University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	27/06/2019
Time	9:00 - 11:35
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins
Apologies:	Gail Byrne (Juliet Pearce deputising), Jane Hayward (Tristan Chapman deputising), Caroline Marshall (Andrew Asquith deputising)

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 May 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**
9:30		Jane Bailey, Non-Executive Director
4.3		**Integrated Performance Report for Month 2 for review**
9:35		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
4.4		**Maternity Service Self-Certification - NHS Resolution 10 Criteria for review**
10:20		Sponsor: Gail Byrne, Director of Nursing & Organisational Development
		Attendees: Suzanne Cunningham, Director of Midwifery & Professional Lead for Neonatal Services and Marie Cann, Midwifery Quality Assurance Manager
4.5		**Finance Report for Month 2 for review**
10:30		Sponsor: David French, Chief Financial Officer

5 **Strategy and Business Planning**

5.1 **Trust Vision, Mission and Staff Voice for approval**

10:40 Sponsor: Paula Head, Chief Executive Officer

Attendees: Tristan Chapman, Deputy Director of Improvement & Partnerships and group of UHS staff members

6 **Corporate Governance, Risk and Internal Control**

Including compliance with the NHS Provider licence conditions.

6.1 **Review of Board Committees Terms of Reference for approval**

11:10 Sponsor: Peter Hollins, Trust Chair

6.2 **NHS Provider Licence Conditions Compliance Self-certification for approval**

11:15 Sponsor: Paula Head, Chief Executive

Attendee: Charlie Helps, Company Secretary

6.3 **7-Day Hospital Services Self-Assessment for approval**

11:20 Sponsor: Derek Sandeman, Medical Director

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

11:25 For ratification in accordance with the Trust Standing Orders, Financial Instructions, and the Scheme of Delegation.

Sponsor: Peter Hollins, Trust Chair

7 **Any other business**

11:30

8 **To note the date of the next meeting: Thursday 30 July 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**

24 May 2019

Press Release: Trauma experts trial use of new enhanced blood transfusion to improve survival

31 May 2019

Press Release: Southampton doctors trial gene therapy for severe bleeding disorder

2 June 19

Press Release: UK woman pain-free after 40 years following world-first nerve stimulation implant procedure

4 June 19

Press Release: Eye experts first in UK to use precision laser to split corneal tissue

7 June 2019

Press Release: Hospital trust celebrates achievements of “outstanding” volunteers

14 June 2019

Press Release: Leading doctor says healthcare staff should routinely advise patients on reducing air pollution

20 June 2019

Press Release: Knee surgeon says warming up before park kickabouts should be “routine and socially acceptable”

11 **Follow-up discussion with governors**

11:35

12 **Clinical Visit - Division C**

11:50

13 **Lunch**

13:05

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30 May 2019
Time	9:00 – 11:30
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins (PTH)
Present	Jane Bailey, Gail Byrne, Cyrus Cooper, Jenni Douglas-Todd, David French, Jane Hayward, Paula Head (PHe), Charlie Helps, Caroline Marshall, Simon Porter, Mike Sadler and Derek Sandeman
In Attendance	Adrian Byrne, Steven Harris, Joanne Mountifield, Sandra Hodgkyns, 1 appointed governor, 1 member of the public, 1 staff member
Minutes	Vicky Boland

1 Chair's Welcome, Apologies and Declarations of Interest

To note received apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.

The Chairman welcomed those present, noted apologies received 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 April 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

To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.

Action item 7) Care Quality Commission (CQC) - GB provided an oral update to the May Quality Committee. The action plan was due for submission to the CQC on 28th May 2019 and would be shared with the Committee once finalised.

Action item 0) IPR Annual Report Safe - JH agreed to circulate the headlines from the David Dalton report.

Action item 5) Research and Development (R&D) - R&D key performance indicators (KPIs) were still in development but these would be monitored through the Strategy and Finance Committee.

Action item 6 was not due for completion until 27th June 2019.

4 Quality, Performance and Finance

4.1 Patient Story

To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.

Derek Sandeman, Medical Director

DS introduced the patient. The Board heard a first-hand account of their patient experience noting the lack of explanation of their sight impairment diagnosis which impacted upon their expectations following this life-changing event. There was also a delay in diagnosis which could have occurred at the bedside as an inpatient and a lack of written patient information.

JD-T queried how these experiences were fed back to the teams involved. DS ensured that feedback was provided to the teams involved.

The Chairman apologised on behalf of the Board for the unsatisfactory nature of their experience with UHS.

4.2 Briefing from Chair of Quality Committee for review (oral)

Mike Sadler, Non-Executive Director

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

- A year-end review of the Quality Improvement Framework (QIF) for 2018/19 and quality priorities for 2019/20.
- Quality assurance framework.
- Complaints update including a discussion about patient advice and liaison services (PALS).
- Consultant job planning update.
- Serious Incidents Requiring Investigation (SIRI) and Never Event reporting.
- CQC action plan.
- Clinical effectiveness and outcomes report highlighting the discussions around paediatric diabetes.
- Review of the Committee's annual programme of business for 2019/20.

PTH asked whether regular updates on progress with the CQC action plan would be provided to the Quality Committee. MS responded that this would be by exception only.

4.3 Briefing from Chair of The Audit and Risk Committee for review (oral)

Simon Porter, SID/Non-Executive Director

SP summarised the items considered at the May meeting of the Audit and Risk Committee:

- Internal audit progress report and final head of internal audit opinion for 2018/19

- Final risk management internal audit report.
- External audit report for 2018/19 covering financial statements and quality report, and draft management representation letters for the annual report.
- Draft annual report and annual accounts 2018/19.
- The national cost collection approval process 2018/19 was approved by the Committee.
- Data protection compliance activities update.
- Fraud, bribery and corruption annual work plan 2019/20.
- Draft board assurance framework (BAF) report template.

PHe asked how the auditors compared the Trust with other Trusts in relation to the 62-day target. SP advised that UHS was an outlier however there was a process in place to remedy this with actions to be completed by June 2019.

The Board congratulated DAF and the finance team for their efforts in completing the annual accounts.

4.4 Briefing from Chair of Strategy & Finance Committee for review (oral)

Jane Bailey, Non-Executive Director

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

- A comprehensive review of the new finance report. As a result of this, there will be a regular separate Cost Improvement Plan (CIP) report.
- Sustainability and Transformation Plan (STP) update. This will be discussed again at the next meeting.
- Capital programme Q4 2018/19 report including themes and learning for the decision-making process

PTH asked how CIP updates would be provided to the Board. JH advised that a monthly report would be provided to the Strategy and Finance Committee and a one-page update would be included within the monthly finance report. JB would provide feedback to the Board via the usual oral update.

4.5 Briefing from Chair of Charitable Funds Committee for review (oral)

Jenni Douglas-Todd, Non-Executive Director

JDT summarised the items considered at the May Charitable Funds Committee:

- The training on charity governance was postponed.
- Strategy for the charity.
- The charity's Vision statement was agreed.
- Year-end income and expenditure report.
- The terms of reference for the committee were reviewed. The Director of Estates was now a member of the Committee.

PTH suggested that the charity be discussed in more detail at a future Trust Board study session.

4.6 Integrated Performance Report for Month 1 including Quarterly Infection Prevention & Control Report for review

To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Infection Prevention Report.

Jane Hayward, Director of Transformation & Improvement

Integrated Performance Report for Month 1

Improving patient journeys

JB asked what plans were in place to improve Emergency Department (ED) performance and how progress would be measured given the unpredictable levels of attendances. PHe provided an overview of performance noting that there were a number of support mechanisms in place to return to the trajectory agreed with our commissioners and regulators. JH suggested that a more detailed update be provided to the July Trust Board study session. JD-T queried whether high periods of demand were analysed to identify trends for the unexpected levels of attendance. PHe, DS and CM attend weekly meetings with the ED team where this was considered. CM summarised the experience of staff within the ED and the new process which was being trialled.

CC sought clarification of the measures required to achieve the 62-day cancer target by December 2019. CM provided an overview of this noting that robotic prostatectomy was a main area of focus.

PTH asked how the improvement in the urgent GP referrals seen in two weeks had been achieved. CM advised that this was due to the recruitment of breast radiologists and that this improved performance was expected to continue.

Delivering value-based health and care

DAF explained the cost per Weighted Activity Unit (WAU) metric.
GB highlighted the significant increase in the percentage of complaints closed within 35 days.

Supporting healthy lives

GB provided an overview noting the national changes to reporting of pressure ulcers and the progress of SIRIs that had exceeded the 60-day target with commissioners.

DS summarised the position for outcomes and the plans to progress this work further. The significant progress recording of smoking status and subsequent intervention.
PTH queried where the strategy in relation to outcomes would be discussed. DS advised that there were plans to introduce an Outcomes Board to refresh the strategy. Regular updates would continue to go to the Quality Committee
MS highlighted the difference between the number of patients that had a recorded smoking status and the number that then went on to receive an intervention. DS advised that those recording the data were non-clinical and patients had to consent to advice and/or treatment by a qualified professional.

Building an expert and inclusive workforce

MS highlighted the improved turnover rate however this needed to be sustained. GB added that registered nurse turnover was at a more satisfactory level.

JD-T queried whether there was a plan for the Trust to achieve the 15% target for black and minority ethnic (BAME) staff at band 7+ by 2023. GB advised that the current performance reflected an increased number of BAME staff at band 7+ but the next step was to focus on those staff at band 8a+.

Being agile in meeting people's needs
MS queried the patient and staff experience implications of defect work orders. DAF agreed to give some consideration to this.

JD-T highlighted the improved performance for statutory and mandatory maintenance completed on time. This reflected the work GB and the Director of Estates were doing in identifying safety issues and prioritising accordingly. JD-T asked if time was invested with staff to enable them to identify safety issues. GB assured the Board that the importance of this was continually emphasised to staff. Matron walkabouts were also undertaken on a weekly basis.

CC sought clarification as to whether there was an aim for all staff to have their own computers or devices. JH advised that plans were in place to ensure staff had sufficient access to devices with the current focus on access for nurses and therapists.

Infection Prevention 2018-19 Q3 Summary
Graeme Jones attended the meeting and presented the summary highlighting the impact of recent norovirus outbreaks and the actions to manage this and address learning.

CC highlighted antibiotic prescribing noting that the duration of prescribing was not at the required level. GJ advised that automatic stop dates had now been added to the electronic prescribing system to address this.

PHe asked what was being done to improve hand hygiene noting this was 'amber' within the report. GJ provided an overview of the actions being taken to improve this.

4.7 Finance Report for Month 1 for review

David French, Chief Financial Officer

DAF provided an overview of changes to Commissioning for Quality and Innovation (CQUINs) and tariffs. The changes to the finance report were also outlined.

DAF presented the month one Finance report, noting for April:

- The Trust delivered a deficit of £2.9m, £0.1m worse than Plan. This was driven by the impact of the Easter holidays and the non-consolidated element of the Agenda for Change pay award.
- Under the single oversight framework, the Trust delivered a score for Finance and Use of Resources of '3'.
- Once non-recurrent items were excluded, the deficit was £3.4m, £0.5m worse than Plan, driven primarily by below-Plan CIP performance.
- Income was £1.1m better than Plan due to high non-elective activity.
- The cash position was £10m above Plan driven by the year-end income position £2.5m above the forecast, capital expenditure £2.5m below

month one planned position and accounts payable balances remained higher than anticipated.

DAF added that a refresh of the Trust's capital prioritisation would take place at the June meeting of the Trust Board.

4.8 Informatics Update for review

Jane Hayward, Director of Transformation & Improvement

Adrian Byrne, Director of Informatics

AB presented the report highlighting progress with the Healthcare Information and Management Systems Society (HIMSS) model.

PTH queried the implications of the initial HIMSS assessment evaluating the Trust at level two overall. AB expressed disappointment at this evaluation and outlined the actions required to reach HIMSS level five. It was noted that further prioritisation would be required to achieve this; an update on which would be provided as part of the Digital Strategy to Board in June or July 2019. PTH added that it would have been helpful if the report had identified the potential financial benefits of achieving the desired HIMSS level as well as the investment involved in doing so.

PHe highlighted the importance of balancing the needs of the national strategy with the Trust's clinical strategy to provide the right level of digital support at ward level.

4.9 Update on Progress on Staff Strategy

Gail Byrne, Director of Nursing and Organisational Development

Steven Harris, Director of Human Resources

Joanne Mountfield, Director of Education

SH introduced the update noting that the staff strategy would be updated during 2019 in conjunction with the production of the UHS long term strategy and the NHS long term people strategy.

MS requested an update on the apprenticeship schemes. JM provided an overview of the schemes which provide a pathway for local people to access on the job training and education. Difficult to recruit areas such as clinical engineering had success with apprenticeships. PTH asked about the number of nurse apprenticeships planned for this year. GB advised that this would be reviewed each year as part of the Trust's strategy and national discussions on nursing supply.

MS suggested that staff wellbeing would impact upon the achievement of the Supporting Healthy Lives goal. Staff wellness and staff engagement were also highlighted as important elements to consider. SH advised that there was a continued programme of work on staff wellbeing, details of which were not included within the report.

PHe highlighted the importance of aligning the Trust's strategy with the national long term people strategy, once published.

5 Corporate Governance, Risk and Internal Control

Including compliance with the NHS Provider licence conditions.

5.1 Self-certification - FT Licence Conditions for approval

Paula Head, Chief Executive Officer

PHe outlined the requirements of the self-certification against FT licence condition G6.

PHe added that a further self-certification would be required in June 2019, and emphasised the importance for the Board to understand the risks when approving the declaration against the remaining two conditions.

5.2 Register of Seals, and Chair's Actions for ratification

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

Peter Hollins, Trust Chair

PTH reported actions taken in the month on behalf of the Board. These were ratified by the Board.

5.3 Emergency Planning Response and Resilience Annual Report 2018/19 for review

11:11

Caroline Marshall, Chief Operating Officer

Sandra Hodgkyns, Head of Security/Emergency Planning (LSMS)

SH provided a brief overview of the report highlighting that the Trust attained a rating of 'substantial' against the Emergency Planning Response and Resilience (EPRR) core standards. The areas that achieved 'partial compliance' related to on-call training, the data protection toolkit and disposal of personal protection equipment (PPE) during a chemical, biological, radiological or nuclear (CBRN) incident.

PTH asked whether there was any significant learning from the major power failure incident in November 2019. SH provided an overview of the learning points which related to communications and the location of the site bed meetings.

PHe asked that the full EPRR core standards assessment was shared with the Board.

6 Any other business

Learning from Deaths Quarter Report

DS informed the Board that the report highlighted that patients with learning difficulties were having a poor experience. An action plan to address this was being developed.

7 Next meeting of the Board

Thursday, 27 June 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 30/04/2019 4.4 Integrated Performance Report for Month 12 including Quarterly Patient Safety Report (QIF) for review				
6.	Flow	Head, Paula	27/06/2019	Pending
	Explanation action item To provide the Board with planned interventions and a trajectory to achieve improvements in flow (to be presented to the Quality Committee and the July Board Study Session).			
Trust Board – Open Session 30/05/2019 5.3 Emergency Planning Response and Resilience Annual Report 2018/19 for review				
34.	EPRR core standards assessment	Marshall, Caroline	27/06/2019	Pending
	Explanation action item Sandra Hodgkyns to share the full EPRR core standards assessment with the Board (as only a summary provided within the report).			
Trust Board – Open Session 30/04/2019 4.4 Integrated Performance Report for Month 12 including Quarterly Patient Safety Report (QIF) for review				
5.	Research and Development	Bailey, Jane	30/05/2019	Overdue
	Explanation action item To return KPIs for R&D to the Strategy and Finance Committee.			
0.	IPR Annual Review	Hayward, Jane	30/05/2019	Overdue
	Explanation action item Future reports to identify those indicators that were mandated nationally.			

Trust Board – Open Session 30/05/2019 4.1 Patient Story				
23.	Written Patient Information	● Sandeman, Derek	30/05/2019	Overdue
	Explanation action item Aide Memoir: To note the lack of available patient information and develop a response/ action.			
Trust Board – Open Session 30/05/2019 4.6 Integrated Performance Report for Month 1 including Quarterly Infection Prevention & Control Report for review				
26.	IPR BA4	● French, David	30/05/2019	Overdue
	Explanation action item To consider the patient experience implications of this indicator: "Number of defect work orders and percentage completed on time."			
25.	Cancer Performance	● Hayward, Jane	30/05/2019	Overdue
	Explanation action item Consider adding a trend line to the cancer performance recovery graph to compare with the target.			

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title Integrated Performance Report 2019-20 Month 2			
Category	Quality, Performance, and Finance		
Agenda item	4.3		
Sponsor	Director of Transformation and Improvement		
Author	Trust Performance Manager		
Provenance	The Integrated Performance Report is reviewed monthly by the Board of Directors		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for REVIEW.		
Relevant strategic goals	✓ 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.
Assurance framework links	• CRR01 – 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 • CRR02 – 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 • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • CRR08 – Lack of inclusion and diversity results in the failure to get the best from every individual • CRR09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • CRR010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status		

Impact assessments	n/a
Other standards affected	n/a

Integrated KPI Board Report Digest

Improving patient Journeys

In May, non-elective rolling 12 month length of stay remains stable at 6.5 days. Bed occupancy in the latest reportable month (April) shows the organisation at the target 95%. There were a large number of beds closed to new admissions due to Norovirus in May outbreaks and it is pleasing therefore that the LOS did not show an increase.

Delayed transfers of care decreased in May to 5.4% (3.3% lower than the same time last year). Longer LOS patients did not achieve trajectory, increasing to an average 224 patients a day in May, this is the first time in 6 months we have been above the target. Some of this may be accounted for by the Norovirus outbreak. A new national weekly review of longer LOS patients is being launched in July to create a new focus on this group.

Having remained below target for seven months last year we have been above our bed occupancy target for the last months. Interestingly this pattern is mimicked in the AMU 8am occupancy data.

Emergency access performance increased slightly in May to 78.0% against a Q1 target of 90.0%. In May we ranked 7th out of a peer group of 8 major trauma centres (8th being worst - Three of the trusts in our Major Trauma Centre benchmark have stopped reporting breaches from May 2019, this is due to the process set out by NHSE for organisations piloting the new Access Standards).

Average time in department reduced by 3 minutes in May but is still 25 mins higher than the same time last year, currently at 3:13 compared to 2:48 in May 2018. Emergency access performance was impacted by high attendances (3.8% higher compared to last year), bed closures from Norovirus and a shortage of medical staff.

A recovery action plan has been developed in association with Mathew Cooke, a national lead. This 6 point plan covers a number of areas including matching demand with capacity, maximising the use of the new ambulatory majors area and working more closely with the Acute Medical Unit, improving patient pathways to facilitate rapid admissions from first assessment (pitstop), improving minors performance by upskilling the ENP workforce and filling vacant posts, reviewing the Hospital and System escalation processes and undertake an ergonomic review of the Emergency Department. A recovery trajectory has been developed based on these actions.

Percentage of patients on an open RTT pathway (waiting list) who have waited longer than 18 weeks in May is at 87.4% against a target of 92%. This is the 5th month in a row RTT performance has improved. There were three patients waiting longer than 52 weeks recorded in May. The total number of patients on a waiting list has increased again in May (for the 4th month in a row).

62 day cancer waiting time performance increased to 78% in April against a target of 85%. UHS ranked 6th (10th being worst) out of a peer group of 10 similar size teaching hospitals a good improvement from last month where UHS was ranked 10th.

31 day cancer waiting time performance was at 93.0% in April against a target of 96%.

2 week GP referral cancer waiting times performance improved again and achieved target for the second month in a row (currently at 95.7%) in March against a target of 93%. UHS last achieved this trajectory in March 2018.

The plan to recover performance against the Cancer action standards focuses on a number of areas including a) ensuring patients are seen or triaged appropriately at the beginning of the pathway, this includes the development of telephone triage in some areas to allow straight to test b) matching capacity with demand throughout the system wherever possible, robotic prostate cancer surgery remains the most challenged area where demand now matches supply but we are unable to catch up on the backlog, which is being hindered by the current national pension issues c) introducing new 28 day pathways in all tumour groups including a new group to oversee this. There is a plan to recover this performance by December 2019 at the latest.

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.

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 18 out of 33 clinical specialties have been visited.

The latest national data (February 2019) showed a median CHPPD for similar size (clinical output) trusts as 5.1 for registered nurses and 8.2 overall, UHS was at 5.1 and 8.3 respectively that month.

For the last 5 months the trust has achieved the target for complaints closed within 35 days, in May we achieved 80% against a target of 70%.

Supporting healthy lives

There has been an increase in C.diff cases (9 in May against a target of 5) however this has been impacted by changes in acquisition criteria which started in April 2019.

Of the 3 overdue SIRI's; 1 is a HSIB case (Incident logged in August), 1 is awaiting an external review and the third one is in relation to a Trust IT system and has involved a large number of patient reviews.

2 National reports were published and subsequently reviewed by UHS in May. 1 Area of concern was identified from the reports:

- (1) National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) COPD clinical audit 2017/18 (data from September 2017 and 2018) relating to oxygen prescribing. An action plan has been requested from lead.

HSMR performance over 12 months remains low due to continued low values from several specialties, though the latest months (Jan & Feb) show a small increase. Neurosurgery and General Medicine remain higher than benchmark.

Rolling 12 month staff sickness absence rates have increased in May, yet remain within target. (<=3.4%). In Q4 2018/19, 37 staff members started Quality Improvement training at UHS.

Patients screened for risky behaviours (alcohol consumption and smoking) were at 98% in May. Of those found to have moderate or high alcohol dependence 88% were given relevant advice or a referral to specialist services. Of those found to smoke 84% were given advice or offered medication.

Building an expert and inclusive workforce

Rolling 12 month staff turnover remained low in May (at 12.7% for a target of <=12%), registered nurses saw the greatest reduction in April.

Registered nurse vacancies in ward-based areas have increased by 0.69% since last month. Registered nurse vacancies in ward-based areas have also increased this month (by 0.15% since last month). These changes are due to promotion of RNs, relocation of staff and reduction in contracted hours mainly following return from maternity leave.

The staff Friends & Family Test results shows that 78% of staff recommend UHS as a place to work (2017/18 Q4 results).

Black and minority ethnic Band 7+ percentage continues to trend upwards and currently sits at 8.4% with a target to reach 15% by 2023

Being agile in meeting people's needs

In April 80.0% estates maintenance helpdesk requests were completed on time against a target of 85% and the percentage of defect work orders completed on time was 84.9% against a target of 85%. All other maintenance targets were met in April.

There has been a continued increase in May in Histopathology requesting and results acknowledgment made via eQUEST linked to continued integration within Endoscopy. Total UHS requesting via eQUEST is at 90.2% and specimens acknowledgement is at 92.3%. This increases patient safety.

There were 1263 UHS patient logins to My Medical Record in May and 365 new registrations, an increase of 551 logins and 175 registrations compared to the same time last year. New registrations will support the collection of PROMs data and virtual patent pathways.

Leading edge research, education and innovation

Research and Development has been rated Amber this month. Actual recruitment is still below CRN target, although ranking has improved this month (from 8th to 7th in the UK). Actual recruitment remains a focus of the action plan being implemented, with several studies anticipating a high recruitment rate in March 2019. Recruitment forecast projections to year end anticipate a total absolute recruitment of 18,000. Complexity (weighted) performance is satisfactory with UHS ranked 2nd in the UK for a number of consecutive months. New KPis will be available in August and we will move to quarterly review.

University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

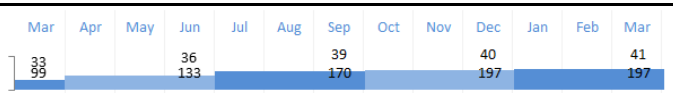
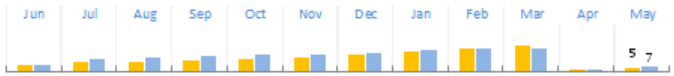
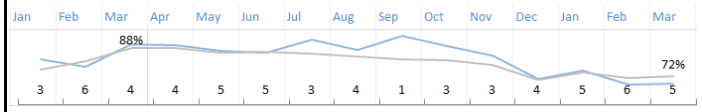
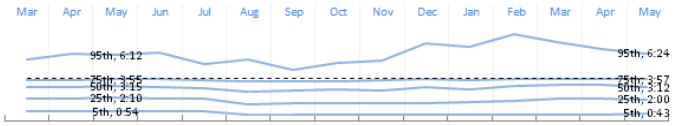
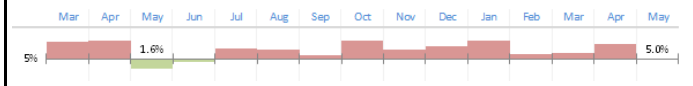
covering up to

May 2019

Executive Sponsor - Jane Hayward, Director of Transformation
Jane.Hayward@uhs.nhs.uk

Report Guide

University Hospital Southampton NHS
NHS Foundation Trust

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 it's control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range).
Variance from Target		Variance from target charts are used to show how far away a variable is from it's 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 it's target.

June 2019

Improve Patient Journeys

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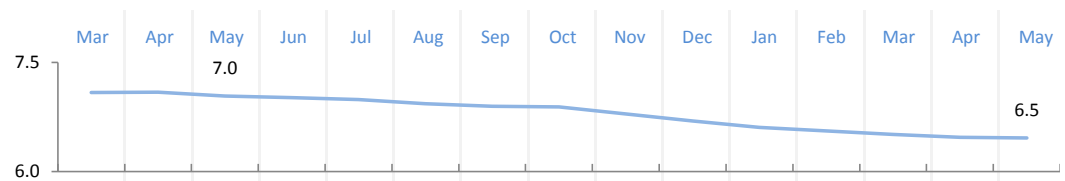
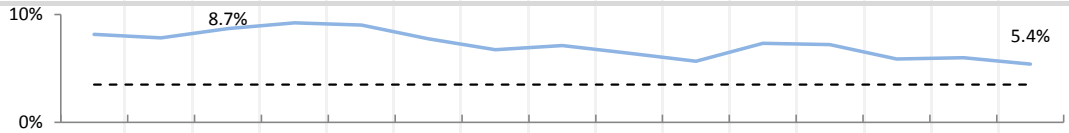
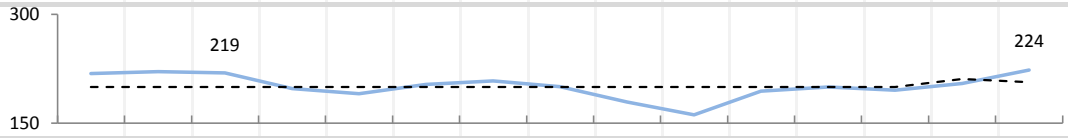
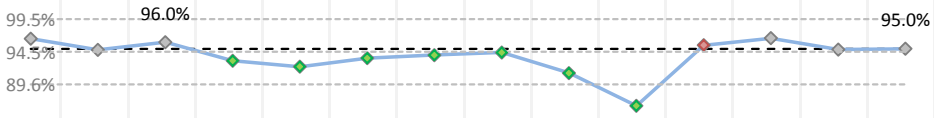
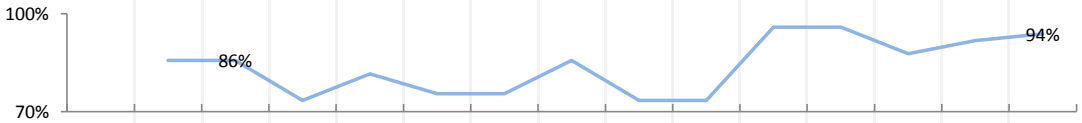
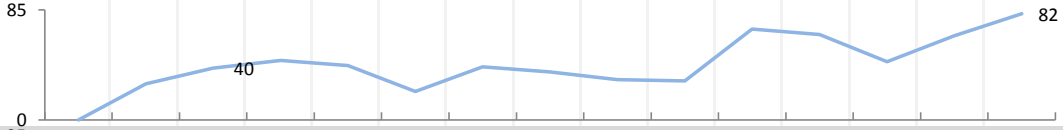
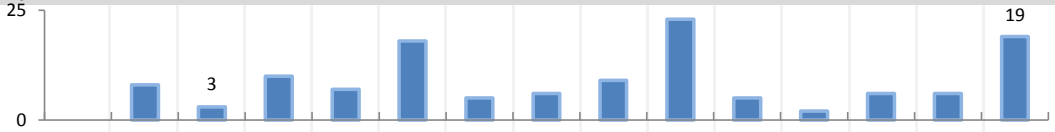
			Monthly Target	YTD
IPJ1	Non Elective LOS Rolling 12 months		<=5.93 by April 2019	-
IPJ2-N	Delayed transfers of care (CQC Calculation)		<=3.50%	5.71%
IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)		207	-
IPJ4	Outliers	in development		
IPJ5-L	Adult midday bed occupancy		90-95%	-
IPJ6	AMU 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		-	-

Current Data | Benchmark
Previous Year | Target

June 2019

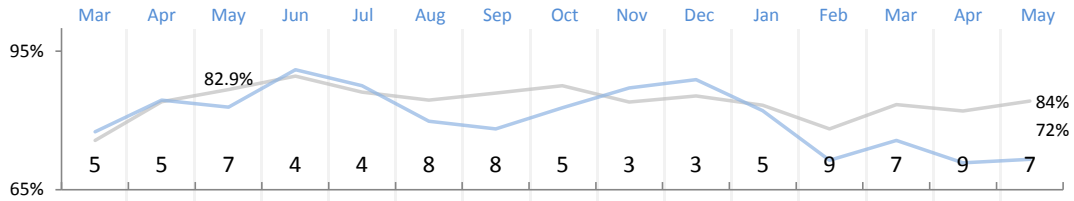
Improve Patient Journeys

University Hospital Southampton NHS
NHS Foundation Trust

Percentage of patients spending less than 4 hours in ED

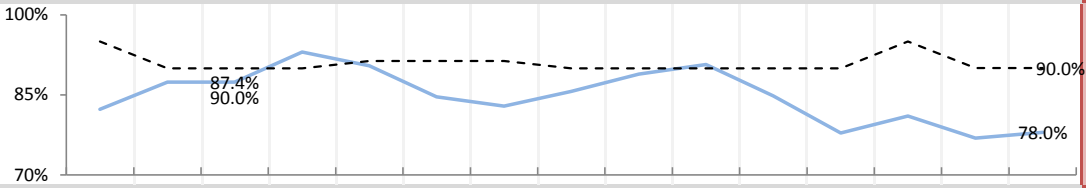
IPJ9-N SGH Main ED (Type 1 and UCH)

Major Trauma Centres (Type 1)
Rank of 11, (8 from May 19 onwards)->



QTD: 71.2% | Q Target: -

IPJ9-N UHS Total



QTD: 77.5% | Q Target: >=90%

IPJ10 Same Day Emergency Care (SDEC)

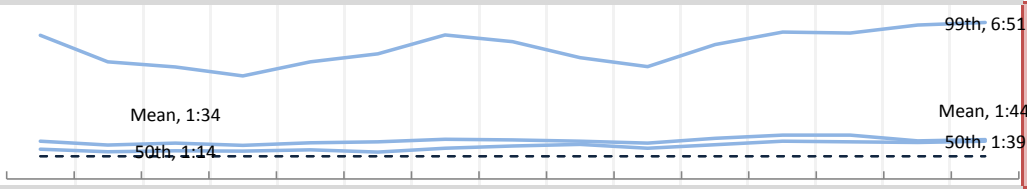
Awaiting national data definition

IPJ11 Time to initial assessment - 95th Centile UHS Total

Metric in development

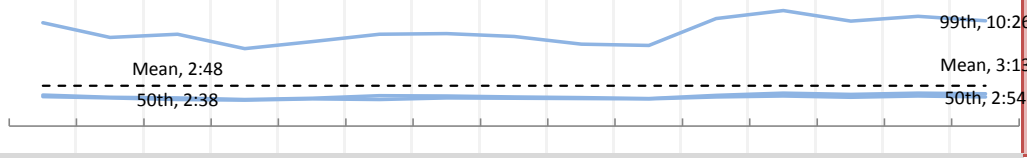
Q Target: -

IPJ12-N Time to treatment - Percentiles UHS Total



QTD: < 1hr for 50th | Q Target: -

IPJ13-N Total time spent in ED - Percentiles UHS Total



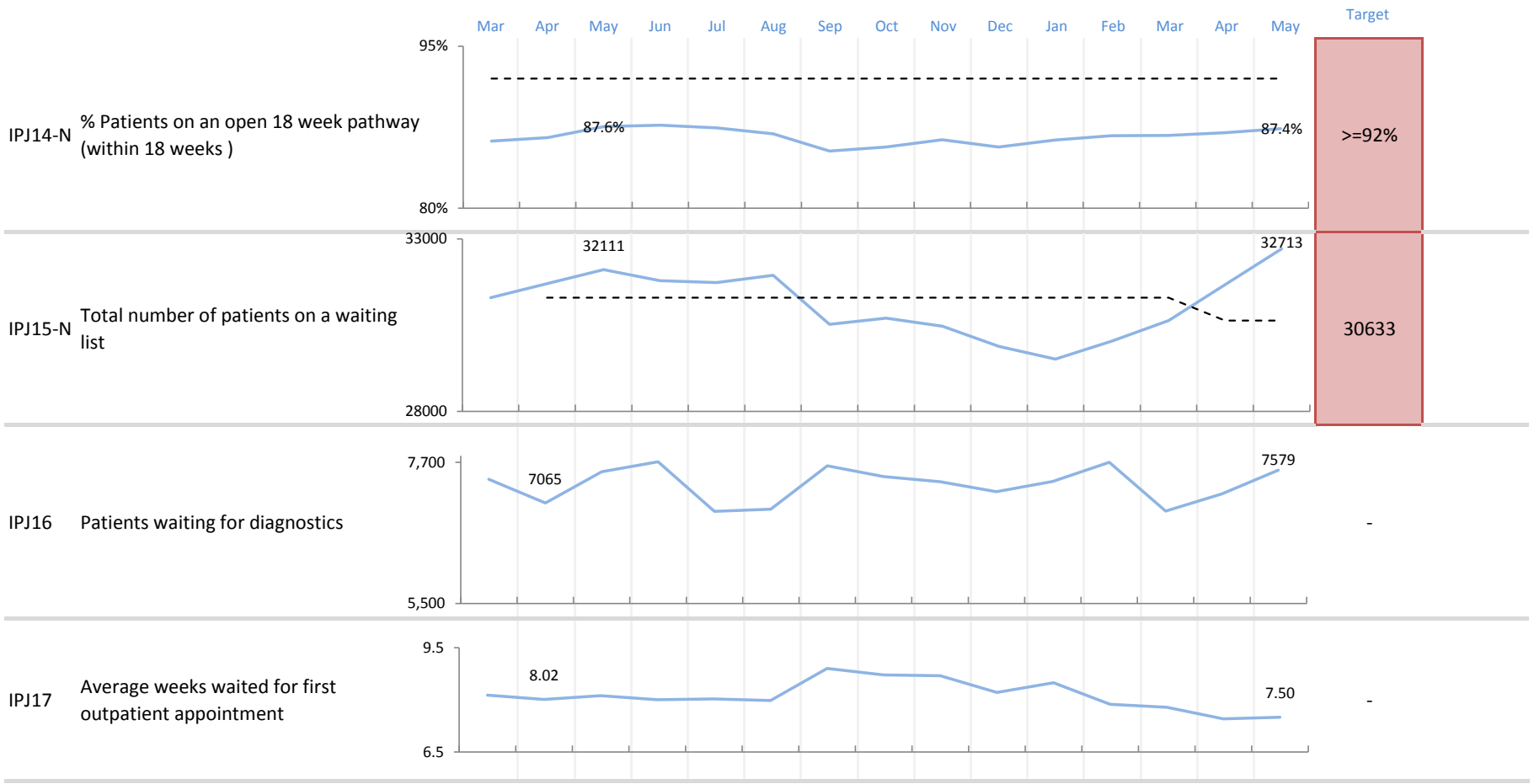
QTD: < 4hrs for 95th | Q Target: -

Current Data | Benchmark
Previous Year | Target

June 2019

Improve Patient Journeys

University Hospital Southampton NHS Foundation Trust



June 2019

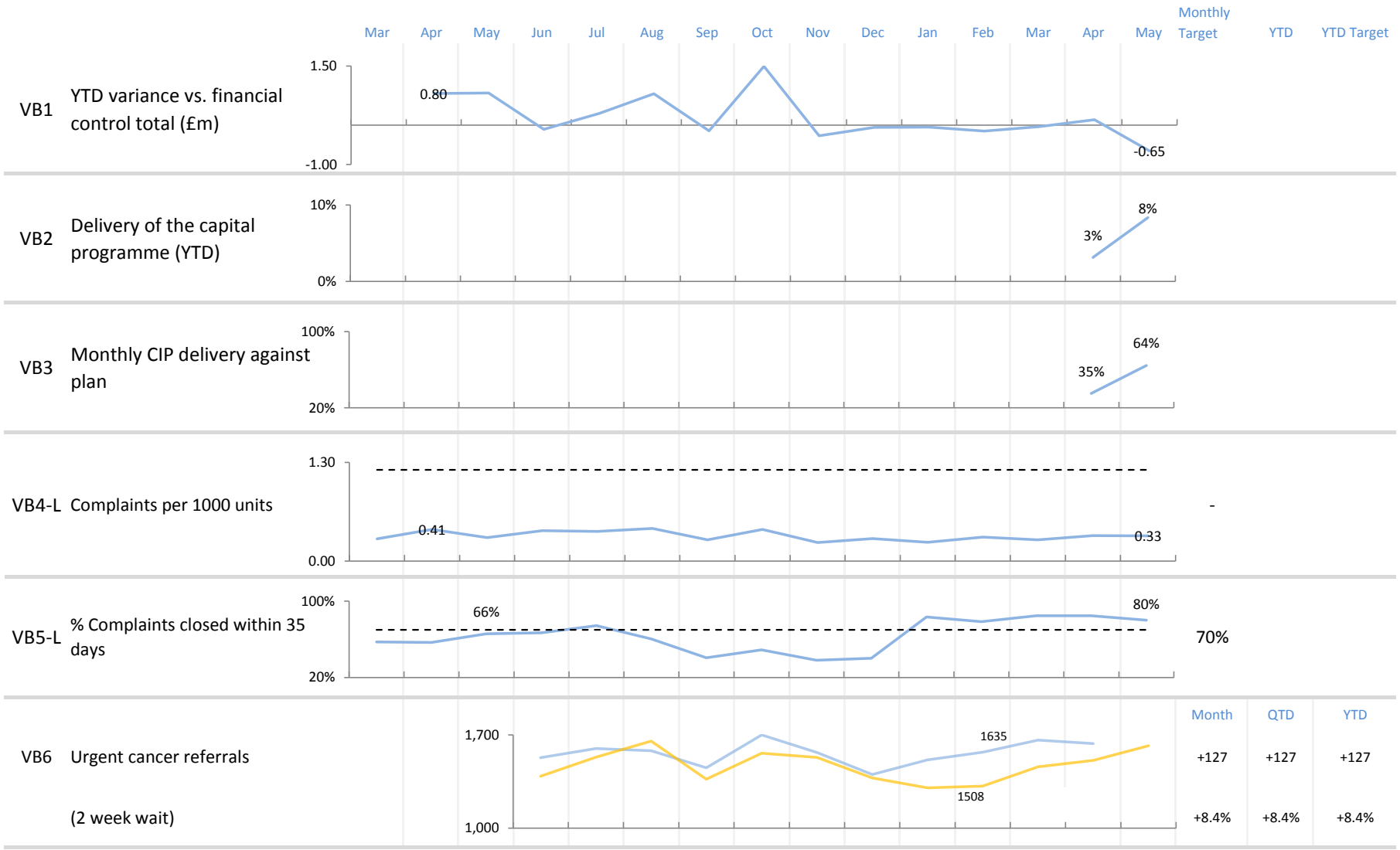
Improve Patient Journeys

University Hospital Southampton NHS
NHS Foundation Trust

			Monthly Target	no.patients to recover target	QTD
62 Day Performance Benchmark	Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr				
IPJ18-N Teaching Hospitals vs. UHS Total	0.9 / 0.5 — 80.9% / 79.5% … 78.3% / 77.6%				-
Rank(of 10)->	8 4 8 10 8 9 10 5 9 10 8 9 10 6				
IPJ19-N 62 day cancer wait performance	88.4% / 80.0% / 71.5% … 77.6%		=>85%	14 of 185	78%
6 of 13 tumour sites achieved 62 day target in May.					
IPJ20-N 31 day cancer wait performance	99.0% / 95.6% / 92.2% … 92.97%		=>96%	25 of 811	93%
6 of 13 tumour sites achieved 31 day target in May.					
IPJ21-N Urgent GP referrals seen in 2 weeks	97.2% / 90.5% / 83.7% … 95.7%		=>93%	0 of 1635	96%
10 of 13 tumour sites achieved 2 week target in May.					
IPJ22 Snapshot of waits > 104 days	7 16 9 29 34 33 29 72 29 28 33 27 33 31		-	-	-
IPJ23 28 Day Metric	Metric in development				

Current Data | Benchmark
Previous Year | Target

June 2019


Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
Monthly Target
YTD
YTD Target
VB1
YTD variance vs. financial control total (£m)
1.50
-1.00
0.80
-0.65
VB2
Delivery of the capital programme (YTD)
10%
0%
3%
8%
VB3
Monthly CIP delivery against plan
100%
20%
35%
64%
VB4-L
Complaints per 1000 units
1.30
0.00
0.41
0.33
-
VB5-L
% Complaints closed within 35 days
100%
20%
66%
80%
70%
VB6
Urgent cancer referrals
(2 week wait)
1,700
1,000
1635
1508
Month
QTD
YTD
+127
+127
+127
+8.4%
+8.4%
+8.4%
Current Data
Previous Year
Benchmark
Target

		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Month	QTD	YTD
VB7	Number of first cancer treatments (i.e. 31 day activity)			500									382				-32	-32	-32
													350				-8.4%	-8.4%	-8.4%
				200															
VB8	Total ED Attendances			14000										9950			+363	+992	+992
														9587			+3.8%	+5.4%	+5.4%
				9000															

VB8: Lymington MIU included from August 2017.

VB9	Non-elective Spells (incl. CDU)			6,700										6411			+175	+593	+593
														6236			+2.8%	+5.0%	+5.0%
				5,000															

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

in development

VB11 Non-Face to Face OPA

in development

VB12	Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)			9.5													-		
								8.8								8.7			
				8.0															

VB12 The total CHPPD rate in the Trust has increased since last month at RN 5.3 (previously 5.4), HCA 3.4 (previously 3.2) overall 8.7 (previously 8.6). The CHPPD for ward based areas in the Trust has increased from last month to RN 3.9 (previously 3.8) HCA 3.4 (previously 3.4) overall 7.3 (previously 7.3)

VB13 Red Flag staffing incidents

in development

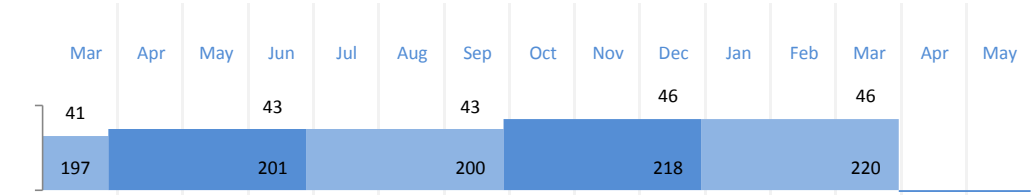
Current Data Benchmark
Previous Year Target

		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Monthly Target	YTD	YTD Target
HL1-N	Cummulative Clostridium difficile (Confirmed lapse in care)															7 11	5	11	<=10
HL2	Number of pressure ulcers causing moderate/severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0			
HL3-N	Medication Errors (severe/Moderate)			4												3	<=3	5	<=6
HL4	Serious Incidents Requiring Investigation (SIRI)			3												2	-	2	-
HL5-L	Number of overdue SIRIs			5												3		0	-

Of the 3 overdue SIRI's; 1 is a HSIB case (Incident logged in August), 1 is awaiting an external review and the third one is in relation to HICCS and has involved a large number of patient reviews.

HL6	Maternity - Continuity of Care	in development	35%
HL7-N	Neonatal admission temperature within range rate	in development	>=80%
HL8-N	Bronchopulmonary Displasia (BPD) rate	in development	<=30%
	Antibiotic usage	in development	
	Number of high harm falls	in development	

Current Data Benchmark
Previous Year Target

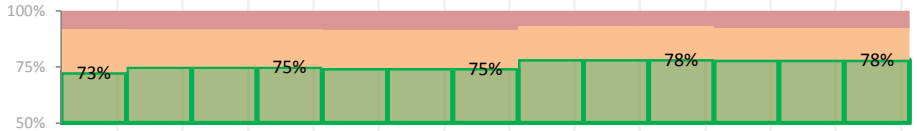


Monthly Target

HL9-L **Outcomes**

Cumulative Specialities with Outcome Measures Developed

+1

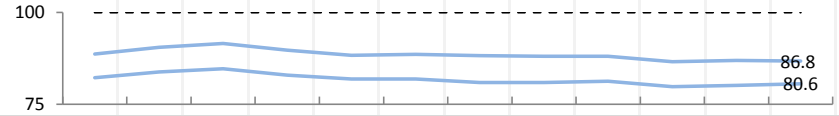


HL10-N Developed Outcomes RAG ratings

-

Of those graded as red, these relate to: Emergency surgery - post op assessment by elderly care, Theatres - Compliance with stop points for safety in theatres, Diabetes mealtimes and choice and IV insulin (although the IV insulin was deemed appropriate therefore no risk), Rheumatology – Compliance with NICE Quality Standard relating to referral, Respiratory Medicine – COPD readmission rates and smoking cessation, Ophthalmology routine screening, Pathology - turnaround times for specimen reporting, Pharmacy – Discharge medicines turnaround times, Trauma and Orthopaedics – knee revision rates and major trauma PROMS / consultant on arrival. All areas which have a red outcome have actions in place. Further information can be found in the Q3 18-19 effectiveness report.

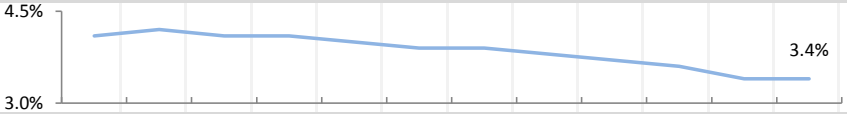
HSMR & SHMI



HL11-N HSMR - UHS

HSMR - SGH

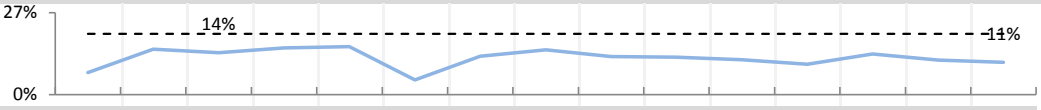
<100



HL12 HSMR - Crude Mortality

-

HHSMR performance over 12 months remains low due to continued low values from several specialties, though the latest months (Jan & Feb) show an increase. Neurosurgery and General Medicine remain higher than benchmark.

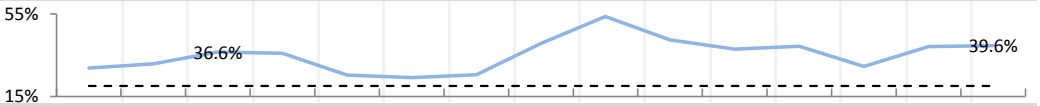


HL13-L FFT response rate - Inpatients

>=20%

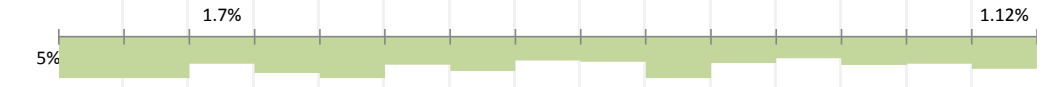
FFT Negative Score - Inpatients

<=5%



HL14-L Maternity FFT response rate

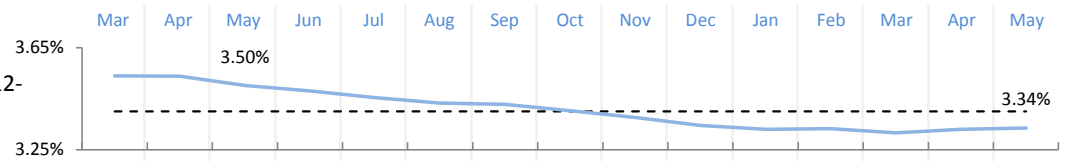
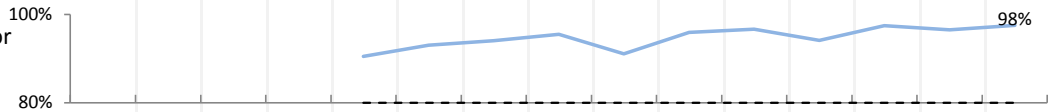
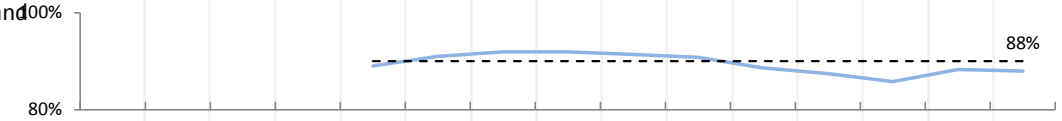
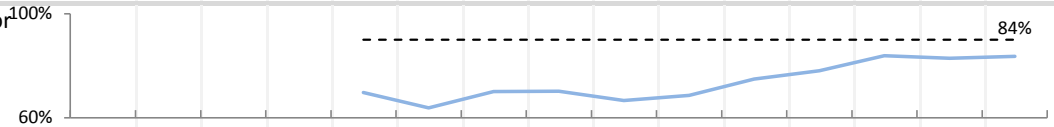
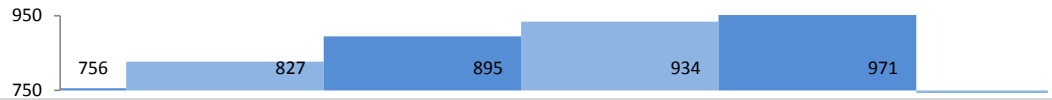
>=20%



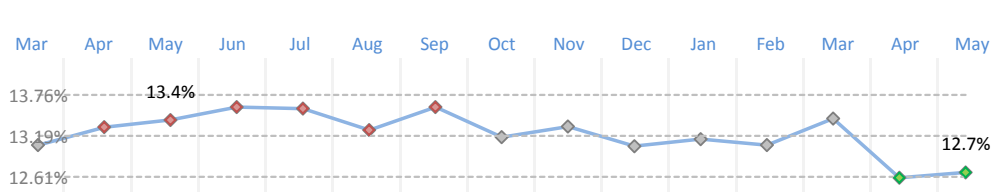
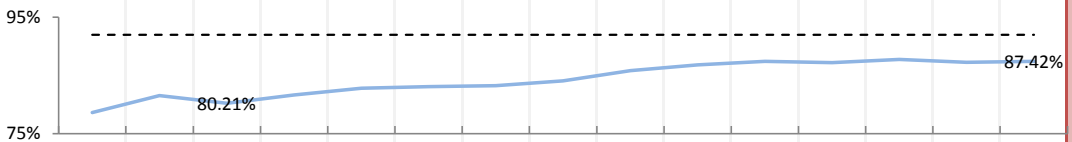
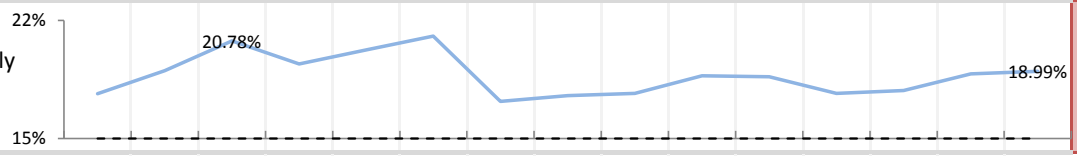
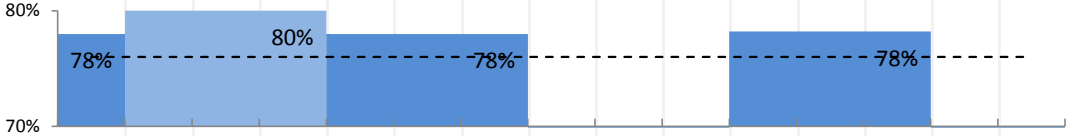
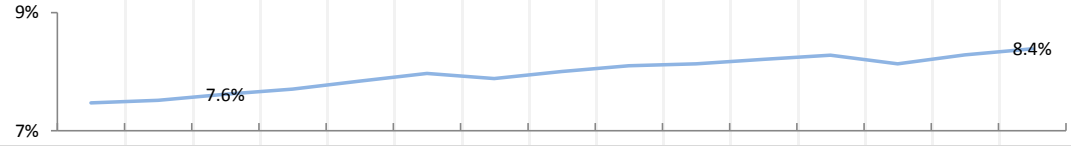
Maternity FFT Negative Score

<=5%

Current Data
Previous Year
Benchmark
Target

			Monthly Target
HL15-L	Staff - Sickness absence - Rolling 12-months		<=3.4%
HL16-N	Percentage of patients screened for alcohol and smoking		>80%
HL17-N	Percentage of patients screened and found to have either moderate or high alcohol dependence given relevant advice or referral		>90%
HL18-N	Percentage of patients screened for smoking and found to smoke that were given brief advice or a medication offer		>90%
HL19	Cumulative Number of staff trained in QI		
HL20	Number of people trained in human factors	This data is not held centrally so this KPI will be removed next month	
HL21	Number of fully accredited wards	in development	

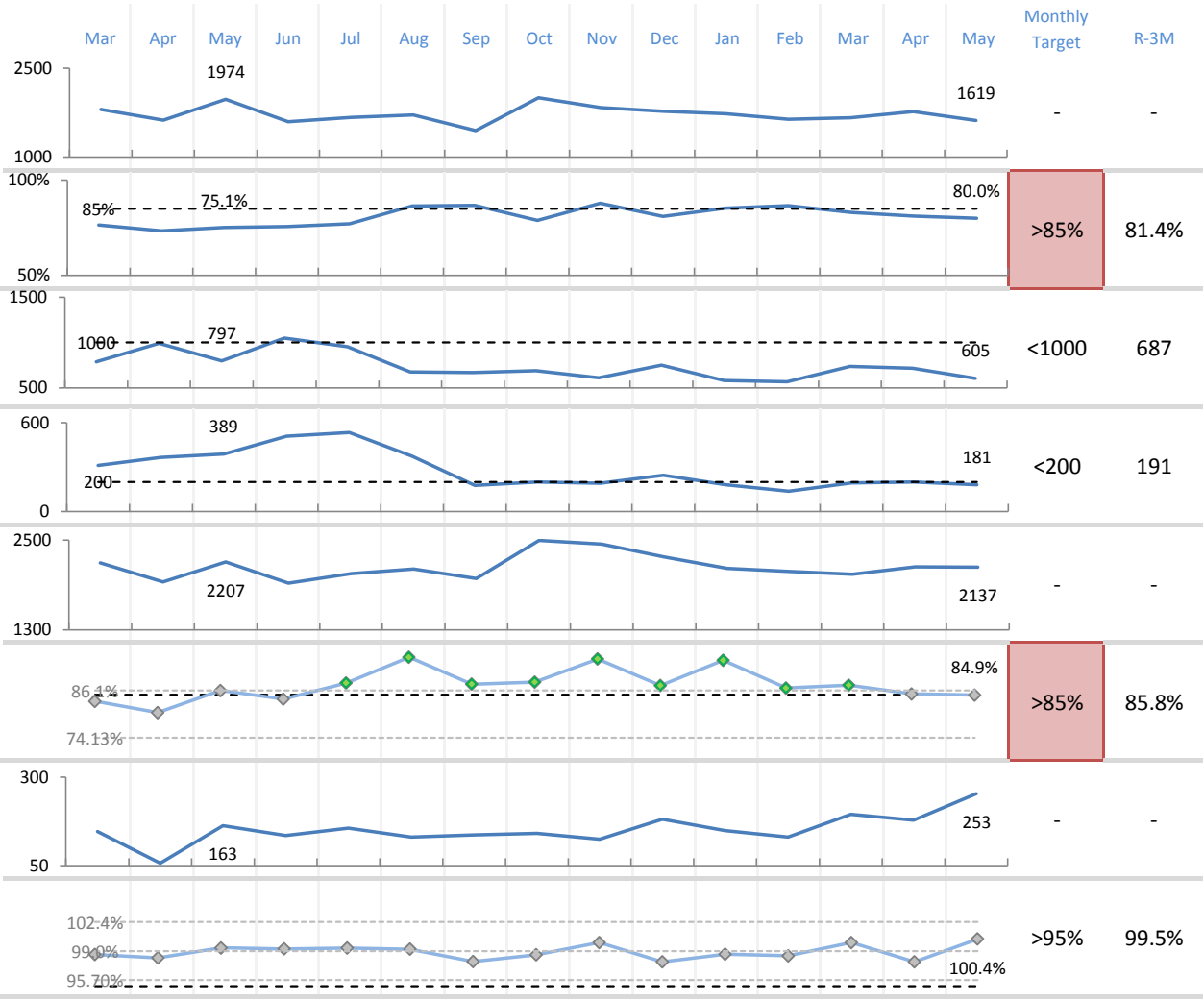
Current Data
Previous Year
Benchmark
Target

			Monthly Target
EW1-L	Staff - Turnover - Rolling 12-months		<=12%
EW2-L	Staff - Appraisals completed (non-medical) - Rolling 12-months		=>92%
EW3-L	Nursing Vacancies (Registered Nurse only in clinical wards)		<=15.00%
EW4-L	Staff FFT - % of staff recommend UHS as a place to work. (Quarterly)		>=76%
EW5	Staff FFT response rate	in development	
EW6-L	Black & Minority Ethnic Band 7+ Percentage		-

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

Current Data Benchmark
Previous Year Target

June 2019



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)

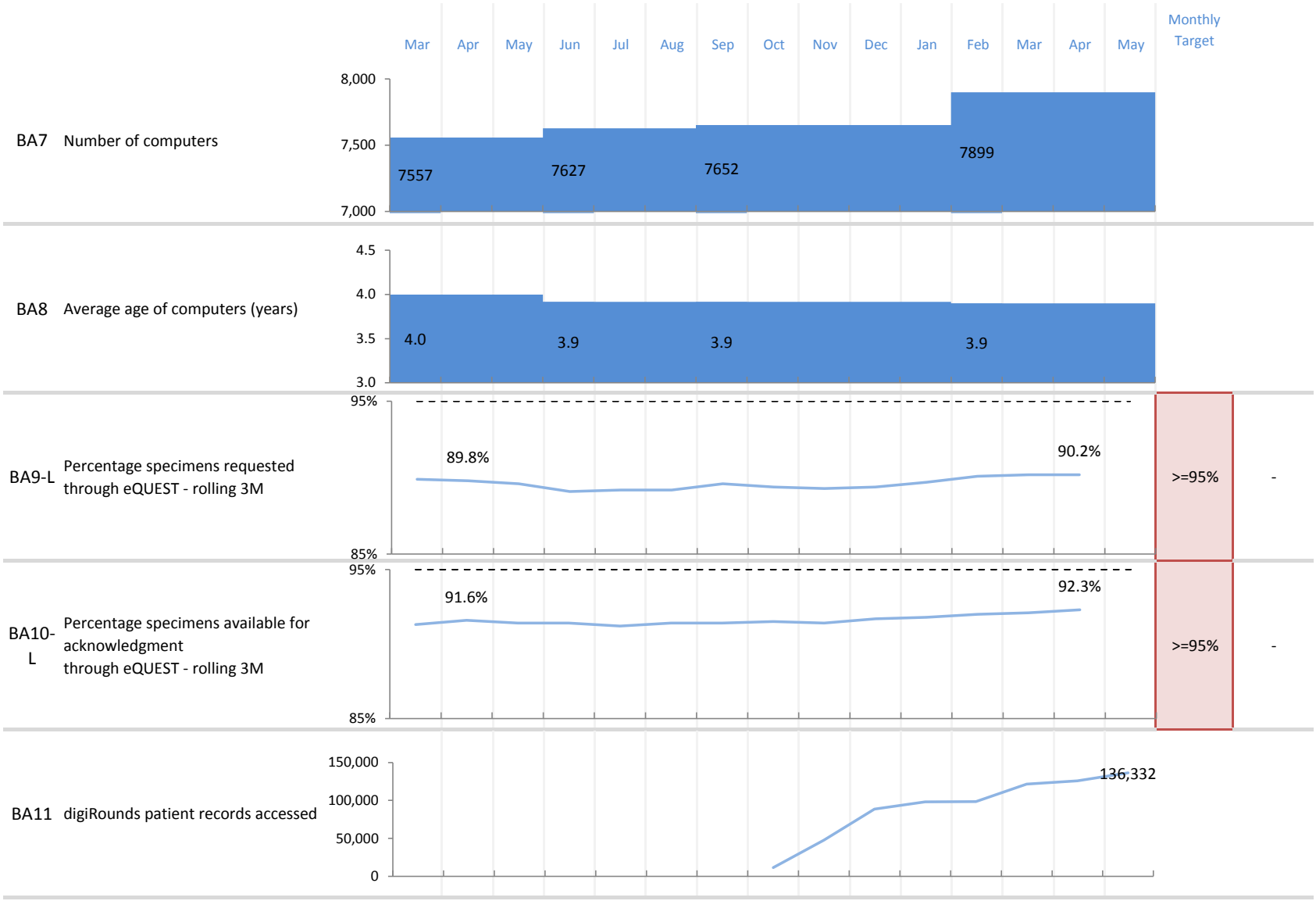
BA4-L Number of defect work orders and percentage completed on time

Preventative Maintenance

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

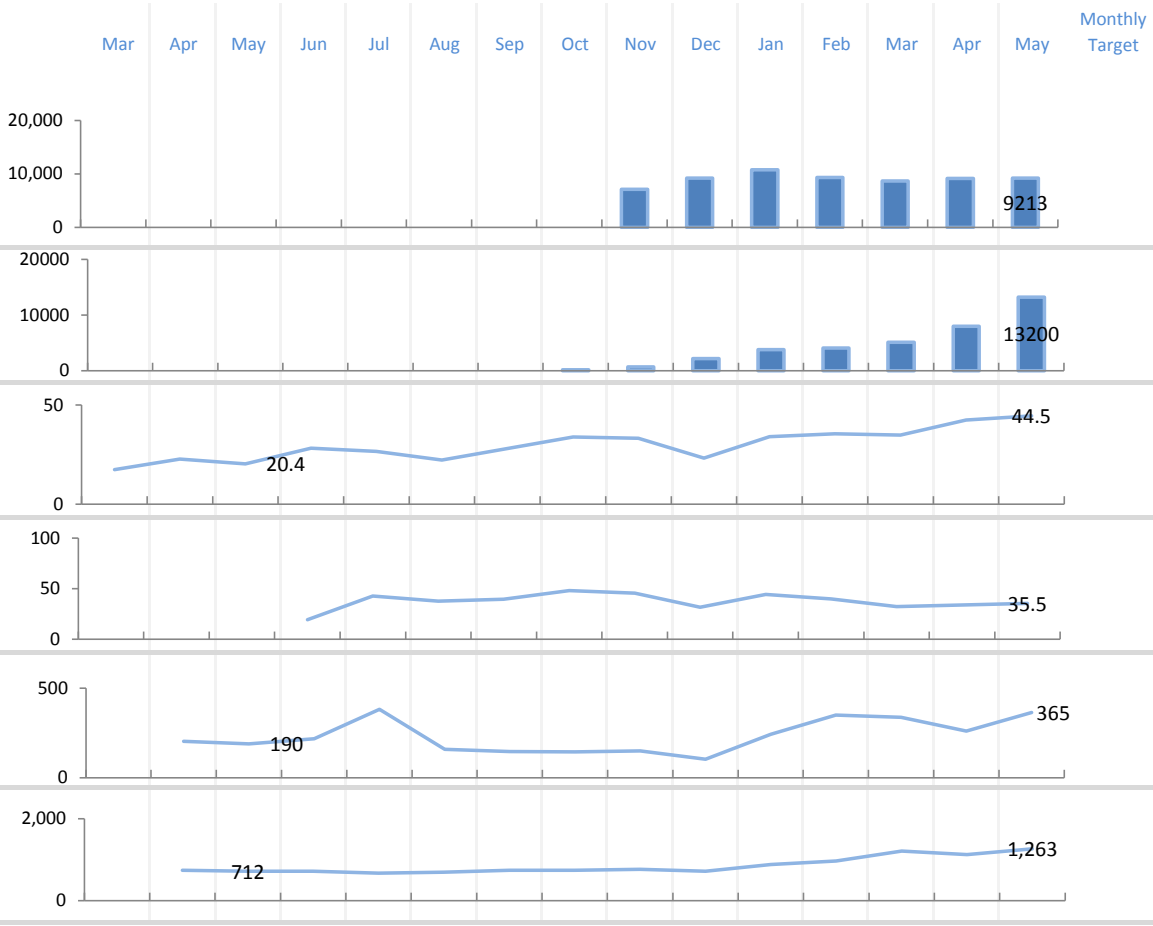
BA6 Estates capital spend vs plan — in development

Current Data
Previous Year
Benchmark
Target



Current Data Benchmark
Previous Year Target

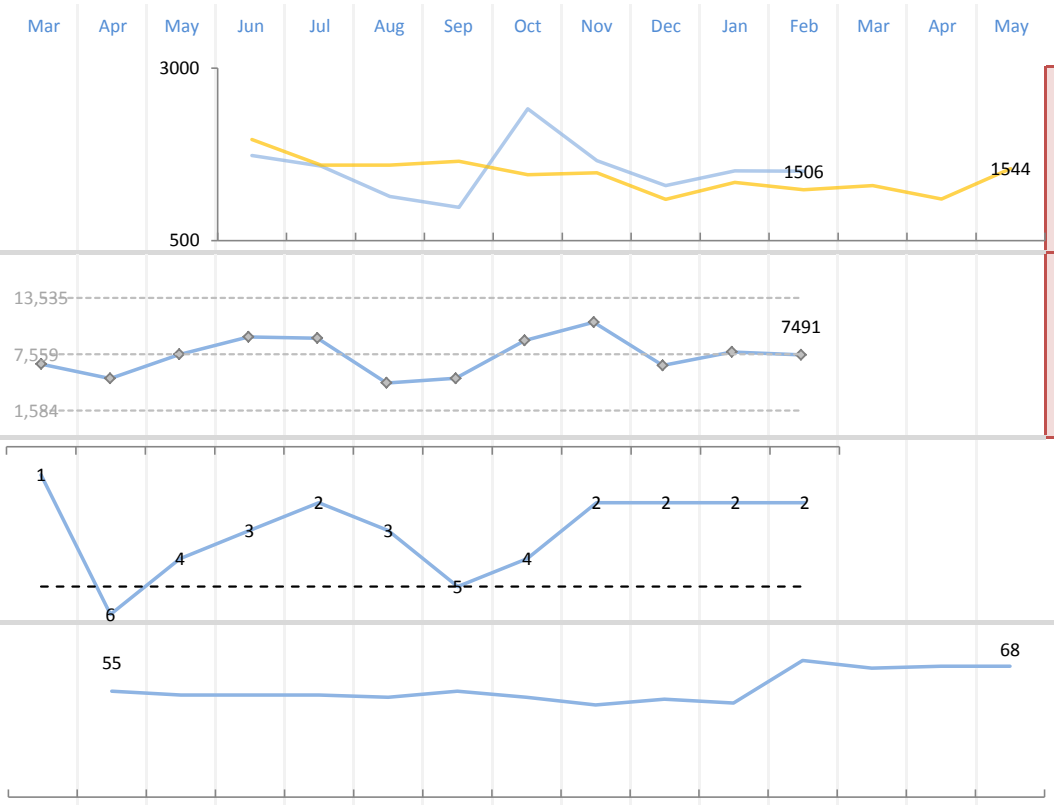
eQuest Results Alerts Sent



Current Data Benchmark
Previous Year Target

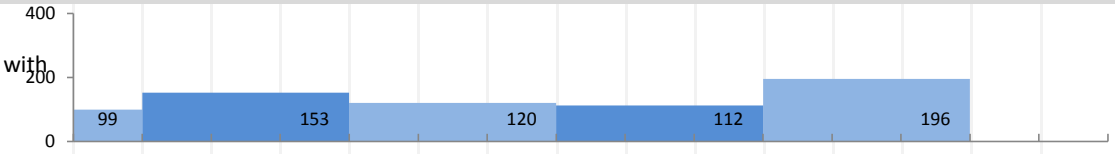
CRN Recruitment

		YTD	YTD Target
LE1-L	Participants Recruited	16461	19900
LE2-L	Weighted Recruitment	82224	82799
LE3-L	Weighted National Ranking - All Studies	-	Top 5
LE4	Specialties Recruiting	-	tbc



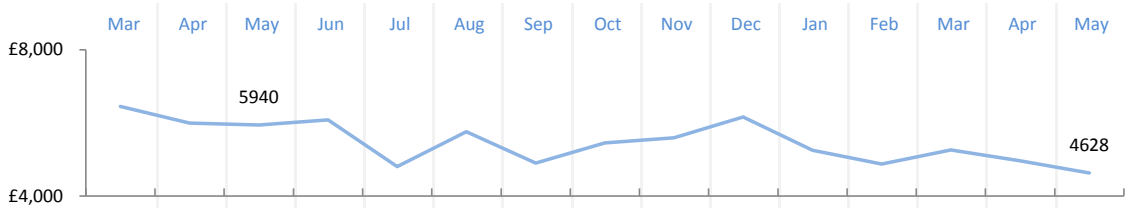
The number of research active UHS specialties has been introduced as a new metric this year in response to implementing the new research strategy and the aim for all specialties to be research active. Having identified whether a specialty is research active or not, we are now trying to understand levels of activity in relation to size of department for this to be more meaningful.

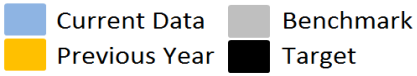
LE5	Papers published in partnership with UOS	



Number of BRC papers published are in line with expectations and more detailed analysis is informing the next BRC bid preparations.

Current Data
Previous Year
Benchmark
Target

LE6	R&D Income per WTE		
LE7-N	Quality of practice experience for doctors in training (annual report with quarterly qualitative updates)		No risk
LE8	Number of Apprenticeship Starts	in development	



June 2019 Changes and Corrections

University Hospital Southampton NHS
NHS Foundation Trust

Section	KPI	KPI Name	Type	Detail
All	All	All	Label change	" - L" or " -N" added to the end of all KPI references to indicate if KPI is local or national respectively.
Healthy Lives	HL19	Cumulative staff trained in QI	New KPI	Late addition agreed during annual content review in May
Improving Patient Journeys	IPJ6	AMU Bed occupancy (8am census)	New KPI	Late addition agreed during annual content review in May
Improving Patient Journeys	IPJ3-N	Extended LOS Census average (Patients with LOS >=21days)	name change	Extended LOS patients are not referred to nationally as Longer LOS patients
Improving Patient Journeys	IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)	definition change	National definition has changed to exclude patients <18 years old and Maternity
Improving Patient Journeys	IPJ9-N	ED Benchmarking	definition change	Cambridge, Imperial college and Nottingham are no longer included in the benchmark of Major Trauma Centers (With both Adult and Children services) as they are piloting the new access standards suggested in the NHS medical directors review of access standards - interim report.
Improving Patient Journeys	IPJ12-N & IPJ13-N	Mean Time to treatment and time in department	correction	a calculation error was dratically inflating these times. The data has been corrected and amended retrospectively

Headlines

•Best complaints Performance
The period has seen the best sustained complaints management performance of the last three years, with 83% of complaints closed within target and an average response time falling to 28 days.

•Themes
Recurrent issues with communication are present across most feedback and complaint channels. These are quite diverse issues, but do impact greatly on the quality and effectiveness of care experienced.

•PALS
PALS has begun to be separated out from Complaints with the intention of providing more responsive support and advice. The team are now recording activity in much more detail and future reports will contain an overview of PALS contact themes.

•FFT activity – tender, workshops, relaunch
FFT response rates continue to underperform, however the team are currently running some staff workshops ahead of a new contract to refresh and relaunch the trust's survey offering. This will provide clinical teams with much more relevant and meaningful data.

•Accessible information standard progress
The recording of accessible information needs went live in March, and has seen steady improvements since then. Issues remain around needs being included in referrals from primary care.

•Accessibility work
Trust is currently in the process of signing up to AccessAble, and this will mean having accessibility guides available across all trust sites and services. The benefit will be for patients and carers to better plan their visit. A hidden disabilities working group has also recently been launched.

•Volunteers
Difficulties with retention remain, and with the loss of a staff post, will continue in the future. The % of starters from applications, and new starters staying on past 6 months remains below optimum level.

Quarter 4 Patient experience summary report

		Performance					Data to latest month		
	Indicator	Target	Q1	Q2	Q3	Q4	Feb	Mar	Apr
Complaints	Complaints received	n/a	124	120	107	103	35	36	44
	Complaints closed within 35 days	= > 66%	63%	59%	42%	83%	79%	85%	83%
	Average working day to close	< = 35	35	32	38	30	31	31	28
	Reopened complaints	n/a	21	17	20	22	10	6	3
	Care home complaints	n/a	18	10	13	21	-	-	-
PALS	PALS contacts	n/a	432	532	668	953	275	254	295
	Complex concerns	n/a	88	91	111	115	42	44	32
	Direct feedback (email / website)	n/a	-	-	-	40	14	19	58
Friends & Family Test	Inpatient positive score	= > 95%	97%	97%	98%	97%	97%	97%	-
	Outpatient positive score	= > 95%	95%	96%	96%	95%	96%	96%	-
	Maternity positive score	= > 95%	99%	97%	90%	95%	89%	95%	-
	ED positive score	= > 95%	94%	96%	85%	85%	100%	95%	-
	Total responses	n/a	5857	5131	3744	6600	1578	2196	-
	Total negative responses	n/a	73	54	97	132	42	36	-
Accessibility	Accessible needs recorded (period)	n/a	0	0	0	12	1	11	23
	Total accessible needs recorded	n/a	0	0	0	12	1	12	35
Volunteers	Applications received	n/a	87	57	98	159	30	75	37
	New starters	n/a	57	28	30	66	21	30	15
Bereavement	Families supported	n/a	478	418	482	541	184	172	182

Nursing and midwifery staffing hours - May 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 specialty, 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.

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	Registered nurses CHPPD	Unregistered Staff CHPPD	CHPPD Overall	Comments
C4 (Solent ward)	Day	1456.2	1280.8	1033.8	1391.8	87.9%	134.6%	3.7	4.0	7.7	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C4 (Solent ward)	Night	1058.0	974.3	713.0	1010.3	92.1%	141.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C6	Day	2828.8	2659.4	180.6	371.6	94.0%	205.7%	7.4	1.1	8.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C6	Night	2047.0	2013.1	0.0	298.5	98.3%	Shift N/A				Safe staffing levels maintained; No requirement for Support workers.
C6 (Teenage Cancer Trust unit)	Day	692.6	710.6	362.3	143.5	102.6%	39.6%	9.1	1.4	10.4	Safe staffing levels maintained; No requirement for Support workers.
C6 (Teenage Cancer Trust unit)	Night	682.5	696.3	0.0	67.3	102.0%	Shift N/A				Safe staffing levels maintained; No requirement for Support workers.
D2	Day	1357.3	1394.0	1326.0	1023.6	102.7%	77.2%	4.1	3.3	7.4	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
D2	Night	852.0	1037.8	1046.5	920.3	121.8%	87.9%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
D3	Day	1672.9	1660.5	833.5	924.2	99.3%	110.9%	4.1	2.6	6.7	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D3	Night	1058.8	1081.8	698.5	799.8	102.2%	114.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Surgical high dependency unit	Day	2150.6	2005.2	403.4	334.2	93.2%	82.9%	14.5	2.5	17.0	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2115.8	1976.6	352.8	351.8	93.4%	99.7%				Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	5459.3	5353.5	1254.7	574.0	98.1%	45.7%	24.5	2.6	27.1	Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Night	5243.5	4956.8	881.0	518.0	94.5%	58.8%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Day	4596.5	4250.2	980.4	716.0	92.5%	73.0%	20.7	2.8	23.5	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Night	4261.5	3962.6	712.3	399.8	93.0%	56.1%				Safe staffing levels maintained; Beds flexed to match staffing.

General intensive care unit B	Day	4059.9	3491.7	380.2	304.8	86.0%	80.2%	24.3	2.3	26.7	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Night	3888.2	3273.5	356.5	345.0	84.2%	96.8%				Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Day	4921.4	4334.4	827.5	327.2	88.1%	39.5%	25.9	2.0	27.9	Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Night	4242.5	3574.0	650.5	282.5	84.2%	43.4%				Safe staffing levels maintained; Beds flexed to match staffing.
E5A	Day	1250.3	1084.5	668.7	964.0	86.7%	144.2%	3.7	2.9	6.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
E5A	Night	714.0	680.8	356.5	435.0	95.4%	122.0%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
E5B	Day	1373.2	1180.9	824.5	915.5	86.0%	111.0%	3.7	2.9	6.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
E5B	Night	702.5	691.0	356.5	553.0	98.4%	155.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
E8	Day	2247.6	1601.3	1569.0	2099.1	71.2%	133.8%	3.1	4.2	7.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
E8	Night	1068.0	1064.5	944.5	1535.8	99.7%	162.6%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F11	Day	2165.7	1422.2	810.3	860.9	65.7%	106.2%	4.4	3.1	7.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F11	Night	951.9	893.9	356.5	749.5	93.9%	210.2%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F6	Day	2182.4	1990.6	669.3	1017.9	91.2%	152.1%	3.6	2.4	6.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F6	Night	1069.5	984.0	706.8	898.0	92.0%	127.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F5	Day	1938.8	1521.6	988.0	1345.5	78.5%	136.2%	3.5	3.0	6.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F5	Night	1058.0	977.5	713.0	839.5	92.4%	117.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Acute medical unit	Day	3687.8	4491.4	4173.9	4251.9	121.8%	101.9%	5.1	4.5	9.5	Safe staffing levels maintained; Staff moved to support other wards.
Acute medical unit	Night	3566.0	3525.0	2010.3	2788.2	98.8%	138.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D5	Day	1343.5	1168.2	1666.7	1685.7	86.9%	101.1%	2.4	3.4	5.7	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D5	Night	1069.5	833.0	926.0	1195.5	77.9%	129.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D6	Day	1108.5	1107.9	1805.9	1621.2	99.9%	89.8%	2.6	3.6	6.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D6	Night	713.0	770.5	801.6	959.4	108.1%	119.7%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Safe staffing levels maintained by sharing staff resource.
D7	Day	708.0	846.5	1172.4	1067.9	119.6%	91.1%	3.5	3.2	6.7	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D7	Night	713.0	770.5	356.5	428.5	108.1%	120.2%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D8	Day	1171.4	1133.9	1550.0	1459.7	96.8%	94.2%	2.6	3.3	5.9	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D8	Night	713.3	751.8	954.2	965.2	105.4%	101.2%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D9	Day	1705.1	1310.8	1173.9	1625.9	76.9%	138.5%	2.5	3.3	5.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D9	Night	1069.5	805.0	591.5	1228.0	75.3%	207.6%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
E7	Day	1100.9	1081.0	1232.5	1415.5	98.2%	114.8%	2.9	3.5	6.3	Band 4 staff working to support registered nurse numbers; Additional beds open in the month; Safe staffing levels maintained by sharing staff resource.
E7	Night	712.5	948.1	696.5	1035.5	133.1%	148.7%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Additional beds open in the month.
Respiratory high dependency unit	Day	1644.7	1293.0	348.5	487.0	78.6%	139.7%	11.0	3.8	14.8	Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
Respiratory high dependency unit	Night	1587.0	1237.3	356.3	379.3	78.0%	106.5%				Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.

C5	Day	1096.5	889.9	769.5	750.7	81.2%	97.6%	3.8	2.7	6.5	Safe staffing levels maintained.
C5	Night	704.5	704.5	356.5	402.5	100.0%	112.9%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D10	Day	1147.3	980.0	1396.0	1319.3	85.4%	94.5%	3.1	3.7	6.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
D10	Night	713.5	679.0	712.5	701.0	95.2%	98.4%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
F7	Day	745.3	754.4	1306.7	1318.2	101.2%	100.9%	2.4	3.3	5.7	Safe staffing levels maintained.
F7	Night	713.0	702.5	701.5	713.0	98.5%	101.6%				Safe staffing levels maintained.
G5	Day	1093.0	1029.1	1786.0	1726.7	94.2%	96.7%	2.1	3.5	5.6	Safe staffing levels maintained.
G5	Night	713.0	701.5	701.5	1104.0	98.4%	157.4%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
G6	Day	1066.7	1075.0	1862.8	1844.3	100.8%	99.0%	2.2	3.7	5.9	Safe staffing levels maintained.
G6	Night	715.0	715.0	1058.0	1081.5	100.0%	102.2%				Safe staffing levels maintained.
G7	Day	705.6	731.3	1453.0	1639.7	103.6%	112.9%	3.4	6.3	9.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
G7	Night	713.0	724.5	1070.5	1070.5	101.6%	100.0%				Safe staffing levels maintained.
G8	Day	1133.0	1086.0	1810.0	1731.0	95.9%	95.6%	2.3	3.4	5.7	Safe staffing levels maintained; Staffing appropriate for number of patients.
G8	Night	696.0	712.5	1069.5	1006.3	102.4%	94.1%				Safe staffing levels maintained.
G9	Day	1086.0	1088.8	1861.5	1916.4	100.3%	103.0%	2.2	3.8	6.0	Safe staffing levels maintained.
G9	Night	713.0	691.5	1058.0	1116.0	97.0%	105.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Paediatric high dependency unit	Day	1613.5	1246.8	0.0	0.0	77.3%	Shift N/A	13.7	0.0	13.7	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1069.5	1060.3	0.0	0.0	99.1%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	2109.2	1513.4	380.0	623.0	71.8%	163.9%	6.2	2.8	9.0	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels.
Paediatric medical unit	Night	1817.0	1294.0	341.3	653.0	71.2%	191.4%				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	1321.0	1179.0	437.0	294.5	89.3%	67.4%	12.0	2.2	14.2	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric assessment unit	Night	1078.0	1064.0	119.5	113.0	98.7%	94.6%				Safe staffing levels maintained.
Paediatric intensive care unit	Day	6164.5	5193.3	534.0	555.5	84.2%	104.0%	26.4	2.4	28.8	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels.
Paediatric intensive care unit	Night	5696.3	5042.2	345.0	391.0	88.5%	113.3%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Piam Brown ward	Day	3103.5	3220.1	148.3	135.3	103.8%	91.2%	13.8	0.4	14.2	Safe staffing levels maintained.
Piam Brown ward	Night	1058.0	1346.0	0.0	0.0	127.2%	Shift N/A				Safe staffing levels maintained.
E1	Day	2149.8	1482.5	710.0	417.5	69.0%	58.8%	6.7	1.8	8.5	Non-ward based staff supporting areas; Safe staffing levels maintained by sharing staff resource.
E1	Night	1460.5	1304.3	345.0	329.3	89.3%	95.4%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G2	Day	777.5	758.8	0.0	0.0	97.6%	Shift N/A	8.9	0.0	8.9	Safe staffing levels maintained.
G2	Night	749.3	753.8	0.0	0.0	100.6%	Shift N/A				Safe staffing levels maintained.
G3	Day	2406.0	1724.0	1245.5	824.5	71.7%	66.2%	6.1	2.5	8.6	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G3	Night	1705.0	1309.0	674.0	452.0	76.8%	67.1%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing.
G4	Day	2464.5	2221.8	1269.5	719.0	90.2%	56.6%	7.7	2.2	9.8	Safe staffing levels maintained; Beds flexed to match staffing.
G4	Night	1705.0	1621.8	682.0	360.8	95.1%	52.9%				Safe staffing levels maintained; Beds flexed to match staffing.

Bramshaw women's unit	Day	1517.6	1207.7	1274.0	1078.5	79.6%	84.7%	3.8	3.5	7.4	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Bramshaw women's unit	Night	713.0	735.5	713.0	713.0	103.2%	100.0%				Safe staffing levels maintained.
Neonatal unit	Day	5668.0	3215.0	824.0	606.0	56.7%	73.5%	7.5	1.2	8.7	Safe staffing levels maintained; Cots adjusted to match staffing.
Neonatal unit	Night	4290.5	4011.1	682.0	524.0	93.5%	76.8%				Safe staffing levels maintained; Cots adjusted to match staffing.
Maternity service	Day	8260.3	8138.8	3604.0	2395.5	98.5%	66.5%	5.7	1.9	7.6	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5377.8	5344.0	2365.3	1973.0	99.4%	83.4%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Cardiac high dependency unit	Day	4975.0	4315.3	1493.7	911.5	86.7%	61.0%	13.5	2.7	16.2	Staffing appropriate for number of patients.
Cardiac high dependency unit	Night	3832.3	3983.4	682.0	770.0	103.9%	112.9%				Additional staff used for enhanced care - RNs.
Coronary care unit	Day	1779.2	1662.9	799.3	957.3	93.5%	119.8%	6.2	3.2	9.4	Band 4 staff working to support registered nurse numbers.
Coronary care unit	Night	1276.0	1417.3	396.0	655.3	111.1%	165.5%				Band 4 staff working to support registered nurse numbers.
D4	Day	1902.4	1222.3	838.8	1225.8	64.2%	146.1%	2.9	3.3	6.2	Skill mix swaps undertaken to support safe staffing across the Unit.
D4	Night	784.8	752.0	682.0	1002.0	95.8%	146.9%				Support workers used to maintain staffing numbers.
E2	Day	1602.7	1201.0	721.8	879.4	74.9%	121.8%	3.9	2.6	6.5	Skill mix swaps undertaken to support safe staffing across the Unit.
E2	Night	715.0	854.5	341.0	476.0	119.5%	139.6%				Patient requiring 24 hour 1:1 nursing in the month.
E3	Day	2799.9	2360.4	1357.5	1579.0	84.3%	116.3%	2.8	2.3	5.1	Band 4 staff working to support registered nurse numbers.
E3	Night	1358.8	1251.0	1353.0	1439.3	92.1%	106.4%				Band 4 staff working to support registered nurse numbers.
E4	Day	2422.2	1447.5	738.0	986.5	59.8%	133.7%	4.0	3.0	7.0	Band 4 staff working to support registered nurse numbers.
E4	Night	1093.8	1028.1	686.8	840.5	94.0%	122.4%				Skill mix swaps undertaken to support safe staffing across the Unit.
Acute stroke unit	Day	1549.9	1545.0	2710.9	2810.4	99.7%	103.7%	2.8	5.3	8.2	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
Acute stroke unit	Night	1023.0	880.0	1684.0	1815.0	86.0%	107.8%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
Regional transfer unit	Day	1754.6	1029.8	386.0	835.1	58.7%	216.4%	7.8	6.5	14.3	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Night	682.0	594.0	627.0	528.0	87.1%	84.2%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E Neuro	Day	1922.0	1627.8	1006.5	1601.8	84.7%	159.1%	3.5	4.0	7.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E Neuro	Night	1364.0	1044.3	1022.3	1426.5	76.6%	139.5%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Day	1433.5	1120.0	385.5	682.8	78.1%	177.1%	7.4	5.3	12.7	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Night	1100.0	738.0	682.0	655.0	67.1%	96.0%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Day	1919.0	1735.2	1900.0	2050.3	90.4%	107.9%	3.7	4.7	8.3	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
D neuro	Night	1354.0	1265.0	1694.0	1761.0	93.4%	104.0%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
F4 Neuro	Day	1600.3	1523.8	744.0	1238.2	95.2%	166.4%	3.8	3.6	7.4	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F4 Neuro	Night	1018.0	960.6	1023.0	1142.0	94.4%	111.6%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Brooke ward (trauma and orthopaedics)	Day	1155.0	1065.5	588.5	578.5	92.3%	98.3%	3.5	2.5	6.0	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Brooke ward (trauma and orthopaedics)	Night	1069.5	714.0	356.5	707.5	66.8%	198.5%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Trauma Assessment Unit	Day	546.3	485.5	345.3	598.5	88.9%	173.4%	4.2	5.0	9.2	Staff moved to support other wards; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Night	341.0	374.0	341.0	407.0	109.7%	119.4%				Patient requiring 24 hour 1:1 nursing in the month; Increased night staffing to support raised acuity; Safe staffing levels maintained by sharing staff resource.

F1	Day	2409.1	2138.2	1553.8	2166.6	88.8%	139.4%	4.2	4.3	8.6	Patient requiring 24 hour 1:1 nursing in the month; Increased night staffing to support raised acuity; Staff moved to support other wards.
F1	Night	1782.8	1841.7	1069.5	1902.5	103.3%	177.9%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Safe staffing levels maintained by sharing staff resource.
F2	Day	1667.8	1261.0	1362.8	2172.0	75.6%	159.4%	2.8	4.9	7.7	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
F2	Night	1022.8	935.8	1022.0	1728.8	91.5%	169.2%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
F3	Day	1681.5	1307.5	2382.5	1754.5	77.8%	73.6%	2.9	4.8	7.8	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
F3	Night	1023.5	825.5	2031.0	1797.8	80.7%	88.5%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
F4	Day	1480.3	1194.3	1238.1	989.1	80.7%	79.9%	3.9	3.2	7.1	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.
F4	Night	1023.3	828.0	682.0	685.2	80.9%	100.5%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Staff moved to support other wards.

Report to the Trust Board of Directors dated Thursday, 27 June 2019	
Title: Maternity Service Self-Certification - NHS Resolution 10 Criteria	
Category	Quality, Performance, and Finance
Agenda item	4.4
Sponsor	Director of Nursing and Organisational Development
Author	Suzanne Cunningham, Director of Midwifery, and Marie Cann, Midwifery Matron for Safety and Quality
Provenance	NHS Resolution (NHSR) first year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme was undertaken in August 2018. The 2018 submission was successful and totalled £600,000 (more than the predicted 10 % maternity premia). The maternity service has shared current compliance and information with commissioner(s) and will plan to share completed 'Board Declaration Forms'.
Classification	This Report is unclassified.
Purpose and recommendation	The paper is presented for DISCUSSION. The purpose of this report is to notify Trust Board that NHS Resolution (NHSR) is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. Maternity services are asking the Board to consider the information and the evidence provided to date demonstrate achievement of 8 of the 10 maternity safety actions and that those achieved meet the required standards. Trust Board members should note the following: 1. Detailed information contained in section 1 highlighting the Trust Board requirements. 2. Progress update in section 2 with supporting evidence provided in Appendix A (separate document). 3. Criterion to note by Trust Board members in section 3. 4. Criterion at risk of non-compliance highlighted in section 4. 5. No evidence is provided to NHS R at their request. The maternity service recommends that members of Trust Board: 1. Acknowledge the status of compliance noted in the report and evidence provided. 2. Be aware of the status of possible non-compliance with some criterion. 3. The requirements for the 'Board Declaration Form' sign off process. 4. Be aware that the information needs to be shared with the local Commissioners (as required). 5. Provide any ongoing monitoring and scrutiny of the NHSR action plan as required.

Relevant strategic goals	☐ 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.
Assurance framework links	Cross-reference to the applicable risk register and Board Assurance Framework entries, if appropriate, for example: • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care		
Impact assessments	The impact of not achieving CNST will be: • The loss of the 10% premium • Loss of additional monies paid		
Other standards affected	What standards will your recommendations affect? • Potential loss of reputation • Potential notification of findings to the CQC		

1. Introduction

In 2018 the maternity service was successful in achieving compliance of the 10 criteria for NHS Resolution (NHS R), Clinical Negligence Scheme for Trusts (CNST). NHS R is operating a second year of maternity CNST as of the clinical negligence claims notified to NHSR Nationally in 2018, obstetric claims represented 10% of the volume but 48% of the value. The scheme aims to incentivise ten maternity safety criterions **(Table 1).** The maternity service will be expecting to provide full compliance in 2019.

Table 1

Criteria for Maternity CNST	
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
2	Are you submitting data to the Maternity Services Data Set to the required standard?
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?
4	Can you demonstrate an effective system of medical workforce planning to the required standard?
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

1.1 Year Two Conditions

To achieve eligibility for payment under the scheme, maternity services must submit a completed ‘Board Declaration Form’ to NHSR by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

a) Maternity services must achieve all ten maternity safety criterions (Table 1 above).
b) The ‘Board Declaration Form’ must be signed and dated by the Trust Chief Executive confirming the following:

- The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the ‘Board Declaration Form’ has been discussed with the commissioner(s) of the Trust’s maternity services.

- The Board must give their permission to the Chief Executive to sign the 'Board Declaration Form' prior to submission to NHSR.

1.2 Year Two Assessment Process

Maternity services are expected to provide a report to their Trust Board Committees demonstrating achievement (with evidence) for each criterion and Board members must consider the evidence and complete the 'Board Declaration Form'. Actions not met must have an action plan stating how compliance will be achieved. As in year one NHS Resolution will use external data sources to validate some of the maternity services responses.

1.3 NHSR Feedback Timescale

Timescale	Date
Completed Board reports with Board sign-off submitted to NHS Resolution	By 12 noon on Thursday 15 August 2019
Trusts will be notified of results	By the end of September 2019
NHS Resolution to confirm and pay discounts	By the end of November 2019

1.4 Year Two Discount

Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.5 Year Two Implications

Maternity services that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST, **but may be** eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

2. Analysis and Discussion

2.1 Progress Update from Maternity Services (Appendix A – Separate document)

Table 1 below confirmation the overall **current** compliance and **predicted** compliance. Appendix A provides the detailed information and evidence to support the compliance.

Table 1

Number	Required Standard	Compliance
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Partial evidence - end of July 2019 submission of MSDSV2 required
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Partial evidence – compliance as of 4th July 2019
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

3. Criterion to Note by Trust Board

A number of the criteria require members of Trust Board have sight of specific and include the following:

3.1 Criterion 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? (Evidence to support compliance can be found in Appendix A, criterion 1)

Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) has developed and establish a National standardised Perinatal Mortality Review Tool (PMRT). The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of ‘review once, review well’. The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across maternity and neonatal units. The maternity service can confirm that the PMRT is used in review processes.

It should be noted that from the 12th to the 31st December 2018 there were 0 cases reported within the service therefore there have been no cases requiring a multidisciplinary review or report.

From 1st January to the 31st March there were 5 cases reported (Table 2) and 5 cases have been recorded on to the PMRT. Of these babies 4 have received a multidisciplinary review and a draft report has been generated (NB this should be within four months of each death). Therefore, for the period above 80% of reviews have taken place and in all cases the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. Actions from the review process are monitored through the governance groups within the service.

Table 2

Date of Incident	Date of Death	MBRRACE Case Number	Date Inputted on PMRT	Date of MDT Review	Cause of Death (if Known)	Actions from PMRT or from MDT Review	Case closed
01/01/19	01/01/19	51106/1	19/02/19	27/02/19	No PM	• CO Monitoring	27/02/19
08/01/19	08/01/19	60762/1	19/02/19	13/03/19		• CO Monitoring. • Aspirin prescribing • Symphysis Fundal Height measurements	Open
02/03/19	02/03/19	62082/1	15/05/19	29/05/19		• Partogram usage	Open
09/03/19	09/03/19	61765/1	14/05/19	TBA	Concealed pregnancy / Cause of death		Open
22/03/19	22/03/19	61494/1	10/04/19	29/05/19		• CO Monitoring	Open

3.2 Criterion 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units (ATAIN) Programme? (Evidence to support compliance can be found in Appendix A, criterion 3)

ATAIN is a programme of work initiated under patient safety to identify harm leading to term admissions, with a focus on reducing harm and avoiding unnecessary separation of the mother and baby. The working team within the maternity and neonatal service have undertaken significant project work to ensure there are appropriate pathways in place for admission into and out of the neonatal unit; that data recording processes are in place to ensure that all parties (including commissioners) are aware of activity and there is an overall action plan in place to address findings from reviews of term admissions which has been agreed at strategic levels i.e. Local Maternity Service (LMS) and the Operation Delivery Network (ODN). All actions that were in place to deliver this programme are and have been shared with the LMS and ODN in May.

3.3 Criterion 4: Can you demonstrate an effective system of medical workforce planning to the required standard? (Evidence to support compliance can be found in Appendix A, criterion 4)

The 2018 General Medical Council (GMC) National Training Survey 20th March to 9th May, reported that 19% of Obstetric and Gynaecology (O&G) trainees at University Hospital Southampton (UHS) disagreed (none strongly) with the statement *'In my current post, educational / training opportunities are rarely lost due to gaps in the rota'*.

In order to minimise the number of training opportunities lost due to rota gaps, there has been agreement at care group level and development of a 'Standard Operating procedure' to ensure trainee sessions are allocated within the rota in the following order of preference:

1. Emergency cover
2. Special interest sessions
3. Other service sessions

3.4 Criterion 5: Can you demonstrate an effective system of midwifery workforce planning? (Evidence to support compliance can be found in Appendix A, criterion 5)

The maternity service has evidence in place to demonstrate that there is an effective workforce plan in place and that a systematic, evidence-based process to calculate midwifery staffing establishment has been undertaken i.e. Birthrate+. Birthrate+ was undertaken in March 2018 and demonstrated how the required establishment for UHS was calculated.

A bespoke case mix was developed based upon the individual staffing needs and demands of Southampton Maternity Services. This in turn was measured against clinical indicators which highlighted the overall wellbeing of mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Together with the case mix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

LW & BBC % Casemix	Cat I	Cat II	Cat III	Cat IV	Cat V
	4.2	16.3	18.9	28.4	32.2

Table to illustrate trajectory to accommodate falling birth rate

	Birthrate+ calculation based on acuity and 5400 births	Actual March 2019 based on 5500 births	Funded May 2019 based on 5400 births
Ratio	1:24	1:25	1:26
WTE MWs	225	220	207

As Birthrate+ was undertaken in March 2018 the maternity service completed a 'table top' exercise which covered a consecutive 3 month period between March 2019 – May 2019. This 'table top' exercise was used to review the workforce and highlight any deficits in staffing levels and the mitigation to cover any shortfalls.

The findings of the review showed a consistent but relative small shortfall in actual shifts to be filled against actual shifts covered. These staffing shortfalls were more marked within the Obstetric Led Pathway as opposed to those within the Midwifery Led Pathway highlighting some imbalance of staff and shift allocations across the service. The daily management of this situation would have involved a senior decision for contingency planning based upon the redeployment of midwifery staff across the service. This would have been done following a helicopter view of activity and acuity levels within each clinical area and a measured approach to see a sharing of staff resources without rendering any identified ward unsafe. It was also noticeable that the month of March saw the largest shortfall of staff when, despite a cohort of newly qualified midwives commencing employment at the beginning of the month, new starters to the Trust were still experiencing a classroom induction period and therefore not included in service delivery.

The assurances currently within the maternity services associated with safe midwifery staff include the following:

- Safe Staffing guideline.
- Escalation process including a daily alert status.
- Operation coordinator to provide helicopter view of the service, escalating to senior management if and when required.
- On call managers overnight.
- On call midwifery staff overnight.
- Specialist midwives/ Non clinical Midwives to be redeployed according to service needs.
- Monthly Workforce reporting within the Trust.
- Daily staffing meeting in the UHS site office (Midwifery Matron to attend daily).
- Daily PAH safety huddle to provide joined up decision making around alert status.
- Daily staffing huddle involving clinical leaders across maternity services to ensure staff are assigned according to fluctuating activity levels.
- NHSP (Bank) backfill as and when required to ensure safe staffing levels are maintained, particularly in response to short term sickness. This avoids any agency use which has been the case since the beginning of 2019.

- NHSP on call midwives allocated on a Friday and Saturday night to be utilised as a further contingency measure following management discretion.

Actions that were put into place as a result of the 'table top exercise' were:

1. Bi-Monthly meeting was set up to discuss workforce concerns from across the service. This meeting will put actions in place to address any issues escalated to senior management team as required.
2. Establish a 'Night coordinator' to have helicopter view of the whole service at night thus ensuring a decision for the redeployment of staff that is both safe and measured. In addition this senior midwife will activate contingency planning at the right time, in the right place with the right staff members as and when required.
3. The development of a "Flexible" team of midwives who will aim to move seamlessly across midwifery pathways, providing safe care to women in order to meet the demands of unpredictable and fluctuating activity levels.
4. In response to the new UHS Business Rules regarding temporary staffing, an action to drive down the use of bank workers (NHSP) across the service will be approached in two ways. Firstly to redeploy staff across midwifery pathways and allocate shifts at the point of roster creation in order to backfill any shortfall (starting with immediate effect for rosters being released for August 2019). Secondly to review existing rosters with intent to address any shortfall in the service through the redeployment and reallocation of staff across the service thereby eradicating any need for temporary staff fill through bank workers. All bank shifts (NHSP) therefore to be cancelled in line with correct processes.

In addition to the Birthrate+ evaluation in March 2018 the maternity service utilises an Birthrate+ intrapartum acuity tool. The Acuity Tool collects detailed information on activity within birthing environments on a 2 to 4 hourly bases and captures information relating to enable the service to know the cause of having too few midwives for the acuity and what action(s) were taken to resolve the situation. Also the data will highlight if there are certain periods in the day/night and days of the week when the acuity is often above the available number of midwives. From this information the service can also record and respond to 'Red Flag' situations i.e. delays in care or detection of deteriorating clinical situation or delay in pain relief.

Once the initial data had been reviewed and clarified the intrapartum acuity tool showed that there is a 100% compliance with supernumerary labour ward shift lead status and that there is provision of one-to-one care in active labour and mitigation to cover any shortfalls.

The number of red flag incidents (Table 3 - associated with midwifery staffing) reported over a consecutive six month time period and within the last 12 months will be reviewed and monitored both within the maternity service and to the Trust Board in the bi-annual reports and local governance meetings. The red flag incidents occurring at the time of reporting would be acted on immediately and where appropriate escalated using the reporting pathways held within the maternity services including Adverse Event reporting and the use of the Safe Staffing Guideline.

Additionally reports will be obtained from Birthrate+ by the maternity Risk lead and incidents will be reviewed and actions monitored by the maternity risk team.

Table 3

Red Flag	Description
RF1	Delayed or Cancelled Time Critical Activity
RF2	Missed or Delayed care
RF3	Missed/Delayed medication during an admission to hospital or midwifery-led unit (for example diabetes medication)
RF4	Delay in providing pain relief
RF5	Delay between presentation and admission
RF6	Delay in continuing IOL/Augmentation
RF7	Delay between admission for induction and beginning or process
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour
RF10	Unable to facilitate women's choice of birth place
RF11	Labour Ward Coordinator not supernumerary

3.5 Criterion 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle? (Evidence to support compliance can be found in Appendix A, criterion 6)

The bundle is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are considered as evidence-based and/or best practice including reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement and effective fetal monitoring during labour. The recommendations have been considered by the service, each of the elements is supported in practice or there is an alternative intervention. All of the recommendations of the bundle are in place and additional actions are in place to further reduce risk. The compliance for the bundle is discussed in a bi monthly Maternity Safety Champion meeting held with the Director of Nursing.

3.6 Criterion 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues? (Evidence to support compliance can be found in Appendix A, criterion 9)

Safer Maternity Care called on maternity providers to designate and empower three individuals to champion maternity safety in their organisation: The role of the safety champions is to support the regional and national maternity safety champions, supporting delivery of safer outcomes for pregnant women and babies. The maternity service's safety champions meet bi-monthly with the Director of Nursing who is the board-level maternity champion to discuss current and on-going safety issues within the service.

As part of this criterion the maternity service must demonstrate that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns (Table 4 below).

Table 4

Concern Raised	Impact	Action Taken	Outcome	Monitoring
Shift rostering challenges	Poor staff experience	Full review of staff rosters and changes made to ensure that there is good period of time off between rostered shifts.	No further reports of inappropriate rostering	Monitored by the Rostering team.
Spit site working		Split site working managed through the PAH Safety Review group	• Improved safety oversite of the risk of being a split site. • Improved support from Site team • Improved communications and transport of patients. • Escalations to Care Group Manager and Divisional team.	Monitored by the PAH Safety Review group.
Light on Labour ward incorrectly working	Safety concern as not able to use appropriately for suturing	Light repaired urgently	Improved safety for suturing.	
Concerns raised by Matrons regarding the regular checking of equipment and fridges.	Risk of ineffective equipment or medicines	To be addressed via the CQC action plan	Full action plan in place linked to the CQC action plan.	Monitored by the Matrons and CQC leads
Concerns raised through the CQC visit by staff • Estates – Meetings held with Estates / Security and Infection Prevention • Lifts • IT connectivity • Development opportunities	Provision of safe care	• Suzanne and Marie are meeting with Infection Prevention team on the 17th June and actions are linked to the CQC action Plan. • The lifts are now all working and there is a call system in place and all 3 lifts can be directed to level D in an emergency. Any failures of the lifts have an escalation and reporting process in place. • Good levels of IT coverage in all areas. There is a bi monthly Trust Digital meeting formed so concerns can be escalated. • Staff encouraged to have IPR and	Full action plan in place linked to the CQC action plan.	Monitored by the Matrons and CQC leads

		seek their manager support for develop opportunities that are available.		

4. Criteria at Risk of Non-Compliance

4.1 Criterion 2: Are you submitting data to the Maternity Services Data Set to the required standard? (Evidence to support compliance can be found in Appendix A, criterion 2)

The maternity service through the Informatics Team provides data known as the 'Maternity Services Data Set (MSDS)'. Evidence of extraction of MSDSv2 data for April 2019 will be available at the end of June 2019. Confirmation of submission will not be known until July 2019.

4.1 Criterion 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

The maternity service are required to provide evidence that in the last training year (July 1st 2018 to July 31st 2019) the following staff (see table 5 below which represents all staff groups) have received a training package that is an 'in-house' multi-professional maternity emergencies training session.

Table 5

Prediction for July based on full booked attendance			
Staff Group	**Total**	**Attended Emergency Training in last 12 months**	**%attendance**
Obstetric Trainees (staff grade, obstetric trainees, clinical fellows, Foundation year)	28	26	92.86%
Consultant Obstetricians	17	17	100.00%
Consultant Anaesthetists	11	9	81.82%
Anaesthetic trainees (contributing to obstetric rota)	8	8	100.00%
UHS Midwives (to include HDU & elective theatre midwife, midwives, midwifery managers, matrons, all areas NHSP - latter separate assurance)	251	244	97.21%
MSWs & Nursery Nurses	66	65	98.48%
Theatre Staff (theatre practitioners, anaesthetic nurse, ODP, theatre recovery and support nurse)	51	39	76.47%
Theatre - maternity Elective (x1 recovery nurse, x1 recovery support worker)??	3	3	100.00%
Day Surgery & Recovery	19	12	63.16%
All	**454**	**423**	**93.17%**

The training includes (but not limited to) fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops. The training schedule and content is based on current evidence, national guidelines / recommendations. Where relevant training will be based on relevant local audit findings, risk issues and case review feedback, and includes the use of local charts, emergency boxes, algorithms and pro-formas.

As the training requirements are complex and involve a number of specific groups, which provides a challenge for both the maternity service and other services to achieve the 90% compliance target. The maternity service Practice Education team are supporting all areas to achieve compliance but the compliance for this criterion this will not be fully known until July.

5. Conclusion

The maternity service continues to assess the evidence in place and take any additional steps that are required to achieve compliance. This report to the Trust Board members demonstrates achievement (with evidence Appendix A) of each of the ten actions where available. A full sign of the 'Board Declaration Form' is planned for the July Trust Board meeting.

The maternity service as required, has shared current compliance information with and will share completed 'Board Declaration Forms' with the commissioner(s) of the Trust's maternity services as required.

The maternity service plans to meet all of the 10 criteria by July 2019 and will continue to deliver any ongoing actions or plans relating to any associated criteria and will receive continued scrutiny and monitoring by a number of groups and committees both internal and external.

To ensure evidence provided to Trust Board members is appropriate and of a suitable level meetings have been arranged before the Trust sign off is required, to scrutinise the evidence and includes

- The Trust Quality Assurance Manager on 19th June
- The Divisional Management Team on the 8th July

6. Recommendations

The maternity service recommends that members of Trust Board:

1. Acknowledge the status of compliance noted in the report and evidence provided.
2. Be aware of the status of possible non-compliance with some criterion.
3. The requirements for the 'Board Declaration Form' sign off process.
4. Be aware that the information needs to be shared with the local Commissioners (as required).
5. Provide any ongoing monitoring and scrutiny of the NHSR action plan as required.

7. Appendices

- Appendix A – evidence of compliance.

Appendix A Detailed Gap Analysis for Maternity Incentive Scheme

Criterion	Detail	
1). Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Requirement** A report has been received by the Trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.	**Standard met? (Y/N)**
	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.	Yes
	b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	Yes
	c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	Yes
	d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.	Yes staring from Quarter 4 2018/19
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • From Wednesday 12 December until Thursday 15 August 2019	
	The report should evidence that the required standards a) to c) above have been met.	**Evidence**
	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans.	**Evidence of - Annual Report to Trust Board (Covering 2018)**

		Maternity Services Annual Report Materr **Evidence of Trust Board in June report (Covering Qtr 1 2019)** **Evidence of QGSG reporting Covering Qtr 1 2019)** Encl D -QGSG meeting Div C Report **Evidence of Maternity Governance Covering Qtr 1 2019)** Agenda WN Governance Meeting . Enc J - May 2019 PMRT Reporting.docx
	Validation of evidence • Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. • NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.	

	Maternity self-assessment		
2). Are you submitting data to the Maternity Services Data Set to the required standard?	**Requirement** This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).		
	Evidence		**Standard met? (Y/N)**
	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details). UPDATE 22/05/2019 – NHS Digital are not providing Scorecards for Feb and March as stated previously.		 CNST Criteria v2 - January 2019.xlsx
	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019.		Yes
	One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019.		Yes
	One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019. **UPDATE** 13/06/2019 slight extension to the submission deadline to Friday 5 July 2019.		**Evidence required – available at end of July**
	Mandatory categories 1-3 must be met to pass Safety action 2		**Standard met? (Y/N)**
	1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood).	Yes **Evidence**  CNST Criteria v2 - January 2019.xlsx
	2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales.	Yes **Evidence**

			 20190301 MSDS v2 UHS response.pdf
	3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019. **UPDATE** 13/06/2019 slight extension to the submission deadline to Friday 5 July 2019.	**Evidence required – available at end of July**
	14 of the 19 optional categories(4-22 must be met to pass Safety action 2)		**Standard met? (Y/N)**
	4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019	Yes
	5	January 2019 data contained valid smoking at booking for at least 80% of bookings	Yes
	6	January 2019 data contained valid smoking at delivery for at least 80% of births	Yes
	7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)	Yes
	8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)	Some data not submitted
	9	January 2019 data contained method of delivery for at least 80% of births	Yes
	10	January 2019 data contained valid baby's first feed for at least 80% of births	Yes
	11	January 2019 data contained valid in days gestational age for at least 80% of births	Yes
	12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded	Yes
	13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded	Not reached the 80% target
	14	January 2019 data contained valid place type actual delivery for at least 80% of births	Yes
	15	January 2019 data contained valid site code for at least 80% of births	Yes
	16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births	Yes
	17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births	Yes
	18	January 2019 data contained valid fetus outcome code for at least 80% of births	Yes
	19	January 2019 data contained valid birth weight for at least 80% of births	Yes
	20	January 2019 data contained valid figure for previous live births for at least 80% of bookings	Yes

	21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance	Yes
	22	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.	Yes
	Validation of evidence • Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. • NHS Resolution will cross-reference self-certification against NHS Digital data. **To note** Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019		
	Maternity self-assessment		
3). Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	**Requirement** Compliance with the below standards		**Standard met? (Y/N)**
	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.		Yes **-** By Sunday 3 February 2019
	b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.		Yes **-** By Sunday 3 February 2019
	c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.		Yes **-** By Sunday10 March 2019
	d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN		Yes - By Sunday 19 May 2019
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019		

		Evidence
	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads	**Evidence of UHS Transitional Care Protocol**  Transitional-Care-Operational-Protocol.pdf
	Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS.	**Evidence of activity recorded electronically on Badgernet**  Evidence of TCU activity from Sunday
	An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews.	**Evidence of audit**  Audit 5956 Unexpected Term adc
	Evidence of an action plan to address identified and modifiable factors for admission to transitional care.	**Evidence of action plan**  ATAIN Action Plan-05-03-2019.pdf
	Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.	**Evidence of LMS** = Yes  SHIP LMS Board Minutes March 2019 F **Evidence of LMS update on action plan**

		SHIP LMS Board Minutes May 2019 Fin **Evidence of ODN confirmation** = Yes (Email to confirm by Gina Outram ODN manager) RE ATAIN Newsletter Jan 2019. **Evidence of Trust Board report** Maternity Services Annual Report Materr
	Validation of evidence • Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form	
	Maternity self-assessment The maternity service is compliant with the requirements of this criterion, with evidence being provided above.	
4). Can you demonstrate an effective system of medical workforce planning to the required standard?	**Requirement** Compliance with the below standards	**Standard met? (Y/N)**
	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.	Yes

	b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.	Yes
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: a) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.	**Evidence**
	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk.	**Evidence of SOP - developed and agreed.**  GMC Report Feb 19.doc **Evidence of submission to RCoG (email from Lead)**  RE NHS R - Medical Workforce ... **Evidence of information to Trust Board evidence (June report)** **Evidence of W&N Governance Minutes available end of June**  Enc A - WN Governance Minutes
	b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met.	**Div A Evidence of compliance**

		 Encl D - Division A.docx **Evidence of QGSG Minutes**  Encl A1 - Draft QGSG Minutes 7.5.19 APPR(
	Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.	**N/A – (for part a)** **Evidence of Standard Operating Procedure (SOP) developed to provide assurance (for part b)**  GMC Report Feb 19.doc **Evidence of information to Trust Board evidence (June report)**
	Validation of evidence Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form	
	Maternity self-assessment The maternity service is compliant with the requirements of this criterion, with evidence being provided above.	
5). Can you demonstrate an effective system of midwifery workforce planning?	**Requirement** Compliance with the below standards	**Standard met? (Y/N)**
	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done.	Yes

	b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service	Yes
	c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)	Yes
	d) A bi-annual report that covers staffing/safety issues is submitted to the Board	Yes
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • Any consecutive three month period between January to July 2019	
	A bi-annual report that includes evidence to support a-c being met. This should include:	**Evidence**
	• A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.	**Evidence of Birth Rate+ report** UHS BR+ Report_March 2018.p
	• Details of planned versus actual midwifery staffing levels.	**Staffing report** Maternity Staffing Report - March - May
	• An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.	**Staffing report** Maternity Staffing Report - March - May
	• The midwife: birth ratio.	**Evidence of Annual report** Maternity Services Annual Report Matern
	• The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.	**Staffing report**

		Maternity Staffing Report - March - May
	• Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls.	**Evidence of Birthrate plus Acuity Tool Report (Nov18-April 19)** Report to Risk & Patient Safety Meetin
	• Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).	**Evidence of Birthrate plus Acuity Tool Process** Process for Red Flag reporting may 19.doc
	Validation of evidence • Self-certification to NHS Resolution using the Board declaration form	
	Maternity self-assessment	
6). Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	**Requirement** Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).	

	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • The scheme will take into account the position of trusts at end July 2019.	
		Evidence
	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).	**Evidence of Trust Board report containing information on SBL**  Maternity Services Annual Report Materr **Evidence of SBL Bundle 12 compliance**  SBL report Southampton RHM Su
	Validation of evidence • Self-certification to NHS Resolution using the Board declaration form.	
	Maternity self-assessment The maternity service is compliant with the requirements of this criterion, with evidence being provided above.	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	**Requirement** User involvement has an impact on the development and/or improvement of maternity services.	
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • From January 2019 to July 2019	
	Evidence should include:	**Evidence**
	Acting on feedback from, for example a Maternity Voices Partnership.	**Evidence of Annual report containing information about MVP**

		Maternity Services Annual Report Materr
	User involvement in investigations, local and or Care Quality Commission (CQC) survey results.	**Evidence of PICKER Report 2018** RHM_MAT18 Picker Management Report (**Evidence of Internal report** Action Plan PICKER response Southamptc **Evidence of Women being involved in bereavement investigations** Enc J - May 2019 PMRT Reporting.docx **Evidence of Women being involved in the 15 Steps review** Labour ward 15 steps review Novemb Broadlands 15 steps review january 2019.

	Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.	**Evidence of meeting**  MVP AGENDA 24-05-2019.docx  MVP Meeting minutes 24-05-2019.docx  Presentation for May 24th.pptx
	Validation of evidence • Self-certification to NHS Resolution using the Board declaration form.	
	Maternity self-assessment The maternity service is compliant with the requirements of this criterion, with evidence being provided above.	
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	**Requirement** 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.	
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • The scheme will take into account the position of trusts by Thursday 15 August 2019. **Evidence should include:**	**Evidence**

	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.	**Evidence of guidance**  Specialist training for maternity services FIl
	Training syllabus should be based on current evidence, national guidelines / recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.	**Evidence of guidance**  Specialist training for maternity services FIl
	There should be feedback on local maternal and neonatal outcomes	**Evidence of feedback on outcomes Qtr 4 18**  Evidence of MQuest feedback on maternit **Evidence of feedback on outcomes Qtr 1 19 available end of June**
	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating	**Compliance will be confirmed July 19**

	department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) **To note** There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety action. Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, then they cannot be counted towards the overall percentage.	
	Validation of evidence Self-certification to NHS Resolution using the Board declaration form.	
	Maternity self-assessment	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	**Requirement** Compliance with the below standards	**Standard met? (Y/N)**
	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)	By Sunday 27 January 2019
	b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues	By Wednesday 27 February 2019
	c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff	By Wednesday 27 March 2019
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27	

	January 2019 b) Must be implemented by Wednesday 27 February 2019 c) Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis	
		Evidence
	Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three	**Evidence of – Gail Byrne attended**  Letter to Head of Midwifery - Exec invit  Wessex Maternal Neonatal Learning Sy  WMNLS flyer October 16th 2018.p
	Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally	**Evidence of Annual report containing QI information**  Maternity Services Annual Report Matern **Evidence of Improvement Plan**  Maternity Services Safety Improvement **Evidence of Quality Improvement Strategy**  Maternity Quality Improvement Strateg

	Evidence of attendance at one or more National Learning Set or the annual national learning event	**Evidence of MatNeo National Learning Set certificate**  MatNeo certificate.docx **Evidence of MatNeo National Learning Set photo**  MatNeo Photo.jpg
	Evidence of engagement with relevant networks and the collaborative LLS	**Evidence of engagement in August 2018**  Southampton Case study DWS final.docx **Evidence of engagement in June 2019**  WMNLS programme 27th June 19.docx
	Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff	**Evidence of Newsletter on staff concerns**  Maternity Mail February 19.pdf  Maternity Mail March 19.pdf

	Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns	**Evidence of information to Trust Board evidence (June report)** **Evidence of ToR for Risk & Patient Safety Meeting**  Amended 2017 TOR for Maternity Neonat **Evidence of Risk report**  Report to Risk & Patient Safety Meetir
	Validation of evidence • Self-certification to NHS Resolution using the Board declaration form	
	Maternity self-assessment	
10). Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	**Requirement** Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.	
	Minimum evidential requirement for Trust Board Timeframes for evidence are as follows: • 1 April 2018 to 31 March 2019	**Evidence**

	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.	**Evidence of Trust level reporting by the Legal team** 9.7.2018 Audit and Risk FINAL.doc Enc b iii Appendix 2 High Level Claims Sun Enc c iii Appendix 2 High Value Claims Sun High Level Claims Summary - no claims Enc b iii Appendix 2 Claims Summary July. **Evidence of Maternity Governance reporting on ENS** Agenda WN Governance Meeting . Enc I - May 2019 NHSR ENS Reporting

	Validation of evidence • Self-certification to NHS Resolution using the Board declaration form • NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
	Maternity self-assessment The maternity service is compliant with the requirements of this criterion, with evidence being provided above.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: Finance Report 2019-20 Month 2			
Category	Quality, Performance, and Finance		
Agenda item	4.5		
Sponsor	Chief Financial Officer		
Author	Gavin Hawkins, Assistant Director of Finance		
Provenance	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.		
Classification	This Report is unclassified.		
Purpose and recommendation	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.		
Relevant strategic goals	☐ 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.
Assurance framework links	Cross-reference to the applicable risk register and Board Assurance Framework entries: • CRR02 – 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 • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care		
Impact assessments			
Other standards affected			

University Hospital Southampton NHS
NHS Foundation Trust

2019/20 Finance Report - Month 2

Report to:	**Board of Directors & Strategy & Finance** **June 2019**
Title:	**Finance Report for Period ending 31/05/2019**
Author:	**Gavin Hawkins, Assistant Director of Finance**
Sponsoring Director:	**David French, Chief Financial Officer**
Purpose:	**Standing Item**
	The Committee is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In May 2019, the Trust delivered a surplus of £0.5m, £0.8m better than Plan. Year to date the Trust is reporting a £2.4m deficit but this is £0.6m better than Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '3'.

2. When non-recurrent items are excluded , the surplus in May 2019 was £0.3m, £0.6m better than Plan. The Board should note that £6.7m of currently unidentified CIP is assumed in the Plan to be delivered in the second half of the year. If CIP was phased equally through the year, the CIP shortfall would have been £1.3m higher in the month and £2.7m year to date.

3. The main themes seen in M2 were:
   - Income was £0.8m better than Plan, predominantly related to high non-elective activity offset ting below Plan elective.
   - Pay was £0.6m worse than Plan in month, with overall pay spend not achieving the pay CIP target. Both bank & agency expenditure increased compared to April 2019 by a combined £0.5m and substantive was up £0.2m in real terms.
   - Total CIP delivery was £1.9m, only £0.1m below Plan, although £0.8m was a catch-up related to April 2019.

4. The cash position was £15m above Plan at £65m. This has primarily been driven by:
   - Year-end income position £2.5m was above forecast at the time the cash plan was agreed
   - Capital expenditure £6m below M2 planned position
   - Accounts payable balances remain higher than anticipated

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.

Finance: I&E Summary

Overall: Red

Total clinical income was £0.8m above Plan.

Non Elective activity was £1.8m above Plan, although blended payment marginal rates reduced this to £1.4m. Elective activity was £0.5m below Plan.

Substantive and bank pay combined was £0.9m above Plan, partially offset by below Plan agency spend (£0.3m) Both bank & agency spend was higher than April 2019.

Whilst the total pay bill for May was £0.4m lower than April but was £0.7m higher in real terms due to the one-off Agenda for Change payment made in April to eligible staff.

Overall CIP delivery was £0.1m behind Plan with £1.9m delivered vs a Plan of £2m. See page 12 for further detail.

Metric	2019/20		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	0.97	4	4
Liquidity rating	19.77	1	1
I&E Margin Rating	-0.81%	3	4
I&E Margin Variance Rating	0.46%	1	1
Agency Variance from ceiling	38.62%	1	1
Use of Resources Average Metric		2.00	2.20
Use of Resources Final Metric		3	3

		Current Month			Year to Date				Full Yr	Ave	To
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m		Plan £m	Done £m	Do £m
NHS Income:	Clinical	52.3	53.1	(0.8)	101.5	103.3	(1.8)	G	630.6	51.6	52.7
	Pass-through Drugs & Devices	9.5	8.6	0.9	18.6	17.2	1.4	R	115.2	8.6	9.8
Other income	Other Income excl. PSF	9.4	8.9	0.5	18.8	18.2	0.5	R	105.0	9.1	8.7
Total income		**71.2**	**70.7**	**0.6**	**138.8**	**138.7**	**0.1**	**A**	**850.8**	**69.4**	**71.2**
Costs	Pay-Substantive	38.6	39.0	0.4	78.1	78.9	0.8	A	461.0	38.9	38.2
	Pay-Bank	1.9	2.4	0.5	3.8	4.4	0.6	R	22.8	2.2	1.8
	Pay-Agency	1.1	0.8	(0.3)	2.2	1.4	(0.7)	G	14.1	0.7	1.3
	Drugs	1.4	1.2	(0.2)	2.3	2.4	0.1	A	14.2	1.2	1.2
	Pass-through Drugs & Devices	9.5	8.6	(0.9)	18.6	17.2	(1.4)	G	115.2	8.6	9.8
	Clinical supplies	5.5	6.5	1.0	11.0	12.1	1.1	R	65.5	6.1	5.3
	Other non pay	10.7	8.6	(2.1)	20.0	18.4	(1.6)	G	105.1	9.2	8.7
Total expenditure		**68.6**	**67.1**	**(1.5)**	**136.1**	**134.9**	**(1.1)**	**G**	**797.9**	**66.9**	**66.3**
EBITDA		**2.6**	**3.6**	(1.0)	**2.8**	**3.8**	(1.1)	**G**	**52.9**	1.9	4.9
EBITDA %		3.7%	5.1%	1.4%	2.0%	2.8%	0.8%		6.2%		
	Depreciation	1.8	2.0	0.2	3.6	4.1	0.5	R	22.6	2.1	1.8
	Non Operating Income/Expenditure	1.1	1.1	(0.0)	2.2	2.1	(0.1)	G	13.3	1.1	1.1
Control Total Surplus / (Deficit)		**-0.3**	**0.5**	**(0.8)**	**-3.1**	**-2.4**	**(0.6)**	**G**	**17.1**	**-1.2**	**2.0**
Memo - Other technical items:											
Provider Sustainability Funding		0.6	0.6	-	1.3	1.3	-	G	12.7	0.6	1.1

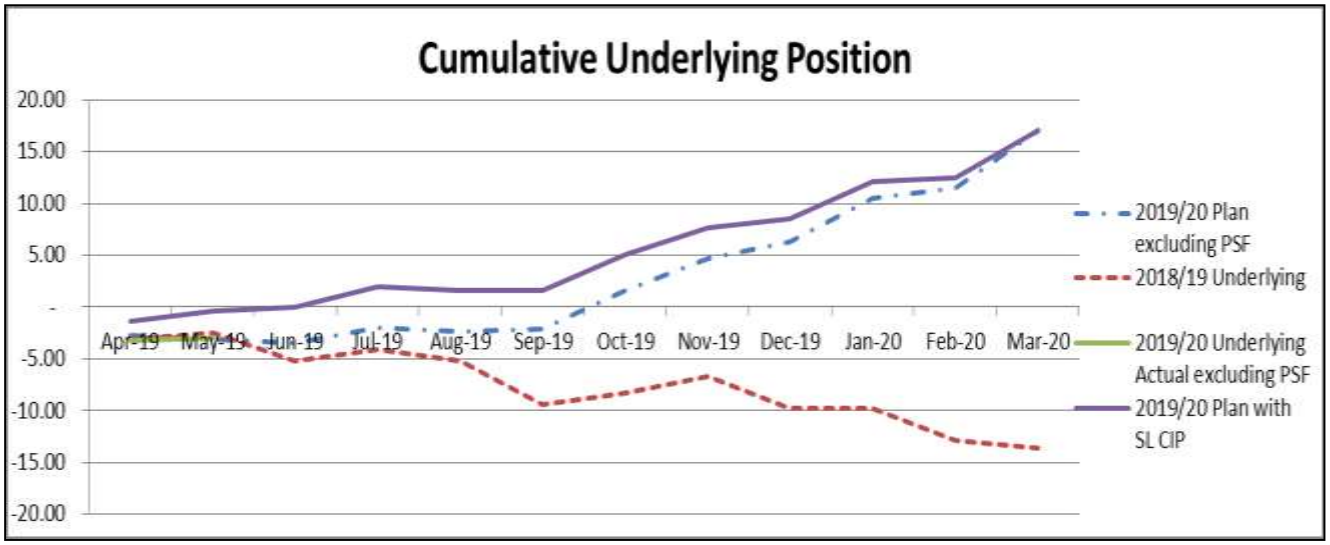
Underlying Run Rate Position

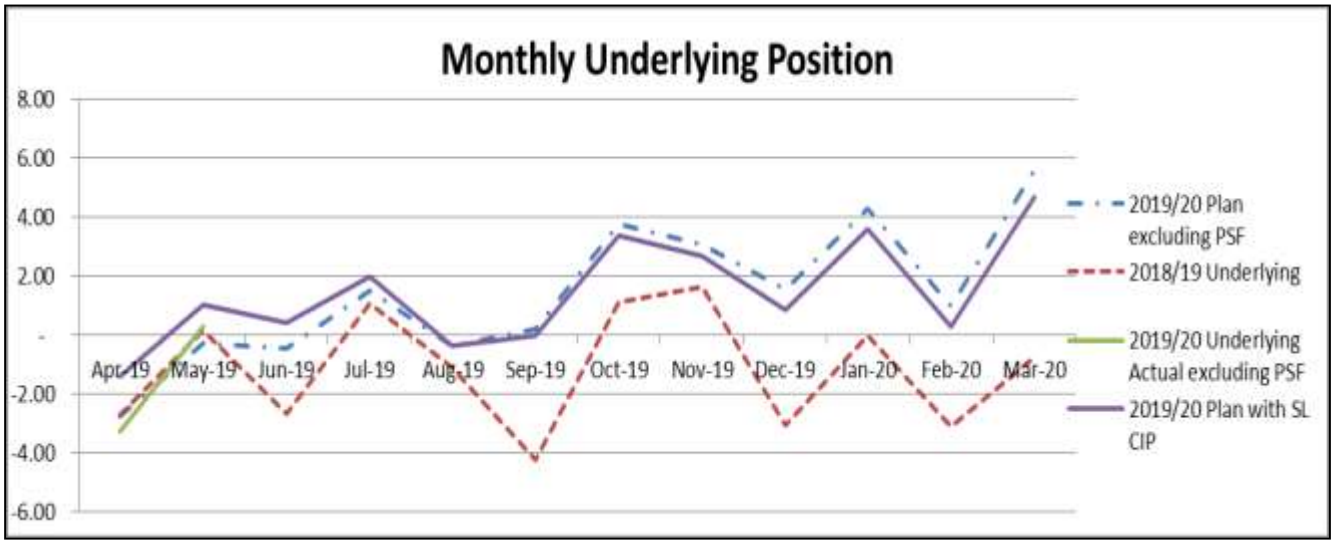
This graph shows the actual underlying position compared to the NHSI Plan.

It also shows an alternative presentation of the Plan phasing assuming that the £40m CIP target is delivered equally each month through the year. On this basis, the Plan would have been £1.3m higher in May 2019.

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.

All figures exclude PSF.





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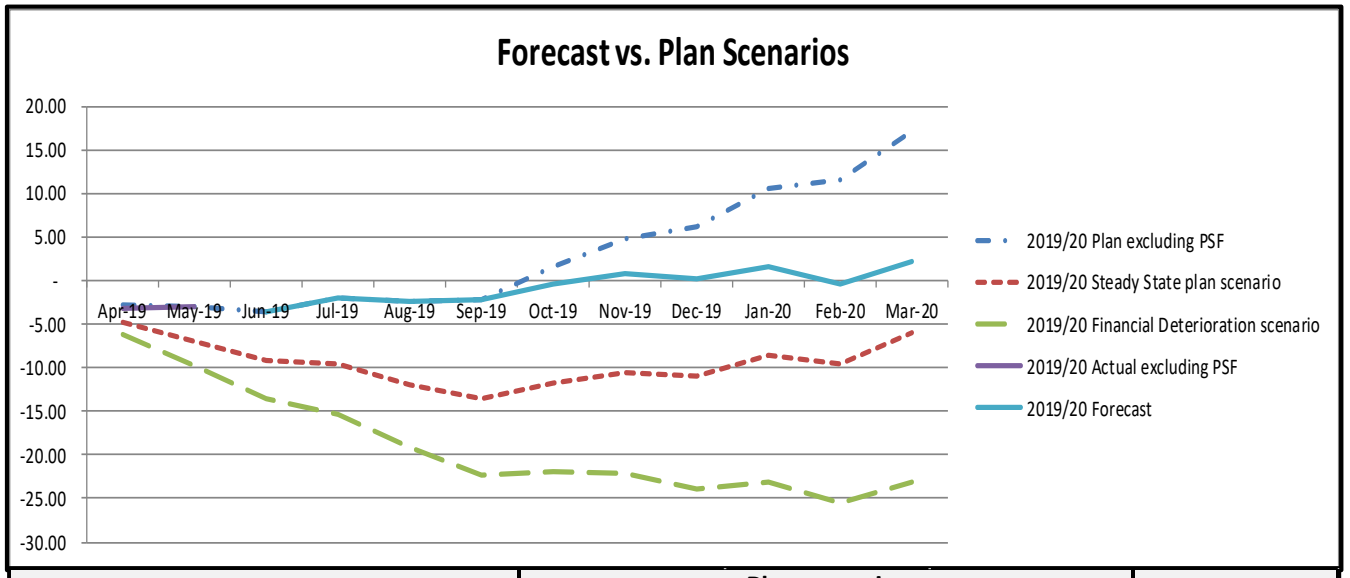
Underlying Run Rate Position

This graph shows potential forecast scenarios for 19/20 surplus out-turn, as shared with Trust Board as part of the 2019/20 planning process.

Currently the forecast is based on estimates post April & May 2019 and is therefore highly uncertain.



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 regularly throughout the year.

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

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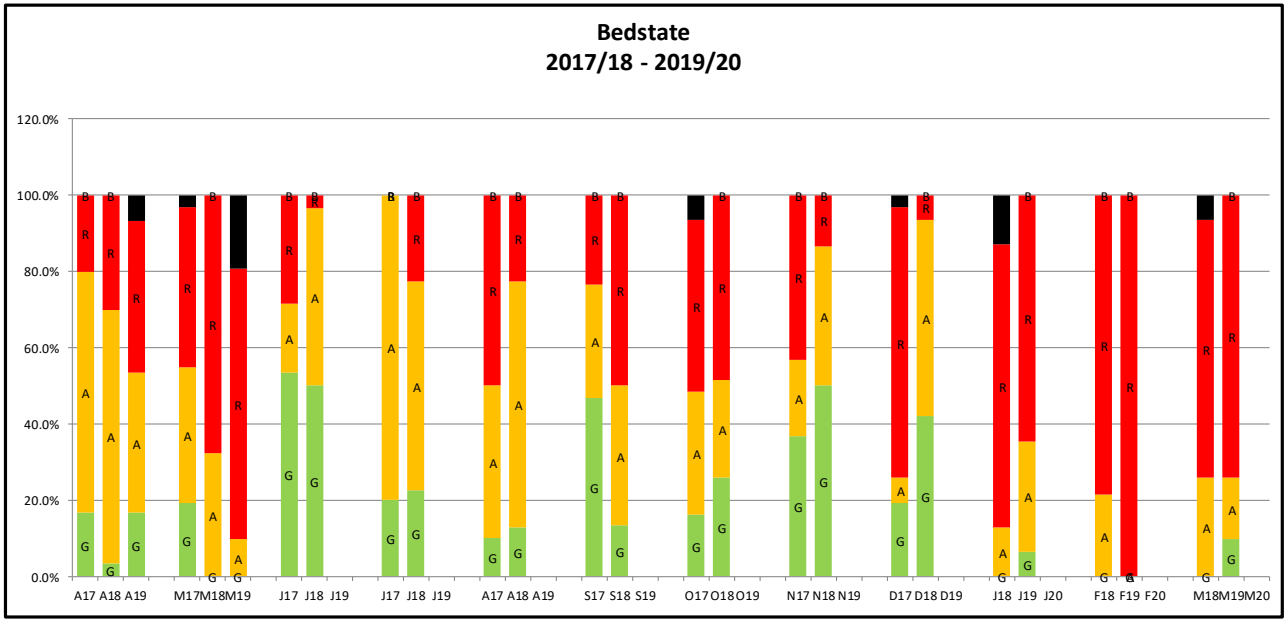
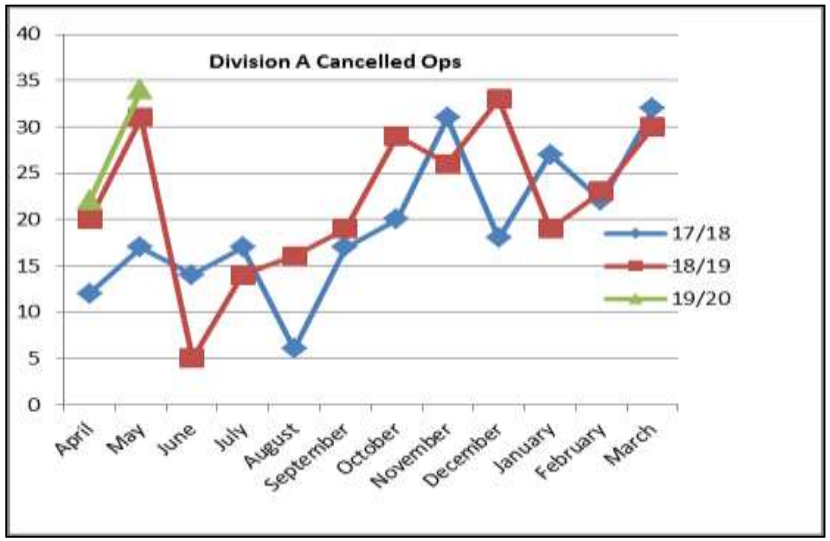
Bedstate – 3yr Comparison

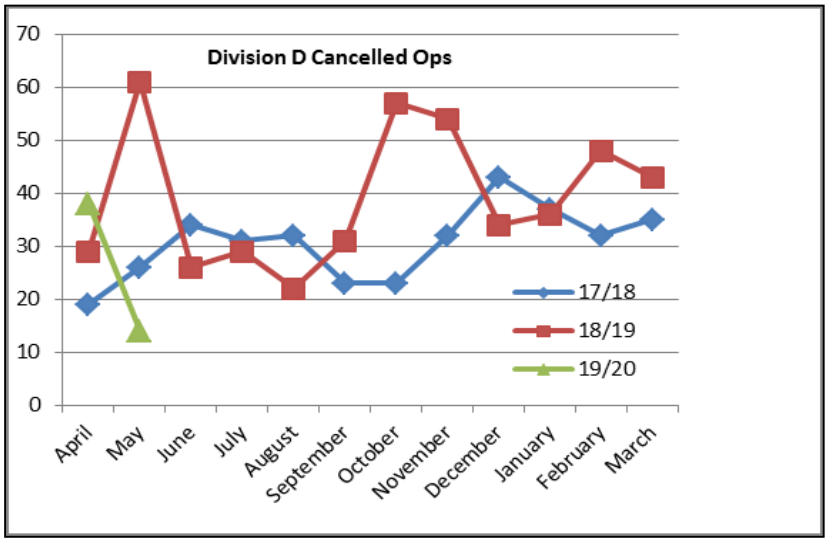
Bed state information for May 2019 highlight periods of Black Alert, which occurred particularly due to an outbreak of norovirus.

The resulting bed closures impacted on bed flow and ED performance in the month. Clinical activity was estimated to be above Plan for non-elective (+£1.8m before blended tariff adjs) and below Plan for Elective (-£0.5m).

On the day cancellations for non-clinically reasons shown below for Divisions A & D comparing 2017/18, 2018/19 & 2019/20.







Clinical Income

The chart shows estimated clinical income in May 2019.

Non-elective inpatient activity was above planned levels and a provision has been taken against the impact of the blended payment tariffs for emergency care.

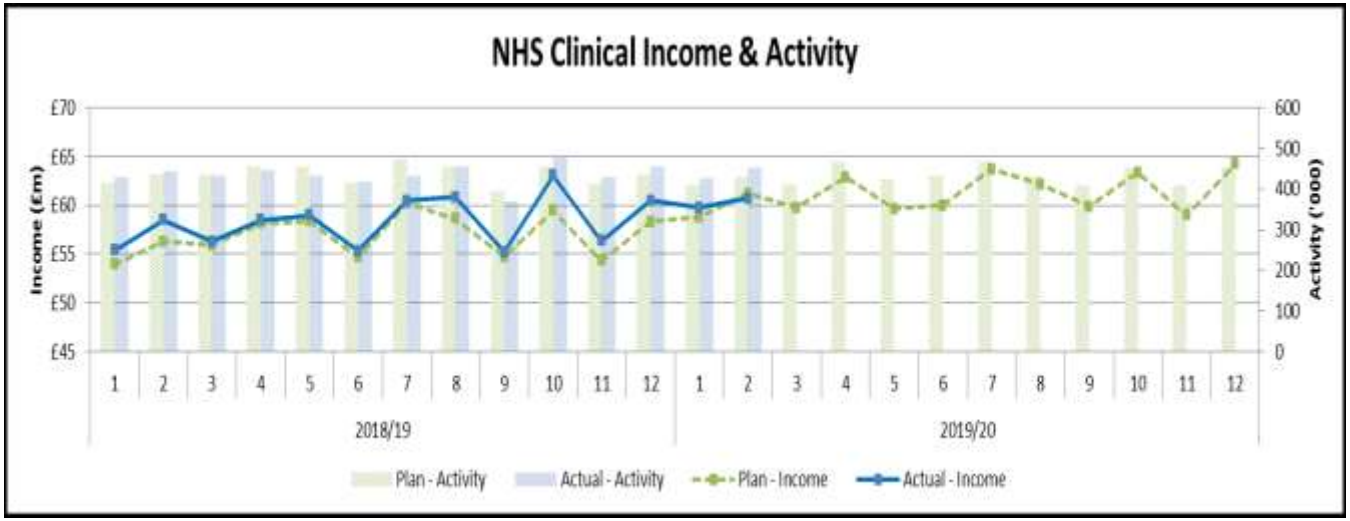
Linked to the high non-elective activity, elective inpatient income was below planned levels in the month. Operationally the Trust faced bed challenges in May 2019 due to norovirus which impacted delivery of the elective programme.

Outpatient activity was above planned levels in the month.

Pass-through drug and device income, within exclusions, was lower than planned levels although this was 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 later in the year.

	2018/19	2019/20				2019/20			Monthly Run Rate	
POD GROUP	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
NHS Clinical Income										
Elective Inpatients	£21,605	£147,526	£23,852	£22,799	£1,053	£12,112	£11,612	£501	£11,400	£12,473
Non-Elective Inpatients	£31,321	£199,948	£32,693	£36,070	(£3,377)	£16,404	£18,221	(£1,818)	£18,035	£16,388
Blended payment adjustment	£0	£0	£0	(£710)	£710	£0	(£355)	£355	(£355)	£71
Outpatients	£12,045	£81,651	£12,991	£13,749	(£758)	£6,662	£7,100	(£438)	£6,874	£6,790
Other Activity	£19,330	£128,481	£21,329	£20,435	£894	£10,799	£10,362	£437	£10,217	£10,805
CQUIN	£2,427	£8,294	£1,351	£1,343	£8	£685	£672	£13	£672	£695
Blocks & Financial Adjustments	£1,595	£6,842	£1,682	£1,613	£69	£1,160	£486	£674	£807	£523
Other Exclusions	£682	£46,795	£7,554	£7,983	(£430)	£3,869	£3,989	(£120)	£3,992	£3,881
Prior month adjustment	£0	£0	£0	£0	£0	£622	£1,055	(£433)	£0	£0
Subtotal NHS Clinical Income	*£89,005*	*£619,536*	*£101,452*	*£103,283*	*(£1,831)*	*£52,313*	*£53,142*	*(£829)*	*£51,641*	*£51,625*
Pass-through Exclusions	£17,573	£115,117	£18,582	£17,210	£1,372	£9,518	£8,631	£886	£8,605	£9,791
Total NHS Clinical Income	**£106,578**	**£734,653**	**£120,033**	**£120,492**	**(£459)**	**£61,830**	**£61,773**	**£57**	**£60,246**	**£61,416**
Non NHS Clinical Income										
Private Patients		£5,887	£1,141	£623	£518	£475	£285	£190	£312	£526
CRU		£2,500	£416	£423	(£7)	£208	£208	(£0)	£212	£208
Overseas Chargeable Patients		£1,412	£236	£221	£15	£118	£58	£60	£110	£119
Total Non NHS Clinical Income		**£9,799**	**£1,793**	**£1,267**	**£526**	**£801**	**£551**	**£250**	**£634**	**£853**
Grand Total	**£106,578**	**£744,452**	**£121,827**	**£121,760**	**£67**	**£62,631**	**£62,324**	**£307**	**£60,880**	**£62,269**



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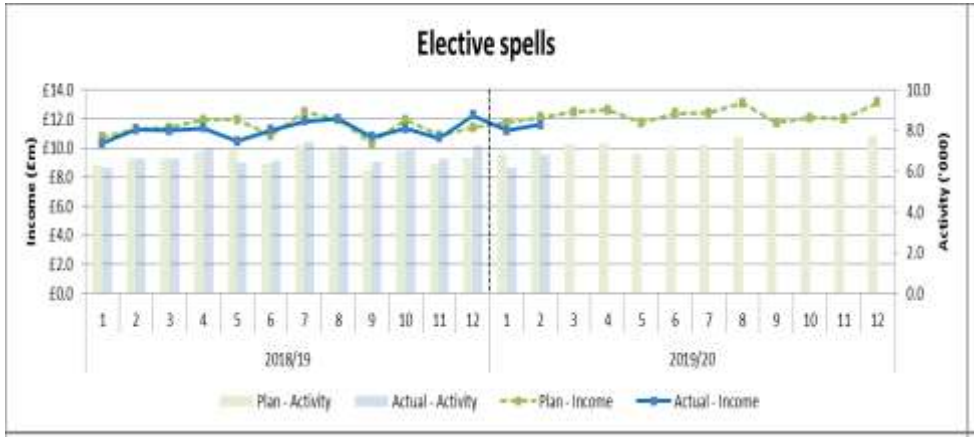
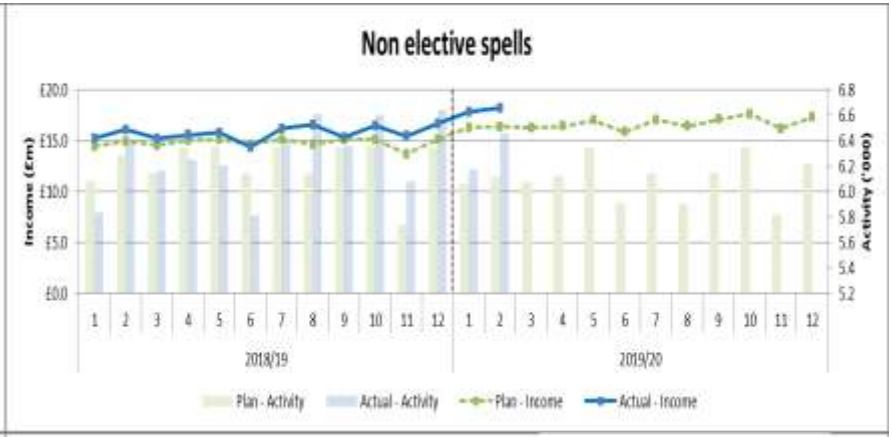
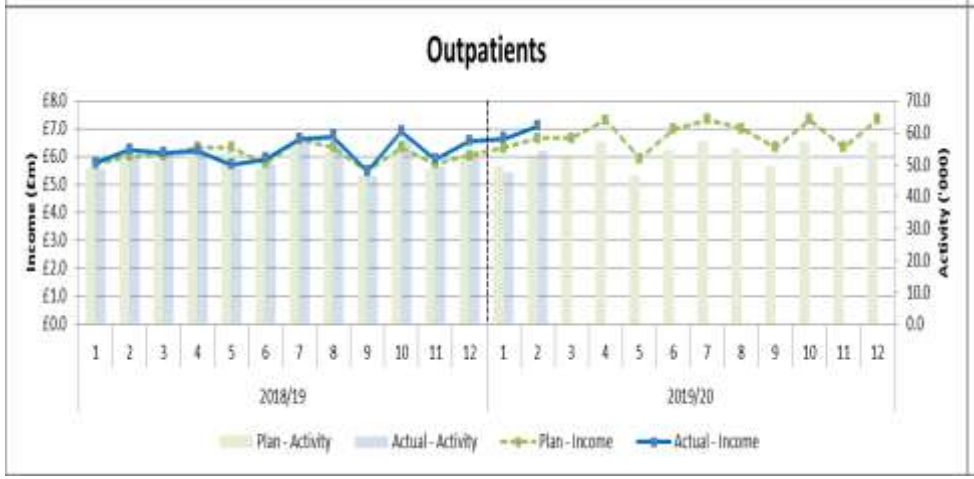
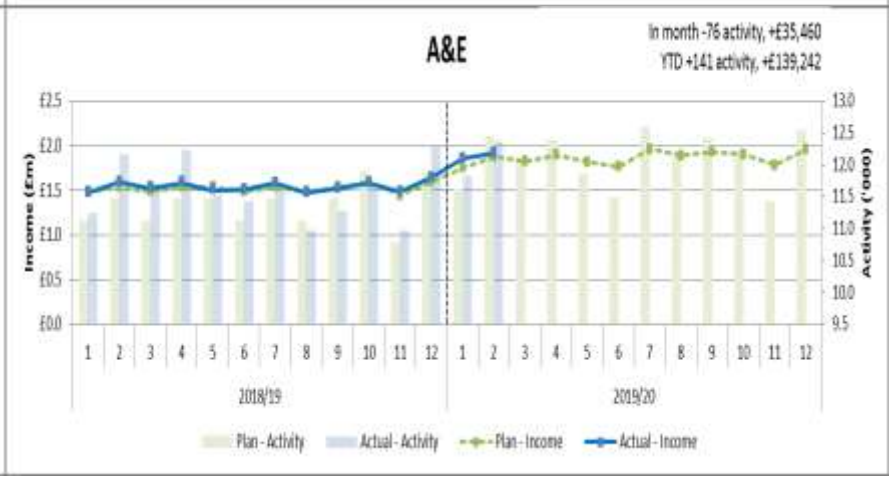
Clinical Income

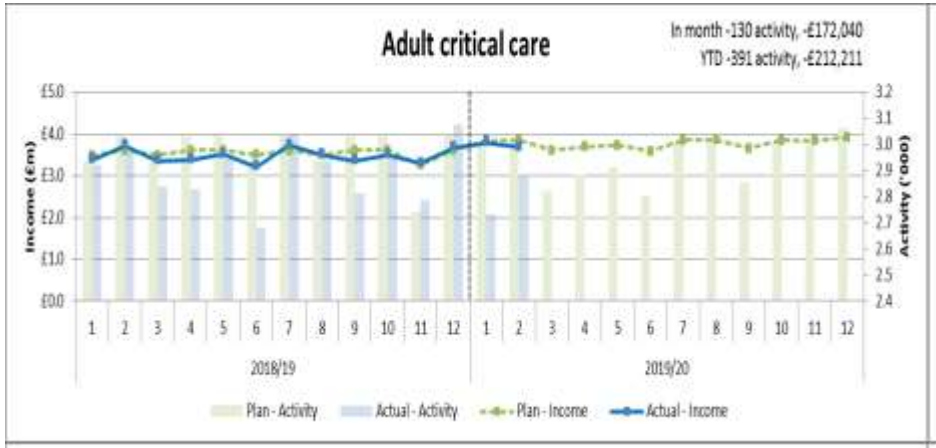


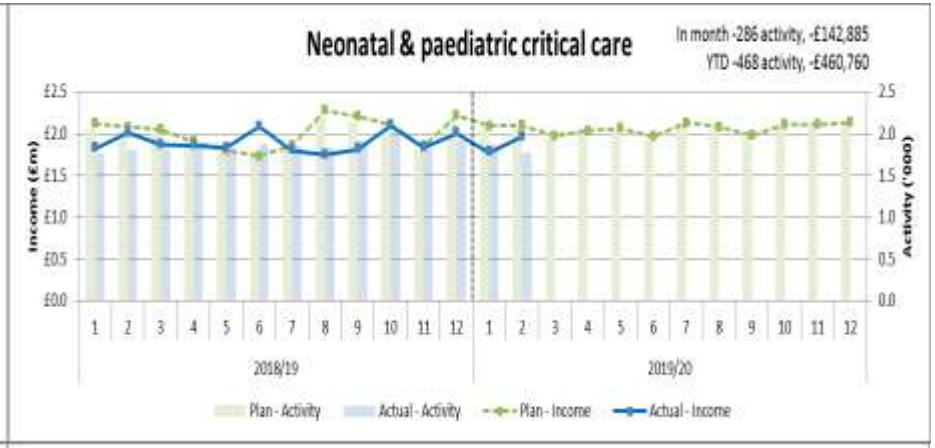


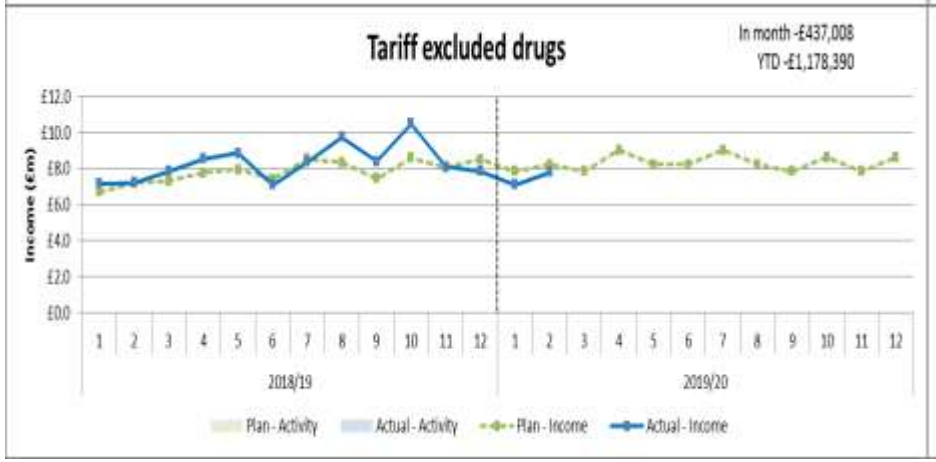


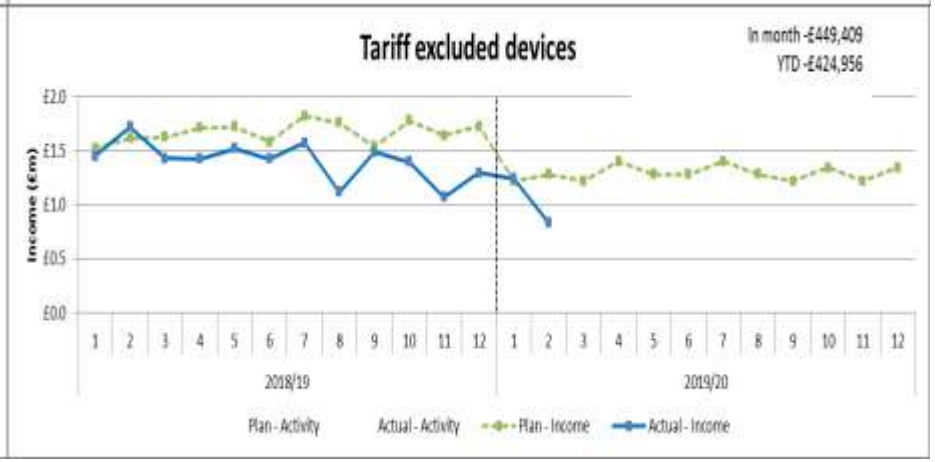


Clinical Income









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.

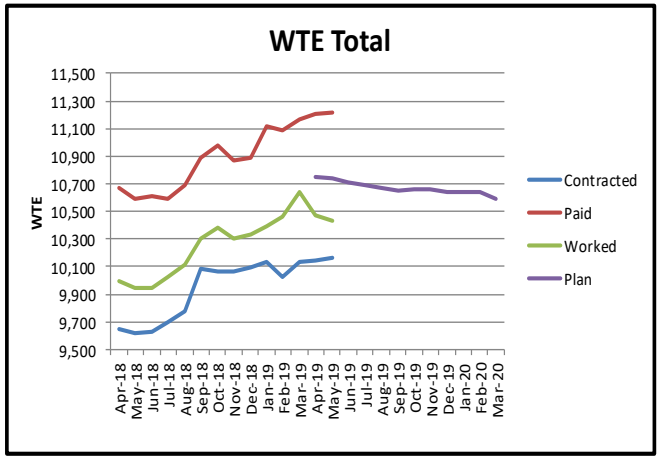
3) 'Paid' is worked WTE but including the WTE equivalent of enhanced rates e.g. weekend working.

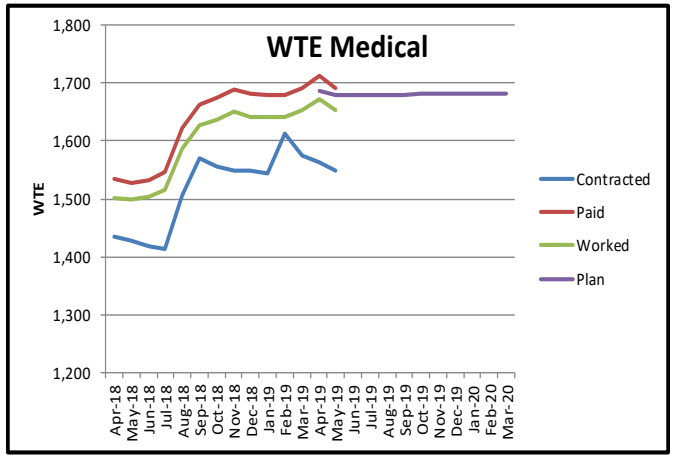
4) 'Plan' = funded WTE.

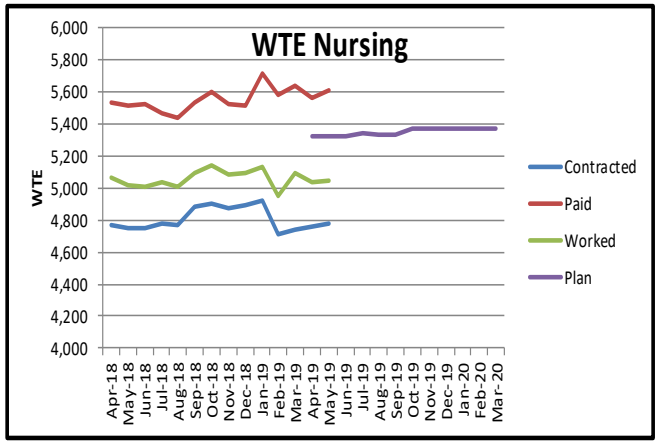
5) 'Other WTE' Plan includes pay CIP yet to be allocated to a specific staffing group, or remains unidentified.

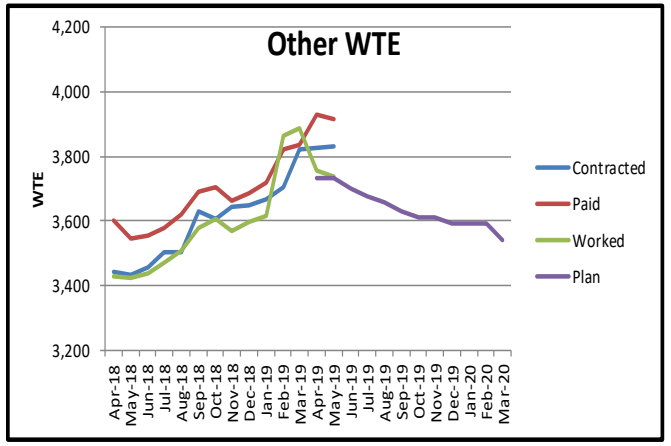
Overall paid WTE increased from April to May 2019 by 13wtes. Whilst other and medical paid wtes reduced nursing paid wtes increased by 47wtes which accounted for £0.2m in terms of nursing pay bill.

Contracted rose marginally (11wtes) and worked reduced by 31wtes.







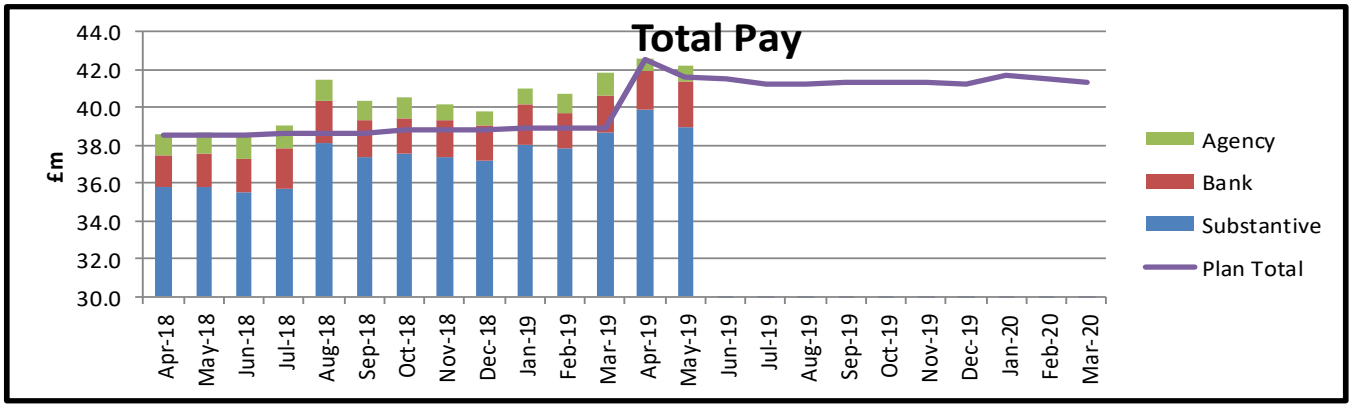


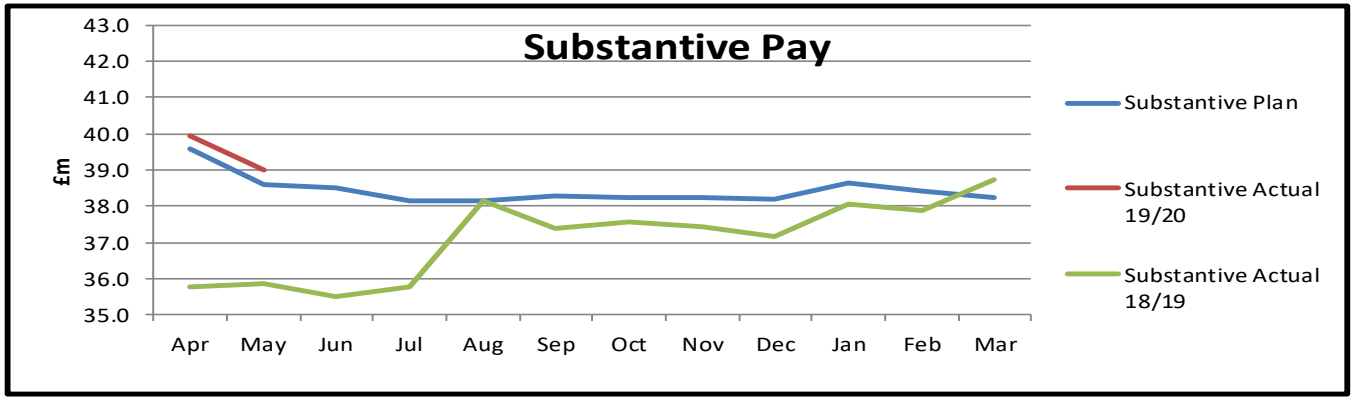
Substantive Pay Costs

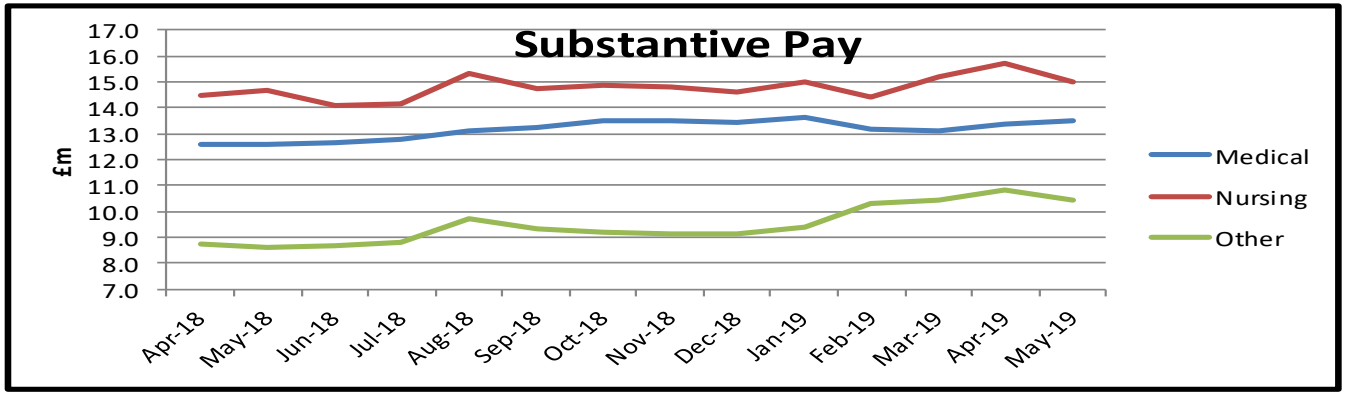
Overall pay reduced in May 2019 by £0.4m, of which £1.1m was due to the one-off AfC pay award payment made to eligible staff in April 2019. In real terms therefore, pay increased by £0.7m, of which £0.2m was substantive, £0.3m bank and £0.2m agency.

Total pay including temporary staffing was £0.6m adverse to Plan in M2. This will include the undelivered element of the pay CIP target.

In June ,TEC approved the introduction of tighter recruitment controls for both substantive and temporary staff, including the creation of a 'recruitment panel' to approve new and replacement posts. The panel will include HR, finance, operational and nursing representatives to ensure decisions are appropriate for clinical quality and safety.







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Temporary Staff Costs

Overall agency spend in May 2019 was £0.8m, £0.2m higher than April 2019 and £0.3m lower than the NHSI agency cap for 2019/20.

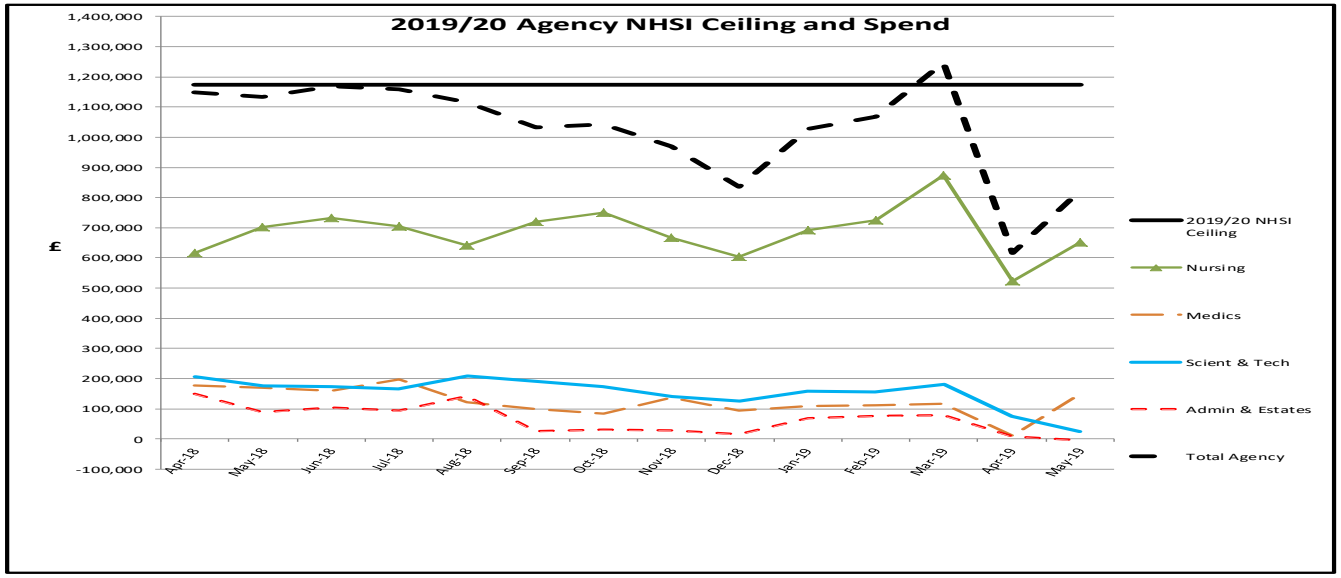
Medical agency increased back to 2018/19 average levels and Nursing accounted for most of the increase from April 2019.

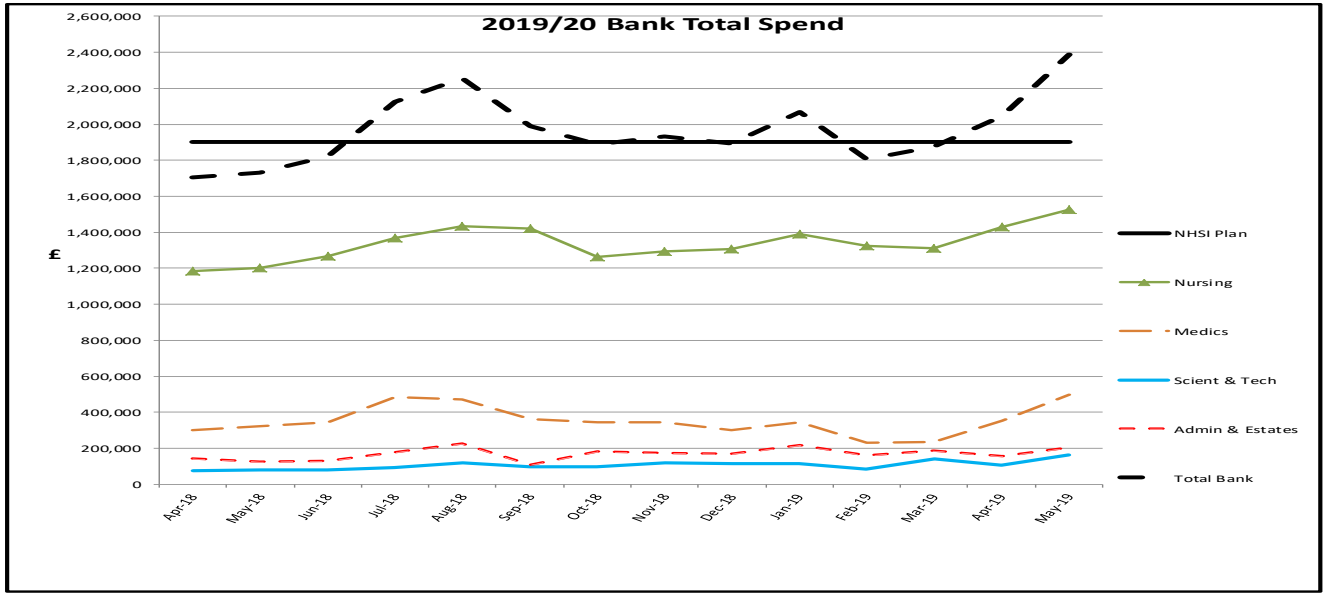
Expenditure on Thornbury continued at the same rate as April 2019, £20k.

Expenditure on bank staff was £2.4m in May 2019, £0.3m more than that spent in April 2019 and £0.5m more than Plan for May 2019.

In overall terms, expenditure on flexible staffing was £0.2m higher than Plan in May.

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 will be sponsored by the Director of Nursing.





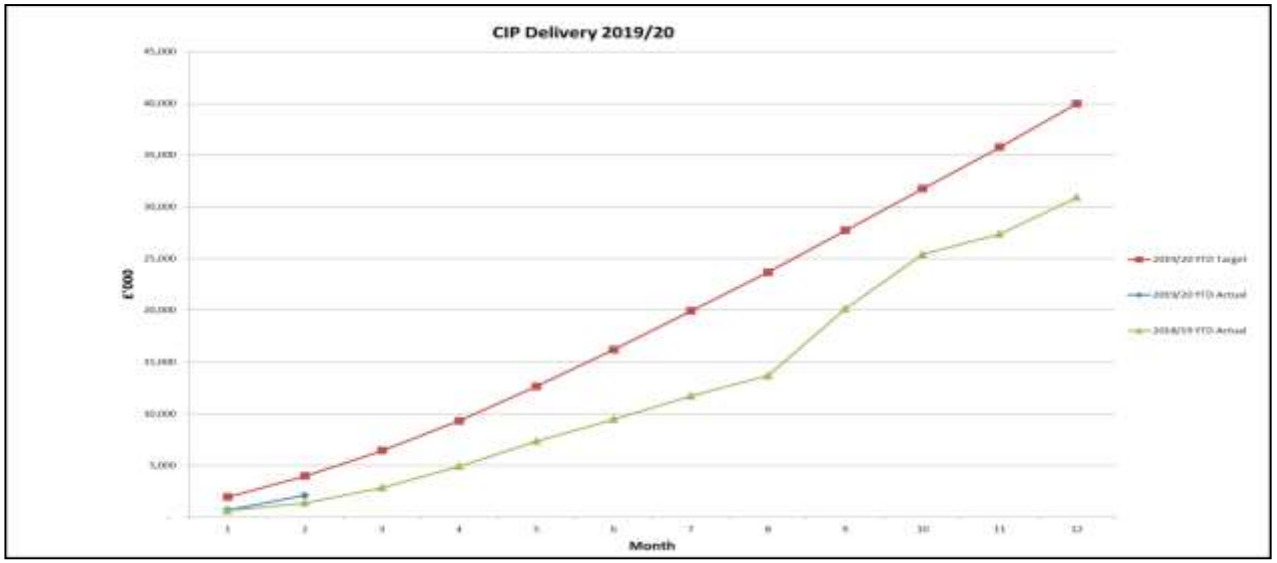
Cost Improvement Programme

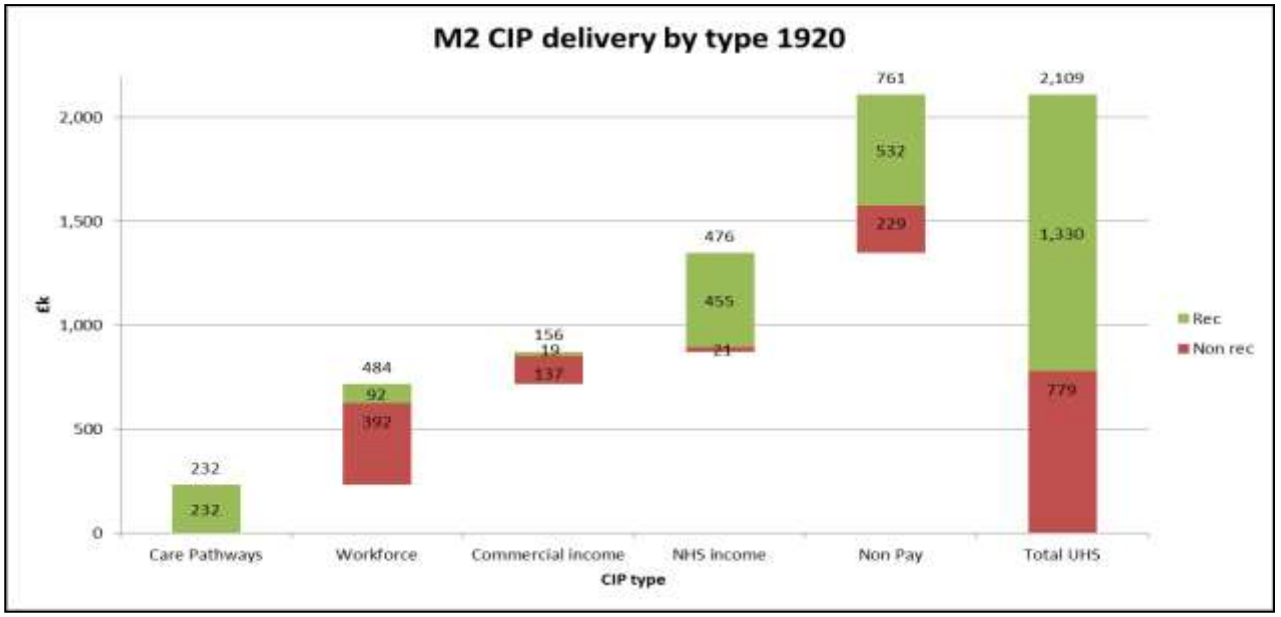
CIP delivery in May 2019 was £1.9m against a target of £2m which included approx. £0.8m of backdated income CIP award for April 2019.

Even when excluding the backdated CIP delivery £1.1m is still higher than that achieved in both April 2019 and May 2018.

Areas for focus in 2019/20 are increasing the profile of 'cost-out' CIP and recurrent schemes. The Trust will also need to increase the pace of CIP delivery to recover the £1.4m shortfall from April and May (£2.6m delivered compared to the target of £4m).

Fortnightly Savings Board, Delivery Board and Divisional Run Rate meetings have been established to improve Trust CIP performance and the underlying financial position of the Trust.





Cost Improvement Programme

The Trust has currently identified CIP of £33.3m, 83% of the target leaving a shortfall of £6.6m.

Of the total identified, £27.4m (82%) is recurrent. This is a higher proportion of recurrent schemes than in previous years.

Schemes identified also include a full-year effect of £3.7m, which off-sets the impact of the non-recurrent schemes.

Work is on-going particularly in central schemes to increase identification.

Division	CIP Target £k	Identified CIP £k	Gap £k	Gap %	Recurrent £k	Non Recurrent £k	Full Year Effect £k
Division A	8,998	8,984	14	**100%**	8,016	968	963
Division B	7,954	7,271	683	**91%**	6,176	1,095	800
Division C	6,569	4,903	1,666	**75%**	2,710	2,193	419
Division D	8,428	7,422	1,006	**88%**	6,466	956	723
Total Clinical Services	31,949	28,580	3,369	**89%**	23,368	5,212	2,905
CFO	2,269	1,877	392	**83%**	1,348	529	374
Transformation	616	387	229	**63%**	337	50	3
COO	379	221	158	**58%**	135	86	20
Nursing and OD	733	290	443	**40%**	243	47	5
Chief Executive	54	0	54	**0%**	0	0	0
Central Schemes	4,000	2,000	2,000	**50%**	2,000	0	400
THQ total and central	8,051	4,775	3,276	**59%**	4,063	712	802
Trust total	**40,000**	**33,355**	**6,645**	**83%**	**27,431**	**5,924**	**3,707**

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.

Excluding length of stay schemes, circa 40% of schemes identified relate to cost out.

Division	Workforce	Non pay and procurement	Length of Stay	NHS income and productivity	Commercial Contracts	Total
Division A	2,128	1,335	2,515	2,570	457	**9,005**
Division B	1,264	2,247	2,619	928	148	**7,206**
Division C	1,531	888	402	1,525	625	**4,971**
Division D	944	1,057	1,510	3,803	91	**7,405**
Trust HQ	561	1,432	26	279	470	**2,768**
Central Schemes	0	0	0	0	2000	**2,000**
Trust total	**6,428**	**6,959**	**7,072**	**9,105**	**3,791**	**33,355**
Profile	**19%**	**21%**	**21%**	**27%**	**11%**	**100%**

Cash

The cash balance was £15m above Plan in M2. This is primarily due to:

1) Receivables balances from end of year clearing earlier than anticipated in Plan.

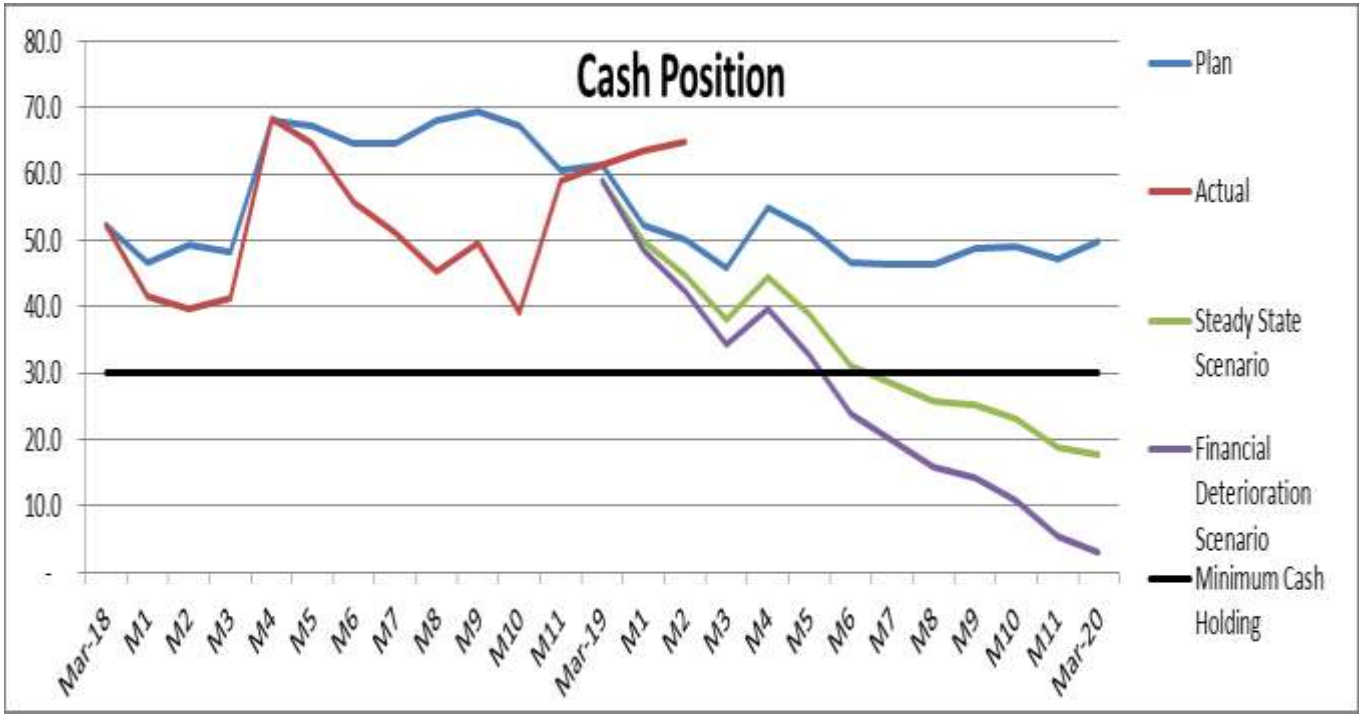
2) Payables balances remaining higher than anticipated due to delays in invoice payment.

3) Year-end position finishing £2.5m above the forecast from which the cash Plan was derived.

4) Capital expenditure £6m below Plan by the end of M2.

We are anticipating receipt of £19.8m PSF from 2018/19 in M3 or M4, depending on the release date from HM Treasury.

Due to a late change to the audited results of a Trust which reduced their PSF eligibility, the year-end distribution of unallocated PSF has been revised. For UHS, this has resulted in the award of an additional £0.9m which will increase our cash balance but not affect our audited 18/19 accounts.



University Hospital Southampton NHS
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Capital Expenditure

Spend remains lower than Plan in M2, due in part to a variance of £1.8m on the New Theatres E Level Project. The scheme was originally planned for completion, however go-live date is now August.

IT schemes includes £0.8m expenditure for the transfer of intellectual property rights from EMIS to secure the future of the CHARTS electronic record system.

Although £0.7m funding was assumed in M1 for Radiotherapy Equipment, the turnkeys costs for Linacs C and D will be incurred between June and September.

As highlighted last month, NHSI have flagged concerns over the national CDEL Plan and the Trust has offered slippage of £6m out of a potential £9m identified.

Slippage includes:
£2m for the stream project - unlikely this year due to delays in securing receipt of external funding.

£3m STP funding (digital outpatients/maternity) – delayed due to the process to release national capital funding.

£4m slipped on internal schemes including £1.1m on eye theatres and £1.6m on neonatal expansion, both delayed for operational reasons.

	Month			Year to Date			Full Year		
Scheme	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Forecast £000's	Variance £000's
Childrens Hospital	0	9	9	0	59	59	1,893	1,453	(440)
ED Adult Resus	0	0	0	0	0	0	1,509	1,501	(8)
IT Schemes	620	1,179	559	1,240	1,608	368	7,450	6,855	(595)
Wave 3 STP Digital	368	8	(360)	736	8	(728)	4,422	1,475	(2,947)
Strategic Maintenance	333	151	(182)	666	434	(232)	4,000	4,000	0
Medical Equipment Panel	175	2	(173)	350	3	(347)	2,100	2,100	0
GICU Expansion inc Front Vertical Extension	382	141	(241)	720	390	(330)	13,614	12,951	(663)
Refurbish Eye Theatre	0	0	0	0	0	0	1,177	100	(1,077)
Energy Efficiency	0	0	0	0	0	0	2,223	2,223	0
Neonatal Expansion	0	11	11	0	11	11	2,309	750	(1,559)
New Theatres E level	2,391	579	(1,812)	2,915	858	(2,057)	3,637	3,274	(363)
Urology Day Unit	311	330	19	353	370	17	2,173	2,177	4
Steam Project	330	54	(276)	380	71	(309)	2,126	71	(2,055)
Princess Anne Theatre Ventilation	216	(17)	(233)	432	15	(417)	580	355	(225)
Spend to Save	92	0	(92)	184	62	(122)	1,104	629	(475)
Radiotherapy Equipment	0	4	4	658	9	(649)	658	834	176
Divisional / Donated Equipment	71	92	21	142	192	50	1,350	1,350	0
Decorative Improvements / Staff Fund	52	14	(38)	104	24	(80)	625	741	116
North Wing Courtyard	0	12	12	139	26	(113)	669	26	(643)
Other Projects	273	362	89	760	594	(166)	3,028	4,607	1,579
Total Excluding Finance Leases	**5,614**	**2,931**	**(2,683)**	**9,779**	**4,734**	**(5,045)**	**56,647**	**47,472**	**(9,175)**
Finance Leases-IISS	484	0	(484)	968	423	(545)	5,815	5,815	0
Finance Leases-Other	167	0	(167)	334	0	(334)	2,000	2,000	0
Total Capital Expenditure	**6,265**	**2,931**	**(3,334)**	**11,081**	**5,157**	**(5,924)**	**64,462**	**55,287**	**(9,175)**
Donated Asset Additions	0	0	0	0	0	0	(3,043)	(2,796)	247
Total Net CDEL Expenditure	**6,265**	**2,931**	**(3,334)**	**11,081**	**5,157**	**(5,924)**	**61,419**	**52,491**	**(8,928)**

Statement of Financial Position

The receivables balance reduced by £1.8m in month, reflecting settlement of an interim year end invoice by NHS England.

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.

Statement of Financial Position	2018/19 Actuals £m	2019/20 YTD Plan £m	2019/20 YTD Act £m	2019/20 YTD Var £m	2019/20 Full Year Plan £m
Fixed Assets	372.4	366.0	367.6	1.7	403.7
Inventories	16.5	16.2	15.3	(0.9)	16.2
Receivables	106.1	83.4	102.3	18.9	75.5
Cash	61.5	50.1	64.9	14.8	49.8
Payables	(110.5)	(94.9)	(113.1)	(18.2)	(82.7)
Current Loan	(3.3)	(4.6)	(3.3)	1.3	(4.6)
Current PFI and Leases	(7.0)	(4.4)	(7.1)	(2.6)	(4.4)
Net Assets	**435.8**	**411.8**	**426.6**	**14.8**	**453.5**
Non Current Liabilities	(18.4)	(18.3)	(18.4)	(0.1)	(18.3)
Non Current Loan	(14.6)	(12.7)	(14.1)	(1.3)	(12.0)
Non Current PFI and Leases	(33.0)	(33.8)	(30.9)	2.9	(34.6)
Total Assets Employed	**369.8**	**347.0**	**363.4**	**16.3**	**388.7**
Public Dividend Capital	211.0	215.0	211.0	(4.1)	223.7
Retained Earnings	125.0	106.5	118.5	12.0	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
Total Taxpayers' Equity	**369.8**	**347.0**	**363.4**	**16.3**	**388.7**

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: Trust Corporate Strategy			
Category	Strategy and Business Planning		
Agenda item	5.1		
Sponsor	Chief Executive		
Author	Chief Executive		
Provenance	The Board has approved the Trust's Vision and the Goals that support this.		
Classification	This Report is unclassified.		
Purpose	The paper is presented for the Board to Ratify the components of the Trust's corporate strategy. The paper has also attached, at appendix 2, the corporate objectives, previously approved by the Board. Following a discussion at TEC these have been reworded slightly so they can be shared with staff and public (abbreviations removed etc but no material changed) and a further objective listed on quality and a further objective on digital as this was felt to be missing. The NHS has recently delivered a Long Term Plan for the future, which in turn has stimulated a review of the Trust's strategy. The components of the Trust's corporate strategy are: • Vision and supporting goals • Mission • Values Frame the development of the clinical strategy – which describes the future from a patient and clinical perspective; and strategic plan – which is the plan that sets out how the clinical strategy will be delivered in detail including workforce and affordability. Although the values of the organisation are well embedded; the previous vision and mission are not well known in the Trust. While the organisation goes through this period of significant change it is important that the people who work for UHS understand what we are trying to achieve in the future (vision) and what the UHS purpose is /why people choose to work here as opposed to anywhere else in the NHS (mission).		
Relevant strategic goals	✓ 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.

Report to the Trust Board of Directors dated Thursday, 27 June 2019	
Board Assurance Framework links	All of the risks to delivering the Trust's strategy are associated with our ability to achieve our vision • CRR01 – 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 • CRR02 – 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 • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • CRR08 – Lack of inclusion and diversity results in the failure to get the best from every individual • CRR09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • CRR010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status
Equality Impact Assessment	There is no adverse impact on any of the protected characteristics within the vision.
Other standards affected	A Board/ Trust approved Vision; Mission and Values are an important component of the well led framework.

Introduction

An organisations strategy provides a direction and a sense of purpose. It describes what the organisation needs to be like to be successful within the future and, in that, a tool for measuring progress. It also provides a common goal or dream for building team work and resolving conflict.

Developing a vision is an important part of a Board's role and the work we did during the study session in February set the frame for taking the vision into the wider leadership team. On further exposure in March the board agreed that a good vision statement should be: Action oriented, innovative compelling and exciting

- ⊡ **Specific**
- ⊡ **Achievable**
- ⊡ **Motivating**
- ⊡ **Guideline for Daily Decisions**
- ⊡ **Shapes organisational culture**

Test: is it long term, will people understand it, is outside comfort zone, measurable and life changing, does it create momentum and is it exciting

With this in mind 5 suggestions were shared with approximately 200 of our senior leadership team through a survey which resulted in 108 responses and, out of this, 65 people wanted the vision to have world- class as the ambition for the organisation.

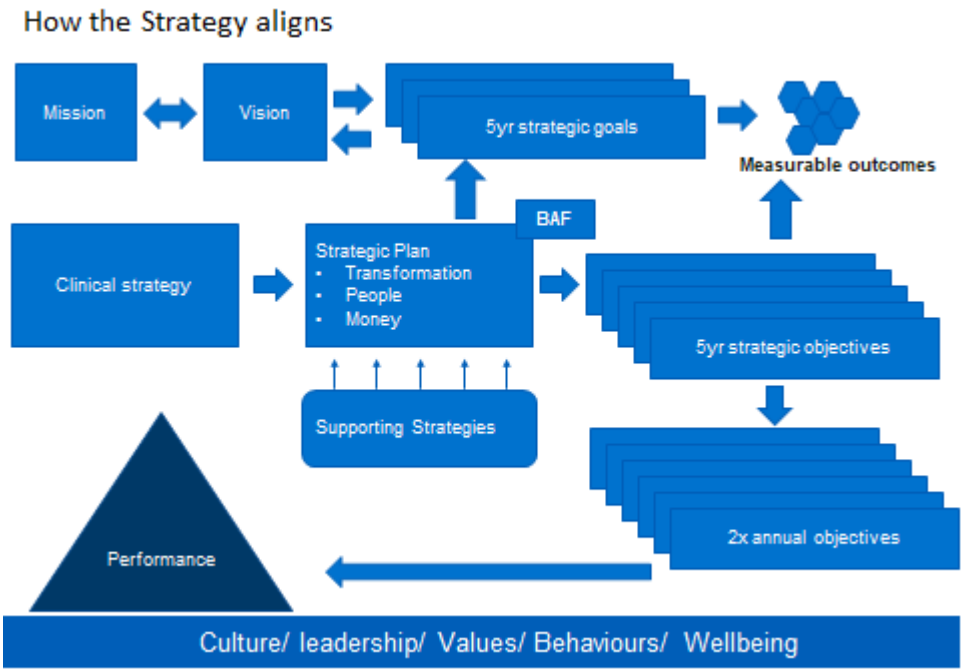
Taking these views into account and the preference for the word everyone, rather than individual or community, the vision for the trust is:

UHS: World-class care for everyone

This is supported by the 6 strategic goals derived from the Long Term Plan that will support us in moving toward this vision in the 5 year period associated with our strategic plan.

- Improving patient journeys
- Delivering value based health and care
- Supporting healthy lives
- Building an expert and inclusive leadership
- Being agile in meeting people's needs
- Creating leading- edge research, education and innovation.

The Board will be able to track the progress, and risks in achieving the vision through the following mechanisms



The corporate strategy sets the way for the clinical strategy which will describe the future in clinical and patient terms and the strategic plan which will set out in detail the necessary change steps; milestones and enablers such as workforce, digital, estate, finances that will ensure that we can deliver our clinical strategy.

One of the most important parts of an organisations culture is its mission statement which is best developed with the engagement of staff. Over the last few months we have been involving the staff through several mechanisms to understand how they see the purpose of UHS – what we do – and how this links to why they come to work here in preference to other local NHS organisations.

A good mission statement should be:

- **Short**
- **Catchy**
- **Inspiring**
- **Ambitious**
- **Reliable and Measurable**
- **Differentiating from Competition**

A separate presentation, attached at appendix 1, describes the approach to developing the mission.

Conclusion

The Board is asked to ratify the components of the corporate strategy including the Trusts Vision (and supporting goals) and the mission.

Setting the UHS Mission &

Staff Voices

UHS Strategic Planning

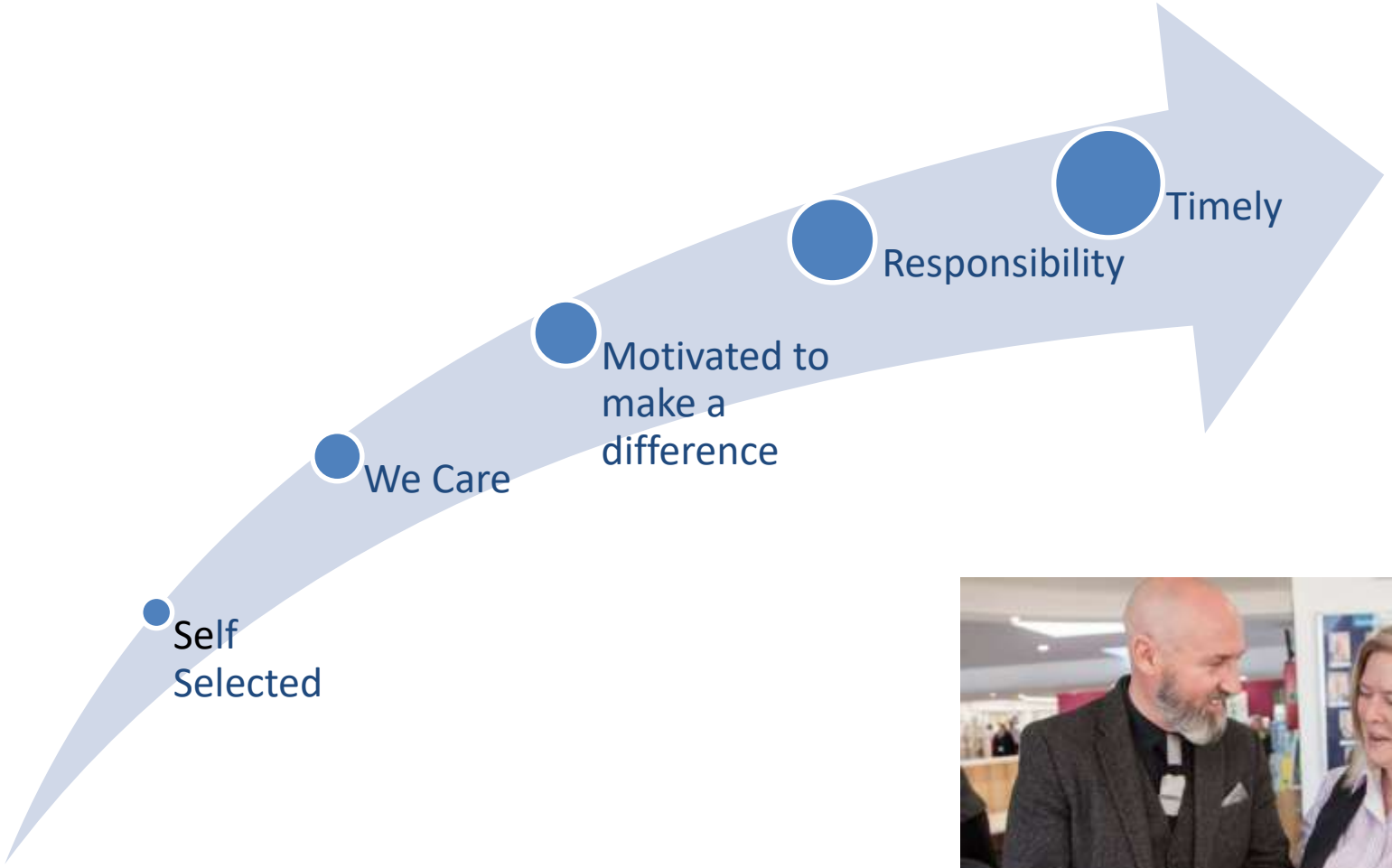
Overview

- 18 volunteers from across UHS
- Engaged with over 900 staff with surveys, interviews and focus groups
- **Objective** - Providing the Staff Voice in the Trust Strategy
- **Aim (Phase 1)** -

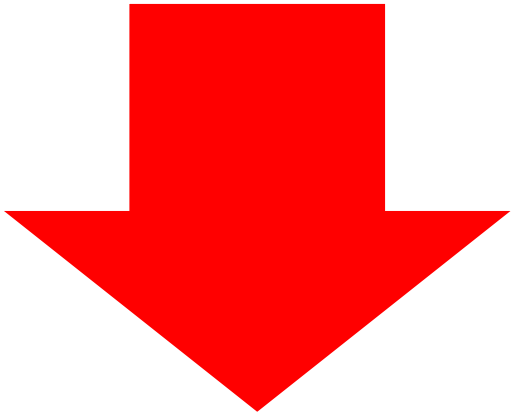
1. Propose a mission statement for UHS
2. What matters to staff right now?

UHS Change Champions: “Developing people; solving problems “

Change Champions - The Team



‘Hopes and Fears’



Address challenges

Take action

Realistic changes

Need reassurance

Tangible feedback

Sense of responsibility

Actions not evident to staff

Short deadline

Must not be a ‘tick-box’ exercise

Why work at UHS?

Teamwork and culture

+

Investment in staff

+

Good local employer

+

Clinical Excellence and specialisms

+

Research and innovation

→

Staff are PROUD to work at UHS

Why did you choose to work at UHS?

Theme	Count (repetition of themes identified by staff groups)	Sub themes (count)
Staff are proud to work at University Teaching Hospital Southampton	7	"A great organisation" / Reputation (4)
They feel part of a great team	16	Teamwork (5) Friendship (2) Culture (9)
Delivering clinical excellence	7	Experience (2) Clinical Excellence (5)
Able to treat any patient, 24/7, 365 days a year	3	Specialist centre
Undertaking ground breaking research and innovation	3	
A good local employer	11	Location (5) Employee benefits (2) Opportunities (2) Job/income (2)
Investing in people and their development	8	Training (4) Professional development (4)
Job satisfaction	4	To make a difference (2)

Setting the UHS Mission

A mission statement should define the purpose of an organisation. It should capture what's unique, what differentiates it from others and should resonate with staff.

The team considered everything they had been told about why staff chose UHS, as well as the Trust vision and values ,and propose the following :

University Hospital Southampton

'Together: we care, innovate and inspire'

Challenges for staff at UHS

Environmental standards

Ever increasing demand

Lack of resources / finance

Staff Shortages

Impact of poor management

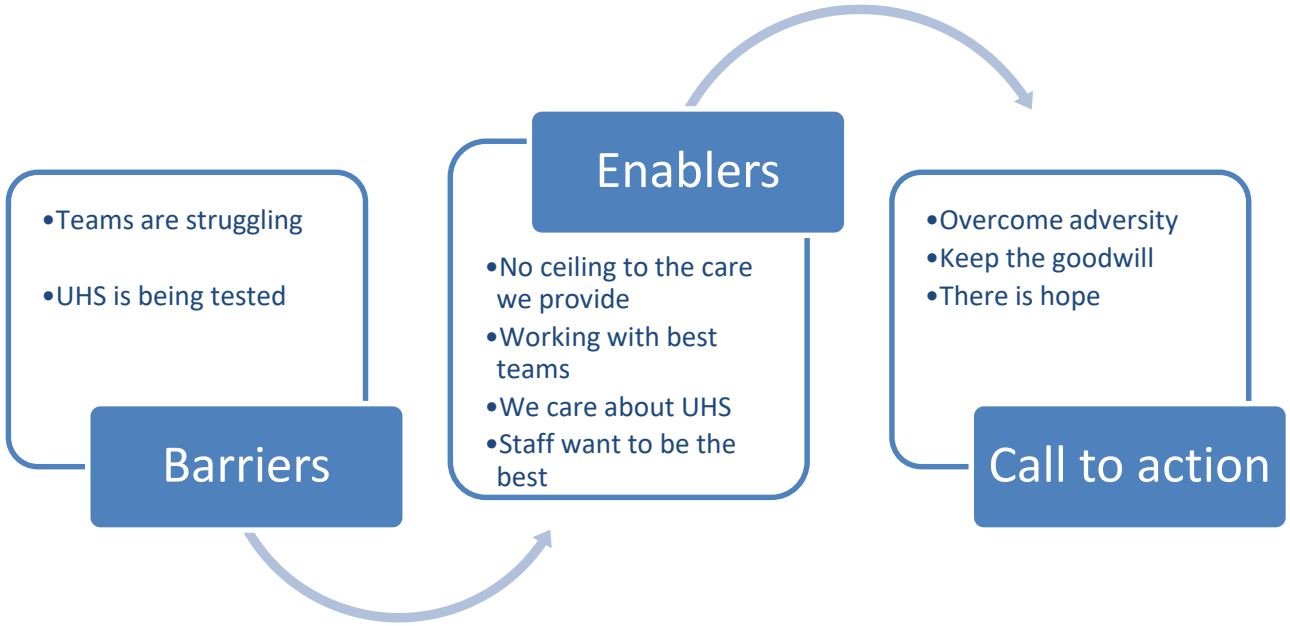
Staff feeling undervalued

Goodwill is hanging on a shoe string

What issues are you experiencing right now?

Theme	Count (repetition of themes identified by staff groups)	Sub themes (Count)
Ever increasing demand	8	Time pressure (4)
Staff shortages	9	Levels (4) Retention (2) Lack of time (2)
Financial pressure	3	
Lack of resources	5	IT (2)
Environmental standards	10	Parking (2) Green space (2) Poor environment (4) Lack of space (2)
Examples of Poor Management	13	Lack of staff voice / involvement (2) Communication (2) Don't promote inclusion (1) Unfair recruitment practice (2) Feel under-valued (3) Unclear identity (1)

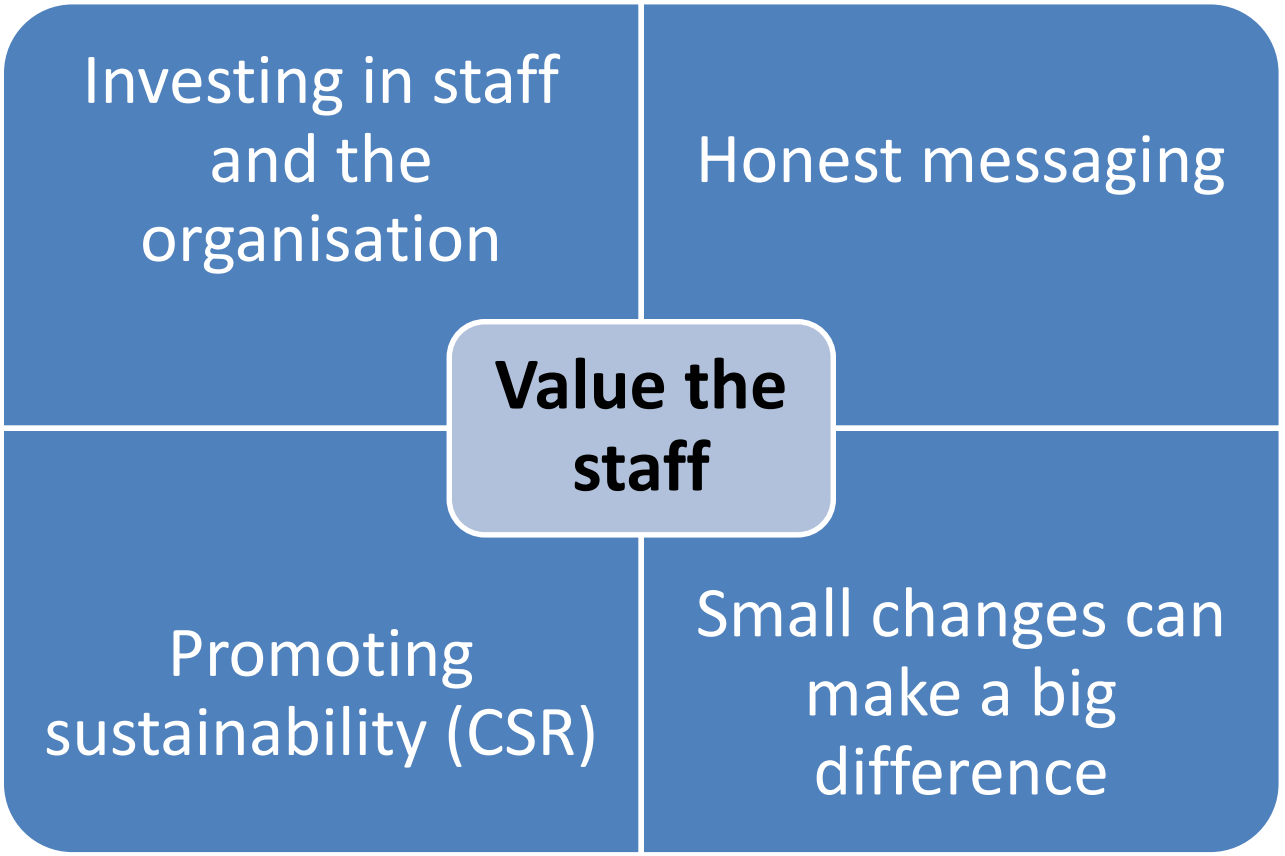
Staff voices



The Challenge?

'How do we match the 'World Class' aspiration whilst meeting the financial challenge and valuing staff, our greatest asset?'

Can the Trust Board support staff by….



	Strategic Goals 2019-2024	19/20 Organisational Goals	KPIs on the IPR
		What and who	
1	Improving Patient journeys (system focus, integration)	1. Write a strategic plan for integrated 'front door' services to address capacity and demand mismatch and enable flow (CM) 2. Secure influence in primary care by establishing the Hospital's role in supporting primary care networks (JH) 3. Promote value based healthcare, particularly: Introduce 'advanced decision making'' (DS) 4. Redesign services to provide timely safe care and meet constitutional access trajectories (CM) 5. Deliver priorities relevant to UHS in the first year of the long term plan including commissioning and long term changes (JH)	Rolling 12 Month NEL LoS Delayed transfers of care (CQC Calculation) Patients with LOS >=21days Census average Early discharge on day (pre-midday) Number of empty beds in AMU at 8am Adult Midday Occupancy (month in arrears) Out of hours ward transfers Number of outliers Number elective operations cancelled and not readmitted within 28 days % patients spending less than 4 hours in ED - UHS Total Time to initial assessment (Types 1 & 3) Time to treatment UHS Total Total time spent in ED Same day emergency care % patients on an open 18 week pathway (within 18 weeks) Total number of patients on an incomplete pathway Patients waiting for diagnostics Weeks Waited for first Outpatient Appointment Urgent GP referrals seen in 2 weeks (month in arrears) 62 day cancer wait performance 31 day cancer wait performance 104 day waits (backlog) Number of Tumour sites achieving 2 week target Number of Tumour sites achieving 31 day target Number of Tumour sites achieving 62 day target 28 day faster diagnosis
2	Delivering value based health and care (value = quality/cost, sustainability)	1. Deliver the Trust financial plan and maximise any national funding (DF) 2. Prepare UHS for the new NHS financial regime (DF) 3. **NEW**: Deliver the Trust Quality Improvement plan to improve safety/experience and outcomes (GB) 4. Build capability for change by embedding quality improvement, innovation and transformation at a leadership level (JH) 5. Deliver the Cost Improvement Plan (CIP) without compromising on quality	Same Sex Accommodation (Non Clinically Justified Breaches) Total Complaints Received Percentage complaints closed within 35 days Urgent Cancer Referrals Number of first cancer treatments Total ED Attendances Non-Elective Spells Face to face Outpatient appointments YTD variance vs. financial control total (£m) Delivery of the capital programme CIP delivery Non face to face Outpatient appointments CHPPD total nursing staff (Care hours per patient day) Number of staff trained in QI techniques Red flag staffing incidents
3	Supporting healthy lives (prevention, wellbeing inequalities, outcomes and experience)	1. Improve staff health and well-being (SH) 2. Improve population health, maximising the impact of UHS touch points (DS) 3. Develop an early warning tool to identify any deterioration in quality (GB)	FFT negative score & response rate - Inpatients FFT negative score & Response rate - Maternity Specialties with outcome measures developed Developed Outcomes RAG rating HSMR - UHS (Hospital Standardised Mortality Ratios) (3 months in arrears) SHMI - UHS (Summary Hospital-level Mortality Indicator) HSMR - UHS Crude Mortality Rate HR - Sickness absence - Rolling 12-months Clostridium Difficile reduction (confirmed lapse in care) Pressure Ulcers (causing severe or moderate harm) Medication Errors (severe/moderate) Serious incidents Requiring Investigation (month in arrears) Number of overdue SIRIs Maternity/Neonatal KPI TBC Antimicrobial resistance KPI TBC Falls KPI TBC Number of people trained in QI Number of fully accredited wards Number of people trained in human factors Percentage of patients screened and found to have either moderate or high alcohol dependence given relevant advice or referral Percentage of patients screened for smoking and found to smoke that were given brief advice or a medication offer
4	Building an expert and inclusive workforce (diversity, engagement, leadership)	1. Close the staffing supply gap in priority groups/services to provide high quality and timely care (SH) 2. Manage overall workforce cost to meet CIP challenge (CM) 3. Measure improvement in staff engagement by increasing participation in staff survey (SH) 4. Increase representation of diverse groups in leadership and decision making (GB) 5. Improve the staff engagement score	HR - Turnover - Rolling 12-months HR - Appraisals completed (non-medical) - Rolling 12-months Nursing Vacancies (Registered Nurse only in clinical wards) Staff FFT - % of staff likely or extremely likely to recommend UHS as a place to work. Staff FFT response rate Black & Minority Ethnic Band 7+ Percentage
5	Being agile in meeting people's needs (organisational elegance/design/flexibility)	1. Reset organisational structure as necessary, responding to changes outlined in the NHS long term plan (PH) 2. Leverage digital capability to support patient empowerment and self care (JH) 3. **New:** Measure staff user satisfaction with the Tust IT systems and use this to support the digital strategy (JH) 4. Be agile in flexing resources, responding to fluctuating demand (CM) 5. Secure strategic influence by establishing UHS role in the transition from STP to ICS (JH)	Number of defect work orders Percentage defect work orders completed on time Estates - Statutory Logged Maintenance Jobs Estates - % Planned Maintenance Completed - Statutory Number of help desk requests completed on time % help desk requests completed on time Unresolved help desk requests Unresolved help desk requests (over 30 days old) Estates Capital spend vs. plan Digital KPIs under review to be added here
6	Leading edge research, education and innovation (research and outcomes)	1. Identify the capacity constraints to expand research and plan to address (DS) 2. Identify priority areas without a research base and set strategy (DS) 3. Improve quality and breadth of education and training programme (GB)	Quality of practice experience for doctors in training (annual report with quarterly qualitative updates) Number of Apprenticeship starts R&D KPIs under review to be added here

Title	Target Source & Implications	Description	Corporate Goal	Mentioned in the NHS Long Term Plan	KPI mentioned in the Clinically-led Review of NHS Access Standards	CQC Pillar	Recommendation	Reason
HR - Turnover - Rolling 12-months	Internal target	% of staff left trust in last 12 month. 12 Month rolling figure reported from ESR, excluding Junior Doctors, reported monthly	An expert and inclusive workforce	Yes - improving staff retention	no	Well led	Remain	
HR - Appraisals completed (non-medical) - Rolling 12-months	Internal target	% of staff have had their appraisal done in last 12 month. 12 Month rolling figure reported from ESR for Non-Medical staff only, reported monthly	An expert and inclusive workforce	no	no	Well led	Remain	
Nursing Vacancies (Total Clinical Wards)	Internal Target	FTE difference between Budgeted FTE (in the month) from Finance system and contracted FTE (at end of the month) in ESR for total workforce in clinical ward areas. Vacancy rate % = (Budget FTE - SIPFTE)/Budget FTE	An expert and inclusive workforce	Yes (unsustainable vacancies, improve working lives, improving staff retention by 2%)	no	Well led	Remove	
Nursing Vacancies (Registered Nurse only in clinical wards)	Internal Target	FTE difference between Budgeted FTE (in the month) from Finance system and contracted FTE (at end of the month) in ESR for Registered Nurse workforce in clinical ward areas.Vacancy rate % = (Budget FTE - SIPFTE)/Budget FTE	An expert and inclusive workforce		no	Well led	Remain	
Staff FFT - % of staff likely or extremely likely to recommend UHS as a place to work.	UHS internal target.	Data collected at the end of each quarter. Survey runs in quarters 1,2 and 4 each year. (May, August & February)	An expert and inclusive workforce	surrogate - Improve staff wellbeing, rewarding jobs, positive culture	no	Well led	Remain	
Staff FFT response rate		Staff FFT response rate	An expert and inclusive workforce		no	Well led	Addition	Strategic Objective
Statutory and mandatory training achieving target	Based on 90% compliance requirements	Count of training courses achieving completion targets (85% for all except Information governance which is 90%) Safeguarding Adults, Child Protection (L3 only) , Infection Prevention - Clinical, Infection Prevention - Non Clinical, Moving and Handling - Practical Only, Fire Safety, Basic Life support and AED Clinical, Basic Life support Non Clinical, Local Induction, Information Governance, Equality & Diversity, Prevent Training.	An expert and inclusive workforce	Yes - right skills and experience	no	Well led	Remove	
Black & Minority Ethnic Band 7+ Percentage	No annual target set but a five-year target of 15%	Percentage of BME staff within the staff on band7 and above bands	An expert and inclusive workforce	Yes - improve equality and opportunities for all backgrounds	no	Well led	Remain	
Number of defect work orders	Internal target	total number of default work orders	Being agile in meeting people's needs	no	no	Well led	Remain	
Percentage defect work orders completed on time	Internal target	percentage default work orders completed on time	Being agile in meeting people's needs	no	no	Well led	Remain	
Estates - Statutory Logged Maintenance Jobs	Internal target	total number of planned statutory maintenance jobs	Being agile in meeting people's needs	no	no	Well led	Remain	
Estates - % Planned Maintenance Completed - Statutory	Internal target	percentage planned statutory maintenance jobs completed on time	Being agile in meeting people's needs	no	no	Well led	Remain	Legal/Health and Safety importance
Estates - Mandatory Logged Maintenance Jobs	Internal target	total number of planned mandatory maintenance jobs	Being agile in meeting people's needs	no	no	Well led	Remove	- combine with Mandatory
Estates - % Planned Maintenance Completed - Mandatory	Internal target	percentage planned mandatory maintenance jobs completed on time	Being agile in meeting people's needs	no	no	Well led	Remove	- combine with Mandatory
Routine Logged Maintenance Jobs	Internal target	total number of planned routine maintenance jobs	Being agile in meeting people's needs	no	no	Well led	Remove	Lower priority
% Planned Maintenance Completed - Routine	Internal target	percentage planned routine maintenance jobs completed on time	Being agile in meeting people's needs	no	no	Well led	Remove	Lower priority
Number of help desk requests completed on time	Internal target	total number of help desk requests	Being agile in meeting people's needs	no	no	Well led	Remain	
% help desk requests completed on time	Internal target	percentage help desk requests completed on time	Being agile in meeting people's needs	no	no	Well led	Remain	
Unresolved help desk requests	Internal target	total number unresolved help desk requests	Being agile in meeting people's needs	no	no	Well led	Remain	
Unresolved help desk requests (over 30 days old)	CQC informed target from 2017 visit	Number helpdesk requests over 30 days old	Being agile in meeting people's needs	no	no	Well led	Remain	Prior focus from CQC inspection
Estates Capital spend vs. plan		Estates Capital spend vs. plan	Being agile in meeting people's needs	no	no	Well led	Addition	
Number of computers	No Target	Number of active computers in trust	Being agile in meeting people's needs		no	Safe	TBC	
Average age of computers (years)	No Target	Average age of active computers in trust	Being agile in meeting people's needs		no	Safe	TBC	
Percentage specimens requested through eQUEST - rolling 3M	Internal target	Rolling last 3 months. Data is produced from 28 days post period end. This allows time for results to be acknowledged by clinicians	Being agile in meeting people's needs		no	Safe	TBC	
Percentage specimens available for acknowledgment through eQUEST - rolling 3M	Internal target	Rolling last 3 months. Data is produced from 28 days post period end. This allows time for results to be acknowledged by clinicians	Being agile in meeting people's needs		no	Safe	TBC	
digiRounds patient records accessed	Internal target only	Number of patient records accessed using digirounds (A clinical support systems for ward round use)	Being agile in meeting people's needs		no	Safe	TBC	
Decision support notifications (email alerts)	Internal target only	number of email alerts to advise users when patients with specific criteria are admitted into UHS	Being agile in meeting people's needs		no	Safe	TBC	
Medxnote	Internal target only	A communication tool similar to WhatsApp used to receive results , correspondence and chat	Being agile in meeting people's needs		no	Safe	TBC	

Title	Target Source & Implications	Description	Corporate Goal	Mentioned in the NHS Long Term Plan	KPI mentioned in the Clinically-led Review of NHS Access Standards	CQC Pillar	Recommendation	Reason
InfoQlik (Daily) Activity	No Target	Number of individual users accessing each dashboard area each day, aggregated up over a month. InfoQlik only - other QlikView dashboards excluded. Data sourced from QV audit logs.	Being agile in meeting people's needs		no	Safe	TBC	
Sap BI user logins	No Target	Total end user logins (if the same person logs in several times, they are all counted). Data sourced from SAP BI user audit data.	Being agile in meeting people's needs		no	Safe	TBC	
My Medical Record - UHS patient registrations	Internal target	Total patients registered per month	Being agile in meeting people's needs		no	Safe	TBC	
My Medical Record - UHS patient logins	Internal target	Total number of patient logins per month	Being agile in meeting people's needs		no	Safe	TBC	
Digital KPIs under review to be added here			Being agile in meeting people's needs				Remain	
FFT response rate - Inpatients	Local target (No longer a CQUIN and no statutory national targets for response rate. FFT remains a contractual requirement for NHS providers. Target is an internal target only.)	Monthly calculation of the number of FFT responses as a percentage of the number inpatients	Healthy Lives	no	NA	Caring	Remove	combined with negative scores
FFT negative score & response rate - Inpatients	Local target (No longer a CQUIN with no monies or fines related to this metric. FFT remains a contractual requirement for NHS providers.)	The percentage of positive promoters (very likely) minus the percentage of negative promoters)	Healthy Lives	no	NA	Caring	Remain	Included in model hospital board assurance metrics. Combine with response rates
Maternity FFT response rate	No longer a CQUIN with no monies or fines related to this metric. FFT remains a contractual requirement for NHS providers.	The number of patients that responded to any of the questions over the total number of maternity patients	Healthy Lives			Caring	Remove	combined with negative scores
FFT negative score & Response rate - Maternity	No longer a CQUIN with no monies or fines related to this metric. FFT remains a contractual requirement for NHS providers.	The percentage of positive promoters (very likely) minus the percentage of negative promoters)	Healthy Lives	no		Caring	Remain	Included in model hospital board assurance metrics. Combine with response rates
Participation in eligible National Audits & NCEPOD Studies	National Target	Participation in eligible National Audits (Quality Accounts) & National Confidential Enquiry into Patient Outcome and Death studies currently participating in	Healthy Lives	no		Effective	Remove	Annual position - charted KPI not required
Number of recently published National Audit reports	National Target	Number of recently published National Audit reports	Healthy Lives	no		Effective	Remove	Trending not useful as based on publications scheduled out of UHS control
National Audit reports with areas of concern	National Target	National Audit reports with areas of concern	Healthy Lives	no		Effective	Remove	No significant trends, other reporting deemed more useful through exception commentary
Specialties with outcome measures developed	Local Target	The number of specialities who have developed patient outcomes to be included in the TEC outcomes report with the number of outcome measures developed	Healthy Lives	no		Effective	Remain	Important to see growth in reporting outcomes
Developed Outcomes RAG rating	No Target	Developed outcomes split by RAG rating according to outcomes TEC report rating	Healthy Lives	no		Effective	Remain	Important to see high level performance in outcomes data
Emergency readmission within 28 days (month in arrears)	Internal target	Monthly, 2 months in arrears. Number of patients readmitted within 28 days divided by the number of admissions per month	Healthy Lives	no		Effective	Remove	stable performance
HSMR - UHS (Hospital Standardised Mortality Ratios) (3 months in arrears)	No identified mortality rate target. ensure no statistically significant diversion from the current rate.	HSMR is the observed mortality rate divided by the expected mortality rate multiplied by 100.	Healthy Lives	no		Effective	Remain	
SHMI - UHS (Summary Hospital-level Mortality Indicator)	No identified mortality rate target. ensure no statistically significant diversion from the current rate.	The SHMI is the number of patients who die following hospitalisation at the trust divided by the expected. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge	Healthy Lives	no		Effective	Addition	SHMI not HSMR is given in Quality accounts and is on the SOF/Model hospital and other high level NHS performance reports
HSMR - SGH (Hospital Standardised Mortality Ratios) (3 months in arrears)	UHS Target should be "within expected range" (no colour) or statistically significantly below the benchmark of 100, i.e. Green	HSMR is the observed mortality rate divided by the expected mortality rate multiplied by 100.	Healthy Lives	no		Effective	Remove	Focus on HSMR and SHMI for UHS

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HSMR - UHS Crude Mortality Rate	No identified mortality rate target. ensure no statistically significant diversion from the current rate.	UHS Crude Mortality Rate is calculated by dividing the number of observed deaths by the number of superspells and multiplying by 100.	Healthy Lives	no		Effective	Remain	Useful context indicator
HR - Sickness absence - Rolling 12-months	Internal target	in last 12 month the total hours lost due to sickness against total contracted hours. 12 Month rolling figure reported from ESR, reported monthly	Healthy Lives	no	no	Well led	Remain	Aligned with strategic objective - "Improve staff health and well being"
Never Events	Target 0. Fines can be imposed	Frequency monthly most recent month	Healthy Lives	no	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods e.g. commentary.
Avoidable High Harm Falls	Local Target	Frequency monthly, month in arrears of SIRI reported falls where an avoidability decision has been reached	Healthy Lives	yes (infection Prevention)	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods e.g. commentary.
MRSA bacteraemia infection and contaminant	National Target. Fine can be imposed.	Count of positive blood cultures	Healthy Lives	yes (infection Prevention)	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods e.g. commentary.
Clostridium Difficile reduction (confirmed lapse in care)	National Target. Fine can be imposed.	Count of positive specimens	Healthy Lives	yes (infection Prevention)	no	Safe	Remain	Priority safety indicator, also useful to monitor as definition is going to change in 2019/20
Grade 2 Pressure Ulcers (month in arrears)	National CQUIN. No Fines but CQUIN monies attached	Monthly calculation in arrears. The number of patients with hospital acquired grade 2 pressure ulcers.	Healthy Lives	yes (Stop the Pressure programme)	no	Safe	Remove	New KPI replacing existing pressure ulcer KPIs
Avoidable Hospital Acquired Grade 3 and 4 Pressure Ulcers (month in arrears)	National CQUIN. No Fines but CQUIN monies attached	Monthly calculation in arrears. The number of patients with hospital acquired grade 3 or 4 avoidable pressure ulcers. Avoidability assessed by Panel	Healthy Lives	yes (Stop the Pressure programme)	no	Safe	Remove	New KPI replacing existing pressure ulcer KPIs
Pressure Ulcers (causing severe or moderate harm)		Number of pressure ulcers that resulted in severe or moderate harm	Healthy Lives	yes (Stop the Pressure programme)	no	Safe	Addition	New KPI replacing existing pressure ulcer KPIs
Diabetes: High harm insulin-related medication errors (high harm)	Local Target	Diabetes: Insulin-related medication errors (high harm)	Healthy Lives	yes (medication safety)	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods e.g. commentary.
Medication Errors (severe/moderate)	National CQUIN. No Fines but CQUIN monies attached	Harm free care. Numerator: Number of patients audited with no harms identified. Denominator: All patients audited. Monthly	Healthy Lives	yes (medication safety)	no	Safe	Remain	
Serious incidents Requiring Investigation (month in arrears)	Local Target.	Frequency monthly most recent month (month in arrears)	Healthy Lives	no	no	Safe	Remain	
Number of overdue SIRIs	Local Target	Number of overdue SIRIs	Healthy Lives	no	no	Safe	Remain	
Safety Express Thermometer	Local Target	Safety Express Thermometer	Healthy Lives	no	no	Safe	Remove	Lower priority indicator
% Thromboprophylaxis Patients Assessed (month in arrears)	Local target	Monthly in arrears. Numerator: Number of inpatients risk assessed for VTE. Denominator: Number of inpatients	Healthy Lives	no	no	Safe	Remove	Discussed in depth at contracting board
Patients appropriately screened for sepsis	National Target. Fine can be imposed.	Percentage emergency patients and inpatients who required sepsis screening appropriately screened taken from a quarterly audit	Healthy Lives	yes	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods. Also discussed in depth at contracting board
Sepsis patients treated in a timely manner	National Target. Fine can be imposed.	Percentage emergency patients and inpatients who had signs of sepsis and required antibiotics within 60 minutes taken from a quarterly audit	Healthy Lives	yes	no	Safe	Remove	Low numbers, charted KPI not required. Instead exception reporting via other methods. Also discussed in depth at contracting board
Maternity/Neonatal KPI TBC		TBC	Healthy Lives	yes	no	Safe	Addition	
Antimicrobial resistance KPI TBC		TBC	Healthy Lives	yes	no	Safe	Addition	
Falls KPI TBC		TBC	Healthy Lives	no	no	Safe	Addition	
10am Assessment Unit Downstreaming	No target but links to national focus - SAFER package of care	Percentage patients transferred from assessment unit to a ward (excluding critical care) before 10am - (on condition that the patient was on the assessment unit before 6am on the day of transfer.)	Improve Patient Journeys	Yes - implement SAFER bundle of care		Responsive	Remove	Surrogate measure for one of the SAFER practices, focusing on other SAFER KPIs
Rolling 12 Month EL LoS	No target	Total bed days used by all discharged elective patients divided by total discharged elective patients. Excludes patients on non-SGH/PAH wards; monthly, most recent month	Improve Patient Journeys	no		Responsive	Remove	Lower priority metric - focusing on non elective LOS
Rolling 12 Month NEL LoS	No target	Total bed days used by all discharged non-elective patients divided by total discharged non-elective patients. Excludes patients on non-SGH/PAH wards; monthly, most recent month	Improve Patient Journeys	no		Responsive	Remain	Most Important LOS measure to focus on
Rolling 12 Month Paediatric LoS	No target	Total bed days used by all discharged Child Health patients divided by total discharged Child Health patients. Excludes patients on non-SGH/PAH wards; monthly, most recent month	Improve Patient Journeys	no		Responsive	Remove	Lower priority metric - focusing on non elective LOS

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Delayed Transfers of Care Census (average)	Local target	Average number of daily count of delayed patients according to the current national DToC guidance. Monthly, most recent month	Improve Patient Journeys	yes - reduce delays		Responsive	Remove	Important flow metric - keeping the CQC calculations version
Delayed transfers of care (CQC Calculation)	National (CQC) Target	Census of all delayed patients according to the current national DToC guidance for each Thursday in month divided by the census for all Trust beds for each Thursday in month; monthly, most recent month.	Improve Patient Journeys	yes - reduce delays		Responsive	Remain	Important flow metric - keeping the CQC calculations version
Patients with LOS >=7days Census average	No Target	Total bed days in month contributed by patients with LOS >= 7 days divided by number of days in month	Improve Patient Journeys	Yes - implement SAFER bundle of care		Responsive	Remove	Important SAFER flow metric - keeping 21 day
Patients with LOS >=21days Census average	National target	Total bed days in month contributed by patients with LOS >= 21 days divided by number of days in month	Improve Patient Journeys	Yes - implement SAFER bundle of care		Responsive	Remain	Important SAFER flow metric - keeping 21 day
Early discharge on day (pre-midday)	Informal national target	Count of total discharges before midday on core inpatient wards, divided by total discharges at any time. Monthly, most recent month	Improve Patient Journeys	Yes - implement SAFER bundle of care		Responsive	Remain	Important SAFER flow metric
Weekend discharges(EL & NEL Combined)	Informal national target	Ratio between average number of weekday discharge volumes and average number of weekend day discharge volumes.	Improve Patient Journeys	no		Responsive	Remove	Lower priority performance indicator
Adult Midday Occupancy (month in arrears)	Internal target of 95% maximum	Total occupied level 1 bed days for patients under the care of non Paediatric CGs divided by the total available level 1 bed days; monthly, a month in arrears	Improve Patient Journeys	no		Responsive	Remain	Important context metric for flow
Red and Black Alerts	No target	Assessment made by Site Control team of bed availability and staffing shortfalls determines status. Total count of red alerts recorded during month at twice daily bed meetings. Monthly, most recent month.	Improve Patient Journeys	no		Responsive	Remove	Lower priority performance indicator - alerts also influenced by several KPIs some of which are displayed in the IPR already
Last minute cancelled operation	National target with no fine for non-achievement	Patients who had their procedure cancelled for non-clinical reasons on the day of admission or the day of surgery	Improve Patient Journeys	no		Responsive	Remove	Lower priority performance indicator
Number elective operations cancelled and not readmitted within 28 days	National target with no fine for non-achievement	Patients who had their procedure cancelled for non-clinical reasons on the day of admission or the day of surgery and whose procedure was not carried out within 28 days of cancellation	Improve Patient Journeys	no		Responsive	Remain	NHS constitution pledge
% elective operations cancelled and not readmitted within 28 days	National target with no fine for non-achievement	Patients who had their procedure cancelled for non-clinical reasons on the day of admission or the day of surgery and whose procedure was not carried out within 28 days of cancellation	Improve Patient Journeys	no		Responsive	Remove	keeping total numbers not percentage version
% Patients spending less than 4 hours in ED - SGH Main ED (Type 1 and UCH) v. Local acute peer group (Type 1)	National Target with funding implications	% patients spending greater than 4 hours in ED (Type 1 and Urgent Care Hub) shown against the average Type 1 performance from Local Acute providers.	Improve Patient Journeys	no	no	Responsive	Remove	UHS total view to be the sole 4 hour KPI in future reports
% patients spending less than 4 hours in ED- Eye Casualty (Type 2)	no target - contributes to National Target RE1.4/RE1.5	Total patients breaching 4hr target in eye casualty divided by total attendances reported for most recent complete month	Improve Patient Journeys	no	no	Responsive	Remove	UHS total view to be the sole 4 hour KPI in future reports
% patients spending less than 4 hours in ED - Lymington MIU (Type 3)	no target - contributes to National Target RE1.4/RE1.5	% patients spending less than 4 hours in ED - Lymington MIU (Type 3)	Improve Patient Journeys	no	no	Responsive	Remove	Lymington will no longer be managed by UHS from June 2019
% patients spending less than 4 hours in ED - UHS Total	National Target	% patients spending less than 4 hours in ED - All UHS departments (Main ED, Eye Casualty, UCH and Lymington	Improve Patient Journeys	no	no	Responsive	Remain	NHS constitution pledge
% patients spending less than 4 hours in ED - Local Delivery System	National Target	% patients spending less than 4 hours in ED - in Local delivery system which is all departments in RE1.4 plus Royal South Hants (RSH) MIU	Improve Patient Journeys	no	no	Responsive	Remove	UHS total view to be the sole 4 hour KPI in future reports
% patients who left the department before being seen (Types 1, 2 & 3)	National target with no fine for non-achievement	% patients who left the department before being seen; monthly, most recent month	Improve Patient Journeys	no	no	Responsive	Remove	Lower priority performance indicator
Time to initial assessment (Types 1 & 3)	National target with no fine for non-achievement	95th centile of time taken between patient arrival in department and initial assessment; monthly, most recent month.	Improve Patient Journeys	no	yes - standard for type 1 & 3 only	Responsive	Remain	Current KPI potentially to be adopted as new NHS Access Standard (exclude type 2)
Time to treatment UHS Total	National target with no fine for non-achievement	Time taken between patient arrival in department and first action out of - immediate assessment, first clinician seen or senior review.	Improve Patient Journeys	no	Yes - package of care completed within 1 hour for basket of critical conditions	Responsive	Remain	Keep surrogate indicator as place holder until final report from NHS Medical director
Total time spent in ED	National target with no fine for non-achievement	95th centile of time taken between patient arrival in department and departure (either by admission or discharge); monthly, most recent month.	Improve Patient Journeys	no	Yes - Change standard to mean total time in department	Responsive	Remain	Current KPI potentially to be adopted as new NHS Access Standard. (include mean average to current chart)
Same day emergency care			Improve Patient Journeys	yes	yes	Responsive	Addition	New standard proposed in Medical directors interim report
Emergency reattendance within 7 days	National target with no fine for non-achievement	Main ED Only. Count of patients with an unplanned attendance who had previously attended within 7 days prior divided by total unplanned attendances; monthly, most recent month	Improve Patient Journeys	no	no	Responsive	Remove	Lower priority performance indicator
ED Conversion (Type 1)	Internal target only	Percentage of all ED attendances that result in admission; monthly, most recent month	Improve Patient Journeys	no	no	Responsive	Remove	Lower priority performance indicator
% patients on an open 18 week pathway (within 18 weeks)	National target; possible outside intervention for prolonged/unexpected poor performance	Patients on an open 18 week pathway yet to receive treatment or be discharged; monthly, most recent month	Improve Patient Journeys	Yes (cut long waits)	yes	Responsive	Remain	NHS constitution pledge
Total patients in backlog	Internal target	Subset of incomplete patients (see above) - total number of incomplete patients who have waited over 18 weeks since referral.	Improve Patient Journeys	Yes (cut long waits)	no	Responsive	Remove	Lower priority performance indicator

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Patients waiting >52 weeks for treatment	No Target	Patients on an open 18 week pathway with a wait greater than 52 weeks	Improve Patient Journeys	Yes (cut long waits)	no	Responsive	Remove	Lower priority performance indicator
Total number of patients on an incomplete pathway	No Target	Total number of patients on an incomplete pathway	Improve Patient Journeys	Yes (cut long waits)	no	Responsive	Remain	Current national focus
Patients on a surgical waiting list	No Target	Patients on an open 18 week pathway who have had a decision to treat and been added to an inpatient waiting list	Improve Patient Journeys	Yes (cut long waits)	no	Responsive	Remove	Lower priority performance indicator
Patients waiting for diagnostics	No Target	Patients on an open 6 week diagnostic wait pathway	Improve Patient Journeys	Yes (cut long waits)	yes	Responsive	Remain	NHS constitution pledge
% of Patients waiting over 6 weeks for diagnostics	National Target	% of Patients waiting over 6 weeks for diagnostics	Improve Patient Journeys	Yes (cut long waits)	yes	Responsive	Remove	focus on numbers not percentage version
Weeks Waited for first Outpatient Appointment	No Target	Average Wait for first outpatient appointment (weeks)	Improve Patient Journeys	no	no	Responsive	Remain	Useful quality indicator
Urgent GP referrals seen in 2 weeks (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of 2-week wait referrals seen by the Trust within 2 weeks of referral from GP or applicable service; Monthly, a month in arrears.	Improve Patient Journeys	no	no	Responsive	Remain	NHS constitution pledge
Breast symptoms referral seen in 2 weeks (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of 2-week wait referrals to the breast cancer service seen by the Trust within 2 weeks of referral from GP or applicable service; Monthly, a month in arrears.	Improve Patient Journeys	no	no	Responsive	Remove	Lower priority performance indicator
Treatment started within 62 days of urgent GP referral (month in arrears) - includes site specific breakdown of data	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients referred as a 2-week wait suspected cancer who require treatment that receive the start of their treatment within 62 days of referral from GP or applicable service; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 62 day KPIs - NHS medical director review of access standards recommendation
Treatment started within 62 days of referral (Breast, Cervical & Bowel) (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients referred as a 2-week wait suspected cancer to the breast, cervical and bowel cancer services who require treatment that receive the start of their treatment within 62 days of referral from GP or applicable service; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 62 day KPIs - NHS medical director review of access standards recommendation
62 Day - Consultant Upgrades (month in arrears)	Local target only	The percentage of non-urgent referrals upgraded to urgent suspected cancers by the consultant and who require treatment that receive the start of their treatment within 62 days of upgrade by consultant; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 62 day KPIs - NHS medical director review of access standards recommendation
62 day cancer wait performance		combined KPI of all 62 day wait targets	Improve Patient Journeys	no	yes	Responsive	Addition	combine with other 62 day KPIs - NHS medical director review of access standards recommendation
Treatment started within 31 days of decision to treat (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients who require treatment that receive the start of their treatment within 31 days of the decision to treat the patient being made; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 31 day KPIs - NHS medical director review of access standards recommendation
Second or subsequent treatment (surgery) started within 31 days of decision to treat (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients who require a second or subsequent treatment of surgery that receive their treatment within 31 days of the decision to treat the patient being made; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 31 day KPIs - NHS medical director review of access standards recommendation
Second or subsequent treatment (anti cancer drugs) started within 31 days of decision to treat (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients who require a second or subsequent treatment of surgery that receive their treatment within 31 days of the decision to treat the patient being made; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 31 day KPIs - NHS medical director review of access standards recommendation
Second or subsequent treatment (radiotherapy) started within 31 days of decision to treat (month in arrears)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The percentage of patients who require a second or subsequent treatment of surgery that receive their treatment within 31 days of the decision to treat the patient being made; Monthly, a month in arrears.	Improve Patient Journeys	no	yes	Responsive	Remove	combine with other 31 day KPIs - NHS medical director review of access standards recommendation
31 day cancer wait performance		combined KPI of all 31 day wait targets	Improve Patient Journeys	no	yes	Responsive	Addition	combine with other 31 day KPIs - NHS medical director review of access standards recommendation
104 day waits (backlog)	National targets and NHSE submission with implications for external scrutiny and Trust reputation	The number of patients treated in the month whose wait for first definitive treatment equal to or greater than 104 days	Improve Patient Journeys	no	no	Responsive	Remain	Change to 104 day backlog instead
Number of Tumour sites achieving 2 week target		Number of Tumour sites achieving 2 week target	Improve Patient Journeys	no	no	Responsive	Addition	Metric that will be able to show if we have general good performance or if there is an outlier in tumour site performance

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Number of Tumour sites achieving 31 day target		Number of Tumour sites achieving 31 day target	Improve Patient Journeys	no	no	Responsive	Addition	Metric that will be able to show if we have general good performance or if there is an outlier in tumour site performance
Number of Tumour sites achieving 62 day target		Number of Tumour sites achieving 62 day target	Improve Patient Journeys	no	no	Responsive	Addition	Metric that will be able to show if we have general good performance or if there is an outlier in tumour site performance
CRN Recruitment - Participants Recruited	Wessex Clinical Research Network (CRN) target	(commercial and non commercial) (month in arrears)	Leading edge research, education and innovation	Yes (increase number of participants in healthcare research)	no	Well led	TBC	
Weighted Recruitment	Wessex Clinical Research Network (CRN) target	(commercial and non commercial) (month in arrears)	Leading edge research, education and innovation	Yes (increase number of participants in healthcare research)	no	Well led	TBC	
CRN Recruitment - Weighted National Ranking - All studies	Wessex Clinical Research Network (CRN) target	(commercial and non commercial) (month in arrears)	Leading edge research, education and innovation	Yes (increase number of participants in healthcare research)	no	Well led	TBC	
Specialties Recruiting	Trust Board request	Using studies open and in follow up aligned to Trust speciality as measure of research activity spread.	Leading edge research, education and innovation	Yes (increase number of participants in healthcare research)	no	Well led	TBC	
Papers published in partnership with UOS	National measure of impact of NIHR infrastructure	Publications which directly cite NIHR Infrastructure funding	Leading edge research, education and innovation	no	no	Well led	TBC	
Income per WTE		Average income generated by R&D per head	Leading edge research, education and innovation	no	no	Well led	TBC	
Quality of practice experience for doctors in training (annual report with quarterly qualitative updates)	National reporting which follows national process if measures are not met	Data to support this metric comes from the national GMC survey with is undertaken annually	Leading edge research, education and innovation	Yes - improve working lives	no	Well led	Remain	
Number of Apprenticeship starts	National Target		Leading edge research, education and innovation	no	no	Well led	Addition	Was in previously - leads to building expert workforce
Same Sex Accommodation (Non Clinically Justified Breaches)	National Target	The number of non clinically justified occurrences where a patient has spent time on a ward with members of the opposite sex. Monthly	Value based health and care	no		Caring	Remain	Important public KPI reported to UNIFY
Nutrition: % of patients with a care plan in place	National Target	Numerator: The number of inpatients in the MUST audit that have a care plan. Denominator : The number of inpatients in the MUST audit. Monthly	Value based health and care	Yes but only in relation to diabetes		Caring	Remove	Was beneficial previously but now at a good sustainable place. Move to annual audit reporting to Nutritional and Hydration steering group
Total Complaints Received	Local Target	(month in arrears)	Value based health and care	no		Caring	Remain	Included in model hospital board assurance metrics
Complaints per 1000 units	Local Target	(month in arrears)	Value based health and care	no		Caring	Remove	Duplicate KPI with different expression
Percentage complaints closed within 35 days	local target (70%)	The percentage of complaints closed within 35 days	Value based health and care	no		Caring	Addition	
Bereavement Survey Response Count	No Target	Number of bereavement surveys returned and input into Picker per month	Value based health and care	no		Caring	Remove	continuing development to find suitable KPI and stronger data
Bereavement Survey Core Questions - % Negative Score	Local Target	Percentage Negative responses recorded against the Core bereavement survey questions	Value based health and care	no		Caring	Remove	continuing development to find suitable KPI and stronger data
New Referrals (month in arrears)	Local target	The total number of accepted referrals received by the Trust; monthly, most recent month. Excluding referrals associated with non face to face activity only.	Value based health and care	no		Responsive	Remove	Indicator to provides useful context
Urgent Cancer Referrals	No Target	The total number of urgent cancer referrals received by the Trust; monthly, most recent month	Value based health and care	no		Responsive	Remain	Useful context metric to support CWT standards
Number of first cancer treatments	No Target	total number patients receiving their first cancer treatment (i.e. total patients covered under 31 day target)	Value based health and care	Yes - increase planned operations and cut waits		Responsive	Remain	Useful context metric to support CWT standards
Main ED attendances (Type 1 and UCH)	No target, but annual activity is commissioned	Count of attendance to Main ED and Urgent Care Hub reported for most recent complete month	Value based health and care	Yes - reduce A&E attendances		Responsive	Remove	covered to "Total ED Attendances"
Other ED attendances incl Eye Unit & MIU*	No target, but annual activity is commissioned	Count of Type 2 & 3 attendances reported for most recent complete month	Value based health and care	Yes - reduce A&E attendances		Responsive	Remove	covered in "Total ED attendances"
Total ED Attendances	No target, but annual activity is commissioned	Count of all UHS ED attendances	Value based health and care	Yes - reduce A&E attendances		Responsive	Addition	Replacing previous split attendance counts
Non-Elective Spells	No target	Count of discharged non-elective spells; monthly, most recent month	Value based health and care	no		Responsive	Remain	Indicator to provides useful context
Elective Inpatient Spells	No target	Count of discharged elective spells; monthly, most recent month	Value based health and care	Yes - increase planned operations and cut waits		Responsive	Remove	Indicator to provide context, better reviewed in finance report against plan

Title	Target Source & Implications	Description	Corporate Goal	Mentioned in the NHS Long Term Plan	KPI mentioned in the Clinically-led Review of NHS Access Standards	CQC Pillar	Recommendation	Reason
Elective Day Case Spells	No target	Count of discharged day cases; monthly, most recent month	Value based health and care	Yes - increase planned operations and cut waits		Responsive	Remove	Indicator to provide context, better reviewed in finance report against plan
Combined Elective Spells	No target	Count of discharged elective spells; monthly, most recent month	Value based health and care	Yes - increase planned operations and cut waits		Responsive	Remove	Indicator to provide context, better reviewed in finance report against plan
Adult Critical Care Bed Days	No target	total in month bed days recorded on the Adult critical care wards	Value based health and care	no		Responsive	Remove	Lower priority performance indicator
New Outpatient Appointments (source: Business Objects)	No target	Count of new OP appointments carried out; monthly, most recent month	Value based health and care	Yes - reducing, moving to other methods		Responsive	Remove	combine with FU appointments (amend only face to face)
Follow-up Outpatient Appointments (source: Business Objects)	No target	Count of follow-up OP appointments carried out; monthly, most recent month	Value based health and care	Yes - reducing, moving to other methods		Responsive	Remove	combine with New appointments (amend only face to face)
Face to face Outpatient appointments	No target	Count of Face to face OP appointments carried out; monthly, most recent month	Value based health and care	Yes - reducing, moving to other methods		Responsive	Addition	NHS long term plan - innovation and improvement using digital platforms to reduce face to face activity
Non face to face Outpatient appointments	No target	Count of non-face to face OP appointments carried out; monthly, most recent month	Value based health and care	Yes - reducing, moving to other methods		Responsive	Addition	NHS long term plan - innovation and improvement using digital platforms to reduce face to face activity
GP Referrals via eReferral	National Target	% GP referrals coming through eReferral	Value based health and care	Yes - digital improvements, patient access		Responsive	Remove	GP eReferrals is now accepted practice, monitoring take up no longer priority for the IPR.
CHPPD total nursing staff (Care hours per patient day)	No target set but UHS will be benchmarked against other trusts	Total care hours each patient received from all nursing staff each day in clinical wards.	Value based health and care	no	no	Well led	Remain	
CHPPD - Registered nurse (Care hours per patient day)	No target set but UHS will be benchmarked against other trusts	Care hours each patient received from registered nurse each day in clinical wards.	Value based health and care	no	no	Well led	Remove	
CHPPD - Unregistered nurse (Care hours per patient day)	No target set but UHS will be benchmarked against other trusts	Care hours each patient received from unregistered nursing staff each day in clinical wards.	Value based health and care	no	no	Well led	Remove	
Number of staff trained in QI techniques	Internal target		Value based health and care	no	no	Well led	Addition	
Red flag staffing incidents	local target		Value based health and care	no	no	Well led	Addition	

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: Review of Board Committee Terms of Reference			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.1		
Sponsor	Chairman		
Author	Chairman		
Provenance	Organisational Governance and Board Performance review action plans.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. The Board is recommended to approve the terms of reference for this review.		
Relevant strategic goals	☐ 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.
Assurance framework links	• CRR02 – 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 • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider		
Impact assessments	There is no assessed adverse impact associated with this programme of work.		
Other standards affected	• NHSI Provider Licence compliance, CQC Well-led Framework, NHS Foundation Trust Code of Governance		

Review of Board Committee Terms of Reference

1. Background

The last overall review of the operation of UHS Board committees took place in 2015.

However, the review of UHS Board performance led by the Chair and dated 8th April 2019 discussed a number of issues in relation to the effectiveness of Board committees and in particular the Quality Committee and the Strategy and Finance Committee. Amongst the issues raised in respect of the former were whether its scope needed to be limited in some way and whether any of its activities might be transferred elsewhere. As far as the latter was concerned, a key issue was whether it could realistically discharge the strategy dimension of its remit. There was a concern common to both in relation to the clarity of the interface with the Board. Accordingly the recommendations of the review included the following;

We should undertake a review of the Terms of Reference and operation of UHS Board Committees making explicit the roles of each in providing the Board with the necessary assurance. In particular;

- We should consider whether, given its very broad potential agenda, the Quality Committee might be re-focussed on providing the Board with assurance in terms of quality in the safety, outcomes and patient experience sense.
- We should also consider whether the Strategy and Finance Committee should evolve in a complementary way into a finance and performance committee (named as ultimately appropriate) or in any other way.
- The processes by which topics are referred to Board committees should be formalised, and the frequency and time commitment required for each committee should be revised accordingly.

2. Discussion

Despite the fact that few issues were raised in relation to either the Audit and Risk Committee or the Charitable Funds Committee with emphasis being on the two committees above, it seems appropriate to consider the overall appropriateness of the UHS Board committee structure. As well as the specific issues raised in relation to the Quality and Strategy and Finance committees indicated above it also seems timely to review the role of the Audit and Risk Committee in relation to the Board Assurance Framework given the observations by the CQC. Accordingly the terms of reference for this review are recommended as below.

3. Terms of Reference

Having due regard to both;

1. Those matters which are formally reserved to the Board and
2. The recommendations of the Board performance review,

the working group should consider and report on;

- Whether the current number and broad remits of UHS Board committees is optimal in achieving effective governance of the Trust. Any case for the incorporation of additional or alternative committees should define the additional benefit in relation to the additional resources (chiefly person-hours) consumed.
- Whether there is sufficient clarity on the respective roles of the Board and board committees in the governance of the Trust.
- Whether there is sufficient clarity on the role of the Audit and Risk Committee in relation to the Board Assurance Framework and the Corporate Risk Register.
- Whether the processes by which topics are referred to Board committees and returned to Board should be formalised as a means of providing the Board with assurance in relation to performance.

- Whether the frequency, length or composition of any of the committees needs to be amended as the result of the above.

4. Other considerations

The working group should consider the interface between individual board committees other internal trust governance groups, including any potential impact on these of the Deloitte review. It will be important to ensure both the robustness and coherence of the whole and the efficient use of management time.

The working group may wish to gather and consider alternative board committee configurations in use by other trusts while recognising that no approach has universal applicability.

The working group may also wish to consider any other feature of the manner in which the committees currently operate, or broader issues which inhibit the effective operation of the committee structure, including that of management culture.

5. Timetable

The working group is asked to present its conclusions and recommendations to the Closed UHS Board Meeting on August 30th.

Peter Hollins

17.06.19

NHS Provider Licence Conditions Compliance Self-certification

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: NHS Provider Licence Conditions Compliance Self-certification			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.2		
Sponsor	Chief Executive		
Author	Interim Company Secretary		
Provenance	This report was considered by the Executive performance management Group on 21 June 2019.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. The Licensee is required to publish within three months of the end of each financial year a corporate governance statement by and on behalf of its Board confirming compliance with the Conditions of its Provider Licence, and at the date of the statement and anticipated compliance for the next financial year, specifying any risks to compliance in the next financial year and any actions it proposes to take to manage such risks. The table attached sets out Conditions FT4 and G6 for which the Board must self-certify along with sources of information and evidence to support a statement that compliance is "confirmed" for each Licence Condition on the certificate. Much of the information provided has been audited as part of the Annual Report and Accounts process and can be considered reliable and accurate. However, the forward-looking statement carries risk associated with continued compliance. Condition FT4 5 (c) requires "to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions." The Board has previously identified significant risk associated with performance which is captured in Risk CRR06 "Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services." Such failure to provide contracted services, and particularly those mentioned in the Handbook to the NHS Constitution, would result in a breach of the terms of the Licence (patients have the right to: start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions; and be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.) The Board is recommended to certify that it is, and will remain compliant with the Conditions of its Provider license, and to maintain close scrutiny of performance and risk throughout the coming year.		
Relevant strategic goals	✓ 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.
Assurance framework links	• CRR01 – 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 • CRR02 – 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 • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • CRR08 – Lack of inclusion and diversity results in the failure to get the best from every individual • CRR09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • CRR010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status		
Impact assessments	There is no assessed negative impact on any inclusion, equality, or diversity in relation to race, religion, age, belief, gender, disability, or other protected characteristic.		
Other standards affected	Compliance with the Trusts FT Provider Licence, the FT Constitution, the Monitor FT Code of Governance, the NHSI Single Operating Framework, NHSR, and Care Quality Commission requirements.		

Condition G6 – Systems for compliance with licence conditions and related obligations	Explanation	Proposed Status	Risks, Mitigations and Maintenance Actions
G6 - 1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:			Principal risks associated with Condition G6 include: • CRR01 – 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 • CRR02 – 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 • CRR03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • CRR04 – Reduced access to resources compromises the quality of services • CRR05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • CRR06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • CRR07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • CRR08 – Lack of inclusion and diversity results in the failure to get the best from every individual • CRR09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • CRR010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status Thiese risks will be tracked and monitored by the Board using the the revised Board Assurance Framework report, updated by the Executive Performance Management Group each quarter, or more regularly as appropriate.
(a) the Conditions of this Licence,		Confirmed	
(b) any requirements imposed on it under the NHS Acts, and	The Trust's strategy and governance arrangements are derived from a thorough assessment of its statutory and regulatory duties and obligations, coupled with the direction set out in the NHS Long Term Plan.	Confirmed	
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	The principles fop the HJS Constitution are reflected in the Trust's own Constitution and in its values as a provider. The seven principles can be seen guiding the focus of the Trust Board in its decision-making and prioritising of resources: 1. The NHS provides a comprehensive service, available to all (by tracking both clinical effectiveness and access to services) 2. Access to NHS services is based on clinical need, not an individual's ability to pay (as reflected in contracts with Commissioners and partners) 3. The NHS aspires to the highest standards of excellence and professionalism (as reflected in clinical accreditation, quality assurance, risk management, and putting patients first) 4. The patient will be at the heart of everything the NHS does (putting patients first, stakeholder engagement, the patient voice, surveys, complaints, insurance, etc.) 5. The NHS works across organisational boundaries (as reflecting in the STP and integrated care modelling under way) 6. The NHS is committed to providing best value for taxpayers' money (as reflected in the audited value for money indicators) 7. The NHS is accountable to the public, communities and patients that it serves (as reflected through our Council of Governors, FT Membership, public engagement activities, and the Board's patient story items)	Confirmed	

G6 - 2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:			
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and	The Accounting Officer's assessment of the evidence available at the end of FY2018/19 concluded that the system of internal control is generally satisfactory, and concurs with the Head of Internal Audit that some opportunities for strengthening and improvement exist. These opportunities will be acted upon in the forthcoming reporting year. This review of the effectiveness of the system of internal control was informed by: • NHSI: Single Oversight Framework Segmentation • Care Quality Commission registration and the results of CQC inspection reports; • Internal audit reports; • External audit reports; • Comments made by the external auditors in their management letter and other reports; • Clinical audits; • Accreditation and peer reviews; • Patient and staff surveys; • Benchmarking information; • Reports by the executive managers and clinical leads within the trust who have responsibility for the development and maintenance of the internal control framework; and • An independent report by Deliotte PLC on divisional performance management and governance, commissioned by the CEO in 2018.	Confirmed	Risk management has been identified as a 'high risk' due to there not being a dedicated risk management team. The Internal Auditor noted that not having a dedicated risk management function has been the underlying root cause contributing to the other findings raised, including the two elements identified as medium risk overall (Business Continuity Management and Major Incident Planning – Follow Up; and Key Financial Systems). • Mitigate by effecting the Governance Action Plan
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.	The Trust regularly reviews the effectiveness of the system of internal control which is informed by a review of the information described in G6 - 2 (above) in various for a with responsibility for monitoring, scrutinising, and challenging evidence on behalf of the Board and Executive. These fora include the: • Audit and Risk Committee • Quality Committee • Strategy and Finance Committee • Executive Performance Management Group • Trust Executive Committee • Quality Governance Steering Groups and its subsidiaries • Divisional Management Boards • Divisional Governance Groups • Company Secretary and Corporate Affairs function	Confirmed	• Maintain by effecting the Governance Action Plan

Condition Condition FT4 – NHS foundation trust governance arrangements			
FT4 - 2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	A well-led inspection conducted by the Care Quality Commission towards the end of the 2018/19 found that the Trust continued to be well-led and made recommendations on how to achieve the highest rating for leadership in 2019/20. The Board has responded to these recommendations by conducting a full and thorough review of its arrangements for divisional performance management and governance, for financial oversight, risk management, and Board performance. These reviews have utilised independent external advisors in addition to the expertise available from the body of non-executive directors and the Company Secretary. The output action plan is to set out robust and unequivocal arrangements for ensuring the constant and continuing compliance with the Trust's NHS foundation trust licence condition FT4 (FT governance) and includes actions identified to mitigate these risks, particularly in relation to: • the effectiveness of governance structures; • the responsibilities of directors and committees; • reporting lines and accountabilities between the Board, its committees, and the executive team; • the submission of timely and accurate information to assess risks to compliance with the Trust's licence; and, • the degree and rigour of oversight the Board has over the Trust's performance.	Confirmed	• Maintain by effecting the Governance Action Plan
FT4 - 3. Without prejudice to the generality of paragraph 2 and to the <u>generality of General Condition 5, the Licensee shall:</u>			
(a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and (b) comply with the following paragraphs of this Condition.	• The Trust aims to either comply with or explain what alternative measures it has established in accordance with the Foundation Trust Code of Governance as advised by the Company Secretary and Corporate Affairs function • The Trust's Standing Orders require that a register of director's and governors' interest is in place and kept up to date (held by the Company Secretary) • An independent governance review was commissioned in 2018 • Supporting action plan in place, all recommendations were accepted • There are no material conflicts of interest in the Board. • Governors elections and by elections are held in accordance with election rules • There is an (interim) Company Secretary in post to provide the Chairman, Chief Executive, and Directors with definitive advice on governance and compliance	Confirmed	• Conduct a review of the 'Monitor' NHS Foundation Trust Code of Governance • Complete review of resourcing for the Corporate Affairs function
FT4 - 4. The Licensee shall establish and implement:			
(a) effective board and committee structures;	The Board has one 'statutory' committee covering the role and function of the Nomination and Appointments Committee and the Remuneration Committee named the 'Remuneration and Appointment Committee'. The 'Audit and Risk Committee' fulfils the role and function of a statutory 'Audit Committee'. The Board has deployed two additional 'Designated' Committees to extend its monitoring, scrutiny, and challenge functions. These are the 'Strategy and Finance Committee', and the 'Quality Committee'.	Confirmed	• Maintain by effecting the Governance Action Plan

(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	The Board has a clear set of core governance documentation setting out its standards for this requirement, including: • UHS FT Constitution • UHS Standing Orders • UHS Standing Financial Instructions • UHS Scheme of Matters Reserved to the Board • UHS Scheme of Delegation • UHS Board Committee Terms of Reference • UHS Accountability Framework • UHS Divisional Partnership Agreements	Confirmed	• Review and revise this set of governance documentation according to a 3-year cycle
(c) clear reporting lines and accountabilities throughout its organisation.	• Finance, quality, and performance management infrastructure including Divisional management grtoups reporting into Trust Executive Committee • CQC Well-led Review 2019	Confirmed	Trust Board Study Session topic: Board Assurance Matrix
FT4 - 5. The Licensee shall establish and effectively implement systems and/or processes:		Confirmed	
(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	• See Annual Governance Statement for 2018/19 as audited and published in the Annual Report and Accounts • CQC Well-led Review 2019 • Use of Resources review 2019 NHSI Review 2019	Confirmed	• Maintain by effecting the Governance Action Plan
(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;	• See Annual Governance Statement for 2018/19 as audited and published in the Annual Report and Accounts	Confirmed	• Maintain by effecting the Governance Action Plan
(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• NHSI: Single Oversight Framework Segmentation (2) • Care Quality Commission registration and the results of CQC inspection reports; • Board perfromance reviews of IPR • Board Assurance Framework report	Confirmed	• Maintain by effecting the Governance Action Plan • Monitor through IPR and Board Assurance Framework report
(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	• The Accounting Officer prepared the financial statements for 2018/19 on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group or the Trust without the transfer of its services to another public sector entity. • They concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period") • The Trust has a comprehensive system of financial management and decision making in place, receiving significant assurance from the Internal Auditor that a sound system of financial control is in place and from the External Auditors Opinion that the Trust is a Going Concern . The Trust has a comprehensive and continuous Business Planning process in place that is overseen by a Steering Group with regular progress reports to the Trust Executive Committee and scrutiny by the Strategy and Finance Committee	Confirmed	• Maintain by effecting the Governance Action Plan
(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	• Data Quality Assessment conoducted for IPR, Finance Report, Use of Resources, and Well-led assessment • • Transition to new Forward Planner for Board and Committees • Adoption of digital governance solutions in support of the Board and Committees (e.g. iBabs) • Ongoing review of Corporate Affairs resourcing	Confirmed	• Maintain by effecting the Governance Action Plan
(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• Risk Strategy • Board Assurance Framework Report • support resources for risk and compliance • This exercise	Confirmed	• Maintain by effecting the Governance Action Plan

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	• Directorate of Strategy and Improvement business planning and monitoring function • Trust Investment Group • Trust Executive Committee • Strategy and Finance Committee • NHSI review of wholly owned subsidiaries	Confirmed	• Maintain by effecting the Governance Action Plan
(h) to ensure compliance with all applicable legal requirements.	• Existing legal resources and outsourced legal specialisms where required	Confirmed	• Maintain by effecting the Governance Action Plan
FT4 - 6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:		Confirmed	
(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	The Board includes a clinical Chief Executive Officer, two clinical Non-executive Directors, a medical Director, and a Director of Nursing. • The Trust was inspected by the Care Quality Commission (CQC) in December 2018 to assess performance in respect of the Well-Led Framework which is the standard measure for leadership across NHS providers. The CQC rated the Trust's standards of leadership overall as 'good' with some areas of outstanding practice.	Confirmed	• Maintain by effecting the Governance Action Plan
(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	The Board deploys a Quality Committee, chaired by a non-executive director. This committee has been established to explore, scrutinise, and gain a deeper understanding of clinical quality on behalf of the Board. The committee provides assurance to the Board on patient safety, patient experience and clinical effectiveness and routinely considers performance against a broad range of qualitative indicators.	Confirmed	• Maintain by effecting the Governance Action Plan
(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;	The Board considered quality-assured data on (including, but not limited to: • Access performance (including emergency department and referral to treatment); • Delayed transfers of care; • Never events/serious untoward incidents; • Complaints; • Emergency re-admissions; • Clinical outcomes; and, • Hospital standardised mortality rate	Confirmed	• Maintain by effecting the Governance Action Plan
(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	As per (b) and (c) above. Additionally, the Board begins each of its public Board meetings with an interview with a patient, carer, family member or staff to hear first-hand about how the Trust's services are experienced. These include both favourable scenarios as well as patient stories where the Trust could have done better. • CQC Inspection Report April 2019: "Our inspectors found a strong patient-centred culture with staff committed to keeping their people safe, and encouraging them to be independent. Patients' needs came first and staff worked hard to deliver the best possible care with compassion and respect. Inspectors saw many areas of outstanding practice, with care delivered by compassionate and knowledgeable staff. Several teams led by example with a continuous focus on quality improvement."	Confirmed	• Maintain by effecting the Governance Action Plan

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	We are committed to the sharing of good practice and learning from incidents, complaints and patient feedback and we achieve this through: • The prompt dissemination of safety alerts, recommendations and guidelines made by central bodies such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE); • Root cause analysis of serious incidents; • Policies that encourage timely and transparent reporting and investigation of adverse incidents and complaints; • Feedback on learning and good practice through 'Safety Matters' communications and updates provided to Quality Governance Steering Group and divisional and care group governance meetings; • Clinical audit; and, • Staff appraisal and development.	Confirmed	• Maintain by effecting the Governance Action Plan
(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Professional and functional reporting lines are established throughout the organisation to enable effective two-way communication between the Board and our wards. These reporting lines are interspersed with specialist management, scrutiny, and governance groups that serve to support staff, test, and capture intelligence throughout the operational care cycle. The Chief Executive maintains an Executive Performance Management Group that meets monthly to assess performance, quality, finance, and HR matters in detail. This groups is fed by the Quality Governance Steering Group which oversees several specialist quality assurance groups, including: patient safety, patient experience, outcomes and effectiveness, regulatory assurance, adult and children safeguarding, health and safety, infection prevention, education, and Divisional Governance Groups. All the sub-groups submit reports regularly. The Trust operates a Clinical Accreditation Scheme, a process where wards or departments are required to demonstrate adherence to standards of care to become accredited. The Trust monitors ward standards through the clinical quality dashboard which focuses performance against key metrics including patient safety, effectiveness, patient experience and outcomes from matron peer walkabouts. The Trust's Quality Improvement Framework (QIF) underpins our quality governance and is updated and reviewed annually and outlines the Trust's 'Ward to Board' approach to escalation of quality matters to the Board, and dissemination of direction from the Board.	Confirmed	• Maintain by effecting the Governance Action Plan
FT4 - 7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.	Succession planning for the Board of Directors is conducted by the Remuneration and Appointment Committee to ensure the continuity and suitability of resourcing for the Board. This includes skill-mix assessments, consideration of current operating environment challenges (for example, Board-level skills for digital transformation), committee chairing skills, clinical and quality insight, and other applicable experience such as HR and governance. The Board is supported by specialist in key areas such as strategy, governance, HR management, data analytics, performance management, quality assurance, and business administration.	Confirmed	• Maintain by effecting the Governance Action Plan
FT4 - 8. The Licensee shall submit to Monitor within three months of the end of each financial year a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.	The Board is cognisant of potential risk to continued compliance with the FT Provider Licence and has establish systems of risk management and internal control to identify, quantify, manage, and mitigate such risk. These systems include a revised risk management system supported by improved risk systems; a revised Corporate Risk Register; a revised and strengthened Board Assurance Framework report; several revisions to Board governance arrangements; revised Executive portfolios, and an ongoing revision of the resources required to support and enable the Board to discharge its duties effectively (FT4 - 7).	Confirmed	• Maintain by effecting the Governance Action Plan

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: 7 Day Hospital Services Self-assessment – Spring/Summer 2019/20			
Category	Quality, Performance, and Finance		
Agenda item	6.3		
Sponsor	Medical Director		
Author	Steve Wheeler, Business Manager to the Medical Director		
Provenance	The Trust is required to submit the Spring/Summer 2019/20, 7 Day Service Board Assurance Framework on 28 June 2019. In order for the Trust to comply with this return the framework must be signed off by the Trust board or appropriate sub-committee and returned by close of play on 28 June 2019.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. The Seven Day Hospital services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed and since 2015 Trusts have been asked to report on four priority standards: • Clinical Standard 2: consultant-directed assessment • Clinical Standard 5: diagnostics • Clinical Standard 6: interventions • Clinical Standard 8: ongoing review The attached template shows UHS responses to the self assessment and is submitted to Trust Board for approval prior to completing the return.		
Relevant strategic goals	✓ 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.
Assurance framework links	• CRR01 – 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 • CRR02 – 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		
Impact assessments	None applicable		

Other standards affected	7 Day Service Board Assurance Framework

University Hospital Southampton NHS FT: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019/20

Priority 7DS Clinical Standards

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Board/sub-committee that signed off this template as an accurate reflection of the Trust's position:	**Trust Board**
Date the template and supporting documentation went to Board/sub-committee:	**Thursday 27th June 2019**
Was this template accompanied by supporting documentation, if so what?	**None**

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The Trust is meeting this standard: Evidence Source 1 - Consultant Job Plan All emergency specialties have consultant on call rotas with either planned ward round review to support the standard or continuous review throughout the shifts. The timing of review is entered through the electronic system, which enables monitoring, however often consultants enter a time at the end of the session rather than the time the patient is reviewed. Despite this we still meet the standard. Evidence Source 2 - Local Clinical Audit In June 2019 UHS carried out a local clinical audit to identify that all emergency admissions receive a clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital. The Trust found that the time to first consultant review for the audit sample was achieved at 96.72%. 3.28% of the sample is uncompliant as the system data showed clinical assessments taking place on the admitting ward prior to the patient being admitted to the ward on the system. The review looked at 11,854 records from the Acute Medical Unit between March 2018 to March 2019 and covered from 7 days a week. On average patients wait a total of 2hr 28mins for an assessment. 2hrs 31mins on a weekday and 2hrs 19mins at the weekend. This is a significant achievement and demonstrates the effective working practices demonstrated by the emergency admissions team. Evidence Source 3 - Wider performance and experience measures The Trust triangulates data to reinforce that the care provided to our emergency admissions is excellent. UHS is particularly proud of the changes which have been made to ensure that there is no difference between mortality at the weekend compared to weekdays. UHS have taken positive steps to ensure that length of stay is not significantly affected by weekends. Weekend discharges consistently make up 20% of the total weekly discharges and this is supported by SAFER principles.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust is meeting this standard: UHS consistently achieve Clinical Standard 5 target across seven days a week, all specialties provide consultant cover and interventions 7 days a week. We provide many of these services for neighbouring Trust's. (IR, MRI, Interventional Endoscopy, Emergency Surgery, PCI and complex Cardio Arrhythmia)	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust is meeting this standard: UHS consistently achieve Clinical Standard 6 target across seven days a week, this is due to radiology working practices and economies of scale.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The Trust is meeting this standard: Evidence Source 1 - Consultant Job Plans Consultant led handover takes place twice a day in GICU (General Intensive Care Unit) and once a day in SHDU (Surgical High Dependency Unit). Job plans are appropriate and sufficient. Evidence Source 2 - Systems to support ongoing review UHS support and have implemented NEWS2 across all adult areas (excluding obstetrics). Patient acuity and needs are updated daily on Drs Worklist. This provides detail on handover and to the on call team. Patients over are stratifying or requiring urgent review are seen by the duty team as highlighted through NEWS2 (or by nursing team) Evidence Source 3 - Local Clinical Audit Twice daily consultant reviews take place in admission areas and high care areas and once daily review in other inpatient wards. The Trust has doubled consultant ward rounds over the past two years and consistently achieves this target. Evidence Source 4 - Wider performance and experience measures The Trust triangulates data to reinforce that the care provided to our high dependency patients is excellent. Outcomes are consistently within the top 10% noticeably. The GMC survey is very positive. Juniors report being very supported by consultants both in and out of hours. We are told that the support out of hours and leadership is a significant strength of the organisation.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
UHS has reviewed performance against these standards and has highlighted areas which show particular progress: Clinical Standard 1 - Patient Experience The trust receives patient feedback through a wide variety of channels. For regular local feedback, such as the Friends & Family Test, results for weekend care can be filtered by date of discharge and free text comments are regularly subject to thematic reviews. Complaints are categorised and reported on thematically to identify emerging trends. All website feedback (NHS choices, Care Opinion) is monitored and shared with relevant teams. Healthwatch attends the trust's patient experience committee and escalates any emergent concerns or themes. Friends & Family Test results for weekend inpatient care show a lower recommend rate than the overall trust score: 93% average rating in Q3 and Q4 for inpatients patients discharged at weekends compared to 97% overall, and in outpatients weekend recommend rate was 92% compared to 96% overall. Performance in ED remained relatively consistent. Clinical Standard 3 - Multidisciplinary Team Review The Trust has processes in place to support MDT review in all specialties within emergency admissions, with the appropriate members to enable assessment for complex/ongoing needs to create an integrated management plan. We have a 7 day a week Frailty service at the front door. In addition the clinical pharmacy service supports UHS 7 days a week, this includes medicine reconciliation and prescription review. At the weekend this service is reduced to identify patients who are higher priority for review (new admissions and high risk conditions or medicines). Areas with high emergency admission numbers i.e. AMU (Acute Medical Unit) and SDU (Surgical Day Unit), receive a dedicated clinical pharmacy service at the weekend. Since Feb-18 UHS has consistently achieved above the 80% medicines reconciliation rate target. Clinical Standard 4 - Shift Handovers All services have timetabled handover twice daily and 7 days a week. Outcomes are documented on Dr worklists in most specialties. Clinical Standard 7 - Mental Health The liaison psychiatry team at UHS in hours (mon-fri 9-5) for wards and 24/7 to the ED and AMU, would aim to respond to CRISIS referrals (e.g someone at imminent risk of harm to themselves or others/active suicidal intent) within 1 hour and URGENT (eg self-harm, suicidal or psychotic but being safely managed within the ward/ area) referrals within the same day, and for non-urgent or routine referrals the response time is 3 days, however the service is significantly under resourced and at times meeting the demand is challenging. The Liaison Psychiatry service at UHS is not resourced or commissioned to provide urgent mental health response to the acute hospital wards out of hours any urgent advice is provided by the SHFT consultant on-call via the bleep holder based at Antelope House. Clinical Standard 9 - Transfer to Community, Primary and Social Care The UHS Complex Discharge Team offers a 6 day service (Sunday to Friday) at present, with significantly reduced service available on the Sunday. Where possible discharges are lined up for the weekend where partners offer a 7 day admitting service/start date. Due to system preparedness for 7 day working, it is not deemed financially viable to offer a full 7 day service at present. Social care is available 7 days a week Clinical Standard 10 - Quality Improvement - HSMR, QI programme The Trust is a positive outlier for HSMR. Our weekend and weekday HSMR is comparible and siginficantly lower than expected compared to our peers locally and nationally. We have a QI strategy with clear leadership and a program across the Trust. The QI team work with the clinical representatives and GIRFT team to ensure that out program focuses on outcomes as well as the Trust's QI priorities.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 27 June 2019			
Title: Register of Seals, and Chair's Actions			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.4		
Sponsor	Chairman		
Author	Charlie Helps, Company Secretary		
Provenance	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.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for RATIFICATION.		
Relevant strategic goals	☐ 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.
Assurance framework links	• CRR02 – 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.		
Impact assessments	None		
Other standards affected	• Monitor NHS Foundation Trust Code of Governance (probity, internal control) • UHS Standing Financial Instructions and Scheme of Delegation		

1. Signing and Sealing

1.1 **Agreement for Lease** between University Hospital Southampton NHS Foundation Trust (Landlord) and The Maggie Keswick Jencks Cancer Caring Trust (Tenant) for the construction of a Maggie's Centre at Southampton General Hospital. Seal number 175 on 29 May 2019.

1.2 **Agreement** between University Hospital Southampton NHS Foundation Trust and The Maggie Keswick Jencks Cancer Caring Trust (Maggie's) for the provision of oncology psychology services. Seal number 176 on 29 May 2019.

1.3 **Deed of Assignment** of Intellectual Property Rights between Ascribe Limited (the Assignor) and University Hospital Southampton NHS Foundation Trust (the Assignee) relating to modules and interfaces within the HICCS environment (Schedule of Works). Seal number 177 on 29 May 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 Vascular Therapy consumables and equipment via NHS Supply Chain National Pricing Matrix Agreement for 2 years at a total cost of £584,430 excluding vat, with savings of £17k in year 1. Approved by the Chair on 21 May 2019.

2.2 **Single Tender Action** for Childcare Vouchers from Fideliti for 1 year at a cost of £1,020,000 excluding vat. Costs are recovered from the staff salary sacrifice scheme. The move to Fideliti has saved the Trust 0.05% per month on the total voucher value. Approved by the Chair on 3 June 2019.

2.3 **Single Tender Action** for Salary Sacrifice Staff Car Scheme with Tusker Direct, for 1 year at a cost of £600,000 excluding vat. The car lease scheme is procured under a compliant framework through NOE CPC. All payments are recovered from staff through current payroll at source. Approved by the Chair on 3 June 2019.

2.4 **Single Tender Action** for Research & Development Salaries 2019-20 from University of Southampton at a cost of £5,000,000 excluding vat. To fund a number of UoS employees' salaries through 2019-20 who are supporting research studies. Approved by the Chair on 10 June 2019.

2.5 **Single Tender Action** for the Assignment of Intellectual Property Rights for HICSS (CHARTS) Electronic Patient Record software from Ascribe Ltd T/A EMIS Health, at a cost of £753,000 excluding vat. Approved by the Chair on 21 June 2019.

2.6 **Award of Contract** for Radiology out of hours reporting service to 4 Ways Healthcare Ltd for 2 years at a total cost of £1,000,000 excluding vat. The contract has been awarded via North of England CPC framework and is based on banded prices and will bring in savings to the Trusst, with further opportunities for more savings if volumes grow. Approved by the Chair on 21 June 2019.

3. Recommendation

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