NHS
University Hospital Southampton
NHS Foundation Trust

QUALITY ACCOUNT 2023/24

Part 1:
Statement on quality from the chief executive

1.1 Chief executive's statement and welcome

I am delighted to be able to present this year's quality account which reviews our performance and progress against the quality of services we provide and sets out our key quality and safety improvement priorities for 2024/25.

There is no doubt that 2023/24 has once again been a challenging year for both us and the wider NHS and social care system. COVID-19 has not gone away, and having safely navigated periods of industrial action, the Trust has experienced a period of heightened operational pressures which has seen record levels of patients in the hospital who were medically fit for discharge. This in turn has caused a considerable backlog of patients in the emergency department, and has also sadly resulted in a significant increase in ambulance handover delays and queues within the adult emergency department footprint. A rise in winter infections further challenged us, and our chief nursing officer introduced several temporary enhanced infection prevention measures including wearing surgical masks in adult clinical areas and temporary visitor restrictions to further limit the risk of spreading those infections. All this has presented both quality and operational challenges.

However, providing great care and achieving great outcomes for the people who use our services continues to be at the heart of everything we do. Our Trust value of 'always improving' supports this. We have continued to keep quality high on our agenda despite our operational pressures. We have demonstrated that maintaining quality and safety does not prevent our operational priorities from being delivered, but rather contributes to our successes. Our operational challenges may change, but we know we will always be working towards solutions, and we consider quality and safety to be an essential part of that work.

This report highlights some of the many successful initiatives which have improved the quality of patient care we have provided over the past 12 months, an overview of our 2023/24 quality priorities as well as our quality priorities for 2024/25. We are proud we have been able to keep our quality focus and achieve most of what we set out to do during 2023/24 to keep improving the experience for the people who use our services.

We are also proud of our long-standing commitment to patient safety and continue to focus on improving the quality of safe care we provide. We have successfully run our clinical quality assurance framework which monitors standards in our clinical areas through quality care dashboards, peer review walkabouts and our clinical accreditation scheme to ensure we have good oversight of our clinical performance across the organisation. The framework focuses performance against key quality metrics including patient safety, effectiveness, patient experience, and outcomes and gives us a rich seam of intelligence to help us to meet our Trust value of being 'better every day'. Our commitment to involving our patients and our staff in quality and safety, our focus on reducing unwarranted variation in outcome and specifically reducing inequalities in quality and safety, our appetite for learning and our mission for continuous, sustainable, and accelerated improvement act as key drivers for our Trust strategies. We will continue to focus on these principles to achieve the best care for our patients and families.

I want to acknowledge how hard our staff are working to keep each other and our patients safe, to innovate and to respond to changing circumstances. Colleagues across all our services have worked ever more closely this year with our partners. As we move further towards working as a whole health and social care system these trusted relationships are proving critical in our ability to respond.

To the best of my knowledge, the information contained in this document accurately reflects our performance, provides a true account of the quality of the health care services we provide, and where we have succeeded and exceed in delivery on our plans. I hope you find this account informative and see that our patients are very much at the centre of everything our colleagues do.

David French
Chief Executive Officer
27 June 2024

1.2 Introduction to this report

Every year all NHS hospitals in England must prepare and publish an annual report for the public about the quality of their services. This is called the quality account and makes us at UHS more accountable to our patients and the public which helps drive improvement in the quality of our services.

Quality in healthcare is made up of three core dimensions:

Patient experience
how patients experience the care they receive.

Patient safety
keeping patients safe from harm.

Clinical effectiveness
how successful is the care we provide?

The quality account incorporates all the requirements of The National Health Service (Quality Accounts) Regulations 2010 (as amended) as well as additional reporting requirements. This includes:

- How well we did against the quality priorities and goals we set ourselves for 2023/24 (last year).
- It sets out the priorities we have agreed for 2024/25 (next year), and how we plan to achieve them.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts.
- Additional information about our progress and achievements in key areas of quality delivery.
- Stakeholder and external assurance statements, including statements from Healthwatch, our Council of Governors, Hampshire and Isle of Wight Integrated Care Board and Southampton County Council's Health Scrutiny Committee.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement

This section provides a look back over the 2023/24 quality priorities at UHS and sets out our quality priorities for 2024/25.

2.1.1 Progress against 2023/24 priorities

Last year we continued our ambition to deliver the highest quality care shaped by a range of national, regional, local, and Trust wide factors. During the year we experienced unprecedented demand on our services, with flow, capacity, infection prevention and safety all presenting challenges. However, we were confident in our ability to keep a focus on our quality priorities, and our teams worked hard to achieve their goals even in these difficult circumstances. We are proud to present what we have been able to complete, and how our successes have continued to drive forward and improve the quality of what we can offer the people who use our services.

Overview of success

No	Quality Priority	Progress
	**We will improve care for people with learning disabilities and autistic (LDA) people across the Trust. We will support staff delivering this care**	**Achieved**
	Supporting patients, service users and staff to overcome their tobacco dependence via a smoking cessation programme	**Achieved**
	Ensure carers are fully supported, involved and valued across all our services by developing our carers support service across the Trust in partnership with Southampton Hospitals Charity	**Partially achieved**
	**Put patients at the centre of transforming the way we deliver care, enabling their voices to improve the quality of care and outcomes for all**	**Achieved**
	**To develop our clinical effectiveness process, connecting to the Trust's Always Improving approach to measuring, undertanding and using our outcomes, to improve patient's care**	**Achieved**
	Developing a culture where all clinical staff have a basic knowledge of diabetes	**Achieved**

PRIORITY ONE
''We will improve care for people with learning disabilities and autistic (LDA) people across the Trust. We will support staff delivering this care''.

Why was this a priority?

The Care Quality Committee (CQC) and NHS England (NHSE) both identified that people with LDA have faced huge inequalities when accessing and receiving health care. Research from the NHSE 'learning from deaths in patients with learning disabilities and autism (LeDeR)' service improvement programme (2021/22) showed that people with LDA die earlier and do not receive the same quality of care as people without a learning disability or who are not autistic.In response to this, we set our ambition to meet the learning disability improvement standards which were developed to help NHS Trusts measure the quality of care they provide to people with LDA. We set this quality priority to help steer us towards achieving the first steps of that ambition.

What have we achieved?

We successfully re-established our LDA working group in November 2023 with an updated terms of reference, and developed an improvement plan using the NHS learning disability improvement standards which highlight key areas for improvement within the Trust. This plan will be the focus of the LDA working group who will now be working with leads from across the Trust to support each workstream.

The LDA team has been re-positioned into our virtual enhanced care group which sits in the Division B management team. This move has aligned the team more effectively with relevant partner services, enabling joined up working with key partners and facilitating improvements in operational and governance support, leadership, and peer support. It positions the LDA team in a stronger space to ensure closer working relationships and learning opportunities to help drive their agendas forward and improve the quality of their services.

The Trust is now an active participant in the Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB) steering group, which has been responsible for planning, and implementing the Oliver McGowan Mandatory Training developed by Health Education England. This training on LDA is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. It is the government's preferred and recommended training for health and social care staff.

E-learning for the training launched here in August 2023, with over 7,850 staff trained at the time of writing (51% of total staff numbers). Work is now underway in partnership with the Trust training, development, and workforce team to launch the Oliver McGowen Tier One webinar. This training is delivered by an external training provider and is for all non-patient facing staff. A training provider who will deliver Tier Two (for all patient facing staff / those with patient contact) has been identified, and we are expecting dates for these full day seminars to be available by Autumn 2024. The LDA team are collaborating with the steering group in a task and finish group looking at how the Tier Two and subsequently Tier Three competencies on the core capabilities framework will be fully met.

In preparation for the roll out of this extended training, we have been growing our numbers of local LDA champions who are training to provide direction and support for staff. Our champions have worked closely with us during the year, helping to shape our approach and being generous with their time and ideas.

We have also worked hard to improve resources for our staff to use in our clinical areas. Successes this year have include providing sensory boxes for all clinical areas, funded by the HIOW ICB. These boxes include noise cancelling headphones, fidget toys, communication books and visual cards to support patients and ward staff. The funding will also provide badges for our LDA champions to help staff and others easily identify them.

The LDA team have established links with the parent carer forum (PCF) for the local area and are now attending regular events. A representative from the PCF has been invited to join our LDA working group to help represent the parent carer voice and work with us to co-design future services and initiatives. The LDA team are working with the Trust lead for patient experience to develop this aspect of the LDA workplan over the next year.

Key areas identified for further improvement.
The Trust LDA working group will identify further areas for improvement in line with the improvement standards.

How ongoing improvements will be measured and monitored.
The Trust LDA working group will monitor achievement of the improvement actions set out in the workplan , and report accordingly on the successes through their care group and divisional governance channels.

What our staff and patient carers tell us

PRIORITY TWO
"Supporting patients, service users and staff to overcome their tobacco dependence via a smoking cessation programme".

Why was this a priority?

Smoking remains the leading preventable cause of premature death and disease, responsible for half the difference in life expectancy between the richest and poorest in society. Smoking tobacco is linked to over one hundred different conditions and just over 500,000 hospital admissions each year, with smokers being more likely to be admitted to hospital than non-smokers.

There is good evidence that stopping smoking improves recovery for a range of acute conditions, and slower decline in chronic conditions. Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities. In 2019 the NHS Long-Term Plan stated that by 2023/2024 all people admitted to hospital who smoke would be offered NHS-funded tobacco treatment services. A new universal smoking offer would also be available as part of specialist mental health services for long-term users of specialist mental health and in learning disability services.

We agreed that becoming a smoke-free site and supporting people to overcome their tobacco dependency via a smoking cessation programme would aid the local community, our people, and our environment.

What have we achieved?

We adopted a collaborative approach to this priority, involving all staffing groups across UHS, service users, external support from the ICB, Southampton City Council and other health settings that have already gone through this journey.

We ran a smoke-free site patient focus group in 2023 which focused on hearing patients views on our plans to go smoke-free. The patients were invited from our involved patient list (patients who can give feedback on and support one off projects), and the focus group was also advertised to our Foundation Trust members group. Patients were asked for feedback on documents, and signage that would be going up to refrain people from smoking around the hospital site. Monthly meetings were initially held, until the group felt there wasn't enough updates to warrant this, so involvement continues to be via email at their request.

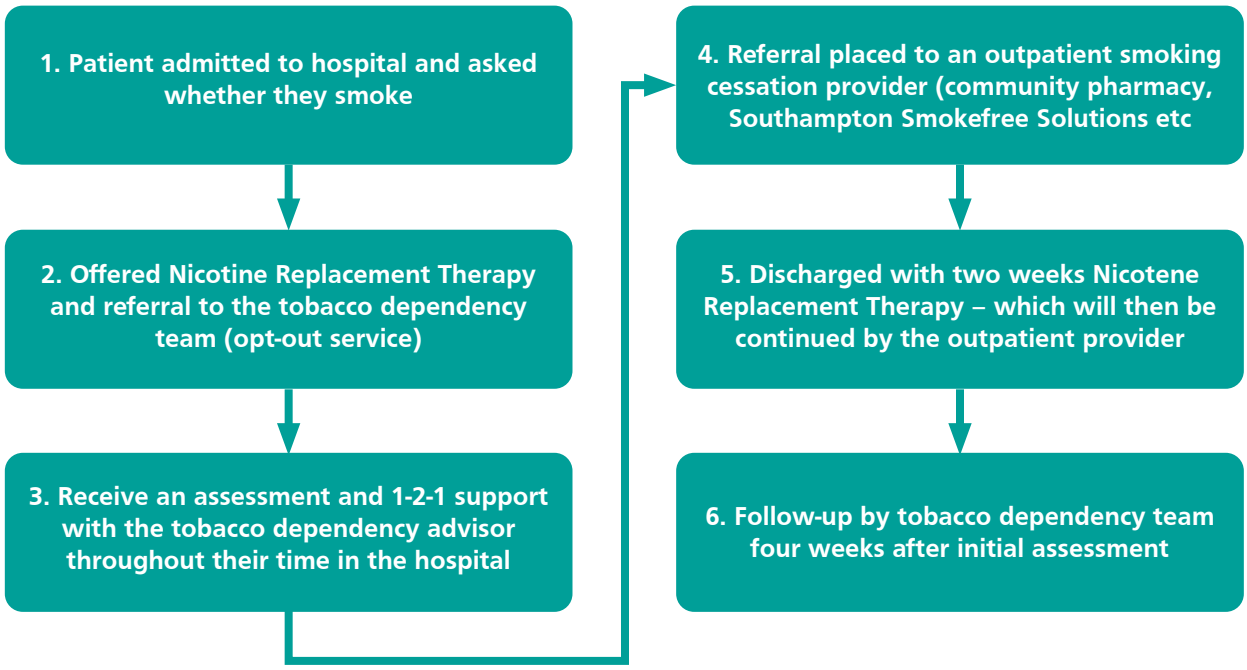
We have published our smoke-free policy which sets out the expectations and guidance for working at a smoke-free site, and our patient and visitor guide which sets out why and how we have become a smoke-free site to our community.

We have included our stance on vaping (e-cigarettes). We support the safe and considerate use of vapes, away from children, and for short term use while on our NHS site and have published guidance on this. This follows current evidence and UK government advice which confirms e-cigarettes or vapes can be an effective short-term aid for adults to quit smoking.

Through the year we have run staff engagement sessions, published advice to our staff on how to approach someone smoking onsite, and completed a week-long 'no smoking day' calendar of events.

We have established a fully trained tobacco dependency team working in the hospital to support patients to not smoke while they are being treated at UHS. There is also an advisor working in the outpatient setting supporting the patients once they have returned home. The team provides the most appropriate alternatives to patients who are tobacco dependent, including timely access to nicotine replacement therapy (NRT) and specialist tailored support. Patients can now also get eight weeks of NRT products for a one-off prescription charge (or free if they don't pay for prescriptions).

We have formalised and described our patient journey as follows :



To help promote and support our policy, we have recruited 30 smoke free champions ,and set ourselves a challenge of recruiting another one-two per day. If we can achieve this, it will enable us to recruit approximately 500 staff members per year. Our champions receive three hours specialist training and are the able to provide patients with brief advice, refer them for specialist support from the tobacco dependency team and advise on the free NRT that can be provided to our inpatients during their stay.

The NHS advises that people with mental health problems, including anxiety, depression or schizophrenia are much more likely to smoke than the general population and tend to smoke more heavily. They also die on average 10 to 20 years earlier than those who don't experience mental health problems, and smoking plays a major role in this difference in life expectancy. Smoking can also interfere with the way medicines such as anti-depressants work, so this year we have been working closely with our mental health teams to find the best ways to support people with mental health challenges who could benefit from stopping smoking. For our staff, our occupational health department now runs a stop smoking programme to support them to become smoke free .The 12-week programme includes weekly follow ups, behavioural change support, carbon monoxide readings, free NRT or advice on best suited treatment for the individual and information and resources to help them quit. The programme involves an initial consultation to assess their current situation and needs to start them off, and regular follow ups.

We have devised the IT changes we would like to bring in to improve our service and referral process, and staff can now download a smoke-free MS Teams background and email signature to show their support.

In December 2023 we began removing smoking shelters across the UHS sites.

At the time of writing, we have successfully supported over 1,130 in-patients with a self-confirmed quit rate of 45.6% at 28 days. Most patients now have their smoking status recorded which makes it easier to the identify those patients who we can offer support to.

We have also supported over 109 outpatients who have successfully achieved a 60% quit rate.

What our staff tell us

Key areas identified for further improvement:

We will continue to work to ensure the Trust's plan to go smoke-free is supported and implemented.
We are in the process of developing our virtual learning environment (VLE) package for UHS staff to promote knowledge and skills at meeting the needs of our smoking population, and in the coming year we aim for at least 100 of our staff to have complete the training. We aim to continue to roll out education to ensure medical staff, ward-based staff, emergency department (ED) staff and new students through face to face and online sessions.

Our data collection process requires streamlining to ensure we can evidence our progress. We would also like our patient proforma to be available electronically, and to develop our metrics to include a four-week follow-up to evidence successful quit rates following inpatient interventions.

We aim to be accessible to more patients and not be limited by postcodes and continue to find ways to support patients with mental health issues to quit.

We will work towards securing a funded service model to continue to support this work.

PRIORITY THREE

''Ensure carers are fully supported, involved, and valued across all our services by developing our carers support service across the Trust in partnership with Southampton Hospitals''.

Why was this a priority?

At the beginning of 2021 we launched our new carers strategy to develop and improve the care and support we provide to unpaid carers while their cared-for person receives treatment at the Trust. In the strategy we set out to learn from organisations that get it right (including community and mental health NHS Trusts, charities, and social care), and translate that learning into an acute setting.

The strategy is funded by our Southampton Hospitals Charity which exists solely to make a difference to patients, families, and carers using UHS services. Funding this project through the charity is fully in-line with the charity's objects and purposes and is real opportunity for the charity to make a difference (which is what our donors tell us they want their gifts to be used for).

The pandemic disrupted our progress against our strategy, but by highlighting this as a quality priority, and with the commitment of support from our charity, we aimed to accelerate the work to improve the support we could offer our carers.

What have we achieved?

Our carers service has now been established and is run by a team of volunteers under the supervision of our carers lead. We have agreed a process where the carers service receives referrals from ward staff but also visits wards to actively seek referrals. Carers support service posters and leaflets have been displayed widely across the organisation encouraging carers to self-refer, with eQuest referral and eDocs now working well for recording interventions.

We have grown the support the team can offer over the year to include creating personised plans to signpost carers to services best placed to help them,and access to rest breaks and time away from the wards during long-stay in patient visits. We can also now offer blue badge parking, food vouchers, temporary beds, and advocacy to help ensure their voices are heard in the hospital and the wider community. The support we provide includes offering emotional support to carers via telephone or in person if they are onsite, signposting to other services in the community liaising with complex discharge teams and mediating on issues around discharges.

We have completed a programme of carers listening events aiming to put patients at the centre of transforming the way we deliver care. Listening lunches covered topics such as our discharge processes and other key areas.

Key themes arising from the events included: improving communication between UHS staff and carers, developing ways to improve fundamentals of care, how to identify informal / non-paid carers, considering the emotional and practical impacts on carers and how we might care for carers. They covered improving signposting and awareness of local resources for carers and increasing the visibility of the carers support service in the hospital and in primary care.

During the year we introduced weekly ward rounds in medicine for older people (MOP) wards to identify carers that need additional support. We also launched a carers café at in our MOP discharge lounge on Wednesdays for carers to book one-to-one session with the carers lead and our newly appointed carers support worker.

We have successfully established joint work with local partners. We represent UHS at the Hampshire Carers partnership board, Southampton Carers partnership board and work in partnership with other NHS Trusts including Southern Health, Solent NHS trust and Portsmouth Hospital. We have established links with the Children's Society and No Limits to support young carers and are attending community events to create awareness and support UHS carers in the community. We now attend Hampshire County Council and Southampton County Council discharge huddles to gain understanding of discharge processes from a carer's perspective, and we have introduced mediation in complex discharge situations involving carers.

What our carers tell us

Key areas identified for further improvement
We will continue the workstreams to put patients at the centre of transforming the way we deliver care, enabling their voices to improve the quality of care and outcomes.

We will look at how best to use the intelligence we gained during 2024, aiming to develop a 'pathway to support', and launch further initiatives in our carers raining packages.

We will appoint a charity-funded carers support worker.

We will develop an even more comprehensive package of concessions and vouchers to help support carers and their cared-for person.

How ongoing improvements will be measured and monitored.
The Charity will develop their own internal governance framework which will work in collaboration with the Charity CEO to monitor improvements.

PRIORITY FOUR
"Put patients at the centre of transforming the way we deliver care, enabling their voices to improve the quality of care and outcomes for all".

Why was this a priority?
We frequently see in our patient feedback and complaints that our patients have not always felt involved in their care, or that they have not been informed on decisions about that care. We recognise that experiences can vary, but we particularly noticed issues where the care of one person spanned several of our services and departments, or where there is less support available depending on disease type. For example, cancer care has a much more support in place for patients to access than medicine has for respiratory disease. In the same way we have been working with and listening to carers, we wanted to recognise and respond to what our patients were telling us by getting them more involved in how we might make improvements to the services we provide. We wanted to focus on how they felt we could improve their experience of using those services, growing a culture whereby we always ensure that our service changes are viewed through the lens of a patient, their family, and friends.

By setting this quality priority our experience of care team committed to ensuring that clinical services are given prompt and 'real time' feedback and are informed and empowered to make changes with the patient voice embedded in their service changes.

What have we achieved?
During 2023/24 we focused on creating more opportunities to hear the patient voice recognising their stories are a continuous improvement tool which can help us identify areas where we can transform patient and carer experience.

We re-introduced patient stories for Trust board meetings, inviting people who use our services to attend to share their experiences with our senior leaders. Patient stories can be positive, negative, or combine elements of both. We encourage our Board to learn from what they hear and use the intelligence to help shape their service improvement decisions going forward. Recently, we had a patient sharing their experience of accessing wig services at UHS. The experience was so poor that it prompted the experience of care team to work with the John Lewis Partnership to provide options for wigs for Black or Asian patients.

During 2023 we started filming patient stories for staff training purposes and are finding these provide valuable insights on how staff can improve on many different aspects of care. The stories covered

the experience of being an in-patient in cancer care, the value a patient experienced from being part of the pelvic mesh support group, the experiences one gentleman had through the treatment and end of life journey he and his wife went on, and a new mother's experience of immediate skin to skin contact following an elective C-section. Our staff tell us that hearing the 'voices of patients' directly give them a greater understanding of the issues and brings reported experience to 'life', providing real insight for them to help guide improving the quality of the care they offer.

For many years we have used the NHSE Friends and Family Test (FFT) as an important way of prompting our patients and their families to send us feedback, but we have not always had a good response rate from our service users. This has meant the value of the patient voice has not always been as great as it could have been. This year we have focused on the areas where feedback has been historically poor to try to improve how much feedback we can encourage.

Responses from our ED were particularly low, so we trialled a new SMS text survey initiative in which patients directly discharged from the department receive an SMS text message with a survey link 24 hours after discharge. There is a sensitively set criteria established for recipients of the SMS survey which excludes attempted suicide, mental health, and miscarriage. Originally, texts were sent at 3pm, but after our trial we changed this to 7pm as we found the most effective time for feedback was between 6-9pm. Since the trial began, there has been a substantial increase in feedback responses. In the three months before the SMS survey was launched the department received 24 responses. After the survey went live, we received 424 responses in the first three months, giving us a much richer seam of intelligence that we can now work with going forward.

To create more opportunities to hear our patient's voices we have established multiple patient groups who we can work closely with. The pelvic mesh service support group started in April 2023, now runs monthly , and is the first of its kind across all pelvic mesh centres. Our experience of care team supported the creation of this group, after the clinical nurse specialist (CNS) and psychologist in the mesh service reported they were hearing from women who didn't feel listened to, felt alone, or had no one to talk to. Multiple guest speakers have attended the groups sessions to offer the women a chance to ask questions outside of their usual clinic setting and hear more about the support these services provide, which includes a pain consultant, physiotherapist, psychosexual therapist, and a urologist. Patient feedback has been at the centre of this group since it began. They have their own feedback survey where patients can share ideas for improvement, share any group practices being adopted, and we offer an evening session for those that work during the day and face-to-face sessions.

During 2023 one of our respiratory consultants decided to explore how to reduce the number of frequent exacerbations within the chronic obstructive pulmonary disease (COPD) patient group . A focus group was held at UHS in October 2023 with patients, their careers, and a mix of staff from the COPD care team and experience of care team attending. Several topics were explored, but two key feedback points were identified : that a named person in primary care was highly beneficial to patients, and how the COPD team can increase the uptake of pulmonary rehabilitation by setting realistic expectations for patients and matching abilities in groups. In response, the service now makes sure they have record of each patients' named contact in primary care, and the rehabilitation team has changed some of its approaches to align with the patient feedback. Further focus groups are now scheduled to continue the collaboration. In June and September 2023 our head and neck cancer CNS invited patients to meet to explore their clinical pathway and any identify any improvement opportunities from diagnosis to treatment. Feedback from this group included advising the waiting area in our radiotherapy treatment centre Compton House was difficult to find and quite 'boring' to wait in. In response we now have a large waiting room, with a television and a coffee and snack bar run by the League of Friends and are working on getting some volunteer companions to support patients in this area and support wayfinding.

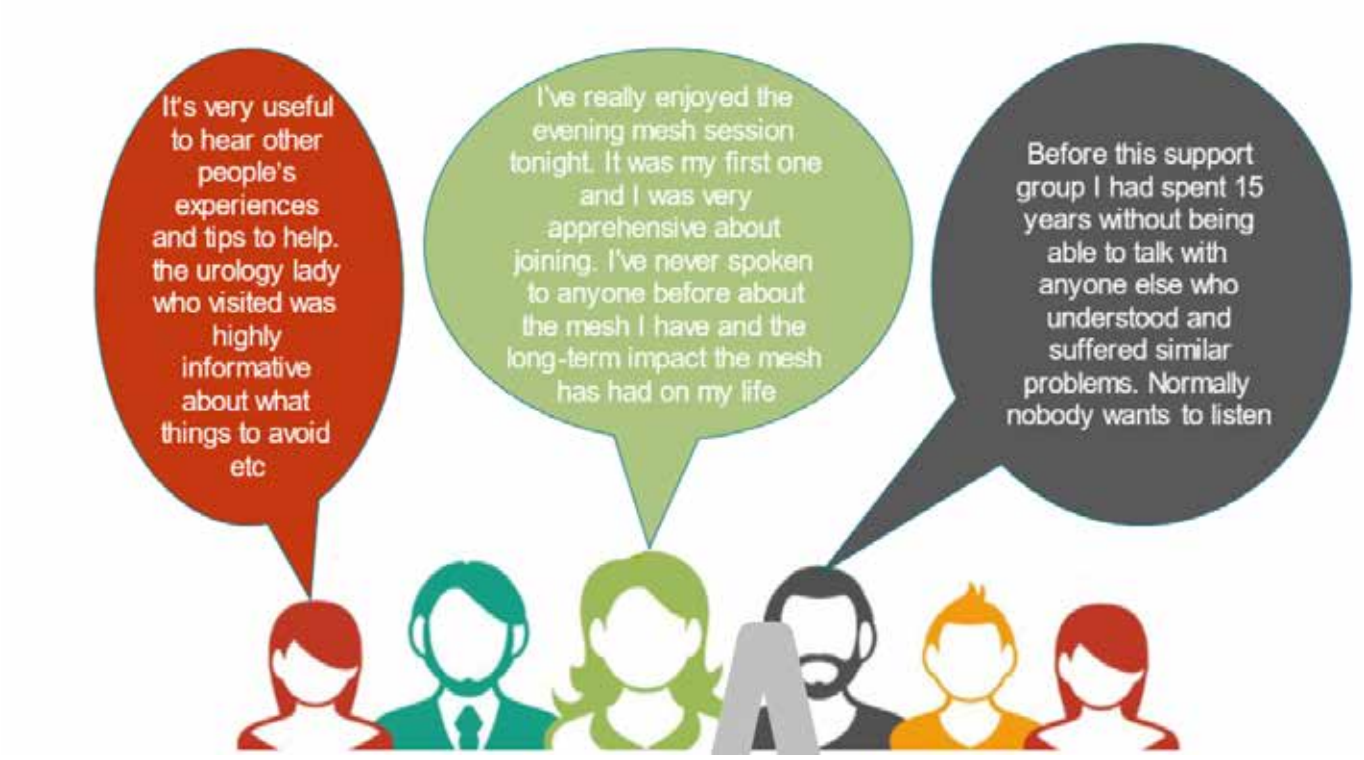
We launched a trauma and orthopaedic focus group in 2023 which aimed to explore ways in which patients can be supported in making difficult decision choices (such as either having their leg amputated or reconstructed). The aim of the first session was to understand how patients made their decisions and how supported they felt during that process. The first session ran December 2023, with a second one in January 2024. Patients fed back that they felt they had limited choice or discussion about options, so the team are now looking at collaborating with patients with lived experience to develop a shared decision-making grid for leg amputation versus reconstruction.

A cystic fibrosis (CF) focus group met for the first time in 2023.The group was led by a specialist dietitian to explore how useful the annual review and report that CF patients receive was. Patient feedback from

the group has prompted changes to how their reports are written which includes reducing medical reduce jargon and increasing explanations for the terms used to make it easier for patients to understand.

Some of the projects patients from our involved patients list have been involved in during the last year include supporting patients in completed surveys about their time spent as in-patients, and they were also interviewed by the Call 4 Concern project manager to collect baseline data about their experiences (this initiative is explained later in document). Patients reviewed palliative care patient information leaflets and our palliative care strategy to advise and represent the patient voice in this work. Patients were sent a link to a pilot self-referral tool for breast issues and were asked to give feedback on how well it worked and how they felt about using it.

What our patients tell us



Key areas identified for further improvement.

At the moment, we can only access the FFT results by manually searching through a database. We are planning to develop a more user-friendly approach to ensuring engagement.

The Trust is a regional centre for many disease types, but there is inequality in provision of support services . We have agreed to set a new quality priority for 2024/25 to address this issue, which can be found later in this document.

How ongoing improvements will be measured and monitored.

The experience of care team monitors its progress internally and reports to the quality committee and Trust board for oversight.

PRIORITY FIVE

"To develop our clinical effectiveness process, connecting to The Trust's 'always improving' approach to measuring, understanding, and using our outcomes; to improve patient's care".

Why was this a priority?

As an ambitious organisation, we want to support our people to achieve world class outcomes by doing the right thing, at the right time, for the right person.

Getting those elements 'right' is essential to being as effective as we can and to making a positive difference in the lives of the people and population we serve. By focusing on the outcomes, we help people to achieve, we can understand how effective we are and where we need to make improvements.

We know that delivering effectiveness by 'doing the right thing at the right time for the right person' involves effort at every level of our organisation. We recognise there are many notable examples in our organisation of where teams deliver outstanding outcomes for the people they serve. However, there are also areas where this is not the experience of people using our services.

Our aim last year was to be able to systematically measure and understand outcomes in all specialties across our organisation, benchmarking against our previous performance and best practice nationally to understand where we are achieving the best outcomes and where we need to improve for the people we serve.

We felt this would allow us to be assured we are a learning organisation that understands where it needs to improve and takes action to prioritise improvement activities as well as knowing when to celebrate and share our success.

What have we achieved?

We have worked collaboratively to develop our clinical effectiveness process across the Trust with informatics, governance and management teams, clinical effectiveness leads as well as those committees we report to. There has been a willingness and notable changes in conversations and approach to engage in clinical effectiveness from clinical teams which is welcomed. The inclusion of patient representation on the clinical assurance meeting for effectiveness and outcomes (CAMEO) panel has been a very positive change , and now ensures conversations focus on what matters to patients.

The CAMEO template has been changed to focus discussions on areas the specialty is proud of (strong or improving outcomes), areas for improvement (poorly benchmarked or worsening outcomes) and planned actions. We have encouraged the use of run and/or statistical process control charts along with benchmarking where available. It also has a focus on patient reported outcome measures (PROM's), and new procedures as well as audit and service evaluations. Details of the national institute for health and care excellence (NICE) and quality standards as well as national and regional reviews are included to cover breadth of clinical effectiveness. This approach has been reflected through our board reporting.

We have re-organised how the clinical effectiveness team work, aligning each team member to a division giving a named link which helps to deepen understanding and improve links with governance and improvement activities locally. We have worked with specialty teams to ensure the metrics presented focus on clinical outcomes, rather than process measures. Support is offered ahead of CAMEO meetings to decide metrics to include and conversations during the meeting include what support is required to enable the collection of outcomes. This combined with the new reporting tool for CAMEO has meant we have a far greater number of specialities utilising data over time.

We are working with informatics to establish a core set of clinical outcome measures which are meaningful to patients, which can be reported centrally (starting with surgical specialities). This, along with creation of redcap databases (secure web applications for building and managing online surveys and databases) for several specialities, will support areas that currently struggle to report outcomes. This is a challenge due to capacity within informatics as well as the small number of clinical outcomes reported onto trust systems.

We have started to develop an education strategy and platform to support staff with several tools used in clinical effectiveness as well as clarity on where and how to record and evidence audit and service improvement.

The updated CAMEO review process aims to improve care group and divisional oversight of where outcomes are being collected, where these are positive/ require improvement and related action plans. This is also increasing oversight of where there are not outcomes reported and the support needed for these areas. We are exploring how we bring clinical effectiveness (outcomes in particular) into the strategy and transformation process the board undertake with care groups/specialities. We are identifying opportunities to bring these together which might save care groups some duplication and feel more joined up for them.

We have started conversations to develop a clear process to connect clinical outcomes to research and improvement teams. We have further events planned to include visiting organisations who are further ahead in this domain.

Quality and patient safety partners (QPSP) have attended 80% (8/10) meetings since they were recruited. Their input has been invaluable to bringing the patients view and priorities into discussions. We are now advertising for more QPSPs to join the panel.

We are now able to evidence that we have increased the number of specialities reporting outcomes. We were aiming for an increase from 80% to 95%, but unpredicted pressures have meant we have only increased to 85% so far. There have, however, been improvements in the quality of metrics being discussed at CAMEO. As we become more streamlined in our focus on clinical outcomes only (without the inclusion of performance measures which have previously been included), we may find that the number of metrics reported to CAMEO reduce. 11% (10/87) areas have included PROMs in their reporting against our target of 25%. Unfortunately, IT resource has meant de-prioritisation of including PROMS on my medical record (MyMR is a personal health record provided to patients by UHS), so specialities have had to use alternative methods.

We have successfully co-designed and implement an updated outcomes reporting tool for specialities that incorporates data over time. We will have 25% (22/87 specialities reporting using this) by the end of 2024.

Key areas identified for further improvement

We will work with specialties who are not currently reporting outcomes to CAMEO outside of the annual process, to start the collection or reporting of outcome measures and to ensure successful contribution to CAMEO going forward.

We will continue to work with specialties to consider the metrics collected and ensuring this focus on clinical outcomes, not process measures and that all focus on what matters most to patients. We will ensure we are sighted on less good as well as the excellent outcomes.

We plan to continue working with informatics on clinical outcome data that can be identified from trust held data and national benchmarking tools and support data collection for teams.

We will launch our educational platform to support staff develop clinical effectiveness in their area.

We have agreed to finalise and get Trust Board sign off on our revised strategy during 2024.

We will set a 2024/25 quality priority to link the effectiveness agenda and strategy as part of an integrated approach quality across the organisation.

We will start to celebrate and share success internally and externally (as appropriate) with support of the communications team.

How ongoing improvements will be measured and monitored.

We will continue to report to quality committee and quality governance scrutiny group with an annual report provided to the Trust executive committee which will cover progress against the priorities and metrics above.

PRIORITY SIX
"Developing a culture where all clinical staff have a basic knowledge of diabetes".

Why was this a priority?

One in five hospital adult inpatients at UHS is someone living with diabetes This is approximately 220 inpatients per day , and it is predicted that this number could increase to one in three inpatients over the next ten years.

Despite there being guidance in place that covers most clinical situations related to diabetes, we still see errors, harms and near misses where guidance has not been accessed or followed. Staff often refer straightforward diabetes cases to the diabetes team which could have been managed at local level if staff were educated, trained and confidant. We also know that action on deranged blood glucose levels is not part of an essential set of actions (situations that automatically trigger an emergency or safety response), and we knew we would like to move to a culture where diabetes assessment and treatment is recognised and managed in the same way as other medical emergencies.

We set our quality priority aiming to promote a standard whereby all ward-based clinical staff would be delivering and supporting safe diabetes care, while also being clearly aware of the risk of neglecting diabetes care or not following Trust guidance. This would improve patient care and safety and allow the specialist diabetic team to address the more complex issues for patients preventing delays in care.

What have we achieved?

Following a collaborative scoping process with our staff and supported by an education grant from Diabetes UK (one of only two hospitals in the country to be granted this), we launched our 'start with the diabasics' initiative in May 2023.

The initiative was designed to raise the profile of diabetes care and management for inpatients across UHS, outlining the key guiding principles that all staff should be aware of. We visited every ward during the launch, delivering themed merchandise (e.g., mouse mats, posters, pens, badges, lanyard cards) to give staff a constant reminder of the need not to forget about delivering the basics of diabetes care for their patients. We presented the diabasics initiative internally at the 'we are UHS' week in October 2023, as well as online at an NHS England patient safety meeting.

To provide the education and training required to support the initiative we rolled out an extensive education programme. A 'diabasics' introductory video was created which has been shown at all Trust staff inductions since July 2023 with over 540 staff now trained at time of writing.

For medical staff, we have completed an education programme for all year one and year two doctors, and over 30 regional trainee doctors received face-to-face education from a diabetes consultant. This included training about what their professional responsibilities in relation to diabetes care is. Our ED senior doctors also received bespoke training to support 'front door' emergency care from the same consultant, and trainee anaesthetists were supported by the diabetes team to develop a diabetes e-learning resource aimed at anaesthetists which has gone live.

Our nursing staff have been working with our diabetes specialist nurses who have delivered education to around for 45 diabetes link nurses, resulting in all ward areas now having a named diabetes link nurse. During October, 35 nurses attended inpatient training events organised by the diabetes team for Band 2 – 4 staff.

For all staff we have redesigned our app-based diabetes guidance to include sections specifically aimed at surgery, oncology, the acute medical unit, and our ED.

A diabetes newsletter is now sent out every quarter to all nursing staff from the diabetes team, and it is available for wider staff groups on our internal sutranet. We regularly participate in national diabetes themed weeks (e.g., hypoglycaemia, insulin safety) with the specialist team visiting wards with educational resources and these visits are well received. We won the national award for 'insulin safety week' given our portfolio of work to date in this area.

A 'ketone Wednesdays' initiative has been created in response to overuse of blood ketone testing (at an estimated waste cost of £100,000 per year). Posters have been delivered to all wards and all meter boxes labelled, and we are monitoring to see what impact this makes.

All clinical staff are now invited to participate in reflective conversations with members of the diabetes team after near misses in diabetes cases related to medication or gaps in care provision are reported. This helps our staff consider, make sense of, and learn through their experiences both as they occur and afterwards.

The diabetes team triages referrals carefully to ensure those referrals are appropriate. Where referrals are not appropriate, the team advises staff on actions and provides support. We have worked with our IT development team to improve glucose related data visibility on CHARTS (a clinical app used to record information for inpatients and outpatients) for clinical teams to help raise awareness of the need for action on deranged glucose levels.

The success of our work has been recognised nationally: our lead diabetes specialist nurse and the diabasics initiative were both shortlisted for a national quality in care diabetes awards in October 2023, and the initiative included as a case study on the Diabetes UK charity website as an example of good practice that could be reproduced elsewhere. A poster on diabasics was also presentation at the national diabetes UK professional conference in London in April 2024.

What our staff tell us

Key areas identified for further improvement.

Errors, harms and near misses continue to occur. There has been at least one organisational wide learning factsheet released linked to a near miss based on staff misunderstanding and not appreciating dangerously high blood glucose levels. We aim to continue to deliver education in response to learning from incidents, and education focused on clinical areas we have not yet delivered our programme to. We will continue to try to improve our diabetes resources as needed based on specific departmental needs and requests.

There is a need to embed national guidance (GIRFT) on diabetes guidance related to the ED and surgery to ensure safe, consistent processes are followed.

How ongoing improvements will be measured and monitored.

A continuation of reviewing referral numbers and appropriateness of referrals to our service (e.g., were basic processes followed first using easily accessible guidance).

A continuation of reviewing numbers of adverse events, near misses, as well as identifying themes, meeting related individuals or teams, seeking to adapt processes and education as needed around delivering diabetes care.

We will survey staff about diabetes confidence at staff training events for diabetes.

2.1.2 Priorities for improvement 2024/25

This section presents our quality priorities for 2024/25. The quality priorities for this year have been developed by reflecting on the continued operational pressures from the last year, with a real focus on the provision of high quality, patient centred care for all our patients. This year's priorities have been designed with support from the executive team, governors, and clinical teams to make sure we are focusing our attention on the key areas which will make the difference to the patients accessing our services. Our priorities are built around our ambitions and intention as a Trust to deliver well-led, safe, reliable, and compassionate care in a transparent and measurable manner.

We have continued to align our priorities to the three core dimensions of quality:

- **Patient experience - how patients experience the care they receive.**
- **Patient safety - keeping patients safe from harm.**
- **Clinical effectiveness - how successful is the care we provide?**

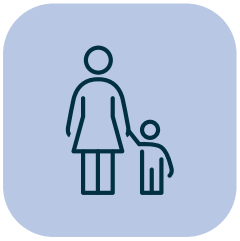
To determine our priorities, we have consulted with key stakeholders including our staff, our Trust's quality committee, the Trust's board, the Trust executive committee, commissioners, patient representatives (through our local Healthwatch group) and our council of governors.

After consultation we assessed each priority by asking:

- Have our patients told us this is important?
- Have our staff told us this is important?
- Will this have a significant impact on improving quality?
- Is this feasible given our resources and timeframe?
- Does previous performance reflect potential for improvement?
- Does this improvement tie in with national priorities or audits?

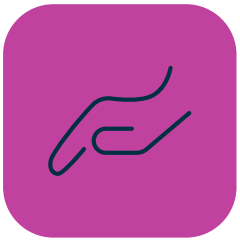
We believed we have chosen priorities that reflect our long-term strategic position, the key areas which will make the difference to the patients accessing our services as well as being responsive to the emerging challenges across the healthcare system. The finalised priorities were presented to the quality committee in March 2023 and were approved by the Board of Directors, in April 2023. The quality committee will provide governance oversight and support to ensure that the quality priorities progress and successfully achieve the required outcomes within the year.

2024/25 Quality Priorities



Patient experience – how patients experience the care they receive

1. Person-centred practice: exploring the provision of a support centre for people using our services
2. Staff choice: creating a behaviour framework behind our values, bringing them to life to improve staff and patient experience (year one)
3. Volunteering: 'a new focus'



Patient safety – keeping patients safe from harm

4. Acuity and deteriorating patients: continuing to improve how we keep patients safe from harm
5. Fundamentals of care

Clinical effectiveness – how successful is the care we provide?

6. Improving our Morbidity & Mortality (M&M) meetings
7. Develop the Trust's approach to reducing the impact of health inequalities (HI) and establishing ourselves as an anchor institution (year one)
8. Develop a UHS quality management system approach

Quality priorities

Quality improvement priority One (Year one)	
Improvement priority	**Core Dimension**
Exploring the provision of a support centre for people using our services.	**Patient experience**

Rationale for selection

UHS is a regional centre for many disease types, but we recognise there is inequality in provision of support facilities in the Trust for all our patients and their friends and families regardless of their clinical conditions. While cancer patients have access to designated centres such as The Maggie's Centre[1] and Macmillan facilities, other disease types have no comparable options despite often having enhanced needs.

Patients who are nearing the end of their life are frequently spending their final days in bays with other patients as side rooms are prioritised for isolation purposes, and there are few areas available that can accommodate a hospital bed for patients to have time with their family away from their clinical setting. Apart from the UHS patient support hub, there are no designated spaces that are accessible for patients, families, or carers[2], often resulting in staff offices and education rooms being inappropriately repurposed to meet their needs .

Growing feedback from complaints and friends and family (FFT) responses emphasis our inability to provide patients and their families access to spaces for respite and support. In addition, a recent UHS carers survey indicated that while we recognise that being a carer can sometimes be demanding both physically and emotionally, there are no designated areas for them to have their own personal needs met.

Creating a bespoke support facility at UHS would help to address these needs and would be the first facility of its kind in an acute Trust in England.

What we will aim to do

During 2024/25 we will start to scope this project, recognising that financial challenges may restrict immediate progress to the planning stages. We acknowledge that realistically year one of this priority may only describe our aspiration, however waiting for the 'ideal time' may also be unrealistic and prevent us achieving any improvement. We will aim to:

- Work with the organisation to identify a physical space (or spaces) which could be repurposed or developed. We are not proposing a new capital build.
- Explore possible funding streams to develop that space with the organisation and other options such as charitable funding. We already have an agreement from The John Lewis Partnership who have pledged to provide some funding.
- Start to design a multi-purpose patient support centre which would be an efficient multi-purpose space with an aspiration to include a discharge lounge (as patient café), carers respite space, hair salon, a mock living room environment for end of life/long term condition patients to enjoy time away from their clinical environments and bookable private discussion rooms for all clinical teams.
- Involve patient partners in the design, including what we will call our facility. Ensure that a diverse range of patients and the public, especially people with lived experience, participate in influencing the design.
- Continue to offer support to people with cancer at The Maggie's Centre and other Macmillan services hosted by UHS, but consider how this may be developed during the interim stage and planning to diversify into the new space once available.

1 The Maggie's Centre is a facility that has been built at UHS providing extra support services for cancer care patients and their families. Patients, family, and friends can drop in to see the trained staff and volunteers who work at the centre.
2 A carer is someone who, without payment, cares for a friend, family member, neighbour, or anybody who could not manage without their help. This could be due to age, physical or mental health issues, substance misuse or disability.

Progress metrics
• We will have identified potential physical space for the facility/facilities. • We will have identified funding streams to develop that space. • We will have recruited patient partners and made progress with our design and naming plans. • We will have explored, and be able to articulate, how this facility will meet the needs of the people who use our services and how it could contribute to improving the experience of people using our services, and a reducing length of stay for some patient cohorts . • We will have seen some reduction in complaints around lack of personalised care, and an increase in compliments submitted. • We will have made progress in reducing the risk of disease inequality, and our current entry into the risk register will reflect this.

Quality improvement priority Two	
Improvement priority	**Core Dimension**
Creating a behaviour framework behind our values, bringing them to life to improve our staff and patient experience	**Patient experience**
Rationale for selection	
The experience of our patients and staff is a key concern for us at UHS. We are aware of studies completed by NHS England (NHSE) which have demonstrated some clear and strong associations between staff behaviour and experience, and how satisfied patients are with their experience in acute trusts. Although the exact link between the observed relationship between staff behaviour and experience and patient experience is complex, those studies suggests that staff know that they provide better care (which leads to better patient experience), if they act with within a common, agreed behavioural framework. Staff who feel well treated by each other and by their organisation, feel supported, and valued are better able emotionally, and psychologically to provide good support and care to patients. Our Trust values of 'patients first', 'always improving' and 'working together' are the foundation of what we believe in, and they drive our actions every day. In turn, our values drive the organisational culture and our behaviours that make that difference to all. We want to make sure everyone (from all staff groups) understands what the desired behaviours are to generate a culture of good staff experience, to live our values at UHS and drive positive patient and staff experiences and improved care.	
What we will aim to do	
• Using the feedback already collected from staff and patients in previous engagement work, we will create a behaviour framework behind our values to bring them to life. • This will be embedded throughout our organisational systems such as appraisal, policies, development programmes, engagement, and education. • The framework will clearly describe the desired behaviours needed from everyone to ensure our values are lived in our organisational culture. These may include kindness, compassion, inclusion, collaboration, and innovation. • We will also create tools, resources and learning to support behaviour change where needed, and continue to celebrate where our values are lived successfully.	

Progress metrics
• We will have created a draft framework and sought feedback from staff and patients. • We will have created mechanisms to measure if the behaviour framework is having a positive impact on the experience of patients, staff, trainees, and learners at UHS. • We will agree our final descriptions by October 2024. • We will have launched across the organisation and embed within organisational structures, processes, systems by November 2024.

Quality improvement priority Three	
Improvement priority	**Core Dimension**
Volunteering – a new focus.	**Patient experience**

Rationale for selection

Our Trust has a long history of involving volunteers in its work. We value the contribution that both our own volunteers and those of affiliated voluntary or charitable organisations can make to the services and care we provide, and supporting volunteers aligns with our mission of being 'better every day'. Our volunteers traditionally undertake roles or provide services which can enhance the care and support of our patients, and which aim to improve the experience of all our visitors over and above what we can ordinarily provide.

Since the onset of the COVID-19 pandemic, volunteering has undergone some transformational changes, including focusing on more holistic care and support, fluidity and increased responsiveness of roles and responsibilities, and greater flexibility in what can be provided. They support our charities and help our staff with occasional administrative tasks. They are involved in safety and quality assurance work and help co-design services. They also support patients with practical tasks such as providing a warm welcome and giving directions and assistance for people finding their way around the hospital. They are generous with time, advice, and have the benefit of their lived experience.

We recruit volunteers through many pathways, but our 'on-boarding' process to orientate them into the Trust can be less effective than it should be. This can lead to delays in bringing volunteers into the organisation, and a variable quality in the experiences of those volunteers. We also recognise we could provide more guidance and support for our volunteer colleagues , and we could work with them more closely to build in flexibility and be more creative in the kind of roles and support they could offer.

What we will aim to do

- We will work with our systems partners to create a unified and standardised approach of volunteer recruitment.
- Our key relationship will be with Hampshire and Isle of Wight VCSE Health and Care Alliance (HIVCA) which will allow us to adopt a more system wide approach, sharing resources, ideas, and opportunities both internally and outside the organisation.
- We will work with HIVCA and foster a collaborative learning environment, by streamlining and standardising the volunteer 'on-boarding' processes.
- We will build on our current 'on-boarding' and training processes where they work well (such as our training days) but provide more first-hand support to our volunteers while they are in their placements.
- We will consider how the Trust's internal policies can create equitable opportunities for a range of volunteers, diversifying the support we can offer to our patients and therefore the wider community.
- We will focus on developing and codesigning new roles for volunteers, and a flexible 'responsive volunteering' process will be introduced to match the organisational pressures as they arise.
- We will consider using the NHS care responder volunteer's app by reviewing if this digital platform could add value (for example it may support pharmacy delivery processes currently undertaken by volunteers), or if there is potential for elements of the app to work with existing Trust platforms and processes.

Progress metrics
• We will have established a partnership with the HIVCA. • We will have developed a systemwide volunteer 'on boarding' process with examples of volunteers working across the ICB's. • We will have developed a more robust support process for volunteers during their placements. • We will have co-designed some new volunteering roles (such as volunteer hairdressers serving the hospitals across the region). • We will have developed a UHS responsive volunteer network, available seven days a week and out of hours with an established support system in place. • We will have explored the volunteer's app and decided if it could add value.

Quality improvement priority Four	
Improvement priority	**Core Dimension**
Acuity and deteriorating patients: continuing to improve how we keep patients safe from harm.	**Patient safety**

Rationale for selection

The recognition, assessment, and escalation of a deteriorating patient (either adult or child) is a key element of our Trustwide patient safety and quality strategy. We aim to improve clinical outcomes for acutely ill patients and are aware that rapid response to patient deterioration (both in and out of hours) is a key determinant of patient and quality outcomes.

The Trust uses the national early warning score (NEWS2[3]) and national paediatric early warning score (NPEWS[4]) to provide our staff with a standardised language and approach to assessing adult and paediatric patients who either present as acutely ill or are showing clinical signs of deterioration. NEWS2 and NPEWS also standardise the recording and analysis of clinical observations and the language used to escalate concerns or instigate calls for concern. The ongoing surveillance of NEWS2 and NPEWS activations and escalations provides a barometer for overall acuity in UHS for both adult and paediatric ward areas.

Over the past two years we have seen a sustained increase in acuity[5] levels across the Trust and have established workstreams to explore common themes and identify key actions to be addressed at local level. A collaborative and inclusive approach to acuity and deteriorating patients is part of our overall strategy to ensure that key learning points are shared across the whole of the Trust.

We also have a duty of care to respond to Martha's Rule, where patients adult and paediatric), relatives and carers have a legal right to a rapid review by a critical care outreach team (CCOT) during an acute deterioration episode in and out of hours. At UHS we are funded for a 24/7 adult CCOT and a 24/7 paediatric outreach team to provide rapid clinical reviews carried out by critical care trained clinical practitioners during an acute clinical deterioration. They also respond to NEWS2 and NPEWS activations. This meets the core recommendation in Martha's Rule, but we do not currently have a fully recruited adult team which is a risk to our patients and the organisation. We also do not currently have a comprehensive audit system to underpin and inform our work and ensure that we continue to understand where learning is required.

As acuity continues to increase, we need to recruit to our full complement of our adult CCOT and educate our staff to an increased level of skill and knowledge to ensure the recognition and management of deteriorating patients. The development of a Trustwide education strategy with core standards for all deteriorating patient education training is essential.

3 a system for scoring the physiological measurements that are routinely recorded at the patient's bedside.
4 The paediatric version of NEWS2
5 acuity is a measure of the severity of the patient's condition and the urgency with which they need to be seen and assessed by a clinician qualified to do this through training and experience.

What we will aim to do

- We will recruit staff to enable us to re-establish a 24/7 adult CCOT.
- We will develop a draft UHS acuity education strategy.
- We will have developed and introduced standards for deteriorating patient education across the Trust.
- We will have developed, piloted, and evaluated a Trust wide acute deterioration education day.
- We will have developed and introduced acuity education on our VLE platform.
- We will have improved our current policy, surveillance ,governance reporting and audit systems by:

Adult

- Reviewing and updating the adult deteriorating patient policy.
- Introducing active surveillance of acuity across UHS in-patient adult ward areas.
- Completing monthly reports of NEWS 2 >5 activations for each in patient adult ward for review and action at ward level.
- Completing monthly 24-hour overview reports of NEWS2 >5 activations for each in patient adult ward for review and action at ward level.
- Completed monitoring compliance of observations in accordance with UHS adult deteriorating patient policy.
- Completing monthly data collection and analysis of NEWS2 Commissioning for Quality and Innovation (CQUIN) data for all unplanned admissions to the intensive care unit (ICU).
- Completing monthly review and analysis of observation compliance with ICU step downs.
- Completing quarterly review and analysis of cardiac arrest data, treatment escalation plans (TEP) and do not attempt cardiopulmonary resuscitation (DNACPR) to ensure compliance with policy and standards.
- Completing monthly review and analysis of sepsis data.
- CCOT to use acuity dashboard to identify and review acutely ill adult patients prior to referral.
- Introduce use of acuity dashboard at all staffing hub meetings.
- Improved organisational oversight of acuity across UHS with implementation of 'PROTECTS.'
- Continue bimonthly deteriorating patient group meetings to review current trends and themes and drive appropriate improvement actions .
- Submit quarterly reports to the patient safety steering group and an annual report to the Trust Quality Committee.

Paediatric

- Embed NPEWS following successful test and trial engagement.
- Analysis of NPEWS data – reported into child health governance and our deteriorating patient group.
- Analysis of parental concerns questions within NPEWS for theming and action planning.
- Review and analysis of all paediatric emergency escalation calls for shared learning across the Trust.
- Regular audit and analysis of the paediatric Call 4 Concern service.
- Continued implantation of safety huddles to identify and facilitate patient flow across Southampton Children's Hospital.

- Embed our Call 4 Concern service across the Trust. This service provides patients/relatives/carers (adult and paediatric) with a simple pathway to access a review by the CCOT at times when they feel that their worries and concerns related to acute deterioration are not resolved by the ward teams. This incorporates the principles of Martha's Rule. We will continue to develop our work associated with Martha's rule, rolling out Call 4 Concern across all in-patient ward areas (adult and paediatric) during 2024/25.
- Develop and implement Call 4 Concern resources for patients/carers with cognitive and/or communication impairment.
- We will audit Call 4 Concern calls every month to identify key themes and hotspot areas and monitor the completion of any actions agreed following these calls.

Progress metrics
• We will have recruited to our adult CCOT. • We will have achieved our education and training aims. • We will have a rolling schedule of analysis of the following data sets described above and be able to evidence where actions have driven improvements for both adult and paediatric services. • We will have used our data (including feedback data) to understand the response to our Call 4 Concern initiative for both adult and paediatric services and will have responded and developed accordingly. • We will have seen a reduction in incident reports and complaints related to failure to rescue for both adult and paediatric services .

Quality improvement priority Five	
Improvement priority	**Core Dimension**
We will ensure that fundamentals of care (FOC) are provided to all our patients in collaboration with our patients, their family, and their carers.	**Patient experience**

Rationale for selection

The term 'fundamentals of care' (FOC) describes the actions taken to meet the physical and emotional needs of patients' and their significant others. These needs are the things that people normally do for themselves if they can and include essentials such as hygiene, eating and drinking, rest and sleep, mobility, going to the toilet, comfort, safety, and medication management.

It also includes what we do to establish and maintain a caring relationship with patients and others through communication. This includes both talking and listening and coming to shared decisions with patients about their care.

It includes how we meet the cultural, spiritual, mental health, emotional wellbeing and dignity needs of people we care for and those that matter to them. FOC is how the interdisciplinary team connects and builds relationships with our patients. It is through these relationships that we can meet, or help the patient themselves, meet their fundamental care needs. This puts the patient at the centre of what we do and helps ensure that we are dealing with the things that matter the most to everyone. We know our patients need to be the focus of the care, not just their illness, clinical condition, or treatment plan. This supports the interdisciplinary team to focus on the meaningful aspects of care, alongside the clinical treatment plan.

While FOC is not a new concept, we are concerned that missed fundamental care has been amplified during the COVID- 19 pandemic. Coming out of the pandemic, we have noted that increasing operation pressures and staffing challenges have created a greater focus on transactional tasks, and away from personalised aspects of care. It is important that we now re-think how we empower and educate our staff at all levels to ensure fundamental care is at the heart of what we do at UHS. In doing so, we aim to improve patient care, recovery, well-being, experience, and quality of life.

What we will aim to do

- We will establish a FOC steering group that will oversee the development of a programme of patient centred to doapproach at the point of care delivery.
- We will work in collaboration with our patient partners, their families, and carers to make sure their feedback and experience directly influences workstreams and co-design of service improvement.
- We will co-design 'care commitments' that clearly articulate what patients and their carers can expect while in the care of UHS, using core domains identified by the FOC steering group.
- Each care commitment will have improvement metrics that we will monitor, review and report on.

- We will develop existing resources to improve the knowledge and skills of our staff to provide FOC in collaboration with our patients, ensuring the delivery of quality care through evidence-based practice and by providing the right equipment to do this.
- We will be involved in the induction and education for all health care support workers, newly qualified nurses, allied health professionals (AHPs) and internationally educated nurses to set our expectations and commitment in the delivery of the FOC.
- We will launch a 'what matters to me' programme. One of the key components of this programme will be supporting staff to work with patients and their carers to align the clinical team priorities with those of the patient.
- We will incorporate FOC into our clinical accreditation scheme assessments to monitor compliance and quality assurance standards.
- We will carry out focused FOC surveys across inpatient areas to monitor improvements.

Progress metrics

- We will see a reduction in the number, severity and nature of clinical incidents that relate to the FOC across inpatient settings.
- We will see a reduction in complaints in the areas of care outlined in our FOC care commitments. We will see an increase in compliments for the same.
- We will see good compliance and improved performance against our improvement metrics and our survey results will evidence this.

Quality improvement priority Six

Improvement priority	Core Dimension
Improving our morbidity and mortality (M&M) meetings.	**Clinical effectiveness**

Rationale for selection

The patient safety incident response framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. It supports our processes for learning and improving patient safety and clinical effectiveness and replaces the old serious incident framework. An important element of the PSIRF is the focus on strengthening the processes for local learning through M&M meetings.

M&M meetings (or clinical review meetings), have a central function in supporting our services to achieve and maintain high standards of care. They allow us to review the quality of the care that is being provided to our patients and learn lessons from outcomes. They are multidisciplinary meetings which provide a safe place for learning, for supporting comprehensive conversations and ensuring governance standards are met. They allow us to identify any opportunities for improvement and are an important opportunity for education. They also provide opportunities for senior staff to model appropriate professional behaviour and engage the significant expertise of clinicians at the point of care. There is also a growing trend in M&Ms to identify how resilience within complex systems enables good outcomes in the face of the kind of challenges and uncertainties which we are experiencing, and which are inherent within healthcare delivery.

What we will aim to do

We will develop a clear framework and set expectations for what is included in the M&M meetings at UHS This may include :

- Standardise preparation and organisation of meetings to ensure they are well-supported and attended.
- Education to promote effective chairing of meetings.

- Setting out types of behaviours that participants should display to ensure discussions are held in an open and inclusive atmosphere.
- Agreeing a process of enhancing active participation across the disciplines.
- Standardising the presentation and discussion of cases.
- Agreeing a process to ensure that actions arising from meetings are successfully completed and that lessons are learned and implemented.
- Providing a safe space for learning.
- Generating actionable learning and/or system improvement agree standardisation of documentation of lessons learned and dissemination of recommendations to ensure action.
- Developing an electronic M&M recording system to capture and evidence outcomes.
- Have a clear escalation process from M&M meetings to the existing governance structure, with recording of actions.

Progress metrics

- We will have completed surveys of terms of reference (TOR) and established our core standards.
- We will have audited the number of M&Ms adopting the electronic recording system.
- We will have audited the actions and escalations from M&M meetings shared via our local governance structures.

Quality improvement priority Seven

Improvement priority	Core Dimension
Develop the Trusts' approach to reducing the impact of health inequalities (HIs)	**Clinical effectiveness**

Rationale for selection

The causes of HIs are complex, but research from bodies such as the National Institute for Health and Care Research (NIHR) and Kings College London has shown that the main drivers are social determinants, the environments people live in, access to employment and the kind of start they had in life. Inequalities are also driven by the ways in which health services are designed and delivered, and by the quality of clinical care received.

The NHS plays an important role in mitigating against these wider determinants and in reducing HI's. All Trusts have a legal and moral duty to consider HIs, and a new requirement from NHSE asks that Trusts describe the extent to which they have exercised its functions consistently with the views set out in the NHSE statement on information on inequalities.

Tackling inequalities in health and care is also embedded in the Care Quality Commission (CQC) 2021 strategy. Alongside the strategy, the CQC have published five equality objectives to support their role in addressing health inequalities and stated they will act if they identify examples of care not being good enough for specific groups of people. They encourage providers to actively seek out, listen and respond to people who are most likely to have difficulty accessing their care or a poorer experience or outcomes from care, and will include this in their assessment frameworks.

Lack of action also has economic consequences for NHS Trusts. It is estimated that HIs cost the NHS £5.5 billion annually, and NHS treatment would be 15% lower if they were removed.

At UHS we are committed to developing a shared understanding of the HIs faced by people in our local communities who use our service and working to embed improvement as part of our definitions of quality, safety, and performance.

What we will aim to do

We will establish a HI steering group/board to oversee the priorities as set out below.

Data
- Understand our data completeness and quality against core HI reporting domains (NHSE statement requirements).
- Assess our baseline against national recommendations (Core20plus5, NHSE HiQiP etc.) and identify improvement opportunities.

Governance and Strategy
- Convene a UHS HI board, with clearly defined TOR, membership, and priorities.
- Develop the Trusts' approach to reducing the impact of HIs and establishing ourselves as an anchor institution.
- Set forward priority planning.
- Track efforts against the anchor institution key actions

Enabling the organisation
- Understand what is already happening in clinical teams by collating records of projects and progress.
- Develop an approach to enabling the organisation to reduce HIs within their services.

Delivering key priorities:
- Choose a small number of HI priorities for the Trust board to focus on. Options to be considered include hypertension, waiting list management, diabetes, obesity, children and young persons (CYP) and maternity.

Progress metrics

Data
- We will be able to report on completeness of our data sets in line with NHSE requirements.
- We will have set a measure for baselining against each of the national priorities and understand current performance against each of these.

Governance/ strategy
- Our HI steering group/board will have been established.
- Our strategy and approach will have been developed and approved by Trust board by end of 2024/25.
- We will have a clear strategy and approach for tackling HI's, developed alongside partner organisations including public health teams and the ICB.
- We will set clear objectives for 2025/26 as part of forward planning will have been agreed by end of 2024/25.

Enabling the organisation
- We will support divisions to identify and deliver work to reduce HIs. We aim to support the identification of at least one HI related opportunity in each care group.

Delivering key priorities
- We will have agreed HI priorities for the Trust Board to focus on.

Quality improvement priority Eight (Year one)

Improvement priority	Core Dimension
Develop a UHS quality management system approach.	**Clinical effectiveness**

Rationale for selection

In April 2023, NHS Improving Patient Care Together (IMPACT) was launched to support all NHS organisations, systems, and providers at every level (including NHSE) to have the skills and techniques to deliver continuous improvement.

NHS IMPACT's five components form the basis of all evidence-based improvement methods and underpin a systematic approach to continuous improvement:

- Building a shared purpose and vision.
- Investing in people and culture.
- Developing leadership behaviours.
- Building improvement capability and capacity.
- Embedding improvement into management systems and processes.

Taking a more integrated quality approach is also a key component of our 'always improving', clinical effectiveness and Trust strategies in support of our 'outstanding patient outcomes, safety and experience' strategic pillar. To establish our current position, we undertook a self-assessment to gauge our organisational maturity against the IMPACT framework and identified 'embedding improvement into management systems and processes' as an area of opportunity to improve and employ best practice. It was also a recommendation from the Thirlwall (Lucy Letby) inquiry that organisations focus on their ability to triangulate different quality indicators to build a holistic view of the organisation or a particular service.

What we will aim to do

To establish an integrated quality approach across the organisation we will:

- Initiate a steering group with representation from divisional and care group management teams, the deputy chief nurse portfolio, clinical effectiveness, corporate affairs, and transformation. Map how quality is currently managed at UHS. This will include:
  - Cataloguing our current quality processes, who owns them and how they are administered.
  - Understanding how these align with the Trust's quality governance structure.
  - Mapping any current interactions between quality processes.
  - Reviewing the current business intelligence that drives our quality processes.
- Undertake a series of individual and group interviews with key stakeholders including board members, operational and clinical leaders, and corporate services that manage quality processes .
- Engage with organisations that have mature quality management systems to understand best practice approaches. Design a future quality management approach that we can move towards over the long term.
- Identify and implement the in-year opportunities to move towards the longer-term infrastructure. These are expected to include:
- Creation of a single quality dashboard that our quality information feeds into.
- Adjustments to governance and process that enable integration between different parts of the quality management system.

Progress metrics

- We will have established the steering group.
- We will produce a report that maps our current quality management processes and captures the feedback from our key stakeholder groups.
- We will set out a design for an integrated quality approach with a series of recommendations and implementation timeline.
- We will have begun to implement some of the recommendations from that report which is likely to include the creation of a single quality dashboard and changes in governance and process.

2.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide relating to the financial year 2023/24. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board of directors has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

2.2.1 Review of services

During 2023/24 UHS provided and/or sub-contracted 103 relevant health services (from total Trust activity by specialty cumulative 2023/24 contractual report). UHS has reviewed all the data available to them on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2023/24 represents 100% of the total income generated from the provision of relevant health services by UHS for 2023/24.

2.2.2 Participation in national clinical audits and confidential enquiries

The UHS clinical audit programme was developed in support of the Trust's vision by putting patients first, working together and always improving. This leads on to a specific strategy for clinical outcomes, to ensure robust and measurable processes are in place to plan locally and participate strategically.

Healthcare Quality Improvement Partnership (HQIP) produces a national clinical audit and enquiries directory which identifies those national audits which are included in the NHSE quality account list 2023/24, those audits which are part of National Clinical Audit and Patient Outcomes Programme (NCAPOP) and those that deliver a Consultant Outcome Publication (COP).

NCAPOP audits are commissioned and managed on behalf of NHSE by HQIP. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, NCAPOP audits provide local trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvements for patients.

The audits listed on the NCAPOP are 'must-do' national audits. The quality accounts national clinical audit list includes audits which we regard as 'best practice' to participate in (in addition to those from the NCAPOP) and for that reason we always include these in our corporate audit plans as a priority where they are relevant to our Trust.

UHS has a strong history for completing clinical audits. The clinical effectiveness team has a robust approach to governing and supporting the completion. We have opened discussions with senior clinical leadership within HIOW ICB regarding the current challenges with contributing to and using the outputs of national audits. Benchmarked data resulting from national audits provides strong guidance on areas of excellence and improvement, however completion can be challenging in its complexity and resource intensiveness, and timeliness of outputs can reduce our ability to be responsive to indications. Real time data supports our clinical teams to be proactive in striving to meet our always improving objectives.

During 2023/24 55 national clinical audits and three national confidential enquiries covered the NHS services that UHS provides. During 2023/24 UHS participated in 93% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

NCEPOD studies participated in during 2023/24 were:
- Testicular torsion.
- Juvenile idiopathic arthritis.
- Rehabilitation following critical illness.

UHS fully supports the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) and all the reviews that take place under this umbrella.

The national clinical audits that UHS participated in, and for which data collection was completed during 2023/24, are listed below (Table A) alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry if known at time of writing this report.

Table A.

No	Total number of NCAs UHS were eligible to participate in (n=55)	Eligible (55)	Participated (51 = 93%)	% Actual cases submitted / expected submissions
1	BAUS Nephrostomy Audit (launch September 2023)			
2	Breast and Cosmetic Implant Registry	✓	✓	37 from Jan – June 23
3	Case Mix Programme (CMP) (ICNARC)	✓	✓	100%
4	Elective Surgery (national PROMS Programme (Hips and Knees)	✓	✓	Data for 22/23 available only 55%
5	Emergency Medicine QIPs – Mental health self-harm	✓	×	*
6	Emergency Medicine QIPs – Care of older people	✓	✓	121
7	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	
8	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	
9	Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	✓	✓	
10	Improving Quality in Crohn's and Colitis (IQICC) (previously Inflammatory Bowel Disease (IBD) Registry)	✓	×	**
11	Learning Disability and Autism Programme - Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	✓	✓	100%
12	National Adult Diabetes Audit – National Diabetes Inpatient Safety audit	✓	✓	
13	National Adult Diabetes Audit – National Pregnancy in Diabetes	✓	✓	100%
14	National Asthma & COPD Audit Programme (NACAP) (asthma in children)	✓	✓	149 so far, runs to 31/03/24
15	National Asthma & COPD Audit Programme (NACAP) (asthma in adults)	✓	✓	

No	Total number of NCAs UHS were eligible to participate in (n=55)	Eligible (55)	Participated (51 = 93%)	% Actual cases submitted / expected submissions
16	National Asthma and COPD Audit Programme (NACAP) (COPD secondary care)	✓	✓	
17	National Asthma and COPD Audit Programme (NACAP) Pulmonary rehabilitation	✓	✓	
18	National Audit of Dementia (NAD)	✓	×	***
19	National Audit of Care at the End of Life (NACEL)	✓	✓	
20	National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	✓	✓	Data entry not required collected nationally
21	National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	✓	✓	
22	National Cardiac Arrest Audit (NCAA)	✓	✓	152
23	National Cardiac Audit Programme (NCAP) - Adult cardiac surgery	✓	✓	
24	National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management (CRM)	✓	✓	1000+ = 100%
25	National Cardiac Audit Programme (NCAP) - congenital heart disease (CHD) Paeds	✓	✓	
26	National Cardiac Audit Programme (NCAP) - Heart Failure audit	✓	✓	
27	National Cardiac Audit Programme (NCAP) - Acute Coronary Syndrome or Acute Myocardial Infarction	✓	✓	550 approx. = 100%
28	National Cardiac Audit Programme (NCAP) - Percutaneous coronary interventions (PCI)	✓	✓	811 = 100%
29	National Cardiac Audit Programme (NCAP) - Mitral Valve Leaflet Repairs (MVLR) Registry	✓	✓	100%
30	National Child Mortality Database (NCMD)	✓	✓	100%
31	National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	✓	partial	****
32	National Comparative Audit of Blood Transfusion – Audit of NICE Quality Standard QS138	✓	✓	20 = 100%
33	National Comparative Audit of Blood Transfusion – Bedside Transfusion Audit	✓	✓	In process
34	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	100%
35	National Emergency Laparotomy Audit (NELA)	✓	✓	*****
36	National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)	✓	✓	
37	National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	✓	✓	

No	Total number of NCAs UHS were eligible to participate in (n=55)	Eligible (55)	Participated (51 = 93%)	% Actual cases submitted / expected submissions
38	National Joint Registry	✓	✓	722 as of 19/01/24
39	National Lung Cancer Audit (NLCA)	✓	✓	
40	National Maternity and Perinatal Audit (NMPA)	✓	✓	
41	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	100%
42	National Ophthalmology Audit Database (adult cataract surgery only)	✓	✓	12000AMD injections and 4000cataracts = 100%
43	National Paediatric Diabetes Audit	✓	✓	
44	National Prostate Cancer Audit (NPCA)	✓	✓	
45	National Vascular Registry (NVR)	✓	✓	100%
46	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
47	Perinatal Mortality Review Tool (PMRT)	✓	✓	100%
48	Perioperative quality improvement programme	✓	✓	18
49	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit, organisational audit	✓	✓	1129
50	Serious Hazards of Transfusion (SHOT) UK National haemovigilance scheme	✓	✓	100%
51	Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓	88
52	Trauma Audit & Research Network (TARN)	✓	×	******
53	UK Cystic Fibrosis Registry	✓	✓	Between 75%-100%
54	UK Renal Registry Chronic Kidney Disease Audit	✓	✓	
55	UK Renal Registry National Acute Kidney Injury Audit	✓	✓	

* RCEM Mental health audit- although we registered to complete the audit, unfortunately no data was submitted
** Improving Quality in Crohn's and Colitis (IQICC)- our HICCS database is no longer linking to the audit database, an upgrade is required to rectify this problem. However, as from April 2024 this audit will no longer be running.
*** National Audit of Dementia (NAD) - the audit has some key requirements which they were unable to meet.
****Epilepsy12- we have completed the organisational part of this audit. The clinical audit has not been completed due to the time requirement (approx. 40 minutes per patient); we do not allocated time for this in staff job plans. Secondary care team have a database which enables process measures such as time to see first fit, time to MRI/EEG etc to be calculated. It also has been incredibly useful in responding to safety alerts e.g., PREVENT programme as able to search for children and young persons on certain medications. Likewise, it has facilitated our participation in research studies as able to contact those with certain conditions. This is not possible with the national data collection.
*****National Emergency Laparotomy Audit (NELA) - UHS currently has no audit lead therefore no information.
****** Trauma Audit & Research Network (TARN) - The national database was cyber attacked in June last year and has been unavailable since, therefore UHS was unable to contribute data. The database is being taken over by NHSE and will become the National Major Trauma Registry (NMTR) - but this is still in development. We've continued to review cases and collect data, but this is on locally held records in the absence of TARN. UHS TARN Team are participating in the first round of User Acceptance Testing for NMTR.

Some of the audit / registries do not need UHS to send them data, such as the cancer collaboration as they take the data from the cancer service databases.

The reports of 19 national clinical audits were reviewed by the provider in 2023/24. Appendix A lists actions identified during 2023/24, which UHS intends to take and UHS intends to take to improve the quality of healthcare provided. Progress already made against these actions is also indicated.

The reports of 97 Trustwide and local clinical audits were reviewed in 2023/24. Appendix B lists the resulting actions to improve quality of healthcare provided.

National Clinical Audit: actions to improve quality identified during 2023/24

National audit title	Actions
1. National Cardiac Audit Programme (NCAP) National Audit of Cardiac Rhythm Management (NACRM) 2023 Summary report (2021/22 data) published June 2023	• Consultants to be made aware of their procedure numbers, and are to be discussed at their annual appraisals – action will be completed in 2024 then ongoing every year.
2. Sentinel Stroke National Audit programme (SSNAP) report published February 2023 data for July – September 2022	• Action plan to address low compliance to be produced by the Multidisciplinary (MDT) team – ongoing review by MDT. • To continue MDT work alongside SLT – action ongoing.
3. National Neonatal Audit Programme (NNAP) report published November 22 data for 2021	• To review infection control practices and care bundles to further improve the reduction in sepsis rates. • Improve data collection for central line related infection rates with entry of lab confirmed cases of sepsis directly into BadgerNet.
4. Fracture Liaison Service database (FLSD) report published January 2023 data 2021	• For key performance indicator (KPI) 3 implement the ADOPT study to increase vertebral fracture identification – action complete. • For KPI 4 continue liaison with WHCCG and commissioners regarding WHCCG patients – action ongoing. • For KPI 10 continue to develop the relationship with GP's and neighbouring fracture liaison services – action ongoing.
5. National Maternity and Perinatal Audit (NMPA) report published June 22 births between April 18 and March 19	• To review the NMPA data and key themes with similar units to gain an understanding of any differences in practice – action ongoing
6. National Emergency Laparotomy Audit (NELA) report	• To change the way patients are booked into theatre to improve risk scoring – action complete. • To review and improve CEPOD efficiency to improve time to theatre – extended hours for CEPOD operating – action complete. • To increase funding to post operative assessment by elderly care clinician input – action complete and consultant to be in post by September / October 2024.

National audit title	Actions
7. National Respiratory Audit Programme (NRAP) National Adult Asthma six monthly reports published July 2023	• To engage with the emergency department to raise awareness that the adult asthma KPIs are dependent on their timeliness of specialist review. • To improve nursing shortages within the asthma team. • To work with the COPD nursing team to provide 7-day cover. • Asthma clinical lead to work with respiratory business manager and matron on increasing staffing
8. National Audit of Care at the End of Life (NACEL) Report published July 2023	• To review actions on the overall end of life action plan which incorporates actions from the NACEL project – action ongoing.
9. Inflammatory Bowel Disease (IBD) registry published September 2023	• To feedback to executive team on the issues with the HICCS database no longer being able to feed into the IBD registry – this audit has now ceased.
10. National Hip Fracture Database report 2023 published September	• To increase theatre capacity and beds to be able to attain the BPT – 1 extra theatre converted to a trauma theatre now sits within footprint. BPT breaches are generally not because of theatre capacity – completed. • To use a similar model this Winter as last and / or adoption of hybrid operating and ring-fenced NOF theatre lists – action completed.
11. National Early Inflammatory Arthritis Audit (NEIAA) published October 2023	• To increase support in collecting and entering the data to the national audit – CE team are helping action complete. • To ensure training is provided to all team members entering data.
12. Child and Young Person Asthma report published July 2023	• To facilitate teaching session for ED staff to remind them how to use the wheeze proforma – ongoing action. • To develop specific treatment stickers to overlay the prescribing section of the wheeze proforma to be prepopulated with appropriate medicines – action complete. • Staff to continue to signpost families and children to smoking cessation advice via posters and QR codes – action complete. • To ensure documentation of inhaler technique a tick box to be added to treatment stickers – action complete
13. National Maternity and Perinatal Audit (NMPA) - live births	• An action plan for all NMPA outcomes to be developed to ensure compliance is met – action ongoing.
14. National Audit Inpatient Falls published November 2023	• To review Falls policy. • To include analgesia prompt on post-fall clinical assessment proforma. • To highlight analgesia on existing assessment checklist – all actions will be completed by December 2024.
15. National Joint Registry Report published October 2023	• To discontinue use of the NexGen knee and reverted to the PFC / Triathlon knee – action complete. • To continue GIRFT meetings to highlight this problem nationally – action ongoing. • To set up a new service to review these patients which is currently with UHS legal team for approval. This clinic will be an additional cost to UHS – action ongoing.

National audit title	Actions
16. National Vascular Registry published November 2023	• To encourage colleagues who offer endovascular services at the hub and spokes to engage with this registry.
17. Breast and Cosmetic Implant Registry	• To find out why the submissions from PAH are not reflected in the submissions table from Jan-Jun 2023. 37 cases submitted but only 5 showing.
18. National Cardiac Audit Programme (NCAP) Acute Coronary Syndrome or Acute Myocardial Infarction	• To audit the local 60-minute target for 'Door to reperfusion' to look for themes and escalate any cases that have an inappropriate delay to care.
19. National Prostate Cancer Audit (NPCA)	• Results to be circulated on the internal positive margin audit once completed. • To be able to collect continence and sexual function outcomes from patients but this requires investment into my medical record (MMR).

Appendix B- Local Clinical Audit: actions to improve quality identified during 2023/24

Audit title	Actions
1. Infection Prevention and Control (IPC) Audit programme Personal Protective Equipment (PPE) Audit report published April 2023	• 52 areas require review by care group managers / care group clinical leads to ensure that they submit audits as per the infection prevention annual audit programme. • 11 areas scored between 85% and 94% to re-audit within 3 months. • 2 areas scored below 85% to draw up action plans and re- audit within 1 month.
2. Infection Prevention and Control (IPC) Audit programme Cleanliness and Decontamination Audit report published April 2023	• 64 areas require review by care group managers / care group clinical leads to ensure that they submit audits as per the infection prevention annual audit programme. • 3 areas scored between 85% and 94% to re-audit within 3 months. • 13 areas scored below 85% to draw up action plans and re-audit within 1 month.
3. Microbiology Sampling in Failed Gamma Nails	• To increase awareness of evidence-based guidelines. • To present project and literature to T&O surgeons during departmental M&M meeting. • To discuss and increase awareness to encourage up-to-date practice in alignment with current guidelines – all actions completed.
4. Infection Prevention and Control (IPC) Audit programme Isolation Audit	• All areas of non-compliance to develop and implement an action plan based on those results. • Care group management team to work with non-submission areas and areas of suboptimal care to become more compliant.
5. Retrospective evaluation to consider the relationship between nutritional intake and ventilatory requirements / oxygen saturations in critically ill adults	• To produce a protocol for management of patients taking oral diet on Intensive Care Unit (ICU) – action complete.

Audit title	Actions
6. Element 3 Saving Babies' Lives: Raising awareness of reduced fetal movements (RFM)	• To work with the SHIP data analyst to improve the reporting data for RFM and computerised CTG – action complete.
7. Element 4 - Saving Babies' Lives: Effective fetal monitoring during labour (EFM)	• To hold a fetal surveillance study day. • To have this as Theme of the week. • To add to labour ward communication board to improve education – all actions complete.
8. Evaluating the record of Smoking status and Audit-C for maxillofacial patients discharged from ward F5	• To share the findings of the audit and recommendations through email with all the Max-fax SHOs, Ward pharmacists, smoking and alcohol team. • To present the importance of recording smoking and alcohol history, findings, and recommendations to all the Max-fax SHOs, ward pharmacists, smoking and alcohol team in a small teaching session. • To discuss the Audit results and action plan in maxillofacial department MNM meeting – all actions complete.
9. Clinical Audit of EQD2 doses for cervical cancer patients receiving EBRT and Brachytherapy over period of 2020-22	• To design a clinical follow-up study to investigate recurrence and/or toxicities for a subset of these audited patients. • To ensure EQD2 dose to Recto-Vaginal point is more visibly clear in the Radiobiology spreadsheet (with conditional formatting) so it is given greater importance during treatment planning. • To add D98 to CTV-HR column to Radiobiology spreadsheet to ensure collection of this data which was referenced in EMBRACE II – all actions complete.
10. BSOTS triage in MDAU	• Further education around the BSOTS triage process, specifically the category of timings. • SEW OBS lead for MDAU to come and shadow in MDAU to support with the process. • Database being created by the data analysts to be able to remove the 'routine labour assessments' from badger net reports. • To keep ongoing audits quarterly to monitor compliance.
11. Element 2A Saving Babies' Lives: Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR)	• To hold education and staff communication around the repeat FGR risk assessment. • To ensure staff are aware of the PAPP-A process changing to include Aspirin, currently being discussed with OBSs team – all actions complete.
12. Spinal emergency admissions bloods audit	• To introduce admission blood checklist to ensure all bloods have been taken to avoid any confusion about which bloods to be taken and to avoid duplication / error. • To arrange teaching for nursing staff – all actions complete.
13. SBAR handover communication tool audit	• To discuss with F level wards leads and put action plan in place to ensure staff sign the SBAR when giving/receiving a telephone handover.
14. MEOWS Modified Early Obstetric Waring System	• To produce a 'MEOWS example' to support staff with the recording on the MEOWS chart. • To hold education sessions around the importance of completing the Respirations as part of observations, or documenting to justify why this has not been completed.

Audit title	Actions
15. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy	• The public health midwife to continue to monitor compliance and make improvements to the stop smoking in pregnancy service. • On-going improvement work to improve smoking quit rates in pregnancy – actions complete.
16. Postnatal Readmissions into maternity services	• QI project in progress for maternity service postnatal readmissions • BFI/infant feeding lead and postnatal leads working to improve/reduce readmissions – actions complete.
17. Element 4 Saving Babies' Lives care bundle (version 2): Quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation	• To continue audits to identify any missed SGA cases – ongoing action.
18. Element 5 Saving Babies' Lives: Reducing preterm births	• To New Preterm birth guideline to be developed. • To complete the MatNeo Preterm birth optimisation project – actions complete.
19. Element 5 standard B Saving Babies' Lives: Reducing preterm birth	• To complete the new AN steroids/preterm birth guideline – action complete. • To complete regular audits – ongoing action.
20. WHO Stop point safety checklist	• To send a reminder email and education sessions to theatre staff to ensure full completion of the form, then reaudit.
21. Induction of labour for pre-labour rupture of membranes	• To be shared at Induction of Labour (IOL) workstream – action complete.
22. Vascular Surgery inpatient proforma audit	• Sign posting reminders to ensure completion of all areas of the proforma. • Induction training for all new vascular staff – actions complete.
23. Compliance assessment of current guidelines for oxygen prescribing	• Teaching to be completed to a group of clinicians/prescribers in acute medical unit. • Posters to be placed in various clinical areas – actions complete.
24. Audit of CT Brain Perfusion Range Coverage	• A change in the wording to "Position bottom of scan box at sella floor. If ANY uncertainty re positioning, please check position with radiologist to be implemented". • Educational material to be disseminated amongst the radiography team. • To deliver a teaching session in near future – all actions complete.
25. Pre-operative fasting for elective surgical adult patients	• To empower nurses to help reduce the fasting times. • To opt out of the guidelines should be the way for senior colleagues who are concerned about risk of aspiration. • To place laminated guidelines on Surgical Day Unit (SDU) as pilot project – all actions complete.
26. Infection, Prevention and Control (IPC) - Saving Lives HII 6 Urinary Catheter Care	• 1 area scored between 85% and 94% are will re-audit within 3 months. • 7 areas scored below 85% will produce an action plan to address non-compliance and provide evidence of implementation and to re-audit within 1 month ensuring compliance addressed through action plan.

Audit title	Actions
27. Infection, Prevention and Control (IPC): Saving Lives HII 1 Central Venous Catheter Care	• 2 areas scored between 85% and 94% are will re-audit within 3 months. • 4 areas scored below 85% will produce an action plan to address non-compliance and provide evidence of implementation and to re-audit within 1 month ensuring compliance addressed through action plan.
28. Infection, Prevention and Control (IPC): Saving Lives HII 2 Peripheral Intravenous Cannula Care	• 4 areas scored between 85% and 94% are will re-audit within 3 months. • 16 areas scored below 85% will produce an action plan to address non-compliance and provide evidence of implementation and to re-audit within 1 month ensuring compliance addressed through action plan.
29. Ockenden report, Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy, Q33	• To continue to audit intended place of birth risk assessments. • To work with the digital team to raise awareness and education around recording this – actions complete.
30. NHS Resolution Safety Action 1: Is the Trust using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	• To start auditing on a quarterly basis to ensure compliance – ongoing action.
31. An audit of gallbladder polyp reporting and referral recommendations in Ultrasound within a Radiology department	• To email sonographers and radiologists with a copy of the guidelines, and a summary of the audit. • To ensure sonographers and radiologists have a clear explanation of the guidelines where there is clear misunderstanding. To include 4 keys learning points for reporting gallbladder polyps – actions complete.
32. Peritoneal Dialysis (PD) Audit	• To discuss with other PD centres regarding MSSA treatment at insertion and post insertion as guidelines do not clearly say yes or no, it is down to centre's choice. • To review UHS trust policy around reducing bioburden and decolonisation. • To discuss amongst ourselves and other centres regarding routine parental retraining and devise a plan. • To educate team and ward staff around the need to reassess all parents after an episode of peritonitis. • To develop a peritonitis proforma to ensure all episodes treated appropriately.
33. To audit the compliance of Physiotherapy and Occupational Therapy management of patients following major trauma against the NICE guideline: Rehabilitation following critical illness	• To encourage use of functional assessment and goal setting form – to be included in major trauma packs and kept within plastic wallet in patients notes. • To change the goals section to discard weeks and include a list of goals only. • To encourage patient involvement – use bubble goal sheets to update doctors' worklist to include day of functional assessment and goal setting. • Create a different way to document impact of functional assessment on onward referrals – all actions complete.
34. Compliance with prescribing oxygen in cardiology	• To send the audit report and advice about O2 prescription as per the British Thoracic Society 2017 guidelines for prescribing oxygen to the FY1s and SHOs of Cardiology via email – actions complete.

Audit title	Actions
35. Aortic Valve Replacement with or without simultaneous CABG in octogenarians: Clinical outcomes	• To re-audit the results and prospectively analyse if AVR patients with CAD are undergoing concomitant CABG or if they are being referred for PCI. • Adherence to EACTS/ECS guidelines to be reviewed. Comparison of postoperative survival and perioperative outcomes would be needed for further conclusions.
36. Compliance assessment of current guidelines for oxygen prescribing	• To teach a group of clinicians / prescribers in Acute Medical Unit (AMU). • Posters to be placed in various clinical areas around AMU. To re-audit in a months' time to confirm the changes – all actions complete.
37. Naso gastric tube check chart audit	• To feed-back results at ANTs study day. • To feed-back results to critical care education leads. • To present results at nutrition and hydration governance group – all actions complete.
38. Clinical audit on appropriate genetics referral for patients with suspected lynch syndrome	• To have a discussion with histology department about reflex BRAF and subsequent promoter hypermethylation testing for patients with MLH1 (+/-PMS2) deficiency. • To ensure patients with MSH2/MSH6/PMS2 deficiency are referred to genetics department – all actions complete.
39. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy	• Communication drive in documentation to increase clean data entry. • To share updated guideline in line with SBL v 3 and NICE NG209. • To have focus group/1:1 training/ update with community team. • To continue to review monthly and action as appropriate – all actions complete.
40. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy	• Enquiry of smoking status at 36-week antenatal appointment, to be promoted by the public health midwives via all usual maternity communication channels. • Ongoing monthly monitoring via the UHS maternity smoking dashboard, with appropriate actions and escalations when required – actions complete.
41. Element 2 Saving Babies' Lives: Fetal Growth: risk assessment, surveillance, and management	• To communicate to staff documentation at booking for Vitamin D supplementation. • To email the triage team to ensure that they are recommending this supplementation to ALL women as per UHS AN booking guideline – actions complete.
42. Element 2 Saving Babies' Lives: Fetal Growth: Risk assessment, surveillance, and management	• To present variance to the ICB for sign off. Previously variance had been approved for Saving Babies' Lives version 2 – action complete.
43. Element 2 Saving Babies' Lives: Fetal Growth: Risk assessment, surveillance, and management	• Findings of audit shared around detection rates for <3rd >37+6 and QI project happening at QA in USS, awaiting results – action complete.
44. Element 2 Saving Babies' Lives: Perinatal Mortality Review Tool (PMRT)	• As per PMRT review group action to be communicated around referral process of USS pathway when concerns with static/tailing growth – action complete.

Audit title	Actions
45. Improving management of urinary incontinence following a stroke	• A meeting with stroke sister and manager to ascertain next steps to get proforma in use on the wards to be arranged. • To contact IT to discuss transferring proforma into inpatient noting – actions complete.
46. Does the facial lymph node require removal during neck dissection for oral cancer?	• To continue the study as a prospective study to increase the sample size. • To collect more data of the patient to see recurrence of disease and survival rate in two groups of the patients. The patients in which facial lymph node was harvested versus patients in which facial lymph node wasn't harvested.
47. Evaluating the record of Smoking status and Audit-C for maxillofacial patients discharged from ward F5	• To meet with pharmacy technician led to update the results and request for pharmacy technicians to record the smoking and alcohol details while interviewing the patient. • To share the findings with the new doctors starting in maxillofacial department and request them to fill in the smoking status and alcohol history.
48. Emollient fire hazard risk and mitigation	• To continue to provide an emollient information leaflet to patients on discharge. • To add emollient safety to the VLE fire safety training T continue raising awareness with the Hampshire Medication Safety Group. • To produce and post a graphic on emollient safety for workplace. • To hold Hampshire Fire Service training for staff – all actions either completed or ongoing.
49. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy	• To improve compliance for all community midwives to be trained as tobacco dependence treatment advisors in line with Trust guidelines. • Communication drive in documentation to increase clean data entry. • To share updated guideline this is now in line with SBL v 3 and NICE NG209. • To have focus groups / 1:1 training / update with community team. • To continue to review monthly and action as appropriate – all actions complete.
50. Element 3 Saving Babies' Lives: Raising awareness of reduced fetal movements	• To update the RFM guideline and circulate to all staff. Main changes around RCOG RM checklist – action complete.
51. Element 4 Saving Babies' Lives: Effective fetal monitoring during labour	• Fetal monitoring leads to implement a buddy system on labour ward for cardiotocography (CTG) peer reviews and communication message. • Re-audit in 1 month to assess compliance. Aim to increase compliance to >80%. • Re-audit 10 sets of notes per month until compliance reaches target of >80% – all actions either ongoing or complete.
52. Element 5 Saving Babies' Lives: Reducing preterm births and optimising perinatal care	• To carry on with monthly audits to monitor and improve compliance with all standards – action ongoing. • To raise awareness / educating staff through the MatNeo project to improve optimisation of the preterm infant. • To appoint a new preterm birth led midwife to support optimisation of the preterm infant – actions complete.

Audit title	Actions
53. Element 1 Saving Babies' Lives: Audit of smoking cessation training provision	• To achieve a minimum ambition of 90% attendance and a stretch ambition of over 95% attendance. • CO monitor use and discussion of results has been placed on the Midwifery Professional Day until December 2024. This is to ensure there is even rostering of staff over the year while balancing the clinical needs of the service. This is in-line with the Core Competency Framework plan made with the maternity practice education team. This session will also be included on the new maternity support workers induction program. • We will be recording training on CO monitoring and ask staff to complete a self-declare competence. • The action plan for 2023 is that VBA training and the smoking cessation pathway within maternity is to be covered within the Midwifery Professional Day, which is attended by midwives and maternity support works. • For 2024, all frontline maternity staff will be asked to completed VBA training via NCSCT e-learning package. This is in-line with the Core Competency Framework Version 2. An update of smoking cessation pathway within maternity will continue to be given face to face within the professional day training. • As per local smoking in pregnancy guideline all community midwives, NEST maternity support workers and selected antenatal core midwives are to be trained to NCSCT standard. At present there are 82 members of staff eligible for training. 74 of these members of staff have been rostered for training thus far. The action plan for the remaining 8 is that 5 have been booked for training in December 2023 and 3 to be booked on to training in 2024. As community staff are in constant flux training needs will be monitored by the public health midwives and the maternity e-rostering team to ensure that staff are adequately trained • Of the 74 members of staff who have attended training only 30 members of staff have provided full evidence. This information has been requested multiple times over the last year. The current action plan is to give a deadline of end October to evidence their training. If this is not provided, these issues will be escalated to their team lead, hours given for this training will be revoked and staff members asked to make up this time clinically. Hours for the training will be given once training has been evidenced – all actions complete.
54. Infection, Prevention and Control (IPC) – Isolation Audit	• 26 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 6 areas scored between 94% and 85% must produce an action plan.
55. Infection, Prevention and Control (IPC) – Sharps Audit	• 53 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 7 areas scored between 94% and 85% must produce an action plan. • 6 areas scored below 85% must produce an action plan. Care group managers and care group clinical leads to provide support for sub optimal areas.

Audit title	Actions
56. Compliance with Management and Monitoring of Nasojejunal Tube Feeding (6463)	• To disseminate and present results to gastroenterology. • To disseminate results to matrons and ward managers. • To disseminate results to dietetics. • To improve NJ tube documentation, to develop a NJ tube checklist. • To review and update Enteral Feeding Guidelines as necessary to arrange nursing staff training. • To identify conferences; ESPEN, BAPEN, BDA, UHS Always Improving where the audit and poster can be presented at. • Pilot NJ tube checklist – all actions complete.
57. Naloxone use at UHS	• To re-write the clinical guideline – action complete.
58. Assessing referrals for Neurology inpatient care, including in-hospital and tertiary centre transfers	• To create new admissions procedure where non-emergency cases (>72h urgent) are admitted as urgent elective cases – action complete.
59. Spinal emergency admissions bloods audit (7504)	• To introduce admission blood checklist to ensure all bloods have been taken to avoid any confusion about which bloods to be taken and to avoid duplication – action complete.
60. Baseline audit of patients up and dressed A baseline audit of the fundamentals of care enhancing safe movement (7595)	• To focus on promoting people to be up and dressed within ongoing fundamentals of care work – action ongoing. • To publicise availability of UHS clothes bank through communication channels – action complete. • To re-audit number of people up and dressed in future following fundamentals of care launch – action ongoing.
61. Enhancing Safe Movement fundamentals of care baseline audit (7606)	• To share results with fundamentals of care task and finish groups and overall implementation groups – action complete. • To explore options on inpatient noting to develop individualised care planning documentation – action complete. • To explore procurement and storage options for walking aids across the organisation – action ongoing. • To develop educational resources to focus on walking aids in reach and standards of care plans – action complete.
62. Identifying if consent and patient views and wishes would have been sought when raising adult safeguarding concerns in UHS (7684)	• To work with IT colleagues to simplify safeguarding concern form on Apex. • To work with partners such as SCAS, SCC and HCC to ensure all referrals sent to Safeguarding team include information regarding consent. • To revise adult safeguarding training to ensure consent and patients views and wishes are included – all above actions ongoing. • To provide VLE page and supervision policy to UHS staff to record safeguarding supervision record – action complete.
63. An audit of the provision of strategies to support communication in patients with communication impairment post stroke on HASU and F8 (7708)	• Following the initial audit, a summary of the audit findings will be emailed to the SLT team detailing the lack of compliance with providing detailed handovers and recommendations following initial communication assessment. • The importance of doing and recording this will be highlighted and the SLT team will be encouraged to provide communication strategies and clear handover to staff and families following initial assessment. • Updates will be given to family members during visiting hours at the patient bedside. This will allow more effective education on the communication impairment, more effective handover of strategies and will allow the SLT's time to be recorded under SSNAP – action complete.

Audit title	Actions
64. Auditing compliance of ward discharge for patients with dysphagia against the oropharyngeal dysphagia policy (6396)	• To feedback results to SLT team – action complete. • To circulate report to ward leads/matrons/division leads – action complete. • To support SLT adding thickener to JAC. • To support pharmacist to add thickener to TTOs for patient discharge. • To re-audit to include the following: - If patients are going to their discharge destination with tins of thickener and with x2 beakers - If patients have correct consistencies on their HMRs - If patients are having correct verbal handovers to discharge destination - If patients who require thickener have it included on their TTOs - If thickener is being prescribed on JAC by SLT - If thickener box on electronic notes is being ticked by SLT
65. Infection, Prevention and Control (IPC) – Sharps Audit	• 32 areas of non-submission must be supported by caregroup managers and care group clinical leads to complete the planned IPC audit programme. • 12 areas scoring between 85% and 94% will be required to re-audit within 3 months. • 2 areas scored below 85% will be required to submit an action plan and re-audit within 1 month.
66. Infection, Prevention and Control (IPC) – Audit of High Impact interventions Urinary Catheter Care Bundle	• Insertion - 23 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 1 area scored between 85% and 94% will be required to re-audit within 3 months. • Ongoing care - 8 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 2 areas scored between 85% and 94% are required to re- audit within 3 months. • 9 areas scored below 85% will be required to submit an action plan and re-audit within 1 month.
67. Infection, Prevention and Control (IPC) – Audit of High Impact interventions Peripheral Intravenous Cannula Care (December 2023 report)	• Insertion – 18 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 1 area scored between 85% and 94% are required to Re audit within 3 months. • 2 areas scored below 85% and will produce action plan to address non-compliance and provide evidence of implementation. • To re-audit within 1 month ensuring compliance addressed through action plan.

Audit title	Actions
68. Audit of High Impact interventions Central Venous Catheter Care (December 2023 report)	• Insertion – 4 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • Ongoing care – 11 areas of non-submission must be supported by care group managers and care group clinical leads to complete the planned IPC audit programme. • 3 areas scored between 85% and 94% are required to re- audit within 3 months. • 3 areas scored below 85% and the following actions will be required to produce an action plan to address non- compliance and provide evidence of implementation. • To re-audit within 1 month ensuring compliance addressed through action plan.
69. Consistent and comprehensive documentation of discharge advice for ACS patients attending CCU, as per ESC guidelines (7539)	• To ensure staff have better awareness of these guidelines amongst junior doctors / ACP / ANP roles. • To add flyers in CCU and doctor's room to enable a quick check – actions complete.
70. Clinical Audit to Assess the Image Quality of KUB Abdomen X-rays (7640)	• To put on some teaching sessions or use CPD mornings to provide face-to face training in positioning. • To inform the superintendents the result of the audit and discuss if there is a need for change of the current protocols – actions complete.
71. Element 2 Saving Babies' Lives: Fetal Growth: Risk assessment, surveillance, and management (7683)	• LMNS meeting - findings of audit shared around detection rates for <3rd >37+6 and QI project happening at QA in USS, awaiting results – action compete.
72. Element 2 Saving Babies' Lives: Fetal Growth: Risk assessment, surveillance, and management (7681)	• To present variance to the ICB for sign off for UHS to scan from 26 weeks – action complete.
73. Saving Babies' Lives 1.1 part 2, Local audit using patient reports to identify pregnant women declining CO screened at booking and 36 weeks (7757)	• To email community midwives to remind of the need for CO testing, details of the current guidance and offer of support if they identify any learning needs – action complete.
74. Saving Babies' Lives Element 2: Fetal Growth: risk assessment, surveillance, and management (7679)	• To send out a poster to community staff to improve awareness and compliance – action complete.
75. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy (7674)	• To create "importance of CO monitoring in pregnancy" for community hubs and social media sharing – action complete.

Audit title	Actions
76. Element 1 Saving Babies' Lives: Booking and 36 weeks co monitoring and smoking status (7676)	• Data quality checks with email to be sent out to community midwives. • To send staff emails and text of current guidance – actions complete.
77. Element 1 Saving Babies' Lives: Reducing smoking in pregnancy 1.4 and 1.6 (7677)	• To share audit results and learning – action complete.
78. Element 2 Saving Babies' Lives: Fetal Growth: risk assessment, surveillance, and management (7679)	• To send out poster communication to community staff to improve awareness and compliance – action complete.
79. Element 4 Saving Babies' Lives: Effective fetal monitoring during labour (7691)	• The Fetal monitoring leads have implemented Buddy system on LW for CTG peer reviews & a communication message on LW – action complete. • To re-audit in 1 month to assess compliance – action complete. • Aim to increase compliance to >80% - action ongoing. To re-audit 10 sets if notes of notes per month until compliance reaches target of >80% - action ongoing.
80. Element 1 Saving Babies' Lives: audit of smoking cessation training provision (7697)	• To email out link for self-declaration to update co monitor training and knowledge of results. • To continue teaching on maternity professional day. Request doctor education led to include VBA to their mandatory training. • To follow up with midwives who have not submitted evidence of training – actions complete.
81. Element 3 Saving Babies' Lives: Raising awareness of reduced fetal movements (7688)	• To update to the RFM guideline and will be circulated to all staff. Main changes around RCOG RM checklist – action complete
82. Element 4 Saving Babies' Lives: Reducing preterm births and optimising perinatal care (7692)	• To complete monthly audits to monitor and improve compliance with all standards – action ongoing. • MDT raising awareness/educating staff through the MatNeo project to improve optimisation of the preterm infant. • A new preterm birth led midwife to be appointed to support Optimisation of the Preterm infant – action complete.
83. Element 2 Saving Babies' Lives: Fetal Growth: risk assessment, surveillance, and management (7679)	• To communicate to staff documentation at booking around Vitamin D supplementation – action complete.
84. Element 2 Saving Babies' Lives: Fetal Growth: risk assessment, surveillance, and management (7679	• To send out a poster to community staff to improveawareness and compliance – action complete.
85. Use of hearing aids with secure battery drawers in audiology (6718)	• Change to notes template for HA reviews and repairs to remind clinician to ask about battery drawer if not previously documented, this can be removed after 1 year – action complete.

Audit title	Actions
86. Auditing Neuro wards' (E Neuro, D Neuro and F4 Spinal) compliance with the implemented International Dysphagia Diet Standardisation Initiative (IDDSI) fluid and diet guidelines and protocols (7393)	• All ward beverage/kitchen areas to have IDDSI posters in clear view. • Training for all ward staff to educate them in the use of correct terminology. • Further education for appropriate ward staff regarding the importance of taster charts and guidelines for documentation on them • Education of Speech and Language Therapy staff re where to put taster charts and ensuring appropriate handover to ward staff – actions complete.
87. Completion of recommended onward referrals following diagnosis of a permanent childhood hearing impairment (PCHI) (5267)	• To present audit findings to team. • To discuss with appropriate staff if ENT referrals are still deemed necessary – actions complete.
88. British Society for Dermatological Surgery (BSDS) National Sustainability Skin Surgery Audit (7667)	• To present audit results locally. • Dr N to continue discussions regarding disposable biopsy kits. • To arrange suturing session with Dr N given variability in suturing practices (dissolvable vs removable). • Reinforce the need to turn computers off at end of sessions – all actions complete. • To trial varying scrub techniques (scrub at start of list only, blue gloves for punch biopsies) and monitor for any adverse events or infection rates – action ongoing.
89. Venous thromboembolism (VTE) Risk Reassessment on Bassett ward	• To ensure the completion of the trust VTE risk re- assessment proforma via the worklist immediately the clinical situation changes. • To review weekly and discuss VTE risk re-assessment of patients on the ward during the board round. • To hand over as well as show other colleagues how to carry out and document VTE risk re-assessment. • To paste reminder / poster at doctors' workstation. • To re-audit to ensure actions have improved compliance.
90. Infection, Prevention and Control (IPC) – Inpatient Hand Hygiene Audit report 2024	• 29 areas and 11 theatres did not complete the audit these areas to be supported by Care group management teams to complete the infection prevention programme of audits. • 17 areas scored between 85% and 94% and 7 areas scored below 85%, all areas to develop an action plan based on their findings to ensure compliance is achieved and maintained.
91. Infection, Prevention and Control (IPC) – Outpatient Hand Hygiene Audit report 2024	• 14 areas did not submit an audit these areas to be supported by Care group management teams to complete the infection prevention programme of audits. • 3 areas scored between 85% and 94% and1 areas scored below 85%, all areas to develop an action plan based on their findings to ensure compliance is achieved and maintained.

Audit title	Actions
92. Assessment of paediatric dietitian prescribed feeds and appropriate paediatric dietetic referrals audited against the 'Nasogastric tube placement and care in paediatrics guideline 2020 Version 6' on PHDU, G2 Neuro, G4, Piam Brown (7596)	• Every patient with a feeding tube to be referred to the dietitians. • Information to be circulated to staff in the Nursing "Big Four". • To re-audit and see if "Big Four" bulletin has increased referrals – action complete. • To update the "Nasogastric Tube Placement & Care in Paediatrics" version 6. To include a directive statement that all patients with a feeding tube must be referred to dietetics, via e-quest, in a certain time – action ongoing.
93. Saving Babies' Lives 1.1 part 2: Local audit using patient reports to identify pregnant women declining CO screened at booking and 36 weeks (7757)	• To email community midwives to remind them of the need for CO testing, details of the current guidance and offer of support if they identify any learning needs – action complete.
94. Modified fluids audit – compliance of bedside jug fluid consistencies against SLT recommendations and related documentation (5425)	• To circulate report to ward leads/matrons/divisi on leads via email. • To offer ward training to ward leads/matrons/division leads via email – actions complete. • To feedback results to SLT team – action ongoing.
95. Screening of iron deficiency (ID) in patients admitted with heart failure (7042)	• To target community iron repletion therapy after hospital discharge is our next intervention. Patients will be screened as in-patients for ID, this will be highlighted in their discharge summery and documented on e-DOCS with eTCI to come back for intravenous iron infusion. • Junior medical staff to highlight on discharge summary/document on e-DOCS and eTCI.
96. Clinical Audit to Assess the Image Quality and Adherence to Protocol of Orthopantograms within ED (7627)	• Audit findings will be presented to staff as a teaching. It will be explained how to avoid making common errors – action complete. • All artefacts are to be removed from the patient prior to OPG imaging. If artefacts are unable to be removed, a CRIS comment must be written justifying because they could not be removed. • Re-audit to be done within 1-2 years. • A member of staff within the ED X-ray department should ideally conduct a re-audit annually or bi-annually to compare their results with the previous audit. This will highlight where improvements can be made, while showing which aspects are being done better or worse after a set period.
97. Trustwide Bed Rail Audit (7169)	• To develop a VLE training session on bed rails – this will take 12 months to finalise – action ongoing. • To develop patient information resource on bed rails – action complete • Bed rail risk assessments to be updated on inpatient noting to ensure compliance with NPSA – This has been added to the risk register due to digital team not being able to complete yet. • VLE resource page to go live - resources to include teaching session, information poster, flow chart and bed rail policy.

2.2.3 Recruiting to research

The number of patients receiving relevant health services provided or subcontracted by UHS in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was over 10,000. We ranked fourteenth for total recruitment amongst all acute NHS Trusts in England and delivered the most COVID-19 studies.

More information about our commitment to research can be found in the section 'Our commitment to research' in part 3 of this report.

2.2.4 Commissioning for quality and innovation (CQUIN) payment framework

The CQUIN payment framework makes a proportion of NHS healthcare providers' income conditional upon achieving certain improvement goals. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

NHS England define CQUIN as 'a mechanism to secure improvements in the quality of services better outcomes for patients and drive to transformational change by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

University Hospital Southampton NHS Foundation Trust income in 2023/24 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework following local agreement.

Further details of the agreed goals for 2023/24 and for the following twelve-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-23-24/

The CQUINS income is conditional upon achieving for

NO.	CQUIN	CQUIN Aims
CCG1	Flu	Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.
CCG3	Prompt switching of intravenous to oral antibiotics	Achieving 40% of patients still receiving IV antibiotics past the point at which they meet the switching criteria.
CCG5	Identification and response to frailty in emergency departments	Achieving 30% of patients aged 65 and over attending A&E or same day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
CCG7	Recording of response to NEWS2 score for unplanned critical care admissions	Achieving 30% of all unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.
CCG6	Timely communication of changes to medicines to community pharmacists via the discharge medicine service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patients chosen community pharmacy within 48 ours following discharge, in line with NICE Guideline 5, via secure electronic message.

NO.	CQUIN	CQUIN Aims
CQUIN08	Achievement of revascularisation standards for lower limb Ischaemia	Following guidance published by the vascular society to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions, and amputation rates. Estimated annual savings are £12 million.
CQUIN11	Achieving high quality shared decision making conversations in specific specialised pathways to support recovery	Achieving high quality shared decision (SDM) making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits, and consequences of the options available to them. This CQUIN indicator highlights the importance of the NICE Guideline on SDM and the GMC Guidance on Decision Making and Consent and supports providers to consider their approach to maximise compliance to those regulatory documents. The specific aim of the 2023/24 indicator is to embed the work in 2022/23 to achieve high quality SDM conversations in certain specialised pathways and to support roll-out of that work more widely across organisation.
CQUIN09	Achieving progress towards hepatitis C elimination within lead hepatitis C centres	While good progress is being made towards the NHSE public commitment to achieve hepatitis C elimination ahead of the WHO target of 2030 and be the first country in the world to do so, currently, the system is becoming blocked up by people diagnosed not making it in a timely fashion into treatment. Time from referral to treatment (RTT) should not exceed 4 weeks (in line with HIV care), but many patients are exceeding this – especially those in addiction services. Such patient cohorts remain able to communicate the disease to others for the period that they are untreated. Further, the longer the time these vulnerable patients remain without treatment, the more likely they are to be lost to the system altogether or to experience negative impact on their liver condition. This CQUIN therefore has a shift in focus relative to the 2022/23 Hep C CQUIN indicator. It is in support of the programme and funding for ODNs to provide the end-to-end care pathway. ODNs are asked to work with partners to generate sufficient capacity to meet the RTT target.
CQUIN10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation. There are a variety of options for treatment with curative intent. This indicator sets out the comprehensive range of treatment modalities that should be considered either individually or in combination. Decisions about treatment options should be taken at cancer multidisciplinary team meetings and involve patients.

2.2.5 Statements from the Care Quality Commission (CQC)

UHS is required to register with the CQC, and its current registration status is registered without conditions attached to the registration.

The CQC has not taken enforcement action against UHS during 2023/24.

UHS has not participated in any special reviews or investigations by the CQC during the reporting period.

The registration details are available on the CQC website.

The CCQ last location inspected the Trust between December 2018 and January 2019. The inspection focused on the quality of four core services: urgent and emergency care, medicine, maternity, and outpatients, as well as management, leadership, and the effective and efficient use of resources. In January 2019 NHS Improvement carried out a Use of Resources (UoR) inspection and the CQC completed their inspection.

The report was published on the 17 April 2019 and the Trust was rated as 'good' overall and 'outstanding' for providing effective services.

On the 15 May 2023 the CQC carried out an announced focused inspection of our maternity service at Princess Anne Hospital as part of their national maternity inspection programme. The inspection looked only at the safe and well-led key questions. They did not inspect the other service run by UHS including the New Forest Birth Centre, as it is currently dormant for delivery of babies.

An inspection report was published on 08 August 2023 with an overall rating. They did not review the rating of the location; therefore, our overall rating of UHS stayed the same ('good'), and Princess Anne Hospital remains rated as 'good'.

The CQC stated 'our rating of this service stayed the same. We rated it as good because:

- Most midwifery staff had training in key skills and worked well together for the benefit of women and birthing people.
- understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well and staff assessed risks to women and birthing people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service.
- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. Staff were clear about their roles and accountabilities. The service engaged with women and birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment. Staff were committed to improving services continually'.

One requirement notice was issued: Maternity and midwifery services Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment, with three 'must do' and three 'should do' recommendations. The Trust developed an improvement action plan to address the recommendations with governance oversight provided by the quality governance steering group.

All sites and services across the organisation are now rated as 'good' in the effective and caring domains, with Southampton General Hospital 'outstanding' in these areas.

Overall rating for this Trust	Good
Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Outstanding
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Requires improvement
Are services at this Trust well-led?	Good

The CQC have now launched their new assessment framework for providers, local authorities and systems called the single assessment framework (SAF). It focuses on what matters to people who use health and social care services and their families and aims to provide an up-to-date view of quality.

This will be the biggest change in the way in which care providers are assessed, inspected, and rated since its formation. Going forward the CQC will use a range of information to assess providers flexibly and frequently. Assessment will not tie to set dates or driven by a previous rating, and assessment will be based on evidence collected on an ongoing basis. On site visits ('inspections') will still be used as a vital tool to gather evidence to assess quality, and evidence will be scored to make judgements more structured and consistent.

With this change brings the opportunity for the Trust to align with this new vision and continue to drive ourselves to provide the best possible care for the people who use our services and the best environment for our staff.

2.2.6 Registration with the CQC

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high-quality care and encourages care services to improve.

Registration with the Care Quality Commission: UHS is required to register with the Care Quality Commission and its current registration status for locations and services is as below.

Regulated activity: Surgical procedures:

Provider conditions: This regulated activity may only be carried on at the following locations:
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton SO16 6YD
- Regulated activity: Treatment of disease, disorder, or injury
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton SO16 6YD
- Lymington New Forest Hospital - Surgical patient pathway and outpatients Wellworthy Road, Lymington, Hampshire SO41 8QD

Regulated activity: Maternity and midwifery services
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton SO40 7AR
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA

Regulated activity: Diagnostic and screening services
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton SO14 0YG

- Southampton General Hospital, Tremona Road, Southampton SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton SO40 7AR

Regulated activity: Transport services, triage and medical advice provided remotely
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton SO16 6YD
- Hampshire and Isle of Wight Air Ambulance (HIOWAA)

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act Provider conditions:
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton SO16 6YD

UHS was registered with the CQC since its inception in 2010 and has maintained its registration without conditions or enforcement action ever since, including 2023/24.

2.2.7 Payment by results

UHS was not subject to the Payment by Results (PbR) clinical coding audit report for 2023/24 by the Audit Commission.

The last PbR audit was in 2013/14 and no further external audits were recommended for the Trust, as we were found to be fully compliant. The Audit Commission has now ceased to exist; however, the Trust continues to maintain an internal audit programme, carried out by Approved NHS Digital Clinical Coding.

2.2.8 Data quality

A vital pre-requisite to robust governance and effective service delivery is the availability of high-quality data across all areas of the organisation. Data quality is an assessment of how accurate, complete, and timely the data entry of patient care and activity is. Data quality is important to the Trust as it helps us keep an accurate record of a patient's journey which supports the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. Poor data quality can result in delays in patient treatment, increased workload, loss of income and misleading data .

The data quality team audit hundreds of records on a monthly basis. We are interested in helping create better data entry across the Trust and continually review areas of interest for improvement.

UHS submitted records between April 2023 – Nov 2023 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As of November 2023 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number were:
- 99.4% for admitted patient care.
- 99.8% for outpatient care.
- 95.3% for accident and emergency care.

which included a valid General Medical Practice Code were:
- 100% for admitted patient care.
- 99.7% for outpatient care.
- 99.5% for accident and emergency care.

UHS will be taking the following actions to improve data quality:

- Data services routinely reviews and updates its data quality checks and procedures to ensure they are robust and in line with any changes to national policy.
- Analyse the data and classify the inaccuracies according to the key error codes.
- Identify areas of poor data quality and bad practices.
- Make recommendations to help improve the quality of data.

2.2.9 Data Security and Protection Toolkit (DSPT)

The DSPT is an online assessment tool that enables the Trust to measure its performance against the national data guardian's ten data security standards. Submission of the DSPT is a mandatory annual requirement.

The Trust's submitted its 2022/23 assessment in June 2023. The Trust was unable to provide the required level of assurance for one of the mandatory assertions. That assertion was 3.2.1 "Have at least 95% of all staff, completed their annual Data Security Awareness Training?". An improvement plan was submitted and accepted by NHS Digital.

As a result, the Trust is 'approaching standards and actions are in place to increase the percentage of staff completing their data security training. This includes regular reporting to senior management and a refresh of the online training package.

2.2.10 Learning from deaths

During 2023/24 2,142 UHS patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Number of deaths per quarter 2023/24

Q1	Q2	Q3	Q4
528	571	578	557

By 31 March 2024, 130 case record reviews and 13 investigations have been carried out in relation to the deaths included in the table above.

In three cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: zero in the first quarter; two in the second quarter; one in the third quarter; and zero in the fourth quarter.

Three, representing 0.14% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of zero representing 0% for the first quarter; two representing 0.1% for the second quarter; one representing 0.05% for the third quarter; and zero representing 0% for the fourth quarter.

These numbers have been estimated using the total incident investigations related to patient deaths referred to and investigated by the patient safety team using the structured judgement review (SJR) and root cause analysis (RCA) methodologies.

These referrals come from medical examiners, adverse event reporting, child death and deterioration group (CDAD), clinical events reviews, the infection prevention team and clinicians involved in care.

From 1 April 2023 until current there were six investigations that the patient died as a direct result of the incident.

Examples of learning from case record reviews and investigations conducted in relation to the deaths identified is presented below:

Case one

Thematic learning – lack of clarity of roles and responsibilities for patients on enhanced observations.

Summary of completed action(s) – relaunch of enhanced care policy with healthcare care assistant (HCA) induction to included session on enhanced care policy.

How learning has been shared – teaching to ward staff, and dissemination through the care group governance teams.

Impact of actions – deepen the understanding and compliance with the enhanced are policy.

Case two

Thematic learning – Stroke recognition, soft signs and confirmation bias not recognised.

Summary of completed action(s) – education on stroke identification through mandatory training and walkabout/trolley dashes on the wards re importance of formal neurological assessment, early CT scan and prompt referral to stroke team. Monthly study days to include.

How learning has been shared – neurological assessment and observations to be include in the medical rolling half day teaching sessions and through nursing mandatory study days.

Impact of actions – staff will have increased knowledge on assessment and recognition of stroke signs and actions required if concerned.

Case three

Thematic learning – Delay in recognising facture hip following an inpatient fall. Due to mechanism of the fall (low impact from sitting position) reduced focus on full assessment for injury.

Summary of completed action(s) – post falls assessment to be fully completed and documented using the falls grab pack. Post falls assessment updated to include more prompts for assessments for injury. MDT education continues in post falls assessment and management.

MDT staff to record and escalate concerns where all teams access the information.

How learning has been shared – Discussed at care group governance and M&M meetings.

Impact of actions – improved communication of concerns between MDT and accurate full body assessment of patients post fall.

Case four

Thematic learning – ensuing that patients placed in enhanced observation bay are maintained wherever possible. Timely assessment of falls risk and completion of post falls documentation.

Summary of completed action(s) – reminder alert placed on electronic documentation highlighting need for review of falls assessment. Importance of staff remining in the observation bay highlighted to staff. Education to all staff on timeliness of documentation completion.

How learning has been shared – Case and learning discussed at ward huddles.

Impact of actions – Documentation will be audited to ensure compliance is maintained. Staff will communicate and plan when a bay cannot be observed.

Zero case record reviews and nine investigations completed after 1 April 2023 which related to deaths which took place before the start of the reporting period.

There are currently one investigations ongoing which relate to deaths which took place during the reporting period, however final actions and therefore learning points are not yet available.

Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the SJR and RCA methodologies.

Zero representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.11 Reporting against core indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital to enable the public to compare performance across organisations.

The tables below provide information against several national priorities and measures that, in conjunction with our stakeholders, form part of our key performance indicators which are reported monthly to the Trust's board.

These measures cover patient safety, experience, and clinical outcomes. Where possible we have included national benchmarks or targets so that progression can be seen, and performance compared to other providers.

All the core indicators are updated with the most recent publications from NHS Digital/NHSE and NHS Improvement/Gov.uk.

The following agreed metrics used in previous years are no longer available as we no longer collect this information:

- Groin hernia surgery and varicose vein surgery. In the past neither hernia repair nor varicose vein surgery were reported on in the quality accounts because the low numbers being performed meant it was not statistically significant. This was confirmed by checking the registries through NHS Digital for hernia and varicose vein surgery for 2017/18 and continues to date. There were only small numbers for hernia repair and no data available for varicose veins. Varicose veins are treated at UHS, but they are dealt with at the independent treatment centre.

- The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period: data has not been collected for the past three years. Our VTE programme continues and aims to reduce preventable harm to our patients by promoting timely and accurate VTE risk assessment and ensuring thromboprophylaxis.

Core indicator 19: the percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	2019/20	2020/21	2021/22	2022/23	2023/24
Emergency readmissions, within 28 days (as average of monthly %)	11.76%	12.4% April – Feb	11.83% April – Jan	11.50%	12.14%

Regulatory/Assurance Statement:
UHS considers that this data is as described for the following reasons: we have a process in place for collating data on hospital admissions from which the readmission indicator is derived. We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. UHS has taken the following actions to improve the percentage of patients readmitted to a hospital, and so the quality of its services by working to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission, working with partners in the system to address long-standing pressures around demand, capacity and patient flow and working closely with system partners to ensure safe discharge practice.

Core indicator 20 : The Trust's responsiveness to the personal needs of its patients during the reporting period.
Extracted from the most current NHS Friends and Family Test (FFT) feedback

RHM	RESPONSE RATE				
A&E	**Q1 2022/23**	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**2022/23**
UHS response rate	0.33%	0.05%	0.10%	0.06%	0.10%
National Average	10.00%	10.25%	9.76%	10.61%	10.18%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%

RHM	RESPONSE RATE				
Inpatient and daycase	**Q1 2022/23**	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**	**2022/23**
UHS response rate	4.86%	5.16%	4.70%	5.10%	4.96%
National Average	19.12%	19.66%	19.08%	19.72%	19.42%
Highest Trust	100.00%	100.00%	100.00%	189.60%	189.60%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%

RHM	POSITIVE				
A&E	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	2022/23
UHS response rate	2.84%	4.55%	3.41%	4.31%	3.51%
National Average	0.08%	0.08%	0.08%	0.00%	0.00%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust	33.33%	39.25%	20.00%	0.00%	0.00%

RHM	POSITIVE				
Inpatient and daycase	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	2022/23
UHS response rate	0.29%	0.19%	0.18%	0.20%	0.21%
National Average	0.09%	0.09%	0.09%	0.00%	0.00%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust	62.67%	64.15%	57.08%	65.82%	57.08

RHM	NEGATIVE				
A&E	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	2022/23
UHS response rate	0.00%	0.00%	0.00%	0.00%	0.00%
National Average	0.00%	0.00%	0.00%	0.00%	0.00%
Highest Trust	66.67%	60.00%	80.00%	197300.00%	197300.00%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%

Regulatory/Assurance Statement:
UHS considers that this data is as described for the following reasons: collating the results of a selection of questions from the national inpatient survey focusing on the responsiveness to personal needs. Benchmarking our performance against our peers.

UHS has taken the following actions to improve the Trust's responsiveness to the personal needs of its patients, and so the quality of its services by continuing to collect real-time feedback from patients as part of its inpatient survey, working to increase the FFT response rate this year and expanding the work of the patient experience and involvement team.

Core indicator 21: The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Staff Recommends Care %	2020/21	2021/22	2022	2023
UHS	92%	83%	78.8%	76.31%
Highest score	100%	58.4%	86.4%	88.82%
Lowest score	39%	38.5%	39.2%	44.31

Regulatory/Assurance Statement:
UHS considers that this data is as described for the following reasons: We use nationally reported and validated data from the national staff survey and our results perform well in comparison to other acute trusts with improvement shown this year.

UHS has taken the following actions to improve the percentage of staff who would recommend the Trust as a care provider, and so the quality of its services by continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received. Consolidating our initiatives, while continuing to pay attention to priority areas of the staff survey: bullying and harassment and health and wellbeing.

UHS considers that this data is as described for the following reasons: We use nationally reported and validated data from the national staff survey and our results perform well in comparison to other acute Trusts with improvement shown this year.

UHS has taken the following actions to improve the percentage of staff who would recommend the Trust as a care provider, and so the quality of its services by continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received. Consolidating our initiatives, while continuing to pay attention to priority areas of the staff survey: bullying and harassment, health, and wellbeing.

Core indicator 23: The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period.

The VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. This was communicated via this letter on 28 March 2020.

Core indicator 24: the rate per 100,000 bed days of cases of C. difficile infection reported within the Trust among patients aged two or over during the reporting period.

The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust among patients aged two or over during the reporting period.

	2019/20	2020/21	2022/23	2023/24
UHS	12.3	38.7	14.12	15.2
National Average	13.2	45.6	16.47	18.5
Highest Trust Score	51	141	53.62	73.3
Lowest Trust Score	0	0	0	0
Lowest Trust Score (non-zero)	1.7	2.3	0.97	3.8

Regulatory/Assurance Statement:
UHS considers that this data is as described for the following reasons: we use nationally reported and validated data; we monitor performance regularly through our Trust Infection Control Committees and daily and weekly taskforce meetings.

UHS has taken the following actions to improve the rate of C difficile infection, and so the quality of its services by: focusing on improving hand hygiene; adopting national and local campaigns including visual prompts and hand hygiene stations prominently positioned at entrances to the hospital and ward areas; raising the profile of infection prevention throughout the Trust and at board level; training staff on infection prevention and hand hygiene; focusing on high standards of cleanliness, screening of emergency and elective patients and focusing on effective antibiotic stewardship and ensuring that patients are effectively isolated and monitoring and feeding back on cases where inappropriate prescribing is a possible contributory factor.

Core indicator 25: the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	Oct19-Mar20	Apr 21-Mar 22	2022/23	2023/24
UHS				
Rate Incidents per 1000 admissions	34.50	38.10	30.20	Data not available*
Number Incidents	6373	1153	11327	
Number Severe Harm	43	78	77	
% Severe harm or death	0.67%	0.78%	0.68%	

Regulatory/Assurance Statement:
* "September 2023 update: We have paused the annual publishing of this data while we consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS." – NHSE Website

Other Information

Patient Safety Indicators data for 2023/24:

	2020/21	2021/22	2022/23	2023/24
Serious Incidents Requiring Investigation (SIRI) from STEIS	90	70	118	No longer collected
VTE	-*	-*	-*	141,740
Never Events	1	6	3	8
Healthcare Associated Infection MRSA bacteraemia reduction	1	No available data	n/a	71
Healthcare Associated Infection Census" (as average of monthly %)	299%	No available data	No available data	No available data
Healthcare Associated Infection Clostridium difficile reduction	63	71	80	97
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	20	No available data	191	206
Falls - Avoidable Falls	2	No available data	61	Process of data capture has changed. This is no longer recorded

Regulatory/Assurance Statement:
UHS considers that this data is as described for the following reasons: we use nationally reported and verified data from the NRLS.

UHS intends to take the following actions to improve this percentage of patient safety incidents reported that resulted in severe/major harm or extreme harm/death and so the quality of its services by continuing to work to eliminate avoidable harm and improve outcomes.

		2018/19	2019/20	2020/21 YTD	2021/22 YTD	2022/23 YTD	2023/24 YTD
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		86.6%	82.2%	59.9%	69.1%	68.7%	62.9%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge		86.3%	75.9%	91.1%	74.3%	61.8%	61.4%
All cancers- 62 day wait for first treatment from:	Urgent GP referral for suspected cancer	73.8%	74.6%	81.3%	73.3%	81.2%	66.5%
	NHS Cancer Screening Service referral	81.5%	89.2%	79.2%	82.1%	62.3%	79.6%
C.difficile variance from plan		-25.0%	9.4%	-1.6%	-17.5%	-40.0%	-76.3%
Maximum 6-week wait for diagnostic procedure		97.9%	97.1%	62.4%	79.2%	75.6%	81.5%

2.2.12 Seven-day hospital services

The seven-day hospital services (7DS) programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed and since 2015 trusts have been asked to report on four priority standards:

Clinical standard two: consultant-directed assessment.
Clinical standard five: diagnostics.
Clinical standard six: interventions.
Clinical standard eight: ongoing review.

The Trust currently meets all four of these standards and delivers a comprehensive 7DS which helps keep patients safe and helps with flow through the hospital seven days a week. This has been particularly important during our recovery from the COVID-19 pandemic, and while working to meet the national challenges around patient flow.

Clinical standard two: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

All emergency specialties have consultant on call rotas with either planned ward round review to support the standard or continuous review throughout the shifts. The timing of review is entered through the electronic system which enables monitoring.

In November 2019 UHS audited compliance and demonstrated we achieved the standard 95.52% of the time. On average patients waited 3 hours 17 minutes for an assessment, 3 hours 41 minutes on a weekday and 2 hours 20 minutes at the weekend. Further audits are planned during 2023/24.

Clinical standard five: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

- Within one hour for critical patients.
- Within 12 hours for urgent patients.
- Within 24 hours for non-urgent patients.

UHS consistently achieves this standard across seven days a week, all specialties provide consultant cover and interventions seven days a week:

- Within one hour for critical patients.
- Within 12 hours for urgent patients.
- Within 24 hours for non-urgent patients.

We also provide many of these services for neighbouring trusts, including interventional radiology, MRI, interventional endoscopy, emergency surgery, percutaneous coronary intervention and complex cardio arrhythmia and microbiology.

Clinical standard six: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

Due to radiology working practices and economies of scale UHS consistently achieves Clinical Standard 6 target across seven days a week for:

- Critical care
- Interventional radiology
- Interventional endoscopy
- Emergency surgery
- Emergency renal replacement therapy
- Urgent radiotherapy
- Stroke thrombolysis and 7-day mechanical thrombectomy cover.
- Percutaneous coronary intervention
- Cardiac pacing

Clinical standard eight: All patients with high dependency needs should be seen and reviewed by a consultant twice daily (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway:

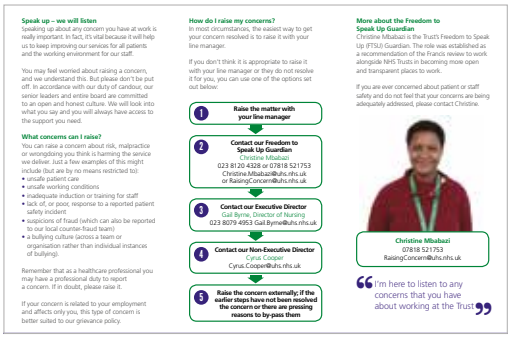
The Trust is meeting this standard by twice daily consultant reviews taking place in admission areas, intensive and high care areas, and once daily review in other inpatient wards.

UHS supported achieving this standard by implementing NEWS2 across all adult areas (excluding obstetrics) as described previously in this report. Patient acuity and needs are updated daily on the doctors' worklist application which provides detail on handover and to the on-call team. Patients requiring urgent review are seen by the duty team as highlighted through the national early warning score (NEWS2) or by the nursing team.

2.2.13 Freedom to speak up (FTSU)

From time to time, conflict arises in the workplace or people may feel they are being treated in ways that make them feel uncomfortable or even bullied. We recognise this can have a profound impact on our staff members' lives and are committed to continuing to promote an open and supportive culture to ensure that all employees, workers, and volunteers feel safe in speaking up about issues of the quality of patient care, safety, or their own personal experiences. We recognised this culture as being vital in promoting an environment where mistakes are acknowledged, learned from, and prevented from happening again.

The Trust has had its own FTSU guardian as an independent and impartial source of advice for those wishing to speak up since October 2017. The role is supported by the FTSU national guardian's office, which is responsible for providing leadership, training, and advice to FTSU guardians.



Speak up – we will listen

Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our senior leaders and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need.

What concerns can I raise?

You can raise a concern about risk, malpractice or wrongdoing you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team)
- a bullying culture (across a team or organisation rather than individual instances of bullying).

Remember that as a healthcare professional you may have a professional duty to report a concern. If in doubt, please raise it.

If your concern is related to your employment and affects only you, this type of concern is better suited to our grievance policy.

How do I raise my concerns?

In most circumstances, the easiest way to get your concern resolved is to raise it with your line manager.

If you don't think it is appropriate to raise it with your line manager or they do not resolve it for you, you can use one of the options set out below:

1. **Raise the matter with your line manager**
2. **Contact our Freedom to Speak Up Guardian**
   Christine Mbabazi
   023 8120 4328 or 07818 521753
   Christine.Mbabazi@uhs.nhs.uk
   or RaisingConcern@uhs.nhs.uk
3. **Contact our Executive Director**
   Gail Byrne, Director of Nursing
   023 8079 4953 Gail.Byrne@uhs.nhs.uk
4. **Contact our Non-Executive Director**
   Cyrus Cooper
   Cyrus.Cooper@uhs.nhs.uk
5. **Raise the concern externally; if the earlier steps have not been resolved the concern or there are pressing reasons to by-pass them**

More about the Freedom to Speak Up Guardian

Christine Mbabazi is the Trust's Freedom to Speak Up (FTSU) Guardian. The role was established as a recommendation of the Francis review to work alongside NHS Trusts in becoming more open and transparent places to work.

If you are ever concerned about patient or staff safety and do not feel that your concerns are being adequately addressed, please contact Christine.

To raise awareness with our staff, the Trust provides FTSU education sessions at Trust induction to ensure that all new starters are aware of the FTSU guardian/champions and our raising concerns (whistleblowing) policy. We provide education to ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively. We also send out regular communications across the Trust to raise the profile and understanding of the raising concerns agenda.

We have a multidisciplinary approach to concerns raised through our monthly raising concerns (whistleblowing) steering group, chaired by an executive lead. The group shares key findings/recommendations from concerns that have been raised to foster a culture of openness, transparency, and learning from mistakes. The group monitors evidence that investigations are evidence based and led by someone suitably independent in the organisation. This information is regularly fedback to the different divisions by the FTSU guardian and champions and work with them and HR on different strategies as well as learning. Future plans include working with the organisational development team to work together on using themes and feedback to work with them in supporting the work culture of the organisation.

We have developed a network of fully trained FTSU champions so that all staff can access confidential and impartial support in times of need. This team of advisors are available to support staff who are subject to, or accused of, bullying, harassment and discrimination while at work; staff who need advice on issues such as conflict in the workplace; and staff who are thinking of leaving UHS. They are there to empower staff to take control over their situation by explaining relevant policies, discussing their available options, and providing practical and emotional support in a safe setting. In the last year we have successfully grown the number of champions from 60 to 104, recruited from all from staff groups.

Our progress and performance are measured through our annual staff survey and FFT results as well as feedback from those who have raised concerns. Benchmarking concerns we have received against national FTSU guardian's office data and the regional FTSU guardian network helps us track our performance. High level findings are presented at Trust Board on a bi-annual basis and include overviews of the cases reported and any themes identified. We also discuss progress against the national FTSU office guidance for NHS Trusts and self-assessment tool, progress against key actions related to the vision and strategy and any relevant benchmarking or recommendations following national publications.

We continue to improve our resource page on our internal sutranet with up-to-date information about our FTSU service, and promotional leaflets and posters available and displayed in all working areas. Our guardian arranged listening events around the organisation with senior management with the aim of understanding concerns and issues around the Trust in different departments.

What our tell us

2.2.14 Rota gaps

The guardian of safe working is responsible for ensuring that working hours are safe for junior doctors; we know that this is important for patient and staff safety.

The guardian also helps support the implementation and maintenance of the contract for doctors in training, has independent oversight of junior doctors' working hours and works with the medical workforce team to identify any training opportunities. The guardian provides a mechanism whereby safety concerns related to working hours and rota gaps can be identified, responded to, and addressed. A regular report is submitted to Trust Board which includes updates on rota compliance, vacancies/gaps and plans for improvement and junior doctor exception reporting.

We act each month to make sure that rota gaps are identified and filled wherever possible. We aim for proactive engagement with Health Education England (HEE) so we can accurately plan targeted campaigns for hard to recruit specialties and the judicious use of locums where necessary. We also embrace the UHS Fellowship and aim to offer the same safeguards for all our junior doctors whether in deanery training posts or not.

There are 646 doctors-in-training employed by the Trust and they all work on the 2016 contract.

There are 418 junior doctors employed in non-training posts; all these doctors work on UHS local terms and conditions which mirror the 2016 contract.

The current vacancy rate is 10.56% which equates to 104 wte vacant posts. Recruitment continues for current vacancies and medical HR are working with departments to plan for future gaps. There are certain specialties where recruitment and retention are particularly challenging including general medicine, PICU and general surgery.

From the 1 July 2022 the NHS Professionals (NHSP) connect contract was ceased and all locum bank duties were processed through Medic OnLine and HealthRoster (software that was already procured and funded by UHS).

The expenditure for locums continues to be high, relating to covering both short-term vacancies and longer-term gaps in the rotas.

The changes in locum rates from September 2022 for doctors in training and subsequent communication have improved clarity for everyone involved and identified departments which have significant challenges in recruitment and retention.

Exception reporting continues to be both low risk and low cost to the Trust.

There is ongoing monitoring of exception reporting and appropriate support given to the consultant rota leads and the medical workforce team.

Medical recruitment remains a high priority for the Trust and there is continued vigilance around rotas, sickness, and sustainability of the working patterns of doctors in training.

Rota annualisation can help alleviate the problem of annual leave and the introduction of the new locum 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.

Work is being carried out around the role of junior doctors, advanced nurse practitioners, physician assistants and a range of non-clinical roles.

These problems reflect the national picture and are well understood internally with improvement plans being generated and reviewed regularly to ensure that the building blocks for a successful junior doctor workforce are in place in UHS.

3.2 Duty of Candour

Our staff work hard to provide services which are safe and of a high quality. Despite this, sometimes things do go wrong, and incidents will occur. When this happens, all healthcare professionals have a professional responsibility to be open and honest with patients. Evidence suggests that openness is welcomed by patients who are more likely to forgive errors when they are discussed fully in a timely and thoughtful manner, and that being open can decrease the distress or trauma felt following an incident.

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We also have a statutory duty to support staff to report adverse incidents, and to support them to be open and honest with patients if something goes wrong with their care which could lead to significant harm. This is called 'duty of candour' and applies to all health and social care organisations registered with the CQC in England. A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. In many cases it is the lack of timely apology that causes the most distress or pushes people to take legal action.

At UHS we have worked hard to ensure that our staff are aware of their obligations against this regulation. We aim to understand, learn, and share truths about harm at both an organisational and individual level. Our organisational values are rooted in genuine engagement of staff, our clinical leadership, building on professional accountability and on every member of staff's personal commitment to the safety of patients.

Our 'being open policy: a duty to be candid' policy clearly outlines the requirements for the Trust to comply with Regulation 20. This includes both the statutory and professional requirements. This policy underpins the Trust's values and aims to ensure:

- The patient's right to openness from the Trust is clearly understood by all staff. That this right is integrated into the everyday business of the Trust. The Trust learns from mistakes with full transparency and openness.
- Patients and their families and carers can trust us to share information with them in an open and collaborative way.
- The Trust works in partnership with others to protect patients.
- Trust staff ensure appropriate support is offered to patients, families, carers, and staff.
- That line managers understand an individual or team may well require support during and after an incident.

The Trust has a range of resources available to support the delivery of the policy, including:

- A patient information leaflet has been developed to be provided to patients and their families where an incident has occurred.
- Duty of candour is a mandatory field in the safeguard incident reporting system.
- Validation of incidents becomes key to ensure that the right level of harm has been determined.
- Training, including a video is available on Staffnet.
- Duty of candour documentation guide forms part of eDocs to support documentation of conversations.
- Template letters have been developed.

We offer to meet patients and families if they would find this beneficial.

Our PSIRF includes reviewing and improving how we engage and involve patients, families and staff following a patient safety incident. This will enhance our duty of candour processes.

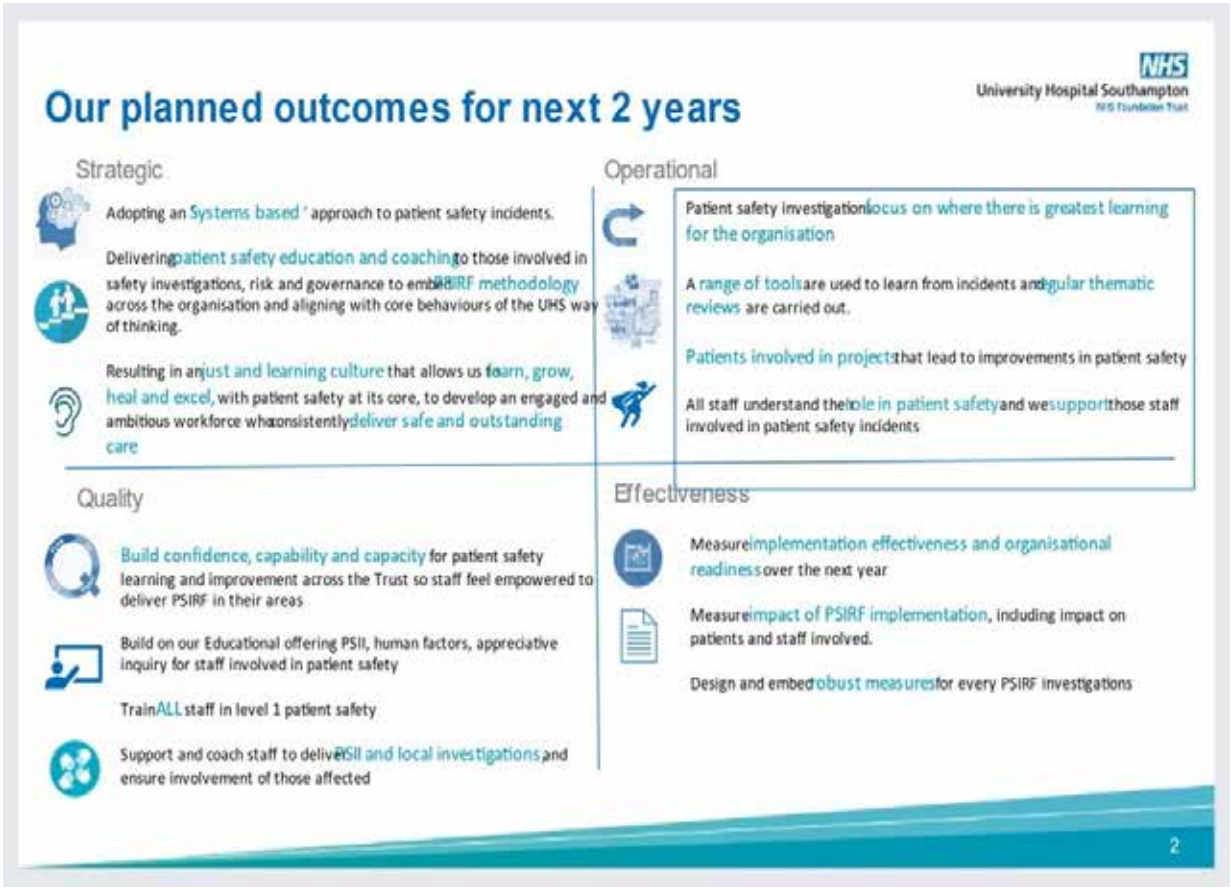
Compliance for duty of candour is supervised by our divisional governance groups, and the corporate patient safety team ensures it is completed for any serious incidents that occur.

Part 3: Other information

3.1 Our commitment to safety

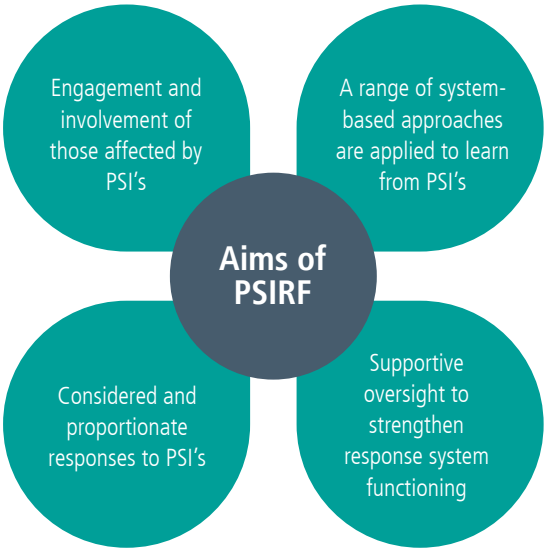
We are proud of our long-standing commitment to patient safety and continue to focus on improving the quality of safe care that we provide. We recognise the importance of a culture where staff are comfortable to report when things go wrong, and we work hard to ensure that the appropriate support for staff is available in an effective, efficient, and timely way.

Individuals can share their experiences and provide feedback regarding any support they have received. We continually work to improve safety in the Trust, learn from incidents and celebrate successes, and this year we have set out our planned outcomes for the next two years:



Last year we reported how we had launched the NHSE PSIRF which replaced the national serious incident framework. This year we have completed our transition and collaborated with our ICB to develop a PSIRF plan and policy to underpin the change.

PSIRF set out a new direction for how the NHS responds to patient safety incidents, focusing on effective learning and improvement, compassionate engagement and embedding a patient safety culture.



Completing our transition has meant there is now greater focus on understanding the impact of systems and human factors in our patient safety incidents and we have greater understanding in the "what" not the "who" in investigations to support a just and learning culture. Not all serious events will lead to a patient safety incident investigation (PSII) – other tools will be available such as after action reviews, clinical audit or M&M meetings, and greater support and involvement is being provided for those involved in patient safety incidents. Our four medical scoping leads have continued to support our case reviews as well as taking on wider patient safety roles including the M&M quality priority described previously in this quality account and developing a human factors and simulation strategy.

We have created a range of resources to support staff with the transition, which includes videos, leaflets and information on our internal sutranet. Our staff support workstream group have developed an information guide and quick reference cards. We have promoted the patient safety syllabus through the NHSE e-learning resource and face to face sessions and designed and delivered bespoke sessions to significantly raise the number of staff trained .


PATIENT SAFETY TEAM

University Hospital Southampton NHS

If you have been involved in a patient safety incident at work, you can expect:

- To be given the chance to share your account of the situation
- To receive a compassionate and kind response throughout the course of the enquiry
- That any learning will be focused on understanding the human factors, systems and processes
- To be offered the opportunity for wellbeing support

supporting our people

Valuing and caring for our wellbeing

Underpinning the move to PSIRF is our introduction to patient safety incidents which has been delivered during this year and is now being updated and refreshed in line with feedback. We are currently planning to deliver cohort five of our patient safety associates (human factors) course. Other courses delivered include after-action reviews training and supporting those affected.

We have delivered oversight training to the Trust Board, divisional management teams, patient safety incident investigation oversight group (PSIIOG) and governance teams (over 50 staff at time of writing), and a further session is planned to support the care group management teams.

The Trust has transitioned to the learning from patient safety events (LFPSE) which replaced the national reporting and learning system (NRLS) and has continued to foster a positive reporting culture and learning from incidents. Next year will see a greater focus on staff training to support improving the quality of our incident reports and their validation.

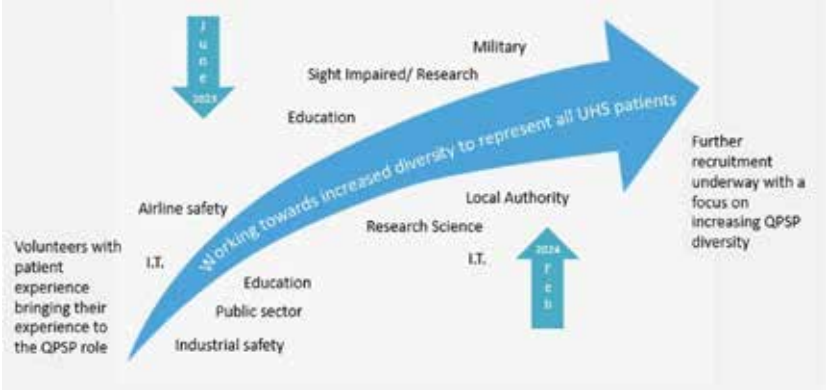
We continue to see a high number of favourable events being reported across the Trust. Favourable event reporting forms (FERF) are a way to show formal appreciation for good aspects of all practice, as well as sharing learning.

Following a successful pilot in 2021 the Trust has recruited six quality and patient safety partners (QPSPs) in 2022 and they have been embedding themselves and their workstreams throughout 2023. During 2023, the work we have competed to develop our QPSP programme has been shared nationally, including through the national patient safety managers network and

internationally at the Institute for healthcare Improvement conference in Copenhagen. We also hosted a day in collaboration with QPSPs from Oxford providers at the IHI conference in London April 2024 .

We have recruited a further six QPSPs this year who started their training with us in November 2023. The additional QPSPs have increased the diversity of our QPSPs to reflect a greater proportion of our UHS patients.

Our QPSPs have supported a wide range of workstreams including sitting on key Trust groups supporting patient safety; patient safety steering group and PSIIOG as well as supporting the transition to PSIRF on the PSIRF implementation and oversight groups.



Other workstream this year include embedding our learning disability and autistic people (LeDeR) reviews which review the deaths of people with a learning disability. The reviews are led by the patient safety team, are multi professional and supported by one of the divisional clinical directors, a named nurse for adult safeguarding and the learning disability team. They aim to learn from events and take actions to improve services. Our ambition is to include the views and feedback from the families to address findings over the next year.

3.2 Our commitment to improve the quality of our patients' experience

We have already presented in the quality priorities section of this quality account some of the work we completed last year which aimed to improve the experience of the people who use our services.
We have continued to build on previous work to grow engagement and support with several initiatives and workstreams during 2023/24.

Last year we reported on some of the progress we had made working with the Gypsy, Roma, and Traveller (GRT) communities. We have continued to develop this work over the last year with the introduction of our new GRT liaison post which focuses on providing support to patients, service users, family, and carers from the GRT community. We can now offer onsite support, telephone support, form filling, liaising with other health care professions and referrals on to other services.

We have developed a new GRT champion training to raise awareness across the Trust, with training days run in collaboration with the Margaret Clitherow Trust, which was founded in partnership with, and for the benefit of, the GRT communities. The training covers GRT history and culture, the challenges faced by the GRT community and how we can create a positive strategy for accessing services. We have had very positive feedback from our current champions, and now aim to have at least one champion in every clinical and non-clinical area so that there is always support when needed.

Our experience of care team also supports staff in meetings with GRT families and liaises with family and staff to ensure cultural needs are met when care and treatment is planned. The team helps staff to plan in collaboration with GRT patients and their families for elective admissions, focusing on how to plan for events such as accommodating large numbers of visitors from the travelling community (particularly in cases of end of life care or bereavement). The team will also offer additional support for the families in times of crisis, and liaise with other agencies including the police, education services in local authorities and the prison service.

We have expanded out to work with other professionals and the wider local community, giving advice on the GRT culture and healthcare needs, and run sessions at Kanes Hill Primary School, which is the local school to our nearest traveller site. These sessions are fun and interactive and focus on healthy living, what to expect should the children ever come into hospital, and where to access help for health including appropriate use of pharmacies, urgent or 111 care and ED. The team recently attended Weston community fun day hosted by Southampton City Council, to share information about GRT culture information and engage people with activities and prizes.

In addition to the work we do outside the Trust focusing on GRT communities, we have also expanded our community work to include attending public engagement opportunities in the area such as the young carers festival, the Southampton Mela festival, University 'freshers' fayres', carers listening lunches, Hoglands Park play days, events at local Temples, and Love Where You Live events.

We have grown our work with our local youth and young adult ambassadors who are passionate about improving the lives of young people and want to use their experience and knowledge to be the voice for effective, meaningful change. We have had ambassadors attending our Council of Governors and supporting a variety of hospital projects and are looking to grow this collaboration.

The bereavement care team provides support to families before and after a bereavement. The team works closely with our wards, responding if families need our support or other support such as the chaplaincy and spiritual care team or the carer and veteran leads. During the last year, our officers have expanded their service to cover support for anticipatory grief, which can be triggered by an impending loss.

As part of our commitment to support all our patients and meet their individual needs, we now have policies to support transgender patient pathways. The aim of these policies is to ensure that clinical responses are patient-centred, respectful, and flexible for people who are considering undergoing, have undergone, or are in the process of undergoing gender reassignment. The principle of respect applies to all, including people who choose to cross dress for reasons that are not associated with gender reassignment.

We have been working on raising awareness and increasing usage of interpreting, translation, and transcription services to support our patients. We can now offer on-demand or prebooked face to face sessions, or sessions via video or telephone. As 15.39% of people in the Southampton locality don't use English as their main or preferred language, we have a new interpreting policy, and staff are now able to request interpreters from a wide variety of languages, and sign language interpreters. We have introduced a Sonus interpreting service to improve the patient experience for our hearing-impaired patients. We also have available the top 26 most important phrases/requirements that patients wish to convey to their caregivers if they do not have the ability to speak. We have provided them in most languages including Croatian, Afrikaans, Bengali, Danish, Ruian, Swahili and Mandarin.

Other areas of quality improvement include introducing volunteer support to patients into ED and providing vital holistic care during inpatient and outpatient visits, running an equipment amnesty, collecting clothing donations to support patients in hospital that need clothes and celebrating our achievements through an experience of care Christmas advent calendar of services.

We celebrated our pets as therapy (PAT) dogs as part of the celebrations for 75 years of the NHS .

Our patient support hub (founded during the pandemic) is a volunteer led single point of access for patients and their carers to request practical support before, during or after their visit or stay at UHS. It has continued to provide a wide range of support over the last year, with 26,177 patients, service users, family, carers, and staff being helped in many ways.

What the people who use our services tell us


Everyone who looked after me went above and beyond. Helped me and was there for me while I was having such a bad time . I was listened to and taken seriously and made to feel safe .All the staff have been amazing
I felt my child received consistently good care and that the staff were always happy to answer my many questions
The care and support were amazing. Felt it really mattered to the team that they were making a difference which they were by encouraging us
I felt confidence in the staff even when treatment did not go to plan, everything was explained in clear language


It was great being in a group and able to support each other and also listen to each other. Will definitely miss the group but feel encouraged and more confident to be active and look after myself better
All the people involved with my care, all do an excellent and amazing job
Both members of staff i saw were extremely friendly and professional making me feel at ease during a procedure. I was very nervous about They made me feel cared for and i can't thank them enough

3.3 Our commitment to improve the quality of our patients' environment.

Patient-Led Assessments of the Care Environment (PLACE) programmes

The environment where we care for patients has a major influence on their experience, and in some cases, their clinical outcomes. We feel all patients should be confident that they will be cared for with compassion and dignity in a clean, safe environment.

PLACE is the system for assessing the quality of the patient environment from the patient's eyes, rather than technical audits. The assessments are led by patients and their representatives and supported by Trust staff. Patient assessors are a representative of the patient demographic in the Trust, and the programme provides a clear message directly from patients, about how the environment impacts upon them, and how our services might be improved or enhanced.

During 2023 assessments were completed at five UHS operational sites. These assessments were 'unannounced', with each one undertaken by teams of assessors balanced between staff and patient representatives. We were fortunate to have the continued support from Healthwatch Southampton, governors, independent representatives, and a strong representation of youth ambassadors. We were also joined with assessors who experience accessibility needs. This broad range of assessors presented a great blend of experiences. Our 2023 results were:

Cleanliness	Combined food	Organisational food	Ward food
97.51%	92.36%	99.26%	91.23%

Privacy, dignity and wellbeing	Condition appearance and maintenance	Dementia	Dementia
83.72%	95.55%	77.40%	80.36%

We now plan to use the information we gathered to improve the environment where this is feasible.

3.4 Our commitment to sustainability and the environment

Delivering world class quality care is more than just about offering the most advanced treatments or delivering the best outcomes, it is also about doing all these things in a sustainable, environmentally responsible way.

We understand the negative impact of some of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.

Environmental sustainability and sustainable development are integral to what we do at UHS, and we feel it should factor into each decision we all make. As the largest employer in Southampton and with an energy consumption equivalent to all the households in Winchester combined, we recognise the influence it has on impacting the environment and population we serve.

UHS set out its response to the challenge of the NHS becoming the world's first health service to reach carbon net zero with the launch of our Green Plan which we published to coincide with World Earth Day 2022. Since then we have continued to work towards improving the health of our local communities and lessening the burden on our organisation and the NHS. We are aiming to achieve carbon net zero to help our community and our people live healthier lives, and by taking a proactive role in lessening our impact and being a leading influence in our community, we can go some way to preventing people becoming ill in the first place.

Environmental change is a factor in some of the conditions that we treat our patients for, and we know quality and air pollution kills 40,000 people a year in the UK. When we surveyed UHS doctors we found they knew air pollution was bad, but never discussed it with their patients because they felt they didn't understand enough about the effects of air pollution and didn't know what to tell their patients. We have recently introduced air quality training led by a national clean air education specialist which covers the facts and figures and suggests ways of talking to our patients about it.

Carbon dioxide and medical gases (such as nitrous oxide and Entonox) contribute a substantial proportion of the NHS' already large carbon footprint. At UHS we use these potent gases which contribute more molecule for molecule than CO2 to greenhouse gas effects. Anaesthetic gases are also incredibly significant in contributing to global warming. To reduce our use, we are moving away from gases to total intravenous anaesthesia. This has been made possible by the introduction of new equipment which enables anaesthetists to choose settings that use less nitrous oxide gas. We also have technology that can safely monitor and automatically adjust the amount given, therefore reducing waste. Our results, published in the Journal of Anaesthesia, show UHS significantly cut its use of nitrous oxide last year resulting in a drop in carbon dioxide equivalent emissions from 2,125 to 448 tonnes annually.

We are sense checking commonly used drugs such as ventolin inhalers which have propellant gas which is powerful. We are encouraging our clinicians to prescribe (where appropriate) inhaled dry powder corticosteroids which are a better treatment choice. One ventolin canister has 1,500 times as much CO2 and is the equivalent to a car driving 200 miles. The equivalent dry powder is the equivalent of driving about 6 miles. We are also encouraging our patients to return used inhalers to their pharmacist for disposal.

This year we have looked at more ways of becoming a more sustainable Trust. We have focused on estates and facilities, supply chains and procurement, travel and transport, biodiversity, food and nutrition and digital transformation. The work of the sustainability board and its sub-groups sit within the foundations for the future strategic pillar.

Making our buildings more efficient, we previously we received a £29.4m grant for a raft of energy efficiency projects including cladding the buildings, replacing old draughty windows, and installing new LED lighting.

We have started replacing the cladding on our laboratory and pathology buildings and replacing the windows with triple glazing. This is expected to reduce gas consumption and save on electricity usage. This year we have also delivered the UHS LED programme using a £823k grant. The thousands of lights being replaced should save the Trust thousands of pounds and dramatically reduce our carbon footprint.

The Trust now generates 60% of all the electricity it uses. This is achieved through our on-site combined heat and power systems (CHP's) which is a technology that produces electricity and thermal energy at high efficiencies using a range of technologies and fuels. With on-site power production, losses are minimized, and heat that would otherwise be wasted is applied to facility loads in the form of process heating, steam, hot water, or even chilled water.

A new solar panel array has been installed on the roof of a development called the Skywalk on the south side of the Trust. The Skywalk has been designed with skylights to support natural lighting during the day, and the solar panels will provide all the other electricity needed to light the Skywalk.

During January, February, and March in 2024, staff across the Trust took part in the switch off challenge to raise awareness about energy waste and reduce our carbon emissions.

Currently, the Trust spends around £9,500 a day on electricity to provide patient care. If every member of staff switches off non-essential equipment when it isn't being used, we can significantly reduce the energy wasted.

We invested in a cardboard bailer which crushes use cardboard enabling us to sell it on.

We have also been focusing on recycling. Every year we produce 15,000 tonnes of clinical waste, but we know correct segregation of waste is imperative to safe, sustainable waste management. When segregation is non-compliant the costs for disposal are charged at the highest disposal rate as contamination cannot compromise the safety of the environment and any threat to human life. We are developing a new waste strategy to ensure waste is managed and disposed of at the highest level of the waste hierarchy (higher category the more heat is required to incinerate it at greater cost). We are completing waste audits for all service areas, introducing food waste collection, and increasing measures to reduce single use plastics. Our theatres' sustainability group have led

a project designed to make it as easy as possible to recycle and we have made significant progress in our waste segregation in their departments, reducing the ratio of clinical to waste recycling from a ratio of 9:1 to around 6:4. We have invested in disposable sharps bins which have replaced the bins which needed to be incinerated, reducing the amount of CO2 we put into the environment

Sustainable travel is being supported by our own lift sharing app, so staff can connect with other staff that live near them, or on their commute, and share lifts. into work.

Going forward, we will continue to collaborate with our staff to develop innovative ideas and initiatives.

3.5 Our commitment to staff

UHS has made a commitment to create a truly inclusive workplace for our staff where everyone can belong. In 2023 we launched our inclusion and belonging strategy which provides the mandate for us to move to action and enable everyone to know what inclusion and belonging "feels like" at UHS. The themes in the strategy have been developed with staff, across a diverse range of groups. It sets out a clear intent to move us to an organisation beyond just being content to acknowledge if our staff are experiencing problems to a place where we take pro-active action to eliminate it.

During 2023/24 we have achieved some key milestones. Our Trust inclusion and belonging strategy has been successfully launched, and a 'big conversations' initiative has facilitated the launch of a 'maturity matrix' which is about understanding our culture of the experiential feel and visibility of equality, diversity, and inclusion (EDI) in all that we do. This has allowed us to understand where our people feel we are as an organisation in our EDI journey.

We are committed to having a workforce which reflects our communities, at all roles, at all levels, and safe and healthy working environments, free from all racism, aggression, hate and discrimination. We are focused on our recruitment processes which are free from bias and are inclusive, and inclusive leadership and management. Our inclusive recruitment programme is now underway with revisions to process, and practice being informed by feedback from our staff. We have recruited a cohort of 24 diverse Band 7 nurses for our Florence Nightingale Foundation positive action leadership programmes (PALP) for nursing and midwifery to commence in September 2024. Our career development workshops have launched and been successfully implemented for PALP candidates, with good feedback. EDI steering groups have been established for all divisions.

In addition, our strategy clearly states our intent to create a culture of anti-racism and anti-discrimination at UHS, and we have developed tools and resources to further support our teams with this. One of our tools is the Belonging Blueprint:

We are developing networks that thrive and support creation of an inclusive and safe place to work. These include our long-term illness and disability network, our OneVoice Network pages, Proud Alliance LGBTQIA+ colleagues and their supporters and allies and our UHS Armed Forces Community (Workplace group).

We have created a UHS staff windows onto wellbeing pages which provide information as to what services and support there is at UHS for the wellbeing of our staff. The pages include information about UHS wellbeing plans and resources, psychological emotional and spiritual support, physical wellbeing support and wellbeing spaces such as a purpose-built wellbeing hub and the roof top garden at Princess Anne Hospital.

We also provide support for financial wellbeing, crisis support, menopause, and post incident support. There are wellbeing plans and a wellbeing steering group which published its first report in 2023. We have wellbeing champions who are peers on the ground, encouraging and supporting colleagues to have well-being conversations and signposting to appropriate support. We have a peer network of mental health first aiders as first line support and are establishing a network of peers trained in having well-being coaching conversation who we call safe space practitioners.

We have enjoyed celebrating the successes of our staff this year, introducing several awards to recognise their achievements. All our awards were based on our values and this year, for the first time, there were both clinical and non-clinical winners for each award category. Categories included patient safety, patient outcome award, patient improvement, organisational improvement, inspirational innovator, team player team leader, team of the year and the CEO award. There were also charity, volunteer, membership, and chairs awards for improving.

To formally recognise a colleague or team in front of the organisation, staff can nominate them as a UHS Star. Each month we select two winners – clinical and non-clinical – and these are judged by our awards panel against our Trust values:

- **Always improving**
- **Working together**
- **Patients first**

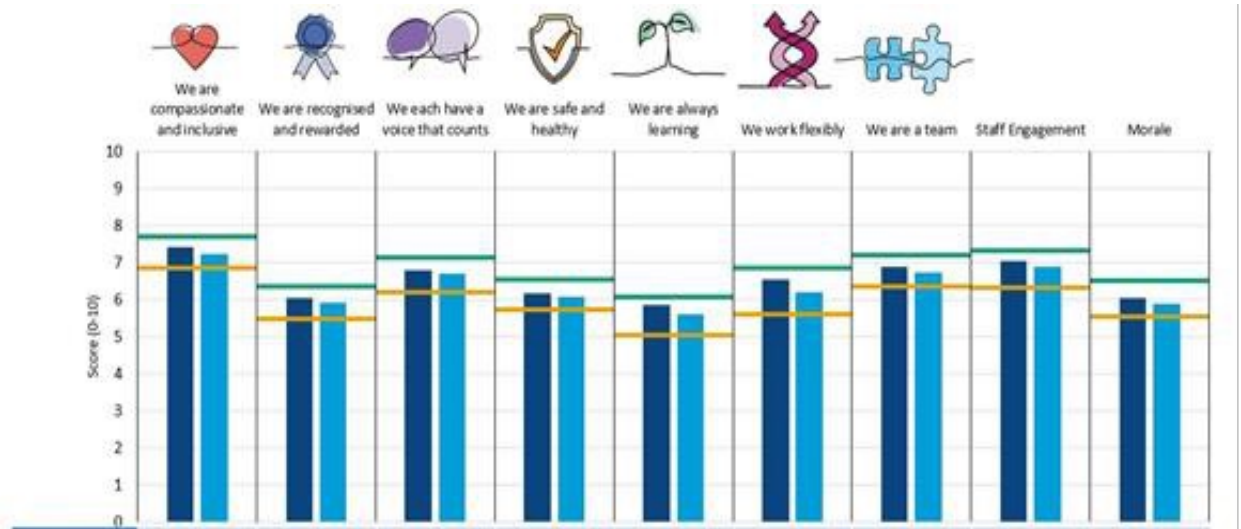
Celebrating our champions
The winners of this year's We Are UHS Champions awards were announced at our ceremony in October 2023 at the Hilton Ageas Bowl.

This was the first time we had been able to hold this event since the pandemic, to celebrate all the incredible individuals and teams who make our Trust so special.

Staff can acknowledge and celebrate a colleague by sending them a High5. There are no set criteria or judging involved – instead this is a quick way they can show their appreciation for a colleague and in return they receive a simple surprise message in their inbox (or mailpoint) highlighting how they've helped to make their colleague's day.

Our spotlight event is a new series of in-person meetings, hosted by David French, CEO, which recognise and celebrate the achievements of our people. There is now also a Spotlight publication, where we update on exciting projects and developments from across the Trust and celebrate and recognise our colleagues.

The annual NHS staff survey continues to be the largest mechanism which enables us to gauge how our staff are feeling.



	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	7.43	6.04	6.81	6.16	5.85	6.54	6.88	7.03	6.05
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	5549	5538	5504	5516	5204	5521	5543	5552	5552

Overall, despite the significant challenges, UHS remains above average across all people promise themes within the survey. UHS also remains in the top quartile of similar organisation for recommendation as a place to work and for staff engagement.

We were pleased to see we have seen improvements in several areas. This included how people can work more flexibly, access to learning and development, and generally an improved satisfaction with line managers and how they are supporting people. It was also good to see improved scores reflecting how teams continue to value each other and feel supported by one another.

3.6 Our commitment to education and training

UHS has always had a strong commitment to education and training. This year our Skills for Practice team have continued to deliver and support several established education programmes to both internal staff and external partners. These programmes include trustwide clinical skills programmes and development, training, and assessment for undergraduate medical students. A key achievement has been the delivery of objective structured clinical examinations (OSCE'S) to second, third and final year medical students in April, May, and July 2023.

Over the last 12 months we have worked to improve our simulation facilities and now have a wider range of manikins to support education, training, and the patient safety agenda.

Our biggest staffing challenge in 2023/2024 has been recruitment, and retention of health care support workers (HCSW). Trustwide focus continues to reduce turnover for HCSW's, including support for health and wellbeing, career opportunities, peer support, and education, training, and development. Centralised recruitment and onboarding have improved retention of newly appointed HCSW's. We have expanded the requirements of the Care Certificate to ensure all clinical support workers have a standardised entry level understanding of patient care. Completion of the Care Certificate remains high with completion rates of 85% trustwide. Skills for Practice continues to operate the health care support worker hub, which is a drop-in service available to all support workers across the Trust. It is made up of centre facilitators who teach the healthcare support worker induction and provide ongoing pastoral support.

There have been almost 1,000 apprenticeship starts since 2017. There are 415 apprenticeships in progress across the Trust of which 315 are clinical apprenticeships and these cover nursing, midwifery, occupational therapy, diagnostic radiology, operating department practitioners, advance clinical practice, and healthcare science. The remaining are business, leadership, improvement, estates apprentices.

Apprenticeships have provided opportunities for career development for all staff and is a component of the Trust's focus to improve retention and build a sustainable workforce. 389 staff have completed their apprenticeship with at least 81 of these have gone onto to start their second or even third apprenticeship in the Trust, these include nursing, finance, clinical engineering, leadership.

We continue to support the practice element of pre-registration programmes from universities across the HIOW footprint and beyond as well as an increasing number of staff who are undertaking clinical apprenticeships.

UHS continue to increase the overall capacity to UCAS/direct entry learners while maintaining a line of sight with regards to all the learners' groups that the organisation supports. This last year has enabled UHS to focus on formalising our capacity position particularly for AHPs while continuing to grow capacity especially in nursing.

UHS is involved in a project across the HIOW footprint through the ICB to establish a single IT approach to capture the utilisation of placements. This IT system will stand UHS in good stead in relation to understanding fully the way in which universities are using their placement allocations, while also giving data on the expansion required of placements linked to the expectations of the NHS Long Terms Workforce Plan.

Project around pre-placement requirements, evaluations, raising concerns and the development of the practice educator of the future are in progress and will soon be joined by the Safe Learning Environment Charter quality assurance process which launched in February 2024.

UHS is very proactive in relation to supporting universities with their curriculum development to ensure that practice has a voice and is enabling validated curricula to remain contemporary.

UHS have three return to practice nurses currently on programme with Bournemouth University – one being a member of staff who initially restarted her nursing career as an HCA. We also have a midwifery returner who is completing her programme on the distance learning programme through Plymouth University. All are expected to successfully complete later this year. Two of the three nursing returners from the previous cohort last year have gone on to take up Band 5 posts within the Trust.

Following our successful pilot with Eastleigh College to provide quality real-world placements to college students on healthcare level 3 programmes, including T Levels, we are now also working with Richard Taunton and Fareham Colleges and have this year 23-24 provided a total of 55 placements across multiple specialities including adult, child health, midwifery, and operating department practitioners (ODP) and therapies. The importance of partnership working with colleges to prepare their students for placement by providing specialist teaching and induction has been positively evaluated in student feedback. College students from previous cohorts have gone on to join both our Registered Nurse Degree apprenticeship and the ODP apprenticeship this year.

We continue to develop apprenticeship uptake in healthcare science and in September 2023 our first L6 apprentice in Neurophysiology started with University of the West of England (UWE).

Our scientist training programme continues to grow, and we are now supporting our first trainee in respiratory physiology, an in-service trainee. We are now officially partnered with the Wessex Genomics service in Salisbury and welcomed their trainees and training officer to our networks and support. We have also accepted two second year trainees transferring from other trusts into clinical immunology and nuclear medicine.

In the Autumn of 2023, we started supporting our first MPharm undergraduates on placements from Portsmouth, Reading and Bath University on the new revised programme. The pharmacy team has worked with the universities to ensure learning outcomes can be met. We continue to work with our networks, particularly community pharmacy and GP practices to consider how to develop the skills for prescribing which will be needed for the 2025 foundation training year for this group of students.

2023 saw the first science manufacturing technician in aseptic production complete her apprenticeship and register with the Science Council. This is the first of a new route of development for this group of specialist staff and gives them a career route comparable to pharmacy technicians in this area.

Work has continued to support the development of a stabilised capacity across all the AHP professions within UHS for students. For some of the AHPs this has resulted in a significant increase in capacity which will support the expected increase in students linked to the NHS Long Term Workforce Plan.

The number of apprentices undertaking AHP professional programmes has continued with staff becoming students in occupational therapy, operating department practitioner, radiotherapy, and diagnostic radiology. These programmes will be very important in supporting the increase demand for new starters into these professions.

Continual professional and personal development (CPPD) funding received from NHS England is key to supporting the development of staff both professionally and personally. This education and training support service delivery and development and the quality and safety of patient care and experience.

CPPD has been a challenging over the last four years in relation to the ability of UHS to fully utilise the funding available from HEE/NHSE. This is because of the COVID effect, (no courses being run, staff release, requirements attached to the funds) and so 2023/24 has been a year of consolidation of position and spend.

UHS is now able to close the last four years spend and focus on the 2024/25 training needs analysis (TNA) which underpins the CPPD spending. UHS is now planning for the next financial year which is likely to be challenging but there is continued focus on assuring that staff are educated and developed and have the knowledge, skills, values, and behaviours our patients and professions expect.

UHS has always supported a bespoke preceptorship for the newly registered staff joining the organisation. Since the launch of the national preceptorship framework for nursing in November 2022, UHS took the opportunity to streamline its preceptorship and developed a multi-professional approach and delivery of a structured agenda. Within this timeframe 557 preceptees have attended the new design preceptorship, a policy has been written and ratified, 427 preceptors across nursing, midwifery and AHPs have undertaken training, preparing them for the role. A preceptorship facilitator has been supporting the redesign and Schwartz rounds are included as a key priority in supporting preceptees. Since October 2022 there has also seen a reduction in the turnover rate of newly registered nurses, internationally educated nurses and AHPs.

In June 2023, UHS was successful in being awarded the Interim Quality Mark for nursing preceptorship, with ongoing work supporting AHP and midwifery in meeting the new framework and principles.

UHS has been participating in a University of Southampton research project in collaboration with the Wessex and IOW consortium. The project is running for a year from July 2023 and has seconded a small team (lead, facilitator, and administrator) to deliver rounds for preceptees. The rounds are evidence based, themed in correlation with our trust values and received consistently positive feedback from participants in relation to the impact on wellbeing, patient care, and teamwork.

In line with the requirements in the NHS contract, the Trust has continued its commitment to the development of professional nurse advocates (PNAs) who are qualified to provide restorative supervision, quality improvement support and education support for all registered nurses to strengthen wellbeing and taff retention. This approach mirrors the professional midwifery advocate (PMA) service provided across maternity services.

The funding for training is provided nationally and UHS has maximised the opportunity to support staff on this master's programme of study.

Since the initial group of six trainees started in 2021 the Trust now has 55 trainee and qualified PNAs across 15 specialities and a healthy waiting list of those wanting to train. Work is now focussed on embedding the service into the wellbeing, transformation and education strategies within the Trust and ensuring staff are enabled to access the growing development support.

Our advanced practice (AP) services have evolved organically over nearly 20 years. The organisation has been at the forefront of establishing this workforce and introducing advanced clinical practice (ACP) roles within services. Recently there have been changes in the national landscape surrounding advanced practice, namely the introduction of the multi-professional framework for advanced practice (HEE 2017) and the establishment of the centre for advancing practice. In November 2022 UHS commissioned an external benchmarking and evaluation project. The aim of the project was to assess the current maturity of the ACP service at UHS and benchmark them against these new national frameworks and landscape.

The recommendations from this exercise outlined, establishing a trust wide career pathway for ACPs , standardising the levels of academic requirements, scope of practice and level of decision making. In specialities where credentialing is not available, implementing a trustwide process and standard that is equitable to credentialing to demonstrate scope of practice, level or autonomy and capabilities is practice was recommended.

Currently we have 218 staff in advanced practice roles – 54 trainees on an apprenticeship pathway and 73 on a commissioned pathway to gaining their MSc in advanced clinical practice.

Workforce key performance indicators and workforce planning data are reported monthly to the Trust Executive Committee (TEC), People and OD Committee (PODC), and the UHS Trust Board in line with our governance requirements, highlighting any risk areas. A monthly staffing status and patient safety report is also submitted. A daily COVID-19-related staffing absence report was provided from mid-2020 to Jan 2023. COVID-19-related sickness data continues to be reported via the people report.

Successful recruitment of registered nurses, medics, and additional clinical service staff increased significantly this year, particularly overseas nurse recruitment.

From April-December 2023, there were increases in the following staffing groups:

- Registered nursing and midwifery workforce has increased by 221 WTE.
- Additional clinical services, including HCAs, has increased by 51 WTE.
- Medical and dental by 57 WTE.
- AHPs by 27 WTE.

Recruitment drives, including successful overseas recruitment, for registered nurses has reduced our vacancy rate from 12% to 5%.

Workforce key performance indicators and workforce planning data are reported monthly to the TEC, PODC and the UHS Trust Board in line with our governance requirements, highlighting any risk areas. There are also regular internal and external (to NHSE and HIOW ICB) reports that have been provided throughout the year on workforce trends, KPIs, and performance. Focus has turned to future forecasting, which we will continue to provide for the 2024/25 year.

Regular (internal and external) workforce reports include the following:

- Vacancy report.
- Weekly workforce trends (substantive, bank, and agency).
- Monthly workforce trends (substantive, bank, and agency).
- Unavailability (headroom).
- Weekly HCSW tracker.
- Monthly appraisals.
- AHP monthly return.
- Monthly divisional breakdown by cost centre of workforce trends (substantive, bank, and agency).
- Care hours per patient day.
- HR reports.
- Monthly provider workforce return (PWR).

Overall, the picture for medical training at UHS has remained positive for 2023/2024. GMC survey feedback was generally good. We have been working on improving induction and have surveyed trainees on their local induction. A follow up survey is planned to include December and February inductions. Our Trust induction has recently been updated to include guidance on social media which follows the updated recommendations from the GMC.

We have many locally employed doctors (LED) and continue to collect feedback on their experience. We have a LED charter setting out what should be offered in terms of education and support. All doctors new to the NHS are given an extended shadowing period before they start. We are currently working towards creating a lead for certificate of eligibility for specialist registration (CESR) who could provide additional support and advice. We were awarded funding to run a CESR study day later in the year. We have updated our in-house educational supervisor course to include a session on locally employed doctors.

Our medical education research fellowship is now in its second full year. The fellowship is a joint project with NHSE. Our first fellow achieved a certificate in medical education and presented five posters and an oral conference presentation. The two current post holders (in a job share) are working on diverse projects including

inclusivity training for medical educators, widening participation in medical school, and regional specialty teaching in ophthalmology. The fellowship has been a catalyst for a culture of rigorously evaluating the education we provide. We now have regular meetings with the University of Southampton Faculty of Medicine to discuss medical education research projects in the trust and the university and to identify areas for collaboration.

The divisional medical education (DME) team is focused on the need to educate and support our trainers, since this is ultimately the best way to improve the experience of trainees. We have built up to a position where we can offer our supervisors a range of in-house educational supervisor update courses. Consultants doing CPPD (to maintain their GMC supervisor status) can choose from courses according to their needs and their areas of work. We evaluate all the supervisor update courses, and the feedback is outstanding. We are also constantly on the lookout for new areas of need.

Feedback from medical students on placement at UHS has continued to improve consistently. This is in large part due to having teaching fellows, who support students with ad hoc drop-in sessions, provide top up teaching and revision, and pastoral support. One of our teaching fellows identified that final year students did not feel well prepared for working on-call shifts. She set up a simulation course, during which students prioritise clinical tasks, answer bleeps, and take handover. This course is delivered jointly to medical and nursing students, hence modelling good multidisciplinary teamwork. The course has been evaluated and presented in poster format.

Preparing for the significant fluctuations in expected student numbers we will be facing over the coming five years remains a key concern and a focus for our planning.

Our challenges include foundation posts in surgery, and we had a recent visit from NHSE and the GMC. This has resulted in mandatory requirements to ensure that the behaviour of all staff is appropriate and to ensure that escalation processes are clear to all staff. The Trust executive and education teams have created a robust action plan to address these requirements and the other recommendations from the report.

Other areas where we were asked to provide feedback following the GMC survey include cardiology, local teaching in medical microbiology, induction in acute medicine and obstetrics and gynaecology. These areas were explored by the divisional DMEs, and feedback provided. Local teaching has now been reinstated within medical microbiology and they are regularly surveying their trainees for feedback. Cardiology has been exceptionally responsive to feedback and put an action plan in place.

The DDU has been running now for 3 years. 22% of consultant staff have accessed the coaching service. A detailed external service evaluation was completed in July 2023 which looked at the gains for those using the service, the experience of the coaches and the needs of the organisation. The service was set up in recognition of the need to provide support for our consultant staff who are under extreme pressure and on whom a functioning clinical team depends on to provide safe patient care. The evaluation shows that the investment is worth it. Consultants appreciate the space and coaching the provided for whatever reason they approach the service. Those interviewed by the evaluation team included consultants new to the Trust and new to the role, those taking on new leadership positions, those approaching retirement and those involved in disciplinary proceedings. The social return on investment of the service was calculated such that for every £1 spent and every 3 consultants who get coaching, the Trust generates £1.47 if those doctors stay in their jobs rather than leaving the Trust and £2.43 if those doctors do not go off sick or come back to work if they were – and these costs are saved to the budget.

3.7 Our commitment to clinical research

We are one of the largest and most prolific teaching hospitals for research in the NHS. We believe that every one of our patients and staff should have the opportunity to be a part of research. As a result, we celebrated over 250,000 people having taken part in UHS research to date which is enough people to fill St Mary's football stadium in Southampton eight times over.

Our commitment to driving research is changing lives and healthcare across the south. One such life is 20-year-old cystic fibrosis patient Luke Southey.

Median survival age for those with cystic fibrosis has gone from 4-5 years in the 1950s to 56 today. This is all thanks to research.

Luke entered a UHS trial for a new treatment aged 15.

"Last year, I asked my mum 'if I wasn't on this medication, where would I be now?'," he says, "and I know it sounds horrible to say, but we didn't think I'd be alive. So, it's had a massive impact."

"I actually remember saying 'it's better than winning the lottery'," says mum Vicki. "I was just absolutely ecstatic that he was getting the chance to start this new drug."

We are delivering research with impact to bring the future of healthcare closer to today. This year, we opened a landmark trial to reduce deaths from sudden cardiac arrests , looking at automatic defibrillators that are fitted under the skin of the chest. The study was led by a UHS cardiologist and 2,000 patients from across the UK took part in the study which aims to define who stands to benefit from this.

We are also striving to improve the lives of those living with multiple sclerosis (MS). This year saw a ground-breaking new trial, using patients' own cells to treat 'aggressive' MS. It builds on research showing the potential of stem-cell transplants in reversing disability.

Our commitment to research is changing lives. We have found a drug used to treat high blood pressure can help women with persistent acne, a 'functional cure' for the blood clotting disorder haemophilia A is gaining global approval based on our research and a drug preventing breast cancer is now available to 300,000 women in England, thanks to studies involving dozens of UHS patients. We also have a website developed by our researchers which is being used by tens of thousands of people to help manage their eczema.

Motorbike enthusiast Peter Garland, 71, was running out of options when his cancer returned after a brief period in remission. He became the first patient in the south to receive a revolutionary new cancer treatment.

"I feel incredibly lucky to have been offered this treatment and to have come through it so well," he says.

"It has already given me another year, and I have been able to get back on with my life and that's amazing."

That treatment, CAR T is a cellular therapy. It involves collecting the patients' own immune cells and modifying them to target

cancer cells. Returned to the body, they fight the cancer cells while avoiding the damage to the body. The treatment can only be offered to patients at UHS thanks to ongoing research.

Our pharmacy advanced therapy unit (PATU) prepares doses of potentially life-changing drugs. These products are being used to treat previously incurable cancers and genetic conditions. Most of these are given to patients in the hospital's specialist research facility.

Research innovations like these are being accelerated through our Southampton emerging therapies and technologies (SETT) centre.

Between 2020-22 our researchers and the public stepped up to test COVID-19 vaccines that forged a path out of the pandemic. We have maintained the momentum of this vital vaccine research during 2023. And are now targeting new global challenges such as mpox and paratyphoid fever.

Respiratory syncytial virus (RSV) is a leading cause of hospitalisation in babies. Most children will have caught it by the time they are two years old. We have led international research into a new immunisation. In a recently completed trial, the jabs reduced numbers needing hospital treatment by over 80%. It is now part of considerations for a national RSV immunisation programme.

Complex supply chains can limit vaccines' reach, and how well they protect us all. UHS's Professor Saul Faust is leading clinical trials for a fridge-free tetanus and diphtheria jab. This could save more lives worldwide, by reaching those without access to clinical facilities. UHS is at the heart of a new series of research hubs serving the region. And new research buses launched this winter are easing trial access for underserved communities.

UHS was also selected to host a major new research delivery network by the Department of Health and Social Care. Serving over four million people in the south, it will coordinate and support research across the NHS.

Our research is also revealing important public health insights for pregnancy and early life. One study has shown that modern diets don't give pregnant women and their babies the nutrients they need. It found nine out of ten women lack vitamins needed for a healthy pregnancy. It has prompted widespread media coverage and sparked continuing research. Babies in Southampton are also helping shape the future of UK newborn screening.

We are offering families the chance to screen for an extra condition during their blood spot test. Spinal muscular atrophy (SMA) is a rare genetic condition. Identifying and tackling it early could give babies affected much better long-term health.

The results from this research will help to determine if screening for SMA should be added to this test.

Hip dysplasia is another condition where early action is vital. It is where the 'ball and socket' joint of the hip does not properly form in babies and young children. Without early treatment, it can lead to debilitating long-term issues.

UHS has led research into this condition for decades. Key to this is a weekly 'hip clinic', held for affected families in our research facility.

At two weeks old, Athena was sent for a scan of her hips. The results set her and her mum, Alexa, on an emotional journey through two research studies.

Athena is now eight years old and is just as active as her friends - running, climbing trees, even doing yoga moves on her paddle board.

"Without this series of surgeries, she wouldn't be able to any of this," Alexa explains. "By now, she wouldn't be able to walk properly. By twenty years old, she would have to have a double hip replacement. My little girl, she wouldn't be able to be what makes her herself.

"How do you say thank you for that? There are no words. They've changed her life." Alexa has written a book about their experience that is now given to other children receiving the same treatment in Southampton.

Research allows us to offer world-class care and it also helps us attract and grow the best people. Our unique research leaders programme (RLP) offers dedicated time and training. Open to nurses, midwives, pharmacists, allied health professionals, clinical scientists, and doctors, it has supported over 30 people in just three years.

Current RLP awardee Dr Sophie Fletcher was recognised this winter in the NIHR British Thoracic Society Clinical Research Network awards. That acknowledged her drive in the understanding and treating a rare lung disease. RLP has helped Sophie carve the time and skills to grow research within her clinical care.

Several of our biomedical research centre researchers also received awards this year:

- Professor Nicholas Harvey gained the prestigious 2023 OrtoMed Medal. This is selected by the Italian Society of Orthopaedics, Medicine, and Rare Skeletal Diseases.
- Professor Philip Calder was awarded the international Hagler Fellowship.
- Professor Cyrus Cooper received the Linda Edwards Award. This is the Royal Osteoporosis Society's highest honour.

Our research nurses were also shortlisted for two Student Nursing Times Award. UHS was a finalist for Student Placement of the Year. Alice Martindale was shortlisted for Student Nurse or Midwife of the Year.

Having a diverse range of people in research is key toto fighting health inequalities, by ensuring advances work for all. Because of this, we are committed to making our research as inclusive as possible. We have worked with our local ICB to develop this agenda. Together with an alliance of voluntary organisations, we piloted engagement with diverse communities. This is providing the basis for sustainable research access.

Over 2023/24 we continued work under the NIHR race equality framework. This is a national self-assessment tool to improve racial equality in public involvement in health and care research. Training on supporting others experiencing racism was rolled out to research staff. This ran alongside work improving diversity monitoring in trials, and piloting multi-lingual communications.

We also invested further in our patient public involvement and engagement team. Together with our dedicated research communications team they are expanding our engagement with diverse groups and building opportunities and support for public and patients to shape our research, supporting our researchers to involve patients and public at every stage.

Conclusion

We are proud of the advances we have made in the quality of services we provide. However, we are not complacent and know that we are still on a journey to achieve excellence in all areas.

This quality account enables us to qualify our progress comprehensively and agree the priorities for 2024/25 . Future reports will therefore present a quantitative delivery against a forecast.

We are confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence throughout 2024/25.

Annex 1:
Statements from relevant integrated care boards, location Healthwatch organisations and overview and scrutiny committees and Council of Governors

Response to the Quality Account from NHS Hampshire and Isle of Wight Integrated Care Board.

Hampshire and the Isle of Wight Integrated Care Board would like to thank University Hospital Southampton NHS Foundation Trust for the opportunity to comment on their Quality Account for 2023/2024. We are satisfied with the overall content of the Quality Account and believe it meets the mandated elements.

We have worked alongside University Hospital Southampton NHS Foundation Trust to seek assurances that the care provided by them meets the required standards for safe, effective care and that experience is key to those accessing it, taking action for improvement where necessary.

We supported University Hospital Southampton NHS Foundation Trust's 2023/24 quality improvement priorities. It is pleasing to note that having fully achieved five of the six key priorities, considerable improvements in several areas are evident, including; improving care for people with learning disabilities and autistic people across the Trust; supporting people to overcome their tobacco dependence and to become a smoke free site; creating more opportunities to hear and utilise the patient voice for continuous improvement; raising the profile and education programme to support all staff in diabetes care and management for inpatients and launching a new carers service with the continuation of this work into 2024/25. It is recommended that monitoring the impact the 2023/24 priorities have had on patient outcomes continues during 2024/25.

It is acknowledged that 2023/24 had more challenges for the NHS, Social Care and the Trust, with continued high emergency demand, patients waiting and operational flow against the ongoing management of Covid-19 and other infections.

Following a Care Quality Commission inspection, Hampshire and the Isle of Wight Integrated Care Board notes that the Princess Anne Hospital remains rated Good overall and has developed an appropriate improvement plan to address the recommendations from the report.

The Hampshire and the Isle of Wight Integrated Care Board note the 2024/25 priorities including exploring the provision of a support centre for all people using the Trust's services; continuing to improve keeping patients safe from harm and a focus on reducing the impact of health inequalities.

Hampshire and Isle of Wight Integrated Care Board welcomes the 2024/25 priorities outlined in the Quality Account and looks forward to University Hospital Southampton NHS Foundation Trust sharing improvements and examples of best practice/innovation at our System Quality Group.

We would like to thank University Hospital Southampton NHS Foundation Trust for inviting us to participate in internal quality meetings and quality visits to support our assurances processes. Thank you for supporting local and system quality improvement by being an active, respected, and valued member of the:

- Southampton Local Quality Group
- Hampshire and Isle of Wight System Quality Group
- Hampshire and Isle of Wight Learning and Sharing Network
- Patient Safety Specialist Network
- Patient Experience Network.

Overall, we are pleased to endorse the Quality Account for 2023/24 and look forward to continuing to work closely with University Hospital Southampton NHS Foundation Trust during 2024/25 in further improving the quality of care delivered to our population.

Yours sincerely

Nicky Lucey
Chief Nursing Officer

Response to the Quality Report from Healthwatch Southampton

Healthwatch Southampton (HWS) is pleased once again to comment on the quality account of the Trust for the year. As in previous years, the account is well laid out and generally, easy to read.

The Chief Executives welcome is good to read. The statement that 2023/24 was once again a challenging year for both UHS and the wider NHS and social care system is undoubtably true. We are particularly aware of the effect of heightened operational pressures which saw record levels of patients in the hospital who were medically fit for discharge causing a considerable backlog of patients in the emergency department, and a significant increase in ambulance handover delays and queues within the adult emergency department. The introduction to the report is very brief but gives a clear overview of the content and is very helpful.

The account is well set out with the results from the year under review (Section 2.1.1) clearly explained in good detail. The table showing the overview of success is helpful and is followed by detail for each topic. It is very good to read that the trust has set out to improve care for people with learning disabilities and autistic (LDA) people across the Trust. The priority to support patients, service users and staff to overcome their tobacco dependence via a smoking cessation programme is now having an effect and although there is still evidence of smoking near the front entrance is noticeably reduced. We regarded the third objective, to ensure carers are fully supported, involved, and valued across all our services, to be important and it is disappointing that the pandemic disrupted the progress.

Nevertheless, we are pleased with what has been achieved and the future plans. The concept to 'put patients at the centre of transforming the way the trust delivers care, was strongly supported by HWS and the examples given in the report are very clear and show the benefit of involving patients. Being a learning organisation that understands where it needs to improve is a very sound objective and it is good that a lot has been achieved under priority 5 and that this will be continued to link the effectiveness agenda and strategy as part of an integrated approach to quality across the organisation. The figures for diabetes amongst adult patients are quite alarming, and with it expected to increase it is important that all staff have a good awareness of the management of this illness.

As usual HWS was consulted on the quality priorities for the coming year which were considered to be important and appropriate for inclusion. The eight quality priorities were developed by reflecting on the continued operational pressures from the last year. HWS accepts that they are built around the trust's ambitions and intention to deliver well-led, safe, reliable, and compassionate care in a transparent and measurable manner.

The format of the presentation is good with the rationale for selection, an explanation of what is to be done and the timeline to monitor progress consistent for each of the priorities. The concept of a support centre is ambitious but well worth pursuing. There is little doubt that there is a strong relationship between staff behaviour and patient experience, and we completely support priority two and emphasise the importance of bringing nonclinical staff on board. Volunteers can provide valued support to the provision of services for patients and this objective is well supported. Issues around acuity and deteriorating patients has been raised as a national issue and it is good to see that the trust is responding by this quality priority. It is important that the trust is aware that coming out of the pandemic, increasing operation pressures and staffing challenges created a greater focus on transactional tasks, and away from personalised aspects of care. It is important to now re- establish fundamental care at the heart of what is done at UHS. The intention to improve the effectiveness of morbidity and mortality (M&M) meetings is important. Reducing health inequalities is an important objective and priority 7is well laid out and should provide the basis for improvement. Finally, priority 8, to Develop a UHS quality management system approach, should provide the basis to improve the management of quality improvement.

Freedom to speak up is important concept in promoting an environment where mistakes are acknowledged, learned from, and prevented from happening again and we are pleased that this is recognised by UHS and actively encouraged. Similarly, emphasis on duty of candour also demonstrates the open nature adopted by the trust when dealing with patients. We are pleased that PLACE inspections were restarted this year and HWS played a full part in the inspection of UHS.

The CQC has rated the trust overall as 'good' with some aspects/areas rated as outstanding. This reflects our own view of the trust activities.

Healthwatch Southampton will continue to work with the Trust to maintain and improve patient experience.
Healthwatch Southampton

Healthwatch Southampton

Response to the Quality Report from our lead governor on behalf of the Council of Governors

Governors have had the opportunity to review and comment on the quality account to ensure that it provides a clear and balanced overview of the quality of care provided to patients at our hospitals. We recognise the tremendous amount of work that goes into producing the quality account and that this reflects the pressures and challenges faced by acute hospitals and other health and social care partners.

Governors have continued to receive regular updates on quality and performance at council of governors' meetings and through our working group committee. Our patient and staff experience working group in particular has focused on both patient and staff survey results, complaints, the rollout of the new patient safety incident response framework, CQC inspection results and staff wellbeing (including the Trust's inclusion and belonging strategy). We have also continued to engage with members through a number of virtual events throughout the year and are looking forward to being able to meet more patients, members and the public in our hospitals and at events in our communities over the coming year.

Governors were also consulted in the development of the quality priorities in 2023-2024 and supported these as key areas on which to focus in improving the quality of care provided to patients. It is encouraging to see successful achievement of the six quality priorities set for that period and such attainment is testament to the hard-work and dedication of all UHS staff. Whilst financial uncertainty continues to be at the forefront of NHS planning, the eight quality objectives set for the 2024/2025 demonstrates UHS' commitment to achieving excellence in services that are aligned to the three core dimensions of quality; patient experience, patient safety and clinical effectiveness. Governors acknowledge the robust methods taken to generate the quality priorities and are pleased to see the use of feedback from patient surveys and complaints, in addition to consultations with stakeholders.

The quality account highlights the extensive quality improvement programme within the hospitals and the benefits being delivered through this. Of note, governors were delighted to see the development of approaches to reduce health inequalities within our diverse community. This reflects the inclusive, learning and open culture developed in the Trust over a number of years and the continued focus on providing high standards of care to patients in a sustainable and equitable way.

Governors continue to be in awe of the dedication of staff, and the strength and support given by the executive and the board, in what has been and continues to be a very trying period in the health system.

Response to the Quality Report from the Health Overview and Scrutiny Panel

The Southampton Health Overview and Scrutiny Panel welcomes the opportunity to comment on the University Hospital Southampton NHS Foundation Trust Quality Account for 2023/24.

Reflecting comments made in previous years, we understand that 2023/24 has been a challenging year for both UHS and the wider NHS and social care system. The Trust has navigated periods of industrial action, managed a rise in winter infections and has experienced a period of heightened operational pressures which has caused a considerable backlog of patients in the emergency department, and has also resulted in an increase in ambulance handover delays.

The panel recognises the impact that the record level of patients in the hospital who were medically fit for discharge is having on the hospital and, in April 2024, convened a meeting to consider the issue with senior representatives from Adult Social Care, the ICB and UHS in attendance. Hospital discharge will remain a focus of the Southampton Health Overview and Scrutiny Panel in 2024/25.

We are encouraged by the Trust achieving five out of six quality priorities set for 2023/24, especially given the pressures outlined above. We also welcome the progress made by the Trust in partially achieving the priority relating to the support UHS provides to carers. It is evident and encouraging that the Trust is making significant progress in ensuring that carers are fully supported, involved, and valued across all UHS services. This aligns with Council policy firmly, as we also value the role of carers and recognise their importance.

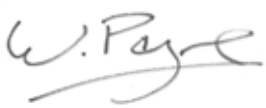
The panel notes the quality priorities for 2024/25, and it supports the focus on addressing the operational pressures experienced by the Trust with a focus on the provision of high quality, patient-centred care. Of particular interest is the priority committing the Trust to reducing the impact of health inequalities and developing a shared understanding of the health inequalities faced by our local communities. The impact of Covid-19 has exacerbated existing disparities across Southampton, and we support efforts that seek to address this issue and we encourage the Trust to engage with the Council's Public Health Team to maximise the impact that can be achieved.

However, we continue to be concerned that with the extensive waiting lists for diagnosis and treatment that the Trust has too many priorities and would benefit from focusing more on this issue without spreading its aspirations too widely. It is vital to concentrate on the area that is arguably causing greatest concern, as remedying it will be the most effective measure of the Trust's success.

The committee looks forward to working closely and positively with UHS to explore how the Trust will be working as part of the Integrated Care System to reduce the number of patients medically fit for discharge and the backlog of people requiring treatment, whilst ensuring that the quality of health services for the people of Southampton improves.

We greatly appreciate and value the work of UHS and your dedicated staff in our city.

Yours sincerely



Cllr Warwick Payne
Chair of the Health Overview and Scrutiny Panel
Southampton City Council