NHS
University Hospital Southampton
NHS Foundation Trust

QUALITY ACCOUNT
2021/22

Part 1:
Statement on quality from the chief executive

1.1 Chief executive's statement and welcome

Welcome to the 2021/22 quality account which I am pleased to present on behalf of University Hospital Southampton NHS Foundation Trust (UHS).

2021/22 has been another year of unprecedented challenge for healthcare, and this year's quality account continues to have a strong focus on our ongoing response to the COVID-19 pandemic. It also includes information about how we are working to restore services for our patients as we move out of the pandemic. It demonstrates that despite the difficulties, we have supported each other and have never been distracted from our commitment to quality.

The challenges of the last year may have been enormous, but there have also been some real positives from the experience. We are working differently and more collaboratively as a health and care system, developing integrated care and rapidly introducing major change across our services, which helps us to focus on and continue to develop the high quality of our services.

As we recuperate and recover from the pandemic, we will be a team of people that together is stronger than ever before. The professionalism of the team and all those involved across UHS has been inspiring in the face of significant adversity. I am grateful for the care, compassion and kindness shown by all colleagues to our patients and to each other during the most difficult of years.

This is a great platform from which to seize all the opportunities we have before us to continue improving the quality of our services and care. As we begin to move forward, the Trust faces another set of challenges as our services have inevitably been affected over the last couple of years. We remain hugely concerned about the national growth in waiting lists for diagnosis and treatment, and for the people who may not have come forward for vital tests or treatment due to the pandemic. We will continue to do everything possible to maximise the number of patients that we can safely treat, and to ensure that patients on our waiting lists are regularly risk assessed and seen according to clinical priority. We are building capacity as quickly as we can and are recruiting more staff so we can treat the patients who need us. I have no doubt that the staff at UHS will continue to keep their focus on the quality of the services and care we give to ensure everyone who comes to UHS will have the best possible experience as they work tirelessly to put patients first.

Quality assurance has remained a cornerstone of our care despite this period of intense pressure. We have consolidated the work we started last year to embed a different approach to governance, reporting and assurance requirements, and our approach as an acute provider has continued to flex and adapt.

We are hugely proud to be playing an important role in the national response to COVID-19, not only through the delivery of essential healthcare, but also through the many research programmes that are helping us globally to understand and better treat the virus, and as the lead provider for the delivery of the COVID-19 vaccine programme to our population. We are investing significantly in our research and development infrastructure to secure our future as leading-edge university teaching hospital.

Equally, we are investing in other significant areas such as refurbishing the hospital, developing innovative digital solutions. We have also launched a sustainability initiative to make the hospital greener, recognising the influence it has on impacting the environment and population we serve. We aim to achieve carbon net zero, resulting in healthier lives for our community and people.

During 2021/22 the Board has been working on our strategy for the next five years, which sets out our ambition for our quality standards and what we want the hospital to be in 2025 for patients and staff. I'm excited to be the person leading UHS to achieve these ambitions, knowing success with be a collective effort. There is so much to do, but I know that working together we will overcome all the challenges because that is what the UHS family does.

The pandemic has challenged us, but it has also driven change, and it has shown what we can do together with the people of our city and region. In spite of the immense pressures we continue to face, our patients are hugely appreciative and grateful for the outstanding quality of care and treatment they receive here at UHS. This is testament to the dedication and hard work of everyone in the UHS family.

The information contained within this report has been subject to internal review and, to the best of my knowledge presents a true and accurate picture of the performance of the Trust.

David French
Chief Executive Officer
21 June 2022

1.2 Introduction to this report

Each 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 and 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?

This report tells you how well we did against the quality priorities and goals we set ourselves in each domain for 2021/22 (last year). It sets out the priorities we have agreed for 2022/23 (next year) and how we plan to achieve them.

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

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

2.1 Priorities for improvement

This section provides a look back over the 2021/22 quality priorities at UHS and sets out our quality priorities for 2022/23.

2.1.1 Progress against 2021/22 priorities

Last year we set our quality priorities to ensure we delivered the highest quality of care shaped by a range of national and regional factors as well as local and Trust-wide considerations. We recognised the overriding issues of significant operational pressures being felt right across the health and social care system and the pressures associated with the second year of the COVID-19 pandemic.

We acknowledged that many of the aims of our priorities could be disrupted by the ongoing pandemic and that we might need to be flexible in adapting the priorities in changing circumstances. We limited ourselves to four priorities in recognition of these pressures and to allow UHS to focus on responding to them.

This year our retrospective review reflects how we addressed the four priorities in the context of our organisational response to the COVID-19 pandemic and the pressing need to work towards restoration of our services. Our challenge was to deliver the highest quality care in the context of these combined pressures.

Overview of success

Figure 1: Priority 1

PRIORITY 1	Introduction of Midwifery continuity of carer (MCoC) for women at risk of complications in pregnancy.
Core Dimension:	Patient safety, patient experience and clinical effectiveness
Achieved	
Why was this a priority?	
We recognise that the relationship between care giver and receiver leads to better safety and outcomes for women and babies in our care. Being cared for and supported through their pregnancy by the same midwifery team helps ensure safer care based on a relationship of mutual trust and respect and offers a more positive and personal experience. Midwifery continuity of carer (MCoC) is a model of care that aims to limit the number of different healthcare professionals a woman sees during her pregnancy. Its aim is for the pregnant woman to receive intrapartum care from a midwife she has met previously during her current pregnancy, thereby providing greater continuity.	

This approach was the single biggest request of women heard during the NHS England 2015 National Maternity Review 'Better Births'. The model has proven beneficial clinical outcomes for women including:

16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks.
24% less likely to experience pre-term birth.
15% less likely to have regional anaesthesia (e.g., an epidural).
16% less likely to have an episiotomy.

The model organises midwives into teams of eight or fewer. Each midwife aims to provide antenatal, labour and postnatal midwifery care to approximately 36 women per year (pro rata), with support from the wider team for out-of-hours care. The 'Better Births' report published in 2016 set out a clear recommendation that the NHS should work towards a shared ambition for the NHS in England of MCoC being the default model of care available to all pregnant women.

To ensure equity in maternity health outcomes the report recommended that roll-out should be prioritised by March 2023 for those most likely to be at greater risk of complications in pregnancy and experience poorer outcomes. NHS England identified this group as woman from Black, Asian and minority ethnic (BAME) backgrounds, those who live in the most deprived decile (IMD-1/Indices of multiple deprivation-1) or those with increased vulnerability (e.g., poor perinatal mental health, history of substance misuse, history of domestic violence).

What have we achieved in 2021/22?

Our service was quick to adopt the model of MCoC. We used a variety of communication forums to engage our staff and patients, including involvement in national and local public MCoC events, staff team meetings, use of digital platforms, newsletters and dedicated time at midwifery study days for education and discussion.

We rapidly established five MCoC teams with each team caring for their own caseload of women in the antenatal, labour and postnatal period. Three are "caseloading" teams meaning they care for their women in labour with an ''on call" commitment night and day and are based in the east, west and centre of Southampton. The remaining two teams are integrated teams who are available for women in labour when they are on a set shift for labour care and are based in the centre and west of the city. All our teams have a linked consultant obstetrician to ensure continuity of obstetric involvement, and a statement of purpose was agreed to describe the roles and responsibilities required to support the delivery of the model.

Before the publication of the 'Better Births' report we had already identified the need for a focus on the needs of Black and Asian women and those living in IMD-1 areas. Following publication of the report we accelerated our work, and since July 2020 Black and Asian women and those living in IMD-1 areas have been included for care in our MCoC teams.

NHS England Ambition target recommendations 2020/21	Percentage achieved by UHS 2021/22
35% of women will be booked to receive care in a continuity of carer team	41.7%
35% of Black, Asian and minority ethnic women booked to receive care in a continuity of carer team	75%
35% of women living in an IMD-1 area booked to receive continuity of carer	80%

How improvements are measured and monitored

MCoC compliance is reviewed at monthly service delivery meetings, at bimonthly maternity safety champion peer review meetings and through the local maternity and neonatal system (LMNS) by analysing data on the regional maternity services dashboard. We monitor the data, which tracks our performance using key performance indicators (KPIs), and report performance and strategic plans to our quality committee and Trust Board.

Our statement of purpose is reviewed every six months by the programme's senior matron to ensure it is responsive and continues to be fit for purpose.

We actively seek feedback from our patients and their families and from our staff.

What our patients told us:

"'I was under X's care from around 19 weeks into my pregnancy after moving to Southampton. She came to visit us at home on most occasions and stayed in regular contact throughout my pregnancy; she also came to visit us at home after I'd given birth too. This was invaluable throughout the pandemic and I felt really reassured having a familiar face throughout."

''My midwife always instilled confidence in me and I felt able to contact her and other members of the team with any worries or concerns no matter how small. I'm extremely grateful for the care I received, Thank you."

"I had my third baby in August and due to my fear of hospitals and anything medical I opted for my first home birth. X from the homebirth team was incredible right from the moment she happened to appear (out of nowhere like a fairy godmother) into my midwife appointment just as I was saying I wanted a homebirth but was worried about it… she told me she would contact me to arrange a Zoom call where we could chat and she could answer all questions."

''My midwife seemed to have this sixth sense where she could tell when I was anxious about something and all of a sudden was telling me it was all going to be okay. She continued my care at my home each time, which was the first time I'd had any pre-natal care at home and it made me so much more relaxed!"

''Even in the two weeks after birth if I needed anything for me or for the baby, I just had to call my midwife, and it would either go through to her or a homebirth midwife on call day or night."

''I would like to say huge thanks to you and your team for the care you have provided. I am so glad that I was under your team. Your advice at each stage of pregnancy helped me to deliver a healthy baby."

''You have always gone above and beyond to make me feel comfortable (as you were aware of my past history). Whenever I started panicking, you calmed me by your friendly support. You had clarified things by providing more information and clarity …. as we were not sure about the options we had."

''You made sure that I will get full support from my consultant and GP where I needed. I cannot imagine my pregnancy journey without you."

''I didn't know them (the midwife team) earlier but they made me feel like they were my sisters."

''I do not think you could have done more than what you did."

''My overall experience is so positive with the support I got from your team."

What our staff told us:

''Working in the team has been the most rewarding thing I have done during my time as a midwife."

''The role is so varied day to day and the fluidity it allows encourages you to constantly learn new skills and broadens your outlook on what defines being a midwife."

''I have supported families throughout their pregnancy, birth, postnatal period and beyond and because of the relationships you nurture with these families they trust you completely."

''My self-confidence at work has grown massively and I now feel happy to facilitate birth at home, in a birth centre or on Labour Ward, wherever my woman wishes."

''This has given me exposure to new experiences, which can feel challenging at times, but by having a supportive team around you, advice is never far away. Caseloading has meant I've been part of the woman's wider support network and understand the challenges she may face during her day-to-day life. This enables strong working relationships with other members of the multi-disciplinary team working with the family, such as safeguarding teams/family nurses/health visitors/obstetric team/social workers and more."

''You really are at the centre of that family, coordinating their care, to improve their outcomes and their experience whilst accessing maternity care."

Key areas identified of opportunities for further improvement

Originally our aspirations for 2022/23 were to grow our teams to ensure we had enough resource to offer MCoC to all Black and Asian women and women living in IMD-1 areas.

Two new integrated teams came online in January 2022, with plans to develop staff incentives to increase this during the year. We agreed to develop a MCoC team for those in IMD-2 and IMD-3 areas in the west Hampshire area where there are currently no IMD-1 areas.

When COVID-19 restrictions relaxed, we had also planned to increase face-to-face engagement with the local maternity workforce and continue to engagement with and sharing good practice across the Southeast region.

On 30 March 2022 the final report of the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust (the Ockenden Report 2022) was published.

The report recommended:
''All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain. The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction."

Following this recommendation UHS has taken the decision to maintain current levels of provision but cease any further roll out.

Figure 2: Priority 2

PRIORITY 2	To support staff wellbeing and recovery
Core Dimension:	Patient safety and patient experience

Achieved

Why was this a priority?

The health and wellbeing of our people and promoting a healthy work environment is one of our top priorities. Since the start of the pandemic we have focussed on what really makes a difference in supporting people to stay well and healthy and have continued to build on this work during 2021/22. During year we have actively listened to our staff and responded to their feedback by including more "in the moment" support, more regular morale initiatives and creating easier ways to access wellbeing support every day.

We have become more flexible and responsive as the year has progressed, provided a range of support and options tailored to the needs of individuals. We have recognised that wellbeing is very personal, and everyone's approach to promoting and sustaining their own wellness may be different.

We appreciated many people were mentally and physically exhausted after the demands of responding to the pandemic. We recognised they would need time, space and support to develop resilience while the pandemic continued, and to recover as pressures eased. We saw that while the overall health and wellbeing scores in the NHS Staff Survey had improve significantly in 2020, the proportion of staff reporting work-related stress had also increased.

What have we achieved in 2021/22?

During the year we continued to introduce programmes, interventions and wider support offerings. The goal of our model is to ensure our staff can access the most appropriate support at the time and place that they need it. In 2021 we employed a staff wellbeing lead/programme manager and a wellbeing administrator as part of our organisational development (OD) team and tasked them with leading on the development and delivery of the wellbeing programme and interventions. A key area of growth and strength for staff wellbeing during the pandemic and beyond is the joined up working of the wellbeing, psychology, spiritual care, occupational health services and peer practitioner communities.

During the early part of 2021 a series of interventions to support reflection and wellness were introduced aiming to provide safe spaces for people to talk, listen, be heard and give feedback on where things could be improved. The OD team worked alongside our psychologists to introduce a variety of different ways that people could be engaged. We invested in the training of peer practitioners called 'safe space practitioners' to be able to provide on-site, in the moment, interventions when people needed them. Strengthening that safe space practitioner peer network means we have trained more staff in safe space coaching and support techniques to enable people to access support when needed. The team are open to any suggestions of other areas where staff would find peer support valuable and to deliver thinking environments.

We also trained appreciative inquiry facilitators to work with staff in self-determined change to enable them to take a positive approach to their own wellbeing, appreciate the things that are going well and adopt a mindset of appreciation and hope.

After a successful pilot in May 2021, we recruited over 100 wellbeing champions working all over the Trust across a range of professions and seniority. Wellbeing champions have been given training, tools and resources to lead on championing wellbeing in their areas. They offer signposting to support, monthly champion meetings sharing ideas and practice and regular updates on wellbeing. They are important links on the ground for the wellbeing team and have their own workplace champion pages on Staffnet (our intranet) for sharing information and mutual support. They carry out regular wellbeing walkabouts wearing pink scrubs to make them highly visible. They are often accompanied by our executive directors and senior clinical leaders who are also available to listen, support and generally help raise morale.

In the latter part of 2021 as the COVID-19 pandemic continued, staff resilience was tested by challenges around increasing staff shortages and the ability for staff to take regular breaks away from clinical areas for rest. We recognised a need for boosting staff morale and devised a wellness and appreciation programme, which took refreshments out to staff including lunch grab bags, fruit boxes, hot drinks and wellbeing treats.

To make it quicker and easier for staff to access wellbeing information we launched Windows onto Wellbeing (WoW), a one-stop page on Staffnet consisting of various wellbeing windows each outlining a variety of aspects of wellbeing information and available support, with links and resources. This is being supplemented by wellbeing leaflets with QR codes, posters and video information.

A staff Facebook wellbeing page was set up, populated by the wellbeing team and any staff who wish to post. This shows the latest wellbeing information, support and training opportunities updated in real time as well as being a platform for inspirational quotes and for people to share wellbeing practice and thoughts.

During 2021/22 we tried to ensure, where possible, that wellbeing was included as an automatic element of all our initiatives and "business as usual". Staff wellbeing was incorporated into many of our educational streams, with wellbeing awareness sessions being included in induction training, team study days and our UHS advocates study day. Team and personal wellbeing action plan templates have been created for use across the organisation, and when our chief nursing officer (CNO) introduced daily ward huddles ('stop for support') for our nursing teams, a key element was the opportunity to check on staff wellbeing and offer support.

Teaching on stress management and post-traumatic stress is delivered by various groups and individuals including the wellbeing programme manager, the OD team, the psychology team and the wellbeing team. Wellbeing conversation workshops have been offered with good uptake and more are being rolled out in 2022/23. Mindfulness and mindful self-compassion workshops were commissioned in 2021/22 and have proved popular.

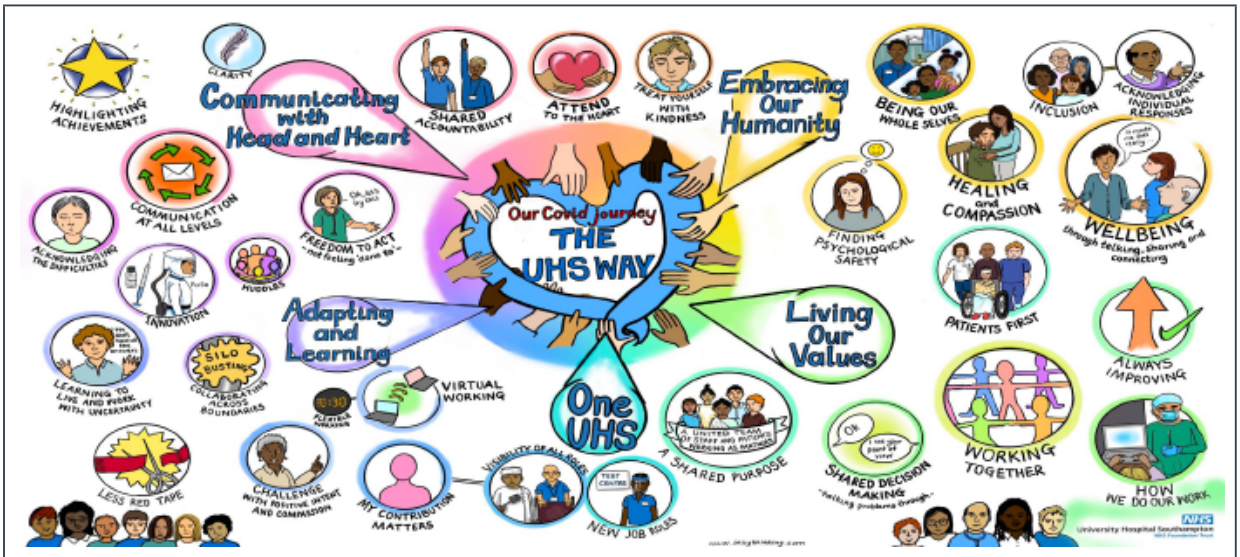
Other initiatives led by our wellbeing programme manager include our domestic abuse project which works with our partners Standing Together to support staff impacted by domestic abuse, our suicide prevention support advisory group, facilitating reflective practice guidance and a small working group which is supporting the patient safety incident response framework (PSIRF) agenda by exploring the impact of being involved in adverse incidents.

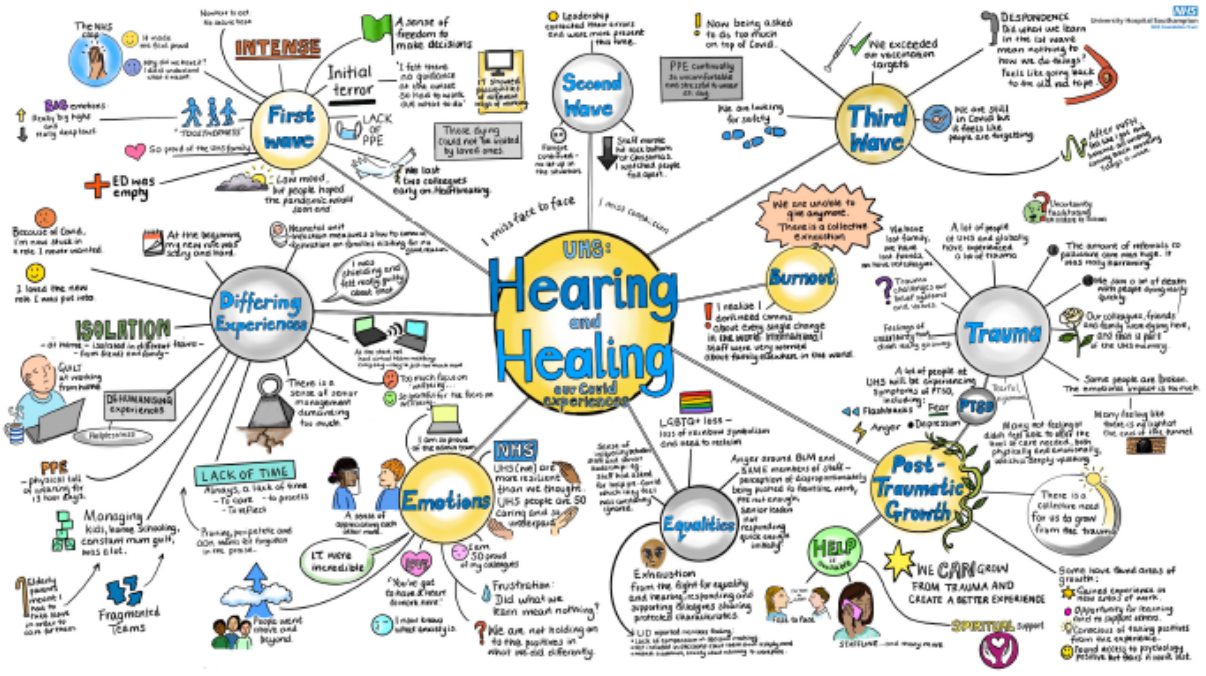
We have an embedded peer support service to provide psychological support to our staff in the context of traumatic events at work. The service is modelled on an evidence-based approach using a trauma risk management (TRiM) methodology which helps to identify risks for people who may suffer poor mental health following traumatic experiences. Our TRiM practitioners support those who have experienced traumatic events and we have increased the number of our practitioners during 2021/22.

UHS is part of a regional mental health first aid (MHFA) faculty which works in partnership across Hampshire and the Isle of Wight and is currently in the process of training peer practitioners as MHFA champions. Our ambition is that our practitioners will go on to participate in 'train the trainer' sessions, sharing training across the integrated care system (ICS).

We also looked at ways to demonstrate how much we value our staff. We wanted to celebrate the hard work, commitment and dedication consistently shown in rising to the challenges of the pandemic. We have promoted our long service awards, which recognise continuous service to the Trust, and our retirement gift scheme, which rewards employees after completing 20 years or more service in the NHS. In December 2021, a festive card containing a gift token from the CEO and Chair was given to all substantive UHS staff in recognition and appreciation of every person's effort and dedication to our patients and families during the year.

We have asked our staff for feedback about our initiatives and used their insights to help shape ongoing work. We have developed a UHS Insights document which summarised how staff were feeling and how the feedback they have given will support people to move forward This is illustrated in the infographics below.





What our staff tell us:

"It all means I can allow myself time, space and kindness to deal with the difficulties during/post [pandemic] knowing that others felt/are feeling the same way I am."

''I really appreciate the way the hospital has prioritised staff wellbeing. It has made us feel as though we are a priority and really valued."

''I have been impressed with how many different options there have been to help us all get through this and help us look after ourselves."

''I've never known staff health be so important to the Trust, and it's made a big difference to how I've coped."

"I don't know if you ever get to hear how people you've seen through TRiM are getting on or not... so I thought I'd give you a little update. I'm back at work on week 2 of a phased return… I'm delighted to say that so far it seems to have worked wonders!"

''The main reason for this email is to say thank you. You were pivotal in the whole journey ensuring I got on the right track to restore my head health early. Without you it's highly likely I'd have probably gone back to work and have ended up in a much worse position and the whole process would have been a lot longer and arduous to get back to where I am today."

"Listening to other staff members' struggles and realising that we are not on our own, we are part of a big team."

"Hearing the different stories but appreciating we were united in suffering, learning, confusion and hope has been helpful."

''I can see senior leaders are human with the same insecurities as us; they've been in our shoes at some point."

'Listening to the situations that others have faced was a real reminder that we have had a shared experience which makes things feel easier. The honesty and openness of others was both enriching and humbling. I left feeling like my faith in humanity had been restored."

"I found that listening to others' experiences was extremely valuable. Although I was obviously aware that we have 'all been in this together' it has at times felt quite lonely and difficult."

How improvements will be measured and monitored

The decision-making, measurement, monitoring and governance of the wellbeing programme is managed by the healthy workplace and wellbeing group which reports into the UHS people board, and then into the people and OD committee. Membership includes representation from occupational health, psychology, spiritual care, peer practitioner groups, HR and health and safety teams and works to support the NHS health and wellbeing framework (2021/22). The people and OD committee reports into Trust Board.

Key areas identified of opportunities for further improvement

It is important to us that we continue to lead compassionately and inclusively, so our people are involved in decision-making, feel hopeful for the future and are confident in bringing their whole selves to work no matter who they are. We want the culture at UHS to reflect our commitment to prioritising the health and wellbeing of all staff so that it is a consideration in every decision we make.

We are working to build confidence and trust in the vast array of support we have developed over the last two years, to drive uptake now awareness is high and to help people find effective help.

Risk of burnout due to exhaustion remains a concern and efforts will be focussed in this area for 2022/23. We have identified temporary wellbeing hub space for staff while we wait for the new staff wellbeing building, which has been made possible with the funding from the proceeds of the auction of the donated Banksy 'Game Changer' artwork. This new building will house a gym, café and space for reflective groups to meet as well as being a base from which the wellbeing team will provide its support.

In 2022/23 several UHS staff will taking part in the first regional diploma in health and wellbeing and a regional wellbeing festival is planned for July 2022, in which we will be taking an active lead.

Our 2021/22 annual NHS staff survey results are positive with our scores relating to wellbeing being above the benchmark average. Contributing factors to wellbeing such as staff engagement, morale, staff experience in areas such as kindness and respect, feeling valued and trusted to do their job were all above the benchmark average.

Our staff experience scored related to violence and aggression at work, bullying, and harassment have also improved and are close to the benchmark average. Our score relating to staff experiencing work-related stress has remained the same at 42%, which has not declined since 2017.

We will continue to work towards improving our staff survey results during 2022/23.

Figure 3: Priority 3

PRIORITY 3	Managing risks to patients delayed for treatment and restoring elective programmes
Core Dimension:	**Clinical effectiveness**
Partially achieved	

Why was this a priority?

The pandemic had a significant impact on waiting times as elective activity reduced to focus on treating patients with COVID-19. In March 2020 only 29 patients were waiting over 52 weeks for treatment, but by March 2021 this had increased to 3,311 patients.

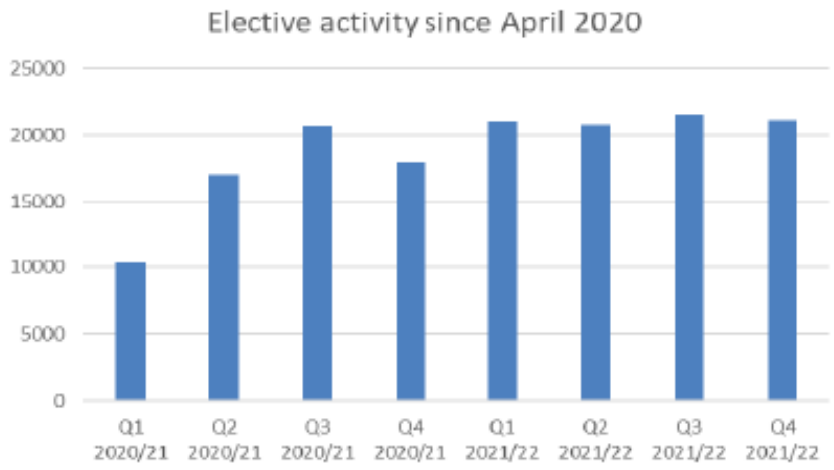
These delays clearly have a significant impact on people's quality of life and, at times, outcomes. During the first wave of the pandemic elective activity reduced substantially, with only 35% of April 2019 levels of activity taking place in April 2020. By 2021 there was a real imperative to move towards managing the pandemic while continuing to treat as many other patients as possible and making sure we communicated effectively with those waiting to help manage the uncertainty and to reduce the backlog where possible.

What have we achieved in 2021/22?

During the first year of the pandemic the Trust set up a clinical prioritisation process, led by the chief medical officer (CMO) that focused on prioritising all patients waiting for surgery to ensure we continued to treat people based on need and urgency. The Trust also implemented a clinical assurance framework (CAF), designed to measure and mitigate risks across the specialities as well as ensuring that resources (e.g., theatres) were allocated in line with anticipated levels of potential harm.

During 2021/22 our hospitals continued to see significant levels of COVID-19 demand with the end of the first wave lasting into May 2021. From September 2021 the number of COVID-19 patients started to increase again, rising to approximately 100 in December 2021 before gradually decreasing. A further wave followed in March 2022, with over 100 COVID-19 patients being cared for in the Trust. Despite this, the Trust continued to see more elective patients in 2021/22 than in 2020/21:

Figure 4: Number of elective patients seen April 2020-March 2022

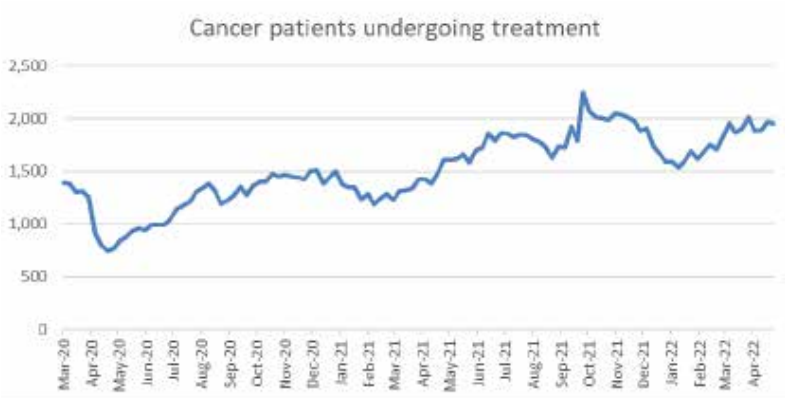


This was despite more stringent and time-consuming infection control measures than prior to the pandemic and reducing theatre capacity to support intensive care staffing. At times, we had up to seven wards repurposed for caring for patients with COVID-19.

Cancer care

We are proud to have maintained all our cancer services throughout the pandemic and believe that we continue to offer clinically effective services to patients. Despite the number of patients being treated for cancer increasing throughout 2021/22 due to a rise in referrals that occurred after each COVID-19 wave, we were able to respond to this increase.

Figure 5: Cancer care patient tracking list July 2020- March 2022



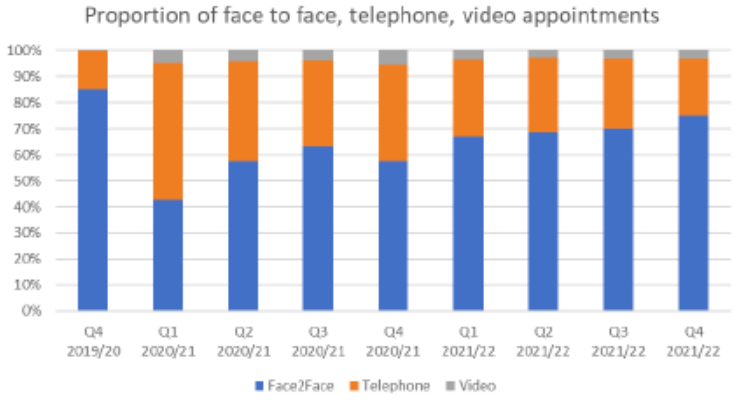
When COVID-19 restrictions in England were relaxed, both in September 2021 and again in February 2022, we saw higher volumes of referrals and two week waits (2WW) performance for urgent referrals has been affected. This is mainly in the breast service with other tumour site performance being broadly maintained. We have seen a relatively stable level of 31-day performance (the target for at least 96% of patients to start a first treatment for a new primary cancer within 31 days of the decision to treat) and 62-day performance (the target that there is no more than 62 days wait between the date the hospital receives an urgent referral for suspected cancer and the start of treatment).

We note that our 62-day performance shows us to be in line with other tertiary teaching hospitals, which illustrates that other hospitals are seeing similar challenges to UHS in relation to cancer. When benchmarking against similar trusts (other large teaching hospitals), we have continued to perform well, and we continue to prioritise cancer services to reduce the number of patients awaiting treatment, including reducing those waiting more than 62 days.

Outpatient services

At the start of the pandemic in 2020 we saw a seismic shift towards non-face-to-face outpatient appointments. The national aspiration was to maintain 25% of patients seen non-face-to-face in 2021/22.

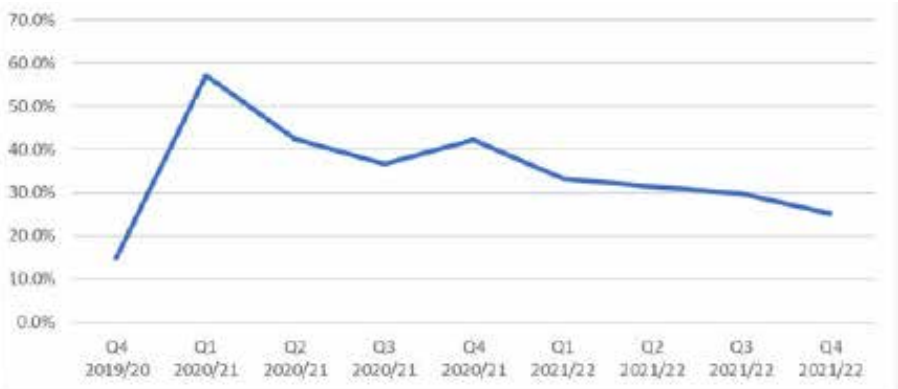
Figure 6: proportion of face to face and non-face to face appointments at UHS



Although the proportion of virtual appointments has naturally reduced compared to levels seen during the pandemic (as some clinics have reverted to a face-to-face service), we have continued to offer virtual outpatient appointments through 2021/22. We recognise that in some cases this provides a more convenient service for patients. We have also rolled out a patient texting programme, which provided an additional safety net. For the specialties with the highest number of long waiting patients we text patients to ask whether their symptoms have worsened and whether they need to speak to a clinician. If they confirm that they do need to speak to a clinician, an outpatient appointment is scheduled for them.

We have also used technology to continue to offer virtual appointments where appropriate and are conducting approximately 30% of our appointments virtually. The Trust has maintained this as a target, and although we have returned to face-to-face appointments where necessary, virtual appointments continue to be a core part of our strategy with our outpatient clinical activity increased to achieve the target.

Figure 7: Proportion of virtual appointments



Diagnostics

During 2021/22 UHS significantly increased the volume of diagnostic activity as the pandemic eased and services adjusted their ways of working, focussing on reducing the longest diagnostic waits first. Despite an increase in diagnostic referrals, the size of the diagnostic waiting list has been held steady, alongside an improved performance.

Alongside community partners in Solent NHS Trust and Southern Health NHS Foundation Trust, the Trust successfully bid for phase one funding to develop a community diagnostic hub. The main hub will be based at the Royal South Hants Hospital (RSH), with other targeted diagnostics being delivered in Lymington New Forest Hospital and Hythe Hospital. These hubs will support a one-stop approach for conditions, delivering tests closer to home and releasing acute diagnostic capacity for the support of inpatients and complex patients.

In late 2021 the Trust completed a Trust-wide patient-led waiting list validation of all patients waiting 33 weeks or longer. Discussions as to how best to continue this as part of a rolling programme rather than a standalone exercise are ongoing.

The Trust worked with third party supplier partners to survey patients by text message or email linked to a secure portal, backed up by paper letters where patient details for digital contact were not available. This saved administrative time, as well as generating a far higher response than traditional methods of validating waiting lists.

The purpose of this initiative was to reassure every patient and confirm if patients were ready to attend (and ask them to indicate a timescale if not), as well as indicate whether COVID-19 concerns were a factor in their wish to delay. We also wanted to know if patients' circumstances had changed, to offer the opportunity of contact with the Trust about their specific circumstances and offer practical and holistic services from the patient support hub.

As well as following up patients whose responses did not match their clinical status, or whose responses flagged concern, all patients requesting contact were followed up by care group administrative and/or clinical teams.

Referral to treatment (RTT)

During 2021/22 UHS has had to continue to manage the impact of COVID-19 on patients on the elective waiting list. We are conscious that some patients have waited a long time from referral to treatment. As referrals have increased post-lockdown (peaking in Summer 2021) , the total number of patients waiting has grown. However, we have reduced and held steady the total number of patients waiting over 52 weeks through 2021/22

Figure 8: RTT Patient treatment list

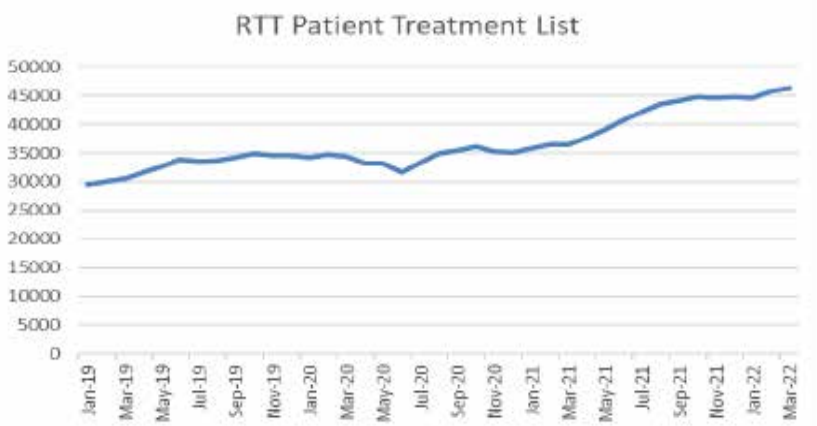


Figure 9 : Patients waiting over 52+ weeks for treatment

In 2021/22 we noted a small, but growing, cohort of patients who had waited more than 104 weeks for treatment due to pressures and constraints associated with the pandemic. This grew from 13 in March 2021, peaking at 171 in December 2021. Throughout 2021/22, our operational teams developed clear plans to address these longest waiters. At the end of March 2022, besides patients who had requested delay of their treatment, we only had five patients who had waited more than 104 weeks for their treatment. Actions to increase capacity and treat these patients include use of the independent sector for specific cohorts of patients (e.g., in the ear, nose and throat (ENT) service) and additional weekend capacity through waiting list initiatives (e.g., Urology 'super weekends').

We have continued to make good progress against our target and, when we remove the patients who are choosing to wait, we are ahead of the plan.

While patients wait for surgery, we have continued to assess them using the CAF, where patients are clinically reviewed based on their previous clinical priority. We use a rating system where priority is given to patients most likely to deteriorate clinically, with P1 being the highest and P4 the lowest risk. Triage takes account of vital signs, pre-hospital clinical course, mechanism of injury and other medical conditions and is a dynamic process and patients are reassessed frequently (e.g., P2 patients every eight weeks, P3 patients every three months, P4 patients every six months). Based on this clinical review patients may be invited for an outpatient review.

What our patients tell us:
''I was very worried about not getting my surgery because of the pandemic, but the hospital was good at keeping in touch so I felt I knew what was going on"

''The news was so bad my dad didn't want to go to the hospital for his tests because he thought the people with covid should have the beds, but he was phoned and the lady was really good at reassuring him that he was important too so he had his tests"

''I was going to wait until the pandemic was over to have my operation, but they got in touch and said they could do it and got me in and did it anyway and I was so pleased"

''Not having to go to the hospital for my outpatient appointment was so much easier. No parking problems, and the doctor was just as good as if I'd been there. I hope this carries on''

''I was so scared my cancer treatment was going to be stopped, but they sent me to another hospital to have it. I've read in the papers about people not getting their treatment, so I am so relieved my hospital could still do it".

How improvements will be measured and monitored

We have a robust reporting processes monitoring this activity which runs from care group and divisional governance and operational reporting through our Trust executive committee (TEC), quality committee and Trust Board. We work closely with our chief operating officer (COO) and executive team to maintain a constant focus.

Key areas identified of opportunities for further improvement

We will continue to work to restore elective activity and reduce waits during 2022/23.

Figure 11: Priority 4

PRIORITY 4	Reducing healthcare associated infection (HCAI)
Core Dimension:	**Patient safety**

Achieved

Why was this a priority?

Healthcare associated infections (HCAIs) are among the most significant causes of morbidity and mortality in healthcare settings. We know prevention of HCAIs is central to providing safe and high- quality healthcare, good patient experience and maintaining safety. It also improves length of stay and helps with our financial and operational management.

According to the World Health Organisation (WHO), HCAIs are common with an estimated 1.4 million affected at any given time and prevalence varying in the developed world from 5.1% to 11.6%. The most recent point prevalence survey of HCAIs in acute hospitals in England (2016), reported the prevalence of HCAIs as 6.6%, and a tertiary care hospital like UHS will be at risk from high levels as it treats many vulnerable patients needing complex support and procedures.

In addition, antimicrobial resistance (AMR) has also been identified by the WHO as one of the top ten major threats to public health. Indiscriminate use of antibiotics in health and farming has led to significant challenges of multi-drug resistant bacteria in certain parts of the world. No new classes of antibiotics have been discovered since 1980, and we are facing the possibility of a world where antibiotics may no longer be effective.

The UK five-year national action plan for tackling antimicrobial resistance (2019-2024) outlines key actions for focusing on infection prevention and control (IPC) and addressing AMR. Consequently, AMR and IPC are important for any healthcare organisation, and a system-wide approach to promoting and monitoring the judicious use of antimicrobials to preserve their future effectiveness is essential.

At UHS we have a dedicated infection prevention team (IPT) committed to supporting the organisation in preventing and reducing HCAIs. The team is made up of a diverse set of professionals with significant experience in infection control, with leadership and oversight from the CNO and director of infection prevention and control. The team drives improvements in patient outcomes by supporting reductions in HCAIs.

What have we achieved in 2021/22?

Unsurprisingly the COVID-19 pandemic has remained a key area of focus for UHS in 2021/22, with a continued emphasis on preventing transmission of infection while supporting the recovery and restoration of services.

In-hospital transmission of COVID-19

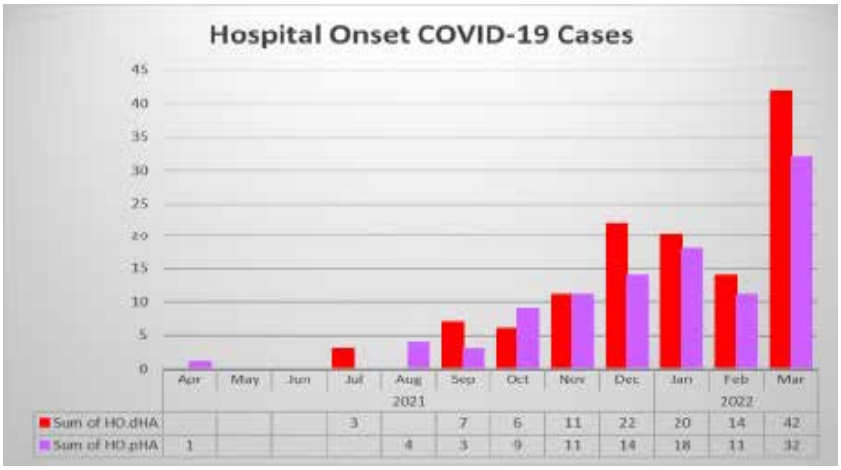
Throughout 2021/22 our COVID ZERO campaigns promoting safety across the workforce and services throughout the pandemic (wash, walk, wear, test and fresh air), and our follow-up #DontGoViral 2021 campaigns continued to be prioritised.

Our COVID ZERO campaign has earned award-winning recognition for 'Best crisis comms' at the 2022 PRWeek UK Corporate, City & Public Affairs Awards.

What have we achieved in 2021/22?

Strategies to prevent and reduce the risk of in-hospital transmission of COVID-19 have remained a priority and have been subject to ongoing review, with actions and improvements taken to reduce the ongoing risk of hospital onset infection and outbreaks. The figure below shows the trend of hospital-onset cases of COVID-19 from April 2021 to March 2022 and follows similar trends as the local and national prevalence of COVID-19.

Figure 10: Cases of Hospital onset COVID-19*.



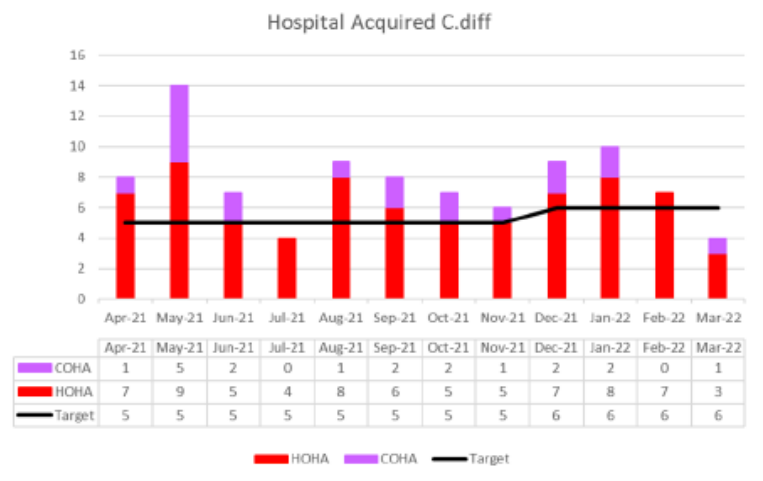
*Classified as "hospital onset-definite hospital acquired" (HO. dHA) when the first positive test is at least 15 days following admission and "hospital onset-probable hospital acquired" when a first positive specimen occurred on days eight to 14 (HO. pHA) following admission

Where cases of hospital acquired infection have occurred, they have been investigated using a root cause analysis (RCA) investigation process either as individual case reviews or part of a wider outbreak investigation. Hospital outbreaks of COVID-19 are robustly managed by the IPT using a formal incident/ outbreak management process and reported in the national outbreak management system with ongoing monitoring until 28 days following the last confirmed case. Learning from individual case investigations or outbreaks is shared promptly across the Trust and used to inform ongoing IPC actions and strategies.

Clostridioides difficile (C. diff)

UHS has seen wide fluctuations in the monthly number of C. diff cases with evidence of cases rising a few months after a major wave of COVID-19 infections. Reasons for the increase are not clear, but are likely to be multifactorial, and possibly related to the use of high-risk antibiotics during the first waves of the pandemic. This increase is being reported nationally with increases in rates of both community onset and hospital onset cases according to UK Health Security Agency (UKHSA) surveillance data.

Figure 11: Trends in hospital acquired C. diff *



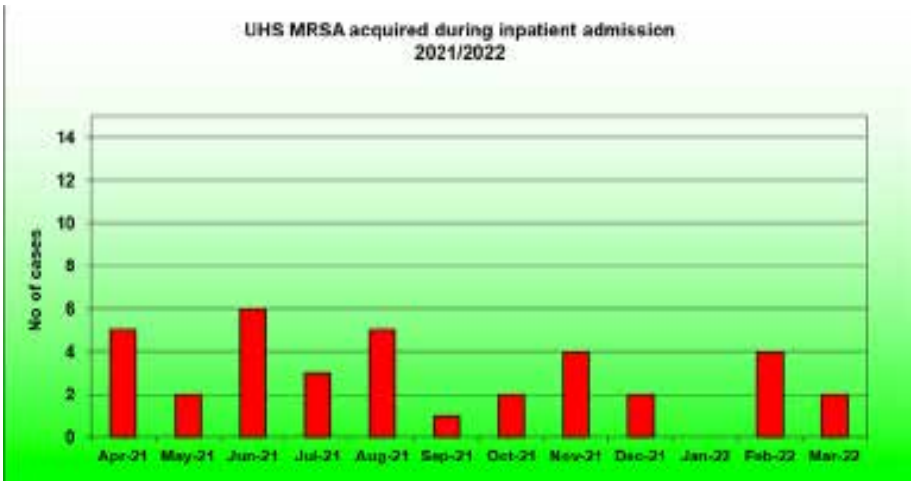
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
COHA	1	5	2	0	1	2	2	1	2	2	0	1
HOHA	7	9	5	4	8	6	5	5	7	8	7	3
Target	5	5	5	5	5	5	5	5	6	6	6	6

*Is classified into community-onset (COHA) and Hospital onset (HOHA) depending on identification of C. diff in community or hospital respectively.

MRSA

In 2021/22, UHS recorded cases of hospital acquired MRSA bloodstream infection as illustrated in the figure below.

Figure 12: Number of patients who acquired MRSA (non-bloodstream infection) during their hospital stay



The downward trend is representative of the trend that has been seen over the last few years.

Blood stream infections (BSI)

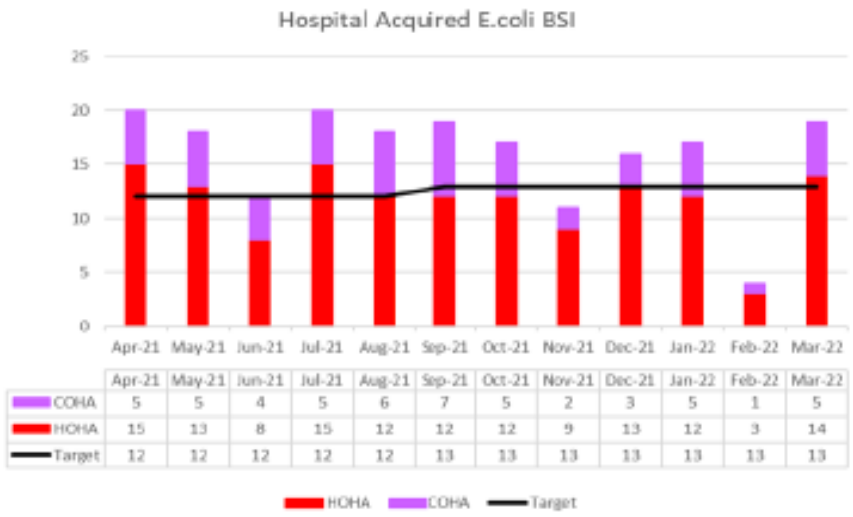
All BSI cases are reviewed by the IPT to identify contributing factors or gaps in practice which may have contributed to infection occurring. They are investigated in detail to identify any learning that may drive improvements.

Overall our reviews have noted that cases are complex with multiple risk factors for infection. A proportion of cases of BSI are assessed as unavoidable, but where infection is thought to have been preventable (e.g., occurred because of the presence of an invasive device such as an intravenous line or urinary catheter), this is followed up with appropriate investigation to identify emerging trends/themes, organisational learning and targeted improvement actions.

The NHS Standard Contract 2021/22 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of defined Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. This includes klebsiella species, pseudomonas and E-coli. Monitoring of MSSA bloodstream infections is also undertaken.

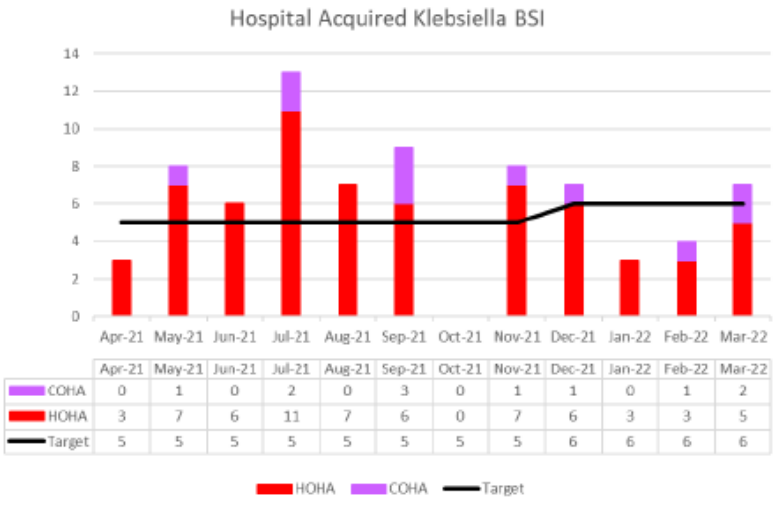
Hospital BSIs are defined as those that occur after the first 48 hours of admission (post 48-hour BSI).

Figure 13: The number of cases of hospital acquired E coli BSI



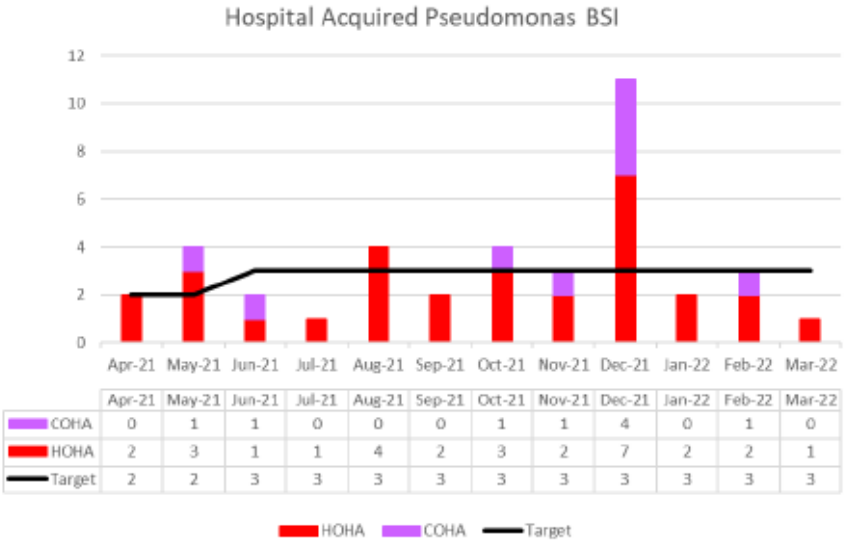
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
COHA	5	5	4	5	6	7	5	2	3	5	1	5
HOHA	15	13	8	15	12	12	12	9	13	12	3	14
Target	12	12	12	12	12	13	13	13	13	13	13	13

Figure 14 : The number of cases of hospital acquired klebsiella BSI



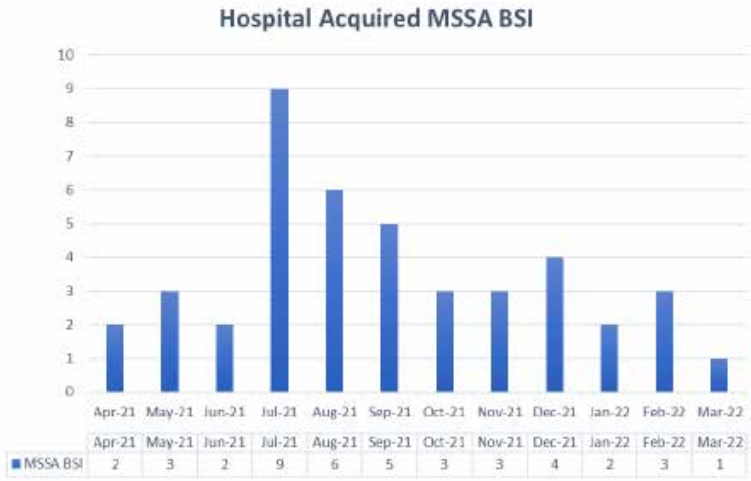
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
COHA	0	1	0	2	0	3	0	1	1	0	1	2
HOHA	3	7	6	11	7	6	0	7	6	3	3	5
Target	5	5	5	5	5	5	5	5	6	6	6	6

Figure 15 : The number of cases of hospital acquired pseudomonas BSI



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
COHA	0	1	1	0	0	0	1	1	4	0	1	0
HOHA	2	3	1	1	4	2	3	2	7	2	2	1
Target	2	2	3	3	3	3	3	3	3	3	3	3

Figure 16 : The number of cases of hospital acquired MSSA BSI



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
MSSA BSI	2	3	2	9	6	5	3	3	4	2	3	1

Vigorous focus and attention to IPC strategies targeted at reducing the risk of hospital transmission of COVID-19 has been central to our ongoing response to the pandemic, whilst at the same time focusing on restoring operational activity. Despite the challenges, UHS has one of the lowest rates of MRSA BSI in the country, and hospital-acquired COVID-19 infection is lower than in comparable hospitals. The health, safety and wellbeing of our patients, communities and staff has remained a priority, and UHS has consistently had lower rates of COVID-19 related staff sickness compared to peers.

What our staff tell us:

''It's been a hard couple of years, but at least I feel confident the hospital has kept us as safe as possible with all of the infection prevention standards.''

''The infection control team has been amazing. Things can change very quickly, but they always seem to be one step ahead."

''I think the COVID ZERO campaign has really helped keep us and the patients safe. I have friends in other hospitals, but we seem to be much better at our infection prevention."

''The visiting restrictions have been hard, but I know they've helped keep infection down, and kept us safer."

''I feel reassured when the infection prevention team come to the ward to talk to us, and there are always updates on Staffnet and Workplace."

''I think we have been ahead of the game with our infection control right from the start."

How ongoing improvements will be measured and monitored

The IPT has well-developed surveillance systems in place to monitor performance indicators including cases of C. diff infection, MRSA BSI, gram-negative bloodstream infection and COVID-19. These surveillance systems are a key component in identifying opportunities to prevent HCAIs and support continuous quality improvement. The data will continue to enable effective monitoring of rates and distribution of infection, trend analysis, detection of outbreaks, monitoring of interventions and predicting emerging hazards.

We also have a process in place for reviewing the clinical pathway of patients with significant HCAI to determine if these are avoidable, with a post infection review (PIR) triggered to identify learning and improvement actions where required. Outcomes of PIR are regularly reviewed by the IPT and learning shared for wider Trust implementation.

Monitoring of required infection prevention practice standards and practice will continue to be undertaken through audit and observations taken by clinical teams, peers and the IPT in line with the annual infection prevention audit programme.

A review of the overall performance of individual clinical areas, looking at both audit data and cases of infection, will be completed by the IPT on a regular basis to facilitate the identification of areas of concern in a timely manner. This process achieves high standards of infection control governance, which is respected at all levels of the organisation.

The performance indicators for HCAI and infection prevention practice standards will continue to be reported and monitored through the Trust infection prevention committee, quality committee, TEC and Trust Board.

Key areas identified for further improvement

While UHS has performed well in relation to several HCAI indicators, improvements are required in some areas. Reduction in C. diff is identified as a key improvement priority in the forthcoming year with key actions identified to support this being:

- Toxin positive inpatient cases of C. diff will continue to be reviewed by the IPT and enhanced surveillance undertaken to review assurance that all elements of the care are being met.
- All hospital acquired cases are reviewed by a consultant microbiologist/infection control doctor to identify learning and actions required.
- The C. difficile antimicrobial review group will review cases to ensure appropriate antibiotic use and duration, with feedback to clinical teams.
- Increased ongoing focus on antimicrobial stewardship via stewardship ward rounds with feedback to clinical teams for improvement.
- Continued focus on cleaning standards and optimising the use of isolation facilities and improving standards of isolation care.
- Reduction in avoidable bloodstream infections has also been identified as an improvement priority for 2022/23 with a focus on improvements in invasive device management and care e.g., intravenous lines and urinary catheters.

2.1.2 Priorities for improvement 2022/23

This section presents our quality priorities for 2022/23. Our priorities are built around our ambitions and intention as a Trust to deliver high quality, well-led, safe, reliable and compassionate care in a transparent and measurable manner.

To determine our quality improvement priorities for 2022/23 we have consulted with key stakeholders including our Trust's quality committee, the Trust Board, the Trust executive committee, commissioners, patient representatives (through our local Healthwatch group) and our council of governors. We have aligned our consultation with feedback from patient surveys and complaints as well as incidents. We have used our progress against last year's priorities to help decide which priorities need continuing focus in 2022/23 and used information gained by:

- **Review of data relating to quality to identify areas for improvement.**
- **Review of the most significant consequences of the COVID-19 pandemic.**
- **Incorporating relevant national priorities and objectives.**

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

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

Once again, we need to recognise that management of the COVID-19 pandemic will continue to be a priority for the foreseeable future, and possibly all of 2022/23. We will remain realistic and be flexible about the ability to release resource to focus on any quality priorities outside of the urgent operational response to the pandemic and the increased numbers of patients waiting for diagnosis and treatment.

The quality committee on behalf of Trust Board has approved the priorities and progress in achieving our quality priorities will be monitored by quarterly reporting to the committee.

Figure 17: Quality priorities 2022/23

No 1

Quality Priority		Core Dimension
Enhancing capability in Quality Improvement (QI) through our Always Improving strategy.		**Clinical effectiveness**
Why we chose this priority	**What we will do**	**Progress metrics**
A consistent language and culture of QI is a central tenant of all outstanding organisations. At UHS, this is typified by our Always Improving value, and underpinned by our Always Improving strategy which sets out our approach to building and maintaining our QI capability and is supported by robust integrated governance. Throughout the pandemic our staff have been agile, flexible and innovative in how they continued to improve care for patients despite unprecedented challenges. However , we recognise that it has often been difficult to prioritise the time to train our staff in the skills required to engage successfully in QI, and difficult to create the space to apply a systematic organisational approach to guide our staff. We are now committing to creating time and space to build momentum during 2022/23, acknowledging that developing our QI capability will act as an enabler and catalyst to support the delivery of all our quality priorities.	• Train our workforce to be able to deliver QI projects by giving them the skills required. • Offer secondments to staff to build quality improvement skills within transformation programmes. • Deliver on the ambitions of our Always Improving strategy by building our improvement culture.	• Train 500 staff in quality improvement techniques. • Support staff to deliver 50 quality improvement projects, encouraging them to select projects that matter to them. • We will record 50 quality improvement projects on the Ulysses (solutions in risk management IT system) to create a rich resource for all staff to access. • We will improve our NHS Staff survey results on the questions relating to improvement (question 3d, am able to make suggestions to improve the work of my team/department; question 3e I am involved in deciding on changes introduced that affect my work area/team/department; question3f I am able to make improvements happen in my area of work).

No 2

Quality Priority		Core Dimension
Developing a culture of kindness and compassion to drive a safety culture.		**Patient safety**
Why we chose this priority	**What we will do**	**Progress metrics**
We recognise that high performing teams promote a culture of honesty, authenticity and psychological safety. This culture requires civility, kindness and compassion, which in turn creates a sense of safety. Behaving in ways that value and respect those around us can enhance teams, optimise performance and improve patient care and safety. Equally, incivility can impact patient care, has been shown to affect how teams' function and make clinical decisions and negatively affects patient outcomes. The Civility Saves Lives campaign (part of the NHS England People Plan 2021/22) aims to raise awareness of the negative impact rudeness can have in healthcare and, conversely, of the power of civility. We aspire to create a strong culture of kindness and compassion to drive a safety culture.	• Develop a communication strategy and complete a high-profile Trust-wide launch linking kindness and compassion behaviours to our Trust values. • Embed kindness training in the UHS Always Improving advocates training led by the transformation team. • Design a standardised methodology to run safety huddles to promote psychologically safe learning space across the Trust. • Use these safety huddles to promote rapid learning and shared understanding from incidents and wellbeing checks across teams. • Roll out just and learning culture work, training leaders in just cultures and develop learning tools to support implementation. • Appreciative inquiry training to be embedding into existing training programmes and delivered across the organisation. • Design a human factors strategy and training plan. Incorporate human factors training across high-risk pathways every month using tools that identify contributory factors in safety investigations to support organisational learning from human factors. • Review the 2021/22 staff survey to assess the baseline of engagement in an organisational culture of kindness and compassion and use this information to inform ways of further engaging our staff.	• We will have completed a successful launch and staff will be able to articulate how kindness and compassion links to our Trust values. • We will aim to train 20 new advocates per month. • Safety syllabus training level 1and level 2 will have been implemented, and 85% of our staff will have received training by April 2023. • Our patient safety team will have established a minimum of one cohort in patient safety incident investigation (PSII) training, which includes the Just Culture guide. • All governance teams will have attended the PSII training by September 2022. • 50% of the serious incident scrutiny group (SISG) core members to have received PSII training by September 2022. • The patient safety education lead will have delivered monthly sessions on human factor training. • Our 2022/23 staff survey will reflect improvement in engagement with this agenda.

No 3

Quality Priority		Core Dimension
We will improve mental health care across the Trust including support for staff delivering care.		**Patient safety**
Why we chose this priority	**What we will do**	**Progress metrics**
In 2020 the CQC identified that acute hospitals (in collaboration with their mental health Trust partners), need to improve the care of patients with mental health needs while they are attending acute hospital emergency departments or receiving in-patient care. This is also supported by NICE guidelines which originated in 2009. A significant number of our patients have psychological needs, and/or co-occurring mental health needs. The majority will present with a physical health requirement which may be a primary physical health need, or as a direct result of a mental health crisis. Many physical health conditions have a direct impact on psychological and mental health, which if not addressed as part of their acute hospital care, will result in poorer outcomes for the patient and increase their length of stay. Optimising mental health is also a core principle of the UHS clinical strategy to bring equity in our approach to identifying and managing physical and mental health needs.	• Ensure that the workforce is knowledgeable and skilled at meeting the physical and mental health needs of all our patients by completing a training needs analysis and continuing to roll out mental health champions training in collaboration with our liaison psychiatry partners. • Complete monthly deep dive audits mapping the patient journey and their access to mental health services and analyse performance to identify QI projects where barriers to timely access are identified. • Identify where improvement can be made in pathways and support for patients detained under the Mental Health Act 1983 (MHA). Agree an MHA administration statement of purpose (SOP), supported by education for staff and monitor compliance through our mental health board. • Ensure that staff in patient-facing roles understand restrictive practice and the legal frameworks and legislation that apply to its use by rolling out de-escalation and breakaway training delivered by the eight trainers within the Trust. • Ensure the Trust mental health strategy is implemented and embedded across all divisions.	• We will have trained 150 UHS staff through the mental health champion's programme. • We will have identified and complete three QI projects informed by the deep dive clinical audit of the patient flow through our emergency department • We will deliver the nationally recommended approved programme of training to clinical staff with an initial target of 100 clinical staff per year. • We will evaluate the success of the programme in collaboration with an external training partner (Maybo). • We will have made our interim mental health strategy available to all and the strategic objectives detailed in it will be completed.

No 4

Quality Priority		Core Dimension
Recognising and responding to deterioration in patients.		**Patient safety**
Why we chose this priority	**What we will do**	**Progress metrics**
National Early Warning Scores (NEWS2) were first produced in 2012 and updated in December 2017. They are a system used to standardise the assessment and response to acute illness, which improves the detection and response to clinical deterioration in adult patients. For child health there is a national paediatric early warning system (PEWS) which is being developed. NEWS2 and PEWS scores are a key element of patient safety and improving patient outcomes that allow us to monitor the acuity in our organisation. The number of activations act as a barometer for the acuteness of the Trust and assist in supporting the need for resources and skills. How rapidly we respond to deterioration in and out of hours is a key determinant of quality and patient outcomes.	• Continue to monitor and analyse NEWS2 activations each month through our governance framework. • Progress the implementation of the national PEWS system in our children's hospital and monitor its impact. • Support the submission of data for Commissioning for Quality and Innovation (CQUIN) associated with deteriorating adult patients (CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions). • Work with the digital/IT team to enhance the current IT systems; providing a real-time, robust escalation and response system to deterioration to inform improvement programmes. • Our resuscitation committee will continue to scrutinise data related to outcomes of cardiac arrest in adults and paediatric patients and feed into the national cardiac arrest audit. • Improve our out of hours doctor's worklist (a tool which provides a concise list of patients for conducting a handover to another physician and for personal management of patients) to support improved responsiveness to deteriorating patients. • Improve documentation in theatres to ensure NEWS2 scores are recorded more accurately. • Improve education and supervision for hard-to-reach groups of staff in relation to deterioration. • Monitor our compliance with sepsis management (recognition and treatment) in the emergency department (ED) and clinical areas.	• We will achieve 95% compliance with NEWS2 scoring in all patients, including those cared for in theatre areas. • PEWS scoring will have been introduced in our children's hospital. • Our quarterly CQUIN data will reflect a high standard of compliance. • We will have sustained or improved our metrics for the national sepsis data submission. • We will be able to evidence a decrease in hospital cardiac arrests. • Patient experience, monitored using patient feedback channels and patient surveys, will reflect a confidence in their safety.

No 5

Quality Priority		Core Dimension
Improving how the organisation learns from deaths.		**Clinical effectiveness**
Why we chose this priority	**What we will do**	**Progress metrics**
A key indicator of an honest, open and transparent culture that prioritises learning is how well deaths are reviewed and what lessons we learn from them. Learning from deaths is a necessary part of clinical and QI work and helps to ensure that patients and families receive the very best clinical care and quality of experience. Success means that no death goes unexamined, and no learning is missed. It means that families and carers are involved and included in discussions about the care and treatment their loved ones received, and that they, where necessary, get the answers they need. We already have an internal medical examiner service (IMEG) where specially trained staff give independent advice about the cause of deaths on our organisation (except for deaths that must be reviewed by a coroner). As this service expands its scope to include all non-coronial deaths in the local community, it is vital that our own internal mortality review processes are robust, rigorous and, most importantly, interconnected.	• Continue to support the growth and expansion of the medical examiner service in the review of all non-coronial deaths in the community. • Ensure that our internal mortality review processes are robust, receive strong engagement from clinicians and involve families as an essential part of the mortality review process. • Establish a learning from deaths steering group. • By introducing a mortality analyst/ coordinator post, ensure that our learning from deaths reporting combines clinical scrutiny with family involvement to drive improvements in care and services. • Share learning from the internal mortality and morbidity (M&M) meetings to all services with a clear expectation articulated that this learning would drive improvement. Use existing governance structures to monitor compliance. • Revisit our existing specialist review processes including learning from deaths of people with a learning disability (LeDeR) and clostridium difficile associated diarrhoea/ disease (CDAD) and urgent case reviews, to assess if they are responsive to the needs of patients and families to promote robust scrutiny. Where gaps are identified, work with the leads to embed this element.	• Embed the new learning from deaths steering group and coordinate more detailed learning from deaths reports as a key group output. • We will create a bi-monthly learning from deaths bulletin for all clinical and relevant non-clinical teams to share learning and improvements. • We will implement a mechanism for evaluating family satisfaction with the medical examiner process to be reviewed alongside our existing bereavement survey. • Through the new mortality analyst/coordinator post, create a learning from deaths dashboard to ensure robust and relevant metrics can be regularly scrutinised for assurance.

No 6

Quality Priority		Core Dimension
Shared decision making (SDM).		**Patient experience**
Why we chose this priority	**What we will do**	**Progress metrics**
SDM is promoted in many healthcare systems and is gaining importance internationally, reflecting patients' expanding knowledge of diseases and treatments through media, increasing numbers of available treatment options and patients' and physicians' preferences for more active patient involvement. SDM involves at least one patient and one healthcare provider. Both parties take steps to actively participate in the process of decision-making, share information and personal values and together arrive at a treatment decision with shared responsibility. SDM is a common feature of best practice guidelines, including the NHS England guidelines for communicating with patients and the National Institute for Health and Care Excellence NICE guidelines on SDM. Giving patients a period of reflection for deciding on treatment and giving consent also reflects the General Medical Council (GMC) guidelines for consent, which also require adopting SDM principles. The 2022 NHS England 'delivery plan for tackling the COVID-19 backlog for elective care' document states that providers will be required to adopt SDM in admitted non-day case pathways by April 2023, and all admitted pathways by April 2024. SDM is a core part of the 2020-2025 clinical strategy at UHS. Initial projects and pilots in services have evidenced the benefits of this approach for our staff and patients and have been well received. Our ambition is to continue to embed SDM Trust-wide, however, we acknowledge work is required to fully meet the gap analysis against this guideline.	• We will build on our SDM pilot scheme and collaborate with NSH England in writing SDM materials which can be used nationally. • We will continue to roll out SDM through more pilot sites, improving our principles and guidance tools. • We will adopt the 2011 nine item SDM questionnaire (SDM-Q-9) assessment tool across the organisation, using digital platforms. This will provide consistency and standardise practice. • Create a SDM training resource that can be accessible across the organisation. • Improve compliance against NICE guidelines.	• We will have established our baseline for staff trained in SDM and increased this by 50%. • We will have increased the number of pathways in which SDM has been introduced by 50%. • We will have achieved 75% use of SDMQ9 across areas using SDM. • Our clinical outcomes team will be able to evidence an improvement in our NICE exceptions report. • Patient satisfaction surveys will reflect a positive response to SDM.

No 7

Quality Priority		Core Dimension
Working with our local community to expose and address health inequalities.		**Patient experience**
Why we chose this priority	**What we will do**	**Progress metrics**
We recognise that avoidable variations and systematic differences in health across our community must be tackled to ensure that everybody can access, receive and benefit from the same high quality of care. COVID-19 has exposed how different communities and individuals can be affected by health conditions and how specific characteristics such as gender, ethnicity or disability can influence access to care. UHS plays a significant role in the health system in our region and it is vital that we take a systematic and collaborative approach to identifying, understanding and removing health inequalities in conjunction with local partners.	• Engage our communities through our health inequalities partnership group, ensuring that we hear from traditionally excluded groups, and explore if there are avoidable inequalities in accessing care and services, variations in the quality and experience of care or differences in clinical outcomes and long-term health prospects. • To achieve this, we will work directly with communities and community groups on their terms to listen, learn and improve. • To help achieve this we will recruit a carers lead, a health inequalities engagement officer (fixed term), a personalised care project officer to ensure care is inclusive (fixed term) and a charity-funded travellers liaison officer to ensure we involve and include the traveller community.	• We will have defined key indicators to measure inequalities across access, experience and outcomes and created a health inequalities dashboard. • We will have a draft Trust health inequalities strategy with a clear action plan and set of objectives. • We will have delivered the first-year objectives agreed in our carer's strategy. • We will have worked with our hospital charity to identify and fund up to five projects that tackle health inequalities and deliver improvements in care and experience.

No 8

Quality Priority		Core Dimension
Ensure patients are involved, supported and appropriately communicated with on discharge.		**Patient experience**
Why we chose this priority	**What we will do**	**Progress metrics**
Communication and robust discharge coordination are the two thematic areas which have a significant impact on the quality of patient experience of their discharge. During the pandemic we made rapid improvements in both areas by health and social care teams working more closely together with a clear, shared goal. However, communication with families and carers was less successful due in part to the restricted visiting introduced for safety reasons during the pandemic. Feedback from our Healthwatch partners and commissioning groups has further reinforced the need for improved patient, carer and family involvement and improved communication during the discharge process as well as prompting more collaborative working between social care and healthcare staff. UHS is committed to establishing a clear, robust communication and discharge process to improve the experience of our patients, carers and their families.	• Equip patients to make informed decisions by holding anticipatory discharge conversations on admission. • Develop a suite of digital and non-digital solutions which can be introduced in the first 24 hours of admission to allow families to access clinicians and play a part in the care planning. • Ensure every patient has a clear discharge plan and planned discharge date on admission. • Ensure all patients on the ward can answer the four key questions recommended by NHS England ahead of discharge: 1. What is the matter with the patient (or what are we trying to exclude)? 2. What have we agreed we are going to do to help the patient's recovery – now, later today and tomorrow? 3. What needs to be achieved to get the patient out of hospital? 4. If recovery is ideal and there is no unnecessary waiting, when should the patient expect to go home? • Foster a culture across the organisation where staff aspire to make every discharge experience safe and efficient through coaching (detail captured in our medically optimised for discharge action plan). • Revalidate best practice discharge training and make this accessible to all staff across the organisation. • Review governance related to discharge. • Renew information relating to discharge ensuring public involvement in the development of that information and agreeing access routes. • Maximise access to the patient support hub and ensure this is visibly accessible to patients using our services. • Hold a patient follow-up focus group to seek feedback from targeted pathways and use the information gained to focus improvement actions. • Share learning from clinical incidents, incident reports and feedback from patients and partner agencies to drive forward quality improvements when we don't get it right.	• A sustained reduction in readmissions up to 30 days post discharge. • A reduction in avoidable adverse events related to discharge. • Patient satisfaction will improve by reduction of discharge related complaints, including those from medicines management and care homes. • Increased update of digital communication for discharge co-ordination. • Sustained reduction of on the day discharge cancellations for non-clinical reasons. • Improvement in National Carer Survey results.

2.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide relating to the financial year 2021/22. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board of directors has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement

2.2.1 Participation in national clinical audits and confidential enquiries

During 2021/22 51 national clinical audits (NCA) and three national confidential enquiries covered NHS services that UHS provides.

During 2021/22 UHS participated in 96% of national clinical audits and 100% of national confidential enquiries of which it was eligible to participate in.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies participated in during 2021/22 were:

- **Epilepsy**
- **Transition from Child to Adult Health Care**
- **Crohns Surgery**
- **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 Child Health Clinical Outcome Review Programme (NCEPOD**

The national clinical audits and national confidential enquiries that UHS participated in, and for which data collection was completed during 2021/22, are listed below (Figure 18) 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 known at the time of writing this report.

Figure 18: Total number of NCAs UHS were eligible to participate in

No	Total number of NCAs UHS were eligible to participate in	Eligible (54)	Participated (49 = 96%)	% Actual cases submitted / expected submissions
1	Case Mix Programme (CMP) (ICNARC)	✓	✓	100%
2	Chronic Kidney Disease Registry - UK Renal Registry	✓	✓	100%
3	Elective Surgery (National Patient Reported Outcome Measures [PROMs] Programme (Hips and Knees))	✓	✓	100%
4	Emergency Medicine Quality Improvement Projects – Pain in Children	✓	✓	100%
5	Emergency Medicine Quality Improvement Projects – Infection Control	✓	✓	100%
6	Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database	✓	✓	96%
7	Falls and Fragility Fracture Audit Programme (FFFAP) Fracture Liaison Service Database	✓	✓	100%
8	Falls and Fragility Fracture Audit Programme (FFFAP) National Audit of Inpatient Falls	✓	✓	100%
9	Inflammatory Bowel Disease (IBD) Audit	✓	✓	100%
10	Learning Disability Mortality Review Programme (LeDeR)	✓	✓	100%
11	National Adult Diabetes Audit	✓	✓	100%
12	National Paediatric Diabetes Audit (NPDA)	✓	✓	100%
13	National Pregnancy in Diabetes Audit	✓	✓	100%
14	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) (asthma in children)	✓	✓	276 100%
15	National Asthma and COPD audit programme (NACAP) (asthma in adults)	✓	×	0
16	National Asthma and COPD Audit Programme (NACAP) (COPD secondary care)	✓	✓	100%
17	National Asthma and COPD Audit Programme (NACAP) (Pulmonary rehabilitation)	✓	✓	100%
18	National Audit of Breast Cancer in Older Patients (NABCOP)	✓	✓	100%
19	National Audit of Care at the End of Life (NACEL)	✓	✓	40 100%
20	National Audit of Dementia	✓	×	0
21	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	✓	✓	100%
22	National Cardiac Arrest Audit (NCAA)	✓	✓	100%

No	Total number of NCAs UHS were eligible to participate in	Eligible (54)	Participated (49 = 96%)	% Actual cases submitted / expected submissions
23	National Cardiac Audit Programme (NCAP) - Adult cardiac surgery	✓	✓	100%
24	National Cardiac Audit Programme (NCAP) - Cardiac Rhythm Management (CRM)	✓	✓	1160 100%
25	National Cardiac Audit Programme (NCAP) - congenital heart disease (CHD) paediatrics	✓	✓	100%
26	National Cardiac Audit Programme (NCAP) - Heart Failure Audit	✓	✓	100%
27	National Cardiac Audit Programme (NCAP) - Acute Coronary Syndrome or Acute Myocardial Infarction	✓	✓	100%
28	National Cardiac Audit Programme (NCAP) - Percutaneous Coronary Interventions (PCI)	✓	✓	96%
29	National Child Mortality Database (NCMD)	✓	✓	100%
30	National Comparative Audit of Blood Transfusion – 2021 Audit of patient blood management and NICE guidelines	✓	✓	10 100%
31	National Early Inflammatory Arthritis Audit (NEIAA)	✓	✓	169 100%
32	National Emergency Laparotomy Audit (NELA)	✓	✓	100%
33	National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)	✓	✓	304 100%
34	National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)	✓	✓	100%
35	National Joint Registry	✓	✓	506 100%
36	National Lung Cancer Audit (NLCA)	✓	✓	276 100%
37	National Maternity and Perinatal Audit (NMPA)	✓	×	0
38	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	✓	✓	100%
39	National Perinatal Mortality Review Tool	✓	✓	100%
40	National Prostate Cancer Audit (NPCA)	✓	✓	100%
41	National Vascular Registry (NVR)	✓	✓	40 100%
42	Neurosurgical National Audit Programme	✓	×	0
43	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
44	Respiratory Audits (BTS) – National Outpatient Management of Pulmonary Embolism	✓	✓	30 100%

No	Total number of NCAs UHS were eligible to participate in	Eligible (54)	Participated (49 = 96%)	% Actual cases submitted / expected submissions
45	Respiratory Audits (BTS) – National Smoking Cessation 2021 Audit	✓	✓	200 100%
46	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient audit, organisational audit	✓	✓	1160 100%
47	Serious Hazards of Transfusion (SHOT) - UK National haemovigilance scheme	✓	✓	100%
48	Society for Acute Medicine Benchmarking Audit (SAMBA)	✓	✓	100%
49	Trauma Audit & Research Network (TARN)	✓	✓	100%
50	UK Cystic Fibrosis Registry	✓	✓	96%
51	Urology Audits – Management of the Lower Ureter in Nephroureterectomy Audit	✓	✓	100%

Due to COVID-19 pressures and fluctuating resources during the year, some of the national audits were suspended and are due to take place next year (2022/23). For the same reasons, UHS were unable to send any data for the National Asthma Audit in Adults and National Audit of Dementia.

The reports of 19 national clinical audits were reviewed by the provider in 2021/22 and UHS intends to take the following actions to improve the quality of healthcare provided (see Figure 19).

Figure 19: National clinical audit: actions to improve quality

National audit title	Actions
1. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Mental Healthcare in Young People and Young Adults Report.	• To develop and promote national guidance outlining the expectations of general hospital staff in the care of children and young people with mental health conditions. • To use HEEADSSS app as a screening tool in young people highlighting mental health issues. the use of risk assessment tool for every patient that presents with a mental health crisis and following referral pathway as agreed with community Child and Adolescent Mental Health Services (CAMHS). • Training in use of risk assessment tool to be provided by new in-reach service. • Lead nurse and doctor in Community Eating Disorder Service (CED) for CAMHS to be actively involved with ensuring policies and procedures are in place. • Liaison CAMHS nurse to be recruited and child health matron responsible for CAMHS to be recruited. • Liaison CAMHS consultant to promote integration of physical and mental health and lead on inpatient service development. • To ensure staff recruitment is completed and environmental development to help with mental health patients whilst awaiting transfer onwards.

National audit title	Actions
	• To review transition services for eating disorders. • To establish a risk management plan for all CAMHS inpatients to address deficiencies. • To review IT systems to enable electronic record sharing between CAMHS and physical health providers. • To develop a competence assessment tool for documentation. • Training in new documentation tool to be provided once developed.
2. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Deaths in Acute Hospitals: Caring to the End.	• Handover process to be audited. • New folders to be introduced in emergency theatres to allow thorough handover of cases.
3. National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) - An Age-Old Problem "Emergency and Elective Surgery in the Elderly.	• A new consultant in Medicine for Older People to be seconded to cardiology, heart failure on a two -year secondment (0.6 full time equivalent. Part of this job plan will involve management of co-morbidity within the cardiology inpatient cohort. • To review in two years once secondment is nearing the end to advise what action will be taken. • Trauma & Orthopaedics (T&O) to review anticipated hip surgical cases in the pre-operative period to review medication to suspend drugs implicated in the development of acute kidney injury (AKI). • All emergency laparotomy cases to be discussed with critical care and allocated to a ward only if clinically allowable. • All elective patients to be reviewed and discussed in a double joint multi- disciplinary team meeting with surgeon, anaesthetics and intensivist to determine best operative pathway. • Clinician exploring models to address lack of medicine for older people physician in surgical specialities (already in T&O).
4. The B-MaP-C Study: Breast Cancer Management Pathways during the COVID-19 pandemic - A National Audit.	• Protocols to be put in place for breast surgery and oncology to ensure that these patients have cancer marking with clip at diagnosis, starting bridging therapy with endocrine agents and modified radiotherapy regimes. The problem is likely to reduce in frequency with increasing vaccination and decreasing COVID-19 numbers with possible restoration of normal service.
5. Surveillance of surgical site infections in NHS hospitals in England, 2019 to 2020 (SSSIS) - Report published 2020.	• IPC SSSIS lead to attend an SSSIS course run by Ethicon on the compliance with NICE guidance to prevent SSI. • Negotiations are underway for adopting PLUS sutures, which are recommended by NICE. • Planning is also underway for introducing the pre, intra and post-operative care bundles to improve compliance with NICE guidance. • To use the Plan/Do/Study/Act QI tool for this part of the project.
6. Female Genital Mutilation (FGM) Report 2020/21 published June 2021.	• Maternity Services will be moving over to a new Badgernet system to improve reporting information.

National audit title	Actions
7. Fracture Liaison Service Database (FLSD) published May 2021.	• Funding to increase staff from one to four to lead significant improvements in the service. • To increase identification of patients with fragility fractures and spinal fractures IT are to develop an electronic referral pathway. • Further IT solutions to be made in radiology and Minor injuries unit (MIU) pathways. • Ongoing project to implement artificial intelligence systems to identify spinal fracture patients, which will anticipate significant increase in identification rate. • Increase in comprehensive bone health assessment with increase of staff. • Increase in falls assessment referrals capacity with increase of staff. • Ongoing discussions with Community independent Services to try and increase data entry issues.
8. Annual Serious Hazards of Transfusion (SHOT) Report 2020 published July 2021.	• Concessionary release to be included in mental health training and competency training. • Final capacity plan to be put in place. • Need to take a further look at the 'Learning from Adverse Events' paper to ensure all nine principles are covered. • To define a process for trending Medicines and Healthcare products Regulatory Agency and Serious Adverse Event reporting (MHRA SAE). • To implement annual point of care (POC) blood gas analysis for all units. • To implement an audit of person-centred care.
9. NCEPOD Non-Invasive Ventilation - Inspiring Change.	• A recruitment drive to add staffing to put Respiratory High Dependency Unit (RHDU) and C5 on an improved staffing ratio.
10. National Paediatric Diabetes Audit (NPDA).	• In process of undergoing a QI project overseen by the Royal College of Paediatricians and Child Health(RCPCH) to improve key care processes. • To ensure ongoing staff training in the new Twinkle database. • To monitor functionality of Twinkle database to meet monthly with Hicom, UHS clinical lead and diabetes administrator.
11. National Asthma and COPD Audit Programme (NACAP) in adults.	• To plan to ensure data is submitted for this audit in 2022.
12. National Joint Registry (NJR) Knee replacement.	• On a monthly basis, we are going to review reasons for revision to ensure all aseptic loosening and infection cases are correctly recorded. • The departmental workplan to be adjusted so that the knee group can monitor the situation carefully. Specifically, it is the intention to introduce a frequent, regular forum for presentation of all pre- and post-operative cases. this will be headed up by a Trauma and Orthopaedic consultant and managed as part of job planning by a consultant orthopaedic surgeon. • Minutes to be recorded as evidence.
13. National Audit of Inpatient Falls (NAIF) report.	• To undertake an audit to assess the gap between actual and reported falls. • Development of education with the moving and handling team to address post fall moving and handling practices.

National audit title	Actions
14. Inflammatory Bowel Disease (IBD) Audit report.	• A dedicated electronic gastroenterology grading matrix to be set up to ensure all new outpatient gastroenterology referrals will be in one place. • To introduce a direct access IBD physician delivered endoscopy service for GP referrals for patients with suspected inflammatory bowel disease.
15. National Bowel Cancer Audit report.	• A data clerk is required to work across colorectal surgery collecting outcome data on several fields, including cancer and pelvic exenteration surgery.
16. National Maternity Perinatal Audit (NMPA) report.	• UHS maternity data and informatics teams to work collaboratively to ensure data submission is accurate and complete.
17. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Balancing the pressure (Long Term Ventilation (LTV)).	• To continue to liaise with service planners/commissioners around integrated care pathways across Hampshire/Dorset/Wiltshire. • Further mapping of commissioning arrangements for LTV provision. • To investigate investment in psychology. • To develop written information about LTV adult service. • To consider independent review of information. • Adult LTV team to attend transition clinics. • To review use of fast-track admission plans.
18. National Comparative Audit of Blood Transfusion (NCABT) 2021 National Comparative Audit of NICE Quality Standard QS138.	• To ensure all patients requiring iron therapy should be started more than four weeks before surgery. • To ensure patients have oral and written information regarding iron transfusion, which can include online resources.
19. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Know the Score (Pulmonary Embolism PE).	• The standardised CT pulmonary angiogram reporting proforma should be audited locally to provide robust evidence, with radiology to audit this.

The reports of 121 Trust-wide and local clinical audits were reviewed in 2021/22 and as result the Trust will take action to improve the quality of healthcare provided (see Figure 20.

Figure 20: Local clinical audit: actions to improve quality

Audit title	Actions
1. Ciclosporin levels (CSA) and testing frequency in patients where the doses are being tapered.	• Audit to be presented and discussed with Bone Marrow Transplant (BMT) consultants. • Dosing is a consultant-led decision and should be repeated if not in range. • CSA level to be checked on days 0 and 1 regardless of whether the level is in range or not on day 0.
2. Early onset Group B Streptococcus (GBS) bacteraemia in Newborn infants.	• Kaiser scoring for infants with known maternal colonisation with GBS is not sufficiently safe therefore to continue to use local current guidelines for GBS.

Audit title	Actions
3. VTE risk assessment of adolescent (13 years and over) patients undergoing major lower limb surgery.	• To discuss with haematologist about current practice and whether change in practice is required for VTE risk assessment of paediatric orthopaedic patients. • To request IT department to make completion of VTE risk assessment pane mandatory for 16- and 17-year-old children undergoing paediatric orthopaedic surgery.
4. Completion of recommended onward referrals following diagnosis of a permanent childhood hearing impairment (PCHI).	• To discuss with appropriate staff if Ear Nose and Throat (ENT) referrals are still deemed necessary. • To present results to appropriate persons.
5. Saving Babies Lives Element 3 - Management of Reduced Fetal Movements.	• To re-audit in a year or because of any incidents.
6. Saving Babies Lives Element 5 Standard A: Reducing preterm births.	• To review in depth all cases that were not compliant with the aim of identifying the cause for not administering antenatal steroids within seven days of birth. • To review in depth all non-compliant cases to identify a common theme, if applicable. • To develop tailored interventions to prevent common themes from reoccurring. • To disseminate the results of the audit. • Clinical lead and audit lead will meet again in June 2021 to discuss the results. • The results to be disseminated among staff and educational resources will be created. • A re-audit to take place in six months' time after interventions planed above have been undertaken.
7. IPCl Sharps Audit Report April 2021.	• 16 ward areas to have the care group manager and care group clinical lead to support them to improve their compliance above 94%. • Five ward areas to produce an action plan and then re-audit to improve compliance to over 94%.
8. IPC Urinary Catheter Care Audit Report April 2021.	• Three ward areas to have the care group manager and care group clinical lead to support them to improve their compliance to above 95%. • Six ward areas to produce an action plan, implement the actions and then re-audit to improve compliance to over 95%.
9. Rates of late onset sepsis in Southampton Neonatal Unit since the introduction of surgical ANNT for central line access, late onset sepsis guideline.	• To improve staff education around line documentation and emphasize two- person technique for insertion (to do this at doctors' induction training).

Audit title	Actions
10. Are we adhering to the VTE prophylaxis protocol? Audit on Respiratory patients in University Hospital Southampton.	• To give a presentation and provide a poster at Wessex QI conference. • To be discussed with Chart's administrators. • The VTE reassessment form to be shown to the junior doctors in medical departments and has been made easier to locate and complete. • To make it clear on the medical notes that reassessment has also been implemented.
11. Review of MRI requests for Inflammatory Back Pain (IBP), requested by Rheumatology and Gastroenterology.	• To liaise with radiology regarding new IBP imaging protocol.
12. Cardiac disease in pregnancy - re-audit.	• A regional cardiac guideline to be developed and shared with referring units. • An e-docs proforma to be updated and shared with referring units.
13. Review of management of infants who are not independently mobile presenting to the emergency department with an actual or suspected bruise.	• To share audit results at the safeguarding governance steering group and paediatric liaison meeting. • To share the audit results at the ED governance group. • To share the audit results at peer review. • Revised bruising protocol, December 2020 to be shared with paediatricians and ED staff, highlighting key changes. • When reviewing process for the paediatric liaison nurses, to escalate to named nurse and ED safeguarding lead consultant if mark/bruise noted and no recorded action that children's social services have been contacted as per standard. • Ongoing bruising protocol training to ED staff. • ISF completion to continue to embed at MDTs and training sessions. • ICON (I – Infant crying is normal C –Comforting methods can help O – It's OK to walk away N – Never, ever shake a baby) completion to continue to embed at MDTs and training sessions.
14. An audit assessing VTE prophylaxis risk assessment on lower limb immobilisation and whether baseline bloods are required to assess.	• Creation of streamlined document with most relevant information regarding Rivaroxaban as VTE prophylaxis in lower limb immobilisation for patient information. • To liaise with governance and IT.
15. Saving Babies Lives Element 1 Reducing smoking in pregnancy.	• To disseminate results at local events, such as MQuEST (Maternity Quality Education and Safety Together), clinical education meeting, maternity mail and theme of the week. • To raise awareness of the importance of asking about the smoking status and performance of CO monitoring at every antenatal appointment. • To develop user-friendly guidance for members of staff undertaking CO monitoring, including how to use the monitor and tips and problem-solving recommendations. • To develop educational resources and training drop-in sessions for members of staff using CO monitoring as part of their clinical role. • To provide training on how to use CO monitoring for those maternity support workers who will be undertaking blood collection duties for women at their booking appointment.

Audit title	Actions
	• To hold discussions with infection prevention regarding the safe reintroduction of CO monitoring during COVID-19 pandemic. • To complete a risk assessment of rooms prior to the reintroduction of CO monitoring, taking into consideration sufficient ventilation to ensure safety of women and midwives. • To check that the right number of CO monitors are available for midwives, to check that CO monitors are in full working condition and the right products are used for cleaning purposes, in compliance with UHS infection prevention policies. • The clinical lead for this element is working in partnership with SHIP(a self- referral service) smoking leads and Local Maternity Systems (LMS). Moreover, it is expected that LMS will release a position statement to request further support from NHS England, since reaching compliance for this element is a common issue across maternity services. • Reintroduction of CO monitoring at every antenatal appointment. This event will coincide with the launch of the new maternity information system (MIS), Badgernet. This MIS will include mandatory questions regarding CO measurements at every antenatal appointment. • Re-audit of ten case notes per month commencing in August until September 2021 to assess performance after implementation of interventions suggested in this action plan.
16. Saving Babies Lives Element 4 - Effective fetal monitoring during labour.	• The obstetric consultants to reach >80% compliance target by 30 September 2021 as agreed by the clinical lead for obstetric consultants. It is expected that obstetric consultants will reach the 90% target by December 2021. • The obstetric trainees to reach >80% compliance target by 30 September 2021 as agreed by the clinical lead for obstetric trainees. It is expected that obstetric trainees will reach the 90% target by December 2021.
17. Saving Babies Lives (SBL) Element 2, additional information. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction.	• To continue quarterly audits for this SBL compliance.
18. Saving Babies Lives Element 2A. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction.	• To undertake an additional audit for questions 1, 2 and 3.
19. Saving Babies Lives Element 2, additional information 2. Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction.	• To ensure the variation of procedures is shared with commissioners and the clinical network. • To ensure a guideline is in place for this part of the element. • A business case to be developed for expansion of ultrasonography.
20. Saving Babies Lives Element 4 - Effective fetal monitoring during labour.	• To plan to re-audit in a year or because of any incidents.

Audit title	Actions
21. Have qualifying cases been reported to Healthcare Safety Investigation Branch (HSIB) and reported to NHS Resolution Early Notification Scheme for April - September 2020 and is there evidence of compliance with Duty of Candour.	• To write to the family who were informed that there would be external investigations ensuring that there is specific mention of the early notification scheme. • To review the duty of candour process for HSIB investigations ensuring that there is clear evidence of discussions. • To amend the governance in maternity and neonatal guideline to include the process for duty of candour in HSIB investigations.
22. Infection Prevention Control - Saving Lives HII 1 Central Venous Catheter Care.	• Insertion: ten areas of non-submission audits to be completed and submitted by 30 June 2021. • Ongoing care: 13 areas of non-submission audits to be completed and submitted by 30 June 2021. • Two areas scored between 85% and 94% to re-audit within Three months ensuring compliance addressed. • Two areas scored below 85% will be required to: produce an action plan to address non-compliance and provide evidence of implementation. • Where non-touch technique non-compliance reported referred to Aseptic Non-Touch Technique (ANTT) training. • Re-audit within one month ensuring compliance addressed through action plan. • Care group managers/care group clinical leads to support the clinical teams, follow up on actions and monitor those areas with sub optimal performance. • A review by care group managers/care group clinical leads is required to ensure that all areas are required to submit audits do so as per the infection prevention annual audit programme.
23. Infection Prevention Control - Saving Lives HII 2 Peripheral Intravenous Cannula Care.	• Peripheral Intravenous Cannula Insertion: 16 areas of non-submission audits to be completed and submitted by 30 June 2021. • Four areas scored between 85% and 94% to re-audit within three months. • Three areas scored below 85% will be required: produce an action plan to address issues and send to Infection Prevention for monitoring. • Where non-touch technique non-compliance reported referred to ANTT support. • Re-audit within one month ensuring compliance addressed through action plan. • Peripheral intravenous cannula ongoing: Seven areas of non-submission audits to be completed and submitted by 30 June 2021. • Two areas scoring between 85% and 94% to re-audit within three months. • 17 Areas scored below 85% and the following actions will be required to produce an action plan to address non-compliance and provide evidence actions implemented. • Where non-touch technique non-compliance reported referred to ANTT support. • Re-audit within one month ensuring compliance addressed through action plan.

Audit title	Actions
24. Post inpatient falls medical response and management.	• To provide education to medical teams on post falls management and elements required to ensure medical reviews are comprehensive and thoroughly documented. • To update eQuest referral options to include an option to indicate the patient has had an inpatient fall and whether any harm is suspected. • To revise and trial an updated post fall medical proforma. • To update falls policy to incorporate elements on post falls management and documentation requirements. • To audit availability and content of post falls grab packs across the Trust to ensure these are readily available to facilitate their use.
25. Re-audit of Door-to-ECG time in the emergency department.	• To gain a pre-triage Electrocardiogram (ECG) more quickly to avoid late diagnosis of ST-Segment Elevation Myocardial Infarction (STEMI). • To create a chest pain box in ambulatory majors to prioritise walk-in patients with chest pain. • To print and utilise new SGH (Southampton General Hospital) Emergency Department (ED) suspected Acute Coronary Syndromes (ACS) guidelines for patients with chest pain. • To continue to push for dedicated ECG bay.
26. Patient Triggered Follow-up (PTFU) for Testicular Cancer.	• The germ cell cancer team to agree that no patient will have PTFU follow-up unless there is documented evidence of an exit interview recorded in the UHS electronic patient record (EPR) system. • The PTFU team will meet with consultant once a month to look at current patients on PTFU and discuss non-compliance. • Patients will be sent one reminder when they have missed an assessment. If patients fail to have their assessment, they will be sent a clinic appointment via the oncology outpatients booking clerks. • All interactions and actions to be documented in the EPR.
27. Fast and Furious - Ultrasound edition.	• To ensure teaching on ultrasound meets the standard set by the Royal College of Emergency Medicine (RCEM). • To set up Sonosite machine so that labels are automatically deleted after images are unfrozen and ensure pre-set labels are available.
28. To assess Neck of femur fractures (NOF) Documentation especially NOF Theatre Checklist in NOF Folder.	• To send an email to all concerned healthcare professionals in the Trauma & Orthopaedics (T&O) care group who are involved in managing NOF patients regarding the importance of ensuring timely and appropriate documentation, especially in promptly filling out the NOF fast-track checklist. • To put up posters for enabling awareness regarding adequate pre-operative documentation in hip fracture patients and its significance to better patient outcomes and improved quality of care.
29. Has an external specialist opinion taken place on all cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death in January to May 2021?	• To discuss the requirement for external clinical oversight for neonatal deaths with Paediatric Intensive Care Unit (PICU) Child Death Review Meeting (CDRM) lead and include within their CDRM process. • To agree the requirements for external clinical oversight for when there are shared care cases and whether additional external clinical oversight is required.

Audit title	Actions
30. Ockenden report, Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy, Q30.	• To make risk assessments at every antenatal contact a mandatory field within the new maternity information system, Badgernet, to improve uptake numbers of full risk assessments. • The new antenatal electronic records/maternity information system, Badgernet, will help to improve record-keeping once fully implemented. • To disseminate the results of this audit to health professionals providing antenatal care at UHS. • To re-audit these standards after the full implementation of the new electronic maternity records/ maternity information system, Badgernet.
31. Management of Supracondylar Fractures in the Paediatric Population.	• To ensure that the proformas for orthopaedic review on admission is used on presentation. • Post-operative monitoring charts will be expanded to include all parameters.
32. Evidence of scheduled Multidisciplinary Team (MDT) ward rounds taking place since December 2020, twice a day, seven days a week.	• To review the staffing guideline.
33. Ockenden report, Immediate and Essential Action 5: Risk Assessment throughout Pregnancy, Q31.	• To disseminate the results of this audit to health professionals providing antenatal care at UHS. • To elaborate a series of interventions to improve record keeping of antenatal records. • To re-audit this standard after the full implementation of the new electronic maternity records/maternity information system Badgernet. • To improve the provision of maternity information to women during antenatal appointments. • To make intended place of birth at every antenatal appointment more intuitive and easier to record.
34. Ockenden report, Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy, Q33.	• To make intended place of birth at every antenatal appointment more intuitive and easier to record. • To make risk assessments and review and discussion of place of birth at every antenatal contact a mandatory field within the new maternity information system, Badgernet, to improve uptake numbers of risk assessment and review of place of birth. • To re-audit these standards after the full implementation of the new electronic maternity records/maternity information system, Badgernet. • To disseminate the results of this audit to health professionals providing antenatal care at UHS.
35. Ockenden report, Immediate and Essential Action 1: Enhanced Safety, Q4 and Ockenden report, Immediate and Essential Action 2.	• To update the UHS local guidance to ensure that there is clarity around having an external reviewer present for perinatal mortality reviews tool (PMRT) case reviews.
36. Maternity clinical documents audit.	• To re-run the Trust document report to check edited maternity documents have been updated correctly.

Audit title	Actions
37. Infection Prevention and Control (IPC) - Multi Professional Hand Hygiene Audit – IN Patient Areas.	• Four areas scored between 94% - 85% to re-audit quarterly. • Five areas scored below 85% are required to be referred to hand hygiene training. • To produce an action plan to address the issues and send to infection prevention for monitoring. • To re-audit within one month ensuring compliance addressed through action plan.
38. IPC - Multi Professional Hand Hygiene Audit – Outpatient Areas.	• Two areas scored between 94% - 85% to re-audit within three months. • Two areas scored 85% are required to be referred to hand hygiene training. • To produce an action plan to address issues and send to infection prevention for monitoring. • To re-audit within one month ensuring compliance addressed through action plan.
39.Screening of faecal/ urinary incontinence in elderly patients admitted to Southampton General Hospital (SGH).	• To present to department (elderly care) medical staff to increase awareness of issue and encourage improved care.
40. First seizures and Driving Advice in the Emergency Department (ED).	• To present audit to ED staff. • To add to 'One Minute Wonder' posters. • Advice on UHS first seizure leaflets available in ED guidelines and printed in majors.
41.Auditing the documentation practices in a Senior House Officer (SHO)-led Ear, Nose and Throat (ENT) emergency clinic.	• Engaging with eDocs development team and SHO training to improve coding.
42. The safe storage of epidurals within University Hospital Southampton NHS Foundation Trust.	• Wards to act and will be visited in the next three months to ensure action has been taken to improve compliance.
43. Medicines refrigerator temperature monitoring.	• To inform ward managers of audit results. • To provide appropriate documentation for compliant monitoring. • To provide advice on request on how to reset thermometers. • Medicines safety team to perform random checks on wards over the next six months and feedback to the ward on the results.
44. Audit of the compliance to complete the treatment escalation plan (TEP) for the patients admitted to the Trauma and Orthopaedics (T&O) department.	• Email to be sent to all T&O staff for raising awareness and improving practice to meet local hospital guidelines. • Local teaching session to advise of the importance of completing this form as this will be re-audited to monitor compliance. • To put up posters in the registrar's office and on the wards for raising awareness about completing the TEP.
45.Compliance with national guidelines for consenting patients for prone spinal procedures.	• A 'Change of Practice' decision to be taken. • A decision will be made to include blindness in all consent forms for prone spinal procedures.

Audit title	Actions
46. Paediatric Vestibular Audit	• To present results at vestibular team meeting
47. Tranexamic Acid (TXA) prescribing in trauma patients.	• To create protocol for Wessex Major Trauma Network to give guidance on when a second dose of TXA should be considered. • To educate staff within emergency department to introduce protocol and reminder of second dose prescribing. • To update emergency department transfer checklist to include "Second dose of TXA required?" prompt.
48. Analysis of fast-track application process in Elderly Care at University Hospital Southampton (UHS).	• To survey nursing staff about their knowledge of and confidence in completing fast-track applications. • To present data at departmental meeting to highlight importance of completing consent forms immediately and group consensus on improving fast-track process. • To re-audit as APEX programme has been updated.
49. Audit of patients with Myasthenia Gravis undergoing Thymectomy at Southampton General Hospital (SGH).	• Development of MDT in Wessex to streamline patient care and improve outcomes.
50. A prospective audit project into the adequacy of pain assessment in patients with Motor Neurone Disease undergoing radiology treatment.	• To introduce a prescribable analgesic protocol to be utilised at the time of admission, which will aim to address analgesic requirements adequately in most of these patients.
51. Use of hearing aids (HA) with secure battery drawers in audiology	• To change to notes template for HA reviews and repairs to remind clinician to ask about battery drawer if not previously documented.
52. First cycle audit assessing the quality of the headache referral pathway and interim report following ongoing quality improvement.	• To include the designing of a proforma to circulate to GP surgeries with the intent of prompting improved pre-clinic assessment, documentation and care. • To discuss with the project lead.
53. Data Transfer to picture archiving communication systems (PACS) 2020.	• To come up with a plan to make sure staff check images are being successfully sent to PACS as they are scanned. • For patients scanned at the end of the day, it would be useful to have a means of a handover for the following day's staff if some data is still to be transferred or processed. • PACS check to be continued with plan to make somebody responsible for ensuring the check gets done. • To speed things up and avoid duplication of work the PACS check should be simplified to specify all required images for a particular scan (as it already does) but without the need to say 'Yes', 'No' or 'N/A' for each one. • Physics to investigate why certain topograms are not being sent to PACS automatically and attempt to fix the problem. • To come up with a plan to keep on top of the Symbia database to make sure it does not reach capacity.

Audit title	Actions
54. Imaging to clear the cervical spine in obtunded patients following trauma: Audit of practice at a regional trauma centre.	• To present at the 2021 audit meeting to update the registrar body on the established best practice to improve vetting standard.
55. A re-audit of hearing aid verification in children.	• To discuss results with relevant staff.
56. Speech and Language Therapy (SLT) Case Note Audit (Paediatrics).	• To feedback results to SLT team and discuss areas for improvement and development. • To agree action points following discussion of the results.
57. Re-audit of the use of clerking proforma for paediatric cardiology patients transferred to E1 ward from PICU.	• To send email to all junior doctors on paediatric cardiology team asking for feedback and suggestions for improvement of PICU step down clerking proforma. • To verbally ask colleagues for feedback and suggestions when able. • To create new clerking proforma. • To raise awareness of and improve availability of new clerking proforma.
58. UHS Environmental Audits Standards Precautions Audit August 2021.	• 16 areas of non-submission to submit their audit by the revised deadline. • 18 areas scored between 94% - 85% to re-audit within three months. • Three areas scored 85% are required to produce an action plan and provide evidence of implementation and to re-audit.
59. UHS Personal Protective Equipment Audit August 2021.	• 28 areas of non-submission to submit their audit by the revised deadline. • Six areas scored between 94% - 85% care group managers/care group clinical leads to provide support to these areas. • One area scored below 85% are required to produce an action plan and provide evidence of implementation and re-audit.
60. Audit on management of hot swollen joints.	• Colchicine to be stocked on both D level wards and Medicine for Older Persons wards for quicker access. • Crystal to be a search item created in eQuest for information. • Distribution of information to be completed to aid searching for non-gynae cytopathology (crystal search tool and request bundles).
61. Abdominal X-rays only when the radiologist says it is ok.	• To continue regular teaching to new doctors joining the department. • To have good use of wall posters to get the message across. • A slide to be added as a screensaver in the ED desktops.
62. An audit review of the treatment options for ingrowing toenails.	• To present the results of the audit in the child health grand rounds.

Audit title	Actions
63. Ockenden report: Maternity Personalised care and support planning. Technical Criteria A.	• To disseminate the results of this audit to health professionals providing maternity care at UHS. • To re-audit these standards after the full implementation of the new electronic maternity records/maternity information system, Badgernet. • To remind health professionals of the importance of accurate record-keeping at professional mandatory days, in maternity newsletters or as theme of the week. • To encourage health professionals to continue using and sharing resources with women to meet individual needs and facilitate woman's or birthing person's informed choice. • To discuss with the digital midwife the possibility of making record-keeping easier for health professionals when documenting the use of resources to meet individual needs and the woman's informed choice.
64. Ockenden report: Maternity Personalised care and support planning. Technical Criteria B.	• To re-audit these standards after the full implementation of the new electronic maternity records/maternity information system, Badgernet. • To disseminate the results of this audit to health professionals providing maternity care at UHS. • To encourage the use of resources in different languages when women do not speak English as their first language by signposting professionals to resources in different languages. • To encourage health professionals to continue using and sharing resources with women to meet individual needs and facilitate woman's or birthing person's informed choice. • To discuss with the digital midwife the possibility of making record-keeping easier for health professionals when documenting the use of resources in different languages to meet women's individual needs.
65. Ockenden report: Maternity Personalised care and support planning. Technical Criteria C.	• To re-audit these standards after the full implementation of the new electronic maternity records/maternity information system, Badgernet. • To disseminate the results of this audit to health professionals providing maternity care at UHS. • To discuss with the digital midwife the possibility of making record-keeping easier for health professionals when recording joint discussions with women on the impacts of any physical or mental health conditions identified through ongoing risk assessment together.
66. Ockenden report: Maternity Personalised care and support planning. Technical Criteria E.	• To re-audit these standards after the full implementation of the new electronic maternity records/maternity information system, Badgernet. • To disseminate the results of this audit to health professionals providing maternity care at UHS. • To discuss with the digital midwife the possibility of making record-keeping easier for health professionals when documenting plans reviewed by or with the woman or birthing person at every appointment. • To discuss with the digital midwife the possibility of making personalised care and support plan in place covering all three elements of the maternity/perinatal journey a mandatory field within the maternity information system, Badgernet. • To raise awareness among health professionals of the relevance of giving the same level of importance to the postnatal period when discussing it with women during antenatal care appointments and undertake personalised care plans with women prior to the birth.

Audit title	Actions
67. Audit of do not attempt cardiopulmonary resuscitation (DNACPR) forms associated with patients with learning disabilities during the pandemic.	• To communicate to staff responsible for initiating DNACPR instructions that these are based on a patients' individual clinical condition through resuscitation training and to reiterate and explain that blanket DNACPRs are not supported. • All staff to be reminded about the legal requirement for involving patients in discussions regarding DNACPR instructions, identifying the reason with clear accurate documentation.
68. Post inpatient falls medical response and management.	• To provide education to medical teams on post falls management and elements required to ensure medical reviews are comprehensive and thoroughly documented. • To update eQuest referral options to include an option to indicate the patient has had an inpatient fall and whether any harm is suspected. • To revise and trial an updated post fall medical proforma. • To update falls policy to incorporate elements on post falls management and documentation requirements. • To audit availability and content of post falls grab packs across the Trust to ensure these are readily available to facilitate their use.
69. An audit to assess the compliance of ward-based therapy rehabilitation of major trauma patients against the NICE clinical guideline 83.	• Core standard 4 – goal setting: to develop a rehabilitation needs and MDT goal setting sticker. • To group therapy paperwork together including goal setting sheet together. • Core standard 5 – Patient information: to develop patient information booklet. • To develop patient survey to involve patients in developing the booklet content. • Core standard 2 – to develop a day three assessment sheet which includes a cognitive screen and functional assessment with goal setting. • To add cognition assessment prompt on major trauma initial interview with risk factor of 48 hours. • Core standard 3 – Function assessments: to pilot study occupational therapy (OT) rehabilitation on F1 to establish what OT involvement has with trauma patients. • To trial joint assessments and goal setting with a functional approach. • Core standard 5: to change major trauma pathway to include discharge section. • To change discharge paperwork and incorporate this into the rehabilitation prescription.
70. Compliance with prescribing oxygen in cardiology.	• To send audit presentation to current FY1s and SHOs working in cardiology for their information.
71. Audit of tracheostomy emergency and bedside equipment and bed signage.	• To clarify with Respiratory High Dependency Unit (RHDU) the access to flexible nasendoscopy. • To discuss with lead consultants the use of capnography with tracheostomy patients. • Aim to develop training package to support educational need on bed signage and emergency equipment across UHS.
72. Cystic Fibrosis Incontinence Care Review.	• To feedback audit findings to the physiotherapy team. • To provide teaching session on incontinence. • To hold discussion around documentation of continence status. • To amend clinic document. • To convert the ICIQ to electronic copy.

Audit title	Actions
73. Venous Thromboembolism (VTE) Prophylaxis for Medicine of Older Person's Department.	• To add sticker for medical notes about VTE, information in induction booklet for incoming juniors and software update proforma.
74. A review of Neurosurgical intracerebral haemorrhage (ICH) referrals during mass COVID vaccination.	• An educational presentation to be given to the neurosurgical registrars at their weekly teaching. • To put printouts of the guidance up on the notice boards in the neurosurgical registrars' office. • To re-audit to evaluate if the actions have been successful.
75. Patient flow through Acute Surgical Unit (ASU) and prescribing compliance.	• A trial of trained advanced nurse practitioners (ANPs) working within ASU from 8am-8pm (Monday - Friday) will be performed to review if the care provided is equal to or better than the current medical provision.
76. Audit of the compliance to complete the treatment escalation plan (TEP) for the patients admitted to the Trauma and Orthopaedics (T&O) department.	• Email to be sent to all T&O staff for raising awareness and improving practice to meet local hospital guidelines. • Local teaching session to be held to advise of the importance of completing this form as it will be re-audited to monitor compliance. • To put posters up in the registrar's office and on the wards for raising awareness about completing the TEP.
77. VTE risk assessment of 16- and 17-year-old patients undergoing major lower limb surgery.	• To hold discussion with haematologist about current practice and whether change in practice is required for VTE risk assessment of paediatric orthopaedic patients. • Requesting IT department to make completion of VTE risk assessment pane mandatory for 16- and 17-year-old children undergoing paediatric orthopaedic surgery.
78. First seizures and driving advice in the Emergency Department.	• Emergency Department SHO to complete a teaching presentation.
79. Auditing the support given to patients with meal ordering on a dementia ward.	• To feedback results to speech and language therapy (SLT) team. • To feedback results to dementia working group. • To feedback results to Bassett Ward. • To feedback results to Serco catering team. • SLT, Serco catering team and dietetics to work together to produce texture-modified photo menus. • To discuss with VLE leads whether Serco catering staff could have some access to Trust training.
80. Auditing availability of snacks of a variety of consistencies on medicine for older people (MOP) wards.	• To share results with Serco catering team.
81. Auditing the prevalence of communication impairments in stroke admissions at University Hospital Southampton (UHS).	• To present audit and results at clinical effectiveness meeting.

Audit title	Actions
82. Prevention and management of pain.	• All ward leaders to remind staff of the need to enter a pain score on SafeTrack with each set of observations. • Senior nursing staff on shift to monitor documentation of patients who have moderate pain score on two or more consecutive occasions to ensure they have a documented plan in place. • Senior nurses to enforce that only registered patient-controlled analgesia (PCA) trained nurses should be recording PCA pump observations. • Ward managers to identify and arrange training on pain assessment for any staff who have not yet received it, confirming with practice development team when all relevant staff are compliant.
83. Prescription of regular flushes after biliary drain inserted through Percutaneous Transhepatic Cholangiography (PTC).	• Interventional radiology team requires improvement and training on documenting drain flushes. • The Hepatobiliary and pancreatic (a) surgical team to ensure they prescribe drain flushes. • The surgical nurses to be made aware of the importance of flushing the PTC drains (unless clearly contraindicated) and the need to contact the junior surgical doctor if drain flushes are not prescribed.
84. Are therapists providing evidenced-based, best practice guidance for patients attending UHS with a history of falls?	• The patient information leaflet to be redesigned and shared with therapy services. • Revised falls policy information to be shared with therapies department for information/education. • Review of current practices in relation to falls post COVID-19.
85. Audit of CT guided lung biopsies.	• Results disseminated to all clinicians involved in CT guided lung biopsies to raise awareness.
86. Hydration assessment and monitoring.	• To attend wards to promote the use of charts and have a focus week on hydration assessment and monitoring.
87. Documentation supporting monitoring patients' fluid balance.	• To disseminate results to individual wards for action. • To arrange focus week to concentrate on areas of lower compliance (recording of weight/ml per hour required, balances at midday and midnight). Week to include focus board and visits to wards by practice development nurses. • To plan for the fluid balance to be added to the online system, this is ongoing with digital services team.
88. Use of outcome measures to monitor improvements in patient recovery during stroke rehabilitation.	• To present results and feedback to the stroke therapy service.
89. Time to antibiotic in patients presenting with neutropenic sepsis and use of MASCC (Multinational Association for Supportive Care in Cancer) score to stratify patients presenting to acute oncology service.	• To present Audit in oncology audit meeting.

Audit title	Actions
90. Reducing risk of overdose with midazolam injection in adults.	• To ensure that areas in division B and division A are recorded that perform conscious sedation and assurance that there is an up-to-date guideline that states midazolam 5mg/5ml should be used. • To confirm that cardiovascular and thoracic unit perform conscious sedation and assurance that there is an up-to-date guideline that states midazolam 5mg/5ml should be used.
91.Audit of reporting turnaround times for material referred for molecular analysis to West Midlands Regional Genetics Laboratory	• RNA/DNA-NGS panel to be requested by reporting pathologist on new diagnostic biopsy/cytology/EBUS/metastatic sample as reflex + resections on request for adenocarcinoma/non-squamous non-small cell carcinoma.
92. Auditing medicine for older people ward compliance with the implemented International Dysphagia Diet Standardisation Initiative (IDDSI) fluid and diet guidelines and protocols.	• To update posters to ensure they are displaying the most up-to-date information. • Ongoing training should be provided to ward staff to ensure that handovers and diet grids are continued to be used with the appropriate terminology. • Supplement posters need to be displayed consistently on all wards. • Staff to ensure they are aware of appropriate supplements for patients on a particular level of thickened fluids and thickened fluids are being prepared to the correct consistency to aid patient compliance and safety.
93. Complications in Head and Neck Free Flap Patients.	• To review antibiotic protocol to consider extending beyond 2xIV antibiotics post-operative doses. • To discuss with MDT regarding consensus moving forward. • To re-audit in three months.
94. Pre-Operative Chest Radiographs (CXR) performed despite a recent prior examination.	• Awareness of staff performing IR(ME)R practitioner justification of completing another CXR. • Awareness of referring clinical staff. • To request all the patient's related imaging once the patient has been accepted by the Trust.
95. Management of pain in patients presenting to the Emergency Department (ED) with ankle fracture/ dislocation.	• Poster to be emailed to all ED staff highlighting results and recommendations. • To present findings within appropriate forum. • To present findings at middle grade teaching.
96. Audit of disposal of controlled drugs, non-controlled drugs, IV fluid and sharps in theatres at UHS.	• To discuss with theatre matrons regarding areas of contention highlighted by audit and clarification of policy. • Increase awareness of correct disposal methods through the following methods: by email to all anaesthetists and posters in theatres.
97. Compliance with MRSA risk reduction local policy within Surgical High Dependency Unit (SHDU).	• To discuss the findings of the audit with Infection Control for critical care. • To discuss with pharmacy whether we can make prescription of MRSA decolonization protocol easier for doctors. • To discuss with all SHDU staff the importance of appropriate adherence to the current MRSA decolonization policy.
98. Documentation of the preoperative CXR result in preoperative clinic assessment.	• To make medical staff aware of the issue of documentation of preoperative CXR. • To present at local meeting.

Audit title	Actions
99. Musculoskeletal therapy outpatient electronic notes audit: quality assurance of virtual and face-to-face consultation patient records using local abbreviation list.	• Working group to meet to amend notes template to address body chart information for new patients and objective/subjective information and goals review in follow-up sessions. • To agree a local abbreviation list. • To agree standardised document title. • To introduce electronic PROMs data via MyMR.
100. Auditing the documentation practices in an SHO-led ENT emergency clinic.	• To engage with eDocs development team and SHOs' training to improve coding.
101. Is delirium assessment in the GICU being performed at the optimum standards?	• Doctors to document in notes during ward rounds and on admission for CAM-ICU to be performed.
102. Unlicensed medicines.	• Where a patient information leaflet (PIL) is not available in English - to contact the manufacture to obtain English PIL - where this is appropriate. • Determine if injections that do not have any information and that have not been issued in the last six months are still required to be kept at UHS. • For injections where there is no information available (no PIL or in Medusa injectable medicines guide) to determine what information is available to nurses at the point of administration. • To complete a mini audit at the RSH to determine if they keep any other unlicensed medicines that are not kept at SGH dispensary.
103. Patient compliance with preparation information for stress cardiac scan.	• Gathering of cardiac magnetic resonance scan reporters in the discrepancy meeting to present the results, discussion on it and suggesting of new ideas e.g., optimisation of SMS information service.
104. Controlled drugs: safe use and management on the neonatal unit.	• Drug order book to be kept in a locked cupboard, location to be confirmed. • Staff education on signing drugs to create a one-minute wonder board. • Staff education on signing drugs to create a model template of 'how to document and sign for controlled drugs' that can be placed in the drug cupboard. • Signing drugs: creating 'checked and correct' stamps. • Create rubber stamp templates for controlled drugs. • Nurse education through email and education team.
105. Measurement of iron parameters in heart failure patients.	• Heart failure European Society of Cardiology guidelines to be presented in ground round cardiology department. • Iron studies in heart failure patients to be designed and published.
106. Re-audit: A review of Neurosurgical ICH referrals during mass COVID vaccination.	• An educational presentation to be given to the neurosurgical registrars at their weekly teaching session. • Printouts of the guidance to be placed on the notice boards in the neurosurgical registrar's office. • To re-audit to evaluate if the actions have been successful.

Audit title	Actions
107. EEG Support and Adjustments.	• To keep track of those who repeatedly do not attend to send a friendly reminder. • To start from February 2021 appointments highlighting all referrals who should be sent a letter to make this more obvious to administrative staff. • All physiologists to gather responses and re-audit again in February 2022 for three months to allow for time for changes with the aim of being able to collect feedback about the support and adjustments on offer.
108. Is an organic cause ruled out in the Emergency Department in patients presenting with psychosis/ mania?	• To advertise and promote the psychosis and mania protocol within the Emergency Department and encourage clinicians to use this tool. • To educate and encourage nursing and medical staff to use the: - psychosis and mania bundle. - psychosis/mania protocol posters. - psychosis/mania education. - psychosis/mania checklist.
109. Auditing availability of snacks of a variety of consistencies on medicine for older people (MOP) wards	• To share results with Serco catering company. • To liaise with Serco to create and implement a finger food menu. • To liaise with Serco regarding the availability of rice pudding and custard pots for patients (including those on modified consistency diets).
110. The impact of electric scooters on a major trauma centre.	• To do further research to assess risks and planning to submit the data to clinical governance. • To engage the local council to improve public safety.
111. Cystic Fibrosis (CF) Incontinence Care Review.	• To feedback to the physiotherapy team these results and discuss reasons surrounding it. • To provide a teaching session on incontinence in CF and the importance of addressing this issue and monitoring it using the outcome measures. • To inform the management on approaches possible and how to refer for specialist intervention. • To add prompt for ICIQ, treatment plan and onwards referral to online paperwork.
112. Patient flow through ASU and prescribing compliance.	• A trial of trained ANPs will be working within ASU from 8am-8pm (Monday - Friday) to review if the care provided is equal to or better than the current medical provision.
113. Indications of plain abdominal films from A&E at Southampton General Hospital.	• Ensure clinicians complete a thorough clinical assessment before ordering an abdominal X-ray (AXR). • Clinicians to seek further advice when in doubt regarding AXR before ordering any more.
114. Assessing pain in dementia patients using the Abbey tool.	• To raise awareness with nurses on the Abbey pain tool available for dementia patients. • To further analysis the use of the behaviour pain assessment tool (BPAT) to test reliability and validity. • If UHS wish to use BPAT will need to seek approval after the analysis has been completed. • Once decision has been made on which pain tool to use to have champion wards and outreach service to promote tool.

Audit title	Actions
115. Measuring and Improving Fractional Efficiency in Radiotherapy.	• To re-audit the time taken to complete the service in both Southampton and Basingstoke to align both sites to complete the required attendances per year.
116. Prevention of hyperthermia in patients with acute brain injury.	• To ensure clear tab on cooling methods. • To educate staff on intervention required when temperature >37.5 in acute brain injury. • To update the Wessex Neuro Guidelines.
117. Use of clinical photography in trauma and orthopaedics.	• To ensure orientation photographs taken on the entire limb or body part prior to photographing the wound or lesion in question.
118. Audit of safe sleep and ICON advice given to families by Maternity and Neonatal Unit Staff.	• To re-audit cases to include a wider number once Badgernet is fully embedded. • Neonatal Unit to review which policy should include the guidelines for discussions and documentation of safe sleep and ICON information.
119. Triage in the Maternity Day Assessment Unit (MDAU).	• To consider consultant obstetric staffing in workforce project - gain consensus from consultant obstetrician group. • Link with practice education team to request time and plan for Birmingham Symptom-specific Obstetric Triage System (BSOTs) update in annual midwifery statutory and mandatory training day. • MDAU leads to meet with audit leads to review green' actions to facilitate increased midwifery-led discharge where appropriate.
120. Prospective audit of 'fast-track'	• Clinical lead to speak to the divisional director regarding assistance with theatre availability to facilitate 'fast-track' Whipple's surgery.
121. Maternity documentation audit.	• To share findings with Badgernet team and discuss plans for audit going forward.

2.2.2 Recruiting to research

The number of patients receiving relevant health services provided or subcontracted by UHS in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 13,000. We ranked ninth for total recruitment amongst all acute NHS trusts and delivered the most COVID-19 studies.

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

2.2.3 Commissioning for quality and innovation (CQUIN) payment framework

CQUIN is a quality framework that allows commissioners to agree payments to hospitals based on the number of schemes implemented and a proportion of our income is conditional on achieving goals through the framework.

UHS income in 2021/22 was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework because the whole framework was suspended in response to COVID-19 without any detrimental impact on provider income.

Block payments to NHS providers will be deemed to include CQUIN, but the practical operation of CQUIN (both local commissioners and specialised commissioning), for NHS providers was suspended until March 2022. NHS providers are not required to carry out CQUIN audits or submit CQUIN performance data, but commissioners and NHS providers are advised they should continue to pay regard to the good practice processes highlighted within CQUIN and make appropriate decisions on how to implement these alongside published clinical guidance.

2.2.4 Statements from the Care Quality Commission (CQC)

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

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

The CQC has not taken enforcement action against UHS during 2021/22.

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 and leadership. In January 2019 NHS Improvement carried out a use of resources (UoR) inspection and the CQC completed its inspection.

The report was published on the 17 April 2019 and the Trust was rated as 'good' overall and 'outstanding' for providing effective services. We were rated as 'good' in the well-led category and for using our resources productively, with a combined UoR and quality rating of 'good'.

During 2021/22 the CQC scheduled inspections remained paused and we have not had a risk triggered inspection.

The Trust has worked hard to maintain contact and communication with our inspectors during this period. We have provided a regular flow of information, updates and escalations on our response to the COVID-19 pandemic, restoration of services, operational and strategic plans and the measures put in place to protect patients and staff.

Monthly contact and quarterly engagement meetings have continued to take place, and UHS looks forward to the next opportunity to have our services re-assessed and our ratings updated as we move towards our strategic goal of 'authentically outstanding'.

Figure 21: Overall rating for UHS 2019

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

2.2.5 Registration with the CQC

UHS is required to register with the CQC and its current registration status for locations and services is as below.

Regulated activity: Surgical procedures:

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

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

Regulated activity: Diagnostic and screening services
- Princess Anne Hospital, Coxford Road, Southampton SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton SO40 7AR

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

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

UHS has been registered with the CQC since its inception in 2010 and has maintained its registration without conditions or enforcement action ever since, including in 2021/22.

2.2.6 Payment by results

UHS was not subject to a payment by results (PbR) clinical coding audit during 2021/22 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 auditors.

2.2.7 Data quality

Data quality refers to the tools and processes that result in the creation of the correct, complete and valid data required to support sound decision-making.

UHS submitted records between April 2021 – March 2022 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As of March 2022 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number were:
- 99.5% for admitted patient care;
- 99.8% for outpatient care; and
- 96.2% for accident and emergency care.

which included a valid General Medical Practice Code were:
- 99.9% for admitted patient care;
- 98.6% for outpatient care; and
- 95.8% for accident and emergency care.

UHS will be taking the following actions to improve data quality:
- 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.
- To evidence the quality of data entry.

2.2.8 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 2020/21 assessment in June 2021, which complied with the revised deadline of 30 June 2021. The Trust was unable to provide the required level of assurance for four of the 110 mandatory assertions and consequently submitted an improvement plan, which was accepted by NHS Digital.

The Trust is 'approaching standards' and due to the increasing impact of COVID-19 and the recent security vulnerability (Log4J), NHS Digital has decided that organisations will no longer be required to submit updated improvement plans and no new deadline will be set for the 2020/21 submission. As such we will remain as 'approaching standards' for 2020/21.

2.2.9 Learning from deaths

During 2021/22 2,002 UHS patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Figure 22: Number of deaths per quarter 2021/22

Q1	Q2	Q3	Q4
403	429	639	531

By 31 March 2022 case record reviews and 171 investigations have been carried out in relation to the deaths included in Figure 21.

In 171 cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 403 in the first quarter; 429 in the second quarter; 639 in the third quarter; and 531 in the fourth quarter.

21 representing 1.1% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of two representing 0.5% for the first quarter; two representing 0.1% for the second quarter; 13 representing 2% for the third quarter; and four representing 0.8% for the fourth quarter.

These numbers have been estimated using the total incident investigations related to patient deaths referred to and investigated by the patient safety team using the structured judgement review (SJR) and root cause analysis (RCA) methodologies. These referrals come from medical examiners, adverse event reporting, child death and deterioration group (CDAD), clinical events reviews, the infection prevention team and clinicians involved in care.

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

Figure 23: Learning from cases

Thematic learning	Summary of completed action(s)	How learning has been shared	Impact of action
Learning was identified in relation to Vancomycin level monitoring in patients.	Education and refresher education delivered to staff groups by pharmacist teams. Explain use of MicroGuide app if staff are new to the Trust and available channels of support. Review undertaken across the Trust regarding the monitoring and recording of medication related levels and communication around these. All anaesthetists to consider all blood levels and available information when reviewing a patient prior to theatre. Review the use of JAC prescribing system in theatres regarding accessibility of equipment and system, understanding barriers to practice and providing clear guidance on expected working. Review of options of recording levels and information on the electronic prescribing system versus a paper chart. Consider if one system can accommodate all medications that have level monitoring requirements for appropriate dosing.	Communication available to staff via video links. Alerts and safety prompts added to electronic prescribing system to reduce error. Learning shared at M&M meetings. Summary of case to be included in the pharmacy session of the doctors' induction to highlight the need for accuracy when prescribing and understanding responsibilities for monitoring.	Improve patient safety, better understanding and knowledge of staff, more accurate communication. All nursing staff will have the appropriate knowledge and understanding to make this process as safe as possible. Medical staff will be aware of how to access guidance and what their responsibilities are in relation to that medication.

Thematic learning	Summary of completed action(s)	How learning has been shared	Impact of action
The out-of-hours referral system for physiotherapy or occupational therapy support is not sufficiently robust, leading to a key referral being overlooked for patient with neuromuscular degenerative disease.	Consultation for an improved system of referral to increase efficiency and reduce risk and enabling staff to automatically refer any respiratory patient with a neuromuscular degenerative disease including out of hours to the physiotherapy team. Education delivered to relevant staff groups. Expanding policy list and guidelines for staff of carers to include the 'expert carers' to encourage the contribution to patient care of the expert carer.	Consultation and outcome are shared throughout organisation.	Improvement of the referral function for referring staff and provide staff with information at a glance to determine if a referral has been made or not. Nursing staff will automatically refer any respiratory patient with a neuromuscular degenerative disease, including out of hours, to the physiotherapy team and better understand the risks. Clearly documented guidelines will provide certainty to staff who are asked to exercise discretion and provide guidance on when next of kin are deemed to be expert carers and allowed to stay with patients with increased care needs.
Fall risk assessment is not always completed in a timely manner as per hospital policy on transfer/post fall/following a change in clinical condition.	Refresher training to be delivered to staff of all grades. Standard revised to include a nurse in charge review of all new admissions to any clinical area to ensure all assessments and documentation have been completed. Compliance will be shared with the nursing staff during daily safety huddles and any barriers to compliance discussed and mitigated. All patients assessed as risk of falls to be referred to therapy for mobility assessment. All patients who are not at base line mobility to be referred to therapy. New handover process operational which includes highlighting any outstanding assessments. Radiology staff induction pack to be updated with Trust falls pack and radiology falls pack.	Shared via safety huddles, peer review programmes and at clinical leader forums and governance groups.	Improved patient care tailored to individual needs. Falls mapping will be the process of a real-time review of each fall occurring on the ward to quickly identify learning as well as information that can be used to identify trends and themes.

Thematic learning	Summary of completed action(s)	How learning has been shared	Impact of action
X-ray results were not actioned post high harm fall No standard operating procedure (SOP) to manage urgent imaging requests.	SOP developed for urgent out-of-hours requests. Explored options to amend the eQuest system to communicate a specific urgency of a request beyond the current option that is limited to 'urgent'. Ward whiteboards, as clinical tools, are now routinely used to highlight and follow up clinical requests.	Communicate SOP across radiology and assess the competence of the administrative team.	High risk scans are identified and actioned immediately, or as soon as it is reasonably practical to do so.
Failure to monitor deterioration - inadequate checking of patient when critical alarm noted.	Teaching to all staff and rules set out for checking patients when a critical alarm is seen and will include getting a response from the patient any time a critical alarm is seen. Introducing signage at telemetry station outlining the expectations. Education to ensure that emergency buzzer to be pulled in the event of nursing staff being unsure of a patient's condition. Teaching all staff how and why we check previous events on the telemetry when an alarm sounds. A review with our education team of our ECG teaching forward nurses. Treatment Escalation Plans (TEPs) to be discussed on ward rounds and clearly documented using TEP forms and placed in medical notes. TEP is handed over when patient is transferred between wards. TEP is reviewed as required. Need for TEP to be documented to be discussed and cascaded through M&M and consultant forums. Removal of medical devices to be documented in medical notes detailing action undertaken. Importance of maintaining documentation standards to be cascaded through M&M meetings and consultant forums.	Education teams, via ward rounds, M&M meetings and consultant forums.	Will ensure that any patient where a critical alarm is shown is checked and a response is given. Clear communication of TEP for all inpatients.

0 case record reviews and 0 investigations completed after 1 April 2021 which related to deaths which took place before the start of the reporting period.

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

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

2.2.10 Reporting against core indicators

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

The tables below provide information against a number of 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.

All the core indicators included are updated with the most recent publications from NHS Digital/NHS England and NHS Improvement/Gov.uk. 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. Nationally not all data collections continued during 2021/22, so data is not as complete as in previous quality accounts.

The value and banding of the Summary Hospital-level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of discharge.

NB: UHS is part of the acute (non-specialist) cluster now (1 of 136 organisations) – the acute teaching trusts cluster ended in 2014 when the National Reporting and Learning System (NRLS) had an internal reconfiguration of how they benchmark organisations.

Figure 24: The value and banding of the Summary Hospital-level Mortality Indicator

SHMI	June 2020 - May 2021		July 2020 - June 2021		Aug 2020 – July 2021	
	Value	OD* banding	Value	OD* banding	Value	OD* banding
UHS	83.17	2	83.1	2	81.78	2
National Ave	100	2	100	2	100	2
Highest Trust Score	119.82	1	120.17	1	118.47	1
Lowest Trust Score	71.69	3	71.95	3	71.88	3
	Sept 2020 - Aug 2021		Nov 2020 - Oct 2021		Dec 2020 – March 2022	
	Value	OD* banding	Value	OD* banding	Value	OD* banding
UHS	81.97	2	82.49	2	85.1	2
National Ave	100	2	100	2	100	2
Highest Trust Score	118.47	1	118.6	1	119.49	1
Lowest Trust Score	71.61	3	71.93	3	71.61	3

*OD definition: the SHMI gives an indication for each non-specialist acute NHS trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected' (SHMI banding=1), 'as expected' (SHMI banding=2) or 'lower than expected' (SHMI banding=3) when compared to the national baseline.

UHS considers that this data is as described for the following reasons: performance data is consistently gathered and data quality assurance checks made. Robust reporting and monthly scrutiny are carried out at multidisciplinary quality committees. We have reported as 'as expected' SHMI ratio for the last four years.

UHS has taken the following actions to improve the SHMI indicator and so the quality of its services by: introducing, embedding and developing the IMEG processes described in the learning from deaths section of this quality report.

Figure 25: The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust since 2020/21

	December 2019 - November 2020	January 2020 - December 2020	February 2020 - January 2021	March 2020 - February 2021
UHS	43.5	43.0	41.5	41.6
National Ave	36.8	37.0	36.9	37.3
Highest Trust Score	59.3	61.5	62.3	62.38
Lowest Trust Score	8.1	7.7	7.2	7.8

	April 2020 - March 2021	May 2020 - April 2021	June 2020 - May 2021	July 2020 - June 2021
UHS	42.7	44.3	43.0	43.5
National Ave	38.0	38.6	38.0	39.1
Highest Trust Score	63.1	64.6	65.0	63.7
Lowest Trust Score	8.5	9.2	38.0	10.6

	August 2020 – July 2021	September 2020 - August 2021	November 2020 - October 2021	November 2020 - October 2021
UHS	40.9	39.7	35.9	34.9
National Ave	39.2	39.2	39.5	39.7
Highest Trust Score	57.6	63.6	63.9	64.4
Lowest Trust Score	11.0	12.0	11.5	11.2

UHS considers that this data is as described for the following reasons: the data is reviewed by the palliative care team, interrogated in line with the key lines of enquiry identified by that team and has reporting and governance arrangements and progress reports to quality committees.

UHS has taken the following actions to improve the percentage of patient deaths with palliative care coded and so the quality of its services by: working with NHS Digital and the specialist palliative care coding team and by continuing to monitor palliative care coding against national best practice in order to ensure that the number of expected deaths is accurately recorded.

The Trust's patient-reported outcome measures scores

Groin hernia surgery and varicose vein surgery : in the past neither hernia repair nor varicose vein surgery was 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.

Patient reported outcome measures (PROMs) data for hip replacement surgery and knee replacement surgery has not been collected nationally during the reporting period. The data below is the last available data.

Figure 26: Hip replacement surgery table 2018-20 only

	2018/19	2019/20	2020/21
UHS	21.68	22.97	Data not available (affected by the suspension of the submission of data)
National Ave (All Providers)	22.26	22.83	
Highest Trust Score (All Providers)	25.38	25.68	
Lowest Trust Score (All Providers)	18.65	18.25	

Figure 27: Knee replacement surgery 2018-20 only

	2018/19	2019/20	2020/21
UHS	21.68	22.97	Data not available (affected by the suspension of the submission of data)
National Ave (All Providers)	22.26	22.83	
Highest Trust Score (All Providers)	25.38	25.68	
Lowest Trust Score (All Providers)	18.65	18.25	

UHS is taking the following action to improve outcomes for hip and knee replacement surgery and so the quality of its services by: continuing to focus on improving participation rates for those surveys which we have responsibility for and by continued oversight of the feedback provided by the elective orthopaedic team.

Figure 28: The data made available to the Trust by NHS Digital with regard to the percentage of patients readmitted to a hospital that forms part of the Trust within 28 days of being discharged from a hospital that forms part of the Trust during the reporting period

Age range	2019/20	2020/21 April-February	2021/22 February-March
0-15	6.34%	6.62%	6.8%
16 or over	8.49%	13.40%	13.86

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.

The Trust's responsiveness to the personal needs of its patients during the reporting period

Figure 29: The Trust's responsiveness to the personal needs of its patients during the reporting period

	2018-19	2019-20	2021-2022
UHS	69.2	67.0	Data not available (affected by the suspension of the submission of data)
National Ave (All Providers)	67.3	67.1	
Highest Trust Score (All Providers)	58.9	54.4	
Lowest Trust Score (All Providers)	85.0	84.2	

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

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

Figure 30: The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

Staff Recommends Care %	2018/19 Q1	2018/19 Q2	2018/19 Q4	2019/20 Q1	2019/20 Q2	2020/21	2021/22
UHS	94%	92%	94%	93%	93%	71%	83%
Highest Trust Score	100%	100%	100%	98%	100%	77.6%	58.4%
Lowest Trust Score	53%	39%	46%	64%	62%	38.5%	38.5%

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

UHS has taken the following actions to improve the percentage of staff who would recommend the Trust as a care provider, and so the quality of its services by: continuing to encourage participation in this survey and by developing local action plans and responses to the feedback received.

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

Figure 31: The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period

Venous thromboembolism (VTE) is a significant risk to hospitalised patients. Our VTE programme aims to reduce preventable harm to our patients by promoting timely and accurate VTE risk assessment and ensuring thromboprophylaxis is prescribed accurately and administered effectively when required.
Our VTE programme continued this year, however 2020-2022 VTE submissions were suspended due to the COVID-19 pandemic.

	Q2 2017/18	Q3 2017/18	Q4 2017/18	2020-2022
UHS	93.47%	93.60%	92.78%	Data not available (affected by the suspension of the submission of data)
National Ave (Acute Providers)	95.19%	97.34%	95.18%	
Highest Trust Score (Acute Providers)	100.00%	100.00%	100.00%	
Lowest Trust Score (Acute Providers)	71.88%	76.08%	67.04%	

	Q2 2018/19	Q3 2018/19	Q4 2018/19	2020-2022
UHS	92.91%	92.49%	92.95%	Data not available (affected by the suspension of the submission of data)
National Ave (Acute Providers)	95.44%	95.65%	95.50%	
Highest Trust Score (Acute Providers)	100.00%	100.00%	100.00%	
Lowest Trust Score (Acute Providers)	68.67%	54.86%	74.03%	

	Q2 2019/20	Q3 2019/20	Q4 2019/20	2020-2022
UHS	92.19%	95.99%	Data not available (affected by the suspension of the submission of data)	Data not available (affected by the suspension of the submission of data)
National Ave (Acute Providers)	95.28%	95.04%		
Highest Trust Score (Acute Providers)	100.00%	100.00%		
Lowest Trust Score (Acute Providers)	71.72%	71.59%		

C. difficile infection

Figure 32 : 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

	2018/19	2019/20	2020/21	2021/22
UHS	10.6	12.3	38.7	Data not available (affected by the suspension of the submission of data)
National Average	11.71	13.2	45.6	
Highest Trust Score	79.65	51	141	
Lowest Trust Score	0	0	0	
Lowest Trust Score (non-zero)	1.6	1.7	2.3	

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

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

Information about our C difficile performance during 2021/22 can be found in part 2 of this report.

Safety incidents

Figure 33: 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

	October 2018 - March 2019	April - September 2019	October 2019 - March 2020	April 2020 - March 2021	April 2021 - March 2022
UHS					
Rate Incidents per 1000 admissions	39.71	36.70	34.50	38.13	38.1
Number Incidents	7,429	6,909	6,373	1,153	1,534
Number that resulted in severe harm or death	40	37	43	90	78
% that resulted in severe harm or death	0.54%	0.54%	0.67%	0.8%	0.78%

UHS considers that this data is as described for the following reasons: we use the nationally reported and verified data from the National Reporting and Learning System (NRLS); our individual incident reporting data is made available by the NRLS every six months.

UHS has taken the following actions to improve these indicators, and so the quality of its services by: continuing to encourage staff to report incidents of harm; the Trust routinely monitors incident rates and the proportion of incidents which result in severe harm or death.

Other information

Figure 34: Other Information

Safety indicators	2019/20	2020/21	2021/22
Serious Incidents Requiring Investigation (SIRI)	48	90	76
Never Events	6	1	5
Avoidable Hospital Acquired grade III and IV Pressure Ulcers	46	20	158
Falls - Avoidable Falls	19	2	5

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

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

2.2.10 Reporting against core indicators

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 the COVID-19 pandemic.

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.

In November 2019 UHS audited compliance and demonstrated we achieved the standard 95.52% of the time. On average patients waited three hours 17 minutes for an assessment, three hours 41 minutes on a weekday and two hours 20 minutes at the weekend.

Because of COVID-19 UHS did not re-audit in 2020 or 2021 but there are plans to do so in 2022. The self-assessment of performance against the 7DS clinical standards and the associated board assurance process was also suspended nationally as a result of the pandemic.

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. 7-day mechanical thrombectomy cover has been delivered since March 2021.
- 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 take place in admission areas, intensive and high care areas and once daily review in other inpatient wards. The Trust consistently achieves this target.

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

2.2.12 Freedom to speak up (FTSU)

The Trust is committed to continuing to promote an open, honest and transparent culture where all employees, workers and volunteers feel safe and supported in speaking up.

The Trust Board and senior leadership team support this vision by acting as role models in promoting a speaking up culture across the organisation in line with the Trust's values and behaviours, and providing the resources required to support the FTSU agenda.

Having a FTSU guardian has given confidence to individuals to raise issues that they would not have raised in the past because they are protected from any repercussions and have the advantage of either confidentiality or anonymity. Our FTSU guardian and champions have a key role in helping to raise the profile of raising concerns in the organisation and promoting a speaking up culture. They provide confidential advice and support to employees, workers and volunteers when they have concerns and encourage them to raise them with the organisation. We had continued to grow our community of champions during 2021/22, and now support 38 champions from a wide variety of backgrounds.

Our guardian is available via a dedicated mobile phone number and email address and responds to all concerns within 48 hours. In 2020/21 we held most meetings using digital platforms to maintain safety, but this year we have gradually transitioned to a mixture of virtual and face-to-face meetings as restrictions ease. We have improved our resource page on our internal intranet with up-to-date information about our FTSU service and promotional leaflets and posters available and displayed in all working areas.

Speak up – we will listen

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

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

What concerns can I raise?

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

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

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

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

How do I raise my concerns?

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

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

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

More about the Freedom to Speak Up Guardian

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

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

Christine Mbabazi
07818 521753
RaisingConcern@uhs.nhs.uk

> "I'm here to listen to any concerns that you have about working at the Trust"

Our FTSU reports directly to Trust Board on a bi-annual basis and the monthly raising concerns (whistleblowing) steering group, which is chaired by an executive lead. Here the guardian can share the key findings/ recommendations from concerns that have been raised to foster a culture of openness, transparency and learning from mistakes.

The Trust also has a raising concerns policy that establishes clear lines of escalation for concerns to be raised, which are as follows:

- Raise the matter with your line manager.
- Contact the FTSU guardian or FTSU champion.
- Contact the executive director responsible for FTSU.
- Contact the non-executive director responsible for FTSU.
- Raise the concern externally.

The continuing effectiveness of this policy is reviewed at Trust Board on a bi-annual basis, and we continue to work to develop and strengthen our processes and structures to continue to support speaking up. The Trust is fully engaged with the National Guardian's Office and the local network of Freedom to Speak Up guardians in the region to learn and share best practice.

What our staff have told us

''You have been working wonders for my friend, you really are a jewel in the UHS crown, thank you for all that you do.''

''I had concerns… about my career progression. On several occasions, you liaised with me on how to remain professional and how to engage with my manager. You requested my consent before sharing or escalating any issues I had raised with you.''

''You escalated the concerns I had raised to senior management, and you represented my interest in these meetings. Through your input I had some positive outcome for some of the concerns I had raised.''

''You kept me informed of the outcomes of meetings.''

''Thank you for your support and it is great that UHS has a freedom to speak up champion.''

''Just to put into writing my thanks for your recent support with several of my team as our Freedom to Speak up Guardian…several have given me direct feedback on how helpful and supportive you have been, which has been very helpful in these stressful times.''

''Oh, thank you so much- I could cry with relief!''

''You're very good at your job - thank you for giving me a voice!''

''I cannot thank you enough!''

2.2.13 Rota gaps

The guardian of safe working hours is responsible for ensuring that working hours are safe for NHS doctors and dentists in training in England; we know that this is important for patient and staff safety and to help maintain quality care.

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

The guardian provides a mechanism whereby safety concerns related to working hours and rota gaps can be identified, responded to and addressed.

A regular report is submitted to the Trust Board which includes updates on rota compliance, vacancies/gaps and plans for improvement and junior doctor exception reporting data is a standing agenda item with the local negotiating committee.

There are 714 Junior doctors in training employed by the Trust and they all work on the 2016 contract.
There are 344 Junior Doctors employed in non-training posts; all these doctors work on UHS local terms and conditions which mirror the 2016 contract.

The current vacancy rate is 10% which has remained reasonably stable. The cost of locum expenditure in the last year was £5,114,005 .Work intensity remains high and the impact both of the COVID-19 pandemic and the beginning of recovery has been significant exception reporting.

- 2339 exception reports have been received at UHS since the implementation of 2016 contract.
- The number of exception reports submitted in each six-month period has varied from 80 to 419.
- The most common reason for the submission of an exception report is additional working hours and the most common resolution is additional payment.
- To date no exception report has been a breach incurring a financial penalty.
- The cost and risk of exception reporting to UHS is currently low .

The junior doctor executive committee led by the chief registrar, continues to meet quarterly with increasing representation from across the specialties. The junior doctor forum meets monthly and remains an informal method of communication between the junior doctors, the chief registrar, and the medical workforce team. The Consultant rota leads aim to meet quarterly to share good practice and discuss current issues in recruitment, retention, and training.

Although current vacancy level is relatively low (10%) staffing remains challenging in some specialties. During the COVID-19 pandemic overseas recruitment decreased and the processes were considerably slower. This area of recruitment is now returning to normal. This decrease was partially offset by the smaller number of UK trained doctors who went to work overseas.

There are several reasons why there is a vacancy rate which leads to high locum expenditure:

- there are not yet enough medical students in training to meet the expanding workforce requirement
- there has been an expansion of the specialty doctor tier which will be required to manage an increased workload.
- the remaining rotas in Emergency Department have now changed from a 1:2 weekends to a 1:3 to be compliant with the 2016 rules - this necessitates more doctors to staff the weekend rotas but benefits weekday working conditions.

There are ongoing concerns over the issue of rota gaps and the safety of areas of the hospital. The situation is unstable and small changes (such as summer annual leave) can reveal the fragility in the system. These problems are national and the Guardian is confident that the divisional management and executive teams are aware of these issues and seeking improvement plans. Rota annualisation should help alleviate the problem of annual leave.

Engagement with the exception reporting system remains variable. The overall impact of the new contract on the financial position and service provision remains unclear and difficult to quantify as so many factors impact rota gap and there is under-usage of the exception reporting system. There is an ongoing need for a wider overview of the workforce. Work is being carried out around the role of junior doctors, advanced nurse practitioners, physician assistants and supporting non-clinical roles. With the increasing workload there is a need for ambitious IT solutions with particular reference to access, functionality and system.

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

Junior doctor and dentist rotas continued to maintain full compliance during the different phases of the COVID-19 pandemic. We redeployed 40 doctors in the first wave, but supported increases in hours for doctors working part-time, accommodated shadow rotas for specialties in need and supported 26 foundation interim year (FiY1s) to start new programmes.

In 2020, UHS embedded systematic evidence-based and triangulated methodological approaches to reviewing staffing levels on a six- monthly basis, linked to budget-setting. This process continues in 2021/22 and beyond under the auspices of operational planning for both workforce and finance.

Workforce key performance indicators and workforce planning data are reported monthly to Trust executive committee in line with our governance requirements, highlighting any risk areas. A monthly staffing status report is submitted and daily COVID-19-related staffing absence report has been provided throughout 2021/22.

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

Successful recruitment of doctors increased significantly this year:

- Junior doctors increased by 24 full-time equivalents
- Medical consultants by 31 full-time equivalents

UHS completed and returned a self-assessment for NHS England and NHS Improvement levels of attainment, and an options paper was prepared to the Trust investment group (TIG) for medic rostering and job planning to achieve compliance. Significant progress was made in 2021/22 in rostering of the medical workforce.

Additionally, 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.

Part 3: Other information

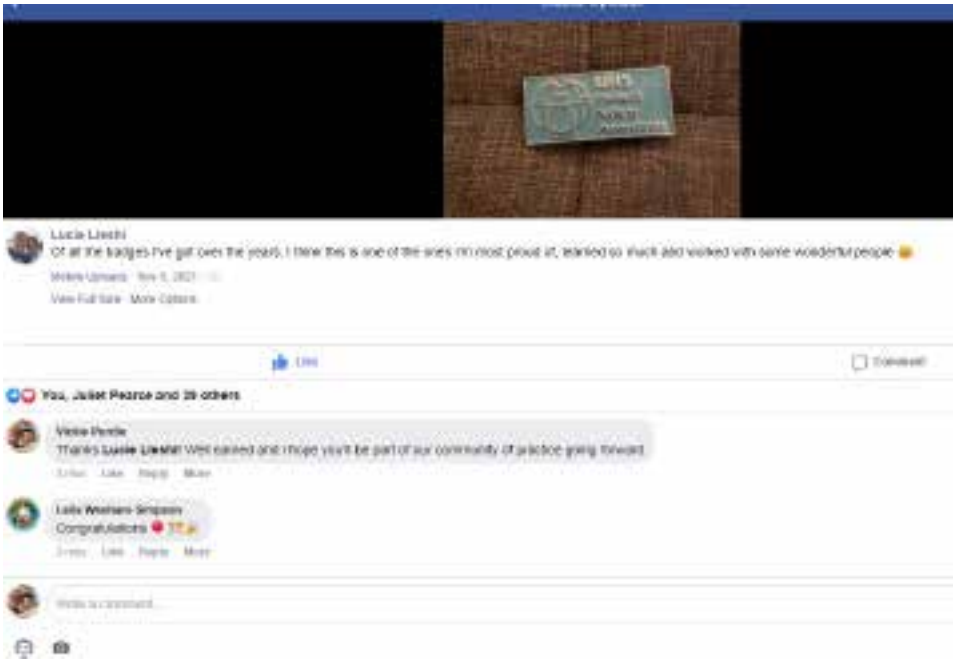
This section presents information about how some of our key services support the quality of the care we offer at UHS.

3.1 Our commitment to safety

We are proud of our long-standing commitment to patient safety and how it contributes to the quality of care that we provide. We recognise the importance of a culture where staff are comfortable to report when things go wrong, and where we learn from incidents and celebrate successes. We work hard to ensure staff keep focussed on safety in all that they do, and that support is available for them when necessary. We encourage our staff to help drive our safety culture, to be enquiring, anticipate and respond to safety issues, learn from times when things go wrong and share their experiences.

In 2021 we nominated two patient safety specialists for the Trust (our head of patient safety and our medical lead for patient safety). Since then both have been actively involved in national meetings working to develop these posts. Our specialists have worked as patient safety experts providing dynamic senior leadership, visibility and support. In addition, they support the development of our patient safety culture, safety systems and improvement activity. They have worked in networks with patient safety specialists from other organisations to share good practice and learn from each other, making them central to patient safety across the NHS in England.

This year we have been progressing our work in developing a culture of safety investigation based on human factors. This approach is more than error or incident analysis, and focusses on rigorous, evidence-based solutions to problems and building resilient systems that enable people to do the right things every time. In 2021/22 we supported 17 staff to undertake human factors online training with an external company, which led to them being awarded the title of patient safety associates. We continued to train new staff during the year to embed human factors expertise across the Trust. We also established a ''community of practice'' for human factors and patient safety associates with membership from across the Trust.



In 2021 we participated in the WHO Patient safety day where the global theme was maternal and neonatal safety. At UHS we also focused on the importance of staff wellbeing during the day, sending our staff wellbeing lead and head of patient safety/patient safety specialist out and about in the hospitals to talk to staff in maternity and neonatal areas and our acute medical unit.

In 2021 the national roll-out of the national patent safety incident response framework (PSIRF) was delayed due to the pandemic. However, we worked during the year to update our gap analysis against the framework with the aim of facilitating inquisitive examination of a wider range of patient safety incidents. We conducted this in the spirit of reflection and learning rather than as part of a framework of accountability. This approach is informed by feedback and draws on good practice from healthcare and other sectors. It supports a systematic, compassionate and proficient response to patient safety incidents which is anchored in the principles of openness, fair accountability, learning and continuous improvement. It also has a strong focus on improving patient and family involvement. The UHS quality governance steering group agreed that UHS will adopt many of the new principles of the framework ahead of the national roll-out, and we have formed a task and finish group that will be working to deliver this during the next year.

As part of our preparation for the roll-out of the PSIRF, we completed a pilot project with eleven patient safety partners, supported by coaching from The King's Fund. We held a series of workshops where we undertook some co-design work looking at the PSIRF and recruited to our formal patient safety partners.

While we wait for the national PSIRF roll-out, we are keeping the profile of this important work high in a variety of ways. One of our existing partners spoke on our patient safety day online event and to the Trust Board as part of their study session, and our patient safety specialists are presenting a poster on the pilot at an international conference in Gothenburg, Sweden in 2022.

Patients and carers are an essential element of all our work at UHS and are core to our value patients first. Nationally there is a drive to create a:

"Pervasive culture that welcomes authentic patient partnership in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety".

The quality improvement, patient safety and patient experience teams are running a joint programme to develop quality and patient safety partners at UHS. This builds on a successful pilot which enabled patient partners to contribute to the design of our new investigation process and advise about how we support patients and families affected by adverse events. These patient partners will be involved in quality and safety activities, including representation at governance and quality committees, and being involved in co-design of quality and patient safety initiatives.

For our patient safety incident investigation training we are moving away from RCA to a systems-based approach to understanding incidents and taking organisational learning – the patient safety incident investigation (PSII). To support this we are providing training in investigation techniques such as how to move from statements to interviews using a facilitated learning approach where we seek to understand the work as done, interactions in teams and why decisions made sense at the time. The training also includes human factors, mapping incidents with a systems approach and building strong action plans. This is supported by our approach to a just and learning culture and we are developing a framework and toolkit to support people in embracing an open and learning approach to incidents.

We held a workshop about just and learning culture with members of the Trust board and other senior leaders in the organisation in November 2021 in preparation for launching the Trust-wide work on just and learning culture.

The Trust's patient safety specialist leads a Trust board study session on the role of the patient safety specialists, implementation of the patient safety incident response framework and feedback on the patient safety partner pilot.

UHS has actively supported the development of the national patient safety syllabus, giving feedback to the academy of royal colleges who developed the packages. Levels one and two were launched nationally in October 2021 and they are available to all staff via our virtual learning environment. We have also appointed to a patient safety education lead who will start in early April 2022.

3.2 Duty of candour

Duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a statutory requirement for all providers registered with the 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 under this regulation. Our 'being open: 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 Staffnet 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.

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

At UHS we remain committed to continually improving our patients' experience, encouraging patient and public involvement and ensuring the innovations we support reflect what matters to the people who will use them.

Although feedback from these groups will remain a vital source of information for us, we are now aiming for people with lived experience (patients and carers or those with other relevant experience) to be involved in all areas of our work, helping to shape services and focus on improving the quality of their experiences.

During 2021/22 we have been supporting teams to involve patients to help design services and review and feed- back on their experiences. Over the year projects have included an ophthalmology engagement group, diabetic retinopathy engagement group, surgical pathway involvement meetings, discharge to assess carers project, a lung cancer innovation group and health inequalities meeting. We have also run learning disabilities and the expert patient listening events, introduced youth ambassadors and involved young people in a children's hospital early warning system project.

With the pandemic continuing into its second year, we recognise how visiting restrictions have continued to impact on our patient and family experience. This has been especially challenging as national restrictions have lifted, because UHS has continued to follow a more cautious approach, prioritising our COVID ZERO campaign to keep safety at the forefront of all that we do.

We have worked hard to mitigate some of the impact visiting restrictions have had, continuing to run our patient property pod, and encouraging families to send messages to their loved ones via our PALS messaging service or use our virtual visiting service. We have tried to be as adaptable and responsive as possible and worked hard to communicate what our visiting plans are and the rationale behind them to the public.

Our patient support hub has worked flexibly around changing patient and family needs, working collaborative with the voluntary and community sector to support uptake of community transport services and support services to help get patients home quickly. The hub also supported calls to patients on our waiting lists, helping keep them up to date and informed. The hub has been one of our major successes in improving the experience of patients and families. It works across organisational boundaries and care settings to ensure that patients receive a consistent level of support from our own volunteers, as well as voluntary organisations in the community. We have also reintroduced volunteers back into our wards and clinical areas where possible, supporting teams to deliver the best care for patients in challenging times.

This year the Trust has benefited from funds raised by Southampton Hospitals Charity, which has allowed us to implement a range of projects and initiatives that have improved the quality of care and experience for our patients and families. These projects are shaped by working with staff and patients to identify opportunities for improving patient experience and then directing charitable funds to make these ideas a reality.

Projects have included the introduction of birthday boxes which mean staff can help patients celebrate their birthdays while in hospital. The boxes include banners, bunting, cards and candles to help ensure patients do not miss their special days.

The charity has helped the hospital play team to purchase an anxiety and worry toolkit. This allows the team to help children with autism or very young children who might be shy, nervous or worried, deal with coming into the hospital. We have cards to help them display how they feel, how they are behaving and what do they need, as well as cards to help them tell us what they are anxious about and how we can help them manage their anxiety.

There is also an anxiety buddy booklet designed for anxiety in older children. This helps them to self-manage their worry and anxiety through a flowchart and learn how to manage their wellbeing. The toolkit enables the child to have a voice if they feel they cannot speak at that specific time.

At the request of the children's emergency department team, the charity funded a range of books dealing with death, grief and bereavement to help children understand what is going on when faced with the death of a loved one.

On a larger scale, the charity raised funds to refurbish the patient gym on our medicine for older people wards. Work on the new gym began in January 2021 following a fundraising campaign and will be a purpose-built specialist facility including elements such as plasma screens and Wii Fit technology to encourage patients to engage in the activities taking place on screens, as well as providing adapted exercise equipment.

To help improve the quality of communication with our patients we have introduced patient information boards across the site, with QR codes linking to key Trust information. This reduces the need for printed versions of information that can go out of date and enables us to ensure patients can get access to the right information when they need it. For patients unable to use QR codes, we offer other formats, including accessible versions.

We also built on the success of our sunflower hidden disabilities scheme which we launched in July 2020. This national scheme enables people with disabilities (particularly hidden disabilities) to flag to staff that additional adjustment or considerations might be required. We have now given out over 800 lanyards, and we continue to receive good feedback on the scheme.

What our patients and staff have told us:

> *''I wasn't allowed to visit at all when my mum was on the ward, but the nurses were brilliant getting her to use the iPad to speak to me.''*

> *''The hub has been a lifeline for us. We got his belongings to him and sent messages, then they helped him get home.''*

> *''The people in the hub were so kind and made such a difference.''*

> *''I have enjoyed being involved in advising how a few projects could go. I appreciate being listened to as a patient.''*

> *''I've been involved in some young persons' projects and felt I made a difference because I know what it's like to be a teenager in hospital.''*

3.4 Our commitment to improving the environment for our patients

We know good environments matter to the care and quality of experience of our patients and their families and help us to maintain a safe environment. Despite an estate of varied age, we are committed to delivering the best environment that we can achieve .We have been running patient-led assessments of the care environment (PLACE) for some years, knowing that they provide motivation for improving quality by providing a clear message, usually directly from patients, about how the environment or services might be enhanced.

The assessments are normally led by patients and their representatives, supported by Trust staff. However, suspension of public attendance in hospitals, and the desire to reduce unnecessary mobility around the hospital led to a central decision to halt national assessments in 2020. This decision is under further review, but at the time of writing remains suspended. We recognised this was entirely appropriate, but we also felt that there has never been a more important time to keep a robust oversight of the environment. In 2021 we negotiated an agreement to run monthly 'PLACE LITE' audits, a smaller version of PLACE conducted locally using 'PLACE LITE' software.

During 2021/22 we ran this programme with our care groups and provided localised action plans which provided both clarity and control. Each assessment produced an outcome report and identified actions required based on the exceptions report. These reports provide scores in accordance with the national reporting structure, although not compared nationally, and each month all scores over the rolling year are combined to provide a rolling Trust score based on all assessments completed.

Ten assessments have been completed during 2021/22 across our sites. We have amalgamated these scores together, to provide an overall PLACE score both as a monthly score and a rolling year to date average, and the scores have been amalgamated to provide a single Trust position.

Figure 32 demonstrates that the combined PLACE assessment for each month in the blue bar, and then the accumulated score each month providing a year-to-date position. In time this will provide an understanding of progress, although as an early roll-out of the programme it will take a sometime to flatten the variance between older challenged and newer estate.

Figure 35: Combined PLACE assessment for each month

The figures below identify the position in each of the key domains of the assessment.

Figure 36: Cleanliness scores

The figures below identify the position in each of the key domains of the assessment.

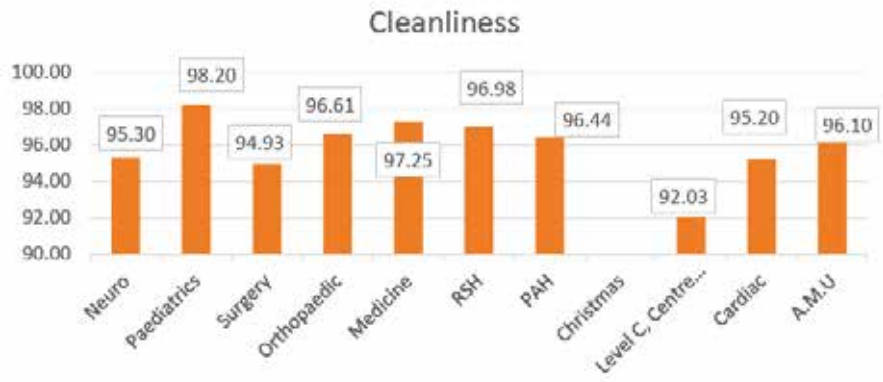
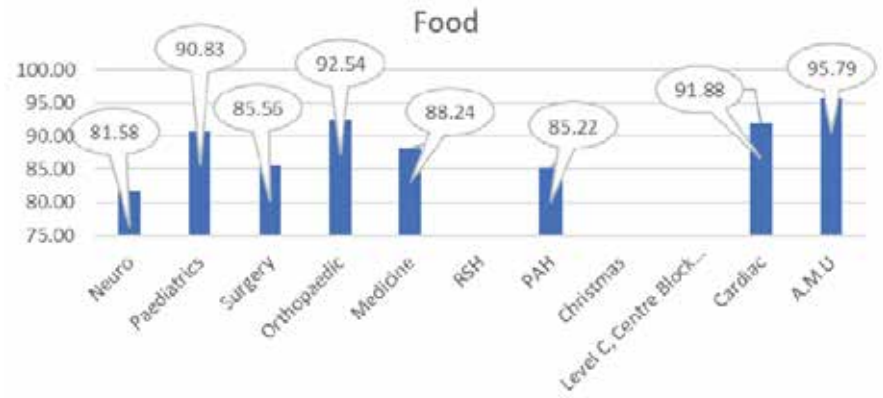
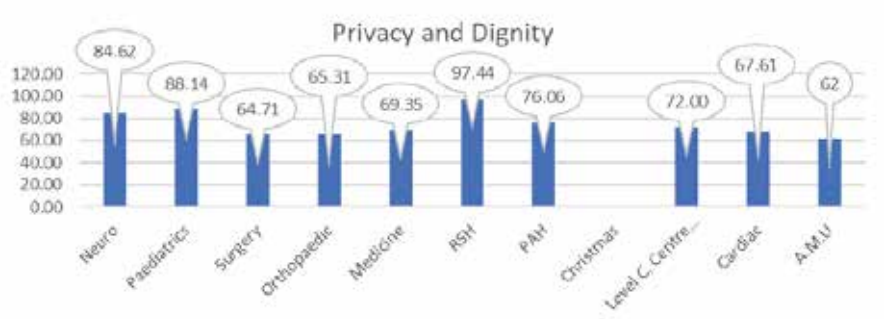


Figure 37: Food scores



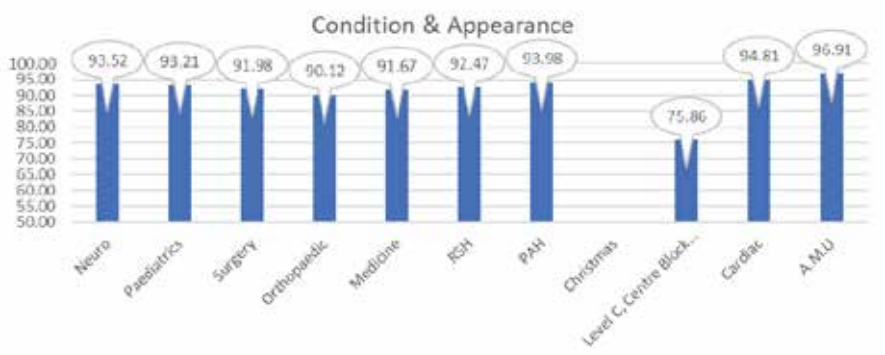
This combines both quality of food, the design and delivery of the meal service, preparation of patients, including food temperature, serving style, taste, texture, suitability, through to clinical involvement in the preparation and readiness of the patient. It also considers disability and dementia aspects such as adaptive cutlery and suitable menus, for example, finger foods.

Figure 38: Privacy and dignity scores



Privacy and dignity continue to provide challenges in the care environment, however, this more granular approach to the issues in individual care groups will enhance the speed of response compared to once annual assessments.

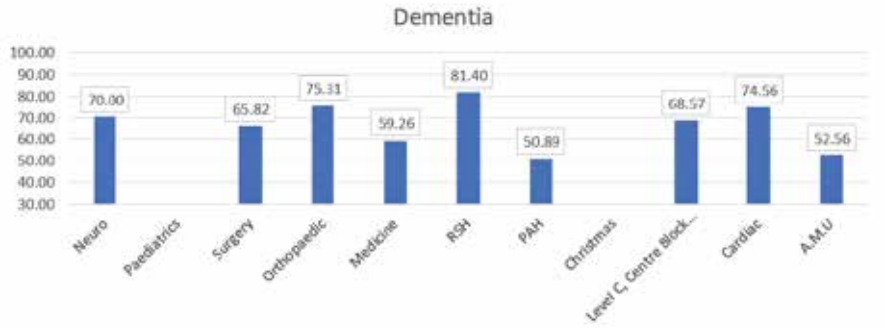
Figure 39: Condition and appearance



The audits have identified that a combination of issues impact on the condition and appearance of the site, from backlog maintenance issues, clutter, overcrowding and a failure to report deteriorating items and areas.

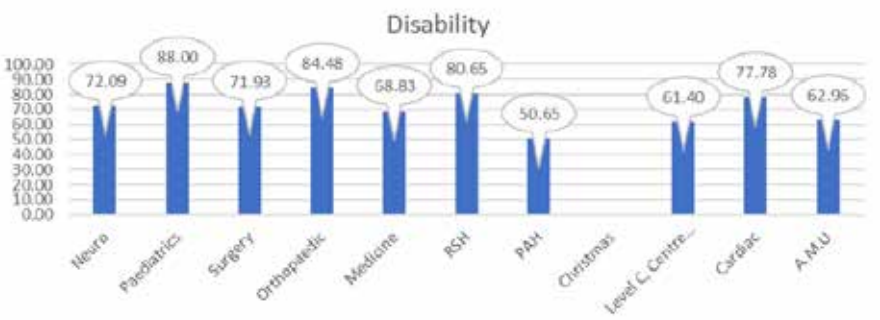
The local action plans address both the immediate remedial actions, but also the closer collaboration with departments at the time should enhance reporting and response.

Figure 40: Dementia scores



Considering patient needs in relation to dementia takes in a range of components, from location awareness (such as coloured rooms for easy identification), to helping orientation with date and time displays. Familiar design is important and even considers flooring to avoid confusion (shiny floors can be perceived as slippery or apparent debris seen in patterns).

Figure 41: Disability scores



We are focusing on the needs of our patients with disabilities, with a range of considerations from access to chair heights. Much of the learning that we have identified from past feedback and from PLACE LITE audits has been incorporated into the 'design guide' that estate projects are creating. This will enable us not only to address issues when identified but should help us to proactively design out some issues where this is possible.

The information we have gathered from these audits has been shared with our PLACE patient assessors who are keen to participate, but who are awaiting approval to return to our sites. We are planning to recruit additional assessors from a wider stakeholder group when authorised, to become more representative of our case mix. We recognise that although UHS is well supported by local Healthwatch and a range of patients, most assessors are of a similar background and to be representative of our patient mix, we need to attract a variety of perspectives. Areas of focus to be progressed are:

- Engagement with health and social care and public service students at colleges/university is being explored.
- Paediatric, youth and transition groups/parents.
- Patient support groups, for example spinal cord injury association.
- Trust members invited at last members' meeting to express an interest.
- Charities have been asked if they receive requests regarding how to get involved in supporting the Trust.

We also have independent assessors who are not currently active but will be reintroduced when appropriate to provide additional assurance about the robustness of the programme.

3.5 Our commitment to staff

UHS is one of the largest acute teaching hospitals in England, providing services to more than 3.7 million people in central southern England and the Channel Islands, with a workforce of 13,000 who deliver excellent patient care every day.

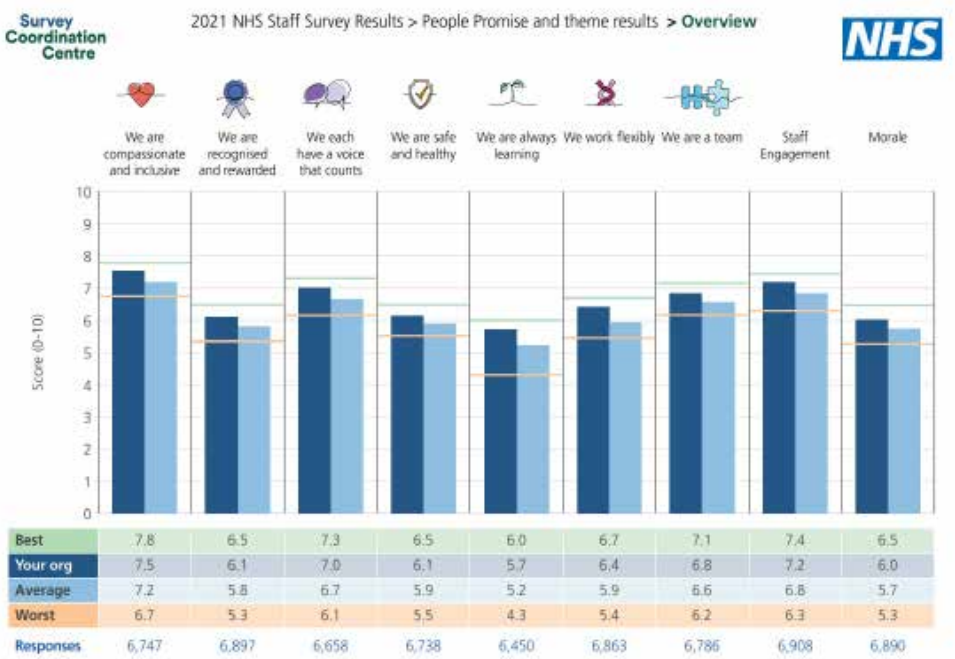
Our vision of ''world class people, delivering world class care'' is underpinned by our constant commitment to making ourselves even prouder tomorrow than we are today of the outstanding quality of patient care, inclusive culture, spirit of teamwork and collaboration both within and outside our organisation. That commitment is embodied in our determination to always improve which directs how we do things at UHS. We call it ''the UHS way'', and it is the thread that brings everything together and provides a unifying measure of our progress towards achieving our corporate vision. The people strategy will deliver its part in this vision by enabling our people to thrive, excel and belong.

We want every member of staff to have the best experience working with us and are continuously looking for ways in which we can achieve that. This is our commitment to staff, and it runs in parallel to the commitment our staff show to UHS and their patients every day.

Our goal is to listen to our diverse UHS family, integrated team members, partners and communities to develop a deeper understanding of how they are treated and what it feels like to work at UHS, and to respond accordingly. We will seek to make year-on-year improvements in the annual NHS staff survey and continue to raise participation. Our staff are able to make such valuable contributions, and the results from the annual staff survey and quarterly pulse survey provide evidence of the improvements that are needed.

For 2021 the NHS Staff Survey 2021 results have been aligned to the themes that make up the national People Promise (see themes below, Figure 39). UHS scored above average on all seven themes plus the staff engagement and morale score in our benchmark group.

Figure 42: Themes of the People Promise



UHS had a response rate of 56.2% (6,985 staff) out of an eligible staff number of 12,428. This is an increase of 6% participation from 2020, an additional 1,238 staff members. The average response rate in our benchmark group was 46.4% and so it is pleasing to see that so many of the UHS family responded.

UHS have scored above average or average for 106 out of the 112 questions compared to other trusts in the acute and community group. Highlights include:

Results	Comment
71.9% would recommend UHS as a place to work.	Whilst we remain high above the national average for this indicator, we have declined 5.1% points from 2020.
85.7% of staff agree that the care of patients/ service users is the organisation's top priority.	Compared to an acute trust average of 75.5%. This is a slight decline of 1.5% from 2020.
UHS achieved the best score across all acute trusts for offering staff challenging work (75.6%).	And staff reporting there are opportunities for career development (64.6%).
83.1% of staff said that they would be happy with the standard of care provided by this organisation if a friend or relative needed treatment.	In comparison to an acute trust average of 66.9%. UHS has declined less than the acute trust average from 2020.
78.2% of staff said that they would feel secure raising concerns about unsafe clinical practice.	A 4.7% increase on 2020. This score is 4.3% above the acute trust average.
75.6% of our staff say the people they work with are kind to one another	Against an average of 68.9%. 77.4% say the people they work with are polite and treat each other with respect

UHS scored below average for six out of the 112 questions compared to other trusts in the acute and community sectors:

- The percentage of staff that were satisfied with their level of pay was 31.7%, which is 0.2% lower than acute trust average and lower than the UHS score of 35.7% in 2020.
- UHS is also slightly above average for the number of staff experiencing physical violence at work from managers with a result of 0.7% and an acute trust average of 0.6%. This is a slight improvement from 2020 where the result was 0.8%.
- The number of teams meeting often to discuss the team's effectiveness was below the acute trust average of 55.6%, with a result of 54.8%. This is a decline from 2020 where the score was 56.1%.
- UHS has less staff working part-time (17.4%) than the acute trust average (19.7%). This number has dropped from 2020 by 1.3%.

The areas to continue our improvement actions include:

- Staffing levels are the top concern among staff, with only 28.2% of staff saying there are enough staff to do their job properly, a 9.8% decrease from 2020. This was the most declined score in the entirety of the survey results. The acute trust average for this question was 26.0%.
- The focus on appraisals was reduced during the pandemic. Whilst 81.9% of staff who completed the survey said they had received an appraisal in the 12 months prior (acute trust average of 80.1%), only 22.3% of UHS staff said appraisal had helped them to improve how they do their job (with an acute trust average of 19.8%), and 35.2% said their appraisal left them feeling that their work was valued by the organisation (with an acute trust average of 29.3%). With 34.3% saying the appraisal helped them to agree clear objectives for their work (compared to an acute trust average of 30.2%).
- Staff looking forward to going to work has dropped from 61.4% in 2020 to 56.35% in 2021, higher than the acute trust average of 52.0%.
- Whilst there have been improvements in areas of inclusion, this still remains a critical priority for the Trust and a major theme of the new People Strategy under the belong pillar.
- The rate of staff experiencing physical violence at work from patients/service users, their relatives or other members of the public (14.1%) has dropped from 2020 (17.3%) but still remains slightly higher than the acute trust average (14.0%). Recognising we have made improvements in this area; it continues to be a priority area of focus going forward.
- Burnout is an area of concern with 46.8% of staff stating that they often or always feel worn out at the end of their working day or shift, 0.4% lower than the acute trust average. Burnout is understandably a critical area of concern for the whole NHS.

The quarterly pulse survey measures the engagement of our staff using nine questions which also form part of the annual staff survey. Some of the findings demonstrated in the two quarterly pulse surveys conducted in 2021/22 have demonstrated that 87% (quarter 2) and 85% (quarter 4) of staff would be happy with the standard of care provided at UHS if a friend or relative needed treatment.

Furthermore, there has been an increase in the quarter four survey scores for the questions 'care of patients is my organisation's top priority' and 'I am able to make improvements happen in my area of work' from the quarter 2 scores, by 0.5% and 0.1% respectively.

Over the course of the past year engagement has slightly declined. With a score of 7.21 in the quarter two pulse survey, 7.18 in the annual staff survey in quarter three, and scoring 7.17 in our most recent pulse survey, in quarter four. Additionally, from quarter two there has been a drop of 6% in the number of staff who say they look forward to going to work, with a score of 53.2% in the quarter four pulse survey.

The continuation of the people pulse surveys will allow us to continue to measure the engagement of our staff, track trends in the data and inform areas requiring improvement across the Trust.

Gaining regular insights and experiences from our staff on how it feels to work at UHS is vital to steer and drive improvements at the Trust and is a crucial factor in our value 'always improving'. The themes from the staff survey will be analysed and engagement will take place at both Trust-wide and divisional and team level. Each team will be supported to create their "top three priorities" to focus in response to the feedback.

The health and wellbeing of our people is a top priority, and this has been described in the retrospective review of quality priority two in this report.

3.6 Our commitment to education and training

This year has remained exceptionally challenging with the need for innovation and flexibility in all aspects of our work. The support and development of our current and future workforce has never been more important. Despite this, our training, development and workforce teams have succeeded in delivering high quality education and workforce deployment and planning. This has enabled us to continue to extend our ability to grow our own workforce with expansion of the range of apprenticeships across the Trust and maintain the quality of educational delivery via the increased use of digital technology. We have ensured that workforce information has enabled the safe and effective deployment of staff and support the training and education of those staff involved in the response to the COVID-19 pandemic.

Our skills for practice team have continued to be exceptional in their flexibility and ability to rise to the challenges and has continued to support a number of established education programmes and new initiatives, several of which have required working across the Trust. Skills for practice continues to deliver our Level 3 senior healthcare support worker apprenticeship, and there have been six successful completions in the last 12 months. The team worked closely with an external end point assessment organisation to ensure this could continue safely during the COVID-19 pandemic. The team support undergraduate medical student training and assessments and are supporting the UHS fit testing hub to ensure students have the appropriate personal protective equipment (PPE) to attend their placements. Third and final year objective structured clinical examinations (OSCEs) were also successfully delivered in July and September 2021.

Skills for practice have opened a new healthcare support worker hub, which is a drop-in service available to all support workers across the Trust. We have recently recruited a dedicated member of staff to deliver all aspects of healthcare support worker training and development.

Our Trust clinical skills training programme has continued throughout the year. The team have been instrumental in developing the training for the vaccination programme and have supported this programme by volunteering time to assist in the hub.

This year we have introduced associate centre facilitators who help facilitate healthcare support worker induction and provide pastoral support for new recruits. They also help new staff to get "signed off" earlier on completion of care certificates. The team have also designed healthcare support worker feedback forms, which have been used across the organisation, and this data is being used to help identify areas of good practice as well as areas where further input is required from the team.

There are now 341 apprenticeships in progress across the Trust. This includes 158 nursing degree and 26 nursing associate apprenticeships. Eight staff completed their nursing associate programme and eight Open University students registered as nurses in October 2021. A further nine nurse apprentices started the programme in February 2022.

We have supported our nurse apprenticeship scheme with an interactive session on applying the nursing and midwifery (NMC) code which was positively evaluated. UHS is also looking to start clinical supervision sessions with our final year students to continue to make links with the NMC code and clinical practice in a positive learning environment. The Trust has also supported other clinical apprenticeships in occupational therapy, diagnostic radiology, operating department practitioners, pathology, advance practice and healthcare science.

The Trust's own apprenticeship centre has successfully completed the training for a number of apprentices in pharmacy Level 2 and senior healthcare support worker Level 3. Some of these apprentices have progressed to higher level programmes such as the pharmacy technician Level 3 or nurse degree apprenticeship. These apprenticeships have provided more participation opportunities for the support workers in the Trust and is part of the Trust's approach to building a sustainable workforce. A further 44 apprentices started before March 2022, including our first group of apprentices on the improvement specialist apprenticeship and learning and development pathway.

The last 12 months have continued to pose challenges to the way we train our medical workforce and the way we deliver education. The rate of change at times has been frenetic, but virtual teaching is now established in all areas of the Trust, and there has been limited face-to-face teaching in certain areas with appropriate safeguards in place.

We have been successful in bidding for a large amount of financial support from Health Education England (HEE) to fund simulation equipment which will be invaluable in helping trainees in craft specialties overcome some of the loss of practical skills that have taken place because of the pandemic. In particular, we have now acquired a state-of-the-art cataract simulator for the eye unit, which will help trainees gain experience in the field of cataract surgery.

We also continue to invest in our medical workforce and recognise that doctors who are starting the careers in the NHS need additional support. In August 2021, the Board agreed to the funding of a month of supernumerary time for all our doctors new to the NHS on the Trust fellowship programme. The initial evaluation of this pilot is hugely positive, and the initiative remains a stand-alone initiative nationally.

Our GMC national training survey results continued to be encouraging and compare us favourably with other university teaching hospitals in the overall standings. There are areas of concern in trauma and orthopaedics and foundation posts in general surgery. Both areas are being evaluated for a workforce review, as it is accepted that the workload for juniors in both areas is a major source of concern.

We were successful in collaborating with HEE on our first medical education research fellowship, and our first fellow started full time in October 2021. It is hoped that this will be the start of closer collaboration between UHS and HEE Wessex along with the universities in Winchester and Southampton in developing high quality postgraduate medical education research, that continues to drive excellence and innovative practice.

UHS continues to work closely and in partnership with Higher Education Providers (HEIs) and HEE both locally and further afield to support the ongoing learning, support, supervision and assessment of all our non-medical learners, including our allied health professional learners. In 2021/22 many of our learners were impacted and their programmes disrupted by the COVID-19 pandemic. UHS has worked with HEI partners to support learners within the organisation in an environment which is under constant change.

To improve this situation we have increased placement capacity for all learners and worked to expand into new placements. Placements in research and specialist teams are now established, and new initiatives include speech and language and dietetic and nutrition postgraduate courses in collaboration with the AECC University.

The Trust continues to support the developments of all elements of advancing clinical practice across a range of professional groups. There are an increasing number of non-medical professionals who are now supported to gain the additional skills to independently support a wide range of patient groups. A Southeast Regional Advanced Practice Faculty has been established and the Trust is an active partner in this as well as networking with Hampshire and the Isle of Wight and national groups to ensure standardisation and benchmarking of service provision.

The new trainee pharmacist learning outcomes were introduced very late on by the General Pharmaceutical Council and the national e-portfolio was only ready several weeks after the trainees started. The training programme for 2021/22 is not substantially different from previous years based on this, however, assessments are being adjusted. The joint placements with primary care networks were extended again to include three and we have four planned for the August 2022 intake.

The second year of the pre-registration pharmacy technician apprenticeship started in September 2021, and we have had significant interaction and support from the provider for the first cohort. There have been adjustments made to the programme for subsequent cohorts with cohort four starting in February 2022, an intake which will take us to 18 trainees.

The learning technology team have continued to work on compiling videos and e-learning modules to support education and training within UHS. This has included modules on chemotherapy, patient falls, blood transfusion for doctors, blood transfusion for healthcare professionals, anti-D blood module and intrathecal chemotherapy, all of which are available through our virtual learning environment (VLE).

It has been a positive year for undergraduate education, despite the challenges. In March 2021 the university gave us very encouraging feedback after a quality assurance visit. Improvement was noted in the engagement from the Trust senior leadership, inductions, student feedback, delivery of summative assessments and overall energy and enthusiasm for teaching. This year we have advertised for several leadership roles, and there has been strong competition each time, reflecting an increased enthusiasm for teaching.

A strong working relationship has been developed with the Southampton University faculty of medicine. This has enabled us to tackle some of the historic funding anomalies surrounding undergraduate education. We have found a way to continue to deliver medical student research projects despite a reduction in funding. We have increased our support for medical student electives, which was an urgent requirement while travel was curtailed. We have managed to reach a comfortable consensus on infection prevention, despite major differences in the policy between the university and the Trust.

There is now a clearly identified group of clinicians responsible for leading on undergraduate education. These are UHS staff who are partly funded by faculty, and they are supported by a SOP which makes the terms of office clear, with proactive integration of university funded programmed activities (PA's) into job plans. This should enable us to sustain the quality of teaching and of placements we provide.

The year ahead will continue to be challenging, and we will have to mindful of the need to ensure that we continue to deliver high quality professional education and training in the context of ever-increasing service pressures. We know we need to work too hard in the current climate to support all staff to maintain continuous personal and professional development and address any gaps that may have developed while we were experiencing the worst of the pandemic pressures. Our Trust continues to monitor and support the development of staff which in turn supports the development of services and the care of our patients.

3.7 Our commitment to clinical research

During 2021/22 our research departments continued the fight against COVID-19. We also restarted paused trials and launched new studies across our services.

We continued our central role in the global COVID-19 vaccine effort having helped propel three vaccines into front-line use. We now led the world-first 'COV-Boost' booster study a nationwide trial comparing immune responses to seven vaccines when used as a third dose. This helped shape the UK's booster roll-out and informed the WHO global booster guidelines. In early 2022 we began trialling lower booster doses of Pfizer and Moderna vaccines for adults. Prompted by COV-Boost data, its findings could help vaccine supplies go further worldwide.

Our Southampton hub facility handled 12,747 participant visits for many of these vaccine trials. Based at the RSH, the trials are part of the regional Wessex vaccine hub that has been crucial to the UK's vaccine pipeline. We are now looking at its future role with our regional partners and see huge potential for it in region-wide, inclusive access to trials as part of an integrated care system.

As Omicron shows, COVID-19 continues to be a 'moving target'. Because of that, vaccine development needs to be continually dynamic, and in December 2021 we opened trials of Cambridge University's candidate vaccine. Using DNA technology to target all coronaviruses, it offers hope for tackling new variants, and even new coronaviruses. As it is a powder stable at room temperature, the vaccine is easier to distribute globally, and is easier to administer as it uses compressed air to push it into the skin rather than being injected.

In January 2021 Southampton began large-scale treatment trials for a developed inhaled Interferon-Beta. UHS is a lead site and the highest recruiter for this study, which builds on delivering the data showing 80% fewer patients needing intensive care after treatment. This trial originating from studies by UHS and the University of Southampton (UoS) partnership and is developed by a UoS spinout Synairgen. It is a standout example of the value and impact of our long-term efforts and investment in research. Our respiratory research teams also led the national ACCORD trial of multiple treatments. Coordinating teams across the UK, Southampton recruited the most patients across all sites.

Late 2021 saw two new national antiviral treatment trials open at Southampton. The PANORAMIC study is evaluating antivirals in the community and aims to assess antivirals for preventing positive cases from needing hospitalisation. It is complemented by the AGILE study evaluating early use of the antiviral Molnupiravir. AGILE is managed by our Southampton clinical trials unit and delivered in the National Institute for Health and Care Research (NIHR) clinical research facility.

Full results of our year-long, national ImmunoCOVID-19 study were published in November 2021 and showed no greater risk of severe COVID-19 for immuno-compromised children and their families. Throughout the pandemic this data informed UK policy, and the published results provided an evidence base for worldwide use. Other studies unpicked the wider impacts of COVID-19 and the pandemic restrictions. These included describing lockdown impacts on parents of babies born before term, and long-COVID-19 implications for hospitalised COVID-19 patients.

As well as the research associated with the pandemic, we continued to focus on and keep open vital non-COVID-19 studies of urgent treatments. Closure of these studies would have meant loss of the only viable treatment for some patients. Those efforts saw initial results of the RiVa study reported in early 2022 which trialled a UoS-developed mix of two immunotherapy drugs in treating resistant or relapsed lymphoma. Led by Dr Sean Lim, it showcases the UoS-UHS partnership's ability to take discoveries from laboratory to bedside.

Huge effort also went into restarting pandemic-hit studies and launching new ones as the pandemic ebbed and flowed. UHS ranked ninth nationally for people recruited to clinical trials and demonstrated standout leadership in many national studies. Our cancer teams enrolled four times as many men into the ATLANTA prostate trial than any other UK site, and in December 2021 we launched a major lymphoma treatment trial.

Our SafeFit initiative continued to support those living through the pandemic with a cancer diagnosis or suspected cancer and in July 2021 we won the Cancer Care Initiative of the Year at the HSJ Value Awards. SafeFit was adapted from our ground-breaking WesFit study, funded by the national lottery and supporting hundreds of people nationwide, the approach gives physical, nutritional and emotional support, and helps prepares cancer patients for surgery (a process known as 'prehabilitation). With some cancer surgery paused due to the pandemic, the team immediately moved to adapt it for remote delivery.

We also take trials to the people: the iDx Lung trial is piloting new tests for early detection of lung cancer and uses a mobile research clinic to co-locate the team with mobile CT scan clinics around Hampshire. By doing this, they aim to collect nasal swab and a blood samples from 10,000 people at higher risk of lung cancer. Tests will look for changes detecting cancer at an earlier, more treatable stage.

Research has also given UHS patients access to advanced therapy investigational medicinal products (ATIMPs). Very few hospitals are able to offer these therapies, which can be the last option open to some. Cutting-edge treatments include gene therapy to replace faulty or missing genetic material, or re-engineer cells to help the body to fight cancers or diseases. Over 2021/22 UHS was able to give eight people access to four ATIMP trials. Our full range of such trials includes:

- Three haemophilia gene therapy studies.
- A new treatment for an incurable motor neurone disease.
- Five trials of cell-engineering treatments for blood, bone, skin and other cancers.

Being able to offer therapies such as these demonstrates research's key role in UHS's strategy and quality of care. We are proud to have been so central in finding new ways of tackling COVID-19 and how we have overcome pressures to advance care across services and specialties. This reflects our expertise, quality of our facilities and the commitment of our people.

3.8 Our commitment to technology

The Trust is committed to using modern technology to help improve the quality of care, safety and patient experience, and 2021/22 has been a very busy year for the informatics service.

In September 2021 the first part of the UHS business intelligence (BI) platform went live. The BI platform is made up of three main components – cloud infrastructure, a new data warehouse and Power BI reporting tools for data and analytics. The BI platform will join up data sets, providing a more comprehensive picture of UHS, its clinical services and its patients. It will provide a platform for the rapid development of healthcare analytics using modern tools to provide applications for clinicians, clinical services, operational teams and other key partners.

UHS will continue to develop reporting and analytics using the BI platform to take advantage of advanced analytics and data science methodologies (machine learning, modelling, etc.) to support patient care, predict future operational positions, provide alerting, etc. The platform enables more effective implementation of information governance requirements and supports assurance through greater transparency, auditability and clarity of reporting sources and data standards. The programme will help deliver the Trust's data insight strategy and the commitment to become a data driven organisation, using data for quality improvement, decision support and clinical care.

Since the platform was launched, reporting applications for outpatients, admitted care and waiting lists have already been released. Power BI has also been used to report oxygen use, support ward length of stay initiatives and ED activity.

In April 2021 the Badgernet system went live providing the maternity service with a complete digital record. The project involved migrating 3,000 active maternity records to the new system to enable the midwifery team to provide continuity of care. UHS informatics service also led a wider programme to roll out the Badgernet maternity system to the three other acute trusts within the Hampshire and Isle of Wight (HIOW) integrated care system (ICS).

Having all four services on the same system will provide significant benefits for midwifery and women as their pregnancy care often moves between hospitals and the lack of ability to seamlessly transfer women's records between the sites used to create a clinical risk. Now we can facilitate this in a digital way which provides time savings and reduces the risk associated with transfers of care where information is incomplete.

During 2021/22 the informatics service continued to support the Trust's efforts in managing the pandemic. An electronic booking system for staff was developed and introduced, and to date over 70,000 COVID-19 vaccinations and around 9,000 flu vaccination appointments have been booked by staff using the system. Having this available as a digital system has saved time for staff especially in occupational health and has reduced the overall administration effort in managing such a large initiative. This system was developed by our APEX development team.

The APEX team have also delivered adult and child safeguarding applications, finishing development work that was underway before the COVID-19 pandemic. New case management features include the ability to record and easily view which key professional is leading each case; the ability to tag safeguarding cases with themes, meeting logs, contact logs, changes to the referral forms and additional information on the cases overview reports.

In September 2021 inpatient noting went live. This solution developed by the APEX team replaces most paper forms used by doctors, nursing teams and therapists on our wards. The nursing component was implemented on F8 stroke ward, enabling nursing and healthcare assistant staff to complete their assessments and care plans on a laptop or iPad. To date it has been used by 450 different staff resulting in a dramatic reduction in paper use.

In July 2021 work was completed to fully implement an electronic "To Come In" (eTCI) solution for child health. This is a function which is used to list patients for procedures or elective admissions and replaces paper forms. This solution is already used for majority of adult specialties and is another example of a digital system improving the process and reducing the risk of paper being lost or misfiled. Having a digital system for TCI enables a complete view of the waiting list.

Attend Anywhere is the Trust's video consultation platform and has been in place since May 2019. Demand for the service increased exponentially in March 2020 when the pandemic precipitated the need for widespread usage of virtual care. Over 41,412 virtual consultations have been held this year, with an average of 1,879 per month taking place in 2021, across over 70 specialties. Numerous benefits have been appreciated by both staff and patients.

Several services care for patients from a wide geographical range, including Cornwall, Gloucester and the Isle of Wight. Attend Anywhere has reduced the need for patients and staff to travel long distances for routine follow-up appointments, leading to time and costs savings as well as environmental benefits. The use of virtual consultations has been particularly important during the pandemic, as some patients may not been seen at all in its absence. Hundreds of staff and patients have been surveyed throughout this period as part of an effort to understand and improve their Attend Anywhere experience. 91.5% of patients surveyed said their video appointment was as effective as a face-to-face appointment, with 96.2% saying they would use the service again. 88.46% of clinicians said that video consultations were easier for patients due to their circumstances, be it travel or mobility restrictions. Others noted that they were able to significantly cut down their waiting lists and get a better sense of the home life and surroundings of their patients.

In addition to virtual consultations, Attend Anywhere has also been used for virtual visiting. This was introduced in April 2020 when physical hospital visits were limited. iPads were supplied to each ward across the Trust, allowing for families to video call their relatives through Attend Anywhere. The service has been extremely well received, with over 15,398 virtual visits taking place.

My Medical Record (MyMR) has continued to be developed and further deployed in 2021 with great success. The progress includes upgrading the smartphone app to provide a more modern and user-friendly interface giving patients a better experience of using digital systems for their care. Through a nationally funded initiative, MyMR is live across the HIOW ICS in the three other acute hospitals, so we are making progress towards all patients in the HIOW locality being able to use this personal health record as part of their healthcare. Over 120,000 patients have registered to use the system and shared decision-making for patients is available in a digital format in the platform. A risk stratification survey tool for patients who are waiting for surgery has been developed in conjunction with the peri-operative medicine team and is now being rolled out. This will enable the clinical teams to have a comprehensive view of a patient's health status and manage them to be as fit as possible for surgery. Patients using My Medical Record now have the option to have a paperless relationship with the hospital and switch off paper letters because all their letters, appointments and results are in the platform.

GuideIT is a digital platform integrated into our system which acts as a repository for clinical pathway maps. The pathways stored on GuideIT cover a range of common clinical conditions and are specific to UHS. There are several benefits that will result from the use of the application. The pathways aim to save time and can potentially reduce the length of stay for patients, without compromising care. Many pathways that have previously been in circulation are unnecessarily large, out of date or otherwise inaccessible. Pathways on GuideIT are concise, with all the information available within a single screen, relieving the need for clinicians to consult multiple sources for treatment advice. The published pathways are put through a rigorous clinical safety process and reviewed at appropriate intervals, which will lead to a reduction in harm and potential litigation costs. The case for the wider rollout of GuideIT will presented to the Trust in 2022.

Nurses across the Trust have been delighted with the Digital Carts that were given to the wards in 2021. Giving the ward nurse in charge their own dedicated mobile device has enabled them to undertake key tasks in real time and improve communication with the use of Microsoft Teams.

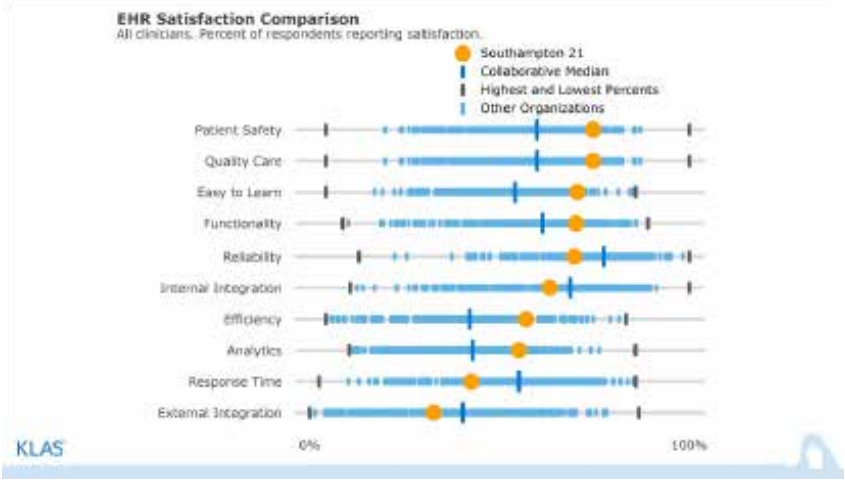
We have continued to use the communications app Medxnote, and this has now been migrated to Microsoft Teams. This allows staff to migrate from alternative solutions (for example, WhatsApp, iMessage or Facebook messenger) to use a cyber secure messaging function, enabling the Trust to meet its information governance standards for patient information data.

We have also completed the Microsoft 365 roll out for all staff. There are many benefits related to this solution, which will become more evident in 2022/23. However, in 2021 this platform enabled the Trust to deliver virtual services for staff including live events for briefing staff. Staff have benefitted from the Teams meeting facility in Microsoft Teams which has enabled staff to 'meet' wherever they are located. With many staff still working at home this has allowed the Trust to continue to operate effectively.

During 2021/22 we have continued to support access to the Trust from off site. The use of DigiRounds at home has provided benefits for consultants who are on call who are able to instantly access real-time patient information via DigiRounds, rather than logging onto a desktop/laptop. This has also meant that handovers have become more efficient as consultants can review clinical details, observations and investigations whilst discussing plans for the patients.

In the early part of 2021, we participated in the KLAS international electronic patient record benchmarking exercise and 3,200 staff completed the survey. The survey results highlighted that staff feel the clinical systems in use at UHS support patient safety and quality care. They are also easy to learn and gave good functionality as well as enabling efficiency.

Figure 43: KLAS international electronic patient record benchmarking exercise



Following the survey results the informatics service has focused on addressing the weaker areas in the survey response. The Trust has benefited from external funding that has enabled significant investment in the IT infrastructure which will provide better reliability and response times including removing over 800 older devices (Windows 7 devices).

In the KLAS survey staff highlighted that external integration (access to patient information from other parts of the NHS) is a challenging area. In February 2021, the Care and Health Integration Exchange (CHIE) for the HIOW ICS completed its migration. Staff have access to this platform via our CHARTS EPR and since it was upgraded over 100,000 patient records have been accessed by UHS clinical staff.

The benefit of being able to see information from other health providers across the ICS gives our staff a more complete view of the patient and will often help inform more rapid and accurate decision making particularly for our very complex patients with co-morbidities.

What our staff tell us:

> *''So many of the IT solutions save time and give me more time to spend with my patients.''*

> *''Attend Anywhere has been a game changer. I can see more patients and start treatment quicker than if they were waiting for face-to-face appointments.''*

> *''So many people tell me Attend Anywhere has made the difference between having an appointment and having to wait until COVID-19 restrictions lifted so they could travel.''*

> *''Clinics are much better used now that some of the appointments are virtual. The clinics aren't as busy which is nicer for patients who don't have to wait so long, and car parking is easier.''*

> *''Virtual visiting has been brilliant and meant families have been able to keep in contact even when they couldn't visit. It's made it less lonely for the patients, and I can speak to families as well.''*

> *''Microsoft Teams has meant I have been able to carry on working from home while protecting myself from the virus. Going forward I can't see us stopping using Teams as its made so many things so much more efficient."*

Annex 1:
Statements from relevant clinical commissioning groups, local Healthwatch organisations and overview and scrutiny committees and Council of Governors

Response to the Quality Report from NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group/Southampton Integrated Commissioning Unit

The challenges that 2021/22 brought in relation to the COVID-19 pandemic are recognised and the Clinical Commissioning Group would like to formally thank University Hospital Southampton NHS Foundation Trust for its part in the continuing system response to COVID-19 management and commend the continued focus on quality improvement during this time.

We are satisfied with the overall content of the Quality Report and believe that it meets the required mandated elements.

2021/22 Priorities for Improvement
We supported University Hospital Southampton NHS Foundation Trust's four Priorities for Improvement during 2021/22, which covered:

- the introduction of the Maternity Continuity of Carer model for women at risk of complications in pregnancy
- supporting staff well-being and recovery
- managing risks to patients delayed for treatment and restoring elective programmes, and
- reducing healthcare associated infection.

The Trust has achieved three of their priorities and partially achieved the priority relating to delayed treatment and the restoring of elective programmes. The work delivered across all four priorities has led to some considerable improvements which has had and will continue to have a positive impact on both patient experience, safety and outcomes and staff wellbeing, for example:

- establishing five Maternity Continuity of Carer teams, with each team caring for their own caseload of women in the antenatal, labour and postnatal period (Priority 1)
- focusing on the needs of Black and Asian women and those living in Index of Multiple Deprivation (IMD)-1 areas (most deprived area) by including them for care in their Maternity Continuity of Carer teams (Priority 1)
- providing extensive support for staff well-being and recovery through a range of initiatives including:
- the appointment of wellbeing champions and safe space practitioners
- the expansion of infrastructure to house a wellbeing hub
- increasing the accessibility of wellbeing support on the Trust's intranet
- the introduction of daily 'stop for support' ward huddles for nursing teams

- the provision of psychological support to hospital staff in the context of traumatic events at work (Priority 2)
- developing clear plans to address long waits and continuing the clinical prioritisation process (Priority 3)
- supporting the CCG review tool for people waiting longer than normal to support further prioritisation of services
- rolling out a patient texting service to provide a safety net for those specialities with the highest number of long waiting patients (Priority 3)
- maintaining cancer services throughout the pandemic (Priority 3)
- prioritising the COVID-ZERO campaigns across the workforce and services (Priority 4)
- focussing on infection, prevention and control strategies targeted at reducing the risk of hospital transmission (Priority 4) as well as being an integral partner supporting the wider Hampshire and Isle of Wight system and Southeast region with infection prevention expertise.

The CCG commends the Trust on the positive testimonies from patients, carers and staff in relation to each of the priorities and looks forward to seeing the Trust further embed these priorities during 2022/23.

National confidential enquires and audits
We are pleased that University Hospital Southampton NHS Foundation Trust participated in all relevant national confidential enquiries and 96% of national clinical audits for which they were eligible to participate. It is noted that, where relevant, actions identified to improve practice and/or patient outcomes have been planned or are being undertaken, for example, a monthly review of reasons for knee revisions to ensure all aseptic loosening and infection cases are correctly recorded; implementation of education to address post fall moving and handling practices to be developed with the moving and handling team and the introduction of new folders in emergency theatres to promote thorough handover of cases.

Local clinical audits
The provider undertook 121 local clinical audits during 2021/22. These have led to the development of a number of improvement actions, for example, undertaking a teaching session on incontinence in Cystic Fibrosis; requesting the IT department make completion of the Venous thromboembolism (VTE) risk assessment form mandatory for 16- and 17-yearold children undergoing paediatric orthopaedic surgery and for senior nursing staff on shift to monitor documentation of patients who have a moderate pain score on 2 or more consecutive occasions to ensure they have a documented plan in place.

The CCG is keen to see the impact of these and other actions, through re-audit, in next year's Quality Account.

Learning from deaths
The CCG notes the learning and actions taken by the provider in relation to learning from deaths, for example, the development of a new handover process which includes highlighting outstanding assessments and the development of a standard operating procedure for urgent and out-of-hours imaging requests.

Collaborative working
The Clinical Commissioning Group would like to thank University Hospital Southampton NHS Foundation Trust for supporting system quality improvement by:

- Continuing to be an active, respected and valued member of the Hampshire and Isle of Wight Sharing and Learning Network
- Contributing to the Hampshire and Isle of Wight Shared Learning newsletter
- Participating in the referral to treatment harm review process
- Being key partners in the Hampshire and Isle of Wight Infection Prevention leads forum.

Awards
The Clinical Commissioning Group extends their congratulations to the Trust for a number of national awards and achievements, including winning recognition for 'best crisis comms' at the 2022 PR Corporate, City and Public Affairs awards and winning the Cancer Initiative of the Year at the Health Service Journal Value awards for the Safefit initiative.

2022/23 Priorities
The CCG are pleased to review the 2022/23 priorities and support the ambition of the eight identified priorities, which include:

- Increasing mental healthcare and support for staff
- Developing a culture of kindness and compassion to drive patient safety
- Undertaking further work to recognise and respond to the deteriorating patient
- Ensuring patients are involved, supported and appropriately communicated with on discharge.

During 2022/23, the Clinical Commissioning Group are keen to work with the provider in relation to optimising patient discharges from hospital to improve the patient experience.

The challenges experienced by the Trust during 2021/22 in relation to information technology systems which have had the potential to negatively impact patient care and safety have been recognised. The Clinical Commissioning Group thanks the provider for its prompt escalations, transparent discussions and the hard work undertaken by divisional and information technology teams to review and rectify the issues. The CCG would like to offer support with any future technology developments across the Integrated Care System and impresses the need for robust provider and system wide governance and testing processes.

The Clinical Commissioning Group looks forward to seeing ongoing progress in the achievement of the constitutional standards, including those for cancer.

Overall, the Hampshire, Southampton and Isle of Wight Clinical Commissioning Group are pleased to endorse the Quality Account for 2021/22 and look forward to continuing to work closely with University Hospital Southampton NHS Foundation Trust during 2022/23 in further improving the quality of care delivered to our population.

Yours sincerely

Julie Dawes
Chief Nursing Officer
Hampshire Southampton & Isle of Wight CCG

Response to the Quality Report from Healthwatch Southampton

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

The year under review has been another extraordinary year in every way. It is not surprising therefore that this year's account has a strong focus on the ongoing response to Covid-19. Service users of UHS FT have reason to be particularly grateful for the work of UHS and the University.

As always, when Healthwatch Southampton had occasion to contact UHS for comment or query, the trust responded promptly and efficiently with a full, honest, and open response. As far as we can judge, this quality account has been written with a similar open and honest format and is complete and accurate with no serious omissions. The Chief Executive's statement and welcome puts the work of the trust in perspective and is a valuable introduction to the quality account.

The overall layout is appreciated starting with clear statements on progress against the 2021/22 priorities. We think this is important as it not only provides a clear assessment of progress but importantly it sets the background for the future priority requirements.

The priority of introducing midwifery continuity of care was clearly well planned and executed. The report on this priority is clear and detailed; the comments and from patients is particularly valuable. We note the comment re the Ockenden report and the trusts decision to assess its position.

We are pleased that the priority to support the wellbeing and recovery of staff was achieved. The use of diagrams is interesting and helps. The new staff wellbeing building is important and should be a great help.

The third priority is obviously of great interest to patients waiting for elective treatment. With the ongoing problems of the pandemic and high numbers of covid-19 patients requiring treatment, it is understandable that this objective was only partially met. It is, however, pleasing that cancer services have been maintained. The increased use of virtual clinics can be valuable for many people. The efforts to increase the volume of diagnostic activity is welcomed. Validation of waiting lists using text and mails where appropriate is also welcomed and provides reassurance to patients, we hope the trust will adopt a rolling programme.

It is good to read that the objective to reduce healthcare associated infections has been achieved and that further work is planned to further reduce these infections.

As indicated in the quality account, HWS was consulted and commented on the proposed quality priorities for 2022/23 and are pleased with them. It is right that quality improvement should be the priority 1, to support the strategy of always improving. The idea of training 500 staff in QI techniques is good. It should help to get the selected quality priorities better understood to all staff. Kindness and compassion cannot be overemphasised and certainly is important for patient safety; we hope this will apply to all staff and all levels and not just those involved in direct care. We are pleased that mental health care is to be prioritised alongside physical needs. Responding to a patient that is deteriorating is obviously important and it is good that the PEWS system will be introduced into the children's hospital. We are pleased that families are to be involved and their satisfaction evaluated as part of the process of learning from deaths. Increasing shared decision making is an important improvement which will be welcomed by many patients, but it must be recognised that some patients will not wish to participate and consider that 'Dr know best'. Health inequalities are apparent, and covid-19 exposed this still further. Working with the local community is the right way to expose and tackle this problem. HWS has received a number of adverse comments about hospital discharge, and we are pleased that our report suggesting improved communication and better collaboration with social services is referenced. We understand the need to discharge patients as soon as they are clinically fit, but it is essential patients and relatives are informed and that they are properly supported.

The trust has a good reputation for honesty and openness, and it is good that the freedom to speak up campaign is helping staff and others to come forward.

Section 3 of the report is interesting reading. We are aware that the Trust has worked hard to improve patient experience and to minimise the obvious difficulties caused by Covid-19. The work of the patient support hub and the efforts of the charity have made a great impact. We are particularly pleased that the Trust values the PLACE inspections and while PLACE has been suspended has introduced PLACE-LITE. The information recorded should be very helpful in design and planning refurbishment etc. Naturally, we hope that PLACE can be re-introduced this year and look forward to playing a major role once again but agree that it would be helpful to expand the patient mix.

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

H F Dymond OBE
Chair Healthwatch Southampton

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

Governors have had the opportunity to review and comment on the quality account to ensure that it provides a clear and balanced overview of the quality of care provided to patients at our hospitals. We recognise the tremendous amount of work that goes into producing the quality account and that this reflects the pressures and challenges faced by acute hospitals and other health and social care partners, particularly during the COVID-19 pandemic.

While the COVID-19 pandemic has limited our ability to visit the hospitals and meet with staff and patients face to face, we have continued to receive regular updates on quality and performance at council of governors' meetings and through our working groups. Our patient and staff experience working group in particular has focused on patient survey results, support provided to patients with learning disabilities and dementia and through the patient support hub, complaints, claims and incidents and staff wellbeing. We have also engaged with members through a number of virtual events throughout the year and are looking forward to being able to meet more patients, members and the public in our hospitals and at events in our communities over the coming year.

Governors were also consulted in the development of the quality priorities in 2021/22 and 2022/23 and supported these as key areas on which to focus in improving the quality of care provided to patients. The use of feedback from patient surveys and complaints in the development of these, as well as consultation with stakeholders, has helped to shape a set of priorities that should make a real difference for both patients and staff. We are also pleased to see the series of challenging and realistic measures to monitor the progress against the priorities set out in the quality account.

The quality account demonstrates the extensive quality improvement programme within the hospitals and the benefits being delivered through this. This reflects the inclusive, learning and open culture developed in the Trust over a number of years and the continued focus on providing high standards of care to patients in a sustainable way.

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

Bob Purkiss MBE
Lead Governor

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

The Southampton Health Overview and Scrutiny Panel (HOSP) welcomes the opportunity to comment on the University Hospital Southampton NHS Foundation Trust Quality Account for 2021/22.

The Panel understand that 2021/22 has been a year of unprecedented challenge for UHS, reflecting the ongoing response to the COVID-19 pandemic, workforce pressures and growing demand for health services. As stated in last year's response the Panel appreciate how UHS staff, students and volunteers have risen to these challenges to meet the health requirements of our population in the most testing of circumstances.

When considering the Trust's progress in meeting the agreed priorities for 2021/22 the Panel recognises that performance must be seen within the context of the combined pressures identified above. In particular, the Panel welcome the developments relating to staff wellbeing. These developments were timely given the challenges around staff shortages experienced by the Trust.

The HOSP is supportive of the quality priorities for 2022/23, however, it is questionable, given the significant growth in waiting lists for diagnosis and treatment, whether the Trust has opted to adopt too many priorities and would benefit from focusing on reducing the number of people waiting for treatment that has risen significantly over the previous two years.

Whilst expressing concerns about the number of priorities, it is encouraging to see a priority that seeks to work with the local community to expose and address health inequalities. The impact of Covid-19 has exacerbated existing disparities across Southampton and as UHS plays a significant role in the health system in Southampton and South-West Hampshire it is vital that the Trust works with partners across the system to help reduce health inequalities.

The Southampton HOSP looks forward to working closely with UHS over the coming year to explore how the Trust will be working as part of the developing Integrated Care System to address the backlog of people requiring treatment, whilst ensuring that the quality of health services for the people of Southampton improves.

Yours sincerely

Cllr Elliot Prior
Chair of the Health Overview and Scrutiny Panel 2021-2022 Southampton City Council