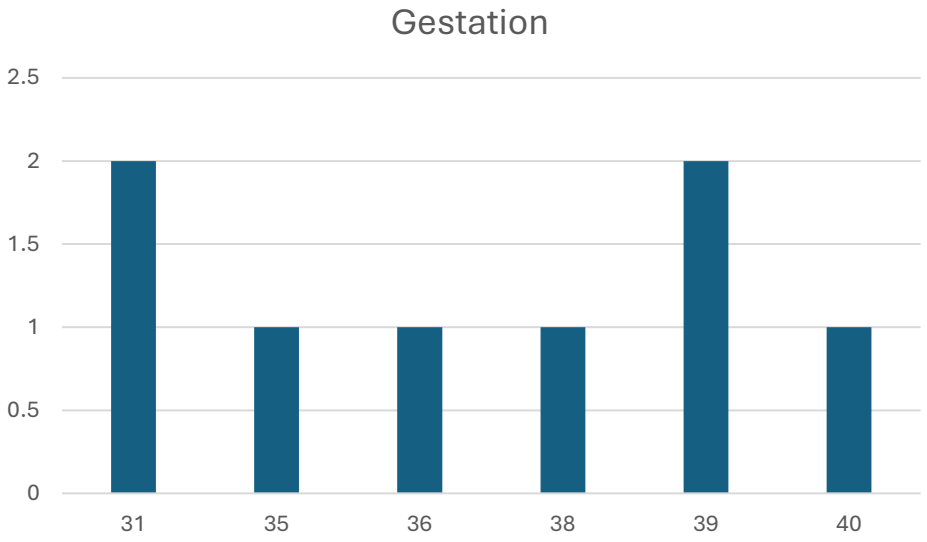
1 NND shortly after birth

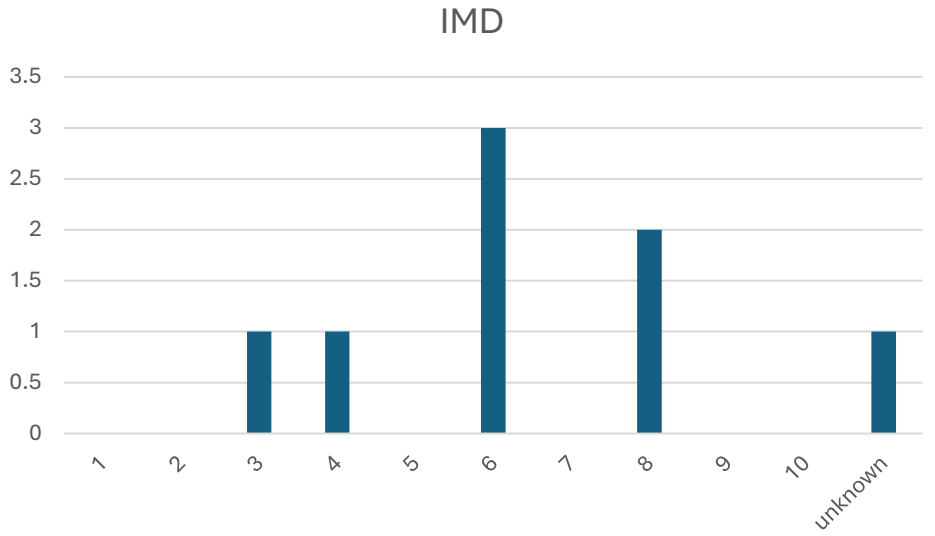
1 Therapeutic cooling – significant HIE care withdrawn and died on day 8 (MNSI case)

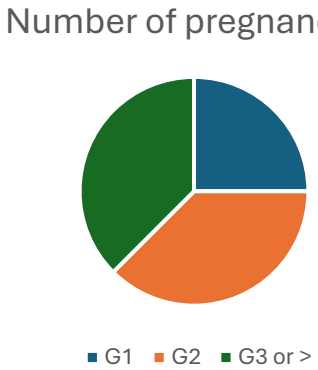
1 baby live, well @ home

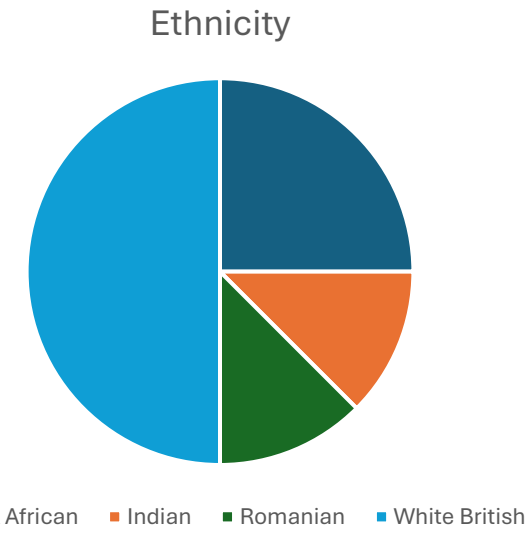
1 baby had short stay in NNU-Special care and then DC home with follow ups (cardiac)

Cases









Summary

- All cases >30 weeks
- High proportion multips (G3 or >)
- 25% Black African
- Higher proportion IMD 6-8 (lower deprived areas)

Risk factors

Risk factors for abruption	Hypertension	Age >35	Previous abruption	Blood clotting disorders	Multiple	Polyhydramnios/PPROM/Intrauterine infection (Chorio), uterine abnormalities/scars.	Smoking	Drug use	Abdo trauma	Short umbilical cord	High maternal stress.anxiety/depression
DA	N	Y- 37	N	N	N	N	Y			Not known/commented on	
SW	N	N- 28	N	N	N	N	E-cigarettes/Vapes	N	N	Not known/commented on	Partner had recent RTA/documented to be stressed due to childcare/support
RN	N	N- 33	N	Known sickle cell trait		Pre-term, prev LSCS	N	N	N	Not known/commented on	
PG	N	N- 27	N	N	N	N	N	N	N	Not known/commented on	History of anxiety
AM	N ? PN raised BP	N- 28	Y (+ prev loss 26+6)	N	N	N	Y	N	N	Not known/commented on	NEST CoC team Previous loss 26+6 abruption
DL	N	N- 31	N	N	N	N	E-cigarettes/Vapes	N	N	Not known/commented on	
AK	N	N- 31	N	N	N	prev LSCS	N	N	N	Not known/commented on	NEST CoC team
AC	N	N- 30	N	N	N	N	N	N	N	Not known/commented on	

Number overall small – 1x smoker, 2 e-cigarettes.

Pathway reviewed for OLC
New TDA's started so increased stop smoking support available

Blood loss

Blood loss	TEG	Products used	ITU admission
1591	Y	Fibrinogen & blood	N
2830	Y	Fibrinogen & blood	N
2500	Y	FFP, blood Fibrinogen	N
1500	N	N/A	N
2000	Y	Blood	N
191	N	N/A	N
1216	Y	Fibrinogen & blood	N
879	Y	Fibrinogen	N

Overall: Well managed – TEG used in 75% of cases.
All patients remined on LW in our HDU

Summary

- 1 MNSI investigation (report in final stages)
- 1 MNSI case declined by family
- 1 MNSI case in progress (delivery December)

Other cases have been reviewed through local process/PMRT and no learning/themes identified in relation to APH/Abruption

Positives: Good Maternal outcomes – use of TEG and appropriate resuscitation.

Friends and Family (FFT) Results
Q3 2025

University Hospital Southampton NHS Foundation Trust

	2025	October	November	December	Q3
Response rate - Trust Target 20%	**Total response rate**	**28.9%**	**33.0%**	**35.2%**	**32.2%**
	Antenatal	27.0%	32.3%	34.8%	31.2%
	LW and birthing unit	27.9%	30.9%	33.1%	30.6%
	Postnatal ward	28.0%	31.6%	33.5%	30.8%
	Postnatal community	32.7%	37.0%	39.3%	36.3%
% of women who would recommend	**Average score**	**82.3%**	**84.2%**	**87.0%**	**84.6%**
	Antenatal	90.8%	91.2%	92.4%	91.5%
	LW and birthing unit	91.7%	93.5%	95.5%	93.6%
	Postnatal ward	78.3%	76.8%	80.9%	78.7%
	Postnatal community	68.3%	75.2%	79.4%	74.5%
% of women who would NOT recommend	**Average score**	**7.1%**	**6.2%**	**2.9%**	**5.3%**
	Antenatal	4.2%	1.6%	0.8%	2.1%
	LW and birthing unit	4.2%	4.1%	3.0%	3.7%
	Postnatal ward	15.8%	13.6%	6.1%	11.7%
	Postnatal community	4.2%	5.6%	1.5%	3.7%
Number of responses		n = 120	n = 125	n = 132	

Response rate	Less than 14.9% / 15-19.9% / Greater than 20%
Would Recommend	Trust rag rating score above 75%. Local rag rating score above 90% = green
Would not Recommend	Trust and local rag rating score above 5% = red

Themes	Actions
1) Communication (lack of/inconsistent advice)	• F level senior support • Built in additional safety huddles 8am, 11am & 6pm.
2) Feeding support	• Plans to remodel Mat/Neo service provided. • Looking at provision to offer ward based 'drop-in support'
3) Clinical care/medication	• Review of timings of drug rounds • Plans to 'SAM' EL LSCS patients.

ATAIN

Appendix 6

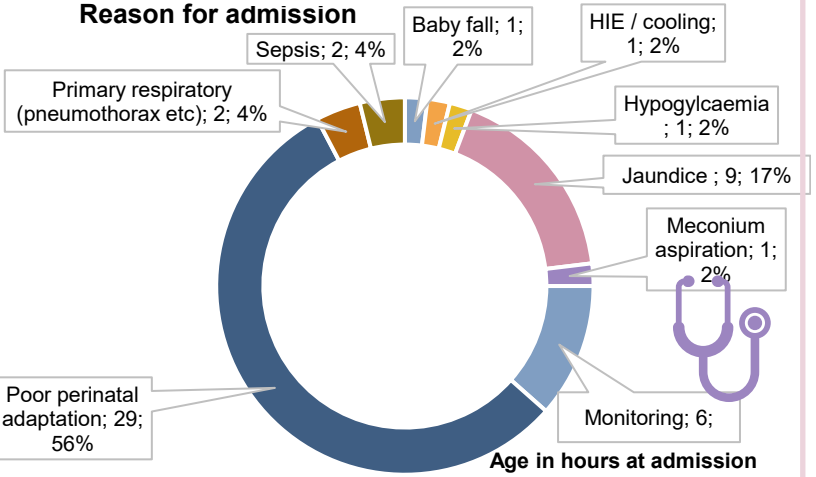
University Hospital Southampton NHS Foundation Trust

Qtr. 3 2025/26 – 52 unexpected term admissions

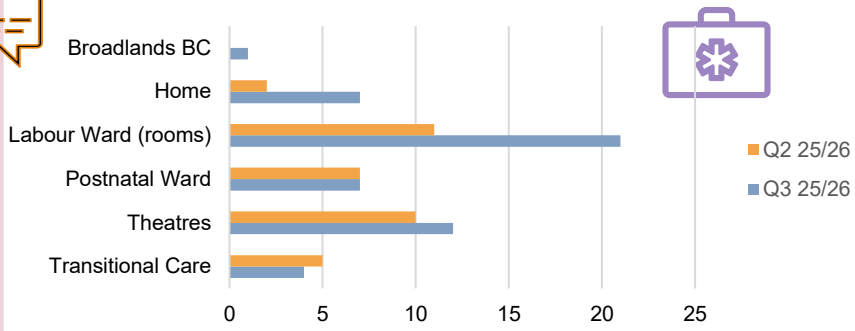
Learning identified

- 24 cases identified for review and 20 reviews completed
- 1 case deemed a potentially avoidable admission
- Issues highlighted:
  - Fetal monitoring interpretation
  - Equipment
  - Thermoregulation
  - Jaundice management
  - Escalation

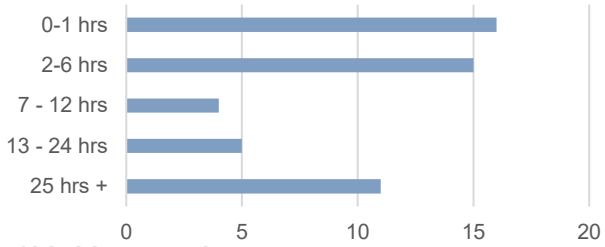
Reason for admission



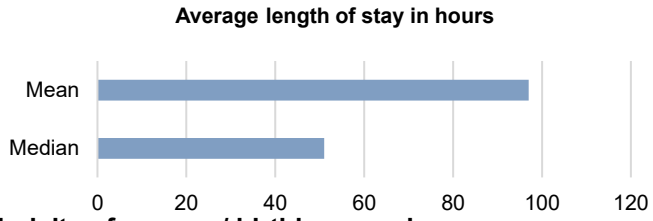
Admission from

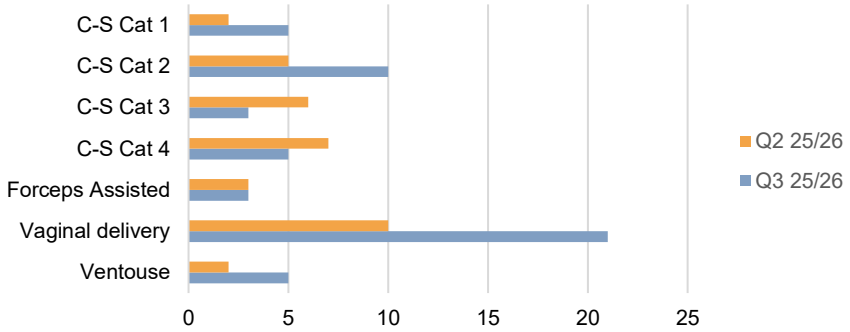


Age in hours at admission

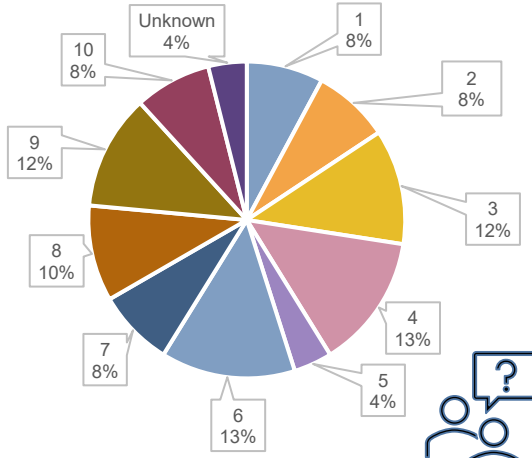


Average length of stay in hours

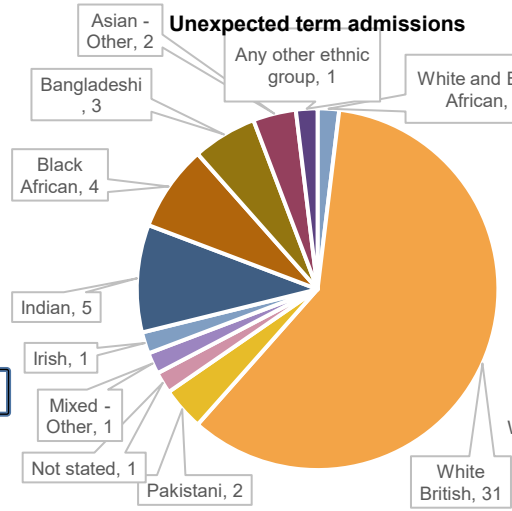




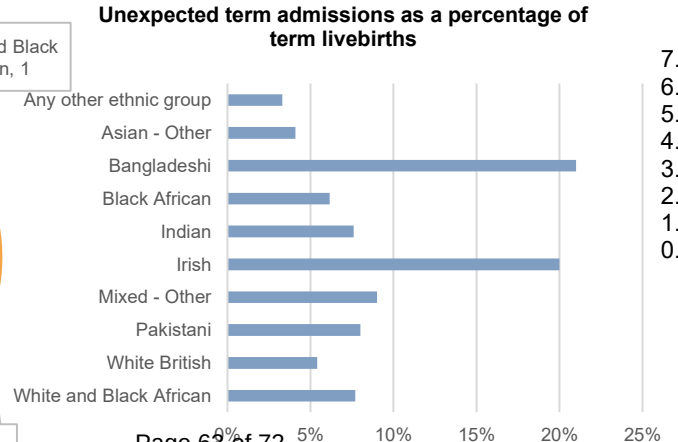
IMD deciles of women / birthing people

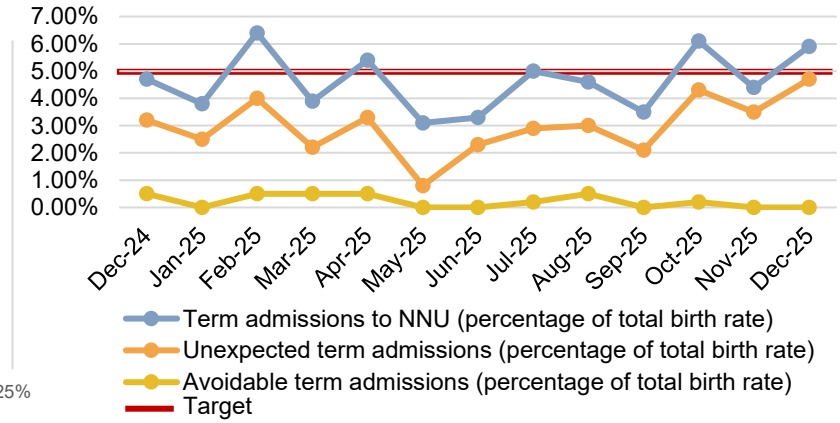


Ethnicity of women / birthing people



Unexpected term admissions as a percentage of term livebirths





University Hospital Southampton NHS Foundation Trust

Appendix 7

Three-year Delivery Plan For Maternity and Neonatal Services Update

This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies and families. At each Quality Committee report we are reporting against one of the 4 themes:

- Listening to and working with women and families, with compassion Objectives 1-3
- Growing, retaining and supporting our workforce Objectives 4-6
- **Developing and sustaining a culture of safety, learning and support Objectives 7-9**
- Standards and structures that underpin safer, more personalised, and more equitable care Objectives 10-12

Theme 3: Developing and sustaining a culture of safety, learning and support.

Objective 7	Develop a positive safety Culture
Ensure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.	2 WTE (3 staff in all) equivalent Mat/Neo QA and Safety Matrons work closely with the Quad and the MNVP. The team are Maternity Safety Champions with key working relationships with: • DOM/HOM • Clinical and Divisional leads, Divisional General Manager for Risk and Patient Safety • ICB/LMNS perinatal and Safety teams This team coordinate the service's submission for NHS Resolution Maternity Incentive Scheme and liaise with key stake holders within and without the Trust to achieve this.
Support all their senior leaders, including board maternity and neonatal safety champions, to	• Attended by the Quadrumvirate and on-line training completed by the Chief Nurse and NED who are both Board level Mat/Neo safety champions.

engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice	
At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture.	• Key communication around mat/neo safety including culture most commonly occur at Mat/Neo Safety Champion meetings where there is key representation from Board level safety champion, the Chief Nurse or Acting Chief Nurse the Quadrumvirate, maternity and neonatal safety champions. These are translated as needed into Quality Committee reports for Mat/Neo safety and the Chair of this committee is the Board level safety champion. • In the last quarter we have had a safety walk around with our Medical Director and our Chief Executive Officer has requested to attend one of our safety walk arounds in the new year early 2026. • A kindness and civility toolkit has been created by our intra-partum maternity matron and 50 + civility champions have completed training to support this agenda. The toolkit is due to be launched early 2026. • The Obs/Op multi-disciplinary meeting with social meet up afterwards has been re-launched moving into 2026
Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.	• Ongoing M and M meetings monthly to encourage multidisciplinary learning with involvement with service users where able • Daily (Monday to Friday) Mat/Neo safety walkarounds with Mat/Neo QA/safety matrons, obstetricians, consultant midwives to discuss any concerns re clinical, physical or psychological safety. Any concerns re ability to escalate clinical concerns. Any barriers to delivery of safe care. This includes culture or incivility. • Fetal Surveillance lead launching an escalation questionnaire with support from CCOT to identify any barriers to escalation • Element 2 of Martha's rule being adopted as 'Call for Concern' and this includes maternity/neonates who are a pilot site for implementing this. This sits within priority 3 of the Trust's Quality Improvement plan. (All staff will be able at any time to ask for review from a different team if they are concerned that their patient is deteriorating). Collaborative working in place with CCOT and the Martha's rule lead with the LMNS.

	• Ongoing plans for implementation of digital recording of maternal observations and collaboration with the CCOT and digital teams to create a dashboard for maternal observations to further improve safe escalation and oversight of deteriorating patients in maternity. • Implementation of NEWTT2 to signpost escalation of the deteriorating neonate completed.
Ensure all staff have access to Freedom to Speak Up training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways	• Freedom to speak up staff within maternity setting • Good links with the Guardian who is known to staff and whose posters and pictures are advertised widely in staff areas within the service
By April 2024, offer the Perinatal Culture and Leadership Programme to all maternity and neonatal leadership quadrumvirates. This includes a diagnosis of local culture through a culture survey and provides practical support to nurture culture and leadership.	• Score Survey Completed during NHSR Year 5 and Quad attended the Perinatal Culture and Leadership Programme • Civility workstreams are live and multi-disciplinary • Civility and multi-disciplinary working/ their successes and weaknesses are live conversations currently and are part of reviews including clinical reviews, incidents, reporting of adverse events generally • Poor, unkind or unhelpful behaviours are challenged with staff supported and there are open channels of communication between the disciplines at the most senior level to monitor these
Objective 8	Learn and Improve
Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.	• FFT feedback has response levels above Trust threshold – positive and negative feedback shared with staff and managers. Where clear themes emerge the management team will seek to understand what has changed and these discussions take place at SLT and senior manager level to support improvement and mitigation to improve patient and user experience ie. Extended visiting hours for partner/trusted person. Overnight stays with a family member where possible for those who are emotionally or physically more vulnerable.
Respond effectively and openly to patient safety incidents using PSIRF.	• New Clinical Events Reviews now have increased systems focus. Strong emphasis on not creating additional victims and an ongoing drive to hear the voice of the service user. This is occurring more often but efforts continue to increase this

Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.	• Twice weekly reviews of clinical events but linked to the rapid mat/neo safety walkarounds to ensure the prioritisation of cases where learning is likely and rapid reviews of cases using key local 'experts' such as our fetal surveillance lead to ensure that good practice is also identified. The aim is to disseminate key and relevant learning after these cases are reviewed. This would involve key stakeholders for support and oversight including: College Tutors, PMA lead, Matron/Managers, Practice Educators, Clinical leads • Women and Newborn Governance meeting monthly • PMRG • CDOP • Formal investigations as PSII's if incidents deemed to have met threshold after discussion at the Trust's New Cases Group
Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. This should include a single point of contact for ongoing dialogue with the trust	• Regular planned meetings with complaints team to ensure that staff at matron level and above have oversight of complaints and their progress. • A request has been raised to the patient complaints team for more information regarding themes to ensure these are being additionally addressed • Our Patient Experience manager liaises directly with service users reporting birth trauma or requesting a reflective discussion. They also have oversight of the CQC Maternity survey outcomes and aim to support co-production of any action plans with our MNVP where possible. • Where any known concerns are raised for current inpatients the matron team would seek to have conversations where possible prior to discharge to mitigate any distress • Rapid Mat/Neo walkaround would aim to identify service users with a difficult experience and offer a conversation promptly • Face to face meetings offer for concerned service users to have the opportunity to ask questions and discuss their outcomes and any organisational learning
Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).	• Recognition of the need to use appropriate translation services. Our service uses translation services liberally and our use is higher than other areas in the Trust.

Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well	• An appreciative enquiry approach is adopted at multi-disciplinary learning from incidents but we also seek to present cases where we can celebrate excellence and this links in to the fuller implementation using PSIRF which also focusses on learning when things have gone well .The M and M meeting occurs monthly and is very well attended. We have been able to invite service users to share their experiences and this has been extremely powerful. As part of our Quality Committee reporting we seek to triangulate claims/complaints with incidents to have a greater understanding of themes and outcomes.
Objective 9	Support and Oversight
Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of their services.	• Quarterly Mat/Neo safety reporting to Quality Committee which includes FFT and other user feedback • Sharing of learning internally and at LMNS level • Regular meetings with MNSI • External reviewers on key panels such as PMRG/CDRM • MNVP – 2way communication and co-production seen as standard where MNVP input is possible • Service user involvement at multi-disciplinary learning events
Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.	• Quarterly reporting to Quality Committee fully embedded via Perinatal Quality Surveillance model but now moving over with aim to fully implement the Perinatal Quality Oversight Model for more direct oversight. • Power BI dashboard being completed to enable reporting of PQOM in more visual terms with the QA team working closely with the digital analyst • Extensive Mat/Neo dashboard identifies UHS performance against key metrics and reporting is linked to any variances around these with communication of actions and progress against these
Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity	• Acting Chief Nurse currently providing executive oversight with NED also an identified safety champion whilst also chairing Quality Committee and exception reporting to Trust Board • Identified Quadrumvirate attend Maternity Safety Champion Meetings and will also support and review Quality Committee and Board reporting. To note – the QUAD membership will be reviewed with some internal role changes during 2026.

and neonatal leads to participate directly in board discussions.	
Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends	• MNVP - regular meetings have taken place when able to attend governance groups and reviews of key patient care and events. Involved in co-production of CQC maternity survey and action plans. • MNVP input links to areas of feedback where improvement may be needed for patient experience • MNVP is invited to Maternity Safety Champion meetings and walkarounds • 2026 will see a change in how MNVP role is managed to reflect more specific input tailored to local need and feedback. This will include ICB appointed engagement officers to increase reach from service users.

Maternity Outcomes Signal System (MOSS) - Charts

Latest Event: **14 Dec 25**
Refreshed: **30 Jan 26**

NHS

Cover page | Summary | Charts | FAQs | Methodology | Data source

MOSS is a safety management system and not a performance management tool. MOSS signals flag potential safety issues, prompting a locally led critical safety check (see Standard Operating Procedures) to determine if there are real safety issues. Safety issues are governed under the Perinatal Quality Oversight Model.

Sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death. Potentially adjusting this data will be reviewed in 2026. Until then, perinatal leadership teams in these sites should remain curious and still proceed with the MOSS critical safety check as part of good practice.

Trust: University Hospital Southampton ...

Chart type: CUSUM and Excess Events ch...

Site: Princess Anne Hospital

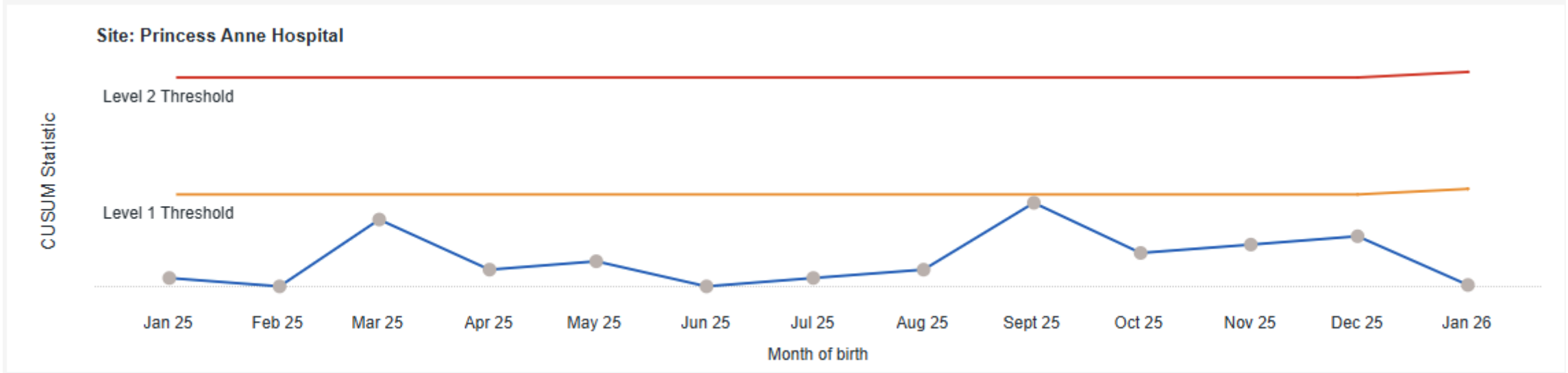
All sites

Glossary of terms

Maternity Outcomes Signal (CUSUM) -- Excess Events chart - University Hospital Southampton NHS Foundation Trust

The CUSUM statistic chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days. The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

The Excess Events plots the individual events cumulatively as they occur over time. Events that contribute towards signals are coloured appropriately to correspond with the level of signal that occurred. This chart can be useful as a companion to the maternity outcomes signal chart to show which events contributed towards the generation of signals. It also shows patterns more clearly over time.
Chart guidance can be found using the "I" icon.


Site: Princess Anne Hospital
Level 2 Threshold
Level 1 Threshold
CUSUM Statistic
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sept 25
Oct 25
Nov 25
Dec 25
Jan 26
Month of birth

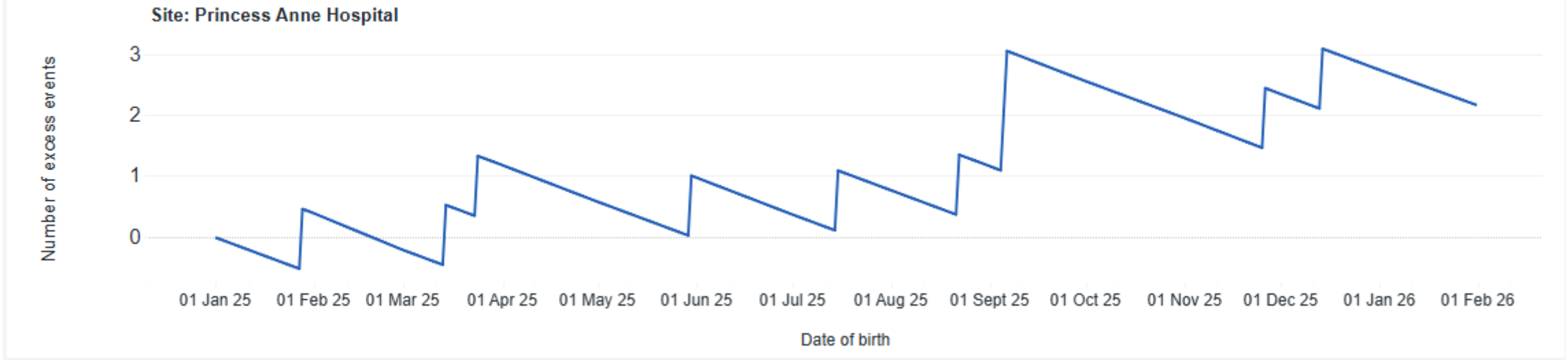

Site: Princess Anne Hospital
Number of excess events
3
2
1
0
01 Jan 25
01 Feb 25
01 Mar 25
01 Apr 25
01 May 25
01 Jun 25
01 Jul 25
01 Aug 25
01 Sept 25
01 Oct 25
01 Nov 25
01 Dec 25
01 Jan 26
01 Feb 26
Date of birth

Table of Events - Trust: University Hospital Southampton NHS Foundation Trust

Date of term birth	Events (term only)	Site name
14 Dec 25	1 Term Stillbirth(s)	Princess Anne Hospital
26 Nov 25	1 Term Stillbirth(s)	Princess Anne Hospital
06 Sept 25	1 Term Neonatal Death(s)	Princess Anne Hospital
05 Sept 25	1 Term Neonatal Death(s)	Princess Anne Hospital
22 Aug 25	1 Term Stillbirth(s)	Princess Anne Hospital
15 Jul 25	1 Term Neonatal Death(s)	Princess Anne Hospital
30 May 25	1 Term Stillbirth(s)	Princess Anne Hospital
24 Mar 25	1 Term Stillbirth(s)	Princess Anne Hospital
14 Mar 25	1 Term Neonatal Death(s)	Princess Anne Hospital
28 Jan 25	1 Term Neonatal Death(s)	Princess Anne Hospital

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.4 ii)

Committee Chair's Report to the Trust Board of Directors 14 May 2026			
Committee:	**Quality Committee**		
Meeting Date:	**27 April 2026**		
Key Messages:	• It was noted that a further never event had been reported. In addition, there had been an increase in the number of category 3 pressure ulcers. The committee noted the risk that capacity challenges could impact quality. • The committee noted the impact of the fire and the loss of critical care beds and impact on teams of being dispersed across the hospital. In addition, the committee noted that the number of patients having no criteria to reside was beginning to increase toward 200 following the significant reduction after the fire. • The committee received an update in respect of the Fundamentals of Care programme, noting the importance of local leadership in terms of getting the basics right. The committee noted that care of those with a learning disability was an area of focus as was the involvement of carers in patient care. • The committee reviewed the quarterly report in respect of mental health, noting a number of changes in the external landscape, including a new flow model at Hampshire and Isle of Wight Healthcare NHS FT and reforms to the Hampshire and Isle of Wight Urgent and Emergency Care pathway. • The committee discussed the Clinical Effectiveness Outcomes report, noting the ambitions for clinical effectiveness as part of the Trust's clinical strategy, including development of a clinical effectiveness dashboard and integration of clinical effectiveness into the Trust's governance structure.		
Assurance: *(Reports/Papers reviewed by the Committee also appearing on the Board agenda)*	**5.14 Maternity and Neonatal Services National Picture Report**	***Assurance Rating:*** **Substantial**	***Risk Rating:*** **Medium**
	• Nationally, there were significant challenges in and scrutiny of maternity services. There had been numerous inquiries, which had indicated recurrent themes, including: failures to listen to the patient, cultural or leadership issues, and workforce numbers. • The negative media lens applied to maternity services was having an impact on the Trust's staff. • Locally, there were challenges in terms of gaps in Band 7-level staff, but support was being provided for recruitment of these posts. • In addition, home births were proving a challenge in terms of supporting these with available resources. • The relative prevalence in the rate of still births in those from global majority backgrounds was being prioritised within maternity governance.		
	6.2 Board Assurance Framework (BAF) Update	***Assurance Rating:*** **N/A**	***Risk Rating:*** **N/A**
	• Risks 1a, 1b, 1c and 4a had been reviewed by the relevant executive directors since they had last been presented to the committee.		

	• The date for the target rate for risk 1a had been extended from 2027 to 2030 in recognition of the gap between the Trust's current position and its target and the level of work required. • Similarly, the target date for risk 1b had been extended from 2027 to 2030.
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 5.5 Report to the Trust Board of Directors, 14 May 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
- Industrial Action
- Violence and Aggression
- Future Workforce Solution
- Tobacco and Vapes Act 2026
- Maternity Standards
- Cut in Carbon Emissions
- Hampshire and Isle of Wight Provider Collaborative
- Music Collaboration with University of Southampton
- Mobile Endoscopy Units

Contents:

Risk(s):

N/A

Equality Impact Consideration:	N/A

Chief Executive Officer's Report

NHS Oversight Framework

On 18 March 2026, NHS England published the latest segmentation and league table data covering the third quarter of the 2025/26 financial year.

There was little significant overall change between the second and third quarters, with the median score worsening slightly from 2.34 to 2.35. There were also some changes in individual measures including:

- 27 fewer acute trusts met their 18-week elective waiting list plan than in Quarter 2.
- 12 fewer acute trusts met the 78% four-hour accident and emergency target than in Quarter 2.
- 23 more trusts were adjudged to be significantly off track on their financial plan.
- Eight more acute trusts met the 28-day faster diagnosis target and four more met the 62-day cancer standard.

In both second and third quarters, 119 trusts were in financial deficit, although the composition of this cohort did change slightly during the period. A total of eight organisations saw changes to their segmentation in Quarter 3 due to changes in the financial override (three organisations improved, five had their segment capped).

Excluding those impacted by the financial override, 34 other trusts moved segments between Quarter 2 and 3, of which eight deteriorated by a reasonably material amount and seven improved. Note: NHS England acknowledges that trusts can move segments due to relatively minor changes and hence separates out those trusts where the change in average metric score is more significant.

The Trust's average score for Quarter 3 was 2.43, which was 0.21 higher than the previous quarter. The Trust remains in segment 3 due to the impact of the financial override. The Trust was ranked 73 out of 134 acute trusts (previously, 51 out of 134).

NHS England is considering changes to the NHS Oversight Framework for 2026/27, including:

- Updates to metrics to align with the NHS Medium Term Planning Framework and Operational Standards.
- Fewer contextual measures not forming part of the scoring and clearer targets.
- Combining metrics with a capability assessment of leadership, governance and delivery capability.
- Reviewing quality scoring and how to enhance and improve this component.
- An overall NHS Oversight Framework rating based on target scores (with financial override), rather than benchmarked quartile performance.

Further updates will be provided to the Board when the framework for 2026/27 is available.

Industrial Action

Resident doctors across England undertook industrial action between 7 and 13 April 2026 following rejection of the Government's pay offer by the British Medical Association (BMA). The Government's offer included an average pay rise of 4.9% in 2026/27, reforms to the pay structure, additional speciality training posts, reimbursement of royal college exam fees, and contract reforms for locally employed doctors. This was the 15th strike in the long-running dispute. Thanks to diligent preparation by operational teams and the willingness of other staff to cover gaps created by the striking doctors, the Trust was able to deliver almost all of its normal level of activity during the strike.

The BMA is currently escalating its industrial action strategy by balloting the remaining major hospital doctor groups in England, specifically consultants and specialty, associate specialist and specialty (SAS) doctors, on whether to take strike action, with ballots expected to run from mid-May to early July 2026. If ballots are successful, the NHS could face the prospect of all key secondary care medical workforce groups being in dispute simultaneously. This represents a

significant escalation from previous single-group disputes to a coordinated whole-workforce challenge, increasing the risk of sustained operational disruption.

Violence and Aggression
According to the latest NHS Staff Survey, almost one in seven NHS staff were physically attacked by a patient or a member of the public in the last year. This is the highest rate for three years.

The Survey also found that nearly one in ten staff said they had been subjected to discrimination from patients and/or the public, the highest on record.

In the 2025 Staff Survey, approximately 14% of UHS staff had reported that they had experienced violence from patients or the public, but this percentage rises significantly to as much as 50-60% in areas such as the Emergency Department, Critical Care, Trauma and Orthopaedics, Neuro, and Medicine.

The Trust is finalising its revised Violence, Aggression and Abuse (VAA) Policy and approach, with both the policy and supporting framework now in the final stages of agreement. The updated policy and framework aim to simplify the processes used to address violence, aggression and/or abuse directed at Trust staff, whilst providing greater clarity for staff on the escalation routes available to them.

Implementation will be supported by a comprehensive communications campaign and targeted training for staff.

The Trust's revised approach, endorsed by the Board in late 2025, has already led to the establishment of a Violence & Aggression Board and issue of a number of formal restrictions against patients and/or members of the public who have acted in a violent, aggressive or abusive manner.

Future Workforce Solution
UHS has been selected as one of 38 early adopters of the new national workforce platform, the Future Workforce Solution. This will replace the Electronic Staff Record (ESR), which is the current national platform for payroll and HR management.

An implementation team has been established at UHS and, working with the NHS Business Services Authority, the Trust will begin preparation for system go-live in August 2027.

Alongside core elements such as payroll and HR administration, the system aims to integrate key workforce functions into a single platform. These include recruitment and candidate management, learning and development, and employee relations. The system also promises significantly improved business intelligence capability.

All trusts in Hampshire and the Isle of Wight are part of the pilot. A community of practice is being established to provide mutual support and to identify opportunities for process and procedural alignment, helping to drive standardisation across the wider health system.

Rostering is not included within the product. The Trust will therefore continue to use RLDatix (Allocate) for e-rostering and job planning solutions.

Tobacco and Vapes Act 2026
On 29 April 2026, the Tobacco and Vapes Bill was granted Royal Assent. The Bill was originally introduced by the previous Government in 2023 but had faced delays due to challenges and the change in Government following the general election. It was subsequently reintroduced as a Bill in November 2024.

The Act will make it illegal to sell tobacco to anyone born on or after 1 January 2009. It also includes measures to ban the advertising and sponsorship of vapes and nicotine products, as well as powers to restrict their packaging, branding and display.

The Act introduces powers to further restrict smoking in certain public places, and the Government has launched a consultation on 13 February 2026 on proposals to extend existing smoke-free places to certain outdoor settings.

Maternity Standards
On 23 April 2026, NHS England announced new clinical standards for maternity services in England to significantly reduce the number of women who die each year during or after pregnancy. These include:

- All pregnant women will be offered an early risk assessment for venous thromboembolism before their first antenatal appointment. Anyone identified as high risk will be offered blood thinners to prevent clots within 72 hours.
- Every woman with epilepsy will have access to a local specialist team and will be offered a tailored plan to help control seizures.
- Women will also be routinely assessed for their mental health with a consistent set of questions and a report provided at their antenatal appointment and referral to specialist NHS perinatal mental health if needed.

Full roll out of these measures is expected by March 2027.

Cut in Carbon Emissions
To coincide with Earth Day on 22 April 2026, the Trust announced that through a major upgrade to the pipework entering its operating theatres, the Trust had reduced the amount of nitrous oxide being released into the atmosphere by around 600,000 litres per year – preventing around 354 tonnes of carbon dioxide being emitted.

Nitrous oxide is used as part of anaesthetic care during some surgical procedures as well as for pain relief. However, anaesthetic gases account for around five per cent of global healthcare emissions, with nitrous oxide being a significant contributor due to its high heat trapping effect and its long time in the atmosphere.

The Trust has decommissioned its piped nitrous oxide manifolds and is instead using small portable cylinders attached directly to anaesthetic machines in theatres. This has eliminated leakage and significantly reduced waste whilst ensuring patients continue to receive safe anaesthetic care.

Hampshire and Isle of Wight Provider Collaborative
The update for the Hampshire and Isle of Wight Provider Collaborative for Quarter 3 of 2025/26 is attached as Appendix A.

Music Collaboration with University of Southampton
In collaboration with the Music Department at the University of Southampton, small-scale live music sessions have been taking place in clinical areas, including neonatal care.

The work has also received recent coverage through BBC South:
https://www.bbc.co.uk/programmes/p0n85ll1

Mobile Endoscopy Units
The installation of two mobile endoscopy units at Southampton General Hospital has been completed with the first patients being seen on 13 April 2026. Work is progressing well at Adanac Park with the installation of three endoscopy units. Work there is more complex due to the need to build concrete pads with water and power connections on which to site the units. Estimated completion date is late May at which point the Trust will be back to normal capacity levels.

My thanks go to the UEL estates team who have done a tremendous job to complete the procurement and installations so quickly and to the endoscopy team who have demonstrated great flexibility and resilience during what has been such a difficult period for the team.

Appendix A

Hampshire and Isle of Wight

Provider Collaborative

HIOW Provider Collaborative:

Quarterly update – Q3 2025/26

Provider Collaborative quarterly update

Hampshire and Isle of Wight Provider Collaborative

Provider Collaborative activity and development: *a summary of the Provider Collaborative's development journey to date, recent activities, and upcoming development plans and strategies*

Provider Collaborative shared measures of success: *Performance to date and movement against the six key shared measures of success.*

Provider Collaborative workplan: *Outline of progress to date against the major programmes in the current workplan.*

Hampshire and Isle of Wight Provider Collaborative: Purpose & Vision

Hampshire and Isle of Wight
Provider Collaborative

The Provider Collaborative will identify and take advantage of shared opportunities and implement collaborative solutions to shared problems. It will work together to deliver more integrated, high quality, and cost-effective healthcare to the population that our Trusts serve across Hampshire and the Isle of Wight.

The Provider Collaborative collectively has the resources, responsibility, and expertise in acute, community, and mental health service delivery to deliver longer-term clinical service transformation that would not otherwise be possible working as individual organisations. While each Trust retains its own identity and individual accountability, the Provider Collaborative will collectively develop and deliver service-specific workplans that optimise patient outcomes and reduce unwarranted variation in quality, access, and cost across the whole of Hampshire and the Isle of Wight.

Provider Collaborative development to date

Hampshire and Isle of Wight Provider Collaborative

Development to date: *Since the inception of the original Acute Provider Collaborative (APC) the Collaborative has maintained a focus on continuous development of its function and governance. This, and the subsequent creation of a workplan, has led to an established purpose and vision, and way of working. The below summarises the* ***main development milestones*** *to date and upcoming plans.*

May - July 2021

- *HIOW in national context, policy, and learning.*
- *Reconciling Trust strategies & commonalities, gaps*
- *Map existing collaboration & agree initial areas of focus*
- *Refine opportunities*
- *what would it take to go further?*
- *Developing a workplan for the next 6 months*
- *Comms: agreeing how progress will be shared*

Sep 2021

- Establish APC
- Agree workplan.
- Fully establish board meetings and support

May – July 2022

- *Review the current list of shared challenges and opportunities that are best solved together.*
- *Review workplan and progress.*
- *Map strategy against workplan.*
- *Map out preferred position, identifying gaps duplication and further priorities for change.*
- *Review workplan and progress.*

June - Dec 2024

- Visual identity
- Agreed purpose and vision
- Agreed shared measures of success
- Formalised Workplan
- Agreed decision making framework
- Confirm form
- Agreed and signed MOU

July 2025

- Creation of 'all-in' Provider Collaborative with Hampshire and Isle of Wight Healthcare

Sep 2025 – March 2026

- Joint Acute Clinical Strategy published
- Agreed 26/27 workplan
- Agree key Commissioning elements
- Agree additional medium-term planning priorities including frailty and elective

2026 / 2027

- **Workplan and Collaborative resourcing**
- **Establish frailty and elective work**
- **Agree with ICB parameters and resourcing for key commissioning elements**

Phase 1 | Phase 2 | Phase 3 | Phase 4

Provider Collaborative development & future activity

Hampshire and Isle of Wight Provider Collaborative

Current & future development milestones:

Development action	Progress	Progress notes
Medium term planning: Frailty	In progress	*Following medium term planning discussions, the Collaborative will develop a programme to deliver Frailty left shift and transformation ambitions including use of Lymington / Western hospitals, development of Hospital at Home, and Adult Mental Health. Resourcing to be agreed.*
Medium term planning: Elective	In progress	*Following medium term planning discussions, the Collaborative will create and elective programme combining the efforts of elective recovery and planned care transformation. Executive leadership and delivery structure to be agreed.*
Workplan development	In progress	*Aseptic Units and Elective Hubs will transition to business as usual; leadership for Clinical Reconfiguration and One ePR should be formalised within the Collaborative*
Collaborative development	In progress	*Resource will be formalised for Collaborative board support*
Commissioning plan	In progress	*Two key aspects of the proposed commissioning plan – DM01 and Clinical Networks – will be explored for 27/28*

Provider Collaborative networking and learning

Hampshire and Isle of Wight Provider Collaborative

Collaborative networking activities: *The Provider Collaborative is part of the National Provider Collaborative Hub (NHSE); Provider Collaboration Programme network (NHSP / NHSE); Southeast APC group (independently organised); Provider Collaboration Leads Network (Moorhouse Consulting), and the Pan South Provider Collaborative Network (NHSE). These and other networking activities provide opportunities for learning and gathering intelligence on trends in Provider Collaborative development and shared challenges*

Networking activity (last 6 months)	Key national & peer learning; trends
Webinars: Reducing elective waiting lists through provider collaboration; Using data to drive improvement and reduce clinical variation; Tackling the productivity challenge (NHSP)	*Emergent models of what will become IHOs e.g. West Hertfordshire* *With the publication of the plan and model ICB there is likely to be a further push towards Collaboratives taking on transformational and performance improvement activities from ICBs;* *Many collaboratives facing challenges of resourcing their transformation activities and workplans; multiple team structures, no consistent framework and transfer of resource is now less viable in the light of required headcount reductions in both ICBs and Providers* *Collaborative funding models include agreed 'fees' or % contributions from Trusts;* *Most Collaboratives are hosted within one of the member Trusts rather than ICBs; National focus on elective transformation across the 'Top 10' specialties by volume*
PC Leads Network sessions: delivering efficiency and productivity; creating the right culture and relationships; Frameworks for resourcing (Moorhouse)	
Southeast APC Group: wide-ranging sessions covering resourcing, culture, leadership, and delivery	
Individual sessions with Collaborative leaders across England (through NHS Hub)	
Briefings and national workshops on the development of Provider Collaboratives to lead transformation across systems (NHSE)	

Provider Collaborative shared measures of success

Measures combined for all member Trusts

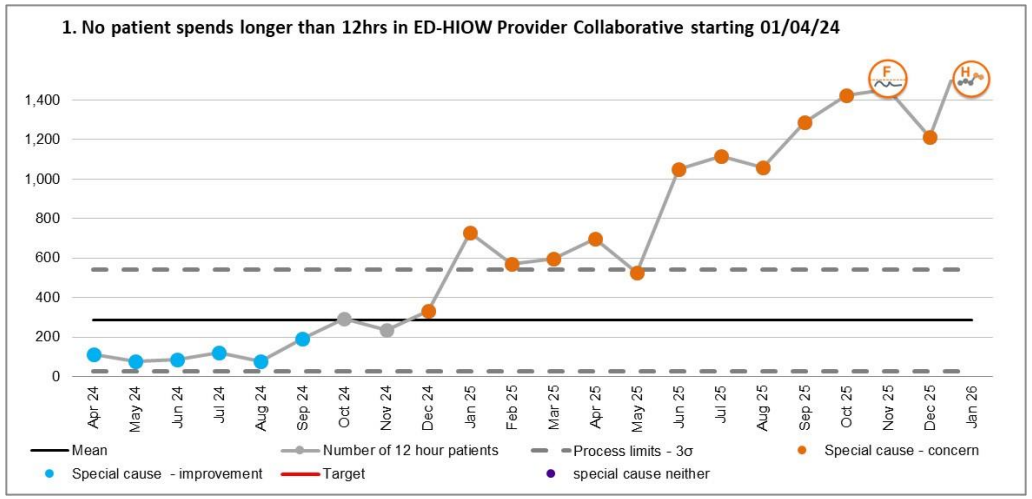
Hampshire and Isle of Wight Provider Collaborative

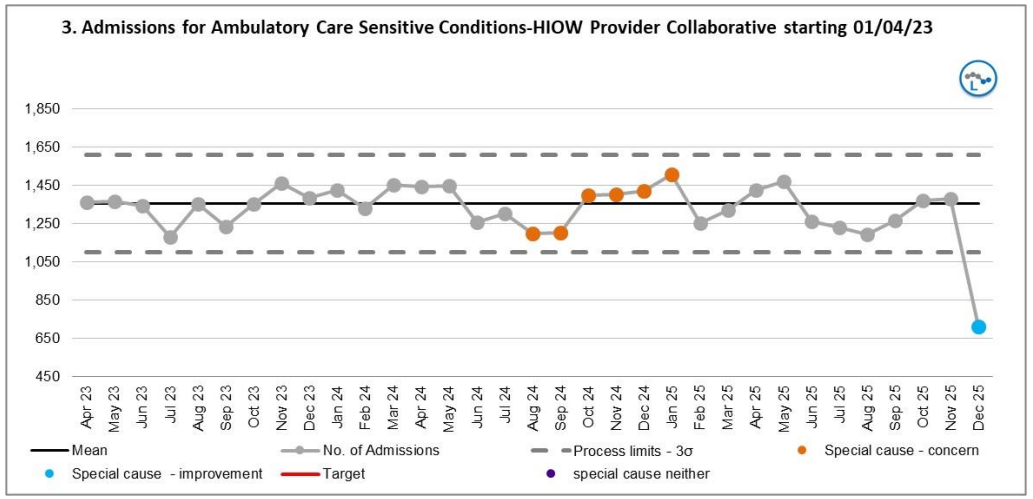
Measure of success	Measure	Previous quarter's performance	This quarter's performance	Movement	
1. No Patient Spends Longer than 12hrs total time in ED	*Number of 12 hr patients*	3,459	4,091	↑	*There has been a further increase in this quarter. (See SPC)*
2. Deliver high quality and equitable planned care	*% 52 Week Waiters (NHS England data by commissioner / provider)*	3.2% *(End of Quarter)*	2.6% *(End of Quarter)*	↓	
3. Fewer emergency admissions for ambulatory care sensitive conditions	*Number of admissions for ACSC (as defined in NHS OF Domain 2)*	3,690	3,463	↓	*This metric has remained at a relatively constant average of 1,300 per month since April 2023. Although the current reduction (See SPC) is probably attributable to coding delays, the trend for previous months suggests there is steady improvement*
4. No Patient waits > 48hrs (2 days) to be discharged once medically fit	*Average days delay after Discharge Ready / NCTR Date. Target 2.0*	2.0	2.0	→	*Improvement in this measure has been maintained. The Collaborative's target is being met. (See SPC)*
5. No patient in crisis without physical health needs attends an acute hospital (as an emergency)	*Number of psychiatric liaison presentations at acute EDs*	2,489	2,303	↓	*This has remained steady over time with some monthly variance in the last 6 months.. (See SPC).*
6. Reduce spend on Corporate Services	*[Measure TBC]*	TBC	TBC	TBC	*This measure – when agreed - will now be generated from the shared corporate services programme*

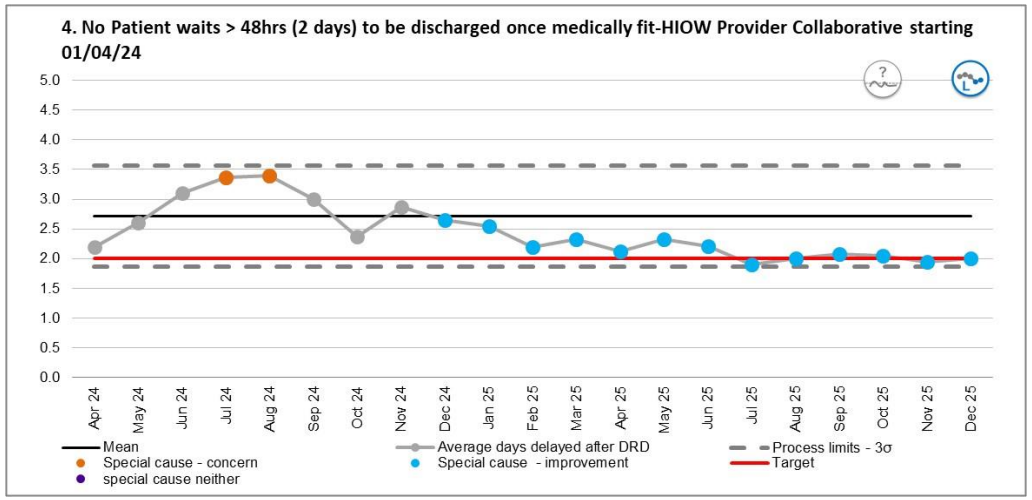
Provider Collaborative shared measures of success

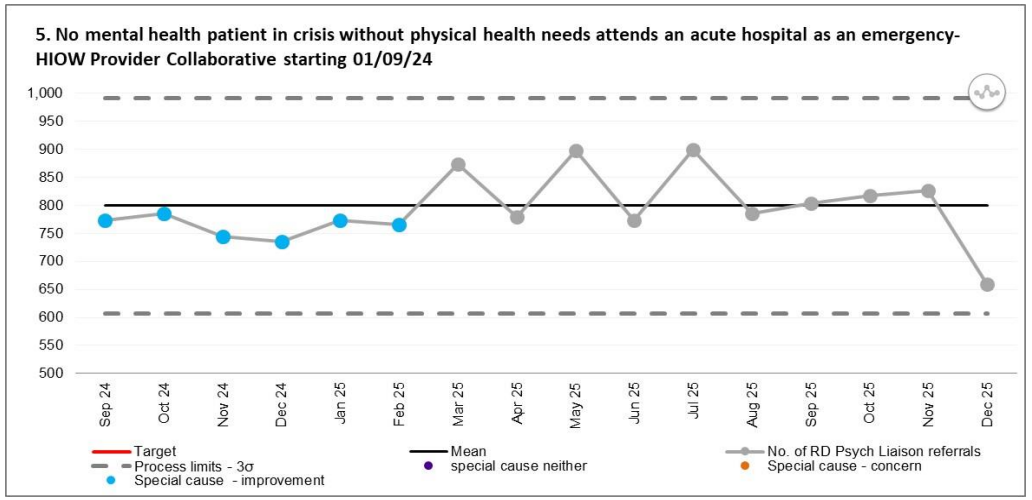
Measures combined for all Trusts

Hampshire and Isle of Wight Provider Collaborative









Provider Collaborative Workplan

Hampshire and Isle of Wight Provider Collaborative

Programme	Collaborative Senior Responsible Executive(s)	System Senior Responsible Officer(s)
Programme: One ePR	Lara Alloway	Tim Cropley
Programme: Clinical Reconfiguration	Lara Alloway; Ruth Williamson; Paul Grundy; Natalie Borman	Colin Williams
Programme: Shared Corporate Services	David French; Sue Harriman; Penny Emerit	Martin De Sousa
Programme: Elective Hubs	Proposed for transition to business as usual	
Programme: Aseptic Units		
Programme development proposals	Two recommendations will be presented to the April 2026 Collaborative Board: An elective programme combining recovery and planned care efforts; Frailty will be added to clinical reconfiguration for governance purposed but with specific leadership and focus	

Workplan: One ePR

Hampshire and Isle of Wight Provider Collaborative

Programme purpose: *Provide a single ePR across the four acute Trusts. Operationalise the eventual product; ensure that the outcome of the programme meets the needs of the individual Trusts and Provider Collaborative.*

Key progress / achievements this quarter	Actions for next quarter
• The OBC progress through to the NHSE programme board was stopped in early Dec due to a reduction in the expected funding for the Frontline productivity programme. • The Frontline productivity programme will not fund EPR for any trusts except group 0 (which we are not). • The 4 Trusts have agreed to fund the production of the new OneEPR OBC, funded only by Trust funds with a reduced affordability cap • Programme team has been reduced to just people directly work Inon the OBC and other procurement documentation	• Production of the new OBC and related tender documents • Agreement from NHSE as to the required oversight required. • Progression of the OBC through Trust governance structures
Improvements required	**Interventions required to deliver**
• Failure to progress the OBC will incur a number of risks including:- • Potential write off of incurred costs to date • Need to pivot programme to one of reducing legacy technology risks caused by end-of-life PAS and other systems.	• Engagement of exec teams across the ICB to support the new OBC • Plan to put in place adequate teams to support the procurement and the change management needed a successful programme.

Hampshire and Isle of Wight Provider Collaborative

Workplan: Clinical Services Review / Clinical Reconfiguration

Programme purpose: *To identify clinical services delivered in HIOW that have unwarranted variation in quality, access, and cost; Look for opportunities where delivering clinical services at a larger scale could provide improved outcomes and value for money for our local population; Balance with the need for local care for frequently accessed and/or time critical services; Deliver a clinical design for collaborative operating models for all acute clinical services addressing these objectives*

Key progress / achievements this quarter	Actions for next quarter
• Joint acute clinical strategy progressed through ICB, UHS, HIOWH, and PHU boards • Pelvic Health: ICB funding granted for trial • OG Cancer: Commissioners are reviewing Trust responses • Breast: Unified pathway implemented and audit completed with improvement in access gap shown • Urology: Centralised HIFU service agreed • H&N Cancer: Stakeholder organisations assessing model options • Cardiology: Second workshop completed, PCI options outlined; technology options being appraised • Maxillo-Facial: MaxFax discovery session held • Rheumatology: First session 23/04 • Vascular: Wessex Vascular Network session held; agreed initial priorities around unified pathways	• Joint acute clinical strategy: Progress Joint acute strategy through HHFT board • Pelvic Health: Commence trial • Breast: Complete audit at HHFT and set next phase priorities • Urology: progress HIFU • H&N Cancer: Fourth session 18th March • Cardiology: Complete PCI journey modelling; hold third workshop • Maxillo facial: Hold second session • Rheumatology: Hold discovery session • Vascular: Next three sessions in place
Opportunities	**Risks & Escalations**
• Opportunity to align ePR and clinical reconfiguration; session held in September to explore opportunities. ePR programme team will join discovery sessions for Wave 2 specialties. • PHU / IOW group and HHFT running clinical model / reconfiguration programmes; can mutually support outcomes and resourcing	• Additional resource is not available or affordable: The programme should continue to be reviewed on an effort vs. benefit basis; seek opportunities to join together existing workstreams from Trusts and the system • Pace of change: progress remains slow. Issues identified include clinical **Time & Capacity**: Clinical and non-clinical; **Competition with other recovery & improvement priorities**: Both at system and Trust level; **Communication**: Communication on the programme has not reached all levels of Trusts; **Access to expertise & decision makers**; **Culture of collaboration**: Trusts have a tricky balance between being held to account on their organisational recovery alongside the need to collaborate; **Leadership resource**: Very little dedicated programme resource with only limited service-specific project resource within Trusts

Workplan: Shared Corporate Services

Hampshire and Isle of Wight Provider Collaborative

Programme purpose: *design, develop, and implement a shared corporate services model that will lead to improved efficiency with high-quality service delivery; a recurrent financial benefit compared to existing outlay; eliminate variation; identify and deliver the vehicle for provider collaboration; A service model structured for continuous improvement and transformation; Integration with common IT systems and digital infrastructure*

Key progress / achievements for this quarter	Actions for next quarter

• Focus on key workstreams:
  • People- agreed subgroups for focus areas and meeting with representatives from each Trust to identify opportunities and milestones. Areas prioritised: EDI, OD, StatMan Training, Occupational Health, Recruitment, Staff Wellbeing/Benefits, AI/Automation
  • Procurement- joint procurement board established with CFO and Procurement Director representation from each organisation. Draft workplan shared alongside resource requirement for consideration
  • Legal- initial meetings held with Corporate Affairs leads from trusts. Learning received from other NHS organisations and NHS England on approaches in this area.
• Met with Staffside representatives to update in March 2026 and positive feedback about approach
	• Agree resource requirement to continue the work in these areas (to Provider Collaborative Board – 1st April)
	• Progress existing areas and deliver in line with agreed milestones
	• Agree approach to further areas

Opportunities	**Risks and escalations**
• Future national developments in People Services present opportunities, particularly replacement of ESR with system that may offer modular improvements to replace existing systems (recruitment, learning management etc). HIOW to be a pilot region for the new system.	• Funding will be required • Cases will need to balance need for immediate financial return with opportunity to invest (in automation etc) to enable longer-term benefits • Need to ensure appropriate comms to staff on progress across the organisations • Need to ensure ongoing Staff side engagement • Capacity: Designing and delivering a Single Corporate Service Model is a complex, multi-year transformation.

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.6	Report to the Trust Board of Directors, 14 May 2026
Title:	Performance KPI Report 2025-26 Month 12
Sponsor:	Andy Hyett, Chief Operating Officer
Author:	Sam Dale, Associate Director of Data and Analytics Gavin Hawkins, Divisional Director of Operations

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

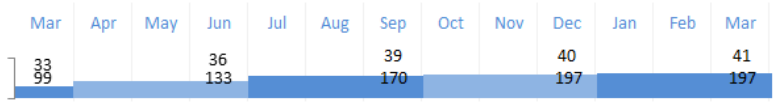
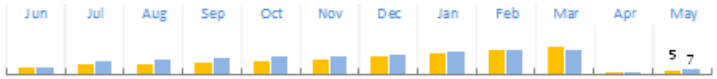
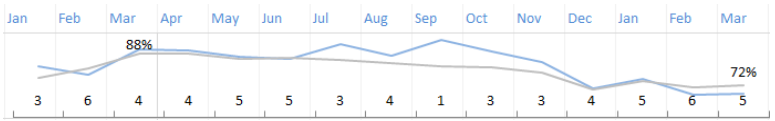
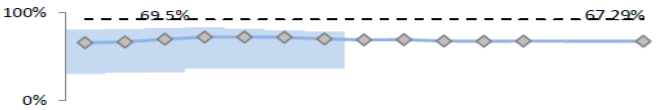
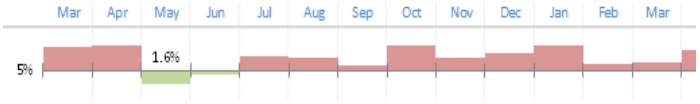
Performance KPI Board Report

Covering up to
March 2026

Sponsor
Andy Hyett, Chief Operating Officer

Author(s)
Sam Dale, Associate Director of Data and Analytics
Gavin Hawkins, Deputy Director of Operations

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.

Reporting Changes to note:

- As requested by the Board, a new metric reporting length of stay has been introduced to the KPI report. The metric reflects average length of stay for patients who have been discharged within the reported month.

Summary

This month's spotlight report explores emergency department performance in 2025/26.

The report highlights that: -

- Emergency Department performance improved materially during the second half of 2025/26, with a 13 percentage point year-on-year improvement by March 2026, strengthening the Trust's relative position among teaching hospitals and South East peers.
- Improvement has been delivered through improved front-door assessment and investigation timing, increased clarity and speed of admission decision-making and strengthened alternatives to admission.
- Early unvalidated April 2026 data suggests improvements are being sustained into 2026/27, with corridor care remaining a principal quality and regulatory risk requiring continued executive and Board oversight.
- Key developments planned for 2026/27 include the building of an Urgent Treatment Centre, the redevelopment of the previous Paediatric ED space and further development of SDEC facilities within downstream specialties.

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

1. In March, the trust made considerable progress on reducing the waiting list and improving both the 18 week performance and the volume of long waiting patients. The reported waiting list for March 26 is 59,683 which is a 4.8% reduction since February 26 (62,707). The 18 week position improved to 63.5% with 1,166 patients waiting over 52 weeks, 53 patients waiting over 65 weeks and zero patients over 78 weeks. Additional activity was delivered through both internal capacity, outsourcing and insourcing. The improvement was also supported by the national extension to the waiting list data submission for March-26. This allowed for additional pathway validations to be completed and further outcoming of outpatient attendances.
2. February's cancer performance metrics are 81.7% for 28 day standard, 74.3% for the 62 day standard and 87.0% for the 31 day standard. Whilst the trust continues to benchmark in the top quartile against peer teaching hospitals for the 28day standard, it has dropped into the bottom half for the other metrics. A number of remedial actions are being progressed particularly to address the loss of endoscopy capacity impacted by the major incident. These actions also include improvement of pathology turnaround times, the 7th Linac coming back online and additional insourcing and outsourcing to free up capacity.
3. The average number of inpatients medically optimised for discharge increased in March (186 patients) but remained well below the ytd average following the reduction seen in February due to the redistribution of patients during the major incident.
4. The closing position for patients waiting over six weeks for diagnostics was 16.2% with a waiting list of 10,556 patients.
5. There were zero cases of MRSA in March and a further reduction in gram negative bacteraemia. The trust finished the year marginally outside the ytd target for both category 2 and category 3 pressure ulcer metrics. There were two medication errors reported.
6. The trust reported zero never events and two PSIIs (Patient Safety Incident Investigations) in March.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Central Ambulance Service (SCAS). In the week commencing 27th April 2026, our average handover time was 14 minutes 31 seconds across 783 emergency handovers and 16 minutes 53 seconds across 51 urgent handovers. There were 27 handovers over 30 minutes and 2 handovers taking over 60 minutes within the unvalidated data. Across March 26, the average handover time was 16 minutes 2 seconds.

Spotlight: Emergency Department (ED) Performance

Executive Summary

This spotlight provides a comprehensive overview of Emergency Department (ED) performance up to March 2026 at UHS, setting out the performance context, the drivers of change over the last 12 months and highlighting the risks and priorities as the Trust enters 2026/27.

ED performance improved materially during 2025/26, with UHS closing March 2026 at 72.5% for activity directly controlled by the Trust (Types 1 and 2), representing a 13 percentage point improvement compared with March 2025. Although this remains below the national operational standard of 78%, the pace and consistency of improvement strengthened significantly in the second half of the year, indicating that improvement is structural rather than episodic.

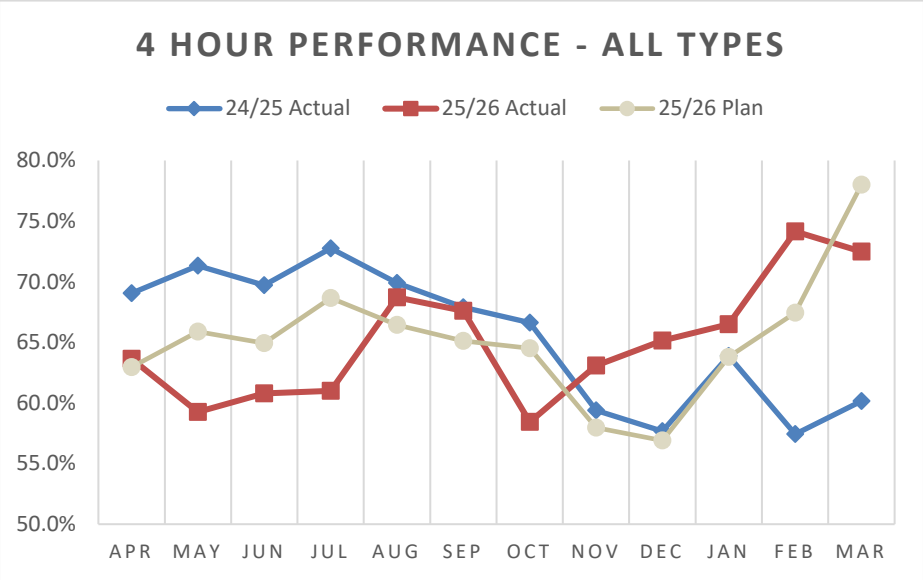
In relative terms, performance improvement has repositioned the Trust among its peers. Benchmarking for March 2026 places UHS 4th among both peer both teaching hospitals and South East acute providers, compared with mid-table positions one year earlier. Early, unvalidated national intelligence suggests the Trust was among the top three most improved acute UEC providers nationally year-on-year.

The principal challenge for 2026/27 is to sustain improvement, close the remaining gap to national standards, and reduce corridor care, which remains a material quality and regulatory risk. ED performance remains highly dependent on whole-hospital flow and capacity, and improvement therefore requires continued Trust wide grip.

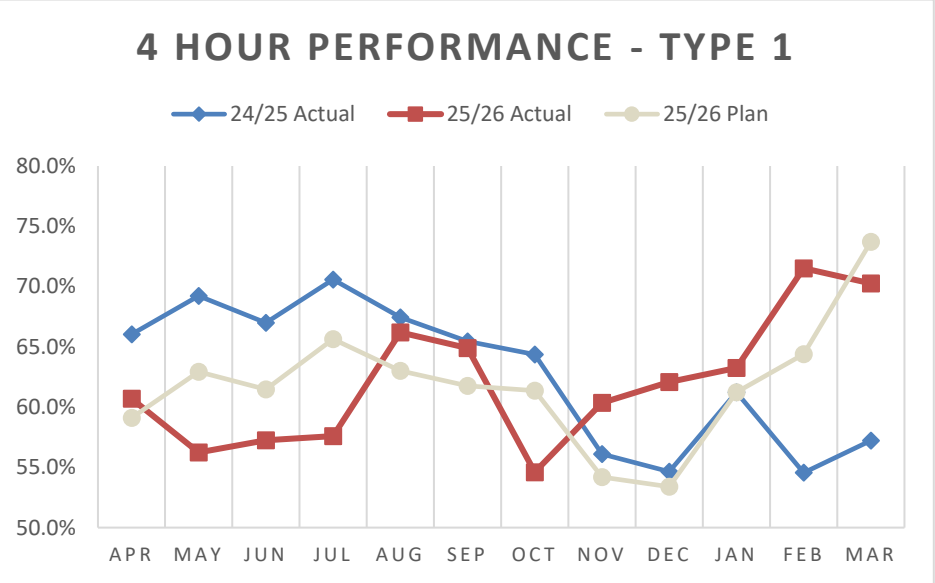
Performance Position

ED performance during 2025/26 must be considered in the context of sustained operational pressure across urgent and emergency care. Attendances have remained high relative to pre-pandemic baselines, with increased acuity, greater complexity, and longer investigation and decision-making requirements. These demand characteristics have placed ongoing pressure on ED capacity, escalation space, and downstream beds. Against this backdrop, the scale of performance improvement delivered during the year is notable, reflecting not only ED-specific interventions but also improvements in admission decision-making and patient flow beyond the department.

The national four-hour emergency access standard for 2025/26 required 78% of patients to be admitted, transferred or discharged within four hours, assessed at system level by March 2026. In year performance against plan for 2025/26 is shown in the graphs below including a comparison to 24/25.



Graph 1: Four hour performance trends – type 1 and 2



Graph 2: Four hour performance trends – type 1

For activity directly controlled by UHS, Type 1 ED performance closed the financial year at 70.3%, representing a 13 percentage point improvement compared with March 2025. When Type 2 activity (including Eye Casualty) is included, combined performance closed at 72.5%, an improvement of approximately 12% year-on-year, but still 5.5 percentage points below the national operational standard.

Performance from Type 3 Urgent Treatment Centres at Lymington and Royal South Hants was not attributed to UHS operational performance during March 2026. When these services are included, system-level performance was approximately 82%, exceeding the national requirement.

From 2026/27 onwards, UHS UEC reporting will again include Type 3 UTC performance alongside the Trust's on-site UTC once operational. Reflecting this broader performance scope, the March 2027 four-hour emergency access target is 82%.

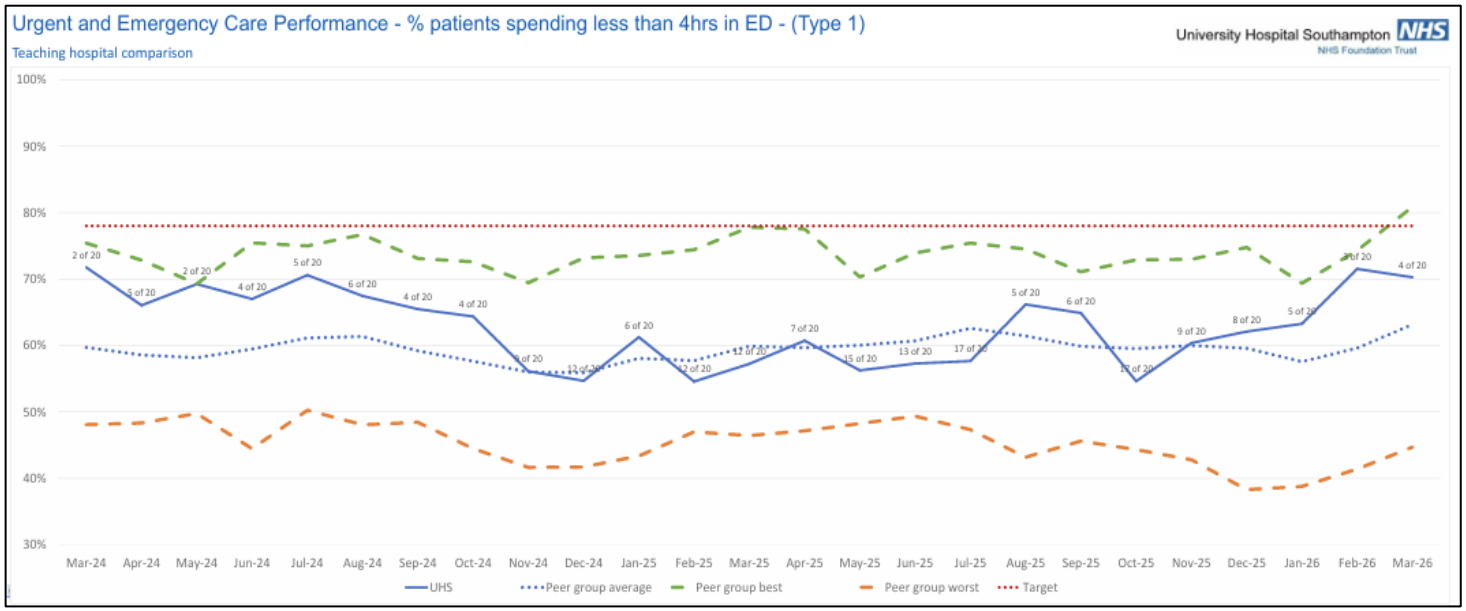
Performance Comparators

Recent statistical commentary and data published by NHS England provides insight into the national NHS position for March 2026. The total number of attendances across all Accident and Emergency (A&E) Departments rose by 1.8% compared to March 2025, indicating a continued increase in demand.

Regarding the national four-hour emergency access standard, 77.1% of patients were admitted, transferred, or discharged within four hours in all A&E Departments during March 2026. This represents an improvement when compared to 74.1% in February 2026 and 75.0% in March 2025.

Focusing on Type 1 A and E Departments, which typically handle the most acute cases, 64.1% of patients were admitted, transferred, or discharged within four hours in March 2026. This figure marks an increase from 59.4% in February 2026 and from 60.9% in March 2025, highlighting positive progress in timely care delivery for the most complex cases across the NHS.

The trust continues to benchmark ED performance against other organisations across the country with specific focus on 20 peer teaching organisations and the 17 providers within the South-East region. UHS's relative position improved substantially during 2025/26. In March 2026, the Trust ranked 4th among peer teaching hospitals and 4th among South East acute providers, compared with 12th and 14th respectively in March 2025.



Graph 3: Four hour performance comparator chart against 20 peer teaching organisations (Type 1 only)

Early, unvalidated DHSC intelligence suggests UHS was the third highest year-on-year improver nationally which is consistent with this substantially improved peer position. While subject to confirmation, this reinforces confidence that improvement reflects genuine operational and structural change rather than reporting artefact.

2025/26 Key Improvement Drivers

Performance improvement during 2025/26 was achieved through a small number of prioritised, high-impact operational initiatives, previously agreed by the Board and delivered at pace with strong executive oversight.

These six key initiatives were: -

- **CT (Computed Tomography) Head pathway redesign**, reducing investigation turnaround times and avoidable ED dwell.
- Establishment of the **Acute Assessment Unit (AAU),** supporting earlier admission decisions and relieving ED congestion while awaiting downstream beds
- **Time-limited minor injury appointments**, smoothing peaks in attendance and better matching demand to available staffing.
- **Consistent front-door redirection,** reducing inappropriate ED attendances and improving streaming.
- **ED-specific Same Day Emergency Care (UCLA),** enabling ambulatory pathways and avoiding unnecessary admission.
- **Clinical Decision Unit (CDU) redesign**, improving throughput for high-volume, lower-complexity patients previously breaching prior to discharge.

Together, these initiatives improved front-door assessment and investigation timing, increased clarity and speed of admission decision-making, and strengthened alternatives to admission. Redesign of investigation pathways, particularly at the ED front door, reduced avoidable delay for high-volume patient cohorts, while additional assessment and decision-making capacity beyond the ED reduced congestion for patients awaiting admission or discharge. Developments in same-day emergency care and changes to minor injury pathways improved demand management and better aligned attendances with available capacity.

Collectively, these interventions reduced ED dwell time and supported improved four-hour performance, delivered through time-limited improvement sprints with clearly defined ownership and benefits tracking.

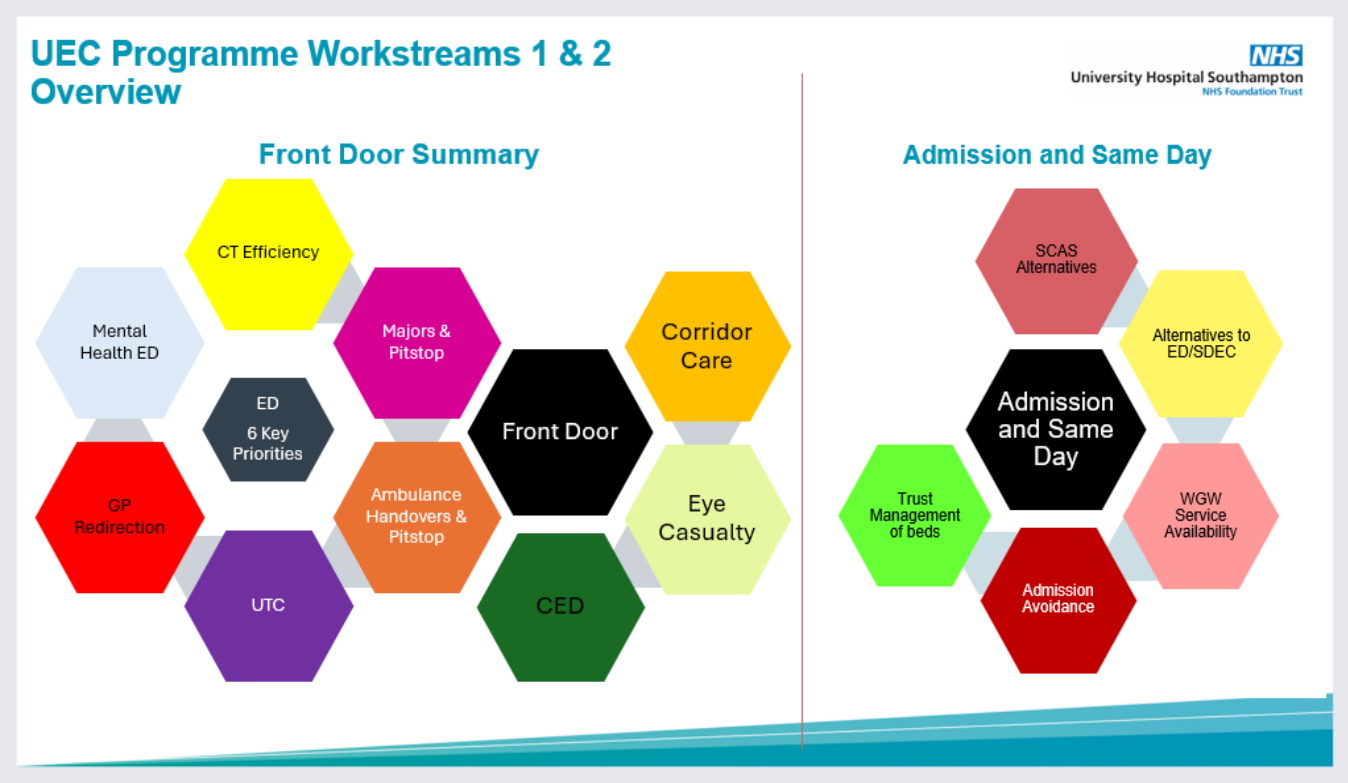
2026/27 UEC and Flow Priorities

The approach for 2026/27 is to manage the Urgent Emergency Care (UEC) and Flow programmes together with a renewed SRE, SRO and transformation lead structure which will feed into our existing Transformation Oversight Group (TOG) structure led by the CEO. The programme is explicitly framed around four priorities, each with defined expectations agreed by the Board: -

- **Four-hour emergency access performance** - achieving 82% by March 2027
- **Length of stay reduction** - delivering a 10% reduction in average length of stay to support sustainable flow and bed availability.
- **Patients with no clinical criteria to reside** – sustaining and further reducing NCTR volumes through strengthened discharge and specialty grip •

- **Corridor care reduction** – materially reducing the number of patients waiting for, or receiving, care in ED corridors, recognising this as a priority quality and regulatory risk.

Several targeted workstreams have been established for the programme, classified as either "front door" (internal to ED) or "admission and same day care" (external to ED but both internal and external to UHS). Each of these workstreams will have a clear set of KPIs and a high level summary is shown below.



Visual 1: UEC Targeted Workstreams

The Trust has received capital funding to undertake four projects designed to enhance our four-hour emergency access performance and further support patient care across multiple workstreams. The funding is to support:

1. The building of an Urgent Treatment Centre on site to be co-located with our existing emergency department. The business case has been supported and both cash and capital funding has now been received. The current plan is for the UEC to be opened in quarter 3 of 26/27.
2. The redevelopment of the previous Paediatric ED space which has been used over the last five years as a Respiratory Assessment Unit (RAU), ambulance holding area and medical surge. Again, the business case has full support, and funding is now being received with the plan to start works following the building of the UTC.
3. The establishment of an onsite Mental Health A&E to support patients attending the ED who are in crisis but with limited or no physical health needs. The business case is under development and funding has been notionally agreed at this stage. This initiative is being taken forward jointly with HIOW.
4. The development of SDEC facilities in the footprint of downstream specialties to support more timely flow through the ED or by avoiding ED altogether. Again, the business case is under development and funding has been notionally agreed at this stage.

The intention from these capital bids is to support demands on our ED to achieve our desired ambitions, however the challenges will be for these schemes to remain cost neutral from a revenue perspective.

Conclusion

UHS delivered a substantial and sustained improvement in ED performance during 2025/26, strengthening both absolute performance and relative position among peers. Improvement is judged to be structural rather than episodic, underpinned by focused operational change and improved system grip.
Early unvalidated April 2026 performance indicates that the positive trajectory seen in the latter part of 2025/26 has been broadly maintained at the start of 2026/27 with four hour performance of 70.3% (all types) against a plan of 71.1%. While April data remains subject to formal validation, this early position provides additional confidence that recent improvements are being sustained beyond year-end.

The strategic challenge for 2026/27 is to embed consistency, close the remaining gap to national standards, and materially reduce corridor care as published by the DHSC for 2026/27. At present on average 15% of our patients spend more than 45mins in an ED corridor (under the national definitions) which is approximately 50 patients. We expect our UEC and Flow programme to go some way in addressing this by reducing the demand in ED (majors) as creating alternatives to ED (SDECs) additional clinical space will be required to ultimately eradicate “corridor care”. The opening of the Urgent Treatment Centre will provide us with further space opportunities.

The integrated UEC and Flow programme provides a credible framework to support this next phase of improvement.

NHS Constitution - Standards for Access to services within waiting times

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

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

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

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

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

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

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

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

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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%	62.6%													63.5%	≥67.4%	62.1%
		50%	4	4	3	3	3	3	4	6	7	7	9	7	7	8		
			5	7	6	5	5	6	5	6	7	6	7	7	9	10		
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 20) South East average (& rank of 18)	100%	72.1%													74.3%	≥75%	74.7%
		40%	2	10	4	10	3	10	7	9	9	8	7	9	6	7		
			2	4	2	3	2	6	2	4	4	5	4	8	2	3		
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 20) South East average (& rank of 17)	80%	57.2%													70.3%	≥78%	61.9%
		40%	9	16	14	10	14	15	15	7	8	14	11	8	4	4	4	
			6	12	12	7	15	13	17	5	6	17	9	8	5	3		
30 - As of April 2025, YTD and **Monthly target changed from 95% to 78%** in line with latest operational guidance																		
41	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	40%	11.3%													16.2%	≤5%	18.26%
		0%	6	6	7	9	9	9	10	11	11	13	13	13	9	12		
			9	6	7	10	11	9	10	9	11	11	11	11	10	10		
41 - As of April 2024, YTD and **Monthly Target changed from 1% to 5%** to reflect latest guidance																		

Outcomes		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
1	HSMR (Rolling 12 Month Figure) - **UHS** HSMR (Rolling 12 Month Figure) - **SGH**	86.3												95.6			≤100	96.3	≤100
		84.6												93.3					
2	HSMR - Crude Mortality Rate	2.2%												2.3%			<3%	2.3%	<3%
3	Percentage non-elective readmissions within 30 days of discharge from hospital	12.3%												12.7%			-	12.7%	-
		Q4 2024/2025			Q1 2025/2026			Q2 2025/2026			Q3 2025/2026			Q4 2025/2026			Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	76			77			74			75			76			+1 Specialty per quarter		
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	36			36			33			34			36			-		
		75			93			90			93			107					
		318			306			311			309			321					

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

Safety		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**				12 8	19 20	29 28	36 41	49 53	59 62	69 69	79 76	88 81	94 85	112 88	120 91	≤9	91	≤100
7	MRSA bacteraemia	1	0	0	1	0	0	1	1	0	0	3	0	2	0	0	0	8	0
8	Gram negative bacteraemia	20	35	18	21	14	22	26	31	24	20	20	10	22	11	9	≤19	230	≤220
9	Pressure ulcers category 2 per 1000 bed days			0.28												0.33	<0.3	0.33	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days			0.21												0.33	<0.3	0.33	<0.3
11	Medication Errors (severe/moderate)			2												2	≤3	26	33
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent 12 months** vs. **Previous 12 months**														2,531	2,801	<2714	2,516	<2550

Safety		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
13	Patient Safety Incident Investigations (PSIIs) (based upon month reported, excluding Maternity)	0														2	-	21	-
14	Never Events		1													0	0	8	0
15	Patient Safety Incident Investigations (PSIIs)- Maternity		0													0	-	0	-
16	Number of falls investigated per 1000 bed days			0.20												0.05	-	0.10	-
18	Red Flag staffing incidents			18												11	-	155	-

Maternity		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
19	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	395 / 496	372 / 466	410 / 494	390 / 450	390 / 448	425 / 447	440 / 472	432 / 411	431 / 456	448 / 480	406 / 407	403 / 452	376 / 469	336 / 449	413 / 479	-	-	-
20	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	1	1	1	1	1	4	4	1	3	0	6	3	3	3	4	-	-	-
21	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women)	47.85% / 42.03%	47.85% / 42.47%	48.54% / 40.98%	48.46% / 37.69%	45.38% / 43.59%	45.65% / 39.76%	45.23% / 42.05%	48.61% / 40.51%	43.62% / 45.01%	51.70% / 41.00%	46.10% / 41.60%	44.91% / 40.94%	47.10% / 39.90%	42.90% / 45.90%	40.20% / 46.70%	-	-	-

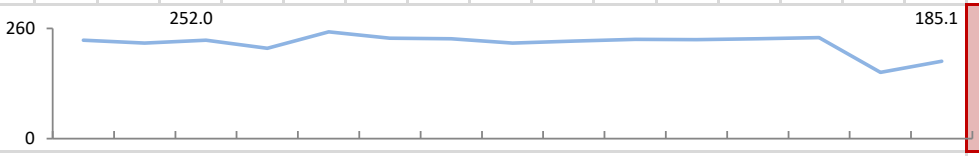
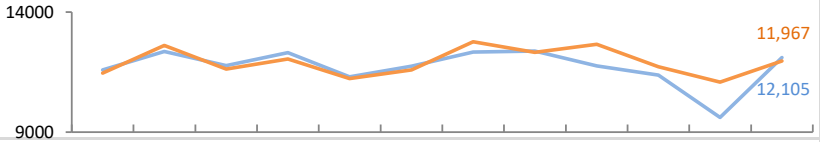
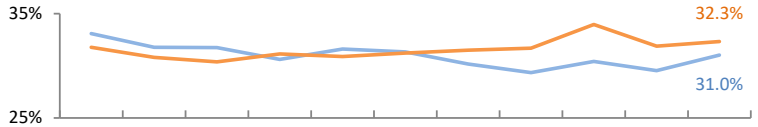
Patient Experience		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
22	FFT Negative Score - Inpatients	3%		2.0%												1.6%	≤5%	0.8%	≤5%
		0%																	
23	FFT Negative Score - Maternity (postnatal ward)	10%		0.7%												2.6%	≤5%	3.1%	≤5%
		0%																	
24	Total UHS women booked onto a continuity of carer pathway	30%		15.3%												15.7%	≥35%	14.0%	≥35%
		0%																	
25	Total Global Majority women booked onto a continuity of carer pathway	100%		21.7%												22.1%	≥51%	18.4%	≥51%
		0%																	
25 - metric renamed from "BAME" to "Global Majority"																			
26	% Patients reporting being involved in decisions about care and treatment	100%		87.7%												87.6%	≥90%	87.0%	≥90%
		80%																	
27	% Patients with a disability/reporting additional needs/adjustments met (total questioned at chart base)	100%		86.3%												91.5%	≥90%	89.2%	≥90%
		80%	323	273	483	491	442	504	416	357	276	338	419	341	357	287	353			
27 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
28	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	110		97												109	-	989	-
		0																	
29	Number of mental health patients spending over 12 hours in A&E	100		39												29	-	440	-
		0																	

Access Standards		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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 17)**	80% 40%	9 6	16 12	14 12	10 7	14 15	15 13	15 17	7 5	8 6	14 17	11 9	8 8	4 5	4 3	≥78%	61.9%	≥78%
		57.2%														70.3%			
															4	4			
															4				
31	Average (Mean) time in Dept - non-admitted patients	05:00 02:00															≤04:00	03:31	≤04:00
				03:25												03:37			
32	Average (Mean) time in Dept - admitted patients	07:00 03:00															≤04:00	05:00	≤04:00
				06:31												03:37			
33	Proportion of patients admitted, discharged and transferred from ED within 12 hours This year vs. last year	100% 92%															-	96.8%	>98.0%
																96.9%			
																96.3%			
59	Inpatient Length of Stay	7 4		5.68												5.13	-	-	-
34	% Patients on an open 18 week pathway (within 18 weeks) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	70% 50%	4 5	4 7	3 6	3 5	3 5	3 6	4 5	6 6	7 7	7 6	9 7	7 7	7 9	8 10	≥67.4%	62.1%	≥67.4%
		62.6%														63.5%			
35	Total number of patients on a waiting list (18 week referral to treatment pathway)	65,000 55,000															-	59,683	-
				61686												59683			

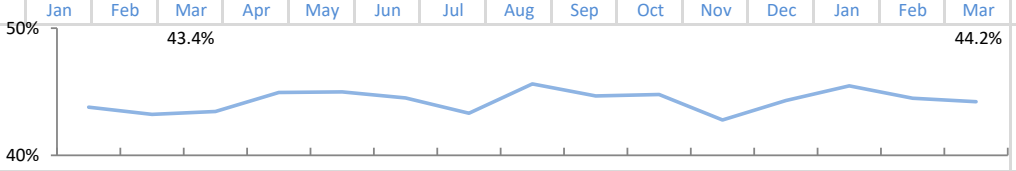
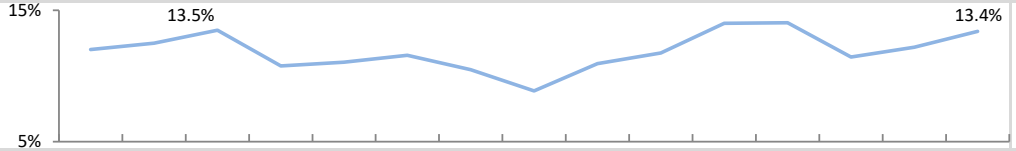
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
36	Percentage of patients on an open 18 week pathway (waiting 52 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	6 7	6 7	1.86% 7	5 7	8 7	8 8	10 8	11 11	13 13	15 14	12 14	11 12	13 13	15 13	1.95%	1.0%	2.0%	1.0%
37	Patients on an open 18 week pathway (waiting 52 weeks+) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	3 10	3 9	1147 9	2 9	2 9	4 10	5 11	8 12	9 12	11 14	9 14	9 13	9 14	10 14	1166	0	1166	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)**	1 7	2 7	21 9	2 10	4 13	8 15	12 16	13 14	13 16	16 16	17 17	17 17	13 14	11 15	53	0	53	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)**	5 4	5 6	1 7	6 1	1 1	1 14	10 16	16 18	20 18	19 17	17 17	18 16	17 15	16 1	0 1	0	0	0
40	Patients waiting for diagnostics			10409												10556	-	10,556	-
41	% of Patients waiting over 6 weeks for diagnostics **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 18)**	6 9	6 6	11.3% 7	7 7	9 10	9 11	9 9	10 10	11 9	11 11	13 11	13 11	13 11	9 10	12 10	≤5%	18.3%	≤5%

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
42	% of patients waiting for a First OP appointment within 18 weeks	72.0%														68.0%	≥71.2%	68.0%	≥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)	72.1%	2	10	4	10	3	10	7	9	9	8	7	9	6	7 / 74.3%	≥75%	74.7%	≥75%
		100% / 40%	2	4	2	3	2	6	2	4	4	5	4	8	2	3			
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)	84.4%	3	6	5	3	9	16	10	5	5	7	13	11	10	14 / 81.7%	≥80%	79.0%	≥80%
		100% / 60%	2	4	5	2	5	18	5	5	4	6	12	11	13	15			
45	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	92.8%	6	14	11	7	7	10	9	11	10	12	14	12	12	15 / 87.0%	≥96%	93.6%	≥96%
		100% / 78%	5	8	7	7	7	7	7	7	6	7	7	9	8	15			

R&D Performance		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
46	Recruitment performance ranking	9	10	11	16	7	7	5	5	6	7	7	10	9	8	8	Top 10	-	-
47	Performance in initiating clinical trials	44%	47%	44%	40%	53%	39%	67%	87%	55%	55%	67%	54%	57%	62%	38%	≥80%	-	-
48	Performance in delivering clinical trials				23%	23%	35%	21%	21%	23%	21%	24%	27%	27%	44%	47%	≥80%	-	-
49	Proportion of sponsored studies open/on track				81%	82%	84%	87%	87%	87%	88%	90%	88%	87%	87%	85%	≥80%	-	-

Local Integration		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
50	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	223	-
51	Emergency Department activity - type 1 This year vs. last year																-	140,641	-
52	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	31.0%	≥25%
52 - Moved to report month in arrears due to known late data entry issues impacting DQ of latest month																			

Digital		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
53	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)			238521												283682	-	283,682	-
54	My Medical Record - UHS patient logins (number of logins made within each month)			39153												38310	-	443,460	-
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		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
57	Percentage of over 65s attending emergency departments to be admitted																-	44.5%	-
58	Percentage of under 18s attending emergency departments to be admitted																-	11.7%	-

University Hospital Southampton
NHS Foundation Trust

Agenda Item 5.8	Report to the Trust Board of Directors, 14 May 2026
Title:	Finance Report 2025-26 Month 12
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 March report are as follows:

- The Trust has reported a £0.1m deficit in M11 (£45.0m deficit YTD). This is in line with the updated Financial Recovery Plan trajectory for M12, targeting an improved year-end position of £45.0m deficit.
- The Trust originally submitted a full year plan to achieve a breakeven position. The forecast is therefore £45.0m adverse to plan.
- The M12 near breakeven position predominantly results from two one-off non-recurring income flows including £2.9m from updating the income calculations for consumed stock which was no longer deferred and £1.3m elective sprint funding. There was also a utilities benefit (lower usage due to a milder Winter).
- The Trust continues to recover from a major incident of a fire in the west wing of the hospital. This has had a major operational impact on the Trust, with the loss of 7 endoscopy rooms and significant loss of bed capacity (currently c. 140). To date £0.9m expenditure has been incurred, fully covered by the receipt of insurance claim funding. The assessment of the total losses remains open.
- The underlying deficit has marginally worsened to £5.3m in M12, compared to a restated £5.1m in M11, albeit noting that February had distorted costs due to the fire, whilst March sees higher bank usage as substantive staff look to take their remaining leave. Underlying deficit drivers remain consistent, namely demand exceeding block funded levels of activity, NCTR patients increasing and MH patient costs.
- WTEs continue to be on a downward trajectory overall yet increased by 133 in M12 to 13,240. Bank and agency costs increased by £0.9m with substantive costs increased by £0.5m.
- Whilst the trajectory is improving overall, it has not been at the pace required to deliver the original plan. Cost improvements have been offset by other pressures.
- UHS continues to deliver significant levels of financial savings, £8.7m has been achieved in M12 and £95.1m YTD. This is however £14.6m behind plan. Transformation programmes centred around patient flow, theatre optimisation and outpatients remain core to this.
- Cash has increased by £15.7m to £45.8m in month. However, despite this the underlying cash position remains a significant risk to the Trust.

Contents:

Finance Report.

Risk(s):

5a

Equality Impact Consideration:	N/A

University Hospital Southampton
NHS Foundation Trust

UHS Finance Report – M12

Financial Position

In M12, the Trust reported a £0.1m deficit, £5.6m adverse to the annual plan. The Trust's underlying position had a marginal deterioration, to £5.3m deficit (when compared to the restated M11 position of £5.1m). The YTD position is now £45.0m which is consistent with the updated financial recovery plan trajectory.

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

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 deteriorated – noting improvements have been seen in the response to the fire.
    - MH has not improved.
    - The Trust has faced significant operational pressures, with increased demand, and periods where additional ward and surge bed capacity has been open
    - New unexpected pressures have materialised, including 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 reduction 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 additional recruitment controls, MARS programmes and divisional restructure.
- In M12 we have reported a £0.1m deficit (£5.6m adverse variance to plan). The near breakeven position predominantly results from two one-off non-recurring income flows including £2.9m from updating the income calculations for consumed stock which was no longer deferred and £1.3m elective sprint funding. There was also a utilities benefit from lower usage due to a milder Winter.

- Due to specific areas of operational pressure and clinical risk, outsourcing expenditure is £5.9m adverse to plan at M12, driven by Cardiac and Dermatology activity. This is partially driving the ERF overperformance outlined above. In addition, activity has commenced for Orthopaedics, Gynaecology and Surgery to target the 65 week wait lists and improve on RTT (£0.3m in M12, £1.3m YTD).
- CIP is reporting below plan by £14.6m YTD to M12 with achievement of £95.1m reported. There is however an underachievement of £24.6m on recurrent CIP offset by an overachievement of £10.0m on non-recurrent CIP.
- The Trust is working hard to improve its financial recovery, with robust governance including the 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 has been above optimal levels.
- A further challenge is the number of Mental Health patients attending the Trust. This creates a significant additional cost, including utilising specialist agency to ensure we have sufficiently skilled staff capacity to care for these patients safely often including additional security costs.
- The Trust remains committed to delivering significant financial improvements in-year; however, it remains an extremely challenging position, and we are unable to continue to absorb additional cost pressures.
- The fire major incident in the Endoscopy suite on 1 February has significantly impacted the financial position. Although some areas of expenditure did reduce, this was already expected due to February being a shorter month and the normal ebbs and flows of costs. Conversations with the insurers continue as loss adjusters survey the site. The finance teams remain vigilant to capture all fire related costs for insurance claim purposes, to date this is £0.9m which have been offset with assumed insurance funding. This excludes any income losses that are still being assessed.

Financial Improvement - CIP

The Trust continues to target month on month financial improvement from its savings and transformation programmes. Key highlights for M12 include the following:

- UHS has delivered £8.7m (>7% of addressable spend) of CIP in M12, which is £4.3m below the 25/26 plan. This brings the YTD achievement of CIP under plan by £14.6m with £95.1m delivered against a target of £109.7m.
- Workforce controls continued to be enacted, including limits on the number of joiners able to start each month. The Trust is £23.8m adverse to the pay expenditure plan for the full year but has delivered additional workforce savings month on month.
- UHS is currently utilising agency for just 0.2% of the total workforce, significantly below the national target. Just 31 agency WTE were utilised in month mainly relating to the support of mental health patients.
- The Financial Improvement Group is established and meeting weekly. This group has approved initiatives across a number of different programmes and projects all targeting sustainable cost reductions and increased efficiency.

Workforce Expenditure

There has been an increase in the total workforce of 133 WTEs in March; workforce numbers are below average levels seen in 24/25 and strict workforce controls continue to be in place. The increase was notable in bank of 167, which is an annual trend, due to substantive staff taking remaining annual leave before the end of the financial year. Substantive staff reduced by 41 in March.

Total pay increased by £3.5m to £72.6m in month, with an increase in substantive, bank and agency costs. The normalised monthly increase is £1.4m after taking out the impact of the annual leave accrual, which is updated annually. Bank costs increased by £0.8m to £4.4m, the highest amount seen all year as a result of the annual leave cover for clinical staff noted above. Agency costs returned to normalised levels and increased by £0.1m. The pay award has been fully accounted for, generating a full year pressure of £2.4m 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. Expenditure for the year is £47.9m which is slightly over the target, predominantly due to pay inflation which was set at 2% in plan and was paid at 3.6% (accounting for £0.5m of the increase).

Capital

In summary the Trust:

- Delivered the internal CDEL plan in full (including receipt of an additional £1.75m in March) – £32m
- Delivered the external CDEL plan in full - £37m
- Total expenditure for the year - £69m.

Slippage across strategic maintenance and Community Diagnostics Centre schemes has been offset by bringing forward planned schemes from future years.

Report To	Board meeting in Public		
Title of Paper	System Report 2025/26 (Month 12)		
Purpose of Paper	For information	**Date of Meeting**	6 May 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	28 April 2026	For information
Future Discussion		
Meeting Name	**Meeting Date**	**Recommendations/Comments**
	Click or tap to enter a date.	

Executive Summary

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

Please note that Month 12 (M12) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 11 (M11), with some exceptions depending on reporting frequency.

Performance Overview

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

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M12)
- Access to Children and Young People's Mental Health Services (M11)
- Average length of stay for Adult Acute Beds (Mental Health) (M11)
- Adults in inpatient care who are autistic, with no learning disability (M11)
- Adults in inpatient care with a learning disability (who may also be autistic) (M11)
- Children in inpatient care who are autistic, have a learning disability or both (M11)
- Diagnostic 6 week waits (9 key tests) (M11)
- Cancer 28 day faster diagnosis (M11)
- Cancer 62 day referral to treatment (M11)
- Time to First Appointment (M12) – *unvalidated*
- RTT 52 week waits (M11)
- RTT waiting list within 18 weeks (M11)
- % of attendances in A&E over 12 hours (M12)

Quality Overview

Quality overview can be found on pages: 9-18

Financial Overview

The purpose of the Month 12 (M12) System Report for Hampshire & Isle of Wight Integrated Care System is to provide details of the financial position for the System as at the end of the 2025-26 financial year.

The System position in month 12 is a deficit of £2.89m compared to a planned surplus of £9.80m, so £12.69m adverse variance to plan in-month.

The System is reporting a final year end position of a deficit £81.43m, compared to a planned year-to-date surplus of £0.47m, so an £81.90m adverse variance to plan at financial year end. This is marginally better than the System Forecast Out Turn reported at M11.

The System submitted a £0.468m surplus plan for 2025/26. This included £63.16m of Deficit Support Funding (DSF). At M12 the System received £44.02m of DSF, with £19.14m withheld by NHS England due to the systems financial performance. This is a component part of the deterioration in the system forecast reported this year.

Workforce Insights

Please note: Hampshire Hospital Foundation Trust was unable to submit its Month 12 Provider Workforce Return to NHS England and is therefore omitted from this report's Plan and Actual Whole Time Equivalent performance.

- Total Workforce: 40,464 WTE, which is 1,201 WTE worse than nationally submitted plan. Compared to February 2026, the system saw an increase of 301 WTE. *(Excluding Hampshire Hospital Foundation Trust from System Totals)*
- All Trusts are worse than plan: HIOWH (43 WTE), IOW (155 WTE), PHU (397 WTE), SCAS (69 WTE), UHS (538 WTE).
- Substantive: 501 WTE worse than plan.
- Bank: 673 WTE worse than plan.
- Agency: 27 WTE worse than plan.
- Compared to March 2025 baselines in submitted Planning templates:
    - Total Workforce: Reduced by 983 WTE.
    - Substantive: Reduced by 1,045 WTE.
    - Bank: Reduced by 148 WTE.
    - Agency: Reduced by 86 WTE.

Workforce performance and assurance has moved to NHS England from 1 April 2026. HIOW ICB are working closely with NHS SE Regional team during this transitional period.
This will be the last System Level Workforce Performance Report to close out 25/26. Regional Level reporting for workforce will be available going forward**.**

Strategic Integrated Commissioning and Better Care Fund (BCF) Monthly Update
BCF update can be found on pages: 22-27.

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

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M12)** – % 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 to 22.7% (compared to 21.4% in M11).

- **Access to Children and Young People's Mental Health Services (M11)** – – below M11 plan with 25,015 vs 25,539 target, improvement on M10. The known data quality issue with a new Provider has been resolved and analysis is underway to determine where we are seeing under performance against planned figures with other Providers, and where existing data quality issues may still be affecting the rate.

- **Average length of stay for Adult Acute Beds (Mental Health) (M11)** – Performance in M11 shows an improvement on previous month but remains above plan (e.g. not achieving plan) with 54 days vs 49 plan.

- **Adults in inpatient care who are autistic, with no learning disability (M11)** – Performance in M11 remains above plan (29 vs 22 plan), but improvement was seen in month. 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 with a learning disability (who may also be autistic) (M11)** – Performance in M11 has deteriorated and remains above plan (37 vs 26 plan) – the gap has widened further against a reduced plan.

- **Children in inpatient care who are autistic, have a learning disability or both (M11)** – Performance in M11 is above plan (8 vs 5 plan) – first increase seen following improved or sustained performance against plan over seven consecutive months.

- **Diagnostic 6 week waits (9 key tests) (M11)** – Performance in M11 shows 5% improvement on previous month for the diagnostic 9 key tests, achieving the in-month operating plan of 25.58%. Total diagnostic activity decreased in month and remains relatively on plan (only 2 above target).

- **Cancer 28 day faster diagnosis (M11)** – Performance in M11 improved and is 1.68% below plan at 78.9%. Performance is 1.6% below national average of 80.5%, and NHS Hampshire and Isle of Wight rank 29 of 42 systems nationally (interquartile).

- **Cancer 62 day referral to treatment (M11)** – Performance in M11 improved marginally to 69.8% (compared to 69.5% in M10) and remains 5.9% below in-month plan. Although NHS Hampshire and Isle of Wight is below plan, performance is above national average of 68.6% and rank 15 of 42 systems nationally (highest quartile).

- **Time to First Appointment (M12) – *unvalidated*** – Latest M12 position shows NHS Hampshire and Isle of Wight is 2.7% below plan, however, this is based on unvalidated data and is subject to change. M11 was 8.1% below plan.

- **RTT 52 week waits (M11)** – In M11, 4,637 patients are waiting over 52 weeks, representing a decrease on M10 (4,835) but not achieving plan.

- **RTT waiting list within 18 weeks (M11)** – Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has improved marginally to 60.7% in M11 (compared to 60.0% previous month) – not achieving in-month plan by 3.8%.

- **% of attendances in A&E over 12 hours (M12)** – Waits from decision to admit (DTA) decreased in M12 to 1,121 (compared to 1,226 previous month) and % over 12 hours from arrival decreased in M12 to 4.8% above M12 plan (e.g. not 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) (M6)** – latest published position for September 2025 shows 67.19% vs 70.5% local target (national target is 77%), representing a 2.74% increase on the September 2024 position. National average is 68.71%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased since September and there is now a difference of 5% between NHS Hampshire and Isle of Wight and the top performing ICB (North East and North Cumbria), with NHS Hampshire and Isle of Wight ranking 31 out of 42 systems, improving from a position of 4th worst nationally / historically. There has been consistent improvement in performance since March 2022. In terms of local data, the latest position in February 2026 shows an improving position to 72.22% in relation to the blood pressure treated to target measure, the highest percentage achieved to date.
- **% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy (CVDP003CHOL) (M6)** – latest published position for September 2025 shows 58.81% vs 60% national target, representing a 3.03% increase on September 2024 position. National average is 64.10%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased and there is now a difference of 10.94% between NHS Hampshire and Isle of Wight and the top performing ICB (South Yorkshire), with NHS Hampshire and Isle of Wight ranking worse nationally.
- **% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance (CVDP012CHOL) (M6)** – latest published position for September 2025 shows 47.17% vs 65% national target. National average is 49.00%. NHS Hampshire and Isle of Wight ranking 27 out of 42 systems.

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

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M12)** – NHS Hampshire and Isle of Wight are ranked 40 out of 42 Integrated Care Boards for their March performance with 669 patients with no CTR as at 12 April 2026, which is 23.00% of total G&A beds available (Lowest quartile)
- **Access to Children and Young People's Mental Health Services (M11)** – NHS Hampshire and Isle of Wight are ranked 11 out of 42 Integrated Care Boards for Febraury 2026 data (Interquartile)

- **Diagnostic 6 week waits (9 key tests) (M11)** NHS Hampshire and Isle of Wight are ranked 31 out of 42 Integrated Care Boards for their February performance with 25.9% (Interquartile)
  The National average is 20.20%.

- **Cancer 28 day faster diagnosis (M11)**, NHS Hampshire and Isle of Wight are ranked 29 out of 42 Integrated Care Boards for their February performance with 78.9% (Interquartile)
  The National average 80.5%

- **Cancer 62 day referral to treatment (M11)**, NHS Hampshire and Isle of Wight are ranked 15 out of 42 Integrated Care Boards for their February performance with 69.8%. (Interquartile)
  The National average is 68.6%

- **RTT 52 week waits (M11)** – NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their February performance with 2.4% (Lowest quartile)
  The National average is 2.1%

- **RTT waiting list within 18 weeks (M11)** – NHS Hampshire and Isle of Wight are ranked 29 out of 42 Integrated Care Boards for their January performance with 60.7% (Interquartile)
  The National average is 61.5%

- **% of attendances in A&E over 12 hours (M12)** – NHS Hampshire and Isle of Wight are ranked 13 out of 42 Integrated Care Boards for their February performance with 7.7% (Interquartile)
  The National Average is 9%

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. Data tables have been included within the report to highlight latest quality performance data.

North East Hampshire transferred to NHS Hampshire and Isle of Wight on 1 April 2026. As part of the transfer of quality, complaints and Learning from Lives and Deaths – people with a learning disability and autistic people (LeDeR) - no quality issues were raised, and no issues of concern were escalated. Four complaints were transferred and five LeDeR reviews. A comprehensive primary care handover was provided. Safeguarding and All Age Continuing Care already covered North East Hampshire

3.1 Regulatory

3.1.1 Care Quality Commission – General Practice: the table below shows the Care Quality Commission inspection **March 2026** overall ratings:

CQC Rating	GP Practices	Details & Date CQC Rating Published
Unrated	2	Eastleigh Medical Practice (Merger of Archers and Parkside) Medina Healthcare (previously Wooton Bridge)
Outstanding	1	Swan Medical Group (April 2020)
Good	122	As per published ratings on CQC website
Requires Improvement	3	Gudge Heath Lane Surgery (November 2025) Emsworth Medical Practice (January 2026) Tower House Surgery (December 2025)

Of the 14 Practices from North Hampshire - all the Practices are rated Good and these will be included in the April 2026 data.

3.1.2 Care Quality Commission dental practices: the Care Quality Commission inspects dental practices on a risk-based basis, including in response to complaints or concerns. It aims to review 10% of practices annually, prioritising those not inspected for over 10 years.

The Care Quality Commission notifies the South East Commissioning Hub of enforcement action and publishes compliance outcomes. Non-compliant providers are expected to receive a follow-up inspection within 12 months. The table below shows all three dental contracts whose Care Quality Commission publication date was in February as being complaint.

Dental Contractor	Current CQC Publication Date	Previous CQC Inspection	
Thornhill Dental Surgery P Manek SO196HQ	17 February 2026: **Compliant**	**02 April 2014** **Compliant**	➡
The Dental Practice Polygon I Rhee and H Rhee SO15 2GD	20 February 2026: **Compliant**	**17 December 2025** **Non complaint** **Well-led**	⬆
Thornhill Dental Surgery S Khanna SO196HQ	17 February 2026: **Compliant**	**02 April 2014** **Compliant**	➡

3.1.3 Care Quality Commission - large system Trusts:

- Hampshire and Isle of Wight Community Healthcare NHS Foundation Trust – following the Care Quality Commission inspections in September and October 2025:
    - the **community-based mental health services** achieved an overall rating of Requires Improvement and received nine breaches of regulation. It received Good in the caring domain and Requires Improvement in the other domains
    - the **urgent treatment centre** achieved an overall rating of Good and Good in all domains
    - the **Child and adolescent mental health wards** achieved an overall rating of Good and Good in all domains.

- **South Central Ambulance Service NHS Foundation Trust – well-led inspection:** the Trust are awaiting the outcome of their Well-Led inspection. Despite improvements in Care Quality Commission ratings in individual areas recently, their overall rating will not change until this has been published.
- **Isle of Wight NHS Trust - Ambulance Service – inspection:** the Trust received an unannounced Care Quality Commission inspection on 24 February 2026. The outcome remains awaited.
- **Isle of Wight NHS Trust - unannounced Inspection:** on 10 February 2026, the Care Quality commission commenced an unannounced inspection of their Emergency Department and Urgent and Emergency Care. The formal report awaited.
- **University Hospital Southampton NHS Foundation Trust - unannounced and well-led inspection:** as previously reported, the Care Quality commission undertook a two-day inspection at University Hospital Southampton NHS Trust on the 25 and 26 November 2025. The focus of the visit was the Children and Young People's Service, Learning Difficulties and End of Life care. Feedback from the visit is awaited.
    - **Portsmouth Hospitals University Trust – unannounced inspection:** on the 17 February the Care Quality Commission commenced a two-day

inspection of maternity services at the Queen Alexandra Hospital. Feedback from the visit is awaited.

3.1.4 Quality Assurance and Improvement Surveillance Levels: all the large Hampshire and Isle of Wight NHS providers remain in routine quality assurance and improvement surveillance levels apart from University Hospitals Southampton NHS Foundation Trust who would move to enhanced surveillance for the number of Never Events reported over a two-year period (all other areas for the Trust remain in routine surveillance). The enhanced surveillance supports the Trust's improvement plan and the assurances required on embedding of the learning.

3.2 Patient and Staff Experience

3.2.1 Friends and Family Test – February 2026: overall, Hampshire and Isle of Wight Friends and Family performance remains positive. From an Integrated Care Board (ICB) perspective, all areas apart from maternity (postnatal community) performed above or the same as the national rate for positive responses. Areas to note include:

Friends and Family Test – February 2026: overall, Hampshire and Isle of Wight Friends and Family performance remains positive. From an Integrated Care Board (ICB) perspective, all areas apart from maternity (postnatal community) performed above or the same as the national rate for positive responses. Areas to note include:

- **General Practice:** positive feedback (93%) in February 2026 remained just higher than the national rate (92%) and the same as the regional rate. Negative feedback was 4%, the same as the national rate but slightly worse than the regional rate (3%)
- **Dental:** positive feedback (96%) highlighted performance as lower than national (97%) and regional (98%) rates. Negative feedback performance was lower than the previous month at 1% the same as both the national and regional rate, reflecting an improved position
- **Ambulance:** both ambulance providers received 17 responses in February 2026, the Isle of Wight NHS Trust ambulance service achieved 100% positive feedback. South Central Ambulance Service NHS Trust achieved 88% positive performance (better than the national rate of 87%) and 6% negative feedback (just better than the national rate of 7%), however, none of the feedback related to NHS Hampshire and Isle of Wight population
- **Acute providers:** system performance remained better than the national positive feedback performance for the month in all areas except postnatal community.

Key areas to note:

  - **Emergency Department:** negative performance at Hampshire Hospitals NHS Foundation Trust (14%) was the same as the

national rate (15%) with positive performance (78%) slightly worse (79%). Of the three sites, Basingstoke and North Hampshire Hospital performed the worst with negative feedback (18%)

The Isle of Wight NHS Trust performed better than the ICB and national rate for both positive and negative feedback – achieving 90% positive results.

- **Inpatients:** negative (5%) and positive feedback (92%) performance for Portsmouth Hospitals University NHS Trust continued to be worse than the national rate. All other Trusts performed better or the same as the national rates
- **Outpatients:** all providers are performing better or the same as the national rates
- **Maternity:** antenatal care at Portsmouth Hospitals University NHS Trust continued to see performance worse than the national rate in both positive and negative feedback. UHS' postnatal ward and community positive and negative feedback was lower than the national rate

- **Mental Health:** latest performance continues to show Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust performing worse than the national rate for positive and negative feedback. It should be noted that the number of responses for each area was low, ranging from 2 – 36. Acute services, Child and Adolescent Mental Health Services, primary care and 'other' did not receive any negative feedback and positive feedback ranged from 90 – 100%. Areas with particularly high levels of negative feedback were:
  - Secondary care community services – 14% negative feedback (29 responses)
  - Specialist services – 14% (36 responses)

- **Community:** community (physical) services at Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust performed better than the national rate for both positive and negative feedback. When analysed by area, Community Healthcare 'other' performed below the national positive rate with 60% positive feedback and 13% negative feedback from 15 responses.

  As part of Schedule 6D in the contract, providers are required to share themes from their Friends and Family Test feedback narrative on a quarterly basis, along with action taken in response and detail of how insights from previous feedback has been used to improve service accessibility and address and health inequalities identified (where relevant). Narrative feedback will be reviewed in July 2026.

  NHS National Staff survey results: the results of the 2025 NHS Staff Survey were published on 12 March 2026 covering data collected between 23 September to 28 November 2025. Providers are in the process of reviewing their data and, as per the contract, will share their improvement plans with commissioners once developed.

Patient-Led assessment of Care Environments (PLACE) 2025 Survey results: the results of the 2025 PLACE survey provide a comprehensive overview of environmental standards and patient experience across Portsmouth Hospitals University NHS Trust, University Hospital Southampton NHS Foundation Trust, Hampshire Hospitals NHS Foundation Trust, and Isle of Wight NHS Trust, benchmarked against national performance.

Overall, system performance is strong in the domains of *cleanliness and condition*, *appearance and maintenance*, with results broadly aligned to, or exceeding, national averages. Greater variation is observed in *food, privacy, dignity* and *wellbeing*, *dementia-friendly design*, and *accessibility for disabilities*, indicating areas where further improvement is required

Key strengths include:

- consistently high *cleanliness* scores across all organisations (97% and above), closely aligned with the national average of 98.55%, demonstrating robust hygiene and cleaning arrangements.
- *condition, appearance and maintenance* is also positive, with Portsmouth Hospitals University NHS Trust and Isle of Wight NHS Trust exceeding national benchmarks and University Hospitals Southampton NHS Foundation Trust and Hampshire Hospitals NHS Foundation Trust performing close to national averages.

Exceptional performance:

- Hampshire Hospitals NHS Foundation Trust *combined food* score (97.69%), which is significantly above the national average,
- Isle of Wight Trust's strong performance in *dementia-friendly environments* (93.16%) and *disability accessibility* (92.70%), both exceeding national benchmarks.

Best practice will be shared across the system. As part of our quality contract management, Individual provider targeted improvement plans will be monitored by the quality team.

Mixed-Sex Accommodation breaches – February 2026: 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 performance remained better than that of England and the South East Region with a February 2026 breach rate of 1.4 representing an improvement in comparison to the previous month (78 cases).

Mixed sex accommodation (MSA) breach number (breach rate) 2025/2026											
2025/26	Feb	Jan	Dec	Nov	Oct	Sept	Aug	Jul	Jun	May	Apr
University Hospital Southampton NHS Foundation Trust	55 (3.0)	93 (4.6)	99 (5.2)	77 (3.9)	117 (5.7)	73 (3.9)	88 (4.7)	109	120	115	112
Portsmouth Hospitals University NHS Trust	0 (0)	21 (1.2)	0 (0)	8 (0.5)	3 (0.2)	7 (0.4)	0 (0)	12	0	0	16
Isle of Wight NHS Trust	0 (0)	0 (0.0)	1 (0.2)	1 (0.2)	1 (0.2)	1 (0.2)	1 (0.2)	No data	1	0	1
Hampshire Hospitals NHS Foundation Trust	8 (0.6)	6 (0.4)	0 (0)	5 (0.4)	3 (0.2)	2 (0.1)	1 (0.1)	3	3	4	3
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	0 (0)	0 (0.0)	0 (0)	6 (5.9)	2 (1.7)	2 (2.0)	0 (0)	No data	0	0	0

Mixed Sex Accommodation (MSA) reporting across Hampshire and the Isle of Wight in 2025/26 demonstrates marked variation between providers. University Hospital Southampton NHS Foundation Trust continues to account for the majority of reported breaches (55–120 per month), reflecting sustained flow pressures and capacity constraints, however, this month represented the lowest number (55) reported since April 2025.

Portsmouth Hospitals University, Isle of Wight NHS Trust and Hampshire and Isle of Wight Community Healthcare NHS Foundation Trust reported no breaches.

Further assurance is required in relation to corridor care in ward areas and use of escalation spaces and the impact on mixed sex accommodation breaches. This is being explored directly with the relevant providers and, where relevant, escalated via the Contract Review Meeting.

NHS Hampshire and Isle of Wight – primary care complaints backlog: at the time of reporting, the backlog of 212 complaints transferred on 1 February 2025 from the South East Complaints Hub remains at 17 open cases. Plans are in place to close these remaining cases.

NHS Hampshire and Isle of Wight – Patient Experience Team activity: during March 2026, the Patient Experience team received 371 new contacts (February 373, January 389, December 330).

The team continues to receive contacts regarding:

- procedures of Limited Clinical Value (PLCV)
- waiting times for attention deficit hyperactivity disorder (ADHD)/autism assessment following Indicative Activity Plan for Right to Choose
- continued delays in starting the new paediatric continence service
- about medicines management withdrawal, restriction or denial of prescribed medication - various issues
- dental access - patients unable to register with an NHS dentist
- access to GP appointments and patient care.

3.3 Safety

3.3.1 Infection Prevention and Control – March 2026: the latest Infection Prevention and Control data for Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection, Clostridioides difficile infections and Escherichia coli bloodstream infections is shown in the table below and shows that the 2025/26 performance trajectories have been exceeded.

March 2026:		
Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection		
Number of cases reported in month	Total number of cases financial year to the end of January 2026	Performance against 2025/26 trajectory
0	25*	Annual trajectory is zero cases
Clostridioides difficile infections		
Number of cases reported in month	Total number of cases financial year to date	Performance against 2025/26 trajectory
48	586 (+65)	586/521
Escherichia coli (E. coli) bloodstream infections		
Number of cases reported in month	Total number of cases financial year to date	Performance against 2025/26 trajectory
116	1480 (+230)	1480/1250

***Plus one out of area MRSA BSI Hospital Onset Hospital Acquired identified at University Hospitals Southampton NHS Foundation Trust which is still under investigation*

Performance by Trust is shown in the table below:

Running total 2025/26 (March 2026) +/- end of year position against annual threshold	HHFT	UHS	PHU	IOW	ICB	Target
Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection	2 (0)	8 (0)	8 (0)	3 (0)	25 (0)	Zero
Clostridium difficile infections	65 (4) +20	98 (3) -1	99 (12) -5	58 (3) -4	586 (48) +65	Based on trajectories for 2025/26.
Escherichia coli (E. coli) bloodstream infections	105 (10) +27	145 (4) +4	170 (17) +29	63 (6) +18	1480 (116) +230	
Klebsiella spp BSI	34 (2) +5	52 (4) -4	61 (6) +19	16 (0) +5	429 (41) +75	
Pseudomonas aeruginosa BSI	10 (0) =	28 (1) +5	19 (2) -6	9 (2) =	154 (12) +25	
MSSA BSI	40 (2)	62 (4)	69 (8)	24 (2)	422 (28)	No threshold

HHFT – Hampshire Hospitals NHS Foundation Trust; UHS – University Hospital Southampton NHS Foundation Trust; PHU – Portsmouth Hospitals University NHS Trust; IOW – Isle of Wight Trust; ICB – NHS Hampshire and Isle of Wight.

3.4.2 Never Events: during 2025/26, 25 Never Events were reported, 24 of which occurred during the financial year. As previously reported, all providers have been focusing on embedding National Safety Standards for Invasive Procedures (NatSSIPs) as part of their local quality indicator contractual requirements. There were no Never Events reported during March 2026.

2025/26 summary - in comparison to the previous year (2024/25) – key messages include:

- **Surgical never events**: an improved position with one less case reported in comparison to the previous year (20 cases 2025/26)
    - retained foreign objects: reduction of 5 (improvement)
    - wrong site surgery case (including blocks): an increase of 3 (worsening position)
    - highest reporters of surgical Never Events occurring this financial year:
        - University Hospitals Southampton NHS Foundation Trust (7) and
        - Portsmouth Hospitals University Trust (6)

- **Medication never events:** a worsening position with one extra case reported in comparison to the previous year (3 cases 2025/26)
    - wrong route: static performance (2 cases)
    - overdose insulin: decline (1 case)
    - Reporters of medication Never Events occurring this financial year:
        - Hampshire and Isle of Wight Healthcare NHS Foundation Trust (2)
        - University Hospitals Southampton NHS Foundation Trust (1).

- There was one ABO Incompatible transfusion of red cells occurring at Portsmouth Hospitals University NHS Trust

- Maternity never events:
    - no maternity related Never Events occurred during 2025/26, representing an improvement in comparison to the previous year when three were reported.

University Hospital Southampton: a peer review visit at University Hospital Southampton is took place on 16 April 2026 and included representatives from NHS Hampshire and Isle of Wight quality team, Health Innovation Wessex and Portsmouth Hospitals University Trust. The team visited obstetrics, dermatology, main theatres and ophthalmology. Feedback was given to the Trust's Acting Chief Nursing Officer and Chief Medical Officer after the visit and will form part of the assurance in relation to their enhanced quality support and improvement level for Never Events.

The Trusts' Qtr. 3, 2025/26 report highlighted that 2273 staff (increase from 1255 in July) had completed "stop points" training. The ophthalmology team had run a study morning for all theatre, outpatient and clinical staff covering team working, civility save lives and National Safety Standards for Invasive Procedures (NatSSIPs) updates in January 2026. A National Safety Standards for Invasive Procedures (NatSSIPs) observational audit was trailed in January – February 2026. A patient involvement workstream is now established with plan to hold a focus group with patients in March/April 2026.

During 2026/27, the provider contracts require them to share a report which includes:

- the number of Never Events reported (with brief detail)
- the outcome of provider audits with the National Safety Standards for Invasive Procedures and associated actions following a review of the results.
- Invasive procedures metrics
- provider assurance levels that National Safety Standards for Invasive Procedures are fully embedded by 2026/27 – evidence of agreement by Executive patient safety lead
- detail of actions being taken in cases where there is not full assurance that standards are being met evidence of Board awareness of areas of non-compliance.

3.5 Clinical Effectiveness

3.5.1 Fractured Neck of Femur Best Practice Tarriff – February 2026: the Best Practice Tariff percentages show much of provider care delivered meets nationally agreed standards. Higher percentages assure that patients are more likely to receive care aligned with best outcomes.

Across the system, performance remains mixed with significant variation between Trusts, but improvements have been seen in a number of areas. In February 2026, all Trusts, apart from the Isle of Wight Trust have seen an improvement in care that meets the Best Practice Tarriff and two Trusts – Hampshire Hospitals NHS Foundation Trust and Portsmouth Hospitals University NHS Trust saw performance exceed that of the England compliance.

Fractured Neck of Femur (# NOF) Best Practice Tarriff: February 2026	England (only – not all)	University Hospital Southampton NHS Foundation Trust	Portsmouth Hospitals University NHS Trust	Isle of Wight NHS Trust	Hampshire Hospitals NHS Foundation Trust
Care that meets best practice criteria	53.2 %↑	8.8% ↑	81.7% ↑	0% ↔	58.6% ↑
Prompt surgery	63.5% ↑	26.5% ↑	81.7% ↑	0% ↓	62.1% ↑
Orthogeriatric assessment	92.4% ↑	97.1% ↑	98.3% ↑	0% ↔	89.7% ↑
Nutritional assessment	97.2% ↑	100% ↑	100% ↔	0% ↓	100% ↑
Delirium assessment	94.3% ↑	50.0% ↑	100% ↔	0% ↔	100% ↑
Physiotherapy assessment	97.1% ↑	64.7% ↓	100% ↔	0% ↓	96.6%↑

Isle of Wight Trust reported 0% across all areas in February 2026 – this will be followed up with the Trust to see if this is a data reporting issue or performance issue.

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

3.5.2 Summary Hospital Mortality Indicator (SHMI): SHMI is the ratio between the actual number of patients who die following hospitalisation at a Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes

deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge.

Summary Hospital-Level Mortality Indicator (SHMI): latest data		
December 2024 – 30 November 2025	Value	Banding
University Hospital Southampton NHS Foundation Trust	0.8349	3
Portsmouth Hospitals University NHS Trust	0.9673	2
Isle of Wight NHS Trust	0.8939	2
Hampshire Hospitals NHS Foundation Trust	0.8717	2

The latest data (up to 30 November 2025) published in April 2026 shows that no Hampshire and Isle of Wight provider had a higher-than-expected observed number of deaths within 30 days of discharge from hospital.

The SHMI guidance continues to highlight that there is a high percentage of invalid diagnosis codes for Portsmouth Hospitals University NHS Trust and therefore values from the Trust should be interpreted with caution. Following an escalation at the Contract Review Meeting, the Trust were required to share an update on their coding and the impact on SHMI data by 15 April 2026. A review has found that Same Day Emergency Care coding had caused an issue, but coding improvements have been seen, however, further improvements are required. The Trust will be providing assurances at the May 2026 Contract Review Meeting regarding their other mortality data.

3.5.3 NHS Resolution: Maternity Incentive Scheme Year 7 - NHS Resolution Safety Standards: the Local Maternity and Neonatal System completed the Year 7 evidence review for the NHS Resolution Maternity Incentive Scheme (MIS). The review supported the overall assurance position reported to the Hampshire and Isle of Wight Integrated Care Boards Public Board on 4 February 2026.

NHS Resolution has formally confirmed that all four Hampshire and Isle of Wight maternity and neonatal services have successfully achieved all 10 Safety Standards for Year 7. This represents the fourth consecutive year across Hampshire and Isle of Wight in achieving full compliance.

3.6 Quality and Equality 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 March 2026, one Quality Impact Assessments was moved from the NHS Hampshire and Isle of Wight panel to the next stage of decision-making.

4. Integrated Care System Financial Overview

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.

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

The final plan for 2025/26 included £63.2m of non-recurrent Deficit Support Funding. Since completion of the 2025/26 planning round, NHS England announced during the year 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 was compliant with national expectations.

The Hampshire and Isle of Wight system received Q1 and Q2 Deficit Support Funding (M1 to M6). Deficit Support Funding for the period (M7 to M12) had previously been communicated as being withheld in full by NHS England. However, at M11 £8.18m was released to the System.

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

Following the movement in forecast at M10 to a deficit £89.71m, the System had assumed no further DSF would be received in 2025-26 financial year. However, in M11 the System received £8.18m of previously held back DSF from NHS England resulting in an improvement to the year-end forecast, moving to a reported £81.54m deficit.

4.1 Financial Position

Table 2 below summarises the in-month and final year-end financial outturn as at Month 12 (March) for all Hampshire and Isle of Wight organisations:

	Surplus / (Deficit) - Financial Position							
	In Month			Year to date / Forecast Outturn			Expected Forecast	
Organisation	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD / FOT Plan £'000	YTD / FOT Actual £'000	YTD / FOT Variance £'000	Expected FOT £'000	Variance FOT £'000
Hampshire and Isle of Wight ICS Total	9,802	(2,888)	(12,690)	468	(81,429)	(81,897)	(81,524)	95

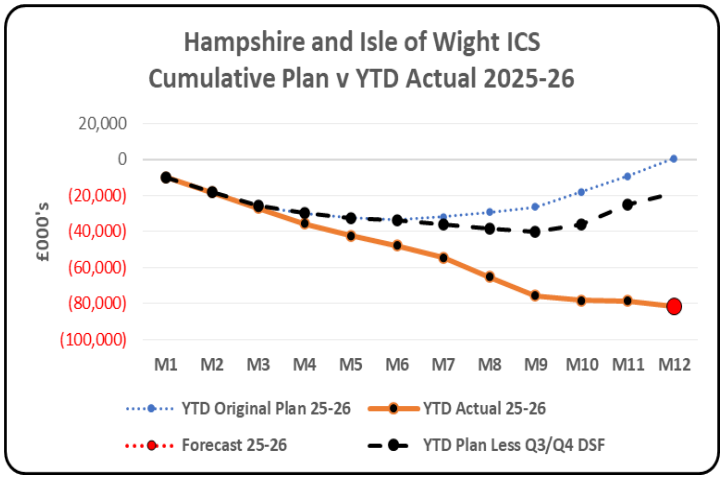
In March 2026 itself, the Integrated Care System (ICS) reported a deficit of £2.89m against a planned surplus of £9.80m, so a £12.69m adverse variance to plan. Year-to-date the system has reported a deficit of £81.43m at Month 12 compared to a planned surplus of £0.47m, therefore an £81.90m adverse variance to plan.

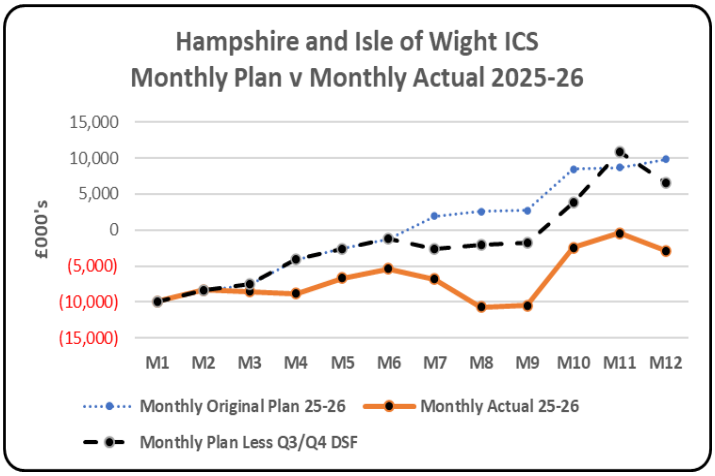
Following the movement in forecast at M10 (January) and further movements in M11 (February) the expected year end position was a deficit £81.54m, the ICS finished the financial year on a deficit 81.43m so marginally better than forecast by £0.09m.

Of the £81.43m deficit reported at year end, £19.14m relates to withheld Deficit Support Funding.

The graphs below summarise the ICS position reported at month 12 (March) 2025/26.

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





4.2 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 remained extant in 2025/26.

Our 2025/26 plan included 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 12 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- *Please note: Hampshire Hospital Foundation Trust was unable to submit its Month 12 Provider Workforce Return to NHS England and is therefore omitted from this report's Plan and Actual Whole Time Equivalent performance.*
- Hampshire & Isle of Wight system is worse than plan by 1,201 WTE in Month 12 2025/26, broken down by Substantive (501 WTE), Bank (673 WTE) and Agency (27 WTE).
- Compared to the previous month (February 2026), the system has seen an overall increase of 301 WTE.
- All Trusts are reporting performance worse than plan: University Hospital Southampton (538 WTE), Portsmouth Hospitals University (397 WTE), Isle of Wight NHS Trust (155 WTE), and South Central Ambulance Service (69 WTE).

Month 12 - Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- *Please note: Hampshire Hospital Foundation Trust was unable to submit its Month 12 Provider Workforce Return to NHS England and is therefore omitted from this report's Plan and Actual Whole Time Equivalent performance.*
- Hampshire & Isle of Wight system is 501 Substantive whole time equivalent (WTE) worse than plan.
- Trusts worse than plan are University Hospital Southampton (353 WTE), Portsmouth Hospitals University (228 WTE), Isle of Wight (111 WTE) and South Central Ambulance Service (11 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 202 WTE.

Month 12 - Bank & Agency Trajectories – Whole Time Equivalent (excluding Integrated Care Board)

- *Please note: Hampshire Hospital Foundation Trust was unable to submit its Month 12 Provider Workforce Return to NHS England and is therefore omitted from this report's Plan and Actual Whole Time Equivalent performance.*
- In Month 12, Total Temporary staffing (Bank & Agency) usage is 2,469 WTE (17.8%) worse than the plan of 1,769 WTE. Bank use, worse than plan by 673 WTE (42.8%). Agency use is worse than plan by 27 WTE (13.7%).
- All Provider Trusts in Hampshire & Isle of Wight are worse than Temporary Staffing plan. Hampshire Hospitals & University Hospital Southampton show the most significant variation to plan by 245 WTE (42.4%) & 184 WTE (27.6%), respectively.

6. Strategic Integrated Commissioning and Better Care Fund (BCF) Monthly Update – April 2026

6.1. Metrics Update

6.1.1 BCF Performance Summary (Latest Position): [Feb '26; Month 11 local data]

For M11, all four Places met monthly targets for emergency admissions (65+) and the target for long-term care home admissions, reflecting strong prevention and community support. Discharge delays remain a challenge for three of the four Places; the Isle of Wight is on track based on February local data.

Note: Latest position reflects Month 11 (February 2026) local data, with national validated data included where available. National data typically lags by 1–2 months and may not align exactly with local reporting periods. M11 reflects performance against revised Q4 targets.

Metric	Southampton	Hampshire	Isle of Wight	Portsmouth
Emergency admissions to hospital for people aged 65+ per 100,000 population	**Plan:** rate:1955 admissions:695 **Performance** ***Local data:*** rate: 1724 admissions: 613	**Plan:** rate:1580 admissions:5132 **Performance** ***Local data:*** rate: 1335 admissions: 4335	**Plan:** rate:1368.6 admissions:585 **Performance** ***Local data:*** rate: 1335 admissions: 579	**Plan:** rate:1849 admissions:591 **Performance** ***Local data:*** rate:1605 admissions: 513
Average length of discharge delay for all acute adult patients	**Plan:** 1.25 **Performance** ***Local data:*** 1.43	**Plan:** 1.12 **Performance** ***Local data:*** 1.34	**Plan:** 1.46 **Performance** ***Local data:*** 1.27	**Plan:** 1.18 **Performance** ***Local data:*** 1.32
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population	**Q4 plan target:** rate: 140.6 admissions: 50 **Performance** ***Local data:*** rate: 118.12 admissions: 42	**Q4 plan target:** rate: 133.9 admissions: 435 **Performance** ***Local data:*** Unavailable	**Q4 plan target:** rate: 168.4 admissions: 72 **Performance** ***Local data:*** rate: 86.56 admissions: 37	**Q4 plan target:** rate: 178.3 admissions: 57 **Performance** ***Local data:*** rate: 118.89 admissions: 38

Performance Summary	
Southampton	**Avoidable admissions:** Performance remains on track, supported by neighbourhood working, Urgent Community Response and improved emergency department (ED) pathways. The focus was on sustaining gains through winter and embedding consistent delivery at neighbourhood level. **Discharge:** Place-level discharge plans, daily multi-agency grip and shared flow dashboards remain in place, with actions focused on home-first practice, transport optimisation and faster onward care. While the fire at UHS has reduced capacity, the Discharge Group has committed

	to achieving the 0.8 target trajectory by Dec 2026. positioning Southampton to perform ahead of both the peer group and national average. **Overall:** The system shifted from planning to delivery. The priority continues to be focussed on pace, consistency and grip to secure admission avoidance gains and accelerate discharge flow. Delivery is being overseen through Place-level discharge and avoidable admissions improvement plans, with progress and risks reviewed via the Discharge and Admissions Group (DAG).
Hampshire	Local data for February showed that performance for emergency hospital admissions and long-term admissions to residential care and nursing homes was within target and on track. The average length of discharge delay for all acute adult patients was 1.34 days against a plan of 1.12. Persistently high no criteria to reside (NCTR) volumes are continuing to impact overall system flow, particularly at the front door, where timely admission for patients remains challenging and seasonal illness acuity has increased. The local DAG continues to review the improvement plan progress and regular system escalation meetings are in place, with a focus on reviewing discharge performance, addressing barriers, and coordinating actions across the system.
Isle of Wight	**Supporting DRD Metric:** National data for January reflected a continued deterioration in performance, with none of the planned sub-metrics achieved. This position is consistent with national trends and those observed across peer Health & Wellbeing Boards (HWB). The Isle of Wight continued to perform better than the peer average for discharge ready date (DRD) (excluding 0-day delays). Local data for February appears consistent with this trend. During March, mini-MADE events have been delivered, alongside a D2A modelling workshop facilitated by Health Integration Partners, which produced an output report and associated recommendations. A review of the community equipment service (CES) specification is underway, and the CES transformation plan has been refreshed to identify key priorities for 2026/27. Complementing this, the CES catalogue review has completed c. 1/3 of items reviewed and a Proportionate Care event, held by the ICB, was well attended by Isle of Wight operational colleagues across the pathway. Procurement of the Carers Support (Health) service is progressing; however, revised milestones have necessitated a three-month extension to existing arrangements, which has been approved. The invitation to tender is scheduled for publication in mid-April. **Supporting Improved Performance in Avoidable Admissions:** National data for December performance was above plan (indicating deterioration), though the Isle of Wight remained better than the England average and as its peer-group median performer. Throughout 2025/26 YTD, variation has broadly reflected regional and national patterns, showing a gradual worsening trend overall; however, only 2 of the 10 months YTD have deviated from anticipated activity. Local data for February indicates a return to plan. Local prevention work outside of the BCF remains coordinated through the Health and Care Plan. As part of the BCF, the initial tabletop review of the Living Well, Early Help service has concluded. There is preliminary appetite to reprocure the contract at the end of this financial year, subject to a full review and consultation to inform future service options. Initial engagement from Public Health has

	also indicated potential interest in collaborative commissioning and service model development.
Portsmouth	Local data for February indicates achievement against the revised ambitions for the admissions avoidance metric. National data for the discharge metric is currently only available up to January, Local data up to February indicates that performance was not on track against the revised metric plan, with an average length of discharge delay of 1.32 against a plan of 1.15. The local DAG continues to review the improvement plan progress and regular system escalation meetings are in place, with a focus on reviewing discharge performance, addressing barriers, and coordinating actions across the system. Local unvalidated data for December indicated performance was on track against plan in Q4 for the residential and nursing admission metric.

6.2 Finance Summary

6.2.1 Headline Finance Overview

6.2.2 BCF Overall Summary Position – Month 12, 2025/26 – (source: ICB BCF Central Expenditure Report

**Please note this is stated as draft as our accounts are not yet audited*

Place	Total BCF Value (£'000)	NHS Spend (£'000)				YTD Actuals (£'000)	YTD Variance (£'000)
		NHS Providers (£'000)	Local Authority (£'000)	Other (£'000)	Total NHS (£'000)		
Hampshire	**178,686**	**73,234**	**47,075**	**2,104**	**122,413**	**122,413**	**0**
IOW	**30,732**	**7,028**	**8,933**	**1,181**	**17,142**	**17,348**	**206**
Portsmouth	**52,433**	**16,556**	**10,695**	**296**	**27,547**	**27,818**	**271**
Southampton	**41,925**	**12,023**	**11,512**	**2,065**	**25,601**	**25,601**	**0**
Total	**303,777**	**108,842**	**78,214**	**5,646**	**192,703**	**193,180**	**478**

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

6.2.3 Key BCF Financial Highlights (Month 12):

Southampton: the position reflects scheme-level adjustments within community wellbeing and prevention, reablement variance associated with discharge to assess (D2A) funding movements and expected variability in the joint equipment service post-provider transition. Overall, pending in line with the financial plan for 2025-26.

Isle of Wight: overspend relates to the Community Equipment Service, reflecting pressures associated with the jointly funded model and transition between providers. Work is underway to review and right-size the future financial envelope, with a small offset from underspend within other areas of the BCF.

Portsmouth: overspend relates to the Community Equipment Service, due to an unforeseen change in provider which incurs additional costs in comparison to the previous provider. The forecast remains variable due to the nature of this change in provider.

Hampshire: spending in line with the financial plan for 2025-26.

6.3 Strategic Integrated Commissioning – Using BCF as the Driver

6.3.1 Workstream updates

Area	Performance Update	Key Issues/Actions	Next Steps
Strategic Integrated Commissioning – BCF programme	• National BCF 2026/27 planning guidance was published in February 2026. Place-based BCF leads within the ICB are now working with local authority partners to develop their respective BCF plans in line with the national framework. Draft plans will be submitted by 17.4.26 for each place to enable feedback and amendments from BCF regional team. • System priorities agreed at the BCF Planning Summit continue to provide a shared direction for BCF development beyond 2025/26, including strengthening Health & Wellbeing Board (HWB) leadership for neighbourhood delivery. • Local Government Association (LGA) support secured following successful expression of interest application. • Actions arising from the Summit are being progressed, with updates shared with stakeholders.	• Progress actions from the BCF Planning Summit, including System Priority 3: strengthening governance and delivery accountability through HWBs. • Use the BCF Maturity Assessment to support targeted review of existing BCF schemes, as well as consideration of schemes operating outside the current BCF framework. • Finalise Section 75 deed of variations by the end of Q4.	• Develop and agree the 2026/27 BCF Plans in partnership with local authority colleagues. • Use LGA support resources to inform HWB leadership discussions and neighbourhood health/BCF planning for 2026/27. • Progress the agreed BCF planning governance timetable across the system, including informal national review, ICB finance assurance and executive sign-off ahead of the 19 May 2026 submission deadline. • Establish a system learning forum to share learning from Isle of Wight and Portsmouth National Neighbourhood Health Implementation Programme (NNHIP) activity. • Continue to align Neighbourhood Health and BCF planning, recognising that much of the narrative development will sit within the wider neighbourhood health context.

6.4. Governance & Forthcoming Quarter Returns

6.4.1 Better Care Fund 2026/27 Planning

National BCF planning guidance for 2026/27 was published in February 2026. Place-based BCF leads within the ICB are now working with local authority partners and wider system colleagues to develop their respective BCF plans in line with the national framework.

The submission comprises a numerical return and supporting narrative setting out how BCF investment will support integrated and preventative care, including admission avoidance, discharge optimisation and improved independence outcomes.

A coordinated governance timetable has been agreed across the system to support plan development, assurance and approval ahead of the national submission deadline of 19 May 2026. This includes informal national review, ICB Finance validation and executive sign-off. All Places are aiming to submit draft narrative and numerical plan templates to BCF regional team for review and feedback by 17 April. IoW have already submitted draff narrative plan with positive feedback received. All feedback will be shared with the BCF Working Group to assist with further review and aligned amendments.

Due to the timing of Health and Wellbeing Board meetings across Places, some areas will utilise appropriate governance mechanisms (including Chair's Action where required) to ensure plans are formally endorsed in line with national requirements.

The agreed planning timeline is set out below:

Milestone	Date	Status
Pre-planning support assessment	31 March	✅
Draft v1 to BCF team (informal review)	17 April	✅
Feedback returned	~24 April	
Final to ICB Finance	25 April	
ICB Finance approval	2 May	
Exec / Chair sign-off	5–9 May	
Submission	12–16 May	
National deadline	**19 May**	
National review period (BCMs review numerical returns)	from 20 May	
Resubmission window closes	26 May	

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

Quarter	Template Available to HWB Areas	Signed off HWB Submission Date
Quarter 1	16-Jun-25 ✅	15-Aug-25 ✅
Quarter 2	29-Sep-25 ✅	11-Nov-25 ✅
Quarter 3	15-Dec-25 ✅	30-Jan-26 ✅
End of Year	23-Mar-26 ✅	5-Jun-26

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

7. Recommendations

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

University Hospital Southampton
NHS Foundation Trust

Agenda item 5.10 Report to the Trust Board of Directors, 14 May 2026	
Title:	People Report 2025-26 Month 12
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:

At the end of March 2026, the Trust remains **significantly above workforce plan**, with total workforce **539 WTE above plan**, driven primarily by increased temporary staffing. Substantive workforce reduced marginally in-month (-41 WTE), largely due to contractual and resident doctor changes rather than leavers, while turnover remains **well below target** at **8.5%**. Total workforce has fallen by 309 WTE from March 25 to March 26. Sickness absence is broadly controlled at **3.85%**, though slightly above target at year end (Target 3.7%).

Temporary staffing usage increased materially in March, with **bank now 198 WTE above plan** and agency has finished the year below plan. Demand has been driven by seasonal trends (end year annual leave) and mental health and enhanced care requirements. Recent bank rate reductions have adversely affected bank fill rates, particularly among multi-post holders, though signs of recovery are evident. Targeted use of agency staffing continues in high-risk areas to mitigate patient safety and RTT delivery risks. Focused recruitment is still underway in critical care, theatres and perfusion.

From a quality and governance perspective, **staffing-related patient safety incidents increased** in March, particularly in Divisions A and B, reflecting sustained acuity and workforce pressure. **Appraisal completion (64%) and statutory/mandatory training compliance (69% / 80%) remain key workforce risks**, requiring sustained recovery action into 2026/27. The Trust closed the year with **89% medical job plans signed off** for NHSE reporting and continued progress on senior medic activity rostering. Despite not reaching the 95% job planning target there has been a huge rise on job planning compliance this year.

26/27 People priorities have been discussed through People Board, TEC and People and OD committee. These will be discussed in Board in May.

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

March 2026

THRIVE EXCEL BELONG

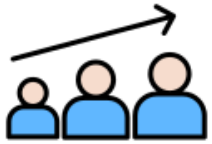
Summary

PEOPLE REPORT OVERVIEW: 2025/26 M12 (March-26)

In-month sickness is currently 3.85%, 0.15 % above target (3.7%).

Appraisal completion rate is currently 64.2%, which is 20.7% below target (85%)

R12m turnover rate (8.5%), which is below target (13.6%).



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

Bank usage increased and is now 198 WTE above plan.

Increase in agency staffing. Agency is 12 WTE below plan.

Increase in patient safety incidents to 109 (98 in February)

Executive Summary

At the end of March 2026, the Trust remains **significantly above workforce plan**, with total workforce **539 WTE above plan**, driven primarily by increased temporary staffing. Substantive workforce reduced marginally in-month (-41 WTE), largely due to contractual and resident doctor changes rather than leavers, while turnover remains **well below target** at **8.5%**. Total workforce has fallen by 309 WTE from March 25 to March 26. Sickness absence is broadly controlled at **3.85%**, though slightly above target at year end (Target 3.7%).

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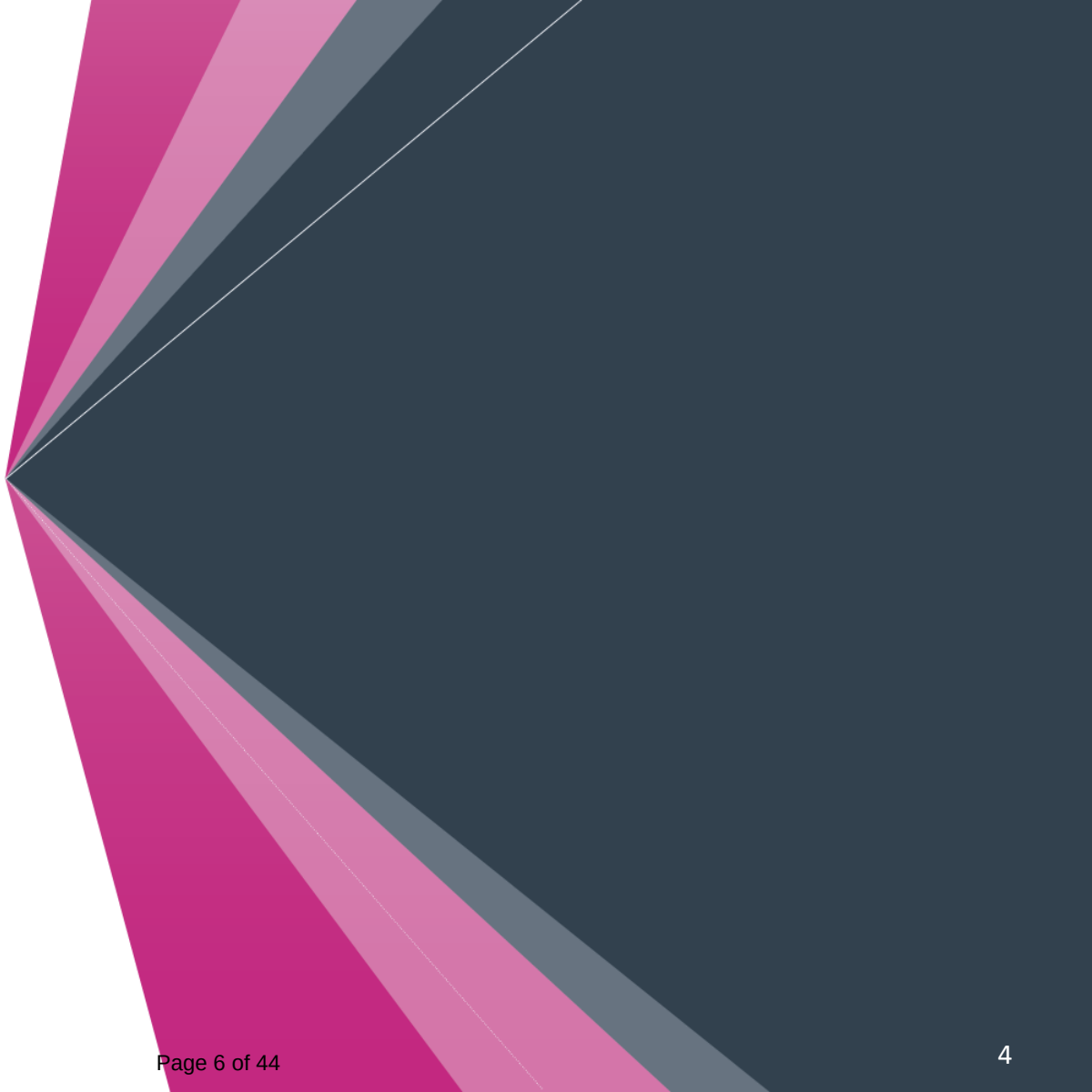
26/27 People priorities have been discussed through People Board, TEC and People and OD committee. These will be discussed in Board in May.

Overall Position



WTE Movement (M11 to M12)

Total Workforce

The total workforce **increased by 133 WTE** to **13,240 WTE** from M11 (13,107) to M12.

During this period, the substantive workforce **decreased by 41 WTE**, while the total temporary staffing **increased by 174 WTE.**

As of M12, the Trust is **above the total plan (by 539 WTE).**

Substantive WTE

Substantive WTE decreased by 41 WTE between end of February and end of March.

The biggest reductions were in Nursing and Midwifery Registered (-16 WTE) and Resident Doctors (-9 WTE). All other staff groups saw a reduction, aside from Admin and Clerical (Divisions) which increased by 2 WTE.

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

Bank & Agency WTE

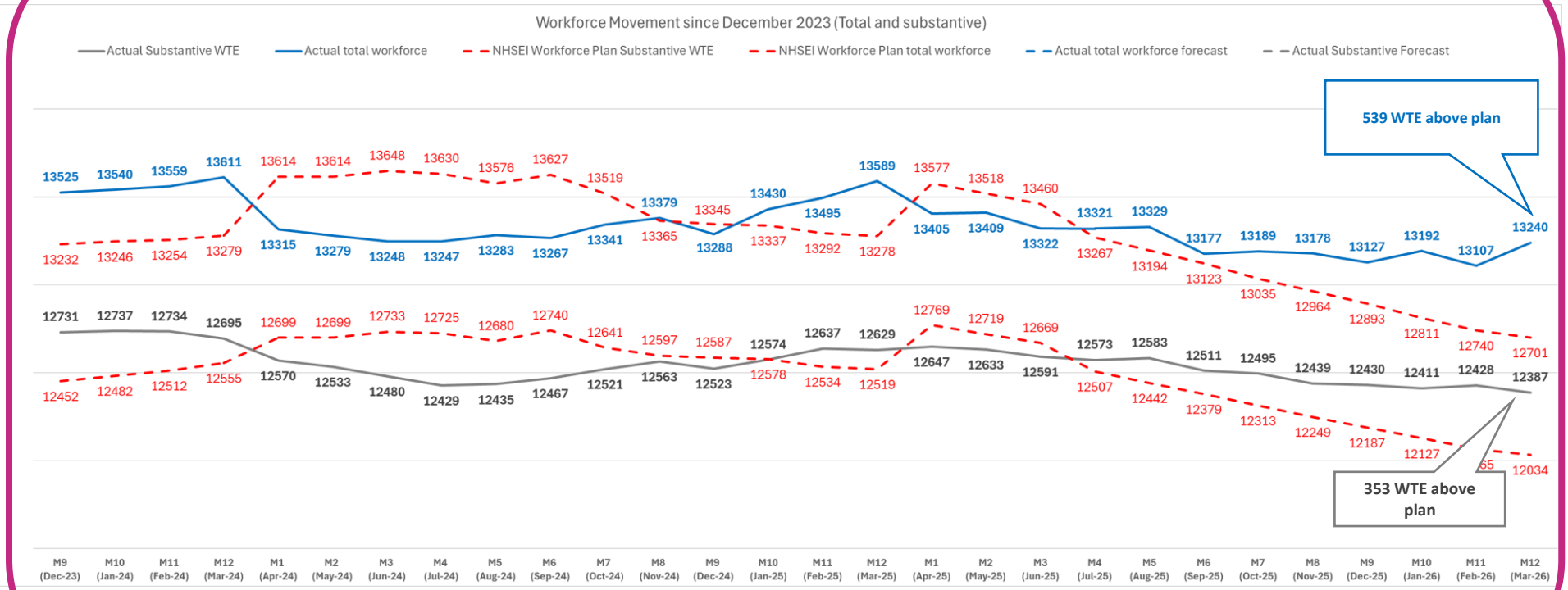
Total Bank and Agency use increased by 174 WTE in March 2026.

Bank increased by 26**%** and **Agency increased** by 30**%** in March 26, compared with previous month.

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

Increase reflects a combination of complex interconnected factors, rather than a single, principal driver. Further information is given on slides 11,16, 21 & 21.

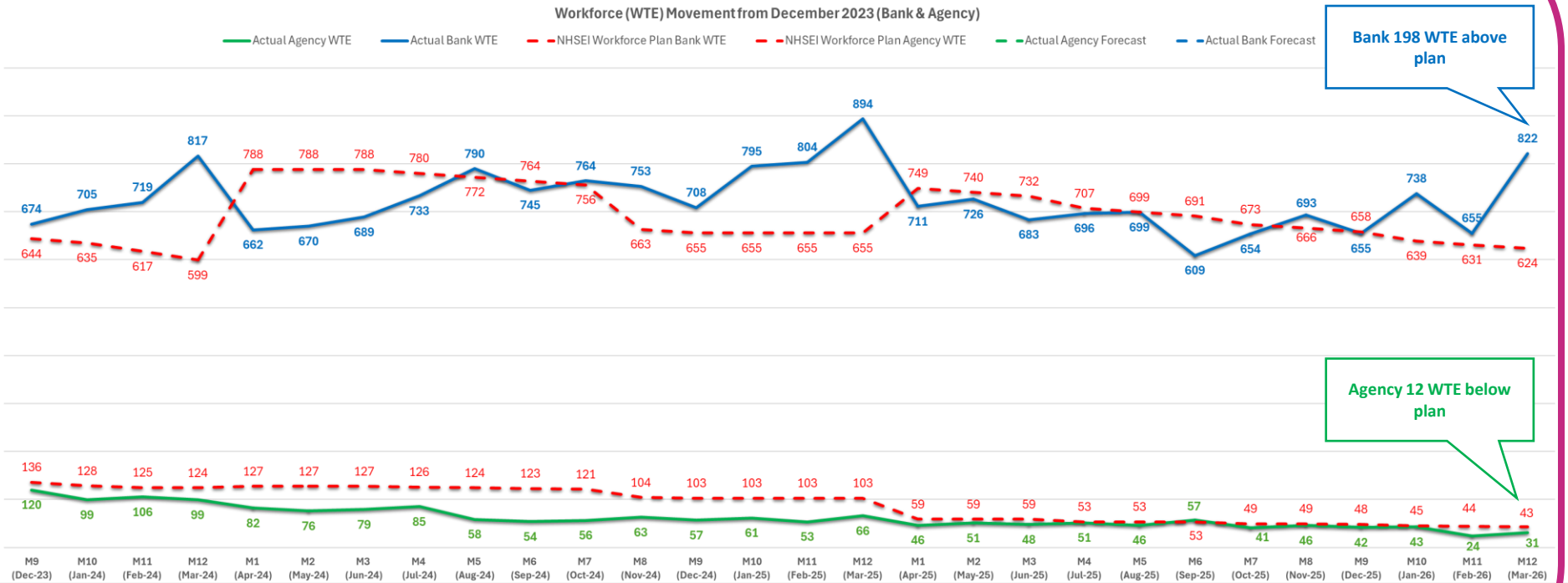
Workforce Trends: Total & Substantive



Source: ESR as of March 2026.

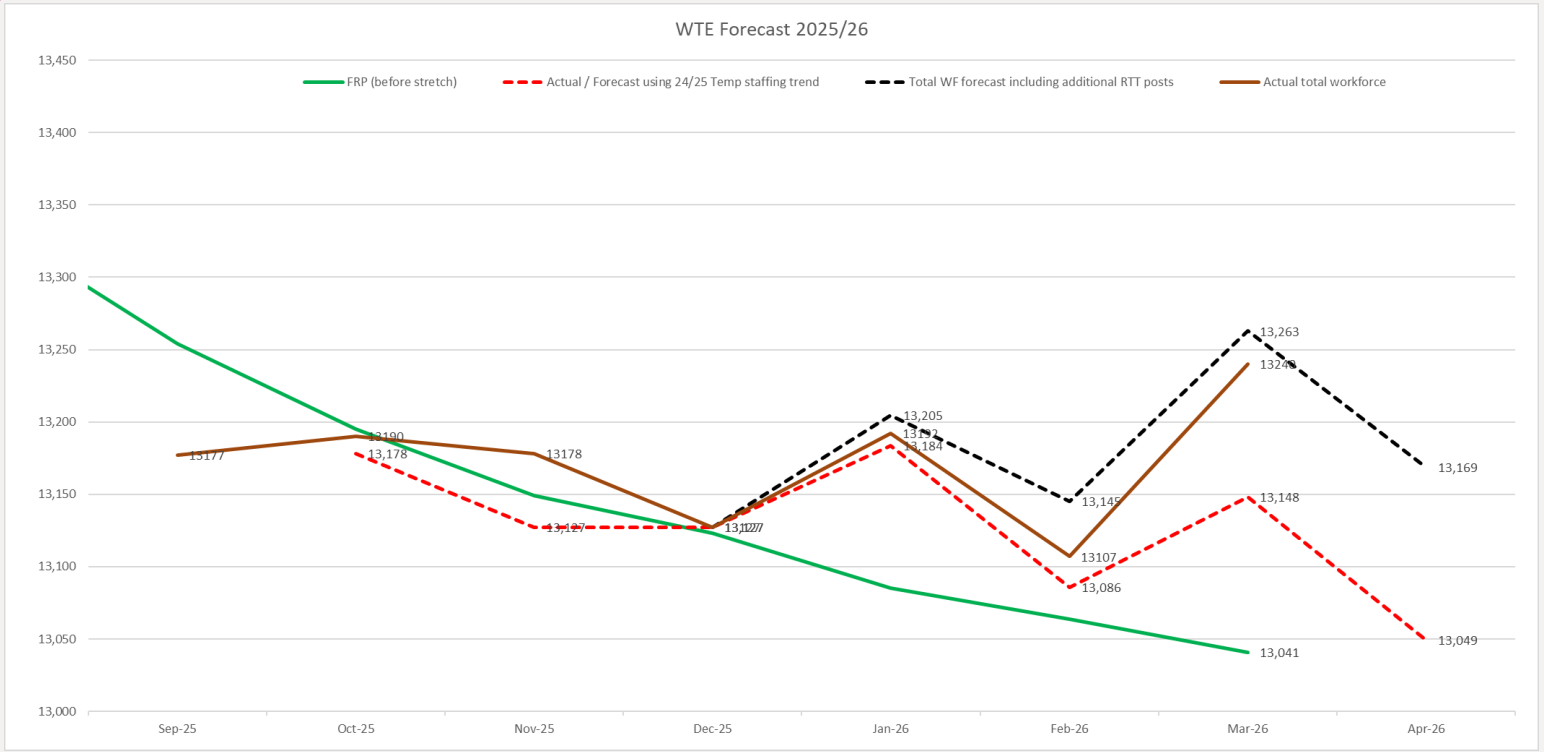
NB: Please note that the hosted service criteria for 2025-26 has been refreshed to include UEL and exclude TDW GP Lead Employer and TDW Education Hosted Posts.

Workforce Trends: Bank & Agency



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

Total WTE Workforce Forecast against FRP

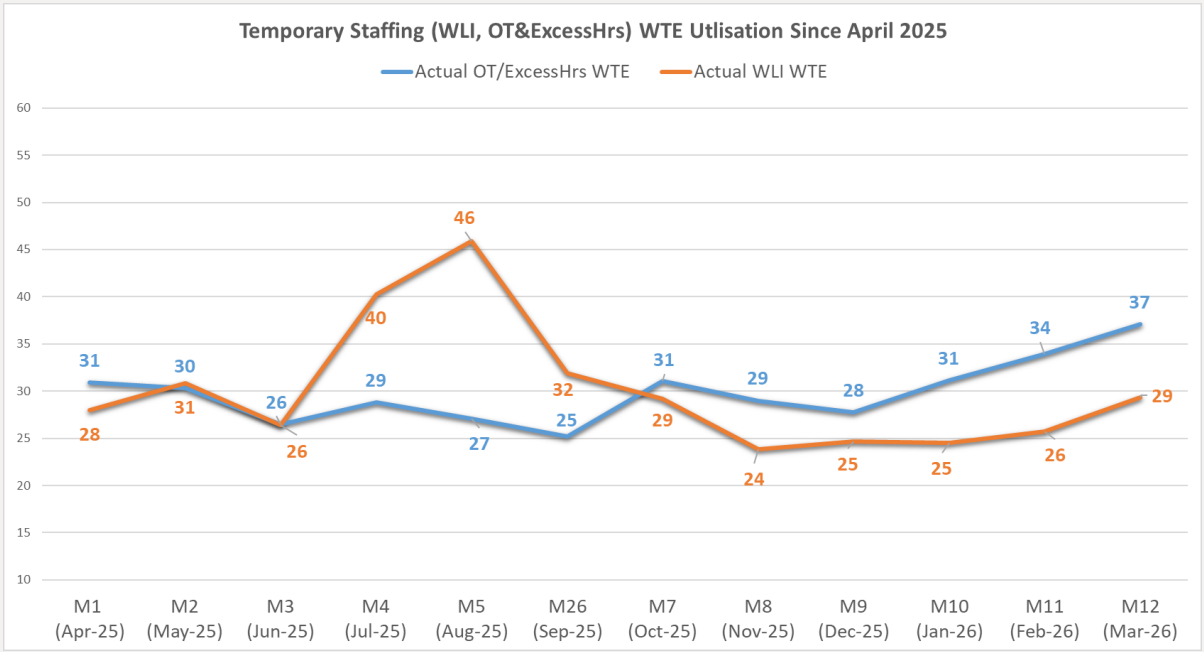


Assumptions on forecast:

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

Workforce Trends: WLI and Overtime

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



Source: Healthroster as of March 2026

Quarterly People Heatmap – 2025/26 Q4

	THRIVE			EXCEL			BELONG	
	AWL as of M12 (Mar 26)	% Turnover	Apprentice numbers (WTE)	Appraisals completed	Sickness absence	% Flexible working requests approved	% of staff at Band 7 and above (BAME)	% of staff band 7 and above LID
UHS Overall	**13025**	**10.03%**	**693.7**	**64.2%**	**4.3%**	**38.9%**	**12.8%**	**13.1%**
Division A Overall	4147	8.7%	188.9	64.7%	4.5%	26.2%	17.3%	13.1%
CV&T	980	7.9%	47.9	64.4%	4.4%	23.5%	18.7%	12.9%
Critical Care	663	9.1%	23.8	65.3%	4.4%	7.4%	12.1%	12.1%
Neuro	502	9.5%	26.1	67.4%	4.0%	20.0%	17.4%	10.5%
Surgery	617	9.3%	25.6	54.0%	4.1%	29.4%	14.1%	12.7%
Theatres & Anaesthetics	925	7.7%	44.5	63.9%	5.1%	36.6%	29.2%	16.9%
T&O	460	7.7%	21.0	77.4%	4.4%	14.3%	21.2%	15.2%
Division B – Overall	3452	9.8%	115.0	63.8%	3.8%	42.3%	14.5%	15.5%
Cancer Care	820	9.2%	30.2	64.5%	4.7%	50.6%	17.1%	18.6%
Emergency Care	744	9.3%	18.7	66.1%	5.2%	53.3%	10.3%	18.7%
Medicine	865	10.5%	47.0	78.8%	4.4%	27.5%	26.5%	6.1%
H&IOWAA	30	4.6%	0.0	15.4%	1.2%			9.5%
Ophthalmology	324	11.5%	13.1	45.1%	4.7%	35.5%	14.3%	5.7%
Specialist Medicine	669	9.6%	6.0	54.5%	4.7%	26.5%	13.3%	16.7%
Division C – Overall	4019	10.0%	259.9	60.7%	4.4%	39.3%	10.4%	12.5%
Child Health	962	10.1%	44.7	65.6%	4.7%	15.2%	1.6%	12.2%
Clinical Support	1003	10.5%	128.7	69.7%	2.6%	30.6%	14.0%	10.5%
Pathology	610	11.3%	39.5	54.8%	4.8%	50.7%	13.2%	16.7%
Radiology	520	8.2%	18.9	73.1%	3.4%	35.4%	9.8%	10.9%
Women & Newborn	925	8.4%	28.2	47.7%	5.7%	51.6%	6.9%	18.2%
THQ – Overall	1407	12.0%	129.8	72.5%	5.1%	49.4%	11.8%	12.0%
Chief Finance Officer	127	13.3%	22.0	44.0%	2.6%	60.0%	11.5%	13.1%
Chief Operating Officer	185	18.9%	1.0	71.4%	7.2%	44.4%	17.1%	5.7%
Clinical Development	88	17.0%	3.0	70.1%	5.0%	16.7%	9.4%	24.5%
Informatics	245	3.7%	27.4	74.2%	2.3%	36.4%	16.5%	10.6%
People / HR	159	12.9%	19.6	77.2%	3.7%	42.9%	7.1%	12.9%
R&D	399	12.7%	19.9	81.4%	3.5%	59.5%	11.5%	8.3%
Training & Education	204	15.8%	37.0	81.5%	3.8%	100.0%		11.1%

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

Key recruitment actions linked to elective work

Staff Group / Area	Issue	Vacancy gap	Action being taken
Clinical Administration	Significant reductions through ICB wide WF controls and plan have left some key RTT linked specialities vulnerable	Divisional Clinical administration has reduced by 100 WTE since March 2025. Targeted action to 50 WTE replacement	• Targeted additional NHSP to support in key areas • Conversion of NHSP staff to perm in key areas • Start dates expedited where possible • Targeted external recruitment to priority areas • Increased support to validation team
Critical Care Nursing (All areas)	Vacancy in Band 5 nursing in Critical Care and reduction in uptake of NHSP shifts. Increased cancellation of elective cases (sickness, acuity, staffing)	Vacancy position in GICU against current establishment is c.30 WTE, however pipeline is positive. Currently reviewing budgets and establishment against future WF demands; presently running with unfunded emergency lists, plus the need to respond to RTT requirements.	• Long lines of agency – proving challenging to gain consistent support as agencies limited due to national 'crackdown' on use of agency workers in NHS. Most agency workers are substantively employed so have limited availability / capacity. • International recruitment of Band 5 CC experienced nurses. Relocation packages offered – challenges with finding Pinned candidates. We no longer have OSCE support capacity in house due to reductions in education workforce. • Ongoing national / local recruitment has proven successful, however caveat : risk of reducing other key areas of UHS nursing e.g. ED, Theatres • General reminder letter on NHSP cancellations to all workers across UHS. Focused conversations with individuals who cancel frequently – limited impact currently. • General offer of internal 3-month secondments in critical care • Review of rostering and deployment to ensure most appropriate deployment of substantive staff; releasing up to 110% of shift requirement to reduce impact of late cancellations. • Revaluation of true capacity requirement to deliver RTT performance in 25/26 linked to medium term plan. Review of establishment / headroom / training pipeline. Recruit to requirement not AWL.
Theatres Scrub	Vacancy in key scrub areas of T&O, ENT OMF, Cardiac, Urology & Neuro	Overall vacancy position 86 WTE	• International recruitment – 10 offered qualified theatre scrub staff. 6 have started so far, challenges with other start dates due to current international instability limiting movement and access to embassies (visa process). • Domestic recruitment including relocation packages where appropriate • Long lines of agency – have increased agency usage further and secured additional high-cost agency support. • Review of rostering and deployment to ensure most appropriate deployment of substantive staff • Revaluation of true capacity to deliver RTT performance in 25/26 linked to medium term plan. Review of establishment / headroom / pipeline.
Perfusion	National shortage specialty	16 WTE in post against AWL of 19 WTE.	• Sustained recruitment and retention premia in place which has been working well • Successful recruitment of external perfusion from neighbouring centre (Oxford) started in January; continuation of NHSP enhanced rate and bonus for multiple shifts worked • UHS representation on newly formed national action group on perfusion supply; unfortunately, this has been curtailed due to decision to national Perfusion body to withdraw from the conversation. • 3 trainees due to complete between September and early 2027 – expect these to join the full rota from March/April 2027 (need time to complete paeds / congenital competencies).

Source: HR

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

Substantive Monthly Staff in Post (WTE) Since March 2023																													
	23/24	24/25												25/26												Movement		
	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M11 to M12	Mar24 to M12	Mar25 to M12
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	295	294	297	302	301	300	300	312	303	306	307	303	304	301	305	303	-2	1	1
Additional Clinical Services	2136	2135	2134	2130	2117	2099	2098	2088	2091	2078	2097	2104	2107	2121	2123	2134	2131	2117	2101	2074	2064	2059	2041	2033	2030	-3	-106	-77
Administrative and Clerical (Divisions)	1386	1399	1387	1374	1366	1363	1356	1347	1342	1328	1340	1348	1352	1352	1350	1327	1316	1298	1282	1273	1258	1257	1254	1246	1248	2	-139	-104
Administrative and Clerical (THQ)	902	904	902	875	864	860	859	852	875	888	897	900	902	899	893	879	874	859	826	822	808	805	800	799	796	-3	-106	-106
Allied Health Professionals	796	803	800	799	788	786	808	815	814	806	807	821	817	823	822	832	831	839	842	849	849	849	846	847	846	-2	50	29
Estates and Ancillary	380	374	372	373	376	373	370	373	407	405	407	415	416	414	409	407	403	398	392	387	387	413	408	406	404	-2	24	-12
Healthcare Scientists	498	499	495	498	496	497	495	504	510	509	512	518	521	523	520	523	524	522	523	525	523	523	523	527	523	-4	26	2
Consultant & Career Grade Doctor	949	947	946	949	948	951	964	965	971	971	976	983	984	990	983	982	986	991	989	989	985	984	986	983	982	-1	33	-2
Resident Doctor	1235	1103	1102	1099	1096	1150	1161	1164	1155	1147	1149	1152	1146	1145	1140	1132	1125	1198	1194	1200	1185	1176	1178	1201	1192	-9	-43	46
Nursing and Midwifery Registered	4053	4052	4039	4030	4025	3998	3998	4055	4041	4038	4039	4032	4013	4010	4024	4008	4003	3990	3990	4010	4024	4010	4025	4028	4012	-16	-41	-1
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	50	49	53	51	-2	-7	-18
Grand Total	12695	12570	12533	12480	12429	12435	12467	12521	12563	12523	12574	12637	12629	12647	12633	12591	12573	12583	12511	12495	12439	12430	12411	12428	12387	-41	-308	-242
	Old	New Counting Criteria																										

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

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

Total Monthly Workforce (WTE) for Since March 23 (Substantive, Bank and Agency)																													
	23/24	24/25												25/26											Movement				
	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M1 (Apr)	M2 (May)	M3 (Jun)	M4 (Jul)	M5 (Aug)	M6 (Sep)	M7 (Oct)	M8 (Nov)	M9 (Dec)	M10 (Jan)	M11 (Feb)	M12 (Mar)	M11 to M12 Movement		Mar24 to M12 Movement		Mar25 to M12 Movement	
Add Prof Scientific and Technic	302	297	300	296	296	301	301	301	300	296	294	298	303	302	303	303	315	305	307	310	306	307	303	306	305	↓	-1	↑	3	↑	2
Additional Clinical Services	2522	2464	2464	2449	2453	2476	2430	2425	2418	2391	2433	2438	2475	2419	2430	2421	2432	2421	2379	2364	2365	2345	2342	2287	2341	↑	54	↓	-181	↓	-133
Administrative and Clerical	2348	2356	2342	2304	2303	2297	2286	2274	2287	2282	2315	2321	2330	2311	2296	2255	2241	2203	2149	2139	2107	2109	2104	2094	2106	↑	12	↓	-242	↓	-225
Allied Health Professionals	826	825	824	822	816	813	834	839	837	825	828	844	845	844	843	849	850	855	858	862	862	864	861	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	438	436	432	433	↑	1	↑	23	↓	-10
Healthcare Scientists	509	508	505	506	509	511	508	517	524	522	525	528	532	532	529	531	532	531	532	534	533	533	533	537	534	↓	-2	↑	25	↑	2
Medical and Dental	2231	2093	2092	2101	2100	2151	2165	2168	2165	2158	2172	2175	2174	2176	2162	2152	2165	2225	2211	2218	2209	2201	2203	2220	2211	↓	-9	↓	-20	↑	37
Nursing and Midwifery Registered	4404	4311	4292	4308	4304	4273	4287	4357	4356	4327	4370	4379	4418	4312	4341	4309	4300	4310	4259	4291	4331	4281	4359	4315	4396	↑	81	↓	-8	↓	-22
Students	58	58	58	58	58	58	58	58	56	56	56	69	69	70	69	68	68	68	67	60	54	50	49	53	51	↓	-2	↓	-7	↓	-18
Grand Total	**13611**	**13315**	**13279**	**13248**	**13247**	**13283**	**13267**	**13341**	**13379**	**13288**	**13430**	**13495**	**13589**	**13405**	**13409**	**13322**	**13321**	**13329**	**13177**	**13190**	**13178**	**13127**	**13192**	**13107**	**13240**	↑	133	↓	-371	↓	-349

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

Bank Increase March 2026

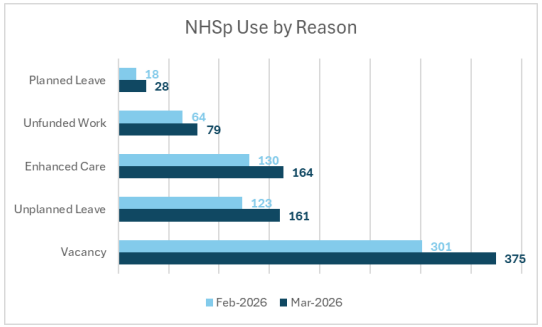
Division A	Feb-26	Mar-26	Change
188 Cardiovascular and Thoracic - Directorate	37	45	8
188 Critical Care - Directorate	37	53	16
188 Division A Management - Sub-Divisional Group	1	1	0
188 Neurosciences - Directorate	23	28	5
188 Ophthalmology and OPD - Directorate	11	11	0
188 Spinal Service - Directorate	6	10	4
188 Surgery - Directorate	26	33	8
188 Theatres & Anaesthetics - Directorate	44	64	21
188 Trauma & Orthopaedics - Directorate	42	48	6
Total	227	293	66

Division B	Feb-26	Mar-26	Change
188 Cancer Care - Directorate	45	58	14
188 Division B Management - Sub-Divisional Group	0	0	0
188 Emergency Care - Directorate	115	140	26
188 HAMPSHIRE AND IOW AA - Directorate	0	0	0
188 Medicine - Directorate	94	122	28
188 Pathology - Directorate	20	22	2
188 Specialist Medicine - Directorate	11	14	4
Total	283	357	74

Division C	Feb-26	Mar-26	Change
188 Child Health - Directorate	29	37	8
188 Clinical Support - Directorate	8	8	0
188 Division C Management - Sub-Divisional Group	7	10	3
188 Radiology - Directorate	7	8	2
188 Women & Newborn - Directorate	45	52	7
Total	97	116	19

THQ	Feb-26	Mar-26	Change
THQ	31	37	6

UEL	Feb-26	Mar-26	Change
UEL	17	19	2



* Reasons with less than 5 WTE attributed are not listed

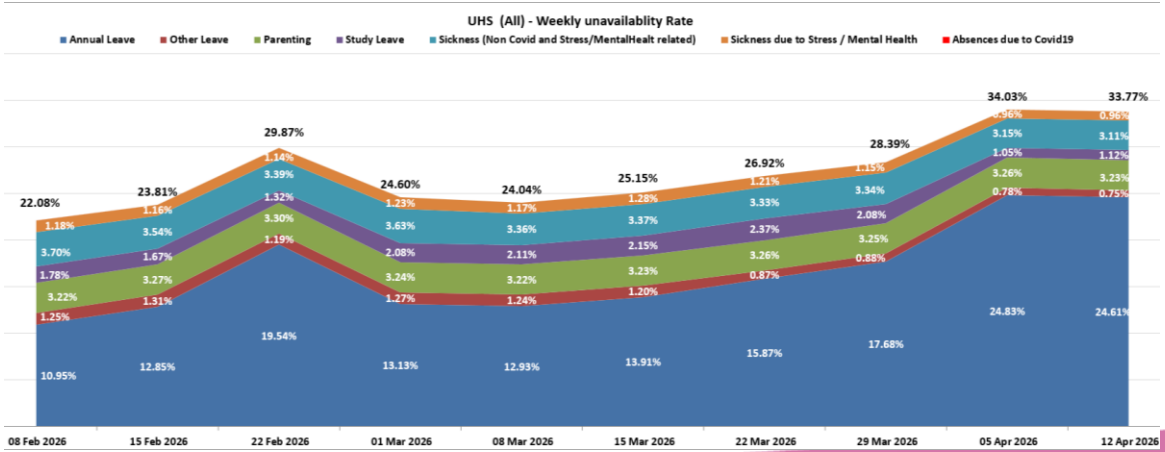
In March 2026, Bank increased by 167 WTE.

Year to year, we generally see a spike in Bank in March.

The data for Match 26 reflects a combination of complex interconnected factors, rather than a single, principal driver.

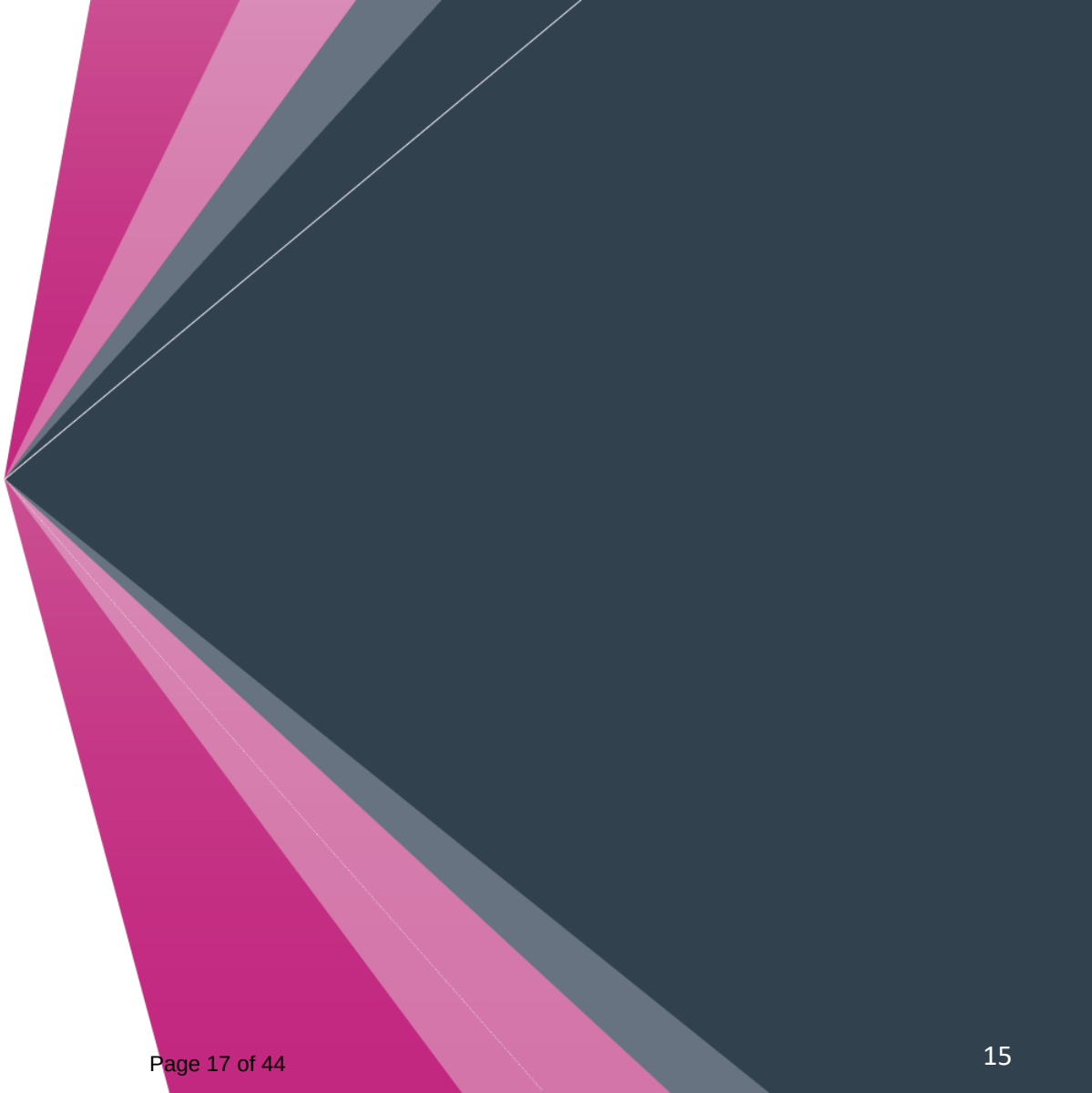
These being:

- **Headroom above the maximum threshold (23%) for the entire month**
- **Increased bank demand overall**
- **Increased Mental Health/Enhanced Care Demand**
- **Staffing challenges in Critical Care**

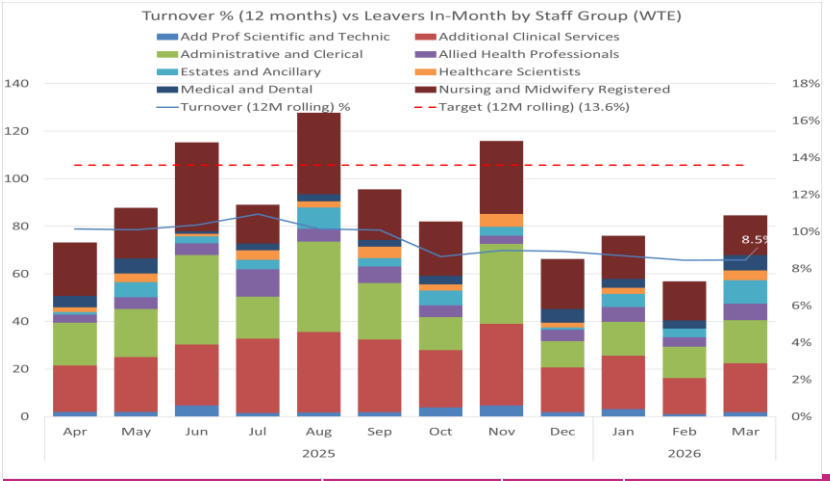


Source: NHSp & Healthroster, March 2026

THRIVE



Turnover



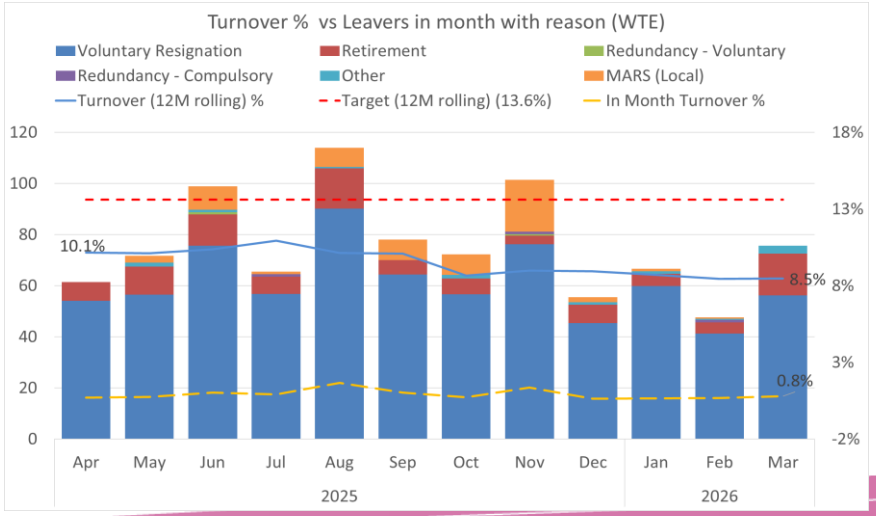
In March 2026, there was a total of 84.6 WTE leavers, 25.7 WTE more than February 2026 (58.9 WTE). Division B recorded the highest number of leavers (29.5 WTE). Within Division B, Additional Clinical Services staff group had the highest number of leavers (10.2 WTE).

Divisions C and Division A had the second and third highest number of leavers (22.5 and 14.8 WTE respectively); with the largest number of leavers for Division C being the Allied Health Professional staff group (5.0 WTE), while in Division A, Additional Clinical Services staff group accounted for 5.3 WTE leavers.

Total leavers by division are as follows:

- **Division A: 14.8 WTE leavers**
- **Division B: 29.5 WTE leavers**
- **Division C: 22.5 WTE leavers**
- **THQ: 13.2 WTE leavers**
- **UEL: 4.6 WTE leavers**

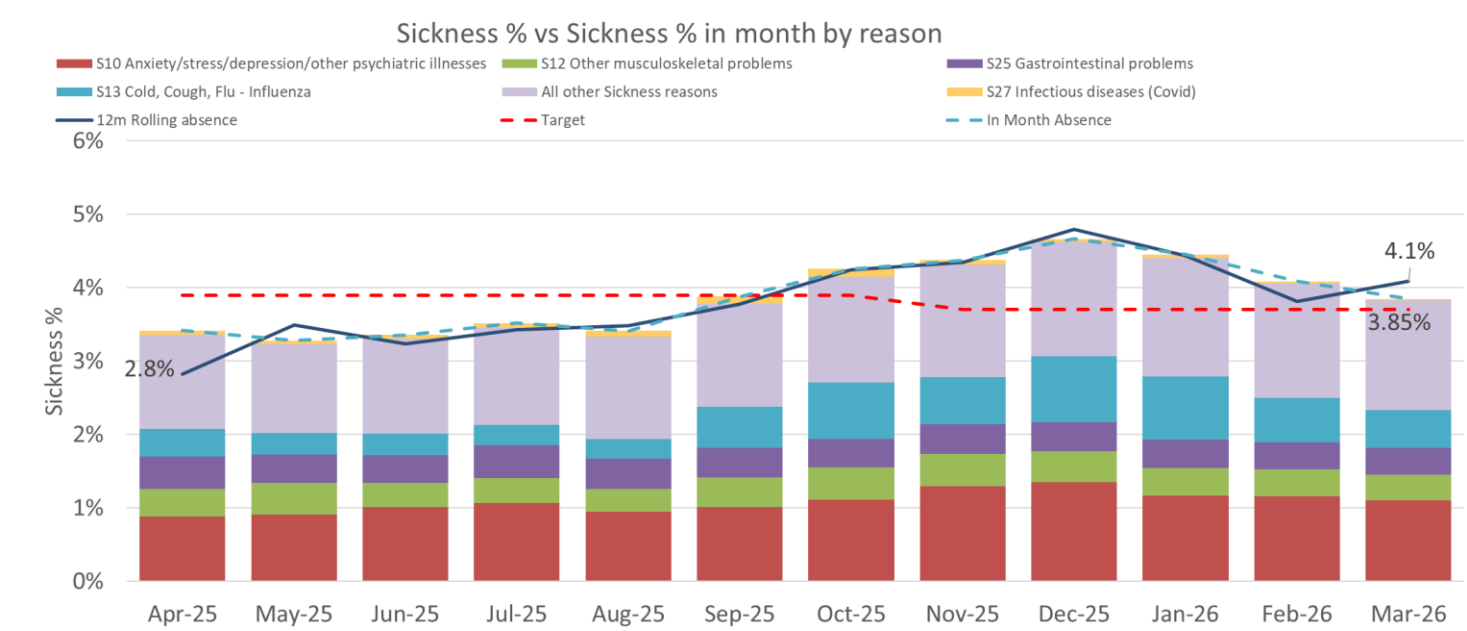
Staffing group	Leavers (WTE) in month	Turnover In-Month	Turnover 12m rolling %
Add Prof Scientific and Technic	1.8	0.6%	9.9%
Additional Clinical Services	20.6	1.0%	14.3%
Administrative and Clerical	18.1	13.1%	12.5%
Allied Health Professionals	7.0	7.9%	8.0%
Estates and Ancillary	9.9	22.3%	21.2%
Healthcare Scientists	4.1	6.7%	6.7%
Medical and Dental	6.5	13.1%	13.3%
Nursing and Midwifery Registered	16.6	7.0%	7.1%
UHS total	**84.6**	**0.8%**	**8.5%**



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

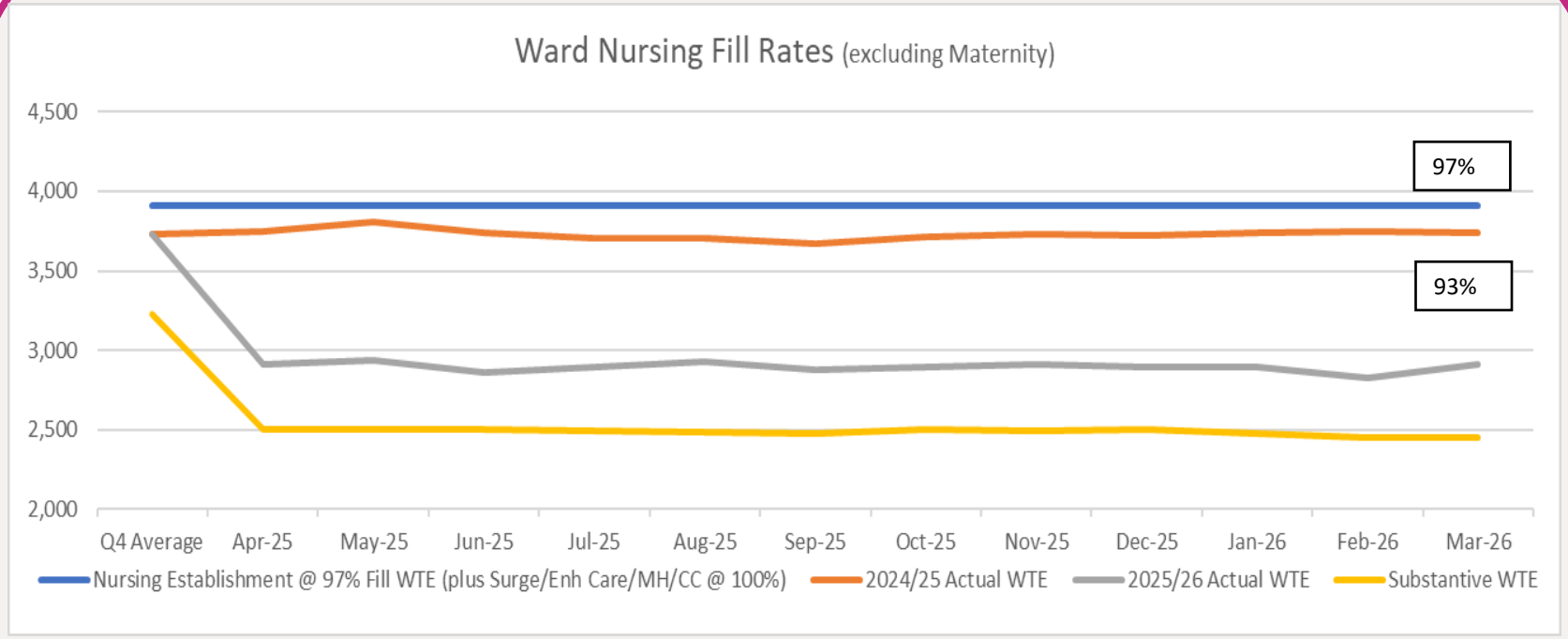
Sickness

Current in-month sickness: 3.85% | Rolling 12-month sickness: 4.1% | Year-to-date sickness 4.05%



Source: ESR – March 2026

Ward Nursing Fill Rates (excluding Maternity)



Source: Finance – March 2026

Temporary Staffing

Status

Qualified Nursing

- **Demand increased** from 348 WTE in Feb to 478 WTE in Mar (+130).
- **Bank filled increased** from 270 WTE to 360 WTE (+90) from previous month.
- **Agency filled increased** to 24 WTE (+6 from the previous month).
- **Unfilled shifts decreased**: 94 WTE remained unfilled (+33 on previous month).
- **Year-on-year demand increased: 3** WTE less than March 2025

Healthcare Assistants

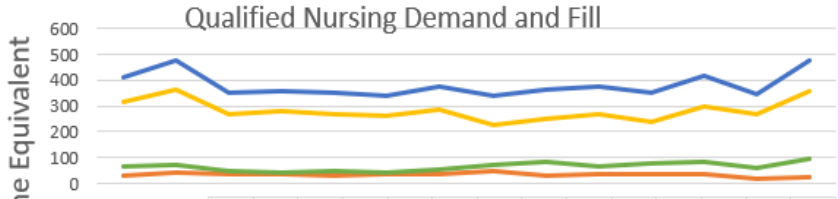
- **Demand increased** from **2**59 WTE in Feb to 329 WTE (+70).
- **Bank filled increased** from 255 WTE to 275 WTE (+50)
- **Unfilled shifts increased** from 34 to 54 (+20 on prior month)
- **Year-on-year demand increased**: 40 WTE higher than March 2025.

Actions

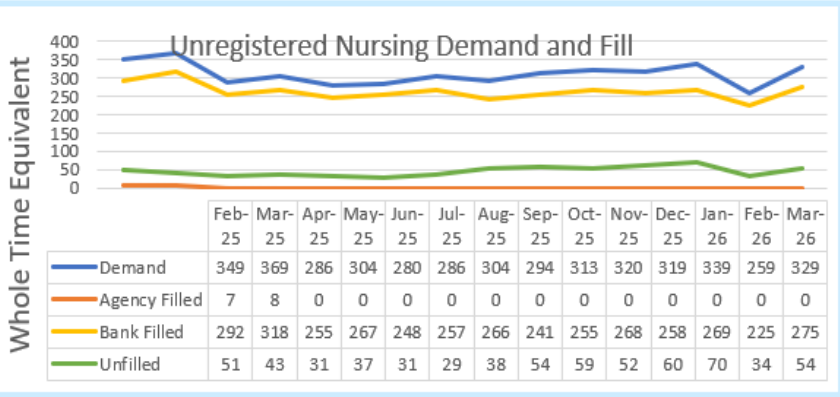
During March, there was a strong focus on Critical Care due to ongoing staffing challenges. Agency workers were engaged to support service delivery and minimise the risk of cancelled procedures. This work continues in close collaboration with Critical Care matrons.

Despite a reduction in available beds resulting from the fire incident, demand across the trust increased throughout March.

Additionally, there has been a notable rise in mental health demand. The ongoing requirement to backfill Band 3 Mental Health worker vacancies with agency-registered staff remains a key concern.



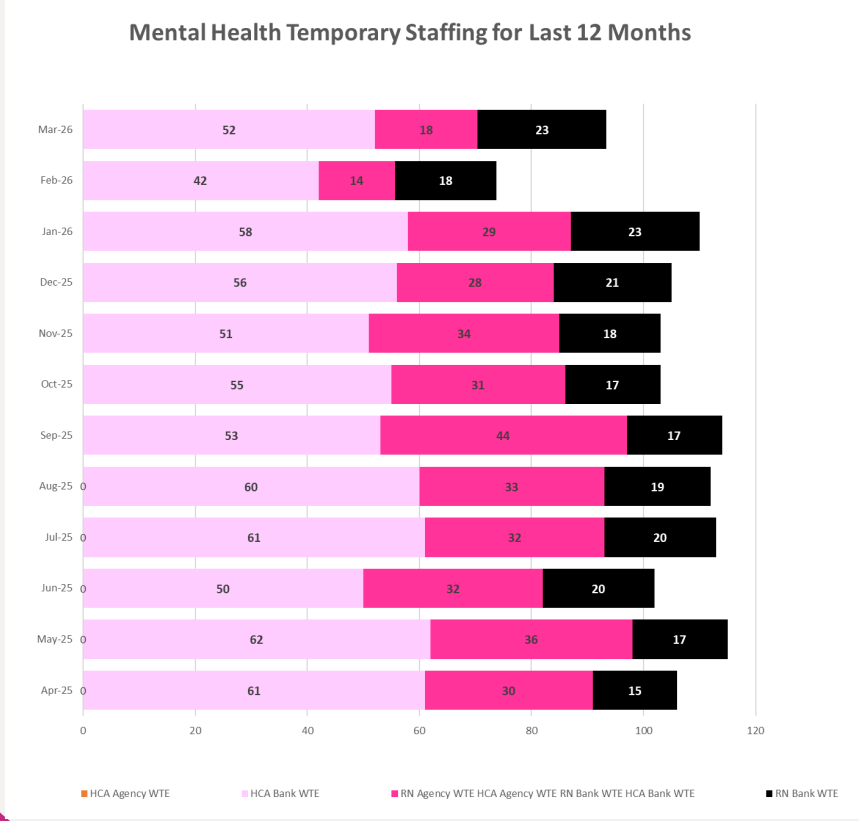
	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Demand	413	475	352	359	351	340	377	339	363	375	349	419	348	478
Agency Filled	33	43	34	38	33	34	35	46	32	39	35	36	18	24
Bank Filled	315	362	268	280	268	262	286	224	249	268	237	299	270	360
Unfilled	65	70	50	42	50	44	56	69	82	68	78	85	61	94



	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Demand	349	369	286	304	280	286	304	294	313	320	319	339	259	329
Agency Filled	7	8	0	0	0	0	0	0	0	0	0	0	0	0
Bank Filled	292	318	255	267	248	257	266	241	255	268	258	269	225	275
Unfilled	51	43	31	37	31	29	38	54	59	52	60	70	34	54

Source: Temporary Resourcing – March 2026

Temporary Staffing: Mental Health



Mental Health Staffing Summary – March 2026

Total Temporary Staffing: 93 WTE (+19 WTE compared to Jan 26).
RMNs: 41 WTE (+10 on Feb 26), of which 18 WTE agency (+4 WTE Feb 26) and 52 WTE bank (+10 WTE on Feb 26).
HCAs: 52 WTE (+10 WTE on Feb 26).
Year-on-Year Comparison: 32 WTE decrease compared to March 2025 (-21 WTE HCAs, +11 WTE RMNs)

Key Challenges & Actions

Ongoing Pressures

- Rising mental health demand continues to create significant safety, quality, and financial pressures – escalated to ICB.
- The ETOC project is reviewing the Enhanced Care strategy and delivery model, supported by NHSE

Transition from Agency to Bank Staff

- Agency fill rates continue to reduce, supporting the shift towards a bank-led model
- NHSP pay rates are currently higher than agency charges, increasing overall staffing costs – this has been escalated for review within the South East Collaborative
- Bank staff can work across HIOWFT, reducing availability for HCA Enhanced Care shifts at UHS

Increased RMN Use for HCA Shortfalls

- The rise seen in March 2026 for RMNs is partly due to backfilling requests for Mental Health HCAs.
- Governance processes are being strengthened to ensure robust approval when RMNs are deployed to cover HCA shortfalls.

Band 2/3 review of Enhanced Care HCA

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

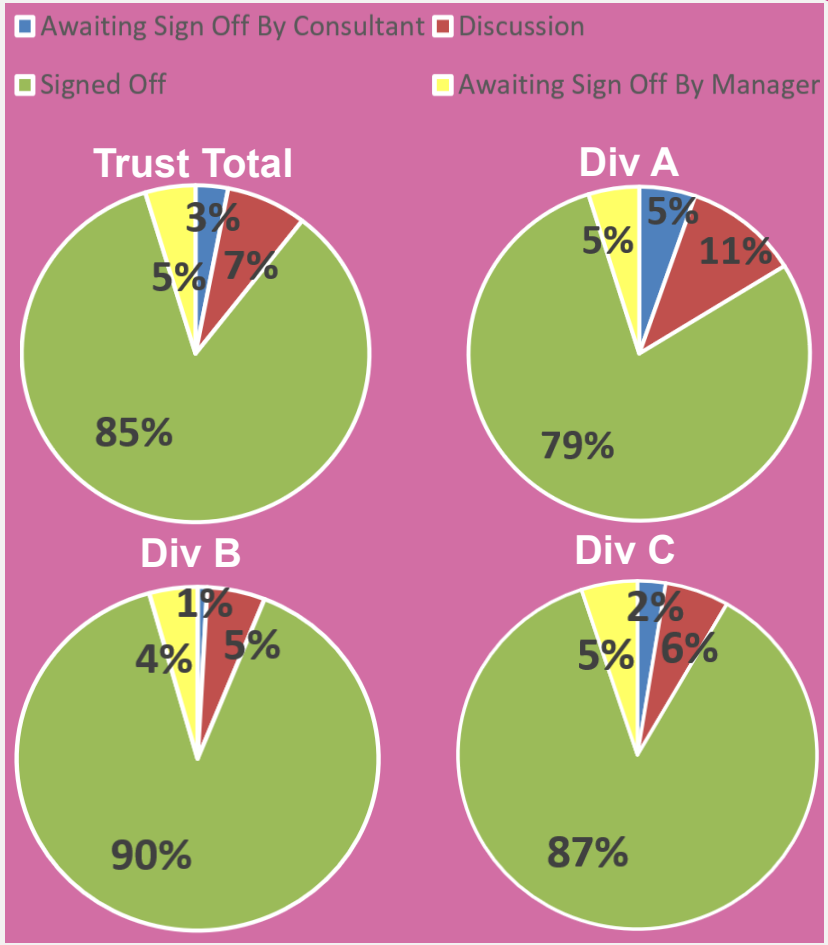
Temporary Workforce Quality

- Ongoing work is focused on developing a workforce suitable for an acute hospital setting.

Source: Temporary Resourcing – March 2026

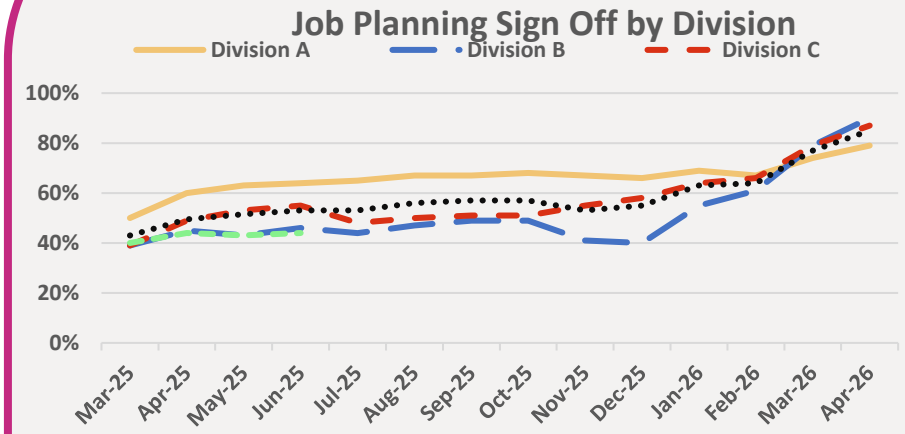
Medical Job Planning End of Year 25/26

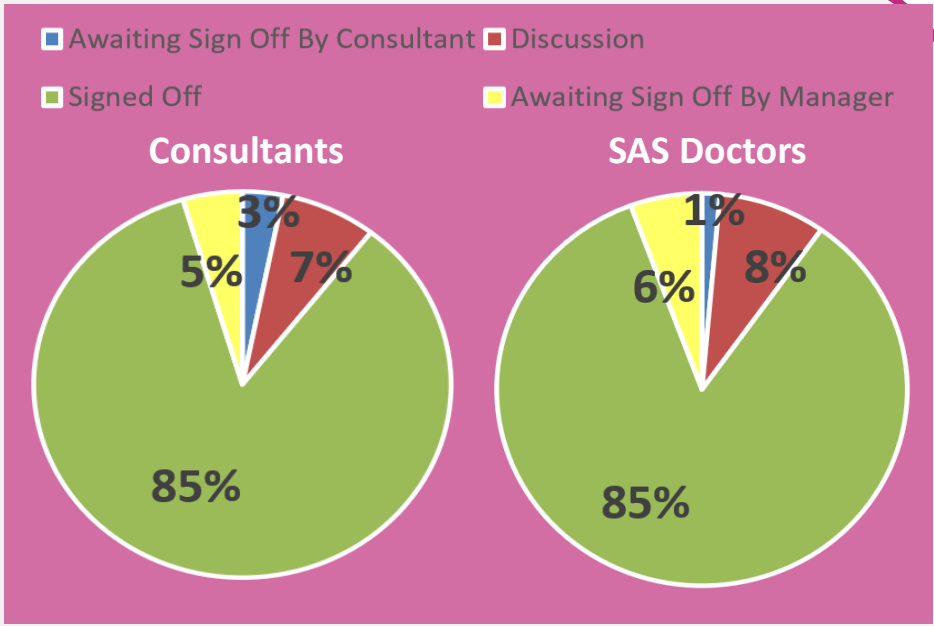
- UHS's submission to NHS England will be for **89% of Job Plan Signed Off** for the target date of 31/3/26. (This excludes, at NHSE's request, Clinical Academics, Honorary Contracts, Locums and Fixed term – Less than 6 months).
- For our regular internal reporting, which includes all the above, UHS has achieved 85% Signed Off.
- 98% of JobPlan accounts are Active (logged into during the last 12 months)
  - 19 accounts remain inactive, including 1 new starter.



Source: Workforce

Medical Job Planning End of Year 25/26





- 157 Job Plans did not get signed off before 31/3/26.
  - 79 were partly agreed (signed off by either Consultant/SAS Doctor or Manager and awaiting the other party's agreement)
  - 78 were still in discussion.

- Programme for 26/27
  - Embed service level job planning across specialties (Q1-2)
  - Link job planning and business cycles, with sign off in Q3
  - Update Job planning policy
    - Responsibilities of individual and lead
    - Escalation processes

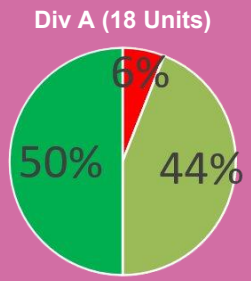
Source: Workforce

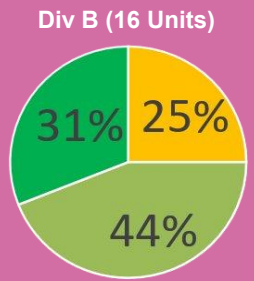
Senior Medics Activity Rostering

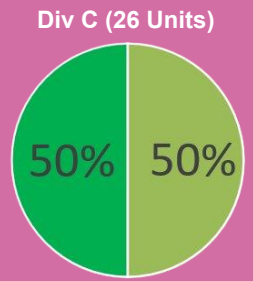
End of Year progress

Senior Medic Units converted to a level of Activity Rostering

- 59 units out of 64 (92%) are set up for activity rostering.
- Remaining 5 units (8%) in progress:
  - 4 units Cancer Care – converted to Activity patterns, waiting for Dept to agree go-live date (Div B 25% currently Basic Duty rostered)
  - 1 unit Anaesthetics – converting to Activity to enable dual testing/running (Div A 6% Core Only).



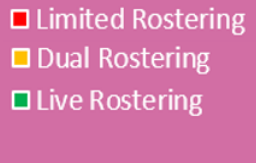


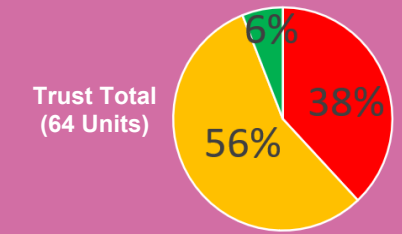


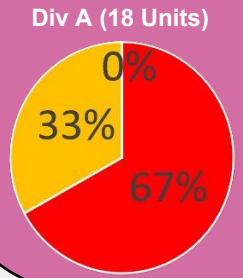
Future considerations

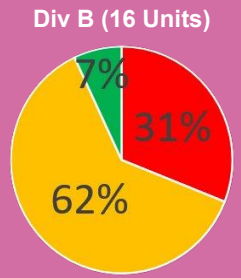
Senior Medic Activity Rostering Engagement

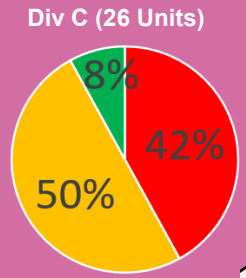
- Further progress rostering with ED & Anaesthetics. This will require support and increased level of engagement to deliver.
- Improve engagement to achieve live rostering across the Trust.
  - Recent department feedback has highlighted a lack of interest, willingness to change and/or lack of department Medical Admin support.







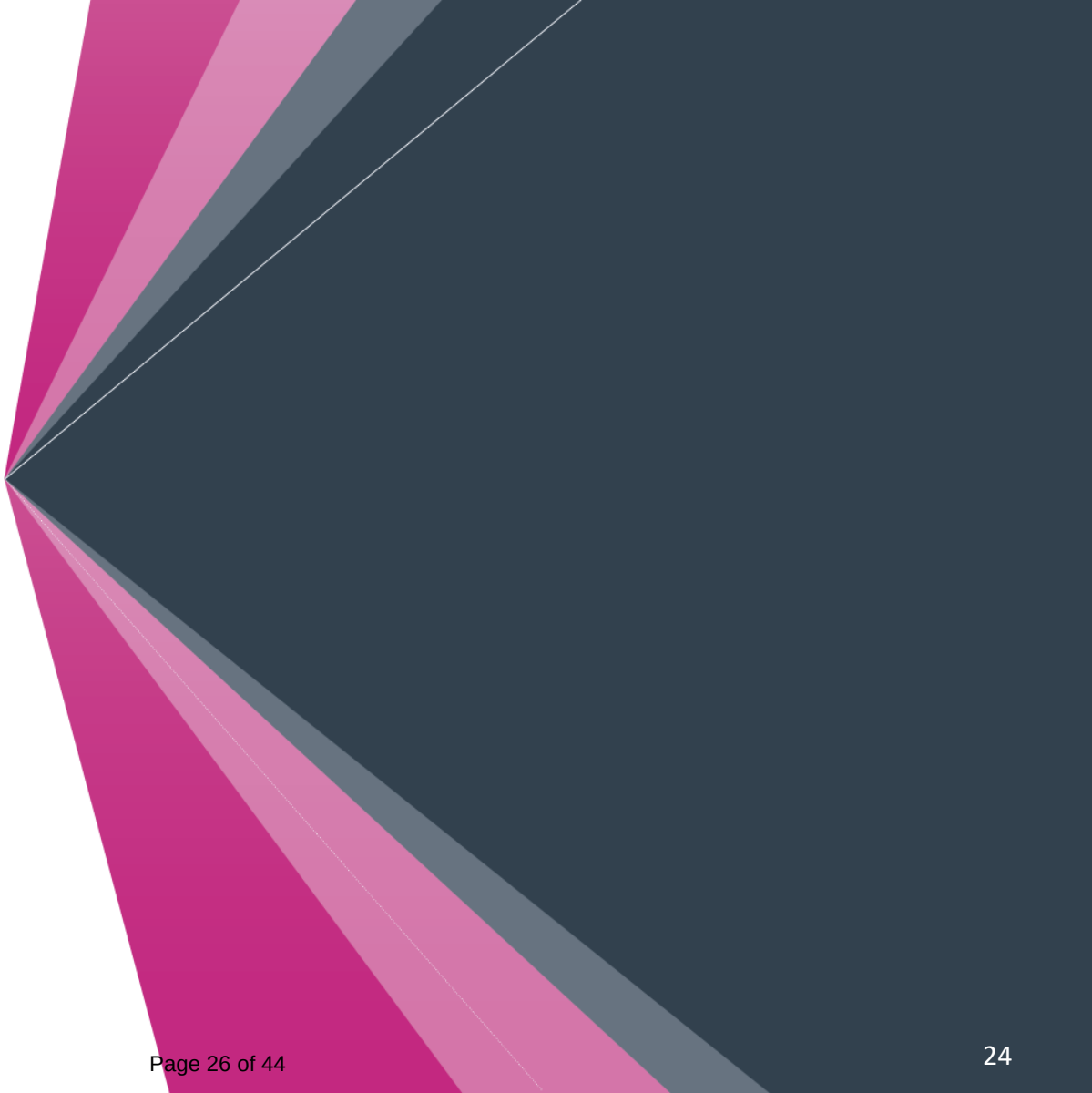




Source: Workforce

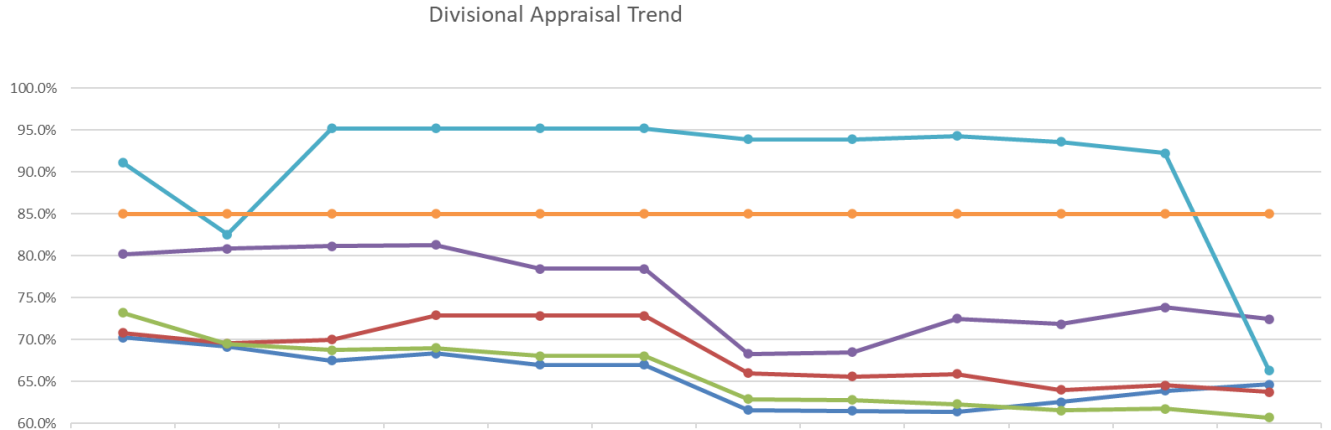
Data 2nd April 2026

EXCEL



Appraisals

The Trust's appraisal completion rate is 64.1% as of March 2026, a decrease of 1.2% from February 2026



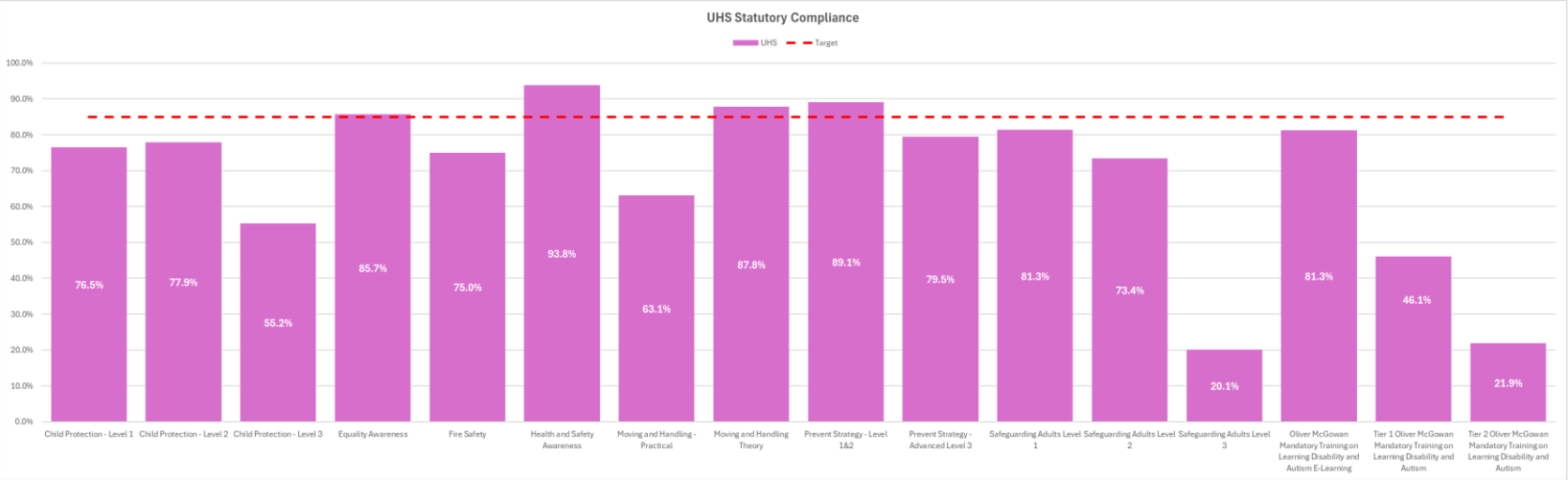
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
188 Division A	70.3%	69.1%	67.5%	68.3%	67.0%	67.0%	61.6%	61.5%	61.4%	62.6%	63.9%	64.7%
188 Division B	70.8%	69.5%	70.0%	72.9%	72.8%	72.8%	66.0%	65.6%	65.9%	64.0%	64.6%	63.8%
188 Division C	73.2%	69.5%	68.8%	69.0%	68.0%	68.0%	62.9%	62.8%	62.3%	61.6%	61.8%	60.7%
188 Trust Headquarters - Division	80.2%	80.9%	81.1%	81.3%	78.5%	78.5%	68.3%	68.5%	72.5%	71.8%	73.8%	72.5%
188 UEL - Division	91.1%	82.5%	95.2%	95.2%	95.2%	95.2%	93.9%	93.9%	94.3%	93.6%	92.2%	66.3%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

UEL appraisal level drops considerably in March 26, this reflects staff who TUPE'd over to UEL on 1st April 2025 had their first appraisal due as of 31st March 26. Whilst this is a large drop for UEL, impact on UHS as a whole is much smaller given UEL's size (294 staff).

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

UHS Statutory Compliance

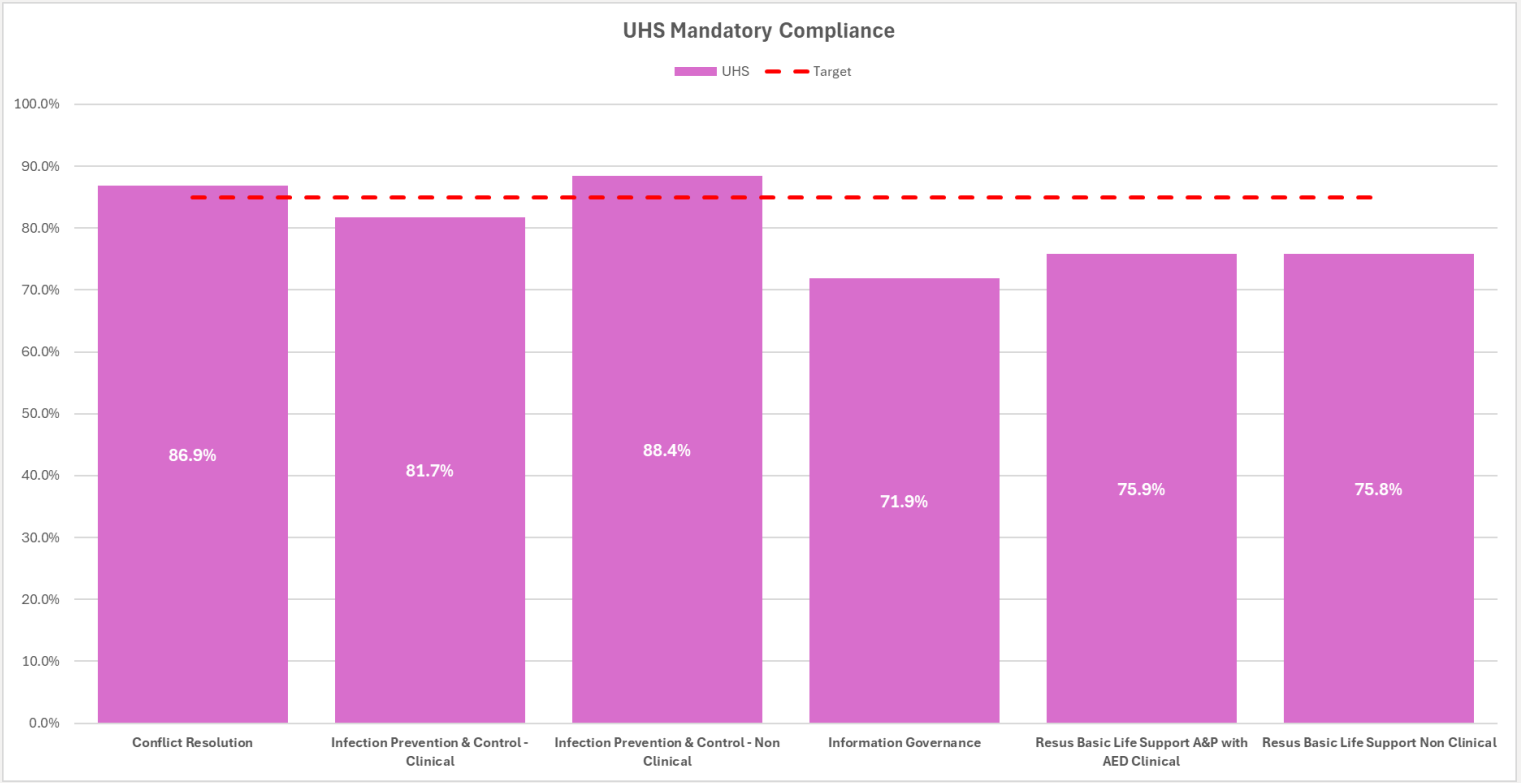
The Trust's average Statutory compliance rate for March 2026 is 69%, with 4 of 16 measures above the 85% target.



Source: Virtual Learning Environment (VLE).

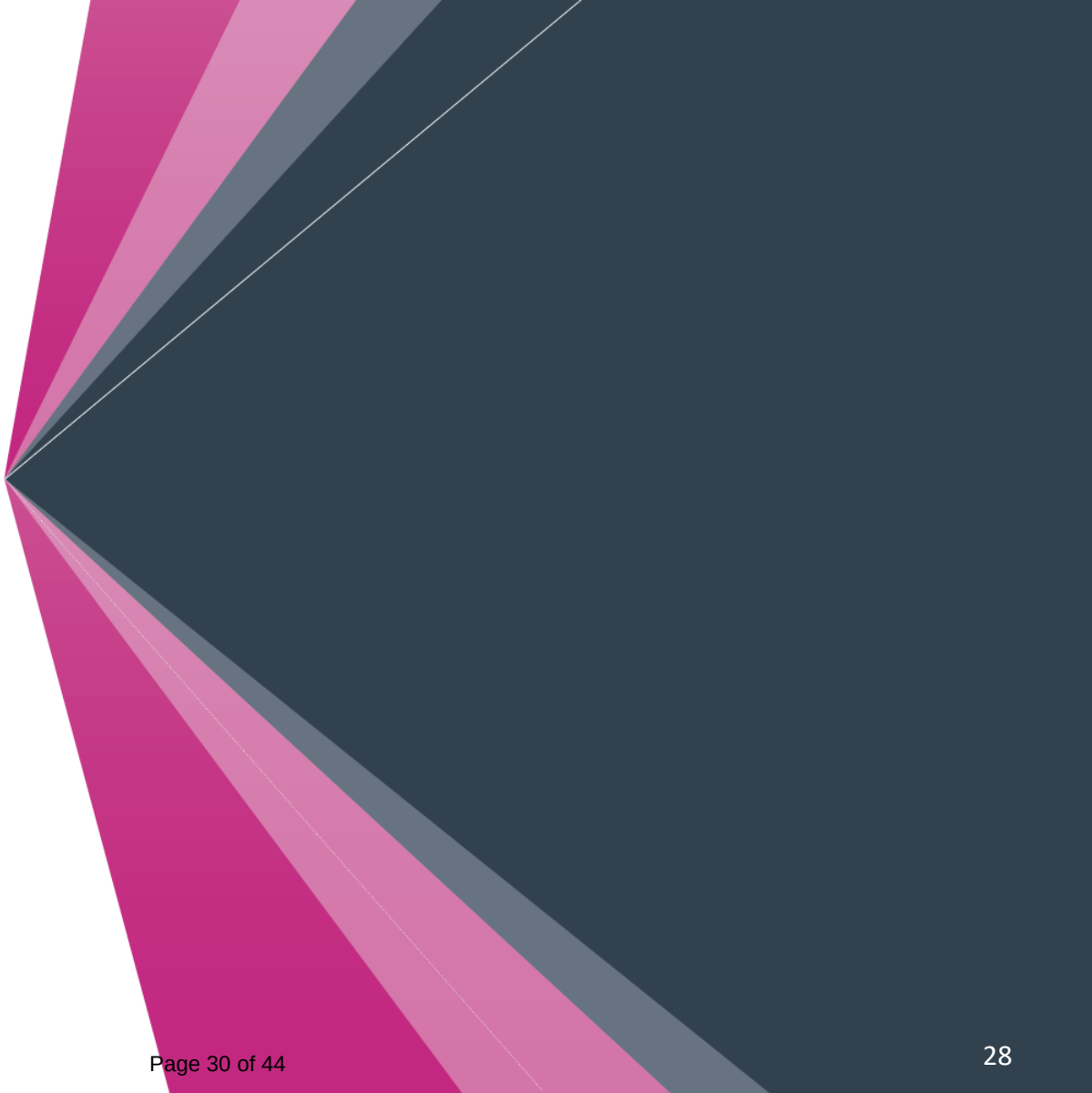
UHS Mandatory Compliance

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

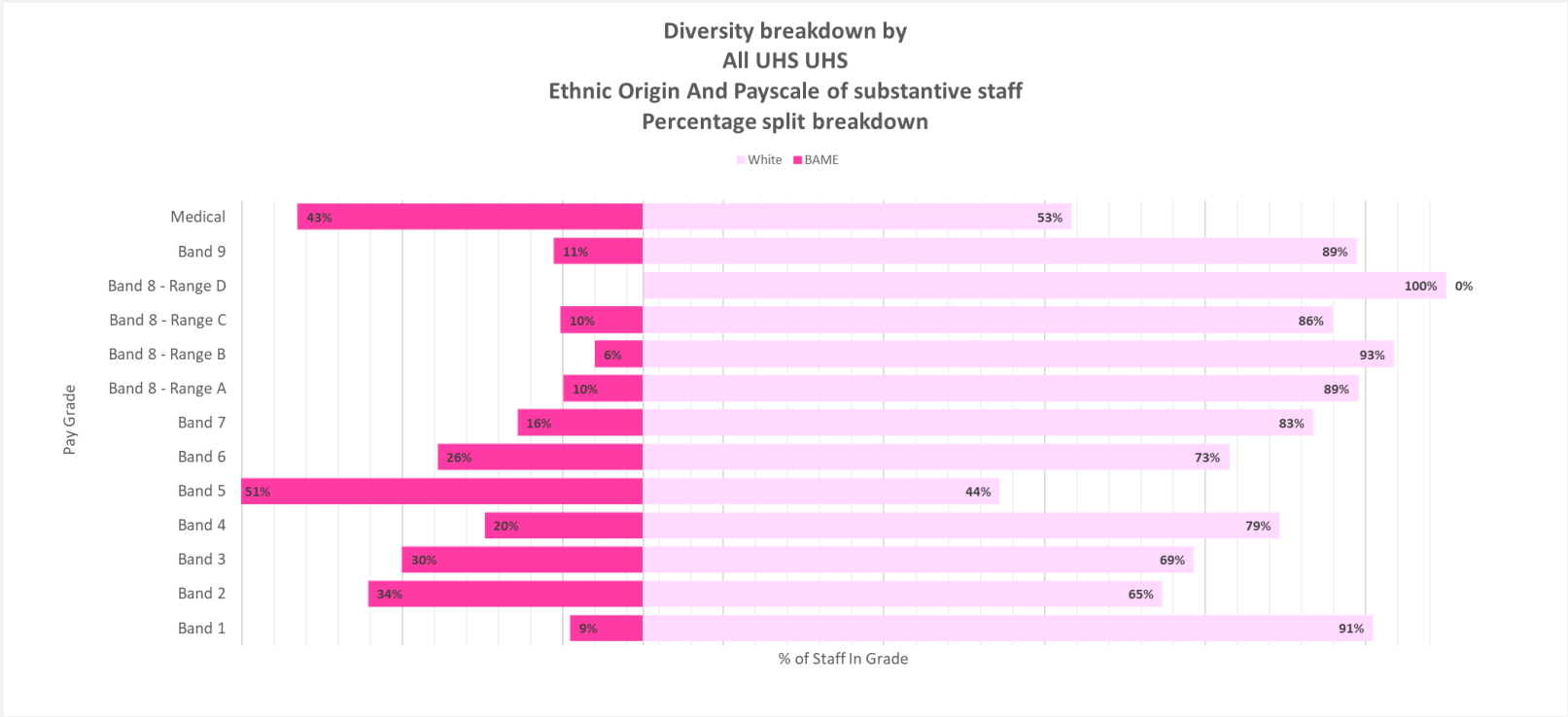


Source: Virtual Learning Environment (VLE).

BELONG

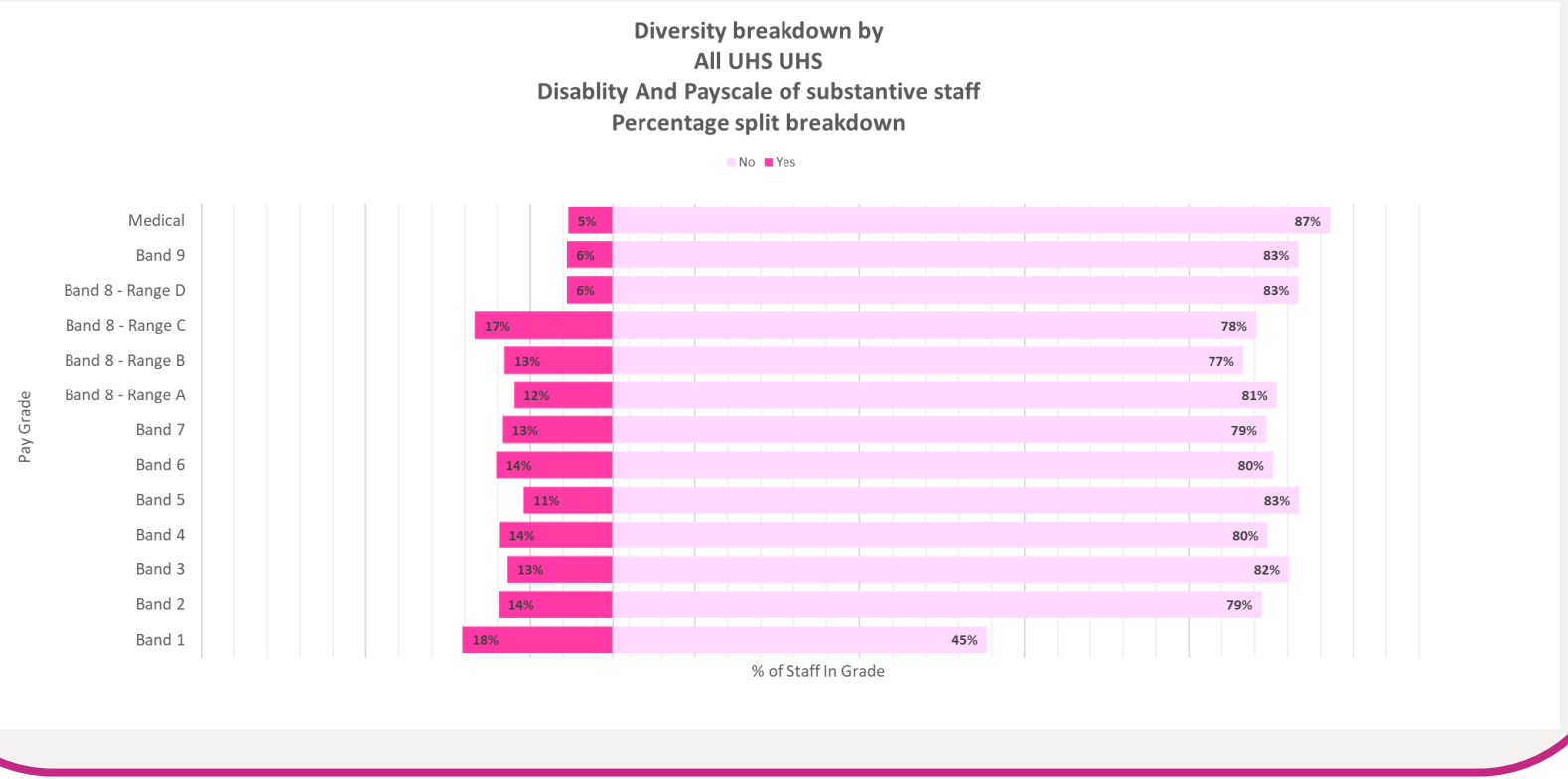


Staff in Post - Ethnicity



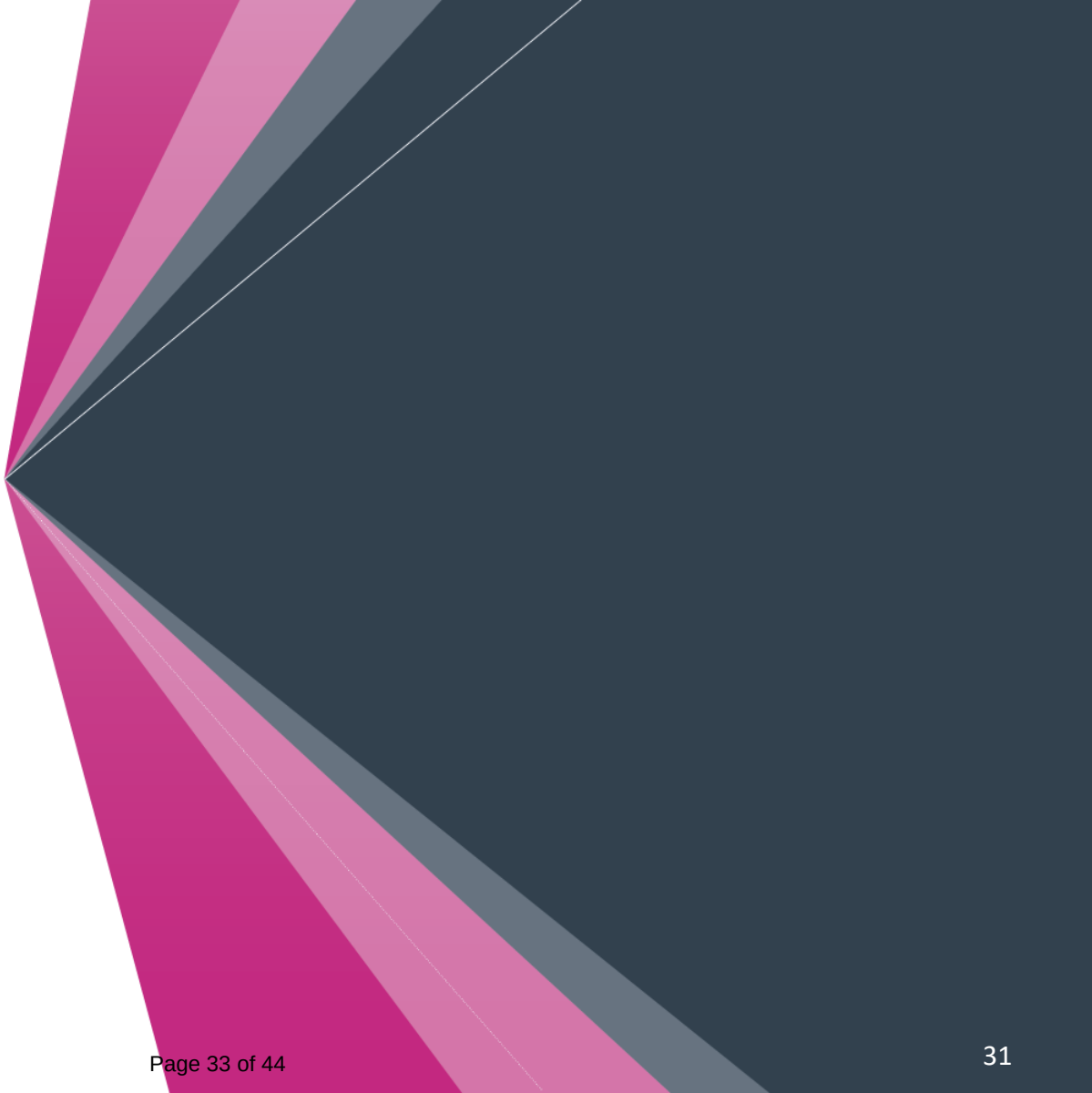
Source: ESR – March 2026

Staff in Post – Disability Status

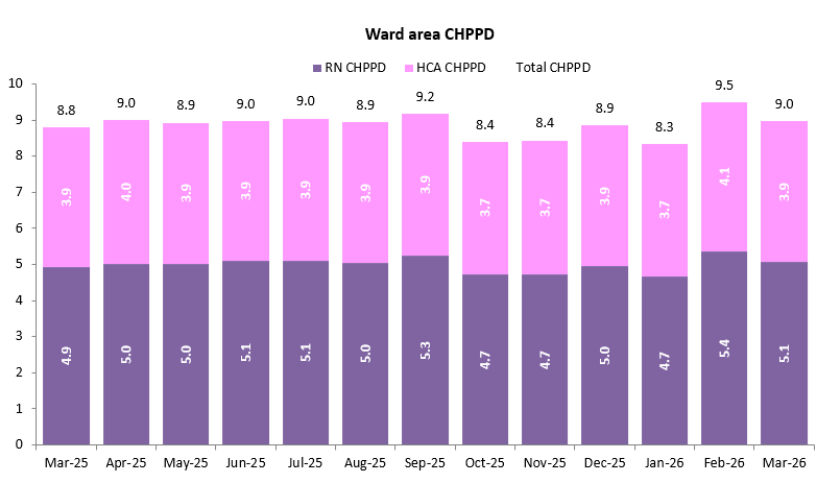


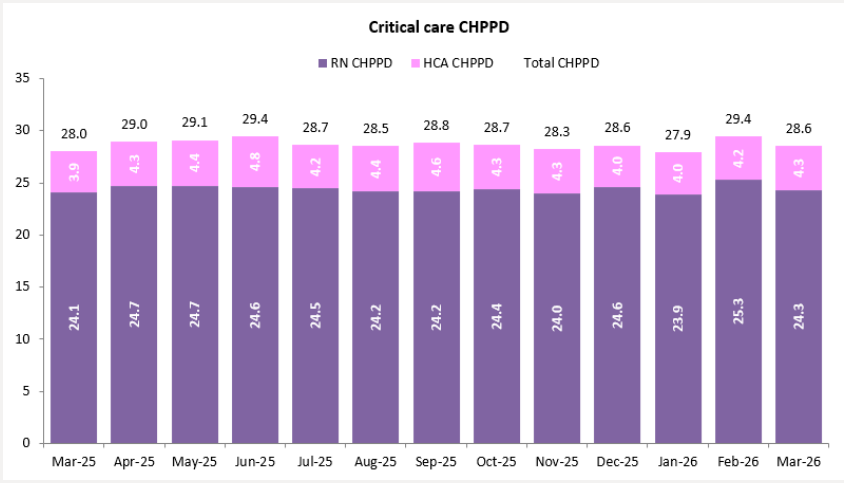
Source: ESR – March 2026

Staffing Safety Data



CHPPD



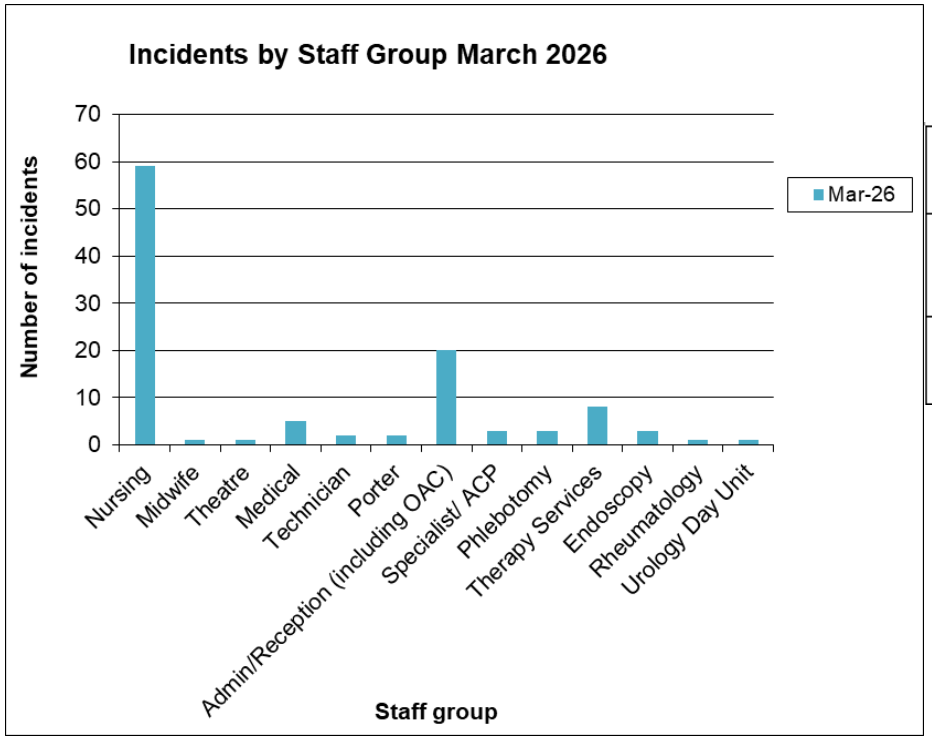


At the beginning of February 2026, the trust had a fire that caused significant damage to the hospital. As a result, many of the wards and areas of intensive care were affected, meaning patients were cared for in different specialties and in areas not normally used for inpatient care throughout February as part of the recovery operation. This has continued into March 2026 with many wards being repurposed for new specialties, and staff moving across areas to maintain staffing levels (noted in the commentary below). Wards have been adaptable and changing constantly to ensure we reduced the number of lost beds and were able to continue caring for our patients. As a result, all of the data for March should be reviewed with caution as it will not accurately reflect all of these arrangements as rosters and specialty codes have not always been changed in line with the ward moves and patient activity has not been accurately reflecting leading to inaccurate CHPPD calculations.

Source: HealthRoster, NHSP & eCamis – March 2026

Patient Safety – Staffing Incidents & Red Flags

In total 109 incident reports were received in March 2026 which cited staffing. This is an increase on the 98 reported in February.



Incidents by Division March 2026 vs February 2026

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
March 2026	52	18	37	2	109
Total	52 ↑ (49)	18 ↑ (8)	37 ↓ (41)	2 ↑ (0)	109 ↑ (98)

Month Incident occurred	Division A	Division B	Division C	THQ	Trust total
February 2026	49	8	41	0	98
Total	49 ↓ (50)	8 ↓ (25)	41 ↑ (35)	0 ↓ (5)	98 ↓ (115)

Source: Safeguard System March 2026

Patient Safety – Staffing Incidents & Red Flags cont.

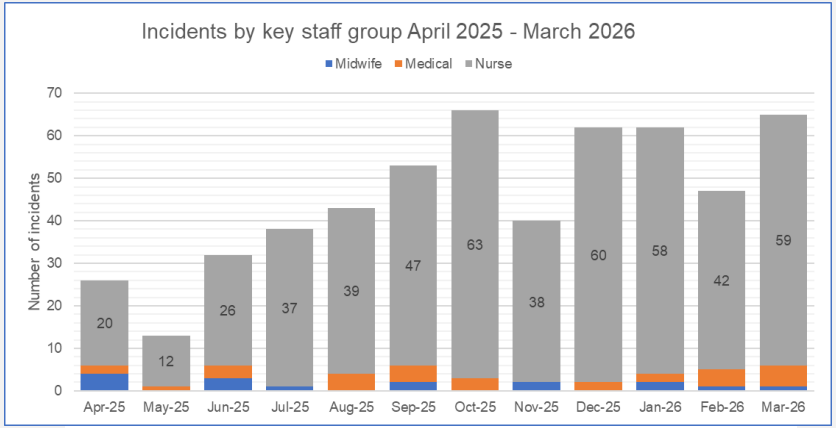
DIVISIONAL BREAKDOWN:

Div A (now including Div D):
52 incidents reported in March, a slight increase to the previous month (49). There were 9 red flags, no change from the previous month.

Div B:
18 incidents were reported in March(significant increase on the 8 in the previous month). There were 3 red flags reported.

Div C:
37 incidents were reported in March (decrease on 41 in the previous month). There were 3 red flags reported, same as the previous month.

THQ:
2 incidents were reported in March (increase on 0 in previous month).



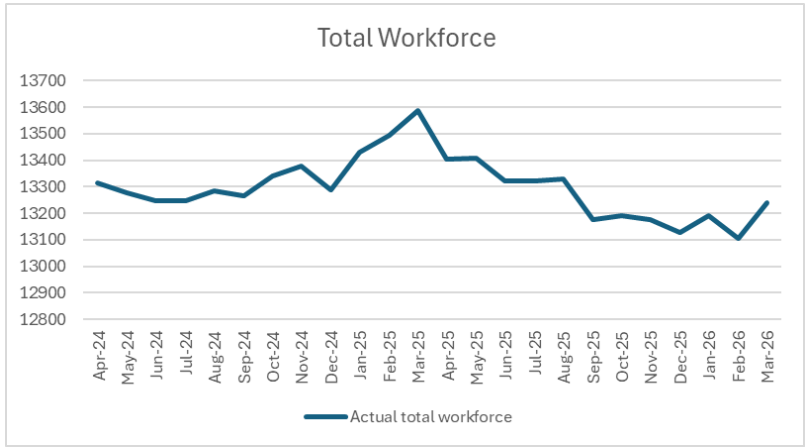
March 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	4	2	1	1
	Delay in pain relief	4	2	1	1
	Delay in observations	3	1	1	1
	Less than 2 registered	0	0	0	0
	Total	**11**	**5**	**3**	**3**

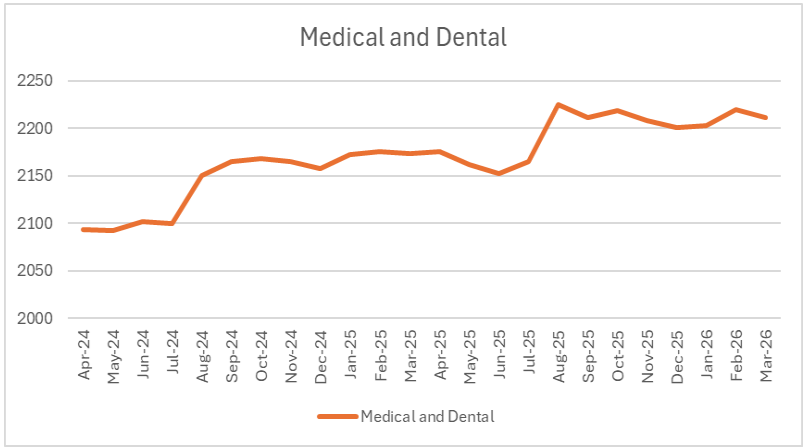
February 2026	Red flag category	Number of reports	Div A	Div B	Div C
	Delay in medication	2	2	0	0
	Delay in pain relief	2	1	0	1
	Delay in observations	5	3	1	1
	Less than 2 registered	5	3	1	1
	Total	**14**	**9**	**2**	**3**

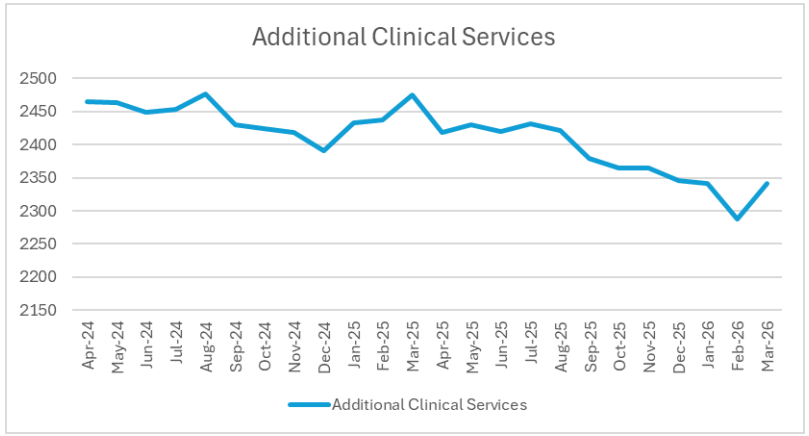
Source: Safeguard System March 2026

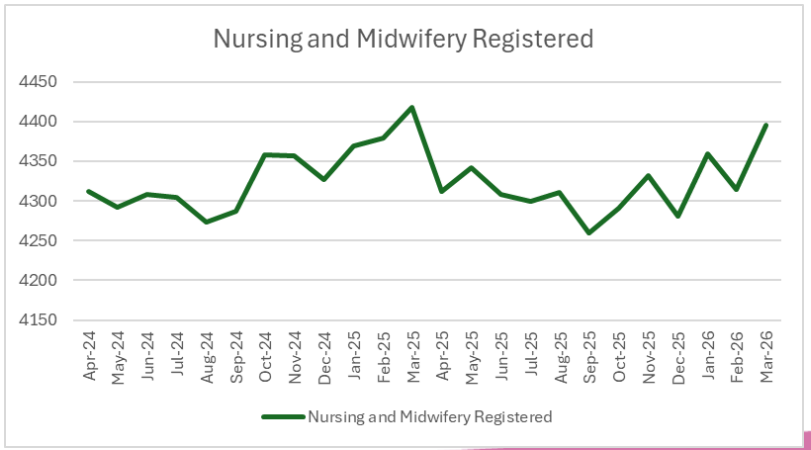
Appendices

Total Monthly Workforce (Substantive, Bank & Agency)



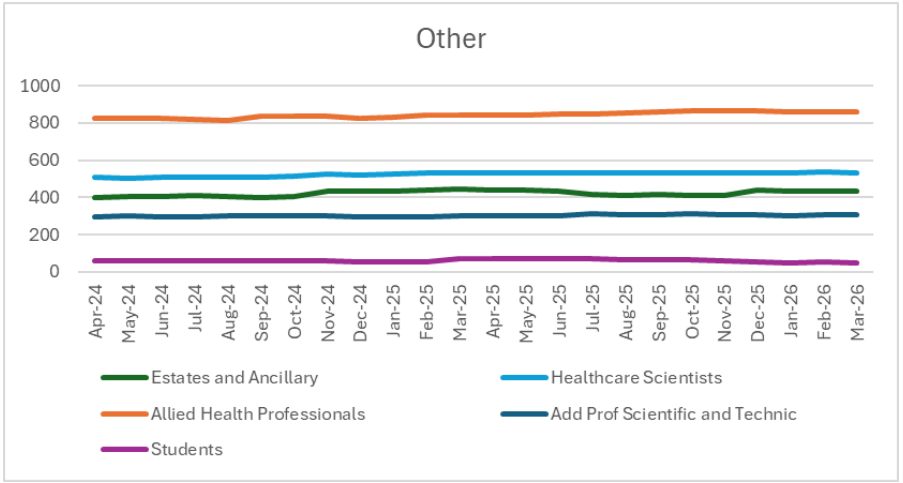


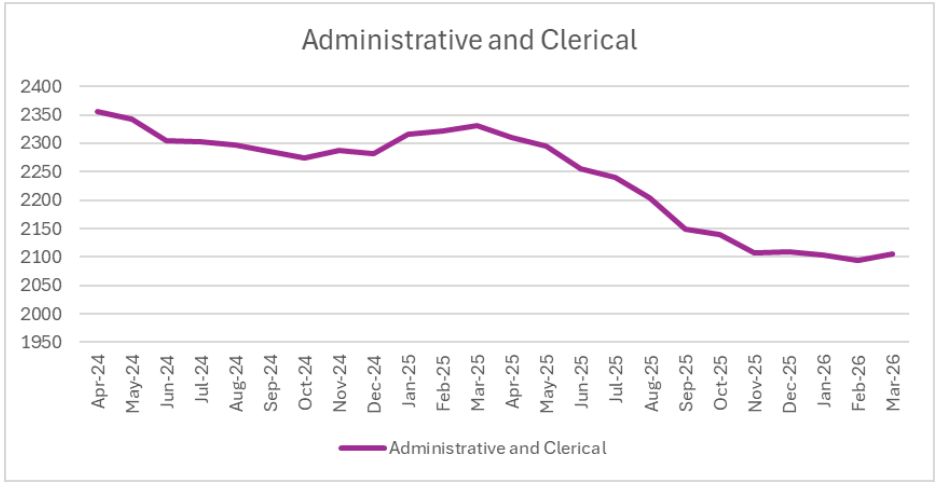




Source: ESR – March 2026

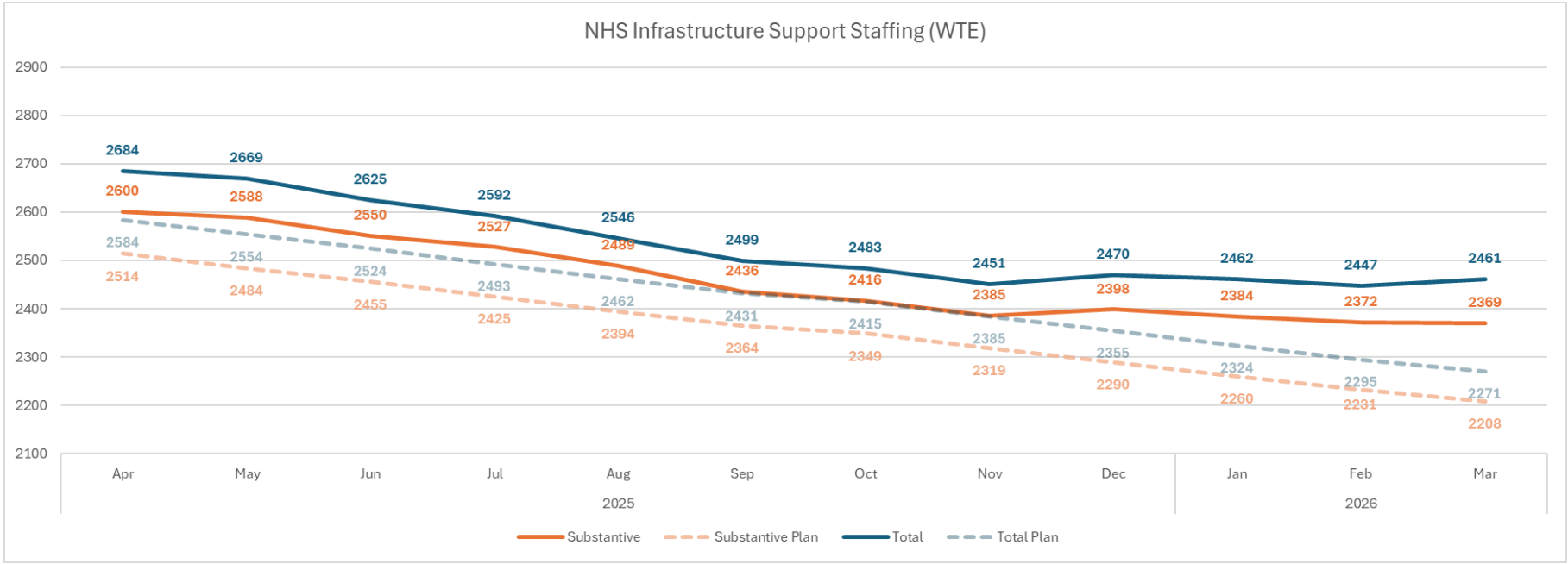
Total Monthly Workforce (Substantive, Bank & Agency)





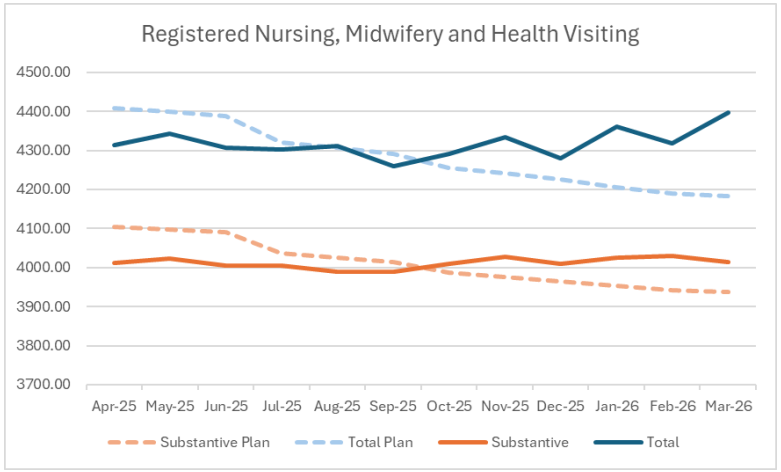
Source: ESR – March 2026

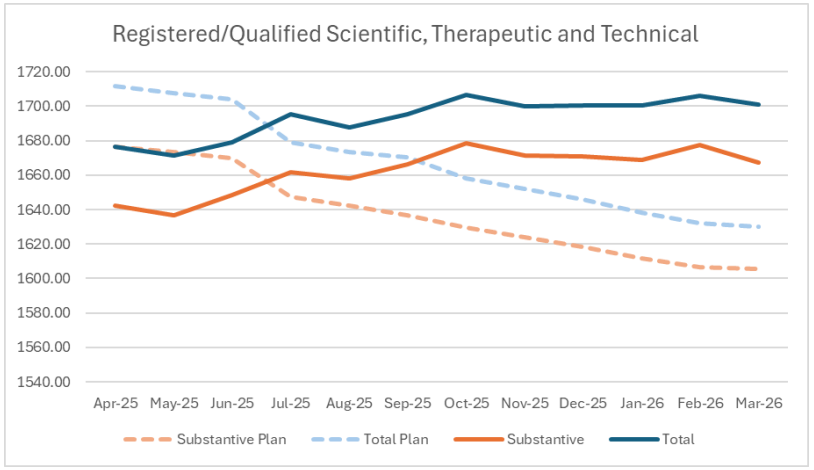
NHS Infrastructure Support Staffing

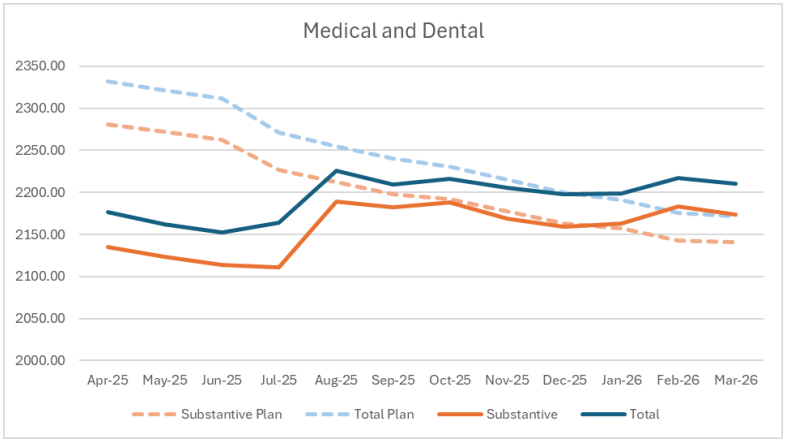


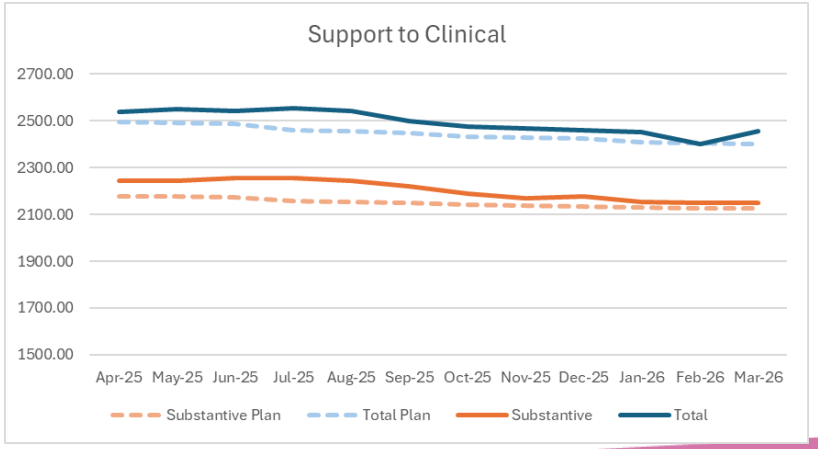
Source: PWR – March 2026

Progress Against Plan by Staff Group





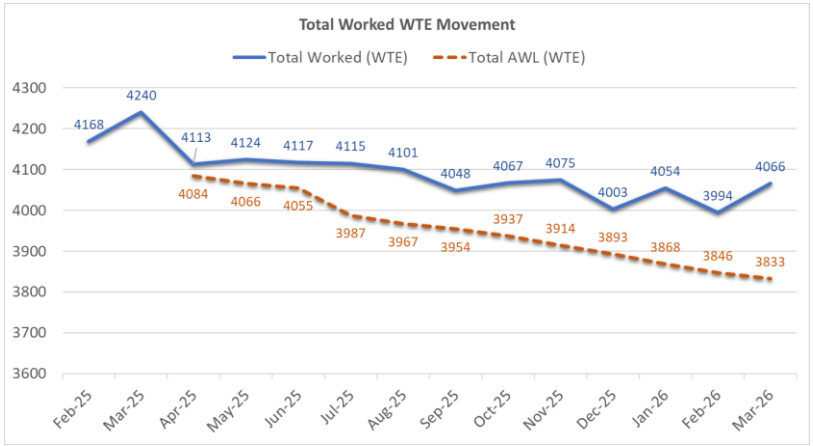




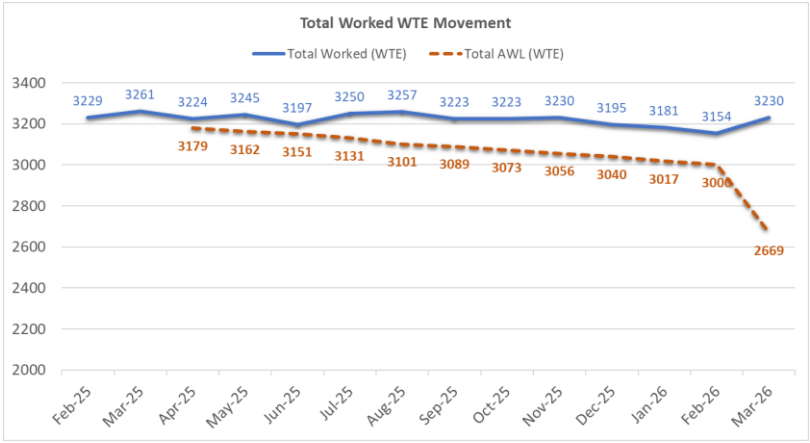
Source: PWR– March 2026

Total Worked Against Total AWL by Division

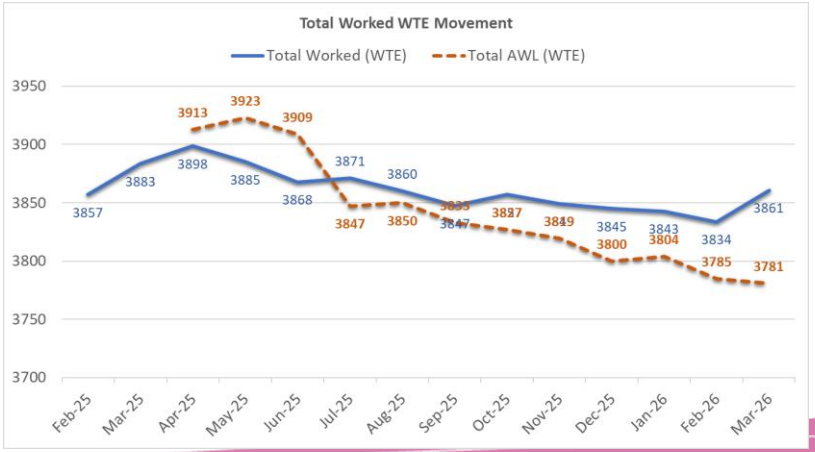
Division A



Division B



Division C



Source: EssBase (Finance) – March 2026

Data Sources

Metric	Data Source	Scope
Industrial Action	HealthRoster	All staff rostered for strike action during IA periods
Substantive Staff in Post (WTE)	ESR (Month-end contracted staff in post; consultant APAs; junior doctors' extra rostered hours)	For 25/26 Exclusions: Honorary contracts; Career breaks; Secondments; WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Additional Hours (WTE)	Overtime & Excess Hours; WLIs; Extra Duty Claims; non-contracted APAs	For 24/25 Exclusions: WPL, CLRN, Wessex AHSN and list of Hosted networks within Divisions.
Temporary Staffing (WTE)	Bank: NHSP; MedicOnline Agency: Allocate Staff Direct (Medical & Non-medical); all other framework and non-framework agencies	Exclusions: Vaccination activity
Turnover	ESR (Leavers in-month and last 12 months)	Trainee/junior doctors excluded
Sickness	ESR (Sickness absence in-month and last 12 months)	No exclusions
Appraisals	VLE (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

Agenda Item 5.11	
Title:	Staff Survey 2025 Results and People Priorities 2026-27
Sponsor:	Steve Harris, Chief People Officer
Author:	Ceri Connor, Director of OD and Inclusion

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		

Executive Summary:

This paper summarises the 2025 NHS Staff Survey results and what they indicate about staff engagement, morale, advocacy and organisational culture, including speaking up, inclusion, patient safety, leadership and wellbeing. The results reflect the impact of sustained operational and financial pressure and accumulated strain on staff over recent years, with several key measures deteriorating. National results in the acute sector have also deteriorated, whilst the rate at UHS has been faster.

Participation reduced to 35% (4,808 staff), well below the acute/acute community benchmark (47%), which is itself a risk to representativeness and a signal of engagement. UHS scored above the national average in four People Promise domains and matched in three; however, for the first time Morale is below the national average (5.73). The overall staff engagement score fell below 7 for the first time (6.7), and advocacy weakened: the proportion recommending UHS as a place to work fell 10 percentage points to 58% (now in line with the national average), while 70% would still be happy with the standard of care provided to a friend/relative (remaining above the national average but down 6 percentage points year-on-year).

Line manager and compassionate leadership indicators are broadly unchanged, but the survey continues to show burnout and wellbeing concerns alongside capacity, staffing and resource constraints.

The results have been widely discussed through People Board, Staff Partnership Forum, TEC and People and OD committee during March and April.

In line with our corporate priorities for next year the paper includes our people priorities for 26/27. These have been discussed through TEC, People Board and People and OD committee and are supported. These have the aim of stabilising the decline and laying the foundations to reverse the trend. UHS has consistently over the last 10 years been a high performing organisation in engagement of people. Our new corporate strategy, and subsequent refreshed people strategy needs to aim to get us back to this position. Our new People strategy will also incorporate the NHS long term Workforce plan once this is published in the summer.

Contents:	
Paper and associated data in appendices Benchmark Report (publicly available here) People priorities (Power Point)	
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:	Annual staff survey results contribute to the annual WRES and WDES which is reported as per the national cycle in September. Any areas of disparity in relation to equity or experience will be addressed in those papers and action plans.

1. Purpose and context

1.1. The NHS Staff Survey runs annually (Sept–Nov) and measures staff experience across the seven NHS People Promise domains. Results also contribute to the assessment of national WRES and WDES.

1.2. It is a key dataset for large-scale, multi-professional feedback and national benchmarking. Regulators use results as an indicator of organisational performance and its links to staff engagement, patient safety, quality and experience. Some key metrics are now included in the NHS national oversight framework used to rank overall trust performance.

1.3. The survey is only one view of culture (particularly if participation is low) and should be interpreted alongside other intelligence: exit and Friends and Family feedback, workforce metrics (sickness, retention, vacancies) and direct staff feedback (e.g., leadership programmes, unions and engagement events).

1.4. While response rates have declined, recent themes broadly align with other staff-morale and engagement intelligence, and the survey remains the only consistent, benchmarkable measure of engagement.

1.5. To understand trends and likely drivers, results should be viewed over time (typically 1–3 or 3–5 years). A five-year summary is provided in Appendix 1.

1.6. Across five years, UHS saw strong post-pandemic engagement and participation, followed by deterioration as financial pressure, recruitment constraints and restructuring increased strain. Despite some improvement in flexible working and inclusion, fatigue and reduced recognition were more evident in 2025, reinforcing the need to renew focus on culture and support.

2. UHS Comparison to the national picture

2.1. UHS reflects national declines in Advocacy, Development, Raising Concerns and Burnout. Line manager scores are stable/improving and remain in line with national trends. 58% would recommend UHS (also the national average). None of the 21 People Promise sub-scores improved nationally; Development and Advocacy fell, and Raising Concerns reached a five-year low (47.6% confident issues would be addressed).

2.2. Appendix 5 summarises HSJ comparator data for large acute teaching hospitals; many show similar deterioration in “recommend as a place to work”.

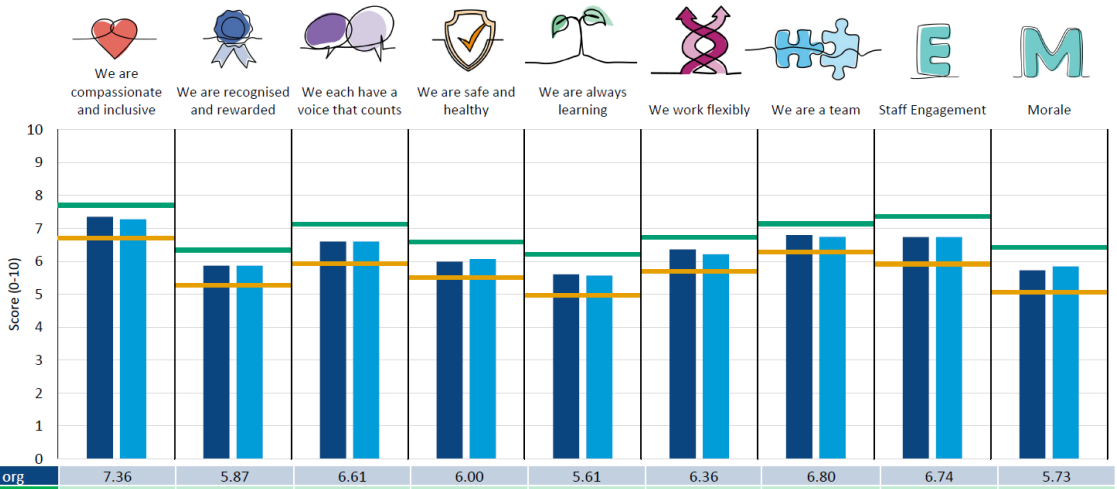
3. UHS results in more detail

3.1. People Promise average and most improved and declined

3.1.1. UHS is above the national average in four People Promise themes (Compassionate and Inclusive; Team; Work Flexibly; Always Learning) and matches in three (Recognised and Rewarded; Voice that Counts; Staff Engagement). For the first time, Morale is below the national average.

People Promise elements and themes (2025)

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.36	5.87	6.61	6.00	5.61	6.36	6.80	6.74	5.73
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4802	4795	4765	4780	4569	4778	4794	4804	4805

3.1.2. The top scores relate to advocacy for care at UHS, flexible working and opportunities to use skills/stretch in role. Lowest scores relate to staffing, capacity and resources, aligning with declines in recommending UHS as a place to work, perceived development opportunity and feeling cared for by the organisation.

Top 5 and Bottom 5 with Most improved and most declined scores

Top 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	71%	60%
q24a. Organisation offers me challenging work	74%	67%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	73%	67%
q24c. Have opportunities to improve my knowledge and skills	72%	67%
q4d. Satisfied with opportunities for flexible working patterns	60%	56%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q3h. Have adequate materials, supplies and equipment to do my work	48%	55%
q3i. Enough staff at organisation to do my job properly	25%	31%
q14d. Last experience of harassment/bullying/abuse reported	49%	54%
q2b. Often/always enthusiastic about my job	62%	66%
q3g. Able to meet conflicting demands on my time at work	42%	47%

Most improved scores	Org 2025	Org 2024
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	73%	68%
q13d. Last experience of physical violence reported	76%	74%
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	78%	77%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	86%	85%
q13c. Not experienced physical violence from other colleagues	99%	98%

Most declined scores	Org 2025	Org 2024
q25c. Would recommend organisation as place to work	58%	68%
q24b. There are opportunities for me to develop my career in this organisation	54%	62%
q25a. Care of patients/service users is organisation's top priority	71%	79%
q3i. Enough staff at organisation to do my job properly	25%	33%
q11a. Organisation takes positive action on health and well-being	51%	59%

Picker

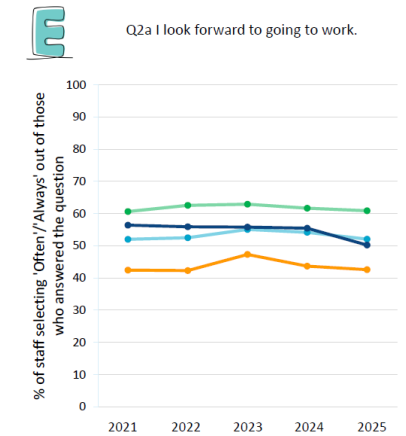
3.2. Engagement, Advocacy, Morale and Work Pressure

3.2.1. Staff engagement is 6.7 (in line with the national average) and morale is 5.73 (below the national average). Year-on-year engagement comparisons are provided in Appendix 2. 58% of staff would recommend UHS as a place to work (down 10 percentage points from 2024), with results varying by staff group; the largest decline is among Nurses and Midwives.

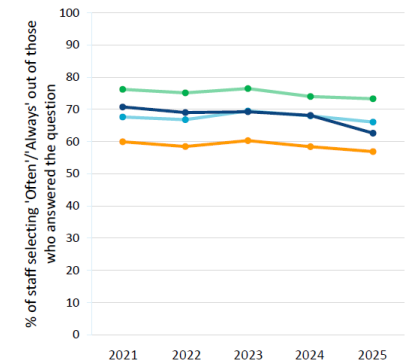
Year	NHS Average	UHS Average	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
2021	58%	72%	65%	70%	73%	70%	56%	67%	79%	73%
2022	56%	69%	59%	68%	69%	69%	57%	72%	74%	70%
2023	61%	68%	63%	67%	70%	71%	53%	67%	69%	67%
2024	61%	68%	62%	68%	68%	68%	63%	68%	73%	70%
2025	58%	58%	56%	59%	59%	70%	52%	60%	61%	54%

3.2.2. "Patient care is my organisation's top priority" fell from 79% (2023/24) to 70%. "Happy with care for a friend/relative" fell from 76% to 70%, still above the national average (60%).

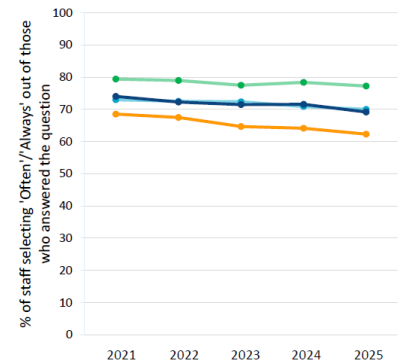
3.2.3. 50% of those who completed the survey said they look forward to going to work, a drop of 5% from 2024, and the same 5% decline seen in enthusiasm to come to work at 62%.



	2021	2022	2023	2024	2025
Your org	56.39%	55.88%	55.81%	55.46%	50.21%
Best result	60.62%	62.54%	62.89%	61.67%	60.88%
Average result	52.00%	52.48%	55.06%	54.17%	52.04%
Worst result	42.40%	42.29%	47.28%	43.67%	42.57%
Responses	6943	6932	5541	5307	4793



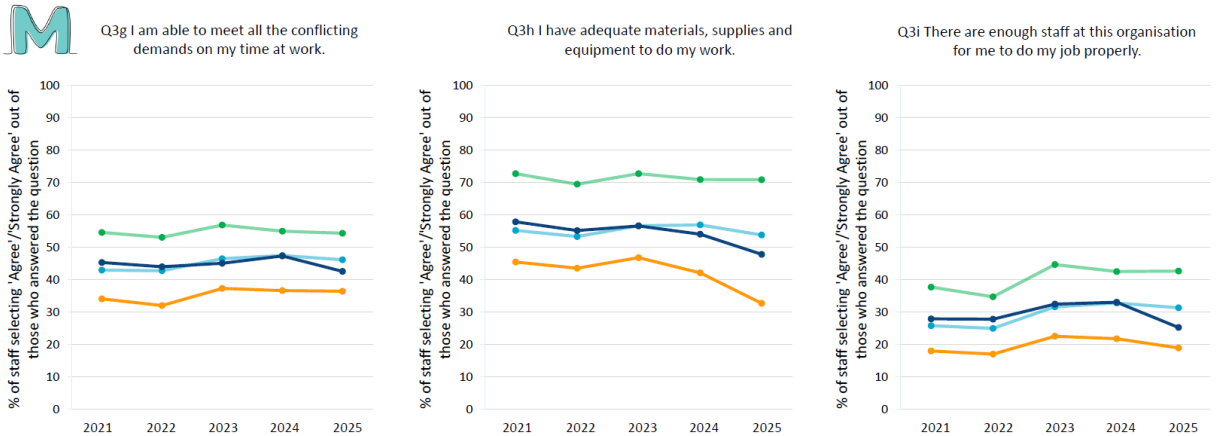
	2021	2022	2023	2024	2025
Your org	70.75%	69.01%	69.23%	68.14%	62.59%
Best result	76.21%	75.11%	76.45%	73.98%	73.28%
Average result	67.62%	66.77%	69.51%	67.95%	66.05%
Worst result	59.95%	58.47%	60.29%	58.42%	56.88%
Responses	6923	6905	5520	5282	4770



	2021	2022	2023	2024	2025
Your org	74.02%	72.24%	71.45%	71.54%	69.15%
Best result	79.40%	78.98%	77.46%	78.39%	77.22%
Average result	72.98%	72.52%	72.34%	70.90%	70.00%
Worst result	68.52%	67.46%	64.64%	64.12%	62.29%
Responses	6930	6917	5519	5281	4763

3.2.4. 30% of survey participants said they are thinking of leaving the organisation, an increase of 5% from 2023 and 2024 when it remained at 25%. However, only 21% said they will look for a job in the next 12 months.

3.2.5. In terms of coping with work pressure, less people feel they are able to meet the demands of work, 42% down from 47%, with 47% saying they have adequate materials, supplies and equipment to do their job, a 7% decline. 25% of staff said there are enough staff at UHS for them to do their job properly. This has declined by 8% from 2024.



	2021	2022	2023	2024	2025
Your org	45.33%	43.98%	45.10%	47.33%	42.57%
Best result	54.61%	53.09%	56.89%	54.99%	54.34%
Average result	42.96%	42.76%	46.52%	47.47%	46.14%
Worst result	34.06%	32.02%	37.31%	36.63%	36.45%
Responses	6889	6927	5538	5316	4792

	2021	2022	2023	2024	2025
Your org	57.90%	55.20%	56.63%	54.08%	47.84%
Best result	72.77%	69.52%	72.79%	70.96%	70.92%
Average result	55.26%	53.34%	56.68%	56.94%	53.84%
Worst result	45.45%	43.54%	46.82%	42.11%	32.70%
Responses	6905	6934	5544	5318	4798

	2021	2022	2023	2024	2025
Your org	27.90%	27.78%	32.44%	33.03%	25.22%
Best result	37.72%	34.72%	44.68%	42.50%	42.65%
Average result	25.79%	24.95%	31.62%	32.78%	31.34%
Worst result	17.94%	17.00%	22.52%	21.73%	18.91%
Responses	6905	6933	5545	5326	4798

3.3. Pay, safety and wellbeing

3.3.1. Satisfaction with pay has remained the same as 2024 at 30%, slightly below the national average at 31%.

3.3.2. Experience of violence and aggression at work in the past 12 months has remained broadly unchanged. 14% of staff reported violence from patients or service users, 0.59% from managers and 1% from colleagues. 23% reported harassment, bullying or abuse from patients or service users, 8% from managers and 16% from colleagues—each within +/-1% of last year.

3.3.3. When reviewing what is happening in the **areas of known high risk,** the results are as follows:

Locality/Service	% of staff saying they **have NOT** experienced violence or aggression from patients/members of the public in the last 12 months.
ED	42.5%
Neuro	49%
Critical Care (L2)	47.2%
T&O	60%
T&O (Trauma F2)	31% (Lowest rating across all L3 teams)
Medicine	49%

3.3.4. Reporting of violence at work has risen year on year since 2023 to 76% (above the national average of 71%). Reporting of harassment, bullying and abuse has fallen slightly from 52% (2024) to 49% (2025). Five-year trends are in Appendix 4.

3.3.5. Wellbeing indicators worsened: 35% report emotional exhaustion (31% in 2024), 31% burnout (27% in 2024) and 37% frustration (+5% year on year). Fewer staff feel UHS supports work–home balance (47% vs 53%), though 57% still report a good balance (above average) and 72% can discuss flexible working with their manager. 50% say UHS takes positive action on health and wellbeing, down 14 percentage points since 2023.

3.4. Teams and leaders

3.4.1. Staff report that leaders listen, provide support and show care. Line manager scores are stable (around 70% across all four questions) and remain above the national average

3.4.2. Team experience remains positive: 80% enjoy working with colleagues, 71% say people are kind, 72% feel treated with respect, 87% understand their responsibilities and 89% feel trusted to do their job.

3.5. Learning, development and careers

3.5.1. Confidence in learning and development has dipped. 58% feel supported to reach their potential (down from 61% in 2023/24) and 59% accessed the right learning and development opportunities in the past 12 months (down 5 percentage points year on year)

3.5.2. Perceived career development opportunities have fallen to 53% (from 62% in 2023/24). However, 72% report opportunities to improve their skills and 74% say UHS provides challenging work.

3.5.3. 54% can access clinical supervision when needed (in line with the national average), slightly down from 57% in 2024 when the question was introduced.

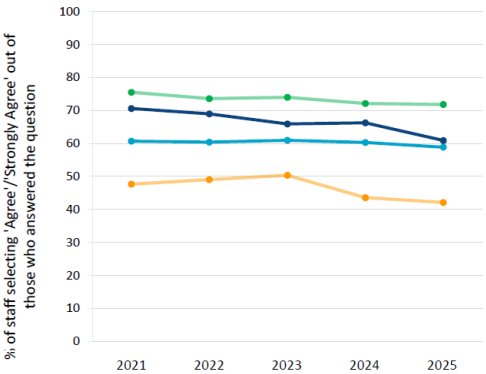
3.5.4. Appraisal: 82% report an appraisal in the last 12 months, compared with a 64.5% completion rate in the VLE (likely affected by delays in recording, despite recent improvements). In the survey, 23% said appraisal helped them do their job, 35% said it helped agree clear objectives, and 32% said it made them feel valued. Appraisal scores dipped slightly this year after improvements in 2023 and 2024.

3.6. Connection between Patient Safety, staff engagement, and morale

3.6.1. There is a clear and evidenced link between declining levels of staff engagement, morale, and the negative impact on patient safety. People feeling safe to speak up about their concerns, and that the concerns will be addressed, have seen a steady decline in the survey results over the past five years. This data can be found in appendix 4.

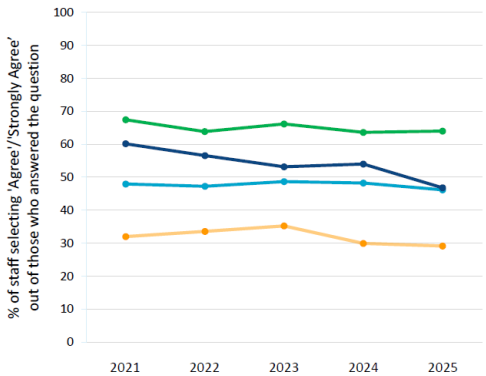
3.6.2. We are now matching the national average in relation to staff confidence that concerns will be addressed if they spoke up, at 46%. The tables below show the results 2021 to 2025.

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2021	2022	2023	2024	2025
Your org	70.62%	68.98%	65.91%	66.27%	60.91%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%
Responses	6670	6925	5521	5306	4787

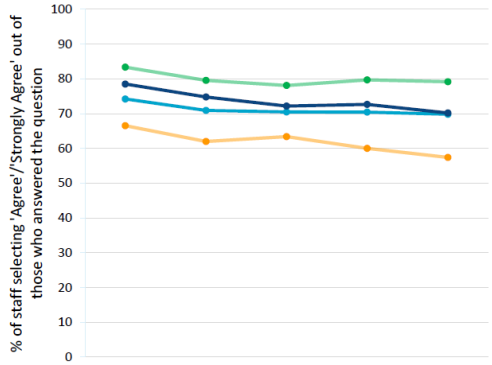
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	60.14%	56.58%	53.15%	54.01%	46.81%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%
Responses	6673	6921	5524	5296	4788

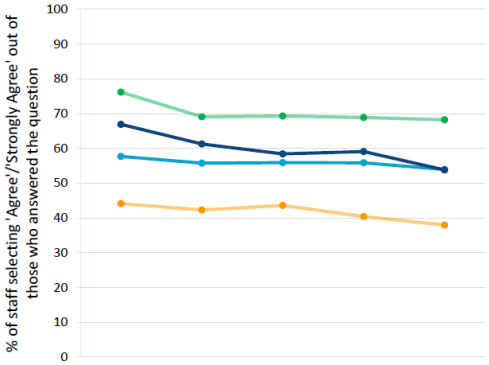
3.6.3. There are high levels of confidence in relation to raising concerns about unsafe clinical practice at 70%, however confidence that the concerns would be addressed has dropped from year on year, from 66% in 2021, where we were significantly above national average, to 53% in 2025, now matching national average.

Q20a I would feel secure raising concerns about unsafe clinical practice.



	2021	2022	2023	2024	2025
Your org	78.52%	74.78%	72.15%	72.68%	70.19%
Best result	83.36%	79.55%	78.09%	79.72%	79.16%
Average result	74.22%	70.95%	70.47%	70.44%	69.82%
Worst result	66.54%	61.98%	63.38%	60.04%	57.41%
Responses	6722	6923	5518	5321	4784

Q20b I am confident that my organisation would address my concern.



	2021	2022	2023	2024	2025
Your org	66.91%	61.27%	58.42%	59.08%	53.81%
Best result	76.20%	69.10%	69.34%	68.88%	68.23%
Average result	57.69%	55.78%	55.93%	55.88%	53.94%
Worst result	44.15%	42.28%	43.60%	40.40%	37.97%
Responses	6724	6919	5509	5315	4775

3.7. Inclusion and Belonging

3.7.1. “We are Compassionate and Inclusive” has been broadly stable over five years, with small declines but remaining above 7/10 (7.01 in 2025, above average). Compassionate leadership has ranged from 7.10–7.21 and is 7.11 in 2025.

3.7.2. Sexual safety (question added in 2023): in 2025, 8.87% reported at least one incident of unwanted sexual behaviour from patients/service users, compared with 3.8% from colleagues; both have increased since 2024.

3.7.3. Discrimination and fairness: 55% feel UHS acts fairly on career progression/promotion, and 71% feel UHS respects individual differences (down 4 percentage points, but above average).

3.7.4. 8% reported discrimination from a manager or colleague (unchanged). Of those who experienced discrimination, race remains the most cited factor (50%).

- Age: 16.41%
- Disability: 13.46%
- Race: 50%
- Religion or belief: 5.97%
- Gender reassignment: 1.32%
- Pregnancy and maternity: 4.69%
- Marriage and civil partnership: 1.23%
- Sex: 18.5%
- Sexual orientation: 3.09%
- Other: 20.66%

3.7.5. Disability and race survey items feed into WRES and WDES (reported nationally in October). The results also provide an indication of staff experience for disabled staff and those from ethnic groups other than White British.

3.7.6. Among 1,015 respondents from other ethnic groups (non-white), 21% reported harassment, bullying or abuse from patients/the public in the past 12 months, and 17% reported the same from colleagues.

3.7.7. Among 1,189 respondents who identified as having a disability, harassment, bullying or abuse was reported from patients/service users (12 months): 11% from managers and 19% from colleagues.

3.7.8. Among disabled staff, the proportion who feel the organisation values their work fell from 40.85% (2024) to 34.76% (2025) (-6.09 percentage points). Also issues still remain in relation to reasonable adjustments (falling from 79% to 76%). This is still a key focus of concerning for the long-term illness and disability group (LID network) and plans set out in the people priorities to address this.

3.7.9. Survey respondent demographics (context):

- 76% Female, 20.5% Male, 0.19% Non-Binary, 4.52% prefer not to say.
- Age: 31–40 (30.45%), 41–50 (25%), 51–65 (26%); 21–30 (14%).
- Ethnicity: 78% White, 13% Asian/Asian British, 4.44% Black/African/Caribbean/Black British, 2.36% Mixed/Multiple, 0.59% Other.
- 25% report a mental or physical health condition expected to last 12 months or more.

(Full demographic breakdown is available in the UHS benchmark report supplied with this paper.)

3.8. Free text feedback

3.8.1. Participants are given the option to provide **free text** comments prior to the completion of the survey. These are provided to UHS separately to the main report, text is not edited but any personal identifiers/names are deleted by Picker prior to sending. Free text comments are not identifiable by division or professional group although if these are included in the original comment, they are provided unedited. Over 600 free text comments were received.

3.8.2. Themes have been analysed to give a flavour of the consistent words or phrases below.

3.8.3. The concerns raised in the free-text comments align with issues raised elsewhere during the year (e.g., Talk2David and We UHS Voices), particularly around the impact of austerity and financial turnaround.

Top Challenging Themes Identified

Theme	Mentions
Staffing shortages & unsafe staffing	~110
Financial cuts & cost-saving measures	~120
Low morale / burnout / exhaustion	~100
Poor management & leadership disconnect	~100
Pay cuts, unfair pay, NHSP rate cuts	~90
Wellbeing not prioritised	~60
Lack of recognition / undervaluation	~60
Facilities & environment issues (parking, food, spaces)	~50
Poor communication & lack of consultation	~100
Career progression & training barriers	~40
Bullying, discrimination, toxicity	~30
Impact on patient care & safety	~70

3.9. Participation as an indicator of engagement

3.10. UHS participation peaked at 56% in 2021 and has fallen year on year; after coffee-voucher incentives stopped, participation dropped by 14% in 2023. It fell below 40% in 2024 (39%) and again in 2025 (35%). The benchmark median is 47%, making UHS an outlier.

3.11. In 2025, completions fell most in Nursing and Midwifery (-247) and Additional Clinical Services (-120); participation comparisons by division and staff group are in Appendix 3. Low engagement likely reflects survey fatigue (the questionnaire has been unchanged for years), limited flexibility/fit for local need, and access barriers for staff without individual email access.

3.12. The quarterly pulse survey has moved to QR-code access, which will be tested to improve access, especially for clinical staff. Fatigue is compounded when staff do not see change from feedback; managers in 2024/25 reported limited control to act on results, reducing encouragement to take part. Whilst line managers cannot control the corporate context and external NHS environment, there are good examples of where local leadership have acted on the results and involved their people, which in turn drives future participation.

4. Regulatory Implications

4.1. Staff survey indicators (Engagement score, speaking up) form components scores used in the National Oversight Framework (NOF) which all NHS provider trusts are ranked with. UHS has been in segment 1 (highest) for the people domain which currently uses staff engagement and sickness absence as its measurement. It is likely these results will drop our domain ranking and may impact our overall NOF rating.

4.2. In the future we understand the NOF is also going to include staff standards which will include sexual safety and violence and aggression. Although not confirmed, it is likely it may well use data from the NHS staff survey as the assessment measure.

5. People Priorities 26/27

5.1. The Trust is responding to a **challenging 2024/25 context**, with financial recovery, restructuring and workforce reductions having negatively impacted staff experience, engagement and trust. Additional operational pressures (including the fire and reduced capacity) have compounded this. The central strategic intent is to **reset the narrative**, moving from cutting and reduction to a **transformation focused agenda**, using the new corporate and clinical strategies to rebuild confidence, experience and engagement.

5.2. In line with our corporate priorities for next year our people priorities for 26/27 have been discussed through TEC, People Board and People and OD committee and are supported. These have the ai**m of stabilising the decline and laying the foundations to reverse the trend**. UHS has consistently over the last 10 years been a high performing organisation in engagement of people, including in some years being close to one of the best performing trusts in the country. Our new corporate strategy, and subsequent refreshed people strategy needs to aim to get us back to this position. Our new People strategy will also incorporate the NHS long term Workforce plan once this is published in the summer. The People priorities focus on 5 key areas and our consistent with our existing Thrive, Excel and Belong pillars. They also link to the national people promise. The areas are:

- Re-prioritising a focus on our people's experience, learning and development
- Delivery of our workforce plan and transformation priorities
- Voice of our people – rebuilding engagement and trust
- Safety of our People
- Inclusion and belonging of our people

5.3. The slides shared with TEC, People Board and People and OD committee are enclosed. A summary of the key priorities is below:

5.3.1. A major priority is to **re-establish a focus on people experience, leadership and development**. This includes relaunching leadership programmes across all levels, strengthening appraisal and career conversations, improving local accountability for staff experience, and developing a long-term education strategy aligned to workforce and clinical priorities. The emphasis is on building capable leaders and embedding development as a core lever for both transformation and engagement.

5.3.2. The Trust will also focus on **delivering the workforce plan in support of operational and financial recovery**. This includes appropriately re-calibrating recruitment controls aligned to budgets, continued targeted recruitment in key pressure areas to support RTT (e.g. theatres, critical care), reducing reliance on temporary staffing, and supporting transformation through digital and automation initiatives. A clear nursing workforce plan and implementation of the future workforce system (replacement for ESR) are key enablers to improve productivity, efficiency and service delivery.

5.3.3. Rebuilding **engagement, voice and organisational trust** is a core priority. This will be achieved through a clearer and more compelling organisational narrative, structured engagement linked to strategy delivery, stronger two-way communication from Board to ward, and increased senior leadership visibility. There is also a renewed focus on psychological safety, including strengthening Freedom to Speak Up arrangements in line with new national recommendations.

5.3.4. Finally, the Trust is prioritising **staff safety, wellbeing, inclusion and belonging**. This includes embedding a strengthened approach to violence and aggression (including sexual safety), reinforcing positive standards of behaviour, and improving support for staff with disabilities or long-term conditions. Inclusion will be advanced through supporting our staff networks, and continuing our positive action leadership programmes.

5.3.5. Overall— and especially through the Trust's transformation programmes—these priorities aim to close the gap between demand and capacity and tackle key drivers of burnout and low morale. Intelligent Automation will be a core programme, streamlining administrative processes to offset reduced resources in these areas.

6. Next Steps

6.1. We will share these priorities across the organisation and build them into a delivery plan. Progress will be monitored through People Board and reported to TEC and the People and OD Committee by the Chief People Officer. Delivery of the transformation priorities, including Intelligent Automation (for which the Chief People Officer is the SRE), will be reported through the Transformation Oversight Group (TOG) and to the Finance and

Investment Committee. The People impact of these programmes will be reviewed by the People and OD Committee.

Appendix 1: The story over the last 5 years

1. An organisational story of survey results; the last five years.

2021: As the NHS moved from pandemic response into recovery (with high demand and backlog), engagement and morale remained positive. UHS achieved its highest participation at 56% (+6% vs 2020). Staff Engagement was 7.2 (best in class 7.4; average 6.8)—down from 7.4 in 2018 but still above 7. 71.9% would recommend UHS as a place to work. These results informed the UHS People Strategy 2022–26 (launched early 2022).

2022: People Strategy and Always Improving programmes progressed, supported by investment in OD and communications (leadership development, Inclusion and Belonging, reward/recognition, revised appraisal, VLE review, and alignment to transformation/CI). Survey signals remained positive: participation dipped to 54%, recommendation held at 69% (top in the South East; 7th nationally), and engagement was 7.1. People Promise themes stayed above average, with UHS best for “We are recognised and rewarded”. Appraisal and learning/development improved, while “enough people to do my job”, pay satisfaction, and confidence to speak up began to soften (still above average). 79% would recommend UHS for friends/family care.

2023: Momentum continued (People Strategy delivery, Inclusion and Belonging, staff networks, recognition framework, CI, and new wellbeing/improvement spaces, including WeAreUHS week). However, rising demand and emerging financial pressures coincided with the first overall declines: recommendation fell to 67.6% and engagement was 7.0 (national average 6.9). Recruitment restrictions began late Q3/Q4.

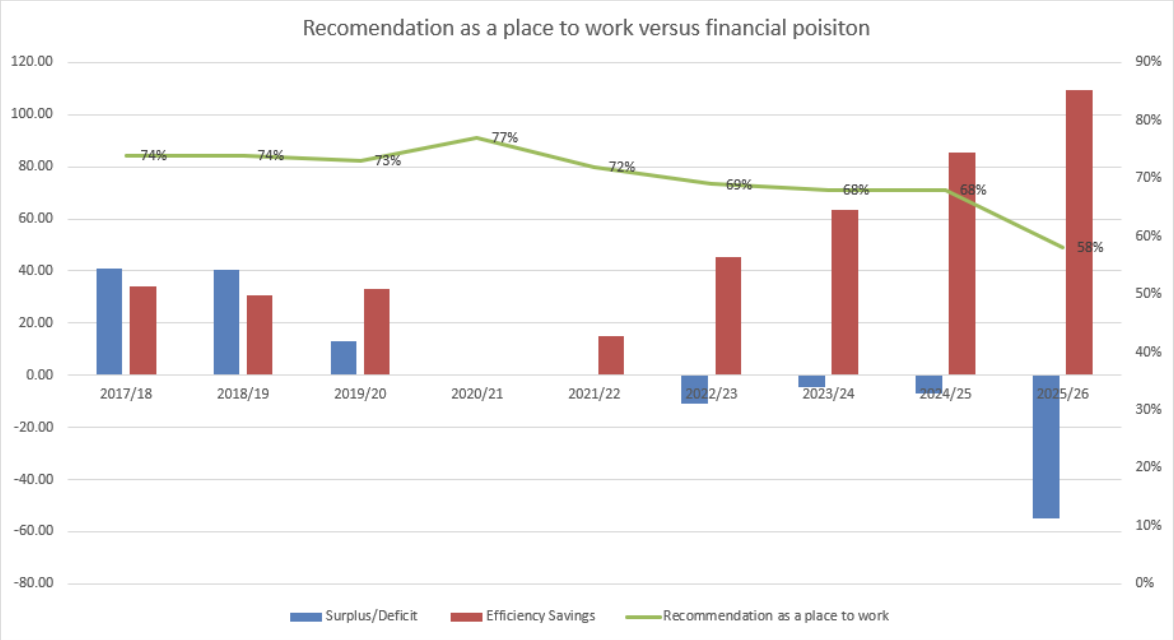
2024: Results were mixed as recruitment constraints increased pressure: engagement stayed at 7.04 and morale at 6.06. Participation fell from 54% to 41% (-14%), dropping below the national average for the first time. Motivation and advocacy softened (67.5% recommend UHS). Ability to make local improvements slowed, burnout rose, and confidence to speak up continued to drift down. Care advocacy remained strong: 79% would recommend UHS for friends/family care (no change). Flexible working and pay satisfaction improved (following industrial action and national pay rises), and manager satisfaction stayed stable, with gains in compassionate leadership and inclusion. The Allyship programme and actions from the F2SU/People Policies review were reflected in improved confidence to report bullying/harassment and feeling that differences are respected.

Indicators in relation to staff ability to make change happen and improve things locally started to slow. Burnout scores also started to decline alongside a slowly declining picture in relation to safety and confidence to speak up. However, our staff said they would still like their friends or family to be treated at UHS, with no change from the previous year, at 79%. In 2024 we saw improvements in satisfaction related to flexible working, and some improvements in satisfaction with pay – following the year of industrial action and subsequent national pay increases. Satisfaction with managers was stable, with improvements related to compassionate leadership and inclusion. The positive impact of the UHS Allyship programme, and the actions taken as a result of the independent review of F2SU and People Policies was evidenced in the 2024 survey results with an improvement in people feeling confident to report bullying and harassment and feeling that differences are respected.

2025: Results reflect another highly challenging year after two years of recruitment/resource constraints and organisational change (moving from four divisions to three). Divisions A and B reported the most strain. Financial recovery decisions (recruitment limits and savings schemes) impacted morale and engagement; the Staff Engagement score fell below 7 to 6.74, matching

the national decline. With fewer staff recommending UHS as a place to work and reduced confidence that concerns will be addressed, the “emotional contract” has weakened; advocacy remains closely linked to culture, leadership visibility, and feeling valued.

The graph below shows the relationship between the decline in Staff Engagement and the Trust’s deficit position and efficiency savings (2020/21 reflects the Covid period). Summer 2025 change (role changes, reduced admin/support capacity, wider senior leadership portfolios, MARS exits, and reduced recruitment) and budget reductions (including a 10% reduction in THQ/Corporate pay budgets affecting OD, Comms, Training and Education, plus a further 5% divisional reduction) coincided with rising operational pressure. This is reflected in weaker psychological safety, higher emotional exhaustion, reduced discretionary effort, and less headroom for line managers to support teams. Morale fell from 6.04 (2023) and 6.06 (2024) to 5.73 (2025), placing UHS below the national average for the first time in this period. Declining capacity, staffing and competing demands align with increased burnout, while reduced recognition and feeling valued reinforce the need for consistent, authentic recognition.



Appendix 2: Engagement score comparison 2023 -2025

Area	Question	UHS 2023	UHS 2024	UHS 2025	Difference 2023 to 2025
Motivation	Often/always look forward to going to work	55.8%	55.3%	49.8%	-6%
	Often/always enthusiastic about my job	69.1%	68.0%	62.3%	-1.1%
	Time often/always passes quickly when I am working	71.6%	71.7%	69.1%	-6.8%
Involvement	Opportunities to show initiative frequently in my role	76.0%	75.3%	73%	-3%
	Able to make suggestions to improve the work of my team/department	73.3%	73.5%	71.7%	1.6%
	Able to make improvements happen in my area of work	58.4%	57.9%	54.5%	-3.9%
Advocacy	Care of patients/service users is organisations top priority	80.1%	79.3%	71%	-9%
	Would recommend organisation as a place to work	67.7%	68.3%	58%	9.7%
	If a friend/relative needed treatment would be happy with standard of care provided by organisation	76.4%	79.3%	70%	6.4%
	Engagement score	7.0	7.0	6.7	-0.3

Appendix 3: Participation rate by Division and Staff Group

When analysing survey results, it is important to consider two elements:

- The % completion vs the total number of respondents (5410)
- The conversation to engagement, the % completions within the eligible in the staff group.

Participation rate by Division compared and % of total Trust completion

Division	Number of respondents	% of total Trust respondents
Division A	1253	25%
Division B	972	19%
Division C	1568	31%
Hosted Services	333	6.6%
THQ	899	17.8%
Trust Total	5025 (Picker)	100%

Participation rates by Staff Group 2025 and 2024

Division	Number of respondents 2025	Number of respondents 2024	Difference
Additional Professional scientific and technical	167	149	+18
Additional clinical services	707	827	-120
Admin and clerical	1499	1544	-45
Allied Health Professionals	394	356	+38
Estates and ancillary	194	241	-47
Healthcare Scientists	266	261	-5
Medical and Dental	391	379	+12
Nursing and Midwifery	1406	1653	-247
Trust Total	**5025**	**100%**	

Appendix 4: Violence, aggression, bullying, harassment, and abuse and patient safety comparison 2021-2025

		Picker Average 2025	2025	2024	2023	2022	2021
Q	**Questions**						
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	85.2%	86.4%	85.2%	87.4%	83.9%	85.4%
q13b	Not experienced physical violence from managers	99.1%	99.4%	99.3%	99.4%	99.4%	99.3%
q13c	Not experienced physical violence from other colleagues	97.9%	99%	98.3%	98.6%	98.5%	98.4%
q13d	Last experience of physical violence reported	73.2%	75.8%	73.7%	69.5%	68.4%	67.2%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	75.0%	78%	76.7%	75.4%	75.0%	77.4%
q14b	Not experienced harassment, bullying or abuse from managers	90.6%	92.1%	92.6%	90.6%	92.2%	92.0%
q14c	Not experienced harassment, bullying or abuse from other colleagues	82.1%	83.8%	84.3%	81.6%	83.4%	84.8%
q14d	Last experience of harassment/bullying/abuse reported	53.7%	49%	52.7%	49.1%	46.0%	48.2%
q15	Organisation acts fairly: career progression	53.4%	56%	61.2%	61.3%	62.4%	62.4%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	90.8%	91.4%	90.8%	91.9%	91.4%	92.5%
q16b	Not experienced discrimination from manager/team leader or other colleagues	91.9%	92%	92.1%	91.9%	92.0%	92.3%
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	91.9%	91.6%	91.7%	91.1%	*	*
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	96.6%	96.1%	96.7%	96.0%	*	*

q18	Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	65.6%	62.5%	65.6%	65.7%	63.3%	*
q19a	Staff involved in an error/near miss/incident treated fairly	58%	59.2%	64.0%	63.4%	64.1%	*
q19b	Encouraged to report errors/near misses/incidents	85.8%	85.5%	86.5%	86.6%	86.9%	*
q19c	Organisation ensure errors/near misses/incidents do not repeat	65.9%	64.6%	68.9%	69.5%	70.1%	*
q19d	Feedback given on changes made following errors/near misses/incidents	59.6%	57.2%	62.1%	61.5%	62.8%	*
q20a	Would feel secure raising concerns about unsafe clinical practice	69.6%	69.6%	72.9%	72.0%	74.9%	78.5%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	53.9%	53.9%	59.4%	58.7%	61.1%	66.7%
q25b	Organisation acts on concerns raised by patients/service users	67.2%	66.6%	73.5%	72.7%	74.6%	79.1%
q25e	Feel safe to speak up about anything that concerns me in this organisatin	59.1%	61.2%	66.4%	66.2%	68.9%	70.6%
q25f	Feel organisation would address any concerns I raised	46.3%	47.3%	54.3%	53.6%	56.4%	60.0%

Appendix 5: HSJ data on Recommendation as a place to work in Teaching Hospitals

Organisation	2021	2022	2023	2024	2025	Change	Response
University College London Hospitals	74%	75%	77%	79%	79%	0	54%
Guy's and St Thomas'	73%	71%	70%	72%	75%	2.5	49%
South Warwickshire University	70%	70%	74%	77%	74%	-2.7	45%
Northumbria Healthcare	78%	74%	77%	73%	74%	0.6	74%
Chelsea and Westminster Hospital	67%	65%	70%	72%	71%	-0.7	52%
North Bristol	63%	62%	71%	70%	71%	1.9	56%
Imperial College Healthcare	64%	66%	69%	71%	70%	-0.3	58%
University Hospitals Bristol and Weston	63%	60%	67%	69%	69%	0	61%
Cambridge	67%	62%	65%	69%	64%	-4.8	54%
Royal Devon University Healthcare		60%	64%	66%	63%	-2.6	33%
Barts Health	60%	56%	62%	63%	62%	-1	44%
St George's	58%	58%	60%	63%	60%	-3.6	42%
University Hospitals of Leicester	56%	55%	64%	65%	60%	-5.1	59%
University Hospitals Dorset	62%	56%	64%	63%	60%	-2.8	55%
East and North Hertfordshire Teaching	57%	53%	56%	61%	58%	-2.9	41%
London North West University Healthcare	55%	53%	58%	63%	58%	-4.3	46%
University Hospitals of North Midlands	54%	51%	58%	61%	58%	-2.8	41%
Sheffield	62%	56%	60%	62%	58%	-3.8	55%
The Newcastle upon Tyne Hospitals	65%	63%	59%	61%	58%	-3.4	62%
Manchester University	54%	50%	57%	60%	58%	-1.9	35%
University Hospital Southampton	72%	69%	68%	68%	58%	-10	35%
Oxford	64%	61%	64%	62%	58%	-3.5	40%
University Hospitals Coventry and Warwickshi	61%	60%	59%	59%	57%	-2	57%
Leeds	64%	59%	64%	62%	57%	-4.9	47%
King's College Hospital	55%	56%	56%	53%	56%	2.7	46%
University Hospitals Sussex	54%	49%	54%	52%	55%	3.4	46%
University Hospitals Birmingham	50%	48%	50%	53%	54%	0.7	38%
Northern Care Alliance		56%	58%	56%	53%	-2.5	48%
University Hospitals Plymouth	55%	51%	58%	56%	53%	-3.5	48%
University Hospitals of Derby and Burton	64%	61%	60%	61%	52%	-9	54%
Nottingham	54%	53%	58%	56%	52%	-3.3	44%
Mid Yorkshire Teaching	53%	51%	53%	54%	52%	-1.4	35%
Portsmouth Hospitals University	58%	50%	54%	49%	49%	0.1	42%
Hull University	56%	47%	55%	50%	47%	-2.8	47%
Wirral University	56%	55%	56%	53%	47%	-6	42%
Norfolk and Norwich	48%	41%	50%	51%	42%	-9	48%
East Kent Hospitals University	46%	43%	44%	44%	40%	-3.5	53%
Mid and South Essex	47%	42%	48%	35%	34%	-1.2	39%

People Priorities 26/27

WORLD CLASS PEOPLE

April 2026

THRIVE EXCEL BELONG

Context

- 25/26 very difficult year **dominated by financial recovery**, Divisional restructure, local organisational change, and workforce downsizing
- **Difficult decisions** eroded the experience and trust of our people
- **Significant drop in staff experience** and engagement in our 2025 staff survey results (expected). National fall in results, but UHS deteriorated at a faster rate
- **Fire has further placed pressure on our people through** significant reduction in bed availability, displacement of staff to unfamiliar settings and diversion of resources.
- Reduced resources in HQ and Divisional infrastructure for people focus
- **Challenging medium-term plan** submission for 2026 – 29 (Operational, financial)

A new opportunity:

- **Reframe the narrative away** from 'cut to change and transform'
- Use new corporate strategy, clinical strategy, and transformation priorities as platform to **rebuild trust, engagement and experience**
- **Re-focus on our people**

Re-prioritising a focus on our people's experience, learning and development

Re-focus on people development and experience, including the importance of quality leadership and management at all levels

Achieved through:

- Reintroduction of **dedicated leadership development programmes** focused on Divisional, Care Group and Clinical leadership – working with COO, CMO, CNO
- **A refocus on individual development** – importance of appraisal career conversations. Using appraisal to support transformation focus and conversations
- Consider findings of the **Divisional Restructure review** and opportunities to further improve configuration
- Accountability for people including **local improvement actions** within Divisions and THQ (linked to local staff survey results)
- **Review education infrastructure,** and develop a long-term education strategy linked to refreshed people strategy and clinical strategy

Delivery of our workforce plan and transformation priorities

Work within the delivery of our plan for 26/27 including a focus on total workforce. A focus on change / not cutting to delivery operational performance, financial efficiency and quality and staff experience improvement.

Key actions to include:

- **Appropriate calibration** of recruitment controls linked to new WF plan and financial budgets
- To focus on **specific RTT related recruitment** (Theatres, crit care, key admin positions) and deliver reductions in vacancy and reliance on bank
- Support the **delivery of the transformation priorities**, specifically the delivery of improved administration processes through the Intelligent Automation workstream
- Support the CNO to develop a **clear nursing WF plan** focusing on the optimum balance of temporary and permanent resources
- Work to implement **the new Future workforce solution** (UHS an early adopter) to deliver benefits and efficiencies on people service delivery

Voice of our people – rebuilding engagement and trust

Strengthen the voice and engagement with our people from Board to ward through a compelling narrative of the trust, immediate priorities for transformation, and our new long-term strategy and vision.

Achieved through:

- **Re-setting the organisational narrative** – focus on change and transformation to deliver for our patients and people.
- Set out a **clear programme of engagement linked to transformation priorities** and **Launch our new Corporate and Clinical Strategy** and provide opportunity for execs, board and senior leaders' visibility with purpose
- **Re-set our expectations at all levels** for our leaders and managers – ensure there are standards of expected two-way communication and engagement in every key department – support the information flow both ways from Board to ward. Provide guides centrally to support these skills
- Building further a culture **of safety to speak up**, - FTSU refresh and publication including clear narratives on how this has made a difference in areas across the trust.

Safety of our People

Safety, particularly from violence and aggression, remains a key area of concern for our people. Continuing the work from 25/26 and embedding is a critical care of focus for this year.

Actions to take for 26/27

- **Launch and embed new VA&A strategic framework (including policy)** across the trust, including local skills to respond, and board oversight. Continue to embed the national priorities on improving sexual safety.

- **Embed the new VA&A board** including expanding exclusions and restrictions

- **Implement a training and skills plan** for VA&A to equip leaders locally to address concerns. **Underpinned by a clear communication plan**, external and internal promotion Be clear on where action has been taken, **and re-set narrative** on organisational tolerance

- Re-focus on actions to **support and prevent burnout**, including local processes and policies on stress risk assessments. Ensure our well-being support packages are well-publicised.

- Continue to take **robust action where the standards** of employee behaviour regarding civility fall below the standards expected at the Trust. Be clear with the indidivauls who have raised concerns, and the Trust where action has been taken without breaching individual confidence.

Inclusion and belonging of our people

Continue to make progress on our UHS inclusion and belonging strategy within the resource envelope we have:

Achieved through:

- Using executive sponsorship, to **re-energise our staff networks**
- Significantly improve the **experience of staff with long-term illness** and disabilities through improvements to our support for workplace adjustments and to work with our LID network to co-design and embed the solution
- Increase representation opportunities at management and leadership levels through another **cohort of our UHS PALP programme** (Positive Action Leadership)
- Continue to **strengthen our anti discriminatory** stance through our new VA&A framework, with clear consequence for patients and service users who deviate

Next Steps

Next actions are as follows:

- Priorities translated **into a clear action plan** to be monitored by People Board and with Board oversight via People and OD committee
- **Building conditions for success**, including ensuring appropriate resources and focus with People Directorate and across the Trust
- To discuss in **open UHS Trust Board in May** in conjunction with our staff survey results
- **Cascade and discussion with our people through** Divisions. Discussion at local Divisional Boards and local divisional planning with HR Business Partners
- During May and June **launch reframed organisational focus** around transformation priorities and new UHS strategy

Outstanding people – New UHS strategy pillar

Ambitions	5 year objectives
• To maximise our position as a university teaching hospital to shape and transform the UHS workforce of today and the future to meet our strategic needs in line with the NHS long term plan • To provide a great place to work, where careers are developed, talent is nurtured, achievement is celebrated, and wellbeing is supported • To create an inclusive environment in line with our values, where improvement and innovation is encouraged and where diversity is valued and everyone feels they belong.	• For our collective ambitions to be shared across an engaged workforce, positioning UHS as an outstanding NHS employer that ranks back in the top 10 acute Trusts for staff engagement and recommendation as a place to work • To have transformed how our people work, through digital automation and improvement programmes working with system partners to provide effective, equitable care across our communities. • To offer industry-leading education and training that ranks UHS in the top quartile of University teaching Trusts for education experience for our people (our staff and our learners) • To empower our staff to lead and deliver change that ranks UHS in the top quartile for all workforce productivity metrics in NHS model hospital

Year 1 priorities	KPI
Safety of our People at UHS - Roll out and embed the new Violence, Aggression and Abuse policy across the trust increasing staff safety and confidence and ensuring stronger consequence for poor behaviours. Ensure alignment to the national Violence reduction standards	• Improved staff satisfaction with Trust response to VAA through the staff survey • Increased number of warnings and exclusions issued by the Trust
Deliver the Trusts transformation and workforce plan for 26/27 including overall management of substantive and temporary workforce costs. Support recruitment in RTT related activity in targeted areas. Target People support to the UHS transformation priorities to support delivery of improved patient experience, staff experience and cost reduction.	• Delivery of overall workforce plan.
Voice of our people – strengthen the voice and engagement with our people from Board to ward through a compelling narrative of the trust, immediate priorities for transformation, and our new long-term strategy and vision. Ensure a consistent cascade and two way communications throughout the trust, strengthening leadership communication capability and opportunities for further executive and senior leader visibility at all levels.	• Staff engagement score increased from 6.74 to 6.9 • Participation rate increase in staff survey to the national average (which was 47% in 2025)
Developing our people – Reinstatement of a full suite of leadership development offerings to support leaders and managers at all levels. Re-focus on appraisal and career development. Ensure continued focus on compassion. Inclusion and belonging in training. Provide skills to support local transformation. Develop a new Education Strategy in line with national priorities and UHS needs. Revise the education, training and development infrastructure at UHS to maximise its impact on our people development now and our workforce of the future.	• Improvement in we are always learning domain in staff survey • Appraisal rates return to at least 85% • Improvement in GMC and NHSE (NETS) learners survey
Inclusion and belonging of our people – To re-energise the staff networks supported by new Executive Sponsorship. Transform the experience of staff with long-term illness and disabilities through significant improvements to our support for workplace adjustments and to work with our LID network to co-design and embed the solution. To deliver a further co-hort of the positive action leadership programme (PALP)	• Action plan developed for each Network • Improvement in staff engagement and adjustment scores in WDES in staff survey

Delivery arrangements	Risks/ opportunities not prioritised
• Oversight of Outstanding People delivery through the UHS People Board reporting to TEC • Board Oversight and scrutiny through our People and OD committee • Delivered through the People Team, Divisional and THQ colleagues and our partnership with our Trade Unions	• Risks to delivery through resources and capacity within the people team • Fractious national industrial relations national context (Continued BMA action and possibly other unions) • External labour market pressures and attractiveness of the NHS versus other sectors • A challenging start point following the difficult 25/26 year at UHS.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.12	Report to the Trust Board of Directors, 14 May 2026
Title:	Learning from Deaths 2025-26 Quarter 3 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 Provision
Risk 919: Paediatric Palliative Care Consultant Cover
New Risk Entry: Specialist Palliative Care Team service provision

Equality Impact Consideration:	Yes – EQIA completed

1. Introduction

The learning from deaths report sets out to satisfy the requirements within the NHS Learning from Deaths Framework. Data is presented from UHS data sources, NHS England and data collected by the Medical Examiners Service (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 (M&M) meetings remain a key focus, with ongoing improvement in data quality and availability to enable organisational learning and Trust-wide dissemination.

2. Analysis and discussion

2.1 Deaths at UHS

Quarter	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	435
Q3	599	651	565	578	498	513
Q4	644	537	489	558	552	
Total	2299	2262	2084	2119	1962	

During Q3 of 2025/26, a total of 513 deaths were recorded across University Hospital Southampton (UHS) sites. This represents a 3% increase compared to 498 deaths in the same period of 2024/25.

Of the deaths recorded in Q3 2025/26:

- 28 occurred in the Emergency Department.
- The remaining 485 were among inpatients.
- Cumulatively this year Q1-Q3 there is an increase of 3% compared to last year which equals 38 deaths.

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:

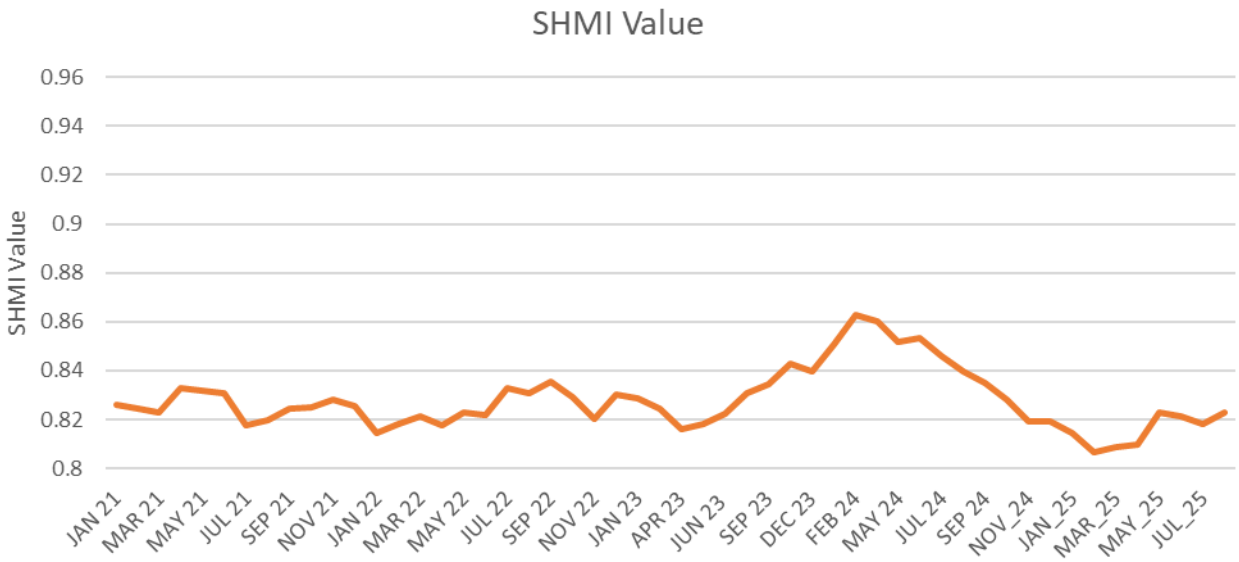
- 11 trusts recorded a '*higher-than-expected'* number of deaths.
- 97 trusts recorded an '*expected'* number of deaths.
- 10 trusts recorded a '*lower-than-expected'* number of deaths.

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 August 2025
- This represents a level consistent with Q2 and a 2% improvement on the like for like figure for Q3 2024/25 of 0.8399.
- UHS is one of only 10 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 NHS England data published 08/01/2025 for 1 September 2024 to 31 August 2025.

Diagnosis Group	SHMI Value	SHMI Banding
Septicaemia (except in labour), Shock	0.9154	As expected
Cancer of bronchus; lung	0.7575	Lower than expected (improved)
Secondary malignancies	0.7362	Lower than expected (improved)
Fluid and electrolyte disorders	0.565	Lower than expected
Acute myocardial infarction	0.7328	Lower than expected
Pneumonia (excluding TB/STD)	0.9038	As expected
Acute bronchitis	0.4592	Lower than expected (improved)
Gastrointestinal haemorrhage	0.779	As expected
Urinary tract infections	0.9247	As expected
Fracture of neck of femur (hip)	0.8182	As expected (improved)

During the 12-month period ending August 2025, five diagnosis-level categories were classified within the '*as expected*' range, while five were identified as '*lower than expected'*. There is no

change in any SHMI Banding from Q2 2025/26, although SHMI value has improved in four Diagnosis Groups.

2.3 Medical Examiner Reviews

During Q3, the Medical Examiner Service (MES) reviewed a total of 1208 deaths. Of these, 458 (37.25%) occurred at University Hospital Southampton (UHS) sites, while 750 (62.1%) were community deaths. This represents a 0.74% decrease compared to the 1217 deaths reviewed in Q3 2024/25.

During the reporting period, 36 acute deaths at UHS were referred to the coroner, representing 7.86% of all deaths at the Trust. Of these referrals, 50% 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 reporting.

2.3.1 Referrals for Morbidity and Mortality (M&M) Learning

During Q3, the Medical Examiner Service (MES) referred 16 deaths to specialty Morbidity and Mortality (M&M) meetings. Of these, 4 resulted in Patient Safety referrals and 2 were referred to LeDeR. Referrals spanned six care groups within UHS and seven community referrals.

Neurology M&M learning feedback
A patient was admitted for 13 days with a severe relapse of multiple sclerosis. No full blood count (FBC) was undertaken during the admission. Following transfer to University Hospital Dorset, the patient was found to have thrombocytopenia and subsequently died.

Learning identified
It is recognised that patients with changes in clinical status or those undergoing procedures should have appropriate blood investigations performed, in line with British Society for Haematology (BSH) guidance on heparin monitoring. The consultant has reflected on this case and amended personal practice to ensure blood test results are reviewed at every consultant ward round.

Actions and recommendations

- When blood tests are requested, results must be reviewed on the same day or appropriately handed over.
- Responsibility for checking results lies with the requesting resident doctor, with senior medical supervision as required.
- Resident doctors are encouraged to use the electronic worklist in addition to verbal handover for outstanding tasks.
- Early escalation to the consultant team is expected if tasks cannot be completed.
- Urgent blood tests should not be requested via Cyclops and must be actioned directly by resident doctors at the time of request.

This quarter, challenges in obtaining information on the dissemination and outcomes of M&M reviews have persisted, as previously reported. Several cases are awaiting review; delays are attributed to incorrect consultant referrals and changes in M&M Leads. Feedback received to date has indicated no significant learning identified.

The new Ulysses mechanism for collating M&M outcomes has now entered the testing phase and is expected to improve the consistency and efficiency of data collection. In parallel, work is ongoing to enhance the inclusivity of the M&M process for both staff and families. These developments are intended to support sustainable improvement and, alongside the Ulyssess module integration 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)

7 cases were reviewed under the LeDeR programme during Q3. Key learning points from these reviews include:

Areas of concern and action:

- There has been a delay in completing discharge summaries. Ongoing focus since Q2 aims to improve timeliness; however, seasonal increases in workload particularly the completion of discharge summaries for deceased patients compete with standard discharge summary demands to support flow through the hospital.

- Delay in referral to the Learning Disabilities (LD) team, particularly where patients are not already flagged. The Q3 recruitment of a Band 6 LD Clinical Nurse Specialist will support routine review of flagged LD patients admitted to UHS.

- Inconsistent quality of DNACPR form is not only a theme in LeDeR but also pointed out during our CQC unannounced inspection. This has prompted an in-depth audit of DNACPR forms. These results will be reported back in Q4.

Examples of good practice:

- Clear evidence of appropriate support and advocacy was demonstrated for a patient with no next of kin who died at UHS. Challenges in facilitating discharge to a suitable placement, due to limitations within community services, were appropriately escalated at the time in line with the LeDeR process**.**

- Evidence noted of supportive conversations had with next of kin to ensure that patients received end of life care as per their wishes.

2.3.3 Learning from death via patient safety

2 cases were closed during Q3

Case 1

Oral medication was given intravenously. Learning was identified around human factors due to the distress involved with caring for a patient end of life distracting staff, along with ward pressures and cognitive load. Confirmation bias was also found as the correct process was completed but cognitive load led to blindness to the wrong formulation being selected but not identified.

Action

- Controlled drug cupboards are kept more organised for clearer visibility and agreement with pharmacy team to ensure stock levels appropriate to ward requirements.
- Promote culture with more focus for staff preparing and administering medication to reduce distractions.
- Continuing education and support for the safe use of subcutaneous continuous infusion through a syringe driver to include communication to the wider care group and across all divisions.
- Checking process to include 'ask-don't tell' mentality in future to remove bias.
- Palliative care team to review medication route accuracy in the policy, using updates to ensure clarity, and that learning is shared across the Trust.
- Consideration of a bung for oral medication bottles that will only allow the use of an oral syringe to increase the number of physical barriers to avoid error.

Case 2

Patient died with urosepsis in Emergency Department (ED) with delays to review.

Action

- Increase Critical Incident escalation process awareness in ED. Review responsibility of the ED senior clinicians/duty manager in escalation process and identify when it is appropriate to escalate a critical incident.
- ED to record communications including Critical Incident escalation requests with the Clinical Site Management Team especially when ED is overcapacity.
- Review and improve the process when it is most appropriate to use the Sepsis Screening and Action Tool document to identify early stage of patients with possible and high risk of sepsis. It was recommended that improvements in the process would be more effective to incorporate at the triage process.
- Identify the escalation process for a patient who is difficult to cannulate and the requirement for Ultrasound Guided Vascular Access.
- Share incident learning with the GP for awareness.
- Share incident learning with the local pharmacy for awareness and possibility of having access to CHIE.
- Continue with the ongoing monthly ED Risk Review meeting to ensure that appropriate risk actions on Risk 187 are in place to mitigate the risk of overcrowding/overcapacity in ED.

2.4 UHS 'End of Life' incident reports

For Q3, there were a total of 29 incidents reported relating to end-of-life care. Overall, the main themes of the incidents were related to:

- **Privacy in death**: 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. Considerable distress was 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) and EOL decisions and paperwork.

- **Lack of commissioned specialist paediatric palliative care on-call service**: This issue has been identified on a recurring basis and is now formally logged on the Trust's Risk Register (Score 12), with ongoing oversight through regular discussion at the End-of-Life Programme Board. Two AERs have highlighted challenges in the care of paediatric patients aged 5 and 16 years, who experienced significant pain and distress during a period when specialist palliative care support was not available over the weekend. The limited availability of out-of-hours paediatric palliative cover contributed to difficulties in symptom management and resulted in distress for both the patients and their families.

- **End of life care management**: These cases involved difficulties using the correct equipment and providing medication in a timely manner, as well as not de-activating an ICD prior to discharge.

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

In Q3 there were two cases closed relating to end-of-life care:

- One family raised concerns regarding perceived insensitivity in end-of-life communication from the attending doctor and a delay of eight days in completion of the Medical Certificate of Cause of Death (MCCD).

  - Learning highlighted the importance of establishing individual preferences before discussing sensitive information. This was shared with the wider team to drive improvements, particularly during out-of-hours periods when knowledge of patients' wishes may be limited.

  - The MCCD was completed within the Medical Examiner Service's acceptable timeframe, despite a minor delay by the medical team.

- A complaint from a family regarding end-of-life care highlighted several areas for learning

  - Education has been provided on medical devices, including cardiac resynchronisation therapy defibrillators (CRT-D), to improve staff understanding of end-of-life care requirements for patients with these devices. Staff are now clearer on the process for requesting device deactivation and aware of the required documentation to be sent by the ward consultant to the cardiology consultant for authorisation.

  - There was continued recognition of the need for clear, jargon-free communication with families, with opportunities for questions and clarification.

  - The importance of privacy at end of life was acknowledged, alongside challenges in delivering this when required; these issues are currently under review by the governance team.

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

The module has been added to the Ulysses IT system and is currently in the testing phase, with access available by request. It has been trialled at Gastro M&M, and review dates have been scheduled to evaluate its effectiveness. The GICU M&M Lead has also agreed to pilot the system with their panel.

4. Specialist Palliative Care Team (SPCT) risk

The SPCT is currently unable to sustain usual service provision due to a significant staffing shortfall, including a 2.92 WTE Clinical Nurse Specialist vacancy compounded by unfilled vacancy and long-term sickness absence. As a result, there is a risk that the team will be unable to deliver a face-to-face seven-day service, which is a national standard for hospital-based specialist palliative care.

This will negatively impact the quality, timeliness, and appropriateness of patient care and experience, with potential consequences including increased hospital length of stay, non-beneficial investigations or treatments misaligned with patient wishes, suboptimal symptom control, and reduced holistic support.

5. End of Life Patient and Family Support

The Bereavement and Family Support Team has partnered with the Anne Robson Trust to introduce Butterfly Friends, supporting patients at end of life and their families, in line with the belief that no one should die alone (unless this is personal choice).

In the first six weeks following the November launch, 11 volunteers completed 142 visits, providing almost 100 hours of companionship. Feedback has been overwhelmingly positive, with the initiative reducing the emotional burden on staff and enabling them to focus on the care of other patients.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.13 Report to the Trust Board of Directors, 14 May 2026	
Title:	Guardian of Safe Working Hours Quarterly Report
Sponsor:	Paul Grundy Chief Medical Officer
Author:	Dr Diana Hulbert Guardian of Safe Working Hours

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

The current fill rate for Resident Doctor posts at UHS is 93.5%.
The amount spent on locums covers both short-term vacancies and longer-term gaps in the rotas. The controls on the locum request process reflect a need for clear financial governance around staffing seen in all NHS trusts.
The Exception Reporting Reforms continue to imbed with an increase across all areas: self-reported hours worked above those contracted, missed breaks, missed educational opportunities and work patterns which may suggest an immediate safety concern.
NHS England has issued a Ten Point Plan to improve the working lives of Resident Doctors, and there is a new Board Assurance Framework.

Contents:

Risk(s):

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

Equality Impact Consideration:	N/A

Guardian of Safe Working Hours

Quarterly Report

Employment and Rotas

In April 2026, the vacancy rate for resident and locally employed doctor posts across the Trust is 6.15%.
Recruitment continues for current approved vacancies, and Medical HR continues to work with departments to plan future gaps. (Appendix 1)

The impact of staff sickness continues to be significant, particularly with flu, covid and norovirus cases, and rotas can be over-stretched. It is not only medical staff sickness that impacts medical rotas; shortages in other professional groups have a significant effect on Residents' work patterns as the hospital becomes inefficient and doctors take on tasks usually carried out by other members of the MDT. This tends to particularly impact the out of hours work burden for some Residents.

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

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

Medical Locum Bank

The use of the internal Medical Locum Bank system has led to more efficient and timely coverage of short-term rota gaps. In addition, specialties with significant challenges are becoming easier to identify earlier, allowing more effective intervention.
At present there are only the premium agreed rates in place for Specialist Registrars in Emergency Medicine and Obstetrics and Gynecology.
Dual Approver was implemented on 1st September 2025 for all duties being sent to the Medical Locum Bank. This is now embedded and working efficiently.
(Appendix 2)

Exception Reporting

Residents are now required to submit ERs as soon as possible but not later than 28 days from the day they occurred.

All ERs relating to missed educational opportunities will go to the director of medical education (DME) for approval and all ERs relating to total hours of work, difference in pattern of hours, inability to take breaks, inability to take SDT, will go to Medical Workforce (MW) for approval.

Until 4 August 26 MW have 10 calendar days from the submission of the ER to complete the investigation; from 4 August 26 this decreases to 7 calendar days.

The Exception Reporting System (ERS) is now confidential, and the Exception Reports (ERs) do not go to Clinical Rota Leads.

As Guardian of Safe Working Hours (GoSWH) I retain oversight of all ERs and these will be reviewed to identify patterns to ensure reports are accurate, valid and adhere to the purpose of exception reporting.

Residents will have their choice of time off in lieu (TOIL) or pay except when a breach of safe working hours mandates the award of TOIL.

Employers must provide access to the ERS to residents within 7 days of starting employment and If access is not provided there is a £250 fine per resident per week for an access and completion breach from 4 February 26 – 3 August 26 which increases to £500 from 4 August 26.

Employers will be fined £500 per resident for a proven information breach; these fines will be paid into a central fund which I as GoSWH oversee. The resident can decide to have this paid into the local fund overseen by me and a Residents' Representative.

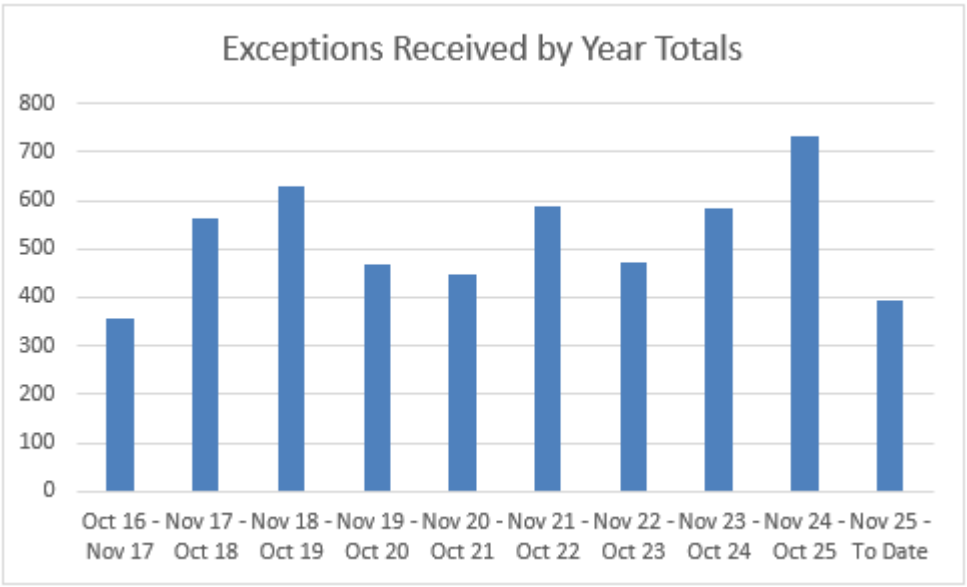
When a verified ER confirms a breach of contractual working time limits or rest requirements, a fine will be levied on the relevant division; the fines will be paid into the local fund. When a verified ER confirms that contractual breaks have been missed on at least 25% of occasions, a fine will again be levied on the employer and the value of the fines will be paid into the same local fund.

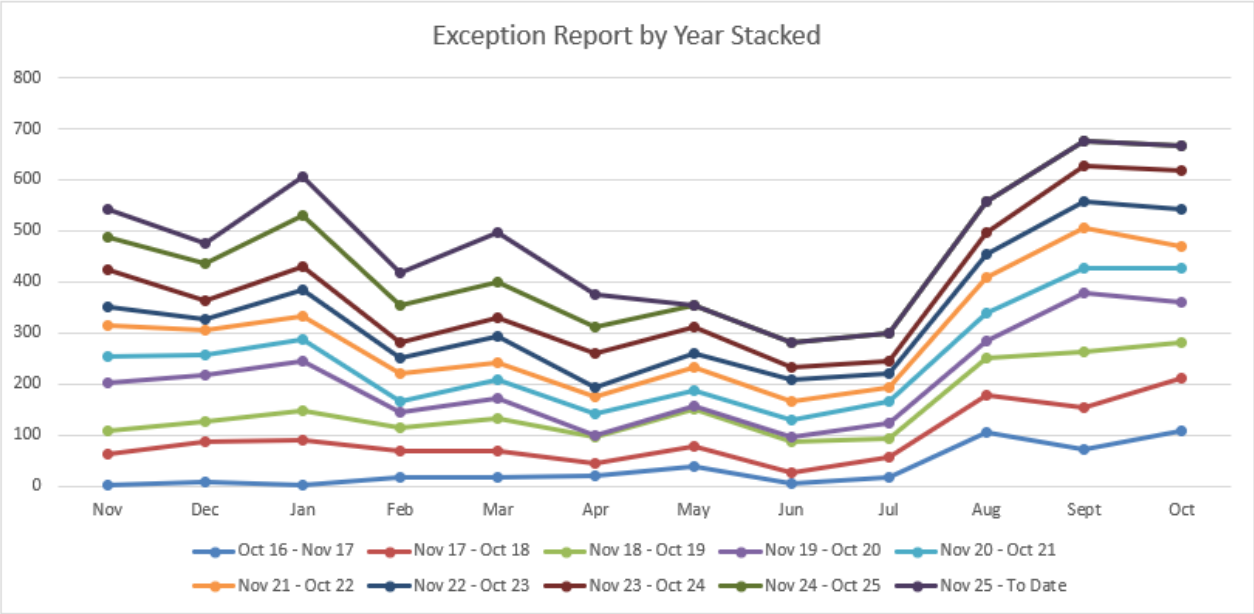
Since these new changes have been in operation the total number of fines levied is 22 at a total cost of £1,817.03 to the divisions; all of these have been for 13 hour shift length breaches. A total sum of £924.09 has been paid for these breaches to the doctors involved.

The funds must be used to benefit the education, training and working environment of Residents and should prioritise wellbeing-focused initiatives. I shall meet regularly with the Resident Doctor Representatives to best decide how this money is spent.

I am now required to oversee and conduct quarterly surveys on breaches of access and completion, information breaches and actual or threatened detriment. These will be included in the report to the Trust Board

The new summary of the ER data is detailed in Appendix 3





Detriment Survey

The exception reporting reform makes it clear that no doctor should be discouraged from exception reporting, or experience detriment as a result of doing so. Therefore, the reform introduced a requirement that as part of this report must include if doctors have experienced detriment because of exception reporting. I have shared an MS Form Survey to all doctors within UHS to enable them to report whether they have experienced actual or threat of detriment, and it is hoped that doctors will engage with this survey, closing date is 17th May 2026.

Self-Development Time (SDT)

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

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

From August 2024 to July 2025, we received 19 exception reports stating missed SDT. From August 2025 to January 2026, we received 17 and from February 2026 to April we received 6.

Again, it is too early to draw any conclusion from this figure; it is possible that the publicity and learning around the changes, confidentiality and the ease of reporting may have led to a rise.

Activity

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

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

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

I am delighted that UHS continues to support the Chief Resident (CR) role which is invaluable for Resident engagement and representation and to give our work perspective and credibility.
At present we are in the fortunate position of having two CRs at UHS.
Dr Guendalina Bonnifacio, a senior neurology Resident, has returned from maternity leave and I am delighted that UHS and the Deanery have agreed that Dr Genevieve Southgate, a senior paediatric palliative care Resident, is able to stay until her CST date in July to provide continuity and overlap during this rather intense period of change and reform in the working lives of resident doctors.
Guendalina and Genevieve are working on several projects including the continuation of the project to provide a management teaching programme for the Registrars at UHS and an on-going review of non-clinical space with a view to potential improvements. In addition, Genevieve who has also been instrumental in the management of the 10 Point Plan at UHS will remain as the named Resident Doctor Peer Lead at UHS
The Doctors Awards took place on May 7th 2026; these awards celebrate success in areas including Teacher of the Year, Rising Star, Always Improving, Patient Champion and Always Improving.

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

Provision of Non-Clinical Space
Members of the Executive are helping the chief resident, the DME and I review the provision of non-clinical spaces alongside our Chief Residents. The scoping exercise has revealed a number of challenges in many areas of the hospital for many colleagues. In most areas of the Trust the lack of space impacts all sectors of the workforce and solutions must be inventive.
We are delighted that the Southampton Hospital Charity has been kind enough to donate £35,000 which will be used to repurpose a bathroom adn a storage detail to create office space for oncology residents. In addition, the Charity has donated £15,000 for equipment and items to improve office space in addition to the provision f basic necessities by the Hospital.

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

In April 2024 NHS E sent a paper to all NHS Trusts outlining a plan to improve the working lives of Resident Doctors.

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

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

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

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

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

The 10 Priority Areas are:

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

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

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

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

To track our progress we are required to submit a Board Assurance Framework (Appendix 4)

Appendix 1 - Vacancy data

Division	Care Group	Cost centre	April 2026 Fill rate	March 26 Fill rate	February 26 Fill rate
A	Critical Care	Anaesthetics	93.85%	93.85%	93.85%
A	Critical Care	CICU	93.85%	100.00%	90.91%
A	Critical Care	GICU	93.85%	97.83%	97.83%
A	Critical Care	NICU	93.85%	90.91%	90.91%
A	Critical Care	SHDU	93.85%	90.00%	90.00%
A	Surgery	ENT	93.85%	100.00%	100.00%
A	Surgery	General Surgery	93.85%	98.04%	96.08%
A	Surgery	OMFS	93.85%	100.00%	100.00%
A	Surgery	Urology	93.85%	100.00%	100.00%
A	CV&T	Cardiology	93.85%	97.37%	97.37%
A	CV&T	Cardiothoracic Surgery	93.85%	97.14%	97.14%
A	CV&T	Vascular Surgery	93.85%	100.00%	100.00%
A	Neurosciences	Neurology	93.85%	100.00%	100.00%
A	Neurosciences	Neurophysiology	93.85%	100.00%	100.00%
A	Neurosciences	Neurosurgery	93.85%	95.65%	95.83%
A	Neurosciences	Stroke	93.85%	100.00%	100.00%
A	Neurosciences	Spinal Surgery	93.85%	100.00%	100.00%
A	T&O	T&O	93.85%	98.25%	96.49%
B	Ophthalmology	Ophthalmology	93.85%	82.14%	82.14%
B	Cancer Care	Clinical Oncology	93.85%	94.74%	94.74%
B	Cancer Care	Haematology	93.85%	87.50%	87.50%
B	Cancer Care	Medical Oncology	93.85%	95.00%	85.00%
B	Cancer Care	Palliative Care	93.85%	77.78%	88.89%
B	Cancer Care	Acute Oncology	93.85%	100.00%	100.00%
B	Emergency	Acute Med	93.85%	95.65%	100.00%
B	Emergency	Acute Med OOH	93.85%	100.00%	100.00%
B	Emergency	ED	93.85%	90.00%	91.43%
B	MOP	MOP	93.85%	97.87%	100.00%
B	Specialist Med	Allergy/Respiratory	93.85%	93.55%	100.00%
B	Specialist Med	Clinical Genetics	93.85%	75.00%	100.00%
B	Specialist Med	Dermatology	93.85%	100.00%	100.00%
B	Specialist Med	Endo/Diabetes	93.85%	75.00%	100.00%
B	Specialist Med	General Medicine	93.85%	100.00%	93.33%
B	Specialist Med	GI Renal	93.85%	93.75%	96.88%
B	Specialist Med	Rheumatology	93.85%	100.00%	100.00%
C	Pathology	Chemical Pathology	93.85%	50.00%	50.00%
C	Pathology	Microbiology	93.85%	75.00%	66.67%
C	Child Health	Paediatric Cardiology	93.85%	84.62%	92.31%
C	Child Health	Paediatrics	93.85%	93.10%	91.38%
C	Child Health	Paediatric Obesity	93.85%	100.00%	100.00%
C	Child Health	Paeds ED	93.85%	70.00%	80.00%

C	Child Health	PICU	93.85%	94.44%	100.00%
C	W&N	Neonates	93.85%	93.75%	90.63%
C	W&N	O&G	93.85%	97.22%	97.22%
C	W&N	Breast Surgery	93.85%	100.00%	100.00%
		Total	93.85%	94.23%	94.65%

Appendix 2 - Locum data

Count of Unit	Column Labels		
Row Labels	Unfilled	Filled	Grand Total
CAN Clin Onc Med Staff	**16**	**9**	**25**
2025	**16**	**7**	**23**
2026		**2**	**2**
Qtr1		2	2
Jan		**2**	**2**
CAN Haem Onc Medical Staff	**41**	**227**	**268**
2025	**31**	**143**	**174**
2026	**10**	**84**	**94**
Qtr1	10	42	52
Jan	**10**	**21**	**31**
Feb		**13**	**13**
Mar		**8**	**8**
Qtr2		42	42
Apr		**42**	**42**
CAN Haematology Medical Staff	**17**	**48**	**65**
2025	**17**	**19**	**36**
2026		**29**	**29**
Qtr1		13	13
Mar		**13**	**13**
Qtr2		16	16
Apr		**16**	**16**
CAN Medical Oncology Medical Staff	**9**	**44**	**53**
2025	**7**	**27**	**34**
2026	**2**	**17**	**19**
Qtr1	2	13	15
Jan	**2**	**3**	**5**
Feb		**2**	**2**
Mar		**8**	**8**
Qtr2		4	4
Apr		**4**	**4**
CAN Palliative Care Medical Staff	**8**	**14**	**22**
2025	**7**	**11**	**18**
2026	**1**	**3**	**4**
Qtr1	1	3	4
Jan	**1**		**1**
Feb		**3**	**3**
CAR Med Staff Vascular	**30**	**61**	**91**
2025	**26**	**44**	**70**
2026	**4**	**17**	**21**

Qtr1	4	10	14
Jan	**4**	**2**	**6**
Feb		**5**	**5**
Mar		**3**	**3**
Qtr2		7	7
Apr		**7**	**7**
CAR Medical Staff Cardiac Surgery	**167**	**501**	**668**
2025	**108**	**221**	**329**
2026	**59**	**280**	**339**
Qtr1	59	218	277
Jan	**59**	**69**	**128**
Feb		**75**	**75**
Mar		**74**	**74**
Qtr2		62	62
Apr		**62**	**62**
CAR Medical Staff Cardiology	**86**	**240**	**326**
2025	**72**	**127**	**199**
2026	**14**	**113**	**127**
Qtr1	14	99	113
Jan	**14**	**45**	**59**
Feb		**32**	**32**
Mar		**22**	**22**
Qtr2		14	14
Apr		**14**	**14**
CC CICU Medical Staff	**19**	**280**	**299**
2025	**15**	**162**	**177**
2026	**4**	**118**	**122**
Qtr1	4	86	90
Jan	**4**	**26**	**30**
Feb		**32**	**32**
Mar		**28**	**28**
Qtr2		32	32
Apr		**32**	**32**
CC GICU & SHDU Senior Medical	**1**		**1**
2025	**1**		**1**
CC GICU Medical Staff	**74**	**108**	**182**
2025	**72**	**67**	**139**
2026	**2**	**41**	**43**
Qtr1	2	33	35
Jan	**2**	**20**	**22**
Feb		**7**	**7**
Mar		**6**	**6**
Qtr2		8	8
Apr		**8**	**8**
CC NICU Medical Staff	**14**	**34**	**48**
2025	**10**	**23**	**33**
2026	**4**	**11**	**15**
Qtr1	4	7	11
Jan	**4**	**3**	**7**
Feb		**3**	**3**
Mar		**1**	**1**
Qtr2		4	4

Apr		**4**	**4**
CC SHDU Medical Staff	**3**	**74**	**77**
2025	**2**	**19**	**21**
2026	**1**	**55**	**56**
Qtr1	1	45	46
Jan	**1**	**19**	**20**
Feb		**7**	**7**
Mar		**19**	**19**
Qtr2		10	10
Apr		**10**	**10**
CHI CED Medical Staff Junior	**12**	**96**	**108**
2025	**12**	**51**	**63**
2026		**45**	**45**
Qtr1		26	26
Jan		**3**	**3**
Feb		**6**	**6**
Mar		**17**	**17**
Qtr2		19	19
Apr		**19**	**19**
CHI CED Medical Staff Senior	**2**	**51**	**53**
2025	**2**	**37**	**39**
2026		**14**	**14**
Qtr1		14	14
Jan		**9**	**9**
Feb		**5**	**5**
CHI Medical Staff Junior	**15**	**89**	**104**
2025	**13**	**54**	**67**
2026	**2**	**35**	**37**
Qtr1	2	30	32
Jan	**2**	**14**	**16**
Feb		**10**	**10**
Mar		**6**	**6**
Qtr2		5	5
Apr		**5**	**5**
CHI Medical Staff Paediatric Cardiology	**4**	**29**	**33**
2025	**4**	**13**	**17**
2026		**16**	**16**
Qtr1		10	10
Jan		**3**	**3**
Feb		**3**	**3**
Mar		**4**	**4**
Qtr2		6	6
Apr		**6**	**6**
CHI Medical Staff PICU	**11**	**13**	**24**
2025	**9**	**7**	**16**
2026	**2**	**6**	**8**
Qtr1	2	5	7
Jan	**2**	**2**	**4**
Feb		**3**	**3**
Qtr2		1	1
Apr		**1**	**1**

CHI Medical Staff Senior		**46**	**46**
2025		**7**	**7**
2026		**39**	**39**
Qtr1		28	28
Feb		**11**	**11**
Mar		**17**	**17**
Qtr2		11	11
Apr		**11**	**11**
CHI Sleep Team	**1**		**1**
2025	**1**		**1**
ECM AMU Medical Staff	**41**	**300**	**341**
2025	**31**	**116**	**147**
2026	**10**	**184**	**194**
Qtr1	10	122	132
Jan	**10**	**28**	**38**
Feb		**47**	**47**
Mar		**47**	**47**
Qtr2		62	62
Apr		**62**	**62**
ECM ED ACPs	**2**		**2**
2025	**2**		**2**
ECM Emergency Dept Medical - Junior Doctors	**130**	**366**	**496**
2025	**104**	**151**	**255**
2026	**26**	**215**	**241**
Qtr1	26	166	192
Jan	**26**	**49**	**75**
Feb		**47**	**47**
Mar		**70**	**70**
Qtr2		49	49
Apr		**49**	**49**
ECM Out of Hours Medical Team	**4**	**64**	**68**
2025	**1**	**40**	**41**
2026	**3**	**24**	**27**
Qtr1	3	24	27
Jan	**3**	**8**	**11**
Feb		**9**	**9**
Mar		**7**	**7**
MED Medical Staff MOP		**4**	**4**
2025		**3**	**3**
2026		**1**	**1**
Qtr1		1	1
Feb		**1**	**1**
MED Medical Ward Based	**86**	**253**	**339**
2025	**75**	**143**	**218**
2026	**11**	**110**	**121**
Qtr1	11	78	89
Jan	**11**	**25**	**36**
Feb		**30**	**30**
Mar		**23**	**23**
Qtr2		32	32
Apr		**32**	**32**

NEU HASU	**1**		**1**
2025	**1**		**1**
NEU Med Staff Neurology	**14**	**35**	**49**
2025	**13**	**15**	**28**
2026	**1**	**20**	**21**
Qtr1	1	13	14
Jan	**1**	**1**	**2**
Feb		**1**	**1**
Mar		**11**	**11**
Qtr2		7	7
Apr		**7**	**7**
NEU Med Staff Stroke		**4**	**4**
2025		**2**	**2**
2026		**2**	**2**
Qtr1		2	2
Feb		**2**	**2**
NEU MedStaff Neurosurgery	**17**	**82**	**99**
2025	**16**	**55**	**71**
2026	**1**	**27**	**28**
Qtr1	1	8	9
Jan	**1**	**4**	**5**
Feb		**1**	**1**
Mar		**3**	**3**
Qtr2		19	19
Apr		**19**	**19**
OPH Medical Staff	**7**	**193**	**200**
2025	**5**	**151**	**156**
2026	**2**	**42**	**44**
Qtr1	2	34	36
Jan	**2**	**27**	**29**
Feb		**3**	**3**
Mar		**4**	**4**
Qtr2		8	8
Apr		**8**	**8**
RAD Wessex Registrars	**5**	**70**	**75**
2025	**4**	**35**	**39**
2026	**1**	**35**	**36**
Qtr1	1	18	19
Jan	**1**	**6**	**7**
Feb		**9**	**9**
Mar		**3**	**3**
Qtr2		17	17
Apr		**17**	**17**
RD Fellows	**1**	**76**	**77**
2025	**1**	**4**	**5**
2026		**72**	**72**
Qtr1		48	48
Jan		**2**	**2**
Feb		**22**	**22**
Mar		**24**	**24**
Qtr2		24	24

Apr		**24**	**24**
SME General Medicine Med Staff	**72**	**303**	**375**
2025	**72**	**158**	**230**
2026		**145**	**145**
Qtr1		115	115
Jan		**47**	**47**
Feb		**35**	**35**
Mar		**33**	**33**
Qtr2		30	30
Apr		**30**	**30**
SME MedStaff Dermatology	**4**	**30**	**34**
2025	**4**	**11**	**15**
2026		**19**	**19**
Qtr1		13	13
Jan		**1**	**1**
Feb		**5**	**5**
Mar		**7**	**7**
Qtr2		6	6
Apr		**6**	**6**
SME MedStaff GI/Renal		**1**	**1**
2025		**1**	**1**
SME MedStaff Rheumatology	**2**	**2**	**4**
2025	**2**	**2**	**4**
SUR Med Staff ENT	**17**	**130**	**147**
2025	**14**	**71**	**85**
2026	**3**	**59**	**62**
Qtr1	3	37	40
Jan	**3**	**12**	**15**
Feb		**9**	**9**
Mar		**16**	**16**
Qtr2		22	22
Apr		**22**	**22**
SUR Med Staff GI	**119**	**393**	**512**
2025	**97**	**219**	**316**
2026	**22**	**174**	**196**
Qtr1	22	89	111
Jan	**22**	**29**	**51**
Feb		**26**	**26**
Mar		**34**	**34**
Qtr2		85	85
Apr		**85**	**85**
SUR OMF Medics	**7**	**56**	**63**
2025	**6**	**35**	**41**
2026	**1**	**21**	**22**
Qtr1	1	18	19
Jan	**1**	**3**	**4**
Feb		**6**	**6**
Mar		**9**	**9**
Qtr2		3	3
Apr		**3**	**3**
T&O Medical Staff	**125**	**623**	**748**

2025	**80**	**334**	**414**
2026	**45**	**289**	**334**
Qtr1	45	198	243
Jan	**45**	**84**	**129**
Feb		**49**	**49**
Mar		**65**	**65**
Qtr2		91	91
Apr		**91**	**91**
THR Anaesthetics Medical Staff	**11**	**80**	**91**
2025	**11**	**45**	**56**
2026		**35**	**35**
Qtr1		28	28
Jan		**8**	**8**
Feb		**10**	**10**
Mar		**10**	**10**
Qtr2		7	7
Apr		**7**	**7**
W&N Med Staff Breast/Endo	**5**	**19**	**24**
2025	**1**	**9**	**10**
2026	**4**	**10**	**14**
Qtr1	4	10	14
Jan	**4**	**7**	**11**
Feb		**3**	**3**
W&N Med Staff Junior	**101**	**425**	**526**
2025	**91**	**269**	**360**
2026	**10**	**156**	**166**
Qtr1	10	107	117
Jan	**10**	**35**	**45**
Feb		**35**	**35**
Mar		**37**	**37**
Qtr2		49	49
Apr		**49**	**49**
W&N Neonatal Med Staff	**5**	**102**	**107**
2025	**5**	**62**	**67**
2026		**40**	**40**
Qtr1		25	25
Jan		**8**	**8**
Feb		**14**	**14**
Mar		**3**	**3**
Qtr2		15	15
Apr		**15**	**15**
SME MedStaff Respiratory		**5**	**5**
2026		**5**	**5**
Qtr2		5	5
Apr		**5**	**5**
Grand Total	**1306**	**5580**	**6886**

Appendix 3 – Exception Reporting Data 01/02/2026 to 30/04/2026

a) Number of exception reports submitted:

Number of exception reports submitted over the last quarter:	**284**

b) Categories of exception reports submitted:

Type of exception report	**Outcome**				**Number of exception reports**
	Pay	**Time off in lieu**	**Penalty/ fine**	**For information**	
Additional hours an unscheduled early start	2	2			4
Additional hours an unscheduled late finish	153	13	22		188
Breaches of non-resident on-call patterns		1			2
Missed Educational Opportunities					17
The inability to take contractual breaks					8
Inadequacy of clinical support					36
Inadequacy of rostered skills mix					3
Raising concerns of a suspected non-compliant rota pattern					2
Detriment or threat of detriment related to exception reporting					0
Information breach					1 being investigated
Access and completion resolved in time					61
Access and completion breaches					0
Access and completion test					61

c) Experiences of actual or threatened detriment:

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Detriment is when an employer, or colleague, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.
Examples maybe:

- Reduced opportunities for training, development or progression compared to their agreed work schedule.
- Reasonable workplace requests rejected unfairly or without consideration as a result of exception reporting.
- Reassignment of duties outside of agreed work schedule review processes and unfairly applied compared to other colleagues in equivalent positions.
- Informal changes to working patterns outside of work schedule review processes and unfairly applied compared to other colleagues in equivalent positions.
- Subjected to demeaning comments or treatment, following exception reporting.
- Subjected to disciplinary action following a legitimate exception report.
- Being bullied or ostracised, as a result of exception reporting

Quarterly survey response rate	Survey closing 17th May 2026
Doctors experiencing actual detriment as a result of exception reporting	
Doctors feeling that they are not discouraged from exception reporting	

d) Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	25

e) Access to individual doctors' exception reporting data:

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.
The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

f) Work schedule reviews related to exception reporting:

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	0

g) Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	We don't currently report on this – but will seek to deliver

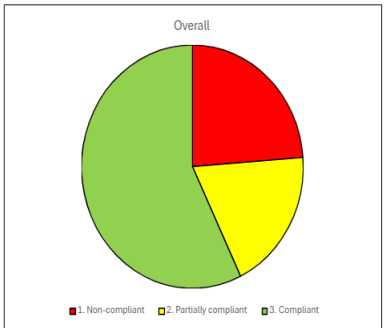
h) Additional information on an ad hoc basis

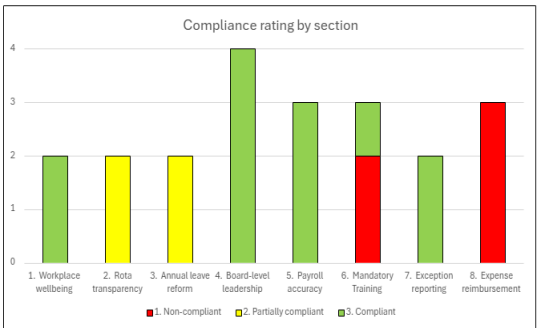
The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

Details
Free text

Appendix 4 - Resident Doctor Board Assurance Framework v1.0

Resident Doctor Board Assurance Framework v1.0						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Submission of original 10 point plan	No gaps			3. Compliant
1.2	Approved improvement plan in place	Ongoing plan for non-clinical space improvements	Financial challenges	Regular review of progress		3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						
2.1	Compliant with 6- and 8-week rota standards	Submission of original 10 point plan - Monthly status reporting to People Board, Medical Education and Workforce Meeting	We are compliant with 90% work schedules being issued to MedicalHR at 10 weeks. Feb 26 rotation we achieved 75.55% at 8 weeks issuing contracts and 69% at 6 weeks issuing duty rosters	Regular review of progress	Supporting the shift of reporting from 10 weeks, to the 8 week and 6 week requirements. Working with Medical HR and Medical Staffing Co-ordinators to support deadlines.	2. Partially compliant
2.2	Clear monitoring of compliance and reported at Board sub-committee level	Will be reported quarterly at Trust Board	No gaps			2. Partially compliant
3. Annual leave reform – Adoption of national best practice initiatives						
System and process are in place to ensure that:						
3.1	Adopted the local annual leave local rules and process questionaire	Submission of original 10 point plan - Current UHS Leave Policy	Requirement to update current UHS Leave Policy to provide more clarity following the minimum standards document	Trust Policy being redrafted		2. Partially compliant
3.2	Completion of rota coordinator training	Ongoing training - Medical Staffing Administrators regular meetings	Completion of training	Completion of training	Reviewing % of Medical Staffing Administrators being trained and content	2. Partially compliant
4. Board-level leadership – Senior leads and peer representatives are in place						
System and process are in place to ensure that:						
4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	Appointed and ratified by Board	No gaps			3. Compliant
4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	Appointed and ratified by Board	No gaps			3. Compliant
4.3	Robust progress updates in place which involve Resident Doctor	Early formation of the Improving Residents' Working Lives Group IRWLG	No gaps		10 point plan discussed at resident doctor forum and LCNC	3. Compliant
4.4	Clear support plan in place to assist the RDPL	The IRWLG meets monthly and is fully supported and endorsed by the Trust				3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						
System and process are in place to ensure that:						
5.1	Implementing payroll improvement methodology	Submission of original 10 point plan				3. Compliant
5.2	Reduction in payroll errors				Reviewing stats being recorded	3. Compliant
5.3	Monthly error reporting compliance undertaken					3. Compliant
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	Will check with Naomi/Faye				1. Non-compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	Yes, Statutory and Mandatory Training oversight group is in place (SMOG)				3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN requirements are necessarily and proportionate	Will check with Naomi/Faye, but I don't think so				1. Non-compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						
7.1	Clearly communicated new approach and local processes to all Resident Doctors	Full communication of all changes , information shared at induction and forums				3. Compliant
7.2	Implemented local and national data reporting requirements	Data will be submitted at Trust Board				3. Compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	In process - processes are being worked to establish new expectations				1. Non-compliant
8.2	Meeting target reimbursement time of 6 weeks.	In process				1. Non-compliant
8.3	Doctor satisfaction meeting ≥80% target	In process				1. Non-compliant





Agenda Item 5.14 Report to the Trust Board of Directors, 14 May 2026	
Title:	Maternity and Neonatal Services National Picture
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Emma Northover, Director of Midwifery

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 paper provides an overview of the current national maternity and neonatal landscape and considers the implications for Maternity Services at University Hospital Southampton (UHS). It draws on the emerging findings of the Amos Review alongside recent national investigations and sets out UHS' current position within this context.

The paper highlights three areas that currently present the most significant challenge for the service:

1. Rising clinical acuity and increasing levels of intervention, including caesarean section and theatre births
2. Governance and safety of homebirth and care provided outside of clinical guidance
3. Emerging inequities in outcomes for women and birthing people from global majority backgrounds.

There is no evidence of systemic failure within UHS Maternity Services, and safe, compassionate care continues to be delivered on a day-to-day basis. However, the combination of increasing service complexity, sustained pressure on the workforce and heightened national scrutiny has elevated the overall risk profile of the service. Continued executive oversight is therefore required.

Contents:

Risk(s):

Equality Impact Consideration:	N/A

National Context and the Amos Review

Maternity and neonatal services across England are operating within a period of unprecedented scrutiny. This has been shaped by the national maternity and neonatal investigation led by Baroness Valerie Amos, alongside several high-profile investigations into individual NHS Trusts following significant adverse outcomes.

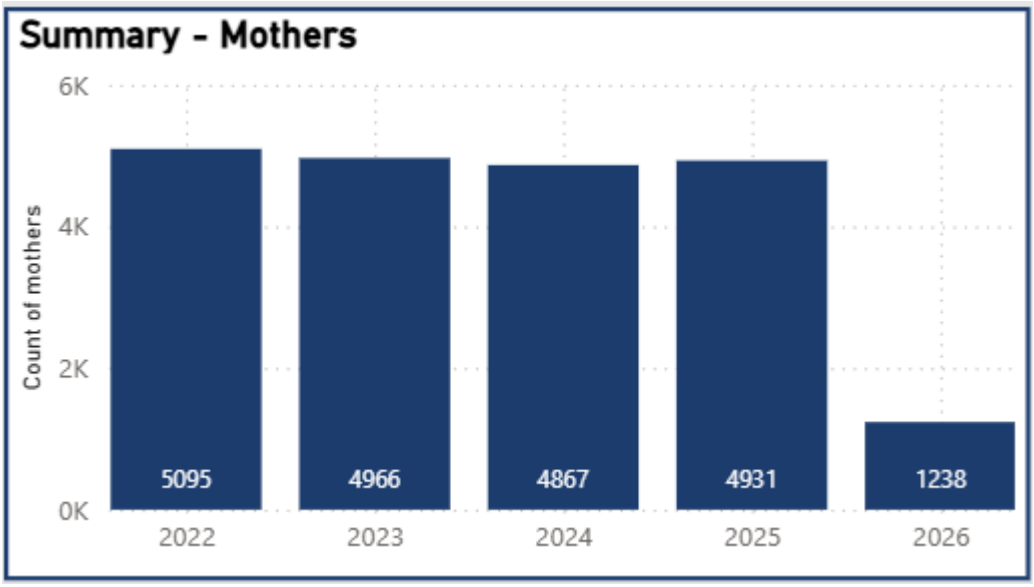
Interim findings from the Amos Review describe a consistent and concerning picture across the system. Women and birthing people, and their families, report not being listened to; communication and compassion are variable when things go wrong; and there are inconsistencies in basic standards of care. In many organisations, underlying cultural and governance issues have delayed learning and improvement.

Trusts that have subsequently come under national investigation have often experienced a combination of rising clinical acuity, workforce fragility, weaknesses in governance oversight and a failure to respond early to emerging risk. The Review reinforces that these challenges are systemic rather than isolated. The final report, expected later this year, is anticipated to set out a national framework for maternity improvement, with clear expectations of Boards and Executive Teams. This provides the context within which UHS, like all maternity providers, must understand and articulate its own position.

UHS Position Within the National Context

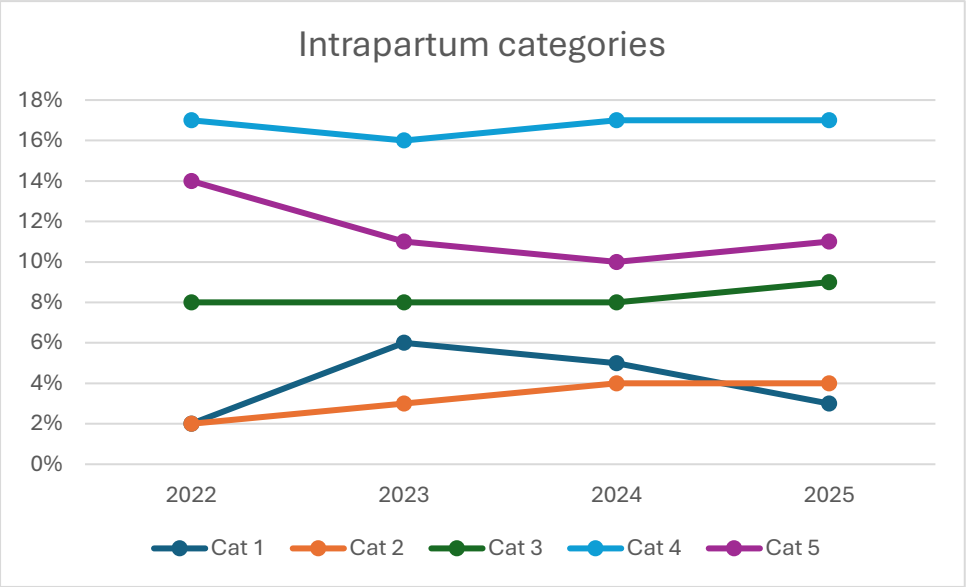
Within this national environment, UHS Maternity Services continue to deliver safe care but are doing so under increasing and sustained pressure. While overall birth numbers have remained relatively stable, reducing from 5,095 births in 2022 to 4,931 births in 2025, there has been a clear shift in the acuity and complexity of the women and birthing people accessing care.

Chart 1. Total number of births (mothers) 2022 – 2026



Increasing numbers of women and birthing people present with complex medical conditions, mental health needs and social vulnerability. These changes have led to higher intensity care, particularly during the intrapartum period, and have reduced the service's ability to recover between peaks of activity. The sections below describe the three areas that now contribute most significantly to the maternity risk profile at UHS.

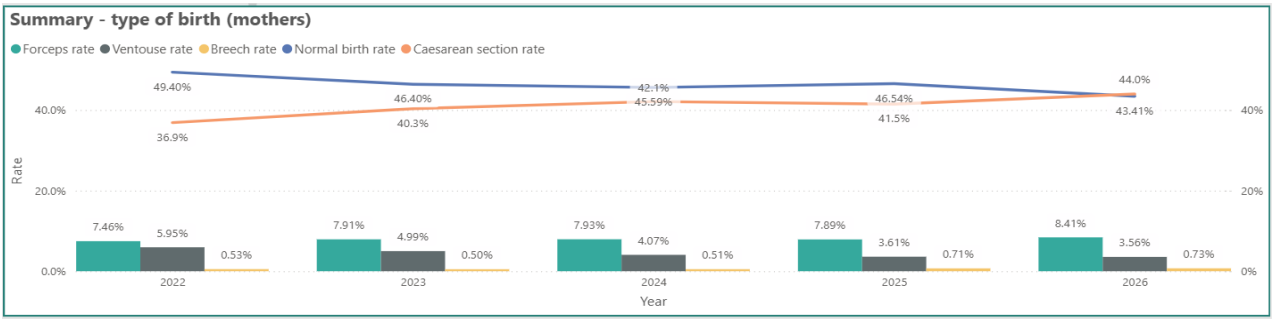
Chart 2. Intrapartum categories from Birthrate+ 2022 – 2025. This demonstrates intrapartum acuity. Categories 4 and 5 are highest complexity in labour often with additional medical or morbidity factors (i.e. diabetes, epilepsy, preterm, significant obesity) vs Category 1 which is low risk in labour.



1. Rising Acuity and Increasing Intervention

Rising clinical acuity is increasingly evident through sustained growth in obstetric intervention, particularly caesarean section births and labour ward theatre activity. Over recent years, the caesarean section rate at UHS has continued to rise across both elective and emergency procedures. This reflects both planned clinical complexity and an increase in intrapartum situations requiring urgent surgical intervention.

Chart 3. Type of birth rate 2022 – 2026 which demonstrates an increase in Caesarean sections and a decrease in the normal birth rate.



Alongside this, there has been a steady increase in births occurring in theatre and in overall labour ward theatre activity. This reflects a population requiring higher risk intrapartum care, greater anaesthetic input and more intensive multidisciplinary involvement. While these interventions are clinically appropriate and essential to maintaining safety, they increase operational intensity through longer lengths of stay, higher postnatal dependency and reduced flexibility across the system.

Chart 4. Labour Ward Theatre Births 2022 – 2026

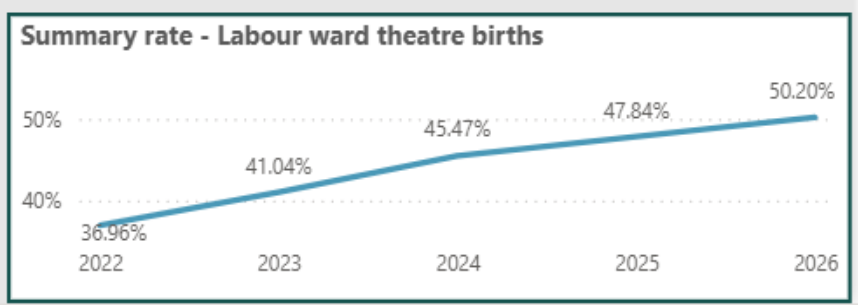
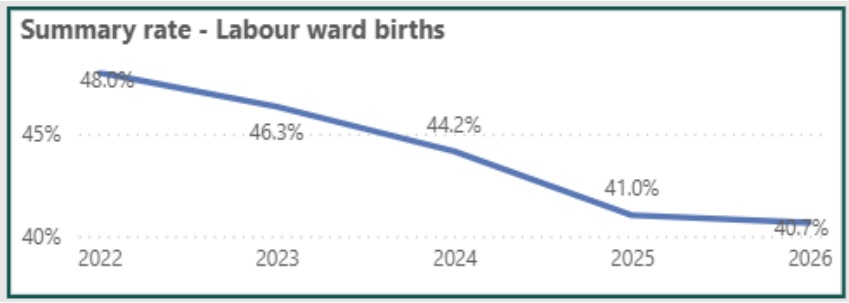


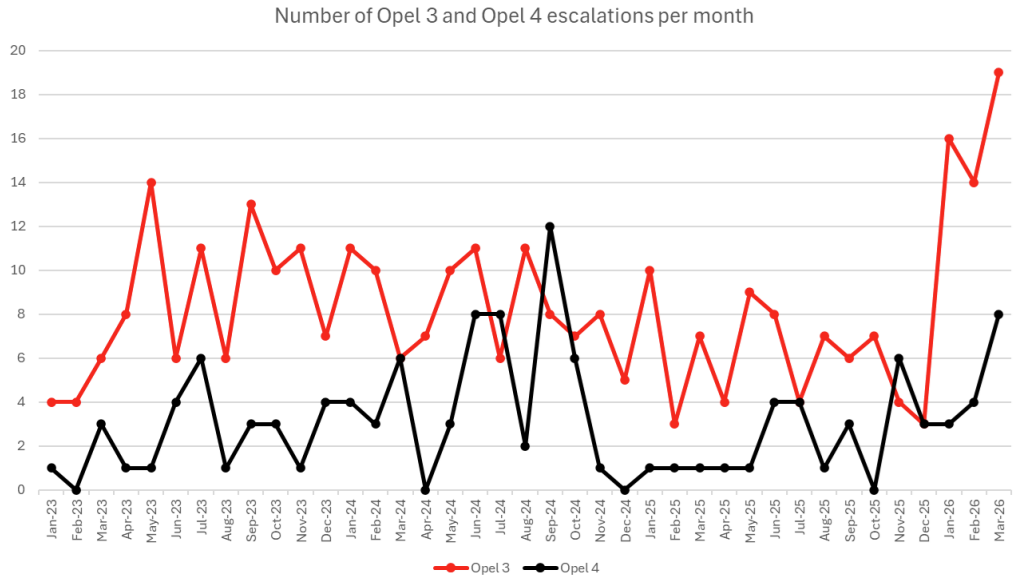
Chart 5. Labour Ward Births 2022 - 2026



There has also been a reduction in the proportion of low-risk births and a corresponding change in case mix within midwifery-led settings, with more women and birthing people requiring labour ward care. Taken together, these trends describe a service operating at a consistently higher level of intensity.

The cumulative impact of rising acuity, increasing obstetric intervention and sustained operational pressure is placing significant strain on the Maternity Service workforce. Higher rates of operative birth and theatre activity require greater multiprofessional input, increased senior clinical decision making and longer episodes of care, often without corresponding recovery time between peaks of activity. These pressures sit alongside existing workforce fragility and have implications for staff resilience.

Chart 6. Number of times Maternity Services escalated to Opel 3 & Opel 4 (Jan 2023-current)



Mitigating workforce pressure remains critical to maintaining safety as service acuity continues to increase.

To objectively assess this position, UHS uses Birthrate Plus, the nationally recognised and evidence-based workforce and acuity tool. The most recent Birthrate Plus review identified a requirement for an additional 8.94 WTE midwives to meet current levels of activity, dependency and complexity. This confirms a mismatch between workforce establishment and service demand and remains a key strategic issue.

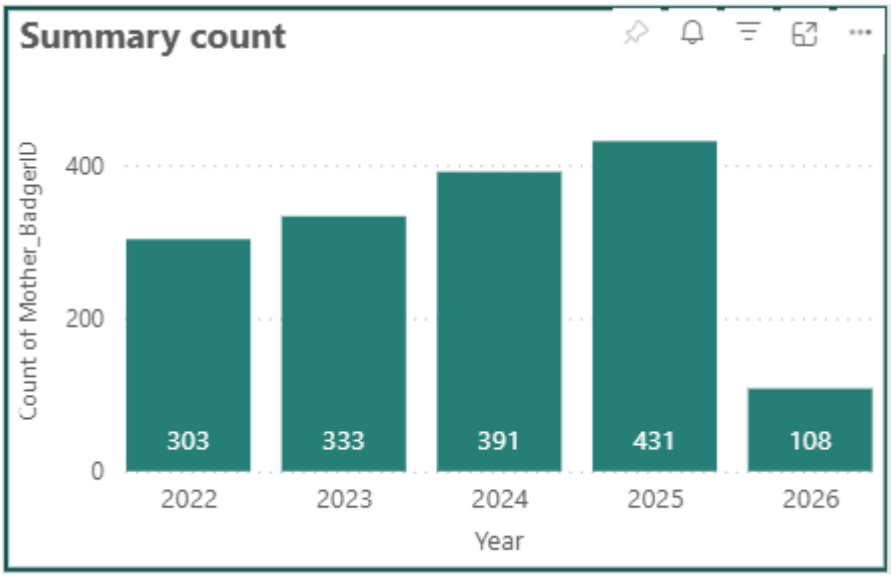
To date, Birthrate Plus recommendations have not been mandated; however, NHSR MIS Year 7 required Trusts to provide a Director of Midwifery led risk assessment where recommended uplifts had not been implemented. It remains unclear whether this approach will continue for NHSR MIS Year 8, and it is therefore possible that future compliance with maternity safe staffing requirements may require implementation of the full Birthrate Plus recommendations.

2. Homebirth and Care Outside Clinical Guidance

A second area of focus is the increasing number of women and birthing people whose care falls outside standard clinical guidance, including those planning births within the homebirth pathway and in the midwifery-led environment. Nationally, this area has received renewed attention following a Prevention of Future Deaths report, leading NHS England to seek assurance from all providers.

At UHS, there has been a notable increase in requests for births that fall outside clinical guidance. This reflects wider national patterns, increasing clinical complexity and a growing emphasis on personalised choice. However, this trend adds further complexity to intrapartum risk assessment, escalation processes and workforce coordination, and increases reliance on robust clinical judgement and senior oversight to ensure safety.

Chart 7. Count of women who had "Having care outside of guidelines" recorded as a current pregnancy risk factor 2022 – 2026



In response, UHS has undertaken a comprehensive review of its homebirth service, examining staffing arrangements, escalation pathways, ambulance transfer processes, equipment readiness, training compliance and documentation standards. The continuing work of the multidisciplinary homebirth working group is enhancing specialist knowledge and skills within the workforce, strengthening confidence and capability in managing complex decision making, and ensuring that care provided outside guidance remains safe and well governed.

3. Changing Population and Outcomes for Global Majority Families

The third key challenge relates to population change and equity. UHS serves an increasingly diverse population, with marked demographic shifts over recent years, including a significant increase in women and birthing people from global majority backgrounds.

Nationally, MBRRACE UK continues to highlight persistent and unacceptable inequities in maternal and perinatal outcomes for Black, Asian and other minority ethnic families. Locally, UHS' neonatal mortality rate remains lower than national comparators at 2.22 per 1,000 live births, which is reassuring. However, the stillbirth rate excluding congenital anomalies has risen to 3.39 per 1,000 total births, more than 5% higher than peer Trusts and representing a deterioration from earlier reporting cycles.

In **2025, 34%** of stillbirths occurred among women and birthing people from global majority backgrounds, despite these groups comprising **23%** of the birthing population. While absolute numbers are relatively small, this signal, alongside national evidence, underlines the importance of focused, ethnicity stratified analysis and targeted improvement work, which is now being prioritised within maternity governance.

Chart 8. Number of Stillbirths for Global Majority women/birthing people 2022 – 2026.

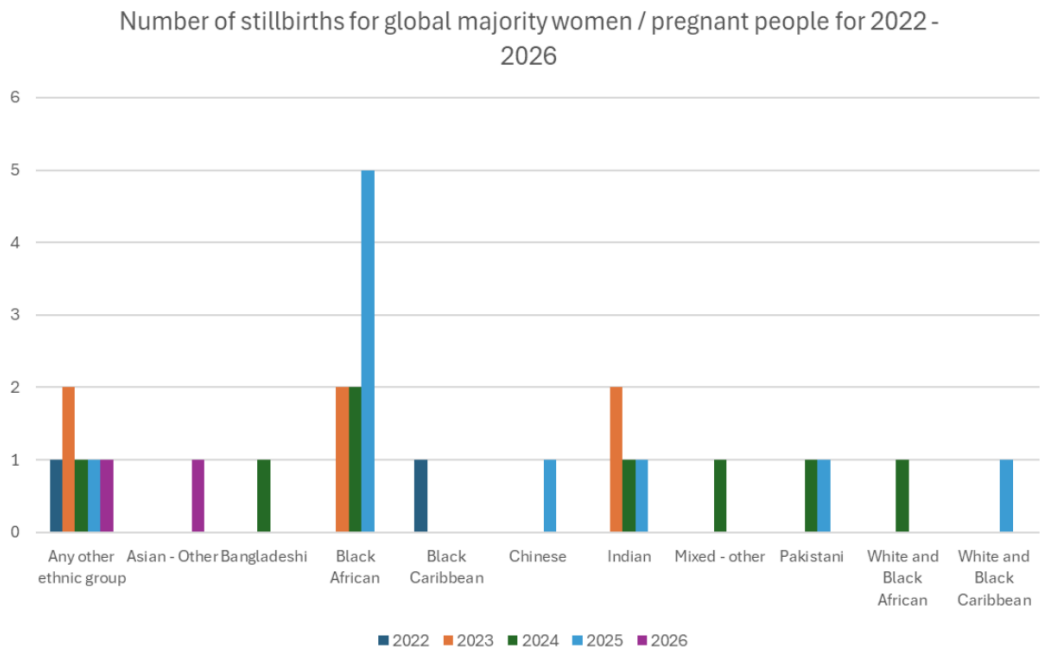
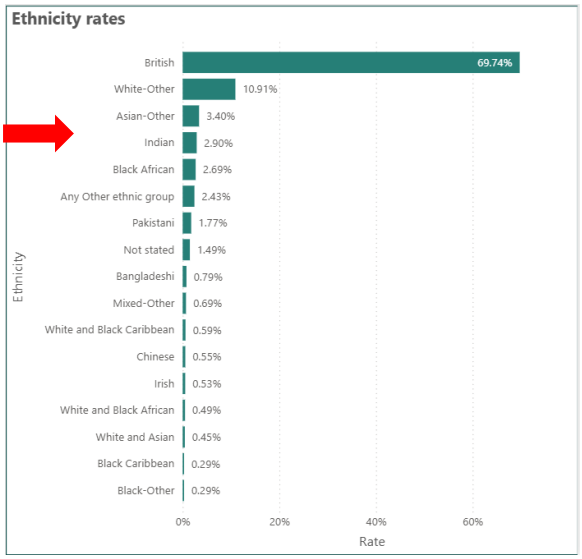
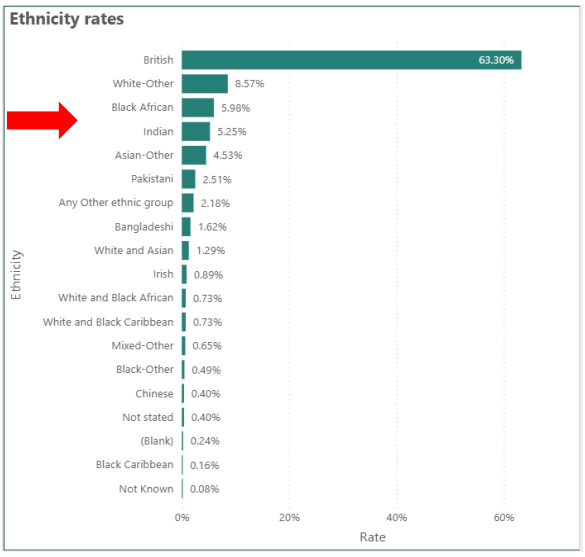


Chart 9. Bookings by Ethnicity - Most significant increase: Black African & Indian populations have doubled, with increases noted across the other Global majority ethnicities.

2022 *2026*



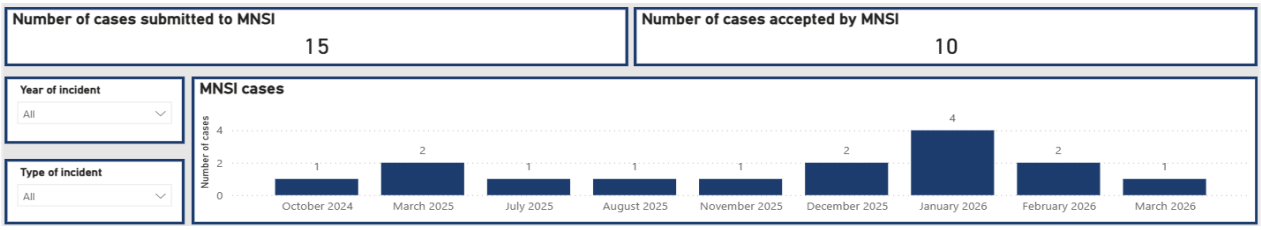


Workforce and Safety Oversight

Workforce fragility underpins each of the challenges described above. Sickness absence among registered midwives remains high at 15.31 WTE (12.16%), predominantly linked to psychological distress and trauma related illness. Gaps at band 7 level continue to affect visible leadership and escalation capacity. While safe staffing is maintained on a shift-by-shift basis, this relies on sustained flexibility and effort and will prove increasingly difficult to sustain in the longer term.

During the reporting period, the service has experienced a cluster of maternity incidents meeting national reporting thresholds. All incidents have been appropriately reported, duty of candour has been applied, and early reviews have not identified systemic or thematic failure. In the current national context, such clusters warrant continued senior oversight and timely investigation.

Chart 10. MNSI (Maternity and Newborn Safety Investigation) reportable cases Oct 2024 – present 2026)



Ongoing high-level support to recruit into band 7 leadership roles, alongside a rolling midwifery recruitment strategy, is welcomed and remains critical to maintaining workforce resilience and securing future midwifery pipeline opportunities.

Overall Position and Assurance

Taken together, UHS Maternity Services are operating within an elevated but manageable risk environment. There is no indication of systemic failure, and the service demonstrates active governance, transparency and responsiveness to national learning. However, national experience illustrates how pressures relating to acuity, workforce stability and equity can accumulate if not actively addressed.

Sustained executive attention to workforce stabilisation, operational pressure and emerging inequities will be essential to maintaining safety, resilience and public confidence, particularly as the Trust prepares for the final recommendations of the Amos Review.

University Hospital Southampton NHS Foundation Trust

Agenda Item 5.15 Report to the Trust Board of Directors, 14 May 2026	
Title:	Antimicrobial Resistance (AMR) Report
Sponsor:	Natasha Watts, Chief Nursing Officer & Director of Infection Prevention & Control.
Author:	Julie Brooks, Consultant Nurse Infection Prevention & Control. Harriet Launders & Jackie Swabe, Lead Anti-infectives pharmacists Dr. Tom-Paul Cusack, Consultant Medical Microbiologist /AMS Clinical Lead.

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 against national AMR targets, outlines current risks and assurance gaps, and responds to NHSE November 2025 “Act Now” call to action, requiring Board- level review and oversight of antimicrobial stewardship (AMS) and Infection Prevention & Control (IPC).

Current performance against the ambitious national AMR targets is variable. Improvements are required in both antimicrobial prescribing/stewardship and IPC practices. Benchmarking/self-assessment using national assurance frameworks has identified gaps in assurance, particularly in relation to the consistency of antimicrobial stewardship practice, monitoring of prescribing quality indicators, and the systematic embedding of AMS within education, training and governance arrangements. Key assurance and capability gaps include limited capacity and resource to consistently monitor prescribing quality & AMS outcomes; inconsistent embedding of AMS in mandatory training; variable implementation of good practice in IV antimicrobial use, IV to oral switch (IVOS), and intravascular device management.

Members of Trust Board are asked to review the report and note current UHS position, challenges and concerns in relation to meeting national AMR targets and to:

- Support executive led actions to strengthen AMS, through measures to reduce reliance on Watch and Reserve antibiotics and mandate and embed routine antimicrobial review as standard clinical practice across UHS.
- Support proposals for the review of AMS infrastructure, including benchmarking of AMS workforce and consideration of digital solutions to enable prescribing oversight, monitoring and quality improvement.
- Support delivery of the Trust’s AMR strategy and identified AMR priorities for 2026/27.

Contents:

Risk(s):

Strategic: Board Assurance Framework Risk number 1C: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

Equality Impact Consideration:	No

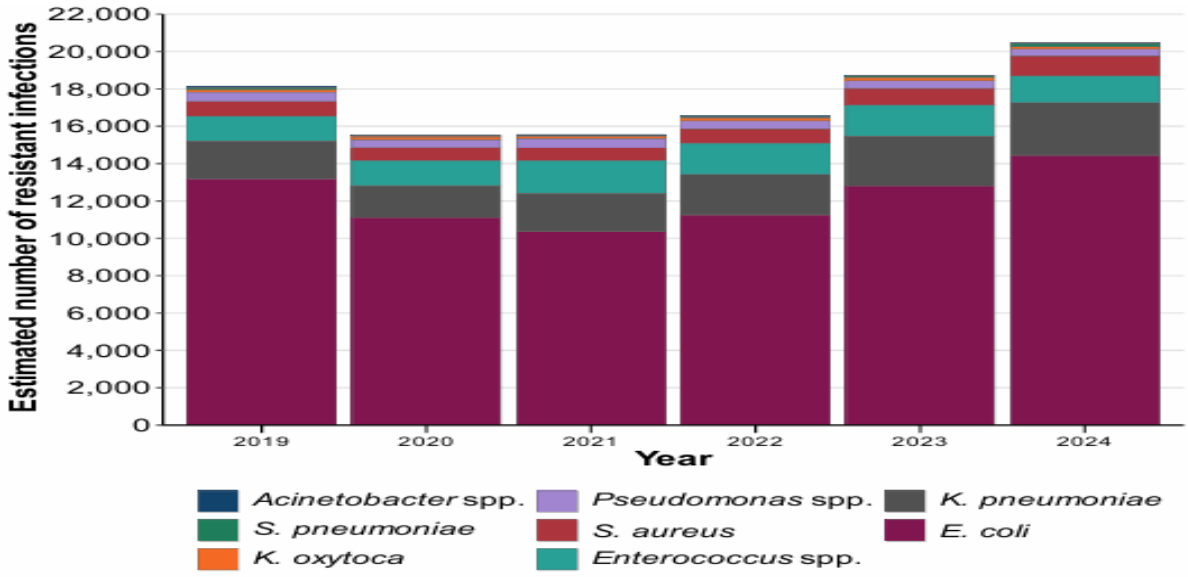
1. Introduction

Antimicrobials are the cornerstone of modern medicine that treat millions of people worldwide. They are used in the treatment of both minor and potentially life-threatening infections in humans and animals and enable surgery, modern cancer therapies and other immunosuppressive treatments which are in increasing use. Antimicrobial resistance (AMR) occurs when organisms become resistant to antimicrobial medicines that usually treat infections they cause. While AMR occurs naturally it is accelerated by over and misuse of antimicrobials.

AMR is one of the top global public health and development threats and is listed on the UK government's National Risk Register. In the UK, AMR is associated with twice as many deaths annually as breast cancer. AMR makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. It also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS through the need for more toxic, intravenous therapies over a longer time course.

The annual English Surveillance Report (ESPAUR) produced by the UKHSA provides monitoring data on pathogen resistance and the chart below shows that there is an upward trend in resistance to *E.coli*, a common cause of severe infections, to one or more critical antibiotics (note differences in COVID-19 years).

Figure 2.2. Annual estimated total of the burden of antibiotic-resistant bacteraemia episodes, England 2019 to 2024



The UK 5-year national action plan (NAP), 'Confronting antimicrobial resistance 2024 to 2029' contains outcomes and commitments to support progress towards the 20-year vision for AMR to be contained, controlled and mitigated, with 9 strategic outcomes organised under 4 themes and ambitious AMR targets (Appendix 1).

Antimicrobial stewardship (AMS) and Infection Prevention & Control (IP&C) are key components in tacking AMR and continue to be key areas of focus within UHS with a 5-year AMR strategy developed and approved in Q3 2025/26. Performance, outcomes and activity in relation to AMS/IP&C are reported, via the Infection Prevention & Control report, to Quality Committee and Trust Board twice a year (Q1 and Q4) and quarterly to the Trust Executive Committee.

In November 2025, NHSE wrote to Trusts ("Act Now" call to action) requesting the following actions to be taken by end Q1 2026 to ensure the organisation is on track to meet the AMR targets in the NAP:

1. Board-level review & Executive oversight – schedule a joint presentation to your board from IPC and AMS teams covering current performance against national AMR targets, benchmarking, key concerns and immediate actions required.
2. Risk and capability assessment – complete assessments (national infection prevention and control board assurance framework, ICB antimicrobial stewardship self- assessment toolkit) to evaluate current performance and compliance; identify gaps in leadership, workforce capability, and resource allocation; inform risk registers and strategic planning.
3. Set priorities and deliver improvement- agree and publish three priority areas for AMR improvement within your organisation.

Progress should be reviewed quarterly, with a formal update to the board at least annually.

2. Current Performance against national AMR targets

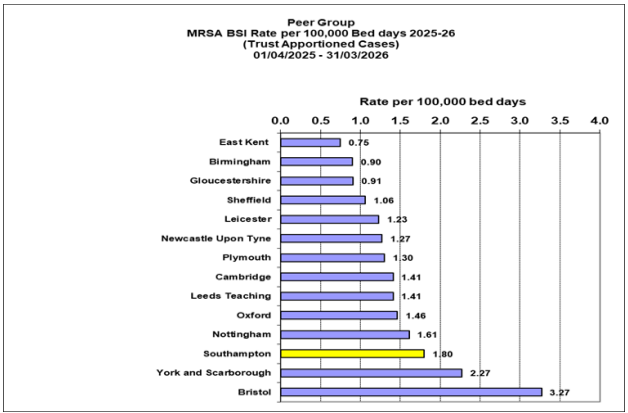
2.1 Reducing the need for, and unintentional exposure to, antimicrobials (NAP Theme 1)

Outcome 1 - Infection prevention and control and infection management	Target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year baseline
	Target 1b: by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline.
Outcome 2 - Public engagement and education	Target 2a: by 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively.

Target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year baseline.

The specified set of drug-resistant infections included in this target can be found in Appendix 2. Monitoring and reporting of a number of these organisms is already routinely included in the scheduled IPC reports to Trust Board. For example, MRSA bloodstream infections (BSIs), gram-negative BSIs, glycopetide resistant enterococcus (VRE), Carbapenem-producing gram negative bacteria. Performance in relation to MRSA BSI is summarised below. Full detail on MRSA and other organisms will be presented in detail in the forthcoming IPC 2025/26 annual report.

	2025-26	2024-25	2023-24	2022-23	2021-22	2020-21	2019-20
MRSA BSI	8	5	7	4	1	1	2



2025/26 Performance

UHS has an attributable MRSA BSI rate of 1.80 cases/100,000 bed days and ranks 12 of 14 self-selected peer acute similar trusts, with similar specialist services as well as those with DGH that have a similar throughput and complexity to UHS DGH type service i.e. gynaecology or rheumatology etc. Top quartile, median and lower quartile marker rates are 0.75, 1.48, and 3.27

Further detail is awaited on national directives, reporting etc. for the full list of specified drug-resistant organisms.

Target 1b: by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline.

Since 2021/22 there has been an annual requirement under the NHS Standard Contract to minimise rates of Gram-negative bloodstream infections (GNBSIs) 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).

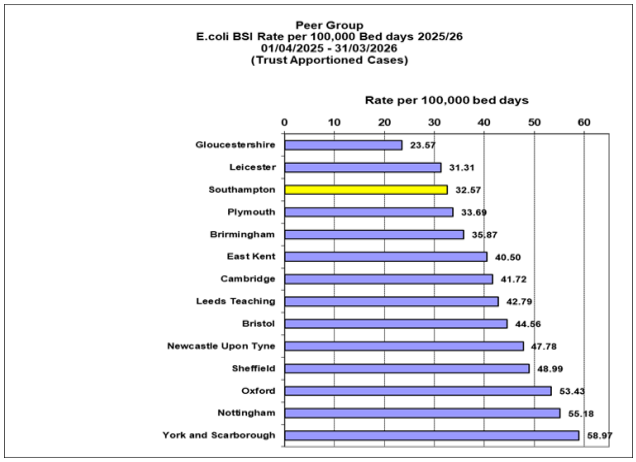
UHS healthcare associated Gram-negative BSIs (nationally set thresholds in brackets).

	2025-26	2024-25	2023-24	2022-23	**2021-22	2020-21*	2019-20*
E coli	142 (141)	200 (141)	147 (120)	154 (127)	138 (151)	67	67
Klebsiella	52 (56)	81 (56)	58 (56)	51 (73)	64 (64)	40	57
Pseudomonas	28 (23)	36 (22)	24 (33)	35 (36)	30 (34)	13	24

*healthcare associated = sample taken 48hrs after admission (numbers using new case attribution definitions to be determined in order to provide 2019-20 baseline figures).
**change in case attribution definitions (as below) and introduction of national target thresholds.

- *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)*

E. coli is the causative pathogen of approximately 80% of all AMR bloodstream infections in the UK. Despite reductions in the numbers of E. coli bloodstream infection cases seen during the COVID-19 pandemic, case numbers have subsequently been rising annually. Performance in relation to healthcare associated (HOHA/COHA) E-coli BSI within UHS has exceeded nationally set thresholds over the last 4 years, although some improvement has been seen in 2025/26.



2025/26 Performance

UHS ranks third out of 14 self-selected peer acute similar trusts, with similar specialist services as well as those with DGH that have a similar throughput and complexity to UHS DGH type service i.e. gynaecology or rheumatology etc., with a rate of 32.57 cases/ 100,000 bed days

It is acknowledged within the NAP that the target to reduce GNBSIs will be challenging in the context of an ageing population with increasing comorbidities. The incidence of GNBSIs is projected to increase and there is limited evidence in the literature for interventions which work to prevent

GNBSIs. Focus within UHS continues to be on reducing avoidable cases of GNBSIs, e.g. those associated with invasive devices.

Driving down infections, the ambition of both targets 1a and 1b, should lead to reductions in prescribing and the associated risk of development of AMR.

Target 2a: by 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively

Further detail is awaited on any national directives and requirements in relation to this target.

2.2. Optimising the use of antimicrobials (Theme 2)

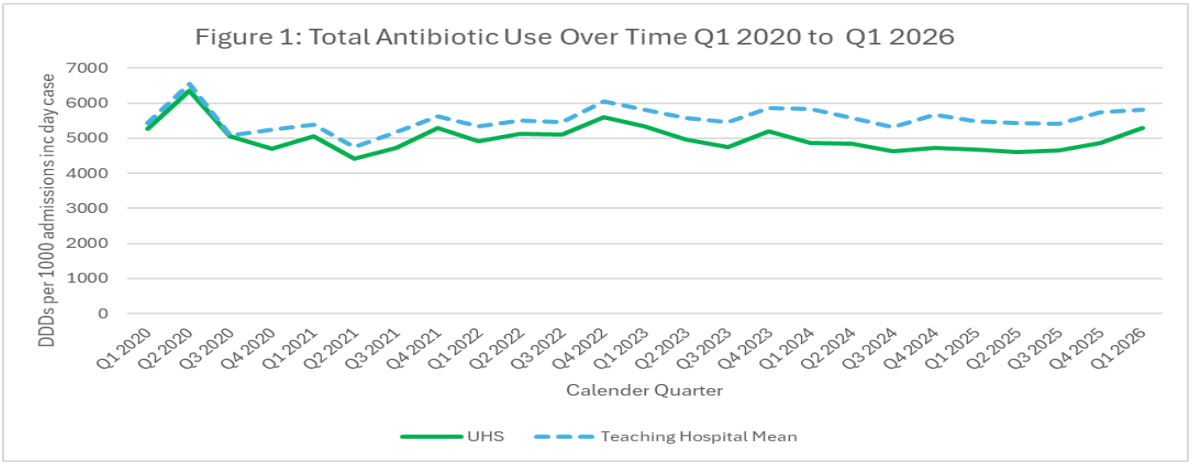
Outcome 4 – Antimicrobial stewardship and disposal	Target 4a: by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline
	Target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system

Target 4a: by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline.

One of the key challenges identified in the NAP is achieving a sustained reduction in overall antibiotic use over time, with a 5% reduction from the 2019 baseline. This equates to a 1% reduction per year, so a 2% reduction in 2025/26 compared to 2019 baseline. UHS achieved a 1% reduction in antibiotic use in 2024/25 compared with 2019 baseline and this trend has continued in Q1 to Q3 2025/26. Overall reduction is 2.08% from April to Dec 2025 (end of year figures become available approx. 6 weeks after month end as it requires finalisation of bed admission data).

Compared with nationally similar trusts, UHS currently performs well in terms of total antibiotic consumption as highlighted in figure 1. A snapshot of quarter 4 2025/6 total antimicrobial use against self-selected similar trusts in terms of activity and size shows UHS placed at 5 out of 10 trusts and below the mean as outlined in figure 2.

However, delivering further reductions to meet the NAP target will require ongoing resource and sustained engagement with prescribers. This includes the delivery of targeted stewardship interventions, ensuring up to date empirical prescribing guidelines that reflect the evolving evidence base for antibiotic choice and treatment duration, and leadership level engagement to embed antimicrobial review as a routine and integral component of every ward round.



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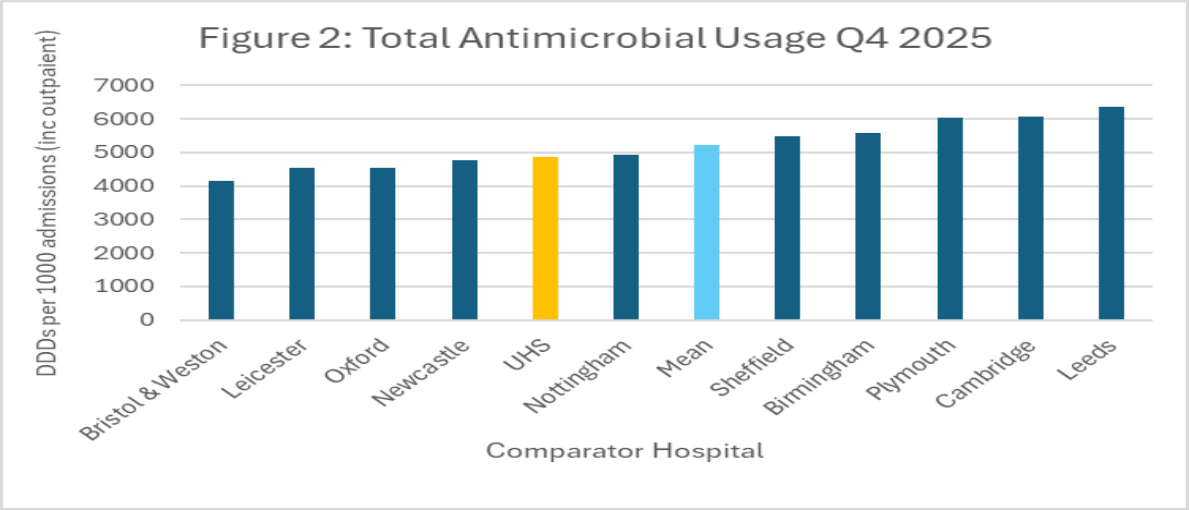
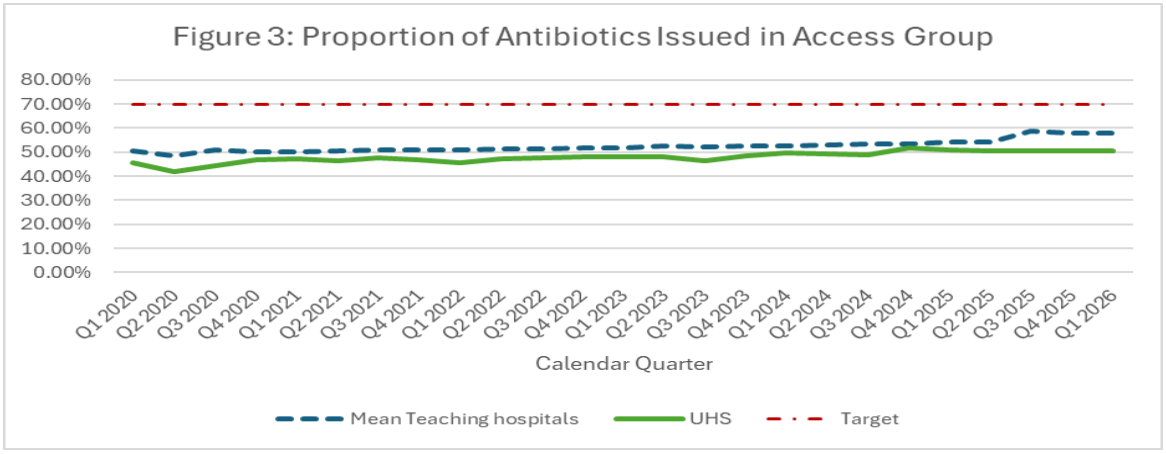


Target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system

The NAP sets a system wide requirement for the proportion of antibiotics prescribed from the Access category of the UK-adapted WHO AWaRe classification to increase to 70% of total human antibiotic use by 2029. Within the AWaRe framework, antibiotics are classified as Access, Watch or Reserve. Access antibiotics are generally narrower spectrum and are recommended as first line therapies, while Watch and Reserve antibiotics are broader spectrum, have activity against more resistant organisms, and should be used more cautiously. Use of Watch and Reserve antibiotics is associated with a higher risk of Clostridioides difficile infection and the development of antimicrobial resistance.

At UHS, the proportion of Access antibiotic use has improved from 45.6% in Q1 2020 to a plateau of 50.6% since Q4 2025. Critical care has the highest proportion of reserve antibiotic prescribing (as would be expected); followed by Cardiothoracics where specialist microbiology advice often informs use for complex infection management; and Specialist Medicine, which largely reflects prescribing for cystic fibrosis patients, where broader-spectrum agents are often necessary to manage resistant infections. Auditing of these areas to determine the appropriateness of reserve antibiotic prescribing is planned, once resources allow, to see if this is indeed the case.

UHS is performing less well than comparable peer trusts at highlighted in Figure 3. Further progress towards the national target will require focused action, including systematic review of empirical prescribing guidelines to prioritise Access antibiotics wherever clinically appropriate, and strengthened antimicrobial stewardship rounds to support timely step-down from Watch and Reserve agents to Access options.

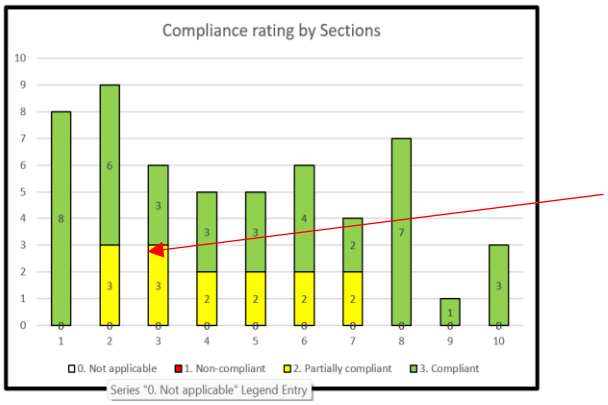


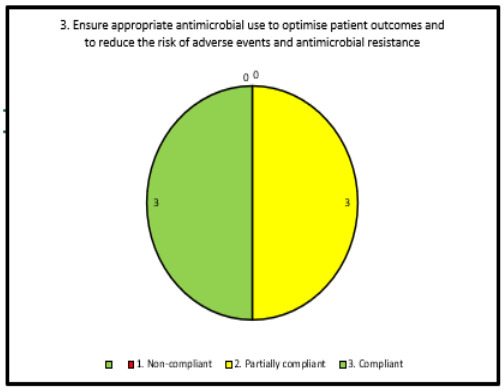
Internal data monitoring of pathogen resistance trends within UHS shows a demonstrable increase in E.coli resistance to co-amoxiclav over the last few years, our first line antibiotic for sepsis and many other severe infections. Interestingly those antibiotics whose use has been restricted recently due to safety or resistance concerns have seen a reduction in resistance, indicating the correlation between increasing use of antibiotics leading to increased resistance of bacteria to that antibiotic.

3. Risk and Capability Assessment

3.1 National Infection Prevention and Control Board Assurance Framework

Self-assessment against the 10 key lines of enquiry (KLE) within the framework was last undertaken in Q2 2025/26 and is currently being reviewed (update to be presented in the 2025/26 IP&C annual report). Gaps in assurance in Q2 resulted in several elements being assessed as partially compliant, including in KLE 3 (ensure antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance).





Key gaps included resource to support and measure adherence to good practice and quality improvement in AMS, monitoring of antimicrobial prescribing, inclusion of AMS in mandatory training.

3.2 The ICB Antimicrobial Stewardship Self-Assessment Toolkit

In line with the call-to-action letter, the AMS team are working collaboratively with ICB colleagues to complete this self-assessment. This work is being led by the ICB team, who are currently experiencing significant pressures due to the ongoing restructuring process. We will continue to support completion of the self-assessment as system capacity allows, noting that completion of the IPC Board Assurance Framework is more specific to acute NHS trusts.

4. Key concerns and immediate actions required

Infection Prevention & Control

7 out of the 8 MRSA BSIs in 2025/26 were related to intravascular devices (6 of which were IV cannula's). Of 292 cases of other healthcare associated BSI (gram negative, MSSA & VRE) that were reviewed in 2025/26, intravascular (IV) devices were identified as the likely source of infection in 10% of the cases. Key learning from the investigation and review of these IV related BSIs identified gaps in practice and assurance related to the management and care of intravenous devices.

In response, an IV device improvement Plan has been developed by the Infection Prevention Team, with executive leadership from the Chief Nurse/Director of Infection Prevention and Control. Improvement actions focus on key areas of IPC practice related to IV device care and require engagement and support from Divisional/Care group and Clinical/Nursing Leaders.

Antimicrobial Stewardship
Key Concerns:

- High use of Watch and Reserve category antibiotics: risk of not achieving the 70% target for Access category antibiotic use.
- Daily review of antimicrobial prescriptions is not embedded practice for all clinical staff/teams.
- Provision of education surrounding AMR and AMS is limited or absent in induction programmes, mandatory training and other educational provision.
- Resource to support and measure adherence to good practice and quality improvement in AMS, for example digital solutions and lack of dedicated clinical pharmacy resource.
- Administrative resource to support monitoring of antimicrobial prescribing.

Actions required:

- Executive level support to embed regular antimicrobial review into everyday clinical practice, in line with the principles of AMS.
- Explore digital solution developments that will support AMS principles of start smart then focus.
- Resource benchmarking with other similar Trusts to determine optimum AMS resource requirements.
- Actions to ensure AMS is routinely embedded into organisation and local educational activity.

5. Priority areas for AMR improvement within UHS for 2026/27.

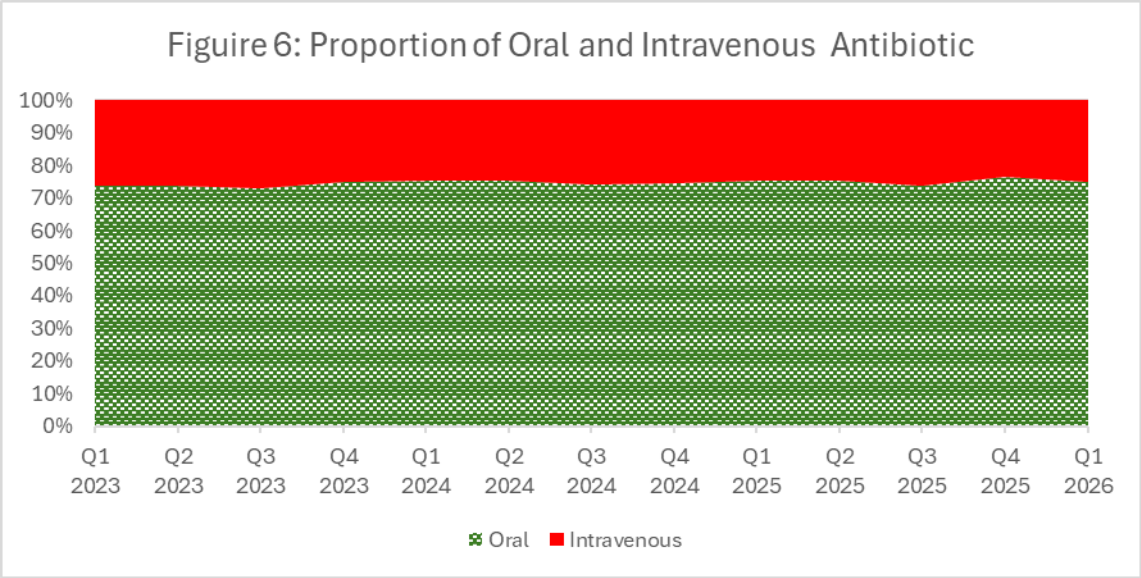
As outlined in the call-to-action letter, three priority areas should be identified for the year, ensuring alignment with the Trust's AMR strategy and the national action plan. The AMST and IPT have identified the following three priority areas for AMR improvement for 2026/27.

1. IV to oral switch (IVOS) of antimicrobials
2. Management and care of intravascular devices.
3. PADL (penicillin allergy de-labelling)

IV to Oral Switch (IVOS)
Objective: To reduce intravenous antimicrobial use trust-wide by 10% by 31/3/2027.

IVOS delivers clear clinical, stewardship and operational benefits for the Trust. Robust evidence demonstrates that early IVOS, when patients meet defined clinical criteria, is safe and does not compromise clinical outcomes, while significantly reducing the risks associated with intravenous therapy, including IV related infections, thrombophlebitis and medication errors. IVOS is consistently associated with reduced length of stay, earlier patient mobilisation, and improved patient experience, saving of nursing time and contributing positively to bed capacity and flow.

Embedding IVOS as a priority action enables measurable quality, safety and efficiency gains, supports multidisciplinary practice, and provides a high impact, low-cost intervention with demonstrable benefits at both patient and organisational level. Despite available resource from the small AMS team focusing on this in the last two years no demonstrable difference has occurred (see figure 6 below). This highlights the need for executive level leadership engagement and further resource to achieve improvements which also come with significant financial savings.



Management and care of intravascular devices.
Objective: To improve the care and management of intravascular devices (specifically IV cannula) and reduce IV related bloodstream infections.

Achieved through ongoing delivery of the UHS IV improvement plan 4 areas of focus:

Improvement Focus			
1. Focus on IP&C practice/actions identified from after action reviews/practice reviews related to IV device care related to: - cannula insertion -ongoing care -documentation	**2. Improve understanding & standards of aseptic non-touch technique practices**	**3.Device stewardship.**	**4.Patient involvement**

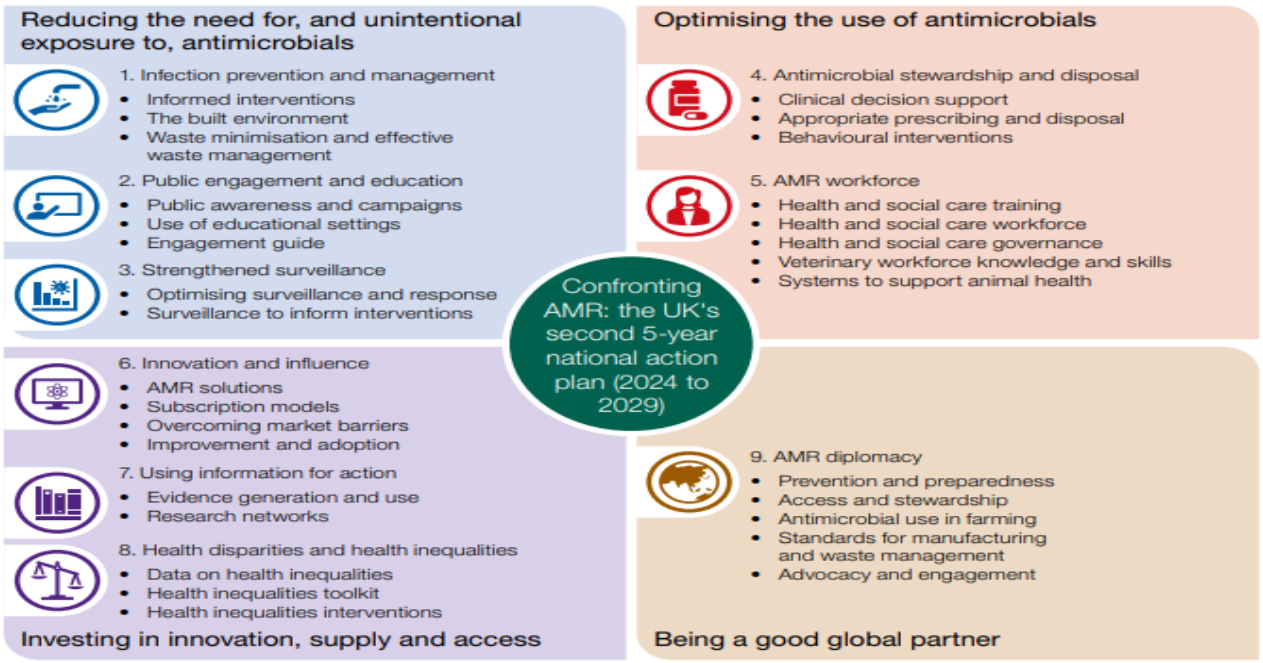
Penicillin Allergy De-labelling
Having an antimicrobial allergy label limits the options of available antimicrobials to treat infection. Penicillin is the most common antibiotic allergy label, but it is thought to be a true allergy in only 10% of the patients reporting it.

A penicillin-allergy label increases the individual's risk of MRSA, *C.difficile* infection and Vancomycin resistant enterococcus (VRE) infections and can lead to prolonged hospital stays and increased mortality through the use of alternative antibiotics that offer inferior treatment. Alternatives to penicillins tend to be broader spectrum and carry their own adverse reactions that can be of consequence, for example fluoroquinolones. Addressing inappropriate penicillin allergy labels is a recognised AMS intervention.

Development and implementation of a penicillin allergy policy to educate staff and patients on the benefits of correctly describing and safe and effective routes for challenging penicillin allergy is the main focus of this area for improvement. Progress in this project will be shared with the updates to this group.

Appendix 1

National Action Plan 2024-2029 Summary and AMR human health targets



Theme 1 - Reducing the need for, and unintentional exposure to, antimicrobials	
Outcome 1 - Infection prevention and control and infection management	Target 1a: by 2029, we aim to prevent any increase in a specified set of drug-resistant infections in humans from the 2019 to 2020 financial year baseline
	Target 1b: by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline.
Outcome 2 - Public engagement and education	Target 2a (see appendix B): by 2029, we aim to increase UK public and healthcare professionals' knowledge on AMR by 10%, using 2018 and 2019 baselines, respectively
Theme 2 - Optimising the use of antimicrobials	
Outcome 4 - Antimicrobial stewardship and disposal	Target 4a: by 2029, we aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline
	Target 4b: by 2029, we aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system

Appendix 2

Specified set of drug-resistant infections

Bacteria	Antibiotic resistance
Escherichia coli Klebsiella pneumoniae Klebsiella oxytoca	• Carbapenem-resistant • Third-generation cephalosporin-resistant (excluding isolates also resistant to carbapenems • Aminoglycoside-resistant (excluding isolates also resistant to carbapenem and/or third-generation cephalosporin) • Fluoroquinolone-resistant (excluding isolates also resistant to carbapenem and/or third-generation cephalosporin and/or aminoglycoside)
Acinetobacter spp.	• Carbapenem-resistant • Aminoglycoside- and fluoroquinolone-resistant (excluding isolates also resistant to carbapenem)
Pseudomonas spp. (specifically, Pseudomonas aeruginosa)	• Carbapenem-resistant • Resistant to 3 or more antimicrobial groups (excluding isolates also resistant to carbapenem)
Enterococcus spp. (Specifically, E. faecalis and E. faecaium only and not other Enterococcus species)	• Glycopeptide-resistant
Staphylococcus aureus	• Methicillin-resistant
Streptococcus pneumoniae	• Penicillin- and macrolide-resistant (excluding isolates only resistant to penicillin) • Penicillin-resistant (excluding isolates also resistant to macrolides)

(Source: annexe table 2.3 of the ESPAUR report 2022 to 2023: annexe).

University Hospital Southampton
NHS Foundation Trust

Agenda item 6.1 Report to the Trust Board of Directors, 14 May 2026	
Title:	Annual Corporate Objectives 2025-26 Quarter 4 Review
Sponsor:	David French, Chief Executive Officer
Author:	Martin de Sousa, Director of Strategy and Partnerships

Purpose

(Re)Assurance	Approval	Ratification	Information
x			

Strategic Theme

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

Executive Summary:

This paper provides an update regarding progress against our corporate objectives for Quarter 4 of 2025-26.

Our objectives were agreed at Trust Board in March 2025. This is the final progress report for this financial year and reflects the position at the end of 25/26.

A scoring summary of progress is below:

Ref	Corporate ambition	Leads	Number of Objectives for 2025/26	Q4 Green	Q4 Amber	Q4 Red
1	Outstanding patient outcomes, safety and experience	COO/CNO	4	2	2	0
2	Pioneering research and innovation	CMO	2	1	1	0
3	World class people	CPO	2	0	0	2
4	Integrated networks and collaboration	COO/CMO	1	0	1	0
5	Foundations for the future	CFO/CEO/CNO/CMO	3	1	1	1
Totals			12	4	5	3
		% against		33%	42%	25%

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

Contents:

Summary of progress + Appendix 1-5: updates in full by strategic theme.

Risk(s):	
Objectives relate directly to all BAF risks.	
Equality Impact Consideration:	NO

Quarter 4 Update
The 2025/26 corporate objectives were approved by the UHS Board in March 2025. Twelve objectives were agreed, which reflected an attempt to focus priorities across our five strategic themes, whilst recognising the breadth and complexity of work that was ongoing in the Trust. Following agreement of the twelve objectives, quarterly milestones were set for each objective to measure progress against across the year, and reporting and RAG status reflects progress against these milestones.

This update reflects progress to the end of 2025/26. The overall picture of delivery reflects what has been a challenging year in many aspects – delivery is red-rated in the achievement of our financial plan, and our two staff objectives relating to workforce and experience. Several other areas are amber rated – some of these are ongoing pieces of work that should achieve the planned ambition but in a longer timeframe than envisaged, whilst others have only been able to partly deliver against the original aims. In some cases, such as clinical collaboration, this is strongly affected by factors outside of UHS' direct control.

Despite this, we do end the year having fully achieved some key objectives, for example delivering our 25/26 quality priorities, and our capital plan. These achievements come in the added context of the challenges to all teams in the organisation in Quarter 4 from the West Wing fire and subsequent response efforts.

Moving into 2026/27 we begin a new cycle of reporting against our updated Trust Strategy. Trust Board members will recognise that many of the objectives set in 2025/26 remain relevant and are incorporated into our renewed ambitions.

A narrative summary by strategic pillar is below, with further detail contained in the appendix.

Outstanding Patient Outcomes, Safety and Experience
Positive progress has been made this year against our quality objectives – as reported through Quality Committee we have achieved delivery against our Quality Priorities for the year, including our Fundamentals of Care programme. Work has taken place to coordinate our Trust and Clinical Strategy objectives and our Quality Priorities for 26/27, as part of developing a more consolidated quality management approach.

Our two transformation priorities (Elective and Urgent & Emergency Care) are both reported as amber due to partial achievement of their overall KPIs for the year. The West Wing fire in February 2026 has led to a refocus of these plans moving into 2026/27, given the significant impact on inpatient capacity.

Pioneering Research and Innovation
Overall progress with Year 2 of our five-year Research for Impact Strategy has been consistent and the key objectives for 25/26 have been delivered in this area. The second objective in this area (delivering Year 5 of the R&I Investment Plan) is amber-rated at year end- this reflects an ongoing discussion about the future plan for the Research Leaders' Programme.

World Class People
Both objectives in this area are red rated at the end of 25/26. This reflects our position of not meeting our workforce plan for 25/26, and the results of our 2025 Staff Survey. Trust Board will be well informed of this from other reporting. Both these elements form a key part of our ambitions for 2026/27 and our five-year strategy, linked closely with our refreshed transformation priorities.

Integrated Networks and Collaboration
Our objective for this area is amber rated at year end. We continue to work with acute and community partners on developing networked models of care in line with the updated

Collaborative Clinical Strategy but have not fully completed the aims that we set out at the beginning of the year. However, we move into 26/27 with a renewed focus on sustaining a reduction in demand through working with partners as part of our response to the West Wing fire, and with our updated transformation programme.

Foundations for the Future

Our year-end financial position of £45m deficit is red rated in terms of achievement. However, this position does include the delivery of £95m of savings, as well as ending a significant improvement on the mid-year scenario. Achieving financial sustainability is a key ongoing priority for UHS. Delivering our capital plan for 25/26 was a key success for us and we are in the process of finalising a plan for 26/27 with Trust Board. Our final objective relating to delivering key strategic priorities in 25/26 (updated Trust Strategy, Private Patient Unit development, Southampton elective hub) is amber rated- this reflects a delay in achieving the planned milestones, but these priorities are still expected to be delivered- in some cases within the early part of 2026/27.

Appendix 1: Objectives Update

Outstanding Patient Outcomes, Safety and Experience

Ref	Lead	Objective	Q4 Milestone	Q4 Update
1(a)	CNO	Improve patient experience and outcomes through continued implementation of the 'Fundamentals of Care' programme.	Following review of the turnaround/intentional rounding challenges, commence a refocus and relaunch of these care requirements in line with the Fundamentals of Care commitments to establish a process that supports outstanding quality care in a complex financial and workforce setting.	Overall Progress: **Green** Achievements: • FoC Board maintained strong governance with over 100 staff trained; new LDA-focused training delivered. • GRACE mobility and rehabilitation trial launched, incorporating What Matters To Me boards. • Outpatients joined the FoC programme; self-assessment tool launched; visibility increased through website and onsite materials. • Reduced FoC-related incidents and significant decline in patient-care complaints; strong patient experience feedback. Progress Metrics: • Reduction in FoC-related clinical incidents. • 'Patient care' complaints reduction from 13.58% to 4.44%. • 92.1% reported good pain control; 87.1% involved in decisions; 88.9% involved in discharge. • Increased FFT response rates. The Fundamentals of Care Project Board has now been rebranded as a 'Steering Group' to acknowledge the ongoing requirement for this work and oversight of initiatives but also to support the work that the new FoC Champions are able to do in their clinical areas, alongside other local QI initiatives. The FoC champions are committed to undertaking the self-assessment tool bi-annually to help us monitor local drivers for improvement alongside other Patient Reported Experience Measures (PREMs) like the Friends and Family Test.

Ref	Lead	Objective	Q4 Milestone	Q4 Update
1(b)	CNO	Deliver the quality priorities for 25/26. **1)Experience of Care** **2)Improving the care of the dying patient and those important to them** **3)Fundamentals of Care:** See above **4)Acuity and deteriorating patients:** **5)NATSSIPs Implementation** **6)Health Inequalities**	The following priorities will be reported on in full at Trust Board. 1)Experience of Care 2)Improving the care of the dying patient and those important to them 3)Fundamentals of Care: See above 4)Acuity and deteriorating patients: 5)NATSSIPs Implementation 6)Health Inequalities	**Green:** As reported to Quality Committee - all six priorities have been achieved, demonstrating improvements across patient safety, patient experience and clinical effectiveness. Delivery was supported by strengthened governance, clear executive leadership and active engagement with patients, carers and clinical teams. The outcomes reflect the Trust's continued commitment to delivering safe, high quality and person-centred care.
Ref	Lead	Objective	Q4 Milestone	Q4 Update
1(c)	COO	Deliver the objectives of the elective programme, including achievement of national targets for RTT improvement.	- Optimise Outpatient capacity by reducing DNA's by 1% increasing PIFU rates by 2% and increasing advice & Guidance by 3363 per month - Optimise theatre capacity by treating 500 additional patients, reducing on the day cancellations by 1.5%, increasing theatre utilisation to 85% and reducing late starts by 10 mins	**Amber:** In outpatients, the programme measures have been partially acheived: 0.54% reduction in DNA's, 12% increase in PIFU usage, 206 additional A&G diversions In theatres, a 0.27% increase in theatre utilisation with no change in the number of cases per 4 hour session and 525 fewer patients treated. This decrease was particularly pronounced from September to February in the wake of NHSP rates being changed This trust reduced its waiting list over the year by 2,003 patients
Ref	Lead	Objective	Q4 Milestone	Q4 Update
1(d)	COO	Deliver the objectives of the UEC programme, including achievement of national target for ED performance improvement.	- Length of stay reduced by 5% enabled by earlier discharge on the day, improving emergency access and enabling cost reduction	**Amber:** Length of stay reduction of 2% achieved supporting bed closures and reduced surge capacity used throughout the summer and autumn. Programme supported ED recovery trajectory and plan which has been on track

Pioneering Research and Innovation

Ref	Lead	Objective	Q4 Milestone	Q4 Update
2(a)	CMO	Deliver Year 5 of the research and innovation investment plan, including the Southampton Emerging Therapies and Technologies Centre (SETT), Research Leaders programme (RLP) and delivery infrastructure.	Prepare onboarding of Cohort 6 - dependent upon securing budget for RLP in 26/27. Promote end of Cohorts 2 and 3 and achievements/ROI/plan for each individual. Celebration event. Deliver UHS/UoS MedTech regulatory event. 3 open source packages to be released through 25/26. Two SETT data and AI independent papers to have been submitted.	Cohort 6 of RLP remains paused, depending on support decision by Trust board. Working group currently developing business case. Future of RLP proposed for 26/27 objectives. Complete - celebration event scheduled for Q1 26/27 In progress - advisory group formed. Event and comms planning has commenced. Complete - Kraken, PteRedactly and Valediction released. Outstanding **Overall progress: Amber**
Ref	Lead	Objective	Q4 Milestone	Q4 Update
2(b)	CMO	Deliver Year 2 of the five-year R&D strategy implementation plan (revised) for Research for Impact.	Evaluate and determine next steps of senior leaders programme Plan for an evaluation of project INSPIRE after 1 year (Autumn 26/27).	In progress - evaluation planned for Q1 26/27 Outstanding - deferred until 26/27, project still in implementation phase. **Overall progress: Green**

World Class People

Ref	Lead	Objective	Q4 Milestone	Q4 Update
3(a)	CPO	Deliver a workforce plan for UHS for 2025/26 which meets the national planning requirements and is safe, sustainable, and affordable.	Completion of medical rostering and job planning programme. Delivery of overall WF plan. Planning for 26/27 in line with national requirements and our revised Trust strategy. Review of implications and actions required from new national workforce plan following 10 year NHS plan.	**Red:** At the end of March 2026, the Trust remains significantly above workforce plan, with total workforce 539 WTE above plan. Bank spiked in March as expected as part of normal season trends. Whilst not hitting the end year target, total workforce has fallen by 309 WTE from March 25 to March 26. Sickness absence is broadly controlled at 3.85%, though slightly above target at year end (Target 3.7%). From a quality and governance perspective, staffing-related patient safety incidents increased in March, particularly in Divisions A and B, reflecting sustained acuity and workforce pressure. Appraisal completion (64%) and statutory/mandatory training compliance (69% / 80%) remain key workforce risks, requiring sustained recovery action into 2026/27. The Trust closed the year with 89% medical job plans signed off for NHSE reporting and continued progress on senior medic activity rostering. Despite not reaching the 95% job planning target there has been a huge rise in job planning compliance this year.
Ref	Lead	Objective	Q4 Milestone	Q4 Update
3(b)	CPO	Deliver targeted improvements in staff experience, engagement, and culture in line with the UHS People Strategy and Belonging and Inclusion Strategy.	Staff Survey results and action planning.	**Red:** Staff survey results analysed and discussed at Trust Board, Trust Executive Committee and wider groups. Results show a reduction in participation rate (35%) and a drop in key metrics such as "recommendation as a place to work". The results overall indicate our staff are still experiencing a level of burnout and concerns for wellbeing, given the scale of change, capacity challenges and financial restrictions on resources over the past year this has clearly shown in the results in relation to these indicators. The trust was required to make a significant number of very difficult decisions last year which have adversely affected these results. A set of people priorities have been agreed with TEC and POD for 26/27 which aim to address the key issues raised in the survey, linking closely with the Trust transformation priorities for the year. These will focus on workforce capacity, development and education, voice of our people, safety of our people, and specific actions on inclusion on belonging.

Integrated Networks and Collaboration

Ref	Lead	Objective	Q4 Milestone	Q4 Update
4(a)	CMO	Develop network relationships within our Integrated Care System, including progression of shared services work with partners.	• Support development of the ICS acute provider collaborative clinical strategy, • Continue membership and support for the ICB acute provider collaborative board • Approval of pelvic floor business case by providers and ICB • Develop and deliver on collaboration plan with HHFT	**Amber:** • The ICS acute provider collaborative clinical strategy has been produced and published. Work ongoing in network groups on priority pathways. • UHS continues to attend and support the aims of the acute provider collaborative • UGI work remains on hold awaiting further decisions from ICB and NHSE on next steps. • Pelvic Floor case completed. A pilot based in Gosport has been funded to demonstrate benefits ahead of full funding decisions • Work with HHFT limited to specific pathway discussions (e.g. maxfax). • The ICB and councils have jointly funded a project team to focus on the process for discharge into the community, we have been collaborating with them on this with the aim of reducing NCTR. • A joint transformation programme has been initiated with HIOWH following the fire. This looks to collaborate on hospital at home, repurposing existing community estate (Lymington and Western) and adult mental health. A bi-weekly joint executive oversight group is in place to ensure pace and delivery

Foundations for the Future

Ref	Lead	Objective	Q4 Milestone	Q4 Update
5(a)	CFO	Deliver the financial plan for 25/26, supported by delivery of schemes within the Improving Value programme.	Target zero savings in opportunity phase or unidentified. Delivery of Full Year Savings Target = £110m Delivery of I&E Plan = Breakeven YTD	**Red:** The trust has reported a £45m deficit for 2025/26 (subject to audit). £95m of savings have been achieved in year against a target of £110m leaving a £15m shortfall. Further to this deficit drivers due to growth of NCTR, growth in mental health patient numbers, and an increased level of unfunded activity has generated financial pressure that could not be mitigated. £5m of Deficit Support Funding was also not received due to the Trust missing its plan. A mid-year scenario of £72m deficit was however significantly mitigated following the implementation of a financial recovery plan, supported by NHS England, together with independent external review offering challenge and support. The outlook for 2026/27 remains challenging with £81m of savings required to deliver breakeven.
Ref	Lead	Objective	Q4 Milestone	Q4 Update
5(b)	CFO	Deliver the prioritised 2025/26 capital programme and set a prioritised capital plan for 2026/27, as well as setting aspirations for future year programmes.	Trust Board sign off capital plan for 2026/27 and potentially future years if required by NHSE/DHSC. Continue monitoring of 2025/26 capital plan including management of risks and mitigations via TIG with escalations to Trust Board where necessary.	**Green:** The trust has delivered its capital plan in 2025/26 totalling £69m. This includes £33m of internally funded capital programmes focusing on digital investments, backlog and strategic maintenance and medical equipment replacement notably within diagnostics. Additionally, £36m has been externally funded by NHS England on specific schemes including the commencement of the Urgent Treatment Centre project, Histopathology investment and the estates safety fund further. The capital prioritisation process for 2026/27 - 2029/30 is well progressed with a Trust Board Study session taking place on 16th April involving multiple stakeholders. This is targeted for Trust Board ratification in May 2026.
Ref	Lead	Objective	Q4 Milestone	Q4 Update
5(c)	CNO	Progress key strategic objectives for this year, to include: a. Elective centre for UHS at RSH b. Progress towards onsite PPU c. Refresh for UHS strategy	a. Mobilisation planning ahead of March 26 UHS/NHSPS lease completion	Lease arrangements (NHSPS/UHS/PPG) being finalised for completion on 1st June. Ongoing detailed planning towards 1st July commencement of services at the RSH
			b. Enter into Stage 3 of procurement-bidder dialogue sessions and negotiations and development of Best and Final Offer (BaFO) procurement Stage 4 in late March. Contract development and amendments will occur throughout dialogue. To note that	Ongoing complex multi-stage procurement process - initial shortlisting completed, dialogue with bidders continuing through May 2026 prior to release of final specification

			BaFO will not be submitted until Q1 2026-27	
			c. Deployment and embedding of new strategy	Trust Strategy key elements agreed at Trust Board in Q4, including plan for 26/27 oversight and study session focus areas. Plan to launch Trust Strategy internally in Spring 2026. Overall objective: **Amber**

University Hospital Southampton
NHS Foundation Trust

Agenda Item 6.2 Report to the Trust Board of Directors, 14 May 2026	
Title:	Board Assurance Framework (BAF) Update
Sponsor:	Natasha Watts, Acting Chief Nursing Officer
Author:	Lauren Anderson, Corporate Governance & Risk Manager Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
x			x

Strategic Theme

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

Executive Summary:

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

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

The Board is asked to note the updated Board Assurance Framework and information contained within this report, including key messages as provided below:

- One risk has increased in rating which is risk 3b (inclusive and compassionate workforce experience), increasing from 12 to 16. Further detail including rationale is included within the report.
- One risk has decreased in rating which is risk 5a (finance), decreasing from 25 to 20. Further detail including rationale is included within the report.
- The target date for achievement of risk reduction has been extended from 2027 to 2030 for risks 1a (capacity) and 1b (outcomes and experience), in recognition of the impact on quality resulting from the sustained operational and financial challenges, and the steps needed to close the gap between the risk we hold now and where we wish to be.
- The risk reduction target has also changed for risk 5b (estates). Whilst risk reduction is still intended by 2030, it is recognised that this is likely to be an incremental reduction as opposed to full reduction in line with risk appetite. Therefore, it is targeted that the risk will reduce from 20 to 16 by 2030, rather than from 20 to 8 as initially set out. Full risk reduction remains the aspiration, however there is no clear route as to how and when that can be achieved.

Contents:

Paper
Appendix A – The full Board Assurance Framework

Risk(s):

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

Equality Impact Consideration:	N/A

1. Purpose

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

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

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

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

2. Key updates

2.1. The board last received the BAF in March 2026. Since then, all risks have been reviewed and updated by the responsible executive(s) and their senior teams.

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

- Audit & Risk Committee 16 March 2026
- Finance & Investment Committee 27 April 2026
- Quality Committee 27 April 2026
- People & Organisational Development Committee 28 April 2026

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

1a Lack of capacity to meet current demand resulting in avoidable patient harm.
This risk remains critically rated at 20 (severe x certain). This risk has been assessed and graded at this level since it was generated in 2022 as excessively high demand on UHS services, and the wider healthcare system, continues. This is also evidenced by the number of operational risks recorded within divisions which relate to capacity and the potential for quality of care to be compromised if this is insufficient. More recently this has also been exacerbated by the significant fire which occurred at Southampton General Hospital in February 2026, as this resulted in loss of the endoscopy unit as well as an initial loss of 200 beds. Whilst the loss capacity is gradually returning, full recovery is likely to take 2 years. The current target risk rating is 6 (moderate x unlikely) which sits within the organisation's tolerable appetite, and the target to achieve this has been extended from 2027 to 2030 in recognition of the current gap and work needed to bridge this.

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.
As previously reported, this risk rating was reassessed and increased to 16 (severe x likely) in Summer 2025. This is in recognition of the impact we know patients to be experiencing, and anticipate that they will continue to experience, due to the tension between clinical/operational demand and the resource available. This is still considered to

be true, therefore as we enter 2026/2027 there is renewed energy and refocus on quality including monthly executive quality walkabouts, refreshed matrons walkabouts, and the annual reset and delivery of quality priorities. The target risk rating is 6 (moderate x unlikely) which we aim to achieve by April 2030 to reduce the risk and align it with the Trust's optimal risk appetite. This is an extension of the previous target date of 2027 in recognition of the current gap between where we are now and where we wish to be.

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.
This risk remains rated at 16 (severe x likely) following the increase from 9 (moderate x possible) in Q2 2024/25. This is in recognition of the increasing infection rates, unsatisfactory audits and observations of practice, and the impact of this. The targeted risk reduction remains at 6 (unlikely x moderate) by April 2027. The risk is currently outside of both our optimal and tolerable appetite, however achievement of the target would bring it into the tolerable range. Current management of this risk includes a refocus on basic practices including support and empowerment of ward IPC link nurses to challenge staff when needed, and a workplan for 2026/27 has also been developed. There is particular focus on IPC practice in invasive devices and this was selected as the quality focus for the executive walkabout in April 2026.

2a) 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.
This risk remains rated at 12 (moderate x likely) following the increase from 9 (Moderate x possible) in Summer 2025. This sits within the Trust's tolerable risk appetite with the intent to reduce this to within the optimal risk appetite by the end of the financial year. The risk has been updated to reflect current improvements in our national recruitment ranking, although there is inability to consistently maintain this due to capacity constraints and workforce reductions. It is noted that NIHR/NHSE have implied that future funding may be related to performance metrics, which may pose a forthcoming risk.

3a) We are unable to meet current and planned service requirements due to the unavailability of staff to fulfil key roles.
This risk is currently graded as a critical risk with a score of 20 (severe x certain), which sits outside of the organisation's optimal and tolerable appetite. The intent is to reduce this risk in line with the tolerable appetite by achieving the target risk score of 12 (severe x possible) by March 2030. The risk has been updated to reflect key priorities and focuses for 2026/2027 as per the workforce plan. Assurances and the action plan have also been updated.

3b) We fail to develop a diverse, compassionate and inclusive workforce, providing a more positive staff experience for all staff.
This risk was previously graded as a moderate risk with a score of 12 (severe x possible) but has now been reassessed and increased to 16 (severe x likely) due to current challenges around morale, wellbeing and motivation, caused by staff burnout and lack of staff. This is evidenced through recent staff survey results and increased occupational health referrals for workplace stress/mental health. The intention is still to reduce this in line with the organisation's optimal risk appetite, with a target risk score of 8 (severe x unlikely) predicted for March 2030.

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.
Following the increase to this risk rating in Q2 2025/2026, this risk remains graded as 16 (severe x likely) which sits outside of our risk appetite. The intention is to reduce the risk in line with our appetite, achieving a risk reduction to 6 (moderate x unlikely) by March 2029. Whilst national direction is still awaited to inform some longer-term actions, and NHSE confirmation of CPD funding is still awaited, the risk has been updated to reflect current action being taken by the Trust and assurances on funding secured from the charity and funding to continue to participate in Oliver McGowan training.

4a) We do not implement effective models to deliver integrated and networked care, resulting in suboptimal patient experience and outcomes, increased numbers of admissions, and increases in patients' length of stay.

The risk remains rated as 9 (moderate x possible) which is in line with the Trust's tolerable risk appetite. The target risk rating evidences the intention to reduce this risk in line with the optimal risk appetite, by reducing this risk rating to 6 (low x possible) by December 2026 through progression of work in key specialities. This is unchanged at present but will remain under review as it is recognised that staff and organisational capacity to network can be challenging, further exacerbated by the level of challenge and change present within UHS and the wider NHS at present. Potential impact of evolving national strategy, direction, and expectation of accountabilities is also noted.

5a) We are unable to deliver a financial breakeven position resulting in:
- **a reducing cash balance impacting on the Trust's ability to meet payment terms for suppliers and staff, meet statutory requirements such as payments to HMRC, and invest in line with the capital plan.**
- **NHS England imposing additional controls/undertakings.**

In recognition of the improving cash position, favourable outcomes to contracting negotiations, and agreement of a breakeven plan for 2026/27, the risk rating has been reduced from 25 (catastrophic x certain) to 20 (catastrophic x likely). It is however noted that this is reliant on compliance with the financial plan set out, therefore could deteriorate again if we are unable to meet this or our cash position deteriorates. Accordingly, the target risk ratings have also been updated to reflect the intention to incrementally reduce this risk with some reduction anticipated by the end of this financial year, and full reduction to tolerable appetite by 2031.

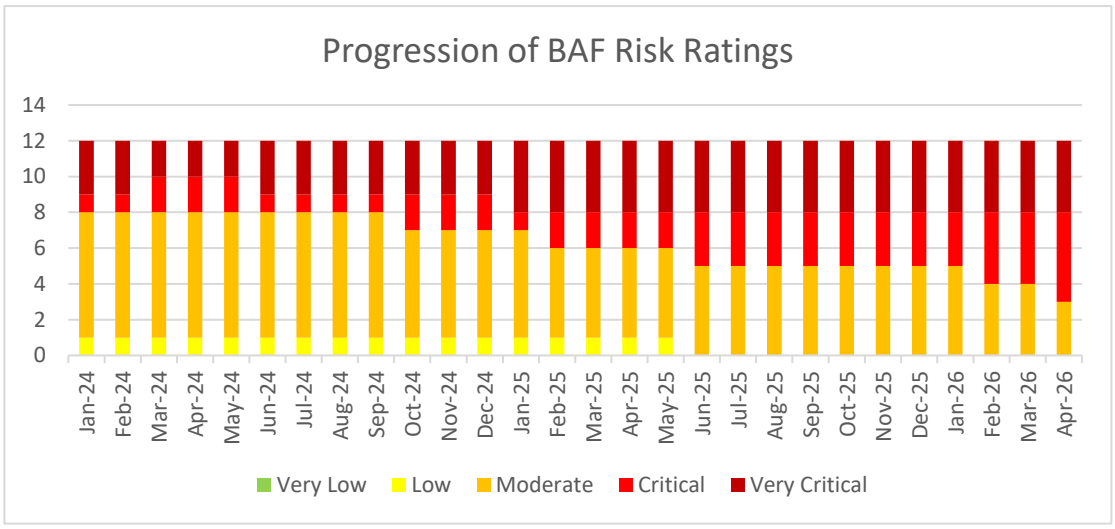
5b) We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity.
This is currently graded as a critical risk for the organisation with a rating of 20 (severe x certain) with the intent of reducing this risk to 16 (severe x likely) by April 2030. Previous aspirations were to reduce this to within appetite by 2030, however it is recognised that there is no clear route to achieve this, therefore an incremental risk reduction has been targeted for then. The longer-term aspiration to reduce this to within appetite remains, but at present there is no established time frame due to the uncertainty on how this can be achieved.

5c) Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation.
In February 2026 the risk rating had been increased from 12 (moderate x likely) to 16 (severe x likely) given the significant operational impact that may occur should this risk materialise, and this remains accurate. Key concerns which demonstrate this impact are reflected within the risk, such as the inability to digitally book patient appointments if the Trust is without a Patient Administration System (PAS) if the existing contract cannot be renewed in 2028 and an alternate system has not been funded and secured prior to this. It

is noted that the PAS is a component of the Electronic Patient Record (EPR) and there is currently no clear route to funding a new EPR at a local or national level. Further risk is associated with the aging digital infrastructure and insufficient funding to address this.

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. This risk remains rated at 8 (low x likely) following the increase in rating 12 months ago. This is within our risk appetite however there is an intention to reduce this further, as low as reasonably practical, by reducing the likelihood of this materialising. Key actions are underway to achieve this, driven by the Green Plan which was ratified six months ago.

2.4. In total there are now 9 critical risks recorded on the BAF, which accounts for 75% of the total risks. The graph below provides a visual demonstration of how this has increased, evidencing the continued and growing tension between clinical and operational pressures, and the constraints of available resources and finances.



2.5. Currently there are 9 risks (all critical risks) with a risk rating outside of the organisation's risk appetite. Each of these articulate a clear intent to reduce the risk and align it with the risk appetite and include actions to demonstrate how this will be delivered. It is recognised that this will take some time with all, but one, risk reductions anticipated to be successful between 2027 and 2031. However as noted in the report above, there is not a clear route or timescale for full reduction of risk in 5b.

University Hospital Southampton NHS
NHS Foundation Trust

UHS Board Assurance Framework (BAF)

Updated April 2026

The Board Assurance Framework (BAF) is a dynamic document which provides assurance against the achievement of our strategic objectives, highlighting those risks that may threaten delivery.

The risks are grouped according to the Trust's key strategic themes:

1. Outstanding patient outcomes, safety, and experience

- 1a: Lack of capacity to appropriately respond to emergency demand, manage the increasing waiting lists for elective demand, and provide timely diagnostics, that results in avoidable harm to patients.
- 1b: Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes.
- 1c: We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital-acquired infections and limit the number of nosocomial outbreaks of infection.

2. Pioneering research and innovation

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

3. World class people

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

4. Integrated networks and collaboration

- 4a: We do not implement effective models to deliver integrated and networked care, resulting in sub-optimal patient experience and outcomes, increased numbers of admissions and increases in patients' length of stay.

5. Foundations for the future

- 5a: We are unable to deliver a financial breakeven position, resulting in: inability to move out of the NHS England Recovery Support Programme, NHS England imposing additional controls/undertakings, and a reducing cash balance impacting the Trust's ability to invest in line with its capital plan, estates/digital strategies, and in transformation initiatives.
- 5b: We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity.
- 5c: Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation
- 5d: We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045.

Executive Summary

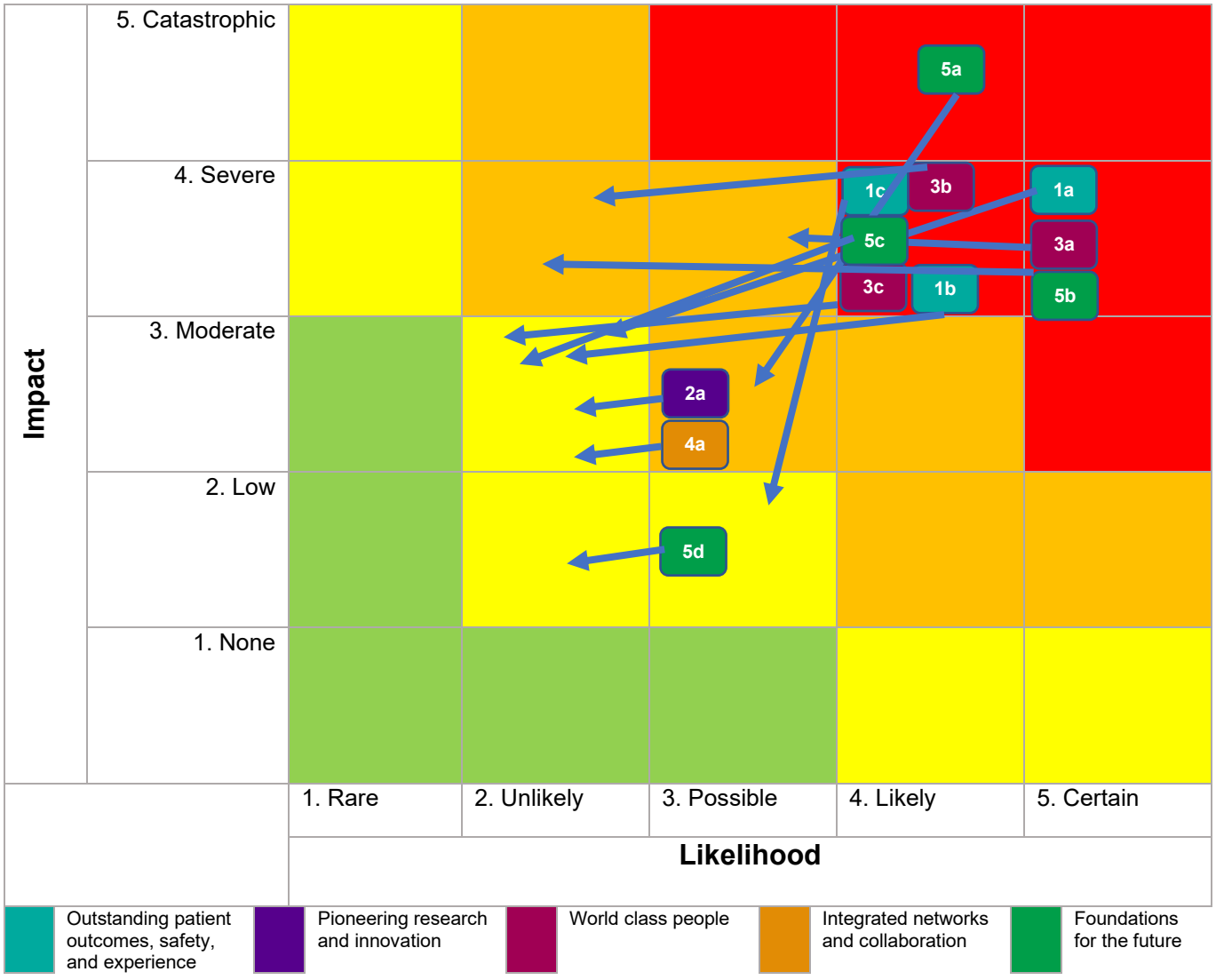
There are 9 critical strategic risks with a red risk rating above 15. These are:

- 1a) Capacity (4 x 5 = 20)
- 1b) Outcomes & Experience (4 x 4 = 16)
- 1c) Infection Prevention (4 x 4 = 16)
- 3a) Staffing (4 x 5 = 20)
- 3b) Inclusive & Compassionate Workforce Experience (4 x 4 = 16)
- 3c) Future Workforce Planning inc. Training & Development (4 x 4 = 16)
- 5a) Finances (5 x 4 = 20)
- 5b) Estates (4 x 5 = 20)
- 5c) Digital (4 x 4 = 16)

At present there are 9 risks with a current risk rating outside of the optimal or tolerable appetite. These are: 1a, 1b, 1c, 3a, 3b, 3c, 5a, 5b, and 5c. All of these risks are being actively treated with the aim of reducing the risk score and all risks set out within the BAF have a target risk rating which sits within the optimal or tolerable risk appetite.

Trajectory

The heatmap provided below demonstrates the current risk rating based on the impact and likelihood, along with an arrow illustrating the target score to be achieved through implementation of planned actions and mitigations.



Outstanding patient outcomes, safety, and experience

1a) Lack of capacity to meet current demand resulting in avoidable patient harm

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If there is inadequate capacity due to increasing demand, suboptimal flow, and limited resources (including funding, workforce, estate, and equipment);	This could lead to an inability to respond to emergency demand in a safe, timely and appropriate manner, delays in elective admissions and treatment, and delays in timely diagnostics;	Resulting in avoidable harm to patients and increased incidents, complaints, and litigation.

Category	Appetite	Status
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 5 20	April 2022	4 x 5 20	April 2026	3 x 2 6	April 2030

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed by the responsible executives in April 2026 with minor updates included to ensure the risk is current. The entry has been considered in the context of the standing risk, as well as in the context of the additional risk faced through recovery from the significant fire which occurred at Southampton General Hospital 01/02/2026. The fire occurred in the endoscopy unit rendering this unusable for an ongoing prolonged period, and also affected a number of wards which had to be evacuated and remain closed reducing our bed count. This was initially reduced by 200, and around a 1/3 of these have now been brought back. A further 60 beds are expected to be regained in Q1 2026/27 and two mobile endoscopy units have now opened on site, but full recovery of capacity is expected to take up to 2 years. Potential options to enable this are currently being assessed, both onsite and offsite.

The impact to ED is also noted as they are experiencing the impact of loss of downstream beds to admit patients to. Opening of the urgent treatment centre will support urgent and emergency capacity, however this has been delayed due to building issues, and is expected to open towards the end of Q2 2026/27 instead of in June 2026. Some assurance can be taken though that ED performance is on a positive trajectory, ending 2025/26 with a 12% increased performance rate in comparison to the previous year.

Contractual negotiations have now concluded to balance planned work and the pay envelope available, and modelling is now underway to understand what capacity is needed to meet demand. Existing mitigations are embedded to regularly validate patients and prioritise them clinically, and additional resource has been secured for admin and clerical staff supporting these pathways. Service specific solutions are also being explored such as use of NHSP/agency and planning additional activity, although it is noted that some attempts at outsourcing have not been as successful as hoped as private providers would require us to provide the surgeon. Final end of year (2025/2026) performance figures are expected by the end of May 2026.

Key controls	Gaps in controls
Clinical Prioritisation Framework. Triage of patient lists based on risk of harm with consultant led flagging of patients of concern.	Excess demand in community and social care combined with cuts to Hospital Discharge Funding may further increase the number of patients in hospital not meeting the criteria to reside.

Capacity and demand planning, including plans for surge beds and specific seasonal planning. Patient flow programme to reduce length of stay and improve discharge. This is governed through the Inpatient Steering Group (IPSG) with senior clinical and non-clinical leadership including the CNO, deputy CMO, and deputy COO. Targeted workstreams underpinning the objectives include criteria led discharge and discharge lounge use. Outpatients and operating services transformation programme focused on improving utilisation of existing capacity and reducing follow up demand. Limited use of independent sector to increase capacity. Urgent and Emergency Care Board established to drive improvements across UEC pathways. UEC recovery plan to support improvements across UEC pathways. UEC standards have been developed and implemented with guidance for site management to ensure that we admit the right patient to the right place. Monitored through patient flow programme board. Rapid Improvement Plans to support improvements across cancer pathways. Winter/business planning which includes business continuity plans, such as the use of surge capacity should this risk be realised. Local NCTR delivery unit for the South West established in 2024/25 and remains underway.	Limited funding, workforce, and estate to address capacity mismatch in a timely way. Lack of local delivery system response and local strategy to manage demand in our emergency department as well as to address delays in discharge from the acute sector. However emerging NHS HIOW transformation programmes are focussed on discharge, planned care, local mental health care, and urgent and emergency care. Challenges in staffing ED department during periods of extreme pressure. Ongoing industrial action through the previous 3 years has presented significant risk to the Trust's ability to meet ongoing demand on our services. This could continue into 26-27. Staff capacity to engage in quality improvement projects due to focus on managing operational pressures. Workforce and recruitment controls result in ward leaders working within the safe staffing numbers as opposed to in a solely supervisory capacity reducing their ability to plan discharges and oversee flow. Lack of a clear capacity and demand plan to resolve cardiac capacity issues in the longer term. Lack of sustainable capacity in some specialities resulting in long wait breaches, e.g. gynae, ENT, some cancer specialities, surgical skin services.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Harm reviews identifying cases where delays have caused harm. Weekly divisional performance meetings with a particular focus on cancer and long waiting patients. Live monitoring of bed occupancy and capacity data. Monitoring and reporting of waiting times. Increase in advice & guidance referrals. **<u>Level Two (Internal)</u>** Implementation of PSIRF with oversight of red incidents at TEC. Transformation programme work plans. An assurance paper was taken to Trust Board in September 2024 in response to a recent BBC Dispatches documentary secretly filmed at Royal Shrewsbury Hospital showing significant delays in urgent and emergency care, and subsequent letter from NHSE outlining steps acute organisations must take to mitigate against potential similar concerns. **<u>Level Three (External)</u>** NHSE and NHS HIOW ICS supportive quality visits to ED.	Local system plans to reduce patients without a criteria to reside are emerging but will take time to evidence results.

Key actions

Emergency Care

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

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

Flow and Discharge

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

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

Elective Activity

COO AH to deliver on set activity targets for 2025/26 (end of year figures expected end of May 2026):

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

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

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

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

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

Urgent Treatment Centre to be opened in Q2 2026/2027.

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

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
74	If there is a continued demand for SDU bed Capacity for inpatients there will be an impact on elective admission flow, patient experience, financial cost and staff well-being	2 x 3 = 6	3 x 2 = 6	31/10/2025
187	Inability to deliver critical services within the emergency department due to increased demand, overcrowding and inadequate flow out of the department, which is resulting in harm to patients.	5 x 5 = 25	4 x 3 = 12	30/04/2027
259	Capacity and Demand in Maternity Services	4 x 4 = 16	2 x 2 = 4	31/03/2026
266	There is a risk that Maternity and Obstetric Theatre Capacity and availability is not able to meet demand at PAH this includes elective and emergency C-section capacity	4 x 5= 20	2 x 2 = 4	31/01/2026
395	This risk is related to the cardiac surgical patients who are on our waiting list that may come to harm whilst they wait for their surgery.	4 x 3= 12	2 x 3 = 6	30/06/2026
443	Lack of capacity within the sleep service resulting in long waits for respiratory and neurological sleep studies, and long waits for outpatient appointments within the neurological sleep service.	3 x 4 = 12	3 x 2 = 6	31/10/2025
652	Prostate cancer capacity	4 x 4 = 16	3 x 2 = 6	31/12/2025
671	Capacity within the melanoma and soft tissue cancer pathways.	4 x 4 = 16	3 x 2 = 6	27/02/2026
687	Impact on patient care due to delayed recovery discharges, because of lack of patient flow throughout the hospital.	2 x 4 = 8	3 x 2 = 6	30/04/2026
697	Delays in surgery for paediatric congenital cardiac patients due to lack of capacity and a growing waiting list	5 x 4 = 20	3 x 2 = 6	31/03/2026
758	Urology stone service - including stent change delays & capacity challenges	4 x 4 = 16	3 x 2 = 6	30/09/2026
766	Inability to deliver a critical service to those with a life threating illness/injury due to our resuscitation bays being overcrowded. Compromised ability to function as the Regional Major Trauma Centre.	5 x 5 = 25	4 x 2 = 8	30/04/2027
767	HoLEP capacity issues	3 x 4 = 12	3 x 1 = 3	31/03/2026
775	Patients with kidney cancer may experience worse outcomes and survival due to capacity issues and delays in their treatment pathways	4 x 3 = 12	4 x 1 = 4	31/03/2026
804	Congenital cardiac (adult & paeds) surgery demand	4 x 4 = 16	4 x 2 = 8	31/03/2026
816	Inability to discharge patients due to non-criteria to reside status and/or ineffective processes will compromise effective flow and result in patient harm, a suboptimal patient experience, and insufficient admitting capacity	5 x 4 = 20	3 x 2 = 6	31/03/2026
822	Ophthalmology Glaucoma Capacity	4 x 4 = 16	4 x 2 = 8	30/06/2026
823	Ophthalmology Medical Retina Service Capacity	4 x 4 = 16	4 x 2 = 8	30/09/2026
840	Paediatric haemodialysis capacity	4 x 4= 16	2 x 3= 6	31/10/2025
845	There is a risk that the obstetrics service will be compromised due to excess levels of demand and unmatched capacity within the consultant team	4 x 2= 8	4 x 1 = 4	31/03/2026
850	Inability to effectively run the pelvic floor service due to staffing and capacity	3 x 3 = 9	2 x 2 = 4	31/05/2026
857	Prostate PIFU Capacity	4 x 3 = 12	3 x 2 = 6	31/03/2026
890	Risk of Patient Harm and Increased Admissions Due to Heart Failure Service Capacity Issues	4 x 3 = 12	4 x 1 = 4	31/12/2025
909	Patients may come to harm with vision loss due to reduced clinics at Lymington Hospital	3 x 2= 6	2 x 2 = 4	30/06/2026
911	If there are no dedicated CAMHS facilities and insufficient CAMHS staff at Southampton's Children's Hospital, coupled with inadequate community and social support to facilitate timely discharge of children and young people with acute mental illness or behavioural disturbances, this may lead to an inability to effectively meet the needs of this patient group	3 x 3 = 9	2 x 3 = 6	31/01/2026

Linked operational risks				
No.	**Title**	**Current risk rating**	**Target risk rating**	**Target Date**
	resulting in a poor experience, delayed care and discharge, and harm; as well as adversely affecting the admitting and treating capacity in other paediatric specialities			
921	Ketogenic diet clinic capacity	3 x 4 = 12	2 x 2 = 4	28/02/2026
922	Increased waiting time for endocrine dynamic function tests (DFTs) could result in poor patient experience and potential patient harm to those waiting for treatment	3 x 3 =9	3 x 1 = 1	05/06/2026
937	Patients attending ASU/SDEC attend via multiple access pathways, leading to overcrowding. This has the potential for patient harm due to treatment delays, unwitnessed deterioration due to patient/staff ratio and environmental layout.	3 x 3 = 9	2 x 3 = 6	26/06/2026
972	Due to an electrical fire in our Endoscopy unit on Sunday the 1st of February 2026, we do not have provision for diagnostic and therapeutic endoscopy for patients. There is a risk of clinical harm due to delays, this may include patient restricted or reduced treatment options, impact patient outcomes and cause significant or catastrophic harm.	5 x 3 = 15	2 x 2 = 4	30/09/2026

Outstanding patient outcomes, safety and experience

1b) Due to the current challenges, we fail to provide patients and their families / carers with a high-quality experience of care and positive patient outcomes

Monitoring committee: Quality Committee	**Executive leads:** COO, CMO, CNO

Cause	Risk	Effect
If demand outstrips capacity, and/or we have insufficient workforce to meet the demand,	This could result in an inability to provide a fully comprehensive, and exceptional, experience of care,	Resulting in not fully meeting the needs of our patients and their families and carers, which may lead to an increase in complaints and poor feedback. Additionally, patents may suffer delays, complications, poorer outcomes, and longer lengths of stay if their needs are not addressed at the earliest opportunities.
Category	**Appetite**	**Status**
Experience	Cautious *The current risk rating is outside of the risk appetite however the target risk rating is within the optimal risk rating.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	April 2026	3 x 2 6	April 2030

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

Current assurances and updates

This risk has been reviewed by the responsible executives in April 2026 and is agreed to remain an accurate reflection of the risk held in consideration of the impact we understand some patients are already experiencing due to the tension between clinical/operational demand and the financial resource available, as well as the likelihood that this will continue throughout the coming months. As we enter 2026/2027 there is emphasis on reigniting our focus on quality, with steps including:

- Review and refresh of matrons walkabouts under the corporate nursing leadership team, with prioritised protection of matron time to engage in this.
- Monthly executive walkabouts led by the Chief Nursing Officer and Chief Medical Officer with dedicated quality focuses. The first walkabout occurred in April 2026 with a focus on IV cannula care.
- Development and delivery of six quality priorities for 2026/2027 aligned to patient experience, patient safety, and patient outcomes.
- Greater oversight and assurance through the quality dashboard under development.

Key controls	Gaps in controls
Trust Patient Safety Strategy and Experience of care strategy. Clinical strategy in development, this will cover priorities for demand management, including collaboration with partners and shift towards community care. The strategy will also cover delivering timely care and access. Organisational learning embedded into incident management, complaints and claims. Learning from deaths and mortality reviews.	Patient experience strategy is out of date and now not in keeping with national and local objectives. New strategy to be co-designed with involved patients once the Trust strategy is finalised in early 2026 in line with the 10 year plan. Patient safety strategy currently under review and refresh. Likely to be completed early 2026.

Mandatory, high-quality training. Health and safety framework. Robust safety alert, NICE and faculty guidance processes. Integrated Governance Framework. Trust policies, procedures, pathways and guidance. Recruitment processes and regular bank staff cohort. Culture of safety, honesty and candour. Clear and supportive clinical leadership. Delivery of annual Always Improving Programme aims. Involvement of patients and families through our Quality Patient Safety Partners (QPSPs) in PSSG, SISG and Quality Improvement projects. Governance of this through role cards, allocation process, and annual reviews. Directory of 2000 patients who are willing to engage in projects and provide a patient voice. Implementation of PSIRF. Patient Involvement and engagement in capital build projects Working with communities to establish health inequalities and how to ensure our care is accessible and equitable. Health inequalities board established with priorities and allocation of dedicated time across multiple roles in the clinical strategy and BI teams. Maternity safety champions. Listening events and community engagement. Equality & Quality Impact Assessment (EQIA) review group. Ward to Board governance and escalation route.	Staff capacity to engage in quality improvement projects due to focus on managing operational pressures . Reduction in head count (decreased bank utilisation) due to the measures taken because of financial challenges. There is no longer any dedicated resource for SDM due to recruitment restraints and prioritisation of work. The clinical strategy team can only respond to small, adhoc, requests for support. However, work across the system on value based care will feed into this. Cost of SMS surveys across the Trust is significant. Patient safety incidents reflect challenges in staffing.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Matron walkabouts and executive led back to the floor. Providing other avenues of FFT feedback that suits the needs of our demographic, or example SMS surveys, ensuring our care is informed by ours patients voice. **<u>Level Two (Internal)</u>** Monitoring of patient outcomes with QPSP input. Clinical accreditation scheme (with patient involvement). Internal reviews into specialties, based on CQC inspection criteria. Quality dashboard, KPIs, quality priorities, clinical audits and involvement in national audits. Performance reporting. Governance and oversight of outcomes through CAMEO and M+Ms Patient Safety Incident Investigation Oversight Meeting Transformation Oversight Group (TOG) including TOG dashboard to oversee impact. Health Inequalities Board	

Established governance oversight and escalation from ward to board through care group and divisional governance groups, as well as the Quality Governance Steering Group and the Quality Committee (sub committee of the board) including AAA (Alert, Advise, Assure) reports. Patient experience week (May 2024 and 2025) evidencing and celebrating FFT and sharing learning from complaints. **Level Three (External)** CQC inspection reporting: Good overall. Feedback from Royal College visits. Getting it right first time (GIRFT) reporting to Quality Committee. External accreditations: endoscopy, pathology, etc. Kitemarks and agreed information standards. Current and previous performance against NHS Constitution and other standards.	

Key actions

Introducing a robust and proactive safety culture:

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

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

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

Launch and implement PSIRF – completed.

Implement the second round of Ockenden recommendations – completed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
645	Increase in mental health patients and ligature risk in ED and AMU	3 x 5 = 15	2 x 2 = 4	30/04/2027
765	Risk to patient safety and patient experience due to a lack of plasma exchange provision for children at UHS	4 x 4 = 16	4 x 2 = 8	26/09/2025
805	Clinical harm and never events may occur if NATSIPPS2 cannot be embedded due to insufficient resource	4 x 4 = 16	3 x 1 = 3	31/03/2026
904	Quality of patient care and treatment may be compromised due to the significant financial challenges faced within the NHS	4 x 3 = 12	4 x 2 = 8	01/10/2026
995	Patients admitted to UHS with mental health conditions may suffer a poor experience or harm from being care for in an acute physical health setting which is not set up to meet their needs	3 x 4 = 12	2 x 2 = 4	01/12/2026

Outstanding patient outcomes, safety and experience

1c) We do not effectively plan for and implement infection prevention and control measures that reduce the number of hospital acquired infections and limit the number of nosocomial outbreaks of infection

Monitoring committee: Quality Committee	**Executive leads:** CNO, COO

Cause	Risk	Effect
If there are gaps in compliance with IPC measures and policy, either due to increased working pressures, or a lack of awareness or understanding,	Patients may acquire a new infection whilst in hospital and there may be nosocomial outbreaks of infection,	Resulting in patient harm, longer lengths of stay, a detrimental impact to patient experience if visiting restrictions are necessitated, and an operational impact as bays and wards are closed.

Category	Appetite	Status
Safety	Minimal *The current risk rating is outside of the stated risk appetite. The target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 3 9	April 2022	4 x 4 16	April 2026	2 x 3 6	April 2027

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

Current assurances and updates

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

It is noted that nationally there has been an increase in infection and this is also true locally therefore it is predicted that we will exceed national infection thresholds for 2025/26, for example MRSA BSIs and CDIFF, although we do not expect to be an outlier in this. 6 out of 8 MRSA BSIs at UHS are related to IV access devices so an IV access device improvement plan has been developed. This includes a recent executive walkabout, led by the Chief Nursing Officer and Chief Medical Officer, where they and their deputies reviewed patients with IV cannulas in to promote best practice and share learning.

Further improvement work underway includes:

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

Key controls	Gaps in controls
Annual estates planning, informed by clinical priorities. Digital prioritisation programme, informed by clinical priorities. Infection prevention & control agenda, annual work plan, audit programme. Local infection prevention support provided to clinical teams. Compliance with NHSIE Infection Prevention & Control Assurance Framework. Focused IP&C educational/awareness campaigns e.g. hand hygiene, IV device management and care, and winter virus awareness. Digital clinical observation system. Implementation of My Medical Record (MMR). Screening of patients to identify potential transmissible infection and HCAIs. Programme of monitoring/auditing of IP&C practice and cleanliness standards. Review of incidents/outbreaks of infection and sharing learning and actions. Risk assessments in place for individual areas for ventilation, bathroom access, etc. to ensure patient safety. Guidance disseminated around identifying potential cases of measles and pertussis and monitoring symptoms following a national and local increase in presentations. Supported by national messaging and encouragement of vaccinations. Education and support provided to clinical areas not meeting expected cleanliness standards, providing by EMT and external providers. The fundamentals of care continue to be rolled out which includes embedding expected IPC measures This also addresses learning from the recent MRSA BSIs and other infections e.g. risk reduction measures for MRSA, focus on hand hygiene practice and correct PPE. Follow-up/review of all new cases of Cdifficile & MRSA for assurance that expected standards are in place to reduce risk of onward transmission. Ongoing review of new cases of healthcare associated bloodstream infections (E-Coli, klebsiella, pseudomonas, MRSA, MSSA, VRE) to identify potential gaps in practice, learning and actions for improvement. Focussed activity/support to wards by the Infection Prevention Team in response to need, including ward reviews/feedback and education and training. Monthly infection prevention and control newsletter continues to be issued in response to current trends, themes, and need. Point of Care testing in AMU. Expedited laboratory testing facilities for respiratory and GI infections.	Transmissibility of respiratory virus infections (e.g. COVID-19, Influenza, RSV), Norovirus and other infections. Resurgence of infections such as measles and pertussis plus emergence of newer infections e.g. Candida Auris and increased national prevalence of multi-drug resistant organisms such as CPE. Familiarisation with response to resurgence of infections such as norovirus, measles, pertussis plus new infections. Challenges in the ability to isolate patients presenting with suspected infection due to limited infrastructure in some areas e.g. limited single rooms/demand on single rooms. IPC measures are reliant on people and their actions will be influenced by human factors, therefore 100% compliance cannot be enforced. Lack of established administrative support with appropriate capacity to facilitate timely contact tracing. Requirement and mitigations to be scoped although currently there are no extraordinary requirements for contact tracing.

CNO/CMO reviews with clinical teams for MRSA cases. Business continuity: up to date ratified pandemic plan reviewed annually as well as the infection outbreak policy.	
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Hand hygiene, IP&C and cleanliness audits. **<u>Level Two (Internal)</u>** Infection Prevention Committee and IP&C Senior Oversight Group. Patient-Led Assessment of the Care Environment. Capital funding monitored by executive. Finance and Investment Committee oversight of estates and digital capital programme delivery. Internal audit annual plan and reports. Quarterly executive monitoring of Estates KPIs (maintenance, cleanliness, fire safety, medical devices, etc.). **<u>Level Three (External)</u>** National Patient Surveys. NHSE/I infection prevention & control assurance framework compliance reporting to executive, Quality Committee and Board.	Ward and bay closures due to norovirus outbreaks. Increase in cases of C.Diff , MRSA BSIs (blood stream infections) and other gram negative BSI above national set thresholds. Not all areas consistently submitting IP&C audits to demonstrate assurance of expected IP&C practices.
Key actions	
• Head of IPC JB leading an ongoing review of IPC policies to ensure they are aligned to the national IPC manual for England, including launch, communication, education and monitoring. Completed policies include MRSA, outbreak of infection, and isolation with the following also underway: C Diff, candida auris, and urinary catheter care. • Head of IPC JB and pharmacy leads launching a new antimicrobial 5 year strategy by the end of 2025/26 / early 2026/27. This combines stewardship and IPC and replaces the previously expired IPC strategy. • Align UHS with the updated national mandatory IPC education packages by the end of 2026/27 – Head of IPC JB. • Focussed IP&C education and awareness campaigns supported by internal and external communications plan, and monthly OPC newsletter, led by Head of IPC JB throughout 2025/26 and into 2026/27. • Implement 2025/26 and 2026/27 workplans to guide improvements in practice and implement learning – Head of IPC JB.	

Pioneering research and innovation

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

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

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

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

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

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12

Current assurances and updates

This risk has been reviewed by the responsible executive in April 2026 and the risk rating and targets are still considered accurate following the increase in August 2025. The reduction in headcount in R&D, and the wider workforce reductions across the organisation, are still having an impact on R&D Trust Board KPIs. Study recruitment levels (TB KPIs for national ranking) are still being met with our national recruitment ranking improving from 9 to 8 but we are still struggling to meet the national metrics for study set-up times and first patient recruited metric. We are seeing an overall improvement in both of these metrics but that improvement is not maintained consistently from month to month. Capacity constraints across clinical support services are impacting on our ability to set-up new studies so we are prioritising opening studies based on known capacity constraints across the clinical delivery system. To support mitigation local actions from an EQIA have been implemented which are ensuring patient safety and data integrity are being maintained for open studies, and local research delivery team capacity is being managed in response to study pipeline demand.

New national NIHR Research Delivery Network funding model for 2026/27 has linked performance for a mix of historical and current performance national metrics to funding allocations – final funding allocations indicate a £500K reduction in funding for 2026/27 compared to 2025/26, although UHS allocation is still 4th highest nationally. Reduction in RDN budget for 2026/27 will be offset by strategic funding secured from the RDN, as well as pay spend reductions secured through the workforce reductions in 2025/26. NIHR / NHSE have also implied a link to delivery against national study set up and recruitment metrics (150 days) to future NIHR infrastructure funding (no further information available at this stage).

Key controls	Gaps in controls
Research strategy, approved by Board and fully funded. Always improving strategy, approved by the board and detailing the UHS improvement methodology.	Operational pressures, limiting time for staff to engage in research & innovation.

Partnership working with the University and other partners. Clinical academic posts and training posts supporting strategies. Secured grant money. Host for new regional research delivery network, supporting regional working. Local ownership of development priorities, supported by the transformation team. Prioritisation of high-risk or high-impact studies when workforce capacity constraints impact through: Staffing capacity constraints are identified and managed to ensure an agile response to areas of high need Manage study set-up pipeline depending upon capacity constraints with a focus on national set-up metrics, high-risk or high-impact studies. Reduction in volume of new studies in set-up depending upon capacity constraints to maintain set-up times, protect study delivery capacity and ensure patient safety.	Limited capacity to support new studies and research areas, relating to hard to recruit areas, turnover, and existing clinical priorities. Research priorities with partners not necessarily led by clinical or operational need. R&D have met their required workforce reduction allocation, so some vacancies are now being filled, but R&D turnover still higher than Trust average. Reductions in research workforce and clinical support services are impacting on our delivery against national performance metrics. Knock on impact on NIHR RDN funding allocations for 26/27 (£500k reduction against 25/26 £7.5m budget) as based on historical and current performance against national metrics. Reduction in RDN budget for 26/27 will be offset by strategic funding secured from the RDN, as well as pay spend reductions secured through the workforce reductions in 25/26. UHS funding allocation is still 4th highest nationally but we are moving to a national funding model where our comparative performance against other hospitals now impacts directly on our funding allocation. Patient safety and data integrity are being maintained for open studies, and local research delivery team capacity is being managed in response to study pipeline demand but this is having an impact on individual and team resilience.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Monitoring research activity funding and impact at R&D steering group. <u>Level Two (Internal)</u> Governance structure surrounding University partnership. Joint Senior operational group. Joint Research Strategy Board. Joint executive group for research. Joint Innovations and Commercialisation Group – UHS/UoS. <u>Level Three (External)</u> Board to Council meetings. MHRA inspection and accreditation. CQC review of well-led criteria, including research and innovation. R&D Trust Board KPI's being monitored closely to benchmark our performance nationally. In February 2026 our national recruitment ranking has declined from 7th in October 2025 to 9th in January 2026 and securing sustainable improvements in study-set up and delivery metrics are proving challenging given workforce capacity constraints.	Limited corporate approach to supporting innovation across the Trust. New national site metrics introduced around clinical trial set up and delivery will be introduced as Trust Board KPIs in 2026/27. NHSE have included a requirement in medium term planning framework that research income and R&D KPIs metrics are reported to TB at least 6 monthly so intention would be to 1) update TB KPIs to reflect national priorities (reported monthly), and 2) introduce a 6 monthly review against the R&D Annual Plan to meet the reporting frequency requirements.

Key actions

Deliver the 2025/26 Annual Plan, including the approved R&I Investment Case, with quarterly updates against progress submitted to the Trust Board through the corporate objectives. Largely on track at end of year with some actions carried over to next year due to capacity constraints. Delivery of 2025/26 Annual Plan and Annual Plan 2026/27 will be brought to TB in June. Karen Underwood

By March 2026, define and implement a UHS contribution plan to the Wessex Health Partners Annual Review, including agreed RoI metrics and resource commitments for the next 3-year term. Delayed by R&D and WHP annual planning cycle – on track by end Q1 2026/27- Karen Underwood.

By March 2026, expand staff engagement initiatives presented to TBSS in February 2025, based on mapping outcomes and staff feedback. Research Champions being launched 24 April 2026, and an implementation plan is being developed to deliver / expand other initiatives. On track. Karen Underwood

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

Implement new digital tools to streamline clinical research delivery by March 2026, aiming for a 10% improvement in recruitment efficiency compared to 2023/24 benchmarks. Capacity constraints and delays in development / identification of systems have impacted on delivery. In-house R&D capability and systems identified and work to specify and resource the development work required underway. Carried forward into 2026/27. Laura Purandare

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

Successfully initiate the NIHR Applied Research Collaboration Wessex programme (UHS host, with UoS – regional bid awarded £16.3m over 5 years) by April 2026, ensuring governance, staffing, and delivery plans are in place. Implementation plan in place, focus initially on core team and functions, then wider research and stakeholder engagement. ARC Partnership Board and associated governance processes and structures being put into place. On track. Catherine Bowen / Michale Boniface.

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

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

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

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

World class people

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

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

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

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

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed and updated with the Chief People Officer in April 2026 with no significant changes required. Current updates and assurances have been provided below, and the action plan updated.

The workforce plan for 2026/27 has been produced with an overarching focus on reduction of 200wte. Successful delivery of the plan is reliant on focussed recruitment, investment support into capacity on RTT pathways, and delivery of transformation programmes and CIPs. The transformation priorities include unscheduled care and elective care, as well as intelligent automation to improve administrative processes and efficiency through the use of technology such as AI. These priorities, alongside the new Trust strategy and clinical strategy, will provide an opportunity to re-engage with the workforce and how we work, aiming to 'transform not cut'. An example of this, linking focussed recruitment and elective care, is significant local effort on recruitment and retention in clinical (and some administrative) critical vacancies across critical care and theatres that deliver RTT pathways. Planning is also underway to maximise our intake of Newly Qualified Nurses this year.

Assurances are provided around improvisations in job planning compliance, which was recorded at 89% in March. Whilst it is acknowledged that this didn't reach the NHSE target of 95%, this is a significant improvement on last year, doubling previous compliance.

As previously reported the Trust's HR team are also monitoring and responding to national developments such as the updates to the Employee Relations Act which received Royal Assent in December 2025. Both Trust Executive Committee (TEC) and People & Organisational Development Committee (POD) have been briefed on the key changes and impact of these, with an action plan now underway. Plans to manage changes to fixed term contracts are due to be presented to TEC and POD, focussed on management of locum (fixed term) medical contracts.

Key controls	Gaps in controls
New 5-year People Strategy and clear objectives for Year 2 monitored through POD. Recruitment and resourcing processes. Workforce plan. General HR policies and practices, supported by appropriately resourced HR team. Temporary resourcing team to control agency and bank usage. Apprenticeships. Recruitment control process to ensure robust vacancy management against budget. Workforce reviews to respond to specific recruitment and retention issues (e.g. the ACP review). Improved data reporting. ICB wide transformation programme established with leadership including the UHS CEO. The focus is on grip and control of temporary staffing use, including supply issues, and corporate services. ICB recruitment panel established to limit recruitment within HIOW for specific roles. Affordable workforce limits have now been agreed with all divisions and THQ. Workforce plan for 2026/27 submitted to ICB. Organisational change policy including management of redeployment. RCP (Recruitment Control Panel). Creation of an organisational change management group to govern the current restructure. Financial Improvement Group established with a supporting Equality and Quality Impact Assessment Review Group. Planned change management and wellbeing support for staff and managers. Continual joint working between finance and workforce to align data and improve forecasting. Established procedures for managing staffing deficits and maintain business continuity including escalation through the staffing hub and use of NHSP/agency where patient safety necessitates this.	Completion of objectives for South-East temporary collaborative. Planned improvements for medical job planning to be implemented. Over reliance on NHSP. Need for a new and refreshed people strategy and long term education strategy.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Fill rates, vacancies, sickness, turnover and rota compliance. **<u>Level Two (Internal)</u>** Review of implications for education and training infrastructure from national workforce plan. **<u>Level Three (External)</u>** NHSI levels of attainment criteria for workforce deployment.	Universal rostering roll out including all medical staff.

Annual post-graduate doctors GMC report. WRES and WDES annual reports - annual audits on BAME successes. Gender pay gap reporting. NHS Staff Survey results and pulse surveys. Temporary staffing collaborative diagnostic analysis on effectiveness. A system wide rostering audit has taken place across Hampshire and Isle of Wight, and UHS have now received the findings which provides strong, positive, assurance of our practice with continued opportunities around medical rostering and job planning.	

Key actions

2025/2026 and 2026/2027 led by CPO SH

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

- Appropriate calibration of recruitment controls linked to new workforce plan and financial budgets.
- Support the delivery of transformation priorities, specifically the delivery of improved administration processes through the Intelligent Automation workstream.
- Support the CNO to develop a clear nursing workforce plan focussing on the optimum balance of temporary and permanent resources.
- Work to implement the new future workforce solution (UHS an early adopter) to deliver benefits and efficiencies on people service delivery.

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

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

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

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

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
20	Potential for mis-diagnosis from non-optimised imaging or unnecessary radiation exposure due to staffing levels in Radiation Protection	3 x 4 = 12	1 x 5 = 5	01/06/2026
67	There is a risk that Consultant demand v capacity shortfall will be the cause of non covered sessions. This includes all areas that require anaesthetic support, such as theatres; POAC - gen and PAH; Critical care; POM etc.	2 x 4 = 8	3 x 2 = 6	27/02/2026
167	MRI physics staffing risk	4 x 2 = 8	2 x 1 = 2	30/04/2026
286	Inadequate staffing in Nuclear Medicine Physics for the size and complexity of the expanded service	3 x 4 = 12	3 x 3 = 9	30/04/2026
458	Demand for therapy input exceeding available workforce capacity putting patients at risk of ELOS and suboptimal input.	3 x 4 = 12	2 x 2 = 4	31/08/2026
604	Risk in epilepsy nursing service	3 x 3 = 9	3 x 1 = 3	31/12/2026
623	Insufficient reporting capacity (Specialist radiologist reporters)	4 x 4 = 16	2 x 1= 2	01/03/2026
646	Reduced ACP Cover across Neurosciences care group	4 x 2 = 8	4 x 1 = 4	03/09/2025
661	Insufficient Medical staff to safely manage patient activity within cancer care	4 x 4 = 16	2 x 3 = 6	28/02/2026
662	Cellular Pathology Staffing and Capacity	4 x 5 = 20	4 x 2 = 8	30/06/2026
726	Ophthalmology clinical/AHP workforce	4 x 3 = 12	4 x 1 = 4	01/01/2027

730	Risk of patient harm due to lack of administrative support for clinical services in surgical care group.	4 x 4 = 16	2 x 2 = 4	28/02/2026
748	There is a risk that patients may be cancelled, have peri-op complications, or longer hospital stays due to staffing concerns within the perioperative care and perioperative assessment clinic service	2 x 4 = 8	2 x 1 = 2	27/03/2026
776	Insufficient clinical pharmacy workforce	3 x 5 = 15	3 x 3 = 9	31/08/2026
791	Outpatients Administration Centre (OAC) - Staffing Risk	3 x 4 = 12	2 x 3 = 6	31/03/2026
837	Quality of patient care and the wellbeing of staff may be compromised if recruitment controls on the nursing workforce are not implemented safely with appropriate oversight and flexibility to meet individual services needs	3 x 5 = 15	3 x 2 = 6	30/06/2026
873	A&C Spinal Staffing	3 x 4 = 12	2 x 2 = 4	30/06/2025
879	IISS Programme (project management resource)	3 x 3 = 9	3 x 3 = 9	01/07/2025
881	Retention and Sustainability of Specialist Neurosciences CNS Workforce	3 x 2 = 6	3 x 1 = 3	31/12/2025
899	Trust recruitment pause, impact on staffing levels and service delivery (EFCD)	4 x 3 = 12	4 x 1 = 4	31/03/2026
903	If admin and clerical vacancies cannot be recruited to there is a risk that operational efficiency may be compromised effecting performance, patient safety/experience, and staff wellbeing.	4 x 4 = 16	3 x 2 = 6	31/03/2026
923	Lack of Obstetric Physician Cover	3 x 3 = 9	2 x 2 = 4	31/07/2026
925	The provision of the congenital/adult cardiac theatre service is at risk due to the lack of ability to retain cardiac scrub practitioners.	3 x 5 = 15	5 x 1 = 5	30/09/2026
931	Insufficient capacity in the paediatric cardiology ACP team to manage current workload nor enable planned expansion of the service	2 x 5 = 10	2 x 2 = 4	31/03/2026
938	Lack of administrative support within Specialist Medicine	3 x 4 = 12	2 x 1 = 2	30/06/2026
942	Paused Recruitment/Head Count Reduction - Maintenance Apprentices	3 x 4 = 12	3 x 1 = 3	28/10/2026
943	Paused Recruitment/Head Count Reduction - Maintenance Chargehands	3 x 3 = 9	3 x 1 = 3	28/10/2026
944	Paused Recruitment/Head Count Reduction - Maintenance Technical Staff	4 x 3 = 12	4 x 1 = 3	28/10/2026
945	Perfusion Workforce Supply and Resilience	4 x 4 = 16	4 x 3 = 12	30/04/2028
948	Impact of recruitment pause on Waste Management Service delivery	3 x 3 = 9	3 x 2 = 6	28/10/2026
952	There is a concern that deteriorating adult patients are at a risk of increased harm due to a reduced Critical Care Outreach service within UHS.	4 x 4 = 16	2 x 2 = 4	31/03/2026
955	Risk to 24/7 microbiology service due to staffing vacancies	2 x 5 = 10	1 x 2 = 2	30/04/2026
958	Supportive and Palliative Care Service provision	3 x 4 = 12	1 x 2 = 2	31/12/2026
971	Risk to patient safety and patient experience due to reduced staffing within the paediatric cardiac nurse specialist team.	3 x 3 = 9	3 x 2 = 6	29/05/2026

World class people

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

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

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
4 x 3 12	April 2022	4 x 4 16	April 2026	4 x 2 8	March 2030

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

Current assurances and updates

This risk has been reviewed by the Chief People Officer in April 2026 and subsequently the risk rating has been increased from 12 (severe x possible) to 16 (severe x likely) in recognition of the growing wellbeing risk to our workforce. This is evidenced through the recent staff survey results which were published in March and show that morale and wellbeing have decreased, with challenges around potential burnout and lack of staff for a sustained period. Metrics such as the proportion of staff recommending their employer as a place to work have fallen nationally, and it is apparent that this is also true at UHS and at a faster pace. Plans are in place to prioritise addressing this and both the transformation priorities and newly revised clinical strategy will provide opportunities to re-engage with staff under a different narrative.

Additionally, the emotional toll of the recent fire is a factor contributing to lower staff morale, motivation and engagement in some areas as some staff have been displaced and are working in different locations or teams. Individual EQIAs and risk assessments are being conducted within the divisions for those areas affected to ensure the impact is fully understood and mitigated where possible.

Prevention and management of violence and aggression towards staff remains a key focus, with both the V&A task and finish group, and V&A executive board fully implemented. The revised policy, including a rapid route to exclusion/restrictions, was ratified in March 2026. This is in use with some restrictions already issued for individual patients displaying unacceptable behaviour.

Key controls	Gaps in controls
Great place to work including focus on wellbeing UHS wellbeing plan developed. Guardian of Safe Working Hours.	Ensure each network has dedicated leadership to continue to support well-functioning and thriving networks.

Re-launched appraisal and talent management programme. Comprehensive employee recognition programme embedded including monthly staff spotlight and annual awards. Proud2BeAdmin & Proud2Bops campaigns and networks. Working group improving working facilities, including oversight of charitable funding allocated to staff wellbeing. Launch of digital appraisal process. Windows into Wellbeing. Leading through change' workshops to support and equip UHS leaders to manage and understand organisational change, lead people and teams through change, and create an environment which facilitates successful change. Regular communications for all staff including briefings and 'Talk to David' sessions, further complemented by targeted communications for specific staff groups such as 'Connect' for senior managers and leaders, and briefings for medical staff. This includes 'UHS Voice' with executives visiting individual teams to ensure this is accessible for all. **Building an inclusive and compassionate culture** Inclusion and Belonging Strategy signed off at Trust Board. Creation of a divisional steering group for EDI. FTSU guardian, local champions and FTSU policies. Diversity and Inclusion Strategy/Plans. Collaborative working with trade unions. Launch of the strategic leaders programme with a cohort of 24 across UHS. Senior leader programme launched. Positive action programme completed – cohort 2. Cohort 3 advertised. Nurse specific positive action programme also launched. All leadership courses now include management of EDI issues and allyship training has been rolled out across the organisation with good uptake. A review of long term illness and disability has been undertaken to utilise external expertise to help review our approaches to reasonable adjustments. Inclusive recruitment review undertaken. EQIA Panel.	Coverage of allyship training to increase to 80% compliance by 31/03/2026 (74% as at March 2025). Improving implementation of national improving working lives actions for junior doctors following national letter May 2024. Organisational capability and capacity to fully support LID, external support being sought.
Key assurances	**Gaps in assurances**
Great place to work including focus on wellbeing	Maturity of staff networks.

Annual NHS staff survey and introduction of quarterly pulse engagement surveys. Guardian of Safe Working Hours report to Board. Regular communications monitoring report Wellbeing guardian. Staff Networks. Exit interview process. Wellbeing Guardian and wellbeing champion. **Building an inclusive and compassionate culture** Freedom to Speak Up reports to Board. Qualitative feedback from staff networks data on diversity. Annual NHS staff survey and introduction of quarterly pulse engagement. Listening events with staff, regular executive walkabouts, talk to David session. Insight monitoring from social media channels. Allyship Programme. Gender Pay Gap reporting. External freedom to speak up and employee relations review.	Maturity of datasets around EDI, and ease of interpretation. Areas for improvement identified through the annual staff survey – remedial action reflected within the People objective. NHSE review of surgical training has resulted in enhanced monitoring from the GMC. Full action plan being implemented including completion of workshops with all consultants working within the area. An independent external review has highlighted issues relating to culture, capability, and capacity within the UHS portering service. Work is underway to address these concerns including negotiations with the Unite union.
Key actions	
2025/2026 and 2026/2027 led by CPO SH Continue implementation of the inclusion and belonging strategy within available financial and people resources. Delivery of Organisational Development support to complement organisational change. Ensure that equality impact assessments are completed and monitored through the EQIA review group. Establish a Violence & Aggression executive led board to oversee and expedite this workstream.	

World class people

3c) We fail to create a sustainable and innovative education and development response to meet the current and the future workforce needs identified in the Trust's longer term workforce plan

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

Cause	Risk	Effect
If there is: • Limited ability to recruit staff with suitable skills to support education; • Lack of current national education financing and changes in the way the education contract will function; • Inflexibility with apprenticeship regime;	There may be: • Inability to develop and implement a strategic vision for development of staff; • A lack of development for staff affecting retention and engagement; • Reduced staff skills and competencies; • Inability to develop new clinical practices.	This could result in: • An adverse impact of quality and effectiveness of patient care and safety; • An adverse impact on our reputation as a university teaching hospital; • Reduced levels of staff and patient satisfaction.

Category	Appetite	Status
Workforce	Open *The current risk rating is outside of the organisations risk appetite however the target risk rating is within optimal appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	4 x 4 16	April 2026	3 x 2 6	March 2029

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

Current assurances and updates

This risk has been reviewed by the Chief People Officer in April 2026 with current key concerns and assurances noted below, and updates to the action plan included:

- Funding for Oliver McGowan training has been secured for 2026/27, providing assurance that this key training can continue.
- The Trust are still yet to receive confirmation from NHSE of CPD funding for 2026/27, likely to be valued at c.£2m.
- The hospital charity has agreed to provide £170k for education and development in 2026/27 for staff groups, such as scientific staff, who do not traditionally attract national allocation for this.
- Appraisal rates have fallen due to increased operational pressures however a key priority for 2026/2027 will be to refocus and re-energise managers with targeted leadership training.
- The national long term workforce plan is still awaited but anticipated Spring 2026.

Key controls	Gaps in controls
Education Policy	Quality and capacity for delivery of appraisals
New leadership development framework, apprenticeships, secondments	Limitations of the current estate and access to offsite provision
In-house, accredited training programmes	Access to high-quality education technology
Provision of high quality clinical supervision and education	Estate provision for simulation training
Access to apprenticeship levy for funding	Staff providing education being released to deliver education, and undertake own development

Access to CPD funding from NHSE WTE and other sources Executive succession planning VLE relaunched to support staff to undertake self-directed learning opportunities. Escalation to NHSE with offer to assist in identifying future solutions. £170k of charitable funds 2026/27 to support education for staff who do not qualify for national CPD funding.	Releasing staff to attend core training, due to capacity and demand Releasing staff to engage in personal development and training opportunities Limited succession planning framework, consistently applied across the Trust. Areas of concern in the GMC training survey National CPD guidance for 2025/26: scope of application is limited by rigid national rules. New national education funding contract published for consultation 29 Feb. Reduced resources and higher levels of control included. Lack of/tighter restrictions in national funding, alongside inflexibility within the apprenticeship regime, remains a significant concern as this may present a reduction in opportunities for staff development, particularly for level 7 apprenticeships.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> Trust appraisal process Utilisation of apprenticeship levy. **<u>Level Two (Internal)</u>** Annual Trust training needs analysis reported to executive. Talent development steering group People Board reporting on leadership and talent, quarterly **<u>Level Three (External)</u>** GMC/NETs Survey Education review process with NHSE WTE.	Need to develop quantitative and qualitative measures for the success of the leadership development programme. Review of implications for education and training infrastructure from national workforce plan. There is a reported inability of staff to participate in statutory, mandatory, and other training opportunities.
Key actions	
Actions are overseen by CPO SH with operational leads indicated where appropriate and will be carried out throughout 2026/27. A refocus on individual development including emphasis on the importance of appraisal career conversations. To increase the proportion of appraisals completed and recorded to 85% and increase staff quality perceptions on appraisal. Reintroduction of dedicated leadership development programmes focussed on divisional, care group, and clinical leadership, working with COO, CMO and CNO, Ongoing specific targeted action to improve areas of low satisfaction in the GMC survey To continue to build the education strategic partnerships and capacity for delivery of the NHS workforce plan and UHS People Strategy including:	

- Continuing to develop our formal partnership with the new UTC
- Developing a partnership agreement with South Hampshire Colleges Group
- Developing a stronger partnership with Solent University
- Reviewing the education infrastructure requirements to support increases in placement capacity and quality (including T Level placements), preceptorship, apprenticeships and internationally educated registrants.
- Preparing UHS for changes to the national apprentice model

Completed actions:

- Deliver a second year of leadership development framework including Strategic and Senior Leaders programmes, Operational Leaders and Implement Team Leaders Programmes – complete.
- Run 2nd cohort of Human Leaders and integrate psychology and trauma informed approaches to leadership programmes – complete.
- Roll out of a targeted programme of development for Care Group Clinical Lead – complete
- A review has taken place within T&D to look at the infrastructure and longterm workforce plan and was presented to POD in Q2 2025/26.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
173	Patients may not be safeguarded appropriately if staff are unaware of their duties and do not have the correct knowledge and skillset due to being non compliant with Safeguarding Adults, MCA, & DOLs training.	3 x 3 = 9	3 x 1 = 3	31/12/2025
833	Safeguarding children Statutory Training Compliance Levels are below required.	4 x 3 = 12	4 x 1 = 4	31/07/2026
894	Delivery of training and development for staff may be compromised if funding is not available due to national restrictions	4 x 3 = 12	2 x 2 = 4	31/03/2026
900	Concern regarding insufficient, unfunded critical care education provision to meet service need and direct impact on staff and patient safety.	3 x 5 = 15	2 x 2 = 4	31/03/2026
965	Operational pressures and insufficient funding may prevent full compliance with statutory and mandatory training presenting a regulatory risk and a risk that staff will not be equipped with the correct knowledge and skills to fulfil their roles.	3 x 4 = 12	2 x 3 = 6	31/03/2027

Integrated networks and collaboration

4a) We do not implement effective models to deliver integrated and networked care, resulting in suboptimal patient experience and outcomes, increased numbers of admissions, and increases in patients' length of stay

Monitoring committee: Quality Committee	**Executive leads:** CEO, CMO, Director of Strategy & Partnerships

Cause	Risk	Effect
Historical structures and culture have not encouraged or enabled collaborative networked pathways. Additionally, and more acutely, NHS organisations are challenged by capacity and financial constraints at present, limiting the ability to network and grow strategically, as available resource is directed to managing current issues instead.	Growth in benign non-specialist activity could prevent UHS capacity being available for tertiary activity which can only be done at UHS.	Waiting times and outcomes for our tertiary work would be adversely impacted. Efficiencies arising from consolidation of specialities would not be realised.

Category	Appetite	Status
Effectiveness	Cautious *The current risk rating sits within the tolerable risk appetite and the target risk rating sits within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
3 x 3 9	April 2022	3 x 3 9	April 2026	3 x 2 6	December 2026

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9	3 x 3 9

Current assurances and updates

This risk has been reviewed with the executive lead in Q4 2025/26 and minor changes made to the controls, assurances, and actions, to ensure it is a current and accurate record. Significant work is underway to advance integrated and networked care and progress continues to be made. There is an expectation that this will take time to establish and embed as it is a complex workstream due to the number and nature of stakeholders and the need to engage and negotiate with them, both internally and externally. Financial limitations can also hinder pace.

It is noted that current pressures and directive to reduce workforce spend across the NHS may impact on the ability and capacity to execute plans if these are not adequately resourced, however the requirement for savings and efficiency may also assist as a driver for working collaboratively. Additionally national direction is shifting accountability, drawing clearer lines in responsibilities between Trusts and commissioning bodies, which may empower organisations to engage in networking when there are clear benefits to be maximised.

Key controls	Gaps in controls
• Key leadership role within local ICS • Key leadership role within local networked care and wider Wessex partnership • UHS strategic goals and vision • Establishment and development of Hampshire and Isle of Wight Acute Provider Collaborative (HIoW APC) to drive improvements in outcomes. • Establishment of UHS Integrated Networks and Collaboration Board • Collaborative CMO/ Director of Strategy meetings have begun/ are being arranged with partner	• Potential for diluted influence at key discussions • Arrangements for specialised commissioning – delegated from centre to ICS – historically national and regional, rather than local. • Engagement and pace from organisations we are looking to partner with is not within our control. • Resource within the UHS clinical programme team can prove challenging. • Resource and capacity within clinical services can also prove difficult, for example pelvic floor has been chosen as a clinical speciality focus, however

organisations to agree priorities and ensure there is executive commitment to delivering network models. • ICS agreement on clinical specialty focus including dermatology, ophthalmology, UGI and pelvic floor. • Support for networks from clinical programme team continues. Integrated networks and collaboration project management post recruited to. • Clinical leaders ICS forum has been started, this group is an opportunity to gain clarity on board level agreement on network opportunities and ways forward. • Participation in the Tim Briggs 'Further Faster' initiative is helpfully facilitating clinically led discussions with increased pace for dermatology, orthopaedics, ENT, spinal and ophthalmology. The primary purpose of the initiative is to increase productivity by, for example, increasing the number of cataracts performed on a list. Positive outcomes are being seen from this work as UHS has successfully increased the number of cataract operations undertaken which has resulted in an increased number of referrals due to reduced waiting times, with NHS referrals now outweighing private referrals Further targeted work includes introduction of a Single Point Of Access for ENT to establish a network for procedures of limited clinical value. The UHS CEO is the SRO for this project and is ensuring alignment with UHS and overall ICB strategy. • A new programme oversight role has been appointed to the ICB to enable progress on clinical networks. We are engaging with this post; sharing priorities, opportunities and challenges with a view moving forward networks within HIOW ICB. • The 'Acute Clinical Services Operating Model programme' has been initiated with agreed focus areas from providers and the ICB, these are Breast surgery, Upper GI, Pelvic floor, Urology, Ophthalmology, Dermatology and Orthodontics. • ICS oversight of waiting lists and forecasts in addition to provider level intelligence.	capacity at UHS is a challenge as evidenced on the operational risk register.
Key assurances	**Gaps in assurances**
<u>Level One (Internal)</u> • Friends and Family Test **<u>Level Two (Internal)</u>** • Outcomes and waiting times reporting. Included within cases for change being built for networks. • Integrated networks and collaborations board set up for regular meetings at executive level. **<u>Level Three (External)</u>** • CQC and NHSE/I assessments of leadership • CQC assessment of patient outcomes and experience • National patient surveys	• Trusts all under significant operational and financial pressure which is challenging prioritisation on elective networking. • Ability to network is difficult and manifests in capacity challenges. • Currently there are no established metrics regarding the establishment of networks due to the significant length of time it takes to set the networks up, however work is underway to set up quarterly objectives and consider KPIs to evidence whether networks being set up are on track.

Key actions
Business case for future working of the Southern Counties Pathology Network has been developed following a CFO/COO workshop Q4 2024/25. This is in consideration of what savings may be achieved as provider of managed equipment and is anticipated to be shared at all relevant Boards in Q4 2025/26. Once all Boards have approved this it will move into the first phase of implementation with appointment of management likely in Q2 2026/27. (CEO DF). UHS took over the lease of the elective hub from April 2026 and plans to run theatres from July 2026. Funding has been approved and a letter of support from the ICB received. (CEO DF). A high level options paper has been developed for Upper GI across UHS and UHD. The ICB and NHSE South East region have also requested that UHS work in collaboration with Portsmouth in consideration to UGI and as of December 2024, 3 consultant meetings have been held between UHS and Portsmouth to progress this. However there is not current alignment across the three organisations on how this will be delivered therefore this is now with the ICB for consideration of how this is commissioned. This is likely to be a longer term piece of work over the next few years led by the ICB. UHS and other providers are currently completing returns to support this decision and define what the service will look like. Work has begun on reviewing the Plastics model for UHS and Salisbury. A detailed review has been completed of activity against plan for all plastics services. An away day has been held to discuss challenges and opportunities and to gain agreement on a way forward. A case for change paper is now being developed, setting out proposal for a single plastics service between Salisbury and UHS. This will be worked up into a business case ahead of 2026/2027. Plastic leadership has also been strengthened within UHS to support this change. (COO AH) Planning underway to increase performance supported by a common assumption across the system and leadership from David French for the ICS elective programme. Steps include increased outsourcing from UHS (Q3 2025/26), and ongoing negotiations for contract offers for 2026/27. Following conversations between clinical leads at UHS and HHFT regarding future networking opportunities that may arise because of and in advance of the development of a new HHFT hospital in North Hampshire (2037 onwards), individual speciality clinical leads have been asked to continue exploring and progressing this. There will be a need to consider clinical reconfigurations to bridge this gap however a forum hasn't yet been established. UHS are keen to work closely with HHFT on this to ensure that we understand any need for redirection of emergency or urgent presentations in the South, which are likely to be the elderly or frail population, and maternity. This is a longer term aspiration. **Completed** NHSE has approved the business case, and funds have been received, for the Winchester Elective Hub which opened September 2025. Mr AK, Ophthalmology clinical lead, leading ongoing improvement work focussed on theatre productivity and point of access for cataract referral. This has been established and NHS provision of cataract care has increased from 40% to 72%, with all patients waiting less than 10 weeks for treatment. Urology Area Network plan was agreed however progress had stalled due to lack of programme management resource and the clinical lead stepping down, alongside challenges in aligning clinician availability across the organisations. This workstream has not come to fruition and is not currently being taken forward.

Foundations for the future

5a) We are unable to deliver a financial breakeven position resulting in:

- **A reducing cash balance impacting the Trust's ability to meet payment terms for suppliers and staff, meet statutory requirements such as payments to HMRC, and invest in line with the capital plan.**
- **NHS England imposing additional controls/undertakings.**

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
Due to existing and growing financial pressures including unfunded activity growth, system pressures (including NCtR and mental health), workforce growth above funded levels, and challenges with the NHS payment infrastructure.	There is a risk that we will be unable to deliver a financial breakeven position and that our cash balance will significantly reduce resulting in an inability to make payments to suppliers and staff, and make payments in line with our statutory requirements.	This may directly impact the organisation's operational ability to provide care to patients if services or staffing are withdrawn due to failure to make required payments. Additionally it may impact on the organisation's ability to grow and transform due to limitations in investment.

Category	Appetite	Status
Finance	Cautious *The current risk rating sits outside of the stated risk appetite, however the long term target risk rating is within the tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Interim & long term target (I x L)	
4 x 5 20	April 2022	5 x 4 20	April 2026	5 x 3 = 15	April 2027
				5 x 2 = 10	April 2031

Risk progression: (previous 12 months)	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Dec 25	Jan 26	Feb 25	Mar 26
	4 x 5 20	4 x 5 20	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25	4 x 5 25

Current assurances and updates

This risk has been reviewed with the Chief Financial Officer in April 2026, and the risk rating has been reduced from 25 (catastrophic x certain) to 20 (catastrophic x likely) in recognition of the improving cash position, favourable outcomes to contracting negotiations, and agreement of a breakeven plan for 2026/2027. Although it is recognised that there are still challenges, and therefore the position could deteriorate again if we are unable to meet our financial plan, the current position and forecast is more stable than previous. Furthermore it is noted as assurance that UHS has now come out of the NOF Segment 5 / Recovery Support Programme.

As predicted, 2025/2026 ended with a £45m deficit. £28m cash support was provided in 2025/2026, and a further £25m has been requested for 2026/2027 to support with mitigation of this risk. Existing mitigations, such as a programme of improvement initiatives overseen by the Financial Improvement Group, also remain in place.

Key controls	Gaps in controls
Internal • Financial strategy and Board approved financial plan. • Financial recovery plan. • Established Financial Improvement Group supported by the Financial Improvement Director. • Transformation Oversight Group (TOG) overseeing delivery of transformation programmes including financial benefits.	**Internal** • Remaining unidentified and high-risk schemes within CIP programme. • Ability to control and reduce temporary staffing levels. • Funding for further rounds of the Mutually Agreed Resignation Scheme. **System wide/external** • Elements of activity growth unfunded via block contracts.

• Implementation of revised recruitment controls, including revised Affordable Workforce Limits (AWLs), reduction in clinical recruitment, and a freeze on non-clinical recruitment. • Robust business planning and bidding processes • Robust controls over investment decisions via the Trust Investment Group and associated policies and processes • Monthly VFM meetings with each Care Group • Monthly cash flow forecast review. Improving Value transformation programme. • Mutually Agreed Resignation Scheme. • Time managed payments to control cash flow. **System wide/external** Financial Recovery Programmes / Transformation Programmes: • Planned Care • Urgent & Emergency Care • Discharge • Local Care • Workforce • Mental Health Formation of new Delivery Units & mapping of UHS resources to support delivery. Improved "grip and control" measures with consistent application across all organisations. **Business Continuity** In the event of zero cash availability, national support to maintain payments for regulatory requirements such as HMRC, and staff payments of salary and pension. Should key resources become unavailable due to inability to pay suppliers, operational management would include established methods of escalation and oversight including HIMTs and emergency Board meetings. This would include risk stratification to minimise impacts to patients as well as diversion of patients/mutual aid if we were unable to provide essential care.	• Reliance on external organisations and partners to support reductions in NCTR and Mental Health. Emerging NHS HIOW transformation programmes focus on this but currently lack detail to provide assurance.
Key assurances	**Gaps in assurances**
Level One & Two (Internal) • Regular finance reports to Trust Board & F&IC. • Full financial report for the system to Trust Board. • Divisional performance on cost improvement reviewed by senior leaders – quarterly. • F&IC visibility and regular monitoring of detailed savings plans • Capital plan based on cash modelling to ensure affordability. • Regular reporting on movements in overall productivity.	• Current short-term nature of operational planning • Lack of assurance in ability to deliver system wide plans focussing on reduction in NCTR, and mental health. • Concern over any further industrial action not incorporated into plan.

Monthly cash reporting to F&IC. **Level Three (External)** • Monthly CFO Meeting • Monthly ICB report on all provider positions • Regional scrutiny meetings.	

Key actions

Ongoing Actions

- Delivery of 2026/27 financial plans (CFO, IH)
- Set programmes/projects for delivery as part of the Financial Improvement Group – underway and ongoing throughout 2025/26 and 2026/27 (CFO, IH).
- Workforce forecasting and delivery of workforce reduction schemes (CPO, SH).
- Develop and implement a financial recovery plan throughout 2026/27 (CFO, IH)
- Maximise opportunities throughout 2025/26 and 2026/27 to bid for national cash support and recover any outstanding cash due to UHS (CFO, IH).

Completed Actions

- Set Divisional/Directorate budgets and ensure appropriate sign-off of budgets, inclusive of revised AWL limits – complete.
- Reset CIP and transformation programmes based on 25/26 targets – complete.
- Embed additional controls to support delivery of the plan, including revised AWL limits and recruitment controls – underway and established.
- Delivery of 2025/26 financial plans (CFO, IH) - complete.
- Develop and implement a financial recovery plan throughout 2025/26 (CFO, IH) - complete.
- Prepare and negotiate contracting arrangements ahead of 2026/27 (CFO, IH) – complete.

Foundations for the future

5b) We do not adequately maintain, improve, and develop our estate to deliver our clinical services and increase capacity

Monitoring committee: Finance & Investment Committee	**Executive leads:** CFO

Cause	Risk	Effect
If the cost of maintenance of our estate outweighs the available funding or does not offer value for money, or the works are too extensive to be able to complete without disruption to clinical services.	There is a risk that our estate will prohibit delivery and expansion of clinical services. Key areas of concern are an insufficient electrical supply, aged electrical systems, inadequate and aged ventilation systems, and aged water and sewage distribution.	This would result in an inability to meet the growing needs of our patients and potential health and safety risks to patients, staff and visitors if the estate is not fit for purpose.
Category	**Appetite**	**Status**
Effectiveness	Cautious *The current risk rating sits outside of our stated risk appetite. The target risk rating sits within our tolerable risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
4 x 4 16	April 2024	4 x 5 20	April 2026	4 x 4 = 16 4 x 2 = 8	April 2030 TBD (Aspiration)

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20	4 x 5 20

Current assurances and updates

This risk has been reviewed with the Chief Finance Officer, and Director of Estates, Facilities and Capital Development, in April 2026 with no revisions to the current risk rating, but alterations to the target risk ratings. Whilst the previous target evidenced an aspiration to reduce the risk to within the tolerable appetite by 2030, it is recognised that there is not currently a clear route to achieve this, and therefore it is anticipated that an incremental risk reduction can be achieved but it is unknown when full mitigation of the risk could be achieved.

The key concerns at present are whether there is sufficient funding and staffing resource to manage this risk. Mitigation planning is underway for 2026/27, informed by the six-facet survey highlighting £205m of backlog maintenance. With a currently anticipated budget c£10m from the estates safety fund, and c£1m from Trust CDEL, it is unlikely this level of backlog will reduce. The prioritisation of maintenance continues, focussed on trying to meet statutory and mandatory requirements, and addressing priority one and two requests, to ensure that available staffing resource is used effectively.

As previously reported, it has also been considered whether the impact of the substantial fire at Southampton General Hospital on 01/02/2026 increases the risk rating. However, whilst it is acknowledged that this has caused significant operational disruption, extensive damage to the estate, and required immediate risk management, it is also considered that the event and the resultant risk have been managed well and assurance should be taken that evacuation plans and business continuity plans have been effective. Therefore, whilst management of significant operational risk is still underway, it is not considered that the strategic risk articulated here needs to be increased at this time, although this position may be revisited dependent on the full results of the investigation into the fire.

Key controls	Gaps in controls
Multi-year estates planning, informed by clinical priorities and risk analysis	Scale of investment and funding is insufficient to fully address identified gaps in the critical infrastructure. Continuing revenue budget pressures to reduce costs as infrastructure is getting more costly to maintain.

Up-to-date computer aided facility management (CAFM) system – new system is in the process of procurement and implementation. Asset register (90% in place) Maintenance schedules Trained, accredited experts and technicians Asset replacement programme Construction Standards (e.g. BREEM/Dementia Friendly Wards etc.) Six Facet survey of estate informing funding and development priorities Clear line of sight to Trust Board for all risks identified. ICB Infrastructure plan completed 2025/26. Review exercise of EFCD business continuity plans, and implementation of action cards, occurred 2024.	Operational constraints and difficulty accessing parts of the site affecting pace of investment including refurbishment. Lack of decant facilities. Reactive system requires re-prioritisation review. Planned maintenance will drop out of the asset register work. Recruitment controls prohibiting recruitment to key roles, now managed within affordable workforce limits.
Key assurances	**Gaps in assurances**
<u>Level One & Two (Internal)</u> Compliance with HTM (Health Technical Memorandums) / HBN (Health Building Notes) monitored by estates and reported for executive oversight Patient-Led Assessments of the Care Environment. Reported to QGSG. Statutory compliance audit and risk tool for estates assets Monitoring at Finance and Investment Committee, including progress of capital investment and review of critical infrastructure risk and updates to Six Facet survey Quarterly updates on capital plan and prioritisation to the Board of Directors **<u>Level Three (External)</u>** Six Facet Survey NHSE Assurance Visits Authorised engineer audits	
Key actions	
<u>Ongoing Actions</u> Develop estates strategy following the finalisation and agreement of the estates masterplan and ICB infrastructure plan – March 2026, DJ. Complete within EFCD, to go to the Executive May 2026. Update and renew the Trust's Green Plan which will support reduction in backlog – December 2025, DJ (Complete). Implement and embed the renewed Green Plan through 2026/2027 and beyond, DJ. Identify future funding options for additional capacity in line with the site development plan, throughout 2025/2026 and 2026/2027 – Executive team supported by DJ for delivery. Implement the HIOW elective hub in 2025/2026 - Executive team supported by DJ for delivery. Delivery of 2025/26 capital plan – D, complete. Delivery of 2026/27 capital plan – DJ. Deliver £8.3m of critical infrastructure backlog maintenance in 2025/26 – DJ, complete. Delivery of the Urgent Treatment Centre through 2026/2027, DJ.	

Additional actions to be agreed/progressed in the future

Agree plan for remainder of Adanac Park site – options appraisal underway to consider future delivery of endoscopy post fire, with Adanac Park one option to be considered.

Site development plan for Princess Anne hospital.

Linked operational risks

No.	Title	Initial Date	Current risk rating	Target risk rating	Target Date
16	Estates Maintenance PPM Programme	26/06/2019	4 x 2 = 8	4 x 1 = 4	28/02/2026
157	Site wide electrical infrastructure resilience, HV and LV.	05/03/2019	4 x 3 = 12	4 x 1 = 4	31/12/2026
260	Insufficient space in the induction of Labour Suite.	28/10/2019	4 x 4 = 16	4 x 1 = 4	31/12/2026
421	There is a risk that the Trust does not appropriately manage or maintain its assets.	28/08/2020	4 x 3 = 12	4 x 1 = 4	31/12/2026
489	Inadequate ventilation in in-patient facilities increases the risk of nosocomial infection and may result in a suboptimal experience for patients and staff who are subject to uncomfortable and excessive environmental temperatures	07/02/2021	5 x 3 = 15	5 x 1 = 5	31/03/2027
727	Black start electrical test	25/07/2023	5 x 2 = 10	5 x 1 = 5	31/12/2026
773	Impact of the Building Safety Act (2022) on Capital Project Delivery	24/01/2024	3 x 3 = 9	3 x 2 = 6	30/11/2026
817	Lack of UPS backup on power failure	28/05/2024	5 x 3 = 15	5 x 1 = 5	31/12/2026
846	PAH – General ward areas and Neonatal Unit air handling units beyond service life	11/10/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
851	Lab and Path Chiller 1 Aged and Not Operational	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
853	Lab and Path Chilled Water Pumps	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2026
854	P.M.S Computer room AC Chillers	06/11/2024	4 x 3 = 12	5 x 1 = 5	01/12/2026
855	West Wing SHDU AC Units - Beyond Service Life	06/11/2024	5 x 3 = 15	5 x 1 = 5	01/12/2026
856	Non-compliant & unmaintainable fire dampers in West wing	12/11/2024	5 x 3 = 15	5 x 1 = 5	31/12/2026
875	John Atwell ward, Single means of fire escape, non-compliant to HTM 05:02, Fire safety legislation.	11/02/2025	5 x 2 = 10	5 x 1 = 5	31/12/2026
876	Fire-fighting dry riser water supply accessibility to Urology Centre, Day surgery unit, is non	11/02/2025	5 x 2 = 10	5 x 1 = 5	31/12/2026

	compliant to HTM 05:02, current Fire legislation.				
877	Poor condition of Car Park 5 (old section multi story)	11/02/2025	5 x 3 = 15	5 x 1 = 5	01/06/2026
897	Centre Block Vertical Extension Chilled Water Capacity	08/05/2025	3 x 3 = 9	3 x 1 = 3	31/12/2026
898	Obsolete fire alarm repeater panels	08/05/2025	5 x 2 = 10	5 x 1 = 5	01/04/2026
899	Trust recruitment pause, impact on staffing levels and service delivery	08/05/2025	4 x 3 = 12	4 x 1 = 4	31/03/2026
908	Non-Compliance with UHS EFCD Design Standards - Adanac Aseptic Suite	17/06/2025	3 x 4 =12	3 x 2 = 6	08/11/2026
942	Paused Recruitment/Head Count Reduction - Maintenance Apprentices	04/12/2025	3 x 4 = 12	3 x 1 = 3	28/10/2026
943	Paused Recruitment/Head Count Reduction - Maintenance Chargehands	04/12/2025	3 x 3= 9	3 x 1 = 3	28/10/2026
944	Paused Recruitment/Head Count Reduction - Maintenance Technical Staff	04/12/2025	4 x 3 = 12	4 x 1 = 4	28/10/2026
949	Neuro Theatre Block Cladding Defects	8/12/2025	5 x 2 =10	5 x 1 = 5	8/12/2026
951	Helipad structural concrete issues	8/12/2025	4 x 3 = 12	4 x 1= 4	31/03/2026
959	Potential Fire Spread via External Cladding	21/01/2026	5 x 3 = 15	5 x 3 = 15	01/04/2026
960	Lack of (suitable, or suitably functioning) fire-alarm activated door closer devices on some fire doors	21/01/2026	5 x 3 = 15	5 x 2 = 10	01/06/2026

Foundations for the future

5c) Our digital technology or infrastructure fails to the extent that it impacts our ability to deliver care effectively and safely within the organisation

Monitoring committee: Finance & Investment Committee	**Executive leads:** COO

Cause	Risk	Effect
If there are inhibitors to implementing and sustaining digital technology either due to funding, capacity, technology, or resource constraints	This could mean that our digital technology or infrastructure is unable to support the Trust in delivering clinical, financial, or operational objectives. Key areas of concerns are the ability to provide reliable and fit for purpose hardware and infrastructure, defence against cyber threats, and being able to recruit and retain the right number of staff with the right skill mix.	Resulting in an inability to provide and maintain the digital infrastructure required to facilitate outstanding patient care, and leading to incidents which would require reporting to national governing bodies.

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

Inherent risk rating (I x L)		Current risk rating (I x L)		Target risk rating (I x L)	
3 x 4 12	April 2022	4 x 4 16	April 2026	3 x 2 6	April 2030

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 25	Feb 25	Mar 25
	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	3 x 4 12	4 x 4 16	4 x 4 16

Current assurances and updates

This risk was reviewed with the Chief Operating Officer and Chief Information Officer in April 2026. No further changes to the risk rating or targets have been made since February 2026 when it was agreed that the risk rating should be increased from 12 (moderate × likely) to 16 (severe × likely), based on the following factors:

- **Electronic Patient Record (EPR) and PAS Risk:** Funding for the procurement of a new Electronic Patient Record (EPR) system has been withdrawn, and there is currently no clear organisational, system, or national plan route to funding. The existing Patient Administration System (PAS), a component of the EPR, remains under contract until March 2028, however the supplier is only supporting limited product development due to a change in business direction and a declining customer base. This creates an immediate risk that the system will not continue to meet UHS requirements, and a significant future risk that the Trust may be unable to renew the contract in 2028 without a replacement system in place. The impact of this is that UHS would cease to have digital ability to book and manage patient appointments. Securing and implementing a new PAS typically requires 18–24 months due to system complexity, therefore planning and identification of funding are now urgent. It is highlighted that theatre booking and scheduling is incorporated within the current PAS and would therefore also require replacing at the same time.

- **Digital Infrastructure Risk:** The risk associated with aging digital infrastructure continues to increase following reduced capital investment, particularly over the last two years. A substantial proportion of hardware is now end-of-life, for example, the oldest network switch is 20 years old, far beyond the typical five-year lifespan. This raises the likelihood of infrastructure failure and associated operational disruption. A seven-year rolling replacement programme has been proposed, subject to funding. A related issue was hardware supporting

Oracle databases, which underpin approximately half of Trust applications, is also end-of-life. This was addressed through 25/26 capital bring forward with work expected to complete by the end of Q1 2026/2027.

- **Cyber Security Risk:** Cyber security is also acknowledged as a continual risk for the organisation, although assurance of risk management is noted as the previously reported cyber security audits have now been completed with only minor findings which have all been actioned. Whilst UHS holds an OPEN risk appetite for adopting technology and innovation to enhance service delivery, this is dependent upon the trust's underpinning commitment to compliance, ensuring our digital systems are secure, resilient and support the safe delivery of clinical care. There is a LOW tolerance for risks (including cyber security) that could compromise operational or financial stability.

Key controls	Gaps in controls
Failure in physical network infrastructure • All Digital UPS tested. • Investment cases for key infrastructure (air cooling and data centres) being developed. ICU and ONH air conditioning has been upgraded to support this. • Replacement of key infrastructure on a case-by-case basis once it fails. • The current Data Centre is end of life with the replacement data centre due to be built in 2026/2027. • Oracle database hardware being upgraded – completion by end of Q1 2026/2027	**Failure in physical network infrastructure** • There is currently no phased replacement of switch and network equipment due to absence of funding.
Cyber Risk • Cyber security infrastructure refreshed and in place. • Staff training on cyber risks, with regular refreshers and clear policies. • NHS Board cyber security training (07/10/2025) • SIRO training conducted covering new SIRO and deputy SIROs.	**Cyber Risk** • Funding: cyber security and recovery capability requires ongoing investment and development. • Ability to enforce more robust training due to lack of time for staff training.
Single points of failure in staffing • Partial implementation of Digital workforce plan. • Prioritisation of key posts. • Upskilling existing staff to provide cross cover. • Additional cover now on senior digital on call. • Trust Integration Engine (TIE) in house out of hours support roster commences 01st May 2026.	**Single points of failure in staffing** • Financial constraints impacting ability to implement workforce plan needed to underpin strategy. This, alongside the rigidity of the AFC banding structure, can result in difficulties attracting skilled staff in a competitive industry.
Implementation and sustainability of digital technology • Inpatient noting for nursing has been rolled out to all appropriate wards, and further developments are being made. Doctors rollout trialled in cancer care, with tweaks being made before further rollout to AMU and MOP.	**Implementation and sustainability of digital technology** • Funding to cover the development programme, improvements, and clinical priorities. • Single EPR business case has not been approved by Boards.
Loss of access to critical IT systems & business continuity • Absolute back-ups of data created. • Business continuity plans developed for Digital team and Wards (utilised in 2 recent incidents). • Robust system and regression testing completed on system developments.	**Loss of access to critical IT systems & business continuity** • Digital can advise clinical teams on business continuity plans but do not own these.

• Scenario testing completed. • All wards have a business continuity device in situ allowing access to patient records in system outages. • All departments have Emergency Resilience and Response Plans (ERRP) in place to operate in the event of a system downtime. • Separate telephone systems are set up in critical areas such as ED to facilitate communication in the event of phone lines being unavailable. • TIE upgrade completed 15/04/2026.	
Key assurances	**Gaps in assurances**
<u>Level One & Two (Internal)</u> Finance oversight provided by the Finance and Investment Committee. Quarterly Digital Board meeting, chaired by the CEO. Digital risks and actions reviewed on UHS Digital leadership team call. UHS Digital risk and benefit manager in post to manage digital risk alongside operational Digital teams. UHS Digital projects and programmes follow standardised project management delivery mechanism which includes risk management embedded as part of their delivery processes (APM, Prince2, Agile, etc). Standardised change control, testing, and assurance processes implemented across the Development team. Regular Trust Board Study Sessions with digital updates. THQ Governance Group (Alert, Advise, Assure). Clinical Safety Officers, weekly hazard workshops, and safety case reviews. **<u>Level Three (External)</u>** KLAS clinician usability surveys every 3 years NHSE annual DPST assessment completed to highlight gaps in services. Annual digital framework capability assessment Cyber security audits	Funding to cover the development programme, improvements, and clinical priorities. Difficulties in realising cash releasing benefits from digital investment. The Trust remains rated as 'approaching standards' for the Data Security and Protection Toolkit (DSPT) with one evidence item outstanding last year and no change anticipated for the 2025/2026 interim submission. This continues to affect Research & Development activity and associated funding.
Key actions	
<u>Recruitment</u> • Ongoing recruitment of key Digital resource to mitigate operational risk throughout 26/27 where recruitment controls allow – JT **<u>Replacement of key clinical systems to more modern systems & future development</u>** • Identify funding to procure and roll out a single EPR across HIOW, previously forecast to go live April 2029, but now subject to funding. JT. • Continually identify opportunities for funding for digital transformation and programmes throughout 26/27 and onwards– opportunities tied to 10 year plan and medium term plan are now materialising (e.g. digital diagnostics capability programme, NHS 5 year capital plan). JT. • Completion of build of data centre – JT. • Upgrades to critical system infrastructure (TIE, LIMS) to be completed, JT.	

Digital Development

- Develop inpatient noting improvements post cancer care trial – 2026/27, JT.

Completed

- To support recruitment actions, leverage capital funding to bring in additional resource where appropriate. JT.
- Acceleration of cyber software upgrades completed 2024/25.
- The air conditioning in the ICU and Old Nurses Home data centres has been upgraded, enhancing its resilience.
- Implementation of MIYA in 2025/26 (complete – JT).
- Lessons learned from LIMS project were shared across UHS Digital, Estates, and other major project teams.
- Inpatient noting for doctors trial in cancer care complete in Q3 2025/26.

Linked operational risks

No.	Title	Current risk rating	Target risk rating	Target Date
282	Workforce Resourcing - There is a risk that the ophthalmology service is not appropriately supported by IT systems to safely deliver current activity.	3 x 4 = 12	2 x 2 = 4	31/03/2027
634	Accommodation / Infrastructure - Fibre optic cabling at the ONH	4 x 3 = 12	3 x 2 = 6	31/12/2026
650	Accommodation / Infrastructure - The trust's data and communications centre facilities are no longer suitable for supporting mission-critical IT services. There is an element of resilience across the network but all of the facilities described have significant problems.	4 x 4 = 16	3 x 1 = 3	30/11/2026
676	Cyber Security - UHS does not sufficiently manage the increased threat from cyber risk.	3 x 4 = 12	4 x 3 = 12	31/12/2026
677	Workforce Resourcing - Insufficient resilience in the UHS network team to support mission critical infrastructure.	5 x 3 = 15	2 x 3 = 6	30/06/2026
679	Accommodation / Infrastructure - Single point of failure on the UHS network (external connections)	4 x 3 = 12	4 x 1 = 4	30/04/2026
736	Accommodation / Infrastructure - Supply of Multitone Devices - Bleeps	3 x 4 = 12	1 x 2 = 2	30/04/2026
757	Cyber Security – If there are unsupported server operating systems this could expose the Trust to cyber attack.	4 x 2 = 8	2 x 1 = 2	01/06/2026
829	Cyber Security - Windows 11 Roll-out before Win10 EOL	4 x 3 = 12	2 x 2 = 4	30/04/2026
929	Current software version on our existing servers is not supported.	5 x 3 = 15	5 x 2 = 10	31/12/2026
930	Oracle Database Appliances (ODAs) are end of life and represent a risk to the estate.	5 x 3 = 15	4 x 3 = 12	31/12/2026
946	Accommodation / Infrastructure - the Trust may be unable to operate its core services due to not having an operational and supported Patient Administration System	5 x 3 = 15	2 x 2 = 4	31/12/2028

Foundations for the future

5d) We fail to prioritise green initiatives to deliver a trajectory that will reduce our direct and indirect carbon footprint by 80% by 2028-2032 (compared with a 1990 baseline) and reach net zero direct carbon emissions by 2040 and net zero indirect carbon emissions by 2045

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

Cause	Risk	Effect
If we fail to deliver the current decarbonisation plan and build upon it to meet 2032 target.	This could lead to increased costs, reputational damage and potentially subject UHS to national scrutiny, as well as adding to risks of worse health for our local population and staff, and increased risk of major climate change consequences.	Resulting in higher costs, reduced national standing and reduced resilience to climate change
Category	**Appetite**	**Status**
Technology & Innovation	Open *Both the current and target risk rating is within the optimal risk appetite.*	Treat

Inherent risk rating (I x L)		Current risk rating (I x L)		Long term target (I x L)	
2 x 3 6	April 2022	2 x 4 8	April 2026	2 x 2 4	December 2027

Risk progression: (previous 12 months)	Apr 25	May 25	Jun 25	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 25	Mar 26
	2 x 3 6	2 x 3 6	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8	2 x 4 8

Current assurances and updates

This risk has been reviewed in Q4 2025/2026 by the responsible executive and Head of Sustainability with no significant changes. Resource and capacity to progress this workstream had reduced through part of the year due to vacancies, however the new Head of Sustainability is now in post and key actions are progressing such as updating of the Green Plan which was completed in October 2025 and ratified by Trust Board in November. This provides opportunity to drive this at a strategic level although resource at an operational level is still insufficient to progress this at pace. Recruitment for a Sustainability Manager is currently underway, to address part of this operational gap.

Key controls	Gaps in controls
Governance structure including Sustainability Board Clinical Sustainability Lead Head of Sustainability Energy Manager Appointment of Executive, Non-Executive and Council of Governors Lead(s) for Sustainability in post. Green Plan 2025-2028.	Clinical Sustainability Plan/Strategy (CSP) Long-term energy/decarbonisation strategy Capacity and reach of the clinical sustainability lead as there are not designated leads/champions within each speciality to influence this change. A proposal for champions has been submitted to TIG and approved, however recruiting to the roles hasn't yet occurred due to the recruitment controls in place. Do not have a fully funded plan to achieve the national targets set out. Future funding streams are uncertain.
Key assurances	**Gaps in assurances**
<u>Level One and Two (Internal)</u> Green Plan and Clinical Sustainability Programme has been approved by Trust Investment Group and Trust Board.	Definition of and reporting against key milestones.

Sustainability Board **Level Three (External)** Progress against the NHS direct emission net zero target by 2040, with an ambition to reach an 80% reduction by 2028 to 2032. Progress against the NHS indirect emissions target to be net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039. Quarterly reporting to NHS England and NHS Improvement on sustainability indicators.	

Key actions

All actions are planned throughout the remainder of 2025/26 and 2026/27 and are led by the Head of Sustainability AT with executive oversight by CMO PG.

Appointment of Sustainability Manager to support Green Plan delivery and clinical sustainability projects (spring 2026).

Develop KPI metrics in respect of the Trust's Green Plan and other related strategies.

Agree further funding requirements to commence the delivery of the strategies and identify opportunity. (Explore low carbon skills funding). This includes funding secured for LED lighting, BMS system improvements, and measures to adapt to climate change.

Progress improvements to the Trust's estate and energy supply, including use of funding from the Public Sector Decarbonisation Scheme. This aims to increase the use of electricity, including solar panels, and phase out use of gas.

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED and repurpose cardiovascular catheters.

It is also noted that whilst the majority of planned programmes of work funded by the public sector decarbonisation scheme has progressed, there have been challenges in the steam duct programme which has meant that further work in the lab and path block has now been put on hold.

Delivery of local initiatives, such as a project to reduce use of single use oxygen probes in ED.

Agenda item 6.3	Report to the Trust Board of Directors, 14 May 2026
Title:	South Central Regional Research Delivery Network (SC RRDN) 2025-26 Annual Performance Review
Sponsor:	Mr Paul Grundy, Chief Medical Officer
Author:	Clare Rook, Network Director, SC RRDN Graham Halls, Data and Analytics Senior Manager, SC RRDN

Purpose

(Re)Assurance	Approval	Ratification	Information
			x

Strategic Theme

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

Executive Summary:

This report provides a performance update for the South Central Regional Research Delivery Network (SC RRDN) region for the 2025/26 financial year.

- **Research Activity:** South Central delivery organisations recruited 76,928 participants to 1,103 studies at 252 sites and across all main clinical specialties.
- **External Pressures:** Regional stability was maintained despite sustained external challenges including recurring industrial action by resident doctors and restricted access to diagnostic imaging infrastructure for research purposes.
- **Strategic Portfolio Shift:** The regional research portfolio has transitioned toward high complexity and non-commercial interventional trials now represent exactly 50 per cent of all recruiting studies. Complexity is an important factor in the hospital-based research funding model starting April 2026.
- **Commercial Growth:** Industry funded research reached a six year high of 263 recruiting studies which can provide the local population with access to novel treatments, while securing additional industry funding to support the region's research infrastructure.
- **Community Research Reach:** Delivery organisations maintained strong activity in community settings and recruitment outside of acute hospitals was over a third of the region's total.
- **Future Funding Risks:** While current activity is robust, the transition to a new national funding model in April 2026 will result in an £868,069 (3.1 per cent) reduction in baseline regional funding for the 2026/27 financial year.
- **Study Set-up Efficiency:** Improving the speed of study set-up remains a critical strategic priority to mitigate future funding risks as the national model closely ties financial allocations to local efficiency.
- **Participant Feedback:** Participant experience remains a significant strength with 96 per cent of respondents reporting they were treated with respect, although a clear opportunity exists to improve how study results are shared with participants.

Contents:

South Central Regional Research Delivery Network 2025/26 Annual Performance Report, Appendix 1 - Other funding model performance measures, Appendix 2 – South Central RRDN Risk Register, Appendix 3 - Glossary.

Risk(s):

1b, 2a (for full details, please see the SC RRDN risk register in Appendix 1)

Equality Impact Consideration:	N/A

1

University Hospital Southampton
NHS Foundation Trust

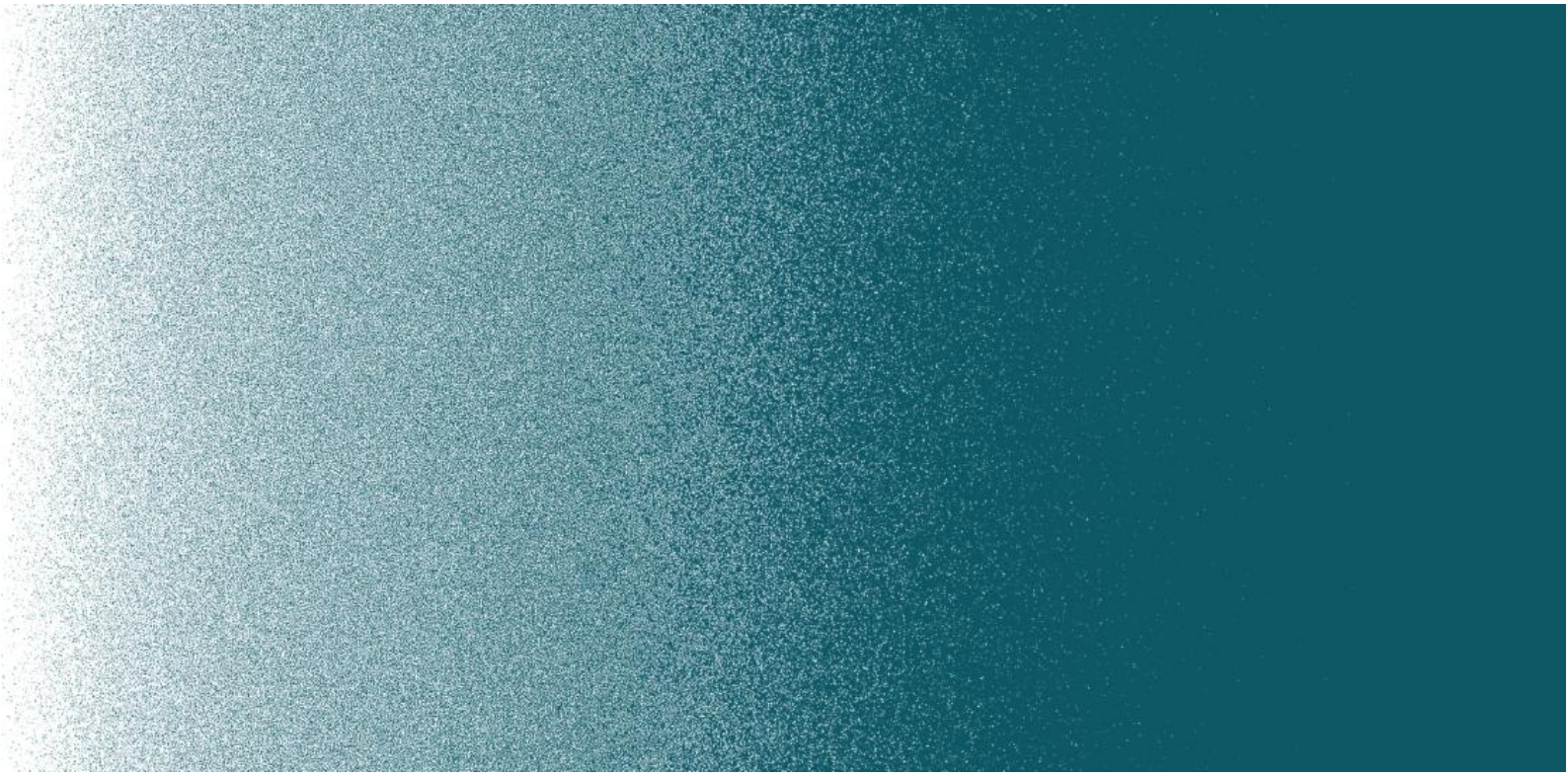
NIHR | Research Delivery Network

South Central Regional Research Delivery Network (SC RRDN) 2025-26 Annual Performance Review

Clare Rook, Network Director

Graham Halls, Data and Analytics Senior Manager

May 2026



Introduction

This report informs the Board of the health and care research activities within the National Institute of Health and Care Research (NIHR) South Central Regional Research Delivery Network (SC RRDN) region during the 2025/26 financial year: 1 April 2025 to 31 March 2026. The report primarily presents performance against the measures included in the RDN funding models, which have been implemented from April 2026.

The NIHR Research Delivery Network (RDN) is funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise, and deliver research across England. Its vision is for the UK to be a global leader in delivering high-quality, inclusive, and accessible research that improves health and care. The RDN's primary purposes are to support the successful delivery of high-quality research as an active system partner and to increase the capacity and capability of the research delivery infrastructure for the future.

For more information about the wider projects that SC RRDN has delivered against the annual plan during 2025/26, view the Annual Report.

Network transition and new ways of working

The 2025/26 financial year has been a period of continued operational transition as the legacy NIHR Clinical Research Network (CRN) Wessex and CRN Thames Valley and South Midlands were integrated into a single organisation. Formed in October 2024 and hosted by University Hospital Southampton NHS Foundation Trust (UHS), the SC RRDN now operates across an updated geography. This aligns with the regions previously served by the NHS Buckinghamshire, Oxfordshire & Berkshire West, NHS Frimley, and NHS Hampshire & Isle of Wight Integrated Care Boards (ICBs). From 1 April 2026, the SC RRDN geography aligns with NHS Hampshire & Isle of Wight and NHS Thames Valley ICBs (Figure 1). This report includes historical research activity from the research delivery organisations in the same region to allow performance to be tracked over a longer period.

Throughout the year, SC RRDN has established its ways of working within the nationally defined team structures. As one of twelve RRDNs in England, SC RRDN now works alongside a national Coordinating Centre as a cohesive RDN organisation, with joint leadership. The RDN also has regional, but nationally aligned, Agile Research Delivery Teams who ensure SC RRDN provides flexible and responsive research support across the region.

Figure 1 - Map of the region covered by SC RRDN; coterminous with the NHS Thames Valley and NHS Hampshire and Isle of Wight Integrated Care Board geography

NIHR RDN Strategic Plan (2025-2030)

In October 2025, the NIHR RDN launched a five-year Strategic Plan refocusing network activities to support the government's health and economic growth missions. Specifically, it aims to deliver on the 'three shifts' outlined in the Fit for the future: Ten Year Health Plan for England and the vision set forth in the Life Sciences Sector Plan.

Throughout 2025/26, SC RRDN delivery organisations supported the government's shift from hospital to community care – known as 'wider care settings'. In the first quarter alone, over 10,000 participants were recruited outside of acute trusts, who are primarily based in hospitals. By the end of 2025/26, recruitment in these wider care settings collectively exceeded that of the region's largest individual NHS Trusts, bringing research to more people where they live. Additionally, SC RRDN

increased public outreach through events and by promoting the NIHR Be Part of Research and Join Dementia Research registries.

Transition to a new national funding model for RDNs

A major operational focus this year has been preparing for a new, nationally agreed funding distribution model that took effect in April 2026. Designed to create a more transparent, predictable and fair system, the framework splits into two distinct operational models:

1. The 'Hospital' Model (NHS Trust-based research): This budget is now nationally calculated and has three components:

- The *historical* allocation makes up 50 per cent of the budget. This is calculated based on the NHS Trust's allocation from the previous financial year, which provides a level of stability.
- *Activity-based funding* makes up 30 per cent, which is driven primarily by recruitment to studies which is weighted based upon the complexity of the study being delivered. It is also linked to the number of studies being delivered by the organisation.
- *Performance elements* make up the final 20 per cent, distributed based on organisational performance against study set-up, efficient study delivery and growth metrics. These align with the government priority areas.

The transition from a regional to a national funding model resulted in an £868,069 (3.1 per cent) baseline reduction for the South Central region for the 2026/27 financial year. However, the region's strong performance in delivering highly complex studies, ranking fifth nationally for complexity-weighted recruitment in 2025/26, positions South Central NHS Trusts well to secure future activity-based funding.

2. The 'Wider Care Settings' Model: To support the strategic shift from hospital to community care outlined in the government's 10 Year Health Plan, funding for wider care settings is managed at a regional level. In the 2026/27 financial year, each RRDN will receive additional funding to support this shift, applying a single distribution model to all wider care settings. Organisations from these settings can access funding in two ways:

- *retrospective activity-based payments*, where support costs are paid upon confirmation of completed activity for delivering research from the RDN Portfolio
- *prospective payments*, awarded to help organisations develop their research delivery infrastructure based on a nationally standardised application.

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Furthermore, the Agile Research Delivery Teams employed by each RRDN will continue to deliver direct support for research in wider care settings. The RRDNs possess the flexibility to move funding between regional wider care and strategic funding pots to dynamically respond to research availability.

Overview of research activity in the SC RRDN region

Recruitment in South Central

During the 2025/26 financial year, **76,928 participants** were recruited to **1,103 studies** at **252 sites** and across **all main clinical specialties** in the South Central region. During this period, the region's organisations recruited **8.9 per cent of the total participants in England**, with only 7.7 per cent of the English population (Figure 2). Delivery organisations in the region have also supported the identification of participants, data collection and other follow up activities on almost **2,500 studies**.

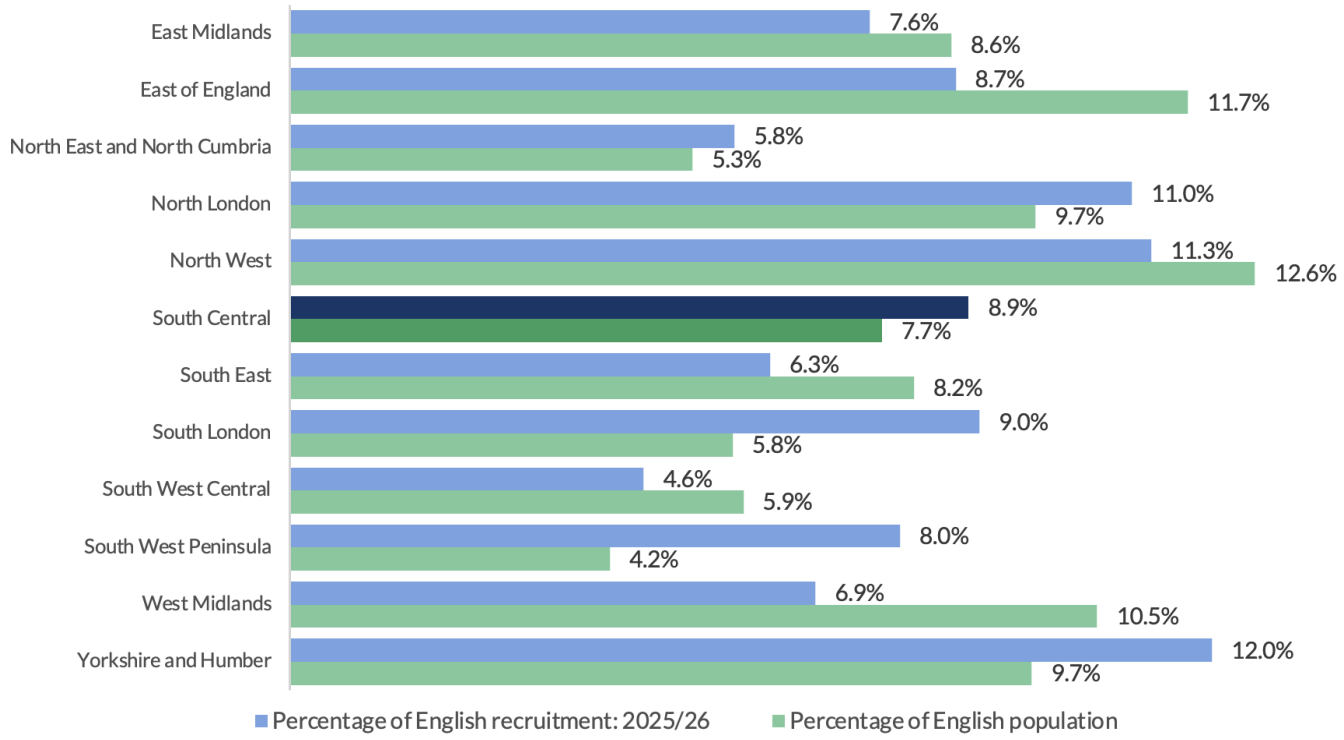

Figure 2 - Proportion of English recruitment in each RRDN region compared to the proportion of the English population in 2025/26

Recruitment was notably high in the first quarter and reached a peak of 10,394 recruits in June largely due to large observational studies in cancer patient reported outcomes and melanoma management (Figure 3). This established a high baseline for the year. Monthly recruitment totals

reduced through the year to reach 3,547 in March, however activity remained statistically stable and within expected limits.

The downwards trend observed in South Central throughout the year aligns with a broader reduction across the whole of England. National recruitment finished with a year-end total of 868,124, down from 1.13 million participants in the 2024/25 financial year. The similarity between regional and national trends suggests a changing national research landscape, with a shift to fewer smaller studies.

SC RRDN developed a recruitment action plan earlier this year to address the sustained reduction in research activity seen locally and across the rest of England. While the core objectives remained steady throughout the 2025/26 financial year the network revised the plan during the third quarter to ensure it stayed relevant to shifting government priorities. This evolution involved a move toward more integrated planning where delivery organisations are now asked to share their local recruitment strategies as part of business planning meetings in the spring of 2026.

The updated recruitment action plan includes closer alignment with the three shifts described in the NHS 10 Year Plan. SC RRDN are now specifically recommending studies that focus on preventative medicine and those that reach communities that are currently under served by research. To support this selection process, a national RDN working group have developed a Regional Intelligence Tool business intelligence dashboard to provide information about the population and research activity in very small to larger geographies. SC RRDN also provide intelligence on the national research Portfolio, which allows the team to identify and target studies of a potentially high impact that are not yet open in this region.

The plan also prioritises the expansion of commercial research through improved relationships with life science sponsors. By building these partnerships earlier in the study lifecycle, the network can better prepare delivery sites for upcoming pipelines and address potential bottlenecks before they impact performance. Further actions including the promotion of the Be Part of Research and Join Dementia Research registries and the exploration of flexible staffing models for studies of a lower complexity continue to provide a foundation for future growth in South Central.

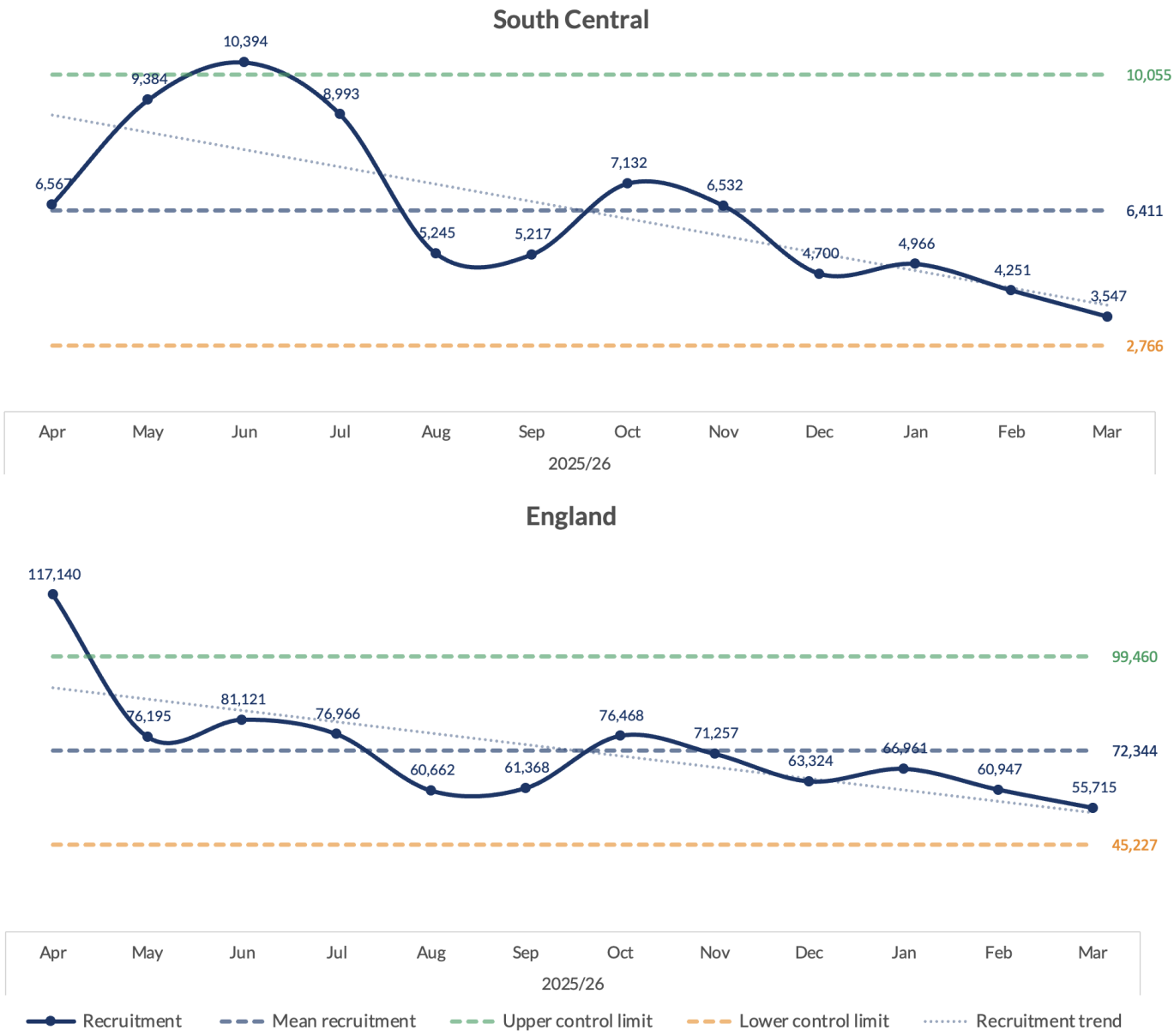

Figure 3 - Monthly recruitment in the South Central region benchmarked against England in the previous twelve months

For reference, quarterly recruitment at delivery organisations within South Central is provided in Figure 4.

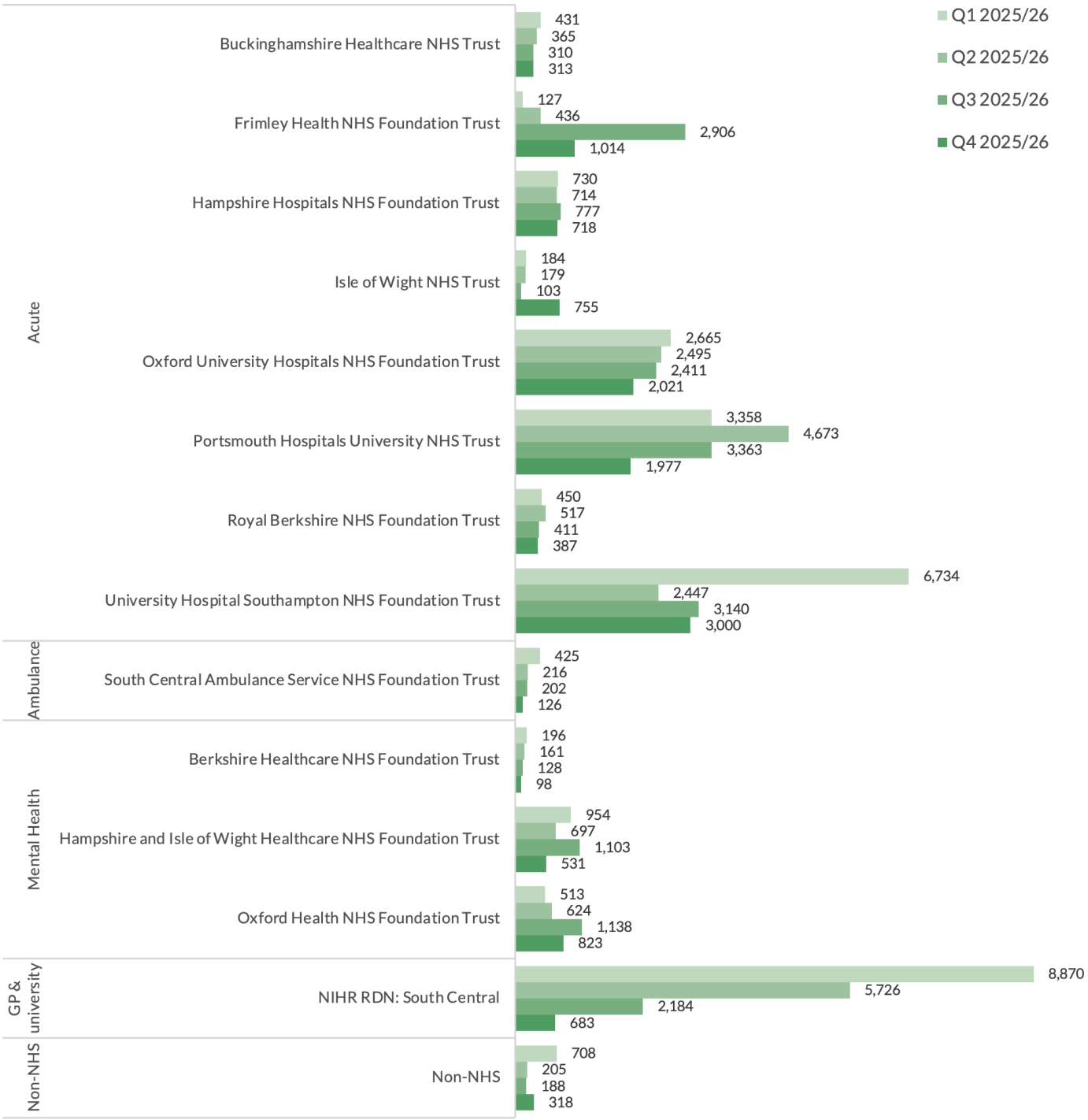

Figure 4 – Recruitment by organisation and organisation type in the South Central region in the previous four quarters

Complexity weighted recruitment in South Central

While recruitment is an important measure of the opportunities available to the population to participate in research, other important aspects are the design and complexity of the research that is delivered.

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Research participation can either be *interventional*, where the patient's care pathway is affected, or *observational*, where there is no change, but important data is collected to answer the research question. Studies also vary in the number of participants they intend to enrol and in the effort required to answer the research question. This concept is known as the study '*complexity*'.

Regions and delivery organisations are expected to have a balanced portfolio of all types of study design and complexity. Each participant is therefore assigned a weighting to create a comparable figure known as *complexity weighted recruitment (CWR)*. The weighting for recruitment in different study types has been updated for the 2026/27 funding model based on an analysis of study data and feedback from stakeholders is shown in Figure 5.

Type of research study	Study funder	Study sample size	Weighting per participant
Interventional	Non-commercial	Less than 5,000	175
Observational	Non-commercial	Less than 10,000	86
Large interventional	Non-commercial	5,000 or above	29
Large observational	Non-commercial	10,000 or above	1
Any commercial research	Commercial	Any sample size	0

Figure 5 – Criteria used for assigned complexity weightings to recruitment

Recruitment on *commercial* research studies is weighted zero because the funding for this research activity is paid directly from the life science industry partners.

During the 2025/26 financial year South Central has an average CWR of 314,148, with significant peaks in activity occurring in May and November (Figure 6). As with unweighted recruitment, CWR trended downwards across the year, while remaining within statistical control limits. CWR serves as a significant component of the new national funding model for the region's hospital-based delivery organisations. If this activity trends downwards, relative to the other English regions, then it should be considered a risk to research delivery funding that will be monitored in future reports.

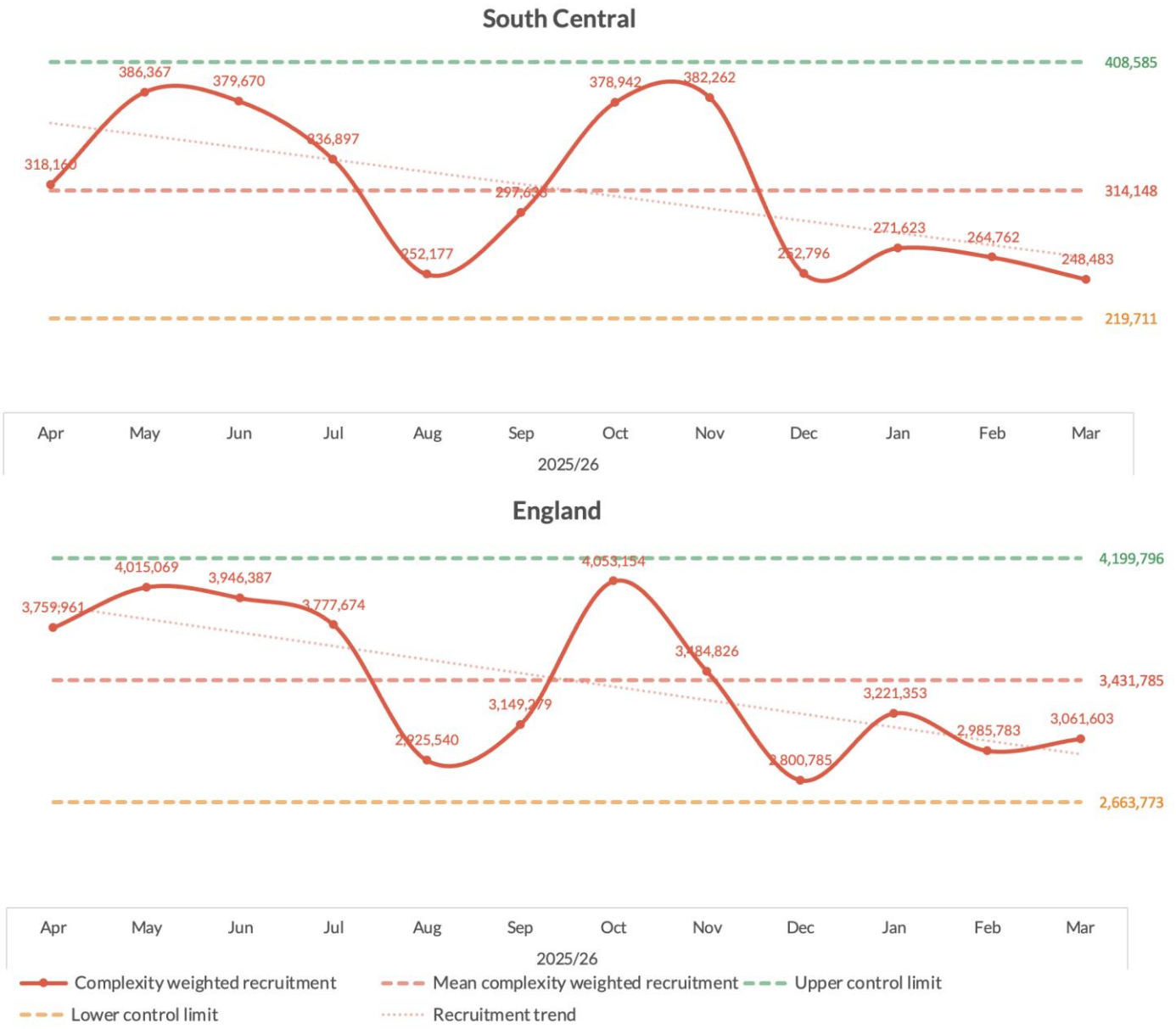

Figure 6 – Monthly complexity weighted recruitment in the South Central region benchmarked against England in the previous twelve months

The downwards trend in complexity weighted activity throughout the year was reflected across the whole of England. Both SC RRDN and English activity show similar seasonal variations with notable reductions in activity during the holiday periods in August and December. The alignment between South Central's performance and national trends suggests that the region is successfully attracting and delivering a proportionate share of the high intensity interventional trials currently available in the national RDN Portfolio.

For reference, quarterly recruitment at delivery organisations within South Central is provided in Figure 7.

Figure 7 – Complexity weighted recruitment by organisation and organisation type in the South Central region in the previous four quarters

Commercial recruitment in South Central

Commercial research, funded and sponsored by the life sciences industry, remains a strategic priority for both the Department of Health and Social Care and the NIHR. Commercial trials provide South Central's local population with access to novel treatment options while supporting the expansion of regional research infrastructure and generating significant savings on treatment costs for participating organisations.

During 2025/26, delivery organisations in the South Central region have recruited **2,459 participants** across **45 sites** on **263 commercial studies**.

Unlike the broader downwards trend observed for other research activity, commercial recruitment in the region and in England is trending upwards (Figure 8). This aligns with the targeted efforts of the delivery organisations and the RDN to attract industry investment.

The highest recruiting studies in 2025/26 included an mRNA vaccine versus placebo trial and a genetic testing study called Discover Me. These accounted for most of the spike in activity during the summer of 2025. Sustaining the growth in commercial activity is essential to secure the additional income needed to expand South Central's delivery capacity and align with the recommendations of Lord O'Shaughnessy's 2023 review into commercial clinical trials in the UK.

Commercial recruitment was distributed across a wide range of care settings throughout the 2025/26 financial year (Figure 9). University Hospital Southampton and Oxford University Hospitals remained the most active among the region's NHS Trusts. Other acute delivery organisations showed positive trends; Portsmouth Hospitals University saw recruitment more than double in the final quarter and Frimley Health demonstrated growth across the year.

Primary care organisations recorded the highest commercial recruitment. The setting continues to play an important role in delivering large scale commercial research to the population near where they live. There is also evidence of emerging growth within mental health delivery organisations as the South Central seeks to diversify the regional portfolio. Hampshire and Isle of Wight Healthcare notably increased its commercial activity by the end of the year which represents its highest volume for the period. This expansion into wider care settings is a key objective for SC RRDN and a government priority because it ensures that commercial research and its potential benefits is accessible to more people.

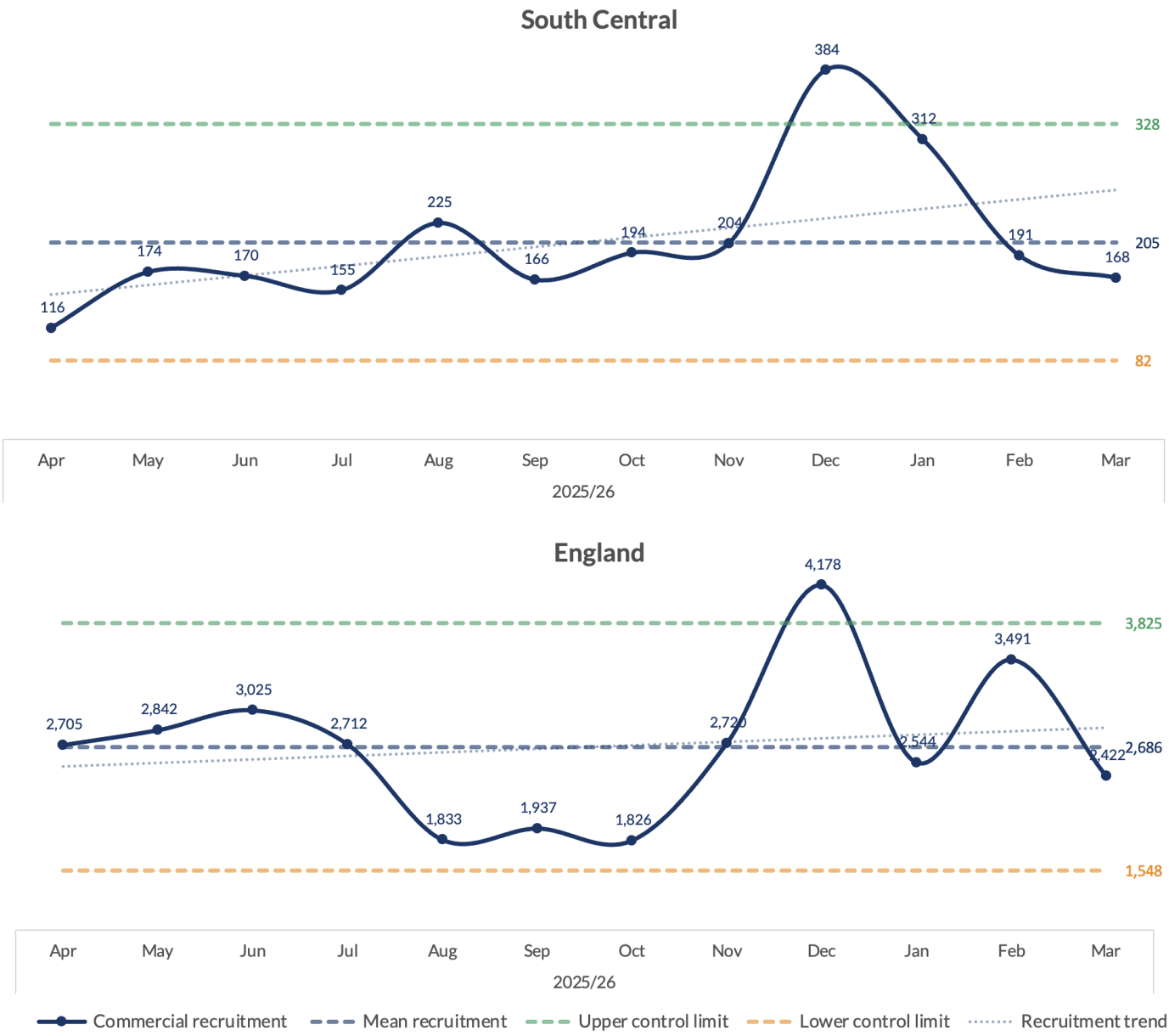

Figure 8 - Monthly commercial recruitment in the South Central region benchmarked against England in the previous twelve months

Figure 9 – Commercial recruitment by organisation and organisation type in the South Central region in the previous four quarters

Summary of South Central recruitment

The research activity in the South Central region, relative to all other RRDN regions in England has been provided in Figure 10 for information.

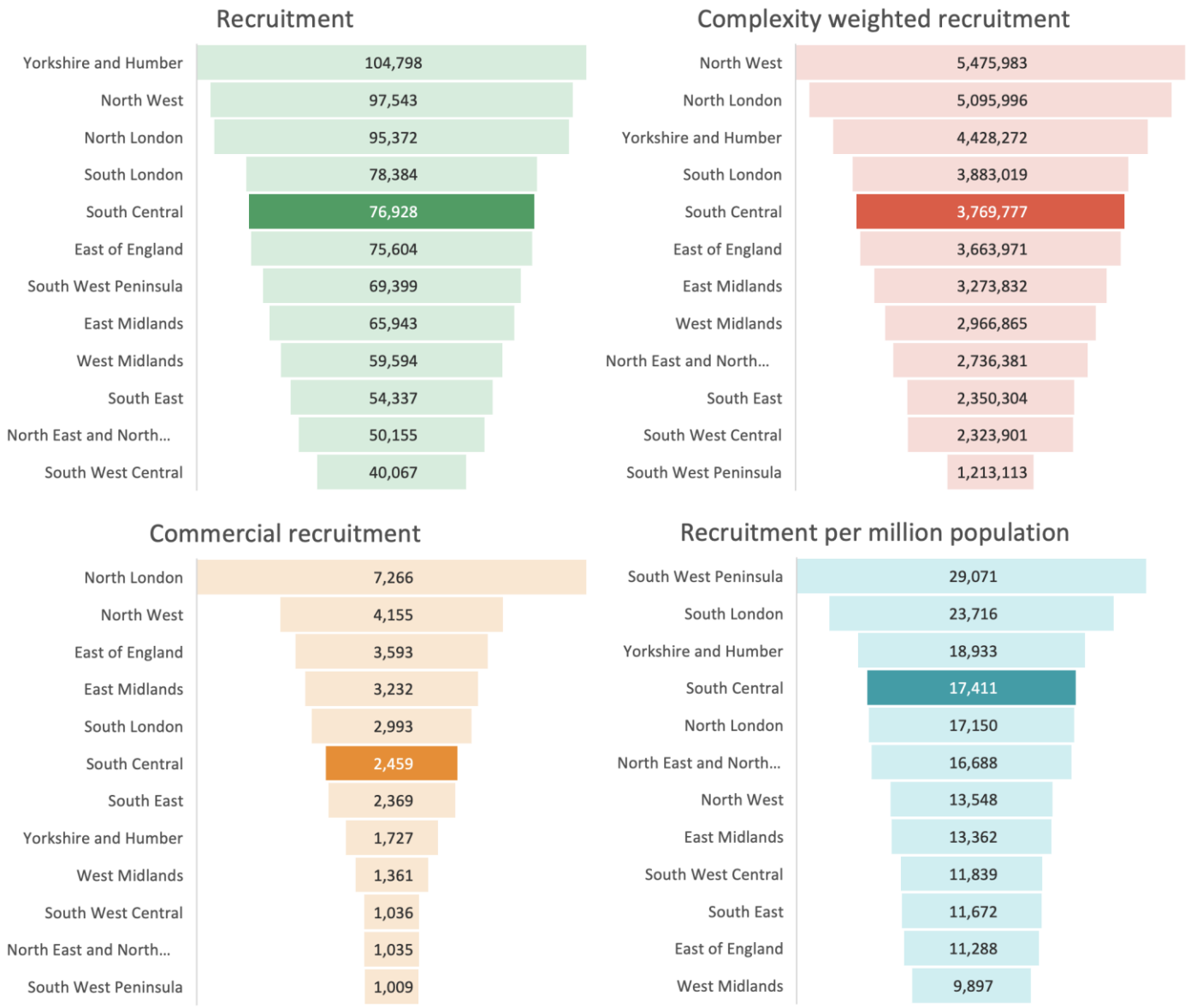

Figure 10 – Recruitment, complexity weighted recruitment, commercial recruitment and recruitment weighted per million population by RRDN region in the 2025/26 financial year

Recruiting studies in South Central

South Central recruited to a total of **840 non-commercial studies** during the 2025/26 financial year. While the overall number of studies has seen a gradual decline from 920 in 2023/24 the composition of the portfolio has shifted toward higher complexity research. Interventional trials now account for exactly 50 per cent of the regional non-commercial portfolio which is an increase from

46 per cent two years ago. This growth in interventional activity has been offset by a reduction in observational studies. This transition suggests a prioritisation from the region's delivery organisations of more intensive clinical trials that often provide patients with access to experimental treatments. However, the trend may also be due to a general reduction in observational studies on the RDN Portfolio.

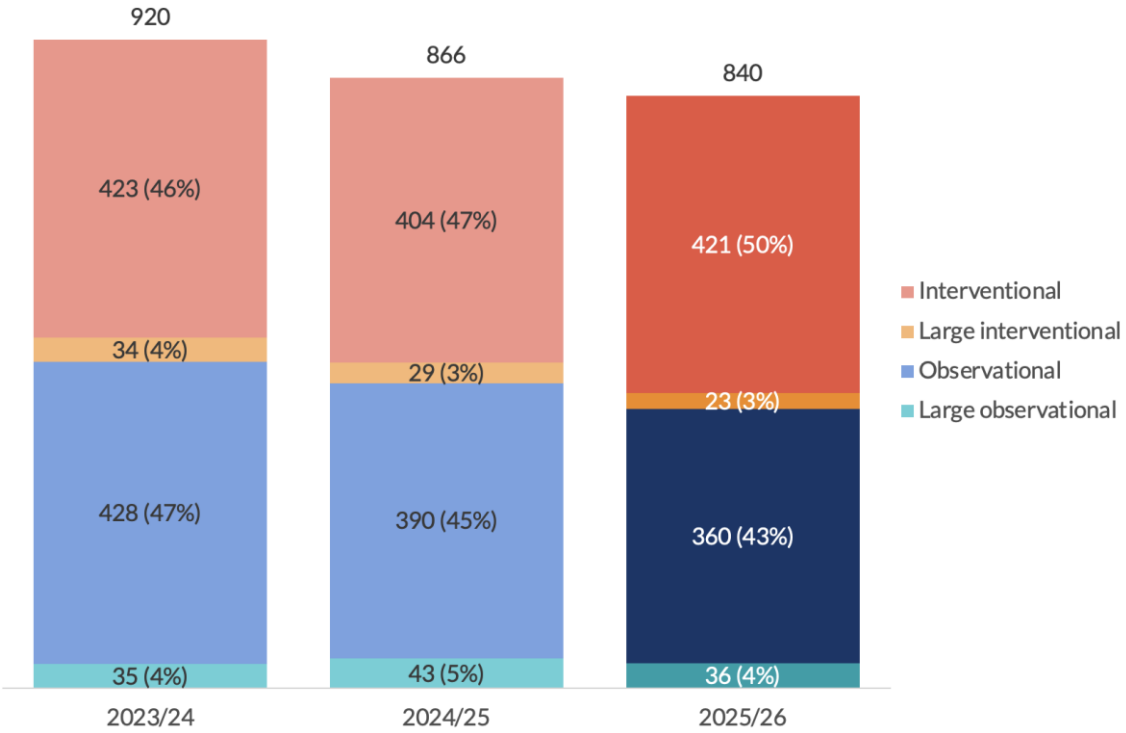

Figure 11 – Recruiting studies by complexity within the South Central region since April 2023

In contrast, the number of commercial recruiting studies in the region increased to 263 during the 2025/26 period (Figure 12). This growth follows a period of stability where delivery organisations supported approximately 250 industry studies annually and represents the highest volume recorded since before the COVID-19 pandemic. By increasing the number of open commercial studies, the region is attracting additional funding to support the long term sustainability of the research delivery infrastructure.

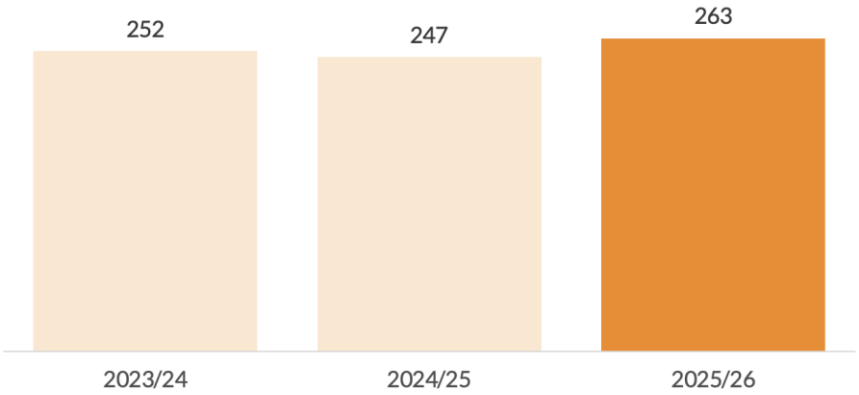

Figure 12 – Commercial recruiting studies within the South Central region since April 2023

In 2025/26, South Central had the fifth highest number of recruiting non-commercial and commercial studies, respectively, among the twelve RRDN regions in England (Figure 13).

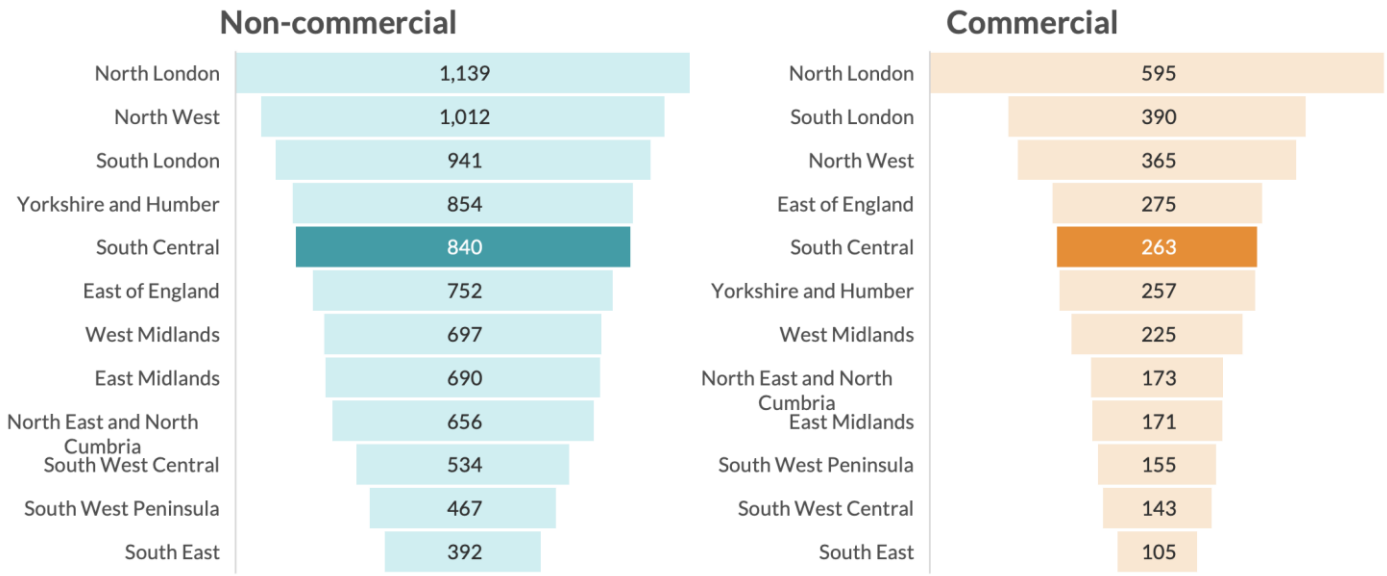

Figure 13 - Non-commercial and commercial recruiting studies by RRDN region in 2025/26

Study set-up

The new national funding model introduces several measures that directly adjust the baseline funding of delivery organisations according to their efficiency in setting up research studies. One metric is the percentage of studies opened at an organisation within sixty days of either Health Research Authority (HRA) approval or the date of sponsor selection, whichever is later. Across South Central, 374 study locations met this sixty day threshold which represents a regional performance of 57 per cent (Figure 14). Within the region, Portsmouth Hospitals University is leading delivery organisation performance with 87 per cent of study locations meeting the metric, followed by Buckinghamshire Healthcare with 78 per cent and Hampshire Hospitals with 77 per cent (Figure 15).

Conversely lower performance at organisations such as Frimley Health and Oxford Health, where only 20 and 26 per cent of study locations respectively met the target, represent a financial risk under the new model. These highlight areas where SC RRDN may be able to provide additional support.

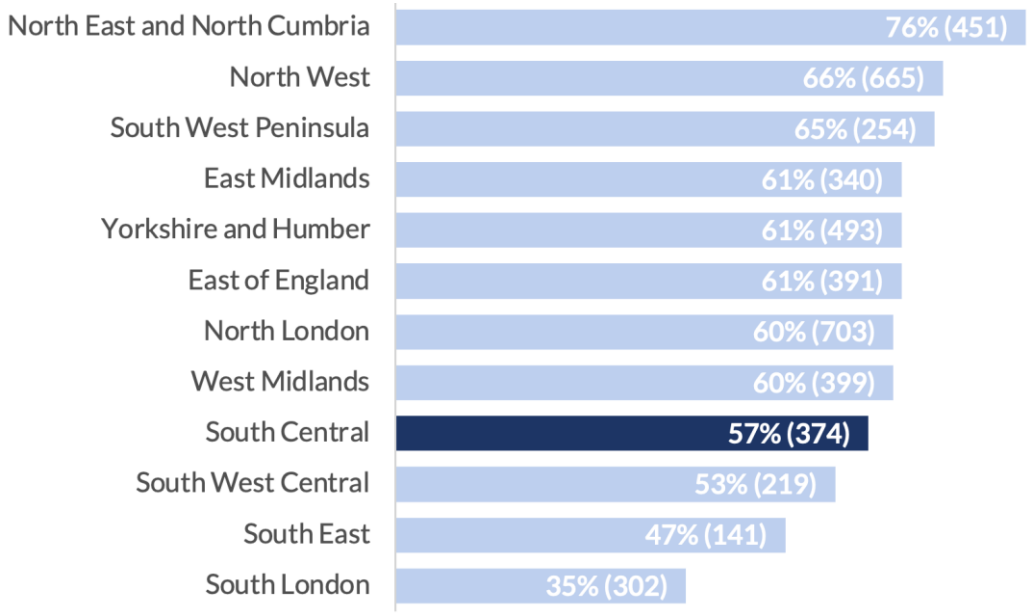

Figure 14 – Study locations open within sixty days of HRA approval or site selection by RRDN region since April 2025

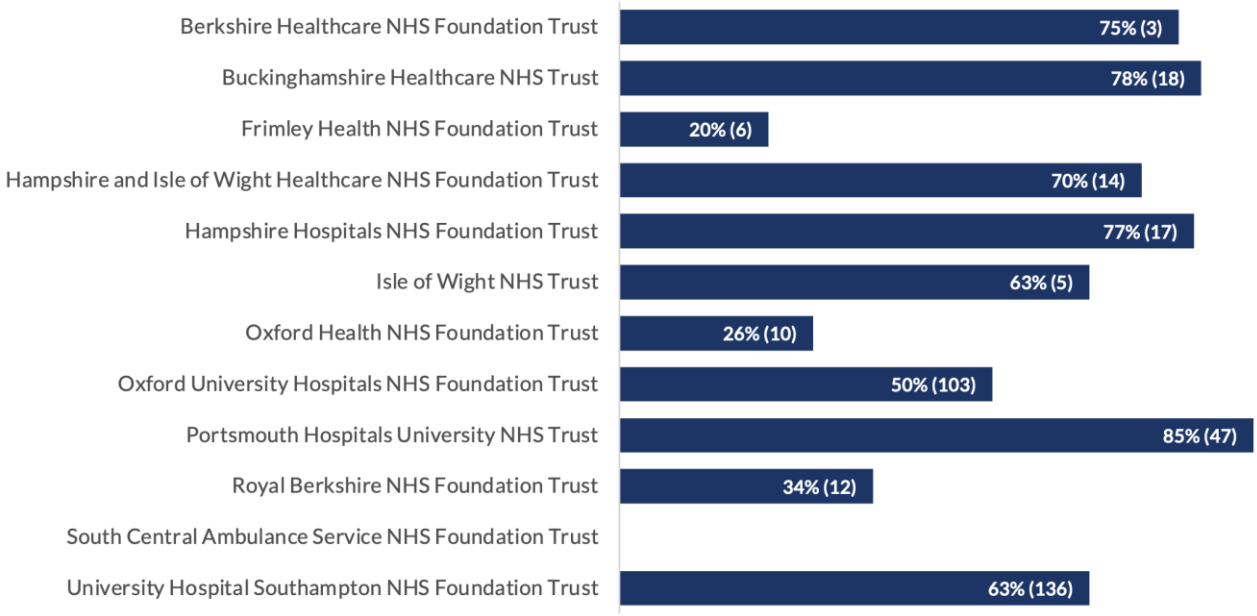

Figure 15 - Study locations open within sixty days of HRA approval or site selection at South Central RRDN NHS Trusts since April 2025

A further performance element affecting baseline funding tracks the percentage of studies achieving first participant's first visit (FPFV) at an organisation within thirty days of site readiness (Figure 16). South Central currently has 149 study locations that achieved this thirty day target, which equates to 40 per cent of the regional total. The Isle of Wight and Portsmouth Hospitals, who share an R&D department, and Berkshire Healthcare have the best performance with 100, 71 and 67 per cent of studies meeting the metric, respectively. Other larger organisations, such as Oxford University Hospitals with 30 per cent and University Hospital Southampton with 37 per cent, are currently performing at or below the regional and national average.

The inclusion of these set-up metrics within the national funding model ensures that financial allocations are linked to the speed and reliability of study delivery. For delivery organisations in South Central, consistent performance on these measures is essential to maintain the region's reputation as an efficient partner for research sponsors. SC RRDN continues to work with delivery organisations to identify and remove local bottlenecks to ensure more study sites can meet these ambitious national targets and protect funding for their future research infrastructure.

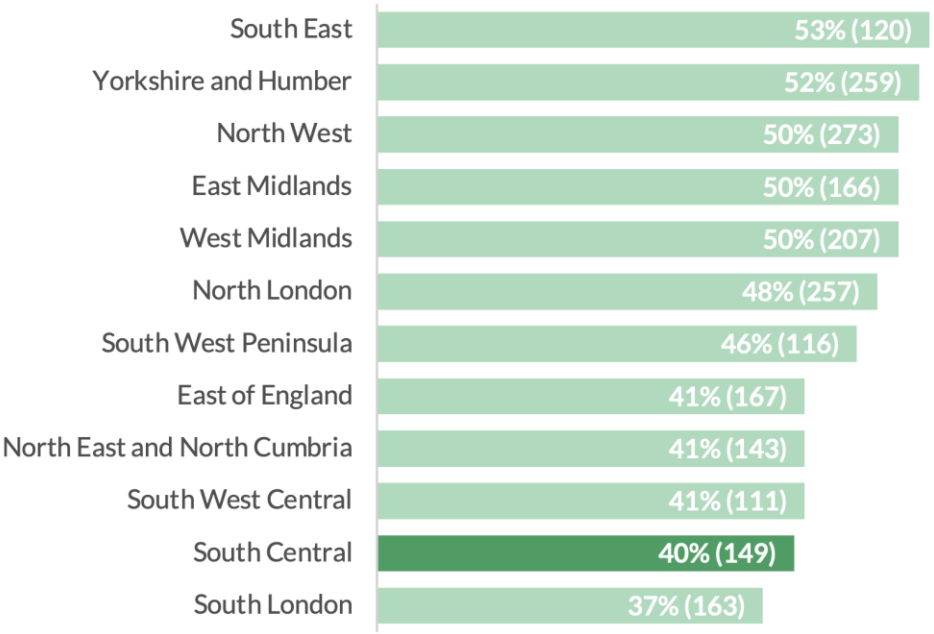

Figure 16 – Study locations achieving the first participant first visit within thirty days of site readiness by RRDN region since April 2025

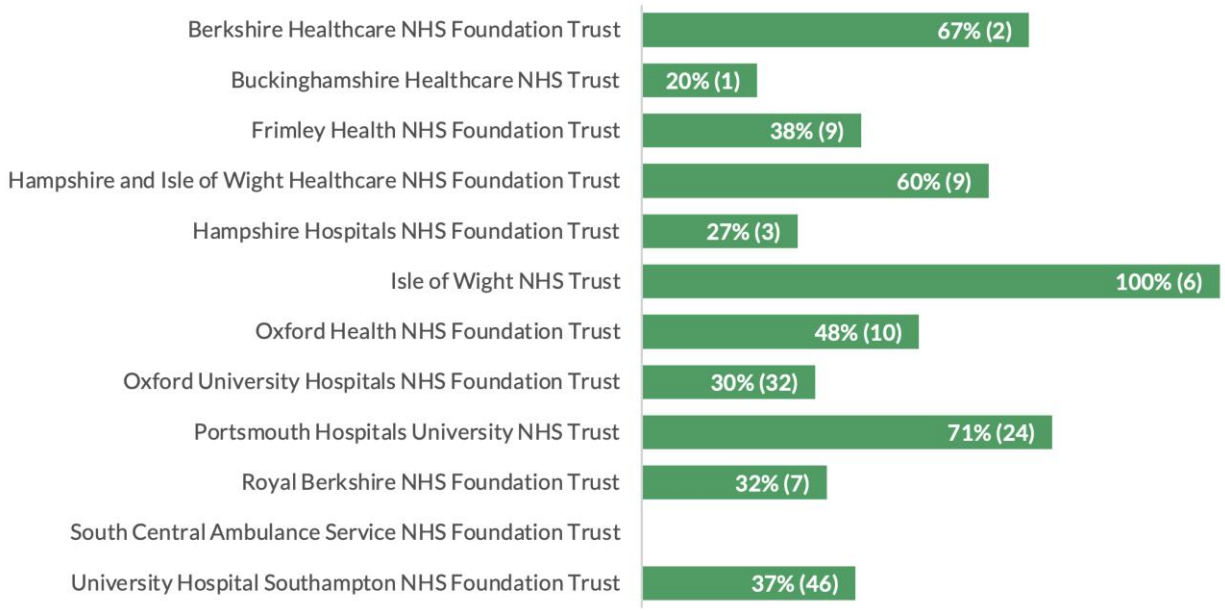

Figure 17 – Study locations achieving the first participant first visit within thirty days of site readiness at South Central RRDN NHS Trusts since April 2025

Participant experience

SC RRDN has continuously monitored feedback through the My Research Experience Survey, which was previously known as the Participant in Research Experience Survey. During the 2025/26 financial year, **1,648 participants** responded to the survey across **246 studies**. Feedback from these respondents remains very positive regarding the quality of care provided with 96 per cent of participants stating they were treated with courtesy and respect (Figure 18). Furthermore, 95 per cent of respondents felt valued for their contribution and 93 per cent felt well prepared to take part in the research.

While the delivery of research is viewed positively there are clear opportunities to improve the ongoing communication provided to participants. Although 90 per cent of participants knew how to contact the research team, only 75 per cent felt they were kept updated throughout the study and only 39 per cent of participants indicated that they were aware of how they will receive the study results. SC RRDN is working with local sponsors and a representative of the NIHR Research Support Service, who provide advice to researchers on building better communication strategies into study protocols during early development. Oxford Health NHS Foundation Trust has also created a 'Guide to keeping in touch with participants', which has been shared nationally and presented to South Central organisations. The importance of clear results communication is further supported by new legislation that took effect on 28 April 2026. This law introduces a legal requirement for all drug trials to inform participants of the results within twelve months of the trial concluding.

SC RRDN regularly share the My Research Experience survey results with research delivery organisations to discuss and monitor strategies based on ongoing participant feedback.

Figure 18 - Summary of the My Research Experience survey results in the South Central region in 2025/26

Other performance measures affecting funding for hospital-based organisations

The 2026/27 RDN hospital funding model introduced 9 new measures under the 'Performance' section. These include the 60 and 30 day set-up metrics which have been summarised earlier in this report. The other measures can be found in Appendix one and are provided for information only. Please note that the data for these measures was last updated in January 2026, for the 2025 calendar year. The Board will be provided the updated data in a future quarterly report when this is made available nationally.

Conclusion

The 2025/26 financial year has been a period of significant activity for South Central despite a challenging national landscape. The region successfully recruited 76,928 participants across 1,103 studies and delivered 8.9 per cent of the total recruitment in England, while representing only 7.7 per cent of the population. The downwards trend in recruitment mirrors a decline observed across the country, however, the region's ability to maintain monthly activity within statistical limits demonstrates the underlying resilience of South Central's delivery infrastructure. This performance

was demonstrated by the volume of activity in wider care settings, where collective recruitment outside of acute trusts exceeded 10,000 participants in the first quarter alone.

A primary success of the year has been the strategic evolution of the regional research portfolio towards higher complexity research. Non-commercial interventional trials now account for exactly 50 per cent of that regional portfolio which is a significant increase from two years ago. Furthermore, the number of commercial recruiting studies in the region increased to a six year high of 263. While overall recruitment figures in previous years were often inflated by exceptionally large observational studies, the underlying trend for commercial recruitment has been upwards throughout the current year. This growth ensures that South Central's local population has access to the latest clinical innovations while securing essential industry investment for delivery organisations, in line with the recommendations of the Lord O'Shaughnessy 2023 review.

However, several significant challenges remain that will require a focused response as the region moves into the 2026/27 financial year. The transition to the new national funding model has resulted in an £868,069 (3.1 per cent) baseline reduction for the region which places additional pressure on delivery organisations. Study set-up efficiency also remains a distinct area for improvement as the region currently ranks ninth nationally for local set-up speed and eleventh for achieving the first participant first visit within thirty days. Improving these metrics is essential to protect future activity based funding as the new model ties financial allocations to the speed and reliability of study delivery.

Finally, feedback from research participants remains a significant regional strength with 96 per cent of respondents stating they were treated with courtesy and respect. While the quality of care provided is high, a clear opportunity to improve how delivery organisations communicate study results back to participants has been identified. Only 39 per cent of participants currently understand this process. Addressing this gap will be a priority for the coming year as delivery organisations seek to maintain and improve the feedback that 94 per cent of the region's participants would consider taking part in research again.

South Central RRDN remains committed to supporting the NIHR's mission to improve the health and wealth of the nation through research and will continue to provide quarterly updates to the Board on South Central's progress and performance.

Appendix

Appendix 1 – Other funding model performance measures: updated January 2026

First UK site to open to recruitment within 60 days of HRA approval – Direct payment

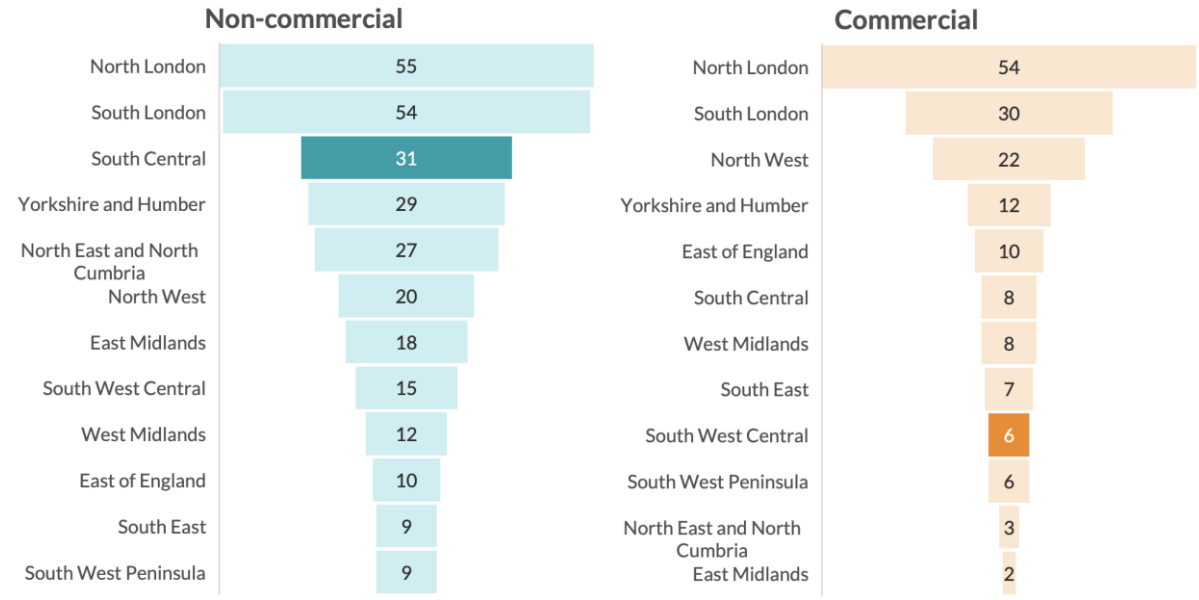

Figure 19 - First UK site to open to recruitment within sixty days of HRA approval on non-commercial and commercial studies by RRDN region in the 2025 calendar year

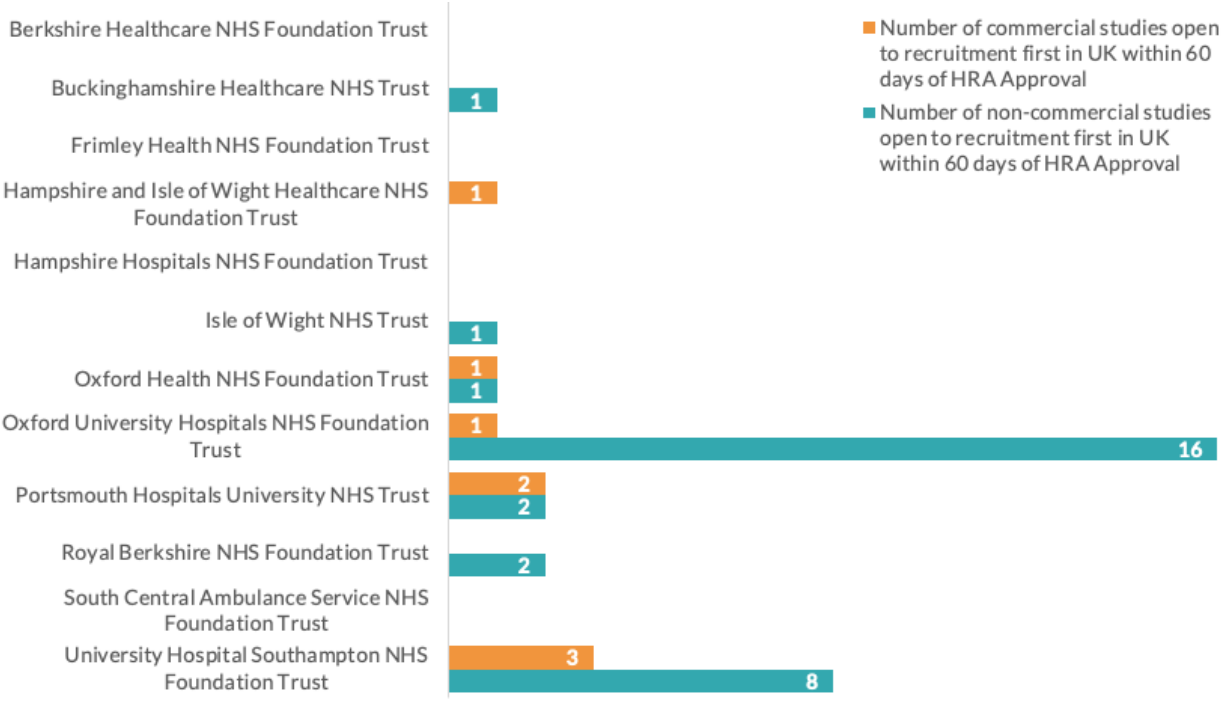

Figure 20 - First UK site to open to recruitment within sixty days of HRA approval on non-commercial and commercial studies at South Central NHS Trusts in the 2025 calendar year

First UK participant recruited within 90 days of HRA approval – Direct payment

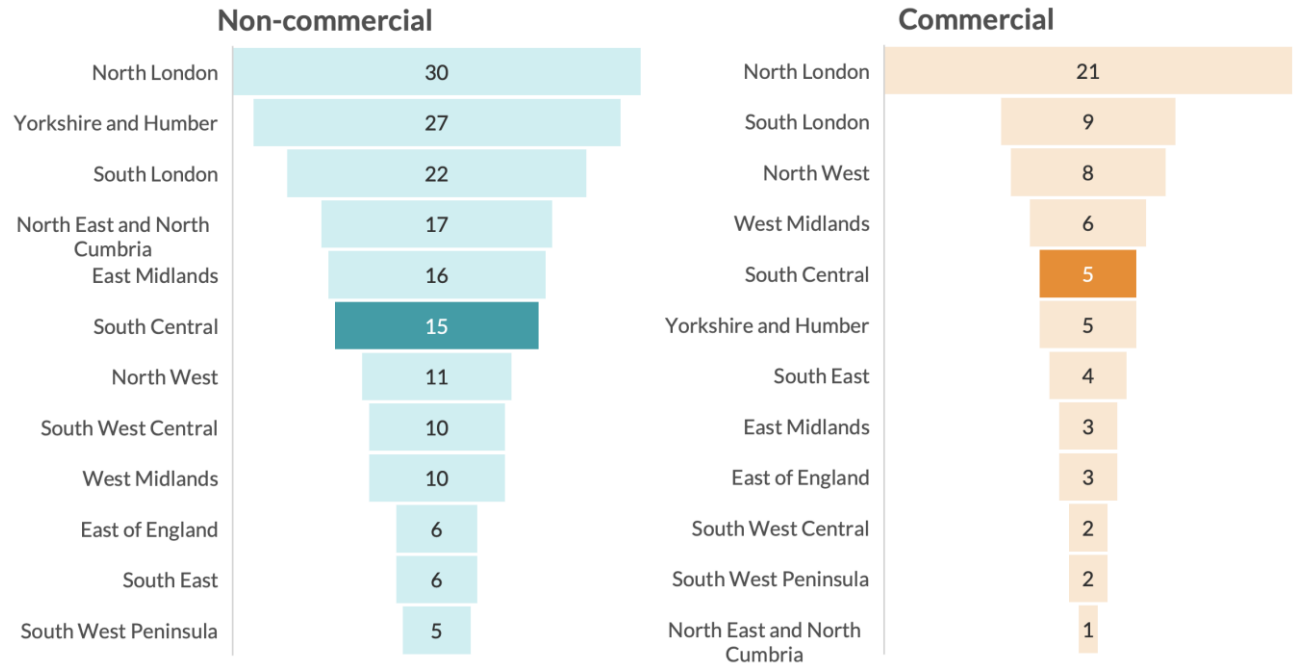

Figure 21 – Studies with first UK participant within ninety days of HRA approval on non-commercial and commercial studies by RRDN region in the 2025 calendar year

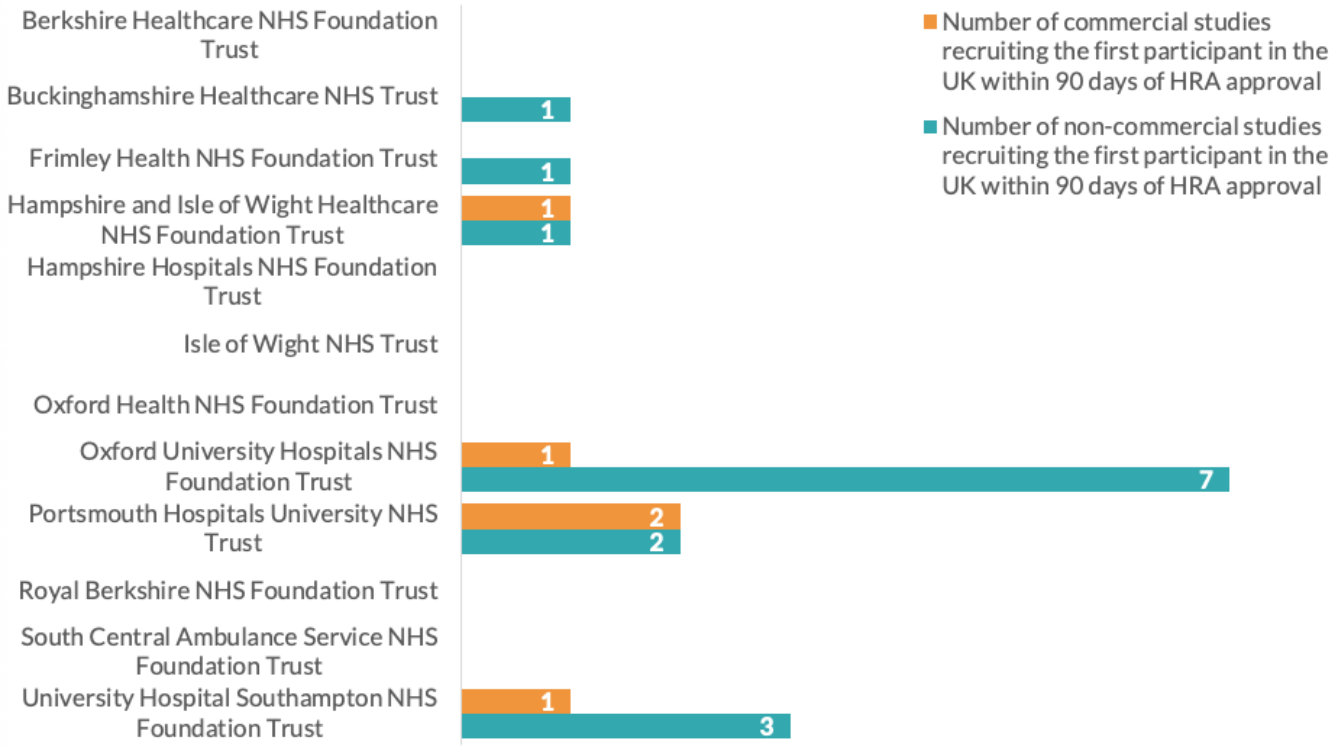

Figure 22 – Studies with first UK participant within ninety days of HRA approval on non-commercial and commercial studies at South Central NHS Trusts in the 2025 calendar year

First European or global site to recruit – Direct payment, commercial studies only

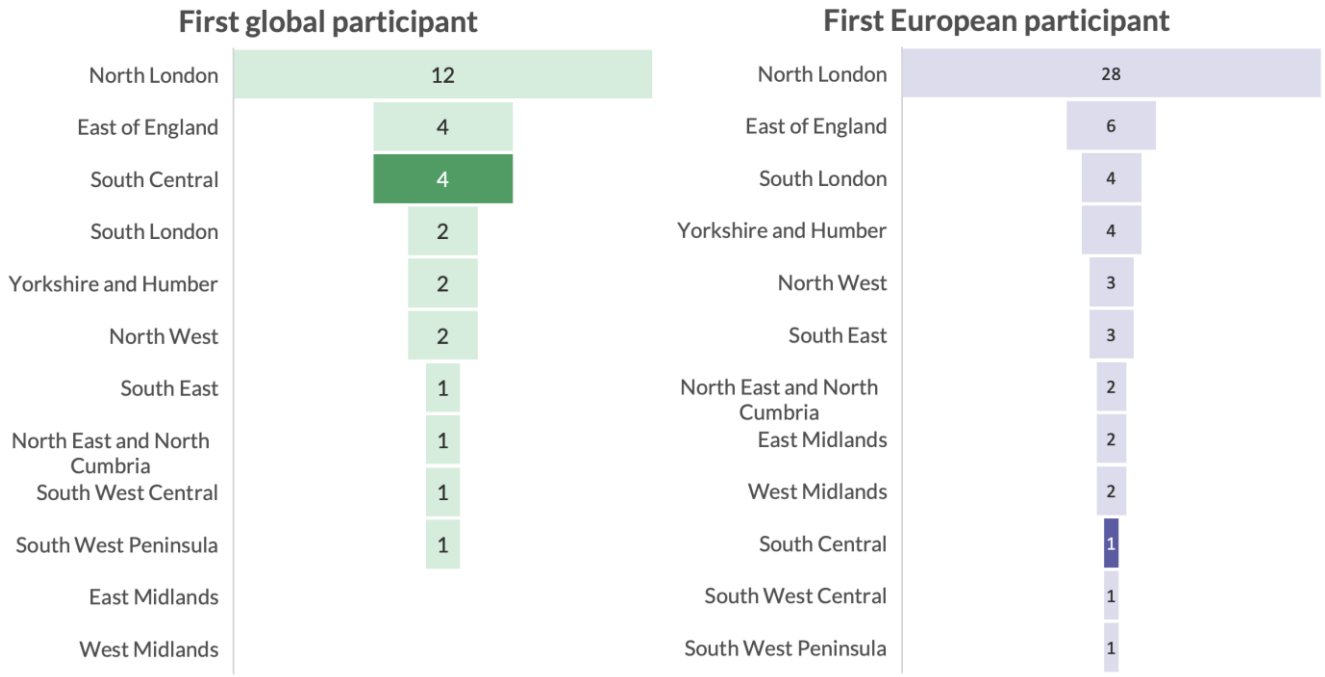

Figure 23 - Studies with the first site to recruit a participant by RRDN region globally or in Europe in the 2025 calendar year

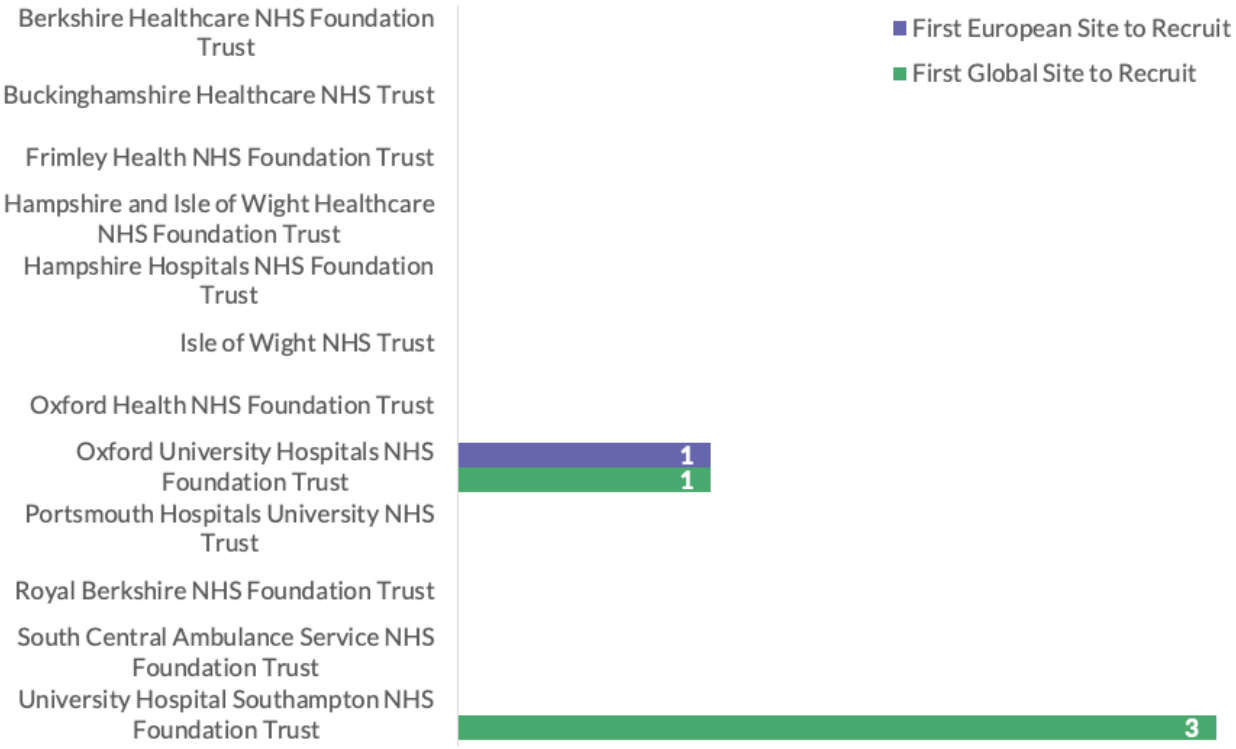

Figure 24 - Studies with the first site to recruit a participant at South Central RRDN NHS Trusts globally or in Europe in the 2025 calendar year

Percentage of commercial studies achieving Recruitment to Time and Target at the site – Performance adjustment to the delivery organisation's baseline funding

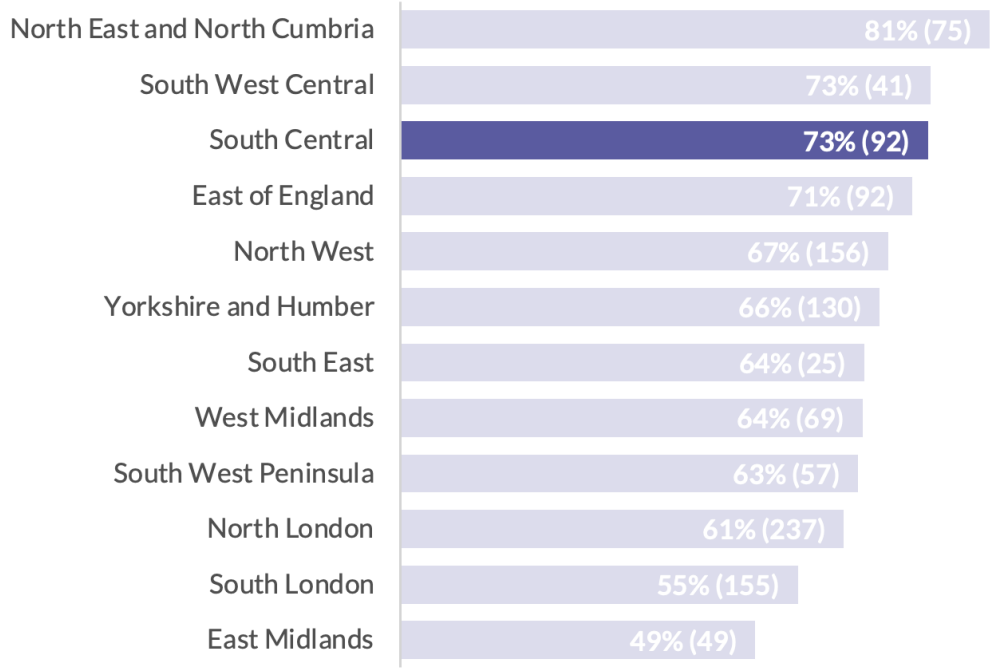

Figure 25 – Commercial study locations recruiting to time and target by RRDN region in the 2025 calendar year

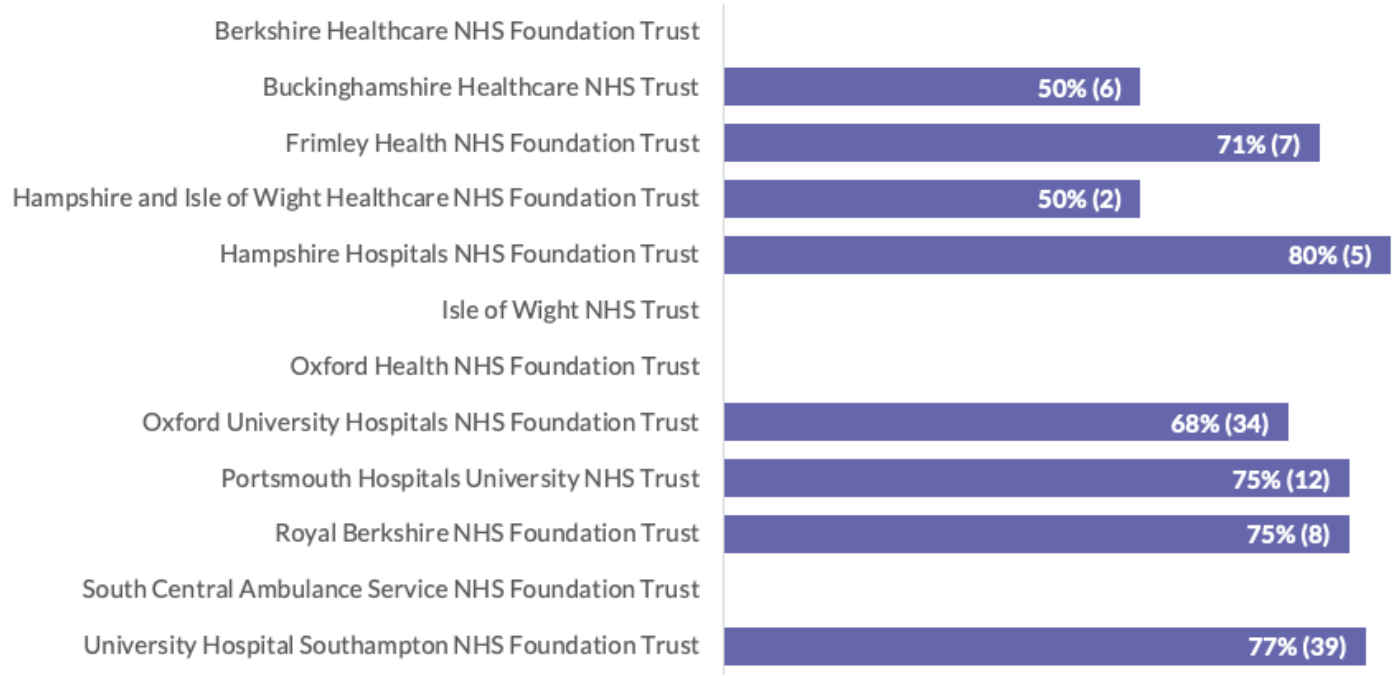

Figure 26 – Commercial studies locations recruiting to time and target at South Central RRDN NHS Trusts in the 2025 calendar year

Increase/decrease in recruitment to interventional commercial trials compared to the previous reporting period – Performance adjustment to the delivery organisation's baseline funding

RRDN	Jan-Dec 2024: Recruitment to interventional commercial studies	Jan-Dec 2025: Recruitment to interventional commercial studies	Increase/Decrease in recruitment to interventional commercial studies
East Midlands	674	539	-135
East of England	1,949	1,859	-90
North East and North Cumbria	752	631	-121
North London	2,219	1,733	-486
North West	2,087	1,499	-588
South Central	1,444	1,041	-403
South East	626	457	-169
South London	1,378	1,217	-161
South West Central	845	558	-287
South West Peninsula	921	586	-335
West Midlands	804	707	-97
Yorkshire and Humber	1,537	1280	-257

Figure 27 - Increase/decrease in recruitment to interventional commercial trials between 2024 and 2025 by RRDN region

Organisation	Jan-Dec 2024: Recruitment to interventional commercial studies	Jan-Dec 2025: Recruitment to interventional commercial studies	Increase/Decrease in recruitment to interventional commercial studies
Berkshire Healthcare NHS Foundation Trust	0	0	-
Buckinghamshire Healthcare NHS Trust	69	15	-54
Frimley Health NHS Foundation Trust	33	19	-14
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	30	14	-16
Hampshire Hospitals NHS Foundation Trust	128	40	-88
Isle of Wight NHS Trust	2	0	-2
Oxford Health NHS Foundation Trust	5	17	12
Oxford University Hospitals NHS Foundation Trust	339	439	100
Portsmouth Hospitals University NHS Trust	106	102	-4
Royal Berkshire NHS Foundation Trust	63	31	-32
South Central Ambulance Service NHS Foundation Trust	46	0	-46
University Hospital Southampton NHS Foundation Trust	623	364	-259

Figure 28 - Increase/decrease in recruitment to interventional commercial trials between 2024 and 2025 at South Central RRDN NHS Trusts

Increase/decrease in the number of interventional commercial trials recruiting compared to the previous reporting period – Performance adjustment to the delivery organisation's baseline funding

RRDN	Jan-Dec 2024: Number of interventional commercial studies recruiting	Jan-Dec 2025: Number of interventional commercial studies recruiting	Increase/Decrease in number of interventional commercial studies recruiting
East Midlands	122	136	14
East of England	167	204	37
North East and North Cumbria	119	135	16
North London	455	476	21
North West	286	298	12
South Central	190	209	19
South East	66	82	16
South London	298	324	26
South West Central	86	100	14
South West Peninsula	85	99	14
West Midlands	148	173	25
Yorkshire and Humber	187	211	24

Figure 29 - Increase/decrease in the number of interventional commercial trials recruiting between 2024 and 2025 by RRDN region

Organisation	Jan-Dec 2024: Number of interventional commercial studies recruiting	Jan-Dec 2025: Number of interventional commercial studies recruiting	Increase/Decrease in number of interventional commercial studies recruiting
Berkshire Healthcare NHS Foundation Trust	0	0	-
Buckinghamshire Healthcare NHS Trust	10	5	-5
Frimley Health NHS Foundation Trust	7	7	-
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	10	5	-5
Hampshire Hospitals NHS Foundation Trust	5	4	-1
Isle of Wight NHS Trust	1	0	-1
Oxford Health NHS Foundation Trust	3	2	-1
Oxford University Hospitals NHS Foundation Trust	98	108	10
Portsmouth Hospitals University NHS Trust	21	22	1
Royal Berkshire NHS Foundation Trust	10	12	2
South Central Ambulance Service NHS Foundation Trust	1	0	-1
University Hospital Southampton NHS Foundation Trust	57	64	7

Figure 30 - Increase/decrease in the number of interventional commercial trials recruiting between 2024 and 2025 at South Central RRDN NHS Trusts

Appendix 2 – South Central Risk Register

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
SCRRDN Reference Number	Risk Category	Risk Title	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col KxL)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
SCRRDN 002	**20. Workforce Learning and Organisational Development**	Impact on Performance Network Agile Research Delivery Team (ARDT) Workforce	**Cause:** Staff exhaustion due to ongoing team vacancies and limited clarity about roles within the new SC regional processes and workstreams. Recruitment freeze remains in place due to the MOC process in its final stages. **Event**: Staff we have invested in and developed to work in this Agile capacity leave and we lose this capability without being able to recruit	Unable to deliver Government priority studies as DHSC expectations of new RRDN contract. Fewer Clinical trials are delivered. This has been further impacted by the separate organisational change processes of the ARDT and management team. Decrease in the number of studies that can be delivered.	4	4	16	1. Ongoing recruitment to the direct delivery team - restarted 2. Wellbeing programme established for the team and delivered by the team 3. Ensure regular check-ins at 1:1 meetings with all staff 4. Continue to keep a close eye on any changes using all possible tools, e.g. 1:1s, team meetings, wellbeing surveys etc 5. Encourage regular taking of annual leave throughout the year, limiting the accrual of TOIL wherever possible. 7. Encourage all staff to take regular breaks during the working day and consider the use of walking meetings etc as a way of stepping away from screens, encouraging interactions. 8. Agile working groups set up and communicated with Agile staff members with opportunities for them to be involved 8. The agile band 7 management team are meeting weekly to support staff and review capacity and capability 10. HoRD and Director of Ops are working with the Senior Agile Manager to support staff and workload as best as possible. 11) staff capacity and capability and well-being is regularly reviewed at agile management meetings on a weekly basis.	Ongoing	3	3	9
SCRRDN 004	**15. Research Delivery**	NHS Pressures	Impact of NHS pressures on clinical services impacting on delivery of Research	Thus causing research staff to be redeployed to clinical services. Impact is reduced workforce to deliver NIHR Portfolio research.	4	4	16	Raised locally with DOs with examples requested. Raised nationally for advice on prioritisation of key activities/studies	Ongoing	4	4	16
SCRRDN 005	**15. Research Delivery**	Supporting departments capacity to support study set up (including 150d studies)	Cause: Reduced access to PET scanning capacity and tracers (amyloid and tau) required for both clinical and research scans. Event: Limited access to PET scans for research purposes. Reduced opportunities for access to research for neurology and oncology patients. Cause: Limited capacity from Pharmacy to review/approve new studies. Event: WIthdrawn from commercial studies in set up."	Sites unable to set up and deliver interventional studies (including 150d). Threat to safety and data integrity if schedule of imaging events cannot be adhered to.	4	4	16	SC RRDN R&D Leadership meeting on 24/3/2026 dedicated to sharing information information about how DO R&D/R&I teams work with Pharmacy colleagues, including: structures, relationships, funding, and ways of handling pressures. This is to be followed up with a half day face-to-face meeting on the 8/6/2026 with R&D Managers and Directors, as well as Lead Pharmacists, invited. This meeting will focus on potential collaborative initiatives and innovations to increase capacity and efficiency in pharacy and support services with the aim of reducing set up times. Ideas from other RRDN areas also to be investigated and shared. Funding specifically for pharmacy at OUH, UHS and RBH has been increased via CSS and contingency funding awards. . The SC RRDN Imaging Specialty Lead, working with the SSS and Industry team, is continmg to engage with organisations to map capacity.	Ongoing	3	3	9
SCRRDN 006	**19. Health and Care Services Engagement**	Thames Valley ICB Engagement	No research engagement at present as TV ICB has been forming. New TV ICB launched on 1st April 2026	Failure to progress with work streams and opportunities missed.	4	2	8	1) Liaise with RDN CC and with fellow RRDNs to align work. 2) Leverage relationships already in place with the former BOB ICS (eg OUHFT and AHSN) 3) Link with with TV ICB CMO - date TBC	Ongoing	3	2	6

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
SCRRDN Reference Number	Risk Category	Risk Title	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col KxL)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
SCRRDN 013	**15. Research Delivery**	Delivery to RDN High Priority Studies - Lead Network (e.g. RECOVERY)	Failure to successfully deliver high priority studies led by SC RRDN	1. Reputational damage to SC RRDN as a lead network, the UK as a place to deliver research and individual delivery organisations 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	2	4	**8**	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Agile delivery team resource allocated to support delivery in all RRDNs 3. Importance of high priority studies communicated to delivery organisations at a senior level 4. Supporting sponsor and sites with timely recruitment uploads to allow recruitment to be closely monitored and issues identified	All ongoing	2	3	**6**
SCRRDN 014	**15. Research Delivery**	Delivery to RDN High Priority Studies - Participating Site	Failure to successfully deliver high priority studies at delivery organisations within SC RRDN	1. Reputational damage to SC RRDN delivery organisations and to the UK as a place to deliver research 2. Potential loss of future studies and associated income 3. Negative impact of staff moral 4. Reduction in commercial income could hinder capacity build and growth within delivery organisations	4	4	**16**	1. Early engagement and frequent communication with sponsor, CRO, VIP, RDNCC, RRDNs, Key Account Managers and delivery organisations. 2. Local Agile delivery team resource allocated to support delivery organisations. 3. Importance of high priority studies communicated to delivery organisations at a senior level	All ongoing	4	4	**16**
SCRRDN 017	**15. Research Delivery**	Risk of studies not being delivered at OUH sites due to the withdrawal of the SC RDN agile team based in Oxford and Horton.	New studies not being approved to be delivered at OUH sites due to SC RDN organisational changes and expectation for the OUH based agile team withdrawal. Timeline not yet known. Risk to current studies on the portfolio not being delivered in their entirety.	1) studies not delivered at OUH due to workforce limitations. 2) SC RDN and OUH organisational reputational damage. 3) uncertainty regarding agile team availability for current and future study delivery.	4	4	**16**	1) Regular meetings held between senior management at OUH and RDN 2) Ongoing review the OUH SC RDN portfolio of studies on a regular basis and subsequent portfolio management including closing studies and stop recruiting to other studies 3) regular review by the senior agile, management team including at the bi-weekly agile management meeting. 4) Transitional arrangements agreed to ensure continuity of study delivery. 5) OUH R&D communication with OUH PIs 6)Transitioning of studies from OUH agile team to OUH R&D with oversight from RDN senior agile management 7) OUH agile team are informed of progress and presenting as a unified RDN / OUH approach.	Ongoing discussions being held with OUH	3	3	9
SCRRDN 019	**21. Business Development and Marketing**	Redirection of senior strategic industry regional industry resources	Risk - The regional industry activities previously completed by the Industry Operations Manager in LCRNs do not have a consistently agreed position in the RRDN structure. Cause - Transition to mandated structure with national focus for LSKAM role and Band 7 Industry Manager role means senior regional industry activity does not have a natural fit in the structure. This includes engagement activity with DOs including challenging behaviours	Effect - Reduction in regional ability to support life sciences activity as a key priority for RDN. Reduction in effectiveness of customer relationships built over 10 years and perception from DOs that senior regional industry support is no longer available. Loss of skilled and experienced industry staff across the network due to uncertainty.	5	4	**20**	Workload regularly reviewed by the Strategic Director, ongoing work to work closely in conjunction with the Study Support team who are supplying operational level input in the day to day challenges of the 150 days. Regularly discussed by the leadership team		4	4	16
SCRRDN 021	**15. Research Delivery**	a) Requirements of "Head count" impacting the ability for Trusts to deliver. b) Research Registered NMAHPs shortage in partner organisations and job freezes in place.	a) Risk: The imperative for Trusts to decrease the head count is impacting on the ability for Trusts to recruit new R&D staff. Cause: central NHS directives b) Cause: Lack of availability of registered NMAHPs. Event :Leading to a shortfall in registered staff qualified to deliver clinical trials	a) Effect - reduced R&D staff in partner Trusts impacting on Study delivery. b) Fewer clinical trials are delivered and/or quality of research conducted becomes reduced leading to reputational damage.	5	3	**15**	a) Regular Meetings with trusts to monitor situation. Raise issue at Operations Board b) To be aware of trusts with job freezes and implications of RRDN funded posts 5. Letter circulated to SC region R&D DIrectors to remind that RDN funding is ring fenced and posts funded through this stream should not be impacted by recruitment freezes, as per the RDN research delivery organisation contract. c) Partner organisations asked to provide examples of impact of staffing limitations on Research Delivery.		4	3	12

	South Central Regional Research Delivery Network		PENDING RISK DESCRIPTION		Pre Response Rating			Response		CURRENT (RESIDUAL) RATING		
SCRRDN Reference Number	Risk Category	Risk Title	Risk Description (to include cause/event)	Effect/Impact	Probability Value	Impact Value	Score (Col KxL)	Mitigation Actions	Mitigation actions Outstanding	Current Likelihood	Current Impact	Current Score
SCRRDN 022	**21. Business Development and Marketing**	Study set up times for commercial studies	Risk - Slow set up times for commercial studies in the context of government led drive to reduce setup time to 150 day but March 2026	- Reputational damage to SCRRDN and SC delivery organisations. - Reduced selection of SC delivery organisations resulting in fewer opportunities for patients and decreased commercial income - Future reduction in commercial study opportunities - Performance against 150 day metric will impact performance element of RDN funding to DOs	5	4	**20**	- NIHR Joint Acceleration plan in place to provide enhance support to candidate studies - D&A app to provide real time setup data to DOs in line with UKCRD metrics - SC RRDN R&D managers meeting with focus on set up times - Support DOs to reduce duplication and streamline set up processes - Appropriate escalation of system wide issues, via industry hub, 150 day worksteams and action group - Regional strategic funding call with commissioned call for projects to support study set-up acceleration. Large awards funded. Total TBC.		4	4	16
SCRRDN 024	**21. Business Development and Marketing**	Failure to see an increase or seeing a decrease in recruitment to commercial studies	Risk - Poor commercial set-up and recruitment performance causes either a drop in commercial recruitment or failure to increase commercial recruitment activity.	Effect - reputational damage, reduction in both commerical contract and RDN funding at DOs Impact - reduction in commercial studies set-up in the UK, reduction in income	4	4	**16**	- Regular review of commercial recruitment performance at RRDN Management and Internal Contractor Governance Group. - Implementation of SC RRDN Recruitment Action Plan. - Renewed focus on SC RRDN Recruitment Action Plan with plan to be updated and shared with DOs. DOs to be asked to share their own recruitment action plans. - Recruitment patterns to be discussed at organisational business planning meetings in Spring 2026.		4	4	16
SCRRDN 027	**16. Information and Knowledge**	LPMS re-tender process due to end just before the 2027/28 financial year will result in a period of disruption to research delivery at the affected organisations	Risk: That the national system due for delivery for March 2027 is delayed. In addition a complicating factor is SC RRDN uses two Local Portfolio Management Systems (LPMS). A re-tender process has begun, led by the NHS BSA, which is due to end with the selection of a single LPMS in England by April 2027. Cause: central NHS directives.	Effect: 1. Delivery organisations affected by the selection will go through a period of significant disruption involving their processes and data being migrated to a new system. 2. SCRRDN staff will have reduced visibility to portfolio information which will impact on processes	5	4	**20**	An existing LPMS exit plan is in place. RRDN Data and Analytics Senior Manager has raised with the RDN project leads the potential disruption in our region and the need for a significant period of time to transfer and test data, cascade training on the new system and troubleshoot issues. Both LPMS providers have confirmed that they can extend their contracts into 2027/28 if required. Update 7/1/2026: the procurement process has been extended nationally by six months. This would mean an implementation date of October 2027.	Ongoing	5	3	**15**
SCRRDN 028	**15. Research Delivery**	Reduction in 2026-27 funding allocated to SC Delivery Organisations impacting on delivery of research	Cause: Following the application of the new NIHR RDN funding model, there has been a reduction in funding going to SC RRDN Delivery Organisations totalling just over £1.1m - the largest monetary impact nationally. Event: Most SC RRDN DOs (with the exception of Portsmouth Hospital University NHS Trust) have seen a reduction in funding with OUH and UHS losing £279,000 and just under £500,000 respectively and most other DOs at or close to the collar.	This will potentially have an impact on the ability of DOs to fund staff resulting in reduced workforce available to deliver NIHR Portfolio research.	4	4	16	Potential use of use of any management team and wider care setting underspend to support DOs while also demonstarting strategic impact. Deployment of Agile team on a case by case basis to support short term requirements	Ongoing	4	4	16
SCRRDN 029	**17. Communications**	Relationship management due to the Strategic Funding and Wider Care Settings funding call outcomes for the financial year 26/27	The SC RRDN have run two funding calls: Strategic Funding and Wider Care Settings. Ther amount requested from applicants to significantly exceeded the SC RRDN funding envelopes allocated for these calls.	Potential reputational risk to SC RRDN stakeholders relationships.	5	3	15	The RDN has met with numerous organisations to feedback and explain funding decisions seeking solutions which include support being supplied from other nearby Trusts and deployment or agile staff to support the organisations to build their portfolio. A limited number of discussions are still continuing. the network has several plans in place to learn from the challenges for the next year's (27/28) funding call due Autumn 2026	1) continue to actively manage expectations through the range of comms available to applicants. 2) SC RRDN Operation Director to flag at a national senior management level. 3) ongoing conversations between SMT members and Setting leads 4) One to one meetings being offered to those who want to discuss their funding allocation outcome.	4	3	12

Appendix 3 - Glossary

South Central research delivery organisation acronyms

Delivery organisation	Acronym
Berkshire Healthcare NHS Foundation Trust	BHFT
Buckinghamshire Healthcare NHS Trust	BHT
Frimley Health NHS Foundation Trust	FH
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	HIOWH
Hampshire Hospitals NHS Foundation Trust	HHFT
Isle of Wight NHS Trust	IOW
Non-NHS organisations in the South Central region	Non-NHS
Oxford Health NHS Foundation Trust	OHFT
Oxford University Hospitals NHS Foundation Trust	OUH
Portsmouth Hospitals University National Health Service Trust	PHU
Royal Berkshire NHS Foundation Trust	RBFT
South Central Ambulance Service NHS Foundation Trust	SCAS
University Hospital Southampton NHS Foundation Trust	UHS

NIHR Regional Research Delivery Network abbreviations and their population

NIHR Regional Research Delivery Network (RRDN)	Acronym	Population
East Midlands	EM	4,934,939
East of England	EoE	6,697,937
North East and North Cumbria	NENC	3,005,519
North London	NL	5,561,092
North West	NW	7,199,831
South Central	SC	4,418,268
South East	SE	4,655,433
South London	SL	3,305,088
South West Central	SWC	3,384,367
South West Peninsula	SWP	2,387,206
West Midlands	WM	6,021,653
Yorkshire and Humber	YH	5,535,065

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.2	Report to the Trust Board of Directors, 14 May 2026
Title:	Register of Seals and Chair's Actions Report
Sponsor:	Jenni Douglas-Todd, Trust Chair
Author:	Craig Machell, Associate Director of Corporate Affairs

Purpose

(Re)Assurance	Approval	Ratification	Information
		x	

Strategic Theme

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

Executive Summary:

This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Standing Financial Instructions and Scheme of Delegation for ratification.

The Board has agreed that the Chair may undertake some actions on its behalf.

The report provides compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Delegation.

Contents:

Report

Risk(s):

N/A

Equality Impact Consideration:	N/A

1 Signing and Sealing

1.1 **Licence to Occupy and Licence to Carry Out Works** between University Hospital Southampton NHS Foundation Trust and Prime Infrastructure Management Services 4 Limited (Licensor) and University Hospital Southampton NHS Foundation Trust (Licensee) relating to temporary endoscopy provision at Plot 5, Adanac Health and Innovation Campus, Adanac Drive, Adanac Park, Southampton. Seal number 310 on 13 March 2026.

2 Chair's Actions

2.1 **Call-off Contract** for Histopathology Service Modernisation to Axlab Limited, for 6 years at a total contract cost of £4,300,000 excluding VAT. Funding from NHSE National Histopathology Service Modernisation Grant covering capital costs, with the Trust incurring maintenance costs from year 2. Signed by the Chair on 20 March 2026. ***NB This is a revised contract and supersedes the action ratified at Trust Board on 10 March 2026, following corrections made relating to equipment details, maintenance costs and contract terms, resulting in increased overall costs.***

2.2 **Contract Extension** for Allocate Workforce Systems software provided by R L Datix, for a further 24 months to 31 March 2028 at a total contract cost of £3,114,520 excluding VAT. Signed by the Chair on 8 April 2026.

2.3 **Variation Agreement** to the 2025-26 Spire Southampton and UHS Main Contracting Sub-Contract for UHS Surgical Activity between University Hospital Southampton NHS Foundation Trust (Head Provider) and Spire Healthcare Limited (Sub-Contractor), effective from 1 April 2025 relating to the extension of the Sub-Contract to 31 December 2026 and amendment to parts of the Sub-Contract. Signed by the Chair on 15 April 2026.

2.4 **Variation Agreement** to the Managed Healthcare Facilities Agreement (2022) between University Hospital NHS Foundation Trust (the Trust) and UEL Estates Limited (UEL). This amendment agreement is effective from 1 April 2025, when the Trust outsourced further parts of its estate to UEL. Signed by the Chair on 15 April 2026.

3 Recommendation

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

University Hospital Southampton NHS Foundation Trust

Agenda Item 7.3 Report to the Trust Board of Directors, 14 May 2026	
Title:	Review of Trust Executive Committee (TEC) Terms of Reference
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

Executive Summary:

It is good practice for a committee to regularly review its terms of reference and the terms of reference for the Trust Executive Committee (TEC) provide for a review to be undertaken annually.

Only minor changes are proposed to the terms of reference for consistency and to correct typographical errors, and to update the committee structure diagram in Appendix A.

The TEC reviewed its terms of reference at its meeting held on 22 April 2026 and supported the proposed amendments.

The Board is requested to approve the terms of reference.

Contents:

Revised Terms of Reference (marked up)

Risk(s):

N/A

Equality Impact Consideration:	N/A

Trust Executive Committee Terms of Reference

Version: 1~~3~~2

Date Issued:	~~11 March 2025~~[ ] May 2026
Review Date:	~~February 2026~~May 2027
Document Type:	Terms of Reference

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2	Constitution	2
3	Membership	2
4	Attendance and Quorum	3
5	Frequency of Meetings	3
6	Conduct and Administration of Meetings	3
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Document Status

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1. Role and Purpose

1.1 The Trust Executive Committee (the **Committee**) is responsible for supporting the Chief Executive Officer in the performance of their duties as accounting officer of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and all Executive Directors in fulfilling the duties and responsibilities delegated to them by the board of directors of the Trust (the **Board**).

1.2 The Committee ensures that executive, divisional and broader clinical and non-clinical leadership are involved in decision-making in areas of strategic and operational significance at UHS.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Chief Executive Officer. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Committee as shown in Appendix A.

2.2 The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other management and Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's Sstanding Ffinancial Iinstructions.

3. Membership

3.1 The members of the Committee will be appointed by the Chief Executive Officer and will be:

3.1.1 the Chief Executive Officer;

3.1.2 all other Executive Directors;

3.1.3 the Deputy Medical Directors;

3.1.4 the Director of Strategy and Partnerships;

3.1.5 all Divisional Clinical Directors;

3.1.6 all Divisional Directors of Operations;

3.1.7 all Divisional Directors of Nursing and Professions;

3.1.8 the Director of Midwifery;

3.1.9 the Director of Research and Development;

3.1.10 the Director of Education;

3.1.11 the Deputy Chief Nursing Officer;

3.1.12 the Chief Information Officer;

3.1.13 the Director of Estates, Facilities & Capital Development;

3.1.14 the Director of Communications;

3.1.15 the Director of Planning and Productivity;

3.1.16 the Commercial and Enterprise Director;

3.1.17 the Deputy Chief Operating Officer;

3.1.18 the Chief Pharmacist;

3.1.19 the Director of Operational Finance;

3.1.20 the Deputy Chief People Officer;

3.1.21 the Associate Director Always Improving;

3.1.22 the Associate Director of Corporate Affairs and Company Secretary (**Company Secretary**); and

3.1.23 the Dean of Medicine, University of Southampton.

3.2 The Chief Executive Officer will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the Executive Directors present to chair the meeting.

3.3 Only members of the Committee have the right to attend and vote at Committee meetings.

3.4 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of strategy, risk or operation that are the responsibility of that individual.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or ~~secretary of the Committee~~Company Secretary in advance.

4.2 The quorum for a meeting will be ten members including at least four (4) executive directors and at least one (1) representative from each division. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When a member is unable to attend a meeting, they may appoint a deputy to attend on their behalf. However, this deputy will not count towards the quorum stipulated in 4.2.

5. Frequency of Meetings

5.1 The Committee will meet monthly and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the ~~secretary of the Committee~~Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee no later than three working days before

the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 Any business case~~s~~ requiring approval of additional expenditure is~~is~~ required to be presented to a pre-TEC meeting, chaired by the Chief Financial Officer or a deputy. The purpose of this meeting will be to ensure the business case contains all the necessary information to support ~~TEC~~ the Committee in making a decision.

6.4 The ~~secretary of the Committee~~Company Secretary (or delegate thereof) will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.5 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 *Objectives and strategy*

7.1.1 The Committee will develop the strategy and operational plans for recommendation to the Board, including strategic objectives and quality priorities, working for the benefit of patients, staff, and other stakeholders.

7.1.2 The Committee will monitor and manage the successful execution of strategy and the delivery of strategic objectives, quality priorities, and financial plans once approved.

7.1.3 The Committee will review and discuss matters of significant strategic concern to the Trust and will make recommendations to the Chief Executive Officer in respect of such matters. These matters can include, but are not limited to:

- Material organisational changes, and
- Proposals to significantly increase or reduce the Trust's workforce or otherwise materially alter its composition.

7.1.4 The Committee will review all business cases for consultant posts and approve any business cases for the creation of new consultant posts.

7.1.5 The Committee will review and approve any business cases relating to staff recruitment or education and training programmes in accordance with the Trust's S~~s~~tanding F~~f~~inancial I~~i~~nstructions.

7.1.6 The Committee will approve significant changes to the Trust's estates strategy.

7.1.7 The Committee will seek to identify opportunities for collaborative working with other organisations in the Hampshire and Isle of Wight Integrated Care System.

7.2 *Performance and operations*

7.2.1 The Committee will receive regular reports in respect of the Trust's financial and operational performance, and in respect of the Trust's workforce.

7.2.2 The Committee will monitor and manage quality and safety of patient care and the delivery of patient outcomes.

7.2.3 The Committee will monitor and manage the delivery of services to nationally mandated standards.

7.2.4 The Committee will monitor and manage operational plans and budgets.

7.2.5 The Committee will seek to optimise the allocation of resources.

7.2.6 The Committee will support the active liaison, coordination, and cooperation between divisions, care groups, and services.

7.2.7 The Committee will ensure that issues of equality, diversity, and inclusivity are considered and addressed.

7.2.8 The Committee will monitor staff experience, identifying actions to support the positive engagement, retention, and recruitment of staff.

7.3 ***Resources***

7.3.1 In accordance with the Trust's Standing Financial Instructions, the Committee will receive minutes from the Trust Investment Group and note the decisions made in respect of the matters delegated to the Trust Investment Group.

7.3.2 Where appropriate, such as where there is a material strategic impact, decisions of the Trust to tender for health-related services will be reported to the Committee.

7.4 ***Governance and risk management***

7.4.1 The Committee will ensure that effective management systems and processes are in place to support the delivery of the Trust's strategy and plans.

7.4.2 The Committee will review any changes to the organisational structure of the Trust, making recommendations for change.

7.4.3 The Committee will review significant risks to the delivery of the Trust's strategy, plans and performance and monitor and manage risk management processes and internal controls, including through regularly reviewing the Trust's operational risk register (especially 'Critical Risks' as defined in the Trust's risk management policy).

7.4.4 The Committee will monitor and manage compliance with relevant legislation and regulations.

7.4.5 The Committee will monitor and manage the integrity of management information and financial reporting systems.

7.5 ***Innovation***

7.5.1 The Committee will identify and support the execution of innovation in the delivery of services and areas of activity.

7.6 ***Policies***

7.6.1 The Committee will consider, and approve as appropriate, policies identified by the Chief Executive Officer for its consideration.

8. Accountability and Reporting

8.1 The Chief Executive Officer will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities. The Committee will receive minutes from these sub-committees, and the respective chairs of these sub-committees shall report matters that should be noted by the Committee.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval, other than changes to the membership and attendees, which will require approval by the Committee alone.

10. References

10.1 National Health Service Act 2006

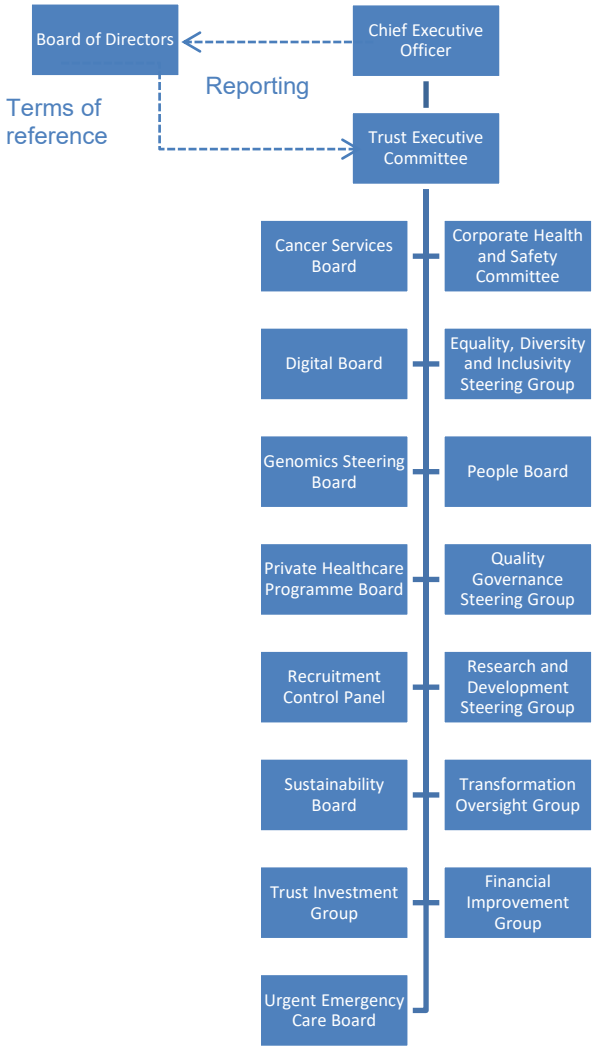
10.2 Code of Governance for NHS Provider Trusts

10.3 NHS foundation trust accounting officer memorandum (August 2015)

10.4 NHS Oversight Framework

10.5 Standing Financial Instructions

Appendix A


Board of Directors
Chief Executive Officer
Reporting
Terms of reference
Trust Executive Committee
Cancer Services Board
Corporate Health and Safety Committee
Digital Board
Equality, Diversity and Inclusivity Steering Group
Genomics Steering Board
People Board
Private Healthcare Programme Board
Quality Governance Steering Group
Recruitment Control Panel
Research and Development Steering Group
Sustainability Board
Transformation Oversight Group
Trust Investment Group
Financial Improvement Group
Urgent Emergency Care Board

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~11 March 2025~~[.] May 2026
Responsible Committee:	Trust Executive Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	~~February 2026~~May 2027
Target audience:	Board of Directors, Trust Executive Committee, NHS Regulators and Staff
Key words:	TEC, Executive, Committee, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Annual review – amendments to 7 to reflect revised emphasis of TEC and role of TIG, amendments to 1.2, 3.1, 3.2, 4.3 and 8.2, and updated reference in 10.2. Insertion of 6.3.~~Minor changes for consistency and to correct typographical errors, and update to Appendix A.
Consultation:	Executive Directors
Number of pages:	8
Type of document:	Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	No
Is this document to be published in any other format?	No