Agenda

University Hospital Southampton NHS Foundation Trust

Group Name: **Trust Board – Open Session**

Date of Meeting: **28 February 2019**

Venue: **Conference Room, Heartbeat Education Centre, F Level, North Wing**

Time: **9.00am**

Apologies to: Sue Diduch, Corporate Affairs Administrator

9.00	1.	Chair's Welcome, Apologies and Declarations of Interest	
	2.	Minutes of Previous Meeting held on 31 January 2019	
	3.	Matters Arising/Summary of Agreed Actions	
	4.	**Quality, Performance and Finance**	
9.15	4.1	Patient Story **(Derek Sandeman, Medical Director)**	Oral
9.30	4.2	Integrated Performance Report for Month 10 including Quarterly Infection Prevention & Control Report for review **(Jane Hayward, Director of Transformation & Improvement)**	
10.15	4.3	Learning from Deaths Quarter 3 Report for review **(Derek Sandeman, Medical Director/Neil Pearce, Associate Medical Director for Patient Safety)**	
10.25	4.4	Freedom to Speak Up Report for review **(Gail Byrne, Director of Nursing & Organisational Development/ Christine Mbabazi, EDI Adviser and FTSU Guardian/Adam Pitt, Senior HR Business Partner)**	
10.35	4.5	CRN: Wessex 2018/19 Quarter 3 Performance Report for review **(Derek Sandeman, Medical Director)**	
10.40	4.6	Briefing from Chair of Strategy & Finance Committee for review **(Jane Bailey, Chair, S&FC)**	Oral
10.45	4.7	Finance Report for Month 10 for review **(David French, Chief Financial Officer)**	
	5.	**Chair's and Chief Executive's Reports**	
10.55	5.1	Chief Executive's Report to note and Chair's Actions to ratify **(Paula Head, Chief Executive/Peter Hollins, Trust Chair)**	
	6.	**Strategy and Business Planning**	
11.00	6.1	Revised Equality, Diversity and Inclusion (EDI) Strategy for approval **(Gail Byrne, Director of Nursing & Organisational Development)**	
11.10	7.	Any other business	
	8.	To note the date of the next meeting: Thursday, 28 March 2019 in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH	

In attendance: Neil Pearce, Associate Medical Director for Patient Safety
Christine Mbabazi, EDI Adviser and FTSU Guardian
Adam Pitt, Senior HR Business Partner
Sarah Herbert, DHN/P, Division A (shadowing Gail Byrne)

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"

11.15-11.30 Follow-up discussion with governors
11.30-12.45 Clinical Visit: Cardio-thoracic care for adults and young people
12.45-1.15 Lunch

Items Circulated:

The following items have been circulated to the Board since the last meeting. Executive directors are happy to take questions from individual members, before the meeting, by e-mail or telephone, or to meet separately to discuss in more detail.

25 January
Press Release: Radio Lollipop launches volunteer recruitment drive

28 January 2019
Press Release: Southampton doctor wins prestigious national award for dementia care

30 January 2019
Press Release: Hospital trust's IT staff hit nation's TV screens in new NHS recruitment ad

1 February 2019
Press Release: Hospital staff and supporters to celebrate development of new cancer support centre

6 February 2019
Press Release Southampton clinicians to screen football fans for diabetes in UK first

8 February 2019
Press Release: Hospital trust to showcase innovations in care to country's top nurse
Press Release: Hospital's 'super' volunteer role improves mealtimes and mobility for older patients

12 February 2019
Press Release: Doctors create innovative hospital 'passport' for older patients

19 February 2019
Press Release: Leading nurse says young dementia patients "falling into void" (embargoed)

University Hospital Southampton NHS
NHS Foundation Trust

Trust Board Minutes – Open Session

Minutes of the Open Trust Board meeting held on Thursday 31 January 2019, in the Conference Room, Heartbeat Education Centre, North Wing, University Hospital Southampton, commencing at 0900 and concluding at 1145

Present:	**Mr P Hollins, Trust Chair**	**PTH**
	Mrs P Head, Chief Executive	**PHe**
	Mr D French, Chief Financial Officer & Deputy Chief Executive	**DAF**
	Mrs G Byrne, Director of Nursing & Organisational Development	**GB**
	Ms J Hayward, Director of Transformation & Improvement	**JH**
	Dr C Marshall, Chief Operating Officer	**CM**
	Dr D Sandeman, Medical Director	**DS**
	Mr S Porter, Senior Independent Director/Deputy Chair	**SP**
	Ms J Bailey, Non-Executive Director	**JB**
	Prof C Cooper, Non-Executive Director	**CC**
	Ms J Douglas-Todd, Non-Executive Director	**JD-T**
	Ms C Mason, Non-Executive Director	**CMa**
	Dr M Sadler, Non-Executive Director	**MS**
In Attendance:	**Mr C Helps, Interim Associate Director Corporate Affairs**	**CH**
	Ms K Nash, Consultant Hepatologist and Guardian of Safe Working Hours	**KN**
	Mr D Cable, EPR Implementation and Services Manager	**DC**
	Mrs T Burt, PA to Trust Chair and Chief Executive (minutes)	
	1 member of public	
	3 members of staff	
	4 governors	

1/19 **Apologies**
None.

Action By

2/19 **Chair's Welcome, Opening Comments and Declarations of Interest**
The Chair welcomed everyone to the meeting.

There were no declarations of a conflict of interest with any items on the agenda.

3/19 **Minutes of Previous Meeting** *(Agenda item 2. Enclosure 1)*
The minutes of the meeting held on 29 November 2018 were **AGREED** as an accurate record subject to the amendments to 163/18 a) final paragraph should read '..were not yet known..' and 165/18 a) second bullet point should read '..impressed by the bedside..'.

4/19 **Matters Arising/Summary of Agreed Actions** *(Agenda item 3)*

4/19 a) *Minute Ref 143/18 a)* Complexity of Employee Relations Cases – It was agreed that this would be discussed at a Trust Board Study Session. — CH

4/19 b) *Minute Ref 159/18 a)* Integrated Performance Report Month 7 - Safe – Dr Mayank Patel, AMU and Diabetes Consultant would be invited to a Trust Board Study Session. — GB/CH

4/19 c) *Minute Ref 171/18 a)* Major Incident 28 November 2018 – PTH had written to Andrew Asquith and Jo Hall.

4/19 d) The Board **noted** the latest position on the actions in summary of actions.

5/19 **Patient Story** *(Agenda item 4)*

a) DS introduced xxxx to the Board.

xxxx talked about the treatment and care given to his son, xxxx. In 2014, when xxxx was 16, he developed pain in his right tibia and was diagnosed with a fast growing osteosarcoma. He began a "tumble dryer" of appointments at St. Richard's Hospital and the family were told that it would be a long, hard road ahead and that xxxx might not survive. He was also referred to the Royal Orthopaedic Hospital in Stanmore, University College Hospital London and then to UHS for chemotherapy. xxxx spent almost a year on the Teenage Cancer Unit at UHS and xxxx said that it felt as though the whole family were "hospitalised" for that period. For the first time, however, they were given "hope". xxxx said that whilst xxxx had received good care from the other hospitals, they were never given any hope and that had been very important to the family.

DS asked whether UHS could have done more to support xxxx and his wife. xxxx said that his wife would have found it helpful to have had some appointments without xxxx but she understood why this was difficult.

Whilst he understood the risk of infection, xxxx said that he "never quite understood" why xxxx could not have some fresh air and a small courtyard to sit in would have been good.

xxxx had been admitted to UHS at the start of his A Levels and xxxx said that the hospital had worked with his college to ensure that xxxx continued with his studies. He had also had sessions with a Clinical Psychologist which he had found really helpful.

xxxx said how proud he was of xxxx. He was now 21, kept "bouncing back" and hoped to become a paediatric nurse.

PHe asked whether xxxx had got bored with the food available in the hospital but xxxx said that bearing in mind xxxx's lack of appetite, he did not think the hospital could have done any better.

MS commented that as treatments became more specialised, families often had to travel further. xxxx said that commuting had become a big part of their lives but a bed had always been available for them on the unit.

PTH thanked xxxx for talking to the Board and said how enormously important these sessions were for Board members.

5/19 b) **RESOLVED**
That the Board NOTE the patient story.

6/19 Integrated Performance Report for Month 9 *(Agenda item 5. Enclosure 2)*

a) Safe

GB advised that:-

- There had been two Never Events, one in Cardiology and one in Ophthalmology. Both were being investigated, together with adherence to stop points in theatre which may be an emerging theme.
- VTE risk assessments remained an area of focus and had come under some external scrutiny. They were currently at 92% against a target of 95%. A new IT solution within e-prescribing was being piloted and would be rolled out in March. Improvements in compliance should be seen from then.
- NEWS2 had now been implemented which would flag up deteriorating sepsis patients.
- In June NHSI had made recommendations on pressure ulcers and had revised the definition and measurement to be used from April 2019.

MS noted that there was no text under S1.8 (Medication errors). DS advised that these were still being investigated in line with the expected timetable; but in summary one related to a communication error regarding a patient being discharged home without a full set of drugs. The other involved a patient becoming severely hypertensive due to a line not being flushed.

6/19 b) Caring

GB advised that:-

- The Trust was struggling to meet the 35 working day target for complaints overall and this was partly due to delays in the receipt of statements from contributors. A quality improvement project had started which would review and redesign the complaints process.
- Progress was being made on the Accessible Information Standard exemplar project and a central hub of resources was now available on Staffnet.

MS advised that ways of helping patients to understand how long they would have to wait in ED minors, had been discussed at the Quality Committee earlier in the week.

JD-T noted the continuing decline in C1.6 (nutrition). GB advised that this had been noted and was being looked into. It was hoped that an IT solution would eventually be available.

6/19 c) Effective

DS advised that 214 outcomes were now being reported from 45 specialties. Other specialties were being encouraged to get involved.

Emergency readmissions continued to be higher than in other trusts and MS advised that this had been discussed at the Quality Committee. Audits may not be providing the information needed and it was felt that the whole pathway needed to be considered. JH suggested that emergency readmission rates may become a KPI in the future.

MS advised that Zoe Pond, Chest Physician, had attended the Quality Committee and had explained the background to the COPD audit. The committee had been reassured by the information given.

6/19 d) Flow

CM said that the whole hospital deserved to be commended for the way it had managed flow during December. There had only been 3 red alerts and the Frailty Unit had been working well. The picture in January was not so positive. JB asked whether the delivery of drugs was slowing flow down. DS advised that there had been a plan for ward based pharmacists but this was now being reviewed by Sue Ladds, due to staffing shortages.

6/19 e) Emergency access

CM advised that in December UHS had performed the best out of the four acute hospitals in the area. The target for Q3 had been achieved and Q2 had been recovered. This had been due to good flow, good processes, the opening of the Frailty Unit and a very positive attitude from the whole hospital. January was currently on 84.8% month to date and whilst this was not as good as December, it made UHS equal best in the region.

MS noted that around 1 in 16 patients had an emergency reattendance. CM suggested that these patients generally fell into one of three groups:-

- those who had been "on the cusp" of whether or not they were discharged
- frequent attenders
- those where something had been missed by the hospital

JH suggested that more needed to be done to support frequent attenders in the community.

6/19 f) RTT

CM advised that the number of RTT patients waiting over 18 weeks had deteriorated in December but this had mostly been due to the major incident on the 30th. Overall, however, progress was being made.

6/19 g) Cancer

CM advised that a new Consultant Breast Radiologist had been appointed. As a result there was an improving picture in terms of patients waiting to be seen within two weeks of referral to the breast service. There was currently a backlog of around 50 patients waiting for prostate surgery but for the last couple of months the Trust had over-performed by doing a couple of extra surgical lists and there had been a slight slackening of demand. Capacity was discussed and it was suggested that there needed to be a greater focus on working with GPs on early diagnosis and management.

6/19 h) Research and Development

DS advised that the local CRN had received very positive feedback following a performance review with the national team last week. Recruitment to trials was currently lower than last year.

6/19 i) Staffing

PHe noted that the sickness absence rate was extremely low and this had helped to reduce reliance on agency. JD-T asked if there was a timeframe for achieving the appraisal target. GB advised that some divisions had already hit it but she would discuss this with Steve Harris. GB

6/19 j) Estates

DAF advised that the target for the number of help desk requested completed on time had been missed but would be achieved by next month.

6/19 k) Digital
JH advised that the data would continue to be refined.

6/19 l) **RESOLVED**
That the Board NOTE the Month 9 Integrated Performance Report.

Quality & Safety

7/19 **Guardian of Safe Working Hours Quarter Report** *(Agenda item 6.1. Enclosure 3)*

a) KN introduced this report and highlighted the following:-

- All junior doctors employed by the Trust were now on the new contract.
- There had been a slight reduction in the vacancy rate.
- Exception reports continued but she did not feel these could be improved.
- She continued to meet junior doctors from each department regularly and her awareness of concerns generally came from these discussions.
- There had been no safety concerns during the quarter.
- The medical registrar's rota had remained well staffed this year.

She advised that juniors in Ophthalmology had been concerned about supervision levels in Eye Casualty and the lack of a consultant lead. This had now been resolved. The School of Surgery had also visited the department and this had helped the juniors. PHe advised that the situation in Ophthalmology was fragile and was being monitored.

JD-T noted that access to laptops varied amongst the juniors, depending on what department they were working in. KN and JH advised that meetings were taking place to establish the overall position.

CM asked if exception reports were mandatory and KN confirmed that they were.

7/19 b) **RESOLVED**
That the Board NOTE the Guardian of Safe Working Hours Quarter Report.

8/19 **Implications of NHS Improvement Publication: Developing Workforce Safeguards October 2018** *(Agenda item 6.2. Enclosure 4)*

a) GB presented this report which was to provide a briefing on the NHSI publication 'Developing Workforce Safeguards', particularly on assurance and governance processes being strengthened and developed to ensure compliance with mandatory NHSI reporting from April 2019.

The publication included 14 key recommendations and a self assessment exercise in November 2018 had identified actions needed to ensure the Trust was compliant. It was, however, at least partly compliant with the majority of the existing recommendations.

She advised that the Board would be required to sign off the workforce plan and that the plan would need to be discussed annually at an Open Board.
PTH asked if the publication had given the Trust any new ideas. PHe said that it suggested the integration of workforce planning with quality, operational and finance performance could be improved.

8/19 b) **RESOLVED**
That the Board NOTE the implications of the NHSI publication: Developing Workforce Safeguards October 2018.

Finance

9/19 Finance Report for Month 9 *(Agenda item 7.1. Enclosure 5)*

a) DAF presented the Month 9 Finance Report and noted that:-

- December had been a "solid month" with a surplus of £1.7m, bringing the year to date surplus to £17.8m which was in line with Plan.
- The Trust had achieved the Q3 control target, the Q3 ED 4 hour target and had also recovered the year to date ED performance so that the Q2 ED PSF had been achieved. This meant that the PSF earned in the quarter had been £9m.
- Excluding PSF the surplus in month was a deficit of £2.3m which was broadly in line with plan.
- The number of cancelled operations had been high with 4 lists lost in December due to anaesthetics, 6 due to theatre staff and 20 due to surgeon availability. It was estimated that the lost income was around £250k p.m.
- The Trust had secured funding from DH for its contractual obligation to increase pay rates for Serco's catering and cleaning staff and settlement had been reached with a construction company's insurer for damage incurred in a flood in 2016. Both of these had helped to improve the month's performance.
- An extraordinary meeting of the Strategy and Finance Committee had re-confirmed the Trust's commitment to its original control total surplus. Achievement of this would unblock up to £9m of PSF and position the Trust to receive a share of unallocated, bonus PSF.
- Achievement of Q4 would be very tight and dependent on delivery of both the CIP and financial recovery plans. FRAP was on track for Q3 but the recovery plan required substantially higher benefit in Q4, which would be challenging. There had been a challenge from Specialised Commissioning on a coding and costing issue which added £2m risk to the Trust's position. However, data for January suggested that the Trust would achieve its year end targets and earn the PSF.
- The control total target for 2019/20 was £30m (the same as this year) but tariff, PSF etc were all changing significantly. These changes were being worked through and the Board would be updated in February.

JB advised that she was fully supportive of the decision taken at the extraordinary Strategy and Finance Committee to keep to the original control total surplus. CM asked whether there was any flexibility in the figure, from the centre, due to the major incident in December. DAF said that there was not but that it had been noted by the centre.

PTH noted that the Trust was some way off the CIP although it had a good track record on delivery. JH thought there would be a strong end to the year and a strong January in terms of CIP delivery.

PHe suggested that there were "lessons to be learnt" from the experience this year, in terms of managing CIPs.

9/19 b) **RESOLVED**
That the Board NOTE the Month 9 Finance Report.

Operational Performance

10/19 **Informatics Update** *(Agenda item 7.2. Enclosure 6)*

a) DC outlined his role and the services he was responsible for. These included the switchboard, electronic patient records and the IT service desk. He highlighted the following from the report:-

- The Trust had a strategy to become paperless and over the next 2-3 years aimed to become the equivalent of HIMSS Level 7. However there was still too much paper in the Trust and the hospital had been assessed at Level 2 during a visit from HIMSS in November.
- The new Digital Board, which was replacing ISSG, would meet for the first time on the 5th February and would be chaired by PHe.

CM congratulated the IT team on the implementation of DigiRounds and said how much time it saved clinicians.

JB was concerned that the time between a folder being returned to the scanning bureau and scanning had increased to two weeks against a target of two days (2.4). JH advised that the clinical risk was being managed and that an external company was now providing support with scanning.

PTH raised the issue of access to IT for junior doctors and DS advised that a small working group had met and that the Chief Registrar and an FY2 were talking to junior colleagues about these problems.

10/19 b) **RESOLVED**
That the Board NOTE the Informatics Update.

Governance

11/19 **Risk Strategy** *(agenda item 9.1. Enclosure 7)*

a) PHe advised that this report was the outcome of work done by the Board on its risk appetite. The report had been recommended for approval at the Trust Executive Committee on the 16th January 2019.

Board members were asked to note an error in 7. Risk Appetite Graphic where the number 2 should move from “effectiveness” to “reputation”.

11/19 b) **RESOLVED**
That the Board APPROVE the Risk Strategy.

12/19 **Chief Executive’s Report** *(Agenda item 9.2. Enclosure 8)*

a) PHe noted that the CEO report had previously included press activity but as this had run to six pages it had not been included this time. She would, however, be happy to circulate it to anyone who wanted to see it.

NEDs were asked to provide feedback on what they would like to see in the CEO report in future.

12/19 b) **RESOLVED**
That the Board NOTE the report.

12/19 c) **Items for Ratification**
Actions taken by the Chair as set out in paragraphs 4.1 – 4.3 were **ratified**.

13/19 **Feedback from Council of Governors' Meeting 24 January 2019** *(Agenda item 9.3)*

a) PTH advised that the Council of Governors had met last week and had discussed the CEO performance report. There had also been a constructive discussion on the operation of the council and it had been agreed that all the working groups would meet on the same day to encourage better attendance. There had been a useful Q&A session with the NEDs with questions about the major incident in December.

JD-T had been asked to stay on for a second term as a NED.

13/19 b) **RESOLVED**
That the Board NOTE the feedback.

14/19 **Briefing from Chair of Audit & Risk Committee** *(Agenda item 9.4)*

a) SP advised that progress against the Plan had been reviewed, that risk management had been considered and that there had been a report on business continuity. There had also been some useful (but not major) recommendations on the internal audit.

14/19 b) **RESOLVED**
That the Board NOTE the briefing.

15/19 **Briefing from Chair of Quality Committee** *(Agenda item 9.5)*

a) MS advised that the Quality Committee had considered the Patient Experience Quarterly Report, had looked at a couple of QIF priorities and had briefly talked about every outpatient encounter adding value. Zoe Pond, Consultant Chest Physician had talked about COPD. There had also been a discussion around stop points in theatre, why some clinicians did not adhere to them and what action should be taken.

DS said that there was currently around an 80% adoption rate at present but that it may be necessary to make this a disciplinary matter in future. CC suggested that stop points should be mandated due to the risk of clinical harm.

15/19 b) **RESOLVED**
That the Board NOTE the briefing.

16/19 **Briefing from Chair of Strategy & Finance Committee** *(Agenda item 9.6)*

a) JB said that a lot of time had been spent discussing where the Trust was now and where it was going. There had also been discussion about performance indicators for next year and the capital programme.

16/19 b) **RESOLVED**
That the Board NOTE the briefing.

17/19 **Any Other Business**
There was no other business.

18/19 **Date and Time of Next Meeting**
Thursday, 28 February 2019, commencing at 0900 in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH.

UHSFT – Directors' Actions Summary for 28 February 2019 Trust Board – Open Session

Action & Minute Reference	By whom	Target Date	Current Status
Trust Board 31 January 2019			
Matters Arising/Summary of Agreed Actions *(Minute Ref 4/19 a)*			
• *Minute Ref 143/18 a)* Staff Strategy Progress Report – Complexity of Employee Relations Cases – to be discussed at a Trust Board Study Session.	CH		
• *Minute Ref 159/18 a)* Integrated Performance Report Month 7 Safe – Dr Mayank Patel, AMU and Diabetes Consultant to be invited to a Trust Board Study Session.	GB/CH		
Integrated Performance Report for Month 9 *(Minute Ref 6/19 j)* Staffing GB to discuss with Steve Harris timeframe for achieving the appraisal target.	GB		

as at 19/2/19

University Hospital Southampton NHS Foundation Trust

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: Integrated Performance Report Month 10			
Category	Quality, Performance, and Finance		
Agenda item	4.2		
Sponsor	Director of Transformation and Improvement		
Author	Trust Performance Manager		
Provenance	Report to the Board provided by the Trust Executive.		
Purpose	The paper is presented for the Board for Review. The Board is requested to consider the performance metrics provided, identify any elements, trends, or emerging themes it wishes to pursue further.		
Relevant to Board goals	✓ Goal 1 – Trusted on Quality	✓ Goal 2 – Delivering for Taxpayers	✓ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	This report relates to all of the aims and objectives contained in the Board Assurance Framework.		
Equality Impact Assessment	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	NHS Provider Licence and Constitutional standards.		

University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

covering up to

Jan 2019

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

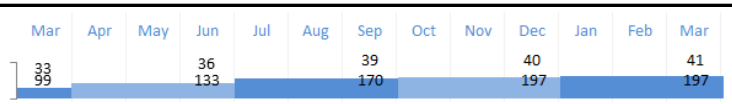
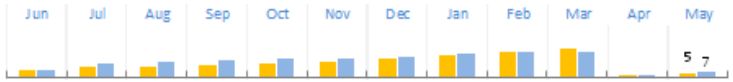
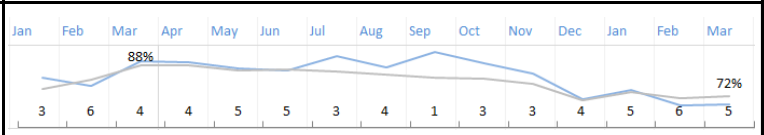
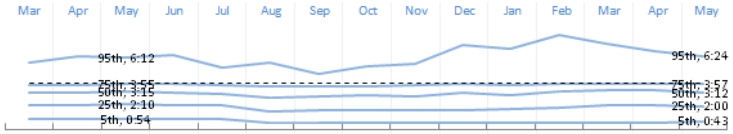
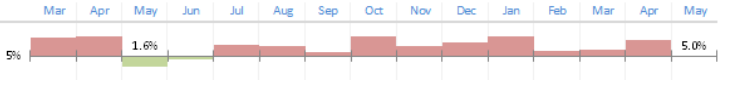
February 2019 Overview

University Hospital Southampton NHS
NHS Foundation Trust

Safe Amber	Safe remains amber this month as UHS has failed some KPI's yet we have seen continued good performance in other areas. There were no never events reported in January. There were no avoidable high harm falls or MRSA infections/contaminants in December. C.Diff performance remains better than year to date target. The overdue SIRI's reduced in January. In 18/19 the Trust planned to reduce pressure ulcers by 20% compared to last year, this trajectory is not currently being met. The themes are being collated and the learning is being shared through Pressure Ulcer Panel. VTE risk assessments remain an area of focus for the Trust with the new IT solution being piloted in AMU, Surgery and T&O in January 2019.
Caring Green	Negative scores across the FFT metrics continue to be within trust target, highlighting good overall satisfaction scores. Response rate for the inpatient FFT survey continues to perform below target. There has been an increase in mixed sex accommodation breaches, and this has been a consequence of winter pressures and ward closures due to outbreaks of norovirus. Percentage of patients with a nutrition care plan continues to reduce, this is currently being investigated.
Effective Green	There were nine national reports published and reviewed in December, of these reports four raised an area of concern (National diabetes audit care processes and treatment, National Diabetes Transition, Fracture Liaison Service Database (FLS-DB) & National Joint Registry Knee revisions). There are now 218 outcomes being reported to TEC from 46 specialities. Of these the majority are green (78%) and only 7% graded red. Emergency readmissions was at 11.2% in December which is just above the average of last 2 years (11%). HSMR remained stable in October well below the national benchmark and crude mortality dropped slightly to 3.8%
Activity Red	New referrals and two week wait cancer referrals dropped in December following expected seasonal variation but continue to be higher than 18/19 in the month, quarter and year to date. Main ED attendances were exceptionally high in January. This is contrary to the normal seasonal trend which sees a reduction in the colume but not complexity of attendances, paediatric attendances have increased the most, but other streams also have increased compared to 17/18. There have been a number of changes year on year in services provided and how services are recorded that make year on year comparison difficult, this includes the Lymington surgical services and outpatients (up from August 17, impacts electives and outpatients), the change in recording CDU chairs (down from September 17, impacts on non electives), the recording of the respiratory centre (April 18,
Flow Amber	The number of Delayed Transfers of Care in the Trust increased in January from 67 to 94. The number of patients who have been in hospital for greater than or equal to 7 days / 21 days also increased yet remained lower than January 2018 by 6% and 8% respectively. Early discharge on the day (pre-midday) in January increased to 22.7% (target 30%).
Emergency Access Amber	Main ED (Type 1) performance reduced in January to 82.1%, compared to UHS January 2018 83.3%, but was 4% above the average of our local peer group. This performance was impacted by ED attendances significantly exceeding volumes in previous years and the onset of winter pressures in the inpatient service. Eye casualty (Type 2) performance is still an area of concern now at 86.3%. Lymington MIU (Type 3) remains at a high level of performance (99.9%) and as a local delivery system we achieved the PSF threshold of 90.3% for Q3 and will need to achieve 95% in March to meet Q4 target.
RTT & Diagnostics Red	Both RTT and diagnostic performance improved in January. The total size of the RTT waiting list reduced to the lowest level in over 12 months whilst the number of patients over 18 weeks reduced to the lowest levels since August 2018 (August 2018 was when patients in our Salisbury Neurology service were added to the UHS waiting list). Diagnostic performance remains below but close to target, performance improved as a result of breakdown related MRI breaches in the previous month being resolved.
Cancer Red	Cancer performance is currently rated red as we are not achieving a number of measures. Recovery of the Treatment started within 62 days of urgent GP referral wait, is likely to be slow and significant challenges are being experienced linked to significant growth in referrals and the number of additional cancers being treated (236 year to date).
Research & Dev Green	Research and Development has been rated Amber this month. October recruitment benefitted from activity on a high recruiting meningitis prevention study. Whilst recruitment to this study has ended recruitment projections to year end are satisfactory. Complexity (weighted) performance is also satisfactory with UHS ranked 2nd in the UK for a number of consecutive months.
Staffing Amber	Staffing has been rated amber this month, despite sustained improvements in the following: HR turnover rates, sickness absence, appraisal rates and vacancy rates of total nursing workforce and registered nurses. The reason for this is that several KPI targets have yet to be reached, including those relating to overall staff turnover, appraisal completion rates and nursing vacancy rates. The sickness target has again been achieved, with a further reduction this month. Care Hours Per Patient day has returned to normal range, with increased activity following the Christmas and New Year periods. The CHPPD for ward based areas in the Trust has decreased from last month as expected (the change in December was partly due to seasonal holiday). This month, patient numbers have increased as normal due to winter pressures.
Estates Green	Estates has been rated green this month as we are meeting all targets in January. The targets missed on a 3 month rolling average are for percentage of help desk requests completed on time and Unresolved help desk requests (over 30 days old).
Digital Green	DigiRounds has demonstrated both time saving in reviewing the patient record during ward rounds, but also the quality of the review that is carried out, as clinicians are able to easily see all the significant elements of the record. It saves junior doctors time in preparing information for consultants (transcribing relevant results etc) prior to the ward round. Records accessed using Digirounds increased to 98,328 in December. Also in December the number of alerts sent using Medxnote increased again to 3777.

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.

February 2019

Safe

University Hospital Southampton NHS
NHS Foundation Trust

Amber

Safe remains amber this month as UHS has failed some KPI's yet we have seen continued good performance in other areas. There were no never events reported in January. There were no avoidable high harm falls or MRSA infections/contaminants in December. C.Diff performance remains better than year to date target. The overdue SIRI's reduced in January. In 18/19 the Trust planned to reduce pressure ulcers by 20% compared to last year, this trajectory is not currently being met. The themes are being collated and the learning is being shared through Pressure Ulcer Panel. VTE risk assessments remain an area of focus for the Trust with the new IT solution being piloted in AMU, Surgery and T&O in January 2019.

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly Target	YTD	YTD Target
S1.1	Never Events									1				1	1		-	3	0
S1.2	Avoidable High Harm Falls		1														<=1	0	-
S1.3	MRSA bacteraemia infection and contaminants					1				1							0	1	0
S1.4	Cummulative Clostridium difficile reduction (Confirmed lapse in care)															31 31	3	31	<=36
S1.5	Grade 2 Pressure Ulcers (avoidable in dark blue).	1 5	3 1	1 5	1 3	6 15	4 4	1 5	4 7	8 7	2 7	3 6	6 10	5 5	2 8		<=10	94(35)	<=72
S1.6	Avoidable Hospital Acquired Grade 3 and 4 Pressure Ulcers	2	2	3	3	4	2	1	1	3	2	1	2	3	1		1	16	<=10

S1.1 There were two never events, both occurred in theatre, one in Ophthalmology and one in Cardiac Surgery. Both incidents are now being investigated and learning will be shared.

S1.5 The number of grade 2 pressure ulcers has remained the same in December as the previous month with 10, continuing the reduction compared to October. Of these 2 were found to be avoidable on investigation and 8 were unavoidable. We remain over trajectory for the 20% reduction in overall numbers this year.

S1.6 There has been only 1 avoidable grade 3 in December which developed on the patients sacrum and occurred on a ward area where no patients have developed pressure damage previously. Clear learning was identified and has been addressed. Ensuring that the patient is positioned regularly remains a focus for all areas. We remain over trajectory to achieve the 20% reduction this year.

Current Data Benchmark
Previous Year Target

February 2019

Safe

University Hospital Southampton NHS
NHS Foundation Trust

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly Target	YTD	YTD Target
S1.7	Diabetes: High harm insulin-related medication errors		0			0			0			0					-	0	<=6.4
S1.8	Medication Errors (severe/Moderate)			2												5	<=3	22	<=30

S1.8 - Of the 5 medication errors in January 1 relates to an external incident from Bournemouth not UHS, 1 was unavoidable and 3 were determined as avoidable. Of the avoidable 2 involve diabetic patients experiencing hypoglycaemia, 1 case is still open and may be downgraded.

S1.9	Serious Incidents Requiring Investigation (SIRI)			0												2	-	36	-
S1.10	Number of overdue SIRIs			0												7	0	-	-

S1.10 3 overdue SIRI's (1 complex paediatric spinal case and 2 are now closed) In addition we have a case being investigated by HSIB (a national NHS body) which does not count against UHS as a breach.

S1.11	Safety Express Thermometer	95%			96%											97%	>=95%	98%	>=95%
S1.12	% Thromboprophylaxis Patients Assessed	95%		93.7%												92.6%	>=95%	92%	>=95%

S1.12 - The roll out of the IT solution within e prescribing was delayed due to glitches in functionality till 24th January. Improvements in compliance will not be seen until March report containing Feb data.

S1.13	Patients appropriately screened for sepsis	100% 60%		76%		76%		85%		98%							90%	-	-
S1.14	Sepsis Patients Treated in a timely manner	90% 60%		82%		77%		86%		82%							90%	-	-

Q3 data will be reported next month.

Current Data | Benchmark
Previous Year | Target

February 2019

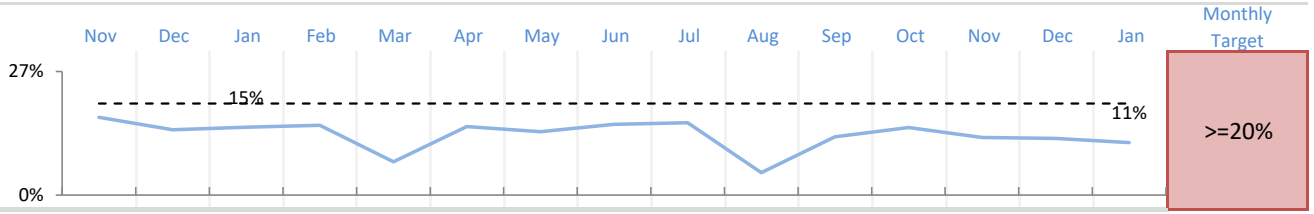
Caring

University Hospital Southampton NHS
NHS Foundation Trust

Green

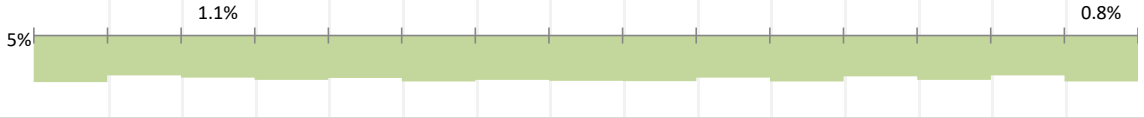
Negative scores across the FFT metrics continue to be within trust target, highlighting good overall satisfaction scores. Response rate for the inpatient FFT survey continues to perform below target. There has been an increase in mixed sex accommodation breaches, and this has been a consequence of winter pressures and ward closures due to outbreaks of norovirus. Percentage of patients with a nutrition care plan continues to reduce, this is currently being investigated.

C1.1 FFT response rate - Inpatients

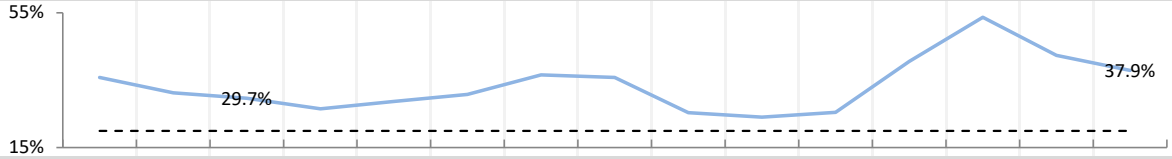


C1.1 A focus on improving response rates will be delayed until a new patient survey contract is in place, to ensure any changes or communication materials are compatible with a potential new platform.

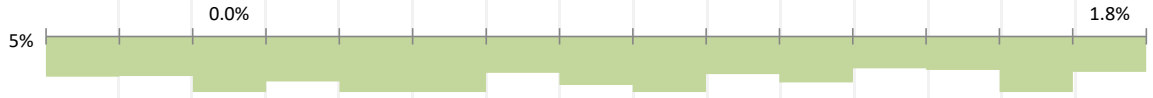
C1.2 FFT Negative Score - Inpatients



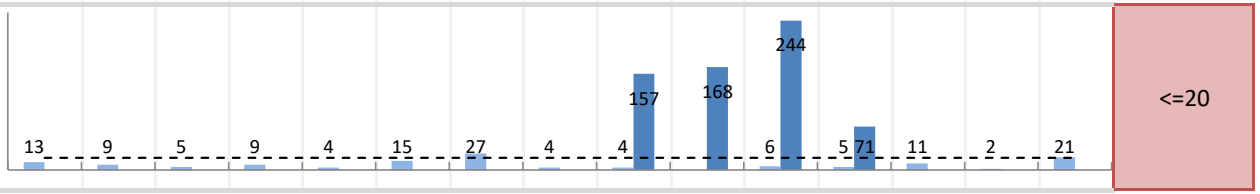
C1.3 Maternity FFT response rate



C1.4 Maternity FFT Negative Score



C1.5 Same Sex Accommodation (Non Clinically Justified Breaches)
Endoscopy Breaches in dark blue - agreed change in practice with CCGs to accommodate essential building works.



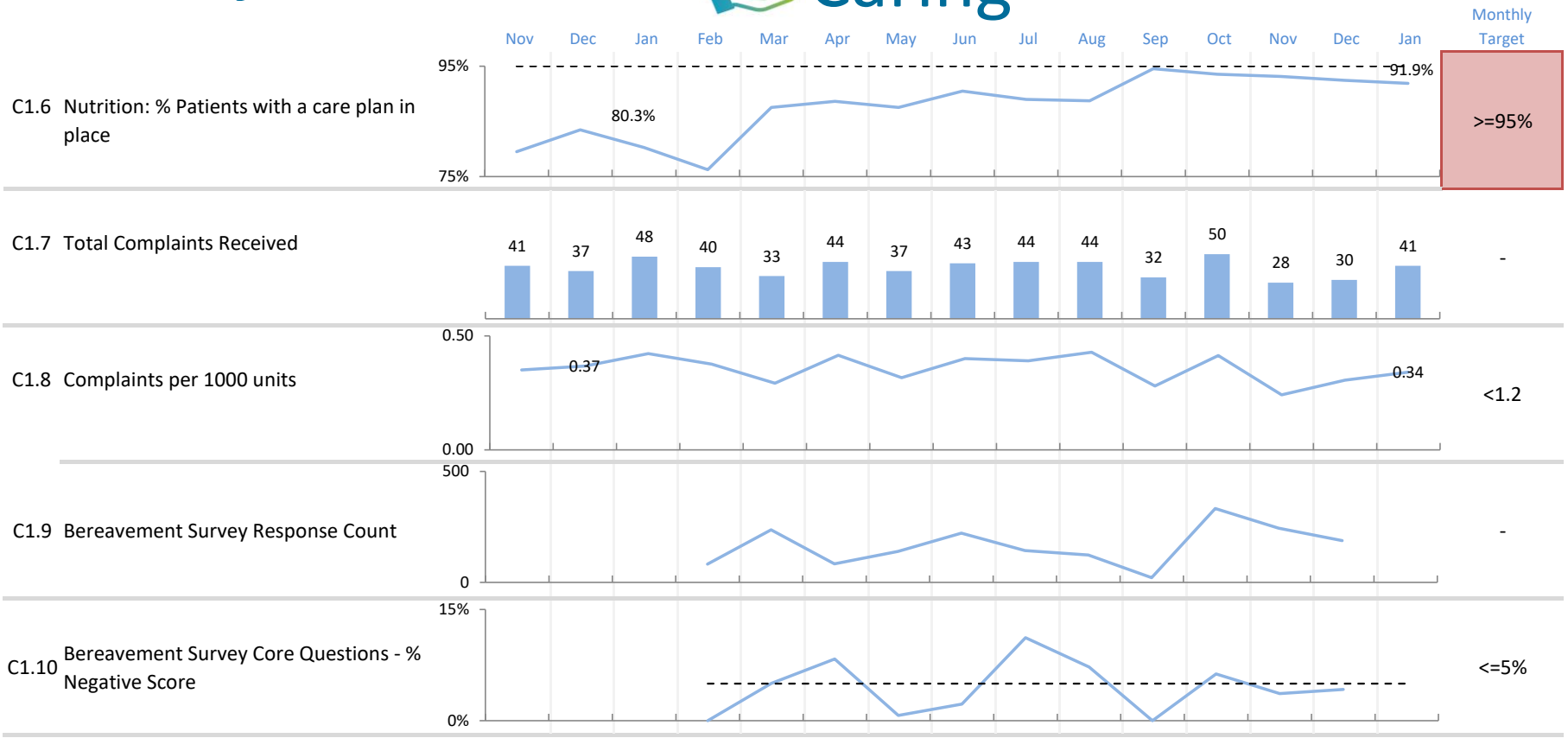
C1.5 There has been a notable increase in mixed-sex accommodation breaches, but nearly all of these occurred in the Coronary Care Unit, where it is clinically justifiable for the patients' most appropriate care. When the patients were ready to move down to a level 1 care setting this has been increasingly difficult due to the ward closures and bed availability due to the norovirus outbreaks.

Current Data
Previous Year
Benchmark
Target

February 2019

Caring

University Hospital Southampton NHS
NHS Foundation Trust



C1.9/C1.10 - January Data unavailable this month

Current Data
Previous Year
Benchmark
Target

February 2019

Effective

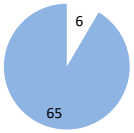
University Hospital Southampton NHS
NHS Foundation Trust

Green

There were nine national reports published and reviewed in December, of these reports four raised an area of concern (National diabetes audit care processes and treatment, National Diabetes Transition, Fracture Liaison Service Database (FLS-DB) & National Joint Registry Knee revisions). There are now 218 outcomes being reported to TEC from 46 specialities. Of these the majority are green (78%) and only 7% graded red. Emergency readmissions was at 11.2% in December which is just above the average of last 2 years (11%). HSMR remained stable in October well below the national benchmark and crude mortality dropped slightly to 3.8%

Quality Accounts 18/19

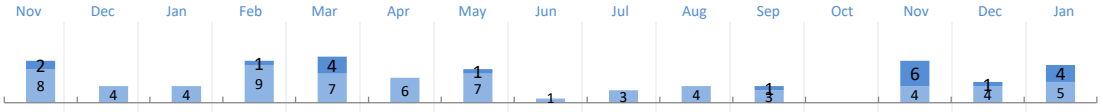
E1.1 Participation in eligible National Audits & NCEPOD* studies



UHS do not participate in the BAUS stress Urinary Incontinence audit as this service sits in Gynae rather than Urology. 3 audits listed on the QA are not undertaking data collection during 18/19 and these are National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI), National Diabetes Audit – in patient and National Mortality Case Record Review Programme. We are awaiting confirmation as to whether National audit of Intermediate Care (NAIC) is applicable to UHS as it was deemed N/A in 2014

National Reports

E1.2 Number of recently published National Audit reports (with areas of concern - dark blue)

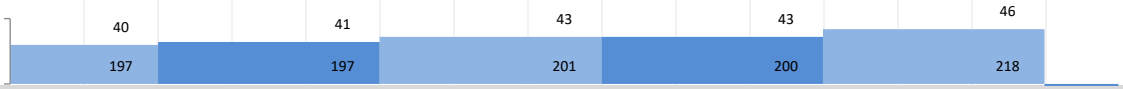


Monthly Target: -

Areas of concern relate to (1) National diabetes audit care processes and treatment targets 201-18 short report – UHS data suggests that type 1 diabetes Blood Pressure management is not in line with the rest of England. The overall Care Processes and Treatment Targets for type 1 and 2 also fall below the England target. (2) National Diabetes Transition audit report 2011-2017, Jan 2019 – post transition targets across some areas. (3) Fracture Liaison Service Database (FLS-DB) Annual report December 2018 – not achieving any of the 10 KPI targets which are a range of process, data completeness and treatment targets. (4) National Joint Registry 15th Annual Report 2018 – knee revision rates since 2003. The remaining 5 reports: (5) Breast and Cosmetic Implant Registry - Oct 16 - June 18 data summary. (6) The UK Renal Registry 20th Annual report (data 2016). (7) 2018 Epilepsy12 National Organisational Audit Report Jan 2019, data from 2017. (8) National Maternity and Perinatal Audit Maternity Admission to Intensive Care in England, Wales and Scotland in 2015/16. (9) National Neonatal Audit Programme (NNAP) 2018 Annual Report (2017 data).

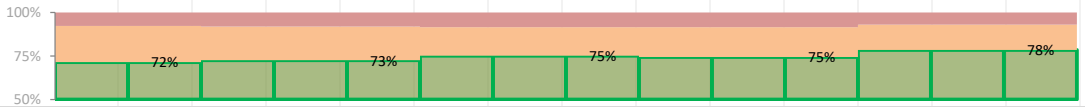
Outcomes

E1.3 Cumulative Specialities with Outcome Measures Developed



Monthly Target: +1

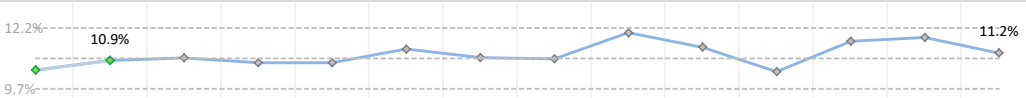
E1.4 Developed Outcomes RAG ratings



Monthly Target: -

There are now 218 outcomes being reported to TEC from 46 specialities (out of a total of 96 specialties). Out of 218 graded outcomes 78% are green and 7 % are graded red. 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.

E1.5 Emergency Readmissions

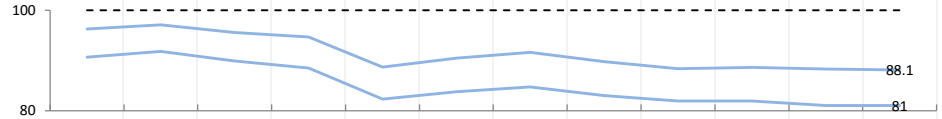


Monthly Target: TBC

HSMR

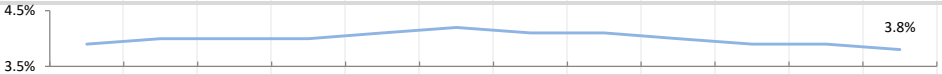
E1.6 HSMR - UHS

HSMR - SGH



Monthly Target: <100

E1.7 HSMR - Crude Mortality



Monthly Target: -

HSMR performance remains low due to continued low values from several specialties and an improvement in performance from previously higher specialties, e.g. Neurology and General Medicine.

Current Data | Benchmark
Previous Year | Target

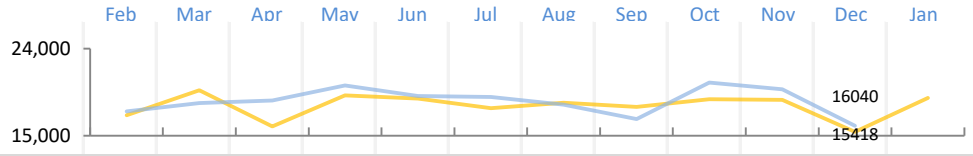
February 2019 Activity

University Hospital Southampton NHS
NHS Foundation Trust

Red

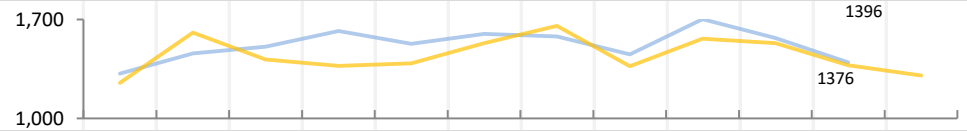
New referrals and two week wait cancer referrals dropped in December following expected seasonal variation but continue to be higher than 18/19 in the month, quarter and year to date. Main ED attendances were exceptionally high in January. This is contrary to the normal seasonal trend which sees a reduction in the colume but not complexity of attendances, paediatric attendances have increased the most, but other streams also have increased compared to 17/18. There have been a number of changes year on year in services provided and how services are recorded that make year on year comparison difficult, this includes the Lymington surgical services and outpatients (up from August 17, impacts electives and outpatients), the change in recording CDU chairs (down from September 17, impacts on non electives), the recording of the respiratory centre (April 18, daycases to outpatients).

		Month	QTD	YTD
RA1.1	New referrals received	+622	+3454	+7153
		+4.0%	+6.5%	+4.4%

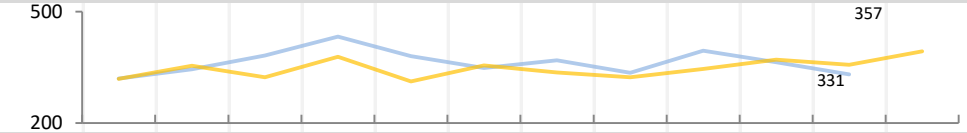


RA1.1 Referrals relating to non face to face outpatient appointments have been removed from the data above.

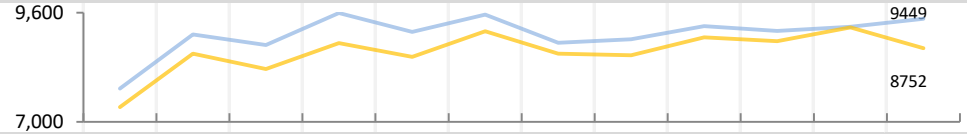
RA1.2	Urgent cancer referrals (2 week wait)	+20	+195	+748
		+1.5%	+4.4%	+5.7%



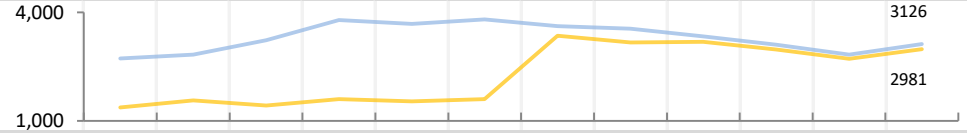
RA1.3	Number of first cancer treatments (i.e. 31 day treatments)	-26	+16	+236
		-7.3%	+1.5%	+7.6%



RA1.4	Main ED attendances (Type 1 and UCH)	+697	+697	+4156
		+8.0%	+8.0%	+4.7%

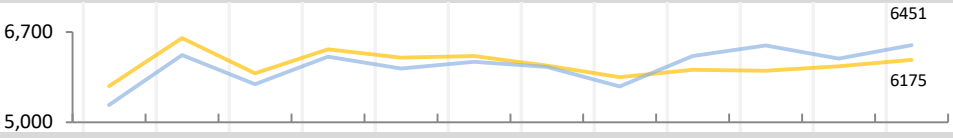


RA1.5	Other ED attendances incl Eye Unit & Lymington MIU	+145	+145	+9513
		+4.9%	+4.9%	+38.8%



RA1.5: Lymington MIU included from August 2017.

RA1.6	Non-elective Spells (incl. CDU)	+276	+276	+304
		+4.5%	+4.5%	+0.5%



RA1.6: 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.

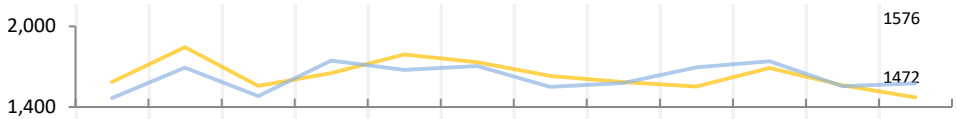
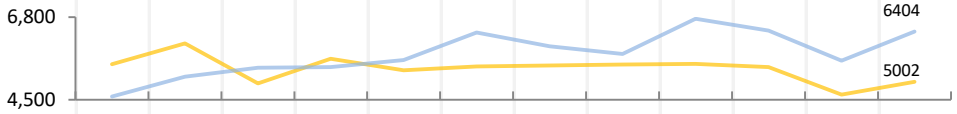
Current Data
Previous Year
Benchmark
Target

February 2019

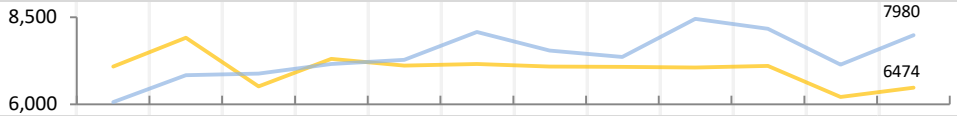
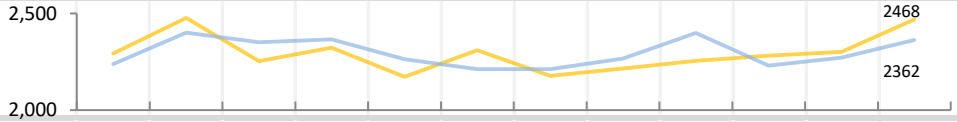
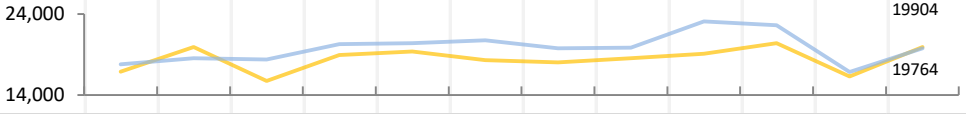
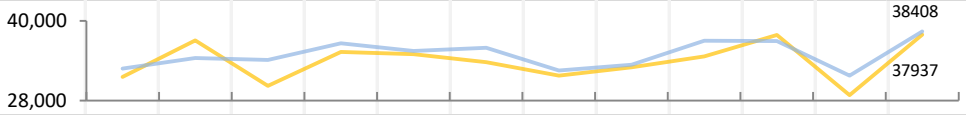
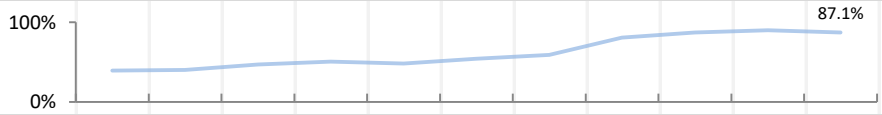
]

Activity

University Hospital Southampton NHS
NHS Foundation Trust

	Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan	Month	QTD	YTD
RA1.7 Elective Inpatient Spells		+104 +7.1%	+104 +7.1%	+79 +0.5%
RA1.8 Elective Day Case Spells		+1402 +28.0%	+1402 +28.0%	+6885 +13.0%

RA 1.8 and RA 1.9: Recent increases in elective day case activity relate mainly to Haematology and other Cancer Care specialities, recording practices for day case and outpatient procedures are being reviewed.

RA1.9 Combined Elective Spells		+1506 +23.3%	+1506 +23.3%	+6959 +10.1%
RA1.10 Adult Critical Care Bed Days		-106 -4.3%	-106 -4.3%	+176 +0.8%
RA1.11 New outpatient appointments		-140 -0.7%	-140 -0.7%	+17166 +9.3%
RA1.12 Follow-up outpatient appointments		+471 +1.2%	+471 +1.2%	+13791 +4.1%
RA1.13 GP referrals via e-referral				

Current Data Benchmark
Previous Year Target

February 2019

Flow

University Hospital Southampton NHS
NHS Foundation Trust

Amber

The number of Delayed Transfers of Care in the Trust increased in January from 67 to 94. The number of patients who have been in hospital for greater than or equal to 7 days / 21 days also increased yet remained lower than January 2018 by 6% and 8% respectively. Early discharge on the day (pre-midday) in January increased to 22.7% (target 30%).

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly Target	YTD
RF1.1	Assessment Unit Downstreaming to an inpatient ward by 10am	11.4%	8.8%	6.1%	7.9%											9.2%	-	-
RF1.2	Elective LOS Rolling 12 months	5.0	4.0	4.2												4.1	-	-
RF1.3	Non Elective LOS Rolling 12 months	7.5	6.5	7.2												6.6	-	-
RF1.4	Paediatric LOS Rolling 12 months	3.0	2.0	2.4												2.6	-	-
RF1.5	Delayed Transfer of Care Census average	130	0	101												94	<=38	95
RF1.6	Delayed transfers of care (CQC Calculation)	10%	0%	7.3%												7.4%	<=3.50%	7.59%
RF1.7	Patients with LOS >=7days Census average	700	500	653												612	-	-
RF1.8	Extended LOS Census average (Patients with LOS >=21days)	300	150	259												237	200	-

Current Data
Previous Year
Benchmark
Target

February 2019

Flow

University Hospital Southampton NHS
NHS Foundation Trust

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly Target	YTD
RF1.9	Early discharge on day (pre-midday)	32% / 16%		23.5%												22.7%	>=30%	24.12%
RF1.10	Weekend Discharge (EL & NEL Combined)	85% / 50%		57.4%												61.9%	>=80%	62.82%
RF1.11	Adult midday bed occupancy	99.2% / 94.7% / 90.3%		97.5%												86.4%	90-95%	-

RF1.11 - We believe December occupancy is understated due to reductions in occupancy surrounding Christmas day and increased number of physical bed spaces were available, however nurse staffing numbers were flexed downwards reducing the number of bed spaces that were staffed and therefore available for patient care. The data above has not yet been adjusted to reflect these actions.

RF1.12	Red and Black Alerts	26	44	2 / 46	8 / 44	41	4 / 19	42	1	12	15	29	32	8	3	40	-	-
RF1.13	Last minute cancelled operations	150 / 0		93												81	-	-
RF1.14	Last minute cancelled operations not readmitted within 28 days	55 / 0		19												7	-	-

RF1.14 - The number of operations not readmitted within 28 days in December reflects the large number of cancellations on 28/11/19 (major incident) and reduced operating capacity due to Christmas and Boxing Day.

RF1.15	% elective operations cancelled and not readmitted within 28 days	5%		20.4%												8.6%	<=5%	10.20%

Current Data | Benchmark
Previous Year | Target

February 2019

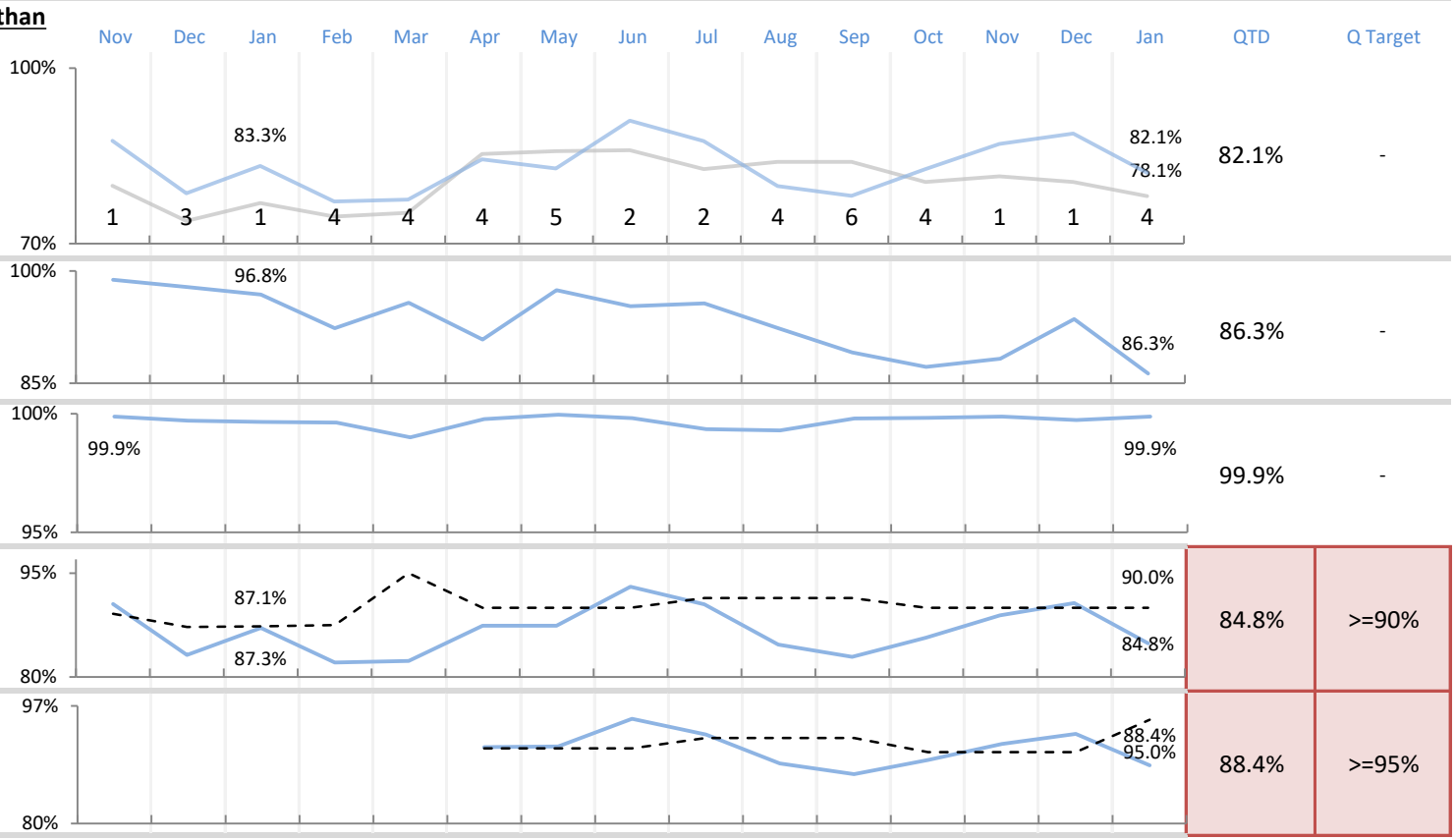
Emergency Access

University Hospital Southampton NHS
NHS Foundation Trust

Amber

Main ED (Type 1) performance reduced in January to 82.1%, compared to UHS January 2018 83.3%, but was 4% above the average of our local peer group. This performance was impacted by ED attendances significantly exceeding volumes in previous years and the onset of winter pressures in the inpatient service. Eye casualty (Type 2) performance is still an area of concern now at 86.3%. Lymington MIU (Type 3) remains at a high level of performance (99.9%) and as a local delivery system we achieved the PSF threshold of 90.3% for Q3 and will need to achieve 95% in March to meet Q4 target.

Percentage of patients spending less than 4 hours in ED



UHS Total (RE1.4) includes SGH all types and lymington. Local Delivery System (RE1.5) is UHS Total and Southampton Treatment Centre (RSH MIU).

Current Data Benchmark
Previous Year Target

February 2019

Emergency Access

University Hospital Southampton NHS
NHS Foundation Trust

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Target	R-3M
RE1.6	% patients who left the department before being seen UHS Total	5%		4.6%											5.8%		<5%	5.7%
RE1.7	Time to initial assessment - 95th Centile UHS Total	Metric in development																-
RE1.8	Time to treatment - Percentiles UHS Total	95th, 3:16													95th, 4:24		< 1hr for 50th	-
		75th, 2:01													75th, 2:37			
		50th, 1:04													50th, 1:30			
RE1.9	Total time spent in ED - Percentiles UHS Total	95th, 6:42													95th, 6:37		< 4hrs for 95th	-
		75th, 3:47													75th, 3:53			
		50th, 2:39													50th, 2:53			
RE1.10	Emergency reattendance within 7 days (Type 1)	9%													7.6%		-	-
		4%													7.8%			
RE1.11	ED Conversion (Type 1)	33%													31.2%		-	-
		25%													30.5%			

Current Data
Previous Year
Benchmark
Target

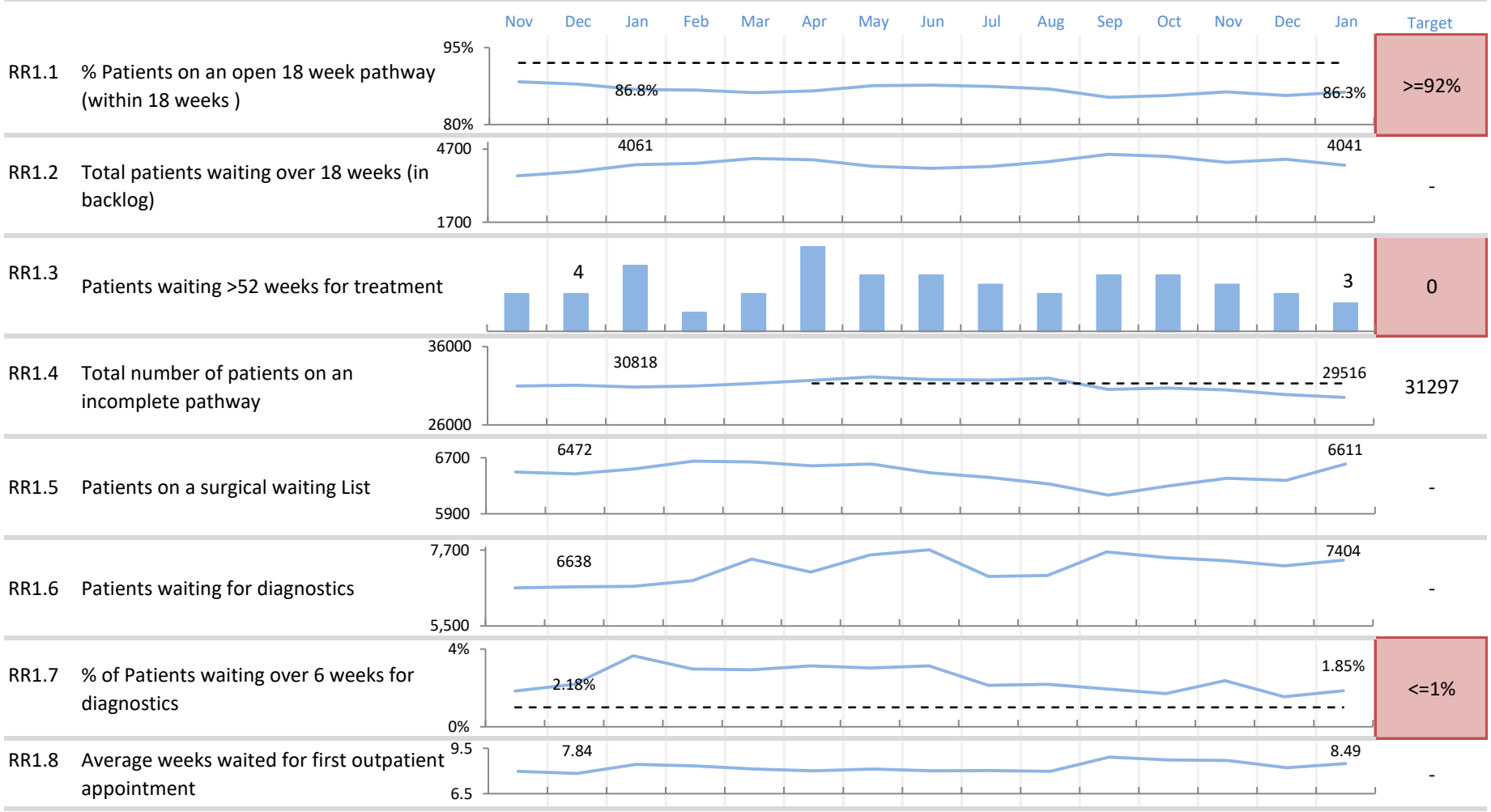
February 2019

RTT and Diagnostics

University Hospital Southampton NHS
NHS Foundation Trust

Red

Both RTT and diagnostic performance improved in January. The total size of the RTT waiting list reduced to the lowest level in over 12 months whilst the number of patients over 18 weeks reduced to the lowest levels since August 2018 (August 2018 was when patients in our Salisbury Neurology service were added to the UHS waiting list). Diagnostic performance remains below but close to target, performance improved as a result of breakdown related MRI breaches in the previous month being resolved.



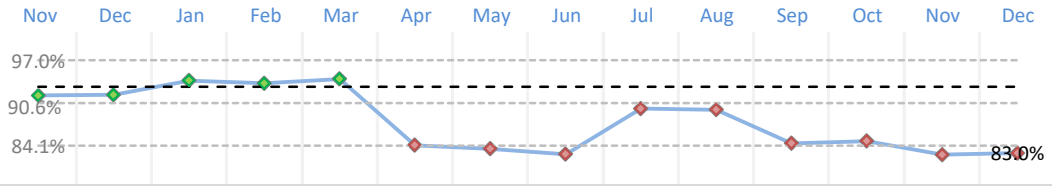
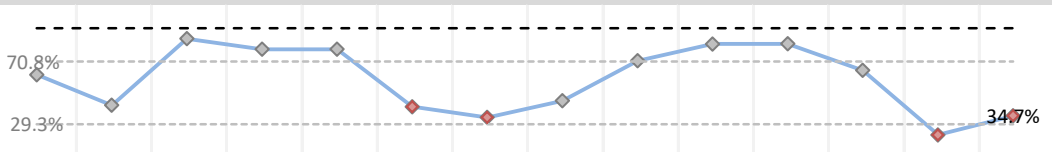
February 2019

Cancer

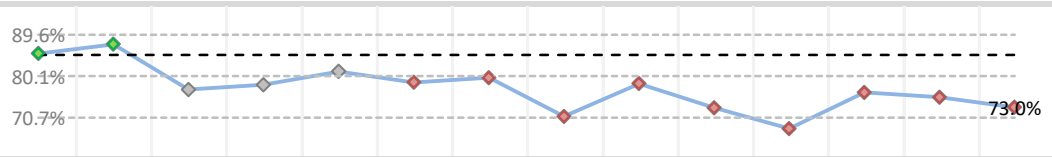
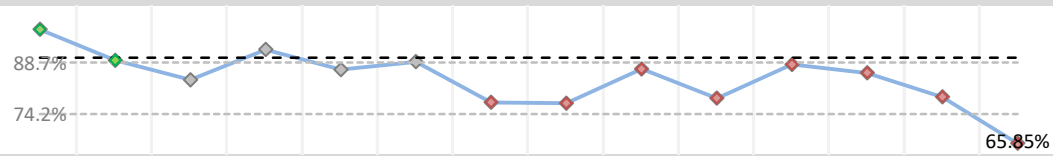
University Hospital Southampton NHS
NHS Foundation Trust

Red

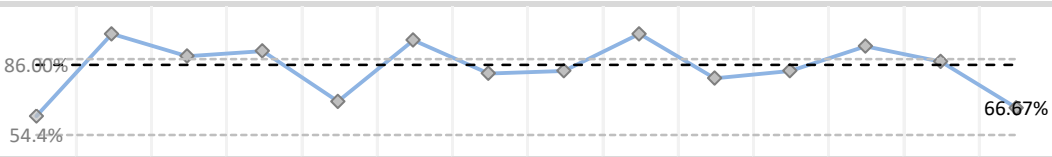
Cancer performance is currently rated red as we are not achieving a number of measures. Recovery of the Treatment started within 62 days of urgent GP referral wait, is likely to be slow and significant challenges are being experienced linked to significant growth in referrals and the number of additional cancers being treated (236 year to date).

			Monthly Target	no.patients to recover target	QTD
RC1.1	Urgent GP referrals seen in 2 weeks		=>93%	139 of 1396	23%
RC1.2	Breast symptoms referral seen in 2 weeks		=>93%	69 of 118	37%

RC1.1 & RC1.2 - In December, achievement of first appointments within 2 weeks continued significantly below target due to challenges in the Breast service. Performance has improved significantly in January and February following commencement of a new Consultant Radiologist in post in January.

			Monthly Target	no.patients to recover target	QTD
RC1.3	Treatment started within 62 days of urgent GP referral		=>85%	18 of 150	75%
RC1.4	Treatment started within 62 days of referral (Breast, Cervical & Bowel Screening)		=>90%	5 of 20.5	77%

RC1.4 - Out of 7 breaches 6 related to Breast Surgery.

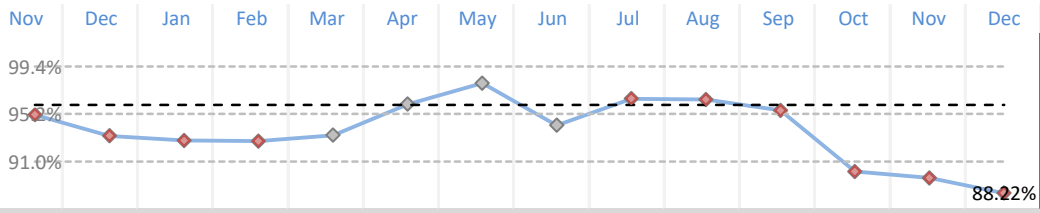
			Monthly Target	no.patients to recover target	QTD
RC1.5	62 Day - Consultant Upgrades		=>86%	1 of 3	88%

Current Data
Previous Year
Benchmark
Target

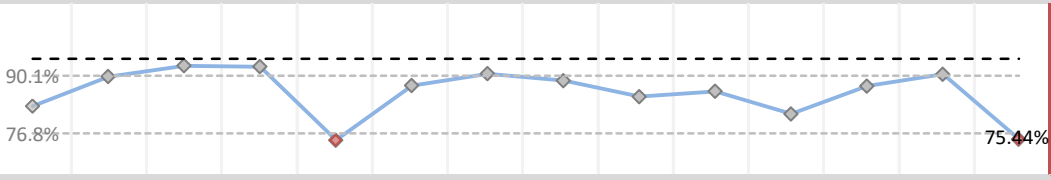
February 2019

Cancer

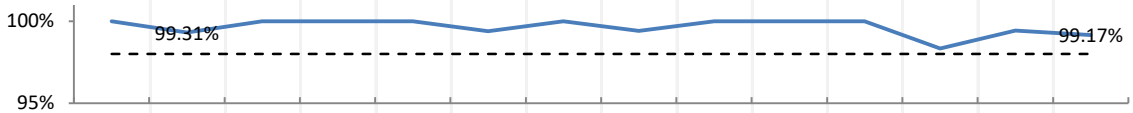
University Hospital Southampton NHS
NHS Foundation Trust

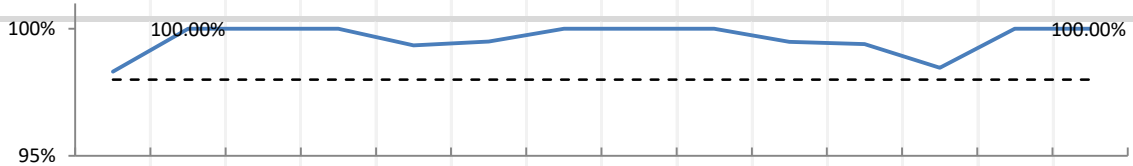
			Target	no. patients to recover target	QTD
RC1.6	Treatment started within 31 days of decision to treat		=>96%	26 of 331	89%

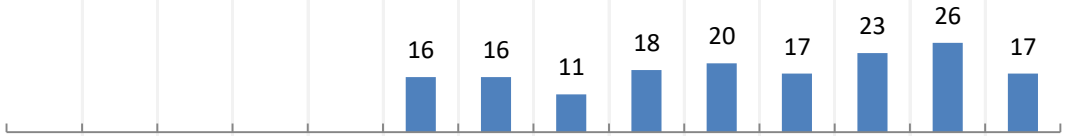
RC1.6 Performance adversely impacted in December by an exceptionally high number of target breaches in Breast Surgery, and in Prostate Surgery.

RC1.7	Second or subsequent treatment (surgery) started within 31 days of decision to treat		=>94%	21 of 114	85%

RC1.7 - In December there were 28 breaches total, of which 19 were in Urology, of which 11 related to Prostate surgery after a period of active monitoring.

RC1.8	Second or subsequent treatment (anti cancer drugs) started within 31 days of decision to treat		=>98%	0 of 120	99%

RC1.9	Second or subsequent treatment (radiotherapy) started within 31 days of decision to treat		=>98%	0 of 189	99%

RC1.10	104 day waits (treated in month)		-	-	-

Principal reasons impacting RC1.10 are prostate surgery (same as RC1.3 & RC1.7), also late referrals of patients referred from other trusts and extended waits due to patient choice.

Current Data
Previous Year
Benchmark
Target

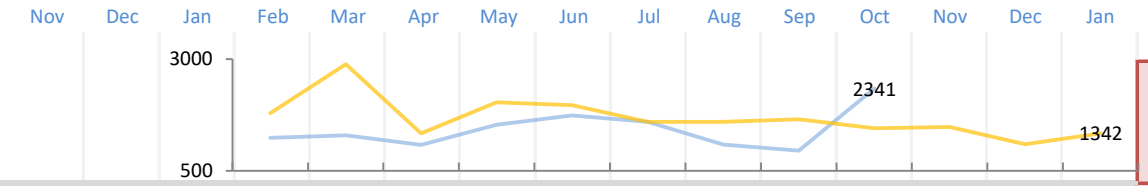
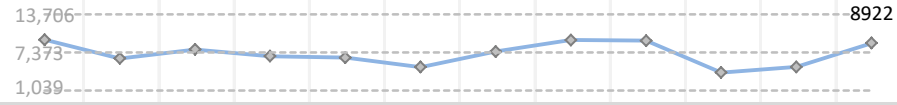
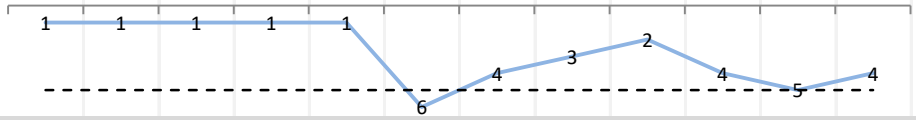
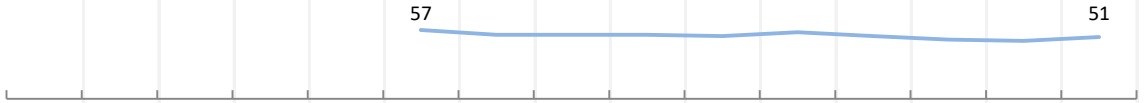
February 2019

Research and Development

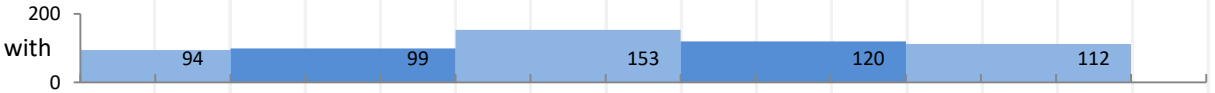
University Hospital Southampton NHS
NHS Foundation Trust

Amber

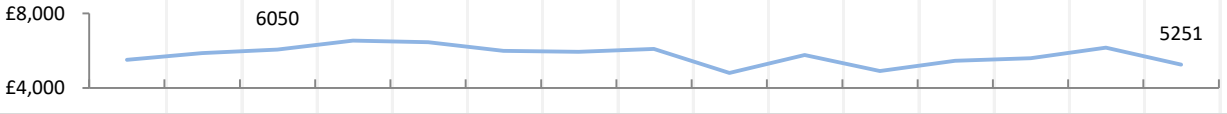
Research and Development has been rated Amber this month. October recruitment benefitted from activity on a high recruiting meningitis prevention study. Whilst recruitment to this study has ended recruitment projections to year end are satisfactory. Complexity (weighted) performance is also satisfactory with UHS ranked 2nd in the UK for a number of consecutive months.

			YTD	YTD Target
	CRN Recruitment			
WR1.1	Participants Recruited		10339	12664
WR1.2	Weighted Recruitment		49104	52690
WR1.3	Weighted National Ranking - All Studies		-	Top 5
WR1.4	Specialties Recruiting		-	tbc

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

	BRC			
WR1.5	Papers published in partnership with UOS		385	400

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

	Activity/Staffing Balance			
WR1.6	Income per WTE		-	-

Current Data
Previous Year
Benchmark
Target

February 2019

Staffing

University Hospital Southampton NHS
NHS Foundation Trust

Amber

Staffing has been rated amber this month, despite sustained improvements in the following: HR turnover rates, sickness absence, appraisal rates and vacancy rates of total nursing workforce and registered nurses. The reason for this is that several KPI targets have yet to be reached, including those relating to overall staff turnover, appraisal completion rates and nursing vacancy rates. The sickness target has again been achieved, with a further reduction this month. Care Hours Per Patient day has returned to normal range, with increased activity following the Christmas and New Year periods. The CHPPD for ward based areas in the Trust has decreased from last month as expected (the change in December was partly due to seasonal holiday). This month, patient numbers have increased as normal due to winter pressures.

		Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Monthly Target
WS1.1	HR - Turnover - Rolling 12-months	13.65%	13.16%	13.3%												13.0%	<=12%
WS1.2	HR - Sickness absence - Rolling 12-months	3.65%		3.56%												3.33%	<=3.4%
WS1.3	HR - Appraisals completed (non-medical) - Rolling 12-months	95%		83.90%												87.44%	=>92%
WS1.4	Nursing Vacancies (Total Clinical Wards)	19%		13.02%												12.44%	<=12.00%
WS1.5	Nursing Vacancies (Registered Nurse only in clinical wards)	22%		18.04%												18.52%	<=15.00%

WS1.4/1.5 Total nursing vacancies have continued to reduce (a decrease of 0.58% since last month), due to over recruitment of unregistered staff. Since December 2018, registered nurse vacancies have decreased, with a slight improvement of 0.14% .

WS1.6	Staff FFT - % of staff recommend UHS as a place to work. (Quarterly)	80%			78%		80%			78%							>=76%
WS1.7	Statutory & Mandatory Training Achieving Target	57	57	57	75	66	75	75	75	75	75	75	84	93	84	84	-
WS1.8	Total nursing staff all inpatient areas - Care hours per patient day (CHPPD)	9.5		8.3												8.5	-

WS1.8 The CHPPD for ward based areas in the Trust is: RN 5.3 (previously 5.6), HCA 3.3 (previously 3.5), total 8.5 (previously 9.1). Decrease attributed to lower patient numbers from seasonal holidays.

WS1.9	Registered nursing staff all inpatient areas - CHPPD	6.0		5.1												5.3	-
WS1.10	Unregistered nursing staff all inpatient areas - CHPPD	3.5		3.2												3.3	-
WS1.11	Black & Minority Ethnic Band 7+ Percentage	8.5%		7.5%												8.1%	-
WS1.12	Quality of practice experience for doctors in training (annual report with quarterly qualitative updates)	Minor Risk			Minor Risk			Minor Risk			Minor Risk			Minor Risk			No risk

Current Data Benchmark
Previous Year Target

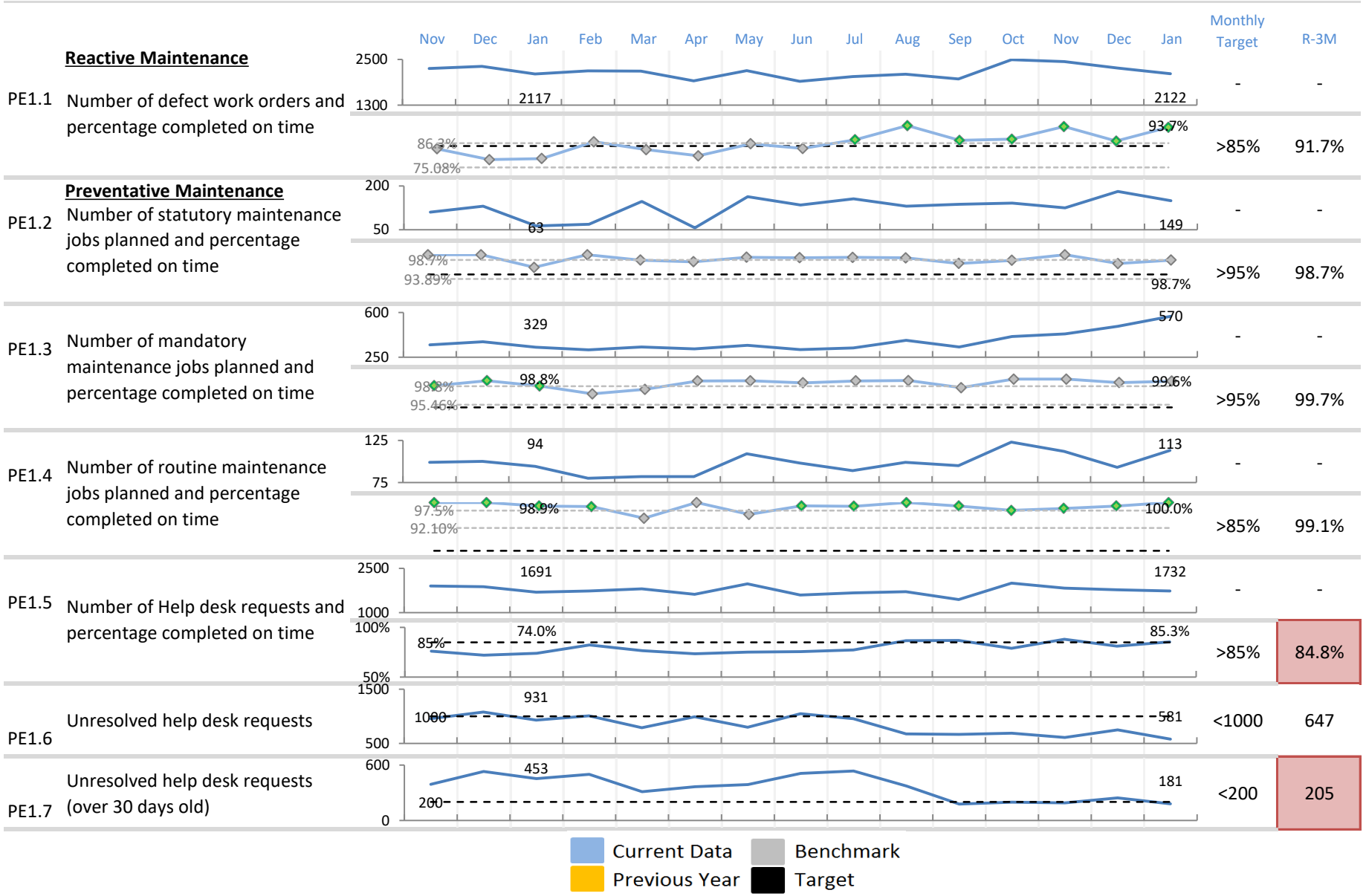
February 2019

Estates

University Hospital Southampton NHS
NHS Foundation Trust

Green

Estates has been rated green this month as we are meeting all targets in January. The targets missed on a 3 month rolling average are for percentage of help desk requests completed on time and Unresolved help desk requests (over 30 days old).

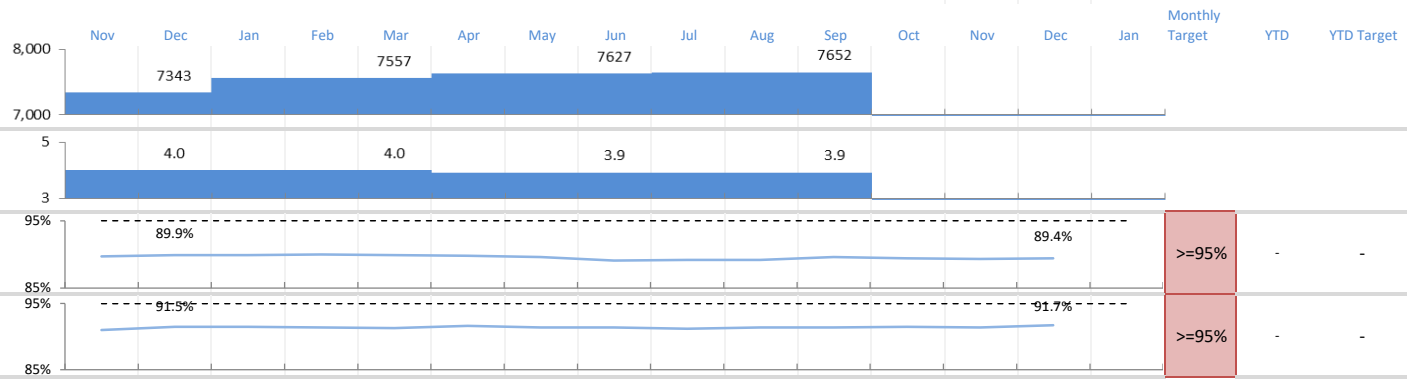


February 2019

University Hospital Southampton NHS
NHS Foundation Trust

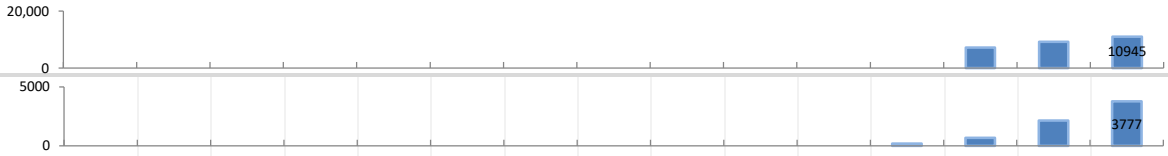
Green

DigiRounds has demonstrated both time saving in reviewing the patient record during ward rounds, but also the quality of the review that is carried out, as clinicians are able to easily see all the significant elements of the record. It saves junior doctors time in preparing information for consultants (transcribing relevant results etc) prior to the ward round. Records accessed using Digirounds increased to 98,328 in December. Also in December the number of alerts sent using Medxnote increased again to 3777.

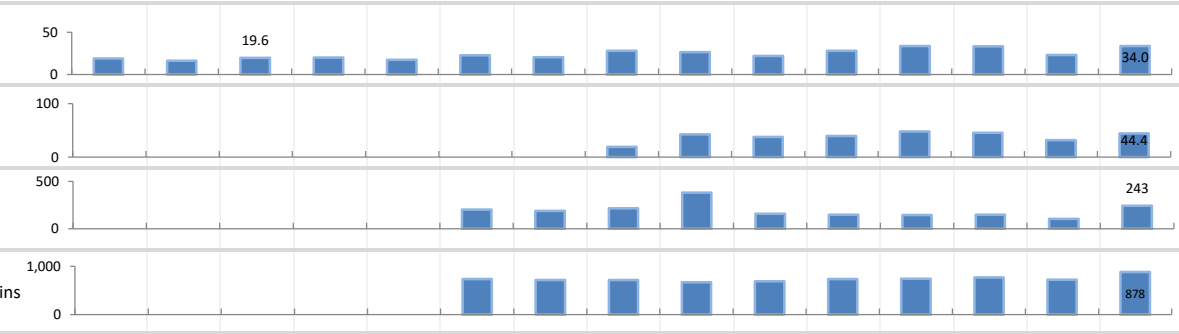


Release 29 of CHARTS goes live on 23rd January 2019. This includes enhancements to histopathology requesting from the Endoscopy Unit and should result in an increase in both requesting and acknowledgment - this will first appear in the April 2019 data extracts.

eQuest Results Alerts Sent



SD1.7 - Use of Medxnote has tripled in month



Current Data Benchmark
Previous Year Target

February 2019

Changes and Corrections

University Hospital Southampton NHS
NHS Foundation Trust

Page	KPI	KPI Name	Type	Detail
		No changes or corrections this month		

Quarter 3 Infection Prevention Summary Report

Category		Q3 RAG	YTD RAG	Action /Comment
Targets:	MRSA bacteraemia reduction	G	R	1 MRSA BSI Contaminant in Q2. Zero-tolerance target breached
	Clostridium difficile infection reduction	R	G	12 attributable cases Q3 2018-19 against a quarterly limit of 11 and 30 cases year to date against an annual limit of 42 cases.
	Prudent antibiotic prescribing	R	R	. Significant reduction (5.2%) in total antibiotic consumption with potential to achieve £65K CQUIN coinciding with introduction of default day 5 stop. No likelihood of achieving £65K narrow-spectrum antibiotic usage CQUIN target
Provide assurance of basic infection prevention practice:	CQC assurance framework	G	G	Overall compliance with CQC outcome 8. The Trust continues to implement actions to improve performance relating to cleanliness and isolation.
	Hand hygiene and Saving Lives high impact interventions	G	G	Overall compliance with saving lives high impact intervention remains high. IN Patient Hand Hygiene audits carried out by Clinical Lead Matron and Ward Leaders in November 2019 showed overall trust score of 95%

Nursing and midwifery staffing hours - January 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) 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 - 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	CHPPD Registered midwives/ nurses	CHPPD unregistered care Staff	CHPPD Overall	Comments
C4 (Solent ward)	Day	1454.3	1336.5	1023.2	1240.0	91.9%	121.2%	3.7	3.5	7.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C4 (Solent ward)	Night	1069.5	973.0	713.0	925.8	91.0%	129.8%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
C6	Day	2867.8	2584.9	133.0	212.3	90.1%	159.6%	7.2	0.5	7.7	Safe staffing levels maintained; Support workers used to maintain staffing numbers.
C6	Night	2058.5	1916.8	0.0	82.5	93.1%	Shift N/A				Safe staffing levels maintained; Staffing appropriate for number of patients.
C6 (Teenage Cancer Trust unit)	Day	716.5	706.7	358.5	140.6	98.6%	39.2%	8.2	1.0	9.3	Safe staffing levels maintained by sharing staff resource; No requirement for Support workers.
C6 (Teenage Cancer Trust unit)	Night	683.8	629.8	0.0	22.0	92.1%	Shift N/A				Safe staffing levels maintained; No requirement for Support workers.
D2	Day	1312.4	1399.8	1040.0	1232.5	106.7%	118.5%	4.2	3.7	7.9	Safe staffing levels maintained.
D2	Night	1058.0	1071.8	713.5	929.3	101.3%	130.2%				Safe staffing levels maintained.
D3	Day	1677.1	1604.0	794.1	892.1	95.6%	112.3%	4.1	2.6	6.6	Safe staffing levels maintained.
D3	Night	1057.8	1044.3	697.5	765.0	98.7%	109.7%				Safe staffing levels maintained.
Surgical high dependency unit	Day	2126.7	2049.6	353.4	340.0	96.4%	96.2%	15.7	2.7	18.4	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2047.0	2024.0	343.8	350.0	98.9%	101.8%				Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	5552.8	4972.8	1253.5	590.0	89.6%	47.1%	25.2	2.8	28.0	Beds flexed to match staffing; Safe staffing levels maintained.
Cardiac intensive care unit	Night	5294.0	4569.2	869.0	472.5	86.3%	54.4%				Beds flexed to match staffing; Safe staffing levels maintained.
General intensive care unit A	Day	4647.7	4357.2	992.1	502.9	93.7%	50.7%	13.2	1.7	14.8	Beds flexed to match staffing; Safe staffing levels maintained.
General intensive care unit A	Night	4228.3	4153.1	713.0	585.5	98.2%	82.1%				Beds flexed to match staffing; Safe staffing levels maintained.
General intensive care unit B	Day	4122.1	3809.9	583.4	408.5	92.4%	70.0%	22.3	2.2	24.5	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
General intensive care unit B	Night	3915.8	3783.5	356.5	343.3	96.6%	96.3%				Beds flexed to match staffing; Safe staffing levels maintained.

Neuro intensive care unit	Day	4876.2	4270.0	805.4	520.5	87.6%	64.6%	26.6	3.4	29.9	Beds flexed to match staffing; Safe staffing levels maintained.
Neuro intensive care unit	Night	4223.5	3620.3	655.5	483.0	85.7%	73.7%				Beds flexed to match staffing; Safe staffing levels maintained.
E5A	Day	1282.1	975.1	650.0	968.0	76.1%	148.9%	3.1	2.7	5.8	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5A	Night	713.0	678.5	356.5	449.5	95.2%	126.1%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Day	1423.0	1199.3	787.0	814.0	84.3%	103.4%	3.6	2.2	5.8	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Night	708.0	689.5	356.5	363.0	97.4%	101.8%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Day	2008.1	1649.4	1651.0	1781.0	82.1%	107.9%	3.1	3.2	6.3	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Night	1076.0	1041.0	942.0	981.0	96.7%	104.1%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Day	2128.5	1328.2	789.6	697.7	62.4%	88.4%	4.3	2.3	6.6	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas.
F11	Night	1070.0	909.0	356.5	511.0	85.0%	143.3%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Day	2208.3	1665.4	661.7	1077.3	75.4%	162.8%	3.1	2.3	5.4	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Night	1058.0	967.0	684.5	830.0	91.4%	121.3%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Day	1951.4	1457.9	984.8	1320.9	74.7%	134.1%	3.1	2.8	5.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Night	1063.0	978.0	717.0	881.5	92.0%	122.9%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute medical unit	Day	4452.7	4024.9	2880.4	3902.3	90.4%	135.5%	4.8	4.2	9.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
Acute medical unit	Night	3560.8	3404.0	1998.3	2648.0	95.6%	132.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
D5	Day	1827.9	1248.4	1053.3	1294.2	68.3%	122.9%	2.5	3.0	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D5	Night	1072.1	884.1	604.5	1243.3	82.5%	205.7%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Day	1591.3	1170.1	1783.0	1702.0	73.5%	95.5%	2.7	3.5	6.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Night	1252.8	848.3	690.0	892.5	67.7%	129.3%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity.
D7	Day	923.2	766.4	1075.5	1055.2	83.0%	98.1%	3.0	2.9	5.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D7	Night	713.0	692.5	356.5	357.0	97.1%	100.1%				Safe staffing levels maintained.
D8	Day	1987.9	1303.4	992.5	1493.2	65.6%	150.5%	3.2	3.3	6.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D8	Night	1061.3	1038.2	598.5	954.0	97.8%	159.4%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D9	Day	1724.5	1063.0	1037.6	1509.9	61.6%	145.5%	2.3	3.2	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D9	Night	1070.0	841.3	601.5	1166.5	78.6%	193.9%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
E7	Day	1555.7	1086.5	845.5	1245.0	69.8%	147.3%	2.7	3.3	6.0	Additional beds open in the month; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
E7	Night	708.0	834.0	713.0	1127.0	117.8%	158.1%				Additional beds open in the month; Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity.
Respiratory high dependency unit	Day	2354.7	1314.0	338.0	527.0	55.8%	155.9%	11.9	4.6	16.6	Beds flexed to match staffing; Staff moved to support other wards; Band 4 staff working to support registered nurse numbers.
Respiratory high dependency unit	Night	2129.8	1346.3	356.5	506.0	63.2%	141.9%				Beds flexed to match staffing; Staff moved to support other wards; Band 4 staff working to support registered nurse numbers.
C5	Day	1061.5	881.8	779.1	585.9	83.1%	75.2%	3.7	2.3	6.0	Safe staffing levels maintained; Staffing appropriate for number of patients.
C5	Night	713.8	714.1	356.5	391.0	100.0%	109.7%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.

D10	Day	1710.0	1293.4	1030.3	1428.5	75.6%	138.7%	4.7	3.9	8.6	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D10	Night	713.0	1279.0	1069.0	678.0	179.4%	63.4%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Safe staffing levels maintained.
F7	Day	733.5	746.2	1309.9	1214.1	101.7%	92.7%	2.4	3.1	5.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
F7	Night	713.0	713.0	713.0	713.0	100.0%	100.0%				Safe staffing levels maintained.
G5	Day	1041.9	1104.5	1821.5	1771.7	106.0%	97.3%	2.2	3.4	5.6	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	712.5	727.0	713.0	1051.0	102.0%	147.4%				Support workers used to maintain staffing numbers.
G6	Day	1083.5	1113.2	1808.0	1900.0	102.7%	105.1%	2.3	3.7	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.
G6	Night	701.5	736.0	1074.5	1070.5	104.9%	99.6%				Support workers used to maintain staffing numbers.
G7	Day	717.8	705.2	1463.2	1304.0	98.2%	89.1%	3.3	5.5	8.8	Staffing plan set higher than national standards; Patient requiring 24 hour 1:1 nursing in the month.
G7	Night	713.0	701.5	1070.5	1070.5	98.4%	100.0%				Staffing plan set higher than national standards; Patient requiring 24 hour 1:1 nursing in the month.
G8	Day	1076.6	1101.4	1740.6	1675.0	102.3%	96.2%	2.1	3.2	5.3	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	713.0	690.8	1058.0	1089.0	96.9%	102.9%				Support workers used to maintain staffing numbers.
G9	Day	1093.1	1090.4	1844.5	1785.2	99.8%	96.8%	2.3	3.6	5.8	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	713.0	726.5	1058.5	1081.5	101.9%	102.2%				Support workers used to maintain staffing numbers.
Paediatric high dependency unit	Day	1620.9	1203.2	0.0	0.0	74.2%	Shift N/A	12.6	0.0	12.6	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1069.5	1062.8	0.0	0.0	99.4%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	2380.7	1533.2	344.5	637.0	64.4%	184.9%	6.4	3.1	9.6	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing.
Paediatric medical unit	Night	2001.0	1305.8	341.0	751.0	65.3%	220.2%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; safe staffing.
Paediatric assessment unit	Day	1325.0	1221.7	574.0	349.0	92.2%	60.8%	9.8	2.1	11.9	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric assessment unit	Night	1069.5	1002.5	172.0	123.0	93.7%	71.5%				Safe staffing levels maintained.
Paediatric intensive care unit	Day	6125.8	5542.7	687.0	469.5	90.5%	68.3%	26.0	2.1	28.0	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5727.0	5463.8	517.5	402.5	95.4%	77.8%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Piam Brown ward	Day	3038.0	2685.7	154.0	152.8	88.4%	99.2%	13.0	0.6	13.6	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Piam Brown ward	Night	1069.5	1088.5	0.0	23.0	101.8%	Shift N/A				Safe staffing levels maintained.
E1	Day	2110.4	1663.4	649.8	617.0	78.8%	95.0%	7.1	2.3	9.4	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing.
E1	Night	1403.5	1365.3	368.0	345.0	97.3%	93.8%				Safe staffing levels maintained.
G2	Day	763.3	751.2	0.0	7.5	98.4%	Shift N/A	8.0	0.0	8.1	Safe staffing levels maintained.
G2	Night	743.5	743.5	0.0	0.0	100.0%	Shift N/A				Safe staffing levels maintained.
G3	Day	2410.5	1769.5	1257.0	1026.8	73.4%	81.7%	6.3	3.0	9.4	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; safe staffing.
G3	Night	1698.5	1440.5	682.0	517.8	84.8%	75.9%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
G4	Day	2594.0	2425.8	1320.5	689.0	93.5%	52.2%	7.1	2.0	9.1	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G4	Night	1706.0	1619.8	682.5	419.5	94.9%	61.5%				Safe staffing levels maintained.
Bramshaw women's unit	Day	1451.8	1163.6	1262.5	1000.0	80.2%	79.2%	4.0	3.6	7.7	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Bramshaw women's unit	Night	714.0	727.5	713.0	701.5	101.9%	98.4%				Safe staffing levels maintained.
Neonatal unit	Day	5813.4	4825.5	1613.0	1595.5	83.0%	98.9%	8.9	2.5	11.4	Beds flexed to match staffing.
Neonatal unit	Night	4433.0	4754.5	1022.0	1155.5	107.3%	113.1%				Increased night staffing to support raised acuity.

Maternity service	Day	8151.5	7784.0	2955.3	2340.0	95.5%	79.2%	5.4	1.8	7.2	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5280.5	4922.8	2029.0	1924.5	93.2%	94.8%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Cardiac high dependency unit	Day	4949.7	4328.4	1491.5	874.5	87.4%	58.6%	14.4	2.9	17.3	Staff moved to support other wards; Safe staffing levels maintained.
Cardiac high dependency unit	Night	3800.3	3753.1	682.0	727.0	98.8%	106.6%				Safe staffing levels maintained.
Coronary care unit	Day	1990.0	1623.5	729.0	881.0	81.6%	120.9%	7.5	3.5	11.0	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
Coronary care unit	Night	1364.5	1361.0	341.0	534.5	99.7%	156.7%				Increased night staffing to support raised acuity.
D4	Day	1884.0	1242.0	831.0	1139.3	65.9%	137.1%	3.0	2.8	5.8	Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
D4	Night	801.3	693.8	682.0	690.3	86.6%	101.2%				Band 4 staff working to support registered nurse numbers.
E2	Day	1542.7	1307.7	787.3	680.3	84.8%	86.4%	3.9	2.6	6.5	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
E2	Night	715.0	696.5	341.0	657.3	97.4%	192.7%				Additional staff used for enhanced care - Support workers.
E3	Day	2879.5	1874.5	1299.5	1943.5	65.1%	149.6%	2.8	3.1	5.9	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Additional staff used for enhanced care - Support workers.
E3	Night	1375.0	1141.3	1354.3	1421.3	83.0%	104.9%				Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
E4	Day	2180.0	1773.7	756.5	892.3	81.4%	117.9%	3.8	3.4	7.3	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E4	Night	1023.0	1183.2	682.0	1767.1	115.7%	259.1%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
F4 Cardiac	Day	1266.0	878.0	840.0	756.0	69.4%	90.0%	3.3	3.2	6.4	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
F4 Cardiac	Night	682.0	616.3	341.0	708.0	90.4%	207.6%				Band 2s to replace regictered nurses on some occasions. Safe staffing maintained. Regsistered nurese often working 1 down on the day shifts, again safety maintained..
Acute stroke unit	Day	1601.0	1693.5	2465.6	2540.9	105.8%	103.1%	3.1	4.5	7.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Acute stroke unit	Night	1034.5	986.3	1354.0	1360.5	95.3%	100.5%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Regional transfer unit	Day	1924.2	1347.5	410.5	716.7	70.0%	174.6%	9.1	6.4	15.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Regional transfer unit	Night	682.0	628.0	682.0	671.0	92.1%	98.4%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E Neuro	Day	1996.9	1425.2	1030.5	1965.9	71.4%	190.8%	3.3	4.4	7.7	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E Neuro	Night	1364.0	1135.8	1023.0	1411.5	83.3%	138.0%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Hyper acute stroke unit	Day	1162.4	974.4	451.5	694.0	83.8%	153.7%	6.2	5.2	11.4	Band 4 staff working to support registered nurse numbers.
Hyper acute stroke unit	Night	682.0	706.8	677.0	715.0	103.6%	105.6%				Band 4 staff working to support registered nurse numbers.
D neuro	Day	1941.5	1744.5	1441.3	1744.3	89.9%	121.0%	3.7	4.0	7.7	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
D neuro	Night	1364.0	1243.0	1359.0	1516.7	91.1%	111.6%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F4 Neuro	Day	1613.2	1466.0	645.0	1311.5	90.9%	203.3%	3.6	3.8	7.5	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
F4 Neuro	Night	1023.0	891.0	1022.0	1178.0	87.1%	115.3%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
Brooke ward (trauma and orthopaedics	Day	1179.3	1008.3	590.5	592.3	85.5%	100.3%	3.6	2.7	6.3	Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Brooke ward (trauma and orthopaedics	Night	1058.0	713.0	356.5	707.5	67.4%	198.5%				Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Trauma Assessment Unit	Day	549.0	395.3	390.0	589.7	72.0%	151.2%	4.1	5.3	9.3	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
Trauma Assessment Unit	Night	341.3	342.5	341.0	370.0	100.4%	108.5%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
F1	Day	2481.4	1850.1	1521.9	2173.0	74.6%	142.8%	3.4	4.4	7.8	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F1	Night	1782.5	1471.5	1069.5	2042.1	82.6%	190.9%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.

F2	Day	1660.3	1302.3	1324.3	2133.5	78.4%	161.1%	2.9	4.9	7.7	Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
F2	Night	1023.0	979.0	1023.0	1735.5	95.7%	169.6%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F3	Day	1678.7	1145.2	2392.3	2137.7	68.2%	89.4%	2.7	5.1	7.8	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
F3	Night	1023.0	836.0	2044.5	1581.8	81.7%	77.4%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: Learning from Deaths Quarter 3 Report			
Category	Quality, Performance, and Finance		
Agenda item	4.3		
Sponsor	Medical Director		
Author	Mark Green, Head of Bereavement Care		
Provenance	Previously reported to Quality Governance Steering Group		
Purpose	The paper is presented for the Board for Review Since 2014 IMEG and TMRG have been undertaking reviews of inpatient deaths. Deaths deemed to have been 'probably avoidable' (>50%) for 2017/18 accounted for 1% of all deaths, lower than reported historically, and this trend has continued throughout 2018/19.		
Relevant to Board goals	✓ Goal 1 – Trusted on Quality	✓ Goal 2 – Delivering for Taxpayers	✓ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	None identified.		
Equality Impact Assessment	None.		
Other standards affected	None identified.		

Learning from Deaths Quarter Report

1 Introduction

In March 2017 the DH published *National guidance on learning from deaths.* From April 2017, Trusts have been required to collect information on deaths, reviews, investigations and resulting quality improvements, and report to its public board meeting via a quarterly paper. This includes assigning an avoidability score to all those deaths reviewed. Whilst there is no requirement to review all deaths, rather only those where concerns are raised by relatives; unexpected deaths; deaths of patients with either a learning disability or a severe mental illness; or deaths in a speciality or treatment group where an alarm has been raised (for example, an elevated mortality rate), we have been undertaking a 'hot review' of all deaths via our Internal Medical Examiner Group (IMEG) process.

2 Key Issues

- UHS introduced the Internal Medical Examiner Group (IMEG) in September 2014, prior to the national drive.
- The group examines all deaths, going beyond the national guidelines and has progressively increased the scope to include
    - All inpatient adult deaths
    - Death in the Emergency Department
    - A paediatric mortality review process.
- The review identifies potential avoidable factors as well as aspects of good care to feedback to the clinical teams.
- The bereavement care team attends IMEG and focuses support where the clinical team discuss issues that might have been specifically stressful for the relatives. This allows a proactive approach to supporting those likely to have stress or conflict complicating their grief.
- In all cases Duty of Candour is discussed where appropriate ensuring that the clinical teams make early contact with the families.
- The proportion of avoidable features identified has reduced over the years and is believed to be a marker of improved care supported by the following observations
    - HSMR has fallen across all hospital sites (Appendix 7).
    - The Trust Mortality Review Group is not identifying issues missed by IMEG and supports the findings.
    - The introduction of IMEG dramatically reduced the number of complaints with care concerns that were not previously identified. This volume has not increased.
    - Junior Dr feedback suggests that the process has changed their practice and it is likely that care is improving as a consequence of IMEG. We additionally share learning with the teams but when relevant to the hospitals through OWL. However the direct hot feedback to the clinical team is possibly the most powerful influence.

3 Enclosed

In appendices 1, 2, 3, and 4, the following are outlined

Appendix 1 IMEG and mortality review data for Q1 – 2018/19 (updated)

Appendix 2 IMEG and mortality review data for Q2 – 2018/19 (updated)

Appendix 3 IMEG and mortality review data for Q3 – 2018/19

Appendix 4 Paediatric mortality review data for Q1 – 2018/19

Appendix 5 Paediatric mortality review data for Q2 – 2018/19

Appendix 6 Paediatric mortality review data for Q3 – 2018/19

Appendix 7 HSMR (rolling 12 month trend for last 3 years)

Appendix 8 Learning outcomes

4 Data Analysis

Reviews and data analysis for Q1 and Q2 2018/19 have been updated, although there are still a small number of cases awaiting further review (n=3). One death in Q2 was identified as having strong evidence of avoidability.

In the third quarter of this year, 566 deaths were reviewed at IMEG. Of these, 3 cases still require an avoidability rating to be assigned, either because we are awaiting post mortem report to establish the cause of death and determine whether further investigation is warranted (n=1), the outcome of case note reviews by TMRG (n=1), or detailed investigations of potentially serious adverse events (n=1).

Of the 563 deaths in Q3 that have already been assigned an avoidability score, one has been identified as probable avoidability.

Details of learning from the two cases having avoidable features are included in Appendix 8.

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

5 Next Steps

Planned changes to the eDischarge Summary will enable doctors to refer deaths to HM Coroner electronically which will significant amounts of time. Part completion of the discharge summary will be a pre-requisite to the IMEG review meeting. This will reduce the amount of paper administration currently generated at IMEG meetings and will allow for more timely data collection.

Introduction of a non-statutory Medical Examiner Service within acute hospital Trusts is due to be rolled out from April 2019 and a business has been prepared for the Trust's Medical Director setting out the requirements of delivering this service. A meeting the HM Coroner was held for 16 November 2018 to discuss how this new service will work in practice and it is envisaged that there will be few changes initially other than the requirement to refer all deaths electronically.

We will continue to work with partners. The process has been shared and adopted by Solent and we are looking at joint learning and will look to support and move investigations with other providers.

6 Learning

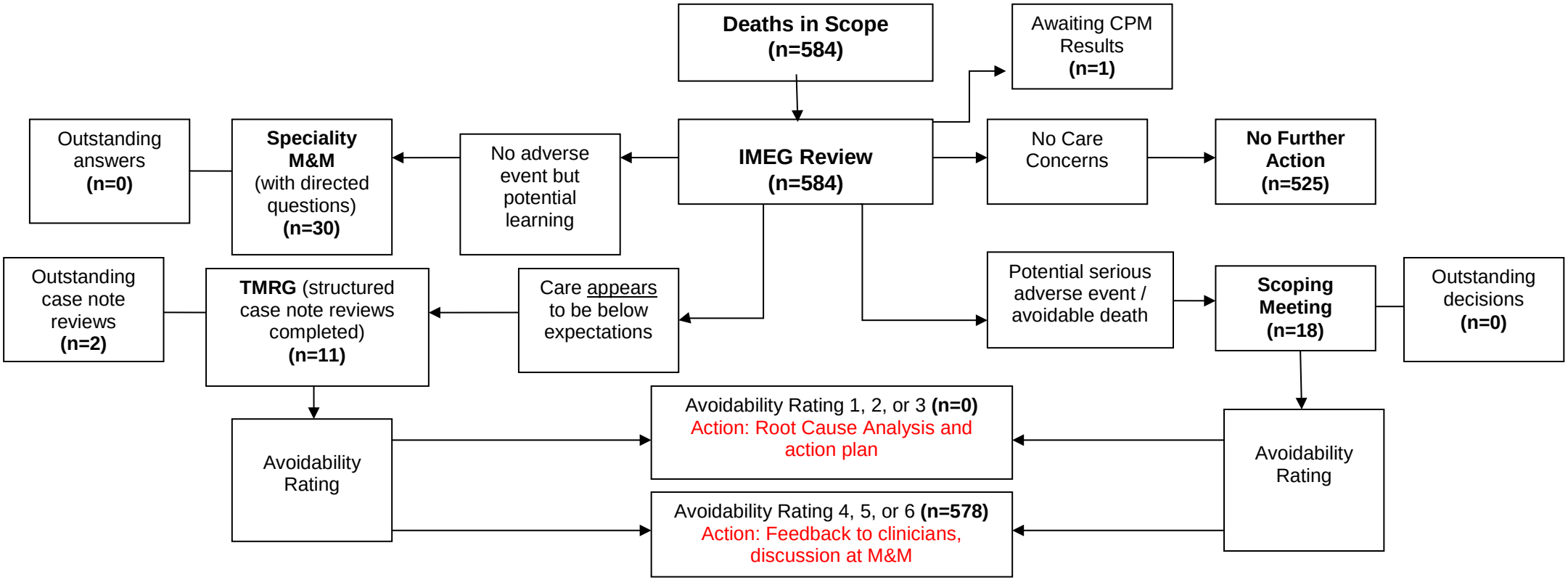
There are several learning points that have been identified from those cases deemed to have avoidable features. These have been actioned with individuals, teams or trust-wide, either in the form of education and training; or by reviewing existing processes or implementing new practices and are set out in more detail in Appendix 8

7 Recommendation

It is recommended that QGSG continues to support the evolution of mortality review within UHS.

Appendix 1

IMEG and mortality review process (Q1 – 2018/19)



Avoidability Rating (non-LeDeR deaths)

1. Definitely avoidable **= 0**
2. Strong evidence of avoidability **= 0**
3. Probably avoidable (more than 50:50) **= 0**
4. Possibly avoidable, but not very likely (< 50:50) **= 8**
5. Slight evidence of avoidability **= 31**
6. Definitely not avoidable **= 539**

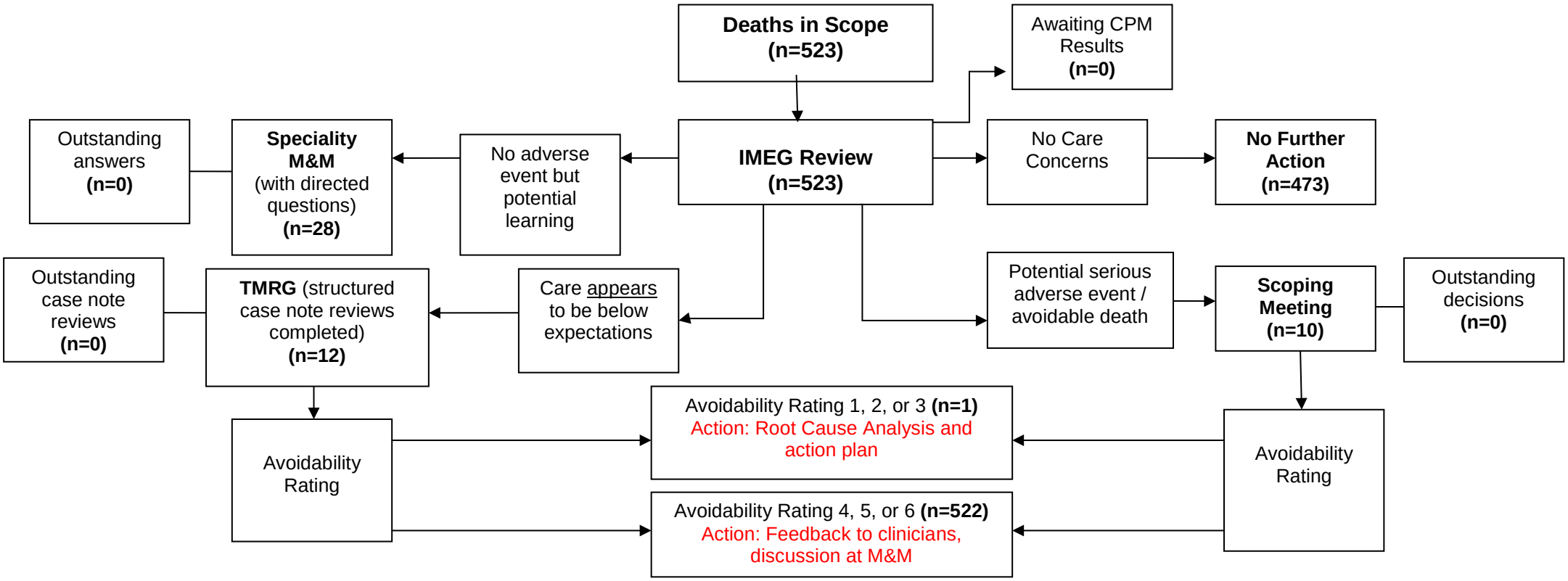
LeDeR deaths

Total LeDeR deaths = 3 (all cases subject to additional review captured within 'scoping' data)

Avoidability Rating – **<3** (for all cases)

Appendix 2

IMEG and mortality review process (Q2 – 2018/19)



Avoidability Rating (non-LeDeR deaths)

1. Definitely avoidable **= 0**
2. Strong evidence of avoidability **= 1**
3. Probably avoidable (more than 50:50) **= 0**
4. Possibly avoidable, but not very likely (< 50:50) **= 11**
5. Slight evidence of avoidability **= 19**
6. Definitely not avoidable **= 492**

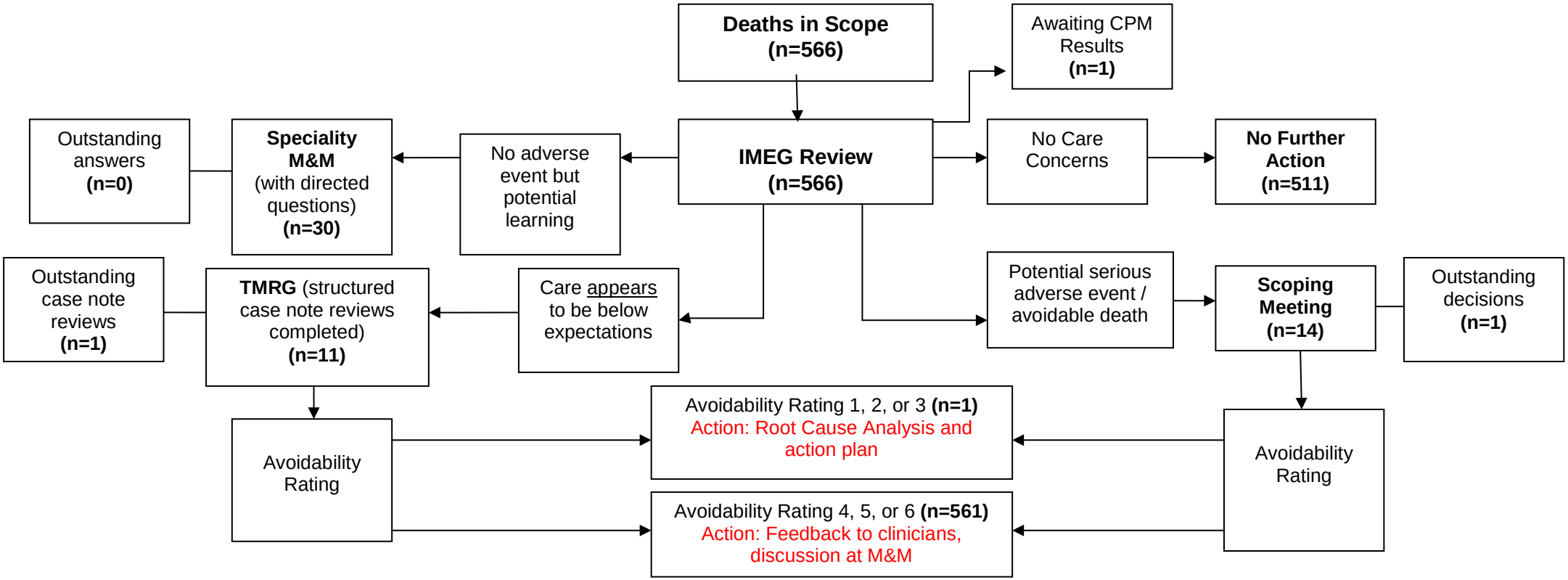
LeDeR deaths

Total LeDeR deaths = **0** (all cases subject to additional review captured within 'scoping' data)

Avoidability Rating –

Appendix 3

IMEG and mortality review process (Q3 – 2018/19)



Avoidability Rating (non-LeDeR deaths)

1. Definitely avoidable **= 0**
2. Strong evidence of avoidability **= 0**
3. Probably avoidable (more than 50:50) **= 1**
4. Possibly avoidable, but not very likely (< 50:50) **= 7**
5. Slight evidence of avoidability **= 20**
6. Definitely not avoidable **= 534**

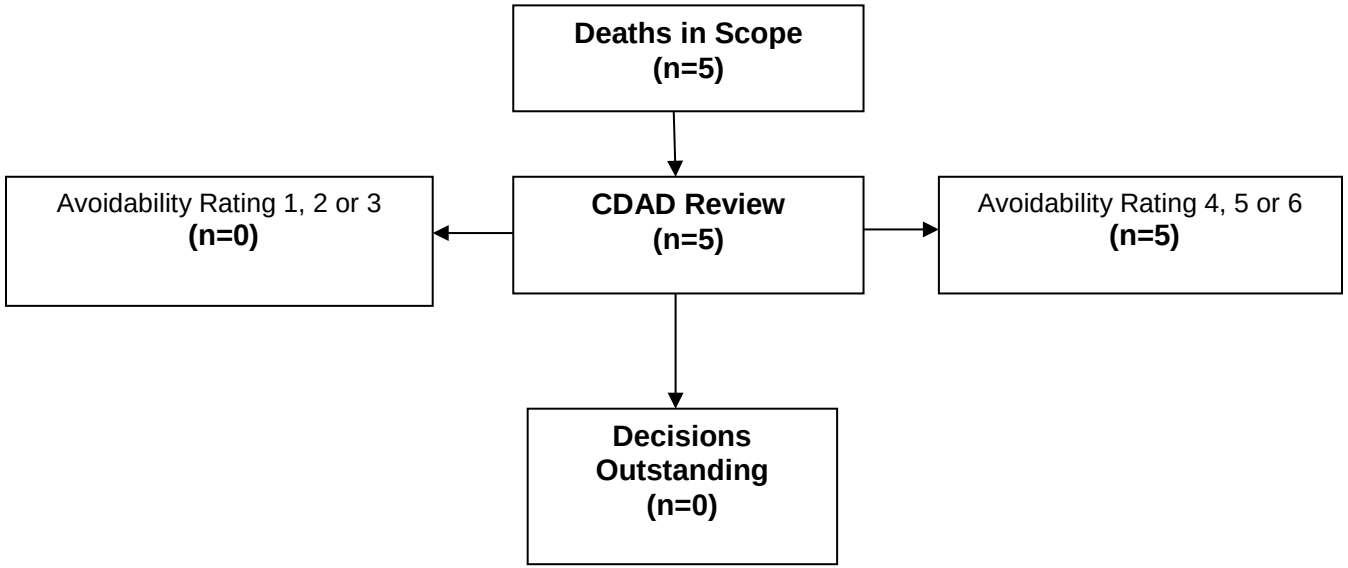
LeDeR deaths

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

Avoidability Rating – **6**

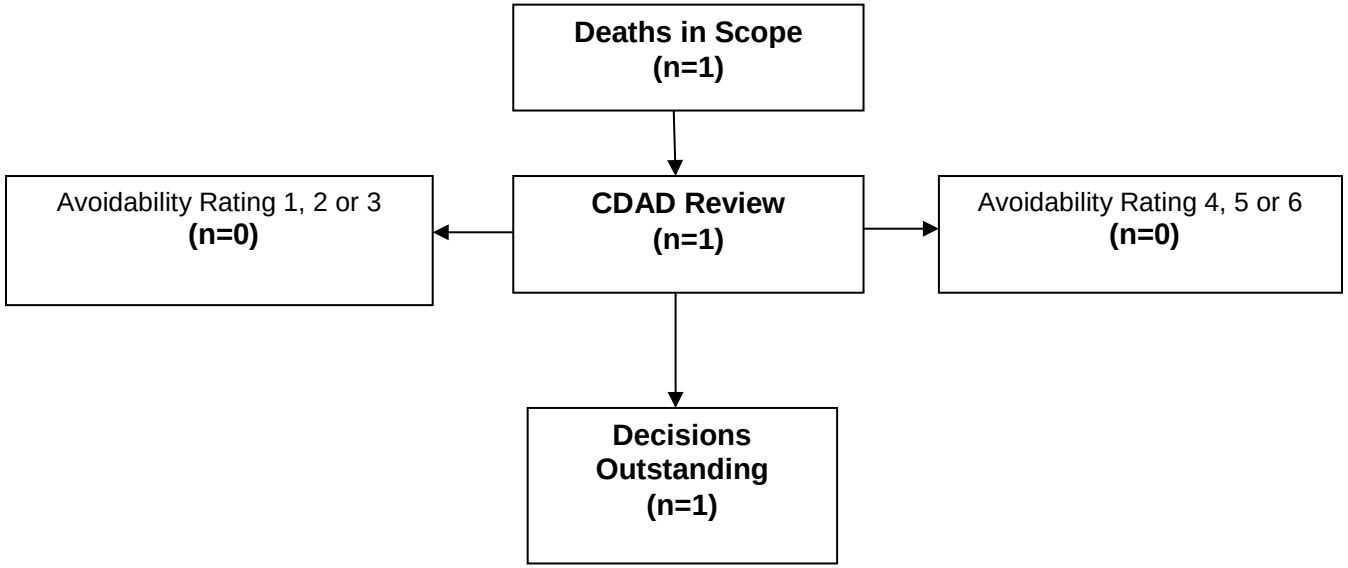
Appendix 4

Paediatric mortality review process (CDAD) (Q1 – 2018/19)



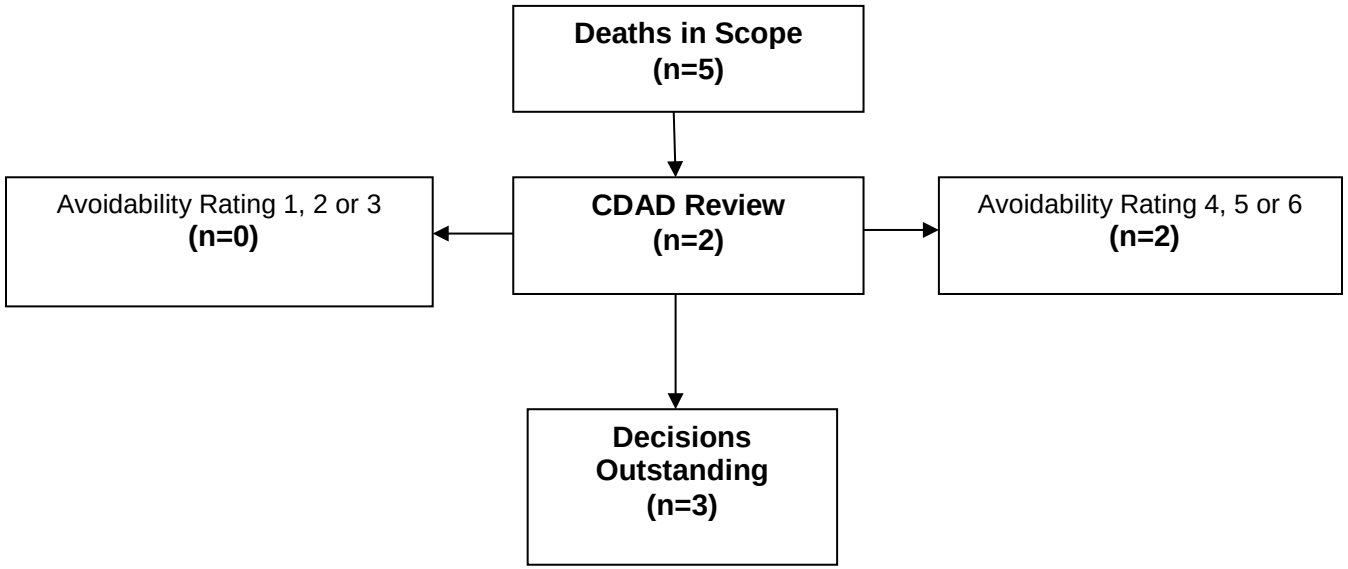
Appendix 5

Paediatric mortality review process (CDAD) (Q2 – 2018/19)



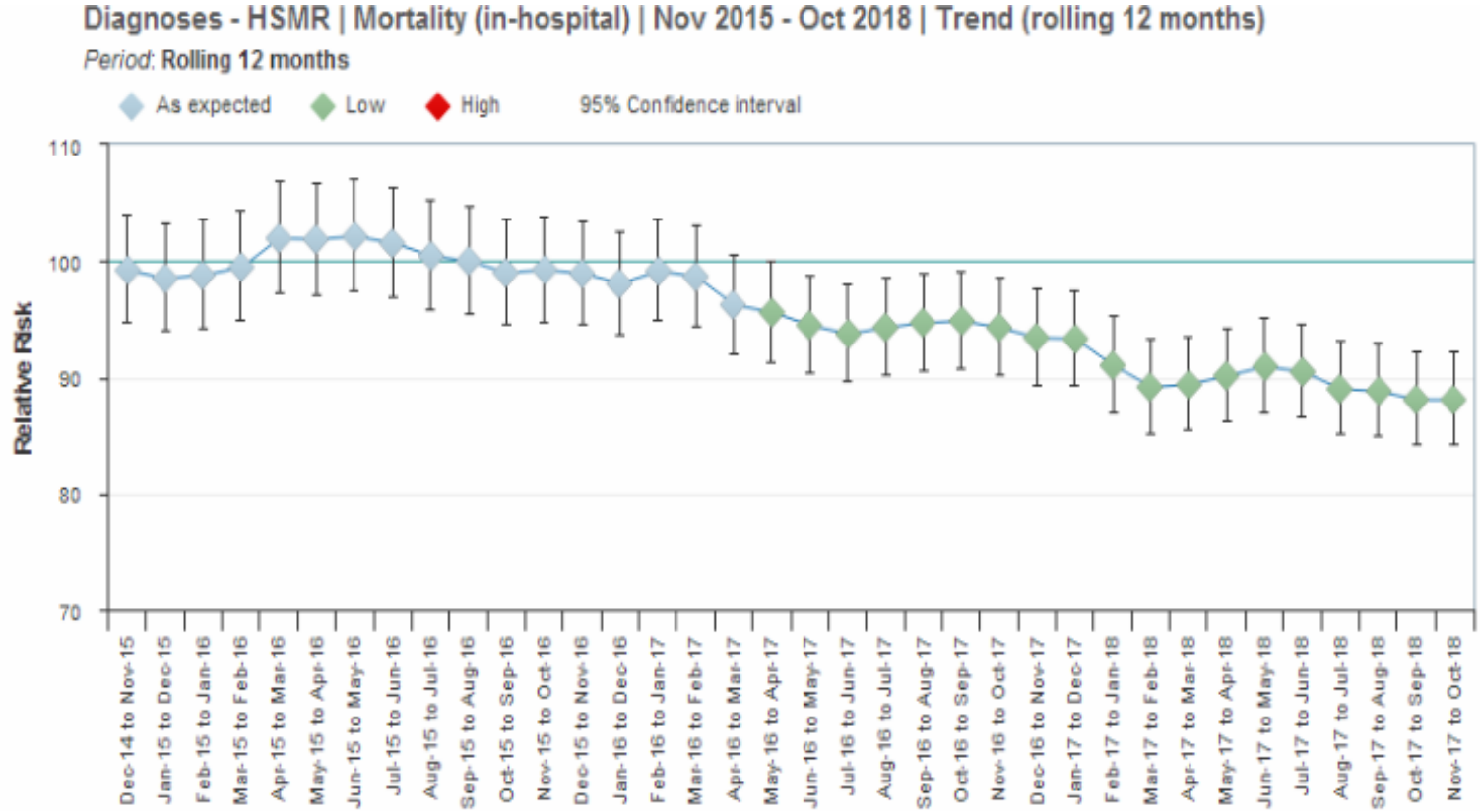
Appendix 6

Paediatric mortality review process (CDAD) (Q3 – 2018/19)



Appendix 7

Rolling 12 month HSMR trend for the last 3 years



Appendix 8

Learning Outcomes

Case 1 – SIRI - High harm Fall

Brief Summary of incident
The patient was admitted to University Hospitals Southampton via the Emergency Department (ED) on 08/08/18 following a fall at home, which was judged to be multifactorial – relating to cognition, urinary tract infection (UTI), gait/balance. The patient had increased confusion and was treated with antibiotics for a suspected UTI[1]. A CT[2] brain scan was performed as patient was taking Apixiban[3]. The scan showed a shallow hyperdense subdural haematoma[4] which was treated conservatively following discussion with the Neurosurgeon. The patient was transferred, via ED and the Clinical Decision Unit (CDU) to the Acute Medical Unit (AMU2) and subsequently to Ward G5 by 10/08/18. The patient was assessed to be medically fit for discharge on 14/08/2018 and fulfilled the criteria for transfer to Bramshaw Women's Unit (BWU) at the Princess Anne Hospital site[5]. There are 8 beds on BWU used by Medicines for Older People (MOP) for patients who are deemed medically fit for discharge, but are awaiting a social service assessment and/or arrangements for discharge. The patient was able to mobilise out to the toilet with assistance from one member of staff and a walking stick and she had been asked to use the call bell (which she had done regularly) due to her falls risk, frailty and visual impairment. During this time the Physiotherapy team concluded that she had returned to her baseline mobility. At approximately 0225 hours on 25/08/18 the patient had an unwitnessed fall, sustaining injury to her right upper eye and right forearm. Immediately following the fall, her Glasgow Coma Score[6] (GCS) was recorded as 14/15 (normal for patient). At 0620 hours nursing staff found the patient unresponsive and following a review by the Out of Hours (OOH) doctor, she was transferred back to Southampton General Hospital by Ambulance for a repeat CT Head scan as her GCS had dropped to 12/15 with large bruising on the right temple and orbit. The patient was diverted to ED as her GCS had deteriorated to 8/15. A CT head was not performed as an intra-cerebral bleed was diagnosed clinically. Following discussion with family that this was not a survivable event she was kept comfortable and transferred to Ward G8 where she died later that day at 1440 hours.
Root cause/s and major contributory factors of the incident being investigated

1 A urinary tract infection is also known as acute cystitis or a bladder infection. A UTI is an infection that affects part of the urinary tract
2 A computerised tomography (CT) scan, also known as a CAT scan, uses X-rays and a computer to create detailed images of the inside of the body
3 An anticoagulant . . . . .
4 A very dense collection of blood between the skull and the surface of the brain
5 The criteria are: that the patient is Medically fit and with a clear plan, discharge summary completed, Consultant in agreement with patient's suitability for transfer to BWU, all social paperwork completed, clear therapy plan in place, not acutely unwell or requiring 1:1 care, to not require more than 2 staff to hoist, can have dementia but can't be wandersome, must not need a low profile bed, must be able to understand English to consent to transfer, all MRSA screening and wound swabs to be negative, all infective patients to be clear & documented by infection control, especially anything that is harmful to pregnant patients.
6 The Glasgow Coma Scale (GCS) is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person. The lowest score is 3 (no response to pain, no verbalisation + no eye opening). A GCS of 8 or less indicates severe injury, one of 9-12 moderate injury, and a GCS score of 13-15 is obtained when the injury is minor

Incident:
The patient was not observed mobilising by staff.
The patient was not observed by nursing staff leaving her bed as one nurse was dealing with a medical emergency relating to another patient and the other member of staff (Healthcare assistant) on duty was at the far end of the ward with gynaecology patients. The 2 remaining members of staff (nurse and HCA) were both on their break at that time (normal practice is one staff member on a break at any time).

It has not been possible to conclusively determine if The patient's previous fall (resulting in a subdural haematoma) influenced this further fall. The post mortem report details the cause of death as acute on chronic subdural haematoma.

Contributory factors to inpatient fall:

- Medical history of a subdural haematoma following a fall at home (however it has not been possible to determine if this influenced the inpatient fall)
- One nurse and one HCA were on their break at the same time

Main issues noted in post-falls management:

- There was a delay in medical review beyond the timescale in the Trust Falls Policy. We are unable to determine that this would have affected The patient's outcome as a CT would not have been indicated had the review occurred 30 minutes post fall based on clinical presentation – stable GCS with no neurological signs.
- Communication failure regarding the OOH referral and triage urgency allocation
- Re-allocation of 1 hour medical review time (requested) to 4 hours by OOH team following triage
- Reduced medical staffing within OOH medical team.

Main recommendations linked to Action Plan in relation to the root cause/s and main contributory factors of the incident being investigated

- Review staffing model on Bramshaw Women's Unit overnight to ensure a minimum of 3 staff members available at all times.
- Review the allocation of staff to their breaks on BWU, especially during the night shift.
- Nursing staff on BWU should ensure they are familiar with the falls policy and actions to be undertaken following a patient fall
- Education and training for all BWU staff to facilitate appropriate use of the emergency 2222 crash call and to improve the use of the SBAR[7] communication
- Revise induction information to OOH team to include Bramshaw Women's Unit at the PAH, where a number of Medicine for Older People patients are located
- Review OOH staffing levels to ensure adequate cover across UHS sites

[7] A communication tool which focuses on Situation, Background, Assessment and Recommendation.

- Creation of a standard operating procedure for the OOH team
- Refer this investigation report to the ROAR group who are currently working on a documented pathway for urgent out of hours medical review
- Enable electronic recording of OOH response and clinical reasoning
- Review OOH compliance with the falls policy

How will any specific learning required to achieve the main recommendations outlined above be delivered

- BWU Staff training regarding obtaining appropriate level of help during acute clinical situation, to include crash call protocol, escalating to site or critical care outreach team, SBAR communication, escalation to site will be added to statutory and mandatory training sessions
- Post fall simulation training by the Trust SIM team for BWU staff
- Case presentation and discussion at the Gynae Mortality & Morbidity Meeting for dissemination of the learning regarding BWU and falls management
- BWU staff have all been reminded of the Trust falls policy and all BWU staff asked to sign to evidence they have re-read the policy
- Statutory and mandatory training sessions for BWU staff will include post-falls management and SBAR communication
- Update OOH medical induction to ensure doctors are aware of all wards covered and their location
- Learning shared at MOP M+M and cascaded to all medical staff working OOH
- OOH team to explore and advise regarding 30minute review request to the OOH system for patient falls, to align with the UHS falls policy

Case 2 – SIRI – Patient administered and received incorrect dose of Clexane whilst being treated presumed Pulmonary Embolism

This case occurred in December and is currently under investigation, but is being treated as a SIRI. The terms of reference for the investigation are:

- Why was there a delay in the patient receiving the initial USS of her groin?
- Why was the patient not prescribed the correct treatment clexane dose?
- Why was anticoagulation not reviewed in light of suspicion and subsequent confirmation of bleeding?
- Was there a missed opportunity for vascular/ interventional radiologist treatment following the second CT and could this have changed the outcome?
- Was subsequent fluid and blood management correct and timely?
- Who had oversight of the patient? Was there sufficient consultant involvement in her care?

Any learning from this case will be included in the next report to QGSG.

University Hospital Southampton NHS Foundation Trust: Learning from Deaths Dashboard - December 2018-19

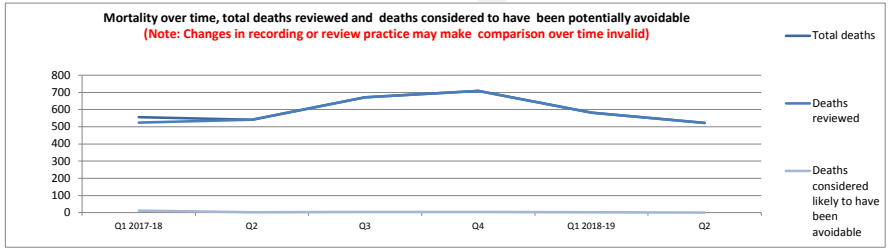
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
181	189	181	189	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
565	523	565	523	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1669	2476	1669	2445	2	23

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

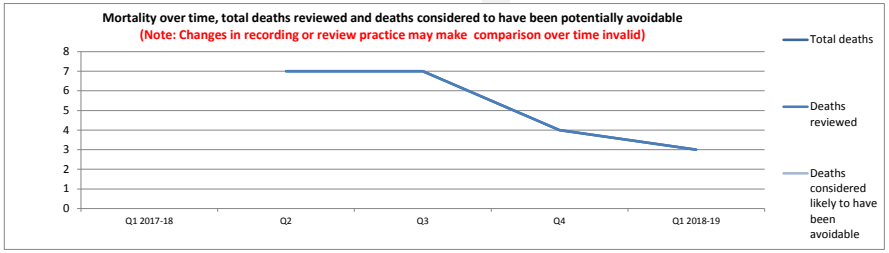
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	0.6%	This Month	2	1.1%	This Month	7	3.9%	This Month	171	94.5%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.2%	This Quarter (QTD)	7	1.2%	This Quarter (QTD)	20	3.6%	This Quarter (QTD)	534	95.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.1%	This Year (YTD)	1	0.1%	This Year (YTD)	26	1.6%	This Year (YTD)	70	4.2%	This Year (YTD)	1565	94.1%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	1	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	18	4	18	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



University Hospital Southampton NHS Foundation Trust

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: Freedom to Speak Up Report			
Category	Quality, Performance and Finance		
Agenda item	4.4		
Sponsor	Director of Nursing and Organisational Development		
Author	Christine Mbabazi & Adam Pitt		
Provenance	This has been discussed at Trust Board and is a 6-monthly report		
Purpose	The paper is presented for the Board for Review. To provide an update on the Freedom to Speak Up (FTSU) agenda and report on the number of cases received by the Trust in quarter 3 of 2018/19. Trust Board is asked to: • Note the number of FTSU cases received to date. • Note the progress made to date in embedding the FTSU agenda. • Note and support the areas of improvement identified through the application of the self-review tool.		
Relevant to Board goals	☑ Goal 1 – Trusted on Quality	☐ Goal 2 – Delivering for Taxpayers	☑ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	None identified.		
Equality Impact Assessment	This report does not affect any persons from any protected characteristic negatively.		
Other standards affected	CQC Well-led domain.		

Freedom to Speak Up Report

1 Executive Summary

Following guidance from NHS Improvement and the national FTSU office, whistleblowing cases have been reframed to include a larger set of categories that staff may be worried about, particularly focusing on issues relating to patient safety. Trusts are encouraged to engender a culture of openness and transparency in all departments. The Quality and HR teams continue to embed the FTSU agenda through information campaigns and engagement with the national office.

The Trust received 11 FTSU cases from October to December 2018. A total of 31 cases have been received since the appointment of the FTSU Guardian in October 2017 to December 2018. Appendix a contains the FTSU dashboard.

The NHS Improvement/FTSU office self-review tool identified four main areas of implementation. These were to:-

- Develop a FTSU vision and strategy
- Communicate the FTSU message
- Establish a network of FTSU Champions
- Share lessons learnt

Please see appendix B for an update on the progress of the above

2 Purpose/Context/Introduction

The purpose of this report is to update Trust Board on the FTSU cases received by the Trust, and to provide an update on the overall progress of the FTSU agenda.

3. Case Update

The Trust has received 11 FTSU cases from October to December 2018. 1 case remains open from Q3 & Q4 2017/18 which relates to patient safety and is currently undergoing investigation. 6 cases remain open from Q1 & Q2 2018/2019 which relate to team dynamics. The remaining cases from this period have been closed.
There are (6 cases) received in Q3 relating to bullying, harassment, and discrimination and (5 cases) relate to unsafe working conditions. A summary of the cases received since Q4 2017/18 are detailed in Table 1 below:

	2017/18	**2018/19**			
Category	**Q4**	**Q1**	**Q2**	**Q3**	**Total**
Breach of confidentiality		1			1
Bullying and harassment	5	4		4	13
Concern over HR process					
Discrimination	1		1	2	4
Team dynamics			2	2	4
Patient safety issue		1	2	1	4
Policy implementation			2	2	4
Recruitment	1				1
Total	7	6	7	11	31

It should be noted that, following guidance from NHS Improvement and the national FTSU office, a wide definition of what constitutes a 'FTSU case' is used by the Trust. Emphasis is placed on creating a culture of openness where staff feel able to raise any matter that they are concerned about, rather than whether it fits within a defined category of concern.

4. Progress on the FTSU Agenda

Following the launch of the updated Raising Concern (Whistleblowing) Policy and FTSU posters, the FTSU Guardian has been visiting departments to introduce herself and speak with staff about the importance of speaking up and raising anything that concerns them.

The NHS Improvement/FTSU office self–review tool identified four main areas of implementation.

- **Develop a FTSU vision and strategy**
  A FTSU vision and strategy was developed and approved by the FTSU steering group last November. Please see appendix C.

- **Communicate the FTSU message**.
  We have continued to communicate the FTSU agenda through leaflets, inductions, posters, matron walkabouts and attendance at Trust meetings.

- **Establish a network of FTSU Champions**
  In December 2018, 12 FTSU Champions were appointed in addition to the existing 10 Staff Support Advisors. 9 FTSU Champions have received training for the role, on 8th February and there is a further training session taking place on the 12th April. FTSU champions are another way of raising the profile of raising concerns in the organisation and promoting speaking up. There is a particular focus on reaching vulnerable staff groups e.g. minority/vulnerable staff groups and agency staff.

- **Share lessons learnt**
  Please see Appendix B for further detail on how each of these areas will be developed over the next 3 months.

4 Next Steps / Way Forward / Implications / Impact

The four key areas outlined in Appendix B will continue to be the main focus during the next 3 to 6 months. A key aspect of this action plan is to develop and train the network of FTSU Champions to support the work of the Guardian.

5 Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received in the last 6 months.
- Note the progress made to date in embedding the FTSU agenda.
- Note and support the areas of improvement identified through the application of the self-review tool.

Appendix A: Freedom to Speak Up Dashboard (October to December 2018)

Case No.	Date Concern Raised	Department	Summary of Concern	Actions Taken	Case Status
21	02.10.2018	Division A	Unsafe working conditions affecting service and patient safety	Passed on to Deputy Director of nursing	**Closed**
22	12.10.2018	NHSP	Unfair treatment and discrimination	Passed on Temporary resourcing lead	**Closed**
23	29.10.2018	Division B	moving and handling/ Slide sheets- unsafe working /patient safety	Passed on Deputy	**Closed**
24	12.11.2018	Division A	Staffing issues and breaking the NMC code	Passed on to DHN – Rachel Davies	**Closed**
25	16.11.2018	Division C	Concerns regarding unfair treatment, bullying and harassment	HR Investigating - RG	**In progress**
26	19.11.018	Division C	Concerns regarding shift patterns of Nurses – shift rota organisation	Passed on to Nursing Director	**In progress**
27	26.11.2018	Division B	Consultants' bullying behaviour	Passed on to Medical Director	**In progress**
28	12.12.2018	Division B	Opening of Department with not enough staff and equipment	Passed on to Executive Director	**Closed**
28	26.11.2018	Division C	Bullying behaviour of line manager	HR Investigating	**In progress**
29	24.12.2018	Division C	Anon – Bullying letters and tweets	HR Investigating	**In progress**
30	28.12.2018	Division D	Bullying behaviour of surgeon	HR investigating	**In progress**

Appendix B: UHS FTSU Self-Review – Main Action Points

#	Assessment Area	Action	Lead	Due	Progress
1	Develop a FTSU Vision & Strategy	Develop a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement	GB	December 2018	Complete – Attached.
2	Communicate the FTSU Message	Ensure staff in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process. To include: - Staffnet resource page - Leaflets and posters detailing process - FTSU Champions (see below)	GB/AP/CM	Ongoing	Core Brief, Staff Briefing, and Staffnet update complete. Updated policy complete. Leaflets have been distributed via payslip in October. We continue to distribute information at staff and doctor inductions and other hospital gatherings and meetings.
3	Establish a network of FTSU Champions	Establish a network of FTSU Champions to encourage a culture of openness and transparency.	GB/AP/CM	April 2019	9 FTSU Champions trained in addition to the 10 staff support advisors. Further training course taking place on 12.04.2019
4	Share lessons learnt	Ensure lessons learnt are shared widely both within relevant service areas and across the trust.	AP/CM	May 2019.	Lessons learnt log to be published on staffnet with testimonials from staff who have spoken up.

Appendix C

Freedom to Speak Up – Vision and Strategy

1. Background and Purpose

Sir Robert Francis's 'Freedom to Speak Up' (FTSU) review[1] recommended that all NHS Trusts develop a more open and supportive culture to ensure that all employees, workers, and volunteers feel safe in speaking up about issues of patient care or safety. Such a culture was recognised as being vital in safeguarding patients from harm and promoting an environment where mistakes are acknowledged, learned from, and prevented from happening again. A national policy was published for the NHS that set out minimum standards and recommendations for developing the right culture for healthcare[2].

In line with national recommendations, the Trust has appointed its own 'FTSU Guardian' as an independent and impartial source of advice for those wishing to speak up. The role is supported by the newly established FTSU National Guardian's Office, which is responsible for providing leadership, training, and advice to FTSU Guardians.

This document sets out the Trust's Freedom to Speak Up vision and strategy and should be read alongside the Trust's Raising Concerns (Whistleblowing) Policy, which is available on StaffNet under Working Here > HR > HR Policies, and the UHS Staff Strategy (2018 – 2023).

2. Our Vision

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

The Trust Board and Senior Leadership Team are committed to this vision and will support it by:

- Acting as role models in promoting a speaking up culture across the organisation in line with the Trust's values and behaviours.
- Providing the resources required to support the FTSU agenda.

[1] Report on the Freedom to Speak Up Review - http://freedomtospeakup.org.uk/the-report/
[2] Freedom to Speak Up: Raising concerns policy for the NHS - https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

Our FTSU Guardian and other champions have a key role in:

- Helping to raise the profile of raising concerns in the organisation and promoting a speaking up culture.
- Providing confidential advice and support to employees, workers, and volunteers when they have concerns and encouraging them to raise them with the organisation.

The Trust is fully engaged with the National Guardian's Office and the local network of Freedom to Speak Up Guardians in the region to learn and share best practice.

3. Our Strategy

The Trust will take the following actions to deliver the vision:

- Provide FTSU awareness sessions at the Trust induction to ensure that all new starters are aware of the FTSU Guardian/Champions and Raising Concerns (Whistleblowing) policy.
- Establish a network of FTSU Champions to increase the number of contact points for individuals or groups who wish to raise a concern.
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively.
- Provide regular communications across the Trust to raise the profile and understanding of the raising concerns agenda.
- Have a multidisciplinary approach to concerns raised through the monthly Raising Concerns (Whistleblowing) Steering Group, which is chaired by the Executive Lead.
- Share the key findings/recommendations from concerns that have been raised to foster a culture of openness, transparency, and learning from mistakes.

4. Outcomes and Measures

The Trust's progress in achieving the vision and strategy will be measured through:

- The annual Staff Survey and Friends and Family Test results.
- Feedback from those who have raised concerns.
- Benchmarking concerns received by the Trust against national FTSU Guardian's Office data and the regional FTSU Guardian network.
- Evidence that investigations are evidence based and led by someone suitably independent in the organisation.
- High level findings provided to the Trust board on a bi-annual basis.

5. Monitoring

A FTSU report will be presented to Trust Board on a bi-annual basis by the FTSU Guardian and the Executive Lead for raising concerns. This will include:

- An overview of the cases reported and any themes identified.
- An assessment of the continued effectiveness of the Trust's Raising Concern (Whistleblowing) Policy.
- Progress against the National FTSU Office guidance for NHS Trusts and self-assessment tool.
- Progress against key actions related to the vision and strategy.
- Any relevant benchmarking or recommendations following national publications.

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: CRN: Wessex 2018/19 Quarter 3 Performance Report			
Category	Quality, Performance, and Finance		
Agenda item	4.5		
Sponsor	Medical Director		
Author	Graham Halls, Business Intelligence Manager and Rebecca McKay, Chief Operating Officer		
Provenance	Annual report 2017-18 submitted at UHS Board meeting on 26th April 2018. Q1 and Q2 2018-19 reports submitted at the UHS Board meetings on 27th September 2018 and 29th November 2018 respectively.		
Purpose	The paper is presented for the Board for Review. The Board is recommended to note the performance of CRN Wessex Q1-Q3 2018/19.		
Relevant to Board goals	✓ Goal 1 – Trusted on Quality	✓ Goal 2 – Delivering for Taxpayers	✓ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	The CRN Wessex UHS Board Assurance Framework is included in appendix 1 to this report.		
Equality Impact Assessment	Not carried out.		
Other standards affected	CQC Well-led Framework (for research)		

1 Purpose/Context/Introduction

1.1 University Hospital Southampton NHS Foundation Trust (UHS) hold a contract with the Department of Health and Social Care to host the local clinical research network – CRN Wessex. The purpose of CRN Wessex is to provide an efficient and effective support to the partner organisations for the initiation and delivery of funded research in the NHS. Some of the research is funded by NIHR, but most is funded by NHS non-commercial partners and industry. This activity makes an important contribution to improve the health of the population and to support economic growth.

1.2 CRN Wessex aims to:

1.2.1 Promote equality of access, ensuring that wherever possible, patients have parity of opportunity to participate in research

1.2.2 Improve the quality, speed and co-ordination of clinical research by removing the barriers to research in the NHS

1.2.3 Streamline and performance manage NHS support for eligible studies to ensure the NHS service support costs of these studies are met in a timely and efficient manner.

2 Key Issues

2.1 Recruitment to NIHR portfolio adopted studies within Wessex in quarters 1-3 2018/19 exceeded the year to date recruitment target by 16 percent, and the same period last year by 15 percent (chart 1). If this continues at the same rate the network is on track for over 50,000 research participants to take part in a research study this financial year.

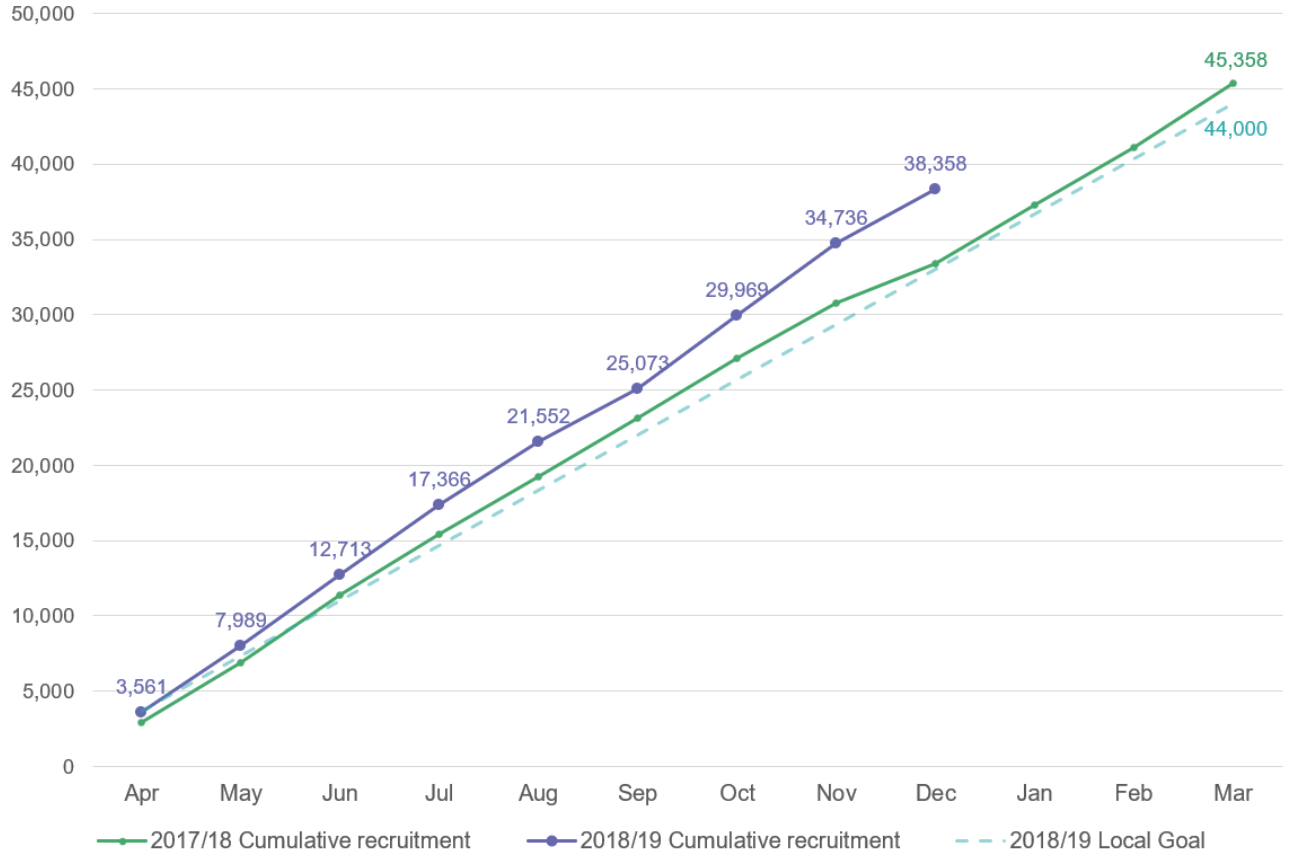


Chart 1: Research recruitment against annual goal in Wessex – Q1-3 2018/19 financial year

2.2 CRN Wessex was ranked eighth of fifteen networks in England for recruitment (chart 2a). When this is weighted for the population of each region Wessex is ranked fifth (chart 2b). The NIHR's funding model is in part reliant on the complexity of research activity that each network delivers i.e. interventional is weighted higher than observational. At Q3 Wessex was ranked sixth for complexity weighted recruitment (chart 2c).

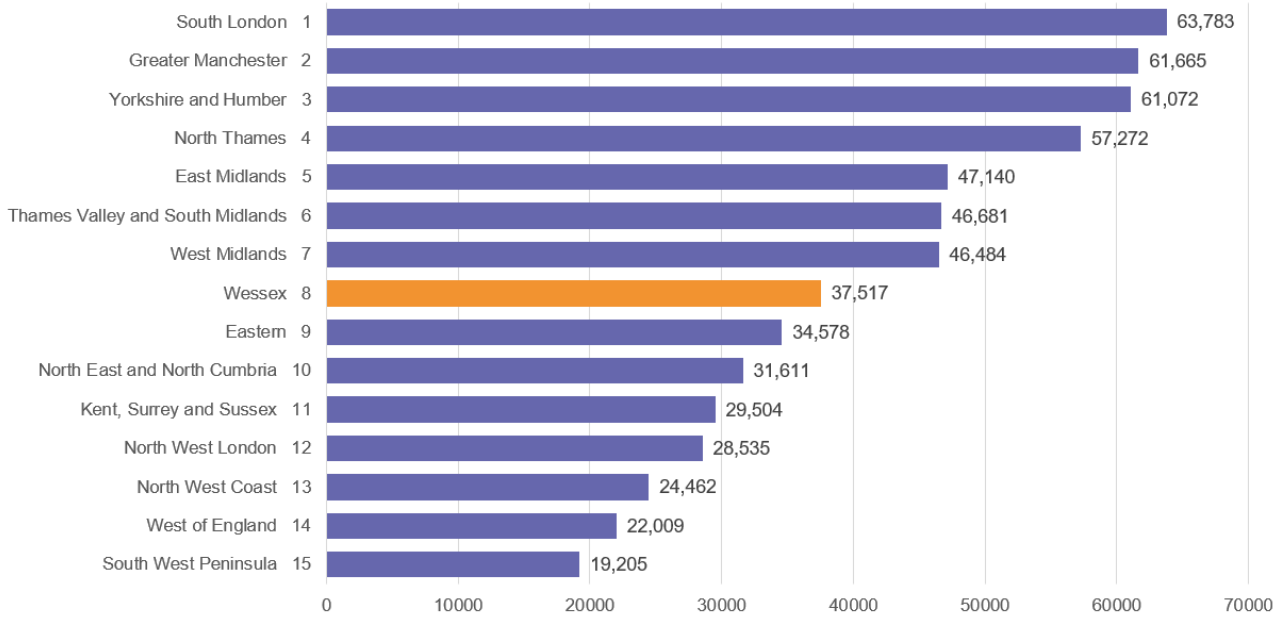


Chart 2a: Research recruitment in each LCRN – Q1-3 2018/19 financial year

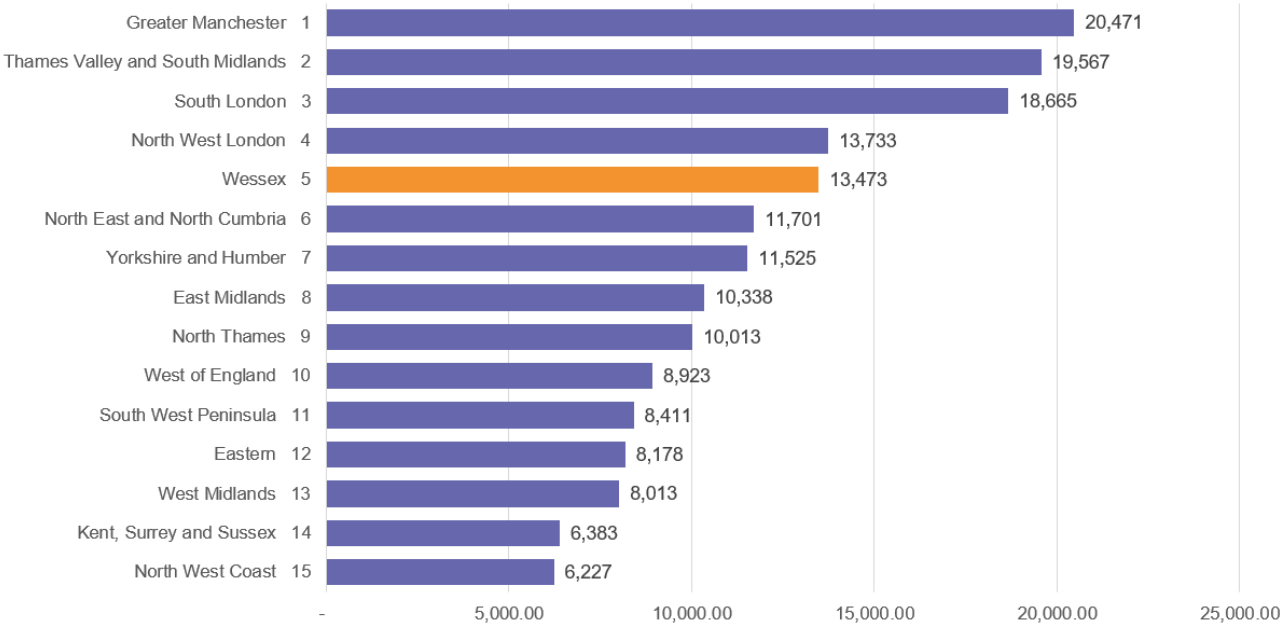


Chart 2b: Research recruitment weighted against location population in each LCRN (recruitment per million residents) – Q1-3 2018/19 financial year

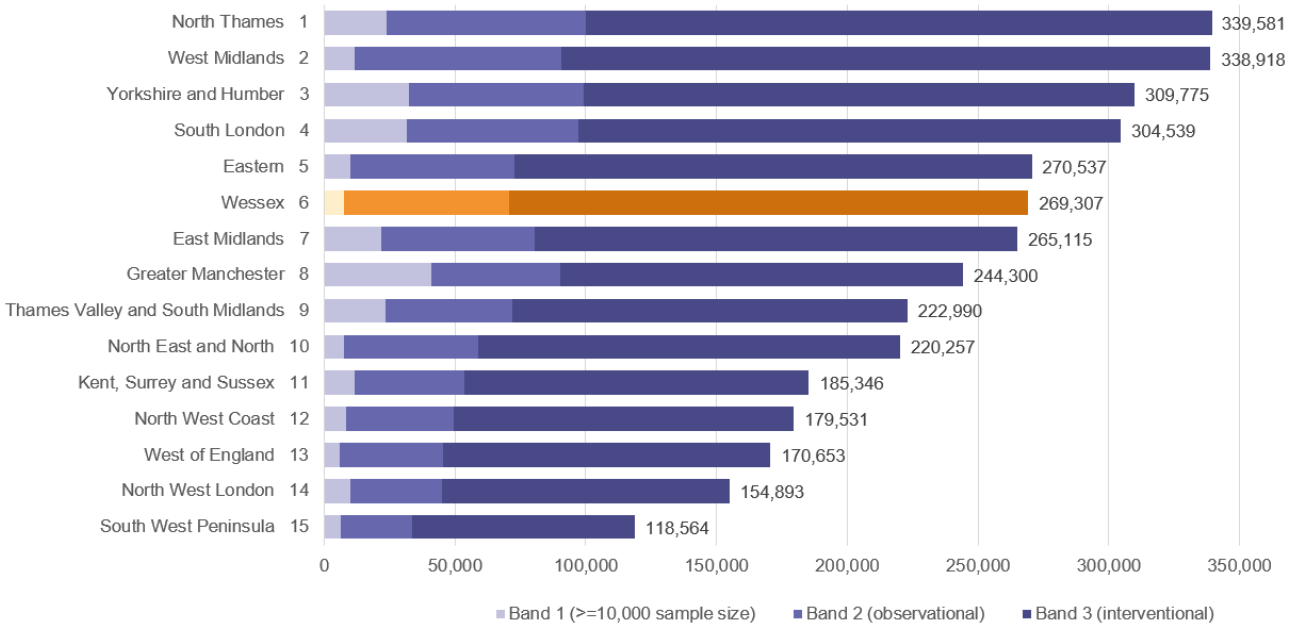


Chart 2c: Research recruitment weighted by complexity in each LCRN – Q1-3 2018/19 financial year

2.3 Seventeen specialties have either increased or maintained their national ranking for research recruitment activity since Q2 2018-19, compared to the fourteen other networks in England. Chart 3 shows each specialty's recruitment and rank at Q3 and change in ranking where applicable.

Specialty	Recruitment	LCRN rank (recruitment)	LCRN rank (complexity weighted recruitment)	LCRN rank (population weighted recruitment)	Variance on Q2
Respiratory Disorders	4,717	1	1	1	0
Children	4,043	2	3	2	1
Critical Care	1,769	3	2	2	0
Dermatology	512	3	4	2	-1
Public Health	1,997	3	2	3	-1
Cancer	4,331	4	8	3	-1
Infection	1,870	4	6	3	0
Surgery	637	4	4	3	2
Haematology	129	5	5	4	-1
Neurological Disorders	541	5	6	5	2
Health Services Research	2,073	6	4	3	-1
Musculoskeletal Disorders	1,196	6	6	3	-1
Gastroenterology	1,410	7	4	4	-1
Injuries and Emergencies	824	7	7	5	2
Primary Care	2,331	7	7	6	1
Ageing	167	8	5	6	0
Ophthalmology	313	8	9	6	2
Hepatology	83	9	11	8	-2
Stroke	591	9	12	6	0
Cardiovascular Disease	1,001	10	4	8	2
Ear, Nose and Throat	40	10	10	8	-2

Specialty	Recruitment	LCRN rank (recruitment)	LCRN rank (complexity weighted recruitment)	LCRN rank (population weighted recruitment)	Variance on Q2
Genetics	1,891	10	7	7	-3
Oral and Dental Health	434	10	2	9	5
Mental Health	1,825	11	11	6	-1
Reproductive Health and Childbirth	1,193	11	11	10	2
Anaesthesia, Perioperative Medicine and Pain Management	1,539	13	11	11	0
Diabetes	260	13	14	12	-1
Metabolic and Endocrine Disorders	20	14	12	14	0
Dementias and Neurodegeneration	662	15	12	12	-3
Renal Disorders	177	15	14	15	0

RAG rated performance - n=15 LCRNs, rank 1-5: green, 6-10: amber, 11-15: red

Chart 3: LCRN ranking by specialty research recruitment – Q3 2018/19 financial year

2.4 At Q2 2018/19 four partner organisations within Wessex were not meeting their year to date targets, with UHS and Solent more than 20 percent below. At Q3 the position has improved (chart 4) with all organisation above or within 20 percent of their target. The shortfall seen at UHS remains a risk for Wessex as their recruitment historically accounts for ~40 percent of the network's activity. To counter this, the UHS R&D department have implemented a plan to enrol more than 7,500 participants in Q4.

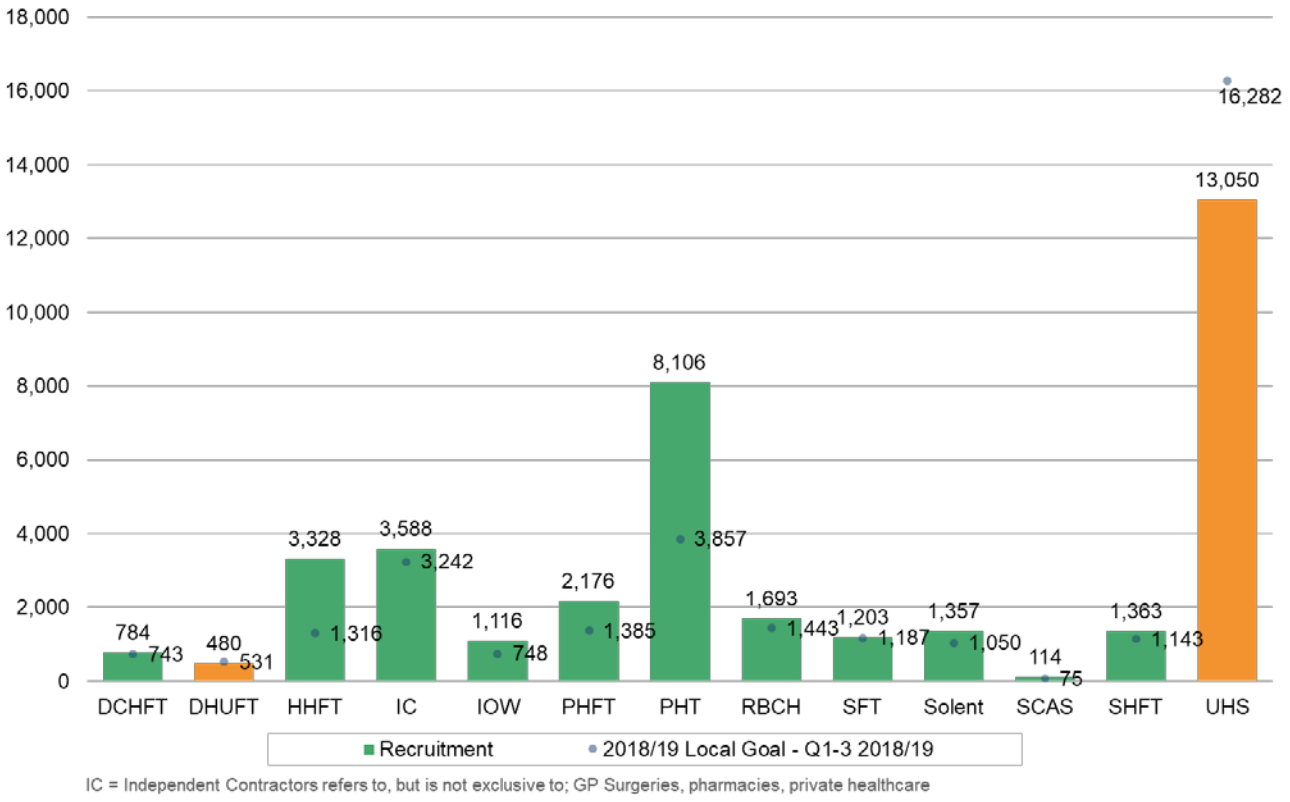


Chart 4: Recruitment by partner organisation against goal – Q1-3 2018/19 financial year

2.5 A comparison of each trust's performance in Q1-3 2018/19 financial year with the same period in 2017/18 shows that seven organisations have grown dramatically for both actual

and complexity weighted recruitment (chart 5). This has compensated for the largest absolute shortfalls seen at UHS, SCAS, DHUFT and RBCH.

Partner organisation	Recruitment (Q1-3 2018/19)	Recruitment (Q1-3 2017/18)	Variance	Variance %	Complexity weighted recruitment (Q1-3 2018/19)	Complexity weighted recruitment (Q1-3 2017/18)	Variance	Variance %
DCHFT	784	878	-94	-11%	3,242	4,685	-1,443	-31%
DHUFT	480	1,013	-533	-53%	3,057	3,358	-301	-9%
HHFT	3,328	1,251	2,077	166%	9,675	5,896	3,779	64%
IC	3,588	3,459	129	4%	21,173	16,770	4,403	26%
IOW	1,116	604	512	85%	4,796	2,389	2,407	101%
PHFT	2,176	1,433	743	52%	14,723	6,716	8,007	119%
PHT	8,106	4,260	3,846	90%	34,866	22,522	12,344	55%
RBCH	1,693	1,908	-215	-11%	7,316	9,134	-1,819	-20%
SFT	1,203	1,000	203	20%	5,931	5,725	207	4%
SOLENT	1,357	1,262	95	8%	8,185	7,890	295	4%
SCAS	114	753	-639	-85%	422	8,246	-7,824	-95%
SHFT	1,363	1,391	-28	-2%	6,163	4,890	1,273	26%
UHS	13,050	14,201	-1,151	-8%	65,763	66,881	-1,118	-2%

Chart 5: Variance by partner organisation against recruitment in Q1-3 2017/18

2.6 Clinical research networks are measured on performance for commercially sponsored studies by the number of research participants they enrol and the time taken to do so. CRN Wessex has fallen from 74 to 66 percent of sites closing having met their commercial study target (chart 6). The largest commercial portfolio is at UHS. The UHS Clinical Lead and CRN Wessex Industry Operations Manager have met and the UHS R&D Steering Group (RDSG) have agreed an action plan.

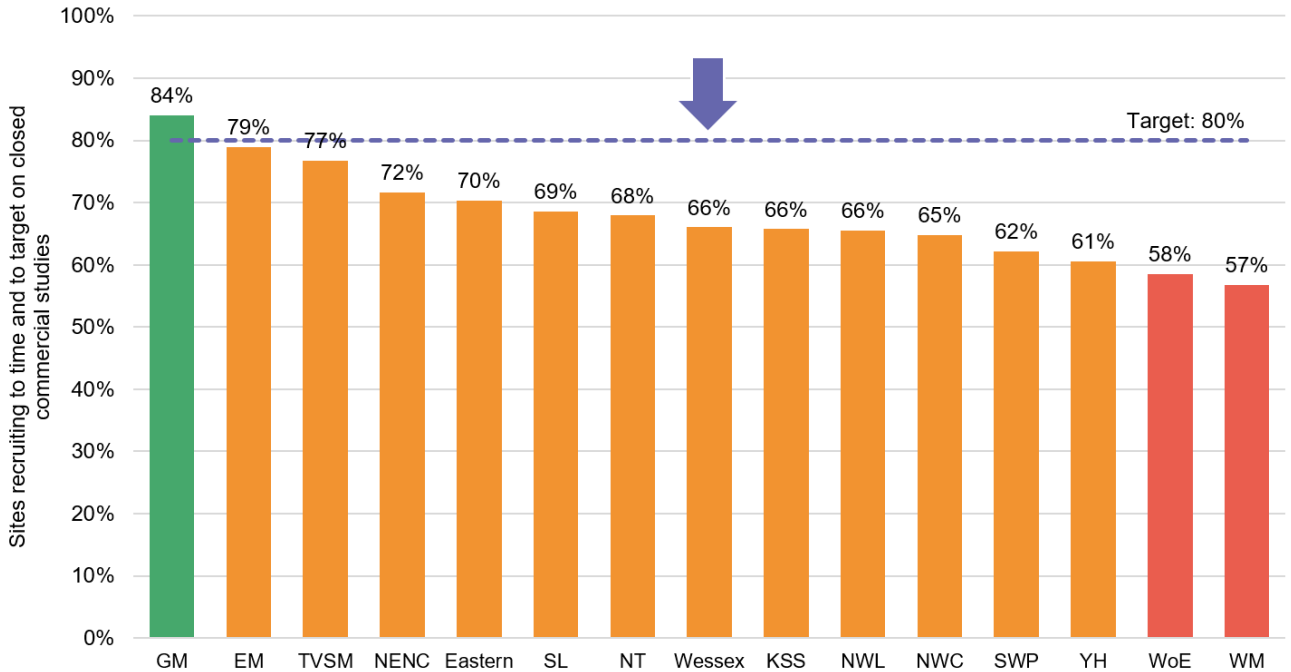


Chart 6: Percentage of sites recruiting on to commercial studies to target and in time by LCRN – Q1-3 2018/19

3 Next Steps / Way Forward / Implications / Impact

3.1 The UHS Board will be updated on progress in 2018/19 with quarterly performance reports and issues escalated via the assurance framework in appendix 1.

4 Recommendation

4.1 UHS Board to note the performance of CRN Wessex Q1-Q3 2018/19.

5 Appendices

5.1 Appendix 1 - CRN Wessex assurance framework

Meetings[1]	Reports[2]	Other
1:1	Performance	Internal finance audit
Executive	Finance	Benchmarking
Partnership	Annual	National review
	Patient survey	Risk register
		Business planning

1:1 meetings

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

Executive group meetings

CRN Wessex executive group meets monthly.

Partnership group meeting

CRN Wessex group meets quarterly.

Performance report

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

Finance report

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

Annual report

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

Patient survey report

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

Internal finance audit

Every 3 years

[1] All governance groups have been convened in accordance with the NIHR CRN CC Performance and operating framework with terms of reference

[2] All reports are submitted using agreed standard templates

Benchmarking

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

Review

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

Risk register

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

Business planning

Formal 1:1 business planning meeting with partner organisations annually.

5.2 Appendix 2 – Glossary

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

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

Local Clinical Research Network (LCRN) Abbreviations & Populations used by the NIHR:

- Eastern (3,787,682)
- EM - East Midlands (4,474,101)
- GM - Greater Manchester (2,962,515)
- KSS - Kent, Surrey and Sussex (4,539,969)
- NENC - North East and North Cumbria (3,122,653)
- NT - North Thames (5,554,518)
- NWC - North West Coast (3,705,762)
- NWL - North West London (2,034,996)
- SL - South London (3,195,885)
- SWP - South West Peninsula (2,249,056)
- TVSM - Thames Valley and South Midlands (2,345,894)
- Wessex (2,742,482)
- WM - West Midlands (5,713,284)
- WoE - West of England (2,419,720)
- YH - Yorkshire and Humber (5,468,101).

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHUFT - Dorset Healthcare University NHS Foundation Trust
- HHFT - Hampshire Hospitals NHS Foundation Trust
- IOW - Isle of Wight NHS Trust

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

Item 4.7

2018/19 Finance Report - Month 10

University Hospital Southampton NHS
NHS Foundation Trust

Report to:	**Trust Board** **February 2019**
Title:	**Finance Report for Period ending 31/01/2019**
Author:	**Gavin Hawkins, Assistant Director of Finance**
Sponsoring Director:	**David French, Chief Financial Officer**
Purpose:	**Standing Item**
	The Board is recommended to review the report

Executive Summary:

In Month and Year to date Highlights:

1. In January 2019 the Trust delivered a control total surplus excluding PSF of £2.8m. Year to date the Trust is on Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '1'.

2. The adjusted position of the Trust in the month once non-recurrent items are excluded was break-even against a Plan target of £2.8m surplus. This was therefore £2.8m behind Plan. The adjusted position has deteriorated from month 9 and the improvement seen in Q3 has not been sustained. Whilst the Financial Recovery Action Plan delivered in Q3, the increased target commencing in M10 has not been delivered.

3. At M9 the Trust signed up to delivering an on-plan financial position for the year. Achievement is worth at least £6.1m (£ element of PSF). There is also a possibility of national distribution of unallocated PSF as a "bonus". This cash would support the Trust's investment in Capital projects in 2019/20 and 2020/21. The Trust needs to deliver closer to Plan positions in M11 and M12 in order to deliver this overall position.

4. The main themes seen in M10 are:
   - Whilst income is above Plan, most of this is due to pass-through drugs. It is not high enough to off-set expenditure above Plan.
   - Pay has increased by £1m since M9. Substantive, bank and agency costs all increased month-on-month, with agency fill-rate of vacancies increasing. A proportion of the increase relates to December pay enhancements for bank holidays.

5. CIP delivery in the month was £2.5m against a target of £2.8m. However, a further £2.7m has been included to recognise the overall on-plan financial position, taking into account the adjustments made to achieve this position.

6. The cash position is £28m below Plan, a deterioration of £8.3m from M9 due to timing differences relating to over-performance. The £28m is primarily made up of timing of Q2 PSF (£1.5m), unpaid income over-performance (£15m) and non-cash movements (£12m). We anticipate this position partially recovering once over-performance invoices are settled, which may be in 2019/20.

Finance: I&E Summary

Total clinical income excl QIPP & PSF was £1.6m better than Plan in the month.

Inpatient activity was estimated to be £0.3m better than Plan (when including adjs such as MRET etc), outpatient activity was estimated to be £0.5m above Plan and other POD activity (mainly critical care and A&E) to be £0.1m worse than Plan.

Exclusions have been estimated to be over Plan by £1.1m, with IPPDDs driving this performance although this is matched within OPEX.

OPEX was £6.3m over Plan excluding QIPP, of which £4.6m is offset by favourable variance in other income. This will include income to offset expenditure items such as; 1) pay award funding from DH (£0.6m), 2) GP lead employer income (£0.3m), 3) R&D income covering non-pay expenditure (£0.7m), 4) increase in National CEAs (£0.2m) paid in January 2019.

Underlying issues in OPEX continue to be poor CIP performance in pay in particular (£0.7m) and a general increase in pay across substantive, bank & agency.

Non-pay adverse variances are driven by £1.1m IPPDDs & £0.7m R&D costs matched in income, and £0.7m poor CIP delivery in the month.

Overall: Amber

Metric	2018/19		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	2.69	1	1
Liquidity rating	15.18	1	1
I&E Margin Rating	3.17%	1	1
I&E Margin Variance Rating	-0.27%	2	1
Agency Variance from ceiling	12.46%	1	1
Use of Resources Average Metric		1.20	1.00
Use of Resources Final Metric		**1**	**1**

		Current Month			Year to Date				Full Yr	Prior Year to Date		Ave
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Var £m	Done £m
NHS Income:	Clinical	62.0	63.6	1.6	595.6	592.5	-3.1	A	713.1	565.3	5%	59.3
	QIPP Reduction	-1.1	-	1.1	-11.3	-	11.3	G	-13.5	-		
Other income	Other Income excl. PSF	7.8	12.4	4.6	77.8	102.2	24.4	G	93.3	79.9	28%	10.2
	Core PSF Income	2.9	2.0	-0.9	19.2	18.3	-0.9	R	25.0	13.7	34%	1.8
Total income		**71.5**	**78.0**	**6.5**	**681.3**	**713.1**	**31.7**	G	**817.9**	**658.9**	**8%**	**71.3**
Costs	Pay	38.9	41.0	2.1	386.9	398.6	11.6	A	464.8	375.2	6%	39.9
	Drugs	9.9	11.3	1.5	89.3	91.1	1.8	A	108.4	78.4	16%	9.1
	Clinical supplies	6.7	7.7	1.0	76.9	77.7	0.7	A	90.2	71.6	8%	7.8
	Other non pay	8.8	10.5	1.7	90.1	100.4	10.3	R	107.7	88.4	14%	10.0
	QIPP Reduction	-1.1	-	1.1	-11.3	-	11.3	R	-13.5	-		
Total expenditure		**63.2**	**70.6**	**7.4**	**632.1**	**667.8**	**35.7**	R	**757.4**	**613.6**	**9%**	**66.8**
EBITDA		**8.4**	**7.4**	**-1.0**	**49.3**	**45.3**	**-4.0**	A	**60.5**	**45.3**	**0%**	4.5
	Depreciation	1.8	1.9	0.2	18.4	18.6	0.3	A	22.1	17.6	6%	1.9
	Non Operating Income/Expenditure	0.8	0.7	-0.1	7.4	4.0	-3.4	G	9.0	7.8	-49%	0.4
Control Total Surplus / (Deficit)		**5.7**	**4.9**	**-0.9**	**23.5**	**22.7**	**-0.8**	A	**29.4**	**19.9**	**14%**	**2.3**
Less Provider Sustainability Funding (PSF)		-2.9	-2.0	0.9	-19.2	-18.3	0.9	R	-25.0	-13.7	34%	-1.8
Control Total Surplus / (Deficit) excluding PSF		**2.8**	**2.8**	**0.0**	**4.3**	**4.4**	**0.0**	G	**4.4**	**6.3**	**-30%**	

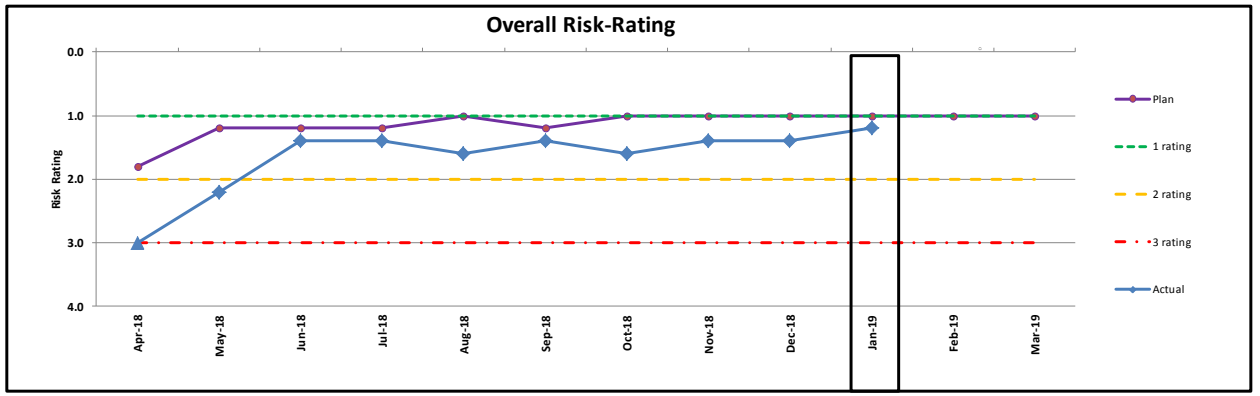
University Hospital Southampton NHS
NHS Foundation Trust

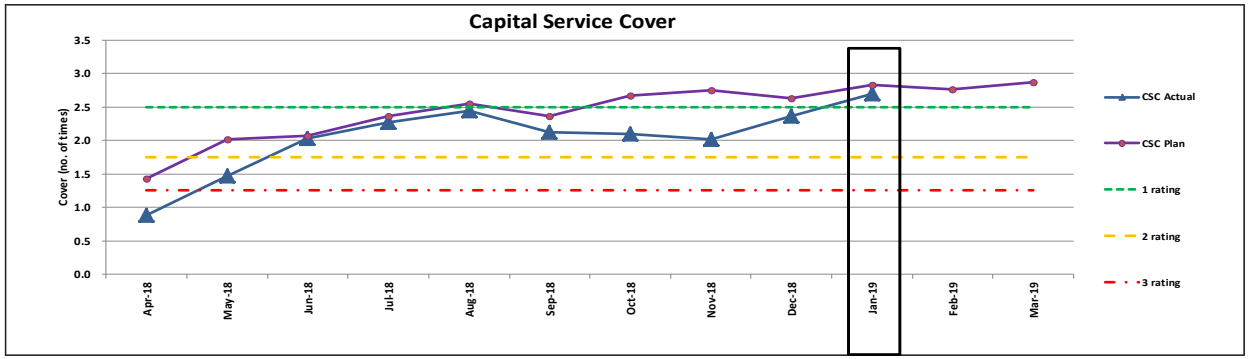
Use of Resource Metric

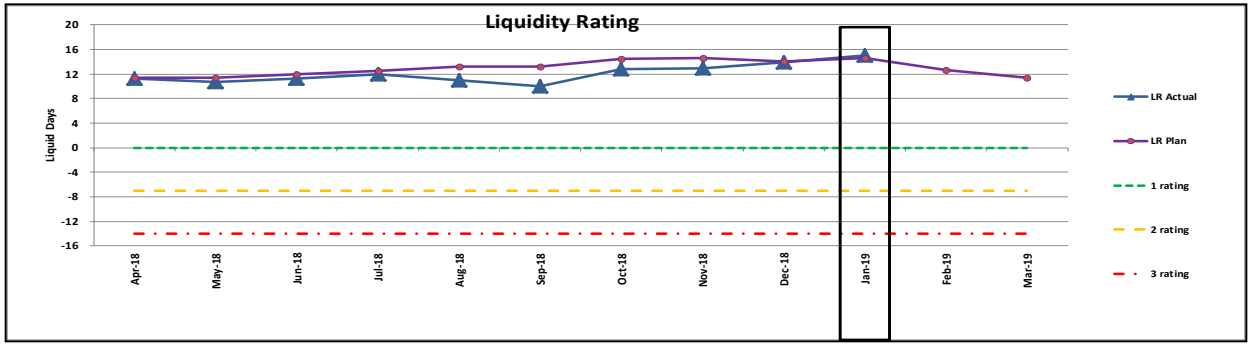
Overall the Trust's Use of Resources score is '1' against a Plan for January 2019 of a '1'.

Capital Service Cover was a '1' compared to a Plan of '1'. EBITDA would need to be £3.4m lower to deteriorate to a '2' or reduce by £24.5m to deteriorate to a '3'.

Liquidity Rating was a '1' and hence on Plan. Liquidity would need to reduce by £30.7m to reduce to a '2'.





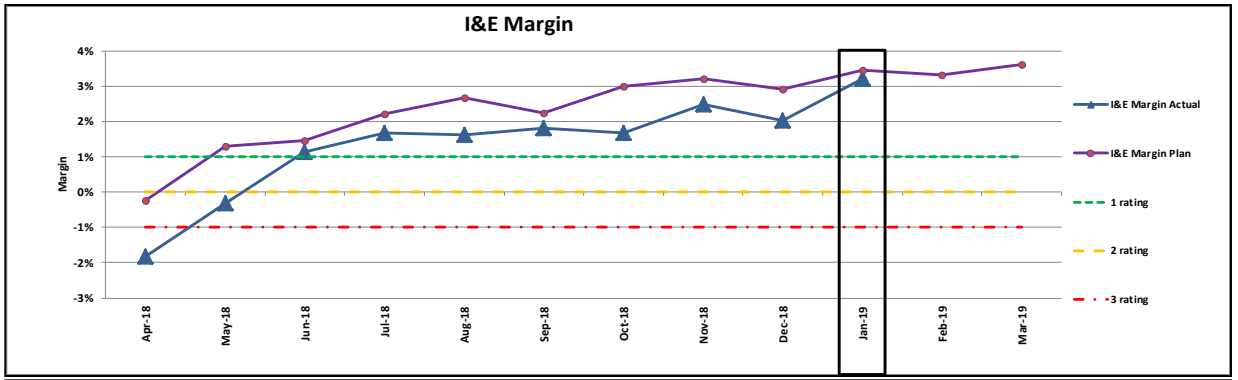


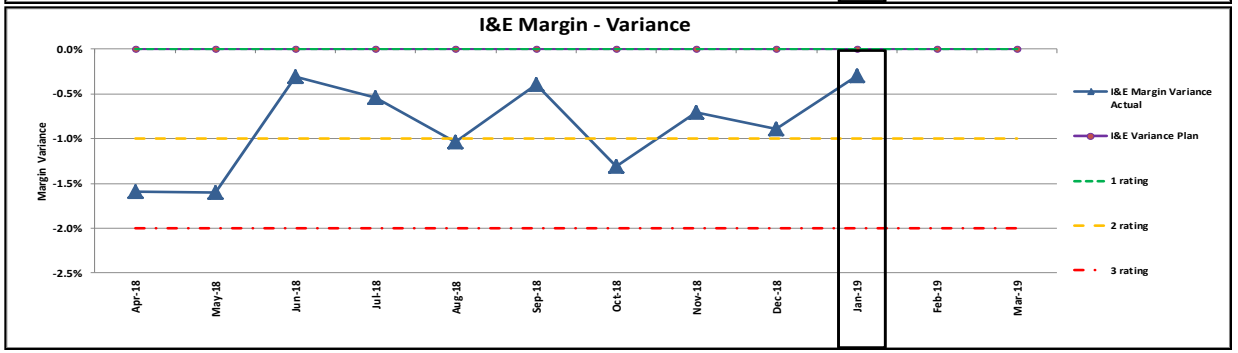
Use of Resource Metric

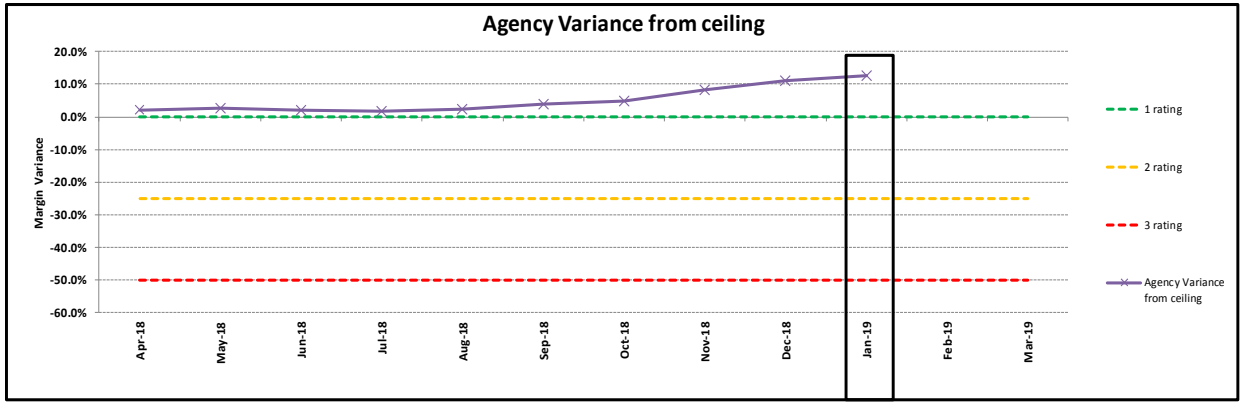
I&E Margin was a '1' and therefore on Plan. YTD surplus would need to deteriorate by £11.5m to reduce to a '2' .

I&E Margin Variance was a '2'. YTD surplus would have needed to improve by £0.7m to achieve the planned rating of '1'. If the YTD surplus reduced by £5.6m the rating would have deteriorated to '3'.

Agency ceiling was a '1'. Agency spending could increase by £1.5m before falling to a '2'. Plan for 2018/19 is to remain at '1' all year.





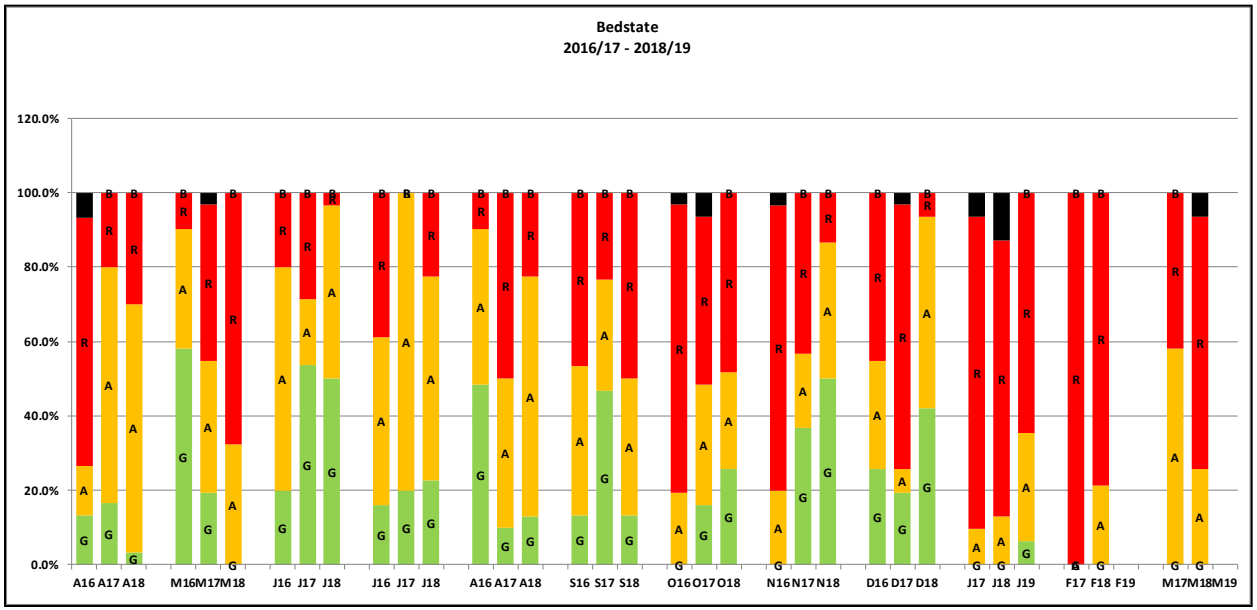


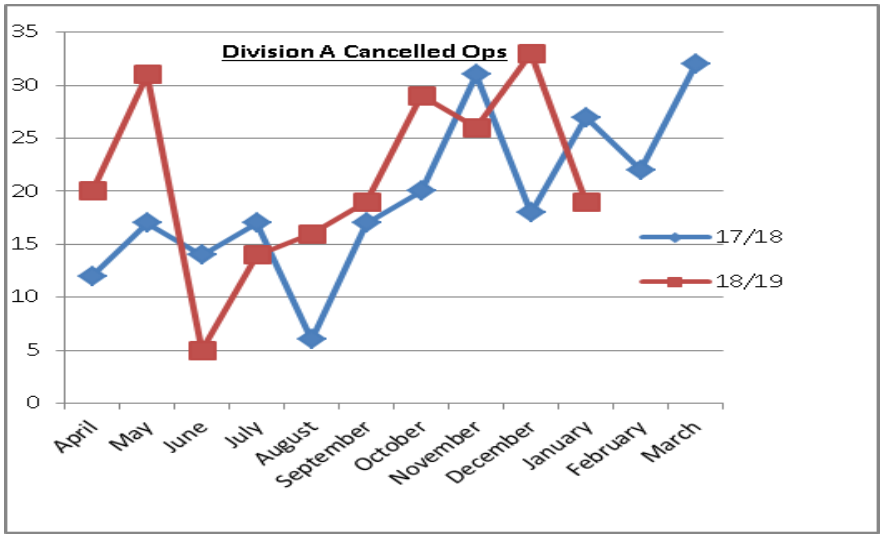
Bedstate – 3yr Comparison

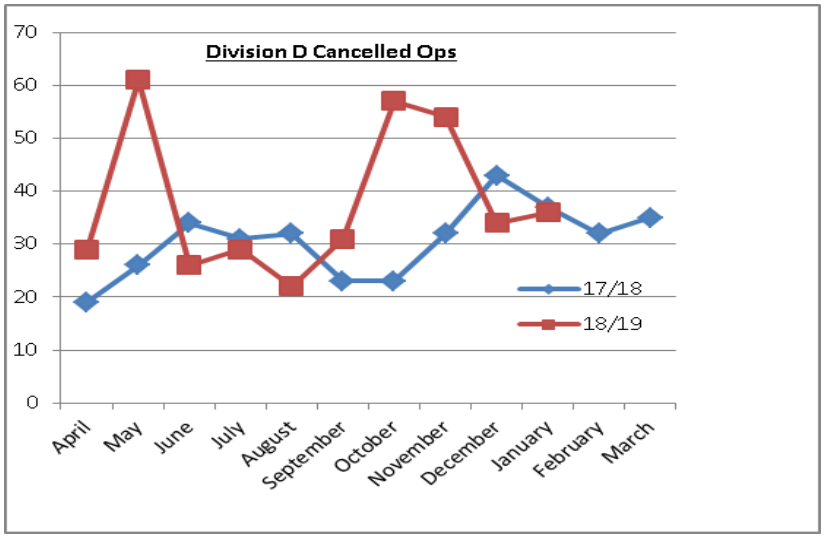
The bed state in December 2018 was favourable compared to December 2016 & 2017 in terms of a higher number of green days and a reduced number of red days.

This improved trust wide bed state in January 2019 positively supported the Trust's elective and non-elective programme when compared to previous year activity.

Information below relates to cancelled operations, reflecting on the day cancellations for Divisions A & D and are related to non-clinical reasons for the cancellation.







Provider Sustainability Funding

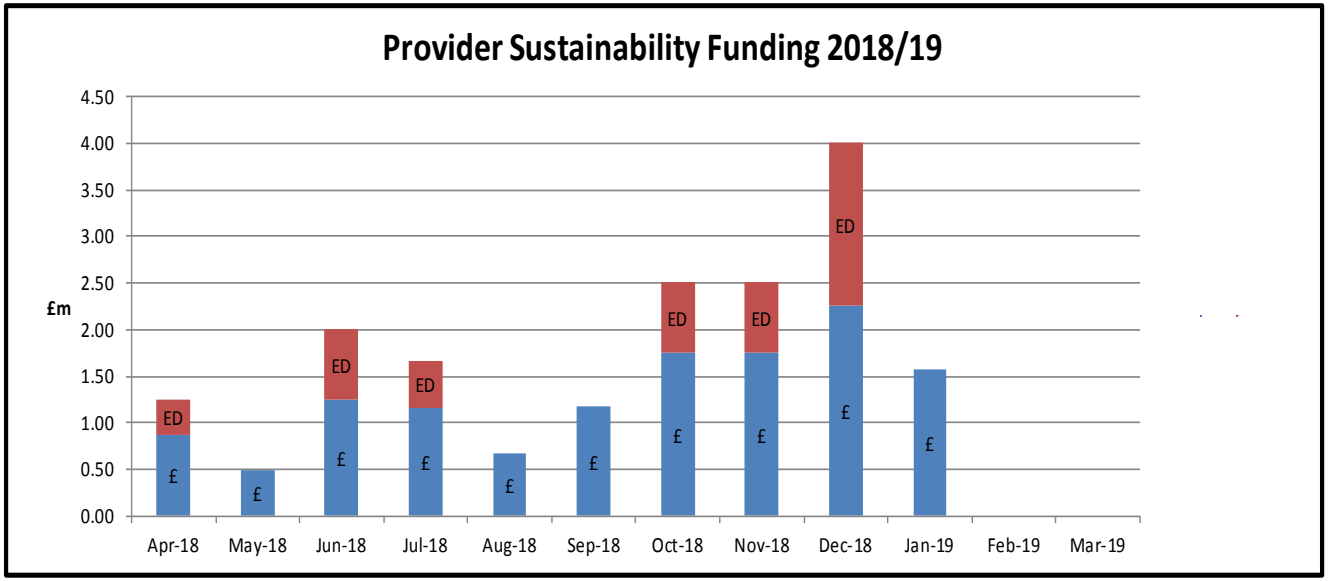
The total PSF planned in 2018/19 is £25m. The amount of PSF available each quarter is 15% Q1, 20% in Q2, 30% Q3 and 35% in Q4.

In Q3 the Trust achieved the required performance to earn PSF for both A&E and Finance and also recovered the year to date position on A&E to also earn the previous missed Q2 PSF.

PSF available in Q4 is as follows:
Q4 £ - £6.1m
Q4 A&E - £2.6m
Total Q4 available: £8.8m

Q4 A&E PSF requires delivery of 95% in March 2019. This is highly ambitious (91.2% achieved in Q3).

In January 2019 we have booked PSF totalling £2m vs a Plan of £2.9m with this £0.9m reduction being related to A&E due to poor performance in the month.



Clinical Income

The chart shows estimated clinical income in January 2019.

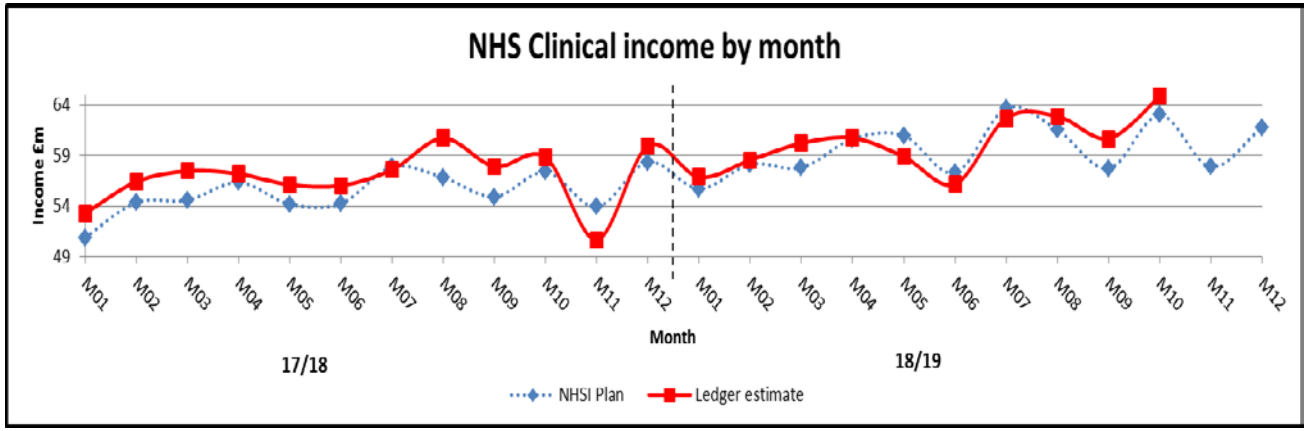
Non-elective inpatient activity was above planned levels. Elective inpatient income was below planned levels in the month, driven primarily by Cardiac Surgery, Neurosurgery, T&O where per spell income is amongst the highest Trustwide.

Outpatient activity was above planned levels in the month in first & follow-up activity.

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

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

	2017/18	2018/19				2018/19			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	£108,195	£139,279	£116,662	£113,793	(£2,870)	£12,127	£11,588	(£539)	£11,379	£12,743
Non-Elective Inpatients	£155,799	£186,781	£156,475	£162,547	£6,072	£15,911	£16,832	£921	£16,255	£12,117
Outpatients	£66,624	£79,327	£66,462	£66,885	£423	£6,901	£7,410	£509	£6,689	£6,221
Other Activity	£83,255	£102,973	£86,085	£83,945	(£2,140)	£8,880	£8,798	(£82)	£8,394	£9,514
Financial Adjustments	£16,103	£31,010	£25,948	£19,182	(£6,766)	£2,562	£2,432	(£130)	£1,918	£5,914
Other Exclusions	£38,435	£47,394	£39,713	£38,165	(£1,548)	£4,121	£3,970	(£151)	£3,816	£4,614
Subtotal NHS Clinical Income	*£468,411*	*£586,763*	*£491,346*	*£484,517*	*(£6,828)*	*£50,501*	*£51,030*	*£528*	*£48,452*	*£51,123*
Pass-through Exclusions	£90,922	£118,202	£97,508	£100,372	£2,863	£10,769	£11,876	£1,106	£10,037	£8,915
QIPP	£0	(£13,536)	(£11,280)	(£333)	£10,947	(£1,128)	(£33)	£1,095	(£33)	(£6,601)
Total NHS Clinical Income	**£559,332**	**£691,429**	**£577,574**	**£584,555**	**£6,982**	**£60,143**	**£62,872**	**£2,729**	**£58,456**	**£53,437**
Non NHS Clinical Income										
Private Patients		£4,993	£4,160	£4,507	£347	£416	£275	(£141)	£451	£243
CRU		£2,499	£2,082	£2,444	£362	£206	£208	£2	£244	£27
Overseas Chargeable Patients		£656	£548	£1,041	£492	£57	£231	£174	£104	(£192)
Total Non NHS Clinical Income		**£8,148**	**£6,790**	**£7,992**	**£1,202**	**£679**	**£714**	**£35**	**£799**	**£78**
Grand Total	**£559,332**	**£699,577**	**£584,364**	**£592,547**	**£8,184**	**£60,822**	**£63,586**	**£2,764**	**£59,255**	**£53,515**



Overall WTEs (paid) and Staff Costs
Substantive, Bank & Agency

Overall paid wtes in the Trust increased by 162wtes to 11,177 in January 2019.

Net of staff recharges, the monthly pay-bill was £41m, which includes £0.6m related to the in month A4C pay award, £0.3m to host the GP lead employer programme, £0.2m for medics pay award and £0.2m for backdated National CEAs.

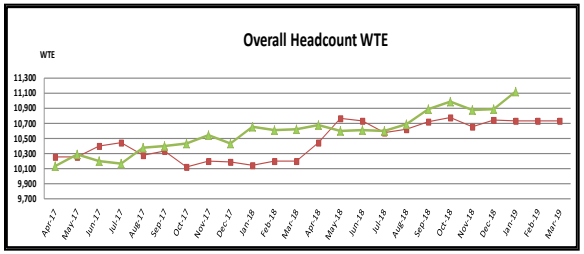
The pay bill spend in January 2019 was £1.1m higher compared to December 2018 and £1.3m higher than the average for 2018/19. Excluding August 2018 when the A4C pay award was backdated this is the highest pay bill month of the financial year.

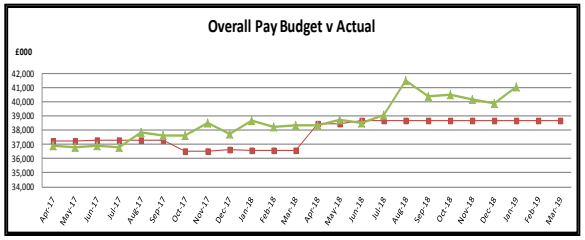
Agency spend increased by £0.1m and bank £0.2m. The majority of the increase was in nursing and midwifery staff group.

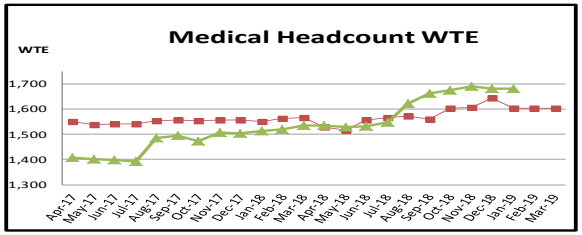
Of the £0.8m increase in substantive, £0.3m relates to bank holiday enhancements & £0.2m backdated National CEAs.

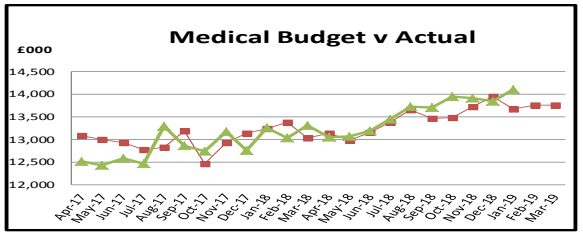
Budget

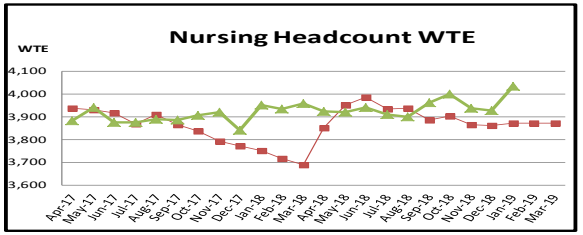
Actual

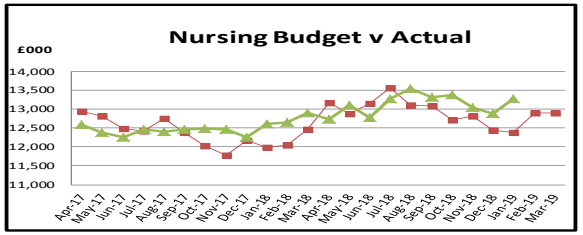


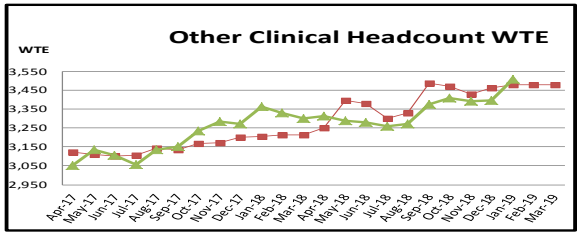


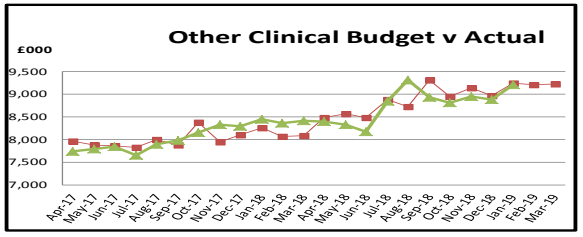


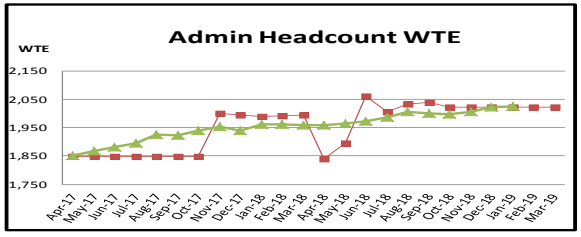


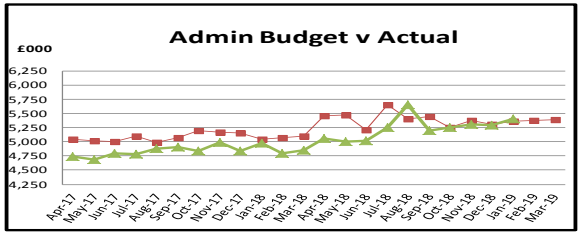












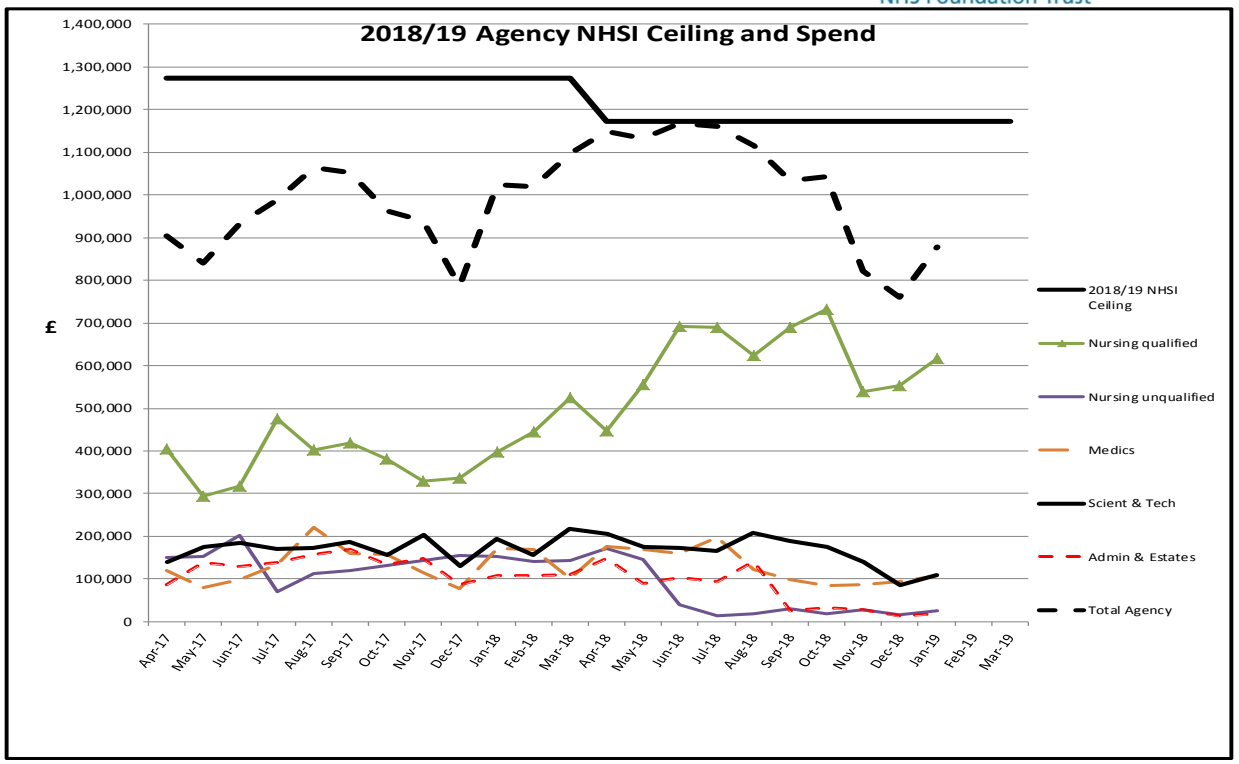
Temporary Staff Costs

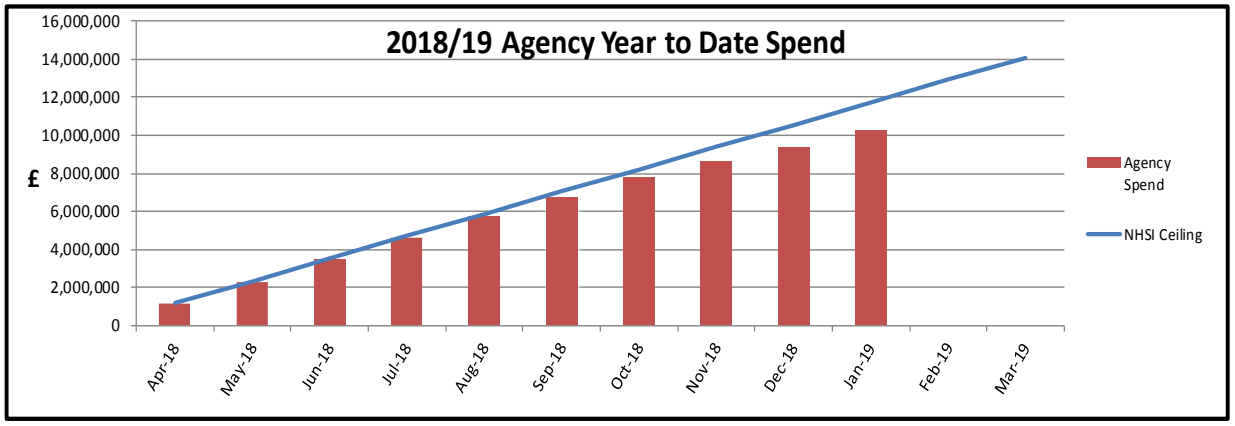
In January 2019 agency spend increased by £0.1m when compared to December 2018 and is back to November 2018 levels. The majority of this increase was in Nursing & Midwifery staff group with Division B identifying an improved fill rate although agency requests were similar to previous months.

The focus on the eradication of the high cost nursing agency Thornbury continues to aid the reduction in overall agency spend, and spend remains low (£64k) although is increasing from November & December 2018.

UHS continues to perform well against the NHSI agency ceiling and the focus is on sustaining the current agency position throughout the winter period; filling substantive positions and incentivising the bank staff to fill vacant shifts.

Trust-wide bank expenditure increased to £2.1m from a run rate of £1.9m per month.





University Hospital Southampton NHS
NHS Foundation Trust

Cash

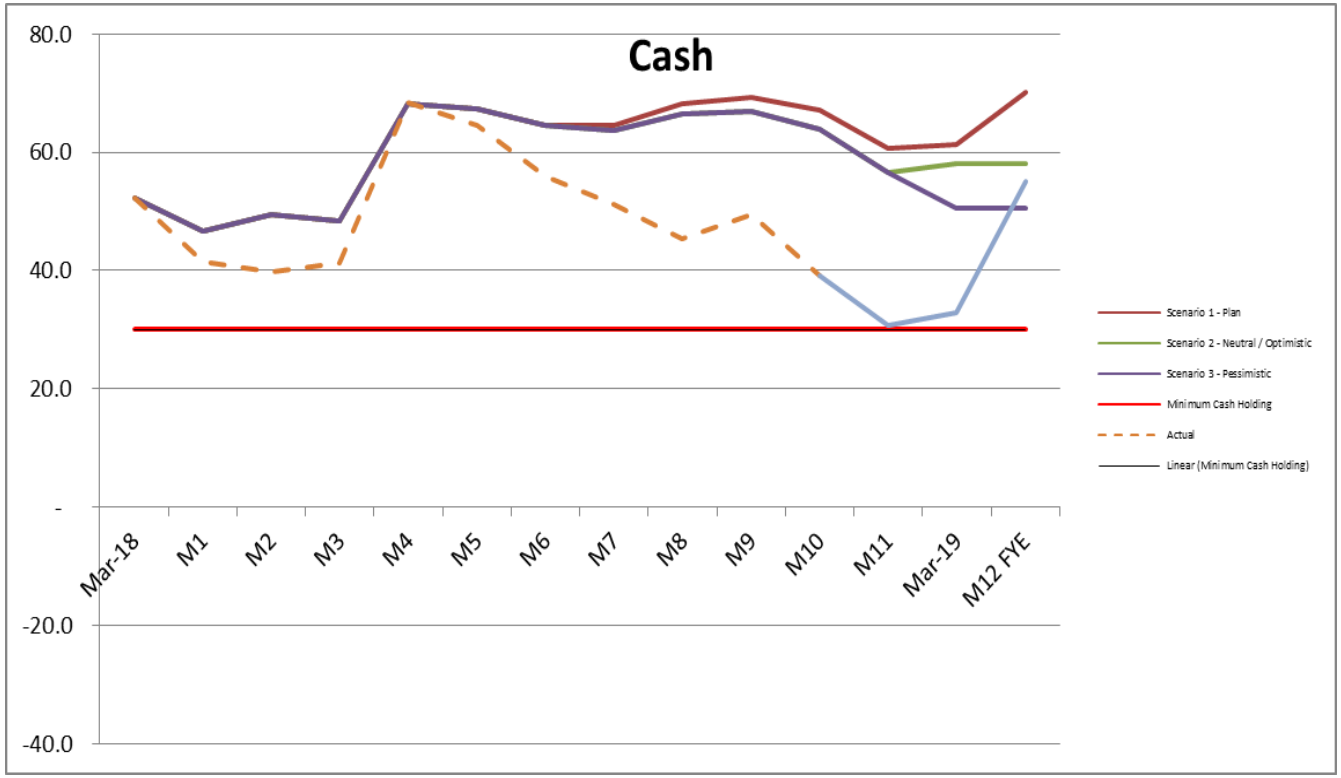
The cash balance is currently £28m below Plan and lower than the M4 forecast scenarios, although much of this is related to timing difference of when cash is received or disbursed. Circa £12m can be attributed to non-cash adjustments to the overall finance position.

The movement in cash vs. Plan from M9 of circa £8m relates to the adjusted financial position (£2.8m), plus further timing differences due to over-performance on income (sales plan transacted in 12ths – January a high income month)

The graph has been updated to show an anticipated full-year effect once timing issues have been resolved. This is based on a number of assumptions:

- timing issue vs. plan does not change materially in 2018/19 (i.e. invoices get paid at same rate as continued over-performance).
- PSF received of Q4 £ (£6.1m) + bonus estimated at £5m.
- Overall financial position does not deteriorate further

The future cash forecast and scenarios will be updated as part of the 2019/20 Operating Plan.



University Hospital Southampton NHS
NHS Foundation Trust

Capital Expenditure

Capital expenditure for the month was £3.9m below Plan and is £9m below Plan year to date.

The major in-month spend was across a number of different IT projects . The credits in month relate to anticipated VAT recoveries on schemes to be novated to UHS Estates Ltd (UEL).

The capital expenditure forecast has reduced significantly due to delays in receipt of central funding and pauses in schemes whilst a capital prioritisation process was undertaken.

The forecast post M10 results is £38.2m (excluding leases) against a plan of £50.8m.

	Month			Year to Date			NHSI
	Plan	Actual	Var	Plan	Actual	Var	Plan
Scheme	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Childrens Hospital	331	(652)	(983)	3,734	3,154	(580)	3,734
IT Schemes	1,285	783	(502)	6,615	5,986	(629)	8,955
Strategic Maintenance	(17)	211	228	3,059	4,418	1,359	4,500
Medical Equipment Panel	(7)	2	9	1,428	1,492	64	2,099
Radiotherapy Equipment Replacement	443	172	(271)	1,714	425	(1,289)	2,520
GICU Expansion inc Front Vertical Extension	1,468	(208)	(1,676)	5,068	895	(4,173)	7,451
Theatre Modernisation	742	232	(510)	2,781	394	(2,387)	4,300
ED Adult Resus	219	8	(211)	850	119	(731)	1,249
Neonatal Expansion	444	11	(433)	1,715	156	(1,559)	2,522
Oceanic Park and Ride	257	5	(252)	995	935	(60)	1,463
Invest to Save	1,198	7	(1,191)	2,327	82	(2,245)	3,000
Urology Day Unit	227	27	(200)	879	99	(780)	1,292
Steam Project	200	83	(117)	772	105	(667)	1,135
Other Schemes	2,060	1,252	(808)	7,763	9,481	1,718	6,613
Profiling adjustment- difference between individual plan phasing and original high level plan	(3,000)	0	3,000	(3,000)	0	3,000	0
Total Excluding Finance Leases	**5,850**	**1,933**	**(3,917)**	**36,700**	**27,741**	**(8,959)**	**50,833**
Leased additions- IISS	750	1,802	1,052	4,500	3,020	(1,480)	5,815
Leased additions- Other	495	0	(495)	1,493	3,313	1,820	2,000
Total	**7,095**	**3,735**	**(3,360)**	**42,693**	**34,074**	**(8,619)**	**58,648**
Less:							
Losses on disposals	-	-	-	-	(5)	(5)	-
Donated asset additions	(263)	(263)	-	(2,630)	(2,630)	-	(3,156)
Performance against Capital Departmental Expenditure Limit (CDEL)	**6,832**	**3,472**	**(3,360)**	**40,063**	**31,439**	**(8,624)**	**55,492**

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: Chief Executive's Report			
Category	Chairman's and Chief Executive's Reports		
Agenda item	5.1		
Sponsor	Chief Executive		
Author	Paula Head		
Provenance	This is a regular report to the Board covering issues of note from the Chief Executive and any actions of ratification proposed by the Chair.		
Purpose	The paper is presented for the Board to Ratify the Chair's actions and to Note. There is one item for approval. 1.Progress with the flu vaccination programme including • Total flu vaccination uptake and opt-out numbers and rates • A list of areas designated higher-risk and the uptake and opt-out rates for each • Details of actions taken to deliver the 100% uptake ambition • A breakdown of the reasons that staff have given for opting-out 2. Achievement of 7 day services standards – for approval 3. Chair's actions for ratification		
Relevant to Board goals	✓ Goal 1 – Trusted on Quality	✓ Goal 2 – Delivering for Taxpayers	✓ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	BAF risk associated with priority 1@ Create better flow for patients through hospital		
Equality Impact Assessment	Flu has had EIA with no discernible impact		
Other standards affected	NHSI require updates on the flu vaccination campaign to be presented in a public Board against the 4 criteria listed in the paper		

Chief Executive's Report

1. 2018/19 Staff Flu Vaccination Campaign

The 2018/19 flu vaccination campaign is drawing to a close at UHS with a total of 68.91% of front line staff receiving the vaccine. The OH team have led a comprehensive campaign of communication and engagement with staff, including holding sessions in areas of low uptake to discuss the benefits of the receiving the vaccination. The campaign has been held in line with the best practice requirements as set out by NHS Improvement. The Trust's performance on flu vaccination will yield £195k (75%) of the full £260k CQUIN payment.

In line with NHSI requirements, staff have also been surveyed on the reasons for not receiving the vaccination. The main reported reasons for non-uptake were fear or experience of side effects (36%), and lack of belief in the evidence of effectiveness of the vaccination (32%). The evidence and issues identified from this year will help to contribute towards planning for next year's campaign.

A detailed report, which addresses the issues requested by NHSI is available in appendix 1.

2. Achievement of 7 day services standards – to approve

NHSE require the Trust to undertake a self-assessment against the 4 main 7 day service standards. This first return is based on the data gathered in 2018 and previously reported to the Board in July 2018. During 2019 the Trust will need to re audit against these standards and the Board again will need to self-certify.

The Trust is meeting all 4 standards and is recognised nationally as a leader in this area.

The Board is asked to approve appendix 2.

3. 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.

3.1 **Single Tender Action for the supply of culture media for Pathology** under the Public Health England (PHE) to UHS Supplier Novation from Thermo Fisher Scientific. This is an interim arrangement allowing the Trust to re-contract under a compliant EU Framework Agreement. Approved by the Chair on 25 January 2019.

3.2 **Award of Contract for Orthopaedic Drill Systems** to Stryker for 5 years at a cost of £586,458 excluding VAT. Approved by the Chair on 30 January 2019.

Title:	Staff flu vaccinations Update
Sponsoring Executive:	Paula Head, CEO
Authors' names & Job titles:	Dr Julia Smedley, Lead for Occupational Health Steve Harris, Director of Human Resources
Main issues / Executive Summary:	Key points: • Flu vaccination performance for 2017/18 amongst front line staff at UHS was 68.9%. • NHSI have directed Trusts to improve performance to 100% of front line staff. The CQUIN target is 75% uptake. • Vaccination is not mandatory, but staff are requested to confidentially document the reason for refusing the vaccine. This information will be reported to NHS England at aggregated level for each Trust. • NHSI has produced a best practice guide, against which Trusts must self-assess. UHS is meeting these requirements. • Flu vaccination performance for UHS is at 68.91% on 13022019. • Uptake is marginally better than last year, but has plateaued, despite ongoing efforts to engage staff and make the vaccine easily available.
Implications:	UHS has achieved 75% of the CQUIN payment (£195k for uptake above 65%), but we are unlikely to achieve the 75% target for full CQUIN payment (£260k).
Action Required:	Board is asked to note the following: • UHS is likely to at least match, and may even improve slightly on last year's performance of flu uptake. We have achieved 75% (£195k) of the full £260k CQUIN payment. • Main reasons for declining (fear or experience of side effects and lack of belief in the evidence of effectiveness) will be taken into account in planning next year's staff influenza vaccination campaign. These are reasons that are difficult to influence even with a careful engagement campaign.
Next Steps:	To begin planning for 2019/20 flu campaign, using learning from this year's process.

1 Introduction and Purpose:

1.1. TEC received a plan for the Trust to meet the 2018/19 CQUIN Health and Wellbeing target in July 2018, which it approved.

1.2. In September 2018, NHS Improvement (NHSI) wrote to all provider organisations to set out further requirements. The aim is for 100% of front line clinical staff to be vaccinated. Organisations should also provide assurance to the public of plans through formally discussing learning from last year's flu campaign, and reviewing their preparedness for this winter, in an open Trust Board session. This was completed in a Board meeting in November 2018.

1.3. This report updates the Board on current flu vaccine uptake, including specified high risk areas, and feedback on reasons for declines amongst staff

1.4. Board is requested to note the progress, and consider further suggestions for increasing uptake in next year's campaign.

2 Key Issues:

2.1 Historical uptake at UHS:

2.1.1 Flu vaccination uptake at UHS has been increasing over the past three years. However, despite taking all the actions recommended by NHS England and NHS Improvement, UHS looks likely to achieve a similar (slightly improved) uptake this year compared to 2017/18. A significant proportion of staff still decline vaccination, despite being well informed about the rationale for protecting themselves and patients.

Year	Performance
2015/16	46%
2016/17	53%
2017/18	68.9%
2018/19	68.91% at 13022019

2.1.2 Comparison with national and local HIOW figures at end of December 2018

- UHS 64.3%;
- England total all Trusts 65.8%;
- Hampshire, Isle of Wight and Thames Valley 61.4%

2.1.3 A breakdown of uptake by Division is provided in Appendix 1. Actions to-date to improve uptake at UHS are summarised in Appendix 2. There has been a huge effort at engagement, including peer group discussions with expert clinicians, and walk-arounds by vaccinators with support from expert clinicians. Many man hours are spent in achieving small gains in uptake of a few per cent.

2.2 Areas of higher risk (to patients):

2.2.1 UHS is required to report separately on clinical areas that are deemed to be higher risk, due to the vulnerability of patients (e.g. immunocompromised). The uptake in these nine areas is summarised in Table 1, below:

Table 1:

Area	Division	Care Group	High risk group	Flu vaccine uptake
1	A	Cancer Care	Acute oncology wards and treatment areas: doctors and nurses.	72%
2	A	Cancer Care	Haematology: doctors and nurses, including bone marrow transplant unit.	67%
3	A	Cancer Care	Radiotherapy treatment.	62%
4	A	Critical Care	All ICU areas (GICU, CICU, NICU etc): nurses and doctors.	57%
5	B	Medicine	Respiratory HDU.	79%
6	B	Specialist Medicine	Cystic fibrosis service.	88%
7	C	Child Health	Children's HDU and PICU, doctors and nurses.	79%
8	C	Child Health	Piam Brown (Children's Oncology).	83%
9	C	Women and Newborn	Neonatal unit: nurses and doctors.	68%

2.3 Reasons for declining:

2.3.1 In January 2019, a survey was sent to the 3,105 staff, for which OH had no detail of vaccination status. Of these, 247 replied that they had been vaccinated elsewhere. Excluding these, and a few who said they do still plan to be vaccinated this year, the survey response was 17%.

2.3.2 Stated reasons for declining are:

Reason:	%*
I don't like needles	7.91
I don't think I'll get flu	9.23
I don't believe the evidence that being vaccinated is beneficial	32.39
I'm concerned about possible side effects	36.72
I don't know how or where to get vaccinated	1.51
It was too inconvenient to get to a place where I could get the vaccination	4.14
The time when the vaccination is available are not convenient	4.90
Previous experience of illness in self or others after the flu vaccine (despite information about vaccine safety)	15.07

Personal belief or personal choice	4.52
Away or unwell when offered vaccine - no specific objection	4.71
Other (contraindication, minimal patient contact)	3.20

*Note: Total is greater than100% as responders could tick one or more reasons for decline

2.3.3 In summary, the survey shows the most common reasons for declining are concern about or actual experience of adverse effects, and lack of belief in the evidence of benefit.

3 Next Steps:

3.1 UHS has taken all steps that have been recommended by NHS England, NHS Improvement and NHS Employers to make information about influenza vaccine easily available to front line staff, and to provide ready access to the vaccine.

3.2 A significant proportion of time and effort has been spent on engaging staff positively. This included direct involvement of a team of peer group champions and expert consultants in leading the messaging, walk-arounds, and using a variety of media (direct emails, Staffnet, Core Brief, staff briefing, team meetings, face to face discussions on a one-to-one or group basis, Workplace App).

3.3 There is clearly still a significant group of staff who are declining due to fear (or previous experience) of adverse effects or lack of belief in the evidence of vaccine effectiveness.

4 Recommendation:

Board is asked to:

- Note the current uptake of flu vaccine. UHS is likely to improve slightly on last year's performance, and will have achieved 75% (£195k) of the full £260k CQUIN payment.

- Note the main reasons for declining (fear or experience of side effects, and lack of belief in the evidence of effectiveness) will be taken into account in planning next year's staff influenza vaccination campaign. These are reasons that are difficult to influence, even with a careful engagement campaign.

Annex 1: Divisional influenza vaccine uptake at 13022019:

	Division A	Division B	Division C	Division D	Trust HQ
AHP's ST & T	62%	61%	77%	66%	79%
Support to Clinical staff (inc clerical, maintenance)	65%	66%	65%	70%	59%
Doctors	61%	67%	65%	61%	86%
Nurses	62%	69%	71%	69%	83%
Totals:	**62%**	**67%**	**71%**	**67%**	**77%**

Annex 2: Actions to date to improve uptake:

Action:	Status:	Timescale:
Purchase of quadrivalent vaccine to increase effectiveness.	Complete	
Continued use of the "I Care" badges for vaccinated staff.	Complete	
Publication of the Board receiving vaccines on 27 September 18.	Complete	
Increase in promotional material and videos from prominent consultant experts to help with myth busting. Payslip message at the end of October. Reinforcement of messaging in November Core Brief.	Complete	
Secure incentives through a random draw of vaccine recipients to receive one of five Sonos wireless speakers.	Complete	
Consistent expectations of local vaccinators to drive up response rate.	Complete	
Continued production of detailed weekly data by OH to TEC membership and to Care Group Managers. To commence during mid-October 2018.	Complete	
Introduce a corporate flu leadership team, with representation from each Division.	Complete	
Occupational Health managed a confidential process of collecting data on reasons for decline as per NHS England requirements. The survey, in January 2019, achieved a response rate of 17%. The main reasons for declining are summarised in the Board report.	Complete	
Daily walk-arounds in clinical areas.	Ongoing	
Thorough validation of data to ensure maximum capture prior to final submission.	Ongoing	February 2019

University Hospital Southampton NHS Foundation Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	The Trust is meeting these standards Clinical standard 2: time to first consultant review. We have achieved 91.7%, (an increase from 70%) for time of first consultant review for weekdays and weekend days combined; a more detailed analysis by day of the week will follow from NHSE. The mean length of time between admission and first consultant review has been reduced again from 17 to 15 hours. This is a significant achievement and demonstrates the change of working practices that has taken place over the last year.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust is meeting these standards Clinical standard 5: access to consultant directed investigations. We consistently achieve this target across all seven days of the week, due to changes in radiology working practices and economies of scale. There are gaps in our weekend MRI, Doppler and Transthoracic Echocardiography services. This is a national theme and UHS is not an outlier.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust is meeting these standards Clinical standard 6: access to consultant directed interventions. We consistently achieve this target across all seven days of the week, due to changes in radiology working practices and economies of scale.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	No the intervention is only available on or off site via informal arrangement	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The Trust is meeting these standards Clinical standard 8: twice daily consultant review in admission areas and high care areas and once daily review in other inpatient wards. This is the area of most significant improvement over the last 2 years and we have doubled consultant ward rounds in those areas and consistently delivered this target since September 2016. Once daily consultant reviews in other areas have also improved from 50% in March 2016 to achieving the target (90%) across all days of the week since September 2016. This level of consultant delivered patient care has continued to be above 90%. The Thrombolysis service will be extended across a wider geography and further hours during 2019.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
These standards have not been reviewed since 2015 but will be reviewed more formally during 2019. The Trust has a culture of developing 7 day services which enhances safety and flow.

7DS and Urgent Network Clinical Services

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

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

Template completion notes

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

Cover sheet for a report to the Trust Board of Directors dated Thursday, 28 February 2019			
Title: Equality, Diversity & Inclusion Strategy			
Category	Strategy and Business Planning		
Agenda item	6.1		
Sponsor	Director of Nursing and Organisational Development		
Author	Gail Byrne		
Provenance	This strategy has been developed through staff and patient stakeholder engagement. It has been presented to Trust Board previously and has been revised as a result and resubmitted to the Trust Executive Committee.		
Purpose	The strategy is presented for the Board to Approve. The EDI strategy is more concise and outlines four key goals which are: • Understanding our local population and reducing health inequalities • Measuring, monitoring and improving patient experience • Building inclusive leadership and talent • Delivering a representative workforce One overarching action plan will be developed to deliver the strategy.		
Relevant to Board goals	✓ Goal 1 – Trusted on Quality	☐ Goal 2 – Delivering for Taxpayers	✓ Goal 3 – Excellence in Healthcare
Board Assurance Framework links	None identified.		
Equality Impact Assessment	Implementing this strategy will have direct impact on each protected characteristic.		
Other standards affected	• CQC Well-led Framework • Equality Act		

University Hospital Southampton
NHS Foundation Trust

Equality, Diversity and Inclusion Strategy 2018 – 2023

Version 4

Forward by Paula Head, chief executive

At University Hospital Southampton NHS Foundation Trust (UHS) we are wholly committed to creating a diverse and inclusive environment. We see it as vital to our future success as a leading organisation in which our people and patients thrive.

We have always set high standards with regard to diversity and inclusion, but recognise that we have not yet achieved these standards in all aspects of our people practices and the delivery of patient care.

Going forward we are committed to embedding this strategy into our organisation in order to achieve the following outcomes: -

- We are fully representative of the communities in which we operate
- There is equity in our promotion and staff do not feel bullied or harassed because of their protected characteristics
- Our patients receive high quality of care whatever their background
- We are reducing health inequalities where they exist

The tenet of this strategy supports our Trust values of patients first, working together and always improving.

We have introduced fairer recruitment processes, inclusive talent management and training for senior managers in equality and diversity, but there is more to be done. We need your support in making this strategy a reality; one where equality, diversity and inclusivity is integral to what we do in the delivery of our service; where we work together and respect and value everybody's differences.

Our Trust Board has committed to the strategy and will monitor its progress. This commitment needs to be embedded in the organisation and extended to all our 11,000 staff and our networks, from local health organisations and the communities we serve.

Thank you in anticipation for your support.

Paula Head

1. Vision

Equality, diversity and inclusion (EDI) are at the heart of our values and cultural ambitions. EDI represents the mutual trust, respect and understanding we expect. EDI is integral to our reputation, success and sustainability, and enables the alignment between what we say and what we do.

Our vision is to have an inclusive culture. We want everyone who comes into contact with us to feel valued and respected.

Going forward we will work energetically to deliver this vision through the goals set out in this strategy.

We want our Trust to become a beacon of equality, diversity and inclusion and be nationally recognised for its work.

2. Introduction

2.1. There are a number of national levers that give us clear direction for EDI. These include the legal framework, the NHS constitution, the NHS Equality Delivery System (EDS), the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), the Accessible Information Standard and the NHS long term plan. To set the context of this strategy our population is outlined in appendix 1 and current workforce in appendix 2.

2.2. This strategy has not only been informed by research and data, but it has also been developed from feedback from staff, public engagement and focus groups. The strategy will build on a number of co-existing Trust strategies and policies such as the UHS forward vision, the people strategy, the patient experience of care strategy, the EDI policy, and the learning disability and dementia strategies.

3. Our EDI framework and goals

3.1 Our EDI framework outlining our goals and how they relate to each other is depicted below:

Goal one : Understanding our local population and reducing health inequalities

We will improve the collection, recording and use of demographic data on patients. This data will be used to inform future decision-making and improve the accessibility of our services for patients from protected groups. We will do this by:

- Reviewing the processes and mechanisms for collating demographic data
- Identifying clinical areas and pathways where inequalities exist (using both local and national intelligence) and develop plans to put such inequalities right
- Developing and implementing the Equality Impact Assessment for future service developments
- Consulting with our local community to hear their voice on health inequalities and work collaboratively with them to address issues

Goal two: Measuring, monitoring and improving patient experience

We will also review all sources of patient feedback to identify areas for improvement so that all groups receive a quality experience. We will do this by:

- Co-designing care with patients and service users
- Ensuring that patients are informed, supported in decisions about their care in ways that are appropriate and customised to their personal needs
- Identifying and prioritising access issues with our estate and providing appropriate solutions
- Ensuring that we have responsive feedback systems to learn from patients and their families

Goal three : Building inclusive leadership and talent

We will develop a leadership style that is inclusive, welcoming and compassionate for all staff enabling them to be themselves at work so that they can deliver the best possible patient care. We will ensure that we support staff in protected groups in their career development and will grow our talent.

We will do this by:

- Continuing to provide the inclusive talent management programme and establish an inclusive talent management board
- To support leadership development through coaching
- Deliver Inclusive Behaviours training at targeted groups
- Provide EDI training and awareness to managers
- Continuing to improve compliance with WRES, WDES, Sexual Orientation Equality Standards (SOES) and the Equality Delivery System 2 (EDS2).
- Increase the level of communication about the inclusivity agenda and actions the Trust is taking including a webpage, blogs and newsletters
- Growing the number of diverse staff in leadership and senior positions across the Trust

Goal four: Delivering a representative workforce

We will look to recruit staff from the widest range of applicants to achieve a workforce, which reflects the diversity of our local community.

We will do this by:

- Supporting and developing the Trust networks ensuring that they are fully representative of Trust staff and their protected groups
- Providing training for all managers on recruitment and selection, and embedding value and competency based interviewing training
- Providing master classes on application and interview techniques
- Taking and demonstrating action from the staff survey results where there is disparity for protected groups (particularly on experiencing bullying and harassment)
- Undertaking cultural reviews where issues or concerns are identified and taking action
- Fostering a culture that enables staff to speak up and an organisation that is actively responsive to staff concerns

4. How we will deliver this strategy

4.1. We will develop one overarching, iterative annual action plan to make this strategy a reality. The EDI steering group will oversee the plan and progress will be formally reported to the Board on a quarterly basis.

4.2. The plan will encompass a number of EDI action plans that have been developed in the Trust, for example, WRES, EDS2, WDES, and the Black, Asian, Minority Ethnic (BAME) focus group action plan highlighting where it will deliver compliance against the standards and actions previously set. The plan will be iterative and actions will be added as they have been identified through implementation, for example, where we have identified health inequalities from local and national intelligence the actions that we will be taking. Having one plan will ensure an appropriate focus on the actions being taken for future delivery.

4.3. WRES reporting requirements are set nationally. The purpose of WRES is to help NHS organisations review their data against the nine WRES indicators (see appendix 3) and produce action plans to close the gaps in workplace experience between white and black ethnic minority staff. The WRES report (based on workforce data and staff survey) and action plan is shared with the Trust Board and staff, presented to lead commissioners and published on our website.

Going forward we will need to report WDES similarly. EDS2 is contractually mandated and is reported annually to our commissioners and published on our website. To avoid duplication we will report progress against this strategy and the annual plan, making the specific requirement, for example, WRES reporting, more explicit.

4.4. We will develop EDI key performance indicators against the goals to monitor and report on progress. This will include our existing board level KPI to increase the number of BAME staff at band 7 and above to 15% by 2023.

4.5. We need to work collaboratively with our staff and our staff networks to support the delivery of this strategy. In the process of implementation we also need to sense check with staff that we are getting it right.

4.6. The governance arrangements for overseeing the plan are outlined in appendix 3.

Appendix 1

Our local population

As with the rest of England, the population of Southampton is changing. These changes have implications for the demand on healthcare services and the ability of the Trust to attract, train and sustain a workforce capable of responding to the resulting changes. UHS also serves a wider population across Hampshire and the Isle of Wight and is a centre for regional services in other counties. Hampshire and Isle of Wight has a population of over two million people, with a complex geography: substantial urban settlements primarily in the south and north contrast the large open areas interspersed with market towns and villages. This variation in deprivation, housing and health requires different solutions.

Headline statistics for Southampton's population:

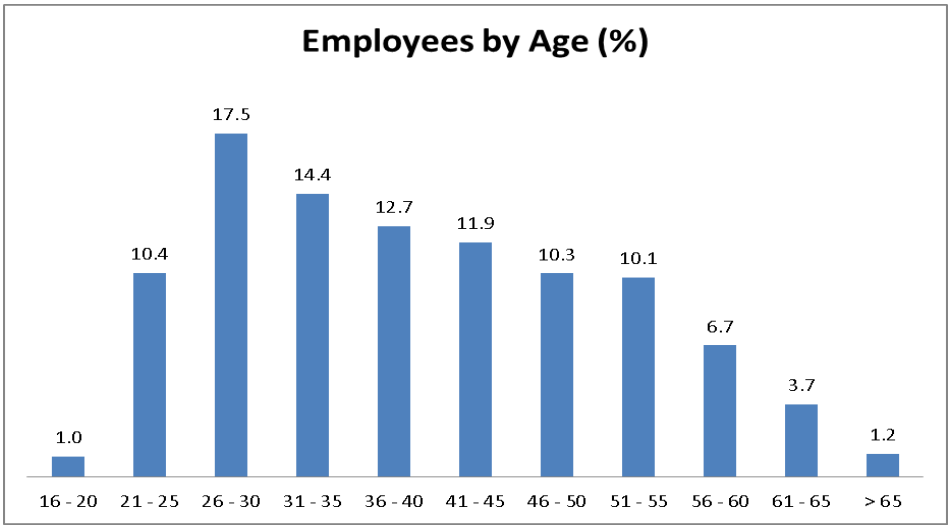
- The current population of Southampton is 254,275 based on the mid-year estimate 2016
- 129,879 (51.1%) are male and 124,396 (48.9%) are female
- 77.7% of residents are white British, those in all other ethnic groups account for 22.3% of the population, with white other being the largest ethnic group within the Black, Asian and Minority Ethnic community
- Southampton now has residents from over 55 different countries who speak 153 different languages
- Around 86,000 people are thought to be living with long-term health conditions such as asthma, diabetes, heart disease, hypertension, epilepsy and severe mental illness
- 18,165 people (7.7%) of the population report their day to day activities are limited due to their health. Of these 714 were aged 0-5 and 8,746 were aged 65 and over (2011 Census)
- There are an estimated 23 to 68 transgender people living in Southampton
- It is estimated that around 15,700 people living in Southampton are lesbian, gay or bisexual
- 45.3% of the population are single (never married), 37% are married, and 0.2% in a registered same-sex civil partnership and 9.1% are divorced
- In 2011, 51.5% of the population identified as Christian, 33.5% have no religious beliefs, 4.2% Muslim, 1.5% Sikh and 1% as Hindu
- It is estimated that there are 26,929 residents whose main language is not English; of these 717 cannot speak English at all and a further 4,587 do not speak it well.
- Southampton is ranked 81st out of 326 Local Authorities in England, with the rank of 1 being the most deprived. According to HMRC data (2010) 26.1% of the city's children live in poverty
- In Southampton the average male life expectancy at birth is 78.7 years and for females is 82.7 years

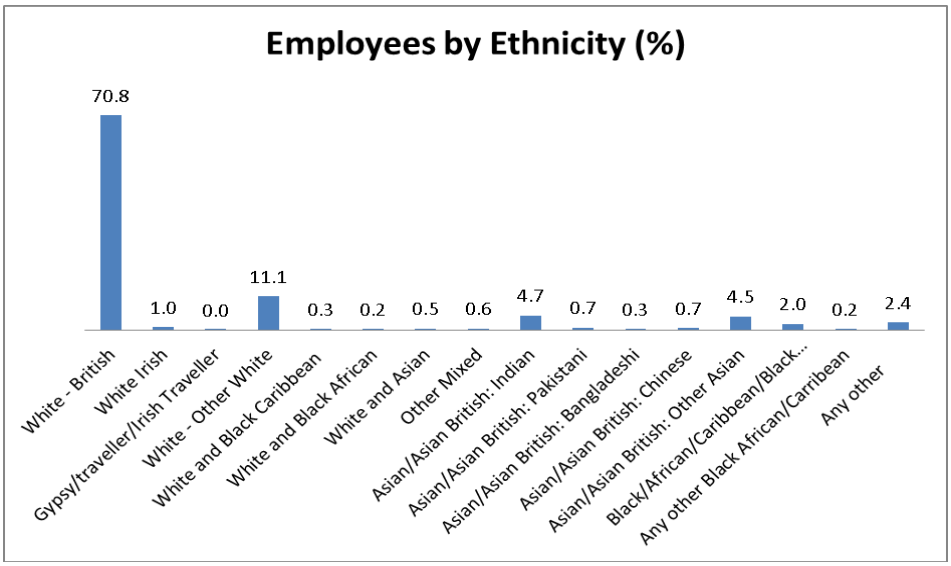
Appendix 2

Our Workforce

UHS has a workforce of 10, 837 staff, our profile looks as follows: -

- 86% of staff are white British and white other while 13.48% are from a Black, Asian and Minority Ethnic background
- 75.6% of staff are female, 24.4% male, with 42% women working part time as compared to just 4.47% of men
- 2.6% of staff have a declared disability
- 1.9% of staff identify as lesbian, gay or bisexual
- 40.2% of staff identify themselves as Christian, 15.6% as Atheist, 6.3% as other, 1.6% Muslim, 1.4% Hindu
- The largest age group within the workforce is age 26-30 (17.5%)





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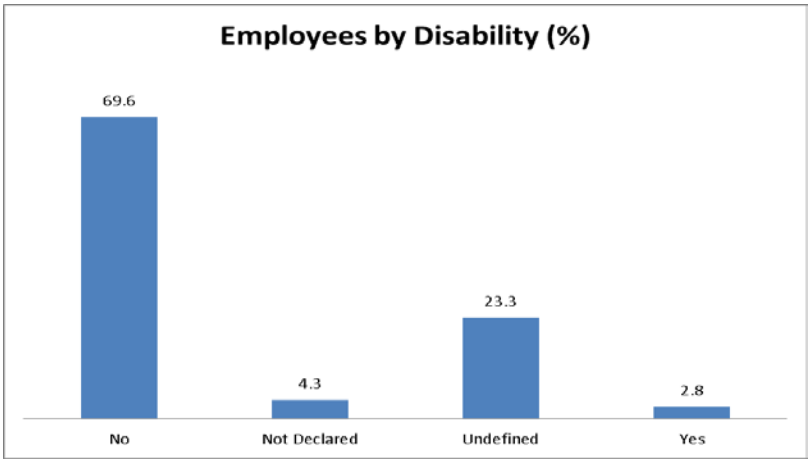

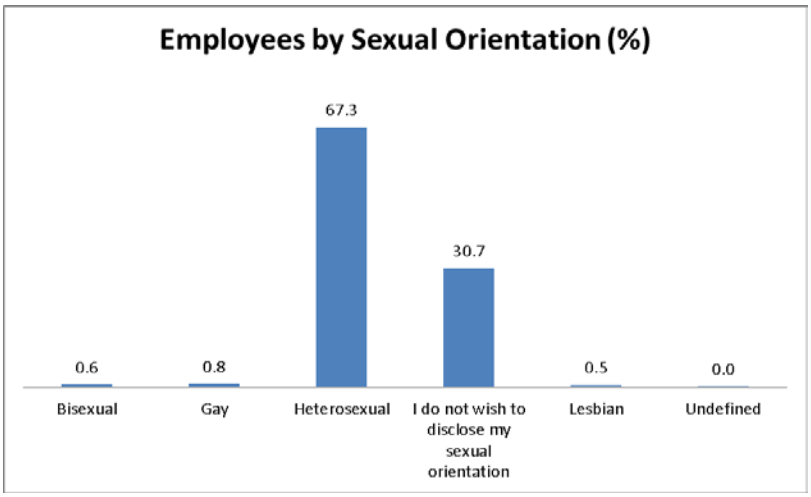

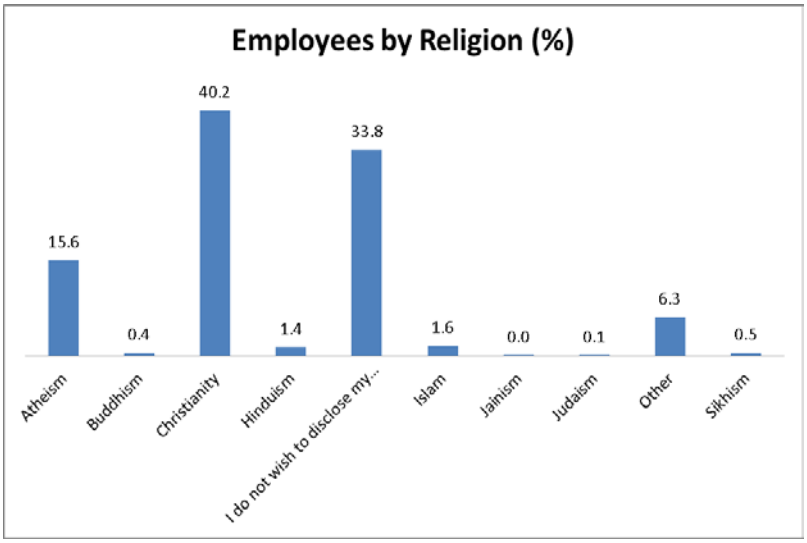

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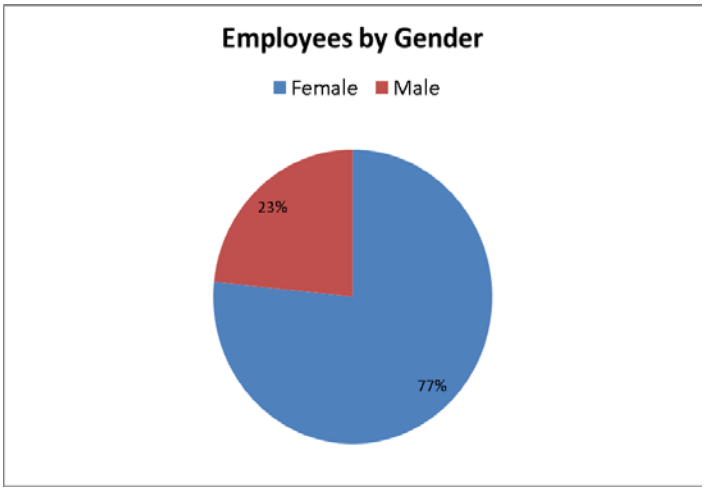
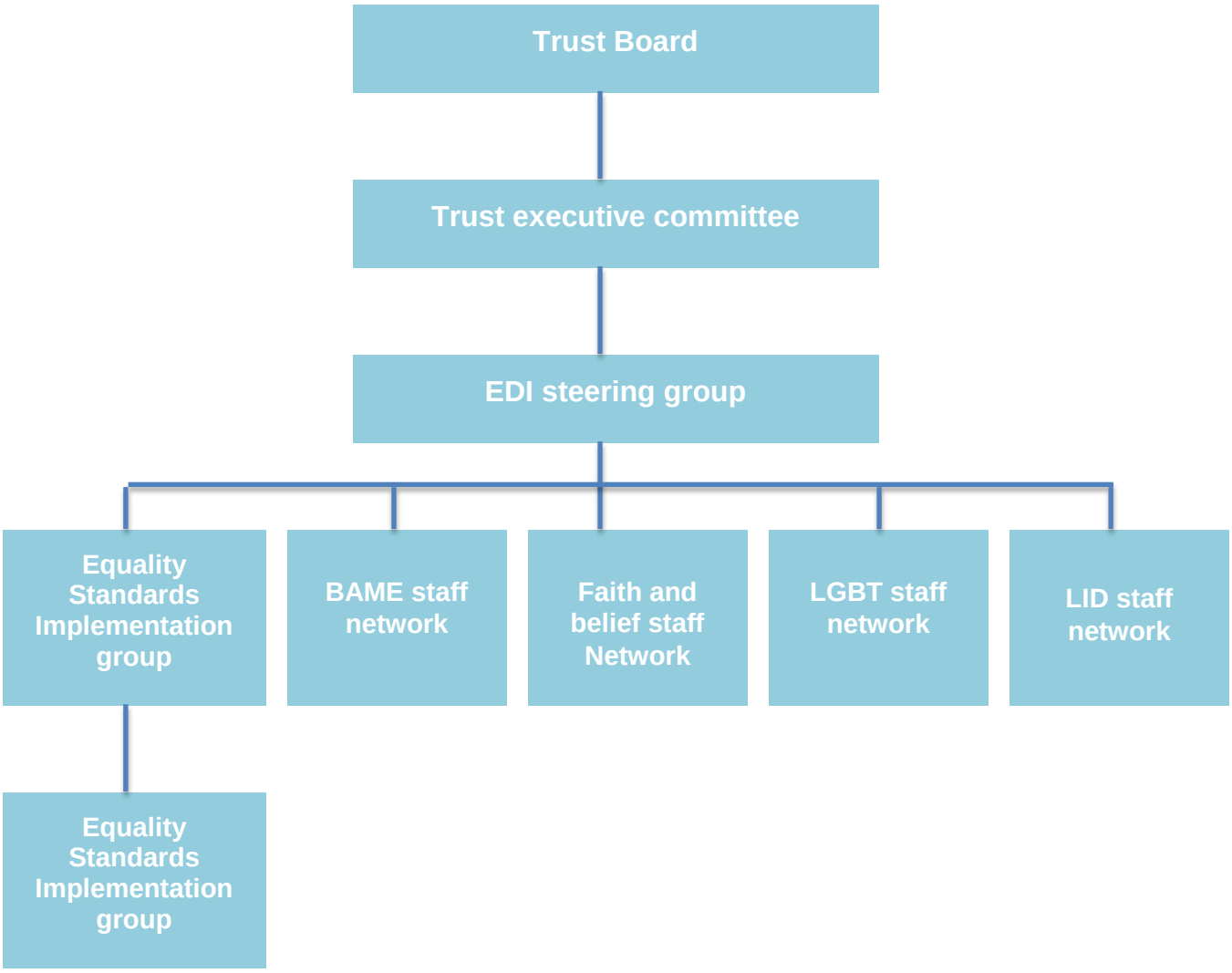


Appendix 3

The governance arrangements for the delivery of this strategy

Our governance arrangements ensure that the Trust Board receives regular assurance that the Trust is meeting its Public Sector Equality Duty. Systems are continuously reviewed and developed to ensure that all of the required data is collected to inform inclusion and diversity activity and that evidence is collated to support national equality standards, e.g. EDS2, WRESWDES and SOES.



Key roles

Board level leads

With overall responsibility and accountability for the Forwardly Inclusive Strategy

- Identified non executive lead for equality, diversity and inclusion
- Identified executive director lead for equality, diversity and inclusion
- Executive sponsors for each staff inclusion network/protected characteristic

Trust Equality, Diversity and Inclusion Leads

With responsibility for the Forwardly Inclusive Strategy and coordination of delivery plans

- Head of equality, diversity and inclusion
- Director of human resources
- Director of nursing and organisational development

Work-stream Leads

Have the responsibility for the implementation of delivery plans and the provision of evidence for national equality standards

- Head of equality, diversity and inclusion
- Head of patient experience
- Inclusion network leads
- Divisional and corporate work stream leads (both workforce and service)

Appendix 4 - Glossary

The nine protected characteristics

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Equality analysis

The Trust is reviewing the way in which it currently carries out Equality Impact Assessments.

A new Equality Impact Assessment guidelines and toolkit will be introduced to better support meaningful equality analysis and empower leaders to identify where a policy, procedure, service, service development or organisational change may have a negative impact on a particular group of people and then to develop action plans or pursue alternative plans to address them.

Equality Impact Assessments will be reviewed centrally, overseen by the equality, diversity and inclusion steering group. These documents will be published on the Trust's equality, diversity and inclusion webpage.

The Equality Delivery System (EDS2)

EDS2 is a framework that enables Trust's to review and improve their performance for people with characteristics protected by the Equality Act 2010. EDS2 supports Trusts to deliver on the Public Sector Equality Duty (PSED).

Our equality objectives have been mapped to the EDS2 goals and utilises this framework to support a performance culture related to inclusion.

Workforce Equality Standards (WRES, WDES and SOES)

The Workforce Race Equality Standard (WRES) is a set of specific measures (metrics) that help enable NHS organisations to compare the experiences of BME and white staff. This information is then used to develop an action plan to enable them to demonstrate progress against the indicators of race equality. Similar standards are being progressed for disability and sexual orientation and are likely to also be contractual obligations with the duration of this strategy.

UHS has reported on WRES for the past four years and is currently preparing for the forthcoming WDES.

WRES nine indicators

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive b oard members), compared with the percentage of staff in the overall workforce.
2. Relative likelihood of staff being appointed from shortlisting across all posts.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of staff accessing non-mandatory training and CPD.
5. KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
6. KF36. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.
7. KF21. Percentage believing the Trust provides equal opportunities for career progression or promotion.
8. Q217. In the last 12 months have you personally experienced discrimination at work from any of the following? (i) Manager/team leader or other colleagues.
9. Percentage difference between the organisation's Board voting membership and its overall workforce.

Accessible Information Standards

The Accessible Information Standard specifies clear processes to identify, record, and meet the information and communication needs of patients, carers, and parents. UHS will improve its compliance with the standard through a pilot project in a service before scaling up to the rest of the Trust.

We will ensure that we have the right resources to meet the information and communication support needs of patients, carers and parents, when they access our services. We will constantly audit and review the current provision of resources, ensuring availability of accessible information formats

To ensure that our processes for identifying, recording, and meeting needs are patient-friendly and effective, we will form a co-production panel of patients and public to help guide our work.

There are a number of key groups that are essential in steering, monitoring and delivering the strategy these are:

Trust board:

The Trust boardhas overall responsibility for delivering services and is accountable for operational performance as well as the implementation of the strategy and policy.

Equality, diversity and inclusion steering group:

The equality, diversity and inclusion steering group co-ordinates all EDI activity to ensure that resources are targeted to support key priority areas. The group also oversees the review and publishing of equality standards data (e.g. WRES, EDS2). It is also responsible for monitoring delivery of the various EDI action plans and providing regular updates to the Board.

Equality standards implementation group:

This is a newly established group that will be responsible for conducting deep dives into equality standards data, i.e. the WRES, WDES and EDS2 to identify root cause analyses for anomalies in the data. Each division will be represented and responsible for developing and delivering on a local action plan that addresses priorities within their areas. Collectively, these local actions will have an impact on the pace of progress towards to overall Trust results in relation to these standards.

Health inequalities group:

A subgroup to the equality standards implementation group, this group will focus on EDS2 goals one and two. It will be set up in the same way and look at specific clinic areas as they are identified as priorities.

Staff networks

The Trust has in place staff networks for the following protected characteristics:

- Black, Asian and Minority Ethnic (BAME)
- Faith and beliefs
- Lesbian, gay, bisexual and transgender (LGBT)
- Long-term illness and disability (LID)

They are a mixture of physical and virtual networks which provide support and advice to staff belonging to these characteristics. They also provide a valuable staff voice and champion the EDI agenda from the perspective of their identified characteristic. Each network has an elected chair and an executive sponsor to ensure a direct link at Board level.

Further networks will be developed for other protected characteristics as appropriate.

Disability Access Group and PLACE Working Group

These two groups are responsible for identifying physical, sensory and virtual access issues to our estates and seeking suitable solutions. They are responsible for monitoring the progress of the actions identified to resolve or reduce the access issue.