NHS
University Hospital Southampton
NHS Foundation Trust

QUALITY ACCOUNT
2024/25

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Part 1: Statement on quality from the Chief Executive

1.1 Chief Executive's statement and welcome

I am pleased to present this year's quality account, which reflects our ongoing commitment to delivering safe, effective and compassionate care for our patients.

2024/25 has been a challenging year for UHS and the wider NHS and social care system. We have navigated operational pressures, with increasing numbers of patients who are medically fit but do not have an onward care package in place to be discharged, alongside a rise in winter infections and a record number of attendances to our emergency department.

In the face of these challenges, our teams have worked tirelessly to enhance patient outcomes, improve service accessibility and ensure that the care patients receive meets the highest standards. I want to recognise the hard work of our staff in ensuring safety, driving innovation, and adapting to changes.

This report highlights successful initiatives that have improved patient care over the past year. It also provides an overview of our quality priorities for 2024/25 and sets out our quality improvement priorities for 2025/26. We are proud to have maintained our focus on quality and achieved most of our objectives, enhancing the experience for those who use our services.

Patient experience is an important priority for UHS. In 2024/25 we have successfully recruited approximately 2,000 'involved patients', which will ensure that we co-design our services with those who use them, keeping our focus on our Trust values of patients first, working together and always improving. 2025/26 promises to be an exciting year for patient experience, with the development of the Patient and Family Support Hub, which will integrate voluntary services and ensure equitable access to support services for all.

Our long-standing commitment to delivering safe, high-quality care is underpinned by the Fundamentals of Care programme - eight care commitments that patients, families and carers can expect from their care at UHS and these statements have been written in conjunction with patients, relatives and staff. In 2024/25 the programme has made significant progress in embedding Fundamentals of Care into our organisational culture. This has been achieved through developing understanding with newly registered professionals in our preceptorship programme, support worker development opportunities and the ongoing empowerment of staff through leadership development.

In 2024/25, we have continued to strengthen our internal quality assurance programmes by aligning the clinical accreditation scheme with the CQC single assessment methodology. We are collaborating with other internal programmes - such as infection control, Patient-Led Assessments of the Care

Environment (PLACE) and friends and family feedback - to triangulate data and enhance oversight of key quality metrics, including patient safety, effectiveness, patient experience, and outcomes. This approach provides us with valuable intelligence to help us uphold our Trust values.

2024/25 marked one year of Patient Safety Incident Response Framework (PSIRF) implementation at UHS which has helped develop 'just and learning' culture across the organisation. Safety awareness has increased through our education programmes that have achieved good attendance and feedback. This coming year we will continue to build on the work that has been undertaken as part of implementation of the national safety standards for invasive procedures (NATSSIPS) 2.

We continue to collaborate with our partners and develop our work as an integral organisation in the integrated health and social care system, building on trusted relationships across organisational boundaries are essential in improving health outcomes for our whole population.

I want to recognise the amazing dedication of our staff in maintaining the safety of both colleagues and patients, fostering innovation, and adapting to evolving circumstances. Throughout this year, our teams across all services have strengthened their collaboration with our partners. As we continue to advance towards an integrated health and social care system, these trusted relationships are proving essential in our ability to respond effectively.

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.

David French
Chief Executive Officer
26 June 2025

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

2. Introduction

Despite it being an extremely challenging year and unprecedented demand in the emergency department during 2024/25, the Trust maintained a strong focus on quality assurance. This was undertaken through established programmes and clinical leadership oversight of key safety and patient experience indicators, including falls, pressure ulcers, and venous thromboembolisms. The Fundamentals of Care initiative continued to be embedded, supported by high-quality peer reviews and weekly matron-led quality walkabouts aligned with CQC domains. The clinical accreditation scheme (CAS) was enhanced with updated documentation reflecting learning from themed walkabouts and aligned with national frameworks. A new governance framework for mortality and morbidity meetings was introduced to improve learning dissemination and escalation. The Trust also opened a Patient and Family Support Hub (P&FSH), advanced volunteer recruitment through a system-wide passporting approach, and began implementing NatSSIPs 2. In response to rising violence against staff, de-escalation training was rolled out, leading to a reduction in physical restraint and violence incidents. The Trust's commitment to continuous improvement was demonstrated through training over 1,000 staff, outperforming NHS averages in improvement metrics, and achieving measurable service enhancements, including a 5.25% reduction in average length of stay, increased theatre throughput, and expanded use of patient initiated follow up pathways.

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 2024/25 (last year).
- It sets out the priorities we have agreed for 2025/26 (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 our Council of Governors, Hampshire and Isle of Wight Integrated Care Board and Southampton County Council's Health Overview and Scrutiny Committee.

2.1 Priorities for improvement

This section reflects on the 2024/25 quality improvement priorities at UHS and outlines our quality improvement priorities for 2025/26.

2.1.1 Progress against 2024/25 priorities

Last year, we upheld our commitment to delivering the highest standard of care, influenced by various national, regional, local, and trust-wide factors. Throughout the year, we encountered unprecedented demand on our services, contending with challenges related to operational, capacity, patient flow, infection prevention, and safety. Despite these difficulties, we were confident in our ability to maintain our focus on quality priorities. Our teams worked diligently to achieve their goals under these challenging circumstances. We are proud to present our accomplishments and how our successes have continued to enhance the quality of services we provide to those who rely on us.

Overview of success

Core dimension	Quality priority	Progress
Patient experience 	Exploring the provision of a support centre for people using our services.	Achieved
	Creating a behaviour framework behind our values, bringing them to life to improve our patient and staff experience.	On hold
	Volunteering - a new focus.	Achieved
Patient safety 	Acuity and deteriorating patients: continuing to improve how we keep patients safe from harm.	Achieved
	We will ensure that Fundamentals of Care (FoC) are provided to all our patients in collaboration with our patients, their family, and their carers.	Achieved
Clinical effectiveness 	Improving our morbidity and mortality (M&M) meetings.	Achieved
	Develop the Trust's approach to reducing the impact of health inequalities (HIs).	Achieved
	Help develop a UHS quality management system approach.	Achieved

2.1.2 Quality Improvement Priorities - 2024/25: Final Reports

Quality Improvement Priority One: Exploring the provision of a support centre for people using our services (year one)

Why was this a priority?

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 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, often resulting in staff offices and education rooms being inappropriately repurposed to meet their needs.

Growing feedback from complaints and Friends and Family Test (FFT) responses emphasis our inability to provide patients, carers 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 have we achieved?

Estate has been identified. Work has started to repurpose the underutilised Macmillan Centre into a generic non-disease specific Patient and Family Support Hub. This agreement made through the Trust Investment Group was to end the current agreement with the Macmillan charity and to approach Southampton Hospitals Charity to support a refurbishment and further investment into the hub (for example funding a carers shower provision).

Key areas identified for further development

- Major grant request submitted to Southampton Hospitals Charity due to go to Charity Trustee Board in March 2025.
- Recruitment of a band 7 mnager role (appointed in January 2025 and starting 31 March 2025);
- Rebranding and merging (of current Patient Support Hub) started in February 2025.

How will ongoing improvements be measured and monitored?
Once the Patient and Family Support Hub is launched there will be a constant drive for patient and service user involvement, co-designing the space, there will be surveys on before and after, end of life quality of care will improve
Progress metrics
• Reduction in adverse event reporting that a patient died in an open bay. • Carers survey improvement. • P&FSH FFT results.

Quality Improvement Two: Creating a behavior framework behind our values, bringing them to life to improve our staff and patient experience

Creating a behaviour framework behind our Trust Values to bring them to life in our everyday work and interactions is still very much a priority. However, the work has been paused to ensure it aligns to the development of the new Trust strategy, both these pieces of work need to be produced side by side. It is anticipated the work on the behaviour framework will commence alongside the development of the overall Trust strategy and timelines for launch and embedding will move to 2025/26.

Quality Improvement Priority Three: Volunteering

Why was this a priority?

To value the contribution our volunteers make to our organisation, we wanted to improve the onboarding process to provide more guidance and support for our volunteer colleagues, and to work with them more closely to build in flexibility and be more creative in the kind of roles and support they could offer.

What have we achieved?

- We worked with our systems partners to complete a successful bid through Volunteering for Health (VfH) and have plans to develop a unified and standardised approach of volunteer recruitment using a passporting system.
- Our key relationship is with the Hampshire and Isle of Wight Voluntary Community and Social Enterprise (VCSE) sector Health and Care Alliance (HIVCA) and it has allowed us to further explore a more system-wide approach, with a view to sharing resources, ideas, and opportunities both internally and outside the organisation on a regular basis.
- We have worked with HIVCA and fostered a collaborative learning environment, aiming to streamline and standardise the volunteer onboarding processes over the coming year.
- We have built upon current onboarding and training processes and are particularly developing the enhanced care training for our volunteers to support their awareness of working alongside patients who have mental health issues, dementia, delirium, learning disabilities and autism.
- We are working with information governance leads to consider how the Trust's internal policies can create equitable opportunities for a range of volunteers, to support them in accessing limited patient records, to allow them to document the interactions that they have with patients in support of the provision of collaborative holistic care.
- We have begun to develop a new "ABC" approach to offering our volunteering roles, co-designing new roles for volunteers, and providing a flexible 'responsive volunteering' process that can support the organisational pressures as they arise and dovetailing the offer from our experience of care teams.
- We have started to build relationships with the NHS care responder volunteer's service looking at how they can enhance our existing offering provided by our responder volunteers.

Key areas identified for further development

- We have more scope to develop a more robust support process for volunteers during their placements through building better relationships between the volunteers and their clinical teams.
- We will grow our volunteering hub space in spring 2025, to offer a more effective space for volunteers to access practical and welfare support from voluntary services, giving them a clear base and point of contact.
- Working with HIVCA in the system-wide partnership, we will continue to explore the VfH funding and how it can develop the 'passporting' system for the volunteers across the network.
- As our new Patient and Family Support Hub becomes established, we will work with the NHS responders and our existing responder volunteers to ensure a more extensive five to seven day/week service (including evenings).

How will ongoing improvements be measured and monitored?
The key metrics for measuring these outcomes will come from: • Our responder volunteer statistics through the Patient and Family Support Hub. • Our outcomes associated with the HIVCA partnership and the VfH bid i.e. progress with a passporting system including potential recruitment of a post to develop and establish this new system.
Progress metrics
• Year one funding from the VfH bid was received by the partnership to develop the partnership with the HIVCA support meetings every six to eight weeks. • The system-wide volunteer onboarding and passporting system has not yet been established but will continue to progress with the partnership. • We will have developed a responsive volunteer network, available five days a week with an established support system in place. • We are an open and inclusive recruiter of volunteers and monitor the equality, diversity and inclusivity of the volunteers we recruit, seeing a more diverse range of volunteers that begins to more accurately represent our local community.

What our patients/relatives/carers tell us

PATIENT SUPPORT HUB

NHS University Hospital Southampton NHS Foundation Trust

"I really tried to bring mum in a paper each day but sometimes that was impossible if I couldn't visit. Mum really enjoyed having these delivered especially as she had no TV in the ward. You made the process very easy and straightforward for us via email.

She really appreciated them as she loves the crossword and it helps keep her brain active after her stroke. She said that the lady who delivered it was so happy and smiley all the time.

Its the little things that can make a real difference when you are in hospital, especially long term."

PATIENT SUPPORT HUB

NHS University Hospital Southampton NHS Foundation Trust

"I have difficulty walking anything more than a few metres, so I have been well supported (by the Patient Support Hub). I usually just phone up, and someone meets me at the hospital entrance, takes me to my appointment, and drops me back to the entrance again.

Its meant I can actually attend my appointments - without the volunteers I would not be able to attend my appointments. Its a wonderful service.

I would 100% recommend using the service to others, I have told some people about it already, more people should know about it. The volunteers are so friendly and helpful."

PATIENT SUPPORT HUB

NHS University Hospital Southampton NHS Foundation Trust

I'd like to say a massive thank you to you and your volunteers for everything you did for me while I was in hospital, your services made a huge difference to me and I seriously cannot thank you enough for all you do and going that extra mile, you absolutely saved my sanity!

thank you

PATIENT & FAMILY SUPPORT HUB

NHS University Hospital Southampton NHS Foundation Trust

What our volunteers have said...

"Go on, be part of a team putting something back into helping others"

"You could not find a nicer group of people to work with, we are a mixed bunch of young students and retirees like me. Such a varied age group I think keeps me from going stale. The best thing though is the enjoyment and pleasure I get from doing it"

"I love interacting with people and making them feel comfortable and happy"

"It has been so satisfying helping people"

"The team are all so lovely, and it's a great way to learn new skills and to try new things!"

"I'm really grateful to everyone in the Patient and Family Support Hub for creating a kind and supportive work environment, and showing me what wonderful teamwork looks like"

Quality Improvement Priority Four: Acuity and deteriorating patients: continuing to improve how we keep patients safe from harm

ADULTS AND PAEDIATRICS

Why was this a priority?

The recognition, assessment, and escalation of a deteriorating patient either adult or child are a key element of our trust-wide patient safety and quality strategy with the aim of improving clinical outcomes for acutely ill patients. How rapidly we respond to patient deterioration both in and out of hours is a key determinant of patient and quality outcomes.

What have we achieved?

Five new starters have successfully completed their supernumerary period. The critical care outreach team (CCOT) resumed its 24/7 service on 16 December 2024. Recruitment for the final vacancies was completed in December 2024, with both new recruits scheduled to commence their roles by 31 March 2025. An education task and finish group has been established, which has conducted a gap analysis with all education leads and reviewed both internal and external training resources. Standards are currently under revision. The medical education and simulation team is testing the Acute Life-threatening Events-Recognition and Treatment (ALERT) course, which includes resident doctors and junior nurses. Initial feedback was presented to the deteriorating patient group on 25 September 2024. The Trust's acute deterioration education day continues to review feedback and evaluations for study days.

The acuity surveillance pilot was successful, and the CCOT is now formally implementing this initiative. Monthly acuity reports are generated at the Trust, division, care group, and ward levels, or through bespoke reporting. These reports incorporate various metrics, including National Early Warning Score 2 (NEWS2) and National Paediatric Early Warning Score (NPEWS) activations, Call 4 Concern activations, a 24-hour overview of NEWS2 activations, cardiac arrest calls, CCOT activations and reasons for referral, and unplanned admissions to the intensive care unit (ICU). Quarterly data on cardiac arrests, Treatment Escalation Plans (TEP), and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) are presented to the resuscitation committee and the deteriorating patient group (DPG). Challenges persist in collecting robust sepsis data.

UHS is participating in the national Martha's Rule pilot programme, with Call 4 Concern implemented in March 2024 and all activations reported on Ulysses. A task and finish group has been established to explore patient wellness questions, which is a fixed agenda item at the DPG. The bi-monthly DPG has been established, with increasing medical engagement, and regular reports are submitted to the patient safety and quality committee (PSSG).

Key areas identified for further development

- Further roll out of Martha's rule UHS-wide including Call 4 Concern.
- Gain feedback from divisional governance teams regarding incidents to ensure learning is identified and appropriate action plans are devised and implemented. Collaboration with maternity and neonatal services.
- Development of acuity dashboard.
- Medium- and long-term service development commenced including workforce planning.

How will ongoing improvements be measured and monitored?
• Bimonthly deteriorating patient group meetings to review current trends and themes, implementation of appropriate actions and evaluation of actions. • Biannual review of deteriorating patient group terms of reference. • Quarterly report to patient safety steering group. • Yearly assurance report – Trust quality committee.
Progress metrics
• Patient observation compliance data. • NEWS2 and NPEWS activations and data analysis. • Analysis of all unplanned admwissions to ICU from ward areas – adult and paediatric for themes to inform education and practice. • Adult and paediatric ICU stepdown data. • Adult critical care outreach team activity and outcome data. • Adult and paediatric cardiac arrest and outcomes data. • Adult TEP & DNACPR data. • Complaints and adverse event reports related to failure to rescue and failure to escalate. • Percentage of patients diagnosed with sepsis within the emergency department receiving appropriate antibiotics within one hour of sepsis diagnosis. • Analysis of adult and paediatric Call 4 Concern data, action plan developed, implemented, and adjusted in response to themes. • Analysis of patient/service user feedback on Call 4 Concern service. • Analysis of staff feedback on Call 4 Concern service.

Volunteers and quality patient safety partners helped to promote the Call 4 Concern work

Quality Improvement Priority Five: Fundamentals of Care

Why was this a priority?

Patient Experience - Fundamentals of Care (FoC) was established as a priority in 2024/25 due to evidence that post COVID we had not yet returned to a less task-focussed and more patient-focussed level of care. The priority was developed to create a foundation and structure to tackle these care standards of care and to challenge practices, in response to patient and relative feedback.

What have we achieved?

Since commencing in late 2023 the following has been achieved:

- We have established the FoC project board and this group continues to meet every three months to provide an overall project view, share successes and opportunities for learning, discuss the workstreams continuing under the eight standards and to escalate challenges through a formal governance structure (through quality committee and QGSG).
- We have had one quality patient safety partner (QPSP) on the project board since conception. Subsequent events have involved two other QPSPs and have broadened the 'patient voice'.

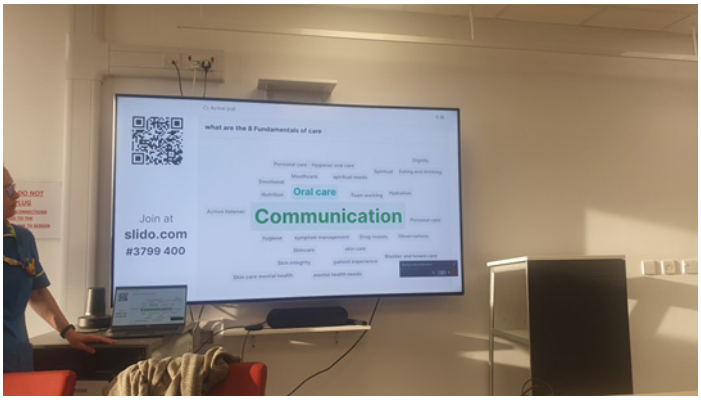
- Each of the standards has a lead who oversees a multi-professional working group with clinical team representation. Some groups have chosen to pair due to links in their primary and secondary project drivers and actions. Matron involvement is driving the patient facing team involvement.
- The project board is minuted, with an action tracker. The board is attended by the corporate nursing team and is supported by our deputy chief nurse, chaired by our head of patient experience. It is also supported by our chief nursing informatics officer, members of the transformation team and communications.
- There is a FoC project manager in place who has worked with the transformation team to create a project plan in collaboration with workstream leads, a communications plan and drive forward key initiatives including business intelligence and the development of a clinical quality dashboard so we can measure the impact of the FoC.
- Enhancing leadership and role modelling of the FoC has been a key focus through leadership in practice study days. These sessions, held three times annually, target leaders across the organisation to address and challenge behaviours related to the FoC. Incorporating the patient voice, these study days are grounded in real patient stories and involve the practical application of skills using simulated patients.

- As part of the patient hygiene working group, we have undertaken surveys using volunteer support, of patients and staff in the clinical decision unit (CDU), acute medical unit (AMU3), trauma assessment unit (TAU) and Macmillan acute oncology service (MAOS) in relation to their experiences of patient hygiene care and the impact of the trial patient hygiene packs.
- Existing surveys, PALS interactions, complaints, adverse event reports (AER), Friends and Family Test (FFT) are followed up and reviewed by senior managers accordingly. These inform the FoC workstream through the head of patient experience.
- Since conception, sharing the patient perspective and reflecting what patients would like to hear from us has been key. The posters around the organisation on our care commitments and resources on staffnet and the virtual learning environment (VLE) for staff, support this. These resources include:
  o Resources developed by each group to share during the monthly focussed trolley dashes.
  o Videos developed by staff for staff, to improve awareness of some key facts about each of the eight standards.

Staff on Bassett ward engaging patients with dementia in crafting activities

- Strong presence of the FoC throughout education as it has been mapped to the health care support worker (HCSW) induction, is included on preceptorship for all staff groups, has been presented to some university students at the University of Portsmouth and is embedded in lots of local training and development initiatives. The head of patient experience delivers many sessions across the organisation and beyond.

Head of patient experience engaging with clinical staff in cardiovascular and thoracics on how to assess the FoC in their area



- The What Matters To Me (WMTM) project was trialled in some clinical areas from October 2024 (F7 and G7). Due to challenges in engaging the volunteer support to maintain this project it has temporarily been halted. The boards have an agreed template, agreed by a QPSP, and based upon feedback from staff and patients. The values of this project are echoed in local projects we have seen.
- The FoC is being reviewed in conjunction with matron walkabout and the clinical accreditation scheme (CAS). Starting in February 2025, a new monthly focus is being established, with five core questions associated with a FoC standard and five specialist questions associated with that topic. This is forming past of ward benchmarking with a new self-assessment tool being implemented.

Key areas identified for further development

- Clinical representation in these working groups is to be re-established/built upon to support further engagement in the clinical areas/teams.
- Continuing to establish links and support in child health, maternity and outpatients to ensure a bespoke but collaborative roll out of FoC.
- To continue strong patient engagement and involvement, linking with involved patients where required with the support of our existing FFT results, the national inpatient and urgent and emergency (U&E) care surveys.
- Resources to continue to grow to create a repository of information for staff and develop their knowledge around the FoC and to support each other in challenging behaviours and practices.
- Employ interim project manager to maintain the project and support new ones whilst the current project manager is on maternity leave, focusing on establishing the dataset to evidence the FoC.
- Strengthen the recruitment of volunteers for WMTM through the successful bid to Volunteering for Health (VfH) through the recruitment and investment in a volunteer coordinator, as part of a partnership with other organisations in Hampshire and Isle Of Wight (HIOW), including the charity sectors.
- Successful implementation and evaluation of WMTM boards across key areas in organisation, with full volunteer support for the obtaining of photographs of the patients from themselves/ families to maintain that person-centred focus.

How will ongoing improvements be measured and monitored?

Improvements will be measured and monitored through FFT feedback, feedback from self-assessment tools and ongoing surveillance of the clinical quality dashboard.

Progress metrics

Reduction in clinical lincidents:
We've seen a decrease in the number and severity of incidents related to the FoC across inpatient settings. A key theme in early 2024 involved patients reporting being asked to urinate in incontinence pads. Six adverse event reports (AERs) were recorded in Q1, with none reported in Q3, indicating improvement.

Reduction in complaints:
While we don't yet tag complaints specifically to FoC, we've observed a decline in 'patient care' complaints - from 14.67% in Q1 to 13.91% in Q3. We're also exploring refinements in complaint categorisation to better align with FoC themes.

Increase in compliments:
Patient and family feedback is gathered through various channels. For example, our urgent and emergency care survey showed an overall satisfaction score of 7.68/10.

Improved oerformance against metrics:
Throughout 2024, we've redesigned our improvement metrics in collaboration with clinical teams. These are now reflected in the clinical quality dashboard, supported by a comprehensive data dictionary developed by our project manager.

Quality Improvement Priority Six: Improving our morbidity and mortality (M&M) meetings

Why was this a priority?

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 multi-disciplinary 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&M meetings 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 have we achieved?

The medical advisor for patient safety is leading efforts on morbidity and mortality (M&M) meetings. A comprehensive framework for M&M meetings at UHS has been developed, establishing expectations for a safe learning environment that is multiprofessional and multi-disciplinary, with a systematic meeting structure and agenda focused on learning, governance integration, and patient-centred care. This framework is supported by a handbook, resources, and education for M&M leads. A dedicated Teams channel has been created to provide resources for M&M leads.

An M&M workshop was held as part of the WHO Patient Safety Day on 12 September 2024, focusing on creating strong learning environments, maintaining patient centrality, and learning from palliative care. The workshop was attended by 20 M&M leads and governance representatives. Additionally, 20 M&M leads attended a study day on 23 January 2025, covering topics such as human factors and systems thinking, PSIRF, keeping the patient central, appreciative inquiry in M&M, creating strong learning environments, managing difficult behaviour, and expanding the scope of M&M beyond mortality. The study day was well received, and another is planned for early April.

Regular meetings are held with M&M leads and the medical patient safety advisor to provide support and identify areas needing assistance. An electronic M&M recording system was developed and trialed to capture and evidence outcomes, but it is no longer supported by the Trust, prompting the investigation of alternatives. A clear escalation process from M&M meetings to the existing governance structure has been established, with actions recorded. M&M meeting outcomes are now a standing agenda item in governance meetings.

UHS - 6 key principles of M&M

Safety
A safe space for learning. A meeting atmosphere that is conductive to open discussion with a focus on 'Just and Learning Culture' and an emphasis on understanding the systems factors, not focusing on individuals.

Multiprofessional and Multi-disciplinary
Ensuring active participation across staff groups and different disciplines.

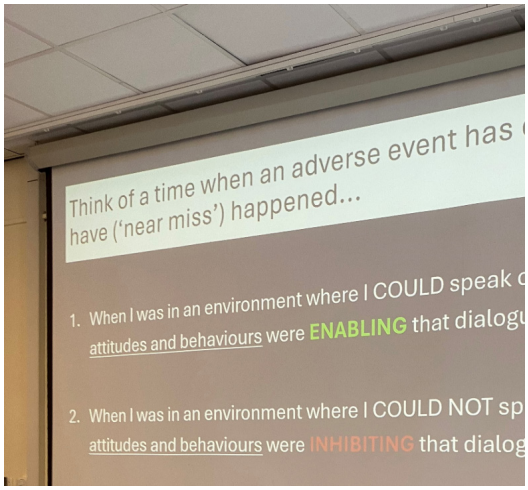
Meeting Framework
Systematic agenda selection process, structured meeting format and objective analysis of data, including consideration of systems factors, and human factors and ergonomics.

Learning Focus
Comprehesive discussions to generate actionable learning and system improvement. Using an appreciative inquiry approach to emphasise and learn from the every day, as well as where things can go wrong.

Governance
Hospital-wide system to record outcomes, lessons learned, and dissemination of recommendations to ensure action and learning. Supporting our integrated approach to quality across the organisation. Folow up to ensure actions are completed. Clear pathways for central reporting and escalation of concerns.

Patient Centred
Keeping the patient and the family central to the learning. Ensuring that the patient voice is heard when learning from events. Completing feedback and duty of candour to help build trust.

Training as part of the WHO World Patient Safety Day: Discussing how to create psychological safety in meetings



Key areas identified for further development
• Development of electronic recording process that can be used for all M&M meetings. • Need to develop stronger links and greater support from local governance.
How will ongoing improvements be measured and monitored?
Regular review of M&M meetings with the M&M leads to ensure that: • M&M meetings are represented by the multi-disciplinary. • Terms of reference are in place. • Incorporating mortality data. • Using a recording app (when available). • Outcomes are linked to actions and governance processes.
Progress metrics
The electronic recording system is not currently supported so we cannot measure this (and it makes it hard to audit actions and escalations as these would be audited via this). Survey of clinical staff (163 replies) and their view on M&M. Key findings: • 73% staff feel UHS views the meetings as important. • 75% that their department views these as important. • 60% that they are fit for purpose. • 75% that they make a difference to patient safety. • 80% agree that systems factors are considered. • 35% felt they were well supported by local governance.

Quality Improvement Priority Seven: Develop the Trust's approach to reducing the impact of health inequalities (HIs) (year one)

Why was this a priority?

The causes of health inequalities are complex, but research has shown that the main drivers of health inequalities 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 both mitigating against the wider determinants and in reducing healthcare-based inequalities. As well as a moral and social responsibility, NHS trusts have a legal duty to consider health inequalities.

A new requirement from NHS England asks that trusts describe the extent to which they have exercised its functions consistently with NHS England's views set out in the statement on information on inequalities.

Addressing health and care inequalities is a core focus of the CQC's 2021 strategy. To reinforce this commitment, the CQC has outlined five equality objectives aimed at tackling disparities in health outcomes. They have made it clear that action will be taken where care falls short for particular groups. Providers are expected to proactively identify, engage with, and respond to individuals who face barriers to accessing care or experience poorer outcomes. These efforts will be reflected in the CQC's assessment frameworks.

Failure to address health inequalities also carries a significant financial burden for NHS trusts. Estimates suggest these disparities cost the NHS around £5.5 billion each year. Eliminating health inequalities could potentially reduce the volume of treatments provided by the NHS by up to 15%, easing pressure on services and resources.

What have we achieved?

Governance

A health inequalities board has been convened, chaired by the chief medical officer and attended by representation across UHS, patient partners, public health teams from the local councils and the population health team within the integrated care board.

The board has set some initial objectives. These will be delivered through five areas of focus, each with a dedicated sponsoring director and a detailed delivery plan. These areas of focus are:

- Clinical priorities.
- Data and measurement.
- Enabling the organisation.
- Communications and engagement.
- Strategy and approach.

Clinical priorities

Three clinical priorities have been set, based on national guidance on services where there is greatest health inequalities impact. The public health leadership from the local councils and integrated care board were involved in this prioritisation to ensure that we chose areas with high prevalence locally, and where it was felt an acute trust can have greatest impact. Priorities set are tobacco dependency, hypertension and obesity.

Tobacco dependency
In Southampton, smoking rates are higher than the national average. It is estimated that one in six Southampton deaths are attributable to smoking (JSNA, 2021). 70% of our lung cancer patients and 86% of our COPD patient deaths are directly attributable to smoking. People who smoke are 36% more likely to be admitted to hospital than non-smokers and have poorer treatment outcomes including reduced response to treatments, prolonged recovery and increased risk of complications, across many areas including surgery, cancer and cardiovascular disease (Royal College of Physicians, 2020). This leads to increased length of stay, higher rates of emergency department attendance and greater pressure upon outpatient clinics due to smoking-related comorbidities.

We have been focusing on improving identification of those who have been admitted who smoke, increasing the delivery of very brief advice to all patients who smoke and increasing referral to tobacco dependency services on the ward for those who do not opt out. We've been reviewing our data to understand how we are supporting those most at risk of being impacted by health inequalities.

Obesity
In 2022 to 2023, 29.5% of adults in Southampton were estimated to be living with obesity, above the national average. Southampton has one of the highest childhood obesity rates in the county. There are a large number of conditions linked with obesity, including cardiovascular disease, hypertension and liver disease.

There is a multi-disciplinary service provided at UHS for children which provides excellent outcomes, reversing clinical impacts such as hypertension and type two diabetes. This programme seeks to identify opportunities to collaborate with our system to prevent the increasing levels of childhood obesity, reflecting the national focus on left shift and prevention. Adult obesity services are in review across our system.

Hypertension
Hypertension is amongst the leading causes of death in Southampton and Hampshire. High blood pressure causes threat to life expectancy linked with stroke, vision loss, heart failure, heart attack, kidney disease/failure. Hypertension identification and control have both been a challenge across Hampshire and Isle of Wight.

Although hypertension treatment is delivered in primary care, there are actions we are taking as a trust to support this important priority. This includes:

- As the largest employer in the city we have the opportunity to improve health by supporting our staff. We are developing materials to support our staff to understand the importance of blood pressure monitoring and approach to accessing help with high blood pressure. We hope this knowledge will extend to families, communities and how we support our patients.
- Support people to 'wait well' whilst on our waiting list, with improved guidance on controlling and monitoring blood pressure while waiting for surgery, reducing the number of cancelled procedures due to high blood pressure.
- Consider how improved data sharing on blood pressure readings between UHS and GPs can support onward support for hypertension.

Data and measurement
Several positive steps have been taken in measuring and understanding health inequalities within our services. These have been:

- Building new dashboard that enables us to assess whether access to our services in equitable related to IMD decile, age, gender and ethnicity.
- Assessment of equitable delivery of smoking cessation services.
- Assessing the acute impact of hypertension control.
- Collaborating with the Integrated care board on producing the data required for national reporting guidelines.

Enabling the organisation
We wish to support staff across our organisation to understand health inequalities, to recognise them within services, to access to tools to enable service change and to have routes to escalate issues. We have appointed a health inequalities officer who will be a key link to support services to achieve this. We have begun developing training that will be available across the organisation. We have also established escalation routes for raising concerns related to health inequalities.

Communications and engagement
There have been a number of excellent case studies communicated during this year through existing communications channels such as the Connect magazine. HELIXR, a pioneering programme that supports vulnerable patients with chronic liver disease through the introduction of peer support workers, attracted news coverage and was featured on the BBC and ITV Meridian in March.

We have been attending events across Southampton including Pride and the Black Business and Arts Festival to show our support and to connect with our communities. We've been reaching out to grow the number and diversity of our involved patients, aiming to reflect the diversity of our population in our feedback and helping us to better serve the needs of our community.

Strategy and approach
We have worked on establishing this approach to delivering health inequalities over the year, which is now seeing results in progress in all prioritised areas for improvement.

We have taken discussions to our Trust Board to establish how we will move this important work forward in years to come. We have also reflected on how population health, prevention and health inequalities will feature in our developing updates to our trust and clinical strategies.

Key areas identified for further development

There are detailed delivery plans for all of our priority areas over the next year, which will enable us to keep driving towards our aims. Highlights from these plans include:

- Designing and publishing health inequalities training for all staff.
- Creating an internal staff campaign, recognising the impact of health inequalities within our people and providing advice.
- Establishing a health inequalities operational group who receive escalations of health inequalities issues and assess trust-wide implications and support improvements.
- Delivery of planned improvements within our three prioritised clinical specialties.
- Connecting with our communities and engagement leads across our city, improving our insights into the local drivers of health inequalities and identifying improvement opportunities.
- Reviewing our use of QEIAs for change and decision making.

- Development of Trust and clinical strategies with making impact on health inequalities included.
- Making use of the data sets we have built to drive change within our services and measure our impact.

How will ongoing improvements be measured and monitored?

We have clear objectives against all priorities with delivery timelines. We will continue to assess our progress in delivering against these.

The dashboards that have been built will enable us to measure change over time, demonstrating where we have been able to impact on the equality of access to services.

We will continue to work with our patients to gain feedback on how well we have met their needs while under our care.

Progress metrics

During 2024/25, we significantly advanced data capabilities to measure health inequalities across UHS services. We now track outpatient and inpatient waiting lists, discharges, and emergency department performance by age, gender, ethnicity, and Index of Multiple Deprivation - enabling long-term impact assessment. Staff access to this data will also be monitored.

While some planned measures were successfully implemented, others remain in progress and will continue into year two (2025/26) of this quality priority.

As part of our hypertension programme, we aimed to reduce theatre cancellations and non-elective admissions. Pathway improvements are underway and will be implemented in 2025/26, supported by expanded data sources. Combined with the Hampshire and Isle of Wight Intergrated Care Board's (HIOW ICB) cardiovascular disease (CVD)-focused 'signature move' in primary care, these efforts are expected to reduce non-elective admissions.

HIOW ICB data for 2024/25 shows:

- ~95 CVD-related ED attendances/month
- ~420 non-elective admitted episodes of care/month
- ~2,340 bed days/month

Our tobacoo quit rates continue to be better than expected nationally.

Throughout the year, the health inequalities board reviewed case studies from eight services, showcasing impactful improvement work. These have been documented to support organisational learning.

Quality Improvement Priority Eight: Develop a UHS quality management system approach (year one)

Why was this a priority?

In April 2023, NHS Improving Patient Care Together (IMPACT) was launched to support all NHS organisations, systems, and providers at every level (including NHS England) 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, the Trust undertook a self-assessment to gauge its 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 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 have we achieved?

- The Trust executive committee (TEC) commissioned a quality report as a standing item to enable integrated organisational oversight of all aspects of quality for consideration alongside the financial, performance and people domains.
- A steering group led by the chief nursing officer with representation from the deputy chief nurse portfolio, clinical effectiveness, corporate affairs, and transformation has been established to create this report, review the quality data requirements and the coordination of quality teams to produce it.
- A review of our current quality board reporting and the care quality dashboard (CQD) has been undertaken. A working group to look at future requirements across all of these use cases and developing these has been established.
- Visits have been undertaken to draw upon learning from other hospitals' approach to quality management systems through a series of online webinars and resources shared through NHS IMPACT and through visits to other trusts. East London NHS Foundation Trust is seen as leading in their quality management system approach and a site visit was conducted in July with learning taken to include in our UHS approach. In February, Salisbury hosted the Trust to demonstrate their quality management system and how it drives the deployment of their trust strategy.
- We have identified opportunities to collaborate across the quality portfolio and work together on these objectives. The health inequalities board has representation from all the quality teams and various workstreams and subgroups are owned across the portfolio in a coordinated approach.

Key areas identified for further development
Initiate the quality report paper to TEC from April 2025 and iterate based on feedback: • Further site visits planned and engagement across the South East regional Learning Improvement Network will enable learning and understanding of best practice from other centres in the South East region. • Review the workplan for the future development of the CQD to be initiated following a workshop to gather requirements from the different use cases that have been identified. This workshop is expected to produce a development roadmap for the quality information. • The Trust has initiated its strategy development process and an emphasis on an integrated quality approach will be a key component within the new framework building on the learning from other centres.
How will ongoing improvements be measured and monitored?
• Feedback will be gathered from the quality report and shared with TEC members. • A development roadmap will be developed for the quality dashboard to monitor progress. • A key milestone will be the management system being set out in the updated Trust strategy in September 2025. • The Trust will undertake a further self-assessment against NHS IMPACT improvement framework to assess any increased maturity resulting from focussing on these priorities.
Progress metrics
• We will track progress via the steering group, chaired by the chief nursing officer. • 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 Priorities for improvement for 2025/26

This section outlines our quality improvement priorities for 2025/26, developed in response to the ongoing operational challenges of the past year. Our focus remains firmly on delivering high-quality, patient-centred care across all services.

These priorities have been shaped through collaboration with our executive team, governors, clinical colleagues, and informed by feedback from patients and staff. This inclusive approach ensures our efforts are directed toward the areas that will have the greatest impact on those who use our services.

Our priorities are grounded in the Trust's commitment to providing well-led, safe, reliable, and compassionate care - delivered transparently and measured meaningfully.

We continue to align our priorities with the three core dimensions of quality:

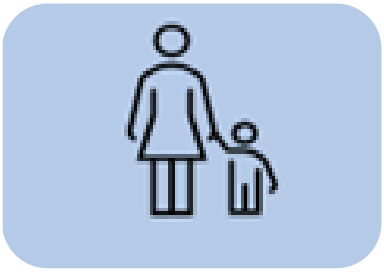
- **Patient Experience** – how patients perceive and experience the care they receive
- **Patient Safety** – protecting patients from avoidable harm
- **Clinical Effectiveness** – ensuring care leads to the best possible outcomes

To identify these priorities, we engaged with a wide range of stakeholders, including staff, the quality committee, Trust Board, executive committee, commissioners, patient representatives (via Healthwatch), and our Council of Governors.

Each proposed priority was assessed against the following criteria:

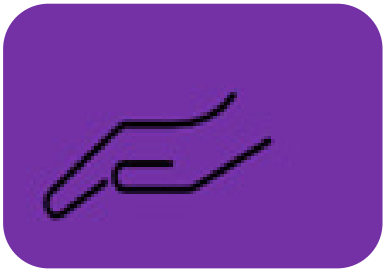
- Is this a concern raised by our patients?
- Is this a concern raised by our staff?
- Will it significantly improve quality?
- Is it achievable within our available resources and timeframe?
- Does past performance indicate room for improvement?
- Does it align with national priorities or audit findings?

2025/26 Quality improvement priorities



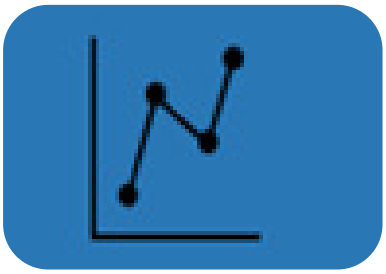
Patient experience - how patients experience the care they receive

- Quality Priority One: Establishing and developing the Family Support Hub to address disease inequalities and meet the needs of all our patients, families and carers (year two).
- Quality Priority Two: Care of the dying patient and those important to them



Patient safety - keeping patients safe from harm

- Quality Priority Three: Acuity and deteriorating patients across the Trust.
- Quality Priority Four: Implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) 2.
- Quality Priority Five: Fundamentals of Care (year two).



Clinical effectiveness - how successful is the care we provide?

- Quality Priority Six: Developing the Trust's approach to reducing the impact of health inequalities (year two).

We believe 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 and Trust executive committee in March 2025. The quality committee will provide governance oversight and support to ensure that the quality improvement priorities progress and successfully achieve the required outcomes within the year. The 2025/26 quality improvement priorities are embedded within the Trust's Five Year Corporate Strategy, under the overarching objective of delivering outstanding patient outcomes, safety, and experience.

Quality Improvement Priority One: Establishing and developing the Patient and Family Support Hub to address disease inequalities and meet the needs of all our patients, families and carers (year two)

Core dimension

Patient experience

Rationale of selection

To provide equitable access to support for all UHS patients and their families/carers.

Key aims

The former Macmillan centre is now rebranding as the Patient & Family Support Hub (P&FSH). The hub will continue to provide services previously offered at the Macmillan centre, such as emotional support, financial advice, complimentary therapies and practical assistance, the ambitions and plans is to expand the service and support available to all patients, relatives and carers.

The plans for the P&FSH:

- Provision of a multi-purpose hub for all patients, carers, and families to address and reduce current health and disease inequalities, integral to this is a refurbishment based on current service users poor feedback on environment.
- Improvement of wellbeing support for the 9,000 patients on elective procedure waiting lists by creating a 'waiting well' service run through the hub, creating equitability in access to information pertaining to their wait list, counselling, health education (in line with Core20PLUS5) and education on coping mechanisms.
- Reduce the dehumanisation of hospital-bound patients, bringing the outside world into the hospital with services such as a hair salon, beauty treatments designed to boost patient wellbeing.
- Private discussion rooms that will be neurodivergent-friendly and bookable by all clinical teams. We aim to create a space away from crowded areas where our patients with autism or learning disabilities do not become overwhelmed. This will also provide an area where sensitive discussions can take place away from a clinical location.
- Provisions for carers respite to support our unpaid workforce. Provide a designated carers shower and dressing room and access to a domestic washing machine.
- Hair and beauty treatments salon/barber to bring the outside world of holistic support into UHS to support long-stay patients improving mental wellbeing. The experience of care team is consistently inundated with hair cut requests. One common complaint from relatives is their loved one looks unrecognisable after a long stay in hospital. The hair salon will be mainly aimed at elderly patients and incentivise back to normal/end pyjama paralysis campaigns.
- To work collaboratively with our community, for example engaging with local colleges and offer health and beauty treatment students to come to the hub to provide free treatments such as manicures/pedicures/massages for long stay inpatients.
- Music sessions in collaboration with University of Southampton musical education department, hosting and supporting music therapy and puppetry for patients to enjoy.
- Access to support for patients/family members potentially arriving distressed by triaging and ensuring safe signposting occurs. Supporting patients/family members with adapting to changes in health conditions etc.

- A mock living room environment created in the room which has accessibility for a hospital bed to provide long-term conditions and end of life patients a comforting space to see their loved ones and have private time away from the clinical environment.
- A designated one-stop accessibility area for all patients, carers and relatives that have additional support needs to access support and assistance for their appointments, and to be further supported by a volunteer where appropriate.
- Outreaching some of what the hub offers to the inpatient areas to ensure that we do not create accessibility inequalities.
- Currently the equality, diversity and inclusion (EDI) demographics for Macmillan centre service users are 70% white, with the average user being a 50–60 year old white woman. We aim to operate and offer services that will encourage diversity and ensure all patients are accessing the support services (for example holding religious celebration events).

Progress metrics

- Patients and families co-designing all aspects of the P&FSH.
- Friends and Family Test feedback and other targeted surveys.
- Data evidencing a diverse range of attendance from patients and families.
- Volume of 'waiting well' attendees.
- Established placements with local colleges.

Quality Improvement Priority Two: Improving the care of the dying patient and those important to them

Core dimension

Patient experience

Rationale of selection

1. Patients and families require clearer, more accessible information about end-of-life care (EOLC), including symptom management, the dying process, and available support.
2. Effective symptom control is essential. A standardised system is needed to assess symptom severity and evaluate treatment effectiveness.
3. Findings from the National Audit of Care at the End of Life 2024 (NACEL) and other feedback indicate that family needs are not consistently identified or met. High-quality EOLC must also support families through bereavement.
4. Communication remains a key concern. Feedback shows that we are not consistently meeting expectations, and there is currently no trust-wide communication training in place.
5. Limited post-bereavement feedback suggests a gap in understanding the lived experience of families. We must ensure our care aligns with the standards we aspire to deliver.
6. The current hybrid documentation system, paper-based care plans and digital assessments, risks incomplete or inconsistent care planning and communication between nursing and medical teams.

Key aims

1. **Raise awareness and embed EOLC strategy**
   Launch the new EOLC strategy trust-wide via communications, clinical leaders, grand rounds, and ward-level engagement.

   Promote use of new family information booklets, patient leaflets (e.g., JIC medication), and the EOLC discharge checklist.

   Use the link nurse programme and trolley dashes to distribute materials and provide on the spot training.

2. **Standardise symptom management**
   Implement a new paper-based symptom observation chart, supported by a clinical guideline.

   Deliver targeted training at ward level, link nurse sessions, and clinical forums to ensure consistent use.

3. **Improve family support**
   Conduct a thematic review of family experiences during EOLC.

   Provide education to clinical and non-clinical staff on recognising and responding to family needs.

4. **Strengthen communication training**
   Advocate for communication to be prioritised in inpatient documentation.

   Expand EOLc communication training through the supportive and palliative care team (SPCT) and clinical educators.

5. **Enhance feedback mechanisms**
   Promote NACEL 2025 participation through SPCT engagement with patients and families.

   Bereavement team to proactively invite families to complete NACEL and a new UHS bereavement survey six months post-loss.

6. **Improve documentation systems**
   Collaborate with the digital team to develop a fully electronic, individualised EOLC plan for both nursing and medical staff.

   Create a digital comfort observation form for future integration into trust-wide systems.

Progress metrics

1. **Awareness and strategy implementation**
   - Completion of patient experience evaluation and action plan.
   - Family feedback and NACEL 2025/26 data.
   - Number of educational sessions delivered.

2. **Symptom management**
   - Number of wards using comfort observation charts.
   - Audit results on chart completion and intervention appropriateness.

3. **Family support**
   - Improvement in NACEL feedback on symptom control.
   - Number of teaching sessions and promotional activities.
   - Staff familiarity with materials (via local survey).

4. **Communication**
   - Number of training sessions delivered.
   - Staff feedback and NACEL family responses.
   - Results from the UHS bereavement survey.

5. **Feedback collection**
   - Increased volume of bereaved family responses to NACEL and UHS surveys.

6. **Digital integration**
   - Implementation of digital EOLC plans and comfort observation documentation in inpatient systems.

Quality Improvement Priority Three: Acuity and deteriorating patients across UHS ADULTS AND PAEDIATRICS

Core dimension

Patient safety

Rationale of selection

Key priorities:

1. Active surveillance of acuity across the Trust in patient adult and paediatric ward areas.
2. Implementation of Martha's Rule recommendations Call 4 Concern (C4C) for all adult and paediatric in-patient ward areas.
3. Trust-wide acuity education strategy.
4. Development of acuity dashboard for adults, paediatrics and neonatal services.
5. Development of key sepsis workstreams across the Trust.

The recognition, assessment, and escalation of a deteriorating patient either adult or child are a key element of our trust-wide patient safety and quality strategy with the aim to improving clinical outcomes for acutely ill patients. How rapidly we respond to patient deterioration both in and out of hours is a key determinant of patient and quality outcomes.

The Trust use the National Early Warning Score (NEWS2) and National Paediatric Early Warning Score (NPEWS) to provide our healthcare professionals 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 within a healthcare setting. NEWS2 and NPEWS standardise the recording and analysing 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 acuteness within the Trust for both adult and paediatric ward areas.

Over the past two years there is sustained increase in acuity levels across UHS. Current workstreams 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 the overall strategy to ensure that key learning points are shared across the whole of the Trust.

This year the focus includes workstreams to ensure that the patient voice is heard and listened to during an acute deterioration episode. The Call 4 Concern service implemented across the Trust provides patients/relatives/carers (adult and paediatric) with a simple pathway to access a review by the critical care outreach team at times when they feel that their worries and concerns related to acute deterioration are not resolved by the ward teams. This encompasses the principles of Martha's Rule where patients/relatives/carers will have a legal right to a rapid review by the critical care outreach team (CCOT) during an acute deterioration episode and the service is available 24/7.

At UHS we have a 24/7 adult critical care outreach team and a 24/7 paediatric outreach team that provide a rapid clinical review by critical care trained clinical practitioners during an acute clinical deterioration for either adult or paediatric patients, thus meeting the core recommendation within Martha's Rule.

In line with the principles behind Martha's Rule there will be an increased focus on developing key sepsis workstreams across UHS.

Highly skilled and knowledgeable healthcare professionals are vital in the recognition and management of deteriorating patients. The development of a trust-wide education strategy for recognising and managing deteriorating patients will provide core standards for all deteriorating patients (adult and paediatric) education training. Early discussions have commenced with our maternity and neonatal colleagues to explore implementation of Martha's Rule within their areas.

Currently there is no provision available for a specific acuity dashboard in adults or paediatrics. Collected data cannot be sourced from one domain causing lack of visibility in this area. A specific dashboard would facilitate the coordinated collation of data across all adult and paediatric inpatient areas to highlight and identify the adult and paediatric dimension of acuity across UHS. This will require future but immediate investment.

Key aims

Active surveillance of acuity across UHS in patient adult and paediatric ward areas
Monthly reports detailing NEWS2 activations exceeding five are generated for each adult inpatient ward to support local review and action. In addition, 24-hour overview reports of such activations are produced monthly to provide a more immediate perspective on patient deterioration.

Unplanned admissions to the Intensive Care unit (ICU) are reviewed and analysed on a monthly basis. Cardiac arrest data undergoes bi-monthly analysis to identify trends and opportunities for improvement. Treatment Escalation Plans (TEP) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation are reviewed quarterly to ensure alignment with policy and standards.

The adult deteriorating patient policy is regularly reviewed and updated, with ongoing monitoring of compliance related to patient observations. Monthly reviews of adult Critical Care Outreach Team (CCOT) network data are conducted, and NEWS2 observation compliance is enforced across all adult inpatient areas.

The acuity dashboard is actively used during all staffing hub meetings. CCOT also leverages the dashboard and biochemistry data to proactively identify and assess acutely ill adult and paediatric patients prior to referral. Early referrals from the emergency department resuscitation area and inpatient maternity services are implemented and evaluated for effectiveness.

In paediatrics, the National Paediatric Early Warning Score (NPEWS) has been integrated into the children's emergency department, with data analysis reported to Child Health Governance and the deteriorating patient group. All paediatric 2222 escalation calls are reviewed and analysed to support shared learning across the Trust, including unplanned admissions to PICU/PHDU.

Weekly multi-disciplinary team (MDT) learning is facilitated through the child death and deterioration (CDAD) forum. The recognition and assessment of the paediatric patient in deterioration (RAPPID) programme is delivered to nurses above Band 4 and resident doctors across Southampton Children's Hospital.

Finally, safety huddles are continuously implemented to support early identification of deteriorating patients and to facilitate effective patient flow throughout Southampton Children's Hospital.

Implementation of Martha's Rule recommendations Call 4 Concern for all adult and paediatric in-patient ward areas.

A monthly audit and multi-disciplinary team (MDT) review of Call 4 Concern calls are conducted to identify key themes and hotspot areas, with appropriate actions implemented based on the identified themes. A patient wellness questionnaire is being piloted in two adult inpatient wards, with results analysed and plans for a roll out across all adult inpatient areas. Resources for Call 4 Concern are being developed and implemented for patients and carers with cognitive and/or communication impairments. Parental concerns questions within the National Paediatric Early Warning Score (NPEWS) are analysed for theming and action planning, supported by the Call 4 Concern pilot in paediatrics. Regular audits and analyses of the paediatric Call 4 Concern service are conducted and reported to the deteriorating patient group. Continue to work with divisional governance teams regarding incidents to ensure learning is identified and appropriate action plans are devised and implemented.

UHS acuity education strategy

- Evaluation of current deteriorating patient education provision across UHS.
- Evaluation of trust-wide deteriorating patient education study day.
- Development and implementation of standards for deteriorating patient education. These are then reviewed on a yearly basis.
- Development and implementation of an acuity education virtual learning environment (VLE) platform.

Development clinical quality dashboard

Collaborate with colleagues across clinical outcomes, patient safety, and experience to develop a contemporaneous, meaningful, and accessible clinical quality dashboard, which includes acuity, that supports teams to drive continuous improvement.

Development of key sepsis workstreams across UHS

- Establish collaborative multi professional sepsis focus group.
- Key workstreams agreed to include education, resources and communication.
- Agree key sepsis data metrics to begin auditing and analysing.

Progress metrics

Governance

- Bimonthly deteriorating patient group meetings to review current trends and themes, implementation of appropriate actions and evaluation of actions.
- Biannual review of deteriorating patient group terms of reference.
- Quarterly report to patient safety steering group.
- Yearly assurance report – Trust quality committee.

What will we measure and analyse

- **Patient observation compliance data.**
- **NEWS2 and NPEWS activations and data analysis.**
- **Analysis of all unplanned admissions to ICU from ward areas – adult and paediatric for themes to inform education and practice.**
- **Adult and paediatric ICU stepdown data.**
- **Adult critical care outreach team activity and outcome data.**
- **Adult and paediatric cardiac arrest and outcomes data.**
- **Adult TEP & DNACPR data.**
- **Complaints and adverse event reports related to failure to rescue and failure to escalate.**

- Percentage of patients diagnosed with sepsis within the emergency department receiving appropriate antibiotics within one hour of sepsis diagnosis.
- Analysis of adult and paediatric Call 4 Concern data, action plan developed, implemented, and adjusted in responsive to themes.
- **Analysis of patient/service user feedback on Call 4 Concern service.**
- **Analysis of staff feedback on Call 4 Concern service.**

Quality Improvement Priority Three: Acuity and deteriorating patients across UHS MATERNITY

Core dimension

Patient safety

Rationale of selection

In line with the three year delivery plan for maternity and neonatal services (NHS England, 2023) implement best practice, including the new Maternity Early Warning tools by 2025.

Improving the early detection of patients who are deteriorating is vital to improving morbidity and mortality; three of the four most common direct causes of maternal death (MBRACE, 2024) would result in abnormal MEWs scores early on.

Improving escalation and involving the whole MDT early, thus improving outcomes within maternity care (MBRACE, 2024).

Cross-site working (Princess Anne Hospital/Southampton General Hospital) poses unique challenges and therefore improved joint working would provide additional opportunities to enhance safety by preventing delays in identification and escalation of deteriorating patients.

Build upon and maintain strong working relationships with maternal medicine and critical care outreach teams, training together and sharing learning.

Key aims

- Implementation of digital recording of maternal observations, to be implemented in conjunction with new MEWs tool.
- Train staff in digitally recording observations.
- Ensure equipment available to record observations digitally (enough iPads in each clinical area).
- Work closely with the critical care outreach team and the maternity digital team to develop a surveillance dashboard.
- Work closely with the Trust Call 4 Concern lead to introduce Call for Concern to maternity. CCOT to have access to and training on the maternity records system (BadgerNET).
- Work with local maternity and neonatal system (LMNS), maternal medicine team and UHS CCOT on training including the PRactical Obstetric Multi Professional Training (PROMPT) and maternity red flags. Open invitation for these teams to attend maternity safety huddle to share learning and/or discuss current patients.

Progress metrics

Audit MEWs

- Are observations being recorded accurately and consistently on BadgerNet?
- Has escalation occurred when indicated?

Audit Call for Concern

- How often is it used, what are the referral themes?
- Patient outcomes where referral made for deterioration.

Audit CCOT surveillance tool

- Number of patients highlighted on dashboard.
- Number of patients reviewed by CCOT and outcomes.
- Patient and staff feedback where critical care outreach review maternity patients in Princess Anne Hospital.

Quality Improvement Priority Three: Acuity and deteriorating patients across UHS NEONATAL

Core dimension

Patient safety

Rationale of selection

Recent publication of Newborn Early Warning Track and Trigger2 framework from the British Association of Perinatal Medicine (BAPM):

This framework is designed for use in postnatal care settings including the delivery suite, postnatal ward and transitional care unit. It describes at-risk groups and provides an updated Newborn Early Warning Track and Trigger (NEWTT2) chart aligning to current recommendations for newborn care and acknowledging feedback from healthcare professionals.

The chart encompasses parental concern to acknowledge the importance of the opinion of the family in addition to the wider multi-disciplinary team. The inclusion of parental concern supports concerns highlighted and recommendations made in recent national maternity investigations.

The escalation and response tools use standardised language to minimise the potential for errors in communication and encourage joint multi-disciplinary team working.

This extended framework provides an escalation tool and a standard response and review tool for the MDT to use jointly.

Key aims

Implementation of NEWTT 2 across the birth environment, postnatal wards and transitional care:

- Training to commence from 10 February 2025.
- Equipment to be ordered (taken time to receive funding approval).
- Plan to go live in March 2025 once >75% of staff in each area has received training, including neonatal medical team.
- Trolley dashes.
- Train the trainer.

Progress metrics

Audit of compliance:

- Has it been undertaken for the appropriate babies?
- Was the frequency of observation undertaken correctly?
- Was the score accurately calculated?
- Did escalation take place if required?
- Was the response to escalation appropriate?

Quality Improvement Priority Four: Implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) 2 at UHS

Core dimension

Patient safety

Rationale of selection

The new National Safety Standards for Invasive Procedures (NatSSIPs 2) represent the progression of the original NatSSIPs. The key aim to standardise, harmonise and educate (SHE) across organisations and procedural teams remains central to the NatSSIPs purpose. Critical changes include bolstered organisational standards and proportionate checks that recognise different levels of risk during major and minor invasive procedures, and the adaptions to processes that may be necessary in life-threatening situations. This standardisation, harmonisation and education goals are set out in the table below.

	Organisational	Sequential ('The NatSSIPs Eight')
Standardise	Safety behaviours, processs, policies, insight, involvement and performance measures across organisations and specialities.	Expected behaviour, safety standards, checklists and format across invasive specialities.
Harmonise	Across groups of hospitals. Across IT systems.	Reduce variation across specialities.
Educate	Commit to safety education, human factors expertise and systems thinking. Create a safety infrastructure, leadership understanding and training in cultural change.	Teach and train in team behaviours, human factors, systems thinking learning / co-production with patients.

Investigations into the increase of never events in 2023 and 2024 has identified that the majority of these had contributing factors related to stop points for safety. The key learning identified:

Thematic analysis of never events

- Surgical mark not visible/clear
- Not listening to patient concerns
- Change in surgical plan and lack of documentaion
- Lack of time out if concerns are raised
- Lack of triangulated checks
- Ability to speak up concerns
- Swab, sharp and instrument count process
- Implant checks not triangulating patent details
- Inexperienced staff with lack of familiarity of processs
- Lack of induction training in stop points
- Distractions during stop point checks

All these factors will be addressed through NatSSIPs2 implementation.

Safer invasive procedures is to be included as a local quality indicator by the ICB within the 2025/26 national contract.

Key aims

- Establish a NatSSIPs oversight committee.
- Set up an invasive procedures committee.
- Establish the following workstreams:
    - o Audit of stops point for safety in theatres and for minor procedures in outpatient and ward areas
    - o Multi-disciplinary safety walkabouts
    - o VLE and induction workstream
- Education: recruitment of medical education led to set up simulation-based MDT training.
- Patient involvement.
- NatSSIPs eight and communications.
- Stop points for safety staff resources.

Progress metrics

- Increase in the completion of VLE stop points training.
- Develop and implement a programme to deliver non-technical skills to the MDT.
- All areas with a never event in the last two years have an up to date audit and action plan for compliance with NatSSIPs2.

Quality Improvement Priority Five: Fundamentals of Care

Core dimension

Patient safety

Rationale of selection

The term Fundamentals of Care (FoC) describes the eight standards that staff across the Trust have committed to in collaboration with the patient, to support the physical and emotional needs of patients', relatives, and carers. This is not a new concept, it underpins the core values of what it means to be a healthcare professional, to truly 'care' and will build upon our achievements in year one. Operational challenges have led the workforce to become more task-focused and less person-focused, taking away from that personalised care experience but we are committed to changing that culture, following our Trust value, patients first.

The FoC exemplifies how the interdisciplinary team connects and builds relationships with our patients, getting to know them and what matters to them as a person, not just as a patient, supporting and encouraging independence and rehabilitation from the beginning of their hospital stay. These activities are the essentials of our daily living such as personal hygiene, skin care, oral hygiene, toileting, eating and drinking, and mobilising. Communication is also essential and includes both listening and hearing patients, understanding what is important to them using communication tools they need, coming to shared decisions with patients about their care and recognising the diversity of our population, embracing accessibility for those with people with learning disabilities, sight/hearing loss or other disabilities, or if English may not be their primary language.

In addition, the FoC encourages us as healthcare professionals to consider the whole person, support cultural, spiritual, mental health, emotional wellbeing and dignity needs of people we care for and those that matter to them.

We know here at UHS that not everyone experiences this level of care, but we acknowledge the need to change the rhetoric from 'we are busy' to 'we are never too busy to care' empowering and educating our staff at all levels to challenge the 'we have not got time' rhetoric and ensure fundamental care is at the heart of what we do at UHS. Thus improving, patient care and experience.

Key aims

We will grow the multi-disciplinary engagement and involvement in workstreams that embrace the FoC and encourage person centred to care.

We will continue to pursue the digitalisation of the Friends and Family Test (FFT), using this data and the national inpatient and urgent and emergency care survey as a baseline, while linking with involved patients where required with to encourage feedback on the FoC.

We will listen to the voice of our patients, their relatives, and carers to make sure their stories and experiences are heard by our workforce to encourage the organisation wide change.

We will ensure the FoC will has clear and measurable improvement metrics as part of a live clinical quality dashboard that will afford ward managers and senior leaders, the opportunity to monitor, review and report on to FoC in their areas.

We will embed the FoC into the matron walkabout and CAS processes, supported by consistent evaluation metrics that ask the patients about their experiences and encourage clinical areas to continually assess and evaluate the FoC in their areas through a self-assessment tool.

We will enhance the availability of existing resources on our virtual learning environment (VLE) in collaboration with our patient partners for all staff groups and embed the FoC into training across the organisation, to improve the knowledge, skills and awareness ensuring the delivery of quality care.

We will continue to test and evaluate the What Matters To Me project, growing our volunteer role to support staff in finding out what is important to the patient and using their personalised board to remind staff of the 'person' they are caring for.

We will continue to establish project links in child health, maternity and outpatients to ensure a bespoke, but collaborative roll out of FoC, considering how these different care environments may impact care.

Progress metrics

- Patient hygiene: we will see an improvement in the number of patients who report having their personal care needs met, particularly within their first 24 hours coming through emergency admission routes.
- Skin integrity: we will support the reduction in incidences of avoidable pressure ulcers across the organisation.
- Communication: we see an increase in the number of people accessing our interpreting services and a reduction in complaints related to interpretation.
- Pain: we will see an improvement in patients reporting that their pain was well controlled when coming through the emergency department.
- Mouthcare: we will see a positive uptake in the implementation of the new mouthcare assessment tool and an improvement in patients reporting that their oral hygiene needs have been met.
- Nutrition and hydration: we will see an increase in patients reporting they are being offered adequate food and drink provisions throughout their hospital stay, including access to equipment for those with conditions or disabilities that impact their ability to do so independently.
- Bowel and bladder care: we will see improved assessment of bowel and bladder habits through increased documentation using the Inpatient Noting system.
- Enhancing safe movement: we will support a reduction in the incidence of high harm falls and high harm falls that have preventable causes.
- Infection prevention: we will see a reduction in nosocomial infections through increased hand hygiene standards and more effective cleaning of equipment.

Quality Improvement Priority Six: Develop the Trusts' approach to reducing the impact of health inequalities (HIs) (year two)

Core dimension

Clinical effectiveness

Rationale of selection

Tackling health inequalities is a key priority for the NHS. At UHS we have been working to have an impact on health inequalities for several years. In 2024/25 we formalised these efforts with a governing board, chaired by our chief medical officer and with a clear programme of improvement based on recognised priorities. This formed the basis of our quality priority in 2024/25.

This year's quality priority is a continuation of the work that started in 2024/25. We intend to continue to grow our understanding and actions as an organisation, improving the equity of access, outcomes and experience of our services across our community.

Key aims

We are continuing our health inequalities board, with focus on five priorities: enabling our organisation, data and measurement, clinical service priorities, communication and engagement and strategy and approach. Each of these priorities have aligned directors to oversee improvement and a detailed delivery plan.

Key priorities and expected outcomes from each of these are listed below:

Enabling the organisation

- Developing supporting structures: set up governance so that teams who identify health inequality related issues know where they can go for help, so that we can understand frequently arising challenges and notice when a problem raised might be affecting other of the hospital too. This will aid improvement, learning from issues identified and escalation of issues that cannot be resolved locally
- Capability building: develop training for our staff to understand health inequalities, identify them within services and access tools to make improvement.
- Delivery of the health inequalities officer role: grow knowledge of the health inequalities officer role across the organisation and utilise this role to share knowledge, training and support improvements.

Data and measurement

- Continue to develop our understanding of inequalities in access across outpatients and diagnostics, inpatients, theatres and the emergency department.
- Enable the measurement of improvement in areas recognised as clinical priorities.
- Enable completion of national reporting.

Clinical priorities

- Improve services and support for patients and staff with obesity (children and adults).
- Improve identification and control of hypertension.
- Improve services and support for patients and staff who smoke.

Communication and engagement

- Adopt health inequalities into leadership and decision making.
- Learning from our communities and our staff.
- Communicating improvements internally and externally.
- Staff support campaign.

Strategy and approach

- Overseeing and agreeing UHS approach and strategy for HIs.
- Overseeing annual delivery against priorities.
- Aligning programme resource.
- Maintaining collaborative working with public health and Integrated care board teams and other local healthcare providers.
- Keeping up to date with national recommendations and expectations, sharing this knowledge with our organisation.
- Overseeing trust-wide improvement and health inequalities maturity.

Progress metrics

- Increasing numbers of staff trained.
- Numbers of health inequalities issues reported (expected to increase through understanding before reducing due to improvement work).
- Case studies shared of successful improvement projects.
- Increased involvement and collaboration with patients and public on improvement.
- Increased use of QEIA templates in decision making.
- Demonstration of improved access to care for obesity, tobacco dependency and hypertension.

2.3 Statements of assurance from the Board

This section includes mandatory statements about the quality of services that we provide relating to the financial year 2024/25. 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.

2.3.1 Review of services

During 2024/25 UHS provided and/or sub-contracted 118 relevant health services (from total Trust activity by specialty cumulative 2024/25 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 2024/25 represents 100% of the total income generated from the provision of relevant health services by UHS for 2024/25.

2.3.2 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 & Enquiries Directory which identifies those national audits which are included in the NHS England Quality Account List 2024/25, those audits which are part of National Clinical Audit and Patient Outcomes Programme (NCAPOP).

NCAPOP audits are commissioned and managed on behalf of NHS England 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've opened discussions with senior clinical leadership within Hampshire and Isle of Wight Integrated Care Board 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 2024/25 68 national clinical audits and four national confidential enquiries covered NHS

services that UHS provides. During 2024/25 UHS participated in 97% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

NCEPOD studies participated in during 2024/25 were:
- Emergency (non-elective) surgery in children and young people.
- Juvenile idiopathic arthritis.
- Blood sodium (hyponatraemia).
- Acute Limb Ischaemic.

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 complete during 2024/25, 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=68)	Eligible (68)	Participated (66=97%	% Actual cases submitted/ expected submissions
1.	BAUS Penile Fracture Audit			Not yet started
2	BAUS I-DUNC (impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of care practices)	✓	x	
3.	BAUS Environmental lessons learned and applied to the bladder cancer care pathway audit (ELLA)	✓		
4.	Breast and Cosmetic Implant Registry	✓	✓	
5.	Case Mix Programme (CMP) (ICNARC)	✓	✓	1677 for 3 quarters
6.	Emergency Medicine QIPs – time critical medications	✓	✓	63 pts
7.	Emergency Medicine QIPs – care of older people	✓	✓	182 pts
8.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	971 all pts
9.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	2910 all pts
10.	Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	✓	✓	
11.	Learning disability and autism programme – learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	✓	✓	100%

No	Total number of NCAs UHS were eligible to participate in (n=68)	Eligible (68)	Participated (66=97%	% Actual cases submitted/ expected submissions
12.	National Adult Diabetes Audit – National Diabetes Inpatient Safety Audit	✓	✓	
13.	National Adult Diabetes Audit – National Pregnancy in Diabetes	✓	✓	100%
14.	National Diabetes Audit – transition	✓	✓	Collects data from database
15.	National Diabetes audit – gestational diabetes	✓	✓	Collects data from database
16.	National respiratory Audit Programme (NRAP) – asthma in children	✓	✓	
17.	National respiratory Audit Programme (NRAP) – asthma in adults	✓	✓	
18.	National respiratory Audit Programme (NRAP) – COPD secondary care	✓	✓	
19.	National respiratory Audit Programme (NRAP) – pulmonary rehabilitation	✓	✓	
20.	National Audit of Care at the End of Life (NACEL)	✓	✓	250 pts
21.	National Cancer Audit Collaborating Centre – National Audit of Metastatic Breast Cancer	✓	✓	Data entry not required collected nationally
22.	National Cancer Audit Collaborating Centre – National Audit of Primary Breast Cancer	✓	✓	
23.	National Cancer Audit Collaborating Centre – National Kidney Cancer Audit (NKCA)	✓	✓	
24.	National Cancer Audit Collaborating Centre – Non-Hodgkin Lymphoma Audit (NNHLA)	✓	✓	
25.	National Cancer Audit Collaborating Centre – National Pancreatic Cancer Audit	✓	✓	
26.	National Cancer Audit Collaborating Centre – National Bowel Cancer Audit (NBOCA)	✓	✓	
27.	National Cancer Audit Collaborating Centre – National Oesophago-gastric Cancer (NOGCA)	✓	✓	
28.	National Cancer Audit Collaborating Centre – National Lung Cancer Audit (NLCA)	✓	✓	
29.	National Cancer Audit Collaborating Centre – National Prostate Cancer Audit (NPCA)	✓	✓	
30.	National Cardiac Arrest Audit (NCAA)	✓	✓	150 Approx
31.	National Cardiac Audit Programme (NCAP) – Adult cardiac surgery	✓	✓	
32.	National Cardiac Audit Programme (NCAP) – Cardiac Rhythm Management (CRM)	✓	✓	

No	Total number of NCAs UHS were eligible to participate in (n=68)	Eligible (68)	Participated ✓ (66=97%	% Actual cases submitted/ expected submissions
33.	National Cardiac Audit Programme (NCAP) – Heart Failure Audit	✓	✓	
34.	National Cardiac Audit Programme (NCAP) – Heart Failure Audit	✓	✓	
35.	National Cardiac Audit Programme (NCAP) – Acute Coronary Syndrome or Acute Myocardial Infarction	✓	✓	100%
36.	National Cardiac Audit Programme (NCAP) – percutaneous coronary interventions (PCI)	✓	✓	100%
37.	National Cardiac Audit Programme (NCAP) – the UK Transcatheter Aortic Valve Implantation (TAVI) Registry	✓	✓	
38.	National Cardiac Audit Programme (NCAP) – Left Atrial Appendage Occlusion (LAAO) Registry	✓	✓	
39.	National Cardiac Audit Programme (NCAP) – Patent Foramen Ovale Closure (PFOC) Registry	✓	✓	
40.	National Cardiac Audit Programme (NCAP) – Transcatheter Mitral & Tricuspid Valve (TMTV) Registry	✓	✓	
41.	National Child Mortality Database (NCMD)	✓	✓	100%
42.	National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	✓	✓	*1 pt
43.	National Comparative Audit of Blood Transfusion – Audit of NICE Quality Standard QS138	✓	✓	
44.	National Comparative Audit of Blood Transfusion – Bedside Transfusion Audit	✓	✓	
45.	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	
46.	National Emergency Laparotomy Audit (NELA) – Laparotomy	✓	✓	
47.	National Emergency Laparotomy Audit (NELA) – No lap	✓	✓	
48.	National Joint Registry	✓	✓	834 (data run to 10/02/2025)
49.	National Major Trauma Registry	✓	✓	600 for 3 quarters
50.	National Maternity and Perinatal Audit (NMPA)	✓	✓	
51.	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	100%
52.	National Ophthalmology Audit Database	✓	✓	
53.	National Paediatric Diabetes Audit	✓	✓	
54.	National Vascular Registry (NVR)	✓	✓	**100%

No	Total number of NCAs UHS were eligible to participate in (n=68)	Eligible (68)	Participated (66=97%	% Actual cases submitted/ expected submissions
55.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
56.	Perinatal Mortality Review Tool (PMRT)	✓	✓	100%
57.	Perioperative quality improvement programme	✓	✓	12 pts
58.	Quality & Outcomes in Oral & Maxillofacial Surgery (QOMS) – Oncology & reconstruction	✓		Data taken straight from other databases
59.	Quality & Outcomes in Oral & Maxillofacial Surgery (QOMS) – Trauma	✓		
60.	Quality & Outcomes in Oral & Maxillofacial Surgery (QOMS) – Orthognathic surgery	✓		
61.	Quality & Outcomes in Oral & Maxillofacial Surgery (QOMS) – Non-melanoma skin cancers	✓		
62.	Quality & Outcomes in Oral & Maxillofacial Surgery (QOMS) – Oral & Dentoalveolar Surgery	✓		
63.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit, organisational audit	✓	✓	100%
64.	Serious Hazards of Transfusion (SHOT) UK national haemovigilance scheme	✓	✓	100%
65.	Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓	100%
66.	UK Cystic Fibrosis Registry	✓	✓	75%-100%
67.	UK Renal Registry Chronic Kidney Disease Audit	✓	✓	
68.	UK Renal Registry National Acute Kidney Injury Audit	✓	✓	

*Epilepsy12: the team have liaised with the national team about the data collection and changes are being made. The 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 Vascular Registry: all key procedures are added but not interventional radiology (IR) at present. National outlier for recording IR cases.

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 15 national clinical audits were reviewed by the provider in 2024/25. Appendix A lists actions identified during 2024/25, which UHS intends to take to improve the quality of healthcare provided. Progress already made against these actions is also indicated.

The reports of 70 trust-wide and local clinical audits were reviewed in 2024/25. Appendix B lists the resulting actions to improve quality of healthcare provided.

2.3.3 Recruiting to research

The number of patients receiving relevant health services provided or subcontracted by University Hospital Southampton in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee was 17,495. We ranked 11th for total recruitment to NIHR portfolio studies – and our total recruitment was 16,102 (portfolio only).

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

2.3.4 Commissioning for Quality and Innovation (CQUIN) payment framework

University Hospital Southampton NHS Foundation Trust income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because CQUIN was "paused" by NHS England for this contracting year.

2.3.5 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. UHS was registered with the CQC since its inception in 2010 and has maintained its registration without conditions or enforcement action ever since, including 2024/25.

The CQC has not taken enforcement action against UHS during 2024/25. UHS has not participated in any special reviews or investigations by the CQC during the reporting period.

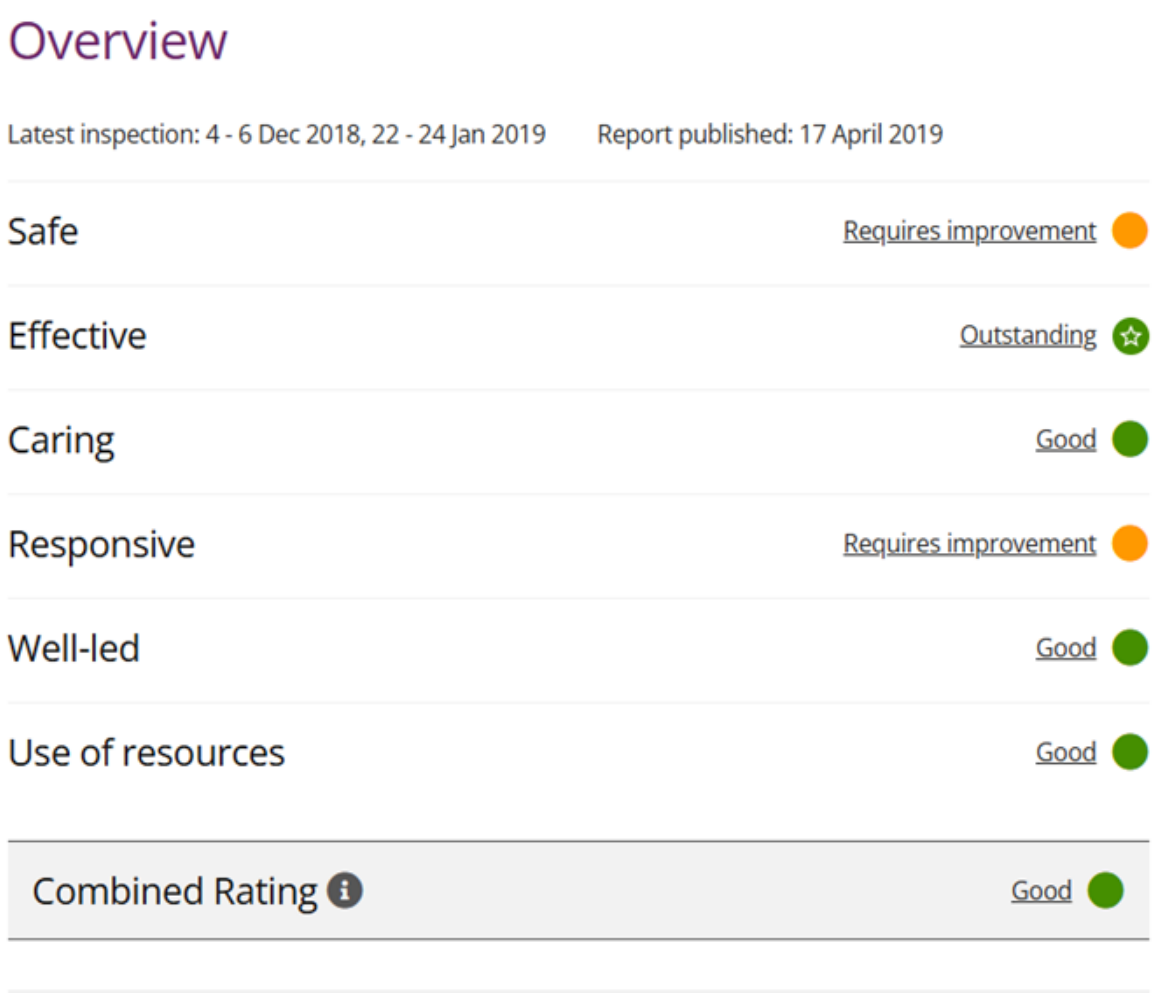
The registration details are available on the CQC website.

The CQC last 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 17 April 2019 and the Trust was rated as 'good' overall and 'outstanding' for providing effective services.

On 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 8 August 2023, confirming an overall rating of 'Good'. As the inspection did not include a review of the location's rating, the overall rating for UHS remains unchanged at 'good', and the Princess Anne Hospital continues to hold a 'good' rating as well.

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.



Data source: CQC

We continue to monitor our performance internally against the highest standards of care. We continue to engage with the CQC through a range of activities including CQC engagement meetings and monthly meetings to discuss escalations, updates and sharing of good news stories.

2.3.6 Payment by results

UHS was not subject to the Payment by Results (PbR) clinical coding audit report for 2024/25 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.

2.3.7 Data quality

High quality data is crucial for robust governance and effective service delivery. It ensures the accuracy, completeness, and timeliness of patient care records, which are vital for tracking a patient's journey. This supports effective care delivery and enhances both care quality and patient safety. Poor data quality can result in treatment delays, increased workload, loss of income, and misleading information. We are proud of our ongoing efforts to improve data quality, which have already led to significant enhancements in patient care and operational efficiency.

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 2024 and November 2024 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As of November 2024 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number were:
- 99.4% for admitted patient care **(no change from last year)**
- 99.8% for outpatient care **(no change from last year)**
- 95.8% for accident and emergency care **(0.5% improvement from last year)**

Which included a valid General Medical Practice Code were:
- 100% for admitted patient care **(no change from last year)**
- 99.9% for outpatient care **(0.2% improvement from last year)**
- 99.5% for accident and emergency care **(0.3% improvement from last year)**

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.
- Raise awareness of data quality and its importance.
- Review and update training materials and guidance.

2.3.8 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 submitted its 2023/24 assessment in June 2024. The Trust was able to provide the required level of assurance for all ten mandatory assertions. As a result, the Trust was able to demonstrate it is practising good data security and achieved 'standards met'.

The DSPT for 2024/25 has been updated to follow the Cyber Assurance Framework (CAF) which provides a systematic and comprehensive approach to assessing the extent to which cyber and information governance risks to essential functions are being managed. The Trust is working towards meeting the five principles of the CAF listed below:
- Managing risk.
- Protecting against cyber-attack and data breaches.
- Detecting cyber security events.
- Minimising the impact of incidents.
- Using and sharing information appropriately.

2.4 Overview of quality performance

2.4.1 Single Oversight Framework

The Single Oversight Framework is the joint NHS England and NHS Improvement framework for assessing trusts' performance against key statutory performance indicators.

Progress against the indicators in the Single Oversight Framework Indicator Threshold 2024/25

		2023/24 YTD	2024/25 YTD
Maximum time of 18 weeks from point of referral to treatment (RRT) in aggregate – patients on an incomplete pathway		62.9%	63.00% (APR-MAR)
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge		61.4%	62.8% (APR-MAR)
All cancers: 62 day wait for first treatment from:	Urgent GP referral for suspected cancer	66.5%	72.7% (APR-MAR)
	NHS Cancer Screening Service referral	79.6%	82.8% (APR-MAR)
C.difficile variance from plan		-76.3%	-26.23% (APR-MAR)
Maximum 6-week wait for diagnostic procedure		81.5%	87.86% (APR-MAR)

Data source: UHS

Different systems have different configurations for emergency care, with many having an urgent treatment centre co-located within their emergency department (ED). When looking at patients across the UHS site, we achieved 65.5% performance in 2024/25, which includes both Type 1 main ED performance of 62.8% and Eye ED. An alternate measure is 'mapped' performance, which takes into account the urgent treatment centres, and therefore gives an overview of the performance for the local population. In 2024/25 this was 77% of patients seen, treated and admitted or discharged in 4 hours.

2.4.2 Reporting against core indicators for 2024/25

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/DHSC.

Core indicator 12: The value and banding of the Summary Hospital-level Mortality Indicator (SHMI) and the percentage of patient deaths with palliative care coded at either diagnosis or speciality levels) for the Trust for the reporting period:

SHMI

	January 24 to December 24			February 24 to January 25		
	Value	OD banding	% patient deaths with palliative care coded	Value	OD banding	% patient deaths with palliative care coded
UHS	0.82	3	33	0.81	3	33
National ave	1.00	-	44	1.00	-	44
Highest trust score	1.33	1	66	1.34	1	65
Lowest trust score	0.70	3	17	0.71	3	17

Data source: NHS Digital

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: SHMI is an NHS Digital-derived tool available nationally and provided to all trusts for monitoring their rates of mortality, amongst other parameters, on a monthly basis. It follows an open and transparent process, based on the mandatory reporting of data all trusts provide via SUS. UHS has had a consistently strong SHMI performance for several years and continues to provide a statistically significantly better than expected trend. The high level of coding depth measured in the monthly SHMI reports give reassurance that the mortality measures are a fair reflection of UHS' performance.

Core indicator 18: The Trust's patient-reported outcome measures scores (PROMs) for:

(i) Groin hernia surgery
(ii) Varicose vein surgery
(iii) Hip replacement surgery and
(iv) Knee replacement surgery

during the reporting period.

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.

PROMS - Case mix adjusted average health gain

	2022/23	2023/24		
Adjusted average health gain	**UHS**	**UHS**	**Highest provider**	**Lowest provider**
Hip replacement primary	21.459	20.6935	25.6601	18.6003
Knee replacement primary	16.1056	18.0494	19.7877	11.7164
Total hip replacement	21.2551	21.1264	25.4922	18.1014
Total knee replacement	15.5383	17.906	20.1149	11.445

Data source: NHS Digital

* Please note, 2024/25 data will be published in February 2026

Regulatory/Assurance statement: UHS considers that this data is as described for the following reasons: adjusted average health gain is a trust level average of the difference between case-mix adjusted patients' health status before and after surgery. We are not classed as an outlier as both measures are not statistically different from the overall England average. UHS intends to improve number of patients completing their pre-operative questionnaires for a richer dataset.

Core indicator 19: The percentage of patients readmitted to a hospital within 30 days* of being discharged from a hospital which forms part of the Trust during the reporting period.

	2023/24	2024/25
Emergency readmissions, within 30 days (as average of monthly %)*	12.34%	12.42%

*UHS report against the NHS England metric of emergency readmissions within 30 days, rather than 28 days.

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.

NHS England (NHSE) no longer calculates or publishes Friends and Family Test (FFT) response rates, as there is no restriction on how frequently patients or service users can provide feedback. NHSE has also clarified that FFT data is not comparable across organisations. However, it can serve as an informal indicator to monitor trends over time within an organisation.

To better assess the Trust's responsiveness to personal needs, asking, "Overall, how was your experience of our service?"- alongside the response rate - offers a more meaningful measure.

Positive responses

A&E	2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	* Q4 2024/25	2024/25
UHS	73.57%	74.43%	81.11%	80.78%	N/A	78.77%
National average	79.41%	78.12%	80.50%	76.59%	N/A	78.40%
Highest trust	100.00%	100.00%	100.00%	100.00%	N/A	100.00%
Lowest trust	0.00%	40.00%	53.13%	12.50%	N/A	35.21%

Inpatient and daycase	2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	* Q4 2024/25	2024/25
UHS	98.21%	97.53%	97.21%	97.85%	N/A	97.53%
National average	94.52%	94.44%	94.76%	94.61%	N/A	94.60%
Highest trust	100.00%	100.00%	100.00%	100.00%	N/A	100.00%
Lowest trust	65.89%	55.93%	53.69%	71.76%	N/A	60.46%

Negative responses

A&E	2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	* Q4 2024/25	2024/25
UHS	17.75%	16.75%	11.11%	13.25%	N/A	13.70%
National average	13.50%	14.04%	12.49%	15.29%	N/A	13.94%
Highest trust	100.00%	52.00%	41.67%	88.00%	N/A	60.56%
Lowest trust	0.00%	0.00%	0.00%	0.00%	N/A	0.00%

Inpatient and daycase	2023/24	Q1 2024/25	Q2 2024/25	Q3 2024/25	* Q4 2024/25	2024/25
UHS	0.60%	0.62%	0.75%	0.62%	N/A	0.66%
National average	2.58%	2.57%	2.51%	2.61%	N/A	2.56%
Highest trust	22.91%	22.25%	16.67%	24.00%	N/A	20.97%
Lowest trust	0.00%	0.00%	0.00%	0.00%	N/A	0.00%

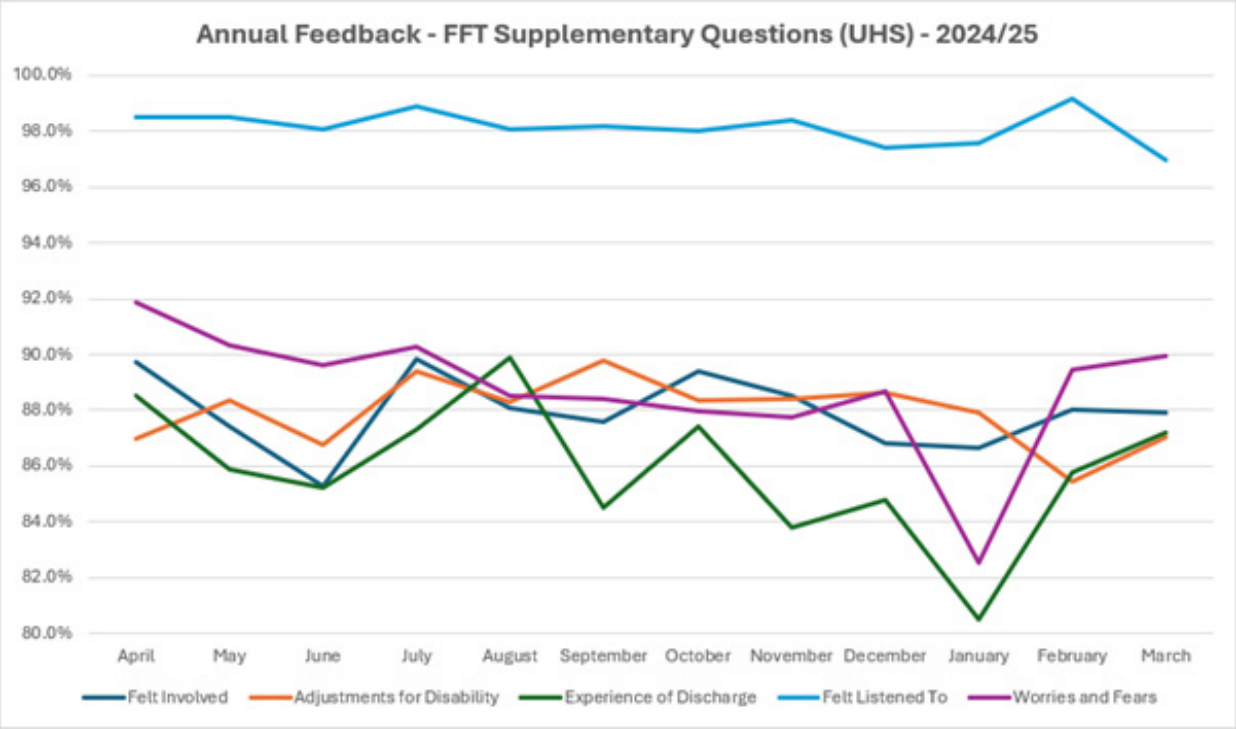
* Please note: The above data is provided by NHS England and Q4 for this reporting year is not currently available. The 2024/25 overall data is based on Q1, Q2 and Q3.

Low UHS response rate to A&E FFT
An SMS text message is sent to every patient following discharge from the emergency department (ED) approximately 48 hours after leaving (with some exclusion criteria in place) prompting them to complete the FFT. Consequently, this does introduce self-selection bias into the completion rates of the survey. Since introducing the SMS FFT, engagement with the FFT survey has increased from single digit engagement to more than one hundred people responding, highlighting the significant increase in completion since SMS was introduced. The Trust aspires to introduce text messaging for FFT surveys post-discharge for all care groups to help improve overall response and engagement rate.

Low negative response rate to inpatient and daycase FFT
Our FFT results continue to show high levels of positive response for inpatient and daycase services, with an average of 97.53% of responses being positive in the first three quarters of 2024/25 (average response rate is 5.67% for this period). Of those who responded, the Trust achieved an average negative response rate of 0.66% in this period, which is considerably below the national average of 2.61%.

UHS FFT: five core Questions results

In the FFT, the Trust captures data beyond the core 'Overall, how was your experience of care' question - the 'supplementary' questions. These focus around five core elements of care and patient experience: feeling involved in care decisions, making adjustments for disabilities, patient experience of discharge, feeling listened to by the clinical team, and feeling able to talk about worries and fears. The Trust consistently scores at least 80% satisfaction in all five of these areas and averages a 98.2% satisfaction rate to patients feeling listened to.



Data source: GATHER

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 is ensuring we are benchmarking our performance against our peers. UHS feedback shows an average of 98.2% of patients feeling listened to from the FFT and consistently receives more than 80% positive responses for our supplementary FFT questions.

UHS has taken the following actions to improve the Trust's responsiveness to the personal needs of its patients: continuing to collect real-time feedback from patients as part of national inpatient surveying, promoting greater awareness and encouraging response to the FFT through use of posters and surveying volunteers, recruiting and engaging involved patients and working to promote the range of services offered through the patient experience 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 and friends.

	2020	2021	2022	2023	2024
Your org	86.77%	83.15%	78.78%	76.27%	76.75%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	5651	6669	6921	5526	5301

Data source: NHS Staff Survey

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: UHS scores significantly above average for this indicator and compares well with other acute trusts in our survey category, ranking 11th out of 122 trusts. Our free text feedback tells us that people who work for UHS are proud of the standard of care provided, and our values drive our approach to putting patients first and always improving. Staff at UHS strive to achieve high patient outcomes and are proud to be part of a large university teaching hospital, with a prominent research and development faculty, with specialist services delivering care regionally and nationally.

UHS intends to take actions to improve the percentage of staff who would recommend the Trust as a care provider, and so the quality of its services, by improving the percentage of staff who complete the annual survey and pulse surveys, and by triangulating other mechanisms of feedback to improve care provision, staff and patient experience. Through a set of trust-wide actions, and locally derived priorities we will celebrate and share what is working well and continue to improve in those areas which have been highlighted. These include supporting leaders and managers to support people to thrive in complex and challenging environments, focus on wellbeing, strengthening our speaking up and feedback culture, and encouraging principles of civility, kindness and inclusion.

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 resumed in 2024/25 following the original suspension due to the COVID-19 pandemic.

VTE risk assessments

	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
UHS	96.00%	95.00%	95.20%	95.16%
National average (acute trusts)	89.00%	89.00%	90.69%	90.62%
Highest trust score (acute trusts)	100.00%	100.00%	100.00%	99.76%
Lowest trust score (acute trusts)	15.00%	14.00%	12.65%	14.27%

Data source: NHS England

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: UHS has continued to collect this data and remain above prescribed national averages (i.e 95%). UHS has taken actions to continue to maintain and improve the above average compliance and the quality of its services, by ensuring there is an ongoing hard block within our standard electronic prescribing system where resident doctors are signposted to complete VTE risk assessment. The data is shared regularly with the chair of the thrombosis committee, it is a standing agenda item on the thrombosis committee and the data is signed off by the chief medical officer.

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:

C difficile per 100,000 bed days

	2022/23	2023/24	2024/25
UHS	21.85	26.36	31.58
National average	26.82	28.38	31.39
Highest trust score	84.38	92.54	77.81
Lowest trust score	0.00	0.00	0.00
Lowest trust score (non-zero)	1.4	5.9	2.3

Data source: UK Health Security Agency (UKHSA)

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 prevention and control (IP&C) committee, quality governance steering group and daily and weekly reviews.

UHS has taken the following actions to improve the rate of C difficile infection per 100,000 bed days of 31.58 and the quality of the services, by:

- Approval and launch of an updated isolation of patients with infectious conditions policy.
- Focused isolation care ward rounds/reviews undertaken by the infection prevention team, supported by education/awareness activities to improve knowledge of the expected standards of practice.
- Ongoing focus on antimicrobial stewardship (AMS) and application of the principles of prudent antimicrobial prescribing – antimicrobial stewardship ward rounds (microbiologists and pharmacists).
- Introduction of combined infection prevention and control and AMS C. difficile ward rounds (by IPT and pharmacy-micro team) with focus on antimicrobial prescribing, including the clinical management of the patient post C. difficile positive result, and IP&C practices.
- Development of an IP&C improvement plan with specific focus on hand hygiene and equipment cleaning.
- Ongoing implementation of the 'give up the gloves' campaign to support reduction of unnecessary use of gloves.
- A successful IP&C awareness campaign throughout the month of October focused on equipment cleaning (especially items shared between patients) and hand hygiene.
- Launch of the clinical cleaning escalation framework.
- Launch of revised 'cleaning roles and responsibilities' framework.
- Actions and ongoing focus on improving clinical cleaning standards, including cleanliness of commodes.
- 'Spring clean' campaign in March 2025 with further focus on equipment cleaning, decluttering, decommissioning damaged/broken items and cleaning of the environment, including focused matron walkabouts.

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.

	2023/24	2024/25
Patient safety incidents (PSIs) - PSIs uploaded to learning from patient safety events - (LFPSE) portal	9,398	8,477
Number of PSIs that resulted in severe/major/catastophic harm*	79	77
PSIs that required a patient safety incident investigation (PSII)**	N/A	9 (APR-MAR)
Never events	8	10 (APR-MAR)
Avoidable hospital acquired grade III and IC pressure ulcers	206	140 (APR-JAN)
Total number of falls with significant harm	46	56 (APR-MAR)
Thromboprophylaxis (VTE) % patients assessed	No data	>95%

Data source: UHS

* Section 2.4.3 Learning from deaths includes details about PSI resulting in death.

** UHS transitioned from the Serious Incident (SI) Framework onto the Patient Safety Incident Response Framework (PSIRF) on 2 October 2023. Methodology changes from SIRIs to PSIIs in 2024/25 make comparisons to historical years not meaningful.

Regulatory/assurance statement: UHS considers that this data is as described for the following reasons: we use nationally reported and verified data from the national reporting and learning system (NRLS).

UHS has taken actions to improve patient safety by continuing to work on actively learning from incidents, by promoting a culture of transparency and collaboration, empowering both patients and staff to play an active role on patient safety investigations.

Other information

Patient safety indicators data for 2024/25:
Public Health England healthcare associated infections (HCAI) data capture system (DCS) national reporting case capture compares rates and counts of infections occurring in organisation of the same type.

Benchmarking (allows users to compare their organisation against other organisations in terms of rates and counts of reported cases) – benchmarking is against nationally reported cases of healthcare associated cases rate per 100,000 overnight bed-days plus day admissions.

UHS healthcare associated figures

	2020/21	2021/22	2022/23	2023/24	2024/25
Healthcare associated infection MRSA bacteraemia reduction	1	1	4	7	5
Healthcare associated infection clostridium difficile reduction	63	74	84	105	120

MRSA performance against national limit

	2020/21	2021/22	2022/23	2023/24	2024/25
MRSA annual limit	0	0	0	0	0
UHS healthcare associated infection MRSA bacteraemia performance	1	1	4	7	5

UHS C.difficile performance against national limit

	2020/21	2021/22	2022/23	2023/24	2024/25
C.difficile annual limit	64	64	61	60	99
UHS healthcare associated infection clostridium difficile performance	63	74	84	105	120
C.difficile variance from plan	-1.6%	15.6%	37.7%	42.86%	17.5%

Data sources: UKHSA

Infection prevention practice standards

There is a UHS Trust annual infection prevention audit programme in place for 2024/25 to monitor infection prevention and control practice standards in clinical and non-clinical areas.

The audit programme is made up of the following:

- High impact intervention audits (care processes to prevent infection) - self-assessed audits.
- Hand hygiene:
    - o The hand hygiene audit process covers a wide selection of staff groups and ensures any missed opportunities for hand hygiene are addressed during the audits.
    - o Monitoring and assurance of hand hygiene practice for inpatient areas in 2024/25 consisted of:

      Self-assessed audits by ward leaders and/or matron with clinical lead.

      Covert audits carried out by an independent infection prevention nurse out of uniform.

      Monitoring and assurance of hand hygiene practice for outpatient areas consists of peer audits.
- Miscellaneous audits – self assessed.

Areas/wards who do not achieve the expected audit standards are required to identify actions for improvement and are offered support and input from the infection prevention team. Processes are in place for regular review of areas not achieving expected standards. Performance in relation to audit standards has been reviewed monthly by the infection prevention team to identify areas of concern/ those requiring additional support to improve practice standards.

Audit title	Actions
Infection Prevention and Control (IPC) audit programme Personal Protective Equipment (PPE) audit	**Use of PPE audit**. A total of 129 areas submitted an audit. Overall, Trust result of 98%. Three elements of the audit fell below the expected 95% standard. 9/129 (7%) gloves not removed immediately after completing a procedure/task (even on the same patient) and hand hygiene performed. 9/129 (7%) face and eye protection not worn by staff if blood and/or body fluid contamination to the eyes of face is anticipated or likely. 8/129 (6%) hand hygiene not performed immediately before putting on and immediately after removing gloves. All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection Prevention and Control (IPC) Audit programme Cleanliness and decontamination audit	**Cleaning and decontamination of clinical equipment audit.** Cleaning of equipment on non-infected patients in non-contaminated area. A total of 129 areas completed the audit and 497 observations undertaken. Overall, Trust result of 96%. Cleaning of equipment on infected patient/in a contaminated area a total of 61 areas completed the audit and 214 observations undertaken. Overall, Trust result of 96%. No elements fell below the 95% expected standard.
Infection Prevention and Control (IPC) audit programme Isolation audit	A total of 82 areas completed the **isolation audit**. The overall Trust score is 98% shows consistent compliance compared to previous audit. One element of the audit fell below the expected 95% standard, 6/82 (7%) failed to complete an isolation risk assessment. All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection, Prevention and Control (IPC) – Saving lives HII 6 urinary catheter care	**Insertion of urinary catheter audit.** A total of 48 areas completed the audit and 165 observations undertaken. The overall Trust result of 100%. Urinary catheter ongoing care audit. A total of 49 areas completed the audit and 237 observations were undertaken. The overall Trust result of 96%. One element of the audit fell below the expected 95% standard, 3/49 (6%) failed to document daily review of short-term catheter including need and reason for ongoing requirement. All areas are responsible for developing and implementing an action plan based upon their results following their audit.

Audit title	Actions
Infection, Prevention and Control (IPC) – Saving lives HII 1 central venous catheter care	**Central venous catheter insertion audit.** A total of nine areas completed an audit and 41 observations were undertaken. The overall trust result of 89%. No elements fell below the 95% expected standard. One area submitted only two observations both identified practice concerns with full eye and facial protection worn this 0% score affected the overall trust score. **Central venous catheter ongoing care audit** A total of 26 areas completed the audit and 130 observations were undertaken. The overall Trust result of 99%. All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection, Prevention and Control (IPC) – Saving lives HII 2 peripheral intravenous cannula care	**Peripheral intravenous cannula insertion audit.** A total of 59 areas completed an audit and 313 observations were undertaken. The overall Trust result of 96%. No elements fell below the 95% expected standard. **Peripheral intravenous cannula ongoing care audit.** A total of 55 areas completed the audit and 351 observations were undertaken. The overall Trust result of 96%. No elements fell below the 95% expected standard.
Infection, Prevention and Control (IPC) – Sharps audit	**Sharps safety audit.** A total of 124 areas submitted an audit. Overall, Trust result of 97%. Five elements of the audit fell below the expected 95% standard. 22/124 (18%) of yellow biobin (sharp containers) contained other items than needles and syringes. 18/124 (15%) of blue pharmacy biobin contained other items then pharmacy waste. 13/124 (10% of sharp container lids not temporarily closed between use. 11/12/4 (9%) of sharps containers not labelled tagged with date locality and signature on assembly. 7/124 (6%) of sharps containers not safely positioned and out of reach of vulnerable people. All areas are responsible for developing and implementing an action plan based upon their results following their audit.
Infection, Prevention and Control (IPC) – Inpatient and outpatient hand hygiene audit	**UHS Trust-wide audit of hand hygiene.** A total of 112 areas were audited and a total of 2220 observations were carried out. Results show an overall Trust score of 93%. An improvement framework specifically for hand hygiene is in place with the aim of driving improvements in practice. Areas will be measured against a performance improvement target. All areas are responsible for developing and implementing an action plan based upon their results following their audit.

Audit title	Actions
Infection Prevention and Control (IPC) – Standard precautions audit	**Standard infection control precautions audit.** A total of 102 areas submitted an audit. Overall, Trust result of 97%. Three elements of the audit fell below the expected 95% standard. 16/102 (16%) yellow biobin (sharps container) only contain sharps such as needles & syringes i.e. no pharmacy bottles or IV fluid bags. 10/102 (9%) waste disposed of into the correct waste stream 6/102 (6%) waste bins are clean, in good working order and a good state of repair.
Infection Prevention and Control (IPC) – Preventing surgical site infection	**Preventing surgical site infection pre-operative audit.** A total of 30 areas submitted an audit. Overall, Trust result 95%. No elements fell below the 95% expected standard. **Preventing surgical site infection intra-operative audit .** A total of 14 areas submitted an audit. Overall, Trust result 100%. No elements fell below the 95% expected standard. Preventing surgical site infection post-operative audit. A total of 36 areas submitted an audit. Overall, Trust result 95%. No elements fell below the 95% expected standard.

Data source: UHS

2.4.3 Learning from deaths

During 2024/25 1,962 UHS patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Number of deaths per quarter 2024/25

Q1	Q2	Q3	Q4
466	446	498	552

Data source: UHS

Mortality and morbidity (M&M) reviews

31 cases were referred for a trust mortality and morbidity review by Medical Examiner Southampton in the year 2024/2025.

In all cases, it was reported that deaths were unavoidable, and care and treatment was appropriate. However, several learning opportunities were identified and discussed.

Thematic learning: documentation in record keeping.

Summary of actions: actions for refresher training on CHADS-VASC and HAS-BLED (clinical prediction tools for estimating risk of stroke for people with Atrial fibrillation) scoring was noted. The importance of clear documentation of the risks considered when planning to withhold anti-coagulation medications was also discussed. Another case highlighted the importance of documentation of upper gastrointestinal (GI) bleeds, and not letting the status of a patient as 'palliative' impact this.

How learning has been shared: discussion at local M&M and feature in Q2 learning from death report, discussed and shared among local departments.

Impact of actions: awareness of importance of clear documentation of discussions of risks and considerations of this by the patient.

Thematic learning: earlier follow ups for patients started on diuretics.

Summary of completed action: a system where patients started on diuretics are reviewed in the day unit within one week of initiation.

How learning has been shared: discussion at local M&M and feature in Q3 learning from deaths report. Learning and new system shared locally for involved teams.

Impact of actions: patients starting diuretics are reviewed earlier reducing the likelihood of any problems being missed.

Thematic learning: availability of TAVI (transcatheter aortic valve replacement). In one case, a patient was referred for TAVI but did not receive this before they died. Care was reported to have been 'excellent' and the death was possibly avoidable but not likely considering the co-morbidities of the patient. However, this highlighted the logistical limitations of TAVI.

Summary of completed actions: the capacity of TAVI was noted as a concern following referral of a case to M&M by the medical examiners service. This was taken for discussion at the respective care group governance meeting.

How learning has been shared: discussion at local M&M and feature in Q3 learning from death report, it was also highlighted to care group governance.

Impact of actions: strengthened awareness of the importance of TAVI in a timely way following referral and highlighted the logistical limitations of having the procedure carried out in a timely way.

Patient safety incidents

The patient safety team received and triaged 11 referrals from the medical examiner from April 2024 until March 2025:

- One case will be subject to a patient safety case review (scheduled for scheduled for 24 April 2025).
- Three cases were directed to be discussed/reviewed at relevant M&M meeting.
- One case was directed to be discussed/reviewed by the adult safeguarding team.
- Two cases were linked to already established workstreams (Trust diabetes working group and infection prevention team).
- Two cases were deemed as not requiring any further action.
- Two cases are under review, pending further information.

By 31 March 2025, 111 cases were triaged by the patient safety team, to establish if any immediate learning and what further investigation, if any was required in relation to the deaths reported above.

	April 2024 – March 2025			
	Q1	Q2	Q3	Q4
Cases triaged	27	14	29	41
Patient safety case review	7	2	7	8
Patient safety incident investigation	2	0	1	0

Data source: UHS

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

A total of 28 cases were subject to a patient safety case review meeting. Three progressed to be investigated as patient safety incident investigations, as per UHS Patient Safety Incident Framework plan.

Two were 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:
- one representing 0.01% for the first quarter.
- zero representing 0% for the second quarter.
- one representing 0.01% for the third quarter.
- zero representing 0% for the fourth quarter.

For 2024/25 the child death and deterioration (CDAD) group reviewed 31 deaths and 170 unplanned admissions to the paediatric intensive care unit (PICU).

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

1. *Patient had regular insulin prescribed, which was due to be given at the same time as NG feed due to start. There was a delay in starting the nasogastric (NG) feed and insulin was administered. Patient had hypoglycaemic episode and became unresponsive.*

Thematic learning: hypoglycaemia caused by unopposed variable rate insulin infusion.

Summary of completed actions: launch of trust-wide group to oversee the diabetes improvement work streams including an updated variable rate insulin infusion (VRII) chart to include intravenous (IV) glucose when no feed is running.

How learning has been shared: teaching to all staff groups involved in care of diabetic patients. Diabetes app promoted to all staff as a quick way to get advice on management of the diabetic patient.

Impact of actions: improve awareness of how to safely manage diabetic patients.

2. *Patient was admitted to ward F4 spinal. She deteriorated with NEWS2 score of 7 and was later found to be unresponsive. Crash call put out and team attended but she did not survive this episode.*

Thematic learning: lack of recognition and escalation of a deteriorating patient. Challenge in identifying most appropriate ward for discharge from general intensive care unit (GICU) when patients are under the care of multiple specialities.

Summary of completed actions: improve usage of Situation Background Assessment Recommendation (SBAR) framework or equivalent when escalating a deteriorating patient. Trust-wide communication to raise awareness of the critical care outreach team (CCOT) and how to contact them. Review discharge policy for complex trauma patients and review use of the trauma multi-disciplinary team (MDT) to ensure best placement.

How learning has been shared: an organisational wide learning (OWL) document describing how to contact and the services available from CCOT. Teaching on management of the deteriorating patient.

Impact of actions: improved recognition and escalation of deteriorating patients. Improve patient transfer from GICU to most appropriate area.

3. *Patient was discharged from UHS on 25 December 2024. His next of kin and care providers were not informed. The following day, his medications were found by the care providers at another patient's location, which led to a welfare check. Patient was found unwell, ambulance called but he sadly died.*

Thematic learning: patient safety incident investigation is still ongoing. Initial review identified learning concerning the discharge process.

Summary of completed actions: N/A (investigation still ongoing).

How learning has been shared: N/A (investigation still ongoing).

Impact of actions: N/A (investigation still ongoing).

2.4.4 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 2: consultant-directed assessment.
- Clinical standard 5: diagnostics.
- Clinical standard 6: interventions.
- Clinical standard 8: 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 2: 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.

Clinical standard 5: 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 6: 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 seven-day mechanical thrombectomy cover
- Percutaneous coronary intervention
- Cardiac pacing

Clinical standard 8: 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.

2.4.5 Freedom to Speak Up

Freedom to Speak Up (FTSU) is for anyone who works in health. This includes any health care professionals, non-clinical workers, senior, middle and junior managers, volunteers, students, locum, bank and agency workers and former employees.

The Trust has a FTSU guardian who is an independent and impartial source of advice for those wishing to speak up. The FTSU guardian is supported by an executive lead and a non-executive lead who are both knowledgeable about Freedom to Speak Up. Gail Byrne is the executive lead for Freedom to Speak Up and her role is to provide the Board with a variety of reliable independent and integrated information that gives the board assurance that:

- Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.
- The Trust provides FTSU awareness 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.
- Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups such as people from ethnic minority backgrounds and agency workers.
- 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 whilst at work, staff who need advice on issues such as conflict in the workplace, and staff who are thinking of leaving UHS. We continued to grow our community of champions and have increased the number of champions from 38 to 78. The champions are from all backgrounds and cover a wide variety of areas at UHS.
- Speak up issues that raise immediate patient safety concerns are quickly escalated.
- Action is taken to address evidence that workers have been victimised because of speaking up, regardless of seniority.

- Lessons learnt are shared widely both within relevant service areas and across the Trust. We have a multi-disciplinary approach to concerns raised through the 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.

- FTSU policies and procedures are reviewed and improved using feedback from staff. The Trust also has a raising concerns policy that establishes clear lines of escalation for concerns to be raised which are as follows:
  o Raise the matter with your line manager.
  o Contact the FTSU guardian or FTSU champion.
  o Contact the executive director responsible for FTSU.
  o Contact the non-executive director responsible for FTSU.
  o Raise the concern externally.

- The FTSU guardian sends a feedback form whenever a case has closed to understand and learn how FTSU is working and seek advise on how to improve.
- Every six months the Trust Board receives a report from the FTSU guardian. The reports are submitted frequently enough to enable the Board to maintain a good oversight of FTSU matters and issues. The reports are presented by the FTSU guardian in person.
- Our progress and performance are measured through our annual staff survey and Friends and Family Test (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. 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.

What our staff tell us

"I just wanted to feedback how supportive and professional my FTSU champion was as a workplace colleague. He was knowledgeable and made my HCA feel at ease. Latterly, he has been able to provide me with further resources that as a ward leader, I can utilise for both this staff member and my team more widely for supportive measures. Happy to discuss further if needed 🙂 but I just wanted to extend my thanks to the FTSU champion and the support your team offers our staff in UHS" 🙂

"I just wanted to share the news with you and thank you for your time and support on this matter. I will be facing a great deal of challenges, no doubt but I am really excited to get the opportunity to develop the service and I hope that I can make a positive impact for the patients and the team around me. Thank you again!"

"You guys are absolutely brilliant. I felt totally supported by my FTSU champions. Can I just say yourself and your team are absolutely fantastic 🙂. I thank you so much for your help."

"Thank you so much for everything and making things possible. I have now started my training from my objectives, and I absolutely love it. I am buzzing. They are really pleased with my progress so far, and are over the moon and think I am getting the hang of it right away, and will get there. All this wouldn't have been possible without your help. I appreciate all you've done for me 🙂 "

"I sincerely appreciate your help, support and compassion throughout this period. Your understanding and patience have been instrumental in navigating this situation, and for that, I am truly thankful. In conclusion, I would like to express my deepest gratitude to you and the FTSU champion. Your intervention and support have been a testament to your kindness, and I feel blessed to have such understanding individuals in my professional network.

2.4.6 Rota gaps

The guardian of safe working is responsible for ensuring that working hours are safe for resident doctors; we know that this is important for patient and staff safety, resident recruitment, resident retention and team morale.

The guardian also helps support the implementation and maintenance of the contract for doctors in training, has independent oversight of resident doctors' working hours and works with the medical workforce team to identify any training challenges.

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 with plans for improvement and resident doctor exception reporting.

In addition, at UHS the guardian has a role as a senior figure for the resident doctors to seek out for advice, concerns, ideas and suggestions about all parts of the resident role. In this role the guardian works closely with the chief resident, the executive and the resident doctor reps.

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 resident doctors whether in deanery training posts or not.

There are 779 resident doctors employed by the Trust and they all work on the 2016 contract. This figure includes hosted posts such as radiology, general practice and foundation community posts.

There are 438 resident doctors employed in non-training posts; all of these doctors work on UHS local terms and conditions which mirror the 2016 contract.

The current vacancy rate is 7.85% which equates to 77 whole time equivalents (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 pathology, critical care and neonates.

From 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 monitored and relates to the coverage of both short-term vacancies and longer-term gaps in the rotas.

The changes in locum rates from September 2022 for resident doctors 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 clinical rota leads and the medical workforce team. There have been 741 exception reports, 90% of which were for working overtime. There have been a small number of exception reports which have raised an immediate safety concern; these related to the breaching of a 13 hour shift. This was appropriately dealt with, the fine levied and the shift changed in subsequent rotas.

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 ongoing around the role of resident doctors, advanced nurse practitioners, physician assistants and a range of non-clinical roles.

NHS England published the Priorities and Operational Planning Guidance paper in March 2024 which had specific recommendations around Improving Junior Doctors Working Lives. In April 2024 actions were requested from each trust to implement these recommendations.

In April 2024 UHS formed a task and finish group to ensure that the appropriate improvements were made. This work is ongoing; many of the recommendations were already in place at UHS and other improvements have been made. Of note this group has been able to open discussions about a number of important issues, most notably non-clinical space for resident doctors, which remains challenging.

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 resident doctor workforce are in place in UHS.

The executive and non-executive teams are fully cognisant of the challenges that resident doctors face and engaged in finding solutions. The medical workforce and the medical education teams work hard to support the residents and optimise their time at UHS.

2.4.7 Duty of Candour

Duty of Candour, Regulation 20 of the Health and Social Care Act 2008, is a statutory requirement for all providers registered with the Care Quality Commission (CQC). It covers any patient safety incident that appears to have caused (or has the potential to cause) significant harm. It requires us to undertake an initial disclosure of the incident, provide a written account, complete an investigation share investigation findings and offer formal apologies.

At UHS we have worked hard to ensure that our staff are aware of their obligations against this regulation. 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.

Our intranet provides up to date resources and advice, and we have an information leaflet to explain how we investigate and learn from incidents. This information includes how we will be open, involve our patients and their families and keep them updated. Every patient (or their family) is contacted by letter following a moderate or high harm incident and are invited to ask any questions they would like answered as part of the investigation. We offer to meet patients and families if they would find this beneficial.

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.

Our planned outcomes for the next 2 years

Strategic

Adopting an 'Systems based' approach to patient safety incidents.

Delivering patient safety education and coaching to those involved in safety investigations, risk and governance to embed PSIRF methodology across the organisation and aligning with core behaviours of the UHS way of thinking.

Resulting in an just and learning culture that allows us to learn, grow, heal and excel, with patient safety at its core, to develop an engaged and ambitious workforce who consistently deliver safe and outstanding care

Operational

Patient safety investigations focus on where there is greatest learning for the organisation

A range of tools are used to learn from incidents and regular thematic reviews are carried out.

Patients involved in projects that lead to improvements in patient safety

All staff understand their role in patient safety and we support those staff involved in patient safety incidents

Quality

Build confidence, capability and capacity for patient safety learning and improvement across the Trust so staff feel empowered to deliver PSIRF in their areas

Build on our Educational offering - PSII, human factors, appreciative inquiry for staff involved in patient safety

Train ALL staff in level 1 patient safety

Support and coach staff to deliver PSII and local investigations, and ensure involvement of those affected

Effectiveness

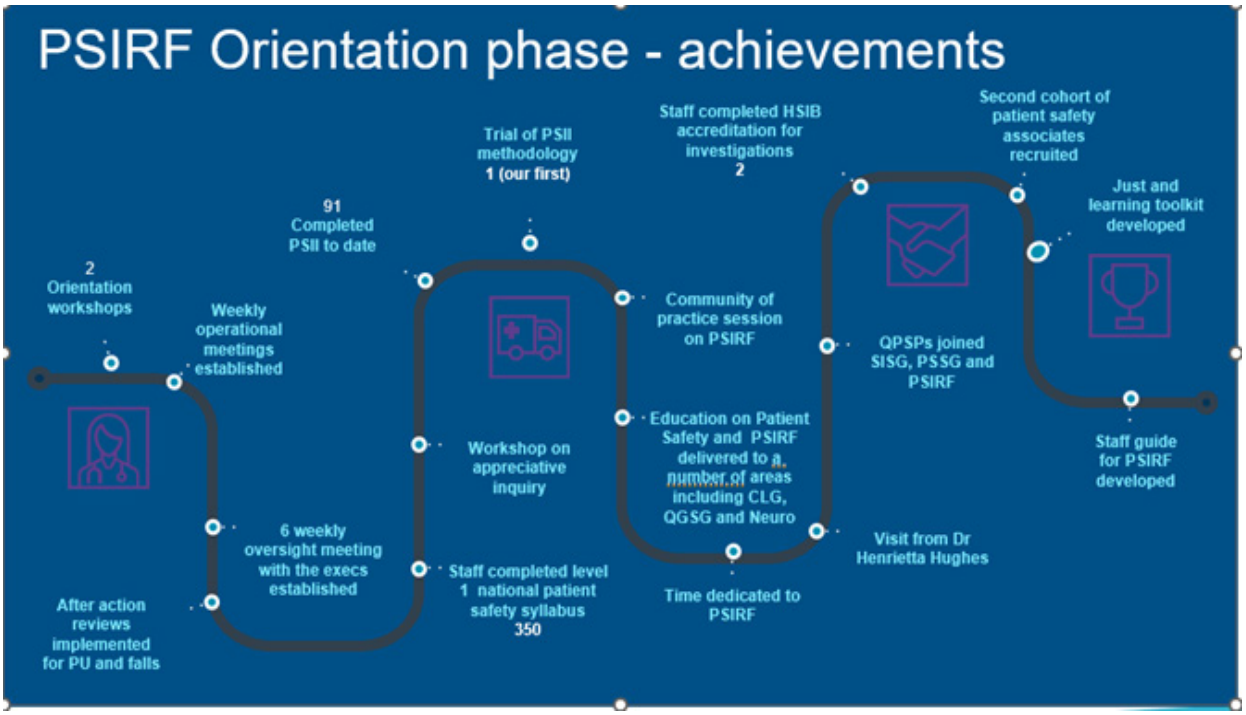
Measure implementation effectiveness and organisational readiness over the next year

Measure impact of PSIRF implementation, including impact on patients and staff involved.

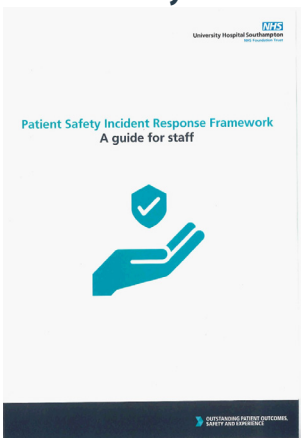
Design and embed robust measures for every PSIRF investigations

Patient Safety Incident Response Framework (PSIRF) implementation

The PSIRF was formally launched in September 2022 by NHS England, and we transitioned away from the serious incident framework onto the PSIRF in October 2023.To support the move the Trust has developed a PSIRF plan and policy and these were ratified through key groups within UHS and in collaboration with our integrated care board. The policy and plan were revised at 6 and 12 months. In July 2024 we were visited by the ICB and members of the HIOW patient safety specialists' network for a PSIRF peer review. We highlighted key achievements:



Patient safety education and human factors



Over the last year we have continued to support educating our staff on patient safety and human factors and supporting the transition to PSIRF. We have not only promoted the patient safety syllabus through NHS England e-learning but had delivered a number of face to face often bespoke sessions to raise the numbers significantly during this year. From February 2025 the patient safety syllabus became role specific to support an increase in compliance. Other courses delivered include after action reviews, thematic reviews, interview techniques and supporting those affected. Master classes have been held to support staff in feeling confident in using the systems engineering initiative for patient safety (SEIPS) and accident mapping (AcciMap).

We have delivered oversight training to the Trust Board, divisional management teams, PSIIOG and governance teams.

Incident reporting

The Trust transitioned last year to the learning from patient safety events service (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 help improve 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.

Quality and patient safety partners (QPSPs)

'I can be the critical friend and provide the constructive challenge'
- Mark Turnball

Mark Turnball is a Quality and Patient Safety Partner (QPSP) at University Hospital Southampton.

A retired engineer whose wife is a former nurse, Mark is a patient at the hospital. When UHS began piloting the Patient Safety Partner initiative in 2021, he jumped at the opportunity. 'I felt that my background in a safety-related environment would be useful,' he says. 'And throughout my married life, my wife had told me of the horror stories she had witnessed at work.'

Mark's role as a QPSP is extensive. He sits on governance and oversight groups and contributes to improvement projects.

He estimates the role takes up about 35 hours a month on average but this varies considerably. The QPSPs have received positive feedback from the groups of which they are a part as well as from senior leaders – the trust's director of clinical law said they had provided a 'new set of senses'.

'We are seen as positive disrupters and I feel I have changed the outcome of some patient safety investigations,' he says. 'I would recommend the role. But not everyone is suited to dealing with the details of an investigation. You need to be able to be able to look at these cases dispassionately, including where someone has died, but there is support from our allocated mentors and buddies and we also have access to the same support mechanisms as the hospital staff.'

Mark adds: 'It's a great role to get involved with. Staff see that I can say things that they are not comfortable to say – I can be the critical friend and can provide the constructive challenge.'

Our QPSPs continue to support a number of patient safety workstreams including the patient safety incident investigation oversight group, new cases group and patient safety steering group. We were successful at winning the HSJ award for involving patients in patient safety for our QPSP programme.

We continue to work with our nine QPSPs in improving how they are allocated to workstreams and how we record their impact.

Mark Turnbull, one of our QPSPs, was asked to write a blog for the patient safety commissioners annual report.

M&M Processes
This year has seen a focus on improving our M&M processes including developing six key principles shared across the Trust.

UHS - six key principles of M&M

Safety
A safe space for learning. A meeting atmosphere that is conductive to open discussion with a focus on 'Just and Learning Culture' and an emphasis on understanding the systems factors, not focusing on individuals.

Multiprofessional and Multi-disciplinary
Ensuring active participation across staff groups and different disciplines.

Meeting Framework
Systematic agenda selection process, structured meeting format and objective analysis of data, including consideration of systems factors, and human factors and ergonomics.

Learning Focus
Comprehesive discussions to generate actionable learning and system improvement. Using an appreciative inquiry approach to emphasise and learn from the every day, as well as where things can go wrong.

Governance
Hospital-wide system to record outcomes, lessons learned, and dissemination of recommendations to ensure action and learning. Supporting our integrated approach to quality across the organisation. Follow up to ensure actions are completed. Clear pathways for central reporting and escalation of concerns.

Patient Centred
Keeping the patient and the family central to the learning. Ensuring that the patient voice is heard when learning from events. Completing feedback and duty of candour to help build trust.

Medical scoping leads – renamed as medical advisors for patient safety
Our medical advisors for patient safety have continued to support our case reviews as well as taking on wider patient safety roles including implementation of guidance for morbidity and mortality meetings and developing a human factors and simulation strategy. Unfortunately two have stepped down this year and recruitment is currently underway to back fill.

LeDeR (Learning from deaths in patients with learning disabilities and autism)
Following a pause in 2021 we restarted our internal LeDeR reviews in 2022 and these have continued throughout 2024. Led by the patient safety team these reviews are multi professional with support from one of the divisional clinical directors, named nurse for adult safeguarding and the learning disability team. Our ambition is to include the views and feedback from the families over the next year.

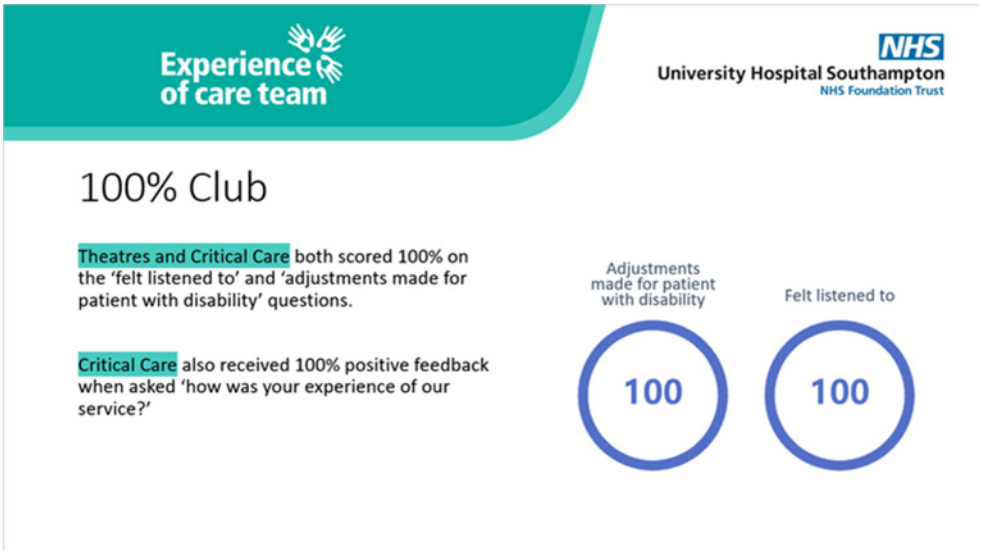
World Patient Safety Day 2024 – 'Get it right, make it safe'
UHS hosted an event on 12 September 2024 to celebrate Patient Safety Day which included speakers on a wide range of topics. Our keynote speaker was Chris Taylor, head of safety and assurance services at the National Air Traffic Services and other speakers focused on consent, patient safety in radiology, QPSPs and 'your sphere of influence'.

3.2 Our commitment to improving 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 in 2024/25.

Last year we reported on the success of the Gypsy, Roma and Traveller (GRT) liaison officer, with a robust education package built and available for virtual learning, and a vast number of staff groups receiving face to face education. We decided to expand this role further to a health inequalities liaison officer. This has enabled the role to replicate the successful model of the GRT workstream to other seldom heard from groups and linking into the Trust health inequalities board and focusing on the Core20plus5 agenda.

Focusing on encouraging our staff to capture patient feedback a new initiative from the experience of care team was launched. 'The 100% club' was launched to celebrate when a care group receives 100% positive feedback in their areas. They receive a certificate titled '100% Club' to positively reinforce great practice, this is then shared at divisional governance meetings. Example below:



We continued to strive for involving patients in decisions about their individual care and ensuring we co-design with our patients any fundamental service changes. A successful collaboration with the My Medical Record team has resulted in the recruitment of approximately 2,000 involved patients. This has ensured that involved patients have supported with projects such as the head and neck forum, five year strategy for the Trust (phase one survey received 475 responses), and the outpatients appointment letter workshop (made up solely of involved patients).

During the summer the youth ambassadors' group (YAG) recruited fresh members following a recruitment drive at Richard Taunton's Sixth Form College to speak to health and social care students. The YAG group led a 'noise at night' project where the young people created posters and videos encouraging patients to be more conscious of inpatient overnight noise, this was an action from the 2024 National Inpatient Survey. The posters have featured on social media and are due to be showcased on the SparkTV (bedside TV) sets.

Our Muslim prayer washing facilities were escalated as a concern due to staff, patients and relatives all experiencing a poor standard when preparing for prayer due to old estates and the volume of use in

that area. The washing facilities are now under construction with specific 'WudhuMate' ablution seats being installed to support our Muslim patients, relatives and staff to prepare for prayer in a bespoke environment. The estimated completion date is February 2025.

UHS successfully passed its Veteran Aware Reaccreditation in June 2024, ensuring that patients from the armed forces community are not disadvantaged in terms of access to and outcomes of healthcare as a result of their military life in line with the principles of the Armed Forces Covenant.

The UHS spiritual care team were cited in the staff survey results with the highest score as point of access for staff support. This is a successful indicator that UHS staff feel supported and are accessing the pastoral support offered by the spiritual care team.

November 2024 saw the first 'experience of care hero' award presented at the UHS monthly Spotlight event, this is the only award nominated solely by UHS patients and family. The success of this has been palpable with staff given a certificate with the patient/family feedback detailed.

We are proud to have successfully launched our Sip 'Til Send campaign, a change practice to empower all clinical areas to allow their inpatients that are nil-by-mouth to sip water until they are 'sent' for their procedure. This campaign not only supports reducing risks of AKI (acute kidney injury) and dehydration, it also supports our Fundamentals of Care programme commitments for mouthcare and nutrition and hydration.

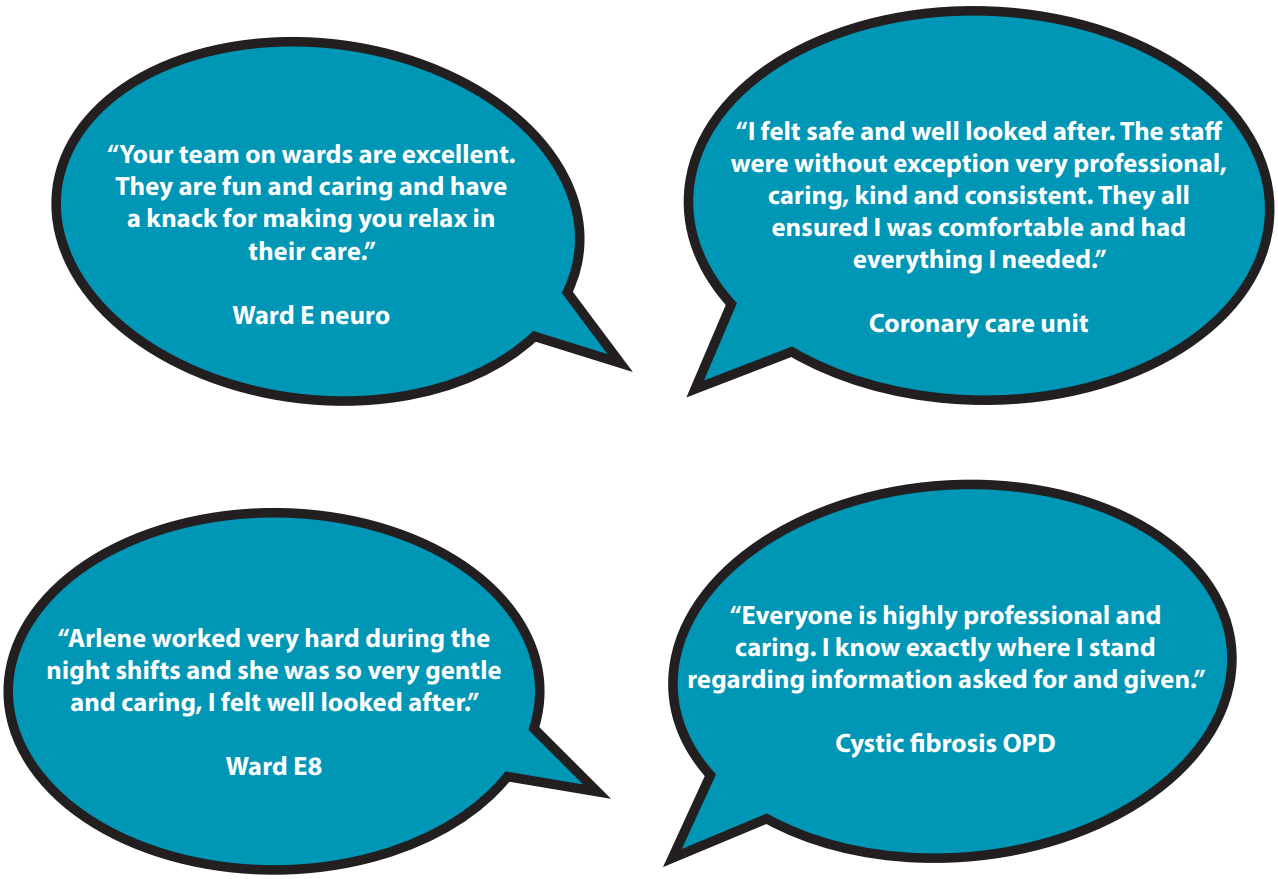
We continue to score an average of 95% for patient reporting via the Friends and Family Test (FFT) that they rate their overall experience of care as "very good" or "good". We have actively encouraged our clinical leaders to monitor patient feedback regularly, to support this "auto reporting" was set up. This means that trust-wide, divisional and care group leads can have a simple one click method to access the GATHER dashboard (software which collates our FFT data). On the 1st of each month the link is emailed out to leaders to review their areas FFT data. This supports our patient facing "You Said … We Did" information boards showcasing to patients and public how the patient voice shapes the care we give at UHS.

"Kept informed of every action and reasons for any waiting."

Emergency department

"The treatment and care were very personal and caring. It was reassuring when you are nervious having an operation. They were excellent and I couldn't be happier with the care I received."

Lymington Knightwood ward



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

Patient-Led Assessments of the Care Environment (PLACE)
The environment in which we care for patients plays a crucial role in their overall experience and, in some cases, their clinical outcomes. We believe that every patient should feel assured that they will receive care with compassion and dignity in a clean, safe setting.

PLACE is a patient-focused assessment system designed to evaluate the quality of the care environment from the patient's perspective, rather than through traditional technical audits. These assessments are led by patients and their representatives, with support from Trust staff. The patient assessors reflect the diverse demographic of those receiving care within the Trust, ensuring that their insights provide a direct and meaningful perspective on how the environment affects them and where improvements can be made.

In 2024, PLACE assessments were conducted across five UHS operational sites. These assessments were unannounced and carried out by teams comprising both staff and patient representatives. We were privileged to have ongoing support from Healthwatch Southampton, Trust governors, independent representatives, Trust volunteers and a strong presence of youth ambassadors. This diverse group of assessors brought valuable insights and experiences, strengthening the overall assessment process.

Our 2024 results were:

Cleanliness	Combined food	Organisational food	Ward food
98.82%	86.58%	99.04%	84.56%
Privacy, dignity and wellbeing	**Condition appearance and maintenance**	**Dementia**	**Disability**
84.41%	95.20%	75.88%	79.75%

Data source: UHS

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

Successful projects
We've had an incredibly productive and impactful year with capital project delivery. A recap of achievements highlighting the key successes of the projects:

1. GICU light touch (intensive care unit)
- Transformation: You've taken a highly dilapidated area and converted it into a modern, welcoming space that enhances both the experience of visitors and staff.
- Impact: Visitors will now have a contemporary, comforting area to enter the ICU, which is crucial in improving the emotional experience for families during difficult times.
- Compliance and efficiency: The project incorporated practical, energy-efficient solutions, ensuring the space is both functional and sustainable.

2. Ward G2 (renovation of 1970s ward)
- Modernisation: A significant overhaul of an outdated 1970s ward with poor facilities into a new, state-of-the-art environment that meets the needs of modern healthcare delivery.
- Patient care: The new ward not only meets healthcare standards but also creates a better environment for both patients and staff, offering a more comfortable and efficient space for patient care.
- Energy efficiency: As with the other projects, this renovation follows building regulations and emphasises energy-efficient technologies to reduce running costs and improve sustainability.

3. Neonatal unit at Princess Anne
- Revitalisation of a 1980s building: The transformation of an older building into a modern facility to treat vulnerable, premature, and critically ill babies is a huge step forward for neonatal care.
- Family-centred design: The addition of a light, airy, and clean space for parents ensures that families can spend quality time with their babies in a comfortable and welcoming environment.
- Compliance and care: The unit was not only renovated to meet the highest standards of patient care and healthcare facility design but also to be in line with modern building regulations, ensuring safety, accessibility, and functionality.

These achievements not only demonstrate our excellent project management team and their delivery but also show a deep commitment to improving patient and staff experience, ensuring that UHS healthcare facilities are fit for the challenges of modern healthcare delivery.

Over the past year, the estates (engineering) team has had a focus on clinical support. The team has sought to work closer to better support the clinical efforts of the trust by responding faster to matters that were having a direct impact on patient outcomes. The feedback from our clinical colleagues has been that we are more responsive now than we have been over the recent few years, which has

meant better uptime of clinical facilities and ultimately improved patient experience. The estates team have been striving to improve our statutory compliance and have been able to achieve a five percent increase on all planned maintenance over the last six months, ultimately meaning that the buildings are more compliant and therefore safer than they have been. Finally, average summer temperatures in the UK have been increasing and this has meant more heat related problems impacting theatre availability due to problems with the equipment installed to cool the theatres in the summer months. Over the winter, significant time has been invested in improving the provision of the cooling equipment to ensure more reliable theatre cooling and we are looking forward to improved theatre availability during the summer.

The estates and facilities compliance and business team plays a crucial role in ensuring that the Trust's patient environment is safe, efficient, and compliant with regulatory standards. Some of the achievements this year have included:

- Developing new fire strategies for Trust buildings to assist with future refurbishment design and investment.
- Reviewing critical infrastructure risks to prioritise investment.
- Implementing a new computer aided facilities management system to ensure that facilities are well-maintained, safe, and conducive to patient care.
- Strengthening emergency preparedness and resilience by reviewing contingency plans for power failures, extreme weather, and facility-related emergencies.

The compliance and business team were proud to be nominated for supporting and enabling the wider estates, facilities and campus development (EFCD) team and were shortlisted for the We Are UHS Champions awards for the team recognition category in October.

3.4 Our commitment to sustainability and the environment

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

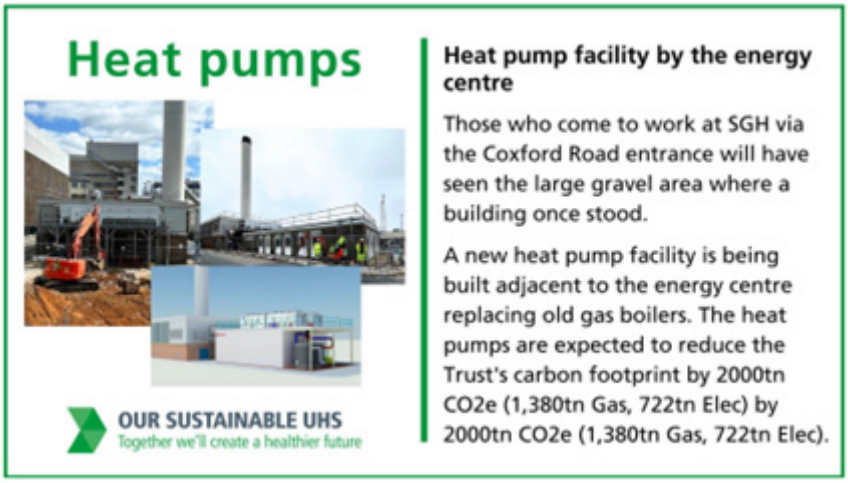
We understand the negative impact of some of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same. Environmental sustainability and sustainable development are integral to all that we do here at UHS, and we feel it should factor 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 in 2022. It outlines how we as an organisation are planning to help address these issues at a local level. Early this year, NHS England published updated statutory guidance to help NHS organisations develop and refreshed green plans to improve care, reduce costs, and minimise waste to continue the NHS' journey to achieving net zero. UHS will be taking steps to refresh the existing green plan and have it approved by Board and published by 31 July 2025.

During this year, we have continued to work towards becoming a more sustainable trust. Progress on ambitions declared in our Green Plan mostly focussed on governance and leadership, estates and facilities, clinical initiatives, air quality and education, digital transformation, travel and transport, waste management, food and nutrition.

In addition to the appointed executive sustainability board lead and its sub-groups, UHS has recently approved a significant increase in investment into clinical leadership for sustainability. This will enable the appointment of divisional clinical leads for environmental sustainability, a lead sustainability pharmacist, and a sustainability matron. These appointments will position UHS at the forefront of reducing environmental harm from healthcare delivery, while also cutting costs and enhancing patient care. The Trust continues to roll out a package of energy efficiency improvements as part of the £29.4 million decarbonisation grant to ensure that our buildings can cope with the impact of the changing climate and reduce our environmental impact.

Works continue with the construction of a new heat pump facility aimed at replacing the old gas boilers. The heat pumps are expected to reduce carbon footprint by 2000 tonnes CO2e.



This year, we also increased the site's LED coverage to 70%. The additional 1,300 efficient lights fitted will generate annual savings of £83k per year with 47 tonnes CO2e reduction.

A solar car port has been designed to go on top of the multi storey car park 4. The 247kW solar panel system will significantly increase our renewable onsite generation. Once completed this year it will generate about £83k financial savings and reduce carbon emissions by 47 tonnes.

The Trust also completed the replacement of 20 Split air conditioning units across lab and path, neuro, South Academic Block and Centre Block as well as six air handling units (AHUs). The new units are more energy efficient and expected to save £95,194 on utilities bills and saving 113 tonnes CO2e.

In January 2025, the Trust received £100k from the NHS Energy Efficiency programme to expand the electricity live sub-monitoring system at SGH. This system enhances visibility and understanding of power usage in buildings, enabling targeted actions to reduce energy waste. It also provides insights into essential and non-essential loads, which is crucial as service demand increases.

We are gradually phasing out fossil fuels by replacing diesel oil used to power localised standby generators with hydrogenated vegetable oil (HVO) an environmentally friendly alternative. This does not only contribute to the local air pollution reduction, but to a drop of 212 tonnes of CO2e with financial savings of £13,804 on Environment Agency fines.

Inhalers account for 3% of the NHS carbon footprint. In the paediatric ED, we have stopped discarding inhalers after a single use. The propellant gas in pressurized metered-dose inhalers (pMDIs) is a very potent greenhouse gas. In collaboration with our infection prevention team, we have instigated a policy that allows staff to reuse these inhalers multiple times, saving money and benefiting the planet.

We have received a grant to completely remove piped nitrous oxide from the Trust and replace it with safer, cheaper, and less wasteful cylinders. The rationale for this change is detailed in last year's report. The transition will be completed by the end of March.

In theatres, single-use plastic caps are being replaced with reusable cotton caps. Each staff member will receive three personalized caps, leading to significant financial savings, reduced plastic waste, and improved safety in theatres through better communication.

In our ophthalmology department, we are transitioning from single-use eye drops to multidrop devices in both outpatient and inpatient areas. This change will help reduce costs and decrease the use of single-use plastic.

On 23 April 2024, a range of clinical staff attended an air quality session facilitated by Dr Malcom White on behalf of Global Action Plan. The session covered the sources, health impact and how clinical staff can discuss the matter with patients, both adults and children. A new air quality group has been formed which will meet quarterly to ensure the learnings are taken forward.

This year, some of the efforts made by the digital transformation team to embed sustainability within their workstream included:

- The redeployment of rarely used Trust computer devices: a recent review by the digital team identified a substantial number of devices that have not been logged into for six weeks or more. The digital department aims to reclaim these unused devices and redeploy them to areas where they are most needed. This initiative is expected to reduce waste and improve efficiency within the Trust.

• Transition to sending appointment letters by text message: in February 2025, 50,000 links were sent, and 31,000 were opened, resulting in a saving of 100,000 sheets of paper. Each paper letter not sent saves approximately £2. If a link is not opened within three days, a paper copy is sent as a backup. This method ensures quicker communication, provides confirmation of receipt and opening, and is environmentally friendly.

- Improved recycling and reuse of old equipment: previously, old equipment was taken away with minimal reuse or recycling after being wiped. The Trust has now engaged a new service provider, ensuring that zero equipment will end up in landfill. Instead, 70% of the equipment will be reused or recycled, generating approximately £100,000 in income.

In the travel and transport area, some progress has been made with the development of a new travel plan to support active and sustainable travel for staff, patients and visitors. The plan is currently going through the final stage of approval. Additionally, the Trust has taken a step to electrify its fleet vehicles. During the lease renewal this year, two internal combustion cars were dropped, and four electric vehicles (EV) introduced. This switch to EVs will contribute to the reduction in air pollution from the Trust's transport fleet. Since September 2024, the Trust has been hosting monthly cycle skills workshops. These sessions aim to promote and support staff towards more active travel alternatives. The December workshop was attended by 13 staff members.

Our waste management team has made significant strides in streamlining our waste collection processes, reducing frequency from daily pickups to just three times a week. This transformation not only enhances our operational efficiency but also minimises the environmental impacts of waste disposal.

Compliance in theatres has increased from 20% to over 90%, saving over £80,000 annually and reducing hundreds of tonnes of CO2. The comprehensive approach to waste management in theatres has led to waste ambassador training being offered to staff to allow the roll out of the theatres waste project to all other areas.

The new sustainable spring/summer menu was launched in May 2024. For the first time these have been re-ordered based on the expected carbon intensity of the protein content. In addition to re-ordering the menu, the team also introduced new smaller portion options to reduce waste and a couple of tweaks to recipes to reduce the carbon intensity. This is a great example of sustainability being baked into decision making and a partnership effort from everyone involved across UHS and Serco.

3.5 Our commitment to staff

In 2022 the UHS people strategy we made a commitment to create a workplace where our staff can thrive, excel and belong. During 2024/25 we have continued to achieve against the commitments set out in the strategy, and within our inclusion and belonging strategy.

We have continued to invest in our leaders and managers, and against our objective of ensuring our workforce is reflective of the communities we serve. We have fully implemented our leadership pathway offering development opportunities for new and emerging leaders, through the organisation to our senior leaders. Over 500 leaders participated in developmental offers in 2024/25, with alumnis positively contributing to improvements across the organisation. We continued with our successful Positive Action programmes to ensure our senior leaders at UHS are representative of our communities, with over 65 leaders participating since the programme began in 2023, and 17% of participants achieving promotion or taken progressive roles since the programmes began. In 2024/25 we also piloted targeted development centres as part of our positive action programmes, providing simulated recruitment practice and feedback, career coaching, and strengths profiling.

We have continued to encourage collaboration and connection across the organisation. In 2024/25, we successfully launched Proud2bAdmin and Proud2bOps networks at UHS, supporting the recognition and development of administration and operational colleagues. As a local member of the national Proud2b movement UHS colleagues are able to access training, mentorship, networking and resources to support local improvement at UHS.

#Proud2bAdmin
AN ADMINISTRATIVE MOVEMENT

#Proud2bOps
AN OPERATIONAL MOVEMENT

With the support of our Armed Forces Network, we were delighted to achieve the Silver Award within the Armed Forces Covenant, this enables us to strengthen the support we give to veterans and reservists.

As we continue to improve safe and supportive working environments, we have reached the milestone of over 10,000 staff attending our actionable allyship training to support a healthy speaking up culture and enable people to take action in the event of discrimination or harassment. In addition, we have increased our Freedom to Speak up infrastructure within local teams, and continued with action to tackle violence, aggression and promote sexual safety. As a result, we have seen an improvement in people feeling more confident to report bullying, harassment, violence and aggression in the 2024 Staff Survey.

In partnership with Southampton Hospitals Charity we have continued with our ongoing programme to refurbish staff rest rooms and support staff wellbeing, we have also made improvements to facilities within our chapel benefitting both staff and patients.

We were pleased to have been awarded the highly commended in the Best Public Sector Benefits category in the Employee Benefits Awards 2024 in recognition of our support for staff financial, emotional and physical wellbeing.

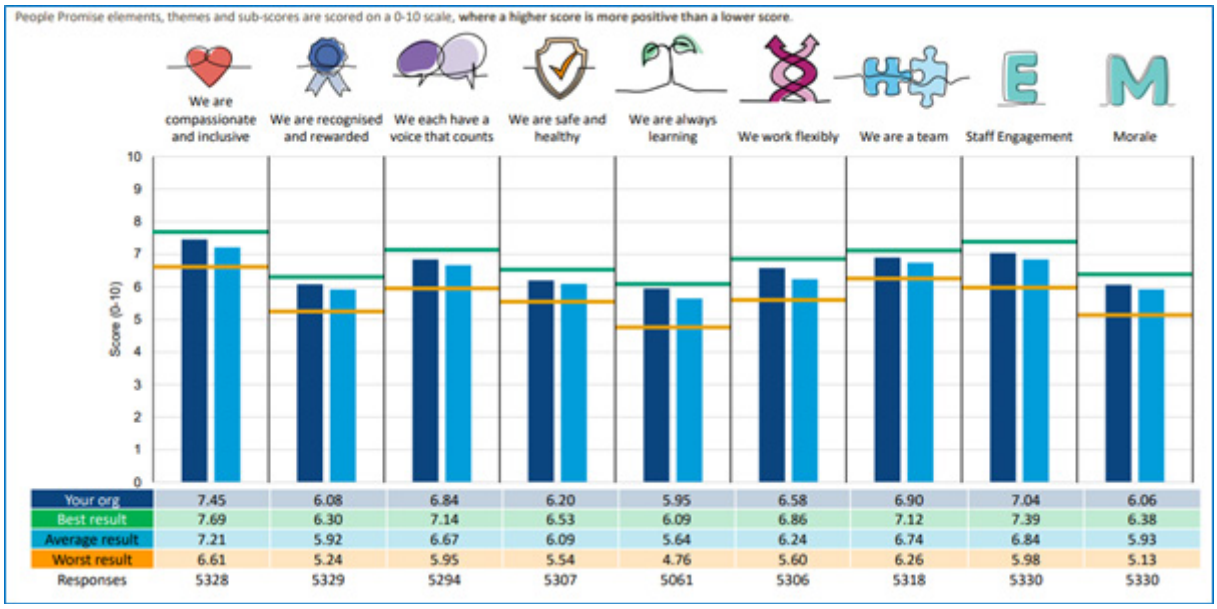
Our reward programmes has continued to thrive in 2024, with over 6,800 staff members nominated through our recognition programme. These nominations highlight the extraordinary contributions made by our dedicated team, whether it's through their clinical excellence or invaluable support in non-clinical roles. As part of We Are UHS week 2024, we proudly celebrated the UHS Champions Awards at a special ceremony at the Hilton Ageas Bowl. This year saw the largest uptake to date, with over 600 nominations across various categories that reflect our core values, further demonstrating our commitment to recognising outstanding contributions from both clinical and non-clinical staff.

In addition to our annual awards, we continue to celebrate our Monthly Stars, receiving 147 nominations throughout the year. These are presented at a monthly spotlight event hosted by David French, our CEO. This event is a fantastic opportunity to celebrate the achievements of our staff, as well as recognise external awards and long service milestones. Following each event, our recognition is shared widely through a monthly publication that has received over 5000 hits, ensuring that the hard work of our staff is acknowledged throughout the organisation.

Our HIGH5 initiative is another unique and impactful way we recognise our staff. Launched in May 2023, this peer-to-peer recognition programme allows staff to celebrate each other's contributions in simple yet meaningful ways. From day-to-day actions that make a colleague's work easier to moments of exceptional teamwork, these recognitions are paired with a certificate that highlights the recipient's positive impact. Since its launch, we've sent 6,016 HIGH5s - a really encouraging metric demonstrating the importance of celebrating and recognising each other. We believe this to be the first system of its kind in the NHS.

The annual NHS staff survey continues to be the largest mechanism which enables us to gauge how staff are feeling, and their experiences at work.

Overall, despite the significant challenges, UHS trust-wide results remain above average across all the NHS people promise themes. UHS is ranked 18th nationally for recommendation as a place to work. We have continued to see improvements in terms of flexible working options, satisfaction with immediate managers, and confidence in reporting violence, aggression, bullying and harassment.



	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	7.45	6.08	6.84	6.20	5.95	6.58	6.90	7.04	6.06
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	5328	5329	5294	5307	5061	5306	5318	5330	5330

Data source: NHS Staff Survey

3.6 Our commitment to education and training

As a university teaching hospital, the training, development and support of our current and future workforce lies at the heart of what we do. We aspire to the highest standards to ensure our staff and students are equipped with the right skills and are supported to deliver the best quality care to our patients. This year we have made good progress in several areas in this endeavour.

The NHS England Safe Learning Environment Charter (SLEC) was launched in February 2024. This charter focuses on the ten components of clinical learning including induction, communication, flexibility and positive identity. This national charter is being rolled out within UHS for non-medical learners in the first instance with the first workstreams around:

- Updating pre-placement information that learners can access as they begin to familiarise themselves with the clinical learning environment and opportunities. This information will support learners to understand the clinical area that they will be attending with both generic and specific information dependant on placement.
- Using the SLEC framework when undertaking student forums – this has proved very positive within midwifery where the outputs from learners has led to a very comprehensive action plan and development of new SLEC based information.
- Local universities have agreed to support the implementation of at SLEC based learner evaluation – this has begun to roll out and will link with action planning.
- Enabling placements and organisations to consider their position in terms of supporting learning with a maturity matrix. With some key components of the SLEC model being supported across UHS, the 2025/26 workstream will be to implement the use of the matrix in terms of an initial assessment, create action plans and then reassess. This will support in line with the CQC approach

of moving from a "reassure to assure" position and enabling students to learn in a positive, supportive and caring environment.

During 2024/25, UHS has supported over 60 international nurse candidates through a nursing and midwifery objective structured clinical examination (OSCE) preparation programme, which is a decrease in numbers from the previous year. This programme has relocated back to the UHS site which enables the delivery of a more flexible programme. International recruitment of candidates has now been paused in line with the national approach, and the Trust is now focusing on providing support for registration and opportunities for OSCE preparation to internal candidates who are employed at band 2, 3 and 4 to enable them to reach their goal of UK registration.

Within the allied health professional (AHPs) several workstreams have been supported with an educational focus. These include:

- A quality improvement (QI) methodology being used to support a pilot educational programme within our clinical support services. This QI project relates to physiotherapists, occupational therapists, dietitians and speech and language staff who are registered or qualified support workers, and the focus is to increase confidence and competence in conducting clinical audits to enhance clinical practice. Outcomes have significantly increased these staff satisfaction metrics, and we aim to deliver more training, practical workshops and coaching to support further practice developments linked to improved clinical effectiveness.
- UHS has implemented Schwartz Rounds within preceptorship programmes for AHPs, nurses and midwives. Staff evaluation has shown a significant correlation between positive staff experience, wellbeing, team working and compassionate care. The Trust is now purchasing its first license and training more facilitators to be able to launch these rounds as a reflective space for healthcare workers (clinical and non-clinical) to reflect on the emotional impact of their work. This will support our people plan, inclusion and belonging strategy and wellbeing strategy to give staff space and time for reflection, connections and empower their voice within the organisation. This should support ongoing wellbeing, retention and organisation culture gains. The Wessex Schwartz Consortium and University of Southampton collaborated on research evaluating the impact of Schwartz Rounds. The research paper is due to be published summer 2025 to showcase our work in partnership with other local trusts and higher educational institutions (HEIs).
- The AHP education lead has introduced a cultural competence for line managers training package (©Seventeen Seconds) to AHPs, nurses and midwives to enhance the knowledge, skills and behaviours of supporting and managing all staff. Funding for this initiative was won through the "stay and thrive" NHS England funding and will support all staff with developing cultural competence within their professional practice through e-learning and facilitated workshops.

Preceptorship (support for newly qualified staff in their first year of registration) is embedded within UHS for all newly registered nurses, nursing associates, midwives, AHPs and return to practice staff. There are national frameworks for each group, but UHS extended this further by successfully piloting this with health care scientists (HCS) last year. This has led to more HCS colleagues joining the programme. Whilst there is not a national framework for this group of professional, UHS felt it important to be fully inclusive in our multi-professional preceptorship.

Overall, in 2024/25 UHS has supported 335 preceptees.

Preceptee and preceptor meetings require protected time to ensure effective planning for the preceptee development. These have historically been challenging to monitor, so the team developed an online system to enable the seamless achievement of documentation and a more accurate measure of compliance. This approach has been effective and has encouraged engagement in these essential meetings across all professions.

UHS has designated preceptor champions within education and clinical areas to promote preceptorship. This year has seen the first 17 nominated champions being recognised for working above and beyond in their role. This is an esteemed accolade for our preceptors, who have been nominated by preceptees and matrons over the past year.

In line with valuing our preceptors, UHS has launched its first designated preceptor development days to deliver a structured and comprehensive career progression approach.

To ensure a robust and effective programme is provided, preceptees were invited to appraise their preceptorship through written evaluations and forums. This provides essential information which will support the future planning of programmes. Some of the most current data demonstrates that 100% of preceptees felt welcomed at the start and 70% felt they had gained confidence at the end of preceptorship. Retention data is also collected, collated and shared as a way of recognising how preceptorship can impact on the retention of our early careers staff. In the most recent review, there was a significantly improved reduction in two yearly turnover of newly registered staff across UHS.

In September 2024, the intake of staff to the scientist training programme (STP) was 14, two in-service and 12 direct entry. This takes our current number of trainees to 45 across many specialties. We have received accreditation by the National School of Healthcare Science (NSHCS) for all our current programmes, most recently clinical scientific computing and respiratory and sleep science and prospectively pharmaceutical science for the 2025 intake.

Our STP training officers have designed a learning contract which we have shared with the NSHCS as part of good practice at their request.

Our pharmacy education team continue to work with our partner universities on developing the placements for the new MPharm course including supporting students to reach the prescriber-ready status which will be required on graduation in June 2025. They also continue to grow the number of pharmacist prescribers in the Trust, currently sitting at 74 trained and registered with 12 in training, some about to register.

The pharmacy team support both L2 and L3 apprenticeships for support workers and trainee pharmacy technicians.

This year our skills for practice team continue to deliver and support several established education programmes to both internal staff and external partners as well as implementing new courses such as Making Every Contact Count/Health Conversation Skills training. A key achievement has been the delivery of objective structured clinical examinations (OSCEs) to second, third and final year medical students in April, May, and July 2024. The skills for practice team are working closely with the University of Southampton Faculty of Medicine to develop and implement a revalidated curriculum which will see an increase in the delivery of clinical skills and simulation training across the curriculum.

Our biggest staffing challenge in 2024/25 continues to be the recruitment and retention of health care support workers (HCSW). Trust-wide focus continues to reduce turnover for HCSWs, 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. Completion of the Care Certificate for all non-registered clinical support workers continues to be a requirement and compliance remains high at over 91% trust-wide. Skills for practice continues to operate the health care support worker hub which became a substantive service in the summer of 2024, this team deliver the support worker development programme to all new HCSWs and provide

ongoing pastoral support to all support workers. Further training opportunities are being offered to both clinical and non-clinical support workers including the roll out of the higher development award (HDA).

A successful programme of housekeeper study days has started this year with high attendance.

UHS continues to provide high quality, real-world placements to further education (FE) college students (age 16 to 18), on a variety of T level programmes including health, digital and estates. UHS is working in partnership with Richard Taunton, Eastleigh and Fareham colleges and have this year (2024/25) provided a total of 75 clinical placements across multiple specialities including adult and child health nursing, midwifery and AHPs, as well as non-clinical placements with our digital and estates teams.

UHS has successfully recruited students on completion of their studies into nursing and midwifery support worker roles and many aspire to complete an apprenticeship with the Trust.

The importance of partnership working with colleges to prepare their students for placement, by providing specialist teaching and induction, is key to their success. Looking forward, UHS have started working with UTC Portsmouth to develop T level placements in healthcare sciences to support local students and future NHS staffing requirements.

UHS has started 1,147 apprentices since our apprenticeship journey began in 2017. There are 469 apprentices currently studying, of these 314 are clinical degree apprenticeships which includes nursing, occupational therapy, midwifery, operating department practitioner, healthcare sciences and youth worker. The remaining non-clinical apprentices include early years educator, learning and skills teacher, academic professional, senior leader, trades and estates.

There have been 81 apprentices who have undertaken more than one apprenticeship, and some of these are on their third. Attrition on programmes has improved year on year with overall attrition under 5%.

Advanced practice (AP) services have evolved organically over the last 20 years in the Trust. The organisation has been at the forefront of establishing this workforce and introducing AP roles within services.

Following external benchmarking and evaluation, a trust-wide career pathway for APs was established and the levels of academic requirements, along with scope of practice and level of decision making was standardised. In specialties where credentialing is not available, a trust-wide process and standard that is equitable to credentialing was implemented to demonstrate scope of practice and capabilities in practice.

Currently we have 240 staff in advanced practice roles. Trainees gain their MSc in advanced clinical practice either via an apprenticeship pathway or a commissioned pathway. Since evaluation and standardisation, we have seen larger numbers of experienced practitioners applying for roles and an improvement in our retention.

Overall, the picture for medical education at UHS has remained positive for 2024/25. GMC survey feedback demonstrated some areas of good practice (clinical genetics, infectious diseases, palliative medicine, rheumatology and urology). Concerns remain in general surgery and the department remains in enhanced monitoring with the GMC; although significant improvement was noted at a NHS England/GMC visit in autumn 2024 and the risk held with NHS England was downgraded.

We continue to work on improving induction and survey trainees on their local induction. Trainers highlighted concerns regarding time to train whilst delivering service in the busy clinical environment.

We have many locally employed doctors (LEDs) and continue to collect feedback on their experience. A cultural review was undertaken in trauma and orthopaedics with strengthened support for LEDs. Feedback to date has been positive. Our LED charter has been updated and relaunched, setting out what should be offered in terms of education and support. We have evolved our in-house educational supervisor course to include a session on LEDs. All doctors new to the NHS are given an extended shadowing period before they start. We have appointed a portfolio pathway (formerly certificate of eligibility for specialist registration) lead who provides additional support and advice and will be hosting a portfolio pathway study day in May.

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. There have been changes regarding the updates and providing feedback to the GMC, but as a trust we will still expect supervisors to complete the required CPD. Consultants can choose from courses according to their needs and their areas of work. In the past year we ran five educational supervisor updates with an attendance of 10-20 people. We have updated the course to include more on supervision of locally employed doctors. In addition we continue to run our inclusive leadership training course. We evaluate all the supervisor update courses, and the feedback is excellent. Furthermore, we collected feedback from our inclusive leadership training and shared this with NHS England South East who chose to showcase it at the education funding agreement self assessment webinars.

We continue to run a new consultant development programme and this year the chief registrar launched a development programme for registrars. Where needs overlap, these sessions have been amalgamated, allowing shared experience and better preparation of senior trainees for starting consultant posts. We have run additional supportive courses including managing conflict for surgical registrars and empowering women in medicine, which have received outstanding feedback. We have a regular education grand round allowing networking and learning for anyone interested in undergraduate and postgraduate teaching. In addition we have launched workshops for resident doctors to learn about opportunities for delivering education within the Trust, to encourage their participation. In 2024 we introduced the ALERT course to deliver simulation training on acutely deteriorating patients for multi-disciplinary teams. We are building on this and undertaking a project to write new programmes that can be tailored to the needs of individual groups.

UHS continues to fulfil its responsibility as the principal placement provider for the University of Southampton medical school, with clinical attachments for students throughout the curriculum, from the birth experience and emergency department experience in year one to the final year placements and assistantships, in over 60,000 education sessions. Following considerable work over the last few years, the visibility of placement funding in care group budgets is now complete and allows individual departments to see the income and support the delivery of excellence accordingly. This has led to the appointment of new placement leads and deputy placement leads in year three and year five medicine and surgery, as well as consolidation of the current positions in other areas. This has allowed the year three medicine and surgery placement leadership teams to ensure we were able to support the increasing number of students on placement from January 2025, by redesigning induction materials, expanding the placements available and use of novel non patient facing clinical teaching. We have maintained the support for administration staff in the computer aided facility management (CAFM) team, including a new appointment following a retirement.

Following a thorough consultation and review of clinical teaching fellow provision, the Trust was proud to support the appointment of two new medical student clinical teaching fellows (CTFs), to take the team to three WTEs. This has brought UHS more in line with other placement providers of a similar size. There is also increasing support for 'part-time' CTFs within placements, most notably surgery, paediatrics, and emergency medicine. Furthermore, we have appointed 0.8 WTE CTF for postgraduate medical education, one WTE for medical education research and have one WTE specialist foundation post in medical education. Together, this team is delivering a range of education related projects alongside bedside teaching on demand, simulation training for third year medical students new to the wards, and multiple small group sessions including to foundation doctors. Our medical education research program, a joint enterprise with the University of Southampton, is expanding and thriving. We have been awarded two grants, one to research medical student placement capacity and the second to look at educators' experience of giving feedback to postgraduate learners. Both will report in 2025. One publication has been accepted and another is under review.

We have formalised the arrangements for the provision of electives to UK and international medical students and are pleased that in partnership with the University of Southampton we are now able to offer selected numbers of these placements.

All University of Southampton medical students in all years of the BM4, BM5, and BM6 programmes now have UHS identity cards. These cards allow access to appropriate clinical areas and give access to other staff benefits such as the wellbeing hub and gym and staff discounts on food.

Looking forward, the team is already planning how to continue to improve both the education delivered as well as facing the challenges of ensuring we are able to support increasing numbers of students as part of the long term workforce plan.

Doctors development unit (DDU) – now part of UHS coaching

The DDU has been running for four years. Over 25% of consultant staff have now accessed the coaching service since it started. 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 can depend on to provide safe patient care. Our evaluation in 2023 shows that the investment is worth it. Consultants appreciate the space and coaching provided, whatever the reason they approached the service. The service keeps people at work, gets them back more quickly when they are off and keeps them working for UHS. In recognition of the proven benefits and working with organisational development, UHS coaching was set up in April 2024 led by The medical DDU lead and the head of nursing for education. The faculty now has 32 qualified coaches, including 17 consultants as well as coaches from a broad variety of backgrounds, both clinical and non-clinical. Another 15 people are currently working on completing their qualification. The multiprofessional faculty are supported by weekly drop-in catch-up meetings for peer supervision and monthly coaching clinics with an external expert coach. 2025 will see the training and qualification of our first internal coach supervisor and some workshops for coaches on working with those recommended for coaching because of professional concerns which has been an increasing part of DDU workload in 2024. In addition to this work, 2025 will bring the opportunity for clinical and care group leads and managers to undertake a coaching conversations course (also available on VLE) with our experienced external coach facilitator. This course was highly rated by two cohorts of matrons who did the course in 2024.

Workforce

UHS has embedded systematic evidence-based and triangulated methodological approaches to regularly review staffing levels linked to budget-setting and service requirements. This is a

collaborative process involving divisions, workforce and finance.

UHS continued to further integrate work between various departments and services to align our internal direction with national policy initiatives such as the NHS People Plan, NHS England and NHS Improvement focus on strategic workforce planning.

Workforce key performance indicators and workforce planning data (including forecasting) 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. These are also reviewed monthly with each division and weekly with the ICB Community of Practice. A monthly staffing status and patient safety report is also submitted.

There are regular internal and external (to NHS England and Hampshire & Isle of Wight ICB) reports that have been provided throughout the year on workforce trends, key performance indicators (KPIs), and performance. Our focus is also on future forecasting and initiatives to reduce our reliance on bank and agency staff. UHS has reduced agency usage by 66% since January 2023, and reduced agency usage further by another 36% since January 2024.

There are now extra approval/control layers needing executive sign off for all agency and non-clinical/medical bank placements and dual approver requirement for nursing bank shifts before being released. New system functionality introduced ensures that available hours in the rosters are being used before a person can work additional bank shifts.

Some of the initiatives include reviews to streamline processes, improving the systems and supporting rostering managers to be able to utilise staff across functions, as well as have better visibility of shifts going out across multi-shift holders. We have managed to bring the full process of placing shifts, approving shifts and take up of shifts into the same rostering system.

Along with the weekly reviews of bank and agency, we are actively reviewing pay rates across the region to ensure there is consistency.

Regular (internal and external) workforce reporting and reviews include the following:

- Monthly people report.
- Vacancy report.
- Weekly and monthly workforce trends (substantive, bank and agency).
- Unavailability (headroom).
- Regular healthcare assistant tracker.
- Monthly appraisals.
- Allied health professional monthly return.
- Monthly divisional breakdown by cost centre of workforce trends (substantive, bank and agency).
- Care hours per patient day.
- Human resources (HR) divisional business partner reports (workforce data, HR data, EDI data, statutory and mandatory training, retention, bank/agency/overtime usage, financial detail).
- Monthly provider workforce return (PWR).
- NHSi monthly temporary staffing data submission via our temporary resourcing team.

From April 2024 to February 2025, there have been successful targeted recruitment in areas of need:

- Medical and dental - 91 WTE.
- AHPs - 17 WTE.
- Healthcare scientists - 19 WTE.
- Estates - 3 WTE.

- The Trust conducted enhanced recruitment of HCAs during January 2025 to combat high vacancy levels, yielding growth of 19 WTE in this staff group.

UHS completed and returned a self-assessment for NHS England and NHS Improvement on levels of attainment and were reviewed by the ICB roster optimisation team. The results continue to be positive, and our teams are working on sharing best practice and establishing benchmarking across the region.

Electronic rostering continues to be fully adopted for all Agenda for Change (AfC) staff and significant progress has been made with medic rostering and job planning. This will improve the workforce capacity and planning for all staff groups, identify gaps in service through accurate recording of activities delivered and identify income generated from activities to contribute to financial planning and objectives.

The Improving Working Lives (Doctors in Training) initiative was launched and UHS is making good progress in meeting the standards.

UHS were early adopters to ensure all previous statutory and mandatory training compliance is transferred over from previous trusts to prevent repetition of training, we are also supporting the digital passporting workstream.

The appraisal process has been improved with new functionality deployed within our virtual learning environment which supports a better quality of conversation and review whilst also enabling better metrics to improve staff pathways with their development and learning.

3.7 Our commitment to clinical research

Research is how we drive better health and healthcare, and 2024/25 saw yet more progress. We changed lives, driving greater inclusion and improved access to cutting edge treatments.

Changing lives
In 2022 former royalty protection officer Allan Peters was diagnosed with terminal cancer. He put his affairs in order and began arranging his own funeral. The newly crowned King Charles sent him a letter of condolence.

Two years later, in July 2024, Allan was cancer free.

That was thanks to revolutionary CAR T cell therapy at UHS. This sees a patient's own immune cells collected and modified to kill their cancer. In 2023, UHS became the first hospital in the South East to offer CAR T - with Allan only the fifth person to receive it.

"I am so grateful to the medical teams that made this happen – it really is like a miracle cure."

Our years-long role in CAR T's research was crucial to this early access. And our Southampton Emerging Therapies and Technologies (SETT) Centre continues to drive work in advanced therapies. That includes studies leading to approval of gene therapy for haemophilia B.

Haemophilia B is a rare genetic disorder that prevents blood clotting. For the 2000 UK people affected even small cuts can be life threatening. They must inject clotting factor IX protein weekly to protect themselves.

The Hope-B trial of Hemegenix, led by UHS consultant haematologist Rashid Kazmi, has changed that. Hemegenix is a one-time infusion, inserting the factor IX genetic code into body cells. This allows the cells to make their own factor IX, raising levels without the need for injections.

John Curley was one of around 50 participants in the study: "It's amazing to think that something I was told was incurable can now be effectively managed with a single-dose treatment. It's revolutionised my life physically and psychologically. I hope that haemophilia will be nothing but a distant memory in 30 years time."

Treatments resulting from UHS research in other areas also entered NHS use this year. Other National Institute for Health and Care Excellence (NICE) approvals included:

- Blood cancer: a new combination treatment for chronic lymphocytic leukaemia (CLL). Trials involving UHS patients showed 58% of people were clear of cancer within three years.
- Cystic fibrosis: the drugs kaftrio, symkevi and orkambi treat the root cause of the disease, bypassing its genetic cause. Over a decade of trials involved UHS researchers and patients, working with maker Vertex.
- Stroke: clot-busting drug tenecteplase, recommended as a treatment option. Based on results from a national trial involving dozens of UHS patients.

Acute hospital, acute healthcare research

Every second counts in stroke, to restore blood supply to the brain and limit lasting damage. UHS hyperacute stroke research centre experts showed that video calls cut treatment times. An average of 20 minutes were saved by paramedics video calling the team to assess patients. Dr Richard Marigold, part of our research leaders programme, led the work:

"For every half an hour you delay treatments in this setting, patients have a 10% less likely chance of returning to independent living. We envision this becoming part of routine clinical practice and hope it will be rolled out across Wessex in the future."

Surgery is core to our care as an acute hospital, and our research continues to improve outcomes:

- The ORANGE II Plus trial showed faster recovery with less invasive keyhole surgery for liver cancer. This saw patients start other treatments, like chemotherapy, faster.
- Surgeons at Southampton Children's Hospital (SCH) became the first in the NHS to use a surgical robot in children's kidney surgery. Results from the landmark trial will guide use of the robot - which enables complex procedures on the much smaller tissues of children.
- Key studies defined better body fluid support during surgery and showed the value of 'surgery

schools' for patients. The findings show that pre-surgery group classes are associated with better recovery and fewer complications.

Other research highlights across our services included:

- Promising results for a new weight loss drug.
- A stick-on breathing sensor giving early warning of patients becoming unwell.
- Identifying benefits of aspirin in preventing cancer in people with diabetes.
- The first positive treatment data in a decade for a rare lung disease.
- Use of microbubbles to heal bone fractures.
- Tackling severe allergies by eating small amounts of the allergen.

Access to trials

Key to these successes is our belief that every patient and staff member should have the chance to be part of research. We combine that with leading roles in regional and national networks. In 2024/25 new collaborations included:

- Hosting a new centre, delivering trials at research hubs across our region.
- Southampton Clinical Trials Unit becoming the national personalised cancer vaccine centre, matching thousands of participants nationwide to trials.
- Joining a £50m national dementia trial network, finding new tests and treatments faster.

All this saw us open a wide range of new studies and trials, not only supporting our services, but also detecting and preventing disease before the need for acute care.

Early diagnoses - vital and fairer

Early, simple diagnosis is key to better quality of life and survival across diseases. It's also key to tackling health inequalities, bringing tests closer to those with poor healthcare access.

In 2024 two studies aiming to do this in dementia launched. The first is trialling blood tests for alzheimer's and other forms of dementia. Over 5,000 people nationwide will help test these less invasive alternatives to current scans and lumbar punctures. In the second, Southampton researchers will develop a portable testing device. This uses a new, 93% accurate, laser-based technology developed at the University of Southampton.

In cancer, DETECTION-2 is trialling a simple blood test for melanoma. This aggressive skin cancer can return after treatment, needing careful monitoring. Frequent use of the blood test could give early warning outside of in-hospital scans. Two further studies are trialling multi-cancer blood tests. They will look at new one-stop tests covering multiple cancers.

Prevention and healthy living, across the lifecourse

Helping people be healthy, avoid hospital and relieve NHS pressures is a priority for us all. Our researchers continue to lead on this, across the lifecourse.

Professor Keith Godfrey leads the new £50m NIHR Challenge Maternity Disparities Consortium. This national collaboration will develop better care and support before and between pregnancies. This builds on work including research begun in 2009, key to NHS advice on vitamin D in pregnancy. It showed that infants born to mothers taking extra vitamin D had higher bone mass. Now new data published in November 2024 showed that this persists to age seven, reinforcing the value of this approach.

In July 2024 we opened a trial to pregnant mothers, tackling respiratory syncytial virus (RSV). RSV hospitalises many babies and young children, killing 20 to 30 infants each year. RSVoyage will test whether vaccination during pregnancy protects babies from birth.

Air quality is a key factor in respiratory disease and allergy. This year we joined a regional collaboration - Clean Air South - to coordinate research. It aims to deliver evidence for better air quality policies and management. It will support studies such as our February 2025 finding that car brake dust particles can be more toxic than diesel exhaust fumes.

A study into better diagnosis of urinary tract infections (UTIs) in care homes launched in June 2024. Preventing distress, antibiotic resistance, and unnecessary or long hospitalisations is a key focus. Other work showed that loneliness inhibits older patients' recovery after a hospital stay. This is informing better discharge planning and support.

Engaging for inclusion

Increasing inclusion is a key focus for our research. It's key to studies that deliver results benefiting all and tackling inequalities.

UHS is one of only two sites in the South giving access to the Improving Black Health Outcomes (IBHO) initiative. It aims to improve clinical outcomes and tackle health inequalities.

The IBHO BioResource will explore how Black communities develop and experience a range of health conditions. These include sickle cell, diabetes, cardiovascular disease and kidney disease.

People from Black ethnic communities have long been under-represented in health studies. That increases the risk of resulting knowledge and treatments not working for them.

Southampton father Ardel Richardson, 38, joined the programme In March 2025: "We need to be proactive. Research programmes like this are key to improving our knowledge and understanding of how these conditions impact Black communities."

Our research community engagement and public and patient involvement teams' outreach activities included:

- Developing research nursing 'link' roles, involving staff in inclusive engagement.
- Mental health engagement with the regionwide Raising Voices in Research (RViR) partnership, in support of NIHR Applied Research Collaboration (ARC) Wessex research.

- Piloting a new governance model, inspired by the viking tradition of 'Things' - twice yearly meetings. Our version brought staff and a diverse cross-section of the public together to shape how research is done.

LifeLab, the health and science engagement programme based at UHS, continued to inspire school students. It received a Royal Society for Public Health award. This recognised their efforts to improve young peoples' health literacy. This year that included a two-day summer school, attended by pupils from 25 schools across Hampshire and Dorset.

Award-winning research
Pioneering staff across our hospital received national and international awards in 2024/25:
Professor Chris Edwards received the AESKU Lifetime Contribution to Autoimmunity Award. A leading expert in inflammatory rheumatic diseases, he has been a consultant rheumatologist at UHS for 23 years.

- Dr Cathy McKenzie and Dr Jessica Bate secured NIHR senior clinical and practitioner research awards. This follows their time on the UHS research leader's programme. This new award supports the next stage of their careers as research leaders.
- Dr Sophie Fletcher received a national award for clinical impact. It recognised her work turning research into better care for fibrotic lung disease.
- Three Southampton researchers became NIHR senior investigators. Professors Miriam Santer, Nicholas Harvey and Tracey Sach are part of our NIHR Biomedical Research Centre (BRC).
- Professor Philip Calder, also part of our BRC, received a lifetime achievement award by the International Society for the study of fatty acids and lipids.
- Professor Tim Underwood was appointed to a national network promoting responsible artificial intelligence (AI) in health and social care. Professor Underwood leads a research team at UHS.
- We also picked up team prizes for COVID-19 and irritable bowel syndrome research, and for more environmentally sustainable research methods.

3.8 Our commitment to technology

The Trust has continued to commit to use of technology to deliver safe, high-quality, patient care in 2024/25.

UHS Digital has a wide portfolio of activities, including managing the Trust's IT infrastructure, protecting the organisation against cyber-security threats, and providing and maintaining vital apps and systems that help clinicians deliver patient care.

Some specific highlights which have benefitted patients and improved their experience includes the roll out of new systems, such as 'eClinic Manager', a video conferencing system that allows patients to attend video-consultations remotely without having to physically come to the hospital.

Medical oncologist Dr Ioannis Karydis frequently uses eClinic Manager for managing consultations with his patients. Minimising contact with other patients helps reduce the risk of infection explained Dr Karydis. He also pointed out that reducing travel is a benefit for patients.

Dr Karydis said: "Being able to do the whole consultation at home offers a large number of benefits for patients. Our patients very often tend to be on the older end of the scale and travelling to the hospital can be an issue."

Another recent highlight has been the ongoing transition to using digital messaging instead of paper letters to manage outpatient appointments. Since the launch of the 'digital letters' system in September 2024, the Trust has sent tens of thousands of text messages and emails instead of posting paper letters.

This has led to a more secure appointment notification service that allows patients to cancel or request to reschedule their appointments more easily. It has obvious financial and sustainability benefits, as well as reducing non-attendance of appointments.

UHS lead digital project manager Jayne Green, who has managed the roll out of the service, said: "Sending outpatient appointment letters digitally has made managing appointments much more convenient and more secure for our patients, and we are beginning to see improved appointment attendance as a result, which is great news for patients and staff alike."

As a commitment to supporting our staff with the increasing use of digital, we now have two clinical digital educators whose purpose is to focus on providing training and support to the ward staff so that we can improve compliance with nursing documentation and other clinical digital systems. This will lead to improvements in how we capture patient information which can be utilised to help facilitate an increase in the quality of care delivered to our patients.

3.9 Conclusion

We are proud of the significant improvements we've made in the quality of our services. However, we remain committed to our ongoing journey towards achieving excellence in every aspect.

This quality account allows us to thoroughly assess our progress and establish priorities for 2025/26. By setting clear goals and benchmarks, we can ensure that our efforts are focused and measurable. Future reports will provide quantitative measures against our targets, offering a transparent view of our achievements and areas for improvement.

We are confident that our priorities, processes, and plans are well-positioned to enhance patient care and hospital experiences. Our dedicated teams are continuously working to implement innovative solutions and best practices. As we strive for excellence throughout 2025/26, we will remain vigilant in monitoring our progress and adapting our strategies to meet the evolving needs of our patients.

Part 4: Appendices

Appendix A - National Clinical Audit: actions to improve quality identified during 2024/25

National audit title	Actions	Action update
1. The Renal Registry report published July 2024	• To review the blood results with IT to ensure the data is being sent to the registry. • To review the BP data as to why it is low.	Ongoing
2. National Vascular Registry report published July 2024	• To be raised within div D governance and discussed further in CAMEO in September an under resourced service which includes theatre capacity, beds, and staffing. • Business case to be developed to allow data entry for interventional radiology.	Complete Ongoing
3. RCEM Care of Older People report published July 2024	• To complete regular audits to ensure compliance. • To hold teaching sessions for new clinicians in the department.	Ongoing audit for 2025
4. Femail Genital Mutilation (FGM) Audit report published July 2024	• To rewrite the policy to include ED adults and adult safeguarding teams.	Complete
5. National Heart Failure (HF) Audit report published June 2024	• A plan to be put in place to audit the 20% who are not being seen by HF team. • A plan to be put in place to audit the 26% not being seen by HF nurse.	Plans in place audit to be conducted
6. National Cancer Audit Collaborating Centre - National Non-Hodgkin Lymphoma Audit report published September 2024	• To improve staging information at MDT. • To re-audit with more contemporaneous data.	Complete Reaudit to be conducted

National audit title	Actions	Action update
7. National Audit of Inpatient Falls (NAIF) report published October 2024	• Additional training to be provided to falls champions about deconditioning in older people. • Patient safety team and Trust falls lead to monitor after action reviews to establish if analgesia is given within 30 minutes of a fall resulting in an injury. • To ensure the changes to data collection are forwarded to patient safety team and actioned for the start of January 2025.	Complete Ongoing Ongoing
8. SSNAP stroke audit report published November 2024	• To develop further business cases to increase staffing numbers and bed capacity in line with national recommendations. • To work with community providers and the ISDN to increase number of patients discharged with early support discharge team and increase six month follow up plans. • A business case for stroke same day emergency care unit to manage mimics. • Radiology: further discussions about how to improve speed and access to imaging at the front door – CT/CTA and MRI. • Thrombolysis: the arrival of tenecteplase as a new thrombolysis drug that can be given more quickly and easily should improve thrombolysis performance, but delays in stroke recognition and assessment at the front door need to be addressed through further education with the emergency department teams, SCAS and through greater use of prehospital video triage.	All actions currently ongoing
9. National Early Arthritis Audit report published October 2024	• To appointment consultants for the early arthritis clinic management. • To provide waiting list initiative clinics at the weekend to catch up on waiting lists.	Complete
10. Case Mix Programme data for 2023/24 report	• To focus on delayed admissions to critical care. • Thames Valley and Wessex Critical Care Network working group to focus on improving capture of time to admit outside critical care. • To add the critical care follow up service onto the risk register.	Ongoing Ongoing Complete
11. National Audit of Primary Breast Cancer report published September 2024	• To circulate quarterly data collection reports to wider team. • To complete an audit on barriers to immediate reconstruction.	Ongoing

National audit title	Actions	Action update
12. National Audit of Metastatic Breast Cancer report published September 2024	• To perform an audit of biopsies for metastatic lesions.	Ongoing
13. Fracture Liaison service database report published January 2025	• To complete a service development project to maintain KPI 3 and KPI 4 post ADOPT study cessation. • To keep communication open with community partners to increase follow up compliance as currently red.	Ongoing
14. National Hip Fracture database report published September 2024	• To keep improvements going on pre and post op 4AT. • To discuss with OG and T&O on streamlining the administrative process for the two databases.	Ongoing
15. NCAP Acute Coronary Syndrome or Acute Myocardial Infarction report published June 2024	• To review with acute coronary syndrome advanced clinical practitioners team monitoring of reasons for delay in treatment.	Ongoing

Appendix B - Local Clinical Audit: actions to improve quality identified during 2024/25

Audit title	Actions	Action update
1. Trust-wide audit of cleanliness and decontamination of clinical equipment April 2024 (5581)	• Matrons and care group leads to ensure 37 areas that did not submit an audit complete as part of the infection prevention audit programme. • Nine areas scored below 85% to develop an action plan and re-audit within one month. • Five areas scored between 85% and 94% to re-audit within 3 months.	Complete
2. UHS personal protective equipment audit April 2024 (5588)	• Matrons and care group leads to ensure 40 areas that did not submit an audit complete as part of the infection prevention audit programme. • Eight areas scored below 85% to develop an action plan and re-audit within one month. • Four areas scored between 85% and 94% to re-audit within three months.	Complete

Audit title	Actions	Action update
3. Documentation of cardiac MDT (7357)	• Formulation of a cardiac MDT proforma.	Complete
4. Auditing electronic prescribing of oxygen supplementation for all admissions to cardiology department (7767)	• To put up a reminder at doctor's station in coronary care unit (CCU) to prescribe target saturations for all patients. • To arrange with CCU nursing team to include an oxygen prescribing tick-box to incoming admissions on the whiteboard.	Complete
5. DVLA advice in patients post MI: A retrospective study (7792)	• Implement face to face discussions with resident doctors and advanced nurse practitioners (ANPs) on changes to discharge summaries. • To send an internal memo to resident doctors and ANPs on the guidelines and intended outcomes. • To re-audit with data following implementation of recommended changes.	Actions complete Waiting for re-audit
6. Optimising management of acute traumatic central cord syndrome: Aligning evidence with practice in Wessex Spinal Service (7812)	• To present the data in local and national meetings to increase awareness and call for change in practice.	Complete
7. Capnography use in adult advanced resuscitation training (7828)	• Promoting additional clear and simple understanding for ALS course candidates surrounding the benefit of capnography, such as using the PQRST aide-memoire. This would fit in well during the associated resuscitation skills teaching station as well as be a useful easy reminder during later practice scenarios. • Consistent and helpful reminders and/or prompts by faculty during ALS course practice scenarios for candidates acting as the team leader and for supporting members of the group to think about using capnography when they have made an intervention to the airway.	Complete

Audit title	Actions	Action update
8. Storage of enoxaparin syringes and loose strips of medication at UHS (7829)	• To present results to medication safety team. • To present results and share report to PSSG. • To cascade report to relevant groups trust-wide including ward leaders and governance leads. • To present results and share report to nursing and midwifery training, development and practice group. • To continue to monitor/review Enoxaparin storage e.g. reviewing Enoxaparin incidents, carrying out spot checks, consider storage in a plain white box (ongoing as part of medication safety work). • To share guidance on Enoxaparin storage on medication safety Workplace page and pharmacy team brief to highlight awareness. • To feedback incidents to manufacturer to highlight issue with syringe packaging.	Complete
9. Audit of delayed cord clamping (DCC) rates in Princess Anne Hospital (7876)	• To add to theme of the week - neonatal and maternity. Aim to provide periprem education regarding DCC jointly with separate audit on thermoregulation. • Teaching session for neonatal team to disseminate audit results.	Complete
10. Naso gastric tube check chart audit (6316)	• To present results at ants study day. • To present results to nutrition and hydration governance group. • To feedback individual departmental results to critical care education leads.	Complete
11. The use of the SNAP protocol for paracetamol overdose in AMU (7719)	• A plan to re-audit in July/August 2024 to review compliance to SNAP.	Waiting for re-audit
12. Audit of the perinatal pathway screening (PPS) tool usage (7871)	• To add to theme of the week to highlight completing the tool and when. • To re-audit in six months' time to monitor an improvement. • To email all community midwives explaining how to complete the tool. • Plan to attend universal and NEST team meetings to discuss the importance of using the PPS tool in pregnancy and where to document.	Complete

Audit title	Actions	Action update
13. Improving patient experience, staff knowledge and skills in the management of children and young people with eating disorders in A&E (7399)	• To develop pro-forma to meet MEED guidelines and aid ED staff to ensure they are carrying out full and appropriate assessments in children's ED department. • To re-audit service with new pro-forma.	Complete
14. Incidence of chylothorax following vascular ring surgery (7713)	• To continue to monitor the incidence of chylothorax following surgery for vascular ring repair. • To collect more data to allow statistical comparison.	Ongoing actions
15. Microbiology sampling in failed gamma nails - A closed loop audit (7457)	• To increase awareness of evidence-based guidelines and present to T&O surgeons during departmental M&M meeting.	Complete
16. Antenatal engagement and pregnancy outcomes in birthing people with an IMD score <5 from a global majority background (7821)	• To make changes to booking pathway with aim of improving timing of booking.	Complete
17. Microbiological diagnostic yield for CT guided disc biopsies in suspected discitis/ osteomyelitis patients (7830)	• A M&M meeting to be held for decision against CT guided biopsies with spine surgeons, MSK radiologist and microbiologists.	Complete
18. Audit of the adrenal venous sampling performed between August 2017 to February 2024 in patients with primary hyperaldosteronism in the University Hospital Southampton NHS Foundation Trust and service review (7845)	• To present in endocrine departmental meeting to agree findings.	Complete

Audit title	Actions	Action update
19. Mental capacity assessment - who can assess capacity? (7106)	• An email with the results will be sent to all resident doctors currently working in AMU and other medical wards, including reference to the Trust mental capacity policy and where to find the relevant information regarding the types of decisions and the relevant HCPs. • To plan to present this at resident doctors teaching to promote learning.	Complete Ongoing
20. MRI safety questionnaires compliance (7877)	• A re-audit to be performed within two months. • To collect feedback to improve the form. • To consider recommendations and feedback after the re-audit.	Complete
21. Intrapartum prophylactic antibiotic in preterm labour (7938)	• The topic will be made theme of the week and awareness posters will be put up on the labour ward. • Plan to develop a preterm prescription bundle on JAC. • Compliance will be re-audited three months after implementation of the recommendations.	Complete Waiting for re-audit
22. QIP lying/standing blood pressure measurement (7947)	• To extend audit in future to other wards and areas. • To put posters of step-by-step Royal College of Physicians method of measuring on all wards. • To add trust-wide standard guidance on symptom documentation (medical notes, digital etc). • To explore a formal training point with nursing management, feedback (e.g. integrate this into a staff training if not already done).	Ongoing
23. UHS isolation audit July 2024 (5592v6)	• 13 areas of non-submission must complete the audit within one month. • Five areas scoring between 85% and 94% will be required to re-audit within three months. • One area scored below 85% will be required to submit an action plan and reaudit within one month.	Complete
24. UHS sharps safety audit July 2024 (5579v7)	• 23 areas of non-submission must complete the audit within one month. • 21 areas scoring between 85% and 94% will be required to re-audit within three months. • Two areas scoring below 85% will be required to submit an action plan and reaudit within one month.	Complete

Audit title	Actions	Action update
25. Evidence-based medicine audit in emergency ophthalmology in a tertiary eye unit: Southampton experience (7847)	• To incorporate the topics showing poor compliance in departmental teaching to improving compliance. • To establish departmental guidelines for clinical conditions where poor evidence was available.	Complete
26. Preventing unrecognised oesophageal Intubation (7375)	• To provide education on intervention of tube placement.	Complete
27. Assessment of the emergency care of open fractures with respect to antibiotic treatment and neurovascular assessment (7495)	• New approach to be put in place to address risk.	Complete
28. Real world audit of novel treatment outcomes in thyroid cancer treatments (7583)	• To increase clinician and allied health professional awareness to manage Lenvatinib toxicities in acute oncology and outpatient setting to ensure patient safety.	Complete
29. HER2 ISH reporting turnaround times audit (7907)	• To consider contacting alternative HER2 ISH service provider. • To consider reflex cutting of FISH sections at the time of requesting HER2 IHC, which may improve overall efficiency of the process depending on HER2 2+ rates. • Breast pathology team to continue to explore all diagnostic options for HER2 testing to decide about testing location and method.	Complete Complete Ongoing
30. Are therapists providing evidence-based best practice assessments and guidance for patients that fall during admission on the medicine for older (7926)	• To provide teaching and/or service improvement methods implemented into practice.	Ongoing
31. Documentation of cardiac MDT (7357)	• Formulation of a cardiac MDT proforma.	Complete

Audit title	Actions	Action update
32. Povidone iodine application (7941)	• To ensure peri-operative team know to apply Poviodone iodine for more than three minutes before cataract surgery according to the infection control protocol.	Complete
33. HbA1C monitoring in home parenteral nutrition (HPN) patients (8026)	• To add HbA1C to micronutrient screen bundle on requesting.	Complete
34. UHS personal protection equipment (PPE) October 2024 audit (5588v8)	• 35 areas of non-submission must complete the audit within one month. • Ten areas scoring between 85% and 94% will be required to re-audit within three months. • Five areas scoring below 85% will be required to submit an action plan and reaudit within one month.	Complete
35. Saving lives HII 8 cleaning and decontamination October 2024 audit (5581v6)	• 27 areas of non-submission must complete the audit within one month. • Nine areas scoring between 85% and 94% will be required to re-audit within 3 months. • 23 areas scoring below 85% will be required to submit an action plan and re-audit within one month.	Complete
36. Saving lives HII 5 ventilated patients August 2024 audit (5574v9)	• One area of non-submission must complete the audit within one month. • One area scoring below 85% will be required to submit an action plan and re-audit within one month.	Complete
37. Saving lives HII4 surgical site infection August 2024 audit (5580v8)	• 17 areas of non-submission must complete the audit within one month. • Three areas scoring between 85% and 94% will be required to re-audit within three months. • Three areas scored below 85% will be required to submit an action plan and re-audit within one month	Complete
38. Saving lives HII2 peripheral intravenous cannula care June 2024 audit (5582v8)	• 11 areas of non-submission must complete the audit within one month. • Three areas scoring between 85% and 94% will be required to re-audit within three months. • Eight areas scoring below 85% will be required to submit an action plan and re-audit within one month.	Complete
39. Saving lives HII1 central venous catheter care June 2024 audit (5584v8)	• Six areas of non-submission must complete the audit within one month • Ten areas scoring below 85% will be required to submit an action plan and re-audit within one month.	Complete

Audit title	Actions	Action update
40. Audit of inpatient prescribing of psychiatric medication (7682)	• Strategies to be developed within team to improve psychotropic medication prescription.	Complete
41. Auditing electronic prescribing of oxygen supplementation for all admissions to cardiology department (7767v2)	• To send an email to new (and existing) cardiology SHOs with the findings and recommendations • To emailing education leads to explore the possibility of presenting the audit during one of their teaching sessions.	Complete
42. An audit of the requesting of CTPAs from AMU and the factors affecting the percentage of positive results (7972)	• Actions plans to include increasing overall CTPA slots for AMU and SDEC which are currently in discussion and development.	Ongoing
43. Auditing compliance of ward discharge for patients with dysphagia against the oropharyngeal dysphagia policy (6396v4)	• To circulate report to ward leads/matrons/ division leads. • To support SLT adding thickener to JAC. • To feedback results to SLT team.	Complete
44. Documentation of drug allergic reactions (7997)	• To raise awareness among doctors in the AMU, about the importance of documenting the allergic status of all patients admitted.	Complete
45. Pulse oximetry screening compliance (8025)	• To discuss where pulse oximetry should be recorded for babies on BadgerNet. • To review pulse oximetry compliance within the neonatal unit. • To review where and how oxygen saturations are recorded for babies. • To discuss whether oxygen saturations should be recorded on S4N and formulate in the guidance if a change is required. • A gap analysis to be undertaken on the BAPM framework for pulse oximetry once available.	Complete

Audit title	Actions	Action update
46. SBAR handover communication tool audit (7560v2)	• 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. • Labour ward staff to ensure any changes to clinical picture after initial SBAR handover is given are telephoned through to a RM. • To continue to audit compliance quarterly and complete adverse events where documentation of handover is missing when there has been a clinical incident.	Complete Complete Continuous auditing
47. Are NHS doctors requesting CT scans appropriately? Audit focusing on resident doctors' compliance with Royal College Guidelines (8044)	• To conduct an audit to ensure CT scan requests by resident doctors align with Royal College of Radiology guidelines.	Complete
48. Local Adherence of Advanced care planning according to NICE guideline (7558)	• To liaise with IT team to develop a digital DNACPR form.	Ongoing
49. Sternoclavicular joints (SCJ) - image quality evaluation (7993)	• To re-audit in a year time to assess for progress. • To provide more training to our staff on how to perform this examination if required, or assess the possibility of bringing back the anatomy of the month and include SCJ.	Waiting for re-audit Complete
50. Saving babies' lives perinatal mortality review tool (PMRT) (7690)	• As per PMRT review group action to be communicated around referral process of USS pathway when concerns with static/ tailing growth.	Complete
51. Documentation of drug allergic reactions (7997)	• To raise awareness among doctors in the AMU, about the importance of documenting the allergic status of all patients admitted.	Complete
52. IPC standard precautions November 2024 audits (5583v8)	• The 40 areas that did not submit an audit must audit within the next month. • 16 areas scored between 85% and 94% and two areas scored below 85%. All areas to develop and implement an action plan based upon their results. • Care group managers/care group clinical leads to provide support to areas not meeting the standards.	Complete

Audit title	Actions	Action update
53. IPC Inpatient hand hygiene May 2024 audit (5575v9)	• The 39 areas that did not submit an audit must audit within the next month. • Re-audit is required by areas of sub optimal performance as per infection prevention audit programme 2024/25. • Care group managers/care group clinical leads to provide support to areas scoring between 94% and 85% - 19 areas. • Areas scoring below 85% will be required to produce an improvement plan and re-audit - 14 areas.	Complete
54. IPC - Hand hygiene practice (covert) November 2024 audit (7506v2)	• Divisions, care groups and clinical teams to review their individual reports and identify areas and actions for improvement as per hand hygiene improvement framework. • Report to be reviewed and discussed at Infection Prevention Committee, with divisional representation, and improvement actions agreed.	Complete
55. IPC - Peripheral intravenous cannula care December 2024 audit (5582v8)	• **Insertion:** The 28 areas that did not submit an audit must audit within the next month. • Two areas scored between 85% and 94% are required to re-audit within three months. • Two areas scored below 85% are required to produce action plan to address non-compliance and provide evidence of implementation. • To re-audit within one month ensuring compliance addressed through action plan. • **Ongoing care:** The 24 areas that did not submit an audit must audit within the next month. • Two areas scoring between 85% and 94% are required to re-audit within 3 months. • Six areas scoring below 85% will be required to produce an action plan to address non-compliance and provide evidence of implementation. • To re-audit within one month ensuring compliance addressed through action plan.	Ongoing

Audit title	Actions	Action update
56. IPC – Central venous catheter care November 2024 audit (5584v8)	• **Insertion:** The three areas that did not submit an audit to audit within the next month. • One area scored below 85% and will be required to produce an action plan to address non-compliance and provide evidence of implementation. • To re-audit within one month ensuring compliance addressed through action plan. • **Ongoing care:** The 19 areas that did not submit an audit to audit within the next month. • One area scored below between 85-94% to re-audit within three months ensuring compliance addressed through action plan.	Complete
57. IPC – Isolation audit report January 2025 (5592v6)	• 13 areas to complete the audit within one month. • 14 areas scoring between 85% and 94% will be required to re-audit within three months. • Two areas scored below 85% will be required to submit an action plan and re-audit within one month.	Ongoing
58. IPC – Sharps safety audit report January 2025 (5579v7)	• 19 areas to complete the audit within one month. • 28 areas scoring between 85% and 94% will be required to re-audit within three months. • One area scored below 85% will be required to submit an action plan and re-audit within one month.	Ongoing
59. Impact of oral cryotherapy on mucositis in high dose Melphalan (HDM) in ASCT (7465)	• To implement/look at the suggested recommendations and review how to implement to improve patient care.	Ongoing
60. Intraoperative IUD insertion during C-Section for contraception (7953)	• To ensure postnatal counselling for women who had intrauterine contraceptive device post ELSCS, to advise temporary contraception until coil position checked. • To use email to send referral form to sexual health. • To disseminate staff education and awareness on PPIUC pathway and follow up - e.g. via theme of the week correspondence. • To liaise with IT and sexual health to streamline referral pathway.	Ongoing Complete Ongoing Ongoing

Audit title	Actions	Action update
61. An audit looking at assisted vaginal delivery in PAH between Jan 2023 and May 2024- failed vs successful assisted vaginal deliveries and neonatal & maternal morbidity/mortality (7986)	• Theme of the week for assisted birth to follow updating of the guideline. • To include need for SR/consultant presence in OT for any trials of birth and documentation of risks discussed if verbal consent given. • Discussion with maternity digital team about possibility of adding drop down check list to BadgerNet for verbal consent for assisted birth.	Ongoing
62. Prescription of prophylactic proton pump inhibitors in patients admitted under the care of thoracic surgery (8000)	• To discuss with pharmacy and include PPIs in the thoracic surgery protocol medications.	Ongoing
63. Saving babies lives element 1 reducing smoking in pregnancy 2024/2025 (8066)	• To raise concerns with community matron regarding change in triage and booking process affecting smoking pathway. • To gain reassurance that changes made are needed and temporary to bring booking date in line with mandated target. • To gain reassurance that CO monitoring at booking will be done within one stop clinics.	Complete
64. Handover from T&O night shift team to dayshift (8079)	• A handover sheet will be implemented into the current practice to measure the compliance rate of efficient and accurate handover of jobs to the day team.	Complete
65. Element 2: Fetal growth: Risk assessment, surveillance, and management (7681v3)	• To present variance to the ICB for sign off. Previously variance had been approved for SBL version 2.	Complete
66. Audit on prescribing in decomp liver disease (8046)	• To present the results during hepatology departmental meeting to raise awareness among prescribers. • To present results during palliative care team educational meeting.	Complete
67. An udit on the provision of antibiotics in patients with dento-alveolar infections both inpatients and outpatients (8153)	• To develop local anti-microbial guidelines for dento-alveolar infections. • To do teaching session for the emergency department.	Ongoing

Audit title	Actions	Action update
68. Saving lives HII 4 surgical site infection February 2025 audit (5580v8)	• 14 areas did not submit an audit to submit their audit within one month. • Care group managers/care group clinical leads to provide support to three areas scoring between 94% and 85%. • Five areas scoring below 85% will be required to produce an improvement plan and re-audit.	Ongoing
69. Saving lives HII 5 ventilated patients February 2025 audit (5574v9)	• Areas involved in the care of ventilated patients are to ensure work is ongoing to sustain 100% compliance. • One area did not submit an audit and must audit within the next month. • Care group managers/care group clinical leads to support the two areas that scored between 94% and 85%. • One area scored below 85% to produce an action plan and re-audit.	Ongoing

Data source: UHS

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committee

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

NHS Hampshire and 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 2024/25. We are satisfied with the overall content of the Quality Account and believe it meets the mandated elements.

We have worked alongside your Trust to seek assurances that the service delivered has met the expected standards for safe, effective and person-centred care, acting for improvement where necessary.

We supported University Hospital Southampton Foundation NHS Trust 2024/25 quality improvement priorities and recognise that having achieved all their key priorities, with one on hold to ensure it aligns with the new Trust Strategy, the Trust has made considerable improvements, including in the:

- provision of a Patient and Family Support Hub
- recognition, assessment, and escalation of deteriorating patients to improve clinical outcomes for the acutely ill
- development of the Trust's approach to reduce the impact of health inequalities, through five specific areas of focus and setting up the new Health Inequalities Board.

It is recommended that these improvements are embedded and that their impact on patient outcomes continues to be monitored during 2025/26. It was positive to see methods for this having already been considered within the Quality Account.

In response to the number of Never Events reported during 2024/25, and in line with the local quality indicators in the contract, that the Trust are continuing to focus on embedding the National Safety Standards for Invasive Procedures 2 (NatSSIPS2) and in ensuring patient safety oversight of continuous improvement. We look forward to seeing the impact of this work through a reduction of surgical safety incidents during 2025/26.

Although there has been a continued increase in demand over the last twelve months, the Trust has consistently demonstrated its commitment to service and quality improvement. In June 2024, the Trust proudly achieved reaccreditation as Veteran Aware, reaffirming its dedication to providing outstanding care for the armed forces community. Several renovations have been made to the patient environment, including the Neonatal Unit at Princess Anne and the Intensive Care Unit within Southampton General Hospital, all enhancing comfort and experience for those accessing care.

We would like to thank University Hospital Southampton NHS Foundation Trust for continuing to invite us to participate in internal quality meetings to support our quality assurance for improvement processes. Also, for supporting local and system quality improvement by being an active, respected and valued member of the Hampshire and Isle of Wight System Quality Group, Transformation Groups, Patient Safety Specialist Network and the Learning and Sharing Network.

We welcome the 2025/26 quality priorities outlined in the Quality Account and look forward to the Trust sharing improvements and examples of best practice and innovation at future System Quality Group meetings.

NHS Hampshire and Isle of Wight are pleased to endorse the Quality Account for 2024/25 and look forward to continuing to work closely with University Hospital Southampton NHS Foundation Trust during 2025/26 in further improving the quality of care delivered to our population.

Yours sincerely

Nicky Lucey
Chief Nursing Officer

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

Within the Trust's governance process, the Council of Governors meet regularly to receive information on key Trust matters and discuss relevant points. We participate in regular 'Governor Focus Sessions' and annual strategy workshops which share knowledge and provide us with continuous updates on key issues. As part of this process, the Draft Quality Account was shared with Governors prior to its finalisation.

The Council of Governors was given the opportunity to fully understand the report, including the priorities for improvement and the rationale for their selection, prior to its completion. We were able to question the report and challenge the decisions from an external viewpoint, particularly that of our constituents.

This was a hugely valuable exercise for us and we considered it a privilege to be involved in the process at that stage. It also helped us to clarify our focus in terms of our governance responsibilities.

It was encouraging to note that most of the previous objectives had been met, despite the significant challenges faced in a very difficult year.

Our discussions around the priorities, and the responses received to our questions, confirmed our confidence in the competence, care taken and efforts made by all in the Trust, and its ability to achieve the latest objectives, despite the increasing level of challenge some of them presented.

We were encouraged that while the priorities identified for 25/26 are clearly based around the quality of care and safety for all patients, they also continue to include specific consideration for patients' families and carers. The development of the Patient and Family Support Hub will make a significant difference for many, as will the end of life care improvements. We will be interested in monitoring the progress metrics for both of these priorities, as well as the Fundamentals of Care standards.

The wide-ranging long-term problem of reducing health inequalities has been a topic of particular interest in our focus groups, so continuing efforts to improve this in our community are particularly relevant, and clearly aligned with the Trust values.

Having access to board committee meetings, we see the continuous focus from the top on achieving the priorities, and the challenge from non-executives and other staff in ensuring that this focus is not lost and solutions to problems are developed collectively. This collaborative culture has clearly underpinned the quality framework, supporting the successful achievement of previous objectives through hard work and dedication of staff, despite the ever-increasing resource restrictions.

It seems clear that the development of these six priorities for 25/26 has been done in consultation with the relevant stakeholders, and therefore reflects the requirements for the Trust accurately and realistically.

Governors recognise the effort and expertise required to produce this paper and appreciate its value in ensuring continuous improvement and transparency. We will follow the progress of these objectives and aim to support their success in any way that we can. Specifically, we will endeavour to ensure that our constituents are aware of the immense amount of work being undertaken towards the strategic quality improvement aims of the Trust.

We will also continue to observe the performance of the Non-Executive Directors to ensure that they are supporting the Board to achieve these objectives and challenging its effectiveness constructively.

The Council of Governors would like to take this opportunity to thank the quality assurance team and all of the staff who work tirelessly to provide a quality service and to ensure that the patient's voice is heard at University Hospital Southampton NHS Foundation Trust.

Response to the Quality Account 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 2024/25.

The Panel is cognisant of the pressures experienced by UHS during the previous financial year. It is noted that Emergency Department attendances increased by 3.2% compared to the previous year; the volume of patients attending UHS with enhanced care needs grew significantly; the Trust experienced a challenging Influenza season; and, on a regular basis, up to 25% of patients were not meeting the criteria to reside.

Given these challenges it is understandable, albeit concerning, that only 62.8% of patients spent less than four hours in the main Emergency Department, and for this measure the Trust was placed in the third quartile when compared to peer teaching hospitals for the final quarter of the year. In addition, despite treating more patients than the previous year, the waiting list has continued to climb, peaking at 61,686 at the end of the financial year.

Reflecting these pressures, the Panel welcomes the focus on improving decision making speed within the Emergency Department and improving timely flow from the department when patients need admission. The system-wide multi-agency transformation programme to improve hospital discharge, that has been considered at meetings of the Southampton HOSP, is also supported and it is essential that this delivers the objectives set within the agreed timeframes.

We are encouraged by the Trust achieving progress on seven out of eight quality priorities set for 2024/25, especially given the pressures outlined above. This reflects the hard work of staff in ensuring safety, driving innovation, and adapting to change. Given the system-wide uncertainty about future plans and targets, the continuity in priorities set for 2025/26 is sensible and understandable. Successful delivery of the quality improvement priorities will make a difference to patients accessing UHS services as well as being responsive to the emerging challenges across the healthcare system.

The Panel looks forward to working closely and positively with UHS in 2025/26. In particular, with the health outcomes of Southampton residents at the forefront of our considerations, Southampton HOSP is keen to consider the planned refresh of the Trust's Strategic Plan, the impact of the abolition of NHS England, and the new NHS 10-year plan, as well as exploring the Trust's response to the requirement to make significant savings in the financial year.

We greatly appreciate and value the work of UHS and your dedicated staff in our city. With that in mind, the Panel would like to place on record our thanks to Joe Teape for his valued contributions at meetings of the HOSP over recent years and wish him success in his new role in the NHS.

Yours sincerely

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