University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	30/07/2019
Time	9:00 - 11:50
Location	Parent Education Seminar Room, F Level, Princess Anne Hospital
Chair	Peter Hollins
Apologies:	Cyrus Cooper
In attendance:	Jo Watts, GDE Programme Manager (shadowing Jane Hayward)

1	9:00	**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.
2		**Minutes of Previous Meeting held on 27 June 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	9:15	**Patient Story** To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.
4.2	9:30	**Briefing from Chair of Audit and Risk Committee for review (Oral)** Simon Porter, SID/Non-Executive Director
4.3	9:35	**Briefing from Chair of Quality Committee for review (Oral)** Mike Sadler, Non-Executive Director
4.4	9:40	**Briefing from Chair of Strategy & Finance Committee for review (Oral)** Jane Bailey, Non-Executive Director
4.5	9:45	**Integrated Performance Report for Month 3 for review** To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Patient Safety Report. Sponsor: Jane Hayward, Director of Transformation & Improvement
4.6	10:30	**Framework of Quality Assurance for Responsible Officers and Revalidation for approval** Sponsor: Derek Sandeman, Medical Director

4.7	**Safeguarding Annual Report 2018/19 for review**
10:40	Sponsor: Gail Byrne, Director of Nursing & Organisational Development Attendee: Tracey Whale, Named Nurse for Adult Safeguarding
4.8	**Informatics Update for review**
10:50	Sponsor: Jane Hayward, Director of Transformation & Improvement Attendee: Adrian Byrne, Director of Informatics
4.9	**Finance Report for Month 3**
11:00	Sponsor: David French, Chief Financial Officer
5	**Strategy and Business Planning**
5.1	**Trust Clinical Strategy 2019-2024 for approval**
11:10	Sponsors: Derek Sandeman, Medical Director Attendees: Tristan Chapman, Deputy Director of Improvement & Partnerships and Sue Leamore, Deputy Director of Strategy
6	**Corporate Governance, Risk and Internal Control**
6.1	**Board Assurance Framework (BAF) Report 2019-20 Quarter 1 Report for review**
11:20	Sponsor: Paula Head, Chief Executive Attendee: Charlie Helps, Interim Company Secretary
6.2	**Feedback from Council of Governors' Meeting 9 July 2019 (Oral)**
11:30	Peter Hollins, Trust Chair
6.3	**Register of Seals, and Chair's Actions for ratification**
11:35	In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Delegation. Sponsor: Peter Hollins, Trust Chair
6.4	**Information Governance and Data Protection Annual Report 2018/19 for review**
11:40	Sponsor: Charlie Helps, Interim Company Secretary
7	**Any other Business**
11:45	To raise any relevant or urgent matters that are not on the agenda
8	**To note the date of the next meeting: Friday 30 August 2019, in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH**

9 **Exclusion of press, public, and others**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board of Directors resolving as follows “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.”

10 **Items circulated to the Board for reading**

27 June 2019

Press Release: Head and neck cancer patient treated with innovative radiotherapy technique in UK first

28 June 2019

Press Release: Southampton researchers secure £3 million for dedicated infection lab

2 July 2019

Press Release: Southampton pharmacist recognised by Prime Minister for diabetes care

24 July 2019 (with Board Papers)

Guardian of Safe Working Hours Quarter Report

11 **Follow-up discussion with governors**

11:50

12 **Clinical Visit - Maternity**

12:05

13 **Lunch**

13:20

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	27 June 2019
Time	9:00 - 13:35
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins
Present	Jane Bailey, Cyrus Cooper, Jenni Douglas-Todd, David French, Paula Head, Charlie Helps, Simon Porter, Mike Sadler, Derek Sandeman, Juliet Pearce, Tristan Chapman and Andrew Asquith.
In Attendance	Suzanne Cunningham, Marie Cann, 1 staff governor, 1 member of staff, 6 members of the public.
Apologies	Gail Byrne (Juliet Pearce deputising), Jane Hayward (Tristan Chapman deputising), Caroline Marshall (Andrew Asquith attending)
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 May 2019

The minutes of the previous meeting were agreed as a true and fair representation of the business transacted subject to the following minor amendments:

- Joanne Mountfield's name to be corrected on page 1.
- Item 4.3 Briefing from the Chair of the Audit and Risk Committee - first paragraph following the bullet points to specify that the query related to how data was collected and not how the Trust performed nationally.

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 34) EPRR Core Standards Assessment - AA agreed to forward this to CH for circulation.

Action Item 5) Research and Development - Performance indicators would be developed as part of the Trust's clinical strategy.

Action 23) Written Patient Information - DS said that patient information was being reviewed in the two specific areas highlighted from the most recent patient stories. A wider review of all patient information would be undertaken as part of the Trust's clinical strategy.

Action 26) IPR BA4 - The defect work orders and percentage completed in time indicator was being reviewed and an update would be provided at the next Trust Board meeting.

Action Items 6, 0 and 25 would be reported via the July Quality Committee and then subsequently to the Trust Board.

PTH highlighted the need to ensure that the list of actions was reviewed alongside the draft minutes.

4 Quality, Performance and Finance

Quality includes: clinical effectiveness, patient safety, and patient experience

4.1 Patient Story

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

DS introduced the patient. The Board heard a first-hand account of their experience noting this was mostly positive. The patient was asked what elements of his experience could have been improved. He suggested some expectation management for patients moving from critical care areas to ward areas, as well as improvements to the discharge process..

The Chairman thanked the patient for sharing their experience at the Trust.

4.2 Briefing from Chair of Strategy & Finance Committee for review

Jane Bailey, Non-Executive Director

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

- A review of the latest financial position for month two.
- A detailed review of Cost Improvement Programmes (CIPs) for 2019-20.
- Sustainability and Transformation Partnership (STP) update continued from the previous month.

PTH requested an update on CIPs. JB provided an overview of the discussion held at the meeting noting there had been improved performance within the month. JB assured the Board that the information provided to the Committee was sufficient and that performance would be reviewed on a monthly basis.

4.3 Integrated Performance Report for Month 2 for review

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

Improving patient journeys

MS highlighted the increasing number of patient moves for non-clinical reasons taking place during the night. AA provided an update adding that this could impact upon the patient's experience. The Board asked that the Quality Committee review this in more detail.

Action 38: Quality Committee to investigate the level of overnight moves of patients for non-clinical reasons.

MS asked how confident the Trust was that the agreed cancer trajectory would be achieved by the end of December 2019. AA summarised current cancer performance and the factors that would impact upon the achievement of the trajectory.

AA provided an overview of Emergency Department (ED) and cancer performance. It was noted that the constitutional targets would be discussed in detail at the July Quality Committee.

DS noted the high bed occupancy levels at 95%.

PTH highlighted the improved 62-day cancer wait performance and queried whether this would be sustained. AA stated that while this was encouraging, a lot of work would be required to sustain the improvement specifically in respect of breast, prostate, head and neck, colorectal and lung cancers.

The Board expressed their thanks to staff for their hard work during this pressured time. The reduction in sickness absence and improvements in turnover were also commended.

Delivering value-based healthcare

JP provided an update on a recent paediatric orthopaedic Never Event which was being investigated. Some immediate actions had been agreed and completed across all theatres.

JB advised that the metrics included in this section differed from those presented at the recent Strategy and Finance Committee.

Action 40: Metrics under this section to be reviewed by DAF to ensure they reflect that discussed at Strategy and Finance Committee.

JB queried whether there was a link between the increasing number of ED attendances and non-elective spells and if this subsequently increased income. DAF provided an overview of the impact of elective and non-elective activity on income. JB asked that a summary of this be provided in the commentary of the report.

Action 41: Commentary to include an update on the impact of elective and non-elective activity on income (DAF).

Supporting healthy lives
MS queried the reasons for the delay in completing the three overdue Serious Incidents Requiring Investigation (SIRIs). JP provided an update on these; one was a Healthcare Safety Investigation Branch (HSIB) case which was delayed due to the new process introduced, the second was awaiting an external review and the final case required review of approximately 1300 records. Only one case of harm had been identified following the latter review.

MS highlighted the number of indicators that were in development and asked when these would be available. PHe advised that as this was a new focus for the Trust that the indicators would be developed through the new clinical strategy.

SP requested an update on the development of clinically driven outcomes noting this work had plateaued. DS advised that work was ongoing to develop this further however focus was being shifted to specialties developing outcomes for high volume areas of work and more patient-reported outcomes.

Building an expert and inclusive workforce
JD-T asked how the current pressures across the hospital were impacting on staff. PHe advised that staff morale was being affected. JP added that staff resilience and good clinical leadership were key to coping with sustained pressures. Staff continued to report feeling supported.

JD-T highlighted that staff appraisals appeared to be on a downward trend. PHe confirmed that this was an area of focus for the divisions.

Review of the report
The Board reviewed the content of the report noting that the summary should provide an overview of performance and highlight the pertinent areas for discussion at the meeting. It was also suggested that a glossary of terms be developed and included at the end of the Board papers.

4.4 Maternity Service Self-Certification - NHS Resolution 10 Criteria for review

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

SC summarised the report advising of the requirements that had changed since last year. The Board were asked to consider the evidence provided to date to demonstrate completion of 8 of the 10 maternity safety actions and that those achieved met the required standards. It was a requirement for the Board declaration to be submitted to NHS Resolution by 15th August 2019.

PTH sought clarification of the two areas of non-compliance. SC explained that these related to maternity emergencies training, for which two training sessions had been booked and all required staff scheduled to attend, and the second was due to a fault with the national system for submitting the maternity data set. This was expected to be resolved by the end of July 2019. The service had

submitted the data required but confirmation of this was not available. JD-T asked what mitigations were in place were these actions not to be completed by the end of July. SC assured the Board that she was confident that training compliance would be completed and that the national team were working to rectify the reporting problem.

AA and CC highlighted table two of the report and queried why one incident had not been subject to a multi-disciplinary review. MC confirmed that all cases would be reviewed and that the service had a four-month period within which to undertake this.

Decision
Following scrutiny of the evidence available specifically that relating to criterion 1, 3, 5 and 6, as set out in the paper, and evidence being forthcoming to the Chief Executive's satisfaction, the Board resolved to authorise the Chief Executive Officer to sign the self-certification in July 2019 on behalf of the Board.

4.5 Finance Report for Month 2 for review

Sponsor: David French, Chief Financial Officer

DAF presented the month two Finance report, noting for May:

- The Trust delivered a surplus of £0.5m , £0.8m better than Plan. This was due to income being £0.8m better than Plan, predominantly related to high non-elective activity offsetting below Plan elective activity.
- Under the single oversight framework, the Trust had delivered a score for Finance and Use of Resoures of '3'.
- Pay was £0.6m worse than Plan in month, with overall pay not achieving the pay CIP target. New business rules had been introduced across the organisation which included a revised recruitment approval process.
- Once non-recurrent items were excluded, the surplus was £0.3, £0.6m better than Plan.
- Total CIP delivery was £1.9m, only £0.1m below Plan.

DAF advised the Board of the risks facing the Trust for 2019/20:

- CIP delivery noting that £8m of CIPs were yet to be identified.
- Underlying run-rate of expenditure exceeding income.
- A potential shortfall in clinical income due to consultant workforce capacity due to pensions taxation.
- NHS Improvement had flagged concerns over the cost of national capital programmes and slippage identified by the Trust totalled £6m.

MS queried whether the underspent capital programme was as a result of local or national decisions. DAF advised of the reasons for the slippage on a number of projects noting this was all due to local decisions and that a national mandate had not yet been received. DAF added that more work was being done to ensure plans were realistic.

PTH asked how the Trust compared with others in relation to the magnitude of its CIP challenge. DAF provided an overview noting that the Trust was in regular contact with colleagues in other Trusts on this issue.

5 Strategy and Business Planning

5.1 Trust Vision, Mission and Staff Voice for approval

Sponsor: Paula Head, Chief Executive Officer

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

PHe introduced the Trust corporate strategy which included the vision, mission and values requesting formal approval by the Board.

PHe introduced the UHS Change Champions who had been working to set the UHS mission and provide the voice of staff. The UHS Change Champions presented to the Board noting that they had engaged with over 900 staff to develop the trust mission.

JB queried the impact on staff of increasing pressure on finance and resources. The Change Champions stated that staff found it difficult to understand finance and pressures when they see new buildings being developed and how this was justified.

JD-T highlighted that 'Goodwill is hanging on a shoestring' from the presentation and queried at what point this may break. The Change Champions felt that this would not happen as staff experienced both good and bad days.

PHe thanked the Change Champions on behalf of the Board. The Board would consider the specific findings in more detail at a later date.

Action 42: Communication to all staff from PHe to be drafted by the UHS Change Champions regarding the mission statement and actions to be taken going forward (PHe).

Decision

The Board resolved to approve the Corporate Strategy.

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

Sponsor: Peter Hollins, Trust Chair

The terms of reference for a review of UHS Board Committee terms of reference were presented for approval.

Decision

The Board resolved to approve the proposed terms of reference for the review.

6.2 NHS Provider Licence Conditions Compliance Self-certification for approval

Sponsor: Paula Head, Chief Executive

Attendee: Charlie Helps, Company Secretary

PHe introduced the annual declaration of compliance with the NHS Provider licence conditions G6 and FT4 which required approval by the Board. CH clarified that the self-certification required the Board to confirm compliance last year and that it would remain so in the forthcoming year. PHe advised of the risks to the Trust maintaining compliance in the forthcoming year. This risk would be continuously scrutinised by the Executive Team and monitored through the Board Assurance Framework.

Decision

The Board resolved to approve the NHS Provider Licence Conditions Self-certification.

6.3 7-Day Hospital Services Self-Assessment for approval

Sponsor: Derek Sandeman, Medical Director

DS presented the self-assessment that required approval by the Board for submission to NHS England (NHSE) on 28th June 2019.

Decision

The Board resolved to approve the 7-Day Hospital Services Self-Assessment.

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

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

Sponsor: Peter Hollins, Trust Chair

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

Decision

The Board ratified the actions taken in month.

7 Any other business

None.

8 Next meeting of the Board

Thursday, 30 July 2019 in the Parent Education Seminar Room, F Level, Princess Anne Hospital.

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 27/06/2019 4.3 Integrated Performance Report for Month 2 for review				
38.	Overnight Patient Moves	Marshall, Caroline	29/08/2019	Pending
	Explanation action item Quality Committee to investigate the level of overnight moves of patients for non-clinical reasons.			
40.	Delivering value-based healthcare	French, David	30/07/2019	Pending
	Explanation action item Metrics under this section to be reviewed to ensure they reflect that discussed at strategy and finance committee.			
41.	Delivering value-based healthcare	French, David	30/07/2019	Pending
	Explanation action item Commentary to include an update on the impact of elective/non-elective activity on income.			
Trust Board – Open Session 27/06/2019 5.1 Trust Vision, Mission and Staff Voice for approval				
42.	UHS Change Champions	Head, Paula	26/07/2019	Pending
	Explanation action item Communication to go out to all staff regarding the mission statement and actions to be taken going forward. UHS Change Champions to draft this and share with Paula Head.			
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	Completed
	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	Completed
	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 5 Chair's and Chief Executive's Reports				
0.	Governance	Helps, Charlie	30/05/2019	Completed
	Explanation action item Governance elements of the CQC report to be extracted and considered as part of the overarching review of Board governance.			
	Explanation Helps, Charlie INcluded in Corporate Affairs objectives for 19/20			
7.	CQC	Byrne, Gail	30/05/2019	Completed
	Explanation action item CQC action plan to be reported to the Quality Committee.			
Trust Board – Open Session 30/04/2019 4.4 Integrated Performance Report for Month 12 including Quarterly Patient Safety Report (QIF) for review				
0.	IPR Annual Report - Safe	Hayward, Jane	30/05/2019	Completed
	Explanation action item David Dalton report to be shared with the Board.			
5.	Research and Development	Hayward, 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.			
0.	IPR for Month 12 - Digital	Hayward, Jane	30/05/2019	Completed
	Explanation action item IT strategy and metrics for inclusion in the IPR to be discussed at Strategy and Finance Committee.			
Trust Board – Open Session 30/05/2019 4.1 Patient Story				
23.	Written Patient Information	Sandeman, Derek	30/05/2019	Completed
	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 4.2 Briefing from Chair of Quality Committee for review (oral)				
24.	CQC Action Plan	Byrne, Gail	30/05/2019	Completed
	Explanation action item Quality Committee to receive exception reports only.			
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.			
Trust Board – Open Session 30/04/2019 3 Matters Arising and Summary of Agreed Actions				
3.	Actions	Helps, Charlie	30/04/2019	Completed
	Explanation action item Company Secretary to update the Actions in accordance with the status of each item agreed by the Board.			
	Explanation Helps, Charlie Entered into iBabs.			

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title Integrated Performance Report 2019/20 Month 3			
Category	Quality, Performance, and Finance		
Agenda item	4.5		
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	• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • BAF10 – 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

The Hospital has remained very busy during June and access targets have not been met in most instances.

The non-elective rolling 12 month length of stay remains at 6.5 days for the third month in a row. This is disappointing as the length of stay reduction programme supports the delivery of patient access targets and the cost improvement programme. A small number of beds have been closed during June and July in specific areas which do not impact on patient care. Adult Bed occupancy has remained stable since January around the target 90-95%. Linked to the length of stay delayed transfers of care remain stable not achieving target, currently at 6% in June. Longer LOS patients have been trending upwards since December 2018, currently at an average 219 patients a day in June, this is the second month in a row not achieving trajectory. A new national weekly review of longer LOS patients has been launched in July to create a new focus on this group linked to the SAFER programme. UHS is working with NHSI to re-launch this programme. Outliers, AMU 8am bed occupancy and non-clinical ward moves remain stable after a step change in January 2019

Emergency access performance remains stable but below trajectory after a step down in performance in January and February 2019. Type 1 performance in June was 72% and we ranked 7th of 8 Major Trauma Centre peers (8th being worst). Local delivery system performance was at 83.2% in Q1 against a target of 90%. A new recovery plan has been developed based on the recommendations of Matthew Cooke, a national clinical advisor. This is being monitored fortnightly with the national team and a new system plan is under development.

Percentage of patients on an open RTT pathway (waiting list) who have waited less than 18 weeks in June is at 86.8% against a target of 92%. There were four patients waiting longer than 52 weeks. The total number of patients on a waiting list has increased again in June (for the 5th month in a row), there has been a technical readjustment following a data validation exercise and reduced clinical capacity linked to the national pensions tax issue. There has also been an impact from increased emergency work, with the need to introduce a second emergency theatre each day.

We are close to achieving the 6 week diagnostic performance trajectory and have kept performance high despite onsite scanners being shut down for building works.

62 day cancer waiting time performance was 72.6% in May against a target of 85%. Performance of the 62 day target in May dropped as a result of increased breaches in colorectal and lung pathways. UHS ranked 9th (10th being worst) out of a peer group of 10 similar size teaching hospitals. There is a plan to recover this performance by December 2019 at the latest. The performance excluding urology patients was 82.3%

31 day cancer waiting time performance remains stable not achieving target after a step down in performance in December 2019. Performance was at 91.01% in May against a local trajectory of 94.7%.

2 week GP referral cancer waiting time performance continues to trend upwards, achieving target for the third month in a row (currently at 96.7%) in March against a target of 93%.

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 21 out of 33 clinical specialties have been visited. With 19 of these now having a clinically lead quality improvement and specialty lead investigation programmes agreed with the GIRFT central team.

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

For the last 6 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

C.diff cases exceeded trajectory in May. This was linked to the identification of colonised patients as there was an increased level screening as a number of patients had norovirus.

HSMR performance over 12 months remains low due to continued low values from several specialties. March 2019 has generally gone down, though Neurology remains a little high.

9 national reports were published and reviewed in June 2019 and 2 Areas of concern were identified:

- National Diabetes Foot Care Audit (NDFA) Third Annual Report (data from 01/04/15 - 31/03/18). Service sits within Solent for our patients – lead for UHS and Solent asked to review and respond.
- NACAP Adult asthma secondary care audit report (Nov 18-March 19) relates to review by specialist within 24hrs of admission lead for UHS asked to review and respond.

Of the 3 overdue SIRI's one is still being investigated by HSIB (since August 18), one was awaiting external review and the third was in relation to HICCS and is now closed

There were 3 never events during April and May and four moderate harm medication incidents in June. All three incidents have been thoroughly investigated.

Rolling 12 month staff sickness absence rates remain below target in June (<=3.4%). In Q1 2019/20, 7 staff members started Quality Improvement training at UHS.

Patients screened for risky behaviours (alcohol consumption and smoking) remain stable well above target (currently 97% against a target >80%. Of those found to have moderate or high alcohol dependence 87% were given relevant advice or a referral to specialist services in June, this

performance is stable bot achieving target (last achieved December 2018). Of those found to smoke who were given advice or offered medication performance in June dropped to 77%.

Building an expert and inclusive workforce

In UHS ward-based areas, total nursing staff vacancies have decreased by 0.44% since last month. Registered nurse vacancies in ward-based areas have also decreased this month (by 0.41% 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, however to offset this 29 Overseas nurses have acquired their PINs.

Targets have been missed for staff turnover and appraisals. Sickness absence rates have increased for the second month but are still below target. UHS has seen improvements in rates of employment for BAME Band 7+ and CHPPD for total nursing. Additionally, the position for the following is stable: statutory and mandatory training compliance (with 8 of 12 measures meeting target) and CHPPD for in-patient nursing staff.

Being agile in meeting people's needs

Estates helpdesk requests remain stable around the target 85%, in June we did not achieve target, currently at 83.3%. Unresolved help desk requests remain stable well below target, in June we had 703 against a target <1000. Unresolved requests over 30 days old are stable around the target, in June we achieved target with 195 against a target <200. Percentage defect work orders completed on time is stable just above the target >85%, currently at 86%. Percentage statutory and mandatory jobs completed on time remains stable well above the target 95%, in June we were at 99.1% *The* EFCD team have looked at the effect of not performing some maintenance tasks in a timely manner and considered how this impacts patients.

The EFCD team have looked at the effect of not performing some maintenance tasks in a timely manner and considered how this impact on patients. A simple comparator of the failure rate of toilets has been selected to look at how long wcs are out of service compared to the total number of toilets that are available. This has been considered for April, May and June 2019. The total number of toilets in SGH and PAH is about 1,100. If all toilets were available 100% of the time this would mean that there are 33,400 toilet days available in an average month. This is equal to 177 in April, 158 in May and 106 in June, or about 0.5%.

There has been a continued increase in Histopathology requesting and results acknowledgment made via eQUEST linked to continued integration within Endoscopy. Total UHS requesting via eQUEST is at 90.3% and specimen's acknowledgement is at 92.6%. This is a good marker of patient safety.

To improve the patient experience and pathways there was a significant increase in UHS patient logins and registrations to My Medical Record in June, this is linked to a new registration method with a plan to increase to 100,000 by the end of this year.

Leading edge research, education and innovation

Research and Development has provided a new set of KPI's this month. UHS was ranked 8th for non-weighted and 2nd for weighted CRN recruitment against a target of being in the top 10 and top 5 respectively. We did not achieve target in Q4 2018/19 for Contract commercial recruitment, coming 16th with a target of being in the top 10.

Comparative CRN recruitment performance by specialty was on target in Q4 2018/19 with 50% specialties ranking as predicted (in the top 5 or top 10 based on prior performance).

Proportion of studies closing in FY on time and to recruitment target (commercial) has trended downward through the year finishing below target at 71% in Q4.

The total number of NIHR CRF & BRC publications in 2018/19 was 581.

There were 9 apprenticeship starts in Q1 2019/20 which is in line with predicted local performance.

Integrated KPI Board Report

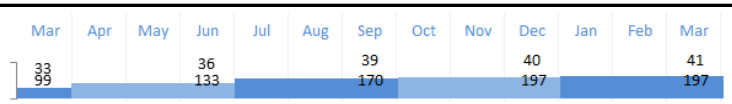
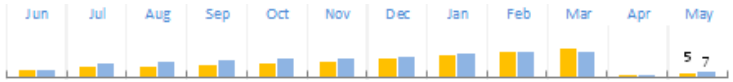
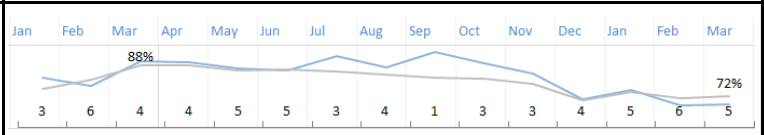
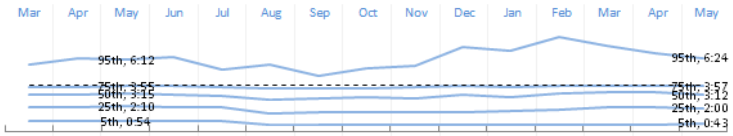
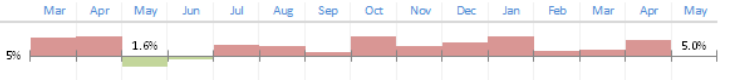
covering up to

Jun 2019

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

Report Guide

University Hospital Southampton NHS
NHS Foundation Trust

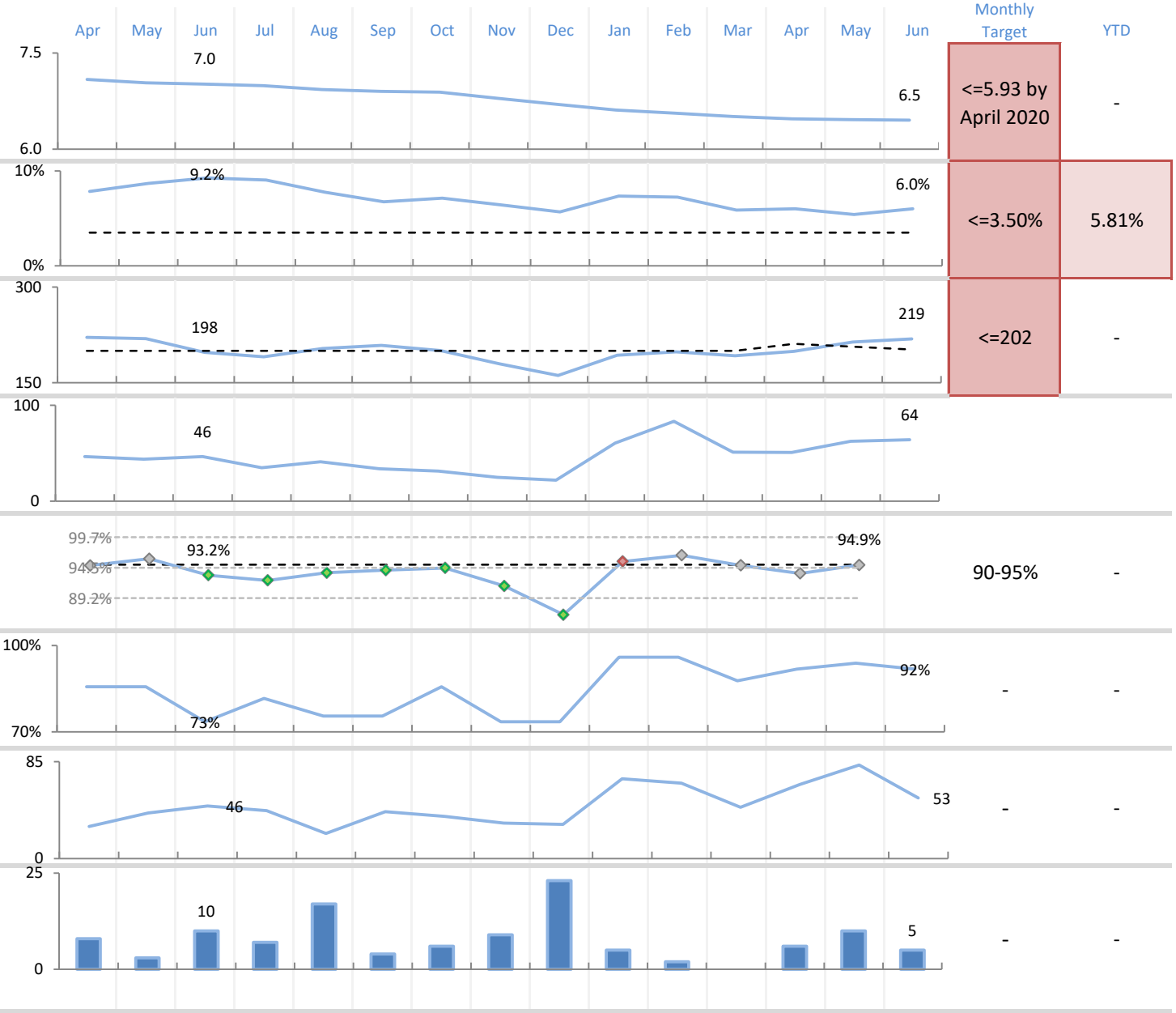
Chart Type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent 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.

July 2019

Improve Patient Journeys

University Hospital Southampton NHS
NHS Foundation Trust

		Monthly Target	YTD
IPJ1-L	Non Elective LOS Rolling 12 months	<=5.93 by April 2020	-
IPJ2-N	Delayed transfers of care (CQC Calculation)	<=3.50%	5.81%
IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)	<=202	-
IPJ4	Outliers weekday (am) census average		
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	-	-

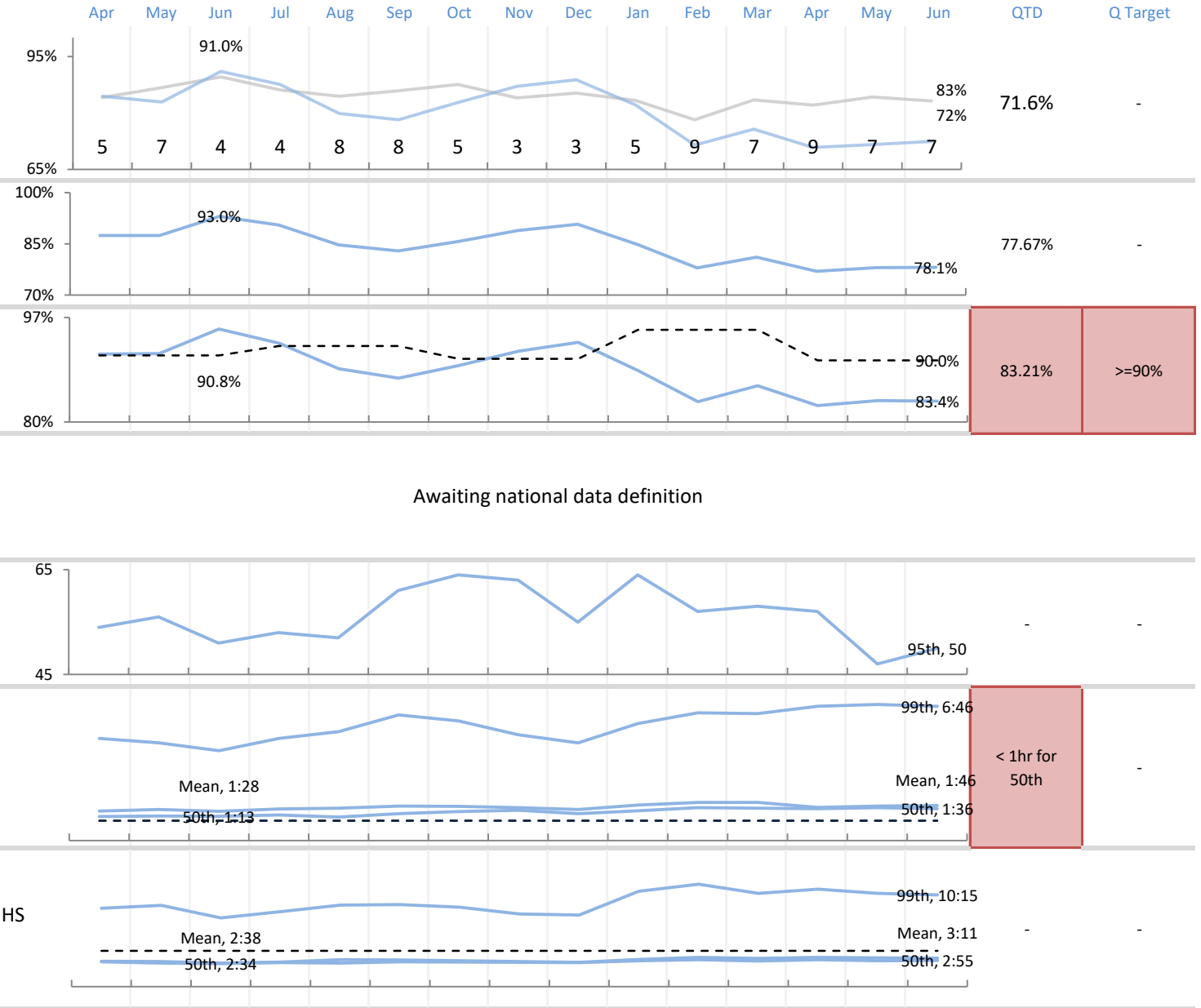


July 2019

Improve Patient Journeys

University Hospital Southampton NHS
NHS Foundation Trust

Percentage of patients spending less than



IPJ9 SGH Main ED (Type 1 and UCH)

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

IPJ10 UHS Total (includes SGH all types and lymington)

IPJ11-L Local Delivery System

IPJ12 Same Day Emergency Care (SDEC) — Awaiting national data definition

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

IPJ14-N Time to treatment - Percentiles UHS Total

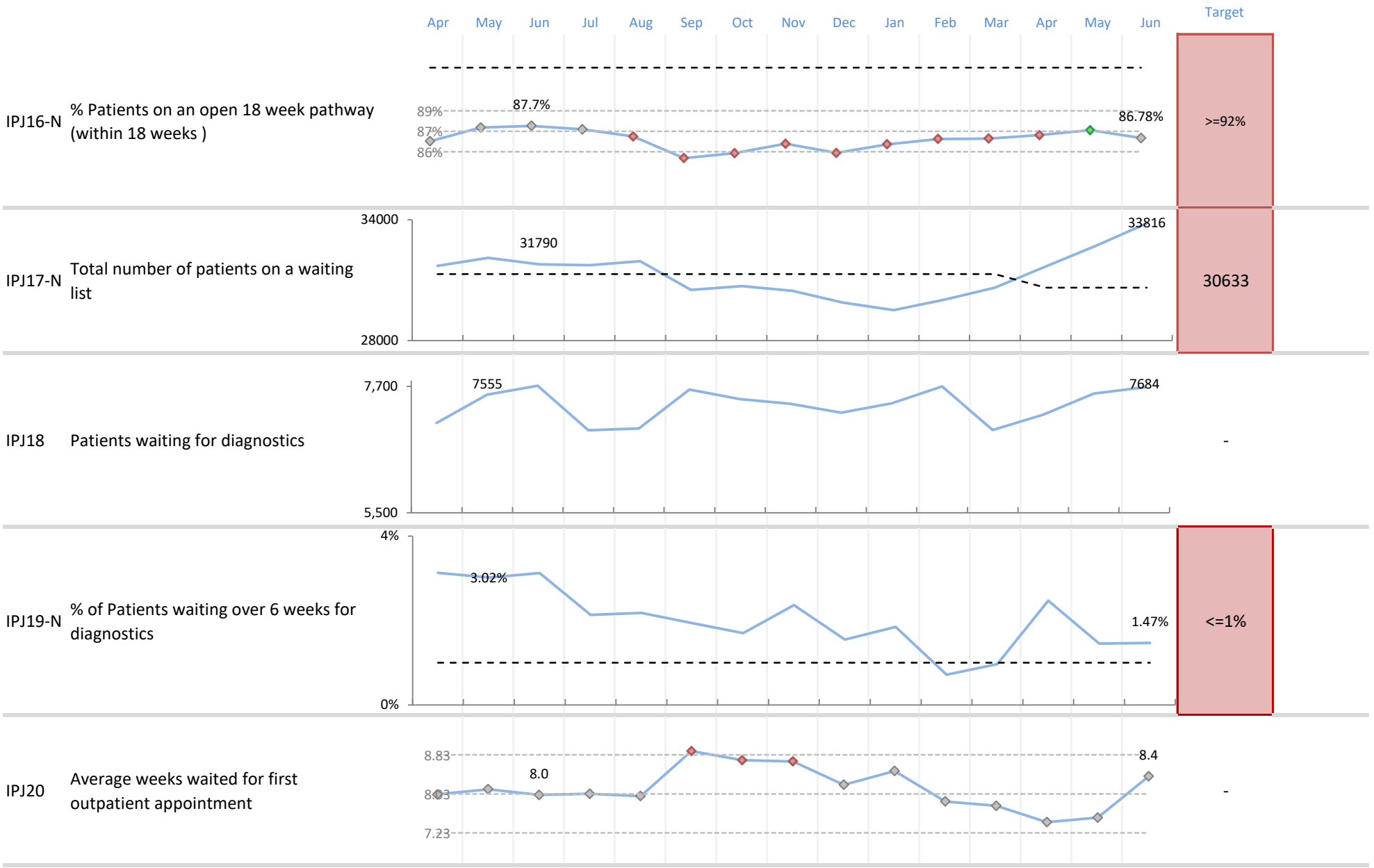
IPJ15-N Total time spent in ED - Percentiles UHS Total

Current Data | Benchmark
Previous Year | Target

July 2019

Improve Patient Journeys

University Hospital Southampton NHS
NHS Foundation Trust



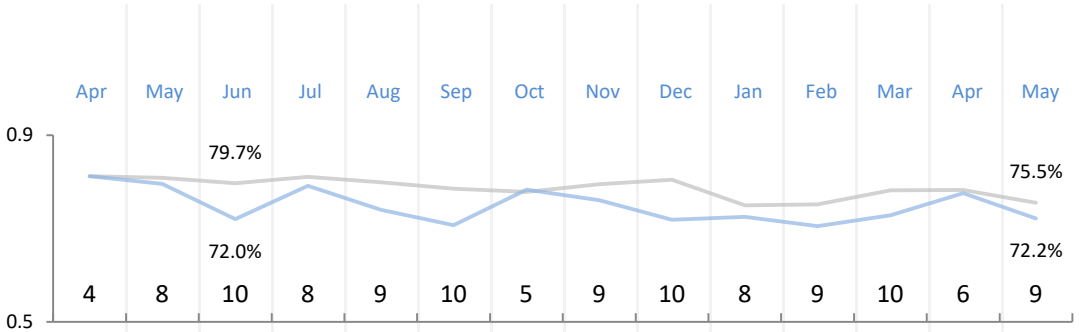
July 2019

Improve Patient Journeys

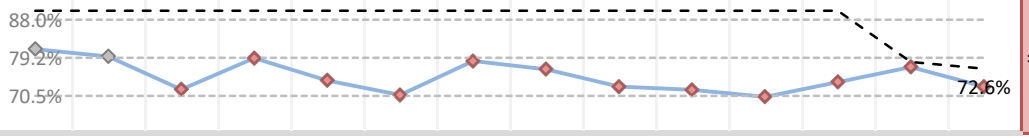
University Hospital Southampton NHS
NHS Foundation Trust

62 Day Performance Benchmark

		Monthly Target	no.patients to recover target	QTD
IPJ21	Teaching Hospitals vs. UHS Total			-

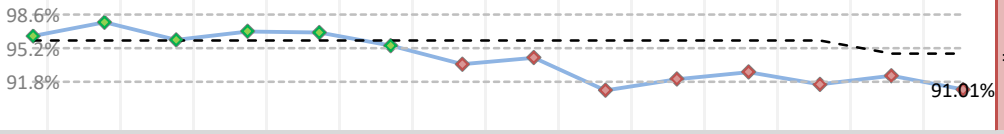


IPJ22-L	62 day cancer wait performance	=>77%	8 of 182.5	75%

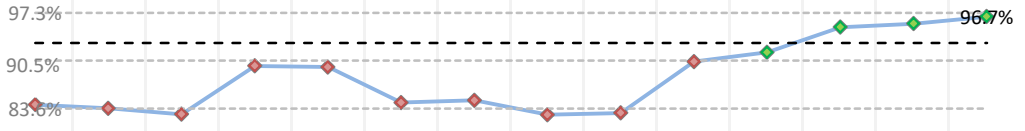


4 of 12 tumour sites achieved 62 day target in May.

IPJ23-L	31 day cancer wait performance	=>95%	31 of 834	92%

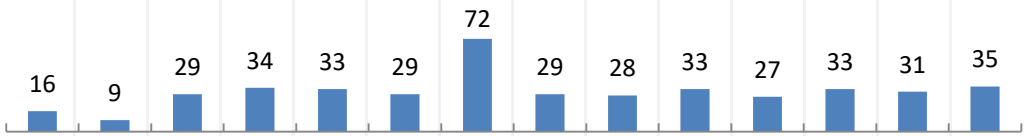


IPJ24-N	Urgent GP referrals seen in 2 weeks	=>93%	0 of 1778	96%

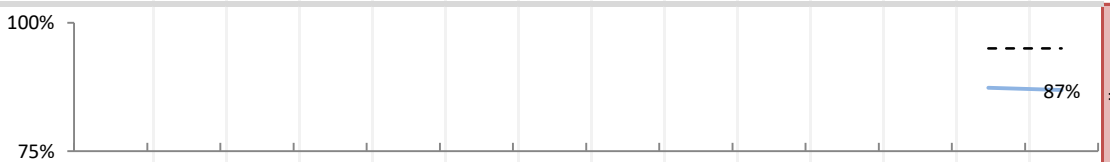


10 of 13 tumour sites achieved 2 week target in May.

IPJ25	Snapshot of waits > 104 days	-	-	-



IPJ26	28 Day Faster Diagnosis	=>95%	114 of 1411	87%



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

Current Data | Benchmark
Previous Year | Target

		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly Target	YTD	YTD Target
VB4-L	Complaints per 1000 units	0.30											0.34	-		
VB5-L	% Complaints closed within 35 days	66%											85%	70%		

		Month	QTD	YTD
VB6	Urgent cancer referrals and Breast Symptoms referrals	+8	+50	+50
		+0.4%	+1.4%	+1.4%
VB7	Number of first cancer treatments (i.e. 31 day activity)	-67	-85	-85
		-15.5%	-10.4%	-10.4%
VB8	Total ED Attendances	+651	+1643	+1643
		+7.1%	+6.0%	+6.0%

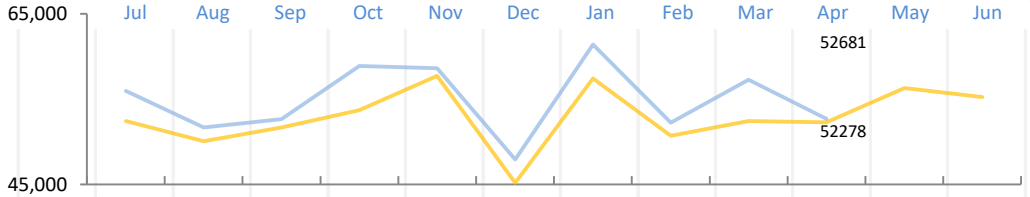
VB8: Lymington MIU included from August 2017.

VB9	Non-elective Spells (incl. CDU)	+84	+675	+675
		+1.4%	+3.8%	+3.8%

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.

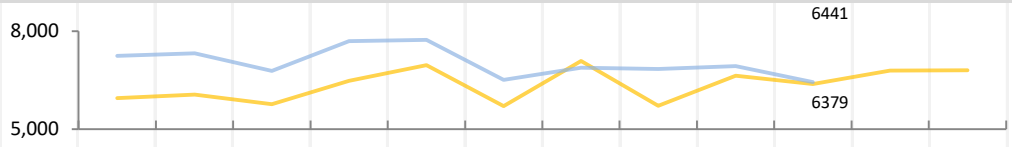
Current Data
Previous Year
Benchmark
Target

		Monthly Target	YTD	YTD Target
VB10	Face to Face OPA	+403		
		+0.8%		

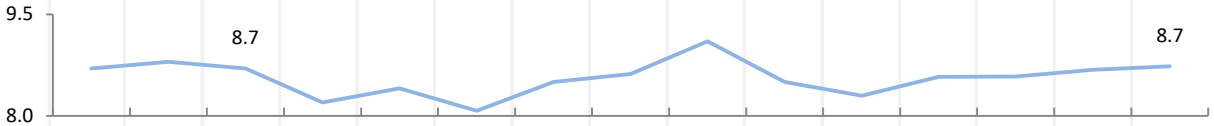


VB10: This currently excludes mymedical record contacts

		Monthly Target	YTD	YTD Target
VB11	Non-Face to Face OPA	+62		
		+1.0%		

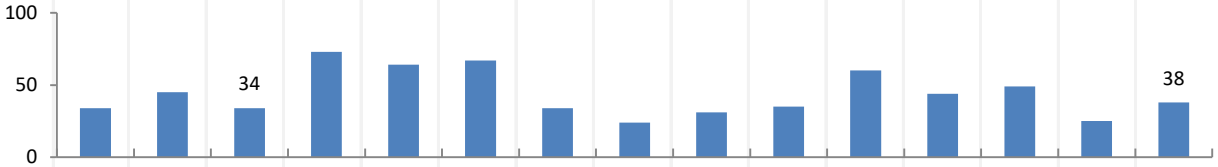


		Monthly Target	YTD	YTD Target
VB12	Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)	-		



VB12 The total CHPPD rate in the Trust has increased from last month to RN 5.5 (previously 5.4) , HCA 3.2 (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 3.9) HCA 3.4 (previously 3.4) overall 7.3 (previously 7.3)

		Monthly Target	YTD	YTD Target
VB13	Red Flag staffing incidents	-		



Current Data
Previous Year
Benchmark
Target

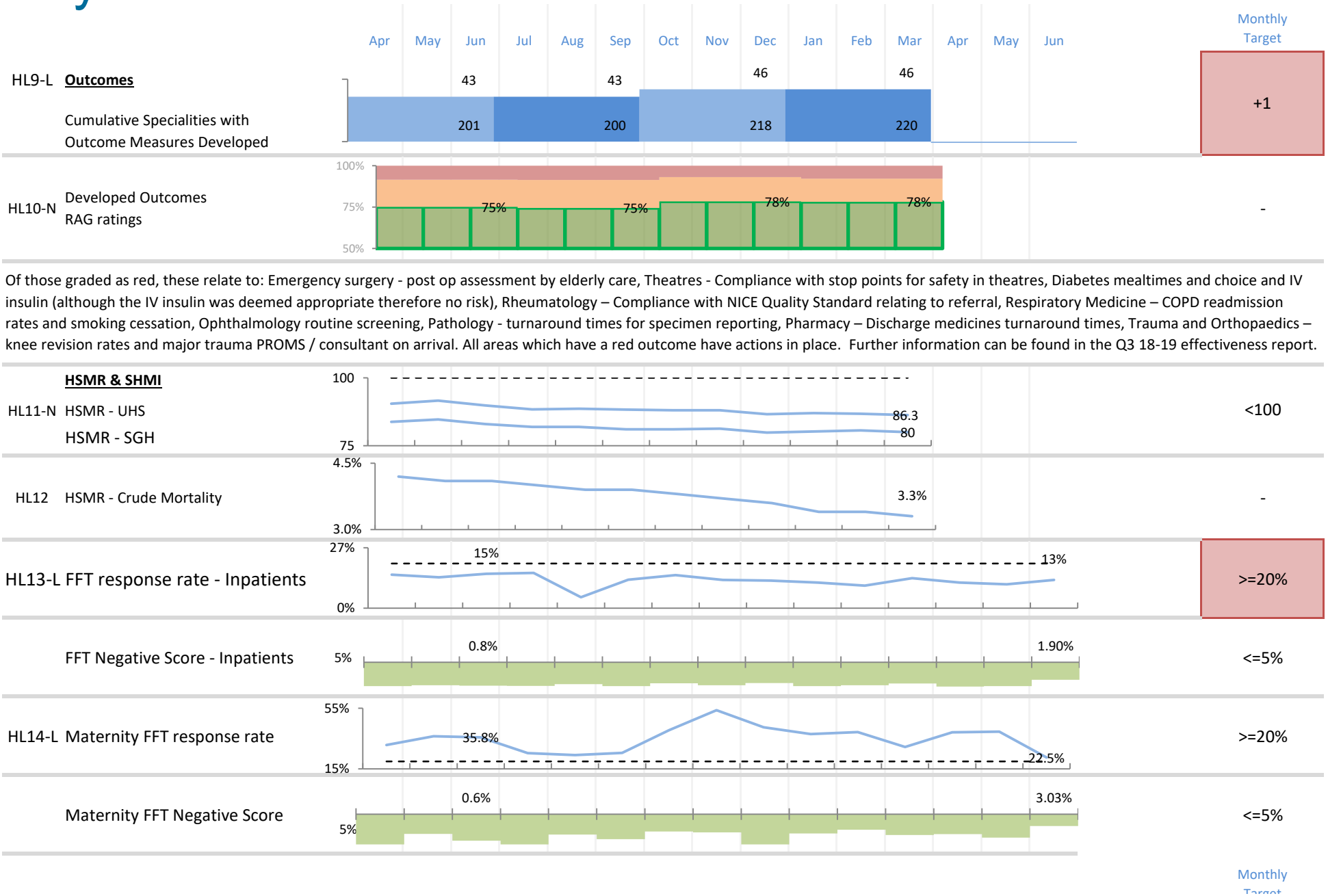
July 2019

Supporting Healthy Lives

University Hospital Southampton NHS
NHS Foundation Trust

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Monthly Target	YTD	YTD Target
HL1-N	Cummulative Clostridium difficile (Confirmed lapse in care)															11 19	5	19	<=15
HL2	Number of pressure ulcers causing moderate/severe harm	2 0														0			
HL2 KPI commenced in April 2019, no historic data available																			
HL3-N	Medication Errors (severe/Moderate)			1												4	<=3	8	<=9
HL4	Serious Incidents Requiring Investigation (SIRI)			3												1	-	3	-
HL5-L	Number of overdue SIRIs			6												3		0	-
HL6-N	Maternity - Continuity of Care															0.063		>=35%	
HL2 KPI commenced in May 2019, no historic data available																			
HL7-N	Neonatal admission temperature within range rate			88%												75%		>=80%	
HL8-N	Bronchopulmonary Displasia (BPD) rate			33%												17%		<=30%	
	Antibiotic usage	in development																	
	Number of high harm falls	in development																	

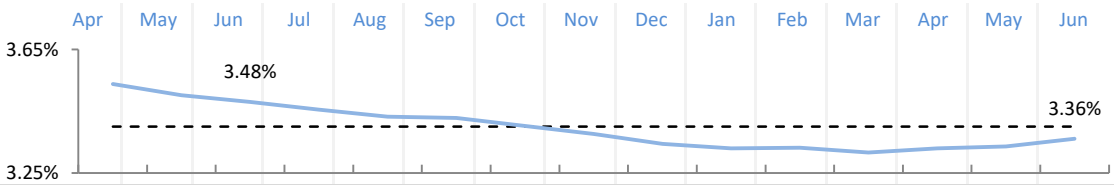
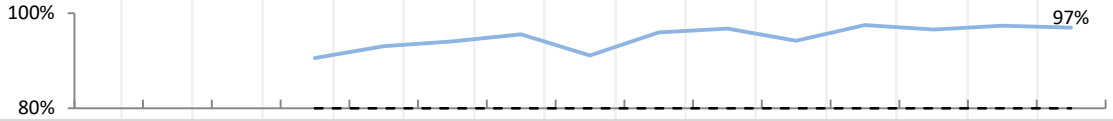
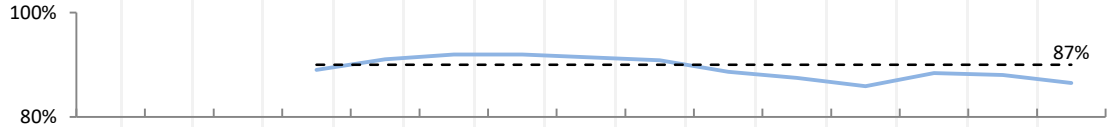
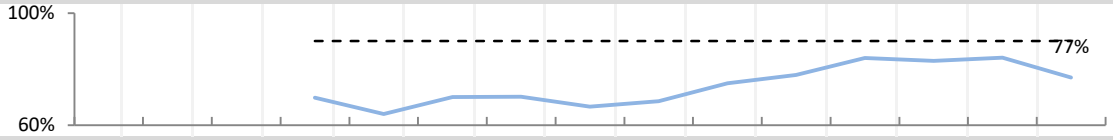
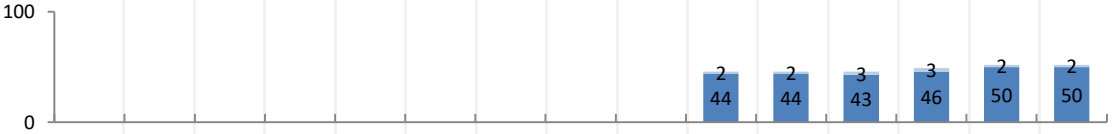
Current Data Benchmark
Previous Year Target


Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Monthly Target
HL9-L Outcomes
Cumulative Specialities with Outcome Measures Developed
43 43 46 46
201 200 218 220
+1
HL10-N Developed Outcomes RAG ratings
100% 75% 50%
75% 75% 78% 78%
-
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 75
86.3
80
<100
HL12 HSMR - Crude Mortality
4.5% 3.0%
3.3%
-
HL13-L FFT response rate - Inpatients
27% 0%
15% 13%
>=20%
FFT Negative Score - Inpatients
5%
0.8% 1.90%
<=5%
HL14-L Maternity FFT response rate
55% 15%
35.8% 22.5%
>=20%
Maternity FFT Negative Score
5%
0.6% 3.03%
<=5%
Monthly Target
Current Data
Previous Year
Benchmark
Target

July 2019

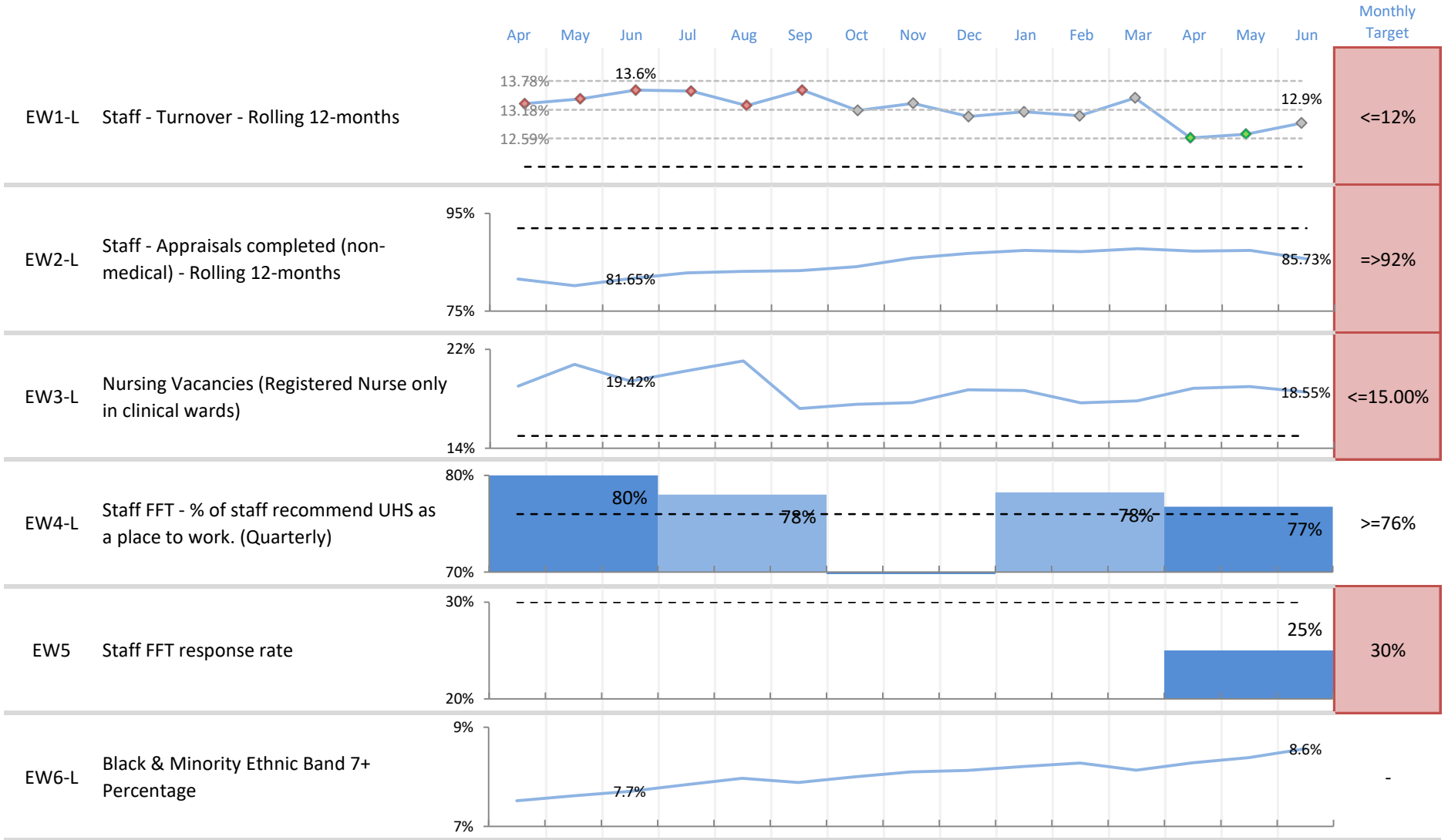
Supporting Healthy Lives

University Hospital Southampton NHS
NHS Foundation Trust

			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		>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		
HL21	Number of fully and partially accredited wards		

Current Data Benchmark
Previous Year Target

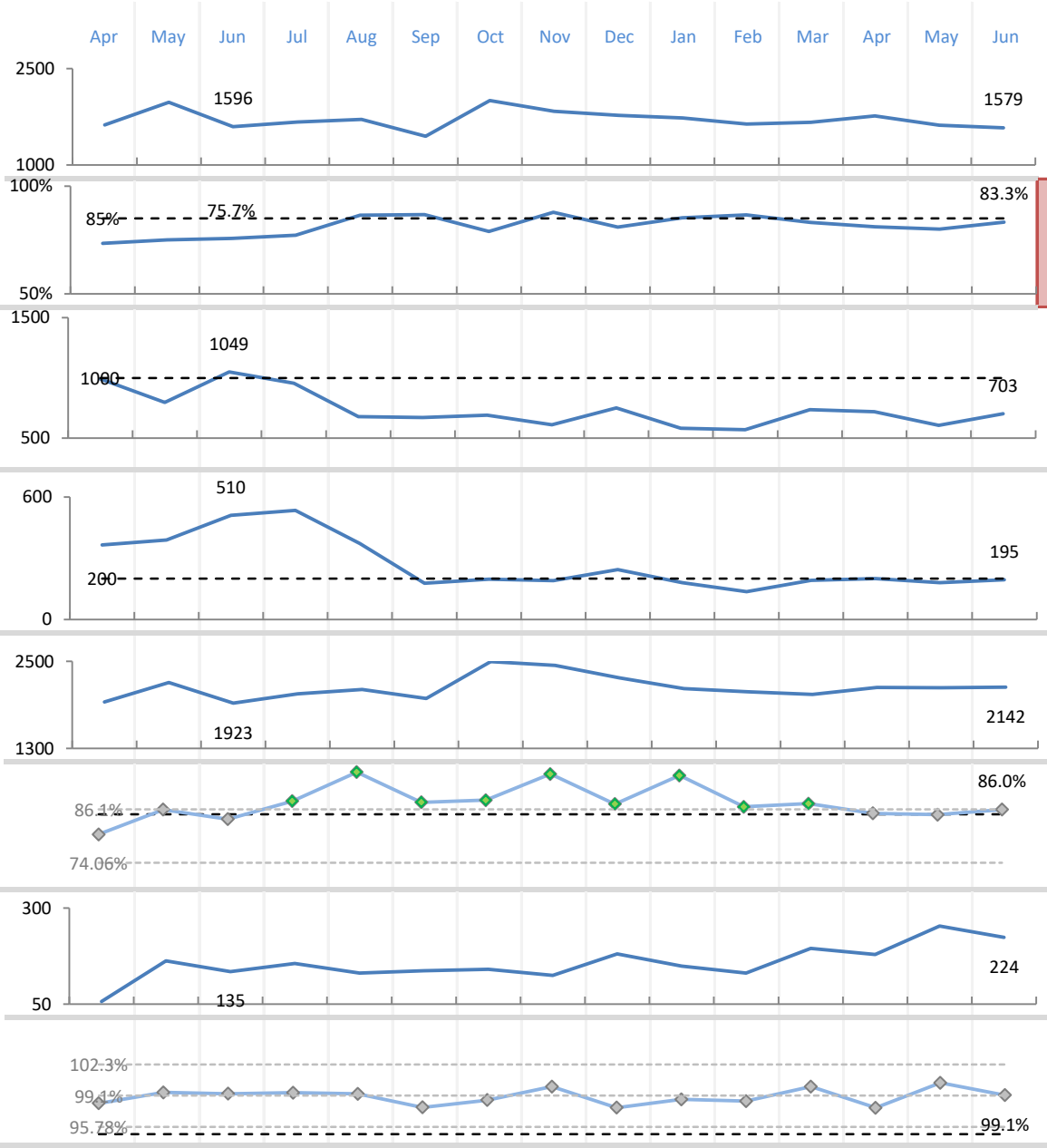
July 2019



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

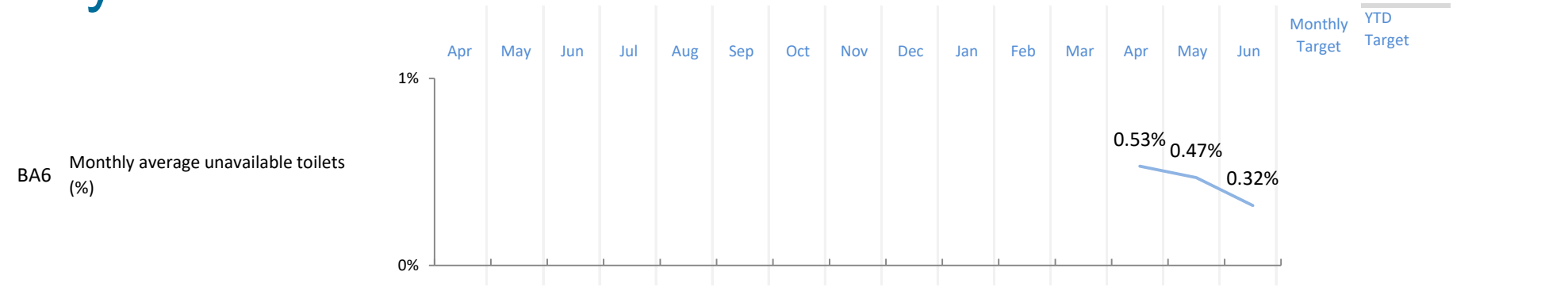
Current Data Benchmark
Previous Year Target

July 2019



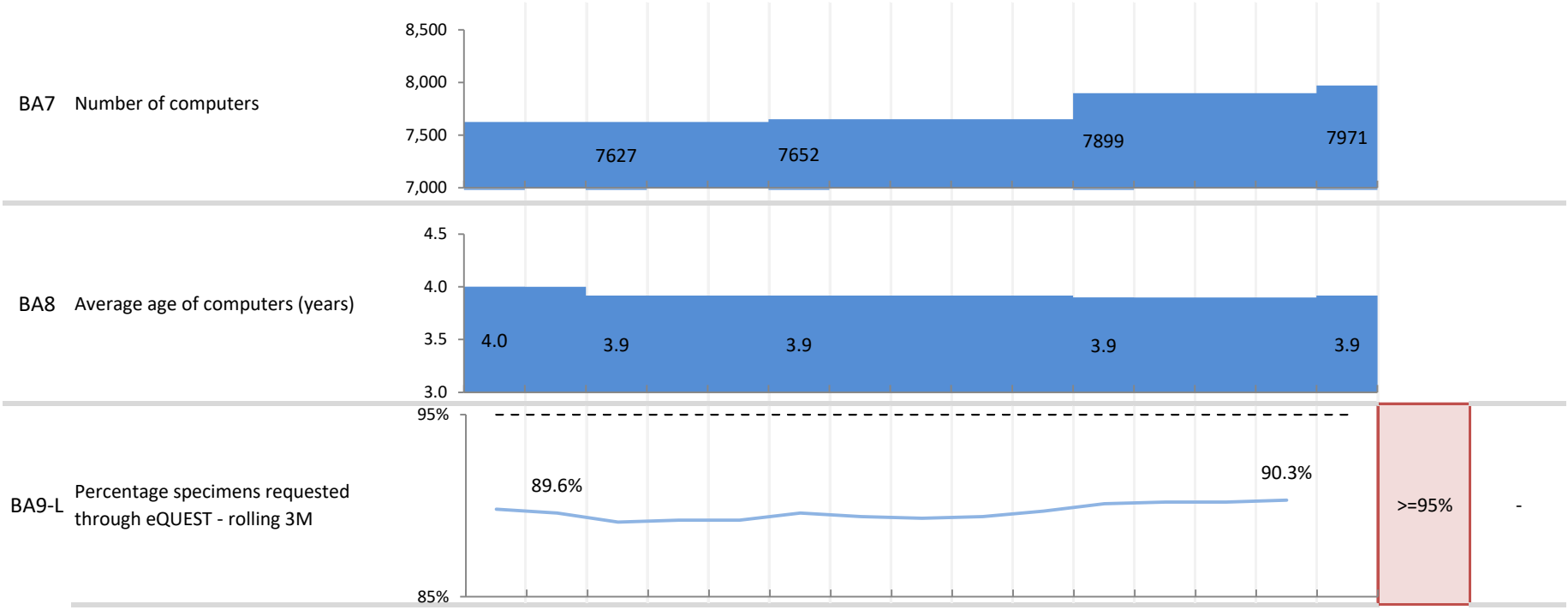
		Monthly Target	R-3M
BA1-L	Number of Help desk requests and percentage completed on time	-	-
		>85%	81.4%
BA2-L	**Reactive Maintenance** Unresolved help desk requests	<1000	676
BA3-L	Unresolved help desk requests (over 30 days old)	<200	192
BA4-L	Number of defect work orders and percentage completed on time	-	-
		>85%	85.4%
BA5-L	**Preventative Maintenance** Number of statutory and mandatory maintenance jobs planned and percentage completed on time	-	-
		>95%	99.2%

Current Data Benchmark
Previous Year Target



BA6 Monthly average unavailable toilets (%)

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



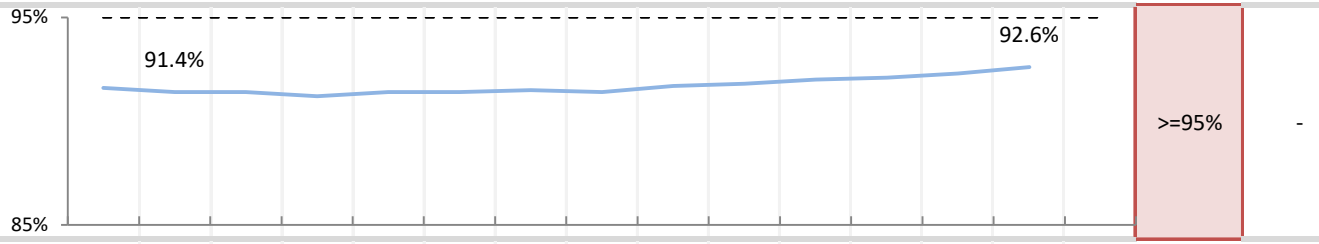
BA7 Number of computers

BA8 Average age of computers (years)

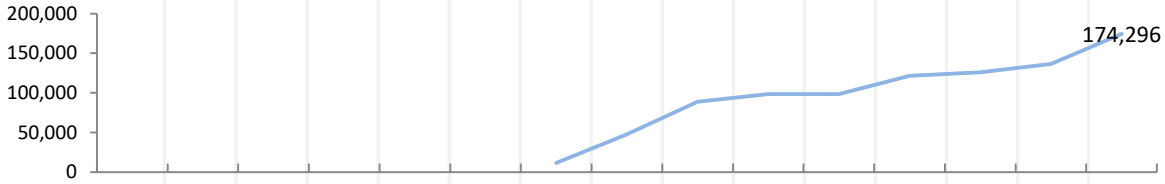
BA9-L Percentage specimens requested through eQUEST - rolling 3M

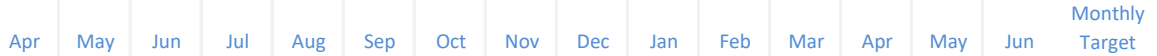
Current Data
Previous Year
Benchmark
Target

BA10-L Percentage specimens available for acknowledgment through eQUEST - rolling 3M



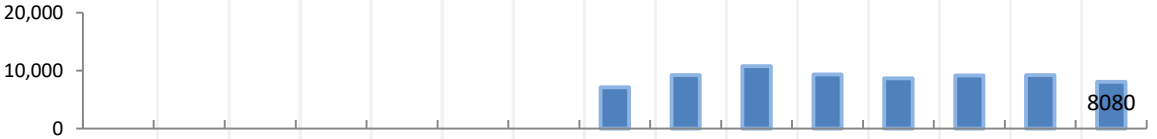
BA11 digiRounds patient records accessed



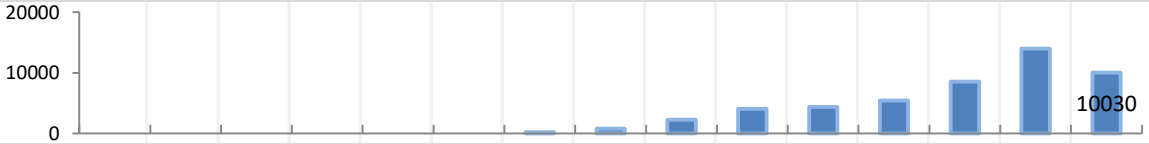


eQuest Results Alerts Sent

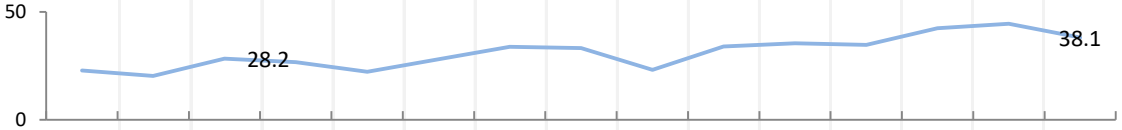
BA12 Decision support notifications (email alerts)



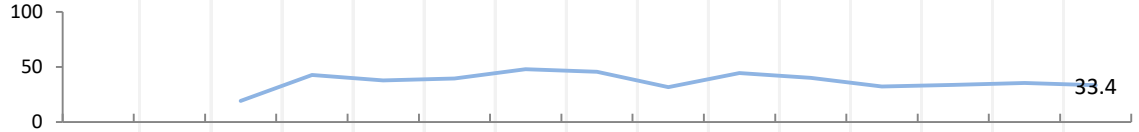
BA13 Medxnote



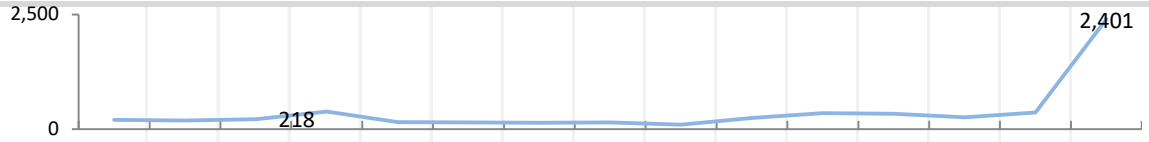
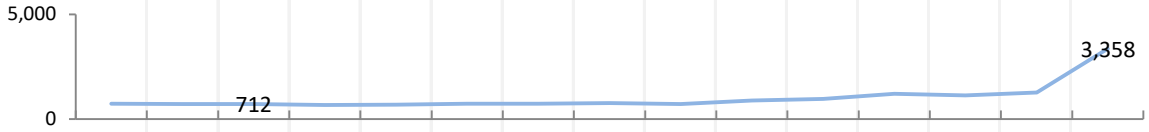
BA14 InfoQlik (Daily) Activity



BA15 Sap BI (Daily) Activity

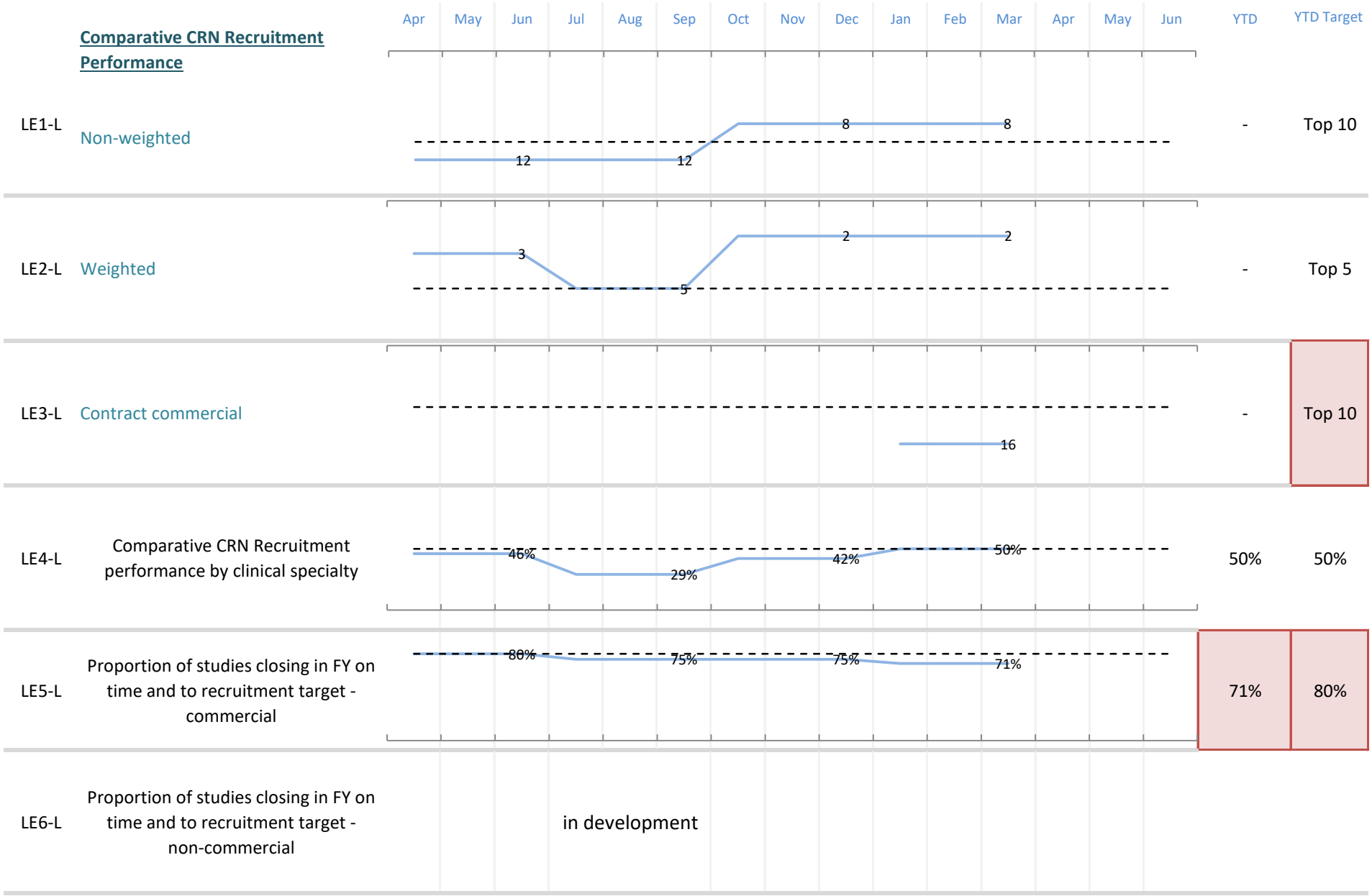


Current Data Benchmark
Previous Year Target

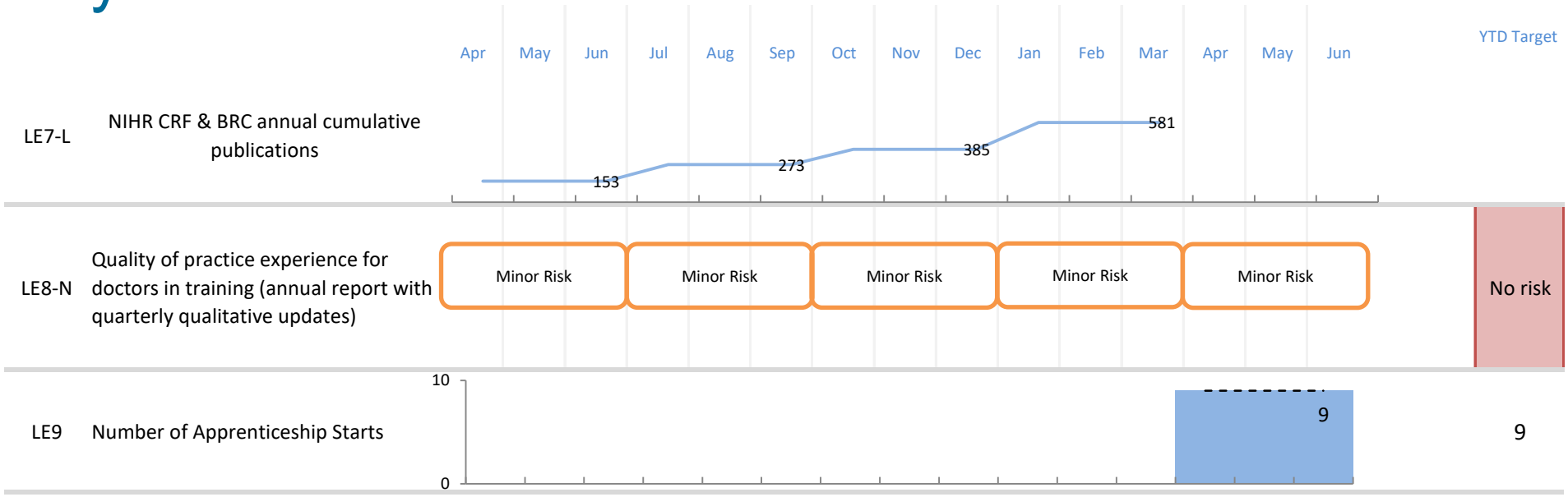
BA16	My Medical Record - UHS patient registrations	
BA17	My Medical Record - UHS patient logins	

Current Data Benchmark
Previous Year Target

July 2019


Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun YTD YTD Target
Comparative CRN Recruitment Performance
LE1-L Non-weighted
12 12 8 8 - Top 10
LE2-L Weighted
3 5 2 2 - Top 5
LE3-L Contract commercial
16 - Top 10
LE4-L Comparative CRN Recruitment performance by clinical specialty
46% 29% 42% 50% 50% 50%
LE5-L Proportion of studies closing in FY on time and to recruitment target - commercial
80% 75% 75% 71% 71% 80%
LE6-L Proportion of studies closing in FY on time and to recruitment target - non-commercial
in development
Current Data
Previous Year
Benchmark
Target

July 2019



Current Data
Previous Year
Benchmark
Target

July 2019 Changes and Corrections

University Hospital Southampton NHS
NHS Foundation Trust

Section	KPI	KPI Name	Type	Detail
Being agile in meeting people's needs	BA6	Monthly average unavailable toilets (%)	New Metric	Requested by David French
Healthy Lives	HL6-N	Maternity - Continuity of Care rate	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Healthy Lives	HL7-N	Neonatal admission temperature within range rate	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Healthy Lives	HL8-N	Bronchopulmonary Displasia (BPD) rate	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Improve Patient Journeys	IPJ4	Outliers weekday (am) census average	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Improving Patient Journeys	IPJ8-N	Last minute cancelled operations not readmitted	Correction	A calculation error resulted in the latest month being incorrect (19 rather than 10). The data has been corrected retrospectively
Improve Patient Journeys	IPJ11	Time to initial assessment -95th Centile UHS Total	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Improve Patient Journeys	IPJ26	28 day FDS	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Leading edge research education and innovation	-	All R&D KPIs	Changed	Delayed KPIs from 2019/20 content review and redesign
Value Based Health and Care	VB1	YTD variance vs. financial control total (£m)	Removed	Duplicate of Finance Report
Value Based Health and Care	VB10	Face to face OPA	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Value Based Health and Care	VB11	Non face to face OPA	New Metric	Delayed KPI agreed in 2019/20 content review and redesign
Value Based Health and Care	VB2	Delivery of the capital programme (YTD)	Removed	Duplicate of Finance Report
Value Based Health and Care	VB3	Monthly CIP delivery against plan	Removed	Duplicate of Finance Report
Value Based Health and Care	VB6	Urgent cancer referrals	Change	Breast sysmtoms added.

- The NHS Patient Safety Strategy. Safer culture, safer systems, safer patients was released in July 2019. Link to document: NHS safety strategy. A brief summary and the commitments can be seen in appendix C
- Two Never Events reported in this quarter: Misplaced NG Tube not detected before use and wrong site anaesthetic block, neither patient came to significant harm. The never event oversight group has been reformed chaired by medical and nursing directors and has now been renamed as the Safety Always Group.
- There were 12 new SIRI cases reported to SISG and 1 infection prevention SIRI
- The trust continued to not meet the 95% target for VTE assessments. An IT solution to remind and assist doctors to complete the VTE risk assessment to allow an easy access opportunity to JAC from Charts has been delayed due to issues between JAC and charts.
- Work is continues to develop guidance to standardise the definition of harm for patients on RTT or cancer pathways who are waiting for treatment outside of agreed national standards, a paper has gone to Quality committee to approve process.
- RCA's completed for 12 hour trolley breeches in ED are now being clinically reviewed to ensure there are no clinical, patient safety or safeguarding concerns.
- A Lying and standing blood pressure (BP) audit has been completed. Changes to the safetrack system to ensure the 'clinical reasons' option for not completing a lying and standing BP are legitimate, and are now complete. First audit results being analysed. Divisions are asked to ensure that all areas have sufficient equipment e.g. stethoscopes to undertake lying and standing BP's.
- The pharmacy team have been relatively consistently reconciling greater than 80% of patients within 48 hours. This can partly be attributed to the increase in the ward based service at the weekends and during bank holidays. Alongside service to new areas such as maternity
- Southampton City CCG have funded a Acute Kidney Injury (AKI) nurse led follow up clinic as one of their 2019/2020 QUIPP. This should support reducing readmissions and improve safety netting for those with AKI stage 2 and 3.
- Incident report rates have now improved to greater than the 35 per 100 bed days.
- Due to Norovirus a total of 10 ward closures occurred (closed to new admissions) along with the closure of 1 bay on wards during period of 5th – 22nd May.
- A total of 95 patients and 8 staff were affected.
- Ward and bay closures resulted in approximately 425 lost bed days between the period 5th-31st May 2019.

Quarterly Patient Safety Report Mar 19 – May 19

Patient safety dashboard – Please note data crosses 2 quarters

Work Stream	Indicator	Annual Target	Mar-19	Apr-19	May-19	QTD	YTD
High Harm Falls	High Harm Falls - Omissions or Deviations	3	0	0	0	0	0
	Total High Harm Falls	55	5	3	5	8	8
Pressure Ulcers	Category 3 and above pressure ulcers - Omissions or Deviations	30	0	4	4	8	8
	Category 2 pressure ulcers	156	9	9	11	20	20
VTE	% of patients that have a VTE risk assessment upon admission	>=95%	92.27%	90.67%	91.89%	91.29%	91.29%
	% of patients that receive appropriate thromboprophylaxis (taken from Safety Thermometer)	>=95%	94.20%	91.84%	93.50%	92.69%	92.69%
Safety Thermometer	Harm Free Care	>=95%	98.13%	97.93%	97.42%	97.67%	97.67%
Medication Errors	A reduction in the number of medication related incidents that occur as a result of a failing in the discharge process	Reduction	9	12	6		
	80% of medicine reconciliations within 48 hours of admission	80% reconciliation	91%	88%	84%	87%	84%
	Decrease of inappropriately omitted doses to less than 3%	<=3%	2.39	2.81	2.87	2.69	2.53
Infection Prevention & Control	MRSA post 48 hour cases	0	0	0	0	0	0
	C difficile cases	43	3	3	8	11	11
SIRIs	Never Events	0	0	1	2	3	3
	95% SIRIs Reported within 2 working days	>=95%	57.14%	80.00%	93.75%	88.46%	88.46%
	SIRIs overdue by 60 days	0	7	3	3	6	6
Incident Reporting	Incidents per 1000 bed days	>35		35.55			
	% of incidents identified as moderate and over	<=4%	5.23%	4.97%	5.21%	5.09%	5.09%

			Q1	Q2	Q3	Q4
Sepsis	90% of patients appropriately screened on admission in ED, AMU, ASU and PAU	90%	94%	99%	97%	95%
	90% of patients with red flag sepsis in ED, AMU, ASU and PAU receive IVAB within 60 minutes of admission and have an empiric review within 72 hours of prescribing antibiotics	90%	92%	80%	85%	95%
	90% of patients who meet criteria for sepsis screening were screened for sepsis for all acute inpatient wards	90%	76%	97%	100%	100%
	90% of patients with red flag sepsis receive timely antibiotics (60 minutes for new admissions or 90 minutes for existing inpatients) and have an empiric review within 72 hours of prescribing antibiotics	90%	76%	86%	84%	91%

Nursing and midwifery staffing hours - June 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	1358.9	1282.7	1022.2	1231.2	94.4%	120.4%	3.5	3.5	7.1	Safe staffing levels maintained.
C4 (Solent ward)	Night	1023.5	954.5	690.0	988.5	93.3%	143.3%				Safe staffing levels maintained.
C6	Day	2782.8	2531.2	105.0	136.2	91.0%	129.7%	7.2	0.4	7.6	Safe staffing levels maintained.
C6	Night	1958.8	1872.5	0.0	132.0	95.6%	Shift N/A				Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	681.7	692.5	343.5	109.7	101.6%	31.9%	7.6	0.7	8.3	Safe staffing levels maintained. Minimal requirement for unregistered staff
C6 (Teenage Cancer Trust unit)	Night	662.3	634.2	0.0	15.7	95.8%	Shift N/A				Safe staffing levels maintained.
D2	Day	1300.0	1472.7	1317.0	891.5	113.3%	67.7%	4.3	3.2	7.5	Safe staffing levels maintained.
D2	Night	678.3	949.3	1034.5	931.8	140.0%	90.1%				Safe staffing levels maintained.
D3	Day	1567.4	1615.9	739.8	897.2	103.1%	121.3%	4.2	2.8	6.9	Safe staffing levels maintained.
D3	Night	1012.5	1013.5	675.0	855.7	100.1%	126.8%				Safe staffing levels maintained.
Surgical high dependency unit	Day	2114.7	1808.4	376.9	314.4	85.5%	83.4%	13.7	2.5	16.1	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2070.0	1731.3	342.5	320.8	83.6%	93.6%				Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	4982.1	5177.6	1233.0	528.5	103.9%	42.9%	23.9	1.8	25.7	Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Night	5085.5	5008.8	838.3	257.5	98.5%	30.7%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Day	4478.7	4108.4	939.2	778.6	91.7%	82.9%	23.1	3.5	26.6	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Night	4115.0	3759.8	689.5	418.4	91.4%	60.7%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Day	3905.6	3290.4	364.9	355.3	84.2%	97.3%	25.4	2.8	28.2	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Night	3786.5	3190.0	345.0	367.8	84.2%	106.6%				Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Day	4731.7	4227.6	787.0	459.8	89.3%	58.4%	25.6	2.5	28.0	Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Night	4110.8	3618.5	630.0	294.0	88.0%	46.7%				Safe staffing levels maintained; Beds flexed to match staffing.

E5A	Day	1220.5	1060.0	652.5	857.0	86.8%	131.3%	3.4	2.4	5.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5A	Night	690.0	667.0	345.0	366.0	96.7%	106.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Day	1328.5	1211.8	786.3	855.8	91.2%	108.8%	3.7	2.5	6.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Night	690.0	692.0	345.0	402.5	100.3%	116.7%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Day	2022.5	1469.8	1402.0	1757.4	72.7%	125.4%	2.9	3.3	6.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing.
E8	Night	1027.5	991.0	884.0	1060.5	96.4%	120.0%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing.
F11	Day	1899.1	1242.4	774.8	793.4	65.4%	102.4%	3.9	2.9	6.8	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Support workers used to maintain staffing numbers.
F11	Night	756.5	727.5	586.5	696.5	96.2%	118.8%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Day	2191.4	1648.4	584.5	1250.0	75.2%	213.9%	3.3	2.6	5.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Night	1035.0	957.7	690.0	797.0	92.5%	115.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Day	1913.5	1453.5	992.0	1218.0	76.0%	122.8%	3.4	2.8	6.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Night	1035.0	955.5	678.5	759.0	92.3%	111.9%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute medical unit	Day	4029.3	4368.2	3933.0	4126.3	108.4%	104.9%	5.6	4.9	10.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Acute medical unit	Night	3438.0	3373.8	1954.0	2707.3	98.1%	138.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D5	Day	1307.8	1310.4	1647.0	1630.8	100.2%	99.0%	2.6	3.4	6.0	Staff moved to support other wards; Safe staffing levels maintained.
D5	Night	1014.0	828.5	914.5	1107.0	81.7%	121.0%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Day	1079.9	1147.9	1623.5	1424.5	106.3%	87.7%	2.7	3.4	6.0	Staff moved to support other wards; Safe staffing levels maintained.
D6	Night	688.5	688.5	852.5	892.0	100.0%	104.6%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
D7	Day	689.0	791.7	1122.1	1154.1	114.9%	102.9%	3.3	3.3	6.6	Staff moved to support other wards; Safe staffing levels maintained.
D7	Night	690.8	748.3	345.0	402.5	108.3%	116.7%				Staff moved to support other wards; Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D8	Day	1082.0	1115.7	1486.5	1319.8	103.1%	88.8%	2.6	3.2	5.8	Safe staffing levels maintained.
D8	Night	690.0	690.8	915.0	965.0	100.1%	105.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D9	Day	1340.5	1293.9	1378.2	1564.9	96.5%	113.6%	2.7	3.3	6.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D9	Night	1030.0	908.0	807.8	1085.0	88.2%	134.3%				Band 4 staff working to support registered nurse numbers.
E7	Day	1086.6	929.3	1305.5	986.3	85.5%	75.5%	2.7	2.7	5.5	Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained.
E7	Night	691.0	702.0	654.0	642.5	101.6%	98.2%				Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained.
Respiratory high dependency unit	Day	1431.5	1206.7	320.2	532.2	84.3%	166.2%	11.4	4.9	16.3	Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained.
Respiratory high dependency unit	Night	1345.0	1110.3	346.0	477.0	82.5%	137.9%				Staffing appropriate for number of patients; Staff moved to support other wards; Safe staffing levels maintained.
C5	Day	1026.0	891.6	761.5	729.1	86.9%	95.7%	3.9	2.7	6.6	Safe staffing levels maintained.
C5	Night	690.0	690.0	345.0	379.5	100.0%	110.0%				Safe staffing levels maintained.
D10	Day	1080.7	890.8	1312.5	1324.5	82.4%	100.9%	3.0	3.9	6.8	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Safe staffing levels maintained.
D10	Night	690.0	655.5	690.0	691.0	95.0%	100.1%				Safe staffing levels maintained.
F7	Day	675.6	710.6	1267.5	1310.5	105.2%	103.4%	2.3	3.3	5.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
F7	Night	690.0	678.5	690.0	690.0	98.3%	100.0%				Safe staffing levels maintained.
G5	Day	1059.4	1055.0	1769.2	1701.8	99.6%	96.2%	2.1	3.4	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
G5	Night	678.5	713.0	943.0	1098.5	105.1%	116.5%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.

G6	Day	1009.1	1046.5	1755.2	1892.7	103.7%	107.8%	2.3	3.9	6.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
G6	Night	690.0	736.0	1035.0	1161.5	106.7%	112.2%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
G7	Day	325.6	343.1	663.5	675.0	105.4%	101.7%	3.8	6.8	10.6	Staffing plan set higher than national standards; Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
G7	Night	322.0	310.5	483.0	492.5	96.4%	102.0%				Staffing plan set higher than national standards; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
G8	Day	1070.7	1068.7	1752.0	1750.7	99.8%	99.9%	2.1	3.4	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
G8	Night	690.0	701.3	1030.0	1057.8	101.6%	102.7%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
G9	Day	1029.1	1139.2	1815.2	1719.5	110.7%	94.7%	2.4	3.6	6.0	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
G9	Night	690.0	723.0	1035.0	1032.0	104.8%	99.7%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
Paediatric high dependency unit	Day	1547.4	1126.2	0.0	0.0	72.8%	Shift N/A	14.9	0.1	14.9	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1035.0	1000.5	0.0	11.0	96.7%	Shift N/A				Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric medical unit	Day	1901.0	1661.5	369.0	485.5	87.4%	131.6%	7.0	2.9	9.9	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; safe staffing.
Paediatric medical unit	Night	1650.5	1280.3	330.0	737.0	77.6%	223.3%				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	1250.5	1034.0	399.0	298.0	82.7%	74.7%	15.3	3.0	18.3	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; HCA's not always required..
Paediatric assessment unit	Night	1042.5	954.0	83.5	93.5	91.5%	112.0%				Safe staffing levels maintained.
Paediatric intensive care unit	Day	6047.2	4634.2	521.3	543.0	76.6%	104.2%	28.0	3.1	31.1	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5518.8	4588.8	448.5	475.0	83.1%	105.9%				Beds flexed to match staffing; Safe staffing levels maintained.
Piam Brown ward	Day	2802.7	2996.6	118.0	152.0	106.9%	128.8%	14.2	0.5	14.7	Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
Piam Brown ward	Night	1023.5	1306.8	0.0	0.0	127.7%	Shift N/A				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
E1	Day	2016.5	1659.2	638.5	413.5	82.3%	64.8%	7.4	1.8	9.2	Non-ward based staff supporting areas; Support workers used to maintain staffing numbers; Safe staffing levels maintained.
E1	Night	1380.0	1310.5	369.0	323.0	95.0%	87.5%				Safe staffing levels maintained.
G2	Day	760.7	674.0	0.0	0.0	88.6%	Shift N/A	9.5	0.0	9.5	Non-ward based staff supporting areas; Safe staffing levels maintained.
G2	Night	719.0	659.8	0.0	0.0	91.8%	Shift N/A				Safe staffing levels maintained.
G3	Day	2312.2	1577.2	1167.0	844.5	68.2%	72.4%	6.8	3.3	10.1	Beds flexed to match staffing; Non-ward based staff supporting areas; Safe staffing levels maintained; 4 beds closed.
G3	Night	1639.0	1133.0	693.0	475.0	69.1%	68.5%				Beds flexed to match staffing; Safe staffing levels maintained; 4 beds closed.
G4	Day	2397.0	1799.2	1206.5	800.3	75.1%	66.3%	7.5	2.9	10.4	Beds flexed to match staffing; Non-ward based staff supporting areas; Safe staffing levels maintained; 6 beds closed.
G4	Night	1650.8	1391.3	660.0	451.0	84.3%	68.3%				Beds flexed to match staffing; Safe staffing levels maintained; 6 beds closed.
Bramshaw women's unit	Day	1390.2	1181.0	1241.7	879.2	84.9%	70.8%	2.5	2.1	4.6	Beds flexed to match staffing; Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing.
Bramshaw women's unit	Night	690.0	678.5	690.0	702.5	98.3%	101.8%				Safe staffing levels maintained.
Neonatal unit	Day	6811.0	4546.2	1589.5	1352.0	66.7%	85.1%	11.2	3.1	14.3	Safe staffing levels maintained; Cots adjusted to match staffing.
Neonatal unit	Night	5281.0	3864.0	1320.0	968.0	73.2%	73.3%				Safe staffing levels maintained; Cots adjusted to match staffing.
Maternity service	Day	7940.3	7879.0	3514.5	2375.0	99.2%	67.6%	5.9	1.9	7.7	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5313.3	5179.5	2300.0	1735.0	97.5%	75.4%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Cardiac high dependency unit	Day	4778.5	4181.6	1407.5	1189.7	87.5%	84.5%	13.4	3.0	16.4	Staff moved to support other wards; Staff moved to support other wards.
Cardiac high dependency unit	Night	3653.5	3758.3	671.0	605.0	102.9%	90.2%				Additional staff used for enhanced care - RNs; Skill mix swaps undertaken to support safe staffing across the Unit.
Coronary care unit	Day	1595.2	1685.7	784.8	887.3	105.7%	113.1%	6.1	3.3	9.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
Coronary care unit	Night	1117.3	1200.0	473.0	704.5	107.4%	148.9%				Skill mix swaps undertaken to support safe staffing across the Unit; Band 4 staff working to support registered nurse numbers.

D4	Day	1806.0	1521.2	821.8	1052.0	84.2%	128.0%	3.6	2.8	6.4	Skill mix swaps undertaken to support safe staffing across the Unit; Additional staff used for enhanced care - Support workers.
D4	Night	750.0	773.0	660.0	764.5	103.1%	115.8%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
E2	Day	1555.0	1443.6	749.8	986.7	92.8%	131.6%	5.0	2.8	7.8	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; staffing moved to extra capacity 18 beds E7/E8.
E2	Night	693.0	1087.8	330.0	442.0	157.0%	133.9%				Additional staff used for enhanced care - Support workers; Additional staff used for enhanced care - Support workers; staffing moved to extra capacity 18 beds E7/E8.
E3 Green	Day	2141.5	1741.7	1276.2	1436.2	81.3%	112.5%	3.0	3.0	6.0	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E3 Green	Night	878.3	890.3	1335.8	1197.0	101.4%	89.6%				Additional staff used for enhanced care - RNs; Band 4 staff working to support registered nurse numbers.
E3 Blue	Day	1166.3	753.0	534.5	591.5	64.6%	110.7%	3.2	2.9	6.2	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers.
E3 Blue	Night	451.0	472.5	462.0	517.0	104.8%	111.9%				Skill mix swaps undertaken to support safe staffing across the Unit; Additional staff used for enhanced care - Support workers.
E4	Day	2055.1	1673.6	728.3	1202.6	81.4%	165.1%	4.6	3.5	8.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; staffing moved to extra capacity 18 beds E7/E8.
E4	Night	946.0	1079.5	561.0	899.5	114.1%	160.3%				Increased night staffing to support raised acuity; Staff moved to support other wards; staffing moved to extra capacity 18 beds E7/E8.
Acute stroke unit	Day	1455.0	1533.2	2638.4	2516.4	105.4%	95.4%	2.9	5.0	8.0	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute stroke unit	Night	990.0	905.5	1644.0	1699.0	91.5%	103.3%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Neuro Regional transfer unit	Day	1610.9	969.5	389.4	744.5	60.2%	191.2%	9.3	8.7	17.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Neuro Regional transfer unit	Night	660.0	495.0	550.0	627.0	75.0%	114.0%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Day	1789.2	1605.5	1036.5	1232.2	89.7%	118.9%	3.8	3.4	7.2	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Night	1254.0	1100.0	990.0	1232.0	87.7%	124.4%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Day	1561.9	1163.0	372.0	614.9	74.5%	165.3%	7.8	5.7	13.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Night	1320.0	759.0	429.0	779.0	57.5%	181.6%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
D neuro	Day	1851.8	1796.8	1834.9	1926.2	97.0%	105.0%	4.2	4.7	8.8	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Night	1293.0	1358.0	1595.0	1606.0	105.0%	100.7%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F4 Neuro	Day	1459.0	1361.7	631.5	1228.7	93.3%	194.6%	3.8	3.8	7.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
F4 Neuro	Night	968.0	915.8	990.0	1067.0	94.6%	107.8%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Brooke ward (trauma and orthopaedics)	Day	1117.3	1057.5	556.8	591.3	94.7%	106.2%	3.6	2.6	6.2	Safe staffing levels maintained.
Brooke ward (trauma and orthopaedics)	Night	1035.0	701.5	345.0	691.0	67.8%	200.3%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Support workers used to maintain staffing numbers.
Trauma Assessment Unit	Day	522.5	418.8	362.0	595.3	80.1%	164.4%	4.2	5.8	10.0	Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity.
Trauma Assessment Unit	Night	330.0	330.0	330.0	429.0	100.0%	130.0%				Additional staff used for enhanced care - Support workers; Increased night staffing to support raised acuity.
F1	Day	2362.2	1913.3	1417.1	2164.7	81.0%	152.8%	3.7	4.3	8.0	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F1	Night	1725.0	1594.5	1034.0	1865.0	92.4%	180.4%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F2	Day	1644.0	1260.8	1326.0	2168.6	76.7%	163.5%	2.8	5.0	7.8	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F2	Night	989.8	912.8	990.0	1684.0	92.2%	170.1%				Additional staff used for enhanced care - Support workers; Additional staff used for enhanced care - Support workers.
F3	Day	1580.8	1338.3	2344.2	1715.8	84.7%	73.2%	3.0	4.9	7.9	Band 4 staff working to support registered nurse numbers.
F3	Night	990.0	803.8	1953.5	1759.5	81.2%	90.1%				Band 4 staff working to support registered nurse numbers.
F4	Day	1401.0	1211.3	1186.1	824.1	86.5%	69.5%	4.0	2.7	6.6	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
F4	Night	990.0	824.4	660.0	549.3	83.3%	83.2%				Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Framework of Quality Assurance for Responsible Officers and Revalidation			
Category	Quality, Performance, and Finance		
Agenda item	4.6		
Sponsor	Medical Director		
Author	Liz Brown		
Provenance	NHS England Requirement The Annual Organisational Audit (AOA) is an element of the Framework of Quality Assurance and is a standardise template for all responsible officers to complete. AOAs from all designated bodies will be collated to provide an overarching status report of the responsible officer function across England. Report submitted annually for Trust Board review.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. The Board is asked to note the information included in this report and acknowledge that the AOA was submitted to NHS England on 31st May 2019. The Board is asked to approve the **"Statement of Compliance" Appendix A**, confirming that the organisation, as a designated body, is in compliance with regulations.		
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: • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6.		
Impact assessments	None		
Other standards affected	• CQC Well-led Framework • General Medical Council Fitness to Practice		

1. Background

1.1 Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2. General

2.1 UHS is subject to the oversight of the NHS England Revalidation Team. As part of this, UHS completes quarterly reports for NHS England and an Annual Organisational Audit (AOA) end of year questionnaire; this was submitted for 2018-19 on 31st March 2019.

2.2 The responsible officer (RO) Dr Derek Sandeman, Medical Director was appointed in October 2015.

2.3 The RO is supported by a Decision Making Group (DMG) comprising of the Divisional Clinical Directors (DCDs), Associate Medical Director, Medical Appraisal Leads, Medical HR, Director of Medical Education and the revalidation administration team. The DMG provides scrutiny over the process and allows proactive management of revalidation. Additionally, the DMG shares judgements on professional standards and appraisal quality.

2.4 The DMG meets monthly and discusses the following:

- Upcoming revalidation recommendations
- Ongoing HR cases, new concerns
- Appraisal compliance
- Quality assurance
- Any other issues related to appraisal or revalidation
- Compliance with the requirement for colleague and patient feedback, CPD and reflective practice

2.5 The revalidation support function transferred to the Medical HR team in October 2018. 2 WTE revalidation coordinators were appointed to support the Medical Director, the DMG and the Trust Appraisal Leads. The team have the responsibility for maintaining an accurate list of prescribed connections; proactively managing appraisal compliance and revalidation, support Trust training courses.

2.6 The Medical Appraisal Policy was updated in June 2019 and is awaiting publication. The policy will be due for review in 2022, but may be updated before this time if required.

2.7 In September 2018, NHS England undertook a quality review with UHS, the final report was favourable. NHS England produced and action plan for UHS, this included 6 areas that required attention. 2 actions are completed; longer term projects are in place for the other areas.

2.8 Pre-employment checks are a mandatory part of the Medical HR process; the revalidation team manage the transfer of information process.

3. Effective Appraisal

3.1 Appraisal is a mechanism focusing on enhancing the appraisees' safety and quality of patient care, supporting professional development and Statutory obligations. It is designed to recognise good practice and performance, provide feedback and assist in the identification of safety and quality of care performance issues so they can be dealt with at an early stage through professional development and support. The appraiser will review the supporting information and discuss these with the doctor to gain a rounded impression of that doctor's practice.

3.2 Every doctor is responsible for ensuring that they are appraised annually on their whole practice, so will need to make arrangements to share information from each of their employers, including private practice, on an annual basis. This is in accordance with the contractual requirements for all doctors. The Trust reserves the right to undertake appropriate action where a doctor fails to take sufficient steps to participate in the appraisal process.

3.3 Doctors with overdue appraisals will be contacted and reminded of their responsibility to complete their appraisal, request an update on the timeline for completion.

3.4 A list of doctors with an overdue appraisal (3 months or more) without acceptable reasons, (sickness, maternity etc) will be submitted to the RO and DMG on a monthly basis, the circumstances of each case will be reviewed with appropriate action determined.

3.5 The Trust's Medical Appraisal and Revalidation policy is compliant with national policy and has been approved via the central policy ratification group.

Appraisers

3.6 There are currently 133 trained consultant appraisers, responsible for 792 Appraisals per annum for consultants and senior doctors. This is a ratio of approximately 1:6 which is within the national recommended ratio of between 1:5 and 1:20. Fellows are appraised by their education supervisor and the appraisal process also covers a formal end of placement review.

3.7 The Medical Appraisal Leads, Sarah Hughes and Victoria McFarlane deliver the appraisal training in-house. All care groups have an appraisal lead.

3.8 The outputs are reviewed by the Appraisal Leads and feed back is given to the appraisers directly.

3.9 Multiple appraisal training sessions take place each year:

- new appraiser training
- appraiser update training
- appraisal awareness training (aimed at fellows and doctors new to the NHS)

3.10 Appraisers are required to attend update training every 2 years.

Quality Assurance

3.11 Currently, the Trust allows doctors to either complete a paper portfolio for appraisal or use an online system, UHS Revalid. Each form 4 appraisal summary is reviewed centrally, monitoring the following:

- Has the correct form been used?
- Has the appraisal been conducted by a trained appraiser who has not completed more than 3 consecutive appraisals for the appraisee?
- Has a Personal Development Plan (PDP) been completed?
- Has the appraisal been signed off appropriately?
- Does it meet all the Trusts requirements and cover all the elements?

3.12 Doctors are invited to fill in a survey after their appraisal; this asks individuals to rate the quality of the appraiser and the suitability of the appraiser.

3.13 A proportion of all appraisal documentation is reviewed via a structured review form. 10% of appraisal documentations are reviewed each year by the Care Group Appraisal Leads, feedback is provided to individual appraisers.

4. Recommendations to the GMC

4.1 During the period 1 April 2018 - 31 March 2019 the RO made 173 Revalidation recommendations. This comprised of 16 deferrals and 157 positive recommendations.

4.2 The deferrals were made to request doctors to collect additional evidence to support the revalidation decision. Where a deferral was recommended, the doctor was notified with confirmation of the actions required.

5. Medical governance

5.1 Complaints and Serious Incidents are discussed and reflected upon as part of the appraisal process. Doctors are able to contact the patient safety and complaints team to obtain details of any incidents.

5.2 Care group and divisional governance teams monitor performance of teams and review complaints and incidents at monthly governance meetings. These meetings incorporate service line management, complaints and litigation, risk reporting and mortality and morbidity data. Divisional governance reports are reviewed at the Quality Governance Steering group chaired by the Medical Director and Health of Nursing and reports to the Trust Executive Committee (TEC) and to the Board. Issues are generally dealt with at the Divisional level, serious issues are escalated to the Medical Director and managed through the Maintaining High Professional Standards Procedures. An annual report of any doctor with more than three complaints is presented to the Medical Director.

5.2 Activity data is available from divisional analysts at the request of doctors and may be discussed as part of the job planning meeting.

5.3 Concerns regarding a doctor's performance or conduct are managed through the Handling of Concerns Relating to the Conduct and Performance of Doctors and Dentists policy. Concerns are normally raised through the divisional management teams and addressed accordingly with support from HR. The Trust has a lead for Patient Safety, Neil Pearce, and a Deputy Medical Directors, Paul Grundy, who both assist the Medical Director with any escalations or serious concerns, through a formal process.

5.4 The Medical Director meets monthly with the Deputy Director of HR to discuss and manage serious cases. Complex cases are reviewed by a Professional Advisory Panel (PAP) and reviewed by the DMG; providing assurance that the most appropriate action has been taken.

5.5 A process is in place for transferring information and concerns between the RO and other ROs where UHS connected Doctors undertake regular work.

6. Employment Checks

6.1 The Medical HR team is responsible for undertaking pre employment checks. Mandatory checks include:

- Identity Check
- Right to Work
- Qualification Checks
- Professional Registration
- DBS check
- References
- Occupational Health clearance

6.2 The Temporary Resourcing Team are responsible for ensuring that appropriate pre-employment documents are provided for any temporary workers, supplied via a locum agency.

7. Summary of comments, and overall conclusion

7.1 Improvements have been made over the last 12 months, the transfer of responsibility to medical HR has been successful and has strengthened the support available to the RO, provided a greater level of robustness and sustainability.

7.2 A patient feedback project has commenced, led by Steve Wheeler. The aim is to create a fair and robust process; the focus will be on the opportunities available to collect patient feedback in outpatients reducing the need to involve consultants in the process.

7.3 Developments have been made to the UHS appraisal system Revalid, an updated version will be available to users later this year. The aim is to mandate electronic appraisals in the 2020/21 appraisal cycle.

7.4 New actions are:

- Continue with plans to make sure there is consistency in scheduling of doctor's appraisals across the organisation.
- Continue to explore ways to encourage a culture that supports tying together job planning reviews with an element of performance management.
- Consider opportunities for involving lay representatives in the revalidation and appraisal process.

8. Recommendations

8.1 The Board is asked to note the information included in this report and acknowledge that the Annual Organisational Audit (AOA) was submitted to NHS England on 31 May 2019.

8.2 The Board is asked to approve the **"Statement of Compliance" Appendix A**, confirming that the organisation, as a designated body, is in compliance with regulations.

Appendix A – Statement of Compliance

The Board of University Hospital Southampton NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive or chairman

Official name of designated body: University Hospital Southampton NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

Appendix A – The Annual Organisational Audit

The Annual Organisational Audit (AOA) for appraisals uses the following definitions:

1 - Appraisal has been completed between 1 April 2018 and 31 March 2019.

2 - An appraisal has not been completed but the RO has approved non-completion e.g. Sickness, Maternity Leave, Career break etc.

3 - An appraisal has not been completed and the reason for this has not been approved by the RO.

	Number of prescribed connections	Completed Appraisal (1)	Approved Incomplete or missed Appraisal (2)	Unapproved Incomplete or missed appraisal (3)
Consultants (includes honorary staff)	748	672	26	50
Staff grade, associate specialist, speciality doctor	44	39	1	4
Temporary or short-term contract holders (includes locums, trust doctors, fellows)	271	154	80	37
TOTAL	1063	865 (81.4%)	107 (10.1%)	91 (8.5%)

The reasons for approved incomplete appraisals (2) are shown in the table below:

Reason	Number
1st Appraisal not yet due (in post less than 1 Year)	87
Sickness	4
Maternity	5
Appraiser delay	2
HR Process	3
Other agreed Postponement	6
Total	107

Report to the Trust Board of Directors dated Tuesday, 30 July 2019	
Title: Safeguarding Annual Report 2018-19	
Category	Quality, Performance, and Finance
Agenda item	4.4
Sponsor	Director of Nursing and Organisational Development
Author	Tracy Whale, Sharon Smithson, Karen McGarthy
Provenance	To provide high levels of assurance as to how UHFST meets its statutory and regulatory requirements for safeguarding and provides an overview of key achievements, key risk and challenges for the period 2018/19. To identify key work streams for 2019/20. This report has been discussed at Safeguarding Governance Steering Group (SGSG), Quality Governance Steering Group (QGSG) and Trust Executive Committee (TEC). Stakeholder engagement has been with SGSG members, QGSG members, Commissioner engagement at QGSG.
Classification	This Report is unclassified.
Purpose and recommendation	The paper is presented for REVIEW. The purpose of this paper is to provide high levels of assurance as to how UHSFT meets its statutory requirements for safeguarding and provides an overview of key achievements, key risks and challenges for the period of 2018/2019. To identify key work streams for 2019/2020. Members of Trust Board are asked if the report gives the required assurance around UHSFT adult and child safeguarding services. Summary of key points: • Key legislative changes related to safeguarding, Working Together to Safeguard Children 2018, The General Data Protection Regulation (GDPR) and the Data Protection Act 2018, Safeguarding Adult's Intercollegiate Document 2018, Safeguarding Children's Intercollegiate Document 2019 • Risks which include; Compliance of safeguarding level 3 children's training – this is being reviewed in collaboration with VLE to enable the required hours of training to be recorded(Intercollegiate 2019), compliance of MCA & DoLs level 2 training due to being a new package, safeguarding adults training levels 2 & 3 due to new Intercollegiate guidance • Key achievements for safeguarding children and safeguarding adults • Key achievements for the Learning Disability and Autism Liaison team which includes the year 1 delivery of the Learning Disability & Autism strategies • Ongoing challenges and risks – specifically around the implementation of the new Mental Capacity Amendment Act (2019) – Liberty Protection safeguards (LPS) • Joint areas of work 2019/20 – to include the development of the safeguarding strategy Members of Trust Board are asked to note and comment on the current risks identified above and the upcoming challenge of the implementation of Liberty protection safeguards (LPS).

<table>
<tr><td rowspan="2">Relevant strategic goals</td><td>✓ Goal 1: Improving patient journeys.</td><td>☐ Goal 2: Delivering value-based health and care.</td><td>✓ Goal 3: Supporting healthy lives.</td></tr>
<tr><td>✓ Goal 4: Building an expert and inclusive workforce.</td><td>✓ Goal 5: Being agile in meeting people's needs.</td><td>☐ Goal 6: Creating leading-edge research, education, and innovation.</td></tr>
<tr><td>Assurance framework links</td><td colspan="3">Cross-reference to the applicable risk register and Board Assurance Framework entries, if appropriate, for example:
BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways
BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6
BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care
BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services
BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care
BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual
BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider</td></tr>
<tr><td>Impact assessments</td><td colspan="3">N/A</td></tr>
<tr><td>Other standards affected</td><td colspan="3">What standards will your recommendations affect?
CQC Well-led Framework, Standard NHS contract Safeguarding Children (including Looked After Children) & Adult and Mental Capacity Act</td></tr>
</table>

1. Introduction or Background

The term ‘safeguarding’ covers everything that assists children, young people and adults at risk to live a life that is free from abuse and neglect and which enables them to retain independence, wellbeing, dignity and choice.

It encompasses prevention of harm, exploitation and abuse through provision of high quality care, effective responses to allegations of harm and abuse, responses that are in line with local multi-agency procedures and lastly, using learning to improve services to patients.

The Trust’s safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change, respond to emerging themes and strive to ensure all safeguarding processes are robust and effective.

UHSFT recognises that safeguarding is a shared responsibility, and remains committed to working in collaboration with multi-agency partners to safeguard the adults and children that use our services.

The purpose of the report is to provide high level assurance as to how UHSFT meets its statutory and regulatory requirements for safeguarding and provides an overview of key achievements, key risks and challenges for the period of 2018/2019. It will also identify key work streams for 2019/2020.

2. Analysis and Discussion

The safeguarding annual report outlines the background, national context and local context, safeguarding range of activity, safeguarding team and safeguarding governance structure, Team activity and data, safeguarding training, Team key achievements, ongoing challenges and risks and joint areas of work 2019/20.

The safeguarding children team have had a busy and productive year. As well as providing daily safeguarding advice, support and liaison with UHS staff and multi-agency partners (appendix 3), the team continue to review and update processes to support staff to have the knowledge and skills to be able to identify when there are safeguarding concerns in relation to a child or an adult at risk and what actions are required to safeguard. To enable this, as highlighted in the main report, reviews have included:

- the safeguarding children policy
- safeguarding children proforma.
- pathway for children who are admitted to UHS
- child protection and safeguarding leaflet, information for parents and carers on the medical management of children when there are concerns about actual or suspected abuse
- level 3 safeguarding children training guidelines.
- multiagency audits and serious case reviews, ensuring recommendations and learning are embedding within UHS
- safeguarding supervision groups for identified key staff
- safeguarding facilitator transition role for 16-21 year olds.

3. Conclusion

The safeguarding annual report has highlighted the safeguarding team’s activity for 2018/19. From a strategic and operational perspective this is pivotal to ensure we continue to improve outcomes for children and adults as identified in the above strategic goals

The joint area for work for 2019/20 includes the development of a safeguarding strategy. The strategy will outline the plan of action for improving the qualitative and quantitative safeguarding outcomes for children and adults under our case

4. Recommendation

For Trust Board to note and comment on the current risks with

- Level 3 Safeguarding children training, ensuring >85% compliance is achieved for the required 12 hours.
- Safeguarding adult training
- MCA and DOLS

5. Appendices

Annual Report 2018-19.

University Hospital Southampton NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT 2018 / 2019

AUTHORS

Tracy Whale, named nurse for safeguarding adults
Karen Mcgarthy, named nurse for safeguarding children
Sharon Smithson, interim named nurse for safeguarding adults

SUMMARY

THE TERM ‘SAFEGUARDING’ COVERS EVERYTHING THAT ASSISTS CHILDREN, YOUNG PEOPLE AND ADULTS AT RISK TO LIVE A LIFE THAT IS FREE FROM ABUSE AND NEGLECT AND WHICH ENABLES THEM TO RETAIN INDEPENDENCE, WELLBEING, DIGNITY AND CHOICE.

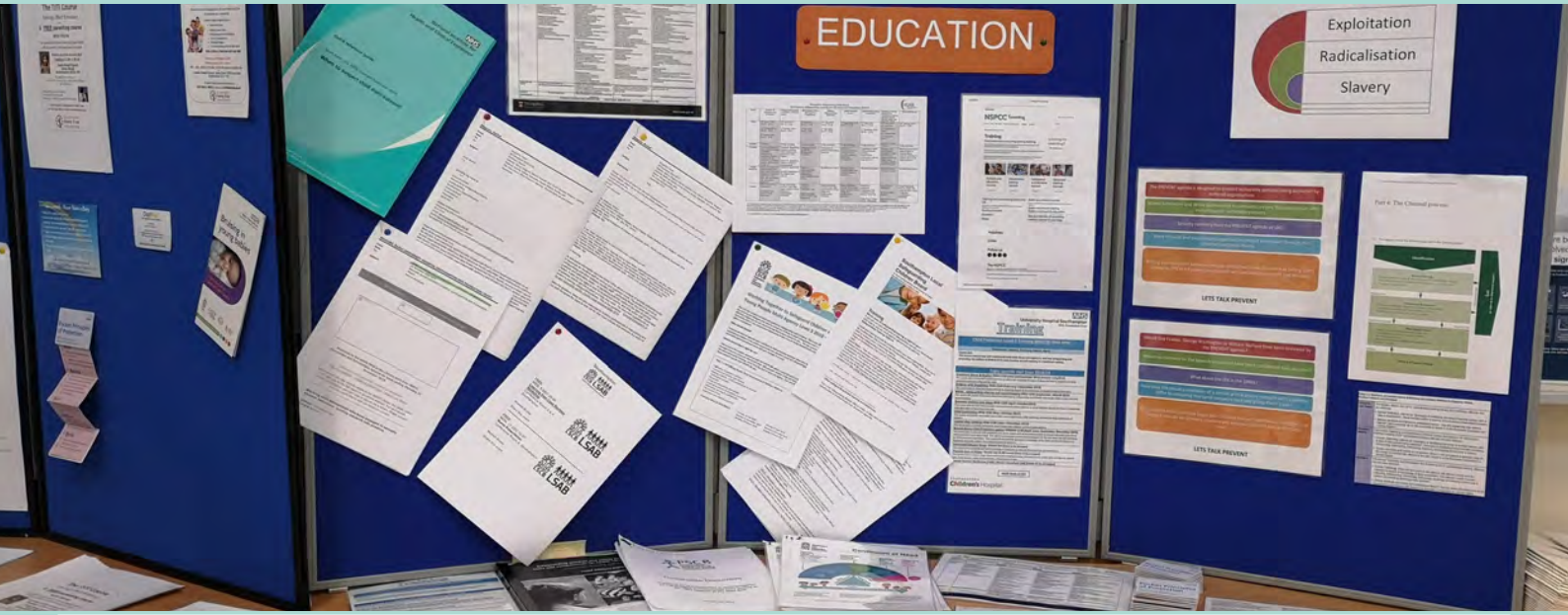
IT ENCOMPASSES PREVENTION OF HARM, EXPLOITATION AND ABUSE THROUGH PROVISION OF HIGH QUALITY CARE, EFFECTIVE RESPONSES TO ALLEGATIONS OF HARM AND ABUSE, RESPONSES THAT ARE IN LINE WITH LOCAL MULTI-AGENCY PROCEDURES AND, LASTLY, USING LEARNING TO IMPROVE SERVICES FOR PATIENTS.

THE TRUST’S SAFEGUARDING TEAM CONTINUES TO PROVIDE A RANGE OF ACTIVITIES TO SUPPORT KEY AREAS OF SAFEGUARDING WORK, EMBRACE CHANGE, RESPOND TO EMERGING THEMES AND STRIVE TO ENSURE ALL SAFEGUARDING PROCESSES ARE ROBUST AND EFFECTIVE.

UHSFT RECOGNISES THAT SAFEGUARDING IS A SHARED RESPONSIBILITY, AND REMAINS COMMITTED TO WORKING IN COLLABORATION WITH MULTI-AGENCY PARTNERS TO SAFEGUARD THE ADULTS AND CHILDREN THAT USE OUR SERVICES.

THE PURPOSE OF THE REPORT IS TO PROVIDE HIGH LEVEL ASSURANCE AS TO HOW UHSFT MEETS ITS STATUTORY AND REGULATORY REQUIREMENTS FOR SAFEGUARDING AND PROVIDES AN OVERVIEW OF KEY ACHIEVEMENTS, KEY RISKS AND CHALLENGES FOR THE PERIOD OF 2019/2020. IT WILL ALSO IDENTIFY KEY WORK STREAMS FOR 2020/2021.

INTRODUCTION



This is the second joint annual safeguarding report since the adult and children's safeguarding teams merged in October 2017. Governance and reporting structures have further evolved, and the 'family approach' to safeguarding is really embedding trust wide.

Whilst the maternity safeguarding service has not formally merged, this year has seen ongoing work to more closely collaborate on a number of work streams. It is anticipated that the safeguarding annual report for 2019/20 will include maternity safeguarding, however for this year it will be reported and submitted separately to the safeguarding governance steering group. There has also been on-going development in terms of how the safeguarding teams and the paediatric liaison service works with safeguarding links in the emergency department as well as the vulnerable adults support team (VAST).

This year has also seen the team expand, which includes the exciting development of four new roles. The first is a band 6 safeguarding facilitator which has focused on transition for 16-21 year olds. This role has proved particularly invaluable in supporting 16 and 17 year olds who are being treated in adult areas, as well as the staff who are caring for them.

The second is a band 3 safeguarding support worker to assist the team with the 'making safeguarding personal' agenda, and improving the quality of the application of the Mental Capacity Act (2005) and Deprivation of Liberty (DoLS).

The last two roles are band 4 learning disability senior healthcare assistants who are providing specific, timely and effective support to patients, staff, relatives and visitors around the learning disability and/or autism agendas. The team is eager to see how these roles can further evolve in the coming year.

During the year, the children's safeguarding team has continued to work in close collaboration with the paediatric liaison nurse service and therefore this activity will be reflected within this report.

A real focus for the coming year will be the development of a safeguarding strategy to continue to drive improvements in safeguarding practices across the Trust and to continue to build on, and embed, these current good practices.

BACKGROUND

University Hospital Southampton NHS Foundation Trust is one of the country's largest university hospitals, with around 1390 beds. The Trust provides a major trauma centre and wide range and complexity of general services across Southampton and South Hampshire, to a population of 1.9 million people. It also provides specialist services such as neurosciences, cardiac services and children's intensive care to over 3.7 million people in central southern England and the Channel Islands.

NATIONAL CONTEXT

Responsibilities for safeguarding are underpinned by legislation and statutory guidance. Safeguarding is the responsibility of all NHS funded organisations and healthcare professionals and should be embedded within core duties across whole organisations. Outlined below are the mandatory and statutory updates from this annum.

Working Together to Safeguard Children 2018

On 29 June 2018, Working Together to Safeguard Children was published. The guidance sets out what organisations and agencies who work with children must and should do to safeguard and promote the welfare of all children and young people under the age of 18 in England. The new guidance sets out the changes needed to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act 2017, and is a significant update to the previous version of the guidance published in 2015.

Key areas where the 2018 guidance differs from the 2015 guidance are:

- Changed the Local Safeguarding Children Board requirement to an equal duty on three local safeguarding partners: the local authority, a clinical commissioning group for an area any part of which falls within the local authority area, the chief officer of police for an area any part of which falls within the local authority area.
- These should: agree on ways to co-ordinate their safeguarding services; act as a strategic leadership in supporting and engaging others; implement local and national learning including from serious child safeguarding incidents.
- Also established the national Child Safeguarding Practice Review Panel giving them authority to commission and publish national reviews of serious child safeguarding cases which they consider are complex or of national importance.
- Introduces child safeguarding practice reviews, in place of serious case reviews.

INTERCOLLEGIATE DOCUMENTS

In August 2018, a new intercollegiate document for adults was published - 'Adult safeguarding: roles and competencies for healthcare staff'.

It was developed to assist in:

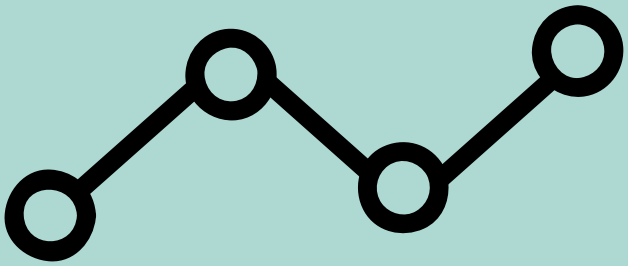
- developing and reviewing job/role descriptions
- assessing clinical competence for different levels of practitioner
- developing personal goals
- performance appraisal.

It is acknowledged within the document that it will not be possible for all staff to access the training within the first year of its publication. However it is expected by the next iteration in 2021 that all staff will have received training to attain the appropriate competencies. Work is underway to review and align adult safeguarding training to this document.

'Safeguarding children and young people: roles and competencies for healthcare staff' - intercollegiate document 2019

In January 2019, a revised intercollegiate document for children's safeguarding was published. This has been updated to include changes to legislation and statutory guidance in England and now includes education and learning logs to enable individuals to record their learning and form a 'passport' to facilitate easier transition between organisations. Levels 1-3 relate to different occupational groups, while Levels 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs and board members including executives, non-executives and lay members.

The document has been presented at the statutory and mandatory operational group alongside the new UHS level three training guidance, with assurance being sought from each division that all staff receive the appropriate competencies consummate to their role.



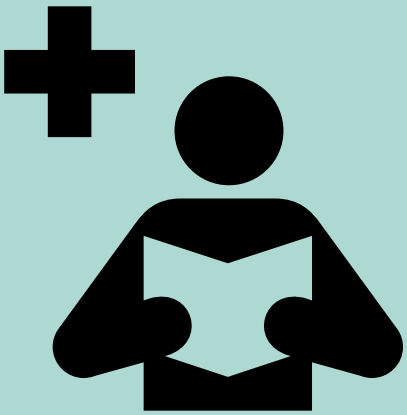
The General Data Protection Regulation (GDPR) and the Data Protection Act 2018

The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information,

The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data. All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information.

Information sharing, advice for practitioners providing safeguarding services to children, young people, parents and carers (2018)

This guidance has been updated to reflect the General Data Protection Regulation (GDPR) and Data Protection Act 2018, and it supersedes the government 'Information sharing: guidance for practitioners and managers' published in March 2015.



A Family Approach Protocol (Hampshire, Isle of Wight, Portsmouth and Southampton safeguarding boards, 2018)

The protocol has been implemented in response to learning arising from serious case reviews, serious adult reviews and domestic homicide reviews in our local areas. It builds on national learning and research which has highlighted the need for professionals to work effectively together to achieve better outcomes for adults, children and their families across all areas.

This protocol and its supporting documents in the online toolkit replace what was previously produced in the Joint Working Protocol (JWP).

Care Act (2014)

Working Together to Safeguard Children (2018)

Mental Capacity Act (2005)

Mental Slavery Act (2015)

Children and Families Act (2014)

The Children Act (2004)

Mandatory Reporting of female genital mutilation (2015)

Safeguarding Children's Intercollegiate Document (2019)

Counter terrorism and Security Act (2015)

The Criminal Justice and Courts Act (2015)

Serious Crimes Act (2015)

NHS Accountability and Assurance Framework (2016)

The Children Act (1989)

Children and Social Work Act (2017)

Safeguarding Adult's Intercollegiate Document (2018)

LOCAL CONTEXT

Locally, the safeguarding team is a key partner agency for safeguarding within Hampshire and Southampton and work in close collaboration with multi-agency partners across the system. We are engaged with local safeguarding boards, which are statutory bodies made up of organisations that work together to safeguard and promote the welfare of adults, children, young people and their families. From an adult perspective, the four local boards (Southampton, Hampshire, Isle of Wight and Portsmouth) are working to collaborate across the local area so as to reduce duplication and increase efficiency for board members. Below is a representation of the boards and sub-groups that the UHS named nurses attend.

HSAB / SSAB (Hampshire Safeguarding Adults Board and Southampton Safeguarding Adults Board)

Domestic sexual abuse strategy group

Learning and review group

Quality assurance group

Policy development group

Workforce development

Prevent working group

Health sub group

Southampton safeguarding children's board

Monitoring and evaluation subgroup

Hampshire safeguarding children's board

Serious case review subgroup

Hampshire & Isle of Wight (HIOW) safeguarding strategic task and finish group

Panel member for commissioned serious case review, safeguarding adult reviews or learning reviews

UHS are signed up to local multi-agency policies and procedures developed by the local safeguarding boards which can be found on the links below;

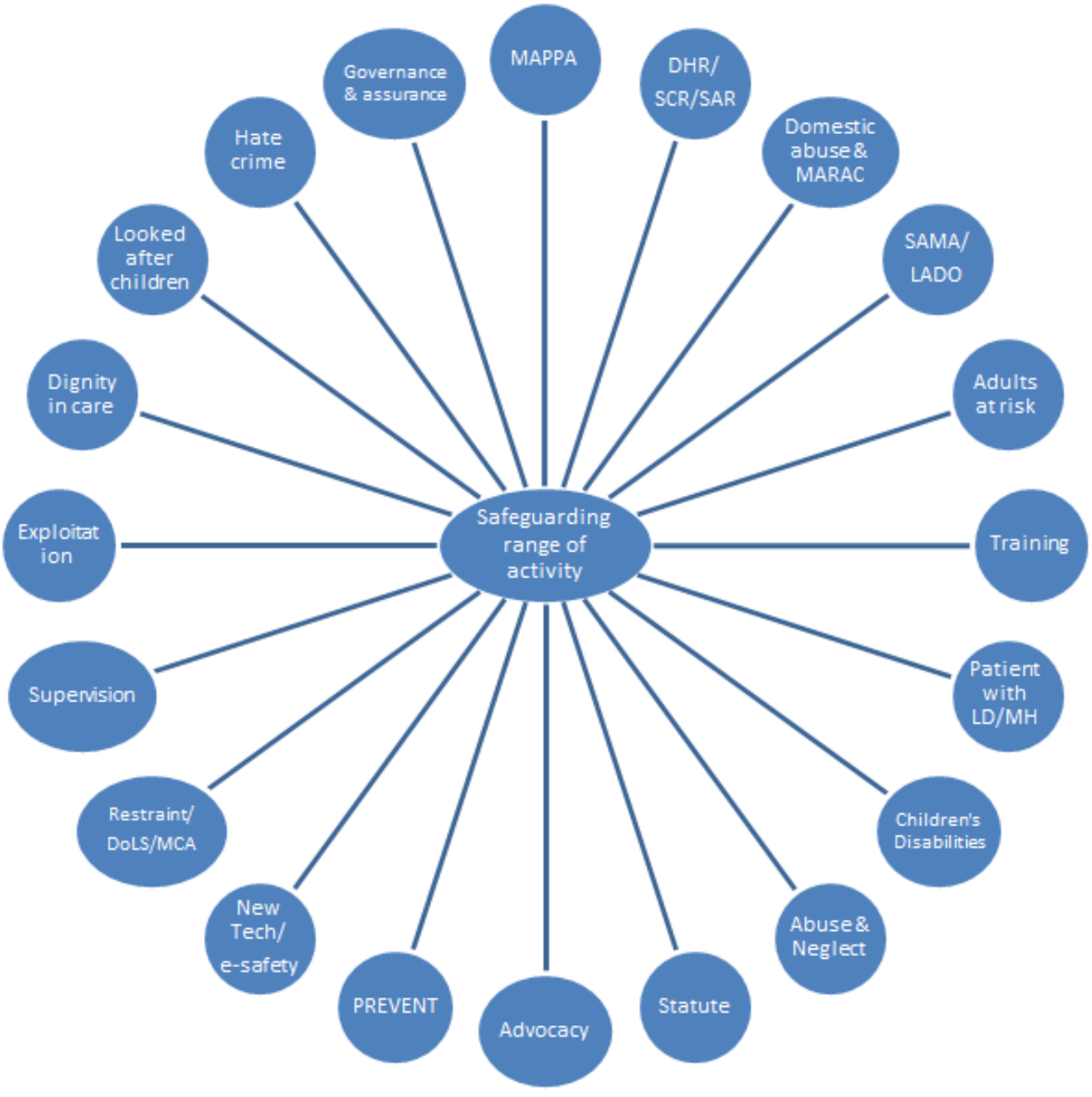
Adults: http://www.hampshiresab.org.uk/wp-content/uploads/February-2017-Multi-Agency-Safeguarding-Adults-Policy-and-Guidance-2nd-Edition-December-2016-v3.pdf

Children: http://4lscb.proceduresonline.com

Local policies reflect this guidance.

SAFEGUARDING RANGE OF ACTIVITY

Below is a diagrammatic visual of the range of activity that the team contributes to in order to safeguard and promote the welfare of children, young people and adults.



All safeguarding work across the Trust is underpinned by the Trust values: patients first, working together and always improving.

SAFEGUARDING TEAM

Director of nursing

Deputy director of nursing and quality

Named dr for safeguarding children - Dr Faye Hawkins x2PA

Director of midwifery

Named nurse safeguarding adults

Named nurse safeguarding children

Consultant midwife for safeguarding children

1x band 7 safeguarding CNS (adults)

2x band 7 safeguarding CNS (children's)

0.8 band 7 for PNMH and DVA

Band 7 - specialist midwife for safeguarding children

1x band 6 safeguarding facilitator adults

1 x band 6 safeguarding facilitators adults and children

1x band 6 safeguarding facilitator children's

1x Band 6 Safeguarding Facilitators

1 x administrator

1x safeguarding adults HCA

2x learning disability CNS

2x learning disability HCA

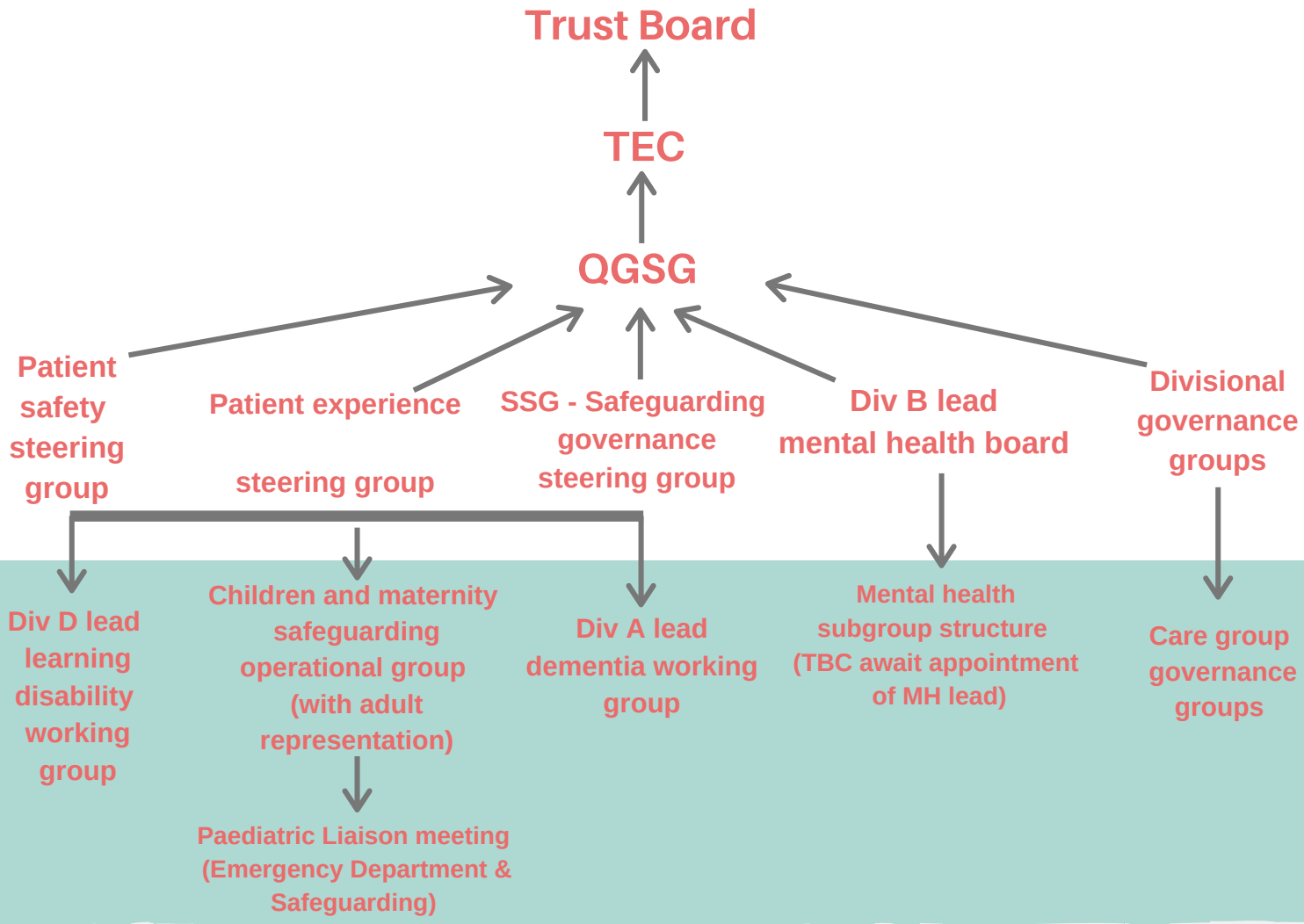
Admin - 1x PA

2x administrators - supporting all staff members

This structure sets out the lines of responsibility and accountability for UHS and has been live since October 2017. The safeguarding team ultimately reports into the director of nursing, who holds the executive safeguarding lead role.

SAFEGUARDING GOVERNANCE STRUCTURE

UHS safeguarding governance steering group structure 2018



Governance and assurance arrangements have continued to strengthen this year.

There are named nurses in post for both the adult and child agendas. The named nurse for safeguarding adults continues to provide strategic support and direction for the safeguarding adults agenda, mental capacity and DoLs, learning disabilities and autism, as well as being the organisational Prevent lead and the safeguarding allegations management advisor (SAMA).

The named nurse for safeguarding children continues to provide strategic support and direction for the safeguarding children's agenda and is the organisational looked after children (LAC) and child sexual exploitation (CSE) lead. The role includes providing support and direction to the midwifery safeguarding team and support to the Trust female genital mutilation (FGM) lead. The named nurse has established links with the local area designated officer (LADO) in relation to safeguarding allegations against staff.

There is a newly appointed named doctor who supports the safeguarding children agenda. The two named doctors have a total of 4 PAs per week to undertake this role.

The Trust Board have annual safeguarding updates and there is a named non-executive director lead for safeguarding as well as a named executive lead for MCA and DoLS.

The safeguarding governance steering group (SGSG) executive safeguarding lead and director of nursing and organisational development. The safeguarding team submits a quarterly report to provide assurance around key performance indicators for safeguarding and mental capacity, as well as updates around the agenda. Any required escalations are highlighted up to the quality governance steering group (QGSG), the Trust executive committee (TEC) and ultimately Trust Board.

The child and maternity safeguarding operational group was implemented in September 2018 in response to the UHS safeguarding governance structure proposal when the team merged in 2017. This meets every other month and is a forum for attendees to gain key safeguarding agenda updates, highlight risk and support the implementation of any learning from reviews. The attendees include the nominated safeguarding doctor and nurse leads within UHS who work with children. These include: midwifery safeguarding, neonatal unit, child health, emergency department and eye casualty. Identified risks are escalated to the safeguarding governance steering group.

The paediatric liaison meeting meets every other month and is chaired by the paediatric liaison nurse specialists (PLNS) and is attended by ED medical and nursing safeguarding leads, named nurse for safeguarding children for UHS and eye casualty representatives. These meetings are utilised to improve upon and disseminate strategic updates, training, policies and processes. Emergency department multi-disciplinary meeting was established in late 2017 and meets every fortnight which is led by the PLNS. The attendees for these meetings are ED practitioners of all grades nursing and medical, UHS safeguarding team, paediatric assessment unit and eye casualty. This offers an opportunity to discuss cases and share learning for development.

The named nurses attend divisional governance forums quarterly to ensure updates, risks, and successes are being communicated.

The safeguarding team continues to hold monthly team meetings to discuss on-going service improvement and risks and challenges to the service, as well as a weekly huddle to discuss operational updates, consider safeguarding case risks and facilitate weekly work allocation. There is also a quarterly meeting with the local authorities to discuss and work through any process concerns.

As well as being accountable to the Trust Board, UHS safeguarding services are accountable to Southampton City CCG, West Hampshire CCG, Southampton Safeguarding Boards for adult and children and Hampshire safeguarding boards for adults and children. A team representative also sits on the local learning disabilities partnership board, the local area LeDeR steering group, and the local Prevent board.

TEAM ACTIVITY

SAFEGUARDING ADULTS

All safeguarding adults referrals are made by an electronic system called Apex. The team continues to work with the technologist to improve the data captured and make the referral forms more user friendly. Appendix 1 demonstrates the team's formal activity data. Wider team activity includes:

- Ensuring advice and support is available Monday-Friday, 9-5 for safeguarding and MCA & DoLS (advice line, email and bleep. Emails monitored twice daily)
- Attendance at daily safeguarding huddles
- Making safeguarding personal - feeding back to patients, families and staff
- Monitoring and support of all on-going section 42 enquiries
- Protection planning
- Complex case management of patients with mental capacity impairment (including advice / support in relation to Court of Protection)
- Complex case management and screening of patients requiring / under DoLs
- Weekly DoLs ward rounds
- Leading on UHS's contribution to any statutory reviews (safeguarding adults reviews / domestic homicide reviews)
- Providing updates, training, education and supervision for safeguarding, MCA & DoLs
- Linking with patient safety and patient experience teams to monitor incidents, SIRIs and complaints for safeguarding concerns
- Monitoring the quality of the safeguarding, MCA & DoLs processes / pathways - assurance & audit
- Development of quarterly MCA newsletter
- Monitoring of compliance and regulation in relation to safeguarding, MCA & DoLS
- Ensuring on-going service improvement / appreciative learning
- Maintaining links with HR in relation to safe recruitment
- Maintaining links with HR for allegations against people in a position of trust - providing the safeguarding allegation management advisor (SAMA) function
- Acting as a point of contact for multi-agency partners
- Representation on the mental health board.

SAFEGUARDING CHILDREN

All safeguarding children referrals are currently made by telephone to the safeguarding children team. All information is collated onto a team log. The safeguarding children team are currently developing an electronic system, Apex, which will follow similar principles to the Adult Apex, this is due for implementation in June 2019. This system will enable accurate recording of data of all safeguarding referrals to the safeguarding children team. Currently the team hold this data on an excel spreadsheet. Appendix 3 demonstrates the teams formal activity data.

- Ensure that advice and support is available Monday-Friday , 9-5 for safeguarding
- Daily safeguarding children huddles to review, allocate new referrals and ongoing cases
- Daily ward rounds by safeguarding facilitators
- Weekly safeguarding contribution to paediatric doctor handover
- Complex case management of children where abuse or neglect is considered or suspected
- Work with UHS staff and external agencies and convene strategy meetings, professional meetings, discharge planning meetings and contribute to rapid response meetings
- Lead on UHS's contribution to any statutory reviews, including scoping for serious case reviews and coordination with midwifery and neonate colleagues. If criteria for a review are met, attending panel meetings in relation to the review and completing reports within timescales, addressing the terms of reference
- Provide updates and education sessions to staff, this includes team updates to child health sisters, care group meeting, clinical nurse specialist meeting, paediatric intensive care unit (PICU) sisters' meeting
- Monitor the quality of safeguarding processes / pathways - assurance & audit
- Monitor compliance and regulation in relation to safeguarding
- Ensures robust governance around safeguarding
- Ensures on-going service improvement / appreciative learning
- Links with human resources (HR) in relation to safe recruitment
- Links with HR for allegations against people in a position of trust -and linking with local area designated officer (LADO), contributing to strategy meetings when required
- Linking with patient safety and patient experience teams to monitor incidents, SIRIs and complaints for safeguarding concerns

SERIOUS CASE REVIEWS

The team have been requested to complete 18 serious case review scopings for children and related family members. Working together 2018 requires local safeguarding children boards to complete this as rapid review process, with majority of submissions required to be submitted within 15 working days.

Serious case reviews and partnership reviews completed by UHS safeguarding and submitted to local safeguarding children boards totalled five. Contribution by the safeguarding team to panel meetings related to open and new serious case reviews totalled five.

To note, from 1 April 2019, the paediatric liaison service will transfer from division B to the safeguarding team. Benefits of the transfer will include:

- ensuring seamless service delivery at times of reduced staffing, enabling all required actions to safeguard children are responded to in a timely way
- utilizing the knowledge and skills of the paediatric liaison nurses to support the safeguarding team in taking the safeguarding agenda forward, including delivery of training and supervision
- enhancing the communication between the teams to manage and assess risk and escalate safeguarding cases when required.

Further detail and analysis will be included in next year's annual report, however we have included Paediatric Liaison data in relation to children's attendances to the Emergency Department (appendix 4).

SAMA/LADO activity (Adults and Children)

The named nurse leads continue to support the organisation when allegations against a person in a position of trust have been made. The number of cases referred to the team for this annum are highlighted in the table below. The named nurses meet monthly with the human resources employee relations lead to discuss any ongoing cases and the safeguarding support required.

Total SAMA	Total LADO
13	15

TRAINING

Training is reported quarterly to the CCG as part of the quality contract, as well as through SGSG where there is divisional representation. Where compliance is a challenge, the named nurses link with divisional governance forums as well as divisional training and education leads for action plans. Current compliance can be found in the table below.

UHS- TRUST wide	
Statutory & Mandatory Training Topic	% Compliant
Safeguarding Children/ Child Protection - Level 1 [3 Years]	90.7
Safeguarding Children/ Child Protection - Level 2 [3 Years]	86.0
Safeguarding Children/ Child Protection - Level 3 [3 Years]	90.5
Safeguarding Children/ Child Protection – Level4	100%
Safeguarding Adults [3 Years]	91.5
Mental Capacity Act / DoLS – Level 2 [3 year]	64.7
Prevent – Level 1 [1 years]	87.2

ADULT TRAINING

This year has included a number of work streams around safeguarding training.

The Mental Capacity Act (MCA) training has been reviewed and updated and now includes levels 1 and 2 (as mapped by the Bournemouth University Mental Capacity Competency Document) as well as DoLs for staff where it is appropriate.

Training compliance is low due to two reasons: firstly, the Trust has not had level 2 MCA training previously and secondly, staff profiles are still being mapped to the appropriate levels. This was highlighted in a recent Price, Waterhouse, Cooper audit and is noted on the organisational risk register.

Face to face educational MCA forums are held bi-monthly and are open to all staff. These forums have received good feedback thus far, and have seen good commitment from a number of multi-disciplinary staff.

In terms of Prevent, the new level 2 and 3 Prevent training packages are now live, however this training package is also in the process of being profiled against job roles. Due to this, only one level of compliance can currently be monitored. The safeguarding volunteer training now includes a Prevent awareness component.

Adult safeguarding training is also logged on the organisational risk register as it is currently not mapped to the new adult safeguarding intercollegiate document. There are both level 1 and 2 e-learning packages available, however these are not profiled against job roles. The Trust is currently using e-learning for health packages, nevertheless a priority for the coming year is to review this training package in collaboration with the children's safeguarding team at levels 1, 2 and 3. Ad-hoc face to face training is given upon request and regular awareness training is given to new volunteers in partnership with the children's safeguarding team.

CHAMPIONS

The safeguarding adults team has recently introduced MCA and DoLs champions to really support application in practice. Whilst this role is in its infancy, there have been two initial meetings to review the link role job description, training needs and develop a quarterly workshop proposal.

Each children's ward has an identified safeguarding champion and it is expected that the champions attend the meetings which are led by the safeguarding children team. The aim of the meeting is to update and disseminate information on the safeguarding children agenda.

CHILDREN'S TRAINING

From a safeguarding children perspective safeguarding children training overall for the Trust is above the required 85% compliance. The training remains on the risk register as there is a review of how the compliance is reported on the virtual learning environment (VLE) to ensure level 3 training requirements of 12 hours minimum every 3 years are captured.

A revised level 3 safeguarding children training guidance has been ratified and rolled out in March 2019. The safeguarding children team are currently working with VLE to ensure the 12 hours minimum requirement over 3 years is captured on VLE. The guidance reflects the updated intercollegiate document 2019. There are some additions to staffing profiles in the document and each divisional education lead has been asked to review this to ensure all staff are profiled correctly.

Additional learning to support staff to increase their knowledge and skills in safeguarding practice include:

- The safeguarding children facilitators are employed to access various departments with the Trust , which includes The Emergency Department, Acute Medical Unit, all adult wards where there are child as inpatients (including Intensive Care Unit areas), Eye Casualty, Eye Short Stay, Princess Anne Hospital, Neuro Wards, Outpatient Departments, Children's x-ray, Bursledon House, Child Health.
- Their role is to support, advise staff on safeguarding cases, and promote education and the development of staff. The safeguarding children team and CAMHS team offer monthly drop in sessions which staff are able to access. The aim is to support and educate staff on how to safeguard children and promote their welfare.
- Each children's ward have an identified safeguarding champion and their role is to attend monthly safeguarding updates which the safeguarding children team facilitate. The aim of the meeting is to educate staff on current safeguarding activity, both locally and nationally. Education updates in the last year have included bruising protocol, looked after children, hidden harm, safeguarding and children with disabilities, foster carers, ICON, training guidelines, was not brought, new processes (safeguarding proforma, flow charts) MASH referrals and record keeping.
- The named doctor holds a monthly Peer Review session where safeguarding cases are discussed. The Peer Review is a forum to support and educate staff on the safeguarding of children and includes updates on relevant policies and procedures.

A number of actions are in place to improve compliance which include:

- Training compliance addressed at the safeguarding governance steering group, where there is a requirement for each division to have a senior representative in attendance. This meeting is held every other month.
- Training compliance is highlighted within the safeguarding quarterly report.
- The named nurse has met with each divisional education lead to ensure all profiling is matched correctly for all levels of safeguarding children training.
- The named nurse, in conjunction with the divisional education leads, has reviewed and revised the level three safeguarding training requirements guidance to support practice; this will include acceptable methods of blended learning (as per intercollegiate document 2019).
- Reporting compliance review with virtual learning environment (VLE).

Child protection level 3	Sessions per year	Cancelled sessions
Professionals study day Refresher	13	0
Risk factors and hidden harm	1	0
Physical abuse	1	0
Fabricated or induced illness	1	2
Emotional abuse and neglect	2	1
Domestic violence	1	0
Children with Disabilities	1	1
Child sexual exploitation	1	1
Consultants and Senior Nurses training	3	0
Bespoke level 3 refresher	4	0

Level 3 safeguarding children training delivered in 2018/19

The table identifies the number of face to face sessions that were available for staff to book onto. The training included professional study days, the content of which supports professionals to have the knowledge, skills, attitudes and values to safeguard children (intercollegiate document 2019). The topic specific courses enable staff to enhance their knowledge and skills further in these particular areas. Cancellations were due to very low numbers booked onto the courses.

All the training delivered has been revised to reflect the national safeguarding agenda and to embed lessons from serious case reviews locally. The feedback has been very positive, examples of this include:

"Interactive, very well presented & ensured everyone's involvement"

"Informative & helpful for practice"

"I feel more confident of who to contact with concerns"

"Well discussed & explained, well planned & interesting"

"Thank you to the instructors. Delivered well"

"Thank you, it was really practical & informative"

"Really interesting/useful course, giving more insight & information in more simple ways. Very enjoyable"

In addition to the level 3 safeguarding children training, level 2 face to face training and training to the volunteers has been delivered by the safeguarding team

Level 2 - six sessions

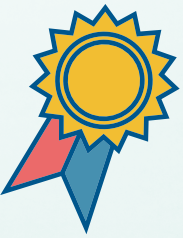
Volunteers - five sessions

SAFEGUARDING DROP-IN CLINICS

These are held on a monthly basis. The aim of the clinic is to provide all staff irrelevant of grade an opportunity to have bespoke teaching, question time and practice reflection.

SAFEGUARDING CHILDREN

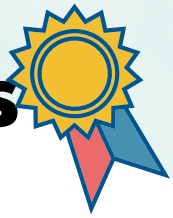
Key achievements



- Review and update of the safeguarding children policy
- Development, revision and implementation of safeguarding proforma. This is in two parts to support practice. There are identified criteria for completion. The proforma includes recording the 'voice of the child'.
- Development and implementation of '*pathway for children who are admitted to UHS and they have an allocated social worker and where there are no new concerns that child abuse is considered or suspected*'. The pathway supports staff to complete the safeguarding proforma as per the criteria and liaise directly with external agencies on child's admission and at point of discharge.
- Review and implementation of level 3 Safeguarding Children training guidelines.
- Joint targeted area inspection (JTAI) – two 'dry runs' were completed as requested by the HSCB and SSCB on intra-familial sexual abuse. An action plan has been developed to address recommendations and learning required.
- Contributed to LSCB, LSAB transition audit - awaiting final report and recommendations and actions for UHSFT.
- Section 11 audit – 4LSCB visit from the evaluation team following the section 11 audit in 2018 and staff survey. The audit identified strengths and some areas of improvement which will be monitored through the safeguarding governance steering group.
- ICON – an information leaflet for parents and carers on infant crying and how to cope. Developed following a serious case review recommendation endorsed by Hampshire Safeguarding Children Board. This is being embedded within UHS – currently maternity and neonatal services have implemented ICON.
- Following a serious case review the four LSCBs has developed a preliminary paediatrics opinion form (PPOF). This is used as part of the strategy meeting process and the purpose is to give a clear paediatric opinion about the likelihood of abuse in writing to professionals.
- Monthly themes to educate staff on safeguarding practice are developed in line with national and local policy and protocols and lessons from serious case reviews.
- Safe sleep - following a recent published serious case review in Hampshire, the four LSCBs have developed a safe sleep task and finish group with UHS representation. Following a further review, UHS safeguarding are revising their sleep advice across both midwifery, neonatal and child health services.
- APEX referral form development for safeguarding children team, planned implementation June 2019.
- Revision of the child protection and safeguarding leaflet, information for parents and carers on the medical management of children when there are concerns about actual or suspected abuse, planned implementation June 2019.
- Further development of safeguarding supervision groups for staff – Bursledon House, clinical nurse specialists, band 7 nurses.
- Maintaining good networks with multi-agency partners and local safeguarding children boards.
- Development of the safeguarding facilitator transition role for 16-21 year olds. This role is key to supporting 16 and 17 year olds who are being treated in adult and child areas. On a daily basis, the wards are contacted for all inpatient 16-17 year olds to ensure there are no safeguarding concerns. The role supports staff to recognise risk and actions required to safeguard.

SAFEGUARDING ADULTS (INCLUDING MCA AND DOLS)

Key achievements



- Hosting an LSAB multi-agency risk framework workshop in February 2019
- Maintaining good networks with multi-agency partners and local safeguarding adults boards
- Prevent E-learning packages now live
- Development of local induction packs for new starters
- Completion of joint safeguarding supervision policy
- Implementation of peer safeguarding supervision with Solent NHS Trust
- Development of volunteer induction training
- Safeguarding learning event held in November 2018
- Development of the safeguarding support worker role
- Support of domestic abuse awareness day in October 2018
- Completion of the safeguarding adults dashboard
- Completion and ratification of updated MCA/DoLS policy
- Appointment of executive MCA lead
- Improved oversight and scrutiny of patients deprived of their liberty within the Trust and the introduction of DoLs ward rounds
- A dedicated 0.8 WTE band 7 supported the team for 10 months to undertake a focused MCA/DoLs project which included:

1. Development of new MCA/DoLS training package
2. MCA awareness week held in October 2018 to promote the new policy and training package. This included attending wards to provide information and advice.
3. Development of the MCA/DoLS newsletter which is produced bi - monthly forums
4. Development of MCA/DoLs bi-monthly forums
5. Development of MCA champion programme

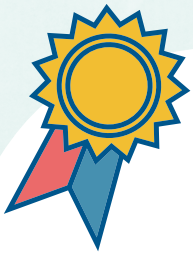
Ongoing challenges and risks

- Safeguarding adults training – a new intercollegiate document was published in August 2018. UHSFT adults and children's are keen to collaborate with NHS partners across the STP footprint to develop a 'think family' training package for levels 1, 2 and 3.
- The MCA and DoLs agenda continues to be a challenge both locally and nationally. Nationally, the Mental Capacity Amendment Act is awaiting Royal Assent and is due to be implemented in Spring 2020. This will see the introduction of the Liberty Protection Safeguards (LPS) which will be a big shift in practice, with a greater emphasis on the Trust to review and sign off deprivations. It does not appear that any extra funding will be available to support implementation, although exactly what this looks like in practice remains to be seen. The Code of Practice is currently in development. Locally, the team will continue to drive improvements through policy development and training in line with national / statutory amendments.

Joint key areas of work 2019/20

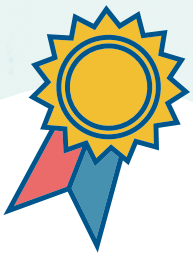
- Raise awareness of the safeguarding dashboard to ensure it is effective in supporting divisional governance arrangements / scrutiny around safeguarding
- Continue to improve governance arrangements to facilitate learning from safeguarding reviews
- Develop joint adult and child training package in line with the respective intercollegiate documents
- Complete the joint supervision policy – awaiting ratification
- Continue alignment around safeguarding agenda specialities e.g. ED and maternity
- Continue to improve the use of technology - Apex
- Continue to raise awareness of the MCA & DoLs agenda including preparation, where possible, for the implementation of LPS
- Completion of the safeguarding strategy

LEARNING DISABILITY /AUTISM LIAISON SERVICE



Key achievements

- Completion and delivery of year one of UHS learning disability strategy 2018-2021.
- Learning disability and autism working group established - commitment from divisional reps and chaired by division head of nursing for division D.
- Proposal for band 4 senior healthcare assistants (HCAs) accepted. Recruitment of 2 x senior HCAs in quarter 3.
- Attendance at Mencap's official launch of the 'Treat me Well' campaign in London (February 2018) which has led to: UHSFT signed up to the three year campaign focusing on improving hospital care for people with learning disability and autism. Awareness raised during learning disability awareness week, June 2018. Free training events secured and run by Mencap for UHS staff (2 x learning disability awareness days and 1 x facilitator training) September / October 2018.
- Development of UHS learning disability champions. 81 members of staff have signed up to the champions programme - 11 attended the first training date in March. A further 30 are signed up over the next two training dates.
- Completed the NHS benchmarking data collection project. This project benchmarked all NHS care providers against the NHS learning disability improvement standards. Awaiting final data analysis and report.
- Automatic email alerts in place from January 2019 (linked to the eCamis flags) resulting in early notification of admissions for patients with a learning disability and / or autism. Increase in referral rates are reflected in the activity data.



- White board symbols for learning disability and autism went live in March 2019 to support in the identification of patients who may need reasonable adjustment.
- Successful applications for two places on Health Education England's Wessex Learning Disability Fellowship programme which commences October 2018 for 12 months.
- Project work from fellowship focuses on increasing the numbers of learning disability nursing students and includes - establishing links with Winchester University, participating on open days (recruitment for nurses) and supporting development of the curriculum.
- Partnership working with head of patient experience on accessible information standards. Working group established.
- Complex and delayed discharge working group established in partnership with adult services and commissioners to explore slow stream rehabilitation services, intensive therapy requirements, lead coordination roles and multi-disciplinary team approach and funding for familiar care staff. Potential for care pathway to be developed.
- Partnership work with Southern Health Foundation Trust and commissioners to develop continuing professional development support for liaison nurses. This includes setting up a network support group for local LD nurses in acute liaison posts.
- Official opening of the changing place toilet facility in line with the national strategy, led by the Mayor of Southampton and the Trust's CEO.
- Representation on task and finish group following a recent local Safeguarding Adults Review (SAR) involving a gentleman with a LD.
- Regular attendance at the LD partnership board, patient experience committee, and end of life steering group.
- Contribution to the complaints process - including partnership working with patient support services and facilitating complex cases.
- Ongoing contribution to the Learning Disability Mortality Review Programme (LeDer) process both locally and nationally.
- Establishment of student nursing placements within the team for both general adult and learning disability nurses in partnership with Hertfordshire, Winchester and Portsmouth Universities.
- Collaboration with children's LD liaison nurse to facilitate smoother transition between child and adult services.

AUTISM SPECIFIC ACHIEVEMENTS

- Completion of UHS autism strategy 2018-2021.
- Secondment post to support the development of the autism strategy and work plan commenced quarter 2. The nurse in post is an expert by experience.
- Autism awareness training presented to patient support services, cardiology conference, surgical pre-assessment teams.
- Agreement to hold autism mortality reviews within UHS (not a requirement of LeDeR but to ensure learning opportunities maximised in line with the NHS improvement standards).
- Development of autism hospital passport.

CHALLENGES

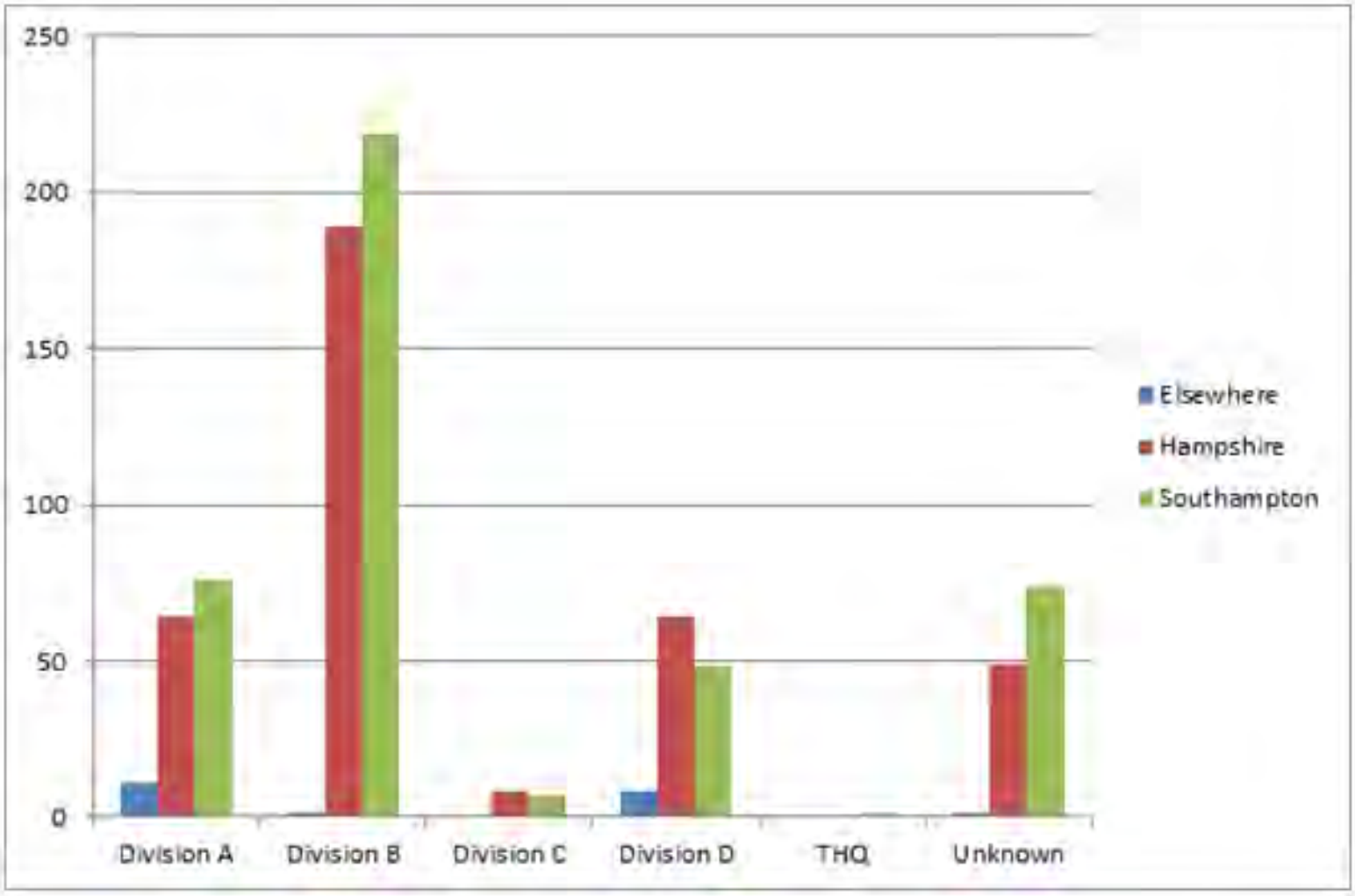
- Recognition that clinicians often have limited awareness and / or knowledge of learning disabilities and autism.
- Poor application of the Mental Capacity Act in practice, especially in complex decision making with these patient groups.
- Lack of clinical lead for learning disability and autism.
- Inconsistent representation of divisional areas at learning disability and autism working group.
- Delayed discharges specific to these patient groups due to change in circumstances, lack of pre-planning and the complexities of recovery and rehabilitation. Evidence of increased length of stay.
- Data collection – there are currently several different ways of referring to the team making it difficult to analyse and triangulate data.

KEY AREAS OF WORK FOR 2019/2020

- Ongoing delivery of the LD and autism strategies
- An increased focus on training, to include ongoing development of the champions programme.
- Learning disability quality contract developed in partnership with local CCG – now in place for 2019/2020 - focused on implementation of the NHS learning disability improvement standards. This includes learning disability / autism friendly wards.
- Development of an Apex module as a model for referring and case managing patients with an LD and / or autism.
- Refresh of the clinical lead role - revisiting roles and responsibilities.
- Ongoing collaboration with the patient experience team to further develop the carers strategy and the use / availability of accessible information.

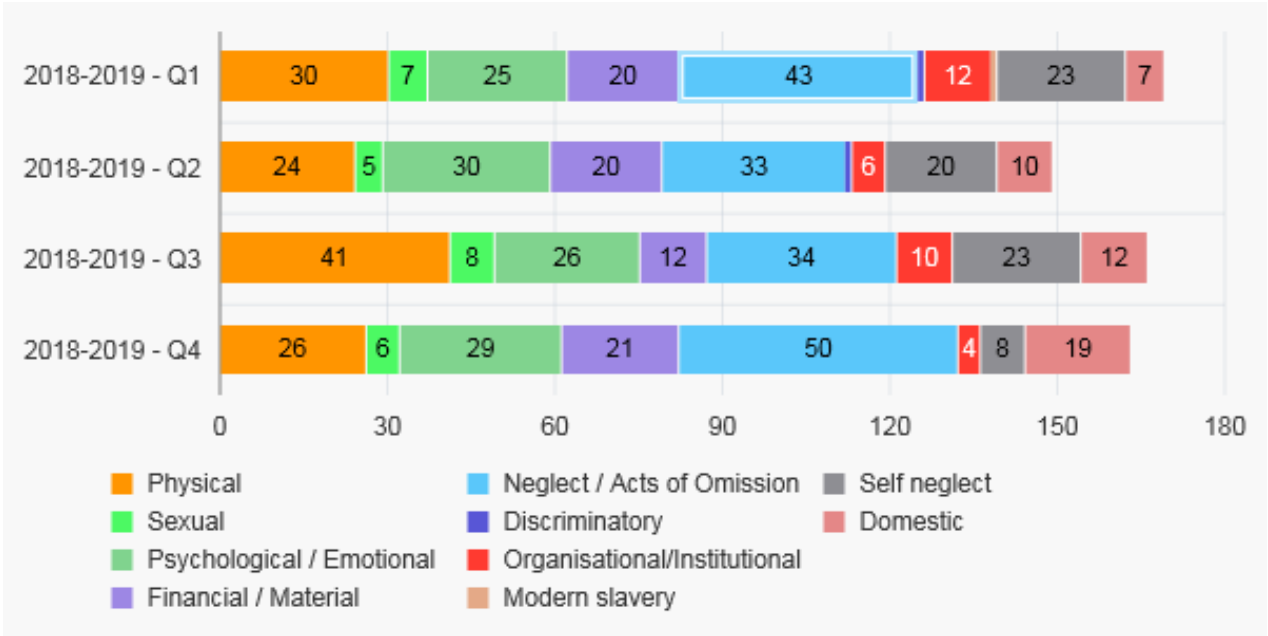
APPENDIX 1 - SAFEGUARDING ADULTS DATA

REFERRALS 01 APRIL 2018 - 31 MARCH 2019 (BY DIVISION AND LOCAL AUTHORITY)



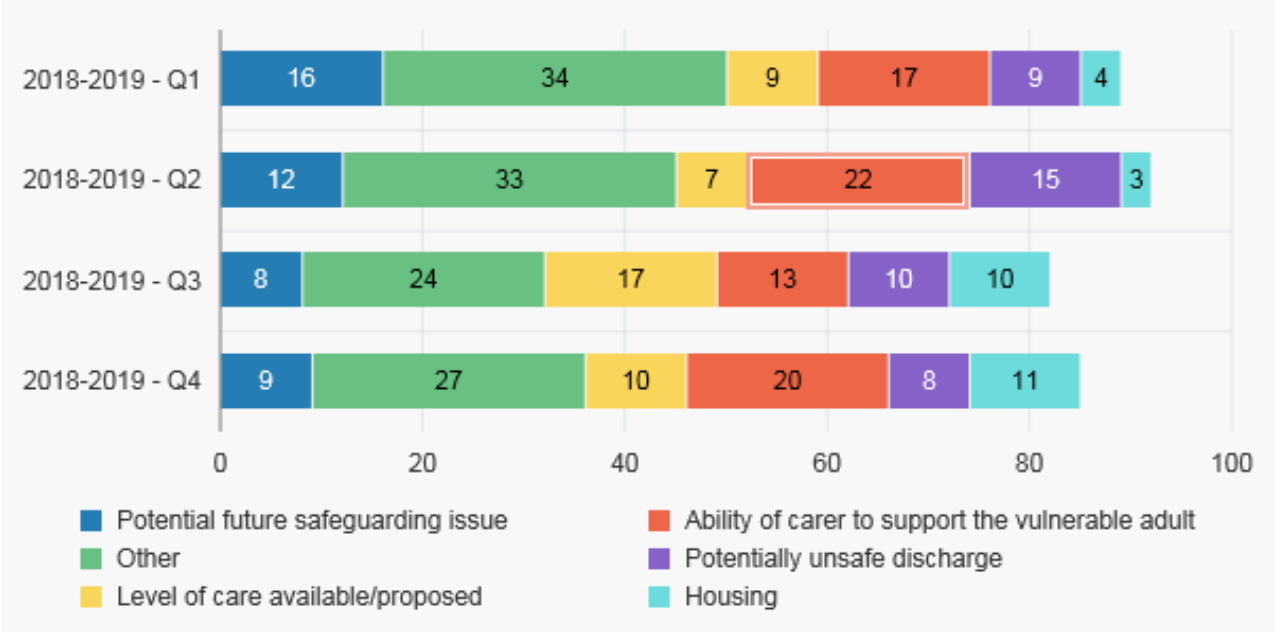
The graph shows that the team received 866 referrals over the year. This is up from 808 referrals in the 17/18 annum. The graph also shows the two main local authority areas that UHS continues to work with. There is a small proportion of other local authorities and this is possibly due to being a regional trauma centre. The team will liaise with these as and when required. The unknown data is from quarter 1 and 2 last year before it became mandatory to record the location from where the concern form is being raised.

CONCERN RAISED BY CATEGORY OF ABUSE 01 APRIL 2018 - 31 MARCH 2019



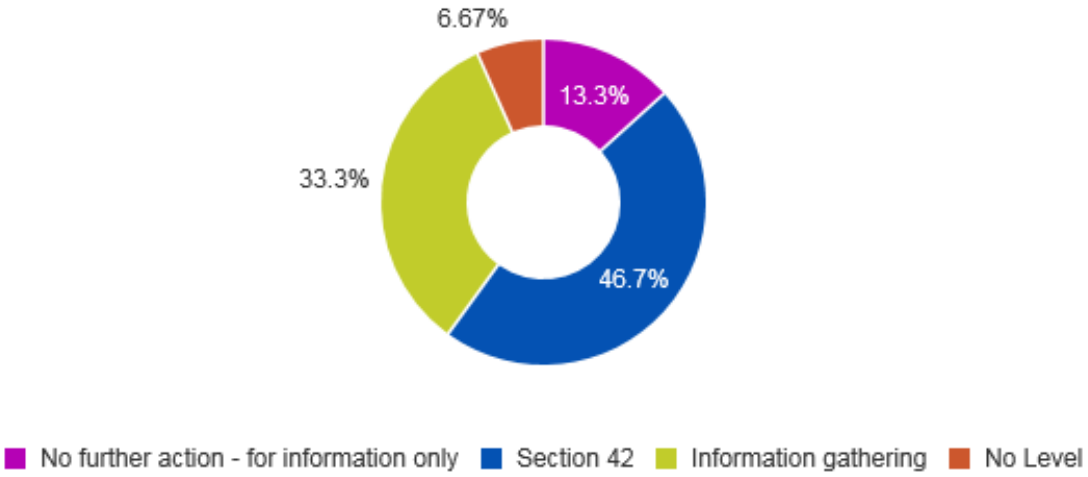
Of the 866 adult safeguarding adult concern forms raised to the team, 646 of those were highlighting suspected abuse or neglect. Neglect / acts of omission remain the highest reported category.

CONCERN RAISED BY OTHER CATEGORY 01 APRIL 2018 - 31 MARCH 2019



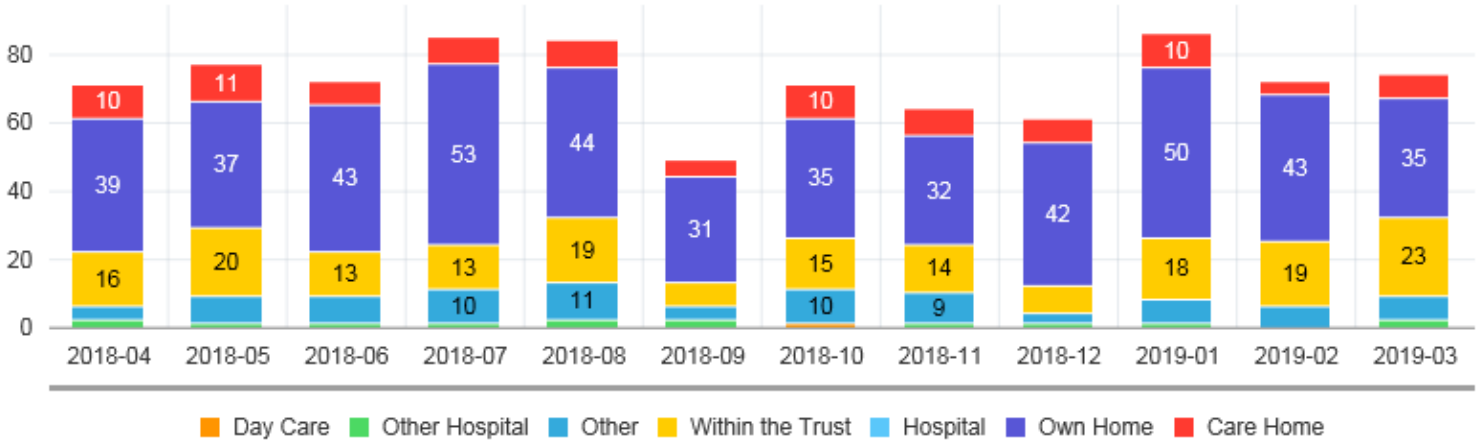
348 of the safeguarding adult concern forms raised were highlighting concerns that do not come under the Care Act (2014) as neglect or abuse. The safeguarding adults concern forms are designed specifically to allow staff to raise any concern and the team will sign post / refer on to the most appropriate service as necessary. NB. Please note that some concern forms will have more than one category ticked.

LEVEL OF ENQUIRY - OPEN CASES 01 APRIL 2018 - 31 MARCH 2019



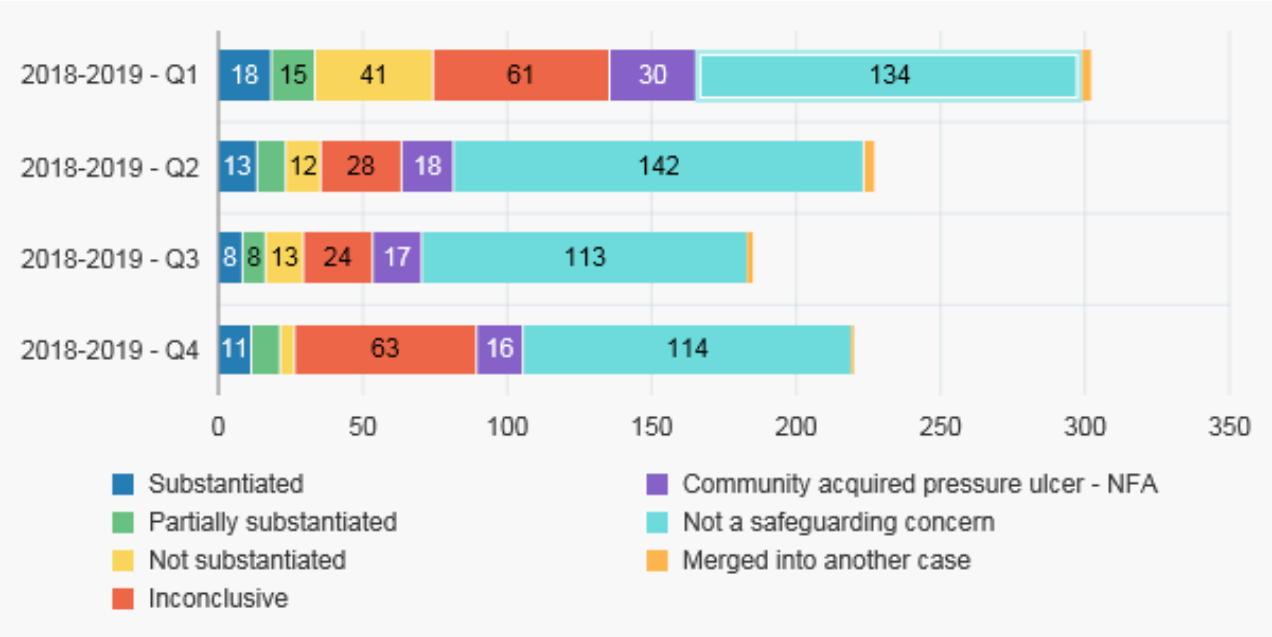
46.7% of the cases where suspected abuse or neglect were raised proceeded to a statutory section 42 enquiry - this is compared to 11% last year. 33.3% of cases required information gathering only. 13.3% of cases required no further safeguarding action - these are the cases which are triaged as not meeting the safeguarding threshold however are often referred to other agencies for complex case management. 6.67% of cases had no data attributed to their outcome. This has now been refined to become a mandatory field therefore will always be captured in the coming year.

CONCERN LOCATION 01 APRIL 2018 - 31 MARCH 2019



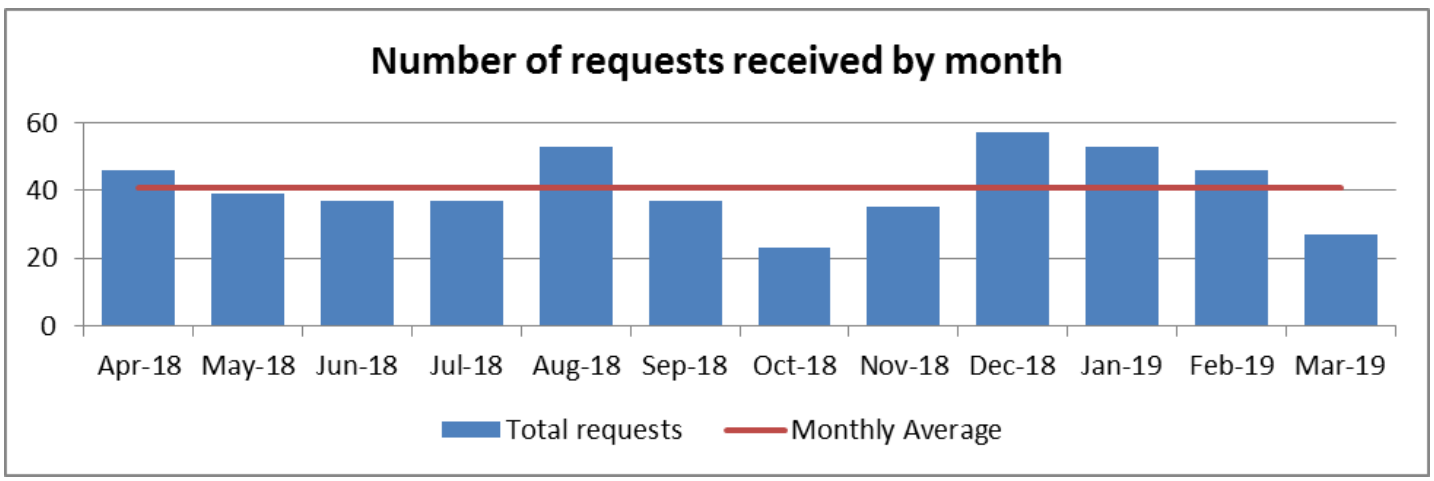
This graph shows that 188 of the concerns raised were due to potential harm or abuse within the trust. These are all screened at daily safeguarding huddle by local authority partners and managed as appropriate. The safeguarding team links closely with the patient safety and patient experience teams to manage concerns as and when appropriate.

OUTCOMES 01 APRIL 2018 - 31 MARCH 2019



The number of cases referred that do not meet the threshold as a safeguarding concern (i.e. meet the 'three part test' as defined in the Care Act, 2014) rose from 212 to 503. This could be due to two reasons - the form is designed to encourage any concern if they feel something isn't right, and that there is an education need around 'what is safeguarding'.

NUMBER OF DOLS REQUESTS BY MONTH

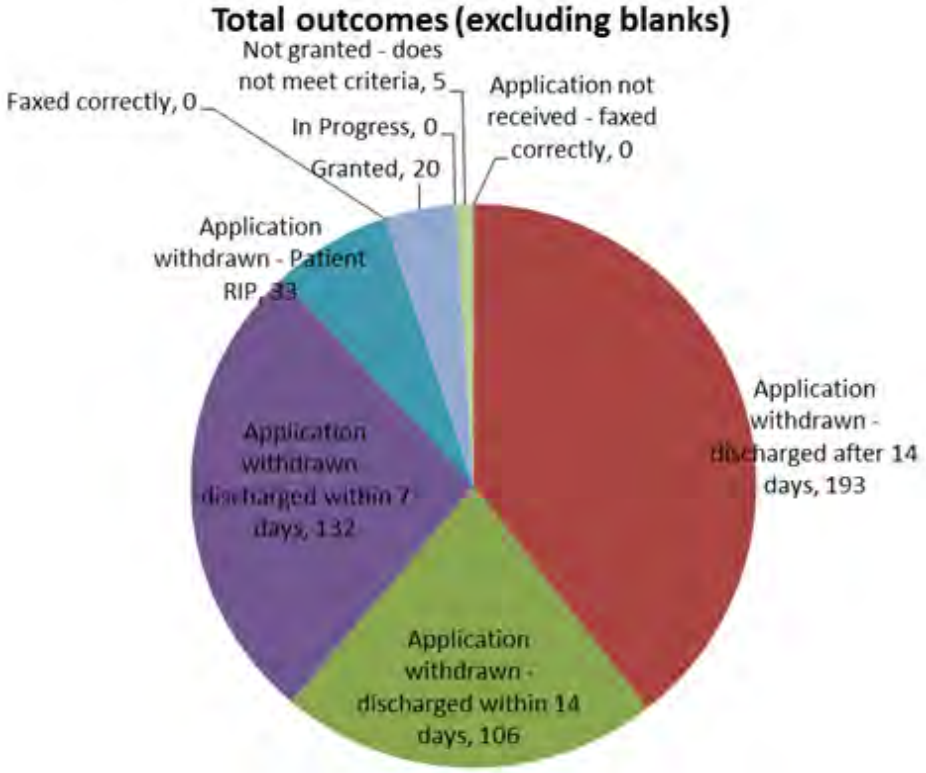


NUMBER OF DOLS REQUESTS BY MONTH SPLIT BY DIVISION AND CARE GROUP

Area	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Area Total
Division A	7	3	10	6	8	4	3	2	6	7	3	2	61
Cancer Care	1	0	2	1	2	1	1	1	1	2	2	1	15
Critical Care	2	2	8	2	5	2	1	1	2	3	1	0	29
Surgery	4	1	0	3	1	1	1	0	3	2	0	1	17
Division B	29	29	20	18	31	20	14	18	30	33	28	25	295
Emergency Medicine	4	5	5	5	5	4	1	1	2	2	0	2	36
Medicine	25	23	15	13	25	16	13	17	28	31	28	23	257
Ophthalmology	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Medicine	0	1	0	0	1	0	0	0	0	0	0	0	2
Division C	0	0	0	0	0	0	0	0	0	0	0	0	0
Women & Newborn	0	0	0	0	0	0	0	0	0	0	0	0	0
Division D	10	7	7	13	14	13	6	15	21	14	15	12	147
CV&T	3	3	1	2	0	10	3	4	9	2	1	2	40
Neurosciences	5	4	3	9	11	3	1	10	6	6	12	6	76
Orthopaedics	2	0	3	2	3	0	2	1	6	6	2	4	31
No Ward	0	0	0	0	0	0	0	0	0	0	1	0	1
Grand Total	46	39	37	37	53	37	23	35	57	54	47	39	504

This table shows that there were 504 DoLs applications made this year which is an increase from 376 last year. Division B continue to make the highest number of applications which is consistent with the care groups that sit within it which include medicine for older people and emergency medicine.

DOLS APPLICATION OUTCOMES APRIL 2018 - MARCH 2019



Only 20 of these applications were granted by the supervisory body. Due to the delay in getting assessed by a best interest assessor (this is a nationally recognised problem which is why there are reforms to the Mental Capacity Act), 464 applications were withdrawn before assessment could be undertaken.

APPENDIX 2- learning disability and autism team activity

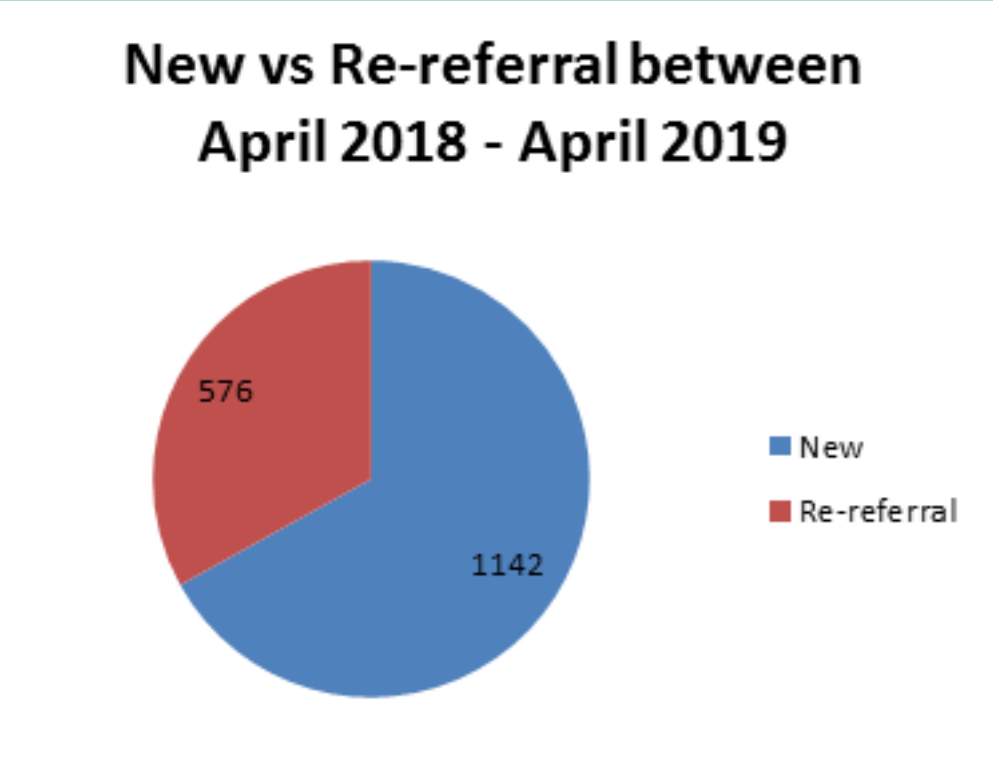
Referrals (source)	No.
EQuest	61
Automatic	249
Other	38
Total	**348**
Automatic referrals by division	
Division A	24
Division B	202
Division C	1
Division D	22
Total	**249**
Automatic Referrals by specialty	**No.**
Learning Disability	226
Autism	11
Inappropriate referrals)	**No.**
Learning Disability & autism	12
Total	**249**
EQuest referrals by division	**No.**
Division A	7
Division B	42
Division C	2
Division D	10
Total	**61**

	Q1	Q2	Q3	Q4	Totals
Total referrals:	153	107	127	348	735
Clinical Group (LD):	123	84	92	337	636
Clinical Group (Autism):	20	17	13	11	61
Inappropriate referrals:	25	6	22	12	65

External referrals	No.	Internal referrals	No.
Referral by family	5	Cardiac CNS	2
Referral by CNLD (Salisbury)	1	Breast CNS	1
Referral by IOW Acute Liaison	1	Colorectal CNS	2
Referral from Choices Advocacy	1	Consultant	2
Email from social worker	2	Ward / ward sister	4
Referral from Southern Health	3	ECST	1
Referred by care provider	1	VAST	1
		Safeguarding	1
		Paediatrics	1
		Internal email referrals (other)	9
Total	**14**		**24**

This years referral figures show a significant increase from last year across all quarters. The number of referrals reflected in quarter 4 reflects the automatic mechanisms now in place for flagging when a patient with a known learning disability and / or autism presents in the trust.

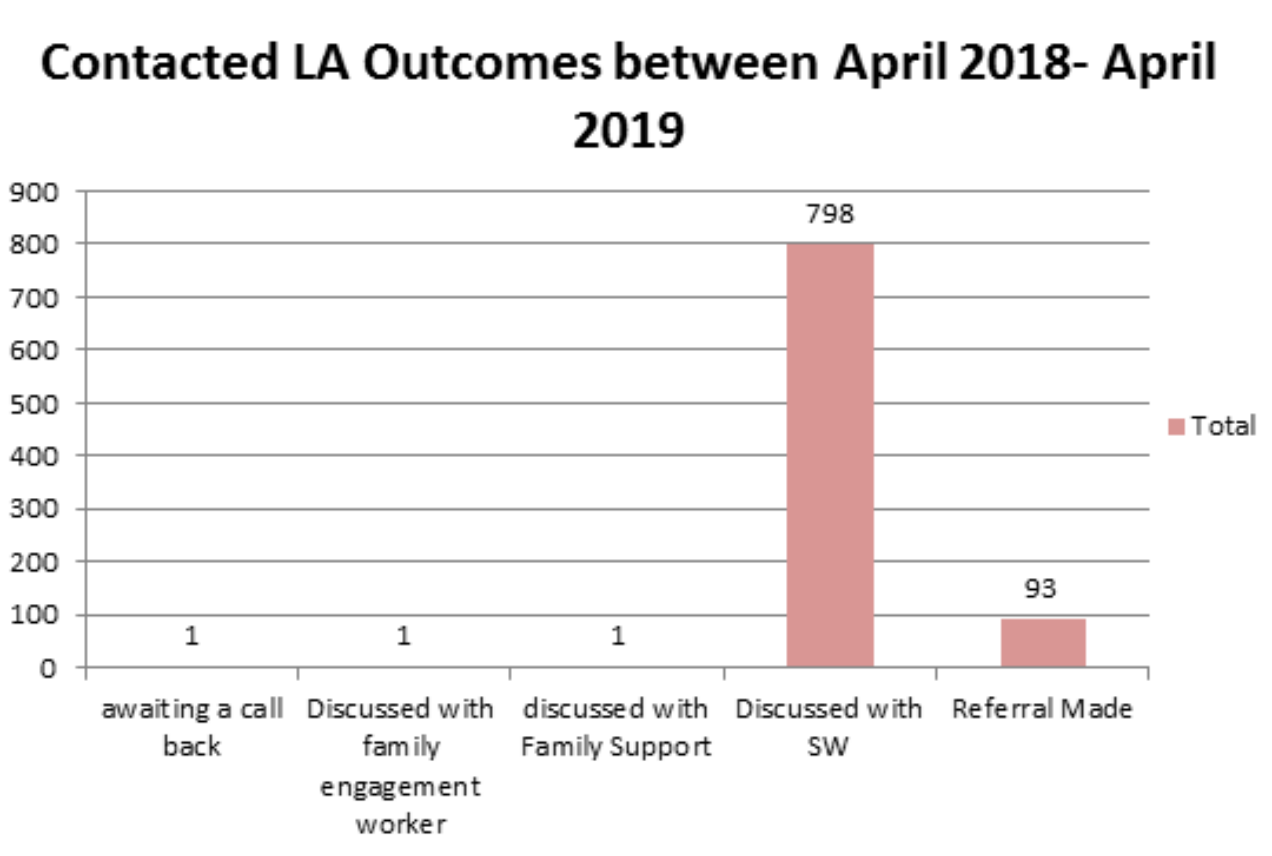
APPENDIX 3 - SAFEGUARDING CHILDREN DATA



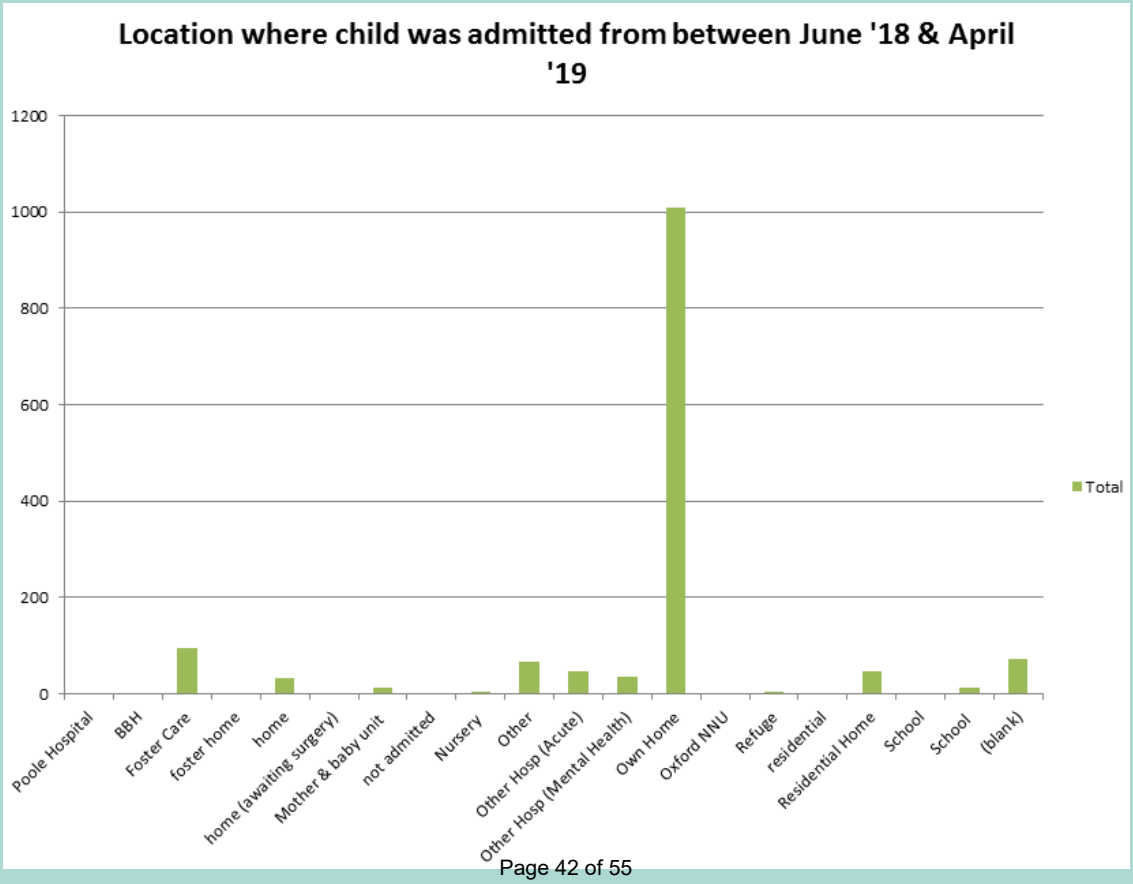
Total referrals - 1718

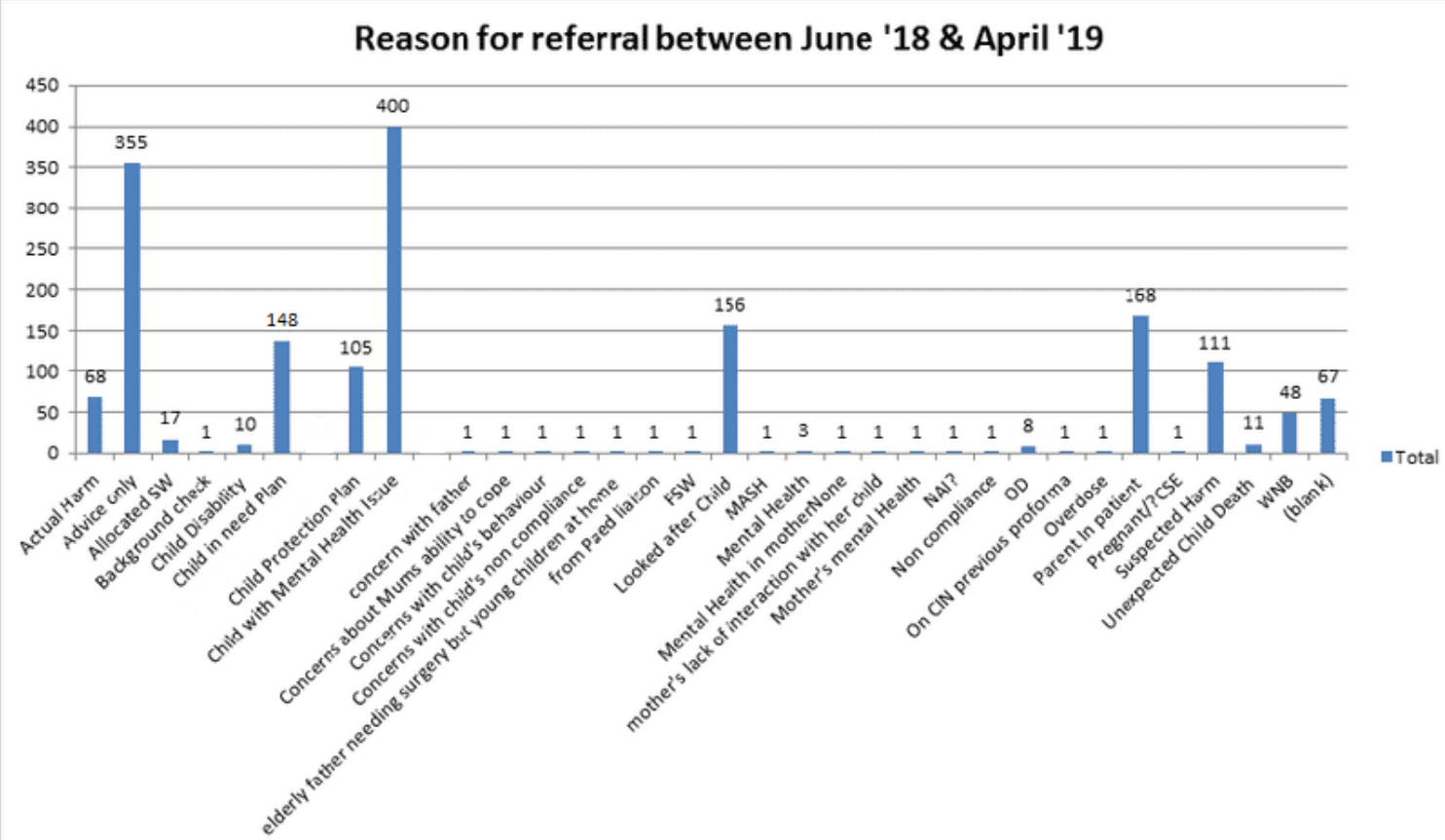
The total number of referrals that the team managed in 18/19 totalled 1718. Reviewing the data, from 2017-2018, the number of referrals to the safeguarding children team totalled 1547, Identifying an increase of 171 for 18/19. The increase could be attributed to more robust capture of advice calls, where the safeguarding nurses are not required to open the case due to the low level of concern but would support staff to take the necessary actions to safeguard the child, which would include liaison with other agencies.

Contacted LA Outcomes between April 2018 - April 2019



This graph shows the numbers of referral to the safeguarding team where children social services were contacted to discuss the case. This would include cases already open to them. The graph also indicates the number of referrals made to children social services where the threshold for assessment (section 17 or 47) by them was required.





This graph identifies the greatest reason for referrals to the safeguarding children team. Significantly the largest reason for referral was for children presenting with mental health issues. The statistic possibly reflects the national picture of increased numbers of children presenting with significant mental health issues. Referrals to the safeguarding children team has enabled collaborative working with the CAMHS team, ward staff and external agencies to safeguard the child.

More detailed analysis has been captured since June 2018. The new Apex referral system which will go live in June 2019 will align with the data analysis from June 2018 on wards. Significantly, a large number of referrals to the safeguarding team were due to children with a mental health issue.

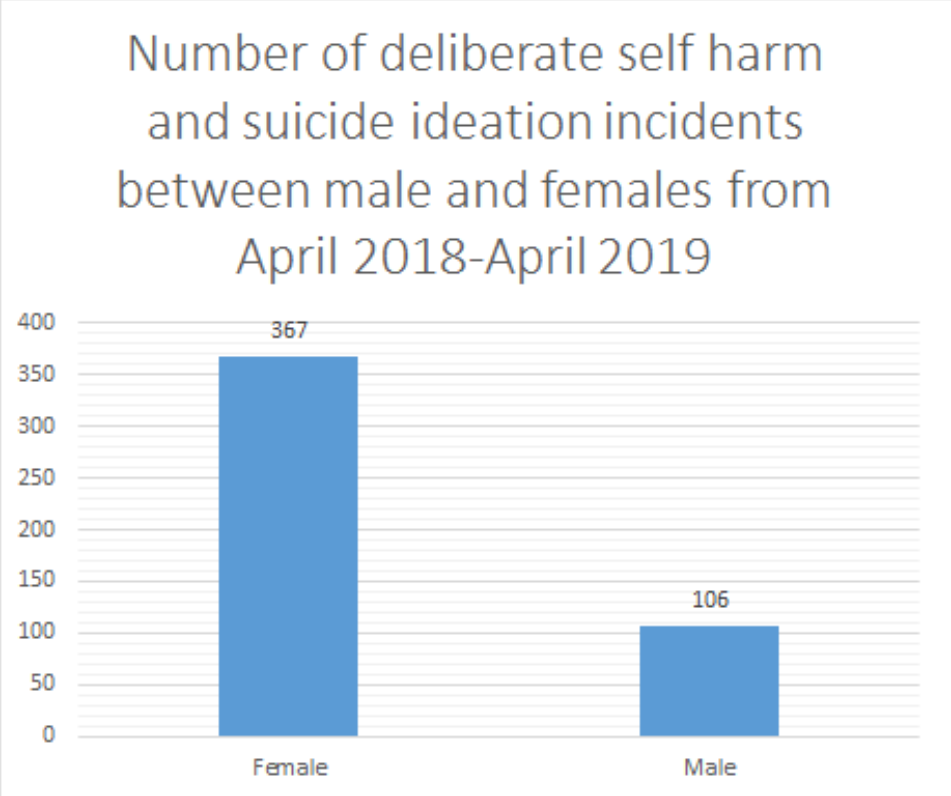
Abbreviations

SW - Social Worker
CIN - Child In Need
FSW - Family Support Worker
MASH - Multi-Agency Safeguarding Hub
NAI - Non Accidental Injury
OD - Overdose
CSE - Child Sexual Exploitation
WNB - Was Not Brought

APPENDIX 4 - PAEDIATRIC LIAISON DATA

Information sharing referrals from the Emergency Department to the Paediatric Liaison Service.

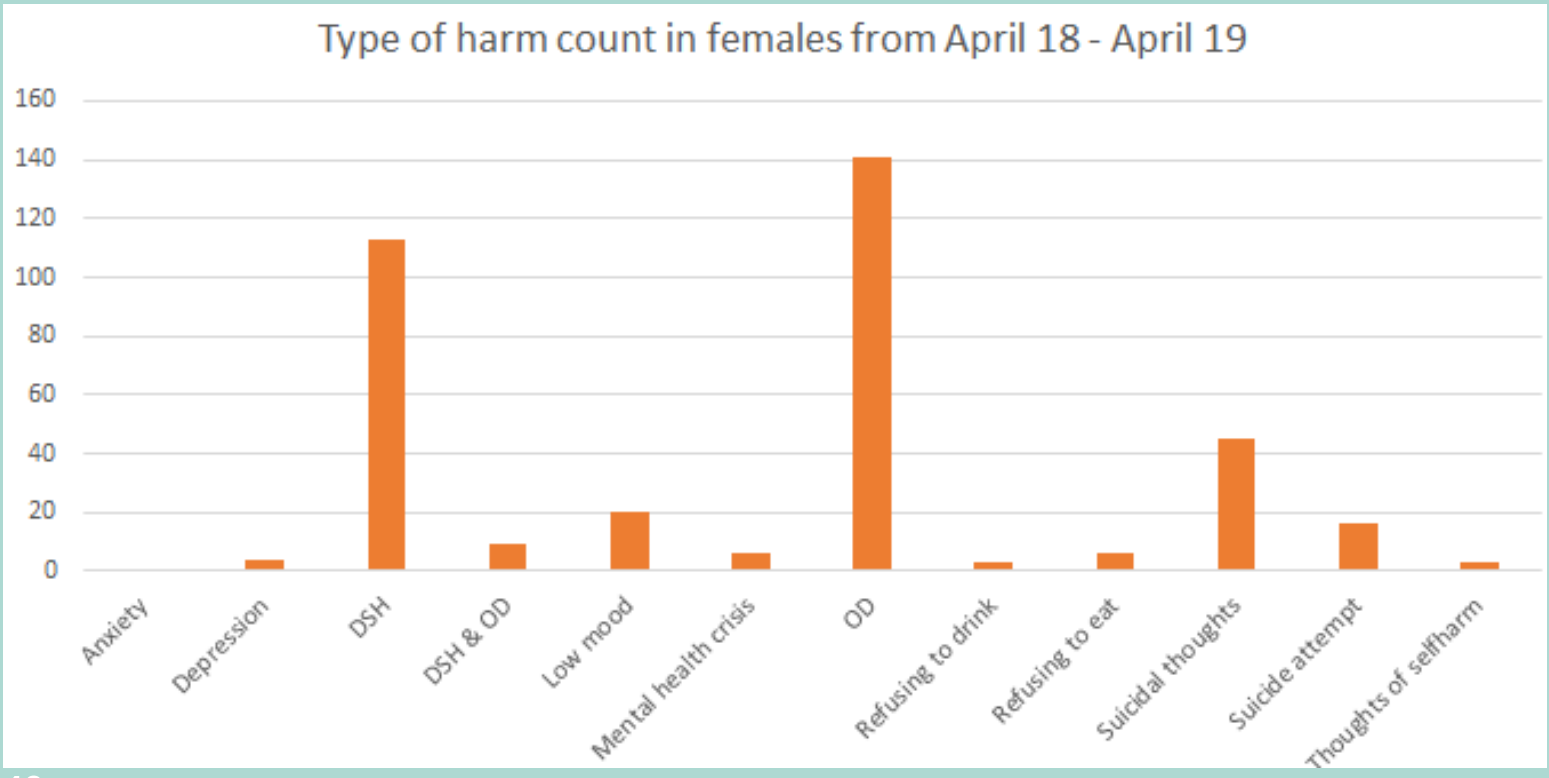
In 2018/19 the Paediatric liaison service received 2794 referrals for the team to action. This is figure is consistent with the number of referral from 2017/18As the service is transferring to the safeguarding team in April 2019, further analysis will be included in the 2019/20 annual report.

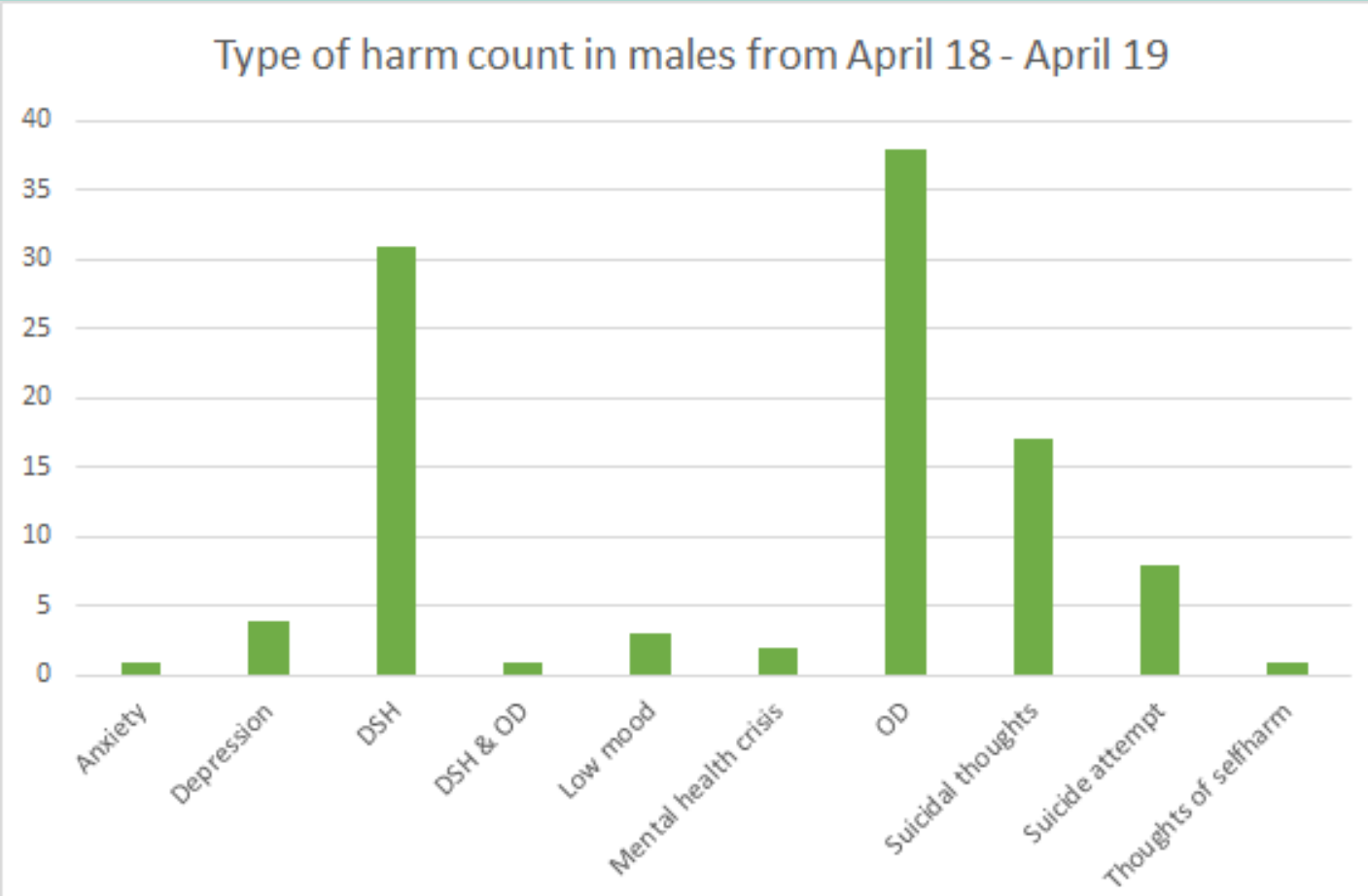


The total number of emergency department attendances at Southampton General Hospital during April 2018-April 2019 was 473 - of which 367 were female and 106 were male. Following these attendances, 264 females and 74 males were admitted to the hospital for further treatment due to their presentation.

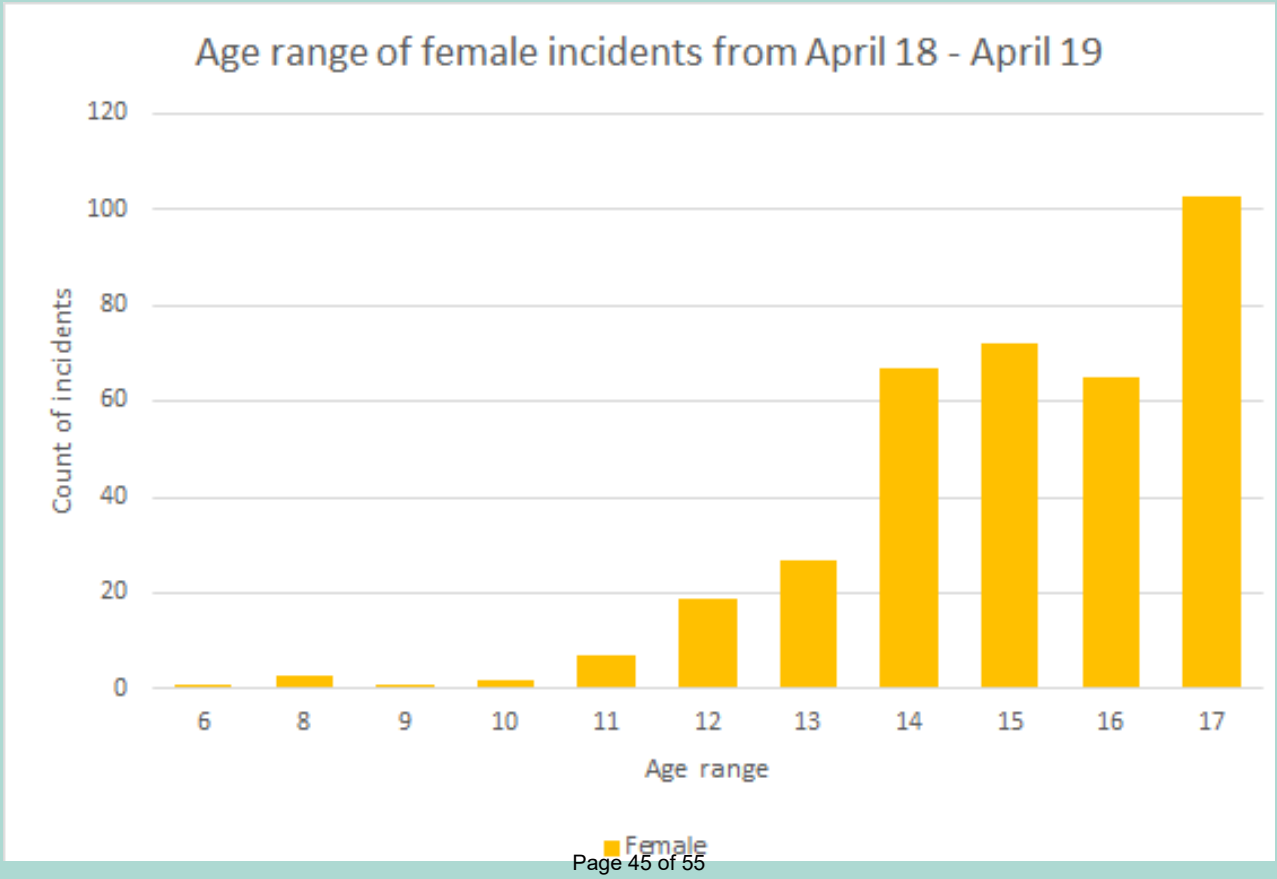
Abbreviations

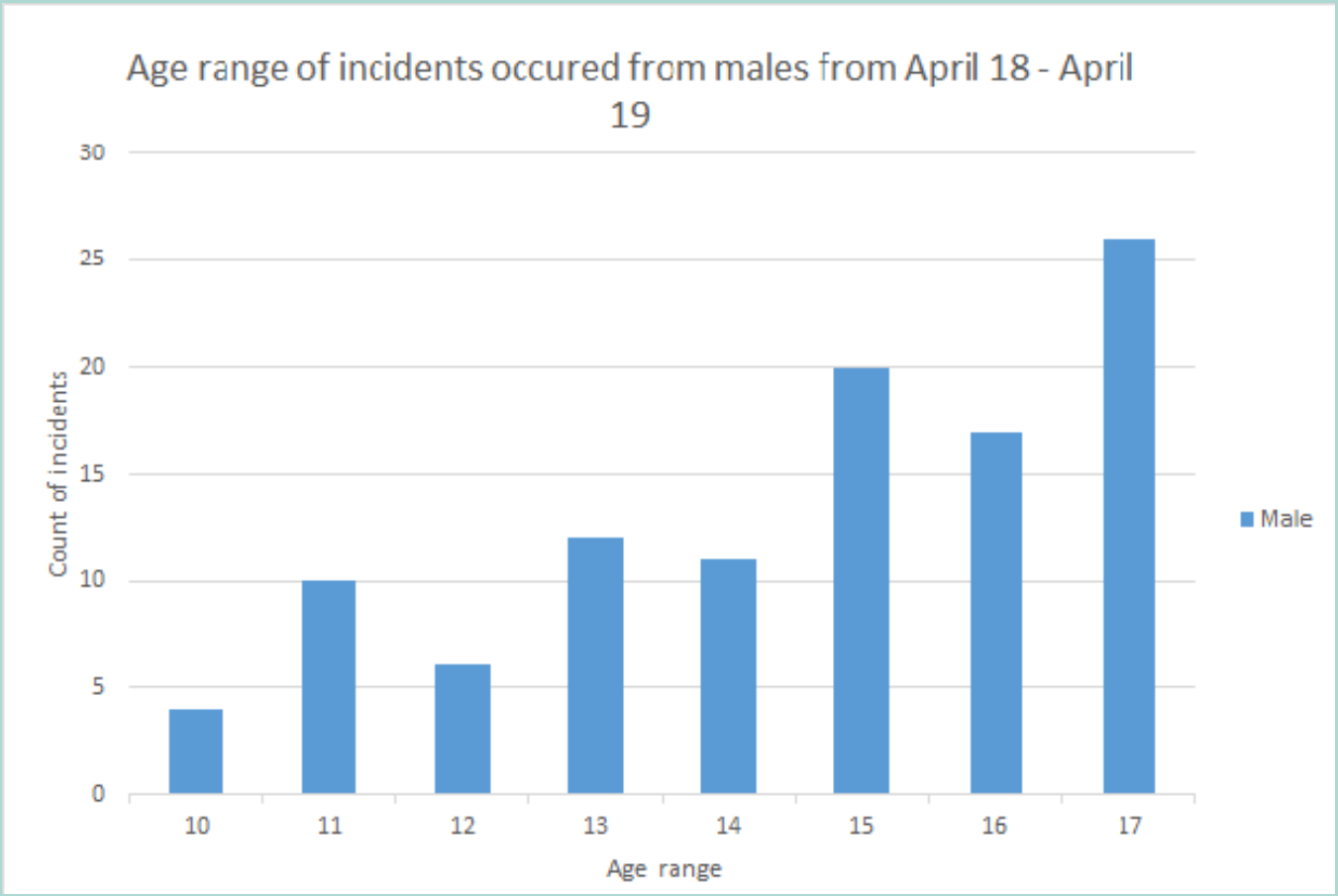
OD - Overdose
DSH - Deliberate Self Harm
LBT - Left Before Treatment

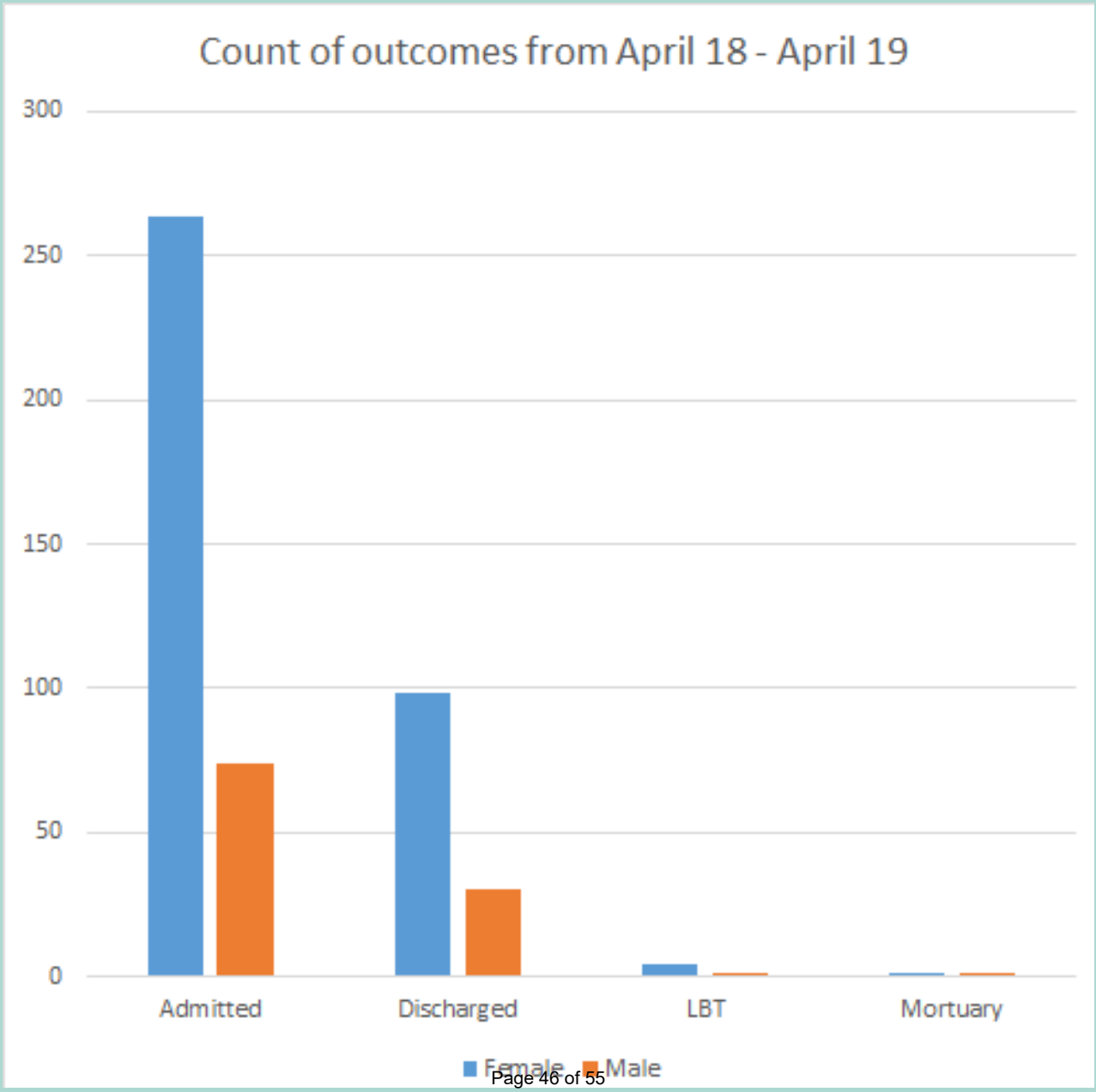




The records identify that the female presentations were significantly higher due to overdoses (113 attendances) and deliberate self harm (113 attendances). Whereas despite Male presentations remaining highest overall with overdoses (38 attendances) and deliberate self harm (31 attendnaces) methods the actual attendance numbers were lower in males.



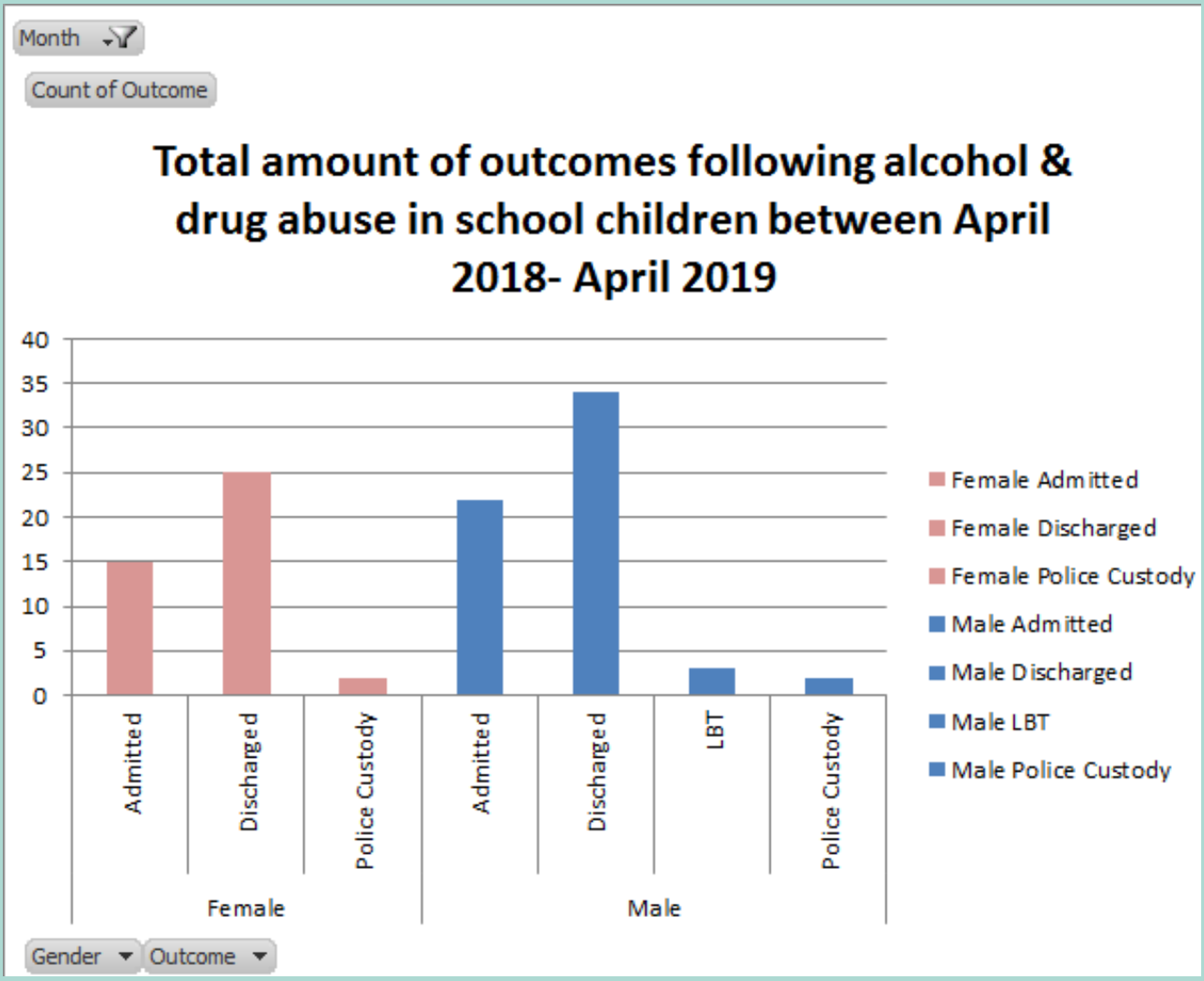

Age range of incidents occured from males from April 18 - April 19
30
25
20
15
10
5
0
Count of incidents
10
11
12
13
14
15
16
17
Age range
Male

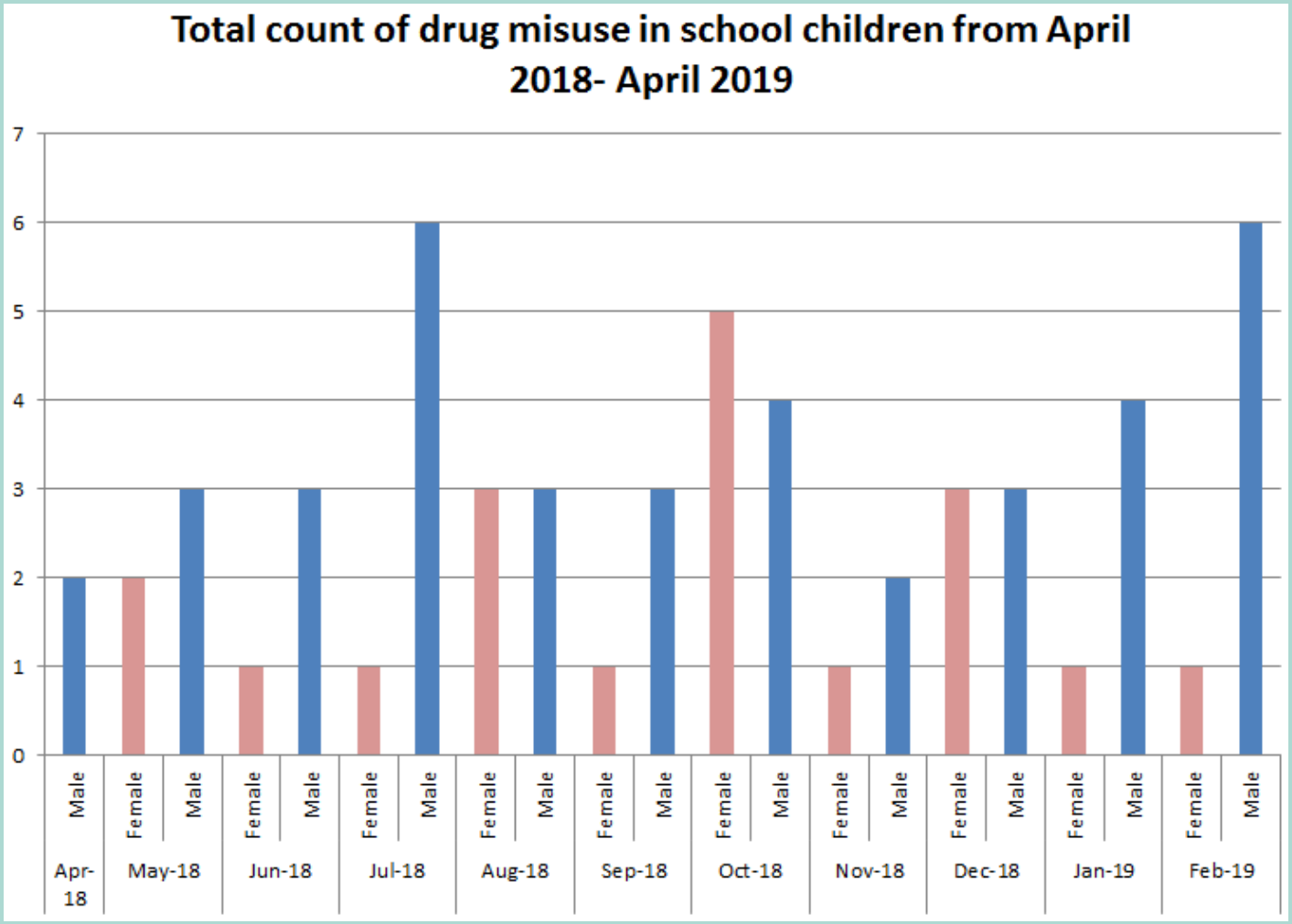

Count of outcomes from April 18 - April 19
300
250
200
150
100
50
0
Admitted
Discharged
LBT
Mortuary
Female
Male

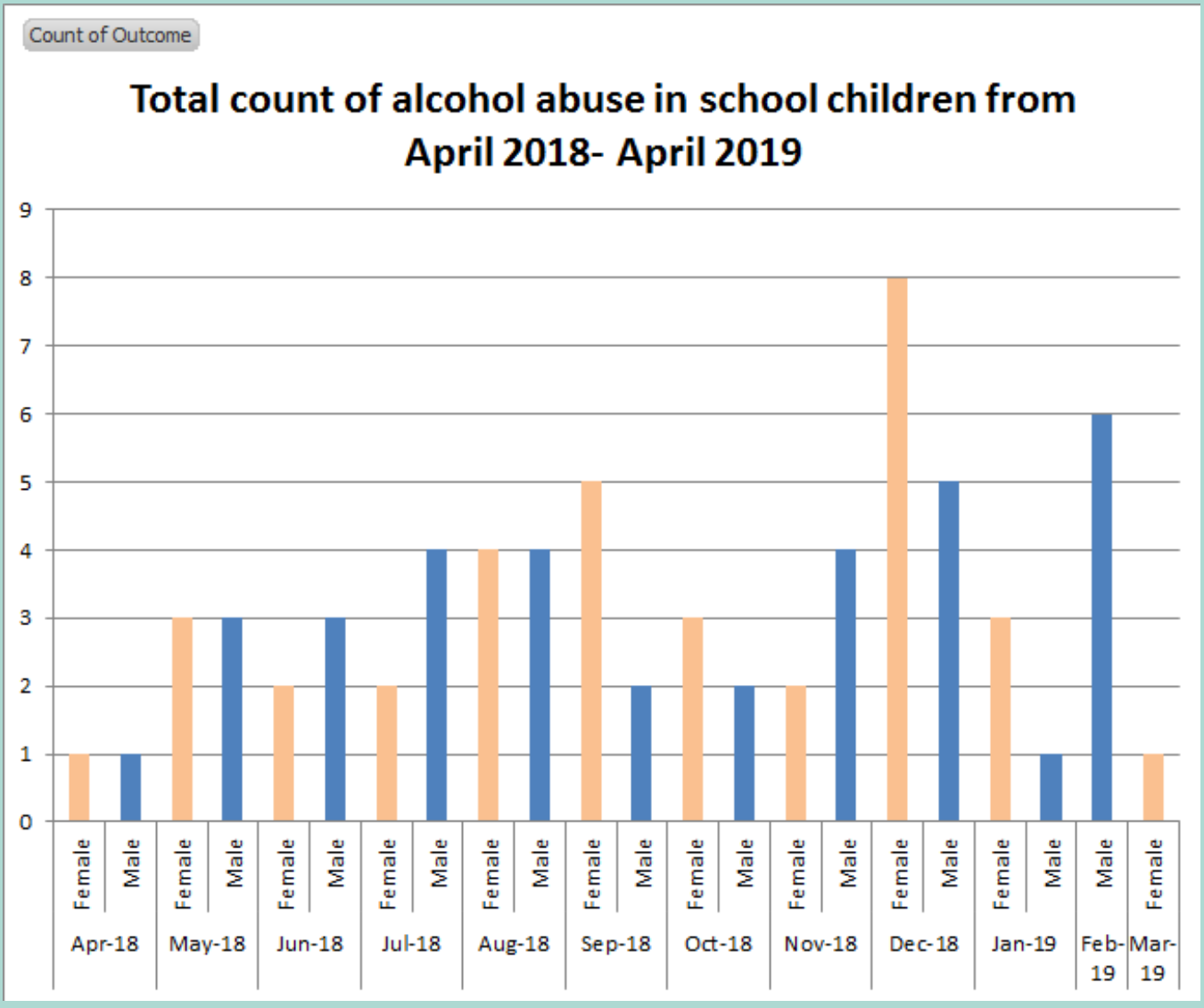
There is a significant increase in the number of deliberate self harm and suicidal ideation emergency department attendances for 17 year old females - 103 incidents - whereas the spike for 17 year old males is not as high with 26 incidents.

This is also reflected with females aged 14 (67 incidents), 15 (72 incidents) and 16 (65 incidents) and males aged 15 (20 incidents) and 16 (17 incidents) with smaller spikes for males aged 11, 13 and 14 years old.

The youngest reported incident was a six-year-old female who was experiencing suicidal ideation. Sadly one 16 year old male and one 11 year old female died in the emergency department due to suicide during April 2018 – April 2019.




Total count of drug misuse in school children from April 2018- April 2019
7
6
5
4
3
2
1
0
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19


Count of Outcome
Total count of alcohol abuse in school children from April 2018- April 2019
9
8
7
6
5
4
3
2
1
0
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Male
Female
Apr-18
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Aug-18
Sep-18
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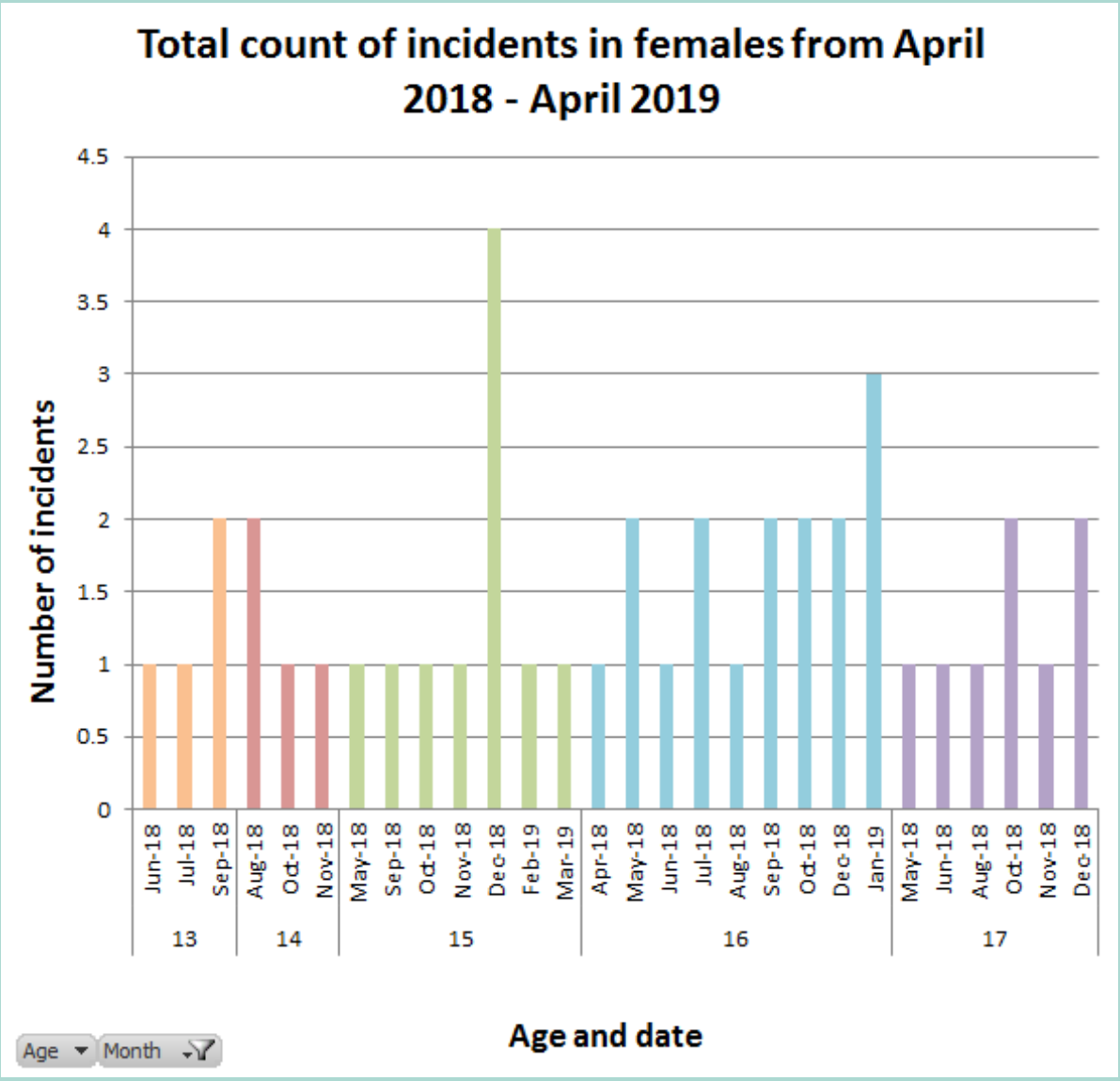
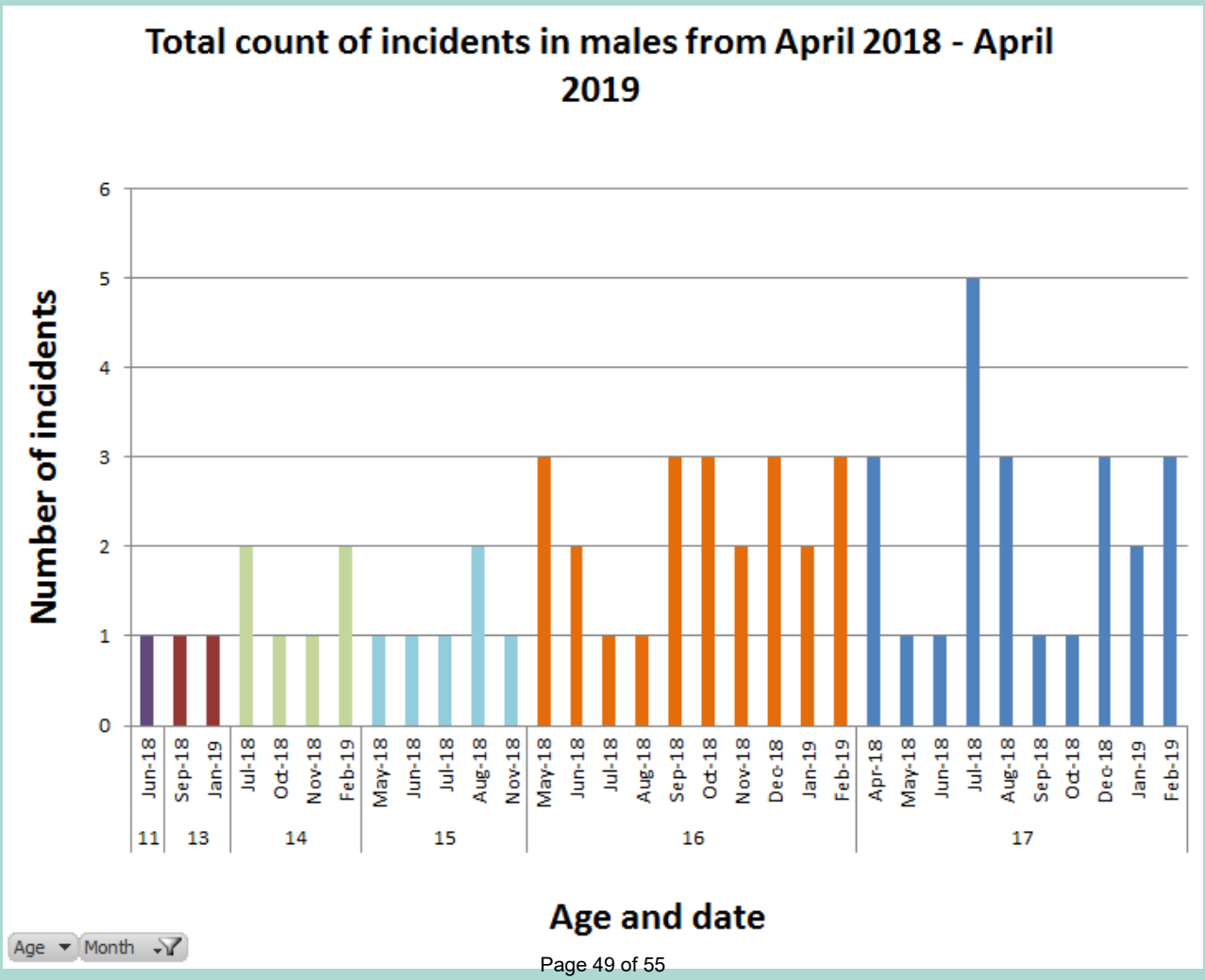
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19


Total count of incidents in females from April 2018 - April 2019
Number of incidents
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Jun-18
Jul-18
Sep-18
Aug-18
Oct-18
Nov-18
May-18
Sep-18
Oct-18
Nov-18
Dec-18
Feb-19
Mar-19
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Dec-18
Jan-19
May-18
Jun-18
Aug-18
Oct-18
Nov-18
Dec-18
13
14
15
16
17
Age and date
Age
Month


Total count of incidents in males from April 2018 - April 2019
Number of incidents
6
5
4
3
2
1
0
Jun-18
Sep-18
Jan-19
Jul-18
Oct-18
Nov-18
Feb-19
May-18
Jun-18
Jul-18
Aug-18
Nov-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Dec-18
Jan-19
Feb-19
11
13
14
15
16
17
Age and date
Age
Month

The total number of emergency department attendances at Southampton General Hospital during April 2018-April 2019 due to alcohol was 69 - of which 35 were male and 34 were female.

The total number of emergency department attendances at Southampton General Hospital during April 2018-April 2019 due to drugs was 58 - of which 39 were male and 19 were female.

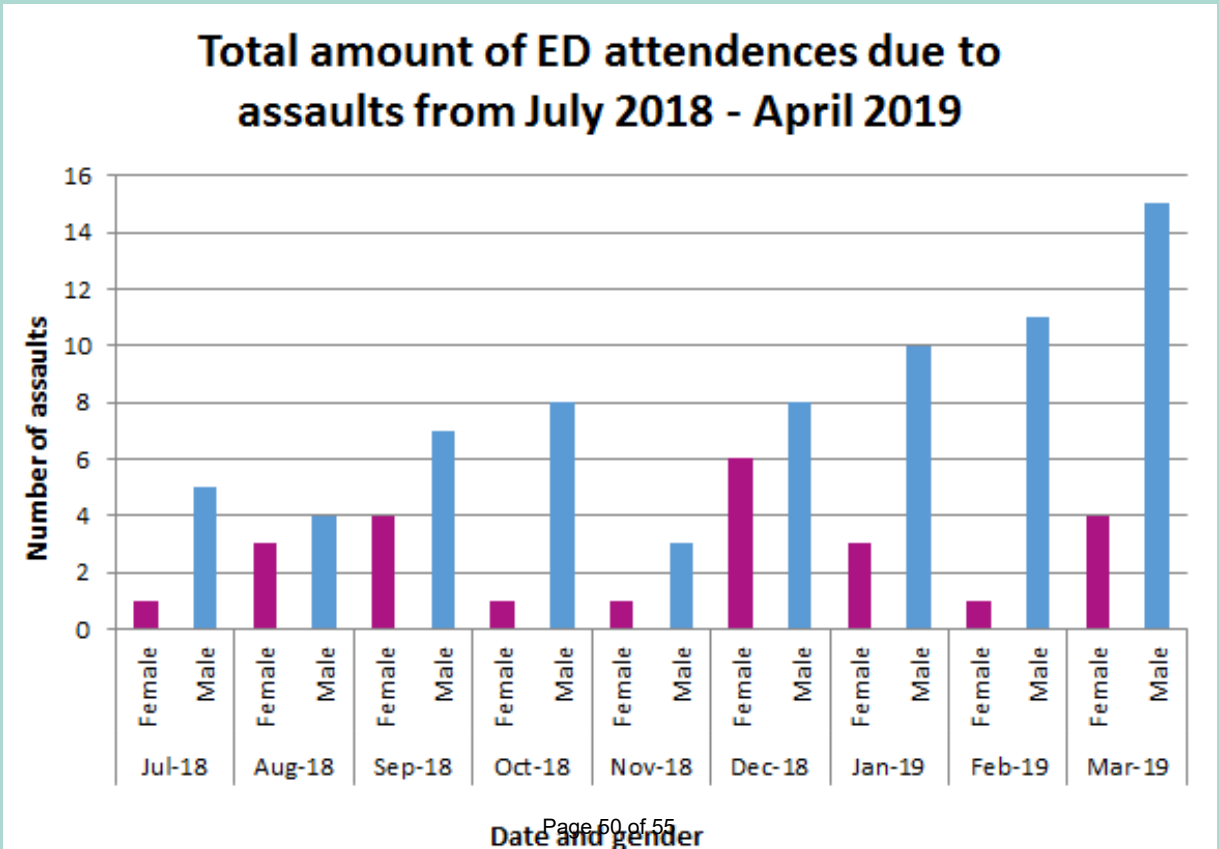
22 males and 15 females were admitted to the hospital for further treatment. Two males and two females were discharged back in to police custody following their emergency department attendance.

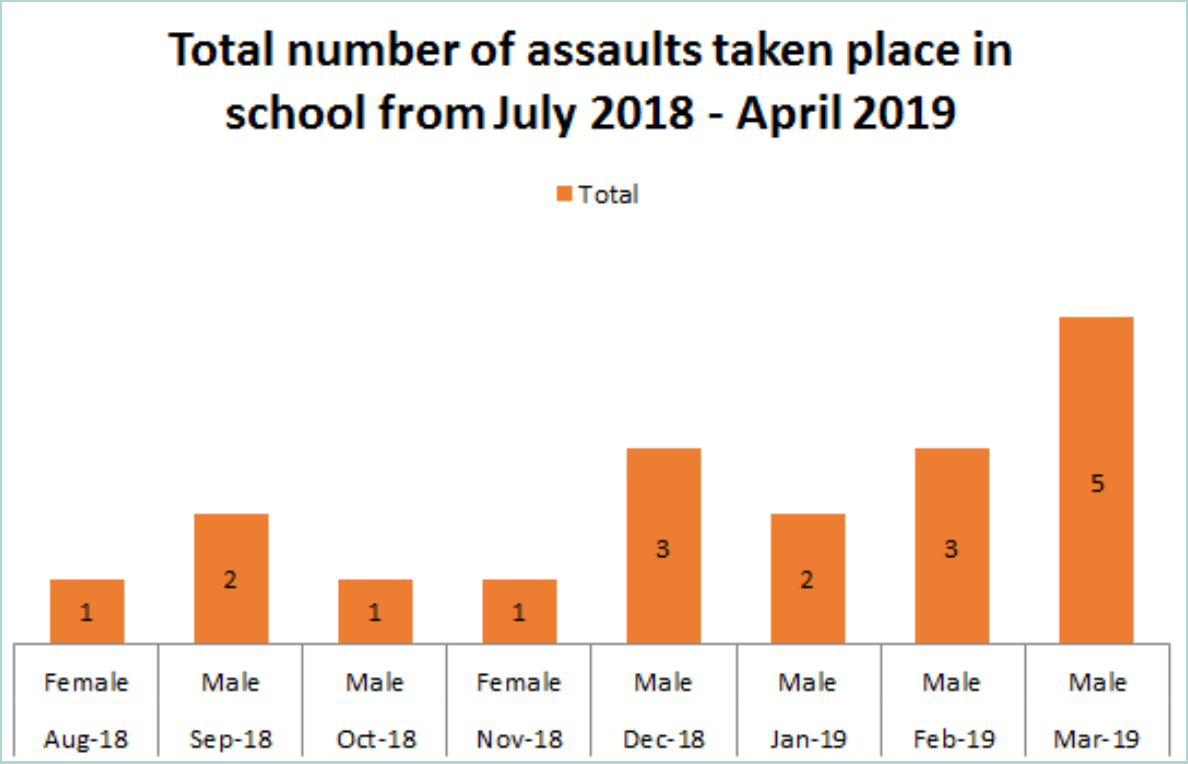
The information identifies that female incidents peaked for different age groups at different times of the year. This is as follows

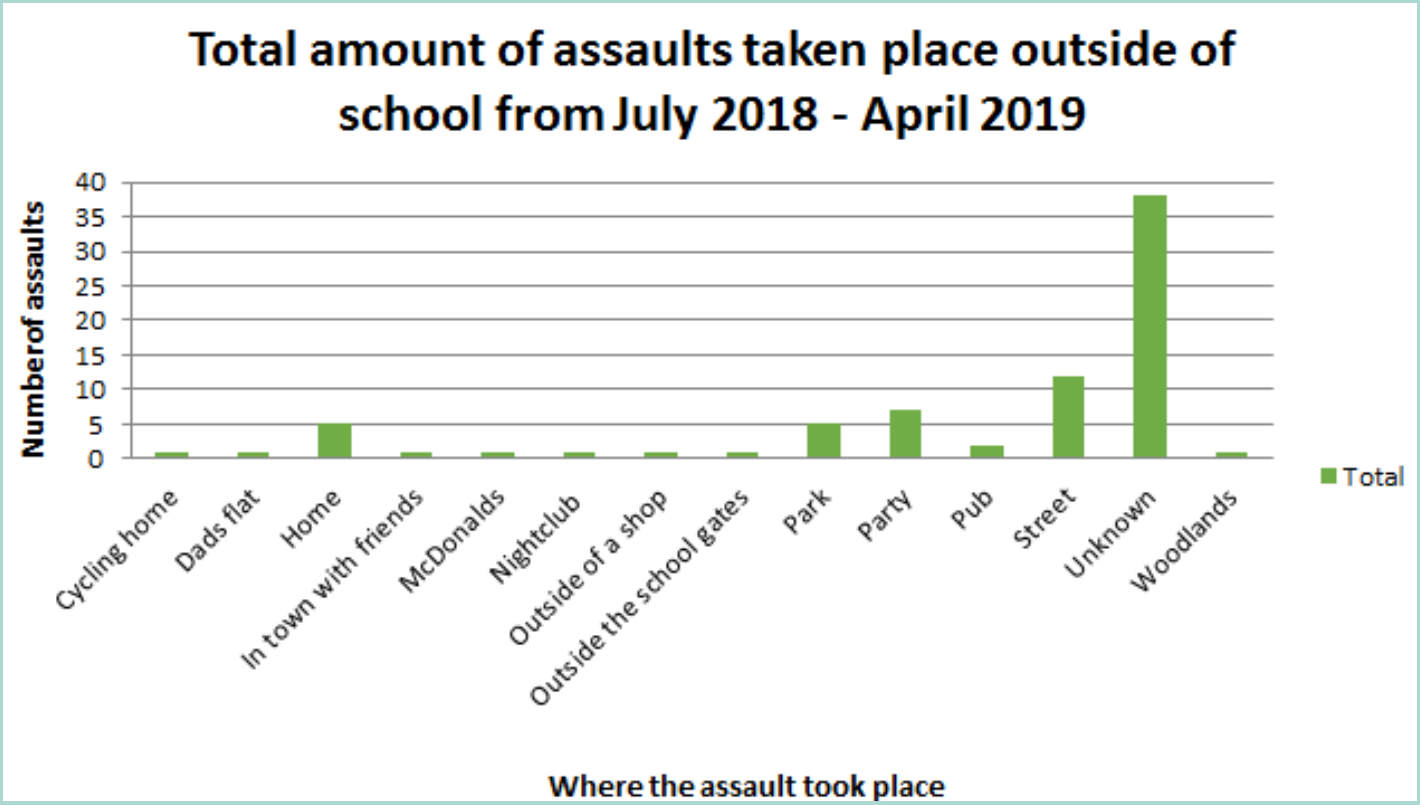
- August and September for females aged 13 and 14 years
- December saw a four times increase for females aged 15 years
- May, July, September, October and December saw equal numbers of incidents rise and a three times increase in January for females aged 16 years
- October and December for females aged 17 years
- Jul and Feb for 14-year-old females

The information identifies that male incidents peaked for different age groups at different times of the year, as follows

- August for 15-year-olds
- 16-year-old males had a significant increase in incidents generally throughout the year of April 2018 - April 2019. Incidents were at their lowest for this group in July and August and at their highest in May, September, October, December and February
- April, August, December, January and February were high for 17-year-old males, with a four times increase in July







The paediatric liaison team started recording this information in July 2018 which is why there is no information prior to this.

The total number of emergency department attendances at Southampton General Hospital during July 2018-April 2019 following an assault was 95 - of which 71 were male and 24 were female.

18 of these assaults occurred at school - two of which were females and 16 males.

Documentation on where the assaults took place when outside of school is not widely recorded. Based on the information available assaults in the street are the most common, secondly are assaults whilst at parties and closely followed by assaults at home or in a park.

The information identifies a steady incline in ED attendances due to assaults since July 2018 - April 2019.

GLOSSARY

The glossary refers the key words or terms that are used within this annual report

LSAB Local Safeguarding Adults Boards covering Southampton and Hampshire.

LSCB Local Safeguarding Children Boards covering Southampton and Hampshire.

CCG Clinical Commissioning Groups covering Southampton and Hampshire

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Clinical governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

DoLS (Deprivation of Liberty Safeguards) are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

Domestic violence and abuse is defined as:
Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality
This can encompass, but is not limited to, the following types of abuse:
psychological
physical
sexual
financial
emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behavior is: An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (Home Office 2012).

Domestic Homicide Reviews DHR are commissioned by local Safer Communities Partnerships in response to deaths caused through cases of domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Hate crime Defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

LADO local area designated officer is involved in the management and oversight of individual cases of allegations of abuse made against those who work with children as set out in the allegations against people who work with children procedure. Their role is to give advice and guidance to employers and voluntary organisations; liaise with the Police and other agencies, and monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

Looked after Child (LAC) is a child who is accommodated by the local authority, a child who is the subject to an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation. In addition where a child is placed for adoption or the local authority is authorised to place a child for adoption - either through the making of a Placement Order or the giving of Parental Consent to Adoptive Placement - the child is a Looked After child.
Looked After Children may be placed with parents, foster carers (including relatives and friends), in Children's Homes, in Secure Accommodation or with prospective adopters.

MAPPA (multi-agency public protection arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (multi-agency risk assessment conference) is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

Mental Capacity Act (2005) provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can make decisions, in which situations, and how they should go about this.

Mental capacity refers to whether someone has the mental capacity to make a decision or not.

NHS (National Health Service) is the publicly funded health care system in the UK.

Person causing the harm is the person or adult who is alleged to have caused the abuse or harm.

PREVENT is the government's counter-terrorism strategy, whose aim is to:

- respond to the ideological challenge of terrorism and the threat from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that needs to be addressed.

SAMA: The Care Act (2014) requires that any employers who are also providers of care and support, not only have a duty to the at risk adult, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them.
To ensure a consistent, fair, proportionate and transparent approach, the Local Safeguarding Adults Board has developed an allegations management framework, strongly advocating that Trust's have a Safeguarding Allegation Management Advisor (SAMA).

Serious adult review (SAR) is undertaken by a safeguarding adults when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

Serious Case Review (SCR) is undertaken by a safeguarding children board when a serious case of child abuse takes place. The criteria for review are outlined in Working Together 2015. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SIRI (serious incident requiring investigation) is a term used for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Informatics Report			
Category	Strategy and Business Planning		
Agenda item	4.8		
Sponsor	Director of Transformation and Improvement		
Author	Adrian Byrne		
Provenance	Report to Trust Board		
Classification	This Report is unclassified.		
Purpose	The paper is presented for DISCUSSION. This is bi-monthly report on progress with informatics programme, regularly reported due to breadth of projects and impact on the business		
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	• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider		
Impact assessments	n/a		
Other standards affected	n/a		

1. Overview

1.1. The objectives for the new digital strategy (under development) will underpin the UHS corporate goals and clinical strategy with digital systems, world class digital services to support "world class care for everyone".

1.2. In line with the national digital strategy recently announced by NHSX, the ambition is to:

- Reduce burden on staff so they can focus on patients
- Provide patient access to digital tools to enhance their care
- Provide safe and easy access to clinical information
- Improve patient safety and care
- Increase trust efficiency and productivity

1.3. There is a constant need to ensure that the plan is not led by technology drivers alone. The UHS Informatics Strategy work has consulted with over a hundred staff and the appointment of CCIOs/CNIO will continue to ensure that a good balance is maintained.

1.4. The digital strategy development work was presented to the digital board in June and it is hoped that a final version will be agreed in September 2019, this is being reviewed at the Digital Board on the 2nd August. The later versions are incorporating the themes from the emerging clinical strategy. There are meetings planned with each of the Divisional management teams to discuss the emerging strategy and a final version should be presented to TEC and Board in September.

1.6 It is recognised that it is important to receive digital user feedback. A major survey was undertaken last year of the consultant body and this has been built into the development of the new draft Digital Strategy, similarly there is a junior doctor's forum regularly feeding back their views. In 19/20 we will work with KLAS [ARCH collaborative] to undertake a more systematic feedback exercise and feed this into the regular reports.

1.5. A significant element of the current strategy is to increase digital maturity as a part of the Global Digital Exemplar (GDE) programme, achievement will be measured against the HIMSS EMRAM [model]. This is a measure of a paperless organization in line with overall national objectives (see PHC 2020 and NHS long term plan [Chapter 5]). The trust is receiving £10m of national funding contributing to this and has committed to a set of associated projects. The final 2 payments (equal to £2.5m) are contingent on the delivery of the programme and HIMSS level 7. Achievement of this target is currently at risk and a meeting with NHS Digital has been arranged in August.

1.6. A digital board has been created to assure the programme. This will approve strategy, direction, investment plans, and refer items to trust board where necessary. In the first two meetings this group has mainly reviewed the digital strategy as well as new business cases, progress against the current work programme, the capital budget and risk register. The risks to HIMSS level 7 achievement and Microsoft licencing have been escalated in this report.

2. Analysis and Discussion

Work this quarter:

2.1. Following expressions of interest and interviews the trust now has three new CCIOs. The plan is to split the work across inpatients focussed work (Dr Mike Celinski), outpatient focussed work (Dr Ashwin Pinto) and a deputy CCIO in Dr Michael Kiuber. The finer details of these part time sessional arrangements are still to be worked out.

2.2. The CCIOs along with the planned CNIO role are an important next step in the development and delivery of the strategy. Capability has come a long way, but we now need to drive adoption and pick the right tools, selecting the right priorities. For example, over 1m pieces of paper per month are currently being hand written and scanned in. The data held on these forms is repetitive, cannot be interrogated and doesn't allow automated decision support. The drive to move this to a digital environment is the next major piece of work and fits with our ambition to reduce the burden on staff so they can focus on patients, provide safe and easy access to clinical information, improve patient safety and care and increase trust efficiency and productivity.

2.3. A TEC paper on renegotiation of the Sectra PACS contract was approved. This needs to be approved by the other boards in the SWASH consortium. Clinical staff will continue to use the successful and well regarded software for image reporting/viewing for a further 8 years.

2.4. TIG has approved a case to update the trusts out of date Oracle database environment (servers and software). The case over five years is around £1m.

2.5. The Business Intelligence investment business case has been approved by TEC. This is a GDE milestone and linked to £1m of national funding.

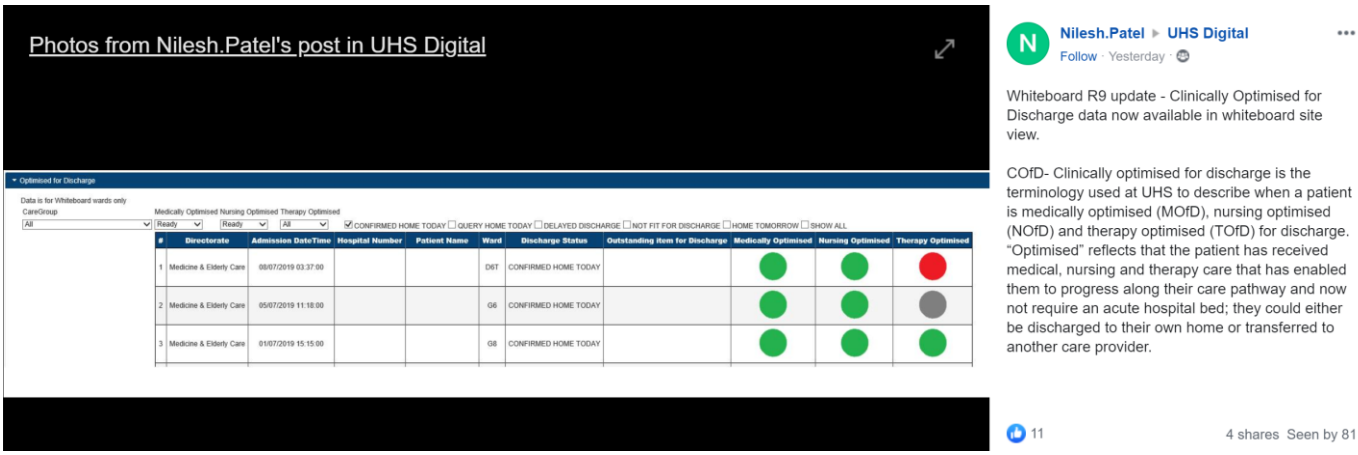
2.6. The acquisition of EMIS IP for CHARTS (HICSS, eQuest, eDocs) has gone through, along with the successful recruitment of staff to develop these vital products. A new work schedule needs to be worked out, as does a strategy for support including other sites who still derive value from them. This is a potential revenue source.

Current work, next quarter:

2.7. We are developing an automated service that will invite patients to My Medical Record on receipt of a referral. An increased number of records will support benefits such as paperless initiatives (switching off all letters to patients) and recruitment to clinical trials whilst easing the admin burden for clinical teams currently registering patients. 30% of outpatients are now taking up the MyMR service with over 20,000 now registered

2.8. Work on the My Medical Record project for Maternity (My Maternity Record) has started and will be available for pilot work during the summer across Hampshire.

2.9. The latest release of the whiteboard has some important patient flow enhancements. The following section from UHS Workplace



Other Risks and Issues

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

3. Recommendation

3.1. To note the report and progress

Glossary and Abbreviations

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

University Hospital Southampton
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Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Finance Report 2019-20 Month 3			
Category	Quality, Performance, and Finance		
Agenda item	4.9		
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	• BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services		
Impact assessments			
Other standards affected			

University Hospital Southampton NHS
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2019/20 Finance Report - Month 3

Report to:	**Board of Directors & Strategy & Finance** **July 2019**
Title:	**Finance Report for Period ending 30/06/2019**
Author:	**Gavin Hawkins, Assistant Director of Finance**
Sponsoring Director:	**David French, Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In June 2019, the Trust delivered a deficit of £0.3m, £0.2m better than Plan. Year to date the Trust is reporting a £2.7m deficit but this is £0.8m better than Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '2'.

2. When non-recurrent items are excluded , the deficit in June 2019 was £0.5m, £0.1m worse than Plan. If CIP was phased equally through the year the CIP shortfall would have been £0.9m higher in the month and £3.5m year to date.

3. The main themes seen in M3 were:
   - Income was £1.5m better than Plan due to better than Plan productivity savings in the month and additional R&D & Educational and Training income offsetting additional costs incurred.
   - Pay was £0.4m worse than Plan in month, with overall pay spend not achieving the pay CIP target. Both bank & agency expenditure reduced compared to May 2019 by a combined £0.4m and substantive was up £0.1m with 30 additional WTE's employed compared to May 2019.
   - Total CIP delivery was £2.1m which is £0.2m more than in May 2019 but still £0.4m below Plan in June 2019.

4. The cash position was £7.6m above Plan at £53.4m. 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 £7.6m below M3 planned position, partially off-set by national funding not being received
   - Accounts payable balances remain higher than anticipated, plus improved receivables position

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.

University Hospital Southampton NHS
NHS Foundation Trust

Finance: I&E Summary

Total clinical income was £0.6m behind Plan, although the Plan was increased to reflect income CIP delivery in the month and to include backdated award (£0.8m in other income favourable variance). The clinical income year to date over-performance of £0.8m is after recognising £2.2m of additional activity linked to productivity.

In month non elective activity was estimated to be £1m above Plan, although blended payment marginal rates reduced this to £0.65m. Elective activity was estimated to be £1m below Plan thus continuing the trend seen in previous months.

Substantive and bank pay combined was £0.9m above Plan, partially offset by below Plan agency spend of £0.5m. Both bank & agency spend was lower than in May 2019 with substantive £0.1m higher with 30 additional WTEs being employed in month.

Of the £1.1m clinical supplies overspend, £0.8m is related to stock movement in T&O which is currently being reviewed.

Overall CIP delivery was £0.4m behind Plan with £2.1m delivered vs a Plan of £2.5m. See slide 12 for further detail.

Metric	2019/20		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	1.29	3	4
Liquidity rating	18.88	1	1
I&E Margin Rating	-0.37%	3	3
I&E Margin Variance Rating	0.38%	1	1
Agency Variance from ceiling	39.89%	1	1
Use of Resources Average Metric		1.80	2.00
Use of Resources Final Metric		2	3

		Current Month			Year to Date				Full Yr		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m		Plan £m	Ave Done £m	To Do £m
NHS Income:	Clinical	52.4	51.8	0.6	154.5	155.3	(0.8)	G	630.6	51.8	52.8
	Pass-through Drugs & Devices	8.8	9.1	(0.3)	26.8	26.1	0.7	R	115.2	8.7	9.9
Other income	Other Income excl. PSF	8.6	10.5	(1.8)	27.4	28.7	(1.3)	G	105.0	9.6	8.5
Total income		**69.8**	**71.4**	**(1.5)**	**208.7**	**210.1**	**(1.5)**	G	**850.8**	**70.0**	**71.2**
Costs	Pay-Substantive	38.4	39.1	0.7	116.6	118.0	1.4	A	461.0	39.0	38.1
	Pay-Bank	1.9	2.1	0.2	5.8	6.6	0.8	R	22.8	2.2	1.8
	Pay-Agency	1.2	0.7	(0.5)	3.4	2.1	(1.3)	G	14.1	0.7	1.3
	Drugs	1.3	1.1	(0.2)	3.6	3.9	0.3	R	14.2	1.3	1.1
	Pass-through Drugs & Devices	8.8	9.1	0.3	26.8	26.1	(0.7)	G	115.2	8.7	9.9
	Clinical supplies	5.4	6.4	1.1	17.0	18.3	1.3	R	65.5	6.1	5.2
	Other non pay	10.3	10.1	(0.3)	30.3	28.5	(1.8)	G	105.1	9.5	8.5
Total expenditure		**67.4**	**68.6**	**1.2**	**203.4**	**203.5**	**0.1**	A	**797.9**	**67.5**	**66.0**
EBITDA		**2.5**	**2.8**	(0.3)	**5.3**	**6.6**	(1.4)	G	**52.9**	2.2	**5.1**
EBITDA %		3.6%	3.9%	(0.4%)	2.5%	3.2%	(0.6%)		6.2%		
	Depreciation	1.9	2.1	0.1	5.6	6.2	0.6	R	22.6	2.1	1.8
	Non Operating Income/Expenditure	1.0	1.0	0.0	3.2	3.2	(0.1)	G	13.3	1.1	1.1
Control Total Surplus / (Deficit)		**(0.4)**	**(0.3)**	**(0.2)**	**(3.5)**	**(2.7)**	**(0.8)**	G	**17.1**	**(0.9)**	**2.2**
Memo - Other technical items:											
Prior Period Adjustment - PSF 2018/19			0.9	(0.9)		0.9	(0.9)	G			
Provider Sustainability Funding		0.6	0.6	0.0	1.9	1.9	0.0	G	12.7	0.6	1.2

University Hospital Southampton NHS
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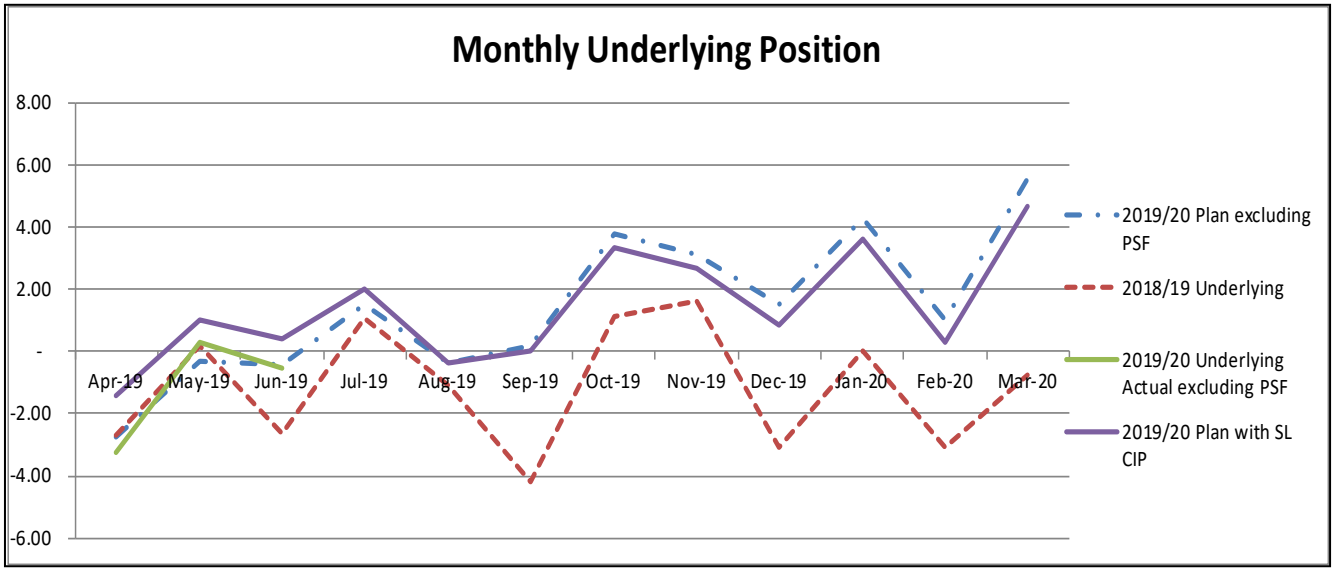
Underlying Run Rate Position

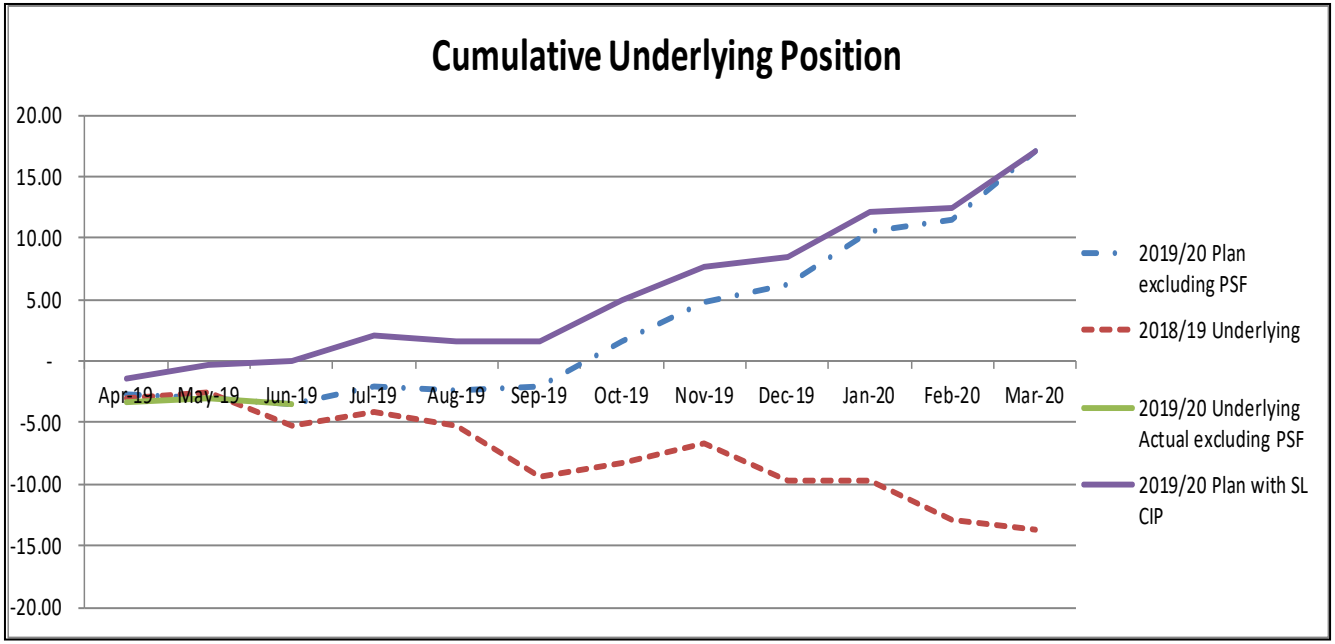
These graph shows the actual underlying position against the NHS Plan of £0.1m worse in month and on Plan year to date.

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 £0.9m higher in June 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 in these graphs exclude PSF including the amount received as a prior year adjustment.



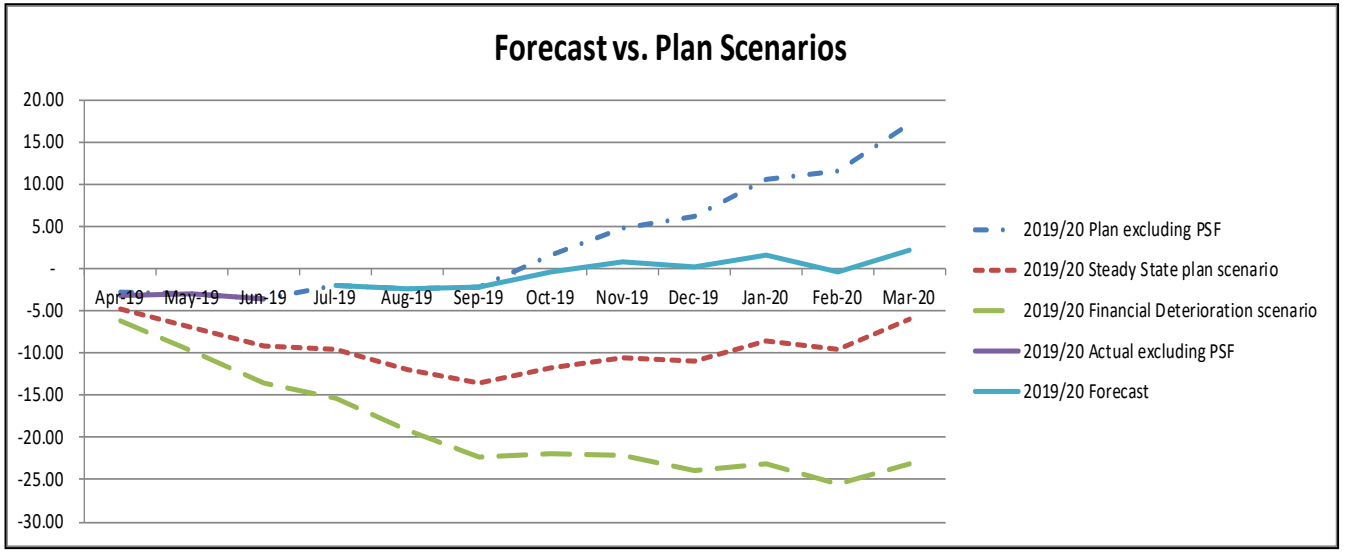


University Hospital Southampton NHS
NHS Foundation Trust

Underlying Run Rate Position

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

Currently the forecast is based on estimates post Q1 and is therefore highly uncertain at this early stage of 2019/20.



This 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**

University Hospital Southampton NHS
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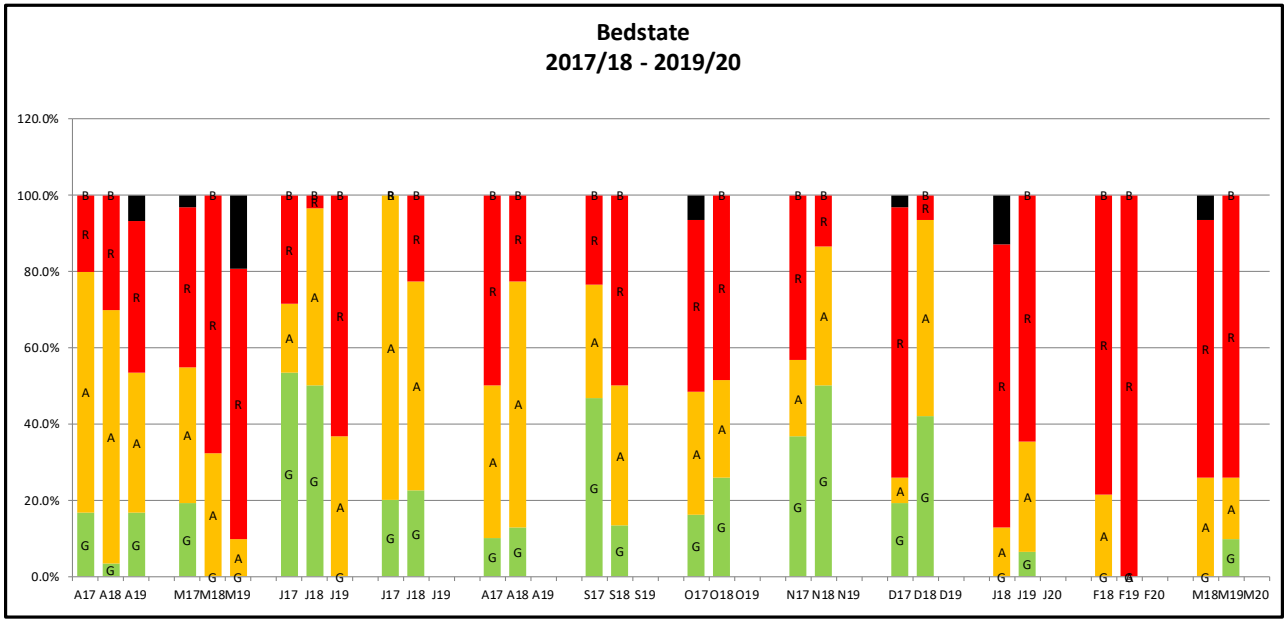
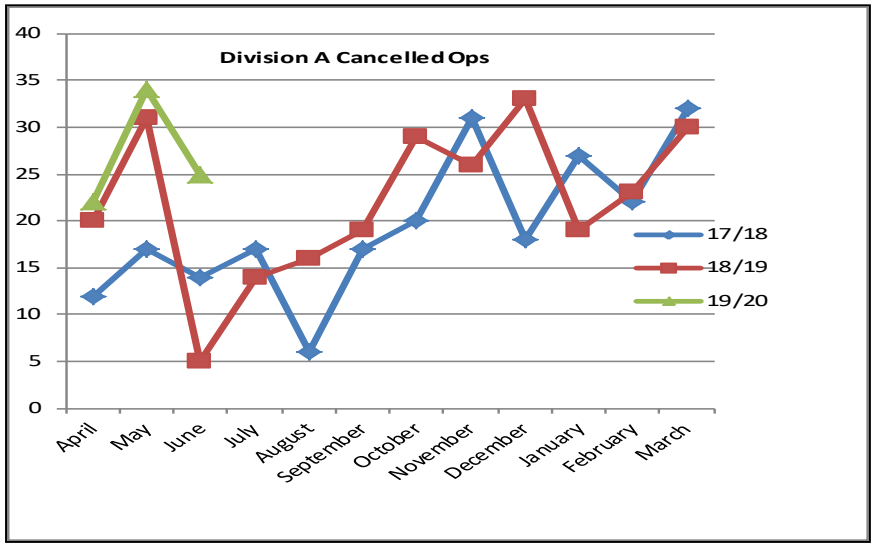
Bedstate – 3yr Comparison

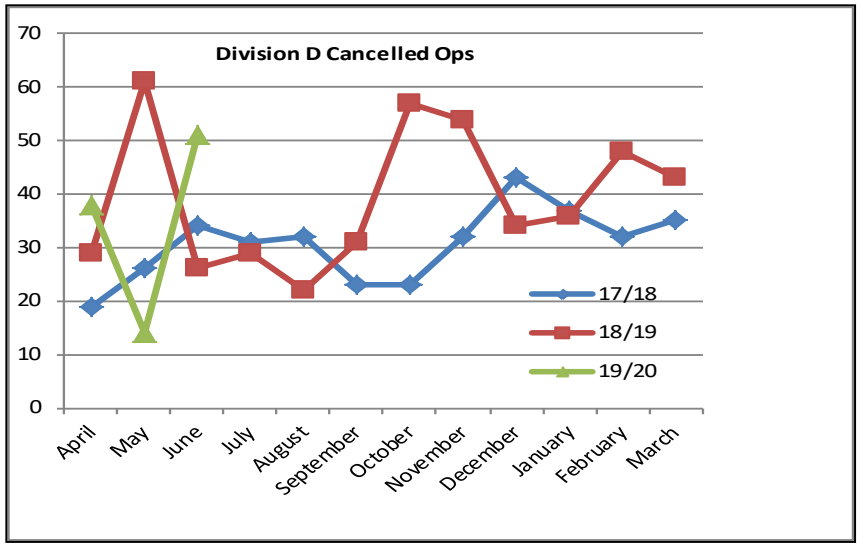
Bed state information for June 2019 highlights over 60% of the time the Trust bed state was red.

Beds were closed on Bramshaw (12) and G7 (14) ward during June 2019 and CVT were given beds on E level from Surgery to staff to manage current demand.

On the day cancellations for non-clinically reasons shown below for Divisions A & D comparing 2017/18, 2018/19 & 2019/20. In June 2019 these cancellations in Division D totalled 51 which is highest since November 2018.







(Fav Variance) / Adv Variance

Clinical Income

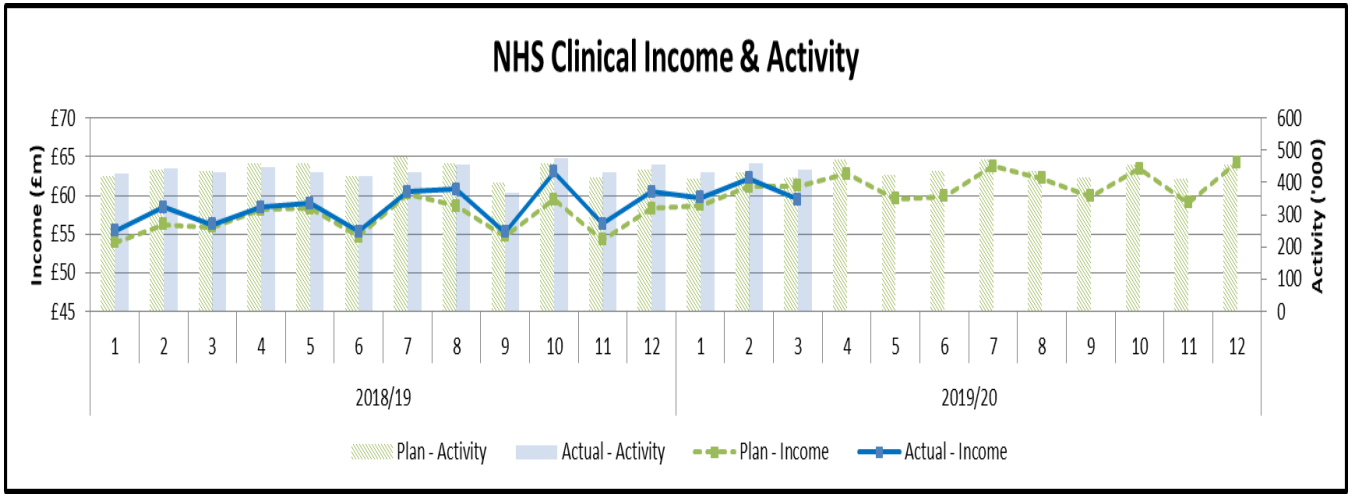
Non-elective inpatient activity was above planned levels and a provision has been taken against the impact of the blended payment system for emergency care on the same basis as in April & May 2019. Elective inpatient income was below planned levels in the month and whilst this is only an estimate does correlate with the increase in cancellations especially in Division D.

Outpatient activity was above planned levels in the month and continues to over-perform at a steady rate.

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

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

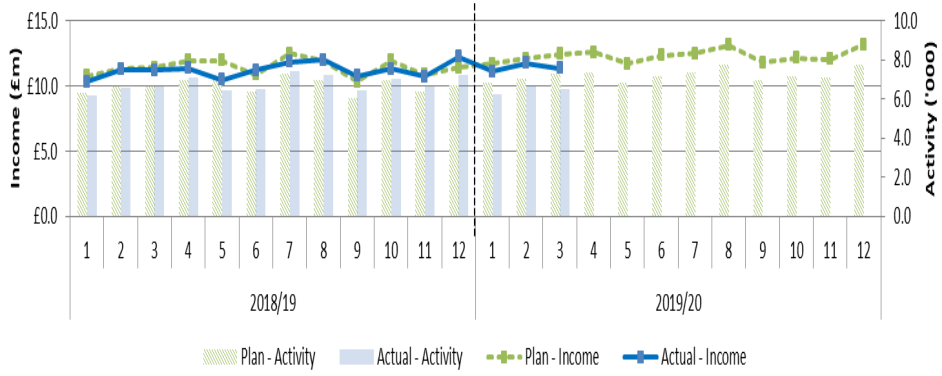
	2018/19	2019/20				2019/20			Monthly Run Rate	
POD GROUP	YTD Actuals £000s	Annual Plan £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	Done	To Do
NHS Clinical Income										
Elective Inpatients	£32,792	£147,512	£36,190	£34,229	£1,961	£12,442	£11,351	£1,090	£11,410	£12,587
Non-Elective Inpatients	£46,563	£199,871	£48,898	£53,422	(£4,523)	£16,283	£17,287	(£1,005)	£17,807	£16,272
Blended payment adjustment	£0	£0	£0	(£1,076)	£1,076	£0	(£358)	£358	(£359)	£120
Outpatients	£18,171	£81,651	£19,566	£20,866	(£1,300)	£6,633	£6,922	(£289)	£6,955	£6,754
Other Activity	£28,751	£128,481	£31,626	£31,299	£326	£10,297	£10,305	(£8)	£10,433	£10,798
CQUIN	£3,632	£8,375	£2,048	£2,103	(£56)	£685	£701	(£17)	£701	£697
Blocks & Financial Adjustments	£1,593	£8,471	£3,892	£1,549	£2,343	£2,119	£179	£1,940	£516	£769
Other Exclusions	£952	£46,419	£12,226	£12,874	(£649)	£3,943	£4,014	(£71)	£4,291	£3,727
Prior month adjustment	£0	£0	£0	£0	£0	£0	£1,405	(£1,405)	£0	£0
Subtotal NHS Clinical Income	*£132,454*	*£620,779*	*£154,446*	*£155,268*	*(£821)*	*£52,400*	*£51,806*	*£594*	*£51,756*	*£51,723*
Pass-through Exclusions	£26,850	£115,237	£26,797	£26,121	£676	£8,786	£9,091	(£305)	£8,707	£9,902
Total NHS Clinical Income	**£159,303**	**£736,016**	**£181,243**	**£181,389**	**(£145)**	**£61,186**	**£60,897**	**£289**	**£60,463**	**£61,625**
Non NHS Clinical Income										
Private Patients		£5,887	£1,616	£1,081	£536	£475	£457	£18	£360	£534
CRU		£2,500	£624	£631	(£7)	£208	£208	(£0)	£210	£208
Overseas Chargeable Patients		£1,412	£354	£390	(£36)	£118	£170	(£52)	£130	£114
Total Non NHS Clinical Income		**£9,799**	**£2,594**	**£2,102**	**£492**	**£801**	**£835**	**(£34)**	**£701**	**£855**
Grand Total	**£159,303**	**£745,815**	**£183,838**	**£183,491**	**£347**	**£61,987**	**£61,731**	**£255**	**£61,164**	**£62,480**



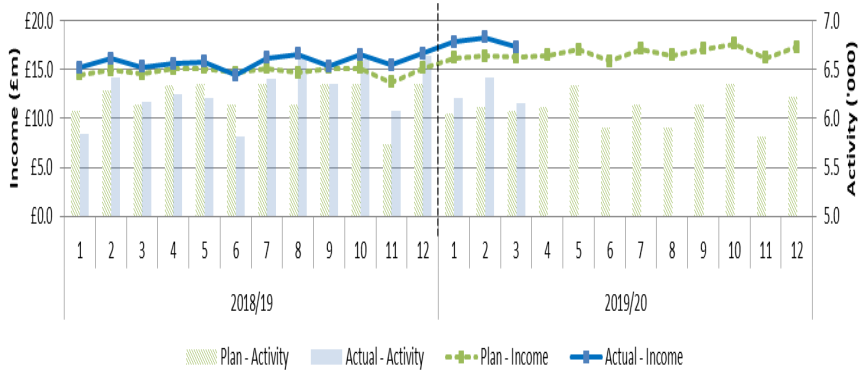
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

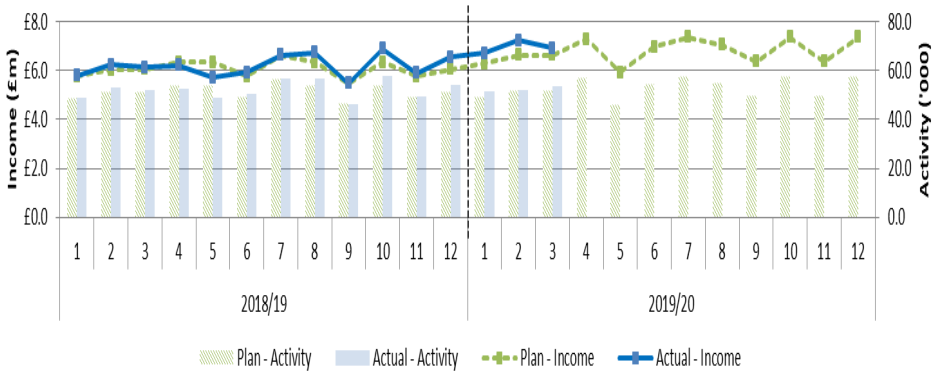
Elective spells



Non elective spells

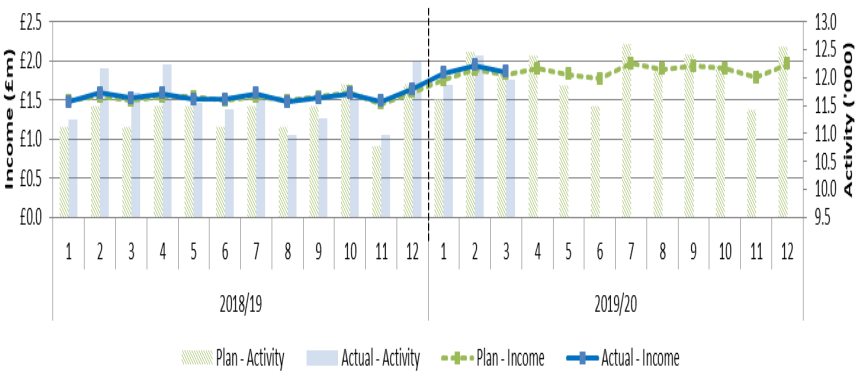


Outpatients



A&E

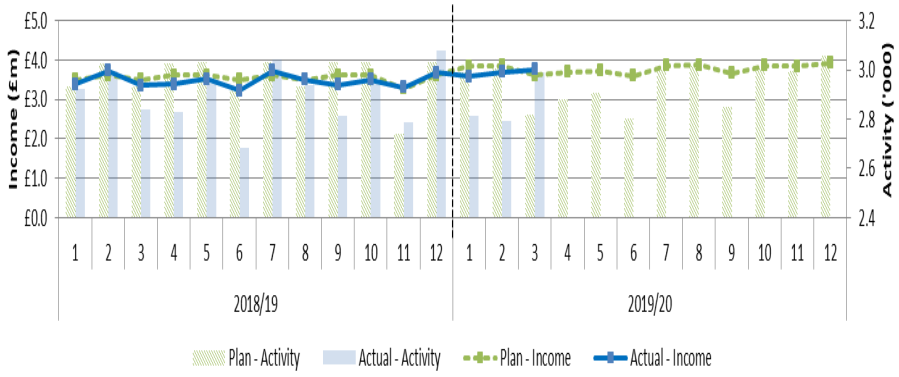
In month -119 activity, +£31,772
YTD +88 activity, +£180,160



Clinical Income

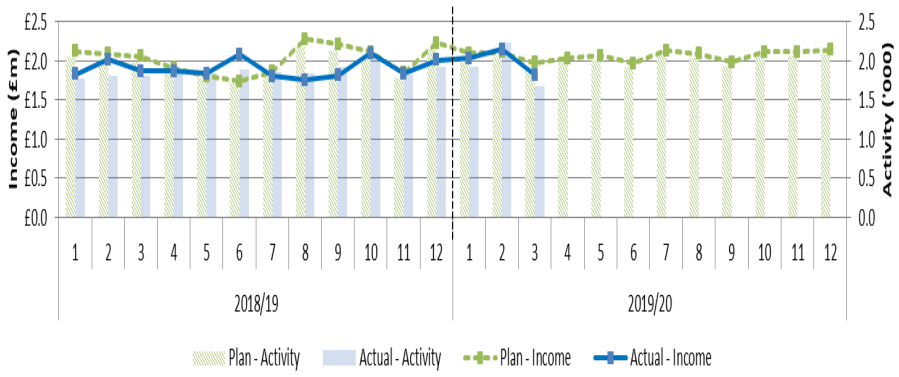
Adult critical care

In month +173 activity, +£154,086
YTD -223 activity, -£273,492



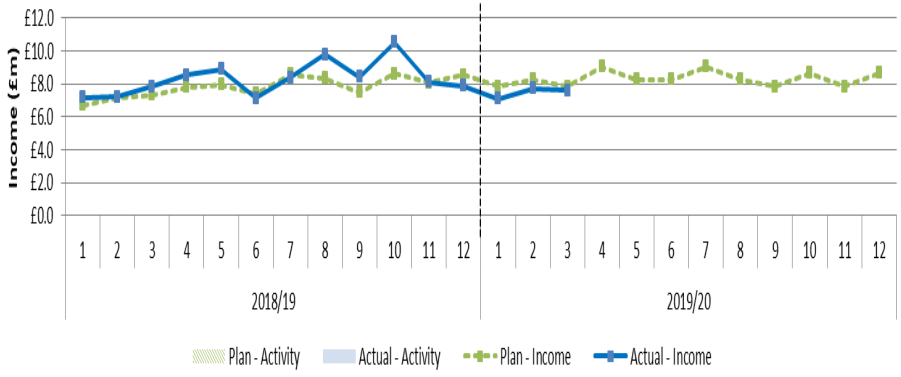
Neonatal & paediatric critical care

In month -264 activity, -£151,820
YTD -223 activity, -£168,758



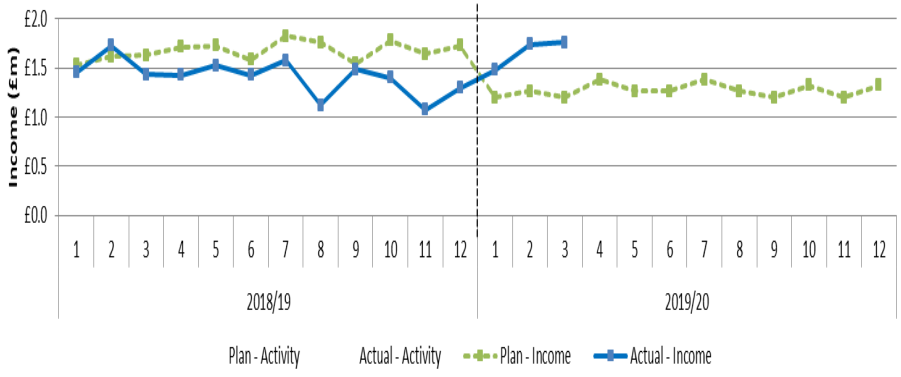
Tariff excluded drugs

In month -£261,297
YTD -£1,520,062



Tariff excluded devices

In month +£559,872
YTD +£1,319,940



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.

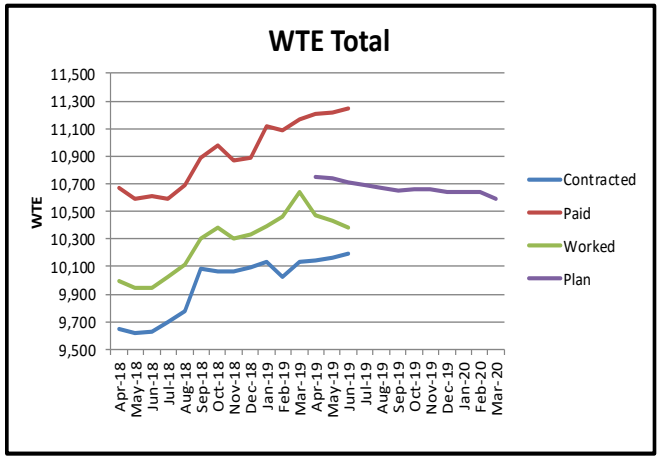
3) 'Paid' is worked WTE but including the WTE equivalent of enhanced rates e.g. weekend working.

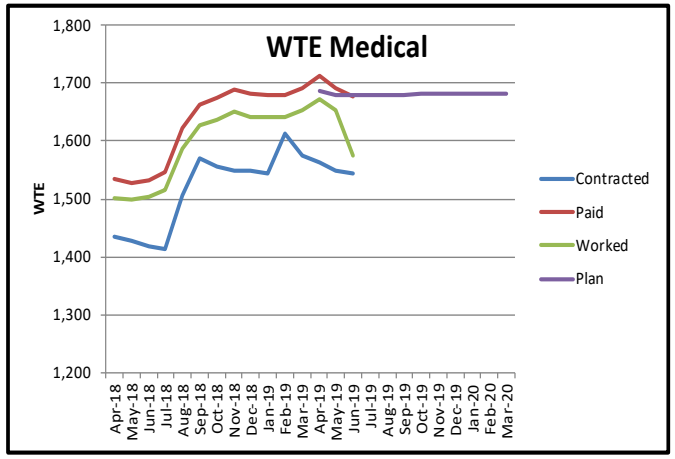
4) 'Plan' = funded WTE.

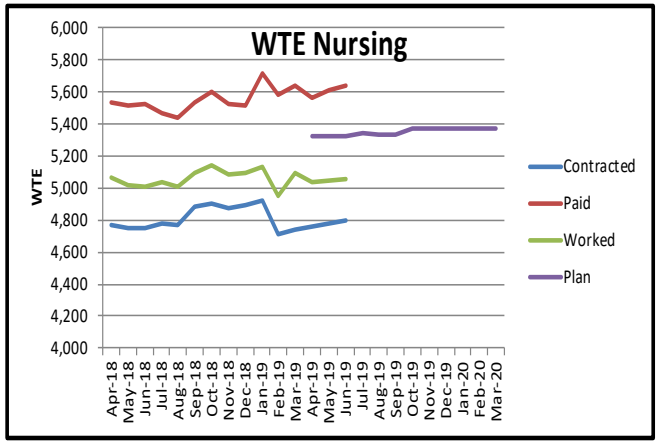
5) 'Other WTE' Plan includes pay CIP yet to be allocated to a specific staffing group, or remains unidentified.

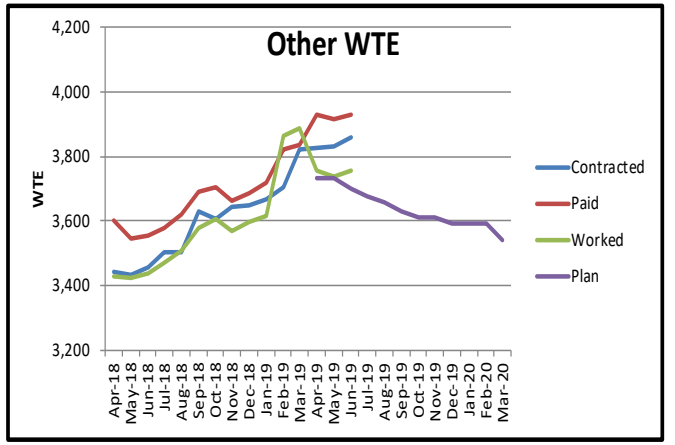
Overall paid WTE increased from May to June 2019 by 25wtes.

Contracted rose by 33wtes and explains the £0.1m increase in substantive pay bill and worked reduced by 52wtes.







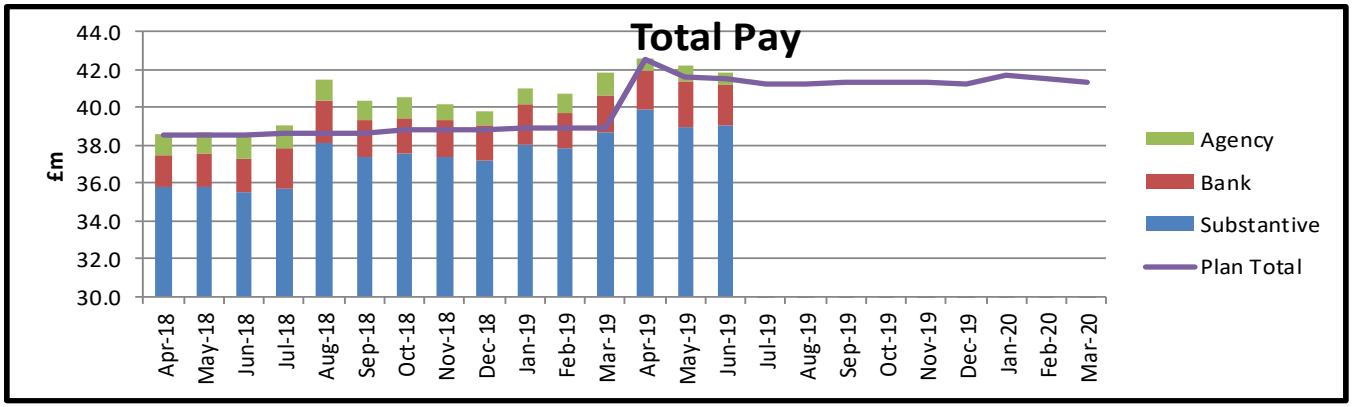


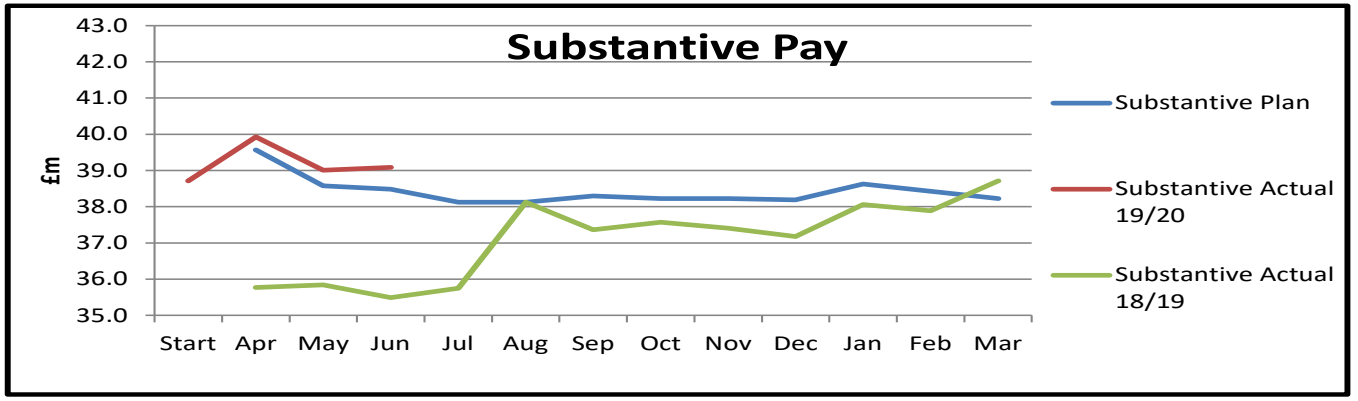
Substantive Pay Costs

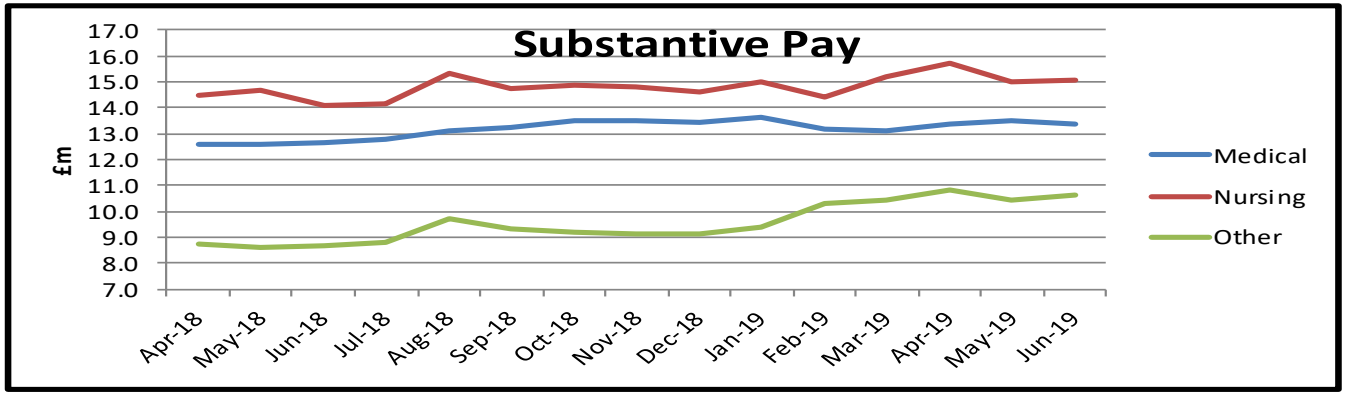
Overall pay reduced in June 2019 by £0.3m when compared to May 2019, of which substantive was +£0.1m, bank, -£0.3m and agency -£0.1m.

Total pay including temporary staffing was £0.3m adverse to Plan in M3. In M2 the Trust was £0.6m adverse to total pay Plan. This will include the undelivered element of the pay CIP target.

In June 2019, TEC approved the introduction of tighter recruitment controls for both substantive and temporary staff, including the creation of a 'recruitment control 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. This panel met for the first time in the beginning of July 2019.







Temporary Staff Costs

Overall agency spend in June 2019 was £0.7m, £0.1m lower than May 2019 and £0.5m lower than the NHSI agency cap for 2019/20.

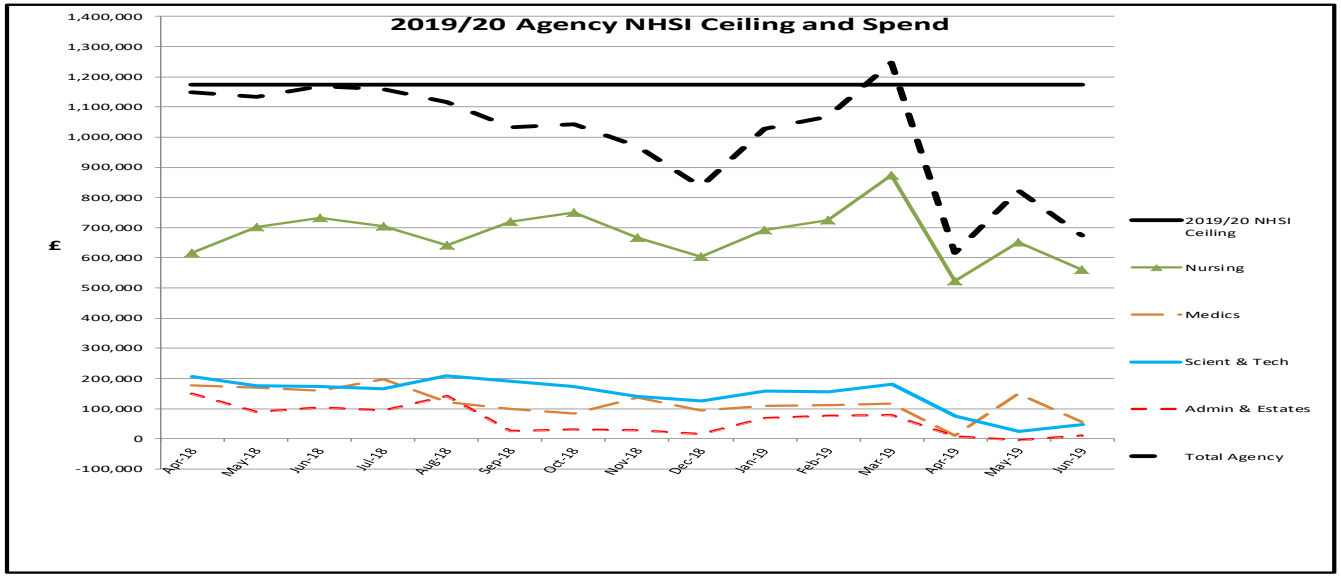
Both medical and nursing agency reduced from May 2019 by £0.1m each with the nursing reduction linked to fewer beds being open across the Trust than in May 2019.

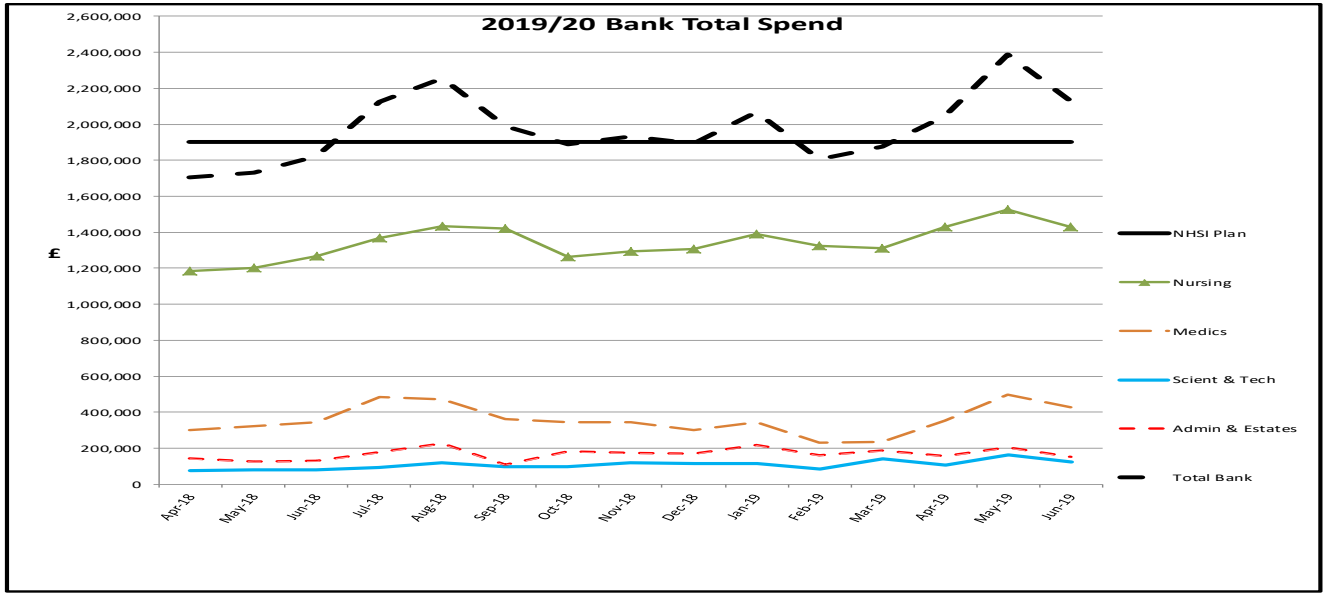
Expenditure on Thornbury doubled from £20k in May 2019 to £40k in June 2019.

Expenditure on bank staff was £2.1m in June 2019, £0.3m less than that spent in May 2019 and a return to the spend level of April 2019.

In overall terms, expenditure on flexible staffing was £0.3m lower than Plan in June 2019 and £0.4m lower than May 2019 expenditure.

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 is sponsored by the Director of Nursing.





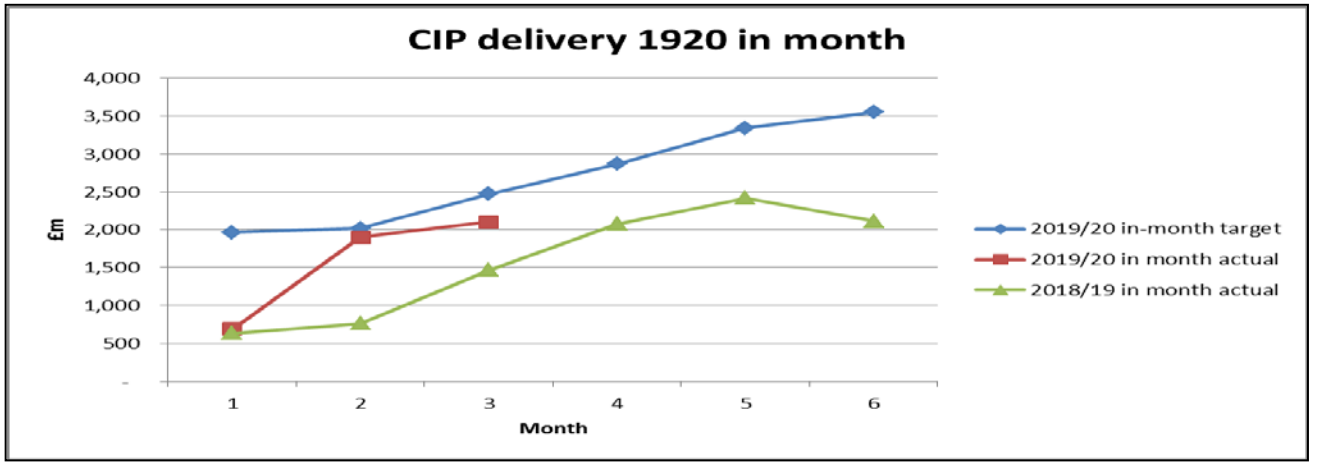
Cost Improvement Programme

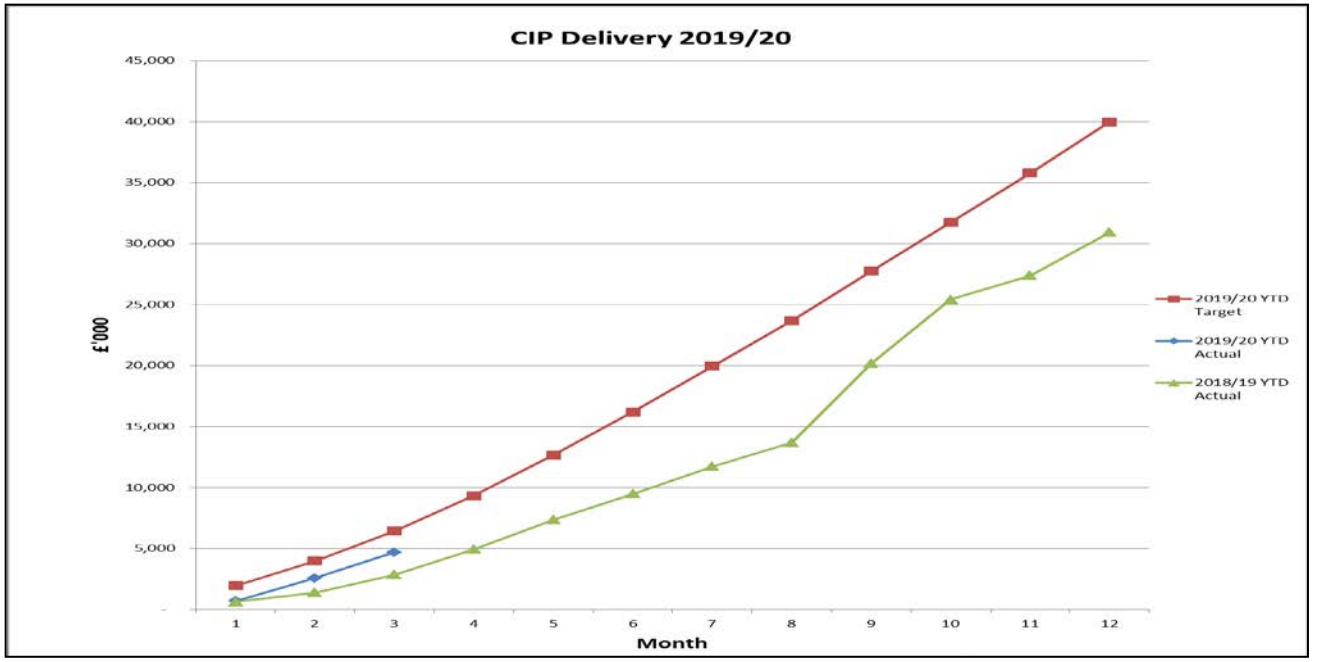
CIP delivery in June 2019 was £2.1m against a target of £2.5m.

This was higher than the delivery in May 2019 by £0.2m and £0.6m higher than that delivered in June 2018.

Total CIP delivery at Q1 is £4.7m, against a target of £6.5m representing a shortfall year to date of £1.8m. This compares favourably by £0.1m vs Q1 in 2018/19.

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





Cost Improvement Programme

The Trust has currently identified CIP of £36.4m, 91% of the target leaving a shortfall of £3.6m.

Identification increased by £3m from M2 with additional schemes being identified related to non-pay, LoS and income.

Of the total identified, £34.5m (86%) is planned to be recurrent.

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

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

Division	CIP Target £k	Identified £k	Gap £k	Identified %	Green £k	Pipeline £k	Non rec £k	FYE £k
Division A	8,998	9,184	(186)	102%	4,345	4,839	1,015	1,246
Division B	7,954	6,995	959	88%	2,332	4,630	1,053	1,144
Division C	6,569	5,742	827	87%	2,960	2,782	2,438	535
Division D	8,428	8,914	(486)	106%	6,624	2,290	974	815
Total clinical services	31,949	30,835	1,114	97%	16,261	14,541	5,480	3,740
CFO	2,269	2,438	(169)	107%	1,173	1,265	699	486
Transformation	616	387	229	63%	150	237	50	3
COO	379	221	158	58%	0	221	86	20
Nursing and workforce	733	490	243	67%	349	141	247	5
CEO	54	0	54	0%	0	0	0	0
Total THQ	4,051	3,536	515	87%	1,672	1,864	1,082	514
Central Schemes	4,000	2,065	1,935	52%	65	2,000	0	413
UHS total	40,000	36,436	3,564	91%	17,998	18,405	6,562	4,667

	Workforce	Non pay	LOS	NHS income	Commercial income	Total
Division A Total	2,183	1,313	2,492	2,729	467	9,184
Division B Total	760	2,288	2,628	1,183	136	6,995
Division C Total	1,499	1,168	344	2,087	644	5,742
Division D Total	934	1,033	1,609	5,247	91	8,914
THQ Total	531	1,986	33	279	707	3,536
Central schemes	0	0	0	65	2,000	2,065
UHS Total	5,907	7,788	7,106	11,590	4,045	36,436
Profile	16%	21%	20%	32%	11%	100%

Cash

The cash balance was £8m above Plan in M3. This is primarily due to:

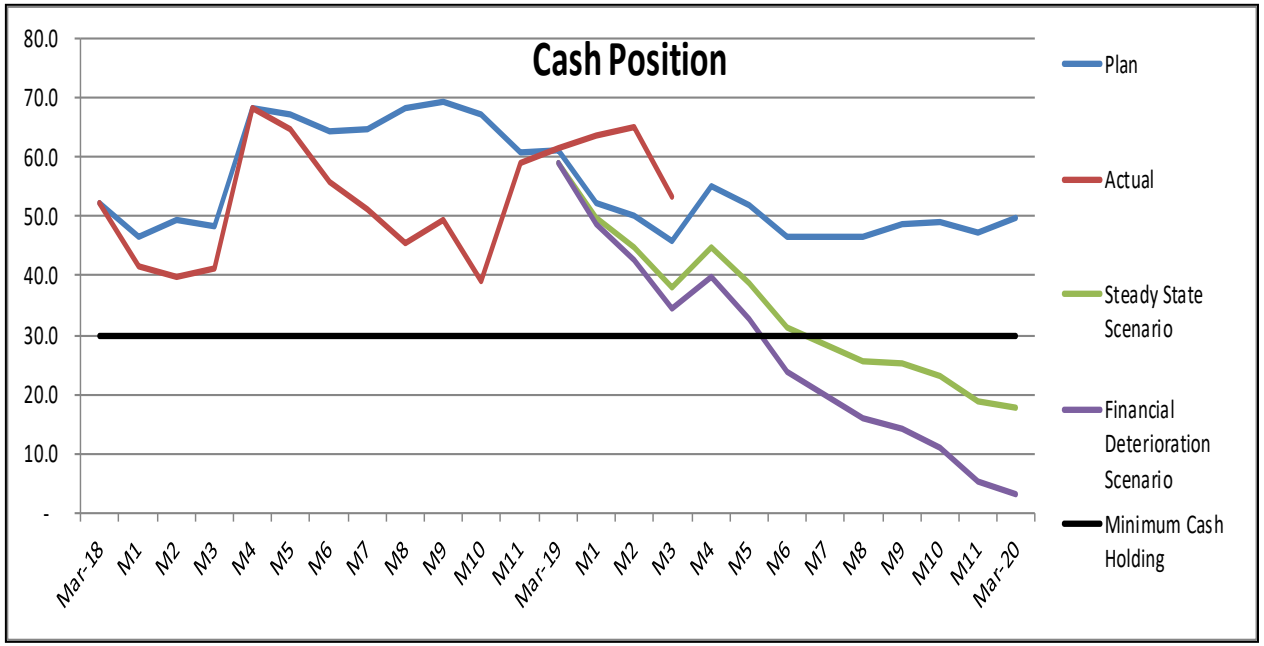
1) Receivables balances from end of year clearing earlier than anticipated in Plan.

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 £8m below Plan by the end of M3, offset by slippage in ability to draw down funds on PDC-funded schemes.

We are anticipating receipt of £19.8m PSF from 2018/19 in M4.



Capital Expenditure

NHS Improvement have asked STPs to reduce their forecast capital expenditure by circa 20% in order to live within the overall NHS "CDEL" limit set by Treasury. The UHS proportion of this reduction is £11.3m.

We have undertaken a review of schemes that are likely to slip, and have forecast circa £12.1m, of which £11.3m is within scope to count against the target slippage. We are therefore able to meet our share. We believe it is in UHS' interests to comply and remain in control of our expenditure. £7m of the slippage relates to delays in receipt of expected national funding.

Spend remains lower than Plan in M3, primarily linked to the forecast slippage outlined above, much of which is linked to external funding (e.g. STP Wave 3 capital – digital and theatres).

UHS intends to review the monthly profile of planned expenditure in line with the revised forecast outlined above.

(Fav Variance) / Adv Variance

Revised Forecast Outturn Position	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	315	124	(191)	315	183	(132)	1,893	1,196	(697)
ED Adult Resus	302	0	(302)	302	0	(302)	1,509	1,501	(8)
IT Schemes	620	459	(161)	1,860	2,067	207	7,450	7,220	(230)
Wave 3 STP Digital	368	18	(350)	1,104	26	(1,078)	4,422	26	(4,396)
Strategic Maintenance	333	540	207	999	974	(25)	4,000	4,000	0
Medical Equipment Panel	175	251	76	525	254	(271)	2,100	2,100	0
GICU Expansion inc Front Vertical Extension	652	318	(334)	1,372	708	(664)	13,614	12,122	(1,492)
Refurbish Eye Theatre	0	0	0	0	0	0	1,177	60	(1,117)
Energy Efficiency	150	0	(150)	150	0	(150)	2,223	1,473	(750)
Neonatal Expansion	215	1	(214)	215	12	(203)	2,309	12	(2,297)
New Theatres E level	428	429	1	3,343	1,287	(2,056)	3,637	3,236	(401)
Urology Day Unit	341	249	(92)	694	619	(75)	2,173	2,177	4
Steam Project	400	32	(368)	780	103	(677)	2,126	103	(2,023)
Princess Anne Theatre Ventilation	56	156	100	488	171	(317)	580	355	(225)
Spend to Save	92	41	(51)	276	103	(173)	1,104	847	(257)
Radiotherapy Equipment	0	140	140	658	149	(509)	658	834	176
Divisional / Donated Equipment	121	(180)	(301)	263	12	(251)	1,350	1,350	0
Decorative Improvements / Staff Fund	51	2	(49)	155	26	(129)	625	741	116
North Wing Courtyard	0	4	4	139	30	(109)	669	30	(639)
Other Projects	154	671	517	914	1,281	367	3,028	4,430	1,402
Total Excluding Finance Leases	**4,773**	**3,255**	**(1,518)**	**14,552**	**8,005**	**(6,547)**	**56,647**	**43,813**	**(12,834)**
Finance Leases-IISS	484	1,314	830	1,452	1,737	285	5,815	4,880	(935)
Finance Leases-Other	167	0	(167)	501	0	(501)	2,000	3,433	1,433
Total Capital Expenditure	**5,424**	**4,569**	**(855)**	**16,505**	**9,742**	**(6,763)**	**64,462**	**52,126**	**(12,336)**
Donated Asset Additions	0	(789)	(789)	0	(789)	(789)	(3,043)	(2,796)	247
Total Net CDEL Expenditure	**5,424**	**3,780**	**(1,644)**	**16,505**	**8,953**	**(7,552)**	**61,419**	**49,330**	**(12,089)**
Memo:									
Internal Funding							37,408	31,706	(5,702)
External Funding							19,239	12,107	(7,132)
Total							**56,647**	**43,813**	**(12,834)**
Total in-scope of national slippage							**56,696**	**45,357**	**11,339**
									20%

Statement of Financial Position

(Fav Variance) / Adv Variance

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

Fixed assets being above Plan is due to the year end asset valuation being higher than anticipated at the point the plan was set.

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	368.6	370.1	1.5	403.7
Inventories	16.5	16.2	15.7	(0.5)	16.2
Receivables	105.9	82.4	111.9	29.5	75.5
Cash	61.5	45.8	53.4	7.6	49.8
Payables	(110.5)	(91.1)	(112.6)	(21.5)	(82.7)
Current Loan	(3.3)	(4.6)	(3.3)	1.2	(4.6)
Current PFI and Leases	(7.0)	(4.4)	(7.2)	(2.8)	(4.4)
Net Assets	**435.6**	**413.0**	**428.0**	**15.0**	**453.5**
Non Current Liabilities	(18.2)	(18.3)	(18.2)	0.1	(18.3)
Non Current Loan	(14.6)	(12.4)	(13.8)	(1.3)	(12.0)
Non Current PFI and Leases	(33.0)	(33.9)	(31.3)	2.6	(34.6)
Total Assets Employed	**369.8**	**348.4**	**364.8**	**16.4**	**388.7**
Public Dividend Capital	211.0	216.1	211.0	(5.2)	223.7
Retained Earnings	125.0	106.8	120.0	13.2	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**	**348.4**	**364.8**	**16.4**	**388.7**

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Trust Clinical Strategy 2019 – 2024			
Category	Strategy and Business Planning		
Agenda item	5.1		
Sponsor	Medical Director		
Author	Tristan Chapman, Derek Sandeman, Sue Leamore		
Provenance	The report outlines the development of the new Trust Clinical Strategy with the attached strategy for approval. TEC, Strategy and Finance Committee and Trust Board have been regularly briefed on the development of the Strategy. In development of the Clinical Strategy internal staff have been engaged through a number of events. External local partners have also had the opportunity to comment during the development of the strategy.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for APPROVAL. To present the new Trust Clinical Strategy to Trust Board. The recommendation is that Trust Board approve the Trust Clinical Strategy.		
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: • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care		

	• BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • BAF010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status
Impact assessments	None
Other standards affected	What standards will your recommendations affect? • CQC • NHS Long Term Plan

1. Introduction or Background

Since March 2019, the Trust has been developing a Corporate 5 year Strategy for UHS that:

- Sets a vision for the organisation and corresponding goals
- Defines the UHS mission, our purpose
-
- Responds to the NHS Long Term Plan
- Identifies priorities for strategic change and builds corresponding plans
- Identifies and addresses key organisational strategic questions
- Responds to the needs of the population
- Is developed collaboratively with staff, patients and health and care system partners
- Aligns with wider health and care system plans
- Is measurable with identified financial implications for change

The Trust has held numerous internal engagement events to consult with various clinical and non-clinical staff throughout the development of the Clinical Strategy. An external engagement event with local partners was also held during the development in order to gather feedback on network models of care and collaborative working across the system.

2. Conclusion

The final version of the Clinical Strategy has now been completed and is attached for approval. A public facing version of this document is intended to be produced following further engagement with patients and the public.

Further work will follow this in order to model what the new Clinical Strategy means in terms of activity, capacity, finance etc.

3. Recommendation

The recommendation is that Trust Board approve the Trust Clinical Strategy.

4. Appendices

- Executive Summary
- Trust Clinical Strategy 2019-2024

UHS CLINICAL STRATEGY 2019-2024

Our staff come to work to provide *world class care for everyone* and have set this as the vision for UHS. The clinical strategy needs to provide a guide on how we will achieve this vision, particularly in a challenging environment. I believe the collective thoughts of our teams outlined in this strategy will show how this can be delivered. Our strategy must also meet the goals set in the NHS long-term plan (LTP) including key pathway changes as well as an expectation to collaborate with partners to create a world class health system. The aims of the LTP align with our vision and provide opportunities through working with others that can make the vision achievable. I am grateful for the advice and input of so many who have created this strategy. This summary does not do justice to all the input but highlights some key messages. A full document captures more of these inputs and provides more detailed explanations of the proposed changes.

Executive Summary

- UHS will provide **world class** clinical care and outcomes to all we serve.
- Continue to be a **leading teaching hospital** with a reputable and innovative research and development portfolio, that attracts the best staff
- We will **deliver comprehensive clinical services, working with partners**. Care from cradle to grave and for all, supporting health and wellness; as well as caring for all illnesses.
- We will deliver the **safest care** through a proactive approach supported in an open culture of learning. We will incorporate systems, approaches and technological support that make it hard to do the wrong thing.
- **Patients will be at the centre** of all our pathways and care. Pathways will support the care delivered by all partners and will be organised so that the patients experience will be seamless.
- We will focus on delivering **'realistic medicine'** and champion shared decision making between patients and clinicians. Whilst our interventions transform the lives of most we care for, we all recognise individuals who do not benefit from our care and who in retrospect would not have chosen treatment. We will ensure that care and intervention delivers effective outcomes bringing meaningful benefit to individuals.
- Our services will be delivered with partners through **3 principle clinical networks** which relate to local, regional and super–regional populations:
    - **Integrated Community** - A local network working with our local health and care system, we will provide world class care to our local population (<1m people).
    - **Hospital Network** - A hospital network will provide acute interventions to a regional population, either in isolation or through collaboration with partner

hospitals where this will provide the opportunity for better outcomes and efficiency (1-3m people).

- **Specialised Services -** A regional network supporting a wider population where the intervention must be delivered at UHS and outcomes are better when supporting a much larger population (3m + people).

- Working with others we will focus on **improving the health of our population**, supporting both health and well-being. We will make every contact count supporting healthcare prevention and early diagnosis. Intervention will be tailored to meet the needs of each community in order to allow equity of access to services and advice. Care will be provided at the right time and right place to deliver the appropriate level of care and best patient experience.

- We will arrange acute services in an **'emergency village'** at the hospital front door for the care of acutely unwell patients. Physicians and surgeons will support ED to deliver an MDT approach to each individual as required, as well as provide virtual support to partners where this increases their confidence in supporting patients in the community.

- **Outpatient provision** will transform with systems matching the best service providers in the world. IT systems will support patient self-management and virtual clinical pathways. As well as efficient services such as: one-stop clinics; 'hospital streets' where all investigations are performed at the same visit as the consultation and virtual follow up and disease monitoring.

- **Paediatrics** will continue to be delivered through strong networks. UHS will support the care of specialised patients working with our DGH partners, as well as further developing the partnership with Oxford where outcomes are dependent on delivering to a wider population.

- **Elderly care** will work with community partners to provide frailty care close to home wherever possible. Ceilings of care related to individual wishes will be matched with appropriate local provision.

- The **emerging GP clusters** will be supported by specialist advice allowing the local delivery of care to patients with multiple and single co-morbidity at cluster level. They will be supported to manage or refer acute deterioration with enhanced confidence through working in stronger partnerships with our front door teams.

- Cancer physicians will **work with diagnostic partners** to support and develop pathways that proactively deliver **early cancer diagnosis** to all our populations.

- **Cancer services** will work within the network to ensure that our wider population is able to receive the best care possible. Care will be provided locally when possible but delivered centrally when this will bring better outcomes. The increasing complexity of care will be affordable from savings in other areas and consolidation, to allow investment in complex treatment including surgical and non-surgical interventions.

- **Specialised services** will serve large populations at Centres of Excellence which have the clinical expertise, capability and infrastructure to provide complex services.

National Reviews for Paediatrics (Neurosurgery, Cardiac), Maternity and Obstetrics are likely to see some service centralised to ensure delivery is safe and sustainable.

- We will be a **leading centre for clinical research**, innovation and teaching

Introduction

UHS is recognised as a **provider of excellent clinical care, with outstanding outcomes**. We will always have a central and growing role as a **major teaching hospital**, delivering excellent care to our local population, alongside specialist care to the sickest patients with the most complex needs of the wider population. Patients with complex needs require the input from many specialised teams in order to consistently deliver the best care and outcomes. To meet the highest expectations and standards we will need to maintain our model of providing comprehensive services to all. This requires the **best clinical teams** with the **highest levels of skill** and **best infrastructure**.

In order to thrive, UHS needs the system to support ever more complex and expensive care when required. It is central to our role and ethos to be able to deliver world leading care. It is unlikely that this cost will be met through a higher tax burden and so will need to be met through **delivering greater value** (cost / quality) in all that we do. This will require our energy and innovation working with partners to deliver high quality, cost effective pathways and this will need to be our focus with clear goals to ensure success.

Working with partners we need to meet the needs of our local population and **reduce demand for hospital services**.

The most empowering change is **a move from competition between providers** to an expectation of collaboration. The system leaders, clinical leaders and managers will be required to lead with the patient and the patient journey at the heart of all decisions. This should result in system redesign that delivers seamless care to the highest standards in the most cost effective models of care. Form will change to meet function.

The most fundamental change we envisage will be the creation of networks of care around all we do. Networks will enable partners to work hand in glove, make strong alliances and deliver world class care and outcomes. These networks will be visible in all our services.

How these changes are designed and delivered will be a task for us all and require our focus and engagement. The rewards will reflect our efforts and **success will be a world class health system** for our population.

Principles underpinning our Clinical Strategy

Our aim is to deliver world class care and outcomes for our populations and patients. Services need to review their pathways and care against the best care models and outcomes in the world and change to benchmark against the best. Networks will bring in the resources and capability of others to help us drive up quality and access, as well as reduce cost overall. We will have 3 principle network models. Services need to consider where they would best sit and consider where they might wish to form alliances.

Emerging Networks

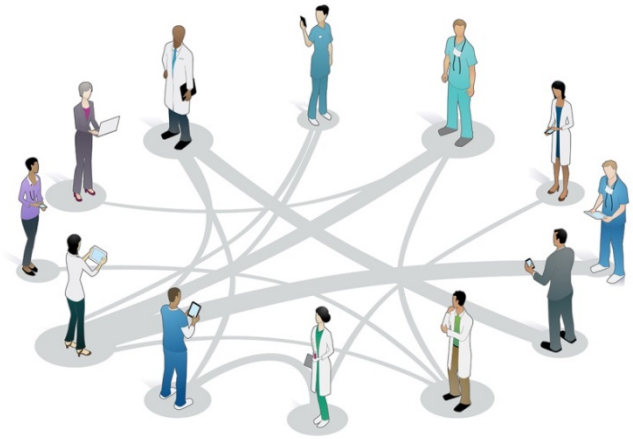
Specialised Services [Integrated]
Complex interventions delivered at UHS, with connected DGH network

Hospital Network [Horizontal]
Hospital Services Delivered Across a Network of Providers

Integrated Community [Vertical]
Integrated Services for the local population (urgent care and LTCs)

EMERGING MODELS OF CARE

- **Super Specialised centres with networks**
- **Genomics**
- **Personalised medicine**
- **Clinical networks**
- **Research-led care**
- **Outreach to support integration**
- **Outpatient redesign enabled by technology**
- **Rapid diagnostic centres**



Network model 1 – Specialised Service Networks

Services in this model are defined by the intervention or care needing to be delivered at UHS. An example would be cardiac surgery. The network would include referring hospitals to ensure the process is seamless and looks at cost throughout the pathway ensuring rapid transfer in and out. Such networks may choose to partner with other regional providers where further subspecialisation or support would add value. Services in this network will also include many not currently considered specialised commissioning, for example: hepatobiliary services. Typically such services will have a catchment area greater than our key population.

Network model 2 – Hospital Networked Care

Services in network 2 could be provided at UHS or at an alternative location. There is not a primary intent to move such services away from UHS, but to empower teams to consider a wider ambition when this will help achieve the best outcomes. An example:

Urology through collaborating with Salisbury and HHFT can see a model that delivers the scale to deliver the best services in a way that would not be possible if they tried to pursue a model of care with us as the only provider. The principle is to provide outpatients at each

unit but UHS to provide complex and cancer therapy, Salisbury working with the plastic surgeons to develop uro-plastics and Winchester to deliver benign work. Each subgroup of this 'Wessex' model will have greater volumes, resilience and expertise through the collaboration, achieving a world class service for patients.

Services in this network predominantly comprise of traditional secondary care elective specialties, both medical and surgical, and are currently delivered locally. Many services will remain local, whilst others will choose to develop a networked service model working with other providers where this allows the development of world class leading services and outcomes.

Capital available is unlikely to provide the required infrastructure for further centralisation without change. It is doubtful that the city will be able to provide sufficient staff and, even if possible, would leave the wider system with redundant capacity and poor resilience elsewhere. We will need to work with partners to utilise their capacity and staff when such a network would deliver a better service. The staff involved in these services are crucial to the provision of emergency care and supporting specialised care and will therefore have a central role in these services. If in designing new models of care a service chooses to deliver some aspect of the pathway off-site then it is important that the delivery is by our staff working in an integrated model.

Where sub-specialisation is required to deliver the best outcomes a service must consider serving a wider population through a network with partners, utilising the facilities of all as illustrated in the proposed urology model.

There may be advantage in developing a specialised cold elective facility off-site to enable the further development of a regional 'specialised hospital' where this allows very high volume sub-specialist and expert care. Whilst orthopaedics is crucial to deliver major trauma and single limb trauma at UHS, the capacity to deliver cold orthopaedic care is already lacking. Working collaboratively in a cold elective focussed facility is being considered by regional orthopaedic surgeons

Finally, some services in this network will have sub-groups of the service that more match Network 1, yet the majority of the service remains independently delivered at all acute sites. For example all providers are likely to deliver colorectal surgery for cancer. There will be centralisation to larger providers of some sub-groups, for example:

UHS will deliver some services to the region such as highly complex colorectal cancer service. Previously patients with recurrent pelvic cancer invading vital structures were offered only palliative care and faced a painful death. Through networked MDTs, those patients will be offered complex surgery, inter-operative radiotherapy and chemotherapy at UHS before being returned to the local providers for ongoing care. This pathway is now offering a 70% chance of survival, a transformational change for these patients that should be available to all.

Care models described will be developed through networks, a degree of shared governance and MDT practice. The key to their success will be through strong clinical relationships, a shared vision and a relentless belief in being the best. It will require strong leadership and all clinicians in the region to engage in the conversation.

Network model 3 – Integrated Community Networked care

Services in this model are likely to be servicing our local population and will benefit from working with our community, primary care providers as well as social care. This will include many medical specialties as well as acute surgical specialties. Teams will develop pathways that help and support other providers to care for patients in the community developing an increase in their capability and confidence. Clinicians may choose to work across the current boundaries. Success will deliver better patient experience and outcomes and care only in the most appropriate place. Payment will reflect the whole pathway so that activity at any part of their service is not critical, however we would expect a reduction in emergency attendance and admissions at UHS if successful. This is strategically important if the Trust is to balance capacity to meet demand for specialised/high acuity care. We will establish exemplar models of care to deliver the best outcomes for patients being cared for in our local system. Our aspirations are for world class outcomes in these services and this will only be possible if we play our part in improving population health and positively impacting the wider determinants of health.

Much of the transformation asked by the long-term plan and our population centres around these pathways. The models of care need to be co-designed with our partners and patients.. The models described have been discussed with key stake holders but will evolve as discussions continue and we and patients experience the changes.

Success will depend on strong relationships and leadership, agreeing clear pathways that are flexible and responsive to the individual needs of patients. Patients need these services to be local and delivered as close to home as possible. Primary care networks supported by community physical and mental health providers working with other partners will be key to designing and delivering these .
Chronic diseases will need to be managed in these local networks. Improving services and outcomes for respiratory diseases (asthma, CDPD), cardiovascular disease and diabetes are key priorities of the long term plan. Prevention, screening and the early diagnosis of cancer is key to affordable health care, keeping people healthy will become the responsibility of all.

Looking after our frail elderly population represents the highest volume of activity. Adopting new care models for those in nursing homes, advanced care planning and community care is essential if we are to provide care closer to home. If we are successful we will avoid unnecessary trips to hospital, provide better care for people at the end of life and enable more people to die in a location of their choice.

Emerging UHS Network Model

The aims, direction of travel and challenges in the LTP are laudable however this can only be **achieved if we all deliver the changes**. These changes need to be significant and will involve us all looking at the way we deliver care, engage in the whole journey and work with partners to create new models of care. If we do achieve these goals it will result in UHS being able to play its part in the system, help us realise our ambition of delivering the best possible acute and specialised care. We therefore need now to be clear of how we will do this and set clear expectations and deliverable goals in our clinical strategy.

Our aim is to deliver world class care and outcomes for our populations and patients. Services need to review their pathways and care against the best models and outcomes in

the world and change to benchmark against the best. We will at times need to use our ingenuity to achieve those ambitions; however we are able to do this with many services already having world class outcomes. Networks will bring in the resources and capability of others to help us drive up quality and access as well as reduce cost overall. We will have 3 principle network models. Services and need to consider where they would best sit and consider where they might wish to form alliances.

CHAPTER 2 – Strategic Enablers

Shared decision making / Realistic medicine

The long-term plan places personalised care at the centre of all we do. A key part of that is shared decision making. In Scotland this is called **'Realistic Medicine'** reflecting the need for a patient to understand the real risks and benefits of a treatment before they embark on a plan which they later regret because they did not have a realistic understanding of the likely outcome for them.

This cannot usually be done by simply adapting our conversations in clinic. It is perhaps the attempt to deliver this through personal effort in a busy clinic that underlies the gap between clinicians belief in patient involvement in decisions and those reported by patients. Effective models require decision making to be part of the pathway and planned at key points with specific planned activities not just added to a busy clinic.

Population Health Management, Prevention and Health Inequalities

We will:

- Support early diagnosis of cancer
- Use the latest business intelligence tools to identify those patients who may need intervention to avoid further deterioration and hospital care.
- Embed prevention into our care pathways and work with Public Health to 'Make Every Contact Count ' (MECC)
- Referring patients to community services such as 'Quitters' at pivotal points in their life
- Support further development of Alcohol Care Services to reduce hospital attendance, admission and ambulance call-outs
- Extend the reach of expert care through supported self-management, using online tools such as video and my Medical Record
- Support mothers and infants through maternity services, in line with aspirations set out in the 'first 1001 days' programme for children
- Work with partners, patients and their families to improve the lives of those with long term conditions e.g. MSK, diabetes, respiratory care
- Work with partners, patients and their families to provide a joined up and equitable approach to mental and physical health.

Outpatients

Vision - The Trust will deliver the most accessible, efficient, caring and patient centred pathway and care for patients not requiring admission or emergency attendance

Outpatient provision will be transformed to facilitate immediate access to care and diagnostics through the use of technology. Patients and other professionals will have direct access to care and advice when they want it and in a way that best meets their need. The outpatient services will focus on only doing things that add value to patients and deliver this in the simplest and most cost effective way. This will be achieved through a meticulous focus on best practice, value and delivery that meets needs and expectations of all patient groups.

To accommodate growth in outpatient demand and create the capacity to respond in a timely way through transforming pathways:

- Patient self-management through a trusted portal
- Virtual pathways. A virtual pathway will manage a patient through a pathway eliminating or reducing the need for clinical engagement
- Direct to test. Patients referred for investigation and only seen if the result requires intervention.
- One Stop. One stop clinics allow decision making either by an organised pathway in a 'hospital street' or through pre-investigation prior to a clinic appointment.
- The use of My Medical Record to allow further development of:
  - Patient triggered follow up
  - Chronic disease monitoring with triggered follow up
  - Virtual review
- Further use of video clinics or telephone clinics
- Development of advice and guidance to support other providers
- Adopt innovative trial designs and delivery to reduce follow-up visits for clinical research

Research

Vision: Research for all

Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our hospital for the benefit of our patients and staff. Our aspiration is that every clinical area will be engaged in high quality research and every patient and member of staff should have the opportunity to be part of a research study. Our mission is to embed research in all of our clinical services and in doing so achieve an international reputation for being a research-led University Hospital.

Digital

Digital is key to our future; its footprint is throughout all our services, processes and pathways. The benefits of Digital need to align with our clinical strategy and be seen in patient safety, experience as well as making it easier for our staff to do their jobs. We need to drive efficiency and productivity through the careful application of systems. We need to measure and improve the impact of digital in both staff time and satisfaction. Our systems need to support pathways, driving efficiency and safety making it hard not to do the right thing.

Improving Safety

The NHS aims to be the safest healthcare system in the world. We aim to be the safest system in the NHS. Our culture will put safety at the heart of all care. To achieve this ambition we will need to transform our approach from one that reacts to events to a proactive systematic process that avoids harm. We will build on our current governance structures, recognising the successes these have delivered. Our focus will move from these governance processes to a proactive safety culture, embracing the principles of Quality Improvement to improve care.

A Proactive Safety System

Careful reviews of healthcare systems reveal around 10% of patient care journeys are associated with potential adverse events of which about 50% are thought to be avoidable [Insert Reference]. Despite a focus on identifying harm, learning from events and sharing this learning there is little evidence that this has delivered dramatic change over the last decade. There are multiple reasons. Firstly it requires harm to occur to trigger action. This assumes that harm identifies the most risky pathways and highlights the greatest risk in that pathway. In reality harm often has more to do with chance, occurring when the metaphorical holes in the Swiss cheese align. Absence of harm does not indicate a safe pathway. We do not have the same focus on near misses yet there is no reason to suspect lessons here might not be more pertinent. When we examine these singular events our response is often overly bureaucratic and often does not provide insight. Staff can cite many examples where we have improved safety; 'stop it for safety', pressure ulcers, MRSA, C.diff, Sepsis and AKI pathways. It is noticeable that these pivotal safety improvements have resulted from a focus on pathways rather than incidence. They have more difficulty naming key lessons and benefit as a result from our learning from events. The reason is that lessons derived from single events are often too specific and narrow to connect with all and guide their thinking.

How do we improve?

We need a strong infrastructure which proactively identifies risk and empowers our staff to make changes that mitigate potential harm through quality improvement. This approach mirrors the pathway improvement process so familiar to us all, usually focussed on efficiency. At critical points in the pathway, instead of looking at efficiency, focus on risk and how to reduce it. There are tools to support this approach which can guide us, looking at patient, human, technical and organisational factors.

For example, in a process that is familiar and automatic, risk occurs because of distraction. If care depends on following a clear protocol, risk is introduced if the protocol is not accessible or if people are too busy. Using tools to guide us with the input of all involved in a pathway allows a proactive identification of risk which in turn allows us to work on how we reduce that risk. This is not dependent on harm and allows a progressive focus on all we do. It is not by chance the most successful safety initiatives we all recall have resulted from a focus on pathway, this approach brings much more effective change.

We have appointed clinical leads to focus on proactive safety systems and quality improvement. They will help us all deliver a robust proactive safety culture, supported by our current governance structures. We will work with patients and families to ensure that improvements are co-designed with them, meeting their needs and delivering the best care.

Values and Behaviours

Our values and behaviours are the foundations of how we work at UHS and remain unchanged.

- Patients first
- Working together
- Always improving

University Hospital Southampton
NHS Foundation Trust

CLINICAL STRATEGY
2019 – 2024

INDEX

CHAPTER 1 – Clinical Strategy and Models of Care

Our Clinical Strategy

University Hospitals Southampton NHS Foundation Trust (UHS) aims to provide world class services in acclaimed models of care, an expert in all we do. This strategy sets out the guiding principles and goals for our services to ensure that we deliver our vision and meet the ambitious NHS Long Term Plan through developing networked services with our partners.

Trust Vision

'World class care for everyone'

Trust Mission

'Together: we care, innovate and inspire'

Trust Values

1. ***Putting Patients First***
   Patients and families will be at the heart of what we do and their experience within the hospital, and their perception of the Trust, will be our measure of success

2. ***Working Together***
   Partnership between clinicians, patients and their families is critical to our success. This extends across organisational boundaries in the NHS, social care and third sector.

3. ***Always Improving***
   We will ensure we are always improving services for patients and prioritise research, education, clinical effectiveness and quality improvement. Our growing reputation in research and development will continue to incorporate new ideas, technologies and greater efficiencies in the services we provide

Trust Strategic Goals

1. **Improve patient journeys** (system focus, integration)
2. **Value based health and care** (value = quality/cost, sustainability)
3. **Healthy lives** (prevention, wellbeing inequalities, outcomes and experience)
4. **An expert and inclusive workforce** (diversity, engagement, leadership)
5. **Being agile in meeting people's needs** (organisational elegance/design/flexibility)
6. **Leading edge research, education and innovation** (research and outcomes)

Corporate Strategy

Vision, Mission, Values & Goals

Strategic Plan (5 Years)

Deliverables & Transformation Enablers:

Quality / Workforce / Estate & Kit / Digital & Data / Education / R&D / £ > Alignment

NHS

The NHS Long Term Plan

Executive Summary

- UHS will provide **world class** clinical care and outcomes to all we serve.

- Continue to be a **leading teaching hospital** with a reputable and innovative research and development portfolio, that attracts the best staff.

- We will **deliver comprehensive clinical services, working with partners**. Care from cradle to grave and for all, supporting health and wellness; as well as caring for all illnesses.

- We will deliver the **safest care** through a **proactive continuous improvement approach** supported in an open culture of learning. We will incorporate systems, approaches and technological support that make it hard to do the wrong thing.

- **Patients will be at the centre** of all our pathways and care. Pathways will support the care delivered by all partners and will be organised so that the patients experience will be seamless.

- We will focus on delivering **'realistic medicine'** and champion shared decision making between patients and clinicians. Whilst our interventions transform the lives of most we care for, we all recognise individuals who do not benefit from our care and who in retrospect would not have chosen treatment. We will ensure that care and intervention delivers effective outcomes bringing meaningful benefit to individuals.

- Our services will be delivered with partners through **3 principle clinical networks** which relate to local, regional and super–regional populations:

    - **Integrated Community** - A local network working with our local health and care system, we will provide world class care to our local population (<1m people).
    - **Hospital Network** - A hospital network will provide acute interventions to a regional population, either in isolation or through collaboration with partner hospitals where this will provide the opportunity for better outcomes and efficiency (1-3m people).
    - **Specialised Services -** A regional network supporting a wider population where the intervention must be delivered at UHS and outcomes are better when supporting a much larger population (3m + people).

- Working with others we will focus on **improving the health of our population**, supporting both health and well-being. We will make every contact count supporting healthcare prevention and early diagnosis. Intervention will be tailored to meet the needs of each community in order to allow equity of access to services and advice. Care will be provided at the right time and right place to deliver the appropriate level of care and best patient experience.

- We will arrange acute services in an **'emergency village'** at the hospital front door for the care of acutely unwell patients. Physicians and surgeons will support ED to deliver an MDT approach to each individual as required, as well as provide virtual support to partners where this increases their confidence in supporting patients in the community.

- **Outpatient provision** will transform with systems matching the best service providers in the world. IT systems will support patient self-management and virtual clinical pathways. As well as efficient services such as: one-stop clinics; 'hospital streets' where all investigations are performed at the same visit as the consultation and virtual follow up and disease monitoring.

- **Paediatrics** will continue to be delivered through strong networks. UHS will support the care of specialised patients working with our DGH partners, as well as further developing the partnership with Oxford where outcomes are dependent on delivering to a wider population.

- **Elderly care** will work with community partners to provide frailty care close to home wherever possible. Ceilings of care related to individual wishes will be matched with appropriate local provision.

- The **emerging GP clusters** will be supported by specialist advice allowing the local delivery of care to patients with multiple and single co-morbidity at cluster level. They will be supported to manage or refer acute deterioration with enhanced confidence through working in stronger partnerships with our front door teams.

- Cancer physicians will **work with diagnostic partners** to support and develop pathways that proactively deliver **early cancer diagnosis** to all our populations.

- **Cancer services** will work within the network to ensure that our wider population is able to receive the best care possible. Care will be provided locally when possible but delivered centrally when this will bring better outcomes. The increasing complexity of care will be affordable from savings in other areas and consolidation, to allow investment in complex treatment including surgical and non-surgical interventions.

- **Specialised services** will serve large populations at 'Centres of Excellence' which have the clinical expertise, capability and infrastructure to provide complex services. National reviews for paediatrics (Neurosurgery, Cardiac), maternity and obstetrics are likely to see some service centralised to ensure delivery is safe and sustainable.

- We will be a **leading centre for clinical research**, innovation and teaching.

About UHS

The Trust is a tertiary centre in the Wessex Region, and one of the largest acute providers in the South of England. It provides local inpatient services for a population of 1.9m, and a tertiary service for a population of 4m for adult services and 5.6m for Children's services. Local services are predominantly provided to Southampton City (SCCCG) and West Hampshire CCG (WHCCG). Regional work comes from the rest of Hampshire, Sussex, Surrey, Wiltshire, Isle of Wight and Dorset. For some more specialised services, patients travel from Devon, Cornwall, the Channel Islands, Berkshire, Oxfordshire, Buckinghamshire and Northamptonshire. The Trust also plays an important role in teaching and training health professionals of the future, and undertaking research and development, in close partnership with the University of Southampton.

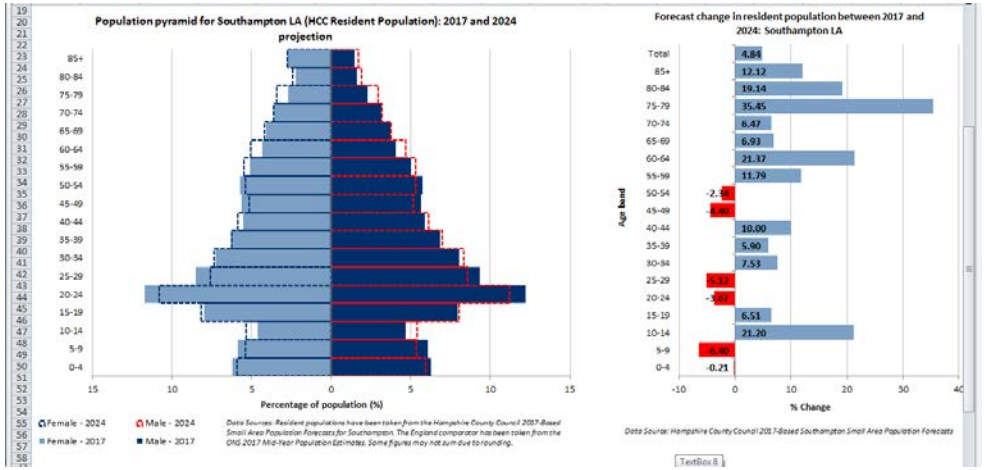
Every year our 11,500 staff:

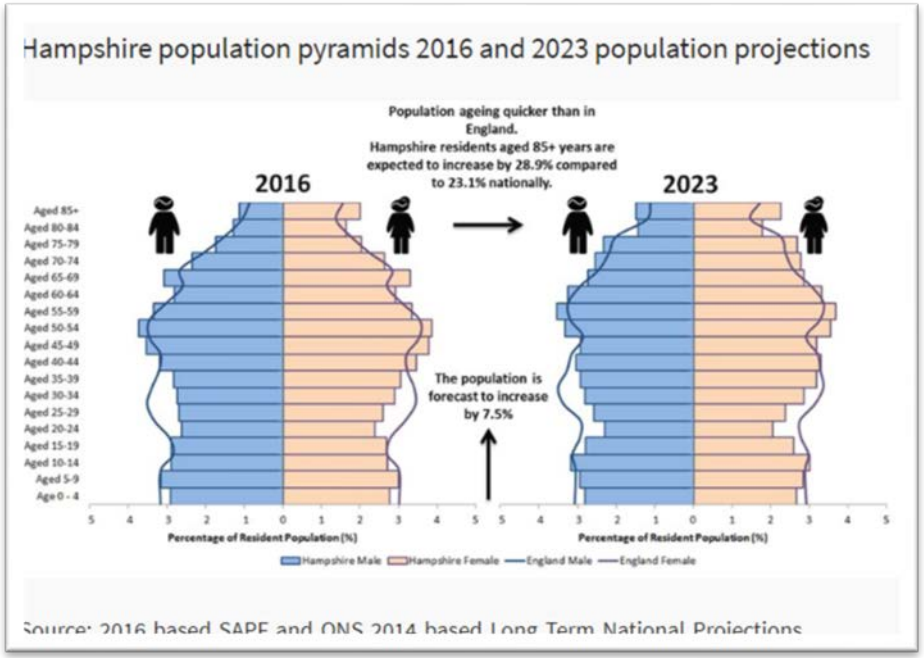
- ***Treat around 150,000 inpatients and day patients, including about 50,000 emergency admissions***
- ***See over 624,000 people at outpatient appointments***
- ***Deal with around 135,000 cases in our emergency department***
- ***Recruit 20,000 patients into research studies***

Activity has been growing across the Trust, reflecting an aging population and increased survivorship due to successful research and advances in treatments. There has also been planned growth in spinal, vascular and stroke care where services have been appropriately centralised. Unplanned care has also grown, despite efforts to stem demand by UHS and system partners. The planned and unplanned growth in activity has impacted on the Trust's ability to meet national performance targets and to follow up outpatients in a timely manner. New Capacity was introduced during 2018/19 and further developments are planned in 2019/20.

Our Population – Southampton and Hampshire

- In 2016, the resident population of Southampton is estimated to be 250,000 and the population of Hampshire is 1.35m
- 20% of Southampton's population is aged between 15 and 24 years compared to just 12.4% nationally. This reflects the large student population
- Both populations have a rapidly growing aging population. The population of Hampshire over 85 is expected to increase by 30% by 2023 (55,000)
- The proportion of children is also expected to increase
- These increases will put a disproportionate pressure on the NHS and every clinical service will need to become an expert in managing frailty. This is reflected in our strategy to provide integrated local care and personalised medicine.
- Within Southampton there is a high incidence of respiratory conditions, diabetes and associated complications. We will work closely with network partners to address these health inequalities, leveraging our expertise across a wider network.





Hampshire and Isle of Wight – Health System Priorities

Hampshire and the Isle of Wight have jointly set system priorities, working through the Sustainability and Transformation Partnership (soon to be an Integrated Care System). These priorities are reflected in the UHS Clinical Strategy.

Improving UEC outcomes	Development of the out-of-hospital urgent care system and deliver enhanced support for care homes. Facilitate access to GP records in GP streaming service, reduce handover delays from Ambulance to ED and further increase the proportion of acute admissions discharged on the day of attendance
Improving Planned Care outcomes and services for people with LTCs	Overall outpatient transformation, and introduce a new integrated diabetes pathway focussed on early intervention, aiming to reduce the number of diabetic amputations in 2019/20. Creating common pathways across a range of long-term conditions such as diabetes, respiratory, cardiovascular, MSK End of life care. Targeted risk stratification leading to fewer contacts with health services for those identified as being at greatest risk
Improving cancer outcomes	Increasing prevention and early detection of cancer, with pathway redesign to support achievement of the new 28-day target
Prevention of ill health	Reducing smoking in pregnancy, support diabetic foot management and maximising the opportunity for prevention interventions each time people come into contact with health services in each provider
Mental health outcomes and services	Suicide prevention, Acute mental health beds, Improving crisis care. Psychiatric liaison services
Cluster development	Sharing learning and best practice in implementing the agreed cluster model
Enablers	Workforce; including developing rotations of staff within pathways and through organisations and It was recognised that partners are working together at STP level on workforce issues and felt that there is a need to localise this is work in Southampton and South West Hampshire Digital; including business intelligence Estates; specifically working on issues that span boundaries

Future Direction

UHS is recognised as a **provider of excellent clinical care, with outstanding outcomes**. We will always have a central and growing role as a **major teaching hospital**, delivering excellent care to our local population, alongside specialist care to the sickest patients with the most complex needs of the wider population. Patients with complex needs require the input from many specialised teams in order to consistently deliver the best care and outcomes. Research enables us to offer leading edge care and new treatment options. To meet the highest expectations and standards we will need to maintain our model of providing comprehensive services to all. This requires the **best clinical teams** with the **highest levels of skill** and **best infrastructure**.

UHS does not sit in isolation but in a wider national and local context. The **NHS Long Term Plan (LTP)** sets a clear vision for the NHS which must drive our corporate and clinical strategy. The LTP is not at odds with our vision; the ambition articulated should lead to the best healthcare in the world. If we are to succeed we need to embrace the LTP as it provides the framework for the NHS to change in a way that will allow the NHS to thrive and succeed despite the pressures of patient need and expectation and in the face of real financial constraints.

When Simon Stevens produced the 5 year forward view, the predecessor to the LTP, it set a similar vision of change. This plan was to be lead through locally developed and delivered System Transformation Plans (STPs). The expectation in the LTP is more explicit and directive and over the next few years we will see **significant change in how services are delivered and funded**. These changes will have the effect of moving us into a **more complex but connected system of healthcare**, away from the simple provider model we have so long been accustomed to. To match the clear expectation we need a refresh of our clinical strategy.

In order to thrive, UHS needs the system to support ever more complex and expensive care when required. It is central to our role and ethos to be able to deliver world leading care. It is unlikely that this cost will be met through a higher tax burden and so will need to be met through **delivering greater value** (cost / quality) in all that we do. This will require our energy and innovation working with partners to deliver high quality, cost effective pathways and this will need to be our focus with clear goals to ensure success.

Working with partners we need to meet the needs of our local population and **reduce demand for hospital services**. Specifically we need to support an increasingly frail and elderly population; reduce demands from preventable illness; facilitate earlier diagnosis; and address local inequalities in health. UHS needs to support others to deliver care in local settings wherever appropriate, only delivering care ourselves where we add additional value. If we and the local system are unable to drive these changes then it will limit our ability to operate as a specialised centre and prevent the investment required to deliver world class outcomes.

The NHS Long Term Plan is aligned with these views. There is a strong focus on **improving community and primary care delivery**. Primary care are organising themselves into networks serving a population of 30,000-50,000 people. This will allow the development of community services that are responsive to the population needs. There will be an enhanced emergency response (patients with acute need being seen within two hours) and re-enablement pathway following admission (with a target acceptance of 24 hours).

There will be a **strong focus on prevention** with goals to reduce risk factors and ensure a healthier population. A plan to drive earlier detection of cancer will deliver better outcomes. By working as a unified team we will improve **the emergency pathway** within the community and at the front door of the hospital. We will play our role **improving care in common diseases** such as diabetes; respiratory and cardiovascular disease as well as focusing on child health and mental health. These are all admirable goals and will help us meet our vision. It is our duty and responsibility to engage in this agenda but also in our interest as success will enable us to deliver our vision.

Triple integration and mental health:

The NHS Long-term Plan sets an ambition for triple integration between physical health, mental health and social care. By working closely with community and mental health partners we will ensure patients receive seamless care as near to their home as possible. By working in partnership we can move patients in crisis to the most appropriate setting and ensure that those patients with multiple needs can receive an equitable and high quality service. Success will improve patient experience, outcomes and reduce system cost.

Population health management:

As an anchor NHS employer in Southampton UHS will champion health and wellbeing in the workforce and local community, focusing on influencing the wider determinants of health. We will play a direct role where appropriate (influencing the reduction of smoking and alcohol) and support partners better placed to influence than ourselves (e.g. air quality). We will play our part in aligning health, care and other sector resources to focus on delivering improved outcomes for people living within the community (e.g. Better Care Fund Southampton). Specifically we will:

- Support early diagnosis of cancer
- Embed prevention into our care pathways and work with Public Health to 'Make Every Contact Count ' (MECC), referring patients to community services such as 'Quitters' at pivotal points in their life
- Support mothers through maternity services and the 'first 1001 days' for children
- Work with partners to improve the lives of those with long term conditions e.g. MSK, diabetes, respiratory care
- Work with partners to provide a joined up and equitable approach to mental and physical health.

The financial model of payment is changing. The intention is to align payment mechanisms with the whole pathway. The rationale is to incentivise pathway change to reduce cost, **in future increased activity will be a cost pressure rather than rewarded** as it is in the PBR payment regime. If we do not respond to these changes we will not be able to invest in care in the best way. Blended payments are effectively a block contract for individual services. The benefits can only be realised if we all focus on the cost of care across the whole pathway.

For example a focus on community foot care in diabetes will reduce cost and spend in the hospital with a result in better outcomes. Our surgeons are already trying to lead this change. In the current model this will reduce income to UHS. However in the future it will reduce cost, not income, a clear example of how these changes can incentivise the system to deliver a different and better outcome for patients whilst also allowing us to invest in our future.

The most empowering change is **a move from competition between providers** to an expectation of collaboration. The system leaders, clinical leaders and managers will be required to lead with the patient and the patient journey at the heart of all decisions. This should result in system redesign that delivers seamless care to the highest standards in the most cost effective models of care. Form will change to meet function.
The most fundamental change will be the creation of networks of care around all we do. Networks will enable partners to work hand in glove, make strong alliances and deliver world class care and outcomes. These networks will be visible in all our services.

- Some specialised services will network with other providers, such as paediatrics with Oxford, and most will network with referring hospitals to smooth pathways.
- Services currently delivered in all acute providers may choose to form networks. We cannot aspire to consistently achieve international benchmarks of quality and outcomes unless we have sufficient scale to afford the latest technology and infrastructure. Networks should also bolster capacity and/or improve value through scale.
- The need for frailty, urgent care and emergency services to develop networks is much heralded nationally. This journey has started locally but there is much more to be done. Integrated access to urgent care will deliver the most visible change to our population.

How these changes are designed and delivered will be a task for us all and require our focus and engagement. The rewards will reflect our efforts and **success will be a world class health system** for our population.

The aims, direction of travel and challenges in the LTP are laudable. The results can only be achieved if every part of the care system engage in change. This will involve us all looking at the way we deliver care, engage in the whole pathway and work with partners to create new models of care. Only if we achieve these goals as a system will we meet our vision of world class care for the populations we serve. We therefore need now to plan how we will do this and set clear expectations and deliverable goals in our strategy.

Delivering Strategic Goals

	Integrated Community Care	Emergency Village	Networked Hospital Care	Rapid Diagnostics	Specialised Care Networks	Realistic Medicine	Proactive Safety Culture	Quality Improvement	Transform Outpatient Care	Embedded Prevention	Research for All
Improve patient journeys (system focus, integration)	✓✓	✓✓	✓✓	✓	✓✓	✓		✓	✓✓	✓	
Value based health and care (value = quality /cost, sustainability)	✓✓	✓	✓✓	✓	✓	✓✓	✓✓	✓✓	✓✓	✓✓	
Healthy lives (prevention, wellbeing inequalities, outcomes and experience)	✓✓	✓	✓	✓✓	✓	✓✓	✓	✓	✓✓	✓✓	✓
An expert and inclusive workforce (diversity, engagement, leadership)	✓		✓✓		✓✓		✓	✓			✓✓
Being agile in meeting people's needs (organisational elegance/design/ flexibility)	✓✓	✓	✓✓		✓✓				✓✓		
Leading edge research, education and innovation (research and outcomes)			✓✓	✓	✓✓	✓✓	✓	✓		✓	✓✓

Principles Underpinning our Clinical Strategy

Our aim is to deliver world class care and outcomes for our populations and patients. Services need to review their pathways and care against the best care models and outcomes in the world and change to benchmark against the best. We will at times need to use our ingenuity to achieve those ambitions; however we are able to do this with many services already having world class outcomes. Networks will bring in the resources and capability of others to help us drive up quality and access, as well as reduce cost overall. We will have 3 principle network models. Services need to consider where they would best sit and consider where they might wish to form alliances.

Emerging Networks

Specialised Services [Integrated]
Complex interventions delivered at UHS, with connected DGH network

Hospital Network [Horizontal]
Hospital services delivered across a network of providers

Integrated Community [Vertical]
Integrated services for the local population (urgent care and LTCs)

EMERGING MODELS OF CARE

- **Super Specialised centres with networks**
- **Genomics**
- **Personalised medicine**
- **Clinical networks**
- **Research-led care**
- **Outreach to support integration**
- **Outpatient redesign enabled by technology**
- **Rapid diagnostic centres**

Network Model 1 – Specialised Service Networks

Services are defined by the intervention or care needing to be delivered at UHS. An example would be cardiac surgery. The network would include referring hospitals to ensure the process is seamless and looks at cost throughout the pathway ensuring rapid transfer in and out. Such networks may choose to partner with other regional providers where further subspecialisation or support would add value. Services in this network will also include many not currently considered specialised commissioning, for example: hepatobiliary services. Typically such services will have a catchment area greater than our key population.

Strengthened networks will support shared governance and pathways with our partner providers and provide better opportunities for research participation. Care should be delivered locally where possible and the negative impact of travel on patients, carers and families must be carefully considered. Clinicians based in other centres should be supported through MDT working, education and shared pathways to support patients locally. The network will consider the pathway as a whole ensuring efficient use of resource in parts of the service.

UHS will be ready to respond to the outcomes of national reviews, for example paediatric intensive care. Where further centralisation is deemed to offer the best outcomes for patients UHS will work with the wider network to ensure seamless pathways and a balance of capacity across the wider network. Cutting edge treatments should be available to the wider population, ensuring equity of provision.

The care and treatment of patients with cancer is becoming more effective and significantly more complex. The best outcomes will always be delivered through earlier diagnosis and this will be a key deliverable. Following diagnosis it is clear that the current evidence and future vision will drive further centralisation and greater co-dependency of increasingly complex multi-disciplinary teams. UHS needs to create the ability and capacity to meet these opportunities for our patients, and where appropriate the system, working in a hub and spoke model.

High-volume centres improve patient experience and outcomes. Such centres deliver increased surgical and other clinical expertise as well as creating efficiency and productivity gains allowing investment in new technology. This is already well evidenced but the drivers are growing when providing cancer care. The Royal College of Surgeons (RCoS) recognise that cancer care will require more complex teams delivering care in fewer larger centres. We already recognise the co-dependency on different specialist surgeons, either planning joint operations or in the face of unexpected complications.

Case example: a cardiac surgeon providing bypass to create a bloodless field in the abdomen allowing a cancer urologist to safely remove a life threatening vascular phaechromocytoma deemed inoperable in other centres.

In the near future surgeons will also need the support of oncologists, immunotherapists and transplant teams working alongside tissue engineers and geneticists in order to plan and deliver a personalised plan for individuals. The RCoS report recognises the need for fewer and larger surgical centres.

Our strategy identifies the need for early diagnosis, multi-disciplinary planning and delivery of care to offer patients the best available options. Patients will be at the centre of decision making about their care. They will be empowered through a personalised approach, allowing an understanding of the personal risks and benefits for them at every stage. They will be encouraged to maximise their wellbeing in our fit for surgery school prior to embarking on treatment. Specialised nurses will work with palliative care and oncology teams to ensure patients are fully informed so that they can be equal partners in key decisions.

The principles underpinning our service will be:

- Rapid diagnostic pathway enhancing the uptake of screening and a pathway for vague symptoms
- A networked model of care with partners
- Specialist surgeons working with a wider MDT
- Complex oncology support including complex DXT (IORT, stereotactic and conformational DXT), immunotherapy, CAR-T cell therapy.
- Care closer to home when possible including the ability to deliver systemic anti-cancer therapy locally
- Rapid management of side effects and complications through acute oncology
- Provision of regional advice and treatment supporting partners when required
- Risk stratified follow up and outcomes measuremed through technology and other means
- Personalised medicine including cancer genetics
- The development of tissue engineering
- Realistic medicine with teams trained in shared decision making and 'fit for surgery'

Genomic Medicine Centres (GMCs) have been established together with a network for Genomic Laboratories as key building blocks of this strategy, as well as with Genomic research. Our future vision for genomics at UHS is:

- Centralised genetic testing at UHS for Wessex including interpretation
- Embedded genomics and personalised medicine across the Trust
- Increased research.

UHS will continue to be the receiving major trauma centre for the South Coast. We will work with network hospital partners to ensure we sustain the necessary skills and capacity to staff this service. An example would be the acute plastics service, a collaboration with Salisbury.

UHS will continue to provide tertiary services for Stroke care, including mechanical thrombectomy. We expect volumes to increase from 60 to several hundred per year over the coming 5 years. Rehabilitation will be provided in local and integrated services and will include the voluntary sector.

Comprehensive provision of specialised services in adults and paediatrics will continue to be a priority at UHS, ensuring comprehensive provision for our wider population, and avoiding the need for patients to be sent further afield. Working with colleagues in other regional centres, e.g. Oxford, will be an important part of maintaining sustainability.

Network Model 2 – Hospital Networked Care

Services in network 2 could be provided at UHS or at an alternative location. There is not a primary intent to move such services away from UHS, but to empower teams to consider a wider ambition in order to help achieve the best outcomes. An example:

Urology through collaborating with Salisbury and HHFT can see a model that delivers the scale to deliver the best services in a way that would not be possible if they tried to pursue a model of care with UHS as the only provider. The principle is to provide outpatients at each unit but UHS to provide complex and cancer therapy, Salisbury working with the plastic surgeons to develop uro-plastics and Winchester to deliver benign work. Each subgroup of this 'Wessex' model will have greater volumes, resilience and expertise through the collaboration, achieving a world class service for patients.

Services in this network predominantly comprise of traditional secondary care elective specialties, both medical and surgical, and are currently delivered locally. Many services will remain local, whilst others will choose to develop a networked service model working with other providers where this allows the development of world class leading services and outcomes.

The continuing expansion of knowledge, complexity of intervention and required infrastructure is driving centralisation in order to deliver the best cost effective outcomes. High volume sub-specialised teams are associated with the best outcomes, and are best able to invest in modern equipment and more attractive to the most able staff. This is seen in both medical, surgical and support teams and is at the core of our current future success.

Care closer to home is important, particularly for those with frailty, chronic conditions or general emergency care. It is less important when considering elective care which is often single or short lived interventions. Here outcomes and experience are usually more important than the site of delivery. Centralisation of services implies a continuous migration of services towards UHS and certainly where complexity and co-dependency demands this we need to have the capacity. Delivering the required capacity will require us to work within networks, creating capacity through different models of service.

Capital available is unlikely to provide the required infrastructure for further centralisation without change. It is doubtful that the city will be able to provide sufficient staff and, even if possible, would leave the wider system with redundant capacity and poor resilience elsewhere. We will need to work with partners to utilise their capacity and staff when such a network would deliver a better service. The staff involved in these services are crucial to the provision of emergency care and supporting specialised care and will therefore have a central role in these services. If in designing new models of care a service chooses to deliver some aspect of the pathway off-site then it is important that the delivery is by our staff working in an integrated model.

Where sub-specialisation is required to deliver the best outcomes a service must consider serving a wider population through a network with partners, utilising the facilities of all. Such models might include the delivery of the most complex component of care at UHS whilst delivering other interventions off-site. Alternatively, some sub-specialties will be delivered only at another provider venue where there will be a larger resilient team. To avoid duplication of investment across all providers the best kit and support should be targeted at defined sites. This recognises capital is likely to be further constrained in the future.

There may be advantages in developing a specialised cold elective facility off-site to enable the further development of a regional 'specialised hospital' where this allows very high volume sub-specialist and expert care. Whilst orthopaedics is crucial to deliver major trauma and single limb trauma at UHS, the capacity to deliver cold orthopaedic care is already lacking and a national issue. Working collaboratively in a cold elective focussed facility is being considered by regional orthopaedic surgeons. The volumes and combined clinical expertise would rapidly support services that match the best in the country. The focus that this would allow through MDT working, clinical research and investment would transform this part of the practice from a position of current frustration to pride.

Finally, some services in this network will have sub-groups of the service that more match Network 1, yet the majority of the service remains independently delivered at all acute sites. For example all providers are likely to deliver colorectal surgery for cancer. There will be centralisation to larger providers of some sub-groups, for example:

UHS will deliver some services to the region such as highly complex colorectal cancer service. Previously patients with recurrent pelvic cancer invading vital structures were offered only palliative care and faced a painful death. Through networked MDTs, those patients will be offered complex surgery, inter-operative radiotherapy and chemotherapy at UHS before being returned to the local providers for ongoing care. This pathway is now offering a 70% chance of survival, a transformational change for these patients that should be available to all.

Care models described will be developed through networks, a degree of shared governance and MDT practice. The key to their success will be through strong clinical relationships, a shared vision and a relentless belief in being the best. It will require strong leadership and all clinicians in the region to engage in the conversation.

Network Model 3 – Integrated Community Networked care

Services in this model are likely to be servicing our local population and will benefit from working with our community, primary care providers as well as social care. This will include many medical specialties as well as acute surgical specialties. Teams will develop pathways that help and support other providers to care for patients in the community developing an increase in their capability and confidence. Clinicians may choose to work across the current boundaries. When a patient needs more specialised care it should be experienced as seamless and a continuous pathway by the patient. Success will deliver better patient experience and outcomes and care only in the most appropriate place. Payment will reflect the whole pathway so that activity at any part of their service is not critical, however we would expect a reduction in emergency attendance and admissions at UHS if successful. This is strategically important if the Trust is to balance capacity to meet demand for specialised/high acuity care. We will establish exemplar models of care to deliver the best outcomes for patients being cared for in our local system. Our aspirations are for world class outcomes and this will only be possible if we play our part in improving population health and positively impacting the wider determinants of health.

Much of the transformation asked by the long-term plan and our population centres around these pathways. The models of care need to be co-designed with our partners and patients. Whilst care delivered by different providers is usually excellent, gaps between us can unfortunately lead to poor experience and outcomes for patients. This is where we must prioritise integration of services to deliver seamless pathways. The models described have been discussed with key stake holders but will evolve as discussions continue and we and patients experience the changes.

Success will depend on strong relationships and leadership, agreeing clear pathways that are flexible and responsive to the individual needs of patients. It will depend on the engagement and input of all those who provide, commission and deliver services from social care, physical and psychiatric care. Patients need these services to be local and delivered as close to home as possible. Primary care networks will be key in designing and delivering these services to meet the needs of their local population, always ensuring equality.

Chronic diseases will need to be managed in these local networks. Improving services and outcomes for respiratory diseases (asthma, CDPD), cardiovascular disease and diabetes are key priorities of the long term plan. This can only be achieved through partnership and integrated delivery. We already provide services in this manner, e.g. the respiratory centre, and there are many more opportunities to work alongside primary and community care. Prevention, screening and the early diagnosis of cancer is another priority which we will need to deliver together.

Looking after our frail elderly population represents the highest volume of activity. Adopting new care models for those in nursing homes, advanced care planning and community care is essential if we are to provide care closer to home. If we are successful we will avoid unnecessary trips to hospital, provide better care for people at the end of life and enable more people to die in a location of their choice.

Overarching Clinical Strategy - Create an Emergency care village at UHS that has the scale and resource to respond and co-ordinate (sift and sort) response to people approaching crisis in their communities. Facilitate support and early decision making from a senior decision maker of the appropriate specialty.

The model may include provision of advice and safety netting, divert to alternative same day or urgent care facilities within the region for diagnostics and treatment or conveyance to UHS. If conveyed to UHS then the patient will need to be assessed by the right senior clinician at the right time and this may involve more than one speciality working together as a single team. Once the senior decision has been made in UHS then the outcome may be:

- Discharge home with or without follow up plan / support from intermediate care
- Transfer to alternative unit (e.g. Lymington, RSH, Winchester, Salisbury)
- Admit to SGH

Other resource currently within UHS may be outsourced to alternative units. The overall aim is that primary care physicians will feel better supported to have the confidence to better manage their patients at home. The core pillars of an Urgent and Emergency Care Village:

Workforce	Estates	Technology	Governance	Process	Patient experience
• One team • Clear mapping of roles and responsibilities • Dedicated surgical and cardiology decision makers • Specialist nurses • Doctors assistants • Therapy • Pharmacy • Phlebotomy • Administrators • Education, training and career progression • Research skills and joint roles	• 5 key clinical areas with space to flex accrding to surges • Enviroment which encourages flow and efficient working • Non-clinical areas - offices, common room and seminar room	• Paperless • Standing work stations with access to all IT needed • Seemless working with EPR (Drs Wlist and ePSAG) • Technology solutions to manage flow and identify staff on-shift • Communications solutions	• Separate sub-division with trustwide ownership • Trauma unit within sub-division • Performace dashboard • Time stamps • Time to consultant decision • Time to move out of UEC • Outcomes • Link with hospital dashboards • QI & research programme • Link with NIHR research recruitment dashboard	• Single clerking proforma accross whole trust starting with GP referral / paramedic notes • Responsive transport • Internal • External • Access to CXR and CT • Links to community health • Pathways to neurology, O&G, cancer care • Pathway for psychiatry	• CQC standards • Clear communication and sign posting • Setting expectations • Divert to urgent care centre • Patient behaviour • Fit for purpose discharge lounge

Intermediate care describes a range of integrated services that: promote faster recovery from crisis; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. These services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. **Four service models of intermediate care are available**: bed-based intermediate care, crisis response, home-based intermediate care, and re-enablement. Crises may be physical, mental or social in nature; often they are a combination of all three elements which cannot be managed in isolation.

Re-enablement is separate to rehabilitation and describes assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks and are delivered by a multidisciplinary team.

Intermediate care can also be considered in terms of i) p*roactive components* where high risk individuals are identified prior to crisis in order to support targeted intervention and case management (risk stratification) and ii) r*eactive components* where individuals who are in crisis have access to a responsive service which offers a suite of options to maximise the chance of recovery.

Future Vision

What would a UHS intermediate care model look like?

6 Principles:

i. ***Home first***
People should be managed in their homes whenever possible and only be admitted to an acute hospital bed when absolutely necessary; this requires responsive community healthcare services and access to homecare plus emergency step up beds and transport. Patients in crisis who remain at home will remain under the care of their usual GP and therefore the confidence of primary care in the resilience and capacity of intermediate care is vital.

ii. ***Same Day Emergency Care (SDEC) Hubs; close working with primary care***
Same Day Emergency Care (SDEC) hubs (e.g. Southampton, Lymington, Winchester) to focus expertise and diagnostic resource; working alongside community urgent response teams (these may be one team).

iii. ***Why not home, why not today?***
Embedding Pathways O (no care); 1 (restart care); 2 re-enablement), 3 (highly complex) to support the timely flow of patients across the system; no organisational or commissioning barriers.

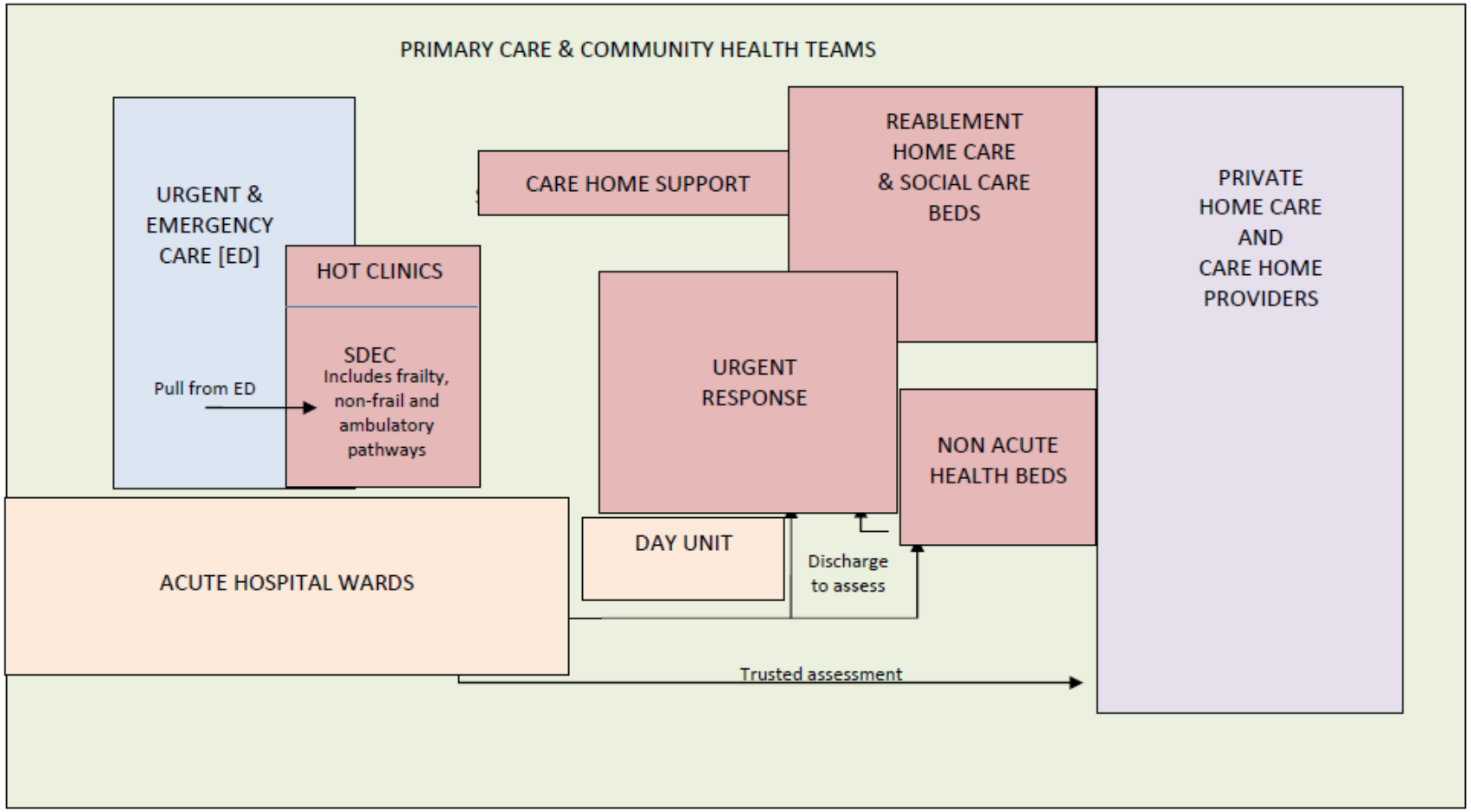
iv. ***Nursing home care and anticipatory care planning (ACP)***
Robust use of a single anticipatory care plan for patients with clear visibility to paramedics and out of hours community care: proactive care and reactive care.

v. ***Efficient use of non-acute beds***
Non-acute beds only used when a person cannot be managed at home; step up and step down; focused rehabilitation and wide acceptance criteria.

vi. ***Mental health a core component in all settings***

The illustration below shows intermediate care within the wider health and social care system. At its centre is a multidisciplinary team of health and social care professionals with expertise in managing older people, strong clinical leadership and decision making and the resource (diagnostic, transport) to support primary care to manage people effectively in the right settings. Robust access to re-enablement home care is vital to maximise the likelihood that people can remain at home.

Relationships between primary and community care, intermediate care (in red) and secondary care



Paediatrics

Overarching Clinical Strategy - Integration of children's services from conception to transition, with single pathways of care from prevention to highly specialised services including community and secondary care services

The NHS long term plan sets ambitious goals to improve children's services from prevention to specialised cancer care. UHS will play its role as the university teaching hospital and work with partners, such as Oxford, to provide world-class care to our catchment populations. The children's hospital will work in the three tiered networks, mirroring adult services. UHS will be one of the main Children's Hospitals in Thames Valley/Wessex and will aim to provide care closer to home. We will create virtual children's hospitals with all sub-specialities and work with a network of providers across the region. Where necessary, we will resolve critical mass issues by engaging acute hospitals within the M25 corridor and develop as a leading clinical research centre.

Children and young people account for emergency department attendances and are the most likely age group to attend A&E unnecessarily[1]. To address this we will work with community and mental health providers to provide holistic care closer to home. We will integrate secondary care with community services, utilising GP hubs in all areas of the STP. We will develop hospital at home with in-reach and outreach from a combined community/secondary care paediatric service. Through these efforts we will avoid unnecessary admissions and facilitate early discharge. We will provide single pathways of care for complex children from tertiary to community.

In all of our work to transform services for children and young people we will play particular attention to ensuring vulnerable children receive equality in services, both during childhood and in transition to adult services.

[1] NHS Long Term Plan

Maternity, Obstetrics and Neonatal

Much like paediatrics, services for pregnant women and new born babies will fall into networks to provide care as close to home as possible but centralising when highly specialised care or equipment is required. The NHS Long Term Plan endorses the continuation of service re-design set out in the Five Year Forward View and 'Better Births' whilst setting further ambitious goals for a reduction in still births, infant mortality and neonatal mortality.

In obstetrics the Trust currently provides the complex maternal medicine service and tertiary fetal centre for the South Coast. The service has a strong reputation and is part of a National Service Review which is likely to result in centralisations of obstetric units in the future to centres of excellence and expertise. We will work with network partners to design a workforce solution which addresses shortfalls across the region. Our maternity services are leading the Local Maternity System Transformation, via collaboration. The vision is to create a single integrated maternity service across HIOW STP. Digital integration is a key part of this which is already underway using UHS MyMR technology as a platform.

The neonatal service already delivers tertiary services for the South Coast and provides a joint hosting with Oxford for the regional neonatal transport service. It is the lead unit within the Neonatal ODN - delivering tertiary neonatal and specialised services for South coast within UHS and the community. We will be ready to respond to recommendations in national reviews such as the Neonatal Critical Care review, delivering the required capacity and benchmarked international standards. Our aim is to turn no local child away from the network and provide seamless transition of long term care into Southampton Children's Hospital. We will continue to develop the range of outreach services offered to facilitate early discharge from hospital setting.

Diagnostics

Radiology and pathology services are moving into networks nationally to achieve economies of scale and workforce sustainability. In line with Lord Carter recommendations UHS will move towards network provision of pathology services. This will involve consolidating work in a more cost effective way, by working in networks and integrating services. This will involve all regional specialised work across the pathology disciplines to be provided at UHS as the "hub", supported by our strong consultant and specialised scientific workforce. Our vision includes:

- To establish UHS as the Cancer Genomics hub for Wessex and potentially beyond
- Centralising specialised work strengthens and gives opportunities to develop existing Research, UoS and Commercial partner links
- Playing to the UHS strengths offset by the network exchange of work for routine and automated work by either movement of specimens or transfer of digital images across the network
- Maintaining UHS as the link between primary and secondary care for specialist interpretation and advice regardless of where specimens are tested

Radiology services already work from a common PACs system which provides a good platform for networked services. This will facilitate education and support for smaller sites to keep certain work there. Our vision is to have Regional Reporting (Diagnostic) Centres. Work in a network will allow hub and spoke arrangements for smaller subspecialised pathways: Paeds, Nuclear Medicine, Cardiac, Interventional (Gen / Neuro / Vasc), Diagnostic/interventional out of hours services.

Working in a network will also enable:

- Insourcing by shared networks / better use of existing regional capacity
- Shared scanning protocols and pathways
- Shortened protocols for certain pathways
- Regional MES to support more up to date kit
- Staff secondments/rotations to support regional training.

Emerging UHS Network Model

Conclusion

The aims, direction of travel and challenges in the LTP are laudable however this can only be **achieved if we all deliver the changes**. These changes need to be significant and will involve us all looking at the way we deliver care, engage in the whole journey and work with partners to create new models of care. If we do achieve these goals it will result in UHS being able to play its part in the system, help us realise our ambition of delivering the best possible acute and specialised care. We therefore need now to be clear of how we will do this and set clear expectations and deliverable goals in our clinical strategy.

Our aim is to deliver the best care and outcomes for our populations and patients. Services need to review their pathways and care against the best models and outcomes in the world and change to benchmark against the best. We will at times need to use our ingenuity to achieve those ambitions; however we are able to do this with many services already having world class outcomes. Networks will bring in the resources and capability of others to help us drive up quality and access as well as reduce cost overall. We will have 3 principle network models. Services and need to consider where they would best sit and consider where they might wish to form alliances.

CHAPTER 2 – Strategic Enablers

a) Shared Decision Making / Realistic Medicine

The long-term plan places personalised care at the centre of all we do. A key part of that is shared decision making. In Scotland this is called **'Realistic Medicine'** reflecting the risks that patients adopt a treatment which they later regret because they did not have a realistic understanding of the benefits and risks.

Most Drs believe that they practice realistic medicine and involve patients carefully in shared decisions. This belief is not shared by patients. Where a consistent programme of shared decision making is implanted there is a 24% reduction in complex intervention and overall better patient outcomes and patient satisfaction.

The current traditional model of decision making puts the clinician at the centre, the only competent decision maker with all the knowledge of outcomes and risks. Patients usually accept this in the face of the gap in understanding and trust in the clinician. However when patients participate in the decision making they bring their personal attitudes to risk, their personal needs into the decision and different choices are often made.

Future Vision

- Shared decision making at every important decision point in care and part of routine consultation

To be effective patients need to understand the illness, its symptoms, the options for treatment and their risks. They need to know the magnitude of the benefit to them and how this will affect their life. The risks of a knee replacement would be considered differently if the benefit is to allow occasional sport versus allowing you to return to independent living.

This cannot usually be done by simply adapting our conversations in clinic. It is perhaps the attempt to deliver this through personal effort in a busy clinic that underlies the gap between clinicians' belief in patient involvement in decisions and those reported by patients. Effective models require decision making to be part of the pathway and planned at key points with specific planned activities not just added to a busy clinic.

Proficiency in delivering shared decision making will require transformational change. Clinicians will need to be trained and pathways adapted to allow complex discussions, often supported by specialist nurses. We will need to create appropriate literature and digital resources to guide patients and clinicians. The benefits to patients are clear, ensuring they are able to receive the care that they need and would choose. The benefit to us is the confidence that we are doing the right thing and that our patients enter a treatment cycle with a realistic expectation. The potential reduction in activity will create capacity to meet our current capacity gap end will repay the investment required.

b) Population Health Management, Prevention and Health Inequalities

The long term plan places prevention and population health management centrally and a priority for all partners in the health and care system. UHS must play its part in leading this agenda. Data will be a key part of this, identifying health need at a local level and proactively targeting resources to address health inequality. This includes both public health data and data from 'operational systems' which can flag patients accessing multiple services and displaying a high risk of needing urgent care. New technology and partnership working will allow the hospital to project expert knowledge to patients and community clinicians, slowing the onset of long term conditions and frailty and reducing overall system demand. The role of the NHS includes secondary prevention. Treating disease and alleviating symptoms to support people leading a happy and healthy life.

Future vision

Specifically we will:

- Support early diagnosis of cancer
- Use the latest business intelligence tools to identify those patients who may need intervention to avoid further deterioration and hospital care.
- Embed prevention into our care pathways and work with Public Health to 'Make Every Contact Count ' (MECC)
- Referring patients to community services such as 'Quitters' at pivotal points in their life
- Support further development of Alcohol Care Services to reduce hospital attendance, admission and ambulance call-outs
- Extend the reach of expert care through supported self-management, using online tools such as video and my Medical Record
- Support mothers and infants through maternity services, in line with aspirations set out in the 'first 1001 days' programme for children
- Work with partners, patients and their families to improve the lives of those with long term conditions e.g. MSK, diabetes, respiratory care
- Work with partners, patients and their families to provide a joined up and equitable approach to mental and physical health.

c) Outpatients

Vision - The Trust will deliver the most accessible, efficient, caring and patient centred pathway and care for patients not requiring admission or emergency attendance

The NHS and UHS need to transform the way we deliver outpatient services. The LTP demands a fundamental redesign through the use of alternatives utilising digital and has set a 5 year target of a 30% reduction in activity. Outpatient models of care have changed little over years and as a result the way we deliver these services has fallen behind the dramatic changes in other sectors and falls far short of the expectation of our population:

Case for change: "If I want a new shirt, provided I order it before 6pm I will have it in the morning, if I want any type of food I can have it delivered to my door at any time. If I am not coping with my diabetes and am frightened you will see me in 8 weeks"

Future Vision

Outpatient provision will be transformed to facilitate immediate access to care and diagnostics through the use of technology. Patients and other professionals will have direct access to care and advice when they want it and in a way that best meets their need. The outpatient services will focus on only doing things that add value to patients and deliver this in the simplest and most cost effective way. This will be achieved through a meticulous focus on best practice, value and delivery that meets needs and expectations of all patient groups.

To accommodate growth in outpatient demand and create the capacity to respond in a timely way through transforming pathways:

- Patient self-management through a trusted portal
- Virtual pathways. A virtual pathway will manage a patient through a pathway eliminating or reducing the need for clinical engagement
- Direct to test. Patients referred for investigation and only seen if the result requires intervention.
- One Stop. One stop clinics allow decision making either by an organised pathway in a 'hospital street' or through pre-investigation prior to a clinic appointment.
- The use of My Medical Record to allow further development of:
  - Patient triggered follow up
  - Chronic disease monitoring with triggered follow up
  - Virtual review
- Further use of video clinics or telephone clinics
- Development of advice and guidance to support other providers
- Adopt innovative trial designs and delivery to reduce follow-up visits for clinical research

i) Direct to Test

a) *Current Patient Story - Mrs F wants to know if she is at risk of osteoporosis and whether she should take preventative treatment. She attends her GP who checks her details against guidelines for screening. Screening is recommended and a letter of referral for DEXA scanning is written. A scan is performed, 8 weeks later as the result is sent to her GP who organises a follow-up appointment. At this appointment she is informed that she has normal bone density and everything is all right.*

b) *Future Pathway - Mrs F logs onto her computer and onto the Staying Healthy page of UHS. She completes an online questionnaire that identifies that she should consider screening and reads the advice provided. Having decided to continue she directly books a convenient time for a scan at UHS. The result shows no osteoporosis and it is sent to her explaining the detail. Mrs F is re-assured and has received care with no clinical visit and only an appointment for the scan; a significant saving of time for her and money for the system.*

ii) One Stop

c) *Current Patient Story - Mr D has a chest pain suggestive of angina and is referred by the GP. He is seen two months later in outpatients and the history suggests acute angina. He is referred for an ECG, stress echo and bloods and receives 3 appointments for investigation. He is reviewed 10 weeks later, his fourth attendance at the hospital for a follow-up consultation when the results are shared and the presence of stable mild Ischemic heart disease is confirmed and a treatment plan discussed.*

d) *Future Pathway - Mr D is referred with symptoms of angina. He fills in an online questionnaire that confirms the likelihood of stable angina and is given options of clinics to attend in the current week. He attends the following day and moves from room to room receiving blood tests, a stress echo, ECG and finally with the results to see the clinician. A diagnosis and management plan is agreed, opportunities to participate in research discussed, and he is discharged back to the GP with a diagnosis of stable mild angina.*

iii) Advice and Guidance – Patient Example

e) *Current Patient Story - Mrs G has raised Ca++. She is referred for a clinic review and managed through a series of outpatient appointments. For each appointment her husband takes time off work to accompany her to the appointment in central Southampton. The trip takes 5 hours in total. The cost of trip including petrol, parking and lost income is £140.*

f) *Future Pathway - Mrs G's GP directs her to the UHS site. She registers with My Medical Record and investigations are organised to identify the cause, look for complications and future risk. A diagnosis of hyperparathyroidism is made and she receives notification with a clear guidance and information including how she may participate in suitable research studies. She chooses between written information, a cartoon description of the key information or a video of an explanation. Following considering the information she opts for conservative management and is placed into the MyMR chronic diseases surveillance path. 5 years later her annual Ca++ review shows it has risen and she is asked to attend to discuss definitive treatment.*

These examples are for illustration. Services will need to review pathways with an aim to provide as much variety of options to improve patient accessibility, to reduce current demand and make room for unavoidable growth. Services should be patient focused with their needs and economic impact considered when designing pathways. Over the next 5 years all services will need to have embedded the principles of one stop, have developed at virtual pathways and where monitoring is required put them into a virtual MyMR pathway.

	What can we do	What do we want to be able to do	Ease/benefit/impact
One-stop (tests before the day)	• Manually review new referrals and equest tests prior to outpatients appointment. • Manually co-ordinate the booking of diagnostics • Manually monitor patients awaiting diagnostics(excel) • Manually book to outpatients following diagnostics	• Diagnostics to be auto-requested once electronic grading / routing slip form submitted (or interim solution) • Automatic process to book outpatient appointment once diagnostic has taken place • monitoring to flag patients that do not undergo instigations in specified time frame	• Reduce human error • Reduce PSC/PPC workload • Release clinician time through removing equest process • Reduce rescheduling due to diagnostics / OP appointment misalignment • Reduced OPFU
Direct to test	• Manually review new referrals and equest tests prior to outpatients appointment. • Manually co-ordinate the booking of diagnostics • Manually monitor patients awaiting diagnostics(excel) • Manually book to virtual clinic following diagnostics	• Diagnostics to be auto-requested once electronic grading / routing slip form submitted (or interim solution) • Automatic process to add patient to a review list (once investigation has taken place • monitoring to flag patients that do not undergo instigations in specified time frame	• Reduce human error • Reduce PSC/PPC workload • Release clinician time through removing equest process • Reduce rescheduling due to diagnostics / OP appointment misalignment • Ensure failsafe monitoring of patients sent straight to test . • Reduced OPFU
Digital pre-assessment	• Transfer the gathering of generic patient information from paper to digital (for a percentage of patients) • Provide a two tier service of F2F or a combination of digital/F2F	• Redesign the current 'pre-assessment questionnaire' and develop specialty specific versions • Simplified registration process • Ability to obtain Diagnostic results from out of area. E.g. Bloods from QA, or ECG from GP surgery • Alternative sign up to MyMr options (other than email address) • ? Patients to be able to self register at 'booths/stations' in outpatients. ? To be able to receive a print out of their next steps and likelihood of having to attend for face to face review	• Reduce repeating information/diagnostics for patients • Reduce PSC/PPC workload • Release clinician time through removing questionnaire completion process • Reduce operation cancellations • Reduce OPFU • Streamlined registration process/self registration process for patients
Virtual	• Register appropriate pathways to MyMR • Manually monitor patients awaiting diagnostics • Manually monitor the co-ordination of monitoring patients on self care pathways • Manually request diagnostics in line with care pathway	• Patient portal with bidirectional communication capabilities and multiple user access (e.g. patient, GP, Consultant) • Diagnostics to be auto requested based upon NICE guidance/Care plan • Automatic process to put patient onto clinician review list post diagnostic/when review required and graded due to urgency (taken from a predefined set of criteria) • Integration with CAMIS, EDMS, Charts and booking solutions	• Increase proportion of patients able to self manage • Prioritise patients requiring clinician intervention • Improve communication across care pathways (patient, primary, tertiary) • Release clinician time • Reduce human error

i) Workforce & Education

University Hospital Southampton NHS Foundation Trust (UHS) has a growing national reputation as a top teaching hospital in the UK and abroad. It attracts candidates locally, nationally and internationally and is also one of the largest employers in Southampton. With almost 11 000 staff working in a diverse range of healthcare related fields, the Trust is an exciting, rewarding and happy place to work.

Much has already been achieved at UHS in relation to its workforce. The Trust has excellent staff survey results that have continued to improve, our education provision and partnership with local institutions is strong most notably the University of Southampton with an excellent reputation regionally. We have a national profile in relation to our delivery of health and wellbeing initiatives; have a strong success with resourcing and recruitment overseas, and a track record of delivering prudent financial performance in relation to workforce expenditure, including reductions in agency spending.

Future Vision

Our vision for the future of workforce and education is simple we need to create an organisation where we can recruit, support, motivate and develop the highest calibre of staff to deliver world class care. World class care is underpinned by the highest quality of education and workforce development ensuring we have the right staff with the right skills in the right place to deliver this. We are an organisation which prides itself on its commitment to our staff and we endeavour to support all learners in reaching their highest potential.

To deliver the care in the future, where a reliance on networked care and integration will be key, we will need to look outside our boundaries to collaborate. Learning and development must happen between and across our partner organisations in health and social care. Fundamentally we need to ensure we educate, train and develop the staff to deliver the aspirations set out within this clinical strategy.

We will need to adapt the way roles develop in the future, enhancing opportunity for advanced practice, increasing scope of healthcare staff at different levels to take on different roles, particularly where resources are scarce. This will result in more roles being cross organisational and cross sector.

We will achieve our people goals by:

- Planning for, attracting, retaining, and deploying the best staff by creating the culture and work environment that makes UHS an employer of choice
- Delivering the UHS culture though our values, and embedding this into all of our day to day work
- Continue to invest in education and training opportunities for our staff, including leadership development
- Focusing on the staff and students of the future by developing our education and training capability for clinical and non-clinical staff
- Ensuring that our leaders and staff understand and deliver our equality and diversity agenda
- Prioritising excellent communication that allows the voice of our staff to be heard and acted upon
- Working with our education stakeholders to offer excellent learning, and placement opportunities to bring high calibre people into roles in the hospital
- Working across boundaries to enable collaborative learning and development
- Being agile with our plans to ensure it meets the emerging clinical strategy for UHS and the national NHS People Plan

j) Research

Vision and Mission: Research for all

Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our hospital for the benefit of our patients and staff. Our aspiration is that every clinical area will be engaged in high quality research and every patient and member of staff should have the opportunity to be part of a research study. Our mission is to embed research in all of our clinical services and in doing so achieve an international reputation for being a research-led University Hospital.

UHS is a centre of clinical academic excellence where new treatments are being discovered, new healthcare professionals are being trained and cutting edge developments are being put into practice.

UHS is a leading centre for clinical research and this activity is central to our future. Research is a key component of our value "always improving" and is vital if we are to improve healthcare. The benefits to UHS and our patients are more immediate and more than just where gained through evolving knowledge and treatments. Patient outcomes are better in research active organisations. The clear outcome benefits are due to many factors, the most significant of which being workforce. Research active organisations:

- Attract and retain the best staff
- Support the development of an inquiring spirit and mind in clinical staff
- Enable staff to work at the forefront of knowledge and current practice
- Offer patients effective new diagnostic and treatments options early
- Promote the same attention to detail and process in clinical care as demanded by research activity

Future Vision

Considering these explanations, it is clear that the outcome benefits for patients arising from being a research active organisation will be maximally achieved through embedding research in clinical and non-clinical roles, departments and care pathways. Research infrastructure should be integrated within clinical services rather than being a separate activity performed solely by research staff. Through this approach we aim to offer the majority of patients the opportunity to participate in research and consolidate our reputation as a research-led University Hospital. Our UHS Research Strategy aims to realise the research potential is all areas of our hospital for the benefit of our patients and staff.

We deliver research working with other key stake holders; the University of Southampton; National Institute of Health Research, other providers including research charities and industry, and patients and members of the public. Our success is dependent on working collaboratively with these partners and will also depend on delivering their priorities through our partnership. The university focuses on 'peaks of excellence' and will be concerned that our ubiquitous approach to research will dilute capacity to deliver it's work. The NIHR through the clinical research network wishes us to deliver research across all clinical areas whilst paying particular

attention to population need, focussing on the things that matter to our people and the service (ageing well, cancer, personalised care, meeting the needs of people with multiple co morbidity, maternity). Industry requires rapid recruitment, high volumes and efficient trials delivery. If we are to meet our priorities and that of our partners it is crucial that we work in partnership and focus on delivering the capacity to meet all these needs rather than limiting our activity to deliver any individual strategic priority. The plan is provided in detail in the UHS Research Strategy but the key priorities for the next 5 years are summarised here.

1. Increasingly embed research within clinical services as they develop in line with UHS Clinical Strategy. Support clinical services to identify and realise ambition and potential thereby increasing opportunities for staff and patients to participate in CRN portfolio research
2. Further develop strategic partnership with the University of Southampton including clear articulation of aligned priorities supported by enablers to increase clinician - academic interaction driving clinically relevant high quality grant and industry funded research
3. Deliver current and secure continued major research infrastructure awards including the NIHR Clinical Research Facility, Biomedical Research Centre, Academic Research Centre, CRUK Cancer Centre, NIHR Antimicrobial Resistance Research Lab
4. Develop and execute strategy to increase engagement and strategic partnerships with Pharma and Medtech to significantly grow contract commercial research
5. Develop skills of workforce, fostering new investigators and multidisciplinary teams, to lead, deliver and support the delivery of research within clinical services
6. Address major barriers to delivering research portfolio such as space and workforce
7. Realise the opportunities afforded by use of digital platforms and data in clinical and operational research
8. Reflecting new configurations in clinical services, work with Wessex and other partners to maximise research opportunities for patients through collaborative initiatives and a 'network-wide' approach

Patient story - *in the run up to her surgery at UHS, Sophia is browsing her UHS "My Medical Record" (MyMR) online account. Her appointment letter had reminded her that UHS is research active and about the ways she could find out more – she's now pursuing one of those routes, searching the trial finder tool in MyMR.*

On finding a trial looking at better management of post-surgery recovery, she answers some simple questions and the tool indicates she is broadly eligible to take part. Her clicking 'Yes' to hearing more sends a notification to the research team, giving them permission to contact her.

Upon admission Sophia has already received the study information and meets the research team in person. They' are able to consent her to the study and upload copies of this to MyMR for her reference. Sophia's status on the Drs Worklist and an icon on the e-whiteboard ensure all staff are aware of her participation throughout the duration of her stay – these system flags, and research activity on the wards have become a standard part of the clinical group's daily work by now. Sophia feels that she's been able to be pro-active in her care, that she has been able to access the latest developments in care and that her participation may help others like her.

k) Digital

Digital is key to our future, its footprint is throughout all our services, processes and pathways. The benefits of Digital need to align with our clinical strategy and be seen in patient safety, experience as well as making it easier for our staff to do their jobs. We need to drive efficiency and productivity through the careful application of systems. We need to measure and improve the impact of digital in both staff time and satisfaction. Our systems need to support pathways, driving efficiency and safety making it hard not to do the right thing.

Future Vision

Our digital vision is "***UHS Digital - world class digital to support "World Class Care for Everyone"***

- To realise the potential for transformation that can be accomplished by strong clinical leadership working jointly with the Informatics service to deliver benefits to patients and staff
- To focus on benefits and outcomes from digital to revolutionise patient care. Improving what we do by utilising the power of technology
- To implement a clinically lead digital strategy that links to and delivers the key needs of pathways, driving safety, efficiency both for patients and clinicians, allowing UHS to deliver the best value clinical care. To harness the best in digital healthcare innovation to do this
- To enable digital transformation of care pathways for all key stakeholders including patients, and to allow us to develop a learning healthcare system, access all patient information, and deliver it in a seamless, intelligent way, so that relevant information is not missed, but any information can be easily found.
- To deliver digital "at point of care" where everyone has the information they need about the patient when they need it, anywhere they are delivering care. To ensure that everything is working first time and stakeholders have the digital support they need to undertake their roles and deliver world class care. To increase and support the digital literacy of our staff and patients
- To put more of the right technology in the hands of every clinical staff member. Implementing the right technology and ongoing assessment of its value and benefit. Minimising the burden of data entry using different technology including speech
- To enable team working for effective communication and sharing of patient information between teams and departments within and outside the Hospital with our health and social care partners. To enhance our position as a regional tertiary centre and provider of world class care.
- To enable information and insight to enhance the management of the individual patient's care, to enable flow and efficiency of the services and to provide knowledge for the care of future patients enabling world class research. To deploy digital enhancements to care such as clinical decision support, artificial intelligence and machine learning to improve safety, efficiency and personalise the care we provide
- To develop "Digital with patients" that helps us put the patient at the heart of everything we do and create opportunities for digital relationships with the patient to improve our administration and clinical services. To harness innovation to care for patients in any location as part of our within walls vision

l) Improving Safety & Quality

The NHS aims to be the safest healthcare system in the world. We aim to be the safest system in the NHS. Our culture will put safety at the heart of all care. To achieve this ambition we will need to transform our approach from one that reacts to events to a proactive systematic process that avoids harm. We will build on our current governance structures, recognising the successes these have delivered. Our focus will move from these governance processes to a proactive safety culture, embracing the principles of quality improvement to continuously improve care.

A Proactive Safety System

Careful reviews of healthcare systems reveal around 10% of patient care journeys are associated with potential adverse events of which about 50% are thought to be avoidable. Despite a focus on identifying harm, learning from events and sharing this learning there is little evidence that this has delivered dramatic change over the last decade. There are multiple reasons. Firstly it requires harm to occur to trigger action. This assumes that harm identifies the most risky pathways and highlights the greatest risk in that pathway. In reality harm often has more to do with chance, occurring when the metaphorical holes in the Swiss cheese align. Absence of harm does not indicate a safe pathway. We do not have the same focus on near misses yet there is no reason to suspect lessons here might not be more pertinent. When we examine these singular events our response is often overly bureaucratic and often does not provide insight. Staff can cite many examples where we have improved safety; 'stop it for safety', pressure ulcers, MRSA, C.diff, Sepsis and AKI pathways. It is noticeable that these pivotal safety improvements have resulted from a focus on pathways rather than incidence. They have more difficulty naming key lessons and benefit as a result from our learning from events. The reason is that lessons derived from single events are often too specific and narrow to connect with all and guide their thinking.

How do we improve?

We need a strong infrastructure which proactively identifies risk and empowers our staff to make changes that mitigate potential harm through quality improvement. This approach mirrors the pathway improvement process so familiar to us all, usually focussed on efficiency. At critical points in the pathway, instead of looking at efficiency, focus on risk and how to reduce it. There are tools to support this approach which can guide us, looking at patient, human, technical and organisational factors.

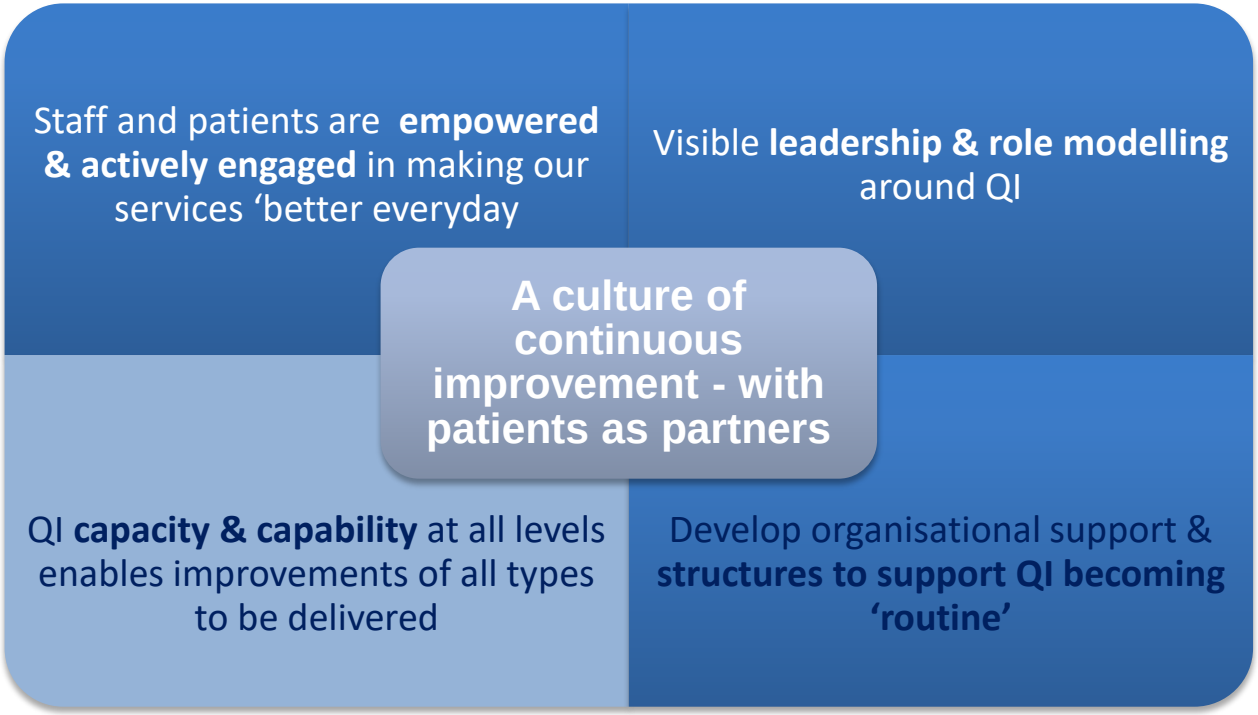
For example, in a process that is familiar and automatic, risk occurs because of distraction. If care depends on following a clear protocol, risk is introduced if the protocol is not accessible or if people are too busy. Using tools to guide us with the input of all involved in a pathway allows a proactive identification of risk which in turn allows us to work on how we reduce that risk. This is not dependent on harm and allows a progressive focus on all we do. It is not by chance the most successful safety initiatives we all recall have resulted from a focus on pathway, this approach brings much more effective change.

We have appointed clinical leads to focus on proactive safety systems and quality improvement. They will help us all deliver a robust proactive safety culture, supported by our current governance structures.

Our **vision** for **Quality Improvement** is to harness the ideas, energy and focus of **all our staff**; people at every level and in every job. Making it a **routine part of everyone's working week.** Our four part strategy will deliver this vision. We will teach evidence based methodologies to enable staff deliver improvements and

promote the IHI 'Model for Improvement' as a guiding framework. We will work with patients and families to ensure that improvements are co-designed with them, meeting their needs and delivering the best care.

Quality Improvement Strategy



We will continue to focus on:

- Mortality and IMEG
- Ensuring we have a culture of continuous improvement with patients as partners
- Compliance with NICE guidelines
- Stop points for safety
- A blameless open culture and fulfil our duty of candour when things go wrong
- Learn from complaints and incidents

- Internal quality reviews

We will introduce:

- A systematic review of pathways to identify and quantify risk
- QI methodology to reduce identified risks
- Empower staff to make immediate changes where they see risk
- Clinical prioritisation agreed at MDTs identifying individual targets in time critical conditions that require more urgent treatment than constitutional standards
- Use real time feedback from patients on quality of care
- Review safety across the whole pathway including care outside UHS

If we are going to deliver world class care it is clear that we should also be at the forefront of safety in healthcare. We need to consider this in all we do.

m) Estate

Overarching Clinical Strategy – deliver fit for purpose estate to meet service need and enable the transformation of service delivery and care

The Trust has a mixed estate of mainly older and some new or newly refurbished, consistent with many similar healthcare organisations. The older buildings, 40-50 years old, require on-going strategic maintenance and reconfiguration within a limited amount of available capital. The Trust conducts a rolling programme, refurbishing up to two wards and theatres every year, subject to available capital and clinical capacity. Following CQC feedback Critical Care has been prioritised for a new building to modernise the current unit.

A public private partnership has provided a new public entrance and communal retail area, fitting of a hospital of this size. This scheme has also provided additional onsite car parking which would not have been available if the Trust had been required to self fund this from it's own capital. Parking onsite remains a priority for clinical staff working unsocial hours and a convenient and efficient park and ride is now available for wider staff. Green spaces will be protected and developed for the benefits of patients and staff. Technology and design will be used to maximum effect, to provide sustainable estate with the best possible environmental conditions.

We will listen to feedback and provide estate and facilities which enable the best possible patient experience and a happy and healthy workforce.

Future Vision

- A better environment for patients and staff
- Refurbishment and regular upgrade of existing theatres
- Refurbishment of aging wards and plan to replace Neurosciences wards (c8 years)
- Completion of the Vertical Extension, providing theatres and clinical capacity to meet demand
- Reconfiguration of estate for service transformation to deliver the clinical strategy
- Investment secured as an enabler for transformation and strategic maintenance to ensure the estate remains fit for purpose
- Develop an estate that is environmentally sustainable into the future

n) Values and Behaviours

Our values and behaviours are the foundations of how we work at UHS and remain unchanged.

Patients first

- The patient's needs and voice will be at the heart of all that we do.
- We will provide comprehensive hospital services from cradle to grave, treating all in a non-discriminatory way, independent of background or disability.
- Care outcomes, experience and quality will be measured and monitored. This information will guide our improvement programmes.
- Care will be provided by highly functional teams and it will be delivered by the most competent team for their needs.
- Patient safety is at the centre of all that we do and all decisions we make. We will work in an open, blameless culture.
- We will endeavour to communicate clearly and effectively with patients, relatives and other staff. We will treat our patients and staff with compassion and courtesy. Information should be available in written form for most conditions.
- Care supported by excellent communication will be delivered in a seamless manner within and without the hospitals.
- Our systems will focus on making it hard to do the wrong thing. We will embrace new technologies that improve care and safety.
- We will embrace the principles of candour and shared learning from complaints, incidents and patient experience.

Working together

- All UHS staff will share a responsibility for the success of their teams, the hospital and the wider community. They will be aware of the local and wider strategies.
- We will embrace a culture that is inclusive, equitable and diverse.
- We will work in an open culture within a respectful atmosphere. We will develop an understanding of the roles and expertise of our teams and those we work with.
- We will work together as teams rather than "alongside".
- Decisions will be made through collective leadership (and not a hierarchical structure).
- Facilitating providing support and access to our expertise as teams will be the guiding principle. We will endeavour to make it as easy as possible for others to receive our help.
- UHS will work with commissioners to understand and help meet the wider strategic objectives. We will be transparent and open and focus on collaborative, working relationships.
- UHS will engage with other local, regional and national partners to develop effective networks that best support the population needs
- We will work with community partners to develop seamless services allowing care to be delivered to best meet the patient needs irrespective of organisations or boundaries.
- We will engage positively with new systems and organisational structures to focus on the best outcome for our patients, embracing new ways of working.

Always improving

- Patient outcomes and experience will drive improvement.
- Teams will be expected and empowered to deliver improvement at every level.
- We will benchmark our services against the best. We will learn from the best.
- Research will be embedded in every team. All patients should have access to appropriate clinical trials.
- Safe care will be delivered through improvement and outcomes with governance structure providing checks and balances.
- We will train our students and doctors to be better than us.
- We will embrace technology to make care safer and more cost effective.
- We will focus on eliminating waste to allowing local resources to be used to deliver the best and most comprehensive healthcare.
- We will work beyond our walls to focus on the whole care pathway.
- We will be at the forefront of clinical expertise and capability in our all specialties.

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Board Assurance Framework (BAF) 2019-20 Q1 Report			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.1		
Sponsor	Chief Executive Officer		
Author	Charlie Helps, Interim Company Secretary		
Provenance	This report is used by the Executive Performance Management Group (EPMG) and Trust Board of Directors to track, monitor, and assess the principal risks to the Board's agreed Strategic Goals, and to respond accordingly. The Company Secretary compiles this report in consultation with each of the Executive Directors and the Chief Executive Officer. The report was considered at the 22 July meeting of the EPMG.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for REVIEW. Each of the six Strategic Goals is assigned to one of the Board's two designated Committees for scrutiny and oversight. It is the role of the statutory Audit Committee to test, on behalf of the Board, that there is a suitable and functioning system of internal control and risk management in place. The BAF Report is provided as a means of closely tracking the risk profile associated with the Board's business model. It allows the Board and its Committees to prioritise their deliberations and to focus on data and intelligence pertinent to its business objectives. The Board is recommended to consider trends and levels of risk to each of the Strategic Goals, assess the validity and suitability of the controls, and to evaluate the evidence provided to substantiate each of the controls.		
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	The following principal risks (BAF Risks) apply to the relevant strategic goals selected above: • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme		

	• BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • BAF010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status
Impact assessments	There is no assessed adverse impact associated with this report.
Other standards affected	NHSI compliance, NHSI Single Oversight Framework, CQC Well-led Framework, NHS Provider Licence Compliance, NHS Constitution Compliance.

1. Introduction and Methodology

The Board has agreed six Strategic Goals for the Trust to pursue in the 2019-20 Financial Year. The Executive has risk-assessed each of these Goals and identified ten principal risks to achieving the goals.

The Board Assurance Framework report captures these six Goals and the principal risks applicable to them using one report sheet per goal. Each goal is assigned to one of the two Designated Board Committees for scrutiny, monitoring, and testing of the evidence provided to substantiate the levels of control applied.

The Trust Board uses the following categories of risk and has defined its 'risk appetite' for each as follows:

Risk Category	Risk Appetite Description
Clinical Innovation	Hungry
Commercial Gain	Open
Compliance	Minimal
Finance/VFM	Cautious
Informatics	Hungry
Partnerships	Open
Quality Effectiveness	Minimal
Quality Patient Experience	Minimal
Quality Patient Safety	Averse
Reputation	Cautious
Workforce	Open

BAF Risks are first assessed for their **inherent score** (the level of risk before any mitigations or control are applied) and then again after controls have been applied to reveal the **residual score**. This residual score indicates the current level of any one risk at any one time of reporting.

One or more risks may apply to each goal.

The difference between the target score (i.e. what the Board's **risk appetite** would expect) and the residual score indicates the amount of risk being carried by the Board for that goal.

2. Analysis and Discussion

2.1 BAF at a Glance

The BAF Report sheet titled "BAF at a Glance" lists the six Strategic Goals, the Board Committee responsible for monitoring the Goal, the number of risks applying, the highest inherent risk score, the target risk score (determined by the risk appetite), the highest residual score, and the gap or difference between the target score and the highest residual score.

The mini bar chart for each goal indicates the category of each risk, the inherent, residual, and target scores.

Looking at Goal 01, from this "at a glance" summary, we can see that:

- The Strategy and Finance Committee monitors Goal 01;
- Two risks apply, one in Compliance and one in Partnerships; and,
- The highest appetite exception score is 12.

In other words, the Board is carrying more risk in this goal than its agreed appetite would consider acceptable/ desirable (according to the Risk Strategy).

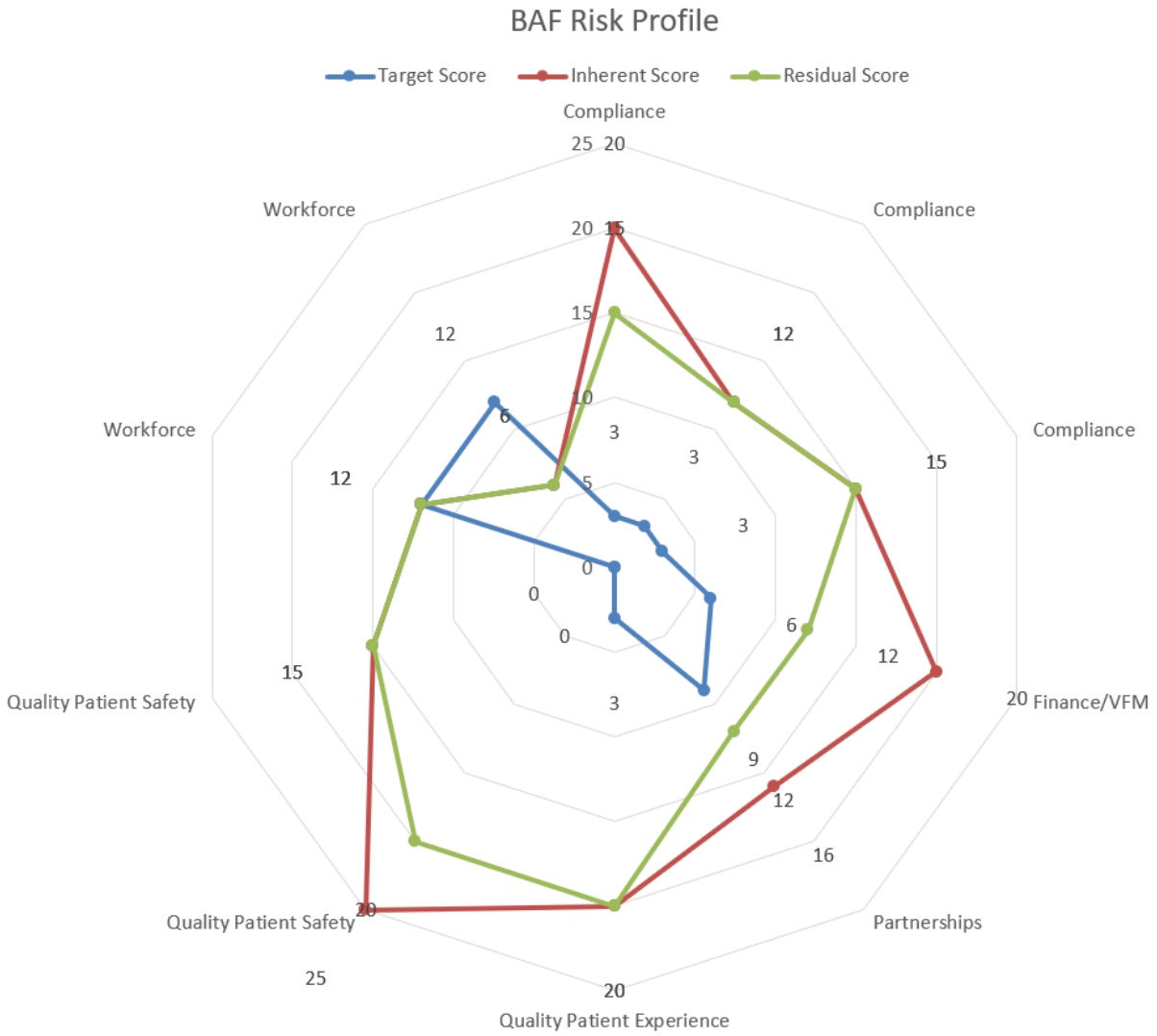
2.2 BAF Risk Profile

The BAF Risk Profile sheet uses a spider graph to summarise all of the BAF Risks showing their category, inherent, target, and residual scores. It allows directors to quickly gauge which areas hold the highest risk to achieving the goals, and the magnitude of these risks.

For this quarter, the graph below indicates that there are three risks in the 'quality' category, all of which are significantly above the target (appetite) score. There are three risks in 'compliance', also significantly above the target (appetite) score; and there is one risk in 'finance' well above the target score.

The workforce risks appear lower than other, but this is a result of the impact of workforce risk being directly on Quality, rather than on the workforce, i.e. the impact of a reduced workforce resource is on patients.

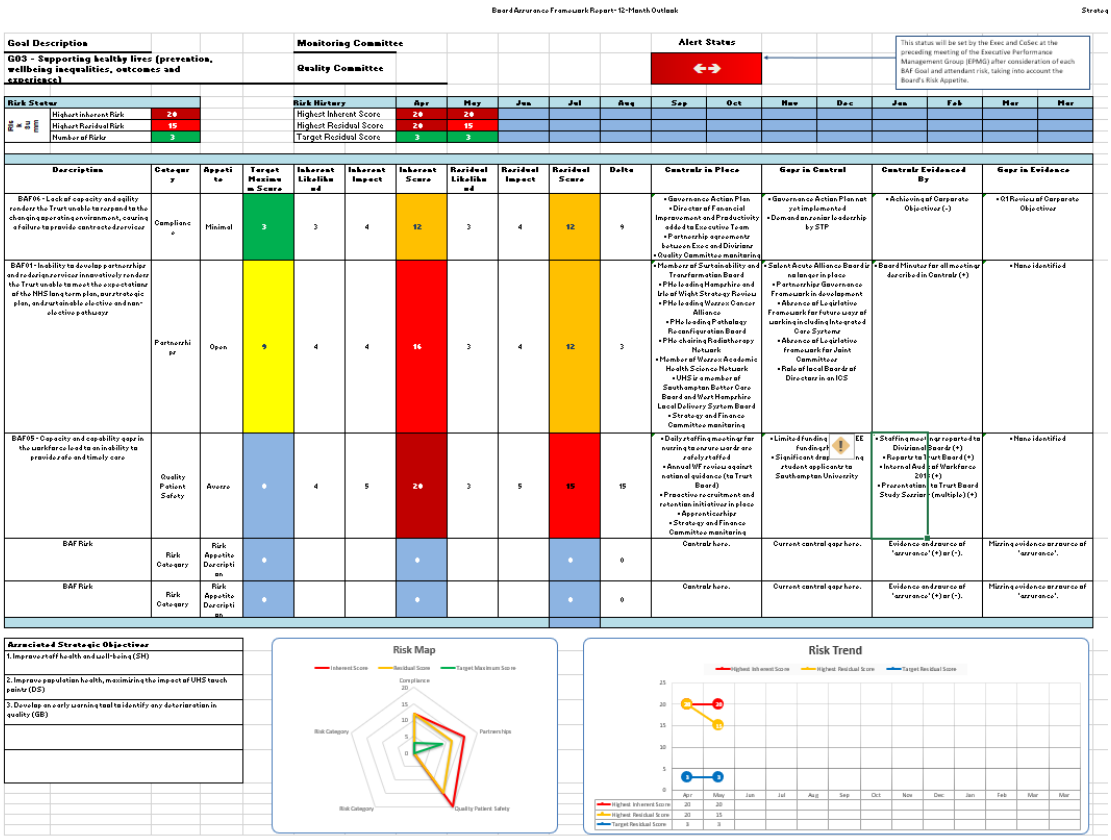
The single 'partnership' risk is less prominently above target but is nonetheless relevant in the context of the overall risk profile.



2.3 Goal Scoresheets

Each Goal Scoresheet sets out the detailed data available for a single goal, including all risk scoring and graphical elements to draw attention to the status of each risk, a trendline, and the actions being taken by the Executive in association with each goal.

There is an 'Alert Status' which is set by the Executive to alert the Board to the status of each goal's risk profile.



2.4 Risk Tolerance

If the Board decides to accept a higher residual score than the appetite would indicate is acceptable, it is effectively 'choosing to tolerate risk in that goal or category. Any decision to tolerate risk should be agreed by consensus and for an agreed time-limited period.

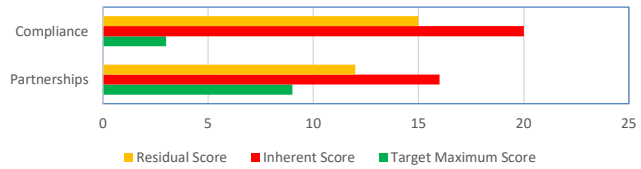
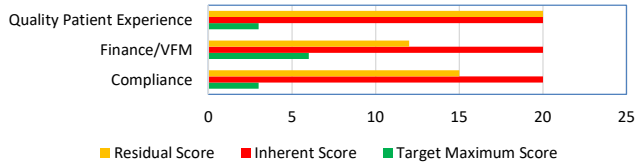
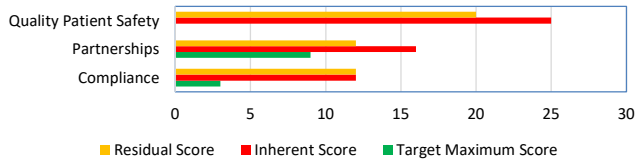
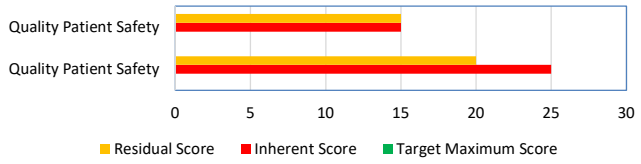
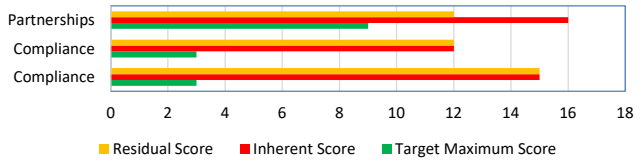
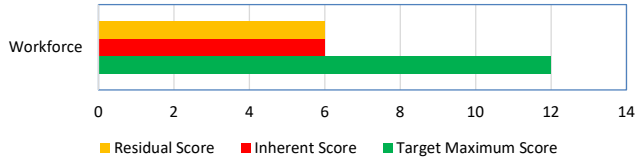
If there is no immediately available way to reduce a residual score to within the target range, the Board should consider alternative approaches, such as re-evaluating the business model, or other risk mitigations.

3. Recommendation

The Board is recommended to consider the levels and trends of risk for each of the Strategic Goals, assess the validity and suitability of the controls, and to evaluate the evidence provided for the mitigation of each risk. The Board should consider also its agreed Risk Appetite and assess whether additional action on any of the goals and risks is required to bring the risk in line with appetite. It may be necessary for the Chairman and Company Secretary to adjust the focus of Board and Committee agendas depending on matters arising from the BAF Report.

4. Appendices

- Detailed BAF Data Report

Goal	Monitoring Committee	Numbr of Risks	Highest Inherent Risk Score	Target Maximum Risk Score	Highest Residual Risk Score	Highest Appetite Exception	At a glance
G01 - Improving Patient journeys (system focus, integration)	Strategy and Finance Committee	2	20	9	15	12	
G02 - Delivering value-based health and care (value = quality/cost x sustainability)	Strategy and Finance Committee	3	20	3	20	17	
G03 - Supporting healthy lives (prevention, wellbeing inequalities, outcomes and experience)	Quality Committee	3	25	3	20	20	
G04 - Building an expert and inclusive workforce (diversity, engagement, leadership)	Quality Committee	3	25	0	20	20	
G05 - Being agile in meeting people's needs (organisational elegance/design/flexibility)	Strategy and Finance Committee	3	16	3	15	12	
G06 - Creating leading-edge research, education and innovation (research and outcomes)	Quality Committee	1	6	12	6	0	

Goal Description

G01 - Improving Patient journeys (system focus, integration)

Monitoring Committee

Strategy and Finance Committee

Alert Status

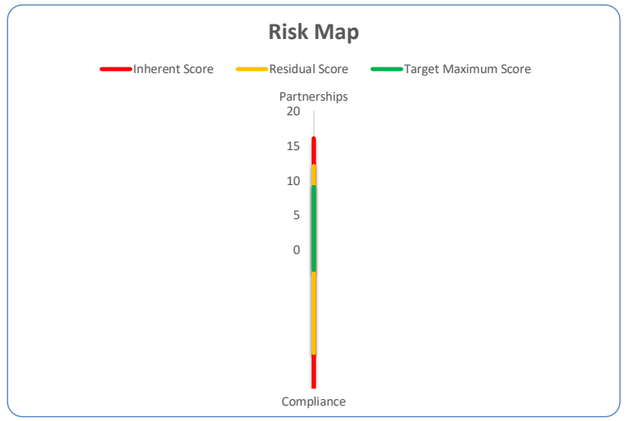
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

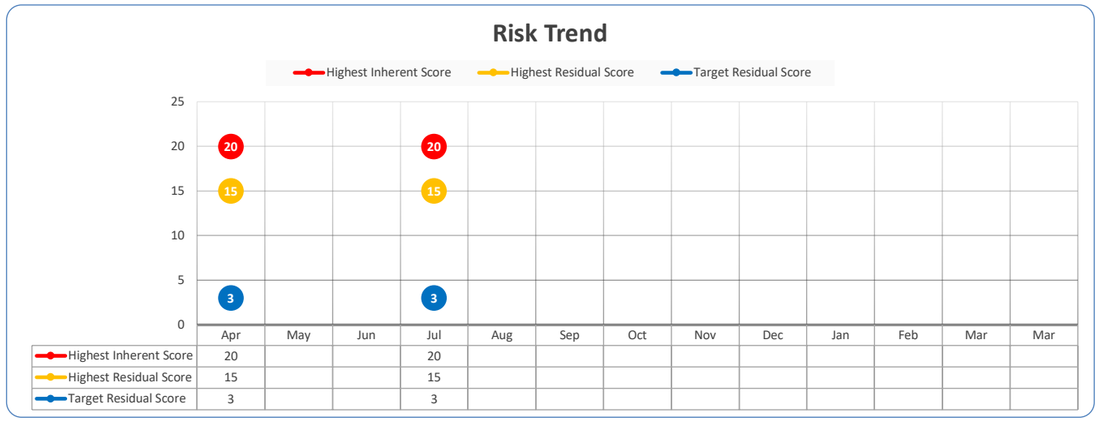
Risk Status		
Risk Summary	Highest inherent Risk	20
	Highest Residual Risk	15
	Number of Risks	2

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	20			20									
Highest Residual Score	15			15									
Target Residual Score	3			3									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF01 - Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways	Partnerships	Open	9	4	4	16	3	4	12	3	• Members of Sustainability and Transformation Board • PHe leading Hampshire and Isle of Wight Strategy Review • PHe leading Wessex Cancer Alliance • PHe leading Pathology Reconfiguration Board • PHe chairing Radiotherapy Network • Member of Wessex Academic Health Science Network • UHS is a member of Southampton Better Care Board and West Hampshire Local Delivery System Board • Strategy and Finance Committee monitoring	• Solent Acute Alliance Board is no longer in place • Partnerships Governance Framework in development • Absence of Legislative Framework for future ways of working including Integrated Care Systems • Absence of Legislative framework for Joint Committees • Role of local Boards of Directors in an ICS	• Board Minutes for all meetings described in Controls (+)	• None identified
BAF02 - Failure to deliver Regulatory requirements results in License breach and a loss of local control with an enforced change in leadership, impacting on Goals 1 to 6	Compliance	Minimal	3	4	5	20	3	5	15	12	• Agreed trajectories with CCGs • IPR • Board Committee scrutiny • NHSI Performance Framework meetings • Implementing NHS Constitution • EPMG oversight • NHSI performance phone calls and COO weekly calls • Strategy and Finance Committee	• Risk to future Provider Licence compliance G6 & FT4	• Failing trajectories (IPR) (-) • Challenged provider status (-) • Provider Licence G6 & FT4 (+)	• None identified

Associated Strategic Objectives
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)





Goal Description

G02 - Delivering value-based health and care (value = quality/cost x sustainability)

Monitoring Committee

Strategy and Finance Committee

Alert Status

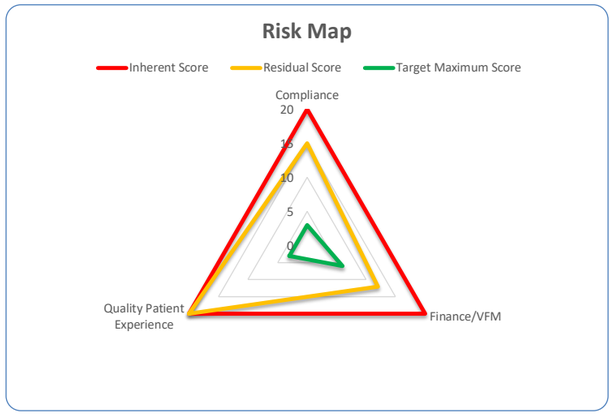
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

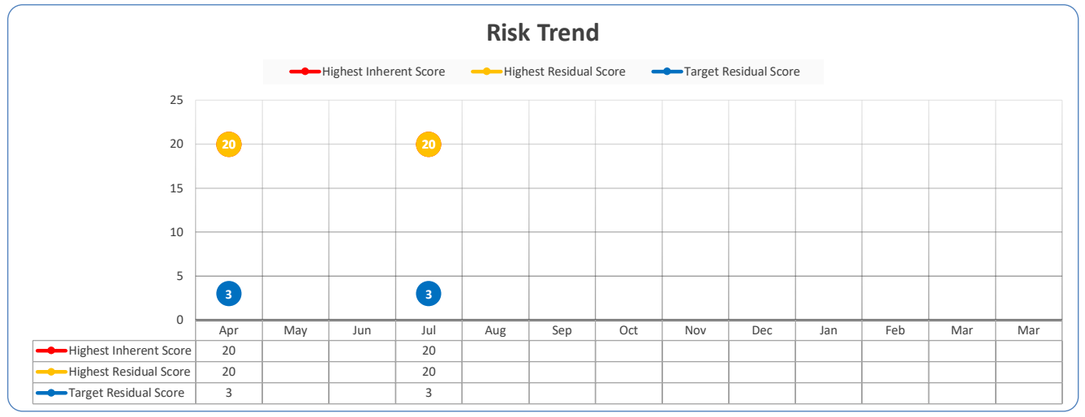
Risk Status		
Risk Summary	Highest inherent Risk	20
	Highest Residual Risk	20
	Number of Risks	3

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	20			20									
Highest Residual Score	20			20									
Target Residual Score	3			3									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF02 - Failure to deliver Regulatory requirements results in License breach and a loss of local control with an enforced change in leadership, impacting on Goals 1 to 6	Compliance	Minimal	3	4	5	20	3	5	15	12	• Agreed trajectories with CCGs • IPR • Board Committee scrutiny • NHSI Performance Framework meetings • Implementing NHS Constitution • EPMG oversight • NHSI performance phone calls and COO weekly calls • Strategy and Finance Committee monitoring	• Risk to future Provider Licence compliance G6 & FT4	• Failing trajectories (IPR) (-) • Challenged provider status (-) • Provider Licence G6 & FT4 (+)	• None identified
BAF03 - Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme	Finance/VFM	Cautious	6	5	4	20	3	4	12	6	• EPMG monthly oversight • SFIs and new business rules restrict recruitment, spend capital, etc • CIP programme headed by new director role (AA) • Management consultancy on productivity issues (e.g. theatre) • Agreed budgets signed off • Control total agreed with nhsi • Agreed commissioning contracts to cover additional activity • Strategy and Finance Committee monitoring	• None identified	• Monthly Finance Report • SFIs • Fortnightly financial run-rate and CIP performance meetings with Divisions • Board scrutiny • Board Committee scrutiny	• None identified
BAF04 - Reduced access to resources compromises the quality of services	Quality Patient Experience	Minimal	3	4	5	20	4	5	20	17	• Stratifying patients to target those at high risk to minimise potential harm • Creating increased capacity (Lymington) • Recruitment strategy • Working with CCGs to create other pathways • Quality summit actions, incl. cancer delayed pathway review • Thematic reviews of SIRIs • Quality Committee monitoring	• Ability to monitor non-Constitutional pathways • Lack of capacity to fully mitigate risk • Lack of ability to engage Consultants to engage in additional activity due to tax/pension issues • Overall theatre/other capacity • ED physical estste and workforce capacity • Medical staff not uniformly escalating concerns	• QGSG monitoring (+) • EPMG (+) • Opthalmology Executive Board (+) • Weekly ED performance meeting led by CEO (+) • Complaints SIRI Mortality Review Group (+) • IMEG (+) • Patient safety team (+) • GIRFT monitoring (+) • Outcomes report CQC report (+)	• Inability to monitor all pathways

Associated Strategic Objectives
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





Goal Description

G03 - Supporting healthy lives (prevention, wellbeing inequalities, outcomes and experience)

Monitoring Committee

Quality Committee

Alert Status

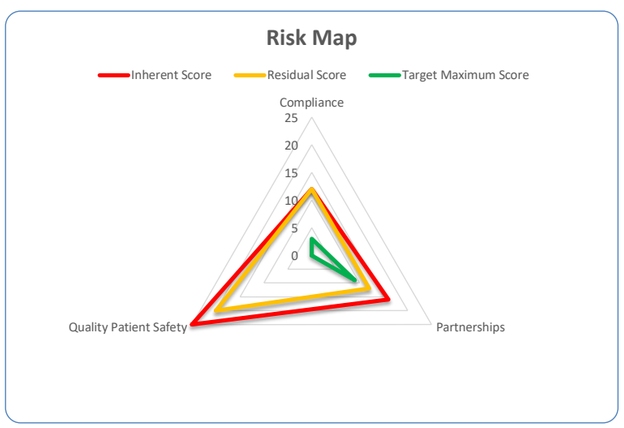
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

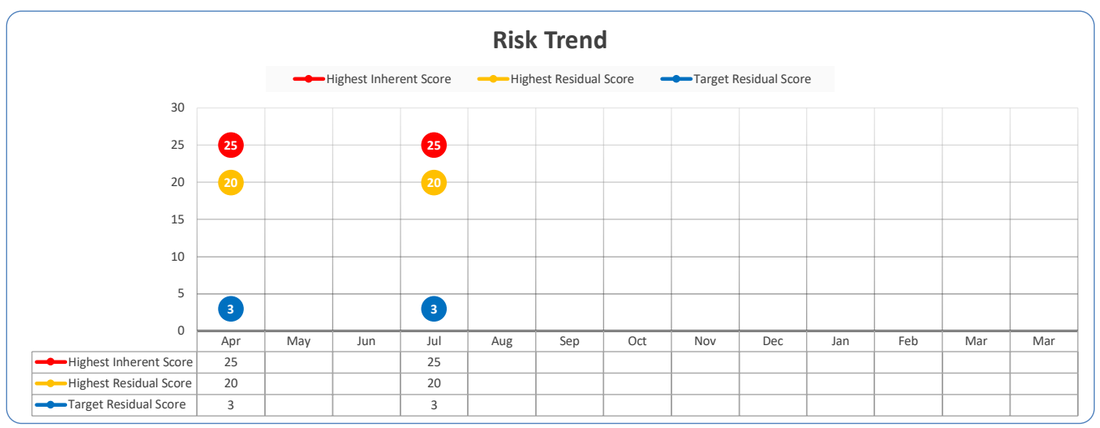
Risk Status		
Risk Summary	Highest inherent Risk	25
	Highest Residual Risk	20
	Number of Risks	3

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	25			25									
Highest Residual Score	20			20									
Target Residual Score	3			3									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF06 - Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services	Compliance	Minimal	3	3	4	12	3	4	12	9	• Governance Action Plan • Director of Financial Improvement and Productivity added to Executive Team • Partnership agreements between Exec and Divisions • Quality Committee monitoring	• Governance Action Plan not yet implemented • Demand on senior leadership by STP	• Achieving of Corporate Objectives (=)	• Q1 Review of Corporate Objectives
BAF01 - Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways	Partnerships	Open	9	4	4	16	3	4	12	3	• Members of Sustainability and Transformation Board • PHe leading Hampshire and Isle of Wight Strategy Review • PHe leading Wessex Cancer Alliance • PHe leading Pathology Reconfiguration Board • PHe chairing Radiotherapy Network • Member of Wessex Academic Health Science Network • UHS is a member of Southampton Better Care Board and West Hampshire Local Delivery System Board • Strategy and Finance Committee monitoring	• Solent Acute Alliance Board is no longer in place • Partnerships Governance Framework in development • Absence of Legislative Framework for future ways of working including Integrated Care Systems • Absence of Legislative framework for Joint Committees • Role of local Boards of Directors in an ICS	• Board Minutes for all meetings described in Controls (+)	• None identified
BAF05 - Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care	Quality Patient Safety	Averse	0	5	5	25	4	5	20	20	• Daily staffing meetings for nursing to ensure wards are safely staffed • Annual WF review against national guidance (to Trust Board) • Proactive recruitment and retention initiatives in place • Apprenticeships • Strategy and Finance Committee monitoring	• Limited funding due to HEE funding shift • Significant drop in nursing student applicants to Southampton University • Reduction in workforce capacity due to national pensions/ tax issue • Capacity issues for radiography and some technicians	• Staffing meetings reported to Divisional Boards (+) • Reports to Trust Board (+) • Internal Audit of Workforce 2018 (+) • Presentations to Trust Board Study Sessions (multiple) (+)	• None identified

Associated Strategic Objectives
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)





Goal Description

G04 - Building an expert and inclusive workforce (diversity, engagement, leadership)

Monitoring Committee

Quality Committee

Alert Status

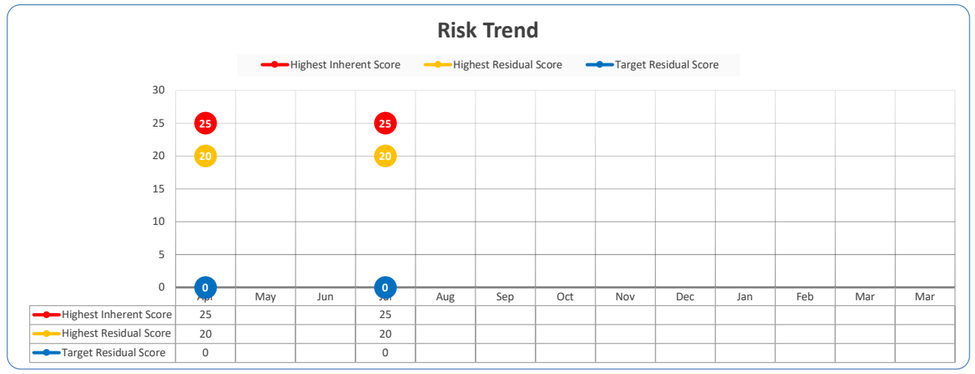
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

Risk Status		
Risk Summary	Highest inherent Risk	25
	Highest Residual Risk	20
	Number of Risks	3

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	25			25									
Highest Residual Score	20			20									
Target Residual Score	0			0									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF05 - Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care	Quality Patient Safety	Averse	0	5	5	25	4	5	20	20	• Daily staffing meetings for nursing to ensure wards are safely staffed • Annual WF review against national guidance (to Trust Board) • Proactive recruitment and retention initiatives in place • Apprenticeships • Strategy and Finance Committee monitoring	• Limited funding due to HEE funding shift • Significant drop in nursing student applicants to Southampton University • Reduction in workforce capacity due to national pensions/ tax issue • Capacity issues for radiography and some technicians	• Staffing meetings reported to Divisional Boards (+) • Reports to Trust Board (+) • Internal Audit of Workforce 2018 (+) • Presentations to Trust Board Study Sessions (multiple) (+)	• None identified
BAF07 - Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care	Quality Patient Safety	Averse	0	3	5	15	3	5	15	15	• Staff engagement monitored through Annual Staff Survey • Divisional and Care Groups have action plans for improvement • Red-flag incidents reported and monitored • "Deliver safe and timely care" • Appraisal rates monitored • Leadership training and development • Freedom to Speak Up Guardians •Culture Survey • Safety Strategy refresh • Wellbeing programme • Supporting staff policy • Mental Health Policy • Occupational Health and EAP • Wellbeing discussion in appraisal • Stress risk assessment process • Staff survey action plans	• High vacancy levels in some areas • Increased and rising levels of demand • Systematic approach to individual conduct and behaviour and the "human factor" • Culture Survey not complete • Safety Strategy Refresh not yet complete • Universal early warning system based on a number of indicators	• Staff Survey by Care Group and Ward level identifies hotspots) (+) • Number of leadership development opportunities taken up (+) • Management of red flag incidents (+) • Appraisal rates (+) • Sickness absence rates • Staff FFT and free text comments • Staff accessing EAP and Occupational Health • Qualitative feedback from forums, change champion and unions	• Real time data on engagment levels (annual engagment score only available)
BAF08 - Lack of inclusion and diversity results in the failure to get the best from every individual	Workforce	Open	12	3	4	12	3	4	12	0	• EDI Strategy approved by Board of Directors • Annual Reporting of national WRES Data and action plan to Board • Annual Reporting of national WDES Data and action plan to Board • Equality, Diversity and Inclusion Strategy • Trust staff networks established • Inclusive talent-management programmes set up • Staff Networks • Recruitment and Selection training and process • Dignity at work procedures • Quality Committee monitoring	• Absence of EDI Annual Plan to support strategy implementation	• Trust Board reports (+) • Action Plans (+) • National benchmarking (+)	• Variable recording of protected characteristics on ESR

Associated Strategic Objectives
1. Close the staffing supply gap in priority groups/services to provide high quality and timely care (SH)
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)



Goal Description

G05 - Being agile in meeting people's needs (organisational elegance/design/flexibility)

Monitoring Committee

Strategy and Finance Committee

Alert Status

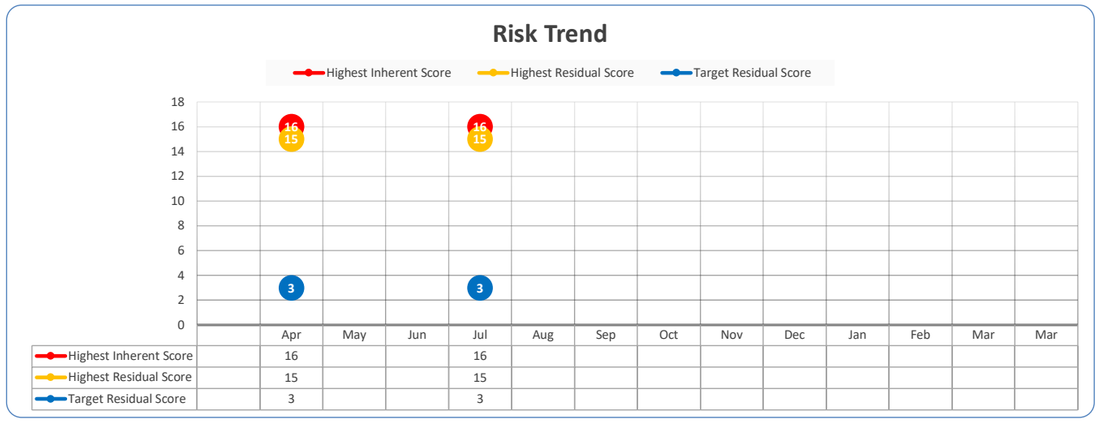
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

Risk Status		
Risk Summary	Highest inherent Risk	16
	Highest Residual Risk	15
	Number of Risks	3

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	16			16									
Highest Residual Score	15			15									
Target Residual Score	3			3									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF09 - Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider	Compliance	Minimal	3	3	5	15	3	5	15	12	• Governance Action Plan • Long Term Plan Implementation Framework	• Governance Action Plan not yet implemented • Absence of Trust Long Term Plan Implementation Framework	• Compliance with provider Licence (+) • CQC compliance status (+)	N/a
BAF06 - Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services	Compliance	Minimal	3	3	4	12	3	4	12	9	• Governance Action Plan • Director of Financial Improvement and Productivity added to Executive Team • Partnership agreements between Exec and Divisions • Quality Committee monitoring	• Governance Action Plan not yet implemented • Demand on senior leadership by STP	• Achieving of Corporate Objectives (=)	• Q1 Review of Corporate Objectives
BAF01 - Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways	Partnerships	Open	9	4	4	16	3	4	12	3	• Members of Sustainability and Transformation Board • PHe leading Hampshire and Isle of Wight Strategy Review • PHe leading Wessex Cancer Alliance • PHe leading Pathology Reconfiguration Board • PHe chairing Radiotherapy Network • Member of Wessex Academic Health Science Network • UHS is a member of Southampton Better Care Board and West Hampshire Local Delivery System Board • Strategy and Finance Committee monitoring	• Solent Acute Alliance Board is no longer in place • Partnerships Governance Framework in development • Absence of Legislative Framework for future ways of working including Integrated Care Systems • Absence of Legislative framework for Joint Committees • Role of local Boards of Directors in an ICS	• Board Minutes for all meetings described in Controls (+)	• None identified

Associated Strategic Objectives
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)



Goal Description

G06 - Creating leading-edge research, education and innovation (research and outcomes)

Monitoring Committee

Quality Committee

Alert Status

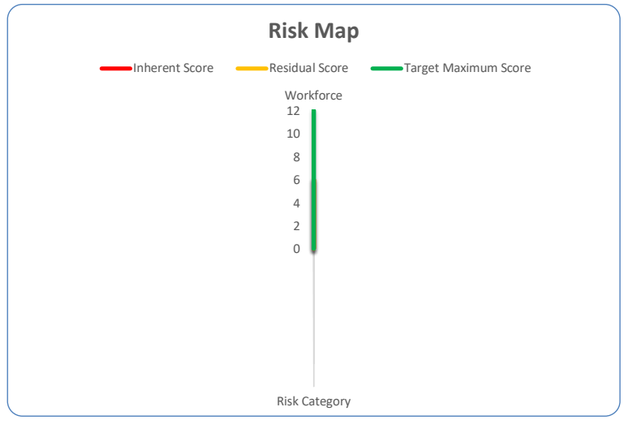
This status will be set by the Exec and CoSec at the preceding meeting of the Executive Performance Management Group (EPMG) after consideration of each BAF Goal and attendant risk, taking into account the Board's Risk Appetite.

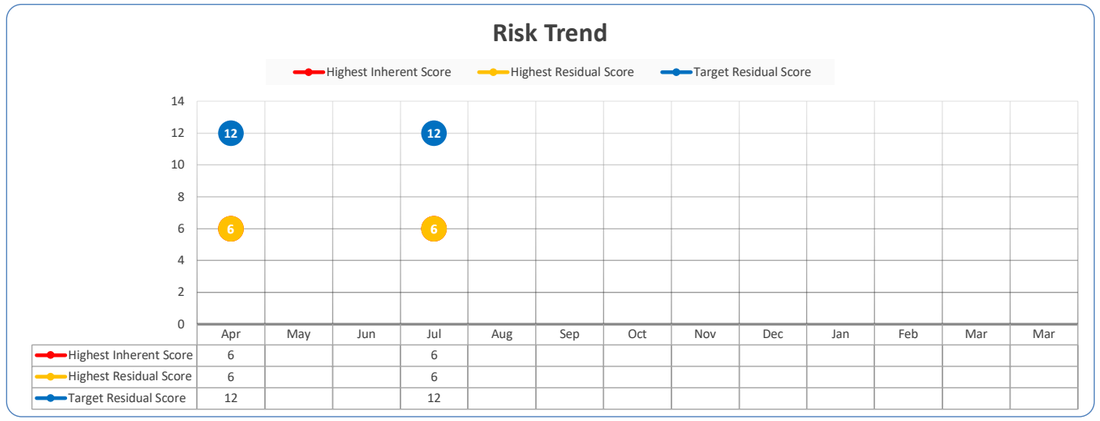
Risk Status		
Risk Summary	Highest inherent Risk	6
	Highest Residual Risk	6
	Number of Risks	1

Risk History	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Mar
Highest Inherent Score	6			6									
Highest Residual Score	6			6									
Target Residual Score	12			12									

Description	Category	Appetite	Target Maximum Score	Inherent Likelihood	Inherent Impact	Inherent Score	Residual Likelihood	Residual Impact	Residual Score	Delta	Controls in Place	Gaps in Control	Controls Evidenced By	Gaps in Evidence
BAF10 - Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status	Workforce	Open	12	2	3	6	2	3	6	-6	• LCRN performance monitoring • Joint research strategic board activity monitoring • Strategic plan for research • Quality Committee monitoring	• Unsighted on rejected activity	• Performance report to NIHR national monitoring team (+) • JRSB & Board of Directors (+) • Second highest ranked recruiting LCRN teaching hospital in UK (+) • Monthly report to Board on % of BAME staff at Band 7+ (+) • WRES and WDES outcome data (+) • Staff survey data regarding equality (+) • Results of Gender pay gap reporting (+)	• Not measuring rejected activity due to capacity constraints • Real time data on diverse staff group engagement • Data on engamgent and experience generally only availale annual in staff survery
BAF Risk	Risk Category	Risk Appetite Description	0			0			0	0	Controls here.	Current control gaps here.	Evidence and source of 'assurance' (+) or (-).	Missing evidence or source of 'assurance'.

Associated Strategic Objectives
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)





University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Register of Seals, and Chair's Actions			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.3		
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 **Underlease**, executed as a Deed, between Hampshire Hospitals Contract Services Limited (Landlord) and University Hospital Southampton NHS Foundation Trust (Tenant) relating to part of Candover Outpatients and Radiotherapy Centre inclusive of adjacent car park situated at Basingstoke and North Hampshire Hospital, Aldermaston Road, Basingstoke, for the provision of radiotherapy service and associated administrative functions. Seal number 178 on 18 July 2019.

1.2 **Agreement**, executed as a Deed, between Southampton City Council and University Hospital Southampton NHS Foundation Trust, pursuant to Section 106 of the Town and Country Planning Act 1990 and other powers, relating to land at Southampton General Hospital, Tremona Road, Southampton, in respect of planning permission for the erection of a 4-storey extension of the north elevation of centre block to create 3,584 sqm of additional floor space including ancillary hospital accommodation (Level C), an extension to the general intensive care unit (level D) and 8 operating theatres (levels E and F) with associated landscaping. Seal number 179 on 18 July 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 the supply of blood, organs and associated services from NHS Blood & Transplant 2019/20 at a cost of £5,422,696 excluding vat. Approved by the Chair on 24 June 2019.

2.2 **Award of Contract** for the supply of Replacement LED Light Fittings, as part of the Trust's overall energy reduction programme, to Edmundson Electrical Ltd at a cost of £1,591,773 excluding VAT. Approved by the Chair on 22 July 2019.

3. Recommendation

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

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Information Governance and Data Protection Annual Report 2018/19			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	6.4		
Sponsor	Company Secretary		
Author	Jonathan Pillinger-Cork		
Provenance	TEC and Trust Board		
Classification	This Report is unclassified.		
Purpose	The paper is presented for REVIEW. The paper is presented for discussion of the latest incidents and issues affecting the hospital in data protection.		
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	• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6		
Impact assessments	This paper is purely to update the Board on data protection developments and does not have any impact.		
Other standards affected	None specified.		

1 Purpose

1.1 The purpose of this report is to provide Trust Board with a summary of Information Governance (IG) activity and performance in the Trust over the last 12 months. It provides a summary of some key developments at a national level summarises the results of the Trust Information Governance Toolkit assessment for 2018/19 and reports on key aspects of IG activity over the last year.

2 Key Issues

National Picture

2.1.1 The General Data Protection Regulation was introduced in May 2018 and we have continued to embed it's new requirements into the Trust's data protection and information governance practices.

2.1.2 The most significant changes included:

- Increase in fines for non-compliance (up to 4% of annual turnover)
- No more 'implied consent', if consent is the basis of the processing, then it must be explicit, specific and unambiguous.
- Enhanced 'right to be forgotten' – in some cases citizens will have the right to demand all personal data an organisation holds on them should be deleted.
- No more charges for request copies of personal data (previously it has been £10). UHS received c.350 requests each month.
- More information about, how, where and under what basis personal information is processed must be provided to citizens prior to them sharing this information.
- Almost all organisations have to appoint a senior Data Protection Officer (DPO) to lead on all aspects of data protection and who should report to the highest level of the organisation.

2.1.3 Whilst our specific programme of compliance ended in late 2018 – we are continuing the process of embedding these changes, updating and improving our record keeping and adjusted working practices to ensure that we are compliant as possible.

2.1.4 During the year since GDPR came in we have seen a marked increase in the number of requests for medical records from members of the public (driven largely by the removal of the ability to charge) and the situation has been exacerbated by the reduction in the statutory time limit to respond to requests (reduced from 40 calendar days to 1 month). Whilst the increase in the number of requests has resulted in an increase in the average time taken to respond, we are introducing new ways of working which we hope will alleviate this issue.

2.1.5 We have had a small number of requests from patients for their records or parts of their records to be deleted, citing their new rights under GDPR. In most instances these requests have been based on information in the patient's medical records which could be embarrassing or

3 New DPO

During the year the statutory role of Data Protection Officer was transferred from the Associate Director, Corporate Affairs to the Head of Data Protection. It was felt that this role should sit with the role which has data-to-day operational responsibility for data protection and this decision was approved by the Quality Governance Steering Group

4 Toolkit Assessment

4.1.1 The Data Security and Protection Toolkit (DSPT) requires NHS Trusts (and other medical bodies) to annually self-assess their level of compliance against a set of data protection standards specific to their organisation type. Acute Trusts are required to meet and submit evidence for c.170 separate assertions – this evidence is audited by PWC and reviewed by NHS Digital,

4.1.2 The results of the DSPT assessment are shared with NHS Improvement and the Care Quality Commission and elements are published in the Trust Quality Account. A satisfactory DSPT assessment is also a pre-requisite for obtaining consent to conduct some forms of clinical research.

4.1.3 The Trust's DSPT submission for 2017/18 submitted as at 30th March 2018. The Trust was compliant in all mandatory areas of the Toolkit.

4.1.4 The new toolkit has undergone significant revision for 2018/19 – the is much more focus on cyber security and ensuring that ICT departments have enough skills and expertise to protect patient and staff data from cyber-attacks, The DPO and other departments have created a work plan of all the assertions and expect to submit an interim assessment to NHSD in October 2019.

5 IG Training

5.1.1 As part of our DSPT compliance the Trust has to provide evidence it has achieved the mandated target for staff IG training compliance set by the Department of health (95% of all staff). This element of DSPT compliance remains a significant challenge for the Trust.

5.1.2 WE require all staff to take an online module or be present at a face to face session each year. The online module is provided by NHSD and the face to face curriculum is based on this module. It includes new assessments with a focus on cyber security.

5.1.3 A high compliance with this specific requirement not only reduces our information risk but is important as it is one of the factors that are considered by the Information Commissioners Office (ICO) when investigating serious incidents of breaches of confidentiality reported by the Trust. It is recognised that a high level of compliance demonstrates an organisational commitment to maintaining data security.

6 IG Incidents and Regulation

6.1.1 The number incidents involving documentation or confidentiality reported by Trust staff is approximately 80 a month. 73% of these incidents were near-misses or the impact on the patient was negligible.

6.1.2 These incidents are investigated and dealt with by local management teams in accordance with Trust incident management procedure. The Trust IG lead provides additional advice and guidance where appropriate. The lessons learned from an analysis of these incidents are shared with divisional governance groups.

6.1.3 In the last 12 months the Trust has reported 8 IG Serious Incident Requiring Investigations (IG SIRI) to the Information Commissioner's Office. These all concerned paper documents being either incorrectly sent to patients or being left in unsecure areas. In all cases, following an explanation of the mitigations put in place and our response to the incidents, by the Head of Data Protection, no regulatory action was taken by the ICO.

7 Freedom of Information

7.1.1 The table below summarises Foil activity and performance over the 12 month period Aug 16 – Jul 17 Aug 17 to Jul 18

	Aug 16 - Jul 17	Aug 17 – Jul 18	Aug 18 - 30th June 2019
Number of requests received	**750**	**780**	**671**
Number of exemptions applied	**90**	**158**	**144**
Completed within 20 Days deadline	**415 (55%)**	**622 (80%)**	**602 (89.7%)**
Average response times (days)	**21**	**13**	**9.8**

7.1.2 FoI continues to impose a burden on IG staff and other members of staff across the Trust who supply information requested under the Act. The number of requests per month has reduced slightly, but the complexity continues to increase.

7.1.3 Foil requesters do not have to identify a purpose for their request therefore it is difficult to clearly identify any trends relating to the source of Foil requests. We can identify the source sector (Press, Charity etc) for about half the requests that we receive. From our analysis we know that 20% of requests are sent in from commercial organisations and at least 15% by people working in the press and media industry. No increase in requests from a single source /sector has been identified with the incremental increase in request numbers being reflected 'across the board'. Popular topics include ICT infrastructure, ophthalmology and arrangements for Brexit.

7.1.4 We have dramatically reduced the average time it has taken to respond to FoI requests and are responding to more requests within the statutory 20 working day deadline.

8 Information Risk

8.1.1 Our key information risk relates to staff and the way they handle sensitive and/or large volumes of data. A lack of awareness of safe handling procedures or a momentary lack of attention can lead to a significant breach taking place. While the former case can be addressed through training it is more difficult to mitigate against the latter scenario

8.1.2 In general terms our electronic information systems are robust and secure and the work to improve our security against cyber-attack has already been highlighted. Increased use of electronic recording and storage of data will reduce the risks associated with paper records especially incidents related to loss and inappropriate disposal.

8.1.3 Due to the nature of our work we necessarily handle large volumes of data and very sensitive data. One of the key challenges is to ensure our staff do not become complacent when continually handling such data but ensure 'best practice' becomes routine and we maintain a high standard of data handling.

8.1.4 While it is not possible to eliminate information risks we continue to improve our framework of policy and procedure and increase staff awareness of best practice to mitigate those identified.

9 Next Steps / Way Forward

9.1 Our key priorities in the coming year will be minimise the re-occurring IG breaches concerning paper and especially lists of patients which are often the focus of the most serious incidents. Part of this is retraining people to ensure that the incidents are minimised and more long term to introduce more electronic solutions so that the transportation of paper is minimised.

9.2 The monitoring and investigation of IG incidents will continue with significant incidents escalated to senior management as appropriate.

10 Recommendation

10.1 Trust Board are asked to:

- Note the achievement of a meeting all the DPST mandatory requirements in 18/19.
- Note the information provided in this report regarding IG training, IG incidents, freedom of information and information risk.

Report to the Trust Board of Directors dated Tuesday, 30 July 2019			
Title: Guardian of Safe Working Hours Quarter Report			
Category	Quality, Performance, and Finance		
Agenda item	10 – Information items		
Sponsor	Medical Director		
Author	Kathryn Nash, Consultant Hepatologist and Guardian of Safe Working Hours		
Provenance	Quarterly report to Trust Board.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for INFORMATION The Board is invited to note the report and ongoing concerns regarding work intensity, exception reporting and rota gaps.		
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	• BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual		
Impact assessments	The Trust aims to ensure that any change in performance does not affect one or more cohorts of people with specific protected characteristics. This equality monitoring is conducted operationally.		
Other standards affected	• NHSI compliance • CQC Well-led Framework		

Main Issues/Executive Summary

Employment and expenditure

All Junior Doctors in Training employed by the Trust are now working on the new contract.

278 non-training Fellows are employed, 91% on 2016 UHS local terms and conditions.

Vacancy rate is currently 11.75%.

Targeted recruitment activities have been successful such that from August vacancy rate is down significantly to **6%**

Exception reporting

- **1594** episodes received since since implementation of Junior Doctor Contract in October 2016 (Appendix 2)
- **442** Doctors have submitted exceptions
- The most common reason is additional working hours and the most common resolution is additional payment
- To date no exception report has been a breach incurring a financial penalty
- Cost to the organisation of exception reporting is currently low, but could increase if reporting is embedded fully

Implications

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

Engagement with the exception reporting system remains variable; whilst it has highlighted some areas that need review, the Guardian currently does not have the confidence that this system is reflecting the true situation across the hospital. The Guardian's awareness of most of the areas of concern highlighted in this report has come from groundwork and direct discussion with departments rather than the exception reporting system.

The overall impact of the new contract financially and on service provision remains unclear and difficult to quantify currently:

- Many factors which impact rota gaps
- Under usage of exception reporting system

Recommendation

The Board is invited to note the report and ongoing concerns regarding work intensity, exception reporting and rota gaps.

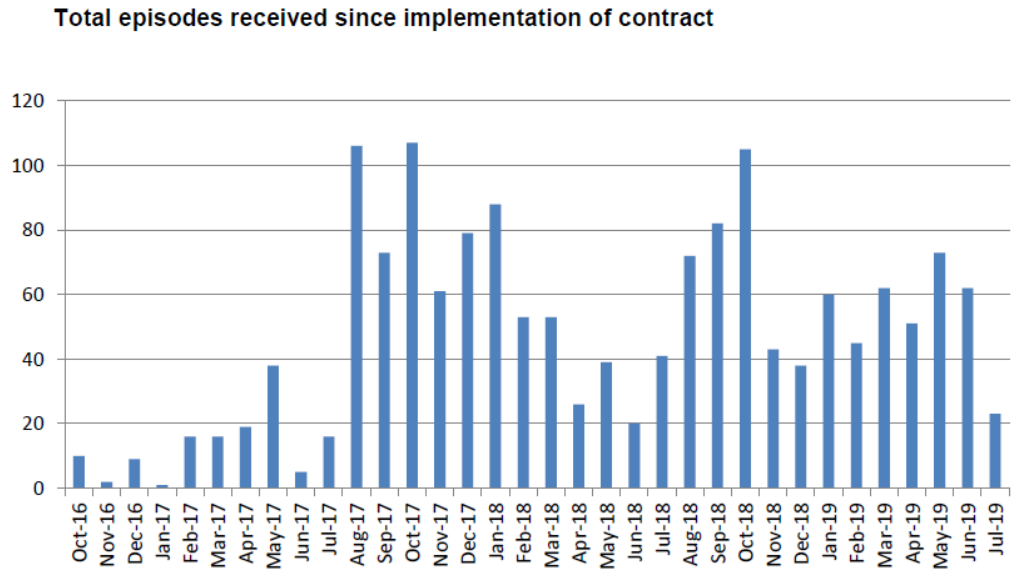
Appendix 1: Summary of junior doctor vacancies across work and total internal locum usage.

Area	Total Current Vacancies	Total hours booked via the bank (Jun 19)	Total bank spend (Jun 19)
Anaesthetics	5	241	16,372
Intensive Care (All)	11	295	19,800
Cancer Care	4	477	23,840
Surgery (inc ENT)	5	631	33,900
Emergency Care (inc AMU)	14	1000	53,650
Pathology	3	0	0
Specialist Medicine and MOP	8	819	48,233
Ophthalmology	2	514	41,654
Child Health	10	278	15,122
O&G / Neonates	3	631	33,483
T&O	8	420	19,337
Neurosciences	4	115	6,101
CV&T	7	490	22,210
Total	84	5911	333,702

Notes:

- Overall vacancy rate remains at ~11.75%
- The position improves from the August changeover with a reduction in vacancy rate to ~6%
- Recruitment continues for known vacancies

Appendix 2.1: Number of exception reports Oct 2016 – Jul 2019 (data extracted from eRota 22.07.19)



Appendix 2.2: Reason for exception

	Division A	Division B	Division C	Division D	THQ
Hours	506	658	106	140	1
Education	45	31	19	6	0
Pattern	14	21	6	18	0
Support	7	7	1	8	0