

## Agenda Trust Board – Open Session

<b>Date</b>	26/09/2019
<b>Time</b>	9:00 - 13:00
<b>Location</b>	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
<b>Chair</b>	Peter Hollins
<b>In attendance</b>	Donna Sharland, Clinical Nurse Specialist - Upper GI Oncology & Lead Nurse - GI Specialist Nursing (shadowing Gail Byrne)

- 1 Chair's Welcome, Apologies and Declarations of Interest**  
9:00 To note received apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
- 2 Minutes of Previous Meeting held on 30 August 2019**
- 3 Matters Arising and Summary of Agreed Actions**  
To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.
- 4 Quality, Performance and Finance**  
Quality includes: clinical effectiveness, patient safety, and patient experience
  - 4.1 Patient Story**  
9:15 To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.
  - 4.2 Briefing from Chair of Strategy & Finance Committee for review (oral)**  
9:30 Jane Bailey, Non-Executive Director
  - 4.3 Briefing from Chair of Charitable Funds Committee for review (oral)**  
9:35 Jenni Douglas-Todd, Non-Executive Director
  - 4.4 Integrated Performance Report for Month 5 for review**  
9:40 To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Patient Experience Report.  
Sponsor: Jane Hayward, Director of Transformation & Improvement
  - 4.5 Finance Report for Month 5 for review**  
10:25 Sponsor: David French, Chief Financial Officer

- 5 Strategy and Business Planning**
- 5.1 UHS Digital Strategy for approval**  
10:35 Sponsor: Jane Hayward, Director of Transformation & Improvement  
Attendee: Adrian Byrne, Director of Informatics
- 6 Corporate Governance, Risk and Internal Control**
- 6.1 Register of Seals, and Chair's Actions for ratification**  
10:45 In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Delegation.  
Sponsor: Peter Hollins, Trust Chair
- 7 Any other Business**  
10:50 To raise any relevant or urgent matters that are not on the agenda
- 8 To note the date of the next meeting: Thursday 31 October 2019, in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH**
- 9 Exclusion of press, public, and others**  
The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.”
- 10 Items circulated to the Board for reading**  
27 August 2019  
Press Release: Leading doctor says kidney patients and families “let down” by poor mental health support and therapy  
5 September 2019  
Press Release: Surgeons begin “potentially game-changing” prostate cancer trial  
15 September 2019  
Press Release: Cancer expert welcomes HPV vaccine for boys but warns against limited rollout  
16 September 2019  
Press Release: Hospital staff to mark patient safety day with drive to improve kindness
- 10.1 Learning from Deaths 2019-20 Quarter 1 Report**  
Sponsor: Derek Sandeman, Medical Director
- 10.2 CRN: Wessex 2019/20 Quarter 1 Performance Report**  
Sponsor: Derek Sandeman, Medical Director

**10.3 Informatics Update**  
Sponsor: Jane Hayward, Director of Transformation & Improvement

**11 Follow-up discussion with governors**

11:00

**12 Clinical Visit - Healthcare Science departments**

11:15

**13 Lunch**

12:30

## Minutes Trust Board – Open Session

<b>Date</b>	30 August 2019
<b>Time</b>	09:00 - 11:00
<b>Location</b>	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
<b>Chair</b>	Peter Hollins
<b>Present</b>	Jane Bailey, David Bennett, Gail Byrne, Jenni Douglas-Todd, Paula Head, Caroline Marshall, Simon Porter, Mike Sadler and Derek Sandeman
<b>In Attendance</b>	Charlie Helps, Ian Howard, 2 governors, 8 members of the public, and 4 staff members
<b>Apologies</b>	Cyrus Cooper, Jane Hayward, David French (Ian Howard to deputise)
<b>Minutes</b>	Vicky Boland

### 1 **Chair's Welcome, Apologies and Declarations of Interest**

The Chairman welcomed those present, noted apologies and asked for any new declarations of interest in matters on the Agenda. No conflicts of interest with items on the Agenda were declared.

### 2 **Minutes of Previous Meeting held on 30 July 2019**

The minutes of the previous meeting were agreed as a true and fair representation of the business transacted.

### 3 **Matters Arising and Summary of Agreed Actions**

Action 38) Patient Moves - This would be discussed at the October Quality Committee.

Action 42) Change Champions - The communication would be sent to staff during September to avoid the busy summer holiday period.

Action 61) Patient Story - GB has spoken to the parent of the child concerned twice. A meeting with the Matron and a feedback session to ward staff were being arranged.

Action 63 and 66) Workforce and Safeguarding - These items were to be discussed at the September Trust Board Study Session.

Action 65) Maternity Indicators - This would be discussed as part of the next Maternity report to the Quality Committee.

Actions 60, 62 and 64 were confirmed as complete.

## **4 Quality, Performance and Finance**

Clinical effectiveness, patient safety, and patient experience

### **4.1 Patient Story**

DS introduced the patient's family to the Board. The Board then heard an account of the patient's experience at UHS from her aunt.

MS asked whether similar experiences had occurred during any previous hospital visits. The family explained that things had sometimes previously gone wrong however these had usually been resolved informally. Unfortunately on this occasion, there was a multitude of failures identified including lack of pain relief, fluids, routine observations, care and compassion. The patient's parents were not listened to and she had suffered mental distress as a result...

GB described actions being taken with the Matrons for Orthopaedics and the Emergency Department (ED). GB queried if there was a plan in place to support the patient returning to the hospital for future treatment. It was confirmed that a plan had been developed utilising the Pets as Therapy (PAT) dogs.

JD-T asked whether the patient was offered treatment in a paediatric environment. The family were told that this was not appropriate as she was over 18 although this would have been more suitable.

PTH apologised on behalf of the Trust and thanked the patient's family for sharing their experience at the Trust. PTH emphasised the importance of ensuring the Trust learned from this and that this learning was communicated back to the family.

### **4.2 Briefing from Chair of Quality Committee for review (Oral)**

Mike Sadler, Non-Executive Director

MS summarised the items considered at the August meeting of the Quality Committee:

- Outpatient services update which included the Care Quality Commission (CQC) action plan.
- Cancer standards and potentially forthcoming changes to these.
- Complex discharge update.
- Learning from Never Events.
- Medicines safety report 2018-19.
- Outcomes update.

### **4.3 Briefing from Chair of Strategy & Finance Committee for review (Oral)**

Jane Bailey, Non-Executive Director

JB summarised the items considered at the August meeting of the Strategy and Finance Committee:

- A review of the latest financial position for month four. Performance had improved within the month however previously identified risks remained.

- A review of Cost Improvement Plans (CIPs) for 2019-20. £38.4m of CIPs had been identified, 54% of which was 'green' rated. Further detail was to be provided in relation to the proportion of income CIPs identified.
- Partnerships update.

#### 4.4 **Integrated Performance Report for Month 4 for review**

Sponsor: Jane Hayward, Director of Transformation & Improvement

CM advised that the tumour site narrative on page 13 had not been updated but could be provided if required and that the Total ED attendances on page 14 no longer included the Lymington minor injuries unit.

##### Improving patient journeys

MS requested an update on the national visit from NHS Improvement (NHSI) as part of the re-launch of the SAFER programme. CM provided an overview of the visit noting that feedback had been positive. Any good practice and learning identified from this and visits to other participants would be shared with the Trust.

CM provided an update on emergency access performance which was currently below trajectory but on an upward trend. CM outlined the actions being taken to improve performance, three of which would have the most impact: changes to the 'minors' stream, the introduction of the new junior doctors with fewer vacancies, and general practice support in ED.

PTH sought more information in relation to bed closures as part of CIPs. CM outlined the rationale for this noting that the Trust had been unable to close the desired number of beds due to increasing emergency demand but was also able to increase elective work, compared to the same period last year, and therefore increased income was generated.

PHe asked CM to expand on the increase in the total number of patients on a Referral to Treatment (RTT) waiting list. CM explained that this was due to a technical readjustment following a data validation exercise meaning patients that should previously have been recorded on a pathway were now included in the data. It was and also due to the impact of the national pensions tax issue which had reduced clinical capacity.

##### Delivering value-based health and care

JB highlighted the target for the percentage of complaints closed within 35 days and had understood this had been increased following discussion at the Quality Committee. MS confirmed that the Committee agreed for this to remain at 70% until performance had been sustained.

MS stated that the outpatient appointment data on page 15 of the report contradicted the information provided at the Quality Committee. DS concurred that significant progress had been made but was not reflected in the data.

##### Supporting healthy lives

JD-T queried whether the impact of the advice offered to patients identified with risky behaviours (alcohol consumption and smoking) was being measured. DS advised that final outcomes were not available as the majority of support was

provided by community services. JD-T asked about the increase in medication errors. MS added that this was discussed at the Quality Committee and was felt to be normal variation, but that this would be monitored to ensure it was not on an upward trend. The Committee was reassured that the level of harm from these errors was low.

PTH noted that the never event that occurred in June was not the first occurrence of such an event involving patient mis-identification. DS advised that further detail would be available once the investigation had been completed.

#### Being agile in meeting people's needs

DB commented that the target of 85% for the percentage of defect work orders completed on time was low and the fact that it was not being achieved at even that level when clinical staff were being expected to meet stretching targets, may be a reflection of how issues were being dealt with by management during times of capital constraint. Feedback from areas visited by Board members had previously highlighted issues with maintenance and that works were not being completed in a timely way.

**Action 80: PHe to feedback to DAF in relation to Board comments on defect work orders. To be discussed at a future Strategy & Finance Committee or Quality Committee.**

#### Leading-edge research, education and innovation

MS highlighted the underperformance in commercial research. DS provided an overview of the factors that were impacting on this noting that a meeting had been planned with the team to discuss this and agree actions.

#### **Quarter 1 Infection Prevention Summary Report**

GB expressed disappointment with the one UHS attributable case of Methicillin-resistant Staphylococcus aureus (MRSA). The Trust was undertaking an infection prevention back to basics campaign in the approach to the winter months.

#### **Nursing and Midwifery Staffing Hours Report**

DB queried whether the Trust was concerned with the nursing fill rates as these were significantly below plan in places. GB stated that this was a concern however this was a national issue. The Trust was pursuing a wide range of solutions to this problem.

### **4.5 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports 2018-19 for review and Action Plans 2019/20 for approval**

Sponsor: Gail Byrne, Director of Nursing & Organisational Development

Attendee: Juliet Pearce, Deputy Director of Nursing for Quality and Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

#### Workforce Race Equality Standard (WRES)

CM introduced the report and action plan noting that this focussed on indicators 5,6,7 and 8. JP outlined the main issues identified and that some progress had been made. Unfortunately Black, Asian and Minority Ethnic (BAME) staff were

still more likely to experience bullying and harassment and whilst this was improving it was not where the Trust would like it to be.

MS noted the improvements made in relation to the recruitment metrics and suggested that the same approach should now be applied to the issue of bullying and harassment from other staff with positive actions identified to address this.

The Trust had completed two inclusive talent management programmes and now had a developing BAME network which would focus on the things that needed to change. MS added that there were similarities between bullying and harassment for staff with disability and long-term conditions suggesting that there were some broader lessons to be learned and actions to be taken to address this for all of the protected characteristics.

JD-T commented that bullying and harassment from patients, relatives or the public was at a high level for all staff and asked what was being done to address this. The Trust's Violence and Aggression Steering Group was reviewing the policy and the threshold for aggression. CM advised that the Trust was also a hate crime reporting centre and that the Trust had close links with Southampton Hate Crime Network.

JD-T highlighted the data for indicator one which suggested that there may be gaps in BAME staff of certain bands in a few years and that this should be addressed now to prevent any future issues. GB advised of the actions that were already in place to address this.

#### Workforce Disability Equality Standard (WDES)

CM introduced the report noting that the data was at present unreliable due to the discrepancy between staff that had declared their disability to the Trust and those that had declared as part of the annual staff survey. This was a national issue.

The Long-term illness and disability (LID) staff network were aware of the issues and leading on the wider action plan. VB, as Chair of the LID group, was asked to comment. VB informed the Board that the Trust had made some progress over the last five years, particularly around physical barriers. More work was required to tackle the wider cultural issues of discrimination, bullying and harassment as well as to give more consideration to the impact of the estate, and staff attitudes on patients with a disability or long-term condition.

PTH thanked the team for the progress made for this important agenda. The Board asked that a further update be provided in six months.

MS felt that there were a number of reports that related to the workforce that were looked at separately and suggested that the Board be given the opportunity to review and discuss these as a whole.

**Action 81: Reports related to workforce to be considered as a whole, as part of JB's review of the Board and its Committees. A specific update on progress in respect of long term illness and disability to be made in February 2020.**

#### **4.6 Freedom to Speak Up 6-monthly Report for review**

Sponsor: Gail Byrne, Director of Nursing & Organisational Development

Attendees: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

CM introduced the reporting providing an update on progress over the last six months. JP highlighted that there were very few cases that had raised patient safety concerns with the majority of cases being part of complex Human Resource (HR) investigations.

PHe stated that the Trust was aiming to create a culture where people could talk to anybody about anything and were signposted to the right place, adding that it would be useful for the Board to hear an anonymous staff story next time this matter was discussed at Board.

GB advised the Board of a recent publication on Freedom to Speak Up which outlined actions that the Trust Board should be taking. An analysis of this would be included in the next report. PTH asked if there was more the Board could do. CM emphasised the importance of finding a solution to the bullying and harassment issues experienced by staff.

#### **4.7 Finance Report 2019-20 Month 4**

Sponsor: David French, Chief Financial Officer

IH presented the month four Finance report, noting for July that:

- The Trust delivered a surplus of £2.6m, £1.1m better than Plan. Year to date the Trust was reporting a £0.1m deficit but this was £1.9m better than Plan. This was a small in-month improvement driven by income being over Plan for both elective and non-elective activity.
- CIP delivery was £3.6m, £0.7m better than Plan. Whilst CIP performance had improved, efforts needed to continue to meet the significant challenge during Quarters three and four.
- The risks to delivery identified at the start of the year remained unchanged at this time.

MS highlighted the latest government policy relaxing the Capital Department Expenditure Limit (CDEL) and asked whether the Trust was planning to revert to its original capital plan. IH advised that the £12m reduction in the plan would be from delays in receiving central funding and expected local slippage. It would not be from cutting schemes.

PTH asked with the effect of blended payments had been as expected. IH said that this was broadly the case.

## **5 Corporate Governance, Risk and Internal Control**

### **5.1 Register of Seals, and Chair's Actions for ratification**

In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Delegation.

Sponsor: Peter Hollins, Trust Chair

PTH reported actions taken in the month on behalf of the Board.

#### **Decision**

The Board ratified the actions taken in month.

## **6 Any other Business**

### **Brexit**

PTH requested an update on Brexit preparations. CM provided an overview of the challenges this would bring and the plans in place to mitigate issues where possible. PHe stated that there had been concerns raised in the media about the timeliness of the flu vaccine. As a result, the Trust's Winter Plan had already been drafted to enable the Trust to address this and other pressures in a timely way.

### **Diabetes Screening**

JD-T and MS provided an update on the diabetes screening event held at the Ageas Bowl on 9th August 2019.

## **7 To note the date of the next meeting**

Thursday 26 September 2019, in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH

## List of action items

Agenda item	Assigned to	Deadline	Status
Trust Board – Open Session 30/08/2019 4.4 Integrated Performance Report for Month 4 for review			
80.	Defect work orders	<ul style="list-style-type: none"> <li>● French, David</li> <li>● Head, Paula</li> </ul>	31/10/2019 <span style="color: yellow;">■</span> Pending
<p><i>Explanation action item</i>  PHe to feedback to DAF in relation to Board comments on defect work orders. To be discussed at a future Strategy &amp; Finance Committee or Quality Committee.</p>			
Trust Board – Open Session 27/06/2019 5.1 Trust Vision, Mission and Staff Voice for approval			
42.	UHS Change Champions	<ul style="list-style-type: none"> <li>● Head, Paula</li> </ul>	30/09/2019 <span style="color: yellow;">■</span> Pending
<p><i>Explanation action item</i>  Communication to go out to all staff regarding the mission statement and actions to be taken going forward. UHS Change Champions to draft this and share with Paula Head.</p>			
Trust Board – Open Session 30/08/2019 4.5 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports 2018-19 for review and Action Plans 2019/20 for approval			
81.	Workforce Reports	<ul style="list-style-type: none"> <li>● Bailey, Jane</li> <li>● Byrne, Gail</li> </ul>	25/09/2019 <span style="color: yellow;">■</span> Pending
<p><i>Explanation action item</i>  Reports related to workforce to be considered as a whole, as part of JB's review of the Board and its Committees. A specific update on progress in respect of long term illness and disability to be made in February 2020.</p>			
Trust Board – Open Session 30/07/2019 4.5 Integrated Performance Report for Month 3 for review			
63.	Integrated performance report - Workforce	<ul style="list-style-type: none"> <li>● Byrne, Gail</li> <li>● Harris, Steve</li> </ul>	10/09/2019 <span style="color: red;">■</span> Overdue
<p><i>Explanation action item</i>  Actions in relation to staff morale and continued workforce issues to be presented to the next Trust Board Study Session.</p>			

Trust Board – Open Session 30/07/2019 4.7 Safeguarding Annual Report 2018/19 for review				
66.	Safeguarding annual report	● Hollins, Peter	10/09/2019	■ Overdue
	<i>Explanation action item</i> To consider the frequency and content of safeguarding reporting in the future.			
Trust Board – Open Session 30/07/2019 2 Minutes of Previous Meeting held on 27 June 2019				
60.	Minutes of the previous meeting	● French, David	30/08/2019	■ Completed
	<i>Explanation action item</i> DAF to amend paragraph 4.5.			
Trust Board – Open Session 30/07/2019 4.1 Patient Story				
61.	Patient story	● Byrne, Gail ● Sandeman, Derek	30/08/2019	■ Overdue
	<i>Explanation action item</i> GB and DS to meet the patient/representative to respond to the feedback provided.			
Trust Board – Open Session 30/07/2019 4.5 Integrated Performance Report for Month 3 for review				
64.	Integrated performance report - Emergency department	● Byrne, Gail	30/08/2019	■ Overdue
	<i>Explanation action item</i> The receptionists' "red flag" list for patients attending ED to be reviewed.			
65.	Integrated performance report - maternity indicators	● Byrne, Gail ● Hayward, Jane	30/08/2019	■ Overdue
	<i>Explanation action item</i> Maternity indicators for inclusion in the IPR to be reviewed.			
Trust Board – Open Session 27/06/2019 4.3 Integrated Performance Report for Month 2 for review				
38.	Overnight Patient Moves	● Marshall, Caroline	29/08/2019	■ Overdue
	<i>Explanation action item</i> Quality Committee to investigate the level of overnight moves of patients for non-clinical reasons.			

Trust Board – Open Session 30/07/2019 4.5 Integrated Performance Report for Month 3 for review				
62.	Integrated performance report - Never Events	● Byrne, Gail	27/08/2019	■ Completed
	<i>Explanation action item</i> A paper outlining the actions being taken in response to the recent Never Events to be taken to the next Quality Committee.			

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title Integrated Performance Report 2019/20 Month 5</b>			
<b>Category</b>	Quality, Performance, and Finance		
<b>Agenda item</b>	4.4		
<b>Sponsor</b>	Director of Transformation and Improvement		
<b>Author</b>	Trust Performance Manager		
<b>Provenance</b>	The Integrated Performance Report is reviewed monthly by the Board of directors		
<b>Classification</b>	This Report is unclassified.		
<b>Purpose and recommendation</b>	The paper is presented for REVIEW.		
<b>Relevant strategic goals</b>	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways</li> <li>• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6</li> <li>• BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme</li> <li>• BAF04 – Reduced access to resources compromises the quality of services</li> <li>• BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care</li> <li>• BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services</li> <li>• BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care</li> <li>• BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual</li> <li>• BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider</li> <li>• BAF10 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status</li> </ul>		
<b>Impact assessments</b>	n/a		
<b>Other standards affected</b>	n/a		

# Integrated KPI Board Report Digest

## Improving patient Journeys

August can be a difficult month for flow in the NHS due to the start of the new medical graduates on the first Wednesday of the month. This affects clinical processing capacity, as the new medical staff learn how to enable all the multiple actions they are in charge of enacting each day. There is considerable preparation made for this, with safety being paramount. We were pleased that the plans held up and that discharges, and our Opel status did not change. That was not the case in all hospitals, with several hospitals declaring Opel 4 by the week after the new intake. August was not a month when we would have expected to reduce LOS.

Delayed transfers of care remain stable not achieving target, currently at 5.7% in August. For UHS this still represents a slight improvement from earlier in the year – in late spring our DTOC numbers were at 6.4% of our occupied beds. This is a different picture compared to the whole of the south-east who saw a 0.3% rise in August compared to April. The average for the whole SE for August is 5.2% - still less than UHS, but with a consistent rise over the year.

Adult bed occupancy has been consistently higher this summer compared to last summer at around 95%, and with no adult beds shut on the SGH site but with closures in Paediatrics and some beds in PAH. We have had an average of 60 additional adult patients in beds throughout this summer compared to last; we had one ward shut last year and also about 25 more DTOC patients, which accounts for the difference.

These additional patients have been emergency admissions, not elective patients. We have had a 7% growth in emergency attendances, and a 4.6% increase in non elective spells accounting for the additional inpatients this summer. The reduction in the LOS compared to last year, and the reduction in DTOCs has meant that we have still had the capacity to continue our elective programme in August, within the constraints of theatre space and anaesthetic capacity.

The number of first cancer treatments increased by 5% associated with a 10% increase in emergency referrals for cancer. This is in accordance with national trends to increase the number of patients referred and reduce the percentage diagnosed in the referral cohort.

The low number of patients cancelled and not readmitted in 28 days (4) reflects patient preference at a time when surgeons and patients are taking holiday. The elective programme was able to proceed as well as expected in August.

A new national weekly monitoring of longer LOS patients (21+ days) has been launched in July to create a new focus on this group linked to the SAFER programme. Patients in this LOS subset are divided into those medically unfit, and those who are a delayed transfer of care. These weekly discharge lists show UHS to be comparable with large teaching hospitals in the South east for patients who are medically unfit (as opposed to delayed transfers of care). NHSI are visiting the 14 hospitals in the SE to inspect their processes around flow and same day emergency care. This visit went well, with positive feedback received. In particular, our SDEC facilities and processes received attention and commendation.

Emergency access performance maintained the improvement seen in July. We are on trajectory for our recovery plan. Type 1 performance in August was 80% and we ranked 6<sup>th</sup> of 8 Major

Trauma Centre peers (8<sup>th</sup> being worst), however were only 0.3% from the average of all trauma centres. Local delivery system performance was at 87.5% in August against a target of 90.0%. The main factors in improvement were the additional junior doctor numbers, and the improved minor injury performance. The recovery plan is being delivered based on the recommendations of Matthew Cooke, a national clinical advisor. This is being monitored fortnightly with the national team and a new system plan has been agreed with weekly CEO oversight.

Percentage of patients on an open RTT pathway (waiting list) who have waited less than 18 weeks in August is at 84.01% and is consistently not achieving the target of 92%. The RTT position overall has worsened by 2% in month. This is due to a 700 increase in the over 18 week backlog position, with a smaller increase in the total waiting list. We have been behind with the validation position over the last three months and we are employing an external company to deliver additional validation of 15,000 pathways, to enable more confidence in the true underlying picture. We know that there will have been some impact from the theatre shortages, and the pensions issue which affects both clinic capacity and theatre sessions. Neurology, which accounts for a high volume of patients has lost several clinics per week now since April. This will be part of the problem, as well as an underlying data issue. There were two patients waiting longer than 52 weeks recorded in August.

6 week diagnostic performance remains stable not achieving trajectory, currently at 2.8% waiting over 6 weeks in August. This is due to endoscopy and neurophysiology capacity.

Average weeks waited for first outpatient appointment has shown a consistent reduction decreasing from 8.90 in September 2018 to 7.57 August 2019.

62 day cancer waiting time performance decreased to 71.7% in July against a local target of 77%. Having exceeded the average teaching hospital last month for the first time in 8 months UHS dropped down in July to rank 8th (10<sup>th</sup> being worst) out of a peer group of 10 similar size teaching hospitals. Pathways across all tumour sites have been affected by diagnostic capacity of all modalities due to consultant workforce shortfall, and also patient choice due to the holiday season, as well as late referrals from other units.

31 day cancer waiting time performance has not achieved the target. Performance was at 91.2% in July against a local trajectory of 94.7%. This is a reflection of theatre capacity as well as complex radiotherapy pathways which require a long time to plan.

2 week GP referral cancer waiting time performance continues to trend upwards, achieving target for the fifth month in a row, currently at 97.7% in July against a target of 93%. This is a significant improvement on the same period last year.

### **Delivering value based health and care**

The Reference Cost Index (RCI) is a measure of relative efficiency within NHS providers. An RCI of 100 indicates costs are in line with the national average, below 100 indicates costs are below the national average. UHS had an RCI of 98 in 2016/17 and 96 in 2017/18 i.e. in 2017/18 UHS was 4% (£27m) more cost efficient than the average NHS Trust.

Cost per Weighted Activity Unit (WAU) is the headline productivity metric used within the Model Hospital. Costs are adjusted for local variations in the cost of providing healthcare using the Market Forces Factor (MFF). In 2017/18 UHS cost per WAU was £3,358 which is in quartile 1 (the lowest 25% in the nation), the national median for 2017/18 was £3,486. The Model hospital in association with the GIRFT team have now published up to date clinical metrics for 7 surgical Specialties, these will be updated at regular intervals in the year for trust to monitor and review.

Getting it right first time (GIRFT) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. Currently at UHS 21 out of 33 clinical specialties have been visited. With 19 of these now having a clinically lead quality improvement and specialty lead investigation programmes agreed with the GIRFT central team.

The latest national data (April 2019) showed a median CHPPD for similar size (clinical output) trusts as 5.4 for registered nurses and 8.8 overall, UHS was at 5.4 and 8.6 respectively that month.

For the last 8 months the trust has achieved the target for complaints closed within 35 days, in August we achieved 80% against a target of 70%.

### **Supporting healthy lives**

C.diff cases achieved trajectory in August with 3 against a target of 5, of these none were deemed a lapse in care. We are above the year to date trajectory due to performance in May (9 against the in-month target of 5).

There was 1 SRI in August 19. Of the 4 overdue SRI's at the end of July one is still being investigated by HSIB (since August 18), 2 have now been closed and 1 will be going to SISG in September.

There were three moderate harm medication related incidents reported in August 2019. There is one incident relating to an incorrect dose of insulin resulting in the need for treatment for low blood glucose. The second incident relates to a missed dose of Daptomycin – the actual harm from this is being reviewed. The third incident relates to omission of hydrocortisone therapy for a patient with Addison's which resulted in the patient becoming unwell. This is being reviewed by the medication safety group.

3 national reports were published and reviewed in August 2019 and 0 Areas of concern were identified.

HSMR performance over 12 months remains low due to continued low values from several specialties. May 2019 has generally gone down. Neurosurgery continues below benchmark in May (3 month run). Neurology remains a little high, though continues to be reducing. Crude mortality continues to decrease.

Rolling 12 month staff sickness absence is just above target in August ( $\leq 3.41\%$ ).

Patients screened for risky behaviours in August (alcohol consumption and smoking) remain stable well above target (currently 98% against a target  $>80\%$ ). Of those found to have moderate or high alcohol dependence 87% were given relevant advice or a referral to specialist services in August, this performance is stable not achieving the target 90% (last achieved December 2018). Of those found to smoke who were given advice or offered medication performance in August was 82% below the target 90%. CQUIN funding has been awarded for further Medicines Management Team members for the duration of the CQUIN – until the end of March 2020. This will allow for some out of hours and weekend work targeting specific areas that there is currently low uptake on. These members will predominately focus on the tobacco advice and offering of medication as it is felt that there is a robust enough system in place currently focussed on the alcohol elements of the CQUIN. We have also now set up a weekly report to inform all members of how we are doing within the quarterly milestone so that focus can be moved if required. There is similarly a monthly Tobacco meeting to discuss any concerns so that any escalations are dealt with in a timely manner.

### **Building an expert and inclusive workforce**

In UHS ward-based areas, total nursing staff vacancies have decreased by  $-0.29\%$  since last month.

Registered nurse vacancies in ward-based areas have also decreased this month by  $-0.84\%$  (6.8 FTE) since last month, which is rare for August, when vacancies normally increase. Net RN movements are as follows: 5.6FTE leavers to non-UHS employment, 3.8FTE internal moves into ward areas and 12.88FTE overseas RN got there pins and moved from Band 4.

Some key targets have been missed for staff turnover and appraisals. However turnover has shown a positive drop over the last few months. Sickness absence rates have increased for the fourth month and is now above target. CHPPD has increased but this is likely to be due to a change in data sourcing compared to last month. UHS has seen improvements in rates of employment for BAME Band 7+. The position for the following is stable: statutory and mandatory training compliance (with 10 of 12 measures meeting target).

The total CHPPD rate in the Trust has increased from last month to RN 5.5 (previously 5.3) , HCA 3.4 (previously 3.3) overall 9.0 (previously 8.6). The CHPPD for ward based areas in the Trust has decreased from last month to RN 4.0 (previously 3.9) HCA 3.9 (previously 3.4) overall 7.9 (previously 7.3)

### **Being agile in meeting people's needs**

Estates helpdesk requests did not achieve target in August (6<sup>th</sup> month in a row), currently at 81.0%. Unresolved help desk requests remain stable well below target, in August we had 664 against a target  $<1000$ . Unresolved requests over 30 days old increased to 250 in August, 50 above a target  $<200$ . Percentage defect work orders completed on time met the target  $>85\%$  in

August. Percentage statutory and mandatory jobs completed on time decreased this month however still met the target 95%. The EFCD team have looked at the effect of not performing some maintenance tasks in a timely manner and considered how this impacts patients.

A simple comparator of the failure rate of toilets has been selected. In August the figure was 0.51%.

Immunology and Histopathology requesting and acknowledgement continues its increase. Total requesting in UHS is at 90.4% and acknowledgment is at 92.7% steady with previous months.

UHS patient logins and registrations to My Medical Record remained high in August following the surge in June linked to a new registration method. The plan is to increase to 100,000 by the end of this year.

### **Leading edge research, education and innovation**

In Q1 2019/20 UHS was ranked 7th for non-weighted and 3rd for weighted CRN recruitment against a target of being in the top 10 and top 5 respectively.

In Q1 UHS are currently ranked 16th for contract commercial study recruitment (against a target of being in the top 10), which has prompted a specific focus on improving our commercial performance.

Comparative CRN recruitment performance by specialty was on target in Q1 2019/20 with 58% specialties ranking as predicted (in the top 5 or top 10 based on prior performance).

Proportion of commercial studies closing in 18/19 FY on time and to recruitment target ended the year below the 80% target at 71% in Q4, however this was an improvement on the 17/18 performance of 57%.

Clinical study set up and recruitment (in particular for the commercial portfolio) has been impacted by capacity constraints across the research infrastructure and by pressures within the clinical services, in particular with regards to pharmacy capacity to set up and deliver clinical trials. Concerns have been escalated to Trust Executives.

The year to date NIHR CRF & BRC publications in 2019/2020 is currently 137 (10% less than same time last year), related to a loss of clinical academic staff. This is a major concern for our next BRC and CRF applications. Actions are currently in progress that will require Trust support in due course.

# Integrated KPI Board Report

covering up to

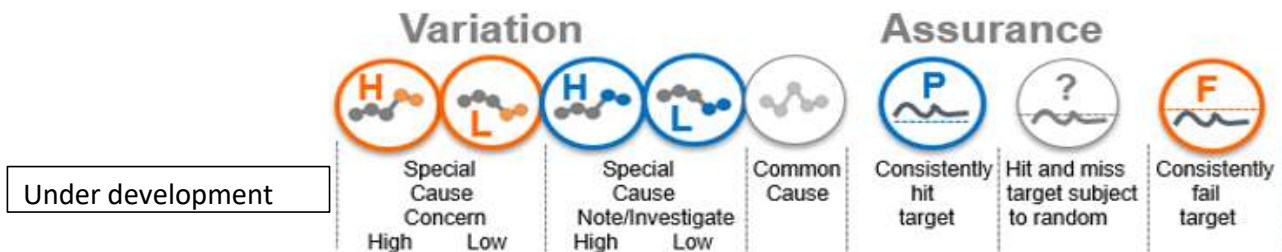
Aug 2019

Executive Sponsor - Jane Hayward, Director of Transformation

[Jane.Hayward@uhs.nhs.uk](mailto:Jane.Hayward@uhs.nhs.uk)

# Report Guide

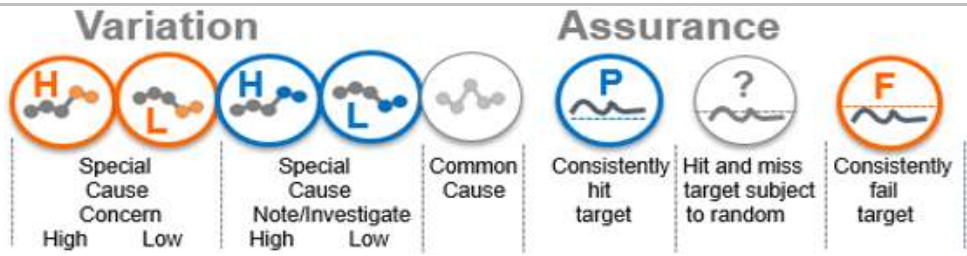
Chart Type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly.
Line Benchmarked		The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month).
Line Percentiles		A line percentiles chart is used to represent the distribution of a variable. The 50th percentile shows the median value, we also show the 5th, 25th (lower quartile), 75th (upper quartile) and 95th centiles.
Control Chart		A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they <ul style="list-style-type: none"> <li>-Go outside control limits</li> <li>-Have 6 points in a row above or below the mean,</li> <li>-Trend for 6 points,</li> <li>-Have 2 out of 3 points past 2/3 of the control limit,</li> <li>-Show a significant movement (greater than the average moving range).</li> </ul>
Variance from Target		Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.



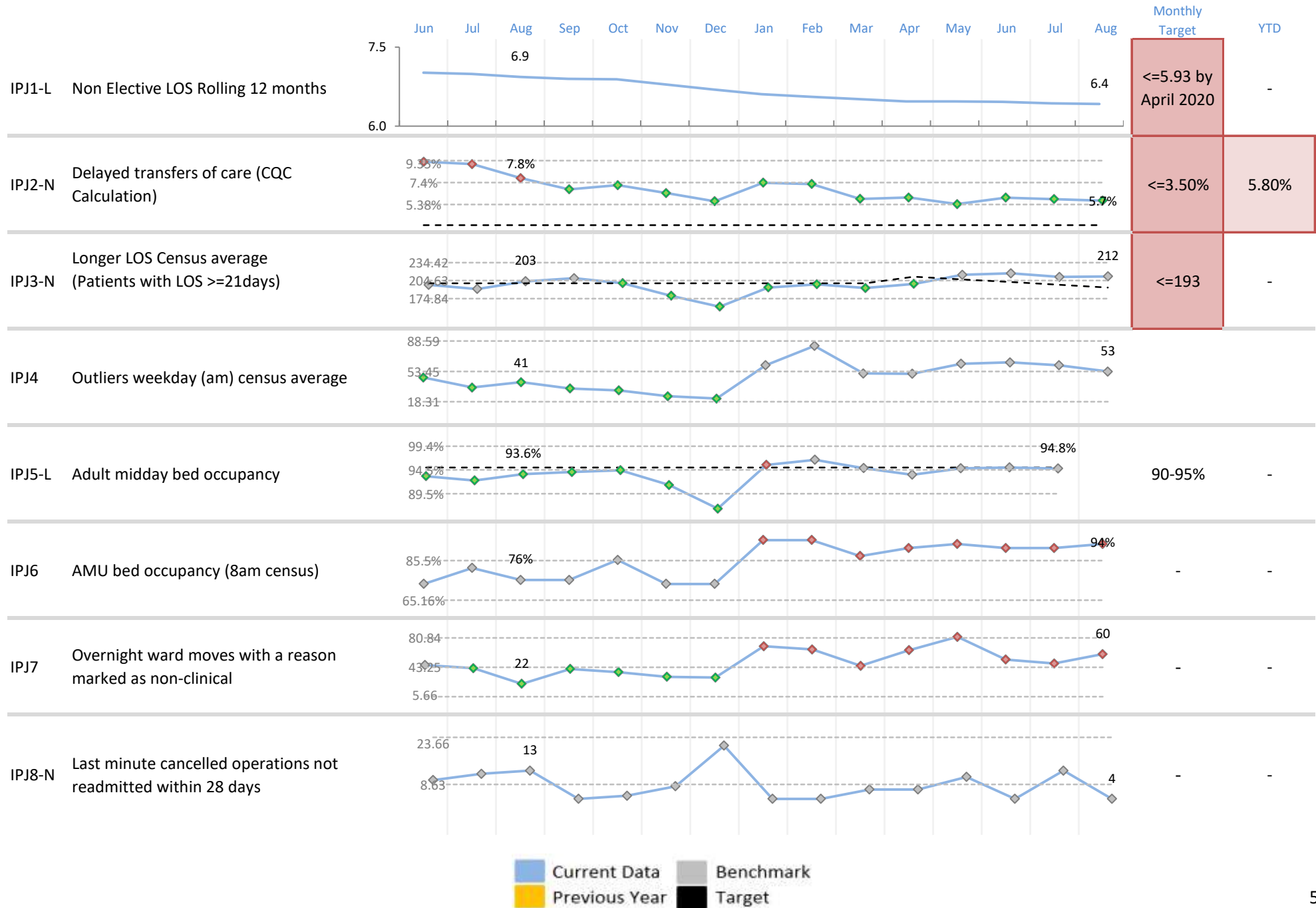
Under development

Improving Patient Journeys

IPJ1-L	Non Elective LOS Rolling 12 months	-	-
IPJ2-N	Delayed transfers of care (CQC Calculation)		
IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)		
IPJ4	Outliers weekday (am) census average		-
IPJ5-L	Adult midday bed occupancy		
IPJ6	AMU bed occupancy (8am census)		-
IPJ7	Overnight ward moves with a reason marked as non-clinical		-
IPJ8-N	Last minute cancelled operations not readmitted within 28 days		-
IPJ9	Percentage patients spending less than 4hrs in ED - UHS Type 1		-
IPJ10	Percentage patients spending less than 4hrs in ED - UHS Total (includes SGH all types and Iymington)		-
IPJ11-L	Percentage patients spending less than 4hrs in ED - Local Delivery System		
IPJ12	Same Day Emergency Care (SDEC)	-	-
IPJ13-N	Time to initial assessment - 95th Centile UHS Total	-	-
IPJ14-N	Time to treatment - Percentiles UHS Total	-	-
IPJ15-N	Total time spent in ED - Percentiles UHS Total	-	-



IPJ16-N	% Patients on an open 18 week pathway (within 18 weeks )		
IPJ17-N	Total number of patients on a waiting list	-	-
IPJ19-N	% of Patients waiting over 6 weeks for diagnostics		
IPJ20	Average weeks waited for first outpatient appointment		-
IPJ22-L	62 day cancer wait performance		
IPJ23-L	31 day cancer wait performance		
IPJ24-N	Urgent GP referrals seen in 2 weeks		
IPJ25	Snapshot of waits > 104 days	-	-
IPJ26	28 Day Faster Diagnosis	-	-

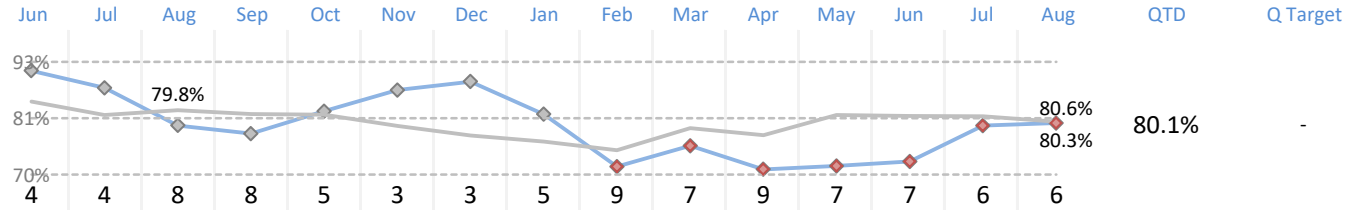


### Percentage of patients spending less than 4 hours in ED

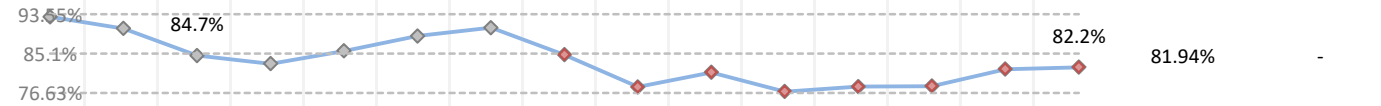
IPJ9 SGH Main ED (Type 1 and UCH)

Major Trauma Centres (Type 1)

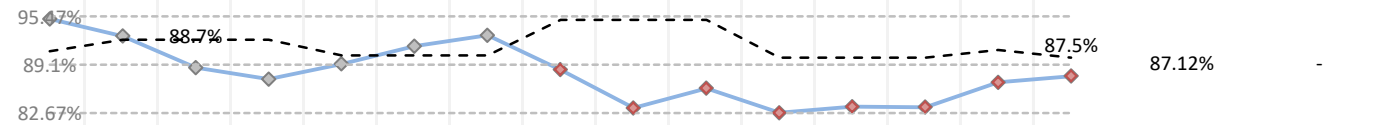
Rank of 11, (8 from May 19 onwards)->



IPJ10 UHS Total (includes SGH all types and lymington)



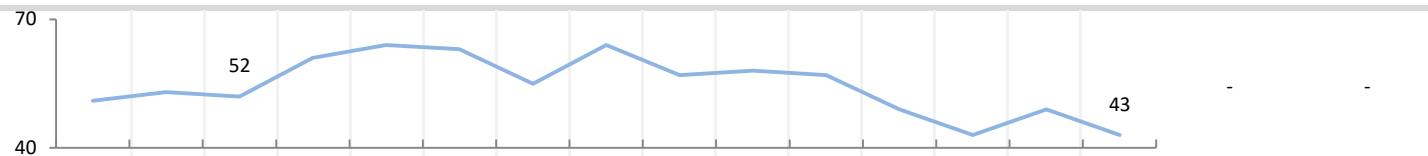
IPJ11-L Local Delivery System



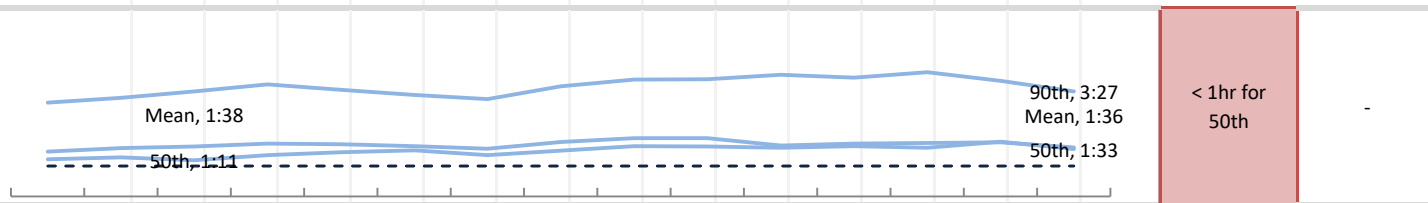
IPJ12 Same Day Emergency Care (SDEC)

Awaiting national data definition

IPJ13-N Time to initial assessment - 95th Centile UHS Total

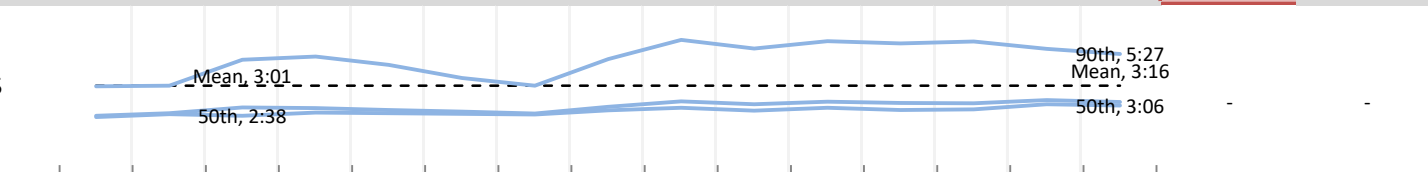


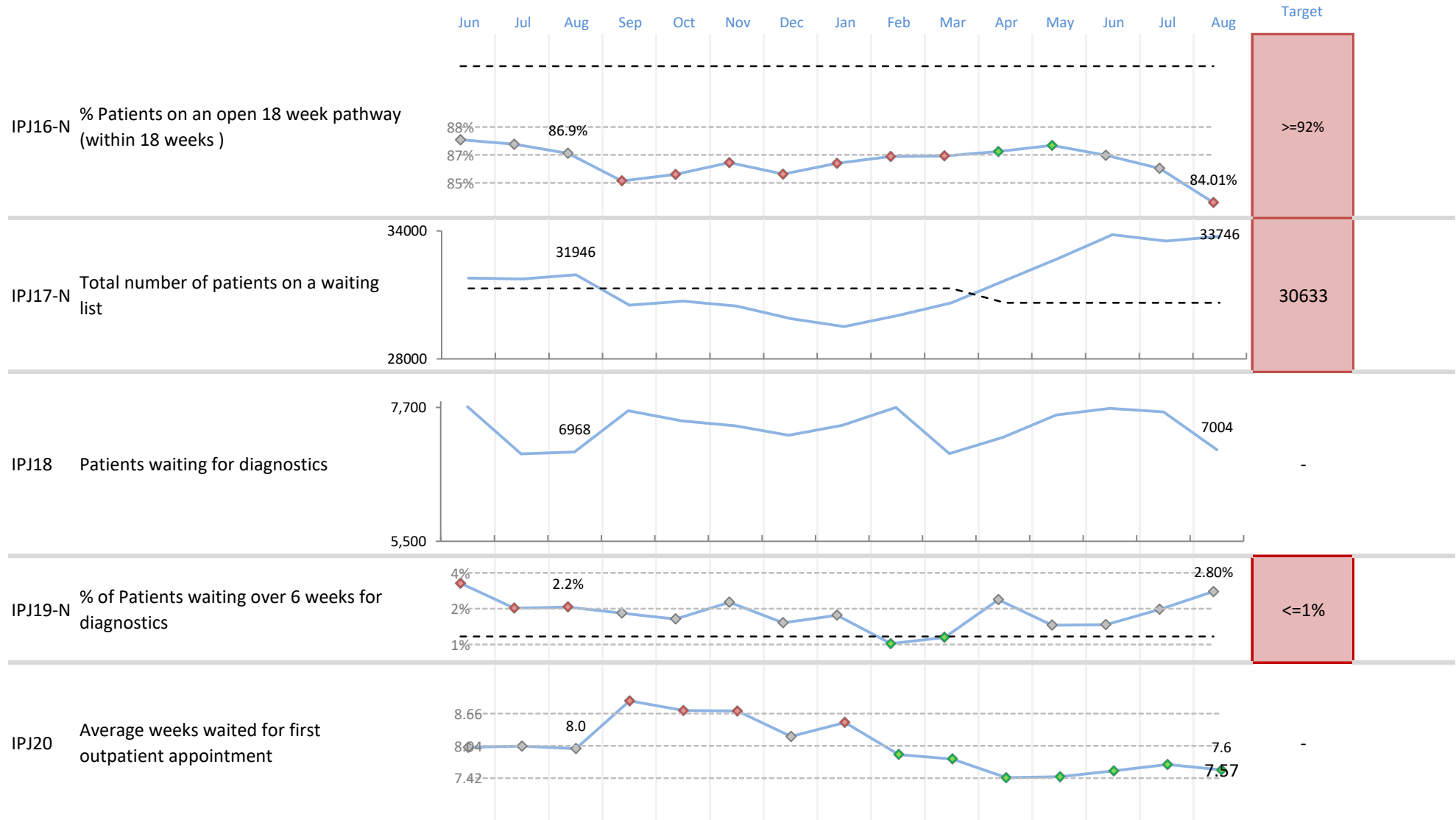
IPJ14-N Time to treatment - Percentiles UHS Total



< 1hr for 50th

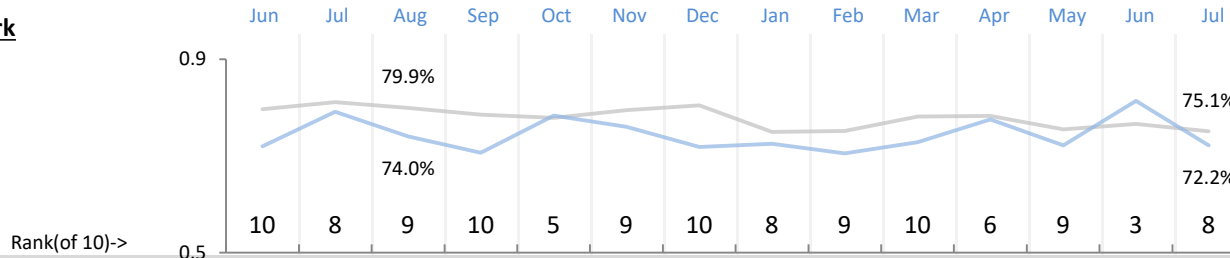
IPJ15-N Total time spent in ED - Percentiles UHS Total





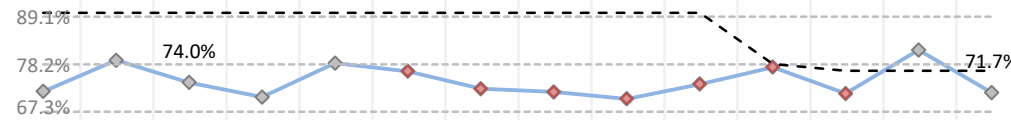
### 62 Day Performance Benchmark

IPJ21 Teaching Hospitals vs. UHS Total



IPJ21 UHS Total performance is taken from NHS Statistics numbers which are static as opposed to the performance shown in IPJ22 which is updated as data is validated.

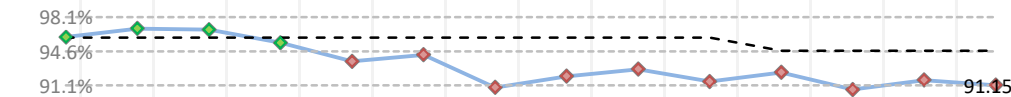
IPJ22-L 62 day cancer wait performance



=>77%	10 of 201.5	72%
-------	-------------	-----

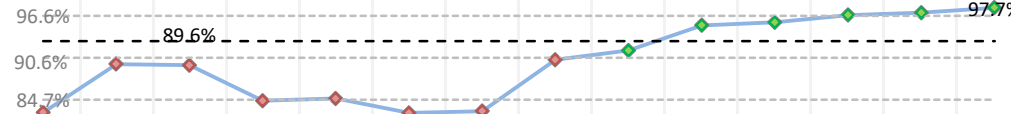
1 of 13 tumour sites achieved 62 day target in July.

IPJ23-L 31 day cancer wait performance



=>95%	33 of 927	91%
-------	-----------	-----

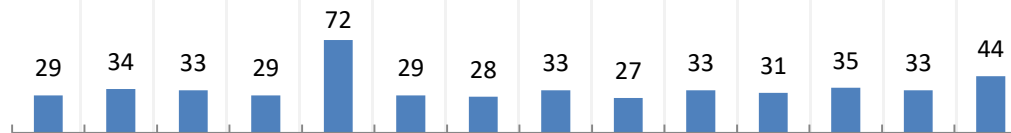
IPJ24-N Urgent GP referrals seen in 2 weeks



=>93%	0 of 1806	98%
-------	-----------	-----

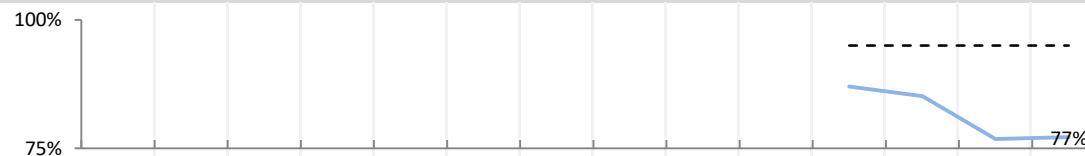
12 of 13 tumour sites achieved 2 week target in July.

IPJ25 Snapshot of waits > 104 days



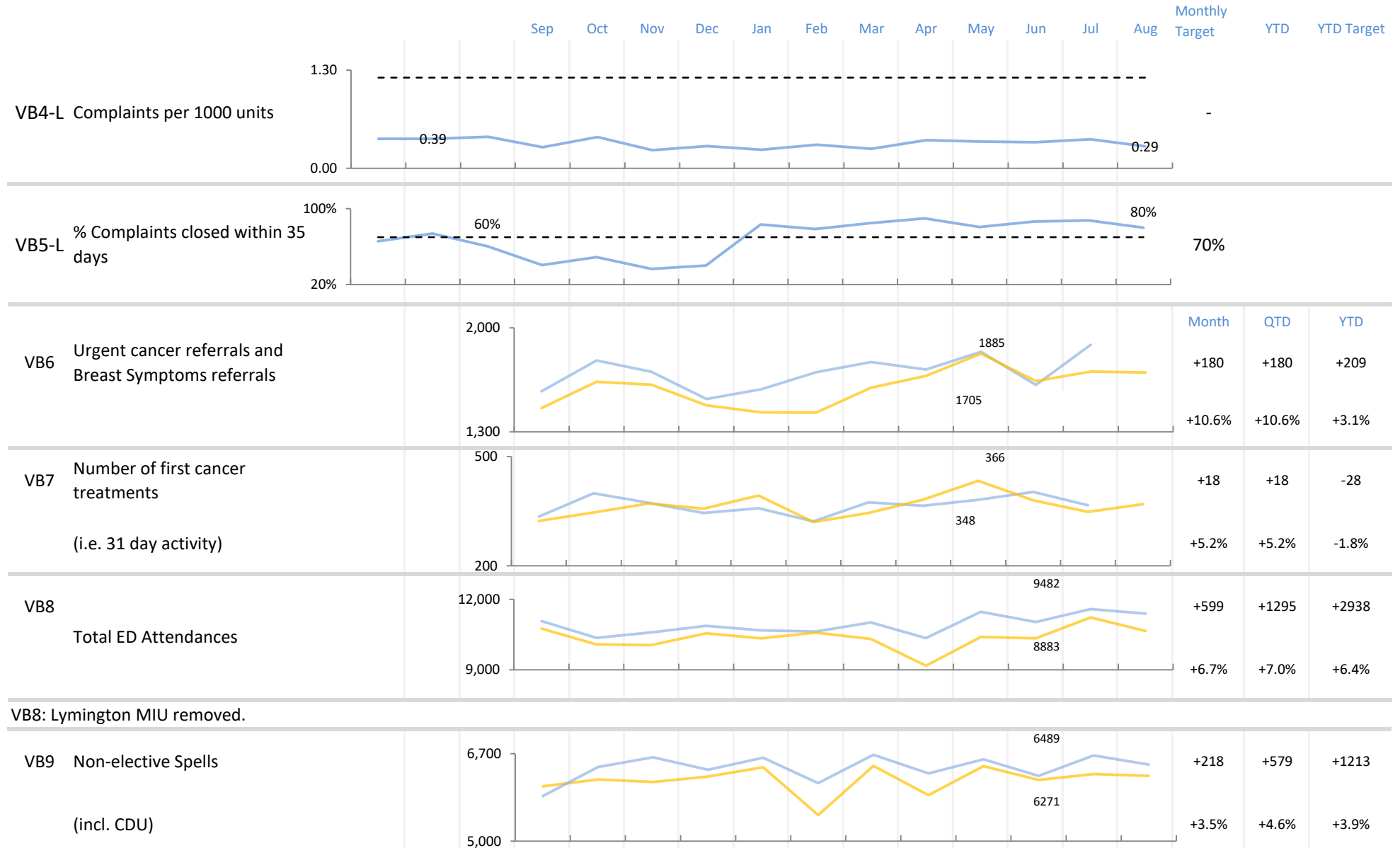
=>95%	291 of 1630	77%
-------	-------------	-----

IPJ26 28 Day Faster Diagnosis



IPJ26 - this KPI is being shadow monitored by UHS in preparation for national submissions beginning April 2020. There is currently no official target.

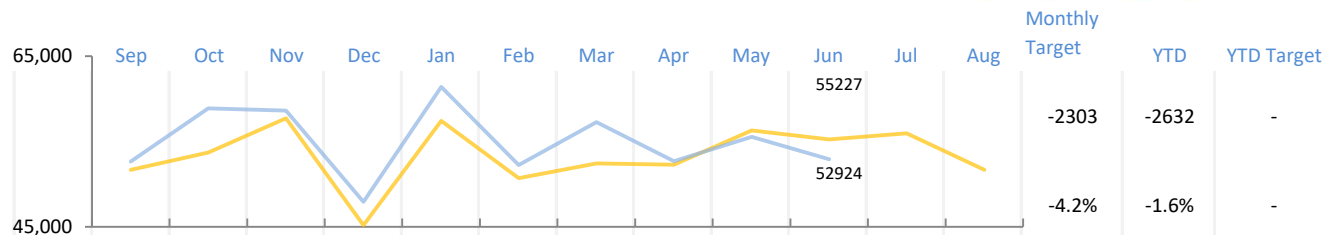




VB9: Operational practice change in counting and coding means that patients who move from ED to the CDU chair area only (not passing through CDU ward areas), are no longer being counted or billed as non-elective spells, resulting in a reduction in approx. 400 spells a month from August 17.

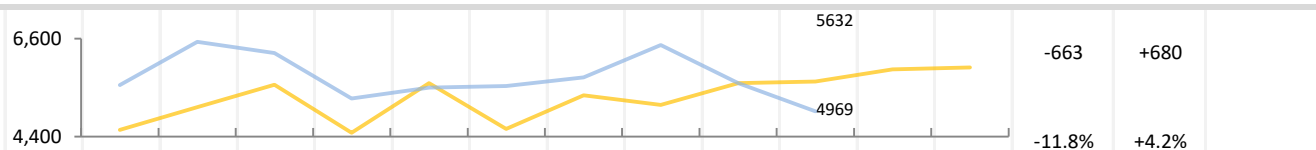


VB10 Face to Face OPA

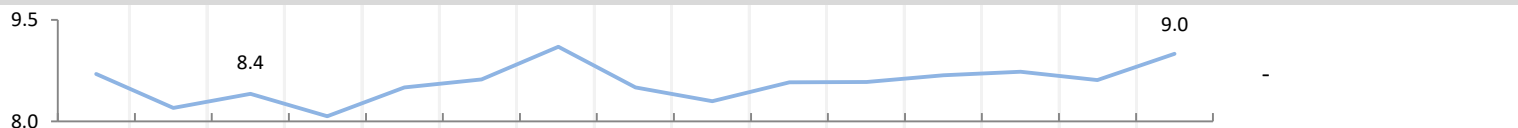


VB10/VB11: This currently excludes mymedical record contacts.

VB11 Non-Face to Face OPA

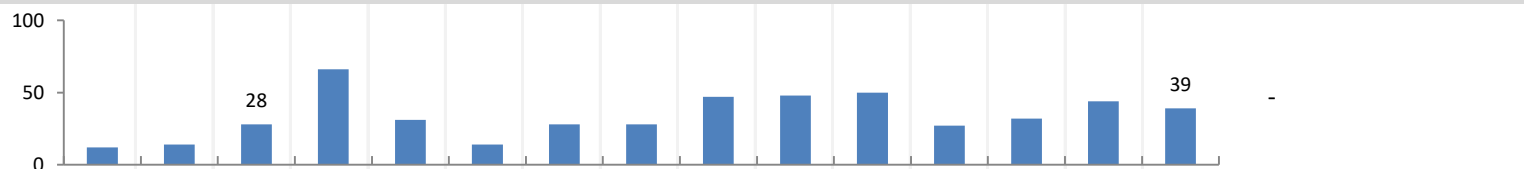


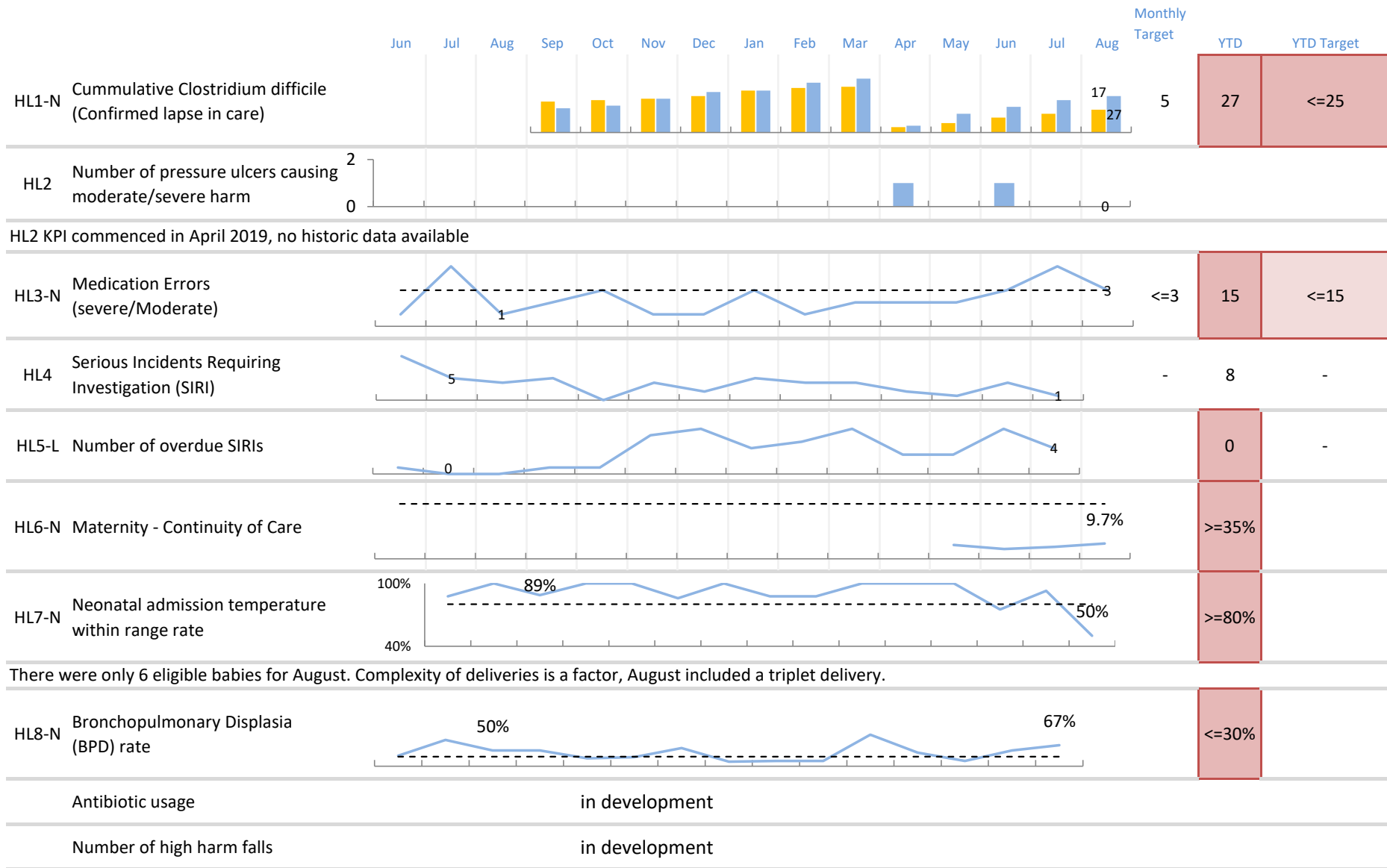
VB12 Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)

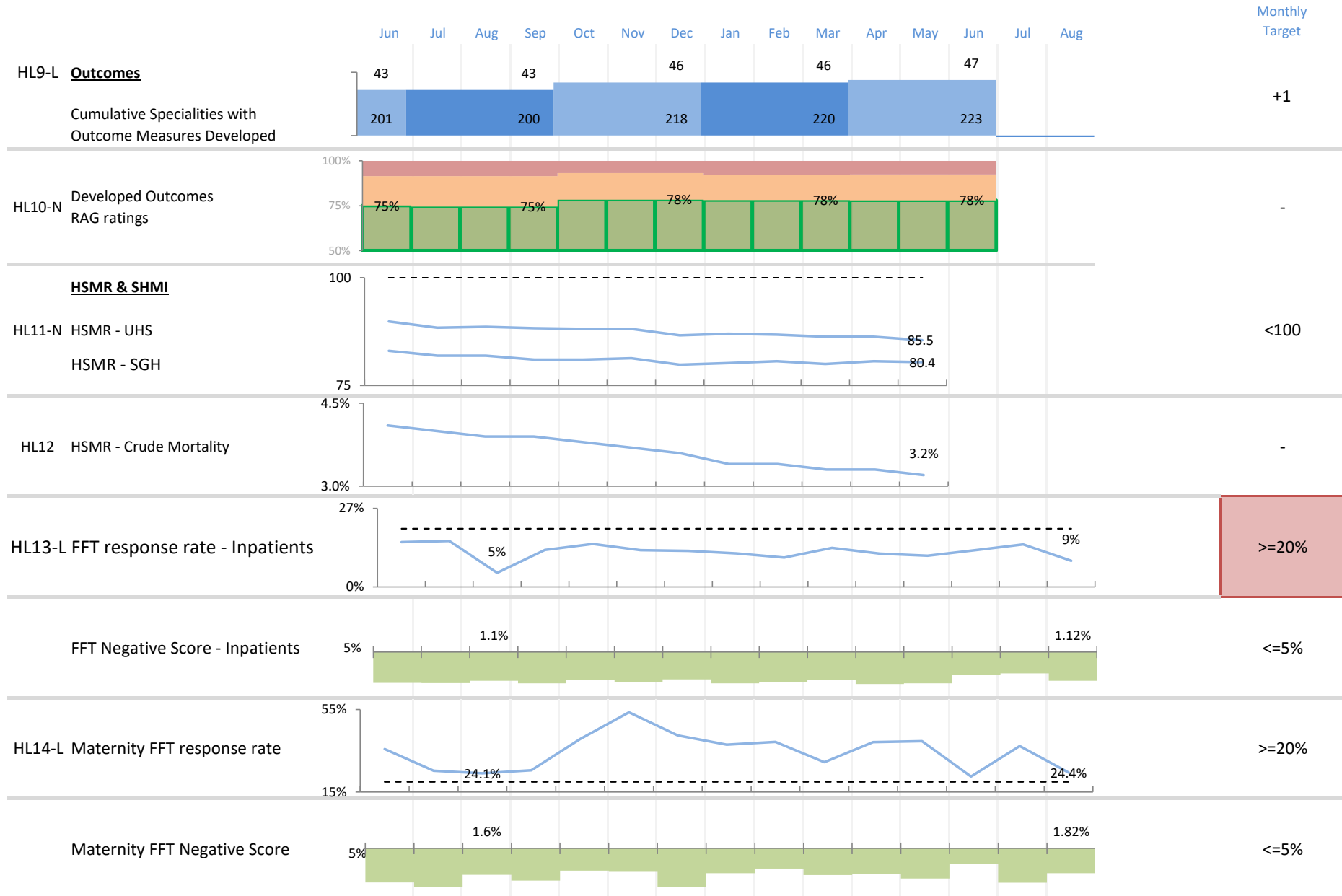


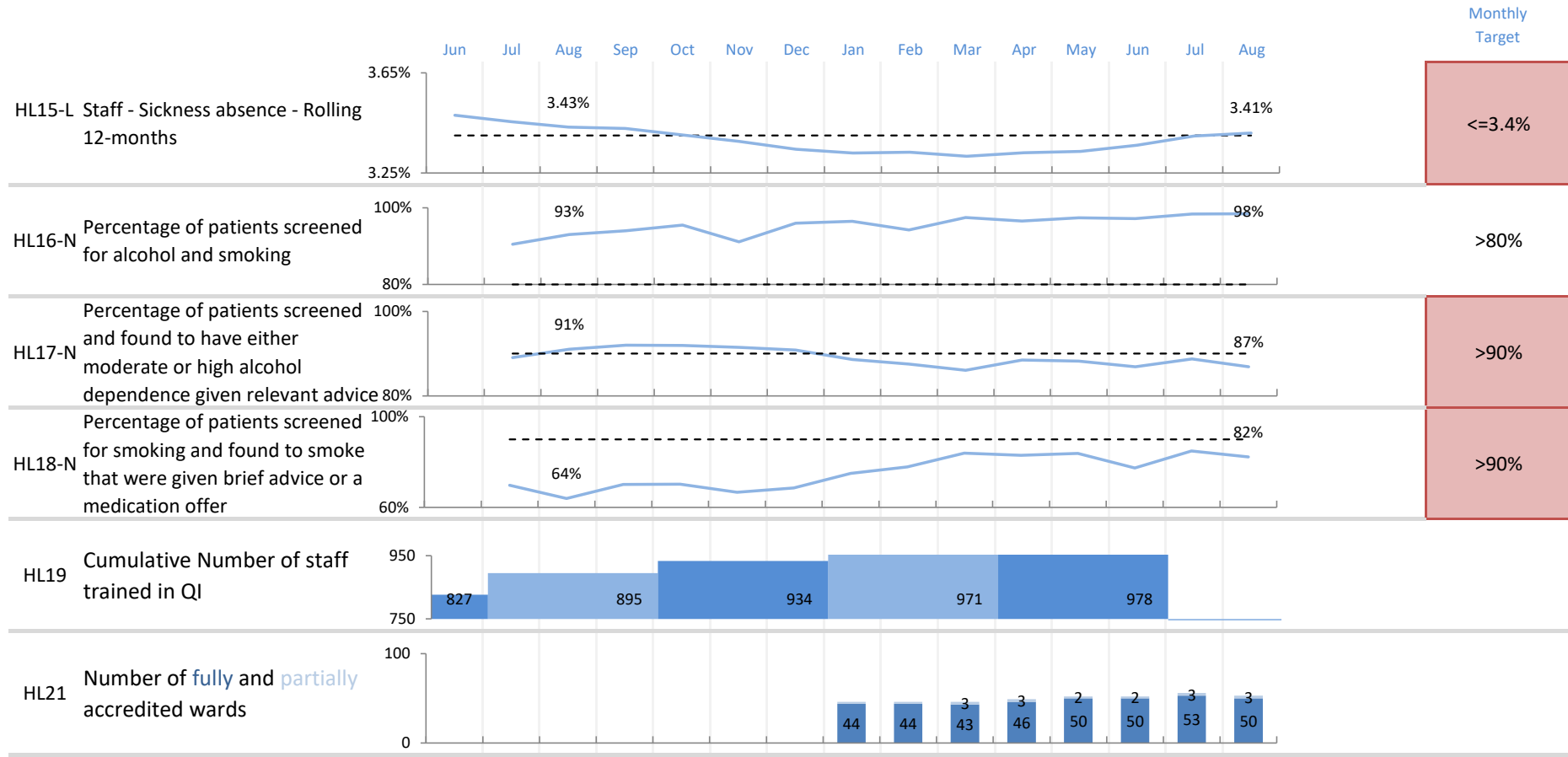
VB12 The total CHPPD rate in the Trust has increased from last month to RN 5.5 (previously 5.3) , HCA 3.4 (previously 3.3) overall 9.0 (previously 8.6). The CHPPD for ward based areas in the Trust has decreased from last month to RN 4.0 (previously 3.9) HCA 3.9 (previously 3.4) overall 7.9 (previously 7.3).

VB13 Red Flag staffing incidents

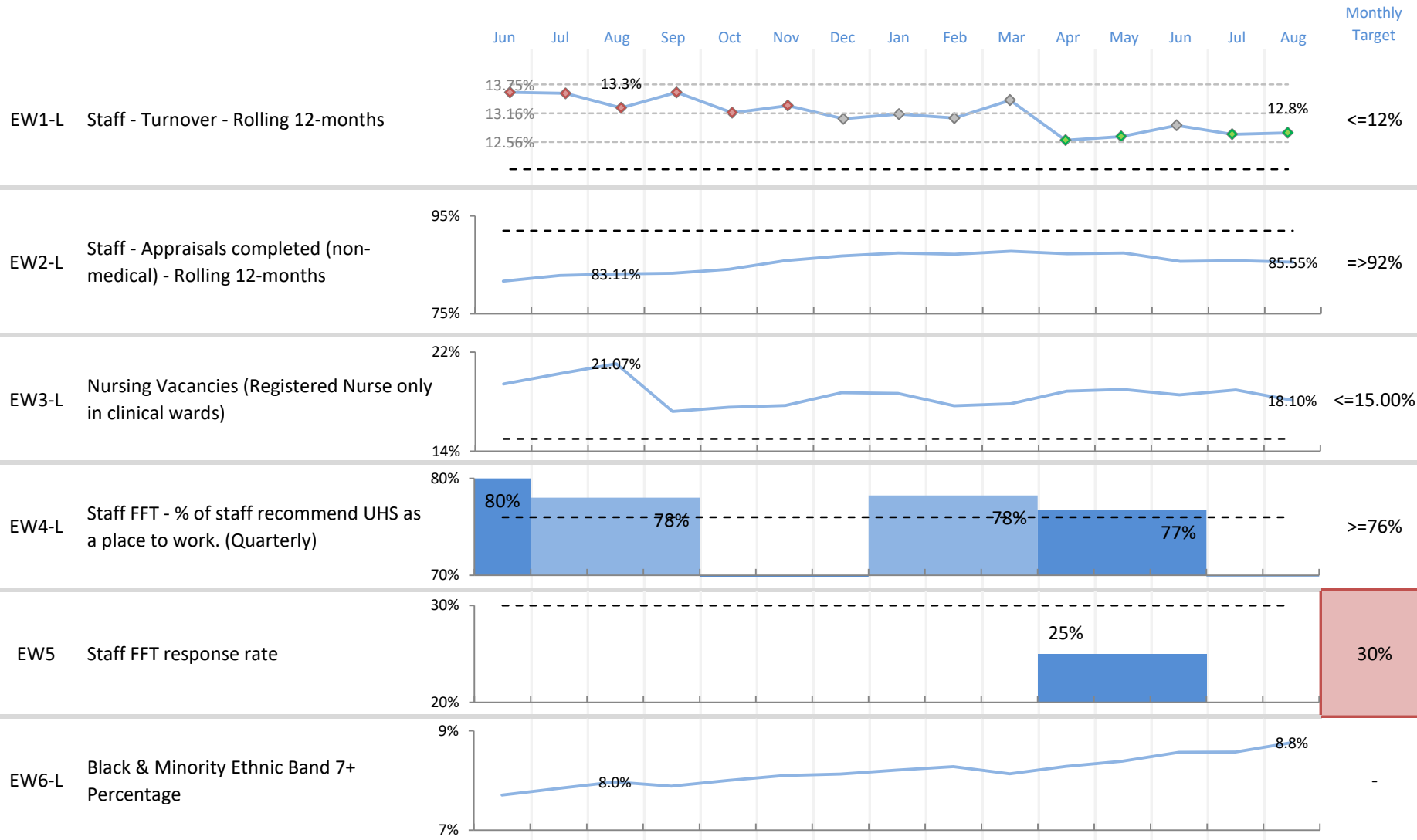








■ Current Data    ■ Benchmark  
■ Previous Year    ■ Target



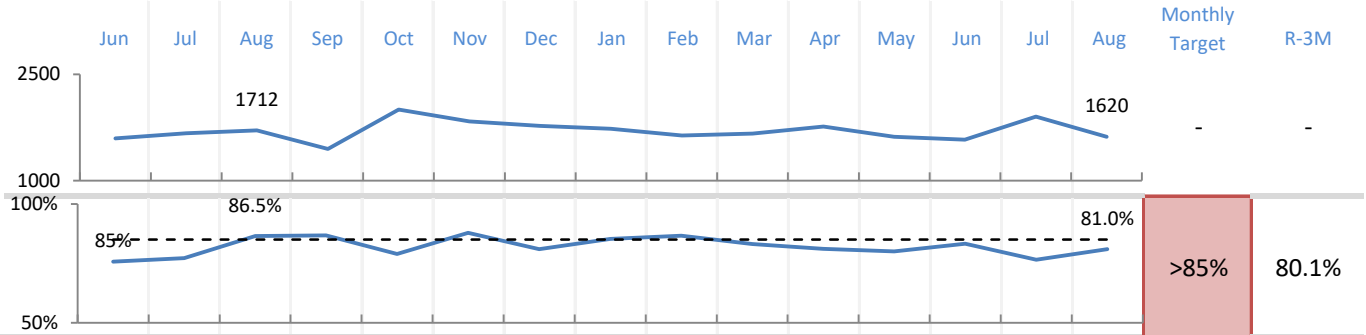
EW6 UHS has a target of 15% Band 7+ BME staff by 2023.





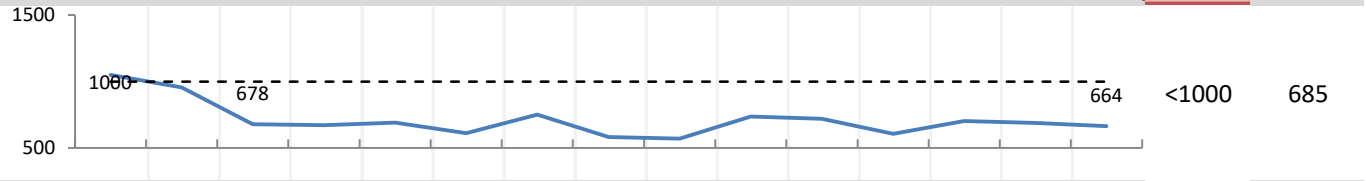
**Estates**

BA1-L Number of Help desk requests and percentage completed on time

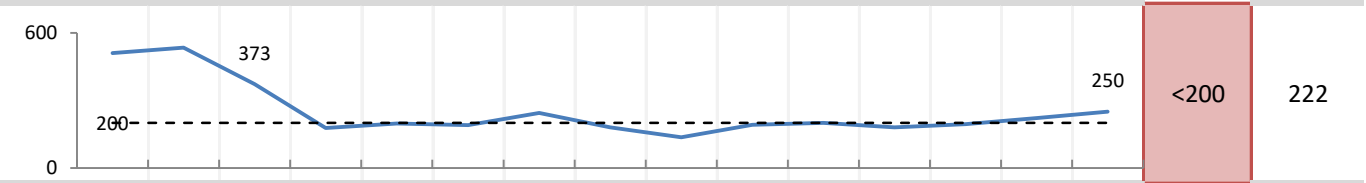


**Reactive Maintenance**

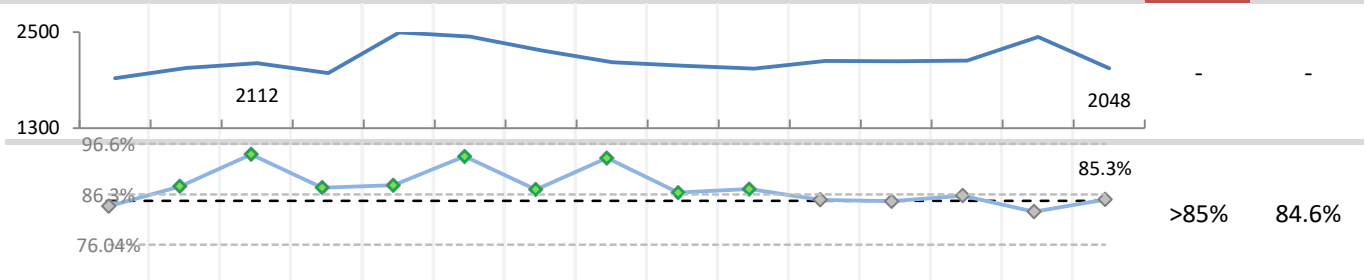
BA2-L Unresolved help desk requests



BA3-L Unresolved help desk requests (over 30 days old)

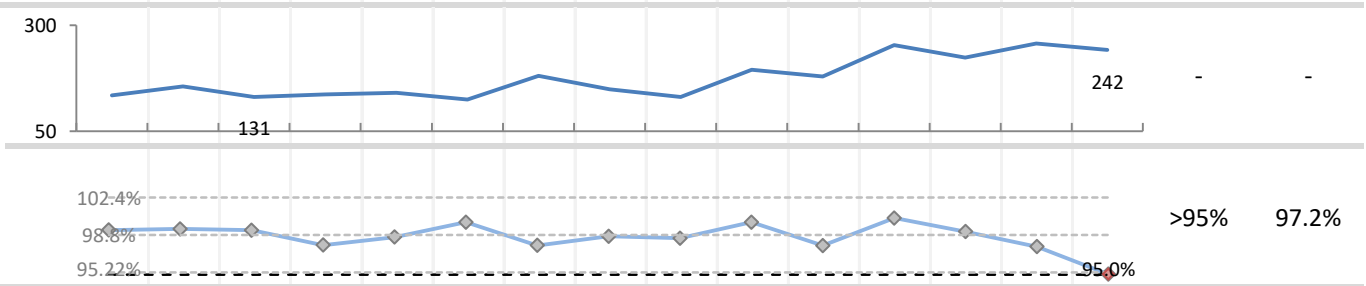


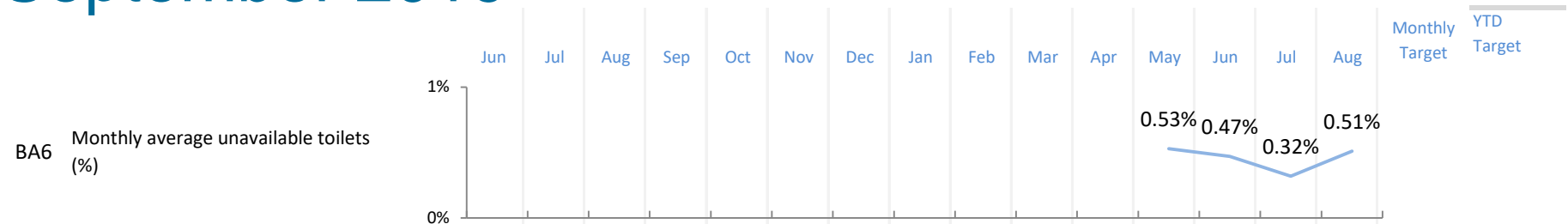
BA4-L Number of defect work orders and percentage completed on time



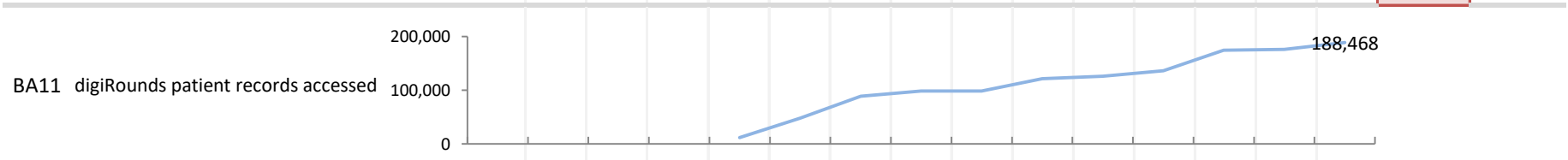
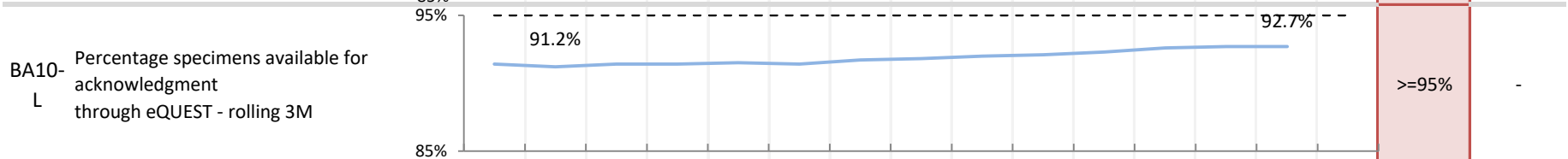
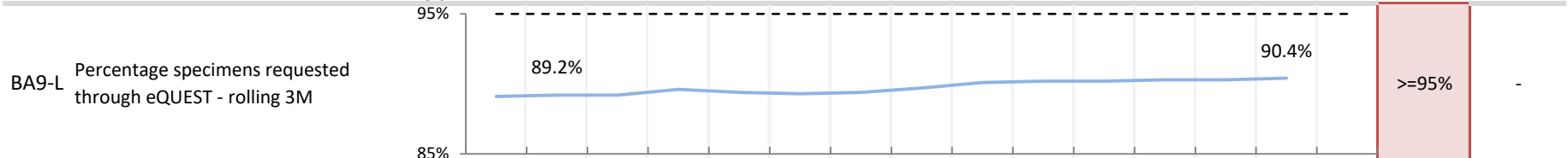
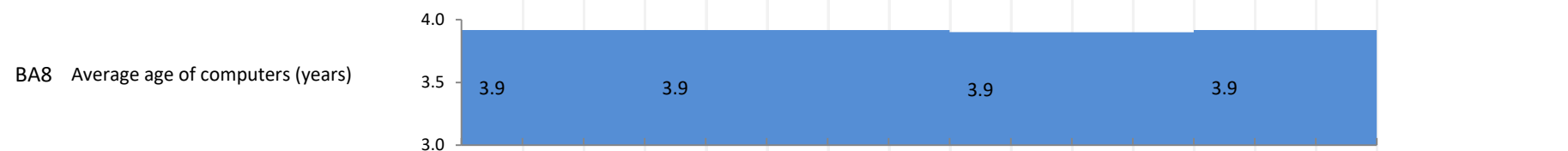
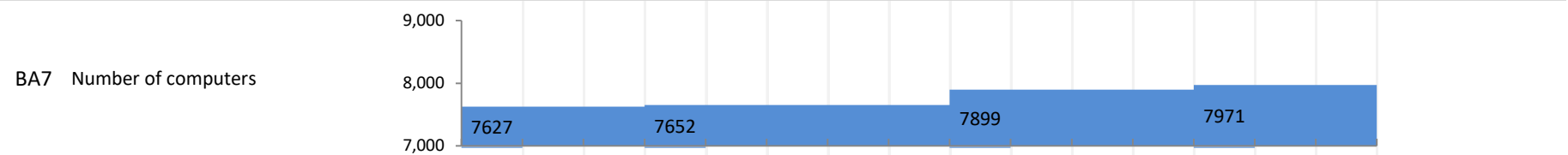
**Preventative Maintenance**

BA5-L Number of statutory and mandatory maintenance jobs planned and percentage completed on time

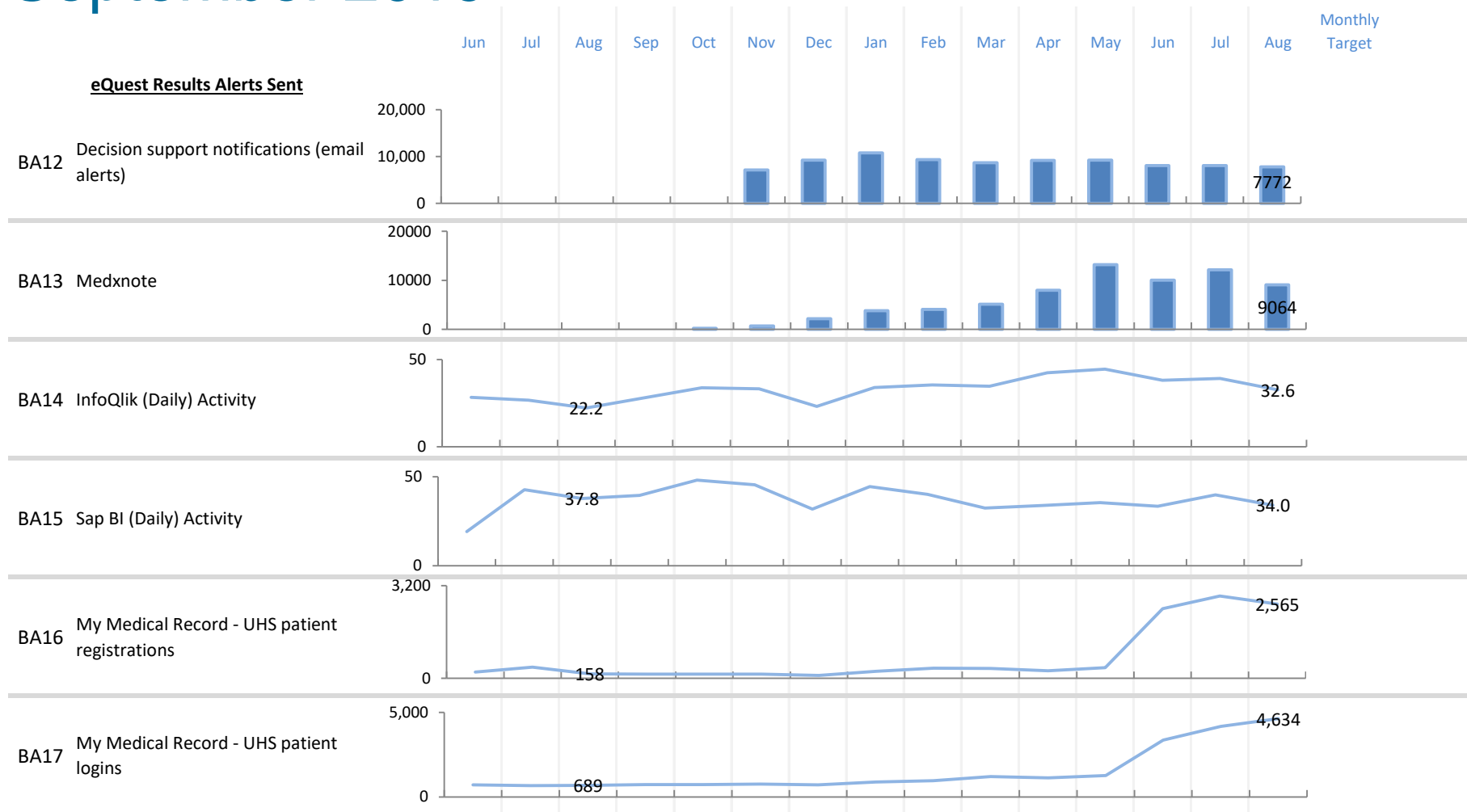




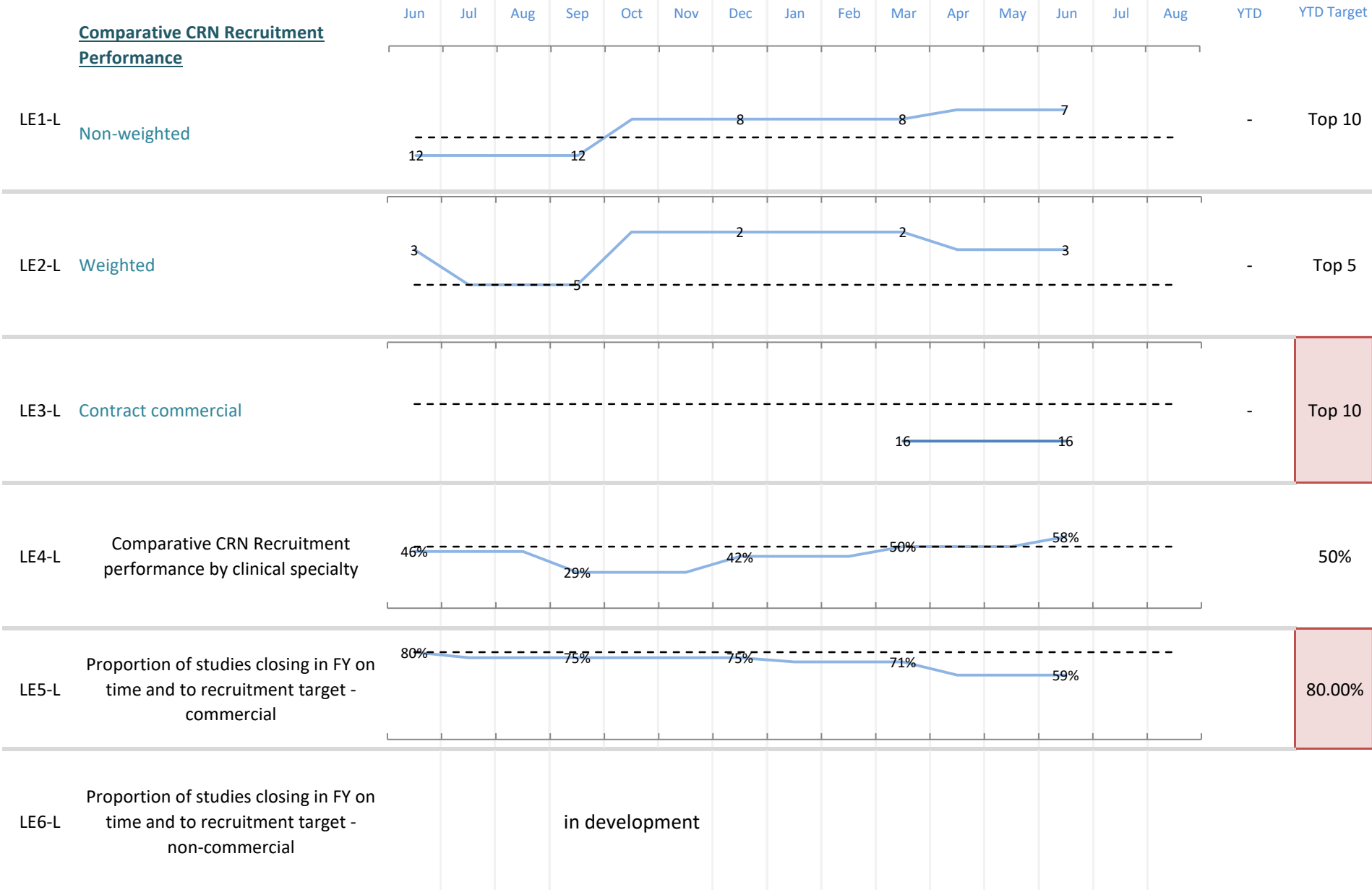
BA6 - This KPI is intended to be a proxy of the impact of maintenance work that is not completed on patients and staff.

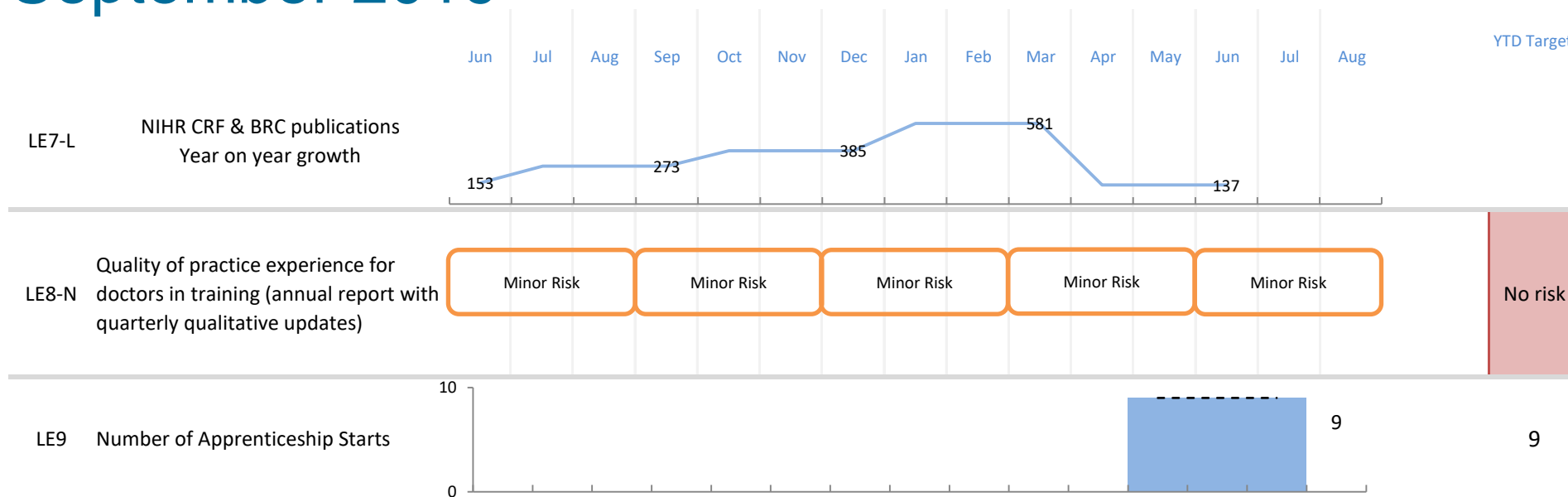


# September 2019



**Comparative CRN Recruitment Performance**





## Quarter 1 Patient experience summary report

### Headlines

#### •Complaints

Case management performance continues to be strong Q1 continued the progress made in Q4 in improving the quality and efficiency of our complaints management processes. 85% of complaints were closed within 35 working days, representing 6 months of sustained high performance.

#### •PALS

Smoking on site a recurrent concern. Over the last four months, the PALS team have received a regular influx of concerns and complaints relating to smoking on site (and around the main entrance in particular). Complainants have identified a mixture of staff and patients smoking outside in this area, including some complaints that reference smoke entering the building through doors and windows (affecting staff in offices).

#### •Feedback

New FFT guidance is due to be published in September The existing question will be removed and replaced with a more general and accessible question: 'Overall, how was your experience of our service?'. It is likely that implementation of the new question will be for April 2020.

#### •Volunteer summary

Net change in numbers of volunteers is -42. Continued issues with the retention of volunteers have resulted in a decrease in overall numbers of active volunteers. A new project looking at opportunities for younger volunteers should help to increase participation of the under-25s.

#### •Patient information

Review rate is under 50% across the trust. There is still a large amount of patient information material that has not been reviewed in over three years. It is important that all information is reviewed within established timescales to ensure up-to-date information is provided for patients.

#### •Accessibility update

Production of access guides has begun AccessAble have been onsite throughout July surveying the hospital site in order to produce accessibility guides for our services. These will be due in November.

## Quarter 1 Patient experience summary report

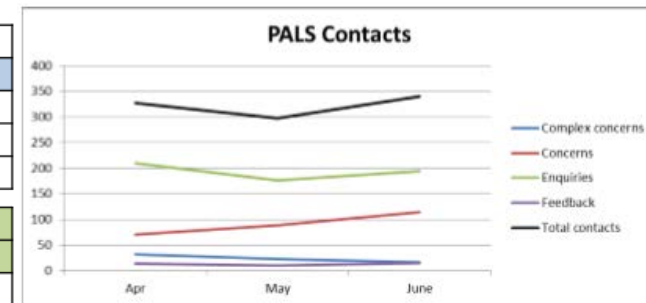
### Complaints

	Indicator
Activity	Complaints received
	Reopened complaints
	Care home complaints
Performance	Average working day response
	% closed within target
	# complaints breaching 35 days

Performance					
Target	Q2	Q3	Q4	Q1	
n/a	120	107	103	130	
n/a	17	20	22	17	
n/a	10	13	21	6	
<35 days	32	38	30	27	
> 80%	59%	42%	83%	85%	
n/a	-	-	34	25	

Q1 breakdown		
Apr	May	Jun
38	48	44
3	8	6
2	1	3
28	25	27
88%	80%	85%
8	7	10

### PALS



### FFT

	Indicator
Friends & Family Test	Inpatient positive score
	Outpatient positive score
	Maternity positive score
	ED positive score
	Total responses
	Total negative responses

Performance					
Target	Q2	Q3	Q4	Q1	
= > 95%	97%	98%	96%	97%	
= > 95%	96%	96%	95%	96%	
= > 95%	97%	91%	92%	90%	
= > 95%	96%	85%	70%	70%	
= > 6000	6340	7872	7454	6629	
< = 300	54	97	128	133	

Q1 breakdown		
Apr	May	Jun
98%	98%	95%
97%	97%	96%
87%	91%	95%
82%	55%	67%
2121	2357	2151
48	45	40

### Volunteers



### Accessible information & communication

	Q2	Q3	Q4	Q1
Patients flagged with needs in period	n/a	n/a	12	84
Total patients with flags on system	n/a	n/a	12	96
Incidents / complaints re. accessible information & communication	-	-	-	
Trust-wide paid-for interpreting expenditure				
Volunteer interpreter appointments	-	-	-	298

## Nursing and midwifery staffing hours - August 2019

### Report notes

Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialling)

Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.

If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)

This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the speciality, interventions, acuity and dependency levels of the patients being cared for.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Over the summer months some ward beds have temporarily changed speciality to support seasonal changes in demand - these bed changes are often swift in nature and for short periods of time so are not always reflected accurately in the data. For July there have been additional beds supported for Cardiovascular patients on E7 which are not reflected in the numbers.

WARD		Registered nurses Total hours	Registered nurses Total hours	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	Total bed occupancy	Registered nurses CHPPD	Unregistered Staff CHPPD	CHP PD Over all	Comments
C4 (Solent ward)	Day	1425.7	1256.3	996.2	1454.7	88.1%	146.0%	632	3.2	3.2	6.4	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
C4 (Solent ward)	Night	1069.3	920.3	713.0	1345.5	86.1%	188.7%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
C6	Day	2807.8	2641.4	156.5	124.0	94.1%	79.3%	614	7.2	0.3	7.5	Safe staffing levels maintained.
C6	Night	2024.8	2036.4	0.0	123.0	100.6%	Shift N/A					Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	699.1	692.1	358.7	94.7	99.0%	26.4%	174	7.4	0.9	8.3	Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Night	672.3	639.3	0.0	44.5	95.1%	Shift N/A					Safe staffing levels maintained.
D2	Day	1338.0	1513.3	1351.0	989.5	113.1%	73.2%	568	4.1	3.2	7.4	Safe staffing levels maintained.
D2	Night	713.0	954.5	1035.0	885.5	133.9%	85.6%					Safe staffing levels maintained.
D3	Day	1633.1	1682.7	786.1	990.1	103.0%	125.9%	633	3.9	2.5	6.4	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D3	Night	1046.3	1066.7	697.5	900.0	102.0%	129.0%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.

Surgical high dependency unit	Day	2174.7	1830.7	395.9	316.2	84.2%	79.9%	259	16.7	3.4	20.1	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2139.0	1759.8	368.0	367.5	82.3%	99.9%					Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	5348.3	4432.4	1211.8	790.8	82.9%	65.3%	427	24.3	3.1	27.4	Safe staffing levels maintained.
Cardiac intensive care unit	Night	5250.6	4045.0	893.0	632.5	77.0%	70.8%					Safe staffing levels maintained.
General intensive care unit A	Day	4596.1	4215.7	1149.4	757.3	91.7%	65.9%	341	24.7	3.4	28.0	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Night	4279.0	3995.6	712.8	492.8	93.4%	69.1%					Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Day	4114.9	3548.5	378.2	364.2	86.2%	96.3%	255	26.1	2.4	28.5	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Night	3928.1	3380.1	356.5	299.0	86.0%	83.9%					Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Day	5188.9	4901.1	912.6	681.3	94.5%	74.6%	307	27.3	2.9	30.3	Safe staffing levels maintained.
Neuro intensive care unit	Night	4533.5	4199.5	714.0	483.0	92.6%	67.6%					Safe staffing levels maintained.
E5A	Day	1229.2	1170.0	715.7	780.7	95.2%	109.1%	503	3.4	2.6	6.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5A	Night	714.0	682.5	356.5	467.0	95.6%	131.0%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Day	1319.4	1142.6	838.5	858.7	86.6%	102.4%	508	3.7	2.4	6.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Night	701.5	713.0	356.5	549.5	101.6%	154.1%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Day	2183.0	1705.7	1788.2	1647.1	78.1%	92.1%	850	3.0	3.5	6.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Night	1065.2	1058.7	1194.5	1123.0	99.4%	94.0%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Day	1944.1	1371.7	794.3	866.9	70.6%	109.1%	506	3.8	3.2	6.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Night	713.0	701.5	713.0	724.7	98.4%	101.6%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Day	2237.4	1871.8	651.2	1417.9	83.7%	217.7%	800	3.2	3.0	6.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
F6	Night	1063.5	1025.3	710.5	867.5	96.4%	122.1%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
F5	Day	1943.2	1498.2	969.5	1275.7	77.1%	131.6%	700	3.3	2.7	6.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Night	1069.5	950.2	713.0	780.0	88.8%	109.4%					Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute medical unit	Day	4273.4	4654.9	3961.1	4310.2	108.9%	108.8%	1388	5.6	5.0	10.6	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
Acute medical unit	Night	3551.0	3520.5	2003.5	2760.7	99.1%	137.8%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Patient requiring 24 hour 1:1 nursing in the month.
D5	Day	1290.1	1370.6	1685.5	1622.0	106.2%	96.2%	817	2.7	3.5	6.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D5	Night	1069.5	820.5	946.5	1182.0	76.7%	124.9%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Day	1108.5	1092.0	1514.7	1460.8	98.5%	96.4%	689	2.6	3.2	5.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Night	713.0	703.5	946.0	908.5	98.7%	96.0%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.

D7	Day	721.2	817.3	1160.5	1008.5	113.3%	86.9%	472	3.0	3.0	6.0	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
D7	Night	714.0	714.0	356.3	379.3	100.0%	106.5%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D8	Day	1085.0	1145.0	1506.0	1469.3	105.5%	97.6%	703	2.7	3.1	5.9	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D8	Night	714.0	852.8	935.5	846.0	119.4%	90.4%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D9	Day	1229.7	1374.6	1647.5	1606.5	111.8%	97.5%	806	2.8	3.3	6.1	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D9	Night	1069.5	770.5	945.5	1196.0	72.0%	126.5%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Respiratory high dependency unit	Day	1524.5	1184.5	355.5	403.8	77.7%	113.6%	204	11.8	5.9	17.7	Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients; Safe staffing levels maintained.
Respiratory high dependency unit	Night	1403.8	1143.5	356.5	351.5	81.5%	98.6%					Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients; Safe staffing levels maintained.
C5	Day	1072.5	926.5	774.0	838.4	86.4%	108.3%	410	4.1	2.8	7.0	Safe staffing levels maintained; Support workers used to maintain staffing numbers.
C5	Night	701.5	735.8	356.5	563.0	104.9%	157.9%					Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D10	Day	1144.5	943.5	1344.8	1258.3	82.4%	93.6%	520	3.0	3.8	6.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D10	Night	713.0	690.0	713.0	736.0	96.8%	103.2%					Safe staffing levels maintained.
F7	Day	703.9	749.6	1316.0	1325.5	106.5%	100.7%	600	2.4	3.2	5.6	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Staffing appropriate for number of patients.
F7	Night	713.0	724.5	713.0	711.0	101.6%	99.7%					Safe staffing levels maintained.
G5	Day	1079.5	1081.3	1791.7	1721.0	100.2%	96.1%	826	2.1	3.4	5.5	Support workers used to maintain staffing numbers; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G5	Night	713.0	725.3	1069.5	1043.5	101.7%	97.6%					Support workers used to maintain staffing numbers; Safe staffing levels maintained.
G6	Day	1068.0	1127.0	1841.1	1855.0	105.5%	100.8%	783	2.3	3.5	5.8	Support workers used to maintain staffing numbers; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G6	Night	701.5	759.0	1069.5	1070.0	108.2%	100.0%					Support workers used to maintain staffing numbers; Safe staffing levels maintained.
G7	Day	728.4	726.5	1462.7	1472.4	99.7%	100.7%	172	3.4	6.1	9.5	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Staffing plan set higher than national standards.
G7	Night	713.0	713.0	1069.5	1084.0	100.0%	101.4%					Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month; Staffing plan set higher than national standards.
G8	Day	1070.2	1164.1	1795.0	1681.1	108.8%	93.7%	830	2.1	3.3	5.4	Support workers used to maintain staffing numbers; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G8	Night	712.5	700.0	1069.5	1067.0	98.2%	99.8%					Support workers used to maintain staffing numbers; Safe staffing levels maintained.
G9	Day	1081.5	1176.1	1833.5	1697.2	108.7%	92.6%	773	2.4	3.6	5.9	Support workers used to maintain staffing numbers; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G9	Night	713.0	690.0	1058.0	1046.5	96.8%	98.9%					Support workers used to maintain staffing numbers; Safe staffing levels maintained.
Paediatric high dependency unit	Day	1599.9	1121.7	0.0	0.0	70.1%	Shift N/A	143	11.9	0.0	11.9	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1069.5	1035.0	0.0	0.0	96.8%	Shift N/A					Safe staffing levels maintained.

Paediatric medical unit	Day	1857.5	1567.7	471.5	727.5	84.4%	154.3%	420	5.4	2.8	8.3	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe Staffing levels maintained.
Paediatric medical unit	Night	1408.0	1211.0	638.0	917.0	86.0%	143.7%					Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
Paediatric assessment unit	Day	1278.9	1050.9	570.0	346.5	82.2%	60.8%	130	6.7	1.5	8.2	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Minimal requirement for band 2 being currently being reviewed. .
Paediatric assessment unit	Night	1072.5	952.0	239.0	188.5	88.8%	78.9%					Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained; Minimal requirement for band 2 being currently being reviewed. .
Paediatric intensive care unit	Day	6219.5	5098.2	687.0	446.7	82.0%	65.0%	329	23.0	2.1	25.1	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe Staffing levels maintained.
Paediatric intensive care unit	Night	5693.5	5031.9	506.0	448.5	88.4%	88.6%					Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
Piam Brown ward	Day	2999.2	3245.8	116.0	118.5	108.2%	102.2%	303	15.0	0.5	15.5	Safe staffing levels maintained; Bed Numbers 12 pateints .
Piam Brown ward	Night	1069.5	1295.5	0.0	0.0	121.1%	Shift N/A					Safe staffing levels maintained; Bed Numbers 12 pateints .
E1	Day	2129.5	1597.5	664.3	431.8	75.0%	65.0%	403	5.7	1.8	7.5	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe Staffing levels maintained.
E1	Night	1437.5	1258.5	392.0	414.5	87.5%	105.7%					Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G2	Day	774.0	747.0	0.0	0.0	96.5%	Shift N/A	141	7.7	0.0	7.7	Safe staffing levels maintained.
G2	Night	747.3	705.8	0.0	0.0	94.4%	Shift N/A					Safe staffing levels maintained.
G3	Day	2427.0	1783.0	1226.8	829.3	73.5%	67.6%	400	4.6	2.1	6.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Bed summer flexing down 4 beds.
G3	Night	1694.0	1455.0	682.0	530.5	85.9%	77.8%					Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained; Bed summer flexing down 4 beds.
G4	Day	2499.3	1852.5	1343.5	939.7	74.1%	69.9%	427	4.7	2.1	6.8	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Bed summer flexing down 6 beds. Safe staffing maintained..
G4	Night	1705.0	1221.5	682.0	539.0	71.6%	79.0%					Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients; Beds flexed to match staffing; Bed summer flexing down 6 beds. Safe staffing maintained..
Bramshaw women's unit	Day	1501.5	1042.0	1232.0	1012.0	69.4%	82.1%	746	6.1	4.4	10.5	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients; Beds flexed down..
Bramshaw women's unit	Night	713.0	702.0	713.0	448.5	98.5%	62.9%					Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients; Beds flexed down..
Neonatal unit	Day	7005.8	4630.7	1660.5	1353.5	66.1%	81.5%	752	9.2	2.6	11.8	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers.
Neonatal unit	Night	5407.5	3743.5	1364.0	936.0	69.2%	68.6%					Beds flexed to match staffing; Beds flexed to match staffing.
Maternity service	Day	8255.7	7409.7	3603.0	2407.2	89.8%	66.8%	2220	5.6	1.7	7.4	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource
Maternity service	Night	5319.3	4858.5	2371.0	1680.0	91.3%	70.9%					Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource
Cardiac high dependency unit	Day	5031.8	4104.7	1435.4	1245.6	81.6%	86.8%	592	13.3	3.7	16.9	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; moving staff from CVT for additional capacity 20 beds E7.
Cardiac high dependency unit	Night	3797.0	3523.3	692.5	891.3	92.8%	128.7%					Staff moved to support other wards; Additional staff used for enhanced care - Support workers; moving staff from CVT for additional capacity 20 beds E7.
Coronary care unit	Day	1550.9	1660.0	817.8	882.5	107.0%	107.9%	476	6.1	3.6	9.8	Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.
Coronary care unit	Night	1309.5	1382.3	473.0	874.8	105.6%	184.9%					Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers.

D4	Day	1841.3	1400.5	874.8	1234.9	76.1%	141.2%	642	3.2	3.6	6.8	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
D4	Night	796.3	770.3	681.8	980.5	96.7%	143.8%					Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
E2	Day	1656.2	1520.7	798.8	1385.8	91.8%	173.5%	508	4.3	3.6	7.9	Staff moved to support other wards; Additional staff used for enhanced care - Support workers; moving staff from CVT for additional capacity for E7 20 beds.
E2	Night	715.0	869.5	336.3	742.0	121.6%	220.7%					Safe staffing levels maintained; Staff moved to support other wards.
E3 Green	Day	2090.7	1294.4	801.5	1625.0	61.9%	202.7%	883	2.9	3.6	6.4	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; awaiting finalisation of roster template.
E3 Green	Night	678.3	647.3	726.0	942.5	95.4%	129.8%					Safe staffing levels maintained; Safe staffing levels maintained; awaiting finalisation of roster template.
E3 Blue	Day	1668.2	955.5	781.7	1094.9	57.3%	140.1%	378	3.3	3.0	6.3	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; awaiting finalisation of roster template.
E3 Blue	Night	682.0	594.0	682.0	803.3	87.1%	117.8%					Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; awaiting finalisation of roster template.
E4	Day	2063.2	1657.6	759.0	1243.8	80.3%	163.9%	595	5.0	3.9	8.9	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; awaiting finalisation of roster template.
E4	Night	935.0	1353.0	520.0	937.5	144.7%	180.3%					Staffing appropriate for number of patients; Additional staff used for enhanced care - Support workers; awaiting finalisation of roster template.
Acute stroke unit	Day	1526.4	1453.0	2685.0	2751.5	95.2%	102.5%	158	6.7	5.6	12.3	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute stroke unit	Night	1023.0	869.0	1714.0	1729.0	84.9%	100.9%					Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Day	1218.9	941.0	402.2	565.2	77.2%	140.5%	715	3.5	3.4	6.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Regional transfer unit	Night	682.0	572.0	594.0	693.0	83.9%	116.7%					Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Day	2019.0	1524.5	1071.0	1531.8	75.5%	143.0%	246	7.2	5.5	12.7	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
E Neuro	Night	1386.0	1142.5	1034.0	1464.0	82.4%	141.6%					Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Day	1596.4	1148.0	382.5	670.9	71.9%	175.4%	756	3.9	5.0	8.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Night	1364.0	862.0	341.0	740.0	63.2%	217.0%					Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
D neuro	Day	1910.0	1662.5	1906.0	1995.8	87.0%	104.7%	607	3.7	3.5	7.2	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Night	1359.5	1188.0	1749.0	1832.5	87.4%	104.8%					Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
SPI F4 Neuro	Day	1619.6	1406.8	678.0	1291.4	86.9%	190.5%	493	3.3	2.4	5.7	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
SPI F4 Neuro	Night	1023.0	946.5	1023.0	1306.3	92.5%	127.7%					Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Brooke ward (trauma and orthopaedic)	Day	1133.5	1008.0	572.1	643.1	88.9%	112.4%	178	3.1	5.3	8.4	Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
Brooke ward (trauma and orthopaedic)	Night	1058.0	713.0	356.5	690.0	67.4%	193.5%					Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Day	539.3	388.5	388.3	530.6	72.0%	136.6%	938	3.9	4.3	8.3	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
Trauma Assessment Unit	Night	341.0	319.0	341.0	352.0	93.5%	103.2%					Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.

F1	Day	2459.6	1847.3	1517.2	2101.8	75.1%	138.5%	769	2.8	5.3	8.2	Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.
F1	Night	1782.5	1467.8	1063.7	1658.7	82.3%	155.9%					Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F2	Day	1640.3	1370.7	1891.7	2173.8	83.6%	114.9%	709	3.1	5.3	8.3	Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F2	Night	1023.5	858.5	1362.0	1821.5	83.9%	133.7%					Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F3	Day	1620.0	1323.7	1627.3	1875.8	81.7%	115.3%	515	3.5	3.3	6.8	Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F3	Night	1023.0	814.3	1443.0	1664.8	79.6%	115.4%					Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F4	Day	1476.0	1218.8	1190.5	912.5	82.6%	76.6%	513	3.8	3.0	6.8	Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F4	Night	1023.3	720.3	682.5	650.0	70.4%	95.2%					Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month.

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: Finance Report 2019-20 Month 5</b>			
<b>Category</b>	Quality, Performance, and Finance		
<b>Agenda item</b>	4.5		
<b>Sponsor</b>	Chief Financial Officer		
<b>Author</b>	Gavin Hawkins, Assistant Director of Finance		
<b>Provenance</b>	This monthly paper provides an update on our financial position This paper is discussed at TEC, S&FC and Trust Board on a monthly basis.		
<b>Classification</b>	<b>This Report is unclassified.</b>		
<b>Purpose and recommendation</b>	The paper is presented for DISCUSSION. The purpose of this paper is to give an update on the financial position of the Trust through the year.		
<b>Relevant strategic goals</b>	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6</li> <li>• BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme</li> <li>• BAF04 – Reduced access to resources compromises the quality of services</li> </ul>		
<b>Impact assessments</b>			
<b>Other standards affected</b>			

**2019/20 Finance Report - Month 5**

<b>Report to:</b>	<b>Board of Directors &amp; Strategy &amp; Finance</b>
	<b>September 2019</b>
<b>Title:</b>	<b>Finance Report for Period ending 31/08/2019</b>
<b>Author:</b>	<b>Gavin Hawkins, Assistant Director of Finance</b>
<b>Sponsoring Director:</b>	<b>David French, Chief Financial Officer</b>
<b>Purpose:</b>	<b>Standing Item</b>
	<b>The Board is asked to note the report</b>

**Executive Summary:**

**In Month and Year to date Highlights:**

1. In August 2019, the Trust delivered a surplus of £0.2m, £0.6m better than Plan. Year to date the Trust is reporting a £0.1m surplus which is £2.5m better than Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '1'.
2. When non-recurrent items are excluded the year to date position is a £2.5m deficit. Non-recurrent items include a reclaim of VAT from 18/19 paid on agency nursing invoices.
3. The main themes seen in M5 were:
  - Income was £1.9m better than Plan due to productivity savings above Plan in the month (£0.9m), expected backdated DH funding for medical staff pay award and improved income in pathology, training & education and EFCD.
  - Pay was £0.8m worse than Plan in month, with £1.5m related to backdated costs linked to medical staff pay award, offset in part by prior year nursing agency VAT reclaim (£1.1m).
  - Total CIP delivery was on Plan at £3.1m for the month, which remains £1.4m behind plan year to date.
4. The cash position was £12m above Plan at £64.0m. We are expecting this to increase further in September when a £16m NHS England invoice is settled. The above Plan position has primarily been driven by:
  - Year-end income position £2.5m was above forecast at the time the cash plan was agreed
  - Additional PSF re 18/19 over and above that assumed at the point the Plan was finalised
  - Settlement of high value invoices in-month from Health Education England
5. Looking forward to the end of 2019/20, the Trust is facing risks relating to:
  - CIP delivery, including unidentified CIP
  - Underlying run-rate of expenditure exceeding income
  - Clinical income shortfall due to consultant workforce capacity relating to pensions taxation
  - These risks are assessed on slide 4 as an expected £15m pressure on our Plan, resulting in a £2m surplus rather than a £17m surplus. This position would result in non-achievement of our Control Total surplus and associated PSF which would restrict cash availability to support our 3-year capital programme. This position will be reviewed post Q2 reporting.



Finance: I&E Summary

Total clinical income was £0.1m better Plan, although the Plan was increased to reflect income CIP delivery in the month to include backdated award (£0.9m of the £2.1m other income favourable variance relates to income CIP performance). In total £5m of productivity schemes have been recognised to M5.

In month non elective activity was estimated to be £1m above Plan, net of full blended payment reduction. Elective activity was estimated to be £0.5m below Plan reflected across a number of specialities, including Gynae due to PAH theatres refurbishment.

Substantive and bank pay combined was £2.3m above Plan (£1.5m backdated med staff pay award), offset by below Plan agency spend of £1.5m which includes a £1.1m backdated adjustment for VAT related to 18/19. Excluding these non-rec adjustments the pay bill was £0.4m above Plan.

Of the £0.8m overspent in other non-pay £0.4m is offset in other income related to R&D activity and the balance is undelivered non-pay CIP.

Overall CIP delivery was on Plan with £3.1m delivered. See slide 12 for further detail.

Metric	2019/20		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	1.54	<b>3</b>	<b>3</b>
Liquidity rating	18.45	<b>1</b>	<b>1</b>
I&E Margin Rating	1.04%	<b>1</b>	<b>2</b>
I&E Margin Variance Rating	0.68%	<b>1</b>	<b>1</b>
Agency Variance from ceiling	62.82%	<b>1</b>	<b>1</b>
<b>Use of Resources Average Metric</b>		1.40	1.60
<b>Use of Resources Final Metric</b>		<b>1</b>	<b>2</b>

	Current Month			Year to Date			Full Yr	Ave Done £m	To Do £m	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m			
NHS Income: Clinical	52.1	52.2	(0.1)	261.1	261.0	0.0	A	630.6	52.2	52.8
Pass-through Drugs & Devices	9.2	8.9	0.3	46.1	46.5	(0.4)	G	115.2	9.3	9.8
Other income Other Income excl. PSF	8.6	10.8	(2.1)	44.4	49.9	(5.5)	G	105.0	10.0	7.9
<b>Total income</b>	<b>69.9</b>	<b>71.8</b>	<b>(1.9)</b>	<b>351.5</b>	<b>357.4</b>	<b>(5.9)</b>	<b>G</b>	<b>850.8</b>	<b>71.5</b>	<b>70.5</b>
Costs Pay-Substantive	38.7	40.7	2.0	193.6	197.3	3.7	A	461.0	39.2	37.7
Pay-Bank	1.9	2.3	0.3	9.6	11.0	1.4	R	22.8	2.2	1.7
Pay-Agency	1.1	-0.4	(1.5)	5.6	2.2	(3.5)	G	14.1	0.4	1.7
Drugs	1.1	1.5	0.3	6.1	6.7	0.6	R	14.2	1.3	1.1
Pass-through Drugs & Devices	9.2	8.9	(0.3)	46.1	46.5	0.4	A	115.2	9.3	9.8
Clinical supplies	6.4	6.4	0.0	29.9	30.7	0.7	A	65.5	6.1	5.0
Other non pay	8.9	9.7	0.8	48.1	48.1	(0.0)	G	105.1	9.6	8.1
<b>Total expenditure</b>	<b>67.3</b>	<b>69.0</b>	<b>1.7</b>	<b>339.0</b>	<b>342.4</b>	<b>3.3</b>	<b>A</b>	<b>797.9</b>	<b>68.3</b>	<b>65.1</b>
<b>EBITDA</b>	<b>2.6</b>	<b>2.8</b>	<b>(0.2)</b>	<b>12.5</b>	<b>15.0</b>	<b>(2.5)</b>	<b>G</b>	<b>52.9</b>	<b>3.0</b>	<b>5.4</b>
<b>EBITDA %</b>	<b>3.7%</b>	<b>3.9%</b>	<b>(0.1%)</b>	<b>3.6%</b>	<b>4.2%</b>	<b>(0.7%)</b>		<b>6.2%</b>		
Depreciation	1.9	1.7	(0.2)	9.3	9.9	0.6	R	22.6	2.0	1.8
Non Operating Income/Expenditure	1.1	0.9	(0.2)	5.5	5.0	(0.5)	G	13.3	1.0	1.2
<b>Control Total Surplus / (Deficit)</b>	<b>(0.4)</b>	<b>0.2</b>	<b>(0.6)</b>	<b>(2.3)</b>	<b>0.1</b>	<b>(2.5)</b>	<b>G</b>	<b>17.1</b>	<b>0.0</b>	<b>2.4</b>
<b>Memo - Other technical items:</b>										
Prior Period Adjustment - PSF 2018/19		-	0.0		0.9	(0.9)	G			
Provider Sustainability Funding	0.8	0.8	0.0	3.6	3.6	0.0	G	12.7	0.7	1.3

Underlying Run Rate Position

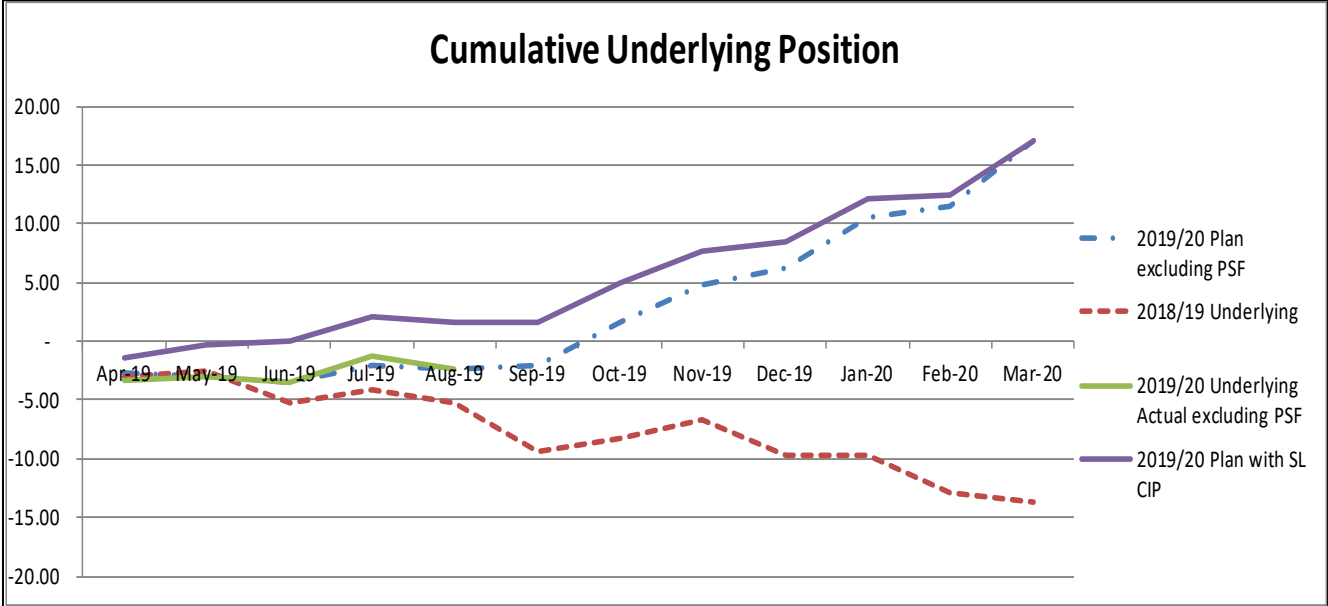
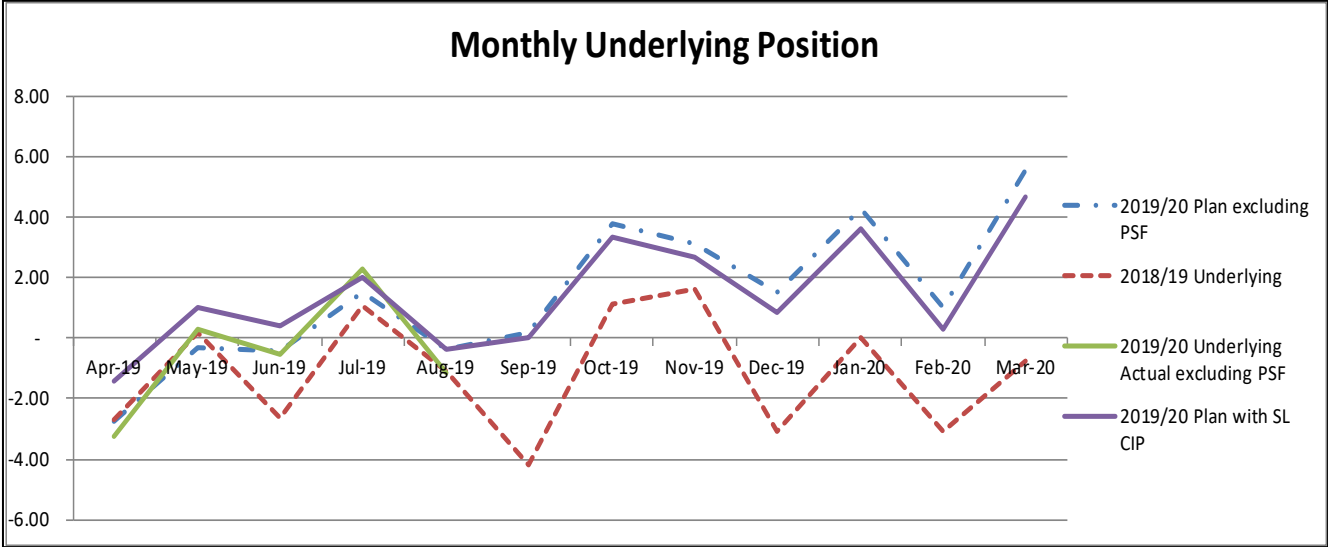
These graphs show the actual underlying position against the NHS Plan of £0.8m worse in month (£1.5m relating to back-dated pay award). This makes the underlying position an on-Plan deficit of £2.4m.

It also shows an alternative presentation of the Plan phasing assuming that the £40m CIP target is delivered equally each month through the year. In August 2019 the CIP Plan vs a Straight-line CIP Plan were the same at £3.1m.

The finance team have agreed a contract payment phasing that is later than assumed in the Plan, which gives a £0.3m benefit per month for the first 6 months. This benefit unwinds from month 7 onwards so is a timing difference only.

The Trust has also benefitted from a £1.1m rebate on nursing agency VAT from 2018/19.

All figures in these graphs exclude PSF including the amount received as a prior year adjustment.



Underlying Run Rate Position

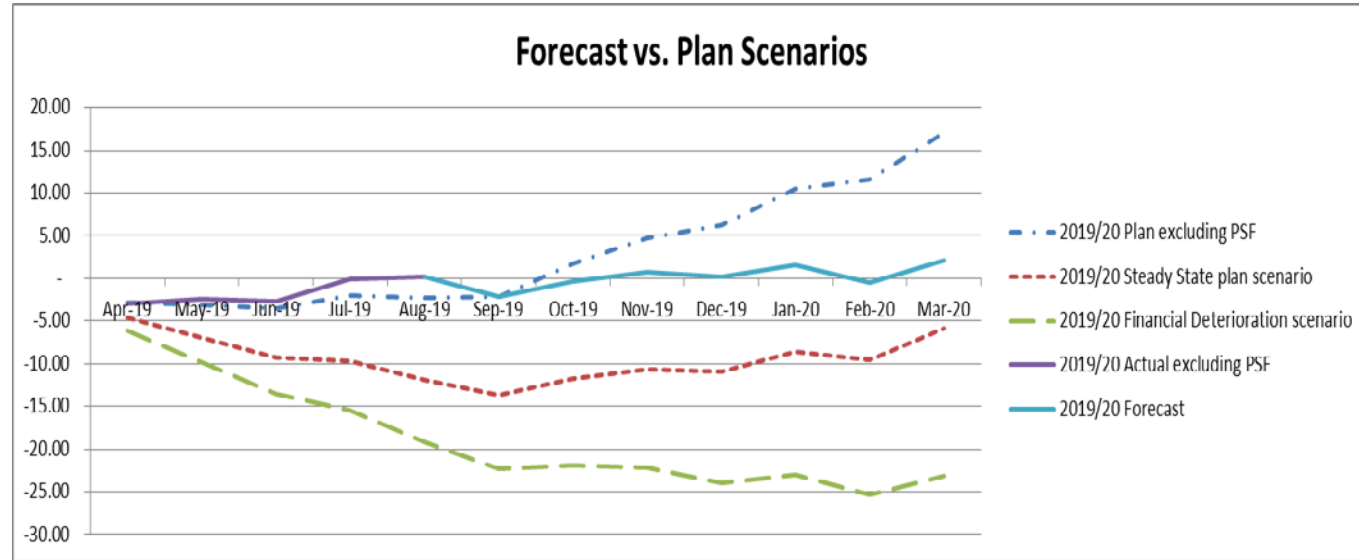
This graph shows potential forecast scenarios for 2019/20 surplus out-turn, as shared with Trust Board as part of the 2019/20 planning process.

Currently the forecast is based on estimates post Q1 and is therefore highly uncertain at this early stage of 2019/20. This forecast will be updated post Q2 performance.

This table outlines the risk and mitigating actions assumed in various scenarios.

Unless financial performance improves, the run-rate suggests a forecasted £15m financial shortfall compared to Plan, mainly driven by CIP identification and delivery.

It is early in the year to draw conclusions on the expected year-end position, which will depend on the success of the financial improvement programme and whether risks materialise or are mitigated. The forecast will be updated following finalisation of Q2 results (September).



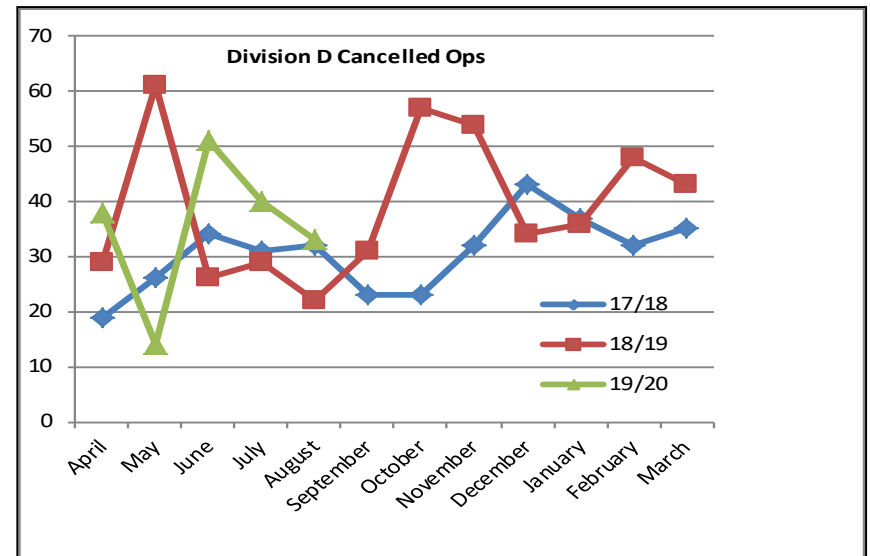
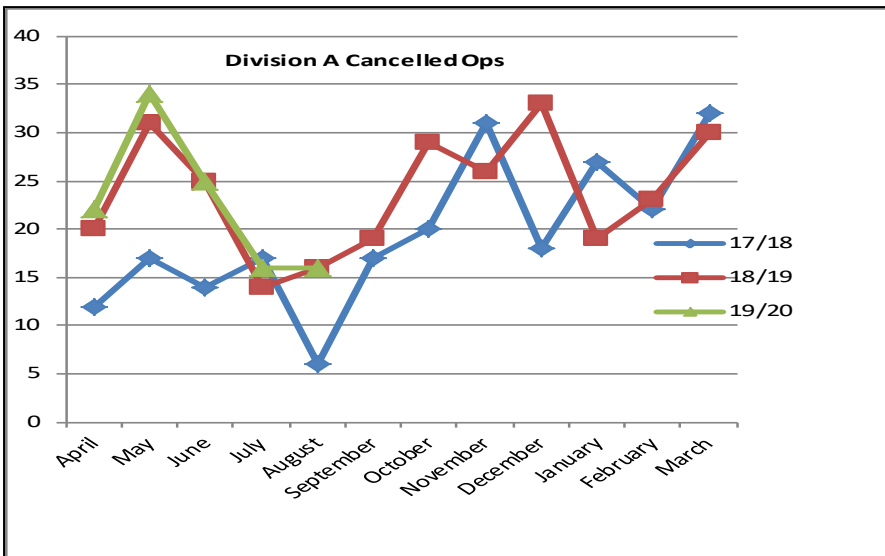
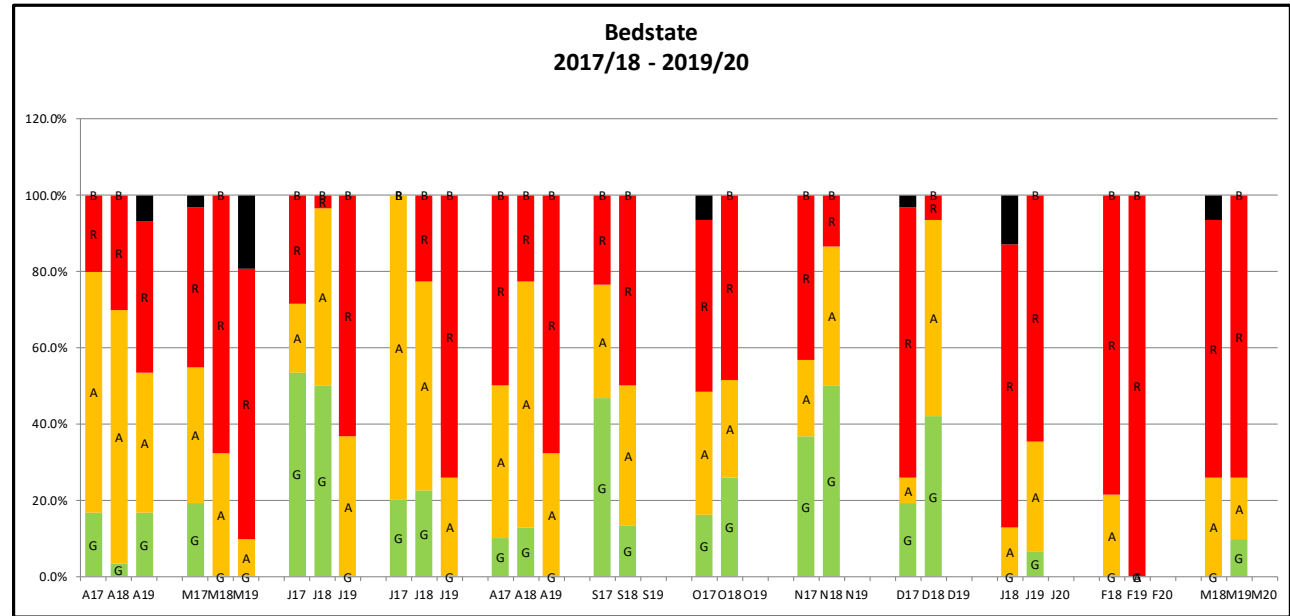
	Plan scenarios			Forecast
	Plan	Steady State	Financial Deterioration	
<b>Financial Surplus (excl. PSF) - Plan</b>	<b>17.1</b>	<b>17.1</b>	<b>17.1</b>	<b>17.1</b>
<b>Risks:</b>				
CIP Delivery / Underlying 18/19 run rate	(10.0)	(19.0)	(26.3)	(19.0)
Underlying Run-Rate deterioration	-	-	(10.0)	
QIPP / Pensions / Other	-	(5.0)	(5.0)	(5.0)
<b>Total Risks:</b>	<b>(10.0)</b>	<b>(24.0)</b>	<b>(41.3)</b>	<b>(24.0)</b>
<b>Mitigations:</b>				
CIP delivery / Financial Improvement	10.0	-	-	7.0
Additional controls / business rules	-	-	-	2.0
<b>Total Mitigations:</b>	<b>10.0</b>	<b>-</b>	<b>-</b>	<b>9.0</b>
<b>Total Net Risk</b>	<b>0.0</b>	<b>(24.0)</b>	<b>(41.3)</b>	<b>(15.0)</b>
<b>Total I&amp;E Position</b>	<b>17.1</b>	<b>(6.9)</b>	<b>(24.2)</b>	<b>2.1</b>

Bedstate – 3yr Comparison

Bed state information for August 2019 highlights over 65% of the time the Trust bed state was red, with no period of green alert which does not compare well with previous years.

Medicine beds (8) remain closed on Bramshaw and ward E7 (18-20) has been handed over to CV&T to manage as an interim measure to offset current demand.

On the day cancellations for non-clinically reasons shown below for Divisions A & D comparing 2017/18, 2018/19 & 2019/20. Whilst not shown below Division B cancellations grew from 3 to 18 in August all related to Ophthalmology.



(Fav Variance) / Adv Variance

Clinical Income

The chart shows estimated clinical income in August 2019.

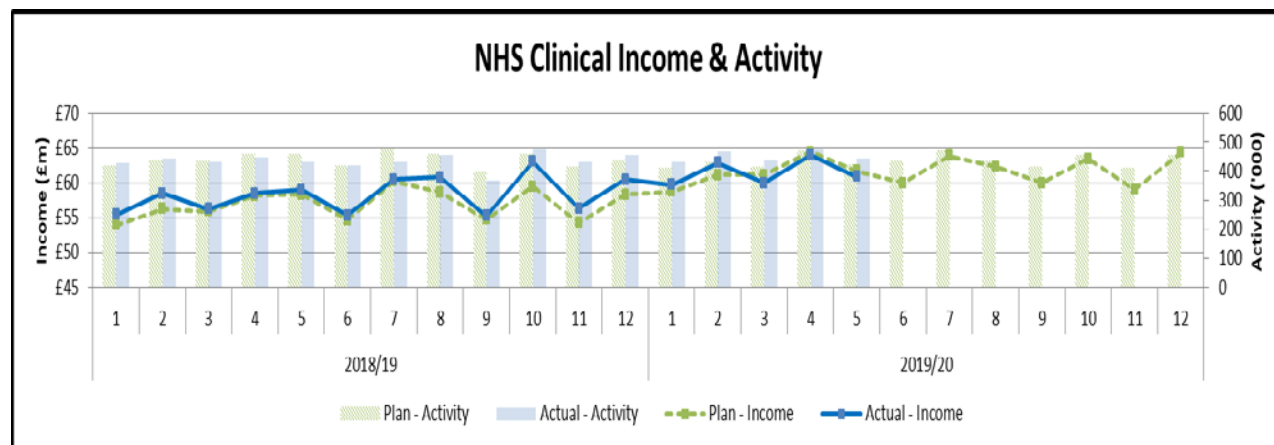
Non-elective inpatient activity was again above planned levels and a provision has been taken against the impact of the blended payment system for emergency care. Elective inpatient income was below planned levels in the month, some of which can be explained by PAH theatre refurbishment works.

Outpatient activity was above planned levels in the month.

Pass-through drug and device income, within exclusions, was lower than planned levels although this is offset by reduced expenditure.

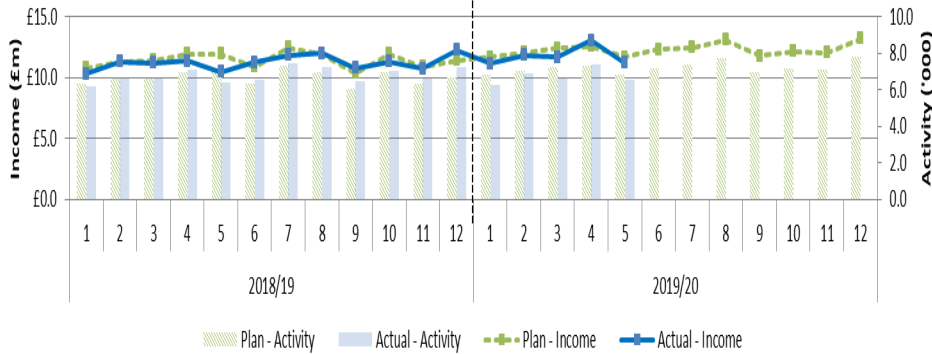
The Trust continues to provide for commissioner challenges and CQUIN failure which will be resolved as data and reports become available.

POD GROUP	2018/19	2019/20				2019/20			Monthly Run Rate	
	YTD Actuals £000s	Annual Plan £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	Done	To Do
<b>NHS Clinical Income</b>										
Elective Inpatients	£54,603	£147,512	£60,402	£58,887	£1,516	£11,682	£11,173	£509	£11,777	£12,661
Non-Elective Inpatients	£77,956	£199,871	£82,329	£89,999	(£7,670)	£17,011	£18,399	(£1,388)	£18,000	£15,696
Blended payment adjustment	£0	£0	£0	(£1,813)	£1,813	£0	(£373)	£373	(£363)	£259
Outpatients	£30,081	£81,651	£32,782	£34,474	(£1,692)	£5,920	£6,130	(£211)	£6,895	£6,740
Other Activity	£47,749	£128,643	£53,120	£53,373	(£252)	£10,638	£10,737	(£99)	£10,675	£10,753
CQUIN	£6,073	£8,375	£3,437	£3,546	(£110)	£679	£696	(£16)	£709	£690
Blocks & Financial Adjustments	£3,437	£12,120	£8,307	£1,314	£6,994	£2,059	£1,280	£779	£263	£1,544
Other Exclusions	£1,671	£46,419	£20,674	£21,253	(£579)	£4,119	£3,995	£124	£4,251	£3,595
Prior month adjustment	£0	£0	£0	£0	£0	£0	£145	(£145)	£0	£0
<b>Subtotal NHS Clinical Income</b>	<b>£221,571</b>	<b>£624,590</b>	<b>£261,052</b>	<b>£261,033</b>	<b>£19</b>	<b>£52,109</b>	<b>£52,184</b>	<b>(£75)</b>	<b>£52,207</b>	<b>£51,937</b>
Pass-through Exclusions	£47,203	£115,237	£46,053	£46,461	(£408)	£9,226	£8,880	£346	£9,292	£9,825
<b>Total NHS Clinical Income</b>	<b>£268,774</b>	<b>£739,827</b>	<b>£307,105</b>	<b>£307,494</b>	<b>(£389)</b>	<b>£61,335</b>	<b>£61,064</b>	<b>£271</b>	<b>£61,499</b>	<b>£61,762</b>
<b>Non NHS Clinical Income</b>										
Private Patients		£6,082	£2,761	£1,800	£961	£499	£407	£92	£360	£612
CRU		£2,500	£1,040	£1,048	(£8)	£208	£208	(£0)	£210	£207
Overseas Chargeable Patients		£1,412	£590	£711	(£121)	£118	£59	£59	£142	£100
<b>Total Non NHS Clinical Income</b>		<b>£9,994</b>	<b>£4,391</b>	<b>£3,559</b>	<b>£832</b>	<b>£825</b>	<b>£675</b>	<b>£150</b>	<b>£712</b>	<b>£919</b>
<b>Grand Total</b>	<b>£268,774</b>	<b>£749,821</b>	<b>£311,496</b>	<b>£311,053</b>	<b>£443</b>	<b>£62,160</b>	<b>£61,739</b>	<b>£421</b>	<b>£62,211</b>	<b>£62,681</b>

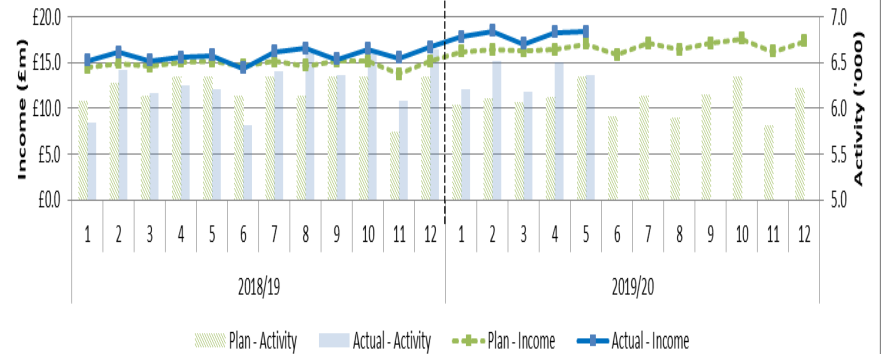


Clinical Income

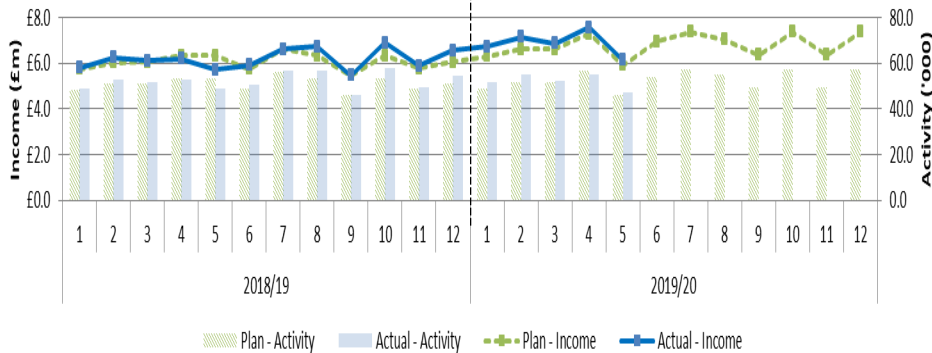
Elective spells



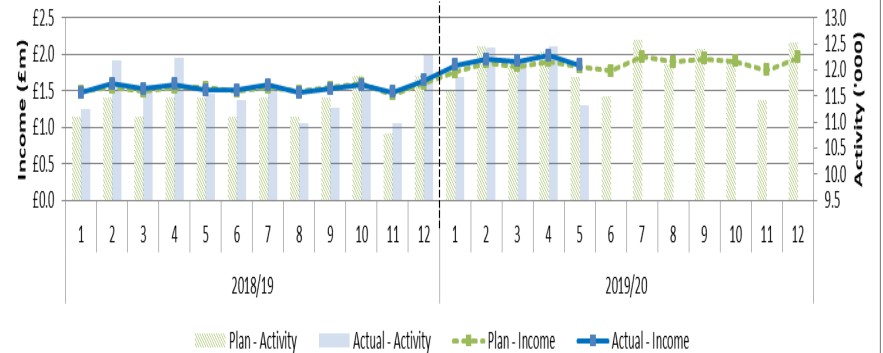
Non elective spells



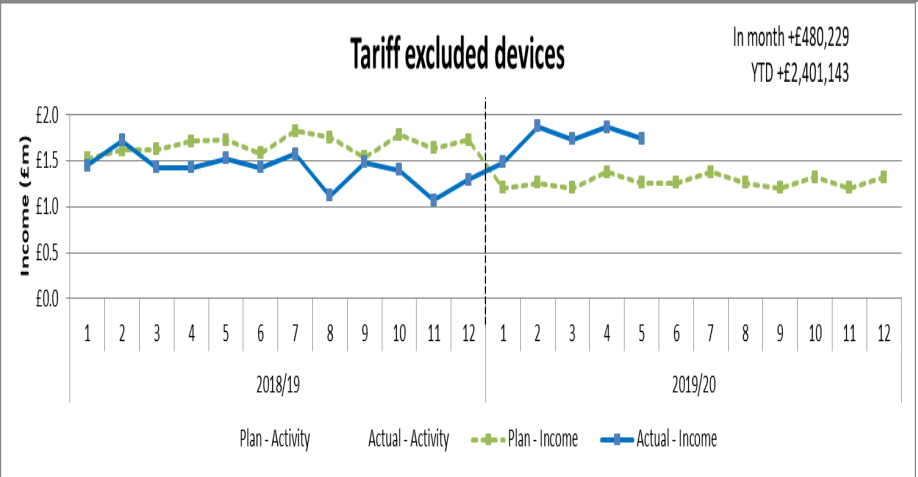
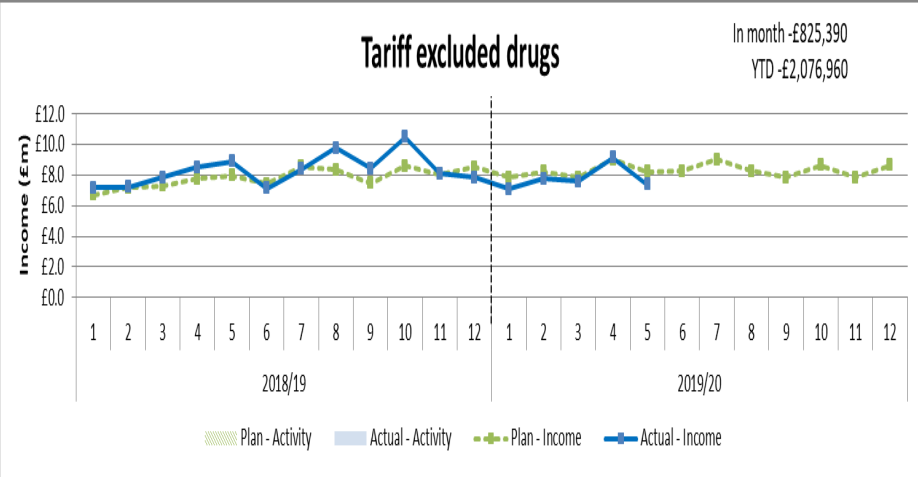
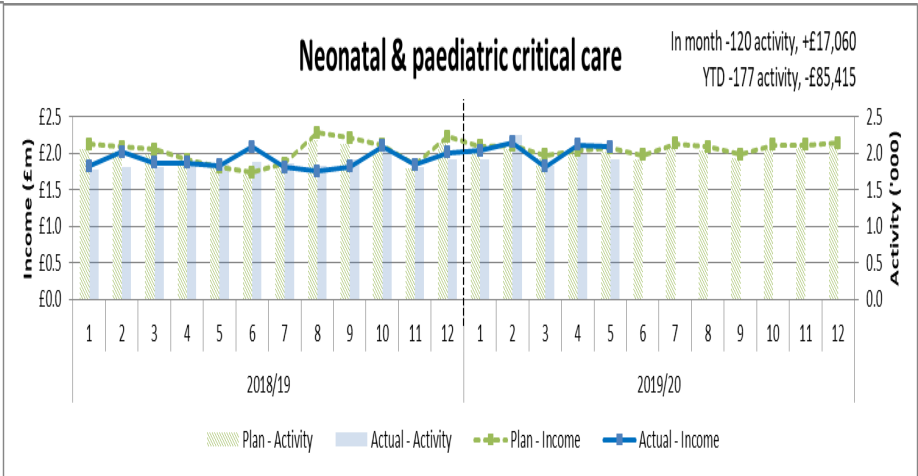
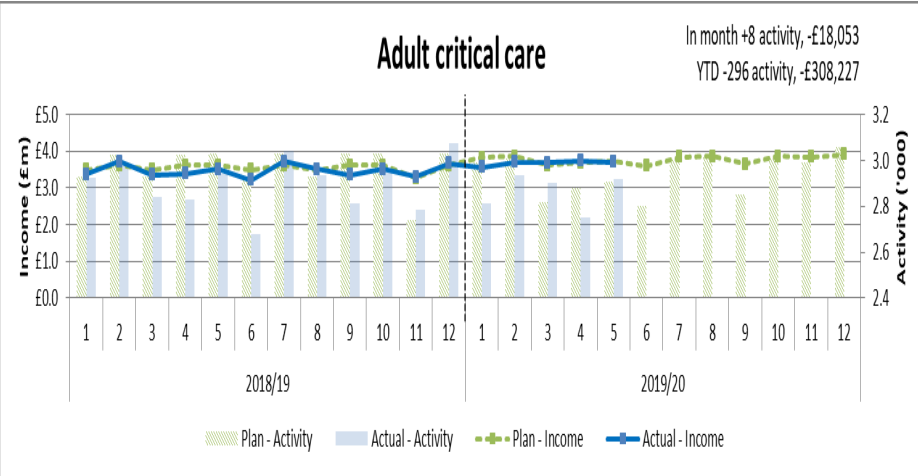
Outpatients



A&E



Clinical Income



WTEs

WTE notes:

1) 'Contracted' is substantive staff in post.

2) 'Worked' is the WTE equivalent of what staff have actually worked in the month, including flexible additional hours.

3) 'Paid' is worked WTE but including the WTE equivalent of enhanced rates e.g. weekend working.

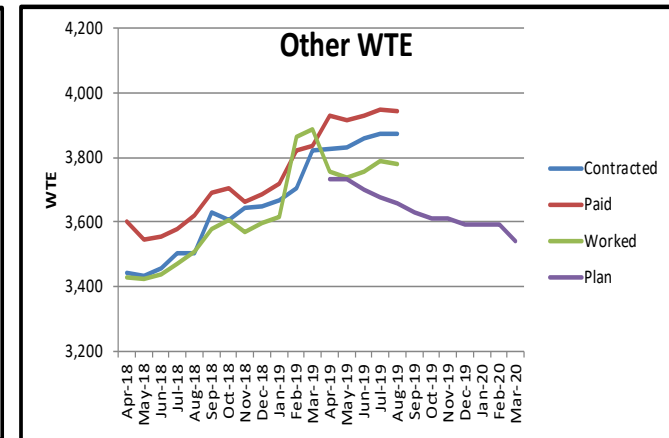
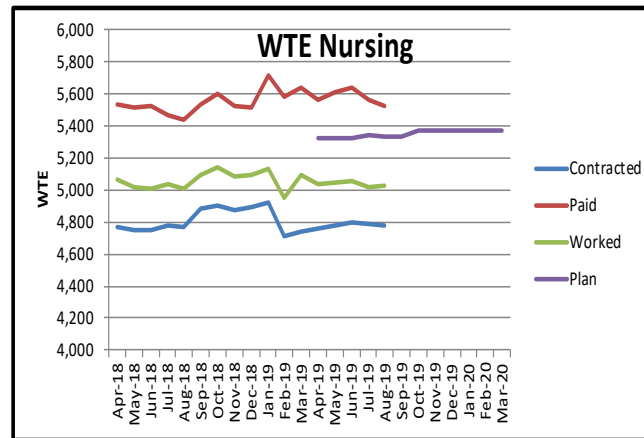
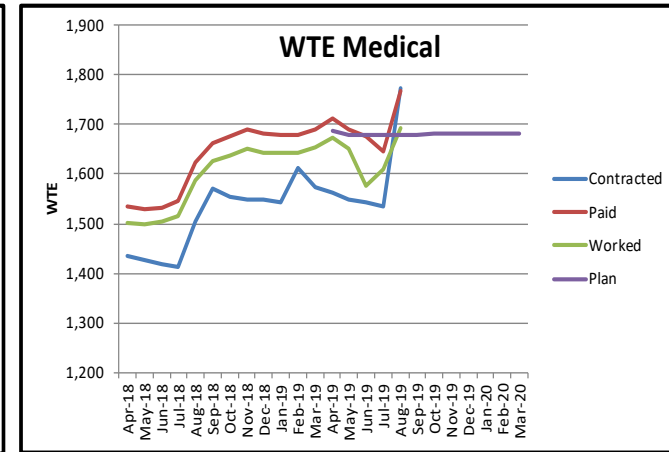
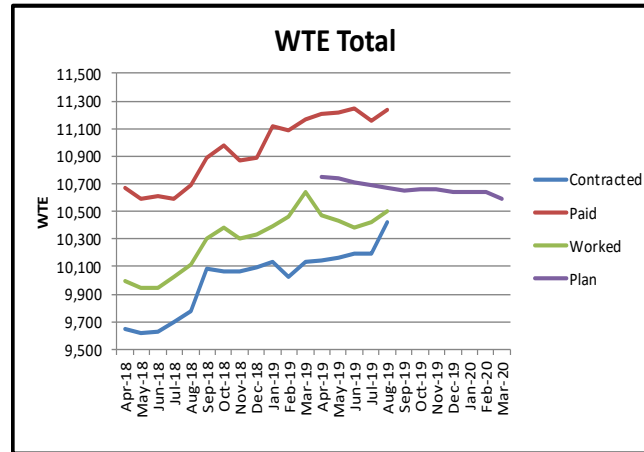
4) 'Plan' = funded WTE.

5) 'Other WTE' Plan includes pay CIP yet to be allocated to a specific staffing group, or remains unidentified/undelivered.

Overall paid WTE increased from July to August 2019 by 82wtes.

Contracted rose by 210wtes (increase was 23wtes June to July) and worked increased by 86wtes.

Increase in contracted wte is exclusively related to medical staff which is currently under review, with a concern that rotation has led to double-counted contracted figures.



Substantive Pay Costs

Total pay expenditure in August 2019 was £42.6m.

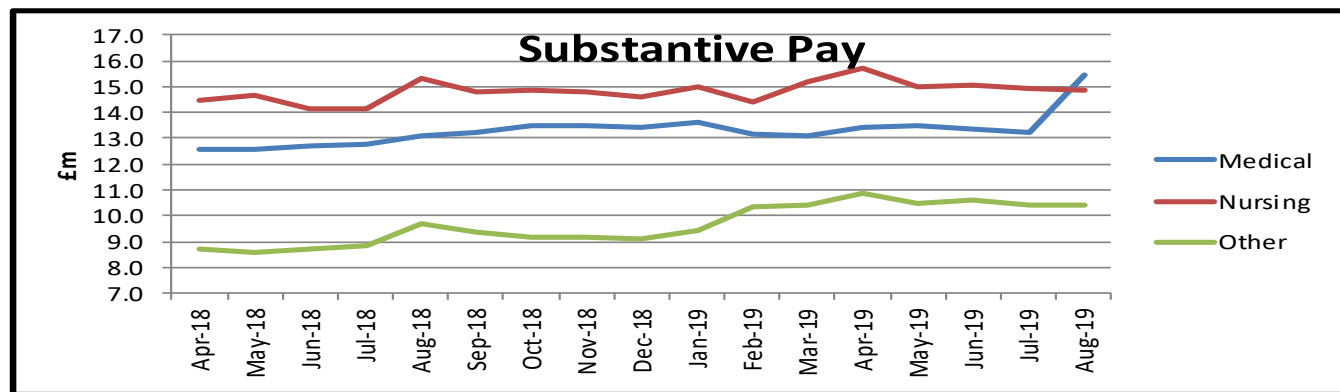
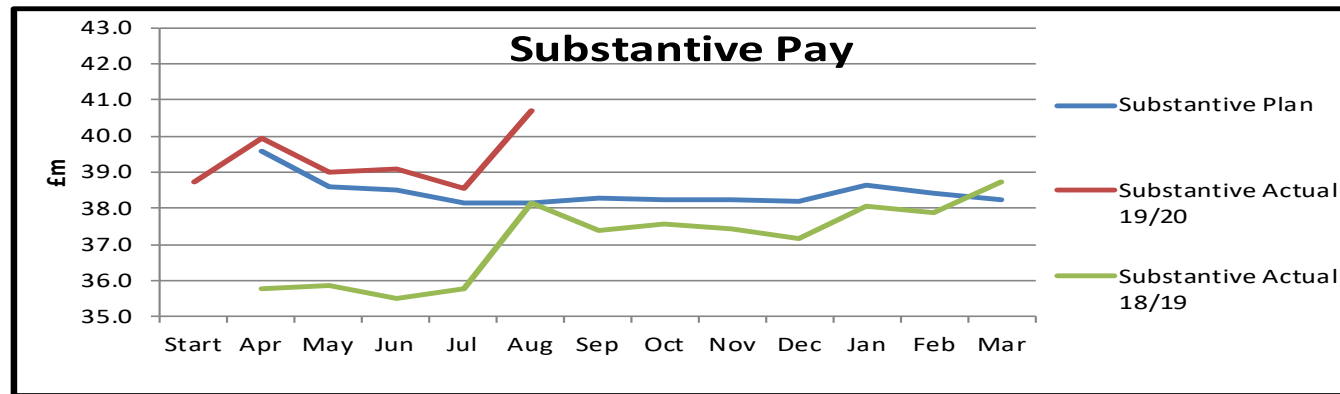
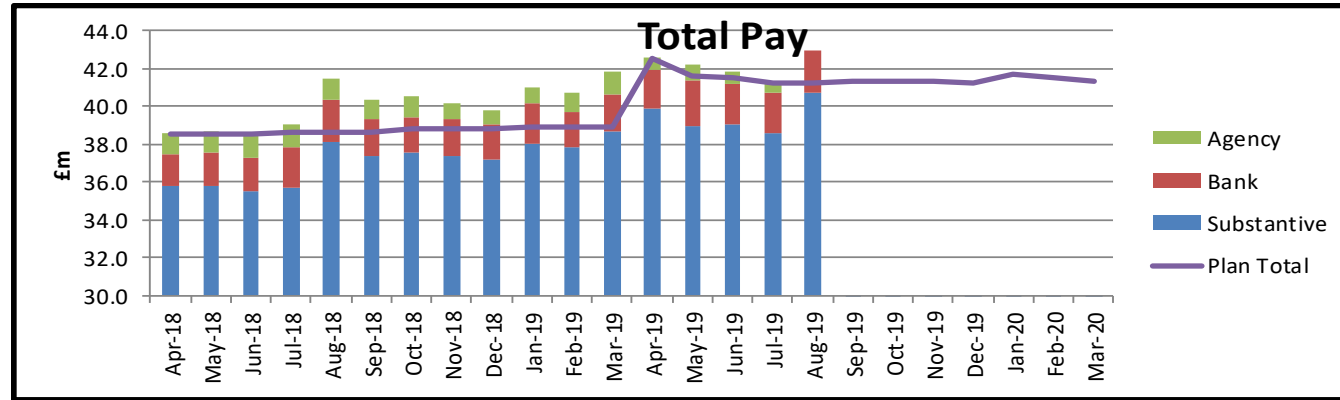
This includes a number of backdated/one-off items, namely:

- +£1.2m medical staff pay award (expected to be paid in September 2019)
- +£0.2m estimated impact of local CEA process (expected to be paid in January 2020)
- -£1.1m VAT rebate on nursing agency

Once normalised the comparison between July to August 2019 was an increase of £0.1m.

In terms of position vs Plan in the month once normalised for the above pay was £0.5m adverse. This is largely due to unidentified/undelivered pay CIP against the pay CIP target agreed at the start of the financial year.

Recruitment Control Panel (RCP) is still meeting weekly to validate new & replacement posts.



Temporary Staff Costs

Overall agency spend in July 2019 was £0.7m, and remains consistent with recent months (July included £0.2m back-dated credit).

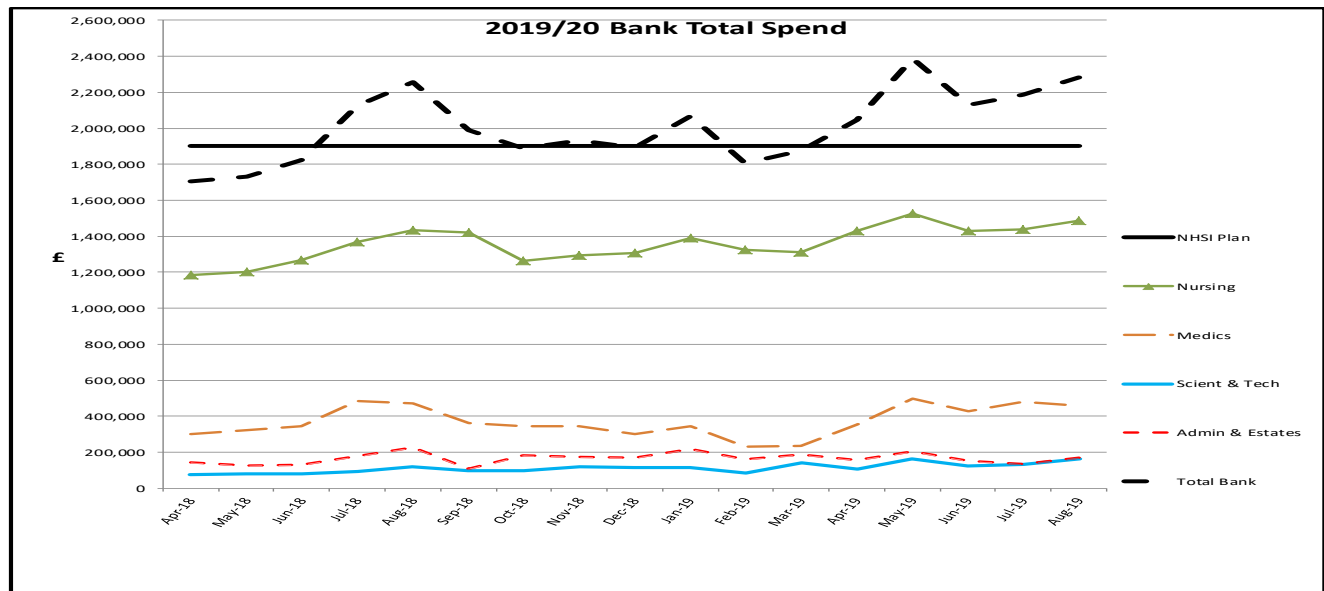
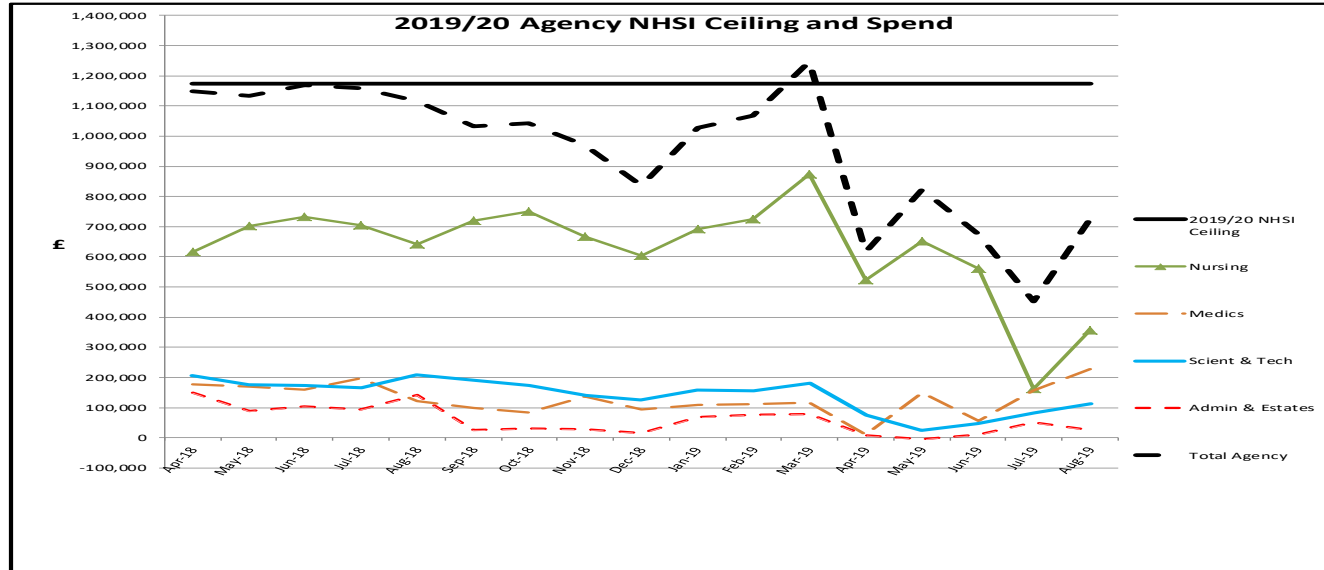
The back-dated credit of £1.1m relating to agency nursing VAT from 18/19 has been excluded from these graphs.

Expenditure on Thornbury increased by £17k in August at £47k. However, this is £104k lower than August 2018.

Expenditure on bank staff was £2.3m in August 2019.

In overall terms, expenditure on flexible staffing was £0.1m lower than Plan in August.

In an initiative to manage temporary staffing more tightly, Savings Board has agreed a proposal to manage headcount headroom to no more than 23%. This project was sponsored by the Director of Nursing.



Cost Improvement Programme

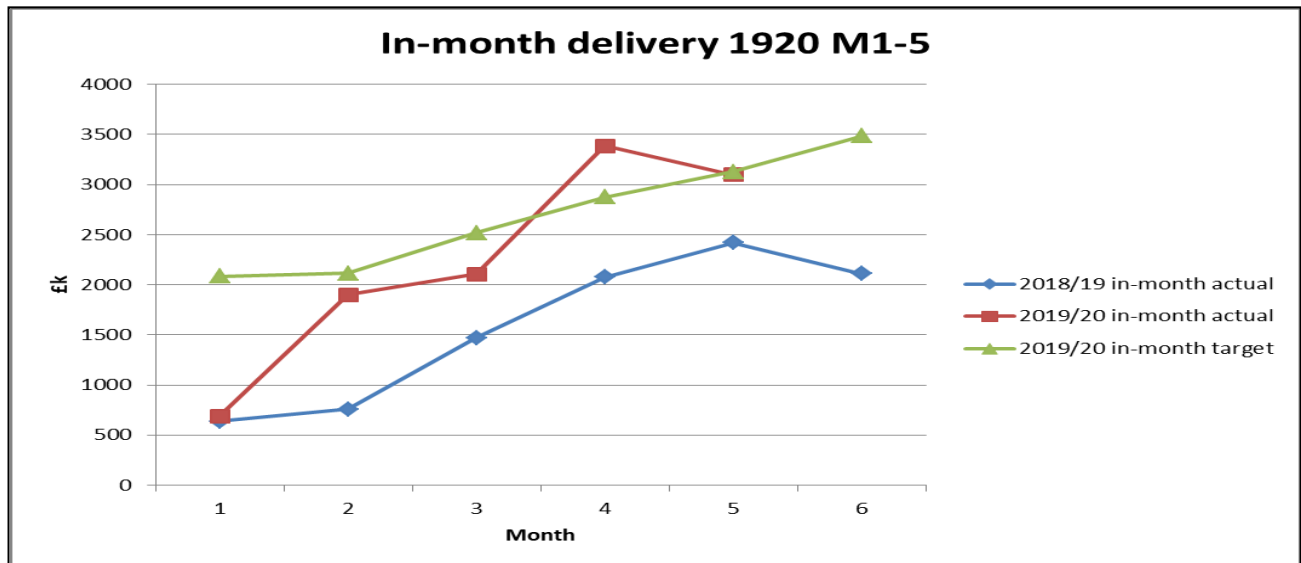
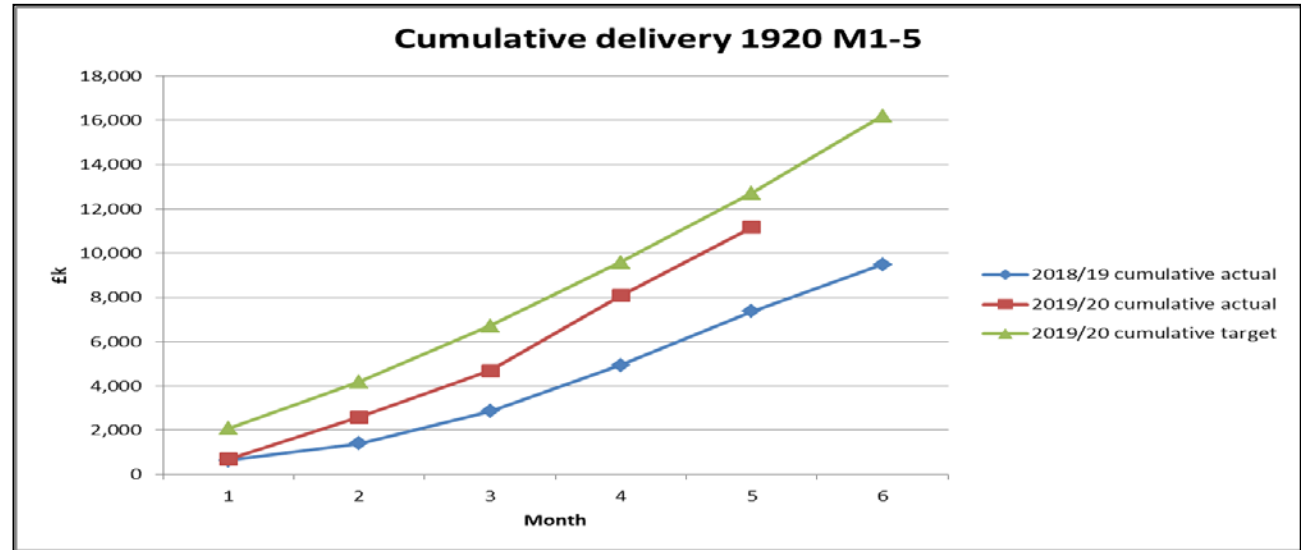
CIP delivery in August 2019 was on Plan at £3.1m.

Income CIP scheme award continues to be high due to strong income performance. The income CIP award in M5 will include some backdated element.

Year to date the Trust is £1.4m behind Plan for 2019/20 although delivery is tracking higher than that previously delivered.

Fortnightly CIP run rate meetings will still focus on the income & expenditure position of each Division vs Plan and also CIP performance at Care Group level.

Going forward Care Groups' have been asked to highlight risks and any mitigations to discuss at the CIP meetings with Execs to firm up the delivery for 2019/20.



## Cost Improvement Programme

The Trust has identified CIP of £39.7m, 99% of the target leaving a shortfall of £0.3m.

Identification increased by £0.7m from July 2019.

Of the total identified, £29.8m/75% is planned to be recurrent, thus highlighting a non-recurrent value of £9.9m/25%. The full year effect of the programme has grown by £1.5m to £7m from July 2019, taking the total recurrent savings impact of the 2019/20 schemes to £36.8m.

Focus in the next 4 weeks is on:

- Ensuring delivery of identified schemes to avoid any slippage
- Reviewing non-recurrent schemes for opportunities to make recurrent
- Discussing risks and mitigations of any identified schemes.

This table outlines the main themes of identified CIP to date. Length of stay schemes will either result in expenditure reductions through closing beds or increases in income from utilising spare beds.

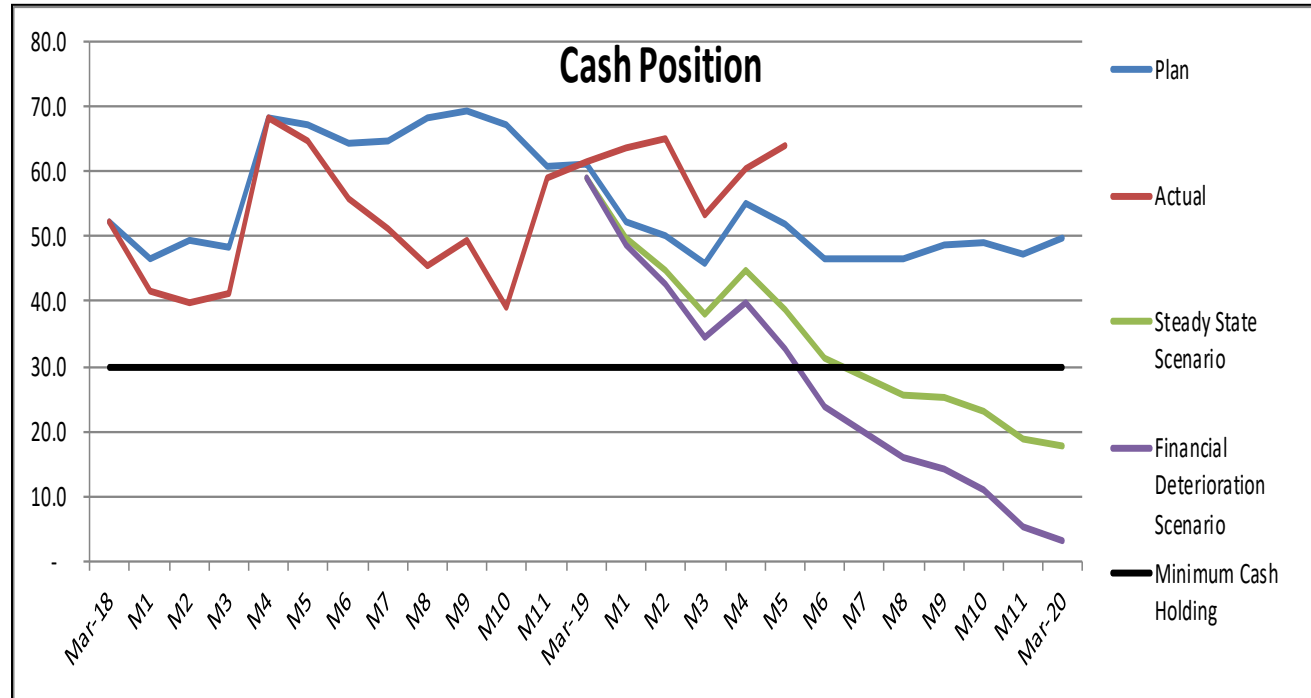
Division	CIP Target	Identified CIP	Gap £k	Identification %
Division A	8,998	8,634	364	96%
Division B	7,954	8,458	(504)	106%
Division C	6,569	6,570	(1)	100%
Division D	8,428	8,845	(417)	105%
<b>Total Clinical Services</b>	<b>31,949</b>	<b>32,507</b>	<b>(558)</b>	<b>102%</b>
Chief Finance Officer	377	609	(232)	162%
Estates Facilities & Capital Development	1,892	1,916	(24)	101%
Transformation	163	187	(24)	115%
Chief Operating Officer	379	388	(9)	102%
Human Resources	312	312	0	100%
Informatics	453	200	253	44%
Clinical Governance	173	110	63	64%
Training, Development & Workforce	248	211	37	85%
Chief Executive	54	25	29	46%
<b>Trust HQ Total</b>	<b>4,051</b>	<b>3,958</b>	<b>93</b>	<b>98%</b>
Central Schemes	4,000	3,198	802	80%
<b>U.H.S. Trust Total</b>	<b>40,000</b>	<b>39,663</b>	<b>337</b>	<b>99%</b>

	Workforce	Length of stay	NHS income	Commercial income	Non Pay	Total
UHS total	6,496	6,048	14,511	4,858	7,750	39,663
Profile of identification	16%	15%	37%	12%	20%	100%
<b>Recurrent £</b>	2,088	6,048	14,073	1,247	6,275	29,731
Recurrent % of total theme value	32%	100%	97%	26%	81%	75%
<b>Non Recurrent £</b>	4,408	0	438	3,611	1,475	9,932
Non Recurrent % of total theme value	68%	0%	3%	74%	19%	25%

Cash

The cash balance was £12.2m above Plan in M5. This is primarily due to:

- 1) Settlement of high value invoices in Education & Training and Research & Development.
- 2) Payables balances remaining higher than anticipated due to delays in invoice payment, although these delays are now reducing.
- 3) Year-end position finishing £2.5m above the forecast from which the cash Plan was derived.
- 4) Receipt of PSF bonuses for 18/19 £9.5m in excess of what was assumed in the Plan.
- 5) Capital expenditure below Plan by the end of M5, offset by slippage in ability to draw down funds on PDC-funded schemes.



## Capital Expenditure

(Fav Variance) / Adv Variance

Scheme	Month			Year to Date			Full Year			
	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Original Plan £000's	Revised Plan £000's	Latest Forecast £000's	Var (from revised) £000's
Childrens Hospital	150	69	(81)	533	396	(137)	1,893	1,196	1,196	0
ED Adult Resus	75	25	(50)	75	25	(50)	1,509	1,501	1,501	0
IT Schemes	450	177	(273)	2,967	2,807	(160)	7,450	7,220	7,220	0
Wave 3 STP Digital	0	6	6	26	34	8	4,422	26	26	0
Strategic Maintenance	280	331	51	1,504	1,569	65	4,000	4,000	4,000	0
Medical Equipment Panel	1	43	42	340	361	21	2,100	2,100	2,100	0
GICU Expansion	780	805	25	3,200	2,142	(1,058)	13,614	12,122	12,122	0
Refurbish Eye Theatre	0	0	0	0	0	0	1,177	60	60	0
Energy Efficiency	0	115	115	0	115	115	2,223	1,473	1,667	194
New Theatres E level	368	190	(178)	2,083	1,829	(254)	3,637	3,236	3,236	0
Urology Day Unit	500	359	(141)	1,609	1,353	(256)	2,173	2,177	2,177	0
Steam Project	0	1	1	103	109	6	2,126	103	103	0
Princess Anne Theatre Ventilation	0	173	173	261	508	247	580	355	355	0
Spend to Save	0	(83)	(83)	105	25	(80)	1,104	847	847	0
Radiotherapy Equipment	150	218	68	449	436	(13)	658	834	834	0
Divisional / Donated Equipment	150	144	(6)	212	217	5	1,350	1,350	1,350	0
Decorative Improvements / Staff Fund	30	0	(30)	56	22	(34)	625	741	741	0
Other Projects	623	568	(55)	2,189	2,112	(77)	6,006	4,472	4,902	430
<b>Total Excluding Finance Leases</b>	<b>3,557</b>	<b>3,141</b>	<b>(416)</b>	<b>15,712</b>	<b>14,060</b>	<b>(1,652)</b>	<b>56,647</b>	<b>43,813</b>	<b>44,437</b>	<b>624</b>
Finance Leases-IISS	0	270	270	1,737	1,584	(153)	5,815	4,880	6,436	1,556
Finance Leases-Other	0	0	0	3,173	3,001	(172)	2,000	3,433	3,433	0
<b>Total Capital Expenditure</b>	<b>3,557</b>	<b>3,411</b>	<b>(146)</b>	<b>20,622</b>	<b>18,645</b>	<b>(1,977)</b>	<b>64,462</b>	<b>52,126</b>	<b>54,306</b>	<b>2,180</b>
Donated Asset Additions	(223)	(263)	(40)	(1,315)	(1,315)	0	(3,043)	(2,796)	(2,796)	0
<b>Total Net CDEL Expenditure</b>	<b>3,334</b>	<b>3,148</b>	<b>(186)</b>	<b>19,307</b>	<b>17,330</b>	<b>(1,977)</b>	<b>61,419</b>	<b>49,330</b>	<b>51,510</b>	<b>2,180</b>

Following a review of the capital programmes a revised forecast of £49.3m has been submitted to NHS Improvement. This is a reduction of £12m on the original Plan, of which £7m relates to delays in the receipt of national funding. This has been used to set a "Revised Plan".

Since this revised submission, NHS Improvement has received more government funding, meaning Trust's are permitted to spend to their original Plan, as long as central funding has been approved.

We are currently forecasting additional expenditure in the Energy Efficiency project as a result of national funding being approved and released. TIG has also approved to bring forward design works on the Vertical Extension, as well as additional costs for leases for replacement of equipment.

## Statement of Financial Position

(Fav Variance) / Adv Variance

Payables balances have stabilised since year-end. The back-log of outstanding payments continues to be addressed. The number of unpaid invoices continues to reduce but remains a critical issue to resolve for the accounts payable team.

Fixed assets is now closer to Plan as a result of a £2.6m impairment of software non-current assets following the revaluation of assets related to the purchase of EMIS software.

Receivables will improve significantly upon settlement of a £16.3m NHS England invoice re 2018/19 performance, which is anticipated on 15<sup>th</sup> September.

Statement of Financial Position	2018/19 Actuals £m	2019/20			
		YTD Plan £m	YTD Act £m	YTD Var £m	Full Year Plan £m
Fixed Assets	372.4	373.9	373.1	(0.8)	403.7
Inventories	16.5	16.2	15.1	(1.1)	16.2
Receivables	105.9	71.5	90.9	19.4	75.5
Cash	61.5	51.8	64.0	12.2	49.8
Payables	(110.5)	(87.1)	(102.8)	(15.7)	(82.7)
Current Loan	(3.3)	(4.6)	(3.4)	1.2	(4.6)
Current PFI and Leases	(7.0)	(4.4)	(7.5)	(3.1)	(4.4)
<b>Net Assets</b>	<b>435.6</b>	<b>417.3</b>	<b>429.5</b>	<b>12.2</b>	<b>453.5</b>
Non Current Liabilities	(18.2)	(18.3)	(18.1)	0.2	(18.3)
Non Current Loan	(14.6)	(11.9)	(13.2)	(1.4)	(12.0)
Non Current PFI and Leases	(33.0)	(34.0)	(31.3)	2.7	(34.6)
<b>Total Assets Employed</b>	<b>369.8</b>	<b>353.1</b>	<b>366.9</b>	<b>13.8</b>	<b>388.7</b>
Public Dividend Capital	211.0	217.8	211.0	(6.8)	223.7
Retained Earnings	125.0	109.8	122.1	12.3	139.5
Revaluation Reserve	33.8	25.5	33.8	8.4	25.5
Other Reserves	0.0	0.0	0.0	0.0	0.0
<b>Total Taxpayers' Equity</b>	<b>369.8</b>	<b>353.1</b>	<b>366.9</b>	<b>13.8</b>	<b>388.7</b>

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: UHS Digital Strategy</b>			
<b>Category</b>	Strategy and Business Planning		
<b>Agenda item</b>	5.1		
<b>Sponsor</b>	Director of Transformation and Improvement		
<b>Author</b>	Adrian Byrne		
<b>Provenance</b>	The Digital Strategy has been discussed at a number of prior sessions including Digital Board, Trust Board Study Session and Strategy and Finance Committee.		
<b>Classification</b>	<b>This Report is unclassified.</b>		
<b>Purpose and recommendation</b>	<p>The paper is presented for APPROVAL.</p> <p>The strategy has been assessed in terms of ambition and direction, and has been discussed with care group/divisional teams. Feedback has been incorporated along the way.</p> <p>The strategy is designed to incorporate corporate goals and clinical objectives within the emergent clinical strategy.</p> <p>Does the plan to address future investment meet with agreement?</p> <p>The digital strategy requires approval</p>		
<b>Relevant strategic goals</b>	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input checked="" type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways.</li> <li>• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6.</li> <li>• BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme.</li> <li>• BAF04 – Reduced access to resources compromises the quality of services.</li> <li>• BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services.</li> <li>• BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider.</li> </ul>		
<b>Impact assessments</b>	Future plans associated with the strategy will be impact assessed		
<b>Other standards affected</b>			

# UHS Digital Strategy

## 1. Introduction

The last digital strategy was developed in 2016. It was called Informatics 2020 with a plan to deliver the informatics platform to assist in realising the trust vision for the period 2016-2020. This strategy covered the strategic context, the electronic patient record, the Information strategy, improvement engagement with patients, communicating with primary care and the technology strategy. Since 2016 there has been a significant change in the digital landscape within the Trust partially influenced by the Global Digital Exemplar programme and nationally due to policy changes. This is largely due to a growing recognition of the importance of digital in sustaining, transforming and delivering healthcare.

The NHS long term plan, published in 2019, indicates a significant emphasis on digital first channels and NHSX has introduced its goals, described as “missions”, as:

- *Reducing the burden on clinicians and staff, so they can focus on patients;*
- *Giving people the tools to access information and services directly;*
- *Ensuring clinical information can be safely accessed, wherever it is needed;*
- *Improving patient safety across the NHS; and*
- *Improving NHS productivity with digital technology.*

The 2019 UHS Digital strategy has incorporated a blend of local and national drivers. Broadly speaking the recommendation is to continue to adopt integration as an architecture, with modules of functionality being delivered around an integration engine within an overall enterprise architecture. The latest thinking on open data, open platforms, and data integration techniques is viewed to be in line with the UHS longer term history of delivering systems in an incremental way.

The overall strategy incorporates supporting components:

- Technology strategy
- Clinical systems strategy
- Business intelligence strategy

An informatics workforce plan will be drawn up early in 2020 to support delivery

## 2. Analysis and Discussion

### 2.1 Initiation and development of early drafts.

The development of the digital strategy started in the summer of 2018. An initiation session was undertaken with the Digital Clinical Reference group chaired by the then CCIO Derek Waller. An external contractor was commissioned to undertake a series of stakeholder interviews and over 125 stakeholders across the Trust have been consulted through meetings and workshops to produce the initial drafts.

### 2.2 Digital Strategy Steering Group

A digital strategy steering group was established in July 2018 with around 12 stakeholders including representatives from clinicians, nurses, AHPs, clinical support services, research, back office services and two patients. The purpose of the Digital Strategy Steering Group was to provide advice and guidance to the team that wrote the strategy, ensuring that there was coverage across UHS. The group met four times. Their objectives included:

- to provide support and challenge which enables the UHS Digital Strategy which covers all of UHS's services and functions, meets the vision and is credible
- Provide suggestions regarding engagement stakeholder groups to ensure that the strategy meets UHS needs.
- Provide suggestions and feedback regarding the approach to presenting the strategy, ensuring that it has the best possible chance of engaging with stakeholders
- Recommend the final draft of the UHS Digital Strategy to the Digital Board

### 2.3 Presentation to the Digital Board

The first draft of the Digital Strategy was presented to the Digital Board in February 2019. A number of changes were suggested. A further version was presented in April 2019 and more changes were identified. Work was then delayed to await the development of the Clinical strategy which the Digital Strategy needed to support. A further draft was presented in June 2019.

### 2.4 Further review and stakeholder sign off

In June, July and August 2019, the Director of Transformation and the CIO engaged with the four Divisions across a number of sessions to discuss the Digital Strategy. A further version was distributed to the members of the Digital Board and a comment form was included to ask for sign off. A large number of comments were received from both these activities and incorporated into the document (see attached document which lists the comments)

### 2.5 Conclusion

The digital strategy has been developed to support the delivery of the UHS clinical strategy and the ambitions set out in the NHS Long Term Plan. There has been a significant amount of clinical input into the strategy with an iterative process for approval.

Overall the approach remains the same, with UHS continuing to adopt integration approach, with modules of functionality being delivered around an integration engine within an overall enterprise architecture.

Some elements of the strategy are funded in the current 3 year capital allocation. Other elements will require business cases to support further internal or external investment.

## 3. Recommendation

Trust Board is asked to approve this strategy.

## 4. Appendices

- One Appendix is included in the document which explains the history and current situation regarding the electronic patient record at the Trust.



# Digital Strategy

---

University Hospital Southampton  
NHS Foundation Trust  
2019-2024



## 1. Introduction

This section sets the scene for the requirements for the strategy. It also describes the vision, objectives, goals and principles for the digital strategy. These have been developed through stakeholder consultation and the digital strategy steering group.

### What is a digital strategy?

A digital strategy is a form of strategic management and a business answer or response to the Trust's clinical and business strategy. This digital strategy outlines the expansion or introduction of technologies to enable clinical and business activities. It seeks to capitalise on new and emerging technology which can help the Trust to become more efficient and effective, increase capacity, reduce risk and improve safety, and transform its clinical and business processes to enable the delivery of world class care.

### What does digital mean?

Digital is the term we are using for the use of technology within the Trust and with our health and social care partners. It covers IT like computers and servers, systems like our CHARTS Electronic Patient Record, and data that we input and information we can extract from systems (both internal and external). It covers existing systems and technology as well as innovation and emerging technology. The scope of digital is ever expanding as it extends into areas of our personal lives, the way we work and how care can be delivered. The boundaries between areas traditionally not part of IT such as medical devices and the use of science in healthcare are now blurring. Overall it's how we will use these elements collectively for the benefit of our staff, patients and wider stakeholders.

### Why do this?

This strategy has been produced to clearly articulate the plans for the implementation of digital at the Trust.

Digital will play a significant role in supporting the NHS in its future sustainability, improvement and development. But more fundamentally without digital, we cannot meet our current challenges in our workforce, the increasing demand for our services and integration of our services with the wider health and social care community.

We want to maximize the opportunities from digital to support to continue to deliver and improve the world class care that UHSFT is known for. As an exemplar specialist tertiary referral and teaching hospital we need to ensure that we have the equivalent provision in digital systems and services to meet our key challenges in enabling our workforce, increasing capacity, meeting changing demand and integration with our health and social care partners.

### Our approach to digital transformation at UHSFT

Our approach to digital at UHSFT will not change. We will continue to build our robust and scalable enterprise architecture approach centred on an integration engine. We will continue to support and develop our common data model and comply with all national data standards. We will continue to invest in our in-house skills within the informatics team to enable us to merge multi-vendor solutions with in-house development to provide the solutions that users want.

We will expand our use of "closed loop" techniques by delivering reminders/alerts and use a range of digital tools to confirm tasks are completed, check and validate actions and increase patient safety. We will replace our existing data warehouse with a highly functional and resilient solution that enables us to develop insight into the past, the present and the future. This will enable us to work smarter in every aspect of our service delivery.

We will enable clinical decision support at the point of care. We will put digital in the hands of all staff that need it, in a mobile and flexible way that increased efficiency.

We will expand the use of My Medical Record, our innovative patient held record solution to support and empower patients in their care and enable staff to transform how care is provided.

We will continue to be agile in meeting the needs of the organisation and implementing innovative solutions and emerging technology as it becomes fit for purpose.

We will continue to commit to support equality of care and access to care.

The Appendix describes our digital journey and where we are now.

## Vision

The vision has been developed to summarise the digital strategy for all stakeholders:

# ***UHS digital – world-class digital support***

## ***“World-class care for everyone”***

## Goals

Our digital goals will deliver in five key areas. The goals reflect those produced by NHSX (called missions) but have been customised for our Trust.

NB - NHSX is a new organisation (2019) that brings teams from the Department of Health and Social Care, NHS England and NHS Improvement together into one unit to drive digital transformation and lead policy, implementation and change.

Goals



Reduced burden on staff so they can focus on patients



Our patients have access to digital tools to enhance their care



Clinical information can be safely and easily accessed



Improve patient safety and care



Increased Trust productivity

The goals underpin our commitment to be user and clinically led in our implementation of digital at UHSFT. The purpose of the goals is to ensure that as this strategy is implemented there is a connection between every project and initiative to these goals. As the success of the strategy is measured over time the outcomes and benefits will be linked to these goals to demonstrate delivery and success.

## Principles for the digital strategy implementation

A set of principles for the implementation of this strategy have been developed by consultation with a wide stakeholder group and the digital strategy steering group, which included staff and patient representation.

The principles are important and we will refer to them as we prioritise the implementation of the digital strategy.

The principles underpin our commitment that our digital programme will be user and clinically led

### Principles for the Digital Strategy implementation



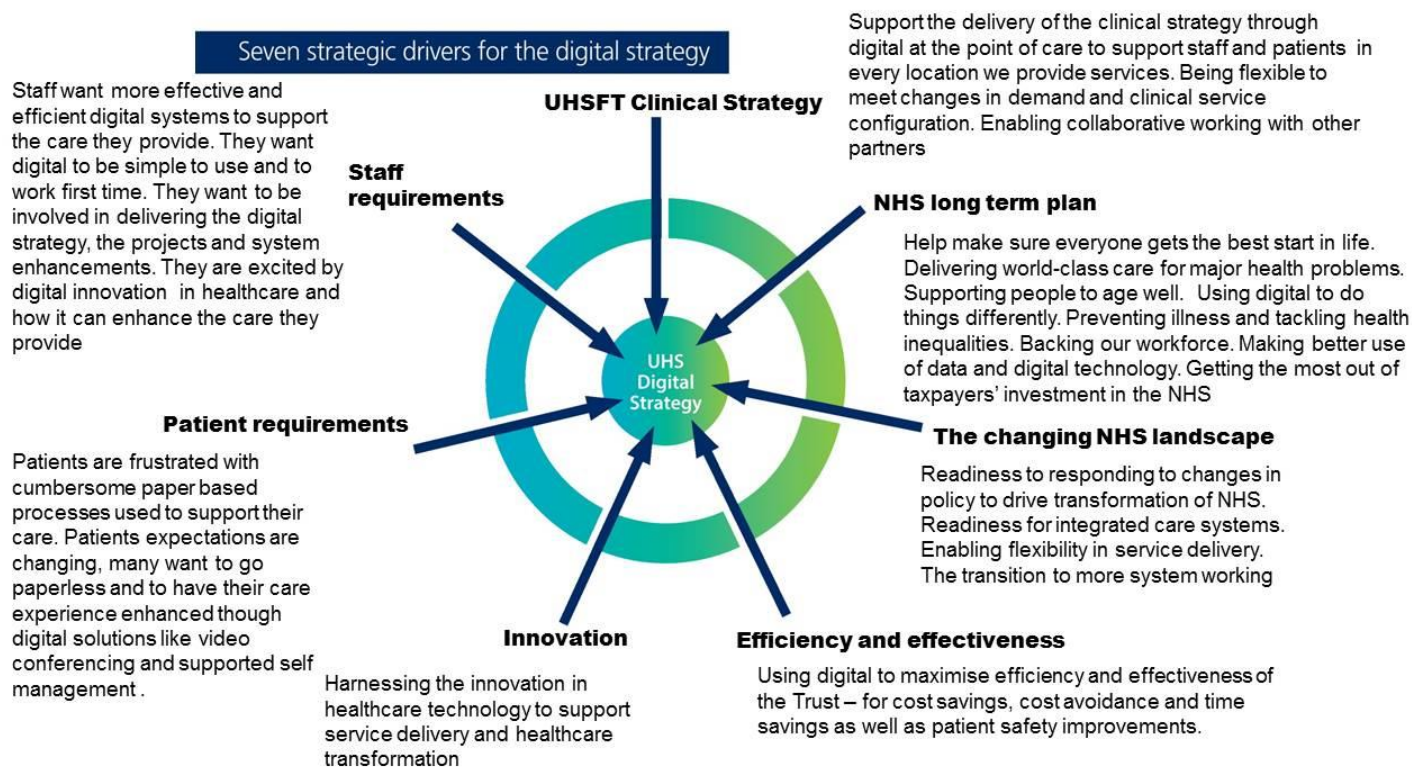
## Objectives

The objectives for this digital strategy are to underpin the corporate goals of the organisation through digital systems:

UHS corporate goal	The role of digital
<b>Improving patients' journeys</b>	<ul style="list-style-type: none"> <li>• <i>Enable sharing of patient information across the health and care system</i></li> <li>• <i>Enable more holistic care provision and networked care</i></li> <li>• <i>Enable integration and sharing of care for future care models</i></li> <li>• <i>Improving safety for patients by providing information and using technology such as alerts and workflow</i></li> <li>• <i>Improving patient experience by making sure they have information about their care</i></li> <li>• <i>Improving patient outcomes by tracking and reporting on outcomes and presenting information to staff to make improvements</i></li> <li>• <i>Enable patients to engage with their healthcare and facilitate co-production</i></li> </ul>
<b>Delivering value based health and care</b>	<ul style="list-style-type: none"> <li>• <i>Reduce the administration burden within care processes by providing digital solutions at the point of care to effectively support patient care</i></li> <li>• <i>Reduce cost of care through improving efficiency by providing digital solutions that enable staff to be more effective and efficient</i></li> <li>• <i>Increase sustainability of service by saving time and increasing direct patient contact time</i></li> <li>• <i>Enabling clinical staff to make best use of their time</i></li> <li>• <i>Using digital technology to innovate and to sustain and improve services</i></li> <li>• <i>Using digital innovation to change the way we work and help address limitations in the capacity of our current workforce such as Artificial Intelligence (AI) to automate some key clinical tasks</i></li> <li>• <i>Making better use of a wide range of information from diverse sources (internal and external) to inform our decision making and ensure we are doing the right thing and doing it well</i></li> </ul>
<b>Supporting healthy lives</b>	<ul style="list-style-type: none"> <li>• <i>Contribute to prevention, wellbeing and reducing inequalities</i></li> <li>• <i>Record and act on patient outcomes and experience</i></li> <li>• <i>Enhance the wellbeing of our staff by enabling effectiveness and reducing stress</i></li> </ul>
<b>Building an expert and inclusive workforce</b>	<ul style="list-style-type: none"> <li>• <i>Deliver digital solutions that are easy to use and have processes for ongoing inclusion of staff in development and enhancement</i></li> <li>• <i>Involve staff in the development and deployment of all new digital solutions</i></li> <li>• <i>Clearly identify the link between the capacity of the workforce and the ability of digital to underpin workforce development</i></li> <li>• <i>Providing digital solutions to address workforce capacity issues such as artificial intelligence (AI)</i></li> </ul>
<b>Being agile in meeting people's needs</b>	<ul style="list-style-type: none"> <li>• <i>Deploying agile processes for development and deployment</i></li> <li>• <i>Reacting to changes in priorities and ensuring the programme of digital system and service deployment is flexible to meet changes in demand and priorities of both staff and patients</i></li> <li>• <i>Using data and insight to spot trends and make changes to our clinical services</i></li> </ul>
<b>Creating cutting edge research, education and innovation</b>	<ul style="list-style-type: none"> <li>• <i>Supporting research through advanced data analytics</i></li> <li>• <i>Enabling education through digital systems and an ongoing programme of ensuring that digital systems are intuitive and easy to use. Enabling clinical innovation through digital systems</i></li> <li>• <i>Collaboration with universities and technology partners to introduce cutting edge technologies</i></li> </ul>

## Strategic drivers

In developing this digital strategy, seven strategic drivers have been identified. These are the primary reasons why we have developed a digital strategy.



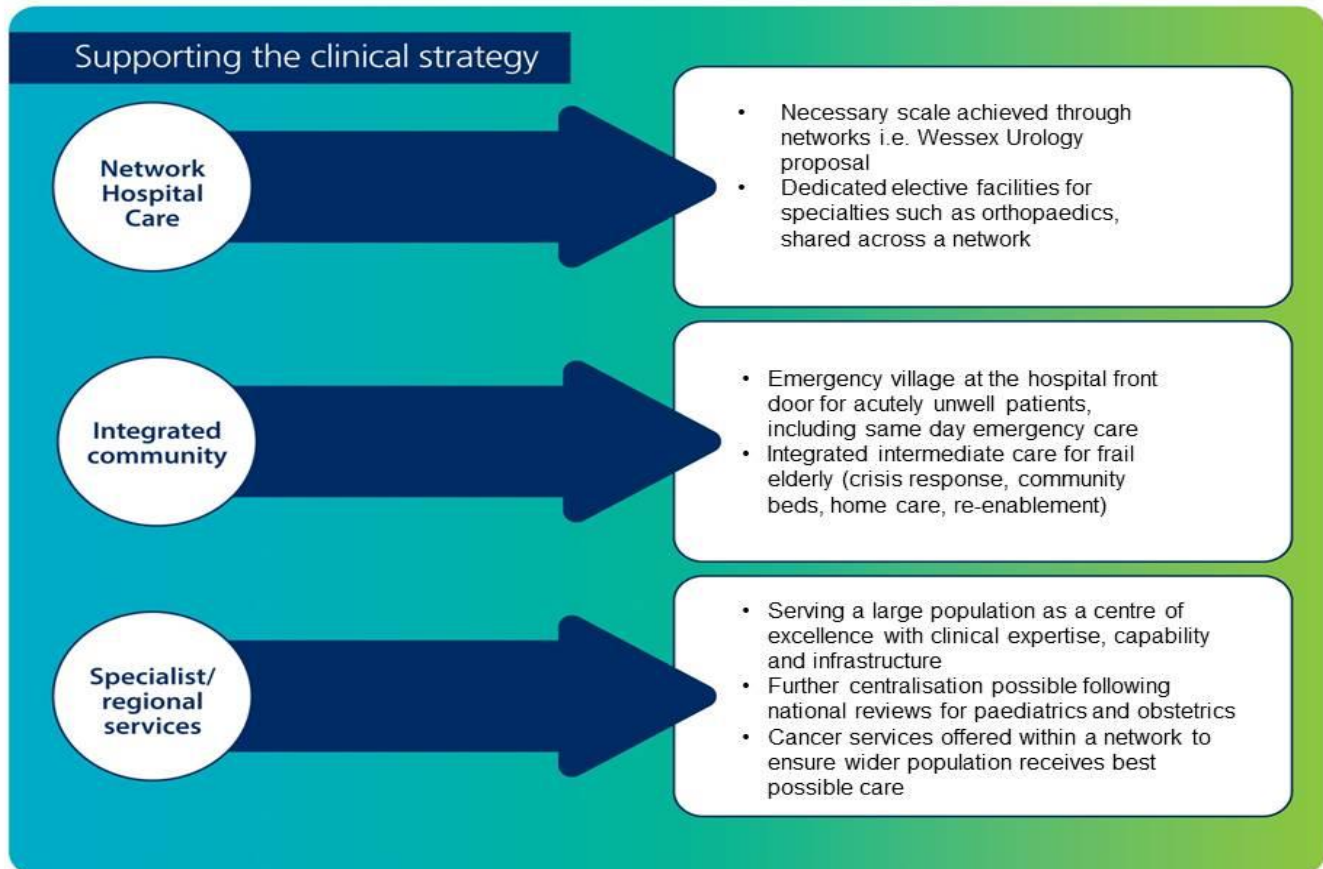
The changing NHS landscape is expected to bring changes in digital investment. We will continue to work with our health and care partners across the STP and the wider Wessex area and use these relationships to bid for future system funding streams.

The UHS clinical strategy is identified as the key driver for the digital strategy. The role of digital in supporting it is explained in the next section.

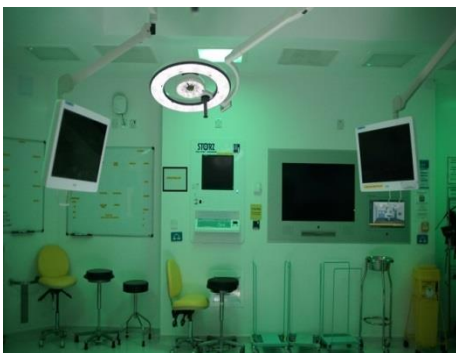
## Supporting the clinical strategy

The Trust's clinical strategy details how services will change over the next few years and outlines three types of configuration.

### The emerging UHS network model and clinical strategy



**We will need to develop a plan for each of these service models and individual services to ensure that digital supports their strategic aims and objectives. Overall to deliver these new models of care the digital provision needs to enable:**



### **Our onsite services at Southampton General Hospital and Princess Anne Hospital to provide specialist / regional services**

- Modern technology at the point of care delivery in every setting from high acuity to outpatients. Systems are fast and easy to use
- More integration between the electronic patient record (EPR) and medical devices to enable rapid clinical decision making
- Ensure it's quick to search and find patient information. "Your" view of patient information is the default setting
- Access to clinical information for all that requires it to deliver patient care. This includes trainees and temporary staff
- Support for research and innovation to ensure we continue to provide world-class clinical care

### Supporting remote working

- As a regional tertiary service the Trust currently provides 6740 clinics at remote locations which provide around 56,000 patient appointments
- Our clinical staff need the same digital experience whether they are on site, in an outpatient clinic miles from UHS, at the New Forest Birthing Centre, or in a local community hospital
- Our mobile clinicians will have access to UHS digital solutions where they deliver care
- Where required staff will be able to access any digital systems from home to enable them to save time and work more flexibly



### Mobile working

- Each clinician will have a mobile device that gives a plug and play experience in every location where they work. Enhancing network capabilities and working with the remote location hosts to ensure technology will work first time

### Interoperability at multiple levels

- Interoperability at a technical, system and data level will be required
- We will join up IT to make our systems talk to systems in other health and social care providers
- We will enable interoperability through our open system design with our health and social care partners to share the information needed to provide integrated care. Diagnostic results, care plans and medical records from other providers (including other acute trusts, community, ambulance and transport, mental health, GPs, social services and private providers) will be accessible and available for our clinical team to review. In a similar way we will share our information and data using open standards with our partners
- All sharing will be underpinned by robust information governance and IT security standards





### Flexible and agile


- Our digital strategy approach - focusing on a few key vendors working on interoperability, open data and standards is highly flexible and agile. It will enable us to respond to emerging requirements as the NHS transforms to deliver the long term plan

### Coproduction and patient engagement

- Patients will be a key contributor to their digital health record through My Medical Record and use of wearables. We will utilise innovation to offer a virtual and paperless relationship with patients

## The implementation plan - five programmes of work

No	Programme name	Programme objective
1	<b>Digital patients</b> 	<ul style="list-style-type: none"> <li>To put the patient at the heart of everything we do, including being the owner and contributor to their health record to improve patient activation and the overall health of the population</li> <li>Creating a <b>digital relationship</b> with the patient to increase decentralisation, decarbonisation and a reduced dependence on a physical estate. This will also increase the reach of the hospital and reduce staff travelling times supporting our IoW or distant patients</li> <li>Enable patients to fully participate and document their own health and care (co-production)</li> <li>Incorporate access via the NHS App for patients to our services</li> </ul>
2	<b>Digital at point of care</b> 	<ul style="list-style-type: none"> <li>Everyone having the information they need about the patient when they need it, this includes the clinician at the bedside or in clinic, the wider clinical team, the site team and the wider care team (such as community team and GPs). This will improve clinical safety and increase productivity</li> <li>Harnessing innovation and new technology to enable more effective and efficient healthcare delivery and improve patient safety such as Artificial Intelligence (A.I)</li> <li>More of the right technology in the hands of every clinical staff member</li> </ul>
3	<b>Enabling team working/ without walls</b> 	<ul style="list-style-type: none"> <li>Our technical approach in using a multi-vendor with open data to deliver digital systems will continue to be used to enable flexibility and agile solution development and delivery</li> <li>We will harness new innovation to enable efficiency for staff</li> <li>We will enable effective, seamless communication between teams and departments both in and outside the hospital to ensure the next element of the patient's care is delivered safely and efficiently</li> <li>We will support a hospital without walls and more effective working with health and social care partners across the integrated care service that is emerging for Hampshire and the wider Wessex /southern region</li> </ul>
4	<b>Information and insight</b> 	<ul style="list-style-type: none"> <li>The creation of business and clinical intelligence to enhance management of the individual patient's care, the flow and efficiency of the services and knowledge used for the care of future patients</li> <li>Deliver merged clinical and business information which will provide holistic evidence for strategic, clinical and operational decisions.</li> <li>Provide insight to improve efficiency and performance</li> <li>Support quality improvement and research through faster, broader access to enriched data and analytics</li> <li>Support population health insight to better understand how to adapt our healthcare provision and collaborate with regional partners to improve the health and care of our patients and the public</li> <li>Analyse outcomes to optimise activities, reduce waste and provide high value healthcare</li> <li>Provide analytics, alerts and insight for all staff</li> </ul>

No	Programme name	Programme objective
		<ul style="list-style-type: none"> <li>Partner with academic and industry leaders to develop and implement emerging technologies and techniques</li> </ul>
5	<p><b>Increased Trust productivity</b></p> 	<ul style="list-style-type: none"> <li>Technology working first time, every time wherever you are based to ensure easy access to clinical systems including single sign on for multiple applications</li> <li>Implementing the right technology and ongoing assessment and agile cycles of improvement acting on staff and patient feedback</li> <li>Minimising the burden of data entry through alternative solutions such as speech recognition</li> <li>Enabling a more seamless user experience of the Trust's multiple vendor digital systems through fast authentication/sign on and patient context</li> <li>Development of digital champions and a programme of digital literacy for staff and patients</li> <li>We will measure the time taken to use digital and the time released for care</li> </ul>

## 2. Looking ahead - five years

### System working

- We will continue to build our scalable technology platform using a multi-vendor / open data approach
- System working will become more important for care delivery, we will enhance our digital relationships and deliver highly functional integration across the care network
- Enhance and further enable collaborative working with other trusts, health and social care partners through high levels of interoperability to enable sharing of patient information
- Sharing of patient information to enable provision of networked care, team working and seamless patient care
- Enable the emerging Integrated Care System and work collaboratively with our partners both within the sustainability and transformation partnership (STP) and across a wider geographical area for our regional speciality services
- More seamless access to systems and patient information



### In our hospital

**Integration:** All core systems will be integrated so you will be able to see all relevant information using only a few applications. Such as prescribing information and patients observations

**EPR:** You will see less paper in the hospital and use devices such as tablets and smartphones to input data and view patient information in real time.

**Remote Monitoring:** You will increasingly use remote monitoring to track patient progress away from the hospital seeing far less patients in outpatient clinics



**Business Intelligence** You will be able to manage clinical utilisation and the ebbs and flows of activity using BI tools that predict when patients peaks are likely to occur, so you can plan for them.

**Management:** You will use digital systems to do many tasks, such as communicating with your colleagues or documenting care you have just given.

**Clinical tools:** Clinical systems will help minimise risk of harm by providing you with alerts and reminders

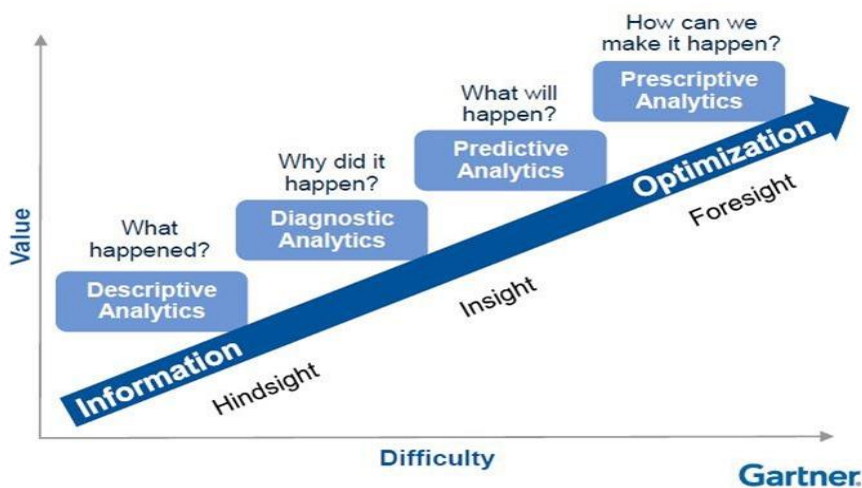
**Patient:** As a patient you will have the option to have a paperless relationship with us in much the same way as you may have with your bank. Receiving all your appointments in a digital format, and communicating with us using our digital portal

## UHSFT staff working away from the hospital

We will support virtual working; the experience for staff will be the same. Users will access the same systems and be provided with enhanced technology to enable their access. Patient care will be provided remotely through a range of digital solutions. We will work with our health and social care partners to deliver digital solutions to enable sharing of information and seamless care for patients.

## How we use information

We will transformation how we use information and data towards predictive and prescriptive analytics.



## The user stories

To bring this strategy to life, this section highlights two examples of how digital will impact on staff and clinical services. This first table explains how we will expand the use of Digital in diagnosis:

Diagnosis
<p><b>Vision</b></p> <ul style="list-style-type: none"> <li>• All diagnostic results will be integrated into clinical systems so any results such as ECG, X-Ray, pathology reports etc can be seen using a mobile device that meets the need of the user.</li> <li>• We will enable transfer of diagnostic results from other healthcare providers so that our clinicians can see these results. For example if we are treating a patient who has had diagnostic tests at Hampshire Hospitals we will enable viewing of these results. Initially via CHIE (the Hampshire Health Record) and then as required directly within clinical records. For pathology tests performed outside of Hampshire we will extend the use of the National Pathology Exchange (NPEX).</li> <li>• We will support research and seek to become a specialist genomics test centre as part of the WOW (West Midlands, Oxford, Wessex) Genomics Laboratory Hub</li> <li>• We will continue to enhance the notification of new diagnostics results so that clinicians know when results are available and can quickly move onto making decisions. Currently this data is presented within a range of digital solutions such as CHARTS dashboard, Medxnote notifications and eWhiteboard.</li> <li>• We will use supplementary systems such as My Medical Record to help support patients to understand their diagnosis, giving them time to absorb it, and supporting any follow questions they may have to their healthcare teams if patient are not in the hospital. Within My Medical Record we will provide condition related information in a digital format. We will offer the messaging solution for patients to ask questions about their diagnosis to their clinical team. We will ensure all patients are given their diagnosis information in a digital format in My Medical Record so that it is all in one place.</li> <li>• Diagnostic coding will move to the SnomedCT national standard (currently ICD10) to facilitate enhanced data sharing and communication with GP systems</li> <li>• We will harness Artificial Intelligence(AI) to reduce the time for diagnosis to be undertaken</li> </ul>

## Diagnosis

### What is currently in place

- A world class order communications system for requesting diagnostic tests and receipt of results.
- Closed loop acknowledgement on results ensuring results are acted upon
- Pathology and Radiology results already integrated into the EPR
- Blood requesting at the bedside (Sample 360)
- All x-rays are digital and can be reviewed by staff as soon as they have been authorised by Radiology. Access to diagnosis has been enhanced with the introduction of digiRounds
- Pilot in digital pathology in place with whole slide scanning

### Delivering the vision

- Purchase a replacement laboratory information systems (LIMS)
- Full implementation of digital pathology
- Renew the SWASH contract for digital radiology
- The Business Intelligence strategy we will be able to extract structured data using (SNOMED CT) that includes the diagnosis information.
- Expand our ability to utilise Medxnote/ messaging app to communication test results to clinical users as soon as they are ready
- Expand our use of XDS for sharing digital images between PACs systems
- Implement services to support stratified medicine
- Implement AI in key areas to support rapid diagnosis

## Benefits of digital in diagnosis

### For Doctors

- Less time wasted in searching for information about diagnosis to enable faster decision making
- Creating more time for clinicians to explain diagnosis to patients, and answer their questions, as they have all the data they need in front of them.

### For Nurses

- Ensuring fast and up-to-date patient information, so nurses can quickly identify any changes in the care that patients need.
- Being able to communicate results to patients as soon as possible, so they are fully involved in their own care.

### For patients

- Diagnostic test results available on My Medical Record in real time where appropriate, reducing potentially anxious waiting times, or trying to find the right phone numbers to call for results.
- Where appropriate enabling patients to reflect on their results before making any treatment decisions.
- Support treatment and facilitate early discharge.

### For AHPs

- Improving communication and collaboration with the AHP team to enable faster decision making and more joined up care

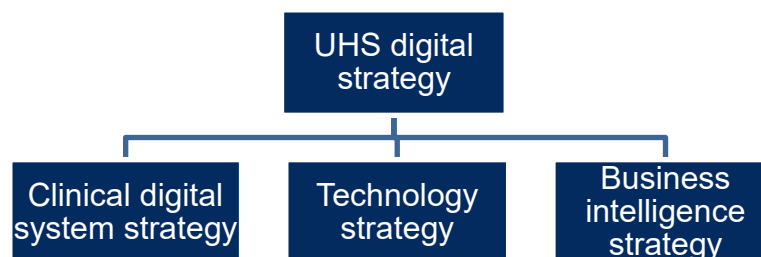
This picture explains how digital will be used to enhance the management of Diabetes

Example of how digital supports a clinical services



### 3. Implementation

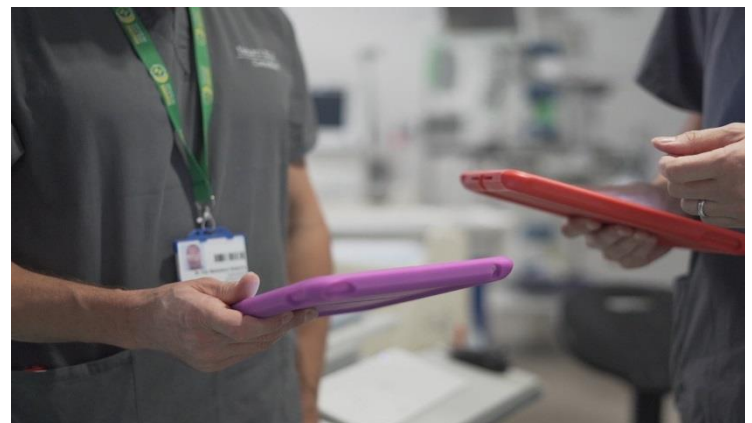
The digital strategy is underpinned by three supporting and enabling strategies. All three documents will be shared in autumn 2019. These documents are being developed with stakeholders and will go through the same consultation process as this digital strategy.



### Technology strategy

The technology strategy will cover :

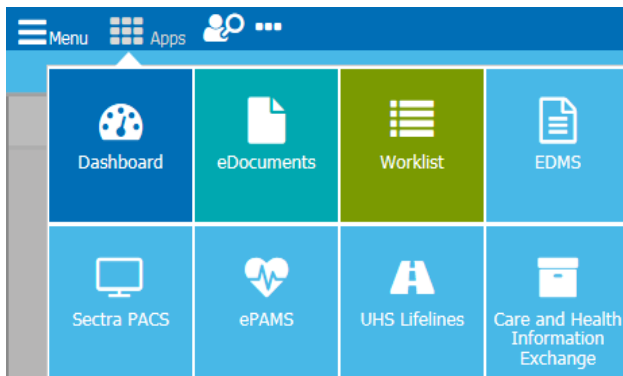
- Technology infrastructure required to deliver improvement – right tools in the right place - user device strategy and enabling user access to give staff time back to care
- The core IT infrastructure
- Easily accessed means using a single sign on solution available to all regardless of location
- Remote and mobile working
- Integration and interoperability strategy – so systems talk to each other and data is entered only once
- Integration of medical devices and wearables into the EPR including remote monitoring and telemedicine
- Integration with other healthcare domains such as medical devices and science
- Experimentation with emerging technology



## Clinical digital systems strategy

The clinical digital system strategy will cover:

- Development of the EPR and enhancement of existing systems to meet our goal that everything works which increases Trust productivity and gives time back to staff for care
- Highlighting key decisions and next steps such as the urgent replacement of the pathology system, a new emergency department system and an option appraisal for a single e-prescribing solution
- Integration of key clinical systems with the electronic patient record including community and primary care to support the integrated care system
- Rationalisation of existing systems where required
- Development of a digital systems support for end users including automation of services and development of skills
- Ensuring our digital systems serve the diversity of our patients and workforce
- Innovation through solutions such as Artificial Intelligence (AI)



## Business intelligence strategy

The business intelligence strategy will cover:

### Evidence driven decisions

- Provide holistic evidence for strategic, clinical and operational decisions.
- Develop and deploy tools for prediction and prevention
- Ensure high quality, broad, standards-based data and governance

### Learning health system

- Provide insight to improve efficiency and performance
- Support quality improvement and research through faster, broader access to enriched data and analytics

### Population health

- Collaborate with regional partners to improve the health and care of our patients and the public

### Value based healthcare

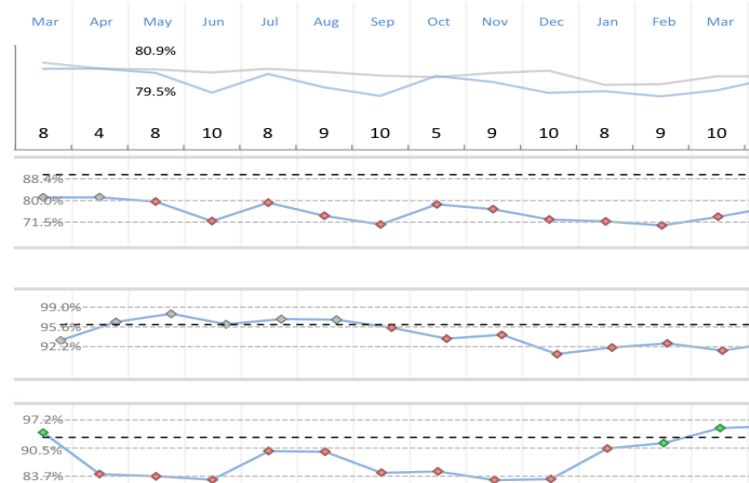
- Analyse outcomes to optimise activities, reduce waste and provide high value healthcare

### Analytics for all

- Provide analytics, alerts and insight for all staff
- Improve access to data and analytics for our patients and the public

### Innovation

- Partner with academic and industry leaders to develop and implement emerging technologies and techniques
- Harnessing the benefits of artificial intelligence and data science



## Non-clinical digital systems strategy

A decision was taken by the Digital Board to focus this strategy on clinical systems. However we need to incorporate non-clinical digital systems into the digital strategy. Traditionally these have been implemented and supported outside of informatics. Our increasing demand for data, analytics and integration will drive the requirement to develop a non-clinical digital strategy with the aim of supporting our vision to be a global leader in digitally enabled care.

It is acknowledge that systems are increasingly crossing the clinical/information divide and providing clinical decision making such as rostering and acuity/dependency scoring.

Non-clinical systems include finance, workforce, and estates for example. Work will start on a non-clinical digital system strategy in 2020.


## 4. Delivering the digital strategy


This section outlines at a high level the building blocks required to deliver the digital strategy. These areas of work will be developed in more detail over the next year into an action plan which will be managed by the newly established Digital Board.


### Roadmap for delivery – the next three years

This strategy contains many actions which will be summarised in an action plan. The action plan is dependent on the investment that can be made available. This next section outlines what you will see over the next three years. A more detailed road map will be provided in due course.

**Text in black means funding has been secured, text in blue means the funding is partially secured but not sufficient to do at scale, and text in purple means the funding has not yet been secured.**

DIGITAL PATIENT		
		
By April 2020	In 2021	In 2022
<ul style="list-style-type: none"> <li>My Medical Record account offered to all patients as part of a first encounter with the Trust providing digital access to patient information, approved results and letters</li> <li>Paper switch off for patients – option will be given to switch off all paper correspondence (clinical and admin)</li> <li>Patient choice on how they receive appointment reminders and notifications</li> <li>Patient video consultations will enable clinical services to set up appropriate patients/clinics for virtual consultation</li> <li>Digital patient reported outcome questionnaires will be available to clinical services. As suitable questionnaires are developed they can be easily deployed on a pathway basis</li> </ul>	<ul style="list-style-type: none"> <li>Patient wearables connected to My Medical Record where patients are on a virtual clinical pathway</li> <li>Patient experience questionnaires available through My Medical Record. Aggregated and anonymised data provided to clinical services and published on Trust website</li> <li>My Medical Record solution for patient medicine management</li> <li>Choice of approved self-care apps connected to the open personal health record so patients can have more involvement in managing their health</li> </ul>	<ul style="list-style-type: none"> <li>Enterprise wide scheduling supporting one stop services and booked patient pathways reducing the number of times a patient has to travel to the hospital</li> <li>Digital care plans so patients can be involved in their healthcare planning</li> </ul> <p><b>Aspirational</b></p> <ul style="list-style-type: none"> <li>Digital way finding for patients and visitors</li> <li>Real time tracking on patients onsite and guided pathways / phone app so patients can easily find their way around the hospitals</li> <li>Choice of connecting personal assistant device to patient's personal health record</li> <li>Digital daily diary for inpatients and their visitors – key information about their care</li> </ul>

<h2>DIGITAL AT THE POINT OF CARE</h2>		
By April 2020	In 2021	In 2022
<ul style="list-style-type: none"> <li>• Mobile [tablet] electronic forms and digital workflow to improve admin and clinical process</li> <li>• Worklists for nurses and allied health professionals (AHPs) to enable more patient focus, better management of tasks and more team coordination</li> </ul>	<ul style="list-style-type: none"> <li>• Mobile clinician (device for every clinician and mobile enabled applications) to support mobile working and easy access to patient information regardless of location</li> <li>• Standardised digitally enabled outpatient facilities on site (laptop and docking station) to improve staff experience in outpatients, save time and increase efficiency</li> <li>• Closed loop bedside administration for medication and blood products to improve patient safety</li> <li>• Enhanced interoperability with community services – coded data exchange to enable the sharing of clinical information across services. Support for integrated care models</li> </ul>	<ul style="list-style-type: none"> <li>• Medical device connectivity to the EPR removing the need for rekeying of data, reducing transcription errors and increasing patient safety</li> </ul> <p><b>Aspirational</b></p> <ul style="list-style-type: none"> <li>• All off site clinic locations to provide same experience and accessibility as onsite facilities and improve patient safety</li> <li>• AI implemented to reduce diagnostic times and staff time. Improve patient care through automating tasks. Enable the workforce to reconfigure to address capacity challenges.</li> </ul>

<h2 style="text-align: center;">ENABLE TEAM WORKING</h2>			
<h3>By April 2020</h3>	<h3>In 2021</h3>	<h3>In 2022</h3>	
<ul style="list-style-type: none"> <li>• Medxnote rollout to enable team communications and management of tasks through messaging from clinical applications</li> <li>• Simplified sign on for clinical staff enabling easier access to multiple systems</li> <li>• Complete Windows 10 rollout which will speed up the use of systems and save time for staff</li> <li>• Enhanced telephony services (unified comms) to enable more effective communications solutions for staff and patients</li> </ul>	<ul style="list-style-type: none"> <li>• Microsoft teams rollout [subject to MS O365]</li> <li>• Interoperability across HIOW. All diagnostic results available from other hospitals in HIOW</li> <li>• Remote working enhancements such as home working</li> <li>• Digital literacy programme for all staff to increase level of digital skills in the workplace and enable staff to make better use of technology</li> </ul>	<ul style="list-style-type: none"> <li>• Use of Microsoft Teams to support collaborative working including video conferencing and shared document management</li> </ul> <p><b>Aspirational</b></p> <ul style="list-style-type: none"> <li>• Interoperability through Wessex, full visibility of the patient clinical record across the Wessex region. Clinical information can be readily shared via standardised electronic transactions with all stakeholders</li> </ul>	

<h2>INFORMATION AND INSIGHT</h2>	 <ul style="list-style-type: none"> <li>Reduced burden on staff so they can focus on patients</li> <li>Clinical information can be safely and easily accessed</li> <li>Improve patient safety and care</li> <li>Increased Trust productivity</li> </ul>	
<h3>By April 2020</h3>	<h3>In 2021</h3>	<h3>In 2022</h3>
<ul style="list-style-type: none"> <li>• Procurement of BI platform to provide a comprehensive data warehouse solution for the trust which will enable access to all information in all Trust systems for reporting and auditing</li> <li>• Clinical decision support to enable digital pathways and provide aid to clinical staff in making decisions about care</li> <li>• Automated clinical coding pilot to improve the coding of information which will aid reporting, audit and income recovery</li> </ul>	<ul style="list-style-type: none"> <li>• Rollout of analytical tools for all staff</li> <li>• Digital outcomes platform and tools to support PROMS and PREMS data collection and reporting. Clinical staff will have access to personalised dashboards to view and act on patient outcomes</li> <li>• Clinical decision support. Complex rules for making decisions will be automated</li> <li>• Digital site office providing whole hospital view of real time activity as well as predictive planning data. Live operations, hospital data at patient level, department level and site level</li> <li>• Predictive information on staffing, acuity, planned and unplanned arrivals</li> <li>• Tracking of patient alerts through a central team to provide assurance and escalation</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated clinical decision support using data from multiple sources. Enable clinical staff to make complex decisions faster and more easily with knowledge bases and information presented in a user friendly way]</li> <li>• Tracking patients after discharge through our patient held record, reviewing their behaviours, experiences of care and their clinical outcomes. Link enhanced prescribing data to outcomes through our business intelligence platform</li> </ul> <p><b>Aspirational</b></p> <ul style="list-style-type: none"> <li>• Complex decision support, ongoing management and notification of critical conditions to improve efficiency, reduce risk and increase patient safety</li> </ul>

INCREASED TRUST PRODUCTIVITY		
By April 2020	In 2021	In 2022
<ul style="list-style-type: none"> <li>All PCs under five years old providing faster access and use of systems</li> <li>Review and improve reliability, accessibility and performance of CHARTS providing faster access</li> <li>Service desk review and increasing first time fixes</li> <li>Survey users and implement feedback loop for IT and system issues</li> <li>Governance structure implemented including a digital programme board to prioritise the work programme</li> <li>Process for innovation and ideas from staff implemented to allow staff to suggest changes and ideas</li> </ul>	<ul style="list-style-type: none"> <li>Single sign on solutions enabling easier access to multiple applications</li> <li>Transition to mobile platforms to support mobile working for all staff</li> <li>Speech recognition for clinical staff to reduce the time taken for data input</li> <li>Electronic tracking of equipment and assets to reduce time spent by staff trying to locate them</li> </ul>	<ul style="list-style-type: none"> <li>Mobile infrastructure implemented – laptop docking and consultant “laptop anywhere”</li> </ul> <p><b>Aspirational</b></p> <ul style="list-style-type: none"> <li>Digitally enabled stakeholders fully engaged in the implementation of the digital strategy and taking an active part in its ongoing development and implementation. All stakeholders committed to maximising the benefits from digital</li> </ul>

## Investment

The Trust has committed an investment of £9 million for 2020/2021 and 2021/2022 to deliver the digital programme. This assumes that the GDE programme is fully delivered and funded. It is expected that external funding opportunities will also become available. The amount of investment that can be secured will impact on the speed of implementation of the digital strategy.

We will continue to build on the system wide digital work we are leading across the STP and support system wide bids for digital innovation.

We will actively seek opportunities to build on the success of My Medical Record our personal health record and consider how we can commercialize some of our digital solution or delivery the capabilities more broadly for system working.

Where required business cases will be developed for individual projects. These will identify the strategic and operational benefits from the investment.

## Benefit realisation

There are significant benefits to be realised from digital for the Trust and its patients. There is also a potential revenue stream from UHS digital and there are a number of UHS systems that are transferable to other healthcare providers. A digital benefits management strategy will be developed; it will link to the implementation programme and prioritise benefits that save staff time and release time to care.

## Workforce plan for informatics

A workforce plan for informatics is required to identify the staffing required to meet the increasing requirements for digital. This includes support and maintenance of the existing system, the growth in digital and how increasing demand is accommodated, support for the development and programmes/projects.

## Monitoring progress

A range of measures will be used to monitor progress including internal metrics such as KPIs for the Digital Board and external metrics such as digital maturity assessments. In addition work will be undertaken both internally and with KLAS on user digital leadership and engagement satisfaction with the digital systems. A key aim is for user to spend less time accessing and recording information and there is a commitment to measuring this.

## Governance

The implementation of the digital strategy requires a multi layered and transparent governance structure which enables delivery. The strategy implementation will be headed by the new Digital Board and a portfolio of strategy and project based sub groups will be established to focus on delivery. Existing sub-groups will be incorporated into this governance structure and where required enhanced.

## Digital leadership and engagement

To make this strategy happen, we need to help the whole organisation to become more digitally capable. It is essential that the staff and patients are involved in developing the plans and are fully engaged in design and implementation. Clinical enablers of change are required to progress the work. They include but are not limited to:

- Chief clinical information officer(s) leading the implementation of digital with the clinicians.
- Chief nursing information officer(s) supporting and enabling the largest staff groups of nursing, midwifery and AHPs
- Clinical safety governance supporting the requirement for sign off of all new implementations. There is a potential high degree of risk associated with the existing and future systems that require clinical scrutiny and sign off. The clinical safety officer role needs to be developed to address this
- Digital champions in all areas to support their colleagues in adapting to digital working and engaging in digital projects
- Digital literacy of all staff. Training and skills required to become a digital workforce
- Supporting professional groups views of the digital workforce
- User and patient engagement via user forums and patient engagement groups.

## Management of risk

The digital strategy has risk attached to it. The key risks that have been identified are:

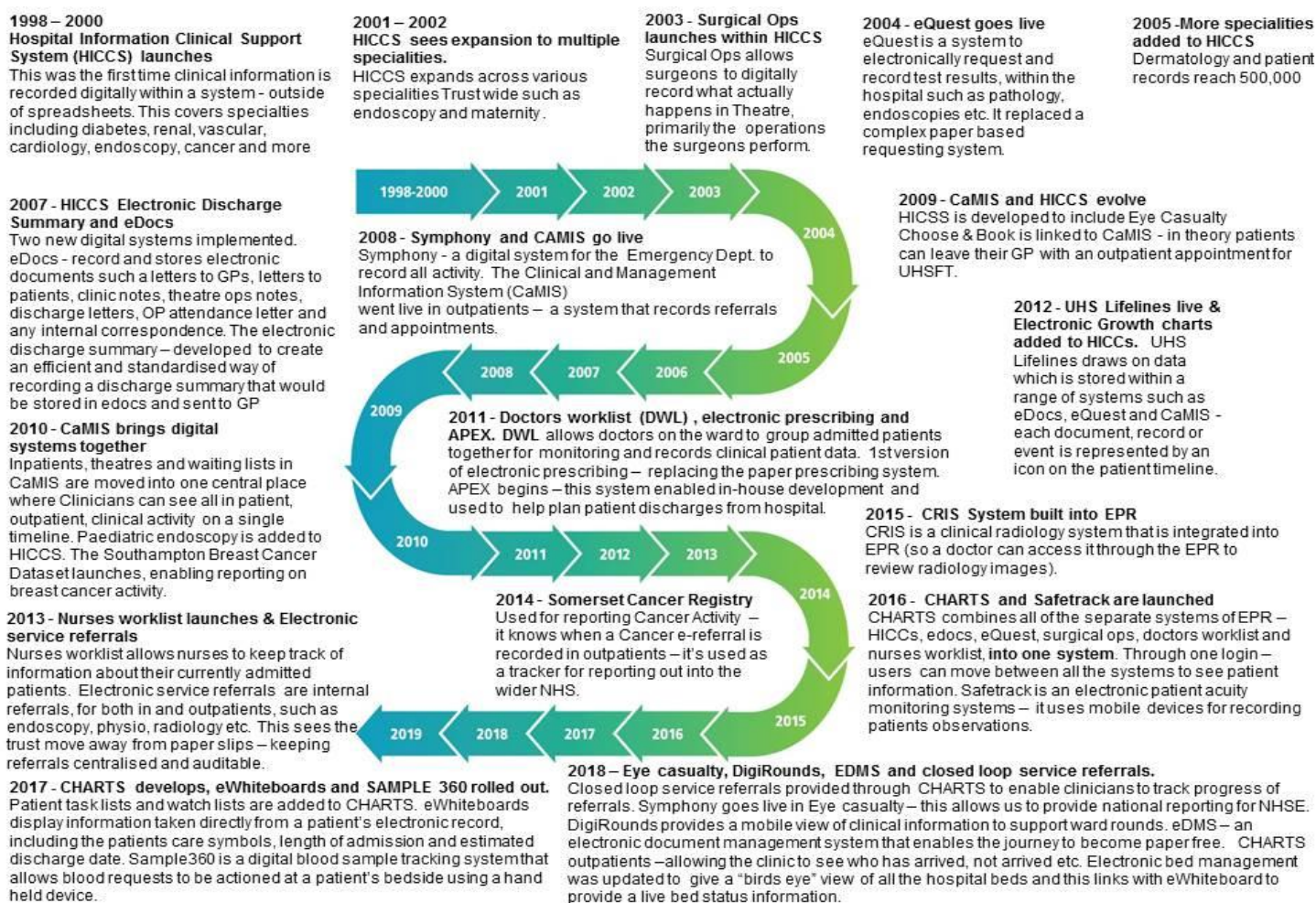
No	Risk	Outcome	Mitigation
1	<b>Lack of digital leadership outside informatics</b>	The implementation of the digital strategy will not be clinically led if the Trust chooses or is unable to invest in digital leadership The solutions will not meet stakeholders' needs. The benefits will not be delivered.	<ul style="list-style-type: none"> <li>• A plan for digital leadership and culture will be developed</li> <li>• Investment in digital leadership agreed and incrementally implemented</li> </ul>
2	<b>Investment plan does not match the vision</b>	Digital does not meet the organisations' needs and cannot deliver the strategy as investment not in place	<ul style="list-style-type: none"> <li>• Benefits realisation plan</li> <li>• Outline investment programme for 2020/21 and 2021/22 has been agreed</li> </ul>
3	<b>Digital is not embedded into the organisation</b>	Digital does not meet the organisational needs and the solutions fail to transform the organisation and patient care. Disjointed decisions/ programmes of work leading to poor implementation of digital and/or uncoordinated approach	<ul style="list-style-type: none"> <li>• Informatics to identify key impacts for Digital Board</li> <li>• Governance to be clarified re prioritisation of digital programme alongside other Trust programmes such as transformation, estates, and workforce</li> <li>• Stakeholder engagement plan to be developed and implemented by informatics</li> </ul>
4	<b>Informatics staff</b>	Digital does not meet the organisation needs because the right informatics workforce is not implemented to deliver and support digital systems	<ul style="list-style-type: none"> <li>• Workforce plan for informatics to be developed and implemented</li> </ul>
5	<b>Incremental implementation</b>	Digital does not meet the organisation needs because the transition is not mandated. Allowing paper processes to continue. Dual running ongoing. Failure to realise benefits and increased costs	<ul style="list-style-type: none"> <li>• Governance</li> </ul>
6	<b>Failure to recognise the opportunity from digital</b>	The digital strategy does not win the hearts and minds of the organisation and fails to maximise the opportunities that getting this right gives us. The benefits and outcomes are not understood by all levels of the organisation. Funding decisions made which don't result in developing a sustainable and responsive workforce based on digital innovation	<ul style="list-style-type: none"> <li>• Engagement and communication</li> <li>• More understanding of the timescales and buy in to staff investment for which there may not be an immediate or even direct return quickly</li> <li>• Explicitly develop the link between a limited workforce and limited investment in digital.</li> <li>• Digital as part of the Trust workforce plan</li> </ul>
7	<b>Changes in the role of the Trust as the NHS long term plan is implemented</b>	The NHS reconfiguration programme means the role of the Trust within the system changes and this digital strategy is no longer fit for purpose	<ul style="list-style-type: none"> <li>• Ongoing review by the Digital Board</li> <li>• This situation would trigger a requirement to review and rewrite the digital strategy to meet the Trust and the system needs.</li> <li>• If trust became directly responsible for wider / population health issues then the strategy will need to change</li> </ul>

A risk register for the digital strategy will be developed and monitored by the Digital Board.

## 5. Appendix - Where are we now?

Our 2015 – 2018 technology strategy laid valuable foundations. It had at its heart an innovative approach which moved away from the accepted path of large enterprise applications provided by a single vendor/system supplier to a more vendor neutral approach that will deliver technology which can flex and scale up to meet the changing needs of healthcare. Overall the Trust has a smaller number of digital systems than those hospitals that have selected a large single enterprise application because of the implementation of HICSS which provides clinical system support within the EPR. A single enterprise solution typically does not cover the specialist clinical systems and these are usually purchased as additional systems. Additionally, the Trust has invested in its integration technology to enable the advanced levels of connectivity. The infrastructure has also been expanded to support remote working and the use of mobile devices. So, not only is the UHS digital approach more integrated but it is also more cost effective and more flexible.

We have worked towards NHS England and NHS Digital standards, where they exist, to implement as much interoperability as possible so that we are in a good place to scale up and work with other partners. The diagram below gives a high-level view of our digital journey so far and highlights some of the main achievements.



In 2019 the electronic 'to come in' referral project (eTCI) was launched and added to CHARTS. It provides a safe and fully auditable means of adding patients to waiting lists for elective surgery and provides a paperless solution to record details of planned procedures in CHARTS.

This progress demonstrates that the digital strategy is building on a track record of incremental development that has significant and beneficial functionality for both staff and patients.

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: Register of Seals, and Chair's Actions</b>			
<b>Category</b>	Corporate Governance, Risk, and Internal Control		
<b>Agenda item</b>	6.1		
<b>Sponsor</b>	Chairman		
<b>Author</b>	Charlie Helps, Company Secretary		
<b>Provenance</b>	This is a regular report to notify the Board of use of the seal and actions taken by the Chairman in accordance with the Scheme of Delegation for ratification.		
<b>Classification</b>	<b>This Report is unclassified.</b>		
<b>Purpose and recommendation</b>	The paper is presented for RATIFICATION.		
<b>Relevant strategic goals</b>	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6</li> <li>• BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme</li> <li>• BAF04 – Reduced access to resources compromises the quality of services</li> </ul>		
<b>Impact assessments</b>	None		
<b>Other standards affected</b>	<ul style="list-style-type: none"> <li>• Monitor NHS Foundation Trust Code of Governance (probity, internal control)</li> <li>• UHS Standing Financial Instructions and Scheme of Delegation</li> </ul>		

## Register of Seals, and Chair's Actions

### 1. Signing and Sealing

- 1.1 **Service Agreement**, executed as a Deed, between University Hospital Southampton NHS Foundation Trust and MSI Group Limited ('Medicare) for the provision of Clinical Services for Lymington New Forest Hospital and Southampton General Hospital. Seal number 180 on 20 September 2019.

### 2. Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The following actions have been undertaken by the Chair. All awards of contract are subject to a full tender process.

- 2.1 **Single Tender Action for Outsourcing NHS Patients** to Spire Healthcare Ltd, at a cost of £5,630,792 excluding vat. Contract backdated to 1 April 2019 and renewed for a further year. Approved by the Chair on 27 August 2019.
- 2.2 **Single Tender Action for Oracle Database & Hardware Refresh** from Data Intensity (formerly Red Stack), at a cost of £996,528 excluding vat. Approved by the Chair on 28 August 2019.
- 2.3 **Single Tender Action for Multi-Storey Car Park Annual Rent** to Canada Life Ltd, at a cost of £926,862 excluding vat. Approved by the Chair on 3 September 2019.
- 2.4 **Single Tender Action for Orthopaedic Consumables** from multiple suppliers via access agreement, at a cost of £795,917 excluding vat. Approved by the Chair on 9 September 2019.

### 3. Recommendation

Trust Board is recommended to ratify the Chair's Actions.

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: Learning from Deaths 2019-20 Quarter 1 Report</b>			
<b>Category</b>	Quality, Performance, and Finance		
<b>Agenda item</b>	10.1		
<b>Sponsor</b>	Medical Director		
<b>Author</b>	Mr Neil Pearce, Associate Medical Director		
<b>Provenance</b>	Quality Governance Strategy Group		
<b>Classification</b>	<b>This Report is unclassified.</b>		
<b>Purpose and recommendation</b>	<p>The paper is presented for INFORMATION.</p> <p>Since 2014 IMEG and TMRG have been undertaking reviews of adult inpatient deaths. Deaths that were deemed to have been ‘probably avoidable’ (&gt;50%) for 2018/19 accounted for 1% of all deaths, lower than reported historically.</p> <p>Trust Board to note ongoing reporting requirements.</p>		
<b>Relevant strategic goals</b>	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people’s needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways.</li> <li>BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6.</li> </ul>		
<b>Impact assessments</b>			
<b>Other standards affected</b>			

## 1 Introduction

In March 2017 the DH published *National guidance on learning from deaths*. From April 2017, Trusts have been required to collect information on deaths, reviews, investigations and resulting quality improvements; and report to its public board meeting via a quarterly paper. This includes assigning an avoidability score to all those deaths reviewed. Whilst there is no requirement to review all deaths, rather only those where concerns are raised by relatives; unexpected deaths; deaths of patients with either a learning disability or a severe mental illness; or deaths in a speciality or

treatment group where an alarm has been raised (for example, an elevated mortality rate), we have been undertaking a 'hot review' of all deaths via our Internal Medical Examiner Group (IMEG) process since September 2014. In April 2019 we adjusted our IMEG system to comply with the new national requirement for the medical examiners system.

## 2 Key Issues

- UHS introduced the Internal Medical Examiner Group (IMEG) in September 2014, prior to the national drive.
- The group examines all deaths, going beyond the national guidelines and has progressively increased the scope to include
  - All inpatient adult deaths
  - Death in the Emergency Department
  - A paediatric mortality review process.
- The review identifies potential avoidable factors as well as aspects of good care to feedback to the clinical teams.
- The bereavement care team attends IMEG and focuses support where the medical team discuss issues that might have been specifically stressful for the relatives. This allows a proactive approach to supporting those likely to have stress or conflict complicating their grief.
- In all cases Duty of Candour is discussed where appropriate ensuring that the clinical teams make early contact with the families.
- The proportion of avoidable features identified has reduced over the years and is believed to be a marker of improved care supported by the following observations
  - HSMR has fallen across all hospital sites.
  - The Trust Mortality Review Group is not identifying issues missed by IMEG and supports the findings.
  - The introduction of IMEG dramatically reduced the number of complaints with care concerns that were not previously identified. This volume has not increased.
  - Junior Dr feedback suggests that the process has changed their practice and it is likely that care is improving as a consequence of IMEG. We additionally share learning with the teams but when relevant to the hospitals through OWL. However the direct hot feedback to the medical team is possibly the most powerful influence.
- All deaths which are required to be reported to HM Coroner are now referred electronically.

## 3 Appendices

Appendix 1 **IMEG and mortality review process (Full Year – 2018/19)**

Appendix 2 **IMEG and mortality review process (Q1 – 2019/20)**

Appendix 3 **Paediatric mortality review process (CDAD) (Full Year – 2018/19)**

Appendix 4 **Paediatric mortality review process (CDAD) (Q1 – 2019/20)**

## 4 Data Analysis

Outstanding reviews and data analysis for the whole of 2018/19 is now complete, the full detail are set out below in appendix 1. Overall, the number of adult deaths deemed to have probably have been avoidable (>50:50) was 7, or <1% of the total number of adult deaths reviewed. Of these, there was strong evidence of avoidability in only 1 case, with none identified as definitely avoidable.

In the first quarter of this year, 606 deaths were reviewed at IMEG, this is slightly up from last year but not a significant jump. All cases get assigned an initial avoidability rating and get adjusted if any

changes are needed, however, all Urgent Case reviews, TMRG and M&M questions have been reviewed and avoidability scores have been update, showing 1 case, or <1% of the total number of deaths reviewed have been deemed as probably avoidable, no cases are reported as having strong evidence of avoidability nor definitely avoidable. On average cases being sent to M&M are similar to previous years, while cases being sent for TMRG review has slightly risen from last year, the number of cases being sent for an urgent case review has dropped. These figures could be due to the medical examiners system being brought in and the introduction of discussions being had with the families when concerns of care are being raised at an early stage in the bereavement process.

Whilst there is no national requirement to report paediatric deaths at trust board level, it seems appropriate to demonstrate that we are providing a similar level of scrutiny for patients of all ages within the trust. We have therefore included details of the number of paediatric death reviews undertaken by the Child Death and Deterioration Group (CDAD).

All outstanding reviews for paediatric patients have been completed for 2018/19 , the full details are set out below in appendix 3. Overall, the number of deaths deemed to have been at least probably avoidable (>50:50) was 2 or 8 % of the total number of deaths reviewed, .

In the first quarter of this year there have been 9 paediatric deaths, this is almost doubled compared to the same quarter last year, however given the small numbers this is not significant on its own and none of these deaths have been classified as probably avoidable. It is notable that overall the proportion of paediatric deaths that are classified as at least probably avoidable is substantially higher than in the adult population. This reflects the different case mix and the very low death rate in paediatric patients, so proportionately avoidable deaths appear much higher. Paediatric patients are also extremely vulnerable when severely unwell and adverse events which adults would normally tolerate can result in a fatal outcome within this patient group. Nonetheless now that CDAD has been in operation for approximately five years it would merit the thematic review of all paediatric deaths rated at least possibly avoidable to see what trends and lessons could be identified. (Action NP to discuss with Jason Barling and Mark Alderton)

With the overall rise in deaths in quarter 1 of the financial year 2019/20, for both adult and paediatric cases, this can be seen as potentially reflecting several factors:

the natural rise in population, with a high proportion of the elderly living on the South coast  
possibly a trend towards inpatient rather than community end of life care  
being a tertiary centre for many specialities we get the sickest patients and ultimately we will have a rise in mortality.

these trends need to continue to be monitored and consideration given to what could be done to facilitate end-of-life care in the community and repatriation of terminally ill tertiary patients for end-of-life care closer to home where appropriate.

However overall the HSMR for UHS remains below that which is expected for us as a trust.

## **5 Next Steps**

Introduction of a non-statutory Medical Examiner Service within acute hospital Trusts began on 1st April 2019. A business case has been presented to the Trust's executive committee setting out the requirements of delivering this service. This has now been approved subject to final sign off to support the resource required to implement the national medical examiners service being confirmed. This is in large part dependent on NHS England confirming the financial reimbursement that they will provide for review of deaths not involving cremation and cases subsequently referred to the coroner. The introduction of the new service has necessitated the Medical Examiner of the day spending greater time reviewing each case and, where applicable, completing cremation form

5. The income from this will be used to support the service along with an additional payment from NHSI for HMC, burial and paediatric cases (as of yet unspecified amount). However, with this increased commitment, there has been a reduction in the number of Consultants able to undertake reviews and additional resource needs to be identified in order to ensure there is sufficient cover available every day and that this cover is sustainable. Over the next quarter we will employ some additional administration support and look to streamline the service to improve on the turnover time and . In quarter three we will need to advertise for a clinical medical examiner's officer to further facilitate and streamline the mortality review process in lines with national guidance for the mandatory medical examiner service. When the business case has been formally approved we will seek to recruit internally to increase our number of medical examiners.

We will continue to work with partners. The process has been shared and adopted by Solent and we are looking at joint learning and will look to support and move investigations with other providers. We have been in negotiation with southern health to consider provision of a medical Examiner service at Lymington.

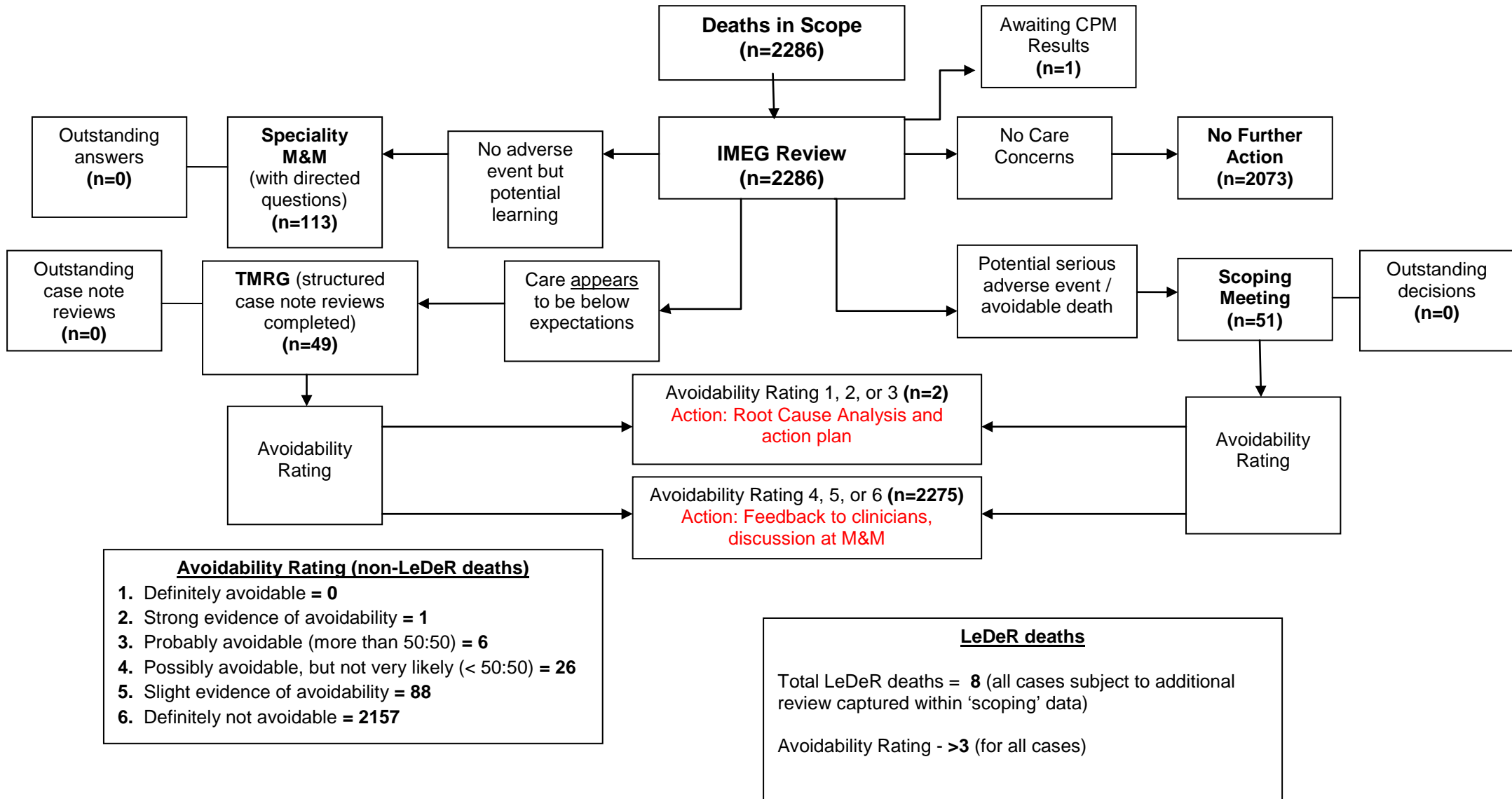
## **6 Recommendation**

It is recommended that members of Trust Board continue to support the evolution of mortality review within UHS.

A thematic review of avoidability and avoidable features in paediatric death over the last five years needs to occur.

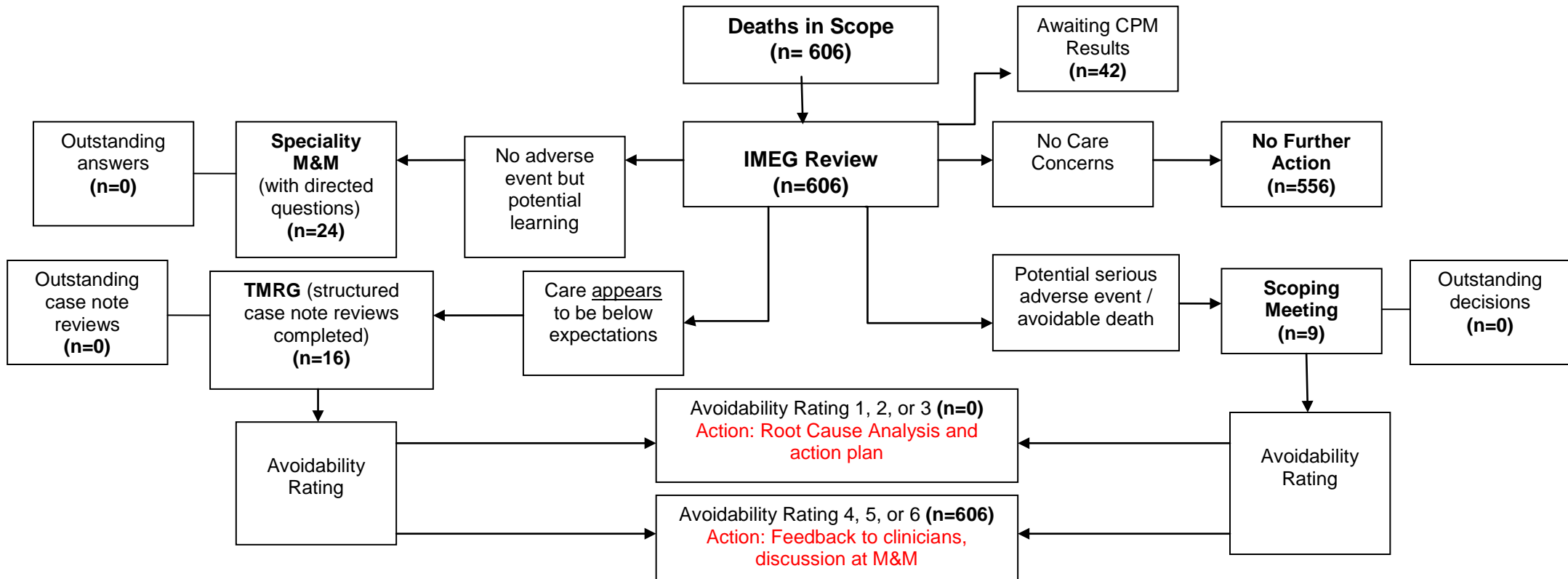
**Appendix 1**

**IMEG and mortality review process (Full Year – 2018/19)**



**Appendix 2**

**IMEG and mortality review process (Q1 – 2019/20)**



**Avoidability Rating (non-LeDeR deaths)**

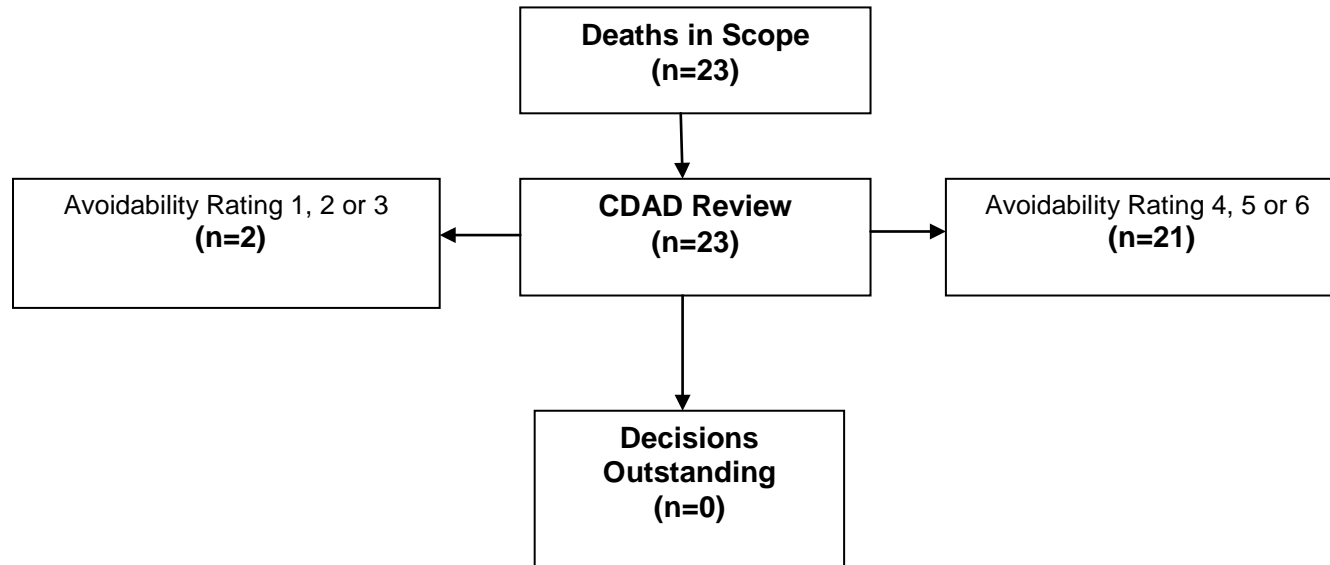
1. Definitely avoidable = 0
2. Strong evidence of avoidability = 0
3. Probably avoidable (more than 50:50) = 1
4. Possibly avoidable, but not very likely (< 50:50) = 5
5. Slight evidence of avoidability = 23
6. Definitely not avoidable = 576

**LeDeR deaths**

Total LeDeR deaths = 1 (all cases subject to additional review captured within 'scoping' data)

Avoidability Rating – 6

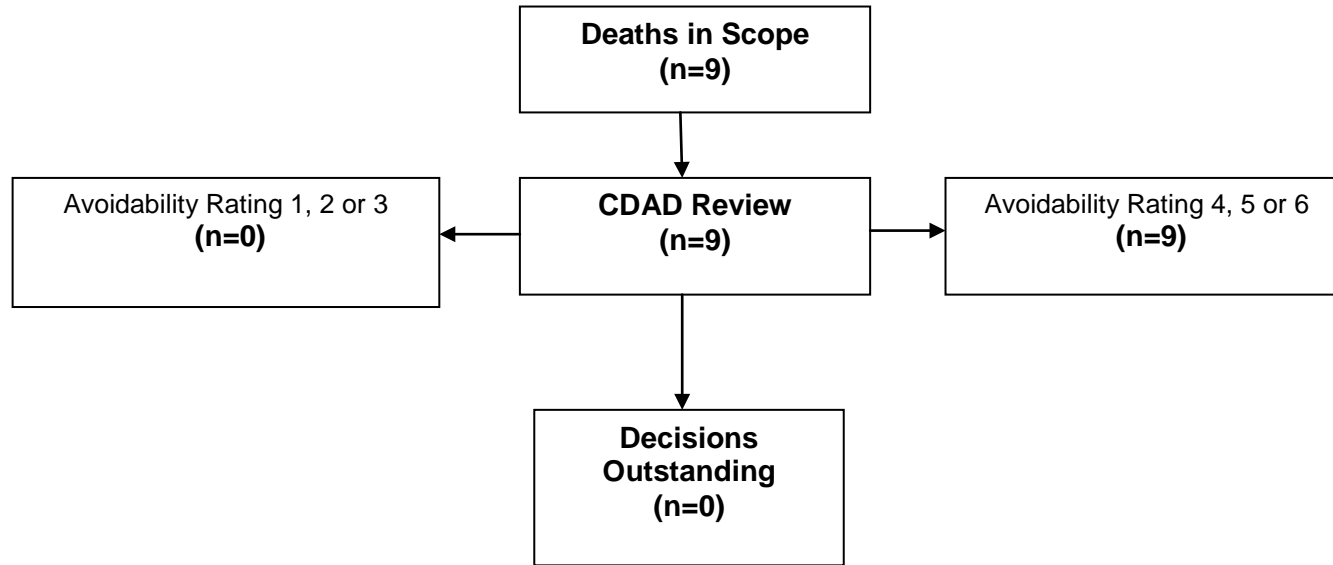
**Paediatric mortality review process (CDAD) (Full Year – 2018/19)**



**Avoidability Rating**

- 1. Definitely avoidable = 0
- 2. Strong evidence of avoidability = 1
- 3. Probably avoidably (more than 50:50) = 1
- 4. Possible avoidable, but not very likely (<50:50) = 2
- 5. Slight evidence of avoidability = 5
- 6. Definitely not avoidable = 14

**Paediatric mortality review process (CDAD) (Q1 – 2019/20)**



**Avoidability Rating Avoidability Rating**

1. Definitely avoidable = 0
2. Strong evidence of avoidability = 0
3. Probably avoidably (more than 50:50) = 0
4. Possible avoidable, but not very likely (<50:50) = 2
5. Slight evidence of avoidability = 5
6. Definitely not avoidable = 2

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: CRN: Wessex 2019/20 Quarter 1 Performance Report</b>			
<b>Category</b>	Quality, Performance, and Finance		
<b>Agenda item</b>	10.2		
<b>Sponsor</b>	Medical Director		
<b>Author</b>	Graham Halls, Business Intelligence Manager and Rebecca McKay, Chief Operating Officer		
<b>Provenance</b>	Q4 2018-19 report submitted at the UHS Board meeting on 30 April 2019		
<b>Classification</b>	This Report is unclassified.		
<b>Purpose and recommendation</b>	<p>The paper is presented for INFORMATION.</p> <p>Summary:</p> <ul style="list-style-type: none"> <li>Over 9,200 research participants were recruited in quarter one 2019/20. This was 15% below the year to date recruitment target, but in line with national performance.</li> <li>Wessex achievement on other key objectives is strong – 100% of Wessex led non-commercial studies closed meeting recruitment to time and to target and study setup times were below the national median.</li> </ul> <p>Recommendation:</p> <ul style="list-style-type: none"> <li>Board to note CRN Wessex’s plan to address the shortfall in recruitment by: <ul style="list-style-type: none"> <li>requesting a revised year end position from partner organisations by 30 September 2019.</li> <li>reviewing and acting on the revised recruitment forecast as required. Possible actions may include an incentivising activity model as this approach was previous effective in increasing research activity.</li> </ul> </li> <li>Monitor activity and performance via quarterly progress reports and the agreed assurance framework in appendix 1</li> </ul>		
<b>Relevant strategic goals</b>	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people’s needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<p>The CRN Wessex assurance framework is included in appendix one to this report.</p> <p>Risks identified on UHS risk registered: CRN01 - Loss of income. CRN Wessex receives their annual financial</p>		

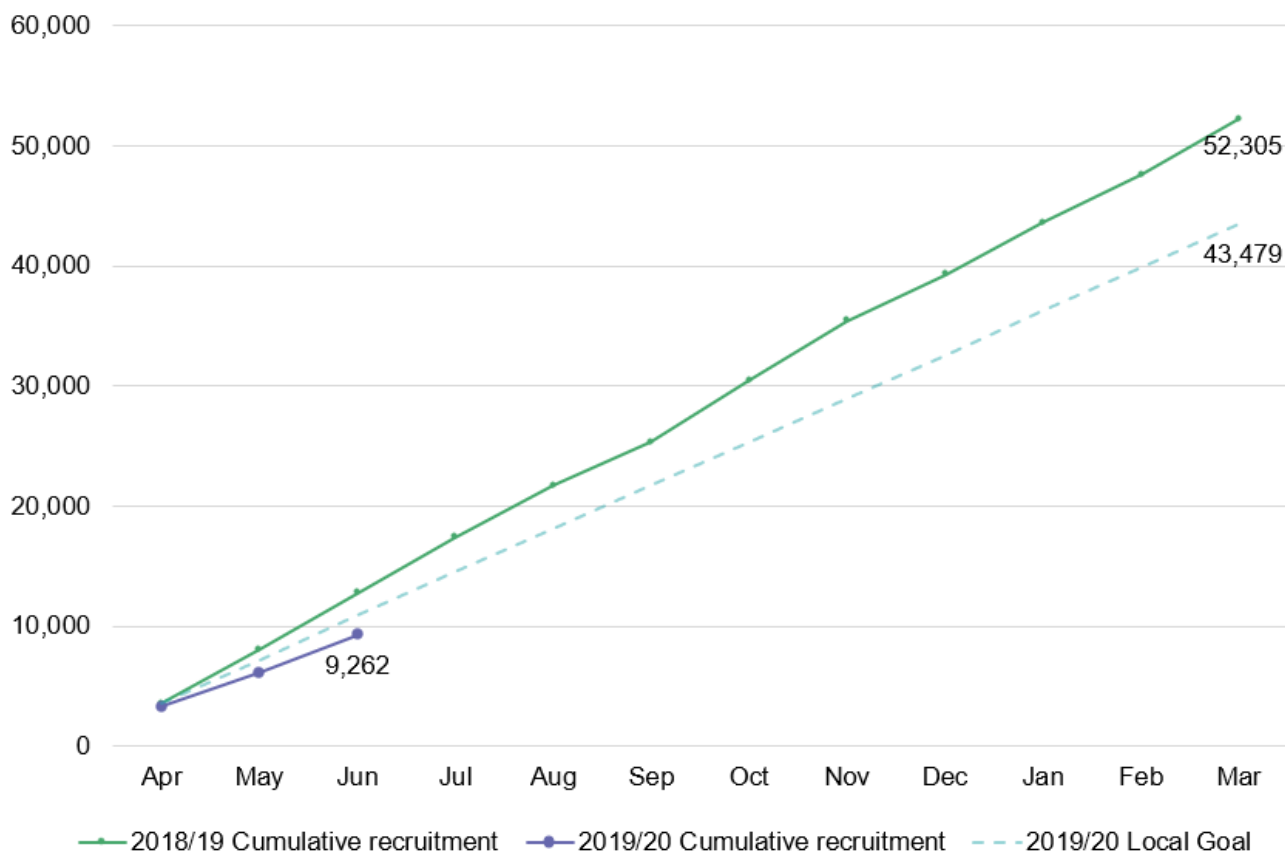
	<p>allocation from the NIHR CCRN based on recruitment activity in the preceding financial year. Any fall in recruitment can result in a fall in income if other LCRNs have maintained or increased their recruitment in the same period.</p> <p>CRN02 - Reduced or no contingency funding may create a lack of flexibility of resource placement.</p> <p>CRN03 - LCRN host contract renewal due 31 March 2022</p> <p>CRN1497 - Decrease in commercial studies seeking adoption. Reduction in portfolio activity and commercial income.</p>
<b>Impact assessments</b>	N/A
<b>Other standards affected</b>	CQC Well-led Framework section W8 (research)

## 1. Introduction or Background

- 1.1 University Hospital Southampton NHS Foundation Trust (UHS) hold a contract with the Department of Health and Social Care to host the local research network – CRN Wessex. The purpose of CRN Wessex is to provide efficient and effective support to the partner organisations for the initiation and delivery of funded research in the NHS. Some of the research is funded by the National Institute for Health Research (NIHR), but most is funded by other non-commercial partners and the pharmaceutical industry. This activity makes an important contribution to improve the health of the population and to support economic growth.
- 1.2 CRN Wessex aims to:
  - 1.2.1 Promote equality of access, ensuring that wherever possible, patients have parity of opportunity to participate in research
  - 1.2.2 Improve the quality, speed and co-ordination of clinical research by removing the barriers to research in the NHS
  - 1.2.3 Streamline and performance manage NHS support for eligible studies to ensure the NHS service support costs of these studies are met in a timely and efficient manner.

## 2. Analysis and Discussion

- 2.1 The performance of Local Clinical Research Networks (LCRNs) is primarily measured on the number of research participants enrolled on to NIHR portfolio research projects. Research recruitment represents opportunities for the population to take part in research that the NIHR considers high quality. Research can also be a source of funding for participating organisations and the wider NHS.
- 2.2 Chart 1a shows CRN Wessex's performance against our agreed target of 43,479 for this financial year, along with recruitment in 2018/19. CRN Wessex was 15% below the year to date recruitment target in quarter one. At the time of writing this deficit has continued into quarter two and therefore actions to mitigate this risk have been listed in the Recommendation section.



**Chart 1a: Research recruitment against annual goal in Wessex – Q1 2019/20**

2.3 A comparison of quarter one recruitment in the 2018/19 and 2019/20 financial years (chart 1b) highlights that the deficit in research activity has been experienced across 13 of 15 LCRNs, with the national average at -29%. Two networks have increased activity (South London and West Midlands) due to a large London mental health study and a School of Public Health study respectively.

2.4 A review of the median study sample size in England shows that this has fallen by 19% since first recorded in 2008/09. The number of recruiting studies has also decreased by 13%. Both factors may have contributed to the dip in recruitment and it should be recognised therefore that CRN Wessex are operating in a challenging environment.

Local clinical research network	2018/19 Q1	2019/20 Q1	Variance
East Midlands	16,953	11,534	-32.0%
Eastern	14,309	7,040	-50.8%
Greater Manchester	23,314	16,239	-30.3%
Kent, Surrey and Sussex	12,721	8,854	-30.4%
North East and North Cumbria	14,083	5,729	-59.3%
North Thames	21,871	15,490	-29.2%
North West Coast	11,203	5,215	-53.4%
North West London	12,213	5,960	-51.2%

South London	20,750	22,448	8.2%
South West Peninsula	8,553	4,980	-41.8%
Thames Valley and South Midlands	13,676	13,001	-4.9%
<b>Wessex</b>	<b>12,750</b>	<b>9,262</b>	<b>-27.4%</b>
West Midlands	19,146	23,339	21.9%
West of England	7,426	4,184	-43.7%
Yorkshire and Humber	25,141	12,689	-49.5%
<b>Total</b>	<b>234,109</b>	<b>165,964</b>	<b>-29.1%</b>

**Chart 1b: Research recruitment by LCRN – Q1 2018/19 versus Q1 2019/20**

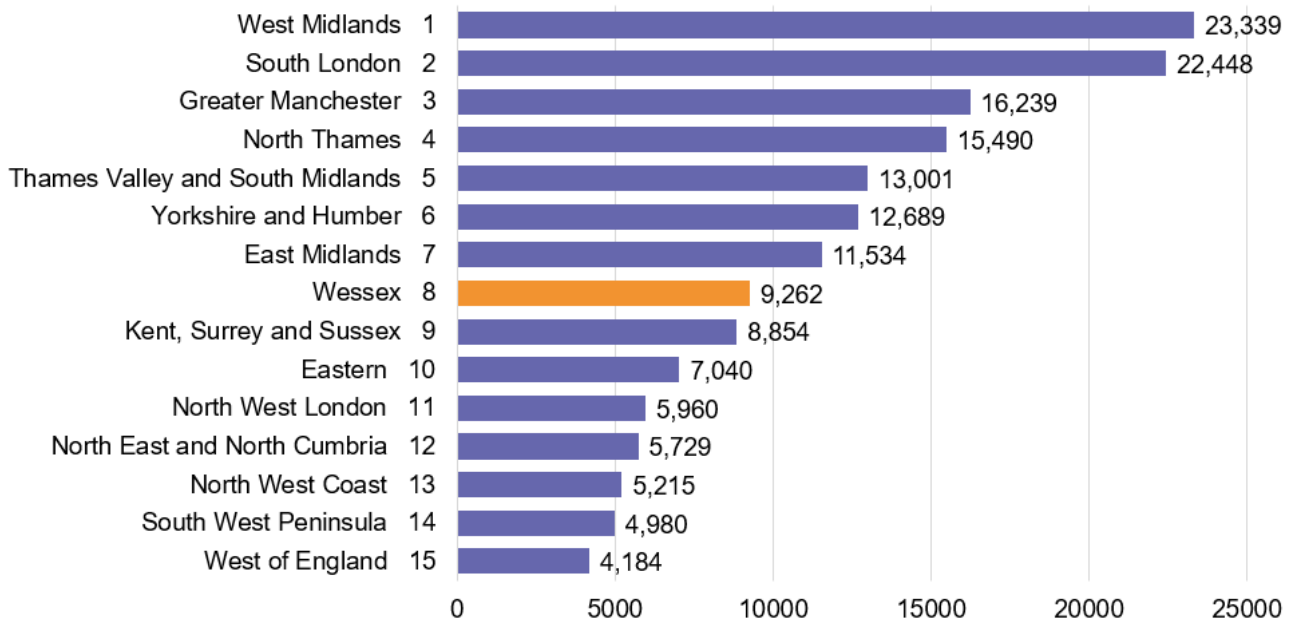
- 2.5 The National Institute for Health Research (NIHR) have assigned CRN Wessex high level objectives (HLOs) for 2019/20 and the definitions and local performance in quarter one is shown in chart two. The performance of these objectives across England is included for comparison.
- 2.6 Commercial recruitment (HLO 1b) has fallen. The CRN industry team are working with partner organisations to promote site participation in commercial research studies and timely study set-up. Pharmacy set-up times have been flagged as a significant risk. Robust feasibility before each study agrees to participate is essential. The industry team is planning a Wessex workshop on feasibility led by Portsmouth, who achieved 100% of their HLO 2a target in quarter one. Compared with 77% for UHS and 50% for RBCH.

High Level Objective	Measure	Target	CRN Wessex	National status	
<b>HLO 1</b>	Deliver significant levels of participation in NIHR CRN Portfolio studies	(a) All studies	43,479	9,262	Amber
		(b) Commercial only	2,000	276	Red
<b>HLO 2</b>	Increase the proportion of studies delivering to recruitment target and time	(a) Commercial RTT (number of participating sites)	80%	72%	Amber
		(b) Non-Commercial RTT (number of Wessex led studies)	80%	100%	Green
<b>HLO 3</b>	Number of commercial studies recruiting in year (cumulative)	(a) Number of new commercial contract studies entering the NIHR CRN Portfolio	-	11	Green
<b>HLO 6</b>	Widen participation in research by enabling the involvement of a range of health and social care providers	(a) Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	92%	Green
		(b) Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies (commercial only)	70%	67%	Amber

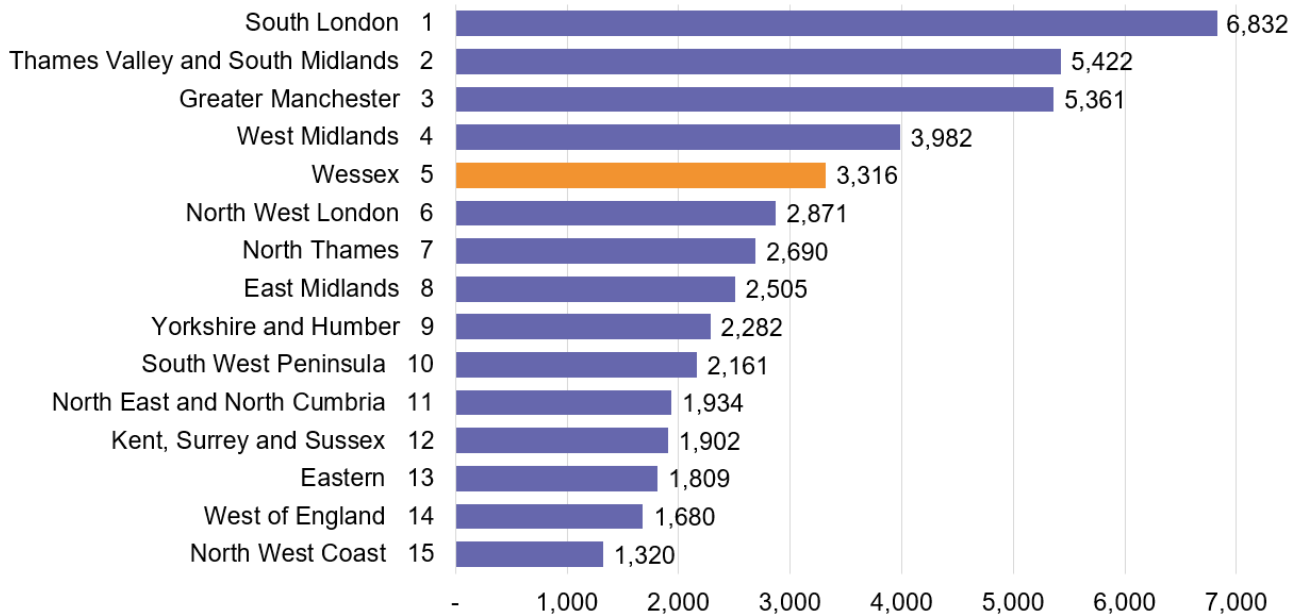
		(c) Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	45%	19% (54 sites)	Red
		(d) Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	2,065 (National target)	9 (not locally measured)	Red
<b>HLO 7</b>	Deliver significant levels of participation in NIHR CRN Portfolio Dementias and Neurodegeneration (DeNDRoN) studies	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	688 (2019/20)	573	Green
<b>HLO 9</b>	Reduce study site set-up times for NIHR CRN Portfolio studies by 5%	(a) Median study site set-up time for commercial contract studies, at confirmed Network sites	80 days	46 days	Green
		(b) Median study site set-up time for non-commercial studies	62 days	43 days	Green

**Chart 2: Performance against NIHR High Level Objectives in Wessex - Q1 2019/20 compared with national performance**

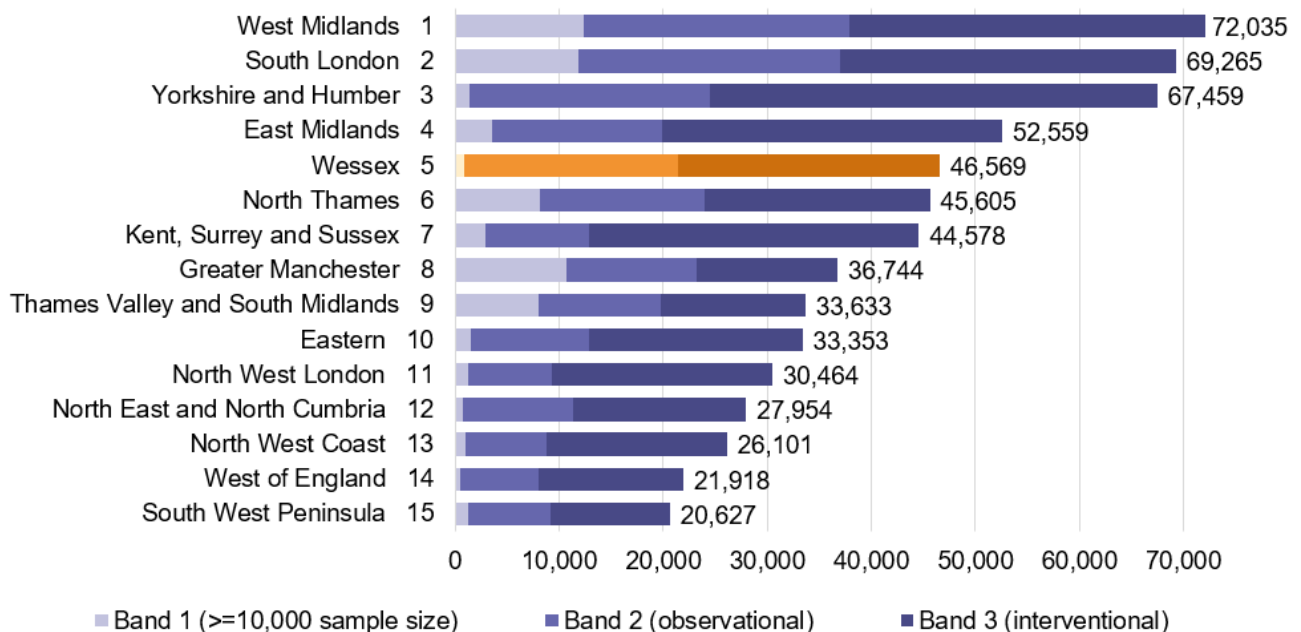
2.7 CRN Wessex recruitment performance is benchmarked against the other LCRNs on a range of measures. Charts 3a-c show the network's rank for unweighted, population weighted and complexity weighted recruitment. CRN Wessex consistently ranks in the top five LCRNs for the weighted measures, indicating we reach more of our population with interventional research that offers patients novel treatment pathways. Please see the glossary in appendix two for further information on complexity weighting.



**Chart 3a: Research recruitment by LCRN – Q1 2019/20**

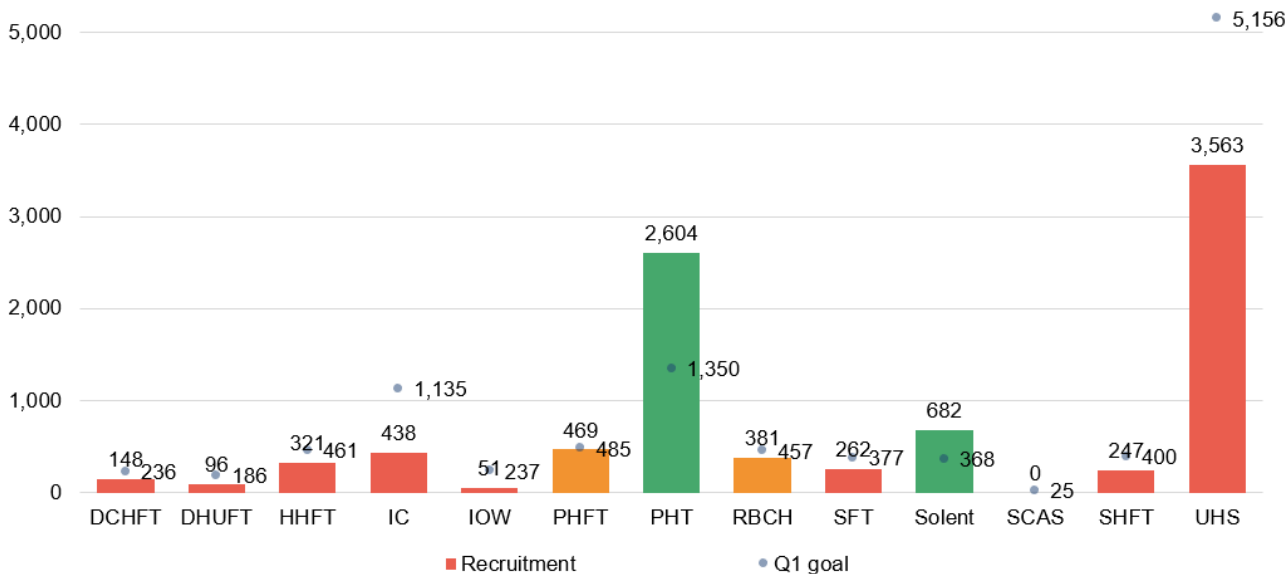


**Chart 3b: Research recruitment adjusted for population by LCRN (recruitment per million residents) – Q1 2019/20**



**Chart 3c: Research recruitment weighted for study complexity by LCRN – Q1 2019/20**

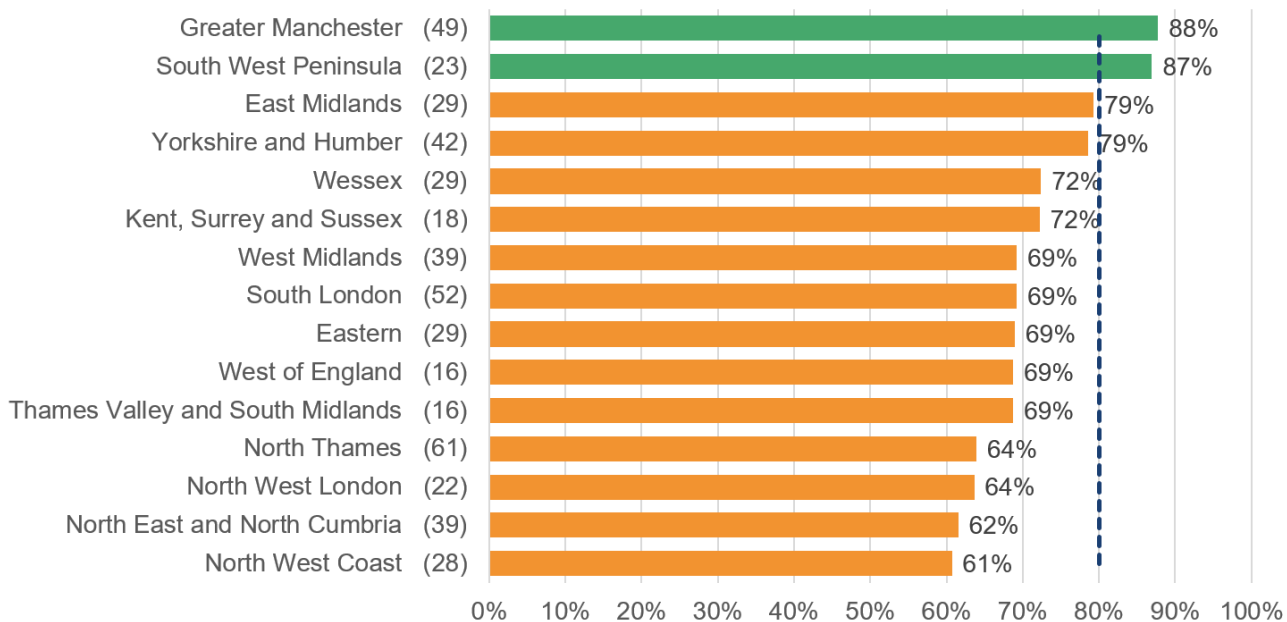
2.8 The performance of CRN Wessex partner organisations against their quarter one recruitment goals is shown in chart four. The performance is red / amber / green rated depending on whether the organisation is achieving their goal (green), within 20% (amber) or not currently meeting the goal (red). Most organisations are not meeting their goal which is in line with the network’s collective performance. The proposed actions to address this are in the recommendation section of this report.



IC = Independent Contractors refers to, but is not exclusive to; GP Surgeries, pharmacies, private healthcare

**Chart 4: Recruitment by CRN Wessex partner organisation against goal – Q1 2019/20**

2.9 Performance on high level objectives 2a and 2b is related to meeting the recruitment target within a stated timescale on commercial and non-commercial studies respectively. This is monitored closely because it is a measure of whether Wessex organisations can reliably deliver research and forms part of the criteria for the funding model. Chart 5a shows that Wessex performance for commercial research was below the NIHR’s 80% target, but above the English average.



**Chart 5a: Percentage of sites commercial studies recruiting to target and in time by LCRN - Q1 2019/20**

2.10 CRN Wessex partner organisations have closed six locally led non-commercial studies in quarter one and all have met their target within their stated timelines (chart 5b).



**Chart 5b: Percentage of LCRN led non-commercial studies recruiting to target and in time by LCRN – Q1 2019/20**

### 3. Conclusion

- 3.1 In quarter one CRN Wessex was demonstrating mixed performance on the NIHRs high level objectives. This performance is however in line with that seen across England. The fall in number of studies and recruitment is a financial risk, but a focus on existing open projects and maintaining short study set-up times is expected to result in improved performance before the end of the financial year.
- 3.2 The UHS Board will be updated on progress during 2019/20 with quarterly performance reports and issues escalated via the assurance framework in appendix 2.

### 4. Recommendation

Note CRN Wessex’s plan to address the shortfall in recruitment by:

- 4.1.1 requesting the revised year end position from our partner organisations by 30 September 2019.
- 4.1.2 reviewing and acting on the revised recruitment forecast as required. Possible actions may include incentivising research recruitment at CRN Wessex partner organisations as this approach was previous effective in increasing research activity.
- 4.2 monitor activity and performance via quarterly progress reports and the agreed assurance framework in appendix 1

## 5. Appendices

### 5.1 Appendix 1 - CRN Wessex assurance framework

<b>Meetings<sup>1</sup></b>	<b>Reports<sup>2</sup></b>	<b>Other</b>
1:1 Executive Partnership	Performance Finance Annual Patient survey	Internal finance audit Benchmarking National review Risk register Business planning Performance reviews

#### **1:1 meetings**

CRN Wessex chief operating officer meets with host executive with responsibility for host contract quarterly.

#### **Executive group meetings**

CRN Wessex executive group meets monthly.

#### **Partnership group meeting**

CRN Wessex group meets three times a year in April, October and January.

#### **Performance report**

CRN Wessex provides a quarterly performance report to the host board.

#### **Finance report**

CRN Wessex provides as quarterly finance report to the host assistant director of finance.

#### **Annual report**

CRN Wessex collaborates with partner organisations to collate an annual report that is submitted to the host for approval and then the NIHR CRN CC.

#### **Patient survey report**

The network conducts an annual survey of patients participating in research. The survey engages with and asks patients about their experiences of taking part in clinical research provides research professionals with a wealth of information which helps to shape how research is designed, conducted and delivered.

#### **Internal finance audit**

Every three years, with the most recent audit in December 2018.

#### **Benchmarking**

<sup>1</sup> All governance groups have been convened in accordance with the NIHR CRN CC Performance and operating framework with terms of reference

<sup>2</sup> All reports are submitted using agreed standard templates

CRN Wessex has an open data platform that provides real time bench marking data. These data are reported to the executive group, partnership group and host board.

### **Review**

CRN Wessex has a review meeting every six months with NIHR CRNCC attended by clinical director, chief operating officer, executive from host with responsibility for the contract and partnership group chair.

### **Risk register**

The register forms part of the host's register and is reviewed every six months

### **Business planning**

Formal 1:1 business review and planning meeting with partner organisations annually.  
Ongoing informal performance reviews with members of the CRN Wessex Operational Management Group.

## 5.2 Appendix 2 – Glossary

Ratios used for weighting complexity of recruitment (non-commercial recruitment only):

- Band 1 - Large Scale interventional or observation studies with a >10,000 participant target (1:1)
- Band 2 - Observational design (1:3.5)
- Band 3 - Interventional design studies (1:11)

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHUFT - Dorset Healthcare University NHS Foundation Trust
- HHFT - Hampshire Hospitals NHS Foundation Trust
- IOW - Isle of Wight NHS Trust
- IC – Independent contractors, including but not limited to primary care and non-NHS organisations
- PHFT - Poole Hospital NHS Foundation Trust
- PHT - Portsmouth Hospitals NHS Trust
- SFT - Salisbury NHS Foundation Trust
- Solent – Solent NHS Trust
- SCAS - South Central Ambulance Service NHS Foundation Trust
- SHFT - Southern Health NHS Foundation Trust
- RBCH - The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust

<b>Report to the Trust Board of Directors dated Thursday, 26 September 2019</b>			
<b>Title: Informatics Report</b>			
<b>Category</b>	Quality, Performance, and Finance		
<b>Agenda item</b>	10.3		
<b>Sponsor</b>	Director of Transformation and Improvement		
<b>Author</b>	Adrian Byrne		
<b>Provenance</b>	Report to Trust Board		
<b>Classification</b>	<b>This Report is unclassified.</b>		
<b>Purpose</b>	<p>The paper is presented for INFORMATION.</p> <p>This is bi-monthly report on progress with informatics programme, regularly reported due to breadth of projects and impact on the business.</p> <p>Presented to TEC 11 September 2019.</p>		
<b>Relevant strategic goals</b>	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input checked="" type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<b>Assurance framework links</b>	<ul style="list-style-type: none"> <li>• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways</li> <li>• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6</li> <li>• BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme</li> <li>• BAF04 – Reduced access to resources compromises the quality of services</li> <li>• BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services</li> <li>• BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider</li> </ul>		
<b>Impact assessments</b>	n/a		
<b>Other standards affected</b>	n/a		

## 1. Overview

- 1.1. The objectives for the new digital strategy (under development) will underpin the UHS corporate goals and clinical strategy with digital systems, world class digital services to support “world class care for everyone”.
- 1.2. In line with the national digital strategy recently announced by NHSX, the ambition is to:
  - Reduce burden on staff so they can focus on patients
  - Provide patient access to digital tools to enhance their care
  - Provide safe and easy access to clinical information
  - Improve patient safety and care
  - Increase trust efficiency and productivity
- 1.3. There is a constant need to ensure that the plan is not led by technology drivers alone. The UHS Digital Strategy work has consulted with over a hundred staff and the appointment of CCIOs/CNIO will continue to ensure that a good balance is maintained.
- 1.4. The Digital strategy will be discussed at a trust board study session in September 2019, prior to review at Digital Board and finalization over the coming month. The work has taken in drivers from the national plan and incorporated themes from the emerging clinical strategy. Divisional management teams are feeding into the direction and priorities and will in future be engaged in a way that ensures that their priorities are addressed.
- 1.6. It is recognised that it is important to receive digital user feedback. A major survey was undertaken last year of the consultant body and this has been built into the development of the new draft Digital Strategy, similarly there is a junior doctor’s forum regularly feeding back their views. In 19/20 we will work with KLAS [ARCH collaborative] to undertake a more systematic feedback exercise and feed this into the regular reports.
- 1.5. A significant element of the current strategy is to increase digital maturity as a part of the Global Digital Exemplar (GDE) programme, achievement will be measured against the HIMSS EMRAM [model]. This is a measure of a paperless organization in line with overall national objectives (see [PHC 2020](#) and [NHS long term plan \[Chapter 5\]](#)). The trust is receiving £10m of national funding contributing to this and has committed to a set of associated projects. The final 2 payments (equal to £2.5m) are contingent on the delivery of the programme and achievement of HIMSS level 7 equivalence. The meeting with NHS Digital that was due to happen in August has been postponed due to availability and is now scheduled for the 8<sup>th</sup> Oct.
- 1.6. The trust IT programme is juggling priorities with the HIMSS objective impacting work that has been commissioned by the junior doctor working group.
- 1.7. A digital board has been created to assure the programme. The risks to HIMSS level 7 achievement and Microsoft licencing have been escalated to this Board and are outlined in this report.

## 2. Analysis and Discussion

### Work this quarter:

- 2.1. The setting up of work plans for the new CCIO arrangements is underway and regular sessions are planned to enable this to develop.
- 2.2. The CNIO role has not yet been recruited but this is planned for the next few months.
- 2.3. The CCIOs along with the CNIO role are an important next step in the development and delivery of the strategy. Capability has come a long way, but we now need to drive adoption and pick the right tools, selecting the right priorities. For example, over 1m pieces of paper per month are currently being hand written and scanned in. The data held on these forms is repetitive, cannot be interrogated and doesn’t allow automated decision support. The drive to move this to a digital environment is the next major piece of work and fits with our ambition to reduce the burden on staff so they can focus on patients, provide safe and easy access to clinical information, improve patient safety and care and increase trust efficiency and productivity. An options appraisal is being developed and will be presented to Digital Board.
- 2.4. Having acquired the IP for CHARTS (HICSS, eQuest, eDocs) from EMIS, along with the recruitment of staff to develop these products, we are now addressing the commercial nature of the

products. 26 other organizations use the endoscopy part of the suite, and indications are that they would like to continue. Discussions are ongoing, but care must be taken not to adversely affect the UHS work programme. UHS could work through a commercial partner.

#### Current work, next quarter:

- 2.5. My Medical Record continues to grow significantly and has around 25,000 registered users. This will be used to drive a savings project over the coming months as we start to switch off paper with the patient's consent. The trust sends over 1m letters annually to patients through a contract with Synertec and directly through post services.
- 2.6. Work on the My Medical Record project for Maternity (My Maternity Record) is about to move into pilot phase across Hampshire. The team were requested to showcase this work at NHS Expo at the beginning of Sept.
- 2.7. A large piece of development work has been specified to bring the discharge summary up to date. The process in place is now very old, and no longer fit for purpose. It has been agreed that this work will be delivered in phases with some urgent fixes in particular addressing a system crashing issue to be delivered in the next quarter.
- 2.8. CHARTS eTCI is a new electronic process to replace paper yellow TCI (To Come In) cards via the CHARTS application.

The process is simple and intuitive for clinicians, completely paperless, providing a safe and fully auditable way of adding patients to waiting lists for elective surgery.

As a trust, we can process 60,000/70,000 patient waiting list entries per year, across all areas & specialities. The system has various benefits including the auditability and elimination of the risk of losing cards in the old system.

- 2.9. The trust digital programme including My Medical Record had a piece published in the [Daily Telegraph](#).



#### Other Risks and Issues

- 2.5 Risks in Microsoft and the licences plus the age of desktops mentioned in the previous report are still being worked upon. There is a significant potential cost pressure on Microsoft licenses.

### **3. Recommendation**

- 3.1. To note the report and progress

## Glossary and Abbreviations

CCIO	Chief Clinical Information Officer. A post created to advance the usability and adoption of digital in health organizations
CHARTS	The core of the UHS Electronic Patient Record (EPR) whose Intellectual Property (code) is now wholly owned by UHS
CNIO	Chief Nursing Information Officer. A companion role to CCIO with nursing and AHP focus.
EMIS	An IT company who own a number of products used at UHS (ED system and patient administration)
EMRAM	The Electronic Medical Records Adoption Model. An inpatient focussed measure of digital maturity, largely about paperless working, coded data and decision support.
GDE	A programme of work set up under NHSE three years ago to improve digital maturity in the NHS. In acute hospitals this has largely been about the HIMMS EMRAM model
HIMMS	Health Information Management Systems Society. US organization and owner of EMRAM
KLAS	A US research organization who are involved with UHS for user satisfaction – peer review
LIMS	Laboratory Information System
My Maternity Record	A specific build of My Medical Record for maternity
My Medical Record	The on line service offered by UHS to its patients, and to other health organizations for theirs
NHSX	New joint NHS organization set up to lead digital, data and technology
PACS	Picture Archiving (digital X-Ray system)
SWASH	Salisbury, Wight and South Hampshire. A consortium for sharing imaging data (PACS) through common supplier contracts
Workplace	The UHS Facebook-like communication platform, hosted by Facebook