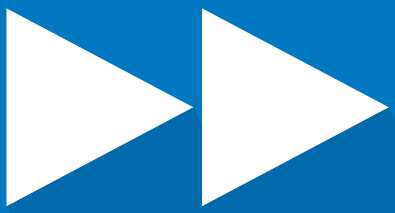
NHS
University Hospital Southampton
NHS Foundation Trust

# ANNUAL REPORT AND ACCOUNTS 2016/17



incorporating the quality account 2016/17
Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

University Hospital Southampton NHS Foundation Trust

# Annual report and accounts 2016/17

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# PERFORMANCE REPORT

# Statement from the chief executive

**More patients than ever before were treated at University Hospital Southampton (UHS) during 2016/17. And despite seeing an extra 41,000 patients than the previous year, we have continued to maintain our patient satisfaction scores with more than 95% recommending UHS. This is just one of many outstanding achievements across our hospitals which we are proud to highlight in this annual report.**

Our ongoing challenge now is tackling the high numbers of patients who could be at home, but who lack support from either health or social care to move out of hospital. There has been some hard work done in this area and we're already seeing signs of improvement.

The latest Friends and Family Test results - the survey which all UHS staff are asked to complete - said that 92% of staff would recommend UHS as a place to be treated, and 77% would recommend it as a place to work. Both these figures are the highest we have ever achieved, and are much better than the national average.

We have been able to invest heavily in improved and expanded facilities for patients and for research. For instance, work has started on the radiotherapy bunker which will house the new linear accelerators used to treat cancer patients and the new Cancer Immunology Centre is also progressing well.

The ongoing investment into diagnostics – particularly radiology but also more specific schemes such as hysteroscopy – should help patients right across the hospital.

We recently received national recognition as a "global digital exemplar"; an award which we anticipate will bring an additional £10 million of national money. Historically, we have spent very little on information technology but, despite this, much has been delivered.This extra national money will make a real difference to patient care through some large-scale informatics projects and will also improve the day to day IT equipment our staff have available to them.

Our new main entrance, which opened last summer, now feels like it has been here forever but I think it is still worth remembering what an improvement it is on the old entrance, and that it was rebuilt without spending any NHS money.

We have been successful in renewing our NHS research funding, through both our Biomedical Research Centre (BRC) and Clinical Research Facility (CRF). This was a tough competition, as we were competing against every other academic medical centre in the country, and the rules were clear that only "world class research" would be funded. So the Southampton research team (UHS and the University of Southampton), led by Rob Read for the BRC and Saul Faust for the CRF, should be very proud that we were successful, and that Southampton research will continue to help patients receive better care across the world.

Children's services are very important to us and thanks to a combination of NHS funds and very generous donations, we have been able to refurbish and expand Piam Brown (paediatric cancer) ward and our paediatric intensive care unit (PICU).

Despite a challenging time for NHS finances, UHS had a successful financial year, ending it with a surplus of £20.4m. This has enabled us to plan increased investment in our estate, particularly for the most vulnerable patients such as refurbishment of high dependency and intensive care facilities for patients of all ages, and theatre and interventional radiology rooms. This means that we will continue to have the facilities to look after the sickest patients in Hampshire and beyond.

In 2016/17 we launched our children's emergency department campaign, alongside the Murray Parish Trust. We're now well on our way to raising the £2 million needed, which will be fund matched by the Government. We hope to start building this summer.

So, while there have been considerable challenges meeting uplifts in demand and managing discharges, there has also been much to celebrate and we look forward to 2017/18.

Fiona Dalton
Chief executive
23 May 2017

# Statement of purpose and activities

**UHS is a large teaching hospital located on the south coast of England. We have a tripartite mission to provide clinical care, educate current and future healthcare professionals, and undertake research to improve healthcare for the future.**

Our clinical care encompasses local acute and elective care for 680,000 people who live in Southampton, the New Forest, Eastleigh and Test Valley. We also provide care for the residents of the Isle of Wight for many services. As the major university hospital on the south coast, UHS provides the full range of tertiary medical and surgical specialities (with the exception of transplantation, renal services and burns) to over 3.7 million people in central southern England and the Channel Islands.

UHS is a centre of excellence for training the doctors, nurses and other healthcare professionals of the future. We work with the University of Southampton and Solent University to educate and develop staff at all levels, including a large apprenticeship programme, undergraduate and post-graduate education.

Our role in research, developed in active partnership with the University of Southampton, is to contribute to the development of treatments for tomorrow's patients. This work distinguishes us as a hospital that works at the leading edge of healthcare developments in the NHS and internationally. In particular we have nationally-leading research into cancer, respiratory disease, nutrition, cardiovascular disease, bone and joint conditions and complex immune system problems. We are one of the largest recruiters of patients into clinical trials in the country.

Over 10,500 people work at the Trust, making it one of the area's biggest employers. We also benefit from the contributions of over 1,000 volunteers. Our turnover in 2016/17 was more than £760m.

# History of UHS

**The Trust has its origins in the 1900s when the Shirley Warren Poor Law Infirmary was built on the site of what is now Southampton General Hospital.**

In the early half of the century, the site began to expand, including the opening of the school of nursing and the creation of the Wessex Neurological Unit. In 1971 a new medical school was opened in Southampton and the 1970s and 1980s saw a significant building programme encompassing the current footprint of Southampton General Hospital, Princess Anne Hospital and Countess Mountbatten House.

During the 1990s, services were increasingly centralised at the general hospital, with the eye hospital and cancer services being relocated from elsewhere in the city. The Wellcome Trust funded a clinical research facility at the hospital in 2001 and this unit remains the foundation for much of the Trust's groundbreaking medical research. In the last decade, development has continued with the opening of the North Wing Cardiac Centre in 2006, the creation of a major trauma centre with on-site helipad and the opening in 2014 of Ronald McDonald House for the relatives of sick children.

Organisationally, Southampton University Hospitals Trust was formed in 1993, creating a single management board for acute services in Southampton. Eighteen years later, University Hospital Southampton NHS Foundation Trust (UHS) was formed (1 October 2011) when Southampton University Hospitals NHS Trust was licensed as a foundation trust by the then regulator, Monitor (now known as NHS Improvement (NHSI)).

# Key issues and risks

1. **Failure to deliver national access targets**, which impacts patient experience and patient safety. Whilst we are meeting some of the national constitutional standards in waiting times, we are not meeting them all. A number of actions have been taken in relation to improving responsiveness and working with local health and social care partners to reduce delayed transfers of care. The Trust will continue to work to reduce delayed transfers of care as well as reviewing the efficiency of discharge processes during 2017/18.

2. **Capacity and occupancy**, which impacts on patient flow and to the quality and timeliness of care. Operational risks have been identified across a number of services/specialties linking to issues around increasing referrals, system capacity and delayed transfers of care. We have mitigated this by implementing daily reviews to assess system capacity and escalation requirements aligning capacity plans with the wider system, developing plans to reduce length of stay with strong clinical leadership and oversight and working with local health and social care partners to reduce delayed transfers of care.

3. **Staffing**, both in terms of recruitment and retention. To mitigate this risk we will continue to focus on making UHS an attractive employer by:
   - continuing to recruit within Europe and further afield
   - working with universities to increase student nurses
   - developing band four posts and apprentices
   - leveraging the 'Think UHS' recruitment brand
   - enhancing medical overseas fellows posts
   - reviewing all junior doctor rotas in light of the new contract
   - using flexible and temporary staff when needed
   - creating different roles linked to our research agenda
   - reviewing training and education to enhance retention

# Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

# Performance reporting

## Reporting structure

As a large NHS university hospital foundation trust, UHS monitors performance within individual teams throughout the year with feedback processes in place to escalate issues to more senior management teams. At a corporate level we have an established executive reporting structure.

This begins with the monthly Trust Board meeting where the executive directors of the Trust will present a high level summary to the chairman and non-executive directors, as well as providing greater detail on key performance changes, risks and issues.

Below this are a number of executive sub-committees attended by a subset of executive and non-executive directors. These are the audit and risk committee, the strategy and finance committee, and the quality committee. These committees will review issues in greater depth, feeding back to Trust Board as appropriate. In addition, there are regular Trust Board study sessions which focus on specific individual issues with the entire Board present.

The Trust executive committee (TEC) meets monthly and is made up of the executive board members and the divisional management teams. Performance and service issues are discussed in greater detail at this meeting.

Finally, there are regular performance meetings between the operational management team (led by the chief operating officer) and the division and care group management teams. These meetings focus on the individual patient and service pathways and developing the detailed plans for improvement.

## Key performance indicators (KPIs)

The Trust publishes a monthly Integrated KPI Board Report on its website which provides both the Board and the public with an overview of performance within the Trust. This report is constantly evolving as new areas of monitoring are developed and new areas of national focus become apparent. For the 2016/17 period the most notable development to the monthly report was a restructuring of the format in order to better align the reported metrics to five key Care Quality Commission questions:

- Are we safe
- Are we effective
- Are we caring
- Are we responsive
- Are we well-led.

The monthly report features the following sections:

- Executive digest – a textual update on the previous month's performance across the Trust written by the director of transformation and improvement.
- Trust overview – the top KPIs identified by Trust Board, RAG-rates for the previous 13 months (see Appendix eight)
- Performance
- Activity
- Capacity
- Emergency department (ED)
- Referral to Treatment (RTT/18 weeks)
- Cancer waiting times
- Finance
- Patient experience
- Patient safety
- Outcomes
- Staffing (HR) and estates
- Education and training
- Research and development

This report also includes summary versions of quarterly reports submitted to TEC which go into greater detail about patient experience, patient safety, clinical effectiveness and outcomes, and infection prevention. In addition, a separate Finance Board Report is submitted to Trust Board on a monthly basis.

## How we monitor performance

In addition to reviewing the data submitted to the Trust Board in these papers, we have a suite of tools available to compare UHS performance to that of comparable trusts around the country. Depending on the measures being monitored, UHS has a number of peer groups to benchmark against including other local providers, major trauma centres and university hospital teaching trusts.

Each NHS Trust will service a different size and type of population and will offer a slightly different range of services so it is important to understand that this benchmarking provides an initial indication of performance rather than an absolute guide to our position nationally.

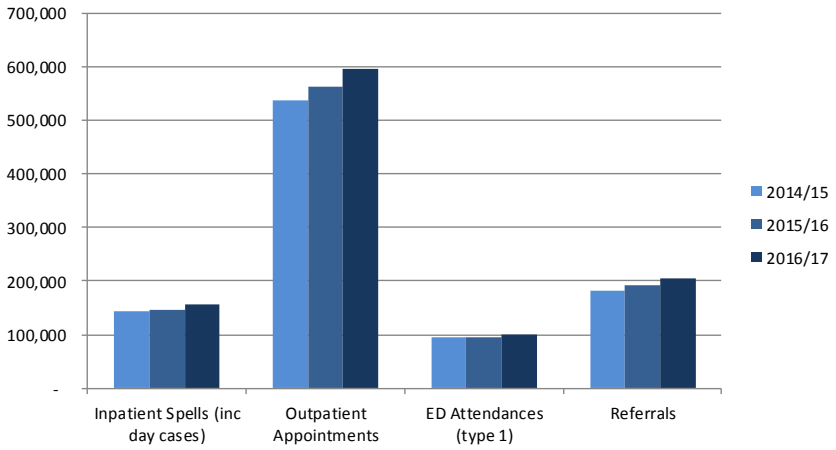
In 2016/17 we have reviewed the National Model Hospital data published by Lord Carter's team at NHS Improvement, this includes the Getting it Right First Time Reports. This data and ability to compare our performance has helped to highlight areas of excellent practice and areas where there is potential to improve. This data is reported regularly to the Transformation Board.

## Detailed analysis and explanation of the development and performance of UHS

Over the past three years we have seen significant increases in all types of activity. Some of this is due to an increase in the range of specialist services we offer, becoming a major trauma centre and the building of the helipad, but much of it is due to the increased and aging population in Southampton and the surrounding area.

The graphs below demonstrate this increase in activity.

**Growth in activity - 2014/15 to 2016/17**

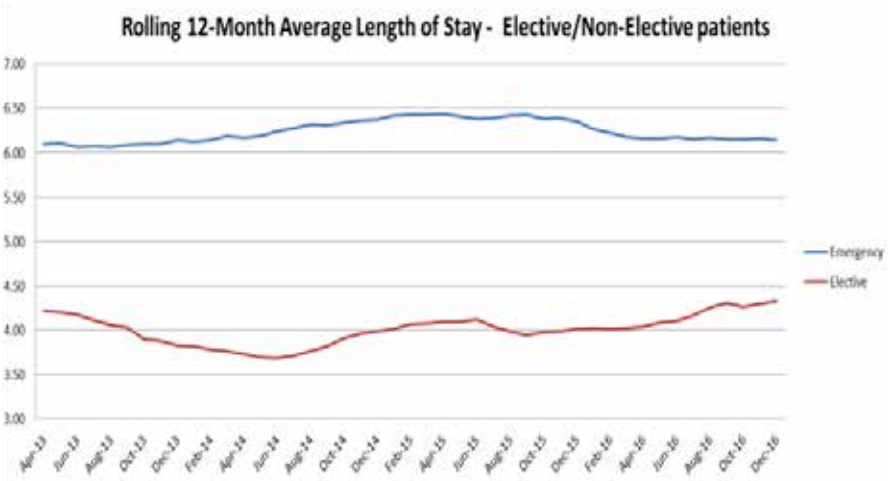



| | 2014/15 | 2015/16 | 2016/17 | Increase 2014/15 to 2016/17 |
|---|---|---|---|---|
| Inpatient spells (inc day cases) | 144,934 | 146,066 | 155,780 | 7.5% |
| Outpatient appointments | 536,949 | 562,972 | 596,621 | 11.1% |
| ED attendance (type one and two) | 94,376 | 95,217 | 99,493 | 5.4% |
| Referrals | 182,407 | 191,888 | 204,840 | 12.3% |

The hospital alert status is decided by the operations centre after assessing the bed and staffing position, and is recorded twice daily at the Trust bed meetings (though the status may change at any time).
Black alert is the highest level of alert and is issued when there are no empty beds available across the Trust with no expected discharges, the emergency department is full, and several ambulances are likely to be delayed for long periods of time, stopping them from responding to 999 calls. In 2014/15 a black alert was recorded 91 times at the twice daily bed meetings. In 2015/16 this was reduced to seven. However, as result of the increasing demand for Trust services this increased to eleven in 2016/17.

Contributing to this change has been the increase in Length of Stay (LoS) for elective patients and bed capacity being impacted upon by the increased number of patients requiring a complex package of care after their discharge. These patients can often have their discharges delayed while beds in community care homes are found and supporting community care packages are arranged.

The chart below demonstrates the change in LoS for elective and non-elective (emergency) patients over the past three years.




2016/17 saw an increased focus on discharging patients earlier in the day and at the weekend. This will remain a major focus for the Trust in 2017/18.

Each of the above metrics will have an impact on the Trust's performance against the three primary nationally reported targets for Referral to Treatment (RTT, or 18 Weeks) performance, emergency department performance and cancer waiting times performance.

### Referral to Treatment (18 Weeks) performance

Due to a change introduced by the Government in 2015 trusts are only required to achieve the Incomplete Pathways target:

1. Incomplete Pathways – 92% of all patients on 18 week pathway and not yet treated should have waited 18 weeks or less at the end of the month.

UHS met the target in quarters one, two, and three of 2016/17. In quarter four the target was met in February and March but performance in January meant that the target was not met for the quarter as a whole.

Achievement of this target in 2016/17 should be set against the aforementioned rise in patient referrals, which highlights the increased demands being placed on the Trust. It is only due to the increased efficiency shown by the Trust's inpatient and outpatient services that it has been possible to meet these targets on an ongoing basis. This is an excellent result and goes against the national trend.

## Emergency department (ED) performance

We did not meet the national target of 95% of all ED attendances being treated and either admitted or discharged within four hours of arrival in any month in 2016/17, but we did achieve our nationally agreed trajectory target. This has been a challenging target nationwide with the winter period being the worst performance the NHS in England has ever recorded.

There are three types of ED that can be included in these figures:

### Type one

A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

### Type two

A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

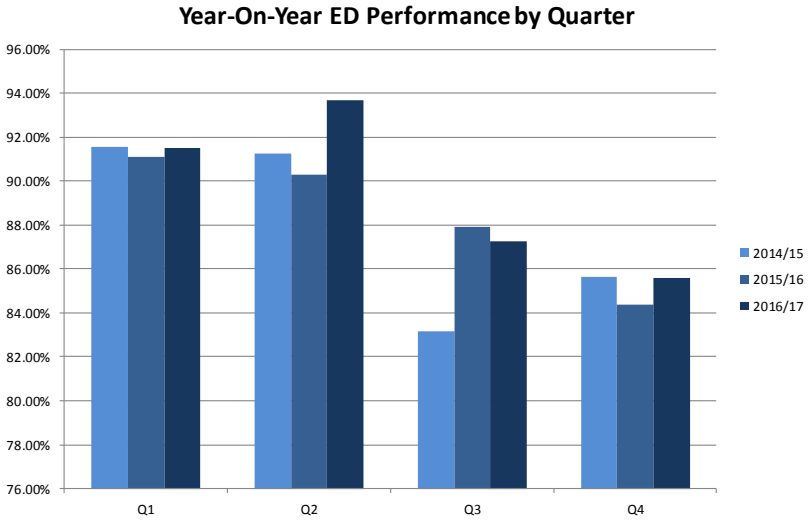
### Type three

Other type of accident and emergency/minor injury unity (MIUs/Walk-in Centres, primarily designed for the receiving of accident and emergency patients. A type three department may be doctor led or nurse led. It may be co-located with a major ED or sited in the community. A defining characteristic of a service qualifying as a type three department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment.

UHS has type one and type two (ophthalmology) departments. The Trust also had a type three (MIU) department until July 2014. Due to the nature of the activity at the MIU, the transfer of this department to another provider reduced UHS performance against the four hour target by approximately 3%. When comparing performance over the long term, it is important to factor this change in.

ED performance improved in quarters one, two, and three of 2016/17 compared to 2014/15 and in quarters one and two over 2015/16, despite the increases in activity. In quarter three performance decreased by 0.6% while activity increased by 1,795 attendances, a 7.5% rise. In quarter four performance was 1.2% better than in 2015/16 and matched 2014/15 performance.

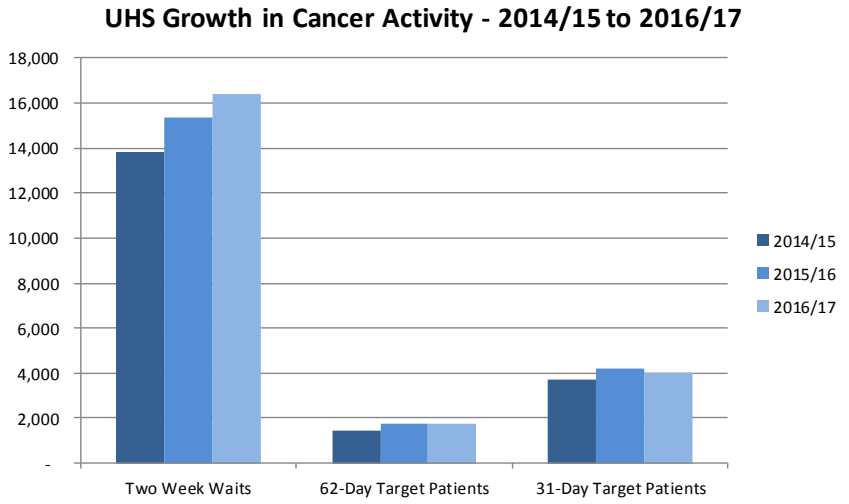
The graph below shows UHS performance against the four hour target over the past three years.



### Cancer waiting times

There are ten separate cancer waiting times measures that the Trust reports to the Department of Health on a monthly basis, each of which can then be split into tumour site specific performance groups. In 2016/17 the Trust met all but one of these measures.

The performance against the targets should be set against the significant rise in activity seen on the cancer pathways. The number of patients referred under the 'two week wait urgent suspected cancer protocol' that were seen within two weeks of their referral, rose by 1,058 (6.9%) in 2016/17. The chart below shows the rise in demand for UHS services over the past three years.




# Regulatory body ratings

### Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from one to four where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from quarter three of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

### Segmentation

During quarter four of 2016/17 the Trust was placed within segment '2' This segmentation information is the Trust's position as at 31 March 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

### Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

| Area | Metric | 2016/17 Q3 score | 2016/17 Q4 score |
|---|---|---|---|
| Financial sustainability | Capital service capacity | 2 | 2 |
| | Liquidity | 2 | 2 |
| Financial efficiency | Income and expenditure margin | 1 | 1 |
| Financial controls | Distance from financial plan | 1 | 1 |
| | Agency spend | 1 | 1 |
| Overall scoring | | 1 | 1 |

The Care Quality Commission (CQC) gave us an overall rating of 'requires improvement' as at December 2014. You can see further details on page 128 of the quality account or in full by visiting www.uhs.nhs.uk or www.cqc.org.uk. The CQC returned in January 2017 to conduct a follow up inspection. We are currently awaiting their full report.

# Environmental matters

A number of projects were undertaken in 2016/17 to reduce our impact on the environment. We have replaced a significant proportion of our external lighting and much of our internal lighting with LED technology. A number of ventilation systems have been upgraded to enable heat recovery and we have launched an awareness programme to help staff work in more environmentally sustainable ways.

In addition to these developments we have implemented a range of measures to ensure that we are using energy more efficiently. For example, we now review and ensure the efficiency of high energy consumption equipment. More information can be found within the environmental sustainability and climate change section of this report.

# Social, community and human rights issues

We recognise our responsibilities under the European Convention on Human Rights (included in the Human Rights Act 1998 in the UK), which are relevant to health and social care. These rights include the:

- right to life
- right not to be subjected to torture, inhuman or degrading treatment or punishment
- right to liberty
- right to respect for private and family life

The Trust is committed to ensuring it fully takes into account all aspects of human rights in our work.

# ACCOUNTABILITY REPORT

# Directors' report

## Composition of the Board

The Board is currently comprised as follows:

**Non-executive directors:**

| | |
|---|---|
| Peter Hollins | chair |
| Simon Porter | senior independent director/deputy chair |
| Professor Iain Cameron | |
| Lynne Lockyer | |
| Dr David Price | |
| Dr Mike Sadler | |
| Jenni Douglas Todd | |

**Executive directors:**

| | |
|---|---|
| Fiona Dalton | chief executive |
| Gail Byrne | director of nursing and organisational development |
| Jane Hayward | director of transformation and improvement |
| Dr Derek Sandeman | medical director |
| Dr Caroline Marshall | chief operating officer |
| David French | chief financial officer |

Each director confirms that at the time the annual report and accounts is approved:

- so far as the director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware

- the director has taken all the steps they ought to have taken as director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

There are no important events since the year end affecting the foundation trust.

No political donations have been made.

The Trust has no overseas branches.

## Trust Board declarations of interest

**Peter Hollins**

Partner in the Jubilee Film Partnership; Chair of CLIC Sargent Cancer Care for Children (a company limited by guarantee); Council Member of University of Southampton.

**Iain Cameron**

Dean, Faculty of Medicine and Member, University Executive Board, University of Southampton; Board Member, Wessex Academic Health Sciences Network; Director (Chair), Medical Schools Council (until 1 July 2016); Director, Medical Schools Council Assessment (until 1 July 2016); Director, UK CAT (Clinical Aptitude Test) (until 1 July 2016); Trustee, Wessex Medical Trust; Joint Chair, University Hospital Southampton/University of Southampton Joint Research Strategy Board; Joint Chair, National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) Southampton Executive Board.

**Simon Porter**

Former Partner in Ernst & Young LLP; Non-executive Director and Chair of Audit Committee, Radian Group; Non-executive Director and Chair of Audit Committee, Octavia Housing.

**Lynne Lockyer**
Board member/trustee of the Brendoncare Foundation.

**David Price**
Chair of RTL Materials Ltd; Chair of Telesoft Technologies Ltd; Chair of Optitune Plc; Chair of Symetrica Ltd; Member of Advisory Board, Silverstream Technologies BV; Treasurer, University of Southampton; Chair of Lontra Ltd (from 1 May 2016).

**Michael Sadler**
GP Specialist Advisor for the Care Quality Commission (until 31 May 2016); External Clinical Associate for PricewaterhouseCoopers.

**Jenni Douglas-Todd**
Managing Director, Diversa Consultancy Limited; Member of the Judicial Conduct Investigative Office; Non-Executive Director, Hampshire Cricket Board (from 2 May 2016).

**Fiona Dalton**
NHS representative on Office for the Strategic Co-ordination of Health Research (OSCHR) Board; Director, Southampton Commercial Estates Development Partnership (CEDP) Project Company Limited, a wholly-owned subsidiary of UHSFT.

**Gail Byrne**
Husband is a consultant surgeon in the Trust; Trustee of Naomi House Children's Hospice.

**Caroline Marshall**
Nil.

**Jane Hayward**
Director, UHS Estates Limited, a wholly-owned subsidiary of UHSFT; Father is Mental Health Act Manager, Southern Health Foundation Trust (voluntary position), member of Assessment Committee for Clinical Excellence Awards South and Public Health England (lay member), a UHSFT Simulated Patient (voluntary position); Mother is a UHSFT Simulated Patient (voluntary position).

**Derek Sandeman**
Director of UHS Pharmacy Limited, a wholly-owned subsidiary of UHSFT.

**David French**
Non-executive director and chair of audit and risk committee, Sentinel Housing Association (renamed Vivid Housing Limited on 23 April 2017); Governor and chair of Audit Committee, South Wilts Grammar School for Girls (until 8 December 2016); Chair of Hampshire and Isle of Wight NHS Counter Fraud Board; Director, UHS Estates Limited, a wholly-owned subsidiary of UHSFT; Director, Southampton Commercial Estates Development Partnership (CEDP) Project Company Limited, a joint venture between UHS and Interserve Prime.

Approved by the Trust Board 23 May 2017.

Chief executive
23 May 2017

# Introducing the Board of Directors

## Trust Board

The Board is made up of the chair, six non-executive directors and six executive directors including the chief executive. Together they bring a wide range of skills and experience to the Trust, such that the board achieves balance and completeness at the highest level. The non-executive directors, including the chair, are people who live or work in the local area and have shown a genuine interest in helping to improve the health of local people. The non-executive directors are determined by the Board to be independent in both character and judgement.

The chair, executive directors and non-executive directors have declared any business interests that they have. The Board is satisfied that no conflicts of interest are indicated in any external involvement. The register of Board members' interests is updated at least annually and is maintained by the company secretary and associate director of corporate affairs. It is available for public inspection from the company secretary and associate director of corporate affairs.

The 'reservation of powers to the Board and delegation of powers policy' sets out the business to be conducted by the Board, or by one of its committees. Any enquiries should be made to: company secretary and associate director of corporate affairs, Trust Headquarters, Mailpoint 18, University Hospital Southampton NHS Foundation Trust, Tremona Road, Southampton, SO16 6YD or telephone 023 8120 6829.

## Senior independent director

The senior independent director role provides a channel through which foundation trust members and governors are able to express concerns, other than the normal route of the chair or chief executive.

## Appointments

Non-executive directors are appointed via open advertisement in accordance with the 'Appointment of a foundation trust non-executive director good practice guide' procedure adopted by the Trust. The process is managed through the governors' nomination committee, a sub-committee of the Council of Governors.

This committee also determines the remuneration and terms and conditions of the non-executive directors. For further details on the appointment of non-executive directors please see page 42-43.

## Development of the Board

The Board held monthly study sessions during 2016/17 where strategic issues, along with emerging issues, were discussed.

## Meetings of the Board

The Board meets once a month in public. Additional private meetings with only the Board, and associated employees of the Trust making presentations to the Board in attendance, are held as required.

Other committees of the Board include: remuneration and appointment committee; audit and risk committee, strategy and finance committee; quality committee and charitable funds committee. Generally the other committees of the Board meet monthly with the exception of the audit and risk committee, which meets five times a year and the appointments and remuneration committee which meets every other month. The frequency of the meetings is set out in each committee's terms of reference. These terms of reference are reviewed at least annually.

The performance of individual Board members is reviewed as set out on page 24 of this report.

### Engagement with Council of Governors

The Trust Board engages with the Council of Governors through the chair and senior independent director. Non-executive and executive directors engage with sub-groups of the council where these are related to their portfolios. Board members meet regularly with governors and have an open invitation to attend formal Council of Governor meetings.

# The people

### Non-executive directors

**Peter Hollins, chair**

Peter graduated in chemistry from Hertford College, Oxford. Joining Imperial Chemical Industries in 1973, he undertook a series of increasingly senior roles in marketing and then general management. Following three years in the Netherlands as general manager of ICI Resins BV, he was appointed in 1992 as chief operating officer of EVC in Brussels – a joint venture between ICI and Enichem of Italy. He played a key role in the flotation of the company in 1994, returning in 1998 to the UK as chief executive officer of British Energy where he remained until 2001. From 2001, he held various chairmanships and non-executive directorships. In 2003, he decided to return to an executive role as chief executive of the British Heart Foundation in which post he remained until retirement in March 2013. He joined Southampton University Hospital Trust as a Non-executive director in 2010, became senior independent director and deputy chairman of UHS in 2014, and was appointed chair in April 2016. He has also been the chair of CLIC Sargent Cancer Care for Children and Young People, and a Council Member of Southampton University, since 2014 and 2016 respectively.

**Simon Porter, senior independent director and deputy chair**

Simon was born and educated in Southampton and then Oxford, graduating with a degree in modern languages (Italian and French). He is a qualified chartered accountant, having spent most of his career with the London office of Ernst & Young, where he specialised first in audit, then in transactions and finally risk management. He was a partner with Ernst & Young from 1994 to 2010. He joined the Trust Board on 1 January 2011 as a designate non-executive director and became non-executive director from 1 June 2011. He is chair of the audit and risk committee and a member of the strategy and finance committee. He also holds non-executive board positions in the social housing sector.

**Professor Iain Cameron**

Iain is professor of obstetrics and gynaecology and dean of the Faculty of Medicine at the University of Southampton. After graduating in medicine at the University of Edinburgh, he underwent postgraduate clinical and research training in Edinburgh, Melbourne and Cambridge. He held the regius chair of obstetrics and gynaecology at the University of Glasgow from 1993 and moved to Southampton in 1999. His main clinical and research interests are reproductive endocrinology and investigation of the impact of the maternal environment on early pregnancy. Iain was chair of Medical Schools Council from 2013-16 and is a member of the UK Clinical Research Collaboration board and the Wessex Academic Health Science Network board. He was appointed as a non-executive director of the MDDUS (Medical and Dental Defence Union Scotland) in April 2017.

**Lynne Lockyer**

Lynne's background is in human resource management and strategic management. She became a non-executive director for Southampton and South West Hampshire in 1996 and the vice chair in 2000. She was chair of Eastleigh and Test Valley South PCT from its inception in 2002 until its disestablishment in 2006. She has taken many roles in the local health economy including being a member of Hampshire's Local Area Agreement Board and nationally was a member of the NHS Confederation Council and the National NHS Leaders Steering Group. She was until recently a course director at the University of Portsmouth and is now an organisation development consultant. She is a trustee of the Brendoncare Foundation.

**Dr David Price**
David is a former chief executive of a FTSE-250 company with broad experience within the electronics, chemical, aerospace, defence, marine, and nuclear industries. He has a successful track record of developing highly complex companies in international markets. He is currently non-executive chairman of Symetrica Ltd, Telesoft Technologies Ltd, RTL Materials Ltd, Lontra Ltd and Optitune Plc. He is treasurer of the University of Southampton and a member of the advisory board of Silverstream Technologies BV. David is a chartered engineer and chartered scientist. He has a degree in electronic engineering, a PhD from University College London and, in 2001 he was awarded an honorary doctorate by Cranfield University for his services to science and engineering. David was made a Commander of the Order of the British Empire (CBE) for his services to industry.

**Dr Mike Sadler**
Mike joined us as a clinical non-executive director in September 2014, from a similar position at an NHS Foundation Trust providing mental health, learning disability and community services. He has chaired our quality committee since June 2016. He works as an advisor and consultant on health and social care services, recently advising on health reform in the Middle East, and in Ireland. He has been chair and technical adviser to the Diabetes Professional Care Conference since 2015, and also worked for the CQC as a specialist adviser in primary care.

Mike graduated from Nottingham University, and was a GP principal in Hampshire before moving into public health medicine. Having achieved an MSc with distinction at the London School of Hygiene and Tropical Medicine, he joined Portsmouth and South East Hampshire Health Authority, holding the joint posts of deputy director of public health and medical adviser. He has since held a series of senior clinical leadership roles in national organisations in both the public and private sector, including as a chief operating officer at NHS Direct and Serco's health division. His last full time role, up until July 2013 when he commenced his portfolio career, was as director of health and social care at West Sussex County Council.

**Jenni Douglas-Todd**
Jenni is a former chief executive of Hampshire Police Authority and the office of the Hampshire police and crime commissioner. After beginning her career in the probation service, she was headhunted into the civil service, at the Home Office, where she spent four years before being becoming director of policy and research for the Independent Police Complaints Commission. In the latter role she was responsible for establishing governance of the new police complaints system. She then spent two-and-a-half years as a resident twinning adviser for the UK, based in Turkey to help set-up a law enforcement complaints system before taking up the role of chief executive of the county's Police Authority. During her three years in the post, she supported the authority in developing effective governance processes to increase accountability and transparency. She also helped the organisation deliver cost-savings whilst still improving performance and developing closer working relations with neighbouring forces.

In 2012, she became chief executive and monitoring officer for the Hampshire police and crime commissioner, where she led the development of the office's vision, mission, values and organisational strategy. She took on the role of investigating committee chair for the general dental council in 2014 and, in April that year, founded the Diversa Consultancy, which supports organisations with changes in business, culture and behaviour. She is also a member of the Judicial Conduct Investigating Office, a public appointment.

## Executive directors

**Fiona Dalton, chief executive**
Fiona was appointed as chief executive in 2013. Prior to re-joining the Trust she held the combined position of deputy chief executive and chief operating officer at Great Ormond Street Hospital for Children. Fiona joined the NHS management training scheme after graduating from Oxford University with a degree in human sciences and began her career in hospital management at Oxford Radcliffe Hospitals NHS Trust in 1996. She then spent four years at UHS as director of strategy and business development before moving to Great Ormond Street Hospital.

**Gail Byrne, director of nursing and organisational development**
Gail joined the Trust in 2010 as deputy director of nursing and head of patient safety. Prior to this, she has worked at the Strategic Health Authority as head of patient safety, and director of clinical services at Portsmouth Hospital. Gail has also worked in Brisbane, Australia as a hospital Macmillan nurse, and as general manager of a special purpose vehicle company for the private finance initiative at South Manchester Hospitals.

**Jane Hayward, director of transformation and improvement**
Jane joined the Trust in 2000 as a clinical services manager for the cardiothoracic directorate after spending two years in Hertfordshire as director of performance and 11 years at Barts and the London Hospitals in various roles including planning, finance and commissioning. Jane has led on human resources, information management and technology, improvement and modernisation and has been chief operating officer. Jane joined the Trust Board in February 2008 and became director of transformation and improvement in January 2014.

**Dr Derek Sandeman, medical director**
Derek was appointed to the Trust as a consultant physician in 1993 and went on to develop a regional endocrine service. Throughout his career he has had extensive clinical leadership experience, most recently serving eight years as clinical director. Derek's leadership roles have also included programme director for postgraduate education and the Wessex Endocrine Royal College representative. He has a strong history of wider system engagement, working collaboratively with partners to improve systems resilience and pathways.

**Dr Caroline Marshall, chief operating officer**
Caroline joined the Trust in 1997 as a consultant hepatobiliary and neuroanaesthetist. She has held the posts of college tutor for the Royal College of Anaesthetists and UHS mentoring and coaching lead. In 2008, she became clinical service director for critical care, and then divisional clinical director for division A between 2010 and 2013. Caroline served as interim chief operating officer between January to December 2014, and was then appointed to the substantive post. Her portfolio includes the Executive lead for cancer and the executive lead for major trauma.

**David French, chief financial officer**
David joined the Trust in February 2016 and leads on finance, procurement, estates and commercial development. He read Economics and Social Policy at the University of London before joining ICI plc, where he qualified as a chartered management accountant. David has extensive healthcare experience from the pharmaceutical industry, mostly Eli Lilly and Company where he held many commercial and financial roles in the UK and overseas. He joined the NHS in 2010 as chief financial officer of Hampshire Hospitals NHS Foundation Trust. He also serves as a non-executive director for Vivid Housing Limited, a social housing provider across Hampshire and the Solent.

## Board effectiveness
On the basis of the expertise and experience described above, the Trust is confident that the necessary range of knowledge and skills exists within the Board of Directors and that its balance, completeness and appropriateness to the requirements of the NHS Foundation Trust constitutes a high performing and effective Board. A register of interests of Board members is outlined within this report and is also available from the associate director of corporate affairs. The effectiveness of the Board of Directors meetings is reviewed at the end of each meeting. Effectiveness of Board sub-committees is monitored through monthly board reports and annual evaluation/review of the terms of reference and work programmes.

## Schedule of Decisions Reserved to the Board
The NHS Foundation Trust Code of Governance requires that there should be a formal schedule of matters specifically reserved for decision by the Board. The Scheme of Delegation shows the 'top level' of delegation within the Trust. The Scheme should be read in conjunction with Trust's Standing Financial Instructions and Standing Orders. A copy of the Schedule of Matters Reserved for the Board can be obtained from the associate director of corporate affairs.

## Attendance at board meetings in 2016/17

| Board member | 12 Apr Extra CS | 28 Apr | 24 May Extra CS | 26 May | 20 Jun Extra CS | 28 Jun | 26 Jul | 27 Sep | 11 Oct Extra CS | 27 Oct | 29 Nov | 16 Dec CS only | 26 Jan | 28 Feb | 28 Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Peter Hollins chair | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Simon Porter non-executive director | ✓ | ✓ | ✓ telecon | ✓ | ✓ telecon | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Iain Cameron non-executive director | ✓ | ✓ | × | ✓ | × | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × |
| Lynne Lockyer non-executive director | ✓ | ✓ | ✓ telecon | × | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| David Price non-executive director | × | ✓ | ✓ telecon | ✓ | ✓ telecon | ✓ | ✓ | ✓ OS only | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ |
| Mike Sadler non-executive director | ✓ | ✓ | ✓ telecon | ✓ | ✓ telecon | ✓ | ✓ | ✓ | × | ✓ | ✓ OS only | ✓ | ✓ | ✓ OS only | × |
| Jenni Douglas-Todd non-executive director | ✓ | ✓ | ✓ telecon | ✓ | ✓ telecon | ✓ | × | ✓ OS only | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ |
| Fiona Dalton Chief executive | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| David French Chief financial officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Derek Sandeman Medical director | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Gail Byrne Director of nursing and organisational development | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Caroline Marshall Chief operating officer | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | × | × | × | ✓ | ✓ | × |
| Jane Hayward Director of transformation and improvement | ✓ | ✓ | × | ✓ | ✓ telecon | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Telecon = telephone conference
OS only = open session only

### Audit and assurance committee (until May 2016)

| Board member | May 2016 |
|---|---|
| Peter Hollins NED<br>chair | ✓ |
| Simon Porter<br>non-executive director<br>senior independent director and<br>deputy chair | × |
| Iain Cameron<br>non-executive director | ✓ |
| Lynne Lockyer<br>non-executive director | × |
| David Price<br>non-executive director | ✓ |
| Mike Sadler<br>non-executive director | ✓ |

### Audit and risk committee (formerly audit and assurance committee) (from June 2016)

| Board member | 18 Jul | 17 Oct | 16 Jan | 20 Mar |
|---|---|---|---|---|
| Simon Porter<br>non-executive director<br>senior independent director and<br>deputy chair | ✓ | ✓ | ✓ | ✓ |
| David Price<br>non-executive director | ✓ | ✓ | ✓ | × |
| Mike Sadler<br>non-executive director | ✓ | ✓ | ✓ | ✓ |
| David French<br>Chief financial officer | ✓ | ✓ | ✓ | ✓ |

# Audit and risk committee

The audit and risk committee (formerly known as the audit and assurance committee) is a non-executive committee of the Trust Board with delegated authority to review the establishment and maintenance of an effective system of integrated governance, risk management and financial and non-financial control, which supports the achievement of the Trust's objectives.

As part of the Trust's on-going commitment to continuous improvement the role and responsibilities of the audit and risk committee were subject to in-year review and revision. The principle change arising from the review was the transfer of responsibilities with regards to 'clinical quality assurance' to the quality committee.

### Composition and meetings

There are three non-executive director members of the committee. The committee is chaired by Simon Porter. Further information on the chair is available on pages 21.

Executive directors attend by invitation, and there is a standing invitation to the chief financial officer. Other executive directors and staff with specialist expertise attend by invitation.

The audit and risk committee met five times between May 2016 and March 2017 in relation to matters covered in this annual report.

## Purpose and remit

The committee purpose is the remit of a 'traditional' audit committee, including an oversight function in relation to financial reporting, systems of internal control, risk management, effective use of resources, appointment and effectiveness of external and internal auditors.

Major topics considered by the committee in-year included:

- Five internal audit reports and related recommendations, arising from an agreed programme of work for the year.
- Five external audit reports including year-end report and management representation letters for financial statements and quality report.
- Final draft annual report and accounts.
- Reference costs approval process.
- Update in relation to maintenance backlog.
- The Trust's treasury management policy and process.
- Revisions to the Standing Financial Instructions for 2016/17.
- Quarterly updates on regulatory activity across the Trust specifically focusing on regulatory inspections, accreditations and peer reviews, and actions arising from these.
- Quarterly review of the Board Assurance framework and operational risk register, which articulates the highest areas of risk to which the Trust is exposed, together with actions to mitigate or manage those risks
- Local counter fraud services are regularly reviewed and update reports were received at each meeting.
- Regular review of internal Referral to Treatment data quality audits and data quality issues in other areas of the Trust.
- Regular review of losses and special payments.
- Review of waivers of competitive tender and the process for reporting.

The committee has also considered the financial statements, including areas of subjectivity or judgement, suitable accounting policies and disclosures in compliance with legal and regulatory requirements. The committee has also reviewed the Trust's annual governance statement and how this is positioned within the wider Annual Report.

Having reviewed the content of the annual report and accounts, the committee has advised the Board that, in its view, taken as a whole:

- it is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy
- it is consistent with the draft annual governance statement, head of internal audit opinion and feedback received from the external auditors.

## Relationship with the Board

The chair reports orally to Trust Board after each meeting of the committee and a copy of the minutes is included in the subsequent Trust Board papers. As a consequence, and due to the extensive involvement of many executive directors and non-executive directors at all of the audit and risk committee meetings, the Trust Board has not requested a written report from the committee. Discussions at Trust Board frequently identify topics for further scrutiny by the committee.

## External auditors

The external audit contract is currently held by KPMG LLP (from 1 November 2012). The contract was originally for three years and was extended by the Council of Governors for the 2015/16 and 2016/17 audits. KPMG regularly report to and attend the audit and risk committee, enabling the committee to monitor their performance. The statutory audit fee for 2016/17 was £55,000 plus VAT and for UHS Pharmacy Ltd and UHS Estates Ltd was £8k plus VAT. The non-audit services provided by KPMG LLP totalled £81k plus VAT. These sums are not material to either organisation. Before considering taking on such work, KPMG have assessed whether or not there is any potential conflict of interest. The largest proportion of the work relates to advice from KPMG's NHS VAT team, who have no role in the external audit of the Trust.

## Governance code

University Hospital Southampton NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code, revised in June 2016. So far as the board is aware, all possible steps have been taken to ensure that all relevant audit information has been disclosed in full to the auditors.

## Performance evaluation of Trust Board and its committees

The Board and its various sub-committees conduct evaluations of their overall effectiveness on a periodic basis.

## Remuneration

Further details of remuneration are given in the remuneration report. The accounting details for pensions and other retirement benefits are set out on pages 45 and 101 of the accounts section.

## Countering fraud and corruption

The Board remains committed to maintaining an honest and open culture within the Trust; ensuring all concerns involving potential fraud have been identified and rigorously investigated. Where guilt has been proven, appropriate civil, disciplinary and/or criminal sanctions have been applied. We work closely with the local counter fraud specialist team to try and prevent and investigate issues as and when they arise. The team have been instrumental in creating an anti-fraud culture, which has enabled maximum deterrent and prevention measures to become embedded in the Trust.

Fraud against NHS is never acceptable and any concerns can be reported via the Fraud and Corruption Hotline on 0800 028 4060. There is also a 'raising a concern' helpline manned by a senior manager which enables staff to confidentially raise concerns about any issues (including fraud, malpractice, clinical negligence and so on).

Cases of potential fraud are dealt with robustly, including termination of employment and potential criminal prosecution.

By maintaining fraud levels at an absolute minimum the Trust ensures that more funds are available to provide better patient care and services.

## Independence of external auditor

This is the fifth and final year for the external auditors' appointment, following the extension agreed by the Council of Governors. The committee considered the independence principles set out by the Auditing Practices Board in relation to the work of our external auditor undertaking non-audit work. We did not identify any risks in this respect, particularly in relation to self-review and familiarity. Our auditors will not be relying on any of the work undertaken when forming their opinion and we do not believe there to be a threat of familiarity. We will continually assess and address any risks to independence as appropriate.

## Internal audit service

We outsource audits to PricewaterhouseCoopers LLP. The internal auditors consider the Trust's system of internal control and agree an annual work programme with the audit and risk committee. This is based on an evaluation of the Trust's profile and risk register. A formal update report goes to the audit and risk committee at each of its meetings.

## Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Trust's performance is set out on the following page.

| Better Practice Payment Code Summary 2016/17 | Number of invoices | Value (£000) |
|---|---|---|
| **Non NHS payables** | | |
| Total non-NHS trade invoices paid in the year | 85796 | 335,603 |
| Total non-NHS trade invoices paid within target | 81864 | 315,979 |
| Percentage of non-NHS trade invoices paid within target | 95.4 | 94.2 |
| **NHS payables** | | |
| Total non-NHS trade invoices paid in the year | 3837 | 42340 |
| Total non-NHS trade invoices paid within target | 3111 | 35046 |
| Percentage of non-NHS trade invoices paid within target | 81.1 | 82.8 |

# Disclosures

In accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2015/16 and the Monitor Code of Governance, UHS is required to include the following disclosures within the annual report.

## Income disclosure

The Trust has complied with the cost allocation and charging guidance issued by the HM Treasury. Income from the provision of goods and services for NHS purposes in England was greater than our income from the provision of goods and services for any other purposes. Other operating income is used to support patient care activities at our hospitals.

## Governance disclosures

University Hospital Southampton NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

So far as the Board is aware, there are no known areas of non-compliance with the code.

A table outlining the disclosure requirements of the Code of Governance is included below.

| Code provision | Requirement | Annual Report page reference |
|---|---|---|
| A.1.1 | The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors. | 20, 23, 38 |
| A.1.2 | The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the Board and those committees and individual attendance by directors. | 20, 42 |
| A.5.3 | The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor | 32-38 |
| FT ARM | The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors. | 33-35, 38 |
| B.1.1 | The Board of Directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary. | 21-23 |

| Code provision | Requirement | Annual Report page reference |
|---|---|---|
| B.1.4 | The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust. | 22-23 |
| FT ARM | The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated. | 20,44 |
| B.2.10 | A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments. | 42-43 |
| FT ARM | The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director. | n/a |
| B.3.1 | A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report. | 18, 21 |
| B.5.6 | Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | 32, 44 |
| FTARM | If, during the financial year, the governors have exercised their power* under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report | n/a |
| B.6.1 | The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the chairperson, has been conducted. | 20, 22-23. 27, 43 |
| B.6.2 | Where there has been external evaluation of the board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust. | n/a |
| C.1.1 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). | 31, 55, 60 |
| C.2.1 | The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls. | 62, 64 |
| C.2.2 | A trust should disclose in the annual report:<br>(a) if it has an internal audit function, how the function is structured and what role it performs; or<br>(b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. | 26, 27 |
| C.3.5 | If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position. | n/a |
| C.3.9 | A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include:<br>• the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;<br>• an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and<br>• if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation | 25-28 |
| D.1.3 | Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings. | n/a |
| E.1.4 | Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report. | 38 |

| Code provision | Requirement | Annual Report page reference |
|---|---|---|
| E.1.5 | The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations. | 21, 36 |
| E.1.6 | The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report. | 36-37 |
| FT ARM | The annual report should include:<br>• a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;<br>• information on the number of members and the number of members in each constituency; and<br>• a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members. | 36-38 |
| FT ARM | The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. | 18, 33-34 |

## Approach to quality governance

'Always improving' is embedded as one of the values in our 'Forward Vision' along with 'Patients First' and 'Working Together'. These are the underpinning values and delivering on quality is the responsibility of Trust Board. The named executive leads for quality are the medical director and the director of nursing and organisational development.

Quality improvement is just one element of a co-ordinated and organisation-wide approach to quality. Each year we define our quality improvement priorities through the development of a Trust-wide Patient Improvement Framework (PIF) with priorities set against outcomes, safety, experience and performance. We consult and agree on these priorities with our staff, our patients and key stakeholders and agree the measures against which we will monitor the improvement. Progress is monitored monthly through our key performance indicator (KPI) report (see page 192) with alternate quarterly deep dive progress reports to the Board. Each of the PIF domains are underpinned by strategies on safety, experience and quality which set out our longer term aims. The results of our priorities are also published in the Trust's quality account, which can be found on page 116.

To embed the qualities at ward and department level we have a Clinical Accreditation Scheme where wards and departments demonstrate their standards of care and the improvements they have made on an annual basis. Wards gain this accreditation by submitting information on the KPIs, patient complaints and compliments to a senior clinical panel with patient representatives who also undertake an unannounced visit of the ward. Wards attaining accreditation are awarded with a certificate, which is presented to them by the director of nursing and organisational development.

The Trust values outlined in our 'Forward Vision' support the organisation being well-led at every level. An organisational development model was developed for 2016/17 to support the implementation of the vision and move to a future organisational state of excellence.

Following a review by the CQC in December 2014 UHS was given an overall rating of 'requires improvement'. Further detail of their findings can be seen in the quality account on page 128 or on our website www.uhs.nhs.uk. The CQC revisited the Trust in January 2017 to see what action had been taken. At the time of preparing this Annual Report we are awaiting the formal findings of this latest inspection.

The following diagram outlines the Trust's quality improvement governance systems' structure and relationships. This infrastructure ensures that the Trust Board has the appropriate oversight of its governance and quality improvement arrangements.


As outlined in the governance systems diagram, there is a further sub-committee of the Board called the quality committee of which both non-executive and executive directors of the Board are members. The purpose of this committee is to provide robust challenge and scrutiny to both operational and quality performance in further detail and on behalf of the Board, taking account of NHS Improvement's Single Oversight Framework and relevant CQC standards.

We have completed the national NHS self-assessment questionnaire and are pleased that this indicates that we are already identifying the expected proportion of deaths with avoidable factors.

The Trust has a Mortality Board aligned with the best practice guidelines forwarded by Monitor (now NHSI). We have processes and assurance that we are identifying avoidable mortality and will be able to publish this data.

The quality governance disclosures should be read in conjunction with information provided in our quality account which begins on page 116.

The Board of Directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

# Council of Governors

Our Council of Governors continues to play a vital part in involving our community in the work we do. They represent our 10,000 public members (patients, carers and local people) to give them a voice at the highest level of the organisation.

The Council of Governors is made up of 13 publicly elected governors, four elected staff governors, and six appointed governors. The governors serve a three year term of office. The Council has five working groups – governors' nominations committee, staff experience group, strategy group, patient experience group and membership and engagement group.

## Composition of Council of Governors

**Public elected governors (13)**

| | |
|---|---|
| Southampton City (coterminous with the Southampton City Council area) | five governors |
| New Forest, Eastleigh and Test Valley (coterminous with the local authority areas of New Forest District Council, Eastleigh Borough Council and Test Valley Borough Council) | four governors |
| Rest of England and Wales | three governors |
| Isle of Wight (coterminous with the Isle of Wight County Council area) | one governor |

**Staff elected governors (four)**

| | |
|---|---|
| Medical practitioners and dental staff | one governor |
| Nursing and midwifery staff | one governor |
| Other clinical staff | one governor |
| Non-clinical and support staff | one governor |

**Appointed governors (six)**

| | |
|---|---|
| Southampton City Clinical Commissioning Group | one governor |
| West Hampshire Clinical Commissioning Group | one governor |
| Hampshire County Council | one governor |
| Southampton City Council | one governor |
| Business South | one governor |
| University of Southampton | one governor |

In addition to the elected Governors, two under-21 representatives are appointed to the Council. As of March 2017 both remain vacant however representatives will be appointed from a local university and a local college.

During 2016/17 there were a number of changes to the Council:

1. Two governors, one from the Southampton City constituency and one from the Rest of England and Wales constituency stepped down from their post during June 2016. Vacancies were held until elections in the summer of 2016 (in addition three vacancies were carried from the previous year).
2. Three governors reached the end of their second three year tenure and one governor reached the end of their first three year tenure in September 2016.
3. The nursing and midwifery governor stepped down from their role in September 2016.
4. Following successful elections in the summer of 2016 ten governors commenced in October 2016.
5. An appointed governor for Southampton City Council stepped down in June 2016. Southampton City Council put forward a nomination for a replacement who commenced in November 2017.
6. Appointed governors from West Hampshire Clinical Commissioning Group and Business South stepped down in January 2017. Replacements have not yet been made.

## Council of Governor meetings

The Council meets every quarter in public. Meetings are advertised on our website, in various places across our sites, and notified to members in our members' newsletters. No business can be transacted at a meeting unless at least half of the governors are present and, of these, not less than half must be governors elected by the public constituencies.

The statutory responsibilities of the Council of Governors are:

- Appoint and, if appropriate, remove the chair and other non-executive directors.
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and other non-executive directors on the recommendation of the governors' nominations committee.
- Approve the appointment of the chief executive.
- Appoint and, if appropriate, remove the Trust's auditor.
- Receive the Trust's annual accounts, and report of the auditor on them and the annual report.
- Approve any annual increases of more than 5% in the Trust's non-NHS income.
- Hold the non-executive directors individually and collectively to account for the performance of the Board of Directors.
- Represent the interests of the members of the foundation trust as a whole and the interests of the public.
- Approve significant transactions (as specified in the Trust's constitution).
- Approve mergers and acquisitions or separation (as specified in the Trust's constitution).
- Approve amendments to the constitution (note that the Board of Directors also has a role as specified in the Trust's constitution).
- Determine that any proposals in the forward plan for non-NHS income will not interfere with the Trust's principal purpose and notify the Trust's directors of the decision.

The constitutional duties of the Council of Governors include:

- Providing views to the Board of Directors on the strategic direction of the Trust; in particular to inform the Trust's forward plan.
- Developing membership of the Trust.
- Regularly feeding back information about the Trust to the membership, and feeding back the views of the constituencies and stakeholder organisations to the Trust.
- Holding the Board of Directors to account in relation to the Trust's performance in accordance with the Terms of licence.
- Complying with the NHS Foundation Trust Code of Governance.

Bryan Bird, Public Governor, New Forest, Eastleigh and Test Valley, was elected lead governor with effect from 28 June 2016 following the departure of Leon Spender from the Council.

All governors are required to disclose details of company directorships or other material interests in companies, where those companies or related parties are likely to do business, or are possibly seeking to do business, with the Trust. A register of interests is maintained and updated regularly. Details of declarations and meeting attendance can be found below.

**Professor Colin Pritchard**, Southampton City Centre (until 30/9/16): Visiting Professor, Department of Psychiatry & Emeritus Professor, School of Medicine, University of Southampton; Research Professor in Psychiatric Social Work, School of Health & Social Care, Bournemouth University. Undertake a range of clinical and policy research analysis that is often health related linked to my university posts.

**Caroline Powell**, Southampton City Centre (until 30/9/16): Director, Centre for Implementation Science, Wessex Academic Health Science Network (AHSN) involving overview of health organisations in Wessex including University Hospital Southampton.

**Leon Spender**, Southampton City Centre (until 28/6/16): Nil

**Pamela Ashurst**, Southampton City Centre (from 1/10/16): Nil

**Sylvia Wyatt**, Southampton City Centre (from 1/10/16): Husband is Professor Jeremy Wyatt, Director of Wessex Institute/Professor of Digital Healthcare, University of Southampton

**Robert Chambers**, Southampton City Centre (from 1/10/16): Employed as Commissioner at Southampton City Clinical Commissioning Group; Wife is Consultant Geriatrician at UHS

**Anthony Havlin**, Southampton City Centre (from 5/12/16): Clerk to Education Admissions and Exclusions Panel; Trustee Treasurer, The Veracity Recreation Ground Trust

**Edward Chaney**, Southampton City Centre (from 1/10/16): Nil

**Heather Parsons**, New Forest, Eastleigh and Test Valley: Director of Where There's a Will charity which supports the General Intensive Care Unit patients and their families at Southampton General Hospital.

**Bryan Bird**, New Forest, Eastleigh and Test Valley: Nil

**Andrew Grapes**, New Forest, Eastleigh and Test Valley: Nil

**Yvonne Binge**, New Forest, Eastleigh and Test Valley (until 11/4/16): Governor, King Edward VI School, Southampton; Chair, Sedgemead Management Company

**Anne Murphy**, New Forest, Eastleigh and Test Valley: Town Councillor in Ringwood; Caseworker for Soldiers, Sailors, Airmen and Families Association (SSAFA), the Armed Forces charity.

**Rose Wiltshire**, Isle of Wight: Volunteer on Enter and View Panel for HealthWatch, Isle of Wight; Volunteer Earl Mountbatten Charity Shop for Kissy Puppy Fund, Isle of Wight; Part-time meet and greet at Earl Mountbatten Hospice, Isle of Wight

**Richard Goldsmith**, Rest of England and Wales: Nil

**John Haydon**, Rest of England and Wales: Nil

**Christopher Godeseth**, Rest of England & Wales (until 28/6/16): Underwriter for medical defence organisation MDDUS

**Bob Purkiss**, Rest of England & Wales (from 1/10/16): Nil

| Governor | Meeting attendance | | | |
|---|---|---|---|---|
| | 28 Jun 2016 | 8 Nov 2016 | 10 Jan 2017 | 14 Mar 2017 |
| Peter Hollins<br>Chair | ✓ | ✓ | ✓ | ✓ |
| Simon Porter<br>Senior independent director/deputy chair | ✓ | ✓ | ✓ | ✓ |
| Rose Wiltshire<br>Elected, Isle of Wight | × | ✓ | ✓ | ✓ |
| John Haydon<br>Elected, Rest of England and Wales | × | ✓ | ✓ | × |
| Christopher Godeseth<br>(until 28/6/16)<br>Elected, Rest of England and Wales | ✓ | | | |

| Governor | Meeting attendance | | | |
|---|---|---|---|---|
| | 28 Jun 2016 | 8 Nov 2016 | 10 Jan 2017 | 14 Mar 2017 |
| Richard Goldsmith<br>Elected, Rest of England and Wales | × | ✓ | ✓ | ✓ |
| Bob Purkiss<br>(from 1/10/16)<br>Elected, Rest of England and Wales | | × | ✓ | × |
| Leon Spender<br>(until 28/6/16)<br>Elected, Southampton City Centre | ✓ | | | |
| Colin Pritchard<br>(until 30/9/16)<br>Elected, Southampton City Centre | ✓ | | | |

continued

| Governor | Meeting attendance | | | |
|---|---|---|---|---|
| | 28 Jun 2016 | 8 Nov 2016 | 10 Jan 2017 | 14 Mar 2017 |
| Caroline Powell (until 30/9/16) Elected, Southampton City Centre | × | | | |
| Pamela Ashurst (from 1/10/16) Elected, Southampton City Centre | | ✓ | ✓ | ✓ |
| Sylvia Wyatt (from 1/10/16) Elected, Southampton City Centre | | ✓ | ✓ | ✓ |
| Rob Chambers (from 1/10/16) Elected, Southampton City Centre | | ✓ | ✓ | ✓ |
| Edward Chaney (from 1/10/16) Elected, Southampton City Centre | | × | ✓ | ✓ |
| Tony Havlin (from 5/12/16) Elected, Southampton City Centre | | | × | ✓ |
| Bryan Bird Elected, New Forest, Eastleigh and Test Valley | ✓ | ✓ | ✓ | ✓ |
| Andrew Grapes Elected, New Forest, Eastleigh and Test Valley | ✓ | ✓ | ✓ | × |
| Heather Parsons Elected, New Forest, Eastleigh and Test Valley | × | ✓ | ✓ | ✓ |
| Anne Murphy (from 1/10/16) Elected, New Forest, Eastleigh and Test Valley | | ✓ | × | ✓ |
| Brian Birch Elected, medical and dental staff | × | ✓ | × | ✓ |
| Katie Prichard-Thomas (until 30/9/16) Elected, nursing and midwifery staff | ✓ | | | |
| Tina Baker (from 1/10/16) Elected, nursing and midwifery staff | | ✓ | ✓ | ✓ |

| Governor | Meeting attendance | | | |
|---|---|---|---|---|
| | 28 Jun 2016 | 8 Nov 2016 | 10 Jan 2017 | 14 Mar 2017 |
| Annette Purkis Elected, other clinical staff | ✓ | ✓ | ✓ | ✓ |
| Anita Beer (until 30/9/16) Elected, non-clinical and support staff | ✓ | | | |
| Amanda Turner (from 1/10/16) Elected, non-clinical and support staff | | ✓ | ✓ | ✓ |
| Joan Wilson Appointed, Southampton City CCG | × | × | × | ✓ |
| Simon Hunter (until 31/12/16) Appointed, West Hampshire CCG | × | × | | |
| Andrew Gibson Appointed, Hampshire City Council | × | × | ✓ | ✓ |
| Cllr Caran Chamberlain Appointed, Southampton City Council | × | | | |
| Cllr Sue Blatchford Appointed, Southampton City Council | | ✓ | ✓ | ✓ |
| Kate Thompson (until 31/12/16) Appointed, Business Southampton | × | × | | |
| Michelle Cowen Appointed, University of Southampton | × | ✓ | ✓ | × |
| Emily Garrett (until 31/8/16) Under 21 Representative | × | | | |
| Kirsten Williamson (until 31/8/16) Under 21 representative | × | | | |
| Aimen Maksoud (from 13/3/17) Under 21 representative | | | | × |

In 2016/17 the Council of Governors has considered a number of items including:

- Annual report and accounts
- Approval of revised Trust Constitution
- Membership engagement
- Performance of the Trust
- Updates in relation to the Sustainability and Transformation Plan
- Review of the draft Quality Account including Patient Improvement Framework
- Consideration of the Trust's strategic direction via review of the Operational Plan

### Disagreements between the Council of Governors and Trust Board

In the event of any disagreement between the Council of Governors and the Trust Board, the senior independent director would be requested to lead on resolution discussions.

### Governors' nomination committee

The Council of Governors is responsible for the appointment, re-appointment and removal of the chair and other non-executive directors of the Foundation Trust, and has established a governors' nominations committee to do so, in accordance with the Trust's constitution.

The committee is responsible for advising and/or making recommendations to the Council of Governors relating to:

- Evaluation of the performance of the chair and non-executive directors
- The remuneration, allowances and other terms and conditions of office for the chair and non-executive directors
- The recruitment process for the selection of candidates for the office of chair or other non-executive directors
- Approving the appointment (by the non-executive directors) of the chief executive

The senior independent director, other non-executive directors and directors may be invited to attend meetings of this committee.

The governors' nominations committee met on two occasions during 2016/17 and considered the following topics:

- Non-executive director appraisals
- Non-executive director recruitment for 2017/18
- Annual review of non-executive director pay and terms and conditions
- Changes to chair's contracted terms

### Governor elections

Governor elections were held in August 2016 for six constituencies: Southampton City (five seats), Isle of Wight (one seat) New Forest, Eastleigh and Test Valley (one seat), the rest of England and Wales (one seat), nursing and midwifery staff (one seat) and non-clinical and support staff (one seat). Nine newly appointed governors commenced in their roles from 1 October 2016 and one further governor commenced in December 2016 following one earlier elected governor being unable to take up the role.

October 2017 will bring an end to the term of office for five of the elected governors. Plans are being developed to run elections throughout the summer with a view to appointing to all vacancies by 1 October 2017. In order to maximise membership engagement and electoral participation all election campaigns are supported through the use of an independent electoral service.

| Constituency | Number |
|---|---|
| Southampton City | 3,139 |
| New Forest, Eastleigh and Test Valley | 3,765 |
| Rest of England and Wales | 1,371 |
| Isle of Wight | 827 |
| Out of Trust area | 5 |

| Age ranges | Number |
|---|---|
| 16 | 1 |
| 17-21 | 36 |
| 22+ | 8,765 |
| Not known | 12 |

| Ethnicity | Number |
|---|---|
| White | 8,361 |
| Mixed | 39 |
| Asian/Asian Black | 225 |
| Black/Black British | 88 |
| Other (inc Chinese) | 64 |
| Not stated | 326 |

Enabling members to help shape the future of the Trust and to ensure that members continue to have a say in the development of the Trust's plans remains a priority. This is achieved through a programme of engagement activities, many of which are organised by the Trust and others have us utilising existing community events within the areas we operate in. From November 2016 to January 2017 there was reduced engagement activity while the membership manager position remained vacant. A new appointment was made in January 2017 with priority given to establishing a revised membership engagement strategy that both improves relations with existing members and encourages new members of the public to join.

Member evenings were held in April and June 2016 on elderly care and genomic medicine respectively, then in March 2017 on ovarian cancer. The evenings were well attended by members and governors with a slight dip in numbers at the March 2017 event, partly we believe due to the length of time between events. Governors engaged with members at the annual members meeting in September 2016.

We have also worked towards improving involvement with other groups in our constituencies such as attending health roadshows with Southampton City CCG and building relationships with bloggers who are interested in the Trust's work and want to help share information and news.

The draft membership engagement strategy is ready to go to the next Council of Governors for approval and will be led by the membership manager and membership engagement group (consisting of governors). It focuses on engagement, recruitment and the development of members' voice so members can truly feel involved within the Trust. Looking forward there are a number of high profile opportunities for membership to be more prominent within both the hospital and community, which we will be involved in.

## Governor development

In order to provide on-going development and support to governors the annual work-programme is developed to include two half day study sessions. In addition to this the full Council of Governors is supported by a number of focused sub-groups. Each of the sub-groups is chaired by a governor, with the development of work plans being governor led. Non-executive directors, executive directors and members of the Trust's senior management team are routinely requested to present on a wide range of topics.

| Examples of topics covered during 2016 include: | |
|---|---|
| • Information governance including Freedom of Information and Confidentiality<br>• Claims and litigation<br>• Patient complaints<br>• Helping patients to sleep better at night project<br>• Support for junior doctors at UHS | • Clinical Quality Dashboard and Clinical Accreditation Scheme<br>• Update on nursing bursaries<br>• P.L.A.C.E assessment results<br>• Review of Council of Governors, effectiveness<br>• Future ways of working between Trust Board and Council of Governors |

Governors are encouraged to complete the National Governor Training Programme offered by the NHS Providers along with attendance at other national conferences, such as the annual NHS Providers Governor conference.

### Engagement with Trust Board

The Council of Governors is chaired by the Trust chair who provides a link between the Board and the Council of Governors. The senior independent director, chief executive and associate director of corporate affairs routinely attend Council of Governors meetings. In addition, non-executive directors and executive directors have an open invitation to attend all Council of Governors meetings, including sub-group meetings. Governors are invited to observe two of the Trust Board sub-committees, quality committee and strategy and finance committee and are also invited alongside Trust Board members on clinical visits.

### Governor expenses

Governors participating in events such as Council meetings are entitled to claim expenses. Expenses are paid at rates agreed by the Council of Governors and include travel by car or public transport, and carer costs. All expenses should be receipted. During the year, six governors claimed expenses totalling £1,204.97.

### Governor contact details

For further details of the Council of Governors please contact the associate director of corporate affairs on 023 8120 6829. You can also email your governor at UHSgovernor@uhs.nhs.uk

# Annual remuneration statement

## Executive changes

The executive team substantive appointments have remained stable during 2016/17. However there have been changes to non-executive director positions.

## New Trust chairman

On 31 March 2016 John Trewby retired as chairman of UHS. John has been an exceptional leader and, during his term of chairmanship, he had steered UHS to achieve many great things in some truly difficult circumstances and we thank him for his guidance. Following an extensive national search Peter Hollins was appointed as the new chairman and formally assumed his new position on 1 April 2016. Peter has been the senior independent director at UHS and a member of the Trust Board.

## New non-executive director

Following the end of her second term, Lena Samuels left her position as non-executive director (NED). We are extremely grateful for the expertise and commitment demonstrated by Lena during her time, particularly on the Equality and Diversity Agenda. Following an extensive national search the Trust appointed Jenni Douglas-Todd to the role of NED which she started on 1 April 2016. Jenni has a focus on equality and diversity.

## Increases to executive pay

### Cost of living increases

The remuneration and appointment committee awarded the executive team a pay rise of 1% to mirror that awarded to all medical and non-medical staff nationally on 1 April 2016. It was decided however that this 1% increase would only take effect for executives from 1 October 2016.

### Specific pay changes

Following salary benchmarking information provided by NHS Improvement (NHSI) during February 2016, the remuneration and appointment committee reviewed the salaries of existing executive directors. Most salaries benchmarked appropriately against information on provided by NHSI, at either below or around the median salary for large acute NHS Trusts of £500m turnover or greater.

The committee were concerned that the salary of the director of nursing and organisational development was a significant outlier at lower than the median. The committee approved an increase in salary effective from the 1 February 2017 to £135,000.

## Non- executive director pay changes

### Changes to pay and terms of Trust chair

The Council of Governors considered the contractual time requirements of the chair position. The contract stipulates a requirement for 'onsite' presence of 3.5 days per week. In review the governors' nomination committee, and following approval at the Council of Governors meeting, it was agreed the level of required onsite commitment would be reduced. However the chair remains flexible to ensure the appropriate level of support, guidance and leadership is provided to UHS. The salary of the chair was also reduced to £47,275.

### Changes to pay of non-executive directors (NED)

The Council of Governors agreed to support the provision of additional allowances of £2,500 per annum to NEDs who take responsibility for chairing the formal Trust Board sub-committees, this change took effect in autumn 2016.

## Senior managers' remuneration policy

The table below sets out a description of the remuneration package for executive directors:

| | |
|---|---|
| Basic pay | Set at point of recruitment, reviewed using pay benchmarking and other relevant information. Recruiting high calibre senior managers is crucial to the delivery of the Trust's objectives. Benchmarking takes into consideration other similar large acute teaching hospitals to ensure salary levels are competitive, but also represent value for money. |
| Other | The Trust does not operate any level of performance related pay for its executive directors at present. In the current financial context this is seen as the right way to operate. |
| Pension | The NHS Pension scheme is a defined benefit public service pension scheme operating on a pay as you go basis. Pension benefits are based upon a mixture of final salary and career average earnings. |

Dr Derek Sandeman and Dr Caroline Marshall have remained on the national consultant contract, which includes national and local clinical excellence awards. In addition to this they are in receipt of allowances as Board members, which is approved by the remuneration committee.

| | Basic pay | Clinical Excellence Awards – National NHS Awards | Allowance | Total (in bands of 5000) |
|---|---|---|---|---|
| Dr Caroline Marshall | ✓ | ✓ | Board allowance | £185-190 |
| Dr Derek Sandeman | ✓ | ✓ | Board allowance for medical director | £190-195 |

## Service contract obligations

There are no service contract obligations that could impact on remuneration, or payments for loss of office that are not disclosed elsewhere in the remuneration report.

## Policy on payment for loss of office

Non-executive directors do not receive a payment for loss of office.

Remuneration for executive directors for loss of office will be defined by the terms and conditions of employment for executive directors. This includes:

- executive directors are contractually entitled to be provided with a minimum of six months notice of termination of employment.
- executive redundancy pay will be based on the prevailing terms, as set out in the national NHS terms and conditions handbook.
- The contractual terms have no link to performance; in exception of a termination connected to gross misconduct, where dismissal may be without provision of notice.

## Statement on consideration of employment conditions

The remuneration and appointments committee reviews executive director salaries on an annual basis; taking account of pay benchmarking and other relevant factors, such as recruitment and retention, and market forces.

The remuneration policy for senior managers is consistent with the rest of the workforce. It is broadly based on the principles of job role responsibility and considers market rates. It was therefore not considered necessary to consult with employees when preparing the senior managers' remuneration policy. As stated elsewhere, pay benchmarking and other relevant information is considered as appropriate.

## Salaries in excess of the pay received by the prime minister

The remuneration committee are also mindful of its obligations to ensure value for money, including scrutiny of any salaries above £142,500 (the salary of the prime minister).

There are four individuals with salaries over this threshold, as outlined below:

| Role | Rationale |
|---|---|
| Chief executive officer | Consistent with salary benchmarking and market rates for a large acute teaching hospital. |
| Chief financial officer | |
| Medical director | Both roles are undertaken by senior consultants who have remained on medical terms and conditions with the addition of an allowance for their Board level responsibilities. |
| Chief operating officer | |

## Non-executive director fees

| Role | Time commitment | Fee type payable | Total (in bands of 5000) |
|---|---|---|---|
| Chair | 2.5 days per week | Annual fee | £47,275 |
| Senior independent director | 4 days per month | Annual fee<br><br>Additional annual payment for SID role | £13,181<br><br>£2,500 |
| Non-executive director | 4 days per month | Annual fee | £13,181 |
| Chair of audit and risk committee | 4 days per month | Annual payment in addition to NED salary | £2,500 |
| Chair of quality committee | 1 day per month | Annual payment in addition to NED salary | £2,500 |
| Chair of strategy and finance committee | 1 day per month | Annual payment in addition to NED salary | £2,500 |

Non-executive directors are able to claim reasonable expenses incurred in conducting their duties (travel and so on). It has been agreed at the Council of Governors during November 2016 that this will be phased out for new NED appointments in the future.

Approved by the Trust Board 23 May 2017

Chief executive
23 May 2017

# Remuneration and appointments committee

### What is the appointment and remuneration committee?

The committee is set up by the Trust to oversee all aspects of executive pay and appointment. The committee will lead the process of selecting a new executive director.

They will also approve any process of Board reconfiguration or restructure, and subsequent financial expenditure on exit packages that may result. These packages may also require approval from other external bodies, such as NHS Improvement or HM Treasury.

The committee is a formally appointed committee of the Board. Its terms of reference comply with the Secretary of States' 'Code of Conduct and Accountability for NHS Boards'.

The remuneration of executive directors is considered through pay benchmarking and other relevant information. In addition, the pay of executive directors is considered in the context of non-executive positions remunerated on national terms and conditions such as Agenda for Change.

### Who attends committee meetings?

The committee is comprised of the Trust chair, the non-executive directors and the chief executive (except where matters relating to the chief executive are under discussion).

The associate director of human resources attends all meetings to advise the committee. The associate director of corporate affairs also attends to keep an appropriate record of proceedings. Neither are members of the committee and are purely there in an advisory in capacity.

### Frequency of meetings

The committee is scheduled to meet four times a year, however on occasions extraordinary meetings are called. Attendees may participate in person or telephone conferencing is permitted in order to maximise attendance.

### Remuneration and appointment committee meeting attendance 2015/16

| Board Member | 12 April | 26 July | 29 Nov | 28 Feb | 28 Mar additional |
|---|---|---|---|---|---|
| Peter Hollins<br>Chair | ✓ | ✓ | ✓ | ✓ | ✓ |
| Simon Porter<br>Non-executive director and deputy chair | ✓ | ✓ | ✓ | ✓ | ✓ |
| Iain Cameron<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | × |
| Lynne Lockyer<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | ✓ |
| David Price<br>Non-executive director | × | ✓ | ✓ | ✓ | ✓ |
| Mike Sadler<br>Non-executive director | ✓ | ✓ | ✓ | ✓ | × |
| Jenni Douglas-Todd<br>Non-executive director | ✓ | × | ✓ | ✓ | ✓ |

### How is executive performance assessed?

The remuneration committee also takes an active role in seeking assurance that the performance of executive directors is actively managed by the chief executive. Executive directors are set a series of annual objectives in April, which reflect the short, medium, and long term aspirations of the Trust as set out in the Annual Plan and 'Forward Vision' document. Their performance is assessed against these objectives at an annual appraisal, and throughout the year.

The chief executive makes a report to the remuneration committee annually to describe how executive directors have performed, and any appropriate action that should be taken to improve performance or support personal development is considered.

### Do any executives receive performance related pay or bonuses?

No element of the executive and non-executive directors' remuneration is performance related at present.

### How is a new executive director appointed?

The process for recruiting executive directors is considered by the committee as the need arises, and involves an analysis of the skills required by the next appointee to the vacancy, both at Board and functional level. The recruitment process will always involve external advertisement, and generally includes an executive search.

We also assess successful candidates against the nationally mandated Fit and Proper Persons requirements (FPPR).

# Governors' nomination committee

### What is the governors' nomination committee?

The governors' nomination committee is a formal group led by the chair of the Trust and Council of Governors. Its purpose is to select new non-executive directors; decide pay and remuneration, and to oversee the process of managing performance.

### How are non-executive directors appointed?

Non-executive directors are appointed by the governors' nominations committee, a committee of the Council of Governors, in accordance with the 'Recruitment process for NED's and Chair Policy' as agreed by the Council of Governors in December 2011.

### How is pay decided for non-executive directors and the chairman?

The remuneration of the chair and non-executive directors is determined by the governors' nomination committee. Their decisions are passed to the full Council of Governors as recommendations for the Council of Governors to endorse, or reject as it sees appropriate.

The committee comprises five governors and the chair. The chief executive and associate director of human resources are in attendance at all meetings to advise the committee. The associate director of corporate affairs is in attendance to keep an appropriate record of proceedings. None of these Trust officers are members of the committee.

The chair does not attend any part of the meetings when matters relating to the chair's remuneration are discussed. This part of the meeting is chaired by the senior independent director, or an independent chair from another Trust.

### How does the committee assess performance of non-executives?

The chair undertakes the performance review of the non-executive directors. The senior independent director will appraise the chair. The performance reviews and appraisals of the chair and non-executive directors are fed back to the governors' nomination committee. This process was agreed by the Council of Governors in December 2011, and has been refreshed in subsequent years.

### How long are Board contracts?

- All executive directors have a substantive contract of employment.
- The chair and non-executive directors are appointed for a term of three years; prior to becoming a Foundation Trust the term of office was four years. All may be reappointed for a further term of office should they wish, with the approval of the governors' nomination committee and Council of Governors.

The chair and non-executive director appointments are due for renewal as shown:

| Name | Position | Term of Office commenced | Term of Office ends |
|---|---|---|---|
| Peter Hollins | Chair | 1 April 2016 | 31 March 2019 |
| Iain Cameron | Non-executive director | 19 December 2014 (This is his second term. His first term was 19 December 2011 to 18 December 2014). | 18 December 2017 |
| Lynne Lockyer | Non-executive director | 1 October 2014 (This is her second term. Her first term was 1 October 2011 to 30 September 2014). | 30 September 2017 |
| Simon Porter | Non-executive director/ Senior independent director from 1/4/16 | 1 June 2015 (This is his second term. His first term was 1 June 2011 to 31 May 2015) | 31 May 2018 |
| David Price | Non-executive director | 28 July 2014 | 27 July 2017 |
| Mike Sadler | Non-executive director | 1 September 2014 | 31 August 2017 |
| Jenni Douglas-Todd | Non-executive director | 1 April 2016 | 31 March 2019 |

## Payments for loss of office during 2016/17

There have been no payments to executive directors for loss of office during 2017/18.

## Remuneration of senior managers 2016/17

| | 2016-17 | | | | | |
|---|---|---|---|---|---|---|
| **Executive director** | **Salary (bands of £5000) £000** | **Taxable benefits Rounded to the nearest £100** | **Annual performance related bonus (bands of £5000) £000** | **Long term performance related bonus (bands of £5000) £000** | **Pension benefits (bands of £2500) £000** | **Total (bands of £5000) £000** |
| Ms G Byrne | 120-125 | n/a | n/a | n/a | 145-147.5 | 265-270 |
| Prof I Cameron | 5-10 | n/a | n/a | n/a | n/a | 5-10 |
| Ms F Dalton | 190-195 | n/a | n/a | n/a | 50-52.5 | 250-245 |
| M D French | 165-170 | n/a | n/a | n/a | 100-102.5 | 265-270 |
| Ms J Hayward | 140-145 | n/a | n/a | n/a | 112.5-115 | 255-260 |
| Mr P Hollins | 50-55 | n/a | n/a | n/a | n/a | 50-55 |
| Ms Lockyer | 10-15 | n/a | n/a | n/a | n/a | 10-15 |
| Dr C Marshall | 180-185 | n/a | n/a | n/a | 42.5-45 | 225-230 |
| Mr S Porter | 15-20 | n/a | n/a | n/a | n/a | 15-20 |
| Dr D Price | 10-15 | n/a | n/a | n/a | n/a | 10-15 |
| Dr M Sadler | 10-15 | n/a | n/a | n/a | n/a | 10-15 |
| Ms J Douglas Todd | 10-15 | n/a | n/a | n/a | n/a | 10-15 |
| Dr D Sandeman | 195-200 | n/a | n/a | n/a | 107.5-110 | 305-310 |

During the year, ten senior managers (nine in 2015/16) incurred expenses in the course of business totalling £5,450. These relate mainly to travel and subsistence.

Pension benefits are calculated as last year's pension multiplied by 20 plus the lump sum compared with this year's after deducting this year's employee pension contributions. All salary relates to pay as directors, except for Dr C Marshall, where £135,000-£140,000 relates to pay as a medical consultant and clinical excellence award and Dr D Sandeman, where £135,000-£140,000 relates to pay as a medical consultant and clinical excellence award.

## Comparison with 2015/16

| | 2016-17 | | | | | |
|---|---|---|---|---|---|---|
| **Executive director** | **Salary**<br><br>**(bands of £5000) £000** | **Taxable benefits**<br><br>**Rounded to the nearest £100** | **Annual performance related bonus**<br><br>**(bands of £5000) £000** | **Long term performance related bonus**<br><br>**(bands of £5000) £000** | **Pension benefits**<br><br>**(bands of £2500) £000** | **Total**<br><br>**(bands of £5000) £000** |
| Ms G Byrne | 55-60 | n/a | n/a | n/a | 110-112.5 | 170-175 |
| Prof I Cameron | 10-15 | n/a | n/a | n/a | | 10-15 |
| Ms F Dalton | 185-190 | n/a | n/a | n/a | 12.5-15 | 200-205 |
| M D French | 25-30 | n/a | n/a | n/a | 40-42.5 | 65-70 |
| Ms J Gillow | 70-75 | n/a | n/a | n/a | | 70-75 |
| Mr P Goddard | 25-30 | n/a | n/a | n/a | 2.5-5 | 30-35 |
| Ms J Hayward | 130-135 | n/a | n/a | n/a | 7.5-10 | 140-145 |
| Mr P Hollins | 15-20 | n/a | n/a | n/a | | 15-20 |
| Ms Lockyer | 10-15 | n/a | n/a | n/a | | 10-15 |
| Dr MJ Marsh | 30-35 | n/a | n/a | n/a | 100-102.5 | 130-135 |
| Dr C Marshall | 180-185 | n/a | n/a | n/a | 17.5-20 | 200-205 |
| Mr A Matthews | 90-95 | n/a | n/a | n/a | 7.5-10 | 100-105 |
| Mr M Murphy | 185-190 | n/a | n/a | n/a | 15-17.5 | 200-205 |
| Mr S Porter | 15-20 | n/a | n/a | n/a | | 15-20 |
| Dr D Price | 10-15 | n/a | n/a | n/a | | 10-15 |
| Dr M Sadler | 10-15 | n/a | n/a | n/a | | 10-15 |
| Ms L Samuels | 10-15 | n/a | n/a | n/a | | 10-15 |
| Dr D Sandeman | 165-170 | n/a | n/a | n/a | 102.5-105 | 270-275 |
| Mr J Trewby | 50-55 | n/a | n/a | n/a | | 50-55 |

During the year, nine senior managers (12 in 2014/15) incurred expenses in the course of business totalling £9,296. These relate mainly to travel and subsistence.

Note: The following directors left during the year - Mr Matthews October 2015, Mr Murphy December 2015, Ms Samuels February 2016, Mrs Gillow October 2015.

## Pension benefits of senior managers

| | 2016-17 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Name and Title** | **Real increase in pension at age 60 (bands of £2500)** | **Real increase in pension lump sum at age 60 (bands of £2500)** | **Total accrued pension at age 60 at 31 March 2016 (bands of £5000)** | **Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5000)** | **Cash equivalent transfer value at 31 March 2016** | **Cash equivalent transfer value at 31 March 2015** | **Real increase in Cash equivalent transfer value** | **Employers contribution to stakeholder pension** |
| | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Ms G Byrne | 5-7.5 | 20-22.5 | 40-45 | 125-130 | 870 | 706 | 80 | |
| Ms F Dalton | 2.5-5 | 0-2.5 | 45-50 | 115-120 | 671 | 593 | 38 | |
| Mr D French | 5-7.5 | 0-2.5 | 20-25 | 0-5 | 260 | 177 | 41 | |
| Ms J Hayward | 5-7.5 | 10-12.5 | 50-55 | 150-155 | 975 | 852 | 60 | |
| Dr C Marshall | 2.5-5 | 7.5-10 | 65-70 | 195-200 | 1445 | 1345 | 49 | |
| Dr S Sandeman | 5-7.5 | 15-17.5 | 65-70 | 200-205 | 1516 | 1351 | 81 | |

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

## Median remuneration

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce

Figures for 2015/16 are shown in brackets:

- The banded remuneration of the highest paid director for the year to 31 March 2017 was in the band £195k-£200k (£195k-£200k). This was 6.8 (6.8) times the median remuneration of the workforce which was £29.0k (£29.0k).
- The banded remuneration of the chief executive for the year to 31 March 2017 was £191.0k (£190.0k). This was 6.6 (6.6) times the median remuneration of the workforce.
- For the year six (three) employees received remuneration in excess of the highest paid director.
- Remuneration ranged from £15.2k to £259.7k (£15.0k to £207.8k).

# Staffing data

We employ over 10,969 staff in a diverse range of roles. The data below presents the staff breakdown for the Trust. Table 1 indicates the substantively employed staff in the organisation. Table 2 includes staff who are engaged on fixed term contract, bank, or honorary contract positions.

Doctors in formal training are employed on fixed term contracts, as they will rotate to different employing organisations during their training periods. This accounts for a high number of medical fixed term contracts.

**Table 1:**
**Staff employed as at 31 March 2017**

| Staff Group | FTE | Headcount |
|---|---|---|
| Additional Professional Scientific and Technical | 314.69 | 356 |
| Additional Clinical Services | 1,542.87 | 1,782 |
| Administrative and Clerical | 1,519.49 | 1,740 |
| Allied Health Professionals | 473.26 | 547 |
| Estates and Ancillary | 395.50 | 429 |
| Healthcare Scientists | 270.49 | 294 |
| Medical and Dental | 600.33 | 634 |
| Nursing and Midwifery Registered | 2,983.74 | 3,386 |
| **Grand Total** | **8,100.37** | **9,168** |

**Average number of staff employed during 2016/17**

| Staff Group | FTE | Headcount |
|---|---|---|
| Additional Professional Scientific and Technical | 315.86 | 355 |
| Additional Clinical Services | 1,458.05 | 1,694 |
| Administrative and Clerical | 1,478.05 | 1,695 |
| Allied Health Professionals | 470.61 | 541 |
| Estates and Ancillary | 382.45 | 414 |
| Healthcare Scientists | 267.40 | 291 |
| Medical and Dental | 594.34 | 628 |
| Nursing and Midwifery Registered | 2,963.10 | 3,363 |
| **Grand Total** | **7,929.85** | **8,981** |

**Table 2:**
**Staff employed through bank, fixed term and honorary contracts as at 31 March 2017**

| Staff Group | FTE | Headcount |
|---|---|---|
| Additional Professional Scientific and Technical | 12.96 | 23 |
| Additional Clinical Services | 72.25 | 146 |
| Administrative and Clerical | 189.17 | 305 |
| Allied Health Professionals | 15.29 | 60 |
| Estates and Ancillary | 19.80 | 48 |
| Healthcare Scientists | 17.28 | 27 |
| Medical and Dental | 795.28 | 1,055 |
| Nursing and Midwifery Registered | 97.04 | 137 |
| **Grand Total** | **1,219.08** | **1,801** |

**Average number of staff engaged through bank, fixed term and honorary contracts during 2016/17**

| Staff Group | FTE | Headcount |
|---|---|---|
| Additional Professional Scientific and Technical | 15.31 | 26 |
| Additional Clinical Services | 74.65 | 149 |
| Administrative and Clerical | 174.89 | 295 |
| Allied Health Professionals | 15.83 | 56 |
| Estates and Ancillary | 12.57 | 47 |
| Healthcare Scientists | 18.66 | 32 |
| Medical and Dental | 789.14 | 1,066 |
| Nursing and Midwifery Registered | 108.02 | 157 |
| **Grand Total** | **1,209.08** | **1,828** |

## Staffing costs

| | Group | |
|---|---|---|
| **Employee Expenses** | **Year ended 31 March 2017**<br><br>**Total £000** | **Year ended 31 March 2016**<br><br>**Total £000** |
| Salaries and wages | **336,253** | 321,013 |
| Social security costs | **34,670** | 26,786 |
| Pension cost - Employers contributions to NHS Pensions | **40,491** | 38,256 |
| Pension cost - other contributions | **17** | 15 |
| Temporary staff - external bank | **9,748** | 7,166 |
| Temporary staff - agency/contract staff | **13,964** | 19,275 |
| NHS Charitable funds staff | **355** | 595 |
| | | |
| Recoveries from Other bodies in respect of staff cost netted off expenditure | **(3,485)** | (3,875) |
| **Total Net Staff Costs** | **432,013** | 409,231 |
| | | |
| Employee Expenses – Staff | **429,671** | 406,716 |
| Employee Expenses - Executive directors | **1,262** | 1,347 |
| NHS Charitable funds: Employee expenses | **355** | 595 |
| **Total Employee benefits excluding capitalised costs** | **431,288** | 408,658 |

Our workforce is predominantly female (Figure 3), and the Trust is well represented by senior female leaders in executive director positions (Figure 5).

**Figure 3:**
**UHS workforce gender profile**

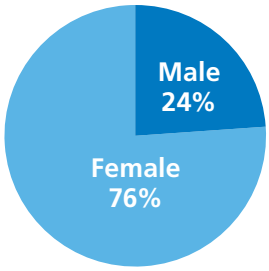



**Figure 4:**
**Gender of non-executive directors**

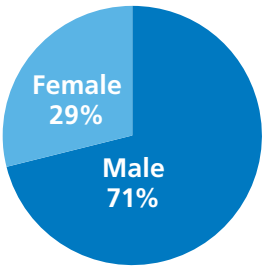
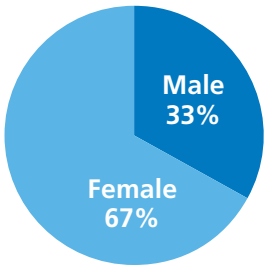



**Figure 5:**
**Gender of executive directors**



### Health and wellbeing of staff

The health and wellbeing of our staff is a key focus for us. Our established occupational health function provides services to UHS and other partner organisations, as well as a range of support services for staff including a 24 hour Employee Assistance Programme providing emergency health and wellbeing advice and support. It will also arrange for support to aid rehabilitation through the 'Return to Health' programme, which was nationally recognised in 2011. This function helps people on long term sickness absence back to work in a supportive and effective manner.

UHS has worked as one of the spearhead site for the NHS England Healthy Workplace project. Our 'Live Well and Inspire' Campaign has resulted in the delivery of free health checks for staff over 40, we have delivered a range of health interventions and programmes including diet advice, resilience training, mindfulness and exercise classes.

Each staff members' annual appraisal also includes a wellbeing discussion, which helps us to identify any issues at work, or with work life balance, and discuss what support we can provide.

Staff absence is managed robustly by line managers, in partnership with human resources and occupational health. Our sickness absence levels compare favourably to other NHS trusts. Review meetings are held if and when attendance levels fall in order to discuss how we can support the individual. We also provide regular training to line managers throughout the year to help them address sickness absence.

### How do we support staff with disabilities?

The Trust has a range of policies and procedures to support staff who are, or who become disabled. We appropriately manage recruitment applications; ensuring that reasonable adjustments are made at interview, and during employment for individuals who meet the minimum requirements of the person specification for the role. The Trust has guidance in its policies to support disabled employees, and works to retain the employment of disabled staff by considering alternative roles where appropriate.

We identified disability as a key issues in our staff experience plans in 2016/17. A number of initiatives have been put in place via working with our Long Term Illness and disability group. This includes work on access via estate and the appointment in November 2016 of an access to work officer in Occupational Health. The aim of this post is to speed up reasonable adjustment implementation. Plans to improve staff experience will focus on disabled staff, and progress will be managed through the Trust's equality and diversity steering committee. More information is available in the equality and diversity section of this report.

# Responding to the staff annual attitude survey

### Our approach to staff engagement

UHS prides itself on working hard to ensure staff engagement.  Our staff engagement scores place us in the top 20% of NHS employers. UHS works to ensure a meaningful two-way dialogue between staff and managers in a number of ways and also works to build a culture of staff involvement in decision and the quality improvement agenda.

Our executive team take a very active role in communication and engagement with staff, including the popular monthly chief executive's blog, and our chief operating officer's hospital bulletin. A number of open sessions are held throughout the year to provide direct opportunity for staff to provide feedback to the team.

We have an active communications agenda, our use of a range of social media as a mechanism of staff engagement has grown considerably during 2016/17, particularly connected to our recruitment branding.

Information is also provided to staff through a range of briefings, such as monthly Core Brief sessions, weekly staff briefing emails. Our internal staff website (Staffnet) also provides regular updates and a range of information on policy and procedure.

## How does the Trust inform and consult staff?

We have two forums through which we inform and consult staff on a regular basis. For medical staff there is a monthly Local Consultation and Negotiation Forum (LCNC), in which senior managers meet with local staff representatives to discuss a range of issues.

For all other staff, we run a monthly Staff Partnership Forum (SPF) where key representatives from local trade union groups meet with management to share information updates and to discuss issues, consult on plans and so on. A rotational agenda is set up, which ensures a range of briefings on key subjects (IT, training, estates, and commercial development, operational pressures and so on) on a regular basis.

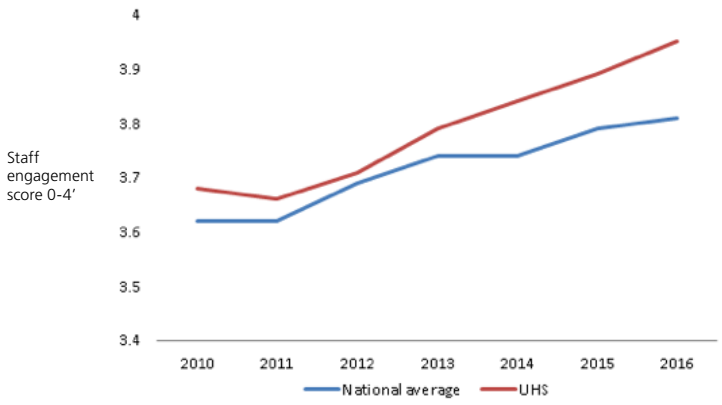
Both forums share chairing arrangements between staff and management, and executive directors and senior managers regularly attend.

Major project developments will also include a local staff representative, as part of steering groups to ensure positive levels of union engagement.

## Our 2016 staff survey results

UHS can celebrate many aspects of the 2016 annual staff survey results. It continues to show our progress towards our vision to create an organisation where we can recruit, motivate, and develop the highest calibre of staff. The Trust is proud of its achievements but it wishes to continue to improve in a number of areas. We are now ranked number five in the best acute trusts for staff engagement scores. Our staff engagements scores have improved year on year since 2010, and at a rate greater than the rest of the NHS.

**Staff engagement scores 2010-2016**




The key items to celebrate from the 2016 staff survey are:

- ✔ UHS has remained in the top 20% for staff engagement scores. This includes the advocacy, motivation and involvement of our staff.
- ✔ UHS results overall remain better than average, and in 17 out of 32 scoring areas we are in the top 20% of acute trusts. The areas in the top 20% include focus on health and wellbeing, openness of reporting incidents, quality of staff appraisals, support communication and recognition from Trust management, effective team working.
- ✔ 77% of UHS staff would recommend the employer as a place to work (Q4 FFT results).
- ✔ 92% would recommend UHS as a place to be cared for (Q4 FFT results).

There are some areas where we need to provide more focus and improvement:

- UHS scores for staff with a disability remain lower than other areas. This category represents the most dissatisfied staff group.
- UHS has deteriorated in its results for BME staff, in relation to discrimination and equal opportunity. Engagement scores however remain high for this group.
- Staff experiencing and reporting violence, aggression, and discrimination needs more specific focus.
- Bullying and harassment of staff is at 23%. Whilst below the national average of 25%, it is still a concern and requires a continued and focused piece of work.

### How do we compare to other NHS Trusts?

UHS performs very well against other comparable NHS acute Trusts. From the 32 key findings:

✔ We rank fifth out of 98 acute trusts for staff engagement (in the top 20%).

✔ We're in the top 20% of all acute trusts for 17 of the key findings.

✔ We have better than average compared to other acute trusts for seven of the key findings.

● We score average compared to other acute trusts for six of the key findings.

✔ We are in the bottom 20% of all acute trusts for none of the key findings.

✘ We are lower than average compared to other acute trusts in two of the key findings. (reporting experiences of violence, and reporting experiences of harassment, bullying and abuse).

### How many staff responded?

The 2016 survey was conducted as a census survey and was sent either electronically or as a paper copy questionnaire to 9201 UHS staff. 3649 staff responded giving an overall response rate of 38%.

This is slightly below average compared to other acute Trusts in England and is a 1% decrease on the 2015 survey response rate of 39%.

| | UHS 2015 | UHS 2016 | Improvement or deterioration |
|---|---|---|---|
| Response rate | 39%<br>(3573 people) | 38%<br>(3649 people) | 1% reduction in response rate. |

## Our top five ranked scores

| Top five ranked scores (compared to the national average for all other acute trusts) | Staff survey 2015 | | Staff survey 2016 | | Improvement or deterioration from previous year |
|---|---|---|---|---|---|
| | UHS | National Average | UHS | National Average | |
| KF7 – % staff able to contribute towards improvements at work | 74% | 69% | 76% | 70% | 2% improvement |
| KF6 – % staff reporting good communication between senior management and staff | 38% | 32% | 43% | 33% | 5% improvement |
| KF31 – Staff confidence in reporting unsafe clinical practice | 3.77 | 3.62 | 3.81 | 3.65 | 0.04 improvement |
| KF5 – recognition and value of staff by managers and the organisation | 3.55 | 3.73 | 3.62 | 3.45 | 0.07 improvement |
| KF15. Percentage of staff satisfied with the opportunities for flexible working patterns | 55% | 49% | 57% | 51% | 2% improvement |

## Our bottom five ranked scores

| Bottom five ranked scores (compared to the national average for all other acute Trusts) | Staff survey 2015 | | Staff survey 2016 | | Improvement or deterioration from previous year |
|---|---|---|---|---|---|
| | UHS | National Average | UHS | National Average | |
| KF 27 – Percentage of staff reporting most recent experience of harassment, bullying or abuse | 37% | 37% | 43% | 45% | 6% improvement |
| KF24 – Percentage of staff reporting most recent experience of violence | 62% | 53% | 66% | 67% | 4% improvement |
| KF29 – % staff reporting errors, near misses or incidents witnessed in the last month | 91% | 90% | 90% | 90% | 1% deterioration |
| KF2 – Staff satisfaction with the quality of work and patient care they are able to deliver | 3.92 | 3.93 | 3.94 | 3.96 | 0.02 improvement |
| KF20. Percentage of staff experiencing discrimination at work in the last 12 months | 11% | 10% | 11% | 11% | Same score |

## How we plan to respond?

Although we have made substantial progress against our corporate action plan set in 2016, we recognise the areas of concern highlighted in both the 2015 and 2016 surveys will require a sustained campaign of action over a longer period of time in order to achieve the cultural and behavioural improvements we wish to achieve.

We will continue to focus on:

- Driving out discriminatory and bullying behaviours from the workplace.
- Taking further steps to protect front line staff from abuse, discrimination, and violence from patients and service users.
- Taking steps to increase reporting by staff of these events, through our electronic incident reporting process.
- Improving staff experience for our disabled and BME staff.

## Expenditure on external consultancy

The Trust spent £112,000 on external consultancy during 2016/17.

## Off-payroll engagements

The Trust is required to seek assurances regarding the income tax and national insurance obligations of any senior staff engagements not paid through payroll and to report any engagements of more than £220 per day for more than six months.

There are no off-payroll engagements of Board members or senior officials with significant financial responsibility.

The Trust does not have a specific policy on off-payroll arrangements. All permanent staff employed are paid through the Trust's payroll. Contractors undertaking a temporary assignment for the Trust will be paid through other mechanisms for services provided. The Trust has also been working towards ensuring compliance with changes to IR35 applicable from 6 April 2017.

| **Table 1: For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last for longer than six months** | |
|---|---|
| No. of existing engagements as of 31 March 2017 | Nil |
| Of which… | |
| No. that have existed for less than one year at time of reporting | Nil |

## Staff exit packages

As a foundation trust, we are required to make disclosures regarding exit packages which have taken place during the financial year. The table below provides anonymised data for those packages.

| Exit package band | Number of compulsory redundancies | Number of other departures | Total number of exit packages by cost band |
|---|---|---|---|
| <£10,000 | 0 | 3 | 3 |
| £10,000 - £25,000 | 3 | 1 | 1 |
| £25,000 - £50,000 | 6 | 3 | 3 |
| £50,000 - £100,000 | 3 | 1 | 1 |
| £100,000 -£150,000 | 0 | 0 | 0 |
| £150,000 - £200,000 | 0 | 0 | 0 |
| Total number of exit packages by type | 12 | 8 | 8 |
| **Total Resource Costs** | **£504,000** | **£205,665** | |

## Non-compulsory departure payments

| Type of exit | Agreement number | Total value |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | **0** |
| Mutually Agreed Resignations (MARS) Contractual Costs | 0 | **0** |
| Early retirements in the efficiency of the service contractual costs | 0 | **0** |
| Contractual payments in lieu of notice | 8 | **£205,665** |
| Exit payment following tribunal or court orders | 0 | **0** |
| Non-contractual payments requiring HMT approval | 0 | **0** |
| Total | 4 | **0** |
| Of which non-contractual payments requiring HMT approval where the value was more than their annual salary | 0 | **0** |

# Statement of the chief executive's responsibilities as the accounting officer of University Hospital Southampton NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require University Hospital Southampton NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and
- guidance
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/ her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Fiona Dalton, chief executive
23 May 2017

# Annual governance statement

## Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of University Hospital Southampton NHS Foundation Trust;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and
- manage them efficiently, effectively and economically.

The system of internal control has been in place in University Hospital Southampton NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

We are dedicated to providing high quality services in environments which are safe for patients, visitors and staff. The Board is committed to providing the resources and support systems necessary to ensure that action is taken to address all identified risks assessed as unacceptable to the organisation.

As accounting officer, I am ultimately responsible for the management of risk and the Board oversees that appropriate structures and robust systems of internal control and management are in place. The director of nursing and organisational development is the designated executive director with Board level accountably for clinical quality and safety supported by the medical director.

The risk management policy has been published on the Trust's intranet which is available to all staff and bespoke risk management training is provided to divisions and care groups. To support this training there is documented guidance on risk and safety management including comprehensive policies and procedures available on the Trust intranet. There is also a Trust whistle blowing policy and a 'raising concerns' helpline in place.

We are committed to the sharing of good practice and learning from incidents, complaints and patient feedback and we achieve this through:

- the prompt dissemination of safety alerts, recommendations and guidelines made by central bodies such as NHS England, the Medical Healthcare Regulatory Authority (MHRA) and the National Institute for Health and Care Excellence (NICE)
- root cause analysis of serious incidents
- policies that encourage timely and transparent reporting and investigation of adverse incidents and complaints
- feedback on learning and good practice through 'Safety Matters' communications and updates provided to Quality Governance Steering Group and divisional and care group governance meetings
- clinical audit
- staff appraisal

## The risk and control framework

The Board of Directors is responsible for overseeing our governance programme. It delegates key duties and functions to its sub-committees. There are four committees within the structure that provide assurance to the Board, these are:

- **Audit and risk committee**: Chaired by a non-executive director, this committee provides objective assurance to the Board and management as to the adequacy and effectiveness of the organisation's system of internal control. In addition to this the committee is responsible for ensuring that all statutory elements of governance are adhered to within the Trust, this includes maintaining oversight of the Trust's risk management structures and processes.

  The committee considers the findings and recommendations of internal and external audit reports, counter fraud reports and monitors our Risk Register and Assurance Framework.

- **Quality committee**: Chaired by a non-executive director, this committee has been established to explore, scrutinise and gain a deeper understanding of clinical quality on behalf of the Board. The committee provides assurance to the Board on patient safety, patient experience and clinical effectiveness, including access (waiting time) standards and oversight of serious incidents and Never Events.

- **Strategy and finance committee**: Chaired by a non-executive director, this committee provides scrutiny of the financial performance and strategy of the Trust; this includes the monitoring of in-year performance to ensure year-end financial targets are achieved, the review of strategic, annual and short term financial plans alongside major business cases.

- **Trust executive committee**: Chaired by the chief executive, this is the Trust's nominated risk committee responsible for advising on key issues, which affect the delivery of services within the Trust, specifically with regards to the quality and safety of patient services and staff experience. In addition the committee is responsible for monitoring operating and financial performance, prioritisation and control of resources and oversight, assessment and monitoring of risk and governance.

There are a range of mechanisms available to these committees to gain assurance that our systems are robust and effective. These include peer review, external inspection, service accreditation, monthly KPI and management reporting, clinical audit and internal and external audit. The Board of Directors receives regular reports from its sub-committees on business covered, risks and issues identified and actions taken. The chair of each committee is required to provide an update at each Board meeting.

Our risk management policy sets out responsibilities for all staff in relation to risk identification, assessment and management. The risk management approach of setting objectives and then identifying, analysing, prioritising and managing risk is embedded throughout the organisation. The process starts with the systematic identification of risks throughout the organisation via structured risk assessments. Identified risks are documented on risk registers. These risks are then analysed in order to determine their relative likelihood and consequence using a 5x5 matrix.

Risks assessed as 'low' represent the lowest levels of threat and actions were limited to contingency planning rather than active risk management action. Such risks were recorded onto local risk registers with monitoring undertaken through care group or team meetings.

Risks assessed as 'moderate' represent moderate levels of opportunity/threat which may have a short-term impact on organisational objectives. Risks in this category were recorded onto divisional risk registers along with supporting action plans for risk treatment. All risks have been subject to ongoing review and monitoring via divisional management team and care group meetings together with the status of controls in place and risk treatment.

A significant risk is defined as any risk which has been identified as being potentially damaging to the organisation's objectives. 'Significant' risks are those assessed as having a risk rating of 15 or above.

'Significant' risks are incorporated within the Trust's Operational Risk Register and were subject to review and scrutiny at the quarterly meetings of the audit and risk committee.

In addition to the Operational Risk Register, we have an Assurance Framework in place, designed to provide the Trust with a method for the effective and focused management of the principal risks which may impact on the achievement of the Trust's strategic priorities. The Assurance Framework sets out:

- strategic priorities
- principle risks
- mitigating controls
- assurances on controls
- gaps in control
- gaps in assurance
- action plans

The audit and risk committee undertakes quarterly reviews of the levels of risk identified and the controls in place to manage them. A summary of the principal governance risks (managed in year) is provided below:

| Principal risk | How they are managed / mitigated |
|---|---|
| Failure to meet the best possible standards of clinical care | Corporate and divisional leads have been identified to support delivery of the Patient Improvement Framework priorities.<br>Clinical accreditation scheme established to ensure that clinical areas are meeting the required standards.<br>Routine monitoring of patient feedback including Friends and Family test and compliments/complaints.<br>Robust mechanisms in place for reporting all incidents and near misses.<br>The Serious Incident Scrutiny Group (SISG) conduct detailed investigation of all serious incidents.<br>The Interim Medical Examiners Group (IMEG) conduct reviews of all unexpected deaths.<br>Medical director and director of nursing oversight of all Never Events.<br>Patient outcomes, experience and safety reports are provided to the Trust executive committee, quality committee and Trust Board. |
| Failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand | Additional funds have been made available as part of ward staffing reviews.<br>E-rostering is in place for all ward staff and the Trust has a single centralised bank for medical and nursing staff (NHS Professionals).<br>Daily reviews of patient acuity and dependency alongside nursing skill mix is undertaken in all ward areas as well as weekly and monthly staffing reviews to ensure that any staffing gaps are identified and addressed.<br>Focused recruitment strategies (including overseas) have been developed for 'hot spot' areas.<br>Strengthening availability of alternative routes into training through apprenticeship models.<br>A staffing status report is presented to the Trust executive committee and Trust Board on a monthly basis providing assurance around staffing risks. |

| Principal risk | How they are managed / mitigated |
|---|---|
| Failure to deliver national access targets<br>(ED, Cancer, RTT) | Internal processes have been improved alongside improving responsiveness from wards.<br>Escalation processes have been implemented for breaches as well as weekly reviews.<br>The Trust continues to work with the local health and social care network to reduce delayed discharged including use of the private sector where appropriate.<br>Pilot new models of care through STP e.g. virtual clinics, reduced follow ups.<br>Attendance at GP workshops within Southampton City.<br>Participation in national improvement programme on frailty and ambulatory emergency care.<br>Performance against targets are closely monitored and reported to both the quality committee and Trust Board monthly via the integrated performance report. |
| Inability to balance demand and capacity:<br>Operational risks have been identified across a number of services/specialties linking to issues around increasing referrals, system capacity and delayed transfers of care (DToCs) | Weekly capacity meetings are held between operations, nursing and estates.<br>Daily operational management reviews include an assessment of system capacity and escalation requirements. Plans to reduce length of stay have been developed with strong levels of clinical leadership and oversight.<br>Capacity plans have been developed with links to wider system capacity plans.<br>Work continues with the local health social care network to reduce delayed discharges. Plan agreed to achieve DToC reduction by March 2017. |
| Failure to deliver financial plan as agreed with NHS Improvement – £16m surplus | Robust budget setting and monitoring processes are in place. A RAG rating system has been implemented to monitor the delivery of cost improvement plans. Divisional management teams attend routine divisional finance reviews with the chief executive and chief financial officer. The Trust has undertaken a number of workforce restructures and service reviews to identify efficiencies, improvements and cost reductions.<br>Management controls in place to restrict the use of agency/interim staff.<br>Regular contract reviews held with commissioners.<br>Good progress on delivery of CQUINs.<br>Finance and KPI report showing monthly and cumulative performance on STF metrics.<br>Monitoring of the financial position takes place monthly at strategy and finance committee, Trust executive committee and Trust Board. |
| Failure to deliver an estate fit for purpose | The Trust has an estates strategy and an agreed capital programme.<br>The Trust is working with local partners and, where appropriate, using charitable funds to address the issues with the estate alongside implementing a clearer internal prioritisation mechanism for estates work.<br>Agreed strategic maintenance plan that prioritises infrastructure risks that have the highest impact and are most likely to fail.<br>Trust Investment Group (TIG) reviews the prioritisation of and approves business cases.<br>The Trust's strategy and finance committee has oversight of this issue. |

The management of risks associated with information and information flows is seen as key within the overall assurance process. We have a range of controls in place to provide assurance that the risks are being managed appropriately and effectively.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting, and the investigation of serious incidents. The Trust Board, through the risk management policy and incident reporting policy, promotes open and honest reporting of incidents, risks and hazards.

UHS has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the Trust. All patient related incidents which have resulted in harm as well as 'near miss' incidents are reported onto the National Reporting and Learning System (NRLS) to aid national trend analysis of incident data. All Trust policies are impact assessed in respect of the nine protected characteristics.

We involve key public stakeholders with the management of the risks that affect them via the following mechanisms:

- working collaboratively with our Clinical Commissioning Groups
- engagement with HealthWatch
- the Council of Governors are consulted on key issues and risks as part of the Annual Plan
- annual members' meeting

### Quality governance arrangements

The quality governance steering group (QGSG) has delegated responsibility from the Trust executive committee and ultimately Trust Board to oversee the Trust's clinical and quality governance arrangements. The group provides a clear vision for healthcare governance within the Trust and supports our Forward Vision. It sets clear performance standards and hold the divisions, corporate functions and where relevant other trust-wide groups, to account for the delivery of the healthcare governance agenda.

The QGSG has a number of sub-groups which include patient safety, patient experience, outcomes and effectiveness, regulatory assurance, adult and children safeguarding, health and safety, infection prevention, education and Divisional Governance Groups. All of the sub-groups submit reports on a regular basis, and any changes in local or national policy practice or care concerns are discussed at the time.

The QGSG provides advice to the relevant sub-committees on the key issues which may impact on the quality of patient experience, patient safety, patient outcomes and regulatory assurance within the Trust. Any areas of high risk of concern will be escalated to the Trust executive committee, the quality committee or other committees as appropriate. The quality committee undertakes extensive reviews of outcomes, complaints and the CQC action plan.

The Trust has a CQC steering group not only to oversee the delivery of the action plan resulting from recommendations made by the CQC at the last inspection but also compliance with the CQC Key Lines of Enquiry (the plan is also reviewed and approved by the quality committee). Progress is reported to QGSG and our commissioners.

The Trust undertakes internal reviews of its services; these reviews are based on CQC standards and so far this year, they have been undertaken within radiology and end of life care. There are two further reviews planned for child health and learning disability.

Additionally, the Trust operates a Clinical Accreditation Scheme, a process where wards or departments are required to demonstrate adherence to standards of care to become accredited. The Trust monitors ward standards through the clinical quality dashboard which focuses performance against key metrics including patient safety, effectiveness, patient experience and outcomes from matron peer walkabouts.

The Trust's Patient Improvement Framework (PIF) underpins our quality governance and is updated and reviewed annually and outlines the Trust's priority areas of focus for quality and progress is monitored from 'Ward to Board'.

**The Trust is fully compliant with the registration requirements of the Care Quality Commission.**

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Approved by the Trust Board 23 May 2017

23 May 2017

# Review of economy, efficiency and effectiveness of the use of resources

### The cost improvement programme (CIP)

The Trust has an active and successful transformation team which supports clinical teams to deliver improvements in quality, cost and performance. The team includes four functions:

- Service improvement managers leading trust-wide transformation projects
- Quality/service improvement training, delivering training to UHS and other local NHS providers
- A project management office, monitoring our CIP programme and co-ordinating transformation governance
- Data analysts, improving data quality, analysis and presentation.

Transformation projects support the CIP and Patient Improvement Framework priorities and are governed by our Transformation Board, led by the chief executive. The CIP has delivered approximately £27m of efficiency in 2016/17, made up of pay and non-pay savings, productivity improvements and associated income. The Cost Improvement Programme is regularly reviewed for any impact on quality, performance or patient experience.

Procurement efficiency plays an important part in delivering savings. The Trust's internal procurement team deliver significant savings each year by effectively negotiating contracts with suppliers.

### Service line reporting and patient level costing

For several years the Trust has produced service line reporting on an annual and now quarterly basis, to assess the profitability of each Care Group within the Trust.

The Trust has a Patient Level Costing (PLiCS) system, which provides timely, regular and accurate information on profitability at divisional, care group and individual patient level. This data is used to identify areas of differing practice and areas of opportunity to improve effectiveness, efficiency and value for money.

### Internal audit

The audit and risk committee reviews the Trust's systems of internal control, including the governance arrangements, as part of the audit programme, assisting the Board with its responsibilities to strengthen and improve the effectiveness of the Board Assurance Framework (BAF).

### Information governance

In the period 1 April 2016 to 31 March 2017 the Trust reported one Information Governance Serious Incident Requiring Investigation (IG SIRI) to the Information Commissioner. The report was submitted in January 2017 when the Trust was informed by a contractor who supplied a radiation protection monitoring service that an unknown third party had copied data from their information record system. The information compromised some personal information of former and current Trust staff subject to radiation protection monitoring. This incident is currently under investigation by the Information Commissioner's Office.

### Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Our quality report for this year represents a balanced view of the Trust, providing commentary on our progress against our quality priorities for the previous year and identifies our focus for next year.

There are a range of ways in which we assure ourselves of the accuracy of the data contained within this report, these include:

- The priorities reflect issues raised from feedback received from patients and service users. They are agreed in consultation with our staff, the Board, our governors and external partners, Commissioners and HealthWatch.

- The priorities and key performance metrics are reported through our clinical quality dash board from ward to Board.

- The Trust Board receives a monthly key performance indicator report and quarterly quality reports on patient safety, patient experience and patient outcomes.

- Quality is overseen by the care group governance, divisional governance, quality governance steering group, Trust executive committee and the Trust Board. In an addition there is quality committee which as a sub-committee of the Board has delegated authority to gain assurance on quality on behalf of the Board.

- We have implemented a clinical accreditation scheme where all wards and departments submit their quality standards and receive an unannounced visit. They receive accreditation, partial accreditation and exemplar status where there has been sustained improvement. This drives up quality, standards of care and consistency.

- Further assurance is provided by matron walkabouts, Executive and Trust Board ward and service visits with a focus of the Trust quality priorities.

The final level of assurance is that the report itself is circulated to stakeholders for their comments on the account and whether it is an accurate reflection and the governors choose a priority to be externally audited for data accuracy.

Each year the Trust undertakes a formal review of data quality risk matrix on each metric used in the Trust Board key performance indicator report. This includes metrics that are reviewed by the Trust performance team and internal and external audit. These reports are presented to the Trust audit and risk committee. Both internal and external audit have reviewed (RTT) data in 2016/17. The internal audit report made one low risk recommendation in relation to this review.

The Trust has a designated Data Quality Group is place, chaired by the director of transformation, in her role as the Executive lead for IT. In the last 18 months a sub group has been established specifically to review and improve RTT data quality as this scored at the highest risk on the data quality matrix.

The Board gains assurance on quality in various ways, via

- Board visits to divisions to review delivery of the quality agenda
- The monthly key performance indicator (dashboard) quality report
- The Clinical Quality Dashboard
- Quarterly Patient Experience, safety and outcome reports to Trust board
- The rolling program of patient improvement framework (PIF) reports covering:
  - patient experience/patient feedback/ patient complaints
  - patient safety
  - clinical outcomes/effectiveness
  - regulatory assurance
  - performance target

In addition, the audit and risk committee, the quality committee and the Trust executive committee receive summaries from the Trust's quality governance steering group (QGSG). We consult widely on our Quality Report with our staff and key stakeholders and with the Board prior to formal submission to parliament.

## Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit and Assurance committee, Trust Executive Committee and the Quality Governance Steering Group and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- NHSI: Single Oversight Framework Segmentation
- Care Quality Commission registration and the results of any CQC inspection
- Internal Audit reports
- External Audit reports
- Clinical Audits
- Accreditation and Peer Reviews
- Patient and Staff Surveys
- Benchmarking information.

The Trust Board and TEC regularly review the Trust's performance in relation to principal risks to the achievement of and the controls in place to assist in the delivery of its key objectives and targets. The Board proactively seeks support in commissioning reviews, support and external assessments in order to improve its overall performance.

The strategy and finance committee's focus on investigating the progress made in the delivery of financial plans and the Boards in-depth analysis of financial, service quality and performance information.

Clinical Audit is given a high importance. The annual clinical audit plan was developed to reflect the priorities of the Trust Board and national best practice. The QGSG ensures that there is a comprehensive programme of quality improvement for the care of patients, reporting on a regular basis to the Trust Board and Trust executive committee on the full range of its activities. The quality committee ensures that clear lines of governance accountability exist within the Trust for the overall quality of clinical care and clinical audit.

Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the audit and risk committee. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of internal audit's work. The methodology used by the Trust's internal auditor (Pricewaterhouse Coopers LLP) scores their opinion into one of four possible categories:

- Satisfactory
- Generally satisfactory with some improvement required
- Major improvement required
- Unsatisfactory

For the period 1 April 2016 to 31 March 2017 the head of the internal audit opinion states:

**Opinion: Generally satisfactory with some improvements required**
**"Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and/or non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.**

**Some improvements are required in those areas to enhance the adequacy and/or effectiveness of the framework of governance, risk management and control.**

**Our opinion is based on:**
- **All audits undertaken during the year.**
- **Any follow up action taken in respect of audits from previous periods.**
- **The effects of any significant changes in the organisation's objectives or systems.**
- **Any limitations which may have been placed on the scope or resources of internal audit.**
- **What proportion of the organisation's audit needs have been covered to date".**

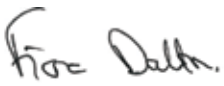
The Trust has an on-going process to assess compliance with the CQC's essential standards and regulations, which includes regular review and on-going monitoring of the evidence to demonstrate compliance with the standards. No issues have been identified from this process which would affect the Trust's registration.

The Trust was subject to an unannounced CQC inspection in January 2017; at the time of drafting this statement the Trust is awaiting formal notification of the outcome of the inspection and the accompanying report. However, based on the verbal feedback provided, there are no significant control issues to report.

In addition, a nominated local counter fraud specialist with a remit of building a strong anti-fraud culture throughout the organisation is commissioned and provides regular reports to the chief financial officer and the audit and assurance committee.

Our external auditors, KPMG, also undertake work around our financial systems to inform their audit opinion, work on our quality report to inform their opinion and provide an opinion on our use of resources. No significant concerns have been raised.

### Conclusion
No significant control issues have been identified. The head of internal audit found from the results of internal audit work in terms of the number and relative priority of findings no high risk areas had been identified.



**Chief executive**
23 May 2017

# Voluntary disclosures

# Equality, diversity and inclusion

UHS has continued to drive the importance of equality agenda during 2016/17. This is outlined below in a number of key areas.

### Race

2016 saw race become a key national, and international issue. The first national Workforce Race Quality Report was published which showed the extent of the challenges within the NHS in this agenda. For the service it made tough reading, with Black Minority Ethnic (BME) staff reporting higher incidences of bullying, harassment and discrimination than white comparators. It also identified discrepancies in the fair application of disciplinary procedures and prospects for recruitment and promotion. Whilst UHS was not a significant outlier with these results there were some similar themes.

Our results are published at www.uhs.nhs.uk/WRES. Positively UHS showed equality in results between BME and non BME staff on disciplinary procedures. However our 2016 survey showed that there was more to do to address harassment and bullying, promotion and career development.

UHS has partnered with national development experts to build a bespoke programme designed to promote local BME talent, specifically aimed mid grades such as bands six and seven. It is hoped that the programme will not only help to provide specific investment in skills to help promote career growth in BMEs, but also support a culture that embraces equality, inclusivity and diversity.

UHS took a robust approach following Brexit. Our chief executive wrote to all staff the day after the results were published to pledge our support to European workers at UHS. We have continued to ensure positive and supportive messages are provided to this vital section of the workforce. Whilst the real impact of Brexit remains unclear, UHS continues to welcome the skills, enthusiasm and commitment of employees from all over the world, and recognises the importance of ensuring a diverse workforce.

### Disability

Disability remains a key issue at UHS. The 2016 Staff Survey results continue to indicate that staff declaring a disability perceive a poor experience working at UHS. The Long Term Illness and Disability Group (LID) have continued to drive a number of improvements. This has included the recruitment of a disability access officer in occupational health specifically created with the aim of increasing the speed of application of workplace assessments and reasonable adjustments.

The group has also set up an access group (sponsored by the director of nursing). This has included ensuring appropriate facilities for assistance and PAT dogs. A number of doors have been changed to enable better access.

### Lesbian, Gay, Transgender, Bisexual (LGTB)

UHS has continued to partner with Stonewall as an equality champion. The Trust has an active LGBT group which champions a number of key activities. In August 2016 UHS participated in the annual Southampton Pride Event. Its stand was well attended providing useful information, in addition to ensuring a platform to promote UHS as a good employer in Southampton.

### Governance and oversight

The director of nursing chairs the Trust's equality and diversity steering group which reports to the Trust executive committee (TEC). The steering group has representation from the network groups, trust management and clinical divisions. The network chairs are invited to TEC and our formal open Trust Board receive reports on progress within equality and diversity at regular intervals.

# Southampton Hospital Charity

Southampton Hospital Charity (SHC) is the Trust's official registered charity. Its objective is to improve the health and wellbeing of NHS patients who use the services of the Trust's hospitals. SHC makes grants to pay for equipment, facilities or amenities which enhance and supplement what the Trust is able to provide with its NHS funds.

This year SHC gave grants to the Trust of £2.528m, the money having been raised largely through the generosity and tireless efforts of donors and supporters in the local community as well as the Trust's own staff. SHC's grants contributed:

- 1.8m for the purchase of equipment
- 324k for patient welfare and amenities
- 220k for staff education
- 142k for research
- 42k for staff welfare and amenities.

SHC's major projects this year included:

- raising £550k towards the refurbishment and remodelling of the Piam Brown children's cancer ward
- the launching of an appeal, in partnership with the Murray Parish Trust, to raise £2m towards the creation of a new children's emergency and trauma department.

The total raised for the benefit of the Trust's patients by SHC since its relaunch in 2008 now stands at £19.2m.

For more information about SHC visit www.southamptonhospitalcharity.org

We are also grateful to a number of other charities for their continuing support:

- The Wessex Neurological Centre Trust ('Smile4Wessex')
- Wessex Heartbeat
- The Friends of the Paediatric Intensive Care Unit (PICU)
- The League of Friends of Southampton General Hospital
- The League of Friends of Southampton Eye Unit
- Southampton Hospital Radio
- Radio Lollipop
- Macmillan Cancer Support
- Marie Curie Cancer Care
- Countess Mountbatten Hospice Charity
- The Charlotte Francis May Foundation
- Where There's a Will.

# Developments in informatics

We have continued to invest in a strategy for information technology and are working towards a paperless environment. In 2016 UHS was recognised in a programme of 12 digital exemplars by the NHS. All of these will receive new money, up to £10m over four years, to advance and demonstrate the benefits of electronic record keeping.

As part of our electronic patient record programme, 2016 saw further extension of digitisation including critical care in neuro and also in some lower acuity areas such as respiratory high care. This means more patients are monitored through automated vital signs collection, with decision support. Temperature, blood pressure and respiratory rate are now collected by mobile devices as this programme rolls out, to enable more timely intervention across the Trust, positively impacting patient safety.

The Clinical Handover and Record of Treatment System is being developed into a cross-professional single point of access platform and use of this system now extends beyond the initial use by medical staff.

In summer 2017, electronic document management and workflow will see a further step towards eliminating the need to manage paper records. Eventually all form data will be collected directly into a variety of devices from tablet computers to PCs.

We have started to roll out a system for digital display of the ward "white board". This will provide better quicker information to the ward with this following the patient if they move. For hospital control, it also provides a vital tool for management.

The My Medical Record system supporting patients online is live for multiple organisations. Test results and letters are now routinely sent into this record, with over 4,000 active patients saving time and unnecessary appointments.

In line with NHS ambitions for access we hope to increase internet availability and access for patients, as well as staff and visitors, who will be able to use their own devices. In future the self-check-in function will grow to include more intelligent services such as tracking and way finding for patients and visitors.

# Leading research into better care

Once again we were at the forefront of the national research effort, giving more people than ever before access to clinical trials. In 2016/17 we consolidated our strong R&D activity and infrastructure, with a top-five national ranking in trial recruitment and the securing over £25 million of National Institute for Health Research (NIHR) facility funding.

### Delivering new research, faster

UHS patients' wide and rapid access to clinical trials is underscored by our recruitment to national portfolio trials of over 18,500 patients, the fourth highest rate amongst English Trusts. Adding participants in our wider research partnerships to this takes our total recruitment to over 20,000.

A £200,000 performance payment for meeting government targets for recruiting to studies in full, on time also highlights the speed and quality of UHS's research delivery. Southampton has been the top-recruiting site national for several studies, including the By-Band bariatric study and a range of ophthalmology trials.

This performance helped secure over £20M in research funding for further investment. Some of that investment is targeted to key specialities, including cardiovascular and diabetes. Elsewhere, our per-patient recruitment premium for clinical teams, which gives money directly back to services, has been expanded to include non-commercial trials.

Strategic partnerships with key pharmaceutical companies were also strengthened, including a key preferred partner deal that gives UHS priority on new trial contracts from a range of companies. Continuation of partnership meetings with major pharmaceutical companies have ensured Southampton remains a key site for drug and vaccine studies.

### Milestones and successes

Together with our partners at University of Southampton, we were awarded several key NIHR infrastructure grants, securing our ability to turn scientific discoveries into treatments.

Our NIHR Biomedical Research Centre (BRC, £14.5 million) award consolidated our existing world-class nutrition and lifestyle BRC and respiratory NIHR Biomedical research Unit into one centre. It also incorporates three cross-cutting themes of microbial science, data science and behavioural science, providing the central focus and support for all our work in these five areas.

Our NIHR Wellcome Trust Clinical Research Facility (NIHR WTCRF) was renewed with funding of £9.2 million over five years. Recognised as one of the safest and highest quality clinical research spaces in the country, the NIHR WTCRF is where all of our early phase studies take place and is critical for complex later phase studies.

Combined with renewal of the Southampton Experimental Cancer Medicine Centre (ECMC). Combined, these awards secure our role in the first rank of UK clinical research sites.

### New facilities

Helping drive the discoveries needed for new treatments the University of Southampton's new Southampton Centre for Cancer Immunology began to take shape on the hospital grounds. Due for completion later in 2017, this £25m facility will consolidate Southampton's international leadership in using the body's own defences to fight cancer, accelerating the cycle of new therapy development, trialling and improvement.

# Investing for the future

The Trust continues to invest in our hospital sites by refurbishing and creating additional capacity where required.

Investments in 2016/17 include:

- The refurbishment and expansion of Piam Brown, the children's oncology ward
- To support the vascular network in the refurbishment of E4 and the creation of a new hybrid theatre
- Enhancing our radiotherapy services with the build of a radiotherapy bunker to house our six new linear accelerators
- Supporting the University of Southampton in building the new Cancer Centre for Immunology
- Continuing to invest in information technology
- Improving the facilities and equipment in nuclear medicine
- Expanding our PICU capacity by two beds with the support of charitable funding
- Continued investment in the infrastructure of the site through the strategic maintenance programme and creating a new decontamination unit for endoscopy and related services
- Creating additional car parking through building a new multi-storey car park

- Building additional support accommodation in the new Business Support offices (Minerva House)
- Working with the Maggie's charity to build a new Maggie's centre in 2017/18
- Continuing to invest in the replacement of the radiology equipment including a new ultrasound suite, MRI and CT scanners, x-ray facilities and angiography suite
- Developing the new plans for the refurbishment of GICU
- Developing plans to expand the Surgical High Dependency Unit by two beds
- Starting the replacement of washers/disinfectors in the sterile services department.

# Environmental sustainability and climate change

The Trust is committed to delivering a world-class sustainable healthcare system that works within the available environmental, financial and social resources; protecting and improving health now and for future generations. We will achieve this through a combination of investment in energy saving initiatives underpinned by Trust-wide staff awareness campaigns promoting sustainability. To embed our sustainability ambitions we are currently producing a Sustainable Development Management Plan (SDMP) for consideration by the Board.

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. An 11% reduction has been achieved since 2007. The target is to achieve a further 17% reduction by 2020.

NHS England has identified the key areas or 'carbon hotspots' across the healthcare service where we should prioritise our carbon reduction activities to help protect the wellbeing of the UK population.

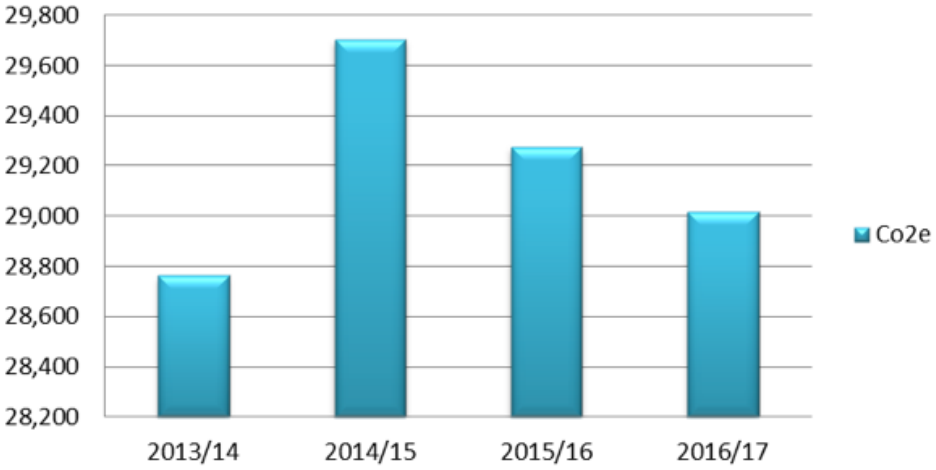
For the year 2016/17, our hospital consumed 38,039,268 kilowatt hours of electricity with more than 70% supplied by the gas fuelled CHP boilers. From the graph below we can see a slight reduction of 0.88% on our energy carbon emissions. This performance is attributed to the fact that we produced more of our own electricity from our combined heat and power plant.

To maintain this trend we are currently carrying out a number of projects. For instance, there is an ongoing energy saving initiative in our neurology theatres which aims to reduce electricity consumption in these areas by fitting the air handling unit motor inverters with PIR Sensors to detect a human presence within the room. If no movement is detected and the theatre doors are shut for a period of time, the plant will shut down until either someone enters the room or the plant restarts in the morning on a timed program. If successful it will be rolled out across other theatres and will therefore significantly reduce the amount of carbon produced.

The following graph tracks carbon emissions over the last four years.

| UHS All Energy CO2e | | | | | |
|---|---|---|---|---|---|
| | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **% Diff** |
| Tonnes | 28,763 | 29,703 | 29,275 | 29,018 | -0.88 |

## Carbon emissions - energy use




A carbon management policy was introduced in April 2013 which sets out the plans and processes to meet these NHS targets.

With the help of Department of Health funding, the Trust has invested £2.6m in energy efficiency schemes including:

- replacing single glazed windows with high performance double glazed units
- improving roof insulation
- changing to more energy efficient light fittings\
- waste heat recovery measures
- introducing new BMS system controls in theatres
- improvements to steam mains thermal insulation
- fitting of automatic internal doors to reduce heat loss along a through corridor

We will continue to invest in energy saving schemes.

A plan to develop on site localised energy production started in the year with the purchase of an anaerobic digester system. This facility uses organic waste to generate electricity and heat, thereby reducing our energy demands. It uses the latest fuel cell and solar panel technology. Since this is a pilot site, the hospital will be at the leading edge of integrated energy technology.

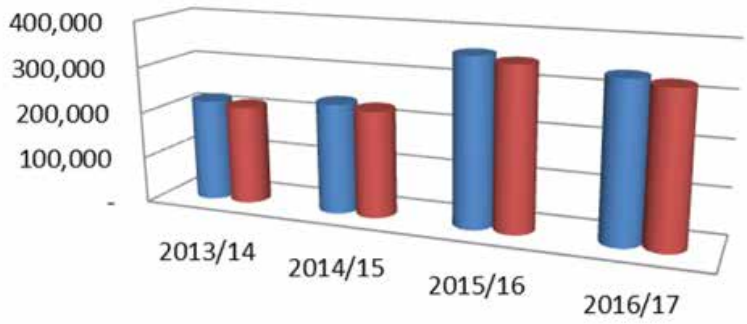
In addition we're investing in Short Term Operating Reserve (STOR) infrastructure plant. At certain times of the day the National Grid needs reserve power in the form of either generation or demand reduction to be able to manage overall energy supply. Where it is economic to do so, the National Grid may procure part of this requirement ahead of time from the Trust through STOR.

Besides the various energy efficiency investments, the Trust has also embarked on a major staff awareness and engagement programme in sustainability which will be supported by the 'Green Guardians Network' – the Trust sustainability champions. This programme aims to bring sustainability away from a purely estates driven agenda, to develop staff competencies around improved patient care and clinical outcomes by engaging staff at all levels, but nursing staff in particular. We want to challenge and innovate healthcare provision with a number of strategic activities throughout the year such as the ongoing Green Ward Competition, training workshops about sustainable healthcare and its many benefits to health and the wider environment or the integration of sustainability into procurement processes to name but a few.

## Finite resource – water

As a Trust we consumed 336,522m3 of water in 2016/17 compared to 360,227 m3 in 2015/16. We achieved 23,705 m3 of water reduction. This is equivalent to 6.6% of carbon C0²e reduced in comparison to the previous year. We will continue to encourage individuals to reduce water wastage and report water leakages in order to improve our water efficiency.

## Carbon emissions - water supply



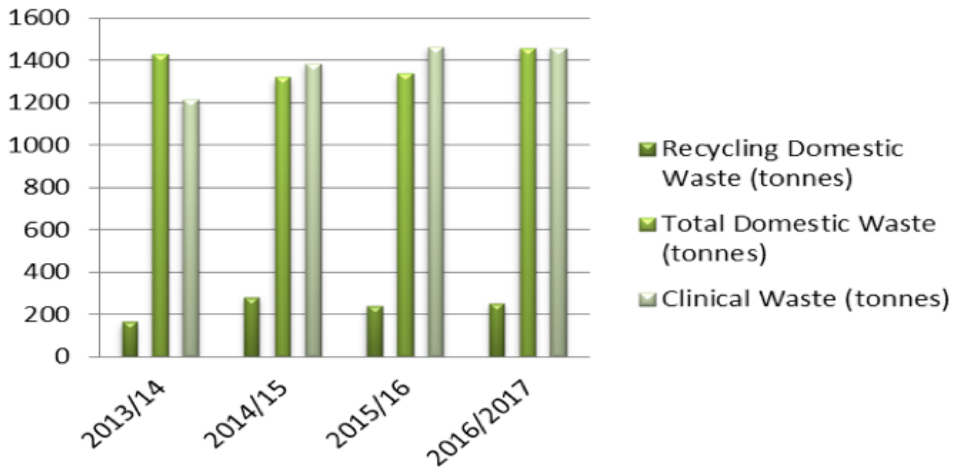

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|
| Water supply M3 | 220,848 | 237,891 | 360,227 | 336,523 |
| Kg C0²e | 213,569 | 230,050 | 348,354 | 325,431 |

## Waste management

Waste management is a key objective of the Trust. The Trust is committed to reducing its carbon footprint and improving the understanding of waste management within the health service. Widely distributed recycling bins encourage the collection of paper, cardboard, plastics, tins and glass. The waste management team also recycle ink cartridges and batteries.

In 2016/17 the organisation recycled 1460 tonnes of domestic waste but recycled less waste than the previous year. Our plan for this year will be to reduce waste wherever possible.

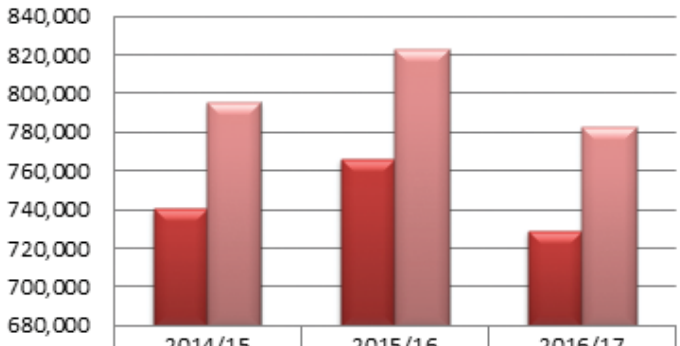
| | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|
| Recycling domestic waste (tonnes) | 165 | 281 | 239 | 254 |
| Total domestic waste (tonnes) | 1430 | 1322 | 1339 | 1460 |
| % recycled or re-used | 12% | 21% | 18% | 17% |
| Clinical waste (tonnes) | 1214 | 1383 | 1463 | 1460 |



## Business mileage

We are committed to improving the local air quality and the health of our community by promoting active travel to our staff. In 2016/17 we observed a 5% drop our travel carbon emissions compared to the previous year. We will continue to encourage staff to use public transport and/or bikes with the aim to reduce our carbon (CO2e) emissions and improve staff wellbeing.

## UHS travel emissions




| | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|
| Business Mileage | 741,038 | 766,473 | 729,117 |
| Carbon equivalent (Kg) | 795,808 | 823,121 | 783,006 |

## Procurement

In conjunction with the national NHS Standard for Procurement 2.5 the Trust will embed processes to ensure sustainable development is assessed, considered, implemented and monitored in procurement decision making. This will be developed in conjunction with the NHS Procuring for Carbon Reduction Roadmap to ensure that goods and services procured by the Trust are designed, manufactured, delivered, used and managed at end of life in an environmentally and socially responsible manner and forms an integral part of the Trust Sustainable Development Plan.

Suppliers to the Trust shall comply in all material respects with applicable environmental and social law requirements in force from time to time in relation to the goods. Where the provisions of any such laws are implemented by the use of voluntary agreements, our suppliers shall comply with such agreements as if they were incorporated into English law subject to those voluntary agreements being cited in our specifications and tender response documents. Suppliers to the Trust shall:

- comply with all policies and/or procedures and requirements set out in our specifications and tender response documents in relation to any stated environmental and social requirements, characteristics and impacts of the goods and the supplier's supply chain;

- maintain relevant policy statements documenting the supplier's significant social and environmental aspects as relevant to the goods being supplied and as proportionate to the nature and scale of the supplier's business operations; and

- maintain plans and procedures that support the commitments made as part of the supplier's significant social and environmental policies.

# ANNUAL ACCOUNTS

# Statement from the chief financial officer

In what has been a difficult year for finances in the NHS, I am pleased to report the Trust has had a successful financial year, achieving a surplus of £20.4m.

Both income and expenditure were higher than anticipated due mainly to higher than expected clinical activity volumes, particularly over the winter months. In some cases, patients who were medically ready to be discharged remained in the hospital longer than needed due to delays in setting up social care packages at home or in alternative care settings. This meant there were more patients occupying beds than anticipated. In financial terms, this unplanned additional activity tends to be more expensive because it includes, for example, paying overtime rates for staff to work additional hours. I would like to recognise the flexibility, resilience and compassion of our staff who have provided excellent care in the face of this increased demand.

Current NHS funding arrangements mean those NHS trusts able to achieve their patient access and financial performance targets are rewarded with additional funding, which becomes available to invest in improved facilities and clinical services. Since UHS achieved its financial targets and the overwhelming majority of its patient access targets for cancer, scheduled and unscheduled care, we were awarded additional NHS funding of £20m in 2016/17. This £20m will now be used to fund a significant capital investment programme in 2017/18; as well as increased investment in IT systems and integration, we will refurbish some older operating theatres, ward accommodation and critical care facilities and will increase 'procedure room' capacity, reflecting the increasing number of minor procedures that no longer require a traditional operating theatre environment.

It should be noted that if the £20m additional NHS funding is excluded from our financial results, the Trust achieved broadly break-even for the year. The Trust's financial target set by the NHS for next year is £10m, with additional national funding of £17m available if this financial and certain A&E performance targets are met. Achieving a £10m surplus in 2017/18 is challenging and will require continued strong financial management, including the delivery of efficiency improvement schemes totalling £29m to offset unavoidable cost increases including the national NHS 1% pay award, the mandatory apprentice levy and significant increases in local authority business rates and clinical negligence insurance premiums.

Achieving our financial targets and the additional NHS funding in 2017/18 is critical for the Trust's cash reserves over the coming years. Our financial performance in 2017/18 will determine our future ability to invest capital expenditure to improve the services, facilities and equipment we can offer the patients we serve. We are building a strong track record of clinical and financial performance hand in hand and we look forward to 2017/18 with confidence. I would like to thank our fantastic staff for all their contributions to such a successful year and thank them in advance for their ideas, energy and commitment to achieve our financial targets in 2017/18 so we can continue to invest to improve our hospitals and the services we provide.

**David French**
**Chief financial officer**

# Foreword to the accounts

These accounts for the period to 31 March 2017, have been prepared by University Hospital Southampton NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Fiona Dalton
Chief executive
23 May 2017

## Independent auditor's report to the Council of Governors of University Hospital Southampton NHS Foundation Trust only

### Opinions and conclusions arising from our audit

**1. Our opinion on the financial statements is unmodified**

We have audited the financial statements of University Hospital Southampton NHS Foundation Trust for the year ended 31 March 2017 set out on pages 81 to 115. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2017 and of the Group's and Trust's income and expenditure for the year then ended; and
- the Group's and the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

| **Overview** | | |
|---|---|---|
| **Materiality**: Group's and Trust's financial statements | £14.8m (2015/16:£13.7m)<br>2% (2015/16: 2%) of total income from operations | |
| **Coverage** | 100% (2015/16:100%) of group assets, income and expenditure | |
| **Risks of material misstatement** | | **vs 2015/16** |
| **Recurring risks** | Valuation of land and buildings | ◀ ▶ |
| | Recognition of NHS and non-NHS income | ◀ ▶ |

Key: ◀ ▶ Risk level unchanged from prior year

**2. Our assessment of risks of material misstatement**

In arriving at our audit opinion above on the financial statements, the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows (unchanged from 2015/16).

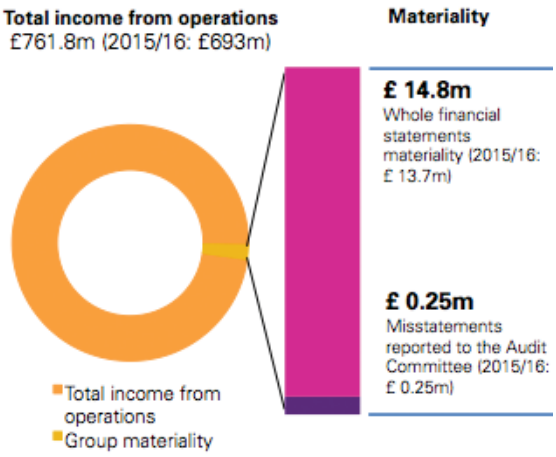
| | **The risk** | **Our response** |
|---|---|---|
| **Land and Buildings**<br><br>(£302.4 million; 2015/16: £293.4 million)<br><br>Refer to page [X] (Audit Committee Report), page [X] (accounting policy) and page [X] (financial disclosures). | **Valuation of land and buildings:**<br>Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset. For non specialised assets, where there is generally an active market, these are usually valued at open market value.<br><br>When considering the cost to build a replacement asset the Group may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic.<br><br>Valuation is completed by Gerald Eve, an external expert engaged by the Group, using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.<br><br>University Hospital Southampton NHS Foundation Trust had a full valuation undertaken at the 31 March 2015, and a desktop valuation performed at the 31 March 2017 resulting in a £1.3 million decrease in the value of the property, plant and equipment balance. | Our procedures included:<br><br>**Agreement of underlying asset records**:<br>We assessed the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Trust estate;<br><br>**Assessment of the external valuer**: We assessed the scope, qualifications and experience of University Hospital Southampton NHS Foundation Trust's valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation.<br><br>**Consideration of valuation assumptions**:<br>We critically assessed the assumptions used in preparing the desktop valuation completed of the Trust's land and buildings to ensure they were appropriate;<br><br>**Impairment review**: We considered how management and the valuer had assessed the need for an impairment across its asset base either due to a loss of value or reduction in future service potential;<br><br>**Additions to assets**: For a sample of assets added during the year we agreed that an appropriate valuation basis had been adopted when they became operational and that the Trust would benefit from future service potential. |

| | The risk | Our response |
|---|---|---|
| **NHS and non-NHS income**<br><br>Income: (£761.8 million; 2015/16: £693 million)<br><br>Refer to page [X] (Audit Committee Report), page [X] (accounting policy) and page [X] (financial disclosures). | **Recognition of NHS and non-NHS income:**<br>Of the Group's reported total income, £620.9 million (2015/16, £573.3m) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Income from CCGs and NHS England make up 81.5% of the Group's income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines, reducing the level of income achievement.<br><br>In 2016/17, the Group and Trust received transformation funding from NHS Improvement. This is received subject to achieving defined financial and operational targets on a quarterly basis. The Trust was allocated £17.4 million of transformation funding. Additional funding is available at year end if targets are achieved. This resulted in a total allocation of £20.2 million.<br><br>An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £250,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts.<br><br>The Group reported total income of £120.4m (2015/16: £98.5 million) from other activities. Much of this income is related to Education or Research and Development and is therefore provided by the Department of Health or Health Education England. Some sources of income require independent confirmations which can impact the amount of the income the Group will actually receive. | **Our procedures included:**<br><br>**Contract agreement**: For the three largest commissioners of the Group and Trust's activity we agreed that signed contracts were in place.<br><br>**Income Billing**: We agreed that invoices had been issued in line with the contracts signed with the three largest commissioners.<br><br>**Agreement of activity**: We agreed the levels of over and under performance reported to the records held on the Group and Trust's activity system.<br><br>**Agreement of balances**: We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were mismatches over £250k we challenged management's assessment of the level of income they were entitled to and the receipts that could be collected;<br><br>**Transformation funding**: We re-performed the Trust's calculation of performance against the financial and operational targets used in determining receipt of transformation funding to determine the amount the Trust was qualified to receive. We agreed the amounts recorded in the accounts to our calculation;<br><br>**Credit note provision**: We assessed how credit note provisions had been recorded to ensure they were accounted for against NHS organisations for the Department of Health consolidated accounts. |

## 3. Our application of materiality and an overview of the scope of our audit

The materiality for the Group financial statements was set at £14.8 million (2015/16: £13.7 million), determined with reference to a benchmark of income from operations (of which it represents approximately 2%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250,000 (2015/16: £250,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group financial statements comprise the parent, University Hospital Southampton NHS Foundation Trust and its subsidiaries, UHS Pharmacy Limited, UHS Estates Limited and Southampton Hospital Charity. The Group team performed the audit of the Group as if it was a single aggregated set of financial information. The audit was performed using the materiality levels set out above and covered 100% of total Group income from operations, Group surplus and Group assets.



**4 Our opinion on other matters prescribed by the Code of Audit Practice is unmodified**

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17; and

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**5 We have nothing to report in respect of the matters on which we are required to report by exception**

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and financial statements taken as a whole is fair, balanced and understandable; or

- the Audit & Risk Committee's commentary on page [X] of the Annual Report does not appropriately address matters communicated by us to the Audit & Risk Committee.

Under the Code of Audit Practice we are required to report to you if, in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17, is misleading or is not consistent with our knowledge of the Group and Trust and other information of which we are aware from our audit of the financial statements.

- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

**6 Certificate of audit completion**

We certify that we have completed the audit of the accounts of University Hospital Southampton NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

## Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities on page [X] the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors. A description of the scope of an audit of financial statements is provided on our website at www.kpmg.co.uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body, for our audit work, for this report or for the opinions we have formed.

**Neil Thomas**
**for and on behalf of KPMG LLP, Statutory Auditor**
Chartered Accountants15 Canada Square, Canary Wharf, London, E14 5GL

May 2017

## CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2017

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| Operating income from patient care activities | **641,364** | 594,536 | **641,364** | 594,536 |
| Other operating income | **120,445** | 98,515 | **117,110** | 95,900 |
| Operating income from continuing operations | **761,809** | 693,051 | **758,474** | 690,436 |
| Operating expenses of continuing operations * | **(729,926)** | (711,407) | **(726,729)** | (708,658) |
| **OPERATING SURPLUS/(DEFICIT)** | **31,883** | (18,356) | **31,745** | (18,222) |
| **FINANCE COSTS** | | | | |
| Finance income | **217** | 209 | **76** | 92 |
| Finance expenses | **(2,835)** | (2,521) | **(2,835)** | (2,521) |
| PDC Dividends payable | **(6,313)** | (6,653) | **(6,313)** | (6,653) |
| **NET FINANCE COSTS** | **(8,931)** | (8,965) | **(9,072)** | (9,082) |
| Losses on disposal of assets | (4,409) | (33) | (4,409) | (33) |
| Movement in fair value of investment property and other investments | **317** | 0 | **0** | 0 |
| **SURPLUS/ (DEFICIT) FOR THE YEAR** | **18,860** | (27,354) | **18,264** | (27,337) |
| **Other comprehensive income** | | | | |
| **Will not be reclassified to income and expenditure:** | | | | |
| Impairments charged to reserves | **0** | (3,807) | **0** | (3,807) |
| Revaluations | **105** | 7,493 | **104** | 7,493 |
| **May be reclassified to income and expenditure when certain conditions are met:** | | | | |
| Fair Value gains/ (losses) on Available-for-sale financial investments | **0** | (150) | **0** | 0 |
| **TOTAL COMPREHENSIVE INCOME FOR THE YEAR** | **18,965** | (23,818) | **18,368** | (23,651) |

note 1.19)

* Included within operating expenses of continuing operations (Group and Trust) in 2016/17 is a credit of £1.3m for a reversal of previous impairments to property, plant and equipment resulting from an increase in the year end desktop valuation (see note 10); in 2015/16 there was an impairment of £18.1m due to the reduction in the desktop valuation.

The notes on pages 85 to 115 form part of these accounts

## CONSOLIDATED STATEMENT OF FINANCIAL POSITION AT 31 MARCH 2017

| | NOTE | Group 31 March 2017 £000 | Group 31 March 2016 £000 | Trust 31 March 2017 £000 | Trust 31 March 2016 £000 |
|---|---|---|---|---|---|
| **Non-current assets** | | | | | |
| Intangible assets | 11 | **7,685** | 6,650 | **7,685** | 6,650 |
| Property, plant and equipment | 12 | **302,351** | 293,397 | **299,969** | 293,268 |
| Investment Property | 13 | **108** | 108 | **0** | 0 |
| Other Investments | 13 | **3,052** | 2,707 | **3,441** | 891 |
| Trade and other receivables | 15 | **3,564** | 3,459 | **3,564** | 3,459 |
| **Total non-current assets** | | **316,760** | 306,321 | **314,659** | 304,268 |
| **Current assets** | | | | | |
| Inventories | 14 | **15,198** | 14,877 | **14,717** | 14,397 |
| Trade and other receivables | 15 | **64,011** | 57,015 | **63,482** | 57,772 |
| Cash and cash equivalents | 17.1 | **35,963** | 23,912 | **33,196** | 21,798 |
| **Total current assets** | | **115,172** | 95,804 | **111,395** | 93,967 |
| **Current liabilities** | | | | | |
| Trade and other payables | 18 | **(77,515)** | (77,488) | **(74,705)** | (78,171) |
| Borrowings | 19 | **(10,479)** | (9,525) | **(10,479)** | (9,525) |
| Provisions | 21.1 | **(2,139)** | (2,548) | **(2,139)** | (2,548) |
| Other liabilities | 20 | **(16,126)** | (12,687) | **(16,126)** | (12,687) |
| **Total current liabilities** | | **(106,259)** | (102,248) | **(103,449)** | (102,931) |
| **Total assets less current liabilities** | | **325,673** | 299,877 | **322,605** | 295,304 |
| **Non-current liabilities** | | | | | |
| Trade and other payables | 18 | **(783)** | (405) | **(2,885)** | (405) |
| Borrowings | 19 | **(48,688)** | (49,783) | **(48,688)** | (49,783) |
| Provisions | 21.1 | **(2,924)** | (2,797) | **(2,924)** | (2,797) |
| Other liabilities | 20 | **(11,078)** | (7,123) | **(11,078)** | (7,123) |
| **Total non-current liabilities** | | **(63,473)** | (60,108) | **(65,575)** | (60,108) |
| **Total assets employed** | | **262,200** | 239,769 | **257,030** | 235,196 |
| **Financed by** | | | | | |
| **Taxpayers' equity** | | | | | |
| Public Dividend Capital | | **195,423** | 191,957 | **195,423** | 191,957 |
| Revaluation reserve | | **24,872** | 24,378 | **24,872** | 24,378 |
| Income and expenditure reserve | | **37,130** | 19,289 | **36,735** | 18,861 |
| Charitable fund reserves | | **4,775** | 4,145 | **0** | 0 |
| **Total taxpayers' equity** | | **262,200** | 239,769 | **257,030** | 235,196 |

The financial statements on pages 81 to 115 were approved by the Board on 23 May 2017 and signed on its behalf by:

Fiona Dalton
Chief executive
23 May 2017

## CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2017

| Group | NHS Charitable Funds Reserves | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Taxpayers' and Others' Equity at 1 April 2016 | **4,145** | **191,957** | **24,378** | **19,289** | **239,769** |
| Surplus for the year | **630** | **0** | **0** | **18,230** | **18,860** |
| Transfers between reserves | **0** | **0** | **392** | **(392)** | **0** |
| Revaluations - property, plant and equipment | **0** | **0** | **105** | **0** | **105** |
| Transfer to retained earnings on disposal of assets | **0** | **0** | **(3)** | **3** | **0** |
| Public Dividend Capital received | **0** | **3,466** | **0** | **0** | **3,466** |
| **Taxpayers' and Others' Equity at 31 March 2017** | **4,775** | **195,423** | **24,872** | **37,130** | **262,200** |
| Taxpayers' and Others' Equity at 1 April 2015 | 4,307 | 190,176 | 20,911 | 46,412 | 261,806 |
| Deficit for the year | (12) | 0 | 0 | (27,342) | (27,354) |
| Transfers between reserves | 0 | 0 | (211) | 211 | 0 |
| Impairments | 0 | 0 | (3,807) | 0 | (3,807) |
| Revaluations - property, plant and equipment | 0 | 0 | 7,493 | 0 | 7,493 |
| Transfer to retained earnings on disposal of assets | 0 | 0 | (8) | 8 | 0 |
| Fair Value gains on Available-for-sale financial investments | (150) | 0 | 0 | 0 | (150) |
| Public Dividend Capital received | 0 | 1,781 | 0 | 0 | 1,781 |
| **Taxpayers' Equity at 31 March 2016** | 4,145 | 191,957 | 24,378 | 19,289 | 239,769 |

| Trust | Public Dividend Capital | Revaluation Reserve | Income and Expenditure Reserve | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Taxpayers' and Others' Equity at 1 April 2016 | **191,957** | **24,378** | **18,861** | **235,196** |
| Surplus for the year | **0** | **0** | **18,264** | **18,264** |
| Transfers between reserves | **0** | **392** | **(392)** | **0** |
| Revaluations - property, plant and equipment | **0** | **105** | **(1)** | **104** |
| Transfer to retained earnings on disposal of assets | **0** | **(3)** | **3** | **0** |
| Public Dividend Capital received | **3,466** | **0** | **0** | **3,466** |
| **Taxpayers' and Others' Equity at 31 March 2017** | **195,423** | **24,872** | **36,735** | **257,030** |
| Taxpayers' and Others' Equity at 1 April 2015 | 190,176 | 20,911 | 45,979 | 257,066 |
| Deficit for the year | 0 | 0 | (27,337) | (27,337) |
| Transfers between reserves | 0 | (211) | 211 | 0 |
| Impairments | 0 | (3,807) | 0 | (3,807) |
| Revaluations - property, plant and equipment | 0 | 7,493 | 0 | 7,493 |
| Transfer to retained earnings on disposal of assets | 0 | (8) | 8 | 0 |
| Public Dividend Capital received | 1,781 | 0 | 0 | 1,781 |
| **Taxpayers' and Others' Equity at 31 March 2016** | 191,957 | 24,378 | 18,861 | 235,196 |

## CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2017

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **NOTE** | **£000** | £000 | **£000** | £000 |
| Operating surplus/ (deficit) | | **31,883** | (18,356) | **31,745** | (18,222) |
| **Operating surplus/ (deficit)** | | **31,883** | (18,356) | **31,745** | (18,222) |
| **Non-cash income and expense:** | | | | | |
| Depreciation and amortisation | **11/12.1** | **20,457** | 21,717 | **20,424** | 21,691 |
| Impairments | **10** | **(1,334)** | 18,101 | **(1,334)** | 18,101 |
| Non-cash donations/grants credited to income | | **(2,271)** | (750) | **(2,271)** | (750) |
| (Increase) in Trade and Other Receivables | **15** | **(7,071)** | (11,018) | **(5,791)** | (12,124) |
| (Increase) in Inventories | **14** | **(321)** | (1,830) | **(320)** | (1,779) |
| Increase in Trade and Other Payables | **18** | **(3,954)** | 10,119 | **(5,234)** | 10,757 |
| Increase in Other Liabilities | **20** | **7,394** | 2,985 | **7,394** | 2,985 |
| Increase/ (Decrease) in Provisions | **21** | **(320)** | 1,975 | **(320)** | 1,975 |
| **NET CASH GENERATED FROM OPERATIONS** | | **44,463** | 22,943 | **44,293** | 22,634 |
| **Cash flows from investing activities** | | | | | |
| Interest received | **8** | **76** | 92 | **76** | 92 |
| Purchase of intangible assets | **11** | **(3,559)** | (3,805) | **(3,559)** | (3,805) |
| Purchase of Property, Plant and Equipment | **12** | **(15,275)** | (9,698) | **(13,096)** | (9,647) |
| Receipt of cash donations to purchase capital assets | | **2,271** | 750 | 2,271 | 750 |
| Investment in subsidiary | | **0** | 0 | **(2,549)** | (50) |
| NHS Charitable funds - net cash flows from investing activities | | **113** | 116 | **0** | 0 |
| **Net cash (used in) investing activities** | | **(16,374)** | (12,545) | **(16,857)** | (12,660) |
| **Cash flows from financing activities** | | | | | |
| Public dividend capital received | | **3,466** | 1,781 | **3,466** | 1,781 |
| Other loans received | | **0** | 1,290 | 0 | 1,290 |
| Loans repaid to the Department of Health | **19** | **(4,927)** | (4,927) | **(4,927)** | (4,927) |
| Other loans repaid | **19** | **(162)** | (78) | **(162)** | (78) |
| Capital element of finance lease rental payments | | **(4,933)** | (4,331) | **(4,933)** | (4,331) |
| Capital element of Private Finance Initiative Obligations | | **(333)** | (314) | **(333)** | (314) |
| Interest paid | **9** | **(701)** | (795) | **(701)** | (795) |
| Interest element of finance lease | **9** | **(1,983)** | (1,541) | **(1,983)** | (1,541) |
| Interest element of Private Finance Initiative obligations | **9** | **(126)** | (145) | **(126)** | (145) |
| PDC Dividend paid | | **(6,339)** | (6,912) | **(6,339)** | (6,912) |
| **Net cash (used in)/ generated from financing activities** | | **(16,038)** | (15,972) | **(16,038)** | (15,972) |
| **Increase/ (decrease) in cash and cash equivalents** | | **12,051** | (5,574) | **11,398** | (5,998) |
| **Cash and Cash equivalents at 1 April** | | **23,912** | 29,486 | **21,798** | 27,796 |
| **Cash and Cash equivalents at 31 March** | | **35,963** | 23,912 | **33,196** | 21,798 |

The notes on pages 85 to 115 form part of these accounts

# Notes to the accounts

## Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts.
The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

## Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

## Going concern

These accounts have been prepared on a going concern basis.

[Disclose details of the basis of management's going concern assessment and material uncertainties]

## 1.1 Consolidation

**NHS Charitable Fund**

Southampton Hospital Charity ("SHC") is a registered charity. University Hospital Southampton NHS Foundation Trust ("the Trust") is the sole trustee of SHC. The Trust has determined that SHC is a subsidiary of the Trust because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with SHC and has the ability to affect those returns and other benefits through its power over SHC. However, as trustee of SHC the Trust is legally obliged to act exclusively in the interests of the charity's beneficiaries - NHS patients – and not (insofar as they diverge) in the interests of the Trust itself or its staff. The balance of funds of SHC at 31st March 2017 was £4.542m (unrestricted) and £0.203m (restricted).

SHC's accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to SHC's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

**Other subsidiaries**

The Trust wholly owns UHS Pharmacy Ltd and UHS Estates Ltd which form part of the consolidated accounts. UHS Pharmacy Ltd provides outpatient pharmacy services. Its turnover for the period ended 31st March 2017 was £13.3m and its gross assets at 31 March 2017 totalled £1.9m. UHS Estates Ltd was established in March 2016 and provides building management services to the Trust for buildings that the company develops. The first of these to be completed was Minerva House. Its turnover for the period ended 31st March 2017 was £0.2m and its gross assets at 31 March 2017 totalled £4.9m, relating to the construction debtor for Minerva House and an asset under construction relating to radiotherapy kit. Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. The amounts consolidated are drawn from the financial statements of UHS Pharmacy Ltd and UHS Estates Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

**Joint ventures**

Joint ventures are arrangements in which the Trust has joint control with one or more parties, and where it has rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. The Trust has one joint venture, Southampton CEDP LLP, which is a commercial partnership with Interserve Ltd for undertaking various developments, the first of which relates to the development of the front of the hospital. The Trust accounts using the net equity method for the joint venture at its financial year end which is 31st December. The joint venture made a small profit (less than £1k) in the year to 31st December 2016. The joint venture is currently constructing a new car park which will be completed in 2017/18.

### 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Revenue from patient care spells that are part completed at the year end are apportioned across financial years on the basis of the number of occupied bed days and average revenue per bed day.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim, but in addition makes an estimate for future claims relating to the period to date. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Trust sells some goods, such as drugs, to other NHS Trusts. Income is recognised on delivery of the goods to the customer.

Grants and donations are recognised as income on receipt. Where the funder imposes a condition that the grant or donation must be used to acquire or construct an asset the income is deferred until that asset is brought into use.

### 1.3 Expenditure on employee benefits

**Short-term employee benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

### 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### 1.5 Property, plant and equipment

**Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- the item has a cost of at least £5,000 or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

The Trust has reviewed its capitalisation of theatre instruments under these criteria and determined that these do not meet the criteria set out above. In changing this treatment, the Trust has actioned this as a disposal in its accounts. This is the most significant element of the loss of disposal of £4.4m shown in the accounts (see note 12.1)

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

The development of the new car park to be operated by the Trust's Commercial Estate Development Partnership in 2016/17 has not been recognised as Trust capital expenditure as this is the responsibility of, and was financed by, a private sector partner separate to the Trust's joint venture.

**Measurement**

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient

regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.  Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

HM Treasury currently adopts a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. A desktop revaluation has been carried out at 31 March 2017. The last full revaluation was undertaken at 31 March 2015.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

- Fixtures and equipment- carried at depreciated historic cost as this is considered to be not materially different from fair value. Fixtures and equipment acquired before 1 April 2008 were indexed and the carrying value of those assets at that date is being written off over their useful lives.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e. management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

**Private Finance Initiative (PFI) transactions**

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17 the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

## 1.6 Intangible assets

**Recognition**
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and the cost is at least Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

**Software**
Software which is integral to the operation of hardware (e.g. an operating system) is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware (e.g. application software) is capitalised as an intangible asset.

**Measurement**
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5. Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

**Amortisation**
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

## 1.7 Revenue government and other grants
Government grants are grants from Government bodies other than income from commissioners for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

## 1.8 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

## 1.9 Financial instruments and financial liabilities

### Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

### De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### Classification and measurement

Financial assets are categorised as loans and receivables.

### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Trust receivables are current and therefore the transaction value is deemed to be the fair value and amortised cost.

### Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

**Impairment of financial assets**
At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

Provision for the impairment of receivables is maintained based on the age of the receivable or if otherwise believed to be irrecoverable.

### 1.10 Leases

**Trust as lessee**

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Imaging Infrastructure Support Service (IISS)

During 2012/13 the Trust entered an agreement for the provision of a comprehensive replacement and maintenance service contract for all major radiological imaging equipment. The contract term is 13 years with a fixed unitary payment covering asset replacement and on-going maintenance. The asset replacements are treated as finance leases and accounted for as above. Where the element of the unitary payment relating to asset replacement is made in advance of the actual asset acquisition that payment is treated as a prepayment. The element of the unitary charge relating to maintenance is charged to the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

### 1.11 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution , and in return the NHSLA settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust.

The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 21.3 but is not recognised in the Trust's accounts.

**Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

### 1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed at note 22, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

### 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In addition, for 2016/17 only, the calculation also excludes the receivable in the Trust accounts the Sustainability & Transformation Fund Quarter 4 incentive and bonus payment. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

### 1.14 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core healthcare and are not subject to tax. However, the Trust's commercial subsidiaries are subject to corporation tax, although none has been incurred in the year ended 31st March 2017.

### 1.16 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

### 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

### 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

### 1.19 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

#### Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

#### Classification of Leases

Under IAS 17 a finance lease is one that transfers to the lessee 'substantially all the risks and rewards incidental to ownership of an asset'. This requires the consideration of a number of factors for each lease such as the lease transferring ownership of the asset to the lessee by the end of the lease term; the lessee having the option to purchase the asset at a price sufficiently lower than fair value at the date the option becomes exercisable for it to be reasonably certain at the inception of the lease that the option will be exercised; the lease term being for the major part of the economic life of the asset even if economic title is not transferred; the present value of the minimum lease payments amounting at the inception of the lease to at least substantially all of the fair value of the leased asset; and the lease assets being of such a specialised nature that only the lessee can use them without major modifications; or lessor's losses associated with cancelling the lease being borne by the lessee; gains or losses from fluctuations in the fair value of the residual accruing to the lessee; and the ability to continue the lease for a secondary period at a rent substantially lower than market rent. The total outstanding commitment for operating leases at 31st March 2017 is £6.2m, and for finance leases £36.645m.

#### Asset lives and residual values

Property, plant and equipment is depreciated over its useful life taking into account residual values, where appropriate. The actual lives of the assets and residual values are assessed annually and may vary depending on a number of factors. In reassessing asset lives, factors such as technological innovation and maintenance programmes are taken into account. Residual value assessments consider issues such as the remaining life of the asset and projected disposal values.

The range of asset lives for intangible assets is as follows:

| | Min Life Years | Max Life Years |
|---|---|---|
| Software | 5 | 10 |

The ranges of asset lives for property, plant and equipment are as follows:

| | Min Life Years | Max Life Years |
|---|---|---|
| Buildings excluding dwellings | 2 | 68 |
| Dwellings | 46 | 46 |
| Plant & Machinery | 3 | 20 |
| Transport Equipment | 5 | 10 |
| Information Technology | 5 | 15 |
| Furniture & Fittings | 10 | 10 |

**Impairment of assets**

At each balance sheet date, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually. In 2015/16, the Trust adopted a revised basis of valuation for building assets which excludes VAT from the cost of rebuilding assets. This basis has been applied again for the accounts for the year ended 31st March 2017.

**Recoverability of receivables**

Provision for non payment is made against all non-NHS receivables that are greater than 180 days old unless recoverability is certain. Provision is made against more recent receivables where there is some doubt concerning recoverability. The provision for impaired receivables at 31st March 2017 was £5.564m (see note 16.1).

For 2016/17 the Trust was eligible for a core allocation of £17.4m from NHS Improvement which depended upon achievement of specified financial and performance targets. The Trust has based its accounts on a figure of £17.183m. There are no significant sources of estimation uncertainty in the calculation of this figure. In addition, depending upon the Trust's outturn financial performance, the Trust was also eligible for incentive and bonus funding. Both the incentive (£1.705m) and the bonus (£1.349m) have been validated and confirmed by NHS Improvement and so are not subject to uncertainty.

**Other liabilities**

The Trust receives income in advance and then recognises this in accordance with revenue recognition criteria set out in IAS 18. As the income has already been received and is recognised according to established criteria this is not considered a source of estimation uncertainty.

**Provisions**

The Trust regularly monitors the position regarding provisions, including legal claims and restructuring, to ensure that it accurately reflects at each balance sheet date the current position in providing for potential future costs from past events, including board resolutions. The total provision for liabilities and charges at 31st March 2017 was £2.139m (see note 21.1).

**Key sources of estimation uncertainty**

There are no key assumptions concerning the future, or other key sources of estimation uncertainty at the balance sheet date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

## 1.20 Accounting Standards that have been issued but not adopted.

The following accounting standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) but not yet required to be adopted.

| Change published | Published by IASB | Financial year for which the change first applies |
|---|---|---|
| IFRS 9 Financial Instruments | July 2014 | Expected to be effective from 2017/18. |
| IFRS 14 Regulatory Deferral Accounts | May 2014 | Not yet EU adopted, and not likely to be adopted for the foreseeable future. |
| IFRS 15 Revenue from contracts with customers | May 2014 | Expected to be effective from 2017/18. |
| IFRS 16 Leases | January 2016 | Not yet EU adopted. Expected to be effective from 2018/19. |

This reflects the EU-adopted effective date rather than the effective date in the standard.

The adoption of these standards in future periods is not expected to have a material impact on the financial statements, with the exception of IFRS 16, which is considered unlikely to have a material impact on the Statement of Comprehensive Income, but will result in all leases with a duration over 1 year being included within the Statement of Financial Position.

## 2. Operating segments

Trust activity is organised into four clinical divisions as follows:

Division A – Surgery, Cancer Care and Critical Care
Division B – Specialist Medicine, Emergency Medicine, Medicine for Elder People and Pathology
Division C – Women and Newborn, Child Health, Clinical Support and Non Clinical Support
Division D – Trauma and Orthopaedics, Cardiothoracic, Neurosciences and Radiology

Each division has its own senior management team.

The Chief Operating Decision Maker (CODM) of the Trust is the Trust Board which is required to approve the budget and all major operating decisions.

The Monthly performance report to the CODM reports the performance of each Divisions operating costs against approved budgets. The financial information below is consistent with the monthly reporting.

| | **Year ended 31 March 2017** | Year ended 31 March 2016 (Restated) |
|---|---|---|
| | **£000** | £000 |
| Division A | **163,835** | 155,676 |
| Division B | **143,972** | 133,067 |
| Division C | **132,251** | 124,702 |
| Division D | **153,887** | 144,854 |
| Total Divisions | **593,945** | 558,298 |
| Adjustment for income included above | **66,855** | 63,826 |
| Headquarters and corporate costs | **46,882** | 45,548 |
| Total Operating Expenses excl charity | **707,682** | 667,672 |
| Depreciation, amortisation, impairments etc | **19,123** | 40,906 |
| Charitable expenditure and running costs | **3,121** | 2,829 |
| Total Operating Expenses incl charity | **729,926** | 711,407 |

The income above relates to divisional incomes that are deducted from operating costs for the purposes of reporting to the CODM.

## 3.1 Operating income by activity

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017 Total** | Year ended 31 March 2016 Total | **Year ended 31 March 2017 Total** | Year ended 31 March 2016 Total |
| | **£000** | £000 | **£000** | £000 |
| **Income from patient care activities** | | | | |
| Elective income | **120,929** | 114,963 | **120,929** | 114,963 |
| Non elective income | **149,318** | 143,382 | **149,318** | 143,382 |
| Outpatient income | **80,001** | 73,641 | **80,001** | 73,641 |
| A & E income | **15,577** | 14,522 | **15,577** | 14,522 |
| Other NHS clinical income | **265,356** | 239,759 | **265,356** | 239,759 |
| Private patient income | **5,892** | 5,159 | **5,892** | 5,159 |
| Other clinical income | **4,291** | 3,110 | **4,291** | 3,110 |
| Total income from patient care activities | **641,364** | 594,536 | **641,364** | 594,536 |
| **Other operating income** | | | | |
| Research and development | **21,555** | 19,315 | **21,555** | 19,315 |
| Education and training | **36,408** | 37,257 | **36,408** | 37,257 |
| Receipt of grants/donations for other capital acquisitions | **2,270** | 817 | **2,270** | 817 |
| Other charitable and other contributions to expenditure | **536** | 520 | **536** | 520 |
| Non-patient care services to other bodies | **14,115** | 13,828 | **14,073** | 13,913 |
| Sustainability and Transformation Fund income | **20,237** | 0 | **20,237** | 0 |
| Rental revenue from operating leases | **34** | 34 | **34** | 34 |
| NHS Charitable Funds: Incoming Resources excluding investment income | **3,293** | 2,700 | **0** | 0 |
| Other Operating Income: | | | | |
| Car parking | **3,730** | 3,710 | **3,730** | 3,710 |
| Staff accommodation rentals | **46** | 35 | **46** | 35 |
| Crèche services | **1,430** | 1,446 | **1,430** | 1,446 |
| Clinical excellence awards | **4,098** | 3,759 | **4,098** | 3,759 |
| Other | **12,693** | 15,094 | **12,693** | 15,094 |
| **Total other operating income** | **120,445** | 98,515 | **117,110** | 95,900 |
| **TOTAL OPERATING INCOME** | **761,809** | 693,051 | **758,474** | 690,436 |

Of total Operating Income of £761.809m, £620.912m was for commissioner requested services (2015/16: £573.305m), and £140.897m was for non-commissioner requested services (2015/16: £119.746m). As per the terms of the Trust's Foundation Trust licence, commissioner requested services are based upon income from CCG's and Clinical Commissioning Groups. Total Operating income from non-NHS sources totalled £33.774m (2015/16: £26.471m).

## 3.2 Operating lease income

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **Total £000** | Total £000 | **Total £000** | Total £000 |
| Rental revenue from operating leases - minimum lease receipts | **34** | 34 | **34** | 34 |
| **Future minimum lease payments due on leases of buildings and equipment expiring** | | | | |
| - later than five years: | **1,043** | 1,068 | **1,043** | 1,068 |

## 3.3 Analysis of income from activities by source

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017 £000** | Year ended 31 March 2016 £000 | **Year ended 31 March 2017 £000** | Year ended 31 March 2016 £000 |
| NHS Foundation Trusts | **458** | 377 | **458** | 377 |
| NHS Trusts | **108** | 243 | **108** | 243 |
| Clinical Commissioning Groups and NHS England | **620,912** | 573,305 | **620,912** | 573,305 |
| Local Authorities | **915** | 237 | **915** | 237 |
| Non NHS: Private patients | **5,892** | 5,159 | **5,892** | 5,159 |
| Non-NHS: Overseas patients (non-reciprocal) | **723** | 459 | **723** | 459 |
| NHS injury scheme (was RTA) | **2,653** | 2,414 | **2,653** | 2,414 |
| Devolved administrations and Channel Islands | **9,703** | 12,342 | **9,703** | 12,342 |
| **Total income from activities** | **641,364** | 594,536 | **641,364** | 594,536 |

## 3.4 Overseas visitors

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017 £000** | Year ended 31 March 2016 £000 | **Year ended 31 March 2017 £000** | Year ended 31 March 2016 £000 |
| Income recognised this year | **723** | 459 | **723** | 459 |
| Cash payments received in-year (relating to invoices raised in current and previous years) | **455** | 524 | **455** | 524 |
| Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years) | **156** | 124 | **156** | 124 |
| Amounts written off in-year (relating to invoices raised in current and previous years) | **67** | 209 | **67** | 209 |

## 4 Group Operating expenses

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 (Restated) |
| | **£000** | £000 | **£000** | £000 |
| Services from NHS Foundation Trusts | **4,500** | 4,237 | **4,500** | 4,237 |
| Services from NHS Trusts | **2,837** | 3,247 | **2,837** | 3,247 |
| Services from CCGs and NHS England | **0** | 60 | **0** | 60 |
| Services from other NHS Bodies | **6,190** | 5,869 | **6,190** | 5,869 |
| Purchase of healthcare from non NHS bodies | **13,570** | 12,729 | **13,570** | 12,729 |
| Employee Expenses - Executive directors | **1,262** | 1,347 | **1,262** | 1,347 |
| Employee Expenses - Non-executive directors | **145** | 158 | **145** | 158 |
| Employee Expenses - Staff | **429,671** | 406,716 | **429,355** | 406,429 |
| NHS Charitable funds - employee expenses | **355** | 595 | **0** | 0 |
| Supplies and services - clinical (excluding drug costs) | **86,903** | 80,108 | **86,903** | 80,108 |
| Supplies and services - general | **18,225** | 17,578 | **18,051** | 17,489 |
| Establishment | **3,229** | 3,425 | **3,206** | 3,409 |
| Research and development | **5,355** | 4,540 | **5,355** | 4,540 |
| Transport (Business travel only) | **278** | 419 | **278** | 419 |
| Transport | **1,438** | 1,281 | **1,435** | 1,281 |
| Premises - Business rates payable to Local Authorities | **2,280** | 2,063 | **2,261** | 2,047 |
| Premises- other | **19,103** | 17,682 | **19,036** | 17,595 |
| Increase/ (Decrease) in provision for impairment of receivables | **705** | 389 | **705** | 389 |
| Change in provisions discount rate(s) | **302** | (19) | **302** | (19) |
| Inventories written down | **61** | 36 | **61** | 36 |
| Drug costs (non inventory drugs only) | **1,855** | 1,827 | **1,855** | 1,827 |
| Drugs Inventories consumed | **92,646** | 85,199 | **93,612** | 86,138 |
| Rentals under operating leases | **1,099** | 681 | **1,083** | 665 |
| Depreciation on property, plant and equipment | **18,503** | 20,088 | **18,470** | 20,062 |
| Amortisation on intangible assets | **1,954** | 1,629 | **1,954** | 1,629 |
| Impairments of property, plant and equipment | **(1,334)** | 18,101 | **(1,334)** | 18,101 |
| Audit fees : | | | | |
| Audit services- statutory audit | **66** | 62 | **58** | 58 |
| Audit services -charitable fund accounts | **9** | 9 | **0** | 0 |
| Other auditor remuneration | **106** | 114 | **63** | 103 |
| Clinical negligence insurance costs | **10,022** | 8,566 | **10,022** | 8,566 |
| Legal fees | **431** | 789 | **407** | 789 |
| Consultancy costs | **112** | 72 | **112** | 72 |
| Internal audit costs - (not included in employee expenses) | **105** | 121 | **105** | 121 |
| Training, courses and conferences | **1,902** | 1,756 | **1,902** | 1,756 |
| Patient travel | **130** | 127 | **130** | 127 |
| Car parking & Security | **674** | 589 | **674** | 589 |
| Redundancy | **106** | 1,128 | **106** | 1,128 |
| Insurance | **593** | 612 | **593** | 612 |
| External financial services | **1,160** | 991 | **1,160** | 991 |
| Losses, ex gratia & special payments | **19** | 93 | **19** | 93 |
| Catering equipment provision | **0** | 1,541 | **0** | 1,541 |
| Other | **602** | 2,627 | **286** | 2,320 |
| NHS Charitable funds: Other resources expended | **2,757** | 2,225 | **0** | 0 |
| **TOTAL** | **729,926** | 711,407 | **726,729** | 708,658 |

## 4.1 Group Other Audit remuneration

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| Other auditor remuneration paid to the external auditor is analysed as follows: | | | | |
| Audit-related assurance services | **9** | 13 | **9** | 13 |
| All taxation advisory services not falling within item 3 above; | **97** | 77 | **54** | 66 |
| All other non-audit services | **0** | 24 | **0** | 24 |
| **Total** | **106** | 114 | **63** | 103 |

## 4.2 Group Losses and Special Payments

| Losses and special payments paid out in the year were as follows: | Year ended 31 March 2017 Cases by number and value Number | £000's | Year ended 31 March 2016 Number | £000's |
|---|---|---|---|---|
| Losses of cash | **14** | **7** | 14 | 8 |
| Bad debts and claims abandoned | **204** | **154** | 396 | 378 |
| Damage to buildings, property etc. (including stores losses) due to: | **12** | **39** | 11 | 36 |
| Total Losses | **230** | **200** | 421 | 422 |
| Ex gratia payments | **33** | **7** | 33 | 11 |
| Total Special Payments | **33** | **7** | 33 | 11 |
| Total Losses and Special Payments | **263** | **207** | 454 | 433 |

## 5.1 Employee Expenses

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **Total £000** | Total £000 | **Total £000** | Total £000 |
| Salaries and wages | **336,253** | 321,013 | **335,965** | 320,773 |
| Social security costs | **34,670** | 26,786 | **34,649** | 26,768 |
| Pension cost - Employers contributions to NHS Pensions | **40,491** | 38,256 | **40,491** | 38,256 |
| Pension cost - other contributions | **17** | 15 | **10** | 10 |
| Temporary staff - external bank | **9,748** | 7,166 | **9,748** | 7,166 |
| Temporary staff - agency/contract staff | **13,964** | 19,275 | **13,964** | 19,275 |
| NHS Charitable funds staff | **355** | 595 | **0** | 0 |
| Recoveries from Other bodies in respect of staff cost netted off expenditure | **(3,485)** | (3,875) | **(3,485)** | (3,875) |
| **Total Net Staff Costs** | **432,013** | 409,231 | **431,342** | 408,373 |
| Employee Expenses - Staff | **429,671** | 406,716 | **429,355** | 406,429 |
| Employee Expenses - Executive directors | **1,262** | 1,347 | **1,262** | 1,347 |
| NHS Charitable funds: Employee expenses | **355** | 595 | **0** | 0 |
| **Total Employee benefits excluding capitalised costs** | **431,288** | 408,658 | **430,617** | 407,776 |

The difference between net staff costs and total employee benefits relates to capitalised staff costs. Total remuneration paid to executive directors for the year ended 31 March 2017 (in their capacity as directors) totalled £1,262k (2015/16 £1,347k). No other remuneration was paid to directors in their capacity as directors. There were no advances or guarantees entered into on behalf of directors by the Trust. Employer contributions to the NHS Pension Scheme for executive directors for the year ended 31 March 2017 totalled £130k (2015/16 £142k). The total number of directors to whom benefits are accruing under the NHS defined benefit scheme (the NHS Pension Scheme) was 6 (2015/16 11).

## 5.2 Average number of employees (WTE basis)

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 (Restated) |
| | **Total Number** | Total Number | **Total Number** | Total Number |
| Medical and dental | **1,349** | 1,284 | **1,349** | 1,284 |
| Administration and estates | **1,737** | 1,639 | **1,737** | 1,639 |
| Healthcare assistants and other support staff | **1,616** | 1,523 | **1,616** | 1,523 |
| Nursing, midwifery and health visiting staff | **3,071** | 2,961 | **3,071** | 2,961 |
| Scientific, therapeutic and technical staff | **875** | 845 | **875** | 845 |
| Healthcare science staff | **451** | 438 | **451** | 438 |
| Agency and contract staff | **229** | 258 | **229** | 258 |
| Bank staff | **308** | 297 | **308** | 297 |
| Other | **136** | 140 | **125** | 129 |
| **Total** | **9,772** | 9,385 | **9,761** | 9,374 |
| Number of Employees (WTE) engaged on capital projects | **18** | 12 | **18** | 12 |

## 5.3 Early retirements due to ill health

From April 2016 to March 2017 there were 4 (Apr 2015- Mar 2016:5) early retirements from the organisation agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements is £258k (Apr 2015- Mar 2016: £266k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority-Pensions Division.

## 5.4 Reporting of other compensation schemes- exit packages

| | Group and Trust | | Group and Trust | |
|---|---|---|---|---|
| | **Number of compulsory redundancies** | **Value of compulsory redundancies** | Number of compulsory redundancies | Value of compulsory redundancies |
| **Exit package cost band (including any special payment element)** | **Number** | **£000** | Number | £000 |
| | **Year ended 31 March 2017** | | Year ended 31 March 2016 | |
| <£10,000 | **0** | **0** | 3 | 10 |
| £10,001 - £25,000 | **3** | **54** | 3 | 46 |
| £25,001 - 50,000 | **6** | **227** | 3 | 102 |
| £50,001 - £100,000 | **3** | **223** | 2 | 139 |
| £100,001 - £150,000 | **0** | **0** | 1 | 135 |
| Total | **12** | **504** | 12 | 432 |

## 5.5 Exit packages: other (non-compulsory) departure payments - 2016/17

| | **Number of other departures** | **Value of other departures** | Number of compulsory redundancies | Value of compulsory redundancies |
|---|---|---|---|---|
| | **Number** | £000 | Number | £000 |
| | **Year ended 31 March 2017** | | Year ended 31 March 2016 | |
| <£10,000 | **3** | **17** | **0** | 0 |
| £10,001 - £25,000 | **1** | **14** | 0 | 0 |
| £25,001 - 50,000 | **3** | **107** | 0 | 0 |
| £50,001 - £100,000 | **1** | **68** | **0** | 0 |
| £100,001 - £150,000 | **0** | **0** | 1 | 121 |
| Total | **8** | **206** | 1 | 121 |

## 6 Pensions

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The government introduced automatic enrolment of staff into a workplace pension in April 2013 (although staff can continue to opt out again after enrolment). In general the Trust's staff are enrolled into the NHS pension scheme. However, there is a small group of staff who cannot be enrolled into the NHS scheme; for example, where they have already started drawing their NHS pension. These staff are auto-enrolled into the National Earnings Savings Trust (NEST) scheme managed by the NEST corporation which is a non-departmental public body accountable to the Department of Work and Pensions. NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. The employer contribution rate for NEST adopted by the Trust currently stands at 1.2% of annual earnings between £5824 and £43000 (this is the minimum rate stipulated). This is due to rise to 2.6% in 2018/19 and then 4% in April 2019. At 31st March 2017 the Trust had 69 members in NEST (31st March 2016: 62) and had made total contributions for 2016/17 of £9k (2015/16: £9k).

## 7.1 Operating leases

| | Year ended 31 March 2017 | | | Year ended 31 March 2016 | | |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Group** | **Buildings** | **Plant & Machinery** | **Total** | Buildings | Plant & Machinery | Total |
| Minimum lease payments | **446** | **653** | **1,099** | 449 | 232 | 681 |
| **Trust** | | | | | | |
| Minimum lease payments | **446** | **637** | **1,083** | 449 | 216 | 665 |

## 7.2 Arrangements containing an operating lease

| | Year ended 31 March 2017 | | | Year ended 31 March 2016 | | |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Group** | **Buildings** | **Plant & Machinery** | **Total** | Buildings (restated) | Plant & Machinery | Total |
| Future minimum lease payments due: | | | | | | |
| - not later than one year; | **258** | **296** | **554** | 457 | 257 | 714 |
| - later than one year and not later than five years; | **868** | **122** | **990** | 859 | 206 | 1,065 |
| - later than five years. | **4,656** | **0** | **4,656** | 4,779 | 0 | 4,779 |
| **Total** | **5,782** | **418** | **6,200** | 6,095 | 463 | 6,558 |
| | | | | | | |
| **Trust** | | | | | | |
| Future minimum lease payments due: | | | | | | |
| - not later than one year; | **258** | **280** | **538** | 457 | 241 | 698 |
| - later than one year and not later than five years; | **868** | **115** | **983** | 859 | 184 | 1,043 |
| - later than five years. | **4,656** | **0** | **4,656** | 4,779 | 0 | 4,779 |
| **Total** | **5,782** | **395** | **6,177** | 6,095 | 425 | 6,520 |

## 7.3 Interest on late payments

There was no interest incurred on late payments in 2015/16 or 2016/17.

## 8 Finance income

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| Interest on bank accounts | **76** | 92 | **76** | 92 |
| NHS Charitable funds: investment income | **141** | 117 | **0** | 0 |
| Total | **217** | 209 | **76** | 92 |

## 9 Finance expenses

| | Group | | Trust | |
|---|---|---|---|---|
| | **Year ended 31 March 2017** | Year ended 31 March 2016 | **Year ended 31 March 2017** | Year ended 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| Interest expense: | | | | |
| Capital loans from the Department of Health | **629** | 784 | **629** | 784 |
| Commercial loans | **57** | 15 | **57** | 15 |
| Finance leases | **1,985** | 1,540 | **1,985** | 1,540 |
| Private Finance Initiative schemes | **126** | 145 | **126** | 145 |
| **Total Finance costs** | **2,797** | 2,484 | **2,797** | 2,484 |
| Unwinding of discount on provisions | **38** | 37 | **38** | 37 |
| **Total Finance expenses** | **2,835** | 2,521 | **2,835** | 2,521 |

## 10 Impairments

| | Year ended 31 March 2017 | | | Year ended 31 March 2016 | | |
|---|---|---|---|---|---|---|
| | Net impairment | Impairments | Reversals | Net impairment | Impairments | Reversals |
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| Other | **0** | **0** | **0** | 3,807 | 3,807 | 0 |
| Changes in market price | **(1,334)** | **0** | **(1,334)** | 18,101 | 18,101 | 0 |
| **Total Impairments** | **(1,334)** | **0** | **(1,334)** | 21,908 | 21,908 | 0 |

All of the amount above was credited (2015/16 £18.101m charged) to the Statement of Comprehensive Income. There was no impairment (2015/16 £3.808m) charged to the Revaluation reserve, however there was a revaluation of £105k (2015/16: £0) credited to the Revaluation reserve.

## 11 Intangible assets

| | Movements for year ended 31 March 2017 | | Movements for year ended 31 March 2016 | |
|---|---|---|---|---|
| | **Software licences (purchased)** | **Total** | Software licences (purchased) | Total |
| **Group and Trust** | **£000** | **£000** | £000 | £000 |
| Valuation/Gross Cost at 1 April | **15,000** | **15,000** | 17,947 | 17,947 |
| Additions - purchased / internally generated | **3,096** | **3,096** | 3,362 | 3,362 |
| Additions - assets purchased from cash donations / grants | **0** | **0** | 40 | 40 |
| Disposals | **(493)** | **(493)** | (6,349) | (6,349) |
| **Valuation/Gross cost at 31 March** | **17,603** | **17,603** | 15,000 | 15,000 |
| Amortisation at 1 April | **8,350** | **8,350** | 13,070 | 13,070 |
| Provided during the year | **1,954** | **1,954** | 1,629 | 1,629 |
| Disposals | **(386)** | **(386)** | (6,349) | (6,349) |
| **Amortisation at 31 March** | **9,918** | **9,918** | 8,350 | 8,350 |
| **Net Book Value at 31 March** | **7,685** | **7,685** | 6,650 | 6,650 |

## 12.1 Property, plant and equipment 2016/17

| | Land | Buildings excluding dwellings | Dwellings | Assets Under Construction and Payments on Account | Plant & machinery | Transport equipment | Information Technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Group** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** | **£000** |
| Valuation/Gross cost at 1 April 2016 | **31,031** | **245,423** | **1,298** | **3,604** | **101,653** | **692** | **9,088** | **75** | **392,864** |
| Additions - purchased | **0** | **7,173** | **0** | **6,694** | **2,847** | **0** | **1,121** | **0** | **17,835** |
| Additions - leased | **0** | **594** | **0** | **0** | **9,618** | **0** | **0** | **0** | **10,212** |
| Additions - grants / donations of cash to purchase assets | **0** | **1,445** | **0** | **105** | **711** | **0** | **10** | **0** | **2,271** |
| Reversal of impairments credited to operating income | **0** | **(15,087)** | **0** | **0** | **0** | **0** | **0** | **0** | **(15,087)** |
| Reclassifications | **0** | **3,144** | **0** | **(3,144)** | **0** | **(6)** | **0** | **6** | **0** |
| Revaluations | **0** | **98** | **7** | **0** | **0** | **0** | **0** | **0** | **105** |
| Disposals | **0** | **(18)** | **0** | **0** | **(11,786)** | **0** | **(3,985)** | **(57)** | **(15,846)** |
| **Valuation/Gross cost at 31 March 2017** | **31,031** | **242,772** | **1,305** | **7,259** | **103,043** | **686** | **6,234** | **24** | **392,354** |
| Accumulated depreciation at 1 April 2016 | **0** | **31,437** | **27** | **0** | **61,596** | **358** | **5,982** | **67** | **99,467** |
| Provided during the year | **0** | **8,239** | **27** | **0** | **9,153** | **83** | **999** | **2** | **18,503** |
| Reversal of impairments credited to operating income | **0** | **(16,421)** | **0** | **0** | **0** | **0** | **0** | **0** | **(16,421)** |
| Reclassifications | **0** | **0** | **0** | **0** | **0** | **(6)** | **0** | **6** | **0** |
| Disposals | **0** | **(12)** | **0** | **0** | **(7,921)** | **0** | **(3,556)** | **(57)** | **(11,546)** |
| **Accumulated depreciation at 31 March 2017** | **0** | **23,243** | **54** | **0** | **62,828** | **435** | **3,425** | **18** | **90,003** |

All of the disposals shown above relate to the accounting disposal of Commissioner Requested Services assets at or beyond the end of their useful economic lives; the assets shown as disposals have all been replaced or superseded by new arrangements, so there is no implication for the delivery of those services.

## 12.2 Property, plant and equipment 2015/16

| | Land | Buildings excluding dwellings | Dwellings | Assets Under Construction and Payments on Account | Plant & machinery | Transport equipment | Information Technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| Group | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Valuation/Gross cost at 1 April 2015 | 23,601 | 240,943 | 1,234 | 561 | 101,331 | 626 | 8,779 | 87 | 377,162 |
| Additions - purchased | 0 | 3,809 | 0 | 1,810 | 3,314 | 0 | 1,133 | 0 | 10,066 |
| Additions - leased | 0 | 17 | 0 | 1,755 | 5,529 | 176 | 0 | 0 | 7,477 |
| Additions - government granted | 0 | 132 | 0 | 0 | 578 | 0 | 0 | 0 | 710 |
| Reclassifications | 0 | 522 | 0 | (522) | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 7,430 | 0 | 64 | 0 | 0 | 0 | 0 | 0 | 7,494 |
| Disposals | 0 | 0 | 0 | 0 | (9,099) | (110) | (824) | (12) | (10,045) |
| Valuation/Gross cost at 31 March 2016 | 31,031 | 245,423 | 1,298 | 3,604 | 101,653 | 692 | 9,088 | 75 | 392,864 |
| Accumulated depreciation at 1 April 2015 | 0 | 0 | 0 | 0 | 61,109 | 393 | 5,903 | 77 | 67,482 |
| Provided during the year | 0 | 9,528 | 27 | 0 | 9,553 | 75 | 903 | 2 | 20,088 |
| Impairments charged to operating expenses | 0 | 3,808 | 0 | 0 | 0 | 0 | 0 | 0 | 3,808 |
| Impairments charged to revaluation reserve | 0 | 18,101 | 0 | 0 | 0 | 0 | 0 | 0 | 18,101 |
| Disposals | 0 | 0 | 0 | 0 | (9,066) | (110) | (824) | (12) | (10,012) |
| Accumulated depreciation at 31 March 2016 | 0 | 31,437 | 27 | 0 | 61,596 | 358 | 5,982 | 67 | 99,467 |

## 12.3 Property, plant and equipment- other entities in Group

| Of the movements above, the following relate to UHS Pharmacy Ltd: | Movements for year ended 31 March 2017 Buildings excluding dwellings £000 | Information Technology £000 | Total £000 | Movements for year ended 31 March 2016 Buildings excluding dwellings £000 | Information Technology £000 | Total £000 |
|---|---|---|---|---|---|---|
| Valuation/Gross cost at 1 April | 110 | 86 | 196 | 59 | 86 | 145 |
| Additions - purchased | 5 | 0 | 5 | 51 | 0 | 51 |
| Valuation/Gross cost at 31 March | 115 | 86 | 201 | 110 | 86 | 196 |
| Accumulated depreciation at 1 April | 22 | 45 | 67 | 14 | 27 | 41 |
| Depreciation provided during the year | 16 | 17 | 33 | 8 | 18 | 26 |
| Accumulated depreciation at 31 March | 38 | 62 | 100 | 22 | 45 | 67 |

| Of the movements above, the following relate to UHS Estates Ltd: | Movements for year ended 31 March 2017 Assets Under Construction and Payments on Account £000 | Movements for year ended 31 March 2016 Assets Under Construction and Payments on Account £000 |
|---|---|---|
| Valuation/Gross cost at 1 April | 0 | 0 |
| Additions - purchased | 2,281 | 0 |
| Valuation/Gross cost at 31 March | 2,281 | 0 |
| Accumulated depreciation at 1 April | 0 | 0 |
| Depreciation provided during the year | 0 | 0 |
| Accumulated depreciation at 31 March | 0 | 0 |

This addition relates to Radiotherapy equipment.

## 12.4 Property, plant and equipment financing

| Net book value at 31 March 2017 | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets Under Construction and Payments on Account £000 | Plant & machinery £000 | Transport equipment £000 | Information Technology £000 | Furniture & fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| **Group** | | | | | | | | | |
| Owned | 31,031 | 190,317 | 1,251 | 7,259 | 16,349 | 132 | 2,809 | 6 | 249,154 |
| Finance Lease | 0 | 595 | 0 | 0 | 23,866 | 119 | 0 | 0 | 24,580 |
| On-balance-sheet PFI contracts | 0 | 3,478 | 0 | 0 | 0 | 0 | 0 | 0 | 3,478 |
| Donated | 0 | 25,139 | 0 | 0 | 0 | 0 | 0 | 0 | 25,139 |
| **NBV Total at 31 March 2017** | 31,031 | 219,529 | 1,251 | 7,259 | 40,215 | 251 | 2,809 | 6 | 302,351 |
| Net book value at 31 March 2016 | | | | | | | | | |
| **Group** | | | | | | | | | |
| Owned | 31,031 | 185,890 | 1,271 | 1,849 | 19,328 | 39 | 3,105 | 8 | 242,521 |
| Finance Lease | 0 | 253 | 0 | 1,755 | 18,997 | 155 | 0 | 0 | 21,160 |
| On-balance-sheet PFI contracts | 0 | 3,515 | 0 | 0 | 0 | 0 | 0 | 0 | 3,515 |
| Donated | 0 | 24,328 | 0 | 0 | 1,732 | 140 | 1 | 0 | 26,201 |
| NBV Total at 31 March 2016 | 31,031 | 213,986 | 1,271 | 3,604 | 40,057 | 334 | 3,106 | 8 | 293,397 |

Of the balance above, the following relates to UHS Pharmacy Ltd:

| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
|---|---|---|---|---|---|---|---|---|---|
| **At 31 March 2017** | 0 | 77 | 0 | 0 | 0 | 0 | 24 | 0 | 101 |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| At 31 March 2016 | 0 | 45 | 0 | 0 | 0 | 0 | 59 | 0 | 104 |

Of the balance above, the following relates to UHS Estates Ltd:

| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
|---|---|---|---|---|---|---|---|---|---|
| **At 31 March 2017** | 0 | 0 | 0 | 2,281 | 0 | 0 | 0 | 0 | 2,281 |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| At 31 March 2016 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

None of the balance relates to the Trust charity.

## 13 Investments

| Group | NHS Charitable funds: Investment property £000 | NHS Charitable funds: Other investments £000 | Other Investments £000 | NHS Charitable funds: Investment property £000 | NHS Charitable funds: Other investments £000 | Other Investments £000 |
|---|---|---|---|---|---|---|
| | Movements for year ended 31 March 2017 | | | Movements for year ended 31 March 2016 | | |
| Carrying value at 1 April | 108 | 2,707 | 0 | 108 | 2,857 | 0 |
| Acquisitions in year - other | 0 | 28 | 0 | 0 | 0 | 0 |
| Fair value gains [taken to I&E] | 0 | 317 | 0 | 0 | 0 | 0 |
| Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income | 0 | 0 | 0 | 0 | (150) | 0 |
| Carrying value at 31 March | 108 | 3,052 | 0 | 108 | 2,707 | 0 |

| Trust | Other Investments Movements for year ended 31 March 2017 £000 | Other Investments Movements for year ended 31 March 2016 (Restated) £000 |
|---|---|---|
| Carrying value at 1 April | 891 | 841 |
| Acquisitions in year - subsequent expenditure | 2,550 | 50 |
| Carrying value at 31 March | 3,441 | 891 |

The inevestment consists of £841k share capital for UHS Pharmacy Ltd and £2,600k for UHS Estates Ltd.

## 14 Inventories

| | Group | | | Trust | | |
|---|---|---|---|---|---|---|
| | **Drugs £000** | **Consumables £000** | **Total £000** | **Drugs £000** | **Consumables £000** | **Total £000** |
| ***Current*** | | | | | | |
| Carrying Value at 31 March 2016 | **3,455** | **11,422** | **14,877** | **2,975** | **11,422** | **14,397** |
| Carrying Value at 31 March 2017 | **3,400** | **11,798** | **15,198** | **2,919** | **11,798** | **14,717** |

## 15 Trade and other receivables

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total 31 March 2017 £000** | Total 31 March 2016 £000 | **Total 31 March 2017 £000** | Total 31 March 2016 £000 |
| ***Current*** | | | | |
| NHS Receivables | **31,910** | 27,069 | **31,908** | 27,069 |
| Other receivables with related partie | **2,885** | 1,717 | **2,885** | 1,717 |
| Prepayments (Non-PFI) | **16,753** | 17,029 | **16,750** | 17,027 |
| Accrued income | **5,538** | 6,000 | **5,697** | 7,126 |
| PDC Dividend receivable | **311** | 285 | **311** | 285 |
| VAT receivable | **1,577** | 1,595 | **1,232** | 1,258 |
| Other receivables | **10,263** | 8,690 | **10,263** | 8,690 |
| NHS Charitable funds: Trade and oth | **338** | 30 | **0** | 0 |
| Provision for impaired receivables | **(5,564)** | (5,400) | **(5,564)** | (5,400) |
| **Total Current** | **64,011** | 57,015 | **63,482** | 57,772 |
| ***Non-Current*** | | | | |
| Other receivables | **3,564** | 3,459 | **3,564** | 3,459 |
| **Total Non-Current** | **3,564** | 3,459 | **3,564** | 3,459 |
| **Total Trade and other Receivables** | **67,575** | 60,474 | **67,046** | 61,231 |

## 16.1 Provision for impairment of receivables

| | Group | | Trust | |
|---|---|---|---|---|
| | **Movements for year ended 31 March 2017** | Movements for year ended 31 March 2016(Restated) | **Movements for year ended 31 March 2017** | Movements for year ended 31 March 2016 (Restated) |
| | **£000** | £000 | **£000** | £000 |
| **At 1 April** | **5,400** | 5,681 | 5,400 | 5,681 |
| Increase in provision | **4,755** | 4,263 | 4,755 | 4,263 |
| Amounts utilised | **(541)** | (670) | (541) | (670) |
| Unused amounts reversed | **(4,050)** | (3,874) | (4,050) | (3,874) |
| **At 31 March** | **5,564** | 5,400 | **5,564** | 5,400 |

## 16.2 Analysis of impaired receivables

| | Group | | Trust | |
|---|---|---|---|---|
| | **Trade Receivables 31 March 2017** | Trade Receivables 31 March 2016 (Restated) | **Trade Receivables 31 March 2017** | Trade Receivables 31 March 2016 (Restated) |
| **Ageing of impaired receivables** | | | | |
| 0 - 30 days | **1,843** | 2,696 | **1,843** | 2,696 |
| 30-60 Days | **0** | 151 | **0** | 151 |
| 60-90 days | **229** | 77 | **229** | 77 |
| 90- 180 days | **902** | 870 | **902** | 870 |
| over 180 days | **2,590** | 1,606 | **2,590** | 1,606 |
| **Total** | **5,564** | 5,400 | **5,564** | 5,400 |
| **Ageing of non-impaired receivables past their due date** | | | | |
| 0 - 30 days | **10,891** | 3,071 | **10,864** | 3,055 |
| 30-60 Days | **1,557** | 2,256 | **1,557** | 2,256 |
| 60-90 days | **1,208** | 518 | **1,208** | 518 |
| 90- 180 days | **530** | 1,408 | **530** | 1,408 |
| over 180 days | **81** | 366 | **81** | 366 |
| **Total** | **14,267** | 7,619 | **14,240** | 7,603 |

## 17.1 Cash and cash equivalents

| | Group | | Trust | |
|---|---|---|---|---|
| | **31 March 2017 £000** | 31 March 2016 £000 | **31 March 2017 £000** | 31 March 2016 £000 |
| Total cash balance | **35,963** | 23,912 | **33,196** | 21,798 |
| Cash at commercial banks and in hand | **3,205** | 2,163 | **438** | 49 |
| Cash with the Government Banking Service | **32,758** | 21,749 | **32,758** | 21,749 |
| Cash and cash equivalents as in SoFP | **35,963** | 23,912 | **33,196** | 21,798 |

## 17.2 Third party assets held by the NHS Foundation Trust

| **Group and Trust** | **31 March 2017 £000** | 31 March 2016 £000 |
|---|---|---|
| Patients' Monies | **6** | 7 |

## 18 Trade and other payables

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total** | Total | **Total** | Total |
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| ***Current*** | | | | |
| NHS payables - revenue | **6,615** | 8,235 | **6,615** | 8,226 |
| Amounts due to other related parties - revenue | **10,662** | 10,359 | **10,662** | 10,359 |
| Other trade payables - capital | **7,304** | 3,314 | **5,095** | 3,314 |
| Other trade payables - revenue | **22,302** | 22,557 | **21,795** | 21,245 |
| Social Security costs | **4,769** | 3,740 | **4,769** | 3,740 |
| Other taxes payable | **4,296** | 4,046 | **4,296** | 4,046 |
| Other payables | **5,313** | 5,176 | **5,308** | 5,172 |
| Accruals | **16,254** | 19,738 | **16,165** | 22,069 |
| NHS Charitable funds: Trade and other payables | **0** | 323 | **0** | 0 |
| **Total Current** | **77,515** | 77,488 | **74,705** | 78,171 |
| ***Non-current*** | | | | |
| Other trade payables - capital | **378** | 0 | **2,480** | 0 |
| Other payables | **405** | 405 | **405** | 405 |
| **Total Non Current** | **783** | 405 | **2,885** | 405 |
| **Total Trade and other payables** | **78,298** | 77,893 | **77,590** | 78,576 |

An amount of £5.706m (2015/16 £5.42m) relating to outstanding pension contributions is included within amounts due to other related parties; this liability was due in April 2017.

## 19 Borrowings

| | Group | | Trust | |
|---|---|---|---|---|
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| ***Current*** | | | | |
| Capital Loans from Department of Health | **4,922** | 4,925 | **4,922** | 4,925 |
| Other Loans | **127** | 121 | **127** | 121 |
| Obligations under finance leases | **5,078** | 4,146 | **5,078** | 4,146 |
| Obligations under Private Finance Initiative contracts | **352** | 333 | **352** | 333 |
| **Total Current** | **10,479** | 9,525 | **10,479** | 9,525 |
| ***Non-current*** | | | | |
| Capital Loans from Department of Health | **20,620** | 25,542 | **20,620** | 25,542 |
| Other Loans | **923** | 1,092 | **923** | 1,092 |
| Obligations under finance leases | **25,096** | 20,748 | **25,096** | 20,748 |
| Obligations under Private Finance Initiative contracts | **2,049** | 2,401 | **2,049** | 2,401 |
| **Total Non Current** | **48,688** | 49,783 | **48,688** | 49,783 |
| **Total Borrowings** | **59,167** | 59,308 | **59,167** | 59,308 |

The Foundation Trust has the following loans with the Department of Health:

| Original Advance Date | Original Loan | Current Balance outstanding | Interest Rate | Date of final repayment |
|---|---|---|---|---|
| | £000 | £000 | % | |
| November 2007 | 3,000 | 283 | 4.85% | March 2018 |
| March 2008 | 7,500 | 750 | 4.19% | March 2018 |
| September 2008 | 8,000 | 1,200 | 4.85% | Sept 2018 |
| September 2010 | 8,000 | 4,529 | 2.74% | Sept 2025 |
| October 2011 | 10,000 | 4,500 | 1.57% | Aug 2021 |
| September 2012 | 5,000 | 2,776 | 0.76% | March 2022 |
| June 2013 | 15,000 | 11,504 | 1.91% | June 2028 |
| Total balance outstanding | | 25,542 | | |

The Trust took out a loan of £1.29m with a commercial lender in 2015/16 at a rate of 4.42%; the current balance on this loan is £1.05m.

## 20 Other liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| ***Current*** | | | | |
| Deferred grants income | **2,612** | 2,602 | **2,612** | 2,602 |
| Deferred income - goods and services | **13,514** | 10,085 | **13,514** | 10,085 |
| **Total Current** | **16,126** | 12,687 | **16,126** | 12,687 |
| ***Non-current*** | | | | |
| Deferred income - goods and services | **11,078** | 7,123 | **11,078** | 7,123 |
| **Total Non-current** | **11,078** | 7,123 | **11,078** | 7,123 |
| **Total Other liabilities** | **27,204** | 19,810 | **27,204** | 19,810 |

## 21.1 Provisions for liabilities and charges

| | **Current** | Current | **Non-current** | Non-current |
|---|---|---|---|---|
| **Group and Trust** | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£'000** | £'000 | **£'000** | £'000 |
| Pensions- Early departure costs | **216** | 215 | **2,924** | 2,797 |
| Other legal claims | **382** | 255 | **0** | 0 |
| Restructurings | **0** | 537 | **0** | 0 |
| Other | **1,541** | 1,541 | **0** | 0 |
| **Total** | **2,139** | 2,548 | **2,924** | 2,797 |

Pensions - Early departure costs relates to future costs of early retirements where the Trust agreed in earlier years to fund the employee for full pension benefits; the "other" provision relates to a provision for a contractual payment relating to catering equipment costs; the restructuring provision related to a number of redundancies and other staff exit package costs.

## 21.2 Provisions for liabilities and charges analysis

| | **Pensions- Early departure costs** | **Other legal claims** | **Re-structurings** | **Other** | **Total** |
|---|---|---|---|---|---|
| **Group and Trust** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| **At 1 April 2016** | 3,012 | 255 | 537 | 1,541 | **5,345** |
| Change in the discount rate | 302 | 0 | 0 | 0 | **302** |
| Arising during the year | 49 | 289 | 0 | 0 | **338** |
| Utilised during the year - cash | (216) | (91) | (537) | 0 | **(844)** |
| Reversed unused | (45) | (71) | 0 | 0 | **(116)** |
| Unwinding of discount | 38 | 0 | 0 | 0 | **38** |
| **At 31 March 2017** | **3,140** | **382** | **0** | **1,541** | **5,063** |
| - not later than one year; | 216 | 382 | 0 | 1,541 | **2,139** |
| - later than one year and not later than five years; | 864 | 0 | 0 | 0 | **864** |
| - later than five years. | 2,060 | 0 | 0 | 0 | **2,060** |
| **Total** | **3,140** | **382** | **0** | **1,541** | **5,063** |

## 21.3 Clinical Negligence liabilities

| | **31 March 2017** | 31 March 2016 |
|---|---|---|
| **Group and Trust** | **£'000** | £'000 |
| Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of the Foundation Trust | **166,783** | 165,297 |

## 22 Contingent liabilities

| | **31 March 2017** | 31 March 2016 |
|---|---|---|
| **Group and Trust** | **£'000** | £'000 |
| Other | **47** | 55 |

This has been calculated by the NHSLA in respect of the Trust's contingent liabilities in respect of non-clinical claims.

## 23.1 Related Party transactions

University Hospital Southampton NHS Foundation Trust is a public benefit corporation authorised by Monitor (now part of NHS Improvement, the independent regulator for NHS Foundation Trusts).

During the year none of the board members or members of senior management or parties related to them has undertaken any material transactions with the Group.

The Department of Health is regarded as a related party. The Trust has had a significant number of transactions with the Department and with other entities for which the Department is regarded as the parent department.

The transactions relate mainly to the provision of healthcare services and the purchase of services in the ordinary course of business. The entities are:

| | **Year ended 31 March 2017** | | Year ended 31 March 2016 | |
|---|---|---|---|---|
| **Group** | **Income** | **Expenditure** | Income | Expenditure |
| | **£000** | **£000** | £000 | £000 |
| | **0** | **0** | 0 | 0 |
| Department of Health | **26,123** | **0** | 25,090 | 0 |
| Portsmouth Hospitals NHS Trust | **1,411** | **3,734** | 880 | 3,661 |
| NHS Litigation Authority | **0** | **10,376** | 0 | 9,154 |
| NHS Southampton CCG | **130,134** | **0** | 121,860 | 0 |
| NHS West Hampshire CCG | **126,284** | **0** | 114,675 | 0 |
| NHS England | **352,267** | **0** | 284,240 | 0 |
| Health Education England | **35,458** | **0** | 38,956 | 0 |
| Solent NHS Trust | **1,697** | **1,210** | 2,292 | 3,017 |
| Other NHS Bodies | **54,661** | **20,580** | 45,514 | 19,438 |
| | **728,035** | **35,900** | 633,507 | 35,270 |

In addition, the Group has had a number of material transactions with other Government departments and other central and local government bodies. These are as follows:

| | | | | |
|---|---|---|---|---|
| NHS Pension Scheme | **0** | **40,491** | 0 | 36,121 |
| National Insurance Fund | **0** | **34,670** | 0 | 26,011 |
| NHS Blood and Transplant | **0** | **6,779** | 0 | 6,077 |
| NHS Professionals | **0** | **19,297** | 0 | 11,206 |
| University of Southampton | **6,408** | **9,499** | 5,799 | 8,927 |
| Other government bodies | **2,181** | **1,744** | 1,455 | 3,594 |
| | **8,589** | **112,480** | 7,254 | 91,936 |
| **Total value of transactions with related parties** | **736,624** | **148,380** | 640,761 | 127,206 |

The Group comprises the Trust, UHS Pharmacy Ltd, UHS Estates Ltd and Southampton Hospital Charity. The Trust has £364k (£364k at 31st March 2016) receivables with Southampton Hospital Charity. It has share capital of £841k (£841k at 31st March 2016), receivables of £20k (£16k at 31st March 2016) and payables of £0k (£1.38m at 31st March 2016) with UHS Pharmacy Ltd, and share capital of £2,599k (£50k at 31st March 2016), and receivables and payables of £353K (£1.125m at 31st March 2016) with UHS Estates Ltd. Transactions with related parties are on a normal commercial basis. UHS Pharmacy Ltd made donations to Southampton Hospital Charity of £310k in 2016/17, a sum equivalent to its estimated profit for the year (2015/16: £332k).

## 23.2 Related Party balances

| Group | At 31 March 2017 Receivables £000 | Payables £000 | At 31 March 2016 Receivables £000 | Payables £000 |
|---|---|---|---|---|
| Department of Health | **320** | **0** | 313 | 0 |
| Other NHS Bodies | **31,826** | **8,455** | 27,041 | 10,120 |
| Other government bodies | **4,462** | **19,727** | 3,312 | 18,145 |
| **Total balances with related parties at 31 March** | **36,608** | **28,182** | 30,666 | 28,265 |

## 23.3 Related Parties- Commercial Estate Development Partner

The Trust's joint venture referred to in Page 5 of the accounts is jointly controlled by the Trust and Partnering Solutions (Southampton) Ltd. The latter is a wholly owned subsidiary of Interserve Prime Solutions Ltd which in turn is a joint venture entity under the common control of the groups headed by Interserve PLC and Prime (GB) Holdings Ltd. The Trust received £222k in 2016/17 and was charged £14k from its joint venture for services rendered. The Trust accounted for £1.954m of expenditure on capital projects undertaken by Interserve in 2016/17.

## 24 Capital Commitments

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total 31 March 2017** | Total 31 March 2016 | **Total 31 March 2017** | Total 31 March 2016 |
| **Group and Trust** | **£000** | £000 | **£000** | £000 |
| Property, Plant and Equipment | **15,547** | 15,434 | **15,403** | 15,434 |
| Intangible assets | **55** | 104 | **55** | 104 |
| Imaging Infrastructure Support Service | **26,374** | 33,830 | **26,374** | 33,830 |
| **Total** | **41,976** | 49,368 | **41,832** | 49,368 |

The Imaging Infrastructure Support Service commitment relates to the purchase of new radiology equipment over the remaining 9 years of the contract.

## 25 Finance Lease obligations

| | **Total 31 March 2017** | Total 31 March 2016 |
|---|---|---|
| **Group and Trust** | **£000** | £000 |
| Gross buildings lease liabilities | **6,368** | 7,397 |
| of which liabilities are due: | **0** | 0 |
| - not later than one year; | **1,029** | 1,029 |
| - later than one year and not later than five years; | **3,211** | 3,557 |
| - later than five years. | **2,128** | 2,811 |
| Finance charges allocated to future periods | **(1,463)** | (1,859) |
| Net buildings lease liabilities | **4,905** | 5,538 |
| - not later than one year; | **684** | 633 |
| - later than one year and not later than five years; | **2,315** | 2,473 |
| - later than five years. | **1,906** | 2,432 |
| Gross plant and machinery lease liabilities | **30,277** | 23,287 |
| - not later than one year; | **5,693** | 4,649 |
| - later than one year and not later than five years; | **18,679** | 14,606 |
| - later than five years. | **5,905** | 4,032 |
| Finance charges allocated to future periods | **(5,008)** | (3,931) |
| Net plant and machinery lease liabilities | **25,269** | 19,356 |
| - not later than one year; | **4,394** | 3,513 |
| - later than one year and not later than five years; | **15,433** | 12,134 |
| - later than five years. | **5,442** | 3,709 |

## 26.1 On-SOFP PFI obligations

| | **Total 31 March 2017** | Total 31 March 2016 |
|---|---|---|
| **Group and Trust** | **£000** | £000 |
| Gross PFI liabilities | **2,752** | 3,210 |
| of which liabilities are due | | |
| - not later than one year; | **459** | 459 |
| - later than one year and not later than five years; | **1,834** | 1,834 |
| - later than five years. | **459** | 917 |
| Finance charges allocated to future periods | **(351)** | (476) |
| **Net PFI obligation** | **2,401** | 2,734 |
| - not later than one year; | **352** | 333 |
| - later than one year and not later than five years; | **1,601** | 1,524 |
| - later than five years. | **448** | 877 |
| | **2,401** | 2,734 |

## 26.2 On-SOFP PFI commitments

| Group and Trust | Total 31 March 2017 £000 | Total 31 March 2016 £000 |
|---|---|---|
| Commitments in respect of the service element of the PFI | | |
| Within one year | **1,526** | 1,513 |
| 2nd to 5th years (inclusive) | **6,105** | 6,052 |
| Later than five years | **1,526** | 3,026 |
| Total | **9,157** | 10,591 |

The Trust's PFI Commitment relates to the Energy Supply Agreement with Veolia PLC (principally for steam heat and management of emergency generators).

## 26.3 Analysis of amounts payable to service concession operators

| | Total for 31 March 2017 | Total for 31 March 2016 |
|---|---|---|
| | **1,527** | 1,513 |
| Unitary payment payable to service concession operator | | |
| Consisting of: | | |
| - Interest charge | **126** | 145 |
| - Repayment of finance lease liability | **333** | 314 |
| - Service element | **1,068** | 1,054 |

## 27 Imaging Infrastructure Support Service commitments

The total commitment with regard to the Imaging Infrastructure Support Service entered into in 2012/13 is as follows:

| | 31 March 2017 | | | 31 March 2016 | | |
|---|---|---|---|---|---|---|
| | Service and maintenance £000 | Finance lease interest and repayments £000 | Total £000 | Service and maintenance £000 | Finance lease interest and repayments £000 | Total £000 |
| - not later than one year; | **3,210** | **4,791** | **8,001** | 3,200 | 4,827 | 8,027 |
| - later than one year and not later than five years; | **12,840** | **19,164** | **32,004** | 12,800 | 19,308 | 32,108 |
| - later than five years. | **11,235** | **16,769** | **28,004** | 14,400 | 21,722 | 36,122 |
| Total | **27,285** | **40,724** | **68,009** | 30,400 | 45,857 | 76,257 |

## 28 Post balance sheet events

There have been no significant post balance sheet events requiring disclosure.

## 29 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to review by the Trust's internal auditors.

### Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. It has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

### Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 5-15 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. Interest charged on finance leased assets is at fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

### Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has relatively low inherent exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the Trade and other receivables note.

### Liquidity risk

The Trust's operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds together with funds obtained from external government borrowing when necessary, along with commercial sources through its finance lease and PFI arrangements.

## 29.1 Financial assets by category

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total** | Total | **Total** | Total |
| | **31 March 2017** | 31 March 2016 (Restated) | **31 March 2017** | 31 March 2016 |
| | **Loans & Receivables** | Loans & Receivables | **Loans & Receivables** | Loans & Receivables |
| | **£000** | £000 | **£000** | £000 |
| Trade and other receivables excluding non financial assets | **47,491** | 40,413 | **92,957** | 41,539 |
| Cash and cash equivalents at bank and in hand | **35,963** | 23,912 | **68,508** | 21,798 |
| NHS Charitable funds: financial assets | **3,052** | 2,737 | **0** | 0 |
| **Total** | **86,506** | 67,062 | **161,465** | 63,337 |

## 29.2 Financial liabilities by category

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total** | Total | **Total** | Total |
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **Other Financial Liabilities** | Other Financial Liabilities | **Other Financial Liabilities** | Other Financial Liabilities |
| | **£000** | £000 | **£000** | £000 |
| Borrowings excluding Finance lease and PFI liabilities | **26,592** | 31,680 | **26,592** | 31,680 |
| Obligations under finance leases | **30,174** | 24,894 | **30,174** | 24,894 |
| Obligations under Private Finance Initiative contracts | **2,401** | 2,734 | **2,401** | 2,734 |
| Trade and other payables excluding non financial assets | **69,233** | 69,784 | **138,278** | 70,790 |
| NHS charitable funds: financial iabilitiests | **0** | 323 | **0** | 0 |
| **Total** | **128,400** | 129,415 | **197,445** | 130,098 |

## 29.3 Fair values of financial assets at 31 March 2017

| | Group | | Trust | |
|---|---|---|---|---|
| | **Book Value** | **Fair value** | **Book Value** | **Fair value** |
| | **£000** | **£000** | **£000** | **£000** |
| NHS Charitable funds: non-current financial assets | **3,052** | **3,052** | **0** | **0** |
| **Total** | **3,052** | 3,052 | **0** | 0 |

## 29.4 Fair values of financial liabilities at 31 March 2017

| | Group | | Trust | |
|---|---|---|---|---|
| | Book Value | Fair value | Book Value | Fair value |
| | £000 | £000 | £000 | £000 |
| Loans | **21,543** | **21,543** | **21,543** | **21,543** |
| Other | **27,145** | **27,145** | **27,145** | **27,145** |
| **Total** | **48,688** | **48,688** | **48,688** | **48,688** |

## 29.5 Maturity of Financial liabilities

| | Group | | Trust | |
|---|---|---|---|---|
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000** | £000 | **£000** | £000 |
| In one year or less | **79,712** | 87,015 | **148,757** | 87,698 |
| In more than one year but not more than two years | **9,239** | 9,540 | **9,239** | 9,540 |
| In more than two years but not more than five years | **23,126** | 21,907 | **23,126** | 21,907 |
| In more than five years | **16,323** | 10,953 | **16,323** | 10,953 |
| Total | **128,400** | 129,415 | **197,445** | 130,098 |

## 30 Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £1m.

# QUALITY ACCOUNT AND QUALITY REPORT 2016/17

# CONTENTS

# Chief executive's welcome

**Our mission is to be better every day and to work with our partners at the leading edge of healthcare for the benefit of patients. The highest quality patient care remains our top priority and this is reflected in our core values of patient's first, working together and always improving, as well as in our annual objectives. We could not do this without our staff and we are proud that in 2016 University Hospital Southampton NHS Foundation Trust (UHS) was rated one of the top performing organisations in the country for staff engagement.**

The Trust was also rated among the top ten in the country for staff being happy with the standard of care provided (82% against a national average of 70%) and the top 20% for staff recommending the Trust as a place to work or receive treatment (4.03 against a national average of 3.76), staff who feel they are able to contribute towards improvements at work (76% against 70%) and good communication between senior management and staff (43% against 33%).

As well as this, the Trust ranked among the top 20% for staff agreeing their role makes a difference to patients (92% against 90%) and organisation and management interest in and action on health and wellbeing (3.79 against 3.61), as well as staff being satisfied with opportunities for flexible working (57% against 51%), satisfaction with resourcing and support (3.40 against 3.33) and recognition and value of staff by managers and the organisation (3.62 against 3.45).

UHS was among the lowest (best) 20% of trusts for the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (23% against 27%).

Like every NHS hospital in the country, we don't have as many permanent clinical staff as we would like, so it's been a pleasure to recently welcome the new deanery junior doctors, the new group of UHS Fellows, overseas recruited staff, our newly qualified nurses and our first group of Foundation Degree Higher Apprentices. We very much hope that all our new colleagues enjoy working here and that they choose to stay or come back. It's vital that we continue to recruit and retain the right staff with the right values from Southampton, the UK, and from all over the world.

Nationally and internationally, the political situation continues to be more unstable and unpredictable than I have ever experienced. Our biggest concern is the impact on staff from overseas. UHS are doing everything that we can, both directly and through groups such as NHS Providers and the Cavendish Coalition (a national body focussing on the impact of Brexit on employment), to lobby the government about the importance of providing certainty to EU colleagues working in the NHS, and the need for a sensible migration policy that enables people from around the world to continue to enter the UK and enrich our health and social care.

2016/17 has been a challenging but rewarding year and we are proud of our achievements. This quality account looks back at some of those achievements and establishes our priorities for 2017/18.

We have shown significant improvements in many areas of patient care such as end of life care safe and timely discharge and responding to and learning from complaints and incidents.

We have also been able to invest in improved facilities for both patients and research. Building work started on the new radiotherapy bunker, and the new Cancer Immunology Centre. The ongoing investment into diagnostics, in particularly radiology but also more specific schemes such as hysteroscopy, should help patients across the hospital.

We have been successful in renewing our research funding, through both our Biomedical Research Centre (BRC) and Clinical Research Facility. There was tough competition for this funding as we were competing against every other academic medical centre in the country, and the rules were clear that only world-class research would be funded. We are proud of the Southampton research team and the knowledge that Southampton research, for instance into childhood obesity, osteoporosis and COPD, will continue to help

patients receive better care across the world. Our extensive participation in research has a positive impact on patient outcome.

We also recently received national recognition as a 'global digital exemplar'; an award which we anticipate will bring an additional £10 million of national money. This will not only be through some large-scale informatics projects, but importantly improving the day-to-day IT equipment staff have available.

Children's services are very important to us and thanks to a combination of NHS funds and very generous donations, we have been able to refurbish and expand Piam Brown (our paediatric cancer ward) and are currently expanding the Paediatric Intensive Care Unit. We have also been raising funds and sponsorship for the new children's emergency department which has been match-funded by the Treasury. Both these developments move us a step closer to the creation of our children's hospital.

The new main entrance has also been completed without NHS money. The Trust is acutely aware that car parking and transport to the hospital is undoubtedly a major concern for both patients and visitors and impacts upon our patients' experience. We have made efforts to reduce the difficulties and have long-term plans to further reduce the problem. This year we have seen good progress on the new multi-storey car park which will be six storeys high with a tiered design to set it back from surrounding properties, and will provide up to 778 spaces.

2016/17 has seen us in financial surplus. This means we can continue to invest in capital investment, such as buildings and equipment. Our current financial position is also enabling us to plan continued investment in our estate, particularly for the most vulnerable patients, for instance expansion and refurbishment of high dependency and intensive care facilities for patients of all ages, and theatre and interventional radiology rooms. This means that we will continue to have the facilities to look after the sickest patients in Hampshire and beyond.

Our financial position is a result of countless acts of imagination, commitment and innovation across the trust all of which has improved our efficiency and allowed us to treat more patients, with less waste and more added value.

I am proud of our achievements and the commitment and dedication of our staff who strive continuously to provide high quality, cost effective and compassionate care. I am constantly left inspired by staff across all areas of work within this Trust, with outstanding displays of commitment, dedication and desire to provide the best possible service even at the most difficult times.

We have also done well in our 2016 in-patient survey which has highlighted many positive aspects of the patient experience. Overall 84% rated our care seven plus out of ten, 83% felt they were treated with respect and dignity and 84 % always had confidence and trust in doctors. 97% of our patients rated our environment very/fairly clean and 91% felt they always had enough privacy when being examined or treated.

Most patients are highly appreciative of the care they receive but there is room for us to improve the patient experience, with particular focus on the patient's experience of discharge and their nutritional and hydration needs.

This report holds our organisation to account for the quality of healthcare services we deliver. We believe it is crucial for the future development of the hospital to be fully transparent and accountable; acknowledging and celebrating our achievements, as well as being open about the areas requiring improvement.

We have shared and developed this report in conjunction with our staff, patients, carers and external stakeholders. To the best of my knowledge and belief the information in this document is accurate.

**Fiona Dalton,**
**Chief executive**
23 May 2017

# Our approach to quality assurance

Always improving is embedded at UHS as one of the values in our 'forward vision' along with patients first and working together. These are the Trust's underpinning values and delivering on them in relation to quality is the responsibility of the Trust Board. The named executive leads for quality are the medical director and the director of nursing and organisational development.

Quality improvement is just one element of a coordinated and Trust-wide approach to quality. In previous years these priorities have been outlined in our patient improvement framework (PIF) with priorities set against outcomes, safety, experience and performance. This year we have listened to feedback from our staff and changed our approach to focus on fewer key priorities in each domain. We recognise that the quality improvement framework should focus on priorities not already led and measured in other key operational strategies and that this will strengthen our message to staff about what the priorities are. The PIF can be found in appendix one.

Our quality improvement framework is underpinned by strategies on safety, experience and engagement, clinical effectiveness and clinical quality and these set out our longer term aims.

To embed quality and provide assurance at ward and department level the Trust has introduced a Clinical Accreditation Scheme (CAS); a process where wards and departments are required to demonstrate adherence to standards of care to become accredited. The wards gain this accreditation by submitting information on key quality performance indicators and patient complaints and compliments to a senior clinical panel. Patient representatives also undertake unannounced visits to the ward or department. Successes are celebrated and areas for improvement are agreed where necessary.

The Trust also conducts Clinical Quality Reviews (CQRs) of nominated services in each division based on the Care Quality Commission (CQC) inspections and identified key lines of enquiry. The objective of the CQR is to provide an internal assurance process which is proportionate, risk based, professionally informed and linked to what matters to patients and staff. This information is also triangulated with feedback around areas of good practice from the division, direct observation during the review and other information collected during the CQR which provides evidence for the overall judgement framework. A formal report and action plan is generated following the review.

The Trust also monitors ward standards through the clinical quality dashboard which focuses performance against key metrics including patient safety, effectiveness, patient experience and outcomes from matron peer walkabouts.

# Our commitment to safety

**Healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm can still happen. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere. We will:**

### Put safety first

Commit to reduce avoidable harm in the NHS by at least half and make public our goals and plans developed locally.

In 2015 the Trust agreed a new ambitious strategy to reduce avoidable harm to all patients within our care and go further and faster to support all clinicians to provide a high level of safe care consistently to all our patients. We fully aligned our strategy to NHS England's 'Sign up to Safety' campaign and, to demonstrate our commitment, we have made public our five key pledges.

### Continually learn

Make our organisation more resilient to risks by acting on the feedback from patients and constantly measuring and monitoring how safe our services are.

As a Trust it is important that we learn and make appropriate changes when things go wrong, and so we take reported incidents very seriously. Using a well-received e-reporting system for incidents (including near misses) facilitates real time reporting and escalation in order that appropriate action is taken. It has also improved the reporting of themes down to ward level and feedback to those who have reported the incident, and allowed meaningful thematic analysis at all levels.

In the national learning reporting system, we benchmark as a top reporting Trust as a result of the higher number of incidents reported per 100 admissions, the timeliness of reporting, and the lower numbers of incidents graded as high and moderate harm.

We focus on a culture which allows staff to 'speak up, speak out' about practice which compromises patient safety as part of the Trust raising concerns (or whistle blowing) helpline. Our staff survey shows that our staff considers UHS as above average in:

- Organisation treats staff involved in errors fairly - 65% against a national average for acute trusts of 54%
- Organisation encourages the reporting of errors - 90% against a national average for acute trusts of 87%
- Organisation takes action to ensure errors are not repeated - 75% against a national average for acute trusts of 69%
- Staff given feedback about changes made in response to errors - 64% against a national average for acute trusts of 55%
- Staff know how to report unsafe clinical practice - 96% against a national average for acute trusts of 95%
- Staff would feel secure raising concerns about unsafe clinical practice - 76% against a national average for acute trusts of 69%
- Staff would feel confident that the organisation would address concerns about unsafe clinical practice - 66% against a national average for acute trusts of 57%

The national safety thermometer is a prevalence audit tool that allows teams to measure harm and the proportion of patients that are harm free from four of the most common and preventable causes (pressure ulcers, patient falls, blood clots and urinary infections due to catheters). The audit is undertaken by our staff on a monthly basis and submitted to a national database for benchmarking.

We have consistently achieved over 95% for no new harms/new harm free care with over 1,100 patients audited each month.

## Be honest and transparent

Honesty and transparency with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

The duty of candour is important legislation that requires us to be open with patients and to investigate and share the findings when things have gone wrong (in cases where the harm is moderate or greater). We involve patients and their families at each stage of our investigation into patient safety incidents and complaints. We contact them at the start of the process to make sure that their concerns are heard and this helps structure the investigation. We keep them updated on progress and share our findings with them at the end of the investigation. We do this in a variety of ways to suit the needs of the patient or family. This builds on our current policy of being open. We acknowledge we can still improve in this area:

**Table 1: Inpatient survey results January 2016**

| **Care and Treatment** | | lower scores are better |
|---|---|---|
| | **Trust** | **Average** |
| Care: wanted to be more involved in decisions | 44% | **44 %** |
| Care :could not always find staff member to discuss concerns with | 60% | **62%** |
| Care not always enough privacy when discussing condition or treatment | 25% | **24%** |

NB: CQC patient survey not published at time of writing

We have worked hard to ensure that our staff are aware of their obligations under the duty of candour, and have provided education and support to enable them to do this.

We provide training to staff of all levels both as part of their induction, education days and through rolling local programmes and cascade training.

Our 'Being Open Policy – a Duty to be Candid' outlines the steps that staff should take and the internal website provides resources and advice. We have a leaflet to explain how we investigate and learn from incidents which includes how we will be open, involve them and keep them updated. Every patient or their family are contacted by letter following a moderate high harm incident and are invited to ask any questions they would like to be answered as part of the investigation. We will also meet with patients and their families if this is their wish. We carry out regular monitoring through the relevant fields on our risk management system Ulysses to monitor compliance.

## Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

UHS are working in collaboration across Hampshire to improve rapid assessment and treatment of sepsis and acute kidney injury (AKI) and improving standards of care and outcomes for patients undergoing emergency laparotomy, sharing our approach and learning across the Wessex Academic Health Science Network (WAHSN). UHS is a key member of the WAHSN Patient Safety collaborative and staff participate in shared learning activities within this collaborative.

## Support

Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate their progress.

In a large organisation such as the NHS things will sometimes go wrong and this will have an impact on all those involved. UHS recognises the importance of ensuring that, where needed, the appropriate support for staff is available in an effective, efficient and timely way. We provide a range of support process for Trust staff involved in an incident, complaint or claim. Individuals have the opportunity to share their experiences and provide feedback regarding the support they have received.

Every year UHS holds a safety conference attended by over 100 delegates from our staff and partners. This is an opportunity to celebrate our successes and share our challenges. Feedback from our staff included:

''I attended the safety study day last week what a fantastic day inspiring speakers, great organisation, one of the best days I have attended in a long time, a credit to our Trust''

''Excellent range of speakers, all very interesting and informative. Good to use individual cases for examples, very impressed with the patient's own story of surviving sepsis, very powerful messages. Glad she is using her experience to help others''

This was also demonstrated via the safety pledges each delegate was asked to write following the conference some of which are shown below:

''To create and publish a safety magazine/newsletter for theatres to educate staff on all matters of safety and safe practice''.

''To ensure that I have the courage to speak up when I have something to contribute to a situation and not assume that the leader has considered all risk factors''.

''My pledge is to ensure my patients remain informed and involved in their care so they feel safe in my care''.

All pledges are emailed to delegates to offer support in implementing them and to follow up on their progress.

# Our commitment to staff

The NHS staff survey results predominantly aim to inform us about staff experience and well-being. Nationally, the survey results provide an important measure of performance against the pledges set out in the NHS constitution. The constitution outlines the principles and values of the NHS in England, setting out a number of pledges that define what staff should expect from NHS employers.

In 2016 our top five results were:

1. KF7. Percentage of staff able to contribute towards improvements at work - 76% against a national average for acute trusts of 70%

2. KF6. Percentage of staff reporting good communication between senior management and staff - 43% against a national average for acute trusts of 33%

3. KF31. Staff confidence and security in reporting unsafe clinical practice - 3.81 against a national average for acute trusts of 3.65

4. KF5. Recognition and value of staff by managers and the organisation - 3.62 against a national average for acute trusts of 3.45

5. KF15. Percentage of staff satisfied with the opportunities for flexible working - 57% against a national average for acute trusts of 51%

We also continued to perform above average for KF21. Percentage believing that Trust provides equal opportunities for career progression or promotion - 88% against a national average for acute trusts of 87%.

**Table 2 KF 21 percentage believing that Trust provides equal opportunities for career progression or promotion 2016 breakdown:**

| **KF21 - Percentage of staff believing that UHS provides equal opportunities for career progression / promotion** | |
|---|---|
| UHS 2015 | 88% |
| UHS 2016 | 88% |
| National average 2016 | 87% |
| | |
| **Breakdown of 2016 results** | |
| White | 89% |
| BME | 78% |
| | |
| Disabled | 81% |
| Not Disabled | 89% |
| | |
| Full time staff | 88% |
| Part time staff | 88% |
| | |
| Age 16-30 years | 90% |
| Age 31-40 years | 86% |
| Age 41-50 years | 88% |
| Age 51+ years | 87% |
| | |
| Men | 86% |
| Women | 89% |

In 2016 our performance for KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was unchanged from 2015 - 43% against a national average for acute trusts of 45%.

To further improve supporting our staff in 2017 UHS are developing a framework of core behaviours to support each of our values and our wider quality strategy and organisational development. The behavioural framework 'living our values' will be used in recruitment, appraisal, performance management and talent management.

Our consultation for this included multidisciplinary focus groups which were held between September and November 2016 and were run by trained internal facilitators. There were lunch-time sessions which were led by the chief executive and director of nursing and one-to-one staff interviews with senior executives (Talent Works) and other staff at our Fab Change Day. There was also online input from Survey Monkey. Approximately 300 staff have been involved in the process so far.

In collaboration with our black and minority ethnic (BME) network, we have developed a workforce race, equality and action (RACE) place against the workforce race quality standard to address inequalities for our BME staff.

Our focus makes explicit behaviours expected in three areas – always improving, patients first, and working together:

- Working with colleagues to agree a shared view of what good looks like and what we need to achieve.
- Joining things together across professional and organisational boundaries to make them easier, better and safer for patients and staff.
- Taking a genuine interest in our colleagues and patients as people.
- Sticking to our word and doing what we say we will do.
- Finding creative ways to bring people together in order to build long-term relationships based on trust and respect.
- Offering constructive feedback to colleagues with intent to help them improve.
- Valuing each other as the most precious resource in UHS.
- Being there for each other during the low points as well as the high.
- Supporting colleagues to develop their potential and enabling everyone to be part of shaping our services.
- Listening to each other and responding to the needs of others.
- Recognising and celebrating the achievements of others.
- Appreciating our diversity and making the most of the difference between us.
- Being proud to be part of UHS and of making a difference for patients.

Over the next 12 months we will continue to promote the NHS Staff Survey and encourage staff to participate. Any issues or concerns identified will be reported to the Board and a suitable action plan developed and implemented. We will use the feedback from the survey to support staff to improve the services we deliver and will share our findings so that we can learn from our mistakes

# Our commitment to education and training

Training health professionals in quality improvement has the potential to impact positively on attitudes, knowledge and behaviours. The healthcare workforce needs to be adequately prepared to ensure it continually understands and measures quality of care in terms of structure, process, and outcomes. To deliver quality care, health professionals must be able to be clear about what they are trying to accomplish, how they will know that a change has led to improvement, and what change they can make that will result in an improvement.

We promote educational experiences whereby health professionals define best practices by reviewing currently available information and literature, compare these with current practice to identify gaps in performance, develop policies, procedures and standards to organise care around the best practices which are intelligently implemented, and then continually monitor them.

We already have significant quality improvement activity in education at UHS, including a training programme to develop professional quality improvement skills across the organisation, and a formal four day training programme in quality improvement techniques.

We also support learner reviews as part of the quality assurance process for learning in clinical areas, and three scientific training programme candidates have completed their training and been retained by the organisation in paediatric cardiology, radiation protection and radiotherapy physics and pharmacy. Good quality training for these candidates is important to us. It ensures that we get the best workforce for the future, highly skilled and prepared for professional practice and demonstrating the correct values and behaviours. It gives the trainee an effective and stimulating training experience and promotes quality at UHS by providing an opportunity to reflect on best practice, and pass on invaluable knowledge, experience and insight. The most important beneficiaries are patients, for whom high quality science is the bedrock of improved care.

Leadership development and human factors are now an integral part of patient safety's scrutiny of avoidable harm incidents and near misses. Delivering human factors education is part of both our leadership development, simulation and clinical skills programmes, ensuring that staff involved in investigation of incidents focus on not just how it happened but, importantly, on how can we prevent it from happening again. These questions are shared within teams so that all who deliver healthcare can learn and change to be safer and better.

We are also fully engaged in apprenticeships and public sector targets for apprenticeships. Our skills for practice leads are participating in national and regional apprenticeship working groups, and post graduate medical training has seen a year on year improvement in ratings via the GMC survey with 2016 seeing 32 areas of statistically significant positive outliers (compared to 13 the year before) and a fall from 41 to 24 of outliers. Scoring especially well were paediatric surgery, respiratory medicine, medical oncology, obstetrics and gynaecology post graduate foundation year doctors in their first year of training (FY1).

Training provides staff with a range of recognised tools and techniques they can apply in appropriate context. In our recent staff survey the Trust has scored in the upper quartile for staff reporting engagement in change and improvement.

# Our commitment to technology to support quality

The global digital exemplar (GDE) programme will run over three years and provide an additional £10m of funding alongside our existing planned investment to fast track the UHS digital strategy. A key aim of the GDE programme is to use digital innovation to deliver significant benefits in quality. The programme will do this in three different ways.

Firstly we will quantify the quality benefits from the projects that are planned as part of the GDE programme. This will include identifying  baseline metrics and then measure them after implementation to validate quality improvements.

Secondly through our GDE communications strategy we will engage with staff, patients and other key stakeholders to identify areas where digital solutions can bring improvements to care and how we work.

Thirdly we will undertake a review of the 2017/18 priorities identified in the quality accounts and identify where planned digital projects and solutions may enhance or help deliver actions and improvement.

# Our commitment to the Care Quality Commission

Our last CQC ratings were recorded in December 2014. Overall, we were rated as 'requires improvement'. We were rated 'good' for caring, effective and well-led services, but 'requires improvement' for providing safe and responsive care.

Our A&E, medical care, maternity and gynaecology, and children and young people's services were rated as 'good' and surgery, critical care, end of life care, and outpatient and diagnostic services, as 'requires improvement'. Countess Mountbatten House was rated as 'good'.

Following the inspection report in 2014 we set up a multidisciplinary group to develop, implement and monitor the action plan against the CQC recommendations. There has been excellent engagement at every level of the organisation and collaborative working with partner organisations to share progress. We publish our progress both internally via our staff intranet and externally on our public website.

In order to reduce delayed discharges we have taken on operational leadership for all teams within the integrated discharge bureau and have agreed new improved processes, we have also invested in new discharge roles and processes to support wards, as well as focusing on simple discharges via our 'Home for Lunch' initiative to increase the proportion of patients discharged by midday.

To improve our estate, particularly our general intensive care unit (GICU), we have installed an Uninterruptable Power Supply (UPS), ensured hoists are repositioned and appropriately maintained within the area and agreed a business case to design and build a new GICU which will improve the experience and care for patients and their relatives.

A comprehensive recruitment plan was put in place to continue to reduce nursing vacancies
We have used recruitment days, return to practice and increased undergraduate commissioning and placement, and overseas cohorts to improve recruitment. We have an established daily Trust-wide review of staffing levels and skill mix chaired by the senior nursing team using safe care electronic solutions and we continue to reduce dependency on agency staff.

The Care Quality Commission (CQC) has since carried out an inspection of our services in January 2017. They inspected the following services: surgery, end of life care, critical care, outpatients and diagnostic imaging. Overall they rated the Trust as 'well-led'.

We have not received any formal feedback from the CQC as yet; however the informal feedback provided was that our staff are "amazing" and that they saw a drive for improvement in every area, and from every team that they met. We believe that the CQC will have seen an organisation which is working hard to provide the best possible care for patients, where we try to always support each other and where we are ambitious to improve. We are sure that they will have witnessed a culture of teamwork and patient-focused care.

# Progress against 2016/17 priorities

**This section outlines how we have performed against the delivery of our 2016/17 quality priorities. Action plans and measures were developed for each of the priorities last year, and performance has been monitored throughout the year by clinical teams and UHS committees.**

Each priority relates to one of the three core areas of quality:

**Patient experience**: meeting our patients' emotional as well as physical needs.

**Patient safety**: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.

**Clinical effectiveness**: providing high quality care, with world-class outcomes, whilst being efficient and cost effective.

## Patient experience

### Priority one: End of Life Care

Our aims for 2016/17 were:

1. Education and training programme: delivering sessions on each of the five priorities for care, honest conversation skills and advance care planning.

2. Continued participation in, and inform of, the national work stream around the Emergency Care and Treatment Plan, working alongside Wessex Collaboration for Leadership in Applied Health Research and Care (CLAHRC) into the use of Treatment Escalation Plans (TEP).

3. Develop an End of Life Care competency framework based on the new recommendations set out within the latest NICE Clinical Guideline 31 (2015) ensuring that staff caring for the dying, within the acute hospital, are supported in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.

4. Development of information for relatives and carers who are supporting an individual whose wish it is to die at home; providing information on who to contact and who will be there for support in their bereavement.

5. Audit the use of the individualised end of life care plan and use the results to inform continuing improvement in the care of the dying.

Our achievements for 2016/17 were:

1. Education and training on the five priorities for care within our Trust is incorporated into other existing programmes of teaching rather than stand-alone sessions. This recognises the difficulty of releasing clinical staff for non-mandated training. The key components of End of Life Care (Recognition, Communication, Involvement, Support Plan and Do) are broken down to ensure that each of these priorities are explored and explained. This is delivered in Trust induction, at ward level and within other formal development programmes such as health care assistant (HCA) training and overseas nurses' sessions. All FY1 and FY2 (post graduate foundation year doctor in their second year of training) doctors receive two sessions of teaching, one primarily about pharmacological and non-pharmacological symptom control and another about care of the dying patient including talking about bad news and the use of the Individualised End of Life Care Plan. Sage and Thyme, a level one communication skills training, continues to be delivered and is now accessed via the Virtual Learning Environment (VLE). Advanced communication skills training will be run internally at UHS from March 2017 and will be free for suitable multi-disciplinary clinical staff.

2. The Trust remains engaged with the Treatment Escalation Plan (TEP) agenda and we continue to participate in and inform the national work stream together with the research conducted by the Wessex CLAHRC. The national launch of the ReSPECT initiative was on the 27 February 2017. The Trust will critically analyse this initiative with the potential to explore a unified Wessex adoption approach with partner organisations and establish the most effective implementation, communication, and training approach. Use of our local UHS Treatment Escalation Plan remains an option alongside the unified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form if widespread use across Wessex is unachievable.

3. The development of an End of Life Care competency framework has been superseded by the national End of Life Care Core Skills Education and Training Framework currently under consultation, which, when ratified, will form the basis of future training and education delivery within the Trust. The national framework is based on a tiered approach ensuring that each staff group receive the appropriate level of training and education in End of Life Care. Local competency documents for clinical band five nurses have been adapted to include awareness of key national initiatives and policy documents [One Chance to Get it Right (2014), Ambitions in Palliative and End of Life Care; A national framework for local action 2015 – 2020, Every Moment Counts (2015), What's Important to me: A Review of Choice in End of Life Care (2015)] together with the UHS document the Individualised End of Life Care Plan for the last days or hours of life. This approach has supported staff in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.

4. Within the acute hospital, the hospital palliative care team provide a patient and carers leaflet with contact details and information about our service. Patients referred to the Countess Mountbatten House community services are given a comprehensive information leaflet detailing the services available. Those patients who do not live within the Countess Mountbatten House catchment area receive information relevant directly from their local community palliative care providers. Families of those patients who pass away while at UHS, are given written information directly by our bereavement team and signposted as needed to bereavement services.

5. The Trust participated in the 2015 National Care of the Dying Audit which was hosted by the Royal College of Physicians. The results, which were disseminated in reports in March 2016, showed:

   - The Trust's usage of syringe drivers at the end of life was in line with the national average at 24%.
   - For symptom management including agitation, pain, dyspnoea, noisy breathing and other symptoms UHS is closely in line with national symptom management, scoring above average by 2-3% in all areas except the management of pain for which the national average is 57% and UHS scored 55%.
   - UHS performed well in the provision of a holistic assessment in the last 24 hours of life at 76% compared to the national average of 66%.
   - For patients who died in hospital there were consistently high levels of documented evidence that within the last episode of care staff had recognised that the patient would probably die in the coming hours or days. However for a significant proportion of patients this recognition was not made in a timely manner. Nationally this was 87%. When sudden or unexpected death was taken into account, UHS was recognising 90% of patients that would die in the coming hours or days in a timely manner.
   - The Choice in End of Life Care Programme review found people identified the importance of thinking and planning for the end of life early, while people are still able to consider and express their wishes, but highlighted the difficulties of initiating these sensitive conversations. The difficulty of these conversions is reflected in the low numbers nationally at 20%. UHS's data showed this happened in 29% of cases reported, and this increased to 33% if adjusted for sudden and unexpected deaths. Based on the national data, it would appear that having the conversation with a relative or nominated person is far less challenging with good levels of engagement nationally and locally. Nationally this sits at 79% when adjusted to exclude sudden and unexpected deaths. UHS performed well in this at 95%.

It is acknowledged that in some areas in 2016/17 we did not perform so well:

- The national average for medication review in the last 24 hours of life was 65%; UHS data demonstrated 53% of patients had this review in the last 24 hours of life.

- Discussion of DNACPR decision making in conjunction with the patient nationally sits at about 36%. UHS recorded 30% in the data they submitted to the National Care of the Dying audit. This data excludes sudden and unexpected deaths.

- Currently UHS does not seek feedback from bereaved relatives. The national average for this is 80% demonstrating a clear need for improvement at UHS.

- The perceived lack of hydration of dying patients was one of the most common complaints reported by the public to the Neuberger Review of the Liverpool Care Pathway. The new NICE Guideline NG31 on 'Clinical care of adults in the last days of life' is very clear on the importance of maintaining hydration, either by patients being allowed and supported to drink, or by clinically assisted forms of hydration. National assessment of hydration status in the last 24 hours of life was 67%. UHS recorded 60% compliance with this assessment process.

The Trust is currently repeating the national audit at a local level using the same methodology. The results will be compared against our previous performance and end of life care will be identified as a priority for 2017/18.

**Priority two: Promote safe and timely discharge of all patients**

Planning for patient discharge is an essential element of any admission to an acute setting, but may often be left until the patient is almost ready to leave hospital. When patient discharge is effective, complications as a result of extended lengths of hospital stay are prevented, hospital beds are used efficiently and readmissions are reduced, and patient experience is improved.

Our aim in 2016/17 was to ensure discharge planning was prioritised by focusing on the essential principles that should be met to ensure that patients do not experience delays at discharge and leave feeling confident and safe to do so.

We already had an Integrated Discharge Bureau (IDB) in the Trust which aimed to provide a coordinated and seamless service to our patients to ensure a prompt and efficient discharge or transfer, whilst taking into consideration their personal preferences as much as possible.

The key elements of the IDB model are collaboration, commitment and enhanced communication throughout the discharge pathway. The IDB already has representation from five organisations working in partnership who aid the discharge process, considering choice and safety, and aiming for assessed needs to be met in a person-centred way and to empower colleagues, patients and families to work collaboratively to improve the patient experience of discharge planning.

In 2016 the IDB focused on introducing new initiatives including a new 'managing complex discharge' policy, the introduction of discharge officers, ward link competencies, continued healthcare coordinators and front loading the discharge process to ensure planning begins upon admission.

The UHS pharmacy department also led on a variety of projects in 2016/17 to help improve the discharge process with regards to discharge medication. This area had been highlighted as an area for improvement via incident reporting and patient feedback.

These projects included;

1. Developing a discharge checklist to ensure that patients received all the necessary medicines, ancillaries and information at the point of discharge. This includes in particular an assurance that nursing homes and rest homes will receive all the information they need at the point of discharge.

2. Developing written advice about the use of taxis to transport medication to patient's home addresses post discharge. Most discharge medication is given to the patient before they leave hospital however; there are occasions when medication is sent on afterwards. We aim to reduce this practice, but to provide more governance and assurance of a safe process when it does need to occur.

3. Planning to develop the role of a discharge pharmacy officer who will be responsible for the reconciliation of the discharge medication, counselling the patient and providing a steer to patients regarding when their medicines/discharge will be ready. They will also support in the proactive management of the discharges.

4. Referring patients who have been assessed as at risk from developing medicine related problems post discharge to their community pharmacy for advice. This is as a result of work published in Newcastle that highlighted improved outcomes in patients referred to their community pharmacy.

5. Scoping the discharge process trying to identify alternative mechanisms of discharge for patients that perhaps have fewer care needs. This is in response to patient feedback highlighting their frustration regarding the lack of options with how their discharge medication is provided.

6. Planning work on a discharge information sheet to explain to patients what their discharge involves and the necessary steps that require completion before discharge.

Whilst we have made progress, we acknowledge that there is still a great deal to do in both the quality and timeliness of patient discharge, and this is why we have chosen this as an ongoing priority for 2017/18.

**Priority three: Responding to and learning from patient feedback (complaints)**

If a patient is unhappy with the care they are or have received we always seek to resolve this as early and effectively as possible to prevent the patient or family feeling the need to make a formal complaint. There are occasions when we can resolve issues by arranging a meeting with the clinicians involved to answer any questions and manage concerns. This can shorten the time taken to provide a response and resolution. We monitor the numbers and themes from these complex concerns.

If the patient or family wish to make a formal complaint, we will complete a formal investigation and provide a written response.

Complaints were identified as a key patient experience indicator in our quality account of 2015/16, and a target set to reduce them. This target would excluding complex concerns (which are investigated against different standards and do not require formal investigation) to below 550 for the year 2016/17.

**Table 3 Percentage of complaints closed within agreed time frames 2016/17**

| 2016/17 | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints received for investigation | 39 | 37 | 47 | 34 | 33 | 27 | 46 | 51 | 44 | 31 | 37 | 32 | 458 |
| % of complaints closed within original 35 days timeframe | 7.6 | 31.82 | 37.21 | 46.67 | 41.86 | 41.94 | 45.24 | 56.60 | 78.43 | 76.74 | 72.73 | 72.5 | 50.78 |

Those cases not closed within the agreed timeline had new timelines negotiated and agreed with the complainants.

**Table 4 Number of complaints and complex concerns received 2016/17**

| 2016/17 | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints received for investigation | 39 | 37 | 47 | 34 | 33 | 27 | 46 | 51 | 44 | 31 | 37 | 32 | 458 |
| Total number of complex concerns | 20 | 24 | 22 | 33 | 26 | 32 | 17 | 27 | 13 | 25 | 24 | 31 | 294 |

**Table 5 Percentage of dissatisfied complaints over total number of complaints**

| By Received Date | Number of Dissatisfied Cases | Number of Complaints | Percentage Dissatisfied |
|---|---|---|---|
| 2015/16 | 49 | 431 | 11.37% |
| 2016/17 | 44 | 458 | 10.48% |

The average time to respond for 2015/16 across the year was 38 days with variation month to month from 24 to 54 days.

Year to date 2016/17 the average remains the same but variation is from 24 to 47 days and consistently in last three months we have been below our 35 day target.

The complaints team also sit on each division's governance boards to advise, inform and support their complaints management, and to help ensure learning is embedded in practice.

## Learning from our complaints

Failings found in consent process and record keeping in relation to procedure to remove ear wax.

**Action taken**
Each patient is given an information sheet which includes advice on potential complications.
Verbal consent is gained and documented before commencement of procedure.
Failings found in consent process and record keeping relating to procedure to remove ear wax.

Discharged too early following surgery. We found that although discharge had been appropriate the written discharge information sheet was inadequate.

**Action taken**
Information sheet reviewed and post operative follow-up phone call introduced a week following discharge.

A vital part of the complaints process is to look for any learning that we can identify and seek to change our practice accordingly.

If complainants are not satisfied by our investigation and response then they can refer themselves to the Parliamentary and Health Service Ombudsman (PHSO).

In 2016/17 there were ten complaints referred to the PHSO concerning UHS and 20% of these were either partially or fully upheld. This compares favourably with the PHSO average of 46% across all NHS trusts.

For each upheld complaint by the PHSO an action plan is developed by the Trust to rectify any failures and an apology given. In some cases a financial settlement can also be requested.

This year we have introduced a follow up phone call to complainants after the receipt of their complaint response to obtain feedback on their satisfaction. We have also started to engage with our local population at community events to inform diverse groups about how to raise concerns or make complaints and as an example have attended the Southampton Pride event late last year. We hope to continue to expand upon this work over the next year. We also will continue to work with our local HealthWatch representatives as they support our complainants through the complaints process.

We have published the first two editions of a tri annual newsletter for UHS staff to support them in ensuring they have a good understanding of the complaints process and how to support our patients and visitors when they raise a concern.

During this past year we have worked hard to reduce our complaint response time, aiming to get this down to a period of 35 working days. This has been achieved for December 2016 and January 2017 with the response time moving from 48 days in April 2016 to 31 days in January 2017.

Themes from issues raised through complaints and complex concerns are shared at the patient engagement and experience strategy group to ensure that this is part of the UHS strategy for improving patient experience.

## Patient safety

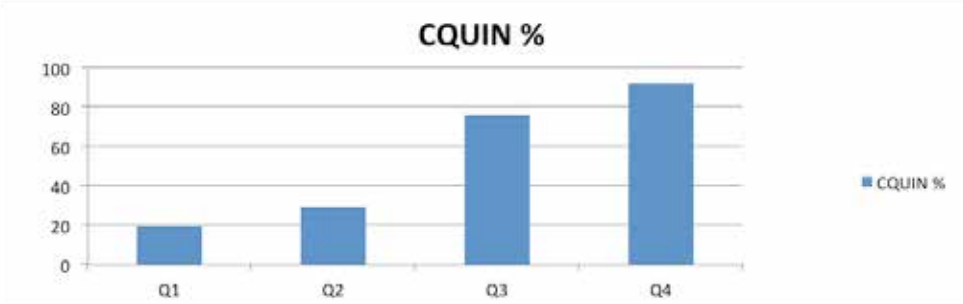
### Priority four: Acute kidney injury (AKI)

Acute kidney injury (AKI) is common in hospitalised patients and has a poor prognosis with the mortality ranging from 10% to 80%. As part of our safety strategy we have been working over the last two years to improve the detection, prevention and management of AKI within the Trust by:

1. Ensuring information about their AKI is sent to primary care, so that these patients receive appropriate blood testing and medication following discharge from the hospital. The goal was that more than 90% of patients would have this discharge information sent to primary care by the end of 2016/17. We measured this by auditing a random sample of 25 patients who had an AKI during their acute hospital stay every month. Four elements of information were required for the discharge information were needed for this information considered to be complete.

2. Alongside the Commissioning for Quality and Innovation (CQUIN) goals we were aiming to improve the recognition and management of patients with AKIs within UHS.

**Table six Percentage of CQUIN achieved by quarter one to four**




Successfully achieving the CQUIN meant we achieved a £1,240,000 cost saving to the Trust.

3. An AKI working group was set up to deliver a multi-professional approach to achieving this goal and an AKI clinical nurse specialist (CNS) was appointed. This key leadership role was to assist in the implementation of an electronic AKI alert that was added to the discharge summary, alongside reviewing all patients with an AKI stage three and being responsible for AKI education to the Trust as well as to assist in reviewing all patients with an AKI stage three outside of critical care areas and advising on their care and management so that local leadership becomes more skilled in this area.

4. Improving AKI education in the Trust with a particular focus on improving the management of hydration for our inpatients and improving fluid balance documentation. This documentation relies on individual staff understanding the fuller picture of hydration and fluid balance beyond the charting of measurements and their responsibilities therein. We developed an e-learning AKI package which was the first of the kind in the country and is likely to be adopted nationally: 400 staff members have completed this to date. Consultant-led education was given to medical students, junior doctors and on consultant led teaching rounds (known as grand rounds) and interdepartmental meetings including elderly care, acute medical unit (AMU), anaesthetics, respiratory and cardiology.

5. An AKI pharmacist was also appointed and completed cascade training with the pharmacist team. The automated section on the electronic discharge summary was launched in October 2015 and this led to a dramatic increase in completion. Clinical pharmacists took a lead role in alerting the prescribers to circumstances that might change the safe or effective dose for individual patients with an AKI alert. This includes changing doses of drugs such as the antibiotic Gentamicin to reduce renal toxicity and prevent new or worsening acute kidney injury.

6. A number of pathways, guidelines and educational resources have been developed to raise awareness of AKI, improve patient management and hopefully reduce incidence of AKI including primary and secondary care pathways on map of medicine and an AKI Care Bundle for patients undergoing elective hip and knee surgery.

In 2016/17 we achieved:

1. A mean reduction in length of stay for patients with an AKI three alert of four days following implementation of AKI alerts, focused AKI education and the appointment of an AKI CNS.

2. A 16% reduction in number of patients with an AKI from January 2015 to September 2016 with significant and sustained falls in total numbers of alerts in medicine, orthopaedics and surgery.

3. A 39% reduction in number of AKI alerts (comparison of April 2015, n=2191 alerts to April 2016, n=1346 alerts).

Moving forward into 2017/18, AKI recognition and management will be a continued priority for effective local leadership which will focus on:

1. Trust-wide rollout of hydration charts and development of an e-learning fluid balance chart package.

2. Learning from AKI mortality and morbidity meetings and incident reports shared trust-wide.

3. More patients with AKI receive a urinalysis at the time of diagnosis.

4. Maintaining the appropriate information sent to primary care for patients with AKI.

5. Ongoing achievement of more than 90% of our patients with AKIs having information about the inpatient management of their AKI and what follow up is required sent to primary care.

6. Ensuring more than 90% of patients with AKI have a urinalysis completed when their AKI is diagnosed. This is important for the correct diagnosis and management of their AKI.

7. A 10% reduction in hospital acquired AKI bed days. We will achieve this through improving the management of hydration for our inpatients and improving fluid balance documentation.

**Priority five: Reduce high harm pressure ulcers and falls**

Our aim in 2016/17 was to continue to reduce the incidence of all pressure ulcers, with particular emphasis on high harm pressure ulcers grade three to four. (Definitions of grades of pressure ulcers are found in appendix two). We have made a clear commitment to reduce the numbers across the Trust and have achieved a year on year reduction by:

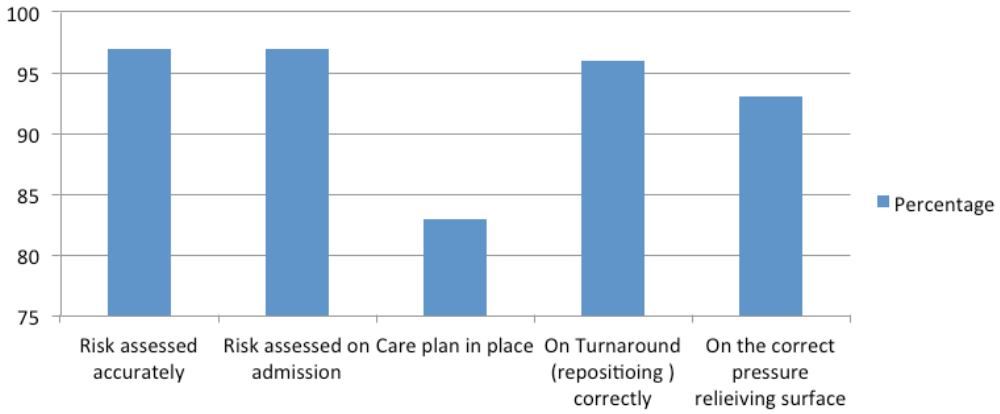
1. The roll out and monitoring of a new UHS developed risk assessment tool to replace the risk assessment tool previously used (Braden). This tool was piloted and evaluated by staff on two ward areas in July 2016 and was found to be clear and simple to use, as well as increasing the accuracy of the assessment. The assessment leads ward staff to a care plan according to the level of risk to ensure that all steps in the process, appropriate to that individual are in place from admission. The new risk assessment tool, pressure risk evaluation and skin screening tool (PRESS) and associated care plans were developed using the latest national guidelines and tailored to support staff in both the prevention and management of patient's risk of pressure damage. Learning from previous investigations had demonstrated that staff using the previous risk assessment were underestimating the risk and no care plans were consistently being documented for individuals. The new tool and care plan process was piloted with excellent results and has now replaced the previous risk assessment in all adult in patient areas.

2. We have also focused on grade two pressure ulcers and now investigate each grade two to identify the root causes of the damage development and to implement actions to change practice and provide support at this early stage to prevent the damage deteriorating.

3. We have focused on better measurement of the process of repositioning which is called Turnaround at UHS. A competency process was developed to ensure that after staff had attended education sessions they were also assessed as being competent with the process in their own ward areas. An audit of the process in each ward area has also been introduced to identify any areas of learning specific to that ward team and allow leaders to monitor areas progress and achievement in line with the process.

The process is being closely monitored and an audit was undertaken at both three months and six months following implementation in late April. Results are shown in the chart below from the three month audit (six month audit data not currently available):

**Table 7 Percentage compliance with key audit areas**




97% of patients had an accurate risk assessment completed and completed on admission. The focus will continue over the next year to improve the use of the care plans, which was a new step in the process and so has taken longer to embed in practice.

All of the prevention initiatives available including the repositioning of patients has achieved a significant reduction in grade two, three and four pressure ulcers so far in 2016/17:

**Table 8 All grade two, three and four pressure ulcers reported 2015-2017**

| Grade three and four | 2015/6 | | 2016/17 | |
|---|---|---|---|---|
| | Avoidable | Unavoidable | Avoidable | Unavoidable |
| April | 2 | 3 | 1 | 5 |
| May | 3 | 3 | 2 | 3 |
| June | 4 | 2 | 1 | 3 |
| July | 4 | 5 | 0 | 7 |
| August | 5 | 6 | 1 | 4 |
| September | 5 | 3 | 1 | 3 |
| October | 4 | 5 | 1 (1 case to determine) | 6 |
| November | 1 | 0 | 0 | 3 |
| December | 2 | 4 | 2 | 2 |
| **Totals** | **30** | **31** | **9** | **36** |
| | **65** | | **45** | |

| Grade two pressure ulcers | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|
| April | 20 | 12 | 13 |
| May | 14 | 19 | 15 |
| June | 24 | 19 | 16 |
| July | 21 | 11 | 11 |
| August | 14 | 21 | 8 |
| September | 24 | 20 | 8 |
| October | 14 | 10 | 16 |
| November | 13 | 15 | 12 |
| December | 19 | 18 | 8 |
| **Total** | **163** | **145** | **107** |

The focus on reduction will continue as a priority over the following year. There is still more work needed to ensure assessment of the risk of pressure ulcer development is completed as soon as possible on admission to enable timely intervention. The support and shared learning will continue to be cascaded to staff via the pressure ulcer strategy and working groups.

In reference to high harm falls, the Trust had an internal target of a 10% reduction in all high harm falls and zero avoidable high harm for 2016/17. High harm includes all falls that result in any fracture and/or severe head injury. An avoidable fall would be a fall where, following investigation, there is insufficient evidence that every reasonable effort was made to reduce the risk of a fall. This could include lack of initial assessment, review of risk on change of condition or following a fall and mitigation of any risk identified.

Year to date we have achieved a 14% reduction in the number of high harm falls, 56 compared to 65 in the same period the previous year. Unfortunately we have not achieved the target of zero avoidable high harm falls, and currently year to date we have reported four. This is, however, a reduction on the previous year's total of six.

It is a recognised risk that patients with dementia are at an increased risk of falls and harm from falls and there has been intensive support for these patients provided by the enhanced care support teams (ECST). The ECST currently support patients in division B and D and can assess and plan care for patients with enhanced care needs (care that is assessed as being over and above the planned daily staffing levels for that area). The team consist of band five registered mental health / learning disability nurses and healthcare support workers. They are able to assess and plan care specific to the patient and work in close collaboration with the ward team. They can provide various levels of support to patients from care planning to providing therapeutic interventions and, if required, one to one care.

Additional initiatives were also being developed. In 2016 medicine for older people introduced 'Bay Watch' which involves placing same sex patients identified as high risk for falls into one ward bay. A member of the multidisciplinary staff is present and visible in that bay all times. The staff members wear an armband to clearly show they are 'on duty' in that bay. The armband is then handed to the next staff member when care is taken over. There have been no avoidable high harm falls within medicine for older people since May 2016.

The emergency department has focused on increasing education and training for staff around the early identification of falls risk, and the coloured wrist bands highlighting risk of falls which they introduced in 2015 has started to roll out into other areas of the hospital including surgery.

**Priority six: Reduce never events**
Never events are a particular type of serious incident that are largely preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.

As an organisation in 2016/17 we carried out 125,615 procedures including surgeries. Most of the procedures that we carry out are uncomplicated, but we would like to work in an organisation that is successful in eradicating all avoidable harm to our patients.

If never events do occur we take them extremely seriously. The Trust has a never event oversight group which consists of members of the executive team, clinical teams and human factors expertise with the aim of scrutinising any never events that occur as well as the safer invasive procedures work stream. Investigations are promptly instigated and action plans generated and completed to ensure learning occurs. Staff involved in never events are supported through the process and learning is widely shared in the organisation.

In 2015/16 UHS reported six never events. In 2016/17 we reported three:

1. A wrong site brain biopsy .This resulted in no harm to the patient as the biopsy was diagnostic and could have been performed on either side.

2. A mismatch of hip components during a total hip replacement which resulted in a return to theatre for revision of the hip.

3. The insertion of an incorrect lens during cataract surgery as it had been calculated based on incorrect patient details.

These investigations are currently ongoing, but immediate actions taken included:

1. A comprehensive review of the processes involved in checking and documentation of hip components intra-operatively.

2. A comprehensive review of the checking process for lens calculations intra-operatively.

These actions will link into the existing work stream within the Trust regarding safer invasive procedures.

## Clinical effectiveness

**Priority seven: Every clinical specialty will identify an outcome measure**
During 2016/17 all divisions within UHS worked towards identifying clinical outcome measures for their services that can best be used to measure improvement in the care they provide. 36 specialities successfully identified outcome measures.

A considerable amount of progress has been made in identifying and reporting the number of areas in the Trust that contribute to national outcomes data collection to assess our performance against other specialist services and also areas who are collecting (or developing) local outcomes data.

We acknowledge we have not fully achieved this, and therefore this is a high priority for the coming year and will continue to be taken forward during the year 2017/18.

**Priority eight: Making appropriate improvements in mortality rates and the way mortality is measured and evaluated**

The patient safety team is targeted and focused on ensuring we deliver the safest and most effective treatment we can. Measuring outcomes provides reassurance and allows us to focus our improvement efforts to deliver changes where most needed. The NHS is appropriately focused on learning from events and in particular from reviewing mortality rates.

It is difficult to obtain representative rates given the different populations we serve. Although we measure and review the crude death rate, its value is limited as it does not take into account the severity of the underlying illness or complexity of the patient group. To improve this we calculate the hospital standardised mortality ratio which adds complexity into the calculation.

This is an imperfect science, however it is a useful tool as it allows a degree of benchmarking but, most of all, it allows the measurement of trends and highlights potential outliers or anomalies which require evaluation.

In order to improve assurance we do not rely on this alone but consider it along with other mortality indicators and outcome measures such as Summary Hospital-level Mortality Indicator (SHMI). The Internal medical examiners group (IMEG) is particularly important. This group examines the notes and discusses the care of every patient who dies at UHS. They look for both good care practice as well as any areas that could be improved; escalating any issues for more detailed scrutiny.

The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the observed number of in-hospital deaths to the expected number of in-hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a case mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The UHS HSMR in 2015/16 was 102.6, while the current Year to Date (YTD) position for 2016/17 is 101.5.

The SHMI is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to the HSMR; however there are some differences in the case mix model. The two models should not be compared directly, but used in conjunction to monitor mortality outcomes. SHMI can also be used as a potential smoke alarm for potential deviations away from regular practice.

The SHMI data shows a consistent quarterly performance below the benchmark (benchmark = one). Over the last three reporting periods the SHMI for UHS was 0.95, 0.96 and 0.96.

The data used to derive HSMR and SHMI is taken from the Hospital Episodes Statistics (HES) data therefore our ability to capture the primary diagnosis (the main condition treated by the clinicians), secondary diagnoses and co-morbidities has a direct impact on HSMR and SHMI.

As part of an annual assessment the Trust undertakes an internal information governance audit submitted to the Department of Health. One of the information governance toolkit audits looks at the information processes involved in the collection of data for clinical coding purpose ensuring information is accurate, consistent and complete. The Trust maintained its level three status (highest level of attainment possible) based on the targets set by the Clinical Classification Service (CCS) regarding coding accuracy. This has been achieved due to continued improvements including additional information systems access and continued clinical coding awareness programs for clinical staff.

An additional priority for 2016/17 involved working with specialities, care groups and divisions to improve knowledge and understanding of HSMR. HSMR and SHMI data are monitored monthly by our central team, all outliers are investigated thoroughly and, where necessary, clinically validated to ensure clinical standards of care have not been compromised. HSMR continues to be monitored and reported to the Trust executive committee, divisional management teams and divisional governance managers on a monthly basis.

# Priorities for improvement 2017/18

In order to determine our priorities for improvement we have consulted with a number of stakeholders including our Trust quality committee, our Trust Board, our Trust executive committee, commissioners and patient representatives (through our HealthWatch group), and our governors. The quality committee on behalf of the board approved the priorities and there will be regular reports on progress to the committee throughout the year.

We have developed this years' patient improvement framework (PIF: appendix one) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints, as well as incidents, and we have taken into account our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus in 2017/18. Priorities are built around our ambitions and intention to deliver well led, safe, reliable and compassionate care in a transparent and measurable manner.

Each priority relates to one of the three core areas of quality:

**Patient experience**: meeting our patients' emotional as well as physical needs.

**Patient safety**: having the right systems and staff in place to minimise the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes.

**Clinical effectiveness**: providing high quality care, with world-class outcomes, whilst being efficient and cost effective.

This section outlines the following 2017/18 quality priorities.

## Patient experience

### Priority one: Improving patients' experience of and the safety of discharge from hospital

#### Why we have chosen this priority

The principles and benefits of safe discharge from the acute hospital setting have been discussed in section 'Progress against 2016/17 priorities Priority two'.

We know from our in-patient surveys that we still have areas related to discharge which need improvement:

Table 9 Inpatient Survey Results January 2016:

| **The Trust has worsened significantly on the following questions:** | | lower scores are better |
|---|---|---|
| | **Trust** | **Average** |
| Discharge: did not feel involved in decisions about discharge from hospital | 51% | 45% |
| Discharge: not given any written/printed information about what they should or should not do after leaving hospital | 34% | 36% |
| Discharge: not fully told side-effects of medications | 64% | 61% |
| Discharge: not told how to take medication clearly | 30% | 24% |
| Discharge: not told who to contact if worried | 10% | 20% |

### What we are trying to achieve

We aim to build on the work completed in 2016/17 by setting clear patient and family expectations around discharge processes right from the beginning of the hospital admission in order to be clear about what people can expect from the start and to fully engage them with the process.

This will include:

1. Standard information to set expectations on admission

2. Standard information for the patients at each stage of the process – templates to be used on the wards

3. Clear process to be followed by the wards in conjunction with the IDB

4. Clear timelines between each stage of the process

In addition we aim to strengthen close working partnerships with other organisations, including primary care, hospital services, social services, voluntary services and the private sector to ensure that communication and consultation with the patient and his/her relatives and carers was of prime importance, commencing at pre admission, throughout their stay and following discharge.
The policy has been accepted by all the partners in the system.

### What will success look like?

Metrics designed to monitor all discharges from the Trust will demonstrate improvement, and feedback via patient surveys, Friends and Family Test, patient forums and HealthWatch will corroborate these improvements.

## Priority two: Meeting patients' nutritional and hydration needs

### Why we have chosen this priority

Ensuring the nutrition and hydration needs of our patients are met has been a priority over previous years with changes and improvements identified and implemented. Patients continue to provide feedback on the meal service they receive and this area of patient care and experience remains a key focus for improvement.

Table 10 Inpatient survey results 2016

| | | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|
| 22+ | Hospital: food was fair or poor | 54 % | 53 % | 50 % | 49 % | 44 % | 49 % |
| 23 | Hospital: not offered a choice of food | 19 % | 19 % | 17 % | 16 % | 15 % | 19 % |
| 24+ | Hospital: did not always get enough help from staff to eat meals | 47 % | 44 % | 46 % | 35 % | 34 % | 43 % |

NB: the survey does not provide a detailed breakdown of which age groups responded to these question, however it is noted that 82.1% of respondents were > 50 years of age, with 22.2 % being 60-69. 24% being 70-79, 17.4 % being 80-89 and 4.3 % being over 90 years of age.

NB: CQC Patient Survey not yet published at time of writing.

### What we are trying to achieve

1. To review the process for nutrition screening in adults and children, to ensure that patients at risk of malnutrition are identified and managed appropriately according to their individual needs.

2. To review and establish compliance with Protected Meals guidelines.

3. To implement a hydration assessment and chart to all adult inpatient areas.

4. Work collaboratively with our new service provider to increase the percentage of patient satisfaction with food.

### What will success look like?

1. Patients are screened for malnutrition on admission to hospital or at pre-assessment and those at risk have an appropriate care plan implemented.

2. Patients are adequately prepared for meals and receive the help they require in an environment conducive to mealtimes.

3. Hydration assessments and charts are used appropriately in all adult inpatient areas.

4. Progress against our performance will be reflected in the national inpatient survey 2017/18.

## Priority 3: Improving care for vulnerable adults

### Why we have chosen this priority

"Living a life free of harm and abuse is a fundamental right of every person. When abuse or neglect does occur, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the concerns raised. In addition, the person must be at the centre of any safeguarding response and must stay as much in control of decision making as possible. The right of the individual to be heard throughout the process is a critical element in the drive to ensure more personalised care and support". The Care Act 2014.

Health services have a duty to safeguard all patients but also to provide additional measures for patients who are vulnerable and less able to protect themselves from harm or abuse. The core definition of a vulnerable adult as defined by the 1997 Consultation "Who Decides?" issued by the Lord Chancellor's Department is:

"A person who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or herself against significant harm or exploitation". This definition of an adult covers all people over 18 years of age.

Safeguarding adults covers a spectrum of activity, from prevention through to multi-agency responses where harm and abuse occurs. Multi-agency procedures apply where there is concern of neglect, harm or abuse to a patient defined under 'No Secrets' guidance as vulnerable.

Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law.

The Department of Health (DoH) document 'Safeguarding Adults: The Role of Health Service Practitioners' reminds health service practitioners of their statutory duties to safeguard adults. It aims to assist practitioners in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations.

### What we are trying to achieve

The Trust's framework for safeguarding adults is based on national guidance and from a policy perspective is jointly shared through the local safeguarding adults' boards. This includes the national guidance detailed within the Care Act 2014, which created a new legal framework for how local authorities and other parts of the system should work together to protect adults at risk of abuse or neglect. UHS and its partnership organisations have agreed how they should work together and the roles they will play to keep adults at risk safe. This approach promotes the development of inter-agency working to make safeguarding personal and individualise care to ensure it meets each person's needs.

The key principles of good safeguarding include empowerment, prevention, proportionality, protection, partnership and accountability. Other important governance frameworks are also in place and ensure good levels of safeguards to keep people safe, these include continuous learning, quality improvements, team work, professional curiosity and challenge.

UHS continues to ensure that adult safeguarding remains a high priority. Key achievements in 2015/16 have included:

1. Development and partial implementation of the learning disability strategy and investment into more learning disability clinical nurse specialist posts.

2. Continual partnership working between clinical and estates teams to refurbish wards and departments so that they are dementia friendly - medicine for older people (MOP) being an exemplar site.

3. Development and implementation of the enhanced care support Team (ECST).

4. Support for carers' through regularly held 'carers' cafés' providing expert support and guidance to people caring for our patients.

5. All patients admitted to our hospital as an emergency are screened for signs of cognitive impairment and referred to their GP.

6. Improved senior leadership and multi agency/disciplinary working on the pathway and resources involved in improving the safety and experience for patients presenting in mental health crisis to ED.

7. PWC internal audit of adult and children's safeguarding with an outcome risk rating of 'low' with key assurances gained of how timely and effectively concerns relating to safeguarding are identified and investigated.

8. Implementation of dragonfly approach in the ED. This is a visual prompt to staff (a picture representing a dragonfly) which alerts staff to the particular needs of the patient with dementia and is currently used throughout the rest of the Trust.

Our priorities for next year include:

1. Meet the rising demand of patients presenting in mental health crisis – grow service, gap analysis of current service delivery against the need to identify gaps and develop a plan to address this.

2. Develop robust training programmes for our staff so they feel well equipped with the clinical skills for example, support patients behaviour to de-escalate, refer to other specialist professional teams.

3. Develop a UHS mental health board to address the challenges and impact for mental health patients and for staff looking after them.

4. Evaluate responsiveness and effectiveness of ECST and potentially expand service.

5. Focus on autism agenda.

6. Develop leadership approach and evaluate progress with dementia strategy.

7. Consider proposal for joining adults and children's safeguarding teams.

8. Share and embed learning from complaints, serious incidents and serious case reviews.

9. Introduce carers' passports.

10. Introduce the vulnerable adult champion role.

11. Develop a combined safeguarding team with associated joint governance and meeting structure.

12. Provide training and awareness on mental health capacity assessment and deprivation of liberty.

### What will success look like?

1. Staff will be competent and confident in caring for vulnerable patients.

2. Increased number of safeguarding referrals received by adult safeguarding teams and improved timeliness of response.

3. Number of complaints from patients, relatives or carer's relating to safeguarding will reduce.

4. Feedback from carer's / relatives will improve.

5. Numbers of serious case reviews will have reduced.

How we will monitor progress for our patient experience priorities:

As national surveys are published yearly or less we measure our performance during the year using our real time patient feedback system. This provides monthly feedback which is shared with all the clinical teams.

At UHS level this data is reviewed in detail at the patient experience and engagement steering group and the high level data is reported to Trust Board. We will report progress against our performance in the national survey next year.

## Patient safety

**Priority four: Recognition and management of the deteriorating patient**

### Why we have chosen this priority

Clinical deterioration can occur at any stage of a patients' treatment or illness, although there will be certain periods during which a patient is more vulnerable, such as the onset of illness or during medical, surgical or dental interventions. Patients who are at risk of deteriorating may be identified before a serious adverse event by monitoring changes in physiological observations recorded by healthcare staff. The interpretation of these changes and timely institution of appropriate clinical management once physiological deterioration is identified is of crucial importance to minimise the likelihood of serious adverse events, including cardiac arrest and death.

UHS is committed to having standards in place for managing the risks associated with the deteriorating patient who has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17.

### What we are trying to achieve

Our purpose is to prevent avoidable deterioration. Our priorities are establishing:

1. Where are we now, how are we performing?

2. Overview of current work streams, serious incident requiring investigations (SIRI), AKI, and sepsis.

3. What and how are we measuring - the role of acuity audits, modified early warning system (MEWS) activation data.

4. Development of an annual plan for acuity improvement including roles and responsibilities, timescales and measures.

5. Escalation on electronic systems (ePAMS) and paper based systems with timescales to move to all electronic systems.

The existing acuity group responsible for monitoring the deteriorating patient has been reviewed and restructured to ensure that it is driven from executive level. This is to increase the trust-wide profile and in acknowledgement that this affects all patients in every division. As part of a re-launch of the group it has been renamed ROAR (recognise, observe, assess, rescue) to reflect its purpose.

The membership includes matrons and/or clinical leads for each care group who are clearly responsible for cascading of actions and information after each meeting, the patient safety team, divisional heads of, nursing (DHN), divisional clinical directors (DCD), AKI nurse, and sepsis nurse, critical care outreach Team (CCOT), out of hours (OOH) team, education teams and consultants. The group's function is as a clinical reference group, providing leadership and guidance to UHS on management of the acutely unwell patients. Shared learning can be achieved through linking in directly with quality steering group.

The group will meet monthly throughout 2017/18 with the above agenda, followed by a case presentation from each division in rotation, i.e. each division will present three patients per year who were unplanned intensive care admissions for learning.

### What will success look like?

We will be able to measure and react to these metrics for improvement:

1. Measurement of baseline/ compliance/improvement.
2. Pulseless Electrical Activity (PEA) cardiac arrests
3. 'False' cardiac arrest calls
4. Unplanned intensive care admissions
5. CCOT call data
6. MEWS/NEWS data
7. Development of an acuity review template
8. Development of unplanned admissions to intensive care template

These metrics may change depending on national and local priorities.

## Priority five: Safer invasive procedure

### Why we have chosen this priority

A patient safety alert was issued by NHS England to launch an NHS-wide programme of work based around the national standards for invasive procedures (NatSSIPs) that were published September 2015.

The alert asked NHS providers to review current clinical practice and ensure the NatSSIPs are embedded into local processes by developing their own local safety standards for invasive procedures (LocSSIPs) in collaboration with staff, patients and the public.

The aim of the NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur. They set out the minimum standards considered necessary for the delivery of safe care during invasive procedures as well as underpinning aspects of education and training.

The NatSSIPs have been set and endorsed by all relevant professional bodies, including the Royal Colleges, the Care Quality Commission, the Nursing and Midwifery Council, the General Medical Council, NHS Improvement, and Health Education England.

### What we are trying to achieve

To embed the NatSSIPs into our own local safety standards to support staff in providing the very best care and treatment for our patients to focus on reducing not only never events but all avoidable harm related to invasive procedures.

### What will success look like?

Our initial focus will be to build on work completed in the theatre environment in 2016/17. The World Health Organisation (WHO) safer surgery checklist used within theatre has been reframed as questions to frame practice and rebranded as 'stop points for safety' to allow safe, effective and consistent safety steps and move away from a tick box mentality.

In 2017/18 this will continue to roll out to all other interventional suits such as interventional radiology and interventional cardiology. We will also introduce team based LocSSIPs for procedures such as central venous catheter and arterial line placement in other clinical areas such as ward areas and outpatient departments.

Compliance will be measured quarterly by monitoring the number of never events, number of staff trained and percentage of each staff group trained, observational audit data and safety culture survey. The results will be reported to the quality and governance committees, scrutinised by audit to identify missing actions or documentation with learning fed back to team meetings. The results will be disseminated throughout the Trust for wider learning.

## Priority six: Recognising and treating sepsis

### Why we have chosen this priority?

Sepsis occurs when the body has an abnormal response to infection. This can be life threatening and if it's not treated quickly sepsis can rapidly progress. Septic shock, the most severe type of sepsis, carries a mortality of 50%.

It is estimated that 44,000 people die in the UK from sepsis each year. For comparison approximately 18,500 patients die each year from myocardial infarction (heart attack). Diagnosing sepsis is far from straightforward and it can mimic a myriad of other conditions.

Key factors that may reduce this mortality rate are the timely recognition of the septic patient followed by rapid administration of antibiotics and other simple supportive therapies - the sepsis six care bundle.

With implementation of the basic elements of care it is believed that 12,000 lives a year could be saved. This equates to 20 lives saved per 100,000 population, 285 fewer hospital bed days and 168 fewer critical care bed days.

### What we are trying to achieve

Our aim is to improve our recognition of patients at risk of sepsis and, as a consequence, allow the early management of septic patients. Not unsurprisingly if patients with sepsis are treated quickly mortality is reduced.

With this in mind, UHS is working towards a hospital-wide, systematic approach for the identification and appropriate treatment of life-threatening infections. Whilst at the same time reduce the chance of the development of strains of bacteria that are resistant to antibiotics.

Through this we aim to reduce death and morbidity related to sepsis in all areas of the hospital. As a result, this will reduce patient length of stay, critical care length of stay and thus improve patient experience and outcome.

### What success will look like?

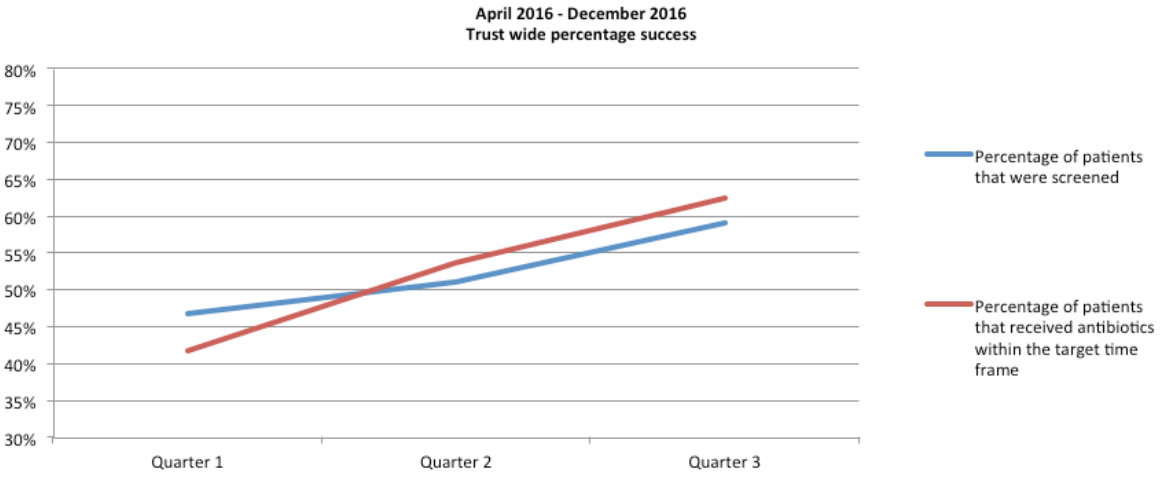
All patients deemed to be at high risk of sepsis will have appropriate screening. Following screening, if sepsis is likely they will receive timely treatment – namely the sepsis six care bundle of which rapid delivery of antibiotics is probably the most important element.

Our success in this trust-wide initiative will be monitored using data collected for the national sepsis CQUIN.

### Current progress:

Programmes have been introduced to acute admitting areas and are slowly being rolled out to all acute inpatient settings. Ongoing for 2017 we aim to continue to roll out the sepsis screening programme to all adult and paediatric wards. Our progress over the last year can be seen below.

Table 11 Roll out of the sepsis screening programme 2016-2017 (Q1-3)




### How we will monitor progress for our patient safety priorities:

Progress will be measured and monitored via clinical boards, the sepsis steering group and reported to the quality committee.

## Clinical outcomes

**Priority seven: Report outcome measures in every specialty across the hospital**

### Why we have chosen this priority

During 2017/18 the plan is to continue developing this work stream across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

### What we are trying to achieve

Our aims for 2017/18 are that every speciality will identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes.

### What will success look like?

Each care group will be able to present their outcomes to a newly established outcomes scrutiny group on an annual basis, demonstrating progress against the identified outcomes.

**Priority eight: Improve care for patients at end of life**

### Why we have chosen this priority

We are committed to a standard whereby any person in our care thought to be approaching their last days of life will receive individual care based on their needs, delivered with compassion and sensitivity by our staff, and that there is regular and effective communication between staff and the dying person and those close to them. We believe these are priorities which must be embraced.

## What we are trying to achieve

The NICE Quality Standard 144, 'Care of dying adults in the last days of life' was published on 2 March 2017 and we wish to align our patient improvement framework for end of life care to this quality standard.

There are four quality statements:

1. Adults who have signs and symptoms that suggest that they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering

2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan

3. Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration

4. Adults in the last days of life have their hydration status assessed daily and have a discussion about the risks and benefits of hydration options

We will achieve this through:

1. Delivering our new five year UHS End of Life Care Strategy so that education and training in care of the dying are delivered for clinical and front-line non-clinical staff caring for dying patients. The scope and level will vary according to staff group and the frequency that they are involved with care of dying patients and their families.

2. The decision that the patient is probably in the last hours or days of life will be made by the multidisciplinary team and documented by the senior doctor responsible for the patient's care. This will be discussed with the patient, if well enough and appropriate, and with family, carers or other advocates.

3. Enhancing our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met.

4. Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying. This will include discussion about what is safe and feasible. This will enable increased numbers of dying patients to be discharged home or be transferred to an alternative place of their choice in a timely manner.

5. Working with relatives and carers to hear their voice about their experiences of end of life care and their ideas for improvement.

6. Continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP).

7. Replicating the National Care of the Dying Audit locally in 2017 ahead the anticipated next national audit round.

8. Audit the use of the individualised end of life care plan and use the results to inform continuing improvement in the care of the dying.

### What will success look like?

1. Staff will be competent and confident in all aspects of end of life care.

2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan which will include:
   - personal goals and wishes
   - preferred care setting
   - current and anticipated needs including preferences for symptom management and maintaining hydration
   - needs for care after death
   - resource needs.

3. The needs of families and others identified as important to the dying person will be actively explored, respected and met as far as possible.

4. Sensitive communication will always take place between staff and the dying person, and those identified as important to them.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, that is agreed, coordinated and delivered with compassion will always be in place.

6. Audit results will have improved from 2016/17 results.

## Priority nine: Reduce the impact of deconditioning and immobilisation on the frail elderly

### Why we have chosen this priority

Frail older adults have reduced functional and physiological reserves, rendering them more vulnerable to the effects of hospitalisation, which frequently results in failure to recover from the pre-hospitalisation functional loss, new disability or even continued functional decline. Alternative care models with an emphasis on multidisciplinary and continuing care units are currently being developed. Their main objective, other than the recovery of the condition that caused admission, is the prevention of functional decline. Despite the theoretical support for the idea that mobility improvement in the hospitalised patient carries multiple benefits, this idea has not been fully translated into clinical practice.

Being in bed, sedentary or just not moving has a measurable impact of immobilisation of patients. This is known to increase length of stay and potentially the need for onward care.

### What we are trying to achieve

At UHS we have three projects developing in 2017/18 to reduce the impact of immobilisation on the frail elderly:

1. Increasing ambulatory care at the front door: ambulatory emergency care (AEC) is an emerging, streamlined way of managing patients who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, support workers and us as an organisation by releasing bed capacity within AMU and improving the delivery of the four hour ED target.

   Since September 2016, the emergency medicine care group has been part of Cohort 10 of the Ambulatory Emergency Care Network, supported by NHS Elect. This is an exciting opportunity which has provided us with access to a network of sites and national experts who have developed their ambulatory care models. Resources are available to the project team to use to support the cycle of the project, including conferences, webinars, analytical tools as well templates for experience based design models.

   During 2017/18 we will re-launch our present ambulatory pathways and rolling out AEC clinics seven days a week, reviewing the headache pathway with ED colleagues and looking at diabetes and superficial thrombophlebitis.

2. Increasing the identification and better understanding of frailty: we are fully engaged with CEDT, Urgent Response (Solent), CAT and Social Services to begin to look at what we can develop to expedite the discharge of patients from CDU and in the future AMU (subject to resourcing).

3. Initiatives to encourage mobilisation on the wards. These will include using the joined ambulatory care network and frailty network led by UHS. There will be a weekly 'stranded patient' reviews to ensure progress is not delayed, and a new care hub will be created in elderly care with a walking track. The hospital therapy team will be included in all these initiatives.

In addition, other initiatives include:

1. Use of trained volunteers and relatives in hospital to encourage older people to be more active.

2. Review the outcome of the 'So Move' feasibility study and support continued use of the project.

3. Implement the 'Eat Drink, Move and Pyjama Paralysis' initiative in AMU and MOP wards. This is an initiative to encourage patients to dress in their own clothes to promote self-reliance in the frail elderly which has been shown to improve their independence, wellbeing, and reduce their length of stay.

### What will success look like?

1. Reduced length of stay for patients in MOP and medicine.
2. More patients being discharged back to original place of residence.
3. A reduction in the number of patients needing onward care.
4. Increase in the number of non-admitted cases from Acute Admissions Unit, AMU and ED.
5. Improvement in gait speed.

### How we will monitor progress for our clinical effectiveness priorities:

Performance will be measured and monitored via clinical boards and reported to the quality committee. Using the Plan-Do-Study Act (PDSA) cycle of improvement, we will continual review the potential for growth.

# Review of quality performance

All NHS trusts are required to report their performance against a statutory set of core quality indicators in a predetermined format in their quality reports to enable readers to compare performance across organisations.

The tables in appendix three provide information against a number of national priorities and measures that, in conjunction with our stakeholders, form part of our key performance indicators which are reported monthly to Trust Board.

These measures cover patient safety, experience and clinical outcomes. Where possible we have included national benchmarks or targets so that progression can be seen and performance compared to other providers.

Clinical coding have not had a payment by results (PbR) audit during 2016/17.

The last PbR audit was in 2013/14 and no further audits were recommended for the Trust as we were found to be fully compliant.

(NB Clinical coding were also audited externally in 2016 by KPMG audit for the Trust's annual Quality Account and PWC as part of the Reference Costs audit)

### Clinical research

Research is at the heart of UHS's efforts to improve care and health. Over the last year alone we have seen the results better protect patients from severe flu, improve surgical patients' recovery, restore sight to those with 'incurable' eye conditions and use standard NHS 999 software to accurately identify heart attacks before the ambulance reaches the scene.

In outright performance measures we have delivered strongly too. Over 2016/17 we were again in the top five Trusts for trial recruitment and secured over £25m of National Institute for Health Research (NIHR) facilities funding.

UHS patients benefit through this performance, with 18,583 patients gaining access to clinical trials, the fourth highest recruitment rate in England. Including participants in our wider research partnerships takes our total recruitment to 19,984.

That access to trials has given those with respiratory conditions arriving in ED diagnosis of severe flu strains in under an hour, rather than days – with demonstrably better care, isolation and reductions in antibiotic use. For cancer patients it's given access to groundbreaking exercise 'prehabilitation' and care, improving tumour reduction ahead of surgery, physical condition and wellbeing before and after surgery, and cutting their time in critical care after surgery.

Similarly, trials using an inexpensive cancer drug have saved the sight of patients with Sorsby's Fundus Dystrophy (SFD), a rare and previously incurable disease causing sight loss in patients as early as their thirties.

Our work also goes beyond the hospital walls, with one study demonstrating that call data from the software used to handle 999 calls, NHS Pathways, accurately predicts heart attacks in 75% of cases – opening the door for better care before and on ambulance arrival.

Our trial recruitment performance also underpins our ability to invest in research and improve services with over £20m of funding secured over the year. It's central to a preferred partner deal that gives UHS priority on new trial contracts, and our strategic partnerships with major pharmaceutical companies, ensuring Southampton remains a key site for drug and vaccine studies.

To support the progress of scientific discoveries into new treatments we have made successful funding submissions, with our partners at University of Southampton, for a NIHR Biomedical Research Centre (BRC, £14.5 million), renewal of our NIHR Wellcome Trust Clinical Research Facility (CRF, £9.2 million) and for renewal of the Southampton Experimental Cancer Medicine Centre (ECMC). Combined, these awards secure our role in the first rank of UK clinical research sites and consolidates our existing world-class researching nutrition and lifestyle BRC, respiratory NIHR Biomedical research and microbial science, data science and behavioural science.

## Review of services

During 2016/17 the UHS provided and/or sub-contracted 107 relevant health services (from Total Trust activity by specialty cumulative 2016/17 contractual report). UHS has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by University Hospital Southampton NHS Foundation Trust for 2016/17.

## CQUINS payment framework

The Commissioning for Quality and Innovation (CQUIN) payment framework makes a proportion of NHS healthcare providers' income conditional upon achieving certain improvement goals. The framework aims to support a cultural shift by embedding quality and innovation as part of the discussion between service commissioners and providers.

NHS England define CQUIN as "a mechanism to secure improvements in quality of services and better outcomes for patients and drive transformational change by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals".

A proportion of UHS income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered a contract, agreement or arrangement with for the provisions of relevant health services, through the CQUIN framework. Further details of the agreed goals for 2016/17 are currently being determined between UHS and clinical commissioning groups.

The conditional income in 2016/17 upon achieving quality improvements and innovation goals was £13,366,000. This compares to the 2015/16 figure of £11,309,000.

We have used the CQUIN framework to actively engage in and agree quality improvements working with our commissioners, to improve patient pathways across our local and wider health economy.

Our CQUIN priorities for 2016/17 can be found in appendix four.

## Data quality

Data quality refers to the tools and processes that result in the creation of the correct, complete and valid data required to support sound decision-making.

University Hospital Southampton submitted records between April 2016 and March 2017 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2016 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number was:

- 99.2 % for admitted patient care
- 99.6 % for outpatient care
- 97 % for accident and emergency care

Which included a valid General Medical Practice Code was:

- 100 % for admitted patient car
- 99.7 % for outpatient care
- 99.9 % for accident and emergency care

University Hospital Southampton NHS Foundation Trust Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. University Hospital Southampton Information Governance Assessment Report overall score for V14 (2016/17) was 73% and was graded Satisfactory meaning the Trust met or exceeded the minimum required level of compliance assessment for all Information Quality and Records Management requirements of the Toolkit for the reporting year.

The Trust has maintained a level 3 accreditation against the NHS Litigation Authority risk management standards for acute trusts which contains two standards specific to records management and record keeping.

UHS recognises that good quality health services depend on the provision of high quality information. UHS took the following actions to improve data quality in 2016/17:

- Continued performance management of data quality via Trust and divisional meetings, the Clinical Coding function, and the IM&T Information Team. These groups use audit reports of patient data and key performance indicators on internal and external timeliness, validity and completion, including Dr Foster comparative analysis information. Areas of poor performance are identified, investigated and plans agreed for improvement.

- A data quality review programme working closely with clinical areas and clinicians to review the quality, timeliness and accuracy of patient level data collection.

- Continued work to reduce data quality problems at the point of data entry through improved system design, changes to software, and targeted support for system users.

- Supported training and education programmes for all staff involved in data collection, including information governance training and the provision of information collection guidance.

- Maintained a programme of regular internal audit, including data quality, record keeping, health records management, information governance and clinical coding audit.

- Continued to maintain and develop improved compliance with the information governance toolkit standards.

- Began a programme of education, training and data quality work to support improved collection and management of patient pathways and waiting times.

### Participation in national clinical audits and confidential enquiries

A clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

During 2016/17 60 national clinical audits and six national confidential enquiries covered NHS services that UHS provides.

UHS participated in 96% (57) of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies that UHS participated in during 2016/17 were:

NCEPOD Mental Health Adults
NCEPOD Acute Pancreatitis
NCEPOD Acute Non Invasive Ventilation
NCEPOD Children and Young People Chronic Neurodisability
NCEPOD Children and Young People Mental Health
NCEPOD Cancer in Children, Teens and Young Adults
The national confidential enquiry for the Trust's maternity and neonatal service MBRRACE Stillbirths and Neonatal Deaths

The national clinical audits that UHS participated in, and for which data collection was completed during 2016/17, are listed in appendix five alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

### Our Patient Reported Outcomes Measures (PROMS) following hip or knee replacement surgery

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the Trust's patient reported outcome measures scores for:

(iii) Hip replacement surgery

(iv) Knee replacement surgery, during the reporting period.

The University Hospital Southampton NHS Foundation Trust considers that this percentage is as described for the following reasons, taken from national dataset using data provided.

The University Hospital Southampton NHS Foundation Trust has taken actions to improve this percentage, and so the quality of its services. The results can be found in appendix six.

# Conclusion

We are proud of the advances we have made in the quality of services we provide. However, our mission is to be better every day, and we recognise that maintaining high quality services relies upon continual day-to-day improvements alongside longer term strategic developments. We are not complacent and know that we are still on a journey to achieve excellence in all areas.

This report enables us to qualify our progress comprehensively and demonstrate in 2016/17 we made good progress against our quality priorities.

We see this as an essential vehicle for us to work closely with our Council of Governors, HealthWatch, our commissioners and the local and wider community on our future quality agenda, as well as celebrating our successes and progress. Working with all our key stakeholders, including patients, we are determined to continue improving to achieve leading healthcare for the benefit of our patients.

We are confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence throughout 2017/18.

# Response to the Quality Account from Southampton City and West Hampshire Commissioning Groups

Southampton City and West Hampshire Clinical Commissioning Groups (CCGs) are pleased to comment on University Hospital Southampton NHS Foundation Trust's (UHS) Quality Account and Quality Report for 2016/17; for the services that they commission.

The CCGs have over the past year continued to work with the Trust in monitoring the quality of care provided to the local population of Southampton and West Hampshire and in identifying areas for improvement.

The Quality Account and Quality Report 2016/17, reflects the Trust's values of always improving, patient first and working together to provide patient centred care through a continued focus on quality improvement and has highlighted some of the positive progress made during 2016/17. It is encouraging to see these include; progress with their end of life care programme, the improved detection, prevention and management of acute kidney injury, reduction in high harm pressure ulcers and falls, as well as responding to and learning from patient feedback.

It is disappointing to note the limited progress with the management of pain and discussions around do not attempt cardiopulmonary resuscitation (DNACPR) at the end of life. Many of the priorities listed in the Quality Account will continue to be a focus for UHS during 2017/18 and have been captured within the Trust's Patient Improvement Framework (PIF).

Whilst the Trust's efforts to reduce preventable harm are recognised with a continued reduction in high harm falls and incidents of pressure ulcers over 2016/17, it is of note that three Never Events were reported and the CCGs will be keen to see the progress and outcomes of the planned initiatives to implement Local Safety Standards for Invasive Procedures (LocSSIPs) and other initiatives to prevent such events occurring in the future.

Commissioners will expect UHS to make further progress in 2017/18 against the ongoing priority the Trust has set itself in improving the quality and timely discharge of all patients recognising that some of this is dependent on system partners, as well the other priorities outlined to meet the rising demand of patients presenting in mental health crisis. This includes the development of a UHS Mental Health Board to address the challenges and impact for patients and the staff looking after them. Commissioners are expecting UHSFT to continue working to improve on key performance standards for Accident and Emergency, 18 week and cancer pathways of care as well as the implementation of sustainable seven day working.

It is positive to see a summary of the Trust's identified learning and actions from both the national and locally initiated clinical audits. However the embedding and success of these identified actions may not be evident until the results of a repeat audit are published.

There is positive feedback reported from staff in the 2016 National Staff Survey which the Trust has pledged to build upon with the development of a behaviours framework and workforce plan to address recognised inequalities for black and ethnic minority staff.

Overall the Quality Account reflects both the challenges experienced by UHS over the last 12 months and highlights some of the work undertaken through their continued ambition to improve the quality of services.

The Quality Account on the whole meets the minimum national expected reporting requirements, but as suggested in 2015/16 could have been strengthened through the inclusion of patient stories.

UHS should be proud of all the initiatives undertaken during 2016/17 and its success in research, successful funding and partnerships with other local partners such at the University of Southampton.

Both Southampton City and West Hampshire CCGs support the quality priorities for 2017/18 which reflect patient and carer feedback and continue to build upon the key priorities from 2016/17 including pain management, recognising and treating sepsis and improving care for patients at the end of life.

Southampton City and West Hampshire CCGs are satisfied with the Quality Account for 2016/17 and look forward to continue working closely with the Trust over the coming year to further improve the quality of services.

Yours sincerely

**John Richards**

**Chief officer**
**Southampton CCG West Hampshire CCG**

**Heather Hauschild**

**Chief officer**
**Southampton CCG West Hampshire CCG**

# Response to the Quality Account from our lead governor on behalf of the Council of Governors

During this past year, our Trust has been under increasing pressure due to the lack of finance available from Government and also political pressures, new 'rules' which are difficult to achieve. It is my belief that those who dictate from the 'Centre' fail to consider that the NHS is run not by machines, but by human beings. Our staff have responded to the challenges that they have been given, both clinically and professionally, with outstanding success.

In a recent staff survey, the responses showed that our staff are happy and proud to be working for a Trust that has achieved so much during the past year. Our staff survey also put us in the top ten trusts in the country.

It was noted in the Governor's Quality Account from last year that, in company with members of the Trust Board, governors may visit wards within the hospital, unannounced, so that they may talk to staff and, if appropriate, patients, to gain a view of the daily pressures that are apparent in running a ward. In all cases the staff were very forthcoming in giving their views and were happy to receive us, with no feeling of being asked questions in an impromptu manner, or being 'put on the spot'. This visit to the wards is now an on-going arrangement for all governors who attend Trust Board meetings.

Each year the University, through its research and development departments, have extended an invitation to the governors, a visit to these areas and have explained, by the researchers, the projects that they are involved it at the time. This visit has become a most popular event and I am pleased that it will now be formally made an annual event.

The pressures being experienced by trusts to perform within their budgets and produce new ways to improve on savings to their costs, has been yet again a huge challenge to our Trust Board and staff. Great credit should be given to the staff in the way they have risen to the challenge and also to the Trust as a whole.

Our Trust has recorded a credible surplus for each month during 2015/16, a situation which, I believe most trusts in the country would not be able to claim. Your governors are appointed to 'hold the Trust Board to account, through the non-executive directors'.

It must be pointed out that we, at UHS, have an exceptional group of executive and non-executive directors, steered by an excellent chair and led by a chief executive officer, who rules with her heart not just her head, coupled with our staff, which is the reason for the great achievements within the hospital. The Council of Governors would also like to be associated with the priorities of care and effectiveness, outlined in the Quality Report.

From the results of a members' survey last year, it was evident to us that feelings were high with regard to the problems of parking within the hospital. The Board have taken this to heart as they realise that this is a serious problem concerning our patients and visitors. It should be noted that plans to build a multi-storey car park are underway coupled with amendments to existing parking areas which hopefully will come to fruition within the near future.

Last October gave us a new intake of governors, five representing Southampton City, one representing New Forest, Eastleigh and Test Valley and one representing the Rest of England and Wales. The Council of Governors had realised that we were not representing the members as well as we should have done. With this in mind we have strengthened our Membership and Engagement Working Party and, with a new chair and help and advice from the Trust's newly appointed membership manager are actively engaged in making arrangements to meet the existing members and members of the public to enrol them and seek their comments.

We also have other active working groups for instance Staff Engagement, Strategy and Finance and Patient Experience. All of these groups are able to call upon members of the Board to arrange presentations applicable to the respective subjects. We also in turn may pose questions to the Board on points arising from those working groups.

Over the past year, your governors have been invited to join several hospital committees, which has added another dimension of expertise within those areas. We also are involved in discussions with NHS Properties to obtain the replacement of many parking spaces at our Countess Mountbatten Hospice in West End.

Last year it was noted that the governors felt the framework in which they operated was not conducive to being able to 'hold the Trust Board to account'. With the support of our chair, Peter Hollins, it is felt that we have gone a long way to changing this situation, in so much that engagement with executive and non-executive directors is at an all-time high.

Your Council of Governors are extremely proud to be associated with University Hospital Southampton and would like to congratulate them with the way they have provided outstanding treatment and care to our patients over the past year.

**Bryan Bird**
**Lead governor**

# Response to the Quality Account from HealthWatch Southampton

HealthWatch Southampton is pleased once again to comment on the quality account of the Trust for the year. We have continued to be involved and consulted by the Trust on many issues. This year's account is well laid out and easy to read and as far as we can judge is complete and accurate with no serious omissions.

The statement from the chief executive is a very useful introduction to the account and it is good to read the statistics on staff involvement and satisfaction. On many occasions, we have been heartened to witness really strong team work and the statistics clearly reflect what we have witnessed.

The improvements made to the Piam Brown ward and the planned expansion of the Paediatric Intensive Care Unit, as well as the improvements made to other wards is welcomed. We have previously commented that we would like to have seen some commitment to improving the estates and environmental aspects of the Trust. Consequently, it is good to read the chief executive's comments that the Trust can plan continued investment in the estate. This is especially welcomed as parts of the hospital are clearly in need of investment. The completion of the new main entrance at the General Hospital has drawn many complimentary comments from the public.

Some HealthWatch members act as patient representatives on the Clinical Accreditation Scheme and these unannounced visits allow us to discuss with patients and subsequently comment on all aspect of patient care and experience; importantly, the Trust has acknowledged the importance of the patient representatives to this scheme. Similarly, we are engaged with the Clinical Quality Reviews.

We are pleased that the priority to improve end of life care continues to make progress. Naturally we are disappointed that the Trust does not appear to have improved seeking feedback from bereaved relatives and we would strongly encourage further action in this regard. We support the fact that this should remain a priority for 2017.

Similarly, whilst recognising some progress on patient discharge we agree it should remain a priority for 2017/18 with the latest inpatient survey results showing that the Trust has worsened significantly on several key questions.

It is pleasing to note that response to patient complaints has improved and that the complaints upheld by the PHSO is lower than the national average.

The commitment to safety is applauded and again our experience is backed up by the national statistics. The Trust is very open when discussing issues that could be improved. On patient safety, it is good to see a reduction in pressure ulcers and falls although it would have been good to see the target of zero avoidable high harm falls achieved. The number of 'never events' reported is an improvement on the previous year. We welcome the open and transparent approach and the desire to learn for these events.

The review of the priorities covered by clinical effectiveness covers the complex subject of clinical outcomes and standardised mortality rates. It is pleasing to see that 36 specialities successfully identified outcome measures but as the Trust did not fully achieve this priority we agree it should be continued into 2017/18. We welcome the fact that SHMI data shows a consistent quarterly performance below the benchmark and that the Trust has maintained its level three status.

Last year we were a little critical of the way some of the future year's priorities were described but this year the descriptions are clear and easily understandable. The three subheadings of 'Why we have chosen this priority'; What we are trying to achieve; What will success look like? make it easy to understand and importantly easy to monitor progress. We were particularly pleased that this year the Trust took the

opportunity to discuss the patient improvement framework (PIF) with us prior to its adoption. As chair of HealthWatch I can confirm that as well as discussing it with HealthWatch it was well debated at several committees concerned with patient experience. We support the PIF and the associated priorities for 2017/18.

Patient satisfaction with the food and food service is an ongoing issue and often a very subjective judgement. Nevertheless, we hope that the new provider will respond to patient feedback and the patient survey results will improve. We repeat our concern that despite a number of very positive initiatives to improve patient experience at mealtimes it is our experience that there is quite a variation between wards.

The participation in clinical research, and the fact that the Trust is in the first rank of UK clinical research sites, is of good news and has a wide implication for long-term improvement for treatments and patient experience.

As reported last year, a small group was established to review the experience of patients and the public with visual and auditory impairment. HealthWatch Southampton is well represented on this Group which fits very well with the requirements of the Accessible Information Standard. Progress of this group has been slow but nevertheless very positive with several recommendations due to be implemented shortly. These will greatly improve the experience of patients and visitors who have visual of hearing disability.

HealthWatch Southampton will continue to work with the Trust to ensure that the best interests of the patients are maintained. We like the Trust's stated intention 'to be better every day' and will support the Trust to achieve it.

**H F Dymond MBE**
**Chair HealthWatch Southampton**

# Response to the Quality Account from the Health Overview and Scrutiny Panel

The Southampton Health Overview and Scrutiny Panel welcomes the opportunity to comment on the University Hospital Southampton NHS Foundation Trust Quality Account for 2016/17.

The Panel were pleased to see positive progress reported against a number of priorities set for 2016/17, including the improved detection, prevention and management of acute kidney injury, reduction in falls and high harm pressure ulcers and progress with the end of life care programme. In addition the Panel were encouraged by the findings from the 2016 National Staff Survey, a clear reflection on the quality of leadership within the Trust.

Recognising workforce challenges the Panel welcomed the introduction by the Trust of a talent management programme to support staff development within the organisation and that consideration was being given to initiating an apprenticeship scheme.

The Panel commend the Trust's management of winter pressures this year, in terms of patient care, and the honest assessment within the Quality Account of performance relating to the safe and timely discharge of patients. The HOSP recognise that progress has been made and that outcomes improved for Southampton residents after Christmas 2016 but that more needs to be done, in conjunction with partners, to ensure that outcomes with regards to delayed transfer of care improve and are sustainable. It is therefore welcome that the safe and timely discharge of patients remains a priority for University Hospital Southampton in 2017/18.

Whilst the Panel recognise that Quality Accounts are required to focus on the performance of individual providers, it would be a welcome addition, given that pathways are becoming more seamless, if future reports make reference to the wider health and care systems and relationships operating in Southampton, and how the Trust are contributing to these joint priorities. Reference in particular to the Trust's contribution to the Hampshire and Isle of Wight STP, and specifically the Acute Alliance would add context and value to the report.

The Quality Account makes reference to an unannounced Care Quality Commission inspection in January 2017. The Southampton HOSP welcome the opportunity to review the feedback from the inspection and the subsequent action plan in 2017/18 and look forward to working closely with the Trust over the coming year to ensure that the quality of services continues to improve.

**Cllr Sarah Bogle**
**Chair of the Health Overview and Scrutiny Panel Southampton City Council**

# Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

1. board minutes and papers for the period April 2016 to May 2017
2. papers relating to quality reported to the board over the period April 2016 to March 2017
3. feedback from commissioners dated 8th May 2017
4. feedback from governors dated 3rd April 2017
5. feedback from local HealthWatch organisations dated 1st May 2017
6. feedback from Overview and Scrutiny Committee dated 27th April 2017
7. the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21st June 2016
8. the national patient survey June 2016
9. the national staff survey March 2017
10. the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2017

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

**Date** **Date**

**Chair** **Chief executive**

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPTIAL SOUTHAMPTON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of University Hospital Southampton NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospital Southampton NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

We refer to these national priority indicators collectively as the 'indicators'.

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2016/17 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 8 May 2017;
- feedback from governors, dated 3 April 2017;
- feedback from local Healthwatch organisations, dated 1 May 2017;
- feedback from Overview and Scrutiny Committee, dated 27 April 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated May 2015;
- the latest national staff survey, dated May 2015;
- Care Quality Commission Inspection, dated December 2014;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated 15 May 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospital Southampton NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospital Southampton NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

## Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by University Hospital Southampton NHS Foundation Trust.

## Basis for qualified conclusion

As a result of the procedures performed in relation to the referral to treatment within 18 weeks for patients on incomplete pathways indicator, we have not been able to gain assurance over the six dimensions of data quality as required by NHS Improvements, with issues identified in relation to the operating effectiveness of the control environment.

## Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from admission to admission, transfer or discharge) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

**KPMG LLP**
**Chartered Accountants**
**15 Canada Square**
**Canary Wharf**
**London E14 5GL**

**May 2017**

# APPENDIX

# Appendix one: Patient Improvement Framework 2017/18

The PIF is a tool to engage and communicate with staff and patients about transformation projects to improve care planned for 2017/18. The priorities have been chosen to reflect areas that are important to our patients and staff that need transformational change and enhanced focus to realise improvements by year end.

- The PIF is not designed to replicate the detail in the Trust strategy and annual plan or cover all of the key performance indicators and work streams for quality.
- The safety strategy, patient experience strategy and the clinical strategy contain detail on the plans and processes to maintain and improve quality for patients at UHS.
- It forms part of the annual quality account where each year we report on progress against last year's priorities and set priorities for the following year

**"Our mission is to be better every day" – Fiona Dalton, chief executive**

**Patient experience**

- Improving patients, experience of discharge from hospital
- Meeting patients, nutritional and hydration needs
- Improving care for vulnerable people

**Patient safety**

- Recognition and management of the deteriorating patient
- Safer invasive procedures
- Recognising and treating sepsis

**Patient outcomes**

- Report outcome measures in every specialty across the hospital
- Reduce the impact of immobilisation on the frail elderly
- Improve care for patients at end of life.

| | |
|---|---|
| **Our values** | Patients first, working together and always improving |
| **Our strategies** | Clinical, Clinical Effectiveness, Patient Safety, Patient Experience, Research, Education and Training, Equality and Diversity, Workforce |
| **Our assurance** | Clinical accreditation, internal quality reviews, KPI monitoring, audit |

# Appendix two: Definitions of pressure ulcer grading

## International NPUAP / EPUAP Pressure Ulcer Classification System (2009)

**Grade one: Non-blanchable erythema**
Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category one may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' persons.

**Grade two: Partial thickness**
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation. *Bruising indicates deep tissue injury.

**Grade three: Full thickness skin loss**
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a category/stage three pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

**Grade four: Full thickness tissue loss**
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling. The depth of a category/stage four pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/stage four ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

# Appendix three: Quality performance data

We have chosen to measure our performance against the following metrics:

| Patient safety indicators | | | | | |
|---|---|---|---|---|---|
| | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2016/17 benchmark** |
| Serious Incidents Requiring Investigation (SIRI) | 195 | 35 | 54 | 63 | 25 for whole year |
| Never Events | 2 | 2 | 7 | 3 | 0 |
| Healthcare Associated Infection<br>MRSA bacteraemia reduction | 5 | 5 | 3 | 1 | 0 |
| Healthcare Associated Infection Census"<br>(as average of monthly %) | 354% | 357% | 363% | 361% | 100% |
| Healthcare Associated Infection<br>Clostridium difficile reduction | 33 | 37 | 35 | 38 | <=3 a month. 43 for whole year |
| Avoidable Hospital<br>Acquired 33* Grade III and IV Pressure Ulcers | 42 | 26 | 36 | 11 | 30 for whole year |
| Falls - Avoidable Falls | 19 | 9 | 3 | 0 | 1 a month. 12 for whole year |
| Falls Assessment tool (timeframe of completed within 6 hours commenced in 2015)<br>Compliance (as average of monthly %) | 95% | 95.70% | 71% | 90.42% | >95% |
| Thromboprophylaxis (VTE)<br>% Patients Assessed (CQUIN) | 95.41% | 95.35% | 95.18% | 94.87% | >=95% |
| Thromboprophylaxis (VTE)<br>Pharmacological prophylaxis (as average of monthly %) | 97.32% | 99.46% | 97.75% | 95.19% | >=95% |

| Patient experience indicators | | | | | |
|---|---|---|---|---|---|
| | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2016/17 benchmark** |
| **National Friends & Family Test Response Rate** | | | | | |
| UHS | | 27.90% | | | |
| Emergency Department | | 37.94% | 10.76% | 6.21% | >10% |
| Inpatients | | 25.15% | 21.74% | 20.28% | >20% |
| Maternity | 21.70% | | 23.38% | 29.07% | >20% |
| **Percentage of patients recommending UHS to their friends & family** | | | | | |
| UHS | | | | | |
| Emergency Department | | | 92.26% | 95.42% | >90% |
| Inpatients | | | 96.16% | 96.68% | >90% |
| Maternity | | | 95.81% | 97.66% | >90% |
| Monthly Real Time Survey - Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (those who gave an answer, as average of monthly %) | 13% | 13.47% | 13% | 11.34% | <=15% |
| Same Sex Accommodation (Non clinically justified breaches) | 16 | 10 | 5 | 3 | 0 |
| Nutrition % of patients with Nutritional screening in 24hrs (as average of monthly %) | 89.10% | 89% | 82% | 80.47% | >=95% |

| Patient outcome indicators | | | | | |
|---|---|---|---|---|---|
| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2016/17 benchmark |
| Emergency readmissions, within 28 days (as average of monthly %) | 10.70% | 10.40% | 10.10% | 10.59% | <=10% |
| Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust | 108.84 | 105.19 | 102.5 | 101.47 (Apr-Dec) | 100 |
| Hospital Standardised Mortality Rate ( HSMR) Southampton General Hospital | 102.53 | 97.64 | 93.63 | 93.14 (Apr-Dec) | <90.1 |
| Hospital Mortality Rate (%) | 1.83 | 1.76 | 1.63 | 1.63 (Apr-Dec) | 1.61 |
| Patient Reportedc outcome measures. PROMS hip replacement data contributed | 68.4% | 74.1% | 86.7% | 74.0% | >=50% |
| Knee replacemnet data contributed | 107.0% | 105.9% | 103.9% | 104.4% | >=50% |

## Readmission data from https://indicators.hscic.gov.uk/webview/ has not been updated since the last Quality Account

Q4 201617 is only Jan-Feb as March's data has yet to be submitted to DoH nationally.

## Friends and Family Test

| RHM | RESPONSE RATE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Emergency department** | | | | | | | | | | |
| | Q1 201516 | Q2 201516 | Q3 201516 | Q4 201516 | Q1 201617 | Q2 201617 | Q3 201617 | Q4 201617 | 201516 | 201617 |
| UHS | 19.60% | 14.30% | 8.94% | 4.81% | 5.23% | 9.52% | 6.02% | 4.39% | 11.96% | 6.53% |
| National Average | 21.15% | 14.55% | 13.05% | 12.72% | 12.99% | 13.19% | 12.18% | 12.45% | 14.90% | 12.73% |
| Highest Trust | 100.00% | 45.12% | 44.57% | 47.22% | 44.43% | 45.31% | 45.03% | 45.46% | 100.00% | 45.46% |
| Lowest Trust | 0.03% | 0.18% | 0.02% | 0.19% | 0.07% | 0.00% | 0.23% | 0.46% | 0.02% | 0.00% |
| **Inpatient and daycase** | | | | | | | | | | |
| | Q1 201516 | Q2 201516 | Q3 201516 | Q4 201516 | Q1 201617 | Q2 201617 | Q3 201617 | Q4 201617 | 201516 | 201617 |
| UHS | 22.66% | 20.64% | 21.22% | 22.54% | 20.79% | 19.11% | 19.87% | 17.30% | 21.74% | 19.44% |
| National Average | 20.51% | 26.08% | 24.43% | 24.43% | 25.77% | 25.12% | 24.26% | 24.32% | 23.87% | 24.92% |
| Highest Trust | 100.00% | 100.00% | 125.00% | 100.00% | 100.00% | 100.00% | 96.67% | 100.00% | 125.00% | 100.00% |
| Lowest Trust | 0.06% | 4.16% | 4.66% | 4.56% | 4.75% | 3.27% | 1.70% | 3.83% | 0.06% | 1.70% |

| RHM | POSITIVE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **A&E** | | | | | | | | | | |
| | **Q1 201516** | **Q2 201516** | **Q3 201516** | **Q4 201516** | **Q1 201617** | **Q2 201617** | **Q3 201617** | **Q4 201617** | **201516** | **201617** |
| UHS | 94.53% | 92.27% | 94.04% | 93.73% | 93.79% | 96.34% | 94.82% | 96.17% | 93.74% | 95.38% |
| National Average | 90.82% | 88.14% | 87.07% | 84.91% | 85.95% | 86.01% | 86.04% | 87.02% | 87.74% | 86.16% |
| Highest Trust | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Lowest Trust | 58.25% | 62.42% | 33.33% | 46.33% | 42.75% | 44.75% | 48.16% | 45.49% | 33.33% | 42.75% |
| **Inpatient and daycase** | | | | | | | | | | |
| | **Q1 201516** | **Q2 201516** | **Q3 201516** | **Q4 201516** | **Q1 201617** | **Q2 201617** | **Q3 201617** | **Q4 201617** | **201516** | **201617** |
| UHS | 95.81% | 83.04% | 96.10% | 96.48% | 96.35% | 96.23% | 97.19% | 96.83% | 92.92% | 96.63% |
| National Average | 92.61% | 95.71% | 95.61% | 95.70% | 95.79% | 95.60% | 95.54% | 95.75% | 95.11% | 95.66% |
| Highest Trust | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Lowest Trust | 61.40% | 74.44% | 71.68% | 72.00% | 67.97% | 66.86% | 75.34% | 75.55% | 61.40% | 66.86% |

| RHM | NEGATIVE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **A&E** | | | | | | | | | | |
| | **Q1 201516** | **Q2 201516** | **Q3 201516** | **Q4 201516** | **Q1 201617** | **Q2 201617** | **Q3 201617** | **Q4 201617** | **201516** | **201617** |
| UHS | 2.10% | 2.72% | 3.12% | 2.95% | 3.03% | 1.89% | 2.49% | 1.59% | 2.54% | 2.26% |
| National Average | 4.15% | 6.09% | 6.89% | 8.37% | 7.62% | 7.61% | 7.63% | 7.01% | 6.37% | 7.52% |
| Highest Trust | 29.13% | 26.11% | 34.78% | 37.23% | 37.69% | 33.31% | 41.03% | 32.28% | 37.23% | 41.03% |
| Lowest Trust | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| **Inpatient and daycase** | | | | | | | | | | |
| | **Q1 201516** | **Q2 201516** | **Q3 201516** | **Q4 201516** | **Q1 201617** | **Q2 201617** | **Q3 201617** | **Q4 201617** | **201516** | **201617** |
| UHS | 1.33% | 0.88% | 1.41% | 1.07% | 1.08% | 1.23% | 0.75% | 0.79% | 1.18% | 0.98% |
| National Average | 3.30% | 1.43% | 1.48% | 1.47% | 1.44% | 1.56% | 1.53% | 1.51% | 1.80% | 1.51% |
| Highest Trust | 21.05% | 9.34% | 10.00% | 11.11% | 10.55% | 13.01% | 8.59% | 9.54% | 21.05% | 13.01% |
| Lowest Trust | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |

## Cdiff per 100,000 bed days

| | **Q1 201516** | **Q2 201516** | **Q3 201516** | **Q4 201516** | **201516** | **201617** |
|---|---|---|---|---|---|---|
| UHS | 9.74 | 11.82 | 9 | 11.3 | 18.9 | 25.8 |
| National Average | 14.91 | 15.04 | 14.7 | 17.3 | 22.2 | 29.7 |
| Highest Trust Score | 66 | 62.57 | 37.1 | 30.8 | 58.2 | 71.2 |
| Lowest Trust Score | 0 | 0 | 0 | 0 | 0 | 0 |
| Lowest Trust Score (non-zero) | 1.1 | 2.8 | 1.2 | 1.2 | 1.2 | 2.6 |

## Patient safety incidents

| | Oct-13 to Mar-14 | | | Apr-14 to Sep-14 | | |
|---|---|---|---|---|---|---|
| | **Rates per 1000 admissions** | **Severe and death** | **Severe and death %** | **Rates per 1000 admissions** | **Severe and death** | **Severe and death %** |
| UHS | 8.35 | 33 | 0.61% | 32.3 | 57 | 0.85% |
| National Ave (Acute Teaching Trusts) | 7.94 | 29 | 0.51% | 33.29 | 20 | 0.52% |
| Highest Trust Score (Acute teaching trusts) | 12.84 | 46 | 0.88% | 74.96 | 97 | 3.05% |
| Lowest Trust Score (Acute teaching trusts) | 4.87 | 1 | 0.03% | 0.24 | 0 | 0.00% |

| | April-15 to Sept-15 | | | Oct-14 to Mar-15 | | |
|---|---|---|---|---|---|---|
| | **Rates per 1000 admissions** | **Severe and death** | **Severe and death %** | **Rates per 1000 admissions** | **Severe and death** | **Severe and death %** |
| UHS | 31.5 | 54 | 0.91% | 35.41 | 61 | 0.90% |
| National Ave (Acute Teaching Trusts) | 39.3 | 20 | 0.43% | 37.15 | 23 | 0.58% |
| Highest Trust Score (Acute teaching trusts) | 74.67 | 89 | 2.92% | 82.21 | 128 | 5.19% |
| Lowest Trust Score (Acute teaching trusts) | 18.07 | 2 | 0.07% | 3.57 | 2 | 0.05% |

| | Apr-14 to Sep-14 | | |
|---|---|---|---|
| | **Rates Per 1000 bed days** | **Severe and death** | **Severe and death %** |
| UHS | 44.46 | 54 | 0.60% |
| National Ave (Acute Teaching Trusts) | 40.02 | 19 | 0.40% |
| Highest Trust Score (Acute teaching trusts) | 71.81 (Northern Devon) | 1 (Royal Devon & Exeter) | 0.02% |
| Lowest Trust Score (Acute teaching trusts) | 21.15 (Luton & Dunstable) | 98 (Pennine) | 1.38% |

NB: UHS is part of the Acute (Non Specialist) cluster now (1 of 136 organisations) – the Acute Teaching Trusts cluster ended in 2014 when the NRLS had an internal reconfiguration of how they benchmark organisations.

## VTE

| | Q1 2014/15 | Q2 2014/15 | Q3 2014/15 | Q4 2014/15 | Q1 2015/16 | Q2 2015/16 | Q3 2015/16 | Q4 2015/16 |
|---|---|---|---|---|---|---|---|---|
| UHS | 95.60% | 95.10% | 95.23% | 95.38% | 95.10% | 95.30% | 95.14% | 95.17% |
| National Ave (Acute Providers) | 96.40% | 96.50% | 96.34% | 96.30% | 96.30% | 96.20% | 95.51% | 95.45% |
| Highest Trust Score) (Acute Providers | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |
| Lowest Trust Score (Acute Providers) | 87.20% | 90.50% | 81.91% | 79.23% | 86.10% | 75.00% | 78.52% | 78.06% |

| | Q1 2016/17 | Q2 2016/17 | Q3 2016/17 |
|---|---|---|---|
| UHS | 95.04% | 95.12% | 94.61% |
| National Ave (Acute Providers) | 95.64% | 95.45% | 95.57% |
| Highest Trust Score (Acute Providers) | 100.00% | 100.00% | 100.00% |
| Lowest Trust Score (Acute Providers) | 80.61% | 72.14% | 76.48% |

## SHMI

| | January 15 - December 15 | | April 15 - March 16 | | July 15 - June 16 | | October 15 - September 16 | |
|---|---|---|---|---|---|---|---|---|
| | Value | OD Banding | Value | OD Banding | Value | OD Banding | Value | OD Banding |
| UHS | 0.95 | 2 | 0.96 | 2 | 0.96 | 2 | 0.95 | 2 |
| National Ave | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 |
| Highest Trust Score | 1.17 | 1 | 1.18 | 1 | 1.17 | 1 | 1.16 | 1 |
| Lowest Trust Score | 0.67 | 3 | 0.68 | 3 | 0.69 | 3 | 0.78 | 3 |

## Palliative care indicator

The percentage of patient deaths with palliative care coded at either diagnosis or specialty level

| | January 15 - December 15 | April 15 - March 16 | July 15 - June 16 | October 15 - September 16 |
|---|---|---|---|---|
| UHS | 44.3 | 42.6 | 42.2 | 43.2 |
| National Ave | 27.6 | 28.5 | 29.2 | 29.8 |
| Highest Trust Score | 54.8 | 54.6 | 54.8 | 56.3 |
| Lowest Trust Score | 0.2 | 0.6 | 0.6 | 0.4 |

The percentage of patient admitted with palliative care coded at either diagnosis or specialty level

| | January 15 - December 15 | April 15 - March 16 | July 15 - June 16 | October 15 - September 16 |
|---|---|---|---|---|
| UHS | 2.35 | 2.15 | 2.19 | 2.29 |
| National Ave | 1.45 | 1.48 | 1.51 | 1.54 |
| Highest Trust Score | 3.46 | 3.28 | 3.61 | 3.67 |
| Lowest Trust Score | 0.49 | 0.01 | 0.01 | 0.01 |

## Hip replacement surgery

| | 2016/17 Q2* |
|---|---|
| UHS | 19.09 |
| National Ave (Acute Providers) | 22.02 |
| Highest Trust Score (Acute Providers) | 25.20 |
| Lowest Trust Score (Acute Providers) | 18.04 |

## Knee replacement surgery

| | 2016/17 Q2* |
|---|---|
| UHS | Too few modelled records (<30) for NHSD to provide a health gain. |
| National Ave (Acute Providers) | 16.88 |
| Highest Trust Score (Acute Providers) | 21.35 |
| Lowest Trust Score (Acute Providers) | 12.65 |

Groin hernia surgery and varicose vein surgery: in the past neither hernia repair or varicose vein surgery were reported on in the Quality Account because of the low numbers being performed not being statistically significant. This was confirmed by checking the registries via NHS Digital for hernia and varicose vein surgery for 2016/17 and there were only small numbers for hernia repair and no data available for varicose vein.

## MRSA screening

| 2016/17 | Q1 16/17 | Q2 16/17 | Q3 16/17 | Q4 16/17 | |
|---|---|---|---|---|---|
| Eligible patients | 15493 | 14731 | 13948 | 17172 | 61344 |
| Screened for MRSA | 57541 | 49099 | 56023 | 58772 | 221435 |
| % achieved | 371.40% | 333.30% | 401.66% | 342.25% | 360.97% |

| 2015/16 | Q1 15/16 | Q2 15/16 | Q3 15/16 | Q4 15/16 | |
|---|---|---|---|---|---|
| Eligible patients | 14943 | 15594 | 15402 | 16270 | 62209 |
| Screened for MRSA | 55759 | 55507 | 56575 | 57688 | 225529 |
| % achieved | 373.14% | 355.95% | 367.32% | 354.57% | 362.53% |

# Appendix four: CQUIN data

| Clinical | CQUIN Scheme | CQUIN Target | National or Local Scheme | Financial Reward for Achieving Scheme |
|---|---|---|---|---|
| CCGs | Sepsis 2a | Screening all patients for sepsis screening is appropriate who arrive through the Emergency Department/ or by direct admission to any other unit | National | £335,000 |
| CCGs | Sepsis 2b | Initiate intravenous antibiotics within one hour of presentation, for those patients who have suspected severe sepsis, Red Flag or septic shock | National | £335,000 |
| CCGs | Staff health and wellbeing - staffing | Introduction of health and wellbeing initiatives covering physical activities, mental health and improving access to physio for people with MSK issues | National | £669,000 |
| CCGs | Staff health and wellbeing – healthy food | Achieve a step change in the health of food offered on the premises and submit national data based on existing contracts with food and drink suppliers | National | £669,000 |
| CCGs | Staff health and wellbeing – flu vaccine | Achieve a 75% uptake on the flu vaccine for frontline clinical staff | National | £669,000 |
| CCGs | Antimicrobial Stewardship 4a | Reduction in antibiotic consumption per 1,000 admissions | National | £536,000 |
| CCGs | Antimicrobial Stewardship 4b | Empiric review of antibiotic prescription | National | £134,000 |
| CCG's | All National CQUINs | All other local CCG's collaborative CQUIN funding split across all National CQUINS | National | £412,000 |
| SCCCG | Outpatient Follow Up | Review current practice of routine face to face follow ups with aim to stop routine face to face follow ups and commence patient initiated follow up | Local | £373,000 |
| SCCCG | Choose and Book | Deliver directly-bookable services to all patients referred from GP and community services | Local | £373,000 |
| SCCCG | Frequent Attendees | Working with community partners, reduce the number of frequent attendances at ED and frequent admissions | Local | £373,000 |
| SCCCG | Cancer 62 day pathway | In depth review of all long waiters >104 days including an RCA and a clinical harm review | Local | £373,000 |
| WHCCG | Non Elective Excess Bed days | A reduction in non elective excess bed days. Improved discharge planning, reduction in length of stay and improved quality care | Local | £720,000 |
| WHCCG | Ambulatory Emergency Care | Focus on developing, implementation and strengthening of AEC protocols to deliver care outside traditional bed based hospital setting resulting in enhanced patient experience and outcomes | Local | £720,000 |
| NHSE | Intravenous Immunoglobulin Panel (IVIg) | Implementation and management of a regional clinical IVIg panel set up by the regional centre and involving the local District General Hospitals. | Local | £535,000 |
| NHSE | Intravenous Immunoglobulin Panel Database | Database of IVIG data | Local | £535,000 |
| NHSE | CF Adherence | Randomised pilot trial providing services for Cystic Fibrosis patients | Local | £162,000 |
| NHSE | Optimal Device | Maintenance and improvement in optimisation of device usage during the year of transition to a centralised national procurement and supply chain | Local | £351,000 |
| NHSE | SACT | Dose banding principles using local and national dose banding tables | Local | £128,000 |

| Clinical | CQUIN Scheme | CQUIN Target | National or Local Scheme | Financial Reward for Achieving Scheme |
|---|---|---|---|---|
| NHSE | Rheumatic MDT | Development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases and to ensure data collection and compliance with existing NHSE commissioning policies | Local | £166,000 |
| NHSE | Audit of clinical intervention rates | Participate in required clinical interventions requested by NHSE | Local | £459,000 |
| NHSE | Adult Critical Care | Baseline and thematic review of delayed discharges over 24 hours from GICU | Local | £351,000 |
| NHSE | Dental | Data reporting standards – Identification of secondary dental activity within commissioning data sets | Local | £13,000 |
| NHSE | Dental | To support local clinical commissioning for dental services | Local | £37,000 |
| NHSE | Hep C Network | Infrastructure governance and partnership working across the healthcare providers | Local | £3,815,000 |
| NHSE | Public Health | No specific CQUIN so funds spread across other NHSE CQUINs | Local | £125,000 |
| | | | Total | £13,366,000 |

# Appendix five: Clinical audit and confidential enquiries data

| | Total number of NCAs UHS were eligible to participate in (n=60) | Eligible (58) | Participated (55 = 98%) | % actual cases submitted / expected submissions |
|---|---|---|---|---|
| 1 | Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | ✓ | ✓ | Continuous |
| 2 | Adult Asthma (BTS) | ✓ | × | N/A |
| 3 | BAUS Nephrectomy Audit | ✓ | ✓ | In progress |
| 4 | BAUS Percutaneous Nephrolithotomy | ✓ | ✓ | In progress |
| 5 | BAUS Prostatectomy Audit | ✓ | ✓ | In progress |
| 6 | BAUS Stress Urinary Incontinence Audit | ✓ | ✓ | In progress |
| 7 | Bowel cancer (NBOCAP) | ✓ | ✓ | 100% |
| 8 | Cardiac Rhythm Management (CRM) | ✓ | ✓ | Continuous |
| 9 | Case Mix Programme (CMP) | ✓ | ✓ | 1212 Cases (every GICU admission) |
| 10 | Child health clinical outcome review programme (NCEPOD) Neurodisability and Mental health in 0-25 years old | ✓ | ✓ | 100% |
| 11 | College of Emergency Medicine (CEM)- Asthma (paediatric and adult) care in emergency department | ✓ | ✓ | 100% |
| 12 | College of Emergency Medicine (CEM)- severe sepsis and septic shock | ✓ | ✓ | 100% |
| 13 | College of Emergency Medicine (CEM)- Consultant sign-off | ✓ | ✓ | 100% |
| 14 | Congenital Heart Disease (Paediatric cardiac surgery) (CHD) | ✓ | ✓ | In progress |
| 15 | Coronary Angioplasty (NICOR) | ✓ | ✓ | 100% |
| 16 | Diabetes Footcare | ✓ | × | N/A |
| 17 | Diabetes in pregnancy (NPID) | ✓ | ✓ | 62 cases |
| 18 | Diabetes Diabetes Transition | ✓ | ✓ | 100% |
| 19 | Diabetes Inpatient Audit (NADIA) | ✓ | ✓ | 100% |
| 20 | Diabetes (Paediatric) RCPCH NPDA | ✓ | ✓ | 100% |
| 21 | Elective surgery (National PROMs Programme) hips and knees<br>Hip participation rate:<br><br>Knee participation rate: | ✓ | ✓ | Yes, continuous<br><br>86.7%<br><br>103.9% |
| 22 | Endocrine and Thyroid National audit | ✓ | ✓ | TBC |
| 23 | Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database | ✓ | ✓ | Continuous |
| 24 | Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database | ✓ | ✓ | Continuous |
| 25 | Falls and Fragility Fractures Audit Programme (FFFAP) national inpatient falls | ✓ | ✓ | In progress |
| 26 | Head and Neck Cancer Audit | ✓ | ✓ | In progress |
| 27 | Inflammatory Bowel Disease (IBD) programme - Biological therapies adult and paeds | ✓ | ✓ | In progress |
| 28 | Learning Disability Mortality Review Programme (LeDeR) | ✓ | ✓ | 15 cases |
| 29 | Lung cancer (NLCA) (LUCADA ) | ✓ | ✓ | Continuous |

| | Total number of NCAs UHS were eligible to participate in (n=60) | Eligible (58) | Participated (55 = 98%) | % actual cases submitted / expected submissions |
|---|---|---|---|---|
| 30 | Major Trauma: The Trauma Audit & Research Network (TARN) | ✓ | ✓ | 100% |
| 31 | Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality | ✓ | ✓ | 100% |
| 32 | Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Mortality | ✓ | ✓ | 100% |
| 33 | Medical and Surgical Clinical Outcome review programme NCEPOD – NIV | ✓ | ✓ | 100% |
| 34 | Medical and Surgical Clinical Outcome review programme NCEPOD –Acute pancreatitis | ✓ | ✓ | 100% |
| 35 | Medical and Surgical Clinical Outcome review programme NCEPOD – Mental health Adults | ✓ | ✓ | 100% |
| 36 | National Adult Cardiac Surgery Audit | ✓ | ✓ | In progress |
| 37 | National Audit of Dementia | ✓ | ✓ | 100% |
| 38 | National Cardiac Arrest Audit (NCAA) | ✓ | ✓ | 118 Team visits which met NCAA scope |
| 39 | National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Workstream | ✓ | ✓ | In progress |
| 40 | National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit | ✓ | ✓ | In progress |
| 41 | National Comparative Audit of blood Transfusion- 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT) | ✓ | ✓ | 29 cases |
| 42 | 2016 Audit of Red Cell and Platelet Transfusion in Haematology (NCABT) | ✓ | ✓ | 40 cases |
| 43 | National Emergency Laparotomy Audit (NELA) | ✓ | ✓ | In progress |
| 44 | National Heart Failure Audit | ✓ | ✓ | In progress |
| 45 | National Joint Registry (NJR) | ✓ | ✓ | 95% |
| 46 | National Ophthalmology Audit | ✓ | ✓ | In progress |
| 47 | National Prostate Cancer Audit (NPCA) (2nd year) | ✓ | ✓ | 100% |
| 48 | National Vascular Registry (NVR) | ✓ | ✓ | In progress |
| 49 | Neonatal Intensive and Special Care (NNAP) | ✓ | ✓ | 737 |
| 50 | Neurosurgical National Audit programme | ✓ | ✓ | 6,617 admissions |
| 51 | Oesophago-gastric cancer (NAOGC) (NOGGA ) | ✓ | ✓ | In progress |
| 52 | Paediatric Intensive Care Audit Network (PICANet) | ✓ | ✓ | In progress |
| 53 | Paediatric Pneumonia | ✓ | ✓ | In progress |
| 54 | Renal replacement therapy (Renal Registry) | ✓ | ✓ | 100% |
| 55 | Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit | ✓ | ✓ | 207 expected every quarter |
| 56 | Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit | ✓ | ✓ | 100% |
| 57 | UK Cystic Fibrosis Registry (Adults and Paeds) | ✓ | ✓ | 100% |

## National Clinical Audit: actions to improve quality

| National audit title | Actions |
|---|---|
| 1. Diabetes Inpatient Audit (NADIA) | • Nursing staff to have twice annual link nurse meetings and diabetes study days.<br>• Bespoke ward/department based teaching to be further arranged as necessary.<br>• Doctors to have regular diabetes education slots and lunchtime departmental teaching as required.<br>• HCP's and undergraduates education sessions to be provided upon request.<br>• Update the diabetes guide and make available on StaffNet.<br>• DiAppBetes (smartphone application to support HCPs for diabetes care) being updated.<br>• Inpatient diabetes E-learning tool to be made available on VLE.<br>• Divisional Education Leads to support areas that need diabetes updates.<br>• Push for increased foot clinic support for patients from West Hampshire. |
| 2. 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients | • To reduce transfusion of platelets from two to one unit in outpatients.<br>• Re-audit in Autumn 2017 looking at intervals between transfusions in Haematology outpatients. |
| 3. Rheumatoid and Early Inflammatory Arthritis | • Quality Standard (QS) 1 & 2 - Improvements to GP education to be made to increase awareness of early inflammatory arthritis (EIA) and to encourage rapid referral of patients suspected of having an EIA directly to the Consultant or via urgent referral through the Choose and Book service.<br>• Looking to introduce an electronic referral form to support the current Choose and Book process.<br>• QS3 - A Consultant-led service to be introduced.<br>• QS4 and S5 - To introduce a formal personalised patient education portfolio with information about their condition, treatment, monitoring requirements and advice line information. |
| 4. National Comparative Audit of Blood Transfusion (NCABT) 2015 Audit of Lower GI Bleeding and the use of blood | • Audit outcomes to be discussed at Surgery care group audit meeting and circulated to clinicians. |
| 5. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal mortality | • Active program is ongoing, which mirrors National initiatives to reduce stillbirth numbers.<br>• Revise guidelines for monitoring fetal growth.<br>• Planned revision of patient information on the importance of reduced fetal movements.<br>• On-going internal review of all perinatal mortality with a view to learning lessons. |
| 6. Elective surgery (National PROMs Programme) - Hips and knees | • An audit of patients reporting worse condition-specific health post-operatively is complete and a report will be circulated once it has been signed off by the lead clinician.<br>• PROMs health gains have been used to produce a patient handout for hip replacements and to highlight areas where post-operative rehabilitation could be changed. This document is now live on the UHS website.<br>• Work with the MSK physiotherapy department to develop targeted occupational therapy.<br>• Further analysis to be carried out. |
| 7. UK Cystic Fibrosis Registry (Adults and Paeds) | • To increase social worker time.<br>• Develop a strategy to address nutritional outcomes in our patients. |
| 8. Coronary Angioplasty (NICOR) | • To continue to perform at same level of care. |
| 9. Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit | • On-going work within the trust to work on CT time within one hour for all strokes admitted. |
| 10. National Joint Registry (NJR) | • A monthly report to ensure all relevant hip and knee replacements are entered onto the NJR. This was instituted in October 2015 and has decreased the number of missing records in the 2015/16 data quality audit.<br>• NJR consent forms are being sent with pre-assessment appointment letters which has help boost the percentage of patients consenting to their data being held on the NJR from 71% in 2013/14 to 95% in 2016/17 to date.<br>• The orthopaedic department are engaged in an ongoing process of validation and implication of individual consultant level data.<br>• Other contributing factors are being identified and addressed. |

| National audit title | Actions |
|---|---|
| 11. Bowel cancer (NBOCAP) | • Improved completeness of submission data |
| 12. National Vascular Registry (NVR) | • Vascular centralisation with Portsmouth Unit moving to Southampton. |
| 13. College of Emergency Medicine (CEM) – procedural sedation | • Development of pre sedation checklist<br>• Development of pre discharge checklist |
| 14. Diabetes (Paediatric) PNDA | • Reviewed and amended team agreed blood glucose targets for patients at team away day on 7th June 2016<br>• Reviewed & amended team agreed HbA1c targets for patients at team away day on 7th June 2016 |
| 15. Medical and Surgical Clinical Outcome review programme NCEPOD – Acute pancreatitis | • To revise the Gall bladder surgery pathway.<br>• To discuss complex pancreatitis cases in an MDT meeting. |
| 16. National Prostate Cancer Audit (NPCA) (2nd year) | • Improvement of data completion for certain fields expected in future years following improved import processes from HICCS. |

## Local Clinical Audit: actions to improve quality

| Audit title | Actions |
|---|---|
| 1. Assessment and prevention of delirium in people with hip fracture | • Education and awareness about the 4AT poster which is to be placed on ward.<br>• Education session for FY1 and SHO doctors working in T&O to include 4AT and audit findings. |
| 2. Six monthly completion of Real-Ear-to-Coupler Difference (RECD) measurements on all permanent childhood hearing Impairment (PCHI) children <5 years | • Staff to continue to ensure RECD measurements are performed at each hearing aid review appointment.<br>• To try to ensure appointments are booked no more than 6 months apart.<br>• If RECD measurements cannot or are not performed the reason for this needs to be documented. |
| 3. Diagnosis and management of clinically isolated syndromes that have a high risk of conversion to multiple sclerosis | • Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a referral to the multiple sclerosis disease-modifying drug clinic or MDT.<br>• Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a follow-up MRI scan after 3-6 months.<br>• Present the results at our regional neurology meeting.<br>• Share results via a group email.<br>• Ensure all MS specialists in the region are in agreement with these recommendations. |
| 4. Drink thickening practices against the process agreed by the Nursing and Midwifery Group (NMG), and the Oropharyngeal Dysphagia Policy. | • Supply/replacement process for the new generic above bed sign to be circulated within the Trust<br>• A crib sheet on how to use bed signs to be produced and circulated.<br>• Bed signage to be covered in all relevant SLT/N&D training.<br>• A rolling ward training programme on how to mix thickened drinks and to follow SLT recommendations will be rolled out.<br>• Rigorous incident reporting of incorrect recommendations to be completed.<br>• Training and process for diet grid sign off by Nurse in Charge to be revisited.<br>• Matrons to support wards on the agreed drink round process.<br>• Matrons to support wards on agreed process for water jug thickening.<br>• Matrons to support wards on following the NPSA alert that tins of thickener must not be left on patient's tables without a risk assessment being carried out.<br>• SLT to provide bespoke ward/staff training when needed. |
| 5. Use of delirium diagnostic tool in elderly care | • To ensure the recommended tool for assessing patients with delirium is available to staff on the relevant wards. |
| 6. Management of diabetic ketoacidosis in adults at UHS | • Nursing and medical staff on AMU will be educated about the need for hourly observations on patients admitted with DKA.<br>• To amend the DKA chart to carry a check box for foot examination.<br>• All patients presenting with DKA and ph<6.9 on a blood gas will be referred to ITU.<br>• Diabetes team will have a new checklist indicating ketone/sick day advice as well as post-discharge follow up. |

| Audit title | Actions |
|---|---|
| 7. Epilepsy surgery: outcomes and complications | • To make alterations in surgical technique to reduce morbidity from temporal lobe resections.<br>• To have less prolonged gaps between operations.<br>• To send notification of adverse outcomes directly to neurosurgical management team.<br>• To have a rapid review of post-operative outcomes to discuss complications more quickly.<br>• A formal re-audit to be completed in 12-18 months. |
| 8. Management of anaphylaxis in paediatric patients presenting to PAU and ED | • To introduce a discharge proforma. |
| 9. An audit of domperidone prescribing in children | • Educate prescribers on the importance of ECG monitoring with domperidone.<br>• Speak to prescribers/consultants and try to come to a solution on length of time medication is taken for. |
| 10. Emergency diabetic eye screening referrals to eye casualty | • New telephone answering service to be installed.<br>• Protocol for referring patients to eye casualty has been redesigned to include faxing of why being referred.<br>• Two-part referral to be amalgamated into one.<br>• Staff to be trained on the new Optimise computer system to be able to view retinal screening images.<br>• Access to the Optimise computer system to be given to staff once trained. |
| 11. Ongoing pain management in the major trauma patient | • Teaching and education on pain scoring in ED to be performed in cooperation with the Acute Pain Team.<br>• Teaching and education on at rest and movement pain scoring performed in cooperation with the Acute Pain Team.<br>• Discussion with Metavision Team re: implementation of rest/movement pain score to be added in the electronic observation chart.<br>• Introduction of regular analgesics and laxatives in the analgesia bundle; teaching and education of the ward staff including T&O doctors (at T&O induction).<br>• Re-audit in six months time once above actions implemented |
| 12. A re-audit of the prevalence of overweight and obesity amongst the local paediatric diabetes population | • Develop resources which are designed specifically to support overweight and obesity patients.<br>• To include prescriptive kilocalorie counting diets and portion sizes in the resources.<br>• Use alternative and more modern methods to communicate with diabetes patients, which better suit their needs.<br>• To make appointments outside of school and parents working hours.<br>• Increasing the use of e-mail to communicate with families about dietary intake.<br>• To improve communication and awareness of local community run exercise and activity programmes that are accessible to the children and young people.<br>• To look at an obesity strategy and resource that links UHS with community activities.<br>• To be part of the Southampton City strategy board for the healthy weight campaign.<br>• To ensure all the diabetes team continue to discuss growth charts and targets with patients and their families in clinic.<br>• To describe in all written communication with parents their child's weight status and their target.<br>• To consider adding nutritional requirements at the top or bottom of each dietetic report given to all patients as standard. Explaining recommended daily grams of carbohydrate and sugar.<br>• To change the written information given to newly diagnosed diabetes patients to have more emphasis on healthy diets and bodyweight.<br>• To keep a record of prevalence of diabulaemia on the database. |
| 13. Perineal repair guideline – patient information leaflet audit | • To use 'Theme of the week' to remind staff to record in the case notes when they have given the perineal repair leaflet to a woman. |
| 14. A re-audit to assess the use of a cough assessment framework in neuromuscular patients admitted with respiratory problems. | • To keep the cough assessment form in ward folders to allow quick and easy access.<br>• Repeat teaching sessions to all teams.<br>• Re-launch interest across all divisions.<br>• To complete a re-audit. |

| Audit title | Actions |
|---|---|
| 15. Children and young people diagnosed with Type I diabetes who are carbohydrate counting at level 3 | • To aim for 100% carbohydrate counting at re-audit in 2018.<br>• To review patients identified as not carbohydrate counting and aim to establish them carbohydrate counting with appropriate support.<br>• To continue to introduce carbohydrate counting at diagnosis.<br>• To carry out another audit in the 2017 audit cycle looking at carbohydrate counting at diagnosis and HbA1c six months on.<br>• To work with the rest of the diabetes team to develop a strategy.<br>• To consider and recognise at the time of diagnosis which patients and families may find carbohydrate counting challenging.<br>• For patients and families who need additional support a home visit or school visit may be required. |
| 16. Audit of GICU & CICU Metavision Recording of Enteral Feeds August 2016 | • To document the times the feed is paused by pausing the infusion line on metavision. |
| 17. A re-audit of patient experience of empathy in clinical encounters with therapy staff during admission to trauma & orthopaedic wards | • To ensure the feedback relates specifically to therapists the word 'Therapy' to be made clearer on the questionnaire.<br>• An alternative version to be considered in order to include those with learning difficulties or cognitive impairments. Similarly, to enable those with communication difficulties to complete the questionnaire independently, a tablet/touch screen version could be used. |
| 18. Is our hand trauma service hitting the British Society for Surgery of the Hand (BSSH) 2007 standards? | • To develop guideline criteria with the hand consultants for access to the hand clinic.<br>• To develop and undertake an education programme to ED clinicians to ensure full implementation.<br>• To discuss with consultants the development and implementation of a teaching programme for the trauma consultant teams.<br>• To develop guideline criteria with the hand consultants for access to the hand clinic to ensure the most appropriate patients are seen by the right team.<br>• To develop a specific pathway for priority patients from ED assessment to definitive surgery. |
| 19. Audit of patient medical notes where the DNACPR audit form recorded that there was no discussion with the patient | • To educate the medical staff on the need to document in patient's medical notes the reasons DNACPR decisions are not communicated to patients.<br>• To be added to the resuscitation training for medical staff. |
| 20. Developmental dysplasia of hips (DDH) - risk factors - timeliness of intervention | • Guideline to be reviewed and republished, ensuring the referral criteria is clear.<br>• Risks register entry (2113) to be update to reflect the timeliness aspect of the PHE criteria.<br>• Audit to be discussed with the DGM and CE lead for child health.<br>• Trust Screening Lead to be made aware of the current non-compliance.<br>• To inform the DCD of the current non-compliance.<br>• Continue to audit to include quarter one, two and three. |
| 21. Anticoagulation after hip or knee surgery in patients on long-term anticoagulation | • Presentation of results at T&O Care Group, M&M & Audits Meeting.<br>• Informing the T&O Consultants and Registrars who were not present at the meeting about the results of the audit and about the necessity to document Anticoagulation plans in the operation notes accurately. |
| 22. Documentation of post take ward round in trauma orthopaedics | • Suggest implementing a set format for post take ward round documentation. |
| 23. Comparison of traditional Norwood procedure and its Sano modification: outcome and indication | • Results of our experience to be discussed between paediatric cardiac surgeons, PICU and cardiologist consultants.<br>• To agree whether to continue with Norwood and Sano modification during stage one, moving the conduit shunt to the right pulmonary artery. |
| 24. An audit on handover practice in oncology | • To create a handover checklist poster.<br>• To create signs on door during handover to minimise distraction during handover, remind other HCP not to interrupt.<br>• To create a permanent bleep for the second twilight SHO on-call.<br>• To create a clear structure for handover including a clear triage system for sick patients.<br>• To put an up-to-date on-call rota in all handover rooms.<br>• To standardise criteria for handing patients over on weekend.<br>• To specify roles of job during on-calls.<br>• To schedule allocated time for handover- normal days and pre-weekend.<br>• To create a job folder for writing routine jobs done and ensure job book available on each ward for nurses to complete.<br>• Identifying SpR/SHO on-call for the day and create a briefing for every morning.<br>• WhatsApp group for easier communication if running late/unable to attend handover.<br>• To ensure adequate training for new staff to manage common emergencies in the department. |

| Audit title | Actions |
|---|---|
| 25. Re-offer of virology screening (antenatal screening) | • Further communication with midwifery staff by newsletter. |
| 26.Intermittent auscultation (IA) audit | • To feedback and educate through the education team regarding documentation of the presence of accelerations and absence of decelerations for both low risk women and women transferred to continuous fetal monitoring.<br>• To feedback and educate through the education team regarding documentation of the reason for transfer to continuous fetal monitoring.<br>• To feedback and educate through the education team regarding undertaking and documenting the maternal pulse as per the guidance.<br>• To remove from the Care Group Risk Register entry (1624) as improved compliance.<br>• Discuss with the consultant Midwives the options and benefits for a 'fresh ears' approach with intermittent auscultation. |
| 27. MEOWS audit | • To add MEOWs activation hotline ext. bleeps for the Coordinator and SHO on handover sheet.<br>• For the Theme of the week, to add education on MEOWs activation scores. |
| 28. Shoulder dystocia re-audit | • To encourage use and completion of shoulder dystocia proforma in paper notes by raising awareness among multidisciplinary team, via: presenting audit at MDT meeting, PROMPT course, and theme of the week.<br>• To promote use of checklist for babies with suspected brachial plexus Injury at PROMPT course.<br>• To raise awareness of entering babies with brachial plexus injury or upper limb fracture details on HICSS or SEND at PROMPT course. |
| 29.High dependency care audit | • To promote documentation standards for admission and discharge on Theme of the Week.<br>• To review guideline.<br>• Ongoing education to be completed during HDU study days. |
| 30. Complications from Botox in squint | • To ensure patients having Botulinum Toxin follow-up within six weeks to ensure measurements are taken at time of maximum efficiency.<br>• To make an improvement to EMG machine to enable greater accuracy with injection.<br>• To continue to record the results of future injections to see if any alterations in practice reduce complication rate and improve success rate.<br>• To maintain the recent increase in number of clinics to meet the demand of patients requiring treatment. |
| 31. Retinal detachment audit | • Audit to be repeated every three months to ensure fellows are adequately monitored and to guide clinical supervision. |
| 32.Outcomes of DCR surgery at UHS | • To discuss audit outcomes with managers to increase theatre capacity. |
| 33. Audit to review DNACPR sheet within patients medical notes to review if signed by consultant | • To reiteration the need for DNACPR forms to be verified by consultants within 48 hours.<br>• To complete spot-checks of DNACPR forms on matron walkabouts. |
| 34. Re-audit of the documentation of critical care rehabilitation for those patients admitted to general intensive care | • Investigate the potential to fund a rehab coordinator post (Job description has been written, awaiting funding).<br>• To develop current information pack (ICU Steps) given to patients on ICU admission to include details about rehab pathway.<br>• To include information regarding potential discharges from the unit in the daily therapist handover meeting.<br>• To include information to review patients prior to discharge will now be in the daily therapist handover meeting.<br>• To develop information pack to give to patients on discharge from GICU in order to provide information to patients and with contact details for follow up clinics.<br>• Reminders to complete CPAx and Barthel scores to be included in the daily therapist handover meeting.<br>• Reminders to review goals to be included in the daily therapist handover meeting. |
| 35. Broken down perineum - The rate and causes of cases where women return to the Maternity Assessment Unit with complications with perineal wound healing | • To raise awareness of the information to be given to patients about PR checking before and after suturing.<br>• To be a Theme of the week. |
| 36. MUST & Food Chart Audit in trauma and orthopaedics | • To arrange a meeting to discuss training needs that need to be implemented from the audit findings. |
| 37. AMU handover/safety audit | • To discuss with CE lead to break down the work list to Elderly care and AMU patients.<br>• To present audit report in AMU teaching and Governance meeting. |

| Audit title | Actions |
|---|---|
| 38. Completion of recommended onward referrals following diagnosis of a permanent childhood hearing impairment (PCHI) | • To report audit findings at the next paediatric meeting on 16th December 2016. |
| 39. Documentation reliability of transthoracic echocardiography in diagnosing morphology of bicuspid aortic valve disease | • To contact HICCS to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for those undergoing aortic surgery.<br>• To contact the department in charge of developing the echo reporting software to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for all echo reports. |
| 40. Management of low Hb on Neuro-intensive Care Unit (ICU) | • To increase awareness of new guidelines within the multidisciplinary teaching.<br>• To update online Neuro ICU guidelines. |
| 41. Giant cell arteritis audit | • To ensure that all patients that have CXR are treated with aspirin (where no contraindication). |
| 42. An audit of speech & language therapy (SLT) and ward compliance with the oropharyngeal dysphagia policy on acute paediatric wards | • To feedback the audit results to the SLT team.<br>• To circulate the report to ward leaders/matrons/division leads via email.<br>• To meet with ward managers and matrons of the respective ward areas to share audit data and together create an action plan for improvement.<br>• To feedback audit results to relevant trust forums/meetings i.e. NMG<br>• To provide training to wards as appropriate.<br>• To provide extra bed-signs to areas that requires them. |
| 43. Completion of peripheral cannula care record | • To reiterate to all medical/nursing staff the need to record insertion date, VIPS scores and removal dates.<br>• To ensure all medical/nursing staff to include reason if cannula has been in situ for more than 72 hours.<br>• To reinforce the above actions to medical staff via email.<br>• To reinforce the above actions to nursing staff via band 7 meeting.<br>• To ensure all nursing staff (via band 7s) are asked to continue to submit AERS for forms not initiated/ completed. |
| 44. Audit of completeness and accuracy of genotyping results in adult cystic fibrosis (CF) | • To add section to annual review to check whether genotype result has been seen. If not available to request result from genetics department or retest.<br>• CF consultant to check all patients genotype at annual review and send extended genotyping where indicated.<br>• The patient registry data to be updated with results available from extended Genotyping. |
| 45. Developmental dysplasia of hips (DDH) - risk factors - timeliness of intervention re-audit | • To communication with the PSC to reiterate appointments should be booked within six weeks of age. |
| 46. Essence of care - promoting health and wellbeing audit | **Intensive care actions**<br>• To change the doctor's documentation on CIS to include health risk factors.<br>• CAM score (to evaluate patients agitation) to be introduced through a focused education programme in CICU.<br>• To use NICU Agitation - Sedation escalation tool using Richmond Agitation Sedation score (RASS) - continuous education and training to all staff.<br>• Sleep assessment documentation to be placed on CIS.<br>• To commence a sleep project to reduce noise at night.<br>• To purchase an audiometer for the unit to assess noise at night. |
| 47. Trust-wide record keeping audit including ED | • To distribute audit results to all clinicians and governance teams at UHS.<br>• To educate clinicians and new doctors on the importance of detail about timing and ability to identify clinicians involved with patients.<br>• Consultants to ensure they educate all members of clinical team when reviewing notes, and also to ensure their trainees documentation is up to standard.<br>• Top tips for doctor to ensure they document allergy status.<br>• Awareness for consultant to check the junior doctors are documenting allergy status. |

| Audit title | Actions |
|---|---|
| 48. Essence of care bowel bladder and continence audit | **Actions from surgical wards**<br>• Share findings and results of audit with Senior Nursing Team on surgical ward areas.<br>• To continue with education to new staff and current staff re: completion of patient elimination assessments for both bowel and bladder.<br>• To meet with Ward Leader on ASU/ASA and F5 to educate nursing staff on completion of elimination assessments.<br>• To work with Nursing leads in bowel and bladder care to produce new Trust guidelines and to continue to scope compliance against care plans for both bowel and bladder assessments.<br>• To work with nursing teams to educate them to complete care plans for catheter removal.<br>• To confirm that all surgical wards have hand wipes available for patient use.<br>**Actions from critical care**<br>• To add a separate form to the nursing task for flexiseal observations to make it more accessible to document care actions.<br>• Bedside flexiseal training sessions to be provided on GICU by the company representative.<br>• CICU will get the flexiseal company representative to provide updates and training.<br>• To produce new "Do Not Enter" signs.<br>• Prompts to be made via email / Hawkeye and forums to increase compliance of the "Do Not Enter" signs use during patient care.<br>• Staff nurse on GICU to liaise with Trust lead nurse specialist for infection prevention to investigate implementing a nurse–led protocol for Trial With-Out Cather (TWOC) specific for critical care.<br>• To increase education on documentation of care plans for urinary care and the TWOC flow chart for the Trust.<br>• To ensure nurses refer to Tissue Viability service (TVS) when skin damage is identified and ensure correct care plan is in place.<br>• Educate staff on correct monitoring treatment and documentation of skin damage.<br>**Actions from elderly and acute medicine wards**<br>• Privacy signs to be attached to all curtains during toileting patients at bedside.<br>• To ensure all curtains are well fitted.<br>• Staff to leave patients alone whilst going to the toilet as long as it is clinically safe to do so.<br>• All patients to be given a call bell when they are left alone whilst toileting.<br>• All patients to be offered to be taken to the toilet rather than using the commode / bedpan as long it is clinically safe to do so.<br>• All staff to be reminded of and educated in the importance of giving patients a choice.<br>• To ensure patients are offered the facility to clean their hands before and after going to the toilet.<br>• To ensure all patients are appropriately referred to community continence services prior to discharge and information to be made available to these patients.<br>• To ensure nursing staff record an accurate plan of care for bowel, bladder and continence that should be discussed with the patient and evaluated and updated as necessary.<br>• To ensure all patients with a catheter to receive appropriate catheter care and for this to be documented regularly and clearly. |
| 49. Saving Lives HII 1 Central Venous Catheter Care | • All care group managers / care group clinical leads to support the clinical teams, follow up on actions and monitor those areas with sub optimal performance.<br>• Care group managers / care group clinical leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme. |
| 50. Saving Lives HII 2 Peripheral Intravenous Cannula Care | • All care group managers / care group clinical leads to support the clinical teams, follow up on actions and monitor those areas with sub optimal performance.<br>• Care group managers / care group clinical leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme. |
| 51. Saving Lives HII 3 Renal Dialysis Catheter Car | • Divisions and care groups to review and discuss this report with areas taking action in order to address those areas with sub optimal performance. |
| 52. Saving Lives HII 5 Ventilated Patients | • Produce action plan to address non compliance (Emergency Medicine Respiratory High Dependency Unit) and provide evidence of implementation<br>• To re-audit within one month ensuring compliance addressed through action plan. |

| Audit title | Actions |
|---|---|
| 53.Saving Lives HII 6 Urinary Catheter Care | • 13 areas that scored below 85% to produce an action plan to address non compliance and provide evidence of implementation.<br>• To refer to training areas that scored low on compliance with Non Touch technique.<br>• To re-audit within one month ensuring compliance addressed through action plan. |
| 54. Saving Lives HII 8 Cleaning and decontamination | • CICU and D8 to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance is addressed through action plan. |
| 55.Multi Professional Hand Hygiene Audit – IN Patient Areas | • Divisions and care groups to review and discuss this report with clinical teams.<br>• Areas to take action in order to address those areas with sub-optimal performance.<br>• A review by all care group managers / care group clinical leads is required to ensure that all teams required to submit audits do so as per the infection prevention annual audit programme.<br>• Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance.<br>• Action plans and notification of re-audit submissions should be emailed to infection prevention team. |
| 56. Hand washing facilities | • Areas to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance addressed through action plan. |
| 57. Environmental audits kitchen | • CMH and Endoscopy to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance addressed through action plan. |
| 58. Environmental audits linen | • Audiology to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance addressed through action plan. |
| 59.Isolation audit | • AMU and paediatrics medical unit G2 to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance addressed through action plan<br>• Care group managers / care group clinical leads are required to support the clinical teams, follow up on actions and monitor those areas with sub optimal performance.<br>• A review by care group managers / care group clinical leads is required to ensure that all medical teams are required to submit audits do so as per the infection prevention annual audit programme.<br>• Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance. |
| 60. Standard precautions audit | • C7 haematology day unit, pulmonary function and complete Fertility to produce an action plan to address issues and send to infection prevention team for monitoring.<br>• To re-audit within one month ensuring compliance addressed through action plan. |
| 61. Auditing ward compliance with the UHS oropharyngeal dysphagia policy on adult wards | • To feedback findings to speech and language team.<br>• To circulate report to ward leads / matrons / divisional leads, etc, via email.<br>• Areas to be encouraged to complete audit as it is difficult to feed back to specific wards due to small sample size.<br>• Managers from areas of concern to be provided with verbal / written feedback.<br>• Audit findings to be discussed at the Catering Operational meeting. |
| 62. Use of chaperones when examining or carrying out intimate cares on children or young people (aged 0-18yrs) in both inpatient and outpatient settings | • To review and update the policy to ensure:<br>  • There is clarity of terms 'formal' and 'informal' chaperone.<br>  • What documentation is required to be completed and when.<br>  • How to report the inappropriate use of a chaperone. |
| 63. To look at the effectiveness of the new portable CT scanner | • To encourage use of the portable CT scanner.<br>• To increase the number of staff who can use the portable scanner. |

| Audit title | Actions |
|---|---|
| 64. An audit of record keeping of strong potassium products in both designated critical and non-critical care areas. | • To discuss whether CCU needs a potassium record book for their own area or if it's acceptable that they use CHDU book.<br>• Cardiac pharmacy team to investigate and discuss with ward manager about keeping appropriate records up to date.<br>• Critical care pharmacist to investigate and discuss with ward manager about keeping appropriate complete records of pre-filled syringes.<br>• Critical care pharmacist to investigate and discuss with ward manager about keeping records up to date on pre-filled syringes and 20% injection.<br>• To consider blue and pink side having a record book each.<br>• Ward pharmacist to investigate and discuss with the ward manager about the missing Piam Brown record book.<br>• Ward pharmacist to investigate and discuss with ward manager about the missing Gynae Theatre record book.<br>• To raise awareness and re-education of the supply and administration requirements of strong potassium products to non-designated critical care areas.<br>• To address the pharmacy involvement around supply and record keeping.<br>• To re-iterate the requirements of the policy that need to be adhered to with regards to administration records. |
| 65. Pharmacy compliance with UHS Controlled Drugs Policy | • To review Pharmacy CD policy.<br>• To review frequency of RSH CD stock checks.<br>• To develop a more efficient way of ordering stock CDs at RSH.<br>• Need to improve specific processes within the dispensary before the next audit. |
| 66. Wessex N.I.C.E (neuro-intensive care emergencies) course simulation-based training | • To run course over two afternoons per month, instead of one whole day. |
| 67. Noise levels in neuro-intensive care | • Source new noise monitors and re-audit.<br>• To discuss results with GICU staff.<br>• To re-audit more widely during both day and night time. |
| 68. Audit to evaluate current practice on Ritaximals infusion by ensuring pre treatment screening is completed before infusion. | • To improve lg check by ensuring staff are aware of completing the check before rituximab is given, as below standard of 60%. |

# Appendix six: Outcome measures data

## Adjusted health gain

| | Reporting Period | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Apr 2015 - Mar 2016 (Provisional, published Feb 17) | | Apr 2014 - Mar 2015 (Final, published Aug 16) | | Apr 2013 - Mar 2014 (Published Aug 15) | | Apr 2012 - Mar 2013 (Published Aug 14) | |
| | UHS | Eng. Ave. | UHS | Eng. Ave. | UHS | Eng. Ave. | UHS | Eng. Ave. |
| Hips | 20.829 | 21.617 | 21.199 | 21.443 | 21.671 | 21.380 | 20.707 | 21.299 |
| Knees | 15.037 | 16.368 | 15.721 | 16.116 | 14.975 | 16.273 | 15.448 | 15.996 |

## Participation rates

| | Reporting Period | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Apr 2015 - Mar 2016 (Provisional, published Feb 17) | | Apr 2014 - Mar 2015 (Final, published Aug 16) | | Apr 2013 - Mar 2014 (Published Aug 15) | | Apr 2012 - Mar 2013 (Published Aug 14) | |
| | UHS | Eng. Ave. | UHS | Eng. Ave. | UHS | Eng. Ave. | UHS | Eng. Ave. |
| Overall | 89.5% | 74.9% | 86.4% | 75.6% | 82.4% | 77.2% | 70.1% | 75.5% |
| Knees | 86.7% | 86.2% | 74.1% | 85.8% | 68.4% | 87.0% | 55.6% | 83.2% |
| Knees | 103.9% | 96.0% | 105.9%* | 95.0% | 107.0%* | 95.0% | 104.0%* | 90.4% |

# Appendix seven: Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care and encourages care services to improve.

Registration with the Care Quality Commission: UHS is required to register with the Care Quality Commission and its current registration status for locations and services is as below.

Regulated activity: Surgical procedures
Provider conditions: This regulated activity may only be carried on at the following locations:
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Treatment of disease, disorder or injury
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Maternity and midwifery services
Provider conditions: This regulated activity may only be carried on at the following locations:
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA

Regulated activity: Diagnostic and screening services
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD
- New Forest Birth Centre, Ashurst Hospital, Lyndhurst Road, Ashurst, Southampton, SO40 7AR

Regulated activity: Transport services, triage and medical advice provided remotely
Provider conditions: This regulated activity may only be carried on at the following locations:
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act
Provider conditions: This regulated activity may only be carried on at the following locations:
- Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
- Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
- Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

UHS has no conditions on registration and the Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2014-2017

# Appendix eight: Overview of performance - pulse KPIs

| | Page | Ref. | KPI | Target | Target source | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Safe | 5 | 1.1.4 | Clostridium Difficile Reduction (confirmed lapse in care | <=4 | National | 4 | 3 | 2 | 4 | 4 | 1 | 2 | 3 | 2 | 3 | 6 | 3 | 5 |
| | 5 | 1.1.2 | MRSA Bacteraemia Reduction | 0 | National | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| | 5 | 1.1.1 | Never Events | 0 | National | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 |
| | 5 | 1.1.7 | SIRIs (month in arrears) | <=2 | Internal | 5 | 5 | 3 | 2 | 4 | 8 | 3 | 1 | 2 | 7 | 7 | 7 | N/A |
| | 5 | 1.1.13 | Safety Express Thermometer | =>95.0% | Internal | 98% | 98% | 98% | 97% | 98% | 98% | 98% | 98% | 96% | 96% | 98% | 95% | 98% |
| | 6 | Focus: | Quarterly Patient Safety Report (Pages 6 - 9) | Notes: | None | | | | | | | | | | | | | |
| 2. Effecive | 10 | 2.1.8 | Rolling 12-Month HSMR - UHS (reported 3 months in arrears) | <100 | Internal | 100.78 | 103.4 | 103.94 | 103.85 | 103.14 | 103.62 | 103.48 | 104.29 | 104.37 | 104.43 | N/A | N/A | N/A |
| | 10 | 2.1.9 | Rolling 12-Month HSMR - SGH (reported 3 months in arrears) | <100 | Internal | 91.85 | 94.76 | 95.45 | 95.4 | 95.10 | 95.89 | 95.42 | 96.47 | 96.78 | 96.69 | N/A | N/A | N/A |
| | 10 | 2.1.4 | Readmissions (month in arrears) | =<10% | National | 10.2% | 10.1% | 10.3% | 10.7% | 10.7% | 10.6% | 10.7% | 10.6% | 11.1% | 11.5% | 9.6% | 10.7% | N/A |
| | N/A | Focus: | None this month | Notes: | None | | | | | | | | | | | | | |
| 3. Caring | 11 | 3.1.2 | FFT Negative Score - Inpatients | <5% | National | 0.86% | 1.09% | 0.95% | 1.24% | 1.11% | 1.33% | 1.27% | 0.83% | 0.66% | 0.78% | 0.73% | 0.84% | 1.16% |
| | 11 | 3.1.4 | FFT Negative Score - ED | <5% | National | 3.16% | 2.06% | 7.83% | 1.97% | 2.00% | 1.44% | 2.50% | 2.55% | 1.84% | 3.18% | 0.56% | 3.00% | 1.79% |
| | 11 | 3.1.6 | FFT Negative Score - Maternity | <5% | National | 0.77% | 0.00% | 0.00% | 0.00% | 0.00% | 0.22% | 0.60% | 0.60% | 0.45% | 0.00% | 0.43% | 0.47% | 0.20% |
| | 11 | 3.1.10 | Complaints Received | N/A | N/A | 43 | 32 | 30 | 45 | 38 | 36 | 29 | 44 | 50 | 47 | 31 | 37 | 32 |
| | 11 | 3.1.9 | Nutrition | >=95% | National | 81.90% | 83.50% | 83.33% | 73.79% | 78.81% | 85.64% | 79.31% | 89.13% | 87.50% | 82.95% | 73.95% | 76.98% | 80.32% |
| | N/A | Focus: | None this month | Notes: | None | | | | | | | | | | | | | |

| | Page | Ref. | KPI | Target | Target source | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4. Responsive | 12 | N/A | Rolling 12-Month Total Inpatients (Elective, Non-Elective & Day Case combined) | N/A | N/A | 146,066 | 146,630 | 146,949 | 147,651 | 147,876 | 149,255 | 149,572 | 150,218 | 151,373 | 151,402 | 152,928 | 153,820 | 155,737 |
| | 12 | N/A | Rolling 12-Month Total Outpatients (New & Follow-up combined) | N/A | N/A | 562,972 | 564,966 | 571,010 | 570,297 | 568,265 | 575,372 | 576,910 | 578,888 | 584,044 | 584,569 | 587,197 | 587,153 | 595,272 |
| | 12 | N/A | Rolling 12-Month Total ED Attendances (All types combined) | N/A | N/A | 113,569 | 113,992 | 114,395 | 114,416 | 115,738 | 115,378 | 116,841 | 117,419 | 117,719 | 118,302 | 118,563 | 117,810 | 117,869 |
| | 13 | 4.1.3 | A&E: % patients spending less than 4 hours in ED (Type 1) | =>95.0% | National | 85.2% | 85.5% | 91.4% | 92.9% | 91.2% | 93.6% | 93.1% | 86.9% | 83.8% | 84.9% | 82.1% | 79.2% | 88.3% |
| | 13 | 4.1.8 | A&E: % patients spending less than 4 hours in ED (Types 1, 2 & 3) | =>95.0% | National | 87.5% | 87.8% | 92.7% | 94.0% | 92.5% | 94.6% | 94.1% | 88.8% | 85.9% | 86.9% | 84.4% | 82.1% | 89.7% |
| | 14 | 4.2.1 | RTT: % Incomplete Pathways Within 18 Weeks in Month | | National | 92.26% | 92.61% | 92.51% | 92.14% | 92.09% | 92.01% | 92.02% | 92.07% | 92.10% | 90.65% | 91.37% | 92.00% | N/A |
| | 14 | 4.2.5 | RTT: Total Patients in Backlog | <1200 | Internal | 2,040 | 2,015 | 2,058 | 2,143 | 2,186 | 2,207 | 2,143 | 2,171 | 2,143 | 2,501 | 2,326 | 2,171 | N/A |
| | 15 | 4.3.1 | Cancer: Urgent GP referrals seen in 2 weeks (month in arrears) | =>93.0% | National | 96.5% | 95.5% | 96.9% | 86.9% | 96.0% | 93.6% | 96.0% | 97.0% | 95.6% | 89.4% | 94.2% | 94.0% | N/A |
| | 15 | 4.3.3 | Cancer: Treatment started within 62 days of urgent GP referral (month in arrears) | =>85.0% | National | 89.8% | 89.0% | 87.5% | 87.2% | 87.6% | 85.5% | 82.3% | 83.6% | 75.6% | 83.0% | 75.7% | 75.5% | N/A |
| | 16 | 4.5.2 | Complex Discharge Census (monthly average) | <=75 | Local | 120.8 | 119.2 | 137.6 | 130.0 | 138.1 | 118.5 | 141.8 | 135.29 | 149.6 | 140 | 123.9 | 116.5 | 115.8 |
| | 16 | 4.5.6 | Red Alerts (monthly total) | N/A | N/A | 40 | 38 | 6 | 12 | 25 | 6 | 28 | 48 | 46 | 28 | 54 | 56 | 24 |
| | 16 | 4.5.7 | Black Alerts (monthly total) | N/A | N/A | 2 | 4 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 3 | 0 | 0 |
| | 16 | 4.5.9 | % Elective Operations Cancelled at the Last Minute | <=1.0% | Local | 1.19% | 1.16% | 1.15% | 1.17% | 1.83% | 0.69% | 1.33% | 1.88% | 1.59% | 1.35% | 1.61% | 1.56% | 1.14% |
| | N/A | Focus: | None this month | Notes: | None | | | | | | | | | | | | | |

| | Page | Ref. | KPI | Target | Target source | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | Mar 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5. Well-led | 17 | 5.1.6 | Staff FFT - % of Staff Likely or Extremely Likely to Recommend UHS as a Place to Work | =>76% | Internal | 76% | 76% | | | 76% | | | "N/A - Trust completes National Staff Survey instead" | | | 77% | | |
| | 17 | 5.1.1 | Turnover - Rolling 12-months | <=10.00% | Internal | 13.56% | 13.54% | 13.36% | 13.20% | 13.71% | 13.24% | 12.87% | 13.36% | 12.93% | 12.92% | 12.78% | 12.65% | 12.87% |
| | 17 | 5.1.2 | Sickness Absence - Rolling 12-months | <=3.00% | Internal | 3.41% | 3.40% | 3.40% | 3.29% | 3.42% | 3.41% | 3.42% | 3.43% | 3.47% | 3.51% | 3.55% | 3.54% | 3.52% |
| | 17 | 5.1.4 | Nursing Vacancies | <=8.00% | Internal | 12.2% | 12.2% | 15.0% | 15.0% | 15.8% | 16.5% | 13.2% | 13.2% | 12.40% | 13.2% | 13.0% | 12.9% | 12.8% |
| | 19 | 5.3.3 | NiHR Patients Recruited | Variable | Internal | 1,853 | 1,318 | 1,824 | 1,808 | 1,479 | 1,313 | 1,328 | 2,039 | 2,094 | 1,422 | 1,634 | 1,431 | 1,198 |
| | 20-23 | Focus: | Ward Staffing Report (+ detailed analysis in Appendix 1) | Notes: | None | | | | | | | | | | | | | |
| 6. Productive | 24 | 6.1.1 | Clinical Income (£000s) | Variable | Internal | 51,557 | 50,958 | 51,711 | 53,495 | 57,039 | 49,799 | 53,779 | 55,709 | 54,771 | 54,687 | 54,854 | 53,509 | 59,756 |
| | 24 | 6.1.4 | Operating Expenses (£000s) | Variable | Internal | 61,142 | 56,291 | 57,667 | 56,389 | 58,984 | 57,720 | 57,458 | 59,744 | 59,803 | 59,206 | 58,918 | 60,294 | 63,660 |
| | 24 | 6.1.5 | EBITDA (£000) pre-donations | Variable | Internal | 1,204 | 2,153 | 1,850 | 7,690 | 14,092 | 2,024 | 4,446 | 4,912 | 3,391 | 3,769 | 5,038 | 2,561 | 6,946 |
| | 24 | 6.1.11 | Financial Sustainability Risk Rating (CoSRR to July 2015) | Variable | Internal | 2 | 3 | 3 | 3 | 3 | 3 | 3 | N/A | N/A | N/A | N/A | N/A | N/A |
| | 24 | 6.1.18 | CIP Delivered (£000s) - Cumulative YTD (For 16/17 this is in-month) | Variable | Internal | 3,112 | 549 | 823 | 2,734 | 1,194 | 1,799 | 2,949 | 1,695 | 3,089 | 2,753 | 2,702 | 2,290 | 4,222 |
| | 24 | 6.1.19 | Cash (£000s) | Variable | Internal | 21,856 | 18,061 | 20,112 | 17,607 | 15,586 | 21,266 | 16,737 | 15,487 | 21,592 | 18,974 | 22,154 | 25,260 | 34,254 |
| | N/A | Focus: | Full detail of financial performance can be found in the separate Finance Report. | Notes: | None | | | | | | | | | | | | | |

# Appendix nine: Glossary of acronyms

## Glossary of acronyms

| | |
|---|---|
| ACS | Acute coronary syndrome |
| AF | Atrial fibrillation |
| AMU | Acute medical admissions unit |
| APACHE | Acute physiology and chronic health evaluation |
| ASU | Acute assessment unit |
| BMI | Body mass index |
| CHD | Coronary heart disease |
| CNS | Clinical nurse specialist |
| CQC | Care Quality Commission |
| CQUIN | Commission Quality and Innovation Payment Framework |
| DIPJ | Distal interphalangeal joint |
| DNA | Did not attend |
| ED | Emergency department |
| EDD | Estimated date of discharge |
| EDI | Equality, diversity and inclusion committee |
| EIN | Ethnicity inclusive network |
| FSRR | Financial Sustainability Risk Rating |
| GICU | General intensive care unit |
| HPCT | Hospital palliative care team |
| HSMR | Hospital Standardised Mortality Rate |
| IMEG | Internal medical examiners group |
| INR | International normalised ratio |
| KPI | Key performance indicator |
| LGBT | Lesbian, gay, bisexual and transgender network |
| LID | Long-term illness and disability network |
| LoS | Length of stay |
| MDT | Multidisciplinary team |
| MIU | Minor injuries unit |
| MTC | Mealtime coordinator |
| MUST | Malnutrition Universal Screening Tool |
| NHS | National Health Service |
| NHSE | NHS England |
| NICE | National Institute for Health and Care Excellence |
| NIHR | National Institute for Health Research |
| OMFS | Oral and maxillofacial surgery |
| PCI | Percutaneous coronary intervention |
| PIF | Patient Improvement Framework |
| PSAG | Patient status at a glance |
| PTFU | Patient triggered follow up |
| RTT | Referral to Treatment |
| SFBN | Staff faith and belief network |
| SHC | Southampton Hospital Charity |
| SHDU | Surgical high dependency unit |
| SHMI | Summary Hospital-level Mortality Indicator |
| SHO | Senior house officers |
| SLT | Sentinel stroke programme |
| SPPOST | Southampton physiotherapy post-operative screening tool |
| SSP | Speech and language therapist |
| TEC | Trust executive committee |
| UHS | University Hospital Southampton |
| WPAI | Work productivity and activity impairment |
| WRES | Workforce Race Equality Standard |

Published June 2017.