

Agenda

Group Name: Trust Board – Open Session
Date of Meeting: 31 January 2019
Venue: Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
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 29 November 2018 | Enclosure 1 |
| | 3. | Matters Arising/Summary of Agreed Actions | |
| 9.15 | 4. | Patient Story
(Derek Sandeman, Medical Director) | Oral |
| 9.30 | 5. | Integrated Performance Report for Month 9 including: <ul style="list-style-type: none"> • Quarterly Patient Experience Report (QIF) • Quarterly Patient Safety Report (QIF) | Enclosure 2 |
| 10.15 | 6. | Quality & Safety | |
| | 6.1 | Guardian of Safe Working Hours Quarter Report to note
(Derek Sandeman, Medical Director/Kathryn Nash, Consultant Hepatologist and Guardian of Safe Working Hours) | Enclosure 3 |
| | 6.2 | Implications of NHS Improvement publication: Developing Workforce Safeguards October 2018 to note
(Gail Byrne, Director of Nursing & Organisational Development) | Enclosure 4 |
| | 7. | Finance | |
| 10.35 | 7.1 | Finance Report for Month 9 to note
(David French, Chief Financial Officer) | Enclosure 5 |
| | 8. | Operational Performance | |
| 10.45 | 8.1 | Informatics Update to note
(Jane Hayward, Director of Transformation & Improvement/
David Cable, EPR Implementation and Services Manager) | Enclosure 6 |
| | 9. | Governance | |
| 10.55 | 9.1 | Risk Strategy to approve
(Paula Head, Chief Executive/Charlie Helps, Interim Associate Director Corporate Affairs) | Enclosure 7 |
| | 9.2 | Chief Executive’s Report to note and Chair’s actions to ratify
(Paula Head, Chief Executive) | Enclosure 8 |
| | 9.3 | Feedback from Council of Governors’ Meeting 24 January 2019 to note
(Peter Hollins, Trust Chair) | Oral |
| | 9.4 | Briefing from Chair of Audit & Risk Committee to note
(Simon Porter, Chair A&RC) | Oral |
| | 9.5 | Briefing from Chair of Quality Committee to note
(Mike Sadler, Chair QC) | Oral |

9.6 Briefing from Chair of Strategy & Finance Committee to note Oral
(Jane Bailey, Chair S&FC)

11.35 10. Any other business

11. To note the date of the next meeting: Thursday
28 February 2019 in the Conference Room, Heartbeat
Education Centre, F Level, North Wing, SGH.

In attendance: Kathryn Nash, Consultant Hepatologist and Guardian of Safe Working Hours
David Cable, EPR Implementation and Services Manager, Informatics

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”

11.45-12.00 Follow-up discussion with governors

12.15-1.30 Clinical Visit

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.

23 November 2018

Press Release Southampton doctors in world-first trial of new nose drop to fight meningitis

3 December 2018

Press Release: Southampton Children’s Hospital becomes first to offer Duke of Edinburgh’s Award to patients

5 December 2018

Press Release: Southampton Children’s Hospital to be part of BBC’s superhero celebrations

10 December 2018

Press Release: Hospital trust launches specialist emergency assessment unit for older patients

14 December 2018

Press Release: Doctors develop app to predict risk of asthma in children

31 December 2018

Press Release: Liver expert warns Dry January can be "perfect decoy" for problem drinkers

10 January 2019

Press Release Nurses perform surgical procedure in expansion of cardiac services

21 January 2019

Press Release Hospital trust develops ‘WhatsApp-style’ flu alert for smartphones

UHSFT – Directors’ Actions Summary for 31 January 2019 Trust Board – Open Session

Action & Minute Reference	By whom	Target Date	Current Status
Trust Board 1 November 2018			
Staff Strategy Progress Report (<i>Minute Ref 143/18 a</i>) An update in relation to the complexity of employee relations cases to be provided to the Board.	SH		
Trust Board 29 November 2018			
Integrated Performance Report Month 7 (<i>Minute Ref 159/18 a</i>) <u>Safe</u> Dr Mayank Patel, AMU and Diabetes Consultant, to be invited to a future Board meeting.	GB		
Equality, Diversity and Inclusion (EDI) Strategy <i>Minute Ref 160/18 a</i> GB/GG to reflect on the points raised and bring the strategy back to Trust Board for approval.	GB		Agenda Trust Board 28/2/19
Any Other Business <i>Minute Ref 171/18 a</i> <u>Major Incident 28 November 2018</u> PH to write to Andrew Asquith, who had operated as Gold Commander and Jo Hall, who had been Silver Commander.	PH		Complete.

as at 23/1/19

Trust Board Minutes – Open Session

Minutes of the Open Trust Board meeting held on Thursday, 29 November 2018 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	PH
	Mrs P Head, Chief Executive	PHe
	Mr D French, Chief Financial Officer	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
	Ms J Douglas-Todd, Non-Executive Director	JD-T
	Dr M Sadler, Non-Executive Director	MS

In Attendance:	Mrs R Chable, Deputy Director of Nursing, Education & Workforce	RC
	Ms G Genco, Head of Equality, Diversity & Inclusion	GG
	Mr N Pearce, Associate Medical Director for Patient Safety	NP
	Mr M Green, Head of Bereavement Care	MG
	Mr A Byrne, Director of Informatics	AB
	Mr S Harris, Director of Human Resources	SH
	Dr J Smedley, Consultant, Occupational Health	JS
	Dr H Artis, Registrar, Anaesthetics (shadowing Dr D Sandeman)	
	Ms V Alexander, Inspector, Care Quality Commission (CQC) (observing)	
	Mrs T Burt, PA to Trust Chair and Chief Executive (minutes)	
	1 member of public	
	2 members of staff	
	5 governors	

154/18 Apologies
Apologies were received from Prof C Cooper, Non-Executive Director and Ms C Mason, Non-Executive Director.

155/18 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.

156/18 Minutes of Previous Meeting (*Agenda item 2. Enclosure 1*)
The minutes of the meeting held on 1 November 2018 were **AGREED** as an accurate record. The initials of those attending needed to be realigned.

157/18 Matters Arising/Summary of Agreed Actions (*Agenda item 3*)

157/18 a) Minute Ref 126/18 a) Safeguarding Annual Report 2017/18 - GB advised that the length of time staff were overdue on safeguarding training varied between 3-6 months but overall compliance was improving.

157/18 b) Minute Ref 138/18 a) Gosport War Memorial Report - GB advised that there had been a DH response to the Gosport War Memorial report. This would be reviewed by the Trust to ensure that actions were reflected in the UHS action plan.

Action By

157/18 c) *Minute Ref 141/18 a)* Research and Development Annual Plan 2018-19 – KPIs were under review and would be included in next year's report.

157/18 d) The Board **noted** the latest position in the summary of actions.

158/18 Patient Story (*Agenda item 4*)

a) DS introduced Aelwen Emmett to the Board. She talked about her experience of being a patient at UHS following a referral by her GP for possible cancer. She chose to come to UHS for investigations as she had been a governor of the Trust and was confident that she would be safe and well cared for. Following a colonoscopy she was introduced to a Cancer Link Nurse. She highlighted the following points:-

- Time spent waiting for appointments was “very frightening”.
- Communication with staff had always been excellent.
- The vital role of the Cancer Link Nurse/Specialist Nurse.
- The support she received from the Chaplaincy Team.
- How important her bed and locker became to her (her “space”)
- That her fears were never dismissed and there was always someone she could talk to.
- She had found hospital food to be a “dispiriting experience”.
- That talking to other patients who had been through the same surgery would have been more helpful than being given documents to read.

JD-T asked how she felt the Trust could ensure that all patients had a voice. She suggested talking directly to patients before they were discharged and encouraging patient groups.

PH thanked Aelwen for sharing her story and asked what message she would like the Board to take away. She said that any diagnosis was difficult for a patient and that the time between diagnosis and treatment was often when fear set in and that support during that time was needed.

158/18 b) **RESOLVED**

That the Board NOTE her patient story.

159/18 Integrated Performance Report for Month 7 (*Agenda item 5. Enclosure 2*)

a) Safe

GB provided an update noting that there had been one Never Event in July when an injection had been given to the wrong eye. The Trust remained above trajectory for Grade 2 pressure ulcers and there was a sustained focus on ensuring that patients were repositioned two hourly, or four hourly (as a maximum) if they had been sat out of bed.

There had been a case of hospital acquired diabetic ketoacidosis due to a failure to prescribe insulin and this was being investigated. DS advised that late or missed doses of insulin could often have a greater impact on patients in hospital as they were already less well; this was unacceptable. MS suggested that the approach of the NHS to diabetes management in hospital needed to be considered, to allow patients to self-administer.

The 90% sepsis target had not yet been achieved. The transfer to NEWS2 would occur that day (29 November 2018).

JB asked whether pressure ulcers were an indication of unsafe nurse staffing levels. GB advised that there had not been a high level of red flags to indicate this and staff were moved around in order to maintain safe nurse staffing levels.

Action: Dr Mayank Patel, AMU and Diabetes Consultant, to be invited to a future Board meeting.

GB

- 159/18 b) Caring
PH noted that the number of complaints was higher than it had been seen for a while. GB advised that she had discussed this with Ellis Banfield, Head of Patient Experience and he had been unable to find a common thread.
- 159/18 c) Effective
DS highlighted the continuing downward trend on HSMR. DAF noted the reduction in emergency readmissions and asked if this was likely to be sustained. JH advised that a great deal of work was being done with this objective.
- 159/18 d) Activity
SP noted the increased number of e-referrals. CM advised that e-referral was proceeding well but there could be a delay between the GP making an e-referral and the patient then booking an appointment. The increase in elective day case activity was noted and JH advised that this was mainly due to a change in delivery of some cancer treatments.
- 159/18 e) Flow
CM advised that overall the number of long stay patients was reducing.
- 159/18 f) Emergency Access
CM advised that the Trust was not where it wanted to be and changes continued to be made to the front door, in ED and to flow throughout the hospital. PH noted the decline in Eye Casualty performance and CM advised that several experienced members of the nursing team had left and more patients were attending. Additional 'hot' clinics were now being run each day in the OP department to help deal with this increase.
MS noted that the 95th centile for patients waiting in ED was 6 hours and he asked what was being done to inform them of the likely delay and to keep them safe. CM advised that the waiting time for patients admitted to a bed was relatively short beyond 4 hours. Patients in the waiting room were alerted to waiting times and made aware of other options, e.g. minor injuries unit, GP hubs and 111 but very few chose to leave.
GB advised that the matrons were looking at the CQC document 'Under Pressure' about managing increased demand in Emergency Departments.
- 159/18 g) RTT
CM advised that the 6 patients waiting over 52 weeks (RR1.3) had been treated by the second week of November. It was encouraging to see that the number of patients on the incomplete pathway (RR1.4) had reduced.
PH asked how patients were told that they were unlikely to have their operation within 18 weeks and CM advised that this was generally done by the surgeon in clinic.
Performance challenges in endoscopy were reducing due to additional work being undertaken with inpatients being scoped in the evening, rather than being added to lists, and the opening of a new procedure room.

159/18 h) Cancer

CM advised that until a year ago the Trust had normally been achieving cancer targets. There had been continued growth in the number of patients and staff had managed to maintain performance by “peddling faster” but this was not sustainable. More qualified staff were needed and a breast radiologist had been appointed and would commence work in January.

There had also been a growth in demand for radical prostatectomies and the Trust had been undertaking robotic work at Spire. There had only been one month during the year when more prostatectomies had been done than were added to the waiting list. The demand was approximately double what had been predicted. The team had worked very hard since the commissioning of the Trust’s own robot and increased their delivery substantially.

159/18 i) Infection Control

GJ advised that there had been a recent “secret shopper” audit across the Trust with Infection Control Nurses observing hand hygiene. Compliance had been less than expected with 1 in 3 opportunities to clean hands at critical moments missed. Compliance had varied from 0% in one area to 100% in another. This data had proved tremendously powerful for divisions and was being used in staff awareness sessions. It was planned to do a re-audit in Q4. JD-T asked if the reasons for poor hand hygiene were known and GJ advised that it was often pressure of work and possibly complacency.

MS noted that prudent antibiotic prescribing was still showing as red and GJ advised that this mostly related to low risk drugs where prescriptions were usually written up for 7 day courses. The Trust was working to encourage shorter courses, e.g. 5 days.

159/18 c) **RESOLVED**

That the Board NOTE the Month 7 Integrated Performance Report.

Quality & Safety

160/18 Equality, Diversity and Inclusion (EDI) Strategy *(Agenda item 6.1. Enclosure 3)*

a) GB advised that this was an important strategy for the Trust as it had a positive impact on staff morale and engagement, which resulted in better outcomes. It had been presented to the Trust Executive Committee and was now with Trust Board for comment and approval.

The following observations were made:-

- The executive team was committed to driving this agenda forward.
- The strategy was an important communication tool to be shared with all staff and the language may therefore need to be simplified (e.g. reword Goals 1 and 2).
- The appraisal system could be used to help embed the strategy.
- The Trust’s priorities should be made clearer.

MS noted that shortlisted white candidates were still more likely to be appointed than shortlisted BME candidates and felt that there should now be more clarity on why this was so. GG advised that this was not felt to be an issue associated with the shortlisting stage.

PHe said that it was crucial to get this strategy right, in order to ensure that the Trust was the place we wanted it to be and where staff wanted to work. She also noted that the senior leadership team was not diverse.

PH thanked GG for her work and noted that several points had been raised which needed to be considered further before the strategy was approved by Trust Board.

Action: GB/GG to reflect on the points raised and bring the strategy back to Trust Board for approval.

GB/GG

160/18 b) **RESOLVED**
That the EDI strategy be brought back to the Trust Board for approval at a future date.

161/18 Workforce Race Equality Standard (WRES) Annual Report and Action Plan
(Agenda item 6.2. Enclosure 4)

- a) GB advised that the Workforce Race Equality Standards (WRES) had become a requirement for national health organisations in 2018, although it had been recognised as good practice since 2015. When compared to other NHS trusts, UHS had performed above the national average for indicators 3, 4, 7, 8 and 9, was in line for indicator 1 and just below for indicator 6. An action plan had been developed.

161/18 b) **RESOLVED**

- I. **That the Board APPROVE the WRES Annual Report and Action Plan**
- II. **That the Board be notified of any subsequent changes to the Plan resulting from change to the EDI strategy referred to above.**

162/18 Learning from Deaths Quarter Report *(Agenda item 6.3. Enclosure 5)*

- a) NP advised that in 2014 the Trust had introduced the Internal Medical Examiner Group (IMEG). Since then there had been a progressive reduction in the number of avoidable deaths and this showed a genuine reflection on improvements in care across the Trust. Mortality review training and education had been cascaded down through teams and many had changed their practice, based on this. Of the 519 deaths in Q2 that had been given an avoidability score, only one had been identified as having strong evidence of avoidability. In April 2019 a non-statutory Medical Examiner Service would be introduced across all acute Trusts. DS said that he was proud of the work the team had done at UHS. MS noted that this was not standard across the NHS and the Trust was an exemplar. The process had been adopted by Solent and UHS continued to work with other partners. PH asked whether enough had been done to raise the profile of what had been achieved within the Trust. DS advised that Simon Stevens was aware of IMEG but more could probably be done. MG had met the coroner recently and he was very supportive of the process.

162/18 b) **RESOLVED**
That the Board NOTE the Learning from Deaths Quarter Report.

Finance

163/18 Finance Report for Month 7 *(Agenda item 7.1. Enclosure 6)*

- a) DAF presented the Month 7 Finance Report, noting that:
- The Trust delivered a surplus of £3.5m, bringing the year to date surplus to £11.1m. This was £3m behind Plan, £1.5m of which was the missed PSF related to the Q2 4 hour target and an operational shortfall of £1.5m.
 - It had been assumed that the Trust would achieve the finance target (£1.3m surplus in the quarter) and the Q3 4 hour target, but not the catch up PSF for Q2.
 - The total available PSF in Q3 was £9.1m of which £5.3m was the finance element, £2.3m Q3 4 hours and £1.5m Q2 4 hours which could be clawed back if the year to date 4 hour performance was on track at the end of December.
 - Q4 PSF would be £8.8m but the Trust was unlikely to achieve this.

163/18 a)
cont'd

- October had been much stronger on income due partly to more working days although inpatient elective income performance was still affected by theatre list cancellations. Many of these were high tariff episodes in Division D. Clinical income was £6m more than September and the highest ever in UHS.
- Pay costs were distorted by a series of transactions not captured in the Plan. Excluding these, pay was £2.5m over Plan.
- Agency costs were below the NHSI agency cap but spend on registered nurses had increased again to over £700k in the month. £200k of this was with a single, high cost agency. The recent intake of newly qualified nurses was helping to reduce agency use.

DS asked whether any adjustment could be made to the control total following the major incident experienced by the Trust on 28th November. DAF said that he would try to make it an exception. While costs were not yet known although they had been estimated at £2m and were likely to include repairs and lost drugs and blood supplies.

163/18 b)

RESOLVED

That the Board NOTE the Month 7 Finance Report.

Operational Performance

164/18

Ward Staffing Nursing Establishment Review 2018 *(agenda item 8.1. Enclosure 7)*

- a) GB noted that nurse staffing and actions being taken on recruitment and retention had been discussed regularly at Board. These discussions had given assurance that robust processes were in place to review ward staffing and any gaps that existed. PH asked how work to close the gap on the four outstanding recommendations from the action plan produced in response to the updated National Quality Board's guidance, was progressing.

GB provided the following update in relation to each of the four recommendations:-

- **Allocated time for the supervision of students and learners** Board members would be visiting clinical areas later in the morning to meet students and look at learning environments.
- **Equality and diversity** Plans were in place to promote equality and diversity and actions would be reported to Board through the Equality and Diversity Group.
- **Recruitment and retention linked to the reduction in agency use** Focus was being maintained on this area.
- **Generational considerations** Work continued through the R&R Steering Group to ensure that generational considerations were included in all workforce initiatives. The Trust was also part of a national research project around flexibility and rostering, which included generational factors.

164/18 b)

RESOLVED

That the Board NOTE the Ward Staffing Nursing Establishment Review 2018.

165/18 Informatics Quarter Report (*agenda item 8.2. Enclosure 8*)

- a) AB highlighted the pictures of the UHS Health Records Library on page 3 of the report. An initial visit from HIMSS had taken place on the 21st November. The aim of the Trust was to achieve HIMSS Level 7 which related to the digital maturity of the organisation. HIMSS had:-

- Noted that the Trust was still very reliant on paper but that the strategy to become paperless was sound.
- Been impressed by the beside closed loop phlebotomy system (item 2.11).
- Felt that the link between HSMR and digital was impressive.
- Found only enthusiastic and knowledgeable clinicians.

PH asked whether staff knew where to find paper prescriptions when eprescribing went down. AB said that they did although there had been learning from the Major Incident this week. PH thanked the IT team for the good humoured and effective way in which they had responded to the Major Incident.

JB said that it was difficult to know how well the Trust was doing on informatics, when it was not linked to a KPI. There had been discussion at the Strategy and Finance Committee about the financial penalty if the Trust did not achieve HIMSS Level 7.

165/18 b) **RESOLVED**

That the Board NOTE the Informatics Quarter Report.

166/18 Staff Flu Vaccinations 2018/19 (*agenda item 8.3. Enclosure 9*)

- a) SH and JS provided an update on the staff flu vaccination programme, which was currently at 58.3% against a target of 70% for full CQUIN payment in 2017/18. JS advised that this compared well within the region, although it was slightly behind on last year. JD-T asked whether enough was known about why some staff chose not to have the vaccine. JS advised that nurses tended to worry about side effects, doctors did not think the evidence was strong enough and others said it was not accessible. PH asked whether the Board could do anything else to help. DS advised that there had been a backlash to the flu campaign last year from clinicians as the presumption that staff protected patients by having it, was weak.

166/18 b) **RESOLVED**

That the Board NOTE the progress last year, lessons learnt and the plan underway for 2018/19.

Governance

167/18 Chief Executive's Report (*Agenda item 9.1. Enclosure 10*)

- a) The Board **NOTED** the Report.

168/18 Briefing from Chair of Quality Committee (*Agenda item 9.2*)

- a) MS advised that the Quality Committee had considered the ED performance, DToC, accreditation issues in cellular pathology, activity reduction and HSMR.

168/18 b) **RESOLVED**

That the Board NOTE the briefing.

169/18 Briefing from Chair of Strategy & Finance Committee (*Agenda item 9.3*)

- a) JB advised that the Strategy and Finance Committee had spent a significant amount of time looking at the Trust's financial performance. They had also considered the Informatics quarterly report, the maternity system and the procurement joint venture.

169/18 b) **RESOLVED**

That the Board NOTE the briefing.

170/18 CRN: Wessex 2018/19 Quarter 2 Performance Report *(Agenda item 9.4)*

The report was for information only.

171/18 Any Other Business

171/18 a) Major Incident 28 November 2018

The Board reflected on the Major Incident that had been declared the previous day and noted that a forthcoming review, to be overseen by PHe, would focus on the physical cause of what had happened and the organisation's response to it. It was noted that all staff had responded extremely well and that the interaction between staff and patients had been positive.

DAF advised that power had been lost at 0610 hours as the result of an underground cable break in one of the two ring mains. The ground around the cable break would be excavated in order to determine the cause of the break and external, expert advice sought.

The Estates Team were thanked for their structured, calm and methodical approach to the incident.

A note of thanks from CM to staff had already been circulated by email and one would also be circulated from PHe. DS acknowledged the support given by external partners, including QA at Portsmouth who had declared an internal incident and brought in additional staff to cope with the extra work generated by UHS closing its doors.

It was **AGREED** that PH would write to Andrew Asquith, who had operated as Gold Commander and Jo Hall, who had been Silver Commander.

PH












172/18 Date and Time of Next Meeting

Thursday, 31 January 2019 commencing at 0900 in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH.

Integrated KPI Board Report

covering up to
Dec 2018

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

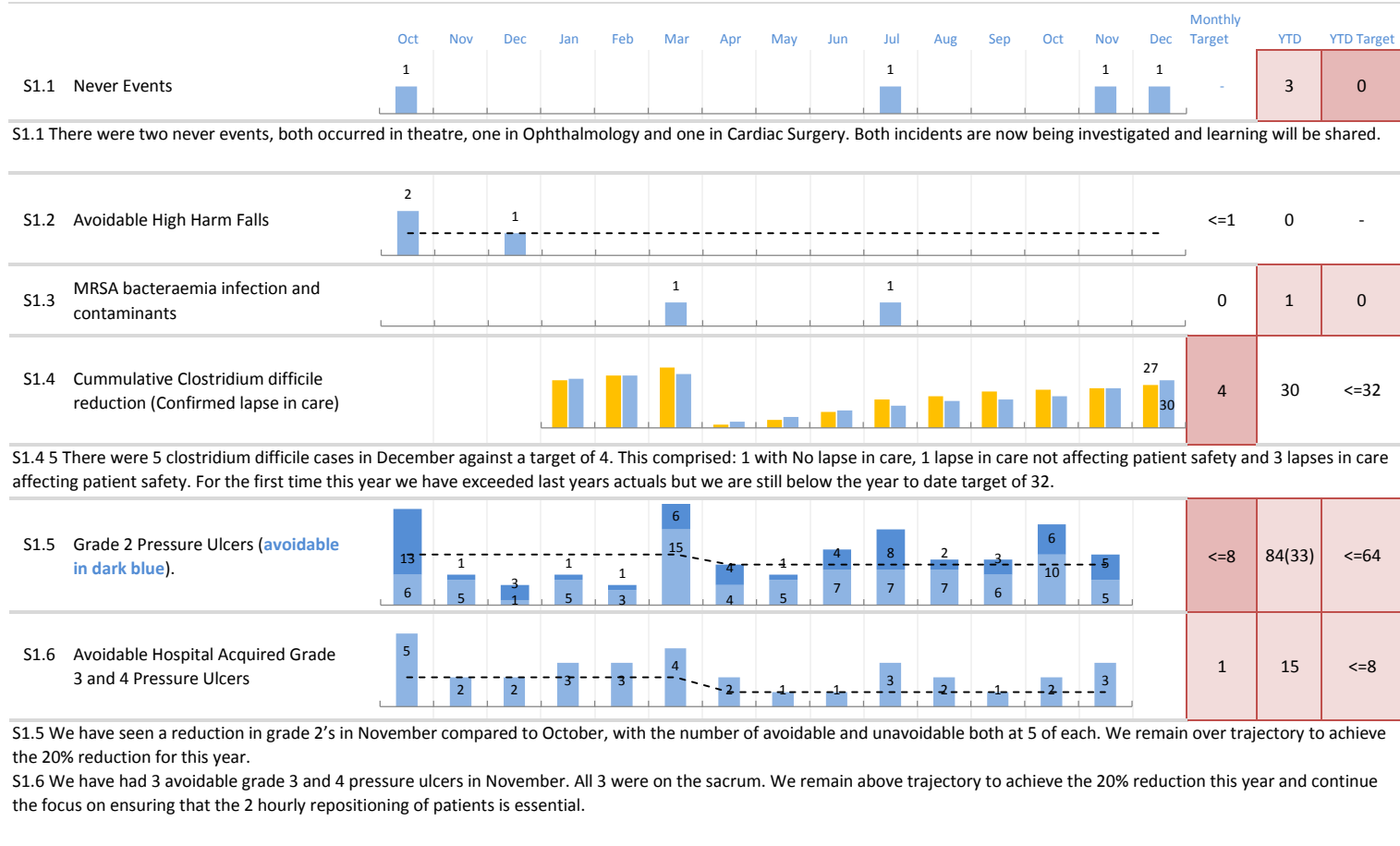
 Safe	Safe remains amber this month as UHS has failed some KPI's yet we have seen continued good performance in other areas. There were two never events reported in December (although one occurred end of November). There was no avoidable high harm falls or MRSA infections/contaminants in December. C.Diff performance remains better than year to date target. 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	FFT response rate for inpatients continues to be under target, but scores are positive. Other FFT indicators are within target range. Mixed-sex accommodation breaches are under target for second consecutive month. Complaints have dropped in number for November and December with no significant variation in the rate of complaints per 1000 units.
 Effective	There were five national reports published and reviewed in December, of these reports one raised an area of concern (National Asthma and COPD audit programme). There are now 214 outcomes being reported to TEC from 45 specialities. Of these, 200 have been graded, with the majority being green (75%) and only 8% graded red. Emergency readmissions was at 11.8% in December which is higher than normal but not outside expected variation seen over the last 2 years. HSMR continues to drop and is well below the national benchmark and crude mortality remains low at 3.9%
 Activity	Two week wait cancer referrals remained high in October and are 6.5% higher year to date and number of first cancer treatments is up 9.1% year to date. Main ED attendances remain high however have not shown the same year on year growth compared to previous months. 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).
 Flow	The number of Delayed Transfers of Care in the Trust continued to trend downwards and in December were lower than the previous 15 months at an average of 67. The number of patients who have been in hospital for greater than or equal to 7 days shows a continued improvement decreasing in December to a total of 554 and patients with a length of stay greater or equal to 21 days has decreased also to 206, a 14% reduction on the same time last year. Early discharge on the day (pre-midday) in December reduced to 21.4% (target 30%).
 Emergency Access	Main ED (Type 1) performance was 8.3% above the average of our local peer group. Eye casualty (Type 2) performance is still an area of concern but has shown improvement in December, now at 93.6%. Lymington MIU (Type 3) remains at a high level of performance (99.7%) and as a local delivery system we achieved the PSF threshold of 90.3% for Q3, also due to the overall local delivery system year to date performance we have regained the PSF target for Q2.
 RTT & Diagnostics	In November a material improvement was achieved in the number of RTT patients waiting over 18 weeks, December has seen a deterioration partly as a result of lower activity levels during December. The total size of the waiting list has remained within the national operating plan target and is decreasing. Diagnostic patients waiting >6 weeks reduced to the lowest levels in 12 months. Further improvements are still important.
 Cancer	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 (250 year to date).
 Research & Dev	Research and Development has been rated Amber this month. Absolute recruitment is comparable to last year minus the patients recruited to one large study which has now ended. Whilst absolute recruitment is less than last year, when adjusted for complexity (weighted) performance is satisfactory. Forecasting to year end indicates performance will be close to target.
 Staffing	Staffing has been rated amber this month because we have missed some KPIs including those relating to overall staff turnover, nursing vacancy and appraisal completion rates. There have been improvements in total turnover rates, appraisal completions and overall nursing vacancy rates, however registered nurse vacancy rates have increased by 0.97% since November. The sickness target has again been achieved, with a fourth consecutive reduction this month. Care Hours Per Patient day is uncharacteristically high due to low patient numbers and acuity.
 Estates	Estates has been rated green this month as we are meeting targets for most KPIs in December. The targets missed this month are for percentage of help desk requests completed on time and Unresolved help desk requests (over 30 days old).

Report Guide

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



Safe remains amber this month as UHS has failed some KPI's yet we have seen continued good performance in other areas. There were two never events reported in December (although one occurred end of November). There was no avoidable high harm falls or MRSA infections/contaminants in December. C.Diff performance remains better than year to date target. 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.

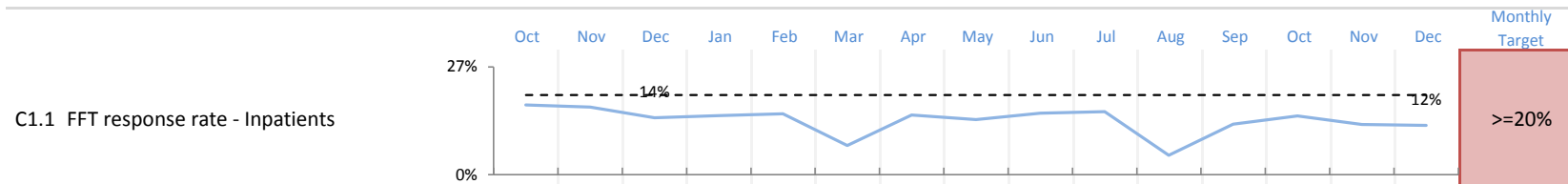




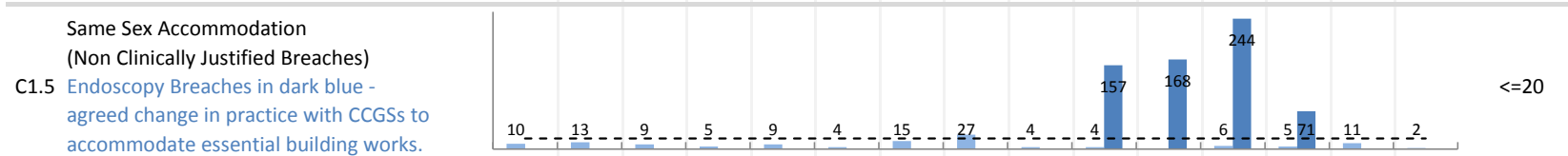
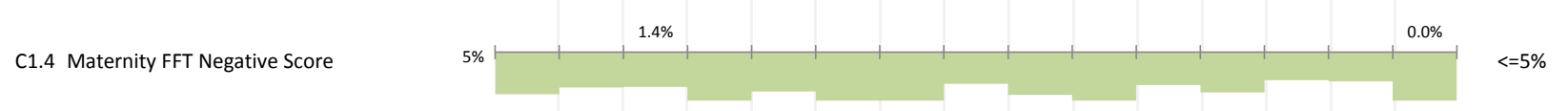
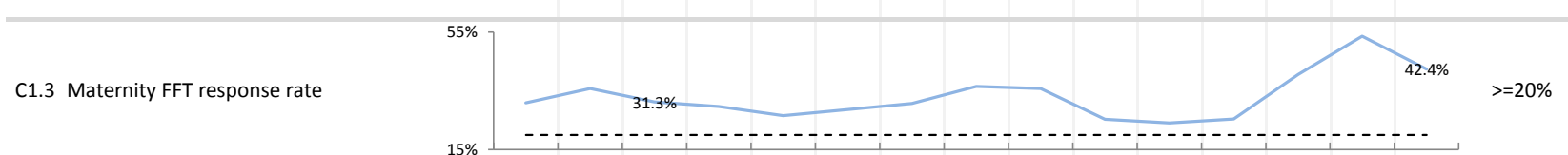
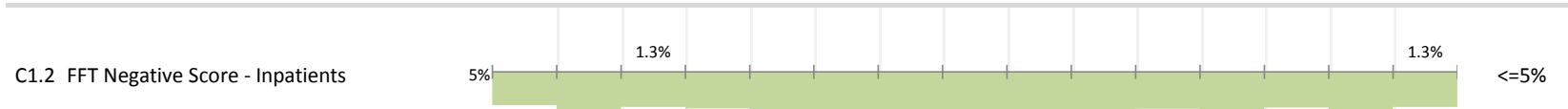
There has been a drop in the timely management of sepsis despite a continued focus on education and sepsis awareness. NEWS2 has now been implemented and should aid the recognition and escalation of deteriorating patients. The data shows that the majority of the delay is from the prescribing to administration of antibiotics, for which there are varying causes. This presents a challenge when trying to identify a solution. A sepsis panel for the last quarter will take place to review all the missed cases with the clinical teams, to assist in the recognition of potential causes in each clinical area. Quarterly data should be available for the next report.

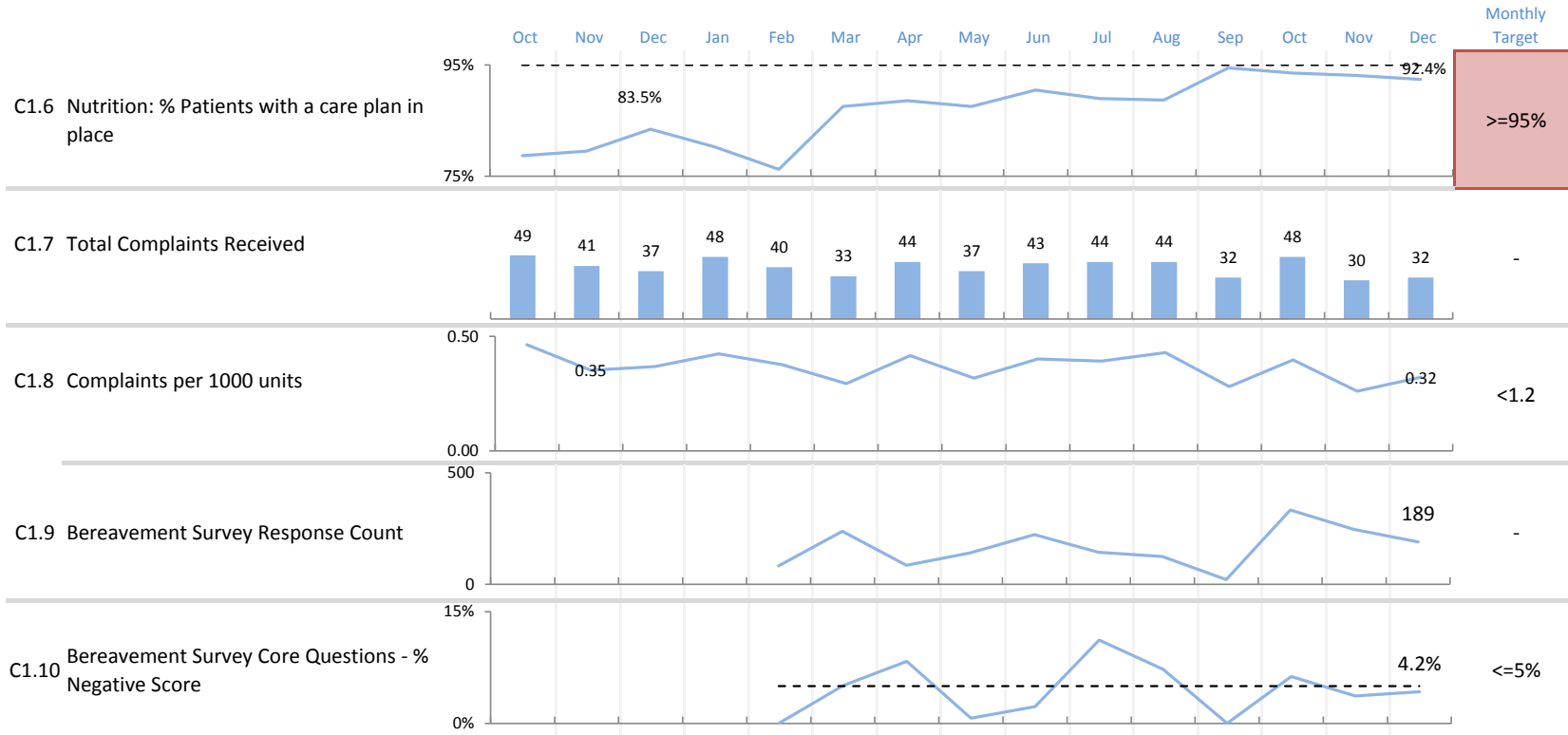


FFT response rate for inpatients continues to be under target, but scores are positive. Other FFT indicators are within target range. Mixed-sex accommodation breaches are under target for second consecutive month. Complaints have dropped in number for November and December with no significant variation in the rate of complaints per 1000 units.



C1.1 FFT response rates are below the trust target, although there has been a trust-wide increase in specialised patient surveys. This reflects the emphasis on getting qualitative feedback that can direct quality improvement. A focus on improving overall response rates is being delayed until a new patient survey contract is in place in May, to ensure any changes or communication materials are compatible with a possible new platform.



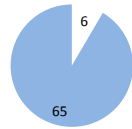




There were five national reports published and reviewed in December, of these reports one raised an area of concern (National Asthma and COPD audit programme). There are now 214 outcomes being reported to TEC from 45 specialities. Of these, 200 have been graded, with the majority being green (75%) and only 8% graded red. Emergency readmissions was at 11.8% in December which is higher than normal but not outside expected variation seen over the last 2 years. HSMR continues to drop and is well below the national benchmark and crude mortality remains low at 3.9%

Quality Accounts 18/19

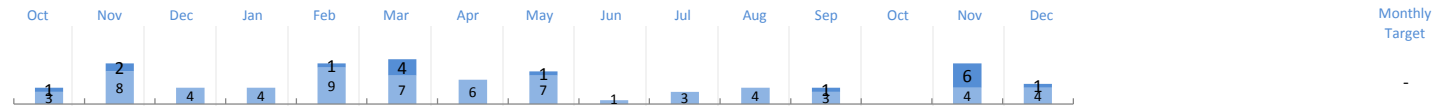
E1.1 Participation in eligible National Audits & NCEPOD* studies



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

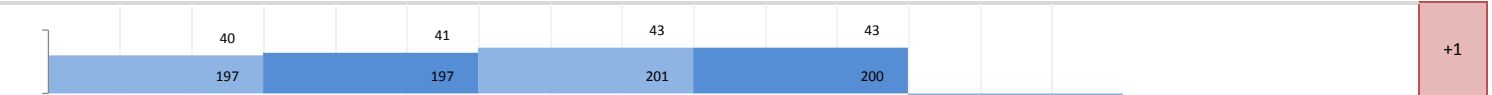
E1.2 Number of recently published National Audit reports (with areas of concern - dark blue)



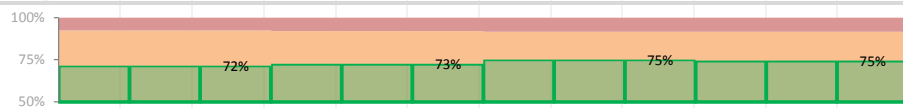
(1) National Asthma and COPD Audit Programme (NACAP) Best Practice Tariff Q2 2018-19, (2) National Vasacular Registry Annual Report 2018 (data from 2017 with some aspects taken from 2015-2017), (3) National Hip Fracture Database (NHFD) Report 2018 (data January to December 2017), (4) Cystic Fibrosis paed and adults 2018 Report (data 2017), (5) National Bowel Cancer Audit Annual; Report 2018 (data 1 April -16 - 31 March 17)
 Area of concern relates to: (1) National Asthma and COPD Audit Programme (NACAP) Best Practice Tariff (BPT) Q2 2018-19: improved in 2/3 aspects (Specialist Respiratory Review and Discharge Care Bundle, however although improved since Q1, we are still not meeting the Specialist Respiratory Review within 24 hours of admission) but still overall failing to achieve the BPT. The Lead is attending Quality Committee in January following COSG report.

Outcomes

E1.3 Cumulative Specialities with Outcome Measures Developed

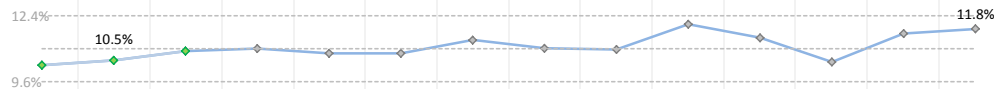


E1.4 Developed Outcomes RAG ratings



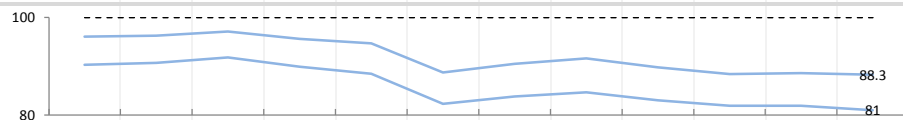
E1.4 - There are now 214 outcomes being reported to TEC from 45 specialities. Of these, 200 have been graded, with the majority being green (75%) and only 8% graded red. Of those graded as red, these relate to: Emergency surgery - post op assessment by elderly care, Theatres - Compliance with stop points for safety in theatres, Rheumatology – Compliance with NICE Quality Standard relating to referral and treatment, Respiratory Medicine – Chronic Obstructive Pulmonary Disease (COPD) readmission rates, Pathology - turnaround times for specimen reporting, Pharmacy – Discharge medicines turnaround times, Cardiology - patients with STEMI receiving Percutaneous coronary intervention (PCI) within 150 minutes, Trauma and Orthopaedics – knee revision rates and major trauma Patient Reported Outcome Measures (PROMS) / consultant on arrival. All areas which have a red outcome have actions in place to improve on these. Further information can be found in the Q1 18-19 effectiveness report. There were no reports published in October.

E1.5 Emergency Readmissions

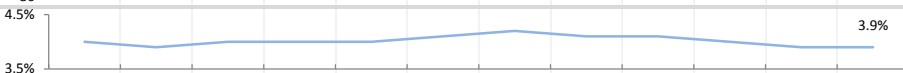


HSMR

E1.6 HSMR - UHS
HSMR - SGH



E1.7 HSMR - Crude Mortality



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

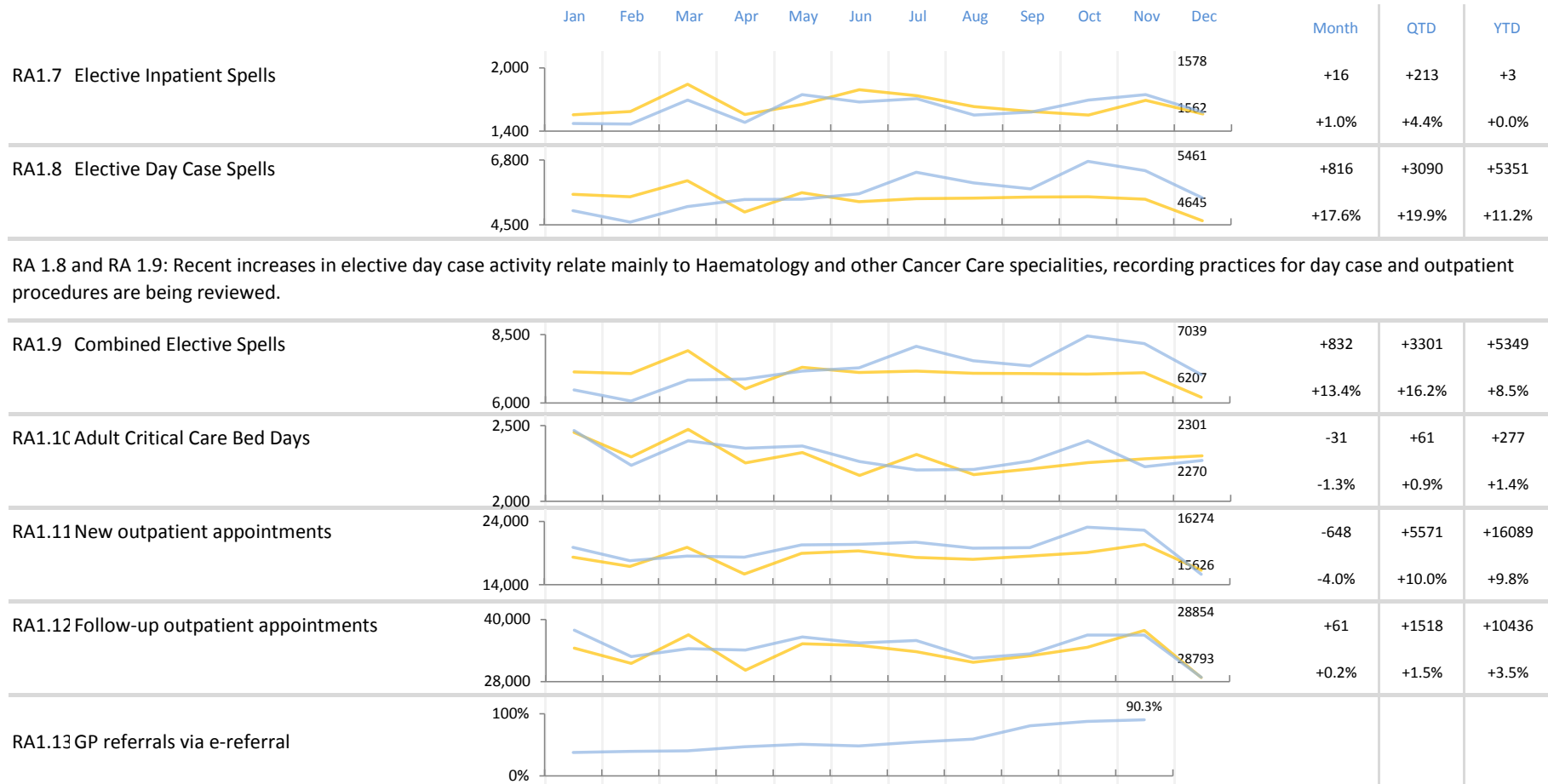


Two week wait cancer referrals remained high in October and are 6.5% higher year to date and number of first cancer treatments is up 9.1% year to date. Main ED attendances remain high however have not shown the same year on year growth compared to previous months. There have been a number of changes 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).



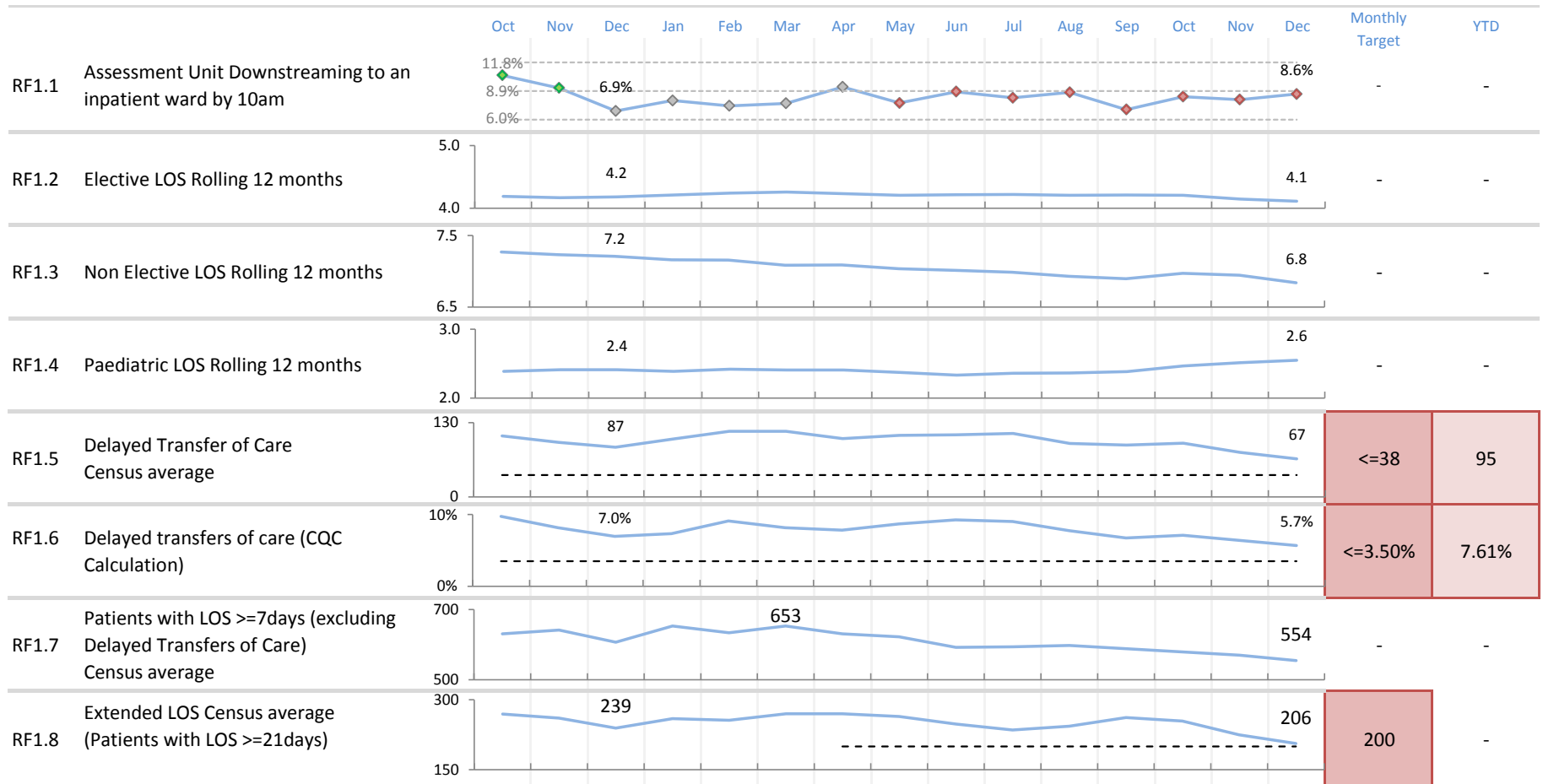
RA1.6: Operational practice change in counting and coding means that patients who move from ED to the CDU chair area only (not passing through CDU ward areas), are no longer being counted or billed as non-elective spells, resulting in a reduction in approx. 400 spells a month. Change in recording of metric from August 17 giving expected reduction.



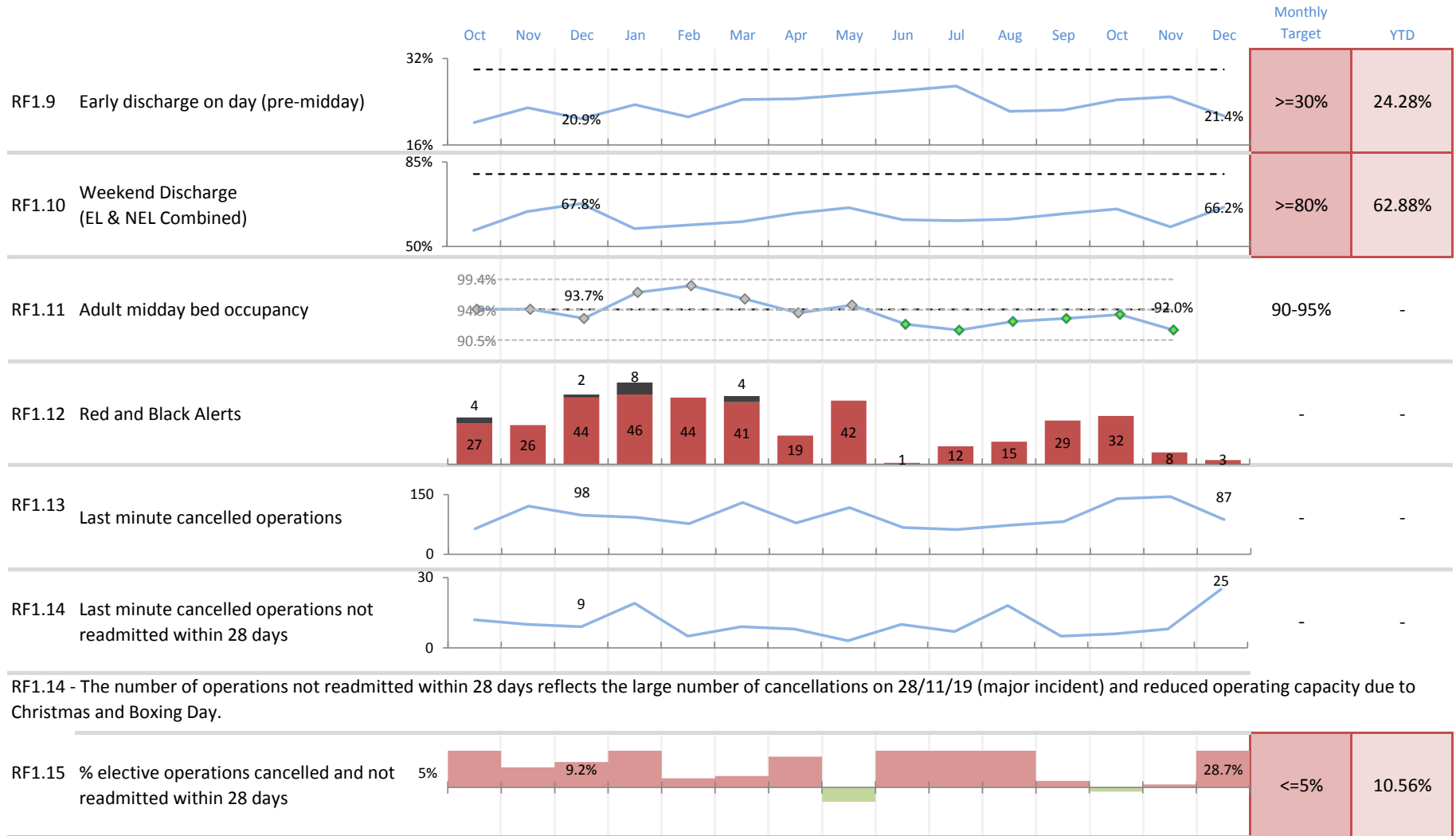


Amber

The number of Delayed Transfers of Care in the Trust continued to trend downwards and in December were lower than the previous 15 months at an average of 67. The number of patients who have been in hospital for greater than or equal to 7 days shows a continued improvement decreasing in December to a total of 554 and patients with a length of stay greater or equal to 21 days has decreased also to 206, a 14% reduction on the same time last year. Early discharge on the day (pre-midday) in December reduced to 21.4% (target 30%).



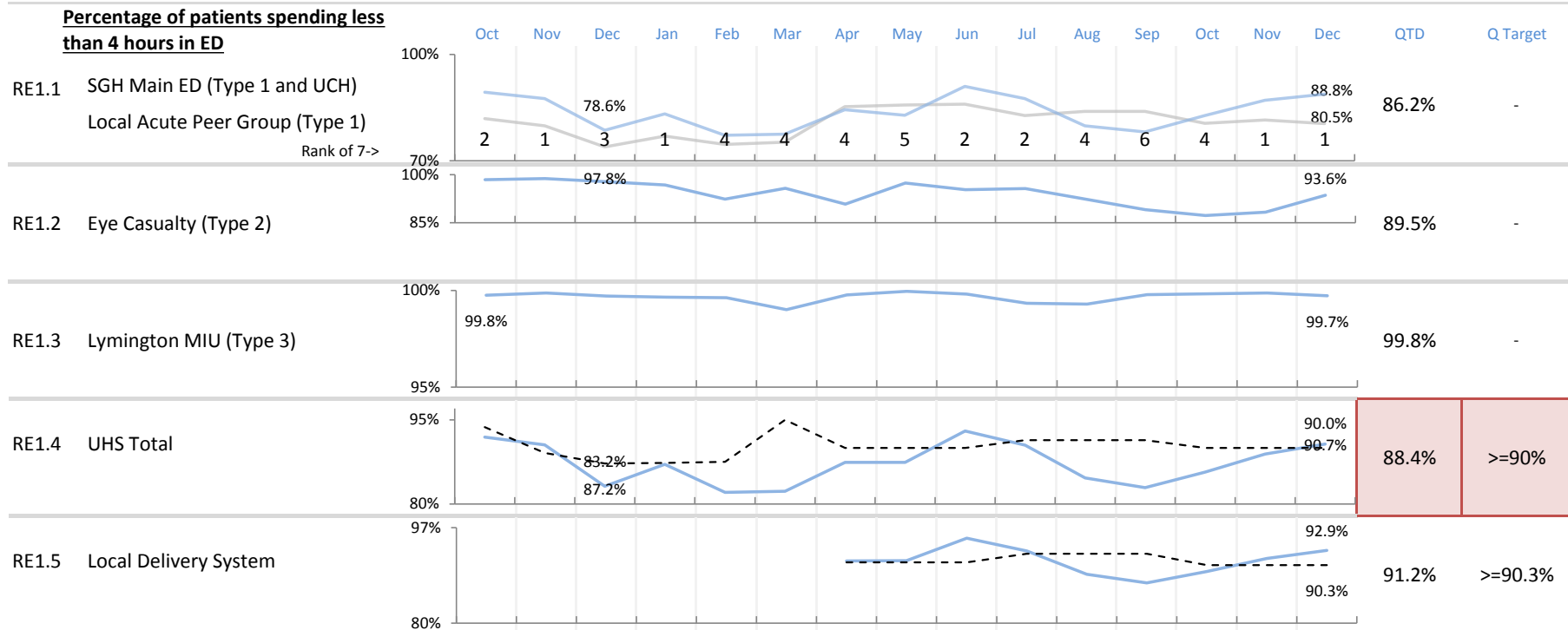
■ Current Data ■ Benchmark
■ Previous Year ■ Target



■ Current Data ■ Benchmark
■ Previous Year ■ Target

Amber

Main ED (Type 1) performance was 8.3% above the average of our local peer group. Eye casualty (Type 2) performance is still an area of concern but has shown improvement in December, now at 93.6%. Lymington MIU (Type 3) remains at a high level of performance (99.7%) and as a local delivery system we achieved the PSF threshold of 90.3% for Q3, also due to the overall local delivery system year to date performance we have regained the PSF target for Q2.



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



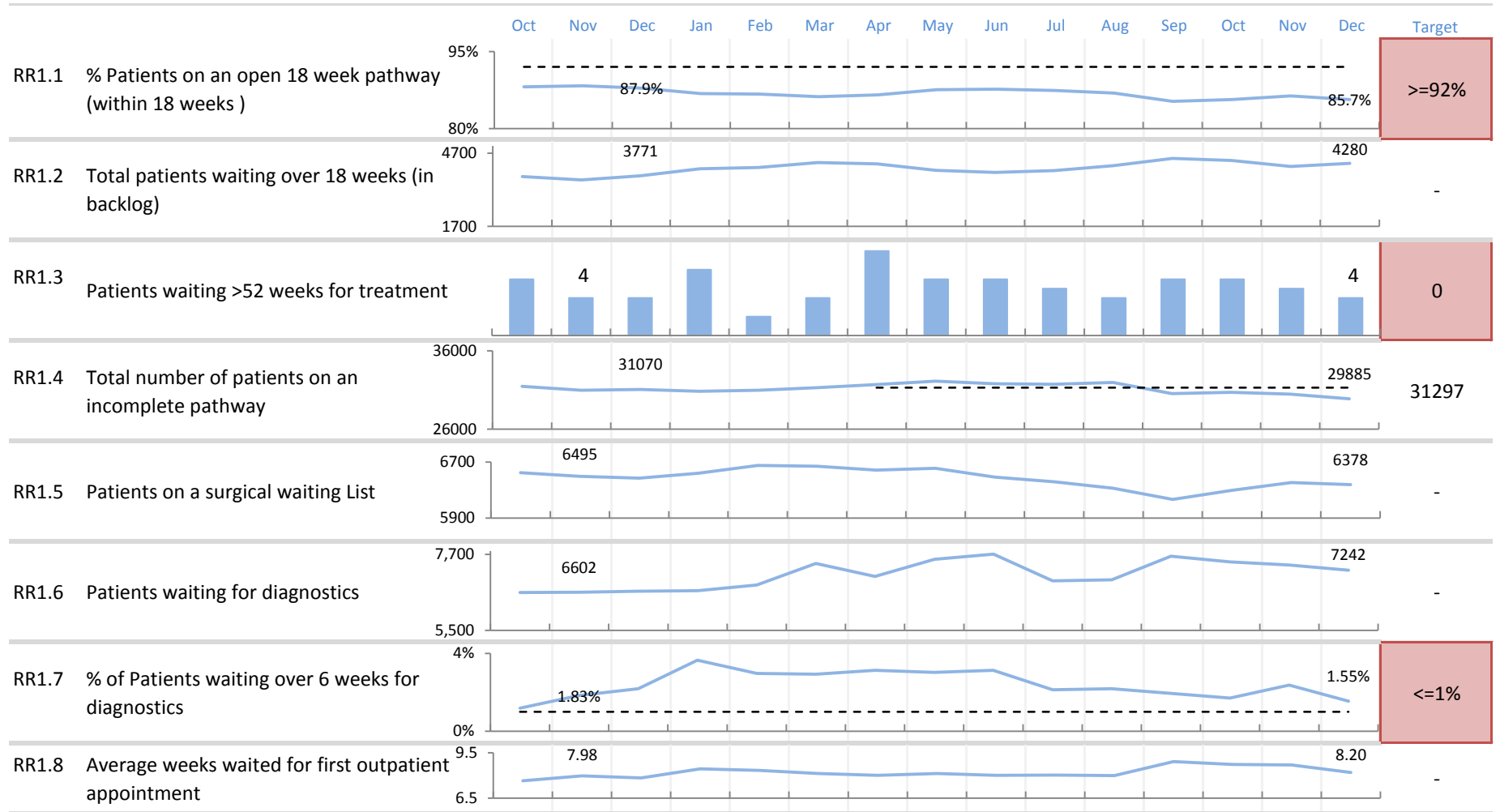


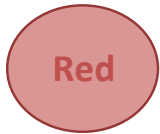
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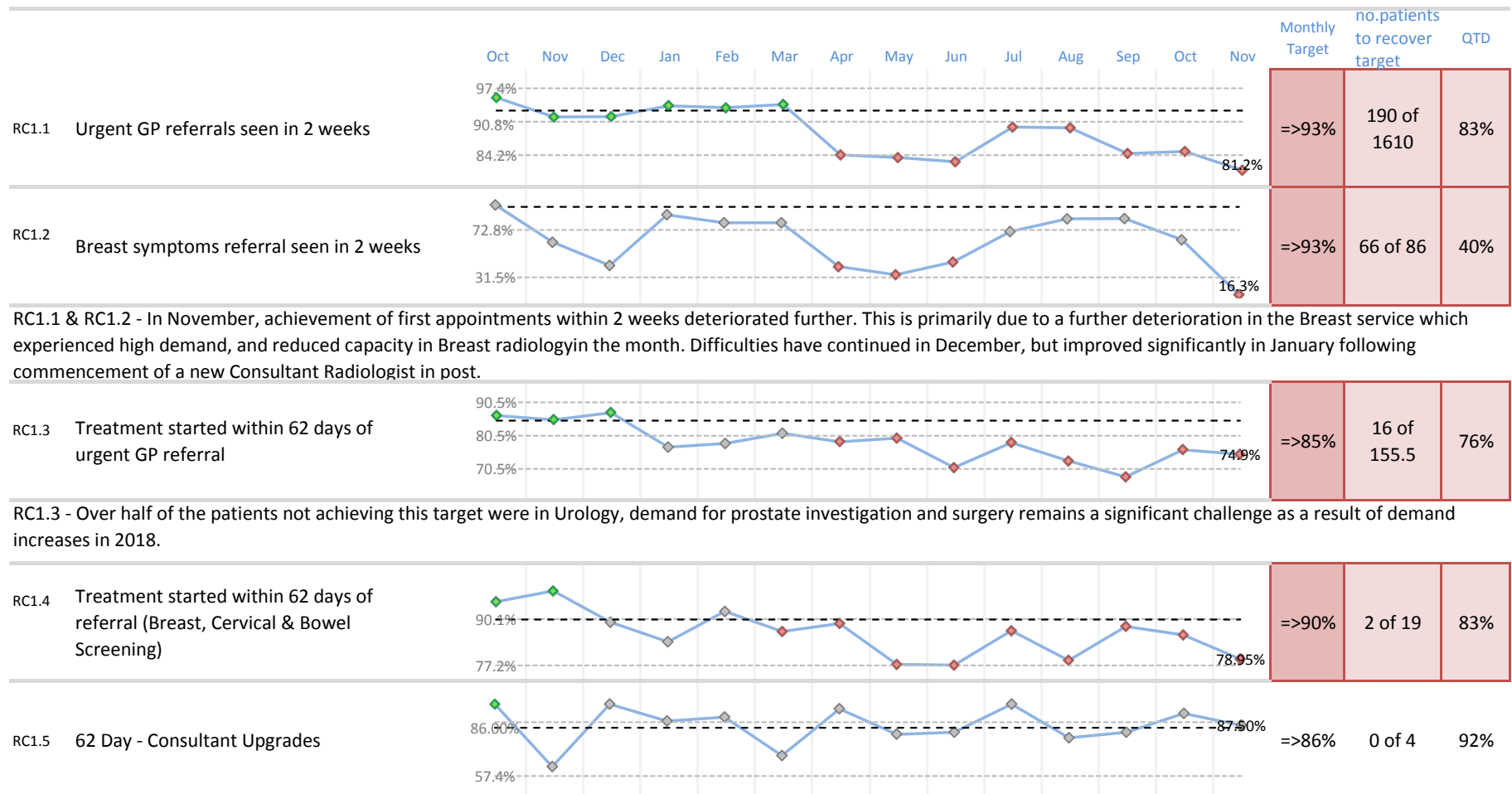
Red

In November a material improvement was achieved in the number of RTT patients waiting over 18 weeks, December has seen a deterioration partly as a result of lower activity levels during December. The total size of the waiting list has remained within the national operating plan target and is decreasing. Diagnostic patients waiting >6 weeks reduced to the lowest levels in 12 months. Further improvements are still important.

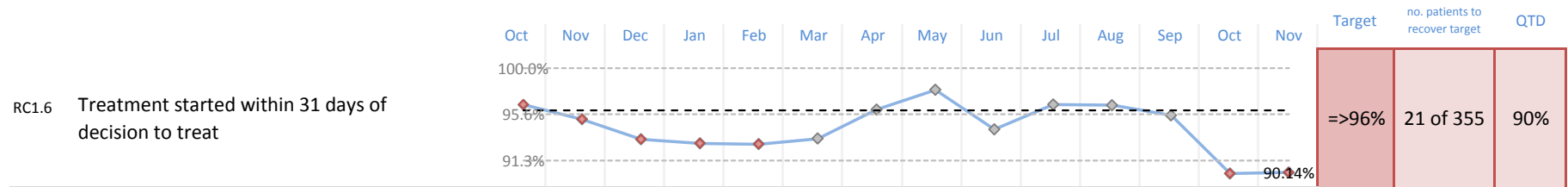




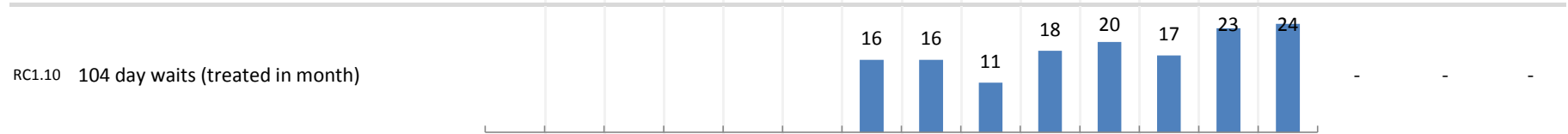
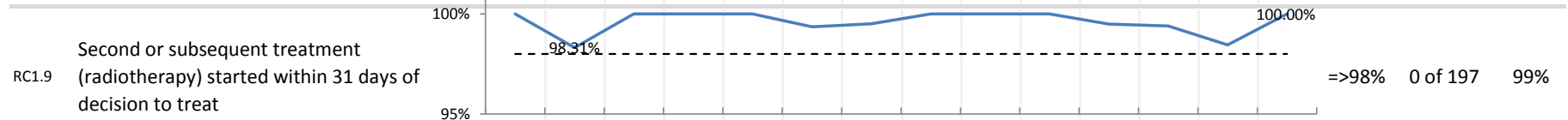
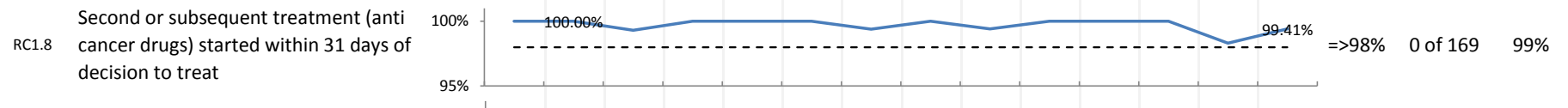
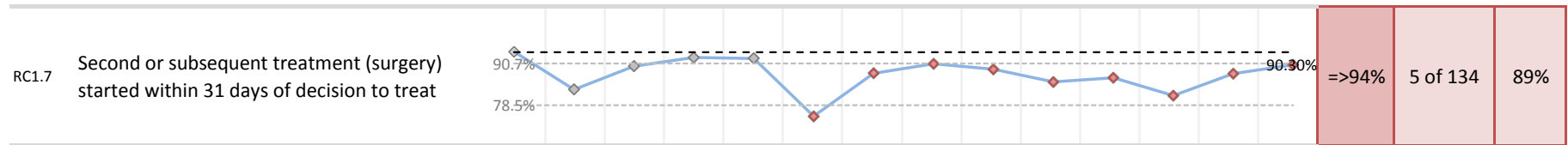
Cancer performance is currently rated red as we are not achieving a number of measures. Recovery of the Treatment started within 62 days of urgent GP referral wait, is likely to be slow and significant challenges are being experienced linked to significant growth in referrals and the number of additional cancers being treated (250 year to date).



■ Current Data ■ Benchmark
■ Previous Year Target



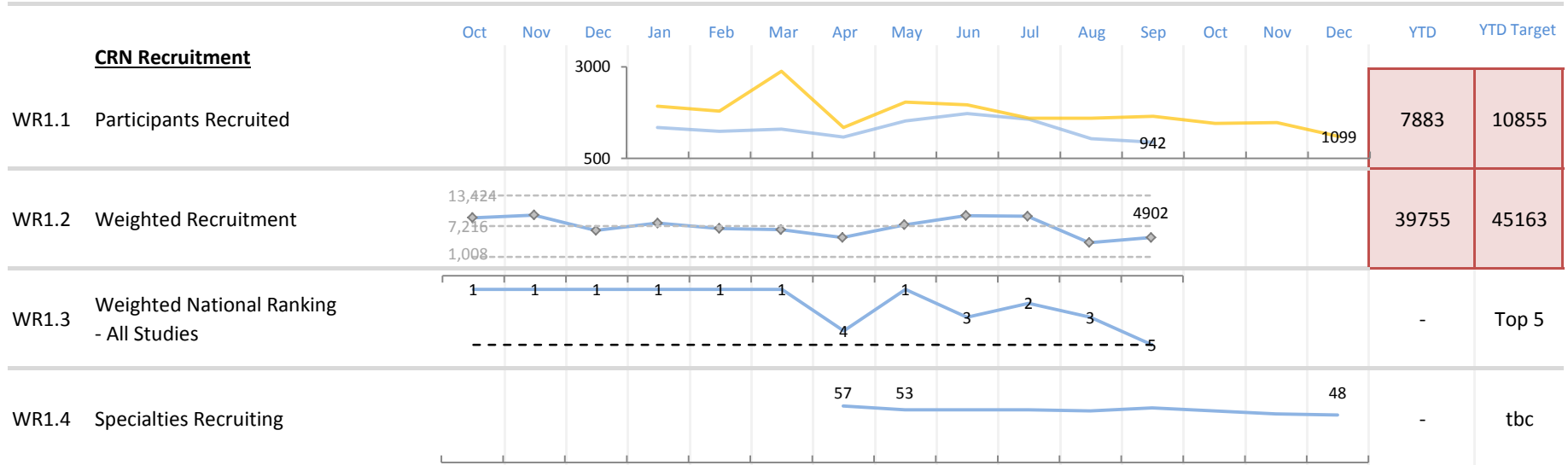
RC1.6 Performance adversely impacted in November by an exceptionally high number of target breaches in Breast Surgery, and in Prostate Surgery.



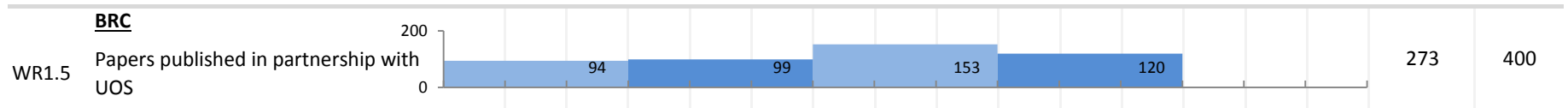
Principal reasons impacting RC1.10 are prostate surgery (same as RC1.3 & RC1.7), also late referrals of patients referred from other trusts and extended waits due to patient choice.



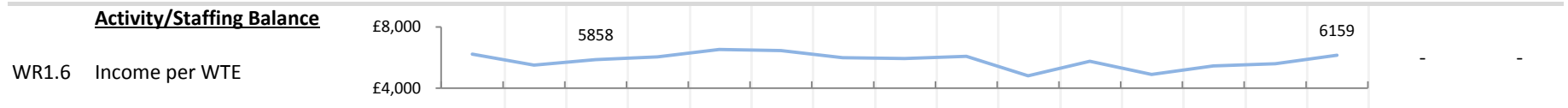
Research and Development has been rated Amber this month. Absolute recruitment is comparable to last year minus the patients recruited to one large study which has now ended. Whilst absolute recruitment is less than last year, when adjusted for complexity (weighted) performance is satisfactory. Forecasting to year end indicates performance will be close to target.



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.

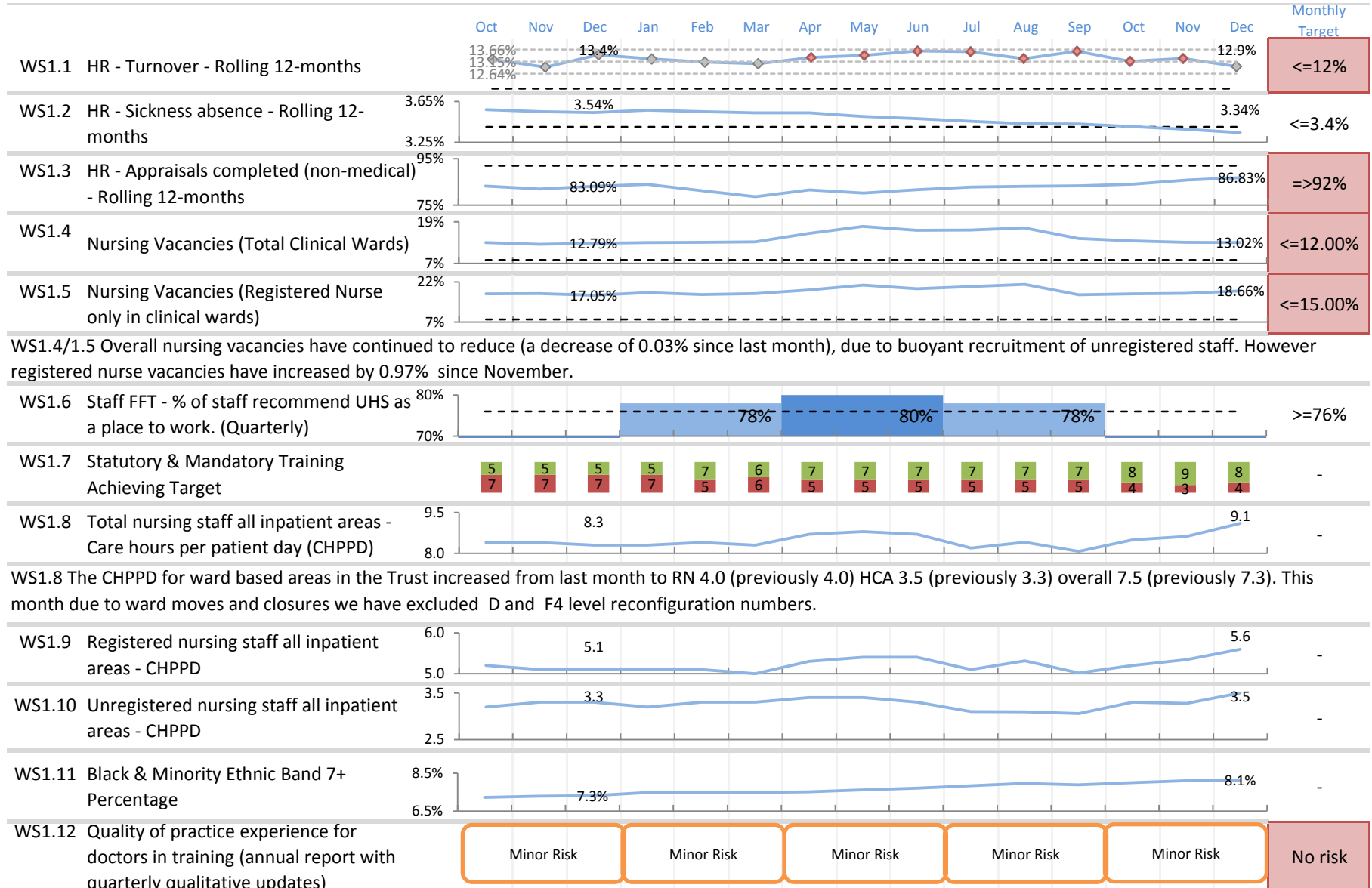


Number of BRC papers published are in line with expectations and more detailed analysis is informing the next BRC bid preparations.



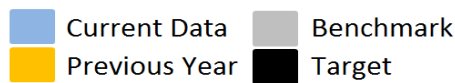
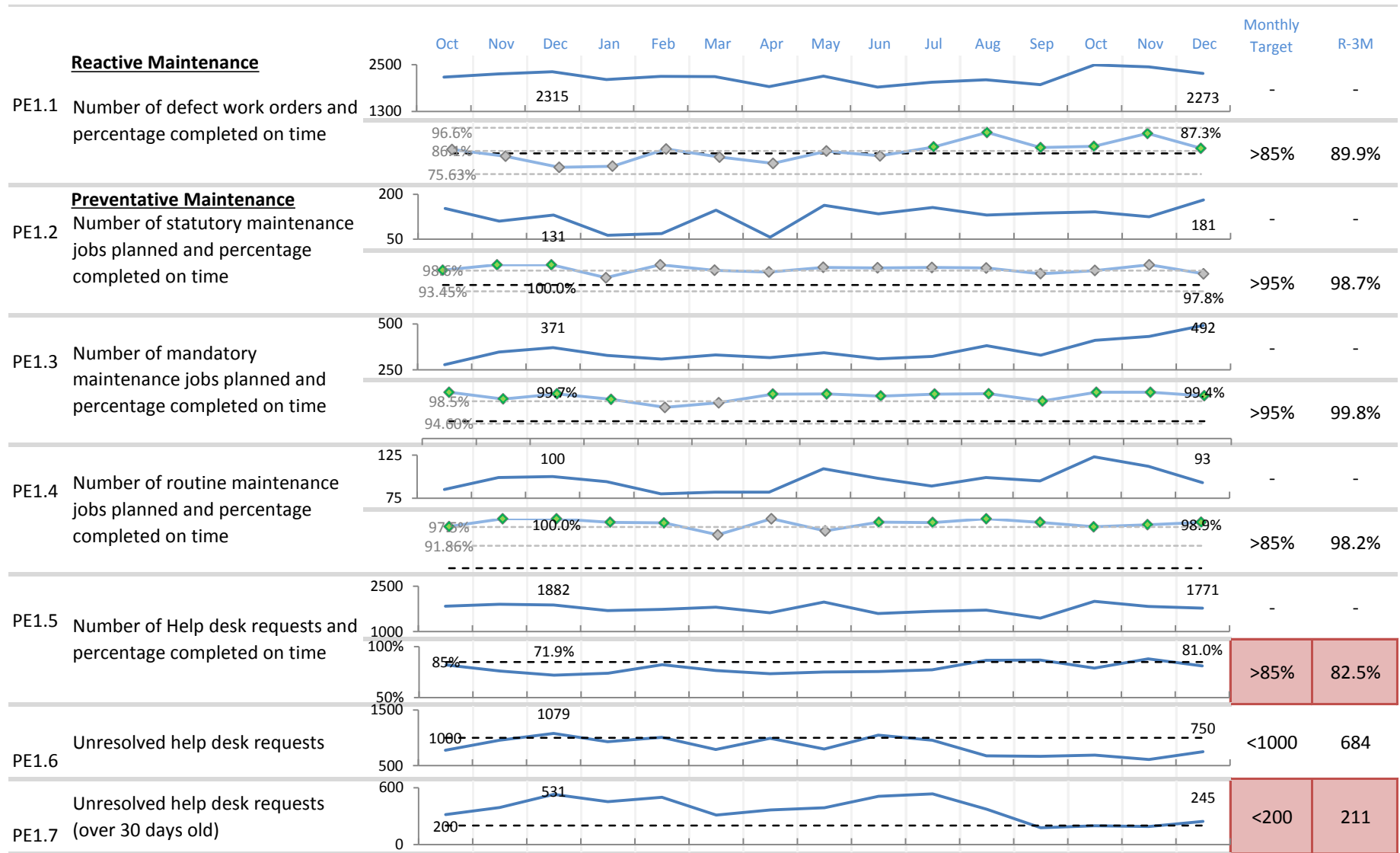


Staffing has been rated amber this month because we have missed some KPIs including those relating to overall staff turnover, nursing vacancy and appraisal completion rates. There have been improvements in total turnover rates, appraisal completions and overall nursing vacancy rates, however registered nurse vacancy rates have increased by 0.97% since November. The sickness target has again been achieved, with a fourth consecutive reduction this month. Care Hours Per Patient day is uncharacteristically high due to low patient numbers and acuity.



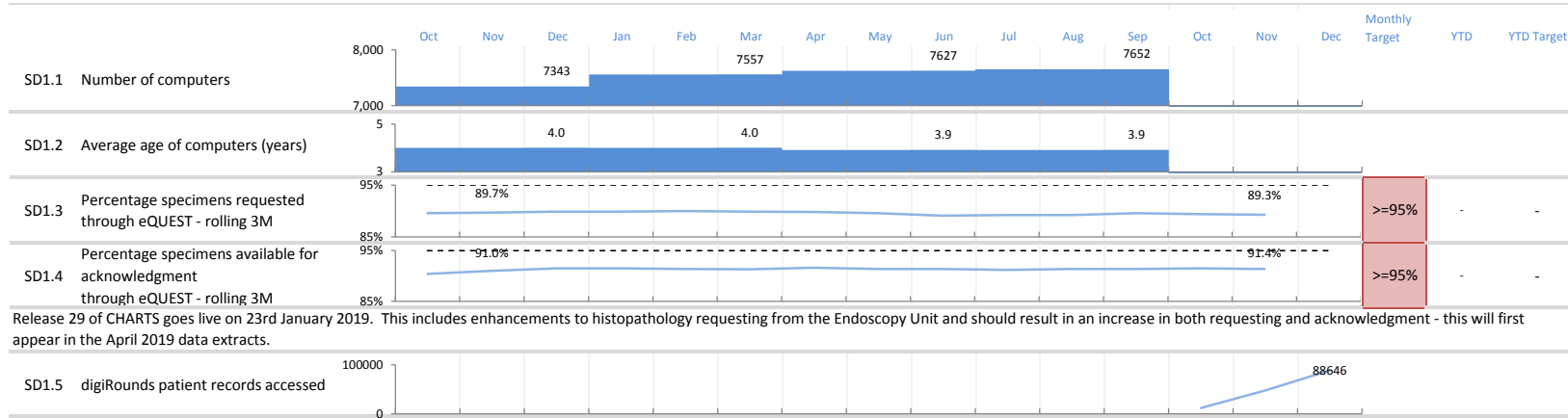


Estates has been rated green this month as we are meeting targets for most KPIs in December. The targets missed this month are for percentage of help desk requests completed on time and Unresolved help desk requests (over 30 days old).



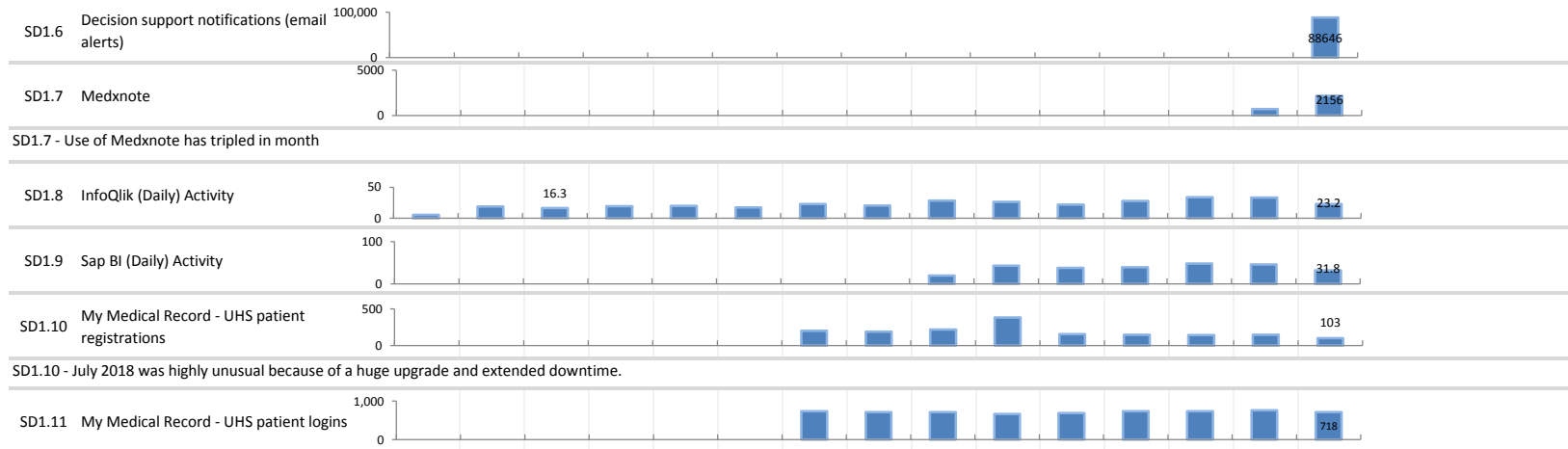


DigiRounds has demonstrated both time saving in reviewing the patient record during ward rounds, but also the quality of the review that is carried out, as clinicians are able to easily see all the significant elements of the record. It saves junior doctors time in preparing information for consultants (transcribing relevant results etc) prior to the ward round. Records accessed using DigiRounds increased to 88,646 in December. Also in DEcember the number of alerts sent using Medxnote tripled to 2156.



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



Quarterly Patient Experience Summary

Board summary

- The trust continues to struggle meeting both the 35 working day target for complaints overall and the 66% target for complaints closed within this time. In Q2, 55% of complaints were closed within 35 days.
- The biggest contributing factor to breached complaints remains delays in receiving statements from contributors.
- A quality improvement project has commenced that will review and redesign the complaints process, working with both staff and patients to co-design and co-produce something that is more effective and engaging in managing and responding to complaints.
- The trust's approach to collecting patient feedback continues to develop beyond focusing purely on FFT. 19 local surveys have come through the team's approval group in the period. These surveys are collecting more detailed feedback from patients using particular services.
- The trust performed well overall in two national surveys, results of which were published in the reporting period: 2017 national cancer patient survey and a quarterly national congenital heart disease survey
- Staff reasons for recommending care at UHS continue to be largely based on their view of the quality of care, their colleagues, and the organisation itself.
- Progress is being made in the Accessible Information Standard exemplar project. A central hub of resources is now available on Staffnet, while a electronic flag alert will be launched late January.
- Carer experience is generally favourable, and local carer organisations have been engaged with and have a bigger presence at the trust. Head of Patient Experience and ED matron participating in council-run project to ensure that carer emergency plans can be put into action should carers be unexpectedly admitted to UHS.
- Unsuccessful bid for further HelpForce funding to continue the mobility volunteer project has impacted plans to develop the project further. However there has been an increase in volunteer-patient contacts in the period, with our PAT dog team in particular reaching many more patients.

Executive Summary

- 1.1 The use of O positive blood for males over 18 will roll out trust wide in December following a successful pilot in ED. This will help to mitigate the national shortage of O negative blood for use in emergencies.
- 1.2 No Never Events were reported in this quarter however it should be noted that 2 were reported in December. One of these was in cardiac surgery and one was in Ophthalmology. Both are currently being investigated to identify learning.
- 1.3 UHS has reviewed the report by the Gosport Independent Panel which seeks to address concerns raised by families over a number of years about the initial care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths is being reviewed by UHS, a paper went to Trust Board in October. In November the Government released its response to the Gosport Independent Panel – no further actions identified for UHS.
- 1.4 In June NSHI released recommendations on Pressure ulcers: revised definition and measurement. UHS are broadly compliant currently, and the Lead Tissue Viability Nurse (TVN) and Div. A Divisional Head of Nursing (DHN) attended a Wessex wide meeting to ensure all local trusts are working collaboratively and ensuring a consistent approach to reporting pressure ulcers. The new terminology will be implemented in April 2019.
- 1.5 SISG escalations to QGSG included access to GA MRI's for paediatrics and the roll out of e-TCI for Surgery.
- 1.6 There were 14 new SIRI cases reported to SISG and 1 infection prevention SIRI - Neurosciences CJD.
- 1.7 Favourable event reporting roll out continues and the numbers reported are steadily increasing. Work is underway to try and link these with Hospital Heroes.
- 1.8** During September, October and November the trust continued to fail to achieve the 95% target for completion of Venous Thromboembolism (VTE) risk assessments. An IT solution has been developed to remind and assist doctors to complete the VTE risk assessment before medication can be prescribed when entering JAC from Charts. After completion of the risk assessment the user will be taken directly to JAC. This will be rolled out initially on AMU and Trauma & Orthopaedics with the proposed go live date of 24th January 2019.
- 1.9** Work is underway to standardise the review of harm for patients on RTT or cancer pathways who are waiting for treatment outside of agreed national standards.
- 1.10 The Safety rules project collaboratively run by UHS and the University of Southampton looked at understanding better why safety rules (e.g. protocols and checklists) are not always followed during invasive procedures. it's the findings and recommendations are now being considered to identify how we could reduce Never Events and make patient care safer during invasive procedures.
- 1.11 A Lying and standing blood pressure (BP) audit is currently underway, and initial actions are in progress (working with the safetrack team to ensure the 'clinical reasons' option for not completing a lying and standing BP are legitimate. The audit is due to be completed by the end of January. Divisions are asked to ensure that all areas have sufficient equipment e.g. stethoscopes to undertake lying and standing BP's.
- 1.12 Updated NICE VTE prophylaxis guideline with significant changes to recommendations was published in March 2018. Several changes in the guideline are being challenged on a national level. Gap analysis completed and work on updating UHS guidance is under way.
- 1.13 The pharmacy team have been relatively consistently reconciling greater than 80% of patients within 48 hours. This can partly be attributed to the increase in the ward based service at the weekends and during bank holidays. Alongside service to new areas such as maternity
- 1.14 There is a continuing risk that the sepsis 2018/19 CQUIN for delivery of antibiotics may not be fully achieved. Whilst we currently only have 82% compliance within 1 hour most of the patients receive antibiotics within 2 hours. At present there is limited evidence to support antibiotics within 60 minutes, but as an organisation we continue to strive to achieve this.
- 1.15 Southampton City CCG are funding a Acute Kidney Injury (AKI) nurse led follow up clinic as one of their 2019/2020 QUIPPs

1.16 Following a successful trial of the electronic urinalysis analysers a bid was put in through the new charitable fund process to fund the first wave of this project. This has been successful and is waiting for funds to be allocated to allow the roll out to begin. This has been through the trust procurement process and the AKI team have been working with the IT/ GDE teams to ensure that the technology will correctly interface with the trust IT systems. It is estimated that it will be rolled out across the phase 1 wards (admission areas & critical care) by the end of Q4.

Patient safety dashboard

Work Stream	Indicator	Annual Target	Sep-18	Oct-18	Nov-18	QTD	YTD
High Harm Falls	High Harm Avoidable Falls	3	0	0	0	0	0
	Total High Harm Falls	55	2	1	1	2	16
Pressure Ulcers	Avoidable grade 3 & 4 pressure ulcers	16	2	2	1	3	14
	Grade 2 pressure ulcers	84	9	16	11	27	85
VTE	% of patients that have a VTE risk assessment upon admission	>=95%	91.39%	89.72%	86.96%	88.43%	91.40%
	% of patients that receive appropriate thromboprophylaxis (taken from Safety Thermometer)	>=95%	91.21%	89.75%	95.20%	92.45%	92.96%
Safety Thermometer	Harm Free Care	>=95%	97.09%	97.29%	97.65%	97.47%	97.59%
Medication Errors	A reduction in the number of medication related incidents that occur as a result of a failing in the discharge process	Reduction	Increase	Decreased			
	80% of medicine reconciliations within 48 hours of admission	80% reduction	84	81	82		
	Decrease of inappropriately omitted doses to less than 3%	<=3%	2.4	2.5	2.7		
Infection Prevention & Control	MRSA post 48 hour cases	0	0	0	0	0	1
	C difficile cases	43	1	2	5	7	25
SIRIs	Never Events	0	0	0	0	0	1
	95% SIRIs Reported within 2 working days	>=95%	83.33%	90.91%	83.33%	88.24%	90.14%
	SIRIs overdue by 60 days	0	1	1	6	7	20
Incident Reporting	Incidents per 1000 bed days	>35	44.55				
	% of incidents identified as moderate and over	<=4%	3.56%	3.96%	5.24%	4.58%	3.65%

Quarterly Patient Safety Report Sep 18 – Nov 18

Sepsis	90% of patients appropriately screened on admission in ED, AMU, ASU and PAU	90%
	90% of patients with red flag sepsis in ED, AMU, ASU and PAU receive IVAB within 60 minutes of admission and have an empiric review within 72 hours of prescribing antibiotics	90%
	90% of patients who meet criteria for sepsis screening were screened for sepsis for all acute inpatient wards	90%
	90% of patients with red flag sepsis receive timely antibiotics (60 minutes for new admissions or 90 minutes for existing inpatients) and have an empiric review within 72 hours of prescribing antibiotics	90%

Q1	Q2	Q3	Q4
94%	99%		
92%	80%		
76%	97%		
76%	86%		

Nursing and midwifery staffing hours - December 2018

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.

During December 2018 there were a number of ward reconfigurations and service reductions which have affected the reliability of some of the figures. For this reason the new ward of D9 which opened at the end of December and F4 ward, which transferred to Cardiac services for part of the month have been excluded from the data.

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	1472.5	1267.7	1059.1	1102.4	86.1%	104.1%	3.9	3.2	7.1	Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing.
C4 (Solent ward)	Night	1070.0	1025.4	701.5	763.3	95.8%	108.8%				Safe staffing levels maintained.
C6	Day	2879.1	2477.0	146.6	225.1	86.0%	153.5%	7.4	0.6	8.1	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
C6	Night	2004.3	1886.0	0.0	143.8	94.1%	Shift N/A				Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	765.4	545.5	364.7	89.3	71.3%	24.5%	7.6	0.7	8.3	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
C6 (Teenage Cancer Trust unit)	Night	673.0	481.0	0.0	11.0	71.5%	Shift N/A				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
D2	Day	1342.4	1356.9	1113.7	1128.6	101.1%	101.3%	4.3	3.5	7.7	Safe staffing levels maintained.
D2	Night	1069.8	1000.5	713.0	771.8	93.5%	108.2%				Safe staffing levels maintained.
D3	Day	1664.2	1553.7	765.0	924.7	93.4%	120.9%	4.1	2.7	6.8	Safe staffing levels maintained.
D3	Night	1046.3	1035.8	697.5	787.5	99.0%	112.9%				Safe staffing levels maintained.
Surgical high dependency unit	Day	2091.3	1912.7	387.2	399.3	91.5%	103.1%	16.4	3.4	19.8	Beds flexed to match staffing.
Surgical high dependency unit	Night	2024.0	1847.2	356.5	372.2	91.3%	104.4%				Beds flexed to match staffing.
Cardiac intensive care unit	Day	5334.8	4799.3	1261.5	548.2	90.0%	43.5%	27.1	2.9	30.0	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
Cardiac intensive care unit	Night	5210.0	4437.5	869.0	440.5	85.2%	50.7%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
General intensive care unit A	Day	4658.1	4341.1	981.4	559.7	93.2%	57.0%	23.4	2.8	26.2	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
General intensive care unit A	Night	4261.8	4045.8	712.0	447.5	94.9%	62.9%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
General intensive care unit B	Day	4139.0	3907.8	597.7	415.7	94.4%	69.6%	28.0	2.6	30.6	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
General intensive care unit B	Night	3917.5	3875.3	356.5	310.5	98.9%	87.1%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
Neuro intensive care unit	Day	4860.0	4819.7	784.1	566.7	99.2%	72.3%	27.2	3.5	30.7	Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
Neuro intensive care unit	Night	4250.0	4221.8	640.5	609.0	99.3%	95.1%				Beds flexed to match staffing; Safe staffing levels maintained by sharing staff resource.
E5A	Day	1243.4	1028.2	695.5	888.2	82.7%	127.7%	3.7	3.2	6.9	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
E5A	Night	713.0	655.5	356.5	605.5	91.9%	169.8%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.

E5B	Day	1429.0	1152.0	819.5	658.0	80.6%	80.3%	3.9	2.5	6.4	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
E5B	Night	714.0	669.0	345.0	518.0	93.7%	150.1%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
E8	Day	1837.0	1600.0	1630.1	1714.5	87.1%	105.2%	3.2	3.6	6.8	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
E8	Night	1059.0	922.5	941.5	1178.5	87.1%	125.2%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
F11	Day	2090.8	1452.4	821.2	661.9	69.5%	80.6%	4.3	2.4	6.7	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Night	1069.5	782.0	356.5	597.0	73.1%	167.5%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Day	2275.4	1661.8	629.1	1090.0	73.0%	173.3%	3.4	2.5	5.9	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
F6	Night	1068.5	977.0	704.5	849.3	91.4%	120.5%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
F5	Day	2039.9	1283.3	948.4	1481.2	62.9%	156.2%	3.2	3.8	7.0	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
F5	Night	1081.5	895.5	708.5	1076.5	82.8%	151.9%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
Acute medical unit	Day	4461.3	3805.3	2985.9	3465.2	85.3%	116.1%	5.5	4.5	9.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
Acute medical unit	Night	3523.8	3175.5	2015.0	2208.4	90.1%	109.6%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
D5	Day	1846.9	1171.6	1036.6	1615.6	63.4%	155.9%	2.4	3.3	5.7	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D5	Night	1073.8	786.0	589.0	1119.8	73.2%	190.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D6	Day	1760.5	1385.0	1857.2	1976.0	78.7%	106.4%	2.8	3.3	6.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D6	Night	1425.5	1161.0	713.0	972.0	81.4%	136.3%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D7	Day	1962.8	1468.1	1008.3	1540.5	74.8%	152.8%	3.2	3.6	6.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D7	Night	1073.0	1097.0	590.0	1299.8	102.2%	220.3%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D8	Day	1771.7	1141.7	980.9	1747.9	64.4%	178.2%	2.3	3.7	6.1	Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
D8	Night	1058.0	749.5	589.3	1258.3	70.8%	213.5%				Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
E7	Day	1489.2	1025.2	855.0	1317.2	68.8%	154.1%	3.0	3.7	6.6	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
E7	Night	702.0	737.3	713.0	873.5	105.0%	122.5%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
Respiratory high dependency unit	Day	2381.5	1178.0	298.0	579.4	49.5%	194.4%	11.6	5.3	16.8	Staffing appropriate for number and acuity level of patients; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Respiratory high dependency unit	Night	2139.5	1220.3	351.0	507.7	57.0%	144.7%				Staffing appropriate for number and acuity level of patients; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
C5	Day	1058.3	847.5	754.6	683.3	80.1%	90.5%	3.9	2.6	6.5	Safe staffing levels maintained by sharing staff resource; Non-ward based staff supporting areas; Staff moved to support other wards; Discussions with divisional head of nursing re ongoing sickness within CS.
C5	Night	713.0	678.5	356.5	361.5	95.2%	101.4%				Safe staffing levels maintained by sharing staff resource.
D10	Day	1613.0	856.5	1104.5	1418.8	53.1%	128.5%	3.0	4.0	6.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
D10	Night	712.5	696.5	1069.5	632.5	97.8%	59.1%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
F7	Day	748.9	758.7	1290.6	1241.1	101.3%	96.2%	2.4	3.2	5.6	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
F7	Night	667.0	718.0	714.0	714.0	107.6%	100.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G5	Day	1093.2	1076.0	1833.4	1881.9	98.4%	102.6%	2.2	3.6	5.8	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G5	Night	713.0	697.0	713.0	1041.0	97.8%	146.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G6	Day	1082.5	1067.9	1793.7	1967.2	98.7%	109.7%	2.4	4.1	6.5	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G6	Night	714.0	713.8	1067.0	1009.5	100.0%	94.6%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G7	Day	742.8	692.8	1479.5	1382.5	93.3%	93.4%	3.4	5.9	9.3	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G7	Night	701.5	713.0	1058.0	1082.0	101.6%	102.3%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G8	Day	1098.8	1081.8	1794.1	1676.9	98.5%	93.5%	2.1	3.3	5.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G8	Night	713.0	690.5	1069.5	1069.5	96.8%	100.0%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G9	Day	1088.3	1065.6	1949.0	1928.3	97.9%	98.9%	2.3	3.9	6.3	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
G9	Night	713.0	713.0	1081.0	1057.5	100.0%	97.8%				Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.

Paediatric high dependency unit	Day	1613.5	1091.2	0.0	0.0	67.6%	Shift N/A	13.3	0.0	13.3	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1069.5	1057.5	0.0	0.0	98.9%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	2406.8	1327.8	360.5	588.3	55.2%	163.2%	6.3	3.1	9.4	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric medical unit	Night	1991.3	1177.3	341.0	671.0	59.1%	196.8%				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.
Paediatric assessment unit	Day	1336.0	1212.0	509.0	349.5	90.7%	68.7%	13.2	2.4	15.6	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric assessment unit	Night	1077.0	1024.5	134.5	59.0	95.1%	43.9%				Safe staffing levels maintained; ; Minimal requirement for care support workers overnight.
Paediatric intensive care unit	Day	6088.5	5532.1	663.0	449.8	90.9%	67.8%	26.7	2.1	28.8	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5691.5	5449.8	529.0	414.0	95.8%	78.3%				Beds flexed to match staffing; Safe staffing levels maintained.
Piam Brown ward	Day	3090.5	2239.0	90.0	215.5	72.4%	239.4%	12.3	1.0	13.3	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Piam Brown ward	Night	1069.5	996.3	0.0	34.5	93.2%	Shift N/A				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
E1	Day	2148.3	1516.0	650.5	510.5	70.6%	78.5%	8.1	2.5	10.6	Beds flexed to match staffing; Non-ward based staff supporting areas; Safe staffing levels maintained; Band 4 working to support registered nurses.
E1	Night	1426.0	1278.0	368.0	360.0	89.6%	97.8%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G2	Day	782.4	767.0	0.0	0.0	98.0%	Shift N/A	9.3	0.0	9.3	Safe staffing levels maintained.
G2	Night	743.5	734.0	0.0	0.0	98.7%	Shift N/A				Safe staffing levels maintained.
G3	Day	2428.5	1623.5	1204.5	858.5	66.9%	71.3%	6.8	3.3	10.1	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Beds flexed to match staffing; safe staffing levels maintained.
G3	Night	1706.0	1236.5	682.0	511.8	72.5%	75.0%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G4	Day	2390.5	2268.3	1274.0	630.8	94.9%	49.5%	7.8	2.3	10.1	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained; Band 4 Vaccinics actively being recruited for.
G4	Night	1695.0	1488.5	682.0	451.0	87.8%	66.1%				Beds flexed to match staffing; Safe staffing levels maintained.
Bramshaw women's unit	Day	1437.9	1100.7	1233.5	1066.0	76.5%	86.4%	3.6	3.6	7.2	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained.
Bramshaw women's unit	Night	690.0	713.0	713.0	713.0	103.3%	100.0%				Safe staffing levels maintained.
Neonatal unit	Day	5771.5	4591.8	2283.0	1336.3	79.6%	58.5%	10.2	2.8	13.0	Safe staffing levels maintained; Number of cots adjusted to support safe staffing.
Neonatal unit	Night	4434.0	4273.2	1529.0	1105.0	96.4%	72.3%				Safe staffing levels maintained; Number of cots adjusted to support safe staffing.
Maternity service	Day	8104.7	7392.0	2696.8	2264.3	91.2%	84.0%	5.2	1.7	6.9	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5258.8	4797.3	1714.0	1748.8	91.2%	102.0%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Cardiac high dependency unit	Day	5003.3	4389.8	1469.3	920.7	87.7%	62.7%	14.9	3.4	18.2	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
Cardiac high dependency unit	Night	3761.8	3742.5	671.0	926.5	99.5%	138.1%				Additional staff used for enhanced care - Support workers.
Coronary care unit	Day	2025.6	1658.1	720.0	935.3	81.9%	129.9%	6.9	3.8	10.7	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Coronary care unit	Night	1364.0	1308.8	341.5	670.5	95.9%	196.3%				Support workers used to maintain staffing numbers; Increased night staffing to support raised acuity.
D4	Day	1916.8	943.5	819.0	1134.0	49.2%	138.5%	2.7	3.0	5.7	Band 4 staff working to support registered nurse numbers; Increased night staffing to support raised acuity.
D4	Night	787.0	582.3	682.0	609.0	74.0%	89.3%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
E2	Day	1601.0	1128.0	770.3	793.0	70.5%	103.0%	3.6	2.8	6.3	Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
E2	Night	715.0	694.8	341.0	614.0	97.2%	180.1%				Additional staff used for enhanced care - Support workers.
E3	Day	2910.7	1744.5	1337.5	1655.5	59.9%	123.8%	2.9	3.2	6.1	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E3	Night	1342.3	1241.0	1359.0	1604.3	92.5%	118.0%				Additional staff used for enhanced care - Support workers.
E4	Day	2183.4	1911.7	787.7	762.0	87.6%	96.7%	4.1	2.6	6.7	Band 4 staff working to support registered nurse numbers.
E4	Night	1023.0	1076.3	682.0	1131.5	105.2%	165.9%				Increased night staffing to support raised acuity; Additional staff used for enhanced care - Support workers.
Acute stroke unit	Day	1547.5	1683.5	2383.6	2581.1	108.8%	108.3%	3.2	4.7	7.9	Additional staff used for enhanced care - Support workers; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute stroke unit	Night	1012.0	990.0	1360.0	1393.0	97.8%	102.4%				Additional staff used for enhanced care - Support workers; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Day	1879.2	1187.4	433.0	495.2	63.2%	114.4%	13.0	7.7	20.8	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Night	682.0	496.0	583.0	501.0	72.7%	85.9%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.

E Neuro	Day	1941.0	1612.3	1075.5	1653.5	83.1%	153.7%	4.0	4.6	8.6	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Support workers used to maintain staffing numbers.
E Neuro	Night	1343.0	1155.0	1023.0	1506.8	86.0%	147.3%				Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Day	1165.5	925.5	476.0	732.5	79.4%	153.9%	7.3	6.6	13.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Additional staff used for enhanced care - Support workers.
Hyper acute stroke unit	Night	655.0	627.0	682.0	682.0	95.7%	100.0%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Additional staff used for enhanced care - Support workers.
D neuro	Day	1938.5	2196.6	1525.3	1648.5	113.3%	108.1%	5.5	4.4	9.9	Additional staff used for enhanced care - Support workers; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Night	1364.0	1673.0	1353.0	1485.0	122.7%	109.8%				Additional staff used for enhanced care - Support workers; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F4 Neuro	Day	1600.0	1460.8	736.5	1268.0	91.3%	172.2%	4.3	4.2	8.5	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Additional staff used for enhanced care - Support workers.
F4 Neuro	Night	1001.0	959.5	1022.0	1104.0	95.9%	108.0%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Additional staff used for enhanced care - Support workers.
Brooke ward (T & O)	Day	1194.8	1026.5	605.0	565.8	85.9%	93.5%	4.1	2.8	6.9	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Brooke ward (T & O)	Night	1058.5	736.5	356.5	633.0	69.6%	177.6%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Trauma Assessment Unit	Day	557.3	326.3	390.3	404.0	58.5%	103.5%	4.1	4.2	8.3	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Trauma Assessment Unit	Night	341.0	352.0	341.0	297.0	103.2%	87.1%				Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
F1	Day	2467.2	1950.7	1547.2	2046.4	79.1%	132.3%	3.7	4.0	7.7	Safe staffing levels maintained by sharing staff resource; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F1	Night	1782.5	1588.7	1062.0	1750.5	89.1%	164.8%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
F2	Day	1677.8	1198.5	1321.8	2190.3	71.4%	165.7%	2.6	5.1	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	880.0	1023.0	1808.0	86.0%	176.7%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
F3	Day	1678.3	1189.3	2457.8	2022.5	70.9%	82.3%	2.9	5.2	8.2	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.
F3	Night	1023.0	902.0	2046.0	1706.0	88.2%	83.4%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.

Trust Board meeting 31 January 2019

Title	Guardian of Safe Working Hours Quarter Report				
Sponsoring Executive	Dr Derek Sandeman, Medical Director				
Authors' names & Job titles	Dr Kathryn Nash: Consultant Hepatologist and Guardian of Safe Working Hours				
Purpose of the paper	<table border="0" style="width: 100%;"> <tr> <td style="text-align: center;">For information <input type="checkbox"/></td> <td style="text-align: center;">To note <input checked="" type="checkbox"/></td> <td style="text-align: center;">Formal approval <input type="checkbox"/></td> <td style="text-align: right;">For decision <input type="checkbox"/></td> </tr> </table>	For information <input type="checkbox"/>	To note <input checked="" type="checkbox"/>	Formal approval <input type="checkbox"/>	For decision <input type="checkbox"/>
For information <input type="checkbox"/>	To note <input checked="" type="checkbox"/>	Formal approval <input type="checkbox"/>	For decision <input type="checkbox"/>		
History	<p>The Guardian role is integral to the 2016 Junior Doctors Contract with the fundamental remit to provide assurance to the Trust Board that doctors' working hours are safe.</p> <p>Kate Nash was appointed to the Guardian role, June 2018</p>				
Main issues / Executive Summary	<p><u>Employment and expenditure</u></p> <p>All Junior Doctors in Training employed by the Trust are now working on the new contract.</p> <p>278 non-training Fellows are employed, 91% on 2016 UHS local terms and conditions.</p> <p>Vacancy rate is 10.25%, which is an improved position. Targeted recruitment activities are taking place in the emergency department and O&G. Medical HR are exploring a number of alternative options to traditional recruitment</p> <p>Locum spend via the internal bank has fallen this quarter to <£200,000 per month (Appendix 1).</p> <p><u>Exception reporting</u></p> <ul style="list-style-type: none"> • 600 exception reports received since 01 Dec 2017 relating to 761 episodes • 186 doctors have submitted exceptions (Appendix 2) • 981 exception reports have been submitted since the contract began (Oct 2016) • The most common reason is additional working hours and the most common resolution is additional payment • No reports deemed "immediate safety concern" in the last quarter. • To date no exception report has been a breach incurring a financial penalty • Cost to the organisation of exception reporting is currently low, but could increase if reporting is embedded fully 				

Activity summary

Junior doctor executive continues to meet quarterly with increasing representation from across the specialities

Consultant Rota Leads meet quarterly to share good practice.

Ophthalmology registrar experience:

Previous concerns regarding working patterns and poor training experience triggered a Deanery visit November 2017. Department have recently appointed some senior cover to eye casualty, which is the main area of concern. Informal feedback suggests trainees are happier. More formal feedback through monitoring the exception reporting system and the future GMC survey is awaited.

Obstetrics and gynaecology registrar rota:

Registrar rota remains fragile with gaps resulting in difficulties with covering on calls. Work schedule review constantly in progress but there are few options for middle grade cover due to national shortage. Recent successful appointment to consultant posts with resident on call commitment should alleviate some of these concerns

Urology/vascular FY1 post:

Further cross divisional meeting and agreement to split this rota with urology posts contributing to surgery on call and vascular on call being supplemented with recruitment from fellowship programme. Aim to implement change in new rotation in August 2019.

Work schedule reviews in progress:

Palliative care registrar rota

Paediatric emergency department:

Clarity is required regarding staffing arrangements and recruitment to posts within the paediatric ED and new assessment area when it opens

Medical registrar on call rota:

This rota continues to be full following recent over recruitment. The medical spine to the out of hours service thus remains robust and in a better position to withstand winter pressures and any vacancies that appear

Workload remains intense in many areas and there is ongoing need for wider overview of the workforce, use of junior doctors, advanced nurse practitioner roles etc across the organization to help with planning for future staffing.

Junior doctor meetings raised concerns about difficulties with IT systems and time spent doing “non-medical” tasks; leads to overtime, exception reporting but also delays in patient flow. Projects are underway to address these concerns:

- Chief registrar leading on project to review and improve discharge summaries
- Working party established to assess and improve IT facilities on wards

Implications

The Guardian remains concerned over the issue of rota gaps and the safety of areas of the hospital (e.g. eye casualty, obstetrics and gynaecology). These are areas of national difficulty and the Guardian is confident that the divisional management and executive teams are aware of these issues and seeking improvement plans

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

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

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

Action Required

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

Next Steps

Next quarterly report due April 19

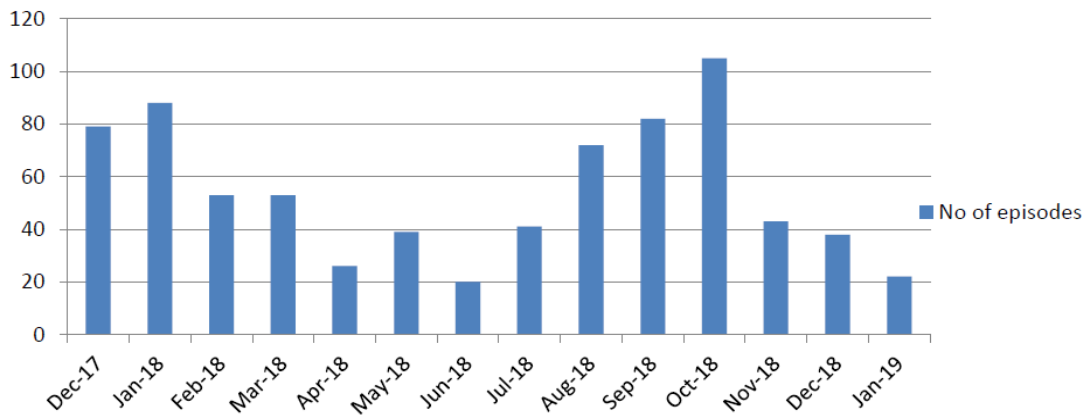
Appendix 1: Summary of junior doctor vacancies across work and total internal locum usage.

Area	Total Current Vacancies	Total hours booked via the bank (Dec 18)	Total bank spend (Dec 18)
Anaesthetics	4	75.5	5604
Intensive Care (All)	6	48	2136
Cancer Care	1	275	15096
Surgery (inc ENT)	4	395	20936
Emergency Care (inc AMU)	14	787.5	47780
Pathology	3	32	1024
Specialist Medicine and MOP	9	213	11146
Ophthalmology	1	287	22956
Child Health	13	171	8921
O&G / Neonates	4	271	14500
T&O	4	504	23176
Neurosciences	8	17	760
CV&T	7	307	15195
Total	78	3383	189230

Notes:

- Overall vacancy rate is ~10.25% and varies across departments
- The majority of bank bookings are made due to vacant shifts and increased workload

Appendix 2.1: Number of exception reports Dec 2017 – Jan 2019 (data extracted from eRota 15.01.19)



	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
No of episodes	79	88	53	53	26	39	20	41	72	82	105	43	38	22
No of exceptions	63	68	53	47	23	35	15	29	42	67	71	38	33	16

Appendix 2.2: Reason for exception

	Division A	Division B	Division C	Division D
Hours	219	370	25	66
Education	24	17	3	3
Pattern	4	10	1	6
Support	3	6	0	3

Appendix 2.3: Exception report outcome:

Outcome of exception report	
Compensation: Time off in lieu	84
Compensation: Overtime Payment	481
No further action	97
Pending	48
Work schedule review	20

Appendix 2.4: Exception report summary and future work

- There is variable engagement with the exception reporting system:
 - Only ~ 20% of doctors have submitted a report
- Solutions will require ongoing education about the system and support across the hospital
- Without robust use of the exception reporting system it is difficult to have confidence in the safety of current junior doctor working and to plan future staffing
- Assuming that information is incomplete it is difficult to predict the future financial risk to the hospital
- Few junior doctors are managing to take their allocated 2 hours SPA time a week.

Actions:

- Presentations given at induction and foundation doctor training days
- Feedback session undertaken with junior doctors
- Continue to work with consultants and junior doctors to promote exception reporting and the benefits of this
- Further work planned to explore reasons for perceived under reporting at junior doctor meetings and with local departments
- Publicise outcomes and changes that result from exception reporting – e.g. work schedule and rota changes
- Continue to work with rota leads to embed SPA time in weekly rotas and encourage juniors to exception report where this is not happening

Trust Board meeting 31 January 2019

Title	Developing Workforce Safeguards, October 2018
Sponsoring Executive	Gail Byrne, Director of Nursing and Organisational Development
Authors' names & Job titles	Tinu Okubadejo, Workforce Development Lead Rosemary Chable, Deputy Director of Nursing, Education and Workforce/
Purpose of the paper	<p>For information <input type="checkbox"/> To note <input checked="" type="checkbox"/> For approval <input type="checkbox"/> For decision <input type="checkbox"/></p> <p>To provide a briefing on the NHS Improvement (NHSI) publication 'Developing Workforce Safeguards' (October 2018), particularly on assurance and governance processes being strengthened and developed to ensure compliance with mandatory NHSI reporting from April 2019.</p>
History	The NHSI publication, implications and initial implementation plan were considered at Education and Workforce Strategy Group on 21st November 2018 and TEC on 16 January 2019, where recommendations and actions were approved.
Main issues / Executive Summary	The publication includes 14 key recommendations on ensuring safe and effective staffing, which will be assessed by NHSI annually. In order to ensure compliance, a number of new governance processes and systems are being developed within UHS.
Implications	Compliance with the recommendations in this publication form part of the statutory obligations for the Trust monitored by NHSI and the CQC.
Action Required	<p>To note:</p> <ul style="list-style-type: none"> • The report and implications identified (including the requirement for board level sign-off of a workforce plan annually and discussion of this plan in a public board meeting). • The actions identified for compliance by April 2019. • Progress with actions to be monitored through the Education & Workforce Strategy Group and monthly staffing status report.
Next Steps	<ul style="list-style-type: none"> • To implement the key changes arising from the recommendations and review and strengthen assurance processes and pathways to Board for workforce issues via Education & Workforce Strategy Group.

1 Introduction

- 1.1 This report is to brief UHS trust board on the recent NHSI publication: [Developing Workforce Safeguards](#) – Supporting providers to deliver high quality care through safe and effective staffing (October 2018). It identifies the implications for UHS following a self-assessment exercise in November 2018 and the actions needed to ensure compliance with NHSI mandatory reporting from April 2019 and alignment with the NHS Long Term Plan.
- 1.2 Compliance with the recommendations in this publication form part of the statutory obligations for the Trust which will be monitored by NHSI and the CQC from April 2019.

2 Key Issues

- 2.1 In May 2018, NHSI published 'Operational workforce planning self-assessment tool: quick guide' with the aim of assisting organisations in the preparation for workforce change and to introduce five new domains to consider in workforce planning: Leadership; Technology; Information, method and governance; Engagement and integration; and Strategy.
- 2.2 This document was reviewed within UHS, from Care Group to Board Level. The main findings of the readiness assessment were that activities supporting workforce planning were variable across the organisation, while the evidence was that all measures were at least partly in place with robust understanding at senior level and within smaller service areas.
- 2.3 This further publication builds on and incorporates the guidance previously issued on workforce planning and self assessment and includes 14 key recommendations framed around:
- Effective workforce planning.
 - Deploying staff effectively.
 - New and developing roles.
 - Structured and systematic approach to workforce changes.
 - Addressing risk and impact on quality.
 - Responding to unplanned workforce challenges.
 - NHSI approach to annual assessments and the integration of workforce into the standard operating framework.
- 2.4 The 14 key recommendations, an assessment against current levels of compliance and immediate UHS actions required to achieve the necessary compliance by April 2019 are detailed in Appendix A.
- 2.5 The self-assessment review process shows a good level of existing compliance with the majority of the recommendations within the report where UHS has previously introduced the emerging guidance from NHSI and the NQB.
- 2.6 A number of new processes and systems are being developed within UHS to ensure compliance. These are particularly focussed on workforce planning as an integral part of the planning cycle, the approach and governance around workforce changes and the ongoing reporting of workforce metrics.
- 2.7 A number of mandatory reporting amendments are outlined, including workforce as part of the Single Oversight Framework (SOF). Trusts will be assessed as part of the annual cycle and support from NHSI will be provided dependent on the level of compliance with the SOF.

- 2.8 The overall purpose of this assessment will be to confirm staffing governance processes are safe and sustainable and integrated into the planning cycle for the trust and it will take effect from April 2019.
- 2.9 From April 2019, Trusts will be expected to provide the following mandatory measures to NHSI:
- Demonstrate governance systems and processes regarding workforce planning and changes. Including the use of evidence-based tools, professional judgement and consideration of outcomes in safe staffing processes (NQB triangulated approach 2016).
 - Have an effective annual workforce process and plan, from frontline to executive level, which is signed off at Board level and discussed in a public board meeting.
 - Provide a specific workforce statement within the annual governance statement for NHSI assessment.
 - Sign off on staffing assurance and governance processes by the medical director, director of nursing and trust board.
 - Provide a full quality impact assessment (QIA) adapted from the NHSI template provided, for any service changes, including role redesign and introduction of new or expanded roles, with involvement at all trust levels and sign-off at executive level.
 - Oversight of integrated workforce, clinical, activity and financial planning, including metrics is required at board level.
 - Adherence to the principles of the Nuffield trust report (2016), NQB guidance (2016) and Carter report (2016).
- 2.10 In terms of current assurance, the review of the recommendations at appendix A demonstrates UHS is complying at least in part with the majority of existing recommendations and the robust adherence in some professional groups and services such as nursing and midwifery has the potential to be quickly adapted to other staff groups.
- 2.11 Compliance will be assessed annually by NHSI and support provided according to a process of segmentation, where fully compliant organisations are given liberty to manage workforce affairs internally. Partial compliance will result in the provision of differing levels of support from NHSI, some of this mandatory.
- 2.12 Assessment of the current compliance level with the new guidance shows UHS is likely to be assessed at level 1 (provider given maximum autonomy, no potential support needs identified) or level 2 (provider offered targeted support in relation to one or more themes).

3 Next Steps

- 3.1 To review and strengthen the current governance decision pathway to board for workforce issues, through the Education & Workforce Strategy group (EWSG), to ensure that risks to workforce safeguarding trust wide are mitigated and concerns escalated to board as required (Appendix B).
- 3.2 To review and update the information reported to board to integrate workforce metrics with quality outcomes and operational and financial performance metrics.
- 3.3 To implement the required actions to comply fully with all new directives, with progress to be monitored through the monthly staffing status report and EWSG, to include the key areas of:

- Assessment against annual governance statements.
- Strengthened workforce planning processes, including annual workforce plan.
- Development and completion of QIAs for service changes, including skill mix and new and extended roles.

3.4 To incorporate into the actions relevant elements from the NHS Long Term Plan and linked workforce guidance including recommendations when these are published.

4 Recommendation



4.1 To note the report and the implications identified for UHS including the requirements for board level sign-off of a workforce plan and discussion of this plan in a public meeting annually.

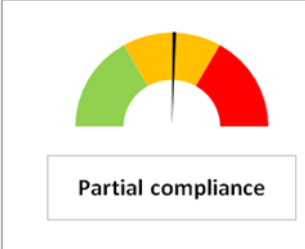
**Developing workforce safeguards – Supporting providers to deliver high quality care through safe and effective staffing
NHS Improvement October 2018**




Summary of key recommendations and action plan



NHSI will be introducing these new workforce safeguards to its annual assurance cycle from April 2019.



The Action Plan linked with the 14 recommendations is outlined in the table below:

Recommendation	Details	Current level of UHS Compliance	Comments and Action required
1	The Trust must formally ensure NQB 2016 guidance is embedded in safe staffing governance. NHSI will assess on this from April 2019.	 <p align="center">High compliance</p>	<p>Although this NQB guidance is well developed in nursing and midwifery as part of the safe staffing agenda, it will be extended to other clinical groups as further detail emerges.</p> <p>Working groups will be set up to review and strengthen these processes, with oversight via the Education and Workforce Strategy group.</p>
2	Trusts must ensure the three components of: evidence based tools (where available), professional judgement and outcomes are used in safe staffing processes. NHSI will assess on this from April 2019.	 <p align="center">High compliance</p>	<p>This element of NQB guidance is well developed in nursing and midwifery as part of the safe staffing agenda. Evidence based tools are already used in other staff groups and services where available.</p> <p>Working groups will be set up to roll out the use of these three components to all clinical groups, with oversight via the Education and Workforce Strategy group.</p>

3	The Trust will be assessed against annual governance statements which should confirm staffing governance processes are safe and sustainable.	New national NHSI requirement from April 2019.	<p>Key action: this is a new area for NHSI assessment from April 2019. The trust will need to include the workforce statement as part of the annual governance statement for 2019/20. Further detail to be issued.</p> <p>Governance processes from service to board level will be strengthened and monitored to ensure the flow of staffing plans to differing organisational levels is well integrated and board are sighted on these elements.</p>
4	An annual governance statement will be reviewed through usual regulatory arrangements and performance management processes: namely integrated and complementing quality outcomes, operational and finance performance measures.		<p>UHS will strengthen the integration of workforce planning with quality, operational and finance performance to produce an overview of workforce information and metrics and broaden the existing integrated reporting to board. Additional NHSI requirements to be implemented from April 2019.</p> <p>Effective workforce planning will be strengthened, the planning cycle will continue to be linked to annual NHSI and HEE cyclical timescales and establishment setting will be done annually with a mid-year review</p>
5	A Single Oversight Framework (SOF) will be used to provide assurance of the degree of compliance with implementation of new guidance. Support will be offered dependant on the level of compliance- this is known as 'segmentation'.	New national NHSI requirement from April 2019.	<p>Key action: this will be assessed by NHSI; details are yet to be confirmed. Assessment of the current compliance level with the new guidance shows UHS is likely to be assessed at level 1 (provider given maximum autonomy, no potential support needs identified) or level 2 (provider offered targeted support in relation to one or more themes).</p> <p>Service leads and managers will gain an understanding of the new assessment focus, familiarisation with the tools and with segmentation arrangements, with a view to achieving levels 1 or 2.</p>

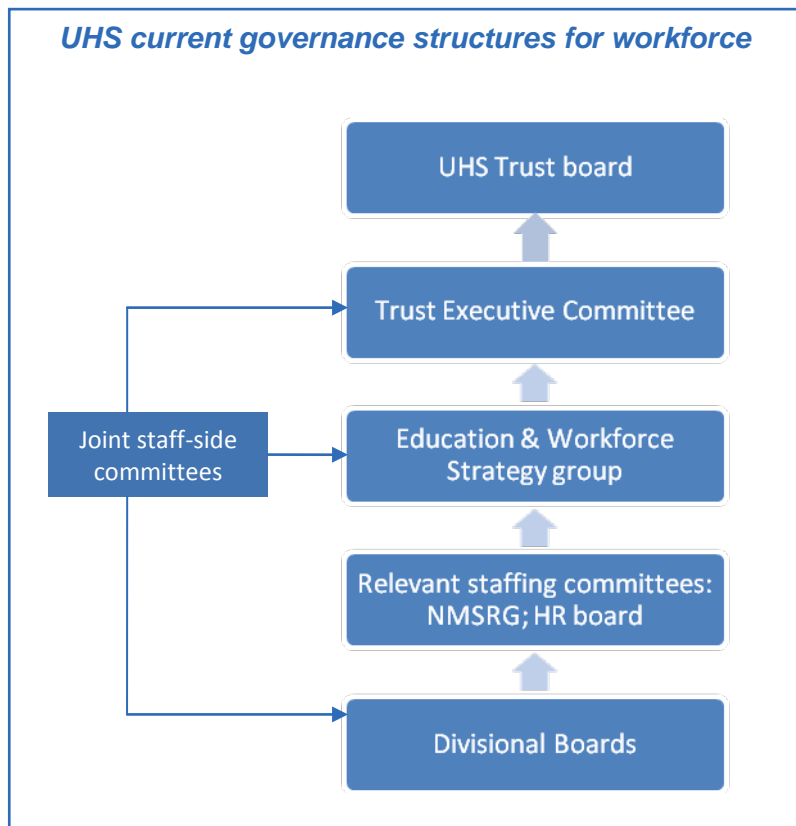
6	The Director of Nursing and Medical Director MUST confirm in a statement to board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	 <p>A semi-circular gauge with four segments: green (left), yellow, orange, and red (right). A black needle points to the green segment. Below the gauge is a white box with the text "High compliance".</p>	<p>Workforce reviews are already presented to board from the relevant clinical director.</p> <p>Quality Impact Assessments are already reviewed by the nursing and medical director for any cost improvement plans involving staffing changes.</p> <p>These will be strengthened and implemented for all staffing changes.</p>
7	Trusts MUST have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the plan in a public meeting.	 <p>A semi-circular gauge with four segments: green (left), yellow, orange, and red (right). A black needle points to the boundary between the green and yellow segments. Below the gauge is a white box with the text "Partial compliance".</p>	<p>Key action: Currently, workforce planning is in place aligned to the financial, activity and performance plan. A formal annual workforce plan is required, with NHSI expectations on the workforce planning process to be fully incorporated in order to meet assessments effectively and to clarify workforce risks.</p> <p>In addition, the six domains highlighted in the NHSI workforce planning toolkit, which differ from previous measures, will be used in the assessment of UHS annual workforce plans.</p> <p>These domains include: future scenario-planning, staff engagement at all levels, use of a workforce planning model, technological and digital systems, evidence of metrics where available, involvement of executive leaders and oversight by external stakeholders.</p>
8	Boards must ensure the organisation has an agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency metrics such as Model Hospital. Trusts should report on these metrics to their boards every month with data to be considered as a whole.	 <p>A semi-circular gauge with four segments: green (left), yellow, orange, and red (right). A black needle points to the boundary between the green and yellow segments. Below the gauge is a white box with the text "Partial compliance".</p>	<p>This recommendation is partly in place, with reporting already included as part of the integrated performance report to board.</p> <p>Current KPIs to be reviewed by EWSG to ensure they align and comply with the new NHSI guidance.</p> <p>Work with the Business Intelligence team should ensure required metrics are incorporated.</p>

9	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency) must be reported to board by ward/service twice a year.	 <p>High compliance</p>	This recommendation is in place and currently well embedded. Full annual establishment review is completed to coincide with the budget setting cycle and Divisions complete a second 'light-touch' review mid-year.
10	There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence based tools.	 <p>High compliance</p>	This recommendation is currently well embedded with any proposed changes always considered as part of the annual cycle for ward staffing reviews
11	Any service changes, including skill-mix changes must have a full quality impact assessment (QIA) review, adapted from the approved NHSI template.	New national NHSI requirement from April 2019.	<p>Key action: new formalised QIA process and procedure will be developed and embedded within UHS culture through EWSG. Currently the quality impacts of changes are considered and evaluation measures included but there is no formal process in place.</p> <p>The NHSI template will be adapted to UHS as an organisation and cascaded for use via senior managers, alongside necessary culture change and training.</p>
12	Any redesign or introduction of new and extended roles should be considered as a service change and must have a full QIA.	New national NHSI requirement from April 2019.	<p>Key action: new QIA processes and procedure will be developed and embedded within UHS culture through EWSG. Currently the quality impacts of new roles are considered and evaluation measures included but there is no formal process in place.</p> <p>The NHSI template will be adapted to UHS as an organisation and cascaded for use via senior managers, with necessary culture change and training.</p>

13	To support day to day operational challenges, the Trust must carry out dynamic staffing risk assessment including formal escalation processes.	 <div data-bbox="887 351 1111 408" style="border: 1px solid black; padding: 2px; text-align: center;">High compliance</div>	Robust systems are currently in place and 'tipping point' systems have been introduced for ward staffing as a result of this document, to escalate and action concerns appropriately.
14	Trust board must agree actions on continuous risks to staffing to maintain safety and care quality e.g. part or full closure of service.	 <div data-bbox="887 593 1111 651" style="border: 1px solid black; padding: 2px; text-align: center;">High compliance</div>	<p>Robust systems are currently in place to maintain safety and care quality, although action is required to ensure new requirements are all covered.</p> <p>There is a need to notify NHSI if services have been closed/curtailed due to staffing issues.</p>

UHS Governance structures for workforce planning

Boards are to ensure they have strong and effective governance frameworks and a systematic and structured approach to workforce changes



Report to:	Trust Board January 2019
Title:	Finance Report for Period ending 31/12/2018
Author:	Gavin Hawkins, Assistant Director of Finance
Sponsoring Director:	David French, Chief Financial Officer
Purpose:	Standing Item
	The Committee is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In December 2018 the Trust delivered a control total deficit excluding PSF of £2.3m, £0.2m below Plan taking the YTD to on Plan. Under the single oversight framework, the Trust delivered a Finance and Use of Resources score of '1'. The Trust achieved Q3 PSF for financial delivery (£5.3m), for Q3 A&E delivery (£2.3m), and also recovered Q2 A&E (£1.5m). Including PSF, the Trust has therefore delivered an on-plan YTD surplus of £17.8m.
2. The underlying position (excluding non-recurrent items) of the Trust in December was a £3.1m deficit, £1m behind Plan. The underlying position has deteriorated from month 8; however it has improved significantly compared to Q2. The 3-month rolling average underlying surplus shortfall has improved to £0.6m behind Plan.
3. At M9 Trusts are required to forecast the year-end financial position to NHS Improvement. The Trust has committed to delivery of its control total plan Achievement is worth at least £6.1m (£ element of PSF), plus £2.6m if A&E targets are achieved in March. 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. In order to deliver this position, the recent improvement needs to be sustained and further improvement delivered as part of the Financial Recovery Action Plan trajectory.
4. CIP delivery in the month was £2m against a target of £2.8m, meaning a £0.8m shortfall to Plan in the month. This slow delivery (£7.7m off-plan YTD) remains a cause for concern.
5. Clinical income (NHS & non-NHS excluding all PSF income) in November 2018 was estimated at £57.2m, £0.2m more than Plan excl. QIPP.
6. Operating costs were £3.1m adverse in the month excl QIPP, £0.6m of which is related to the Agenda for Change pay award, £0.3m to hosting the GP Employer programme, both of which are offset by other income from DHSC plus £0.1m related to the medics pay award. A further £0.8m is due to under delivery of CIP. An additional £1.1m of R&D costs and pass through drugs both offset by income also accounts for the in month OPEX adverse variance to Plan.
7. The cash position is £19.8m below plan, an improvement of £3m from M8 due to payment of over-performance invoices. The balance is primarily timing of Q2 PSF (£1.5m), unpaid income over-performance (£9m) and non-cash movements (£9m). £10.5m outlined above is expected to be a timing issue of cash receipts only.



Finance: I&E Summary

Total clinical income excl QIPP & PSF was £0.2m better than Plan in the month.

Inpatient activity was estimated to be £1m better than Plan (including adjs such as MRET etc), outpatient activity £0.2m below Plan and other POD activity (mainly critical care and A&E) £0.4m worse than Plan.

Exclusions have been estimated to be over Plan by £0.2m, with IPPDDs driving this performance although this is matched within OPEX.

OPEX was £3.1m over Plan excluding QIPP, £1m relates to the in month A4C & medics pay award and GP lead Employer programme. The balance to the pay overspend is related to weak CIP delivery.

Non-pay adverse variances are driven by £0.2m IPPDDs & £0.9m R&D costs matched in income, and £0.7m weaker CIP delivery in the month.

Asset utilisation and efficiency continues to be a key priority to enable the Trust to recover its Plan run rate performance.

Underlying deficit was £3.1m in the month excl PSF which was £1m worse than Plan.

Overall: Amber

Metric	2018/19		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	2.51	1	1
Liquidity rating	14.05	1	1
I&E Margin Rating	2.80%	1	1
I&E Margin Variance Rating	-0.11%	2	1
Agency Variance from ceiling	11.06%	1	1
Use of Resources Average Metric		1.20	1.00
Use of Resources Final Metric		1	1

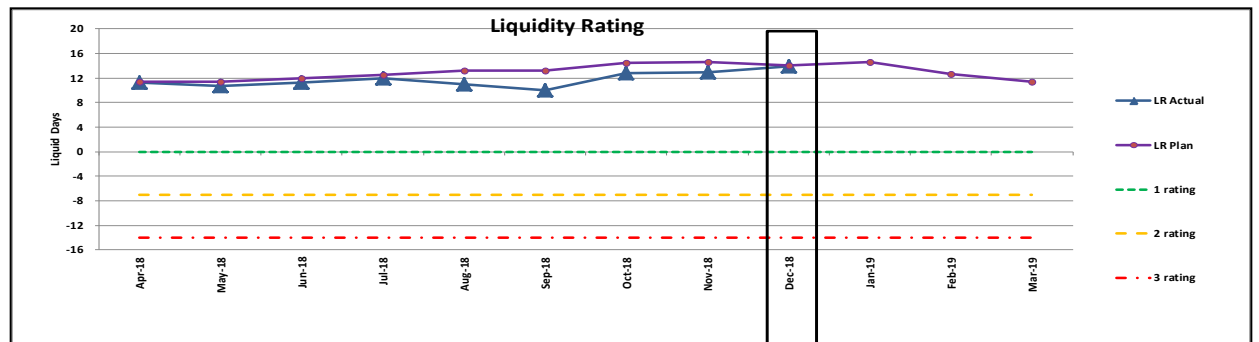
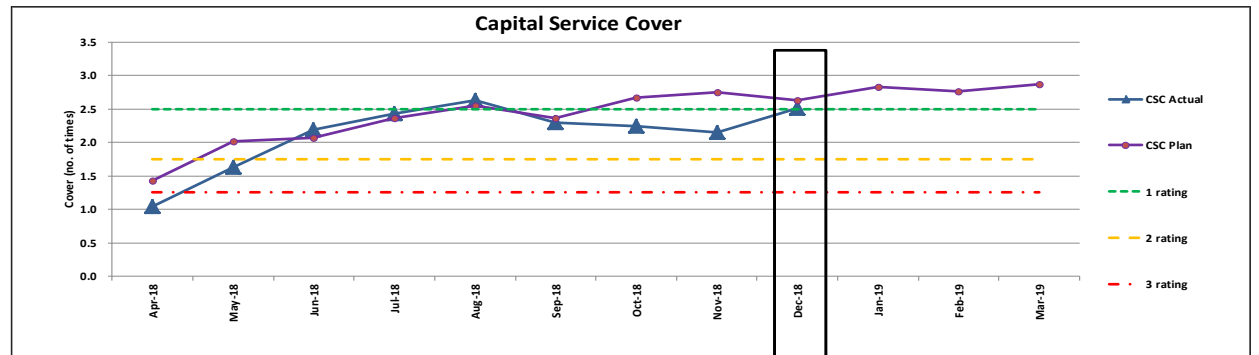
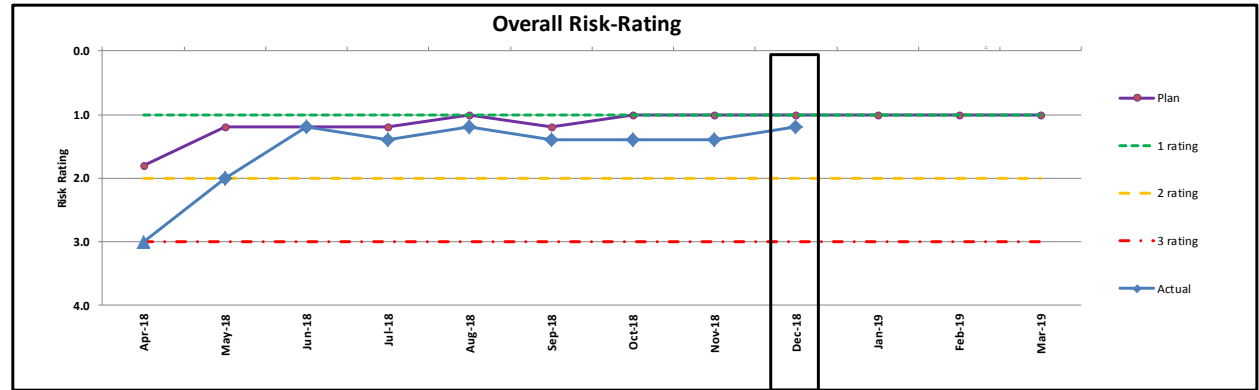
	Current Month			Year to Date			Full Yr	Prior Year to Date			Ave Done £m
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Var £m	
NHS Income: Clinical	57.0	57.2	0.2	533.7	529.0	-4.7	A	713.1	507.8	4%	58.8
QIPP Reduction	-1.1	-	1.1	-10.2	-	10.2	G	-13.5	-		
Other income Other Income excl. PSF	7.8	10.4	2.7	70.0	89.8	19.8	G	93.3	71.3	26%	10.0
Core PSF Income	2.5	4.0	1.5	16.3	16.3	-	G	25.0	11.6	41%	1.8
Total income	66.2	71.6	5.5	609.8	635.1	25.3	G	817.9	590.6	8%	70.6
Costs Pay	38.8	39.9	1.0	348.0	357.5	9.5	A	464.8	336.5	6%	39.7
Drugs	8.6	9.2	0.5	79.5	79.8	0.3	A	108.4	71.4	12%	8.9
Clinical supplies	8.0	7.7	-0.3	70.2	69.9	-0.3	G	90.2	66.3	5%	7.8
Other non pay	8.9	10.7	1.8	81.4	90.0	8.6	R	107.7	77.3	16%	10.0
QIPP Reduction	-1.1	-	1.1	-10.2	-	10.2	R	-13.5	-		
Total expenditure	63.2	67.4	4.2	568.9	597.2	28.3	R	757.4	551.5	8%	66.4
EBITDA	3.0	4.3	1.3	40.9	37.9	-3.1	A	60.5	39.1	-3%	4.2
Depreciation	1.8	1.9	0.1	16.5	16.7	0.2	A	22.1	15.8	6%	1.9
Non Operating Income/Expenditure	0.7	0.7	-0.1	6.6	3.3	-3.2	G	9.0	7.0	-53%	0.4
Control Total Surplus / (Deficit)	0.4	1.7	1.3	17.8	17.8	0.0	G	29.4	16.3	10%	2.0
Less Provider Sustainability Funding (PSF)	-2.5	-4.0	-1.5	-16.3	-16.3	-	G	-25.0	-11.6	41%	-1.8
Control Total Surplus / (Deficit) excluding PSF	-2.1	-2.3	-0.2	1.5	1.6	0.0	G	4.4	4.7	-67%	

Use of Resource Metric

Overall the Trust's Use of Resources score is '1' against a Plan for December 2018 of a '1'.

Capital Service Cover was a '1' compared to a Plan of '1'. EBITDA would need to be £0.3m lower to deteriorate to a '2' or reduce by £19.3m 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'.

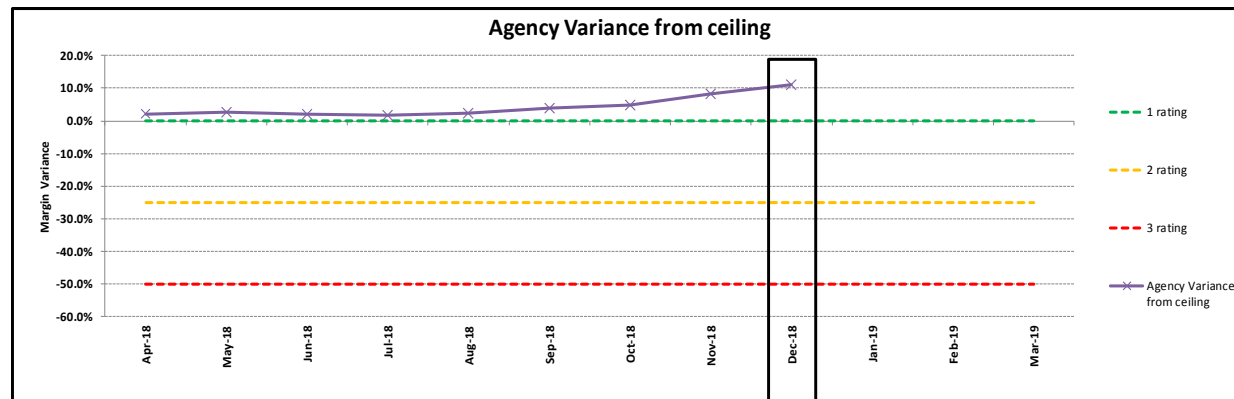
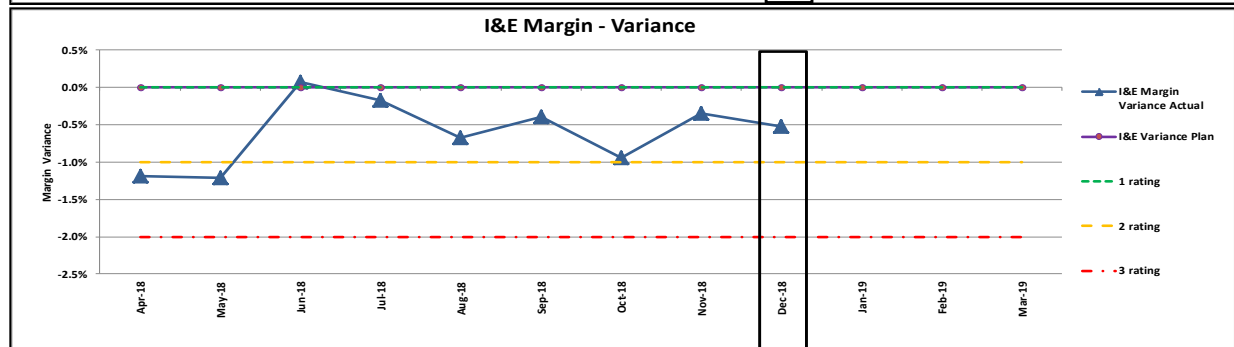
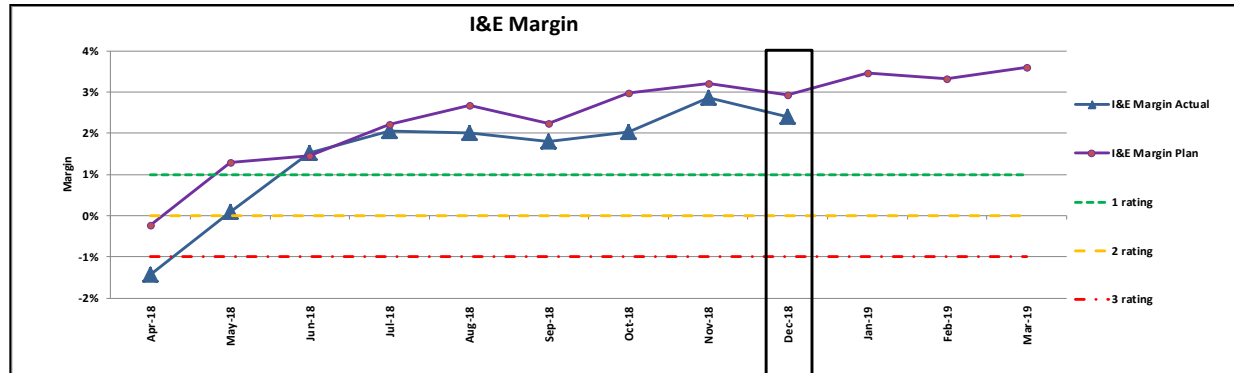


Use of Resource Metric

I&E Margin was a '1' and therefore on Plan. YTD surplus would need to deteriorate by £10.5m to reduce to a '2'.

I&E Margin Variance was a '2'. YTD surplus would have needed to improve by £0.8m 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 £1.2m before falling to a '2'. Plan for 2018/19 is to remain at '1' all year.

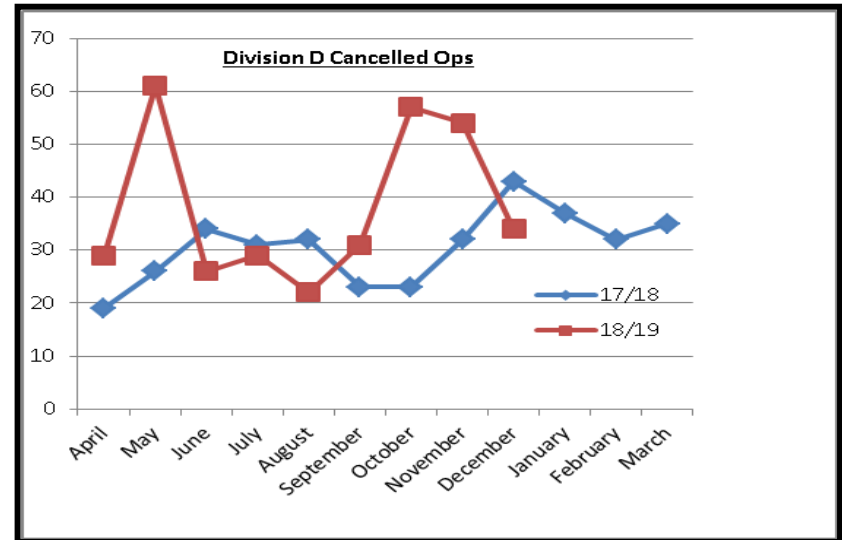
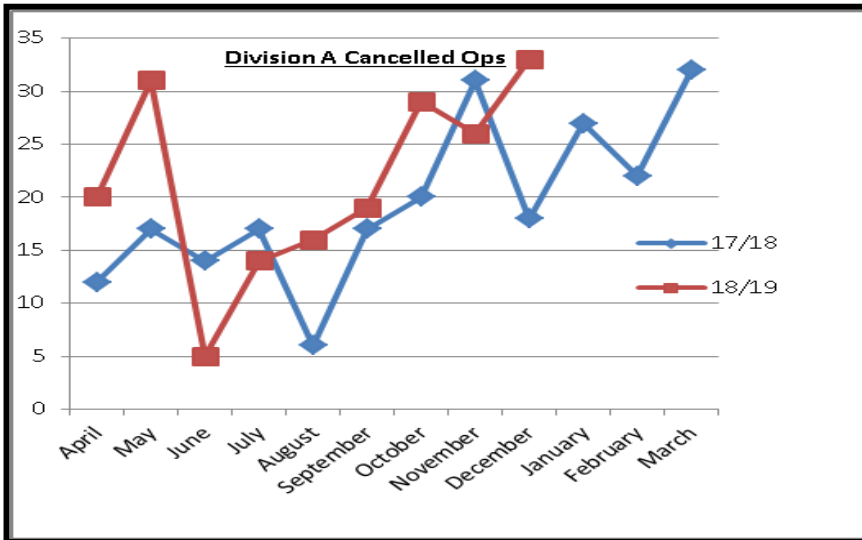
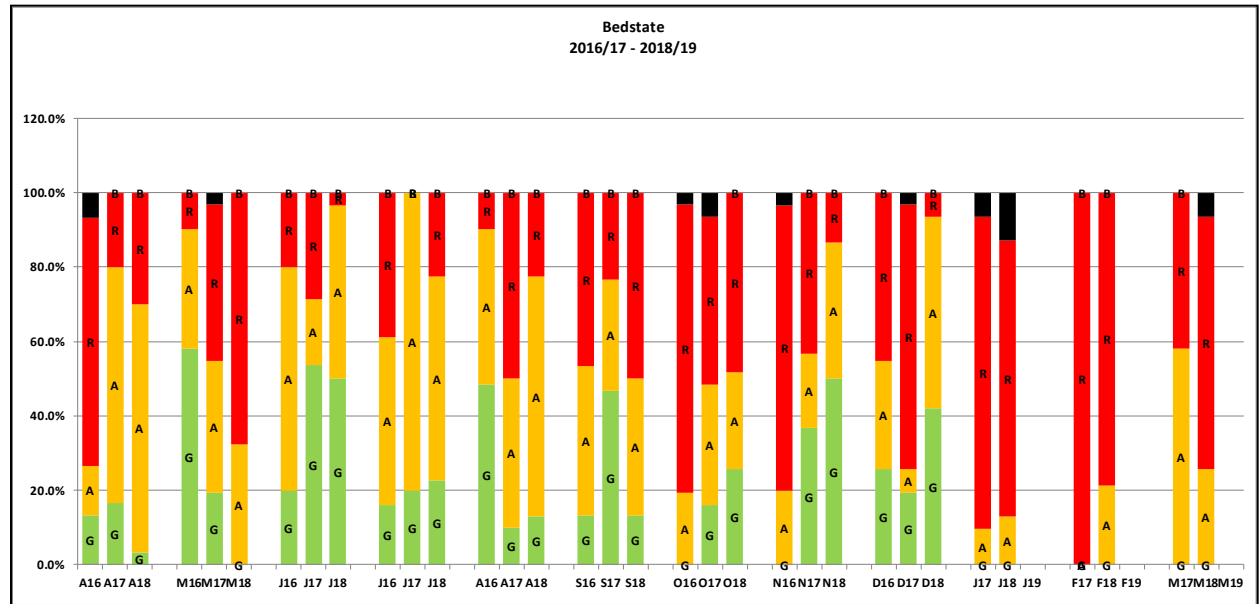


Bedstate – 3yr Comparison

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 December 2018 positively supported the Trust’s elective and non-elective programme and increased our ability to achieve the emergency access target .

Information below relates to on the day cancelled operations for Divisions A & D. The reasons for the increase in Div A in December are being investigated.



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.

In Q3 2018/19 PSF achieved was:

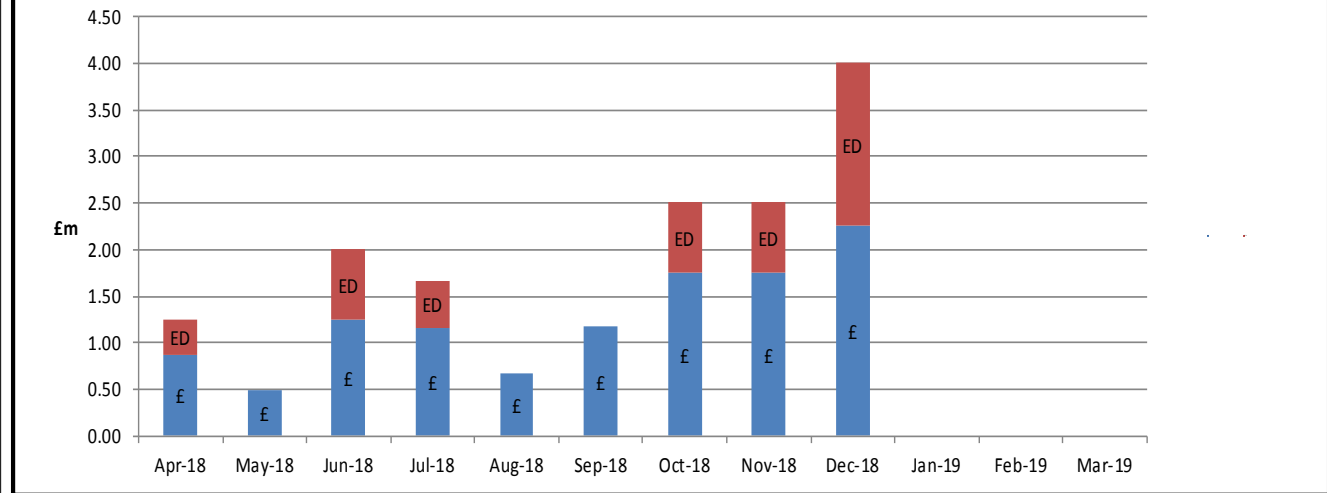
Q3 finance	£5.3m
Q3 A&E	£2.3m
Q2 A&E catch up	£1.5m
Total Q3:	£9.1m

PSF available in Q4 is as follows:

Q4 finance	£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 a challenging target (91.2% achieved in Q3).

Provider Sustainability Funding 2018/19



Clinical Income

The chart shows estimated clinical income in December.

Non-elective inpatient activity was above planned levels. Elective inpatient activity was also above planned levels in the month despite the effects of the power cut impacting December performance.

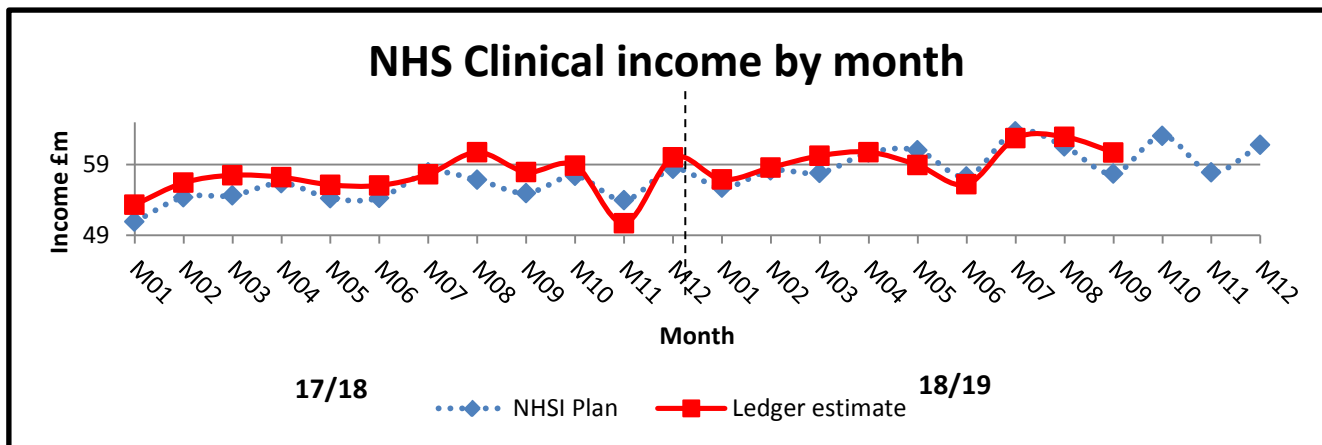
Outpatient activity was slightly below planned levels in the month.

A&E activity was slightly below planned levels as well as critical care.

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 a proportion of commissioner challenges and CQUIN failure which will be resolved as data and reports become available.

POD GROUP	2017/18	2018/19				2018/19			Monthly Run Rate	
	YTD Actuals £000s	Annual Plan £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	Done	To Do
NHS Clinical Income										
Elective Inpatients	£98,036	£139,279	£104,536	£102,107	(£2,429)	£10,490	£11,030	£540	£11,345	£12,390
Non-Elective Inpatients	£139,093	£186,781	£140,564	£145,703	£5,139	£15,911	£16,407	£496	£16,189	£13,693
Outpatients	£59,328	£79,327	£59,561	£59,166	(£396)	£5,964	£5,811	(£153)	£6,574	£6,720
Other Activity	£74,703	£102,973	£77,205	£75,483	(£1,721)	£8,707	£8,299	(£408)	£8,387	£9,163
Financial Adjustments	£14,492	£31,010	£23,387	£16,834	(£6,553)	£2,373	£2,081	(£292)	£1,870	£4,726
Other Exclusions	£34,615	£47,394	£35,592	£33,965	(£1,627)	£3,560	£3,387	(£173)	£3,774	£4,476
Subtotal NHS Clinical Income	£420,267	£586,763	£440,844	£433,258	(£7,586)	£47,004	£47,015	£11	£48,140	£51,168
Pass-through Exclusions	£82,619	£118,202	£86,739	£88,725	£1,987	£9,341	£9,719	£378	£9,858	£9,826
QIPP	£0	(£13,536)	(£10,152)	(£300)	£9,852	(£1,128)	(£33)	£1,095	(£33)	(£4,412)
Total NHS Clinical Income	£502,886	£691,429	£517,431	£521,684	£4,253	£55,217	£56,700	£1,483	£57,965	£56,582
Non NHS Clinical Income										
Private Patients		£4,993	£3,744	£4,233	£489	£416	£296	(£120)	£470	£253
CRU		£2,499	£1,876	£2,235	£360	£211	£208	(£3)	£248	£88
Overseas Chargeable Patients		£656	£491	£809	£318	£52	(£10)	(£63)	£90	(£51)
Total Non NHS Clinical Income		£8,148	£6,111	£7,278	£1,167	£679	£493	(£186)	£809	£290
Grand Total	£502,886	£699,577	£523,542	£528,961	£5,419	£55,896	£57,193	£1,297	£58,773	£56,872



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

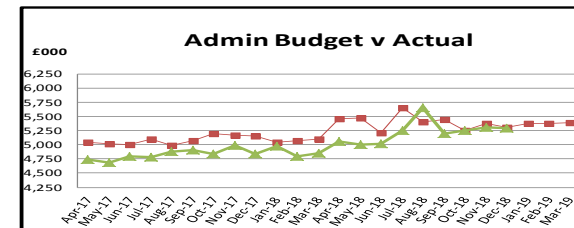
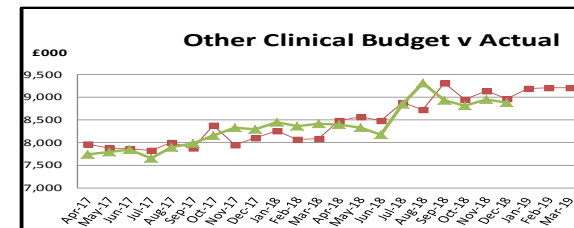
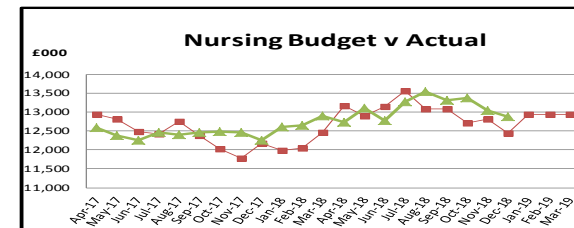
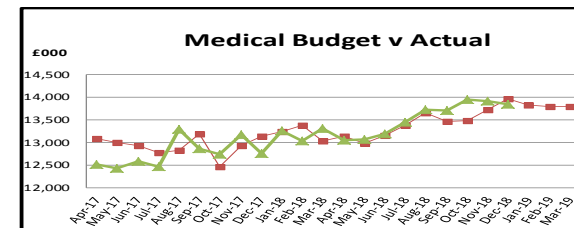
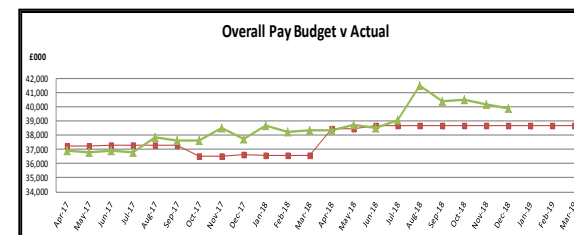
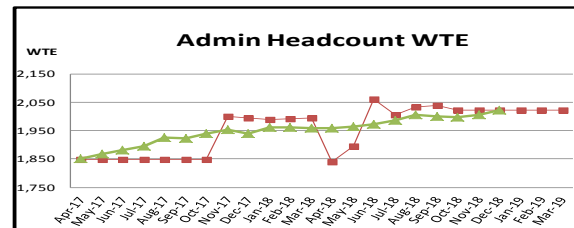
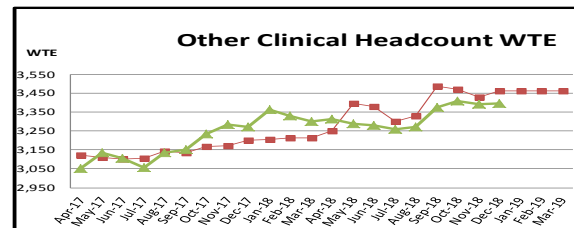
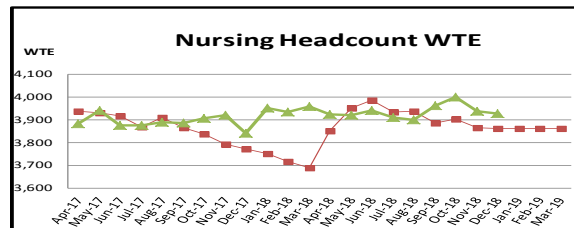
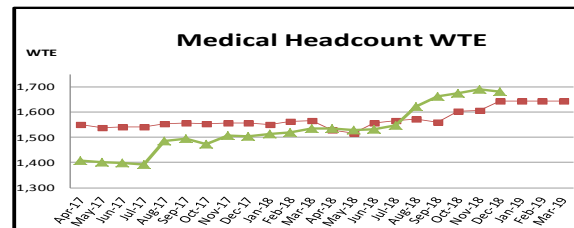
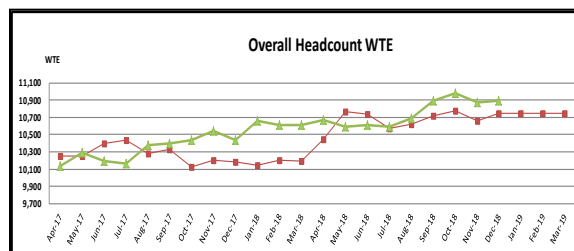
Overall paid wtes in the Trust reduced to 11,015 in December 2018, a reduction of 79 wtes.

Net of staff recharges, the monthly pay-bill was £39.9m, which includes £0.6m related to the in month A4C pay award, £0.3m to host the GP lead employer programme and £0.2m for medics pay award.

The pay bill spend in December 2018 was £0.3m lower compared to November 2018 and on the average for 2018/19.

Agency spend reduced by £0.1m and was the lowest for 18mths; WTEs reduced proportionally.

Bank spend and WTE decreased marginally with most of this reduction being in medical staff.



■ Budget
▲ Actual

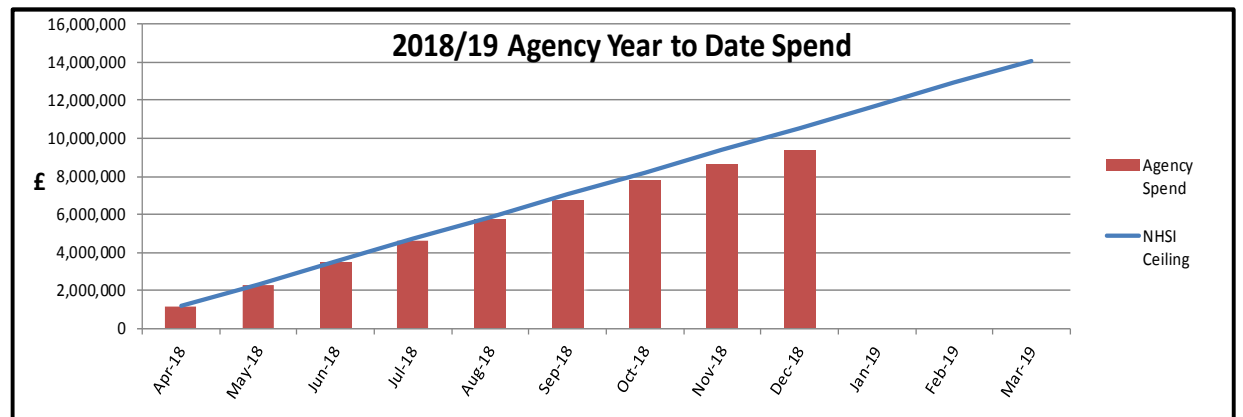
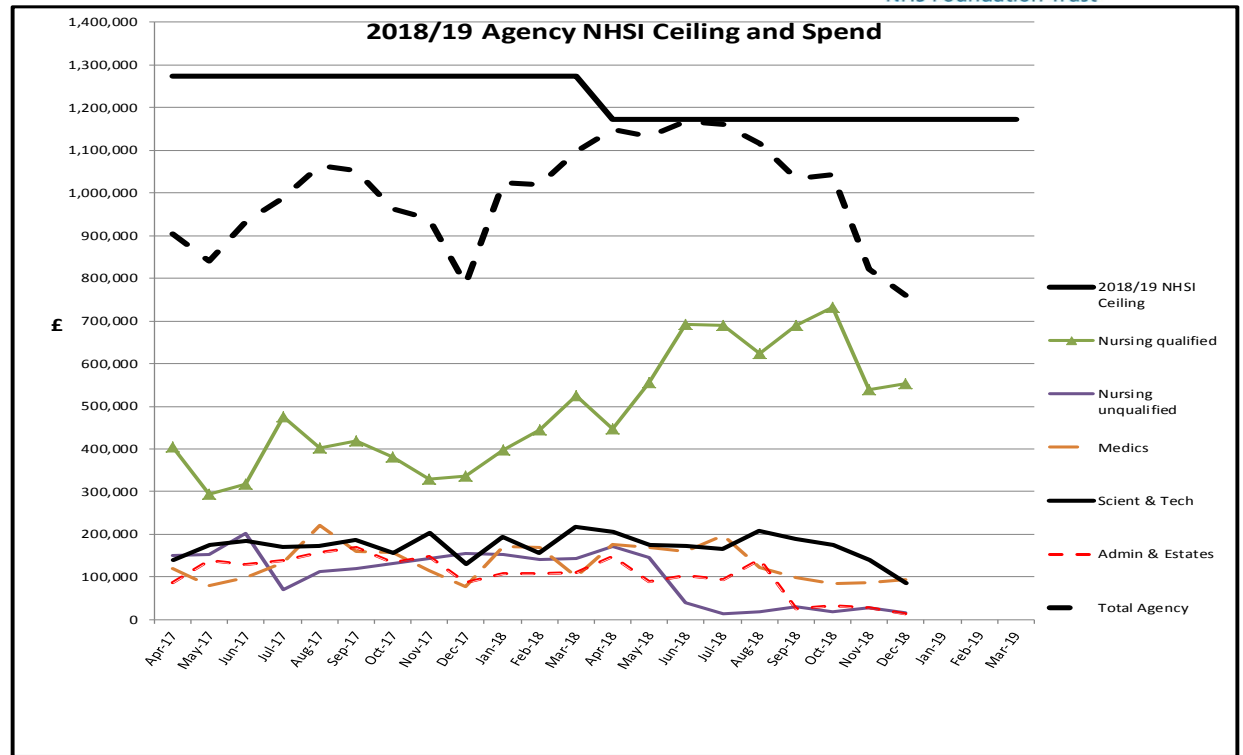
Temporary Staff Costs

In December 2018 agency spend decreased by £0.1m when compared to November 2018. The majority of this reduction was in Scientific & Technical staff.

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 (£40k)

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 remained at £1.9m for the month.



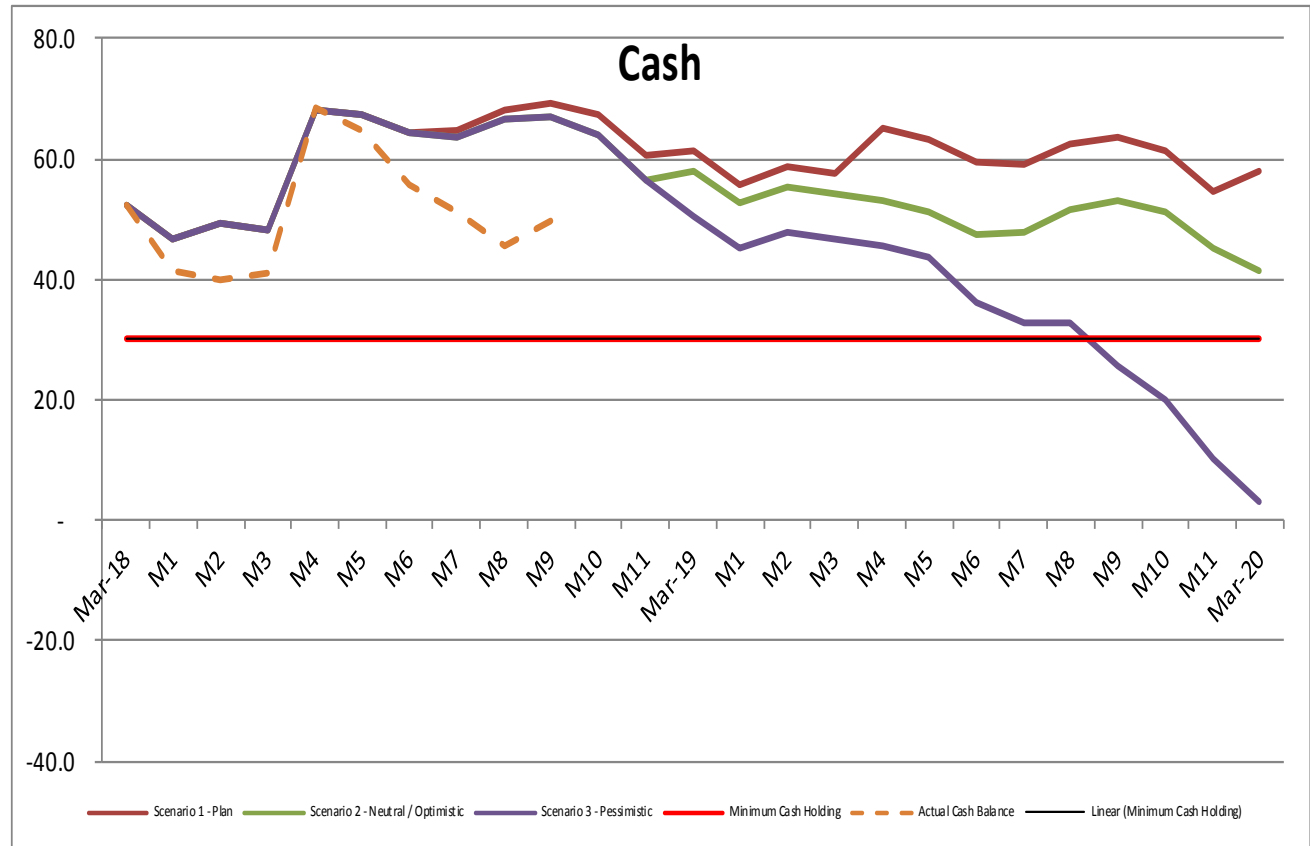
Cash

This slide now shows the cash position against the Plan and scenarios based on the position at M4. The cash forecast and scenarios will be updated as part of the 2019/20 Operating Plan.

The cash balance is currently £19.8m below Plan and lower than the forecast scenarios, although much of this is related to timing difference of when cash is received or disbursed. However, circa £9m can be attributed to non-cash non-recurrent P&L impacts.

The £19.8m shortfall represents a combination of lower working capital of £20.7m, lower operating cash flows of £3.1m and higher financing costs of £3.2m offset by lower investing activities of £7.2m.

The operating cash flow is linked to the underlying financial position outlined in this finance report. The working capital issue mainly represents differences on prepayments, receivables and deferred income.



Capital Expenditure

Capital expenditure for the month was £2.2m below Plan and is £5m below Plan for the year to date.

The major in-month spend was across a number of different IT projects and the Children's Hospital scheme.

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 in M8 was £38.5m (excluding leases) against a plan of £50.8m. This is currently being reviewed with a view to reducing the capital forecast further.

Scheme	Month			Year to Date			NHSI Plan £000's
	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	
Childrens Hospital	55	696	641	3,403	3,806	403	3,734
IT Schemes	603	710	107	5,330	5,203	(127)	8,955
Strategic Maintenance	386	315	(71)	3,076	4,207	1,131	4,500
Medical Equipment Panel	113	1	(112)	1,435	1,490	55	2,099
Radiotherapy Equipment Replacement	254	49	(205)	1,271	253	(1,018)	2,520
GICU Expansion inc Front Vertical Extension	595	(66)	(661)	3,600	1,103	(2,497)	7,451
Theatre Modernisation	448	40	(408)	2,039	162	(1,877)	4,300
ED Adult Resus	127	0	(127)	631	111	(520)	1,249
Neonatal Expansion	255	9	(246)	1,271	145	(1,126)	2,522
Oceanic Park and Ride	148	46	(102)	738	930	192	1,463
Invest to Save	64	0	(64)	1,129	75	(1,054)	3,000
Urology Day Unit	131	35	(96)	652	72	(580)	1,292
Steam Project	115	21	(94)	572	22	(550)	1,135
Other Schemes	1,506	712	(794)	5,703	8,229	2,526	6,613
Total Excluding Finance Leases	4,800	2,568	(2,232)	30,850	25,808	(5,042)	50,833
Leased additions- IISS	0	0	0	3,750	1,218	(2,532)	5,815
Leased additions- Other	248	0	(248)	1,245	3,313	2,068	2,000
Total	5,048	2,568	(2,480)	35,845	30,339	(5,506)	58,648
Less:							
Losses on disposals	-	-	-	-	(5)	(5)	-
Donated asset additions	(263)	(263)	-	(2,367)	(2,367)	-	(3,156)
Performance against Capital Departmental Expenditure Limit (CDEL)	4,785	2,305	(2,480)	33,478	27,967	(5,511)	55,492

Trust Board Meeting 31 January 2019

Title:	Informatics Update
Sponsoring Executive:	Jane Hayward, Director of Transformation & Improvement
Authors' names & Job titles	Adrian Byrne, Director of Informatics
Purpose of the report:	For information <input type="checkbox"/> To note <input checked="" type="checkbox"/> For approval <input type="checkbox"/> For decision <input type="checkbox"/>
History	Issue previously considered by TEC
Main issues / Executive Summary	This is the regular report from Informatics which has been increased in frequency due to the GDE programme acceleration. The new Digital Board will take forward strategy development and will replace ISSG in a new form
Implications	None
Action Required	1. Note contents of report
Next Steps	None required

1. Purpose

- 1.1. The trust has a strategy to become a paperless organization in line with overall national objectives (see [PHC 2020](#)) and the Global Digital Exemplar (GDE) programme. The digital maturity of the organization will be measured over the next 2-3 years with the aim of becoming the equivalent of [HIMSS Level 7](#). A first visit from HIMSS took place in November. The move to electronic noting is the single largest gap between current practice and the fully mature model. UHS will do this in stages, initially scanning in much of the form data, but moving to increased direct digital data entry, becoming more structured and coded over time. The implementation of the Electronic Document Management System from Hyland OnBase is therefore a major step in this process.
- 1.2. Note that the GDE programme does place constraints on trust latitude for prioritization, as a programme of work has been agreed to achieve the HIMSS 7 objective.
- 1.3. During this period of intense activity, it is felt that increased progress reporting will be necessary. The GDE programme sees the trust receive an additional £10m in capital over a 3.5 year period. Monitoring will also be increased at executive level with the creation of a Digital Board effectively upgrading the current Information Systems Strategy Group (ISSG).

2. Key Messages

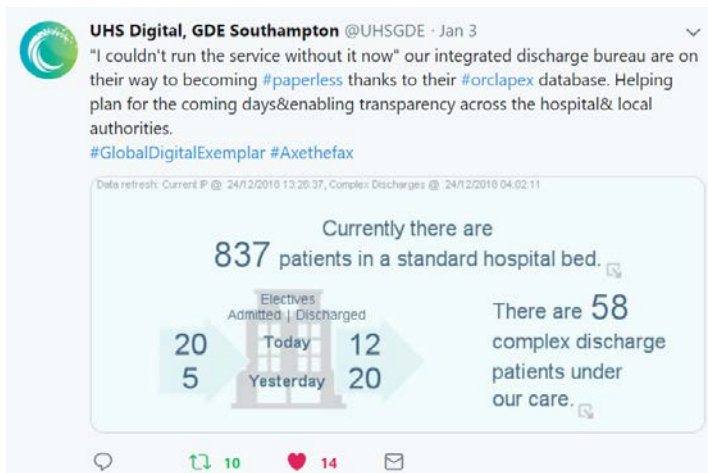
- 2.1. The new Digital Board first meeting has been arranged for the afternoon of 5th Feb, this will replace ISSG and has a much broader membership.
- 2.2. The digital strategy development work continues, and the first Digital Board meeting will review a draft of this report:
 - A specialist has been appointed to complete this work and carry out most of the interviews
 - The Trust Board feedback has been incorporated following the study session but if anyone would like to add anything further please contact the GDE programme gde@uhs.nhs.uk

- 2.3. The Trusts ambition to be paperless, and the aim of the GDE programme, can be assessed through an internationally recognised measure called HIMSS. The initial assessment document for the HIMSS staging showed that the Trust is currently quite low due to the percentage of paper in the make-up of the overall record. Although many important clinical documents and orders are now electronic, the volume of paper prevents UHS being placed higher up this scale regardless of other developments. We will not move beyond level 2 unless this can be addressed. To address this we must increase direct data entry by nurses and AHPs. New groups have been established to tackle this.
- 2.4. The EDMS project completed the initial roll out as planned, and the library has been successfully exited. The current time between folder being returned to the scanning bureau and scanning has increased to around two weeks against a target of 2 days. This, and the time PSFs are being sent to the bureau, is a patient safety risk. We are now using external support for scanning and this should reduce this risk by the end of February.
- 2.5. A new provider digitisation fund is now available, the Health System Led Investment programme (HSLI). Although the HSLI programme (£412m nationally, around £7m in the STP) is aimed at acute trusts it largely bypasses UHS as a GDE. However, as we are working on an enterprise scheduling contract for the future of outpatients, we have been selected to lead an STP wide project on this. Final bids are still to be approved but this should bring around £650k into the programme over the next two years.
- 2.6. Derek Sandeman, as Medical Director, is leading a piece of work to support the junior doctor's digital experience. A detailed action plan has been developed. Meanwhile:
 - We are hearing more positive reports about wireless connectivity generally, and have been doing some detailed analysis on it
 - The free to public NHS WiFi has launched in the trust
- 2.7. UHS must continue to monitor the Microsoft licence situation. We are still hoping for a national solution, but this will be a large call on the future Trust finances (est. excess of c.£1m pa). Current licences for MS Office expire in 2020. There are many positives about moving to MS Office 365 especially around team working, as evidenced by a recent visit to The Maudsley where they have done this.

Recent Developments

- 2.8. After a negotiation taking over a year, HHFT have been confirmed as UHS partner (fast follower) in the GDE programme. Related to this, their CCIO Tamara Everington is working with UHS and Thom Daniels on the intelligent use of clinical data to drive a better early warning score system.
- 2.9. The National Early Warning Score (NEWS2) was successfully implemented with the Safetrack eObs system. This will improve patient safety.
- 2.10. Metavision critical care went live in PICU in November, completing the final part of the original roll out of level 3 beds.

2.11. The communications channels are growing for the programme with the @UHSGDE Twitter account currently having around 300 followers (also see @MyMedRec and @TheOpenPHR). The digital communications team are putting out one or two messages per week and board members, and the public, are encouraged to follow and share these successes, as this will aid both internal and external comms.



UHS Digital, GDE Southampton @UHSGDE · 27 Dec 2018
 Since EGCs have been introduced in outpatients, the number of children who have had their height and weight recorded has increased from 33% to up to 100% in certain specialties #NHS #DigitalHealth #GlobalDigitalExemplar

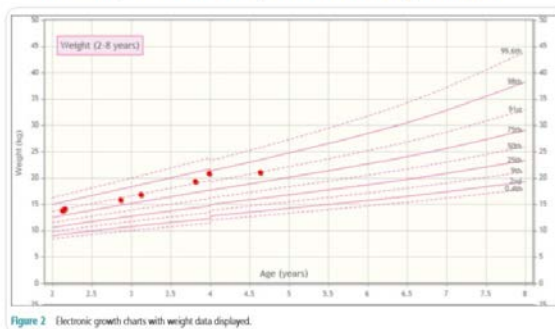


Figure 2 Electronic growth charts with weight data displayed.

2.12. The DigiRounds mobile app has been rolled out to teams using the iPads that were funded from the capital programme. This speeds up the Board round, increases patient safety and allows patients to see their images at the bedside.

2.13. MedXNote (secure messaging for clinicians) is now supporting numerous use cases for results. One positive item communicated in December was around positive flu results where staff are quickly notified of these results to ensure quick isolation.

3. Next Steps / Way Forward

3.1. What is coming up in the next period:

- Although the GDE programme board chaired by NHSE CIO Will Smart, scheduled for the 14th Nov did not happen due to unforeseen circumstances, a visit from Will has been organized for the 7th March. This will be an opportunity for UHS to showcase work that has been ongoing in the reported areas.
- The recent successes in patient flow (Whiteboard, DigiRounds, MedXNote, Apex etc) have led to the trust being asked by NHSE to host a workshop along with the Southern Acute Alliance – Feb/Mar

- Work on the My Medical Record project for Maternity (My Maternity Record) has started and will be available for pilot work during the summer across the Acute Alliance
- I am very pleased to announce the Prof Caroline Moore has agreed to speak to the My Medical Record steering group on 5th Mar, about the pioneering work they have been doing at UCL with PROMS using the platform hosted by UHS (MyMR)
- UHS invited to speak at HIMSS 2019 on the My Medical Record and Open PHR approach, during Feb in Orlando
- Digital KPIs are being developed for the trust board and a larger set of performance indicators for the digital board (Feb meeting). The KPIs are being designed to ensure that they show where digital is enabling the organization rather than KPIs about digital activity in and of itself. Board members will have already seen some of this detail.
- The senior management team will continue to work with the junior doctors to ensure they have the right tools to support them in their day to day work.
- The digital strategy and business intelligence strategy will be completed.
- EDMS phase 2 will commence with the move to more direct data entry
- Subject to final confirmation the Trust will upgrade the e-prescribing system

Trust Board meeting 31 January 2019

Title	Risk Strategy
Sponsoring Executive	Paula Head, Chief Executive
Authors' names & Job titles	Charlie Helps, AD Corporate Affairs
Purpose of the paper	For information <input type="checkbox"/> To note <input type="checkbox"/> For approval <input checked="" type="checkbox"/> For decision <input type="checkbox"/>
History	This Risk Strategy was commissioned by the Chief Executive on behalf of the Board of Directors to set out formally the Board's Risk Appetite and approach to the treatment of risk. It was authored by the AD Corporate Affairs in the capacity of Company Secretary. The Trust Executive Committee scrutinised the draft on 16 January 2019 and recommends the Strategy for approval.
Main issues / Executive Summary	The purpose of this Risk strategy is to define the Board's agreed approach to risk. It sets out, the nature of delegation to the Chief Executive, the Board's risk appetite, lines of accountability and responsibility, and the oversight, monitoring and reporting requirements of the Board.
Implications	The Executive has prepared a revised Risk Management Policy to reflect the Strategy and will revise the procedures for risk management across all four Divisions and the Trust Headquarters.
Action Required	The Board is recommended to approve the Strategy for adoption and implementation.
Next Steps	The Executive will implement this Strategy in tandem with the adoption of the Ulysses Risk Module which was purchased and installed in 2018.

Risk Strategy

Document Data			
Subject:	Risk		
Document Type:	Strategy		
Document Reference	(enter document library ref#)		
Document Status:	DRAFT		
Document Owner:	Company Secretary		
Executive Lead:	Chief Executive		
Approval Authority:	Trust Board of Directors		
Review Cycle:	12 Months		
Date Version Effective From:	01/02/2019	Date Version Effective To:	31/01/2019

Introduction

All health and social care providers operate in an environment that can be unpredictable, fast-changing, and sometimes hazardous. Several factors could impact our ability to meet our agreed objectives. The effect of this uncertainty and unpredictability on those objectives is known as risk.

This Board Strategy describes how the Board of Directors (the Board) will treat the risk that is inherent in providing services in a health and social care environment. It defines the differing roles of the Board and the Executive, the principles and standards it undertakes to abide by, and how it will take advantage of opportunities that are revealed during the assessment and handling of risk generally.

It is incumbent on the Board to ensure that a suitable and robust system of risk management and internal control is installed and maintained across the Trust's operations. The Board delegates responsibility to the Chief Executive (CE) to establish and maintain those systems, and to manage risk.

The Board requires the Audit Committee, served by both Internal and External Auditors, to assess the suitability and efficacy of those systems. The Board will also use data from other sources to triangulate and test the integrity of the reports it receives on risk and internal control.

The Board makes sincere commitments to patients, carers, and other service users, to staff and the public on the undertakings it makes for ensuring the safety and quality of their experience of the Trust's services and premises.

Details of risk policy and procedure are available in separate documents including the Risk Management Policy and accompanying guidance.

Document Change Control				
Date of Version	Version Number	Lead for Revisions	Type of Revision	Description of Revision
14/12/2018	0.01	Company Secretary	New	New procedural document for consideration and consultation
21/12/2018	0.02	Company Secretary	Redraft	To include Board Risk Appetite approved 20 December 2018

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1. Introduction

- 1.1 An understanding of the risks that UHS might encounter is crucial to the provision of health and social care services that achieve all three elements of quality as defined by Lord Darzi and NHS Improvement: *Patient Safety, Clinical Outcomes, and Patient Experience*. This definition can be extended to apply not only patients and their careers, but our staff, partners, and the public. Without proper risk management, all these groups could be at risk.
- 1.2 Our work is, by its nature, a high-risk activity and the process of risk management is an essential mechanism of internal control. Effective risk management¹ processes and activities are central to providing the UHS Board with evidence that its measures for governing the Trust are effective.
- 1.3 For this relationship between the Board and risk to be successful, separation of duties between the Board and the Executive is required. The Board cannot 'manage' risk because it has no management function (more than half of the Board Directors are Non-executive).
- 1.4 The Board can and does set the strategic direction of the Trust, defines the objectives and outcomes required, sets the working parameters and standards, delegates responsibility to the Chief Executive for management, and establishes suitable monitoring mechanisms through which it can judge the status of each of these elements.
- 1.5 The Board uses its committees to conduct this monitoring. The schematic at Appendix A – Separation of Duties shows the different roles of the Board and the Executive. On the left, the Executive is responsible for managing the objectives set by the Board through to successful completion. On the right, the Board sets the strategic direction, delegates responsibility, and continuously monitors progress and status using its committees.

2. Purpose

- 2.1 The purpose of this Risk strategy is to define the Board's agreed approach to risk. It sets out, the nature of delegation to the Chief Executive, the Board's risk appetite, lines of accountability and responsibility, and the oversight, monitoring and reporting requirements of the Board.

3. Regulatory and Control Context

- 3.1 NHSI utilise their 'Single Oversight Framework' which requires that all Trusts can demonstrate that they are remaining within the terms of their Provider Licence. It is therefore imperative that the Trust is aware of any risks (e.g. associated with new business or service changes) which may impact on its ability to adhere to this framework.
- 3.2 The Care Quality Commission (CQC) takes risk management into account when assessing the Trust's leadership capability and capacity when conducting Well-led reviews.
- 3.3 The Board Assurance Framework (BAF) Report provides the Trust Board with insight into the status of its compliance with the terms of the NHS Provider Licence as well as its progress towards achieving agreed organisational objectives. The BAF

¹ Risk management can be defined as the awareness, identification, assessment, and prioritisation of risks followed by a coordinated application of resources and actions to minimise, monitor, and control the probability and/or impact of untoward events and outcomes (risk treatment).

reflects the risks to these objectives, and any mitigations in place to ameliorate such risks.

- 3.4 All NHS bodies are required to sign an Annual Governance Statement (AGS) and must have verifiable evidence to support the Board's statements on Governance, Risk Management, and Internal Control.

4. Statement of Commitment

- 4.1 We, the Board of Directors, are committed to developing and implementing a risk strategy that will identify, analyse, evaluate, and control the risks that potentially threaten the delivery of our strategic and corporate objectives. The Board Assurance Framework report (BAF) will be used by the Board and its committees to identify, monitor, and evaluate risks to the achievement of the strategic objectives. It will be interpreted alongside other sources of evidence including the Integrated Performance Report, Risk Register, and any exception reports generated internally or externally.
- 4.2 We are committed to working in partnership with our staff to make risk awareness and management a core organisational standard and process and to ensure that it becomes an integral part of the Trust's philosophy and culture. This risk strategy represents a developing and evolving approach to risk and will be updated annually, or as and when our learning shows better and more effective ways of treating risk.
- 4.3 While the management of risk underpins the achievement of the Trust's objectives, we know that effective risk management is imperative not only to provide a safe environment and improved quality of care, it is very significant in the business planning process for both upside and downside modelling. We are committed to taking the Trust's risk profile into account throughout our business planning and review.
- 4.4 We will make a public declaration of our compliance with, and achievement of the standards we set ourselves in the Annual Governance Statement. Our Auditors will review Governance, risk management, and internal control statements.
- 4.5 We are committed to ensuring the availability of suitable system and human resource to support the implementation of this Strategy.

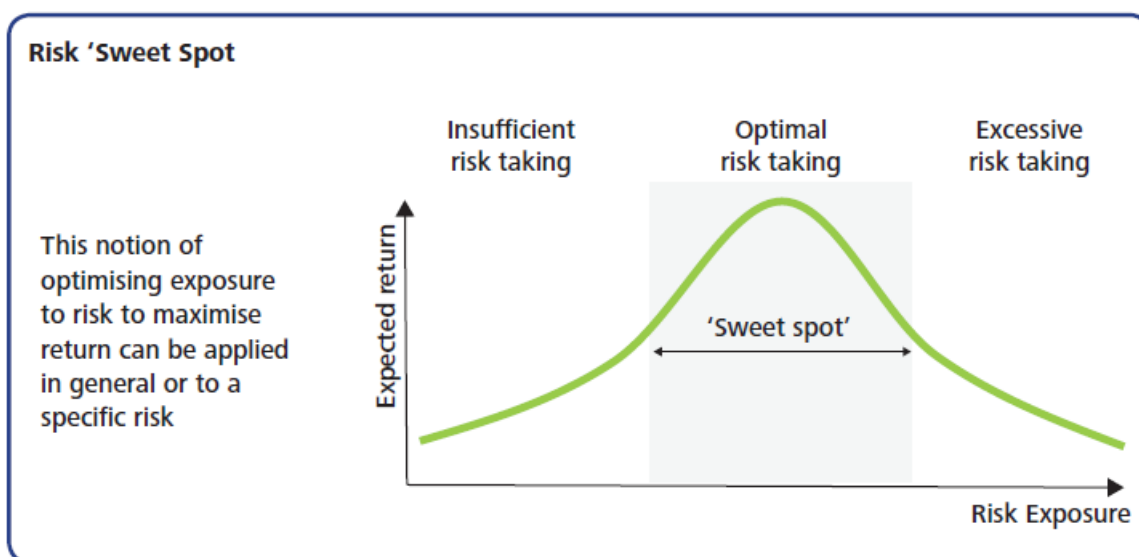
5. Scope of Risk

- 5.1 Risk is present in the following key business areas:
- Clinical Innovation: factors, actions, and decisions that could affect the quality of care
 - Compliance: factors, actions, and decisions that could affect the Trust's compliance with its statutory duties and regulatory requirements
 - Finance, Commercial, and Competition: factors, actions, and decisions to alter the size or function of the organisation that could affect the quality of care, sustainability, or reputation of the Trust
 - Partnerships: established to support the Trust's aims and benefit the people we serve and other stakeholders, that could affect the quality of care, sustainability, or reputation of the Trust
 - Reputation: factors, actions, and decisions that may impact positively or negatively on stakeholders' perceptions of the Trust

- Quality Effectiveness: factors, actions, and decisions that may affect the achievement of favourable outcomes for our service users
- Quality Experience: factors, actions, and decisions that may affect the experience of our service users
- Quality Safety: factors, actions, and decisions that may affect safety
- Workforce: factors, actions, and decisions that may affect our workforce
- Informatics: factors, actions, and decisions that may affect informatics and the digital environment

6. Board Statement of 'Risk Appetite'

- 6.1 The Board has considered the appropriate level of total risk exposure we are prepared to operate within. This is defined in the Board's 'Risk Appetite' which allows us to decide at what level the exposure to risk exceeds our risk capacity, i.e. the resources available to manage and recover from adverse impacts.
- 6.2 It also allows us to understand the ideal levels of risk and opportunity that enable us to pursue our organisational goals and objectives effectively and safely (the 'sweet spot'). The diagram provided by Deloitte LLP, 2016, illustrates this so-called 'sweet spot'.



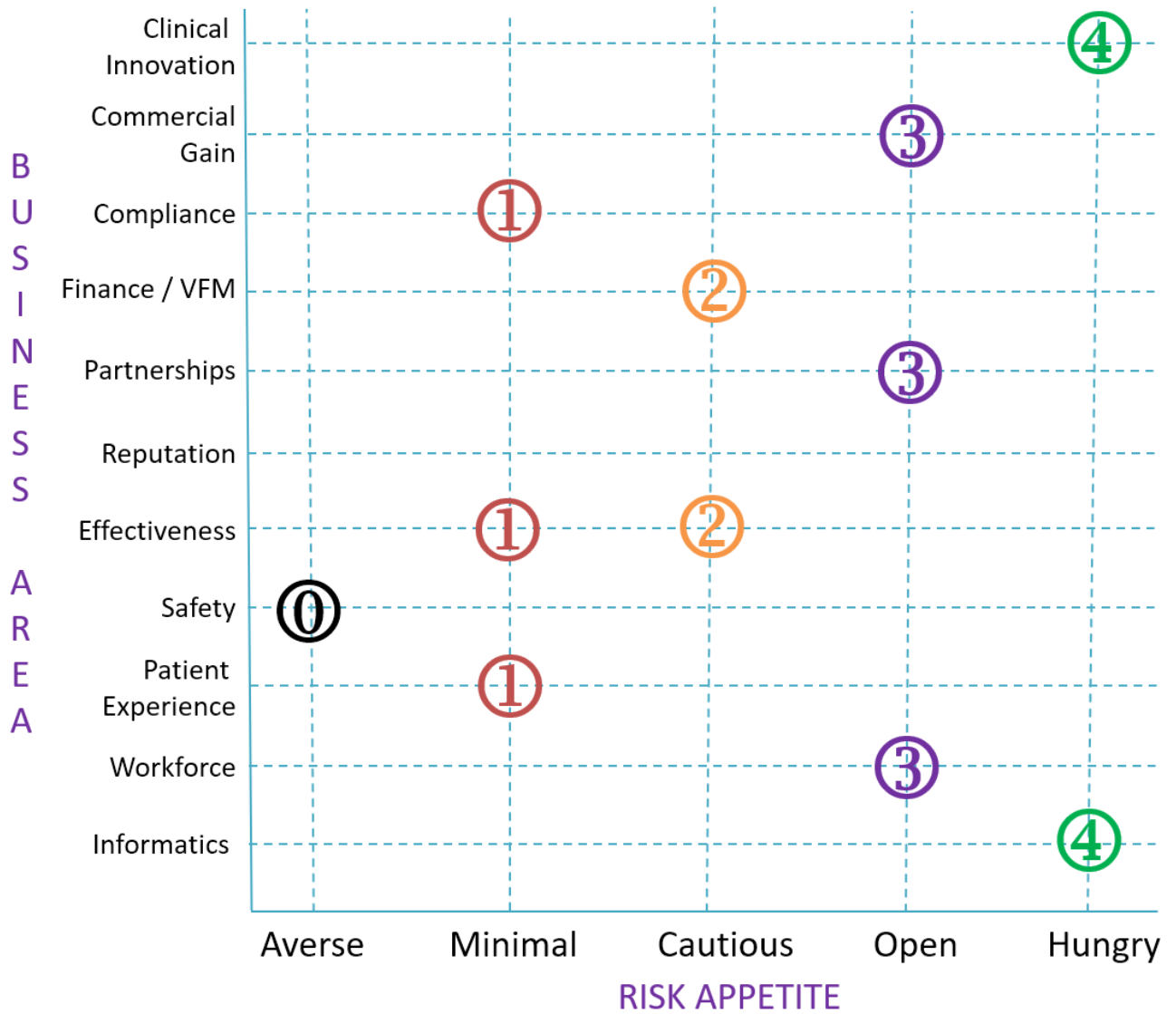
- 6.3 Defining our Risk Appetite and keeping it under review allows us to:
- Have informed debates and make better and safer decisions;
 - Provide management with a clear picture of the profile of risks facing us, and where this gives us advantages or problems;
 - Consider future strategy based on our capacity for risk;
 - See areas where we can take on more activity and those where we need to hold back;
 - Identify parts of business plans that might step outside of the 'sweet spot'; and,
 - Allow management to identify areas of activity that present an unacceptable level of risk.

- 6.4 In précis form, our Risk Appetite is:
- The Board is averse to (has no appetite for) any risk of harm to people, whether they be patients, carers, staff, the public, or partners;
 - We have a minimal appetite for breaches of regulatory compliance;
 - We will actively seek opportunities for development and improvement, including business and research opportunities, where risk is either minimal or can be easily controlled.
- 6.5 In the domains of lowest appetite, this means that reducing these risks as far as is reasonably practicable will take priority over meeting our other business and strategic objectives.
- 6.6 Where business and strategic risks can be effectively controlled, and within clearly defined limits of authority, positive opportunity-taking will be encouraged to deliver innovation, service improvement or greater efficiency in our operations.
- 6.7 The Trust has adopted the following definitions for its risk appetite:

Appetite	Definition
④ Hungry	The Trust is confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust, and is eager to be innovative and to choose options offering potentially higher business rewards.
③ Open	The Trust is willing to consider all potential delivery options and choice while also providing an acceptable level of service (and value for money).
② Cautious	The Trust prefers safe delivery options that have a low degree of risk and may only have limited potential for reward.
① Minimal	The Trust prefers ultra-safe delivery options that have a low degree of risk and only for limited reward potential (as low as reasonably practicable).
⓪ Averse	Avoidance of risk and uncertainty is a critical organisational objective.

- 6.8 The graphic overleaf represents the Board's Risk Appetite in each of the areas of our business.

7. Risk Appetite Graphic



8. Delegation to the Executive

- 8.1 We, the Board delegate the management of risk to the Chief Executive. We expect the CE to develop suitable policy provisions and to establish appropriate mechanisms and behaviours to identify, analyse, evaluate, and control and treat risk. We expect that as a minimum, the Executive will establish a formally constituted management group to review the Risk Register at least once a month. The membership of this group should include all Executive Directors and should be advised by the Company Secretary and the Risk Manager.
- 8.2 The Board retains responsibility for addressing strategic risk as a Unitary Board with all directors sharing a joint and several responsibility for all decisions of the Board.

9. Risk Objectives for the Executive

- 9.1 The Board's governance objectives for risk will be achieved through the work of the Executive by:
- Installing and maintaining a sound system of risk management and internal control;
 - Developing and implementing a Risk Management Policy in line with this strategy which documents procedures and guidance on the control of risk;
 - Ensuring that all staff are adequately trained and competent to execute their duties in respect of risk management;
 - Continuing to demonstrate and model the application of risk management principles in line with the risk strategy and policy;
 - Adopting a risk-based approach to decision-making by the Executive;
 - Including risk assessments when writing reports for the Executive and Board;
 - Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust;
 - Maintaining a comprehensive register of risks (clinical and non-clinical) and reviewing the risks regularly;
 - Ensuring controls are in place to effectively mitigate risk and are understood by those expected to apply them;
 - Ensuring gaps in control are rectified and assurances reviewed and acted on promptly;
 - Monitoring risk management arrangements, continually seeking learning and improvement from lessons learnt; and,
- 9.2 Reporting exceptions to the system of risk management and internal control to the Board. The Company Secretary shall maintain a register of exceptions, including breaches of Standing Orders and Standing Financial Instructions.

10. Reporting, Documentation and Evidence

- 10.1 We will rely on various sources of evidence upon which to base our sense of assurance on then status, efficacy, and suitability of the systems of risk management and internal control operated by the Executive. These will include audit reports, committee scrutiny reports, and status reports by the Executive.

- 10.2 This Board oversight and scrutiny will rely on various forms of documentation, including:
- The Board Assurance Framework Report (BAF) as the mechanism through which the Board receives assurances that the Trust is actively pursuing its strategic and corporate objectives and that the risks to these objectives are appropriately treated;
 - The Strategic Risk Register and Corporate Risk Register shall reflect the organisation's risk profile. They will contain the significant risks identified by the Trust, describe the controls in place and give the strength and quality of assurance available on how well the risks are managed.
- 10.3 These documents support the Board in making a declaration on the effectiveness of the Trust's system of risk management and internal control in the Annual Governance Statement.
- 10.4 Board committees with responsibility for oversight and scrutiny will regularly report to the Trust Board any new risks identified and any concerns relating to possible gaps in control for new and existing risks.
- 10.5 The Board Committees will test the integrity of the evidence provided to them and will report to the Board on the levels of assurance they have derived from the evidence they have seen.
- 10.6 The Board will keep this Strategy and its risk appetite under review and will update the risk appetite as and when learning from experience demonstrates that an adjustment is required.

11. Responsibility for Monitoring Compliance with this Strategy

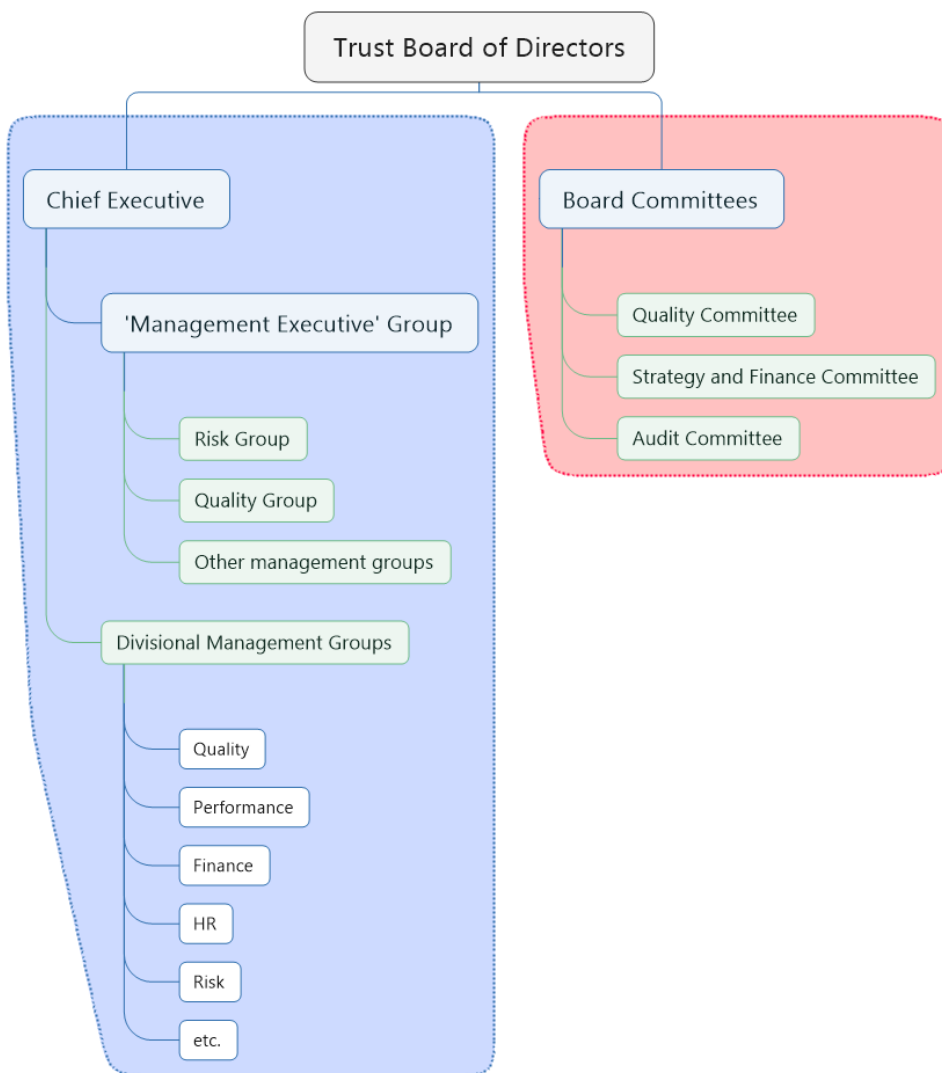
- 11.1 The Board shall review this strategy annually.
- 11.2 The organisational risk management structure shall be reviewed at the annual Board risk workshop.
- 11.3 The Risk Manager shall monitor compliance with this Strategy, the Risk Management Policy, and associated procedures.
- 11.4 The implementation of this strategy shall be monitored using the annual internal audit review.
- 11.5 The 'Risk Management Group' shall monitor the implementation of the annual risk management objectives using quarterly progress reports provided by the Risk Manager.

12. Associated Documentation

- 12.1 This strategy must be read in conjunction with the following procedural documentation:
- (a) Risk Management Policy
 - (b) Risk Management Procedure
 - (c) Incident Management Policy
 - (d) Handy Guide to Risk Management

13. Appendix A – Separation of Board and Executive Duties

- 13.1 The Board of Directors sets the strategic direction of the Trust, defines the objectives and outcomes required, sets the working parameters and standards, delegates responsibility to the Chief Executive for management, and establishes suitable monitoring mechanisms through which it can judge the status of each of these elements.
- 13.2 The Executive manages the achievement of objectives to fruition, establishes systems and processes for risk management and internal control, and reports its progress to the Board of Directors both directly, and through the Board Committees.
- 13.3 This separation of duties ensures the Executive has the freedom to act from day to day, and the Board does not become involved in managing the activities of the Trust.



Trust Board Meeting 31 January 2019

Title	Chief Executive's Report on Current Issues
Sponsoring Executive	Paula Head, Chief Executive
Authors' names & Job titles	Sue Diduch, Corporate Affairs Administrator
Purpose of the paper	<p>For information <input type="checkbox"/> To note <input checked="" type="checkbox"/> Chair's Actions for ratification <input checked="" type="checkbox"/> For decision <input type="checkbox"/></p> <ol style="list-style-type: none"> 1. To alert Trust Board to current news items available on the website. 2. To inform Trust Board of business undertaken by Trust Executive Committee (TEC). 3. To inform Trust Board of the signing and sealing undertaken in accordance with SFIs. 4. To seek ratification of the Chair's actions undertaken with regard to contracts in accordance with SFIs.
History	Monthly report.
Recommendations	<ol style="list-style-type: none"> 1. Note this report. 2. Ratify the actions undertaken by the Chair (paragraphs 4.1 – 4.3).

1. Current News

Current news is available on the Trust website at <http://www.uhs.nhs.uk>

2. Trust Executive Committee (TEC)

The Trust Executive Committee (TEC) is a formal standing committee of the Trust, which executes actions from the Board and supports the operational management of the Trust. The agenda for the January 2019 meeting is attached at Appendix 1 and reports are available to Board members on request.

3. Signing & Sealing

The Seal of the Trust is required to be fixed to some documents. There was 1 seal fixed for the period of this report.

3.1 Loan Agreement between University Hospital Southampton NHS Foundation Trust (the Lender) and UHS Estates Limited (the Borrower) for the sum of £4,300,000. Seal number 164.

4. 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.

- 4.1 **Single Tender Action for Photopheresis machine consumables and maintenance** for Cancer Care from Therakos for four years at a total cost of £1,061,474 excluding vat. Approved by the Chair on 21 January 2019.
- 4.2 **Single Tender Action for Bone Marrow Donor Searches**, for Cancer Care from Anthony Nolan Charity at a cost of £1,200,000 excluding vat. Approved by the Chair on 21 January 2019.
- 4.3 **Award of Contract for Laboratory Medicine Managed Service** for Pathology to Beckman Coulter UK Ltd until 31 August 2021 at a total cost of £943,096 excluding vat. Approved by the Chair on 21 January 2019.

5. Recommendation

- 5.1 To note this report.
- 5.2 To ratify the actions undertaken by the Chair (paragraphs 4.1 – 4.3)

<h1 style="margin: 0;">Trust Executive Committee</h1>	<h1 style="margin: 0;">Agenda</h1>
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Date of Meeting: 16 January 2019
Venue: Conference Room, Heartbeat Education Centre, F Level, North Wing
Time: 8.00-10.30am
Apologies to: Sue Diduch, Corporate Affairs Administrator

Time	Agenda Item	Enc/Oral
8.00	1. Chair's Welcome, Apologies and Declarations of Interest	
	2. Minutes of Previous Meeting held on 14 November 2018	Enclosure 1
	3. Matters Arising/Summary of Agreed Actions	Enclosure 2
	4. Quality & Safety	
	<i>Discussion Items</i>	
8.10	4.1 Quality & Safety Update (Gail Byrne, Director of Nursing & Organisational Development/ Derek Sandeman, Medical Director)	Oral
8.20	4.2 Patient Safety 2018/19 Quarter 2 Report (Gail Byrne, Director of Nursing & Organisational Development/ Juliet Pearce, Deputy Director of Nursing for Quality)	Enclosure 3
8.30	4.3 Patient Experience 2018/19 Quarter 2 Report (Gail Byrne, Director of Nursing & Organisational Development/ Ellis Banfield, Head of Patient Experience)	Enclosure 4
8.40	4.4 Draft Quality Improvement Framework (QIF) Priorities 2019/20 (Gail Byrne, Director of Nursing & Organisational Development/ Juliet Pearce, Deputy Director of Nursing for Quality)	Enclosure 5
	5. Operational Performance	
	<i>Decision Items</i>	
8.50	5.1 New Consultant Business Case: General Paediatrics with interest in Neurology to lead Epilepsy Service (Derek Sandeman, Medical Director/Peter Wilson, DCD, Division C)	Enclosure 6
8.55	5.2 New Consultant Business Case: Clinical Oncology Breast Lymphoma Haematology UHS/Salisbury (Derek Sandeman, Medical Director/Andrew Webb, DCD, Division A)	Enclosure 7
9.00	5.3 Learning from Major Incident (Caroline Marshall, Chief Operating Officer/Andrew Asquith, Deputy Chief Operating Officer)	Enclosure 8
	<i>Discussion Items</i>	
9.10	5.4 Implications of NHS Improvement publication: Developing Workforce Safeguards October 2018 (Gail Byrne, Director of Nursing & Organisational Development/ Rosemary Chable, Deputy Director of Nursing, Education & Workforce/Tinu Okubadejo, Workforce Development Lead)	Enclosure 9
9.20	5.5 Apprenticeships Update (Gail Byrne, Director of Nursing & Organisational Development/ Jo Mountfield, Director of Education/Steve Harris, Director of Human Resources/Anita Esser, Head of Wider Healthcare Teams Education)	Enclosure 10 [No Enclosure 11]
9.25	5.6 Informatics Update (Jane Hayward, Director of Transformation & Improvement/ Adrian Byrne, Director of Informatics)	Enclosure 12
9.35	5.7 Access Times and Operational Performance for December 2018 (Caroline Marshall, Chief Operating Officer/Andrew Asquith, Deputy Chief Operating Officer)	Oral

	6.	Finance	
		<i>Discussion Items</i>	
9.45	6.1	Finance Report for Month 9 (David French, Chief Financial Officer)	Enclosure 13
9.55	6.2	Financial Recovery Action Plan update (David French, Chief Financial Officer/Ian Howard, Deputy Director of Finance)	Enclosure 14 Oral
	7.	Strategy	
		<i>Decision Items</i>	
10.05	7.1	Risk Strategy (Paula Head, Chief Executive/Charlie Helps, Interim Associate Director Corporate Affairs)	Enclosure 15
	8.	Information Items NO DISCUSSION	
	8.1	Postgraduate Medical Education Gradings and Hotspots Quarter Report (Derek Sandeman, Medical Director)	Enclosure 16
	8.2	Patient Level Information & Costing System (PLICS) – Service Line Reporting 2018/19 Quarter 2 (Ian Howard, Deputy Director of Finance)	Enclosure 17
	8.3	Contracting and the National Payment System 2019 (Jane Hayward, Director of Transformation & Improvement)	Enclosure 18
	8.4	Staffing Status Report (Gail Byrne, Director of Nursing & Organisational Development)	Enclosure 19
	8.5	Capital Programme 2018/19 Quarter 3 Report (David French, Chief Financial Officer/Jane Hayward, Director of Transformation & Improvement)	Enclosure 20
	8.6	Quarterly Market Update (Jane Hayward, Director of Transformation & Improvement)	Enclosure 21
	8.7	Replacement Consultant Business Case: Neonatal Medicine (Derek Sandeman, Medical Director/Peter Wilson, DCD, Division C)	Enclosure 22
	9.	Minutes from TEC Sub-Committees and Reporting Groups	
	9.1	Research & Development Steering Group 18 October 2018 (Christine McGrath)	Enclosure 23
	9.2	Education and Workforce Strategy Group 20 September 2018 (Gail Byrne)	Enclosure 24
	9.3	Quality Governance Steering Group 6 November 2018 and 4 December 2018 (Gail Byrne)	Enclosure 25
	9.4	Trust Investment Group 8 November 2018 and 13 December 2018 (David French)	Enclosure 26
	9.5	Division A Board 18 October 2018 (Greg Chapple)	Enclosure 27
	9.6	Division B Board 26 September and 31 October 2018 (Duncan Linning-Karp)	Enclosure 28
	9.7	Division C Board 25 September, 30 October and 19 December 2018 (Martin De Sousa)	Enclosure 29
	9.8	Division D Board 16 November 2018 (Jacqui McAfee)	Enclosure 30
10.25	10.	Any Other Business	
	10.1	Agenda for the next meeting – TEC 13 February 2019 (papers to be received by Corporate Affairs by noon 7 February 2019)	Enclosure 31
	10.2	New Consultant Business Case: AMU (Derek Sandeman, Medical Director/James Adams, DCD, Division B)	Enclosure 32

Apologies: Mark Bagnall (Paula Melhuish to deputise)

In Attendance: Ellis Banfield, Head of Patient Experience
Rosemary Chable, Deputy Director of Nursing, Education & Workforce
Tinu Okubadejo, Workforce Development Lead
Anita Esser, Head of Wider Healthcare Teams Education